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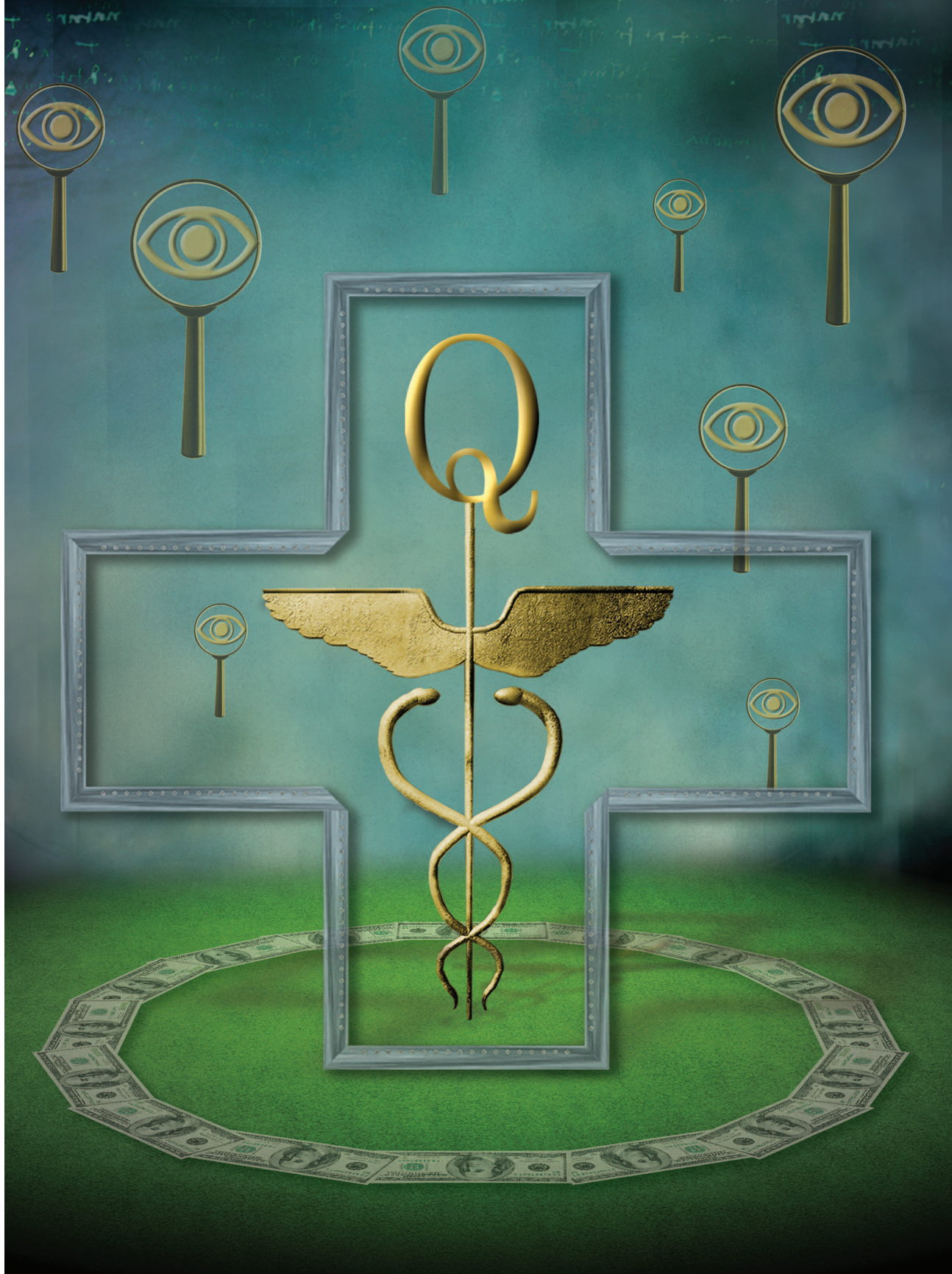
# AVOIDING QUALITY FRAUD



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 enforcers have recently become more 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 principal concern. Each year since 2003, the OIG's Work 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 Guidances 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 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 a malpractice or other personal injury case. 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 Tucker House nursing home in Philadelphia 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 those patients was a false claim because the home was obviously not feeding patients, and Tucker House settled for $535,000. The same theory was used in dozens and dozens of subsequent "quality fraud" settlements all around the country. In one of them, a federal appeals court just a few months ago (June 2008) found that none of the insurers for a nursing home was obligated to pay anything, including defense costs, even when the home thought it was covered for billing errors. It was the failure to provide promised levels of care and not billing errors that was the real problem, the court said.

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 ignored obviously poor quality because the financial benefits from the unnecessary admissions were so substantial. Still further, in a Missouri nursing home case, in addition to false claims, the chief executive officer and three facilities were charged with conspiracy and fraud and paid a very high price: jail, criminal fines, exclusion from Medicare and Medicaid, and a civil settlement. The government argued successfully that the company had such rigid budget constraints that they should have known the facilities could not provide adequate staffing, which led to quality failures.

## THE ENFORCERS SPEAK

Against this sobering background, both the OIG and the DOJ have recently identified quality and, particularly, the board's responsibility to ensure high quality as a critical issue to which they will direct their attention.

In 2006, the most high-profile prosecutor in the country on these issues laid out the ways in which boards could be liable for failure to monitor the quality of care in the organization. James G. Sheehan, formerly an assistant U.S. attorney in Pennsylvania and now the inspector general for New York State Medicaid, listed four critical questions that would determine the government's prosecution effort:

1. Has there been a systemic failure by management and the board to address quality issues?
2. Has the organization made false reports about quality or failed to make mandated reports?
3. Has the organization profited from ignoring poor quality or ignoring providers of poor quality?
4. Have patients been harmed by poor quality or given false information about quality?

Sheehan's prosecutorial theory rests on the answer to the question: "What is the quality we are paying for?" Implied in every claim submitted by a provider, Sheehan asserts, is that the provider is reducing medical errors and adverse events; improving outcomes; complying with best-practice guidelines or requirements; and reducing cost for the same outcomes. Sheehan has left a well-trained DOJ staff behind him to carry on his national work while he pursues the special quality and other fraud problems in New York Medicaid.

Directed to hospital trustees, the OIG jointly authored in 2007 with the American Health Lawyers Association (AHLA) guidance on "Corporate Responsibility and Health Care Quality." The OIG/AHLA document closely parallels and reinforces the arguments of the DOJ on quality fraud, while it identifies additional points of potential liability.

## NEW LIABILITIES

As payers' focus on quality performance and pay for performance increases, and quality reporting programs proliferate, the potential for fraud and abuse in quality performance escalates. These liabilities are not limited to public programs. Because of mail and wire fraud statutes, if you put a stamp on it, if you send an e-mail or a fax, and if the statements made to a payer to obtain money are inaccurate, you are liable for making false claims, even in a commercial program.

Quality measurement and reporting is fraught with potential fraud pitfalls. Inconsistencies in quality data submitted by different people in the same organization, failure to take action upon data that is tracked, and neglecting to report unfavorable data, have all been identified by the OIG as potential fraud bases. The OIG is particularly interested in collaborative arrangements among otherwise independent providers to achieve high-quality scores and whether those relationships will run afoul of the Stark or antikickback statutes. Specifically, the OIG cites as potential minefields—gainsharing programs, electronic health 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 to perform effectively, the board may well 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 only interested in claims that are inaccurate, 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. Prosecutors report that many whistle-blowers are disgruntled employees. Those who have access to data about quality performance measures, nurse staffing levels, infection control issues, equipment purchasing and upgrade decisions and other sensitive matters 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 various "planks" of the campaign to prevent needless deaths. While this likely changed the standard of care for malpractice overnight, 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 health care delivery systems, in part because of new market 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. **T**

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## WHAT'S A BOARD TO DO?

Trustees can take specific actions to reduce the risk of quality fraud. Our short list is drawn from best practices noted in the Institute for Healthcare Improvement's "Boards on Board" elements, as well as the American Health Lawyers Association guidance for boards.

**1. Pay attention to quality.**

The best boards spend at least 25 percent of their time as a board on quality and safety matters, reviewing performance, setting goals, clarifying expectations, and most importantly, asking hard questions. Among the hardest questions boards should ask are:

- Does the decision we just made put us at increased risk for quality fraud?
- Are we knowingly profiting from poor quality (e.g., re-credentialing poor-quality but high-revenue physicians, or approving excessively lean staffing budgets)?
- Are we really hearing the quality concerns of patients, families, nurses and physicians—the insiders who can become whistle-blowers?
- Are we hearing about quality and safety failures when they occur? How are we holding hospital management accountable for resolving these issues?
- Do we truly understand the quality and safety performance data shown to us as the board? If not, what are we doing to improve our oversight capability?
- How do we know that our publicly-reported quality data are consistent, complete and at least as accurate as our publicly-reported financial data?

**2. 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 splendid 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.