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# COMPLIANCE HOTLINE™

THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

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## OIG shifts focus to civil monetary penalties

*Corporate integrity agreements undergoing significant changes, OIG says*

The federal government recently lost its ability to prosecute state entities under the False Claims Act when the Supreme Court ruled the practice unconstitutional. Now the government is filling that vacuum with expanded use of civil monetary penalties (CMPs). "Legally, we still have a viable action under the civil monetary penalties law against states and state entities, regardless of whether such actions can be pursued under the False Claims Act," says **Gregory Demske**, a counsel in the Health and Human Services' (HHS) Office of Inspector General (OIG).

According to Demske, the OIG is stepping up its involvement in cases where state entities are not pursued in the wake of the Supreme Court's decision in the *Stevens v. Vermont* case. In that case, the court ruled that states and state entities are not "persons" subject to liability under the False Claims Act.

Demske says the OIG also is working on an increasing number of cases involving CMPs for kickbacks. "We have a civil monetary penalty up to three times the amount of the kickback and up to $50,000 per violation," he explains. "That is obviously a significant penalty that we can bring, and we are working on quite a few of those cases."

Demske also warned health care attorneys at the American Health Lawyers Association's annual conference in Washington, DC, Nov. 2 to expect

*See **OIG enforcement**, page 2*

## New compliance challenges alter acquisition landscape

An increasing number of health care organizations are paying the price for compliance problems that existed at target companies prior to acquisition. One example is the University of Pennsylvania Health System, which recently paid $12 million to settle an issue relating to the partial hospitalization program of its target acquisition, the Presbyterian Medical Center.

Penn acquired Presbyterian in 1995, and most of the patients in the partial hospitalization program who raised allegations of improper reimbursement

*See **Acquisitions,** page 4*

## How to negotiate an effective government settlement

Hospitals and other providers entering settlement negotiations with the government increasingly face an array of competing interests, warns **Cliff Johnson**, assistant U.S. Attorney in Jackson, MI. "It is not just an assistant U.S. Attorney," he warns. There are also investigative agencies in the Department of Health and Human Services, the FBI, and the Office of Inspector General, as well as fiscal intermediaries to name a few, he says. "You have a number of players who have varied and sometimes competing interests," asserts Johnson. "One of the challenges is to consider all the interests that are at play to find an approach that can mollify all sides."

Johnson says providers also must know who their audience is depending on the region. "Negotiating with folks in the South may be different than negotiating with folks in other places," he asserts. He says that means providers should consider local counsel if they don't think they

*See **Effective negotiation**, page 3*



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# OIG enforcement

*Continued from page 1*

more exclusion actions. The OIG's 3,350 exclusions in the just-completed fiscal year marked a record. But the OIG's commitment to processing cases brought by the OIG as well as other agencies has not abated, according to Demske. Most of the exclusions came from providers who lost their license in a particular state, as well as mandatory exclusions based on convictions. "There are several other categories, and they are all basically going up over time," he reports.

Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed, the government has had far more resources at its disposal to investigate cases and impose administrative sanctions, Demske adds. That fact is reflected in the OIG's just released final statistics for FY 2000, which include more than 200 successful prosecutions and total monetary recoveries of more than $1.2 billion (including criminal and CMPs).

The OIG also raked in more than $1 million for Emergency Medical Treatment and Active Labor Act violations, otherwise known as patient-dumping cases, for the third year in a row. With the maximum fine standing at $50,000, that represents 48 judgements or settlements, notes Demske. But that is actually a slight decline from 61 settlements and judgements worth $1.72 million in FY '99 and 53 settlements and judgements that pulled in $1.8 million in FY '98.

Demske says corporate integrity agreements (CIAs) also are undergoing significant changes. He says the agreements reached in FY 2000 reveal several themes. For example, now that most providers entering CIAs have existing compliance programs, he says it has become "paramount" to take into consideration the effectiveness of these agreements.

"The existence of a compliance program is one thing, but we really can't tell just by its existence how effective it is," he explains.

On the other hand, when self-disclosure occurs, Demske says, the OIG assumes the program is effective and is therefore more deferential in determining whether a CIA is appropriate and what terms should be required. That follows the OIG's open letter regarding self-disclosure issued in March, which suggested that CIAs might not be required when self-disclosure occurs.

Moreover, Demske says that when the OIG does impose a CIA against a self-disclosure, it is typically much more flexible, especially in the audit provisions.

"We have deviated quite a bit from our normal standards for audit provisions in our self-disclosure cases by allowing a greater role for internal audit as opposed to an independent review organization," Demske reports. The scope of the audits sometimes is narrower, and existing audit methodologies are permitted if providers can show they are using reliable methods.

Finally, he says the OIG typically forgoes the remedy of exclusion for breach of the CIA when self-disclosure takes place. "There is no magic number for what the OIG considers a low error rate," Demske cautions. But self-disclosure shows that a provider has been doing self-audits, which makes the OIG more comfortable with its audit methodology, he explains.

Over the last year, Demske says there also has been an increasing level of sophistication and detail in the audit provision of the CIAs. "Those are generally the most costly part of the CIA," he adds. "Over time, we think the requirements have become better because they have become more specific, particularly with regard to providers who have developed sophisticated work plans about where and how audits should be done."

Demske says the OIG's future guidance documents are likely to be smaller documents that focus only on the risk areas for particular sectors

*(Continued on page 3)*

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of the health care industry. That was the approach the OIG recently adopted in soliciting comments on risk guidelines for ambulances. "We probably won't go through the entire litany of the seven elements for each of our future guidance documents," he reports. ■

# Effective negotiation

*Continued from page 1*

speak the language.

Health care attorney **Greg Luce** of Jones Day in Washington, DC, says one way providers can navigate this terrain is through the use of four settlement propositions. While they may seem intuitive, Luce says they are often overlooked in the health care field, where many attorneys aren't day-to-day litigators.

Here are the four propositions that Luce says are critical:

**Settlement proposition #1:** Settlements resolve actual cases, not just prosecutorial theories. Luce says it is important to remember that settlements are not just theories. "It is important to apply some discipline to those discussions," he says. "If you receive a letter from the U.S. attorney's office, it doesn't mean you have a case."

According to Luce, health care attorneys should begin by assessing the strength of the case and liability asserted, including the risks of trial, risk of publicity, and risks of assenting to a corporate integrity agreement.

**Settlement proposition #2:** Settlements finally resolve all actual or threatened litigation with certainty. "At bottom, this is one of the biggest problems with corporate integrity agreements," says Luce. "You never quite finish settling your case."

But there are many other issues to be considered, he adds. Piecemeal resolutions should be avoided, warns Luce. "If you are in front of the U.S. Attorney's office and they have a serious issue, get the related issues resolved then, not later," he argues. "Don't allow it to become so narrowly articulated in [a] settlement agreement that other conduct, which has arisen in the course of their review, is now putting it back in the same chair a few months later."

Understanding the applicable time period of the conduct in question is also critical. That means understanding what you are being accused of and what you are being released from, Luce says. The settlement should be final and certain, he says.

**Settlement proposition #3:** The settlement team should be the trial team. Luce says this is one of the biggest areas of conflict or potential error, particularly for defense counsel. "It is important to gather everybody together," he says. That includes trial counsel, not just regulatory attorneys. "If you do not have the credibility to take your case to trial, you are significantly hampering your ability to settle the case on appropriate terms."

Luce says key management should be involved, including the financial officer. "It is very important that they understand whether they are at the settlement table or just involved behind the scenes," he asserts. "This is not like malpractice or commercial litigation," adds Luce. "It tests the heart and soul of the organization."

In addition, there is almost always a consulting expert who is critical to performing quantitative analysis, according to Luce. Providers need somebody to both determine the risk in monetary terms, as well as to explain sometimes to the government what the actual calculation is. "Medicare reimbursement is not intuitive," he asserts.

The compliance officer is a new face at the table in many of these negotiations, adds Luce. That is especially the case with corporate integrity agreements because the burden of that agreement is largely going to fall on that person.

**Settlement proposition #4:** The settlement should not be worse than the outcome would be at trial. This should seem intuitive, says Luce. But the truth is that settlements in the health care industry frequently are less a product of the legal risk than of the public exposure risk, he argues.

"The catastrophic damage risk associated with the False Claims Act is there but is rarely tested," Luce explains. "But the honesty and integrity of the organization is something that you cannot lightly play with." He says monetary amounts should reasonably be related to the challenged conduct, but adds that these amounts are typically not a major problem.

Finally, Luce warns that settlement terms should not require a waiver of the attorney-client privilege. "The attack on the attorney-client privilege is constant and never-ending," he asserts. "You must understand that the attorney-client privilege is going to be on the table during your negotiations," he warns. ■

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## Acquisitions

*Continued from page 1*

were patients in the program prior to Penn's acquisition of the hospital.

**Karl Thallmer**, a partner in the Philadelphia office of the law firm Reed Smith, says it is instructive to note that the prosecutor said Penn failed to do a thorough due diligence before acquiring the program, and it may have sat on what it knew for too long, thereby allowing, in the interim, a whistle-blower to bring a claim.

But this trend is not only a concern for large publicly traded corporations, warns **Katie McDermott** of the Philadelphia-based Blank Rome. As evidence, she points to a recent $300,000 settlement that followed a deal struck by a podiatrist in Maryland and two other podiatrists who bought his practice.

During the course of that negotiation, representations were made about the economic viability of the practice and its annual revenues. But after the transaction was completed, the purchasers discovered that some revenue was coming from uncovered services and filed a *qui tam* suit.

The podiatrist pled guilty to a felony last month for defrauding the Medicare program and is paying the government $301,000, which represents treble damages from the amount that the government apparently found in the audit.

"This is a good illustration of what can happen in these transactions and why due diligence, even for small and medium providers is important," McDermott argues.

She also warns providers to take note of a shifting landscape in this arena. One important issue is due diligence, which she says has taken an urgent turn in response to government investigations of health care providers. "Many of the False Claims Act settlements of the last several years have dealt with successors," she notes.

According to McDermott, that is particularly true in the lab industry, as evidenced by the record settlement entered into by Fresenius earlier this year.

Another trend providers should note is the whole issue of financing health care transactions and practices, says McDermott. She says banks are now getting involved in compliance issues and want to have an understanding that they are not extending a significant line of credit to a health care entity that is under investigation and could have major liability.

"The banks are starting to wake up to the fact that their interests are dramatically affected by these government enforcement initiatives," asserts McDermott.

She says some banks are even starting to ask about compliance plans and fraud and abuse questions before giving a physician's practice a line of credit. That means hospitals and physicians must inform the bank when they are under investigation, prepay review by contractors or if they have had a temporary suspension, she says.

*(Editor's note: See an upcoming issue of* Compliance Hotline *for advice on how to perform effective due diligence.)* ■

## Quorum agrees to $18 million Medicare settlement

Quorum Health Group Inc. of Brentwood, TN, and its subsidiary, QHG of Alabama Inc., have agreed to pay $18 million to settle claims that they defrauded the Medicare Program from 1988 to 1998, the U.S. Department of Justice announced Oct. 27.

The civil settlement resolves allegations that Quorum and Flowers Hospital defrauded Medicare by shifting costs to Home Care Services (HCS), a home health agency owned by Quorum and Flowers Hospital, and improperly used HCS to bill Medicare for unallowable costs.

The government alleged that Quorum and Flowers Hospital shifted costs from the hospital to HCS by improperly charging hospital costs on HCS' Medicare cost report.

As a result, the government says, Quorum and Flowers Hospital received excessive reimbursement from Medicare, including hospital employee salaries and benefits, costs of the hospital's physical therapy department, and hospital medical malpractice insurance premiums. ■

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