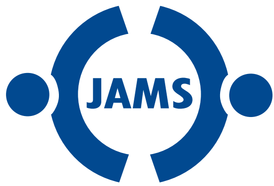

Resolving Allegations of Health Care Fraud – Does the Mediator Matter?

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Since 1993, the Department of Justice has made the fight against health care fraud and abuse a top priority.[1] Now that a "baby boomer" retires every 7.5 seconds,[2] the consequent growth of entitlement programs such as Medicare has also resulted in exponential growth of enforcement efforts.[3]

More money flowing to more health care providers invites more scrutiny from the federal government, particularly the Department of Health and Human Services ("HHS") and the Department of Justice ("DOJ"). The DOJ reports that the allegations of health care fraud continue to rise. Of the approximately 100 fraud cases that settled last year, it is estimated that more than half were health care related, generating more than one billion dollars worth of settlements. Since 1997, the federal government has collected $11.87 billion on behalf of health care programs.[4]

There is more at stake than money. Health care fraud is no longer just about white collar crime. It has expanded to include quality of care issues including home health care, assisted living, specialty hospitals and pain management specialists. Prosecutors may now view fraud enforcement not only as a means to penalize wrongdoers, but also as a method of ensuring higher quality health care. However, the inclusion of quality of care concerns adds new issues to fraud cases. Real victims become directly involved in the prosecution of fraud, understanding of such cases may require medical as well as regulatory expertise, and care-related compliance or performance issues become more difficult to monitor.

Changing quality of care is a lot to ask of litigation, as fining facilities is not the same as changing behavior and fixing bad care. Adjudication of complex cases becomes even more challenging when enforcement processes designed primarily to deter behavior by assessing penalties are forced to address quality of care. State Medicaid prosecutors will face similar challenges when allegations of patient/resident abuse, neglect, or exploitation are asserted.[5]

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Health care fraud claims are frequently negotiated

With the number of fraud related issues increasing almost as rapidly as the number of cases, it is not surprising that most health care fraud cases are resolved before a verdict is rendered. Health care lawyers know that most matters settle, even allegations of health care fraud. As a result, most health care lawyers, particularly white collar defense and transactional attorneys, include some of the legal profession's finest negotiators.

Howard Young, formerly with the Office of Inspector General ("OIG") at HHS and now a member of the law firm Sonnenschein, Nath and Rosenthal, states that most allegations are successfully resolved through negotiation. "As the government develops new theories of use for the False Claims Act ("FCA"), particularly in the areas of pharmaceuticals and medical devices, defense counsel have been quick to respond. While some matters are litigated on jurisdictional issues, few are litigated to final judgment. Fraud defense has essentially become a negotiation practice," he says.[6]

Some litigators approach fraud negotiations as classic "single issue" negotiations. Steve Altman, an attorney in private practice who was formerly with the DOJ's Fraud Division says, "These negotiations are often characterized by one thought, it's only about the money. And the amounts of money aren't small."[7] A single case of health care billing fraud may allege thousands of single violations, each of which may be trebled and each generating its own penalties.[8]

Where a mediator matters

Negotiators find that health care fraud negotiations that present an array of issues, including quality of care, are best managed with a third party. "There is often a significant gap between the government's and the client's perspectives of culpability, issues of intent, and damages issues," says Young. "Despite our success as negotiators, these unique issues create a subset of cases that present atypical barriers

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to resolution. In those, our clients enlist the services of a qualified mediator. The mediator can coordinate multiple parties, including relators,[9] some of whom may have competing interests. Both the client and the government can benefit from the analytic view of an informed, neutral third party."[10]

A good mediator can deal with interpersonal and care-related issues, help orient the parties to the government's perspective, and ensure private parties that they have been heard by the other side. A mediator with expertise in health care, and health care fraud, is even more valuable. Such mediators may be called upon to clarify issues specific to health care fraud cases including:

- The difference between economic issues, damages and penalties in the FCA;
- The fact that knowledge of health care fraud may not require intent;
- Attorney fees for relators' counsel;
- The respective roles of multiple parties, private claims, and collateral matters, such as the possibility of exclusion or debarment; and
- The role in mediation, if any, of the OIG.[11]

The DOJ has criteria that guide whether to use mediation in every case. FCA cases, however, present additional issues for the use of mediation, as mediators and parties may not be familiar with the FCA's enforcement provisions. This may be increasingly true as the scope of fraud matters has expanded to include other federal and state programs in Medicare, Medicaid, and Tricare[12] that might involve allegations ranging from *qui tam* to kick-backs and upcoding.

"Mediation may be useful to the government in certain cases," says Dodge Wells, Assistant Director of the Department of Justice Civil Fraud Division, "but for different reasons. The mediator can help parties overcome barriers that are created by parties' lack of familiarity with the relevant statutes, enforcement policies, and settlement latitude."[13]

When to mediate? "At the intersection of anger and litigation fatigue," says Altman.[14]

Few dispute the goal of ensuring better health care through enforcement efforts and their deterrent effect. Health care fraud litigation generates much attention and significant revenues. However, litigation may be less adept at meeting the goal of improving health care delivery, at least not without significant transaction costs. To the extent that resolution of fraud allegations depends on negotiation, it is incumbent upon negotiators to be as effective as possible. Where fraud negotiations are complicated by the barriers cited above, mediation is advised.

Another benefit of mediation is earlier resolution of allegations. Where there is prompt recognition after an allegation of fraud has been made that there was not fraud, a health care provider has a better chance to stay in business. The enhanced communication required by mediation means that the government may be in a better position to understand the health care practice in question. Where fraud is found, the patient and the taxpayer each benefit from rapid resolution.

Conclusion

Is mediation the cure to all health care fraud disputes? Of course not. However, when a client reports that fraud has been alleged, many attorneys begin to circle the wagons. Working with the DOJ and HHS to devise an effective mediation strategy just might provide the road out.

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1 "Health Care Fraud Report, fiscal Year 1998," United States Department of Justice, Office of the Deputy Attorney General.

2 Remarks by William D. Novelli, Executive Director and CEO, AARP, Presented at Meeting of The Wisemen, The Harvard Club, New York, NY on February 21, 2002.

3 "Health Care Fraud Report,"op cit.

4 Excerpts of comments made by Alice S. Fisher, Assistant Attorney General, Criminal Division, U.S. Department of Justice Washington, DC, at the 17th National Health Care Fraud Institute, New Orleans, LA. May 18, 2007.

5 See note 5.

6 Remarks of Howard Young at the American Bar Association Section of Dispute Resolution Annual Meeting on April 28, 2007. Workshop was entitled "Mediating Health Care Fraud Disputes, Does the Mediator Matter?"

7 Comment at the American Bar Association Section of Dispute Resolution Annual Meeting in Washington DC on April 28, 20007.

8 For example, a provider against whom billing fraud is alleged might be liable for penalties calculated on a *per violation basis.* Under the False Claims Act (FCA), a person who knowingly submits a false claim to the United States may be liable for a civil penalty of between $5,000 and $10,000, plus up to three times the amount of damages sustained. The FCA defines "knowingly" to mean that the claimant (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth of falsity of the information; or, (3) acts in reckless disregard of the truth of falsity of the information.

9 In *qui tam* cases, *relators* may report fraud to the government, who then initiates litigation.

10 June 15, 2007 interview of Howard Young, Esq., Partner, Sonnenschein, Nath and Rosenthal, Washington DC.

11 The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) makes an independent assessment of whether entities resolving health care fraud claims will be entitled to continue in the Medicare program.

12 Tricare is the program run by the Department of Veterans Affairs to deliver health care to veterans.

13 Comments made at the American Bar Association Section of Dispute Resolution Annual Meeting in Washington DC on April 28, 2007.

14 Comments made at the American Bar Association Section of Dispute Resolution Annual Meeting in Washington DC on April 28, 2007.