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CORRIDORS

News for North Carolina Hospitals
from the Health Law Attorneys of Poyner Spruill LLP

Money Talks, But Who's Listening?

by Kim Licata

Money talks, and for hospitals and physicians this can become a real problem when negotiating a fair-market-value compensation arrangement. Hospitals and physicians negotiating compensation arrangements may have more people "listening into" their discussions than they may want or even realize. The federal case of *United States of America ex rel. Michael K. Drakeford, M.D. v. Tuomey d/b/a Tuomey Healthcare System*, C.A. No. 3:05-CV-2858-MJP, provides hospitals and physicians with insight into how the government views compensation under employment contracts. So, how do you keep yourself out of the trouble when negotiating and accepting a physician employment agreement?

In *Tuomey,* a physician, Dr. Drakeford, brought a federal lawsuit alleging that Tuomey's referrals from employed part-time physicians violated several federal statutes, from the False Claims Act to the Stark law, because of the allegedly excessive compensation offered by the hospital to referring physicians that polluted claims submitted by the hospital for reimbursement from Medicare and Medicaid. Dr. Drakeford owned the only orthopedic clinic in Sumter County when the hospital offered him a part-time employment agreement. Dr. Drakeford sought legal counsel over the propriety of the proposed arrangement (who expressed compliance concerns), who in turn with hospital counsel engaged an attorney who had formerly worked on issuing formal guidance to providers through fraud alerts and advisory opinions. The former government attorney discussed the proposed arrangement with attorneys for the hospital and for Dr. Drakeford and expressed concerns about the compensation and the valuation opinion received by the hospital. When Dr. Drakeford requested to meet with Tuomey's board about his concerns with the proposed arrangement, the hospital sent Dr. Drakeford a new policy regarding contact with the hospital board without any meeting or further discussion with him or his counsel.

What was going on in Sumter County, South Carolina that drove up compensation? For one thing, Tuomey is the only hospital located in the county and therefore the only provider of various surgical and other services in the county. This changed when a medical group was approved by the state to develop an ambulatory surgery center in the county, although, at nearly the same time, Tuomey was approved to develop an outpatient surgery center. Allegedly, Tuomey was concerned that procedures would shift away from Tuomey and its new outpatient surgery center to the competitor ASC, and approached various physicians in an effort to maintain their relationship. This fact, according to Dr. Drakeford and the government, led the hospital to enter into improper financial relationships (through an affiliated physician group) with 18 part-time physicians working in different specialties. Recruited physicians were paid a base salary and bonuses based on the dollar value of receipts that Tuomey received for that physician's services or on the number of procedures that physician performed.

continued on page three

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T Minus 60 Days and Counting: CMS's New Repayment Deadline

by Steve Shaber

The Basics. The Patient Protection and Affordable Care Act, Public Law 111-148 (Act), creates new potent requirements for providers and suppliers to return Medicare and Medicaid overpayments. Subsection 6402(d)(1) of the Act says:

If a person has received an overpayment, the person shall—

- Report and return the overpayment to the Secretary [of the U.S. Department of Health & Human Services], the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
- Notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

In Subsection 6402(d)(2), the Act goes on to set the deadline to return the overpayment:

An overpayment must be reported and returned under paragraph (1) by the later of --

- The date which is 60 days after the date on which the overpayment was identified; or
- The date any corresponding cost report is due, if applicable.

Note that everyone will always have at least 60 days to report and reply, but providers who file cost reports may have longer, because they may have until their next cost report is due.

Failure to return the overpayment on time is a so-called "reverse" false claim. Subsection 6402(d)(3). Like any other false claim, it is potentially subject to the per-claim penalties and treble damages in the federal False Claims Act, 31 U.S.C. § 3729.

The new provisions apply to all Medicare and Medicaid providers and suppliers (as well as Medicaid managed care organizations, Medicare Advantage organizations, and Medicare prescription drug plan sponsors), but not to beneficiaries. Subsection 6402(d)(4)(C). The provisions apply to any and all funds the provider or supplier receives from Medicare or Medicaid which, after reconciliation, the provider or supplier is not entitled to receive or retain. Subsection 6402(d)(4)(B).

Note this is *not* part of the new Stark Voluntary Self-Referral Disclosure Protocol, OMB Control Number 0938-1106, discussed elsewhere in this issue, but it complements the Protocol.

The Judgment Calls. No one should ignore the teeth in this provision, but it does also have some potential leeway built into it, which providers – both hospitals and physicians – can use to their reasonable advantage when they realize they have probably received and must deal with an overpayment. The key thing to remember is the 60-day repayment period to report and return starts on the date the overpayment is "identified." Identified does not mean suspected, detected, or "guess-timated." Identified means – within reason and good faith – known and calculated. Some things cannot be known and calculated within 60 days of being suspected or detected, but necessarily take longer. Therefore, when an overpayment is suspected, the provider does not need to race to meet an impossible 60-day deadline. Instead, the provider and can take these steps:

1. Immediately assign someone qualified to figure out if there has been an overpayment and, if so, how much. You may want to assign it to counsel to take advantage of the "attorney work product" rules.
2. Quickly set a prompt, but reasonable, schedule for determining if an overpayment exists and, if so, how large it is. If you can do it in 60 days, so much the better. But the most important thing is to be able to show you worked steadily and reasonably.
3. Document the investigation to identify the overpayment while it is going on. During the investigation, use the future tense and choose words such as "suspect," "investigate," "inquire," and "look into" to describe your efforts. Avoid the past tense, and shun words such as "identified," detected," and "determined" until you actually have reached solid conclusions.
4. If you identify overpayments in stages, report the overpayments and refund the money in stages.
5. Do not forget to report the reasons for the overpayment, and correct these reasons going forward.
6. Consider whether you want to (i) report to and repay the government or (ii) report to and repay your contractor, carrier, or intermediary.
7. Be diligent and make the repayments as soon as you reasonably can.

Following these steps, diligently and in good faith, should protect a provider who is trying to meet the requirements of the law but cannot get the work done in just 60 days.

These steps are not, of course, camouflage for the provider who wants to delay or avoid repayment. Unreasonable delays will violate the provisions of the False Claims Act, which say willful ignorance or deliberate disregard of the facts is equivalent to actual knowledge.

Conclusion. With these developments, there is no doubt that a provider has a duty to report and repay Medicare and Medicaid overpayments. Moreover, the penalties for failing to do so are severe and are ignored only at your peril.

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Money Talks...
continued from page one

Legally, what happened? Dr. Drakeford sued, the government intervened, and a jury found that Tuomey violated the Stark Law and owed the federal government almost $45 million before interest. Tuomey faces a new trial on whether the hospital violated the federal False Claims Act (which increases Tuomey's potential exposure by over $227 million, a charge that had previously been dismissed) because of the judge's decision to exclude certain testimony, particularly the testimony of the former government attorney and of Tuomey's chief operating officer. In late October 2010, Tuomey lost its appeal to the Fourth Circuit to have the appellate court entertain the order for a retrial on the False Claims Act (and prevent retrial). Tuomey has also appealed the $45 million verdict and maintains its innocence.

Which elements of the Tuomey part-time employment agreements concerned the government? The complaint, as amended, identified several questionable provisions, including:

- **Compensation:** Compensation was in excess of 130% of the physicians' net collections on the procedures performed and was significantly out of line for physicians in similar specialties.
- **Exclusivity:** Physicians were penalized if they did not refer to Tuomey for services. Outside counsel had suggested Tuomey revise the agreement to permit patient choice of another provider and referral where the patient's best interest would be met by receiving services from a different provider, but these changes were not made.
- **Non-Compete Clauses:** These provisions prevented the physicians from providing outpatient surgeries within a 30-mile radius of Tuomey during the agreement and for two years after the agreement's termination.

Perhaps one of the more problematic facts of the case was that the hospital's interest in the physicians arose after the approval of the competing ambulatory surgery center and a financial analysis by the hospital showed an appreciable revenue drop if certain services were performed at the ASC versus at Tuomey.

What lessons can be learned from this?

First of all, hospitals should establish appropriate policies relating to internal reporting of potential compliance issues. Such a policy should encourage discussion of concerns, involve appropriate investigation of expressed concerns, protect the person raising concerns from any adverse action, and foster an environment of compliance consciousness and proactive monitoring.

Second, failing to interact appropriately with a potential whistle-blower or concerned person, whether or not a policy is followed, can have grave legal and financial consequences. Working with a concerned person to identify and address a compliance concern is much less expensive in the long run than facing that person and the United States government in a lawsuit.

Third, hospitals cannot blindly rely on valuation opinions. Tuomey had received a valuation opinion that the compensation was fair market value, but the government said Tuomey's reliance on the opinion that 131% of net collections was fair market value was not reasonable. The valuator's own data in the opinion letters given to Tuomey showed similar physicians were paid 49% to 63% of net collections, substantially less than the proposed compensation. The underlying opinion did not pass the smell test.

Finally, remember, if something sounds too good to be true, it generally is, or at least the government will think it is! Approach all financial relationships between hospitals and physicians with an eye toward what is reasonable and fair market value and obtain appropriate counsel to review agreements.

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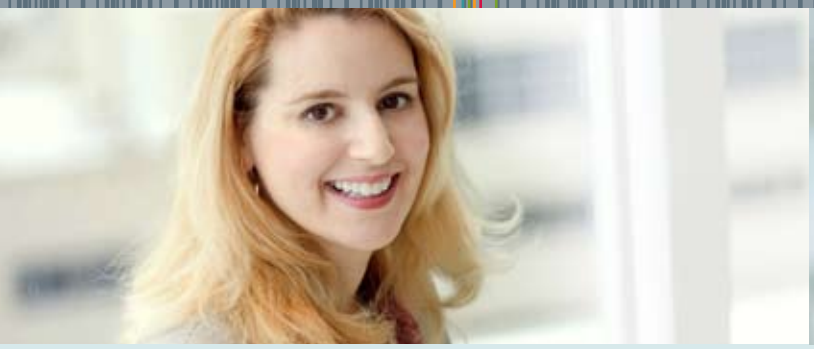

Self-Disclosure Déjà Vu?

by Kim Licata and Chris Brewer

The Voluntary Self-Referral Disclosure Protocol (SRDP) recently released by the Centers for Medicare and Medicaid Services (CMS) looks remarkably familiar. The new SRDP permits hospitals and other providers who believe that they are or might be providing services in violation of the federal Stark physician self-referral law (42 U.S.C. § 1395nn) to disclose such actual or potential violation to CMS in the hopes of resolving the matter as favorably as possible. Required by the health care reform law, the SRDP is specifically limited to reports of actual or potential violations of the Stark self-referral law, so-called Stark-only violations. In contrast, the Self Disclosure Protocol used by the Office of Inspector General (OIG) of Health and Human Services should be used to disclose potential violations that are based, at least in part, on the anti-kickback statute, False Claims Act, or civil monetary penalties.

The table in this article shows the comparison between the Self-Referral Disclosure Protocol and the Self Disclosure Protocol.

Considerations Before Self-Disclosure

The decision of whether to disclose an actual or potential violation of any federal law is one that should be made in consultation with qualified legal counsel after a full internal investigation of the facts and circumstances giving rise to a disclosure. A few points to consider before disclosing a matter are:

- Will the disclosure resolve all the potential fraud and abuse violations involving the disclosing party? If not, what other laws and regulations are implicated and how can these violations be resolved? Disclosure may give other agencies a heads-up that they ought to take a closer look at you and your business partners.
- Have you thoroughly investigated your business's compliance with applicable laws and regulations to ferret out all potential issues and implemented corrective action with ongoing monitoring for any areas of noncompliance?
- Disclosing actual or potential violations means facing substantial civil penalties and fines, even if the final settlement amount is reduced from treble damages (to some other agreed-upon amount), and you have invited the government into your home to have a look around.
- Voluntary disclosures may adversely affect relations with business partners or health plans, as well as potentially result in termination from the state Medicaid program and/or termination of business agreements.
- Voluntarily providing otherwise privileged or confidential information undermines the protection of this information, making it discoverable by others.
- Substantial expenses are involved in the disclosure process and post-disclosure monitoring, separate and apart from any fines and penalties.
- A provider must consider whether the provider has (or can obtain) the financial and other records (going back six years or as far as required) to do the analysis necessary to determine the extent of violations and damages (or penalties) owed.
- Further complexities are added to the decision when clinical staff has changed, as disclosure implicates a privilege waiver and has other serious considerations. Disclosure may potentially impact former and new staff members in a number of ways.

Conclusion

The determination that a disclosure is or is not in the best interest of you and your business requires careful and deliberate analysis of the benefits and the risks involved. Disclosure is a process that, once begun, cannot be undone and requires a detailed legal and financial picture of your business.

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Comparison Between the Self-Referral Disclosure Protocol and the Self-Disclosure Protocol

Similarities in Both	Differences in SRDP
Full Disclosure: Disclosure of all information relevant to the alleged violation.	Method of Filing: Electronic filing via email, along with a mailed original and file copy. CMS's email acknowledgement of the filing tolls the 60-day repayment period for the duration of the investigation as to disclosed violations.
Governmental Inquiry: Notification of any known ongoing governmental inquiry or investigation (and description of such notice).	Complete Legal and Financial Analyses: The disclosure must include a detailed description of the violation and applicability of the Stark law to the matter and a detailed financial analysis with the initial disclosure for the period of noncompliance, including a final amount, itemization by year, and methodology.
Agreement Not to Appeal: Agreement not to appeal any overpayment assessed as part of the settlement agreement.	Past Conduct: The disclosing party must disclose past similar conduct and any prior enforcement actions (civil, criminal, regulatory, or payment suspensions).
Mitigating Factors: Mitigation factors may reduce penalties depending on the facts and circumstances of the violation, but the government is not bound to resolve a disclosed violation or reduce the penalties associated with the same under the SRDP.	No Claims of Privilege or Limits on Documents Disclosed: Cooperation means no limits on supporting documentation.
Additional Violations: Treatment of discovered additional violations as outside the scope of the disclosure.	Separate from Advisory Opinion Process: Disclosing party is limited to one or the other, but not both simultaneously.
Full Cooperation: Expectation of full cooperation of the disclosing party in the process.	Required Use for Parties under Corporate Integrity Agreements: The SRDP must be used by parties with CIAs or certification of compliance agreement to report Stark-only violations, with a copy of the disclosure sent by the disclosing party to the OIG.
Restrictions on Repayment: Repayment may only be made with CMS' permission after CMS verifies the amount to be repaid.	

TriCare Network Contracts Create Affirmative Action Obligations for Hospitals

by Danielle Barbour

The Office of Federal Contracts Compliance (OFCCP) has made no secret of its desire to impose affirmative action obligations on hospitals. It moved quite a bit closer to this goal last month by winning a case against a hospital that had signed a TriCare network contract. In *OFCCP v. Florida Hospital of Orlando*, the hospital challenged OFCCP's jurisdiction over it, and the administrative law judge ruled in OFCCP's favor. While this case dealt with a hospital in Florida, hospitals here in North Carolina can expect to see OFCCP issuing Notices of Audit to facilities in North Carolina, because the Florida case is strong precedent supporting OFCCP's jurisdiction over hospitals that contract to provide TriCare network services.

OFCCP is the federal government agency charged with enforcing Executive Order 11246, Section 503 of the Rehabilitation Act, and the Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA). Companies that have a contract or subcontract of $10,000 or more with a federal executive agency, such as the Department of Defense, are subject to the OFCCP's regulations. TriCare is a Department of Defense program that provides worldwide health care for active duty and retired military and their families. Humana Military Healthcare Services, Inc. is the direct contractor with the Department of Defense for administration of the program. Humana's contract provides that it "shall provide a managed, stable, high-quality network, or networks, of individual and institutional healthcare providers. Humana subcontracts with hospitals and doctors to provide network services for TriCare beneficiaries.

OFCCP has taken the position that a healthcare provider that enters into a network contract with Humana must comply with the equal opportunity/affirmative action obligations of Executive Order 11246, Section 503 of the Rehabilitation Act of 1973 and VEVRAA. On October 18, 2010, an administrative law judge upheld OFCCP's position, finding that because Florida Hospital of Orlando had entered into a medical contract with Humana to provide medical services to TriCare beneficiaries, it was a covered government subcontractor.

The ALJ rejected Florida Hospital of Orlando's argument that TriCare is structured like Medicare and therefore should not be considered a covered government contract. OFCCP has previously conceded that provider agreements pursuant to which hospitals and other health care providers receive reimbursement for services covered under Medicare parts A and B are not covered government contracts under the laws enforced by OFCCP. However, the TriCare contracts are not simply reimbursement arrangements but are contracts to provide the actual medical services, and thus OFCCP, and now the ALJ, distinguishes the TriCare contracts from Medicare provider agreements.

This decision will provide OFCCP with the ammunition it needs to pursue other hospitals that have entered into contracts to be TriCare network providers, and to require them to comply with the equal opportunity/affirmative action obligations. These obligations include implementing an Affirmative Action Program. This requires employers to create written Affirmative Action Plans for minorities, women, veterans, and disabled applicants and employees. In addition, companies must engage in affirmative action outreach activities. These activities include listing open positions with the Employment Security Commission and communicating with and encouraging referral of applicants from veterans' and disabled advocacy groups. The regulations also require companies to evaluate personnel actions and compensation on an annual basis to see if specific racial, ethnic, or gender groups have been negatively impacted. Finally, regulations impose special record-keeping requirements for applicants. OFCCP routinely audits government contractors and subcontractors to determine whether they are in compliance with these obligations, and to look for and remedy discriminatory employment decisions. Failure to comply with the equal employment opportunity/affirmative action obligations places companies at significant risk. Sanctions can include back pay, required reporting, and the loss of federal contracts.

All hospitals should review their TriCare contracts and determine whether OFCCP could contend that they are subject to the equal employment opportunity/affirmative action obligations, and decide whether they intend to implement Affirmative Action Programs or try to dispute OFCCP's jurisdiction if a Notice of Audit is received.

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