

Congress Substantially Broadens Scope of False Claims Act

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By Dennis S. Diaz, David V. Marshall and Adam D. Romney

Recent changes to the federal False Claims Act (FCA) have substantially increased legal risk to health care providers furnishing Medicare or Medicaid services.

First, the knowing retention of any government overpayment, including routine Medicare overpayments, can now be pursued by the government even though the initial receipt of the overpayment, or the submissions that caused the overpayment, may not have been, at the time, knowingly false. This, despite the fact that Medicare and Medicaid overpayments can arise in many contexts, including through innocent mistakes in an exceedingly complex regulatory environment.

Second, a false claim now includes claims submitted to *agents* of the federal government. Thus, health care providers who submit claims for Medicare or Medicaid reimbursement to agents such as Medicare or Medicaid managed care plans now fall within the expanded scope of the FCA.

Providers should exercise a great deal more care in assessing and implementing corrective measures, and in making repayments, following discovery of an overpayment. These are difficult issues that require a careful weighing of obligations and risks.

Background to changes

The FCA changes, contained in the Fraud Enforcement and Recovery Act of 2009 (FERA), were designed to improve the government's ability to investigate and prosecute financial frauds such as mortgage, securities and financial institution fraud, and other frauds related to federal assistance and relief programs (such as the Troubled Assets Relief Program, or TARP). However, the spill-over effect of FERA's broad language may reach many health care providers that participate in the Medicare and Medicaid programs.

Knowing retention of overpayments

A provider now violates the FCA if it conceals, improperly avoids or decreases an obligation to pay money to the government. False claim liability will now attach regardless of whether the provider ever submitted a false claim to get government money or used a false statement to hide it.

FERA makes this change by defining an "obligation" in the FCA to include the "knowing" "retention of an overpayment." The FCA defines "knowing" to mean that a person: "(1) has actual knowledge of the information; (2) acts in deliberated ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information." Accordingly, any knowing retention of a government overpayment will now pose risk under the FCA, regardless of the innocence of the acts that caused the overpayment in the first place.

Several courts have held that a false claim can be predicated on the violation of other laws (e.g., violation of the Stark law or anti-kickback statute). By expanding the definition of "obligation" to include the retention of an overpayment, false claim liability now extends to the knowing and improper retention of a Medicare or Medicaid overpayment. Overpayments arise in many contexts:

- Innocent billing or coding mistakes by provider staff;
- Improper or insufficient documentation of services by providers;
- Patient ineligibility for Medicare or Medicaid at the time the services were provided;
- Erroneous Medicare or Medicaid payment where there was another responsible payor;
- Billing of services subsequently discovered not to be covered by federal programs;
- Innocent billing of services typically covered but later determined not to be "reasonable and necessary"; or
- Payor error with respect to medically necessary covered services.

Many types of innocuous overpayments could now potentially lead to false claim liability. If a provider discovers or "knows" of an overpayment and either retains the funds, avoids repayment or does not make a full refund to the government, the entity is vulnerable to enforcement and penalties under the FCA.

Congress removes "presentment clause" and amends intent element in the FCA

Section 4 of FERA also extends potential false claim liability to claims previously beyond the scope of the FCA. The Section 4 amendments were made in response to two recent federal cases.

In the case of *Allison Engine Co. v. United States ex rel. Sanders*, the U.S. Supreme Court decided that the FCA requires the federal government to prove that a defendant "intended" the government to pay a claim. There was no liability under the FCA unless a recipient of federal funds intended to defraud the government itself.

In another case, *United States ex rel. Totten v. Bombardier Corp.*, the D.C. Circuit Court decided the FCA's presentment clause limits false claim liability only to entities that directly "presented" a claim to the federal government for payment. Thus, a provider that presented a claim for payment to an agent of the government, instead of directly to the federal government, did not present a false claim within the meaning of the FCA, even if that claim was ultimately paid with federal funds.

Now, there is liability whether or not the recipient intends to defraud the government or the recipient presents a claim directly to the government for payment. To address the issue of intent presented in the *Allison Engine* decision, FERA removed the language requiring a person using a false statement "to get [a false claim] paid or approved by the government" and replaced it with a requirement that the false statement be "material to" a false claim. To address the "presentment clause" issue presented by the *Totten* decision, FERA simply deleted the language from the FCA that required direct presentation of a claim to the government in order for liability to attach.

This means that Medicare or Medicaid dollars dispensed through any agent could lead to false claims liability. Agents of the Medicare and Medicaid programs include Medicare Administrative Contractors, Medicare and Medicaid Advantage Organizations, Medicaid HMOs, and other types of Medicare or Medicaid managed care plans. Submitting a false claim to any of these entities, or the knowing retention of an overpayment from any of these payors, could be grounds for liability under the FCA.

These Section 4 amendments take effect retroactively as if enacted on June 7, 2008, and apply "to all claims under the [FCA] that are pending on or after that date."

Investigative authority

FERA also expands the authority of the attorney general to investigate false claims. FERA increases the attorney general's ability to issue Civil Investigative Demands pursuant to the FCA and allows designees of the attorney general to issue them. FERA further amends the FCA to allow greater sharing of information retrieved in FCA investigations with qui tam relators and others.

Conclusion

These changes to the FCA became effective May 20, 2009; however certain amendments, as discussed, are retroactive. The new law creates substantially more risk for providers, and enables the government and whistleblowers to pursue enforcement in situations that historically would not have been the subject of the FCA's draconian remedies.

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New Stark Amendments Affecting "Under Arrangements," "Percentage" and "Per-Click" Leases: Deadlines Approaching, Rumors Flying

04.22.09

By Robert G. Homchick

Last fall a flurry of articles, alerts and announcements warned the health care industry of the impending demise of both physician-owned "under arrangements" as well as "percentage" and "per-click" leases.

The amendments to the Stark regulations, published in the 2009 Inpatient Prospective Payment System Final Rule ("2009 IPPS Final Rule"), revised the definition of "entity" to limit the ability of physicians to provide services to hospitals under arrangements and amended several Stark exceptions to prohibit rent payments based on either a percentage or a per-use formula in space and equipment leases. The Centers for Medicare and Medicaid Services (CMS) recognized that these changes would disrupt a number of existing relationships and thus delayed their implementation until Oct. 1, 2009.

In the months following the issuance of the 2009 IPPS Final Rule, some in the industry have reconfigured or unwound affected arrangements, others have made plans to do so, and a third group has been waiting in the hope that CMS will reverse its position.

Faint hope: a legal challenge, a new administration and a stakeholder session

The filing of a lawsuit challenging the amendments affecting under-arrangement transactions, a change in administration and the announcement of a stakeholders' "Convener Session" to address the efficacy of the Stark law, have all provided hope to those in the waiting mode. Unfortunately, the lawsuit was recently dismissed (a ruling favorable to the government) and the change in administration has not yielded any revision of CMS's Stark policy. The upcoming Convener Session on the Stark law, in which Representative Stark and lawyers from Davis Wright Tremaine will participate, could provide useful suggestions for regulatory or statutory reform. Those suggestions, however, are not likely to result in any concrete changes before Oct. 1, 2009.

Consequently, the rumors that CMS or even Congress may intervene and delay the implementation of the Stark amendments in the 2009 IPPS Final Rule must be viewed with suspicion. While anything is possible, a delay in the rules affecting under-arrangement contracts and per-use and percentage leases is a long shot. Providers should develop a strategy for restructuring or unwinding relationships that are inconsistent with the Stark amendments in the 2009 IPPS Final Rule. Waiting for government to delay the Oct. 1, 2009, implementation date is not a prudent course.

A summary of the revisions to the Stark regulations that go into effect on Oct. 1, 2009, is set forth below.

1. Services provided under arrangements: changes to the definition of entity

In the 2009 IPPS Final Rule, CMS changed the definition of entity to include both (a) the person or entity that "presented a claim" to Medicare for the designated health service (DHS); and (b) the person or entity that "has performed" the DHS (notwithstanding that another person or entity actually billed the services as DHS).

By changing the definition of entity to include persons and entities that "perform" DHS, CMS effectively converted to "DHS entity" status any physician group practice or other organization that provides inpatient and/or outpatient services under arrangement with a hospital.

Consequently, any physician who maintains a financial relationship with that under-arrangement organization can make DHS referrals to the organization only if that financial relationship fits within a Stark exception. While it may be possible to structure a physician's compensation arrangement with an under-arrangement organization to satisfy a compensation-arrangement exception, only under limited circumstance will a physician be able to hold ownership or investment interests in an under-arrangement provider.

Given these changes, most physicians involved in under-arrangement relationships with hospitals are confronted with the choice of either (a) divesting their ownership or investment interests in the under-arrangement organization, or (b) restructuring the under-arrangement relationship. If physicians choose to restructure their under-arrangement relationships, they should do so by Oct. 1, 2009.

2. Percentage-based compensation and unit-of-service (per-click) payments in space and equipment leases

As part of the 2009 Final IPPS Rule, CMS also narrowed the circumstances under which percentage and per-click compensation are permissible. More specifically, CMS revised the office-space and equipment-lease exceptions, as well as the fair-market value and indirect-compensation arrangements exceptions to prohibit the use of both percentage-based compensation formulae and per-click rental payments.

Thus, a joint-venture entity owned by physicians that leases equipment to a hospital may not receive a per-use rental payment if the physicians refer patients to the hospital, prompting the use of the leased equipment. Similar limitations apply to the lease of office space or other real property. As noted above, these revisions go into effect Oct. 1, 2009.

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RAC Stop Work Order Lifted: RAC Moving Forward

02.09.09

By Kathleen H. Drummy and Kent B. (Bernie) Thurber

Last year, a Medicare Recovery Audit Contractor (RAC) contract award dispute necessitated an automatic halt to the implementation of the permanent RAC Program roll out. That dispute has now been settled, and has resulted in some of the RAC responsibilities being subcontracted to the challengers. As a result, Centers for Medicare and Medicaid Services (CMS) announced on Feb. 6, 2009, that the stop work order has been lifted, and it will now implement the permanent RAC Program, which authorizes RACs to conduct postpayment reviews of claims and to search for improper payments, both overpayments and underpayments.

The final RACs and their jurisdictions are as follows:

- **Diversified Collection Services, Inc. of Livermore, Calif. – Region A** (encompassing Rhode Island, New Hampshire, Vermont, Massachusetts, Delaware, Connecticut, New York, Pennsylvania, New Jersey and Maine)
- **CGI Technologies and Solutions, Inc. of Fairfax, Va. – Region B** (encompassing Minnesota, Michigan, Wisconsin, Indiana, Illinois, Kentucky and Ohio)
- **Connolly Consulting Associates, Inc. of Wilton, Conn. – Region C** (encompassing South Carolina, North Carolina, Florida, Colorado, New Mexico, Texas, Oklahoma, Alabama, Tennessee, Georgia, Mississippi, West Virginia, Virginia, Louisiana and Arkansas)
- **HealthDataInsights, Inc. of Las Vegas, Nev. – Region D** (encompassing Montana, Wyoming, North Dakota, South Dakota, Utah, Arizona, Washington, California, Oregon, Idaho, Nevada, Nebraska, Kansas, Iowa, Missouri, Hawaii and Alaska)

Certain responsibilities in Regions A, B and D will be subcontracted to PRG-Shultz, Inc. (the Demonstration RAC for California and other Western states) and to Viant Payment Systems, Inc. in Region C.

The CMS Feb. 6 Notice did not identify timelines for when the RACs might begin their reviews. However, prior to imposition of the stop order, CMS had promised to hold educational meetings, including town hall meetings, to introduce each RAC to providers in its region and to clarify the process. We expect that CMS will update the schedule of the rollout in the near future.

Now that the permanent RAC Program is finally ready to rollout nationwide by Jan. 1, 2010, all manner of health care providers may be audited. Preparation for the RAC Program therefore is appearing as a key concern for every provider's 2009 internal agenda. Preparation efforts include assessing the completeness of medical records, reviewing and assessing familiarity and compliance with coverage and coding requirements, and learning RAC procedures and appeal deadlines. Taking such steps can be expected to help the provider:

- Respond faster and with less expense to RAC requests
- Reduce the number of RAC denials
- Avoid missed appeal deadlines
- Make appropriate corrections to operations

We recommend that all providers pay close attention to the strict timelines associated with RAC record requests and appeals of RAC denials. Failure to respond timely to a RAC record request will result in an automatic denial. Failure to submit requests for appeals of the RAC denials, or to the provider supporting documentation early in the administrative appeal process, may deprive the provider of its opportunity to challenge the RAC denial, absent good cause for late filing or late submission.

In light of many legal and factual concerns that surfaced in the RAC Demonstration Project, and despite CMS efforts to redesign the RAC Program to incorporate "lessons learned," close monitoring of the rollout of the permanent RAC Program and careful consideration of preserving appeal rights is recommended should systemic problems surface. As a result, you may wish to consult with legal counsel at an early stage of any RAC denial or appeal.

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