Health Law Alert: Increased Health Care Fraud Enforcement Targets Local Providers, Just as New Anti-Fraud Laws Become Effective

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Fighting health care fraud is a great money maker for the government. In 2008 alone, federal regulators recovered over $1 billion through health care fraud and abuse enforcement efforts. This might explain why President Obama's 2011 budget includes a request to more than double funding for fighting fraud, with the amount set to increase from $250 million to $561 million. In the past, enforcement actions have tended to focus on large organizations in bigger cities. In recent months, however, a series of settlements against smaller providers, many in rural areas, have been announced, suggesting that fraud fighters are starting to concentrate their efforts on conduct that may have escaped scrutiny thus far. Meanwhile, the government's best fraud fighting tool, the False Claims Act, has been amended in ways that make it even more powerful. At the same time, the new Minnesota State False Claims Act is set to go into effect on July 1, 2010.

In the coming weeks, Gray Plant Mooty's Health Law and Litigation teams will be holding a roundtable focusing on these changes and other developments in health care fraud enforcement. Please be sure to watch for an invitation for this free roundtable. In the meantime, we have provided a summary of several recent events of note.

Rural Hospital Fined Millions for Excessive Salaries to Employed Physicians in Violation of Stark Law

Last fall, Covenant Medical Center in Waterloo, IA, paid a $4.5 million settlement to regulators to resolve claims that the hospital submitted false claims to Medicare based on referrals from five employed physicians that violated the Stark Law. The matter arose when a competing medical group complained to regulators that Covenant was paying excessive compensation to lure physicians away from that group. This initial complaint later led to the filing of a False Claims action against Covenant. Covenant asserted that the compensation paid to its physicians complied with the Stark Law's exception for employment relationships because the arrangements were commercially reasonable and involved fair market value payments. The government claimed that the Stark Law had been violated because the physicians were paid at rates that exceeded fair market value for the services the doctors provided. According to the press release announcing the settlement, the doctors received payments that were among the highest received by any physicians in Iowa.

This case is important because it is one of the first to focus exclusively on fair market value compensation paid to hospital-employed physicians as a basis for violating the Stark Law. For years, providers have relied on broad protections in the Stark Law's exception for employment relationships as protecting these arrangements. The Covenant case suggests a new focus on compensation surveys as a tool to be used by regulators in evaluating the legitimacy of these arrangements. Facilities will need to think closely about how payments to their employed physicians match up against productivity measures and salaries at comparable organizations.

Rural Wheaton Community Hospital, Referring Physician Hit with False Claims Settlement

Another recent case involves the 25-bed Wheaton Community Hospital, a critical access hospital located in rural Traverse County, MN. In early January, the DOJ announced that the Hospital would pay $563,000 to settle a False Claims Act case involving hospital admissions that were allegedly not necessary or extended for no medically necessary reason. In addition, Dr. Stanley Gallagher, a Traverse County physician who allegedly ordered the bulk of the disputed admissions, agreed to pay $283,000 to resolve his own liability. As with so many other False Claims cases, the Wheaton matter arose when another physician, who used to share clinic space with Dr. Gallagher, filed a qui tam action. The DOJ later intervened in the case and took over the prosecution against Wheaton Hospital and Dr. Gallagher.

Several things stand out about this case. First, it involved a challenge against Dr. Gallagher's judgment in making decisions about the medical necessity of hospital admissions. This was not a matter where allegations were made about services not being performed or upcoded to obtain higher reimbursement. Rather, it involved regulators taking the position that Dr. Gallagher's judgment was faulty and that the hospital erred in relying on his judgment. However, hospitals are in a difficult position because they generally need to rely on the medical judgment of their admitting physicians. The Wheaton matter may make some facilities feel like they need to more closely monitor their physicians' actions. Second, while regulators have not hesitated to challenge medical necessity decisions in the past, these types of cases have not typically turned into False Claims matters. This is because pursuing a False Claims action is much harder than pursuing an administrative recovery. Finally, as a small, rural facility, Wheaton Hospital is the type of provider that has historically flown under fraud regulators' radar in the past. This case, as well as the Covenant matter, suggests that regulators have moved their focus beyond the larger cities and health systems that have so often been targeted before.

Hospital Settles First Ever Stark Case Focused Solely on Non-Monetary Compensation

While the Stark Law regulates all payments physicians receive from parties to which they refer, there have been so many situations where the law is blatantly ignored that regulators have not made technical violations a primary focus of their enforcement efforts to date. However, a recent settlement involving Memorial Hospital in Dayton, OH, suggests that this approach might be changing and that smaller violations

are becoming increasingly of interest to regulators.

The Stark Law's non-monetary compensation exception permits hospitals to give physicians things like flowers, tickets to sporting events, dinners, and other gifts without the physicians having to provide services in return, so long as the value of the gifts does not exceed $355 (adjusted for inflation) annually. The catch is that if this amount is exceeded, then all referrals from the recipient physician violate the law. In late 2008, Memorial Hospital realized that it had provided gifts to 10 physicians in excess of the annual limit by about $310 per physician. The 'gifts' involved weather clocks provided to some of the doctors, as well as cost the hospital incurred in taking some of them to a seminar with board members. While arguments existed that the costs of bringing the physicians to the seminar were not actually "non-monetary compensation," but rather a perfectly legitimate business expense, the hospital took a conservative position and self-disclosed the overpayments to the government. To resolve the matter, regulators required the hospital to pay a $30,000 fine.

This case is important for several reasons. First, regulators need to be taken seriously when they say that providing gifts that are valued even slightly more than the annual limit can violate the Stark Law. Second, facilities need to have a mechanism in place for tracking the payment of these gifts. If regulators come calling, it will be helpful to demonstrate the amount, timing, and nature of the gifts involved. Finally, additional training about the nuances of the non-monetary exception and other regulatory standards might be worthwhile. It can be difficult for hospital decision-makers to understand that one too many bouquets of flowers can land their facility in hot water without ample training on this topic.

New Fraud-Fighting Tools Suggest Increased Focus in 2010

Regulators already have an arsenal of fraud fighting weapons at their disposal. This apparently is not enough, however, as is demonstrated by amendments to the federal False Claims Act that became law in 2009. These amendments, contained in the Fraud Enforcement and Recovery Act, have made it easier for regulators to pursue False Claims violations and have expanded the scope of conduct that is subject to the False Claims Act. Minnesota's new false claims law will also go into effect in a matter of months. This law will allow private plaintiffs, as well as the Minnesota Attorney General and city and county attorneys, to pursue the kinds of violations that previously were too small to garner attention of federal regulators.

UPCOMING HEALTH LAW AND LITIGATION ROUNDTABLE

A slate of seasoned Gray Plant Mooty attorneys will discuss these and other issues at a roundtable event to be held in the coming weeks. If you would like further information about any of the topics discussed above, please contact Jesse Berg (612.632.3374, jesse.berg@lathropgpm.com) or Tim Johnson (612.632.3208, tim.johnson@lathropgpm.com). Otherwise, be sure to watch for an invitation to the upcoming roundtable.

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