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Court deals further blow to FCA enforcement

But health care attorneys point to spiraling number of False Claims Act cases in lower courts

A recent decision by the District of Columbia Circuit Court of Appeals is further evidence that the courts may reign in the growing number of False Claims Act cases brought by *qui tam* relators and the U.S. Department of Justice that attempt to "bootstrap" other violations under the False Claims Act, according to several health care attorneys.

Even though some claims aren't considered false under the act, relators increasingly allege that claims submitted to the government contain express or implied certifications of compliance with other laws and regulations. But attorney **John Boese** says the DC Circuit Court's June 30 decision in the *Siewick* case adds "great weight" to similar circuit court decisions that reject this theory.

In that case, the relator claimed that the defendant knew, or should have known, that it was not entitled to payment under the False Claims Act. But the court held that "a false certification of compliance with a statute or regulation cannot serve as the basis for a *qui tam* action under the False Claims Act unless payment is conditioned on that certification."

Ed Rauzi, an attorney with Davis Wright Tremain in Seattle, also points to language used by the court that underscores arguments made by the Chicago-based American Hospital Association and others seeking an amendment to the False Claims Act.

"The implications of Siewick's position are

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Momentum builds behind health care anti-fraud bill

Sweeping health care anti-fraud legislation received the strong endorsement of the Department of Health and Human Services' (HHS) Office of Inspector General, the Health Care Financing Administration (HCFA), and numerous state officials at a hearing on Medicare fraud before the House Subcommittee on Government Management, Information and Technology last week. But that bill will probably not be the last of its kind introduced this session, reports an aide to Subcommittee Chairman

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Office of Inspector General outlines its top concerns

While nearly all hospitals now have some type of compliance program in place, they also face the growing challenge of keeping those programs and their messages fresh, according to **Howard Young**, counsel at the Health and Human Services' (HHS) Office of Inspector General (OIG). "As these programs mature, I think the reality is that people are going to get a little bit tired of ongoing compliance training," he warns.

Young contends that retaining the attention of senior executives in this area is "absolutely essential." But he says that's easier said than done. To do this, Young says hospitals must carefully tailor their training to specific departments and sometimes even individuals. "This is going to be a real challenge on both time and resources," he warns. "But in order to keep your message fresh, you must constantly look for new approaches to compliance." That is especially true when it comes to training, which is the aspect that most employees

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extraordinary," the DC Circuit Court asserted near the end of its decision. "On Siewick's theory, any contracting party that misunderstands its legal entitlements and therefore fails to recover on an invoice in full would be liable under the False Claims Act — except in instances where it was unaware of the facts that led to its failure to recover in full," the court added. "This is not a prescription for fair or efficient contracting."

According to Boese of the Washington, DC-based law firm Fried Frank, the Siewick decision also undermines the decision in *U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corporation,* where the court denied the defendants' motions to dismiss False Claims Act claims that were based on alleged violations of the anti-kickback statute.

Steven Meagher, a health care attorney with Phillips Cohen in San Francisco, agrees that the *Siewick* decision flies in the face of that ruling. He explains that in *Thompson*, the government argued that had it known there was a kickback arrangement, it would have acted to disallow any of those services. "The DC circuit agrees that in order to be a violation of the False Claims Act you have to actually have a false claim," he asserts.

Meagher notes that the Thompson case is only a small part of the overall case against Columbia. He says the real significance of the DC Circuit decision is that it is one more indication that the courts are moving in the direction of requiring a close nexus between certification and payment. "There has to be a causal relationship between certification and payment of the claim," he says.

He says that means cases involving cost reports would be affected by this trend because the government has intervened in those cases. For example, he points to the portion of the case against Columbia that alleges it kept two sets of books, one of which was submitted to Medicare with allegedly inflated claims. "The certification on the cost report, which says the hospital complied with all applicable regulations, is central in that case," he says.

"The False Claims Act does not provide a remedy for a violation of any law or regulation." Rauzi argues. But he also warns that even as circuit courts appear to reign in the False Claims Act, the number of cases filed under the act continues to grow. "The place to watch is the trial courts because there are a lot of people coming out of the woodwork with these kinds of claims," he asserts. "That's where I think the action is." ■

Top concerns

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encounter, he adds.

According to Young, that is only one of the emerging challenges facing hospitals. Here are several other areas that Young says hospitals should pay close attention to as compliance programs continue to mature:

♦ **Compliance officers as whistle-blowers.** If hospitals were harboring any doubt about the appropriateness of compliance officers turning into whistle-blowers, Young did everything he could to erase them at the American Health Lawyers Association's recent meeting in Washington, DC. "There is nothing in the False Claims Act *qui tam* provision that would prevent a compliance officer or person engaged in the compliance function from filing a *qui tam* suit," he argues. In fact, Young says frustrated compliance staff often make the "perfect *qui tam* relators."

"I don't think the government would discourage those types of people coming forward," he adds. Typically, he says their message and job function

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has been frustrated at some level within the organization, and they often have "an interesting story" to tell.

Whether there is something in the employment agreement of a compliance officer that might prevent this is another matter, Young concedes. But he also questions whether such a provision would be enforceable.

♦ **Physician involvement.** According to Young, one area the OIG is hearing a lot about these days is physician involvement in compliance programs. He notes that while most of the OIG's corporate integrity agreements (CIAs) are with hospitals, the physician staff at those hospitals are legally a separate entity. That raises the questions about whether those physicians are bound by the CIA, he says.

Young concedes that busy physicians are often not very interested in compliance training and says the OIG tries to address that fact in its CIAs. But he adds that hospitals must still attempt to educate not only the employees such as the billers and the coders, but also physicians. "We think it's a 'no brainer' that any employed physicians that are employees of the hospital can be required to attend training," he asserts. But he adds that it may be harder to get buy-in from large groups of physicians that are on the medical staff but not under contract.

Young reports that some CIAs now require hospitals to make a good-faith effort to train these physicians. But when annual reports show that only a fraction of physicians attended any compliance training, that sends the OIG the wrong signal, he cautions.

"We generally do not demand 100% participation," he adds. To work around busy physician schedules, he says some hospitals now produce videotapes and audiotapes or make other types of training available to physicians, he adds.

Young notes that some hospitals have even teamed up to provide training, especially in inner cities where physicians serve on multiple staffs. But that carries risks, he cautions. "Training should pertain to a specific institution, and not all hospitals in the same city share all the same compliance goals or compliance mechanisms," he explains.

♦ **Outsourcing compliance functions.** Young says another area the OIG is starting to hear more about is the outsourcing of various compliance functions. Outsourcing the hotline function is not uncommon, and Young says the OIG does not take exception to that as long as vendors respond appropriately. But how hospitals respond to calls made to the hotline is their responsibility. "You can't outsource that response," he cautions.

Young adds that while the OIG does not look sideways at lawyers and accounting and consulting firms that help develop and implement compliance training, it is critical that the training is tailored to that particular provider or entity. He says the OIG takes a dim view of "canned training modules" that do not provide ample opportunity for questions or address the needs of specific provider populations.

"Outsourcing the compliance officer function is a tough one," Young cautions. He notes that the OIG's draft guidance for physicians says that several small practitioners can share a compliance officer. "Logistically, however, there are a lot of issues to work out in that regard," he warns. "It can be difficult for an individual to wear multiple hats and serve as a compliance officer for multiple providers."

On the other hand, outsourcing the audit function to an independent review organization is actually required by the OIG in many of its CIAs. But even there, he says that organizations with significant resources that outsource all those functions and fail to develop internal expertise in this area are selling themselves short.

"If a provider or entity chose to outsource the entire compliance program function — and some providers have asked us about that — I think it raises serious doubts about their commitment to compliance and whether they truly understand the message they are sending to their employees," says Young.

♦ **Measuring effectiveness.** According to Young, measuring effectiveness is critical not only for improving compliance mechanisms but also explaining that program to the OIG should a CIA suddenly become warranted. "If a provider comes to us and says it doesn't need a CIA, it's going to be critical that it is able to measure and document effectiveness," he explains.

Young says the OIG has seen a range of various benchmarking techniques. But many of them fall short. For example, the number of calls to a hotline is not always an effective measure, he says. That's because some institutions have very good "open door" policies that encourage complaints to be

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brought directly to senior executives. "That is perhaps the best type of compliance culture," he says. "But if that is what happens in your institution, make sure that you document it." ■

Anti-fraud bill

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Stephen Horn (R-CA).

Horn's aide says the congressman plans to incorporate some of the things learned at the July 25 hearing into legislation now being drafted. At the hearing, HCFA's Director of Program Integrity **Penny Thompson** said the agency strongly supports the Medicare Fraud Prevention and Enforcement Act introduced by Rep. Judy Biggert (R-IL) in the House, and a companion bill introduced by Sen. Susan Collins (R-ME) in the Senate. That legislation would strengthen the Medicare enrollment process and expand certain standards of participation. It would also give law enforcement agencies additional tools to pursue health care fraud, including site inspections and background checks, registration of billing agencies, and expanded access to the Health Integrity and Protection Database.

The legislation would also limit the use of discharge in bankruptcy proceedings for provider liability and make Medicare carriers and fiscal intermediaries liable for claims submitted by excluded providers.

Notably, the subcommittee heard direct testimony from several convicted felons now serving time for bilking Medicare. Raymond Mederos, who was sentenced to a seven-year jail term, and Denis Spencer, who owned a laboratory in southern California, detailed the schemes they used to defraud the Medicare program before the subcommittee. ■

Committee hears dueling tales of anti-fraud efforts

Witnesses told members of the House Commerce Oversight and Investigations Subcommittee July 18 that fraudulent medical equipment providers may have ripped off California's Med-Cal program to the tune of $1 billion over the last few years, despite an aggressive effort by federal law enforcement officials to root out fraud and abuse.

Worse yet, California medical equipment dealer **Ruben Assatourian** told the subcommittee that seasoned Medicare criminals are now expanding their targets. He says that adult day programs, an increasingly popular state-subsidized option for family members who want to avoid placing parents in institutionalized care, are fast becoming "the next jackpot" for career criminals.

Federal Bureau of Investigation Deputy Assistant Director **Thomas Kubic** countered that California has implemented numerous measures including a moratorium on termination clauses, expanded inspections and background checks, and a moratorium on durable medical equipment providers that should serve as a model for other states. He also pointed to some 300 investigations still under way in that state.

General Accounting Office Associate Director **Leslie Aronovitz** argued that the Health Care Financing Administration and state Medicaid programs should improve coordination of their joint efforts in this area. Specifically, she says the administration must know a lot more about ongoing state activities. An aide to Subcommittee Chairman Fred Upton (R-MI) said it is uncertain whether any legislation will emerge to address those areas. ■

Advisory opinion program to end in three weeks

The statute that set the Department of Health and Human Services' (HHS) Office of Inspector General's (OIG) advisory opinion process in motion three years ago is set to expire in three weeks, unless Congress acts to reauthorize it.

OIG spokeswoman **Alwyn Cassil** confirms that her office will continue to accept and process requests for opinions received prior to Aug. 21. But she says it remains unclear how the OIG will handle any requests that come in after that date absent a legislative mandate to extend the program. Since the program was authorized three years ago, the OIG has issued 41 opinions. ■