

DOJ MUST REEVALUATE USE OF FALSE CLAIMS ACT IN MEDICARE DISPUTES

by

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One of the U.S. Department of Justice's ("DOJ") highest priorities for the past several years has been to conduct a "war on health care fraud." A major component of its efforts has been federal prosecutors' use of the federal False Claims Act ("FCA"). Because DOJ's use of this law is certain to continue, if not intensify, it is valuable to reflect upon one of the past year's key developments regarding the FCA, one which DOJ, healthcare providers, and policymakers must consider when this often punitive civil enforcement law is invoked — the General Accounting Office's ("GAO") August 1999 critical assessment of DOJ's activist use of this law. *Medicare Fraud & Abuse: DOJ's Implementation of False Claims Act Guidance in National Initiatives Varies*, GAO/HEHS-99-170 (Aug. 1999) ("*Medicare Fraud & Abuse*"). The August 1999 report is the second of two Congressionally-authorized GAO reports reviewing the implementation of DOJ's FCA guidelines regarding Medicare. Throughout 1999, DOJ implemented a program of massive, industry-wide enforcement actions against healthcare entities which were predicated upon the assumption that these entities are knowingly operating unlawfully. In the government's initial enforcement efforts, various United States Attorneys' Offices would write to all healthcare entities that, based solely upon a computerized run of claims submitted rather than any individualized investigation, they believed

were violating the FCA. The letters threatened these entities with treble damages and massive civil penalties unless they agreed to settle their claims. Because this non-traditional law enforcement technique was deemed to be abusive, Congress in 1998 proposed legislation to amend the FCA. To head off congressional reform of the FCA, DOJ issued guidelines regarding its use of the FCA in national programs, including measures to review the actions of U.S. Attorneys' Offices to ensure that those Offices properly construed and consistently applied the law.

In reviewing DOJ's implementation of these guidelines, GAO found that DOJ's oversight of U.S. Attorneys' Offices' compliance with the guidelines was "superficial." The GAO also found that these Offices varied widely in their application of DOJ's FCA guidelines, thereby undermining consistency in the enforcement of the law, which was a primary goal underlying their promulgation.

The GAO's findings are not surprising. The advantage to national initiatives is that they conserve resources by permitting DOJ to switch the burden of proof to healthcare entities to establish that they did not violate the FCA so that DOJ will not have to invest the resources necessary to prove a violation. The guidelines switch the burden back to DOJ to prove a violation on a case-by-case basis, thereby undercutting the advantage of embarking upon national initiatives in the first instance. The primary lesson of GAO's report is that DOJ's guidelines are unworkable and that the Department should eliminate its program and the huge bureaucracy it will need to appropriately administer it.

DOJ'S Improper Use of National Initiatives. Prior to 1986, the federal FCA was rarely invoked and, when used, was generally used only after a person had been criminally convicted of defrauding the United States. During the mid-1980s, as alarming reports of \$2,000 toilet seats

garnered media attention, Congress resolved to reform the FCA to make it a more useful tool in eradicating fraud. Congress reduced the threshold of knowledge a person must have from specific intent to defraud (which was the rule in the majority of circuit courts of appeal) to mere “reckless disregard” or “deliberate ignorance” of the truth or falsity of the claim. The changes led to increased use of the FCA, and a dramatic rise in civil damages paid into the U.S. Treasury under the Act. Large FCA recoveries undisputedly make good press for local United States Attorneys. Hence, it was predictable that abuse in the form of over-enforcement would shortly follow. The dirty little secret underlying FCA enforcement is that given the civil penalty provision and the costs and risks associated with litigation, the rational move for any healthcare provider accused of fraud is to settle the action even if the government’s likelihood of success is incredibly small. A short numerical example proves the point. Take a laboratory that submits 2,000 claims (each worth \$50) that DOJ asserts breach the FCA. The company’s potential liability under the FCA is \$20,300,000. That is, 2,000 claims times a potential \$10,000 penalty per claim (equals \$20,000,000), plus \$50 (the amount of damage per claim) times 2,000 (the amount of claims submitted), which equals \$100,000, which is then trebled for a sum of \$300,000. Add to that litigation costs of \$100,000 for a grand total of \$20,400,000. Assume the company believes that DOJ has only a one-percent chance of success. Multiplying the one percent to \$20,400,000 yields a sum of \$204,000, an amount that is more than double the amount of alleged single damages. That is the amount for which a rational company would settle the action.

Aggressive, politically-savvy United States Attorneys can do the math as well as anyone and hence the advent of “national initiatives.” The 72-Hour Window Project was the first national initiative spearheaded by the United States Attorney’s Office in the Middle District of

Pennsylvania. That project focused upon whether hospitals billed separately for outpatient services that had already been covered as part of the Medicare's inpatient payment. Although the project drew some criticism, for the most part it escaped detailed scrutiny because: (1) a number of Inspector General audits had questioned the practice (thereby providing hospitals with some notice regarding the government's interpretation of the rules); (2) the dollar amount of projected damages was relatively small; and (3) the United States Attorney's Office carefully tailored its letters so that the vast majority of hospitals would pay no more than an overpayment with no penalty. (For example, according to a July 1998 GAO Report, of the 2,400 hospitals that had settled with DOJ, about 1,700 were required to simply pay the estimated overpayment with interest.)

Having whetted its appetite for easy recoveries, another U.S. Attorney's Office embarked upon another massive project, the "lab unbundling project." This project investigated whether hospitals billed Medicare separately for each blood test performed concurrently on automated equipment. The U.S. Attorney's Office (and other Offices that pursued these claims) employed the same *modus operandi* as they did with the 72-Hour Window Project. That is, they wrote to hospitals and threatened treble damages and substantial civil penalties (while acknowledging that their Office had not investigated the facts underlying the hospitals' payment of claims) and invited the hospitals to prove their innocence in light of the United States Attorney's Office's blanket accusation. This project, however, drew substantially more criticism. First, unlike the 72-Hour Window Project the government had no paper trail establishing that the healthcare industry had notice regarding the government's interpretation of these rules. Second the projected dollar amount of overpayment was higher in many cases. Third, the government ultimately, as its "demand" letter made clear, was seeking more than simply an overpayment.

The lab unbundling project resulted in wholesale prosecutorial abuse. GAO's August 1999 report documents the extent of the government's overreaching. As the following examples revealed, U.S. Attorneys' Offices made broad allegations and threats when only a minimal review would have made clear that their expansive allegations lacked evidentiary support:

- “In 1997, one U.S. Attorney’s Office sent letters to about three dozen hospitals in the state alleging that the hospitals might have submitted false claims and asking them to volunteer to conduct self-audits of their laboratory billings. At this time, however, the officials had not verified the accuracy of the data they were relying on to support this allegation, nor did they have information showing that false claims were knowingly submitted. The office did not initially respond to hospital requests that it provide the data supporting its allegations of false claims. When some hospitals did not promptly decide whether to volunteer for self-audits, they were warned that the government would seek the full penalties of the False Claims Act if the office did the audits itself. The office continued to assert that hospitals had submitted false claims. For example, in a late 1997 letter to an attorney representing one of the hospitals, the office said it did not consider the matter to be a mere overpayment case. Rather, the letter said that the office would agree to settle the case for an amount equal to twice the overpayment, absent extenuating circumstances. Ultimately, the office obtained additional data that revealed that the original data used to select the hospitals for investigations had apparently overstated the hospitals’ billing errors. In late 1998, more than a year after the investigations had begun, the office concluded that about one-fourth

of the hospitals should not be pursued for False Claims Act violations.” *Medicare Fraud & Abuse*, at 12.

· “[Also] in 1997, another U.S. Attorney’s Office alleged that about 10 hospitals had violated the False Claims Act, but the office lacked evidence that the claims were false — let alone that the hospitals were knowingly submitting false claims. The allegations were based on a computer analysis of claims data that indicated these hospitals had received the largest overpayments from unbundling laboratory services. . . . According to the officials, all of the completed audits found insignificant billing errors that could not, in their view, support a False Claims Act case. Officials conceded that investigations against some, maybe all, of these hospitals might not have been started had they done a better analysis of the claims data” *Medicare Fraud & Abuse*, at 13.

Further, other GAO findings indicated that the United States Attorneys’ Offices’ approach was driven by headline-grabbing settlements rather than any perceived breach of the FCA:

· “In late 1997, one U.S. Attorney’s Office notified about two dozen hospitals that they were under investigation because the office had identified certain claims that may have been submitted in violation of the False Claims Act. However, officials told us in March 1999 that these hospitals had actually been selected primarily because they were the largest billers of Medicare in the state, not because the office had evidence that they were unbundling laboratory claims.” *Medicare Fraud & Abuse*, at 11.

Additionally, the GAO found that another United States Attorney's Office conceded that it lacked resources to comply with DOJ's guidelines:

- “Officials at another U.S. Attorney’s Office acknowledged making False Claims Act allegations against 75 hospitals in 1997 before obtaining sufficient evidence to support the allegations Officials told us that they did not know if [sic] these hospitals had knowingly submitted false claims at the time they made the allegations. Investigations against some of the hospitals were dropped after further analysis by the office indicated that the estimated overpayments to them were small [The Office] did indicate . . . that opening so many investigations at the same time had strained their resources and, as a result, establishing whether all of these hospitals had knowingly submitted false claims . . . would be time-consuming and difficult.” *Medicare Fraud & Abuse*, at 12.

DOJ National Initiatives Should Be Terminated. The GAO has found that DOJ's compliance with its own guidelines has been “superficial.” This finding is interesting because U.S. Attorneys' Offices have mandated that healthcare entities implement comprehensive compliance programs as part of settlement agreements which leads one to hope that these entities are more successful at adhering to their compliance guidelines than DOJ has proven to be at following its own compliance guidelines.

But DOJ's failure was predictable. Proper enforcement of the FCA is labor intensive, requiring the painstaking, accurate work of a team of auditors, investigators and prosecutors. Various U.S. Attorneys' Offices, lacking the resources to prosecute several FCA actions at one time, inverted normal law enforcement practices under which investigation precedes accusation

with national projects under which they would first accuse and then urge the accused to investigate themselves.

The nugget of truth underlying the latest GAO report on national initiatives is that U.S. Attorneys' Offices lack the resources to conduct national projects that are consistent with DOJ's guidelines, which now require an individualized determination that each entity has violated the FCA. That is why national projects — with their concomitant “demand” letters — were created in the first instance. That is also why DOJ's oversight and administration of the national projects have been superficial.

Rather than engage in a pretense of compliance with these guidelines, DOJ should simply abandon the concept of national projects, which is based upon the clearly erroneous premise that a significant number of entities in an industry that is substantially comprised of non-profit companies knowingly violate the law. The termination of these initiatives would also permit DOJ to eliminate an added layer of bureaucracy (the staffers charged with monitoring the Department's compliance) and allow the personnel to return to the serious duty of law enforcement utilizing proper law enforcement techniques that mandate investigation prior to accusation.