HEALTHCARE LITIGATION NEWS

ESSENTIAL LEGAL UPDATES FOR THE HEALTHCARE INDUSTRY | WINTER 2008

United States Supreme Court Will Decide Whether False Claims Act Requires Presentment of Claims

On October 29, 2007, the United States Supreme Court granted a writ of certiorari and agreed to review the Sixth Circuit Court of Appeals' decision in *United States ex rel. Sanders v. Allison Engine Co., Inc.* In that case, the Sixth Circuit reversed a district court decision that the plaintiff-relators must prove that false claims were "presented" to the federal government for payment. Specially, the Sixth Circuit concluded that "presentment" of the claims to the federal government was not required to prove a violation of the False Claims Act. The Sixth Circuit concluded that the False Claims Act "covers all claims to government money, even if the claimant does not have a direct connection to the government." The Sixth Circuit's opinion conflicts with the opinion reached by the D.C. Circuit in *United States ex rel. Totten v. Bombardier Corp.* In that case, the D.C. Circuit concluded that the False Claims Act does require presentment of false claims to the government in order for there to be liability under certain sections of the Act. Current Supreme Court Chief Justice John Roberts authored the *Totten* opinion when he served on the D.C. Circuit Court. The Third, Eighth and Eleventh Circuit Courts have all agreed with the D.C. Circuit Court's holding in *Totten*. Thus, the Supreme Court's review of *Sanders* should resolve the conflict between Circuit Courts.

Specifically before the Supreme Court is the question of whether a plaintiff alleging a False Claims Act claim under 31 U.S.C. § 3729a(2) or 31 U.S.C. 3729(a)(3) must prove that a party actually submitted a false claim to the federal government or whether it is sufficient to show that federal funds were used to pay the claim. The Court's decision will certainly affect the scope of the False Claims Act, potentially expanding liability under the Act. For example, if the Supreme Court decides that a party is subject to False Claims Act liability by making a false claim that was paid using federal funds (and not necessarily submitted to the federal government), then any person who submits a claim to an entity that (1) received federal dollars and (2) possibly used those dollars to pay the person's claim could be subject to False Claims Act liability. As such, even persons who receive funding or payments from a person who happen to receive federal funds (including a physician who receives Medicare dollars or a healthcare organization that receives federal grant dollars) could be subject to False Claims Act liability even if they never submitted a claim for payment directly to the federal government. Such a ruling – coupled with the increasing trend towards recognizing implied certification of compliance with federal laws – would expand the False Claims Act's reach. Numerous individuals and organizations never subject to False Claims Act liability for treble damages and mandatory fines and penalties would then be open to potential liability.

Even if the Supreme Court reverses the Sixth Circuit's opinion, it is possible that "presentment" could still be a requirement of the past. Indeed, as discussed elsewhere, the United States Senate is considering a bill that proposes to revise the False Claims Act so that it expressly eliminates the requirement that a false claim be presented to the government before liability under the Act may attach. Thus, healthcare providers and organizations should take extra caution when conducting any transactions involving payments from entities or individuals that receive federal funds. ■

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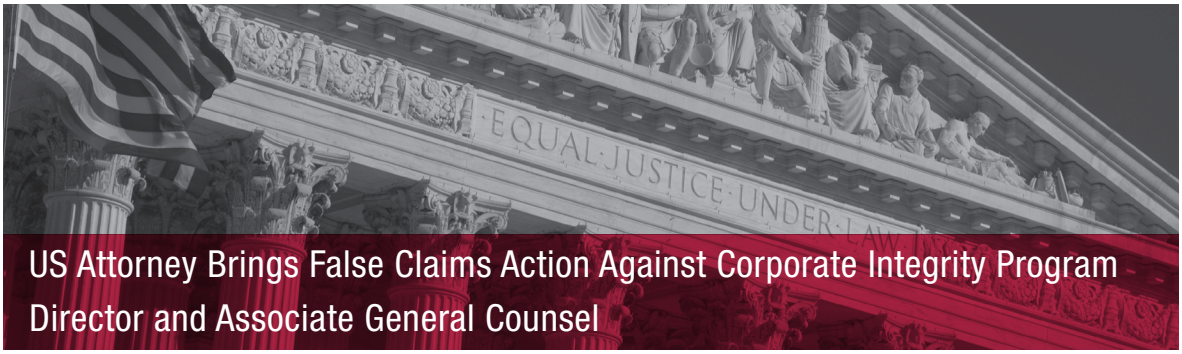

US Attorney Brings False Claims Action Against Corporate Integrity Program Director and Associate General Counsel

A recent case filed in federal court in Florida illustrates that individuals, not just large institutional healthcare providers, must be aware that they may be potentially liable for alleged fraud and abuse. In *United States of America v. Sulzbach,* (filed September 18, 2007 in the United States District Court for the Southern District of Florida), the United States Attorney's Office seeks to impose civil liability on a former Corporate Integrity Program Director and Associate General Counsel in connection with alleged false reimbursement claims submitted to the Medicare program.

The Complaint alleges that the Corporate Integrity Program Director submitted false certifications of program compliance to the government, and failed to stop her employer from violating the law and to report the violations to the government. According to the Complaint, two existing companies merged in 1995 to form Tenet Healthcare Corporation (which operates hospitals throughout the United States). One of the companies, National Medical Enterprises, Inc., ("NME") was operating prior to the merger under a Corporate Integrity Agreement with the government. NME executed the agreement in June 1994 to settle allegations that it had engaged in illegal conduct. After the merger, Tenet continued to operate under the Corporate Integrity Agreement, according to the Complaint.

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The agreement allegedly required Tenet to provide the Department of Health and Human Services with, among other things, annual compliance reports that certified that the company was in compliance or

Widespread Changes Proposed to False Claims Act

Both chambers of Congress are considering legislation that would propose sweeping amendments to the False Claims Act. On September 12, 2007, Senator Charles Grassley (R-Iowa) introduced Senate Bill 2041, which is co-sponsored by Senators Richard Durbin (D-Illinois), Patrick Leahy (D-Vermont), Arlen Specter (R-Pennsylvania) and Sheldon Whitehouse (D-Rhode Island).

Titled the "False Claims Act Correction Act of 2007," S. 2041 would significantly alter the False Claims Act, as it has been construed by the federal courts since the passage of the 1986 amendments to the Act. In particular, the proposed changes would:

- eliminate the requirement that any false claim be presented directly to the federal government.
- vitiate the United States Supreme Court ruling in *Rockwell Int'l Corp. et al v. United States* by drastically limiting the availability of the "public disclosure" and "original source" defenses to False Claims Act claims.
- narrow the definition of "publicly disclosed information." *Qui tam* relators cannot bring a False Claims Act claim based on information that is publicly available. The offered revisions would exclude as "publicly disclosed information" any information that is obtained through the Freedom of Information Act or exchanges with law enforcement or federal government employees.
- allow relators to review any information obtained by the Department of Justice through its investigations of potential violators of the False Claims Act.
- revise the statute of limitations on False Claims Act claims from six years to ten years and allow additional government claims to "relate back" to the date on which the *qui tam* suit is filed under seal. Since these cases may remain sealed for several years, this "relation back" provision undercuts the limitations periods for these other claims and makes it difficult to know whether a claim is time barred.
- expand the False Claims Act protections against whistleblower retaliation to cover agents and government contractors (in addition to employees) who suffer discriminatory treatment because of acts they or certain others take to stop a False Claims Act violation.

The House of Representatives is also considering similar legislation. House Bill 4854, introduced and sponsored by Representative Howard Berman (D-CA), proposes virtually all of the same changes offered in S. 2041. Unlike S. 2041, it also seeks to nullify the more stringent pleading requirements established under Federal Rule of Civil Procedure 9(b) for fraud-based claims. And, it calls for retroactive application of the amendments to any claim pending in any court on the effective date of the new legislation.

Currently before the Senate and House Judiciary Committees, these two bills would greatly expand the reach of the Justice Department as it attempts to curb fraud, waste and abuse in the federal government. Consequently, healthcare organizations and providers may face even greater risk of False Claims Act liability. ■

noncompliance with federal program legal requirements. In 1997, a Tenet executive allegedly wrote an internal memorandum expressing concern that certain physician employment contracts at a Tenet hospital violated the Stark statute. The matter was referred to the Corporate Integrity Program Director, who also served as Associate General Counsel at Tenet. After reviewing the memorandum, the Corporate Integrity Program Director allegedly retained an outside law firm to opine on the various physician contracts. According to the Complaint filed by the United States Attorney's Office, the law firm concluded that the physician employment agreements were illegal under the Stark law. In particular, the law firm's report allegedly found that a number of the physicians were

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compensated in amounts that exceeded the net revenue generated by their practices and that the physicians' compensation was tied to the volume of laboratory referrals the physician made to the hospital.

The Complaint claims that shortly after receiving the law firm's report showing that the physician contracts were illegal, Tenet submitted its annual compliance report to the government as required by the Corporate Integrity Agreement. As part of this report, the Corporate Integrity Program Director allegedly signed a sworn declaration stating the annual compliance report had been prepared under her direction, and that to the best of her knowledge Tenet was in material compliance with all federal program regulations. And, despite receiving the outside firm's report that the physician employment contracts with the hospital violated Stark, Tenet allegedly continued to illegally bill Medicare for referrals from these employed physicians.

Not surprisingly, when the government discovered the report from the outside law firm (which was apparently obtained as part of a settlement Tenet made with the government in which it agreed to pay $920 million to resolve various fraud and overcharge claims), it considered the sworn declarations of the Corporate Integrity Program Director to be false. Despite having received a large settlement for its previous fraud and overcharge claims, the government elected to bring a separate action directly against the Corporate Integrity Program Director.

The US Attorney's Complaint seeks to impose personal liability on the Corporate Integrity Program Director, and seeks to recover treble damages and penalties from her, less the "partial payment" the government allegedly received from previous settlements with Tenet. Although the Complaint does not specify the amount of damages sought, it may be safely inferred from the facts alleged that the government claims against the Corporate Integrity Program Director involve extremely large sums. This case illustrates at least two important points. First, all certifications made in connection with reimbursement claims to the federal government must be carefully reviewed to ensure their accuracy prior to submission to the federal government. Second, in appropriate circumstances, individuals who make such certifications may be held personally liable if the certifications are false. Such liability can be imposed even if the individual makes such certifications not for his or her own personal reimbursement claims, but on behalf of an institutional provider or other healthcare entity. ■

Healthcare Litigation Updates

- **The Centers for Medicare &** Medicaid Services ("CMS") released the Stark II, Phase III final rule on August 27, 2007. It was published in the *Federal Register* on September 5, 2007 and became effective on December 5, 2007. CMS is delaying until December 4, 2008 the effective date of the Phase III "stand in the shoes" provisions for certain compensation arrangements involving physician organizations and academic medical centers or integrated 501(c)(3) healthcare systems. Notice of the delay was published in the November 15, 2007 *Federal Register*.
- **On July 12, 2007, the House of** Representatives introduced House Bill 3013, the Attorney-Client Privilege Protection Act of 2007 (which was introduced by the Senate earlier in January 2007 and was the subject of Senate Judiciary Committee hearings in September 2007). The Attorney-Client Privilege Protection Act would provide healthcare entities (and other organizations) with relief from the federal prosecutorial guidelines established in the Department of Justice's McNulty Memorandum. The House Bill, which was amended and passed, as amended, and on November 13, 2007, was received in the Senate and referred to the Senate Judiciary Committee the next day.

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Healthcare Litigation Updates *(Continued from inside)*

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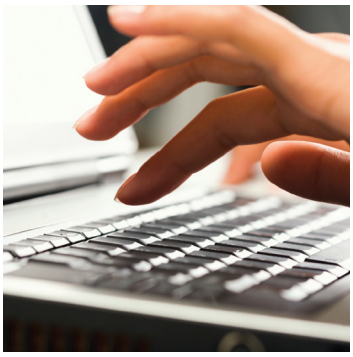

- **In early October 2007, the Department** of Health & Human Services (HHS) Office of the Inspector General (OIG) released its 2008 Work Plan, which delineates those programs and activities that will undergo additional evaluation and scrutiny in 2008 and 2009. The Plan targets several Centers for Medicare & Medicaid Services (CMS) programs for further investigation. For example, OIG plans to investigate payments made to Medicare inpatient hospitals for "new services and technologies," payments made to long-term care hospitals, Medicare providers' bad debt payments and recoveries of prior year write-offs, the accuracy of coding and claims associated with Home Health Resource Groups, nursing facility cost reports for compliance with guidelines under the Provider Reimbursement Manual, the appropriateness of payments for hospice care in nursing homes, Medicare "incident to" services, Medicaid payments made to nursing homes for patients transferred to hospitals, Medicaid Home Health Agency claims, and Medicaid payments to providers for transportation services.

- **On June 12, 2007, the Eleventh Circuit** Court of Appeals declined to recognize the medical peer review privilege in federal discrimination cases. In *Adkins v. Christie*, although the Eleventh Circuit acknowledged that all fifty states and the District of Columbia recognize a medical peer review privilege for documents relating to medical peer review proceedings, it concluded that the goal of the privilege – i.e., "vigorous oversight of physicians' performance" – did not outweigh or override the goal of determining whether there has been employment discrimination against a particular physician. In so holding, the Eleventh Circuit follows the lead of the Fourth and Seventh Circuits in refusing to recognize the medical peer review privilege in the context of federal discrimination and antitrust claims, respectively. The defendant hospital, hospital administrator and individual staff physicians who served on the hospital's medical executive committee all filed with the United States Supreme Court a petition for a writ of certiorari, which the Court denied on January 7, 2008. ■

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