Hospitals Accused of Violating the False Claims Act Through Ownership of the PPO For Their Self-Funded Employee Health Plans

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On August 27, 2015, following notification by the government that it had decided not to intervene, the United States District Court for the Middle District of North Carolina, ordered that a *qui tam* complaint charging Carolinas Medical Center (CMC) and N.C. Baptist Hospital (Baptist) with violating the False Claims Act (FCA) be unsealed. The complaint, which was originally filed in June 2009, accuses the hospital groups of violating the FCA based on their co-ownership of MedCost, a managed care company that was the Preferred Provider Organization (PPO) and Third Party Administrator (TPA) for their respective self-funded employee health plans.

The relator, a former benefits manager at Baptist, alleges that the hospitals defrauded the government by filing false cost reports that overstated their health plan costs, resulting in higher Medicare payment rates for hospitals in the region, and by negotiating higher payment rates with MedCost than they negotiated with other PPOs, resulting in excessive payments to themselves for their own employees' health care services.

The alleged scheme reflects the complexity of the Medicare Prospective Payment System (PPS), which pays fixed amounts for Inpatient Services (Diagnosis Related Groups or DRGs) and Outpatient Services (Ambulatory Patient Classifications or APCs). Each group or classification has similar resource and labor needs to provide the services, with labor costs comprising 71% of the DRG payment, and 60% of the APC payment.

Because labor costs vary across the country, the government uses the "Wage Index Factor" to adjust the DRG and APC payment rates for hospitals in different geographical regions (Core Based Statistical Areas or CBSAs). The Wage Index Factor, which is calculated for each hospital and for the entire CBSA is based on the Average Hourly Wage (AHW). The AHW, which is based on the information in the hospitals' annual cost reports, is derived by adding the total labor costs (wages, salaries, and benefits), and dividing that number by the total number of employee hours worked. The resulting Wage Index Factor is then multiplied against the government's base rates to arrive at the DRG and APC payment rates for each CBSA. The relator alleges that CMC and Baptist overstated their employee benefit costs in their cost reports, which contributed to a higher salaries and benefits figure and, thus, inflated the DRG and APC payment rates for the CBSA.

According to the relator, the inflated health plan costs flowed from the conflict of interest created by the hospitals' ownership of their own PPO. The relator claims that CMC and Baptist negotiated *higher* payment rates with MedCost than the rates they provided other PPOs. The alleged false claims hinged on the hospitals' failures (a) to comply with Medicare regulations requiring that self-funded insurance plans be managed by independent fiduciaries, and (b) to identify any "related party" vendor transactions in their cost reports. As a consequence of these alleged failures to comply with the requirements, the relator alleges, the hospitals were paid excessive and fraudulent rates for their services, and the allegedly inflated costs were reflected in the salaries and benefits information in CMC and Baptist's cost reports, inflating each hospital's Wage Index, and contributing to a higher Wage Index Factor for the CBSA.

On August 14, 2015, more than six years after the relator filed the original complaint, the government filed its Notice of Election to Decline Intervention. Over the government's objection, the district court ordered the entire court file unsealed, with the possible exception of the relator's

disclosure statement and exhibits. The relator has until September 30, 2015 to notify the court of his "position regarding the need and/or legal basis for continued sealing of said document."

Between August 2009 and February 2015, the government filed twelve motions for an extension of time in which to decide whether to decline or to intervene in the case. Based on the information contained in the requests, the government's six-year investigation of the allegations appears to have been both extensive and thorough.

The earliest requests cited the complexity of the Medicare regulations regarding cost reports, and the significant time and expertise required to analyze the hospitals' cost reports. In August 2011, the government informed the court that the HHS OIG Office of Audit Services (OAS) had completed almost all of Baptist's audits for the time period from 1999 through the most recently submitted report, that it was still working on CMC's cost reports, and that audits of CMC's eleven affiliate hospitals also were necessary.

By February 2012, in addition to the ongoing audits, the government was reviewing the "extensive documentation produced by Baptist and MedCost." The audits of the CMC hospitals' cost reports were still not complete in February 2013, but the government reported continuing discussions with Baptist's counsel "regarding Baptist's theory of the case." In August 2013, the government confirmed that Baptist's cost reports for the years in question had been audited, and that "most of the audits of CMC's cost reports are now complete."

In the August 2013 application for an extension, the government described a recent presentation by Baptist "identifying specific defenses and providing additional information to assist in the factual and legal analysis of the complex issues regarding related party rules, self-insurance requirements, cost report accounting, and wage index determinations." The government noted that the Centers for Medicare & Medicaid Services (CMS) needed additional information "in order to opine on whether Baptist has violated the related party rules and if so, how the cost report and the wage index would be affected." In February 2014, the government reported that CMS needed "time to analyze the information [that had been received] from Baptist and the relator in order to determine if false claims have been submitted to the government."

Based on the August 2014 application, it appears that, following the completion of the audits by OAS, the government asked CMS to resolve the two issues raised by the relator: (1) whether the hospitals were required to have a fiduciary because their plans were self-insured, and (2) whether MedCost was a "related party," as defined by Medicare, that Baptist failed to disclose on its own cost report and that costs of services provided to its own employees were inflated in the cost reports. The application states: *"CMS has now opined that Baptist is/was not required to have a fiduciary for its self-insurance plan so that allegation in the complaint has been resolved."* (emphasis added). CMS had, however, requested additional information "in order to opine on whether Baptist violated Medicare's 'related party' rules and whether Baptist inflated its costs for medical services provided to its employees."

The government filed its last request for an extension in February 2015. Noting that it was still waiting for CMS to issue its opinion on the "related party" issues, the government stated that, "Until we receive this opinion, we do not know if we have a viable case and therefore cannot make a decision to intervene or decline in this case." In August 2015, the government informed the court that it had declined to intervene in the case.

While the government has remained silent concerning its reasons for declining to intervene, it is a possible, even logical, assumption that CMS concluded that MedCost was not a "related party," as defined by Medicare. This, in conjunction with the earlier CMS opinion that Baptist was not required to have a fiduciary for its self-insurance plan, suggests, therefore, that CMS did not consider that the hospitals' cost reports were false. Since the FCA requires the submission of *false claims*, it is an open question whether there is a basis for the relator to continue the suit.

However, while the hospitals' ownership of the PPO for their self-funded employee health plans may not support a claim under the FCA in this case, the arrangement has raised scrutiny in other areas. Around the time the relator filed this case, Baptist employees sued the hospital, alleging that the hospital used MedCost as its PPO in order to be able to charge higher prices for services it provided to its own employees.

Under the Employment Retirement Income Security Act (ERISA), most employers are prohibited from using companies they own to provide health benefits to their own employees – unless they have demonstrated to the U.S. Department of Labor (Labor Department) that they are putting the employees' interests first. Baptist settled the case, agreeing to pay nearly $5.4 million and to take steps to lower medical costs for its employees. In contrast to CMS's finding that Medicare did not require Baptist to have a fiduciary for its self-insurance plan, as part of the settlement, an independent fiduciary was appointed to determine whether Baptist could continue to use MedCost.

In 2010, the relator also filed a complaint on the same grounds against CMC with the Labor Department. CMC, which is part of a municipal hospital authority, Carolinas Healthcare System, established by statute, argues that the ERISA requirements do not apply in their case, because the statute excludes government employees. The Labor Department's investigation, however, remains ongoing.

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