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EXPANSIVE THEORY OF LIABILITY FOR MEDICARE CLAIMS STRUCK DOWN

Christopher Cook and Nolan Young

A United States court of appeals has rejected a theory of False Claims Act (FCA) liability that, if adopted, could have had devastating consequences for hospitals and other Medicare providers. In *United States ex rel. Conner v. Salina Regional Health Center, Inc.*,[1] the Tenth Circuit held that an allegedly false certification on a hospital's Medicare cost report does not automatically render false all claims submitted by that provider. Instead, the court imposed a materiality requirement on such "false certification" claims under the FCA, holding that liability attaches only if the false certification "[led] the government to make a payment which it otherwise would not have made."

On October 2, 2008, the United States Court of Appeals for the Tenth Circuit affirmed the dismissal of a *qui tam* action under the FCA that alleged that the Kansas hospital fraudulently submitted claims for Medicare payment by falsely certifying in its Medicare cost reports that it was in compliance with all Medicare laws and regulations. Had the court accepted the whistleblower's theory of liability, hospitals would have been subject to liability under the FCA and treble damages for any regulatory violation, even if it had no impact on reimbursement. Moreover, the potential damages would have been devastating—three times the entire Medicare reimbursement for each of the years in question.

1 543 F.3d 1211 (10th Cir. 2008).

A version of this article appeared in the January 2009 issue of the Health Care Compliance Association's *Compliance Today.*

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In rejecting the whistleblower's theory, the court established two important propositions: (1) allegedly false certifications of compliance with Medicare laws and regulations contained in a provider's annual Medicare cost report do not render all claims for reimbursement submitted by that provider false within the meaning of the FCA; and (2) alleged violations of Medicare conditions of participation, as opposed to conditions of payment, do not trigger liability under the FCA.

BACKGROUND

This case arises out of a *qui tam* complaint filed in 2001 against Salina Regional Health Center (SRHC) in Salina, Kansas, by relator Brian E. Conner, M.D., an ophthalmologist and eye surgeon on staff at SRHC. During the mid-1990s, SRHC administrators challenged Conner's practices in the operating room and his treatment of the hospital's scrub staff. Conner, in turn, complained to SRHC that its scrub staff was underqualified and its facilities and equipment failed to meet required standards of care. Conner also contended that the SRHC failed to investigate or review complaints concerning quality-of-care issues. Ultimately, in 1995, as a result of a dispute over surgery performed by Dr. Conner on a particular patient, SRHC suspended Conner's privileges. In 1996, SRHC offered to restore Conner's privileges. The hospital offered to adopt Conner's recommendation that he work with SRHC's surgery department to provide additional training to the hospital's scrub staff and further stated that "[i]f surgical scrub staff assigned to work for [Dr. Conner] d[id] not meet [his] needs, [he] w[ould] be responsible for contracting with preferred scrub staff for [his] procedures." Conner later refused to sign a cooperation agreement that required him to provide his own scrub staff when he was not satisfied with SRHC's staff, and the hospital ultimately declined to reappoint him to its medical staff.

Conner's complaint alleged that SRHC violated numerous Medicare laws and regulations, including regulations regarding quality-of-care issues. According to Conner, SRHC falsely certified compliance with all Medicare laws and regulations on its annual cost report, triggering liability under the FCA. Under Conner's theory of liability, SRHC's technical regulatory violations and subsequent cost report certifications would trigger liability under the FCA for three times the amount of its entire annual reimbursement as reported on the cost report; this totaled more than $100 million in claimed damages for each of the SRHC cost report years challenged.

Conner further alleged that SRHC violated the Anti-Kickback Statute by soliciting remuneration from Conner in exchange for Medicare referrals. Here also, Conner alleged that SRHC's failure to comply with the law rendered claims submitted to Medicare false under the FCA.

THE COURT'S FINDINGS

The United States Court of Appeals for the Tenth Circuit rejected the relator's false certification theory, because the alleged regulatory violations were immaterial to the government's payment decision. The court rejected Conner's broad theory of liability, holding that "there is 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." Instead, the court "explicitly adopt[ed] a materiality requirement in the context of false certification claims."

As the court made clear, not every false statement included within a claim will trigger FCA liability. Rather, liability under the FCA arises only if a false or fraudulent statement or claim "leads the government to make a payment which it would not otherwise have made." Here, the Tenth Circuit noted that:

> [a]lthough this certification [contained in the cost report] 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.

Accordingly, the court held that failure to comply did not render all claims submitted by SRHC false.

In reaching its decision, the Tenth Circuit was careful to distinguish Medicare conditions of participation from conditions of payment:

> Conditions of participation, as well as a provider's certification that it has complied with those conditions, are enforced through administrative mechanisms, and

> the ultimate sanction for violation of such conditions is removal from the government program. . . . Conditions of payment are those in which, if the government knew they were not being followed, might cause it to actually refuse payment.

According to the court, the "detailed administrative mechanism" established by the Centers for Medicare and Medicaid Services (CMS) is better suited than the courts to manage the participation of program providers and compliance with conditions of participation. Under that scheme, the government considers substantial compliance with Medicare laws and regulations a condition of continued participation in the program, and "it does not require perfect compliance as an absolute condition to receiving Medicare payments for services rendered."

The court illustrates the absurd consequences that would follow from the finding that any violation of Medicare laws and regulations would preclude payment from Medicare and support an action under the FCA:

> [C]onsider if Conner'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. . . . As the Second Circuit has cautioned, courts are not the best forum to resolve medical issues concerning levels of care.

THE RELATOR'S KICKBACK ALLEGATIONS

The court dismissed the relator's kickback allegations, because SRHC neither solicited a kickback nor offered to provide referrals to the relator. The court likewise found Conner's anti-kickback allegations insufficient to state a claim under the FCA. Conner alleged that SRHC violated the Anti-Kickback Statute by forcing him to provide scrub staff at his own expense in exchange for the receipt of the hospital privileges and the attendant right to receive Medicare referrals. Accordingly, Conner alleged that SRHC's Medicare cost report certifications were false. The court dismissed Conner's anti-kickback allegations, finding that SRHC neither solicited remuneration from Conner nor offered to provide Conner with Medicare referrals. Because it found that Conner's allegations did not state a claim within the meaning of the Anti-Kickback Statute, the court explicitly declined to reach the issue of whether a violation of the Anti-Kickback Statute can support a cognizable FCA allegation under an express false certification theory.

CONCLUSION

In summary, the United States Court of Appeals for the Tenth Circuit rejected an expansive theory of liability under the FCA that would have subjected hospitals and other health care providers to liability for any statutory or regulatory violation, regardless of its impact on reimbursement. The court held that false certifications of compliance with Medicare laws and regulations contained in a provider's annual Medicare cost report do not render all claims for reimbursement submitted by that provider false within the meaning of the FCA. In order to trigger liability under the FCA, the alleged violation must have impacted the government's payment decision. The ruling announced by the court is precedent in the Tenth Circuit, meaning that propositions espoused must be followed by all federal courts in Colorado, Kansas, New Mexico, Oklahoma, Utah, and Wyoming. Although the ruling is not binding on the federal courts in other states, it is considered "persuasive."

Under the ruling, an effective compliance program remains essential to the operations of any health care provider that renders services to beneficiaries of government health care programs, such as Medicare and Medicaid. Even in the Tenth Circuit, violations of all Medicare rules and regulations are enforceable through administrative sanctions, including exclusion from government programs. Moreover, to the extent that statutory or regulatory violations impact the government's payment decision, those violations remain enforceable and subject to treble damages under the FCA.

LAWYER CONTACTS

For further information, please contact your principal Firm representative or one of the lawyers listed below. General email messages may be sent using our "Contact Us" form, which can be found at www.jonesday.com.

R. Christopher Cook
1.202.879.3734
christophercook@jonesday.com

Nolan Young
1.202.879.3728
nsyoung@jonesday.com

Christopher Cook is a partner and Nolan Young is an associate in Jones Day's Washington Office.

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