Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	Law Enforcement (Partial) (1 page)	01/03/1996	P6/b(6), b(7)(C), b(7)(F)
002. paper	Personal (Partial) (1 page)	ca. 1995	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Jennifer Klein
OA/Box Number: 10855

FOLDER TITLE:
Fraud & Abuse [3]

2014-0209-S
ms735

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division

Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

SPECIAL

FROM: Bob Pellicci -- **395-4871**

DATE: Jan 5 **TIME:** 950 am

Pages sent (including transmittal sheet): 6

COMMENTS:

~~Correction~~ Corrects error in materials previously sent to you by Justice (Debra Cohn).

TO:

Jennifer Klein

LaVarne Burton

*LaVarne, please share with Judy Berk & Mac Thornton -- thanks

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

January 4, 1996

Note for Bob Pellici

From: Greg Jones

Bob, there was an error in the paper I gave you yesterday.

The figure in the second to last line, last page, has been changed from $18M to $73M (total of approximately $120M). If you'd advise WH/HHS, I'd appreciate it.

cc: David Haun

HEALTH CARE FRAUD RESOURCES FOR
DEPARTMENT OF JUSTICE INVESTIGATORS AND PROSECUTORS

The Attorney General made health care fraud a top priority.

DOJ INVESTIGATORS AND PROSECUTORS HANDLING HEALTH CARE FRAUD CASES HAVE INCREASED BUT HAVE NOT KEPT UP WITH NEED.

While health care fraud resources expended on health care fraud investigations, civil and criminal prosecutions have increased during the last year, they have not kept apace with the need for such resources.

The Federal Bureau of Investigation has made a serious commitment to combatting health care fraud as measured through numbers of cases and numbers of agent work years.

FBI health care fraud cases worked have increased

FY 93	1,518
FY 94	2,186
FY 95	2,670

FBI agent work years on health care fraud has increased

FY 93	147 FBI work years
FY 94	225 FBI work years
FY 95	253 FBI work years

The FBI estimates that somewhere between 55 and 75 percent of the number of current health care fraud investigations involve Medicare.

Notwithstanding this increased commitment to health care fraud, FBI field offices report significant unaddressed work, which they do not presently have the available agents to address. Based on the rate of increase in its case load and an assessment of the unaddressed work, the FBI estimates its agent needs in the FY 97 to be 207, with additional increases in the future.

Increased Prosecutorial Commitment to Health Care Fraud

Given the past increase in health care fraud investigations by the FBI and others in the past, the health care fraud caseload for Department of Justice civil and criminal prosecutors also has increased.

Numbers of civil matters has increased[1]

	matters pending	matters terminated
FY 93	411	81
FY 94	712	586
FY 95	1,806	281

Numbers of civil cases has increased[2]

FY 93	29
FY 94	75
FY 95	60

Numbers of criminal matters has increased

	matters pending	matters terminated
FY 93	621	130
FY 94	1,066	226
FY 95	1,247	454

Numbers of criminal cases filed has increased

FY 93	105
FY 94	146
FY 95	229

Numbers of criminal convictions has increased

	cases	defendants
FY 93	73	96
FY 94	103	140
FY 95	178	255

The projected increased growth in health care fraud investigators must be met by a commensurate increase in the numbers of civil and criminal prosecutors.

To keep apace of this dramatic increase in health care fraud workload, the number and cost of prosecutors has also increased. For example, the following records the growth of expenditures on prosecutors handling health care fraud cases in U.S. Attorney's

---

[1]These numbers are significantly underinclusive; they do not include numbers of civil matters or civil cases litigated by the Civil Division exclusively. Further complicating recordkeeping, an additional code for civil health care fraud case was adopted in Fiscal Year 1994.

[2]Many civil health care fraud matters are resolved in favor of the government without a case being filed.

Offices.[3]

	1993	1994	1995
FTE	71 (54 atty)	113 (89 atty)	145 (113 atty)
Amount	$6,641,340	$11,258,530	$15,177,750

ADDITIONAL DOJ INVESTIGATORS AND PROSECUTORS NEEDED TO ADDRESS HEALTH CARE FRAUD PROBLEM.

In sum, the Department of Justice has determined that we need additional investigators and prosecutors to handle health care fraud, the requisite positions and monies as set forth below. These numbers represent supplements to the existing base expenditures.

		$ in Thousands
FBI investigators	207 agents and related support[4]	$35,424
Prosecutors (matching increase in FBI investigators)	50 prosecutors and related support[5]	9,306
Prosecutors (matching increase in HHS OIG investigators)	Conference Bill 29 to 39 attorneys & support	$5,407-$6,901
	or	
	Administration Proposal 111 attorneys & support	$20,609
Grand Total		$65,339

[3]These figures underestimate both the number and cost of attorneys handling criminal and civil health care fraud cases because they do not include the attorneys in the Criminal Division and Civil Divisions in Washington who handle health care fraud cases.

[4]Each agent is estimated to cost $126,000, each clerical/administrative $51,000, and each investigative support $88,000.

[5]Assumes 5 agents to 1 attorney, plus limited supervisory/coordinating attorneys. Each attorney at a year cost of $163K. Also assumes 1 support for every three attorneys at $68K.

PROPOSAL FOR FUNDING INVESTIGATORS AND PROSECUTORS AT THE DEPARTMENT OF JUSTICE:

There are three potential sources of funds for financing the additional Department of Justice investigators and prosecutors: Medicare Trust Fund; control account; and mandatory appropriations from the General Fund. As set forth below, the Department of Justice favors a mandatory appropriation from the General Fund for the Department of Justice.

Should the Medicare Trust Fund be selected, the use of these funds would appropriately be limited to Medicare law enforcement and the Department of Justice pledges to ensure such focused use through the adoption of FBI and DOJ case tracking and reporting mechanisms now used for other restricted funding sources (e.g., Three percent fund; FIRREA). Such funding surely would facilitate Medicare law enforcement but would not be available for combatting health care fraud in other federal health care plans or private insurance plans.

The Control Account would be jointly administered by HHS and DOJ. Yet the $10 million cap under the Administration proposal would prevent the fund from covering the full resource needs of the Department. Moreover, numerous agencies potentially may lay claim to this Account. Finally, DOJ continues to oppose the depositing of criminal fines into this account, because it would deprive the Crime Victims Fund of badly needed funding.

The Department endorses a mandatory appropriation from the General Fund to address the investigative and prosecutorial resources needed to fight health care fraud. Such funding would be available for any health care fraud case and would be less administratively burdensome for both the Departments of Justice and Health and Human Services. We recognize that the cost of this appropriation will somewhat offset the savings generated from enactment of this legislation, but we believe that this cost is realistic and acceptable to everyone who understands the horrendous waste - billions of dollars - caused by health care fraud and we are confident that this expenditure will yield greater recoveries in the future.

Recommendation:

Therefore, we recommend a mandatory appropriation from the General Fund for the Department of Justice -- not only the FBI -- of $65 million plus base of $40 million for FBI, $15 million for US Attorneys, and a smaller amount for Civil and Criminal Divisions. If the mandatory appropriation from the General Fund cannot be increased from $47 million as in the Conference Report, we recommend funding for the Department of Justice for the remaining $73 million from the Medicare Trust Fund and Control Accounts.

FAX

Health Division

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

TO: Debra Cohen, Department of Justice

FROM: **Tim Hill**
202/395-7831 (voice)
202/395-3910 (fax)
hill_t@1.eop.gov (e-mail)

cc: Jennifer Klein

Number of Attached Pages: 1

NOTES:

Per your conversation with Jennifer Klein, attached is a draft side-by-side describing the differences between the Conference, Coalition and Administration anti-fraud provisions.

I would be happy to talk to you about the side by side, or the fraud provisions generally, if you have any further questions.

Side by Side Comparison of Medicare Proposals

	Conference Agreement	Coalition	Administration
V. Fraud and Abuse			
Fraud and Abuse	--Establishes an expenditure account in the HI Trust Fund made up of gifts and bequests, criminal fines and forfeitures involving a federal health care offenses, CMPs and assessments imposed in health care cases, general fund transfers and false claims act recoveries. --Authorizes $5.9 billion in mandatory spending from the account over seven years for HCFA, FBI and HHS IG. --Requires HHS IG and AG to coordinate health care fraud enforcement. --Authorizes the HHS IG retain the cost of investigating fraud cases. --Incentive program for beneficiaries to report fraud. --Extend current Medicare fraud penalties to all federal health plans - Increases civil monetary penalties and exclusion authority. --Requires HHS and DoJ to offer guidance and interpretive rulings on behavior that might violate the anti-kick back laws. --Makes it a crime under the Social Security Act to convert assets to become eligible for a State health care program. --Makes it harder to apply CMPs by making the standard of proof higher. --Adds a health care section to the criminal code. --Expands investigation authority of state fraud control units. --creates an adverse action database. --$3.5 billion in savings.	--Establishes an account in the Treasury made up of gifts and bequests, criminal fines and forfietures, CMPs and false claims act penalties. The account funds $4.2 billion in mandatory spending over seven years for HCFA anti-fraud activities --Authorizes $1.5 billion in mandatory spending from the HI and SMI trust funds over seven years for HHS IG anti-fraud activities. --Incentive program for beneficaires to report fraud --Authorizes 3, 18 month demonstration programs. --$2.4 billion in savings over seven years.	--Authorizes $3.7 billion over five years in mandatory spending from the HI and SMI trust funds for HCFA and the HHS IG. --Estaolishes a $10 million per year account made up of gifts and bequests, criminal fines and forfeitures involving a federal health care offenses, CMPs and assessments imposed in federal health care cases, and false claims act recoveries to support other federal health programs and the Attorney General. -- Increases civil monetary penalties and exclusion authority. --Extends current Medicare fraud penalties to all federal health plans --Extends Medicare anti-kickback penalties to all private health plans - Increases civil monetary penalties and exclusion authority. --Adds a health care section to the criminal code. --Expands investigation authority of state fraud control units. --Reforms Medicare's contracting authority. --creates an adverse action database. --$2.4 billion in savings over 7 years.

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[001]

January 3, 1996

Note for: Jennifer Klein, WH
Bob Pellici, OMB
David Haun, OMB
Tim Hill, OMB
Judy Berek, HCFA
Lavon Burton, HHS
Mac Thornton, HHS/OIG

From: Greg Jones, Justice Leg. Affairs 514-2113

Attached is material pertaining to DOJ health care fraud resource requirements. It was prepared as a result of last Thursday's interagency meeting at the White House. Debra Cohn asked that I forward it to you.

There are four pages attached.

Thank you.

cc: Frank Kalder, DOJ/Budget
Faith Burton, DOJ/OLA
Debra Cohn, DOJ/ODAG
Joyce Branda, Civil
Karen Morrissette, CRM
Iden Martyn, EOA
(b)(7)c (b)(7)f (b)(6)

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Recommendation:

Therefore, we recommend a mandatory appropriation from the General Fund for the Department of Justice -- not only the FBI -- of $65 million, plus base of $40 million for FBI, $15 million for US Attorneys, and a smaller amount for Civil and Criminal Divisions. If the mandatory appropriation from the General Fund cannot be increased from $47 million as in the Conference Report, we recommend funding for the Department of Justice for the remaining $18 from the Medicare Trust Fund and Control Accounts.

DEPARTMENT OF HEALTH & HUMAN SERVICES
ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET
202-690-6396 FAX: 690-5405

TO: SEE LIST BELOW **FROM:** JOHN CALLAHAN

FAX NUMBER_____

DATE 1-11-96
TIME_____
Page 1 of 2

IMMEDIATE ACTION ___ **FOR YOUR INFORMATION** X

PER YOUR REQUEST ___ **RESPONSE NEEDED** ___

REMARKS:

BOB PELLICCI 395-6148✓
JENNIFER KLEIN (WAITING FOR FAX#)
TIM HILL 395-7840✓
DEBRA COHN 307-0097✓
NANCY-ANN MIN 395-9119✓
JUDY BEREK 690-6262✓
MCTHORNTON 205-0604✓
BRUCE VLADECK 690-8220 ✓
JUNE GIBBS BROWN 6262 619-0521✓

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

JAN 11 1996

To: Nancy-Ann Min
Associate Director for Health and Personnel

From: John J. Callahan
Assistant Secretary for Management and Budget

Re: Department of Justice Funding for Medicare Anti-Fraud and Abuse Activities

As part of the reconciliation bill negotiations, the Department of Justice has requested that the Administration seek $120 million in mandatory funds to support health care anti-fraud and abuse activities of the FBI and DOJ. This amount includes $65 million in new funding and a base of $55 million in discretionary funds that are currently being spent for such activities.

HHS strongly supports the provision of adequate funds for DOJ efforts to reduce health care fraud and abuse. We also agree with DOJ that Medicare Trust Fund monies should be available to support such efforts to the extent that the activities relate to Medicare. However, when Trust Fund monies are used, there must be a clear audit trail substantiating the Medicare relationship.

DOJ has suggested two options to use as the authority for the proposed mandatory spending. Under the first option, the $47 million funding that is already contained in the reconciliation bill conference report. HHS believes that certain revisions must be made to the bill language regardless of whether it is expanded to accommodate the DOJ proposal. As it now stands, the reconciliation bill would allow Medicare Trust Fund monies to be used for Medicaid Fraud Control Units (MFCUs), the FBI, DOJ and other Federal health agencies to combat fraud and abuse in public and private health plans. The reconciliation bill should be revised to limit Trust Fund spending only to the Medicare portion of such investigations and prosecutions. Likewise, the proceeds from these cases should be returned proportionately to the various health programs involved.

Finally, to the extent that FBI and DOJ anti-fraud activities are funded from the Medicare Trust Funds, we also question the average cost assumptions that are used to support the DOJ request. The cost assumed by DOJ are much higher than HHS spending for similar activities in the Office of the Inspector General and in the Office of the General Counsel.

John J. Callahan

cc: June Gibbs Brown, HHS/OIG
Bruce Vladeck, HHS/HCFA
Debra Cohn, DOJ/ODAG

LEVEL 1 - 1 OF 6 STORIES

Health Line

October 19, 1995

SECTION: POLITICS & POLICY

LENGTH: 1107 words

HEADLINE: MEDICARE II: ADMIN. "ATTACKS" GOP ANTI-FRAUD MEASURES

BODY:

"The Clinton administration charged (10/18) that the House Republican Medicare bill would seriously weaken the government's ability to fight $18 billion a year in fraud and ripoffs," WASH. POST reports. The administration said that the House bill "would undermine existing anti-kickback provisions and rules that prevent doctors from referring patients to outside facilities that the doctors own." HHS Sec. Donna Shalala and Attorney General Janet Reno spoke at a press conference 10/18 "as Democrats mounted a last minute battle against Republican plans to reduce Medicare spending by $272 billion over the next seven years." Reno said, "The House Medicare bill would make it more difficult for us to prosecute medical providers for fraudulent conduct" (Rich, 10/19). PHILA. INQUIRER reports that administration expressed support for the anti-fraud measures contained in the Senate Medicare reform bill (Zaldivar, 10/19).

CONCERNS: Administration officials said the House GOP bill "weakens" the government's ability to prosecute medical facilities, hospitals and other providers "who offer doctors cash kickbacks or other forms of renumeration in exchange for patient referrals." Currently, according to Reno, the law requires federal prosecutors "to prove that 'one purpose' of the kickback was to induce referral of health care business." The House bill, however, "'would require the government to prove' that obtaining a referral was the most important and primary purpose, a much higher standard of proof." In addition, the House bill would "significantly cut back" on a 1989 anti-self referral law that prohibits doctors from referring patients to an outside facility in which they have a financial stake (see AHL 10/4). The House proposal would still "apply" self-referral restrictions "to some types of outside facilities, such as clinical labs and occupational therapy facilities." But home health services, durable medical equipment companies, outpatient drug pharmacies, radiation therapy facilities and others would be exempted. Shalala said that the House bill would also "relieve health care providers of the legal duty to use reasonable diligence for ensuring that the Medicare and Medicaid claims are true and accurate (Rich, 10/19).

GOP RESPONSE: "House Republican leaders (10/18) agreed to toughen" the fraud and abuse provisions "to quell last minute concerns." Reps. Steven Schiff (R-NM) and Christopher Shays (R-CT) "offered an amendment to criminalize health care fraud." The amendment was approved unanimously 10/18 by the House Rules Committee. Shays said, "We are going to make a lot of noise

about this because fraud, waste and abuse is 10 percent of the cost of Medicare. It blows our minds to think we're not talking about a few dollars. We're talking about tens of millions of dollars." The House bill would now make "health care crimes such as fraud, theft, embezzlement, false statement, bribery, graft and illegal renumeration, including kickbacks" a federal offense.

WISHFUL THINKING: WASH. TIMES reports that the "House GOP leadership hopes the change will neutralize one of the most potent arguments against" their reform bill. However, "despite objections from both sides," GOP leaders "left in place" the provision that makes it "harder to convict doctors and other health care providers under a federal anti-kickback law." House GOP leaders said they "may abandon" the anti-kickback provision "when Senate and House bills are reconciled in conference" (Roman, 10/19).

REAX: A N.Y. TIMES editorial addresses the anti-fraud measures contained in the House bill: "The problems of physician self-referral and many of the other regulatory issues are becoming progressively less important over time. As capitated plans become commonplace, the issue for health care policy is whether the financial incentives will result in too few tests, not too many. But Medicare is likely to remain a bastion of fee-for-service coverage for years to come. The Republicans are right to prune the regulation. But why can they never stop short of excessive leniency?" (10/19).

MEDICAID CONCESSION: House Commerce health and environment subcommittee Chair Michael Bilirakis (FL) announced 10/18 that the House GOP Medicaid plan will not repeal "existing federal protections for the spouses and adult children of nursing home patients." The announcement "came after" Bilirakis and Rep. Nathan Deal (R-GA) "convinced" Commerce Committee Chair Tom Bliley (VA) "that individuals should not be forced to lose everything because their spouse or parent requires nursing home care" (Bilirakis release, 10/18). CONGRESS DAILY reports that the provision had "been the focus of complaints from House and Senate Democrats and President Clinton." The Senate version also contains the provisions (see AHL 10/2) (10/18).

LANGUAGE: ENGLISH

LOAD-DATE: October 19, 1995

LEVEL 1 - 2 OF 6 STORIES

The Washington Post

October 19, 1995, Thursday, Final Edition

SECTION: A SECTION; Pg. A08

LENGTH: 868 words

HEADLINE: Administration Attacks House Medicare Proposal; GOP Measure Would Undermine Government's Anti-Fraud Efforts, Shalala and Reno Say

BYLINE: Spencer Rich, Washington Post Staff Writer

BODY:

The Clinton administration charged yesterday that the House Republican Medicare bill would seriously weaken the government's ability to fight $ 18 billion a year in fraud and ripoffs of the federal health insurance program for the elderly.

Instead of strengthening the government's hand as Republicans claim, the administration said the GOP bill would undermine existing anti-kickback provisions and rules that prevent doctors from referring patients to outside facilities that the doctors own.

"House Republicans are opening gaping holes in the consumer protections afforded to 37 million Medicare beneficiaries," charged Secretary of Health and Human Services Donna E. Shalala at a news conference with Attorney General Janet Reno.

"The House Medicare bill would make it more difficult for us to prosecute m dical providers for fraudulent conduct against patients and the Medicare system," Reno said.

Reno and Shalala spoke out yesterday as Democrats mounted a last-minute battle against Republican plans to reduce Medicare spending by $ 272 billion over seven years. The House is scheduled to vote on the Medicare proposal today.

Doctors groups have long sought to undo some of the anti-fraud provisions that the Republicans now are seeking to roll back. Clinton and other Democrats have alleged that the GOP leadership cut a deal with the American Medical Association and other doctors' groups in order to win their support for the bill as a whole. The AMA said some of the GOP provisions are merely an effort to correct "regulatory overreach" and bring "common sense into the regulation of medicine."

For example, an AMA spokesman said, if a community needs some equipment which is not otherwise available and not likely to be provided by a commercial group, there is no reason why local doctors should not be allowed to build a facility for it and refer patients to it -- yet in some cases the impact of the existing law is that the equipment is never made available.

House Ways and Means Committee Chairman Bill Archer (R-Tex.) took sharp issue with charges that the GOP is weakening anti-fraud enforcement.

The Washington Post, October 19, 1995

"The GOP Medicare bill powerfully clamps down on fraud and abuse," Archer said yesterday.

"One, we create 37-million new anti-fraud agents by empowering senior citizens with the right to collect rewards based on fraudulent errors they find on their bills. Two, we double civil penalties" against fraud.

"Three, we create new criminal penalties for those who fraudulently abuse the Medicare program."

These new penalties were added Tuesday night.

"Four, thanks to a bipartisan amendment, we provide $ 515 million to enhance and increase."

Finally, he said, the bill provides added funds to Medicare for state-of-the-art software to help fight fraud.

Among the major GOP initiatives criticized yesterday by Reno and Shalala, and earlier by HHS Inspector General June Gibbs Brown:

* The bill severely weakens the government's hand in prosecuting medical facilities, hospitals and other health care providers who offer doctors cash kickbacks or other forms of remuneration in exchange for patient referrals. Forms of disguised kickbacks can include "consultant fees" and "research grants," but actually may be simply rewards for referring patients.

Such payments can be prosecuted under the criminal anti-kickback statute which federal prosecutors view as difficult to enforce. Reno said that "existing law requires the government to prove that 'one purpose' of the kickback was to induce referral of health care business. The language of the House bill would require the government to prove" that obtaining a referral was the most important and primary purpose, a much higher standard of proof. Reno said that "would place beyond the reach of prosecution many kickbacks."

* Provisions in the GOP bill significantly cut back on the scope of a 1989 anti-self referral law that restricts doctors from referring their patients to an outside facility with which they have a "financial relationship." Shalala said studies had shown that doctors who own a laboratory or clinic order more tests and services for their patients than are received by Medicare patients in general.

Under the GOP bill, the ban still would apply to some types of outside facilities, such as clinical labs and occupational therapy facilities. But the ban no longer would apply to facilities in which the doctor had a financial interest, such as home health services, durable medical equipment companies, radiation therapy facilities, outpatient drug pharmacies, firms providing prosthetics and orthotics, and several others.

Archer said the bill also "keeps provisions where there is evidence of abusive investment and referral arrangements."

* In addition, the bill would relieve health care providers of the legal duty to use reasonable diligence for ensuring that the Medicare and Medicaid claims are true and accurate. This means training employees on how to submit correct

and accurate bills, supervising what they do and the like. Removing this requirement "will have the effect of increasing the government's burden of proof" in false claims cases, Shalala said.

GRAPHIC: Photo, DONNA E. SHALALA REP. BILL ARCHER

LANGUAGE: ENGLISH

LOAD-DATE: October 19, 1995

LEVEL 1 - 4 OF 6 STORIES

October 18, 1995, Wednesday, BC cycle

LENGTH: 574 words

HEADLINE: House set for decisive vote on Medicare reform

BYLINE: By Joanne Kenen

DATELINE: WASHINGTON

BODY:

House Speaker Newt Gingrich Wednesday predicted victory when the Republican-controlled chamber votes on historic changes in the 30-year-old Medicare program for the elderly.

Gingrich said he was still working to win over some Republicans before the Thursday vote, particularly those from rural areas worried about how payment arrangements might affect hospitals in their districts.

"I think we will have the votes to pass Medicare," Gingrich said. "Rural America has always gotten far less money out of Medicare than big cities...We are working very hard to change that and have a fair program for every American."

Republicans after a flurry of last minute meetings agreed Wednesday night to accomodate rural lawmakers, aiming to make less populated areas more attractive for private health plan expansion by guaranteeing higher payments for Medicare patients.

Asked whether the party now had the backing of the rural bloc, Wisconsin Republican Steve Gunderson told reporters Wednesday night: "We do now."

Attorney General Janet Reno and Health and Human Services Secretary Donna Shalala denounced the Republican bill at a Justice Department news conference, saying it would make it more difficult to prosecute fraud and other abuses.

"This would seriously undermine our efforts," said Reno, who has made health-care fraud one of her top priorities, while Shalala warned it "would open the floodgates to waste, fraud and abuse."

Republicans did move to incorporate stronger fraud rules, including criminal penalties, in the bill Wednesday. And they dropped a few provisions- like a guarantee that Medicare would cover anti-nausea drugs for cancer patients- that had made it into the earlier versions of one but not both of the committees that had worked on the legislation.

Republicans say they are patching up the financial holes in the social safety net for the elderly and disabled and keeping Medicare alive for the coming baby boom generation.

"It is innovative, bold and long-term," House Ways and Means Committee Chairman Bill Archer, R-Texas, said of the bill his committee drafted.

Reuters North American Wire, October 18, 1995

Democrats accuse Republicans of ripping the social safety net to shreds and raiding health care for the vulnerable to pay for tax cuts for rich.

"They're not preserving Medicare. They're filling a great big hole in our nation's wallet" created by the tax cuts, charged Massachusetts Democrat Joe Moakley.

Democrats have been trying to rally the public against the Republican plan but have never had high hopes of turning the tide in the House. They failed to get major changes in the final version of the bill before the House Rules committee Wednesday, and they are unlikely to fare much better when they offer a substitute bill during the debate Thursday.

A more likely scenario is a presidential veto followed by a compromise with the help of Senate moderates.

The House and Senate bills differ slightly but both aim to cut projected Medicare spending by $ 270 billion, or 14 percent, over seven years.

In the House, Medicare will come to a vote Thursday as an independent bill and will later rolled into an overall budget bill. The strategy is to try to separate Medicare savings from the tax cut in the public eye, although it also puts the spotlight on members of Congress who may be voting for cuts to hospitals back home.

The Senate will wrap Medicare into its big budget bill, and the vote could come late next week.

LANGUAGE: ENGLISH

LOAD-DATE: October 19, 1995

THE REAL COSTS OF FRAUD AND ABUSE

While according to *The Washington Times* (10/13/95) the House Leadership "place low priority on Medicare crooks," the Clinton Administration continues to crack down on waste, fraud and abuse in the Medicare and Medicaid programs. According to the General Accounting Office, fraud and abuse added 10 percent -- of $17 billion -- to the cost of Medicare last year. And the health of the 37 million Americans who depend on these programs is compromised with every fraudulent scheme.

A few examples clearly illustrate the costs of fraud and abuse on our health care system and the real successes that come with tough enforcement.

- **National Medical Enterprises, Inc.** National Medical Enterprises (NME) admitted and treated patients unnecessarily, kept patients hospitalized longer than necessary in order to use up available insurance coverage, billed federal programs multiple times for the same service, billed federal programs when no services were actually provided, and billed Medicare for payments made to doctors and others that were intended solely to induce referral of patients.
  The Results: NME recently agreed to pay $324.2 million in damages and penalties to resolve the fraud case against them.

- **Caremark International**. Caremark International, a Northbrook Illinois home health care chain gave bonuses to doctors to refer Medicare and Medicaid patients to the company's facilities.
  The Results: Caremark agreed to pay $161 million in fines and penalties.

- **ABC Home Health Services Inc.** ABC Home Health Services Inc. of Brunswick Georgia (now known as First American Health Care of Georgia) is one of the largest private home health care firms in the country. ABC has been accused of submitting fraudulent cost reports to Medicare between 1989 and 1993. The company has been accused of billing Medicare for personal airplane trips, maid service for an executive's private condominium, a lease on a BMW for an executive's son, political contributions and ghost employees. [St. Petersburg Times, 8/26/95]
  The Results: ABC was indicted in August on 82 counts of defrauding Medicare.

- **Robert Kuncl.** Robert Kuncl is a retired electrician living in Chicago. In 1986, Mr. Kuncl's doctor implanted a cardiac pacemanker 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 pacemaker, he received the services of a prostitute, a free trip to Hawaii, and other forms of kickbacks.
  The Results: The doctor, the pacemaker dealer and nine others were convicted of fraud.

- **Dr. Sunil Lahiri.** As part of a kickback scheme, Dr. Lahiri, an oncologist in California, gave patients numerous and unnecessary prolonged infusions of chemotherapy and repeated blood tests and vitamin injections.
  The Results: In December 1994, an HHS administrative law judge found that "[Dr. Lahari] severely inconvenienced these patients and caused a significant deterioration of their quality of life at a time when their life expectancy was very short . . ." Dr. Lahari has been permanently excluded from the Medicare program.

STATEMENT OF ATTORNEY GENERAL RENO ON HEALTH CARE FRAUD PROPOSAL PENDING IN THE HOUSE OF REPRESENTATIVES

OCTOBER 18, 1995

I am concerned about provisions in the House Medicare bill that would make it more difficult for us to prosecute medical providers for fraudulent conduct against patients and the Medicare System. These provisions are wholly inconsistent with the Senate bill, which would facilitate our law enforcement efforts against health care fraud that harms us all, and particularly those most vulnerable.

I understand that some Members of the House have indicated that law enforcement should not be criminally prosecuting health care providers. I believe health care fraud is so detrimental to the health and pocketbook of Americans, that I made health care fraud one of my major initiatives. I

believe perpetrators of health care fraud should not be immune from criminal prosecution because they commit their crimes in a doctor's office, in a board room, or in a laboratory, rather than in the street. White collar crooks who pay or take kickbacks in health care endanger the health of patients and steal money from all of us.

Experts estimate it may cost Americans as much as $100 billion a year. That is why we need stronger, not weaker, provisions in the House bill. The Senate bill, under the leadership of Senator Cohen and with bi-partisan support, provides those strengthened provisions.

Particularly at this time, when we need to preserve every Medicare Trust Fund dollar, we cannot allow Medicare money to be spent on bribes paid to doctors and others as inducements for the referral of Medicare patients. Even more importantly, we cannot allow financial inducements to corrupt

the professional judgment of medical providers -- providers who Americans have been taught to trust. Decisions which physicians make day in and day out -- whether and where to hospitalize a patient, what laboratory tests to order, what surgical procedure to perform, what drug to prescribe, and how long to keep a patient in a psychiatric facility -- affect the health and well being of our elderly parents and of our children. Allowing those decisions to be made under the influence of kickbacks would be wrong.

The House bill would place a very high, additional burden on the government in its attempts to prosecute those who pay or receive kickbacks for the purpose of inducing the referral of Medicare business. Existing law requires the government to prove that "one purpose" of the kickback was to induce the referral of health care business. The language of the House bill would require that the government prove

that the payment was made for "the significant purpose of inducing" the referral--language that would immunize arrangements that are dressed up to disguise the payor's motive. This would seriously undermine our efforts and would place beyond the reach of prosecution many kickbacks which are calculated to induce referrals and which adversely affecting the judgment of medical providers. From the perspective of federal law enforcement, and, I believe, from the perspective of patients who seek their doctors' advice, this is not an acceptable result.

Ultimately, this isn't a choice between prosecuting violent crime and health care fraud: Both of them do real harm to real people and deserve vigorous enforcement action. I hope that the House legislation will support, not undermine, our efforts.

Department of Justice

STATEMENT

OF

GERALD M. STERN

SPECIAL COUNSEL, HEALTH CARE FRAUD

DEPARTMENT OF JUSTICE

BEFORE THE

COMMERCE COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

CONCERNING

H.R. 2425

HEALTH CARE FRAUD AND ABUSE PROVISIONS

PRESENTED ON

OCTOBER 3, 1995

Thank you very much for this opportunity to discuss the health care fraud provisions of H.R. 2425.

The Attorney General in 1993 named health care fraud enforcement her number two initiative, behind violent crime. Since then the Department of Justice has had a coordinated health care fraud enforcement program, which involves increased resources, increased investigations and prosecutions, greater cooperation among investigative and regulatory agencies, and coordinated use of all available sanctions -- criminal, civil, and administrative.

The Department of Justice has a very active health care fraud enforcement program. We believe it would be seriously undermined by certain of the bill's provisions.

Section 15104: Voluntary Disclosure Program. This Section would mandate the establishment of a voluntary disclosure program. Since the Inspector General of HHS recently announced a pilot voluntary disclosure program, in conjunction with the Department of Justice, we question the need for this provision.

This Section provides that the Secretary of HHS may waive, reduce, or mitigate any sanctions against individuals who make voluntary disclosures, including statutory sanctions which include criminal remedies. As noted above, the Attorney General has the exclusive authority to enforce federal criminal laws. Accordingly, the Department of Justice opposes this provision.

We also do not endorse the provision in Section 15104 that would bar qui tam actions under the False Claims Act against

entities or individuals who make disclosures with respect to acts or omissions which constitute grounds for imposition of enumerated sanctions. First, the False Claims Act already provides a reduction of liability of any person or entity where that person or entity has voluntarily disclosed wrongdoing to the government and satisfied other statutory criteria. Second, even if such a restriction were appropriate, the statute as drafted would presumably prohibit qui tam actions where the allegations of wrongdoing were not disclosed but somehow were related to the matters disclosed. That result is not warranted and unwise. Finally, modifications of the qui tam provisions, if any, should be done in the context of amendments to the False Claims Act generally and should not be limited to voluntary disclosures involving health care fraud.

Section 15106: Consolidated Funding for Anti-Fraud and Abuse Activities Under Medicare Integrity Program. Although Section 15106 is rather complex, it seems that this Section would create a Fund consisting of monies from the following sources: monies currently used by the Health Care Financing Administration to fund the anti-fraud activities of the Medicare carrier and intermediary Fraud and Abuse Units; proceeds of administrative penalty actions; criminal fines; and penalties and damages (after restitution and relators' awards) recovered under the False Claims Act. Pursuant to the bill, these funds would not be used to supplement the health care fraud enforcement activities of law enforcement agencies. Rather, the funds would be used to "enter

into contracts with private citizens" for the review of activities of providers, audits of cost reports, education of providers, beneficiaries, and others.

The Department of Justice has several concerns about this Fund for private anti-fraud activities. First, by establishing an Anti-Fraud and Abuse Trust Fund to finance private contractors but not law enforcement and federal health care program agencies, the bill arguably could be read to transfer to private contractors traditional law enforcement responsibilities, although we doubt this was the sponsor's intent.

Second, although the need for funding for federal health care fraud enforcement efforts has grown, the bill provides funding for private entities but no funding for law enforcement agencies. The number of health care fraud prosecutors and investigators simply has not kept pace with the dramatic increase in the number of criminal and civil health care fraud investigations and prosecutions presently handled by the Department of Justice. This problem will only grow more acute in the future. For example, the Federal Bureau of Investigation has 1760 health care fraud matters under investigation, up from 1051 in 1993. In addition, the Department of Justice receives health care fraud cases from numerous agencies other than the Federal Bureau of Investigation, such as the Department of Health and Human Services ("HHS") and the Department of Defense as well as private insurers. Further exacerbating the demand on resources, the bill itself imposes expanded duties upon the Department of

Justice and HHS, such as the requirement that all requests for special fraud alerts be investigated and acted upon. The efficacy of any health care fraud enforcement program depends on adequate resources for law enforcement.

Our third concern involves the source of the funds for the new Anti-Fraud Fund. Specifically, the Department of Justice does not endorse depositing criminal fines into the Fund. Criminal fines are not presently deposited into the Treasury but rather into the Crime Victims Fund to be used to assist and compensate victims of crimes all over the country. We do not support diverting fines from this critical law enforcement activity.

Section 15108: Establishment of Health Care Anti-Fraud Task Force. This Section requires the establishment of a Health Care Anti-Fraud Task Force, which would have a separate "accounting of its finances," and have a separate staff, distinct from the rest of the Department of Justice components. The Attorney General would be required to consult with an Advisory Group in connection with the establishment of the Task Force. We believe that it is unnecessary to separate the Department's health care fraud enforcement effort from the rest of the Department's enforcement activities in this manner. Such a structure represents an unnecessary administrative burden that could serve to detract from our overall enforcement efforts. By mandating fully staffed operational segments of the Task Force, the proposal limits the discretion of individual United States Attorneys to respond to

changing investigative and prosecutorial needs, which may vary greatly over time and between judicial districts.

Moreover, the proposed structure risks disrupting the present health care fraud enforcement effort which has had so many demonstrated successes. The Attorney General in 1993 named health care fraud enforcement her number two new initiative, behind violent crime. Since then, the Department has had a coordinated health care fraud enforcement program, headed by a Special Counsel for Health Care Fraud reporting directly to the Deputy Attorney General. The Special Counsel has been chairing an Executive Level Health Care Fraud Policy Group which has been meeting monthly since November, 1993 to coordinate the health care fraud efforts of the Department of Justice and HHS. As part of this effort, the Department of Justice has increased its investigations and prosecutions, facilitated greater cooperation among investigative and regulatory agencies and coordinated the use of all available sanctions -- criminal, civil and administrative.

At the local level, every United States Attorney's Office has a criminal and civil health care fraud coordinator. They lead health care fraud working groups in all judicial districts experiencing significant health care fraud. These groups allow all federal and state agencies working on health care fraud enforcement collectively to share information on emerging fraudulent schemes, develop joint enforcement strategies, and decide priorities. Changing this successful law enforcement

structure to create a separate nationally based health care fraud task force would be counterproductive and risks omitting particular agencies with strong records of health care fraud enforcement.

Section 15212 (c): Limiting Imposition of Anti-kickback Penalties to Actions with Significant Purpose to Induce Referrals. This Section would overturn case law interpreting the Medicare anti-kickback statute and serve to heighten the government's burden of proof in criminal anti-kickback prosecutions.

Kickbacks are pernicious because they corrupt the medical providers' decisionmaking, often replacing profit for patient welfare. Kickbacks have lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment, at great additional expense to the American consumer and taxpayer.

The courts have interpreted the Medicare anti-kickback statute (42 U.S.C. 1320a-7b) to prohibit the payment of remuneration if "one purpose" of the payment is to induce referrals of services which are paid for by Medicare. United States v. Greber, 760 F. 2d 68 (3rd Cir. 1085). See also United States v. Kats, 871 F.2d 105 (9th Cir., 1989); United States v. Bay State Ambulance, 874 F.2d 20 (1st Cir. 1989). In light of this interpretation of the criminal intent element of the offense, the government is charged with the burden of proving beyond a reasonable doubt that one purpose of a payment is to

induce referrals. As with many intent based prosecutions, the prosecution must often rely on circumstantial evidence to prove the intent required by the statute.

To further heighten the prosecution's burden of proof, as would occur upon enactment of Section 15212(c), would seriously undercut the government's health care enforcement efforts in the anti-kickback arena. To require the government to prove that the remuneration was paid for the "significant purpose of inducing" referrals, is tantamount to immunizing a range of conduct which was, in truth, intended to induce referrals. Moreover, the phrase "significant purpose" is vague and will result in unnecessary and burdensome litigation. In sum, the proposed amendment will seriously undercut our anti-kickback enforcement efforts.

Instead, we believe Congress should be expanding our anti-kickback authority to cover the inducement of the referral of business that is paid for by any government health care program and to provide a civil anti-kickback remedy. Our anti-kickback enforcement efforts have confronted significant obstacles because of the limited coverage of the current Medicare/Medicaid anti-kickback statute. Defense counsel routinely argue that the statute does not apply unless the majority or totality of a provider's business is paid for by Medicare/Medicaid. They also contend that the absence of an explicit civil anti-kickback remedy limits the government's opportunities to recover damages and civil penalties. To rebut these arguments, kickback

prosecutions now require extensive prosecutorial resources. Nevertheless, we were able to prosecute and settle two major anti-kickback cases in the last year obtaining convictions and settlements of $379 million in one case and $161 million in the second case, which returned significant savings to the Medicare Trust Fund and the Treasury. To limit our ability to bring such cases, rather than to strengthen our statutory authority, would seriously impair our health care fraud law enforcement efforts.

Section 15215: Issuance of Advisory Opinions. This Section requires the Secretary of HHS to issue advisory opinions concerning, inter alia, what constitutes a violation of the criminal Medicare anti-kickback statute. The Department of Justice opposes this provision on both legal and practical grounds.

First, the Department of Justice has the exclusive authority to enforce all federal criminal laws. This authority extends to all prosecutorial decisions, including those based on the Medicare anti-kickback statute. In that regard, the rendering by an agency other than the Department of Justice of opinions concerning the prosecutive merit or lack of prosecutive merit of a particular case would be beyond that agency's authority. Furthermore, we feel that it would be inappropriate for the Department of Justice to defer to another department's judgment, such as HHS, regarding what constitutes a prosecutable case under any criminal provision of the United States Code.

Second, we believe that the rendering of advisory opinions is generally ill-advised. This is especially true where, as in the instant case, a violation of the statute depends on proof of a knowing and willful intent to do the act proscribed. For obvious reasons, a putative defendant's presentation of the "relevant" facts is apt to be slanted and incomplete and, therefore would be a poor basis on which to render a prosecutive judgment. Assuming that HHS is not going to conduct an investigation of each advisory opinion request which is filed, the prosecutor will, in all likelihood, have inadequate information on which to base his or her decision.

Third, we are concerned that advisory opinions would produce unnecessary problems in the context of a subsequent criminal and/or civil prosecution by introducing additional factual issues into these cases relating to the interpretation and applicability of the advisory opinion at issue.

In sum, we believe that the rendering of advisory opinions would immunize the individuals who committed the conduct to which the opinion relates, and would engender complex litigation in other cases in which the defense would rely on advisory opinions.

Thank you for the opportunity to provide our views on these important proposals.

SAMPLE HEALTH CARE FRAUD KICKBACK CASES

United States v. National Medical Enterprises Psychiatric Hospitals, Inc., U.S. Dist. Ct. for the District of Columbia, Cr. 94-0268.

National Medical Enterprises Psychiatric Hospitals (NME) pled guilty to two separate felony Informations, which charged that NME subsidiaries bribed doctors and other referral sources to refer patients for admission to NME psychiatric hospitals and substance abuse facilities and, in one instance, to an acute care hospital. Paid $379 million to settle government claims.

United States v. Caremark Inc., U.S. Dist. Ct., ED Ohio.

United States v. Caremark Inc., U.S. Dist. Ct., D. MN, Cr. 4-94-95.

Home health care chain paid doctors through consulting agreements and other arrangements to refer patients - pled guilty to kickback violations. Paid $161 million to settle government claims.

United States v. Greber, 760 F.2d 68 (3rd Cir. 1085).

40% referral fee to doctors who ordered cardiac monitors - Defendant convicted of kickback violations.

United States v. Kats, 871 F.2d 105 (9th Cir., 1989).

Lab owner who kicked back 50% of Medicare payments for referrals from medical services convicted of kickback violations.

United States v. Bay State Ambulance, 874 F.2d 20 (1st Cir. 1989).

Hospital official who received payments from ambulance service convicted of kickback violations.

Robert Kuncl. In 1986, Robert Kuncl, a retired electrician from Chicago, had a "mystery pacemaker" implanted in his chest. One could not determine the brand, serial number, or expiration date of the device. Mr. Kuncl's cardiologist later admitted that he received the services of a prostitute, a trip to Hawaii, and other types of kickbacks from the pacemaker dealer. **The Results:** The doctor, the pacemaker dealer and nine others were convicted of misbranding pacemakers, changing their expiration dates, giving kickbacks, and/or overcharging.

The Washington Times ★★ WEDNESDAY, OCTOBER 18, 1995 / PAGE A3

NATION

GOP Medicare bill seen to favor fraud

By Nancy E. Roman
THE WASHINGTON TIMES

Under the House Republicans' new, more lenient standard for prosecuting Medicare kickback cases, the government would likely have lost the two largest fraud cases in history and the $560 million recovered from them, federal legal experts say.

Sources have said that under the House GOP Medicare bill, the federal government will lose about one quarter of all it recovers in Medicare-fraud cases. Last year, it recovered $550 million. The Congressional Budget Office (CBO) has estimated the cost of GOP changes that soften anti-kickback and self-referral laws to be $1.1 billion over seven years.

Democrats have latched onto this soft spot in the GOP Medicare reform proposal and plan an all-out offensive against the fraud provision as it heads to the floor tomorrow.

At a press briefing scheduled for today, Attorney General Janet Reno is expected to highlight a provision that would make it harder for her department to prosecute providers who accept kickbacks.

The Republican plan to reform Medicare by expanding choices for the elderly while saving $270 billion over seven years is expected to pass with almost all of the House's 233 Republicans.

But the GOP's decision to increase the burden of proof in Medicare kickback cases has brought an onslaught of criticism, some from within its own ranks.

"We are going to claim a certain amount of savings through eliminating fraud," said Rep. Steven H. Schiff, New Mexico Republican, a former prosecutor who fought to strengthen the provisions. "To make that claim stick, we need strong fraud provisions. I don't think we've done it."

Government prosecutors have cited Caremark as a recent example of a case that could not have been won under the new law.

Caremark pleaded guilty in June to paying kickbacks to doctors who steered patients to its services, such as administering intravenous drugs or liquid nutrition to patients with cancer, AIDS or other serious illnesses.

Caremark made weekly payments to doctors who referred patients to its services. The payments averaged about $75 per patient, and some doctors earned as much as $80,000 a year from the kickbacks. The kickbacks were disguised as research grants and billed to Medicare and Medicaid, according to government documents.

Caremark agreed to pay $85.3 million in restitution to the federal government, $44.6 million to compensate states for overbilling Medicaid, and other civil penalties and fees bringing the total settlement to $161 million.

In 1994, National Medical Enterprise (NME) pleaded guilty on eight criminal counts and agreed to pay $379 million in fines and restitution. The Justice Department had charged the company with patient abuses including "keeping patients longer than was necessary" to collect insurance, billing for false diagnoses and denying patients necessary services.

Gerald B. Stern, special counsel for health care fraud for the Justice Department, said yesterday circumstantial cases like Caremark and NME will be much harder to win if the GOP proposal becomes law. "You end up doing a mathematical argument: Was over 50 percent of the intent for this purpose?" he said.

Another Justice Department official, who requested anonymity, said Caremark's fraud would have been impossible to prove under the new GOP standard.

The anti-kickback statute makes it a crime to knowingly and willfully offer or receive anything of value in exchange for the referral of Medicare or Medicaid business. Courts have interpreted it to bar payment if "one purpose" of it is to induce referrals of services paid for by Medicare.

The GOP bill would require it to be "the significant purpose," which is much harder to prove in court.

The American Medical Association lobbied for the change. "It is appropriate to make a clear distinction between wrongdoers and those who are appropriately referring patients based on what will best serve the patient's needs," said an AMA lawyer who requested anonymity.

Rep. Tom Coburn, Oklahoma Republican, an obstetrician who helped to draft the anti-kickback language, said the law was changed to make its legal standard consistent with those in other anti-kickback laws, like those affecting housing.

June Gibbs Brown, inspector general of the U.S. Department of Health and Human Services, has testified that "for the vast majority of present-day kickback schemes, the proposed legislation would place an insurmountable burden of proof on the government."

Republican ex-prosecutor upset by handling of program's abuse

By Nancy E. Roman
THE WASHINGTON TIMES

Rep. Steven H. Schiff, New Mexico Republican and former prosecutor, said the fraud and abuse provisions in the GOP Medicare reform plan would make it harder to prosecute Medicare fraud.

"I support the GOP Medicare reform generally, but the fraud and abuse provisions are woefully inadequate," he said.

Mr. Schiff worked as a prosecutor in Bernalillo County, N.M., from 1981 to 1989 and now serves on the House Judiciary crime subcommittee. He has two main problems with the GOP proposal:

- It fails to criminalize Medicare fraud.
- It raises the threshold of proof necessary to convict a doctor, hospital or other care provider under federal anti-kickback statutes.

"Very simply, that will make it more difficult to prosecute kickback cases," Mr. Schiff said.

Under current law, prosecutors must prove only that "one purpose" was to induce a kickback. Under the GOP overhaul, it would have to be "the significant purpose."

Mr. Schiff said he is the No. 2 Republican on the Judiciary crime subcommittee but no one has ever mentioned to him any problem with the existing standard.

"It makes it considerably more difficult to prove fraud, but, more importantly, without any reason that I can see," he said.

Mr. Schiff said he has unsuccessfully lobbied the Republican leadership to change the anti-kickback statute and to criminalize Medicare fraud.

Last month he introduced a bill that would:

- Better coordinate anti-fraud enforcement among federal agencies and within the states.
- Prevent practitioners who have been barred from the Medicare program for reasons such as false billing from re-entering Medicare.
- Make Medicare fraud a crime. Most Medicare fraud now is prosecuted under statutes prohibiting wire and mail fraud.

The GOP proposal incorporates the first provision and addresses the second concern but does not make Medicare fraud a crime.

House Speaker Newt Gingrich has said he does not want to criminalize Medicare fraud until violent criminals and drug dealers are off the streets.

"That is the exact same salacious reasoning that is being used to try to turn drug pushers and burglars loose," Mr. Schiff said. "Of course we need to take murderers and rapists off the street. But significant white-collar criminals need to go to prison also."

10 Texas Psychiatrists Sue Ex-Patients Over Fraud Accusations

By HOLCOMB B. NOBLE

In a [illegible] of highly unusual legal [illegible], a group of 10 prominent [illegible] psychiatrists is suing former [illegible] their lawyers and the [illegible] company for whom the [illegible] worked under contract, [illegible] that the doctors were defamed by patients who say they were [illegible] in psychiatric hospitals for long [illegible] solely to collect the insurance.

The psychiatrists, who are under [illegible] investigation in connection [illegible] one of the largest health-care [illegible] in American medical [illegible], are also threatening to sue a [illegible] patient for what they say [illegible] testimony before Congress last summer. The patient, [illegible] Deaton, testified that while hospitalized, he was restrained in a [illegible] for 250 days, but that once [illegible] insurance was canceled, he was [illegible] the hospital.

[illegible] such testimony is afforded Congressional immunity [illegible] prosecution or lawsuits.

Mr. Deaton is one of 67 former [illegible] who charged in suits filed [illegible] in 1992 that they had been [illegible] in Texas psychiatric hospitals as part of a plan by National [Me]dical Enterprises, a large private [illegible] hospital chain based in [Santa] Monica, Calif., to defraud insurance companies and the Federal [government] of millions of dollars.

In a 1993 settlement of the suits, [the] company agreed to pay $13 million; 67 of the patients had been hospitalized at the Brookhaven Psychiatric Pavilion in Dallas, where [the] doctors practiced. And last June, [a] division of the chain pleaded guilty [to] Federal criminal and civil charges that included paying kickbacks to doctors in return for patient referrals. The chain paid a $379 million fine, the largest levied for health [illegible].

The [illegible] has brought a $4 million [illegible] suit against the lawyer for [the] 67 former patients, Robert Andrews of Fort Worth, Tex., putting the names of the 67 on the public [record]; [illegible] are under age 18 and [illegible] not previously been identified as having been former psychiatric patients. The doctors also sued James Moriarty, a Houston lawyer who [illegible] the past three weeks has [brought] suit on behalf of 450 more [illegible] of whom he said had [been] mistreated at Brookhaven.

In a suit filed yesterday, the Dallas psychiatrists sued National Medical Enterprises, contending that the [cor]poration's conduct had damaged [illegible].

Mr. Andrews called the doctors' case against him and the former patients "an obvious attempt to intimidate my young clients and keep them from testifying in a possible forthcoming criminal prosecution."

Mr. Moriarty said the doctors' action "has to be the dumbest thing I've seen since I've been practicing law."

"My daddy told me that if someone calls you a liar and cheat and a fraud," Mr. Moriarty said, "you need to remember the rule about libel: if you sue him, he's liable to go out and prove that every word of what he said is true.

"I'm sitting here, reviewing the hospital records of patients covering some 250 doctors and therapists and psychiatrists," he said, "trying to figure out which ought to be sued, which ought to be in jail and which ones ought to have complaints filed against them before the State Board of Medical Examiners."

William Smith, lawyer for the doctors' group, Dallas Psychiatric Associates, denied that their suit had been filed to intimidate former patients. "The doctors are merely asserting claims for the damage that has been done based on the untrue statements these people have made," Mr. Smith said.

James Harrington, a law professor at the University of Texas, called it "outrageous that a former psychiatric patient or patients should be under this kind of attack — particularly one giving Congressional testimony." He said he was certain the doctors would not prevail in Texas, where newly strengthened free-speech laws "assure people very powerful rights to speak out on matters of important public policy without fear of being sued."

Paul E. Coggins, the United States Attorney in Dallas, declined to comment on the doctors' suit. But Justice Department officials said the office was exploring whether to intervene to insure that the suit did not hinder its current investigations.

Lawsuits in the mental health field have always been difficult and rare. Diagnoses are subjective to some degree, and psychiatrists are often unwilling to testify against one another. In addition, former patients frequently encounter presumptions or biases against them as reliable witnesses.

"It's very unusual for doctors to sue their own patients," said Marc Franklin, a law professor at Stanford University. Professor Franklin said doctors tended to remain quiet, not wanting people to know that their reputations were under attack. "Even when the patient sues, it probably isn't a major attention getter," he said, "but that's not the case when the doctor sues."

Mark Graham for The New York Times

Robert Andrews, left, a Fort Worth, Tex., lawyer, is being sued by a group of psychiatrists over allegations of fraud by former mental patients. With Mr. Andrews are three former patients, who also are subjects of the lawsuit, from left, Banning Lyon, Mark Rotello and John Deaton. The television shows a videotaped deposition by Dr. Gary Lee Etter, one of the psychiatrists who filed the lawsuit.

Witness

'Shackled to Bed,' Congress Is Told

Mr. Deaton, 34, was the lead-off witness last summer at a hearing on health care fraud and abuse before the House subcommittee on crime and criminal justice. Mr. Deaton testified that at age 17, while suffering from depression, he voluntarily entered Brookhaven Pavilion. He gave this account: Early in his stay, a nurse noticed a notebook of poems he had written. Deciding they were "inappropriate," she confiscated them, and he became angry. His doctors responded by having him strapped to his bed, telling his family that this was done for his safety.

At various points in his highly emotional testimony, he said:

¶"I was secured to my bed by a body netting — from just below my neck to my ankles."

¶"I was refused basic human dignity — not allowed outside for a breath of fresh air for nearly a year. I had no hugs, no handshakes, no pats on the back.

"I ate, slept, bathed, attended to personal hygiene, changed clothes, endured therapy and eliminated waste shackled to my bed."

¶"I was held in bondage for insurance money, an abuse which should not be allowed to happen in America."

Once his insurance company refused to make further payments, Mr. Deaton testified, he was released from the hospital and ordered to a state institution. There, doctors determined that he was not in need of hospitalization, and he was released.

In a Jan. 17 letter to Mr. Andrews, Mr. Smith stated that his clients, the doctors, would take action against Mr. Deaton unless he paid $25,000 to redress damages they say they suffered as a result of his Congressional testimony. Mr. Smith asserts that by testifying before Congress, Mr. Deaton violated the 1993 settlement agreement with National Medical Enterprises that included an agreement that he would not speak publicly about the case.

"Look," Mr. Smith said, "this is a breach of contract. It's as simple as that."

Christl Sulzbach, associate general counsel for National Medical Enterprises, said it was her legal opinion that the agreement did not preclude Mr. Deaton's testifying before Congress. As for the doctors' suit, she said, "We have not had an opportunity to study this new litigation so cannot comment."

Representative Charles E. Schumer, the Brooklyn Democrat who headed the subcommittee when Mr. Deaton testified, said: "The action by the doctors is the height of hard-headed arrogance. It's possible we will call them in for an explanation."

Mr. Andrews said the doctors could claim no protection from the N.M.E. agreement and referred the letter to the United States Attorney's office. Law-enforcement officials said the office was determining whether the latter violated Federal criminal statutes aimed at protecting Congressional witnesses. Normally, such witnesses are granted legal action.

Restraints

Recognizing Risks For Patients

Mr. Deaton was not the only former patient to speak out. In their suit, the Dallas psychiatrists accuse Mark Rotella, 24, of slander, saying he told acquaintances that the "doctors which treated him received a $10,000 bonus for each bed filled over the Christmas holiday." The doctors also accuse Banning Lyon, 23, of libeling them in statements to reporters from The Dallas Morning News and Business Week.

Mr. Rotella has denied making any such statements. Mr. Lyon said he was released from liability for prior statements in his settlement with National Medical Enterprises.

In an interview last year before he settled with the hospital chain, Mr. Rotella said that as a 16-year-old he had been upset over his parents' divorce and would occasionally skip school. He and his mother argued often, he said, so she took him to a psychiatrist. Almost before he knew it, he was committed to Brookhaven where, he said, he was kept against his will for 16 months.

During that time, he said, he was held down by a five- or six-man psychiatric emergency team for "horsing around" with his roommate and other such infractions.

Mr. Rotella has filed a countersuit against the 10 psychiatrists, complaining of this treatment, which he said was ordered by the doctors, and contending, for example, that one of them, Dr. Angela Wood, ordered him shackled for eight days. Hospital records state that Mr. Rotella had been "out of control." Dr. Wood is president of the American Society for Adolescent Psychiatry. Through Mr. Smith she declined to comment, and a spokesman for the society said it had not addressed the issues in the Brookhaven case.

Several other Brookhaven patients have charged in similar suits against the Dallas psychiatrists that they were restrained there for weeks or sometimes months at a time. According to the national standard for American hospitals set by the Joint Commission on Accreditation of Healthcare Organizations, restraints are to be used on psychiatric patients as infrequently as possible and removed as quickly as possible.

"If restraints are used at all, normally they are removed within hours — they present risks of injuring patients physically as well as psychologically," said Dr. Dennis S. O'Leary, the commission's president.

Several leading psychiatrists said in interviews that long-term restraints were almost never used in American hospitals. Mr. Smith said Brookhaven used restraints only when necessary, but the Texas Department of Mental Health issued an order in 1992 under which Brookhaven was closed because of the restraint practices.

Mr. Rotella said in his counterclaim that he was never a threat to himself or others, that Dr. Wood never developed a standard treatment plan for him at the hospital and that the treatment he did receive amounted to "child abuse." Mr. Smith called the accusations untrue.

M

Referral Fees And Bonuses

A division of National Medical Enterprises, N.M.E. Psychiatric Hospitals, pleaded guilty in Washington last June to Federal civil and criminal charges, including paying kickbacks to doctors and others for referring patients and paying bonuses to doctors and hospital staff members on the basis of how many beds were filled. National Medical Enterprises agreed to pay the $379 million fine.

After entering the guilty plea, the Justice Department in Washington said it would turn its attention to individuals involved in the case.

Mr. Coggins, the United States Attorney in Dallas, has since indicted Peter Alexis, until 1987 the company's regional vice president in Texas, on charges of conspiracy, making false statements and making payments to doctors "in order to induce referrals" of patients to the company's hospitals. Mr. Alexis and others with responsibility for running the psychiatric chain during the late 1980's and early 90's have yet faced criminal charges. N.M.E. has since paid most of its psychiatric hospitals and installed new management.

But little action has been taken against any of the doctors and health care workers.

Mr. Alexis, a former "administrator of the year" for the corporation's psychiatric division, pleaded guilty to charges of conspiracy and making false statements, admitting that he paid more than $30 million to psychiatrists and others for patient referrals. As part of the guilty plea, he said he had paid $400,000 annually to the Brookhaven doctors in return for patient referrals. National Medical Enterprises also said in its guilty plea that the Brookhaven doctors had received $400,000 a year for referrals.

On Jan. 10, Mr. Alexis was sentenced to five years' probation after Federal investigators said he had cooperated in significant ways in the criminal investigation.

Mr. Smith denied that the Dallas doctors ever received payments in return for patient referrals. He said his clients provided "the best possible care" to patients who needed treatment. He said that Mr. Alexis had "cut a deal" with prosecutors and that his accusations were his attempt to mitigate his sentence.

Mr. Smith also denied that the psychiatrists prolonged patients' hospital stays to increase insurance payments.

But in a 1992 court deposition by one of Mr. Smith's clients, Dr. Gary Lee Ester, Mr. Andrews presented a 1988 memorandum written by a local National Medical Enterprises official to company executives stating that "we have weekly meetings with the M.D.'s which has a goal of controlling discharges, A.M.A.'s and improving our length of stay." An A.M.A. is a patient who leaves the hospital against medical advice.

Mr. Smith acknowledged that the doctors met on a weekly basis, but he said that they did so to discuss treatment plans.

Mr. Moriarty said he did not plan to countersue on the action brought against him personally. "I don't want these culprits to use up all the money on side cases," he said. "But I'll tell you what I will do. I have 25 people down here working night and day putting together the evidence for the patient cases. And there is absolutely no question that these doctors' conduct will receive the highest level of scrutiny."

Commenting on the doctors' suit, Mike Moncrief, a Texas state Senator who conducted hearings in 1991 and sponsored new state laws that extend greater protection to hospitalized psychiatric patients, said: "I find it very disconcerting, when I have seen so much abuse in our psychiatric institutions, to see now what would appear to be an abuse of our legal system in a way that could work against the kind of reforms we worked so hard for."

The Chair

Adding Up Losses For One Teen-Ager

Banning Lyon has recently been legally adopted by his lawyer, Mr. Andrews, and today will change his name to Banning Andrews. The remarks for which he is being sued were made to reporters for The Dallas Morning News and Business Week.

Subsequently, in an Op-Ed article in The New York Times of Oct. 15, 1993, he wrote that he had been kept at Brookhaven for 353 days, spending some days confined to a chair, facing a wall, as punishment. His father, an airline pilot, had extensive insurance with Aetna. When Aetna cut off the insurance payments for his hospitalization, Mr. Lyon said, he was released.

"At night I was allowed to get off the chair I had been confined to all day, facing the wall," he wrote. "The air blowing through the thin vent in my window was moist and smelled of water and earth. Watching the storm I could image myself being rocked by the surf in California where I grew up.

"Maybe we'll get some compensation, but what's the value of swimming in the California surf to a teen-ager?"

Two days after the Op-Ed article appeared in The Times, Mr. Lyon and the other former patients reached the settlement with National Medical Enterprises.

The Washington Times

DATE: 10/13/95

PAGE: A-1

Gingrich places low priority on Medicare crooks

Defends cutting anti-fraud defenses

By Nancy E. Roman
THE WASHINGTON TIMES

House Speaker Newt Gingrich yesterday defended GOP moves to reduce penalties and enforcement efforts against Medicare fraud by saying it's more important to lock up murderers and rapists than dishonest doctors.

The Georgia Republican cited "murderers out after three years" and "rapists who don't even get tried" in response to a question at a seniors gathering to promote the GOP Medicare overhaul. "For the moment, I'd rather lock up the murderers, the rapists and the drug dealers," he said. "Once we start getting some vacant jail space, I'd be glad to look at it."

The GOP bill in the House would weaken laws against kickbacks and self-referrals in the Medicare program. The Congressional Budget Office has estimated the seven- cost of relaxing those laws to be $1.1 billion.

Gerald M. Stern, special counsel for health care fraud at the Justice Department, said one provision would overturn a common interpretation of Medicare anti-kickback case law and increase the burden of proof in criminal prosecutions.

Rep. Pete Stark, the California Democrat who drafted the anti-kickback and self-referral statutes, called Mr. Gingrich's comments "arrogant and gratuitous."

"To put O.J. Simpson, the Menendez brothers and Claus von Bulow in the same category as physicians who get kickbacks and who steal from the government is not the issue," Mr. Stark said. "Republicans are in the position of having weakened protections that we put in [Medicare law] at the urging of the Reagan and Bush administration."

Mr. Stark said Republicans weakened the provisions to shore up support from the American Medical Association, a wealthy lobby representing 300,000 doctors.

Rep. Tom Coburn, Oklahoma Republi[illegible] and obstetrician who helped draft the new anti-kickback provisions, said the changes simply would put medical professionals on equal footing with other professionals subject to such laws.

Courts have interpreted the Medicare anti-kickback law to prohibit a payment if "one purpose" of it is to induce referrals of services paid for by Medicare.

The GOP bill would change that to "the significant purpose," which Mr. Stern and others said is much harder to prove in court. Under this standard, he said, the government would not have won two big cases this year that led to fines of hundreds of millions of dollars.

Kern Smith, an assistant commerce secretary under Presidents Johnson and Kennedy, posed the question about lighter fraud rules to Mr. Gingrich at a forum sponsored by the Coalition to Save Medicare, a group backing the GOP reforms.

The 73-year-old Democrat said he's gone "around the country selling your plan" but found seniors vexed by the new fraud rules. He said they were hard to defend.

"I've been around Washington for a long time, and you are giving the Democrats something to clobber you with," Mr. Smith said.

Mr. Gingrich said Republicans are willing to negotiate on fraud and abuse provisions, leaving open the possiblity of the bill being changed on the House floor.

"We can be talked out of it if there is enough public pressure," he said.

A senior House aide yesterday said the legal standard in the anti-kickback law was changed to make it consistent with other such laws "without a lot of thought, and it is something that could be changed."

Republicans spent much of the summer discussing Medicare changes with seniors, and many found that fraud topped constituents' complaints. Many seniors erroneously thought eliminating fraud and abuse could solve Medicare's money woes.

Republicans have created other ways to reduce fraud, such as: allowing seniors to keep a portion of money recovered from fraud cases they report; establishing a voluntary disclosure program for corporate managers who uncover wrongdoing in their companies; and increasing the maximum civil penalties for health care fraud.

The CBO estimates that these changes would save $2 billion over seven years.

Democrats support some of these changes but argue that relaxing kickback and self-referral laws would undermine the success achieved in reducing Medicare fraud.

After Democrats upbraided Republicans for going soft on fraud, the House Ways and Means Committee added $100 million to the budget of the Inspector General's Office to prosecute fraud and abuse. The CBO estimates that the additional money would produce $700 million more in Medicare fraud fines.

Rep. Sam M. Gibbons of Florida, ranking Democrat on the Ways and Means Committee, said it will be difficult to block the softer fraud rules without public outcry.

"The Republicans are all marching in lock step," Mr. Gibbons said. "In my lifetime I've never seen anybody march in lock step like this."

Remarks

Donna E. Shalala

Secretary of Health and Human Services

at

Press Conference on Health Care Fraud and Abuse

October 18, 1995

GOOD AFTERNOON:

Tomorrow the Republican majority in the House of Representatives plans to ram through a Medicare bill that slashes $270 billion dollars from that vital program.

House Republicans say this legislation is necessary to save the Medicare program from bankruptcy.

~~Yet,~~ At the same time they make these huge cuts, House Republicans are opening gaping holes in the consumer protections afforded to Medicare beneficiaries.

Like many Americans, I was appalled by the comments last week by House Speaker Gingrich on the subject of combatting waste, fraud, and abuse in our health care system.

I do not think the American people agree with the Speaker's apparent belief that combatting fraud and abuse in Medicare should not be a high priority.

The Speaker's comments are particularly disturbing in light of the Republican party's insistent and persistent demand that we cut half a trillion dollars from Medicare and Medicaid.

How can they, in good conscience, ask senior citizens to pay thousands of dollars out of their pocket for their health care if they are unwilling to keep their end of the bargain and protect the integrity of these programs?

How can they, in good conscience, promise to maintain a minimal guarantee of help for disabled Americans and then renege on that promise?

How can they, in good conscience, say they are protecting the income of poor senior citizens while they delete protections against seniors being charged an unlimited amount above and beyond Medicare's recognized charges?

The answer is they can't justify their actions -- not in good conscience.

That is why House Republicans have been telling the public that they are protecting senior citizens and cracking down on waste, fraud, and abuse while their legislation does just the opposite.

In fact, the only surprising thing about this is that the Speaker was so up front about what his party is up to.

The fact is that the Republican Medicare plan being voted on this week on the House floor would open the floodgates to waste, fraud and abuse.

And it would erase important consumer protections that protect 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 that the House Republicans propose.

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, they did not receive the kind of treatment that would have abated or even cured their cancer.

Convicted of fraud?

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 consumers.

Yet House Republicans are poised to vote for a Medicare bill that would declare open season on the Medicare trust fund.

Specifically, the House bill would do the following:

- Repeal protections against kickbacks and self-referrals that protect patients against doctors who put their own profits ahead of the needs of their patients.

- 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.

- Loosen the restrictions on the payment of kickbacks related to the referral of Medicare patients.

Diff. from first one?

- Establish a costly and ultimately unnecessary advisory opinion process on criminal authorities pertaining to Medicare and Medicaid that would tie up every agency responsible for rooting out waste, fraud, and abuse; and

- Allow physicians to charge beneficiaries an ~~additional~~ amount ~~if they are unwilling to accept~~ above Medicare's fee.

These proposed changes have the potential of placing the 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 accomplishment in combatting fraud in Medicare and Medicaid.

At my Department -- in close cooperation with the Department of Justice -- we have 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 [five?] 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 step back.

No matter how the Republican members of the House vote tomorrow, we cannot -- and we will not -- put the Medicare program and the people it serves in financial jeopardy.

I also want to stress that as we protect the financial integrity of Medicare, we must also protect the quality of the care our senior citizens receive.

The Republican Medicare plan makes two changes to Medicare law that I believe will endanger beneficiaries.

First, it would repeal the bipartisan, common ground standards for clinical laboratory services.

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.

Second, the Republicans 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 a decade of investigation into the sometimes frighteningly poor quality of care provided in some of our nation's nursing homes.

For thirty years, our nation has worked to improve the health and the lives of senior citizens.

Tomorrow's vote threatens to endanger that progress by changing course.

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.

Department of Justice

FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 18, 1995

AG
(202) 616-2765
TDD (202) 514-1888

AG RENO AND HHS SECRETARY SHALALA DISCUSS HEALTH CARE FRAUD AND MEDICARE LEGISLATION

WASHINGTON, D.C. -- Attorney General Reno and Health and Human Services Secretary Shalala will hold a press availability on **Wednesday, October 18 at 1:30 pm at the Main Justice Building, Conference Room B** to discuss their concerns about provisions of the pending House Republican Medicare Bill which might impact adversely on the prosecution of health care fraud and abuse.

The House of Representatives is expected to take up Medicare legislation tomorrow, and there has been controversy over its effect on health care fraud enforcement efforts.

Gerald Stern, Special Counsel for Health Care Fraud at the Department of Justice, will be available for background at 1:00 pm in Conference Room B.

(NOTE: The availability is open to federally credentialed reporters only. Other reporters wishing to attend the availability must be cleared through the Office of Public Affairs at the Justice Department.)

# # #

95-539

DRAFT

STATEMENT OF ATTORNEY GENERAL RENO ON HEALTH CARE FRAUD PROPOSAL PENDING IN THE HOUSE OF REPRESENTATIVES

OCTOBER 18, 1995

I am concerned about provisions in the House Medicare bill that would make it more difficult for us to prosecute medical providers for fraudulent conduct against patients and the Medicare System. These provisions are wholly inconsistent with the Senate bill, which, under the leadership of Senator Cohen, would facilitate our law enforcement efforts against health care fraud which harms us all, and particularly those most vulnerable.

I understand that some Members of the House have indicated that law enforcement should not be criminally prosecuting health care providers. I believe health care fraud is so detrimental to the health and pocketbook of Americans, that I made health care fraud one of my major initiatives. I

believe perpetrators of health care fraud should not be immune from criminal prosecution because they commit their crimes in a doctor's office, in a board room, or in a laboratory, rather than in the street. White collar crooks who pay or take kickbacks in health care endanger the health of patients and steal money from all of us.

Experts estimate it may cost Americans as much as $100 billion a year. That is why we need stronger, not weaker, provisions in the House bill. Particularly at this time when we need to preserve every Medicare Trust Fund dollar, we cannot allow Medicare money to be spent on bribes paid to doctors and others as inducements for the referral of Medicare patients. Even more importantly, we cannot allow financial inducements to corrupt the professional judgment of medical providers -- providers who Americans have been taught to trust. Decisions which physicians make day in and day out --

whether and where to hospitalize a patient, what laboratory tests to order, what surgical procedure to perform, what drug to prescribe, and how long to keep a patient in a psychiatric facility -- affect the health and well being of our elderly parents and of our children. Allowing those decisions to be made under the influence of kickbacks would be wrong.

The House bill would place a very high, additional burden on the government in its attempts to prosecute those who pay or receive kickbacks for the purpose of inducing the referral of Medicare business. Existing law requires the government to prove that "one purpose" of the kickback was to induce the referral of health care business. The language of the House bill would require that the government prove that the payment was made for "the significant purpose of inducing" the referral--language that would immunize arrangements that are dressed up to disguise the payor's

motive. This would seriously undermine our efforts and would place beyond the reach of prosecution many kickbacks which are calculated to induce referrals and which have the effect of adversely affecting the judgment of medical providers. From the perspective of federal law enforcement, and, I believe, from the perspective of patients who seek their doctors' advice, this is not an acceptable result.

LEVEL 1 - 5 OF 74 STORIES

Los Angeles Times

October 8, 1995, Sunday, Home Edition

SECTION: Part A; Page 1; National Desk

LENGTH: 2113 words

HEADLINE: RAMPANT FRAUD COMPLICATES MEDICARE CURES

(can we use these cases? Do we know more?

BYLINE: By ELIZABETH SHOGREN, TIMES STAFF WRITER

DATELINE: WASHINGTON

BODY:

A nursing home operator in Northern California bilks Medicare out of nearly $4 million, and might have gotten away with it if he hadn't submitted forged invoices from bogus firms listing their addresses as New Hamshire -- without a "p" -- and Lubbock, Miss.

Senior citizens in southern Florida are duped into giving their Social Security numbers to door-to-door solicitors who say the seniors are eligible for free milk; the conspirators use the numbers to defraud Medicare out of $14 million.

A home health care service with operations in 22 states bills Medicare for $85,000; investigators later learn the money was used to send gourmet popcorn to doctors in order to encourage them to employ the firm's services.

According to the General Accounting Office, schemes like these added 10% -- or roughly $17 billion -- to the cost of Medicare last year. That's more than the federal government's total bill for providing cash welfare assistance to poor families with children.

As members of Congress wrestle with competing plans for overhauling the massive system that provides health care to the elderly and disabled, they face an uncomfortable reality: Perhaps no other government program is as rife with fraud as Medicare, but the virtual impossibility of rooting it out means that reformers must cut benefits deeper and squeeze providers harder in order to achieve the savings they want.

Republicans and Democrats alike claim that significant savings can be achieved by ridding Medicare of waste, fraud and abuse, and they are competing

with each other to prove their prowess as fraud-busters. But nonpartisan government accountants say the proposed reform plans would do little more than scratch the surface of Medi- care fraud.

The Congressional Budget Office, for example, estimates that the House Republican reform blueprint would recover only $2 billion of the more than $120 billion likely to be stolen from Medicare over the next seven years.

Some officials are warning that reform legislation could actually make matters worse. The inspector general of the Department of Health and Human Services contends that the House GOP plan "would cripple the efforts of law enforcement agencies" to control Medicare abuse and prosecute doctors and other medical professionals who take kickbacks by placing an "unsurmountable burden of proof on the government."

In fact, one section of the House reform package is titled "limiting the imposition of anti-kickback penalties."

"They know what they're doing," said Gerald Stern, special counsel for health care fraud at the Justice Department. The House plan, he said, would "seriously undermine" multi-agency efforts to investigate and prosecute fraud, which have won the government hundreds of millions of dollars in recent settlements.

Congressional Democrats are using the issue to attack their Republican colleagues. At a congressional hearing last week, Sen. Tom Harkin (D-Iowa) said the GOP plan "could be more appropriately called the Scam Artists Protection Act."

House Republicans argue that their proposals are designed to reduce unnecessary regulation of doctors and would not facilitate fraud. "The Administration is fabricating and inventing reasons why doctors should not be able to have their regulatory burdens reduced," said Ari Fleischer, spokesman for the House Ways and Means Committee, which drafted the measure.

By contrast, the Administration has praised the anti-fraud provisions contained in the rival reform plan drafted by Senate Republicans. "There are some dramatic additional tools (for fighting fraud) in the Senate bill," Stern said in an interview. "For example, it makes health care fraud a crime; it gives subpoena authority to the attorney general on health care cases; it expands anti-kickback statutes."

The Senate measure would permit Justice Department civil fraud attorneys access to grand jury information in health care cases, an authority they already have in cases involving financial institutions. It would earmark $200 million initially -- and 10% more each year for seven years -- for investigation and prosecution of Medicare fraud.

After being on a legislative back-burner for decades, health care fraud has become a hot issue as medical costs spiral out of control and Congress finds it necessary to harness the rapid growth of Medicare and Medicaid. Many lawmakers now seem convinced that if they hope to sell a skeptical public on the necessity of reduced benefits or higher premiums, they had better do something to seriously attack the problem of fraud at the same time.

Clinton Administration officials have felt the heat.

Two years ago, Atty. Gen. Janet Reno cited health care fraud as her second priority -- behind violent crime -- and launched a multi-agency effort to crack down on offenders. The FBI has put more agents on health care cases, up from 97 in 1992 to 249 this year, and Director Louis J. Freeh argues that many more are needed to unmask the increasingly intricate scams employed by Medicare and Medicaid crooks.

"The problem is so big and so diverse that we are making only a small dent in addressing the fraud," Freeh said in testimony before a Senate committee.

Fraud in other federal programs, such as food stamps, is minuscule by comparison. The Agriculture Department estimates that less than $1 billion of the $24 billion paid out in food stamps in 1994 went to ineligible applicants who filled out forms incorrectly, and in only a portion of those cases was there an intent to defraud. While Medicare crooks can walk away with millions of dollars, a typical food stamp cheat ends up with a couple extra months of government subsidized groceries after starting a new job.

Organized crime kingpins view health care fraud as a new frontier, the FBI director said, and cocaine distributors in Southern California and southern Florida are diversifying into Medicare abuse because the profits are greater, the chance of detection is slimmer and the penalties are minor.

"There are all sorts of schemes out there," said Steve Meagher, a former prosecutor in the U.S. attorney's office in San Francisco who now represents whistle-blowers in medical fraud cases. "It's like the Wild West when it comes to Medicare."

Most Medicare fraud goes undetected, the country's top investigators say, because the health care system is based on trust between health care providers and patients.

"Who suspects their physician or hospital of doing something improper?" asked Robert Richardson, regional inspector general for investigations in the San Francisco office of the Health and Human Services Department.

Another reason the system is rife with abuse is that the people who decide

what costs are necessary -- medical providers -- are the same people who benefit monetarily from those decisions. Patients do not pay directly for most services, so they do not have a direct incentive to check up on their doctors.

"Put those two things together and that's an easy system to target," said John Hartwig, deputy inspector general for investigations at HHS.

The huge number of Medicare recipients -- 38 million nationwide -- and the sheer volume of claims -- 700 million per year -- also contribute to the problem of fraud.

"One of the difficulties is that there are such a tiny number of people involved in it percentage-wise, but they're getting so much money," Richardson said.

Even when investigators believe that they've discovered someone cheating the system, it takes considerable time to build a case.

Frank Aiello, owner of a 99-bed Bay Area nursing home, is believed to have stolen as much as $4 million from Medicare from 1990 to 1994, before federal agents wrapped up their case against him.

It took two years to accumulate enough evidence to justify filing charges. The case was finally clinched when Aiello tried to pass off phony invoices for medical equipment he supposedly purchased for his nursing home in Lincoln, Calif.

An investigator in the case, who spoke on condition of anonymity, said Aiello provided invaluable assistance himself by misspelling New Hampshire and transplanting the city of Lubbock from West Texas to Mississippi on invoice letterheads that he faked to try to trick investigators.

During a search of the nursing home's offices, investigators found two sets of books, one listing the bogus medical supply purchases and another recording the real purchases, which included feed for animals at Aiello's ranch.

One reason Aiello was able to steal from Medicare for so long was that he paid $500 under the table to a clerk for Mutual of Omaha Insurance Co., which processed the Medicare claims, to speed up his payments. Aiello was found guilty and is in jail awaiting sentencing.

Many Medicare fraud cases are far more difficult to pin down because "the cases we see today are much more complicated," Richardson said.

A few decades ago, a typical fraud case might have involved a doctor submitting bills for client examinations when he was really in the Bahamas.

Today, many scams take advantage of the fact that most billing is done from computer to computer.

Consider the case of the two sisters from Simi Valley who managed to steal $7 million from Medicare in the early 1990s by describing regular bandages, which cannot be charged to Medicare, as surgical dressings, which can.

One of the sisters cooked up the scheme while working as a low-level billing clerk in a hospital. One day she mistakenly entered the code for surgical dressings instead of for bandages, discovering quite by accident the potential payoff. The mistake grew into a multimillion-dollar scam.

The sisters started out by offering their services as billing experts to a nursing home, promising to recover more money from Medicare than the facility had received in the past. The venture was so successful, the women eventually hired a staff and expanded into a nationwide billing company serving 70 nursing homes.

The scheme was derailed because of a power struggle over the management of one of the nursing homes, the Regency Hill Convalescence Hospital in Pittsburg, Calif. The sisters were hired by the new owners, who were promising to make the operation more cost-effective. The old managers, offended at the suggestion that they were inefficient, brought in a consultant to examine the sisters' Medicare claims.

The consultant discovered that they were routinely charging for surgical dressings for patients who had not had surgery. By that time, Medicare had already paid out some $7 million in fraudulent claims submitted by the sisters over 10 months.

Both women are now serving prison sentences.

"If they hadn't done it so much, they might not have been caught," said the case investigator, who spoke on condition on anonymity. "People are greedy. They don't get caught the first time out, (so) their sights get bigger and bigger."

Law enforcement officials say Medicare fraud is so difficult to detect that it will probably never be eliminated. But they argue that significant progress can be made if more investigators are hired -- and if taxpayers come to better understand that they ultimately are stuck with the bill.

In some areas, concerted efforts already are under way to beef up enforcement.

Health care crime became so rampant in southern Florida, for instance, that

the federal government opened a new office in Miami to concentrate specifically on Medicare and Medicaid fraud. One of the staff's functions is to meet with older people and tell them what they should look for to make sure they are not victims of a scam.

While such efforts are expensive, many officials see them as necessary. They note that the monetary payoff for health care fraud is much greater than for most types of crime, and the problem will only escalate if authorities fail to respond aggressively.

Some signs of progress are evident. This summer, Caremark International, a Northbrook, Ill., home health care chain, pleaded guilty to giving bonuses to doctors to refer Medicare and Medicaid patients to the company's facilities. The company agreed to pay $161 million in fines and penalties.

The case is one of several kickback schemes pursued by the Clinton Administration as part of its anti-fraud initiative.

"Kickbacks are pernicious because they corrupt the medical providers' decision-making, often replacing profit for patient welfare," said Stern, the Justice Department special counsel. "Kickbacks have led to grossly inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment -- at great additional expense to the American consumer and taxpayer."

St. Petersburg Times
August 26, 1995, Saturday, City Edition

SECTION: TAMPA BAY AND STATE; Pg. 1B

DISTRIBUTION: TAMPA BAY AND STATE; TAMPA TODAY

LENGTH: 624 words

HEADLINE: Home health company indicted

SOURCE: Compiled from Times Wires

DATELINE: WASHINGTON

BODY:

A private home health care company with outlets in Tampa Bay was indicted Friday on charges of defrauding Medicare of more than a million dollars, the Department of Justice said.

The 82-count indictment by a federal grand jury indicted ABC Home Health Services Inc., one of the largest private home health care firms in the country, and four of its top executives in an alleged conspiracy to defraud the federal health program for the elderly.

ABC, now known as First American Health Care of Georgia, and its operators were accused of submitting fraudulent cost reports to Medicare between 1989 and 1993.

First American has at least 65 agencies in Florida, including outlets in St. Petersburg, Clearwater, Tampa and Inverness.

Harry Dixon, U.S. attorney for the southern district of Georgia, said the indictment by the grand jury in Savannah was the culmination of a lengthy investigation.

The company denied the allegations and said it would fight the charges.

"First American is committed to the highest of ethical standards and believes that its policies and practices have been and continue to be consistent with the spirit and intent of all applicable laws and regulations," said J. Alan Welch, associate general counsel for the company.

The indictment named Robert "Jack" Mills, 57, chairman and chief executive;

Margie Mills, 56, president and chief operating officer; Arthur DeLozier, 47, chief accountant; and James McManus, 57, former transportation director at ABC.

Penalties range from five to 10 years' imprisonment and fines of $ 100,000 to $ 250,000 for each count.

The allegations include charges that the company billed Medicare for personal airplane trips to Mexico, college football games and other excursions. The company also is accused of billing Medicare for political contributions and for ghost employees.

Despite its legal problems, First American continues to receive Medicare reimbursements for its patients while it fights the Health Care Financing Administration's order in March to exclude the company from the Medicare program. An administrative law judge is expected to hear the case this fall.

Before the indictments, reports by the Health and Human Services inspector general and the General Accounting Office portrayed a firm that grew rapidly while billing the federal government for marketing services, lobbying and purchase of new agencies.

In a review of the company's 1992 bills, the HHS inspector general found that ABC Home Health of St. Petersburg and ABC Home Health of Inverness were among the 32 home health agencies owned by the company that submitted fraudulent claims.

In 1987, for instance, ABC submitted bills for $ 3,832 in maid service on a condominium owned by Jack and Margie Mills and $ 5,132 for the lease on their son's BMW and for his college costs.

ABC's 1992 Medicare bills included $ 1.7-million in salaries, benefits and travel that the inspector general found unallowable. The auditors counted 17 "associate directors of community affairs," whose activities included soliciting patients for the home health care agencies.

It spent thousands on marketing gear with the ABC name, such as pens, refrigerator magnets and emery boards.

It also billed Medicare for tickets to The Phantom of the Opera and for presents to state legislators, including 98 bags of Vidalia onions for $ 686. And Medicare paid $ 72,500 for board of directors fees - on a board made up of five members of the co-owners' immediate family.

ABC officials could not immediately be reached for a response to the indictments.

Chicago Tribune

August 19, 1995 Saturday, NORTH SPORTS FINAL EDITION

SECTION: NEWS; Pg. 16; ZONE: N

LENGTH: 371 words

HEADLINE: AUDIT FINDS ABUSES IN MEDICARE BILLING

BYLINE: Scripps Howard News Service.

DATELINE: WASHINGTON

BODY:

Federal auditors studying why Medicare's home health-care costs rose $5 billion over four years have found many apparently improperly billed expenses, including large liquor bills for health executives, $1 million conferences and lobbying costs.

Those costs unrelated to patient care should not have been billed to Medicare and should not have been paid, according to audits done by the Department of Health and Human Services' inspector general and the General Accounting Office.

In one case, the inspector general is trying to recover $14 million in unallowable expenses from the former ABC Health Care, which now is named First American Health Care and based in Brunswick, Ga.

In another case, the federal government obtained Medicare fraud convictions this summer of three executives of Healthmaster, a home health-care company based in Augusta, Ga. The executives were accused of using Medicare reimbursements for political contributions and personal expenses. The government hopes to recover $13 million if the health company is sold.

First American Health Care, with operations in 22 states, is facing a potential penalty of seven years of exclusion from Medicare participation, but is appealing.

Spokesman Jeff Stives of First American said the company was careful to follow federal regulations.

The $16,000 for liquor expenses for an employees' conference, for example, was not prohibited by regulations when it was submitted in 1992, he said.

However, the inspector general's report said Medicare guidelines show that any claimed expenses "must be related to patient care and necessary for the maintenance of the health-care entity."

Congress is making an intense study of Medicare operations this year to try to reduce its expected growth by about $270 billion over the next seven years.

Federal audits also have found other unallowed expenses that Medicare was billed for by home health companies and paid, including $9.7 million for computer software that wasn't operational and more than $500,000 for promotional items-such as coffee mugs and refrigerator magnets-bearing corporate logos that were given to doctors, hospitals and other potential sources of patient referrals.

LANGUAGE: ENGLISH

LOAD-DATE: August 19, 1995

The Boston Globe

July 22, 1995, Saturday, City Edition

SECTION: METRO/REGION; Pg. 21

LENGTH: 477 words

HEADLINE: Woman testifies against Newton psychiatrist in fraud trial

BYLINE: By Judy Rakowsky, Globe Staff

BODY:

A Framingham mother delivered dramatic testimony yesterday about how a Newton psychiatrist bullied her and her daughter to keep them from helping federal authorities investigate the doctor's alleged Medicare fraud.

C. Marcia Everett testified that Dr. Richard Skodnek pointedly reminded her that if she and her daughter cooperated with authorities, notes of her daughter's psychiatric sessions might become part of the public record of a criminal case.

Skodnek, 47, is charged with billing Medicare thousands of dollars for treatment he allegedly never gave, for threatening a federal grand jury witness and obstructing justice.

The doctor is accused of billing Medicare for people he never met, billing for patients who had moved away and overbilling for patients he did see.

Skodnek is using an insanity defense, which his lawyer Jeffrey Denner told the jury makes sense considering he is worth millions and had no need to falsify bills.

Everett took the stand to testify that she was "furious" after a 15-minute telephone call recorded by federal agents in which Skodnek repeatedly warned her that confidential psychiatric notes he made about her daughter, Catherine, would be made public if she spoke to agents from the Department of Health and Human Services or the FBI.

Everett's name was allegedly used without her knowledge on some of the fraudulent billings, and she assisted investigators despite Skodnek's warnings.

"Let me just say that in those sessions we went over all sorts of things," Skodnek said on the tape."And Cathy had all sorts of issues and, and if her

husband were to get, or excuse me, her ex-husband were to get those records, it could hurt her."

Skodnek told her the agents would say, "We're only interested in looking at Dr. Skodnek's billing of sessions or whatever." But, he said, "The reality is I've spoken to other doctors that had this happen. Then they would ask me for records."

Everett testified that she accompanied her daughter to Skodnek's office fewer than 10 times to be supportive. The first time she came along, she said, Skodnek asked if he might bill Medicare on her insurance to save her daughter money.

She agreed, she said, because, "I was brought up in a generation that thought that if the doctor said it was OK, it was OK."

The mother said she got copies of bills for 89 treatment sessions Skodnek billed Medicare during late 1992 and early 1993, when she was undergoing surgery and radiation treatment for cancer.

"I said, 'There's a terrible error here, I wasn't even available on those dates,' " she explained to the jury.

Skodnek, she said, told her bureaucracies like Medicare "always make a mess out of everything," and he would correct it. Months later, an agent from the Health and Human Services inspector general's office called Everett and the bills were not corrected.

LANGUAGE: ENGLISH

LOAD-DATE: July 24, 1995

Access No: 9300103773 ProQuest - The New York Times (R) Ondisc
Title: 10 TEXAS PSYCHIATRISTS SUE EX-PATIENTS OVER FRAUD ACCUSATIONS
Authors: HOLCOMB B. NOBLE
Source: The New York Times, Late Edition - Final
Date: Friday Feb 24, 1995 Sec: A National Desk p: 18
Length: Long (2581 words) Illus: Photo
Subjects: MENTAL HEALTH & DISORDERS; SUITS & LITIGATION; FRAUDS & SWINDLING; HEALTH INSURANCE; LIBEL & SLANDER; DOCTORS; DALLAS (TEXAS)
Names: DEATON, JOHN

Abstract: In connection with one of the largest health-care fraud cases in American medical history, a group of ten prominent Dallas psychiatrists is suing former patients, their lawyers and National Medical Enterprises, the health care company for whom they worked under contract at the Brookhaven Psychiatric Pavilion. The suit charges that the doctors were defamed by patients who say they were kept in psychiatric hospitals for long periods solely to collect the insurance.

Article Text:

In a series of highly unusual legal actions, a group of 10 prominent Dallas psychiatrists is suing former patients, their lawyers and the health care company for whom the doctors worked under contract, charging that the doctors were defamed by patients who say they were kept in psychiatric hospitals for long periods solely to collect the insurance.

The psychiatrists, who are under Federal investigation in connection with one of the largest health-care-fraud cases in American medical history, are also threatening to sue a former patient for what they say was libelous testimony before Congress last summer. The patient, John Deaton, testified that while hospitalized, he was restrained in a body net for 200 days, but that once his insurance was canceled, he was released from the hospital.

Normally such testimony is afforded Congressional immunity from prosecution or lawsuits.

Mr. Deaton is one of 67 former patients who charged in suits filed beginning in 1992 that they had been abused in Texas psychiatric hospitals as part of a plan by National Medical Enterprises, a large private for-profit hospital chain based in Santa Monica, Calif., to defraud insurance companies and the Federal Government of millions of dollars.

In a 1993 settlement of the suits, the company agreed to pay $15 million; 47 of the patients had been hospitalized at the Brookhaven Psychiatric Pavilion in Dallas, where the doctors practiced. And last June, a division of the chain pleaded guilty to Federal criminal and civil charges that included paying kickbacks to doctors in return for patient referrals. The chain paid a $379 million fine, the largest levied for health care fraud.

The doctors also brought a $1 million libel suit against the lawyer for the 67 former patients, Robert Andrews of Fort Worth, Tex., putting all the names of the 67 on the public record; some are under age 19 and had not previously been identified as having been former psychiatric patients. The doctors also sued James Moriarty, a Houston lawyer who within the past

three weeks has brought suit on behalf of 450 more patients, 40 of whom he said had been mistreated at Brookhaven.

In a suit filed yesterday, the Dallas psychiatrists sued National Medical Enterprises, contending that the corporation's conduct had damaged them.

Mr. Andrews called the doctors' case against him and the former patients 'an obvious attempt to intimidate my young clients and keep them from testifying in a possible forthcoming criminal prosecution.'

Mr. Moriarty said the doctors' action 'has to be the dumbest thing I've seen since I've been practicing law.'

'My daddy told me that if someone calls you a liar and cheat and a fraud,' Mr. Moriarty said, 'you need to remember the rule about libel: if you sue him, he's liable to go out and prove that every word of what he said is true.

'I'm sitting here, reviewing the hospital records of patients covering some 250 doctors and therapists and psychiatrists,' he said, 'trying to figure out which ought to be sued, which ought to be in jail and which ones ought to have complaints filed against them before the State Board of Medical Examiners.'

William Smith, lawyer for the doctors' group, Dallas Psychiatric Associates, denied that their suit had been filed to intimidate former patients. 'The doctors are merely asserting claims for the damage that has been done based on the untrue statements these people have made,' Mr. Smith said.

James Harrington, a law professor at the University of Texas, called it 'outrageous that a former psychiatric patient or patients should be under this kind of attack -- particularly one giving Congressional testimony.' He said he was certain the doctors would not prevail in Texas, where newly strengthened free-speech laws 'assure people very powerful rights to speak out on matters of important public policy without fear of being sued.'

Paul E. Coggins, the United States Attorney in Dallas, declined to comment on the doctors' suit. But Justice Department officials said the office was exploring whether to intervene to insure that the suit did not hinder its current investigations.

Lawsuits in the mental health field have always been difficult and rare. Diagnoses are subjective to some degree, and psychiatrists are often unwilling to testify against one another. In addition, former patients frequently encounter presumptions or biases against them as reliable witnesses.

'It's very unusual for doctors to sue their own patients,' said Marc Franklin, a law professor at Stanford University. Professor Franklin said doctors tended to remain quiet, not wanting people to know that their reputations were under attack. 'Even when the patient sues, it probably isn't a major attention getter,' he said, 'but that's not the case when the doctor sues.'

Witness
'Shackled to Bed,' Congress Is Told

Mr. Deaton, 24, was the lead-off witness last summer at a hearing on health care fraud and abuse before the House subcommittee on crime and criminal justice. Mr. Deaton testified that at age 17, while suffering from depression, he voluntarily entered Brookhaven Pavilion. He gave this account: Early in his stay, a nurse noticed a notebook of poems he had written. Deciding they were 'inappropriate,' she confiscated them, and he became angry. His doctors responded by having him strapped to his bed, telling his family that this was done for his safety.

At various points in his highly emotional testimony, he said:

*'I was secured to my bed by a body netting -- from just below my neck to my ankles.'

*'I was refused basic human dignity -- not allowed outside for a breath of fresh air for nearly a year. I had no hugs, no handshakes, no pats on the back.

'I ate, slept, bathed, attended to personal hygiene, changed clothes, endured therapy and eliminated waste shackled to my bed.'

*'I was held in bondage for insurance money, an abuse which should not be allowed to happen in America.'

Once his insurance company refused to make further payments, Mr. Deaton testified, he was released from the hospital and ordered to a state institution. There, doctors determined that he was not in need of hospitalization, and he was released.

In a Jan. 17 letter to Mr. Andrews, Mr. Smith stated that his clients, the doctors, would take action against Mr. Deaton unless he paid $25,000 to redress damages they say they suffered as a result of his Congressional testimony. Mr. Smith asserts that by testifying before Congress, Mr. Deaton violated the 1993 settlement agreement with National Medical Enterprises that included an agreement that he would not speak publicly about the case.

'Look,' Mr. Smith said, 'this is a breach of contract. It's as simple as that.'

Christi Sulzbach, associate general counsel for National Medical Enterprises, said it was her legal opinion that the agreement did not preclude Mr. Deaton's testifying before Congress. As for the doctors' suit, she said, 'We have not had an opportunity to study this new litigation so cannot comment.'

Representative Charles E. Schumer, the Brooklyn Democrat who headed the subcommittee when Mr. Deaton testified, said: 'The action by the doctors is the height of hard-headed arrogance. It's possible we will call them in for an explanation.'

Mr. Andrews said the doctors could claim no protection from the N.M.E. agreement and referred the letter to the United States Attorney's office. Law-enforcement officials said the office was determining whether the letter violated Federal criminal statues aimed at protecting Congressional witnesses. Normally, such witnesses are granted immunity from legal action.

Restraints
Recognizing Risks For Patients

Mr. Deaton was not the only former patient to speak out. In their suit, the Dallas psychiatrists accuse Mark Rotella, 26, of slander, saying he told acquaintances that the 'doctors which treated him received a $10,000 bonus for each bed filled over the Christmas holiday.' The doctors also accuse Banning Lyon, 23, of libeling them in statements to reporters from The Dallas Morning News and Business Week.

Mr. Rotella has denied making any such statements. Mr. Lyon said he was released from liability for prior statements in his settlement with National Medical Enterprises.

In an interview last year before he settled with the hospital chain, Mr. Rotella said that as a 16-year-old he had been upset over his parents' divorce and would occasionally skip school. He and his mother argued often, he said, so she took him to a psychiatrist. Almost before he knew it, he was committed to Brookhaven where, he said, he was kept against his will for 18 months.

During that time, he said, he was held down by a five- or six-man psychiatric emergency team for 'horsing around' with his roommate and other such infractions.

Mr. Rotella has filed a countersuit against the 10 psychiatrists, complaining of this treatment, which he said was ordered by the doctors, and contending, for example, that one of them, Dr. Angela Wood, ordered

him shackled for eight days. Hospital records state that Mr. Rotella had been 'out of control.' Dr. Wood is president of the American Society for Adolescent Psychiatry. Through Mr. Smith she declined to comment, and a spokesman for the society said it had not addressed the issues in the Brookhaven case.

Several other Brookhaven patients have charged in similar suits against the Dallas psychiatrists that they were restrained there for weeks or sometimes months at a time. According to the national standard for American hospitals set by the Joint Commission on Accreditation of Healthcare Organizations, restraints are to be used on psychiatric patients as infrequently as possible and removed as quickly as possible.

'If restraints are used at all, normally they are removed within hours -- they present risks of injuring patients physically as well as psychologically,' said Dr. Dennis S. O'Leary, the commission's president.

Several leading psychiatrists said in interviews that long-term restraints were almost never used in American hospitals. Mr. Smith said Brookhaven used restraints only when necessary, but the Texas Department of Mental Health issued an order in 1992 under which Brookhaven was closed because of the restraint practices.

Mr. Rotella said in his counterclaim that he was never a threat to himself or others, that Dr. Wood never developed a standard treatment plan for him at the hospital and that the treatment he did receive amounted to 'child abuse.' Mr. Smith called the accusations untrue.

Money

Referral Fees And Bonuses

A division of National Medical Enterprises, N.M.E. Psychiatric Hospitals, pleaded guilty in Washington last June to Federal civil and criminal charges, including paying kickbacks to doctors and others for referring patients and paying bonuses to doctors and hospital staff members on the basis of how many beds were filled. National Medical Enterprises agreed to pay the $379 million fine.

After obtaining the guilty plea, the Justice Department in Washington said it would turn its attention to individuals involved in the case.

Mr. Coggins, the United States Attorney in Dallas, has since indicted Peter Alexis, until 1992 the company's regional vice president in Texas, on charges of conspiracy, making false statements and making payments to doctors 'in order to induce referrals' of patients to his company's hospitals. No one else with responsibility for running the psychiatric chain during the late 1980's and early 90's has yet faced criminal charges. N.M.E. has since sold most of its psychiatric hospitals and installed new management.

But little action has been taken against any of the doctors and health care workers.

Mr. Alexis, a former 'administrator of the year' for the corporation's psychiatric division, pleaded guilty to charges of conspiracy and making false statements, admitting that he paid more than $20 million to psychiatrists and others for patient referrals. As part of his guilty plea, he said he had paid $480,000 annually to the Brookhaven doctors in return for patient referrals. National Medical Enterprises also said in its guilty plea that the Brookhaven doctors had received $480,000 a year for referrals.

On Jan. 10, Mr. Alexis was sentenced to five years' probation after Federal investigators said he had cooperated in significant ways in the criminal investigation.

Mr. Smith denied that the Dallas doctors ever received payments in return for patient referrals. He said his clients provided 'the best possible care' to patients who needed treatment. He said that Mr. Alexis

had 'cut a deal' with prosecutors and that his accusations were his attempt to mitigate his sentence.

Mr. Smith also denied that the psychiatrists prolonged patients' hospital stays to increase insurance payments.

But in a 1992 court deposition by one of Mr. Smith's clients, Dr. Gary Lee Etter, Mr. Andrews presented a 1990 memorandum written by a local National Medical Enterprises official to company executives stating that 'we have weekly meetings with the M.D.'s which has a goal of controlling discharges, A.M.A.'s and improving our length of stay.' An A.M.A. is a patient who leaves the hospital against medical advice.

Mr. Smith acknowledged that the doctors met on a weekly basis, but he said that they did so to discuss treatment plans.

Mr. Moriarty said he did not plan to countersue on the action brought against him personally. 'I don't want these culprits to use up all the money on side cases,' he said. 'But I'll tell you what I will do. I have 25 people down here working night and day putting together the evidence for the patient cases. And there is absolutely no question that these doctors' conduct will receive the highest level of scrutiny.'

Commenting on the doctors' suit, Mike Moncrief, a Texas state Senator who conducted hearings in 1991 and sponsored new state laws that extend greater protection to hospitalized psychiatric patients, said: 'I find it very disconcerting, when I have seen so much abuse in our psychiatric institutions, to see now what would appear to be an abuse of our legal system in a way that could work against the kind of reform we worked so hard for.'

The Chair

Adding Up Losses For One Teen-Ager

Banning Lyon has recently been legally adopted by his lawyer, Mr. Andrews, and today will change his name to Banning Andrews. The remarks for which he is being sued were made to reporters for The Dallas Morning News and Business Week.

Subsequently, in an Op-Ed article in The New York Times of Oct. 15, 1993, he wrote that he had been kept at Brookhaven for 353 days, spending some days confined to a chair, facing a wall, as punishment. His father, an airline pilot, had extensive insurance with Aetna. When Aetna cut off the insurance payments for his hospitalization, Mr. Lyon said, he was released.

'At night I was allowed to get off the chair I had been confined to all day, facing the wall,' he wrote. 'The air blowing through the thin vent in my window was moist and smelled of water and earth. Watching the storm I could image myself being rocked by the surf in California where I grew up.

'Maybe we'll get some compensation, but what's the value of swimming in the California surf to a teen-ager?'

Two days after the Op-Ed article appeared in The Times, Mr. Lyon and the other former patients reached the settlement with National Medical Enterprises.

Caption:

Photo: Robert Andrews, left, a Fort Worth, Tex., lawyer, is being sued by a group of psychiatrists over allegations of fraud by former mental patients. With Mr. Andrews are three former patients, who also are subjects of the lawsuit, from left, Banning Lyon, Mark Rotella and John Deaton. The television shows a videotaped deposition by Dr. Gary Lee Etter, one of the psychiatrists who filed the lawsuit. (Mark Graham for The New York Times)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

Acting Assistant Secretary for Public Affairs
Phone: (202)690-7850 Fax: (202)690-5673

To: Jennifer Klein

Fax: 456-2898 Phone: 456-2599

Date: 10/18 Total number of pages sent: 3

Comments:

As discussed, here are our "case studies" — I've sent ours to DOJ w/ a note. I expect theirs will be better than ours, but you never know.

M-

200 Independence Avenue, S.W., Bldg. HHH, Room 647-D, Washington, D.C. 20201

solely intended to induce referrals of patients.

- The government recently determined that hundreds of elderly patients were implanted with "mystery" pacemakers, with no brand, serial number, or expiration date. After a lengthy investigation and trial, a pacemaker dealer and others were convicted of misbranding pacemakers, changing their expiration dates, giving kickbacks to physicians, and overcharging.

In 1986, Robert Kuncl, a retired electrician from Chicago, had a "mystery pacemaker" implanted in his chest. One could not determine the brand, serial number, or expiration date of the device. Mr. Kuncl's cardiologist later admitted that he received the services of a prostitute, a trip to Hawaii, and other types of kickbacks from the pacemaker dealer. The dealer and nine others were convicted of misbranding pacemakers, changing their expiration dates, giving kickbacks, and/or overcharging.

"REPUBLICANS PLACE LOW PRIORITY ON MEDICARE CROOKS"

- An October 13, 1995 article in The Washington Times leads with the headline above and quotes Speaker Gingrich as saying "...For the moment, I'd rather lock up the murderers, the rapists and the drug dealers. Once we get some vacant jail space, I'd be glad to look at it (Medicare fraud and abuse)."

- The Speaker just doesn't get it. While the vast majority of health care providers are honest practitioners, there are others who defraud and abuse the Medicare system and the patients who are served. In fact, the General Accounting Office says that fraud and abuse wastes 10 percent of our total health care spending. More importantly, fraud and abuse put the elderly and disabled at risk.

- While the Clinton Administration has launched major efforts to reduce fraud and abuse in Medicare, House Republicans have sold out to the American Medical Association -- agreeing to a plan that would undermine our ability to enforce anti-fraud and abuse laws and that would eliminate protections for the elderly disabled.

FOR EXAMPLE:

1.) THE HOUSE BILL WOULD UNDERMINE LAW ENFORCEMENT EFFORTS TO REDUCE FRAUD AND ABUSE

- The House Republican Plan Would Make Anti-Kickback Statutes More Lenient:

  The House Republican bill will seriously undercut anti-kickback enforcement efforts. The Republican plan would make it considerably more difficult, if not impossible, to prosecute such cases by increasing the standard of proof. Under current law, the courts have prohibited any form of remuneration that is provided in exchange for patient referrals. The Republican plan would prohibit such payments only if the primary purpose of the payment was to induce referrals. Practically, this would mean that at least 51 percent of the motivation of a payment must be shown to be unlawful. How do you prove the degree of motivation to break the law? The result of this provision would be to immunize a range of conduct which was, in truth, intended to induce referrals.

  The Harmful Effects of Kickback Arrangements: Kickbacks are pernicious because they corrupt the medical providers' decisionmaking, often replacing profit for patient welfare. Kickbacks have lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment, at great additional expense to the American consumer and taxpayer. The current anti-kickback statute

was designed to ensure that medical decisions are not influenced by financial rewards from third parties. The Republican proposal would instead encourage providers to abandon their medical judgement and refer patients to the highest bidder.

Most kickbacks have sophisticated disguises like consultation arrangements, returns on investments, etc. These disguises are hard for the government to penetrate. Under the Republican proposal, where the defendant could argue that there was some legitimate purpose for the payment, the prosecution would have to prove beyond a reasonable doubt, through circumstantial evidence, that the defendant actually had another motive that was "the significant reason for the payment. For the vast majority of present-day kickback schemes, the proposed amendment would place an insurmountable burden of proof on the Government. Moreover, there is no record of trivial cases being prosecuted under this statute.

Cases that Demonstrate the Kickback Problem: We were able to prosecute and settle two major anti-kickback cases the last 15 months, obtaining convictions and settlements of $379 million in these two cases which returned significant savings to the Medicare Trust Fund and the Treasury. The Republican proposal would seriously undermine such efforts, and signal to providers that as long as they can point to some sham purpose for the payment, the government will not be able to prosecute them for their bribery activity.

- The Republican Plan Would Immunize Providers Against Civil Monetary Penalties

The House Republican plan would make the CMP provisions for fraudulent claims more lenient by relieving providers of the duty to use reasonable diligence to ensure their claims are true and accurate. Providers would have to flagrantly abuse or defraud the program in order for the statute to apply.

How Civil Monetary Penalties are Applied: The existing 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.

> The statute includes the "knows or should know" standard for the mental element of the offense, a well defined concept. 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 "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.

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 are never audited or investigated.

The proposal would redefine 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.

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.

Cases that Illustrate the Civil Monetary Penalty:

TO BE PROVIDED

2.) THE HOUSE REPUBLICAN PLAN WOULD ELIMINATE CONSUMER PROTECTIONS FOR MEDICARE BENEFICIARIES

The House Republican Plan Would Encourage Abusive Physician Self-Referrals

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.

The House Republican bill would repeal the prohibition on self-referral as it applies to compensation arrangements. If this part of the statute were repealed, health care facilities and suppliers could provide inappropriate incentives to physicians to overutilize certain services.

What's Wrong With Physician Self-Referral: The concern with physician self-referral is that decisions about patient care

should not be influenced by the profit motive.

The existing statute contains a number of broad exceptions so that legitimate arrangements between physicians and other health care facilities and suppliers can be accommodated.

Cases Illustrations of Abuse: In 1989, the OIG found that patients of referring physicians who own or invest 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, 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 independent clinical laboratories by patients of physician owners cost the Medicare program an estimated $28 million in 1987.

- The House Republican Plan Would Eliminate Quality Standards for Clinical Labs in Physician Offices

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) require all clinical labs, including physician office labs, to meet minimum quality standards based on the complexity of the tests they perform.

The House Republican Bill 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.

How CLIA Protects Consumers: Data from surveys and proficiency testing show more deficiencies in physician office labs than in other clinical labs. Many deficiencies found by CLIA surveyors involve serious problems that endanger patient safety and health. For example,

A number of laboratories have failed to follow the directions that accompany equipment or test supplies. One laboratory performing strep testing never had a positive strep result. A CLIA surveyor found that the lab was inaccurately performing the test because it failed to read the labels on the bottles of chemical reagents used in the test. The lab never performed quality control checks, and as a result of the inaccurate procedure, all test results were negative. This failure to detect and treat strep infections could have allowed the infection to spread which can lead to rheumatic heart disease and death.

Case Illustrations of How CLIA Works: An obstetrician/gynecologist performed glucose tolerance tests on pregnant women using equipment that had no records of calibration, maintenance, or quality control procedures. An inspection of the lab found quality control materials that were frozen and outdated. The resulting inaccurate glucose test results in pregnant women could have led to the misdiagnosis of gestational diabetes, which may endanger the life of the mother and baby.

CLIA surveys and proficiency testing provide physician office labs with feedback about problems of which they are unaware. New data show that CLIA has helped these labs improve their testing quality.

The Department is continually reviewing ways to reduce the burden and improve the entire CLIA system. Major steps have already been taken toward streamlining CLIA oversight for physician office labs, including:

Granting CLIA waivers for 35 percent of physician labs,
Allowing grandfather provisions and phase-ins of personnel requirements,

Providing exemptions from routine surveys for many physician labs and flexible survey options for others, and

"Deeming" physician labs that are accredited by private organizations, and exempting labs in states with equivalent state-level standards.

The House Republican Plan Would Eliminate Quality Standards That Protect Nursing Home Residents

The proposed block grant of Medicaid would repeal the 1987 law signed by President Reagan that established quality standards for nursing homes and institutions caring for people with mental retardation. The Medicare proposal would gut similar quality standards for Medicare beneficiaries.

Why Nursing Home Quality Standards are Valuable: The 1987 law and subsequent amendments have let to dramatic improvements in the quality of nursing home care. The use of chemical and physical restraints has dropped significantly. The number of registered nurses on duty in nursing homes has increased, as has the training of nurses' aides. Nevertheless, the threat of poor care, abuse and neglect is still very real. Surveyors have continued to find substandard care at some nursing homes. For example:

Cases that Illustrate the Value of Nursing Home Standards

-- One resident in an Indiana facility was hospitalized after maggots and larvae were found in a foot would -- the nursing home said it did not have enough staff to give baths.

-- A mentally retarded resident in a Texas facility was hospitalized after being "force fed" with a syringe while in a head lock and then aspirating the milk.

-- Residents in a Maine facility developed severe pressure sores after entering the facility. In most cases, the development of the pressure sores could have been avoided.

The Federal Government, through Medicare and Medicaid, is the largest single payor of nursing home care, accounting for over 30 percent of all expenditures for nursing home care. It is both prudent and appropriate for the Federal government to ensure that it purchases quality nursing home care for Medicare and Medicaid beneficiaries.

Major Protections Would No Longer Exist.

Progress in eliminating chemical and physical restraints could vanish. Since the nursing home reform law went into effect, the number of drugged or tied up residents has been reduced. Use of physical restraints has declined by at least 50%; chemical restraint reduction estimates range from 19% to 59%.

Training and testing of nurse aides, the front-line care givers in nursing homes, would no longer be required. This would be a monumental blow to quality of care. If anything, nurse aide training is needed more now than ever because the acuity level of nursing home residents has increased due to earlier hospital discharges.

State nurse aide registries would be eliminated. These registries keep track of individuals who have completed approved training and testing as well as those aides who abuse, neglect, or steal from residents. These registries are a resource to the public and other health care providers as well as nursing homes.

Residents could no longer rely on uniform national standards to protect their

right to be treated with dignity, their right to be free from abuse, or their freedom to manage their own money.

TALKING POINTS ON CRIMINAL ANTI-KICKBACK PROVISIONS OF H.R. 2425

Current Law: 42 U.S.C. 1320a-7b prohibits the payment or receipt of any form of remuneration (thing of value) in exchange for the referral of Medicare or Medicaid business. The courts have interpreted the statute to prohibit the payment of such remuneration if "one purpose" of the payment is to induce referrals of services which are paid for by Medicare/Medicaid. United States v. Greber, 760 F.2d 68 (3rd Cir. 1985); See also United States v. Kats, 871 F.2d 105 (9th Cir., 1989); United States v. Bay State Ambulance, 874 F. 2d 20 (1st Cir. 1989). Therefore, the government is charged with the burden of proving beyond a reasonable doubt that one purpose of a payment is to induce referrals. The prosecution must often rely on circumstantial evidence to prove the intent required by the statute.

The Republican Proposal: H.R. 2425 would require the government to prove that "the significant purpose" of the payment was to induce referrals. The phrase "the significant purpose" implies that there can only be one "significant" purpose of a payment. If so, at least 51 percent of the motivation of a payment must be shown to be unlawful. The result of this provision would be to immunize a range of conduct which was, in truth, intended to induce referrals. Moreover, the phrase "significant purpose" is vague and will result in unnecessary and burdensome litigation. In sum, the proposed amendment will seriously undercut our anti-kickback enforcement efforts.

The Harmful Effects of Kickback Arrangements: Kickbacks are pernicious because they corrupt the medical providers' decisionmaking, often replacing profit for patient welfare. Kickbacks have lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery, drugs, tests and equipment, at great additional expense to the American consumer and taxpayer. The current anti-kickback statute was designed to ensure that medical decisions are not influenced by financial rewards from third parties. The Republican proposal would instead encourage providers to abandon their medical judgment and refer patients to the highest bidder.

Most kickbacks have sophisticated disguises, like consultation arrangements, returns on investments, etc. These disguises are hard for the Government to penetrate. Under the Republican proposal, where the defendant could argue that there was some legitimate purpose for the payment, the prosecution would have to prove beyond a reasonable doubt, through circumstantial evidence, that the defendant actually had another motive that was "the significant" reason for the payment. For the vast majority of the present-day kickback schemes, the proposed amendment would place an insurmountable burden of proof on the Government. Moreover, there is no record of trivial cases being prosecuted under this statute.

Cases that Demonstrate the Kickback Problem: We were able to

prosecute and settle two major anti-kickback cases in the last 15 months, obtaining convictions and settlements of $379 million and $161 million in those two cases, which returned significant savings to the Medicare Trust Fund and the Treasury. The Republican proposal would seriously undermine such efforts, and signal to providers that as long as they can point to some sham purpose for the payment, the government will not be able to prosecute them for their bribery activity.

Case Illustrations of How CLIA Works:

An obstetrician/gynecologist performed glucose tolerance tests on pregnant women using equipment that had no records of calibration, maintenance, or quality control procedures. An inspection of the lab found quality control materials that were frozen and outdated. The resulting inaccurate glucose test results in pregnant women could have led to the misdiagnosis of gestational diabetes, which may endanger the life of the mother and baby.

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Cases that Illustrate the Value of Anti-Kickback Laws

- In December, 1994, an oncologist practicing in California was determined to have rendered substandard and unnecessary services to cancer patients. An HHS Administrative Law Judge found that Dr. Sunil Lahiri, "deprived many patients of the opportunity to receive treatment that could abate or cure their cancer, or at least minimize the suffering associated with advanced stages of cancer. By having these patients endure numerous prolonged infusions of ... chemotherapy, and repeated blood tests and vitamin injections of marginal efficacy, [Dr. Lahiri] severely inconvenienced these patients and caused a significant deterioration of their quality of life..."

- The government entered into a settlement agreement in which National Medical Enterprises, Inc. agreed to pay $324.2 million in damages and penalties to resolve charges of fraudulent practices at many of its psychiatric and substance abuse facilities. Among the claims were admitting and treating patients unnecessarily; keeping patients hospitalized longer than was necessary in order to use up available insurance coverage; billing federal programs multiple times for the same service; billing federal programs when no services were provided; and billing Medicare for payments made to doctors and others that were

FACTUAL EXAMPLES OF KICKBACK ARRANGEMENTS

1. Drug company starts a "frequent flyer" drug marketing program. Drug company gives doctor airline frequent flier points each time doctor places new patient on the drug company's product.

2. Pharmacists get paid a fee for each customer who switches from drug company A's product to drug company B's product.

3. Doctors are given money, in the form of research grants which only require small amount of record keeping work. The research grants are actually disguises for kickbacks paid in return for doctor prescribing a particular drug.

4. Psychiatric hospital chain hires doctor as a "director." Fees paid to the doctor are actually a disguised kickback paid to induce the doctor to place his patients in the psychiatric hospital.

5. Medical clinic paid recruiters a finder's fee for each patient which the recruiter brought to the clinic. Medical clinic then renders millions of dollars of unnecessary services to Medicaid patients.

6. Psychiatric hospital makes "sweetheart loans" to doctors who increase patients' length of stay in hospital.

7. Doctors' Group markets itself to multiple hospitals as "consultants" who can provide the hospital with lots of geriatric admissions from the nursing homes the doctors service. The "consulting" agreement is a sham; the hospitals are actually paying the doctors for referring geriatric patients to the hospitals.

8. Company pleads guilty to paying kickbacks to doctors. As part of a global settlement, company pays hundreds of millions of dollars to resolve claims resulting from the company's and the doctors' fraudulent practices, including admitting and treating patients unnecessarily, keeping patients hospitalized longer than necessary in order to use up available insurance coverage, and billing Medicare for payments made to doctors and others that were intended to induce referrals of patients to the facilities.

9. Medical supply company pays doctors to order durable medical equipment for their patients. Doctors order the equipment for patients that the doctors had not examined and for patients that did not need the equipment. Instead of medical equipment, patients received microwave ovens and air conditioners.

10. Hospitals pay finders fees to employees of labor unions, U.S. government agencies' employee assistance counselors, and probation officers for sending individuals to be treated at the hospitals.

11. Home infusion companies pay doctors under sham consulting agreements, partnership arrangements, and research agreements to refer patients for treatment by the home infusion company.

12. Surgical dressing company gives a favorable line of credit to nursing home company to induce nursing home to purchase millions of dollars of surgical dressing kits.

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. paper	Personal (Partial) (1 page)	ca. 1995	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Jennifer Klein
OA/Box Number: 10855

FOLDER TITLE:
Fraud & Abuse [3]

2014-0209-S
ms735

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[002]

KICKBACKS

(b)(6) sets up his stepson in echocardiogram/kidney ultrasound business. (b)(6) approaches four physicians' groups, agrees to split profits on their referrals.

Stepson acquires low-rent machine, hires poor quality technicians, has echocardiograms read by physicians with no supervisory or oversight responsibility. Referring physicians use service, despite complaints, because of referral fees.

Two examples: A patient with kidney pain had a kidney ultrasound by this company-Clinimed, Inc. - report came back - "ultrasound of the kidneys grossly normal." Patient had had one of his kidneys removed several years before. Fortunately his treating physician was aware of this fact.

A second patient had an echocardiogram done. The reading physician noticed an artificial heart valve, but had the artificial valve in the wrong place - on the wrong valve.

Our expert, Karen Eberman, manager of the echocardiography laboratory at Penn, described the echocardiograms done by this company as the worst she'd ever seen. No quality control program existed.

Case declined for criminal prosecution. Civil case settled with substantial penalty, agreement by (b)(6) to lifetime exclusion from Medicare.

Case is significant because in usual course of business, physicians never see echocardiogram itself-only report of reading physician.

Kickback statute, though not used in prosecution, was effective in obtaining cooperation of physicians - they knew they had potential liability and assisted in investigation.

DEPARTMENT OF HEALTH & HUMAN SERVICES

401-9920

Amy Busch
Special Assistant in Public Affairs
Phone: (202) 690-6889 Fax: (202) 690-5673

To: Jennifer Klein, ~~Cabinet~~ DPC

Fax: 456-2878 Phone: _____

Date: 10/17 Total number of pages sent: 4

Comments:

Attached are fraud and abuse crackdown stories, as requested. They come from our IG's office.

NY Times Feb 24, 1995 P. A 18 Ten Texas Psychiatrists follow

→ Nexis search stories to

Amy Busch

Kelly Crawford 616-2765

1:20

In 1987, with bipartisan support, Congress enacted the **Medicare and Medicaid Patient and Program Protection Act** (Pub. L. 100-93), providing enhanced administrative authorities for sanctioning aberrant health care providers. Under the Department's existing program exclusion authorities, approximately 1500 health care practitioners and providers who rendered substandard or unnecessary services to program beneficiaries, or otherwise engaged in fraudulent or abusive activities, were excluded from the Medicare and Medicaid programs in FY 1995.

One example, is the exclusion in December 1994 of an oncologist practicing in California. After a lengthy hearing process, a Departmental Administrative Law Judge imposed a permanent program exclusion on Dr. Sunil R. Lahiri, a physician who was determined to have rendered substandard and unnecessary services to cancer

patients. The judge found that:

> He deprived many of these patients of the opportunity to receive treatment that could abate or cure their cancer, or at least minimize the suffering associated with advanced stages of cancer. By having these patients endure numerous prolonged infusions of ... chemotherapy, and repeated blood tests and vitamin injections of marginal efficacy, [Dr. Lahiri] severely inconvenienced these patients and caused a significant deterioration of their quality of life at a time when their life expectancy was very short. This record of unnecessary and excessive treatment, when combined with [Dr. Lahiri's] refusal and inability to follow Medicare billing practices, leads me to conclude that [his]eagerness to generate the maximum amount of Medicare billings was a principal factor in his choice of treatment for patients.

Likewise, in another case, the Government entered into a settlement agreement with National Medical Enterprises, Inc. (NME) to resolve charges of fraudulent practices at many of its psychiatric and substance abuse facilities. NME agreed to pay $324.2 million in damages and penalties to the United States for losses it caused to Governmental health care financing programs. The Agreement resolved claims of fraudulent and abusive practices at NME facilities, including admitting and treating patients unncessarily, keeping patients hospitalized longer than was necessary in order to use up available insurance coverage, billing federal programs multiple times for the same service, billing federal programs when no services were actually provided, and billing Medicare for payments made to doctors and others that were solely intended to induce referrals of patients.

And in yet another case, the Government recently determined that hundreds of elderly patients were implanted with "mystery" pacemakers. One could not determine the brand, serial number or expiration date of the pacemakers implanted into Medicare

beneficiaries. After a lengthy investigation and trial a pacemaker dealer and others were convicted of misbranding pacemakers, changing their expiration dates, giving kickbacks to physicians, and overcharging.

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