CHCPP NEWS
COMMISSION ON HEALTH CARE POLICY AND PRACTICE

CHCPP News replaces the Commission on Health Care Policy and Practice's monthly SNM Network News which was circulated to over 500 members. This column will appear monthly and the Commission encourages submission of news concerning managed care, local health reform, technology and outcomes assessments, practice guidelines or other policy as it relates to nuclear medicine. Please submit comments or suggestions to Wendy Smith, Associate Director of Health Care Policy at fax (703) 708-9015 or via e-mail at wsmith@snm.org.

Fraud and Abuse Provisions

The Health Insurance Portability and Accountability Act of 1996, a package of health insurance reforms has been signed into law by President Clinton. With regard to health care providers, the bill includes several significant changes to Medicare and Medicaid fraud and abuse laws. Furthermore, several provisions may affect the operations and offerings of managed care organizations, including HMOs. Most of the following fraud and abuse amendments are effective January 1, 1997. While many of the following provisions are self-implementing, some require U.S. Department of Health and Human Services (DHHS) to conduct rulemakings in the near future.

Augmentation of Enforcement Capabilities

The DHHS Inspector General (IG) and the U.S. Attorney General are required to jointly establish a national health care fraud and abuse control program to coordinate Federal, state and local efforts to combat fraud and abuse. In addition, a new Medicare Integrity Program is established under which DHHS may contract with private entities to undertake medical, utilization and fraud review, cost report audits, secondary pay or determinations, and education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues.

Beneficiary Incentive Programs

The bill requires DHHS to establish a program to encourage individuals to report information on fraud and abuse.

Extension to all Federally-Funded Health Care Programs

The bill extends to all Federally-funded health care programs (e.g., CHAMPUS), except the Federal Employee Health Benefits Program (FEHBP), criminal and civil Medicare and Medicaid anti-fraud and abuse provisions. As such, the likelihood that an individual provider is subject to the Federal fraud and abuse laws is far greater than under current law.

Advisory Opinions

The bill permits persons to petition DHHS for written advisory opinions about whether an arrangement constitutes prohibited remuneration under federal anti-fraud and abuse laws, satisfies the requirements of an existing safe harbor, and/or constitutes grounds for imposition of civil and criminal sanctions under Federal anti-fraud and abuse laws, among other things. DHHS must respond to such a request with an advisory opinion within 60 days. Advisory opinions would be binding on DHHS and the parties requesting the opinion. This provision is extremely controversial. As a compromise with the Department of Justice, the provision sunsets after four years from the date of enactment, forcing Congress to re-enact it at that time.

Within 180 days after the President signs the legislation, DHHS must publish regulations specifying, among other things, the procedures governing the application and response processes. Care should be taken in deciding under what circumstances an advisory opinion should be sought.

Safe Harbors and Fraud Alerts

The bill requires DHHS to publish annual notices in the Federal Register soliciting proposals for modifications to existing safe harbors and new safe harbors, and to issue final rules implementing such changes or additions as the Secretary of DHHS deems appropriate. Additionally, any person may request that the IG issue a special fraud alert informing the public of practices which the IG considers to be suspect or of particular concern under Medicare or Medicaid.

Mandatory Exclusions

The bill requires DHHS to exclude from Medicare and Medicaid for a minimum of five years individuals convicted of felony offenses relating to health care fraud or controlled substances. The bill retains discretionary authority in DHHS to determine whether to exclude from Medicare and Medicaid individuals convicted of misdemeanor offenses relating to health care fraud or controlled substances. The bill also establishes minimum exclusion periods for a variety of other offenses.

Data Collection Program

The bill requires DHHS to establish a national health care fraud and abuse data collection program for reporting final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners. Government agencies and health plans are required to report such adverse actions on a monthly basis. Information in the database is available to government agencies and health plans.

Additional Offenses Subject to Civil Monetary Penalties

The bill increases significantly the amount of civil monetary penalties (CMPs) for offenses related to health care fraud and abuse to establish parity with penalties provided under the Federal False Claims Act. The bill increases CMPs from $2000 plus twice the amount of each false claim to $10,000 plus three times the amount of each false claim. The bill also adds the following offenses to those subject to CMPs:

- Engaging in a pattern or practice of presenting a claim for an item or service based on a code that the person knows or has reason to know will result in greater payments than appropriate;
- Submitting a claim that the person knows or has reason to know is for medical items or services that are not medically necessary;
- Offering remuneration to an individual eligible for Medicare or Medicaid benefits to induce that individual to order or receive from a particular provider, practitioner, or supplier any item or service reimbursable under

(Continued on page 40N)

CHCCP News
(Continued from page 34N)
Medicare or Medicaid; or

• Falsely certifying that an individual meets Medicares requirements to receive home health care while knowing that the individual does not meet all such requirements.

Standard of Intent Required in Civil Monetary Penalty Cases

In CMP cases, the government currently must prove that a person "presents or causes to be presented" a claim that the person "knows" or "should know" is false or fraudulent. The bill creates a tougher burden of proof for the government by requiring the government to establish that the person knowingly presented, and by defining the standards to require that a person had either actual knowledge of the fraudulent nature of a claim, or acted in "deliberate ignorance" or "reckless disregard" of the law. In practice, this may only be a modest change because it essentially codifies case law. This amendment is effective January 1, 1997.

Amendments to the Federal Criminal Code

The bill adds to the general Federal Criminal Code acts of health care fraud, theft, embezzlement, obstruction of investigations and false statements with respect to Federally-funded health care programs, thus subjecting such acts to criminal penalties. The bill also provides that a court imposing a sentence on a person convicted of a federal health care offense may order the person to forfeit all real or personal property that is derived from the criminal offense.

Disposition of Assets for Purposes of Qualifying for Medicaid

The bill criminalizes the act of knowingly and willfully disposing of assets by transfer for purposes of becoming eligible for benefits under Medicaid.

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Consumers in Massachusetts are one step closer to knowing their physicians medical malpractice and outcomes-based performance records due to a bill that was recently signed into law by Governor William F. Weld. The bill surprisingly had the support of the Massachusetts Medical Society and the State's Board of Registration in Medicine. The law establishes two provider profiling initiatives. The first outlines principles for future outcomes-based report cards on physician and hospital performance. The second, and more controversial, initiative spells out how physician malpractice claims should be made public. The legislation also includes plans to publish the malpractice reports on the Internet by May 1997, a provision that required a delay until security issues could be investigated. This law is cutting edge. "I'm not aware of any other state moving ahead with this kind of legislation," says James Winn, MD, executive vice president of the Federation of State Medical Boards.

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AHCPR's Center for Health Care Technology recently published a Health Technology Assessment on Bone Densitometry: Patients with End-Stage Renal Disease. The assessment presents detailed analyses of the risks, clinical effectiveness and uses of medical technologies. These reports are prepared to assist federally financed health care programs (e.g., Medicare) with coverage decisions. To receive a copy of the report call AHCPR's Clearinghouse at 800-358-9295 and request AHCPR publication No. 96-0040.

The Health Care Financing Administration (HCFA) is not likely to have the data to fully comply with a congressional deadline for reporting on the reimbursement of telemedicine services, a telemedicine association representative reported. Under the health insurance reform bill (HR 3103) HCFA would be required to report to Congress by March 1, 1997 on Medicare reimbursement of telemedicine services. The report is to be based on data from current demonstration projects already under review as well as any data the agency can gather from other ongoing telemedicine networks. HCFA is supposed to analyze the cost of health care services delivered through telemedicine and make recommendations for Medicare reimbursement.

Few data are available because the actual data collection part of the demonstration projects, which are designed to test physician reimbursement for Medicare services, have not been started according to the American Telemedicine Association. According to a HCFA official, the agency will make its report to Congress based on whatever information is available. The expansion of telemedicine reimbursement could put a financial strain on the Medicare program and there are additional concerns of overutilization. Under current Medicare policy, only teleradiology services are reimbursable.

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Cost-effectiveness analyses of medical treatments have been hampered by a lack of consistent standards, according to a report issued by the U.S. Public Health Service on how to better compare the costs and benefits of health care treatment strategies. The report, Cost Effectiveness in Health and Medicine, was prepared by a 13-member panel of nonfederal physicians, economists, ethicists and scientists who were appointed in 1993 to improve standards for economic evaluation of medical care. For more information, call Martha Gold, MD, project director, at 202-634-7821.

Managed care giant PacifiCare's planned $2.1 billion purchase of FHP International Corp. would create one of the largest HMOs in the West, placing increased competitive pressure on Kaiser Permanent and other western managed care organizations, analysts say. In addition, this latest HMO mega-merger would create by far the largest Medicare risk provider in the country.

—Wendy Smith, MPH, SNM associate director of heath care policy