CCH Health Care Compliance LETTER

Volume 11, Issue 6 health.cch.com March 18, 2008

Judiciary committee, DOJ debate proposed FCA amendments

The False Claims Act (FCA) (31 U.S.C. §3729, *et seq.*) has yet to fulfill its true potential for combating fraud, said Senate Judiciary Committee Chairman Patrick Leahy (D-Vt.) at a February 27, 2008, hearing on "The False Claims Act Corrections Act of 2007" (S. 2041).

In recent years, the FCA has become the government's most effective tool against fraud, Leahy said, noting that since 1986, it has been used to recover more than $20 billion lost to fraud. Yet the Department of Justice (DOJ) has failed to dedicate sufficient lawyers and investigators to pursue fraud cases, he added. The department has a backlog of more than 1,000 false claims cases, which at its current pace would take nearly 10 years to resolve, even if no new cases were brought.

Leahy also noted that for every dollar spent enforcing the law in health care cases, the government recovered $15 on behalf of the American taxpayer. "There's no excuse for failing to pursue these cases aggressively," he said.

Provisions of the bill. When introducing the bill, Senate Finance Committee ranking member Charles Grassley (R-Iowa) said recent court decisions have weakened the government's ability to recover tax dollars lost to health care and defense fraud and other areas of spending.

Among other things, S. 2041 would amend the FCA by weakening the public disclosure bar, prohibiting waivers of FCA liability, and expanding the Act's scope by imposing liability on individuals who submit claims to any recipient of federal funds, not just to the United States government.

DOJ comments. Michael Hertz, DOJ Deputy Assistant Attorney General, Civil Division, countered that there is "no pressing need for major amendments at this time," noting that the FCA and its *qui tam* provisions "have proven to be an extremely effective weapon in the government's fight against fraud."

Hertz explained that although the administration is sympathetic to some of the proposed amendments, "it cannot support the bill in its current form." According to Hertz, the administration, is concerned about the proposals narrowing the public disclosure bar to permit those with no first-hand knowledge beyond that available in the public domain to serve as relators, and permitting government employees to serve as relators in certain circumstances, "which is unsound public policy as all government employees have an obligation to report fraud." Moreover, he said, many provisions of the proposed legislation deal with issues that have not been fully resolved by the courts.

CCH Washington Bureau, Feb. 27, 2008

Wolters Kluwer Law & Business

Site visits reveal noncompliance with DMEPOS supplier standards

The Office of Inspector General's (OIG's) unannounced site visits to 905 suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in Los Angeles County in late 2007 revealed that the suppliers failed to comply with several of the Medicare supplier standards, according to an OIG report issued last month.

To determine the suppliers' compliance with Medicare standards, the OIG focused on two standards with which compliance could be verified quickly through direct observation. These standards include four specific requirements:

(1) The supplier must maintain a physical facility.
(2) The facility must be accessible during business hours.
(3) The facility must have a visible sign.
(4) The supplier's hours of operation must be posted.

Findings. Three percent of the suppliers (30 of 905) did not maintain appropriate physical facilities. Instead of finding operational facilities for these suppliers, the OIG found that 20 facilities were vacant; eight did not appear to be DMEPOS facilities; and two listed invalid addresses with the National Supplier Clearinghouse, so their existence could not be confirmed.

Nine percent of the suppliers (85 of 905) were not open during posted or reasonable business hours on at least two site visits. The average weekly hours of operation posted for these suppliers was 30 hours compared to 44 hours among the suppliers that were open during business hours. Another nine percent of the suppliers were open but failed to post signs indicating a business name, hours of operation, or both.

Fourteen percent of the suppliers met the requirements for the standards that the OIG reviewed, but more than half of the beneficiaries served by these suppliers did not receive other Medicare services from an ordering physician within a six-month period preceding the DMEPOS claim. Although Medicare does not require physicians to conduct in-person examinations of patients to write a prescription for most DMEPOS, physicians generally provide services prior to ordering DMEPOS for their patients.

In addition to performing site visits, the OIG analyzed the suppliers' Medicare billing patterns. In the 12 months beginning July 1, 2006, Medicare allowed approximately $245 million for DMEPOS provided in Los Angeles County, $21 million of which was for suppliers that did not maintain physical facilities or were not open during the unannounced site visits.

Recommendations. The OIG recommended that CMS strengthen the DMEPOS supplier enrollment process and ensure that suppliers meet Medicare supplier standards. Specifically, the OIG recommended that CMS: (1) conduct more unannounced site visits to suppliers; (2) perform more rigorous background checks of high-risk suppliers; (3) focus monitoring and enforcement on high-risk suppliers; (4) increase prepayment review of DMEPOS claims; (5) require suppliers in high-fraud areas to reenroll more frequently than every three years; and (6) establish a minimum number of hours of operation and minimum inventory requirements for product and service types. ■

OIG Report, No. OEI-09-07-00550, Feb. 1, 2008, Health Care Compliance Reporter ¶530,659.

Antitrust

Divestiture needed to preserve competition in Las Vegas MA market

The proposed acquisition of Sierra Health Services, Inc., (Sierra) by UnitedHealthGroup, Inc. (United) has been blocked by the Department of Justice (DOJ) Antitrust Division, which cited concerns over the effects of the merger on the Medicare Advantage (MA) health insurance market in the Las Vegas area.

Background. On February 25, 2008, the DOJ filed a civil antitrust suit in district court to stop the acquisition. According to the complaint, United's acquisition and the resulting market share of the combined company would allow it to increase prices and reduce the quality of MA plans sold to seniors in the Las Vegas area.

United is the largest health insurer in the country, with reported 2007 revenues of approximately $75 billion. Sierra is the largest health insurer in the Las Vegas area, with reported 2007 revenues of nearly $2 billion. United and Sierra represent the top two sell-

continued on page 3

CCH Health Care Compliance Letter

Portfolio Managing Editor
Pamela K. Carron, J.D., LL.M

Coordinating Editors
Susan Smith, J.D., M.A.
Matthew Mann, J.D.
Valerie Witmer, J.D.

CCH Washington Bureau
Paula Cruickshank
DOJ, FTC–John Scorza
SEC–Peter Feltman
Health Law–Catherine Hubbard, M.A.
Tax–Jeff Carlson, Steve Cooper

Designer
Craig Arritola

Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

CCH Health Care Compliance Letter is published 24 times a year by CCH, a Wolters Kluwer business, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is $305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Health Care Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A.

Antitrust (cont.)

ers of MA plans in the Las Vegas area, and their proposed merger would have resulted in a combined company with control of 94 percent of the MA health insurance market in the Las Vegas area, according to the DOJ. Currently, approximately 82,000 people in Clark and Nye counties, which make up the Las Vegas area, are enrolled in MA plans, accounting for approximately $840 million of annual commerce.

In establishing the MA program, Congress intended that vigorous competition among private MA insurers would lead insurers to offer seniors more affordable benefits, provide a wider array of health insurance choices, and be more responsive to the demands of seniors. As a result, MA plans offer affordable rates, coverage, and benefits not available through traditional Medicare.

Proposed settlement. Concurrently with the filing of its complaint, the DOJ filed a proposed settlement that, if approved by the court, would resolve the lawsuit and the DOJ's competitive concerns about the acquisition. Under the proposed settlement, United must promptly divest most of its assets relating to its MA business in the Las Vegas area. The DOJ has tentatively approved Humana, Inc. as the acquirer, and United must first attempt to sell the assets to Humana before selling to another purchaser.

"This divestiture ensures that senior citizens and others will continue to benefit from competition between sellers of Medicare Advantage products," said Thomas O. Barnett, Assistant Attorney General in charge of the DOJ's Antitrust Division. "We are committed to preserving competition in the health insurance industry because this competition spurs insurers to lower prices, enhance services, and offer innovative new products."

The proposed settlement and the DOJ's competitive impact statement will be published in the *Federal Register* and available for comment for 60 days.

DOJ News Release, Feb. 25, 2008. ■

Medicare

RAC demonstration project nets big gains

A 2007 CMS demonstration project using recovery audit contractors (RACs) in California, Florida, and New York has collected or repaid $371.5 million in improper Medicare payments. Although some of the recovery amount was overturned on appeal, repaid as underpayments to providers, or absorbed as costs for the RAC project, $247 million was returned to the Medicare Trust Funds in 2007.

Background. The RAC project was authorized by §306 of the Medicare Modernization Act of 2003 (MMA), which directed HHS to conduct a three-year demonstration program using RACs to detect and correct improper payments in the Medicare fee-for-service program. The demonstration project was designed to determine whether the use of RACs would be a cost-effective method to ensure that improper payments to Medicare providers are detected and corrected and to help protect the Medicare Trust Funds. Since 2005, the project has collected approximately $440 million.

Common problems. Examples of the payment problems CMS identified through the demonstration project include: (1) providers getting paid twice after submitting duplicate claims; (2) claims paid according to outdated fee schedules; (3) providers failing to submit documentation when requested, or failing to submit enough documentation to support a claim; (4) payments made for services that were incorrectly coded; and (5) payments made for services that were not medically necessary or did not meet the Medicare medical necessity criteria for the setting where the service was rendered.

The RACs noted that most of the improper payments resulted from noncompliance with Medicare coverage and coding requirements.

Expansion. Although the program originally started in California, Florida, and New York, it has expanded to Massachusetts, South Carolina, and Arizona. CMS has begun the expansion process by initiating a full and open competition for four permanent RACs to begin after the end of the RAC demonstration in March 2008.

Since 1999, the error rate in the amount of incorrect claims submitted by providers has dropped from 14.2 percent to 3.9 percent. In 2007, of the $371.5 million collected, 96 percent constituted overpayments received from health care providers and 4 percent involved underpayments reimbursed to providers. ■

CMS RAC Status Report, Feb. 1, 2008, Health Care Compliance Reporter ¶350,075.

Congress to consider dramatic expansion of False Claims Act: How will a bigger, stronger False Claims Act impact compliance officers?

by Lisa A. Estrada, Esq., Contributing Editor

Already one of the most powerful tools in the government's health care fraud enforcement arsenal, the federal False Claims Act[1] will undergo a dramatic expansion if amendments recently introduced in Congress become law, and with support from a bipartisan coalition of some of Washington's most powerful lawmakers– including Senate sponsor Charles Grassley (R-Iowa), House sponsor Howard Berman (D-Calif.), Senate Judiciary Committee Chair Patrick Leahy (D-Vt.), and Senate Judiciary Committee Ranking Member Arlen Specter (D-Penn.)– odds are good that health care entities soon will face a bigger, stronger False Claims Act.

False Claims Act history

Dating back to 1863, President Abraham Lincoln first proposed the False Claims Act (FCA) as a weapon against contractors intent on bilking the Union Army. In its original form, one of the FCA's key enforcement mechanisms was a provision allowing private individuals to bring civil actions against government contractors on the government's behalf.

Congress intended that these citizen-initiated suits, or *qui tam* actions, would lead to a public partnership with private individuals who closely observed or were involved in fraud. As part of the partnership agreement, the private individuals bringing suit on behalf of the government were entitled to a portion of the monetary damages recovered as a "bounty."

By the mid-1900s, however, a series of restrictive judicial interpretations of the Act, coupled with legislative measures limiting *qui tam* actions, led to a dramatic reduction in the number of *qui tam* actions to a few per year. This trend continued until the mid-1980s when the issue of government fraud caught the attention of the media after Sen. Grassley exposed the Defense Department's $600 toilet seat and $748 pliers. The resulting public furor and perception of "rampant fraud in Government programs" led the Senate to add new teeth to the century-old Act by broadening the jurisdictional reach of the Act and strengthening the *qui tam* provisions.

Of particular importance, Sen. Grassley's 1986 amendments increased financial incentives for individuals with information about government fraud to come forward; so called "whistleblowers" now could share up to 30 percent of damages. The 1986 amendments also strengthened provisions prohibiting adverse employment actions by employers seeking to retaliate against whistleblowers.

These changes to the law proved a powerful incentive for both the government and private citizens to develop and push new and inventive uses of the FCA, including an application to Medicare and Medicaid claims. In the 10 years following the adoption of the 1986 amendments, the number of pending civil health care fraud matters skyrocketed—from 270 in fiscal year 1992 to over 4,000 in fiscal year 1997.[2]

Since then, the FCA has been front and center in the health care industry. The government has recovered billions of dollars, and many whistleblowers have walked away millionaires. The threat of both government- and whistleblower-initiated actions has helped to fuel the development of aggressive compliance programs, voluntary disclosures of improper practices, and educational efforts aimed at preventing health care fraud. Despite these successes, however, Sen. Grassley and other proponents of expansive fraud enforcement powers apparently believe that broader powers and whistleblower protections are necessary.

Bracing for change — what compliance officers need to know

If enacted, the FCA amendments proposed by Sen. Grassley and Rep. Berman would create several new risk areas for health care entities. Several of the proposed changes that would significantly impact the work of health care compliance officers are discussed below.

Whistleblower protections

Compliance officers frequently field complaints about suspected improper activity and may be involved in decisions about how best to respond to employees or others who have reported fraud. For these reasons, compliance officers must be familiar with the FCA provisions protecting whistleblowers from retaliation.

The 1986 amendments to the FCA included provisions protecting whistleblowers from adverse employment actions

or discrimination by their employers. If, upon learning that an employee has filed—or plans to file—a *qui tam* action, an employer discharges, demotes, suspends, harasses, or otherwise discriminates against the employee with respect to her employment, the employer may be liable for two times the amount of back pay, interest, and special damages. It is important to note that an employer can be liable for a whistleblower retaliation claim even if the fraud allegation underlying the *qui tam* action is shown to be without merit.

Expanding the class of whistleblowers protected from retaliation

Only current and former employee-whistleblowers are protected by the existing law. Courts generally have found that independent contractors, subcontractors, and other agents fall outside the class of people protected by the FCA retaliatory discrimination provisions. As a result, under current law, entities generally are free to terminate a relationship with a consultant, subcontractor, or other agent whom it learns is pursuing a FCA case against it. The amendments proposed by Sen. Grassley and Rep. Berman would change this by prohibiting adverse actions against "any employee, government contractor, or agent."

Agent is a very broad term. An agent is any person authorized to act on another's behalf. The proposed amendments, therefore, would dramatically expand the class of protected whistleblowers. For example, consider the following hypothetical situation involving a skilled nursing facility (SNF) that contracts with a third-party billing service (TPB):

> The SNF learns that a TPB employee is reporting information about the SNF's billing practices to her private attorney for purposes of a *qui tam* action. The SNF informs the TPB that it will terminate the contract unless the TPB removes the employee from its account and restricts her access to information about the SNF's billing information. The TPB then terminates the employee.

Under current law, the actions taken by the SNF do not appear to implicate the FCA's whistleblower protections because there is no employment relationship between the SNF and the TPB or its employees. The SNF, therefore, may protect its interests vis-à-vis the TPB without incurring additional FCA liability.

If the proposed amendments become law, however, the SNF's actions could create a liability risk. Because the TPB is the SNF's agent under the contract, the SNF's threat to terminate the contract may be considered retaliatory discrimination against the TPB that would be actionable under the FCA. In addition, the TPB employee herself may be considered the SNF's agent. Her termination—made at the SNF's urging—could lead to a retaliatory discharge cause of action against the SNF.

As this hypothetical demonstrates, the proposed amendments would expand rather dramatically the class of people who could bring a retaliatory discrimination action against a health care entity. As such, if the amendments become law, compliance officers may be forced to play a more active role in relationships with business partners, independent contractors, and other agents.

Clarifying the types of activities that trigger whistleblower protection

Another proposed change to the FCA retaliatory discrimination provision would clarify the types of activities that trigger protections. Under current law, whistleblower protections kick in when an employer responds to actions taken by the employee "in furtherance of a [*qui tam* action]." For example, an employer may not punish an employee for investigating, initiating, testifying in, or assisting with a *qui tam* action that has been or will be filed. Most courts have determined that this requires that there be some nexus between the employee's actions and a viable FCA action.

The proposed amendments appear to loosen this standard. If the amendments succeed, whistleblower protections will be triggered by actions "in furtherance of…efforts to stop 1 or more violations of [the FCA]." The exact import of this change is unclear and certainly would need to be fleshed out by the courts, but it does appear that the proposed amendments are intended to broadly extend whistleblower protections to people who take actions to stop purported fraud without regard to whether their actions are connected to an existing or future *qui tam* claim.

Moreover, if history is a guide, the definition of fraud actionable under the FCA will continue to evolve and expand, creating great uncertainty for compliance officers about exactly what conduct by an employee would trigger whistleblower protections. For example, the government's recent push to treat certain quality of care issues as FCA violations suggests that employees who raise quality of care concerns—no matter the validity—might be entitled to whistleblower protections under the proposed amendment.

Invalidating waivers or releases of qui tam liability

Since the 1986 amendments, courts have reached different conclusions on the question of whether a severance agreement under which a former employee releases all claims should preclude the former employee from initiating a *qui tam* action. Most courts considering the question have declined to enforce such waivers or releases on public policy grounds.

In 2005, however, a Georgia district court bucked this trend. In *United States ex rel. Whitten v. Triad Hospitals, Inc.*,[3] a hospital company's former compliance officer—after entering into a severance agreement broadly releasing all claims against his former employer—filed a *qui tam* action alleging health care billing fraud. The compliance officer received a substantial cash payment in exchange for the release.

After reviewing the fraud allegations, the government declined to intervene. The district court determined that a re-

lease of *qui tam* actions should be enforced in cases in which the government has declined to intervene. At the time of this ruling, some commentators suggested that it could open the door to early dismissal of nonintervened *qui tam* cases initiated by terminated employees. Although an appeals court overruled the district court's ruling, it did not expressly reject the conclusion that some releases of liability should be enforced to preclude *qui tam* actions.

Apparently responding to the opening created by *Whitten*, Sen. Grassley and Rep. Berman have proposed language that would appear to slam the door shut on such pre-filing releases of *qui tam* liability. The proposed amendments would add a provision stating that "[n]o claim for a violation of [the FCA] may be waived or released by any action of any person, except insofar as such action is part of a court approved settlement of a false claim civil action."

Although the language and meaning of this provision is less than clear, it does appear that the sponsors are intent on allowing *qui tam* relators to have their cake and eat it, too. In other words, relators will be permitted to pursue *qui tam* actions despite having already collected payment for the release of the same action.

Providing a roadmap for government employee whistleblowers

One of the most significant proposed changes would define the circumstances in which a United States government employee may initiate a *qui tam* action based on facts gathered and information learned in the course of his government employment.

Following the 1986 amendments, controversy arose about the extent to which the FCA permits government employees—particularly those who derive their information from ongoing government investigations—to serve as *qui tam* relators. Courts considering the question expressed concern that allowing such cases to proceed would destroy the statute's distinction between the government and relator, contravene the Act's purpose to create private-public partnerships, and create impermissible conflicts of interest for federal employees.

Consistent with these concerns, in *United States ex rel. Maxwell v. Kerr-McGee Oil and Gas Corp.*,[4] a Colorado district court recently dismissed the claim of a government auditor whose official responsibilities included reporting fraud to the government because he did not "voluntarily" provide the information to the government prior to filing his claim.

Apparently in response, Sen. Grassley and Rep. Berman have proposed amendments that would expressly permit government employees to file *qui tam* actions but also would allow the government to dismiss such actions in certain circumstances. Specifically, the government may move to dismiss government employee-initiated actions if the relator derived "all the necessary and specific material allegations...from an open and active fraud investigation by the Government." Further, the government may move to dismiss government employee-initiated actions if the relator learned the underlying information in the course of the person's employment and failed to properly disclose the information to his superiors, his agency's inspector general (if any), and the attorney general.

Although presumably intended to limit the ability of certain government employees to bring *qui tam* actions, the proposed provision likely will lead to more government employee-initiated actions because it provides government employee relators with a clearly defined mechanism—or roadmap—for initiating a *qui tam* action based on information derived in their official capacities. Moreover, the proposal leaves dismissal of these actions entirely in the hands of the government. There would be no mechanism for a *qui tam* defendant to make the case, or a court to make an independent determination, that the public interest is harmed by allowing the action to proceed.

Should this provision become law, the takeaway for compliance officers will be that their interactions with government auditors or investigators may lead to *qui tam* actions. Of course, this would seem to run directly counter to the government's goals of encouraging voluntary disclosures and fostering collaborative compliance efforts.

Redefining government funds

Responding to several recent decisions in the government procurements context, the proposed amendments would significantly broaden the definition of government funds and thereby expand the sources of money that fall within the scope of the FCA.

The FCA penalizes the submission to the government of false or fraudulent claims for payment—or claims for government money. In recent cases, government contractors have successfully defended FCA claims by showing that not all funds that the government touches should be considered government money. These cases involved claims submitted to Amtrak (a federal government grantee) and the Coalitional Provisional Authority in Iraq (an entity principally controlled and funded by the United States government but which administered funds on behalf of Iraqi citizens).

To address these perceived gaps in FCA liability, the proposed amendments would define the "government money or property" that falls within the FCA's scope to include:

- money or property belonging to the government;
- money or property the government provides, has provided, or will reimburse to a grantee to be spent on the government's behalf or to advance government programs; or
- money or property belonging to any person or entity on whose behalf the government collects, possesses, transmits, administers, manages, or acts as custodian of money or property.

What would adoption of this broader definition mean in the health care context? That will have to be fleshed out by the courts, but it seems likely that such a change would make the FCA a more attractive enforcement tool in several previously untapped areas. These might include claims submitted to international coordinating authorities like the World Health Organization, Public Health Service grantees like Ryan White programs, or independent providers to tribal health programs. Interpreted expansively, the provision might even reach custodial funds held by the government in situations in which it takes over management of a nursing facility, for instance.

Although the impact this proposed change may have on the health care industry remains to be seen, if enacted, this provision will force compliance officers to think outside the box about what types of claims for payment can trigger FCA liability.

Extending the statute of limitations to 10 years in all cases

Since the 1986 amendments, the FCA provision defining the statute of limitations has perplexed many compliance officers and lawyers alike. Actions generally are barred if not brought within six years of a violation. If the result is a longer limitation period, however, an action may be brought within three years of the date on which a responsible government official discovered or should have discovered the violation. But in no event may an action be brought more than 10 years after the violation.

Sen. Grassley and Rep. Berman propose to simplify this statute of limitations maze by applying a straight 10-year statute of limitations. This proposed statute of limitations may be simpler to administer, but it also would represent another significant expansion of FCA liability—in many cases, sweeping in an additional four years of claims.

If adopted, this provision almost certainly will require compliance officers to reevaluate compliance plans, billing audit procedures, and document retention plans.

The prospects

Without a doubt, the FCA amendments proposed by Sen. Grassley and Rep. Berman will be refined and, to some degree, rewritten as the proposals wind their way through the legislative process. It seems likely, however, that at some point in the not too distant future, health care compliance officers will be forced to deal with the reality of a bigger, stronger FCA.

They will need to be alert to a probable expansion of whistleblower protections, an increased likelihood that government auditors and investigators will emerge as *qui tam* relators, and the likely emergence of new FCA risk areas as the sources of money as well as the time periods covered by the statute are enlarged. In addition, this strengthening of the FCA—which undoubtedly will heavily favor whistleblowers—is sure to energize the *qui tam* bar and generate a next wave of FCA litigation activity. Compliance officers will serve their organizations well by being out in front of that wave. ■

Reprinted from the Journal of Health Care Compliance, Vol. 10, No. 2, March-April 2008.

Lisa A. Estrada is a health care litigation partner at Arent Fox LLP in Washington, DC. She concentrates her practice on representing health care providers in government investigations, False Claims Act enforcement actions, qui tam litigation, and fraud and abuse counseling. She can be reached at 202/828-3424 or by email at estrada.lisa@arentfox.com.

1 31 U.S.C. §3729 *et seq.*

2 GAO Report, "Application of the False Claims Act to Hospital Billing Practices," GAO/HEHS-98-195, July 10, 1998, *Health Care Compliance Reporter* ¶550,001.

3 *United States ex rel. Whitten v. Triad Hospitals, Inc.*, No. CV202-189, 2005 U.S. Dist. LEXIS 26208 (S.D. Ga., Oct. 27, 2005), Health Care Compliance Reporter ¶800,062.

4 *United States ex rel. Maxwell v. Kerr-McGee Oil and Gas Corp.*, 2007 WL 987538, (D. Colo., March 30, 2007).

Trends

Kaiser plan falls under NPIA exemption to Robinson-Patman Act

The purchase and use of discounted pharmaceuticals by Kaiser Foundation Health Plan, Inc. (Kaiser), in connection with a proposed program to provide health care services to persons covered under health benefits plans offered by self-insured employers falls within the Non-Profit Institutions Act (NPIA) exemption to the Robinson-Patman Act (RPA) (15 U.S.C. §13), according to a recent advisory opinion issued by the Federal Trade Commission's (FTC's) Bureau of Competition.

The proposed program. Kaiser is a nonprofit corporation based in California that provides care to its members as a health maintenance organization (HMO) in California and other states. Under the proposed program, employers will contract with Kaiser to provide a range of covered services under the employers' plans, and the employers then will pay Kaiser on a fee-for-service basis for the services Kaiser provides.

NPIA exemption. In general, the RPA prohibits price discrimination in the sale of goods to equally-situated distributors when the effect of such sales is to reduce competition. The NPIA, however, exempts from the RPA many transactions involving hospitals and other nonprofit institutions. To determine whether Kaiser's proposed program met the NPIA exemption, the FTC addressed two questions: (1) whether the entity or entities that will be purchasing the discounted pharmaceuticals qualify as eligible nonprofit institutions under the statute; and, if so, (2) whether the pharmaceuticals purchased for the proposed program pursuant to the NPIA exemption will be used for a purpose that qualifies for the eligible entity's or entities' "own use."

FTC analysis. According to the FTC, with certain caveats, Kaiser's proposed program would fall within the NPIA because: (1) in previous litigation concerning its traditional HMO program, Kaiser had been held by the Ninth Circuit Court of Appeals to be an "eligible entity" under the NPIA; (2) its drug purchases under the proposed program appear to be for Kaiser's "own use" in that they will further Kaiser's intended institutional function; and (3) all the savings earned through the use of the NPIA-discounted pharmaceuticals will accrue only to Kaiser, and not to the self-insuring employers. ■

FTC News Release, Feb. 14, 2008; FTC Advisory Opinion, Feb. 13, 2008.

Senators heed AHIP's call for increased regulation of MA marketing

In response to the ongoing problem of abusive sales tactics by rogue Medicare Advantage (MA) sales agents and increased scrutiny of the problem by the administration and Congress, the America's Health Insurance Plans (AHIP) board of directors has asked for additional oversight of the MA and Medicare Part D plan marketing activities. After meetings with the heads of several large, private insurance companies, Senate Finance Committee leaders have indicated more legislation is on the way.

AHIP, an association of private health insurers, released a proposal on March 4, 2008, calling for a ban on door-to-door marketing, cross-selling, cold calls, and any inducements for beneficiaries to enroll. Its statement also called for strengthening consumer disclosures, verifying that beneficiaries intended to enroll, providing additional agent and broker training, and other protections. The board also wants states to have more tools to ensure that state insurance regulators know which companies an agent or broker is marketing for and can act quickly to address any inquiries or abuses.

Karen Ignagni, Chief Executive Officer of AHIP, said the board wanted to ensure that seniors will be given accurate information and protected from unscrupulous marketing practices. Senate Finance Committee Chairman Max Baucus (D-Mont.) called AHIP's recommendations a "huge step forward" and said he expects the group to work with the committee to ban predatory marketing tactics. "I intend to write these and other protections for seniors into law with my Medicare bill this year," he added.

Senate Finance Committee ranking member Charles Grassley (R-Iowa) said CMS and industry action are needed to curb abuses; however, he said, "it may be faster to pass legislation to beef up enforcement." ■

CCH Washington Bureau, March 5, 2008.

In the News

Consulting firm settles FCA allegations for $3 million

Besler & Company, Inc., a health care consulting firm, and its principal, Philip Besler, have agreed to pay the United States nearly $3 million plus interest to settle allegations of fraud against the Medicare program. "Today's settlement makes clear that the Department of Justice is prepared to protect the Medicare program by seeking redress not only against health care providers who commit fraud but also against anyone who participates in that fraud," said Jeffrey S. Bucholtz, Acting Assistant Attorney General for the Justice Department's Civil Division. The settlement resolves allegations that between January 2001 and August 2003, Besler & Company advised hospitals to purposefully inflate charges for inpatient and outpatient care to make the cases appear more costly than they were, and thereby augment their outlier reimbursements.

DOJ News Release, Feb. 5, 2008.

Hospital system settles FCA claims, enters CIA

Cathedral Healthcare System, Inc. has agreed to pay the United States $5.3 million plus interest to settle allegations that it defrauded the Medicare program. The settlement resolves allegations that between January 1998 and August 2003, the Newark, New Jersey-based hospital system improperly inflated charges for inpatient and outpatient care to make the cases appear more costly than they were and, thereby, obtained outlier payments from Medicare that it was not entitled to receive. The settlement resolves three separate whistleblower lawsuits brought under the federal False Claims Act. In addition to the settlement, Cathedral has entered into a corporate integrity agreement with the HHS Office of Inspector General to ensure continued compliance with Medicare regulations.

DOJ News Release, Feb. 4, 2008.

FTC challenges chiropractic associations' group boycott

The Federal Trade Commission (FTC) has challenged the conduct of two Connecticut chiropractic associations and one of their attorneys to implement a collective refusal to deal with a cost-saving health plan in Connecticut in violation of §5 of the FTC Act. The FTC's complaint alleges that the Connecticut Chiropractic Association (CCA), the Connecticut Chiropractic Council, and Robert L. Hirtle (CCA's legal counsel) conspired through a campaign of meetings and other communications to encourage and facilitate a collective refusal to deal with American Specialty Health. According to the FTC, the challenged conduct was a naked boycott among competitors and a clear per se violation of the antitrust laws. Along with the complaint, the FTC has submitted a proposed consent order that prohibits the parties from entering into or facilitating any agreement among chiropractors: (1) to negotiate with payors on any chiropractor's behalf; (2) to deal, not to deal, or threaten not to deal with payors; or (3) on what terms to deal with payors.

FTC News Release, Feb. 5, 2008.