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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

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| TO: Nancy-Ann Min | Take necessary action | ☐ |
| Joseph Minarik | Approval signature | ☒ |
| | Comment | ☐ |
| THRU: Barry Clendenin BC | Prepare reply | ☐ |
| Ken Schwartz | Discuss with me | ☐ |
| | For your information | ☐ |
| | See remarks below | ☐ |
| FROM: Ed Chase/Tim Hill ETC BH | DATE: 5/23/96 | |

REMARKS

Attached for your signature is a memorandum to the Director on the appropriate response to a Department of Justice letter on financing for health care fraud (incoming letter also attached). Separate Health Division and TCJS recommendations are presented.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

MEMORANDUM FOR THE DIRECTOR

FROM: Nancy-Ann Min
Joseph Minarik

SUBJECT: Department of Justice Views on Seeking an Amendment to Health Insurance Reform Legislation to Protect the Medicare Hospital Insurance Trust Fund

*Issue*

The Department of Justice (DOJ) is appealing the Health/Personnel RMO decision to seek an amendment to the House and Senate health insurance reform bills to mitigate any potential threats to the Medicare Hospital Insurance (HI) Trust Fund resulting from the fraud funding provisions in the bills. DOJ prefers that the Administration support an administrative agreement between HHS and DOJ as a means to address this potential threat. This memorandum presents the Health Division's (HD) and the Transportation, Commerce, Justice, and Services Division's (TCJS) views and recommendations on the DOJ appeal and seeks your guidance.

*Background*

The House and Senate versions of health insurance reform each contain fraud and abuse provisions similar to those in the President's balanced budget plan. Resources from the HI Trust Fund would be made available for enforcement efforts in anticipation of significant recoveries. Unlike the President's plan, both the House and the Senate bills allow the expenditure of HI Trust Fund resources on non-Medicare enforcement activities and require that various fines and penalties from non-Medicare related health care fraud enforcement be deposited in the HI Trust Fund. Justice wants the flexibility to pursue the most promising Federal health care cases, regardless of whether they are Medicare or non-Medicare. In the HD's view, it has always been the Administration's policy that resources in the HI Trust Fund should be used for Medicare purposes only.

Based on HHS and HD recommendations, the Health/Personnel RMO is seeking an amendment to the health insurance reform bills to ensure the appropriate use of HI Trust Fund resources. The amendment (which is still in draft) is modeled on the process established in current law to "reconcile" the source of funds (e.g., the SMI and HI Trust Funds and General Funds) for administrative expenses related to Medicare and Medicaid at HHS.[1] Use of this reconciliation approach would require that the Trust Fund be made "whole" for resources devoted

[1] HHS' administrative expenses for Medicaid are initially paid out of the HI Trust Fund, which is subsequently reimbursed from the General Fund as these activities are not Medicare related.

to non-Medicare fraud cases, either through recoveries or transfers from the general fund. Implementation of this amendment would require that both HHS and DOJ undertake a certain level of administrative tracking to account for Medicare and non-Medicare enforcement activities (expenditures and recoveries).

DOJ is appealing the decision to seek an amendment, believing that the likelihood of the fines and penalties flowing to the HI Trust Fund being less than non-Medicare expenditures is extremely small. DOJ also opposes any fix -- legislative or administrative -- that would require "needlessly burdensome" accounting procedures that are out of proportion to the amount of money involved. DOJ also believes that pursuing an amendment could put passage of the entire fraud and abuse control program in jeopardy. DOJ recommends that the issue be dealt with through an administrative agreement between the two departments.

*HD Analysis and Recommendation*

The HD understands DOJ's concerns with the RMO's position, but believes that we should maintain the decision to seek an amendment protecting the integrity of the HI Trust Fund. DOJ and HHS have already agreed that, absent an amendment, they intend to mitigate any threat to the Trust Funds administratively by establishing accounting systems to track Medicare and non-Medicare recoveries and expenditures related to the bill. An amendment clarifies DOJ's and HHS' intent and strengthens the Administration's stand on protecting the solvency of the HI Trust Fund by eliminating any threat posed by the legislation.

We believe that at this point it is impossible to tell, as DOJ believes, if the threat to the Trust Fund is "small." Neither DOJ nor HHS have provided an estimate of the amount of penalties and fines that will be returned to the Trust Fund as a result of this legislation. Nor did CBO provide such an estimate in its scoring of these provisions. As you may recall, the inability to estimate the amount of fines and penalties that might result from this legislation is one reason that the Administration originally proposed this policy as a demonstration (in the President's December balanced budget plan).

The HD is also not suggesting that DOJ or HHS create "needlessly burdensome" processes to enforce the amendment. DOJ and HHS have agreed that with or without a change in the legislation they need to establish new--or enhance existing--systems to track Medicare and non-Medicare related expenditures and recoveries under this program because: (1) this is a new mandatory program and will not be subject to routine oversight typically provided by the Appropriations committees, (2) the bill language requires a yearly report on revenues collected and disbursed under the program, and (3) there is a good chance that GAO will be asked to audit the program as part of the Conference Report language.

The HD disagrees with DOJ's proposition that pursuing an amendment threatens passage of the fraud and abuse control program. In fact, the Administration is pursuing, at DOJ's recommendation, changes to other fraud and abuse provisions in the legislation. Either the

proposed amendment, like DOJ's other recommendations, are accepted or rejected, pursuing it in and of itself does not threaten passage of the entire program.

In the end, seeking an amendment does not impose any administrative burden on HHS or DOJ beyond what will be required if the bill were to pass as drafted. Nor does seeking an amendment threaten passage of the bill. Rather, supporting an amendment strengthens the Administration's position with regard to protecting the solvency of the HI Trust Fund.

Recommendation. The HD recommends that you not accept DOJ's appeal.

*TCJS Analysis and Recommendation*

TCJS is sympathetic to the HHS concern that health care fraud enforcement not pose a risk to the integrity of the HI Trust Fund. However, in our view, HHS is seeking to fix a problem which is not likely to exist, will be extremely small if it does exist, and will be corrected by the Congress if such deficiencies should actually occur. And, current reassurances notwithstanding, past discussions and correspondence from HHS indicate that their proposed solution would require an accounting system that will be very burdensome on DOJ, especially considering the amount of money involved.

Funds to be transferred to DOJ from the Trust Fund are $23 million in 1997 and will rise to $35 million by 2000. Based on historical experience, a significant portion of these funds will be used for Medicare cases. For illustrative purposes, using 25% of the 1997 DOJ funds for non-Medicare cases would represent less than $6 million of Trust Fund money "at risk."

The balance of the 1997 health care fraud resources -- $97 million -- goes to the HHS IG; these funds are under the control of HHS and should be devoted solely to Medicare if the department is concerned about integrity of the Trust Fund. DOJ should not be forced to accept a legislative amendment that is largely aimed at internal HHS operations. The direct appropriation to the FBI for health care fraud would come from the general fund, not the HI Trust Fund, and is not part of this issue.

The Trust Fund would suffer only if fines and penalties from DOJ's non-Medicare cases are less than the expenditures for these cases. As noted above, the maximum exposure of the Fund is $23 million in 1997 (and only $6 million in the example assuming that DOJ will continue to work a significant number of Medicare cases). The Health Division is concerned that there is no estimate of fines and penalties to compare to these expenditures, since CBO did not make an estimate of fines and penalties in their scoring of health care reform. However, losses would be small even under a worst case scenario that assumes no recoveries -- and such an assumption would be contrary to experience. The lack of CBO scoring does not logically lead to the conclusion that there is a problem that has to be solved through an amendment and associated accounting system.

The bottom line is that the problem is not likely to exist, and even if it does, would be very small based on the exposure level and likely recoveries. It is, therefore, difficult to justify the need for a legislative solution, especially when it might open up the health care fraud legislation to changes that both departments consider unacceptable. HHS and DOJ should work together on an administrative solution for this issue and development of a mutually agreeable system for Congressional reporting.

Recommendation. TCJS recommends that the Administration not seek an amendment to the health insurance reform bills.

*Decision*

Accept DOJ appeal _____

Reject DOJ appeal _____

Please see me _____

U. S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General — Washington, D.C. 20530

May 17, 1996

Honorable Alice Rivlin
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Director Rivlin:

This responds to an OMB request for the Department's views on legislative language that the Department of Health and Human Services (HHS) proposes be inserted in H.R. 3103, the Health Coverage Availability and Affordability Act. HHS' proposals relate to provisions in the bill, now passed by both House and Senate, that fund law enforcement efforts to combat health care fraud.

HHS offers two versions of its proposed legislative language; each would require DOJ to track all of the anti-fraud work funded under the bill in order to keep account of how much of this enforcement work relates to Medicare and how much to non-Medicare health programs. HHS would then require that varying portions of the non-Medicare enforcement costs be reimbursed out of the General Fund of the Treasury, rather than being funded out of the Medicare Trust Fund, as is currently required by the bill.

We strongly object to these proposals for several reasons. First, there is a substantial risk that opening up this funding issue in the conference committee will invite far more sweeping changes from those who oppose the anti-fraud program altogether. This could defeat a key legislative initiative that the President, the Attorney General, and the HHS Inspector General have championed for three years. Second, the legislative changes HHS seeks are unnecessary because their only legitimate purpose can be achieved with less burden by an administrative arrangement that DOJ and HHS can jointly implement. Third, the language HHS proposes would impose substantial administrative burdens on the Department's law enforcement efforts. Given these factors, we strongly urge the Administration to reach an administrative, rather than legislative, solution to any perceived problems in H.R. 3103's funding provisions.

Risk to the Health Care Fraud Funding Provisions

Over the last three years, the Administration and various congressional committees have worked on health care fraud legislation that included law enforcement funding provisions similar to those contained in H.R. 3103. On March 28, 1996, the House passed H.R. 3103. As passed by the House, the bill included funding language similar to the Administration bill at that time. The Statement of Administration Policy did not suggest that the language in H.R. 3103 should be changed in any way and HHS never objected to the funding language in the bill.

In light of this history, we believe it is both awkward and risky for HHS--at this late date--to suggest to House and Senate conferees that the bill's funding provisions are flawed and require correction. The House- and Senate-passed funding provisions are essentially identical and, hence, we do not expect that those provisions will otherwise receive much attention in the conference. We believe such inattention well serves the Administration's goal of obtaining fraud and abuse legislation, including funding for law enforcement activities.[1] We are advised by congressional staff that there are those who would like to see law enforcement deprived of the resources provided in the current legislation and that opening the conference up to debate on those provisions would jeopardize them.

Our concern is heightened by the fact that both versions of HHS' legislative proposals would require additional transfers for the health care fraud program out of general revenues. Given the contentiousness of CBO's scoring of this bill, earlier in this Congress, we think any proposal that requires further use of Treasury revenues will invite unwanted controversy. Based on our experience in following these issues for the past three years, we believe these warnings have merit and that it is not in the interests of the President's anti-health care fraud initiative to pursue a legislative modification.

Objections to Specifics of HHS' Proposals

1. The Funding Provisions of H.R. 3103

Before turning to the details of HHS' proposals, it is useful to outline briefly the law enforcement funding mechanism

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[1]Indeed, in floor statements and other comments, Members of Congress and their staff have emphasized that the purpose of this legislation is to provide needed resources to law enforcement units engaged in health care fraud work; at no time has any legislator even hinted that the purpose of this provision is, as HHS now suggests, to "enhance the HI Trust Fund with additional monies."

established in H.R. 3103. The Act finances expanded investigations of health care fraud by the FBI with a direct appropriation from the Treasury. Funding for other law enforcement entities that combat health care fraud is handled differently. The Act creates a health care fraud and abuse control account (the "Account") to be administered by the Attorney General and the HHS Secretary and financed as follows. First, the Act authorizes the annual appropriation of a fixed amount from the Medicare Trust Fund to this Account, beginning at $104 million in fiscal year 1997 and gradually rising to approximately $240 million in fiscal year 2003 and in all subsequent years. HHS' OIG is guaranteed a fixed portion of this funding, and the remaining amount is available not only to DOJ, but theoretically to any entity engaged in health care fraud enforcement.

Second, the Act provides for replenishing of the Medicare Trust Fund through the deposit of amounts equal to all monetary recoveries -- other than restitution -- into the Trust Fund. At present, restitution recovered in any health care fraud case is returned to whatever health care plan -- public or private -- incurred the loss. (Thus, restitution in Medicare fraud cases is deposited in the Medicare Trust Fund; restitution in Federal Employee Health Benefit or CHAMPUS cases is returned to those programs. H.R. 3103 would not alter this practice.) By contrast, nonrestitution monetary recoveries in health care fraud cases are currently not used for any health care purpose. Rather, fines are deposited into the Crime Victims Fund for the use of state victims compensation programs and victims' organizations; forfeitures are deposited in the Asset Forfeiture Fund for use by federal, state and local law enforcement; and civil monetary penalties, treble damages and civil penalties are deposited in the U.S. Treasury. Under H.R. 3103, amounts equal to all of these nonrestitution monies -- which have no affiliation with a particular health plan -- would henceforth be deposited into the Medicare Trust Fund. The channelling of these "New Monies" into the Trust Fund will begin at the same time that H.R. 3103 authorizes annual transfers out of the Trust Fund to support anti-fraud enforcement work.

2. HHS' Weak Argument for Legislative Change

In recent weeks, HHS has raised the possibility that this anti-fraud funding arrangement in H.R. 3103 may somehow jeopardize the integrity of the Medicare Trust Fund. In a prior submission to OMB (a copy of which is attached), DOJ has demonstrated that this putative threat is more theoretical than real. The Trust Fund as presently constituted could only be diminished under H.R. 3103 in the unlikely event that the New Monies and enhanced recovery of Medicare restitution do not equal the costs of the annual anti-fraud transfers out of the Trust Fund. HHS and DOJ agree that the augmented deposits into the

Trust Fund are expected to exceed those anti-fraud enforcement costs. Nevertheless, to guard against even a theoretical risk to the Trust Fund, DOJ has proposed a draft Memorandum of Understanding between HHS and DOJ (a copy of which is also attached) that would ensure the Trust Fund's integrity.

The preamble to HHS' most recent proposals for legislative change, however, makes clear that HHS' primary concern is not about the integrity of the Trust Fund as it is currently constituted. Rather, HHS believes that some of the New Monies that will be deposited into the Trust Fund should be excluded from any transfer out of the Trust Fund that might support health care fraud enforcement that is not related to Medicare. We know of no evidence that Congress intended to place such a constraint on New Monies, and HHS offers none. Indeed, in its preamble, HHS says it simply "presume[s] that all monies obtained in Medicare cases (including fines and penalties) are Medicare monies that, because of the new legislation, rightly belong in the HI Trust Fund." It is only because HHS believes Congress neglected to specify this constraint on the use of New Monies that HHS believes H.R. 3103 must be amended to protect the "integrity" of the Trust Fund.

We are not aware that Congress ever considered--as a stand-alone policy--requiring that amounts equal to fines, damages and penalties from Medicare fraud cases be deposited into the Medicare Trust Fund. On the contrary, Congress embraced such deposits only as part of an overall initiative to expand and support health care fraud enforcement. Having mandated the deposit of New Monies in that context, Congress could have further specified that the portion of New Monies corresponding to penalties, damages and fines from Medicare fraud cases should be accounted differently from the amounts corresponding to non-Medicare cases. But Congress did not do so, and nothing in its failure to do so in any way threatens the integrity of the Medicare Trust Fund. More to the point, nothing in Congress' failure to do so suggests that this Administration should now seek to have such a constraint imposed by inserting new statutory language that will only burden law enforcement and endanger the provisions.

3. Objections to HHS' Legislative Proposals

We have the following preliminary comments on the merits of HHS' legislative proposals, which were forwarded to us by OMB yesterday. OMB staff have instructed us to limit our comments to this proposal, which we understand to have superseded a prior HHS legislative proposal and HHS' prior position paper on tracking so-called "Medicare-related" monies. As we have made clear to OMB staff, we have significant objections to these prior HHS

submissions.[2] But consistent with OMB's request, we will not set forth in detail these objections herein but reserve our opportunity to comment on them should they be proposed anew.[3]

Version 1 of HHS' current legislative proposals is difficult to evaluate because of ambiguous wording. Under that version, the Attorney General and HHS Secretary would annually determine what portion of the prior year's "DOJ wedge amount" was devoted to non-Medicare enforcement. (The "DOJ wedge amount" is the amount of the prior year's anti-fraud transfer out of the Trust Fund that was allocated to DOJ.) Having determined the non-Medicare portion of the wedge amount, the Attorney General and HHS Secretary would then certify "the amount, if any, which

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[2]The relationship between HHS' previous legislative proposal and its prior position paper on tracking "guidelines" is unclear and at times inconsistent. For example, the legislative language referred only to the goal of "insur[ing] that the Hospital Insurance Trust Fund has been fully reimbursed for any expenditures made from the Account that are not related to the Administration of Title XVIII." On the other hand, the guidelines sought to impose numerous other mandates on the Department of Justice: 1) tying expenditures of Account monies to receipts in health care fraud cases; 2) characterizing nonrestitution monies in health care fraud cases based on the amount of restitution in a particular case and on the entity from which it derived; and 3) accounting of "absolute amount" of monies used for non-Medicare purposes. None of these mandates is grounded in HHS' proposed legislative language and we presume HHS is not proposing incorporating such guidance in any administrative arrangement to implement the legislative proposals it now offers.

[3]The Department's objections to the tracking "guidelines" previously proposed by HHS are many, including the following: first, by tying enforcement expenditures to monetary recoveries from specific types of fraud cases, the guidelines undermine the Department of Justice's longstanding authority to determine unilaterally its investigative and prosecutorial priorities; second, by having the level of Medicare enforcement dictated by the level of prior monetary recoveries in Medicare cases, the guidelines contravene DOJ's well-publicized all-payer health care fraud enforcement strategy; third, the guidelines impose an administrative tracking system needlessly burdensome and practically impossible given the Department's present lack of a tracking system for Medicare fraud enforcement; and fourth, the guidelines require characterizing the nonrestitution monetary recoveries based exclusively on the amount of restitution, an amount which may have little if anything to do the amount of a fine imposed in a criminal case or the amount of civil penalties levied in a False Claims Act case.

should be transferred from the General Fund of the Treasury to the [Medicare] Trust Fund, in order to insure that the ... Fund has been fully reimbursed for any expenditures not related to the Administration of Title XVIII." The difficulty in interpreting this language lies in the term "fully reimbursed." Does HHS contemplate that any of the New Monies deposited in the Trust Fund will be taken into account in calculating reimbursement?

Read literally, Version 1 seems to suggest that the New Monies will be ignored and that any portion of an annual wedge amount that is devoted to non-Medicare enforcement should be fully matched by a reimbursement to the Trust Fund from the Treasury. However, inasmuch as the preamble to HHS' legislative proposals argues that New Monies must be carefully segregated into "Medicare-related" and "non-Medicare-related," we suspect HHS may intend that the latter type of New Monies should be taken into account when calculating whether the Trust Fund has been "fully reimbursed." If this reading of Version 1 is correct, it imposes significant administrative burdens.

Dividing New Monies--that is, amounts equal to treble damages, fines, forfeitures, and civil monetary penalties--into "Medicare-related" and "non-Medicare-related" can be difficult, arbitrary and misleading. In our experience with health care fraud prosecutions, many cases involve offenses against more than one health care program, and we do not segregate and characterize nonrestitution monetary recoveries according to the various programs that have been defrauded. In its preamble, HHS suggests making such characterizations on the basis of the proportions of restitution recovered, yet restitution does not always measure the harm in a particular case. For example, there may be a kickback case, in which there is no loss to the government that we can articulate, or there may be patient harm which generates a significant fine unrelated to the amount of loss to the government. In these circumstances, the proportionality method that HHS proposes for determining the extent of "Medicare-related" recoveries would be misleading. Even if we were to implement the formula proposed, HHS' statement that "We believe the Department of Justice accounting system could accommodate the above principles" is unfounded. Such a characterization of recoveries by health care plan must be done manually; it cannot be accomplished by computer systems. Given that there are presently over 1,000 criminal investigations and 1,000 civil investigations at the Department of Justice, this is potentially very burdensome.

A further problem with Version 1 of HHS' proposal is equally a problem under Version 2. Both versions would require DOJ--seemingly, for as long as H.R. 3103 remains law--to track and account for the amount of each year's wedge amount that is spent on Medicare and non-Medicare fraud enforcement. We object to any legislative proposal that requires an administrative tracking

system that is needlessly burdensome.[4] Both Versions 1 and 2 require tracking of expenditures of the wedge monies into Medicare and non-Medicare activities. The Department uses time as a vehicle to measure expenditures on particular subjects of enforcement. If a prosecutor spends three hours researching the mail fraud statute in a case involving Medicare and CHAMPUS, it is obviously not an easy matter to determine how that time should be allocated. If an investigator is reviewing a physician's contract with a hospital to ascertain whether there were any improper payments, it is once again difficult to determine how this should be characterized. Requiring that such judgments be made on a daily basis in hundreds of cases can impose real administrative burdens. Yet, the proposed legislative language appears to require such accounting in perpetuity, long after it has become clear that the relatively small sum in the annual DOJ wedge amount for health care fraud enforcement has been more than offset by New Monies deposited in the Trust Fund and thus cannot disturb the integrity of that Trust Fund. In contrast, DOJ proposed an administrative solution that minimized the need to perform this tracking while at the same time guaranteeing the integrity of the Medicare Trust Fund.

DOJ also is very wary of Versions 1 and 2 because each contemplates that DOJ must demonstrate to Congress which portion of its overall non-Medicare anti-fraud enforcement was funded by wedge monies and therefore gives rise to a reimbursement from the Treasury to the Trust Fund. As DOJ repeatedly has advised HHS and OMB, DOJ presently tracks health care fraud expenditures, but does not classify these expenditures as Medicare or non-Medicare, although a significant, if not predominant, part of the Department of Justice's health care fraud work involves Medicare. Therefore, we do not have a Medicare base on which to rely to perform the type of tracking of the wedge amount apparently sought by HHS. Moreover, we have long opposed creating dedicated slots for health care fraud prosecutors or investigators, a development that would significantly hamper the ability of U.S. Attorneys and the FBI to respond to the most severe and pressing criminal problems.

A final objection is prompted by the language in Version 2 and concerns the source of the reconciliation funds. Version 2 states that the reconciling reimbursement will come from some "other appropriation or Fund," without specifying what that may

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[4]Although the Act authorizes the HHS OIG to use the health care fraud and abuse control account monies for Medicare as well as Medicaid activities, the HHS proposal does not impose upon itself any of the strictures that it wants to impose on DOJ. In its preamble, HHS merely states that "authorized OIG spending from the Account will be for only Medicare activities." There is no tracking burden or reconciliation mandate.

be. Were DOJ bound to finance the reconciliation at the end of the year from its own appropriations, this would impose an untenable situation, requiring DOJ to set aside reserve funds at the beginning of the year and entailing impossible administrative burdens. OMB staff have advised us that, at the end of the year, if the Attorney General and the Secretary of HHS decide that some reconciliation needs to take place and the Medicare Trust Fund must be reimbursed for some wedge funds, then the Treasury, and not DOJ appropriations, will be the source of that reimbursement. Notwithstanding OMB's reassurance, the absence of such language in the proposal is disconcerting especially as the vagueness of the language might lead a Member of Congress to expect that the Department would be using its own appropriations funds.[5]

We understand from OMB staff that the views expressed in this letter will be reviewed outside the normal Legislative Reference Division process and that a final decision as to HHS' proposals will be made by OMB's Health Financing Section. We request that DOJ be given the opportunity to consider appealing the Section's decision--should it be adverse to DOJ's position--before that decision is presented as an Administration position to congressional Members or staff.

Thank you for the opportunity to comment on these legislative proposals. If we can provide any additional information or be of any further assistance, please do not hesitate to contact me.

Sincerely yours,

Andrew Fois
Assistant Attorney General

Enclosures

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[5]Additionally, we propose that the word "Account" be changed to "Fund" on the third to last line of the proposed legislative language, to indicate that the transfer from the "other appropriation or Fund" is to the HI Trust Fund, not the Medicare Account.

# ENSURING THAT NEW ANTI-FRAUD PROVISIONS DO NOT DISTURB THE INTEGRITY OF THE MEDICARE TRUST FUND

Objective: Congress is expected soon to enact a new program to combat health care fraud and abuse. The Departments of Justice and Health and Human Services agree that this new program should be administered in a way that protects the integrity of the Medicare Trust Fund. DOJ has developed a proposed mechanism to ensure that monies that are placed in the Medicare Trust Fund under current law will only be used to fund DOJ's anti-fraud activities that are confined to Medicare enforcement. The proposed mechanism is essentially this: DOJ will devote the anti-fraud funding authorized under the proposed Act to Medicare enforcement until sufficient new funds are deposited in the Medicare Trust Fund to permit the Department to undertake non-Medicare enforcement, as well. This proposed mechanism is described in more detail below and set forth in technical terms in an attached draft of a Memorandum of Understanding between DOJ and HHS.

Legislative Background: Title V of the proposed Health Insurance Reform Act of 1996 ("the Act") establishes a new health care fraud and abuse control program, jointly administered by the Departments of Justice and Health and Human Services. The Act promotes investigation of all forms of health care fraud by the FBI and investigation of medicare and medicaid fraud, in particular, by HHS' Inspector General ("the IG"). Through expansion of the criminal and civil statutory tools, the Act also enhances DOJ's prosecution of health care fraud cases involving all public and private health plans so that the results of the FBI's and the IG's investigations can be fully exploited.

Funding of Anti-Fraud Activities: The Act finances the FBI's expanded investigations with a direct appropriation from the Treasury. By contrast, the expanded investigations by the IG and the enhanced prosecutions by DOJ are funded by a transfer of monies from the Medicare Trust Fund. The combined amount to be transferred out of the Trust Fund for these two purposes is strictly limited in the Act, beginning at $104 million in fiscal year 1997 and gradually rising to approximately $240 million in fiscal year 2003 and in all subsequent years.

To ensure that these annual transfers do not deplete the resources of the Medicare Trust Fund, the Act directs that amounts equal to four additional sources of monies that are generated in health care fraud cases henceforth be placed into the Trust Fund. Those four additional sources are: (1) criminal fines, (2) civil monetary penalties, (3) forfeitures and (4) non-restitution damages. Prior to passage of the Act, no amounts equal to the fines, penalties, forfeitures and non-restitution damages collected in such cases were deposited in the Trust Fund. Rather, fines were

simply deposited in the Crime Victims Fund, forfeitures were simply deposited in the Asset Forfeitures Fund, and civil monetary penalties and non-restitution damages were simply deposited in the general fund of the U.S. Treasury. By directing that amounts equal to these sums (hereafter, the "New Monies") henceforth be deposited in the Medicare Trust Fund, Congress ensured that the corpus of the Trust Fund would not be reduced by the transfers of monies out of the Trust Fund that the Act requires to finance the IG's and DOJ's anti-fraud activities.

Impact on Medicare Trust Fund: The Congressional Budget Office satisfied itself that the revenues newly generated by the Act for the Trust Fund would equal or exceed the anti-fraud transfers out of the Trust Fund (beginning at $104 million/year) that the Act requires. HHS and DOJ are also confident that the annual amount of New Monies to be added to the Trust Fund will exceed the $104 million (and subsequent amounts) in annual anti-fraud transfers out of that Trust Fund. Thus, DOJ and HHS anticipate that the Act will bring about a net increase in the Medicare Trust Fund. A question has been raised, however, as to the impact on the Trust Fund if for some reason the level of New Monies falls short of expectations.

The answer depends on how the anti-fraud money that will be transferred out of the Trust Fund is used. When such funding is used to investigate and prosecute Medicare fraud, the funding will inure to the benefit of the Medicare Trust Fund even if the prosecutions yield less than the expected amount of fines, penalties, forfeitures and non-restitution damages (i.e., New Monies) because such prosecutions will at least yield recovery of Medicare restitution damages, which automatically are deposited in the Medicare Trust Fund. To the extent that the anti-fraud funding is used to investigate and prosecute non-Medicare fraud (e.g., fraud involving CHAMPUS, FEHB, Veteran's benefits or other health care programs) and such prosecutions produce less than the expected amount of New Monies, it is conceivable that the transfers from the Trust Fund that will support such prosecutions will deplete the Trust Fund by more than it is replenished. This potential difficulty is more theoretical than real because (1) a very substantial portion of DOJ's health care fraud prosecutions do involve Medicare, (2) Medicare prosecutions are expected to yield more money for the Trust Fund than they cost, and (3) even non-Medicare prosecutions will yield New Monies that will be deposited into the Medicare Trust Fund.

Proposed Mechanism to Protect Trust Fund Integrity: To guard against even the remote possibility that the funding of DOJ's anti-fraud prosecutions would jeopardize the integrity of the Medicare Trust Fund as presently constituted, DOJ and HHS could enter into a Memorandum of Understanding. The MOU would ensure that none of the money being transferred out of the Trust Fund to support DOJ's anti-fraud activities will be expended on non-Medicare prosecutions until sufficient New Monies have been deposited into the Trust Fund

to pay for these prosecutions. This can be done by a simple mechanism that will impose a minimum of administrative and accounting burden on DOJ and will preserve DOJ's flexibility to pursue the health care fraud prosecutions it deems most promising.

The MOU will require that in the first fiscal year under the Act, DOJ will expend an amount on Medicare enforcement that equals or exceeds the amount of the anti-fraud transfer DOJ receives out of the Trust Fund for that year. The reason for requiring this is that, when this transfer is made at the outset of fiscal year 1997, no New Monies will yet have been deposited in the Trust Fund.

During that first fiscal year, however, DOJ will begin to keep a running tally of all New Monies that are deposited in the Trust Fund. At the end of each year, this tally will be adjusted to take into account the extent to which DOJ's annual expenditure on Medicare enforcement has fallen short of the annual anti-fraud transfer DOJ received in that year. Of course, during the first fiscal year that the Act is in force, there will be no shortfall. But in subsequent years, any portion of the anti-fraud transfer that is not matched by DOJ expenditure on Medicare enforcement will necessarily have been spent on non-Medicare enforcement. This portion of the anti-fraud transfer that was devoted to non-Medicare expenditures will be deducted from the running tally of New Monies. By deducting these non-Medicare enforcement amounts from the running tally of New Monies, DOJ will produce what might be called a tally of net New Monies. DOJ will then compare this tally of net New Monies to the amount of the anti-fraud transfer that it will receive in the coming year under the Act. If the net New Monies in the Trust Fund exceed the amount of the coming year's anti-fraud transfer out of the Trust Fund, DOJ will be free to spend that next year's transfer on whatever mix of health care fraud prosecutions it deems most promising--which may be primarily, or even exclusively, Medicare fraud prosecutions.

Minimizing Administrative and Accounting Burdens: In order to minimize administrative and accounting burdens, DOJ may at some point decide not to segregate the hours that its anti-fraud prosecutors spend on Medicare fraud from those hours that are devoted to non-Medicare fraud. If DOJ does so decide, then in any year in which that decision is in force, DOJ will simply assume--for accounting purposes--that all of the prosecutorial efforts funded by the anti-fraud transfer have been devoted to non-Medicare prosecutions. If DOJ adopts this simplified approach, then at the end of the year, the full amount of that year's anti-fraud transfer from the Trust Fund to DOJ will be deducted from the running tally of New Monies that have been deposited into the Trust Fund.

This adjusted tally (the amount of net New Monies) will again be compared against the amount of the anti-fraud transfer that--pursuant to the Act--DOJ will receive in the coming year. If there are enough net New Monies deposited in the Trust Fund to cover the

full amount of the coming year's anti-fraud transfer to DOJ, the Department will again be free to use that anti-fraud funding for whatever mix of health care fraud prosecutions--which may be predominantly Medicare prosecutions--that the Department believes are most promising.

The Need for Augmented Tracking: In the unlikely circumstance that, in a particular year, the tally of net New Monies deposited into the Trust Fund is not as large as the anti-fraud transfer to DOJ, then DOJ's options for spending that money will be more constrained. For that year, DOJ would need to re-establish a system to segregrate those hours spent by its anti-fraud prosecutors on Medicare fraud from those hours spent on non-Medicare fraud. DOJ would then have to ensure that its expenditures on Medicare enforcement for that year would be at least as large as the amount by which the anti-fraud transfer exceeds the tally of net New Monies. (And, at the end of such a year, only that amount of the anti-fraud transfer that exceeds the amount of DOJ's Medicare enforcement expenditures for the year would be deducted from the running tally of New Monies.)

Summary: This regime for protecting the integrity of the Medicare Trust Fund is embodied in the attached draft of a Memorandum of Understanding. The mechanism set forth in the MOU is conservative--that is, it will more than preserve existing funding for the Trust Fund--because it requires that any anti-fraud transfer out of the Trust Fund that is devoted to non-Medicare prosecutions will be paid for solely with New Monies. It thus ignores the substantial new funds that will accrue to the Trust Fund as a result of restitution damages obtained in Medicare fraud cases. Those funds are simply an unacknowledged boon to the Trust Fund that will not be drawn upon to fund non-Medicare prosecutions.

[ D R A F T ]

MEMORANDUM OF UNDERSTANDING

HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT

Combatting health care fraud and specifically Medicare fraud is a goal shared by the Department of Justice ("DOJ") and the Department of Health and Human Services ("HHS").

The Health Insurance Reform Act of 1996 ("Act") provides that the HHS Secretary, acting through the Office of the Inspector General of HHS, and the Attorney General shall establish a program to coordinate law enforcement programs to control fraud and abuse with respect to health care.

The Act establishes a Health Care Fraud and Abuse Control Account (the "Account"), housed in the Federal Hospital Insurance Trust Fund ("Medicare Trust Fund") to be used to cover the costs of the administration and operation of the health care fraud and abuse control program. The Act mandates an appropriation to the Medicare Trust Fund of monies not presently deposited in the Trust Fund, including monies equal to the following amounts, which are hereafter collectively referred to as "New Monies":

(i) Criminal fines recovered in cases involving a federal health care offense;

(ii) Civil monetary penalties and assessments imposed in health care cases;

(iii) Amounts resulting from the forfeiture of property by reason of a federal health care offense; and

(iv) Penalties and damages obtained under the False Claims Act, 31 U.S.C. §§ 3729-3733, in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

The Act also provides for the appropriation to the Account of monies from the Trust Fund in such sums (subject to an annual limit) as the HHS Secretary and the Attorney General certify are necessary to carry out the health care fraud and abuse control program as described in the Act. With respect to administering the Account, DOJ and HHS agree to the following:

1. The Account should be administered to maximize effective use of the funds to combat health care fraud and abuse with minimum administrative burden, consistent with compliance with the Act.

2. The Act provides that the Attorney General and the HHS Secretary may certify appropriations to the Account in an amount

up to $104,000,000 for fiscal year 1997, with increases of 15 percent in the six succeeding years, and with no increases in subsequent fiscal years.

3. The Act guarantees that the Inspector General of HHS ("IG") will receive an amount of the annual appropriation to the Account, subject to an annual minimum and maximum that increase each year through fiscal year 2003. These funds must be used by the IG to implement the health care fraud and abuse control program with respect to the medicare and medicaid programs consistent with compliance with the Act.

4. The difference between the total annual appropriation to the Account under [proposed] 42 U.S.C. § 1395i(k)(3)(A)(i) and the portion of that amount allocated to the IG is referred to as the "wedge amount". The portion of the wedge amount that is then allocated to DOJ will be referred to as the "DOJ wedge amount."

5. At the end of each fiscal year, DOJ will compare the following two sums:

Sum A will consist of the total amount of New Monies deposited in the Trust Fund since the Act became law.

Sum B will consist of the total of the amounts (if any) by which DOJ's annual expenditures on Medicare enforcement (since the Act became law) have fallen short of the DOJ wedge amounts, to be calculated as follows:

i) In each fiscal year in which DOJ's Medicare enforcement expenditures equal or exceed that year's DOJ wedge amount, the portion of that wedge amount to be included in Sum B will be zero; and

ii) In each fiscal year in which DOJ's Medicare enforcement expenditures are less than that year's DOJ wedge amount, the balance of the DOJ wedge amount--i.e., the portion devoted to non-Medicare enforcement--shall be included in Sum B. However, for any fiscal year in which DOJ has not utilized a system to determine what portion of prosecutorial hours were devoted to Medicare enforcement, DOJ shall treat that year's DOJ wedge amount as having been entirely devoted to non-Medicare enforcement, and that year's full DOJ wedge amount will be included in Sum B.

The result of the comparison of Sum A with Sum B at the end of each fiscal year shall determine how the DOJ wedge amount is used in the next fiscal year, as follows:

i) If Sum A is less than or equal to Sum B, DOJ will ensure that its Medicare enforcement expenditures in the next fiscal year shall equal or exceed the

next year's DOJ wedge amount;

ii) If Sum A exceeds Sum B but by an amount that is less than the DOJ wedge amount for the next fiscal year, DOJ may in the next fiscal year expend less than that DOJ wedge amount on Medicare enforcement but the difference between those Medicare enforcement expenditures and that DOJ wedge amount may not exceed the difference between Sum A and Sum B; and

iii) If Sum A exceeds Sum B by an amount that is greater than the DOJ wedge amount for the the next fiscal year, DOJ may pursue whatever mix of health care fraud prosecutions it deems most promising, without needing to ensure any particular level of expenditure on Medicare enforcement in that next fiscal year.

6. During the first fiscal year in which the Act is effective, DOJ agrees to expend an amount on Medicare enforcement that equals or exceeds the DOJ wedge amount for that year.

E X E C U T I V E  O F F I C E  O F  T H E  P R E S I D E N T

13-May-1996 12:34pm

TO: Jennifer L. Klein

FROM: Timothy B. Hill
Office of Mgmt and Budget, HD

CC: Nancy-Ann E. Min
CC: Barry T. Clendenin
CC: Mark E. Miller
CC: Thomas M. Reilly

SUBJECT: RE: Fraud and Abuse

This is what HHS has sent over lately.

Of course HHS (and to a certain extent DoJ) are phoning in changes hourly, so I doubt that this is the exact langauge that we will eventually end up with. But the overall structure and concept will be very similar.

The language is lifted from the Social Security Act and mirrors authority that HHS and SSA currently have to reconcile the amounts they spend on administrative activities funded from the HI, SMI, OASDI, and SSI trust funds (i.e., HHS, SSA and the Treasury can currently "swap" money from various funds. For example, the general fund will reimburse the HI trust fund for administrative outlays made from HI related to Medicaid.)

Add to section 501(k) of the Senate bill the following new subsection:

(k)(6) RECONCILIATION OF ACCOUNTS.--

(A) After the close of each fiscal year the Secretary of Health and Human Services and the Attorney General shall jointly determine the portion of the costs charged during such fiscal year to the Account which do not relate to the administration of Title XVIII. After that determination has been made, the Secretary of Health and Human Services and the Atorney General shall certify to the Managing Trustee the amount, if any, which should be transferred from the General fund of the Treasury to the Hospital Insurance Trust Fund, in order to insure that the Hospital Insurance Trust Fund has been fully reimbursed for any expenditures made from the Account that are not related to the Administration of Title XVIII.

(B) The Managing Trustee is authorized and directed to

transfer any such amounts in accordance with any certification so made.

E X E C U T I V E  O F F I C E  O F  T H E  P R E S I D E N T

10-May-1996 07:53pm

TO: Nancy-Ann E. Min
TO: Christopher C. Jennings

FROM: Timothy B. Hill
Office of Mgmt and Budget, HD

CC: Barry T. Clendenin
CC: Mark E. Miller
CC: Parashar B. Patel

SUBJECT: A fraud and abuse "glitch"

I had a lengthy conversation with James Costello this evening.

The bottom line is that Justice is not in agreement with the decision to seek a legislative fix to the flow of funds issue.

James is mostly concered that:

(1) DOJ was not consulted on the decision to seek a fix (nor, for that matter, were they consulted on the final design of the POTUS legislation) and that a fix could disproportionately affect Justice (by making them have to do tracking etc that HHS won't have to do) and

(2) seeking a fix could jeapordize the bill, a conclusion based on Justice's work with Hill staff on this issue over the past three years.

I politely walked him through our technical justifications for seeking a fix, but indicated that his concerns were not technical and as such I could not really resolve them.

I advised him that given the fact that discussion with conferees could take place at any time, he needed to talk to you very soon. You should expect a phone call early on Monday.

My reaction to his concerns are:

1. No one is trying to cut Justice out of the decision making process. This issue is about making sure the HI Trust Fund is protected, no one is talking about taking money away from Justice or making them conform to accounting/tracking standards that are different than what will be required of HHS.

2. No one is going to fall on their sword over this issue. If the reaction on the hill is truly negative to this fix, I find it hard to believe that we would fight very hard given the other important issues involved in this legislation. (NOTE: I also suggested to James that if he or his staff knew conclusively that there will be a visceral reaction to this fix, they might want to let us know where this reaction is going to come from.)

# HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

CONTACT: HHS Press Office
(202) 690-6343

## HHS REPORTS PROMISING FIRST YEAR FOR "OPERATION RESTORE TRUST" INITIATIVE

HHS Secretary Donna E. Shalala today marked the first-year anniversary of HHS' anti-fraud initiative, Operation Restore Trust, saying new approaches in the pilot program have already produced $42.3 million in recoveries. This constitutes a return of $10 in recoveries for every $1 spent on the project.

The pilot project is operating in five states, and the Clinton Administration has proposed expanding it to all 50 states in the coming fiscal year.

"Operation Restore Trust has pioneered new partnerships within the federal government, new cooperation with states, and new ways of targeting and stopping fraud in the Medicare and Medicaid programs," Secretary Shalala said. "In its first year, Operation Restore Trust has proved its value, and the President wants to extend its reach to every state in the nation."

With first-year targeted demonstration project funds of $4.09 million, Operation Restore Trust has produced $42.3 million in restitutions, fines, settlements and recovery of overpayments. This includes $24.5 million returning to the Medicare Trust Fund from criminal restitutions, fines and recoveries; $14.1 million returning to the Trust Fund as a result of civil judgments, settlements and penalties; and $3.7 million returned to the Treasury as a result of services inappropriately billed or medically unnecessary services rendered.

HHS Inspector General June Gibbs Brown said that "Operation Restore Trust is proving what it was meant to prove: that a new focus on fraud and abuse, and new cooperative approaches, can help us to better protect federal Medicare and Medicaid dollars."

The initiative was announced by President Clinton last May at the White House Conference on Aging. It is aimed specifically at fraud, waste and abuse in three high-growth areas of Medicare and Medicaid: home health agencies, nursing homes (including hospices), and durable medical equipment suppliers.

- MORE -

Inspector General Brown said that out of 272 Medicare and Medicaid cases currently under investigation in the three targeted payment areas, 244 are new cases that were opened as a result of the Operation Restore Trust initiative. She said 64 of the cases are joint efforts with other law enforcement agencies.

Operation Restore Trust is focused on five states (New York, Florida, Illinois, Texas, and California) which account for 38.5 percent of Medicaid beneficiaries and 34 percent of Medicare beneficiaries.

New approaches being tried under the initiative include:

- Use of sophisticated statistical methods of targeting providers for investigations and audit
- Use of teams of HCFA data staff, IG auditors and nurses from state agencies to conduct comprehensive reviews of rehab and skilled nursing facilities with unusually high Medicare reimbursement rates. Reviews looked both at facility-specific issues as well as potential systemic problems
- Increased emphasis on concerted planning and executing of investigations with the Department of Justice and other law enforcement agencies
- Use of public forums and focus groups both to disseminate information to beneficiaries and providers about known fraudulent techniques, and to gather information from them
- Training and empowering state Aging Ombudsmen to detect and report fraud and abuse in nursing homes
- Use of state survey officials who regularly monitor care in home health agencies to help identify inappropriate and fraudulent billing (see separate press release).

Other accomplishments during the first year include:

- o 35 criminal convictions and 18 civil judgements have been obtained since March 1, 1995, in cases folded into the ORT project and benefiting from the increased attention, focus, and support provided by ORT. In addition, 93 program exclusions of individuals and corporations have been taken.
- o A new HCFA satellite office has been established in Miami which, in addition to its other activities, is heavily involved in outreach to the local community to alert the public and local businesses to health care fraud schemes.

- o A toll-free Hotline ("HHS-TIPS") has been established to receive information on possible waste, fraud and abuse.

Bruce Vladeck, administrator of the Health Care Financing Administration, said, "The object of Operation Restore Trust is not only to punish fraud and abuse, and to recover funds, but more important to identify areas of vulnerability and prevent fraud before it happens."

Vladeck said that a number of significant potential program changes have been identified as a result of Operation Restore Trust, which could prevent more than $1 billion a year in fraud, waste and abuse. The recommended changes are being developed as legislative, regulatory, and administrative actions.

The HHS Office of Inspector General, the Health Care Financing Administration and the Administration on Aging are the three agencies within HHS which are jointly heading the Operation Restore Trust initiative. The project has also involved an intergovernmental team comprised of federal and state personnel, including the Department of Justice and the United States Attorneys offices across the country.

HHS Assistant Secretary for Aging Fernando Torres-Gil said the nation's elderly are particularly vulnerable to unscrupulous providers: "Seniors who are receiving care under Medicare and Medicaid deserve to get the highest quality of care from providers who obey the law."

Services targeted by Operation Restore Trust were chosen because they are three of the fastest-growing cost areas in Medicare and Medicaid.

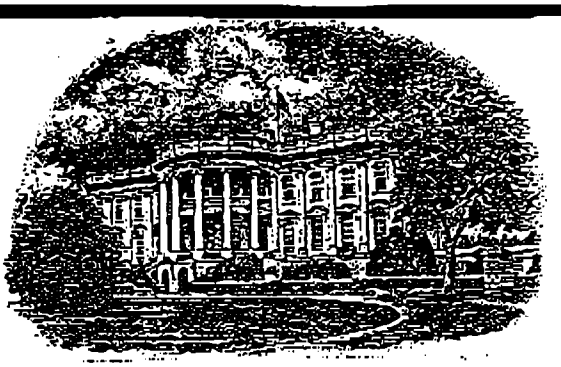
Under President Clinton's FY 1997 budget proposal, the approaches successfully piloted in the demonstration project would become part of a nationwide initiative. The President's budget also contains proposals for providing increased and more stable funding for anti-fraud efforts in Medicare and Medicaid. Altogether the President's proposals for a nationwide anti-fraud initiative for Medicare and Medicaid would involve FY 1997 spending of $597 million, an increase of $158 million over current funding levels. The total saving expected from the additional spending is $3.5 billion over seven years (1997-2003).

###

# FAX COVER

## Health and Personnel Division

Executive Office of the President
Office of Management and Budget
OEOB, Room 262
Washington, D.C. 20503



**DATE:** May 2, 1996

**TO:** Jennifer Klein

**AGENCY:**

**FAX NO:** 6-2878

**FROM:** Nancy-Ann Min
Associate Director for Health and Personnel

Phone Number (202) 395-5178
Fax number (202) 395-9119

**Number of pages (including cover)** _____

**COMMENTS:** Could you give me your reaction to this? Thx

NA

May 2, 1996

# Health Division

**Office of Management and Budget**
**Executive Office of the President**
**Washington, DC 20503**

**Please route to:** Nancy-Ann Min

**Through:** Barry Clendenin
Mark Miller

**Subject:** More Fraud and Abuse Issues

**From:** Tim Hill

Decision needed XX
Please sign ____
Per your request ____
Please comment ____
FYI ____

With Copies for: AK, TR, Labor Branch, HD Chron, HFB Chron.

Phone: 202/395-7831
Fax: 202/395-3910
Email: hill_t@1.eop.gov
Room: #7026

The purpose of this memorandum is to seek your guidance on three fraud and abuse issues. These issues need to be resolved so that the Administration can begin briefing Congressional staff regarding the Administration's position on fraud and abuse provisions in the House and Senate health insurance reform bills.

**Issue #1: Department of Labor (DoL) Role in Enforcing Fraud and Abuse.**

Background. The proposed legislation in both the House and Senate establishes a fraud and abuse control program that gives broad authority to both the HHS Inspector General and the Attorney General to (1) coordinate all federal, state, and local fraud and abuse enforcement programs; (2) conduct investigations, evaluations, audits, and inspections relating to the delivery of and payment for health care; and (3) issue interpretative rulings or advisory opinions concerning the application of certain health care fraud and abuse sanctions.

*DoL's Position.* DoL is concerned that the scope of this program's authority encompasses ERISA-covered health benefit plans; but the proposed legislation does not include the Secretary of Labor as a principal in the control program. The proposed legislation also establishes new crimes to combat health care fraud and abuse without clarifying that the Secretary of Labor has the authority to investigate them with respect to ERISA-covered health plans. DoL is very adamant that they be included in the control program and indicated that they will complain to the Secretary if their concerns are not addressed

*DoJ and HHS' Position.* DoJ and HHS disagree with Labor, believing that nothing in the proposed legislation diminishes ERISA's current authority or necessarily requires DoJ or HHS to investigate ERISA related fraud. Rather, DoJ and HHS argue that Labor is on par with DoD, VA, OPM etc who are also not principles in the program, but who will also

not see any diminished impact on their authority. See the attached DoJ analysis on this issue (Tab A).

Discussion: It is my sense, based on conversations with DoL, HHS and Justice staff, that the proposed legislation does not give DoL any problems that a good memorandum of understanding between HHS, Justice and Labor can't fix.

Recommendation: The Administration should not pursue a legislative change requiring Labor to be part of the control program. If Labor presses, we could work with the Conferees to try and get language included in the conference report clarifying that Congress' intent on this issue is not to diminish DoL's, or any other federal programs', enforcement authority. The Labor branch agrees with this assessment (see attached email at Tab B).

**Agree** ✓ **Disagree** _____ **Discuss** _____

**Issue #2: Treatment of Certain ERISA-related Fraud and Abuse Recoveries**

Background: The proposed legislation requires that various fraud related fines and penalties be deposited to the Hospital Insurance Trust Fund.

*DoL's Position.* DoL believes that the proposed legislation does not ensure that penalties assessed in ERISA cases will be used to make participants and beneficiaries whole for losses (i.e., receive restitution) before being paid into the HI Trust Fund.

*HHS and DoJ Position.* DoJ believes, and we concur, that the proposed legislation does not create the problems that DoL asserts that it does. The proposed legislation only deals with fines and penalties -- the laws which guide restitution to parties that have been defrauded are not at all changed by this bill. Under the proposed legislation, participants in ERISA sponsored plans will be made whole before fines and penalties are deposited to the HI Trust Fund. See the attached DoJ analysis on this issue (Tab A).

Recommendation: The Administration should not seek an amendment on this issue.

**Agree** ✓ **Disagree** _____ **Discuss** _____

**Issue #3: Should there be a Legislative Fix to the Flow of Funds Issue?**

Background: The proposed legislation does not explicitly state that Medicare Trust Fund outlays are only to be used for Medicare-related administrative activities.

*Justice and HHS IG Position.* Justice and HHS argue that no fix is needed, that the flow of Medicare Trust Funds can be accounted for administratively. In a perfect world, HHS

would prefer a legislative fix to this issue, but they are worried that pressing for a fix on this issue could jeopardize the entire bill.

*OMB Staff and HCFA Position.* OMB staff and HCFA leadership each believe that a legislative fix is the best way to ensure that Medicare Trust Fund dollars are properly accounted for.

Discussion: We are not convinced that the flow of funds issue can, or should, be resolved administratively for the following reasons.

- **Seeking other Legislative Changes to Fraud and Abuse Language.** The reason we originally focused on an administrative fix was because we did not want to open the bill up to debate in Conference for fear that the fraud and abuse provision would be dropped entirely. This no longer seems reasonable, as HHS and Justice, at Chris Jennings' prompting, are drafting legislative changes to other parts of the fraud and abuse language (e.g., anti-kick back, adverse action data base). If the Administration is going to pursue changes to other parts of the fraud and abuse legislation, we should pursue a change for the flow of funds issue as well. In addition, HHS is asserting that the issue is "conferenceable" as a result of the Rockefeller letter.

- **Administrative Fix Will be Difficult.** Discussions with HHS and Justice staff indicate that it is going to be very difficult for HHS and DOJ to actually agree on the accounting systems that will be necessary to track Trust Fund recoveries and outlays.

  For example, Justice believes that penalties (as opposed to restitution) assessed in Medicare cases are not "Medicare-related." These penalties now go to the general fund; under the proposed legislation they go to HI Trust Fund. Justice believes that just because the proposed legislation requires the penalties to be deposited into a different account (the HI Trust Fund), does not mean that their basic nature changes, they are still "general fund" revenue. Under this view, Justice does not believe they need to track recoveries as Medicare or non-Medicare at all. On the other hand, HHS believes that all penalties should be tracked as Medicare or non-Medicare, based on the type of case they were levied in.

- **Creates Bounty Hunter Incentives.** Relying on an administrative fix could lead to a process whereby resources are allocated to administrative activities based on the level of recoveries generated by those activities. In other words, the amount of money that Justice will be able to spend on non-Medicare activities could be directly proportional to the amount of money they return to the Trust Fund. In effect, we could be using a "bounty hunter" decision rule for spending policy at DoJ -- the more they collect from non-Medicare cases, the more they can spend on non-Medicare activities.

  The Administration and Congress rejected this "bounty hunter" concept; neither the current health insurance reform bills nor the Administration's draft bill directly links the amount of recoveries to the amount of spending available.

Note that seeking a legislative fix does not mean that we should stop discussions on how to implement this policy administratively. Rather, we should be very aggressive on this front for two reasons. First, we may not get a change to the bill, and our concerns notwithstanding, we will have to ensure a segregation of funds administratively. Second, even if we get a fix, we are going to want HHS and Justice to establish systems to track the money they spend and the money they save as the result of this program. We are engaged in ongoing discussions with the HHS IG and DoJ on this issue and will be meeting early next week to iron out some of their differences.

Recommendation: The Administration position should be that we want a legislative fix that (1) ensures that HI Trust Fund dollars are only used for Medicare activities and (2) does not relate the amount of recoveries to the amount of administrative dollars available. Our options here include:

- Reverting to the original Administration bill. This is obviously preferable. However, adopting the Administration bill in whole would involve more than making minor changes to the Conference language, and as such may not be possible.

- Drafting a minor change to the Conference bill that makes very clear that expenditures on the fraud and abuse control program should be funded from both the general fund and the HI Trust Fund in amounts proportional to the control programs Medicare and non-medicare activities. See the attached mark-up as an example (Tab C).

If you agree that we should pursue a fix I will share our draft language with Justice, HHS and our GC to seek their views.

**Agree** _____ **Disagree** _____ **Discuss** _____

**Next Steps**

As you requested, we are scheduling a meeting with DoL, HHS and Justice for Tuesday to discuss the disposition of the DoL related issues. We might want to use that time to discuss the flow of funds issue as well.

Please let us know how you would like to proceed.


A

DOJ Talking Points in Response to
"Fraud and Abuse: DOL's Role in Combating Fraud and Abuse"

Issue: DOL has investigative authority over offenses which victimize ERISA plans. The FBI also possesses investigative jurisdiction over crimes which affect ERISA plans; the DOJ prosecutes ERISA crimes. There is no provision in the House or Senate bills which dilute or narrow the jurisdiction of the DOL in this arena.

Senate bill: The Senate bill establishes a control program that tasks the Attorney General and the Secretary of HHS with "coordinating" federal, state, and local health care fraud enforcement. The bill further provides that "nothing in this Act shall be construed to diminish the authority of any Inspector General", thus making it clear that the functions assigned to HHS by the Act do not supplant the existing function and jurisdiction of other investigative agencies.

Neither the Senate bill nor the House bill confers authority on the Attorney General or on HHS to issue interpretive rulings or advisory opinions concerning ERISA matters. Such rulings/opinions are only to be issued concerning specific fraud/kickback crimes contained in Title 42, which does not include ERISA issues.

Neither bill changes existing law concerning court ordered restitution. Under existing law, courts order defendants to make restitution payments to the victims of crimes, whether those victims are ERISA plans, individuals, private plans, or government programs. This is true in health care fraud cases, and in all other criminal cases. It would be inappropriate to change existing restitution law in order to afford preferential treatment to one category of victim in one category of crime -- ERISA victims in health care fraud offenses.

Similarly, it would be inappropriate to divert criminal fines in one sub-category of offense (ERISA crimes) from the use to which all criminal fines are put -- deposit in the Crime Victims Fund to be used to support programs for all victims of crimes.

Nor should existing law concerning forfeiture be altered for one category of offense (ERISA crimes). Under existing law, forfeiture proceeds from various categories of offenses, only one of which is health care fraud, is deposited into the DOJ Asset Forfeiture Fund. Those forfeiture proceeds are available for remission to victims of the offenses through existing procedures. Those existing procedures are incorporated into the Senate bill. Accordingly, in addition to court ordered restitution, there is a mechanism by means of which forfeiture proceeds are used to compensate victims of crimes, including ERISA crimes.

House bill: The House bill contains provisions similar to those in the Senate bill.

# EXECUTIVE OFFICE OF THE PRESIDENT
# OFFICE OF MANAGEMENT AND BUDGET

## ROUTE SLIP

TO: Chris Jennings
Jennifer Klein

Re: Rockefeller letter re: Fraud + Abuse

| | |
|---|---|
| Take Necessary Action | ___ |
| Approval or Signature | ___ |
| Comment | ___ |
| Prepare Reply | ___ |
| Discuss With Me | ___ |
| For Your Information | ✓ |
| See Remarks Below | ___ |

FROM: NANCY-ANN MIN DATE: April 29, 1996

REMARKS:

Here's the Rockefeller letter — I am going to send to Justice so they're aware. Don't know if HHS "authored" or "glom-work."

# United States Senate

WASHINGTON, DC 20510-6002

April 25, 1996

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
SD-219
United States Senate
Washington, DC 20510

Dear Mr. Chairman,

I want to make sure you are personally aware of a concern I have regarding an anti-fraud provision now incorporated in Senators Kassebaum and Kennedy's bipartisan "Health Care Insurance Reform Act" passed by the Senate on April 23, 1996.

As you know, the Dole/Roth omnibus amendment created a Fraud and Abuse Control Fund to finance investigative and prosecutorial activities related to health care fraud. This fraud control fund would receive funding from general appropriations as well as from the Medicare Hospital Insurance Trust Fund.

I am concerned that this provision, as currently drafted, would allow money from the Medicare Hospital Insurance Trust Fund to be used to fund activities related to non-Medicare health care fraud. While I support the use of Medicare Trust Fund dollars to finance activities in which Medicare is one of several payors being defrauded, I am very concerned that this bill would also allow Medicare Trust Fund dollars to be used to underwrite activities which do not directly benefit Medicare beneficiaries.

I understand our respective staff members spoke about this issue last week, the night of April 18, during the closing hours of the floor debate on this important bill. I am told that your staff assured mine that the intent of this legislation is not to have Medicare Trust Fund dollars spent on non-Medicare purposes. I am writing to confirm that understanding. I do not believe that Medicare Trust Fund dollars should finance non-Medicare fraud control activities. I sincerely hope that we can work together to ensure that the statutory language of the conference report will specifically safeguard any unintended diversion of Medicare dollars.

The Honorable William V. Roth, Jr.
April 25, 1996
Page 2

Thank you for your attention to this matter. Best regards.

Sincerely,

John D. Rockefeller IV

Bill, I really believe this case makes Trafficant and we can keep the funds I signed for the proper purposes.

Many thanks,

cc: The Honorable Robert Dole
The Honorable Nancy Landon Kassebaum
The Honorable Edward M. Kennedy

November 13, 1995

Mr. Eddie Janek
Galveston County Commissioner
West County Building
11730 Highway 6
Santa Fe, Texas 77510

Dear Eddie:

Thank you for your letter regarding fraud and abuse in the Medicare program. I appreciate your concerns about this important issue.

Since its creation thirty years ago, the Medicare program has helped to preserve the health of millions of Americans, and I am determined to see that it functions even more effectively and efficiently. I am concerned that plans by Republicans in Congress to reform the system would open the door to greater waste, fraud, and abuse, and that these measures would eliminate vital consumer protections that guard the health and income of older Americans.

Despite this threat, my Administration has been hard at work to strengthen and protect Medicare. Earlier this year, we introduced a three-part plan to combat fraud and abuse. Under our plan, the Department of Health and Human Services and the Department of Justice launched Operation Restore Trust, an effort to work with state and federal agencies to investigate waste, fraud, and abuse associated with home health agencies, nursing homes, and durable medical equipment suppliers. Additionally, HHS is creating a new, more stable budget mechanism to fund Medicare program-integrity activities. Finally, the HHS Office of the Inspector General has new authority to investigate and prosecute in cases of fraud and waste within the Medicare and Medicaid programs. These efforts have already resulted in numerous indictments and convictions, and are serving to fundamentally strengthen the Medicare system.

I believe we must do more among these lines, not less. Be assured that I will continue to fight to ensure that our nation does not turn its back on the health and well-being of our citizens, both young and old. I appreciate your interest in these important issues and welcome your involvement.

Sincerely, BILL CLINTON

BC/SEM/JFB/JRS/ckb-emu (Corres. #2558516)
(11.janek.e)
cc: IGA
Jen Klein, WW

1/29/96

The current version of the Administration's bill does not reflect HCFA's suggestions (or the suggestions from the OIG) for improving the Conference Agreement language on fraud and abuse, which has been incorporated in the bill.

1. Sections 8104 and 8144. Replace with section 11435 of original Administration bill. Makes criminal authorities applicable to all health plans.

2. Section 8105. Amend to give the OIG 120 days to either grant or deny a request for an interpretive ruling. Provide OIG with discretion to decide whether an investigation relating to a request for a fraud alert is appropriate.

3. Section 8113. Replace with section 11403(b) of original Administration bill. Provides permissive exclusion for all individuals with an ownership or control interest, regardless of their knowledge of the actions leading to the sanction.

4. Section 8121. Replace with section 11406 from original Administration bill. Provides access of all final actions in Final Action Data Base, including ones that result from a negotiated settlement.

5. Section 8131. Replace section 8131(b) with section 11402(b) from original Administration bill. Does not include requirement that individual knows or should know of the conduct. Add to section 8131(d) the ability for CMPs to be levied against those who provide medically unnecessary services only after a pattern of abuse is established.

6. Delete section 8133. It provides for a higher standard before issuing CMPs for HH than for other providers.

7. Section 8145. Replace with section 11436 of original Administration bill because it also covers audits and inspections.

8. Section 8146. Replace with section 11437 in original Administration bill because it is applicable to all health plans.

9. Section 8151. Replace with section 11407 of original Administration bill which limits the expansion of NFCUs authority to cases primarily involving Medicaid.

10. Add section 11410 of original Administration bill to authorize the interception of wire, oral, or electronic communications in certain cases.

G:\DIRECTOR\TAG\POLICY\CO.MLM

FOR RELEASE UPON DELIVERY
WEDNESDAY, OCTOBER 18, 1995

*REMARKS BY

DONNA E. SHALALA

SECRETARY OF HEALTH AND HUMAN SERVICES

PRESS CONFERENCE ON HEALTH CARE FRAUD AND ABUSE

WASHINGTON, D.C.

*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

OCT-18-1995 16:02 FROM TO 9456287B P.04

GOOD AFTERNOON:

I am pleased to join the Attorney General here today to discuss a very serious concern that she and I share about the Republican Medicare bill making its way to the House floor.

Tomorrow the Republican leadership in the House of Representatives plans to ram through a Medicare bill that slashes $270 billion dollars from this vital health care program. At the same time they make these huge cuts, House Republicans are opening gaping holes in the consumer protections afforded to 37 million Medicare beneficiaries.

Like many Americans, I was appalled by the fact that the Republican Medicare bill in the House breaks with more than two decades of bipartisan work to protect Medicare beneficiaries against the cost and the heartbreak of waste, fraud, and abuse. The American people do not agree with House Republicans' apparent belief that combatting fraud and abuse in Medicare should not be a high priority. In fact, they have made it clear that they want their Medicare dollars spent wisely and carefully.

The House bill stands in stark contrast to the bipartisan effort being made in this one area in the Senate. House Republicans say they are protecting senior citizens and cracking down on waste, fraud, and abuse while their legislation does just the opposite. The fact is that the Republican Medicare plan headed for the House floor would open the floodgates to waste, fraud and abuse. It would erase important consumer protections that guard the health and the pocketbooks of our senior citizens.

Let me share with you a couple of examples of the kind of fraud that is detected and prosecuted under current rules that could well slip through the loopholes of the House Republicans' Medicare bill. Robert Kuncl is a retired electrician living in Chicago. In 1986, Mr. Kuncl's doctor implanted a cardiac pacemaker in his chest that had no visible namebrand, no serial number, and no expiration date. Eventually, Mr. Kuncl's doctor admitted that in return for implanting this "mystery pacemaker," he received the services of a prostitute, a free trip to Hawaii, and other forms of kickbacks. The doctor, the pacemaker dealer, and nine others were convicted of fraud.

Just last December, an oncologist practicing in California was found to have rendered substandard and unnecessary care to cancer patients. While this doctor was giving his patients unnecessary and repeated blood tests and vitamin infusions, he denied them treatments that could have abated or even cured their cancer.

These kind of cases are heartbreaking. But think about how much worse things would be if we took the authority away from our

justice system to step in and protect Medicare consumers. Yet House Republicans are poised to vote for a Medicare bill that would declare open season on the Medicare trust fund, making it easier for dishonest practitioners to defraud and abuse the program.

I want to talk about five major flaws in the Republican Medicare plan in the House.

First, the House bill would severely weaken protections against kickbacks and self-referrals that protect patients against doctors who put their own profits ahead of the needs of their patients.

Second, it would relieve doctors, hospitals, home health agencies, and nursing homes of the duty to make sure that their Medicare and Medicaid claims are accurate and true.

Third, it would repeal the bipartisan, common ground standards for clinical laboratory tests performed in doctors' offices. These standards were created -- and signed into law by President Reagan -- in response to evidence that many senior citizens were receiving shoddy, inaccurate lab tests.

Fourth, it would repeal quality standards for nursing home care under Medicare and Medicaid. Again, these standards were created in bipartisan legislation signed by President Reagan. They were the product of nearly two decades of investigation into the frighteningly poor quality of care provided in some of our nation's nursing homes. And they have led to dramatic reductions in the use of physical restraints and drugs to immobilize nursing home residents in their beds and wheelchairs.

Finally, the House Republican Medicare bill would allow physicians in certain cases to charge beneficiaries unlimited additional amounts if the doctor is unwilling to accept Medicare's fee.

These proposed changes have the potential of placing Medicare and the senior citizens it serves at risk for huge financial losses. These proposals stand in stark contrast to the Clinton Administration's record of solid accomplishment in combatting fraud in Medicare and Medicaid.

My Department -- in close cooperation with the Department of Justice -- has launched Operation Restore Trust, a two-year pilot project operating in five states -- New York, Florida, Illinois, Texas, and California. This program is already paying dividends.

Using multi-disciplinary teams of auditors, evaluators, investigators, and prosecutors, Operation Restore Trust has already yielded 20 criminal convictions, seven civil judgments,

and seven indictments -- in just seven months. As a result, we have collected $32 million dollars in fines, recoveries, settlements, and civil monetary penalties. And we have established a voluntary disclosure program with the Justice Department so that providers or their employers can come forward to report suspected fraud and abuse.

These are important steps forward in our national battle against waste, fraud, and abuse. Clearly, now is not the time to turn back.

For thirty years, our nation has worked to improve the health and the lives of senior citizens. Tomorrow's vote in the House threatens to endanger that progress by reversing course and neglecting fundamental quality of care standards in Medicare. That is not a change we can afford to make.

I'm pleased to turn this microphone over to the distinguished Attorney General for her remarks.

# HOUSE REPUBLICAN MEDICARE BILL WEAKENS BATTLE AGAINST HEALTH CARE FRAUD AND ABUSE

## THE HOUSE REPUBLICAN MEDICARE PLAN WEAKENS ANTI-KICKBACK LAWS

- **The House Republican plan would make it difficult, if not impossible, to prosecute doctors and other health care providers for accepting kickbacks -- money or other compensation in return for referring patients.**

- Currently, Medicare prohibits *any form of remuneration* in exchange for patient referrals. The House plan would prohibit such payments only if the *significant purpose* of the payment was to induce referrals.

- Kickbacks can corrupt medical providers' decision making -- often replacing patient welfare with profit. Kickbacks also can lead to inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment.

- Most kickbacks have sophisticated disguises that are hard for the government to penetrate. For the vast majority of present day kickback schemes, the Republican Medicare bill would place an insurmountable burden of proof on the government.

- In the past 15 months, the Clinton Administration was able to prosecute and settle two major cases involving kickbacks, obtaining convictions and settlements of $540 million, returning significant savings to the Medicare Trust Fund and the Treasury.

## THE HOUSE REPUBLICAN MEDICARE PLAN WEAKENS PENALTIES FOR FRAUD

- **The House Republican plan would make it more difficult to impose civil monetary penalties (CMP) on doctors and other health care providers who file fraudulent claims.**

- Existing CMP laws penalize doctors and other medical providers who "know" or "should know" that their practices are fraudulent. That standard places a duty on health care providers to use "reasonable diligence" to ensure that claims submitted to Medicare are true and accurate.

-more-

**THE HOUSE REPUBLICAN MEDICARE PLAN ENCOURAGES ABUSIVE PHYSICIAN SELF-REFERRALS**

- **The House Republican bill would seriously undermine the current bipartisan prohibition on doctors referring their Medicare patients to health care facilities in which they have a financial interest.**

- Under current law, Medicare and Medicaid do not pay for certain designated health services where the physician who orders the services has an ownership or investment interest in or a compensation arrangement with the facility or business entity that provides the service.

- Physicians who refer their patients to facilities where they have a financial relationship can have their medical decisions affected by their profit motives.

- Before the current prohibitions were in effect, the HHS Office of the Inspector General (OIG) found that patients of physicians who owned or invested in independent clinical laboratories received 45 percent more of such services than all Medicare patients in general.

- Since the 1989 OIG study, nine more major studies have been published which, taken as a whole, clearly demonstrate that utilization rates of medical items or services tend to increase as a result of financial incentives directed to physicians who order those items or services.

**THE HOUSE REPUBLICAN MEDICARE PLAN ELIMINATES QUALITY STANDARDS FOR CLINICAL LABS IN PHYSICIANS' OFFICES**

- **The House Republican Medicare plan would repeal the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as applied to physician office labs.** (89,000 of the 152,000 clinical labs registered under CLIA are physician office labs.)

- Before CLIA, physician office labs had very uneven performance standards. ~~For example, one lab consistently mis-performed tests for Strep infection.~~ As a result, all test results were negative.

- CLIA requires all clinical labs, including physician office labs, to meet minimum quality standards based on the complexity of the tests they perform. CLIA surveys and proficiency testing provide physician office labs with feedback about problems of which they are unaware, helping them to improve their testing quality.

- Working with physicians, HHS has already taken steps to streamline CLIA oversight. Further fine-tuning -- not gutting -- is what is needed.

**THE HOUSE REPUBLICAN MEDICARE PLAN ELIMINATES QUALITY STANDARDS THAT PROTECT NURSING HOME RESIDENTS**

- **The Republican proposal to block grant Medicaid would repeal a 1987 law, signed by President Reagan, that established quality standards for nursing homes and institutions caring for people with mental retardation. The GOP Medicare proposal would gut similar quality standards for Medicare beneficiaries.**

- A 1986 report by the Institute of Medicine documented an epidemic of substandard care in nursing homes around the nation. In 27 states, IOM found *at least one-third of facilities* had care so poor that it jeopardized the health and safety of residents.

- The bipartisan 1987 law has led to dramatic improvements in the quality of nursing home care. The use of chemical and physical restraints has dropped significantly and the number of registered nurses on duty in nursing homes has increased, as has the training of nurses' aides.

**THE HOUSE REPUBLICAN MEDICARE PLAN ELIMINATES PROTECTIONS AGAINST EXTRA CHARGES TO MEDICARE BENEFICIARIES**

- **The Republican proposal would allow physicians participating in many of the new health plans to impose unlimited charges on beneficiaries at the time they receive care.**

- Current law prohibits hospitals and doctors from charging patients large amounts above Medicare's recognized fees. Doctors who do not agree to accept Medicare fees as payment in full can only charge 15% above those fees.

- The average Medicare beneficiary has an income of $13,000 a year and spends 20% of that on out-of-pocket medical expenses for things like prescription drugs and Medicare cost-sharing.

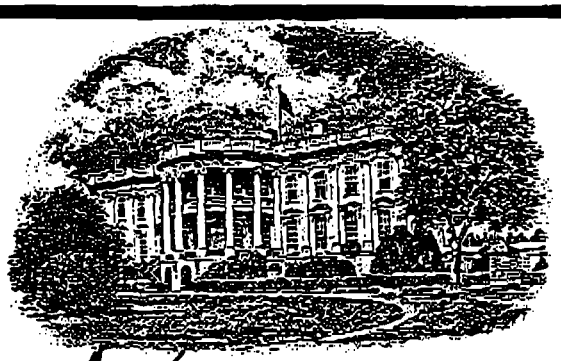
- Beneficiaries in so-called Medicare-Plus plans could be forced to pay even more out of their pockets for covered Medicare services.

# # #

# FAX COVER

## Health and Personnel Division

Executive Office of the President
Office of Management and Budget
OEOB, Room 262
Washington, D.C. 20503



**DATE:** 1/23/96

**TO:** Jen Klein

**AGENCY:** WH

**FAX NO:** 6-2878

**FROM:** Nancy-Ann Min
Associate Director for Health and Personnel

Phone Number (202) 395-5178
Fax number (202) 395-9119

**Number of pages (including cover)** 2

**COMMENTS:**

EXECUTIVE OFFICE OF THE PRESIDENT

22-Jan-1996 07:20pm

TO: Nancy-Ann E. Min

FROM: Timothy B. Hill
Office of Mgmt and Budget, HD

CC: Barry T. Clendenin
CC: Mark E. Miller
CC: David J. Haun

SUBJECT: DoJ Phone Call re Fraud and Abuse Provisions

CC: Jennifer Klein — I think we should think where we are on this. NC

I received a call this afternoon from Debra Cohen at the Department of Justice regarding the fraud provisions in the Administration's latest balanced budget plan.

She has two concerns: (1) the Conference Agreement (upon which the latest version of the Administration's fraud and abuse provisions are based) provides neither the funding flexibility nor the funding levels sought by Justice and (2) there are other non-resource related problems (i.e. criminal fines being deposited into the Medicare Trust Funds) with the Conference Agreement that Justice would like revised.

As described below, I think I addressed Debra's concerns. There is still a chance that she, or the Deputy AG, might call you or Bob Litan about this issue, particularly since LRD plans on sharing the revised legislative language with Justice once it is drafted.

Funding Issues.

Funding For Justice in the Conference Agreement. The Conference Agreement provides a total possible level of funding for Justice of $84 million--$47 million in mandatory appropriations for FBI (roughly $7 million above FBI's base spending for Medicare anti-fraud activities) and another $34 million, distributed at the discretion of the Attorney General and the Secretary of HHS, for prosecutors and other activities (DoJ's base funding for prosecutors and other activities is $15 million).

Justice's Concerns. Justice has asked for a Justice-wide (as opposed to an FBI specific) mandatory appropriation of $120 million--including $55 million in base spending and a $65 million increase--and is concerned that the levels in the Conference Agreement are not as high. Justice is also concerned with the

Conference Agreement's provision that the AG and HHS "share" $31 million for prosecutors and other activities (HHS made assertions at a meeting last month that HHS should get all of this money).

My Response. I told Debra that the resource issues were largely dictated by CBO scoring. The Conference Agreement funding levels are what CBO believes can be reasonably spent. Increasing resources for Justice beyond these levels will likely result in less savings and necessitate another Medicare offset in the package. I also told her, regarding the "sharing" of money between HHS and Justice, that HHS would not necessarily have the last word on what would happen to these funds.

Saw Nestor, Rubens. Finance staffer, agrees.

Non-Resource Issues

Justice's Concerns. Justice does not like several provisions of the Conference Agreement, particularly provision requiring the deposit of criminal fines--which now go to a victims compensation fund--into Medicare Trust Funds.

My Response. We should be able to accommodate these types of changes as we re-draft the bill, to the extent that they would not effect scoring (I do not believe that Justice's changes would).

L agree

FUNDING FOR HEALTH CARE FRAUD ENFORCEMENT
IN CONFERENCE REPORT

1. Funding Source for Control Account includes criminal fines and forfeitures, diverting these monies from specified funds serving other important law enforcement activities, i.e., respectively the Crime Victims Fund and the Assets Forfeiture Fund now available to participating federal, state and local law enforcement agencies.

2. Mandatory appropriations from the General Fund are set forth for FBI, but not for prosecutors; we support mandatory appropriations from the General Fund for the Department of Justice to enable us to provide the requisite investigators, prosecutors and support staff for effective health care fraud enforcement.

3. Medicare Trust Fund monies available for Department of Health and Human Services Office of Inspector General and others to combat law enforcement will be significant in aiding Medicare law enforcement but will not be available for nonMedicare enforcement (e.g., other federal health care plans and private insurance); this necessitates other funding for federal law enforcement.

4. All monetary recoveries (other than restitution, relator's fees and single damages) will be deposited into the Medicare Trust Fund, even when recoveries derive from cases involving nonMedicare funds (e.g., Champus, private insurance).

12/12/95

# COMPARISON OF THE HEALTH CARE FRAUD AND ABUSE PROVISIONS OF THE CONFERENCE AGREEMENT AND ADMINISTRATION PROPOSAL[1]

| | Conference Agreement | Administration Proposal | OIG Recommendation (Most important = bold face) |
|---|---|---|---|
| Medicare Anti-Fraud and Abuse Program (MAAP) | Establishes a mandatory spending account in the Medicare Part A Trust Fund to cover the costs of the anti-fraud and abuse control program as the Secretary and the Attorney General certify are necessary for these purposes. For FY 96, not more than $104 million; for each FY 97-02, the limit for the preceding year, increased by 15%; for each FY after FY 02, the limit for FY 02. All health care fraud law enforcement agencies are eligible to receive funding. | Assures a dependable mandatory source of funds for five years for all OIG Medicare anti-fraud and abuse activities by supporting them through the Medicare Trust Funds.<br><br>For FY 96, $130 million; FY 97, $181 million; FY 98, $204 million; FY 99, $223 million; and FY 00, $244 million. (Section 11421) | **Support the concept in both bills of funding Medicare law enforcement activities from the Medicare Trust Funds. Support the funding levels proposed in the Administration proposal; OIG would be able to fully utilize such funds to reduce fraud and abuse.**<br><br>**Disagree with Conference Agreement proposal to use Trust Funds monies for non-Medicare law enforcement activities.**<br><br>Prefer the Conference Agreement proposal to continue this funding into the future, instead of limiting the funding to a five year period. |

[1] The Conference provisions analyzed are contained in H.R. 2491, dated 11/20/95. The Administration provisions analyzed are contained in the document released 12/08/95.

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Medicare Anti-Fraud and Abuse Program (continued) | For activities of the OIG[2] with respect to Medicare and MediGrant, from the amounts appropriated above from the Medicare Part A Trust Fund: for FY 96, not less than $60 million and not more than $70 million; increased as specified; for each FY after FY 01, not less than $150 million and not more than $160 million.<br><br>For the activities of the FBI, there are appropriated from the general fund of the U.S. Treasury: for FY 96, $47 million; increased as specified; and for each FY after FY 01, $114 million. (Section 8101(b)) | (See above) | (See above) |
| Medicare Integrity Program | Would provide a stable source of funding for HCFA Medicare payment safeguard activities by supporting them as a mandatory program with funds from the Medicare Part A Trust Fund. Funding for FY 1996 would be not less than $430 million and not more than $440 million and would increase in subsequent years. (Sections 8102; 8101(b)) | Similar, but funds program out of Medicare Part A and B Trust Funds.<br><br>Funds the program only through FY 2000. For FY 96, $430 million increasing each year until FY 00, $670 million. (Section 11422) | Support both proposals. Prefer Conference Agreement's proposal to fund activities beyond a five year period. |

[2] References to OIG are to HHS/OIG.

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Anti-Fraud Account | Criminal fines, civil monetary penalties (CMPs), amounts resulting from forfeitures (after payment of costs of asset forfeiture have been made), and penalties and damages obtained under the False Claims Act (other than funds awarded to a relator or for restitution) in health care cases will be considered income to the Medicare Part A Trust Fund. (Section 8101(b)) | Creates a government-wide anti-fraud reinvestment fund to be used at the discretion of the Attorney General and HHS/IG to prevent and detect health care fraud and abuse in all agencies dealing with health care. Amounts to supplement appropriations.<br><br>Deposits into the account include CMPs and penalties and damages obtained under the False Claims Act (other than funds awarded to a relator or for restitution) in health care cases.<br><br>No more than $10 million can be deposited into the account each year. (Section 11423) | OIG could support either proposal as long as the basic funding levels in MAPP continue, as described above.<br><br>If the Administration Proposal is adopted, recommend that IGs be authorized to share in proceeds from asset forfeitures involving cases in which they are involved. |
| Fraud and Abuse Control Program (to coordinate law enforcement efforts relating to health care) | Creates a Fraud and Abuse Control Program coordinated by OIG and the Attorney General. (Section 8101(a)) | No provision. | Support Conference Agreement. |
| Investigative and Other Costs | Authorizes OIG to receive and retain court-ordered or agreed-to costs of investigations, audits and for monitoring compliance plans. (Section 8101(a)) | No provision. | Support Conference Agreement. |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Civil Monetary Penalties (CMPs) | Extends many current Medicare/Medicaid CMPs to all federal health care programs. (Section 8131(a)) | Similar. (Section 11402(a)) | Support both proposals. |
| | IGs of departments with federal health care programs can initiate CMPs with respect to their own programs, and in certain cases, with respect to other federal health care programs. (Section 8131(a)) | Similar. (Section 11402(a)) | Support both proposals. |
| | New CMP for excluded individuals retaining ownership or control interest in participating entity. Applies only to those with an ownership or control interest who know or should know of the action constituting the basis for the exclusion or any officers or managing employees. (Section 8131(b)) | New CMP for excluded individual retaining ownership or control interest (including directors) or who is an officer or managing employee. (Section 11402(b)) | Support Administration proposal. Requirement in Conference Agreement that individual knows or should know of the action is superfluous since the excluded individual, by definition, knows or should know of the conduct. |
| | New CMP for claims for items or services based on an incorrect code ("upcoding"). (Section 8131(d)) | Similar. (Section 11402(e)) | Support both proposals. |
| | New CMP for providing medically unnecessary services. (Section 8131(d)) | No provision. | Support Conference Agreement. |
| | New CMP for inducements to beneficiaries. (Section 8131(g)) | Similar. (Section 11402(f)) | Support both proposals. |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Civil Monetary Penalties (CMPs) (continued) | New CMP for signing a certification for home health services knowing that "all" of the requirements for home care are not met. (Section 8133) | No provision. | Object to Conference Agreement since it includes a higher standard than other CMPs and requires that "all" requirements are not met. |
| | No provision. | New CMP for violations of the anti-kickback statute. (Section 11402(f)) | Support Administration Proposal. |
| | No provision. | New CMP for employers billing for services furnished, directed or prescribed by an excluded employee. (Section 11402(c)) | Support Administration Proposal. |
| | Increases amount of authorized penalties under section 1128A from $2,000 per false item or service claimed to $10,000. (Section 8131(c)) | Similar. (Section 11402(d)) | Support both proposals. |
| | Would make the CMP provisions for fraudulent claims more lenient by redefining the term "should know" so that providers would only be liable if they act with "deliberate ignorance" of false claims or if they act with "reckless disregard" of false claims. (Section 8132) | No provision. | **Object to Conference Agreement. See Tab A.** |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Kickbacks (among health care providers) | Extends kickback statute to all federal health care programs. (Section 8104) | Extends kickback statute to all health care benefit programs. (Section 11404) | Support both proposals. Prefer Administration Proposal since it is applicable to all health plans. |
| | Creates new broad managed care exception to the Medicare/Medicaid anti-kickback statute. (Section 8116) | No provision. | **Object to Conference Agreement. See Tab B.** |
| | No provision. | Creates new CMP for kickbacks. (Section 11402(f)) | Support Administration Proposal. |
| | No provision. | Creates private right of action for kickbacks. (Section 11404) | Support Administration Proposal. |
| PRO (Quality of Care) Sanction Provisions (Section 1156 of SSA) | Strengthens enforcement of PRO provisions. (Sections 8114; 8131(e)) | Similar. (Section 11405) | Support both proposals. |
| Final Adverse Action Data Base | Creates data base. Final adverse actions do not include settlements in which no findings of liability have been made. (Section 8121) | Similar. The public would also have access to the data base. Requires separating of all final adverse actions, including those resulting from settlements. (Section 11406) | Prefer Administration Proposal since it provides access to the public and contains all relevant final actions (whether or not they result from a negotiated settlement). |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Criminal Authorities | Creates new health care fraud statute applicable to federal health care programs. (Section 8141) | Similar, but statute is applicable to all health plans. (Section 11431) | Prefer Administration Proposal since it is applicable to all health plans. |
| | Authorizes forfeiture of property that constitutes or is derived, directly or indirectly, from proceeds traceable to the commission of a health care offense. (Section 8142) | Similar. (Section 11432) | Support both proposals. IGs should be authorized to share in proceeds from asset forfeitures involving cases in which they are involved. |
| | Authorizes injunctive relief. (Section 8143) | Similar. (Section 11433) | Support both proposals. |
| | Creates new false statement statute applicable to federal health care programs. (Section 8144) Also extends Medicare and Medicaid false statement statute to federal health care programs. (Section 8104) | Creates new false statement statute applicable to all health plans. (Section 11435) | Prefer Administration Proposal since it is applicable to all health plans. |
| | Creates criminal statute prohibiting obstruction of criminal health care investigations. (Section 8145) | Similar. Statute also covers audits and inspections. (Section 11436) | Prefer Administration Proposal. |
| | Creates new theft or embezzlement statute applicable to federal health care programs. (Section 8146) | Similar, but statute is applicable to all health plans. (Section 11437) | Prefer Administration Proposal since it is applicable to all health plans. |
| | Amends money laundering statute to add federal health care offense as an "unlawful activity." (Section 8147) | Similar. (Section 11438) | Support both proposals. |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Criminal Authorities (continued) | Authorizes investigative demand procedures in investigations relating to health care fraud. (Section 8148) | Similar. (Section 11439) | Support both proposals. |
| | No provision. | Authorizes interception of wire, oral or electronic communications in certain cases. (Section 11410) | Support Administration Proposal. |
| | No provision. | Authorizes certain disclosure of grand jury information. (Section 11434) | Support Administration Proposal. |
| | Extends criminal provision prohibiting the submission of claims for services by unlicensed physicians to all federal health care programs. (Section 8104) | No provision. | Support Conference Agreement. |
| | Prohibits the conversion of assets in order to become eligible for benefits under a State health care program. (Section 8117) | No provision. | Support Conference Agreement. |
| | No provision. | Adds health care offenses to RICO statute. | Support Administration Proposal. |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Exclusions (from participation in health care programs) | Adds new mandatory exclusions from Medicare and Medicaid for felony convictions related to health care fraud and controlled substances. (Section 8111) | No provision. | Support Conference Agreement. |
| | Establishes minimum period of exclusion for certain permissive exclusions (e.g., 3 years for certain convictions). (Section 8112) | Similar. (Section 11403(a)) | Support both proposals. |
| | Adds new permissive exclusion from Medicare and Medicaid for individuals with an ownership or control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the sanction or who is an officer or managing employee of the sanctioned entity. (Section 8113) | Similar, but includes all individuals with an ownership or control interest (including directors) or officers or managing employees of the sanctioned entity regardless of their knowledge of the actions leading to the sanction. (Section 11403(b)) | Support Administration Proposal. |
| | No provision. | Creates permissive exclusion for providers who charge excessive fees or prices. (Section 11403(c)) | Support Administration Proposal. |
| | No provision. | Provides that exclusions are not subject to the automatic stay imposed under the Bankruptcy Code. (Section 11403(d)) | Support Administration Proposal. |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| State Medicaid Fraud Control Units | Expands authority of MFCUs to: (1) patient abuse cases in all board and care facilities; and (2) fraud cases in all federal health care programs, if the affected agency approves. There is no requirement that expansion of authority in fraud cases is limited to cases in which the case is primarily a MediGrant fraud case. (Section 8151) | Similar. Provision states that the expansion of authority in fraud cases is limited to cases in which the case is primarily a Medicaid fraud case. (Section 11407) | Support Administration version, but recommend delegation to IG's of authority to approve the investigation. |
| | OIG no longer dispenses the funds and no longer has authority to certify and recertify the Units, thus eliminating OIG's oversight role. (Section 7001) (Both the House and Senate reconciliation bills had retained OIG certification authority, which was eliminated by the conference.) | Continues current status. | Prefer Administration version. If Conference Agreement is adopted and if MFCU funding exists as part of Medigrant block grant, OIG has no objection to the elimination of OIG oversight. |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Physician Self-Referral | Repeals prohibitions based on compensations arrangements. (Section 8201) | No provision. | **Object to Conference Agreement. See Tab C.** |
| | Deletes many of the services subject to the prohibition. (Section 8202) | No provision. | Object to Conference Agreement. |
| | Delay in implementation of effective date. (Section 8203) | No provision. | **Object to Conference Agreement. See Tab C.** |
| | Repeals site-of-service requirement in the "in-office ancillary services" exception and creates a lenient "general supervision" requirement. (Section 8204(a)) | No provision. | **Object to Conference Agreement. See Tab C.** |
| | Clarifies some exceptions and creates several new exceptions. (Section 8204) | No provision. | Object to Conference Agreement. |
| Recovery of Overpayments from Bankrupt Providers | No provision. | Bars Medicare providers and suppliers from obtaining discharge under the Bankruptcy Code of their obligation to repay to the Secretary overpayments received from the Medicare Trust Funds. (Section 11408) | Support Administration Proposal. |

| | Conference Agreement | Administration Proposal | OIG Recommendation |
|---|---|---|---|
| Provider Guidance | Requires issuance of interpretative rulings, additional safe harbors and fraud alerts. (Section 8105) | No provision. | Support Conference Agreement with two exceptions: (1) OIG should have 120 days to either grant or deny a request for an interpretive ruling (as opposed to 90 and 60 days in the proposal); and (2) OIG should be given the discretion to decide whether an investigation relating to a request for a fraud alert is appropriate. |
| HMO Intermediate Sanctions | Creates sanctions. (Section 8115) | ~~Similar~~. No Provision | No objection to ~~either proposal~~ Conference Agreement. |
| Beneficiary Incentive Programs | Requires HHS to provide beneficiaries explanation of benefits with respect to each item or service for which Medicare payment may be made. (Section 8103(a))<br><br>Establishes program to encourage beneficiaries to report fraud and abuse and suggestions on improving the efficiency of the Medicare program. Provides for payment to beneficiaries in certain cases. (Section 8103(b)) | No provision.<br><br>No provision. | Support Conference Agreement.<br><br>No objection to Conference Agreement. |
| Grants to States to Revoke Licenses of Unqualified Providers | No provision. | Authorizes HHS Secretary to make such grants to states. (Section 11409) | Support Conference Agreement. |

A.

**RECONCILIATION AGREEMENT WOULD MAKE CIVIL MONETARY PENALTIES FOR FRAUDULENT MEDICARE/MEDICAID CLAIMS MORE LENIENT BY RELIEVING PROVIDERS OF THE DUTY TO USE "REASONABLE DILIGENCE" TO ENSURE THEIR CLAIMS ARE TRUE AND ACCURATE.**

**Background:** The existing Medicare and Medicaid civil monetary penalty (CMP) provisions regarding false claims were enacted by Congress in the 1980's as an administrative remedy, with cases tried by administrative law judges with appeals to Federal court. In choosing the "knows or should know" standard for the mental element of the offense, Congress chose a standard which is well defined in the Restatement of Torts, Second, Section 12. The term "should know" places a duty on health care providers to use "reasonable diligence" to ensure that claims submitted to Medicare are true and accurate. The reason this standard was chosen was that the Medicare system is heavily reliant on the honesty and good faith of providers in submitting their claims. The overwhelming majority of claims filed by providers are never audited or investigated.

Note that the "should know" standard does not impose liability for honest mistakes. If the provider exercises reasonable diligence and still makes a mistake, the provider is not liable. No administrative complaint or decision issued by the Department of Health and Human Services (HHS) has found an "honest mistake" to be the basis for CMP sanction.

**Reconciliation Proposal:** Section 8132 would redefine the term "should know" in a manner which does away with the duty on providers to exercise reasonable diligence to submit true and accurate claims. Under this definition, providers would only be liable if they act with "deliberate ignorance" of false claims or if they act with "reckless disregard" of false claims. In an era when there is great concern about fraud and abuse of the Medicare program, it would not be appropriate to relieve providers of the duty to use "reasonable diligence" to ensure that their claims are true and accurate.

B.

**RECONCILIATION AGREEMENT WOULD CREATE AN EASILY ABUSED EXCEPTION FROM THE MEDICARE/MEDICAID ANTI-KICKBACK STATUTE FOR CERTAIN MANAGED CARE ARRANGEMENTS.**

**Background:** The Medicare and Medicaid anti-kickback statute (42 U.S.C. Sec. 1320a-7b(b)) makes it a criminal offense knowingly and willfully (intentionally) to offer or receive anything of value in exchange for the referral of Medicare or Medicaid business. The statute is designed to ensure that medical decisions are not influenced by financial rewards from third parties. Kickbacks result in more medical services being ordered than otherwise, and law enforcement experts agree that unlawful kickbacks are very common and constitute a serious problem in the Medicare and Medicaid programs.

Today, there is great variety and innovation occurring in the managed care industry. Some managed care organizations, such as most health maintenance organizations (HMOs) doing business with Medicare, consist of "capitated, at risk" entities with providers under contract. The entity and its providers assume complete financial risk for the quantity of medical services needed by the population they serve. In this context, the incentive to offer kickbacks for referrals of patients for additional services is minimized. If anything, the incentive is to reduce services.

However, many other managed care organizations, such as the typical Preferred Provider Organization (PPO) exist in the fee for service system, where the traditional incentives to order more services and pay kickbacks for referrals remain. In the fee for service system, the payer (like Medicare) remains at financial risk of additional services, not the PPO. While broad protection from the anti-kickback statute may be appropriate for capitated, at-risk entities like the HMO described above, such protection for managed care organizations in the fee for service system would invite serious abuse.

**Reconciliation Proposal:** Section 8116 would establish a broad new exception under the anti-kickback statute for any arrangement where a medical provider is at "substantial financial risk" whether through a "withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement." There is no provision authorizing the Department of HHS to define the vague terms. The lack of definition of any of these vague terms would result in a huge opportunity for abusive arrangements to fit within this proposed exception. What is "substantial" risk? Fifty percent? Twenty percent? Ten percent? Since the kickback statute is a criminal statute, any vagueness in terms operates in favor of the defendant, and against the government.

What is an "incentive pool?" Could not kickbacks be in the form of an incentive pool? What is "any similar risk arrangement?" What does that term exclude?

Nefarious organizations could easily escape the kickback statute by simply rearranging their agreements to fit within this overly broad exception. For example, if a facility wanted to pay doctors for referrals, the facility could acquire various ancillary services, like a home

health agency, durable medical equipment dealer, etc. The facility would then enter into contracts with a number of physicians, each contract establishing some device whereby the doctors share significantly in the risk of profit and loss (i.e., they would share some risk, at least theoretically). [In actuality, such cozy referral arrangements have resulted in very high profits; the downside risk is only theoretical.] Having entered these contracts, the entity could pay blatant kickbacks for every referral, and it would all be perfectly legal.

The CBO assigned a considerable cost to this provision, because of the ease with which it could be abused by those wishing to profit from referrals. The damage to the programs consists of the overutilization of services which kickbacks have been shown (in the professional literature) to engender.

If the concern is that the kickback statute is hurting innovation, as observed above, there is now an explosion of innovation in the health care industry, especially in managed care. No one in Government is suggesting that managed care arrangements, formed in good faith, violate the kickback statute. There has never been any action against any such arrangement under the kickback statute.

C.

## RECONCILIATION AGREEMENT WOULD SERIOUSLY WEAKEN THE MEDICARE/MEDICAID PHYSICIAN SELF-REFERRAL LAW

The overall concern with physician self-referral is that decisions about patient care should not be influenced by the profit motive. Section 1877 of the Social Security Act was enacted in 1989 as a comprehensive mechanism to deal with the problem of self-referral by physicians. It prohibits Medicare and Medicaid payments for certain designated health services (DHS) where the physician (or immediate family member) who orders the service has a "financial relationship" with the entity providing the DHS. The term "financial relationship" includes both ownership and compensation arrangements. The statute contains a number of broad exceptions so that legitimate arrangements between entities and physicians can be accommodated.

Ten major studies have appeared: one by the HHS/Office of Inspector General, one by the General Accounting Office, one by the State of Florida, four published in the New England Journal of Medicine, and three in the Journal of the American Medical Association. These studies, taken as a whole, demonstrate that utilization rates of medical items or services tend to increase as a result of financial incentives directed to physicians who order those items or services. The increased utilization of services attendant to self-referral would have an impact on Medicare and Medicaid expenditures.

The Reconciliation bill contains a number of provisions that would seriously weaken the physician self-referral law, among them: repealing the overall prohibition of remuneration through "compensation arrangements," delaying the effective date for most of the statute, and expanding the "in-office ancillary" exception.

### Repealing the prohibition of remuneration through "compensation arrangements"

Background: In order to gain control of remuneration paid to physicians by entities which benefit from physician referrals, the Congress limited (1) investments by physicians, and (2) other types of payments to physicians, i.e., "compensation arrangements." While the concept of "compensation arrangements" is quite broad, there are many broad exceptions for legitimate types of remuneration, such as payments for: rental of equipment or space, consultation services or employee services, physician recruitment, and a variety of other arrangements. These exceptions all contain appropriate safeguards to ensure that a physician will not unduly profit from referrals. For example, these exceptions generally contain a requirement that the compensation cannot be based on the value or volume of referrals between the parties.

Reconciliation Proposal: Section 8201 would repeal the prohibition on self-referral as it applies to compensation arrangements. If this part of the statute were repealed, entities that provide DHS could readily switch remuneration to physicians into some form of compensation arrangement. The danger would be that entities might provide inappropriate incentives to physicians in the guise of some kind of compensation, for example, excessive

consultation fees, excessive rental fees for part time use of part of the physician's office, etc.

**Delaying the effective date**

Background: Section 1877 was completely effective for referrals made on or after December 31, 1995. (Prior to that time, certain provisions had been effective only for clinical laboratory services.) On August 14, 1995, HCFA issued final regulations governing referrals for clinical laboratory services. Pending publications of final regulations on the other DHS, enforcement will rely on the language of the statute. Most of what is prohibited is clear by the terms of the statute itself. For example, one cannot "joint venture" an entity offering DHS with physicians who refer there. In addition, the Department of Health and Human Services will rely on the final clinical laboratory regulations, where interpretation of the law in the context of referrals for clinical lab services is equivalent to situations involving referrals for the other DHS.

Reconciliation Proposal: Section 8203 would delay implementation of provisions covering DHS and certain exceptions until final regulations have been issued. Considering that such self-referral practices might generate unnecessary costs to the Medicare and Medicaid programs, any delay of these provisions would have budgetary effects.

**Expanding the "in-office ancillary" exception**

Background: Section 1877 contains an exception for DHS provided in a physician's office -- the "in-office ancillary" services exception. There are different rules that apply to referrals by physicians who are solo practitioners and physicians who are members of group practices. In both cases, the exception contains requirements regarding who performs the service, where the service is performed (so-called "site-of-service" requirements) and billing.

In the case of solo practitioners, the in-office ancillary services exception applies if the service is furnished by the physician or by individuals who are directly supervised by the physician. The services must be furnished in a building in which the physician furnishes physicians' services unrelated to the furnishing of DHS. In regulations, HCFA has defined "direct supervision" to mean "supervision by a physician who is present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed."

In the case of group practices, the exception applies if the service is furnished by the referring physician, a physician who is a member of the same group practice as the referring physician or by individuals who are directly supervised by the referring physician or another physician in the group. (The definition of "directly supervised" discussed above applies in this situation.) The services must be provided either in a building where the referring physician (or member of the same group) provides physicians' services unrelated to the DHS, or in another building which is used by the group for the provision of some or all of the group's laboratory services or the centralized provision of the group's DHS (other than laboratory services).

The purpose of the original exception was to permit physicians to have their own in-office laboratory, a fairly common practice prior to the enactment of section 1877. The supervision and site-of-service requirements ensured that the laboratory (or other DHS) was a legitimate part of the physician's traditional office practice.

Reconciliation Proposal: Section 8204 would repeal the site-of-service requirement in section 1877 and would replace the term "direct supervision" with the term "general supervision." Under the proposed definition of "general supervision," the physician would not need to be physically present when the individual performed the service, but would have to be "legally responsible" for the services provided by the individual.

These two major changes to the in-office exception would transform the exception from applying to "in-office" services to applying to any joint venture where the physicians are general partners, that is, where they take legal responsibility for the entity. Under this approach, a physician or group of physicians could own an MRI facility that was not located in their office, and could receive lucrative returns on investment resulting from their referrals. This would create a sizeable loophole to the statute.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

LRM NO: 3338

FILE NO: 1770

URGENT

12/22/95

LEGISLATIVE REFERRAL MEMORANDUM

Total Page(s): 7

TO: Legislative Liaison Officer - See Distribution below: Connie Bowers for

FROM: Janet FORSGREN (for) Assistant Director for Legislative Reference

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bowers_c@a1.eop.gov

SUBJECT: JUSTICE Proposed Report on Health Care Fraud and Abuse Prevention Provisions in the Administration's budget reconciliation legislation, "Federal Health Care Payment Integrity Act"

**DEADLINE: 2:00 p.m., Tuesday Tuesday, December 26,1995**

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

**Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

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**RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM**

LRM NO: **3338**

FILE NO: **1770**

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.
If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.
You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: Connie BOWERS 395-3803
Office of Management and Budget
Fax Number: 395-6148
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: JUSTICE Proposed Report on Health Care Fraud and Abuse Prevention Provisions in the Administration's budget reconciliation legislation, "Federal Health Care Payment Integrity Act"

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

Office of Legislative Affairs
U. S. Department of Justice

Office of the Assistant Attorney General Washington, D.C. 20530

Honorable Newt Gingrich
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

This is to apprise you of the strong support of the Department of Justice for the health care fraud and abuse prevention provisions of the Administration's budget reconciliation draft bill, the "Federal Health Care Payment Integrity Act of 1995." These proposals are similar in many respects to provisions included in the conference report on H.R. 2491, the "Balanced Budget Act of 1995."

Key provisions of the Administration's proposal, which we consider essential to effective health care fraud investigations and prosecutions, are highlighted below.

Grand jury disclosure. Section 11434 of the Administration's draft bill would provide for disclosure of grand jury information for use by government attorneys in civil proceedings. A provision to this effect was included in the House- and Senate-passed reconciliation bills; however, it was deleted in the conference report on H.R. 2491. This provision is similar to one enacted as part of the Financial Institutions Reform and Recovery Act of 1989 (FIRREA) (codified at 18 U.S.C. § 3322a). The FIRREA grand jury provision has proven to be critical in actions against persons and institutions in financial institutions fraud cases. By facilitating the sharing of information between criminal prosecutors and civil attorneys, the Administration's grand jury proposal would enable us to proceed more quickly and efficiently to recover losses to federal health care programs, such as Medicare, Medicaid, CHAMPUS, and the Federal Employee Health Benefits Program, to obtain damages, which are deposited in the Treasury, and to prevent perpetrators of fraud from dissipating their assets before we can take action to recover our losses.

Creation of new health care fraud offenses. The Administration's draft bill would create new criminal offenses relating to health care fraud, many of which were, in one form or another, included in the conference report on H.R. 2491. In particular, the Administration's proposal would establish new criminal offenses for: health care fraud (section 11431); illegal remuneration (i.e., "kickbacks") in connection with health care programs (section 11404)[1]; false statements concerning health care matters (section 11435); obstruction of criminal investigations relating to federal health care offenses (section 11436); theft or embezzlement in connection with health care (section 11437); and health care fraud-related activity in connection with money laundering (section 11438). Importantly, the Administration's proposals extend to all health care plans, both private and public. The conference report on H.R. 2491 covered only government-funded plans, coverage that we regard as needlessly narrow and of limited usefulness.

Other enforcement provisions. Other important health care fraud enforcement provisions contained in the Administration's draft bill (and, in some cases in the conference report on H.R. 2491) include proposals to: provide for criminal forfeitures in connection with health care fraud offenses (section 11432); permit a court to provide injunctive relief in connection with health care-related offenses (section 11433); provide for health care fraud offenses as predicates under the RICO statute and as a basis for requesting authorization for interception of certain oral, wire and electronic communications (section 11410); and establish new procedures under which the Attorney General or her designee may administratively subpoena certain documents or records in connection with activities relating to health care fraud (section 11439). We believe that these additional enforcement mechanisms would be important tools in our law enforcement effort, and that they should be included in any final reconciliation bill.

Resources. The civil and criminal investigation and prosecution of health care fraud is one of the very highest priorities of the Department of Justice. Adequate health care enforcement depends upon sufficient resources for health plan administrators, investigators and prosecutors to ensure our ability to punish wrongdoers and to recover money for the Medicare Trust Funds and the United States Treasury. We therefore support additional funding for the Office of Inspector General of the Department of Health and Human Services. Without

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[1] In addition, as we have recommended previously, we believe that Congress should enact a civil anti-kickback remedy. Defense counsel argue that the absence of an explicit anti-kickback remedy limits the government's opportunities to recover damages and civil penalties.

an additional infusion of funds, however, the Department of Justice will not be equipped to respond to the rapidly growing health care fraud case load that we expect in the years ahead. For example, as of October 1995, the FBI had 1,760 health care fraud matters under investigation, up from 1,051 in 1993 -- an increase of nearly 70 percent. Consequently, we recommend that the Department of Justice -- as well as the Department of Health and Human Services -- be provided with additional funding to continue the fight against health care fraud and abuse.

There are several options available to accomplish this objective. (1) First, the $10 million annual cap on amounts that may be deposited in, or transferred to, the government-wide anti-fraud fund contained in section 11423(a)(1)(C) of the Administration's original draft bill should be deleted. In view of the magnitude of the health care fraud problem, the Administration has, upon further review, concluded that this limitation would unduly limit the usefulness of the government-wide anti-fraud fund. (2) In addition, we note that the Department of Justice actively prosecutes and investigates cases under the Medicare statutes.[2] Accordingly, we suggest that the Department of Justice be afforded access to funds in the Medicare trust funds specified in section 11421 of the Administration's draft bill, subject to the same terms and conditions that would apply to the Office of Inspector General of the Department of Health and Human Services (e.g., that any such funds would be employed only for investigations and prosecutions pertaining to fraud in the Medicare program).[3] (3) Finally, we would support for inclusion in any final budget reconciliation package language similar to that contained in the conference report on H.R. 2491, the "Balanced Budget Act of 1995," which would have provided a direct appropriation from the General Fund of the Treasury and would have appropriated funds from a trust fund to a Control Account for various law enforcement-related purposes, including

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[2]Indeed, FBI investigators (and personnel from the Office of Inspector General of the Department of Health and Human Services) were critical in achieving the single largest recovery to date in a health care fraud case involving Medicare and other federal health programs. In that case, involving National Medical Enterprises, total criminal and civil penalties amounted to $379 million.

[3]Permitting the Justice Department to share in funding under the Medicare program would be consistent with other provisions of the Administration's draft bill. See section 11423(a)(3)(A) (requiring, inter alia, the Secretary of the Treasury to transfer amounts to the government-wide anti-fraud fund equal to civil monetary penalties and assessments recovered under titles XI (general provisions), XVIII (Medicare), and XIX (Medicaid) of the Social Security Act).

investigations and prosecutions, as determined by the Attorney General and the Secretary of Health and Human Services.[4]

With respect to the provisions of the conference report on H.R. 2491 pertaining to health care fraud, we believe that they represented a significant improvement over earlier versions of the legislation, especially H.R. 2425. During the past several months, we have worked closely with the Congress to ensure that any health care fraud legislation that is ultimately enacted does not include counterproductive provisions.

For example, one provision of H.R. 2425 would have inappropriately elevated the government's burden of proof in Medicare anti-kickback prosecutions. Another provision would have required the Secretary of Health and Human Services to issue legally binding advisory opinions regarding what activity does or does not constitute a violation of the criminal anti-kickback statute -- a determination properly made only by Federal prosecutors. A third provision would have improperly ceded the authority of the Attorney General to the Secretary of Health and Human Services to waive criminal sanctions against persons or entities who make voluntary disclosures of wrongdoing to the Secretary. This provision would have impaired the Attorney General's exclusive authority to enforce federal criminal laws. Yet another proposal would have established a "National Health Care Anti-Fraud Task Force," which would have needlessly detracted from the government's enforcement efforts. None of these proposals were included in the conference report on H.R. 2491.[5]

As the Congress and the Administration consider the details of a new budget reconciliation bill that is consistent with the principles and priorities of the President, we strongly urge that you support, and encourage others to support, health care fraud legislation that includes the provisions of the Administration's

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[4]We note that under section 8101 of the conference report on H.R. 2491 (enacting proposed section 1128C(b)(2)(C)(i) of the Social Security Act (42 U.S.C. § 1328(b)(2)(C)(i))), amounts transferred to the trust fund would include amounts equal to criminal fines recovered in health care fraud cases. We oppose the transfer of criminal fines to the trust fund. Criminal fines should be deposited in the Crime Victims Fund, consistent with 42 U.S.C. § 10601, et seq.

[5]We note that section 8116 of the conference report on H.R. 2491 would have established a new exception to the criminal anti-kickback statute for certain managed care arrangements. We do not perceive a need for this provision, think it would very likely be subject to abuse, and recommend that it not be included in any final budget reconciliation package.

draft bill (including enhanced resources) that are discussed above. To do otherwise could send an inaccurate and misleading message to the Nation about the Federal Government's commitment to dealing with the problem of health care fraud in a thorough and responsible fashion.

Thank you for your attention to this matter. If we may be of additional assistance, please do not hesitate to call upon us. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this report.

Sincerely,

Andrew Fois
Assistant Attorney General