UNITED STATES DEPARTMENT OF JUSTICE

ADDRESS BY ATTORNEY-GENERAL JANET RENO

American Hospital Association

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P R O C E E D I N G S

ATTORNEY-GENERAL RENO: Good afternoon. I thank you for the opportunity to speak with you today about our efforts to deal with health care fraud in this country and what we can do working together.

Yes, whether it be Baptist Hospital which, unfortunately, has a picture of me as a kid on a pony in its lobby because the pony came from the stable where Baptist Hospital now stands or what I saw in Minneapolis or what I have seen in so many hospitals across this country.

I just appreciate all that you do for your individual patients, for your community, and to try to improve health care for all Americans.

I came to the Justice Department dedicated to one effort at enforcement: to try to reach out to those people who wanted to comply with the law and do everything I could to work with them to make the law understood, to arrive at common terms, to arrive at common understandings of what is expected.

At the same time, I wanted to be prepared for those who would thumb their nose at the law to take vigorous enforcement action because I found, no matter what the profession, no matter what the industry or business, most people wanted to see that the law was complied with, they wanted to do the right thing, and they appreciated it when wrongdoers were brought to justice.

I know from my mail how strongly some of you feel, but I want to tell you here and now:I am dedicated to working with you in every way possible to make sure that the law is not abused, that we work together for our common aim.

Health care fraud is one of my highest priorities, but the strategy involves two components, first of all, strong civil and criminal enforcement which has been facilitated by recent legislative changes, and, second and equally important, is what I alluded to plus more, to reach out to work with the industry but to understand from cases that we see occur what can be done to prevent the fraud in the future. What check and balance was missing? What can the industry learn? What can we learn that will help prevent that fraud for the future?

We want to encourage providers to adopt compliance programs under which they can accept responsibility for policing their own activities. I know there are questions about how that should be done. Let's work together to do it. Let's work together in open, candid communication that can make a difference.

The reason we should all be in this together is that health care fraud cheats beneficiaries and taxpayers out of billions of dollars every single year.

These fraudulent schemes put billions of dollars in the pockets of individuals and providers who cheat the system while at the same time we can't pay for lifesaving drugs to fight AIDS or to provide some frequent screenings to detect and prevent cancer and other life-threatening illnesses.

While most health care providers are law-abiding, the Inspector General of the Department of Health and Human Services recently found that the Medicare Program alone has overpaid hospitals, doctors and other health care providers by as much as twenty- three billion dollars and that forty percent of Medicare payments made to home health care providers were improper.

Now, when I saw that figure, I said, "Does all that come from fraud"? And I want to make clear what the answer is. It's not all fraud; it's not outright fraud.

But I think we've got to understand what the dimensions are. I don't want to make reference to billions of dollars worth of losses. I want to try to work with you to define what the range of the problem is so that we can devote sufficient resources to taking effective action against it.

Whatever the case, I don't think there's anybody in this room that would disagree with the fact that we're losing millions of dollars each year to fraud. The President and the Congress have made fighting it a national priority, and, working together, I think we can do something about it.

We need to respond aggressively not only to cover taxpayer funds that have been to squandered and to penalize and deter those cheating the system but, also, fraud undermines the public's confidence in the integrity of the Medicare and Medicaid Programs.

These programs provide such essential medical services to millions of elderly, poor, and disabled Americans. To ensure the continued vitality of these programs in the future, we must assure that these programs are not rife with fraud and abuse.

But dollars alone do not tell the full story about the impact of health care fraud on the American people. Unscrupulous practices done solely to wring more money out of the health care system can pose a direct threat to the lives and the health of patients.

Let me just share a few examples with you from cases the Department has recently initiated. In one, patients were abused and received seriously inadequate care at psychiatric centers for youth. A psychiatrist and his corporation employed unlicensed therapists to provide mental health services to patients but billed the government for over $5.2 million as though the doctor had performed the services himself.

A San Diego ophthalmologist stole $16 million from Medicare by performing medically unnecessary surgeries. This doctor often saw more than 150 patients a day and on some days performed 45 surgeries a day with each patient receiving six separate procedures unrelated to any medical need.

We cannot allow financial inducements to corrupt the judgment of professional medical providers. Basic medical decisions, whether and where to hospitalize a patients, what lab tests to order, what drugs to prescribe, and how long to keep a patient in a hospital must be based on what is best for the patient's health, not on what is best for a doctor's or a hospital's bottom line.

Federal anti-kickback statutes allow many schemes that violate this common sense rule, and the Department's policy is to rigorously pursue these cases.

Recognizing that fraud is all too pervasive in the health care system, the President and Congress provided substantial new resources in the Kassebaum-Kennedy bill. The results of our efforts demonstrate how widespread the fraud problem is and how much more we must do.

Since 1992, criminal health care fraud prosecutions and convictions have increased by over 400 percent. Last year, more than 2,700 individuals and businesses were excluded from federal health care programs, a 93-percent increase over 1996.

Last year we recovered more than $1 billion in criminal fines, civil settlements, and administrative penalties. Nine hundred sixty-eight million dollars of the funds recovered were returned to the Medicare Trust Fund. Money that would have lined the pockets of scam artists is now going, instead, to preserve the Medicare Trust Fund and to improve the health care for millions of Americans.

As I have noted, we have established a balanced program that encompasses the two key components of enforcement and prevention. Our enforcement policy is aimed at preventing, detecting, investigating, prosecuting, and punishing health care fraud.

We will use all the tools at our disposal, criminal, civil and administrative, to root out health care fraud by deterring fraudulent conduct, by punishing offenders, by recovering funds to compensate the government's losses, excluding providers from federal health care programs, stopping ongoing fraud before additional harm can be inflicted on the health care system, and requiring the adoption of corporate compliance programs to prevent future crimes.

We can and will use criminal prosecution to punish knowing or intentional schemes to defraud Medicare, Medicaid or private health care programs or conduct that runs afoul of the criminal anti-kickback statute.

Just this past week, criminal charges were filed as a result of a three-year undercover investigation code-named "Operation Overdraw." Through an undercover medical business, the investigation discovered that dozens of health care entities in Connecticut and New Jersey, such as clinical laboratories and suppliers of durable medical equipment, were engaging in an extensive fraudulent activity including kick-back schemes, "upcoding" of bills submitted to Medicare and Medicaid, mail fraud, and federal tax violations.

The use of civil laws is a critical component of our enforcement policy. The Department of Justice will bring civil enforcement actions, including actions under the False Claims Act, where the provider knew or acted in reckless disregard or deliberate ignorance of the fact that false and fraudulent bills were submitted to Medicare, Medicaid, or other federal health care programs where the provider knew or acted in reckless disregard or deliberate ignorance of the fact that false and fraudulent bills were submitted.

I stress that language because I know this issue is of great interest to the AHA, and I want to make the Department's policy perfectly clear. It is not the policy of the Department of Justice to punish honest billing mistakes, nor do we prosecute doctors or hospitals for mere negligence. Under the False Claims Act, such honest mistakes or simple negligence do not amount to a false claim.

There is always an open door at the United States Attorney's Offices and at Main

Justice. If one of your members sincerely believes that it is being pursued for a simple mistake, the attorney for that hospital should contact the government's attorney and set up a meeting to explain the hospital's point of view.

I want to make sure that we listen carefully and thoughtfully. I don't want to be a part of an institution bringing unjust or unsubstantiated cases any more than you want to have to defend them. I want to make sure that we pursue the law the right way.

Now, some people, when I talk to them, say, "Well, these are just words and she seems like a nice person and she's got this big institution and she can't make sure that it follows that principle." I have found that the institution itself is dedicated to following that principle, but I follow this issue regularly. I have what's called an "8:30 Get-Back List," and this issue is now prominent on that get-back list. I want to make sure that we are responsive on this issue.

But where there is a reckless disregard, where people have gone beyond simple negligence, I'm going to use the law but use it, again, the right way.

What I would ask of you, If you have problems, if you feel like you have not gotten a hearing in the U.S. Attorney's office or at Main Justice, let me know, let us follow through. There reaches a point where we may find ourselves in respectful disagreement, but we will talk this out and see if we can't reach a common understanding when the facts and the law justify it.

In the cases that we are pursuing, there is substantial evidence that the providers involved, including hospitals, acted with knowledge or in reckless disregard of the fact that the bills they submitted were false.

In fact, in some cases, we are seeing clear patterns of over-billing frequently coupled with inadequate internal procedures to ensure that the claims submitted to Medicare are true and accurate. Simply put, these are not cases where we are seeking to punish someone for honest billing mistakes.

We believe and the law requires that all providers, including hospitals, must take responsibility for ensuring the accuracy of the bills they submit for reimbursement. We will not apologize for using the False Claims Act to help accomplish that goal.

More recently, the Department also has used civil actions under the False Claim Act to redress the provision of inadequate care to patients of nursing homes.

Just within the last two weeks, we filed a civil False Claims Act complaint against three Pennsylvania nursing homes and their corporate owners for provision of inadequate care to their patients. Five patients died as a result of the inadequate provision of medical care such

as nutrition, wound care, diabetes management, as well as placing one patient, who was unable to speak, in a scalding tub of 138-degree water.

The owner of the nursing homes has agreed to pay the United States $500,000 and to implement a comprehensive compliance program to settle these allegations.

As a comment, one of the areas that I would like to work with you on in these months and years ahead is how we address the problem of elderly abuse.

So many members here in this room have led the way, through appropriate pediatric trauma facilities, to let us know more about child abuse and how to diagnose it and how to prevent it and how to treat it.

We have, with increased life expectancy in this country, a special responsibility to explore elderly abuse as well, whether it be in the home, an adult congregate living facility, or other institution. I think we can do so much in this area, for certainly modern medicine has given us a whole new understanding of how we can prolong life and make it a good life if we do it the right way.

The Department also works closely with the Department of Health and Human Services to pursue administrative sanctions where appropriate. There are a number of mandatory and discretionary exclusion authorities available to regress abusive and fraudulent conduct in federal health care programs. We provide the Department of Health and Human Services as much information as we can for its use in these proceedings.

The Kassebaum-Kennedy legislation also provided another important tool, the adverse action databank. This databank will be an important source of information concerning the identities of persons and entities against whom adverse actions are taken and their known affiliates.

The Department of Health and Human Services will disclose final adverse actions upon request to federal, state, and state government agencies and health plans.

The Department of Health and Human Services also will establish regulations to ensure the accuracy of information in the database and to protect the privacy of patients' records. I think this is so important, and, should you have suggestions as to how we can improve accuracy and take appropriate precautions to protect privacy, I welcome them.

I'm very proud of the Department's enforcement efforts, but equally important to our enforcement efforts are our efforts to prevent health care fraud from occurring in the first place.

In this area, we have a two-pronged approach, first, fostering efforts with the health care industry to develop effective compliance programs and providing guidance concerning liability under the anti-kickback statute where appropriate and, secondly, empowering patients to be partners in our efforts to root out fraud and abuse.

We participated in the recently-concluded negotiated rulemaking to establish safe harbors under the anti-kickback statute prompted by a concern that a literal application of the anti-kickback statute might prohibit otherwise beneficial managed care arrangements.

Congress directed the Department of Health and Human Services in conjunction with the Department of Justice and others to provide appropriate safe harbors for such beneficial arrangements.

The Committee has proposed two safe harbors to protect such beneficial managed care arrangements while ensuring that the proposed safe harbors do not authorize business arrangements which provide an inappropriate financial incentive for referrals.

As I am sure you all know, the Kassebaum-Kennedy legislation also established an advisory opinion process to provide guidance on whether specific transactions violate the anti-kickback or civil monetary penalty statute.

Under this process, providers and others can request a formal opinion from the Department of Health and Human Services as to whether certain conduct or business arrangements violate the statute or fall within a regulatory safe harbor. This is another avenue providers can use to ensure that they are following the law, and to date a number of advisory opinions have been issued.

I would again ask you, if you don't think that these advisory opinions are helpful, if you think we can improve on them, we would always welcome your suggestions as to what can be done to address the issue at hand and yet, at the same time, whenever appropriate, to better inform the industry and the community.

However, probably the most effective measure to prevent health care fraud is for hospitals and providers to adopt compliance and voluntary disclosure programs. I know that the AHA has undertaken a number of steps to work with the hospital industry to develop and implement effective compliance programs, and I think that this is a very positive step.

We have been working closely with the Department of Health and Human Services in its development of model compliance guidance for clinical laboratories and the soon-to-be-released hospital compliance plan, and I want to commend the HHS Inspector General, June Gibbs-Brown, for her efforts in this area. We look forward to working with her office on the next model compliance plans, which will concern HMOs and home health agencies.

Our emphasis on corporate compliance plans represents a fundamentally different approach from traditional law enforcement. Rather than the FBI and the Inspector General policing corporations, they would police themselves. Rather than an adversarial relationship between law enforcement and corporations, there would be a relationship of cooperation and mutual support.

Through corporate self-governance, business leaders will build a corporate culture emphasizing integrity in which ethical conduct goes hand in hand with profitability and becomes a way of doing business.

So many of your members already have built that corporate culture which emphasizes integrity, which emphasizes the finest service to the patient, which emphasizes service to the community, and I would like to see that spread throughout the industry.

Certainly, compliance programs give companies a leg up in dealing with prosecutors. Prosecutors have wide discretion to consider mitigating evidence both at the charging stage, when the prosecutor decides whom to charge and what charges to bring and at sentencing, when the court decides punishment.

An effective compliance program can increase the company's chances of obtaining a satisfactory civil resolution as opposed to a criminal case with possible forfeitures and exclusion. An effective compliance program showing that the company has done its best to act responsibly to prevent wrongful activity and to root it out when it occurs is perhaps the best way for a corporation to protect itself from the dire consequences of indictment and conviction.

Even if the prosecutor chooses to bring criminal charges, the United States sentencing guidelines for corporations convicted of crimes provide another compelling reason to adopt effective compliance programs.

Substantial reductions in criminal fines can be obtained by companies that have an effective program to prevent and detect violations of the law and fully and responsibly cooperate with the government by voluntarily disclosing employer misconduct.

I want to emphasize that prosecutors will examine compliance programs carefully to satisfy themselves that the programs really have teeth. We will not be fooled by paper policies and programs. We will want to interview employees and check to be sure that the programs are real.

Our experience has shown that some programs are not specific or strong enough to have any chance of working because they lack the backing of top management. Without the

commitment of top management, a corporate compliance program is literally worthless.

The ultimate question the prosecutor has to answer in each case is does the compliance plan work. I want to emphasize one other thing: when I speak of corporate compliance, I mean not only the existence of a program to prevent fraud but also one that investigates it and reports it.

Making a voluntary disclosure should be part of a business executive's or corporate counsel's calculus when he discovers that one or more of his employees are engaged in fraudulent conduct.

When a corporation discloses wrongdoing, makes full restitution, and takes swift disciplinary action against the employees engaged in the misconduct, the federal interest in prosecuting the corporation may be greatly reduced, and the Department will view the corporation more favorably.

On the other hand, the corporation that learns of criminal activity and fails to report it or fails to cooperate fully with the government cannot expect to obtain the same benefits.

An additional benefit from voluntary disclosure is that the False Claims Act provides an incentive for companies to voluntarily disclose employee misconduct in that a court has discretion under the act in certain circumstances to impose as low as double rather than treble damages if a company reports employee wrongdoing within 30 days.

As I mentioned, one area in which we are looking to do more outreach education is outreach in education of patients. A recent survey commissioned and released by the American Association of Retired Persons revealed that an overwhelming majority of Americans believe fraud is increasing in our health care system, and they are willing to personally assist in the fight against fraud and abuse.

However, the public is confused about how to report suspected fraud and abuse and is unaware of our efforts to combat health care fraud. We are exploring ways in which we can better educate the public about health care fraud, the government's enforcement efforts to combat fraud, and how to report instances of suspected fraud.

I place a high priority on this kind of outreach, not only in connection with health care fraud but in other areas such as telemarketing fraud and consumer fraud.

We want to educate the consumers of health care and to enlist them as our first line of defense. As we empower citizens with such information concerning health care fraud, we'd also notify them about the Department of Health and Human Services Fraud Hotline, 1-800-HHS-TIPS.

The President has also proposed legislation that would require information on how to report suspected fraud and abuse included on every explanation of medical benefits that a patient receives from the Medicare Program. In this way, patients can assist our efforts to detect and prevent fraud and abuse at the earliest possible stage in order to minimize the losses to the government.

But I would also like to work with you and work with others concerned about this issue to look at the cases that we've prosecuted, the cases in which we have secured a conviction, and see just what caused the problem in the first place, how it was permitted to occur, how it happened because there was not that check and balance, there was not that process in place, the auditor didn't follow-up in the right way, what we can do together to install systems of checks and balances and other processes and procedures that can ensure the full and honest delivery of health care.

As I indicated, I have watched a large number of your members as they served their patients with diligence, dedication, and great professionalism. I have watched as you've serve communities. I have watched as you have worked with government to try to address the problem of health care fraud.

You do such much for so many. You represent what is best about those who deliver health care.

I want to work with you so that the concern reflected by your being here today can be spread across this country, and together we can develop for all who deliver health care that culture, that thought, that ethic that we're going to do it in the best, most honest way possible and in a way that is in the best interest of the people we serve.

Thank you so much for this opportunity.

(Whereupon, at approximately 3:30 p.m., the PROCEEDINGS were adjourned.)

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