# FROM ESCOBAR TO YATES… WHAT ARE YOUR ODDS?

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# Learning Objectives

This session will provide attendees with a perspective on issues that might not be on their radar, but should be. With specific focus on individual liability related to actual or potential compliance issues, this session provides guidance on identifying and addressing these difficult issues.

At the end of this session, you will know:

- The impact of the Escobar and Healogics cases, as well as the Yates Memo, and how all of these may apply to you.
- About recent issues that the government has focused its attention on regarding corporate compliance and individual liability.
- Areas that deserve additional attention given the government's close scrutiny of the healthcare industry and how to approach these areas at your organization to protect yourself and the company.

# Introduction

- As professionals in revenue cycle the world is "tipping" as it relates to compliance.
- Odds are high that you will find yourself in the cross- hairs of some of this issues.
- Today we will discuss the following topics: Escobar case, Healogics case, and Yates Memo.

# Compliance is a "Party of Many"

Your billing data becomes the data reviewed to develop the case against your organization and under Yates, maybe you too.

Department of Justice
HHS Office of Inspector General
Centers for Medicare & Medicaid Services
Medicare Fraud Strike Force
Medicaid Fraud Control Units

They all have the same goal: **Recover $$ from Fraud.**

# False Claims Expansion

The Government has passed laws that make it easier for relators to make a case:


- The Fraud Enforcement and Recovery Act of 2009 (FERA)
- The Affordable Care Act (ACA)
- Reverse False Claims
- False Claim – knowingly presents a claim to Government for services not provided, medically unnecessary, filed inaccurately
- Reverse False Claim – Retention of a payment that you are not entitled to

Has become easier to prove these claims in a lawsuit

Very active relators / Qui Tam activity.

# Qui Tam

- What is it?

**Qui tam pro domino rege quam pro se ipso in hac parte sequitur** - *"One who brings an action for the King as well as for himself."*

A private citizen may file suit on behalf of the Federal government and keep a portion of the proceeds.
The Government may intervene, decline, or dismiss the suit.

Relator's share equals 15-30% of recovery

- 2017 – Government recoveries are 10 to 1 from Qui Tam
  - $2.44 Billion out of $2.47 Billion comes from Qui Tam

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# Reverse False Claims Liability

- Anti-Kickback Statute and Stark Law liability
  - AKS has penalties
    - Civil penalties may include three times the amount of the kickback plus up to $74,792 (in 2017) per kickback
    - Criminal penalties may include fines, imprisonment, or both
  - Stark penalties
    - Repayment of claims, Civil Monetary Penalties up to $24,253 (in 2017) for each service
- False Claims Act penalties on top of AKS and Stark
    - Maximum per claim penalty of $21,916 PLUS three times damages to the government
  - AKS and Stark law issues, if not addressed, can become false claims
  - Retention of a known overpayment

# Known Overpayments

- CMS Issued the 60-Day Overpayment Rule
  - Discusses credible information of an overpayment
  - When the 60-day clock starts
  - Duty to investigate and quantify
  - Reasonable diligence
  - Six-year lookback period
  - Reporting and refunding overpayments

# What Results in a False Claim

- False or fraudulent?
  - Anything that is not true
- Condition of **Participation**
- Condition of **Payment**
- When is something done knowingly?
- What is material?

# Escobar: Supreme Court Case

- Creating a new world:

  *Universal Health Servs., Inc. v. U.S. ex rel. Escobar, 136 S. Ct. 1989 (2016)*

  - ❖ Allowed implied certification BUT relied on whether material to payment
  - ❖ Unanimous decision
  - ❖ Implied certification can form a basis for liability under certain circumstances
  - ❖ Courts continue to parse *Escobar* regarding materiality requirement

    -Circuit splits have developed

- "Material to the government's decision to pay"

# Escobar – thoughts…

- False Claim
- "Implied Certification" means that when one submits a claim to the Government, one is certifying compliance with all underlying laws, rules, regulations, and contacts terms.
- Add materiality?
  - U.S. ex re. Dresser v. Qualium (California)
- Based on Escobar, a False Claims Act complaint must not only possess the **materiality of the false representations**, but then it must also explain **why those misrepresentations are material**.
  - Increased opportunity for **Motion to Dismiss** and **Motion for Summary Judgment**

# Recent Impact of Escobar

- *United States ex rel. Ruckh v. CMC II* , No. 8:11-cv-01303 (M.D. Fla.)
  - Relator alleged operator of 53 SNFs in Florida schemed to defraud the government over a four-year period by misrepresenting the medical conditions of and treatments provided to SNF patients.
  - The United States and state of Florida both declined to intervene in the case.
  - Jury found the defendants liable for more than $115 million in damages, which became a judgment of nearly $348 million after triple damages and statutory penalties.
  - On January 11, 2018, the judge granted the defendants' motion for judgment as a matter of law and vacated the jury verdict on the basis of materiality.

# How Does Escobar Impact the Revenue Cycle?

1. Post Escobar – is it "material"?
2. Does the codes on the claim represent specificity of services – that without it, the Government would not pay?
3. The removal of the 5% "bright-line" error rate from the OIG—if it ever really existed.

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# Healogics: Dealing with Vendors

*"If you have a hammer, everything looks like a nail."*

- We hire vendors for their specific expertise.
- Recent Healogics settlement (DOJ, June 20, 2018) $22.51 million to settle false claims for unnecessary hyperbaric oxygen (HBO) therapy.

THE UNITED STATES DEPARTMENT of JUSTICE

# DOJ's Yates Memorandum

- Issued September 9, 2015
- "Individual Accountability for Corporate Wrongdoing"
- Emphasized DOJ's commitment to combat fraud "by individuals"
  - DOJ will scrutinize corporations and their compliance programs as it investigates and prosecutes fraud
  - DOJ's criminal Fraud Section instituted a Corporate Health Care Fraud Unit.
- Purposes and Benefits:
  - Proper parties are held responsible for their actions
  - Results in a change of corporate behavior
  - Serves as a deterrent to future fraudulent behavior
  - Increases public confidence in the justice system
  - Increases consistency in handling outcomes of federal investigation.

# Yates Memo Explained

- Evidence of a strong compliance program when can self-identify a concern
- Self-disclosure to the Government in order to resolve issue (and prevent whistleblower liability)
- DOJ clarified that credit for cooperating with the Government when an issue is being investigated will be more challenging
- An "all-or-nothing" approach:
  - Requires corporations to disclose to the DOJ all relevant facts about individuals' involvement in the misconduct in order to qualify for *any* cooperation credit

# Elements of the Yates Memo


Established six DOJ policy directives:

1. All criminal and civil corporate investigations shall also **focus on individuals** at the outset;
2. Absent extraordinary circumstances, **individuals will not be released from civil or criminal liability** when a matter is resolved with a corporation;
3. Civil prosecutors should **evaluate whether to prosecute individuals** based on factors beyond ability to pay;
4. Corporations will not receive any cooperation credit without providing to DOJ **all relevant facts about individuals** involved in alleged corporate wrongdoing;
5. No DOJ prosecutor should resolve a matter with a corporation without **"a clear plan to resolve related individual cases"** ; and,
6. Civil and criminal prosecutors should consistently and routinely consult with each other during all phases of investigations.

# Yates (continued)

- Regardless of whether the organization has voluntarily reported the misconduct and fully cooperated with the investigation, it cannot benefit from *any* credit unless it has provided the requisite information regarding the involved employees.
- Encourages organizations to take all necessary investigative actions, discover who is responsible for the misconduct, and report those findings to the DOJ, which would then pursue those individuals to the fullest extent of the law.
- No longer solely corporate responsibility for actions of individuals.

# Beyond Sanctions

- No longer simply fines for the organization
- Individuals face:
  - Financial penalties
  - Criminal liability
  - Exclusion


- Recent settlements are demonstrating the impact on corporate executives when issues are addressed

# CEO Liable

- Prime Healthcare Services
  - One of the largest hospital systems in the nation entered into a settlement with DOJ for $65 million (August 3, 2018)
  - Government alleged that between 2006-2012 Prime engaged in a deliberate corporate-driven scheme to increase inpatient admissions of Medicare beneficiaries who presented to the ED
    - Admissions were not medically necessary- upcoding
  - Whistleblower was former Director of Performance Improvement at one of the hospitals
    - She will receive $17 million dollars of the settlement
  - CEO and founder, Dr. Prem Reddy, will pay $3.35 million of the settlement

# CFO Held Liable

- Former Chief Financial Officer and Chief Operating Officer of Southeast Orthopedic Specialists
  - September 14, 2017 in Jacksonville, FL
  - While employed he oversaw operations and finances of practice
  - Focused on his role in billing, or causing to be billed to Federal health care programs, certain services he knew or should have known were not medically necessary and reasonable
  - Agreed to pay $100,000 for his conduct
  - Practice settled with Government for $4.48 million

# CEO Held Liable

- Tuomey Settlement
  - Hospital settled with Government for $72.4 million in 2016 after a judgment of $237 million stemming from a jury verdict
  - Involved Stark law violations of compensation arrangements with physicians that exceeded fair market value

- CEO settled with the Government personally in 2016
  - $1 million settlement, excluded for four years from federal health care programs
  - Evidence at trial demonstrated that the CEO "ignored and suppressed warnings from one of Tuomey's attorneys that the physician contracts were "risky" and raised "red flags."

# Tenet Settlement

- Tenet agreed to a $514 million settlement related to kickbacks paid to a clinic for the referral of their patients to Tenet hospitals neonatal services reimbursed by Medicaid
- Former Senior VP indicted on healthcare, mail and kickback charges in 2017
  - Alleged that he and co-conspirators "falsified Tenet's books, records, and reports and made and caused to be made materially false, fraudulent and misleading representations and omissions to the government"
- Also indicted, former CEO of one hospital and the President and CEO of the clinic
  - Charges include: conspiracy to defraud United States, paying and receiving health care bribes, wire fraud, falsifying books and more

# Physicians Are Not Immune

- DOJ highlighted settlements and judgments with individuals under the False Claims Act
  - Totaled more than $60 million in last Fiscal Year
- After 21st Century Oncology LLC paid $19.75 million to resolve allegations that it billed Federal health care programs for medically unnecessary laboratory tests, DOJ entered settlements with various individual urologists:
  - $3.8 million settlement with a physician for allegations that he referred unnecessary tests to a laboratory owned and operated by 21st Century Oncology
- A pain management physician who agreed to the entry of a $20 million judgment to resolve allegations that he billed Federal health care programs for surgical monitoring services that he did not perform and for medically unnecessary diagnostic tests

# Halifax Settlement – Pre-Yates

- Halifax Hospital Medical Center and Halifax Staffing Inc. (Halifax)—a hospital system based in the Daytona Beach, FL area—paid $85 million to resolve allegations that they violated the FCA by submitting claims that violated the Stark Law (March 2014)
  - Based on improper compensation pools for physicians
  - Reported by former Compliance Officer who was then the Director of Physician Services
  - Relator raised the issue to management and her concerns were not addressed
  - Individuals were not indicted

# Hypothetical – St. Joseph Medical Center

- $22 million to settle allegations under the FCA for unlawful remuneration under the AKS, the Stark law violations for series of professional services contracts with a cardiology group
  - Alleged group received payments above fair market value, for services not rendered or that were not commercially reasonable and were entered into for the purpose of inducing referrals by group to hospital
- What could have happened with current focus on individual culpability?
  - Executives
  - Physicians
- Who could have spoken up to prevent these payments?

# Future of Yates

- Will the current Administration make changes?
- DOJ is reviewing policies within the Department, including Yates memo
- Granston Memo issued January 10, 2018
  - Outlines a number of factors that DOJ attorneys should use to determine whether the DOJ should seek dismissal when it has otherwise declined to intervene
- Rod Rosenstein, Deputy US Attorney General:
  - "*The solutions of the past are not necessarily the right solutions today. Circumstances change. We should not blindly accept past practices.*"
  - He has also said, "*Who made the decision to set the company on a course of criminal conduct*?"
  - Indicates DOJ investigations will continue to focus on these individuals, unclear what credit to corporations

# Fraud Takedown 2018

- National Health Care Fraud Takedown Results in Charges Against 601 Individuals Responsible for Over $6 Billion in Fraud Losses (June 28, 2018)
  - Largest takedown in US History
  - Large focus was opioid overuse and misuse
  - Many federal agencies included in this coordinated effort – DOJ, FBI, HHS-OIG, DEA, Fraud Strike Forces
  - Defendants allegedly participated in schemes to submit claims to Medicare, Medicaid, TRICARE, and private insurance companies for treatments that were medically unnecessary and often never provided

# Revenue Cycle Impact: Be Proactive Not Reactive

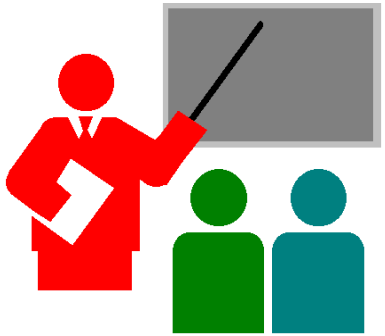
- You may be on front line to identify an issue
- See something, say something
  - Engage in discussions in your organization
  - Ask questions and document responses
  - Follow up with appropriate personnel if concerns persist

# How is Your Organization Doing?

- Strong compliance officer and plan in place to identify, investigate and calculate overpayments
  - Must be able to address concerns raised—whistleblower liability
- Monitoring efforts are in place and well documented, including regular self-audits, internal statistical analysis, third party reviews
- Areas to be monitored
  - Coding; Claim accuracy; Medical Necessity documentation
  - Physician compensation relationships and payments
  - Vendor contracts – any connections to physicians or referral sources

# Educate the Right Personnel

- Board members, executives and decision-makers regarding their obligations should be handled by your compliance officer.
- Policies must be in place for addressing complaints of wrongdoing
- If actual or potential fraud or abuse issue identified
  - Make sure investigated
  - Determine how to address and correct
  - Document decisions made and actions taken
- Remedial actions
  - Repayment
  - Focus on remedial actions for culpable individuals
  - Document all actions taken



# Hurdles Faced in Maryland

- Effort to align as much as possible between HSCRC "reporting" and what Medicare expects in "billing"
- Increased sophistication in medical treatment and clarifying how to handle in Maryland
- Staff coming in from out-of-state and learning the differences
- MAC that handles Maryland and non-Maryland hospitals
- Limited budgetary resources

# Some Areas With Current Activity

- What is "regulated", what is not, what is hospital-owned?
- Is PECOS set up correctly?
- Telehealth – requirements for Medicare, Medicaid and/or payers may be different
- Employed Physicians
  - Your due diligence: what you can inherit
  - Impact to your hospital or health system
- Medicare's 60-day repayment rule

# Questions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