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Data-mining continues to raise privacy concerns

by Gordon R. Shea, J.D. and Raio G. Krishnayya, J.D.

Senator Patrick Leahy, the Ranking Minority member of the Senate Judiciary Committee, is raising concerns with the use of so-called "data mining" techniques by the federal government, and particularly by the Department of Justice (DOJ).

Statistical trends. The concerns are expressed in a January 10, 2003, letter that Leahy sent to Attorney General John Ashcroft. "I am interested in determining the extent to which the Justice Department is relying on data-mining and how the Department is addressing... concerns with appropriate safeguards on the collection, use and dissemination of information obtained through data mining," Leahy wrote. The "concerns," Leahy identified, "include the specter of excessive government surveillance that may intrude on important privacy interests and chill the exercise of First Amendment-protected speech and associational rights."

As reported in *For security's sake: homeland security trumps HIPAA protections*, CCH Healthcare Compliance Newsletter Vol. 6, Issue 1, (Jan. 21, 2003), "data-mining" rests on the premise that the electronic world contains trillions of bits of information that organizations who maintain electronic records keep in "data warehouses" for protection and maintenance purposes. However, the vast amount of data makes analysis of the data for statistical trends virtually impossible without the use of data-mining techniques. The concept of data-mining requires analysts to define the data that is to be sampled. Analysts then develop a model that explains the relationships of the data, which is tested through a sampling of the data. Data-mining experts are quick to caution that while data-mining results can provide statistical predictions about relationships, it cannot identify a causal connection between the events quantified and the predicted outcomes.

After President Bush signed the Homeland Security Act of 2002 into law on November 25, 2002, a major crossover between homeland security and medical privacy was born. Specifically, the Homeland Security Act's allowance for "data-mining" could test historical notions of privacy protection, especially with respect to medical privacy. The data-mining provision arguably contravenes the purpose of the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA).

Broad inquiry. Leahy's recent letter to Ashcroft does not specifically mention healthcare privacy. Nevertheless, Leahy's broad inquiry regarding DOJ data-mining

Letters to the Editor

The CCH Healthcare Compliance team welcomes comments regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Jeff Reinholtz, Managing Editor at reinholj@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at http://health.cch.com.

policies implicates the potential conflict between data mining efforts and HIPAA's Privacy Rule. Leahy's questions cover 5 general topic areas:

- Data-Mining operations currently underway within the DOJ;
- The Foreign Terrorist Tracking Task Force;
- Compliance With The Privacy Act of 1974;
- DOJ Coordination with the Department of Homeland Security; and
- Admiral John Poindexter's Total Information Awareness Project (TIA) — As CCH has previously reported, Reagan Administration National Security Advisor John Poindexter is assisting the Defense Advanced Research Project Agency (DARPA) in an endeavor known as the Total Information Awareness (TIA) Project to, as Leahy puts it, "develop technologies for rapid language translation, commercial transaction data-mining, and interagency analysis and decision-making tools."

Leahy has queried Ashcroft, "[t]o what extent are you and the Department of Justice consulting or collaborating with Admiral Poindexter or the Department of Defense in designing and implementing TIA surveillance tools and related programs?"

A copy of Leahy's letter is available thorough the Senator's on-line press page at http://leahy.senate.gov/press/200301/011003.html. ■

CCH Chicago Bureau, Feb. 03, 2003

Privacy Rule court challenge continues

by Gordon R. Shea, J.D.

An appeal by the South Carolina Medical Association (SCMA), joined by other plaintiffs, seeking to overturn the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) was recently heard before the United States Court of Appeals for the Fourth Circuit in Richmond, Virginia, according to information released by the SCMA via its website, http://www.scmanet.org.

2001 follow-up. The appeal is the continuation of an attack on the Privacy Rule that SCMA originally leveled in 2001. SCMA reported that the three-judge panel of the Fourth Circuit that heard the appeal included Judges Roger L. Gregory, William W. Wilkins, and William B. Traxler.

SCMA's complaint about the Privacy Rule is threefold:

- Congress improperly delegated its power to write the Privacy Rule to the executive branch's Department of Health and Human Services (HHS)
- HHS exceeded the scope of the authority that the text of HIPAA itself vested in the agency when it drafted the Privacy Rule; and
- the Privacy Rule's preemption provision is unconstitutionally vague.

In August of 2002, the federal court for the District of South Carolina ruled against SCMA's challenge deeming the actions of Congress and HHS in promulgating the Privacy Rule "sufficient," and the plaintiffs' legal criticisms "not sufficiently persuasive." The South Carolina district court's decision — issued on the very day that changes to the Privacy Rule (such as an elimination of the Rule's prior patient consent requirement) were confirmed — followed an earlier federal court decision in Texas that had likewise upheld the Rule. The Texas decision was not appealed.

Modicum of concern. The District of South Carolina decision, however, was accompanied by a written opinion in which Judge Terry L. Wooten expressed a modicum of concern about the way the federal government had handled the Privacy Rule. Wooten deemed Congress's delegation of Privacy Rule authority to HHS "not overly laden with detailed guidance." Furthermore, Judge Wooten called SCMA's argument that HHS exceeded its authority "important;" and wrote that he found HIPAA's Privacy Rule preemption language "troubling." The judge also ventured out on a bit of a Constitutional limb by announcing that he had applied a "less strict" Constitutional scrutiny of the Privacy Rule because the entities that are subject to the Rule are business interests that "are in a position to plan and prepare for compliance carefully, well in advance" of the Rule's compliance date. Such a characterization would almost certainly be disputed by the many HIPAA-covered entities that have spent months and years grappling with HIPAA's many complexities. ■

CCH Chicago Bureau, Feb. 4, 2003

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Unless otherwise noted, all paragraph references are to the CCH Healthcare Compliance Reporter.

Hospital gets interest in surgical center — no ASC safe harbor

by Geraldine S. Stroka, J.D., R.N.

The Office of Inspector General (OIG) permitted a medical center to acquire an ownership interest in an orthopedic ambulatory surgery center (ASC), indirectly-owned, by a physician group through a holding company, despite the failure of the proposed arrangement to meet the safe harbor criteria for jointly-owned ambulatory surgery centers. The OIG would not impose administrative sanctions under the Anti-kickback Act because the proposed arrangement contained multiple safeguards that reduced the risk of fraud and abuse to an acceptable level.

Equity Interest and multiple agreements. This proposed arrangement included the following agreements: (1) the medical center's acquisition of an equity interest in the ASC, under a two-phase option agreement; (2) a credit agreement; (3) a management services agreement; (4) a facility support agreement; (5) a surgical center lease; (6) a group lease; and (7) a non-competition agreement. The proposed agreement was contingent on the last five agreements, called the ancillary agreements. Important facts are (1) the hospital was a not-for-profit, and (2) the physician group (Group) met the group practice safe harbor.

Under Phase I of the Option Agreement, the hospital would purchase a 15% ownership interest in the ASC in exchange for certain capital contributions and a line of credit for the ASC. The Group would guarantee the *pro rata* share of the resulting loan. If the hospital elected to exercise its Phase II option, the Hospital would acquire a 40% interest under similar terms.

The medical center certified that each of the five ancillary agreements met the applicable safe harbors. For purposes of this proposed arrangement, the two safe harbors applicable are the investment interest in ambulatory surgical centers jointly-owned by hospital and physicians, 42 C.F.R. §1001.952 (r) (4), and the personal services and management contracts, 42 C.F. R. §1001. 952 (d).

Fraud and abuse issues. The OIG determined that there were five elements in this proposed arrangement that made it susceptible to fraud and abuse. The five areas of concern were: (1) the hospital could influence referrals by its control over hospital-affiliated physicians; (2) eight of the group shareholders did not meet the one-third practice income test under the ASC safe harbor; (3) the group holding company held the investment interest in the ASC; (4) the facility support and management service agreements did not meet the one-year requirement of the applicable safe harbor; and (5) the arrangement was contingent on the execution of the non-competition agreement that barred certain actions.

Safeguards. The OIG determined that its concerns in the five areas could be allayed. To counter the OIG's concerns about its control over referrals, the medical center stated that it would limit its ability to direct or influence referrals by not tracking, paying or encouraging hospital-affiliated physicians' referrals to the ASC. The OIG determined that one-third practice income test was achieved because the non-qualifying physicians performed surgical procedures that met requirements. The medical center made certain certifications that decreased the OIG's concerns about the lack of the minimum one-year term requirement in the facility support and management service agreements. Lastly, the restrictions in the non-competition agreement were narrowly tailored for a legitimate business purpose.

Importance. In this opinion, the OIG would not sanction the participants in this proposed arrangement if they complied with all of their certifications, even though all the elements of the jointly owned ASC safe harbor were not met. In issuing this opinion, the OIG recognized that barring joint ownership of ASCs might place hospitals at a competitive disadvantage when they are forced to compete with physician-owned ASCs.

Healthcare facilities and providers need to review all proposed arrangements to determine their compliance with applicable safe harbors. If all elements of applicable safe harbors cannot be met, participants need to certify compliance in any areas that fail to meet the safe harbor. ■

OIG Advisory Opinion 03-02, Jan. 21, 2003, ¶150,199

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On The Front Lines

The Discount Safe Harbor — Part 2

by Paul DeMuro, J.D.

In this second part of his two-part series, Paul DeMuro, a partner in the San Francisco and Los Angeles offices Latham & Watkins, continues his discussion of the discount safe harbor with a look at the safe harbor protection it affords offerors, U.S. vs. Shaw, et. al, and three relevant OIG Advisory Opinions.

The discount safe harbor also provides safe harbor protection to offerors. The "offeror" of a discount is an individual or entity who is not a seller under the safe harbor, but promotes the purchase of an item or service by a buyer under the safe harbor at a reduced price for which payment may be made, in whole or in part, under Medicare or a state healthcare program.[1]

To satisfy the requirements of the discount safe harbor, the offeror must comply with all of the applicable standards within the following three categories.

If the buyer is an HMO or a CMP acting in accordance with a risk contract, or under another state healthcare program, the offeror need not report the discount to the buyer.[2] If the buyer is a cost reporting entity, the offeror must comply with the following two standards:

(1) The offeror must inform the buyer in a manner reasonably calculated to give notice to the buyer of its obligation to report such a discount and to provide certain information requested, and

(2) The offeror of the discount must refrain from doing anything that would impede the buyer's ability to meet its obligation under the safe harbor.[3]

If the buyer is an "other category buyer," the offeror must comply with the following two standards:

(1) The offeror must inform the individual or entity submitting the claim or request for payment in a manner reasonably calculated to give notice to the individual or entity of its obligation to report such a discount and to provide certain information requested; and

(2) The offeror of the discount must refrain from doing anything that would impede the buyer's or seller's ability to meet its obligations under the safe harbor.[4]

The discount safe harbor appears to have been barely considered by the courts. In fact, the one court that has considered the discount issue, the court in *U.S. v. Shaw, et al.*,[5] where a criminal defendant argued that his motion to dismiss a count of a superseding indictment for failure to state a crime should be granted, actually construed the "discount exception" to the anti-kickback statute.

The defendant was the President of NMC Medical Products (MPD), a wholly owned subsidiary of National Medical Care, Inc. (NMC). NMC manufactured, sold and distributed products used in kidney dialysis. MPD sold these dialysis related products to the NMC-owned clinics and to facilities not owned by NMC. NMC also had another division called the Life Chem Division that provided clinical laboratory blood testing services to the NMC-owned clinics and to dialysis clinics not owned by NMC.

The government alleged that the defendant, as the president of MPD, conspired to pay remuneration to independent dialysis clinics for the purpose of inducing those clinics to use Life Chem's laboratory services. The government alleged that the inducements took the form of rebates and special pricing, grants, entertainment and hunting trips, and write-offs of bad debts for blood laboratory tests of indigents, educational grants, etc.

The defendant argued that he should prevail on his motion to dismiss, because the overt acts charged were protected by the "discount exception" of the statute. The court held that the government did not have to state in the indictment that the defendant's conduct does not fall within the "discount exception." It noted that "the discount exception" does not serve as an additional element of the criminal offense. It serves, instead, as a framework around which arguments of the parties regarding the evidentiary issues, such as how the government is to prove beyond a reasonable doubt that the defendant acted with the requisite state of mind, may be presented at trial.

The OIG has authored three relevant advisory opinions: 02-10, 01-8, and 99-3. In 02-10, a company manufactured and distributed dialysis equipment and supplies. Through one of its subsidiaries, the company sold its equipment and supplies to providers and suppliers of dialysis services throughout the country. The equipment and supplies included equipment and supplies for both hemodialysis and peritoneal dialysis. The hemodialysis equipment and supplies were used primarily in dialysis facilities and other institutional settings, while the peritoneal dialysis equipment and supplies were used almost exclusively by self-dialyzers in the home or at work. Some supplies are used in both home dialysis and peritoneal dialysis.

The company proposed to offer two types of discount arrangements of dialysis equipment and supplies: (1) a uniform discount based on the aggregate annual purchases by the purchaser of any and all dialysis equipment and supplies sold

by the company; and (2) a discount based on total annual purchases of certain designated or all items if the purchaser buys a minimum quantity of one or more certain items.

The company agreed to meet the terms of the safe harbor with respect to reporting the discounts, informing the buyer, etc. The company also certified that the proposed discounts were not dependent upon any other arrangement among the company, its related entities, its customers, or any other party.

The OIG noted that Medicare Part B reimburses for outpatient maintenance dialysis under three methodologies, and while all are different, all three are capped at about the same amount. The OIG also noted that the proposed discounts encouraged the company's customers to purchase goods for which payment may be made in whole or in part under a federal healthcare program, and thus they implicate the anti-kickback statute.

The OIG held that the first proposed discount would not be problematic, because it applied to a total value of supplies purchased, whereas the second proposed discount was problematic because it did not apply equally to all products on the basis of sales price, and it required the purchaser to buy a minimum quantity of one or more of certain items. Although proposed discount one also included a bundled discount, in the case of proposed discount two, the identity of the product is variable, and thus, the payment methodology is unknown. In addition, the OIG was concerned that it did not know whether the discounts would be "tiered" so that greater levels of product purchasers would lead to greater discounts. The OIG concluded that it could not determine whether dialysis goods would be supplied at a reduced charge in order to induce the purchaser of a product or whether the federal healthcare program would share appropriately in the discount.

In OIG Advisory Opinion No. 01-08, a company proposed to market and sell to state-licensed nursing facilities a comprehensive program to manage pressure ulcers. The program proposed to couple the purchases of the company's therapeutic mattresses with the purchase of skin and wound care products and a program warranty.

The program was a three-year contractual arrangement consisting of three conjoined components: (1) the discounted sale of the company's therapeutic mattresses and other support surfaces together with limited replacement warranties; (2) a prospectively-fixed, per resident/per diem payment for skin and wound care products; and (3) a limited warranty for certain monetary liabilities resulting from the program's failure to meet its stated objective: managing pressure ulcers.

All of a facility's existing mattresses would be replaced with the company's therapeutic mattresses. The facility would pay a negotiated, fixed, discounted price per bed and receive (1) a non-powered therapeutic mattress for each bed, (2) a specified number of wheelchair cushions and therapy pads based upon the number of residents in the facility, (3) a sufficient quantity of advanced powered therapeutic mattresses to address residents' wound care needs, and (4) on-line access to a wound documentation system and a certified wound care specialist.

The second component of the program required a participating facility to pay a fixed, daily fee per resident in exchange for an extensive skin and wound care program which includes all non-prescription skin and wound care products required to meet the needs of the facility's residents.

The final component of the program was the program warranty. Under the program warranty, the company agreed to reimburse a participating facility for the first set amount of liability insurance deductible actually paid per resident during the contract term and resulting from judgments for skin or wound deficiencies.

The OIG noted that the items and services provided under the program were potentially reimbursable by Medicare or Medicaid, but they are not separately reimbursable under Medicare Part A, but included in a per diem payment under the SNF prospective payment system.

The OIG also noted that the program's pricing arrangement cannot fit into the discount safe harbor since it bundles several distinct items and services. The OIG analyzed the program's pricing arrangement in its entirety to determine whether, based on a totality of facts and circumstances presented, it poses a risk of fraud and abuse.

The OIG concluded that the following factors which, taken together, lead it to consider that the program's pricing arrangement for therapeutic mattresses, other support surfaces, and skin and wound care products poses minimal risk of fraud or abuse:

(1) The program covers all beds and all residents of a participating facility and pricing is uniform, regardless of a resident's payor;

(2) Participating facilities are reimbursed pursuant to a global, all-inclusive rate, either by Medicare Part A or Medicaid, for the vast majority of items and services included in the program. There is little apparent risk of abuse from the bundling of items and services, all of which are reimbursed primarily by a single, global, all-inclusive rate, since the financial incentive for the facility receiving a fixed payment is to reduce total costs;

(3) Of all of the items and services provided in connection with the program's bundled pricing arrangement, only surgical wound supplies are potentially separately reimbursable under Medicare Part B, and the opportunity to bill for such items are rare and are a very small percentage of the program's price; and

(4) There is no risk of potential "swapping" of low program prices for the company's opportunity to provide other unrelated items or services to participating facilities since

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the program is the only other financial arrangement between the company and the participating facilities.

The OIG also evaluated the warranty proposed as part of the program, and noted that the warranty safe harbor only protects warranties or "items," not a warranty on a combination of items and services. It noted, however, that the program's items, especially its mattresses and other support services, were the linchpin of the program and program warranty, and that the vast majority of the costs of the program were for the items and the anticipated benefit is principally attributed to the mattresses and other support services.

In OIG Advisory Opinion 99-3, company A, a wholly owned subsidiary of company B, a distributor of therapeutic mattresses used for the treatment and prevention of pressure ulcers, proposed an arrangement involving two types of mattresses or support services: a powered support service (a therapeutic mattress system) and a non-powered support service (a pressure relieving mattress).

Company A proposed offering Medicare-certified skilled nursing facilities (SNFs) special pricing for the therapeutic mattresses for patients undergoing treatment for pressure ulcers. Company A rents the SNF a powered mattress for 30 days at a fixed price. The price includes provision of the non-powered mattress at no additional charge, to be used when the patient's condition improves such that he or she no longer requires the powered mattress. If the patient continues to require a powered mattress after the initial 30 days, company A will provide the powered mattress for an additional 30 days at half of the original 30-day rental. The cost to the SNF for all of this would be less than what it would have to pay company A under standard pricing.

Company A wanted to market the proposed arrangement directly to its major customers, and it also wanted to contract with durable medical equipment (DME) suppliers to serve as sales agents to market the proposed arrangements to some SNFs. The DME sales agents would receive twenty percent of collections as their compensation.

Company A advised that the market for the proposed arrangement would be primarily SNFs that are being reimbursed for Medicare Part A services using the new prospective payment system. One purpose of the proposed arrangement was to encourage SNFs to use the non-powered mattress as a routine step-down treatment and to demonstrate that such use can help prevent recurrences of ulcers, thereby saving costs and minimizing the SNF's risks under the new PPS system.

"The government appears to want to strike a balance between the benefits of market competition in lowering prices and safeguarding against fraudulent and abusive practices...."

The OIG noted that the statutory discount exception did not protect bundled discounts, and neither does the discount safe harbor. The OIG noted that the proposed arrangement involved a bundled therapeutic mattress package consisting of an initial 30-day powered mattress rental, which includes a non-powered mattress, and, if needed, an additional 30-day rental period at half price. The OIG declared that where no items are bundled, it would examine the circumstances to determine the desirability of prosecuting such arrangements. The factors that the OIG will look at may include: (1) the amount of the benefit that is reported and passed along to the programs, (2) whether the items are separately reimbursable, and (3) the intent behind the arrangement.[6]

The OIG agreed not to subject the proposed arrangement to sanctions under the anti-kickback statute, noting that it posed a minimal risk of kickback violations. It also noted that the methodology used by company A to apportion the discount between the powered or non-powered mattress is reasonable, and assuming proper reporting by SNF purchasers, will assure that the price reported to any federal healthcare program for each product will fairly reflect the value of the discount. Moreover, the mattresses that are the subject of the proposed arrangement will be primarily in SNFs that will be reimbursed a fixed, prospectively determined amount for Part A beneficiaries. The SNFs have an incentive to be prudent purchasers.

From the three OIG Advisory Opinions that address the discount safe harbor, and from the federal register's safe harbor discussion, one can glean certain major policy considerations in which the government seems to be interested. The government appears to want to strike a balance between the benefits of market competition in lowering prices and safeguarding against fraudulent and abusive practices that take advantage of the federal program.

The government also wants to make sure it gets its fair share of any discount. It closely scrutinizes how the discounts are apportioned among payors and products. It wants to make sure accurate full pricing and cost information is available.

The government also is concerned about swapping, which is trading the discount for other federal business, and locking in buyers and purchases. It examines whether a discounting practice will have the effect of leading to higher program costs and utilization.

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1 See 42 C.F.R. § 1001.952(h)(4).

2 Id.

3 Id.

4 Id.

5 106 F. Supp. 2d 103 (D. Mass. 2000).

6 See 56 Fed Reg. 35978.

State false claims case illustrates multi-jurisdictional problem

by Raio G. Krishnayya, J.D.

Last October, an Illinois state case, *People ex rel. Levenstein v. Salafsky*, focused on the issue of whether a university medical center could be considered a state entity for purposes of the Illinois Whistleblower Reward and Protection Act (WRPA). In addition, however, *Levenstein* raises the issue about the conflict between a state false claim suit and a federal case involving a different claim, but both cases arising from the same operative facts. The case is important as it raises an otherwise untested area of False Claims Act (FCA) jurisprudence about which law applies when an employee believes that he or she has been retaliated against for investigating false claims that could arguably be raised in both the federal and state forums.

MSP activities suspicious. In 1990, the whistleblower in the Illinois state case, Joseph Levenstein, M.D., joined the University of Illinois-Chicago College of Medicine as a faculty member. One year prior, Bernard Salafsky, M.D., became the University's regional dean, which put him in charge of the University's financial operations for its College of Medicine. Specifically, this authority placed Salafsky in control over the University's Medical Service Plan (MSP).

The MSP is a fund created by state law for the exclusive purpose of managing the revenue generated from the University's clinical services. Salafsky was charged with the responsibility for overseeing billing, collection and fund disbursement related to the MSP.

During his term overseeing the MSP, several of Salafsky's colleagues, including Levenstein, took issue with the way Salafsky managed the MSP. Subsequently, Levenstein, along with some colleagues, formed a committee for the purpose of overseeing Salafsky's management of the MSP. The intervention by the committee occurred because of an April 1995 report by Salafsky that indicated a $400,000 deficit in the MSP account. However, despite the deficit, Salafsky declared that the MSP would fund the building of a clinic in Rockford, Illinois.

No-bid contract. What the committee later learned was that the contract for the clinic announced by Salafsky was the product of "no-bid" contractual negotiations. According to the complaint, in mid-1995 Salafsky entered into an agreement with a corporation that did not technically exist until the end of 1995. Worse yet, Salafsky bypassed the statutorily required bidding process and simply entered into an agreement with the contractor for the sale of the clinic to the University. The complaint alleged that Salafsky's offense was his failure to notify the board of trustees about his interests in the contract.

Levenstein's assertions against Salafsky continued by asserting that as a result of Salafsky's improper conduct, the University grossly overpaid for the clinic. In essence, the complaint alleges that the University, pursuant to Salafsky's authority, paid for the land upon which the clinic was to be built, prior to signing the contract. Later, the land was conveyed to an intermediary who reconveyed the land back to the contractor. The contractor then sold the land and completed construction on the clinic for which the University paid a second time.

Further offenses. Levenstein's allegations against Salafsky continued to include other abuses of the MSP. For example, Levenstein cited the University by-laws, which allow for a "discretionary" MSP account separate from the University's general MSP. The discretionary MSP is funded through a ten percent tax on the general MSP. According to Levenstein's accounting, the discretionary MSP should have maintained a balance of approximately $200,000. The actual amount, prior to Salafsky's transmittal of the funds to the contractor, was in excess of $600,000.

Furthermore, Levenstein alleged that Salafsky maintained unassigned MSPs that were not reported within the list of University accounts. The University records indicated that this mysterious account held approximately $29,400,000 in credits and $2,900,000 in ambiguous charges. While it was argued that its MSP was merely a "bookkeeping device," the balance sheets showed substantial activity for approximately one and one half years of its existing five, and that within that time period, the account grew by approximately $23,000,000.

WRPA claim. Each of these assertions were fodder for Levenstein's claim that Salafsky had violated the Illinois equivalent of the federal FCA or WRPA. WRPA states:

> Any person who knowingly presents, or causes to be presented, to an officer or employee of the State or a member of the Guard a false or fraudulent claim for payment or approval is liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State sustains because of the act of that person.

Under WRPA, Levenstein argued that Salafsky's improper manipulations of MSP funds falsely caused the board of trustees to overpay for the building of the clinic. Furthermore, Levenstein argued that Salafsky's maintenance of an unassigned MSP amounted to fraud, and therefore caused improper expenditures by the board of trustees.

Interestingly, Salafsky countered with two arguments. First, Salafsky suggested that the University could not be considered a "state" entity for purposes of WRPA. Thus, even if the board of trustees had falsely overpaid for the clinic, this action was outside the scope of WRPA. His counter-argument was based on a provision under the Illinois MSP law that allows a University entity to "opt in" as a state agency. Thus, Salafsky presented documentation demonstrating that the University had not exercised its right to "opt in" as a state entity pursuant to the MSP statute's requirements.

This argument, however, did not save Salafsky from Levenstein's pursuit. Although the Illinois Appellate Court for the Second Circuit conceded that the University was not a state entity in the traditional sense or that the University had not "opted in" under the MSP statute, the "opt in" provision alone was not

determinative as to whether the University could recoup under WRPA.

The appellate court noted that the language of WRPA had been intentionally modeled closely after the federal False Claims Act. The importance of this similarity, according to the court, is that both WRPA and the FCA were designed to combat fraud that occurred where a nexus between government or state funding and false or fraudulent transactions existed. Thus, the appellate court articulated that where a substantial nexus between state funding and the claim at issue is demonstrated, a claim under WRPA could still survive.

In the case of Salafsky's alleged misrepresentations, Levenstein would need to show that a significant portion of the funds disbursed to Salafsky's contractor were derived from state funding. Clearly the University, which is engaged in clinical services, would be entitled to Medicaid reimbursements from the State of Illinois as well as other state grant monies. Thus, if in further litigation Levenstein proved the existence of such a nexus, his WRPA claim would survive under the ruling of the appellate court.

Federal case. Salafsky's second counterargument against Levenstein's WRPA challenge focused on a pending federal case with Salafsky and Levenstein as parties. The basis for the federal case involved allegations by Salafsky, along with several other colleagues, alleging that Levenstein had sexually harassed certain individuals at the University. Levenstein filed the federal suit in the U.S. District Court for the Northern District of Illinois (*Levenstein, M.D., v. Salafsky*, N.D. Ill., No. 97 c 3430, Feb. 4, 2002) asserting that Salafsky and his colleagues had abrogated his procedural due process and equal protection rights, which amounted to constructive discharge while investigating the sexual harassment claims.

While the record indicated that several of the complainants declined filing formal actions against Levenstein, some pursued action through the University's administrative process. The University administrative process was initiated by a letter sent to Levenstein advising him of the sexual harassment claims by his colleagues and students.

The letter indicated that University policy allowed Levenstein to respond to the claims in writing, but that he was required to do so within ten days of receipt of the letter. Levenstein responded within the allotted time, denying the accusations. Following the exchange of written correspondence, the University conducted a formal investigation, which included an interview of the complainants. The outcome of the investigation resulted in a recommendation that Levenstein be restricted from positions of authority over female colleagues and students. Levenstein appealed this finding but was denied, opening the door for Salafsky to initiate Levenstein's termination from the University.

In late December 1995, Salafsky wrote a letter to the Dean of the University suggesting that Levenstein be "removed from the faculty of the University." Salafsky further noted that the recommendations of the investigating panel that Levenstein be restricted from positions of authority over female colleagues or students would be untenable. Thus, Salafsky concluded, "it is quite impossible to place Dr. Levenstein in a teaching, research, or clinical position where he would not have some sort of supervisory responsibility or be in a position of authority which he could again abuse." Concurring with Salafsky, the Dean posed Salafsky's recommendations to the University Chancellor, who turned the matter over to the University President. The process continued until over a year later Levenstein resigned from his post, and according to a letter by Levenstein to the president, "certain that the system had been rigged against him...."

WRPA revisited. The bitter series of facts surrounding Levenstein's federal case became the basis for Salafsky's argument that the WRPA case (the Illinois case) was an improper forum for redress since the operative facts of the federal case were intertwined with Levenstein's WRPA case. The appellate court, however, dismissed this argument on the basis that although the operative facts are intertwined, the legal elements of each case were substantially different and therefore, not legally related. In other words, Levenstein was required in federal court to demonstrate that his civil rights had been violated in conjunction with allegations of sexual harassment, whereas in the Illinois case, Levenstein was required to prove that a substantial state nexus existed for the claims paid by the University and that Salafsky knowingly caused the University to falsely pay those claims.

In retrospect, Salafsky's argument that the Illinois forum was improper for the WRPA claim may not have been entirely off base. WRPA does contain an anti-retaliatory provision that would prohibit an employee from being "discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against...." Thus, arguably Levenstein's civil rights claim could have been attached to his WRPA suit asserting that Salafsky and the University violated the anti-retaliation clause of WRPA. It would seem that both the Illinois appellate court and the federal district court were fully cognizant of the fact that Levenstein's accusations of financial fraud were, to a greater or lesser extent, intertwined with his constructive discharge claim. Thus, Levenstein could have brought all his claims within the WRPA realm without resorting to federal litigation.

In contrast, however, Levenstein could not have necessarily brought his WRPA claim into federal court, or could he? On the one hand, if the appellate court's nexus test is derived from FCA precedence, then Levenstein could have asserted that some of the funds improperly paid by the University were derived substantially from federal funding vis-à-vis Medicare reimbursements for clinical services. Even if Levenstein felt that a FCA claim was too attenuated, he could have sought the federal court to exert supplemental jurisdiction over his WRPA claim.

Why Levenstein did not attach an anti-retaliation claim to his WRPA suit or why he did not file a federal FCA suit to attach to his civil rights claims is not entirely clear. However, this case is probably one of the few cases that factually approaches the question of what law applies if an employee is retaliated against by his or her employer for investigating a false claim, federal or state? ■

***People ex rel. Levenstein v. Salafsky*, Ill.Ap. Ct. 2nd Dir., No. 2-01-0378, Oct. 31, 2002, ¶370,017**