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OIG lets managed care incentive plans off the hook

A new coalition of health care providers seeks to subvert federal gainsharing prohibition

While the Health and Human Services Office of Inspector General (OIG) scrambles to clarify its broad and unexpected prohibition against physician gainsharing arrangements, a coalition of health systems, hospitals and physician practice groups is gaining momentum in its bid to change the law behind the OIG's controversial position.

Late last week, Lewis Morris, the assistant inspector general for legal affairs, issued a letter stating that the OIG's July 8 advisory bulletin pertained only to fee-for-service gainsharing arrangements. Physician-hospital incentive plans for Medicare and Medicaid beneficiaries enrolled in risk-based managed care plans aren't subject to the civil monetary penalty (CMP) provisions in the Social Security Act of 1986.

"There was a lot of concern about that after the advisory bulletin was published," says **Marylou King**, JD, an attorney with McDermott, Will & Emery in Washington, DC. King says that, to many physicians, the bulletin seemed to skirt the question of whether such managed care-based gainsharing arrangements were subject to CMPs. "It had always been assumed that physician incentive plan protections flowed down through the HMO organization to protect the providers. But then, nobody ever thought this July gainsharing bulletin would come out. It called into question [plans involving] Medicare and Medicaid beneficiaries enrolled in managed care plans."

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How to instruct staff without obstructing justice

The worst has happened. Federal agents pursuing a health care fraud investigation are at your door with a search warrant or request for records, and your office is thrown into disarray.

How well you've prepared your staff to handle the shock and confusion of the investigators' initial assault could make all the difference for your practice, experts say.

Your first move is to ask the agent in charge to instruct his or her people not to talk to your employees, says **Philip L. Pomerance**, a health

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Feds scour travel records to prove billing fraud

Federal prosecutors in South Carolina allege that the Charleston-based Medical University of South Carolina (MUSC) and its affiliated physician practice, University Medical Associates (UMA) violated the False Claims Act by submitting bills to Medicare for physicians who weren't present when the billed-for service was provided.

Experts say the case highlights the importance of scrutinizing Medicare claims to make sure bills aren't simply submitted in the attending physician's name, regardless of who performed the service.

Stuart Andrews, JD, an attorney with Nelson, Mullins in Columbia, SC, who represents the medical center and the physicians group in the case, acknowledges that until the mid-1990s, UMA routinely billed under the attending physician's name, even if the attending physician wasn't available and another physician provided the service in question. "The patients received the services, and the government got what it paid for," he says.

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Gainsharing plans

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Alwyn Cassil, a spokesperson for the OIG, admits the bulletin was vague: "While it drew some distinctions between managed care and fee-for-service, it never came right out and said that we find CMPs don't apply to managed care arrangements," she says. "Consequently, we had a number of questions from people about that, so we wanted to go ahead and send a clear message to the industry."

The confusion arose in part because of the convoluted history behind the CMP sections of the Social Security Act. Initially, sections 1128A(b)(1) and (2) of the act prohibited payments by both hospitals and Medicare or Medicaid managed care plans to induce physicians to reduce clinical services. Four years later, however, the act was amended to allow managed care organizations to implement physician incentive plans, as long as the organization didn't induce the reduction of medically necessary care or put physicians at financial risk for services they didn't provide.

After the OIG dropped its July 8 bombshell against gainsharing, many industry experts began to wonder if some new and emerging types of physician incentive plans would create problems under the CMP provisions, even though they were technically managed-care based.

"The bulletin was so broad that it threw some doubt on how these plans should be treated — were they considered to exist at the provider level or at the HMO level?" King says. "This letter appears to take care of that concern by saying that, if [the beneficiaries for whom care is being provided] are in managed care plans, it's the way we thought it was before the bulletin and everybody can just relax."

Gainsharing on the fee-for-service side of the fence, however, remain very much in the domain of the CMP statutes, and there's no evidence that the OIG plans to soften its hard line against physician-hospital incentive arrangements.

That's why King's firm, McDermott, Will & Emery, is backing a newly formed coalition of health systems, hospitals, and physician groups pushing to change the CMP statute to allow certain types of fee-for-service gainsharing plans.

"The OIG bulletin suggested very strongly that the way to restore the ability of hospitals to enter into these arrangements is a legislative fix," King says. "We have a broad base of clients who have either entered into these arrangements or were considering them and believe they have value. So it seemed a natural thing for us to help facilitate this coalition."

The coalition's main problem with the OIG's interpretation of the law is that, by the OIG's own admission, the law could discourage the creation of arrangements that achieve positive results both for patients and for Medicare.

"Obviously, a reduction in health care costs that does not adversely affect the quality of health care provided to patients is in the best interests of the nation's health care system," the bulletin's authors admit. "Nonetheless, the plain language of [the act] prohibits tying the physician's compensation for such services to reductions or limitations in items or services provided to patients under the physician's clinical care."

One option the coalition is considering is to add a medical necessity provision to the CMP statute. "It would remain illegal for hospitals and physicians to share savings that would result in the limiting of medically necessary services," King says. "But there would be other cost savings and other ways in which they could achieve cost savings without cutting into medically necessary services. None of these [gainsharing] programs was ever premised on the idea of saving money at patients' expense." ■

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Don't let yourself get snared in gainsharing loophole

According to **Edward Kornreich**, JD, an attorney with Proskauer Rose in New York City, there's a loophole in the OIG's July 8 advisory bulletin against hospital-physician incentive arrangements.

Kornreich says the OIG bulletin, which he considers a "shocking broadside against gainsharing," seems to leave open the possibility that the law doesn't prohibit hospital programs that reward physicians for reducing the cost of items and services provided to hospital patients — as long as the programs don't reward the physicians for reducing the quantity and quality of those items and services.

Kornreich argues that two potentially acceptable programs not specifically mentioned by the OIG are:

- financial incentives targeted to the use of more economical hospital supplies, such as pharmaceuticals or medical devices;
- the adoption of more efficient practices, such as scheduling and the timely preparation of charts and reports.

If you're planning to explore this loophole, however, use caution, advises **Marylou King**, JD, an attorney with McDermott, Will & Emery in Washington, DC. It might work if the physician is being paid a flat fee, she says. "But if [the hospital] is paying physicians on the basis of a percentage-sharing arrangement of what's saved, I don't think that would be permitted."

Alwyn Cassil, a spokesman for the OIG, adds that anytime an arrangement involves a physician receiving a cut of the savings, "then there is potentially a problem, because in the view of the OIG there becomes an inducement to limit care to patients." ■

MUSC case

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A source close to the case says UMA's admission of its previous billing practices isn't by itself damning: "During the last decade, there's been a wider and more specific understanding of what the Health Care Financing Administration [HCFA] has expected in terms of documentation. As it became clearer that HCFA had an expectation that every bill should be submitted under the name of the physician who provided the service, then the providers conformed to that."

The problem in this case, according to prosecutors, is that at least in some instances, the physicians at UMA whose names appeared on Medicare claims weren't anywhere near the hospital when the services were performed. For example:

- Prosecutors allege that in 1992, UMA billed for care supposedly provided by Peter Gazes, MD, even though he was spending two weeks in Greece at the time.
- Another physician was allegedly in Saudi Arabia when UMA submitted bills in his name, according to prosecutors. The U.S. attorney's complaint says that residents and interns performed the actual work.

Earlier this month, MUSC and UMA won a small victory in the case, when U.S. District Court Judge Weston Houck ruled that the U.S. Attorney's office could not broaden the scope of its investigation by examining the personal records of 54 more physicians affiliated with UMA.

Currently, prosecutors have investigated the records of 47 UMA physicians, including their credit card records, personal calendars, hotel and car rental receipts, and travel agency records, to determine whether the physicians were actually present at MUSC when bills were submitted in their name.

Even though charges haven't yet been brought against the individual physicians, that doesn't mean they're off the hook, Andrews says. "The government will be seeking damages against the practice, rather than against the individual members or owners of the practice." And while no one's talking money yet, UMA and its member physicians could stand to take a crippling financial blow if the government proves its case.

The qui tam suit was originally brought by several MUSC employees, including the former business manager of the department of ophthalmology, and a former director of internal audits and financial reporting at MUSC. The government joined only one of the claims the qui tam relators filed, the one regarding absentee billing, Andrews says.

Attorneys in the case will spend at least the next two months gathering depositions. The case is scheduled to go to trial in March 2000. ■

Instructing staff

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care lawyer with the Chicago firm of Hinshaw & Culbertson. If the agents continue in their attempts to interrogate the staff, continue to state your objection.

Next, advise your employees that they have the right not to answer the questions directed to them. However, you must not tell them outright not answer questions; the investigators may construe that as obstructing justice or even witness tampering. Object strenuously if you believe an agent is intimidating anyone. If employees agree to be interviewed, insist that your lawyer be present during the interview. Record the interview, if possible.

Quietly — and as quickly as possible — send all nonessential employees home. Advise the agent in charge that you are sending the employees home for the day.

"In rare instances, you may want to stay open the rest of the day, but it is generally better to close during a search," says Pomerance.

It might be worthwhile to keep some employees on site to help the agents call up computer information and other documents subject to search, if only to reduce the risk of damage to your property, Pomerance says. "Make it clear to the agent in charge that you are not consenting to the search, but that the employees are here to ease the disruption and damage to your business caused by the search," says Pomerance. "Then send all remaining employees home."

The agent in charge has no authority to detain the employees. He or she may ask for a list of the employees' names, addresses, and phone numbers. You aren't required to produce this information, but you might as well; the investigators will discover it anyway during the search, and providing it up front may reduce employee contact with the agents, Pomerance says.

Remember that because most employees will be confused or even afraid, you should reassure them that business will continue as usual. Also, talk with your lawyer about how to best educate employees about the allegations being brought.

"Clients often are very resistant to educating their staff about the nature of the investigation. However, I believe that it is far better for an employee to learn about the search from a supervisor or co-worker than to receive information by watching the 10 p.m. news," says Pomerance.

You may also get questions from employees about their need to hire a lawyer. "You must talk with your attorney about the right of employees to individual counsel — and whether the practice should pay for it — as soon as is practical," says Pomerance.

"Remember that the investigators may contact key employees right after the search while the shock is still fresh," he says. "You may want to advise employees of their ability to retain counsel before an agent knocks on their door. Finally, make certain that no employee attempts to remove company property from the search scene, or to destroy or hide any property or materials." ■

Y2K test reveals serious flaws in physician systems

If you're waiting until the last minute to submit test claims with Y2K dates to your Medicare claims-processing contractors, be advised: Results from a test by one HCFA contractor suggest that these test claims have a good possibility of failing, according to a report from the Englewood, CO-based Medical Group Management Association.

About 900 of the 7500 providers who submit electronic claims to Medicare contractor Nationwide use a courtesy claims software package called MITCH, which Nationwide provides. The MITCH software is in the national standard format (NSF) and is Y2K-compliant.

But in a recent test of 501 files submitted using MITCH, 107 files failed to process initially (21%). Although most of the failures were chalked up to improper submission procedures, about 3% reflected a more serious problem. In those cases, providers sent in claims with dates of service in 1900, 1901, etc., when the dates should have reflected 2000, 2001, etc. Since the MITCH software relies on a system-generated date, Nationwide concluded that the hardware and/or operating system of the PCs being used by these providers were not compliant. Thus, these providers were unable to generate dates later than 12/31/1999. ■