"The False Claims Act: Are Healthcare Providers at Risk?"

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I. *INTRODUCTION*

"America's health care providers are under siege by federal law enforcement and investigative personnel." This statement was made recently by Richard Davidson, president of the American Hospital Association, in a letter to Attorney General Janet Reno, Department of Health and Human Services Secretary Donna Shalala, and Inspector General June Gibbs Brown in which he asked the government for a six-month moratorium on the initiation of new actions under the False Claims Act. The Inspector General answered for the government: "No!"[1]

Federal investigations of health care fraud quadrupled over the last five years. This stepped up investigation includes improved coordination among criminal and civil prosecutors, their state counterparts and administrative entities.[2]

A two year pilot program targeting five states and coordinating fraud enforcement efforts, Operation Restore Trust ("ORT"), has been very successful and is being expanded to a dozen more states. ORT focused on home health care, nursing homes and durable medical equipment suppliers in the five states targeted. Almost $188 million owed the government was identified, with $23 recovered for each $1 spent.

The *Wall Street Journal* reported that the Federal Bureau of Investigation's ("FBI") probe of health fraud by Columbia/HCA now involves 700 FBI agents. In a companion article, the *Journal* indicates that many in the government believe that in a former case against National Medical Enterprises, now renamed Tenet, the wrong signal was sent to the industry by not making top officials subject to criminal prosecution. While National paid a $380 million fine, no one connected with the hospital chain went to

jail.[3] On July 31, 1997, the federal grand jury in Florida handed down indictments of three Columbia mid-level executives.

In an interview with the *Journal*, Michael Siegel, assistant U.S. attorney in Tampa, Florida, commenting on the Columbia case in general and health care fraud generically, said that practices that were largely overlooked in the past because of scarce law-enforcement resources are now coming under intense scrutiny.[4] A lot more resources are now available for enforcement activities.

Following the Columbia indictments, the Associated Press reported the indictments of 12 more individuals, including five physicians, in a home health care scam in Florida. They were charged with defrauding Medicare of over $15 million.[5]

There is no question that the heat is on health care providers. The enforcement authorities are moving ahead with gusto, and Congress and the Administration are providing the tools and resources.[6] Some of these activities include:

! A significant increase in the number of FBI agents assigned to health fraud cases.

! A 60 percent increase in investigation of health fraud cases.

! A significant increase the number of attorneys involved in prosecuting health care fraud.

! Creation of a new Medicare Integrity Program for fraud detection.[7]

! A significant increase in the number trial attorneys assigned to health care fraud cases.

! Greater cooperation among the various agencies and enforcement authorities with the health care fraud task forces.

Health care providers that pay lip service to assuring compliance with Medicare and Medicaid laws and regulations

may wake up to serious trouble. As discussed below, the government is using the False Claims Act to get multimillion dollar settlements, fines, civil monetary penalties, not to mention exclusion from the federal health care programs and adverse publicity.

On the positive side, the fraud enforcement authorities appear to be backing off, at least to some extent, on their Physicians at Teaching Hospitals ("PATH") initiative. According to BNA, the government agreed on July 11, 1997 to drop 16 of the 49 audits that were under way. PATH is an audit program by the OIG's office to review allegedly improper billings by medical schools and hospitals for services provided by residents rather than the attending physician. However, according to an OIG spokeswoman, the audit has targeted 125 medical schools and hospitals and will continue.

The downscaling of the PATH program is probably more the result of concern for the fairness of the program expressed by members of Congress than an indication that the government is scaling back on fraud enforcement. Over the past six months, nearly 50 members of Congress have formally expressed their concerns to the Secretary and the OIG. The concern relates to the retroactive application of the "physician presence" standard in regulations published July 1, 1996.

II. *FEDERAL FALSE CLAIMS ACT*

What is the False Claims Act?

! A federal statute that prohibits, among other things, anyone from presenting a false or fraudulent claim for payment to the Federal Government, or causing the use of a false record to get a claim paid by the Federal Government.

! In the health care context, this would include billing for work not performed, upcoding, billing for unnecessary services, and even billing for services that were obtained in violation of other regulations (such as the anti-kickback statute).

History of the False Claims Act

- The original Act was passed in 1863, under President Lincoln, to combat fraud by war profiteers.

- The Act was amended in 1986 to encourage its use as a weapon against fraud. The number of cases filed since the 1986 amendments has risen from 33 in 1987 to 278 in 1995.

How does the False Claims Act Work?

- The False Claims Act provides a financial incentive for people with knowledge of false claims against the Federal Government to come forward. It does so by awarding a successful relator (the plaintiff in a False Claims Act case) with between 15-30% of any recovery from a defendant.

- The relator files a False Claims Act suit (also called a "qui tam" suit) on behalf of the United States. It is filed under seal (not a public document), along with a disclosure statement providing evidence to the government.

- While under seal, the government investigates the allegations, and decides whether to intervene. During this period, the defendant may not even be aware a False Claims Act case has been filed. If the government intervenes, the government is the primary prosecutor (although the relator still has input), and the relator receives 15-25% of any recovery. If the government does not intervene, the relator can still go forward with the suit and, if successful, receives 25-30% of any recovery.

How Do You Prove a False Claims Act Violation?

- The relator must show that the defendant was responsible for a false claim to the Federal Government. The evidence of this is initially presented in a "disclosure statement," submitted to the Government when the complaint is filed. This disclosure statement sets forth all of the evidence the relator possesses regarding the false

claim, and generally points the Government to additional persons or documents that would substantiate the allegations.

! The evidence provided needs to be as detailed as possible. It is not sufficient to base a complaint on rumors of wrongdoing; there should be specific allegations showing the time, date, place and content of any false claim. It is also helpful to have documentation supporting the allegations.

! The false claim must be shown by the civil standard - preponderance of the evidence (more likely than not); it does not have to be shown by the criminal standard - beyond a reasonable doubt. Specific intent to defraud need not be shown. "Knowingly" is defined to include acting with "deliberate ignorance" or "reckless disregard" of the truth or falsity of the information.

! These burdens of proof were clarified and relaxed by the 1986 amendments, in part to prevent the ostrich or "head in the sand" defense. For example, a physician signing off on a HCFA 1500 form would find it difficult to defend a False Claims Act violation by claiming that he knew nothing of the billing practice and left it all to his staff.

What Damages Are Recoverable?

! A defendant found liable is responsible for treble damages, costs, attorneys' fees, and penalties. The penalties are a mandatory $5000 - $10,000 per false claim. For example, if a physician submits five HCFA 1500 forms to Medicare for five separate physicals that were never performed, and that physician receives $50 for each physical, the damages could be as follows:

-Compensatory damages of $250 (for the five physicals), trebled to $750;

- Reasonable costs of prosecuting the suit;

- Reasonable attorneys' fees for the relator;

and

- Statutory penalties between $25,000 and $50,000.

Who Can Bring a False Claims Act Case?

! Anyone with knowledge of the illegal conduct. This is often a current or former employee of a defendant. However, if the relator "planned and initiated" the false claims violation, the award to the relator may be reduced; if the relator is criminally convicted for his or her role, they must be dismissed from the suit.

Are There Time Limits for a False Claims Act Case?

! suit must be brought within six years from the date of the false claim, or within three years after the Government knows or should have known of the false claim, but in no event later than ten years after the false claim.

What Limitations Are There on False Claims Act Suits?

! If the allegations in the False Claims Act suit were already "publicly disclosed," the relator has to be the "original source" of the allegations who brought the information to the Government before filing an action.

! No False Claims Act suit can be brought where the allegations are already the subject of a civil suit or administrative civil monetary penalty proceeding where the Government is a party.

! Government knowledge or waiver of the false claim does not provide an absolute defense, but may make it difficult to prove a False Claims Act case.

What Are the Risks of Filing Suit?

! Once a decision to intervene is made, the case is unsealed, and the identity of the relator is

revealed. This may lead to retaliation by a defendant. However, a section of the False Claims Act provides strong protections for whistleblowers, and may be successfully invoked whether or not the underlying False Claims Act violation is ever proven.

- If the defendant prevails in the suit, and the court finds the suit was clearly frivolous, vexatious or brought for harassment, then the court may find the relator liable for the defendant's expenses and fees.

Is the False Claims Act Being Used in the Health Care Field?

- Not only has the number of False Claims Act cases risen dramatically since 1986, but also there is a distinct trend toward health care fraud cases. In 1994, only 18% of the cases involved health care fraud; of the current cases, approximately 40% involve health care fraud.

- Of the top five False Claims Act recoveries in 1996, four were in the health care field (the recovery against Laboratory Corporation of America was the largest - $182 million for medically unnecessary tests submitted to Medicare, Medicaid and CHAMPUS). In early 1997, there was a recovery against Smith-Kline Beecham in the amount of $325 million.

- Two recent cases in the Sixth Circuit have held that violations of the anti-kickback and/or self-referral laws can result in False Claims Act liability. One court stated: ". . . it is clear that the False Claims Act was intended to cover not only those situations in which the claims themselves are false but also those situations in which a claimant engages in fraudulent conduct with the purpose of inducing payment by the government . . . ."

III. *COMPLIANCE PLANS*

Compliance programs are essential for healthcare organizations as early warning systems and as a method to

quantify fraud exposure. As discussed above, owners, officers and managing employees of healthcare organizations may expose themselves to liability for failure to detect fraud. A compliance plan can provide detection and allow corrective measures to be taken before the enforcement authorities are alerted. It allows employees to feel secure in reporting fraud and abuse to management, rather than to the authorities.

There are four main reasons why an effective compliance plan gives an organization protection from false claims act sanctions:

- Limits the exposure to *qui tam* suits;

- Lessens the potential fines and assessments for civil violations of federal healthcare laws;

- Lessens financial risk exposure under the federal sentencing guidelines; and

- Avoids the imposition of a mandatorily imposed compliance plan as part of a settlement agreement, with onerous reporting and audit requirements.

The elements of an effective health care compliance plan include:

- It is comprehensive and organization-wide.

- It addresses primary areas of concern where coding, billing and/or cost reporting takes place.

- It has continuous monitoring by management and regular auditing.

- It incorporates a system where employees and medical staff can report problems.

- It provides protection from reprisal for those who identify problems.

- It evaluates management on commitment to compliance plan success.

- It holds managers accountable for subordinate training in compliance planning.

- It identifies a chief compliance officer, preferably the CEO or a person who directly reports to the CEO.

A compliance plan begins with the governing authority passing a resolution directing the establishment of a compliance plan and a legal audit to commence the process. Actions taken to implement the process of developing a compliance plan include:

- A legal audit is performed.

- The date when the compliance planning process begins is established by the date of the resolution.

- If the legal audit identifies violations of the law, the organization must immediately report the violations.

- Repay the involved government agency any funds obtained as a result of violations.

- If the audit identifies criminal behavior, advise individuals who may be culpable to obtain the advice of a criminal lawyer.

- The organization should also seek the advice of a criminal lawyer.

- After the audit, formulate the compliance plan. It should:

    - Include a position statement by the organization.

    - Detail the practices in all areas where problems may occur, or have occurred.

    - Spell out the chief compliance officer's duties.

    - Reference corporate policy on record retention.

Effective compliance planning is not easy. However, to avoid the risks and penalties of False Claims Act sanctions when fraud is identified, an organization must undertake these difficult efforts.

IV. *ENHANCED FRAUD AND ABUSE ENFORCEMENT UNDER THEHEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT*

In passing the Health Insurance Portability and Accountability Act ("HIPAA") in the summer of 1996, Congress significantly increased the weapons available to the federal government to fight health care fraud and abuse, including:

- Creation of a number of new health care related crimes.
- Additional grounds for exclusion where an individual has an ownership or control interest in or is an officer or managing employee of a sanctioned entity.
- Increased civil monetary penalties.
- Additional funds appropriated for investigative agencies
- A Health Care Fraud and Abuse Control Account (the "Account") created within the Medicare Trust Fund that will receive criminal fines, civil monetary penalties and assessments, forfeitures, and recoveries for False Claims Act cases.
- A program to encourage individuals to report health care fraud and abuse, including whistleblowers receiving a portion of the amount recovered.

VI. *THE BALANCED BUDGET ACT OF 1997 ANTI-FRAUD PROVISIONS*

The Balanced Budget Act of 1997 goes beyond HIPAA's anti-fraud funding measures by creating nine new anti-fraud provisions, including:

! Permanent exclusion for those convicted of 3 health care related crimes.

! Authority of Secretary DHHS to refuse to enter into Medicare agreements with individuals or entities convicted of felonies.

! Explanation of benefits forms to contain a statement discussing fraud and a toll-free telephone number to report complaints to the OIG.

! Exclusion of entity controlled by family member of a sanctioned individual.

! Civil monetary penalties where a person contracts with an excluded provider.

! Increased penalty for kickback violations to $50,000 for each violation.

! DME providers must disclose ownership and DME providers and home health care agencies, comprehensive outpatient rehabilitation facilities and rehabilitation agencies must provide a surety bond of $50,000.

! Providers to supply Social Security and employer identification numbers to DHHS.

! Mandatory and permissive exclusions extended to all federal health care programs.

ENDNOTES

1. "Hospitals Seek Moratorium on Medicare Billing Fraud Inquiries," *Health Lawyers News*, August 1997, p. 7.
2. See discussion below at 4 for the additional funding provided by the Health Insurance Portability and Accountability Act of 1996 for fraud enforcement activities.
3. See discussion below at 4 concerning provisions of the Health Insurance Portability and Accountability Act of 1996 which makes managing employees and investors subject to sanction for an entity engaged in health care wrongdoing.
4. Rodriguez, Eva M., "In Columbia Inquiry, a Fine Line Defines Fraud," *The Wall Street Journal*, August 11, 1997, p. A3.
5. "Medicare Fraud Alleged," *The Cincinnati Enquirer*, August 11, 1997, p. A2.
6. See discussion at 4-5 regarding enforcement tools and funding provided by the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997.
7. See discussion at 4 for a review of the Medicare Integrity Program enacted under the Health Insurance Portability and Accountability Act of 1996.