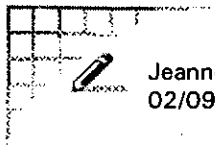
NLWJC - Kagan

DPC - Box 029 - Folder 018

Health - Medicare Fraud & Abuse

Health- Medicare - fraud



Jeanne Lambrew
02/09/99 03:44:44 PM

Record Type: Record

To: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP

cc:
Subject: Medicare fraud news

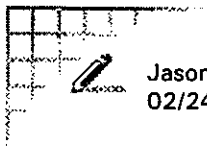
Chris may have already let you know about this, but just in case:

HHS Office of Inspector General press conference on Medicare fraud. On Tuesday, the independent, OIG held a press conference to announce its annual report on improper Medicare payments. (we just learned of it today). It found:

Error rate down by 35 percent from last year, 50 percent from 1996. In FY 1997, the OIG estimated that Medicare made $20 billion on improper payments; in 1998, this amount was reduced to $12.6 billion. This improvement was attributed to improved program oversight and enforcement and greater provider compliance.

"Examples of improper payments include a community mental health center that was paid $21,421 for services later determined by medical reviewers to be medically unnecessary. In another case, a skilled nursing facility billed Medicare $10,428 for a 51-day skilled-nursing stay by an elderly patient. Because medical records showed that the patient received only maintenance-level, nonskilled care, the payment was denied. In a third case, a physician billed Medicare $871 for 40 hospital visits. The medical records, however, supported only 18 visits. In each of these instances, and in all other cases where improper payments were specifically identified, action was taken to deny the claim and to recover the overpayment."

Health - Medicare fraud



Jason H. Schechter
02/24/99 11:46:40 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: Statement by the President: Medicare

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 24, 1999

STATEMENT BY THE PRESIDENT

I am pleased to join the Department of Health and Human Services, the Department of Justice and the AARP in launching the new "Who Pays? You Pay" campaign, a new initiative to combat fraud and abuse in the Medicare program.

This new campaign is another step towards ending the fraudulent practices that rob taxpayers and threaten the future of the Medicare trust fund. Today, we are partnering with beneficiaries to teach them how to detect Medicare fraud. We have worked with, and we will continue to work with, those in the provider community who are equally committed to eliminating health care fraud.

We have a long-standing commitment to crack down on fraud, waste, and abuse, and I am proud to say that since 1993, the Administration's efforts have saved taxpayers more than $38 billion, with health care fraud convictions increasing by more than 240 percent. The partnership between providers, the law enforcement community, and beneficiaries created by this initiative is a critical step towards ending waste, fraud, and abuse in the Medicare program. Physicians, nurses, hospitals, and nursing homes know that it is in everyone's best interest to weed out the bad apple providers who threaten our ability to provide high-quality and affordable health care for older Americans.

I congratulate Secretary Shalala, Attorney General Reno, and the AARP for their commitment to preserve the Medicare program and ensure the provision of high-quality, affordable health care to our senior citizens.

Health - Medicare fraud

PRESIDENT CLINTON:
FIGHTING MEDICARE FRAUD, WASTE AND ABUSE

December 7, 1998

"For more than 30 years, Medicare has been much more than a government program. It has been a way for us to honor our obligations to our parents and grandparents. Medicare is an expression of the old and profound American belief that the bonds of mutual love and support between the generations must remain strong. Any threat to Medicare is a threat to these sacred bonds."

President Clinton
December 7, 1998

Today, at a White House event, President Clinton unveils a new legislative package that will save Medicare over $2 billion by combating fraud, waste and abuse. In addition, the President announces new administrative efforts to ensure that Medicare contractors are cracking down on fraudulent activities.

NEW LEGISLATIVE PACKAGE TO SAVE MEDICARE. President Clinton will send Congress a comprehensive legislative package to fight fraud, waste and abuse in the Medicare program as part of his FY 2000 budget. The President's proposals, which will give HCFA more tools to root out fraud in the Medicare system, include:

- **Eliminating Excessive Medicare Reimbursement for Drugs**. A recent report by the HHS Office of Inspector General (OIG) confirms that Medicare pays hundreds of millions of dollars more for common and costly drugs than it would if it used market prices. The Administration's proposal bases Medicare payments on the actual acquisition cost of these drugs to the provider, eliminating mark-ups and substantially reducing Medicare costs.
- **Ending Overpayments for Epogen**. An OIG report found that the current reimbursement rate exceeds the current cost of the drug by at least 10 percent. This proposal reduces Medicare reimbursement to reflect current market prices.
- **Preventing Abuse of Medicare's Partial Hospitalization Benefit**. A recent OIG report found that providers are abusing Medicare by billing for partial hospitalization services that were never given or provided to fewer patients than billed for by providers. This proposal ensures that Medicare only reimburses for services actually given by placing stricter controls on the provision of services.
- **Ensuring Medicare Does Not Pay for Claims Owed by Private Insurers**. Private insurers of working Medicare beneficiaries are required by law to be the primary payer of health claims, but private insurers do not always pay these claims. This proposal requires private insurers to report all Medicare beneficiaries they insure to HCFA and gives HCFA greater authority to fine these insurers.
- **Empowering Medicare to Purchase Cost-Effective High-Quality Health Care**. Presently, Medicare has limited authority to contract out with institutions that have a track record of providing high-quality care at a reasonable price. This proposal expands this authority to urban areas that have multiple providers, which will enable Medicare to provide high-quality care at less cost.
- **Requesting New Authority to Enhance Contractor Performance**. HCFA does not have the authority it needs to terminate contractors who do not effectively perform their duties. This proposal would give HCFA authority to contract with a wider range of carriers and terminate them if they necessary. It would also have greater authority to oversee contractor performance.

NEW ACTIONS TO HELP ENSURE MEDICARE CONTRACTORS FIGHT FRAUD. The President's announcements about new administrative efforts to ensure contractors are cracking down on fraud and abuse include:

- **Contracting with Special Fraud Surveillance Units to Ensure Detection of Fraudulent Activities**. OIG reports show many Medicare contractors do a poor job of investigating fraud. The Administration fought to include in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) new authority to contract with specialized fraud surveillance units or "fraud fighters," which are better equipped to audit cost reports and conduct activities to detect fraud. The first fraud unit will begin this spring.
- **Implementing the Competitive Bidding Demonstration for Durable Medical Equipment**. The OIG found that Medicare rates for hospital beds are higher than rates paid by other payers. HCFA will begin a demonstration this spring that will use competitive bidding to decrease payments for hospital beds and other medical equipment, which will lower Medicare costs.
- **Requiring Contractors to Report Fraud Complaints to OIG Immediately**. Many contractors defer reporting cases of suspected fraud to the OIG when the dollar amounts are low. This month, HCFA will send memorandums to all contractors requiring them to refer cases of suspected fraud to the OIG immediately, regardless of the amount of money involved.
- **Announcing New Comprehensive Plan to Fight Fraud and Abuse**. By early next year, HCFA will release a new Comprehensive Plan for Program Integrity to improve efforts to cut down on fraud and abuse. This plan will outline new strategies to fight fraud, including the enhanced use of audits and improved management tools.

BUILDING ON A COMMITMENT TO FIGHTING FRAUD, WASTE AND ABUSE. The President's announcements today build on the Administration's longstanding commitment to cracking down on fraud, waste and abuse in the Medicare system. Since 1993, the Administration's efforts have saved taxpayers more than $20 billion, with health care fraud convictions increasing by more than 240 percent.

Health – children's coverage
and
Health – Medicare fraud + abuse

Hope you go Elena.
Sorry for not getting this to you sooner.

MEMORANDUM

January 15, 1997

TO: Rahm

FR: Chris

RE: Fraud and Children's Health

cc: Bruce and Gene

As per your request, here is an outline of the anti-fraud announcement that I think can be made next week. Also attached is the children's health announcements that we discussed that we can (and in my opinion) should make.

Anti-Fraud and Abuse Announcement. We could do this either as an event that Donna and Janet Reno do sometime earlier in the week (remember Melissa wants it as soon as possible) or we can wait for the Saturday radio address with the President. Regardless, any such announcement would release:

- The first Justice/HHS/IG report following the enactment of the Kennedy/Kassebaum law, which empowered and provided full funding for our ongoing anti-fraud and abuse enforcement activities. The report touts we have captured and returned to the Medicare Trust Fund $1 billion.

- A new regulation that requires medical equipment suppliers to purchase surety bonds to ensure the Trust Fund is protected when fraudulent suppliers go bankrupt and/or are caught cheating Medicare.

- A new requirement directing HHS to conduct on-site inspections for medical equipment suppliers to ensure that they are, and continue to be, legitimate providers of goods and services.

- (We could also release some or the rest of our anti-fraud and abuse initiatives that are currently in the budget to pay for the Medicare buy-in; most fall in the abuse, rather than the fraud categories, but it could be helpful in illustrating our ongoing commitment. If we can come up with any others, we can throw those in as well).

CHILDREN'S HEALTH IDEAS:

Leak Out Good News About Children's Outreach Initiative to NY TIMES for Monday, which responds directly to the President's concern about the 3 million uninsured children eligible, but not enrolled in Medicaid. Pear is extremely interested in this population and would doubtless love to do a piece on what we are doing administratively and in the budget for this population. I believe he would play up the story big for the POTUS and the FLOTUS, since these policies are popular state option proposals, which will get validation from Governors and children's groups. Pear will likely validate the policies because there is some money behind them, but the good news is it doesn't sound like big money -- less than $200 million a year.

Schedule Event in February With President and First Lady Announcing First States Taking Advantage of New Children's Health Provisions Included in the BBA. We have two, perhaps as many as four, states that are on the cusp of being approved as the first states coming on line for the new Children's Health Insurance Program (CHIP). Two states have Democratic Governors and two states have Republican Governors. We could do a great event in which Republicans and Democrats would have every reason to sing the praises of this new program and the kids it will cover.

And, by the way, we could set up additional such state-approval events with the First Lady in all sorts of positive settings -- like in child care programs and schools -- where our new outreach proposals will work toward signing up hundreds of thousands of children.

As always, these events need some time to prepare to do well. Please give us as much advance notice as possible. Clearly, it would extremely helpful if we could get closure on these issues sometime tomorrow.

Health –
Medicare fraud + Abs

PRESIDENT CLINTON ANNOUNCES UNPRECEDENTED PROGRESS IN FIGHTING MEDICARE FRAUD AND ABUSE

January 23, 1998

Today, President Clinton announced the first annual Justice/Health and Human Services progress report on the nation's successful efforts in cracking down on Medicare fraud and abuse. He also unveiled a series of new legislative and executive actions to build on the Administration's impressive record in this area including:

- **A Justice/HHS Report Which Documents Nearly $1 Billion Returned to the Medicare Trust Fund in Just One Year**
- **A 10-Step Anti-Fraud and Abuse Legislative Package That Saves Medicare At Least $2 Billion**
- **Unprecedented Steps To Involve Medicare Beneficiaries in Identifying and Combating Fraud and Abuse**
- **Nationwide On-Site Inspections To Target Medical Supplier Rip-Off Artists**
- **A Nationwide Conference, With Law Enforcement Officials and Others, Designed To Identify the Next Steps To Fight Fraud and Waste**

A Justice/HHS Report Which Cites Nearly $1 Billion in One Year in Savings For the Medicare Trust Fund. On Monday, the President is sending the first annual report of the Health Care Fraud and Abuse Control Program -- created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) -- which shows remarkable progress in rooting out health care fraud and abuse. In FY1997 alone, the first full year of anti-fraud and abuse funding under HIPAA, the Federal government recorded the most successful year ever in the nation's efforts to detect and punish fraud and abuse against Medicare. These efforts:

- **Returned nearly $1 billion to the Medicare Trust Fund** from collections of criminal fines, civil judgements and settlements, and administrative actions. This was the largest recovery amount ever collected in one year.
- **Excluded more than 2,700 individuals and entities from doing business** with Medicare, Medicaid, and other federal and state health care programs for engaging in fraud or abuse -- a near doubling (a 93 percent increase) over 1996.
- **Increased convictions for health care fraud-related crimes** by nearly 20 percent.
- **Opened 4,010 civil health care matters** -- an increase of 61 percent over 1996.

A New 10-Step Anti-Fraud and Abuse Legislative Package That Saves Medicare At Least $2 Billion Over Five Years, including the following:

- **Eliminating overpayments for certain drugs**, which the Inspector General has reported Medicare currently overpays for;
- **Ensuring Medicare does not pay for claims that ought to be paid by private insurers,** such as taking steps to ensure that Medicare is aware of liability settlements and of other coverage obligations of private insurers;
- **Asking providers that may be cheating Medicare to pay for a portion of their audits,** which will allow Medicare to double the number of audits and weed more risky providers out of the program;
- **Ensuring that providers do not leave Medicare strapped with bills by declaring**

bankruptcy.

Unprecedented Steps To Involve Medicare Beneficiaries in Identifying and Combating Fraud and Abuse. The President is announcing new steps to involve Medicare beneficiaries in rooting out fraud and abuse, such as:

- **Providing beneficiaries with new information on how to report fraud.** Starting next month, Medicare beneficiaries across the nation will receive a toll free number to call to report fraud and abuse in Medicare on every statement, bill, and claim, making it easier to crack down on fraud and abuse; and
- **Rewarding beneficiaries for fighting fraud.** Provisions in the Kassebaum-Kennedy legislation will be implemented this spring that give beneficiaries rewards for reporting fraud (what percentage will we reward? And is there is minimum and maximum).

Nationwide On-Site Inspections To Eliminate Rip-Off Artists and Scam Medical Equipment Suppliers. To ensure that medical equipment suppliers are providing medical devices they claim they are, the President is directing the Health Care Financing Administration to conduct nationwide on-site inspections of medical suppliers.

An Unprecedented Conference To Bring Together Law Enforcement, Providers, Beneficiaries, and Others To Identify the Next Steps To Fight Fraud and Waste. While the Administration has a long record of fighting fraud and abuse, we must do more. Today, the President is announcing that this spring, the Health Care Financing Administration will hold a conference including consumers and their representatives, law enforcement officials, private insurers, health care providers, and beneficiaries, to build on the successes we have achieved in fighting fraud and abuse in the nation's health care system.

Health - medicare fraud

'97 DEC 12 P4:05

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON MEDICARE FRAUD
DECEMBER 13, 1997

Good Morning. I'd like report to you today on the latest challenges in our fight against waste, fraud and abuse in our Medicare system -- and to share with you how we must address them. Medicare and Medicaid are more than just programs; they are the way we honor our parents and the seniors who dedicated their lives to making this country strong and prosperous, the way we strengthen the families who keep our social fabric together, the way we provide our poorest children a fair and healthy start in life.

Waste, fraud and abuse in Medicare and Medicaid diminishes our ability to provide high-quality, affordable care for our citizens. These activities rob taxpayers even as they harm our most vulnerable citizens. Medicare fraud alone costs billions of dollars every year, amounting to an unfair fraud tax on all Americans, but especially on senior citizens who have to pay higher premiums and out-of-pocket costs. Our taxpayers have a right to expect that every cent of their hard-earned money is efficiently and effectively spent on high quality medical care for deserving patients.

That is why we have worked hard to crack down on waste, fraud and abuse in Medicare and Medicaid. Since 1993, we have assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 240 percent and we have saved some $20 billion in health care claims. Two years ago, the Department of Health and Human Services launched Operation Restore Trust, which has already recovered $187.5 million in fines and settlements. This year's historic Balanced Budget Act, which ensured the life of the Medicare Trust Fund for another decade, also gave us an array of new weapons in our fight to keep scam artists and fly-by-night health care out of Medicare and Medicaid. And earlier this fall, I announced new actions -- from a moratorium on new Medicare applicants to a doubling of audits to a certification renewal process -- to root out fraud and abuse in the home health industry.

Sometimes the waste and abuses aren't even illegal, but embedded in the system. Last week, the Department of Health and Human Services found that our Medicare program has been systematically overpaying doctors and clinics for prescription drugs -- overpayments that last year alone cost taxpayers some $447 million. Such waste is simply unacceptable. These overpayments occur because Medicare reimburses doctors according to the published average wholesale price -- "the sticker price" -- for drugs. Few doctors, however, actually pay full sticker price. In fact, some pay just one tenth of the published price. That is why I am sending to Congress the same legislation I sent last year -- legislation that will ensure doctors are reimbursed no more and no less than the price they themselves pay for the medicines they give Medicare patients. A more modest version of this bill passed last summer, but the savings to taxpayers is not nearly enough. We must do more. The legislation I support will save $700 million over the next five years. I urge Congress to pass it.

There is no room for waste, fraud and abuse in Medicare and Medicaid. Only by putting a permanent stop to it can we honor our parents, protect our taxpayers and build a world-class health care system for the 21st century.

Health -
medicare fraud + abuse

THE PRESIDENT HAS SEEN
9-22-97

Modernization For Medicare Grinds to Halt

A1

By ROBERT PEAR

WASHINGTON, Sept. 15 — The Clinton Administration has terminated the contract for a vast new Medicare computer system that had been promoted as a way to speed payment of claims, improve customer service and combat fraud in Medicare, the nation's largest health insurance program, officials said today.

GTE, the main contractor, had been hired to consolidate and modernize Medicare's far-flung computer systems. But those systems were so antiquated and complicated that they thwarted the company's efforts.

Federal officials said the job of straightening out Medicare's computers had turned out to be far more complicated than they had anticipated — in part because Federal officials did know exactly what the current system, run by 72 private insurance companies around the country, was actually doing.

Medicare officials said the computer project, known as the Medicare transaction system, was behind schedule, over budget and plagued with problems.

The project was supposed to create a single national computer system to pay doctors, hospitals, laboratories, nursing homes, health maintenance organizations and others who care for Medicare patients.

Medicare officials said today that they would now try a more gradual approach, working on individual pieces of the system rather than tackling the entire project at once.

In a letter to GTE, Bartlett C. Smetana, a contract officer at the Department of Health and Human Services, ordered the company to "stop all work, make no further shipments, place no further orders and terminate all subcontracts," except for a small amount of work on computer software to handle payments to H.M.O.'s. The letter is dated Aug.

Continued on Page A26

Continued From Page A1

15, but it was made available by Administration officials today.

Laurie L. Boeder, a spokeswoman for the department, said: "GTE was not performing adequately. The cost and pace of work on the contract were unacceptable."

Robert E. Doolittle, a spokesman for the government systems unit of GTE, which had 90 people working on the Medicare project, said: "We regret that the Government terminated our contract. The project was far more complex than anyone anticipated at the time we were hired to develop the system in 1994."

Until a few months ago, Medicare officials were consistently upbeat in their public statements about the new computer system and brushed aside the skepticism expressed by Congressional auditors.

In announcing the contract with GTE in January 1994, Donna E. Shalala, the Secretary of Health and Human Services, said, "We're going to move from the era of the quill pen to the era of the superelectronic highway." She said the new computers would pay one billion bills a year, drastically reducing the need for people to file claims on paper.

Medicare claims are now reviewed and paid by 72 contractors using at least 10 computer systems, with many local variations and adaptations. Some variations reflect differences in local medical practices. Most of the contractors are Blue Cross and Blue Shield plans or private insurers like Aetna and Cigna.

Administration officials had said the new computer system would take Medicare into the 21st century. Vice President Al Gore cited it as an example of the new "health information infrastructure."

Medicare benefit payments are expected to rise 50 percent in the next six years, to $300 billion in 2003.

An overhaul bogs down in Medicare's complexity.

In November 1996, Dr. Shalala told the White House, "An acceptable alternative to the Medicare transaction system does not currently exist." She said the new computer system would help investigators combat fraud by detecting suspicious billing patterns, including unnecessary services and the submission of multiple claims for the same services.

In a recent audit, June Gibbs Brown, inspector general of the Department of Health and Human Services, said that Medicare had overpaid health care providers by $23 billion last year. Outdated computer systems were unable to detect erroneous payments, she said.

Representative Bill Thomas, the California Republican who is chairman of the Ways and Means Subcommittee on Health, said he was pleased that the Government had terminated the GTE contract. He dispatched auditors to determine how much had been spent on it.

Estimates of costs varied. Ms. Boeder said the Government had spent $43 million. GTE said it had received $30 million.

Documents from the Federal Health Care Financing Administration, which runs Medicare, indicate that the Government made "net investments" of $102 million in the new computer system from January 1994 to September 1996.

"The total amount of the GTE cost overrun is $65.3 million," one of the documents says. "Both H.C.F.A. and GTE underestimated, in their planning, the number and complexity of Medicare requirements."

The Federal Government has spent more than $200 billion on information technology in the last decade, and the General Accounting Office, an investigative arm of Congress, said it had observed similar problems at other agencies with ambitious computer projects, like the Federal Aviation Administration and the Internal Revenue Service.

Mr. Thomas said he was concerned that with the end of the fiscal year just two weeks away, tens of millions of dollars earmarked for the new Medicare computer system would be used for other purposes instead of being returned to the Treasury. Ms. Boeder said the money "will go back to the Treasury."

Auditors from the accounting office said Medicare officials had never clearly defined the requirements for their new computer system and had repeatedly changed the requirements. In addition, they said, Medicare and GTE officials started to design the new computer system before they had fully defined the requirements, so it was almost certain that technical problems would occur.

In a report in early 1995, the Government said the new Medicare computer system would begin "live processing of Medicare claims in September 1997" and be "fully operational in September 1999."

John J. Callahan, the Assistant Secretary of Health and Human Services in charge of the budget, told the White House in November that the Medicare transaction system would save almost five times as much as it cost. He estimated that the savings would total $3 billion from 1999 to 2006.

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Reed
Jennings
COS

The New York Times
TUESDAY, SEPTEMBER 16, 1997

Health - medicare fraud/abuse

MEMORANDUM

September 15, 1997

TO: Bruce, Elena

FR: Chris and Sarah

RE: Paper for SEIU speech

Attached is the background paper for the President's SEIU speech today including:

(1) One-pager on fraud announcement;

(2) One-pager on the President's overall accomplishments in fraud;

(3) One-pager on legislation on quality and consumer protections the President is urging Congress to pass today; and

(4) Q&As

Please call with any questions.

PRESIDENT CLINTON UNVEILS NEW WEAPONS TO FIGHT FRAUD IN HOME HEALTH CARE

Today President Clinton added three new weapons to the anti-fraud arsenal to combat fraud and abuse in the home health industry. The President announced: (1) an immediate moratorium on all new home health providers coming into the Medicare program; (2) a new renewal process for home health agencies currently in the program; and (3) a doubling of audits that will help weed out bad apple providers. These actions are consistent with recommendations by the Inspector General at the Department of Heath and Human Services following a recent report on fraud in the home heath care industry.

DECLARING A FIRST EVER MORATORIUM TO STOP HOME HEALTH PROVIDERS FROM ENTERING THE PROGRAM. The moratorium will give the Administration the opportunity to implement new regulations to provide better safeguards and protections to screen out problem home health providers. This action is consistent with strong evidence that the best way to stop fraud and abuse in our Medicare program is to prevent bad apple providers from ever entering the program. Home health care is the most rapidly expanding part of Medicare, with nearly 100 new home health providers entering Medicare each month. This moratorium -- which will authorize the Department to grant exceptions for areas of the country with no access to home health care services -- will be in place about six months until a new regulation. It will enable HHS to implement regulations to help prevent risky providers including:

- **Posting surety bonds of at least $50,000:** Home health agencies will be required to post surety bonds of at least $50,000 before they can enroll or re-enroll in Medicare. Surety bonds have proved to be an effective way to prevent bad apple providers from entering Florida's Medicaid program;

- **Requiring a minimum number of patients prior to seeking Medicare enrollment:** This will require home health agencies to establish an agency's experience in the industry before serving Medicare enrollees; and

- **Targeting home health agencies more likely to abuse Medicare:** This regulation will require home health agencies to submit detailed information about all of the businesses they own. This will ensure they do not use shaky financial transactions to exploit Medicare, such as preventing billing through companies that do not exist or are unauthorized to bill Medicare for services. This loophole allowed one home health agency in Georgia to defraud Medicare of $16.5 million before being found and convicted.

IMPOSING TOUGH NEW STANDARDS ON HOME HEALTH AGENCIES THROUGH A NEW REENROLLMENT PROCESS. Under this new rule, HCFA will re-enroll home health providers every three years. Home health agencies will be required to submit an <u>independent</u> audit of its records and practices at the time of re-enrollment. The new regulations HHS will implement during the moratorium will apply to <u>all</u> home health agencies -- making it easy to kick out fly-by-night operators who are more likely to cheat Medicare. Currently HCFA can kick providers out of Medicare only if they have been convicted of fraud.

DOUBLING THE NUMBER OF AUDITS AND INCREASING CLAIMS REVIEWS TO WEED OUT BAD APPLE PROVIDERS. HCFA will nearly double the number of comprehensive home health agency audits it performs each year -- from approximately 900 to 1800. They will also increase the number of claims reviews by 25 percent from 200,000 to 250,000. This increased oversight will build on HHS efforts already underway to increase investigations, prosecutions, and audits under Operation Restore Trust, the Department's comprehensive initiative.

PRESIDENT CLINTON ADDS THREE NEW WEAPONS TO BUILD ON STRONG RECORD OF FIGHTING FRAUD AND ABUSE

Today President Clinton added three new weapons to the anti-fraud arsenal to combat fraud and abuse in the home health industry. The President announced: (1) an immediate moratorium on all new home health providers coming into the Medicare program to allow the Health Care Financing Administration to implement new regulations to prevent fly-by-night providers from entering Medicare; (2) a new renewal process for home health agencies currently in the program to ensure that all Medicare providers have to abide by these tough new regulations; and (3) a doubling of audits that will help weed out bad apple providers. These actions are consistent with recommendations to reduce fraud in home health by the Inspector General at the Department of Heath and Human Services following a recent report on fraud in the home heath care industry. These new initiatives build on the President's unprecendented record of fighting fraud and abuse in Medicare and Medicaid.

Took Strong Action to Fight Fraud and Abuse Right When He Took Office. The President's first budget closed loopholes in Medicare and Medicaid to crack down on fraud and abuse. In 1993, the Attorney General put fighting fraud and abuse at the top of the Justice Department's agenda. Through increased resources, focused investigative strategies and better coordination among law enforcement, the Justice Department increased the number of health care fraud convictions by 240 percent between FY1993 and FY1996 and we have saved taxpayers more than $20 billion.

Launched Operation Restore Trust -- a Comprehensive Initiative to Fight Fraud and Abuse in Medicare and Medicaid. Two years ago the Department of Health and Human Services launched Operation Restore Trust, a comprehensive anti-fraud initiative in five key states. Since its inception, Operation Restore Trust has identified $23 for every one dollar invested; identified more than $187.5 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties owed to the Federal Government.

Obtained Additional Resources to Fight Fraud and Abuse When the President Signed Into Law Kassebaum-Kennedy Legislation. In 1996, the President signed the Health Insurance Portability and Protection Act (Kassebaum-Kennedy) into law which, for the first time, created a stable source of funding for fraud control. This legislation is enabling HHS to expand Operation Restore Trust to twelve states.

Passed New Initiatives to Combat Fraud and Waste Proposed by the President in the Balanced Budget Act of 1997. The Balanced Budget Act the President signed into law in August also included important new protections to fight fraud and abuse in Medicare and Medicaid. These new initiatives included:

- requiring providers to give proper identification before enrolling in Medicare;
- implementing new penalties for services offered by providers who have been excluded by Medicare or Medicaid;
- establishing guidelines for the frequency and duration of home health services;
- clarifying the definition of part-time or intermittent nursing care which will clarify the scope of the Medicare benefit and will make it easier to identify inappropriate services;
- establishing a prospective payment system (PPS) for home health services to be implemented in FY 1999, enabling HCFA to stem the excessive flow of home health care dollars;
- clearly defining skilled services so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs a simple service such as their blood drawn;
- and eliminating periodic interim payments that were made in advance to agencies and not justified until the end of the year.

PRESIDENT CLINTON CALLS ON CONGRESS TO PASS EXISTING LEGISLATION TO IMPROVE CONSUMER PROTECTIONS AND QUALITY HEALTH CARE

Today in his speech before the Service Employees International Union (SEIU), President Clinton called on the Congress to take immediate action to pass existing legislation to improve consumers protections and quality health care. The President asked Congress to pass right away three bills currently before it that he has already endorsed that would: (1) ensure women are allowed to stay in the hospital at least 48 hours after a mastectomy; (2) put in place anti-gag rules that give patients the right to know their treatment options; and (3) prevent health plans to discriminate on the basis of genetic information. The President also asked Congress to work to pass legislation to adopt the new strong federal standards on medical privacy.

Implementing Anti-gag Rules for Private Health Plans. Patients should have the right to be informed of all of their treatment options -- not just the cheapest. The President has already banned gag rules that prevented doctors from telling Medicare and Medicaid patients about all their options for treatment. Today he is calling on Congress to do its part -- pass legislation protecting patients in private health care plans so that no American is left in the dark about how best to treat his or her illness. President Clinton encouraged Congress to pass legislation similar to that proposed by Representative Ganske and Representative Markey.

Allowing Women to Stay in the Hospital at Least 48 Hours Following a Mastectomy. This legislation -- sponsored by Representative DeLauro and Senator Daschle and already endorsed by the President -- would ensure that a women will be allowed to stay in the hospital at least 48 hours undergoing a mastectomy. It would guarantee that decisions of when to leave the hospital are made between a woman and her doctor rather than a health plan. Earlier this year, the First Lady brought national attention to the horrifying practice of kicking women out of the hospital on the same day they undergo mastectomies. The President strongly encouraged the Congress to hold hearings and pass legislation on this important issue.

Preventing Health Plans From Discriminating on the Basis of Genetic Information. Important advances in genetics are offering new potential to identify hidden genetic disorders and spur early treatment. While these new strides will fundamentally change the way that we treat diseases, genetic information can also be used to discriminate against or stigmatize individuals. President Clinton called on Congress to pass legislation that will prevent health plans from denying or dropping coverage or raising premiums on the basis of genetic information. The President has already endorsed the principles of the legislation introduced by Representative Slaughter and Senator Snowe. In a similar vein, later this year the Administration will release a report which makes recommendations to prevent discrimination based on genetic information in the workforce. The President encourages the Congress to move forward on that issue as well.

Adopting Strong New Federal Standards to Protect Medical Privacy. Medical records were once protected by our family doctors -- who kept handwritten records about us sealed away in big file cabinets. Today, revolutions in the health care delivery system mean that entire networks of insurers and health care professionals have access to this now computerized private and personal information. Today the President called on Congress to enact legislation to protect medical privacy in the information age and to adopt the new strong federal standards on privacy such as those issued by Secretary Shalala last week.

FRAUD ANNOUNCEMENT IN THE PRESIDENT'S SEIU SPEECH
QUESTIONS AND ANSWERS

Q: HOW CAN YOU JUSTIFY IMPOSING A MORATORIUM ON HOME HEALTH CARE AGENCIES? CERTAINLY MOST OF THESE AGENCIES ARE PROVIDING MUCH NEEDED CARE FOR MEDICARE BENEFICIARIES.

A: There is an urgent need to make fundamental changes in the way that Medicare does business with some home health care providers. We already have over 10,000 home health providers. Currently, almost 100 new home health care providers enter Medicare each month.

In response to concerns about unbridled growth in this industry and growing evidence of fraud, the Inspector General recommended imposing a moratorium in a recent report on the problems of the home health care industry. There is strong evidence that the best way to prevent fraud and abuse is to prevent bad apple providers from getting into the program in the first place. Today's action will enable HCFA to focus on implementing strong new regulations to provide new safeguards and protections to ensure that fly-by-night providers do not get in Medicare in the first place.

Q: BUT WON'T THIS DENY OLDER AMERICANS ACCESS TO MUCH NEEDED HOME HEALTH SERVICES?

A: Not at all. The moratorium will authorize the Department to grant exceptions for areas of the country with no access to home health care services.

Q: HOW LONG WILL THE MORATORIUM BE IMPOSED FOR?

A: The moratorium will only be in place for about six months, while the Department of Health and Human Service implements the new regulations.

Q: IS THIS THE FIRST MORATORIUM THAT MEDICARE HAS EVER IMPOSED?

A: This is the first ever moratorium that HCFA has ever imposed on the home health industry. However, HCFA recently imposed a moratorium on Durable Medical Equipment providers in Florida.

This moratorium was recommended by the Inspector General in her recent report on the problems in the home health industry. With nearly 100 new home health agencies per month, it is critical that HCFA take time to implement strong new regulations to ensure that fly-by-night providers cannot get into the Medicare program.

Q: WHERE DOES THE AUTHORITY TO IMPOSE THE MORATORIUM COME FROM AND WHEN WILL IT BEGIN?

A: The Secretary of Health and Human Services has the responsibility and the authority to ensure the fiscal soundness of providers who give care to Medicare beneficiaries. This moratorium will begin immediately so the Department can begin implementing the new regulations to provide new protections to keep risky home health providers out of the program.

Q: WHAT WILL THE NEW REGULATIONS DO?

A: The new regulations will enable HHS to implement strong new protections and safeguards to help prevent risky providers from entering Medicare including:

- **Posting surety bonds of at least $50,000:** Home health agencies will be required to post surety bonds of at least $50,000 before they can enroll or re-enroll in Medicare. Surety bonds have proved to be an effective way to prevent bad apple providers from entering Florida's Medicaid program;

- **Requiring a minimum number of patients prior to seeking Medicare enrollment:** This will require home health agencies to establish an agency's experience in the industry before serving Medicare enrollees; and

- **Keeping out home health agencies likely to fraudulently bill Medicare:** This regulation will require home health agencies to submit detailed information about all of the businesses they own. This will ensure they do not use shaky financial transactions to exploit Medicare, such as preventing billing through companies that do not exist or are unauthorized to bill Medicare for services. This loophole allowed one home health agency in Georgia to defraud Medicare of $16.5 million before being found and convicted.

Q: WILL YOU NEED LEGISLATION TO IMPLEMENT THESE NEW REGULATIONS?

A: No. Some of the regulations are from legislation that was part of the Balanced Budget Agreement the President signed into law this summer. The other regulations HCFA has the authority to implement without legislation.

Q: SOME OF THE HOME HEALTH AGENCIES ALREADY SERVING THE MEDICARE PROGRAM ARE DEFRAUDING THE PROGRAM: WHAT IS THE PRESIDENT DOING ABOUT THE EXISTING PROBLEM PROVIDERS?

A: The President also announced today that he is doubling the number of audits -- from 900 to 1800 -- and increasing the number of claims reviews by 25 percent -- from 200,000 to 250,000. This will help HCFA weed out the bad apple providers already defrauding Medicare.

Second, the President is taking new action to require home health agencies to re-enroll in Medicare every three years. Home health agencies will be required to submit an independent audit of its records and practices at the time of re-enrollment. The new regulations HHS will implement during the moratorium will also apply to all home health agencies -- making it easy to kick out fly-by-night operators who are more likely to cheat Medicare. Currently HCFA can kick providers out of Medicare only if they have been convicted of fraud.

Q: WHAT ELSE HAS HCFA DONE TO ACT AGAINST THE PROBLEM PROVIDERS IN THE HOME HEALTH INDUSTRY IDENTIFIED BY THE INSPECTOR GENERAL?

A: During the past two years, HCFA has taken action to deal with many of the providers identified as problem providers by the Inspector General. Of the 698 agencies identified in the IG's recent report, HCFA has already taken action against the vast majority of them including:

- Collecting overpayments from 437 agencies;
- Referring an additional 75 to law enforcement; and
- terminating 67.

Q: WHY ARE THE ACTIONS THE PRESIDENT IS ANNOUNCING TODAY ONLY PICKING ON THE HOME HEALTH INDUSTRY? CERTAINLY FRAUD AND ABUSE EXISTS IN OTHER PARTS OF THE MEDICARE PROGRAM.

A: Home health care is one of the fastest growing industry in Medicare. Approximately 100 new home health care agencies are applying to get into the Medicare program each month. The Inspector General has recommended this moratorium on home health care providers so that HCFA can implement tough new regulations to keep risky, fly-by-night providers out of the program. There is strong evidence that the best way to stop fraud and abuse is to prevent bad apple providers from entering Medicare in the first place.

That being said, we are aware that fraud and abuse exists in other parts of Medicare. We have taken action in the past to address these problems, such as implementing Operation

Restore Trust -- a comprehensive anti-fraud initiative in five key states. The President will also be reviewing additional measures to stop fraud and abuse in other parts of the Medicare program and will take new action in these areas. Fraud and abuse is a serious problem that is undermining our health care system. We must do everything we can to stop it.

Health - Medicare fraud

THE PRESIDENT HAS SEEN
7-22-97

Chris —
You've seen this,
yes?
Elena

copied
Reed
COS

THE PRESIDENT HAS SEEN
7-22-97

Today's debate: FIXING MEDICARE

Medicare wastes billions as inept management rules

OUR VIEW **While debate rages over paring benefits, the system shovels away $23 billion a year in waste and fraud.**

The 32-year-old Medicare system just had its first comprehensive financial physical. And federal reviewers discovered it's ailing — badly.

In fact, the $300 billion medical system for the nation's 38 million elderly and disabled is a financial wreck.

Most disturbing is the news that 14 cents of every tax dollar spent on Medicare is spent to overpay doctors, hospitals and other health providers. In 1996 alone, taxpayers spent $23 billion on improper or illegal medical bills that should not have been paid — an amount so large that it outstrips any abuse in recent memory, $100 a year for every person in the country.

Some of the improper payments involved phantom documentation. Like the case of a doctor who was paid $523 for 10 hospital visits when he made only two.

Other claims were for unnecessary care. One home health agency, for instance, paid nearly $12,000 to provide physical therapy to a patient who didn't need it.

Of the medical bills audited, 30% contained mistakes. And reviewers say Medicare's actual error rate probably is even higher since the audit was designed to root out only the most obvious errors and fraud.

Perhaps the audit shouldn't have come as a suprise. The Health Care Financing Administration, which administers Medicare, was warned by auditors in 1994 about shoddy accounting systems. And outside critics have long contended that Medicare presents a tempting target for abuse. After all, the government reviews only 9% of the 800 million medical bills it pays each year.

But for five years, those who run the program have assured Congress that their fraud-fighting efforts were unparalleled. And even now, the problem isn't fully exposed. The program's accounting system is so chaotic that auditors had no way to review several billion-dollar accounts.

Wasting billions

Here's a breakdown of the overpayments uncovered in the Medicare audit:

Problem	% of total payment errors[1]	Value (billions)
Not medically necessary	[illegible]	[illegible]
Insufficient documentation	33%	$ 7.6
No documentation	[illegible]	[illegible]
Incorrect billing codes	9%	$ 2.0
Noncovered services	[illegible]	[illegible]
Other	3%	$ 0.6
Total	[illegible]	[illegible]

[1]percentages exceed 100 because of rounding)

Source: Office of the Inspector General, Department of Health and Human Services

For Congress, the error couldn't have come at a more awkward time. The amount squandered exactly matches the amount Congress plans to trim from Medicare benefits to balance the federal budget.

The bitter irony was not lost on Rep. Bill Thomas, R-Calif., who heads the subcommittee that oversees Medicare. He promised more money to combat medical fraud.

That, coupled with rigorous audits, should help. Fraud investigators for Travelers/Aetna Property Casualty Corp. recover $25 for every dollar spent on fraud control.

But such measures can only expose Medicare's flaws, not repair them.

For Medicare fraud to reach this point on the shock scale, its managers had to be incredibly inept. For years, they ignored horror stories from patients, providers and their own field representatives. They tinkered with a system that required fundamental reform. Even now, they insist they're on the right track.

Not likely. Without an overhaul, Medicare will never enjoy fiscal health.

THE PRESIDENT HAS SEEN
1-13-97

ensuring that drug users do not serve in high government positions with significant responsibility for law enforcement, including the enforcement of drug laws, outweighs a candidate's legitimate expectation of privacy.

- **GE Patent Infringement:** Eleventh hour negotiations averted a suit against the General Electric Company (GE) for patent infringement. NIH owns a patent for an enhancement of magnetic resonance imaging (MRI). GE makes and sells MRI machines including this capability, but GE refused to accept a license under the NIH patent arguing that its machines used techniques developed prior to the patent. On January 2, NIH asked DOJ to bring suit against GE. After negotiations produced little progress, DOJ informed GE that we would file suit. On December 31, GE agreed to purchase a license from NIH.

- **Health Care Fraud Guidelines:** Attorney General Reno and Secretary Shalala agreed upon a Health Care Fraud and Abuse Control Program and Guidelines as required by the Health Insurance Portability and Accountability Act of 1996. The program and guidelines are not public, but will be distributed in the near future to law enforcement and interested others. They emphasize process and broad goals, and cover (1) coordination of Federal, State, and local law enforcement programs to control fraud and abuse; (2) investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care; (3) enforcement of the civil, criminal and administrative statutes applicable to health care; (4) industry guidance, including advisory opinions, safe harbors, and special fraud alerts relating to fraudulent health care practices; and (5) establishment of a national data bank to receive and report final adverse actions against health care providers.

- **Louisiana Attorney Conduct Provision:** On December 23, the U.S. filed suit against the La. Supreme Court and the La. Bar Association, among others, seeking a declaration that a La. ethics rule governing subpoenas issued to lawyers is unconstitutional. The challenged ethics rule imposes special requirements on all attorneys licensed to practice by the La. bar, including federal prosecutors, who seek to subpoena a lawyer to appear in a grand jury or other criminal proceeding. The requirements include obtaining prior judicial approval of the subpoena after a hearing. The complaint alleges that this rule conflicts with federal rules of criminal procedure and interferes with the conduct of federal criminal investigations and prosecutions, and that such application is preempted by the Supremacy Clause of the Constitution. The suit asks the court to invalidate the rule as it applies to federal prosecutors and to permanently enjoin the state bar from enforcing the rule against federal prosecutors.

Health care -
Medicare fraud

March 25, 1997

MEDICARE FRAUD ANNOUNCEMENT

DATE:	March 26, 1997
LOCATION:	Roosevelt Room
BRIEFING TIME:	11:45 am - 12:15 pm
EVENT TIME:	12:15 pm - 12:45 pm
FROM:	Bruce Reed Chris Jennings

I. PURPOSE

You will be introducing new legislative initiatives to fight waste, fraud, and abuse in our health care system. These initiatives establish tough new requirements for individuals and companies that wish to participate in Medicare or Medicaid, and build on your strong record in this area. This event will also highlight the success of Operation Restore Trust in Florida -- one of the five states participating in your comprehensive anti-fraud initiative -- and your efforts to bring the Federal and state governments together to fight fraud and abuse.

II. BACKGROUND

In poll after poll, Americans report their belief that fraud and abuse is one of the biggest cost problems in our health care system. A recent study by the American Association of Retired Persons found that Americans believe that fraud and abuse is an enormous problem in our health care system.

Your strong efforts to fight fraud and abuse over the last four years have helped save more than $20 billion in health care claims through policy changes, penalties, recoveries, and claim denials. Your 1993 budget closed loopholes in Medicare and Medicaid that allowed waste and fraud and abuse. Two years ago, the Administration launched Operation Restore Trust, a comprehensive anti-fraud initiative in five key states that has produced returns of $10 for every $1 invested. The Kassebaum-Kennedy legislation you signed last year expanded Operation Restore Trust nationwide for the first time, creating a stable source of funding for fraud control. Your 1998 budget also contains a number of anti-fraud and abuse proposals intended to

root fraud out the home health agencies and skilled nursing facilities.

The legislation you are proposing today will build on these past successes by focusing on three areas: (1) preventing fraudulent providers from getting in the system in the first place. Evidence from Florida and elsewhere has revealed that the most effective way to fight fraud and abuse is to prevent potential fraud from ever entering the system; (2) improving more traditional enforcement, such as civil monetary penalties; and (3) minimizing abuses for providers in the system, such as assuring appropriate benefits for mental health benefits and linking hospice payments to the geographic location of the service.

III. PARTICIPANTS

Briefing Participants:
Secretary Shalala
Deputy Attorney General Jamie Gorelick
Governor Chiles
Erskine Bowles
Sylvia Mathews
John Podesta
Bruce Reed
Chris Jennings
Elena Kagan
Rahm Emanuel
Mike McCurry
Don Baer

Event Participants:
Secretary Shalala
Governor Chiles

Audience:
Deputy Attorney General Jamie Gorelick
Bruce Vladeck, Administrator of Health Care Financing Administration
June Gibbs Brown, Inspector General
Maryland Attorney General Joseph Curran
13 Representatives of the Senior Citizens organizations
HHS and Governor Chiles' Staff

IV. PRESS PLAN

Pool Press.

V. SEQUENCE OF EVENTS

- You will enter the Roosevelt Room accompanied by Secretary Shalala and Gov. Chiles.
- Secretary Shalala will proceed to podium. You and Gov. Chiles will take your seats.
- Secretary Shalala will make remarks and introduce Governor Chiles.
- Governor Chiles will make remarks and introduce you.
- You will make remarks, and potentially take questions from the Pool.
- The Pool will depart, and you can either greet the invited guests or depart.

VI. REMARKS

Remarks Provided by Speechwriters.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

Health Care Fraud

February 21, 1997

NOTE TO: Bruce Reed
Rahm Emanuel
Chris Jennings
Nancy Ann Min
Janet Murguia
Emily Bromberg
Barbara Wooley
Elena Kagen

Per our conversation yesterday, please find attached a summary description of the fraud and abuse proposals that could be included in an Administration initiative next month. Preliminary discussions with HCFA indicate that we could have legislative language ready by March 13.

Rich

Richard J. Tarplin

Attachment

cc: Melissa Skolfield

File: Health - Medicare fraud and abuse

ANTI-FRAUD and ABUSE LEGISLATIVE PROPOSALS

Proposals that OMB has Approved of for Inclusion in a "Spring" Anti-Fraud Bill:

Program Integrity

- **Social Security Numbers** - Under this proposal the Secretary would have the authority to require providers and suppliers to disclose their Social Security Numbers (SSNs). The SSA would be required to verify the validity of the SSNs.

  Rationale: With the knowledge of a national, unique personal identifier, this proposal would provide an important tool to improve our ability to deny entry into Medicare to fraudulent and unscrupulous providers and suppliers.

- **Provider Enrollment Process** - This proposal would authorize the Secretary to assess an application fee for all Medicare providers at times of enrollment or reenrollment. Under the new enrollment process, a corrective action plan would need to be instituted and any overpayment recouped before a provider would be given another billing number. Additionally, HCFA would have the authority to revoke a provider number if it is determined that the provider is engaged in fraud or abuse.

  Rationale: One of the most effective and efficient measures to combat Medicare fraud and abuse is the verification of provider enrollment applications to ensure that only legitimate health care providers are able to bill Medicare. Current law authorizes the Secretary to collect application fees from physicians. However, certain other provider types (e.g. DME suppliers) require a more comprehensive review and, as such, require incremental funding to satisfy enrollment requirements.

- **Enrollment Waiting Period After Denial** - This proposal would specify that if an application has been denied, there would be a six-month waiting period before the provider could reapply.

  Rationale: Instituting a six month waiting period would allow sufficient time for the applicant to meet the conditions of participation. Further a six month moratorium would prevent denied applicants the ability to inundate HCFA with applications that are not significantly different from the application that was denied.

Hospice

- **Prevent Duplicative Payments for Hospice Services** - This proposal would clarify that a hospice can receive payment from either Medicare or Medicaid for dually eligible beneficiaries, but not both.

Rationale: Under current law, when dual eligibles who are nursing home residents elect the Medicare hospice benefit, Medicaid continues to pay at least 95% of the full nursing home rate (which includes both room and board and to some extent, medical and social services) and Medicare pays the hospice per diem (which covers the provision of all hospice benefits, including medical nursing, home health aide, and social services). The nursing home would be expected to provide the palliative care.

- **Benefit Period Modifications and Limitation on Total Available Hospice Days** - This proposal would replace the current third and fourth hospice benefit periods with a finite number of thirty and/or sixty-day periods (after the two 90-day periods).

  Rationale: The hospice benefit is intended for beneficiaries with terminal illnesses. However, there have been instances where beneficiaries have been under the hospice benefit, for example, for more than two-years. This proposal would limit the hospice benefit by allowing a beneficiary to be able to use only 360 days of hospice care in their lifetime.

- **Limitation of Liability and Beneficiary Protection** - This proposal would clarify that if a hospice submitted a claim for a beneficiary that they had reason to believe was terminally ill we would pay the claim upon appeal. In this instance, neither the hospice nor the beneficiary would be liable for the services.

  Rationale: Under current law the beneficiary is unprotected and a hospice may seek full payment from the beneficiary for denied claims for hospice care furnished to the beneficiary.

- **Hospice Payment at Location of Service** - This proposal would link payment for hospice services to the zip code of the site where the service was furnished.

  Rationale: This proposal would ensure that payments reflect the prevailing costs in the areas where services are furnished, not the higher cost urban areas where agencies tend to locate their parent offices.