



HEALTH CARE FRAUD REPORT



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Condell Medical Center: Voluntary Disclosure as a Means to Get the Deal Done

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Imagine that you are in the middle of due diligence for the potential sale of a hospital and you discover medical office space leases to physicians at rates below fair market value, improper loans to physicians, and hospital reimbursement to doctors who performed patient services without written agreements.

What would you do?

In the case of one Chicago-area hospital and its suitor, the answer was to self-disclose the potential violations and engage in a hectic exchange of information and dialogue with the Government, which culminated in what appears to be the largest voluntary disclosure settlement in a health care case in False Claims Act history.

This article provides an overview of the recent Condell Medical Center settlement and discusses some of the significant aspects of this case, including that:

(1) Condell's self-disclosure was made directly to the U.S. attorney's office instead of to the Office of Inspector General pursuant to the OIG's Self-Disclosure Protocol;

(2) the self-disclosure was reduced to a settlement agreement in a little more than six months despite the number of issues involved; and

(3) the size of the settlement serves as a further reminder of the significant liability providers can incur due to violations of the federal Stark Law or Anti-Kickback Statute ("AKS").¹

The Settlement and Alleged Misconduct

On Dec. 1, 2008, Patrick J. Fitzgerald, the U.S. attorney for the Northern District of Illinois, announced that Condell Health Network, the parent corporation of Condell Medical Center, had agreed to pay \$36 million to the United States and the State of Illinois as a result of filing false claims for reimbursement.

The settlement resulted from a voluntary disclosure made by Condell while the hospital, a 283-bed, non-profit facility located in Libertyville, Illinois, was in the process of being acquired by Advocate Health Care, a not-for-profit organization and the Chicago area's largest hospital operator.

Condell was not required to enter into a Corporate Integrity Agreement ("CIA") as part of the settlement, and the acquisition closed later on the same day that the settlement was announced.

According to the settlement agreement, the Government contends that from Jan. 1, 2002, until Dec. 31, 2007, Condell submitted reimbursement claims that were false due to violations of the Stark Law and the AKS. The Government alleged that Condell violated the Stark Law and AKS through improper arrangements

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¹ The authors gratefully appreciate the time given by the prosecutor and defense counsel in providing their perspective on this case. The authors' characterization of the facts is exclusively their own.

with physicians involving leases of medical office space, recruiting arrangements, and professional service agreements:

■ **Lease Arrangements.** The Government alleged that Condell leased space to physicians in medical office buildings that it owned and operated at rates that were below fair market values or for which Condell allowed rent abatement or deferred collection of rental payments.

■ **Recruiting Arrangements.** The Government alleged that Condell entered into financial support agreements and loans with physicians that permitted the physicians to “work off” the amounts owed at hourly rates that were greater than fair market value and with activities that did not benefit the community. The Government further alleged that Condell failed to assess whether there was a community need to support certain recruiting arrangements, offered agreements to physicians already in its service area, entered into agreements that benefited individual physicians or physician groups rather than the community, and entered into multiple recruiting agreements with the same physician or physician groups. Additionally, the Government alleged that Condell paid its physician recruiters incentive bonuses and that many of the support agreements prohibited physicians from obtaining admitting privileges at other hospitals.

■ **Professional Service Arrangements.** The Government alleged that Condell paid physicians for services through arrangements that were not set forth in writing and that Condell had written agreements with some doctors that did not satisfy the applicable safe harbors for professional service agreements.

The Condell case was settled without litigation, and little has been publicly disclosed regarding the underlying misconduct. Thus, it is not known the number of physician relationships at issue, the amount of financial benefits conferred on any physician or group of physicians, or whether the alleged violations were disparate acts or part of some concerted action.

As part of the settlement, Condell agreed to pay the United States \$33.12 million relating to Medicare claims and to pay the State of Illinois \$2.88 million relating to Medicaid claims. No information was provided regarding how damages were calculated or allocated among the categories of alleged misconduct.

Interestingly, and consistent with other recent settlement agreements with the Department of Justice, in the provision of the settlement agreement that addresses what happens if Condell files for bankruptcy within the preference period, Condell agreed that the United States and the State of Illinois have a valid claim against Condell in the amount of \$150,000,000. The Agreement provides no insight regarding how this number was calculated.

The Self-Disclosure Protocol

Potential Stark or AKS issues can come to the attention of a provider from a variety of sources, such as an internal audit, a complaint from an employee or patient, or a government subpoena. It also is not uncommon for Stark or AKS issues to surface in the course of due diligence of a proposed transaction as was the case in the Condell settlement. If a Stark or AKS violation is found to exist, then the provider must decide whether to refund any overpayment or to self-disclose the violation.

The OIG has issued a Self-Disclosure Protocol (“SDP”), which subsequently has been revised by certain “Open Letters,” as a means to encourage health care providers to voluntarily report possible fraudulent conduct in the hope of receiving lenient treatment by the OIG.² To participate in the SDP, a provider must notify the OIG of the potential violation by providing certain information set forth in the SDP, including the federal health programs affected; whether a government investigation already exists; a complete description of the conduct being disclosed; a completed internal investigation or commitment regarding when such investigation will be completed; an estimate of damages and the methodology used to calculate that figure or a commitment regarding when the provider will complete such estimate; a statement of the laws potentially violated; and a certification of good faith and truthfulness.

Following the disclosure, the OIG will seek to verify the information submitted by requesting additional information from the provider, interviewing parties involved, verifying damages, and generally evaluating the disclosure. If accepted into the SDP, the OIG then works with the provider to determine the appropriate resolution. In such case, the provider’s participation in the SDP can lead the OIG to forego the provider’s permissive exclusion from federal health care programs, to resolve self-disclosure financial penalties at a multiple of the amount of the benefit conferred as opposed to a multiple of per-claims statutory amounts, and to not impose a CIA or a less-stringent Certification of Compliance Agreement (“CCA”).

Self-disclosure also affords a provider more control over the investigation process and allows the provider potentially to resolve the matter without the publicity, distraction, and expense of a government investigation or a whistleblower lawsuit. Additionally, the provider may be able to reduce its potential exposure under the False Claims Act by settling for double damages as opposed to treble damages if the matter is litigated.

The news is not all good as self-disclosure also entails risks to the provider. The SDP does not obligate the OIG to resolve a matter in a particular manner, and the OIG may still refer the matter to the Department of Justice for possible civil or criminal proceedings. Additionally, making the self-disclosure could result in admissions of liability or waiver of privileges that could compromise a provider’s ability to defend against other legal proceedings.

Condell’s Self-Disclosure

As noted above, Condell chose to voluntarily disclose to the U.S. attorney’s office instead of the OIG under the SDP. The manner in which the self-disclosure occurs depends on the particular circumstances facing the provider. In the instant case, when issues of potential non-compliance came to the attention of Condell and Advocate during the diligence process, the prevailing consideration was not just to resolve the issues but to resolve them in a manner that would not delay the sale of the hospital to Advocate.

Notably, Condell was facing a deteriorating financial condition caused in part by the termination of the hos-

² The OIG originally issued the Self-Disclosure Protocol on October 30, 1998, see 63 Fed. Reg. 58399, and then subsequently issued an “Open Letter to Health Care Providers” on April 24, 2006, and April 15, 2008.

pital's contract with Blue Cross Blue Shield. The acquisition by Advocate represented a financial lifeline and opportunity to return to the Blue Cross Blue Shield network, but the lifeline could only be obtained by the deal closing.

With the need for speed, Condell and Advocate made the decision to take this matter to Assistant U.S. Attorney Linda A. Wawzenski, who serves as the deputy chief of the civil division for the Northern District of Illinois. Having handled other matters with Ms. Wawzenski in the past, counsel for Condell believed, and counsel for Advocate concurred, that Ms. Wawzenski would appreciate the circumstances facing the local hospital and be flexible to work with the parties and their time constraints. Additionally, Ms. Wawzenski is an experienced health care fraud lawyer, having handled other cases such as *United States v. Rogan*, which meant that she was up to speed on the controlling legal issues and had relationships with folks at DOJ and OIG that would enable her to bring together the decision-makers needed to approve any settlement.

That is not to say that this case would not have been resolved just as quickly if the parties approached the OIG first, but where speed was of paramount concern, in this instance, the parties chose to go to a lawyer with whom they were experienced.

In late May 2008, Brian D. Annulis of Katten Muchin Rosenman, who served as counsel for Condell, and Katherine A. Lauer of Latham & Watkins, who served as counsel for Advocate, met with the U.S. attorney's office for the first time. The lawyers talked in general terms about the issues that had been discovered and discussed with Ms. Wawzenski a work plan to capture the information that the Government wanted to see regarding the issues.

Condell and Advocate then proceeded to execute the work plan, producing information requested by the Government, addressing questions, making a more detailed factual presentation, and eventually working up and discussing settlement numbers. During the process, Ms. Wawzenski served as the sole point of contact for Condell and Advocate and handled coordination with the OIG, the Civil Division of the Department of Justice, and the State of Illinois.

Ms. Wawzenski described the Condell settlement as a "textbook example" of how a voluntary disclosure should be conducted. She noted that Condell and Advocate came as a team to make the initial disclosure and then worked together throughout the disclosure process. Condell and Advocate informed the Government from the outset of the transaction timeline and the desire to resolve the issues of non-compliance within that timeframe. Although the timeline initially seemed aggressive, the parties did their part by providing information quickly, with some information being provided on the same day it was requested, and providing information in a detailed fashion, with the Government always receiving what it asked for.

Ultimately, Condell was able to reach a settlement agreement with the Government in a little more than six months after the initial disclosure, which did not delay the closing of the acquisition. While Condell and Advocate were motivated to push a quick settlement, it is encouraging that the Government recognized that the disclosure issues had to be resolved in order for the sale of the hospital to occur and then responded by moving

promptly so that patient care at the hospital was never interrupted.

Lessons Learned from Condell Settlement

The manner in which to self-report depends on the circumstances of the particular case. Perhaps the most important lesson from the Condell settlement is that providers and their counsel must carefully evaluate the manner in which to voluntarily disclose information to the Government and choose the method best suited for their case.

Although the SDP provides a proven mechanism for resolving conditions of non-compliance, it does not have to be followed precisely in every situation.

The more you know about the people you will be dealing with, the better. One of the most difficult aspects of engaging in a self-disclosure is the uncertainty of how the Government will respond. Although some consistent practices are followed, the reaction to a self-disclosure and the expectations by government counsel toward providers engaging in a self-disclosure can differ from district to district and among OIG personnel.

If counsel does not have a previous relationship with the particular government lawyer or lawyers who handle health care fraud matters for a district, they should do their homework by talking to other lawyers who do have experience with the particular government lawyer.

Once you self-disclose, be prepared to provide information quickly. Once the decision to self-disclose is made, the provider must be prepared to conclude quickly any investigations and assessments required by the government and to respond promptly to additional requests for information. This includes having the appropriate resources in place such as legal counsel and accounting or other consultants to compile, analyze, and provide information effectively and efficiently. Not surprisingly, the speed that a matter can be resolved turns in large part on how quickly the provider can provide information requested by the Government.

Be prepared to address issues that arise during due diligence. Both buyers and sellers should anticipate that the across-the-board scrutiny of physician relationships that occurs during the diligence process in a hospital transaction may reveal compliance issues not previously known by the seller.

Additionally, even if the seller was aware of a particular compliance issue, many Stark and AKS issues are notoriously complex to analyze and come down to judgment calls on which the buyer and seller may reasonably differ.

For example, compliance solutions that worked for the seller as part of the operations process may not be acceptable to the prospective buyer who is faced with assuming the liability of the seller's provider agreement and number. Although some buyers consider the possibility of obtaining a new provider agreement and number in order to avoid successor liability, doing so is often a drawn-out process that can result in cash flow problems that make a transaction financially unworkable. This means that the buyer must be prepared to resolve issues of non-compliance that may arise in diligence.

Providers must closely monitor physician relationships or risk significant liability. This case also serves as a reminder of the significant potential liability faced by providers under the Stark and the AKS. The Government takes the position that the proper measure of damages under the False Claims Act for a Stark Law or AKS violation is the total value of Medicare and/or Medicaid reimbursement received by the hospital for services ordered by the physician with the improper arrangement.

Thus, even if the financial benefit provided to the physician was only a few thousand dollars and the services provided were medically necessary, the potential damages and penalties from a single Stark Law or AKS violation theoretically could reach into the millions of dollars based on the volume of referrals from the physician. For this reason, providers should make every effort to develop robust compliance programs to closely monitor their physician relationships and to address any issues that arise.