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WHY *THOMPSON* IS WRONG: MISUSE OF THE FALSE CLAIMS ACT TO ENFORCE THE ANTI-KICKBACK ACT

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I. INTRODUCTION

In March 1995, a private citizen filed suit against Columbia/HCA Corporation, alleging, among other things, that false certifications of compliance with the Medicare Anti-Kickback Act ("AKA")¹—a criminal law with no private right of action—

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The views reflected herein present case law that remains subject to appeals and further review and reconsideration in other courts and cases. The statements herein do not necessarily present the position of the authors' firm or clients of the firm and should not be imputed to them. The reader should also note that Mr. Boese and his firm represented the defendants in a number of cases cited in this Article and represent some of the defendants in these cases in different matters.

1. 42 U.S.C. § 1320a-7b(b) (1994 & Supp. III 1997).

violated the civil False Claims Act ("FCA").² Now on remand from the Fifth Circuit, *United States ex rel. Thompson v. Columbia/HCA Healthcare Corporation*³ has proven to be one of the most closely-watched cases in the health care industry. The District Court for the Southern District of Texas recently denied the defendants' renewed motions to dismiss, thus opening the door for a private, self-appointed prosecutor to proceed in a suit declined by the government, premised on allegedly criminal acts.

Thompson is most important because it is not the usual fraud and abuse case. It does not involve overbilling, upcoding,⁴ the provision of medically unnecessary goods and services, or any true overcharge to Medicare or Medicaid.⁵ Rather, Thompson alleges that claims for medically necessary goods and properly administered health care services are rendered "false" solely because of allegedly inaccurate certifications of compliance with health care laws and regulations, including the AKA.

The ruling in *Thompson* is wrong, and it is wrong for three reasons. First, *Thompson* is wrong because it accepts the argument that Medicare payments are conditioned on blanket certifications of compliance with health care laws and regulations. This argument defies logic and common sense, given the extraordinary overbreadth of the certification at issue. Moreover, the government's claim is contrary to its own practice of frequently ignoring certain technical violations of the AKA, a practice made explicit in the Department of Health and Human Services' ("DHHS") own Advisory Opinions.

Commentators have observed that the *qui tam* provisions of the FCA limit the government's exercise of prosecutorial discre-

2. 31 U.S.C. §§ 3729-3733 (1994).

3. 20 F. Supp. 2d 1017 (S.D. Tex. 1998). The *Thompson* decision also holds that alleged violations of Medicare self-referral laws (the "Stark" laws) are actionable under the FCA. *Thompson*, 20 F. Supp. 2d at 1047. The Stark law violations alleged in *Thompson* require a distinctly different analysis and are beyond the scope of this discussion.

4. "Upcoding" refers to the practice of billing a payor for a more expensive service than that which was actually provided. Publication of the OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8990 n.15 (1998).

5. The relator argued initially that overbilling could be inferred when kickbacks exist. That argument was rejected by the district court and affirmed by the Fifth Circuit. *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 903 (5th Cir. 1997).

tion by investing private citizens with the ability to overrule a government decision not to prosecute certain technical violations of the law.⁶ Others have noted that the overbreadth of the AKA and the narrow scope of its regulatory safe harbors allow for excessive and arbitrary exercises of prosecutorial discretion by the government.⁷ By permitting *qui tam* enforcement of the AKA, however, *Thompson* allows an enforcement regime to exist in which the government is invested with both too little *and* too much prosecutorial discretion. This regime leaves providers at the mercy of unpredictable, inconsistent, and perhaps abusive exercises of prosecutorial discretion by the government, while simultaneously imposing upon providers the risk that *qui tam* relators or even another branch of the government will overrule a government decision not to prosecute. The uncertainty created by such an enforcement environment thus undermines fundamental principles of the rule of law.

Second, *Thompson* is wrong because it assumes that every violation of the AKA will be prosecuted by the government and result in a criminal conviction or exclusion, the sole remedies available under the AKA prior to 1997.⁸ The AKA contains specific, limited remedies and, most importantly, leaves enforcement decisions in the hands of the government and liability decisions in the hands of a judge, jury or agency board. This is important because the range of conduct proscribed under the AKA has been acknowledged by the government to be extremely

6. See, e.g., William E. Kovacic, *Whistleblower Bounty Lawsuits as Monitoring Devices in Government Contracting*, 29 LOY. L.A. L. REV. 1799, 1824 (1996).

7. See, e.g., James F. Blumenstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 218 (1996).

8. Although recent legislative and regulatory developments have expanded the civil monetary penalties available for AKA violations, these sanctions did not exist at the time relevant to the allegations in *Thompson*. Under the Balanced Budget Act ("BBA") of 1997, Pub. L. No. 105-33, 111 Stat. 251, violations of the AKA may lead to the imposition of a civil monetary penalty ("CMP") of up to three times the amount of the prohibited remuneration and \$50,000 per violation. 42 U.S.C. § 1320a-7(a)(7) (1994 & Supp. III 1997). See also PAMELA H. BUCY, HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW, § 5-72.1 (1996 & Supp. 1999) (stating that the CMP provisions of the BBA "create[d] an intermediate sanction for violations of the federal anti-kickback statute"). Violations of the AKA may also give rise to exclusion from participation in federal health care programs. See 42 C.F.R. § 1001.951(a)(2) (1998); 42 U.S.C. § 1320a-7b.

broad.⁹ The scope of potential liability for AKA violations, however, was circumscribed by court decisions interpreting the AKA to require proof of specific intent. Moreover, the government itself limits enforcement in safe-harbor regulations and advisory opinions.¹⁰ The *Thompson* court assumes that every AKA violation will be enforced and will be enforced successfully, for otherwise there could be no FCA liability. This assumption has no basis, and it should have been rejected as a matter of law.

Finally, *Thompson* is wrong because it permits a claim under § 3729(a)(7) of the FCA, the "reverse false claims" provision, based on alleged but unproved "violations" of the AKA. For liability to arise under § 3729(a)(7), a current "obligation" to pay the government must exist, and future contingent liabilities do not suffice. *Thompson* improperly seeks to transform an inchoate, potential and undetermined liability under the AKA into a present obligation to pay the government, which is required for liability to arise under the FCA.

Thompson wrongly allows the civil FCA, a statute of limited applicability with enormous liabilities, to be the enforcement mechanism for the entire Medicare/Medicaid regulatory regime. Worse, *Thompson* allows enforcement by private individuals despite, and sometimes contrary to, established government policy.

II. AN OVERVIEW OF *UNITED STATES EX REL. THOMPSON V. COLUMBIA/HCA HEALTHCARE CORP.*

The *Thompson* case arose in the context of rapid and unprecedented change in the health care industry. Costs were exploding under traditional fee-for-service payment plans, which are commonly believed to create incentives for the overutilization of health care resources because provider compensation is based on the volume and type of services provided. Federal regulators and health care providers alike looked for

9. See Preamble to the Final Anti-Kickback Safe Harbor Provisions, 56 Fed. Reg. 35,952 (1991) (to be codified at 42 C.F.R. § 1001.951) (proposed July 29, 1991).

10. See, e.g., *United States v. Kats*, 871 F.2d 105, 108 (9th Cir. 1989); *United States v. Bay State Ambulance & Hosp. Serv., Inc.*, 874 F.2d 20, 29-30 (1st Cir. 1989); *United States v. Greber*, 760 F.2d 68-69, 72 (3d Cir. 1985).

new ways to manage the delivery of medical care.

The federal government responded with command and control regulations intended, in theory, to reduce overutilization and thus reduce health care costs. In the process, the government focused on the widely-held, though probably exaggerated, perception of rampant fraud and abuse in the health care system. Government sources are frequently cited as estimating that approximately ten percent of every health care dollar spent is wasted on fraud and abuse.¹¹ Some commentators question the accuracy of that figure, however, and a close reading of a recent government audit reveals that this figure may well overstate the extent of true health care fraud.¹² The Department of Health and Human Services Office of the Inspector General ("DHHS-OIG") stated in a fiscal year 1997 ("FY") report that it estimated "overpayments" totaling approximately \$20.3 billion (11% of total fee-for-service billings).¹³ However, the Office of Inspector General ("OIG") noted that "[t]hese improper payments resulted from provider billings for services that were insufficiently documented, medically unnecessary, incorrectly coded, or noncovered. The improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud."¹⁴

Indeed, the DHHS-OIG audit identifies lack of proper documentation as the most pervasive problem, and the care at issue may well have been rendered under perfectly legitimate circumstances.¹⁵ The fact that extraordinarily busy health care professionals may fail to devote the appropriate attention to medical record keeping is a failing that, though significant, hardly rises to the level of fraud. In fact, in February 1999, the government announced new statistics indicating that improper Medicare payments have been reduced by half since 1996.¹⁶ A careful

11. See Pamela H. Bucy, *Health Care Reform and Fraud By Health Care Providers*, 38 VILL. L. REV. 1003 (1993) (citing PROSPECTIVE PAYMENT ASSESSMENT COMM'N, REPORT AND RECOMMENDATION TO THE CONGRESS 15 (1993)).

12. See DHHS-OIG AUDIT OF THE HEALTH CARE FINANCING ADMINISTRATION'S FISCAL YEAR 1997 FIN. STATEMENTS 5 (1998) [hereinafter FINANCIAL STATEMENTS].

13. See Judith Havemann, *Medicare Stems Errant Spending*, WASH. POST, Feb. 10, 1999, at A21.

14. See FINANCIAL STATEMENTS, *supra* note 12.

15. See Havemann, *supra* note 13, at A21.

16. *Id.*

look at these statistics, however, reveals that "documentation errors" were down from 46.77% of the total "improper" payments in 1996 to 16.83% of the total in 1998.¹⁷ Inspector General June Gibbs Brown admitted that she could not estimate how much of the decline was related to better documentation of legitimate care rather than to fraud.¹⁸

The AKA prohibits conduct that is considered normal and even highly desirable in other settings—the payment of commissions and bonuses, the offering of volume-related discounts, or the offering of perquisites to valued professionals, for example.¹⁹ The rationale is that such conduct is believed to increase the risk of overutilization of health care resources. As a result, Congress and the DHHS have subjected many of these otherwise normal business practices to significant civil and criminal penalties under the Medicare and Medicaid anti-fraud and abuse laws.²⁰

During this same period of increasing government regulation, health care providers entered into new types of economic relationships with physicians as "managed care" became the buzz words of the eighties and nineties. Despite dramatic changes in the way that health care is paid for,²¹ health care providers still benefit by attracting certain patients to their facilities, and they continue to seek efficient and legal ways to do so.

This regulatory environment was complicated further by the government's realization that not all conduct it had made illegal actually harmed the public—indeed, the government stood to gain from some of the same market-driven practices, including the offering of discounts to favored customers. The government carved out narrow exceptions—referred to as "safe harbors"—to the otherwise illegal behavior, where the government believed

17. *Id.*

18. *Id.*

19. *See generally* Medicare and Medicaid Programs: Physicians' Referrals to Health Care Entities with which They Have Relationships, 63 Fed. Reg. 1659 (1998) (to be codified at 42 C.F.R. pts. 411, 424, 435, 455) (proposed Jan. 9, 1998).

20. *See generally* Medicare and Medicaid Programs: Physicians' Referrals to Health Care Entities with which They Have Relationships, 63 Fed. Reg. at 1659.

21. In some cases, the government began paying on the basis of a particular diagnosis, under the "diagnosis related group" system, rather than based on the individual services provided, under the "prospective payment system." *See* 42 U.S.C. § 1395 (1982 & Supp. V 1987).

that the risk of abuse was low or that the practice benefitted the government.²²

In the late 1980s and early 1990s, providers therefore found themselves subjected to competing and contrary pressures—the pressure to be economically efficient and to use normal market forces to reward profitable behavior, on one hand, and the pressure of government laws and regulations that penalized and even criminalized the same market-driven conduct, on the other. A decade later, many providers remain confused about the boundaries of permissible conduct under the current regulatory and legal regime.

In the midst of all this change, one of the most successful and rapidly growing corporate providers was the Columbia/HCA health care system. It was “widely admired on Wall Street as aggressive and cost-efficient.”²³ Now the largest hospital-owning corporation in America, Columbia/HCA has been beleaguered by a series of *qui tam* suits filed under the FCA, some of which remain under seal.²⁴

One of those suits was filed by James Thompson, a physician who participated in the very economic relationships he now claims were “fraudulent.” Thompson’s complaint was unsealed in August 1995, after the government investigated his allegations and declined to join his suit. He alleges that Columbia/HCA and other Columbia affiliates (referred to hereinafter collectively as “Columbia”) violated Medicare anti-kickback and self-referral laws by providing various inducements to physicians in order to increase the number of Medicare referrals to Columbia facilities.²⁵ Specifically, Thompson claims that Columbia offered free

22. See Preamble to the Final Anti-Kickback Safe Harbor Provisions, 56 Fed. Reg. 35,952 (1991); Clarification of the OIG Safe Harbor Anti-Kickback Provisions, 59 Fed. Reg. 37,202 (1994); 42 C.F.R. § 1001.951.

23. Lucette Lanado, *Lawyer for Columbia Whistle-Blowers: "Part Therapist,"* WALL ST. J., Jan. 7, 1999, at A13. Although Columbia remains the largest hospital-owning corporation in America, it has recently been divesting itself of hospitals as patient volumes have declined. See Jerome T. Levy, *Columbia/HCA Fraud Cases to Settle?*, N.Y. L.J., Mar. 22, 1999, at 11; Barbara Kirchheimer, *Columbia Endures a Week of Setbacks*, MOD. HEALTHCARE, Mar. 1, 1999, at 20.

24. *JPML Denies DOJ's Request to Consolidate All Columbia/HCA Qui Tam Cases*, 4 ANDREWS HEALTH CARE FRAUD LITIG. REP. 3, 6 (1999).

25. Plaintiff's Third Amended Complaint at 9, *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d 1017 (S.D. Tex. 1998) (No. C-95-110).

or reduced-rate hunting and fishing trips, reduced rents, loans to finance capital investments in Columbia entities, and "consultation" fees that were actually intended to permit risk-free investing in Columbia facilities.²⁶

Thompson argues that these alleged AKA violations "taint" all claims for medical services provided by the defendants and that they are "false claims," even though the services rendered were medically necessary and properly coded.²⁷ Thus, according to the *Thompson* case, these services violate the FCA because, and only because, they violate the AKA.²⁸

Thompson claims that he was assured by Columbia officials that his financial arrangements were "legal and ethical, in accordance with Federal Medicare requirements."²⁹ He claims to have been told "repeatedly" that Columbia lawyers had verified the propriety of the arrangements.³⁰ However, Thompson also notes in his Complaint that in 1994, Columbia officials were reviewing their policies because of the need for compliance with Medicare fraud and abuse regulations.³¹

Without the use of the FCA as a private enforcement vehicle, a private citizen like Thompson would have no right to prosecute alleged violations of the AKA or the laws prohibiting self-referrals. Congress charged various agencies of the government, including the DHHS and the Justice Department, with investigating and prosecuting such alleged offenses. Increasingly, however, self-appointed prosecutors like Thompson are—properly or not—invoking the *qui tam* provisions of the civil FCA in suits premised on alleged regulatory violations, hoping to recover up to 30% of any judgment or settlement, plus fees and costs. In the process, they may enrich themselves significantly.

26. Plaintiff's Third Amended Complaint at 11, *Thompson* (No. C-95-110).

27. *See id.* at 8-17.

28. *Id.* at 42.

29. *Id.*

30. *Id.*

31. Plaintiff's Third Amended Complaint at 42, *Thompson* (No. C-95-110).

III. A BRIEF OVERVIEW OF THE CIVIL FALSE CLAIMS ACT

A. *Historical Overview*

The civil FCA is a Civil War-era statute that was enacted to remedy clearly fraudulent conduct—billing the government for work that was not performed or for products that were not delivered, for example. In 1861, at the outbreak of the Civil War, a House Committee began a two-year investigation into reports that the government was being charged exorbitant prices for inferior goods.³² The government's urgent need to garner resources for "suppressing the rebellion"³³ led to the sorts of opportunistic behavior—abuses as old as human history—that make war-time profiteers rich. For two years, the Committee heard testimony regarding outrageous prices charged for the charter of steamships³⁴ and worthless weapons.³⁵ The investigation involved hundreds of pages of testimony and "found that the most astounding and unblushing frauds had been perpetrated."³⁶ The House investigation resulted in the court martial of an officer who was accused of extracting enormous bribes and kickbacks from suppliers, "prostituting [the] office of quartermaster," "squandering and wast[ing] . . . of the public funds," and "disgrac[ing] the service."³⁷

The Committee also began, but retreated from, an investigation into the "commissions" received by federal officers in New York customs houses. This retreat engendered protest and a minority report from Representative Van Wyck, who hinted that the Committee retreated from the investigation because of pres-

32. H.R. REP. NO. 37-49 (1863).

33. H.R. REP. NO. 37-2 (1861):

34. H.R. REP. NO. 37-2, at 2-18.

35. *Id.* at 39.

36. *Id.* at 83.

37. H.R. REP. NO. 37-49, at 6. (1863). The 1863 version of the FCA, which combined both civil and criminal sanctions, provided for arrest and trial by a court-martial, with punishment by "fine and imprisonment, or such other punishment as the court-martial may adjudge, save the punishment of death." See The False Claims Act, ch. 67, § 1, 12 Stat. 696 (1863) (codified as amended at 31 U.S.C. §§ 3729-3733 (1994)).

sure from powerful business interests.³⁸ These customs officers shared in the "fines, penalties and forfeitures incurred by violations of the revenue laws and matters of the like."³⁹ The Committee concluded that although in some cases these fees were "too large,"⁴⁰ it was reluctant to withdraw "a portion of that stimulus which, according to the recognized motives of human action and the established usages of all commercial nations, has been found necessary to impel even the most conscientious officials to extraordinary vigilance in the detection of frauds and the punishment of crimes."⁴¹

The Committee relied upon an obvious and fundamental truth about human nature: that economic self-interest motivates most people. This fundamental truth is also at the heart of debates over the propriety of the FCA's *qui tam* provisions in general and the facts of *Thompson*, in particular. Health care providers have a legitimate right to pursue their own economic self-interest, to pursue a reasonable profit, and to be fairly reimbursed for their services. The existing regulatory and FCA enforcement environment, however, pits providers against private citizens using the FCA to pursue their own economic self-interest, an interest that may be, but often is not, in the public interest.⁴²

The culmination of the House Committee's investigation was the enactment of the civil FCA in 1863. This powerful civil fraud statute has sent thousands of private citizens, known as *qui tam*

38. Representative Van Wyck complained that "[t]he leniency of the government towards these men is a marvel which the present cannot appreciate and history never explain." H.R. REP. NO. 37-50, at 47 (1863).

39. *Id.* at 2.

40. Customs officers allegedly received bounties of as much as \$40,000 per year (in 1862 dollars), in addition to salary. According to Congress, this amount was worth roughly \$360,000 in 1986. See 132 CONG. REC. H6479 (daily ed. Sept. 9, 1986) (statement of Rep. Glickman) (asserting that \$2000 in 1863 would have been worth over \$18000 in 1986).

41. H.R. REP. NO. 37-49, at 3 (1863).

42. Judges and legislators alike have openly acknowledged that *qui tam* relators are often motivated by factors other than the common good or sound policy. The frank analysis of the sponsor of the original civil FCA, Senator Howard, is that the law sets "a rogue to catch a rogue." CONG. GLOBE, 37th Cong., 3d Sess. 9556 (1863) (remarks of Sen. Howard). In *United States ex rel. Schumer v. Hughes Aircraft Co.*, 520 U.S. 939, 949 (1997), Justice Thomas noted that "[a]s a class of plaintiffs, *qui tam* relators are different in kind than the Government. They are motivated primarily by prospects of monetary reward rather than the public good."

relators, in pursuit of fraud against the government. Since sweeping amendments in 1986, which expanded the rights of relators and reduced certain barriers to filing suit, litigation under the FCA has skyrocketed.⁴³ Government contractors, health care providers and other recipients of federal funding now realize, in ways they may never have before, that by accepting federal funds, they face the risk that they will later be forced to turn over enormous sums to private citizens, their attorneys and the government.

B. Liability Under the Civil False Claims Act

Among the claims in Thompson's suit are alleged violations of § 3729(a)(1)-(2) and (7) of the civil FCA. These three sections of the FCA are, in fact, the ones most frequently invoked in FCA litigation, but only subsections (a)(1) and (a)(7) require extensive treatment here.⁴⁴

1. *Alleged Violations of § 3729(a)(1).*—Section 3729(a)(1) is the most common source of liability under the civil FCA, and it provides, in relevant part:

Any person who—

- (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for

43. The Justice Department publishes statistics regarding the number of FCA suits filed by *qui tam* relators; those numbers do not include the also significant number of cases filed solely by the government under the FCA. In 1987, 33 *qui tam* FCA suits were filed, and by 1997, that number increased to 534. A total of 2770 *qui tam* suits were filed by May 1999. FCA STATISTICS, JUSTICE DEPARTMENT'S LATEST STATISTICS ON QUI TAM CASES FILED AND FCA RECOVERIES (1999) (last modified Sept. 30, 1999) <<http://www.ffhsj.com/quitam/fcastats.htm>>.

44. Thompson claims that the allegedly false HCFA Forms 2552 constituted separate and independent violations of § 3729(a)(2). See Plaintiff's Third Amended Complaint at 16-17, *Thompson* (No. C-95-110). Section 3729(a)(2) imposes liability upon any person who "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government." 31 U.S.C. § 3729(a)(2) (1994). Because liability arises under § 3729(a)(2) only when all of the elements of a false claim under § 3729(a)(1) have been demonstrated, liability under this "false statements" section of the FCA is essentially duplicative, and these allegations are not germane to this discussion of liability.

payment or approval . . . is liable to the United States Government⁴⁵

a. "False Claims"

Thompson claims that Columbia submitted false Annual Cost Reports to the Health Care Financing Administration ("HCFA") and that these allegedly false cost reports constituted false claims under § 3729(a)(1).⁴⁶ Specifically, Thompson asserts that from 1990 until the present, Columbia's Cost Reports (HCFA Form 2552) contained false certifications of compliance with health care laws and regulations and that these allegedly false certifications rendered the Cost Reports false.⁴⁷ Thompson further alleges that the government would not have paid any Medicare claims for services rendered in violation of the AKA.⁴⁸

The certifications upon which plaintiff bases his allegations include so-called "implied" certifications of compliance, as well as two different express certifications that were contained in HCFA Form 2552 between 1990 and the present. An analysis of the certification issues is contained in Section V.C. below.

If Thompson's case proceeds to trial, a threshold determination first must be made as to the alleged "falsity" of Columbia's claims. Even under Thompson's theory, since allegations of "falsity" are premised solely on violations of the AKA,⁴⁹ there must be an initial finding that the AKA was indeed violated before any liability can exist under the FCA. Thus, Thompson must first establish all elements of an AKA violation in establishing the "falsity" of Columbia's claims. Any other approach results in an inappropriate reduction in the government's (or *qui tam* relator's) burden of proof.

45. 31 U.S.C. § 3729(a)(1).

46. Plaintiff's Third Amended Complaint at 12, *Thompson* (No. C-95-110).

47. *Id.* at 14, 17.

48. *Id.* at 13.

49. The elements of liability under the AKA are discussed in detail in Section IV. See also *infra* pp. 42-46.

b. Scierter and Burden of Proof

Section 3731(c) of the FCA provides that “the United States shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.”⁵⁰ Thus, Thompson must prove that each HCFA Form 12552 presented annually by Columbia from 1990 to the present was a “false claim” for payment and that Columbia submitted the claims knowing (or with reckless disregard or deliberate ignorance) that the claims were false.

c. Causation and Reliance

Very important issues that arise in *Thompson* relate to whether the plaintiff can prove causation and reliance as elements of liability under 31 U.S.C. § 3729(a)(1) and (2)—that is, whether the plaintiff can prove that the government relied on the allegedly false statement in paying the disputed claims. These issues are examined in greater detail in Section IV below.

d. Damages

The parties in *Thompson* dispute whether it is necessary to prove damages under § 3729(a)(1). Courts are split on this issue, and the district court in *Thompson* held on remand that proof of a pecuniary injury to the public fisc is not required under the FCA.⁵¹ This is particularly important in FCA cases like *Thompson*, which are based solely on violations of the AKA, because under the *Thompson* theory, medical treatment that is properly administered and medically necessary may still violate the AKA. In the criminal case of *United States v. Jain*,⁵² for example, a psychologist was convicted of, among other things, violations of the AKA and the Federal Mail Fraud statute.⁵³ The government conceded that the services were medically necessary and

50. 31 U.S.C. § 3729(a)(1)-(2).

51. *Thompson*, 20 F. Supp. 2d at 1047.

52. 93 F.3d 436 (8th Cir. 1996).

53. 18 U.S.C. § 1341 (1994).

that the patients were hospitalized appropriately at a facility described by government witnesses as "likely the best acute-care psychiatric hospital in the region."⁵⁴ Because there was no evidence that the government was cheated, i.e., paid any more than it would have in the absence of a kickback or that patients received substandard or unnecessary care, the mail fraud conviction was reversed, but the AKA conviction was affirmed.⁵⁵

2. *Alleged Violations of § 3729(a)(7).*—A second theory of liability alleged under the FCA in *Thompson* is the "reverse false claims" theory under § 3729(a)(7).⁵⁶ This section of the FCA, added only recently in the 1986 amendments, imposes liability for the knowing creation or use of a false record or statement to conceal, avoid or decrease an "obligation" to pay money or transmit property to the government.⁵⁷ Section 3729(a)(7) was added to the FCA in response to court decisions that had strictly interpreted the definition of "claim." Before the 1986 amendments to the FCA, § 3729(a)(1) and (a)(2) provided a remedy for "direct" false claims made to obtain money from the government. However, there were no provisions for liability for the "reverse" of a false claim—false statements made to avoid returning money owed to the government.⁵⁸ Before 1986, every appellate court to consider the issue declined to extend the FCA to situations in which the defendant was accused of trying to decrease an obligation to the United States.⁵⁹

While a number of legal issues arise in interpreting § 3729(a)(7), the most important and most litigated is the defini-

54. *Jain*, 93 F.3d at 439.

55. *Id.* at 443.

56. *Thompson* raised the reverse FCA theory for the first time in an amended complaint after remand from the Fifth Circuit. See Plaintiff's Third Amended Complaint at 51, *Thompson* (No. C-95-110).

57. 31 U.S.C. § 3729(a)(7).

58. See S. REP. NO. 99-345, at 8-17 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5273-82.

59. *United States ex rel. Rabushka v. Crane Co.*, 122 F.3d 559, 565 n.8 (8th Cir. 1997); see, e.g., *United States v. Howell*, 318 F.2d 162, 166 (9th Cir. 1963) (no false "claim" where defendant operating cleaning concession on public land understated gross receipts to decrease amount owed United States under contract to pay government a percentage of gross receipts); *United States v. Marple Community Record, Inc.*, 335 F. Supp. 95, 100 (E.D. Pa. 1971) (false statements to allow defendants to use second-class rates rather than higher postage rate do not violate FCA).

tion of "obligation," since that is the linchpin for liability. The language of § 3729(a)(7) of the FCA is very clear: it refers to an "obligation to pay or transmit money or property to the Government."⁶⁰ And in defining what constituted an "obligation to the government," the legislative history refers to "moneys owed."⁶¹

Despite this unequivocal language, Thompson and other *qui tam* relators have improperly sought to expand the limited reach of the reverse false claims provisions to include potential and future obligations. Thompson claims that by falsely certifying compliance with health care laws and regulations, Columbia sought to avoid an obligation to repay sums paid by the government throughout the years covered by the relevant Cost Reports. However, this claim skips an essential step: the government had not taken any steps under the AKA to prosecute or exclude Columbia for the violations alleged by Thompson. The attempt to impose reverse FCA liability for alleged violations of the AKA that have never been prosecuted and for which no judgment or agency decision has been entered circumvents the clear requirement of § 3729(a)(7)—that moneys must first be owed to the government before a defendant can possibly attempt to avoid an obligation to pay.

C. Enforcement Mechanism

1. *Whistleblower Suits Under the FCA's Qui Tam Provisions.*—While American customs officials no longer receive a percentage of penalties collected on behalf of the government, a new breed of private federal enforcers may.⁶² As noted in the 1861 House Report, people are motivated to uncover and report fraud when they have an economic interest in doing so, and the civil FCA permits relators to file suit on behalf of the government and receive up to 30% of amounts recovered.⁶³ This privi-

60. 31 U.S.C. § 3729(a)(7).

61. See, e.g., H.R. REP. NO. 99-660, at 20 (1986); S. REP. NO. 99-345, at 15, 18 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5280, 5283.

62. A theoretical exception may exist if customs officials successfully pursue a *qui tam* suit, although in reality, FCA suits by government employees seldom succeed. See, e.g., *United States ex rel. Fine v. Chevron, U.S.A.*, 72 F.3d 740 (9th Cir. 1995). For a full discussion of this issue, see JOHN T. BOESE, CIVIL FALSE CLAIMS AND QUI TAM ACTIONS ch. 4 (1993 & Supp. 1999).

63. 31 U.S.C. § 3730(d). The current version of the FCA provides that successful

lege, unique in modern jurisprudence but a relatively common device in early American statutory and British common law,⁶⁴ has produced truly phenomenal recoveries for some relators⁶⁵ (and their attorneys).⁶⁶

2. *The Government's Role in Qui Tam Suits.*—The *qui tam* provisions of the FCA require that such actions be brought in the name of the government.⁶⁷ The Justice Department and the local U.S. Attorney must be served with a copy of the complaint, which is to be filed under seal, and a written disclosure of material facts relating to the alleged fraud.⁶⁸ The government has sixty days (although much more time—as long as several years—is usually granted by the court upon request) to investigate the allegations and determine whether it will intervene in the suit.⁶⁹ If the government intervenes, it has primary responsibility for prosecuting the suit.⁷⁰ If the government declines intervention, the relator has the right to proceed with the ac-

relators who have not participated in fraudulent conduct may receive between 15% and 25% of the proceeds if the government intervenes in the case (and thus takes primary responsibility for prosecuting the action), and between 25% and 30% when the government declines intervention. In its original form, the FCA provided relators with up to 50% of amounts recovered. See The False Claims Act, ch. 67, § 6, 12 Stat. 696, 698 (1863).

64. See BOESE, *supra* note 62, ch. 1; see also Note, *The History and Development of Qui Tam*, 1972 WASH. U. L.Q. 81 (1972).

65. See Pamela Sherrid, *How to Really Make a Killing in Health Care: The Rewards to Whistle-Blowers Soar*, U.S. NEWS & WORLD REP., Nov. 2, 1998, at 48 (describing a relator's \$21 million recovery; relator's counsel has informed the author that relator's recovery was actually \$29.2 million); *United States ex rel. Merena v. SmithKline Beecham Corp.*, No. 93-5974, 1998 WL 166256 (E.D. Pa. Apr. 8, 1998) (awarding more than \$52 million to relators).

66. 31 U.S.C. § 3730(d)(2) provides that successful *qui tam* relators "shall . . . receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs." Additionally, relators' counsel often enter into contingency agreements with their clients. The costs to counsel representing *qui tam* plaintiffs can be very high, however. See, e.g., Deanna Hodgin, *Why Jackson Tufts Tanked*, THE RECORDER, Mar. 1, 1999, at 1 (describing the demise of a well-respected, mid-sized firm that was attributed in part to the economic pressure of bankrolling a *qui tam* suit that resulted in a \$389 million jury verdict, which was subsequently reduced to \$90 million).

67. 31 U.S.C. § 3730(b)(1).

68. *Id.* § 3730(b)(2).

69. *Id.* § 3730(b)(4).

70. *Id.* § 3730(c)(1).

tion.⁷¹ The government has declined intervention in *Thompson* and in another suit against Columbia raising almost identical allegations, *United States ex rel. Pogue v. American HealthCorp.*⁷²

The government also has the right to settle *qui tam* suits over the objections of the relator and to dismiss a *qui tam* suit if the relator is provided with notice and an opportunity to be heard on the matter.⁷³ The government has rarely exercised the right to dismiss *qui tam* suits in which it chooses not to intervene,⁷⁴ although a judicious use of this prerogative would relieve many of the negative effects of *qui tam* litigation, especially where *qui tam* relators seek to enforce statutory and regulatory regimes under which they would otherwise enjoy no private right of action.

In fact, the government successfully dismissed *qui tam* suits that it conceded were meritorious, after it convinced the court that the suits were against the public interest. In *United States ex rel. Sequoia Orange Co. v. Baird-Neece Packing Corpora-*

71. *Id.* However, the Fifth Circuit recently ruled that sovereign immunity under the Eleventh Amendment precludes *qui tam* suits against state entities and institutions where the government declines intervention. *United States ex rel. Foulds v. Texas Tech Univ.*, 171 F.3d 279, 294 (5th Cir. 1999). *But see United States ex rel. Rodgers v. Arkansas*, 154 F.3d 865 (8th Cir. 1998); *United States ex rel. Stevens v. Vermont Agency of Natural Resources*, 162 F.3d 195 (2d Cir. 1998). The Supreme Court recently granted certiorari in *Stevens* to review whether the Eleventh Amendment precludes private relators from commencing and prosecuting an FCA suit against an unconsenting state. *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 119 S. Ct. 2391 (1999).

72. 914 F. Supp. 1507 (M.D. Tenn. 1996). The government has, however, intervened in at least three other *qui tam* suits against Columbia: *United States ex rel. Alderson v. Columbia/HCA Healthcare Corp.*, No. 97-2035-CIV-23E (M.D. Fla. filed 1999); *United States ex rel. Ortega v. Columbia/HCA/Healthcare Corp.*, No. EP-95-CA-259H (W.D. Tex. filed 1999); and *United States ex rel. Schilling v. Columbia/HCA Healthcare Corp.*, No. 96-1264-CIV-T-23 (M.D. Fla. filed 1999). In some of these suits, Columbia is accused of making false statements regarding capital-related costs, interest expenses, depreciation and non-allowable costs. The relator in *Ortega* also alleges upcoding and AKA violations. See *Feds Intervene In Texas Whistle-Blower Suit Alleging Kickbacks, Upcoding Claims Against Columbia/HCA*, MEALEY'S MANAGED CARE LIABILITY REP., June 16, 1999; see also Jerome T. Levy, *Columbia/HCA Fraud Cases to Settle?* N.Y. L.J., Mar. 22, 1999, at 11; *JPML Denies DOJ's Request to Consolidate All Columbia/HCA Qui Tam Cases*, 4 ANDREWS HEALTH CARE FRAUD LITIG. REP. 3, 6 (1999).

73. 31 U.S.C. § 3730(c)(2)(A)-(B).

74. William E. Kovacic, *Whistleblower Bounty Lawsuits as Monitoring Devices in Government Contracting*, 29 LOY. L.A. L. REV. 1799, 1820 (1996).

tion,⁷⁵ relators alleged that Sequoia Orange's competitors were violating agricultural regulations intended to protect market conditions for citrus products. This suit was only one of numerous *qui tam* suits raising similar allegations, some of which were joined by the government. In the face of mounting industry opposition, the regulation at issue was formally suspended by the Department of Agriculture, and the government withdrew from those suits in which it had intervened. Almost ten years after the highly contentious litigation started, the Ninth Circuit ruled in favor of the government's decision to dismiss all pending *qui tam* suits relating to the regulation, noting that this authority is analogous to the exercise of prosecutorial discretion.⁷⁶

D. Damages and Penalties

Defendants found to have violated the civil FCA are liable for treble damages and penalties of \$5000 to \$10,000 per false claim.⁷⁷ The potential for high recoveries makes such suits especially attractive to plaintiffs (which was, after all, Congress' intent)⁷⁸ and places great pressure on defendants to settle even meritless suits.⁷⁹

In a case like *Thompson*, the penalties would be a relatively small portion of any recovery; if the Annual Cost Report is the allegedly false claim or reverse false claim, Columbia risks penalties of at most \$10,000 for each Annual Cost Report filed during the relevant period. Under the relator's theory, however, Columbia's potential liability for damages is staggering: the

75. 151 F.3d 1139 (9th Cir. 1998).

76. *Sequoia Orange*, 151 F.3d at 1143.

77. 31 U.S.C. § 3729(a).

78. S. REP. NO. 99-345, at 23-24 (1986), reprinted in 1986 U.S.C.A.N. 5266, 5288-89.

79. As noted in the public remarks of an Assistant Attorney General, "[t]riple damages are substantial enough; but couple that with the \$5000-\$10,000 in penalties for each request . . . for reimbursement, and the government's potential damages mount very quickly. The math is easy to do: for every 100 false claims a . . . provider submits, it can face liability for \$1 million in penalties alone." Stuart M. Gerson, Assistant Attorney General, Civil Division, U.S. Dep't of Justice, Increasing Criminalization of Health Care, Remarks at the Annual Meeting of the American Bar Association, Public Contracts Section (Aug. 11, 1991); see also Harvey Berkman, *Spoils to Bounty Hunters, Federal Contractors Gripe*, NAT'L L.J., Mar. 4, 1996, at B1-2.

relator claims that Columbia was not entitled to receive payment for any Medicare claims from 1990 until the present, and the measure of damages under his theory would be three times the amount of Medicare payments received during that time.⁸⁰

Conversely, some FCA cases involve minimal damages but enormous penalties, where a large number of very small claims are filed. If, for example, a laboratory submits 1000 bills in which the government is overcharged by \$1.00 in each bill, the government's damages, trebled, equal only \$3000. At \$5000 to \$10,000 per claim, however, the penalties mount to between \$5 million and \$10 million for a \$1000 overcharge. Such results do implicate the Eighth Amendment's prohibition against excessive fines and penalties, however.⁸¹

IV. A BRIEF OVERVIEW OF THE AKA

The AKA is a criminal statute that was first enacted in 1972,⁸² and it has been amended several times since then. In its original form, it had a more limited scope, imposing liability only for conduct affecting the Medicare and Medicaid programs. The conduct prohibited was limited to the payment of "kick-backs, bribes and rebates," and violations were classified as misdemeanors.⁸³

As legislators faced growing pressure to reduce health care costs, Congress demanded more aggressive prosecution of health care fraud. Congress broadened the reach of the AKA increased the monetary penalties that may be imposed, strengthened the

80. Plaintiff's Third Amended Complaint at 51, *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d 1017 (S.D. Tex. 1998) (No. C-95-110).

81. U.S. CONST. amend. VIII; see also *United States ex rel. Bajakajian*, 524 U.S. 321 (1998); *United States v. Halper*, 490 U.S. 435 (1989) (subsequently rejected as to double jeopardy challenges to FCA penalties, but not as to the Excessive Fines Clause, by the Supreme Court in *Hudson v. United States*, 522 U.S. 93 (1997)); *United States v. Advance Tool Co.*, 902 F. Supp. 1011 (W.D. Mo. 1995), *aff'd*, 86 F.3d 1159 (8th Cir. 1996); *United States ex rel. Smith v. Gilbert Realty*, 840 F. Supp. 71 (E.D. Mich. 1993).

82. Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 92-603, § 242(b)-(c), 86 Stat. 1419 (1972) (codified at 42 U.S.C. §§ 1395nn(b), 1396(h)(b) (1972)).

83. See *id.*

administrative remedies available, and changed the criminal penalty from a misdemeanor to a felony.⁸⁴

Criminal prosecution is within the authority of the Department of Justice ("DOJ") and the U.S. Attorney's Office. In addition, the Secretary of the DHHS, through her designee, the Inspector General ("IG"), can exclude the participation in Medicare or Medicaid any provider whom the IG determines to have violated the AKA.⁸⁵ This administrative sanction can be finally imposed by the IG only after the provider accused of the AKA violation has been given notice and the opportunity to contest the violation, including a hearing and appeals, and after a final decision is reached by the IG.⁸⁶

A. Liability

In its present form, § 1128(b) of the Social Security Act⁸⁷ imposes harsh criminal penalties for the knowing and willful offer, payment, solicitation or receipt of "any remuneration (including any kind of kickback, bribe, or rebate)" in return for referrals that will be paid for under a federal health care program.⁸⁸ Under the Health Insurance Portability and Account-

84. Most recently, the reach of the AKA was expanded under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, and the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.

85. 42 U.S.C. § 1320b(a)(5) (1994); see *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995).

86. 42 C.F.R. § 1001 (1998). See generally HEALTHCARE EXCLUSIONS: A COMPREHENSIVE GUIDE ch. IV (1997).

87. 42 U.S.C. § 1320a-7b(b) (1994 & Supp. III 1997).

88. The AKA provides, in relevant part:

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for

ability Act ("HIPAA"), the application of the AKA was expanded to cover all federal health care programs except the Federal Employee Health Benefit Program.⁸⁹

The AKA is a criminal statute and does not contain a private right of action, either express or implied.⁹⁰ Private citizens may not initiate suits based solely upon AKA violations.⁹¹ Rather, criminal prosecutions under the AKA must originate from the DOJ, and administrative exclusion proceedings must originate with the IG.⁹²

The AKA is a "specific intent" statute.⁹³ Judicial interpretation of the intent requirement of the AKA has led to an extremely expansive scope of liability. In *United States v. Greber*,⁹⁴ the court considered the appeal of an osteopath convicted of violating the AKA. Dr. Greber owned a company called Cardio-Med, Inc., which provided cardiac monitoring services that were billed to Medicare.⁹⁵ When payment was received from Medicare, Cardio-Med forwarded a portion of the fee to the referring physician.⁹⁶ The government introduced testimony of Dr. Greber from an earlier civil proceeding, where he testified that "if the

not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b)(1)-(2).

89. Pub. L. No. 104-191, § 204, 110 Stat. 1936, 1999-2000 (1996).

90. *West Allis Mem'l Hosp., Inc. v. Bowen*, 852 F.2d 251, 255 (7th Cir. 1988) (noting the strong presumption against creating implied private rights of action and that legislative history "supports the conclusion that it is the Government, and not private parties, which is charged with the enforcement of the Medicare program").

91. *West Allis Mem'l Hosp.*, 852 F.2d at 255.

92. *Id.*

93. 42 U.S.C. § 1320a-7b (1994).

94. 760 F.2d 68 (3d Cir. 1985), *cert. denied*, 474 U.S. 988 (1985).

95. *Greber*, 760 F.2d at 70.

96. *Id.* at 70.

doctor didn't get his consulting fee, he wouldn't be using our service. So the doctor got a consulting fee."⁹⁷

Dr. Greber argued that under the AKA, the government was required to prove that the only purpose of the fee was to induce future services; he claimed that compensating physicians for services actually rendered did not constitute a violation of the AKA.⁹⁸ The court disagreed, interpreting the law expansively and holding that if one purpose of the payment was to induce future referrals, the Medicare statute has been violated.⁹⁹ The court went on to state that "[e]ven if the physician performs some service for the money received, the potential for unnecessary drain on the Medicare system remains. The statute is aimed at the inducement factor."¹⁰⁰

Other courts have followed the Third Circuit's ruling,¹⁰¹ although at least one circuit court acknowledged that a distinction could be made as to the quantum of intent involved.¹⁰² In *United States v. Bay State Ambulance and Hospital Rental Service, Inc.*,¹⁰³ the First Circuit upheld a conviction based on instructions to the jury that made the distinction between "primary" and "incidental" purposes for the payment. The court cited *Greber* approvingly but found no error in a jury instruction that stated:

If you find that payments were made for two or more purposes, then the Government has to prove that the improper purpose is the primary purpose or was the primary purpose in making and receiving the payments. It need not be the only purpose, but it must be the primary purpose for making the payments and for receiving them. *You cannot convict if you find that the improper purpose was an incidental or minor one in making the payments.*¹⁰⁴

97. *Id.*

98. *Id.* at 71.

99. *See id.*

100. *Greber*, 760 F.2d at 71.

101. *See, e.g., United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *Polk County v. Peters*, 800 F. Supp. 1451 (E.D. Tex. 1992).

102. *See, e.g., United States v. Bay State Ambulance & Hosp. Rental Serv., Inc.*, 874 F.2d 20 (1st Cir. 1989).

103. 874 F.2d 20 (1st Cir. 1989).

104. *Bay State Ambulance*, 874 F.2d at 29 (emphasis added).

Thus, the First Circuit appears to have implicitly accepted that a peripheral or very secondary desire to induce referrals would not give rise to liability under the AKA. This acknowledgment is important because many legitimate payments are made with the hope (at some level) of a continuing economic relationship between the parties.¹⁰⁵

The universe of potentially illegal conduct under the AKA was circumscribed greatly by the Ninth Circuit's ruling in *Hanlester Network v. Shalala*.¹⁰⁶ The Ninth Circuit held that the "knowingly and willfully" language of the law requires the government to prove that the defendant *knew* that the AKA prohibits offering or paying remuneration to induce referrals and that the defendant engaged in the conduct with the specific intent to disobey the law.¹⁰⁷ The Eighth Circuit adopted a somewhat lower intent requirement, holding that it is only necessary to prove that the defendant knew his conduct violated a "known legal duty."¹⁰⁸

B. What Constitutes "Remuneration" Under the AKA

The term "remuneration" is not defined in § 1320a-7b(b), but the language of the AKA refers expansively to "any remuneration . . . in cash or in kind."¹⁰⁹ Section 1320a-7b(b)(3) excludes several protected practices, including the granting of discounts that are properly disclosed and reflected in charges made to federal health care programs.¹¹⁰ Amounts paid by em-

105. See, e.g., BEST PRACTICES HANDBOOK IN ADVISING CLIENTS ON FRAUD AND ABUSE ISSUES 19 (1999) (stating that many health care lawyers take the position that "it is possible to structure an agreement that passes legal muster so long as the elements of the arrangement are objectively proper—even where the client intends or intended to encourage referrals . . . if the arrangement resulted from arm's length negotiations, and the arrangement involves the purchase of substantial and important services at fair market value") [hereinafter BEST PRACTICES HANDBOOK].

106. 51 F.3d 1390, 1399-1400 (9th Cir. 1995). *Hanlester* was not a criminal case, but an appeal from an exclusion decision by the IG. Thus, the court's decision interpreting the necessary intent applies both to criminal and administrative sanctions. *Hanlester Network*, 51 F.3d at 1399-1400.

107. *Id.* at 1400.

108. *United States v. Jain*, 93 F.3d 436, 441 (8th Cir. 1996).

109. 42 U.S.C. § 1320a-7b(b)(1) (1994 & Supp. III 1997).

110. *Id.* § 1320a-7b(b)(3).

ployers to employees are also excluded from the definition of prohibited "remuneration" under the AKA.¹¹¹

The government has taken the position that virtually every other item of value can be considered to be "remuneration" and, hence, illegal if offered for the purpose of inducing referrals.¹¹² Despite the language of the statute and its own pronouncements, the government has indicated that there is a basic threshold for the amount of "remuneration" that warrants government attention. For example, in proposed self-referral safe harbors,¹¹³ the government proposed an exception for certain *de minimis* remuneration not to exceed \$50 per gift or a \$300 annual aggregate.¹¹⁴ The types of compensation cited by the government as "*de minimis*" included trinkets like coffee mugs and note pads.¹¹⁵

However, the government has also taken the position that other "incidental benefits"—including some which many people are likely to take for granted and which are not typically viewed as compensation—can be considered remuneration.¹¹⁶ For example, the government has stated (again in the context of proposed self-referral safe harbors) that free parking might be considered "remuneration" if it is provided to a physician for periods of time that do not coincide with his or her rounds.¹¹⁷ The government has also stated that the long-standing tradition among medical professionals of offering professional courtesy—where other physicians and their family members are treated for free or at significant discounts—may be impermissible under fraud and abuse laws, including the AKA.¹¹⁸

111. *Id.* § 1320a-7b(b)(3)(B).

112. Medicare and Medicaid Programs: Physicians' Referrals to Health Care Entities with which They Have Relationships, 63 Fed. Reg. at 1699.

113. Of course, the self-referral safe harbors relate to an entirely separate statutory regime. The government's definition of "de minimus" in the context of the safe harbor regulations is provided simply for illustrative purposes.

114. Medicare and Medicaid Programs: Physicians' Referrals to Health Care Entities with which They Have Relationships, 63 Fed. Reg. at 1699.

115. *Id.*

116. *See id.* at 1713-14.

117. *Id.* at 1714.

118. Thomas W. Greeson, *Pitfalls of Professional Courtesy: Doctors' Free Services to Fellow Physicians May Be Fraudulent*, FULTON COUNTY DAILY REP., Apr. 2, 1999, available in LEXIS, News Library, Fulton File; see Nancy Ann Jeffery, *Doctors Take Gloves Off Over "Courtesy" Treatments*, WALL ST. J., Feb. 16, 1999, at B4.

C. Penalties

Violations of the AKA are felony offenses, and conviction gives rise to a criminal fine of up to \$25,000 and/or imprisonment for a period of up to five years.¹¹⁹ In addition, the Secretary of the DHHS can exclude providers who have violated the AKA from participation in federal health care programs. Indeed, under the HIPAA, the DHHS is now *required* to exclude from Medicare and Medicaid providers convicted of felonies "in connection with the delivery of a health care item or service" and felonies relating to fraud and "financial misconduct."¹²⁰ The IG has issued a final rule which states that "the scope of an OIG[s] exclusion [under the HIPAA] extends beyond Medicare and the State health care programs to all Federal health care programs (as defined in § 1128B(f) of the Social Security Act)."¹²¹ The government has also taken the position that the tax-exempt status of a provider is threatened by AKA violations.¹²² Additionally, individual providers are likely to have hospital staff privileges revoked upon conviction of AKA violations.

D. When a Violation Is Not a "Violation": The "Safe Harbor" and Advisory Opinion Process

1. *Safe Harbors*.—The scope of potential liability under the language of the AKA is clearly and dangerously expansive, particularly as interpreted by courts such as the *Greber* court. In 1987, Congress responded to the alarm sounded by the health care community by enacting legislation authorizing the promulgation of safe harbor regulations that would immunize certain technically illegal transactions from liability under the AKA.¹²³

119. 42 U.S.C. § 1320a-7b(b) (1994 & Supp. III 1997).

120. 42 U.S.C. § 1320a-7(a)(3) (1994), amended by HIPAA, Pub. L. No. 104-191, § 211, 110 Stat. 1936 (1996).

121. Health Care Programs: Fraud and Abuse; Revised OIG Exclusion Authorities Resulting From Public Law 104-191, 63 Fed. Reg. 46,676 (1998) (to be codified at 42 C.F.R. pts. 1000-1002, 1005).

122. See James F. Blumenstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM J.L. & MED. 205 n.133 (1996).

123. See 42 U.S.C. § 1320a-7(b)(3)(E) (1994 & Supp. III 1997). This legislation

Four years later, the first ten safe harbors were published,¹²⁴ with three additional safe harbors following in 1992.¹²⁵ Although seven additional safe harbors were proposed in 1993, they have not been issued as final rules.¹²⁶ The Proposed Rules state expressly that compliance with the Proposed Rules does not necessarily provide safe harbor protection.¹²⁷

The preamble to the safe harbor regulations acknowledges the wide reach of the AKA, stating that "[b]ecause the statute is so broad, the payment practices described in these safe harbor provisions would be prohibited . . . but for their inclusion here."¹²⁸ The safe harbors cover transactions that are deemed to pose little or no threat of abuse or to be otherwise desirable or legitimate arrangements.¹²⁹ Those safe harbors created, to date, are quite detailed and narrowly drawn, and providers must comply strictly with every aspect of the regulations in order to be protected from potential AKA liability.¹³⁰

Providers have complained that the existing safe harbors

was vigorously opposed by both the IG of the DHHS and the DOJ, for reasons that are discussed in greater detail, *infra* pp. 27-29.

124. Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35,952 (1991) (to be codified at 42 C.F.R. pt. 1001) (proposed Jul. 29, 1991). These safe harbors covered certain investment interests, space rentals, equipment rentals, personal services/management contracts, the sale of physician practices, referral services, warranties, discounts, employees and group purchasing organizations. *Id.*

125. Health Care Programs: Fraud and Abuse; Amendments to OIG Exclusion and CMP Authorities Resulting from Public Law 100-93, 57 Fed. Reg. 3298, 3330 (to be codified at 42 C.F.R. pt. 1001) (proposed Jan. 29, 1992). The three additional safe harbors cover waivers of coinsurance and deductibles, benefits offered by health plans, and price reductions offered to health plans. *Id.*

126. See Health Care Programs: Fraud and Abuse; Additional Safe Harbor Provisions under the OIG Anti-Kickback Statute, 58 Fed. Reg. 49,008 (to be codified at 42 C.F.R. pt. 1001) (proposed Sept. 21, 1993).

127. See Health Care Programs: Fraud and Abuse; Additional Safe Harbor Provisions under the OIG, 58 Fed. Reg. at 49,008. The proposed, but never finalized, safe harbors cover investment interests in rural areas, investment interests in ambulatory surgical centers, investments in certain group practices, physician recruitment, obstetrical malpractice insurance subsidies, certain referral agreements for specialty services, and cooperative hospital service organizations. *Id.*

128. Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. at 35,952-58.

129. *Id.*

130. "[S]afe harbor protection is afforded only to those arrangements that precisely meet all of the conditions set forth in the safe harbor." 99-8 Op. DHHS-OIG (1999).

are too narrow. As a result, Congress included two provisions in the HIPAA intended to provide greater guidance on the scope of permissible conduct. Under the HIPAA, the DHHS must publish a notice in the Federal Register annually, soliciting proposals for additions or changes to the safe harbor regulations.¹³¹ The HIPAA also directed the DHHS to issue advisory opinions in consultation with the Attorney General.¹³²

2. Advisory Opinions.—In July 1998, the DHHS issued its final rules regarding the issuance of advisory opinions by the DHHS-OIG.¹³³ The DHHS and the DOJ strenuously resisted the responsibility of issuing Advisory Opinions for a number of significant reasons.¹³⁴ The DOJ argued that it was inappropriate to issue Advisory Opinions regarding the application of a criminal law based upon a provider's presentation of the facts, where the really critical determination is the intent of the provider.¹³⁵ The DHHS has also objected to the resources that will be required to implement the advisory opinion process, and the Inspector General, June Gibbs Brown, has gone on record stating that the DHHS would seek repeal of the advisory opinion legislation.¹³⁶

However reluctantly the DHHS may be approaching the advisory opinion mandate, it has, nevertheless, implemented final rules outlining the advisory opinion scope and process. The final rules provides that the DHHS will, with input from the DOJ, issue opinions regarding what constitutes prohibited remuneration under the AKA, whether an arrangement fits into the safe harbors, and whether an activity constitutes grounds for imposition of civil or criminal sanctions.¹³⁷

131. 42 U.S.C.A. § 1320a-7d(a)(1) (West Supp. 1999).

132. *Id.* § 1320a-7d(b).

133. Medicare and State Health Care Programs: Fraud and Abuse; Issuance of Advisory Opinions by the OIG, 63 Fed. Reg. 38,311 (1998) (to be codified at 42 C.F.R. pt. 1008).

134. See Kaz Kikkawa, Note: *Medicare Fraud and Abuse and Qui Tam: The Dynamic Duo or the Odd Couple?*, 8 HEALTH MATRIX 83, 101 n.92 (1998) (citing Thomas S. Crane et al., *Congress Strengthens Anti-Fraud and Abuse Juggernaut*, 5 HEALTH LAW REP. (BNA) 37 (1996).

135. Kikkawa, *supra* note 134, at 101 n.91.

136. *Id.* at 101-02.

137. Medicare and State Health Care Programs: Fraud and Abuse; Issuance of

The DHHS issued nineteen advisory opinions in 1998, and by August 15, 1999, it had issued an additional eight advisory opinions.¹³⁸ The opinions deal with a wide range of activities, and they vary in their complexity. At least six of the eight opinions issued by August 15, 1999 conclude that the proposed scenarios *could* potentially generate prohibited remuneration under the AKA, if the requisite intent to induce referrals were present.¹³⁹ Importantly, however, the OIG also said that it will not subject the conduct described in the advisory opinion requests to sanctions arising under the AKA, despite the technical violation of the law.¹⁴⁰

The DHHS takes the position that the advisory opinion system, like the safe harbor system, is intended only to protect "those arrangements that pose little or no risk of fraud or abuse to the Federal health care programs."¹⁴¹ In fact, individual advisory opinions have been described by the DHHS as "particularized case-specific" safe harbors, which are "simply . . . a determination by the OIG, in the exercise of prosecutorial discretion, not to impose sanctions for specific arrangements that may constitute technical violations of OIG authorities."¹⁴²

Proponents of the existing advisory opinion system argue that the OIG has simply formalized and publicized the prosecutorial decision-making process it is otherwise entitled to use under the extremely broad reach of "anti-fraud" statutes. While all parties benefit when this decision-making process is made more open, advisory opinions offer no protection to any party other than the parties to which the opinion is issued. Moreover, the opinions are issued with many caveats and provisos, and virtually any small change in the facts presented to the government (including evidence that there was an intent to induce referrals) wipes out the limited protection offered under the opinion in the

Advisory Opinions by the OIG, 63 Fed. Reg. 38,311. Advisory opinions are also to be issued regarding what constitutes an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. *Id.*

138. See Op. DHHS-OIG (1998); Op. DHHS-OIG (1999) (last modified July 13, 1999) <<http://www.dhhs.gov/progorg/oig/advopn/index.htm>> [hereinafter 1998 & 1999 Advisory Opinions].

139. See 1998 & 1999 Advisory Opinions, *supra* note 138.

140. See *id.*

141. *Id.*

142. *Id.*

first place.

The fundamental flaw in the existing regime is that it undermines the legitimacy of the rule of law: prosecutors and providers alike must be governed by specific guiding principles for their conduct. The current system sweeps a wide range of conduct—conduct that has good, bad and neutral effects on the public fisc—into a prohibited class. It then invests extraordinary power in prosecutors to determine what conduct is criminal¹⁴³ in a process where that determination may well depend upon who the provider is.¹⁴⁴

Objections were raised during the advisory opinion rule-making process because the DHHS stated its intention to issue advisory opinions only to parties who revealed their identity. A commenter correctly observed that the focus of the advisory opinion should be on the factual circumstances of the arrangement, not on the identity of the parties. The government's response to this objection was that it believes that

the identity of parties is sometimes important to rendering an informed decision about an arrangement. There may be different implications under the sanction authorities for different parties in similar factual circumstances. For example, the analysis of a proposed joint venture arrangement under the anti-kickback statute may depend on whether or not the proposed investors are potential referral sources or have other business relationships.¹⁴⁵

The government's reply begs the question, however, because providers are obviously capable of disclosing information about potential referral sources and other business relationships without being identified. The reply leaves unanswered the commenter's very legitimate question: why should the identity of the parties matter as long as the facts are accurately presented? And if the government is capable of making a determination based upon certain facts, that determination should apply to

143. See Blumenstein, *supra* note 122, at 218.

144. See, e.g., 99-6 Op. DHHS-OIG (1996) (stating that the "institutional history" of the provider merited a deference to its billing policy "that would be inappropriate for an identical policy implemented today").

145. Medicare and State Health Care Programs: Fraud and Abuse; Issuance of Advisory Opinions by the OIG, 63 Fed. Reg. 38,311, 38,315 (1998) (to be codified at 42 C.F.R. pt. 1008).

other similarly-situated parties, and the "particularized" safe harbor should become a generalized one.¹⁴⁶

V. COURT PROCEEDINGS IN UNITED STATES
EX REL. THOMPSON V. COLUMBIA/HCA HEALTHCARE
CORPORATION

A. *The First District Court Decision
Dismissing Thompson*

The *Thompson* case has already had a complicated procedural history. The district court initially dismissed Thompson's claims, which, as initially pled, involved three primary allegations: 1) that *all* Medicare claims submitted while the defendant was allegedly violating health care fraud and abuse laws were false, in and of themselves, under the FCA, 2) that false certifications of compliance in Annual Cost Reports rendered all claims submitted to Medicare during the periods covered by the certifications false, and 3) that the alleged violations of fraud and abuse regulations necessarily led to overutilization and, hence, to false claims.¹⁴⁷

As to the first allegation, the district court observed that the primary issue was whether the alleged fraud and abuse law violations are "*a fortiori* false claims under the FCA."¹⁴⁸ The court concluded that, unlike cases in which Medicare is billed for services that are clearly not covered, the claims submitted by

146. See, e.g., BEST PRACTICES HANDBOOK, *supra* note 105, at 29.

Normally it is assumed that standards for criminal culpability must be established by a body that is answerable to the public (the legislative body) or, if done by administrative action, be clearly articulated through [the] "notice and comment" process. . . . [i]n the advisory system process,] the standards are being articulated only by the administrative agency, without any public notice or hearing process. . . . The theoretical distinction between prosecutorial discretion in applying rules to prior conduct and the advisory function of ruling in advance on proposed courses of conduct should not necessarily determine the outcome of this constitutional issue. The better question is, which decisions should be made on an ad hoc basis and which decisions are of a more general nature and are better made on pre-established criteria.

Id.

147. *Thompson*, 938 F. Supp. at 401.

148. *Id.* at 403.

Columbia were not clearly false Medicare claims.¹⁴⁹ The court concluded that:

Thompson has not stated a claim unless he has sufficiently alleged that the defendants have submitted claims that are false or fraudulent (i.e., claims or claim amounts that the government would not have had to pay but for the fraud). Allegations that medical services were rendered in violation of Medicare anti-fraud statutes do not, by themselves, state a claim for relief under the FCA.¹⁵⁰

In addressing the plaintiff's argument that allegedly false certifications in the defendants' Annual Cost Reports (HCFA Form 2552s) were a basis for liability under the FCA, the court ruled that it was necessary for the claims themselves (that is, the individual claims for reimbursement) to be false or fraudulent.¹⁵¹ The court therefore reasoned that allegedly false certifications in Form 2552s did not render the individual claims false.¹⁵² The court also rejected Thompson's claim that kick-backs necessarily result in overbilling for unnecessary medical services because Thompson was unable to identify any instance in which the defendants actually billed for unnecessary services.¹⁵³

B. *The Fifth Circuit Decision*

On appeal, the Fifth Circuit concurred with the district court's ruling that "claims for services rendered in violation of a statute do not necessarily constitute false or fraudulent claims under the FCA."¹⁵⁴ The court noted its earlier decision in *United States ex rel. Weinberger v. Equifax, Inc.*,¹⁵⁵ in which it concluded that the FCA was not "an enforcement device" for the statute at issue in that suit, the Anti-Pinkerton Act.¹⁵⁶ The

149. *Id.* at 407.

150. *Id.*

151. *Id.* at 406.

152. *Thompson*, 938 F. Supp. at 406.

153. *Id.* at 407.

154. *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 902 (5th Cir. 1997).

155. 557 F.2d 456, 460-61 (5th Cir. 1977).

156. *Thompson*, 125 F.3d at 902.

Fifth Circuit also affirmed the lower court's dismissal of claims relating to allegedly unnecessary services, holding that Thompson had supplied nothing other than statistical studies to support his claim and that nothing in those studies implicated the defendants.¹⁵⁷ As such, Thompson's claims were deemed to be mere speculation.¹⁵⁸

However, the court went on to rule that claims to the government may be fraudulent if the government has conditioned payment upon accurate certifications of compliance with statutes or regulations.¹⁵⁹ Columbia argued (and continues to argue) that the certifications of compliance contained in Annual Cost Reports are not a prerequisite to the government's payment of Medicare claims; the relator disputed this but was unable to produce any support for his assertion.

Finding that the record was insufficient to determine whether the government had indeed imposed such conditions on the payment of Medicare claims, the Fifth Circuit reversed this portion of the district court's decision.¹⁶⁰ The case was remanded to the district court for a determination of several issues, including whether, or to what extent, payment of Medicare claims was conditioned on the defendants' certifications of compliance.¹⁶¹

157. *Id.* at 903.

158. *Id.*

159. *Id.* Other courts have relied on the same reasoning. See, e.g., *United States ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013 (7th Cir. 1999); *United States ex rel. Hopper v. Anton*, 91 F.3d 1261 (9th Cir. 1996); *Luckey v. Baxter Healthcare Corp.*, 2 F. Supp. 2d 1034 (N.D. Ill. 1998); *United States ex rel. Joslin v. Community Health of Md.*, 984 F. Supp. 374 (D. Md. 1997).

160. *Thompson*, 125 F.3d at 902.

161. *Id.* at 902-03. The court also instructed the district court to determine whether claims for services rendered in violation of Stark laws are false or fraudulent claims in and of themselves, and if so, whether the alleged Stark law violations gave rise to separate violations of § 3729(a)(2), as the making of false statements to obtain payment of false or fraudulent claims. *Id.* at 903. However, as previously noted, the purpose of this Article is to analyze only the issues raised relating to the alleged certifications of compliance with the AKA.

C. *The District Court Reconsiders the "False Certification" Issue*

On remand, Columbia renewed its motions to dismiss and for summary judgment on the grounds that the certifications in the Cost Reports were not a prerequisite for payment. The DOJ filed an *amicus* brief in the district court opposing the motions and supporting Thompson, even though the DOJ has not chosen to intervene and take over the *Thompson* litigation.¹⁶² In its *amicus* brief, the DOJ described the various certifications that had been attached to Columbia's HCFA Forms 2552.¹⁶³

1. *Pre-1992 Certifications.*—Before 1992, the HCFA Form 2552s required the health care provider to certify that "to the best of my knowledge and belief [the Hospital Cost Report] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted."¹⁶⁴ The certification also states that "intentional misrepresentation of any information contained in this cost report may be punishable by fine and/or imprisonment under federal law."¹⁶⁵

2. *Post-1992 Certifications.*—After 1992, the HCFA revised the certification. The first lines of the certification state that the

162. *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d 1017, 1041 (S.D. Tex. 1998); *United States' Amicus Curiae Brief in Response to Defendants' Second Amended Motion to Dismiss, United States ex rel. Thompson v. Columbia/HCA Healthcare Corporation*, 20 F. Supp. 2d 1017 (S.D. Tex. 1998) (No. C-95-110). The DOJ commonly files *amicus* briefs in *qui tam* litigation in which the United States does not intervene. The rationale for this policy is that the government remains the real party in interest in *qui tam* litigation and thus maintains an interest in ensuring that the FCA is interpreted in accordance with the DOJ's views. See, e.g., *Brief for the United States of America, as Amicus Curiae as Represented by the Attorney General at 2-3, United States ex rel. Minnesota Ass'n Nurse Anesthetists v. Allina Health Sys. Corp.*, No. 4-96-734, 1997 U.S. Dist. LEXIS 21402, at *1 (D. Minn. May 7, 1998) (No. 4-96-734).

163. *Thompson*, 20 F. Supp. 2d at 1041 (citing *United States' Amicus Curiae Brief in Response to Defendants' Second Amended Motion to Dismiss, Thompson* (No. C-95-110)).

164. *Id.* (quoting the Goldberg Declaration, see *infra* pp. 34-45).

165. *Id.*

Cost Report is

to the best of my knowledge and belief . . . a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.¹⁶⁶

Only two certifications containing this language were submitted by Columbia during the period covered by the relator's original complaint.¹⁶⁷

Above the certification, the post-1992 Form states that falsification or misrepresentation of information in the report is subject to criminal, civil and administrative sanctions. The language also warns that similar sanctions may result if the services at issue were affected by a kickback or were otherwise illegal. Noticeably absent is any language indicating that payment for services claimed will be denied under any circumstances.

3. *The Goldberg Declaration.*—The DOJ attached to its *amicus* brief the declaration of the Acting Chief of HCFA's Provider Audit Operations Branch (the "Goldberg Declaration").¹⁶⁸ In this declaration, the cost reporting process is described, and it is noted that reports for large providers can be as long as 250 pages. The DOJ also attached a copy of a 214-page case study published by Blue Cross and Blue Shield after the relator filed his suit. The study, entitled *Commentary and Case Study: Medicare Cost Reporting Forms*, makes obvious the fact that the clear, primary purpose of the annual cost report is to provide an accounting and reconciliation of actual and projected expenses and services. The cost report clearly is not designed to be a record of statutory and regulatory compliance.

The Goldberg Declaration provides that "[u]nder both versions of the certification, HCFA understood that the certifier was representing that the services provided in the cost report

166. *Id.*

167. Brief in Support of Columbia Defendants' Second Amended Motion to Dismiss, or in the Alternative, for Summary Judgment at 12, *Thompson* (No. C-95-110).

168. *Thompson*, 20 F. Supp. 2d at 1041.

were not infected by a kickback.¹⁶⁹ The declaration concludes that the HCFA considers forms with false statements to be invalid, and it conditions payment and provider eligibility on truthful statements in the cost report.¹⁷⁰

4. *The District Court Decision on Remand.*—Based heavily on the DOJ's brief and the Goldberg Declaration, the district court denied the renewed motion to dismiss and allowed the case to proceed. The court held that the "alleged prohibited financial arrangements among Defendants and referring physicians made the certifications false statements."¹⁷¹ Although the court did not rule directly on the so-called "implied certifications" of compliance alleged by the relator, it observed in a footnote that this theory could be the "Achilles heel" for the relator in other, similar litigation.¹⁷² The court concluded that whether an implied certification could form a basis for Thompson's claims was "not relevant here because of the express certifications of compliance."¹⁷³

Additionally, the court held that the relator stated a separate and independent violation of § 3729(a)(2) based on the allegedly false records (presumably the allegedly false cost reports) that the relator claimed were submitted to the government.¹⁷⁴ The court concluded that the relator could proceed with his AKA-based FCA claims because he had supplied evidence (the Goldberg Declaration) that the government "conditioned its approval, payment, and Defendant's retention of payment funds on those certifications."¹⁷⁵ The court also mentioned the relator's allegations under § 3729(a)(7), but it did not provide an

169. *Id.* at 1042.

170. *Id.*

171. *Id.* at 1046. The court also held that the express language in the Stark law prohibited payment for services rendered in violation of Stark. The court concluded that such claims are therefore actionable under the FCA. *Id.* at 1047.

172. *Thompson*, 20 F. Supp. 2d at 1048 n.33.

173. *Id.* The Fourth Circuit recently held in *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 787 (4th Cir. 1999), that "liability for a false certification will lie only if compliance with the statutes or regulations was a *prerequisite* to gaining a benefit, and the defendant *affirmatively certified* such compliance" (latter emphasis added).

174. *Thompson*, 20 F. Supp. 2d at 1049.

175. *Id.* at 1047.

analysis of those claims.¹⁷⁶

A co-defendant ambulatory surgery provider, Corpus Christi Bay Area Surgery ("CBAS"), argued that the issues remanded by the Fifth Circuit did not apply to CBAS. As an ambulatory surgery center, CBAS is not required to file annual cost reports or certifications of compliance to receive Medicare payments.¹⁷⁷ Although the district court did not rule directly on this point, the court cited only the possibility of liability based on CBAS's corporate relationship with Columbia in denying CBAS's motion to dismiss.¹⁷⁸ Implicit in this ruling is an acknowledgment that CBAS is not subject to liability under Thompson's theories in the absence of a false certification of compliance.¹⁷⁹

VI. WHY THOMPSON IS WRONG

With this lengthy background in mind, the legal flaws and policy issues underlying the *Thompson* case emerge quite clearly.

A. *Thompson Is Wrong Because It Accepts the Government's Claim that Medicare Payments Are Conditioned on Blanket Certifications of Compliance with Health Care Laws and Regulations.*

On remand, the district court concluded that Thompson provided sufficient evidence that Medicare payments were conditioned on accurate responses to the certifications in HCFA Form 2552 to withstand the defendants' summary judgment motion and to allow the case to go to trial.¹⁸⁰ In reaching this conclu-

176. *Id.* at 1049.

177. *Id.* at 1022.

178. *Id.* at 1049.

179. Other courts have reached this conclusion directly. *See, e.g.*, *United States ex rel. Klump v. Dynamics Corp. of Am.*, No. C-1-95-1016, 1998 U.S. Dist. LEXIS 21934 (S.D. Ohio Nov. 17, 1998). In *Klump*, the government sued a contractor and a subcontractor under the FCA. *Id.* at *1. The government alleged that the prime contractor signed certain certifications of compliance, but it conceded that it did not allege that the subcontractor had done so. *Id.* at *6. The court dismissed those claims as to the subcontractor, holding that in the absence of alleged certifications of compliance, the government could not prove entitlement to relief under the FCA. *Id.* at *7.

180. *Thompson*, 20 F. Supp. 2d at 1046.

sion, the court relied heavily on the Goldberg Declaration, discussed above, in which the government claims that the HCFA Form 2552 certification was material to its decision to pay (or not to demand a refund of) Columbia's Medicare claims.¹⁸¹

Based simply upon the declaration itself and applicable law, the court's reliance on the Goldberg Declaration was misplaced. First, it is important to remember today (four years after the *Thompson* suit was initially filed) the context in which the alleged violations took place. In 1990 and 1991, the first two years covered in Thompson's original complaint, the certification made absolutely no reference to compliance with health care laws and regulations. From 1992 until 1995, the certification contained the extraordinarily overbroad representation that the signer is "familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this Cost Report were provided in compliance with such laws and regulations."¹⁸² There is no specific reference in either certification to the AKA or to any of the other thousands of Medicare provisions. By 1992, the first thirteen safe harbors had only recently been promulgated. As one journalist has noted, "many people in healthcare remember the era as a time of genuine confusion and anxiety."¹⁸³ Attorneys who specialize in Medicare fraud and abuse still find that the boundaries of permissible conduct remain quite unclear.¹⁸⁴

One critic of aggressive government prosecution of health care providers has noted that there are "more than 130,000 pages of rules and regulations for all government healthcare programs, over 100,000 of which are related to Medicare."¹⁸⁵ It is hard to take seriously the government's contention that it

181. *Id.*

182. *Id.* at 1035 n.21.

183. J. Duncan Moore, Jr., *Healthcare on Trial: Kansas City Conspiracy Case Could Have Broad Impact on the Industry's Business Practices*, MOD. HEALTHCARE, Feb. 15, 1999, at 2; see also Official Transcript of Trial, *United States v. Anderson*, No. 98-20030-01, 1998 U.S. Dist. LEXIS 12229 (D. Kan. July 21, 1999) (noting the extremely unsettled state of the law in announcing a judgment of acquittal in favor of two health care attorneys accused of conspiring with a hospital to hide the hospital's allegedly fraudulent conduct).

184. See generally BEST PRACTICES HANDBOOK, *supra* note 105.

185. *Rx for the Health Care System*, WALL ST. J., Oct. 8, 1998, at A18 (quoting Robert R. Waller, M.D., President and CEO of the Mayo Foundation).

really expects the signer of this certification (in many cases the Chief Financial Officer ("CFO") of a hospital or network of hospitals) to be truly "familiar" with all of those Medicare regulations¹⁸⁶ or to be able to truthfully certify that every service provided was in total compliance with all of those regulations at all times. The government's position is undermined by the sweeping and unqualified nature of its assertion.

Additionally, the Cost Reports to which the allegedly false certifications were attached are themselves extraordinarily complex accounting records that require the interpretation and application of many government policies that are simply unclear and subject to "good faith differences of opinion."¹⁸⁷ And most importantly, as was previously noted, there is nothing in the express language of the certification indicating that payment of otherwise proper and appropriate claims would be conditioned on either accurate certifications of compliance or on the absence of kickbacks.¹⁸⁸

The government's claim to have conditioned payment on the certifications in dispute is disingenuous, and it reveals that Thompson's case suffers several fatal flaws: if the government did not really expect total compliance with health care laws and regulations, then it did not rely on the allegedly false certifications; the certifications were not material to the government's decision to pay Columbia's health care claims; and the certifications therefore did not cause any injury to the government.

1. *United States v. Data Translation, Inc.*—Chief Judge (now Justice) Breyer provided a cogent and common-sense analysis of very similar issues in *United States v. Data Translation, Inc.*,¹⁸⁹ a case that has direct application to the issues raised by the government's professed reliance on the certification in

186. See, e.g., TIMOTHY P. BLANCHARD, *MEDICARE AND MEDICAID FALSE CLAIMS: LEGAL COMPLEXITIES AND DEVELOPING ISSUES* 41 (1996) (explaining that "[it is well recognized that] Medicare and Medicaid regulations are among the most complicated and confusing regulatory schemes in the United States").

187. *Id.* at 20-21.

188. Clearly, no provider can or should expect to be paid for patently fraudulent Medicare claims, such as claims for services that were not provided or were upcoded. For the reasons explained above, however, the claims in the *Thompson* case do not fall into this category.

189. 984 F.2d 1256 (1st Cir. 1992).

HCFA Form 2552. In this case, the government alleged that Data Translation, Inc. ("DTI") failed to disclose properly discounts that it provided to other customers.¹⁹⁰ The government claimed that this failure violated the terms of its contracts with DTI and the civil FCA.¹⁹¹ Specifically, the government asserted that DTI was contractually obligated to provide answers in a price discount questionnaire that were "not significantly inaccurate or incomplete."¹⁹²

The court reviewed two aspects of the "literal language" of DTI's agreement with the government: the business context of the agreement and the statutory context of the agreement.¹⁹³ It then provided a "practical reading" of the terms—the type of reading that the *Thompson* court should have adopted.¹⁹⁴

a. The "Literal Language" of DTI's Agreement with the Government

The government asserted that the DTI contract disclosure language should be read literally—that the company was required to reveal every single price discount ever provided to any customer.¹⁹⁵ The defendant conceded that it had not done so.¹⁹⁶ The court noted that language in the contract did indeed seem to call for such disclosure.¹⁹⁷

The court also noted the testimony of a witness called at trial, an expert on General Services Administration ("GSA") procurement policies who had actually helped develop the agency's policies. The following testimony was recorded:

Q: So if there is ever a situation in which you vary from your standard terms and conditions, *ever, ever*, you're supposed to report that down there?

190. *Data Translation, Inc.*, 984 F.2d at 1257.

191. *Id.*

192. *Id.* at 1259.

193. *Id.* at 1263. The *DTI* decision also discusses the negotiating context in which the contract was made, analyzing facts that are not applicable to this discussion.

194. *Id.*

195. *Data Translation Inc.*, 984 F.2d at 1260.

196. *Id.*

197. *Id.*

A: Yes.

Q: Ah. And you're supposed to report *every instance* of it?

A: Yes, so we can evaluate that.

Q: Every time, huh?

A: Yes.¹⁹⁸

After reviewing this testimony, the court concluded:

We concede the circumstance to which the Government points with pride, namely, the exhaustiveness of the disclosure that the language literally demands. *But, it is that very circumstance that creates a problem.* Exaggerating to explain our point, we find the Government's interpretation a little like that of, say, a park keeper who tells people that the sign "No Animals in the Park" applies literally and comprehensively, not only to pets, but also to toy animals, insects, and even chicken sandwiches. *If one met such a park keeper, one would find his interpretation so surprisingly broad that one simply would not know what he really meant or what to do.*¹⁹⁹

The scenario described above is precisely the situation in which bewildered health care providers find themselves. The overbreadth of the government's contractual language in DTI pales in comparison to the sweeping certification required by the government in HCFA Form 2552. Worse still, providers are asked to certify complete compliance with a law—the AKA—that is itself extraordinarily broad in its reach. The AKA criminalizes a wide range of conduct, much of which is benign and represents little or no threat to the integrity of federal health care programs. Moreover, the government has never prosecuted, and clearly never intends to prosecute, much of that conduct.²⁰⁰ As one observer has noted, "the modern American health care industry is akin to a speakeasy—conduct that is illegal is rampant and countenanced by the law enforcement officials because the

198. *Id.* at 1260-61 (emphasis added).

199. *Id.* at 1261 (emphasis added).

200. "Read literally, the statute would preclude physicians granted medical staff privileges (something of value) from admitting patients (referrals) to the hospital, particularly given the fact that many medical staff by-laws require a minimum number of admissions to maintain active staff status. However, enforcement authorities have never read the statute quite so literally." BEST PRACTICES HANDBOOK, *supra* note 105, at 19.

law is so out of sync with conventional norms and realities of the marketplace.²⁰¹

b. Business Context

The next step in Judge Breyer's analysis has equally compelling applicability to the facts of *Thompson*. In considering the business context of the transaction, Judge Breyer concluded that "[a]n ordinary business person would not seem likely to interpret the form literally, for, read literally, the form asks a business to shoulder a compliance burden which will often seem inordinately difficult or impossible to carry out."²⁰² Judge Breyer further observed that "no reasonable person . . . could have believed that the Government really wanted the complete and total disclosure for which the language seems to ask."²⁰³ Similarly, no reasonable health care provider could have been expected to believe that, given the extraordinarily complex regulatory regime in which they operate, the inordinately overbroad prohibitions against normal business practices imposed under the AKA, and the evolving nature of the government's guidance on safe harbors at the time of the events giving rise to this suit (and to this day), the government really conditioned payment of federal health care benefits on complete and total regulatory and statutory compliance.

The *DTI* court further noted that no matter what the subjective intent of the author of the GSA's procurement regulations may have been, "common sense" supported its conclusion that a reasonable business person would not have interpreted the government's disclosure requirements literally.²⁰⁴ The *Thompson* court observed in dicta that it could invalidate an administrative agency's interpretation of the statutory scheme it administers only if the interpretation was unreasonable,²⁰⁵ but the *DTI* decision illustrates how easily the *Thompson* court could and should have concluded that the HCFA's interpretation of the Cost Report certifications was unreasonable.

201. Blumenstein, *supra* note 122, at 218.

202. *Data Translation, Inc.*, 984 F.2d at 1261.

203. *Id.*

204. *Id.* at 1262.

205. *Thompson*, 20 F. Supp. 2d at 1046.

c. *The Statutory Context*

Finally, Judge Breyer analyzed the governing procurement laws and regulations and concluded that the elaborate compliance efforts that would be necessary for strict compliance would run counter to the underlying statutory purpose—that is, assuring that the government paid the lowest possible cost for its goods and services.²⁰⁶ The court concluded that:

a system that lays down a literal rule with which compliance is inordinately difficult, turning nearly everyone into a rule violator, and then permits the agency to pick and choose when and where to enforce the rule, is obviously undesirable. It destroys in practice the very hope of rationally cabining agency discretion that the rulemaking process promises in principle.²⁰⁷

After reviewing all of the factors described above, the court concluded that whatever the government's intent, an objectively reasonable person in the circumstances would not have believed that literal compliance was required.²⁰⁸ Judge Breyer's conclusions apply with equal force to the current health care enforcement environment under the AKA. Health care providers today are placed in the same "undesirable" situation described by Judge Breyer. Moreover, the costs of assuring complete and total compliance are disproportionate to the benefits that would be derived from total compliance, and they would strain the resources of an industry already stretched to the limits of its capacity, as reimbursement rates diminish and the population ages.

2. *Materiality and Reliance.*—As discussed in Section II above, courts are split as to whether it is necessary to prove damages in establishing liability under the FCA.²⁰⁹ The *Thompson* court concluded that it is not necessary to prove injury to the public fisc under the FCA²¹⁰ and that the government is injured, in any event, when it pays claims it would not have

206. *Data Translation Inc.*, 984 F.2d at 1262.

207. *Id.*

208. *Id.* at 1263.

209. See *infra* Section IV; pp. 22-23.

210. *Thompson*, 20 F. Supp. 2d at 1046.

paid but for the defendants' allegedly false certifications.²¹¹ The court also noted the relator's argument that such allegedly fraudulent conduct imposes costs of detection and investigation on the government.²¹²

In establishing liability under the FCA, however, it is necessary to prove that the government relied on the allegedly false statement or claim.²¹³ The Fifth Circuit reached this conclusion in *Thompson* when it remanded the case for the district court to determine whether, or to what extent, payment of Medicare claims was conditioned on defendants' certifications of compliance.²¹⁴ In other words, the Fifth Circuit instructed the district court to determine whether the information in the certifications was *material* to the government's decision to pay Columbia's claims and whether it *relied* on those certifications in doing so.

Although the government claims (via its *amicus* brief and the Goldberg Declaration) that the certifications were material and that it did rely upon them, the historical facts are to the contrary. Over the last several years, the DHHS has excluded hundreds, perhaps thousands, of health care providers for violations of the AKA. In no published case, however, has the DHHS or the DOJ ever filed an FCA case seeking FCA damages amounting to retroactive recovery of all the federal funds that were paid to the newly-excluded provider.

At least three courts have observed that the failure of the government to cease funding in the face of evidence of alleged fraud raises legitimate questions of materiality and reliance.²¹⁵

211. *Id.* (stating that "[t]he [Goldberg] [D]eclaration . . . makes clear the nexus between the certifications and the injury to the government").

212. *Id.* at 1034.

213. Courts are split on this issue, but the better reasoned decisions hold that proof of materiality and reliance is necessary under the FCA. *See, e.g.,* United States *ex rel.* Butler v. Hughes Helicopter, No. CV 89-5760, 1993 U.S. Dist. LEXIS 17844, at *43 (C.D. Cal. Aug. 25, 1993), *aff'd*, 71 F.3d 321 (9th Cir. 1995) (requiring materiality of allegedly false statement or claim); United States v. Hibbs, 568 F.2d 347 (3d Cir. 1977) (holding that the subject matter of the false statement must be the direct cause of the government's subsequent loss). *But see* United States v. Board of Educ., 697 F. Supp. 167, 179 (D.N.J. 1988) (rejecting reliance as an element of liability under the FCA). *See also* BOESE, *supra* note 62, ch. 2(a)(2)(a), for a detailed discussion of causation, materiality and reliance as elements of liability under the FCA.

214. *Thompson*, 125 F.3d at 902-03.

215. *See* United States *ex rel.* Lamers v. City of Green Bay, 168 F.3d 1013 (7th

In *United States ex rel. Lamers v. City of Green Bay*,²¹⁶ the Seventh Circuit concluded that under the facts presented, an allegedly false statement was immaterial to the government's funding decision, even if it were an outright lie.²¹⁷ The court also found that the government had not relied on the allegedly false statement and that it therefore was not fraudulent under the FCA.²¹⁸ The court noted that the government awarded an additional grant even when it knew that the program was not in strict regulatory compliance and that any claim that it was being "duped" was therefore absurd.²¹⁹

Another court denied the government's summary judgment motion in *United States v. Carpentieri*,²²⁰ a case in which the government filed FCA claims against a postal worker accused of making false claims in an employment application. The defendant allegedly falsely stated that his past and present medical condition permitted him to perform the duties of a postal carrier, when he had, in fact, previously been in a motor vehicle accident that led a physician to certify that he was "totally disabled" and unable to work for nearly eighteen months.²²¹ Only a few months after beginning employment with the postal service, he

Cir. 1999); *United States v. Intervest Corp.*, No. Civ.A. 3:98CV531BN, 1999 U.S. Dist. LEXIS 15640 (S.D. Miss. Aug. 10, 1999); *United States v. Carpentieri*, No. 96 Civ. 6460(LBS), 1999 WL 156368 (S.D.N.Y. Mar. 23, 1999).

216. 168 F.3d 1013 (7th Cir. 1999).

217. *Lamers*, 168 F.3d at 1013.

218. *Id.* at 1019.

219. *Id.*

220. No. 96 Civ. 6460(LBS), 1999 WL 156368 (S.D.N.Y. Mar. 23, 1999).

221. *United States v. Carpentieri*, 23 F. Supp. 2d 433, 434 (S.D.N.Y. 1998). In *Intervest* the court granted summary judgment on behalf of the defendant, concluding that false certifications clearly were not material to the government's funding decisions. *Intervest*, 1999 U.S. Dist. LEXIS 15640, at *10-11. The defendant in *Intervest* was accused of falsely certifying that the apartments it owned and managed, which received subsidies under the Department of Housing and Urban Development's Section 8 Voucher Program, were "decent, safe and sanitary." *Id.* at *1. The government's own on-site inspection revealed that the units were in very poor condition, and the defendant had been required to submit corrective action plans between 1993 and 1998 because it received "below average" inspection report ratings. *Id.* at *3. The government continued to pay the defendant's claims during this period, despite the inspection results. *Id.* In granting summary judgment for the defendant, the court noted that although the government may have had a ministerial, "technical" requirement that the certifications be signed in order for the claims to be paid, the certifications were not "substantively" material to its decisions to pay the claims. *Id.* at *11.

claimed to have been injured in an accident in a postal service vehicle.²²² The defendant applied for and received benefits under the Federal Employees' Compensation Act ("FECA"), and the government sought recovery of those amounts under the FCA.²²³

In denying the government's summary judgment motion, the court observed that "complex and novel" questions were raised by the facts.²²⁴ Specifically, the court noted that the government agency responsible for making benefits determinations (the Office of Workers' Compensation Program ("OWCP")) had been apprised of the allegations but, nevertheless, had not reversed its benefits award.²²⁵ The court observed that this inaction raised questions of fact as to the materiality, reliance and injury elements of the government's claim that it was entitled to the return of FECA benefits.²²⁶

The cases discussed above thus lend support to the argument that the court's reliance on the Goldberg Declaration was misplaced. Even if the government truly believes that health care providers must be in complete and total compliance with health care laws and regulations in order to receive payment from federal health care programs, that belief is unreasonable in light of the complex maze of statutes and regulations covered by the HCFA Form 2552 certification. Moreover, the government's decision to continue paying Medicare claims to those it accuses of AKA violations and its failure to seek return of the monies paid in the past raise serious doubts about the materiality of the allegedly false certifications and the government's reliance on the allegedly false certifications.

Perhaps most importantly, all three of the above factors—the unreasonableness of the government's expectations, the lack of materiality, and the lack of reliance—support the argument that the defendants did not "knowingly" submit "false claims" for payment. The FCA imposes liability only for the submission of claims that are actually false. The defendants in *Thompson* lacked the requisite intent to submit a false claim for

222. *Carpentieri*, 23 F. Supp. 2d at 434.

223. *Id.*

224. *Carpentieri*, 1999 WL 156368, at *2.

225. *Id.*

226. *Id.*

payment because a reasonable person would not interpret the HCFA Form 2552 certification as a representation of complete and total statutory and regulatory compliance. Thus, defendants would not reasonably view the certification as "false," and it follows, therefore, that the defendants did not "knowingly" submit a "false claim." While questions of intent are normally considered matters requiring the presentation of facts, a number of courts have held, as a matter of law, that a defendant could not have the requisite intent if the state of the law was unsettled.²²⁷ Alleging an FCA violation based on an AKA violation appears to be such a case.

B. Thompson Is Wrong Because the AKA Is Not Self-Enforcing and Requires Discretionary Government Enforcement

More typical Medicare/Medicaid FCA cases are based on direct violations of "self-enforcing" Medicare or Medicaid regulations or statutes. For example, if a doctor or hospital "upcodes" a service to a patient, the provider violates the specific Medicare regulations that provide how much the government will pay for a particular health service. Similarly, a durable medical equipment supplier or a laboratory that provides medically unnecessary equipment or services violates specific regulations regarding for whom and under what conditions such costs are paid by the government. In these situations, there is no issue of intent, and there is no issue of discretionary government enforcement. This is not true with the AKA because liability under the AKA requires not only a violation, but also a determination of the requisite intent and successful enforcement by the DHHS or the DOJ.²²⁸

1. *When a Violation is Not a "Violation."*—As discussed in Section IV, the the DHHS-OIG has concluded in the majority of its recent advisory opinions that the conduct at issue technically violates the AKA.²²⁹ The OIG has, however, informed the re-

227. See, e.g., *United States ex rel. Hagood v. Sonoma County Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991).

228. See 42 U.S.C. § 1320a-7b(b) (1994 & Supp. III 1997).

229. See *infra* pp. 27-29.

questers that it will not proceed against them with respect to any action taken by the requester in good faith reliance on the opinion, provided that all of the material facts have been fully, completely and accurately presented and that the requester complies with any representations that were made to the DHHS in requesting the opinion.²³⁰

The OIG's determination that the conduct constitutes a "technical violation" of the AKA raises a number of critical questions, however. If the conduct is a technical violation of the AKA, must the provider identify this conduct in the certifications of subsequent Cost Reports filed with the HCFA? Would a certification that fails to identify this conduct be subject to FCA liability in a suit initiated by another branch of the government, even though the conduct itself has received the blessing of "a particularized safe harbor" from the OIG? Can the government, or a *qui tam* relator, file an FCA suit over conduct that occurred *before* the issuance of the Advisory Opinion? If a *qui tam* relator elects to file such a suit, can the DOJ be expected to commit the necessary resources to have the suit dismissed?

More fundamentally, however, these "safe harbors" and "advisory opinions" point, irrefutably, to the second fundamental flaw in the *Thompson* case—that some "violations" of the AKA are not, and should not be, enforced. The examples in the advisory opinions are clearly stated to be technical violations of the AKA because they involve "remuneration" given to encourage referral of patients. Yet, the OIG, the primary government enforcer of the AKA, says that it will not enforce these violations.²³¹

230. See, e.g., 99-7 Op. DHHS-OIG (1999) (last modified July 13, 1999) <http://www.dhhs.gov/progorg/oig/advopn/1999/ao99_7.htm>.

231. This does not mean that different branches of the government may not have different views on enforcement. Among the boilerplate limitations routinely contained in the Advisory Opinions is the statement that "[t]his advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services," even though the OIG is required to issue its Advisory Opinions in consultation with the Attorney General. *Id.* Theoretically, but certainly not politically, the DOJ could proceed to prosecute the opinion requester. A reverse form of this administrative schizophrenia was demonstrated recently in Greenbelt, Maryland, where the local U.S. Attorney's office filed an FCA suit based on alleged quality of care deficiencies. *Northern Health Facilities, Inc. v. United States*, 39 F. Supp. 2d 563 (D. Md. 1998). The nursing home subsequently entered into a consent agreement with the U.S. Attorney's office and began its efforts to remedy the deficiencies. *Northern*

This need for enforcement is what distinguishes a violation of the AKA from the other "self-enforcing" regulations and statutes that, if violated, result in FCA violations, assuming the intent necessary under the FCA. The AKA requires enforcement—criminally by the DOJ or administratively by DHHS-OIG.

2. The Government Exercises Both Too Much and Too Little Prosecutorial Discretion in Applying the AKA and the False Claims Act.

a. Prosecutors Have Too Much Discretion

As implemented, the AKA invests the government with too much discretion, making an extremely broad range of otherwise normal conduct illegal, while allowing the government to pick and choose which violators to prosecute. The extraordinary breadth of the government's discretion imposes a high risk of arbitrary and capricious decision-making upon health care providers. This lack of certainty about the scope and application of the law and the potential for criminal sanctions violates fundamental principles of the rule of law and implicates the constitutional vagueness doctrine.

By accepting the assertion that payment of Medicare claims was conditioned on accurate certifications of compliance, the *Thompson* court perpetuated and expanded this impermissibly broad exercise of prosecutorial discretion. One critic of the current fraud and abuse prosecution environment complains that "everyone had better learn to say 'Mother, may I?' before taking a step in any direction."²³² Worse still, providers forced to play

Health Facilities, 39 F. Supp. 2d at 567. Only weeks after the consent order was signed, the HCFA, which was not a party to the consent order, notified the nursing home that it was terminating its Medicare participation, a decision that led to the closing of the nursing home. *Id.* In an order denying the nursing home's request for a temporary restraining order, the court held that, although it was within the HCFA's authority to terminate the home's Medicare funding, this result was "inequitable." *Id.* The court concluded that the outcome was against the public interest and that "Greenbelt and its residents are caught in a conflict between competing Governmental objectives which they cannot control." *Id.* at 577 (citing Plaintiff's Memorandum at 39, *Northern Health Facilities, Inc. v. United States*, 39 F. Supp. 2d 563 (D. Md. 1998) (No. CIV.A. AW 98-4006)).

232. James V. DeLong, *Rule of Law: Just What Crime Did Columbia/HCA Com-*

this game with the government can find it disrupted at any time by another kid on the block, the *qui tam* relator.

b. *The OIG's Decision Not To Prosecute Certain "Technical Violations" of the AKA May Be Trumped by Qui Tam Relators or Other Branches of the Government*

Permitting a *qui tam* relator to enforce alleged violations of a criminal statute under the FCA, as the *Thompson* court has, creates perhaps the worst of all possible worlds for health care providers. All of the negative policy implications raised above are compounded and magnified when private citizens are permitted under the FCA to participate in the government's enforcement efforts purely for personal profit. Thus, the beneficiary of a DOJ decision not to enforce the AKA because prosecution would not be in the public interest may find that the DOJ's exercise of prosecutorial discretion was trumped by a *qui tam* relator who is not at all troubled by the same policy concerns.

The possibility of a *qui tam* relator trumping a government decision not to prosecute is exacerbated by the DOJ's refusal to exercise its authority to dismiss frivolous *qui tam* suits or suits that are against the public interest. The FCA requires the government to affirmatively move for the dismissal of meritless suits, a process that requires a modest commitment of prosecutorial resources.²³³ To decline intervention, however, the DOJ may simply file a notice of declination under § 3730(e)(4)(B).²³⁴

The government has little incentive, however, to dismiss a suit of questionable merit because it is entitled to a significant portion of any recovery—regardless of how small it is—obtained by a relator who proceeds with an FCA suit, despite the government's declination.²³⁵ The total amount recovered in cases in which the government declines intervention is, in fact, a tiny percentage of overall recoveries under the FCA. The government's own statistics reveal that less than 6% of total

mit?, WALL ST. J., Aug. 20, 1997, at A15.

233. See 31 U.S.C. § 3730 (1994).

234. *Id.* § 3730(b)(4)(B).

235. See *id.* § 3730(d).

monetary recoveries obtained since the 1986 amendments to the FCA was recovered in suits declined by the government.²³⁶ Moreover, this small percentage of the government's recoveries was obtained at the expense of a great deal of meritless and frivolous litigation, some of which inevitably generated bad law and needless appeals.

In summary, health care providers today are expected to operate in an almost Kafkaesque environment, where conventional conduct is made illegal and where the government is permitted broad prosecutorial discretion, the exercise of which is unpredictable and subject to being overruled by both private citizens and other branches of the government. Worse still, the *Thompson* decision improperly allows relators to prosecute FCA suits under the "reverse false claims" provision of the FCA, even where there has been no determination that money is owed to the government.

c. *Thompson Is Wrong Because It Permits a Claim Under § 3729(a)(7) of the Civil False Claims Act, the "Reverse False Claims" Provision*

Section 3729(a)(7) of the FCA, also referred to as the "reverse false claims" provision, imposes liability upon any person who "knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government."²³⁷ This provision was added to the FCA when it was amended in 1986.²³⁸ To prove liability under this section, the government (or *qui tam* relator) must prove that the defendant had an existing obligation to the government.²³⁹

236. See FCA STATISTICS, JUSTICE DEPARTMENT'S LATEST STATISTICS ON QUI TAM CASES FILED AND FCA RECOVERIES (1999) (last modified Sept. 30, 1999) <<http://www.ffhsj.com/quitam/fcastats.htm>>.

237. 31 U.S.C. § 3729(a)(7).

238. *Id.*

239. See, e.g., *United States ex rel. American Textile Mfrs. Inst., Inc. v. The Limited*, No. 98-3889, 1999 WL 710275, at *4 (6th Cir. Sept. 14, 1999) (finding that "a plaintiff may not state a reverse false claim unless the pertinent obligation attached before the defendant made or used the false record or statement"). Readers should note that Mr. Boese argued this case for the defendants. The *ATMI* case is discussed in greater detail, *infra* pp. 53-54.

After *Thompson* was remanded to the district court for further factual development, the relator moved to amend his complaint to include the allegation that the defendants knowingly violated the reverse false claims provision of the FCA.²⁴⁰ The relator claimed that Columbia's false certifications were made in order to reduce its alleged obligation to refund amounts collected in alleged violation of the Medicare fraud and abuse laws.²⁴¹ Providers receive periodic payments from fiscal intermediaries throughout the year and then perform a final reconciliation of amounts due to or from the government in the Annual Cost Reports.²⁴² *Thompson* argues that the allegedly false certifications of compliance created an "obligation" to refund amounts that were paid to Columbia throughout the year.

Although the district court provided little analysis of the issues presented by the "reverse false claims" allegation, the relator was granted leave to file an amended complaint adding the alleged reverse false claims violations.²⁴³ In delivering its opinion, the court simply stated:

Plaintiffs allege that in submitting their reports, Defendants knowingly made, used, or caused to be made or used, false records or statements (the false and fraudulent certifications) to obtain from the government approval or payment for false or fraudulent Medicare claims, in violation of 31 U.S.C. § 3729(a)(2). Such conduct, claim Plaintiffs, constitutes the presentation of false claims within the meaning of § 3729(a)(1). They further allege that Defendants knowingly made and caused to be made such false and fraudulent records or certifications that in turn were used to conceal, avoid or decrease obligations to pay money to the United States in violation of § 3729(a)(7).²⁴⁴

While there is no case law on point, the relator's allegations that the Columbia Defendants made or caused to be made false statements to the government to obtain payment of claims based

240. *Thompson*, 20 F. Supp. 2d at 1040.

241. *Id.* at 1035.

242. United States' *Amicus Curiae* Brief in Response to Defendants' Second Amended Motion to Dismiss at 16, *Thompson* (No. C-95-110).

243. *Thompson*, 20 F. Supp. 2d at 1049.

244. *Id.*

on them is a literal and logical application of the statute. Therefore the court concludes that the relator has stated a claim under § 3729(a).²⁴⁵

There is, in fact, significant case law dealing with attempts to treat potential regulatory violations as reverse false claims. Despite some earlier lower court decisions,²⁴⁶ case law in the last several years has developed compelling arguments against the imposition of § 3729(a)(7) liability for alleged regulatory and statutory violations. Most important is the clearly worded language of the FCA itself, which imposes liability only for attempts to avoid paying the government an "obligation."²⁴⁷

The legislative history of the 1986 amendments refers twice to "money owed,"²⁴⁸ and money is not owed to the government until an adjudication that a statutory or regulatory violation did indeed occur. An *ex post facto* determination that a statute or regulation was violated does not give rise to a retroactive obligation to pay; rather, the obligation to pay fines or penalties arises only upon a formal finding that a violation in fact occurred.²⁴⁹ Such findings are not the basis for reverse false claims liability under § 3729(a)(7).²⁵⁰

Shortly after the passage in 1986 of the legislation containing § 3729(a)(7), the DOJ took the position that

[f]alse claims submitted . . . to avoid payment to the Government of administrative fines, penalties, or forfeitures . . . or criminal fines . . . are not the stuff of False Claims Act lawsuits, regardless of whether the fine or forfeiture, payment of which has been evaded, is imposed in connection with the violation of a federal benefits program.²⁵¹

245. *Id.* at 1049.

246. *See, e.g.,* *Pickens v. Kanawha River Towing*, 916 F. Supp. 702 (S.D. Ohio 1996).

247. 31 U.S.C. § 3729(a)(7).

248. S. REP. NO. 99-345, at 15, 18 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5280, 5283 (stating "an individual who makes a material misrepresentation to avoid paying *money owed* the Government should be equally liable under the Act as if he had submitted a false claim").

249. *United States ex rel. S. Praver & Co. v. Verrill & Dana*, 946 F. Supp. 87, 93 (1996), *aff'd on reconsideration*, 962 F. Supp. 206 (D. Me. 1997).

250. *S. Praver & Co.*, 946 F. Supp. at 93.

251. Memorandum of the United States in support of its Motion to Dismiss at 6-7 n.4, *Thompson* (No. C-95-110); *United States ex rel. Sequoia Orange Co. v. Oxnard*

And, in *United States ex rel. S. Praver & Co. v. Verrill & Dana*, the court noted that:

obligation in the False Claims Act refers to something more than potential liability or moral or social duty; a legal obligation seems to be the touchstone. I may negligently cause damage to another in a car accident, but morality aside, I have no tort-based obligation to pay or transmit money to her until she obtains a judgment. I may breach a contract, but absent a specific remedy provided in the contract, I have no obligation to pay or transmit money to the other contracting party until he obtains a judgment. I may even violate the False Claims Act, but until the government or private relators obtain judgment, I have no obligation to pay or transmit money.²⁵²

The DOJ recently advocated a new definition of the term "obligation," however, in *United States ex rel. American Textile Manufacturers Institute, Inc. v. The Limited*²⁵³ ("ATMI"). In *ATMI*, the relators alleged that the defendant violated customs laws and regulations and that these alleged violations gave rise to liability under § 3729(a)(7). The district court dismissed the case, holding that "the language of § 3729(a)(7) is not so broad as to encompass every statutory or regulatory violation which might lead the United States to attempt to assess a fine or other type of monetary penalty against the violator."²⁵⁴

On appeal, the DOJ filed an *amicus* brief, urging the court to affirm the lower court's ruling, but on different grounds. Concerned that these decisions could interfere in cases based, *inter alia*, on Medicare Cost Reports, the DOJ argued that "obligation" should be defined more broadly. The DOJ urged the Sixth Circuit to reject the rationale of *Praver* and *United States v. Q Internal Courier, Inc.*²⁵⁵ and to instead adopt a definition of

Lemon Co., No. CV-F-91-194 OWW, 1992 WL 795477 (E.D. Cal. May 4, 1992), cited in Order Granting Defendants' Motion To Dismiss at 41, *United States ex rel. American Textile Mfrs. Inst., Inc. v. The Limited, Inc.*, No. C2-97-776, 1997 U.S. Dist. LEXIS 18142 (S.D. Ohio Nov. 13, 1997), *aff'd on reconsideration*, 179 F.R.D. 541 (S.D. Ohio 1997) (No. C2-97-776).

252. *S. Praver & Co.*, 946 F. Supp. at 94.

253. 190 F.3d 729, 738 (6th Cir. 1999).

254. No. C2-97-776, 1997 U.S. Dist. LEXIS 18142 (S.D. Ohio Nov. 13, 1997), *aff'd on reconsideration*, 179 F.R.D. 541 (S.D. Ohio 1998).

255. 131 F.3d 770 (8th Cir. 1997).

“obligation” based on different criteria. It argued that where the government has granted the defendant a right, privilege or benefit, § 3729(a)(7) applies to false statements made to avoid payment of a contractual or monetary obligation, even in the absence of a judgment and even if the “obligation” is merely potential.

In a unanimous decision, the Sixth Circuit expressly declined to adopt the position advocated by the DOJ. It ruled instead that

A defendant does not execute a reverse false claim by engaging in behavior that might or might not result in the creation of an obligation to pay or transmit money or property to the government. Contingent obligations—those that will arise only after the exercise of discretion by government actors—are not contemplated by the statute. Examples of contingent obligations include those arising from civil and criminal penalties that impose monetary fines after a finding of wrongdoing: as opposed to quasi-contractual obligations created by statute or regulation (such as the imposition of a standard mailing rate), contingent obligations (such as the imposition of a civil penalty for an antitrust violation) attach only after the exercise of administrative or prosecutorial discretion, and often after a selection from a range of penalties.²⁵⁶

Similarly, the Eighth Circuit ruled in *United States v. Q International Courier, Inc.*²⁵⁷ that Private Express statutes and their implementing regulations did not create an “obligation” under the FCA to pay domestic postage.²⁵⁸ The court held that while these statutes and regulations prohibited and set penalties for certain conduct (the delivery of domestic bulk mail from offshore sites allegedly to avoid paying higher domestic mail rates), they did not impose a legal duty to pay domestic postage.²⁵⁹ Rather, the court ruled that “[a] potential penalty, on its own, does not create a common-law debt.”²⁶⁰

Alleged violations of the AKA create potential fines and penalties, but they do not likewise create an existing, determi-

256. *ATMI*, 190 F.3d at 738.

257. 131 F.3d 770 (8th Cir. 1997).

258. *Q International Courier, Inc.*, 131 F.3d at 774.

259. *Id.*

260. *Id.*

nate obligation to pay the government.²⁶¹ Similarly, alleged violations of the AKA, in and of themselves, do not give rise to an obligation to repay the government moneys paid under Medicare.²⁶² Rather, to the extent such violations might give rise to FCA liability (a position refuted above), the FCA liability would have to be premised upon alleged *direct* violations under § 3729(a)(1) and (a)(2), as the *Prawer* court held.²⁶³ Reverse false claims liability does not “automatically [spring] into existence”²⁶⁴ upon violation of a statute or regulation. Until prosecution occurs and penalties are imposed, the defendant has no “obligation” to the government which creates liability under § 3729(a)(7).

Thus, by permitting a cause of action under the reverse false claims provision of the FCA, the *Thompson* court improperly overlooks the critical fact that all remedies under the AKA are *prospective*. There are no automatic sanctions that “spring into existence” when the AKA is violated; rather, the government must identify the violation; prosecute it; and obtain a judgment or administrative remedy. No money is due until civil, criminal or administrative penalties are imposed.

VII. CONCLUSION

In ruling that false certifications of compliance with health care laws and regulations—including the AKA—may give rise to liability under the FCA, the *Thompson* court perpetuated a regime in which health care providers are subjected to a degree of uncertainty that undermines bedrock principles of the rule of law. A government constrained by laws, and not by the fiat of bureaucrats or *qui tam* relators, requires clear standards that can be applied without resorting to the excessive discretion that exists when the AKA, its “safe harbors” and its advisory opinion system are engrafted upon the already potent sanctions of the civil FCA.

261. *S. Prawer & Co.*, 946 F. Supp. at 93-94.

262. *Id.*

263. *Id.* at 93.

264. *Id.*

