False Claims Act Update

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The FCA is the Fraud Enforcement Vehicle to Choice

- Recent efforts made by the DOJ’s Health Care Fraud Prevention and Enforcement Action Team (“HEAT”), CHANGES TO FCA’s public disclosure bar and other fraud enforcements initiatives helped increase fraud recoveries. FY 2014, more than $6 billion in FCA recoveries.
  - $3 billion recovered under the *qui tam*, or whistleblower provision of the FCA
  - $2.3 billion involving fraud committed against federal healthcare programs
- Since January 2009, $14.5 billion recovered
False Claims Act Risk Areas

- Reporting and Repaying Overpayments
- Services Not Rendered
- Lack of Medical Necessity
- Upcoding
- Inpatient vs Observation Patient Admissions
- Risks for Failure to provide Appropriate Service
- Stark Violations
- Kickbacks in contractual relationships between physicians, hospitals and manufacturers
- False Certifications
- Inflating Cost Reports
- Research Grant Fund
Elements of an FCA Offense

- The Defendant must:
  - Submit a claim (or cause a claim to be submitted)
  - To the Government
  - That is false or fraudulent
  - Knowing of its falsity
  - Seeking payment from the Federal treasury
  - Damages (maybe)
  - Reverse False Claim: Reimbursement received inappropriately and knowingly decide to keep reimbursement and do not repay or process claims
Knowing & Knowingly

• No proof or specific intent to defraud is required
• The Government need only show person:
  ➢ Had “actual knowledge of the information”; or
  ➢ Person acted in “deliberate ignorance” of the truth or falsity of the information; or
  ➢ Person acted in “reckless disregard” of the truth or falsity of the information
PENALTIES

- Civil penalty from $5,500 to $11,500 per false claim
- Three times the amount of damages which the Government sustained
Qui Tam Relators

• The federal False Claims Act is a _qui tam_ statute, meaning that private citizens ("relators") may file complaints alleging violations of the FCA under seal on behalf of the U.S. Government and receive at least 15% but not more than 25% of any amount recovered by the Government.

• Once a whistleblower files a suit, the Department of Justice must decide whether to "intervene" (i.e., take over and prosecute the suit).

• If the government does not intervene, the case is unsealed and the whistleblower may proceed on his/her own with some Government monitoring.
 Qui Tam/Whistleblower Provisions

- The FCA contains *qui tam*, or whistleblower, provisions. *Qui tam* is a unique mechanism in the law that allows citizens to sue, on behalf of the government, in order to recover damages. 31 U.S.C. § 3730(b).
  - Disgruntled employees
  - Unhappy patients
  - Estranged spouses
Qui Tam/Whistleblower Provisions

- A qui tam suit initially stays “under seal” (confidential) with the Court for at least 60 days during which the U.S. Department of Justice can investigate and decide whether to join the action.

- Once a whistleblower files a suit, the Department of Justice must decide whether to “intervene” (i.e., take over and prosecute the suit).

- If the government does not intervene, the case is unsealed and the whistleblower may proceed on his/her own with some Government monitoring.

- Whistleblowers can recover:
  - 15-25% of the settlement or judgment if DOJ participates; or
  - 30% if DOJ declines to intervene.
In 1943, Congress amended the FCA to jurisdictionally bar “parasitic relators” by prohibiting suits based on information in the Government’s possession.

In 1986, Congress revised the jurisdictional bar to encourage *qui tam* suits by removing the Government possession concept. Nevertheless, it sought to balance encouraging true whistleblowers with preventing parasites, so it added the “Public Disclosure Bar.”

March 23, 2010, PPACA sought to make it easier for DOJ & relators to avoid the operation of the Public Disclosure Bar.
PPAC Changes – “Public Disclosure”

• No longer stated in terms of a jurisdictional bar.
  ➢ More vigilance required early; must be in an answer or dispositive motion or may be waived.

• The court is not required to dismiss a relator’s action if the Government opposes a defendant’s motion to dismiss.

• Revision of the definition of “publicly disclosed”:
  ➢ Information only from “Federal” proceedings “in which the Government or its agent is a party”;
  ➢ Information only from a “Federal report, hearing, audit or investigation”;
  ➢ “News media” remains the same.
    • No definition of “news media”
    • Consider press release regarding overpayment refunds and self-disclosures.
PPACA Changes – “Original Source”

- PPACA modifies the original source requirement:
  - Only requires a relator to have “knowledge that is independent of and materially adds to the publicly disclosed allegations,” which omits the prior requirement that the knowledge be “direct and independent of . . . the information on which the allegations are based.”
  - “Independent knowledge” and “materially adds” are undefined.
The Fraud Enforcement and Recovery Act of 2009 (FERA) modified the definition of “claim” to include:

“any request or demand . . . for money or property and whether or not the United States has title to the money or property, that –

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(ii) Is made to a contractor, grantee, or other recipient, if the money or property, is to be spent or used on the Government’s behalf or to advance a Government program or interest, . . .”
Expansion of FCA Liability for Retention of Overpayment Obligation

- This may be the single most significant development for the healthcare industry

- Previously, a “false claim, record, or statement” was required to violate the FCA. Now, “knowing” and “improper” concealment or avoidance of an obligation is sufficient.

- Under FERA, if one knowingly and improperly retains an overpayment from the Government, there is potential liability. This is known as a “reverse false claim.”

- “Improperly” is not defined.
The FERA amendments added a definition of “obligation” to mean: “an established duty, whether or not fixed, arising from ... the retention of any overpayment.”

The FCA’s requirement to report and return overpayments is linked to the new definition of “obligation” in the statute.
Required Repayments

• The SRDP is needed because ACA/Health Reform requires prompt repayment of overpayments.
• Section 6402 of the ACA requires that all overpayments be reported and returned by the later of:
  - (i) sixty (60) days after the date on which the overpayment was identified; or
  - (ii) the date any corresponding cost report is due.
• When a disclosure is made according to the SRDP repayment obligations are suspended until a settlement agreement is reached or a disclosing entity is removed (or removes itself) from the SRDP.
Assuming provider diligently quantifies the potential overpayment during the “lookback” period with due diligence, 60-day reporting period does not commence until the amount of the overpayment has been determined.
Historical case resolution model:

1. Corporation plea/False Claims Act settlement
2. Corporate integrity agreement with possible exclusion of an irrelevant subsidiary
3. No personal liability or exclusion.
The Department of Justice in October, 2010, announced intention to pursue individuals.

Lew Morris, from the Office of Inspector General, in February 2, 2011, Congressional testimony:

- Notes large providers may consider settlement “cost of doing business”

- Wants to “alter the cost-benefit calculus” of corporate executives who run companies that settle

- Express intention to increase individual exclusions
Trends in Individual Liability

- Synthes/Norian: October 2010 Corporate plea to felony off-label marketing/improper clinical trials
  - $23.5 million settlement amount
  - Divestiture required
  - Corporate Integrity Agreement
  - Four executives plead guilty to misdemeanor’s with jail sentences
• Stryker Biotech, LLC settlement January 30, 2012:
  - Corporate misdemeanor plea with $15 million fine
  - Charges still pending against Chief Executive Officer, dropped against other individuals

• Wellcare Indictment:
  - Indictment of five former executives of Medicaid HMO, including former CEO, CFO and GC
United States vs. Borrasi (Eleventh Cir, May 4, 2011)

- Alleged conspiracy between physician and two executives of inpatient psychiatric hospital to compensate Dr. Borrasi and his group in exchange for increase Medicare referrals.
  
  - Defense was that payments were for part-time employment relationships for administrative services.
  
  - Testimony at trial included “false titles,” “faux job descriptions,” “false time sheets.” Physicians did not perform any of the administrative duties.

- Criminal conviction of physician and CEO with 72 month jail sentence.
Community Health Systems

- CHS, through its affiliated hospitals, allegedly billed for inpatient services that should have been billed as outpatient or observation services.
- CHS also allegedly increased inpatient admissions by admitting patients as inpatients when it was not medically necessary.
- Finally, CHS allegedly billed Medicare for services referred to a hospital by a physician who was offered a medical directorship that was in violation of the Stark Law.
- Settlement: $98.15 Million
Halifax Health

- **Allegations:**
  - Lawsuit brought by the former Director of Physician Services at Halifax Health alleges that contracts with six (6) oncologists violated the Stark law and other relevant Medicare laws.
  - Allegations that Halifax submitted 74,000 false claims to Medicare with potential damages and penalties exceeding $1 Billion.

- **Settlement:**
  - March 2014 – Stark Law Allegations Settled for $85 Million
  - July 2014 – Short Stay (Observation vs. Inpatient Admission) Allegations Settled for $1 Million
• Arrangement:
  ➢ Bonus pool would be equal to 15 percent operating margin for the medical oncology program. The payments to individual doctors would be based on each individual oncologist’s personally performed services.
  ➢ Halifax argued that the arrangement met the employment exception under the Stark law since the physicians were employed.
  ➢ Summary Judgment: The bonus was not based solely on personally performed services but also included services provided including revenue from referrals made by the oncologists for DHS.
Amedisys

- Amedisys, a home health company, allegedly billed Medicare for nursing and therapy services that were medically unnecessary or provided to patients who were not homebound, and otherwise misrepresented patients’ conditions.

- In addition, it was also alleged that the Anti-Kickback Statute and the Stark Law may have been violated due to improper financial relationships with referring physicians.

- Settlement: $150 Million
The hospital allegedly billed for numerous unnecessary coronary stents and catheterizations performed on patients who did not need them.

Further, the hospital allegedly violated the Stark Law by paying certain physicians salaries that were unreasonably high and in excess of fair market value.

Settlement: $41 Million
Saint Joseph Health System

- The hospital allegedly submitted claims for a variety of medically unnecessary cardiac procedures.
- Further, the hospital allegedly violated the Stark Law and the Anti-Kickback Statute by entering into management agreements that financially benefited the physicians as an inducement to refer.
- Settlement: $16.5 Million
Questions