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Early Evidence of Compliance Program Effectiveness Is Inconclusive

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The Honorable John L. Mica
Chairman
Subcommittee on Criminal Justice, Drug Policy
and Human Resources
Committee on Government Reform
House of Representatives

The Honorable Christopher Shays
House of Representatives

Concerned that fraud, abuse, and improper payments threaten the finances of both elderly Americans and Medicare—the federal health care program that insures nearly 39 million beneficiaries—the Congress has acted in the past 3 years to provide additional resources and new enforcement tools to the Department of Justice, the Department of Health and Human Services' (HHS) Office of Inspector General (OIG), and the Health Care Financing Administration (HCFA) to improve Medicare safeguards. To date, the use of these new tools and resources has generated growing numbers of health care enforcement actions resulting in unprecedented recoveries of overpayments and penalties. However, the increase in enforcement actions has raised concerns among hospital and other provider groups that their members have been unfairly targeted and penalized for honest billing errors.

Despite disagreements about the appropriateness of enforcement activities, the provider community and those charged with ensuring compliance with Medicare requirements agree that health care providers should follow Medicare's rules, and that compliance programs often can help providers do that. In general, a compliance program is the internal set of policies, processes, and procedures that a provider organization implements to help it prevent and detect violations of Medicare laws and regulations. In addition, providers and members of the enforcement community agree that an effective compliance program can demonstrate a provider's intent to comply with Medicare's rules and requirements.

Recognizing the important role that compliance programs could play in helping health care providers and the enforcement community work together to reduce improper payments by Medicare, you asked us to determine (1) how prevalent are compliance programs among hospitals and other Medicare providers, (2) what costs are involved with

compliance programs, and (3) to the extent effectiveness can be measured, how effective these programs are.

To address these questions we interviewed 30 Medicare providers—25 hospitals and hospital-affiliated providers and 5 nonhospital providers—about their experience implementing compliance programs. We interviewed the five nonhospital providers for comparison purposes only. We also contacted professional associations—in particular, the American Hospital Association (AHA), the Health Care Compliance Association, the Ethics Officers Association, and the University HealthSystem Consortium (UHC)—to obtain their perspective on compliance programs. We also obtained information on the implementation of compliance programs from HHS-OIG and Justice officials.

Our review focused almost exclusively on hospital and hospital-affiliated providers (elsewhere in this report referred to collectively as "hospitals") because they receive the largest share of Medicare funds and are the focus of several current enforcement actions. We selected the majority of these 25 hospitals on the basis of a literature search that indicated a compliance program in place at that institution.[1] The hospitals in our study include private for-profit and not-for-profit as well as public hospitals. This sample includes hospital chains, independent community hospitals, physician groups associated with teaching hospitals, public hospitals, and rural hospitals. All 25 of these hospitals have or are instituting formal compliance programs. Some have signed corporate integrity agreements requiring the implementation of compliance procedures.[2] (See app. I for a description of our methodology.)

Results in Brief

Although there is no comprehensive data on the number of providers with compliance programs, many hospitals are implementing them. Two recent hospital surveys, one focusing on academic health centers and the other including a broad range of hospital types, found that most hospitals responding either had or planned to soon implement a compliance program. The hospitals in our study told us that they felt compelled to implement a compliance program for a variety of reasons, including the heightened enforcement environment, suggestions from HHS-OIG, and

[1]We were referred to the other providers in our study by agency and association representatives who told us the providers had implemented or were implementing formal compliance programs.

[2]Corporate integrity agreements are executed as part of a civil settlement between a health care provider (or an entity responsible for billing for the provider) and the government to resolve cases of alleged health care fraud or abuse. These HHS-OIG imposed programs are in effect for a period of 3 to 5 years.

expectations that HCFA and accrediting bodies would soon require compliance programs. Although compliance programs are apparently becoming widely accepted, most of the hospitals in our study have only recently begun implementation.

Hospitals report that compliance programs require an investment of considerable time and money. However, measuring the cost of compliance programs is difficult. Hospitals in our study could not always distinguish costs attributable to their compliance programs from those of their normal operations, in part because the hospitals often had existing compliance-oriented activities that were subsumed by the compliance program. Nevertheless, hospitals reported a variety of significant direct costs, such as salaries for compliance staff and professional fees for consultants and attorneys. For example, compliance department salary estimates ranged from $15,000 to $2.5 million. However, according to the information we were able to obtain, direct compliance program costs appear to account for a very small percentage of total patient revenues—less than 1 percent in all but one of the hospitals we studied. The hospitals also reported indirect costs, such as time spent by employees in compliance-related training and away from their regular duties. These indirect costs are more difficult to measure and may be larger than the direct costs reported.

The principal measure of a compliance program's effectiveness is its ability to prevent improper Medicare payments. However, it is difficult to measure effectiveness in this way because of the lack of comprehensive baseline data and the existence of many other factors that could affect measurement results. Other measures have been suggested as a proxy for measuring compliance program effectiveness, such as the amount and frequency of refunds of overpayments identified by the provider and the frequency of self-disclosures of potential provider misconduct. Hospital officials in our study agreed that these are valid indicators of compliance program effectiveness but also pointed to other indicators—such as increased employee knowledge of compliance policies and procedures. Hospital officials in our study reported that the benefits of their compliance programs outweigh their costs. They believe that these programs will reduce their liability under the fraud and abuse statutes. Further, Medicare contractors reported that they have received refunds of provider overpayments with more frequency—in one case, a $2.7 million refund reportedly identified through the provider's compliance program. We have also noted an increase in formal provider self-disclosures during the last few years. However, this preliminary evidence does not

demonstrate that compliance programs have reduced improper Medicare payments.

Background

With the increased focus on health care fraud and abuse in recent years, the government has identified widespread improper billing by Medicare providers. While in the past the government might have simply sought repayment, it has begun to invoke the penalties and damages prescribed in the False Claims Act in some cases. The False Claims Act has become one of the government's primary enforcement tools because it allows recovery of losses to federal health care programs, and the damages and penalty provisions provide a deterrent effect. The act provides that anyone who knowingly submits false claims to the government is liable for three times the amount of damages plus a mandatory penalty of $5,000 to $10,000 for each false claim.[3] The term "knowingly" is broadly defined to mean that a person (1) has actual knowledge of the false claim, or (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard for the truth or falsity of the information.[4] In the health care setting, where providers submit thousands of claims each year, the potential damages and penalties provided under the False Claims Act can be quite large.

The widespread application of the False Claims Act to improper Medicare billings has heightened providers' attention to the importance of compliance with Medicare program requirements. In February 1997, HHS-OIG released its first guidance[5] for compliance programs in the health care industry—Model Compliance Plan for Clinical Laboratories. Since then, HHS-OIG has issued three additional provider-specific compliance guides and revised the laboratory model. Through these guides HHS-OIG encourages providers to improve and enhance their internal controls so that their billing practices are in compliance with Medicare's rules and regulations. However, use of the guides remains voluntary. Table 1 shows the current HHS-OIG compliance guides and the dates they were issued.

[3]31 U.S.C. 3729(a).

[4]31 U.S.C. 3729(b).

[5]Throughout this report, referred to as "guide(s)." The "Hospital Guide" can be found at 63 Fed. Reg. 8987 (Feb. 23, 1998). This and the other compliance guides can also be found at HHS-OIG's website: http://www.dhhs.gov/progorg/oig.

Table 1: Office of Inspector General Health Care Compliance Program Guides

HHS-OIG guide	Date issued
Compliance Program Guidance for Hospitals	February 1998
Compliance Program Guidance for Home Health Agencies	August 1998
Compliance Program Guidance for Clinical Laboratories (revised)	August 1998
Compliance Program Guidance for Third-Party Medical Billing Companies	November 1998

All of the HHS-OIG compliance guides provide for seven components of comprehensive compliance programs:

1. Written policies and procedures, including standards of conduct.

2. Designation of a compliance officer responsible for operating and monitoring the compliance program.

3. Regular employee education and training programs.

4. A reporting mechanism to receive complaints anonymously.

5. Corrective action policies and procedures, including disciplinary policies, to respond to allegations of noncompliance.

6. Periodic audits to monitor compliance.

7. Investigation and correction of identified systemic problems, including policies addressing the nonemployment of sanctioned individuals.

Each of the compliance guides also highlights what HHS-OIG calls "risk areas," or areas of special concern, which HHS-OIG has identified through its investigative and audit activities, and which it believes the internal policies and procedures of compliance programs should address. While the risk areas are generally specific to a type of provider, several of the risk areas are included in more than one guide. Risk areas identified by HHS-OIG include potential Medicare billing infractions such as billing for items or services not actually provided and billing for a more expensive item or service than provided. HHS-OIG cites other Medicare rules and

regulations as risk areas as well, including the Stark physician self-referral law[6] and the antikickback statute.[7]

HHS-OIG believes that the compliance guides have significantly advanced the cause of corporate compliance with federal health care program requirements and is planning to issue guides for other health care providers serving Medicare beneficiaries. These include durable medical equipment companies, Medicare+Choice organizations offering coordinated care plans, nursing homes, and hospices. (The regulations implementing the Medicare+Choice program require Medicare+Choice organizations to implement compliance plans.[8])

Providers' compliance programs, among other things, are to be considered by Justice attorneys in determining whether the provider "knowingly" submitted a false claim, according to detailed guidance on the use of the False Claims Act in health care matters which was issued by the Deputy Attorney General in June 1998.[9] While this guidance primarily addresses national health care initiatives, such as the 72-hour Window Project,[10] it also directs Justice attorneys to consider prior remedial efforts such as self-disclosure of potential wrongdoing. We recently issued the first of two legislatively mandated reports on Justice efforts to implement its new False Claims Act guidance.[11]

Hospitals Are Implementing Compliance Programs

According to the results of two hospital surveys, our interviews with observers in the health care field, and our study of 25 hospitals, it is apparent that many hospitals are implementing formal compliance programs. However, the actual prevalence of such programs is difficult to determine precisely. Often hospitals are driven in their compliance efforts,

[6]42 U.S.C. 1395nn. The "Stark" laws prohibit referrals for certain services payable under Medicare if the referring physician (or a party related to the physician) has a financial relationship through either ownership or compensation with the entity providing the service.

[7]42 U.S.C. 1320a-7b(b). The antikickback statute prohibits providers from knowingly and willfully offering, paying, soliciting, or receiving—either directly or indirectly—any remuneration in order to induce the referral of any patient or business item for which payment may be made, in whole or in part, by the government.

[8]See 42 C.F.R. 422.501 (63 Fed. Reg. 34968 (June 26, 1998)). Medicare+Choice organizations have until January 1, 2000, to implement a compliance plan. The regulations require that the plan include elements similar to the seven elements identified in the HHS-OIG guides.

[9]See Guidance on the Use of the False Claims Act in Civil Health Care Matters located at http://fca.aha.org/guidance6-98.html.

[10]The 72-Hour Window Project is described later in the report.

[11]Medicare Fraud and Abuse: Early Status of Justice's Compliance With False Claims Act Guidance (GAO/HEHS-99-42R, Feb. 1, 1999).

at least in part, by the requirements of agreements with the government resolving allegations of provider misconduct. Hospitals that agreed to implement compliance procedures to resolve billing or fraud issues told us they are implementing compliance programs that go well beyond the requirements of the agreements. Because their programs are relatively new, only a few of the hospitals in our study have completely implemented all of the policies and procedures that they have identified as being part of their compliance program.

Accurate Count of Compliance Programs Is Not Available

Medicare providers are generally not required to report on their compliance programs to federal agencies or other entities so there are no readily available data on their prevalence. Even if providers were required to report this information, the task of measuring the prevalence and composition of compliance programs would still be complicated by several factors. Most important, the lack of an accepted definition of a compliance program would make any tabulation problematic. HHS-OIG's hospital compliance guide itself states that "there is no single 'best' hospital compliance program, given the diversity within the industry."[12]

In addition, determining whether or not the components of a compliance program have been meaningfully implemented is inherently subjective. For example, whether or not a provider is conducting billing audits is subject to interpretation. While two compliance programs may each call for a sampling of all claims, their sampling methodologies may differ significantly. Further, one provider may review past claims when a problem is identified, and another provider may audit only current claims.

Indications Point to Compliance Programs Being Implemented

Despite these inherent measurement difficulties, there are indications that compliance programs are being implemented, in some fashion, by many hospitals. We spoke with members of hospital groups, federal agency representatives, and other observers in the health care and compliance fields who all said that compliance programs are increasingly prevalent. A few hospitals in our study told us that they believe compliance programs are becoming an industry standard. In addition, two recent hospital surveys indicate that compliance programs are being implemented. First, a February 1998 copyrighted survey by UHC (which has 84 academic health center members) found that 97 percent of the 64 respondents either had a

[12]Hospital Guide, 63 Fed. Reg. 8988.

compliance program in place or planned to implement one soon.[13] Also, a recent survey of 4,300 hospitals by AHA found that 96 percent of the 1,902 respondents indicated that they have a formal compliance program in place or plan to implement one within the coming year.[14]

Efforts to Initiate Compliance Programs Are Driven in Part by Settlement Agreements With the Government

About 2,000 hospitals have agreed to implement certain compliance procedures—in some cases a full compliance program covering all Medicare risk areas—as part of an agreement with the government to settle billing issues under the False Claims Act. Nearly all of the 25 hospitals in our study had agreed to implement compliance procedures as part of a settlement agreement for at least some part of their operations. Seventeen of the hospitals in our study agreed to implement compliance procedures as part of a settlement under Justice's 72-Hour Window Project.[15] The 72-Hour Window Project investigates whether hospitals have separately billed Medicare for outpatient services, which are already covered by a Medicare inpatient payment, such as preadmission tests provided within 72 hours of admission. The compliance procedures required under this project include installing and maintaining computer systems to identify such outpatient services before the hospital bills Medicare as well as training billing personnel on the 72-hour rule. These settlements do not cover any risk area other than the 72-hour rule, do not require ongoing monitoring, do not require the appointment of a compliance officer, and do not impose any obligations on the hospital to report any potential violations uncovered.

At least 6 of the 25 hospitals in our study agreed to implement more comprehensive corporate integrity agreements (CIA) to settle charges of misconduct in their Medicare operations. A CIA is an agreement between a health care provider and HHS-OIG in conjunction with the settlement of a case alleging health care fraud or abuse. CIAs are generally specific to the provider and case, set requirements for a term of 3 to 5 years, and are a condition of the provider's continued participation in Medicare and other federal health care programs. While CIA requirements vary, they generally

[13]UHC was to update this survey in February 1999, with results expected to be released to members by May 1999.

[14]Because fewer than 50 percent of the surveyed hospitals responded, the results cannot be generalized to all of the hospitals that received the survey.

[15]Several of these organizations are large systems with many hospitals. In some cases only one or a few of the system's hospitals were required to implement these procedures, while in other cases more than half of the system's hospitals were so required. Over 4,600 hospitals were targeted by this national initiative, and at least 1,600 have agreed to implement compliance procedures as a part of their settlement. See Medicare: Application of the False Claims Act to Hospital Billing Practices (GAO/HEHS-98-195, July 10, 1998).

include (1) the appointment of a Compliance Officer; (2) mandatory compliance training; (3) internal and/or independent external reviews of either specified risk areas, the implementation of the agreement provisions, or both; (4) notice to HHS-OIG of material violations when identified; (5) annual reporting to HHS-OIG; and (6) continuing CIA responsibilities after organizational changes such as mergers and acquisitions. If a provider fails to comply with the CIA, HHS-OIG reserves the right to exclude the provider from Medicare and other federal health care programs or, alternatively, impose monetary penalties. HHS-OIG has recently negotiated CIAs that require compliance procedures covering all laws, regulations, and guidelines relating to federal and state health care programs—not only those relevant to the allegations in the case.

Most of the hospital officials we interviewed told us that they felt compelled to implement more extensive compliance procedures than required of them by the federal government.[16] Twenty-two of the 25 hospitals we reviewed have government-imposed compliance procedures of some type; nearly all of the 22 told us their compliance programs go beyond the requirements of any settlement agreements they are subject to—often far beyond. For instance, as of December 31, 1998, 10 of the hospitals in our study have only the compliance procedures associated with the 72-Hour Window Project imposed upon them. Yet 9 of those 10 say they have implemented or plan to soon implement a more comprehensive compliance program with procedures covering risk areas such as medical necessity, laboratory billing, and upcoding.

When asked why they felt the need to develop more rigorous compliance programs, these hospital officials mentioned the heightened enforcement environment, HHS-OIG guides and workplans showing a continued enforcement focus on hospital billing, and expectations that HCFA and accrediting bodies would soon require compliance programs. Some providers and observers in the field noted that HCFA's requirement that managed care plans participating in the new Medicare+Choice program implement compliance programs may be an indication that compliance programs will eventually be mandated.

Few Compliance Programs in Study Are Fully Implemented

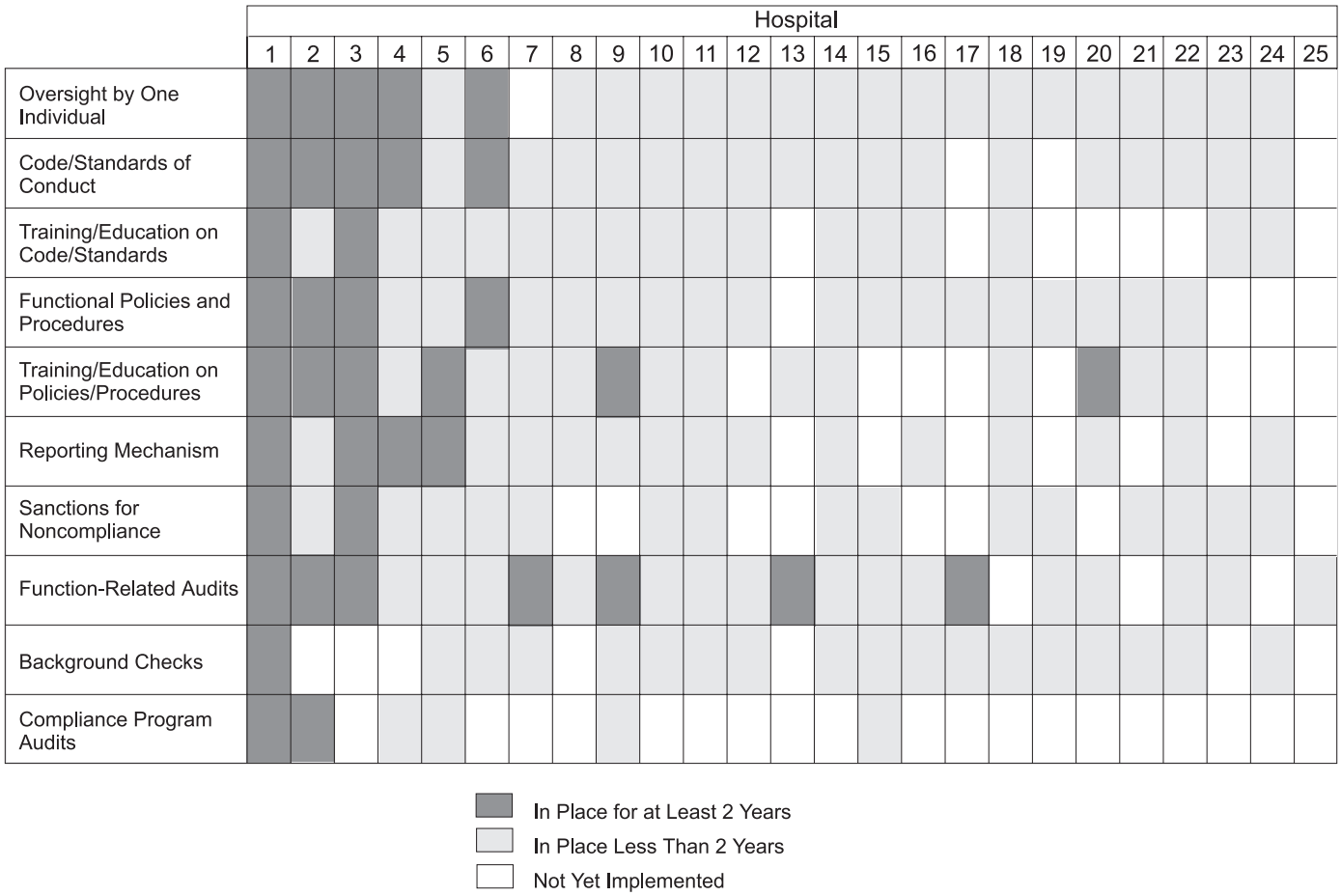
Very few of the hospitals in our study have fully implemented their compliance programs. All 25 of them identified policies, processes, and procedures that they said were important parts of their programs.

[16]Requirements for providers to implement compliance procedures can be imposed through the settlement agreement by Justice and HHS-OIG or through an associated CIA.

However, only five of the hospitals have implemented all of the policies, processes, and procedures identified. Seventeen hospitals have not conducted compliance program audits, to ensure that the policies, processes, and procedures of their compliance program have been carried out. Seven hospitals still need to introduce the compliance program to their employees. Six hospitals have not started doing background checks to identify sanctioned individuals, and two hospitals have yet to establish an organizational code of conduct.

Figure 1 shows the implementation status and history of the various components of the compliance programs being implemented by our study's hospital providers.

Figure 1: Compliance Program Implementation Reported by Hospitals



Hospitals Report Compliance Program Costs Are Considerable

According to the hospitals in our study, the implementation and operation of compliance programs entail a considerable commitment of time and money. However, among hospitals that could provide us with direct compliance program cost data, only one appears to spend more than 1 percent of total patient care revenues. All of the hospitals in our study identified direct cost components, such as salaries and fringe benefits for compliance officers and staff, consulting and legal fees, and outside audit services; but determining the costs of these and other components of compliance programs was difficult for our hospital providers. The lack of a compliance budget was the main reason for this difficulty; the hospitals

could not always distinguish the costs attributable to their compliance programs from those of their normal operations. The components for which hospitals could estimate costs, as well as the actual cost estimates, varied widely among the hospitals. Hospital officials pointed out that their compliance programs also generate indirect costs, which are more difficult to measure and may be greater than the direct costs.

Compliance Program Costs Are Difficult to Measure Accurately

Fifteen of the hospitals in our study did not specifically budget for compliance activities, limiting their ability to give us precise or comprehensive figures for their compliance program costs. Without a compliance budget, these officials were hard-pressed to distinguish the costs of their compliance program-related activities from the costs of their normal business operations. In addition, the compliance officials we interviewed differed as to their treatment of costs absorbed by departments other than their own. Some considered these to be costs of their compliance program, others did not. Eight hospitals in our study told us their ability to report compliance program costs was further limited because they had difficulty identifying costs they would have incurred even without their formal compliance programs. For example, officials at six hospitals said they had long audited medical records on a periodic basis and that the compliance program merely formalized their methodology.

The challenges in capturing compliance program costs were borne out by UHC's February 1998 membership survey. In addition to determining which of its members were implementing compliance programs, UHC attempted to gather comprehensive information about the cost of compliance program components. The consortium found that while members could identify some cost information, they generally could not provide cost estimates for all compliance program components.

Estimates for Compliance Program Direct Costs Vary Widely

In general, the cost estimates given to us by hospitals fell under the following compliance-related categories: development of policies, processes, and procedures; oversight activities; background checks; training and education; auditing; operation of reporting mechanisms, such as a compliance hotline; and attorney fees and investigations. The hospital officials we spoke with could not address the costs associated with each of these categories because of differences in how they organized their compliance programs and how they funded these activities. In those cost categories for which we received more than one hospital's estimates, the

costs reported varied widely. The relation of these costs to the organizations' revenues varied as well. In one case, the direct costs identified by a hospital chain with relatively comprehensive cost estimates were less than 1 percent of the chain's revenue. In another, the compliance officer of a hospital-affiliated physician practice plan estimated the costs of its compliance program to be over 2 percent of the plan's revenue.

One direct cost figure frequently identified by hospitals was the annual salary(ies) of the compliance officer/staff. The low cost reported was $15,000 at a mid-sized hospital where the compliance officer devoted 10 percent of his time to compliance and the hospital received substantial support and guidance from its system parent. The highest estimated cost was $2.5 million at a large hospital system where the compliance staff included four full-time attorneys and support staff. Audit costs (both internal and external) were the most frequently identified direct cost component, with estimates ranging from $17,000 to about $3.8 million per year.

Compliance Programs Have Indirect Costs

The hospitals in our study also identified many significant indirect costs associated with their compliance programs. Foremost among these was employee and physician time spent away from regular duties while attending compliance-related training. Indirect compliance program costs were not generally estimated by the hospitals in our study, but hospital officials told us these costs might be larger than the direct costs. For example, the compliance officer from a hospital that did estimate some indirect costs told us that the organization spent approximately $2 per employee to present its compliance program training. However, he estimated the value of the time spent by the employees away from their normal duties while attending the training to be $25 per employee, over 10 times as much. Other indirect compliance program costs identified by hospitals in our study include the time of high-level executives spent on compliance program development and oversight, and lower revenues as a result of conservative billing practices.

Early Evidence of Compliance Program Effectiveness Is Inconclusive

The principal objective of compliance programs, and hence the most direct measure of their effectiveness, is their performance in preventing improper Medicare payments. However, baseline data on the amount of improper payments made to providers is lacking; and the costs associated with gathering such baseline data—or comparison data for providers without compliance programs—have precluded the use of this

effectiveness measure. Lacking such a direct measure, HHS-OIG plans to continue using various indirect measures, including refunds of provider-identified overpayments and self-disclosures of potential misconduct, to determine whether or not compliance programs are effective. Officials from HHS-OIG and Justice told us they anticipate that, as providers fully implement their compliance programs, provider-identified refunds and self-disclosures should increase, at least initially. Another possible indicator of effectiveness mentioned by law enforcement authorities is the frequency of disciplinary actions taken against noncompliant employees. Hospital officials in our study agreed that these measures could indicate compliance program effectiveness, but pointed to some others as well. The most frequently mentioned was increased employee awareness of proper billing rules and other compliance policies and procedures.

While each of the measurement criteria mentioned has limitations that prevent conclusive proof that the elements of compliance programs reduce improper Medicare payments, there are preliminary indications that such programs can have a positive effect. For example, some Medicare contractors have reported refunds of provider-identified overpayments, although neither they nor HCFA keep track of this indicator on a systematic basis. Self-disclosures of potential misconduct by providers have been reported by HHS-OIG, Justice, and hospital officials, although the number of self-disclosures reported is small. Hospital officials also reported taking disciplinary actions against noncompliant employees and instituting corrective actions, such as remedial training of billing staff. Finally, the hospitals in our study overwhelmingly believe that the benefits of their compliance programs exceed their costs.

Refunds of Provider-Identified Overpayments

Because compliance programs are relatively new to the health care industry, HHS-OIG and Justice officials say they have yet to come across many that led to refunds of provider-identified overpayments. These officials do acknowledge, however, that some billing errors are inevitable. Therefore, they expect that as effective compliance programs are implemented, these errors will be detected and such detection will lead to an increase in refunds of provider-identified overpayments. HHS-OIG officials think this will happen because the monitoring of compliance across the risk areas identified by their compliance guides will probably cause providers to examine billing issues that they had not examined before. HHS-OIG and Justice officials further expect that as compliance programs mature, providers' compliance with Medicare billing rules

should increase and refunds of provider-identified overpayments should then decline.

Others we spoke with cautioned that a variety of factors could contribute to an increase in refunds of provider-identified overpayments—not just the effectiveness of compliance programs. For example, a change in Medicare billing rules or the institution of a new payment system might cause errors that could lead to an increase in refunds of provider-identified overpayments. Similarly, provider operational changes, such as entering a new line of business or acquiring another provider, could lead to an increase in overpayments returned. Moreover, while several hospitals in our study were hopeful that over time the billing errors detected by their compliance program would decline, a few felt that billing errors might not, in fact, decline because of the complexity of Medicare rules. Therefore, tracking refunds of provider-identified overpayments—either for an individual provider or for providers overall—may not be sufficient to determine effectiveness of compliance programs.

HCFA officials and some Medicare contractors we talked with told us that although they do not routinely track refunds of provider-identified overpayments, they have noted an increase in such refunds within the last 2 years.[17] Without extensive research, these Medicare contractors were not able to tell us the actual amount of all such refunds. Nevertheless, two of the contractors were able to identify some amounts refunded. For example, one recently received a $2.7 million refund from a home health agency that said the overpayment was identified through its compliance program. In this case, after reviewing documents provided by the agency and reviewing the actions the agency has taken to ensure future billings are correct, the contractor is now in the process of assessing the agency's method for determining the refund amount. This contractor also received a $200,000 refund from a teaching hospital. One of the other two contractors we spoke with also reported that it had received refunds of overpayments, reportedly due to compliance programs.

Several hospitals indicated their compliance program had led to refunds of overpayments or informal self-disclosures. Generally, refunds of overpayments arose pursuant to an internal audit of a specific functional area identified by HHS-OIG as high-risk. For example, one hospital told us it does quarterly audits of its compliance with physician billing rules and has refunded identified overpayments when it was too late for them to

[17]These refunds are for groups of erroneous claims and are in addition to refunds Medicare contractors receive under the longstanding practice of submitting corrected claims or in settlement of a cost report.

resubmit the bill. The hospitals in our study generally viewed such refunds of overpayments to Medicare's contractors as informal self-disclosures to the government. Yet several hospitals were concerned that the contractors they deal with did not know how to process the refunds of self-identified overpayments, and a few expressed concern that the contractors would automatically refer these refunds to HHS-OIG.

Self-Disclosures of Potential Misconduct

HHS-OIG and Justice officials told us of one hospital provider who formally self-disclosed potential misconduct after a review of its billing procedures. These officials expect to see more formal self-disclosures such as this one, because the HHS-OIG compliance guides and the Sentencing Guidelines for Organizations both say misconduct identified by a compliance program should be reported to HHS-OIG or Justice.[18] HHS-OIG requires that providers who enter into CIAs report on the implementation of the agreement, and these reports usually include disclosures of refunds of overpayments and of potential misconduct.[19] Both HHS-OIG and Justice officials told us they have used speaking engagements and public documents to support and encourage providers to self-disclose as part of an effective compliance program.

Some hospital officials agreed that as compliance programs are implemented, self-disclosures of possible wrongdoing might increase. However, most hospitals said they expect that the increased awareness of compliance issues created by an effective compliance program will result in the prevention of misconduct that otherwise might occur. Therefore, there may be fewer instances of potential misconduct for providers to self-disclose. As a result, tracking self-disclosures of potential misconduct—either for an individual provider or for providers overall—may not be an appropriate indicator of effectiveness.

HHS-OIG has operated a formal voluntary disclosure mechanism since 1995 and revised the process in October 1998. Providers who identify potential

[18]The U.S. Sentencing Commission guidelines for the sentencing of organizations states that the organization will not get credit for an effective compliance program if, after becoming aware of an offense, the organization unreasonably delayed reporting the offense to appropriate governmental authorities. See USSG 8C2.5(f). The term "appropriate governmental authorities" does not encompass governmental agents, such as Medicare contractors. See USSG 8C2.5(f) (n. 11). The guide for hospitals states that where there is credible evidence of "misconduct [that] may violate criminal, civil or administrative law, [ ] the hospital promptly should report" the misconduct to Justice or HHS-OIG. See Hospital Guide, 63 Fed. Reg. 8998, n. 56.

[19]HHS-OIG officials told us that they plan to use this reported information, once it becomes due, to determine the effect of CIAs, which providers have agreed to implement in order to settle billing and fraud issues with the government.

misconduct within their organizations can use this mechanism to self-report such potential misconduct. The hospitals in our study generally did not see formal disclosure as a viable option. As of December 31, 1998, only 20 providers had applied to use this mechanism, and it is not clear that those who did formally self-disclose did so as a result of a formal compliance program.[20] (See app. II for further discussion of formal voluntary disclosure mechanisms.)

Although few providers have used the formal self-disclosure mechanism, some of the hospitals in our study told us they had informally contacted HHS-OIG or Justice officials to discuss billing problems in their organization before returning an overpayment to Medicare. In some instances, the problem was identified through their compliance program. The typical informal self-disclosure that hospitals described to us involves the provider's attorney approaching an HHS-OIG or Justice representative and describing the issue on behalf of the provider. Hospitals and hospital associations and their advisers told us self-disclosure is fraught with risk, and therefore it is a step that is taken only after careful consideration of the ramifications.

Other Possible Indicators of Compliance Program Effectiveness

Justice, HHS-OIG, and the hospitals in our study identified other possible indicators of compliance program effectiveness. For example, HHS-OIG and Justice have said they will be looking for disciplinary actions taken by providers against employees who have not followed compliance procedures. The hospitals in our study that reported overpayment refunds and self-disclosures told us that they also took additional corrective actions such as remedial training, discipline, and modification of compliance program policies and procedures. For example, some hospitals associated with physician groups told us they used special procedures to review the bills for physicians with documentation problems. A few of these hospitals make the physician either absorb this expense, foot the costs of remedial training, or pay some other type of monetary sanction in an attempt to improve that physician's compliance. Several hospitals have had trainers teach correct billing and coding techniques to the employees who are identified by audits as having weaknesses in these areas.

The major intangible indicator mentioned by hospitals is an increased corporate awareness of compliance as shown by frequent calls to

[20]In its technical comments on this report, HHS-OIG told us that since December 31, 1998, it has received 14 additional disclosures.

compliance staff and/or hotlines for guidance. Sixteen hospitals told us that an improved employee knowledge of compliance issues, risk areas, and procedures is something they will consider in evaluating the effectiveness of their compliance efforts. Some plan to measure this knowledge in conjunction with compliance training by asking employees questions such as "What is our hotline number?" and "What risk areas does our organization face?" A few hospitals will have employees respond to hypothetical situations so the compliance officer can judge whether or not the employee knows what to do when faced with concerns regarding compliance with Medicare rules.

Providers Report Benefits of Compliance Programs Exceed the Costs

Almost all of the hospitals in our study believe their liability under the fraud and abuse statutes will be reduced as a result of their compliance programs. For most of them the reduction of improper payments and their attendant liabilities is a benefit that exceeds the costs of their compliance programs. In addition to this benefit, hospitals expressed hope that they would receive some form of recognition of their compliance efforts if they should be the targets of an investigation by the federal government. They also believe the compliance program helps foster an improved culture for "doing the right thing." Additionally, several hospitals said their compliance program helps them maintain their reputation in the community. These hospital officials told us that these benefits, where realized, also indicate compliance program effectiveness.

Several of the hospitals we interviewed told us they received such recognition when they were the target of an investigation. One hospital, with a long-standing compliance program, told us that it was subject to an HHS-OIG Physicians at Teaching Hospitals audit.[21] This hospital credited its compliance program with enabling it to arrange not only a less expensive method for conducting the audit but, ultimately, a written resolution of the audit without findings.[22]

Five hospitals that had entered into settlements with Justice and HHS-OIG told us that their compliance efforts were recognized in the form of nonexclusion from Medicare, less onerous future compliance requirements, or less than treble damages. However, more hospitals expressed concern about not getting such recognition from law

[21]GAO reviewed this multistate initiative. See Medicare: Concerns With Physicians at Teaching Hospitals (PATH) Audits (GAO/HEHS-98-174, July 23, 1998).

[22]An HHS-OIG official told us that HHS-OIG did not evaluate this provider's compliance program as part of the audit.

enforcement agencies. At least one hospital system claimed that a U.S. Attorney did not give it credit for its preexisting compliance program in a settlement because the U.S. Attorney believed the hospital involved had not effectively corrected prior misconduct. Nevertheless, Justice and HHS-OIG officials told us, and have publicly stated, that they will consider the presence of an effective compliance program when settling allegations of improper billing by hospitals.

During our study we attempted to determine whether U.S. Attorneys have encountered compliance programs in the course of their investigations and whether the presence of a compliance program affected the investigation. Because Justice does not track whether health care providers it investigates have compliance programs, we asked Justice officials to contact the U.S. Attorneys' offices responsible for most of the districts where the providers in our study were located. In these 20 districts, the U.S. Attorneys reported four closed cases in which the health care provider investigated had a compliance program in place at the time of the investigation. One case involved the self-disclosure and refund of an overpayment identified in a compliance program audit. This case was closed with no action taken by Justice. In another case, the U.S. Attorney reported that a provider being investigated for billing problems had a compliance program in place that appeared to have prevented billing problems, and the investigation was dropped.

In the remaining two cases, although a compliance program was in place at the time of the alleged misconduct, the U.S. Attorneys involved indicated they did not reduce damages when arriving at the settlement. U.S. Attorneys also reported that several providers under current investigation have compliance programs that were in place at the time of the alleged misconduct. However, because these cases are still open, Justice officials will not discuss whether or how the presence of a compliance program will affect the final disposition of these cases.

Conclusions

In addition to stepping up enforcement actions, HHS-OIG, HCFA, and Justice have all encouraged the adoption of compliance programs in the hopes of reducing improper Medicare payments. The voluntary compliance of hospitals and other Medicare providers is crucial to reducing the improper payments that continue to plague the program.

Although determining the prevalence of such programs is difficult, there is a consensus among providers and agencies that these programs are

becoming more widespread. Furthermore, despite the investment of time and resources that compliance programs entail, many hospitals believe the benefits of these programs—particularly reduced liability under the fraud and abuse statutes—outweigh their costs. Finally, while the effectiveness of compliance programs is difficult to determine with certainty, HHS-OIG, HCFA, Justice, and providers themselves believe that compliance programs can reduce improper Medicare payments.

Agency Comments and Our Evaluation

We provided a draft of this report for comment to HHS-OIG and Justice. The following summarizes their comments and our responses.

HHS-OIG expressed concern that the title of the report does not reflect its view that compliance programs are effective in promoting compliance with requirements of federal health care programs. HHS-OIG points to the consensus among the hospitals in our study that the benefits of compliance programs exceed their costs as evidence of compliance program effectiveness. Finally, HHS-OIG identified several other indicators that improper payments in the Medicare program may have declined, such as its recent review of Medicare fee-for-service payments. In this review HHS-OIG reported a decline in its estimate of improper payments, from $10.6 billion in fiscal year 1997 to $7.7 billion in fiscal year 1998. We included the views of HHS-OIG and providers regarding the benefits of compliance programs in our report. However, we continue to believe that the principal measure of compliance programs' effectiveness is their effect on improper payments. The evidence available to date does not show that compliance programs have reduced improper Medicare payments. Indeed, HHS-OIG acknowledges that it does not have empirical evidence supporting a causal relationship between a decline in improper payments and implementation of compliance programs. HHS-OIG also provided technical comments, which we incorporated as appropriate. HHS-OIG's comments appear in appendix III.

Officials from Justice's Executive Office for United States Attorneys reviewed the draft and offered technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable June Gibbs Brown, HHS Inspector General; the Honorable Nancy-Ann Min DeParle,

Administrator of HCFA; the Honorable Janet Reno, U.S. Attorney General; the organizations we visited; and other interested parties.

Please call me at (312) 220-7600 or Paul Alcocer at (312) 220-7709 if you or your staffs have any questions about this report. The other major contributors are Barbara A. Mulliken and Victoria M. Smith.

Leslie G. Aronovitz
Associate Director, Health Financing and
Public Health Issues

Contents

Abbreviations

AHA	American Hospital Association
CIA	corporate integrity agreement
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of Inspector General
UHC	University Health System Consortium
VDP	Voluntary Disclosure Program

Methodology

To determine how prevalent compliance programs are among Medicare providers, we interviewed officials at HCFA; HHS-OIG; and provider-affiliated associations, including the American Hospital Association (AHA) and the Health Care Compliance Association. We also reviewed some of the results of two 1998 compliance program surveys conducted by the University HealthSystem Consortium and AHA. In addition, we asked providers about their perspective on the prevalence of compliance programs among their peers.

To determine what costs are involved with compliance programs, we interviewed 30 Medicare providers. We contacted 37 providers, and 30 of them were willing to speak with us directly about their compliance programs. We selected these providers on the basis of a variety of factors that indicated a compliance program in place at that institution. These factors included articles commenting on a compliance program, prior interviews with GAO personnel indicating a compliance program, active corporate integrity agreements, referrals by agency and association officials, and application to HHS-OIG's Voluntary Disclosure Program. The 30 providers we interviewed represent a range of provider type, geographic service area, organizational size, religious affiliation, and profit status.

Of the 30 provider organizations interviewed, 25 of them are hospitals or hospital-affiliated organizations, including physician groups. Our review focused primarily on hospital providers because they receive the largest share of Medicare funds and are the focus of several current enforcement actions. (The remaining five Medicare providers are an independent clinical laboratory, a home health organization, a durable medical equipment provider, a skilled nursing provider, and a managed care organization. We interviewed these nonhospital providers for comparison purposes only). We asked provider-affiliated association officials about their perspective on the cost of compliance programs among their member organizations. We also asked approximately 30 vendors of compliance-related products and services for the prices of their products and services, but used these for comparison purposes only.

To determine how the effectiveness of compliance programs should be measured, we interviewed officals at the Department of Justice, HHS-OIG, and provider-affiliated associations; several observers in the field; and 30 Medicare providers. We also reviewed the Federal Sentencing Guidelines for Organizations, case law referencing compliance programs, HHS-OIG Compliance Guides, Model Compliance Manuals, and the marketing

material of approximately 30 vendors of compliance-related products and services. To determine whether compliance programs are effective, we interviewed three Medicare contractors, Justice, HHS-OIG, and HCFA with regard to the presence of the measures that had been identified. We also interviewed provider-affiliated associations, several observers in the field, and 30 Medicare providers about their perspective on the effectiveness of compliance programs but used this information for comparison purposes only. We also reviewed the results of HHS-OIG's Voluntary Disclosure Program.

We conducted our work at HCFA, HHS-OIG, Justice, and selected provider and provider-affiliated association offices. We performed our work between May 1998 and February 1999 in accordance with generally accepted government auditing standards.

HHS-OIG's Voluntary Disclosure Program/Protocol

In May 1995, HHS-OIG and Justice initiated a pilot Voluntary Disclosure Program (VDP) in conjunction with the Operation Restore Trust initiative[23] for providers to report instances of possible misconduct. In "An Open Letter to Health Care Providers," HHS-OIG stated that the success of this and other such initiatives would be best ensured through cooperative efforts with providers. However, the VDP pilot was ostensibly open only to the providers targeted by Operation Restore Trust.[24] Moreover, acceptance into the program was predicated on strict eligibility requirements being met. The disclosure had to be on behalf of an entity and not an individual, and the entity could not be under investigation at the time of application.

During the VDP pilot period—May 1995 through May 1997—Justice was a signatory to the agreement with the self-disclosing provider and HHS-OIG upon entry into the program. However, because of the low number of applications during the pilot period, Justice chose to no longer participate in this program. After assessing the pilot program and exploring criticisms leveled at it, HHS-OIG decided to continue these efforts under a Voluntary Disclosure Protocol (Protocol). The two hospitals we spoke with that were accepted into VDP told us that despite a high level of HHS-OIG cooperation, the application process was arduous and expensive.

Table II.1: reports the activity, by calendar year, in HHS-OIG's VDP/Protocol.

Table II.1: Activity in HHS-OIG's Voluntary Disclosure Program/Protocol

	Providers that applied	Applications accepted	Cases settled
1995	6	3	2
1996	4	4	1
1997	1[a]	0	[b]
1998	9	5	0
Total	**20**	**12**	**3**

[a]Provider applied after the pilot VDP had ended.

[b]Not applicable.

[23]The purpose of this 2-year demonstration project was to illustrate that extensive collaboration among law enforcement agencies would result in greater effectiveness and efficiency in preventing and detecting fraud and abuse in certain targeted services reimbursed by Medicare and Medicaid. Operation Restore Trust was aimed specifically at fraud, waste, and abuse in three areas: home health, nursing homes, and durable medical equipment suppliers. It targeted providers in five states: New York, Florida, Illinois, Texas, and California.

[24]According to the pilot VDP statistics given to us by HHS-OIG, none of the applicants met the criteria. Justice officials told us it was their understanding that no voluntary disclosures were submitted during the pilot period by entities within the scope of the program.

As table II.1 illustrates, the number of disclosures under VDP and the Protocol has been small. An HHS-OIG official told us he believes that with Justice no longer a formal partner in the program, it is unlikely that this Protocol will be highly utilized. However, in the belief that VDP's strict application requirements were discouraging providers from applying, HHS-OIG removed the eligibility requirements from the Protocol.[25] It should be noted, however, that like the VDP, the Protocol does not offer any assurances to self-disclosing providers.[26]

[25]63 Fed. Reg. 58,399 (Oct. 30, 1998). HHS-OIG continues to determine whether the disclosing provider is under investigation. According to the Protocol, HHS-OIG will not continue to work with a provider that is under investigation if the collaboration interferes "with the efficient and effective resolution of the inquiry." 63 Fed. Reg. 58,400.

[26]63 Fed. Reg. 58,401. ("The HHS-OIG is not bound by any findings made by the disclosing provider under the Provider Self-Disclosure Protocol and is not obligated to resolve the matter in any particular manner.")

Comments From the Department of Health and Human Services' Office of Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAR 16 1999

Mr. William J. Scanlon
Director, Health Financing and
Public Health Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Scanlon:

Enclosed are the comments of the Office of Inspector General (OIG) on the General Accounting Office's (GAO) draft report entitled, "Medicare: Early Evidence of Compliance Program Effectiveness is Inconclusive." The comments represent the tentative position of the OIG and are subject to reevaluation when the final version of this report is received.

The OIG appreciates the opportunity to comment on this draft report prior to its publication. On behalf of the OIG, we also thank you for the professional and cooperative manner in which GAO officials and staff conducted this review.

Sincerely,

June Gibbs Brown
Inspector General

Enclosure

Comments of the Office of Inspector General
on the U.S. General Accounting Office's Draft Report,
"Medicare: Early Evidence of Compliance
Program Effectiveness is Inconclusive"

As the above-captioned General Accounting Office (GAO) report contains no specific recommendations, the Office of Inspector General (OIG) offers only the following general and technical comments.

General Comments

In addition to our law enforcement efforts, the OIG has undertaken a number of affirmative outreach efforts to increase the awareness of health care providers as to the importance of compliance with the requirements of Federal health care programs. We have placed great emphasis on enhancing the knowledge of providers as to how to achieve such compliance. Among these outreach efforts are OIG Special Fraud Alerts, advisory opinions, the OIG's newly-revised Provider Self-Disclosure Protocol, and, most importantly, the OIG compliance program guidances, which are discussed at length in GAO's report (at pages 5-7). The OIG believes that it is largely as a result of these, and other measures it has taken to provide voluntary guidance to the health care industry, as well as the Government's enforcement efforts, that compliance programs have become much more prevalent in the health care community. In addition, we have reason to believe, based on our experience in working with the health care industry in developing these guidances and resources, that corporate compliance programs are proving to be effective in ensuring compliance with Federal health care program requirements.

Now on pp. 4-5.

Our initial comment, therefore, relates to the title of GAO's draft report. Given GAO's probative findings as to the significant advances compliance programs have generated, the title itself may be somewhat misleading, and may not accurately reflect GAO's findings with respect to the effectiveness of compliance programs. While there may be a variety of opinions with regard to what constitutes an effective compliance program, or what causes a compliance program to be effective (as stated in the section of the draft report with the same caption as the title of the report, see pages 15-16), there appears to be widespread agreement from both the Government and private sector that compliance programs are indeed effective, i.e., that these programs are worth their cost both to the provider and to the Government programs (see GAO draft report at pages 20-21). Therefore, it may well be that the only inconclusiveness lies with respect to (1) Government and provider experiences in determining the particular elements of compliance programs that demonstrate effectiveness or (2) the difficulty in empirically demonstrating causality. Overall, the OIG's experience, as echoed by GAO's findings in its report, has been that such programs have significantly advanced the cause of corporate compliance with Federal health care program requirements.

Now on p. 13.

Now on p. 18.

Now on p. 13.

In reconsidering this issue, and to avoid the incorrect impression that compliance programs may not be effective, GAO may want to take a broader look at the objectives and benefits of compliance programs. For example, GAO states that the principal objective, and most direct measure of effectiveness of compliance programs, "is their performance in preventing improper Medicare payments." (See page 15, lines 1 and 2 of the section with the same caption as the title of this report.) While this is certainly one of the most important objectives of a compliance program, adopting a broader perspective as to a compliance program's intended objectives and benefits may result in a modification of GAO's findings regarding effectiveness.

We believe that in addition to preventing improper Medicare payments, important objectives and benefits of compliance programs include: increasing employee awareness of applicable Federal health care program requirements, compliance issues, risk areas and internal procedures; creating a centralized source for distributing information on health care statutes, regulations and other program directives related to fraud and abuse issues; developing procedures that allow the prompt, thorough investigation of alleged misconduct by corporate officers, managers, employees, independent contractors, physicians, other health care professionals and consultants; developing a methodology that encourages employees to report potential problems; identifying and preventing criminal and unethical conduct; concretely demonstrating to employees and the community at large the entity's strong commitment to honest and responsible provider and corporate conduct; improving the quality of patient care; mitigating against wrongful intent (which will have an impact on potential sanctions against providers under the Federal Sentencing Guidelines, as well as the OIG's administrative exclusion authorities); making less onerous the requirements of any corporate integrity agreement (CIA) that may be imposed upon a provider by the OIG (in that the OIG considers and incorporates, to the extent appropriate, a provider's existing compliance program in fashioning a CIA); and limiting corporate director liability. Considering this broader list of objectives and benefits, many of which were acknowledged by providers interviewed by GAO, the OIG believes that the evidence of compliance program effectiveness is not as inconclusive as indicated by the title of the draft report.

Further, with respect to the relationship between compliance programs and the reduction of improper payments made by the Medicare program, there are several indicators pointing towards an increase in the appropriateness of payments made to Medicare health care providers.

One clear example of this improved track record is demonstrated in the results of the OIG's most recent review of Fiscal Year (FY) 1998 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare statutes and regulations. This is the third year that the OIG

has estimated these improper payments. The OIG's FY 1998 review disclosed that an estimated $12.6 billion in improper Medicare benefit payments were made, or about 7.1 percent of the $176.1 billion in processed fee-for-service payments reported by the Health Care Financing Administration (HCFA). This estimate for FY 1998 was $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion. The 1998 result ($12.6 billion) is a 45 percent decline since FY 1996 ($23.2 billion). (See "Improper Fiscal Year 1998 Medicare Fee-For-Service Payment," CIN: A-17-99-00099, February 1999).

While the OIG does not have empirical evidence supporting a specific causal relationship between the error rate decline and corrective actions taken by providers, including their implementation of corporate compliance programs, we believe that the growth of provider compliance programs is one of the significant contributing factors. We believe a strong inference can be made that increased compliance is based in large part on the Government's various fraud and abuse initiatives, including OIG's guidance to the health care industry on the importance of, as well as how to establish, corporate compliance programs.

There are two additional indicators of general relevance, i.e., a decrease in the Medicare hospital case mix index and a record-low Medicare inflation rate. While it is not possible to attribute these indicators specifically to compliance, it is probable that increased care in billing, coding, documentation, and other compliance efforts by providers are factors that help account for them.

Specifically, the prospective payment system (PPS) hospital case-mix is a discharge-weighted mean of codes claimed for Medicare payment. HCFA's Office of the Actuary found that between FY 1997 and FY 1998, for the first time, there was actually a decrease in case-mix, despite a steady increase between FY 1983 and FY 1997. The Office of the Actuary stated that some of the decrease in case-mix was likely to be attributable to the Government's enforcement efforts "to combat fraud and abuse," which may have "prompted hospitals to code less aggressively." (See November 19, 1998 Memorandum entitled, "Analysis of PPS Hospital Case-Mix Change between 1997 and 1998," from Gregory Savord, Office of the Actuary, HCFA, to Richard S. Foster, Chief Actuary.)

Second, the overall rate of growth of Medicare increased only 1.5 percent in 1998, the smallest increase in the history of the program. Many commentators have credited the Government's efforts to curb fraud and abuse, including the promotion of compliance, as one of the most important factors accounting for this small increase in growth. (For example, see Medicare Growth in '98 Was Slowest Since Plan's Start, N.Y. Times, January 12, 1999.)

Clearly, the Government's enforcement efforts and OIG's concomitant compliance measures are having a significant beneficial impact on the manner in which the health care industry operates. It would be fair, we believe, to characterize the effectiveness of these compliance measures not as "inconclusive," but as "promising."

Organizations at Which GAO Conducted Interviews

Alton Ochsner Medical Foundation, New Orleans, La.
American Hospital Association, Washington, D.C.
Beaumont Rehabilitation and Skilled Nursing Centers, Westborough, Mass.[27]
Catholic Health Initiatives, Denver, Colo.
Catholic Healthcare West, San Francisco, Calif.
Cook County Hospital, Chicago, Ill.
Coventry Health Care, Bethesda, Md.
Deborah Heart and Lung Center, Browns Mills, N.J.
Ethics Officers Association, Boston, Mass.
Gottlieb Memorial Hospital, Melrose Park, Ill.
Health Care Compliance Association, Philadelphia, Pa.
Holy Cross Health System, South Bend, Ind.
Home Health Corporation of America, King of Prussia, Pa.
Home Life Medical, Inc., Woburn, Mass.
Huguley Memorial Medical Center, Fort Worth, Tex.[28]
Joint Commission on Accreditation of Healthcare Organizations, Oak Brook, Ill.
Lewistown Hospital, Lewistown, Pa.
MedCentral Health System, Mansfield, Ohio
Meridia Health System, Cleveland, Ohio[29]
Montefiore Medical Center, Bronx, N.Y.
Parkland Health and Hospital System, Dallas, Tex.
Poudre Valley Hospital, Ft. Collins, Colo.
Provena Saint Therese Medical Center, Waukegan, Ill.[30]
Quest Diagnostics, Teterboro, N.J.
Quorum Health Group, Brentwood, Tenn.
Reedsburg Area Medical Center, Reedsburg, Wis.
Rural Wisconsin Health Cooperative, Sauk City, Wis.
Southern Illinois Healthcare, Carbondale, Ill.
Southern Illinois University, Springfield, Ill.
Sutter Health, Sacramento, Calif.
Tenet Healthcare Corporation, Santa Barbara, Calif.
Texas Health Resources, Irving, Tex.
UCSF Stanford Health Care, San Francisco, Calif.
University HealthSystem Consortium, Oak Brook, Ill.
University of Colorado Medical Services Foundation, Denver, Colo.
University of Virginia Health Services Foundation, Charlottesville, Va.

[27]A member of The Salmon Family of Services.

[28]A member of Adventist Health System.

[29]A member of Cleveland Clinic Health System.

[30]A member of Provena Health.

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