Mr. Chairman, and members of the Committee. I am Lewis Morris, Assistant Inspector General for Legal Affairs in the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS). I appreciate the opportunity to testify before you today on health care initiatives pursued under the False Claims Act. In particular, I wish to voice our very serious concerns about recent efforts to dilute the effectiveness of the Act, as the Act applies to the health care industry in this country.

There is before this Committee a proposal by the American Hospital Association (AHA) that would raise unprecedented barriers to the Government's ability to pursue those who knowingly or recklessly take advantage of our taxpayer-supported health care programs. We urge the Congress to weigh carefully the impact of this AHA proposal on worthy law enforcement efforts, and to reject its overly lenient standards for establishing health care fraud.

In my testimony, I will provide an overview of the extent of fraud and other systemic vulnerabilities, the available enforcement tools, the troubling ramifications of the AHA proposal, our national projects, and our extensive efforts to work proactively with industry to develop appropriate fraud prevention measures.

I. Extent of Fraud and Other Improper Practices

FYs 1996 and 1997 Financial Statement Audits of HCFA

Billing errors and billing fraud are costing Medicare billions of dollars.

Just last Friday, on April 24, 1998, the OIG issued its 1997 Financial Statement Audit of the Health Care Financing Administration (HCFA). We estimate that the dollar value of improper Medicare fee-for-service benefit payments made during FY 1997 totaled approximately $20.3 billion nationwide. This $20.3 billion represents about 11 percent of the $177.4 billion in fee-for-services payments made by HCFA in FY 1997. The improper payments for hospital inpatient and outpatient services in FY 1997 was estimated to be $6 billion. These numbers compare with our estimates that approximately $23 billion in Medicare fee-for-service payments in FY 1996 were improper, with improper inpatient and outpatient services payments estimated at $8 billion.

While we do not know what portion of these amounts were attributable to fraud, this continuing error rate is unacceptably high for Medicare generally, and for hospitals in particular. We have encountered enough examples of reckless billing practices to be very concerned about the extent of fraud. In fact, the above audit figures may not reflect the magnitude of Medicare fraud. Sophisticated fraud schemes fabricate the necessary medical documentation in an effort to thwart detection. Our recent audits of HCFA might not uncover such a scheme.

Simply put, Medicare is highly vulnerable to fraud and other improper billing practices. One problem is the program's sheer size. Today, Medicare outlays exceed $200 billion annually; it has 38 million beneficiaries, and its contractors process and pay well over 800 million claims per year. Since only about 9% of Medicare claims are reviewed, the program is highly dependent on the care and honesty with which providers prepare and submit claims. Providers have a duty to prepare true and accurate claims for their goods and services.

Hospitals

I would now like to share just a few examples of fraud uncovered by the Government in the hospital industry.

In 1995, a component of a large east coast university health system agreed to pay $30 million to the U.S. Government to settle allegations that the institution submitted false Medicare bills for faculty physician services. The institution's own internal memos showed it knew that for a physician to bill for a service performed by a resident, the physician had to be physically present, "at the elbow" of the resident. However, the institution encouraged its physicians to bill for services performed by others. The second questionable practice was billing by faculty physicians for in-patient services at the highest levels of the 5-tier coding system for hospital visits, without reference to the services actually performed. In fact, the institution printed forms for physician billing which left off the two lowest-reimbursed codes altogether.
In 1997, two east coast billing consultants settled charges that they enlisted more than 100 hospitals in schemes to aggressively and inappropriately manipulate Medicare's billing rules to increase payments. Some hospitals did the right thing, and told the consultants that their advice promoted fraud and would not be followed. Unfortunately, many hospitals used the consultants to make a quick buck at the Medicare program's expense. As part of the settlement with the U.S. Attorney's Office, the consultants have agreed to cooperate in the Government's ongoing investigation of these hospitals.

In 1997, a Midwest medical center agreed to pay $17.5 million arising out of allegations that it paid two physicians over $1 million to refer an estimated $42 million in Medicare business to the hospital. The hospital designed sham "consulting agreements" with the physicians and paid them over an 11-year period in exchange for patient referrals. The doctors did not perform the services specified in the agreements and were paid far more than market value for those they did perform.

In all of these hospital cases, the False Claims Act was an essential component of the Government's enforcement effort. The AHA proposal to amend the False Claims Act would adversely affect enforcement efforts with respect to all health care providers, not just hospitals. Here's a sample of what we are uncovering in other health care industries:

**Laboratories**

During FY 1997, OIG concluded "Labscam," a multi-year interagency initiative targeted at abusive marketing and billing practices by the nation's largest independent clinical laboratories. We found a number of improper activities, including unbundling clinical laboratory tests, billing for tests not performed, inserting false diagnosis codes to obtain reimbursement, double billing for laboratory tests for patients with end stage renal disease, payment of kickbacks, and billing for calculations which were both unordered and medically unnecessary. The Federal Government's case against the abusive laboratories, all told, resulted in three corporate criminal convictions, and will ultimately produce recoveries of more than $800 million.

**Home Health**

First American Health Care of Georgia, Inc. was the largest privately held home health care provider in the country. When our investigation began, the company was known as ABC Home Health, and Jack and Margie Mills were the majority shareholders and chief officers of the company and its subsidiaries. Offenses included shifting unallowable costs to Medicare. The company and its owners claimed items and services that benefitted the owners personally as reasonable and necessary "general and administrative" expenses related to the care of Medicare patients. These fraudulent claims included golf course memberships, greens fees, a family vacation, and a BMW for a son in college. After extensive investigation and audits by the Office of Inspector General, the Mills and the parent company were convicted in 1996 of several Medicare-related criminal offenses and received significant prison time. In a related settlement, $255 million was returned to the United States.

On a smaller scale, the co-owner of a Washington, D.C. home health agency billed for 1,450 skilled nursing visits for which there was no evidence that the visits were made. It also billed for home nurse visits when patients were actually hospitalized. The co-owner was sentenced to 27 months in prison and ordered to pay full restitution of $100,000 defrauded from the Medicare and Medicaid programs.

**Medical Equipment and Supplies**

One of the highest-reimbursed Medicare suppliers of incontinence care products, Ben Carroll, agreed to plead guilty to conspiracy to defraud Medicare of more than $70 million. He had actually collected $45 million. He distributed adult diapers (which are not covered by Medicare) but billed Medicare for female urinary collection pouches. He agreed to forfeit $32 million in seized bank accounts, paid $2.5 million in restitution, and was sentenced to 10 years imprisonment.

2. **Critical Enforcement Tools Provided by Congress**

The above examples hint at the breadth of the improper practices plaguing Medicare and other federally funded health care programs. To stem the tide of abuses and to protect Medicare's beneficiaries, we have adopted an attitude of "zero tolerance" of Medicare fraud and abuse. And we are pleased that the American Hospital Association and many other groups have embraced the "zero tolerance" goal. To achieve this goal, the Government relies on a number of enforcement options--criminal, civil, and administrative, as well as educational outreach efforts. Chief among the enforcement tools has been the False Claims Act.

Congress deserves great credit for its amendments to the False Claims Act in 1986, amendments that have improved the Government's ability to recover false or fraudulent payments. Now, the False Claims Act imposes treble damages liability and civil penalties of $5,000 - $10,000 per claim on any person who knowingly presents, or causes to be presented, a false or fraudulent claim for approval to the U.S. Government. See 31 U.S.C. sec. 3729.
The Act is the primary means of recovering damages for losses to the Medicare Trust Fund (and to the U.S. Treasury as a whole). It is also the primary means of recovering fraudulently claimed dollars from health care providers, including hospitals. To prove liability, the Government must show actual knowledge of falsity, reckless disregard for truth or falsity, or deliberate ignorance of truth or falsity. "Deliberate ignorance" reaches those who consciously ignore or fail to inquire about readily discoverable facts that would alert them that a given claim is false.

It is absolutely critical to note that billing errors due to simple negligence, mistakes, or inadvertence are actionable under the False Claims Act. The government must prove at a minimum a "deliberate ignorance" or a "reckless disregard" of the truth or falsity of the claims submitted by the provider.

In our experience, the penalty provisions of the False Claims Act are also a crucial deterrent to repeat offenders. If a provider or supplier gets caught actually bilking the system, i.e., submitting claims recklessly, and only has to pay the money back, there is precious little incentive for the wrongdoer to stop.

The qui tam provisions of the False Claims Act, also amended in 1986, have provided the incentive for whistle blowers to overcome the substantial detriment and obstacles to speaking out. Most of the time, a whistle blower is a health care employee with inside knowledge of wrongdoing. When he/she blows the whistle, he/she invariably becomes an outcast in the industry. However, the qui tam provisions allow such whistle blowers to act as private attorneys general and bring suit under the False Claims Act seeking recoveries against defrauders of government programs. The Department of Justice then determines whether or not to intervene in the case; the case may proceed without DOJ. In either case, the whistle blower, or "relator," may share in any later recoveries. In just the hospital industry alone, from January 1, 1995 to April 17, 1998, OIG's figures show that 199 qui tams were filed against hospitals. The law is working as intended. Whistle blowers are stepping forward, and billions in false claims are being recovered as a result. In the last ten years, qui tam cases in which the government has intervened have produced approximately $1.8 billion in recoveries. About half of these recoveries were in health care cases.

The AHA proposal will adversely impact the fight against health care fraud and abuse. While the AHA proposal does not amend the qui tam provisions themselves, it would make the underlying substantive cause of action quite onerous to pursue. Thus, the qui tam provisions will effectively be gutted. The crucial information provided by whistle blowers will be lost in most cases because the insiders will not come forward to the Government.

Health Care Fraud and Abuse Control Program Mandated by the Health Insurance Portability and Accountability Act (HIPAA)

Congress has repeatedly recognized the magnitude of health care fraud, and has provided other crucial fraud fighting tools. In 1996, Congress and the President gave law enforcement a major boost through the Fraud and Abuse Control Program, authorized in the Health Insurance Portability and Accountability Act of 1996. The program is designed to provide a framework and resources to coordinate Federal, State, and local law enforcement efforts. It mandates a comprehensive program of investigations, audits, and evaluations of health care delivery; authorizes new criminal, civil, and administrative remedies; requires guidance to the health care industry about potentially fraudulent health care practices; and establishes a national data bank to receive and report final adverse actions imposed against health care providers. The Act also provides an innovative mechanism to fund these new anti-fraud efforts, thereby assuring that needed resources are always available for the effort.

The recent report detailing the substantial recoveries to the Medicare Trust Fund brought about by HIPAA demonstrates that the Congress invested wisely in the effort to control health care fraud and abuse. Indeed, in January, 1998, HHS and DOJ jointly issued the first annual report of the Health Care Fraud and Abuse Control Program. The report provides some helpful measures of recent progress made in the effort to control health care fraud and abuse. During fiscal year 1997:

- $1.087 billion was collected in criminal fines, civil judgments and settlements, and administrative impositions.
- $968 million was actually transferred to or restored to the Medicare Trust Fund, and $31 million was recovered as the federal share of Medicaid restitution.
- More than 2,700 individuals and entities were excluded from federally sponsored health care programs, a 93% increase over 1996.
- Federal prosecutors opened 4,010 civil health care matters, an increase of 61 percent over 1996.

At the same time, it is important to keep these results in perspective. Hospitals paid approximately $73.2 million last year to settle potential False Claims Act liabilities with the government, while they received over $100 billion in Medicare payments.
The bottom line is that the problem of health care fraud is real and it is massive in scope. The AHA proposal would hamstring the Government's use of the most important tool we have in stemming the tide. I will now briefly share some specific reasons why this would occur.

3. The American Hospital Association's Proposal

Individual Provisions

The AHA proposal would erect serious obstacles to pursuing Federal health care fraud. Curiously, these obstacles would not be imposed on any other defrauders of federal programs. But under the AHA's proposal, regardless of what some advocates state, members of the health care industry would enjoy from the False Claims Act in many situations.

Material Amount Required in Order to Be Actionable

Under the AHA proposal, for a false claim to be actionable where submitted to a "federally funded health care program" (e.g., Medicare, Medicaid, the Children's Health Insurance Program), the Government's damages must be for a "material amount." That term would more specifically be defined in regulations to be promulgated by the Secretaries of Health and Human Services and Defense. Because the AHA seeks to have its proposal made retroactive in effect, current enforcement efforts would grind to a halt until a regulatory definition of "materiality" successfully navigates the protracted rule making procedures. And defining when the Government's fraud losses are "material" would defy a simple answer.

The AHA proposal mandates that the American Institute of Certified Public Accountants' (AICPA) definition of materiality be used in the joint HHS and DOD regulations. AICPA defines materiality as "the magnitude of an omission or misstatement of accounting information that, in the light of the surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would have been changed or influenced by the omission or misstatement." This is explicitly and necessarily a subjective standard. AICPA itself recognizes that "an illegal payment of an otherwise immaterial amount could be material if there is a reasonable possibility that it could lead to a material contingent liability or a material loss of revenue."

While the AHA proposal seems to require that the Secretary quantify a specific proportion of an entities' claims that must be fraudulent before being deemed "material," AICPA makes plain that what is material is very much context-dependent, and requires the consideration of any number of quantitative and qualitative factors. While useful for accounting purposes, this is not a workable standard for an enforcement statute of general applicability.

Specifically, it would be quite inappropriate to create some set percentage or dollar threshold below which fraud would go unpunished. For example, the AHA has suggested a threshold of $100,000 of false claims in any claim category before the False Claims Act could apply. AICPA suggests, from an accounting perspective, that materiality may range from 5% to 10%. Such proposals would result in large "free for fraud" zones. If you multiply the number of providers by the number of potential categories, many billions of dollars could be fraudulently claimed with no remedy under the False Claims Act. While most everyone voices support for "zero tolerance" for fraud, this AHA proposal amounts to a safe harbor for fraud, as long as the loss to the Medicare program is not too big in any one of a provider's categories of claims.

The AHA proposal mandates other prerequisites to finding "materiality." Only Medicare claims can be aggregated with other Medicare claims when demonstrating that a claimant has surpassed the "material" threshold, and then, only if the claims are made in the same calendar year. Consequently, the same claimant may well be defrauding Medicaid, but those false claims must be counted separately. Claimants would be free to cheat so long as they are savvy enough to consistently steal only a "non-material" amount from each program, each year.

Furthermore, under the AHA proposal, improper claims cannot be aggregated in order to establish materiality unless they can be shown to have been part of a "pattern" of "related acts or omissions." These barriers further reduce the remote possibility that the government could demonstrate materiality with respect to false claims by any but the smallest and most corrupt Medicare providers.

What is "material" at a Fortune 500 corporation invariably will not be so for a small "mom and pop" health care company. Many corporate financial statements, particularly those of massive health care conglomerates, might not consider even a $1 million contingent liability as material relative to total assets. The AHA proposal may well give such a $1 million false claim a "free pass," because if the corporation bills Medicare $100 million each calendar year, $1 million may not be deemed "material." Consequently, enforcement will likely become regressive, in that smaller health care entities will be the primary target of False Claims Act enforcement.

II. Standard of Proof Ratcheted Up
The AHA proposal raises the standard of proof for all false claims to federally-funded health care programs, even claims that manage to satisfy the onerous "materiality" requirements. "Clear and convincing evidence" (much closer to a criminal standard) would be required, rather than a preponderance" standard (the standard in civil cases). This relaxed standard will invite members of the health care industry to be less vigilant in avoiding abusive behavior.

Model Compliance Plans - A "Substantial Compliance" Safe Harbor

The AHA proposal seeks to immunize claimants who are in "substantial compliance" with a model compliance plan issued by the HHS Secretary in conjunction with the DOD Secretary. This vague term ("substantial compliance") will require definition, presumably by regulation. We are greatly concerned as to how it will be determined what constitutes "substantial compliance."

The AHA proposal, by its own language, does not mandate that HHS/DOD issue compliance plans, nor are they mandated anywhere else. HHS has never issued such plans in conjunction with DOD. More importantly, the "model compliance" issued to date by HHS has been non-binding "guidance," not the text of actual compliance plans. This guidance approach, requested by trade groups, including AHA, allows actual compliance plans to be flexible and to be tailored to the needs and capabilities of the individual provider. It should be noted that the OIG and (heretofore) the health care industry agree that there can be no "one size fits all" compliance scheme.

The AHA proposal thus creates yet another anomaly: under the U.S. Sentencing Commission guidelines, an effective compliance plan warrants just a downward adjustment with respect to fines imposed upon a corporate defendant for its criminal conduct. By contrast, the AHA proposal would grant civil immunity to health care defrauders with a compliance plan. Ironically, conduct which enjoys civil immunity could still be the subject of a criminal prosecution.

IV. Safe Harbor for Reliance on "Agency" Advice

The AHA proposal also seeks to immunize claimants who have relied on erroneous information from a "Federal agency," or "an agent thereof." First, we always take guidance of carriers, intermediaries and other official pronouncements into consideration in our cases. It is only fair that we do so. However, the AHA proposal goes much further. The AHA proposal invites claimants to "shop" carrier and intermediary personnel, and encourages "gaming" of the system. Under the AHA proposal, the erroneous guidance does not even have to be in writing for a fraudster to benefit from this immunity provision.

There is a longstanding general principle that "the United States is neither bound nor estopped by acts of its officers or agents in entering into an arrangement or agreement to do or cause to be done what the law does not sanction or permit." Utah Power & Light Co. v. United States, 243U.S. 389, 409 (1917). See also Federal Crop Insurance Corp. v. Merrill, 332 U.S. 380 (1947) (court held that the government was not bound by the unauthorized representations of its agents in advising a farmer that his crop was insured when, under regulation, over 80% was not). Although more recent case law and the decisions of the Comptroller General have softened this rule of law, a person relying on erroneous advice must show his/her reliance was reasonable under the circumstances.

Where the issue of contractor guidance arises, we consider whether the agency or contractor guidance was in fact inaccurate, whether the provider in fact relied upon it and, indeed, whether that reliance was reasonable in light of other available information. The AHA's suggested "safe harbor," however, would confer immunity even when the provider knew that the person providing the guidance was acting outside of his or her authority or was providing misinformation.

Again, with respect to HCFA and HCFA contractor guidance, it must be emphasized that law enforcement most certainly takes into consideration whether there was reasonably clear guidance in place before a case is pursued. This is a key factor in evaluating whether behavior was egregious, or a simple mistake based on good faith reliance on erroneous advice.

Although we believe the AHA proposal is not the answer to the concerns that have brought us here today, we wish to address the objections by the industry to the concept of national enforcement projects. Specifically, I will discuss in detail the "DRG 72 Hour Window" project, which is the subject of particular industry concern.

4. National Projects

When the federal law enforcement community detects repeated and widespread violations of the same or related Medicare rules, we may undertake nationwide projects targeting that abuse. National projects also allow us to pursue abuses that are not large cases individually, yet, collectively, cause significant drains on the Medicare Trust Fund. While these are national projects focused on pervasive abuse, it is also important to keep in mind that each case is evaluated and pursued on its own merits.
The industry proponents of the relaxing of False Claims Act standards have been critical of these OIG and DOJ-coordinated national enforcement efforts. We feel that it is important for us to dispel misconceptions about these initiatives. As an example, the first national project affecting all Medicare hospitals was the "DRG 72 Hour Window" project. The rule underlying this project is simple. Hospitals which are paid by Medicare under the Prospective Payment System ("PPS") receive a set amount for hospital admissions for particular types of illnesses ("Diagnostic Related Groups" or "DRGs"). The Medicare regulations require that non-physician outpatient services rendered in connection with such hospital admissions (and within a three day "window" of such admissions) not be billed separately to Medicare. Rather, such services are included in the pre-established fee paid to the hospital for the admission itself.

Between 1987 and 1992, the OIG performed four nationwide audits of the Prospective Payment System (PPS) hospitals' billing of non-physician outpatient services. Each audit revealed widespread violation of the "DRG 72 Hour Window" rule. The first OIG audit covered the period between October 1983 and January 1986. OIG determined that approximately $28 million was improperly paid to hospitals in violation of the rule during that time frame. The OIG supplied HCFA with computer listings of the claims paid improperly. HCFA, through its contractors, then pursued repayment, and put the hospitals on formal notice of their noncompliance.

The second OIG audit covered payments made to hospitals between February 1986 and November 1987. This time, approximately $40 million in improper payments were identified. Once again, OIG asked HCFA to recoup the payments and put the hospitals on notice. Yet again, HCFA recovered the improper payments, and put the hospitals on notice of their improper billing practices.

When OIG revisited the issue a third time, we found approximately $38.5 million in improper payments for the period December 1987 to October 1990. HCFA again expended the considerable resources necessary to recover the overpayments.

After each of the first three audits, HCFA instructed the Medicare fiscal intermediaries to recover the overpayments and further educate the hospitals on how to conform to the rule. Each time, funds were recouped and notices issued. Unfortunately, hospitals' performance overall did not improve despite these repeated, explicit efforts by HCFA and its contractors.

In 1993, the fourth OIG audit identified approximately another $8.6 million in improper billings from November 1990 to December 1991. By this point, the HCFA contractors had been catching more of the claims before they were paid. All told, the first four audits identified approximately $115.1 million in Medicare overpayments to hospitals caused by the improper billings. The OIG presented the results to the U.S. Attorney for the Middle District of Pennsylvania to devise a plan to recover the continuing overpayments, with penalties, from hospitals in Pennsylvania. Based upon early results, the U.S. Attorney for the Middle District of Pennsylvania then developed a national plan to replicate the Pennsylvania experience across the nation.

In 1996, OIG audited this issue a fifth time, identifying an additional $27 million in potential improper payments for the period January 1992 through December 1994. Incredibly, even after all of the previous public OIG audit reports and HCFA's repeated efforts to remind hospitals of the requirements, OIG's fifth audit revealed that with respect to the hospitals' claims processing systems, the necessary edits at hospitals were not sufficient, or were nonexistent. All of this left the question: What would it take to get hospitals to comply with the "DRG 72 Hour Window" rule?

The first four OIG audits revealed tens of thousands of individual small dollar overpayments by some 4,660 hospitals nationwide. Certainly, a prevalent pattern of abuse had been identified. At the same time, the individual overpayments were low (generally less than $100 each), and the total number of improper claims submitted by individual hospitals was relatively small. The average overpayment for the entire five year period was only about $10,000 per hospital, though some overpayments reached $1 million. Approximately $58 million has been recovered to date as a result of the national project efforts. In short, repeated audits and resulting recoveries of simple overpayments (with interest) and repeated notice to the industry proved wholly ineffective in stemming the abuse. Moreover, interest is normally only charged from the date an overpayment is identified, yet another windfall for the hospitals.

Innocent mistakes? Perhaps initially. But at some point, repeated failure to abide by explicit notice becomes, at a minimum, reckless behavior. We had every reason to believe that without this remedy, false claims would continue. And the Medicare program could not depend on the OIG to repeatedly audit compliance. Yet, without the continued audits, the program and taxpayers would suffer annual improper losses in the millions of dollars due to this abuse.

This recklessness has tangible and significant cost to society. The OIG and HCFA resources necessary to identify and recover these improper payments is not insignificant. And Medicare beneficiaries are injured even more directly. Many of the services billed by hospitals in violation of the "DRG 72 Hour Window" rule are subject to a 20% coinsurance, or "co-payment." Consequently, senior citizens on fixed incomes unnecessarily have paid millions to hospitals for charges which should have been included in the inpatient payment.
Even after involving the Department of Justice and the False Claims Act, we have approached this problem judiciously. A great many hospitals which violated the billing requirement were placed in what was called "Tier zero;" the False Claims Act would not be applied to these hospitals. Rather, they have or will have the opportunity to simply pay the money back with interest.

The remaining hospitals identified in the national project were divided into three tiers: Tiers 1, 2, and 3. This ranking was based primarily on a ratio of the number of false claims submitted in relation to the hospital's bed size. Hospitals with 10 or fewer false claims were grouped into Tier 1. In settling their liability under the False Claims Act, the Tier 1 hospitals are treated just like the zero tier hospitals--they merely have to return the money with interest.

It stands to reason that the number of false claims should be considered in relation to a hospital's size, as reflected by its number of beds. Consequently, Tier 1 includes those hospitals with the lowest false claims to bed size ratio, while Tier 3 includes those hospitals with the highest ratio (and thus the most flagrant violations). False Claims Act penalties were proposed based on the severity of the hospital's conduct, beginning with Tier 2.

With the active participation of the AHA early in the national initiative, the Department of Justice and OIG developed a model settlement mechanism that included repayment with interest, penalties where appropriate, and two other important features. The first requires the hospital to conduct a review of patient accounts and records to identify instances where the Medicare beneficiaries (or the Medicaid program if the person was dually eligible for both Medicare and Medicaid) paid the hospitals for deductibles or coinsurance. Within 90 days of settlement, the hospital would agree to refund to the beneficiary, when feasible, the amount identified. A second provision of the settlement requires the hospital to establish both computerized and manual controls to prevent future billing for outpatient services included in the outpatient payment under PPS.

Some statistics: It is my understanding that approximately 3,000 hospitals to date have received letters from DOJ. Some 1,700 of these have had to pay no penalty whatsoever. Approximately 500 of these 1,700 hospitals have been grouped in the zero tier, and approximately 1,200 have been grouped in the first tier. As for the flagrant, or Tier 3 cases, I would like to share a few examples.

A 560-bed east coast hospital paid $976,035 to settle allegations that it had made 346 erroneous claims as determined by the fourth OIG audit, and 1,056 improper claims as determined by the fifth OIG audit. A 502-bed hospital in the southeast paid $836,852 to settle allegations that it improperly made 238 claims during the fourth OIG audit period, and 1,200 improper claims during the fifth OIG audit period.

The national "DRG 72 Hour Window" project shows a reasonable approach to a situation where hospitals generally refused to recognize their collective responsibility to bill Medicare correctly. Enforcement action became necessary with respect to significant violators; the rest paid only overpayments and interest. However, OIG is not relying only on enforcement; we are seeking to engage hospitals at the front end -- to prevent their getting in trouble in the first place. 5. Compliance: The OIG's Commitment to Assisting the Health Care Industry

June Gibbs Brown, the Inspector General at HHS, is personally committed to efforts beyond just enforcing past violations and punishing wrongdoers. Under her leadership, OIG has also engaged in numerous proactive outreach efforts designed to help the industry comply at the front end, by identifying and preventing health care fraud and abuse generally. Indeed, hospitals in particular have reacted quite positively to the Inspector General's initiatives.

These outreach efforts are even made available through the Internet, to anyone who wishes to review them. For the record, the OIG Website may be found at www.hhs.gov/progorg/oig. Some of these public outreach and prevention efforts include:

The February 1998 "Office of Inspector General's Compliance Program Guidance for Hospitals." This document presents basic procedural and structural guidance for developing a hospital compliance program that will avoid false or improper claims. Hospitals owe a duty reasonably to ensure that the claims they submit to Medicare are true and accurate. This guidance is intended to assist hospitals and their agents and subproviders to fulfill that duty. It suggests that hospitals develop effective internal controls that promote adherence to applicable federal and state law, and the program requirements of federal, state and private health plans. Fundamentally, compliance guidelines are intended to foster a culture within an organization that promotes the prevention, detection, and resolution of conduct that does not conform with Federal and State law, program requirements, or the provider's ethical and business policies. This is a critical prevention mechanism that is rapidly gaining acceptance in the health care industry. Indeed, the hospital guidance was developed with substantial input from the American Hospital Association, the American Medical Association and other industry groups. We are currently developing guides for home health providers, billing services, health maintenance organizations, and durable medical equipment suppliers.

The OIG Advisory Opinion Process. Mandated by the Health Insurance Portability and Accountability Act, OIG issues advisory opinions to requesters on whether certain conduct, including certain business arrangements, constitutes a violation of applicable
law, including, in particular, the anti-kickback statute. (The OIG advisory opinion regulations may be found at 42 CFR part 1008). Twelve such opinions have been issued to date.

Special Fraud Alerts. While advisory opinions offer one-on-one guidance, OIG Special Fraud Alerts sweep more broadly, by seeking to identify practices in particular segments of the health care industry that are particularly vulnerable to abuse. These alerts are published in the Federal Register, posted on the Internet, and are available upon request to any interested party. As just one example, in March 1998, OIG issued a special fraud alert concerning fraud and abuse in nursing home arrangements with hospices.

OIG Workplan. Our annual workplan is available on the Internet, so interested parties can identify areas of particular OIG interest and emphasis.

These and other efforts demonstrate our real commitment to assist providers in complying with Medicare's requirements, and avoiding the submission of improper claims. Providers owe a duty to Medicare reasonably to ensure that the claims they submit are true and accurate. We suggest that careful compliance efforts are necessary to discharge this duty. These efforts will prove cost effective for the providers in avoiding liability. Regardless, we must not forget that the lax compliance efforts of the past have been grossly damaging to the solvency of the Medicare Trust Fund.

With the above proactive examples, we have attempted to demonstrate that law enforcement is not, as suggested, looking to prosecute providers for innocent errors. On the contrary, we are engaged in an extensive, good faith effort to work with the industry to prevent potential liability for fraud and improper billing before it even occurs.

Conclusion

For the reasons explained, the Office of Inspector General strongly opposes the AHA proposal.

The False Claims Act is an invaluable tool in the Government's continuing effort to control health care fraud and abuse. In an era when the long-term solvency of Medicare is in doubt, and when our audits reveal huge losses due to improper payments, and when taxpayers, the Congress, and the Administration are rightfully demanding a more concerted law enforcement effort, it would not be wise to weaken the protections afforded by the False Claims Act.