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# Stark Wars: Competing bills vie to amend law

*Health care industry united in support for Thomas proposal to eliminate Stark's compensation provision*

Last week, the first shots were fired in the Congressional battle to amend the complex and controversial Stark physician self-referral laws.

On Wednesday, Rep. **Bill Thomas** (R-CA), who heads up the pivotal House Ways and Means Health Subcommittee, unveiled a bill that would completely eliminate the part of the law governing compensation arrangements. A day later, Rep. Fortney Pete Stark (D-CA), the author of the law that bears his name, announced a set of counter-amendments that would revise but not eliminate the compensation provisions. **(For a complete breakdown on the differences between the competing bills, see comparison, page 2.)**

The Stark law, enacted in 1989 and expanded in 1993, was intended to bar physicians from referring Medicare patients to clinics for laboratory services where the physicians might benefit financially from the referral. Currently, it restricts all referrals based on ownership interests and compensation arrangements.

But according to Thomas, "under current law, compensation arrangements have been virtually impossible to enforce because almost anything can be considered 'compensation' — such as when a hospital gives a doctor free parking."

Senior Congressional aides say efforts to simplify the physician self-referral laws gathered steam in

*See **Stark wars**, page 3*

## OIG final rule beefs up civil monetary penalties

Last week, the Health and Human Services Office of Inspector General (OIG) released its final rule revising the agency's exclusion and civil monetary penalty (CMP) authority for providers who commit fraud and abuse.

Essentially the same as the proposed rule published in the *Federal Register* on Sept. 2, 1998, the final rule codifies provisions set forth in the Balanced Budget Act of 1997.

The revised exclusion and CMP authorities under the rule include:

*See **Tougher CMPs**, page 4*

## HCFA comes under fire for lax oversight of carriers

Two recent General Accounting Office (GAO) reports and a heated debate in the House Commerce Committee could mean that further changes are in the works regarding the Health Care Financing Administration's (HCFA) oversight of its Medicare contractors.

According to the GAO, HCFA's oversight of its 64 Medicare claims administration contractors has been so weak the agency can't guarantee that contractors are paying providers appropriately. "HCFA still does not regularly check contractors' internal management controls, management and financial data, and key program safeguards to prevent payment errors," says the GAO. In fact, HCFA's headquarters does not even set oversight priorities, but instead cedes that responsibility almost entirely to regional office reviewers.

In a separate report, the GAO says every major investigation by the OIG, Federal Bureau of Investigation, and U.S. Department of Justice it reviewed

*See **HCFA oversight**, page 3*

INSIDE:

# The Proposed Stark Amendments: A Comparison

| Current Law | Thomas 1999 | Stark 1999 |
|---|---|---|
| Bans compensation between doctors and health providers. But there are many, complex exceptions to the ban. | Compensation ban totally abolished. | Replaces most exceptions with a single fair market value test. Keeps exception for physician recruitment and de minimis gifts. |
| Requires direct physician supervision of those providing designated health services. | General supervision (meaning the physician is legally responsible but doesn't need to be present on site). | General supervision, but physician must be on site. |
| Defines group practice. | Removes HHS Secretary's authority to add more conditions. | Clarifies that a group practice should be a "unified business." |
| Includes managed care exemption. | Includes no provision. | Exemption extended to Medicaid managed care and Medicare+Choice. |
| Makes exception if there is no alternative provider. | Defines rural exception as meaning 75% of service in rural area. | An exception if HHS Secretary determines area is underserved. |
| Reporting and Civil Monetary Penalties (CMPs) for failure to report. | No provision. | Repeals reporting requirement. Abolishes CMPs for failure to report. |
| Designated health services. | Removes eyeglasses, lenses from list. | Removes eyeglasses, lenses from list. |
| Administration of law. | Amendments effective upon enactment, regardless of when regulations are promulgated. | Requests for advisory opinions must be answered within 60 days. |
| Exceptions. | No provisions. | Includes durable medical equipment, parenteral and enteral in exception for in-office ancillary services. |

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## Stark wars

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April, when Republican members of Thomas' House Ways and Means Health Subcommittee grilled top Health Care Financing Administration officials over the complexity of the existing statutes, as well as the agency's failure to issue final regulations, six years after the law was expanded.

Within hours of Thomas' press conference announcing his bill to eliminate the compensation provisions, virtually every major medical association issued statements supporting it, including the American Medical Association, the Medical Group Management Association, the American Medical Group Association, the American Academy of Family Physicians, the American Hospital Association, and the Federation of American Health Systems.

Stark himself was quick to condemn the Thomas bill, calling it "pro-fraud" and claiming that eliminating the compensation provisions will effectively gut the self-referral law. "We do not believe the government's authority to regulate compensation relationships should be deleted," says Stark's press secretary, **Anne Montgomery**. "It's the heart of the law. If you take it out, we go back to the days of the 1980s, when physicians set up all kinds of referral-for-profit schemes. It's not necessary, it's wrong, and it would be extraordinarily bad for health policy. And it would cost Medicare an awful lot in overutilization."

Stark's proposed amendment would, he claims, simplify the compensation provisions by replacing most of the compensation exceptions with a single "Fair Market Value" test. Under that test, a compensation agreement must be in writing, cover a definite period of time, and the compensation must not depend on the volume or value of referrals. The compensation in the contract must be at a "reasonable fair market rate."

That doesn't go far enough for Thomas supporters, who remain eager to see the compensation provisions stripped out of the law entirely. They claim that, besides being confusing and complex, the compensation provisions aren't necessary, since most referral-for-profit schemes are already prohibited by the anti-kickback statute, says **Anders Gilberg**, an analyst with the Medical Group Management Association in Englewood, CO. "The only difference is that with the anti-kickback statute, the government has to show that there was some intent to defraud," he says.

Montgomery argues that the anti-kickback statute's fairly high burden of proof standard would allow many questionable arrangements to slip through the cracks. "You would never be able to uncover the kinds of things with the anti-kickback law that the physical self-referral law prevents," she says.

With both bills now set to be introduced in Congress as soon as the session resumes, health care experts are optimistic that some type of Stark reform will pass by the end of the year. But if nothing is passed in 1999, there's little chance it will be passed in the election year of 2000, cautions **Brent Miller**, director of government affairs at the Alexandria, VA-based American Medical Group Association. "And that means it probably won't happen for a long time," he says. ■

## HCFA oversight

*Continued from page 1*

was triggered by the filing of a qui tam action by a current or former employee. In none of those cases had HCFA detected the contractors' fraudulent activity.

HCFA has begun to take steps to improve its oversight, but the GAO concludes it is too early to tell whether those measures will address the "fundamental problems."

The reports were released on July 14 as part of a hearing of the House Commerce Committee. At that hearing, committee chairman Tom Bliley (R-VA) alleged that HCFA's poor oversight of Medicare carriers is wasting "billions of dollars" and jeopardizing the integrity of the Medicare program. He vowed to initiate major changes in HCFA's oversight function.

**George Grob**, deputy director of the Health and Human Services Office of Inspector General (OIG), underscored Bliley's comments by noting that in addition to the nine civil settlements and two criminal convictions his office already has under its belt, that office is now actively investigating no fewer than 21 former or current contractors.

Grob told the committee his office has found significant "weaknesses and vulnerabilities"

throughout those operations. "Of all the problems we have observed," Grob asserts, "perhaps the most troubling has to do with contractor's own integrity, [including] misusing government funds and actively trying to conceal their actions, altering documents and falsifying statements that specific work has been performed."

In some cases, Grob says contractors used "bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts." In other cases, he says, carriers simply turned off system edits designed to prevent inappropriate payments.

**Alissa Fox**, executive director for legislative policy at the Blue Cross Blue Shield Association in Washington, DC, acknowledges that some carriers have committed fraudulent acts but cautions against any sort of legislative overreaction. "We think everybody in this process needs to do a better job," she says. "That means Congress, HCFA, and our plans. There are plenty of issues that can be identified in all three camps."

Fox argues that HCFA already may have created more oversight headaches for itself with its handling of the Medicare Integrity Program, in which HCFA is awarding contracts to private companies to conduct medical review of claims. "The best way to manage this program is to have one contractor with a single point of accountability," she says. "If you start fragmenting the operations — having one entity conduct claims processing and another conduct medical review — there are going to be problems. HCFA's going to have to sit on top of all these different contractors to make sure that a single claim is being processed properly. And that kind of thing leads to a lot of finger-pointing." ■

## Tougher CMPs

*Continued from page 1*

- Expanding the OIG's power to exclude providers beyond Medicare and the state health care programs to all health care programs.
- Establishing permanent exclusions for individuals convicted of three or more health care-related crimes and 10-year exclusions for individuals convicted of two health care-related crimes.
- Assessing CMPs of up to $10,000 against institutional providers that knowingly employ or enter into contracts for medical services with excluded individuals.
- Establishing a new CMP of up to $25,000 for health plans that fail to report information to the Healthcare Integrity and Protection Data Bank.
- Creating CMPs of up to $50,000 for providers who violate the anti-kickback statute, including a maximum penalty of not more than three times the amount of remuneration offered, paid, solicited, or received in the kickback scheme.

The final rule went into effect July 22. ■

## AMA launches offensive against anti-fraud plans

Responding to votes taken by delegates at its recent annual meeting, the Chicago-based American Medical Association (AMA) has taken a harder line in opposing federal anti-fraud efforts.

Skeptical of the Health Care Financing Administration's fraud and abuse statistics, the AMA plans to commission an independent audit of Medicare Part B to determine how extensive physician-related health care fraud really is.

In addition, the AMA is targeting two separate anti-fraud plans identified by delegates as particularly harmful or unfair to physicians. These include the "senior spies" program, promoted by the American Association of Retired Persons in Washington, DC, with help from HCFA and the Federal Bureau of Investigation. AMA's intention is to repeal the part of the program that provides a financial incentive to seniors who turn in their physicians.

Also raising the ire of the AMA is the Healthcare Integrity and Protection Data Bank (HIPDB), which is expected to be up and running by October. Mandated by the Health Insurance Portability and Accountability Act of 1996, HIPDB was supposed to become operational on May 19, but undisclosed technical problems have created delays, says **Kay Garvey**, a spokeswoman for the Health Resources and Services Administration, the agency that administers HIPDB.

Designed to identify and track physicians who have committed health care fraud, HIPDB will compile civil as well as criminal judgments. AMA claims the system serves as an "attack" on physicians and doesn't include proper due process protections. ■