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Reflections on Healthcare Fraud Enforcement and Corporate Compliance... with a Kentucky Flavor

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Reflections on Healthcare Fraud Enforcement and Corporate Compliance. . .with a Kentucky Flavor*

*John E. Steiner, Jr.***

I. "THEY'RE IN THE GATE"

At a Washington, D.C. press conference in the fall of 1994, the Clinton Administration (including representatives from the White House, the Health Care Financing Administration (HCFA)—since renamed the Centers for Medicare and Medicaid Services (CMS)—the Department of Justice (DOJ), and the Office of Inspector General of the Department of Health and Human Services (OIG) publicly announced that healthcare fraud was a top enforcement-priority. Providers and suppliers across America were informed that healthcare fraud would be the number two enforcement-priority for the Department of Justice. Number two, after the number one priority which was violent crime. Prior to the press conference, healthcare fraud was eleventh on the DOJ's priority list. I listened to that press conference, read the press releases and thought about the significance of that day, particularly since the Administration described this new initiative as "Operation Restore Trust."

II. "AND THEY'RE OFF"

In early 1995, while serving as Senior Counsel for the American Hospital Association (AHA) at its Chicago headquarters, I received a call from a member hospital. The caller was the Chief Financial Officer with a small hospital in Eastern Pennsylvania. His voice had a noticeable stress level.

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* At the time this article was written, the author was transitioning from his position in Kentucky to his current position with CTCA. He thoroughly enjoyed the people and experiences he had in Kentucky and pays tribute to that state's great horse-racing history in this article.

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He asked for my fax number and told me that he wanted me to read a certified letter sent to his hospital from the U.S. Department of Justice. Little did I know that this was the start of the DOJ's "Medicare 3-Day Window" national healthcare fraud enforcement initiative. Behind this initiative was the collective might of HCFA, OIG and the DOJ. This first national fraud enforcement initiative would reach nearly all members of the AHA.

The caller faxed me the letter. I carefully read it—twice. The end of the letter offered two undesirable choices: agree to proceed in a timely fashion to settle the alleged fraud with the DOJ, or, in lieu of settlement, proceed to litigate the civil False Claims Act allegations and face high statutory penalties if you lose. I immediately called the Assistant United States Attorney in Harrisburg, Pa. who signed the letter. We discussed the situation and she told me that the DOJ intended to send similar letters to all hospitals in America. I replied, "If you send this letter to all of our members, I'll probably get 10,000 similar calls, 5,000 from our members and 5,000 from their lawyers and consultants." With that, the starting gates opened and we were off to the races.

III. FIRST TURN

As the False Claims Act letters started to reach hospitals across America, increased attention was given to the technical requirements of the Medicare 3-Day Window rule, especially the operational and mechanical details for complying with that rule. The AHA also became more engaged with the OIG, HCFA and the DOJ in discussing both national healthcare fraud initiatives and the complexities of Medicare program requirements in general. The AHA met more frequently with federal agencies to probe and confirm the government's theories, objectives and expectations. From my perspective, it appeared that the federal government was shifting to an enforcement approach for several reasons:

- To restore trust in our system of healthcare coverage and payment by placing more accountability for compliance directly on providers and suppliers. In short, both sides acknowledged in these meetings that there was room for improvement;

- To try to reduce the rate of growth of healthcare expenditures, especially for allegedly "medically unnecessary services," duplicate billing, and billing for services not rendered;

- To send a message to the provider and supplier community that better internal business practices, procedures, and internal controls were needed;

- To recoup money from the provider and supplier community to demonstrate the effectiveness of Operation Restore Trust.

IV. SECOND TURN

As the healthcare fraud enforcement pack rounded the second turn on its way to the backstretch, the provider trade associations (e.g., AHA, AMA, AAMC, etc.) collectively became more engaged and focused on behalf of its membership. This was to be expected, in part, because additional national fraud projects were being launched—e.g., Operation Bad Bundle (related to payments for laboratory services), the Physicians at Teaching Hospitals (PATH) initiative, etc. As enforcement activity increased, so did the provider community's efforts to improve compliance awareness and suggest remedies.

I was fortunate, during this part of the "race," to be serving as Senior Counsel for the American Hospital Association. In my position at that time, I worked with a group of advocates and lawyers to engage in structured discussions with the DOJ, HCFA and the OIG. In addition, via its Regional Policy Boards, the AHA solicited ideas and built consensus for an appropriate response by the AHA. One component of that response was a suggestion to the OIG that it endorse model, voluntary compliance guidance for hospitals.

V. THE BACKSTRETCH

During one of several meetings between the OIG and the AHA, I suggested to June Gibbs Brown, the Inspector General of HHS, that she might want to consider publishing model voluntary compliance guidance for hospitals. I knew that Inspector General Brown had significant experience with the Department of Defense and was knowledgeable about the Defense Industry Initiative of the mid-1980s. That initiative was undertaken, at the direction of President Ronald Reagan, by our nation's military defense contractors to address compliance concerns with defense procurement practices. That experience produced model compliance guidance for defense contractors that was uniformly adopted for that industry.

At that same meeting, I also pointed out that our nation's approximately 5,000 hospitals might enter into multiple settlement agreements with the DOJ and the OIG, each of which would have to be carefully monitored, both by the hospitals and by Independent Review Organizations. Also, in the event of perceived breaches of the settlement agreements, the DOJ would have to proceed to file False Claims Act cases against the offending hospitals. This scenario did not seem to me to be the best way for a superpower to address problems in an essential industry with, generally,

inelastic demand and significant government oversight. The OIG agreed with that perspective and soon thereafter engaged the AHA and other healthcare trade associations in a public/private dialogue on voluntary compliance guidance for hospitals.

VI. THIRD TURN

As the voluntary compliance guidance concept gathered speed and traction, several drafts of model guidance were exchanged between the OIG, DOJ, HCFA and industry representatives. From my perspective, these meetings and draft exchanges were very valuable and constructive. I received encouraging comments from government personnel who emphasized how useful the public/private collaboration was to crafting an acceptable document. In the course of this work, the DOJ made clear that its discretionary authority to prosecute and enforce the law, especially criminal provisions, would be carefully analyzed throughout our discussions. This was not a surprise, especially since the same issue was addressed in crafting voluntary compliance guidance for the defense industry. The different enforcement authorities and practices of the OIG and DOJ became very clear to me as we continued through the third turn of this race. I recommend that anyone with a compliance or management role periodically review the OIG Model Voluntary Compliance Guidance for Hospitals. That exercise reinforces both the major compliance risk areas and heightens one's awareness that many of those risk areas may be enforced both by the OIG and the DOJ.

VII. FOURTH TURN AND HOME STRETCH

The OIG's Model Voluntary Compliance Guidance for Hospitals was published in February 1998. From the start of the "race," i.e. the launch of Operation Restore Trust, to the publication of the Model Guidance, the industry and federal agencies covered a great distance. The audience had been waiting, somewhat impatiently, for the Model Guidance to appear because there was a lot at stake. What would be the stated benefit of adopting a voluntary compliance program? How many resources would it take to properly design, implement and administer an effective program? And how many new launches of national healthcare fraud initiatives were waiting behind the bend?

Answers to these questions became clearer as those responsible for writing and publishing the Model Guidance made public appearances to multiple audiences across the country. The strongest theme to emerge from the guidance was that a "paper" program would not be considered effective. However, the OIG was considerate of the variances in resources and expertise available to hospitals and said as much throughout the Model

Guidance. That is why it is useful to periodically consult the Model Guidance, as supplemented, for a grounding on the government's expectations.

VIII. THE FINISH LINE

The race to the finish, i.e. the goal of tempering unbridled enforcement with good judgment and sound compliance efforts, stayed on track till it ended in the general satisfaction of government and private sector audiences.