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False Claims Act faces key challenges in circuit courts

Excessive penalties, quality of care, and actual loss surface as main points of contention

Even as the False Claims Act continues to dominate the federal government's health care anti-fraud efforts, circuit courts are debating a range of issues that may reshape the False Claims Act landscape in important respects, experts say.

For example, despite the Supreme Court's recent decision that states are not "persons" subject to *qui tam* litigation, whistle-blowers continue to press claims against state government officials in their individual and official capacities, reports False Claims Act expert **John Boese** of Fried Frank in Washington, DC.

According to Boese, the first two appellate courts to consider this issue either have completely rejected or severely limited such claims. Most recently, a panel of the Eighth Circuit Court of Appeals concluded that state officials cannot be sued for actions taken in an official capacity and cannot be considered a person under the False Claims Act.

In the other case, a Ninth Circuit panel affirmed the dismissal of False Claims Act claims against the former attorney general of California and other state employee defendants, ruling that state personnel sued in an official capacity have absolute official immunity, says Boese.

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OIG targets excessive transfer DRG payments

Hospitals routinely are violating federal patient transfer rules when they discharge patients to post-acute settings, the Health and Human Services (HHS) Office of Inspector General (OIG) recently concluded. The agency estimates that Medicare paid approximately $52.3 million nationwide in excessive DRG payments to PPS hospitals as a result of erroneously coded discharges between Oct. 1, 1998, and Sept. 10, 1999.

In the final rule, the Centers for Medicare and Medicaid Services (CMS) indicated that hospitals maintain their responsibility to code the discharge based on the discharge plan for the patient. If the

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How to develop an effective audit methodology

A top priority for almost all compliance officers is performing audits to measure their compliance efforts. **(See *Compliance Hotline*, Oct. 22, 2001, "How to develop an effective audit protocol.") Sheryl Vacca**, a director with Deloitte and Touche in Sacramento, CA, says that before compliance officers develop an audit methodology plan, they must assemble a team. "It is important for you to develop your team from within and decide who that team is going to be," she says.

According to Vacca, it's important to know what other departments are doing because those departments may not look at the same areas from a compliance perspective. "They may look at it as documentation issue," she explains. "They are not tying it necessarily to a claim."

Vacca says one group that should be represented is legal. The legal department can help perform investigations and help define the worst

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False Claims Act

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That is only one of the debates under way in circuit courts, however. **Margaret Hutchinson**, Assistant U.S. Attorney in the U.S. Attorney's office in Philadelphia, says another looming question is whether the government has to suffer an economic loss in order for a false claims action to be sustainable. Currently, the circuit courts are split over this question, she says.

The Third Circuit issued a decision in June that concluded the government must suffer a loss in order for a false claims action to go forward. But it then revised that opinion to say that only the possibility of a loss is required.

"That is a fascinating development," says Hutchinson, adding that it brings the Third Circuit back in line with the other circuit courts that have ruled in this area.

In another notable development, she says the Sixth Circuit recently determined that even if a provider provides goods or services that are of higher quality then those contracted for, it still can be sued under the False Claims Act if it violates the terms of the contract.

The circuits are "all over the map" on this issue, reports Hutchinson. "These are recent decisions, and I don't think the issue is over," she adds.

Despite that fact, most prosecutors still want to see a financial loss before bringing a case, argues *qui tam* plaintiff attorney **Marc Raspanti** of Miller Alfonso & Raspanti in Philadelphia. The same holds for most *qui tam* plaintiff attorneys. "Whenever I bring a case to a prosecutor, I am looking for a loss, quite frankly," he says.

Another issue being debated is whether the False Claims Act is an appropriate tool for addressing quality-of-care issues. Hutchinson's colleague, Assistant U.S. Attorney **David Hoffman**, has used the False Claims Act in the nursing home arena successfully.

"In those cases, it is not about how much he is going to recover," asserts Hutchinson. "It is all about behavior change." That includes putting into place significant corporate integrity agreements, as well as monitoring and auditing mechanisms, she explains.

"We have been very effective and successful in using the False Claims Act weapon to address quality of care, and I don't think that is going to go away," warns Hutchinson. "That is only going to continue and improve, and you are going to see an increase in it."

According to Raspanti, what looked like a malpractice case 10 years ago now is fodder for a False Claims suit under quality of care. But a body of case law now is emerging that makes it a difficult area to assess, he adds.

From a plaintiff attorney point of view, Raspanti says the challenge is how to take a quality-of-care issue in one nursing home and make any money from it. "You are starting to see national chains being hit with quality-of-care theories that are no more than an extension of what prosecutors were doing when they were taking on a single nursing home," he reports.

To date, however, there are not many reported cases, and Raspanti says the courts are struggling with whether or not this is an appropriate use of the False Claims Act. For one thing, it is difficult to quantify the damages, he says. Not all of the initial cases filed in this area were based on well-articulated theories, he adds.

Yet another issue that is the subject of heated debate in the circuit courts is whether treble damages and the $5,500 mandatory minimum under the False Claims Act constitute an excessive fine prohibited by the Eight Amendment.

"There are decisions all over the map on that issue," says Hutchinson. Most notably, she points to a recent Ninth Circuit decision that held that if

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the fines and penalties allowed under the False Claims Act are grossly disproportionate to the gravity of the offense, they violate the Eighth Amendment.

According to Raspanti, the difficulty here is defining "excessive." He says the answer to that question is largely in the eye of the beholder. ■

Audit methodology

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case scenario that can occur as a result, she explains. In addition, compliance officers are more likely to get the buy-in from senior management if they are able to warn them about what could potentially come out of the audit, she adds. "Then they know ahead of time what is going on and they can be prepared for that potential."

It also is important to include risk management, she says. "They have a whole different view on life when it comes to certain areas, and they also have great assets," she explains.

Internal audit should be part of the team as well. "If you don't have your own internal audit group, at least find someone who is skilled in the audit methodology," says Vacca. "Whether they are knowledgeable in the risk area or not, they are knowledgeable regarding methodology, and you never know where your audit results are going to go," she explains.

In terms of resources, Vacca says compliance officers must use what they have. "That is the reality of the situation," she asserts. "You are not going to be able to have third parties come in and do your reviews or your audits 100% of the time."

It also is critical that compliance officers identify who is going to be responsible for the resolution. "That is not the compliance officer's responsibility," Vacca warns. "They have oversight into that, but the people who own it need to take care of the problem and make sure it is resolved."

In a broader sense, it can spell trouble when a compliance officer's job description makes him or her responsible for compliance within the organization, warns **Dan Roach**, vice president and corporate compliance officer for Catholic Healthcare West. "My belief is that the compliance officer should be responsible for developing the processes, the policies, and procedures for developing the education programs, for developing the reviews and shepherding the compliance process, but ultimately is it operation in an organization that is responsible for compliance."

He says it is the role of the chief operating officer or somebody else to ensure that the department heads actually are implementing the program that compliance officers develop. "There are very few health care systems that I am aware of where the compliance officer has the authority to hire and fire people at the operating level, and that is the ultimate trump card," he explains.

According to Roach, audit processes do not always require external review. Processes can be developed where departments evaluate their own work along with some type of oversight or limited review of the work that they have done to make sure they are applying the criteria appropriately.

"That is a way to push the auditing down into the organization," argues Roach. Doing so also will serve a useful education function for the organization, he says.

Roach says compliance officers also must consider whether to use a concurrent or retrospective review. Most lawyers typically prefer some type of a concurrent review rather than a retrospective review, because a retrospective review can cause a lot of problems, he says.

But the downside to concurrent review is that many times you don't have the complete picture, and it is typically more difficult to generate results.

Roach says that a distinction sometimes is made between accounting and auditing. "As a lawyer, I don't particularly care whether we call it a review or we call it an audit," he says. "If we identify situations where we have been overpaid, we have the same legal obligation to correct it."

Roach says that any time overpayments are discovered, the money must be returned to the fiscal intermediary even if the cases are isolated and not part of a pattern. "But unless there is a significant pattern or evidence of some kind of intentional wrongdoing or reckless disregard, it probably should stop at the [fiscal intermediary]," he adds. ■

Transfer payments

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hospital subsequently learns that post-acute care was provided, the hospital should submit an adjustment bill. However, the agency acknowledged that hospitals will not always know the disposition of patients.

"It is a crazy system, and it puts the hospital in a difficult position," says **Deborah Hale**, president of Administrative Consultant Service in Shawnee, OK. That is because hospitals often lack the resources to track patients once they are discharged, she explains.

Hale says that if hospitals do their job well in planning for discharge by looking at all the options and knowing what all the possibilities are, that is about as much as they can do.

According to the OIG, CMS has no controls in place to prevent excessive payments to prospective payment system (PPS) hospitals for erroneously coded patient discharges that are followed by post-acute care, such as care in a skilled nursing facility or a home health agency.

According to the OIG, there were more than 1 million discharges between Oct. 1, 1998, and Sept. 10, 1999, within the 10 specified DRGs. Of these discharges, 14,890 claims were followed by post-acute care treatment that fell within the window of time necessary to categorize the discharge as a qualified discharge/post-acute care transfer and met all of the criteria necessary to potentially result in an overpayment.

The OIG determined that 14,741 of those claims were erroneously coded, and the agency estimates that Medicare paid $52,311,082 in excessive DRG payments to PPS hospitals as a result of these erroneous codings.

Medicare payment rules provide that in a transfer situation, payment is made to the final discharging hospital, and each transferring hospital is paid a per-diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

As of Oct. 1, 1998, a discharge from a PPS hospital with one of the 10 specified DRGs to a post-acute care setting is treated as a transfer case. The applicable post-acute care settings are a hospital or hospital unit that is not reimbursed under PPS, a skilled nursing facility, or home if there's a written plan of care for the provision of home health services and the services begin within three days of the discharge.

In addition to recovery of overpayments, the OIG recommends that CMS establish edits in its Common Working File to compare beneficiary inpatient claims potentially subject to the post-acute care policy with subsequent claims. According to the OIG, this will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claims. CMS officials concurred with these findings and recommendations. ■

OIG says Medicare home health still accessible

Access to services was the primary concern when the Medicare home health prospective payment system (PPS) was implemented last year. But so far that does not appear to be a problem, according to the Health and Human Services Office of Inspector General (OIG), which recently weighed in on this area.

The agency looked at Medicare home health beneficiaries, known as "community" home health beneficiaries, who begin receiving these services without first having been discharged from an acute care facility.

The OIG says these patients appear to have access to Medicare home health care. But it adds that concerns surfaced regarding barriers for Medicare patients with certain medical conditions, confusion regarding Medicare eligibility, and coverage, as well as home health agency staffing shortages.

In most instances, the OIG says it found the reported experiences of community beneficiaries to be similar to those discharged from the hospital into home health services.

The OIG estimated that roughly 40% of Medicare home health beneficiaries do not have a prior hospital or nursing home stay. According to the OIG, there is some evidence that this patient population has more chronic conditions than hospital-discharge patients. ■