Success Of Novel FCA Theory Would Burden Health Providers

By **Lacey Bangle, Lily Becker and John Wolfe** (March 16, 2021)

Lacey Bangle

Lily Becker

John Wolfe

In U.S. v. Catholic Health System of Long Island Inc., a case the district court itself recognized could have "broad-reaching ramifications for healthcare facilities," the U.S. Court of Appeals for the Second Circuit will soon consider whether a legally sufficient False Claims Act claim can be predicated upon an alleged violation of a federal felony criminal statute prohibiting conversion of federal health care benefits.[1]

Judge Margo K. Brodie of the U.S. District Court for the Eastern District of New York recently certified an interlocutory appeal of her denial of a motion to dismiss the complaint incorporating this novel theory. In moving for appeal, the defendants argued:

> No other federal court in the nation ... has addressed whether a facility that receives Medicare or Medicaid funding violates 42 U.S.C. § 1320a-7b(a)(4)[2] if it fails to specifically earmark and segregate those government funds for the sole and exclusive benefit of the program beneficiaries.[3]

The operative complaint alleges that the defendant operators of a health care system committed fraud — theft by conversion — in seeking government reimbursement funds and impliedly made a false certification related to funds allegedly improperly diverted to components of the system unrelated to the services for which the funds were reimbursed.

If the Second Circuit allows this theory to proceed, it could create new administrative burdens for tracking use of reimbursed funds and open health care operators to more and more costly litigation. Plaintiffs in these types of cases will have another legal theory to rely on, and suits will be difficult to defeat prior to discovery because the question of whether government funds were properly spent is one of fact.

Theories at Play

The defendants operate a health care system that includes hospitals and nursing homes. The relator, Michael Quartararo, a former administrator at one of the defendants' nursing homes, alleged the defendants developed a scheme to improperly divert Medicare and Medicaid reimbursed funds by improperly charging one of their nursing homes for fraudulent overhead and other costs.

Examples included: administrative and utilities costs for other facilities; portions of salaries for various staff members that allegedly had few if any responsibilities for the nursing home; and inflated costs for laboratory services.

Relying on an implied false certification theory,[4] the relator alleged that this conduct violates a criminal statute, Title 42 of the U.S. Code, Section 1320a-7b(a)(4), which prohibits conversion of federal health care benefits for purposes other than the intended beneficiary, and the failure to disclose this violation rendered the nursing home's reimbursement claims false under the FCA.

The operative complaint alleges that the defendants converted funds by using government reimbursed funds for services other than for the benefit of the patient for whom reimbursement was sought.

It further alleges that the diversion of resources resulted in diminished quality of care for residents.[5] The complaint does not allege how care was diminished or that the defendants failed to provide any required service to residents.

The defendants countered in their motion to dismiss that (1) there is no applicable law or regulation requiring that they "earmark or otherwise tie specific Medicare or Medicaid funds to specific patients" as a condition of reimbursement, and (2) that reimbursement levels are set at a fixed per diem basis and are not adjusted based on individual patient needs.[6]

According to the defendants, the nursing home is not required to return any excess payments if the cost of patient care is less than per diem reimbursements.[7]

They also argued that Congress intended Section 1320a-7(b)(a)(4) only "to address the scenario in which 'an entity makes an application for payment for care rendered to a beneficiary, but on receipt of that payment from the government, does not provide the care or service underlying the request.'"[8]

The District Court's Order Denying Defendants' Motion to Dismiss

The district court relied on two Second Circuit decisions as offering support for the relator's position that Medicaid and Medicare funds "are, to some extent, tied to the provision of services for the intended beneficiaries in whose name the funds were awarded."[9]

The court also disposed of the defendants' argument that the relator had not plausibly alleged improper use of government payments that were in a general account where government reimbursement funds are comingled with funds from other sources.

The court appeared to accept the relator's argument that "'there is simply no requirement that Relator tie a specific beneficiary dollar in a deliberately comingled operating account to a specific non-Medicare or non-Medicaid expense" in alleging violations of the statutes at play.

The court explained:

> Although Relator's claims may ultimately fail at the summary judgment stage if, after discovery, he cannot provide proof of a single instance in which Defendants submitted a claim for reimbursement within the period of operation of the alleged scheme, Relator has produced evidence of representative claims submitted by Defendants to the [New York State Department of Health] within the relevant period, which satisfies Relator's burden at the motion to dismiss stage.[10]

The court, thus, did not appear to credit the defendants' argument that the relator would have a burden — at any point in the litigation — to show that specific government funds were used for improper purposes.

Instead, the court indicated that the relator could succeed on his claims if he provided "proof of a single instance in which Defendants submitted a claim for reimbursement within the period of operation of the alleged scheme."[11]

Implications for Health Care Operators

The district court's holding would seem to require facilities receiving Medicare and Medicaid reimbursements to segregate those funds so that the entire amount is used for the care of the specific patient for whom the facility sought reimbursement.

Of course, this would impose massive administrative burdens upon providers, and, in the context of residential care facilities, and others that are similarly compensated, seems contrary to Medicare and Medicaid's fixed per diem fee structure.[12]

Such a process would also likely pose significant challenges to integrated health care systems that seek efficiencies through sharing administrative and other overhead costs among different components of the system.

If a disgruntled employee thinks, for example, that too much of a shared administrator's salary is being paid with federal reimbursement monies, the employee may be able to bring an FCA suit and survive a motion to dismiss, regardless of whether the cost-sharing allocation is appropriate or not.

The district court was certainly correct about the potential far-reaching consequences of its decisions for the health care industry. If the Second Circuit does not course-correct, health care providers could face an administrative nightmare or a wave of costly litigation from whistleblowers who disagree with the way they are allocating government funds.

Lacey Bangle is an associate, and Lily Becker and John Wolfe are partners, at Orrick Herrington & Sutcliffe LLP.

The opinions expressed are those of the author(s) and do not necessarily reflect the views of the firm, its clients or Portfolio Media Inc., or any of its or their respective affiliates. This article is for general information purposes and is not intended to be and should not be taken as legal advice.

[1] United States ex rel. Quartararo, v. Catholic Health System of Long Island Inc. , No. 12-CV-4425 (MKB), 2021 WL 681085, at *9 (E.D.N.Y. Feb. 22, 2021); 2021 U.S. Dist. LEXIS 31934 (E.D.N.Y. Feb. 22, 2021).

[2] 42 U.S.C. § 1320a-7b(a)(4) prohibits a party who "having made application to receive [a federal health care] benefit or payment for the use and benefit of another and having received it, [from] knowingly and willfully convert[ing] such benefit or payment or any part thereof to a use other than for the use and benefit of such other person."

[3] Quartararo, 2021 WL 681085, at *8.

[4] Courts may find a violation of the FCA where a defendant has submitted a claim for payment to the government that makes "specific representations about the goods or services provided," where the "defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths," – i.e., where the defendant has impliedly, but falsely, certified compliance with material legal requirements in billing the government.
Universal Health Servs. Inc. v. U.S. , 136 S. Ct. 1989, 2001, 195 L. Ed. 2d 348 (2016).

[5] See Quartararo, No. 12-CV-4425 (MKB), Dkt. No. 47, ¶ 95 (May 25, 2017).

[6] Quartararo, No. 12-CV-4425 (MKB), 2020 WL 3960514, at *10 (E.D.N.Y. July 13, 2020) (quoting Quartararo, Dkt. No. 61-6, p. 7 (Nov. 13, 2017)).

[7] Quartararo, No. 12-CV-4425 (MKB), Dkt. No. 61-6, p. 8 (Nov. 13, 2017)).

[8] Quartararo, 2020 WL 3960514, at *11 (quoting Quartararo, No. 12-CV-4425 (MKB), Dkt. No. 61-6, p. 11 (Nov. 13, 2017)).

[9] Quartararo, 2020 WL 3960514, at *11-12. ("Theplain language of section 1320a-7b(a)(4) ... specifically addresses the scenario in which one 'converts' a 'benefit or payment or any part thereofto a use other than for the use and benefit of such other person.'").

[10] Id. at *14.

[11] See id.

[12] While it varies from state to state, nursing homes (and many other types of health care providers) are generally reimbursed for every day they provide care to a Medicaid or Medicare beneficiary, using rates set during a "base year" that considers various cost components and not based on the cost of care the particular beneficiary required.