AVOIDING QUALITY FRAUD

Many boards are paying attention to quality because they have recognized that improving the safety and quality of care is central to the mission and strategies of hospitals and health care systems. But few trustees are aware of an additional reason to pay close attention to quality reports: If a hospital is not delivering high-quality care and the board knew or should have known about it, yet they did nothing while the institution continued to submit claims to Medicare (and other payers), then the hospital’s leadership (including trustees) can be considered to have committed “quality fraud.”

This article: reviews the background of liability for “quality fraud;” highlights what enforcers have said about trustee responsibility for these issues; elucidates new risks; and offers some practical guidance to navigate the new terrain.

OLD WINE IN NEW BOTTLES

Throughout the history of the Medicare program, hospitals have been penalized for egregious quality failures. For example, the secretary of the Department of Health & Human Services (HHS) can terminate Medicare’s provider agreement with a hospital for failing to meet the conditions of participation, which include quality requirements. As one example, in 2007, the Centers for Medicare & Medicaid Services (CMS) inspectors found that Haywood Regional Medical Center, Clyde, N.C., failed to meet four Medicare conditions of participation. Trustees should note that “Governing Body” was the first deficiency listed. Haywood was dropped from the Medicare program and, although the hospital regained Medicare payment three months later, patient volumes fell to half their usual level and the hospital essentially depleted its reserves. Termination of participation in the Medicare program has been rare, but CMS’ use of this severe penalty appears to be increasing. In addition, the government can formally exclude hospitals for years for providing items or services to patients that are substantially in excess of the patient’s needs or of a quality that fails to meet professionally recognized standards of care. This was the threat the government used against Tenet’s Redding (Calif.) Medical Center for providing unnecessary surgeries.

Similarly, there are quality-relevant civil money penalty statutes on the books. These laws, which involve stiff fines, do not require the government to meet the criminal burden of proof (“beyond a reasonable doubt”) nor even to go to court to impose them. Targeted behaviors include submitting claims for a pattern of services that a person knows or should know are not medically necessary, providing false or misleading information that could be expected to lead to a premature discharge, making payments...

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to physicians to reduce services to patients, and using incentive plans that put physicians at substantial financial risk. Quality fraud enforcement has become very aggressive. Every one of the Model Compliance Guidance documents published by the Office of the Inspector General (OIG), beginning in 1998, and supplemented in 2005, mentions quality as a primary concern. Each year since 2003, the OIG and New York Plans have devoted increasing resources to quality and medical necessity issues. For 2008, they pay special attention to the Joint Commission’s oversight responsibility and to patient safety and quality in physician-owned hospitals.

The primary objective of the Model Compliance Guidelines has been the prevention of false claims liability. The sweep of the false claims statutes, which can be enforced by the Department of Justice (DOJ) as well as the OIG, is very wide. Any statement made to secure reimbursement that is inaccurate can be a false claim. While false claims violations require intent, Congress retains explicit statutory authority, and courts, on their own, have established that intent can be inferred from a pattern of behavior. Reckless disregard as to the accuracy of claims is enough to find a violation. Just not paying attention is as bad as or even worse than active intent.

An even bigger risk is the whistle-blower—who can allege quality fraud in secret and then get up to 30 percent of any financial recovery—whether by settlement or verdict. False Claims Act penalties are $11,500 per improper claim, plus triple the charges, and the dollars mount very quickly. This has become a very lucrative arena among the bar, in part because lawyers are not limited in their fee agreements with these plaintiffs the way they are for malpractice or other personal injury cases. Enormous sums of money are at risk in these cases.

Quality failures have been explicitly targeted by the government as false claims cases. For example, as long ago as 1996, patients in the Tuckership nursing home in Pennsylvania were found to have terrible bedsores. The DOJ investigated and learned that one of the factors contributing to the aggravated bedsores was malnutrition. The DOJ asserted that every day of care paid for could be a false claim based on the data suggesting that the patient was not really improving. The data were in the chart, and the patient was not getting the appropriate care.

Similar issues arose in the United Hospital settlement in 2003 in which the Michigan hospital pled guilty and paid a $1.05 million fine for poor quality services and medically unnecessary pain management procedures. The government argued that the facility obviously paid money for reimbursement and that the negligence was the real problem, the court said. Quality fraud claims were dangerous because the data was obvious and because the information was all in the chart. The nurses were not doing it, and the doctors were frequently not aware of it.

In addition, because of new market demands for improved hospital quality, hospitals are using incentive plans that put physicians at substantial financial risk. Quality measurement and reporting is fraught with potential liabilities. For example, quality scores and whether those relationships will run afoul of the Stark or anti-kickback statutes. Specifically, the OIG cites as potential fraud the failure to report quality scores, use of risk adjustment, and record donations, and service-line joint ventures. The OIG has also singled out physicians’ failure to document the quality of care rendered as a source of liability for hospitals. Where a facility fails, the board of trustees will become the focus of attention. As a result of the Redding (Calif.) Hospital fiasco, Tenet signed a Corporate Integrity Agreement that imposes quality monitoring and reporting requirements on the board, with verification of their activities conducted by an outside auditor.

The Department of Justice is also interested in whether hospitals are reporting quality data accurately, especially with regard to the Hospital Quality Alliance reporting mandate. The DOJ is not interested in programs that are accurate, but also in false statements supporting those claims, false statements to avoid repaying money to the government and statements that imply services were medically necessary and met all payment conditions. Implied payment conditions include claiming the services were supervised by appropriately trained personnel and provided by clinicians with appropriate privileges. From the prosecutors’ perspective, publicly reported data about quality is a potential fraud and abuse treasure trove.

These issues will also be of interest to whistle-blowers and prosecutors report that many whistle-blowers are disgruntled employees. Those who have access to data about quality performance measures, nursing staff levels, infection control issues, equipment not being limited by budget constraints and other situations and other variances related to quality and safety may become whistle-blowers. Another potential focus of attention may come from hospitals’ adoption of the Institute for Healthcare Improvement’s “100,000 Lives Campaign.” More than 3,500 hospitals signed up, which implied that they were willing to adopt as part of a larger campaign to prevent needless deaths. While this likely changed the standard of care for malpractice oversight, a hospital that signed up for the campaign but failed to implement the “planks” could be targeted by those prosecutors interested in what Sheehan refers to as “promises made but not kept.”

CONCLUSION

An ever-rising bar for quality performance is the new reality for hospitals and physicians alike, often by virtue of new government demands for improved hospital quality. In addition, because of the tight connection between quality and payment, federal prosecutors now focus on quality as a predicate for fraud enforcement. Ensuring quality of care is the right thing to do. It’s also a good business strategy. And in case that’s not enough of an incentive, there is now a third reason to pay serious attention to quality—the risk of federal prosecution for quality fraud.

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1. Bring quality and compliance programs together.

In many institutions, compliance has developed separately from the rest of the business, often in an effort to maintain the independence of its functions. Unfortunately, all too many times this leads to a splintered isolation of the compliance office. The integration of quality concerns into the compliance function has the capacity to strengthen both quality improvement and compliance—and is a good step toward preventing quality fraud.