The False Claims Act: Where It Stands

BY PETER LEIBOLD, JD

The False Claims Act (FCA) is a powerful and, when used appropriately, important tool to fight fraud. It was enacted to deter fraud by contractors who submitted a relatively few, large claims to the Department of Defense. However, many healthcare providers believe it is not unreasonable to ask the government to consider adapting the law to apply more appropriately to a field in which healthcare providers annually send hundreds of millions of relatively small claims to the Medicare program. While legislation to amend the FCA is not likely to pass Congress this year, its development has spurred the Department of Justice to issue guidelines regarding its own behavior in enforcing the act.

Mr. Leibold is general counsel, Catholic Health Association, St. Louis.

Stewardship

In embracing and carrying forward Christ's healing mission, institutionally based Catholic healthcare services have certain responsibilities guided by the Church's teaching and normative principles. A central component of that responsibility is the mandate that Catholic healthcare institutions exercise responsible stewardship of available healthcare resources.[1] This responsibility of stewardship requires our institutions not to defraud patients or the government and is an affirmative obligation to set and enforce the highest standards of behavior and competence. In the words of Card. Joseph Bernardin,

> Finally, I would emphasize among medicine's professional obligations the setting and enforcing of the highest standards of behavior and competence. Although those who defraud government and private insurers, those who are incompetent or venal, those who look the other way at colleagues' wrongdoing are undoubtedly a minority, the profession is demeaned by them and must repudiate them.[2]

Thus Catholic healthcare has a special obligation to ensure that it sets the highest standards of ethical conduct. Each institution and system should draft and enforce a corporate compliance program that communicates the mission of the sponsors. Yet no ideal of ethical behavior or the most effectively enforced corporate compliance program can eliminate the confusion and oversights that occur in the administration of programs as complicated as Medicare and Medicaid. For this reason, the government, in proposing and enforcing "fraud and abuse" laws, should diligently respect the line between deliberate fraud and mistakes created by reasonable confusion about the requirements of a government program. Some say the government has failed to honor this necessary and appropriate distinction in its enforcement of the FCA.

FCA Provisions

The FCA[3] was originally enacted in 1863 to aid the government in prosecuting gunpowder manufacturers who sold sawdust, rather than gunpowder, to the Union Army during the Civil War.[4] Congress amended the act during World War II to diminish its power in response to essential defense contractors' assertions that whistleblower actions were hurting the war effort.[5] In 1986, however, Congress reacted to certain high-profile fraud investigations in the defense industry by reinvigorating the FCA as "a major fraud-fighting weapon."[6]

The FCA establishes liability for persons who commit any of seven listed offenses against the government. The most important of these statutory provisions are knowingly submitting a false claim, knowingly making a false statement in support of a false claim, conspiring to have a false claim paid, and knowingly making a false statement to avoid or decrease an obligation to pay the federal government.[7] Generally, any person who commits one of the seven offenses "is liable to the United States Government for a civil penalty of not less than $5,000 and not more

than $10,000, plus 3 times the amount of damages which the Government sustains . . . ."[8] This harsh penalty is designed to deter fraudulent activity against the government.

The FCA requires that the enumerated offenses be committed "knowingly," which is defined as: "1. hav[ing] actual knowledge of the information; 2. act[ing] in deliberate ignorance of the truth or falsity of the information; or 3. act[ing] in reckless disregard of the truth or falsity of the information, and no proof of specific intent is required."[9] An expansive definition of "knowledge," rather than requiring a specific "intent" to defraud, provides the government with enormous latitude in pursuing cases against individuals submitting claims to the federal government. If the enforcement agency believes that a person could have taken steps to discover the truth or falsity of a claim, even if the person truthfully did not know that a claim submitted was false, the person can be held liable under the statute.

The FCA provides that the federal government or any "person" may bring an action under the act. In this way, the FCA empowers whistleblowers to act as private attorneys general to protect the government from "fraud."[10] These actions are called *qui tam* actions, and the whistleblower is called a *qui tam* relator. Unlike the traditional "standing" requirement in which litigants must have been harmed by the action of which they complain, the FCA allows a litigant to bring a claim even when the private plaintiff has not been injured by the defendant's conduct.[11] The statute sets out specific standards by which the government and a *qui tam* relator bring a suit. Importantly, the relator shares in the government's recovery –25 percent to 30 percent if the government chooses not to intervene; 15 percent to 25 percent if the government does intervene.[12]

Focusing Anti-Fraud and Abuse Statutes on Healthcare Providers

In 1988, 85 percent of recoveries under the FCA arose from defense fraud, while only 1 percent arose from healthcare fraud. Enforcement agencies have now changed their focus. In 1994 and 1995, defense fraud accounted for roughly 50 percent of all recoveries, while healthcare fraud accounted for 35 percent.[13] "In the last ten years, *qui tam* cases in which the government has intervened have produced approximately $1.8 billion in recoveries. About half of these recoveries were in healthcare cases."[14] During fiscal year 1997, federal prosecutors opened 4,010 civil healthcare matters (including actions under the FCA), an increase of 61 percent over 1996.[15]

In 1988, only 1 percent of recoveries under the FCA came from healthcare fraud; by 1995, healthcare fraud accounted for 35 percent of recoveries.

The government has pursued numerous and imaginative types of FCA causes of action against healthcare providers. Many of these have been challenged by the healthcare providers involved. Two of the largest initiatives to date have been the Physicians at Teaching Hospitals (PATH) Project and the DRG (diagnosis-related group) 72-Hour Window Project.

In the PATH Project, the government alleges two types of false claims submitted by hospitals and academic health centers: (1) "upcoding" (billing for a procedure that pays more than the service actually performed); and (2) a failure to document the presence of supervising physicians at visits or procedures performed by residents.[16] The healthcare community has responded that the Health Care Finance Administration's (HCFA's) guidance on when a physician must be physically present has been vague and often inconsistent with the guidance provided by fiscal intermediaries. In addition, the Office of Inspector General (OIG) seems to be applying different standards retroactively to prior, acceptable conduct.[17]

In the DRG 72-Hour Window Project, the OIG is investigating the billing of outpatient services within 72 hours of an inpatient admission. According to the OIG, certain nonphysician outpatient services performed within 72 hours of an admission to the hospital should not have been billed to the Medicare program separately. The Department of Justice has identified 4,660 hospitals as targets of the investigation.[18]

William L. Lane, president of Holy Name Hospital in northeastern Massachusetts, pointed out in an April 1998 House committee hearing that a survey of 22 hospitals in Massachusetts revealed that out of over 2 million bills submitted in a three-year period, only 2,960 bills were alleged to be incorrect, an error rate of 0.12 percent. These errors had a billing value of $450,000, but the U.S. attorney threatened to impose false-claims fines and penalties of up to $35,971,544. The final settlements reached by these hospitals was for $943,203.[19] The American Hospital Association (AHA) argues that HCFA's guidance relating to the rules governing reimbursement for procedures performed in the days before an inpatient admission has ranged from "intermittent and inconsistent to nonexistent."[20]

While the government has used the FCA in numerous other controversial ways to pursue the billing practices of healthcare providers, many hospitals are particularly concerned about two recent developments. The first is the government's effort to persuade courts to take a broad

view of the statute's definition of "knowing." "[T]he government and other private plaintiffs are aggressively pushing the scienter element to its extreme in an attempt to discover where the line between simple negligence and reckless disregard will be drawn by the courts."[21] This effort by the Department of Justice and the OIG has led to a seemingly justifiable outcry by hospitals that they are being threatened with confiscatory fines and penalties for honest mistakes.

The second is the approach that U.S. attorneys, the Department of Justice and the OIG have used in approaching hospitals and other healthcare providers about alleged violations of the FCA. At the April hearing on the FCA, Lane described a scenario in which 83 hospitals received "demand" letters from the local U. S. attorney alleging violations with penalties in the tens of millions of dollars.[22] Each hospital was then given the option of "settling" the unproven claim for substantial amounts of money if the hospital responded to the demand letter within 20 days. The risk of not settling the claim, of course, is a later encounter with an impatient prosecutor wielding a statute with enormous penalties and an extremely flexible definition of a "knowing" submission of a false claim.

Corrective Legislation

Rep. Bill McCollum, R-FL, and Sen. Thad Cochran, R-MS, have introduced companion bills in the Senate and the House of Representatives to amend the FCA.[23] Each bill would amend the FCA in the following ways:

- Impose a *de minimis* standard such that overpayments from Medicare below a certain percentage would not result in FCA fines or penalties exceeding the amount of the overpayment plus interest
- Establish a safe harbor for providers who submitted a false claim based on advice given by HCFA or its fiscal intermediaries and limit fines or penalties to actual damages plus interest
- Raise the burden of proof in FCA actions against healthcare providers to a "clear and convincing evidence" standard
- Disallow an FCA action for a claim submitted by a person that is in substantial compliance with a model compliance plan issued by the Secretary of Health and Human Services (in consultation with the Secretary of Defense)

Many in the hospital community support these bills. They believe them to be reasonable efforts to ensure that a law originally aimed at fraud in the defense industry is applied fairly to the claim-rich environment of federal healthcare programs.

Many in the hospital community support bills introduced by Rep. Bill McCollum, R-FL, and Sen. Thad Cochran, R-MS, to amend the FCA.

As Don Richey, administrator of Guadalupe Valley Hospital in Seguin, TX, made clear: "Please understand that Medicare billing is extremely complicated. The regulations for Medicare are at least three times the size of the Internal Revenue Code."[24] With the hundreds of millions of claims filed by hospitals and healthcare providers each year and the complicated nature of reimbursement regulations, the FCA should be tailored to the specific needs and demands of healthcare.

Enforcement Guidelines

H.R. 3523 has obtained almost 200 cosponsors, and the Department of Justice issued a memorandum in June to those enforcing the FCA.[25] The memorandum implicitly acknowledges the legitimacy of healthcare providers' complaints about the methods used by the government in enforcing the act. Importantly, however, the guidance does not and cannot change the rather expansive legal standards used to interpret the language of the FCA.

In the memorandum, Deputy Attorney General Eric Holder states:

> This guidance is being issued to emphasize the importance of pursuing civil False Claims Act cases against health care providers in a fair and even-handed manner, and to implement new procedures with respect to the development and implementation of national initiatives.[26]

The guidance specifically requires enforcement officials to make good-faith, substantive inquiries into whether a false claim exists and whether the false claim was submitted "knowingly." The deputy attorney general provides guidance on whether a healthcare provider acted knowingly: Was the provider on actual or constructive notice of the rule or policy on which a potential case could be based? Was the rule clear? Does the provider have a compliance plan? Has the provider taken remedial steps?[27]

The guidance specifically disavows the method of demanding settlement of a claim before even discussing the factual circumstances with the healthcare provider: "Regardless of the form of initial contact, Department attorneys must ensure that health care providers are afforded: (i) an adequate opportunity to discuss the matter before a demand for settlement is made, and (ii) an adequate time to respond."[28] The guidance encourages departmental attorneys to treat healthcare providers with respect in numerous other ways,

Prospects for amending the FCA this year have now dimmed.

including a section entitled "Minimizing Burdens Imposed on Providers During Investigations."

While the guidance will not provide the protection offered by H.R. 3523 and S. 2007, its issuance demonstrates that hospitals struck a responsive chord in elected officials by simply demanding to be treated fairly while being investigated for possible violations of law. But now that the guidance has been issued, political prospects for enacting legislation to amend the FCA this year have dimmed. Just days after the guidance was issued, the chief Democratic sponsor of H.R. 3523, Rep. William Delahunt, D-MA, withdrew his support for the bill. Delahunt claimed that the legislation had been successful by spurring the administration to issue the guidance, and now Congress should wait to evaluate whether the guidance would resolve the legitimate issues raised by the hospital community. His action makes it highly likely that Congress will do just that. □

The author wishes to thank Stacey Dunlap for her assistance in the preparation of this article.

NOTES

1. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, U.S. Catholic Conference, Washington, DC, 1995, p. 6.
2. Joseph Bernardin, *Renewing the Covenant with Patients and Society*, Catholic Health Association, St. Louis, 1995, p. 10.
3. 31 U.S.C. 3729 *et seq.*
4. L. Aussprung, *Fraud and Abuse*, 19 J.Legal Med.1, March 1998.
5. G. Eiland, *How to Respond when the Feds Show up at the Door*, presentation to the System In-House Counsel Committee of the Catholic Health Association, April 29, 1998.
6. P. Bucy, *Where to Turn in a Post-Punitive Damages World: The "Qui Tam" Provisions of the False Claims Act*, 58 Ala. Law. 356, November 1997.
7. J. Boese, *Anatomy of a False Claims Act Case*, NHLA/AAHA Healthcare Fraud and Abuse: Compliance and Enforcement, October 30-31, 1997, p. 20.
8. 31 U.S.C. 3729(a)(1).
9. 31 U.S.C. 3729(b).
10. Bucy, supra note 6.
11. Bucy, 357. But see *U.S. ex rel Joyce Riley v. St. Luke's Episcopal Hospital*, 1997 U.S. Lexis 16954 (October 21, 1997). (Failure to require injury in fact to *qui tam* relator violates U.S. Constitution.)
12. 31 U.S.C. 3730(d)(1), (2).
13. Fried, Frank, Harris, Shriver & Jacobson, Department of Justice press release on *qui tam* enforcement of civil False Claims Act, November 29, 1995.
14. Morris, supra note 2, at 4.
15. Morris.
16. Aussprung, supra note 4, at 18.
17. J. Steiner, and M. Hutchinson, *National Hospital Investigations*, NHLA/AAHA Healthcare Fraud and Abuse: Compliance and Enforcement, October 30-31, 1997. Cites correspondence between AHA and the Association of American Medical Colleges (AAMC) and the Secretary of Health and Human Services and the Inspector General. On April 27, 1998, a district court in California dismissed for lack of ripeness a lawsuit filed by the AAMC against the federal government related to the government's handling of the PATH audits. AAMC press release, April 30, 1998.
18. Aussprung, supra note 4, at 57.
19. U.S. House Committee on the Judiciary, Subcommittee on Immigration and Claims, April 28, 1998.
20. U.S. House Committee.
21. Aussprung, supra note 4, at 6-7.
22. U.S. House Committee.
23. H.R. 3523 and S. 2007, the Health Care Claims Guidance Act.
24. U.S. House Committee.
25. Eric Holder, *Guidance on the Use of the False Claims Act in Civil Health Care Matters*, U.S. Department of Justice, Washington, DC, June 3, 1998, p. 1.
26. Holder.
27. Holder, pp. 2-3.
28. Holder, pp. 4-5.