

renowned author, a distinguished civic leader, and an outspoken champion of the rights of District residents.

I rise to recognize Pastor Hicks on the occasion of the Metropolitan Baptist Church's 20th Pastoral Jubilee for their pastor, when the more than 7,000 members of the church are celebrating his many accomplishments and contributions. Pastor Hicks has been a leader in bringing women into the ministry and has advocated the ordination of women. He has established programs at the church that are much-praised models for churches around the Nation for people living with AIDS and their families, for prison inmates, for seniors, and for youth. He has rebuilt his historic church and made it a center for revitalization of its inner city neighborhood.

Dr. Hicks has become a leading voice in pursuing the democratic right of self government for District residents. When the Congress forced a death penalty referendum on the District in 1992, Dr. Hicks was chair of the campaign against the death penalty. He led the campaign not only as a civic leader of the community, but also as a minister of the Gospel who, like many of the ministers in the District, opposes the death penalty on religious grounds.

Dr. Hicks' dissertation for his doctoral degree from Colgate Rochester Divinity School in 1972, "Images of the Black Preacher: The Man Nobody Knows," was published in 1977. Since then he has been widely published in religious publications. His two most recent volumes are "Preaching Through a Storm" and "Correspondence with a Cripple From Tar-sus."

In recognition of his extraordinary talent in his calling, *Ebony* named Dr. Hicks one of the "Fifteen Greatest African-American Preachers" in 1993. Mr. Speaker, I ask that Members of this body, the U.S. House of Representatives, join me in saluting the dynamic leadership of Rev. Dr. H. Beecher Hicks, Jr.

MEDICARE AND MEDICAID BENEFICIARY PROTECTION ACT OF 1997

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 7, 1997

Mr. STARK. Mr. Speaker, today I am introducing the Medicare and Medicaid Beneficiary Protection Act of 1997, a bill designed to continue our fight against health care fraud, waste, and abuse in the Medicare and Medicaid Programs.

THE PROBLEM

The General Accounting Office [GAO] has estimated that fraud and abuse could be as much as 10 percent of total health care spending. This best estimate—that 10 percent of the Nation's \$1 trillion health bill is lost in waste, fraud, and abuse—includes both the private and public sector. Consider this . . . Federal baseline outlays for Medicare are approximately \$208 billion in fiscal year 1998—and 10 percent of waste, fraud, and abuse roughly equals the \$23 billion we cut each year in this year's budget reconciliation bill. If we were tougher on health care fraud, we wouldn't have to cut payments from the honest, hardworking providers who justly should receive payment for their services.

A recent audit by the Health and Human Services Office of Inspector General [HHS OIG] estimated that approximately \$23 billion—about 14 percent of the total Medicare fee-for-service benefit payments—had been improperly paid through the Medicare system. These errors included everything from simple mistakes to outright fraud. Most improper payments were due to the lack of any or adequate documentation to support the claimed service—lack of medical necessity; incorrect coding; and noncovered or unallowable services. All the money improperly paid, however, was wasteful.

RECENT LEGISLATIVE EFFORTS ARE PROMISING BUT NOT ENOUGH

We should be proud of recent legislative efforts. The Health Insurance Portability and Accountability Act and the Balanced Budget Act of 1997 made significant strides in combating fraud, waste, and abuse in the Medicare and Medicaid Programs. With bipartisan cooperation, we enacted unprecedented tools for fighting what has become one of the favorite crimes of the 1990's—cheating the Government of billions of dollars through health care fraud. This new legislation designs a fraud fighting program that coordinates the efforts of a broad array of law enforcement and health care agencies. Equally as important, it authorizes funding to support the work of law enforcement and the development of new detection and enforcement techniques.

Total fines, restitutions and recoveries achieved this year from OIG criminal and civil investigations totaled \$1.2 billion. This is five times higher than recoveries for fiscal year 1996. Approximately 2,500 health care providers and entities were excluded from doing business with the Medicare, Medicaid, and other Federal and State health care programs because of violations of the law—an 80-percent increase from the 1,400 exclusions in fiscal year 1996.

Although we're heading in the right direction, massive fraud schemes to defraud the Government continue. Here are just a few examples.

A psychologist billed for more than 24 hours of therapy in a single day.

A home health agency charged for visits to patients' homes when the patients were actually hospitalized.

A nursing home submitted claims for surgical dressings on behalf of patients who had not undergone surgery.

A fictitious diagnostic firm collected payment for nonexistent lab work on dead people.

One beneficiary was charged \$5,290 for tape over a 6-month period of which \$5,000 was excessive. Medicare paid for but the beneficiary probably did not receive, 66,000 feet or 12.5 miles of 1-inch tape.

Although recent legislation is a good first step, we need to do more. In a August 19, 1997, statement, Gregory Anderson, director of corporate and financial investigations for Blue Cross and Blue Shield of Michigan said it best—despite increased enforcement and the publicity of million dollar settlements with large, multi-State health corporations, "the rewards outweigh the risks today."

The bill I am introducing today aggressively continues the fight. My message should be clear to those who do business with Medicare and Medicaid—the fight against health care fraud is just beginning.

FINANCIAL AND COMPLIANCE AUDITS SHOULD BE A COST OF DOING BUSINESS WITH MEDICARE AND MEDICAID

I want to highlight one particular provision in this bill—the use of compliance and financial audits. Unfortunately, it's relatively easy for fraudulent operators to escape detection because the Health Care Financing Administration [HCFA], which oversees the Medicare and Medicaid Programs, is woefully lacking in resources to provide adequate oversight and to track down abusers. Over the past 7 years, the number of Medicare claims processed rose 70 percent, while HCFA's budget for reviewing claims grew less than 11 percent. Adjusting for claims growth and inflation, funding for review dropped from 74 cents to 48 cents per claim. As a result, the proportion of claims reviewed dropped from 17 percent to 9 percent. In the especially problematic home health area, reviews plummeted from 62 percent in 1987 to a target of 3 percent in 1996.

In many industries, it is standard operating procedure for businesses to fund independent audits of their compliance with Federal laws and regulations. For example, banks have paid for independent government financial and compliance audits since the 1800's. In fact, the Office of the Comptroller of the Currency is a special branch of the Treasury Department that is fully funded through fees it assesses for conducting bank audits. It's time we do the same for providers and suppliers who do business with the Medicare and Medicaid programs.

Health care spending consumes an ever-increasing portion of the Federal budget—now at least 20 percent. And the Federal Government pays a third of our Nation's health care bills—more than any other single source. We are the largest purchaser—isn't it time we become a wiser purchaser? And isn't it imperative that we have tighter reins on an area that consumes so many of our tax dollars?

Banks have for many decades borne the financial responsibility for demonstrating their legitimacy. It is an accepted cost of the privilege of keeping other people's money. Medicare and Medicaid providers are being given the privilege of taking taxpayers' money, without the corresponding responsibility for proving their legitimacy. The appalling level of fraud, waste and abuse in the programs is the unfortunate result.

HHS doesn't have the funding to audit all categories of providers that have abusive track records. Even if it did, taxpayers shouldn't have to foot the bill. Twenty three billion dollars says it's time to make Federal audits a cost of doing business with the Nation's largest health care payer, the Federal Government.

WE SHOULD BE DILIGENT IN OUR FIGHT AGAINST HEALTH CARE FRAUD

It's simple for me—individuals found to intentionally, systematically and repeatedly defraud Medicare and Medicaid should go to jail. We should have a zero tolerance for repeat offenders. We should not hide behind free market language as an excuse for criminal behavior. The fight against health care fraud should be aggressive and on-going. Medicare beneficiaries deserve the best we can offer—quality care at an affordable price with strong protections against unscrupulous providers.

The following is a summary of the bill:

I. Title I—Revisions to Sanctions for Fraud and Abuse

A. Subtitle A—Exclusion Authority

1. Sec. 101—Clarifies the application of mandatory exclusion based on felony convictions relating to controlled substances to individuals involved in health care.

2. Sec. 102—Clarifies the period of exclusion based on loss of license.

3. Sec. 103—Clarifies the application of sanctions to Federal health care programs.

B. Subtitle B—Civil Monetary Penalties

1. Sec. 111—Repeals the clarifications concerning levels of knowledge required for the imposition of civil monetary penalties.

2. Sec. 112—Allows for civil monetary penalties to be applied for services ordered or prescribed by an excluded individual or entity.

3. Sec. 113—Permits HHS to pursue civil monetary penalty actions after consulting with the Attorney General.

4. Sec. 114—Clarifies payment practice exception authority to definition of remuneration.

5. Sec. 115—Extends subpoena and injunction authority.

6. Sec. 116—Clarifies amounts of civil monetary penalties.

7. Sec. 117—Applies anti-dumping sanctions against physicians who refuse an appropriate transfer at a hospital with specialized capabilities or facilities.

C. Subtitle C—Criminal Penalties

1. Sec. 121—Kickback penalties for knowing violations

2. Sec. 122—Repeals expanded exception for risk-sharing contract to anti-kickback provisions

3. Sec. 123—Expands criminal penalties for kickbacks

4. Sec. 124—Treats certain Social Security Act crimes as Federal health care offenses

D. Subtitle D—Miscellaneous Provisions

1. Sec. 131—Repeals HIPAA advisory opinion authority

2. Sec. 132—Clarifies identification numbers to be used with adverse action data base

3. Sec. 133—Clarifies who may have access to information in adverse action data bank

II. Title II—Improvements in Providing Program Integrity

A. Subtitle A—General Provisions

1. Sec. 201—Limits the use of automatic stays and discharge in bankruptcy proceedings for provider liability for health care fraud.

2. Sec. 202—Requires certain providers to fund annual financial and compliance audits as a condition of participation under the Medicare and Medicaid programs

3. Sec. 203—Makes clear that Medicare carriers and fiscal intermediaries and State Medicaid agencies are liable for claims submitted by excluded providers.

4. Sec. 204—Reforms Medicare Hospital Outpatient Payment Policies.

5. Sec. 205—Standardizes forms used for certifications of medical necessity and certifications of terminal illness.

6. Sec. 206—No mark-up for drugs, biologicals or nutrients; requires use of national drug code numbers in Medicare claims.

7. Sec. 207—Adjusts hospital payments to reflect excess payment resulting from a financial interest with downstream facilities.

Subtitle B—Other Provisions

1. Sec. 211—Inclusion of cost of home health services in explanation of Medicare benefits.

2. Sec. 212—Prohibits "cold-call" marketing for Medicare+Choice plans.

III. Title III—Provider Enrollment Process—Fees

1. Sec. 301—Fees for agreements with Medicare providers and suppliers.

2. Sec. 302—Establishes requirements and fees for Medicare overpayment collections.

3. Sec. 303—Requires an administrative fee for Medicare overpayment collection.

IV. Title IV—Payment Improvements

A. Subtitle A—Mental Health Partial Hospitalization Services

1. Sec. 401—Limits location of provision of services.

2. Sec. 402—Clarifies qualifications for community mental health centers.

3. Sec. 403—Requires audit of providers of partial hospitalization services.

4. Sec. 404—Implements prospective payment system for partial hospitalization services.

5. Sec. 405—Provides for a demonstration program for expanded partial hospitalization services.

B. Subtitle B—Rural Health Clinic Services

1. Sec. 411—Decreases beneficiary cost sharing for rural health clinic services.

2. Sec. 412—Implements a prospective payment system for rural health clinic services.

CAMPAIGN FINANCE HEARINGS
ARE CREATING AN ATMOSPHERE
OF DISCRIMINATION AGAINST
ASIAN-AMERICANS

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 7, 1997

Mr. LANTOS. Mr. Speaker, a number of concerns have been expressed over the past few months regarding the manner in which Chairman BURTON and the majority members of the House Government Reform and Oversight Committee have conducted their investigation into campaign finance abuses during the 1996 election campaign. There have been complaints that the investigation is too partisan, that it is duplicative and poorly managed. After 9 months and literally millions in taxpayer funds, this investigation has been beset with delays, staff resignations, poorly conducted investigations, and bungled procedures.

At the recent meeting of the committee at which committee members voted to extend immunity to a few witnesses who will testify at a hearing later this week, I raised a matter of the most serious concern to me. Mr. Speaker, I would like to call to the attention of the House those concerns which I raised during the meeting of the committee.

Mr. Speaker, this House and the committee investigating campaign finance must be particularly sensitive about the possible discriminatory effects that the investigation may have on Asian-Americans. There is a grave danger that stereotyping and Asian bashing will become, and in many instances have become, part and parcel of this investigation.

There is a long history of discrimination against Asian-Americans in this country. We all remember chapters of that history, perhaps the most shameful of which is the incarceration of tens of thousands of United States citizens of Japanese origin during the Second World War.

This investigation, perhaps inadvertently, has contributed to stereotyping and race bait-

ing. As one who is singularly conscious of this issue, I want to call attention to this issue, because Asian-Americans have as much right to participate in the political process as do Americans of any other national origin. Deliberately or otherwise, Asian-Americans have been the target of both of these investigations to an unacceptable and overwhelming degree.

While some might consider the question of Asian bashing ludicrous and outrageous. Organizations representing Asian-Americans do not. A petition with the U.S. Commission on Civil Rights was filed on behalf of the leading organizations representing Asian-Americans. These organizations believe that members of some of this Nation's most important institutions have acted irresponsibly and carelessly to allegations of campaign finance wrongdoing by scapegoating and stereotyping of Asian-Americans.

In point of fact, affiliates and subsidiaries of foreign-owned corporations have made vastly greater contributions to both political parties than the issues that we are dealing with in the Burton investigation. A Canadian-owned corporation gave \$2 million to the political parties. An Australian-owned corporation gave \$674,000, and an additional \$1 million to the California Republican Party. Brown and Williamson, a British-owned tobacco company, gave \$642,000.

None of these foreign-owned corporations have been the subject of any inquiry by either the Senate or House committee. As a matter of fact, in July, the Federal Election Commission levied the largest fine in history on a foreign contribution, and that contribution was made by a citizen of German origin. He has not been hauled before either committee.

Mr. Speaker, it would be absurd and an escape from reality to argue that there is not an Asian tone to these hearings. It is my hope that as hearings in the House commence that we will all remain acutely conscious of these most sensitive issues.

IN HONOR OF NEW YORK STATE
SENATOR LEONARD P. STAVISKY

HON. CHARLES E. SCHUMER

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 7, 1997

Mr. SCHUMER. Mr. Speaker, one of the pleasures of serving in this legislative body is the opportunity we occasionally get to acknowledge publicly outstanding individuals in our communities.

The Franklin D. Roosevelt Democratic Association of New York will be presenting its first ever Life-Time Achievement Award to State Senator, and dear friend of mine, Leonard P. Stavisky. To list the accomplishments of this great man would take up more pages that I would be allocated in the CONGRESSIONAL RECORD. To those of us who know him so well, I do not have to tell you of the Senator's accomplishments in the field of education, city and State government, and the many issues with which he has been involved. I am just amazed that one person could accomplish so much.

I congratulate you Leonard for over 30 years of service dedicated to the public good. Your example and your friendship over the years has meant so much to me, and I am