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Letters to the Editor

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NCVHS "troubled, disturbed" by HIPAA findings; "widespread disruption" likely

by Gordon R. Shea, J.D.

The National Committee on Vital and Health Statistics (NCVHS) is sounding the alarm on the Privacy Rule, issuing a strongly-worded letter to Department of Health and Human Services (HHS) Secretary Tommy Thompson warning that there is a "generally low level" of privacy implementation as the Rule's compliance date nears.

Following September hearings that the NCVHS's Subcommittee on Privacy and Confidentiality held in Boston, NCVHS reports in the letter that it was "surprised and disturbed" by its findings, and in fact was "so troubled by the Boston testimony" that the full Committee felt compelled to report to Secretary Thompson before holding further scheduled hearings later this year. NCVHS also tells Thompson that, in its view, there are "high levels of confusion and frustration" with the Privacy Rule, and that there is a "likelihood of widespread disruption of the health care system as we approach the" Rule's April 14, 2003, compliance date.

The good news. Section 1172(f) of the Health Insurance Portability and Accountability Act (HIPAA) — which is part of HIPAA's Administrative Simplification provisions — charges the NCVHS with making recommendations to HHS on aspects of the HIPAA Privacy Rule. The NCVHS Subcommittee's September 10th – 11th Boston inquiry took testimony from a rather small sample of providers, hearing from 28 witnesses, all from the northeast.

Most of these witnesses, according to NCVHS's letter, expressed "widespread support for the goals of the Privacy Rule;" many larger providers, the letter says, testified that they have made "substantial progress" towards achieving compliance with the Rule in advance of the government-mandated compliance deadline. Many providers testified that they found guidance promulgated by HHS's Office of Civil Rights (OCR) helpful, and some opined that the Privacy Rule merely codifies what was essentially "an ethical imperative" for providers already.

Never heard of HIPAA? "Overall, however," NCVHS reports, the Privacy Rule implementation picture is not good. "Some covered entities decided to wait until the final Privacy Rule amendments were published in August, 2002" before beginning to focus on the Rule, according to the NCVHS. Some providers, the group's letter reports, "especially those in small towns and rural areas, have never heard of HIPAA, do not think it applies to them, or confuse their obligations under the Privacy Rule" with other regulatory mandates.

While some provider testimony at the hearing praised OCR, NCVHS's letter nevertheless concludes that OCR's "failure to make available sample forms, model language, and practical guidance has left covered entities at the mercy of an army of vendors and consultants, some of whose expertise appears limited to misinformation, baseless guarantees, and scare tactics."

Parade of horribles. The "likelihood of disruption" cited by NCVHS stands to create a virtual parade of horribles across the healthcare system, the letter suggests. The letter says this parade may well be aggravated by the "unprecedented scope of the Privacy Rule" and the fact that implementing the Rule "is undoubtedly more difficult than" implementing of previous administrative healthcare mandates.

In fact, according to the NCVHS missive, problems have already begun. For example, state and municipal governments reported to the Subcommittee that they are "lacking the budget or personnel to draft their own HIPAA documents and design training programs to comply with the Privacy Rule." In addition, public "health agencies at all levels have indicated that some providers and hospitals already are failing to report essential public health information because of the erroneous belief that it is prohibited by HIPAA." Furthermore, some "public health clinics told the Subcommittee that they lack the resources to translate essential notices into the numerous languages spoken by their patients as well as to provide the necessary training" to their employees.

The NCVHS letter suggests that these problems stand to multiply soon. For example, the letter reminds Secretary Thompson that "tens of millions of acknowledgements of privacy notices will need to be signed, including by patients picking up prescriptions at retail pharmacies." Home healthcare providers told the Subcommittee that "they are unsure how to protect the confidentiality of protected health information when it is stored in the homes of their patients." Large employers that run employee benefit plans "have received no guidance on when their benefits-related activities are subject to the Privacy Rule. Furthermore, nobody seems to know whether HIPAA or state law applies in the numerous instances in which the laws conflict."

"Several orders of magnitude — quickly." The NCVHS letter does contain some recommendations for mitigating the situation.

NCVHS was "so troubled by the testimony," it reported to Thompson prior to further hearings.

The NCVHS letter says that the group believes that HHS's "HIPAA implementation assistance efforts need to be increased by several orders of magnitude – and quickly." The letter calls for a "substantial increase in resources and personnel" and a "massive public education program" to familiarize the public with the Privacy Rule's requirements for notices, acknowledgements, and authorizations. Covered entities, the letter says, "need targeted education programs in various formats," and OCR in particular "needs to produce and disseminate sample forms, including notices, acknowledgements, and authorizations, with simple wording and in multiple languages. It also needs to provide prompt technical assistance, including responding to the thousands of requests for explanation and clarification sent by covered entities. OCR also needs to expand partnerships with professional associations, industry organizations, state agencies, and other affected parties to leverage and reinforce" compliance activities that have already begun.

The NCVHS's letter to Secretary Thompson was signed on behalf of the group by NCVHS Chairperson Dr. John R. Lumpkin. A copy of the letter may be found on the Internet at http://ncvhs.hhs.gov/020927lt.htm. NCVHS's Subcommittee on Privacy and Confidentiality has two additional field hearings scheduled this year: an October 29th – 30th session in Baltimore, Maryland, and a November 6th – 7th hearing in Salt Lake City, Utah. ■

CCH Chicago Bureau, Oct. 17, 2002

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Seven corporations sentenced for Medicare and Medicaid fraud

by Sharon Sofinski

The U.S. Attorney for the Middle District of Florida has announced that seven corporations were sentenced to five years' probation and ordered to pay cumulative restitution of $5,477,152 to the Medicare and Medicaid programs.

The corporations—DBB, Inc.; G.S. Care Corp.; Gold Star Healthcare, Inc.; MedCare Distributors, Inc.; T-Tech Medical Services, Inc.; Trans-Capital Investment Group, Inc.; and Fulcrum Services, Inc.—were involved in a massive healthcare fraud scheme involving fraudulent billings for durable medical equipment (DME). The corporations operated primarily in the Tampa Bay, Florida, area, and each had previously pled guilty to felony offenses related to the scheme.

The sentencing resulted from an extensive investigation into fraudulent billings by DME companies. The continuing investigation, named "Operation Hardgear," is being conducted by the following agencies: the Federal Bureau of Investigation, the Office of Inspector General of the U.S. Department of Health and Human Services, the Medicaid Fraud Control Unit of the Florida Attorney General's Office, and the Internal Revenue Service.

Prior to the sentencing of the seven corporations, the investigation had netted guilty pleas in this case and other related cases from eight individuals and four other DME companies. Trial for the remaining defendants is scheduled for mid-January 2003. A copy of the news release can be found at www.usdoj.gov/usao/flm/pr/080702sent.pdf.■

CCH Chicago Bureau, Sept. 30, 2002

OIG Work Plan highlights

by Raio G. Krishnayya, J.D.

On October 2nd, the Office of Inspector (OIG) released its Fiscal Year 2003 Work Plan. While the Work Plan facially appears to be merely a carbon copy of the Fiscal Year 2002 Work Plan, the OIG has made some changes. Below are a few of the highlighted changes that healthcare providers should consider, especially as relevant to governmental fraud and abuse investigations.

Health Care Fraud. The OIG began its "Health Care Fraud" section by discussing the importance of contributing "significant amount[s] of resources" to investigate fraud and abuse. In addition, there was mention of the collaborative effort on the part of various law enforcement agencies as well as the OIG to ferret out false or fraudulent Medicare and Medicaid billing — nothing new there.

However, two new sections have been added indicating significant importance to the issues of pharmaceutical fraud and quality-of-care issues. See *Pharmaceutical industry gets draft Guidance from OIG*, CCH Healthcare Compliance Letter, Vol. 5, Issue 20, Oct. 14, 2002. As to the issue of pharmaceutical fraud, the OIG explicitly mentioned that it will create special task forces comprised of assistance from the Drug Enforcement Agency as well as state and local law enforcement, to investigate specifically these types of cases. The objectives of these task forces are to:

- deter the illegal use of prescription drugs;
- curb the danger of street distribution of highly addictive medications;
- stop drug price inflation; and
- protect Medicare and Medicaid programs from making improper payments.

With regard to the quality-of-care issue, the OIG has made this a priority in light of the increasing growth of the aging population.

FCA and CIAs. Another major change between the two work plans is the express language in the 2003 Plan that indicated the OIG's interest in resolving False Claims Act (FCA) cases. Not only did the OIG vow greater involvement in FCA suits but also indicated that it may exercise its exclusionary authority in conjunction with pursuing FCA claims. The 2003 Work Plan stated that Corporate Integrity Agreements will continue to be an integral part of resolving FCA claims as well as for maintaining future compliance with FCA offenders.■

Office of Inspector General, Fiscal Year 2003 Work Plan, Oct. 2, 2002, ¶154,106

Watchdogs, lapdogs, and jumped sharks: Compliance beyond Enron

by Gordon R. Shea, J.D.

> *"…America's greatest economic need is higher ethical standards … When abuses like this begin to surface in the corporate world, it is time to reaffirm the basic principles and rules that make capitalism work: truthful books and honest people, and well-enforced laws against fraud…. We need men and women of character…."* – *President George W. Bush, July 9, 2002*

Back in May, in a CCH Healthcare Compliance Newsletter article entitled *Enroned: Document Retention Lessons From a Business Scandal* (Vol. 5, Issue 9), the example of bankrupt energy company Enron was used to extrapolate some lessons about the need for healthcare facilities to have good document retention policies.

The litany of scandals that has enveloped the corporate world since that article appeared can be encompassed merely by naming some of the companies that have been affected: Tyco, Global Crossing, WorldCom. Even GE's venerable retired CEO Jack Welch has come under the watchful eye of the Securities and Exchange Commission (SEC).

What does this have to do with the healthcare industry? Consider the following examples:

- The HealthSouth corporation – which was already on the defensive about options exercised by its CEO and a pending False Claims Act case against it in Alabama – recently admitted that it is being investigated by the SEC. HealthSouth also recently announced that its board was appointing a "Special Litigation Committee" and will add a new independent director to its ranks.
- In February, just as the Enron scandal was gaining media traction, a doctor of osteopathy wrote the Nevada state attorney general to ask: "What laws exist in Nevada to hold corporations that affect the quality of health care delivery accountable for their actions?
- At this fall's Fraud & Compliance Forum in Washington, D.C., there were no fewer than four different discussions scheduled with the word "Enron" in their title.
- The Health Care Compliance Association recently announced that it is collaborating with the Microsoft Corporation to hold a National Symposium on corporate responsibility.

Given this, now seems to be a good time to draw some larger lessons for the healthcare compliance community.

Small Picture: Details Count

Little things matter — particularly if they fit a larger pattern. Almost already forgotten, one of the great mini-dramas in the past few months of business news was the trial of Andersen Accounting. In June, Andersen, Enron's accounting partner, was found guilty of obstructing justice —though only after a jury deliberated for several days and at one point even announced that they were deadlocked.

Surprisingly, the outcome of the case did not turn on what the government considered its mountains of evidence that Andersen engaged in massive document shredding. Instead, what undid Andersen was a fairly innocuous looking e-mail that one of the firm's lawyers, Nancy Temple, sent to another Andersen employee. "I have suggested deleting some language that might suggest we concluded that the release [of company financial reports] was misleading," wrote Temple. To the jury foreman in the Andersen case —who appeared to be the lone holdout juror opposed to convicting Andersen as deliberations continued— this was enough to show that there was at least one "corrupt persuader" at Andersen who convinced the company to hide information.

But given that the Andersen trial turned on a single sentence in an e-mail, does that mean that all the handwringing about document shredding was for nothing? Not really; the lessons on this point are somewhat complicated.

One matter stressed in CCH's last *Enroned* article was, "you don't get 'do-overs.'" Tampering with documents (whether it's called "tampering," "editing," or "file grooming") is at least as bad as not keeping them in the first place. Before Andersen's Ms. Temple deleted important language in her client's documents, perhaps she should have considered how that decision would play out.

On the other hand, the Temple e-mail did not stand completely alone. It's important to remember the road that brought the jury to that e-mail. The vast majority of the 12-person jury in the Andersen case was, by most reports, ready to convict the company shortly after all the evidence was in. For even the one or two jurors who held out against conviction, it's doubtful that the Temple e-mail alone would have been sufficient to convict Andersen. Instead, that e-mail was the proverbial straw that broke the camel's back; as the last item of evidence piled on top of reams of other evidence, that e-mail did significant damage.

Thus, seemingly little matters like an e-mail can become particularly important where the corporate culture is already lax.

Orwellian language. The Temple e-mail also suggests another lesson: words matter, even down to the name of a company's particular policies.

For example, companies often have specific policies on when documents are to be shredded. These policies are often called "document retention policies" when in fact, such policies aren't

really about document *retention* – they're about document *destruction*. The ultimate aim of such policies is to tell employees when they should shovel paper into the shredder and when they shouldn't. The Andersen court case raised this issue but did not turn on it. Other cases, however, have. The John Deere company lost a little-noticed products liability case in a rural Wisconsin court a few years ago on essentially this issue. Plaintiffs lawyers convinced both a judge and jury that Deere's so-called "document retention policy" was really, well, what it was: a policy on when to *destroy* — not how to *keep* — important papers.

Recognize your entity's policies for what they are, and don't try to cover over them with Orwellian distortions of language.

Big Picture: Cultural Change

The broader lesson in all of this, however, is one of organizational culture.

Checks and balances. When the histories of both the Andersen and Enron corporations are traced back, it becomes apparent that both companies "jumped the shark" — i.e., began their long downhill slide — soon after they began engaging in incestuous patterns of self-dealing. Enron, for example, created a series of shadowy off-the-books partnerships to hide company debt. Another Andersen accounting client, the French corporation Vivendi, recently faced its own mini-scandal when it was accused of trying to have its books cooked to promote the company's goal of transforming itself from a beverage company into a multimedia conglomerate. And for its part, Andersen went from being the firm that set the standard in the conservative world of accounting to a bankrupt shell company after it developed and fostered a consulting business.

While it's admittedly unlikely that most healthcare businesses will ever exceed their brief the way, say, Vivendi did, healthcare entities should work to ensure that their corporate cultures are filled with checks and balances rather than yes-men who sign off on every decision.

A practical example: the Health Insurance Portability and Accountability Act (HIPAA) requires that covered providers hire privacy officers. To whom will such officers report? How much independence will your organization give its privacy officer? These are the kinds of questions that should be answered now, before there is a chance for Andersen/Enron-style institutional nepotism to take hold.

Higher standards. Beyond this, there is a broader need in all business communities, including healthcare, for simple higher standards.

Take the following example. Section 164.530(f) of the Health Insurance Portability and Accountability Act (HIPAA) contains a new duty for covered entities: such entities must mitigate harm in the event that protected health information is disclosed by a business associate. In other words, if a patient's sensitive health information leaks out, any attempt to simply sweep the disclosure under some corporate rug is now illegal. At least initially, however, healthcare entities will have to use their own ethical compasses to decide exactly how much help they give to the aggrieved patient as they attempt to "mitigate" the inadvertent disclosure.

HIPAA's section 164.530(f) mitigation clause is also an example of how ethical mandates can be imposed from above when government regulators fear that they can't trust entities. It is a rather mild example, however, and the government mandates could get far more intrusive and burdensome if healthcare companies don't keep watch on themselves. A variation on this occurred with Enron. As the Enron scandal rolled on through this year to encompass several giants of corporate America, Congress passed the Sarbanes-Oxley Act to impose new duties on CEOs, and the SEC promulgated plans for a new federal body to oversee accountants. If healthcare entities don't act now to make sure they are avoiding Enron-style mistakes, they too invite such intrusion.

Even if this doesn't happen, higher ethical standards are still very much on the minds of government officials, and healthcare entities may still find higher standards imposed upon them. Take the case of the Eckerd Corporation, a pharmaceutical corporation that was recently accused by Florida's Attorney General of improperly using private health information for commercial purposes. Eckerd's case was ultimately settled out of court, but the terms of the settlement included Eckerd funding a new million-dollar ethics chair in the Florida A&M university's school of pharmacy. This creative resolution may portend things to come.

Which dogs will hunt? Proving that the current wave of corporate scandals is nothing new, one of the most pithy summations of the problems of corporate governance was given by a judge named William C. Conner back in 1997, in the case of *AUSA Life Ins. Co. v. Ernst & Young,* 991 F. Supp. 234, 248 (1997) (S.D.N.Y.). Chastising an accounting firm that became too close to a client, Conner scolded: "The 'watchdog' behaved more like a 'lap dog.'"

As healthcare companies begin coming under increased scrutiny from the SEC and other regulators, and as they begin complying with their mandates to create new sub-corporate bodies to look after such matters as security and privacy, they need to check the "dogs" that run in their corporate cultures. To ensure that their corporate cultures stay healthy, healthcare entities should make sure that the dogs that "hunt" in their institutions are the watchdogs instead of the lapdogs.n

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Governmental knowledge defense — a dichotomy of interpretations

by Raio G. Krishnayya, J.D.

One of the key elements to a False Claims Act (FCA) case is the issue of knowledge. The FCA prohibits a person from submitting claims for reimbursement knowing that the claims are false or fraudulent. In some cases, however, the knowledge element not only applies to defendants facing FCA suits, but also to the government when a rarely used, but powerful defense is raised. This defense asserts that despite the claim being false, no FCA liability may be imposed because the government had knowledge of the so-called erroneous condition and subsequently chose to pay the claim anyway. Consider this argument in the context of a recent U.S. Court of Appeals for the Fourth Circuit decision, *United States ex rel. Becker v. Westinghouse Savannah River Company.*

The Westinghouse Savannah River Company is a South Carolina-based nuclear facility owned by the United States government. The government, through the Department of Energy (DOE), maintains contracts with Westinghouse to operate the facility. The funding that Westinghouse received for operation of the facility, as detailed in the *Becker* case, was as follows. First, Westinghouse would submit claims to the DOE for approval. If the DOE approved the funding, Westinghouse's claim would have been submitted to the President for inclusion in the operations budget and then sent to Congress for approval.

In 1995, however, the system changed due to DOE reorganization. The oversight of Westinghouse operations became the responsibility of the Office of Environmental Management (OEM), a division of the DOE. However, a rule had been promulgated that stated that accounts to be transferred to the OEM that were originally with the DOE, required congressional approval before a transfer could occur. Ultimately, the DOE authorized Westinghouse accounts to be transferred by the OEM despite the ambiguity as to whether Congress had actually approved this transfer.

Acquiescence. The whistleblower in this case, Martin Becker, alleged that the submission of claims by Westinghouse to the OEM despite clear approval by Congress was equivalent to the submission of a false claim. Although Becker's assertion may have been factually true — that there was no clear congressional approval — the erroneous claims argument became moot when the DOE had authorized Westinghouse to submit its claims to the OEM. Why?

The Fourth Circuit had a very simple answer; the DOE is an extension of the government. Therefore, the DOE's acquiescence to pay a claim despite the existence of a requisite condition, removed Westinghouse's claims — even if factually false — for reimbursement, from the FCA's purview. According to the Fourth Circuit, "DOE's full knowledge of material facts underlying any representations implicit in Westinghouse's conduct negates any knowledge that Westinghouse had regarding the truth or falsity of those representations."

Historically not all the same. The Fourth Circuit's decision does not stand alone in the FCA body of law. In its opinion, the court cited several other circuits that follow the Fourth Circuit's recognition of the "government knowledge defense." One circuit that provided fodder for the Fourth Circuit's assertion was the Seventh Circuit in *United States ex rel. Durcholz v. FKW, Inc.* The facts of the *Durcholz* case were similar to the *Becker* case and were heavily relied upon by the Fourth Circuit.

In *Durcholz* the government had hired a contractor to dredge a sedimentation pond; however, the contractor was told to submit its billing for services not performed. The Seventh Circuit found that the change in invoicing had occurred at the government's direction despite the fact that the contractor knew the billing was erroneous.

The *Durcholz* case is the cornerstone for the "government knowledge defense." While many circuits accept the "government knowledge defense," some circuits do not hold that it completely bars a FCA suit. Consider a Fifth Circuit decision in *United States v. Southland Management Corporation* (CCH ¶301,453). The Fifth Circuit declined to accept the "government knowledge defense" as an absolute defense. Instead, the Fifth Circuit held, "we would permit a 'government knowledge defense' primarily in the rare situation where the falsity of a claim is unclear and the evidence suggests that the defendant actually believed his claim was not false because the government approved and paid the claim with full knowledge of the relevant facts."

The distinction. The importance of contrasting the *Becker/Durcholz* line of cases from the *Southland Management* line of cases cannot be missed. *Becker* and *Durcholz* assert that the "government knowledge defense" is an absolute **defense.** In other words, proof that the government **knew** that the claim was false precludes the FCA suit from advancing forward, *i.e.* no FCA liability. *Southland Management* asserts that government knowledge is merely counter **evidence** to an assertion that the person who made the claim submitted a false or fraudulent claim. In other words, the proof of governmental knowledge could be used to negate an element of the FCA. As a practical matter, the difference is between winning the suit early in the pleadings stage of the case or trying to win the case at a potentially costly and risky trial.■

U.S. ex rel. Becker v. Westinghouse Savannah River Co., 4th Cir., No. 01-2452, Sept. 27, 2002, ¶301,461

$729K not grossly disproportionate when compared to $86 million

by Raio G. Krishnayya, J.D.

Healthcare providers often worry about liability issues under the False Claims Act (FCA). Although providers worry significantly about FCA liability, the practical ramifications associated with the monetary penalties are, in one sense, far more troubling. One must realize that FCA suits are a two-front battle. On the one hand, defendants must show that their reimbursement claims were not "know-

ingly" false or fraudulent. On the other, if litigation reveals that they are liable or if there is a settlement of the case with the government, then the subsequent worry focuses on damages.

Ironically, while there are a number of defenses that may be asserted to address the first front of the battle, there are few to address the second front. However, a recent case illustrates an interesting (even if currently unsuccessful) approach to the issue of damages. The case is *United States v. Mackby*.

Mackby originated in the federal district court in northern California and was filed after an investigation by the Centers for Medicare and Medicaid Services (CMS) and the Department of Justice (DOJ) revealed that Peter Mackby falsely submitted claims for Medicare reimbursements. Mackby owned and operated a physical therapy clinic (the Asher Clinic), which provided physical therapy services to Medicare patients. According to the government, however, Mackby sought Medicare reimbursement through the use of an unauthorized provider number — provided unknowingly by his father who happened to be a physician. Between 1992 and 1996, Mackby used his father's provider number to file 8,499 false claims. The government, however, sought to penalize Mackby for only 111 of those claims.

After a three-day bench trial, Mackby was held liable under the FCA and was ordered to pay damages in the amount of $729,454.92. Mackby appealed and the case went before the U.S. Court of Appeals for the Ninth Circuit. The Ninth Circuit upheld the judgment of the federal district court that found Mackby liable; however, the Ninth Circuit sent the case back to the district court to make a determination about the validity of Mackby's argument that the damages constituted a violation of the Eighth Amendment.

Not excessive. Mackby argued that the $729,454.92 judgment violated the Excessive Fines Clause of the Eighth Amendment. The Eighth Amendment prohibits the government and states from levying excessive fines or for allowing cruel and unusual punishment. A 1998 U.S. Supreme Court decision (*United States v. Bajakajian*, 524 U.S. 321 (1998)) has laid out the analysis for determining whether punitive damages violate the Excessive Fines Clause. There are two prongs to such a challenge.

- A defendant must show that the payment to the government is a **punishment** for a particular offense; and
- The payment is **grossly disproportionate** to the gravity of the defendant's offense.

The Supreme Court has laid out certain factors to assist courts in determining whether punitive damages meet these prongs.

- whether the offense is related to other illegal activities;
- other possible penalties as well as a comparison between the level of damages imposed and the maximum amount allowed under the law,
- the extent of the harm caused, and
- the amount of the forfeiture as compared to the gravity of the offense.

On remand, the district court considered Mackby's Excessive Fines Clause argument in the context of these factors. Ultimately, the court held that Mackby was unsuccessful in his challenge. One of the most notable factors against Mackby's argument was the number of false or fraudulent claims that the government alleged he had submitted, 8,499 claims. The court calculated that if the government had chosen to pursue all 8,499 claims, Mackby could have been liable under the FCA for $86 million. Instead the government only challenged 111 of the 8,499 claims. The court found that the $729,454.92 was well within the limits prescribed by the FCA and therefore, constitutionally acceptable.

Not entitled. As part of his challenge Mackby tried to assert that the imposition of damages was unconstitutional because the government did not suffer any actual loss as a result of submission of his claims. His argument followed the logic that under the Medicare laws, he was *defacto* entitled to Medicare reimbursements for the physical therapy services actually provided. Furthermore, according to Mackby, the rates paid by the government were substantially less than the rates the government would have paid had those Medicare beneficiaries received the same services at another provider.

While arguably Mackby's assertion that the government "*got a real deal*" by paying for his services instead of somewhere else, it failed to address the fact that the damages were grossly disproportionate to the offense charged. The premise of the court's holding as to this argument was that Mackby's offense was that he falsely submitted to the government that he was authorized to receive reimbursement for services provided. In reality, he was not authorized. The government materially relied on Mackby's claim of authority and subsequently, erroneously reimbursed Mackby for unauthorized services. See *Emerging unconventional FCA defenses*, CCH Healthcare Compliance Letter, Vol. 5, Issue 9, May 13, 2002.

Not merely a "billing technicality." Along the same lines as the above argument, Mackby sought to assert that the Medicare rules for billing for physical therapy services were "arcane." He further submitted that the Excessive Fines Clause barred imposition of the $729,454.92 in damages because the government's filing of a FCA claim was initially suspect anyway. Not surprisingly, the court neither held the Medicare billing rules to be "arcane" nor was the court willing to entertain the assertion that the filing of FCA claims against Mackby was suspect.

The general demeanor of Mackby's Excessive Fines Clause claim seemed to substantiate the court's belief that not only were the damages imposed more than fair but also that Mackby was without remorse for his conduct.

> Mackby's actions amount to much more than a "billing technicality" — they reflect a serious, ongoing, and deliberate course of conduct designed to obtain Medicare payments for which he was not qualified. Mackby's continued refusal to assume responsibility for his misconduct underscores the need for a sizeable judgment to deter him and others from engaging in similar conduct.

Lessons learned. Arguably, Mackby's lack of contrition may have hurt his Ex-

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cessive Fines Clause challenge. However, contrition is not necessarily a legal requirement when appealing a judgment (although there is an argument to be made that sometimes it can be extremely helpful). And arguably, Mackby's assertion that the Medicare billing rules are "arcane" didn't help his case (even if true). Furthermore, the assertion that the Excessive Fines Clause was violated by the government's pursuit of a FCA claim probably didn't help either. Yet, Mackby's Excessive Fines challenge was not entirely a moot exercise.

An important lesson of *Mackby* is to realize that under some scenario, the damages imposed may be grossly disproportionate. For example, under the *Bajakajian* case cited by the court, the defendant was convicted for not reporting the over $300,000 he was carrying for travel, to a U.S. Customs Agent when asked. When the government sought to forfeit the entire sum of money, the fine was grossly disproportionate because the underlying offense was, according to the Supreme Court, a reporting offense. Furthermore, the Court noted that compared to other offenses such as money laundering, tax evasion, drug dealing and so on, the reporting offense would not warrant forfeiture of the entire sum of money.

Therefore, had Mackby's claim not been almost 8,500 instances of fraudulent claims and had the government sought treble damages against Mackby, there may have been an Excessive Fines Clause argument. On the other hand, in this post-Enron debacle age, courts as well as legislators may be less receptive to an argument that essentially asserts that large fines have overly burdened the perpetrator of fraud.■

United States v. Mackby, N.D. Cal., No. C 98-1310, Sept. 3, 2002, ¶305,259

Woman could not challenge hospital until pregnant

by James Taylor, J.D., Contributing Editor

A woman did not have standing to challenge the accessibility of facilities at a community birthing center because she was not yet pregnant. According to a federal district court in Maine, the woman's stated intention to become pregnant was not sufficient for her to state a claim against the birthing center (*McInnis-Misenor v Maine Medical Ctr*, DMaine, 10 ADD ¶10-123).

Family Center bathrooms inaccessible. The 42-year-old plaintiff had rheumatoid arthritis affecting all of the major joints in her body. As a result, she was unable to walk and used a wheelchair.

According to the plaintiff, she and her husband desired to have a child. As a result of her age, disability, physical size, and pelvis shape, her obstetrician advised that any pregnancy would be considered a high-risk pregnancy. There was only one hospital in her vicinity that could accommodate high-risk pregnancies. However, the hospital's patient rooms and other areas of its Family Center were not accessible to persons in wheelchairs. Specifically, the bathrooms were not large enough to accommodate wheelchairs.

In anticipation of the plaintiff's prior delivery of a baby at the facility, the hospital spent $5,300 to reconfigure a private room on the Birth Center wing to make it more accessible for her. However, the plaintiff was unable to be transferred to the Family Center after her birth because of the inaccessible bathrooms. Now desiring to give birth to a second child, the plaintiff sued the hospital under the Americans with Disabilities Act after the hospital declined to reconfigure a Family Center room for her in anticipation of a second pregnancy.

"Far from being actual or imminent," the court further reasoned, "the harm is conjectural; if [she] never becomes pregnant, they will never confront it."

Pregnancy required for standing. According to the court, the plaintiff lacked standing to sue the hospital for the simple reason that she was not pregnant. "Even granting that she remains of childbearing age and that [she is] actively attempting to achieve pregnancy, it is inherently unknowable when (if ever) [the plaintiff] will become pregnant," stated the court.

"Far from being actual or imminent," the court further reasoned, "the harm is conjectural; if [she] never becomes pregnant, they will never confront it."

Moreover, the court rejected the plaintiff's argument that immediate action was necessary because of the short time period involved in a pregnancy. "The effectuation of the remedial goals of the ADA - as important as it is - is not a concern to which the requirements of standing must yield. In any event, there is no reason to believe that requiring [the plaintiff] to wait to sue until [she] is pregnant would, as a practical matter, leave them remediless under the ADA. As [the hospital] points out, this court has a demonstrated ability to move along a case involving needed injunctive relief, and if such an injunction were granted, would have discretion to deny a stay pending appeal. Moreover, as [the hospital] also observes, to the extent [the plaintiff] fails to attain standing to seek the relief here requested, she is free to press the attorney general to seek such relief."

"The bottom line," concluded the court, "is that [the plaintiff] will not have such standing until such time (if any) as [she] becomes pregnant."■

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