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Medicare
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Today's debate: **FIXING MEDICARE**

Medicare wastes billions as inept management rules

OUR VIEW While debate rages over paring benefits, the system shovels away \$23 billion a year in waste and fraud.

The 32-year-old Medicare system just had its first comprehensive financial physical. And federal reviewers discovered it's ailing — badly.

In fact, the \$300 billion medical system for the nation's 38 million elderly and disabled is a financial wreck.

Most disturbing is the news that 14 cents of every tax dollar spent on Medicare is spent to overpay doctors, hospitals and other health providers. In 1996 alone, taxpayers spent \$23 billion on improper or illegal medical bills that should not have been paid — an amount so large that it outstrips any abuse in recent memory, \$100 a year for every person in the country.

Some of the improper payments involved phantom documentation. Like the case of a doctor who was paid \$523 for 10 hospital visits when he made only two.

Other claims were for unnecessary care. One home health agency, for instance, paid nearly \$12,000 to provide physical therapy to a patient who didn't need it.

Of the medical bills audited, 30% contained mistakes. And reviewers say Medicare's actual error rate probably is even higher since the audit was designed to root out only the most obvious errors and fraud.

Perhaps the audit shouldn't have come as a surprise. The Health Care Financing Administration, which administers Medicare, was warned by auditors in 1994 about shoddy accounting systems. And outside critics have long contended that Medicare presents a tempting target for abuse. After all, the government reviews only 9% of the 800 million medical bills it pays each year.

But for five years, those who run the program have assured Congress that their

Wasting billions

Here's a breakdown of the overpayments uncovered in the Medicare audit:

Problem	% of total payment errors ¹	Value (billions)
Not medically necessary	37%	\$ 8.5
Insufficient documentation	33%	\$ 7.6
No documentation	14%	\$ 3.3
Incorrect billing codes	9%	\$ 2.0
Noncovered services	5%	\$ 1.2
Other	3%	\$ 0.6
Total		\$23.2

¹Percentages exceed 100 because of rounding.

Source: Office of the Inspector General, Department of Health and Human Services.

fraud-fighting efforts were unparalleled. And even now, the problem isn't fully exposed. The program's accounting system is so chaotic that auditors had no way to review several billion-dollar accounts.

For Congress, the error couldn't have come at a more awkward time. The amount squandered exactly matches the amount Congress plans to trim from Medicare benefits to balance the federal budget.

The bitter irony was not lost on Rep. Bill Thomas, R-Calif., who heads the subcommittee that oversees Medicare. He promised more money to combat medical fraud.

That, coupled with rigorous audits, should help. Fraud investigators for Travelers/Aetna Property Casualty Corp. recover \$25 for every dollar spent on fraud control.

But such measures can only expose Medicare's flaws, not repair them.

For Medicare fraud to reach this point on the shock scale, its managers had to be incredibly inept. For years, they ignored horror stories from patients, providers and their own field representatives. They tinkered with a system that required fundamental reform. Even now, they insist they're on the right track.

Not likely. Without an overhaul, Medicare will never enjoy fiscal health.

USA TODAY • MONDAY, JULY 21, 1997

PHOTOCOPY
PRESERVATION

We're on the right track

OPPOSING VIEW The government already moved to stop waste and fraud. It saved \$6 billion last year.

By Bruce C. Vladeck

No one is more committed to stopping fraud and abuse in Medicare than the people who run Medicare. That's why we worked shoulder to shoulder with the auditors and welcome their findings as a road map to further improvements.

The audit shows we have been on target in fighting fraud and abuse, and we must do even more to make sure claims are filed, documented and paid properly. The estimate of improper payments in the audit and the reasons — inadvertent errors, insufficient documentations, fraud and abuse — provide a guide.

We're already taking action, and we'll put even more reforms into place over the next two years. We have made solid, measurable progress, and this audit, the first of its kind for Medicare, will help us target our scarce resources to do even better.

We began in earnest four years ago when President Clinton declared "zero tolerance" for fraud and abuse and launched our Integrity Program, an interagency initiative of prevention and early detection.

Last fiscal year alone our efforts saved \$6 billion — \$14 saved for every \$1 spent on safeguarding Medicare.

Operation Restore Trust, started two years ago in five states, identified \$23 in waste, fraud and abuse for every \$1 spent investigating. Based on that success, we're expanding it to 12 states.

Supercomputers at Los Alamos National Laboratory help detect patterns of abuse. And the president is fighting for legislation to crack down even harder. It would enable us to bar felons, ban kickbacks, and close loopholes that fraudulent suppliers use to declare bankruptcy and avoid repaying Medicare when they get caught.

In its 31 years, Medicare has vastly improved the health and welfare of seniors and disabled citizens. We are the world's largest health-care insurer, processing 800 million claims a year at a far lower administrative cost than any private company. But only in the last five years have modern accounting principles and the standards that go with them been applied — making Medicare run more like a business.

We've come a long way in five years. But we still have work to do, and this audit will be a big help.

Bruce C. Vladeck is administrator of the Health Care Financing Administration, Department of Health and Human Services.

No time for 5 and dime

There was no need to stop the presses last week when Wall Street welcomed Woolworth Corp.'s decision to close its 400 five-and-dimes. Sentiment has no place in a bull market. Woolworth rose 2½ points Thursday to \$27.56 before settling to close Friday up two. For investors, the stores' loss was their gain.

That's fitting, in a way. Over several generations, some large number of American youth had their first and hopefully only experience with another loss-gain dynamic at the expense of Woolworth stores: petty larceny. Small treasures — a toy, a cosmetic, a big-little book — were laid out with great faith and scant attention. The lesson learned from getting caught (or not getting caught and feeling guilty) was formative.

Of course, pilferage had little to do with the end of the five-and-dime. For that, you must blame the realities of retailing in the late 20th century: Languishing downtowns, where Woolworth was a fixture; suburban malls, which house more consumer options; discount megastores like Wal-Mart. With its vast array of merchandise, Wool-

worth was a proto-megastore, and there's no telling how many small merchants it put under. But by dint of its pressed tin ceilings and wood-plank floors and downtown locations, the chain retained a community ambience nonetheless.

In this way, consumers may not be totally blameless. The chain wasn't shoplifted into closure. But it was abandoned to it. These days, who needs a single place where you can buy a parakeet toy and a spool of thread and some nice cotton stockings and a grilled cheese sandwich? We have specialty stores for those things. We have outgrown the thrifty values on which Woolworth was based.

Could it be we have just moved up-market? A half-century ago, a Woolworth pianist would play sheet music for you so you could decide if you wanted to spend your hard-won nickel for it. In music stores today, you can pick up headphones and listen to a compact disc before charging its \$15.99 cost on your plastic. Is that the same essential service? If you think so, you have a future on Wall Street.



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FOLLOWING 8 PAGES

TO: CHRIS JENNINGS

FAX # _____

FROM: CHARLIE SALEM

DATE: 9-3-96 TIME: 5:00

NOTE: Medicaid Fraud in Florida -

MEMORANDUM

TO: Chris Jennings
FROM: Charlie Salem *CS*
SUBJECT: Managed Care in Florida
DATE: September 3, 1996

I am attaching some background information on Florida's efforts to curtail Medicaid fraud. A summary of the bill, signed by the Governor, on Medicaid managed care reform is also included. Doug Cook has just completed an editorial board swing on this issue – you may want to get some of his impressions.

There was a minor bill, vetoed by the Governor which would have provided individual lawsuits against HMOs by consumers alleging an inappropriately denied service. The Governor's veto was based on his belief that these disputes could be better handled through Subscriber Assistance Panels.

As you know, in addition to state efforts to curtail Medicaid fraud, there is an ongoing state-federal partnership with HHS and the Justice Department to reduce the number of unscrupulous providers for both Medicaid and Medicare.

Hope this information helps. Please call me if you have any questions.

Florida Sets The Pace

- ◆ Proving ground for new fraud-fighting initiatives
- ◆ Florida strategies copied by Medicare and other states
- ◆ Medicare DME reviews “straight from Florida’s book,” according to the Health Care Financing Administration (HCFA)
- ◆ Florida’s \$50,000 surety bond requirement being considered for federal implementation
- ◆ HCFA encouraging Medicaid directors across the nation to use Florida’s provider enrollment agreement

Fighting Fraud in Florida

- ◆ **Provider Reenrollment Initiative** — on-site visits; FDLE background checks; surety bonds; purge of inactive providers; and reenrollment of all providers for a projected savings of \$10 million
- ◆ **New Provider Agreement** — disclosure of owners, managers and principals; five-year limit on enrollment subject to renewal; easier to prosecute
- ◆ **New System Edits** — \$8 million savings
- ◆ **Billing Analyses/Audits** — identified \$14.3 million in overpayments; sanctioned 83 providers in 1995-96
- ◆ **Intercepted/Pended/Stopped Payment** — \$4.6 million since January
- ◆ **Since July 1993, 461 suspected fraud referrals to Medicaid Fraud Control Unit** — 263 in 1995-96 alone
- ◆ **Since January, 89 Agency referrals made to Statewide Grand Jury**
- ◆ **Disenrolled 62% of DME providers and 41% of home health agencies**

Special Initiatives

- ◆ **Clinic Initiative** — \$1.3 million in claims suspended; \$10 million savings on projected 1996 claims; terminated 55 providers
- ◆ **Durable Medical Equipment Initiative** — 99 cases referred to MFCU; terminated 49 providers billing under post office box scam; on-site reviews to detect phantom providers
- ◆ **Home Health Initiative** — 11 referrals to MFCU; expenditures dropped 43.5 percent; new 60-visit limit
- ◆ **Transportation Initiative** — In Palm Beach, \$13 million savings and 10 providers suspended/three terminated; expenditures dropped 14.7 percent statewide

The Next Steps

- ◆ Partnership — national, state and local levels
- ◆ Better coordination between state-federal regulators and law enforcement
- ◆ Provider enrollment limits — credentialing, competitive bidding, quality of care reviews, outcome measurement
- ◆ Enhanced system edits, making it tougher to receive payment for fraudulent claims (ProDUR, physician utilization review system)
- ◆ More aggressive criminal prosecution of high-profile abusers

Medicaid 1996/97 Prepaid Health Plan Statutory Changes

Assignment

- Requires the agency to approve a merger or acquisition of a plan when approved by the Department of Insurance unless the plan is not in good standing.

Capitation rate adjustment

- Specifies that the plans' capitation rate has been adjusted to cover the cost for third party choice counseling services, enrollment and disenrollment.

Competitive Bid

- Reserves the right of the agency to competitively bid the contract.

CPHU Agreement

- Changes the agreement to reflect public provider requirements.

Disenrollment

- Requires the agency to be responsible for processing plan disenrollments.
- Specifies procedures to be used by plans for informing each member of the new disenrollment requirements.

Emergency Medical Condition Emergency Services and Care Emergency Services

- Adds statutory definitions for emergency services.
- Requires plans to pay for trauma and pre-hospital emergency services without prior authorization.
- Requires plans to reimburse providers for emergency services to providers at the lesser of the provider's charges; usual and customary charges; an agreed upon rate; or the Medicaid rate.
- Specifies that the determination of an emergency is made by hospital personnel.

Enrollment

- Specifies the agency will be responsible for enrollment of recipients into the plan.
- Specifies the agency will verify the intent of the recipient to join the plan.
- Specifies procedures for plans to use for pre-enrollment transmissions to the agency.

Enrollment Notification

- Specifies plans' responsibilities for new enrollee notifications.

EPSDT

- Requires plans to achieve a 60% EPSDT screening rate.

Family Planning

- Requires the plan to refer enrollees for postpartum visits and family planning.
- Requires plans to offer counseling and family planning to all women and their partners.

Grievance

- Allows members with grievances the right of appeal to the Statewide Provider and Subscriber Assistance Panel.

Insolvency Protection Account Waiver

- Allows the agency to waive the insolvency protection account when evidence of adequate insurance or reinsurance are in place.

Licensing

- Requires all plans (excluding certain public entities) to be commercially licensed by the Department of Insurance.
- Requires certain public entities to be commercially licensed by the Department of Insurance by July 1, 1997.

Marketing

- Minor wording changes to reflect final statutory language.

Marketing and Pre-enrollment

- Adds new sections, moves marketing and pre-enrollment activities into related section of the contract.
- Minor wording changes to reflect final statutory language.

Out of Plan Use of Non-Emergency Services

- Requires plans to reimburse authorized services provided by any physician or hospital out of the plan's geographic service area at a rate negotiated with the provider or at the lesser of: the usual and customary charge made to the general public by the hospital or physician or the Medicaid reimbursement rate established for that provider.

PCP Active Patient Load

- Requires plans to ensure, through physician certification, that a primary care physician (PCP) has an active patient load of no more than 3,000.
- Defines active patient as a patient who is seen by the same primary care physician, or physician assistant or advanced nurse practitioner under the supervision of the physician, at least three times within a calendar year.

Public Providers

- Requires plans to pay without prior authorization, claims for immunizations, treatment of communicable diseases, family planning, pharmacy, and urgent health services provided in a school setting.

Quality Assurance

- Requires plans to quarterly review five clinical areas.

Rate adjustment

- Provides for periodic cost adjustment to reflect the plans' portion of total cost for choice counseling, enrollment and disenrollment.

Sanctions

- Defines the agency's ability to fine for willful or nonwillful violations of the contract.

Therapy Services

- Requires the agency to reimburse certified school match programs for school based therapies.

PRESIDENT CLINTON ANNOUNCES UNPRECEDENTED PROGRESS IN FIGHTING MEDICARE FRAUD AND ABUSE

Today, President Clinton announced the first annual progress report by the Departments of Justice and Health and Human Services on the nation's successful efforts in cracking down on Medicare fraud and abuse. He also unveiled a series of new legislative and executive actions to build on the Administration's impressive record in this area, specifically, he announced:

- **That Nearly \$1 Billion Has Been Returned to the Medicare Trust Fund in Just One Year**
- **A 10-Step Anti-Fraud and Abuse Legislative Package That Saves Medicare at Least \$2 Billion**
- **Unprecedented Steps to Involve Medicare Beneficiaries in Identifying and Combating Fraud and Abuse**
- **Nationwide On-Site Inspections to Target Medical Supplier Rip-Off Artists**
- **A Nationwide Conference, With Law Enforcement Officials and Others, Designed to Identify the Next Steps to Fight Fraud and Waste**

THE PRESIDENT ANNOUNCED:

A Justice/HHS Report Which Cites Nearly \$1 Billion in One Year in Savings For the Medicare Trust Fund. On Monday, the President is sending to Congress the first annual report of the Health Care Fraud and Abuse Control Program -- created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) -- which shows remarkable progress in rooting out health care fraud and abuse. In FY1997 alone, the first full year of anti-fraud and abuse funding under HIPAA, nearly \$1 billion was returned to the Medicare Trust Fund, the largest amount ever. These efforts:

Returned nearly \$1 billion to the Medicare Trust Fund from collections of criminal fines, civil judgements and settlements, and administrative actions. This was the largest recovery amount ever collected in one year.

Excluded more than 2,700 individuals and entities from doing business with Medicare, Medicaid, and other federal and state health care programs for engaging in fraud or other professional misconduct -- a near doubling (a 93 percent increase) over 1996.

Increased convictions for health care fraud-related crimes by nearly 20 percent.

Pursued 4,010 civil health care fraud cases -- an increase of 61 percent over 1996.

A New 10-Step Anti-Fraud and Abuse Legislative Package That Saves Medicare At Least \$2 Billion Over Five Years, including the following:

Eliminating overpayments for certain drugs, for which the Inspector General has reported Medicare currently overpays.

Ensuring Medicare does not pay for claims that ought to be paid by private insurers, such as taking steps to ensure that Medicare is aware of liability settlements and of other coverage obligations of private insurers.

Asking providers to pay for their audits, which will allow Medicare to double the number of audits.

Ensuring that providers do not leave Medicare strapped by declaring bankruptcy.

Unprecedented Steps to Involve Medicare Beneficiaries in Identifying and Combating Fraud and Abuse. The President is announcing steps to involve Medicare beneficiaries in rooting out fraud and abuse, such as:

Providing beneficiaries with new information on how to report fraud. Starting next month, Medicare beneficiaries across the nation will receive a toll-free number to call to report fraud and abuse in Medicare on every statement, bill, and claim, making it easier to crack down on fraud and abuse; and

Rewarding beneficiaries for fighting fraud. Provisions in the Kassebaum-Kennedy legislation will be implemented this spring that give beneficiaries rewards for reporting fraud.

On-Site Inspections Across the Country to Eliminate Rip-Off Artists and Scam Medical Equipment Suppliers. To ensure that medical equipment suppliers are providing the medical devices they claim, the Department of Health and Human Services is conducting nationwide on-site inspections of medical suppliers.

A National Conference to Bring Together Law Enforcement, Providers, Beneficiaries, and Others to Identify the Next Steps to Fight Fraud and Waste. While the Administration has a long record of fighting fraud and abuse, we must do more. Today, the President is announcing that this spring, the Health Care Financing Administration will hold a conference including consumers and their representatives, law enforcement officials, private insurers, health care providers, and beneficiaries, to build on the successes we have achieved in fighting fraud and abuse in the nation's health care system.

PRESIDENT CLINTON UNVEILS TEN LEGISLATIVE PROPOSALS AS PART OF HIS ONGOING ANTI-FRAUD, WASTE, AND ABUSE COMMITMENT

- (1) **Eliminating Wasteful Excessive Medicare Reimbursement for Drugs.** A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare paid more than double the actual average wholesale prices, and in one case paid as high as ten times the amount. This proposal would ensure that Medicare payments are reduced to the actual amount that the drugs cost.
- (2) **Eliminating Overpayments for Epogen.** In a 1997 report, the HHS Office of Inspector General (OIG) found that reducing the Medicare reimbursement for Epogen (a drug used for kidney dialysis patients) to reflect current market prices would result in more than \$100 million in savings to the Medicare program and beneficiaries.
- (3) **Doubling the Number of Audits to Ensure That Medicare Only Reimburses for Appropriate Provider Costs.** Right now, not all cost-based providers (e.g., hospitals, home health, non-PPS, skilled nursing facilities) are audited. This proposal would assess a fee to cover all audits and cost settlement activities for health care providers. These steps help ensure that Medicare only makes payments for appropriate provider costs.
- (4) **Lowering Medicare's Payments for Equipment Through a Nationwide Competitive Pricing Program.** Competitive Pricing would let Medicare do what most private and other government health care purchasers do to control cost -- lower costs by injecting competition into the pricing for equipment and non-physician services.
- (5) **Eliminating Abuse of Medicare's Outpatient Mental Health Benefits.** The HHS Inspector General has found abuses in Medicare's outpatient mental health benefit -- in particular, Medicare is sometimes billed for services in inpatient hospitals or homes. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.
- (6) **Creating Civil Monetary Penalties for False Certification of the Need for Care.** Recent HHS Inspector General reports identified providers who inappropriately certified that beneficiaries needed out-patient mental health benefits and hospice services. This proposal would impose penalties on physicians who falsely certify their patients' need for these two benefits.

- (7) **Preventing Providers From Taking Advantage of Medicare by Declaring Bankruptcy.** Providers who have defrauded and abused Medicare often file for bankruptcy in order to avoid paying fines or returning overpayments, leaving Medicare strapped with the bills. This proposal would give Medicare priority over others when a provider files bankruptcy.
- (8) **Taking Action to End Illegal Provider “Kickback” Schemes.** A serious area of fraud is “kickback” schemes, where health care providers unnecessarily send patients for tests or to facilities where the provider is financially rewarded. While we have established criminal penalties for these schemes, additional tools are needed to stamp out this practice: specifically, allowing prosecutors to get a court order to put an immediate halt to such schemes, and to allow civil as well as criminal remedies.
- (9) **Ensuring Medicare Does Not Pay for Claims Owed by Private Insurers.** Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. These proposals would take steps to address these problems including: requiring insurers to report any Medicare beneficiaries they cover; allowing Medicare to recoup double the amount owed by insurers who purposely let Medicare pay claims the group plan should have made; and imposing fines for not reporting no-fault or liability settlements for which Medicare should have been reimbursed.
- (10) **Enabling Medicare to Capitate Payments for Certain Routine Surgical Procedures Through a Competitive Pricing Process With Providers.** This will expand HCFA’s current “Centers of Excellence” demonstration enabling Medicare to receive volume discounts on these surgical procedures and, in return, enabling hospitals to increase their market share and gain clinical expertise.

ANTI-FRAUD, WASTE AND ABUSE LEGISLATIVE PROPOSALS FROM HCFA

Provider Accountability

- o **Sanction Authority** - This proposal would improve our ability to levy penalties on and sanction fraudulent providers.

First, this proposal would create a new civil monetary penalty for physicians who certify that an individual meets Medicare requirements to receive partial hospitalization and hospice services while knowing that the individual does not meet such requirements.

Second, this proposal would correct the statutory oversight which failed to specify a dollar amount for civil money penalties that may be imposed upon: nonparticipating physicians who bill more than the limiting charge; providers who bill for clinical diagnostic laboratory tests; physicians who bill on an unassigned basis for services rendered to dually eligible beneficiaries; nonparticipating physicians who fail to notify beneficiaries of the actual charge of elective surgery; suppliers who fail to supply DME without charge after all the rental payments have been made; nonparticipating radiologists who bill more than the limiting charge; nonparticipating physicians who bill more than the limiting charge for mammographies; physicians that bill for assistants at cataract surgery; nonparticipating physicians who do not make refunds to beneficiaries for medically unnecessary and/or poor quality of care services; physicians who repeatedly bill beneficiaries for certain diagnostic tests in excess of the limiting charge; nonparticipating physicians and/or suppliers that bill in excess of the limiting charge.

Third, this proposal would authorize civil money penalties to be levied on providers that violated the anti-kickback statute.

Fourth, this proposal would authorize civil money penalties against anyone who knows or should know that they are submitting claims for services ordered or prescribed by an excluded individual.

Fifth, this proposal would allow civil money penalties to be levied on hospitals or other providers who hire excluded individuals.

Sixth, this proposal would extend the testimonial subpoena power and injunctive authority that the Secretary has for civil money penalties to other administrative sanctions such as exclusions.

Seventh, this proposal would overrule the Hanlester decision, such that the government need not prove that perpetrating providers had actual knowledge of the anti-kickback laws.

Eighth, this proposal would clarify that under the anti-dumping statute, physicians who are on-call to speciality hospitals must respond to a call from the hospital to come in to the speciality unit (e.g. a burn center) in order to examine and stabilize the emergency medical condition of an individual who is proposed to be transferred to that unit.

Ninth, this proposal would clarify that the Federal Employees Health Benefits Program plans are subject to health care anti-fraud and abuse sanctions.

Tenth, this proposal would create a new, generalized offense against kickbacks paid in connection with any public or private health care benefit program or plan. Those convicted under this provision would be subject to up to five years' imprisonment as well as to fines.

Eleventh, this proposal would allow civil penalties to be levied upon violators of the anti-kickback laws in connection with a federal and/or state health care program. Violators would be subject to civil money penalties of \$25,000 - \$50,000 for each violation, as well as treble damages of the total amount of the kickback.

Rationale: This proposal would provide the authority to further protect beneficiaries, Medicare and Medicaid.

This provision (which parallels the authority created in HIPAA for false certification of home health services) by penalizing physicians for inappropriate admissions to partial hospitalization programs, would create a real incentive for physicians to certify need for partial hospitalization services only for those individuals who meet Medicare requirements.

Without dollar amounts being specified, certain current law civil money penalties cannot be implemented.

Current law provides for criminal penalties or exclusion for those who violate the anti-kickback statute, both of which are very stiff remedies for a health care institution. A new CMP would provide an intermediate remedy.

A loophole exists in OIG's civil money penalty (CMP) authority which establishes a penalty for claims submitted by an excluded provider for items or services furnished directly by them. This existing CMP authority does not address (1) another party who provides a service ordered by an excluded provider, after that other party is put on notice of the exclusion, and (2) penalizing the excluded provider for ordering a service paid for by Medicare or Medicaid.

The OIG continues to have a problem with hospitals and other types of providers hiring individuals who are in excluded status. Hospitals are generally required to query the National Practitioner Data Bank (NPDB) regarding health care practitioners being hired or being granted clinical privileges. The NPDB includes all OIG exclusions. Also, hospitals are required to query the NPDB on all such practitioners every two years. Where an initial check of the exclusion list on a hiring is not done, or where the two-year check is not done, the CMP should apply. This CMP applies where the employer knew or should have known of the exclusion.

These investigative tools are needed in the complex investigations of fraud, kickbacks and other prohibited activities.

The 1995 decision of the Ninth Circuit (CA) in the Hanlester Network v. Shalala case radically interpreted the terms of the statute to put very high burdens of proof on the government. Although this case is binding only in that circuit, a return to the normal burden of proof in criminal cases should be made by legislation.

This proposal would close a loophole in the coverage of the anti-dumping statute.

This proposal would allow the Federal Employees Health Benefits Program (FEHBP) the opportunity to use current civil and criminal sanctions that are otherwise available to combat fraud and abuse. FEHBP is financed with almost 72 percent appropriated funds and is a government, not a private program which needs the authority currently denied to it to deter and punish fraudulent claims and other program abuses.

This proposal would fill a gap in current law by extending federal anti-kickback criminal sanctions to all public and private health care programs and plans.

This proposal would complement the proposed criminal anti-kickback laws and would ensure that the government has at its disposal a complete arsenal of anti-kickback enforcement weapons for use in health care fraud cases affecting federal and state health care programs.

- o **Increase Flexibility for Future Bad Debt Payments** - This proposal would give the Secretary the flexibility to revise the methodology for making payments to hospitals for bad debt from Medicare beneficiaries. (This proposal is budget neutral.)

Rationale: DHHS is under a moratorium, enacted in OBRA87, from changing any aspect of Medicare bad debt payment policy. Medicare currently reimburses hospitals for 100% of bad debt attributed to its beneficiaries. This proposal would lift the moratorium although no specific changes would be proposed at this point.

Provider Enrollment Process

- o **Improve the Provider Enrollment Process** -This proposal would clarify the provider enrollment process, and strengthen HCFA's ability to combat fraud and abuse by not allowing "bad actors" to become Medicare providers and/or suppliers.
 - First, the Secretary would have the authority to deny entry into Medicare those provider applicants that were convicted of a felony. HCFA would deny these applicants a billing number.
 - Second, the Secretary would be authorized to collect a fee for all Medicare and Medicaid applicants when they apply for enrollment or re-enrollment. If an application is denied, a six-month waiting period must be completed before the provider could reapply. The fee would cover administrative costs in processing the application and administering the HIPAA National Provider Identification program requirements to validate applications. If HCFA determines that an overpayment has occurred, the payment must be recouped before the provider would receive another billing number.
 - Third, this proposal would enhance the provider enrollment process by screening for potential fraudulent Medicare providers and suppliers. The Secretary would receive authority to require providers, physicians and other suppliers, managing employees, and all owners of providers and suppliers to disclose both their Employer Identification Numbers (EINs) (where an EIN exists) and their Social Security Number (SSNs). The Social Security Administration would be required to verify the validity of the SSN's.
 - Fourth, this proposal would close a loophole which allows an entity to inappropriately escape an exclusion in certain circumstances. Under current law, the Secretary may exclude an entity which is owned or controlled by an excluded individual. However, some entities are escaping this provision by the excluded individual transferring the ownership to an immediate family member, although the excluded individual remains in "silent" control. This new provision allows the

Secretary the discretion when making the determination whether to exclude to disregard such a transfer of ownership.

Rationale: The proposal improves the provider enrollment process by enhancing HCFA's tools for identifying and reducing fraud and abuse. Denying convicted felons entry into Medicare safeguards the program. Requiring a Medicare applicant fee and instituting a six-month waiting period after denial of entry improves HCFA's ability to process applications. The disclosure of provider and supplier EINs/SSNs increases the ability to deny Medicare entry to fraudulent and unscrupulous applicants. It would also enhance HCFA's/HCFA contractor ability to: identify related entities; detect prospective providers, physicians and other suppliers who should not be allowed to become participants in the Medicare program; and identify situations where existing providers, physicians and other suppliers improperly employ/utilize excluded individuals/entities. Charging user fees for provider numbers provides administrative savings. This user fee also helps HCFA cover the costs of administering the National Provider Identification program, required by HIPAA.

Prudent Purchasing

- o **Bankruptcy Provisions** - These proposals would protect Medicare and Medicaid interests in bankruptcy situations. - A provider would still be liable to refund overpayments and pay penalties and fines even if he filed for bankruptcy. Quality of care penalties could be imposed and collected even if a provider was in bankruptcy. Medicare suspensions and exclusions (including for not re-paying scholarships) would still be in force even if a provider files for bankruptcy. If Medicare law and bankruptcy law conflict, Medicare law would prevail. Bankruptcy courts would not be able to re-adjudicate our coverage and/or payment decisions.

Rationale: This bankruptcy provision would provide us with improved standing under bankruptcy law. When providers, suppliers or third party payers go out of business, whether due to discovery of fraudulent behavior or not, Medicare would be in a strengthened position to regain any wrongly paid monies. Additionally, this proposal would ensure that individuals and plans that owe financial obligations to Medicare, (or who have been excluded) would not be able to seek relief from the bankruptcy courts.

- o **Value of Capital When Ownership of an Institution Changes**- This proposal would deem the sales price of an asset to be its net book value. The proposal would also apply to all providers.

Rationale: There have been instances in which SNFs or hospitals currently game the system by creating specious "losses" in order to be eligible for additional Medicare payments. For example, a seller might claim that a significant portion of the purchase price of a hospital is attributable not to the value of the hospital building and other capital assets, but to the value of the certificate of need, the already assembled hospital staff, or some other intangible asset. By minimizing the value attributable to the capital assets, the seller is able to record a lower sales price, and a greater "loss" on the sale. The seller is then entitled to partial reimbursement for the loss from Medicare. This existing loophole is especially problematic in the case of hospitals paid under PPS for capital because the prospective capital payments to the new owner are unaffected by the low valuation of the hospital (prior to PPS, the new owner would be somewhat disadvantaged by the gaming because their cost-based capital payments would have been lower because of the low sales price). Further, this proposal would eliminate the need for any payment adjustments for gains or losses.

- o **Clarify the Definition of Skilled Services** - This proposal would exclude venipuncture from the eligibility criteria for intermittent skilled nursing services. Venipuncture currently qualifies as skilled nursing care and therefore meets the eligibility criterion for intermittent skilled nursing services under the home health benefit. If the other criterion are met (homebound, etc.), then a beneficiary who only requires venipuncture for the purpose of obtaining a blood sample as his/her qualifying skilled need, would be entitled to all of the other covered home health services including home health aide services. If venipuncture for the purpose of obtaining a blood sample is the only skilled service that is needed by the beneficiary, that individual should not be eligible for the home health benefit.

Rationale: Eliminating venipuncture as a qualifying skilled service for Medicare home health eligibility will limit payments for other home health services for beneficiaries who would otherwise be ineligible for services under the home health benefit.

- o **Hospice Benefit Modifications** - This proposal would revise hospice coverage and payment policies.

First, after the two initial 90-day periods this proposal would replace the current third and fourth hospice benefit periods with an unlimited number of thirty-day periods.

Second, as the President's FY98 budget bill proposed for home health, this proposal would link payment for hospice services to the geographic location of the site where the service was furnished.

Third, this proposal would also limit beneficiary liability under hospice care. Currently, the major cause for denial of hospice claims is the fact that the beneficiary was not terminally ill within the meaning of the law (i.e., did not have a prognosis of six months or less of life at the time the services were rendered). If a hospice claim is denied because the patient was not terminally ill, the patient's liability for payment would be waived and the hospice would be liable for the overpayment unless it could prove that it did not know or have reason to know the claim would be disallowed. The standard of proof would be high since both the law and HCFA instructions are explicit as to the requirement and there are well established protocols for documentation of medical prognosis.

Rationale: This proposal would allow HCFA to ensure that the hospice benefit is used for those beneficiaries with a terminal illness, but it would not terminate hospice care from those fortunate to survive longer than expected. This proposal would also 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. Under current law, a beneficiary receiving hospice care is unprotected from financial liability should the beneficiary turn out to be not terminally ill. A hospice may seek full payment from the beneficiary for denied claims for hospice care. The proposal would provide beneficiaries with protection in cases where they receive hospice care services in good faith, even if they are not, in fact, terminally ill.

Mental Health

Clarify the Partial Hospitalization Benefit -- This proposal would establish coverage requirements and limitations to minimize program abuse. This proposal would also preclude providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or nursing home. It would also provide the Secretary broad authority to establish through regulation a prospective payment system for partial hospitalization services that reflects appropriate payment levels for efficient providers of service and payment levels for similar services in other delivery systems. (The current cost reimbursement system would stay in place until the Secretary exercises this payment authority.)

Rationale: This proposal would discourage development of partial hospitalization programs targeted to patients in their homes or in settings where there is a residential population, such as nursing facilities and assisted living facilities. Finally, the partial hospitalization benefit was intended to be a less-costly alternative to inpatient psychiatric care. The current reasonable cost reimbursement methodology has resulted in excessive payment and

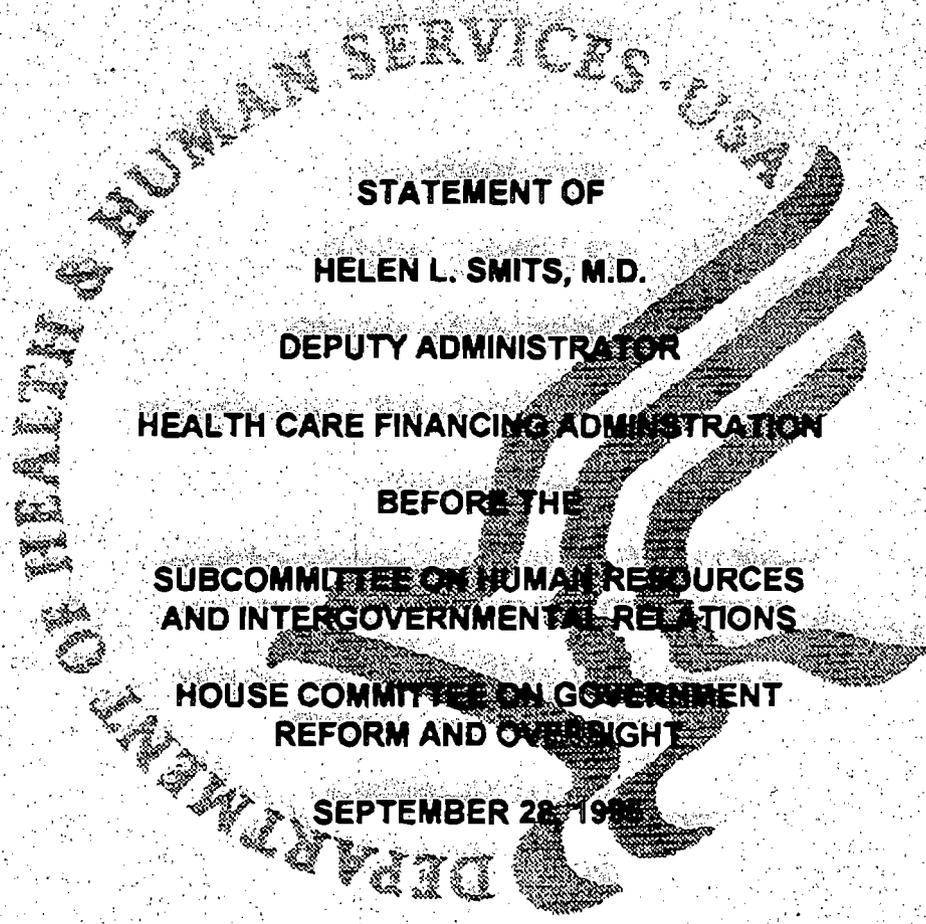
inappropriate payment for items and services that are excluded from the definition of partial hospitalization services.

Define CMHCs for Medicare Participation -- This proposal would provide authority for the Secretary to establish through regulation Medicare participation requirements for CMHCs (health and safety requirements, provider eligibility standards). Additionally, it would provide authority for CMHCs to be surveyed by state agencies to determine compliance with Federal requirements or investigate complaints upon request. This proposal will be accompanied by a user fee or specific appropriation for survey money. It would also prohibit Medicare-only CMHCs.

Rationale: Currently, a CMHC is defined as an entity that provides certain mental health services that are listed in the Public Health Service Act and meets applicable state licensing or certification requirements. Since 2/3 of the states do not license or certify CMHCs, this definition is insufficient to ensure that appropriate organizations become Medicare providers. Prohibiting Medicare-only CMHCs would discourage establishment of programs targeted to Medicare beneficiaries.

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File: 191th Case Fraud & Abuse



STATEMENT OF
HELEN L. SMITS, M.D.
DEPUTY ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS
HOUSE COMMITTEE ON GOVERNMENT
REFORM AND OVERSIGHT
SEPTEMBER 28, 1988



Mr. Chairman and Members of the Subcommittee:

I am happy to be here today to discuss H.R. 2326, the "Health Care Fraud and Abuse Prevention Act of 1995," as well as to provide updates on the Health Care Financing Administration's (HCFA's) efforts to combat fraud and abuse in the Medicare and Medicaid programs.

HCFA is committed to preventing fraud and abuse in the Medicare and Medicaid programs. However, we must recognize that fraud and abuse is pervasive throughout the health care industry in this country; Medicare and Medicaid are not the only targets. The private sector faces at least as great a problem as the government. As a result, public/private partnerships that bring together the best thinking and the best practices are the key to reducing fraud and abuse. HCFA is continuing its acknowledged leadership in using innovative and aggressive strategies while we work closely with our partners in the private sector and the States.

We also note the leadership role of the Department of Labor through its Pension and Welfare Benefits Administration and Office of Inspector General in combating health care fraud in private employment-based health benefit plans. We urge that, to the extent health care fraud provisions include these private plans, this bill reflects the Department of Labor's important role.

The "Health Care Fraud and Abuse Prevention Act of 1995" speaks to many of HCFA's concerns in combatting fraud and abuse in health care programs. In fact, in a number of areas, the bill reflects activities that HCFA and its Federal partners, the HHS Office of Inspector General and the Department of Justice, are already engaged in. I would like to compliment Mr. Schiff, Mr. Shays, Mr. Towns and their cosponsors for advancing the debate by introducing this bill. Before I begin my comments about the bill, I want to provide you with an update on HCFA's activities in this area.

Since Mr. Vladeck testified before you in June, the Administration has proposed legislation, "The Medicare and Medicaid Program Integrity Act of 1995," to create the Benefit Quality Assurance Program for Medicare and the HHS Fraud and Abuse Control Fund.

Under the Benefit Quality Assurance Program, HCFA would establish specialized, multi-year contracts for program integrity activities. At present, funding for HCFA program integrity activities is subject to the variability of the budget process. This instability makes it difficult for HCFA to invest in innovative strategies to control fraud and abuse. Our contractors also find it difficult to attract, train, and retain qualified professional staff, including auditors and fraud investigators.

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The Benefit Quality Assurance Program would provide a level funding stream for a five-year period. This proposal would allow HCFA the flexibility to invest in new and innovative strategies to combat fraud and abuse. It would help HCFA to shift emphasis from post-payment recoveries on fraudulent claims to pre-payment strategies designed to ensure that more claims are paid correctly the first time.

The HHS Fraud and Abuse Control Fund would allow the Department to reinvest savings from settlements and court awards in Medicare and Medicaid fraud cases, after the programs had been made whole, through a fund that can be used to finance further fraud investigations.

Experience has shown that investment in anti-fraud and abuse activities yields a high return. Our proposals would help provide stable funding for these activities and thus help assure that we reap this benefit.

While legislative changes are certainly important, we have made great strides in curbing fraud and abuse under current law. HCFA has pioneered initiatives aimed at prevention, early detection, and coordination. We have financed cutting-edge computer technology through our contractors. We support the development of "state-of-the-art" technology -- increasingly sophisticated information systems -- used by us and our private partners to detect and to deter fraud and abuse.

Focusing on Fraud: The South Florida Workgroup

A successful partnership was created to tackle serious fraud and abuse problems in South Florida. Medicare and Medicaid expenditures in Florida are among the highest in the nation, and fraud and abuse is a serious factor in a variety of health care settings. To address this problem, we established a joint initiative including HCFA, our claims payment contractor, the Florida State Medicaid agency, the HHS Office of the Inspector General, and the Florida Attorney General's Office Medicaid Fraud Control Unit.

The workgroup was formed to provide support and recommendations to HCFA and the Florida contractors about what could and should be done to combat the chronic fraud and abuse in South Florida. The group's effort represented an unprecedented degree of coordination. As a result of its work, we have identified over \$100 million in savings and recoupments over five months. HCFA is looking carefully at areas identified as particularly vulnerable to fraud including home health services, durable medical equipment and independent physiological laboratories.

- o Because of fraud-related investigations, HCFA suspended payment to 44 South Florida providers since this summer,

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preventing the payment of \$2.2 million in Medicare funds.

- o The U.S. Attorney's office, acting on information detailed by HCFA contractors, has frozen more than \$4 million in bank accounts pending further investigation of several providers.
- o As a result of our coordinated effort to share information on fraud activities with our contractors, the Florida Medicare contractor conducted intensive medical review of claims for outpatient therapeutic mental health treatment programs. As a result of this review, the contractor denied 77 percent of services billed for 1994. Medicare saved \$3 million in Dade and Broward counties alone in 1994.

HCFA has also formed the Program Integrity Group to help identify possible areas of program weaknesses and will help coordinate its activities. The Program Integrity group consists of high level HCFA officials whose expertise will help identify problems in the Medicare and Medicaid provider enrollment process.

This group is currently examining ways of limiting participation of suppliers and providers to those that appear to be legitimate business entities. When considering these options, however, we are conscious of the need to assess the reporting burden and costs that new requirements may pose for honest providers.

Operation Restore Trust

The South Florida workgroup involved an unprecedented degree of cooperation between public and private entities. Based on our successful experience in South Florida, HCFA and the Inspector General have formed a new partnership of Federal and State agencies to crack down on Medicare and Medicaid fraud and abuse. We believe we can accomplish more by working together as partners than we can each achieve alone with the same resources.

This partnership, Operation Restore Trust, is a demonstration targeting five of the most populous states -- New York, Florida, Illinois, Texas and California. These five states account for nearly 40 percent of all Medicare and Medicaid beneficiaries. Our partners include the Office of the Inspector General, the Administration on Aging, the Department of Justice, state government and private sector representatives.

The partnership will identify and penalize those who willingly defraud the government. It will alert the public and industry to known fraud schemes. The partnership will also help identify and correct the vulnerabilities in the Medicare and Medicaid programs. The initiative targets four types of health care providers -- nursing facilities, hospices, home health agencies, and durable medical equipment suppliers.

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Tactics include HCFA and IG financial audits; stepping up criminal investigations, civil and administrative penalties, and recovery actions; and increasing surveys and inspections of long-term care facilities in cooperation with State officials. In order to inform beneficiaries, the public and industry, the HHS Inspector General will issue special fraud alerts to notify the public and the health care community about schemes in the provision of home health services, nursing care and medical equipment and supplies. Additionally, a fraud and waste report hotline -- 1-800-HHS-TIPS -- is available for public use.

Operation Restore Trust emphasizes improved communication between Federal and State agencies. In addition, we are demonstrating the use of State quality surveyors to scrutinize possible fraud and abuse by targeted providers. If our experience in South Florida is any indication, this joint effort should yield a substantial savings to the Government.

Under Operation Restore Trust, HCFA has recently opened a satellite office to specifically combat Medicare and Medicaid fraud and abuse. The Miami office will provide assistance to Federal, State and local law enforcement authorities in Medicare and Medicaid investigations. I would like to take this opportunity to share with you some of the results of our Miami office to date.

- o A Miami area businessman has been charged with stealing \$120 million by submitting fraudulent Medicare claims. His network of bogus companies extended from Miami through Fort Lauderdale. For three and a half years, physicians and beneficiaries were paid to assist in filing false claims. The businessman has agreed to plead guilty and faces up to 15 years in prison for 2 counts of mail fraud and a probation violation.
- o 18 defendants have been charged with more than \$20 million in fraudulent Medicare claims. This scam involved 5 different providers submitting claims for medical equipment and medications. Providers paid managers of retirement communities for lists of beneficiaries and also bribed physicians to sign prescriptions. The defendants each face up to a 5 year prison term and a fine up to \$250,000 and restitution.

The Miami office has also provided assistance to HCFA's Medicare claims processing contractors and the Medicaid State Agency to improve and increase the productivity of their program integrity projects.

- o We investigated 200 beneficiaries whose account numbers were used to bill thousands of services in dozens of scams under investigation by HCFA and law enforcement. Beneficiaries

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reported that their Medicare cards (containing their Medicare number) were either lost, stolen, or misappropriated.

In response, the Medicare contractor has adjusted its automated claims processing system to reject claims for services to beneficiaries who have received excessive line items of service during the past 30 days. The system is now rejecting about 1,300 claims per day with annualized savings projected at \$60 million.

If the claim is rejected, a denial message is printed on the Explanation of Benefits and sent to the beneficiary stating that usage has exceeded normal limits and that documentation of the need for the service must be submitted for an appeal of the denial. To date, no appeals have been received.

- o Further adjustments to the automated Medicare claims processing system eliminate payment for certain procedures and establish boundaries on usage for other procedures. These automated reviews have saved an average of \$600,000 per month. Annualized savings have been estimated to be \$10 million.
- o For fiscal year 1995, the Medicare contractor has identified and sought repayment for \$12 million in overpayments.

HCFA Is Improving Its Capacity to Prevent Billing Abuse

We are taking a significant step in improving contractor ability to detect billing abuses by installing a new set of edits based on a year long study we have conducted with Administar. These changes will benefit the Medicare Program and its beneficiaries by reducing spending for inappropriately billed services by approximately \$300 million per year.

Health Care Fraud and Abuse Prevention Act of 1995

I would like to take this opportunity to comment on specific components of H.R. 2326. Much of the bill would be administered by the Inspector General or the Department of Justice. I will, in general, defer to them on comment pertaining to these sections.

We support the general principle behind the Health Care Fraud and Abuse Control Account, which is similar to the Fraud and Abuse Control Fund proposed by the Administration and contained in H. R. 2280, introduced by Mr. Dingell. We believe such accounts can be very helpful in providing stable funding for fraud and abuse prevention, detection, and investigation.

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However, we have concerns about the sources and use of funds in the Control Account, for example, the bill as drafted would include in the Control Account monies collected as civil money penalties (CMPs) that are unrelated to program integrity. These include administrative penalties under Medicare and Medicaid, such as those levied on skilled nursing facilities as intermediate sanctions in place of termination.

These penalties are used to address quality of service issues rather than program integrity and are not related to the activities conducted by the Inspector General or the Department of Justice. Since these penalties are not related to program integrity, we suggest they be excluded from this Account.

We support the permissive exclusion authority in section 301. This authority would alleviate the problem of allowing individuals whose companies have defrauded the Medicare program from obtaining new companies which bill the Medicare program.

The bill's provision relating to inherent reasonableness, section 303, points toward a significant problem with how Medicare now sets the prices it pays for medical equipment and supplies. While we are proceeding with the initiative described in this section, our current inherent reasonableness process, determined by statute, is cumbersome and lengthy and prevents us from responding flexibly to changes in the medical marketplace. In many instances, Medicare is forced to pay prices far in excess of wholesale or even retail prices. Medicare's current payment policies are largely determined by statute, and we endorse giving Medicare statutory authority to set its payment rates for medical equipment and supplies to better reflect the impact of market forces.

We strongly support involving our beneficiaries in combatting fraud and abuse. As we testified in June, we believe beneficiaries are our "eyes and ears," and they provide us with a great many leads about potential abusive or fraudulent situations. Beneficiaries are regularly advised about how they can help combat fraud and abuse through material we send them when we pay a claim. We include this information in the Medicare Handbook, the next edition of which will be sent to all beneficiaries early in 1996. In fact, since we are already actively informing our beneficiaries about fraud and abuse and using them as an important first line of defense, we believe that a statutory mandate is unnecessary.

Regarding the contractor liability provision in section 301, our contractors are already under definite instructions not to pay claims from excluded providers. While we are not aware that there is any significant problem in this area, making contractors liable for such claims, where a pattern of problems is demonstrated, could help insure compliance with these

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instructions.

Conclusion

As you can see, there are many areas where we agree. HCFA is committed to working with our partners and the Members of this Subcommittee to confront the challenge of fraud and abuse. As technology changes and our health care system becomes more complex, HCFA continues to ensure access to high-quality, cost effective health care to 70 million of our most vulnerable Americans -- the aged, disabled and citizens with low incomes. Similarly, the Department of Labor continues to ensure that the promise of health coverage, which nearly 100 million workers, as well as their dependents, receive through over 4.5 million employer-sponsored health benefit plans, is kept.

For the past thirty years, HCFA has efficiently paid the health care bills of virtually all senior citizens and today pays for the care of about 20 percent of the nation's children. However, just as medical care improves and changes, so must the Medicare and Medicaid programs.

Taxpayers and Medicare and Medicaid beneficiaries deserve our assurance that each benefit dollar is being spent for needed care and services. HCFA continues to demonstrate the commitment, authority, and leadership to provide this assurance. Through partnerships between government and private industry and sophisticated information technology, we can save Medicaid and Medicare from waste.

AARP NEWS

*For further inquiry, contact American Association of Retired Persons • Communications Division
601 E Street, N.W. • Washington, D.C. 20049 • (202) 434-2560*

**Contact: Ted Bobrow/Valerie Rheinlein
(202) 434-2560**

**Statement by AARP Past President Eugene Lehrmann
on President Clinton's Proposal to Fight Health Care Fraud
March 25, 1997**

The American people need to know that waste, fraud and abuse in the nation's health care system will not be tolerated. AARP is pleased that President Clinton has announced new steps to strengthen the government's enforcement efforts in the fight against health care fraud.

AARP found in a recent study that 93 percent of Americans believe that health care fraud is widespread. The study clearly indicates that the American people believe that the status quo is no longer acceptable and that efforts to crack down on fraudulent activity must be expanded. Eighty percent said they were not aware of any efforts to reduce health care fraud. We must not allow concerns about fraud to undermine the nation's confidence in its health care system.

Many of the proposals announced today add teeth to the government's existing enforcement efforts. For example, AARP supports the proposal to require health care providers to list their Social Security or Employer Identification numbers when applying to participate in the Medicare or Medicaid programs. This would allow the Health Care Financing Administration to more effectively weed out those who have a history of fraudulent activity.

Health care consumers are willing to do their part in the fight against fraud. The study found that 90 percent of Americans believe it is their "personal responsibility" to report suspected fraud and that they would be willing to identify fraud if they knew how to recognize it and what to do about it. In addition to the steps announced today, more must be done to inform the public about health care fraud and how they can support the steps being taken to fight it.

AARP believes the proposals announced by the President today send a clear message that the fight against health care fraud is just beginning in earnest. AARP will work with the Administration, the Congress and our members to ensure that these efforts are as effective as possible.

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March 24, 1997

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue N.W.
Washington, DC 20050

Dear President Clinton:

The National Hispanic Council on Aging (NHCoA) would like to endorse the measures you will announce tomorrow to fight waste, fraud, and abuse in health care. This legislation is sure to benefit the aging and preserve the integrity of Medicare and Medicaid.

The NHCoA has been a strong advocate of measures that seek to protect the integrity of Medicare and Medicaid programs. These health care programs have long been a safety net for a majority of our elderly, and their continued existence acknowledges that healthcare should be available to all.

It is, indeed, unfair, to deny our constituency the right to healthcare due to abuses in the system. Rather, these abuses need to be stopped and providers should adhere to higher accountability standards. The measures you propose, i.e., strengthening the provider enrollment process, imposing new sanctions, and closing loopholes, will achieve this purpose.

I applaud your efforts and look forward to working together to strengthen and preserve these programs.

Sincerely,

A handwritten signature in black ink, appearing to read 'Marta Sotomayor', is written over a dotted vertical line.

Marta Sotomayor, Ph.D.
President and CEO

NATIONAL HISPANIC COUNCIL ON AGING

2713 Ontario Rd. N.W. ● Washington D.C. 20009

(202) 745-2521 (202) 265-1288 FAX (202) 745-2522 E-Mail: NHCoA@aol.com

National Committee to
Preserve Social Security
and Medicare



March 24, 1997

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mr. President:

The National Committee to Preserve Social Security and Medicare, on behalf of our 5.5 million members and supporters, commends you for your continuing efforts to fight waste, fraud and abuse in the health care industry. While we have not had an opportunity to fully analyze the legislation, we believe the "Medicare/ Medicaid Anti-Waste, Fraud and Abuse Act of 1997" is overall an important measure that will build on current efforts to strengthen procedures for identifying fraud in the Medicare and Medicaid programs.

A major effort to prevent fraud and abuse is essential and appropriate -- particularly at a time when Congress is considering ways to ensure the solvency of the Medicare program for current and future beneficiaries.

The "Medicare/Medicaid Anti-Waste, Fraud and Abuse Act of 1997" establishes stringent requirements for individuals and companies that wish to participate in Medicare and Medicaid. These measures will assist in our efforts to ensure that Medicare and Medicaid funds go toward patient care.

Sincerely,

Martha A. McSteen
President



National Council of Senior Citizens

President
Harry Guenther
Executive Director
Steve Protulis

1331 F Street, N.W. • Washington, DC 20004-1171 • (202) 624-9549 • FAX (202) 624-9547
8403 Colesville Road, Suite 1200 • Silver Spring, Maryland 20910-3314 • (301) 578-8800 • Fax (301) 578-8999

March 25, 1997

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

Dear Mr. President:

Medicare and Medicaid, together with Social Security, provide the underpinning of a decent standard of living for the Nation's seniors. Charges and instances of fraud, waste and abuse in Medicare and Medicaid weaken public support for these programs to the loss of America's families. The National Council of Senior Citizens supports all efforts to advance the integrity of Medicare and Medicaid and to assure that fraud and waste will be uprooted at every point in the health care funding and service process.

The National Council of Senior Citizens applauds the Administration's proposed set of legislative initiatives to give more effective authority to the Federal government to fight health care fraud. We urge that Medicare monies recovered through enhanced resources and coordination be returned to the Part A Trust Fund to aid your efforts to advance Medicare solvency.

NCSC will continue to work for solutions to Medicare and Medicaid's problems without cuts in coverage or quality of care.

Thanks for your continued good works in behalf of senior citizens and their families.

Sincerely yours,

A handwritten signature in cursive script that reads "Steve Protulis".

Steve Protulis
Executive Director

MATZ · SHEA · BLANCATO
PUBLIC AND GOVERNMENT RELATIONS**FAX COVER PAGE**

DATE: March 24, 1997

TO: Bill White

FROM: Bob Blancato
Chairman, National Silver Haired Congress
Advisory Council

OF PAGES: 1

On behalf of the National Silver Haired Congress, I would like to offer our full support to the President's measures to fight fraud, waste and abuse in health care, which he will announce on March 25, 1997.

THE NATIONAL COUNCIL ON THE AGING

409 Third Street SW Washington, DC 20024 TEL 202 479-1200 TDD 202 479-6674 FAX 202 479-0735 <http://www.ncoa.org>

For Immediate Release

Press contact: Victoria Wagman
202-479-6613

The National Council on the Aging Backs Efforts to Fight Fraud in Medicare and Medicaid

WASHINGTON, D.C., March 25, 1997— The National Council on the Aging (NCOA) today affirmed its broad support for efforts to prevent fraud and waste in the Medicare and Medicaid programs.

“It’s essential to make sure these programs are working fairly and efficiently so the most vulnerable in our older population can be assured to getting the medical attention they need,” said James Firman, president and CEO of NCOA.

“While NCOA supports anti-fraud measures, we also want to make sure that they don’t inadvertently prevent access to essential medical services.”

NCOA also supports the idea of using the resources and expertise of senior centers and the aging network throughout the U.S. as a front line of defense against fraud and waste.

The National Council on the Aging is a center of leadership and nationwide expertise in the issues of aging. NCOA is committed to promoting the dignity, self-determination, well-being, and contributions of older persons and to enhancing the field of aging through leadership and service, education and advocacy. Founded in 1950 and headquartered in Washington, DC, NCOA has a diverse national membership that includes professional and volunteers, service providers, consumer and labor groups, businesses, government agencies, religious groups, and voluntary organizations.

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Partnering to Shape the Future



HEALTH CARE FRAUD SURVEY

**Conducted for the American Association of Retired Persons
(AARP)**

**by International Communications Research (ICR) Survey
Research Group**

March 1997

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

*File
HMO rates* 

For Release on Delivery
Expected at 9:00 a.m.
Tuesday, February 25, 1997

MEDICARE HMOs

**HCFA Could Promptly
Reduce Excess Payments by
Improving Accuracy of
County Payment Rates**

Statement of William J. Scanlon, Director
Health Financing and Systems
Health, Education, and Human Services Division



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the rates Medicare pays health maintenance organizations (HMO) in its risk contract program, Medicare's principal managed care option.¹ As you know, Medicare's method for paying risk contract HMOs was designed to save the program 5 percent of the costs for beneficiaries who enroll in HMOs. However, 10 years of research on Medicare's costs under HMOs has found that the program's rate-setting method results in excess payments to HMOs because HMO enrollees would have cost Medicare less if they had stayed in the fee-for-service sector.² Recently, the Physician Payment Review Commission (PPRC) estimated that annual excess payments to HMOs nationwide could total \$2 billion.³

A number of proposals have been made recently to help alleviate Medicare's HMO payment problems. For example, the proposed Balanced Budget Act of 1995 called for, among other things, mechanisms to lessen rate disparities across geographic areas and to decouple annual HMO rate increases from annual fee-for-service spending increases. The administration's current budget proposal adopts several provisions from the proposed Balanced Budget Act but also adds new twists—such as an across-the-board reduction in Medicare's HMO payments that would lower the payments from 95 percent to 90 percent of estimated fee-for-service costs. Under the auspices of the Health Care Financing Administration (HCFA), which administers the Medicare program, several demonstration projects are planned or under way, including efforts to improve risk adjustment and using a process of competitive bidding to set rates.

At the request of the Subcommittee's Chairman, we reviewed HCFA's method for setting HMO rates to identify feasible options for promptly reducing the amount of excess payments. A comprehensive discussion of our work is included in a forthcoming report. In conducting our study, we reviewed previous research on Medicare's HMO rate-setting method, analyzed available HCFA data, and had our findings reviewed by experts on HMO payment issues, including staff at PPRC and HCFA.

Today, I would like to focus my comments on our proposed modification to HCFA's HMO rate-setting method. We believe this modification could help reduce excess HMO payments under Medicare's current payment method, the administration's method, or other methods that rely on fee-for-service costs to set initial HMO rates or update

¹Other Medicare managed care plans include cost contract HMOs and health care prepayment plans, which together enroll fewer than 2 percent of the total Medicare population. Because Medicare pays these plans using methods other than capitation rates, they are not the subject of this statement.

²See the attached list of related GAO products.

³This estimate was contained in material presented to the Commissioners for their December 12-13, 1996, meeting.

those rates. Central to the current method and proposals for setting HMO rates is an estimate of the average cost of serving Medicare beneficiaries under fee-for-service in defined geographic areas (currently, counties). The actual rates paid HMOs for an enrollee are set by adjusting these averages up or down based on the enrollee's "risk" of incurring higher or lower costs. Considerable attention has focused on the failure of current risk adjustment methodology to adequately account for favorable selection, the term used to describe the tendency of HMOs to attract a population of Medicare seniors whose health costs are generally lower than those of the average beneficiary. Our work centers on the estimate of average cost of serving a county's beneficiaries: the county rate.

* In summary, we found that HCFA's current method of determining the county rate produces excess payments. Because HCFA's method excludes HMO enrollees' costs from estimates of the per-beneficiary average cost, it bases county payment rates on the average per-beneficiary cost of only those beneficiaries that remain in the fee-for-service sector and ignores the costs HMO enrollees would have incurred if they had remained in fee-for-service. Research has shown the costs of those remaining in fee-for-service to be higher on average than the likely costs of HMO enrollees. A difficulty in correcting the problem is that HCFA cannot directly observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. Our proposed modification is designed to fix that problem. We developed a way to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our approach produces a county rate that represents the costs of all Medicare beneficiaries and could result in hundreds of millions of dollars in savings to Medicare.

HOW MEDICARE DETERMINES AN HMO'S PAYMENT RATE

Essentially, HCFA's calculation of its per-enrollee (capitation) rate can be expressed as follows:

Capitation rate = average per-beneficiary cost x .96 x
risk adjustment factor

Medicare pays risk HMOs a fixed amount per enrollee—a capitation rate—regardless of what each enrollee's care actually costs. Medicare law stipulates that the capitation rate be set at 96 percent of the costs Medicare would have incurred for HMO enrollees if they had remained in fee-for-service.⁴ In implementing the law's rate-setting provisions,

⁴Section 1876(b)(4) of the Social Security Act (42 U.S.C. 1396mm(a)(4) (1994)).

HCFA estimates a county's average per-beneficiary cost and multiplies the result by 0.95.⁵ The product is the county adjusted average per capita cost rate.⁶

HCFA then applies a risk-adjustment factor to the county rate. Under HCFA's risk-adjustment system, beneficiaries are sorted into groups according to their demographic traits (age, sex, and Medicaid, institutional, and working status). HCFA calculates a risk factor for each group—the group's average cost in relation to the cost of all beneficiaries nationwide. For example, in 1995 the risk factor for younger seniors (65- to 70-year-old males) was .85, whereas for older seniors (85-year-old or older males) it was 1.3. HCFA uses the risk factor to adjust the county rate, thereby raising or lowering Medicare's per capita payment for each HMO enrollee, depending on the individual's demographic characteristics.

MEDICARE'S HMO RATE-SETTING METHOD HAS LED TO EXCESS PAYMENTS

One reason the HMO rate-setting method overstates the expected fee-for-service costs of HMO enrollees is that it uses only the cost experience of fee-for-service beneficiaries. If the health status of the mix of beneficiaries enrolled by HMOs were the same as the health status of those in fee-for-service, using fee-for-service beneficiaries to estimate the expected fee-for-service costs of HMO enrollees would be an appropriate method. However, because research has shown that HMOs have in general enrolled healthier-than-average beneficiaries, the beneficiaries remaining in fee-for-service represent a sicker-than-average population.⁷ This, in turn, means that using data on fee-for-service beneficiaries exclusively produces HMO payment rates higher than envisioned when the current rate setting provisions were enacted.

Medicare's risk adjustors explain about 3 percent of the variation in individual-level health care costs and are thus not adequate to account for the cost differences among beneficiaries. The difficulty is that, within the same demographic group, HMO enrollees are healthier than fee-for-service beneficiaries; for example, 70-year-old males in HMOs are, on average, healthier than 70-year-old males in fee-for-service. Medicare's risk

⁵A 5-percent discount is taken on the premise that, compared with fee-for-service care, managed care plans achieve certain efficiencies. For example, HMOs can negotiate with hospitals, physicians, and other providers to obtain discounts on services and supplies.

⁶Medicare determines four capitation rates for each county, one each for part A aged, part B aged, part A disabled, and part B disabled.

⁷HCFA's Health Care Financing Review, a 1996 study using postdisenrollment data, estimated that HMO enrollees' costs were 12 percent lower than average, while a 1996 PPRC study using preenrollment data estimated that enrollees' costs were 37 percent lower than for comparable fee-for-service beneficiaries.

adjustor is said to be inadequate because, while it makes broad distinctions among beneficiaries of different age, sex, and other demographic characteristics, it does not account for the significant health differences among demographically identical beneficiaries. The cost implications of health status differences can be dramatic—for two demographically alike beneficiaries, one may experience occasional minor ailments while the other may suffer from a serious chronic condition.

INCLUDING HMO ENROLLEES'
COSTS IN COUNTY AVERAGE
IMPROVES ACCURACY OF COUNTY RATES

Independent of improved risk adjustment, modifying the method for calculating the county rate would help reduce Medicare's excess HMO payments. In setting county rates, HCFA currently estimates the average Medicare costs of a county's beneficiaries using the costs of only those beneficiaries in Medicare's fee-for-service sector. This method would be appropriate if the average health cost of fee-for-service beneficiaries were the same as that of demographically comparable HMO enrollees. However, in counties where there are cost disparities between Medicare's fee-for-service and HMO enrollee populations, this method can either overstate the average costs of all Medicare beneficiaries and lead to overpayment or understate average costs and lead to underpayment. Correcting this problem is difficult because it is impossible to observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. Therefore, we developed a method to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our method consists of two main steps:

- First, we compute the average cost of demographically similar new HMO enrollees during the year before they enrolled—that is, while they were still in fee-for-service Medicare. These fee-for-service costs are available through HCFA's claims data.
- Next, we adjust this amount to reflect the expectation that a new enrollee's use of health services will, over time, rise.⁵

Having completed these steps, we combine the result with an estimate of the average cost of fee-for-service beneficiaries. This new average produces a county rate that reflects the costs of all Medicare beneficiaries.

⁵Our analysis adjusts for (1) the tendency for enrollees' costs to become more like—or "regress" toward—the fee-for-service cost mean after joining an HMO and (2) the costs incurred by HMO enrollees who die while enrolled. How our method accounts for these costs is discussed more thoroughly in our report.

Selected 1995 County Rates
Produced Substantial Excess Payments

To illustrate the effect of our approach, we analyzed data for counties with different shares of beneficiaries enrolled in HMOs. We chose counties within a single state to eliminate variations attributable to state differences. We selected California because it covers 36 percent of all Medicare HMO enrollees and includes counties that in 1995 had the nation's highest HMO penetration rates. We found that our method could have reduced excess payments by more than 25 percent. Although better risk adjustors could further reduce the large remainder of excess payments, improvements to risk adjustment require developing direct measures of health status, which is a complex effort that may take years.

The following key points also emerged from our analysis:

- First, for the counties that we analyzed, we estimate that total excess payments in 1995 amounted to about \$1 billion (of about \$6 billion in total Medicare payments to risk HMOs in the state). Of that amount, applying our method for setting county rates would have reduced the excess by about \$276 million.
- Second, the excess payments attributable to inflated county rates were concentrated in 12 counties with large HMO enrollment and ranged from less than 1 percent to 6.6 percent of the counties' total HMO payments, representing between \$200,000 and \$135.3 million.⁹ Despite the size of these amounts, the application of our method would have produced relatively small changes in the monthly, per-beneficiary capitation payments, ranging from \$3 to \$38.
- Third, our analysis did not support the hypothesis, put forward by the HMO industry and others, that the excess payment problem will be mitigated as more beneficiaries enroll in Medicare managed care and HMOs progressively enroll a more expensive mix of beneficiaries. Our data—which include counties with up to a 39-percent HMO penetration in 1995—indicated that the disparity between Medicare rates and our rates is larger in counties with higher Medicare penetration. For example, the four counties with the highest rates of excess payment, ranging from 5.1 to 6.6 percent, were also among the counties with the highest enrollment rates in 1995.

⁹For the state's remaining 46 counties, excess payments attributable to inflated county rates amounted to less than 3 percent of the 58-county total.

Data Are Available to Enable HCFA
to Promptly Adjust County Rates

Because the data we used to estimate HMO enrollees' costs come from data that HCFA compiles to update HMO rates each year, our method has two important advantages. First, HCFA's implementation of our proposal could be achieved in a relatively short time. The time element is important, because the prompt implementation of our method would avoid locking in a current methodological flaw that would persist in any adopted changes to Medicare's HMO payment method that continued to use current county rates as a baseline or fee-for-service costs to set future rates. Second, the availability of the data would also make our proposal economical: we believe that the savings to be achieved from reducing county-rate excess payments would be much greater than the administrative costs of implementing the process.

CONCLUSIONS

Medicare's HMO rate-setting problems have prevented it from realizing the savings that were anticipated from enrolling beneficiaries in capitated managed care plans. In fact, enrolling more beneficiaries in managed care could increase rather than lower Medicare spending—unless Medicare's method of setting HMO rates is revised. Our method of calculating the county rate would have the effect of reducing payments more for HMOs in counties with higher excess payments and less for HMOs in counties with lower excess payments. In this way, our method represents a targeted approach to reducing excess payments and could lower Medicare expenditures by at least several hundred million dollars each year.

Furthermore, our approach is useful under several possible scenarios, including whether (1) the Congress adopts any proposal that uses current county rates as a baseline, (2) HCFA develops and adopts improved risk adjustors, or (3) the Congress takes no action and preserves Medicare's current rate-setting process.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions.

For more information on this testimony, please call Jonathan Ratner, Associate Director, on (202) 512-7107 or James C. Cosgrove, Assistant Director, on (202) 512-7029. The analysis was conducted by Scott L. Smith, Project Director, and Richard M. Lipinski, Project Manager. Other major contributors to this statement included Thomas Dowdal and Hannah F. Fein.

RELATED GAO PRODUCTS

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

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PRESIDENT CLINTON ADDS THREE NEW WEAPONS TO BUILD ON STRONG RECORD OF FIGHTING FRAUD AND ABUSE

Today President Clinton added three new weapons to the anti-fraud arsenal to combat fraud and abuse in the home health industry. The President announced: (1) an immediate moratorium on all new home health providers coming into the Medicare program to allow the Health Care Financing Administration to implement new regulations to prevent fly-by-night providers from entering Medicare; (2) a new renewal process for home health agencies currently in the program to ensure that all Medicare providers have to abide by these tough new regulations; and (3) a doubling of audits that will help weed out bad apple providers. These actions are consistent with recommendations to reduce fraud in home health by the Inspector General at the Department of Health and Human Services following a recent report on fraud in the home health care industry. These new initiatives build on the President's unprecedented record of fighting fraud and abuse in Medicare and Medicaid.

Took Strong Action to Fight Fraud and Abuse Right When He Took Office. The President's first budget closed loopholes in Medicare and Medicaid to crack down on fraud and abuse. In 1993, the Attorney General put fighting fraud and abuse at the top of the Justice Department's agenda. Through increased resources, focused investigative strategies and better coordination among law enforcement, the Justice Department increased the number of health care fraud convictions by 240 percent between FY1993 and FY1996 and we have saved taxpayers more than \$20 billion.

Launched Operation Restore Trust -- a Comprehensive Initiative to Fight Fraud and Abuse in Medicare and Medicaid. Two years ago the Department of Health and Human Services launched Operation Restore Trust, a comprehensive anti-fraud initiative in five key states. Since its inception, Operation Restore Trust has identified \$23 for every one dollar invested; identified more than \$187.5 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties owed to the Federal Government.

Obtained Additional Resources to Fight Fraud and Abuse When the President Signed Into Law Kassebaum-Kennedy Legislation. In 1996, the President signed the Health Insurance Portability and Protection Act (Kassebaum-Kennedy) into law which, for the first time, created a stable source of funding for fraud control. This legislation is enabling HHS to expand Operation Restore Trust to twelve states.

Passed New Initiatives to Combat Fraud and Waste Proposed by the President in the Balanced Budget Act of 1997. The Balanced Budget Act the President signed into law in August also included important new protections to fight fraud and abuse in Medicare and Medicaid. These new initiatives included:

- requiring providers to give proper identification before enrolling in Medicare;
- implementing new penalties for services offered by providers who have been excluded by Medicare or Medicaid;
- establishing guidelines for the frequency and duration of home health services;
- clarifying the definition of part-time or intermittent nursing care which will clarify the scope of the Medicare benefit and will make it easier to identify inappropriate services;
- establishing a prospective payment system (PPS) for home health services to be implemented in FY 1999, enabling HCFA to stem the excessive flow of home health care dollars;
- clearly defining skilled services so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs a simple service such as their blood drawn;
- and eliminating periodic interim payments that were made in advance to agencies and not justified until the end of the year.