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MONDAY
JUNE 14, 1999

OIG issues sweeping model plan for MCOs

Controversial plan recommends MCOs identify, prioritize, and report their own risk areas

On June 10, the Department of Health and Human Services Office of Inspector General (OIG) released what **Mac Thornton**, OIG's chief counsel, calls its most important model plan to date, for managed care organizations with Medicare+Choice programs. Thornton predicts the detailed draft program will have a major impact on how managed care organizations deal with hospitals, home health agencies, and other providers.

Thornton unveiled the model plan last Thursday at the Health Care Compliance Association's Managed Care Conference in Washington, DC. He said it will likely be published in the Federal Register this week with a 30-day comment period. He anticipates the final program will be released by late summer or early fall.

The voluntary draft program offers guidance to managed care organizations that provide care to Medicare+Choice-coordinated care plans. These plans already serve more 6 million of the country's 39 million Medicare beneficiaries, and that number is expected to rise sharply over the next few years. However, because plans are paid a fixed monthly amount for each beneficiary's care, the government is concerned about the incentive those plans have to limit the care they offer. The Health Care Financing Administration (HCFA) already requires these plans to have a compliance program in place that includes seven key elements but gives them broad discretion in how

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False Claims Act spurs new insurance against suits

If you're among the growing number of providers looking for additional protection against the False Claims Act, it may be time to consider an option that was until recently available only to major health care delivery systems — traditional indemnity insurance.

The recent trend toward criminalizing false claims has spurred the development of a new insurance policy designed to protect providers from the high cost of a False Claims Act investigation. According to its architects, what makes the

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KPMG case questions legality of reserve funds

Allegations that international accounting giant KPMG assisted Columbia/HCA Healthcare Corp. in a scheme to defraud Medicare have raised serious questions about how the federal government now views several standard industry practices, including the keeping of reserve funds.

"We used to just settle these sorts of questions at year's end," observes one health care attorney. "Now, all of the sudden, the government is alleging criminal activity."

At issue is a federal suit filed last year alleging that KPMG helped some Columbia-owned Florida hospitals set up secret monetary reserves. The government argues that KPMG executives failed to advise Columbia to correct a cost report the accounting firm knew was misleading. Instead, the government alleges, KPMG advised the hospital to establish a reserve fund as protection in case the hospital was audited. The government also claims that Columbia had a second set of

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Medicare+Choice

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to meet those requirements. That is where the OIG's plan comes in, providing a more specific and focused level of guidance.

Even so, many observers were surprised by the scope of the OIG's recommendations. "My expectation had been that these guidelines would focus on the process for compliance and not the substance, but I think you will see in there that there is a lot of substance," asserts **Wendy Krasner**, a health care attorney with the Washington, DC-based firm McDermott, Will & Emery. "Whether we quarrel with it or not, there is a lot in there."

For Krasner, one particular point of contention is the model plan's recommendation that managed care organizations look at all the areas where their companies face possible exposure and prioritize them accordingly. Asking a provider to do that is tantamount to asking them the hand a potential auditor a map of potential land mines, she says.

Thornton acknowledges that this model plan represents a departure from the OIG's previous plans. "The other guidance documents basically concern billing issues," he says. "But this document addresses many policies which concern the direct provision of care to Medicare beneficiaries. That is why we feel this guidance is perhaps the most important of all the ones so far."

According to Thornton, the OIG's "four top areas of concern" regarding Medicare+Choice programs include:

- **Underutilization and quality of care.** Thornton says the OIG has a "serious concern" about organizations that inappropriately withhold care. Providers should pay particular attention to gag rules and physician incentive plans.
- **Marketing materials and personnel.** Thornton points to a recent General Accounting Office study that highlighted problems with marketing materials and says his office is now focusing on how some managed care organizations might be limiting beneficiaries' choice of providers. He also says his office urges firms to "employ rather than contract" the personnel responsible for developing these materials.
- **Selective enrollment.** Thornton says the OIG is "very concerned" about the practice known as "cherry-picking" or selective marketing, in which organizations find ways to enroll only the healthiest patients.
- **Disenrollment.** Citing a recent review that showed beneficiaries were being disenrolled just before they were supposed to receive expensive services, Thornton says the OIG is now investigating the causes behind these disenrollments. ■

Reserve funds

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books that were reviewed and in some cases compiled by KPMG.

"We think the lawsuit is without merit," says **John Fidler** of KPMG's corporate office in Montvale, NJ. He adds that the work that KPMG performed was "quite limited" in helping Columbia prepare its cost reports. "It is important to point out that we did not audit those cost reports," he says. "We simply assisted Columbia in the preparation of those reports."

Nevertheless, KPMG's involvement in the Columbia trial has unleashed a host of questions about the complex area of "reserve funds." According to **Paul Duffy**, a partner with PriceWaterhouseCoopers in Charlotte, NC, there is nothing new or unusual about the use of a reserve fund in the health care industry. "The practice of setting up of a reserve relating to a

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cost-reporting process has been around forever," Duffy explains. "Every industry reports reserves. It is a normal accounting practice whenever there is uncertainty and a firm wants to make sure their financial statements reflect that uncertainty."

But a reserve is not a second set of books, cautions **Mac Henderson**, a partner with PriceWaterhouseCoopers in Washington, DC. According to Henderson, one of the concerns that accounting firms harbor is that the government may try to portray reserves as evidence that somebody is hiding something. "I think one of the issues that this trial is going to address is conduct and knowledge," he says. "The government alleges Columbia included known non-reimbursable items on their cost report and maintained the reserve in case they were caught."

"What is on trial here is whether Columbia filed for something they knew, or should have known, should not have been reimbursed vs. the practice of calculating reserves," agrees Duffy. "Anytime you have two sets of anything, the government is going to ask questions," he says. "And if you have one with a high number and one with a low number, they are always going to want to know why they are getting the high one."

Duffy adds that when hospitals do ask Medicare program intermediaries for guidance on whether or not something is allowable, intermediaries sometimes seem afraid to give advice. "What you have is a lot of providers with information that is unclear, but they're unable to get advice about what should be filed," he says.

Gabe Imperato, a health care attorney with Broad & Cassel in Fort Lauderdale, FL, says several important lessons can already be drawn from the Columbia/HCA case. "The first is that if providers know they have been overpaid by a government payer or even a private payer, they should take immediate steps to resolve that overpayment liability," he says. "By no means should they ever take steps to conceal it in an effort to retain that money."

According to Imperato, that principle is being applied in a number of other investigations that aren't making headlines. He says the government has made it clear that it takes seriously the obligation of participants in the Medicare and Medicaid programs to disclose the receipt of unauthorized benefits they may have received mistakenly and make efforts to repay them. "The government's position is that if you are in that situation and you don't [repay], you may have committed a crime and possibly a civil false claim," he says.

The Columbia case also illustrates the fact that the feds are closely examining instances of fraud in the cost-report reimbursement process in this case as well as several other cases currently pending. "Cost report fraud is a path that is being blazed in the Columbia case but it is an area of scrutiny that is being applied across the board," Imperato says. Finally, the Columbia/HCA case shows that nobody is immune from liability. That includes the principal providers as well as consultants who may have conspired with or otherwise aided them in the activity. ■

False claims insurance

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program unique is that it offers protection not only against the costs of defending a false claims charge but against penalties for reckless disregard that may follow. Since tens of millions of dollars are potentially on the line, the new program is getting a lot of attention.

The program was jointly developed by Boynton & Boynton, a regional insurance agency in Fairhaven, NJ, that specializes in health care and QuadraMed, a software development firm in Bethlehem, PA. The policy is underwritten by Lloyd's of London.

Several similar products are already available, according to experts. However, those plans carry high deductibles and premiums and are only practical for large health care delivery systems.

The new program is generating a lot of attention, even though no provider has actually purchased a policy yet. "The problem is that everybody thinks it is a great idea, but nobody budgeted for it last year," says **Scott Satterfield** of the insurance firm Carpenter Moore in San Francisco, CA. Some providers are also waiting for someone else to take the first step.

Moreover, the program can mean a significant investment for a large provider. "I have a couple of large facilities that have been quoted over $300,000 in premiums," reports Satterfield. "Even

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though they are very close to buying it, they have not done it yet."

Nevertheless, the concept behind the new program has more advocates than detractors. "I think it would be prudent for any provider to take a long, hard look at these policies because in the current environment, there are so many investigations going on that the likelihood of even the most pristine provider coming under some sort of government scrutiny is much higher than it used to be," says **Charles Murdter**, an attorney with the Seattle-based firm Davis, Wright & Tremaine.

"At the end of the day, you may be given a clean bill of health, but the cost of the investigation can be so high that it really does make sense trying to insure yourself against those costs," adds Murdter, a former federal prosecutor with U.S. Department of Justice.

Jeffrey Schwartz, a health care attorney with Fox, Rothschild, O'Brien & Frankel in Philadelphia, takes a similar view: "I always tell my clients in the anti-trust arena, and I might even tell them in the false claims arena, if they get good coverage with a reasonable deductible and reasonable coverage it's probably a smart thing to buy."

Boynton & Boynton president **Jay Lynch** says the program was developed as a hospital-based product and put on the market five months ago. But demand from physician groups, nursing homes, and others led his firm to re-engineer the program to apply the same coverage to other markets. "We were already covering physicians who were employed by hospitals," he says. "But the feedback we got from the market was that people would like to see it for physician groups that are not necessarily affiliated with a hospital."

Boynton & Boynton's new program is unique in that it requires providers maintain an automated compliance program, says **Joe Russo**, a health care attorney with Russo & Russo in Bethlehem, PA. "It's great to have manual compliance plans, but it's extremely important, especially for large integrated delivery systems, to have an automated compliance plan where all the information is centralized." This also gives underwriters the ability to perform continuous risk assessments.

Lynch says a program for physicians was approved several weeks ago and that his firm is roughly two months away from completing a similar product for nursing homes.

Several similar products are currently being developed. For example, some insurance companies offer a product that defends against the cost of a government investigation, but it provides no liability coverage for any ensuing fines.

Satterfield adds that several carriers that insure hospitals for liability are also developing similar products but most of them will only sell to their own insured. "Right now, Boynton's program is the only one available to the open market that anybody can purchase," says Satterfield. ■

Hospital pays $4.5 million in pneumonia probe

Doctors Hospital of Hyde Park in Chicago will pay the United States $4.5 million — the largest settlement of its kind to date — to settle allegations that it misused a pneumonia diagnosis code in claims submitted to Medicare and Medicaid between 1993 and 1997, the U.S. Department of Justice has announced. The hospital becomes the sixth victim of a whistle-blower suit first filed in 1996 by Health Outcomes Technologies, a Philadelphia software firm.

The U.S. alleged that from January 1993 to June 1997, Doctors Hospital improperly billed Medicare and Medicaid with a principal diagnosis for a rare category of pneumonia. The suit alleged that about 15,000 false and fraudulent claims resulted in roughly $37 million in overpayments.

According to the suit, the number of bacterial pneumonia cases paid for by Medicare in 1993 and 1994 that were billed under the ICD-9 code 482.89 and DRG 79 was less than 4% of all pneumonia cases. In contrast, Doctors Hospital averaged nearly 35% over the same period.

The settlement agreement requires the hospital to pay the $4.5 million in four installments of roughly $992,000 over the next two years after receiving credits for about $291,000 already repaid to Medicare and Medicaid. Health Outcomes Technologies will receive $519,391 for its role in the litigation. The hospital has also entered into a corporate integrity agreement with the U.S. Department of Health and Human Services and agreed to assist in related cases. ■