AMERICAN HEALTH CONSULTANTS®

COMPLIANCE HOTLINE™

THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

MONDAY
DECEMBER 4, 2000

Feds targeting fraud in Medicare managed care

Top Department of Justice official outlines the DOJ's blueprint for uncovering fraud

Chicago-based United Healthcare of Illinois recently became the country's second major HMO to fall victim to the government's war on Medicare managed care organizations. But federal investigators predict it won't be the last.

Late last month, United agreed to pay the government $2.9 million to settle allegations that it defrauded Medicare for improperly categorizing some of its beneficiaries living in several Illinois counties as being institutionalized and reaping enhanced per capita advance payments it was not entitled to. That follows a $15 million agreement the government reached with Miami-based Humana earlier this year to settle similar charges.

According to **Dan Anderson**, an attorney in the civil division at the U.S. Department of Justice (DOJ), the government now is working to uncover schemes by managed care companies that are sometimes buried in the complex web of managed care Medicare agreements.

Exactly how many more companies will fall prey to these investigations is an open question, however. "When you look at the universe of providers in areas such as physicians and hospitals, there are not nearly as many HMOs," explains Assistant U.S. Attorney **Linda Wawzenski**, who represented the government against United. "It is a much smaller number, relatively speaking."

*See **Managed care**, page 2*

HHS proposal takes heat off research whistle-blowers

The Department of Health and Human Services (HHS) released a proposed rule Nov. 27 aimed at protecting from retaliation whistle-blowers who make claims related to public health research projects supported by federal funds. "What I see happening here is that the government is turning up the heat to get the information it needs to move forward with these investigations," asserts **Kendra Dimond**, an attorney with Arent Fox in Washington, DC.

While all whistle-blowers are afforded protections

*See **Research whistle-blowers,** page 3*

Weed out post-acquisition problems with due diligence

Hospitals and other health care organizations are paying an increasingly high price for inadequate due diligence prior to an acquisition. But **Katie McDermott**, partner with the Philadelphia-based law firm Blank Rome, says organizations can minimize their risks by performing effective due diligence that begins with a careful examination of several key areas, including *qui tam* and other government investigations, corporate integrity agreements, and compliance plans.

McDermott, a former federal prosecutor, says the first thing organizations should look for is the existence of any *qui tam* whistle-blower suits. For organizations such as laboratories that have been the targets of national initiatives, she says there is likely a potential *qui tam* suit lurking somewhere that the government may or may not be able to disclose.

She recommends making a specific inquiry regarding the provider's relationship with the

*See **Due diligence**, page 3*

INSIDE: **OIG APPROVES FREE TRANSPORTATION SUBJECT TO CONDITIONS** 4

Managed care

Continued from page 1

Anderson reports that he recently surveyed offices investigating managed care companies and uncovered several broad themes. "They are not necessarily the simple schemes that we used to see where doctors were not rendering the services that we paid for," he asserts. Instead, federal investigators are zeroing in on so-called "enhanced payments."

While Medicare typically pays managed care plans a set fee per patient per month, plans are paid more money if patients are in end-stage dialysis or if they are "dual-eligible" patients enrolled in a Medicaid program as well as Medicare.

Plans also receive more money for patients institutionalized in a nursing home or hospital. The basic theory is that all these patients are sicker and require more care.

In the case of Humana, Anderson says the plan was submitting claims to Medicare for dual-eligible patients who were never enrolled in Medicaid. "This went on for a couple of years, and the bottom line is that we paid about $15 million more than we should have paid for the patient population," he asserts.

According to Anderson, another problem area involves patients who are no longer institutionalized. He says plans are doing a dismal job in this area, and in at least one investigation underway investigators believe it was deliberate. "Like an ostrich, they stuck their heads in the sand knowing that they got more money if they didn't report to us that the patient was no longer institutionalized," asserts Anderson. He says he expects a resolution in that case to be announced shortly.

Also causing great alarm among federal investigators are so-called "forced disenrollments," Anderson reports. He says it has always been the government's theory that once a Medicare managed care patient got sick, the plan would bend over backwards to disenroll him or her and get the patient back into a fee-for-service plan.

He claims the Office of Inspector General's database has uncovered more than $224 million in fee-for-service fees that were paid to six plans within three months of discharging certain patients enrolled in Medicare managed care.

Had the patients remained in the plan, Medicare would only have paid $20 million through capitated payments, he says.

DOJ's investigation in that area is ongoing, Anderson reports. But he adds that it is a "surprisingly complex" area. In some cases, patients opted out of the plan on their own after learning about an illness.

But in other instances, it was the physicians working for the plan, either as subcontractors or as employees, who initiated or encouraged the disenrollment. "Just giving advice is not necessarily a fraudulent or criminal act," he asserts. But any illegal remuneration connected to it would be another matter. "We are investigating that to see what, if any, legal action can be taken against those doctors," he says.

According to Anderson, whistle-blower suits so far have had little impact in the area of Medicare. In part, he says that is because it is difficult to quantify the damages for a plan that may be rendering only 25% of all the care provided.

Health care attorney **Lynn Snyder** says hospital compliance officers should note that the primary area of vulnerability in managed care has been at the state level where numerous enforcement activities have targeted the prompt payment of claims.

Snyder, of the Washington, DC-based Epstein, Becker & Green, says that hospitals struggling to receive prompt payment would benefit by staying abreast of these activities. ■

Compliance Hotline™ is published every two weeks by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. *Compliance Hotline*™ is a trademark of American Health Consultants®.

SUBSCRIBER INFORMATION
Please call **(800) 688-2421** to subscribe or if you have fax transmission problems. Outside U.S. and Canada, call **(404) 262-5536**. Our customer service hours are 8:30 a.m. to 6:00 p.m. EST.

Due diligence

Continued from page 1

government that begins with any subpoenas or contact letters but also includes any informal inquiries from the Department of Health and Human Services Office of Inspector General (OIG) or U.S. Attorneys' offices.

McDermott says organizations also should look carefully at survey results to assess the provider's quality of care. She notes that every survey that may result in a civil monetary penalty (CMP) is automatically referred to the U.S. Attorney's office. "If a provider has a proposed CMP, you can be sure that it has been referred for evaluation to the U.S. Attorney's Office," she warns.

McDermott says the next area to look at is any corporate integrity agreement (CIA) the company may be operating under. "If they are under a CIA, there is going to be significant documentation that shows how they are doing with some of these issues," she says. The acquiring entity also may wish to secure a confidentiality agreement. "You are going to want to look very carefully at the agreement and its reporting requirements, notwithstanding the desire of the provider to keep that information confidential," she says.

In addition, organizations should review annual reports to the OIG, hotline logs, and other items that provide a snapshot of the operations at the institution from a compliance perspective. According to McDermott, compliance hotline logs can offer a very effective roadmap for conducting due diligence. "Be very wary of companies that have no calls or few calls, because that is really the worst thing that can happen when you are looking at an effective compliance plan," she warns.

McDermott says organizations obviously will want to review the provider's compliance plan and assess how effectively the provider has implemented it. But that means going beyond simply asking if it has a plan and a designated compliance officer, she cautions. "You want to test a fundamental question about the philosophy of the company regarding reimbursement, compliance and personnel," she asserts. "Those are the three arenas where you are going to find fraud and abuse issues."

For example, McDermott notes that she recently examined one provider that placed compliance plan training on-line on an intranet. "They were able to make compliance part of company operations in a very meaningful way," she says. "That was very effective and led me to believe they have a good corporate philosophy regarding compliance."

McDermott says organizations also should investigate the provider's attitude about reimbursement. "It sounds a bit cavalier to ask about their attitude about reimbursement," she adds. "But you are going to want to get a picture of their relationship with the Medicare contractor and what sort of issues they have had over the last few years."

In addition, McDermott says organizations should try to find out if the provider has many disgruntled employees. "You want to look at the complaints filed against the company from a personnel perspective, even if they didn't make it into a compliance review," she argues. The compliance officer may not keep a good record of complaints and issues that arise, explains McDermott. "You want to ask about some employment issues, which may be a good indicator of what is going on," she says. ■

Research whistle-blowers

Continued from page 1

under the False Claims Act, Dimond says the research community often interacts in a unique fashion. "It is a very tight community," explains Dimond, who used to advise the National Institutes of Health regarding research compliance. She says the fear is that they will not be trusted by other research organizations after becoming a whistle-blower.

Over the past few years, HHS has encouraged people with research and clinical information to come forward, says **Robert Wanerman**, Dimond's colleague at Arent Fox. "There is real recognition that the people who are in the field know what is going on," he says. But in addition to giving whistle-blowers an opportunity to defend themselves in a forum where they can confront those who may retaliate, the proposed rule also would place certain requirements on the institution they work for.

Institutions covered by the proposed rule would

Continued on page 4

have to establish written procedures for whistleblowers that include specific mechanisms for preventing retaliation. They also would have to establish mechanisms to process whistle-blower complaints and authorize administrative remedies.

To receive federal funds, institutions would have to include in their application an assurance that it has written whistle-blower protection procedures outlined in the proposed rule.

In short, the government is telling institutions they must have these programs in place in order to secure federally funded grant support and keep it in place, says Wanerman. "The government's only power is the power of the purse, and it is going to exercise it."

Wanerman notes that the proposed rule also includes a provision about reporting by the institution to the Office of Research Integrity (ORI). As soon as a retaliation compliant is filed, the institution must submit a report to ORI along with regular updates. ■

OIG OKs free transportation subject to conditions

The Department of Health and Human Services' Office of Inspector General (OIG) determined last week that a hospital offering free transportation services to patients receiving extended courses of treatment does not violate the prohibition against inducements to beneficiaries as long as certain conditions are met.

Sandy Teplitzky, who heads the health care practice at the Baltimore-based law firm Ober Kaler, says he is encouraged by the OIG's approach in this opinion. In short, he says it is another example of the OIG concluding that if the intent is bad, a transaction may violate the anti-kickback statute, but that, because of the protections included in the proposal, sanctions would not be imposed.

Andrew Josephs, vice president at Strategic Management Systems in Alexandria, VA, says the OIG typically does not look at arrangements strictly in terms of the financial ramifications of a potential kickback. He adds that it is important for compliance officers to understand that community benefit factors heavily in the OIG's assessment of a potential kickback violation. "That is clear in this opinion," he asserts. "There is a substantial community benefit here for indigent patients that is not being advertised."

Josephs also points out that the hospital's proposed agreement is not designed to bolster its position in the marketplace because it is the only hospital in a wide geographic area. "That is a consistent theme that can be taken from advisory opinions and applied to situations that may have a very different set of facts," he says.

"The opinion is very fact-specific," adds Teplitzky. "It does not approve all patient transportation services, but only those in the particular situation that met each of those elements." That means any hospital considering a patient transportation program should carefully examine each of the elements outlined by the OIG.

The OIG notes that many arrangements involving free transportation have important and beneficial effects on patient care. However, because these arrangements sometimes lead to inappropriate steering of patients, overutilization, and the provision of medically unnecessary services, they must be evaluated on a case-by-case basis that considers several risk factors including:

- The population to whom free transportation services is offered.
- The nature or type of free transportation services offered.
- The geographic area in which free transportation services are offered.
- The availability and affordability of alternate means of transportation.
- Whether free transportation services are marketed or advertised and, if so, how?
- The type of provider offering the free transportation services.
- Whether the costs of the free transportation services will be claimed directly or indirectly on any Federal health care program cost report or claim or otherwise shifted to any federal health care program.

Teplitzky also points out that in the regulations that were published under the incentives to beneficiaries provision, there was a reference to transportation. "That reference was considerably narrower than the type of proposal that was approved in this advisory opinion," he says. ■