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Limiting The Scope Of The False Claims Act: The Tenth Circuit's Decision In *United States ex rel. Conner v. Salina Regional Health Center*

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In November 2008, the Department of Justice (DOJ) announced that it secured more than \$1.34 billion in False Claims Act (FCA) recoveries in fiscal year 2008. Almost the full amount of these recoveries – \$1.12 billion – stemmed from health care cases.

As DOJ stiffens its resolve to enforce the FCA, it is important to monitor FCA case law developments to evaluate areas that create the greatest risk of exposure to liability for health care companies.

Recently, a significant court decision shed important light on the potential scope of the FCA. In *United States ex rel. Conner v. Salina Regional Health Center*,¹ the Tenth Circuit considered the extent to which a private *qui tam* plaintiff (known as a “relator”)

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could invoke the FCA when that person, a physician, believed that a hospital did not provide him with adequate staff to perform surgery and violated other conditions of participation with which hospitals must comply to participate in the Medicare program.

The ruling addresses potential areas of exposure and important FCA defenses. More specifically, in *Salina Regional Health Center*, the Tenth Circuit appropriately ruled that a false hospital cost report certification does not breach the FCA if the false certification did not cause the government to pay additional funds to the hospital. The court's ruling will help to rein in some broader theories that *qui tam* plaintiffs have invoked under the FCA.

Salina Regional Health Center

In *Salina Regional Health Center*, the relator, an ophthalmologist and eye surgeon on the hospital's medical staff, contended that the hospital submitted false claims because, in its cost report, it certified that it complied with the rules and regulations governing the Medicare program when, in fact, the hospital had failed to comply with a number of Medicare's conditions of participation.² For example, the relator claimed that the defendant had failed to provide adequate nurses and other personnel; failed to establish a quality assurance program that meets regulatory standards; failed to properly maintain medical records; and dumped patients without proper screening, evaluation and treatment.³

Specifically, the relator asserted that if a hospital knowingly breaches any Medicare rule or regulation (no matter how trivial the violation), then all claims that the hospital submits are actionable under the FCA,

because a hospital official certifies in its cost report that he or she is “familiar with the laws and regulations regarding the provision of health care services, and the services identified in this cost report were provided in compliance with such laws and regulations.”⁴ The basis for the relator's theory is that the government would not have paid any claim if it had known of the false certification.⁵

In *Salina Regional Health Center*, however, the Tenth Circuit rejected the view that a false hospital cost report certification, by itself, triggers FCA liability. Specifically, the court pointed out that the FCA only applies if a false certification “leads the government to make a payment which it would not otherwise have made.”⁶ The court concluded that a hospital cost report certification does not serve this function. Instead, the court ruled that a hospital certifies compliance with Medicare rules, on the cost report, as a “condition of participation” – not a “condition of payment” – meaning that a hospital certifies compliance to maintain its ability to participate in the Medicare program and not simply to receive payment.⁷

The court based its conclusion on the plain language of the cost report certification, the fact that a false statement by itself (without a false or fraudulent demand for payment) does not create FCA liability, the remedial administrative process regarding participation in the Medicare program, and the policy that expert administrators – not private citizens or courts of law – ought to administer the Medicare program.

First, as to the cost report certification's plain language, the court pointed out that the certification, on its face, does not indicate that any non-compliance with a Medicare

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rule or regulation would result in denial of payment:

Although this certification represents compliance with underlying laws and regulations, it contains only general sweeping language and does not contain language stating that payment is conditioned on perfect compliance with any particular law or regulation. Nor does any underlying Medicare statute or regulation provide that payment is so conditioned. Thus, by arguing that the certification's language is adequate to create an express false certification claim, [the relator] fundamentally contends that any failure by [the hospital] to comply with any underlying Medicare-reimbursable service renders this certification false, and the resulting payments fraudulent. Lest there be any doubt about the potential impact of this proposed theory, [the relator] estimates that the United States has been damaged by [the hospital] in an amount exceeding \$100,000,000 per year in reliance on allegedly false certifications.⁸

Second, the court ruled that the cost report certification, standing by itself, was insufficient to create FCA liability because “[l]iability [under the FCA] does not arise merely because a false statement is included within a claim, but rather the claim itself must be false or fraudulent.”⁹ Thus, according to the court, a false certification did not create FCA exposure, unless that statement caused the government to pay a claim that it would not otherwise have paid.¹⁰ Here, that would not be true unless the government would refuse to pay for a particular item or service because, as the relator alleged, the hospital failed to provide adequate nurses and other personnel; failed to establish a quality assurance program that meets regulatory standards; failed to properly maintain medical records; and dumped patients without proper screening, evaluation and treatment. The court found that a mere regulatory breach of these regulations would not immediately disqualify the hospital from payment, and, hence, the false cost report certification could not result in FCA liability.¹¹ As the court noted, “[r]eading the FCA otherwise would undermine the government's own administrative scheme for ensuring that hospitals remain in compliance and for bringing them back into compliance when they fall short of what the Medicare regulations and statutes require.”¹² The court also noted that the relator did not cite any regulations or case law showing that the government normally seeks retroactive recovery of Medicare payments for services based upon violations of conditions of participation.¹³

Third, the court believed that Medicare's complex and remedial administrative process

supported its ruling that a cost report certification was a condition of participation, not a condition of payment. Specifically, the court noted that, before participation in the Medicare program, hospitals must undergo inspections and are subject to a “validation survey” that ensures ongoing compliance with Medicare conditions.¹⁴ However, if, as a result of the survey, a provider appears non-compliant, the government does not immediately suspend Medicare enrollment or billing privileges. Rather, the relevant regulations permit the provider to create a plan of correction and allow a reasonable period of time – usually 60 days – to address any deficiencies.¹⁵ Only after finding that the provider has not “substantially” complied may the government, at its discretion, terminate a Medicare participation agreement.¹⁶

Given this process, the court ruled that the hospital's cost report certification represents the provider's assurance that it continues to comply with the requirements of Medicare participation, because implied in this certification is the recognition that the provider could face consequences through the administrative procedures described above if it falls short of substantial compliance.¹⁷ However, because the court concluded that, in the first instance, *substantial* compliance – and not necessarily *perfect* compliance – was all that was required under the detailed administrative mechanism for managing Medicare participation, the cost report certification did not serve as a condition of payment.¹⁸

Fourth, the court concluded that policy considerations supported its ruling because, if relators were permitted to institute *qui tam* actions regarding a hospital's compliance with conditions of participation, then relators would be empowered to supplant the Medicare program's carefully crafted administrative review process and inappropriately transfer authority from expert administrators to determine whether Medicare's complex rules have been breached to unaccountable, non-elected private *qui tam* relators and ultimately courts of law:

[C]onsider if [the relator's] view of the certification were correct. An individual private litigant, ostensibly acting on behalf of the United States, could prevent the government from proceeding deliberately through the carefully crafted remedial process and could demand damages far in excess of the entire value of Medicare services performed by a hospital. If successful, the consequences of such an action would likely be catastrophic for hospitals that provide medical services to the financially disadvantaged and the elderly.... Further, rather than relying on the experience of state agencies to survey compliance, such a broad reading of the

FCA and the certification would burden the federal courts with deciding whether medical services were performed in full compliance with a host of Medicare statutes and regulations. As the Second Circuit has cautioned, “courts are not the best forum to resolve medical issues, concerning levels of care.” *Mikes*, 274 F.3d at 700. It is therefore with good reason that the agencies of the federal government, rather than the courts, manage Medicare participation in the first instance in cooperation with the states and accreditation organizations. See *id.* (“[P]ermitting *qui tam* plaintiffs to assert that defendants' quality of care failed to meet medical standards would promote federalization of medical malpractice, as the federal government or the *qui tam* relator would replace the aggrieved patient as plaintiff.”) And when an individual plaintiff is harmed, state tort law remains a powerful incentive for hospitals to provide quality care. There is thus no basis in either law or logic to adopt an express false certification theory that turns every violation of a Medicare regulation into the subject of an FCA *qui tam* suit.¹⁹

Conclusion

As the government's and relator's recoveries under the FCA continue to mount, the decision in *Salina Regional Health Center* offers hope that its precedent may chill *qui tam* plaintiffs – and their counsel – from invoking the sledgehammer of the FCA to police every potential technical, non-material violation of law. The court's decision also offers hope that other courts will also realize that expert health care administrators – and not self-interested, financially incentivized private citizens or non-expert courts – should evaluate compliance, in the first instance.

¹ 543 F.3d 1211 (10th Cir. 2008).

² 543 F.3d at 1214.

³ See United States ex rel. Conner v. Salina Regional Health Ctr. Inc., 459 F. Supp. 2d 1081, 1084 (D. Kan. 2006) (describing allegations), *aff'd* in relevant part, 543 F.3d 1211 (10th Cir. 2008).

⁴ 543 F.3d at 1218 (quoting 42 C.F.R. § 413.24(f)(4)(iv)).

⁵ *Id.*

⁶ *Id.* at 1219 (citations omitted).

⁷ *Id.* at 1220.

⁸ *Id.* at 1219.

⁹ *Id.* (quoting United States ex rel. A+ Homecare, Inc. v. Medshares Mgmt Grp., Inc., 400 F.3d 428, 443 (6th Cir. 2005)).

¹⁰ *Id.*

¹¹ *Id.* at 1219-20.

¹² *Id.* at 1220.

¹³ *Id.* at 1221.

¹⁴ *Id.* at 1220.

¹⁵ *Id.* at 1220-21 (citing 42 C.F.R. § 488.28(a), (c) & (d)).

¹⁶ *Id.* at 1221.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*