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NEWSLETTER

# How Can Professional Liability Carriers Effectively Monitor Health Care Risks?

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The federal government's attack on health care fraud continues. In recent months, settlements have been announced involving major teaching hospitals, home care companies, individual physicians, drug companies and many others. There is virtually no segment of the health care industry that is immune from these investigations.

And with the enormous financial implications of the False Claims Act, where the government can recover both treble damages and substantial per false claim penalties, the financial exposure can be substantial for any health care provider and its management. Coupled with these enormous financial implications is the increased wave of qui tam - or whistleblower - cases, which can be brought by inside sources who then recover a share of the proceeds of a False Claims Act case. When the whistleblowers in the SmithKline litigation took home approximately $52 million, the likelihood of significant qui tam suits increased exponentially. Exposure involves both settlements/judgments and the increased likelihood of the need to defend investigations.

While this enforcement agenda continues, the federal government also has adapted its enforcement strategy to encompass "preventive" activities, through the imposition of "corporate integrity agreements" as part of the settlement of large scale cases and the creation of "model" compliance agreements for various segments of the health care industry. Any professional liability carrier that provides coverage to health care providers may wish to be cognizant of the requirements of these programs and aggressively seek to understand a potential policyholder's internal compliance programs as the best means of judging the likely risk exposures faced by that company and its management.

Compliance programs have become an increasingly important focus of the HHS Inspector General's activities. Going back to the government's settlement with National Medical Enterprises in 1994, the Office of the Inspector General (OIG) has entered into corporate integrity agreements with providers accused of fraud. These agreements are negotiated business protocols, requiring specific activity in the future by providers, designed to prevent fraud from re-occurring.

These integrity programs typically are quite harsh, and conventional wisdom is that they require more than the Sentencing Guidelines would require for a program to be effective, because the OIG has determined that significant wrongdoing has occurred. These corporate integrity agreements have been entered into in most large fraud settlements in the past few years. The OIG recently released on its Web site a list of the hundreds of providers subject to these corporate integrity agreements and has hired new staff to assist in monitoring compliance with these agreements. *See* www.dhhs.gov/progorg/oig.

Following these corporate integrity agreements, which are designed to ensure that pre-existing problems do not re-occur, the OIG also has been working on developing "model" programs for various segments of the health care industry to encourage prevention-oriented activities on a broad scale, independent of any specific problems. When the first of these programs, for the clinical laboratory industry, was developed, the HHS Inspector General announced the program with an "Open Letter to the Health Care Industry," which stated that compliance programs are a critical component in "promoting a high level of ethical and lawful corporate conduct" and that one of the best ways to fight health care fraud is to create an "atmosphere that encourages voluntary compliance and self-disclosure by health care providers."

Since that first program, the Department has issued guidance for durable medical equipment suppliers, third-party medical billing companies, home health agencies, hospitals, hospices and a revised version of the clinical laboratories guidance, as well as a draft guidance for the managed care industry.

For any health care provider, it is critical to use the OIG measuring sticks as guidelines for the development of a corporate compliance program. Most health care fraud cases do not result in criminal convictions at the end of a trial, but instead are resolved through negotiations. Therefore, in evaluating whether a company's program is sufficient, these measuring sticks will be used by prosecutors, in the exercise of their discretion, rather than as part of a formal evaluation by a sentencing judge. Accordingly, these "effective" elements can be used to persuade a prosecutor to accept a smaller settlement or, perhaps more importantly, to refuse to bring charges in the first place.

In order to properly understand the risks presented by health care providers, professional liability carriers may wish to evaluate where best to obtain information concerning potential problematic practices and the likely areas of government investigative attention. In particular, they can:

- Monitor the HHS Inspector General's Office Model Compliance Programs;
- Monitor the list of health care entities that have "Corporate Integrity Agreements";
- Monitor the IG "Work Plan" that details the investigative areas under review by HHS (the FY 2000 plan was released on the OIG web site on October 5, 1999);
- Review Fraud Alerts and other guidance that comes from HHS and the Department of Justice; and
- Review contractual entanglements of health care providers, linking them to other health care providers that also may have fraud and abuse concerns.