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FERA Amendments to False Claims Act Likely to Generate More Cases Against Healthcare Providers

Recent substantive and procedural amendments to the Federal False Claims Act (“FCA”) enacted under the Fraud Enforcement and Recovery Act of 2009 (“FERA”) are expected to fuel growth in the number of whistleblower-generated cases brought against healthcare providers—including LTACHs. The FERA amendments closed a loophole in the FCA that previously prevented overpayment cases from being brought against providers. The FCA now allows whistleblowers to bring false claims actions against providers who knowingly and improperly keep government funds paid to them in error. FERA was signed into law May 20, 2009.

Retention of Overpayments

FERA expands the “reverse false claim” provision of the FCA, which now makes even the retention of funds that were paid in error a violation. In the past, the government rarely pursued an entity that obtained or received funds in error. FERA now explicitly states that *concealing or avoiding the “obligation” to return funds is a violation of the FCA*. FERA broadly defines an “obligation” as an “established duty, whether or not fixed,” that can arise from a variety of contractual relationships. Additionally, the provision makes it a violation to conspire to violate the reverse claim section of the statute.

This amendment resolves past confusion about whether repayment is in fact mandatory. However, the length of time required for retention of an overpayment to become a liability remains unclear, as well as what constitutes a reasonable repayment period. Government prosecutors and investigators, however, have recently indicated that healthcare providers may continue to retain excess payments for a reasonable period of time pending

audits or payment reconciliations. Further, FERA appears vague as to whether the new provision applies to overpayments made prior to passage of the legislation.

Reversal of *Allison Engine*

FERA also legislatively reverses the Supreme Court’s 2008 *Allison Engine Co. v. U.S.* decision. In *Allison Engine*, relators filed a *qui tam* suit against subcontractors for allegedly violating the FCA. *Allison Engine* held that subcontractors on a Navy project were not liable under the FCA because they submitted false compliance certifications to the primary contractor and not directly to the government. The Court further held that because the primary contractor, not the government, paid the falsified bill, the suit failed to prove that the subcontractor “intended that the false record or statement be material to the government’s decision to pay or approve the false claim.”

FERA reverses *Allison Engine* by expanding the chain of liability to include entities that *directly or indirectly make claims for government funds*. This means that a false record or statement need only be “material to a false or fraudulent claim.” FERA amends the FCA by broadly defining “materiality” as a record or statement “having a natural tendency to influence, or being capable of influencing, the payment of receipt of money or property.” “Claim” is now defined as a request for money, regardless of “whether or not the United States has title to the money or property.” *This means that intent to submit a false claim is now irrelevant*. Liability attaches even if a subcontractor is unaware that Federal funds are implicated. The legislative reversal of *Allison Engine* applies retroactively to cases pending in Federal courts as of June 7, 2008—two days prior to the *Allison Engine* decision.

FERA further expands the types of relationships that give rise to FCA liability by removing the “presentment” requirement. Presentment previously

required that a claim actually be “presented” to a government officer or employee. This revision eliminates the requirement that the claim be submitted to the government. This presentment requirement also applies to state Medicaid programs.

Expanding Whistleblower Protections

FERA expands *qui tam* relator “whistleblower” to contractors or agents that may report fraud. Some of these individuals may now fall outside the scope of employee relationships. In the past, employee whistleblowers only received protection if they took actions in furtherance of an FCA action. *FERA extends the scope of protection to individuals that make an effort to stop a violation*, whether or not that effort was made in furtherance of a *qui tam* suit. Therefore, the revised statute seeks to provide protection for an employee, contractor or agent who reports misconduct to their employer or company before a suit is filed.

Furthermore, procedural changes made to the FCA will impact the way the government investigates and litigates FCA claims. *FERA expands the amount of information available to relators by allowing them to access information gained through government subpoenas*. FERA increases utilization and sharing of Civil Investigative Demand information with relators, consultants and counsel. Additionally, FERA allows the government to share information gathered by relators with state and local law enforcement. These changes not only increase a relator’s access to information but also expand an entity’s potential liability at the state and local level.

Expansion of the Statute of Limitations

FERA allows a government complaint to relate back to an original relator’s complaint. This change allows for a delayed intervention by the government and inhibits a defendant’s ability to build a defense. Since complaints are often filed under seal, this eliminates the defendant’s benefit of notice. Years may pass before a defendant is notified of a *qui tam* action.

Recommendations

Both Federal investigators and the OIG in its 2010 Work Plan have reaffirmed that heightened FCA enforcement is a priority. Healthcare providers therefore should take steps to minimize exposure to severe financial penalties by:

- Updating outdated or incomplete compliance programs and record retention policies;
- Updating current billing procedures to screen funds received and identify overpayments;
- Ensuring that voluntary disclosure programs are in place to root out potential fraud; and
- Scrutinizing contracts that may involve government funding.

Key Guidance Provided Regarding Application of MMSEA Exceptions to LTACH Development, Relocation and Changes of Ownership

Section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”) established, among other things, a three-year temporary moratorium on the establishment of new LTACHs and LTACH beds, subject to certain limited exceptions. When rules implementing the moratorium were released by CMS in an Interim Final Rule on May 22, 2008, CMS did not specify which change of ownership and facility relocation activities by existing LTACHs and LTACH satellites would continue to be permitted under the moratorium. In fact, CMS specifically advised the industry that such questions should be directed to their Medicare Administrative Contractors, and that the CMS Regional Office would address specific situations on a case-by-case basis.

Having been bombarded by recurring questions from LTACHs, trade organizations, consultants and attorneys, CMS relented in its Final Rule for rate year (“RY”) 2010 by providing the following key guidance (see 74 FR 43989-43990, Aug. 27, 2009):

1. Is an existing LTACH or an existing satellite permitted to relocate? An existing LTACH or satellite may relocate in accordance with state survey

agency policies as long as there is no increase in the number of beds at the new site. For example, if state surveyors would typically allow LTACH A with 100 beds to move to a building 8 miles away and LTACH A maintains the same provider agreement, the moratorium would not preclude the re-opening of the 100 bed LTACH in the new location. However if an LTACH has a new provider agreement at the new location, it would be a new LTACH and therefore would be subject to the moratorium.

2. May an LTACH under development that meets an MMSEA moratorium exception undergo a change in ownership?

Qualifying Period Exception. A new LTACH that meets one or more of the exceptions at sections 114(d)(2)(A), (B) and (C) of MMSEA may undergo a “change of ownership” (see change of ownership guidelines listed in 42 C.F.R. 489.18) and may still qualify for the exception, if certain requirements are met. Specifically, if meeting the “qualifying period” exception at section 114(d)(2)(A) (i.e., a facility began its qualifying period for payment as an LTACH on or before December 29, 2007), a change of ownership where the new owner takes over the original provider agreement would not affect the hospital’s qualification for an exception.

Written Development Agreement and Capital Expenditure Requirement. If the hospital or entity claims to meet the exception set forth at section 114(d)(2)(B) (i.e., that it has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for an LTACH, and has expended before December 29, 2007, at least 10% of the estimated cost of the project (or, if less, \$2,500,000), but the developing entity was sold, eligibility for the exception can be granted to the original owner. However, a determination would be made by the CMS Regional Office responsible for initially granting the exception regarding whether it is still the same LTACH or entity that would meet the requirements of section 114(c)(2)(B) of MMSEA.

CON Approval. Finally, if the hospital or entity developing the LTACH is basing its exception on section 114(c)(2)(C) of the MMSEA (i.e., that a CON was obtained in a state where one was required on or before December 29, 2007), a determination would need to be made by the state agency regarding whether the originally-issued CON is transferable to a new owner or whether a new CON would be required in order to proceed. If a new CON is required, the hospital or entity would not meet the statutory December 29, 2007 deadline and therefore, would not qualify for an exception to the moratorium.

3. May an existing LTACH merge with another LTACH? CMS would apply its longstanding policy regarding hospital mergers so that the merger of two LTACHs would result in one LTACH’s provider number being voluntarily terminated and the other serving as the provider number for the new entity. The moratorium on the increase in hospital beds would apply to the sum of the beds that existed in both LTACHs as of December 29, 2007.

4. Are two satellites of the same LTACH permitted to consolidate? Two satellites of the same LTACH are not permitted to consolidate during the moratorium. The reason for this is that the result of the satellites consolidating would be an increase in the number of beds in one satellite, which is precluded by section 114(d)(1)(B) of the MMSEA.

5. How does the moratorium affect a remote location of a LTACH? Section 114(d) of the MMSEA does not subject remote locations to the moratorium, but it is still essential to determine if the facility in question is actually a “remote location—and not a satellite of a LTACH.” If the “remote location” is located on the campus of another hospital, it is defined as a satellite under 42 C.F.R. 412.22(h), and is subject to the moratorium. A remote location of an LTACH that is not a satellite, because it is provider-based and not co-located with another hospital, however, would operate under the provider number of its main LTACH. Therefore, where establishing a remote location adds beds under that provider number, in the aggregate, it is subject to the moratorium.

6. Is an LTACH permitted to reduce its bed count and open a remote location (not a satellite) with those beds so that there is no increase in bed count under the LTACH's provider number? If an LTACH adds a provider-based location that does not increase the aggregate number of beds at the LTACH, because it has decreased the number of beds at the main campus by at least an equivalent number of beds, the LTACH would not have violated the moratorium. A reduction in the number of beds at an LTACH and an equivalent increase in the number of beds at its satellite, however, would be prohibited by section 114(d)(1)(B) of the MMSEA.

7. Does the moratorium have any impact on the ability of a new Inpatient Rehabilitation Facility (IRF) or Inpatient Psychiatric Facility (IPF) to co-locate with an existing LTACH without affecting its Medicare certification? The moratorium provisions have no impact on whether an IRF or an IPF may co-locate with an existing LTACH. All providers that would be affected by the co-location, however, would be required to comply with "separateness and control" regulations at 42 C.F.R. 412.22(e) and the existing LTACH would be required to meet the notification requirements at § 412.22(e)(3) (i.e., the LTACH would be required to notify CMS in writing of its co-location and provide the name, address, and Medicare provider number of those hospital(s) with which it is co-located).

8. May a new owner of an LTACH obtain a new Medicare provider agreement as part of a change of ownership without being required to satisfy an MMSEA exception. CMS noted that in the sale of an LTACH (generally its assets) to a new owner, there is a significant difference between a situation where a new owner assumes the old owner's provider agreement versus a situation where a new provider agreement is sought by a new owner. Obtaining a new provider agreement is considered to be tantamount to developing a new LTACH—an activity precluded by the MMSEA unless one of the above statutory exceptions is met. This is consistent with CMS's longstanding policy intended to encourage

successor parties (even those purchasing assets) to assume a seller's Medicare provider agreement. Therefore, where an asset sale and purchase is contemplated, a potential purchaser would be prudent to perform extensive due diligence regarding seller's Medicare billing and coding practices, known reimbursement errors and outstanding WPS, RAC and RAC-type audits.

Be on the Lookout For—

Red Flag Rules Update: Hope for Healthcare Providers. The House Financial Services Committee is sending legislation (H.R. 3763) to the floor that addresses concerns over Federal Trade Commission rules requiring a broadly defined mix of "creditors," including healthcare providers, to implement identity theft prevention programs. With the "red flag" rules compliance deadline slated for November 1, 2009, the bill, introduced by Rep. John Adler (D-New Jersey), would exclude health care, accounting, and legal practices with 20 or fewer employees from the "creditor" category. The legislation has two co-sponsors: Reps. Paul Broun (R-Georgia) and Mike Simpson (R-Idaho). Under the FTC rules, creditors are required to develop programs to identify relevant patterns, practices, and specific activities that are "red flags" for possible identity theft.

Monthly LTACH Poll Results

Which post-acute care provider do you think will benefit the most if comprehensive healthcare reform legislation is passed? (16 votes)

- Home health agencies (13%)
- Hospices (0%)
- Inpatient rehabilitation facilities (6%)
- *LTACHs* (56%)
- Skilled nursing facilities (25%)

Which post-acute care provider do you think will benefit the least if comprehensive healthcare reform legislation is passed? (15 votes)

- Home health agencies (20%)
- Hospices (27%)
- Inpatient rehabilitation facilities (6.5%)
- LTACHs (6.5%)
- *Skilled nursing facilities (40%)*

Other Recent GreisGuide Posts

- [The Future of LTACHs: A Case Study for Industry Consolidation](#)
- [Senate Finance Committee Approves Health Care Reform Bill and Moves toward Reconciliation](#)
- [Proposed Healthcare Legislation: Effects on Tax-Exempt Organizations](#)

Upcoming Events

- Oct. 20: [CECC-Sponsored Panel Discussion: Withholding and Withdrawing Artificial Nutrition and Hydration: Medicine, Ethics and Religion](#)
- Oct. 21: [McGladrey Webcast: Seller Preparation: Leveling the Playing Field in a Buyer's Market](#)
- Oct. 22: [McGladrey Webcast: Preparing Your Portfolio Companies for Exit](#)
- Oct. 21-23: [2009 NALTH Mid-Year Event: Physician Education Clinical Conference](#)
- Oct. 29: [AHLA Teleconference: False Claims Act Enforcement for the Health Industry-The FERA Game Changer for Compliance and Enforcement](#)
- Nov. 2-4: [AHLA Fundamentals of Health Law Conference](#)
- Dec. 3-5: [ALTHA Advocacy Meeting: Making the Case for Long Term Acute Care Hospitals and Post-Acute Care Providers](#)
- Jan. 13-15, 2010: [ALTHA 2010 National Clinical Conference](#)
- Feb. 17-19: [AHLA 2010 Long Term Care and the Law Conference](#)

- Mar. 25: [ALTHA Capital Markets Meeting](#)

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