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FOR IMMEDIATE RELEASE

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CLINTON ADMINISTRATION RELEASES GRANTS TO FIGHT FRAUD AND ABUSE

The Clinton Administration today awarded more than \$2.25 million in grants for new programs to complement Medicare's ongoing anti-fraud efforts.

The grants are funded by a special account created by the Health Insurance Portability and Accountability Act (HIPAA), signed into law last August by President Clinton. Today's announcement comes on the one-year anniversary of this groundbreaking legislation, which, for the first time, created a stable source of funding for fraud control activities.

Among the grants announced today are "Health Care Fraud and Abuse Control Grants" totaling more than \$1.5 million which will be administered by the Department of Health and Human Services' Health Care Financing Administration (HCFA), the HHS Inspector General and the Department of Justice (DoJ). The grants are being distributed to nine state agencies, the District of Columbia, the Department of Defense, and the Internal Revenue Service. They will cover the cost of audits, inspections, equipment, provider evaluations, investigations, prosecutions and consumer education.

HHS' Administration on Aging (AoA) also announced an additional 15 anti-fraud grants totaling \$750,000, which will be administered through state offices on aging. The grants will help expand the department's highly successful "Operation Restore Trust" health care anti-waste, fraud, and abuse program, launched in 1995 as a five-state pilot project. Currently, Operation Restore Trust is identifying \$23 in waste, fraud, and abuse for every \$1 invested, and is being expanded to 12 new states.

"These grants will bring new tools and new people into the front lines of our fight against health care fraud and abuse," said HHS Secretary Donna E. Shalala. "The fight against Medicare fraud and abuse is a joint effort. It requires federal, state and local officials working together. We must continue to identify existing problems, take action against those who violate the law, and work with Congress to close loopholes and stiffen laws and penalties."

"Money spent to fight fraud and abuse is money well spent, as our ongoing anti-fraud efforts clearly show that returns far exceed expenditures," said Bruce C. Vladeck, Administrator of the Health Care Financing Administration which runs Medicare. Besides Operation Restore Trust's 23-to-1 return, the Medicare Integrity program is saving \$14 for every \$1 spent by making sure Medicare payments are appropriate, noted Vladeck.

"These projects represent a significant expansion of our ongoing battle against waste, fraud and abuse, and they make the most of our vast network of state and tribal agencies, ombudsman programs, and community-based service providers," said Acting Principal Deputy Assistant Secretary for Aging William F. Benson. "It is these people on the front lines who are key to stopping fraud and abuse in its tracks."

The Health Insurance Portability and Accountability Act (HIPAA) established the Health Care Fraud and Abuse Control Account, a key proposal of the Clinton Administration, to which money is deposited

annually from the Medicare Part A Trust Fund to help finance expanded fraud and abuse control activities. The additional funding, \$104 million in FY 1997 and nearly \$120 million in FY 1998, will fund the activities of the HHS Inspector General, the Department of Justice and others to coordinate federal, state and local health care law enforcement programs; conduct investigations, audits, evaluations and inspections relating to the delivery and payment of health care; help facilitate enforcement of civil, criminal and administrative statutes on health care fraud and abuse; provide guidance to the health care industry on fraudulent health care practices; and establish a national data bank to receive and report final adverse actions against health care providers.

"These grants are another clear warning to dishonest health care providers that, under the Clinton Administration, government agencies are cooperating as never before to eliminate fraud and abuse," said Inspector General June Gibbs Brown.

The Health Care Fraud and Abuse Control Program grants announced today are awarded to:

- **California and New York Offices of Attorneys General: \$300,000** These states are sharing this grant and together will develop an automated system for managing health care fraud investigations and prosecutions. California's case management system software will serve as a starting point and be adapted for "beginning to end" oversight of all activities involved in complaint registration, investigation, audit, and prosecution.
- **Alabama Office of Attorney General: \$232,700** The grant will help train investigators to do computer search and seizures and use other modern techniques for health care fraud prosecution, replace obsolete equipment in the Medicaid Fraud Control Unit, and conduct an outside review of fraud and abuse controls in the state's new Medicaid hospital reimbursement system.
- **Colorado Department of Health Care Policy: \$213,334** The grant will be used to look for loopholes that foster fraud and abuse where health care programs overlap, and to see if new or more stringent rules could close these loopholes. It also will be used to learn how to validate patient diagnoses in order to prevent abuse of a new system in which managed care payments are adjusted for the health status of their members.
- **Nebraska Department of Insurance: \$100,000** The grant will help purchase a computerized relational data base, the equipment necessary to operate it, and related training in its use.
- **North Carolina Department of Insurance: \$28,932** The funds will be used to contract with medical professionals, statisticians and electronic data processing personnel to help investigators detect fraud, obtain convictions, and recover funds. They also will help develop methods to prevent fraud and abuse.
- **Pennsylvania Department of Public Welfare: \$112,315** The grant will buy new software to reduce the evaluation and preparation time for fraud and abuse cases by two to three weeks. The grant also will provide funds to purchase upgraded computer equipment.
- **Tennessee Department of Commerce & Insurance: \$121,700** The grant will be used to improve and coordinate actions among the public, private industry and law enforcement agencies. Investigators will be trained to detect workers compensation and health care plan frauds. Consumer insurance complaint investigators will be taught to recognize fraud and abuse. And the public will learn ways in which to recognize fraud and abuse.

- **Wisconsin Office of Attorney General: \$58,988** The Senior Sleuth Project will utilize the talents of senior citizen volunteers to catch health care fraud "artists" preying on the elderly with Internet health care scams. The grant money will provide a full-time investigator, training materials and computer equipment.
- **District of Columbia Department of Health and Medical Assistance: \$83,776** The grant will help purchase computer software to reduce fraudulent billing for health-related transportation services, develop electronic communications between the District's Government Fraud Investigative Unit and the Medical Assistance Administration, and provide services and training for fraud and abuse detection.
- **Internal Revenue Service: \$107,000** The funds will bolster Criminal Investigation unit health care fraud investigations. A Health Care Fraud Training Seminar and a special seminar on managed care fraud will be conducted.
- **Department of Defense Inspector General: \$195,612** The Defense Criminal Investigative Service will purchase computer hardware and software to establish 12 additional on-line sites for direct access, downloading and analysis of data from the Office of the Civilian Health and Medical Program of the Uniformed Services' Care Detail Information System.

The AoA grants all involve collaborative efforts, usually among several state agencies and sometimes private organizations. They are going to:

- **Arizona Aging and Adult Administration, Phoenix, Ariz. - \$50,000** The project will train retired professionals to identify and refer cases of fraud, waste and abuse. It will implement a system to ensure tracking of referrals and will produce a comprehensive training manual, as well as a guide for obtaining and utilizing volunteer resources and videos.
- **California Department of Aging, Sacramento, Calif. - \$50,000** The project will enhance fraud tracking systems. Activities will include a report-generating software mechanism, a number of educational brochures and feature articles, and advanced curriculum training sessions designed to educate the aging network, consumers, and families to identify and report instances of health care waste, fraud and abuse.
- **Colorado Division of Aging and Adult Services, Denver, Colo. - \$50,000** The project will train professionals, para-professionals, volunteers and consumers to empower older persons to detect and act on suspected waste, fraud and abuse.
- **Florida Department of Elder Affairs, Tallahassee, Fla. - \$50,000** The project will target Medicare/Medicaid/insurance fraud, waste and abuse outreach and education to disabled and minority beneficiaries and their families.
- **Georgia Division on Aging Services, Atlanta, Ga. - \$50,000** The project will educate providers in the aging network, older Georgians, and their families and caregivers about health care fraud, waste and abuse.
- **Illinois Department on Aging, Springfield, Ill. - \$50,000** The project will distribute materials at nursing home pre-screenings and in-home care assessments, develop a response system to track referrals, and train nursing home ombudsmen and National Senior Service Corporation volunteers.

- **Massachusetts Executive Office of Elderly Affairs, Boston Mass. - \$50,000** The project will teach Medicare and Medicaid beneficiaries what is included under their health coverage, and how to identify and report possible fraud and abuse.
- **Missouri Division of Aging, Jefferson City, Mo. - \$50,000** The project will establish a statewide committee to develop training materials, engage in outreach and education activities, outline a media campaign, and develop speaker's bureau packets.
- **New York State Office for the Aging, Albany, N.Y. - \$50,000** The project will develop a computerized, trainee-friendly curriculum to train professionals and the general public, expand outreach efforts to underserved regions and senior center public forums, strengthen statewide efficiencies in detecting and reporting fraud, waste and abuse, and establish evaluation measurement tools.
- **Ohio Department of Aging, Columbus, Ohio - \$50,000** The project will educate certified providers and suppliers about appropriate and lawful billing and service provision practices, establish a system of reporting and tracking that is easily accessible and understandable to consumers, convene citizen summits, develop training manuals and outreach materials, and establish tracking protocols.
- **Pennsylvania Department of Aging, Harrisburg, Pa. - \$50,000** The project will educate older people about fraudulent practices, develop local and regional planning groups, establish local reporting systems in cooperation with state and federal agencies, encourage self-monitoring and reporting by provider companies and educate provider employees about reporting procedures.
- **Tennessee Commission on Aging, Nashville, Tenn. - \$50,000** The project will provide consumer-directed informational materials and train-the-trainer sessions which are specifically targeted to advocates working with older clients and their families. These activities will then be delivered through a state network of over 150 senior citizen centers and fifty AARP chapters.
- **Texas Department on Aging, Austin, Texas - \$50,000** The project will initiate a state-wide education/awareness project to educate older persons, their families, caregivers, and aging network providers. Products will include a training curriculum and informational resources, additional trained volunteers at the regional/community level, public service announcements and a complaint and referral process.
- **Virginia Department for the Aging, Richmond, Va. - \$50,000** The project will establish a statewide beneficiary outreach council, conduct train-the-trainer sessions targeted toward volunteers in the insurance counseling and ombudsman programs, conduct regional education workshops for older Virginians and their families and develop educational materials.
- **Washington Aging and Adult Services Administration, Olympia, Wash. - \$50,000** The project will establish a state level coalition to design a training curriculum, brochure, and media materials and strengthen coordination between state and federal agencies responsible for investigating health care fraud. Identification and reporting methods will be incorporated into training materials, orientations, survey tools, publications and resource guides.

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Note: HHS press releases are available on the World Wide Web at: <http://www.dhhs.gov>.

Date: Thursday, August 21, 1997

FACT SHEET

Contact: HHS Press Office (202) 690-6343

THE CLINTON ADMINISTRATION'S COMPREHENSIVE STRATEGY TO FIGHT HEALTH CARE FRAUD, WASTE AND ABUSE

***Overview:** Since 1993, the Clinton Administration has focused unprecedented attention on the fight against fraud, abuse and waste in the Medicare and Medicaid programs. Today, the result is a series of investigations, indictments and convictions, as well as new management tools to identify wasteful mispayments to health care providers.*

The heightened focus on fraud and abuse since 1993 by the HHS Inspector General, the FBI and Department of Justice, HHS' Health Care Financing Administration and others throughout government is yielding a new, more detailed picture of fraudulent activities aimed at the Medicare and Medicaid systems. New surveys and audits have helped investigators pinpoint areas of vulnerability and ongoing patterns of abuse, which in turn are leading to changes in law enforcement and administrative actions.

At HHS, Secretary Shalala launched Operation Restore Trust, a ground-breaking project aimed at coordinating federal, state, local and private resources and targeting them on areas most plagued by abuse. During its two-year demonstration phase, the project returned \$23 for every \$1 of project costs. In addition, the Secretary led the way toward steady, guaranteed funding for anti-fraud efforts by the HHS Inspector General.

Since 1993, actions affecting HHS programs alone have saved taxpayers more than \$20 billion and increased health care fraud convictions by 240 percent. However, many more years of intense effort will be needed both to identify wrongdoers and to obtain convictions. The budget bill signed by President Clinton this week includes many new fraud fighting tools sought by the Administration.

In addition, HHS on August 21, 1997, awarded more than \$2.25 million in grants for new programs to aid in the fight against health care fraud and abuse. These grants are funded by the Health Insurance Portability and Accountability Act (HIPAA), signed into law last August by President Clinton. More than \$1.5 million in "Health Care Fraud and Abuse Control Grants" will be administered by HCFA, the HHS Inspector General, and the Department of Justice. The HHS Administration on Aging also announced a total of \$750,000 in grants to be administered through state offices on aging, which will help expand the Department's highly successful Operation Restore Trust program.

Clinton Administration Ongoing, Anti-Fraud Efforts

Operation Restore Trust: In May 1995, President Clinton launched Operation Restore Trust (ORT), a comprehensive antifraud initiative in five key states designed to test the success of several innovations in fighting fraud and abuse in the Medicare and Medicaid programs. The Health Care Financing

Administration (HCFA), the Inspector General, and the Administration on Aging are working in partnership to carry out ORT. In the first year of the program, ORT identified \$23 in overpayments for every \$1 spent looking at the fastest-growing areas of Medicare, including home health care, skilled nursing facilities, and providers of durable medical equipment. In May, 1997 Secretary Shalala announced a new, two-year, 12-state expansion of ORT to look at additional areas of fraud and abuse this year.

- **Fraud and Abuse Hotline:** In June 1995, HHS expanded the 1-800-HHS-TIPS hotline started in 1994 to report fraud and abuse in Medicare and Medicaid programs. Nearly 14,000 complaints that warranted follow-up action have been received since it began service. The hotline is staffed Monday through Friday, 8 a.m. to 5:30 p.m. Eastern Standard Time.
- **Administration on Aging Ombudsman Program:** As a partner in Operation Restore Trust, the Administration on Aging has trained thousands of paid and volunteer long term care ombudsman and other aging services providers to recognize and report fraud and abuse in nursing homes and other long term care settings.

Guaranteed and Expanded Funding: In August 1996, President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) legislation into law, which for the first time created a stable source of funding for fraud control. This law established the Health Care Fraud and Abuse Control Account, a key proposal of the Clinton Administration, to which money is deposited annually from the Medicare Part A Trust Fund to help finance expanded fraud and abuse control activities. The additional funding, \$104 million in FY 1997 and up to almost \$120 million in FY 98, is divided between the HHS Inspector General and the Department of Justice to coordinate federal, state and local health care law enforcement programs; conduct investigations, audits, evaluations and inspections relating to the delivery and payment of health care; help facilitate enforcement of civil, criminal and administrative statutes on health care fraud and abuse; provide guidance to the health care industry on fraudulent health care practices; and establish a national data bank to receive and report final adverse actions against health care providers.

- **Expanded Office of the Inspector General (OIG):** In FY 1997, the Office of the Inspector General received approximately \$70 million from the Health Care Fraud and Abuse Control Account. The funding is being used primarily to open six new field offices to facilitate enforcement actions, increasing from 24 to 29 the number of states in which the OIG is present. The funds will also establish a fraud and abuse database to identify health care providers who have been the subject of adverse actions as the result of illegal or abusive practices and award grants to partner agencies engaged in investigations, prosecutions and audits of health care fraud and abuse. Since October 1996, the OIG has been involved in the resolution of approximately 420 cases that led to settlements totaling approximately \$1 billion for the Medicare Trust Fund.
- **Increased Efforts by the Department of Justice (DOJ):** The Department of Justice was allocated approximately \$24 million of the money appropriated from the Health Care Fraud and Abuse Control Act to step-up their efforts to investigate fraud and abuse and enforce criminal and civil statutes applicable to health care fraud and abuse. In the last four years the Department of Justice has increased resources, focused investigative strategies, and improved coordination among law enforcement to fight health care fraud. Due to DOJ's comprehensive efforts, the number of health care fraud convictions increased by 240 percent since FY 1992.

Education Efforts: HCFA's contractors educate the provider billing community, including hospitals, physicians, home health agencies and laboratories about Medicare payment rules and fraudulent activity.

This education covers current payment policy, documentation, requirements and coding changes through quarterly bulletins, fraud alerts, seminars and, more importantly, through local medical review policy.

Los Alamos National Laboratory: The lab is developing sophisticated pattern detection methods for application to Medicare's vast data banks. These methods will help identify and target suspect claims which need additional review. This effort could start directing investigators to new cases of fraud and abuse.

Clinton Administration Efforts to Combat Waste and Abuse in Health Care

The Medical Integrity Program (MIP) and Payment Safeguards: This system of payment safeguards, also authorized by HIPAA, identifies and investigates suspicious claims throughout Medicare, and ensures that Medicare does not pay claims other insurers should pay. MIP also ensures that Medicare only pays for covered services that are reasonable and medically necessary. HCFA's current payment safeguards are already paying dividends in cost savings. These safeguards comprise a comprehensive system which attempts to identify improper claims before they are paid, to prevent the need to "pay and chase." HCFA's current strategy for program integrity focuses on prevention and early detection. Some of the payment safeguard activities include: the Medicare Secondary Payer Program, medical review, cost report audits and anti-fraud activities. The payment safeguard activities returned \$14 for every \$1 spent, and saved \$6 billion in FY 1996. The Secondary Payment Program alone, which is identifying whether insurers should pay claims that in the past have inappropriately been paid by Medicare, is expected to save more than \$1.1 billion in 1997.

Correct Coding Initiative: In 1994, HCFA began the Correct Coding Initiative by awarding a contract for the development of correct coding policy for all physician billing codes referred to as current procedural terminology (CPT) codes. Implemented in 1996, this enhanced pre-payment, control and associated software update resulted in savings of about \$217 million in its first year. In Fiscal Year 1998, HCFA will continue to develop coding policy and edits with a focus on new CPT codes with the potential for high utilization.

Tighten Standards of Home Health Care Through the Conditions of Participation Regulation: The Clinton Administration proposed to revise the federal standards (Condition of Participation) that home health agencies must meet in order to participate in the Medicare program. The new rules require home health agencies to be more accountable for the care they provide and to conduct criminal background checks for the aides they hire.

Substantive Claims Testing: HCFA is now working to develop a substantive testing process to help determine not only whether claims are paid properly, but also whether services are actually rendered and medically necessary.

Administration Legislative Efforts to Continue to Fight Against Fraud And Abuse

President Clinton's FY 1998 budget proposal included several additional anti-fraud provisions. In addition, in March 1997, President Clinton introduced new legislation, the "Medicare/Medicaid Anti-Waste, Fraud and Abuse Act of 1997," that established tough new requirements for individuals and companies that wish to participate in Medicare and Medicaid.

Most of the Clinton Administration's recommendations were included in the budget bill signed by the President on August 5, 1997, including:

- Penalties for services offered by a provider who has been excluded by Medicare and Medicaid.
- Penalties for hospitals who contract with providers who have been excluded by Medicare and Medicaid.
- Civil monetary penalties levied on providers that violated the anti-kickback statute, under which the physician received some kind of incentive for referring patients.
- Requiring health care providers applying to participate in Medicare or Medicaid to provide their Social Security numbers and their employer identification numbers so HCFA can check an applicant's history for past fraudulent activity.
- Barring felons from participating in Medicare and Medicaid.
- Establishing a prospective payment system for home health services, to be implemented by Oct. 1, 1999. Moving to a PPS system will be a tremendous tool to stem the flow of home health care dollars. We will set, in advance, what we will pay for a unit of service, how many visits will be included in that unit and what mix of services will be provided.
- Paying home health services based upon the location where the service is provided-the patient's home-as opposed to where the service is billed. This will stop agencies from getting higher urban reimbursement when, in fact, the service occurred in a lower-cost rural setting.
- Eliminating periodic interim payments to home health agencies. These payments were previously used to encourage Medicare participation and now are no longer necessary.
- Developing guidelines for the use of home health services such as how many home health visits should be required for various conditions. These standards will empower HHS to crack down on providers who are offering excessive services for various conditions.
- Tightening eligibility for home health services so that providers can no longer game the system by certifying patient eligible for home health services simply because they need blood drawn on a regular basis. There is a benefit for blood drawing services only.

The Clinton Administration has urged Congress to enact the additional anti-fraud provisions proposed by the President, but that were not included in the budget. These provisions include closing a loophole that allows providers to bill for partial hospitalization services for enrollees who are already in inpatient settings and changing the law to assure that Medicare cheats can't escape repaying the program by declaring bankruptcy.

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

File fraud
& Abuse

AUG 19 1997

MEMORANDUM FOR THE PRESIDENT

I know you are concerned, as I am, about recent reports suggesting widespread fraud and abuse among home health agencies participating in the Medicare program. This memorandum provides information on those reports and outlines the steps we have taken and are taking to combat fraud and abuse in home health care. It also outlines further actions we are considering.

As you know, home health care, available to any homebound beneficiary who requires skilled care, is the fastest growing expense in the Medicare program. This rapid expansion began in 1989, when, as the result of a lawsuit, changes in Medicare regulations expanded eligibility and eliminated the cap on the number of visits. To some extent, the rapid growth in home health utilization and spending is also a natural result of the successful implementation of the inpatient hospital prospective payment system, which has dramatically reduced the length of hospital stays for Medicare beneficiaries. In 1996, more than 10 percent of Medicare beneficiaries received home services, at a total cost of \$18 billion. The number of home health agencies has also grown exponentially, and about 9,000 home health agencies currently serve Medicare beneficiaries. The rate of growth in the number of home health providers has slowed significantly in the past year, however, as the screening process has improved.

The recent reports outlining widespread fraud among home health agencies are one indication of the Administration's success in targeting waste, fraud and abuse in Medicare. As you know, your Administration has focused unprecedented attention and new resources on this effort since 1993. The result is a series of investigations, indictments and convictions, as well as new management tools to help us better manage Medicare.

In particular, Operation Restore Trust (ORT) has been a ground-breaking project aimed at coordinating federal, state, local, and private resources and targeting them on areas most plagued by abuse. During its two-year, five-state demonstration phase, the project returned \$23 for every \$1 of project costs; identified more than \$187.5 million in fines, recoveries, settlements, audit disallowances and civil monetary penalties owed to the Federal Government; and achieved 74 criminal convictions, 58 civil actions, and 218 provider exclusions. One thing ORT does is train state surveyors who review home

health agencies to look for care being provided that is not covered by the Medicare program. ORT has now been expanded to 12 states. *- does it plan to go to all 50*

Your decision to use trust fund monies to launch broader investigations by the HHS Inspector General, the FBI and the Department of Justice has allowed us to increase fraud convictions by 240 percent since 1993. These reviews and investigations have given new impetus to structural changes we have proposed in Medicare, many of which were approved in the Balanced Budget Act.

Background on HHS Office of the Inspector General Reports

There are two OIG reports on home health care, which were released concurrently on July 28. Both reports involved Operation Restore Trust (ORT) states: California, Texas, Illinois, New York, and Florida. As you will recall, we selected these states for the original ORT demonstration in 1995 because they represent a significant portion of Medicare beneficiaries and payments (about 35 percent of both). In fact, I specifically asked the OIG to focus its review on home health agencies in these states because we expected that home health was particularly subject to abuse.

The first OIG report focused on a random sample of 250 home health claims in four of the five ORT states (California, Texas, Illinois, and New York). It was designed to be a diagnostic tool that would gauge general patterns and the scope of the problem; it was not designed to be a complete audit of individual agencies with immediate follow-up actions. The OIG estimated that up to 40 percent of services billed either: (a) were not reasonable and medically necessary, (b) did not have valid physician orders, (c) lacked supporting documentation, or (d) did not involve beneficiaries who met the definition of "homebound"—a prerequisite for coverage. (It is worth noting that HCFA loses about half of the cases in which we challenge medical necessity.)

To correct these problems, the OIG recommended that the reimbursement system for the home health benefit be restructured. Specifically, the OIG recommended:

- instituting a prospective payment system so that agencies would no longer have an incentive to inflate volume and intensity of services;
- setting limitations on the number of reimbursable visits; *→ wasn't this addressed by coverage?*
- requiring preauthorization of payment;
- requiring beneficiary copayments; *— we opposed*

- emphasizing the definition of “homebound” in the Medicare guidelines and include additional guidance on certain standards;
- requiring intermediaries to notify beneficiaries of claims made on their behalf;
- requiring intermediaries to enhance medical review by augmenting it with physician and beneficiary interviews; and
- requiring physicians to examine patients before ordering home health services.

In the second report, the OIG reviewed files provided by HCFA and its intermediaries on close to seven hundred “problem providers” in the five ORT states. For purposes of the review, OIG defined “problem provider” as one that exhibited one or more specific characteristics, including reporting inappropriate costs, submitting claims for services that were not medically necessary or not rendered, failing to file cost reports or filing unauditible reports, or demonstrating significant certification deficiencies, or uncollected overpayments.

OIG analyzed the most common abuses identified in the “problem provider” files and made recommendations on steps that could be taken to address them. Specifically, the report concluded that limited resources hamper fiscal intermediaries’ oversight efforts and recommended a number of legislative changes, including:

- eliminating periodic interim payments, a system whereby providers receive payments in advance of providing services;
- requiring surety bonds;
- requiring user fees to cover the cost of certification, comprehensive reviews and recertifications;
- creating a data bank of owners, principals, and related organizations;
- requiring Social Security and employer identification numbers as part of the application;
- enhancing certification requirements related to the relevant experience and financial status of home health agencies and their owners and principals; and
- eliminating home health agencies’ ability to discharge Medicare debt through bankruptcy.

use OIG file

use OIG file

We note that many of the characteristics and practices identified by the OIG in these two reports are not inherently fraudulent. The "problem provider" report was never intended to be the basis of law enforcement actions against individual providers; rather, it was intended to provide insight into ways home health agencies are able to exploit the program and to provide suggestions to prevent abuse. The report did not contain sufficient evidence to take fraud sanction action against any of the 700 agencies.

→ nothing legislative recommended

HCFA's Response to Home Health Problems

For the past two years, we have been attacking fraud and abuse in home health, and in Medicare in general, with every available tool. In a real sense, the current attention is a result of our own success in this area—the recent indictments announced by the Department of Justice, and the OIG reports, would not have been possible were it not for the heightened focus and new resources this Administration has directed at Medicare fraud and abuse. Our successes also secured the additional resources we obtained in last year's Health Insurance Portability and Accountability Act (HIPAA).

Balanced Budget Act Provisions Implementing OIG Recommendations

In 1997 the Administration proposed, and the Balanced Budget Act you signed included, the most significant recommendations made by the OIG. The BBA includes a number of provisions that will help control growth through appropriate payment, including:

- authority to establish a prospective payment system for home health services, to be implemented October 1, 1999. Moving to PPS will be a tremendous tool for stemming the flow of home health care dollars. Instead of open-ended billing, HCFA will set in advance what it will pay for a unit of service, how many visits will be included in that unit, and what mix of services will be provided. In short, providing questionable services will no longer be profitable;
- authority to bar felons from ever participating in Medicare again;
- separation of home health services into two distinct benefits under Medicare Part A and Medicare Part B;
- defining limits on hours and days that home health care can be provided;
- elimination of periodic interim payments that were made in advance to agencies and not justified until the end of the year (part of moving to prospective payment system);

- billing by location of service rather than location of the agency's headquarters. This will stop agencies from getting higher urban reimbursement when, in fact, the service occurred in a lower-cost rural setting;
- establishment of guidelines for the frequency and duration of home health services. Payments would be denied for visits that exceed the established standard; and
- clarification of the definition of part-time or intermittent nursing care. This clarifies the scope of the Medicare benefit and will make it easier to identify inappropriate services.

In addition, several other key Administration proposals to fight fraud were enacted, including:

- new penalties for kickbacks. Providers who pay kickbacks to induce referrals would be subject to civil money penalties of \$50,000 per violation;
- authority to require health care providers applying to participate in Medicare and Medicaid to provide their Social Security numbers and their employer ID numbers so that the agency can screen out those who have committed fraud in the past;
- a clear definition of skilled services so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs blood drawn; and
- authority to deny payment to agencies that bill for far more services than other agencies do in similar situations. The authority goes beyond just home health providers and can be applied to any Medicare provider.

In fact, the only significant OIG recommendations that were *not* part of the Balanced Budget Act were:

- requiring beneficiary copayments;
- imposing a more stringent definition of "homebound" (although a study of the definition is required);
- requiring user fees;
- eliminating home health agencies' ability to discharge Medicare debt through bankruptcy; and

- refusing to enter into a provider agreement with any home health agency that is not financially sound, owes money to the Federal Government, or has filed for bankruptcy.

You are well aware of the advantages and disadvantages of requiring beneficiary copayments. While this might well dampen utilization and reduce spending, we are concerned that the beneficiaries who use home health care—many of whom are poor, frail, and elderly—would bear the brunt of this approach. The Administration did propose a provision to impose a more stringent definition of “homebound,” but groups representing disabled beneficiaries protested this as discriminatory and the Congress (including key Democrats in the House) was unwilling to move forward on it. With respect to user fees, the Administration proposed user fees to cover the cost of certifications of home health agencies in your FY 1998 budget, but the Congress has shown no interest in enacting them. I will be recommending that you re-propose user fees in your FY 1999 budget. We would also recommend that the proposal in the FY 1998 budget to eliminate the ability of home health agencies to discharge their Medicare debts through bankruptcy be submitted to Congress again in the FY 1999 budget. Finally, with respect to the OIG’s last recommendation, we agree that we should refuse to enter into provider agreements with home health agencies whose owners and principals do not live up to certain financial standards, and we are examining appropriate ways to do this.

New Rules to Tighten Requirements

In addition, on March 5, 1997, we announced two new proposed rules resulting from a comprehensive three-year evaluation of Medicare’s home health benefit. One rule would revise the “Conditions of Participation” that all home health agencies must meet in order to participate in the Medicare program. The rules we proposed would take several steps to protect beneficiaries and improve quality. These include:

- requiring that home health agencies conduct criminal background checks of home health aides as a condition of employment;
- expanding the current home health aide qualifications to include nurse aides who have completed appropriate nurse aide training or competency evaluation requirements;
- requiring home health agencies to discuss with patients the expected outcomes of care so that patients can be more involved in planning their own care; and

- requiring home health agencies to coordinate all care prescribed by physicians for their patients. Under current rules, several agencies can serve one patient without the coordination that is need to assure quality.

A second proposed regulation would require home health agencies to use a standardized system called OASIS —the Outcomes and Assessment Information Set— to monitor patients' conditions and satisfaction. Under OASIS, home health agencies must perform a standardized assessment of new patients within 48 hours to determine immediate care and support needs. Home health agencies are then required to update this initial assessment continuously until a patient is discharged to reflect changes in the patient's condition and to measure patient and family satisfaction. Agencies must also evaluate the results of OASIS assessments and apply this information to agency practices as part of their continuous quality improvement programs. This standardized measurement system helps both inspectors and agencies identify opportunities to improve performance and patient satisfaction. The regulations are in various stages of the clearance and comment process, and we are committed to implementing final rules at the earliest possible date.

Enforcement Actions Against “Problem Providers”

As previously noted, the “problem providers” reviewed by the OIG were identified by HCFA and its intermediaries. During the past two years, HCFA has taken action to deal with many of the providers that were identified as “problem providers” in the OIG review. Of these 698 home health agencies, HCFA has:

- terminated 67;
- referred an additional 75 providers to law enforcement; and
- collected overpayments from 437 entities.

In addition, one was convicted as an individual, and four others as members of a convicted national company.

Therefore, of the 698 providers implicated in the OIG report, HCFA has already dealt with a substantial number of them. HCFA continues to scrutinize carefully all of the remaining identified providers to determine appropriate action, but OIG reviews thus far have indicated that a substantial number of these agencies may not be doing anything fraudulent. The OIG confirmed that this is consistent with its expectations and that the “problem provider” report was never intended to be the basis of a law enforcement initiative against any of these providers.

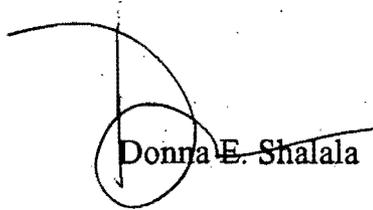
Additional Actions Under Consideration

I have directed HCFA to present me with recommendations, in the next month, for additional actions we can take to combat home health fraud and abuse. Among possible actions, HCFA is considering promulgating additional requirements to promote financial stability, foster experienced and competent management, ensure a business history that is free of fraud, and ensure adequate review of patients by physicians certifying them for eligibility. HCFA is also intensifying its review of home health payments to providers and will suspend payments where there is reliable evidence of fraud and abuse. (We should note that suspension sometimes is not pursued because it would jeopardize other law enforcement activities.) Finally, HCFA is considering directing additional FY 1998 program integrity resources toward home health agency audits to ensure that we are finding the fraud and abuse quickly and dealing with it expeditiously.

→ not much new stuff here.

Conclusion

The first round of the Administration's comprehensive strategy to fight waste, fraud and abuse in Medicare is already reaping dividends, but much more remains to be done. With new statutory authority under the Balanced Budget Act, coupled with new resources we are receiving under HIPAA, we are in a better position to target fraud in home health care and other areas. It is incumbent upon us to use these new authorities and resources aggressively to eliminate the types of problems identified in the OIG reports. As described above, we already have acted, or are in the process of acting against many of these problem agencies, but we need to accelerate our progress. While we are aggressively pursuing structural reforms to help us target fraud, we must continue to press for legislative changes that Congress has not yet agreed to. The ongoing evaluation of our efforts to date will help us further refine and target our resources for future requests. We will be recommending to you as part of our fiscal year 1999 budget submission the second round of anti-fraud proposals (Operation Restore Trust II). In combination, they represent the most comprehensive and rigorous effort in the history of the program.


Donna E. Shalala

8570
-0725
7/3

A CORPORATION
1020 FAIRFAX STREET, FOURTH FLOOR
ALEXANDRIA, VIRGINIA 22314
PHONE (703) 684-5236 FAX (703) 684-3417
E-MAIL DVACTHO@AOL.COM

Fax Transmittal Sheet

TO: Chris Jennings

FROM: David Vienna

DATE: July 22, 1997

This transmission consists of 2 page(s) including the cover page. Please call 703/684-5236 if there is any problem with this transmission. The return fax number is 703/684-3417.

See attached letter from CalPERS



Executive Office
P.O. Box 942701
Sacramento, CA 94229-2701
(916)

July 22, 1997

VIA FAX: (202) 456-2878

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton:

The California Public Employees' Retirement System (CalPERS) prides itself on the high quality, efficient delivery of health benefits provided to our retirees, including the more than 117,000 who are enrolled in Medicare. Therefore, I support your efforts to strengthen and preserve the Medicare system.

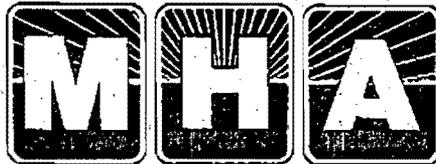
However, I am deeply concerned with how the proposed changes to the Medicare managed care payment rates outlined in the Senate budget reconciliation bill will affect beneficiaries. My fear is that if changes are too drastic initially in some areas of the country, Medicare beneficiaries could be faced with increased out-of-pocket costs, reductions in benefits, and disruptions in choice. Although these consequences may not be intended, they are very real possibilities.

Under the Senate version, the State of California will be hit by a disproportionate share of the payment reductions which would adversely impact our State's Medicare beneficiaries. Consequently, the House Ways and Means Committee payment reform provisions are preferable to the Senate proposals. The House version more closely meets the objectives of reasonable payment reform by addressing the disparities in Medicare managed care payments for different areas of the country fairly, establishing a floor for payments in any area and ensuring sustainable updates in payments each year.

You are urged to accept a budget bill which includes the House Ways and Means Committee language on Medicare managed care payment reform and reject any proposal similar to that of the Senate when negotiating the final budget reconciliation bill.

Sincerely,

Margaret T. Stanley
Assistant Executive Officer
Health Benefit Services



Massachusetts Hospital Association

WASHINGTON, DC OFFICE

499 S. Capitol St., SW
Suite 405

Washington, DC 20003

Phone: (202) 863-0400

Fax: (202) 488-7987

FAX COVER SHEET

Date: 7/22/97

TO: Chris Jennings

ORGANIZATION: _____

FAX NUMBER: 456-7028

FROM: Ben Grasse

TOTAL PAGES SENT (including cover sheet): 4

ADDITIONAL COMMENTS:

COALITION FOR RESPONSIBLE MEDICARE AND MEDICAID REFORM

JOHN W. MCCORMACK POST OFFICE • P.O. BOX 2192 • BOSTON, MA 02106

July 21, 1997

The Honorable William Jefferson Clinton
President
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear President Clinton:

As Congress and the Administration continue its current deliberations over the budget reconciliation legislation, we would like to communicate the following concerns:

- A \$5 co-payment per home health visit should not be implemented. Many frail low-income beneficiaries receive multiple home health visits per week, and could ill-afford the additional cost. A co-payment charge will increase the cost of Medigap insurance premiums, which are already quite costly. Beneficiaries unable to afford the co-payment will be forced to forgo other necessary expenses or at worst will be institutionalized prematurely to access care.
- Normative guidelines for the frequency and duration of home health visits should not be implemented. Such guidelines would in practice become rules to which providers would adhere, and we fear that beneficiaries with heavy care needs would not receive an appropriate level of services.
- Part B premiums should not be increased for wealthier beneficiaries without an offsetting expansion of subsidies for lower-income beneficiaries. Approximately 40% of Massachusetts elders have incomes below 200% of the federal poverty level, and can ill afford a significant premium increase. We urge you to insist that the full \$1.5 billion for such subsidies which was included in the Administration's initial budget agreement be included in the final legislation.
- We also support the appointment of a Commission to examine the long-term financial health of the Medicare Program. Many of the larger changes contained in the congressional bills will alter the manner in which benefits are provided to beneficiaries and will expand the provision of managed care and the use of the new entities to manage care. A commission will help evaluate the impact of the proposed changes before drastically altering the Medicare program.

There are many more issues raised by the House and Senate bills reforming the Medicare program. We look forward to working with you on all such issues in the coming months. If you have questions or need more information about any of the issues we have raised, please do not hesitate to contact Bea Grause at (202) 863-0400.

COALITION FOR RESPONSIBLE MEDICARE AND MEDICAID REFORM

JOHN W. MCCORMACK POST OFFICE • P.O. BOX 2192 • BOSTON, MA 02106

MEMBER ORGANIZATIONS

AIDS Action Committee of Massachusetts
AIDS Housing Corporation
Alzheimer's Association of Eastern Massachusetts
American Association of Retired Persons (Massachusetts Chapter)
Association of Massachusetts Homes and Services for the Aging
Boston Senior Home Care
Center for Community Health Education, Research and Service (Northeastern University)
Children's League of Massachusetts
Commonwealth Center for Fiscal Policy
Conference of Boston Teaching Hospitals
Health Care for All
Home Health Care Association of Massachusetts
Hospice Federation of Massachusetts
Licensed Practitioner Nurses of Massachusetts
Massachusetts Ambulance Association
Massachusetts Association of Older Americans
Massachusetts Caring for Children Foundation
Massachusetts Council for Homecare Aid Services
Massachusetts Extended Care Federation
Massachusetts Hospital Association
Massachusetts Human Services Coalition
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Medical Society
Massachusetts Medicare Advocacy Project
Massachusetts Nurses Association
Massachusetts Organization of Nurse Executives
Massachusetts Senior Action Council
Massachusetts Society for the Prevention of Cruelty to Children
Massachusetts Society in Health Care
Massachusetts Statewide Council
Mental Health Corporation of Massachusetts
Minuteman Homecare
Multiple Sclerosis Society (Massachusetts Chapter)
National Committee to Preserve Social Security and Medicare
New England Medical Equipment Dealers Association
Older Women's League of Massachusetts
Young Elders of America

**CONCERNS ABOUT MEDICARE HOME HEALTH COPAYMENT
PASSED BY SENATE JUNE 24, 1997**

PROPOSAL

- Adds a new \$5 payment per Part B home health visit for beneficiaries, with an annual limit on the copayments equal to the hospital deductible (\$760 in 1997). This provision is intended to reduce unnecessary utilization.

CONCERNS

- **Unlikely to change utilization significantly.** Because over three-fourths of Medicare beneficiaries have Medigap or Medicaid, the provision would neither substantially reduce utilization of services nor decrease overall spending on home care.
- **Severe impact on low-income.** For the 15 percent of beneficiaries without coverage, these costs may be excessive.
 - A widow with income just above poverty (about \$8,000) could pay close to 10 percent of her income on this copay alone.
 - About 43% have incomes lower than \$10,000 and already spend about 25% of their income on out-of-pocket health costs.
 - Two-thirds are women and one-third live alone. One in four is over 85 years old.
- **Unfunded mandate to states.** Because Medicaid covers cost sharing for about 6 million Medicare beneficiaries, its spending would increase as a result of this provision. CBO estimates that state costs could rise by \$700 million over 5 years.

**CONCERNS ABOUT RAISING THE MEDICARE ELIGIBILITY AGE
PASSED BY SENATE, JUNE 24, 1997**

PROPOSAL

- Extend the eligibility age for Medicare from 65 years old to 67 years old. This provision would be phased in one month at a time, so that it would be fully implemented in the year 2027. The goal is to extend the life of the Medicare Trust Fund.

CONCERNS

- **Increase the number of uninsured.** Up to 200,000 Americans could become uninsured if Medicare eligibility age were raised to 67, according to the Urban Institute.

This is because:

- **Different than Social Security.** Social Security gives people who retire before eligibility a portion of their benefits, so that postponing eligibility age has less of an impact. Medicare gives nothing to early retirees.
 - **Already problems with coverage.** An increasing number of 55 to 65 year olds are becoming uninsured. Many are early retirees. Between 1993 and 1995, the proportion of employers offering coverage for early retirees dropped by 10%.
 - **Few affordable alternatives.** People in their 60s face higher health costs, higher premiums, and fewer choices. As employers pull back from retiree coverage, a disproportionate number of 60 to 64 year olds have turned to the individual insurance market. In this market, insurers may consider health and age in setting premiums, making it more expensive than group coverage.
- **No policies to address problem.** The Senate bill contains no provisions that would assist people waiting longer for Medicare to find affordable health coverage.

**CONCERNS ABOUT THE MEDICARE HIGH-INCOME PREMIUM
PASSED BY SENATE, JUNE 24, 1997**

PROPOSAL

- Increases the Medicare Part B premium for higher-income beneficiaries:

Single beneficiaries: Begins at \$50,000 with full payment at \$100,000

Couple: Begins at \$75,000 with full payment at \$125,000

If the Medicare premium is about \$67 per month in 2002, this means, for people at the upper end, an increase of \$200 per month or \$2,400 per year for a single, and \$4,800 per year for a couple.

CONCERNS

- **Creates complex new bureaucracy.** In practice, a high-income premium requires a complex new process:
 - IRS sends tax information to HHS before the beginning of the year. HHS uses the latest available tax information to determine who gets a high-income premium for the subsequent year
 - HHS sends notices to beneficiaries to check income. Beneficiaries verify income.
 - HHS sends income information to Social Security Administration, which deducts higher premiums from Social Security checks, or HHS sets up its own collections and billing process
 - IRS sends tax information to HHS at the end of the year to check actual income against projected income
 - HHS would increase or decrease the next year's premiums based on the previous year's error -- plus interest if the beneficiary did not pay enough in premiums. If the beneficiary had died, the surviving spouse or estate would have to pay the premium owed.

This complexity has led the Congressional Budget Office to discount savings from this new premium by about 30 percent.

- **Could encourage seniors to leave Medicare.** If higher income elderly face the full cost of the Medicare premium, they might drop out of Medicare Part B. This could leave Medicare with the sicker, more expensive beneficiaries. The HCFA Actuaries assume that twice as many beneficiaries will drop out of Medicare if they must pay the full cost of the premium rather than 75% of the premium.

THOMAS, CALIFORNIA, CHAIRMAN
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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
 WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

May 8, 1997

File

To: Chris Jennings

From: Bill Vaughan *Bin*

Re: Medicare Budget Reconciliation

After last night's meeting between Archer and the Committee Democrats, it is clear the only thing Ways and Means Republicans think they agreed to was \$115 billion net and the home health transfer after 100 visits. Period.

I believe Thomas is in process of writing a "Chairman's mark" for mark-up around June 3. There is talk of talking to us (but Archer said the tax mark would be done in the tradition of former Chairmen--in which Rosty would just announce a package after consulting with some Members one on one), but it has not happened yet. Thomas reportedly has caucused with his Members once.

In talking about this with Bridgette Taylor and Stark, it seems to me that Thomas may present us with a mark that will NOT be as good as the agreed on Medicare budget proposal, and that our first--and last--line of defense would be to move the "budget agreement" as a substitute to the Thomas mark.

Help! Would it be possible to get language on the post CBO-scored \$82 billion changes offered by the Administration, so that we can assemble a united substitute amendment?

Thank you for your thoughts on this.....obviously we should talk at your convenience.

**Talking Points
Medicare/Medicaid Fraud
Press Conference
The White House
March 25, 1997**

- I am delighted to be here today with President Clinton and Secretary Shalala.
- Fraud and abuse in Medicare and Medicaid are a constant threat to the quality and availability of health care to our most vulnerable citizens.
- As administrators of the Medicaid program the states wage a constant battle against fraud and abuse.

- Medicaid fraud rips critical life-saving services away from our neediest citizens.
- To be good stewards of the public trust, we must aggressively fight this problem wherever it occurs – we've been doing that in Florida.
- Our successful partnership with President Clinton's Operation Restore Trust team in South Florida will help drive new federal legislation to give states the information and tools to more aggressively attack fraud, generate Medicaid savings and uphold the people's faith in this important program.

- Through President Clinton's leadership, Florida has successfully partnered with Secretary Shalala and Operation Restore Trust. The results have been dramatic.
- Nearly \$200 million will be saved this year and next from new initiatives designed to weed out fraudulent providers and prevent future abuses.
- Florida's successful initiatives include:
 - 1) A new Medicaid provider agreement and reenrollment of the 82,000 providers in Florida, including a Florida Department of Law Enforcement background check.

2) A \$50,000 surety bond requirement and on-site inspection for all "high-risk" providers, such as durable medical equipment providers, laboratory services, non-physician owned clinics, and transportation providers.

3) Over 500 suspected fraud referrals to the State Attorney General's Medicaid Fraud Control Unit.

4) Over 200 referrals to the Statewide Grand Jury.

5) Sharing of all important provider information between Medicare and Medicaid.

6) Joint investigations – most recently during the State’s annual survey of 20 nursing homes in South Florida, a review of some of the services being provided found that many services were inappropriate for the patient (such as mental health services for Alzheimer’s patients). An estimated \$1.5 million was identified and is being returned to the Medicare program.

7) Targeted investigations – suspicious billing patterns led to the on-site inspection of 19 laboratories. The results: the labs were billing for tests they did not have the equipment to conduct. Over \$4 million in overpayments was identified.

- Florida's success in fighting health care fraud can and should be copied by other states.
- As Congress considers the President's package it should also encourage states to aggressively pursue anti-fraud initiatives. States should have the flexibility to reinvest fraud savings into providing health care coverage to some of the 10 million uninsured children in our nation.
- Secretary Shalala, thank you for your partnership in our efforts. Mr. President, thank you for your leadership in this war on fraud.

- Q:** The proposal calls for new civil monetary penalties, but HCPA has been criticized for the infrequent use of the civil monetary penalty powers it now has. What reason is there to believe that these new powers will be used effectively?
- A:** Due to a statutory drafting error, it is impossible for us to impose many of the civil money penalties (CMPs) Congress has given us the authority to levy on fraudulent providers. Whether or not we use CMPs must be decided in the context of the overall legal strategy for dealing with each individual case -- whether it is appropriate to pursue criminal or civil action.

Questions and Answers 10-Year Medicare Savings

Question

In your February budget release you said the 5-year Medicare savings were \$100 billion and the six-year savings were \$138 billion. Now you say it is \$106/\$146 billion. What changed?

The President's budget submitted in February was scored by OMB at \$100 billion over 5 years. A few technical changes were made to this package after the budget numbers were transmitted, including changes to respond to CBO's different baseline assumptions.

Question

The savings from the home health transfer are significantly higher in the 10-year period. Why?

They are not significantly different. This time-frame is twice as long as the previous time-frame. We said the five-year figure was \$82 billion and the six-year figure was \$102 billion. The amount increases as the change in the baseline compounds.

It is very important to note that these savings are NOT part of the \$106/\$146/\$369 billion in savings in 5/6/10 years. They restore the intent of the Medicare statute and strengthen the Part A trust fund by transferring these non-hospital-related costs to Part B.

Question

Since the President was so critical of the Republican plan to cut \$270 billion from Medicare, doesn't this \$369 billion cut seem awfully large?

No. Remember that the \$270 billion was over seven years and the \$366 billion figure is over 10 years. More importantly, there are SIGNIFICANT differences in the policies behind these numbers. The Republican plan would have capped the contribution per beneficiary and significantly increased premiums and out-of-pocket costs for seniors. The President's plan protects seniors and continues the historic defined benefit package.

TALKING POINTS
10-Year Medicare Savings
in
President Clinton's Balanced Budget

- The President's budget includes a major commitment to preserve and modernize the Medicare program. Through a series of reforms and restructurings, it saves \$365.9 billion over the next 10 years (FY98-07). These savings come from total baseline spending of \$3.158 trillion during that 10-year period.
- The President's plan extends the solvency of the Medicare trust fund to 2007 – ten years from now. Without this action, Medicare's Hospital Insurance trust fund would be bankrupt in 2001, just four years from now.
- The President's plan restructures the home health benefit so that hospital-related home health visits are paid out of the Hospital Insurance trust fund and non-hospital related visits are paid out of the Part B Supplemental Medical Insurance Trust Fund. This reflects the original intent of the Medicare. The President's package of home health reforms are designed to control the rapid growth of this benefit.
- The President's plan addresses the short-term deficit in the Medicare program and lays the groundwork for a bipartisan effort to deal with the long-term challenge of the retirement of the Baby Boom Generation.
- The President's plan modernizes Medicare by offering beneficiaries new preventive benefits and new choices (PPOs and PSOs).



United States
of America

Senator John Breaux

Democrat-Louisiana

Contact: Bette Phelan, Laine Glisson, 202-224-4623; Bob Mann, 504-382-2050

**For Immediate Release
September 25, 1997**

**Contact: Barry Phelps
(202) 224-1467**

STATEMENT OF SENATOR JOHN BREAUX ON HOME HEALTH ROUNDTABLE

Note: Senators John Breaux (D-La.) and Charles Grassley (R-Iowa), ranking member and chairman of the U.S. Senate Special Committee on Aging, invited 11 home health care anti-fraud experts, including Louisiana Health Secretary Bobby Jindal, to attend a private roundtable today. The day-long seminar was an in-depth follow-up to their committee hearing on home health fraud in July. It was designed to assist the senators in legislating a remedy to the problems identified at that hearing.

Sen. Breaux issued the following statement:

WASHINGTON (Sept. 25) -- "This has been an excellent opportunity to hear from experts representing a wide range of perspectives and views. I am especially pleased that Louisiana Health Secretary Bobby Jindal could come to Washington again to discuss home health fraud and to share his insight on how we can reduce and ultimately eliminate it.

"I think the diversity of our participants demonstrates that both Sen. Grassley and I have approached this issue without any rigid ideas of what should or should not be done to improve home health care services. Our purpose was to bring experts with differing views together to talk about solutions we might pursue in Congress.

"We certainly did not expect a consensus to come out of all these discussions and did not expect a specific legislative remedy to be ready to share with you today. But we did expect these eminent experts and policymakers to bring us closer to those goals and I think we have certainly done that today.

"We know that every Medicare dollar that goes to fraud cannot go to patient care. But this is not a hopeless case — there are solutions to home health fraud. Some were included in the 1997 Balanced Budget Act, some were recently announced by the President, and others are in place now in Louisiana and other states.

"The challenge facing the members of this roundtable was to make recommendations that protect the overwhelming majority of honest providers and beneficiaries who genuinely need home care services. We will continue to address the number of problems that have crept into the home health care industry in recent years."

An outline of the roundtable agenda is attached



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

February 21, 1997

NOTE TO: Bruce Reed
Rahm Emanuel
Chris Jennings
Nancy Ann Min
Janet Murguia
Emily Bromberg
Barbara Wooiey
Elena Kagen

Per our conversation yesterday, please find attached a summary description of the fraud and abuse proposals that could be included in an Administration initiative next month. Preliminary discussions with HCFA indicate that we could have legislative language ready by March 13.

A handwritten signature in cursive script that reads "Rich".

Richard J. Tarplin

Attachment

cc: Melissa Skolfield

ANTI-FRAUD and ABUSE LEGISLATIVE PROPOSALS

Proposals that OMB has Approved of for Inclusion in a "Spring" Anti-Fraud Bill:

Program Integrity

- o **Social Security Numbers** - Under this proposal the Secretary would have the authority to require providers and suppliers to disclose their Social Security Numbers (SSNs). The SSA would be required to verify the validity of the SSNs.

Rationale: With the knowledge of a national, unique personal identifier, this proposal would provide an important tool to improve our ability to deny entry into Medicare to fraudulent and unscrupulous providers and suppliers.

- o **Provider Enrollment Process** - This proposal would authorize the Secretary to assess an application fee for all Medicare providers at times of enrollment or reenrollment. Under the new enrollment process, a corrective action plan would need to be instituted and any overpayment recouped before a provider would be given another billing number. Additionally, HCFA would have the authority to revoke a provider number if it is determined that the provider is engaged in fraud or abuse.

Rationale: One of the most effective and efficient measures to combat Medicare fraud and abuse is the verification of provider enrollment applications to ensure that only legitimate health care providers are able to bill Medicare. Current law authorizes the Secretary to collect application fees from physicians. However, certain other provider types (e.g. DME suppliers) require a more comprehensive review and, as such, require incremental funding to satisfy enrollment requirements.

- o **Enrollment Waiting Period After Denial** - This proposal would specify that if an application has been denied, there would be a six-month waiting period before the provider could reapply.

Rationale: Instituting a six month waiting period would allow sufficient time for the applicant to meet the conditions of participation. Further a six month moratorium would prevent denied applicants the ability to inundate HCFA with applications that are not significantly different from the application that was denied.

Hospice

- o **Prevent Duplicative Payments for Hospice Services** - This proposal would clarify that a hospice can receive payment from either Medicare or Medicaid for dually eligible beneficiaries, but not both.

Rationale: Under current law, when dual eligibles who are nursing home residents elect the Medicare hospice benefit, Medicaid continues to pay at least 95% of the full nursing home rate (which includes both room and board and to some extent, medical and social services) and Medicare pays the hospice per diem (which covers the provision of all hospice benefits, including medical nursing, home health aide, and social services). The nursing home would be expected to provide the palliative care.

- o **Benefit Period Modifications and Limitation on Total Available Hospice Days** - This proposal would replace the current third and fourth hospice benefit periods with a finite number of thirty and/or sixty-day periods (after the two 90-day periods).

Rationale: The hospice benefit is intended for beneficiaries with terminal illnesses. However, there have been instances where beneficiaries have been under the hospice benefit, for example, for more than two-years. This proposal would limit the hospice benefit by allowing a beneficiary to be able to use only 360 days of hospice care in their lifetime.

- o **Limitation of Liability and Beneficiary Protection** - This proposal would clarify that if a hospice submitted a claim for a beneficiary that they had reason to believe was terminally ill we would pay the claim upon appeal. In this instance, neither the hospice nor the beneficiary would be liable for the services.

Rationale: Under current law the beneficiary is unprotected and a hospice may seek full payment from the beneficiary for denied claims for hospice care furnished to the beneficiary.

- o **Hospice Payment at Location of Service** - This proposal would link payment for hospice services to the zip code of the site where the service was furnished.

Rationale: This proposal would ensure that payments reflect the prevailing costs in the areas where services are furnished, not the higher cost urban areas where agencies tend to locate their parent offices.

TIMOTHY B. HILL

01/15/97 05:31:45 PM

Record Type: Record

To: Sarah A. Bianchi/OMB/EOP
cc: Mark E. Miller/OMB/EOP, Barry T. Clendenin/OMB/EOP, Caroline B. Davis/OMB/EOP, John M. Richardson/OMB/EOP
Subject: Fraud savings in package



Here is a slightly redrafted paragraph--

Combats Fraud and Abuse. This budget contains a strong fraud and abuse package, which builds on the initiative we enacted last year in the Kassebaum-Kennedy health insurance reform bill. The budget also includes measures to eliminate fraud in home health care, ensuring that home health agencies are reimbursed based on pricing of the location of the service rather than the pricing at the location of the billing office, which tends to be located in higher cost urban areas, and by giving the Secretary of Health and Human Services the authority to deny payments for excessive home health use. The budget also repeals several provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which weaken the enforcement of anti-fraud activities, such as the exception to the anti-kickback status for certain managed care plans, the requirement for advisory opinions, and the weakening of the current standard for assessing penalties in Medicare and Medicaid.

Also, per your request, here is the list of things that could be referred to as addressing fraud and abuse in the package (\$s in millions).

	<u>five year</u>	<u>six year</u>
MSP - <i>Medicare secondary</i>	7,460	10,180
Repeal of KK costers	330	400
Home health location of service	370	460
Home health PIP	970	1,050
SNF consolidated billing	(40)	(60)
Total	9,090	12,030

Please call me with questions.

Managed care exception to anti-kickback
civil no netting payment
Diving standard - Kickback
PAAB services. nh bill case
cost periodic interim payments - what we think

\$ 81.9 ~~~~~ 72

\$116 ~~~~~ OPDs 103

13

Formula driven overpayment

PRESIDENT CLINTON ANNOUNCES MEASURES TO FIGHT WASTE, FRAUD, AND ABUSE IN HEALTH CARE

Today, President Clinton announced plans to send Congress new legislation to fight waste, fraud, and abuse in health care. The "Medicare/Medicaid Anti-Waste, Fraud and Abuse Act of 1997" establishes tough new requirements for individuals and companies that wish to participate in Medicare or Medicaid. The new legislation follows on four years of focused effort by the Clinton Administration that has helped save more than \$20 billion in health care claims through policy changes, penalties, recoveries, claims denials, and settlements. The legislation will also build on the Justice Department's comprehensive efforts to fight health care fraud. Due to the Justice Department's increased resources, focused investigative strategies, and better coordination among law enforcement, the number of health care fraud convictions increased by 241 percent since FY 1992.

NEW LEGISLATION

Strengthening the Provider Enrollment Process. The bill makes a series of changes in provider enrollment rules, including:

- Barring Felons. The Secretary of Health and Human Services would be authorized to deny participation in Medicare and Medicaid for any person who has been convicted of a felony.
- Requiring Provider Identification Numbers. HHS would require health care providers applying for participation in Medicare or Medicaid to provide their Social Security numbers and their Employer Identification numbers for use as their provider identification number. The Health Care Financing Administration could then check an applicant's history for past fraudulent activity.
- Requiring Remedial Action Plans. Providers who are rejected for participation in Medicare or Medicaid would be required to submit a remedial plan and to wait six months before reapplying for participation.

New Sanctions. The Federal government's ability to levy sanctions against providers of Medicare services who commit fraud would be strengthened through the use of new civil monetary penalties, including:

- Penalizing False Certification. Physicians who falsely certify that an individual meets certain Medicare requirements would be subject to penalties.
- Barring Kickbacks. Providers that violate Medicare's prohibition against kickbacks -- such as referring a patient to a facility owned by the provider -- would be subject to penalties.
- Prohibiting Hiring of Excluded Individuals. Hospitals or other providers would be fined if they are found to have hired individuals who have been excluded from Medicare.
- Specifying Civil Monetary Penalties. The bill would specify dollar amounts for civil monetary penalties that may be imposed on certain providers.

Closing Loopholes. The President's proposal protects Medicare and Medicaid beneficiaries by closing loopholes that can allow fraud and abuse to occur.

- Eliminating Fraudulent Use of Bankruptcy Protections. The President's plan would close a loophole that allows Medicare and Medicaid providers and suppliers found to be engaging in fraudulent practices to avoid paying the administrative penalties and returning the money they owe by declaring bankruptcy.

- Eliminating Abusive Charges Under Home Health Care Benefits. This proposal would close a loophole in current law that automatically makes anyone who needs blood drawn at home eligible for a variety of more expensive home health services. Current law has allowed some providers to use an inexpensive service as a gateway to bill Medicare for other more lucrative services.
- Cracking Down on Abusive Uses of Medicare Reimbursement. Under the President's proposal, HHS would deem the sales price of a health care institution to be its net book value, closing a loophole that allows sellers to create a phony "loss" and take advantage of reimbursement from Medicare.
- Assuring Appropriate Billing for Mental Health Benefits. The President's proposal would halt providers from pretending to furnish partial hospitalization services in a beneficiary's home or in an inpatient or residential setting. The proposal would also provide authority for the Secretary of Health and Human Services to establish new tougher standards for Community Mental Health Centers (CMHCs), and would provide authority for CMHCs to be surveyed by state agencies to determine compliance with Federal requirements or investigate complaints upon request.
- Preventing Abuse of Hospice Benefits. This proposal would link payment for hospice services to the geographic location of the site where the service was furnished, as the President's FY 1998 budget bill proposes for home health care. This would allow payments to reflect the prevailing costs in the areas where services are furnished, not the higher cost urban areas where agencies tend to locate their parent offices.

PRESIDENT CLINTON'S FY 1998 BUDGET PROPOSALS

The policies proposed today are designed to work in tandem with other anti-fraud and abuse proposals in President Clinton's FY 1998 budget proposal. These proposals include:

- Paying home health services based upon the location where the service is provided -- the patient's home -- as opposed to where the service is billed. This provision eliminates higher reimbursements that accrue to HHAs with parent offices located in urban centers.
- Eliminating periodic interim payments to home health agencies. These payments were previously used to encourage Medicare participation and are now no longer necessary.
- Requiring all skilled nursing facilities (SNFs) to bill Medicare for all services (with some exceptions) their residents receive and prohibit payment to any entity other than the SNF for services or supplies furnished to Medicare-covered patients.

BUILDING ON PREVIOUS CLINTON ADMINISTRATION ACTIONS

Since taking office, President Clinton has made combating waste, fraud, and abuse in health care a major priority. President Clinton's first budget closed loopholes in Medicare and Medicaid that had allowed waste, fraud, and abuse to occur. And in 1993, at the President's urging, the Attorney General put fighting health care fraud at the top of the Justice Department's agenda. Since 1993, the Justice Department has dramatically increased health care fraud investigations, criminal prosecutions, and convictions. To build on these efforts, two years ago, the Clinton Administration launched Operation Restore Trust, a comprehensive anti-fraud initiative, in 5 key states. Since its inception, Operation Restore Trust has produced returns of \$10 in overpayments for every \$1 invested. In 1996, President Clinton signed the Kassebaum-Kennedy legislation into law, expanding Operation Restore Trust nationwide, and for the first time, creating a stable source of funding for fraud control.

PRESIDENT CLINTON ANNOUNCES MEASURES TO FIGHT WASTE, FRAUD, AND ABUSE IN HEALTH CARE

Today, President Clinton announced plans to send Congress new legislation to fight waste, fraud, and abuse in health care. The "Medicare/Medicaid Anti-Waste, Fraud and Abuse Act of 1997" establishes tough new requirements for individuals and companies that wish to participate in Medicare or Medicaid. The new legislation follows on four years of focused effort by the Clinton Administration that has helped save more than \$20 billion in health care claims through policy changes, penalties, recoveries, claims denials, and settlements. The legislation will also build on the Justice Department's comprehensive efforts to fight health care fraud. Due to the Justice Department's increased resources, focused investigative strategies, and better coordination among law enforcement, the number of health care fraud convictions increased by 241 percent since FY 1992.

NEW LEGISLATION

Strengthening the Provider Enrollment Process. The bill makes a series of changes in provider enrollment rules, including:

- Barring Felons. The Secretary of Health and Human Services would be authorized to deny participation in Medicare and Medicaid for any person who has been convicted of a felony.
- Requiring Provider Identification Numbers. HHS would require health care providers applying for participation in Medicare or Medicaid to provide their Social Security numbers and their Employer Identification numbers for use as their provider identification number. The Health Care Financing Administration could then check an applicant's history for past fraudulent activity.
- Requiring Remedial Action Plans. Providers who are rejected for participation in Medicare or Medicaid would be required to submit a remedial plan and to wait six months before reapplying for participation.

New Sanctions. The Federal government's ability to levy sanctions against providers of Medicare services who commit fraud would be strengthened through the use of new civil monetary penalties, including:

- Penalizing False Certification. Physicians who falsely certify that an individual meets certain Medicare requirements would be subject to penalties.
- Barring Kickbacks. Providers that violate Medicare's prohibition against kickbacks -- such as referring a patient to a facility owned by the provider -- would be subject to penalties.
- Prohibiting Hiring of Excluded Individuals. Hospitals or other providers would be fined if they are found to have hired individuals who have been excluded from Medicare.
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FRAUD AND ABUSE

I. FRAUD AND ABUSE

A provision in the Kennedy/Kassebaum bill strengthens Federal efforts to combat health care fraud, waste, and abuse. It would increase resources to expand currently successful efforts at HHS, Justice, and Labor to root out fraud and abuse, such as Operation Restore Trust.

II. PURPOSE

This provision continues and intensifies Federal efforts to root out health care fraud and abuse through enhanced oversight and enforcement activities.

III. IMPACT

- This provision will save about \$3.5 billion in Federal funds over seven years.
- The provision will have a significant effect on private health plan savings by strengthening Federal efforts to detect and prosecute fraud and abuse.

IV. SPECIFIC PROVISIONS

- Creates the Health Care Fraud and Abuse Control Program to combat health care fraud and abuse in both public and private health plans. This program will be coordinated by HHS and the Attorney General. In 1997, over \$100 million is designated to fight fraud and abuse in the Medicare and Medicaid programs.
- Establishes the Medicare Integrity Program to provide a stable source of funding for efforts to assure the integrity of Medicare.
- Strengthens enforcement efforts by creating a new criminal statute and new civil penalties for health care fraud and abuse. The funds recovered under this provision would be returned to the Medicare trust fund.

V. ADMINISTRATION HISTORY ON ISSUE

The Clinton Administration has been aggressive in developing and implementing new strategies to combat managed care fraud and abuse. In 1995, the Clinton Administration launched "Operation Restore Trust" to combat Medicare fraud and abuse. The increased funding provided in the Kennedy/Kassebaum legislation will expand this program nationwide. Many more of the bill's provisions to enhance enforcement are similar to provisions in the President's proposed legislation.

DRAFT**HEALTH CARE FRAUD AND ABUSE CONTROL*****Introduction:***

The Department of Health and Human Services, through the Health Care Financing Administration (HCFA) and the Department's Office of the Inspector General (OIG), has stood in the forefront of the insurance industry in re-engineering current procedures to guard against fraud and abuse. As health care delivery systems become increasingly complex, our activities must expand.

Health Insurance Portability and Accountability Act of 1996

The Kennedy-Kassebaum Act includes new legislative provisions sought by the Administration to assist the federal government in its efforts to combat waste, fraud, and abuse.

The legislation creates a Health Care Fraud and Abuse Control Program to be coordinated by HHS-OIG and the Attorney General to be funded from an appropriation from the HI Trust Fund in amounts certified by the Secretary of HHS and the Attorney General. The legislation also establishes a Medicare Integrity Program funding source for Medicare payment integrity activities in HCFA. The legislation also strengthens health care law enforcement efforts by extending many current Medicaid and Medicare civil monetary penalties to all federal health care programs, by giving HHS and DoJ more authority to exclude providers from federal programs, by encouraging beneficiaries to report instances of fraud and abuse, by establishing an Adverse Action Data Base against health care providers, suppliers, or practitioners who commit fraud, and by creating a federal fraud statute.

According to CBO, this law will save about \$3 billion in federal funds over seven years, and will have a significant effect on private health plan savings by strengthening federal efforts to detect and prosecute fraud and abuse.

Operation Restore Trust (ORT)

In preparation for the eventual passage of the fraud control provisions in Kennedy-Kassebaum, this Administration has embarked upon a \$7.9 million demonstration project, Operation Restore Trust, to develop new and innovative methods to combat health care waste, fraud, and abuse. Operation Restore Trust is a two-year effort to combat health care fraud, waste and abuse in the five states with the highest Medicare expenditures: California, Florida, New York, Texas and Illinois.

In "Operation Restore Trust," HHS designated an interdisciplinary project team of federal and state government representatives to target Medicare abuse and misuse in these five States.