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Who's watching the watchers?

Former Medicare carrier settles suit for $144M

In a case that raises the question of who watches the watchers, a Medicare carrier has paid $144 million in civil and criminal fines to settle a whistle blower suit — the government's largest settlement ever with a Medicare contractor.

Health Care Service Corporation, the former Blue Cross/Blue Shield Part B Illinois contractor, has pled guilty to obstructing a federal audit as well as conspiracy to obstruct the audit. HCSC also admitted to six incidents of making false statements.

The charges involved "manipulating work samples and falsifying reports used by HCFA to evaluate how well HCSC was performing its contractual duties," according to an OIG statement. "HCSC concealed its poor performance and falsely claimed superior performance."

The plea agreements follow a 14-count indictment earlier this month of five current and former HCSC employees. They're charged with conspiring to defraud, obstructing a federal audit, mail fraud, wire fraud and making false statements. Two other former employees have pled guilty to conspiracy and other charges and are awaiting sentencing. HCSC itself opted not to renew its Medicare contract last year, and is only processing claims until a replacement takes over.

The plea, which includes $4 million in criminal fines and a $140 million civil settlement, is the culmination of a qui tam suit filed by a HCSC employee who charged that the carrier had:

- Altered records of its claims processing

*See **Watchers**, page 2*

Defending yourself against whistle blowers: Two views

If you're looking for a magic talisman that will keep whistle blowers at bay, forget it. Sooner or later you are going to make a billing or other error that violates the False Claims Act, and an employee inflamed by anger or greed can file a qui tam suit. Here's some advice from experts on both sides of the issue:

The defense: Your best protection is to have a compliance plan in place, says veteran qui tam defense attorney Jack Boese, JD, with Fried Frank Harris in Washington, D.C. A good compliance

*See **Whistle Blowers**, page 2*

Clinton cracks down on nursing homes

Nursing homes are facing a withering barrage of fraud and abuse controls as the Clinton administration targets facilities that provide poor patient care. The White House announced a slew of quality control measures that could mean big fines or exclusion for guilty providers.

"For states with poor enforcement, it's going to be a shock," says Peggy Goldstein, assistant executive director of the California Association of Health Facilities, Sacramento.

Clinton's directives mean nursing homes will face:

- Automatic sanctions — without a grace period for corrections — for providers found guilty a second time of resident abuse.
- More frequent nursing home inspections for chronic violators. Inspections will be done at staggered times and during nights and weekends.
- More civil monetary penalties. "HCFA will instruct states to impose civil monetary penalties for each instance of serious or chronic violation,"

*See **Nursing Homes**, page 4*

Watchers

performance.

♦ Failed to process claims in accordance with HCFA guidelines.

♦ Responded slowly to physician and beneficiary inquiries.

The case involved performance incentives that the carrier received from HCFA. The investigation centered on HCSC's Marion office, says company spokesman Bob Kieckhefer. "Employees felt pressured to perform to their maximum for the reputation of themselves and their company," Kieckhefer says. He admits that some employees had been paid incentives based on their performance, though he adds that the incentives probably were not a contributing factor to falsifying performance data.

HCSC began an internal investigation in 1995 after it became aware of the suit. The carrier dismissed four employees in its Marion office, installed a new government contracts team and instituted new internal controls. These include expanded ethics training for employees as well as enhanced monitoring, says Kieckhefer.

HHS Inspector General June Gibbs Brown says investigations of other Medicare contractors are under way. "Rogue contractors have been caught cheating the program in the past," Brown says. "And I am sure, because of the vast amount of money spent on Medicare, others will be tempted to scam the program in the future."

Past cases of alleged contractor fraud and abuse include:

♦ BC/BS of Florida paid $10 million in 1993 to settle charges that it didn't properly screen provider claims.

♦ BC/BS of Massachusetts paid $2.75 million to settle charges that it falsified its performance reports. The same contractor also paid $700,000 last year to settle a case in which it was accused of submitting false statements on its application to be a Medicare HMO.

♦ BC/BS of Michigan paid $51.6 million to settle charges that it falsified cost reports and used Medicare funds to pay claims that should have been handled by other insurers.

♦ BC/BS of California paid $12 million in 1997 for falsifying documents and destroying claims.

Ironically, the plea came as providers and their supporters in Congress have launched an offensive to weaken the False Claims Act. At a press conference, Brown didn't miss the opportunity to blast the critics of the FCA. "It is one of the most potent weapons against fraud and abuse," she said. "Because of its deterrent value it should not be tampered with, as some have proposed." ■

Whistle Blowers

Continued from page 1

plan will not only help to prevent billing problems, but more importantly, will give employees a chance to report their grievances. Giving employees a place to report problems, and then investigating, will satisfy some — but not all — potential whistle blowers, Boese believes. "Whistle blowers are self-righteous," Boese adds. "They are people who believe they are right and want to show how smart they are. You have to give them an opportunity to vent."

Your best move is to maintain a special compliance hotline. Still, even hotlines or drop boxes aren't a panacea. "Most whistle blowers don't use a hotline even if one does exist," notes Boese.

The plaintiff: "If there are hotlines and the complaints are responded to, great things will happen," agrees Los Angeles attorney Mark Kleiman, who's currently representing whistle blowers in 17 false claims suits against health care providers. Even if a suit is filed, your foresight will show that at least you tried to address the problem once the whistle blower brought it to your attention, he says.

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Continued from page 2

The catch is that too often, providers don't listen or they actually retaliate against employees who report compliance problems, according to Kleiman. "The folks I've talked to [who filed suits] either no longer worked there, got fired or decided no one was going to listen to them." In one of his cases, an employee reported a complaint to a provider's hotline, and in another the employee made her report through the chain of command. In both cases, the employee was fired.

Kleiman disputes the notion that whistle blowers are eager to go to court. "One of my clients is a single mother with two kids. A qui tam suit and losing her job were the last things she wanted."

If you don't want employees to go find a false claims attorney, you'd better keep them happy, warns Kleiman. It's not so much a question of pacifying them as making them feel that their complaints have been heard and acted upon. "You don't just want to say 'thank you'," Kleiman says. "Once in a while you want to say, 'Hi, we just wanted to let you know that we're pulling documents and we've hired an outside auditor.'"

Note: The rules change if you encounter a blackmail situation, Kleiman acknowledges. Say an employee threatens to file a false claims suit unless his demotion is rescinded. "You don't want to roll over in an employment situation," Kleiman says. But even if you don't give in, you had better investigate whatever problems the employee mentioned. ■

OIG eases its rules for advisory opinions

Attorneys for providers — but not trade associations — will be able to obtain advisory opinions for their clients under final regs just put out by OIG. The regs, published in the July 16 *Federal Register*, will also make it easier for providers to get opinions on whether their actions violate the anti-kickback statute.

The changes are in response to public comment on the interim advisory opinion rules that OIG published in February 1997. In particular, the agency received several letters complaining that the existing rules only allowed the parties to an arrangement to request an opinion. Technically, that meant only providers could make such requests. OIG now will specifically allow attorneys to request opinions on behalf of clients, as long as their clients themselves are eligible to ask for an opinion.

But this generosity won't extend to trade associations, which some critics say should be able to request opinions that would apply to all of their members on various national issues. OIG says this would be unfeasible because a given opinion is only binding upon the party that receives it. "It is unlikely that a party could precisely duplicate an approved arrangement," the agency notes. "Invariably, there would be differences, some of which might be significant." OIG cites the same rationale for not issuing model advisory opinions that providers could use as a template. Regulators do promise, however, that providers will be able to obtain guidance from upcoming fraud alerts as well as safe harbor regulations that promise immunity from prosecution under the anti-kickback statute.

The agency is not budging from its policy of requiring all parties to an arrangement to be identified in the request, despite complaints that it's not always practical to list every one. But whether some of the parties are in a position to affect referrals, for example, could have a bearing on the agency's decision, replies OIG. However, the final rule does allow a small escape hatch by noting that in a case involving managed care, or pricing for thousands of customers, it may not be feasible to list all parties. Providers can state in their request why they can't list every party. Nor will requests need to include provider ID numbers.

There won't be much relief, either, for providers who are financially deterred from asking for an opinion. OIG has not specified a fee schedule, except for a mandatory $250 initial deposit, though requestors can specify a maximum dollar threshold beyond which OIG would cease processing the case. "Many commentors suggested that the solution to this dilemma would be for the OIG to provide a fee estimate based on an initial review of the request," the agency notes. But OIG claims that it hasn't been issuing opinions long enough to devise a fee schedule. However, regulators will offer a "non-binding, good faith estimate" to any provider that asks for one.

Note: OIG says most of the 14 opinions it has

already issued have cost $1,500 to $3,000, with some priced even lower. Other changes in the advisory opinion process include:

♦ **The Stark connection**. HCFA is gearing up to meet a Balanced Budget Act requirement that it provide advisory opinions for the Stark self-referral laws. OIG now expects requests for an anti-kickback advisory to mention if there is a request for a Stark advisory on the same arrangement.

♦ **Specific statutes.** OIG can issue opinions regarding Section 1128 of the Social Security Act, which covers everything from kickbacks to doing business with excluded parties. Providers requesting opinions should now specify which part of Section 1128 their request addresses. Providers who want a ruling as to all aspects can expect both the process to take longer and OIG to ask for additional information.

♦ **Documents.** Descriptions of documents can now be submitted in lieu of the actual items. In addition, only those portions of a document relevant to the request need be filed.

♦ **Grace periods.** Providers will be given time to change their operations if OIG later rescinds or modifies an opinion. ■

OIG okays incentives in union contracts

Hospitals that want to reward employees based on admissions — without running afoul of the anti-kickback statute — can take comfort from the latest OIG advisory opinion (No. 98-9).

The opinion concerns a contract being negotiated by a Delaware hospital and the union representing its nurses, aides and service employees. The union is part of a coalition of six unions that help members and their dependents gain access to various health plans.

The hospital proposed paying its nurses a bonus, as part of their hourly wages, that would be pegged to the number of coalition members admitted as hospital inpatients every six months. Compensation would be decided by a formula that would vary with total admissions, plus an additional 1% of hourly wages at each of several thresholds. The bonus would be capped at 4% of the base hourly wage rate. Admissions would be counted on an aggregate basis rather than by specific services. No employee in a position to make referrals would be eligible for the bonus, and the proposed contract would include guidelines that bar union members from paying anyone in the coalition health plans to use the hospital.

The hospital asked OIG whether this arrangement would violate the anti-kickback statute's ban on payments to induce referrals. The agency concluded the compensation meets a safe harbor that exempts "any amount paid by an employer to an employee ... for employment in the provision of covered services," according to the opinion.

OIG also gave a thumbs-up regarding whether the deal would violate the rule against paying beneficiaries to use a particular provider. The law frowns on payments that would affect a patient's choice, but not nominal payments, the opinion says. ■

Nursing Homes

Continued from page 1

says a White House statement.

♦ Special attention for nursing homes that belong to chains with a bad record.

♦ Tougher inspections as HCFA beefs up training of inspectors in states that are not found to be adequately protecting patients. HCFA also will implement standard evaluation protocols to be used by states.

♦ More aggressive state enforcement as HCFA threatens to pull federal funds for states that conduct lax surveys.

♦ Residents and their families will be informed of their nursing homes' plans for controlling abuse and theft.

♦ More prosecutions as HCFA refers more cases to OIG and the Justice Department.

♦ Survey results and violation records will be posted on the Internet.

The administration also will ask Congress to mandate criminal background checks for nursing home employees, push for a greater number of trained workers, and institute a nursing ombudsman program through the Administration on Aging.

These moves come in the wake of a new HHS report that dismisses proposals to have JCAHO perform surveys rather than HCFA, as well as suggestions that the current survey system be replaced with nursing home incentives and quality improvement initiatives. ■