False Claim Act Whistleblower Cases Are Rising

(March 3, 2015): The federal False Claims Act (FCA), **31 U.S.C. §§ 3729 - 3733** is the primary civil enforcement tool utilized by the U.S. Department of Justice (DOJ). Enacted in 1863, this Civil War era statute was passed by Congress in an effort to address the fraudulent acts of government contractors providing goods and services to the Union Army. While originally passed to serve deter government military contracting fraud, the scope and use of the statute has greatly expanded over the last 150 years. False Claims Act whistleblower cases are rising, along the variety of allegations of health care fraud by individuals and entities . The purpose of this article is to examine the impact, if any, of the passage of the Patient Protection and Affordable Care Act (Affordable Care Act) on the number of health care "***qui tam***" (also commonly referred to as "***whistleblower***") cases that have been filed under the federal False Claims Act

I. Impact on the False Claims Act – Passage of the Affordable Care Act:

On March 23, 2010, President Obama signed the Affordable Care Act into law. While the primary purpose of the 906 page legislation was to make health care insurance accessible and affordable for millions of uninsured Americans, the law also introduced a number of fundamental changes to the False Claims Act. Several of these important changes are outlined below:

- ***The Affordable Care Act Amended the Definition of Two Key Terms Under the False Claims Act.***

Under the Affordable Care Act, the definition of the term ***"public disclosure"*** (as utilized under the False Claims Act) was amended to abolish the public disclosure bar. The definition of "public disclosure" was further revised to permit a *qui tam* relator to bring a whistleblower action that is based on allegations that have been previously disclosed in government or private litigation (as long as the relator meets the statutes "original source" requirements.

Prior to the passage of the Affordable Care Act, if a qui tam relator sought to bring an action based on public disclosures, the relator was required to qualify as an ***"original source"*** and have "direct and independent knowledge" of the facts alleged to constitute violations of the False Claims Act and have provided that information to the government prior to filing suit. Under the Affordable

Care Act, a *qui tam* relator is now only required to have "knowledge that is independent of and materially adds to the publicly disclosed allegations . . ." As you can imagine, this change makes it significantly easier for an individual to meet the False Claims Act's original source requirements.

Ultimately, the changes implemented under the Affordable Care Act to the False Claims Act's public disclosure bar and the original source doctrine have made it easier for a relator to file a case involving public disclosure issues

- ***The Affordable Care Act Defines Improperly Held Overpayments as an "Obligation," Within the Meaning of the False Claims Act.***

Under the Affordable Care Act, a health care provider's liability under the False Claims Act was significantly broadened to cover identified "overpayments" that were improperly retained for more than 60 days. More specifically, 42 U.S.C. 1320a-7k(d) was revised to define "overpayments" as "Medicare funds received or retained to which a person is not entitled, after applicable reconciliation." Overpayments must be reported and returned to the government (typically a Medicare Administrative Contractor) within 60 days of identification. Should a health care provider fail to return an overpayment within the statutorily required period, the overpayment then qualifies as an "obligation," thereby subjecting the provider to liability under the False Claims Act.

- ***The Affordable Care Act Makes it Clear that a Violation of the Federal Anti-Kickback Statute May Also Constitute a Violation of the False Claims Act.***

As set out in §6402(f)(1) of the Affordable Care Act, any claims constituting a violation of the federal Anti-Kickback Statute (42 U.S.C. §1320a-7b(b)) qualify as "claims" for purposes of the False Claims Act (31 U.S.C. §§ 3729 et seq.). In addition to this fundamental change, the Affordable Care Act also arguably lowers the scienter and intent standards required for a violation of the Anti-Kickback Statute. As §6402(f)(2) of the Affordable Care Act provides, in order for an individual or entity to commit a violation of the federal health care Anti-Kickback Statute ***"a person need not have actual knowledge of this section or specific intent to commit a violation of this section."***

II. False Claims Act Whistleblower Cases are Growing:

Collectively, the changes set out above make it much easier for both a relator and the government to bring a False Claims Act case against a health care provider or supplier. Notably, the number of new health care *qui tam* cases filed in 2010 (the Affordable Care Act was signed into law on March 23, 2010) rose to 385, a new high at that point in time. In FY 2013, the number of health care qui tam cases reached an all-time of 501 cases. While there was a slight drop (to 469 cases) in the number of health care qui tam cases filed in FY 2014, all indications are that FY 2015 may again challenge the record of cases filed in FY 2013.

III. Overview of the False Claims Act's Qui Tam Provisions:

One of the most unique elements of the False Claims Act is that it authorizes private parties having direct knowledge of fraudulent conduct to bring a civil suit (on behalf of the government) against an individual or entity that has violated the statute. These civil suits are known as "*qui tam"* actions, and the private parties who initiate such actions are called "relators". Qualified relators may share in any monies recovered as a result of their *qui tam* action.[1]

A *qui tam* action is initiated when a relator files a Complaint – along with supporting documentation – "under seal" in federal court. When a case is filed under seal, it means that all records associated with the whistleblower are maintained on a non-public docket by the Clerk of the Court. A copy of the complaint is given to the judge assigned to the case. The relator's attorney also serves a copy of the complaint on the Attorney General in Washington, D.C. and on the U.S. Attorney in the federal judicial district in which the case has been filed.[2] By statute, the government is initially given 60 days to evaluate whether to "intervene" in the *qui tam* case that has been brought against the defendant. In almost all cases, the government will seek an extension to allow it an opportunity to further investigate the allegations. After showing "good cause" for an extension, most federal courts readily grant the government's request for an extension. It is not at all uncommon for a *qui tam* to remain under seal for over a year (and often much longer) while the government reviews the allegations. The seal is important for several reasons:

- ***The government can quietly investigate the allegations without the defendant knowing that their company is under investigation.***
- ***The mere existence of a government investigation can be devastating on the public's view of a company. Moreover, if a company is publicly-traded, the publicity surrounding a government investigation can severely affect the price of a company's stock—despite the fact that the allegations at issue have not been investigated or proven at this point in the process.***

After concluding its evaluation, the government may elect to proceed with the complaint and intervene in the case or it may decline to intervene. If the government decides to intervene in the action, then the relator has the right to remain a party to the action. If the government decides not to intervene in the case, the *qui tam* relator may elect to proceed on his or her own against the defendant. Notably, the government always retains the ability to intervene in the case at a later time. From a practical standpoint, if the government decides not to intervene in a case, in all likelihood the relator will seek to dismiss the suit. Unlike the government, a relator's ability to investigate a False Claims Act case is quite limited, both in terms of resources and in terms of investigative tools. As a result, the government's decision to decline to intervene severely impacts a relator's ability to move forward with the case.

IV. What Can You Do to Reduce the Likelihood of a False Claims Act Whistleblower Case:

In light of the changes to the Affordable Care Act outlined above, it is imperative that health care providers and suppliers comply with all applicable medical necessity, documentation, coding and billing regulations. An effective Compliance Program can serve as an invaluable tool and can greatly assist providers and suppliers in their efforts to stay within the four corners of the law. As Supreme Court Justice Oliver Wendell Holmes wrote:

***"Men must turn square corners when they deal with the Government."*[3]**

Effectively, Justice Holmes' comment serves as a continuing caution for individuals and entities who participate in government programs. Unfortunately, it isn't always that easy for a health care provider or supplier to determine whether an overpayment exists, especially in complex cases where a patient has secondary insurance and/or the number of claims processed (as charges, credits, and corrections) may be quite large. Additionally, due to the complexity of Medicare coverage and payment rules, two reasonable individuals may disagree as to whether an overpayment is present. Despite the fact that two reasonable minds may disagree on whether an overpayment exists, the fact remains that a health care provider or supplier is ultimately responsible for repaying any overpayments due to the government. In order to avoid potential False Claims Act liability, it is imperative that you fully research any outstanding issues and determine the scope of any overpayment to be reported and repaid to the government.

V. Final Remarks:

An effective compliance plan can assist in the identification and proper handling of overpayments, thereby reducing the provider's risk of committing a violation of the False Claims Act. Health care providers and suppliers should review their current Compliance Plan to better ensure that internal audit and review mechanisms are in place so that any overpayments can be readily identified and repaid to the government within the 60-day deadline. The decision of whether to disclose and return an overpayment, whether to a MAC, the Department of Health and Human Services – Office of inspector General (HHS-OIG), or to the Department of Justice (DOJ), may differ depending on the facts. Depending on the size or complexity of an overpayment, a health care provider may need to contact legal counsel for advice on how to best handle a specific overpayment. Due to the 60-day deadline, if legal counsel is to be involved, they should be contacted as soon as possible.

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[1] Relators can receive between 15% and 25% of any recovery in a *qui tam* action where the government has intervened in the case. In a non-intervened case, a relator may recover up to 30%. Consequently, there is a tremendous financial incentive to file and pursue these types of actions.

[2] The relator must also serve a "disclosure statement" on DOJ (normally, it is provided to the U.S. Attorney's Office) which sets out the evidence that the relator has in support of the allegations set out in his/her Complaint. This statement is not filed with the Complaint.

[3] *Rock I., Ark. & La. R.R. v. United States. 254 U.S*. 141. 143 (1920). As Supreme Court Justice Felix Frankfurter commented, this statement "does not reflect a callous outlook. It merely expresses the duty of all courts to observe the conditions defined by Congress for charging the public treasury " *Federal Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).