GEORGIA HEALTH LAW DEVELOPMENTS

A PUBLICATION OF THE HEALTH LAW SECTION OF THE STATE BAR OF GEORGIA

WINTER 2012

NOTICE

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Health Law Section

Health Law Developments

MESSAGE FROM THE CHAIR

Greetings Health Law Section Members,

We are excited about the activity going on with the Section and the fact that more Section members are getting involved than ever before.

Our joint program co-sponsored with the Centers for Disease Control (CDC) is just around the corner. To be held February 16, this program will provide a unique opportunity to look inside the CDC, to hear from our U.S. Attorney Sally Quillian Yates and the HHS deputy associate general counsel, Paula Kocher, and obtain CLE credits in the process. In addition to learning about the unique history and operations of this vital agency and the ways in which CDC handles legal issues (including in conjunction with the U.S. Attorney's Office), attendees will be able to tour the CDC Emergency Operations Center and Museum. Thanks to Mark Kashdan and Alan Rumph for taking the lead on planning this event.

The Health Law Section also is sponsoring the Fundamentals of Health Law program upcoming on March 2 at the State Bar Center. Thanks again to the chair Rod Meadows for planning the program.

Much appreciation goes to all of the authors who contributed to this edition of the Health Law Section newsletter. In this edition, Lynn Adam informs of Veterans Administration Treat Programs as an alternative to prison sentences for Georgia Veterans, Douglas Witten gives an update on efforts to create insurance exchanges, and Brian McEvoy and Todd Swanson describe the Department of Justice's recent efforts to combat Health Care Fraud. Thanks to Brian McEvoy for his assistance in publishing the newsletter.

The Executive Committee continually seeks to prepare meaningful programs for our Section and provide you with information relevant to the practice of health care and we hope that you have benefited from these efforts. We invite our members to submit articles, reports, and proposals for presentations that would be informative to the membership.

It is an honor to serve as Chair this year. Please let me or anyone on the Executive Committee know if you have any ideas or suggestions to help us better serve you.

Best regards,

James W. Boswell
Chair, Health Law Section

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WELCOME, NEW EXECUTIVE COMMITTEE MEMBERS!

We would like to congratulate and thank the new members of the Executive Committee of the Health Law Section. These Executive Committee members are already becoming highly involved in the work of the Section, and we are honored to have them serve. The new members are:

Lynn Adam
King & Spalding

Mark Kashdan
CDC

Keith Mauriello
Arnall Golden Gregory

Lynette Rhodes
DCH

Brian Stimson
Alston & Bird

VA Treatment Programs: An Alternative to Jail for Georgia Veterans?

Lynn A. Adam
King & Spalding LLP

How can Georgia criminal courts assist veterans returning from Iraq and Afghanistan? They can establish veterans treatment courts to divert veterans facing imprisonment for nonviolent offenses to treatment programs funded by the United States Department of Veterans Affairs (VA). This article describes a nationwide movement that is now taking root in Georgia to establish veterans treatment courts, which not only save money for state taxpayers but also help veterans to obtain needed treatment and make a successful transition to civilian life.

Origins

In 2008, Judge Robert T. Russell of Buffalo, New York, established what is believed to be the nation's first veterans treatment court. Judge Russell's Court has become a national model for courts around the United States. He took action after observing on his criminal docket a growing number of veterans with substance abuse and mental health issues related to their military service.

Judge Russell recognized that service-connected health issues were driving many veterans into the criminal justice system. He created a diversion court, allowing a veteran an opportunity to stay clean and sober while receiving treatment and court supervision in lieu of possible incarceration. Judge Russell's Court is said to have no recidivists - he won't allow veterans to drop out of the program, and they don't get in trouble with the law again either.

National Movement

Today, at least 8 states have adopted veterans court legislation, and approximately 80 veterans courts are operating in the United States. The VA, the National District Attorneys Association, the American Bar Association, the American Legion, and many other veteran advocacy organizations strongly support veterans treatment courts.

Georgia Courts

At least two Superior Courts in Georgia have established formal veterans treatment courts, and we have prepared legislation for consideration by the General Assembly to create a uniform mechanism for Georgia courts to adopt such programs and best practices. The Governor and General Assembly are actively considering legislation to increase the use of a variety of diversion programs in Georgia, known as accountability courts, including veterans treatment courts.

More than 774,000 veterans live in our State.[1] Legislation endorsing veterans treatment courts would demonstrate our commitment as a community to supporting veterans who have served our country, often with great personal sacrifice. It also would address the unique needs of veterans whose military service is a contributing factor to their involvement in the criminal justice system.

Like other diversion courts, veterans treatment courts save taxpayer dollars because the cost of treatment is far less than the cost of incarceration. Moreover, veterans often may obtain VA healthcare services, which cost nothing for Georgia's state and local governments. By contrast, our State spends more than $1 billion every year on prisons. National data indicates that approximately 9% of jail inmates are veterans, and the vast majority of them are nonviolent offenders.[2]

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[1] *See* http://www.va.gov/VETDATA/Veteran_Population.asp (data as of 2010).

[2] *See* http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2019

VA Healthcare Services

Service members returning from Iraq and Afghanistan are eligible for VA healthcare services for a period of 5 years or more following separation from service. A veteran in prison, however, is not entitled to VA healthcare services.[3]

Nearly 20 percent of returning combat veterans suffer from symptoms of PTSD or major depression, but many do not seek treatment for a variety of reasons.[4] Veterans who experience Traumatic Brain Injury or other physical injuries also may turn to substance abuse and exhibit destructive behaviors that lead to contact with the criminal justices system. An increasing number of veterans are homeless, and the unemployment rate for veterans is consistently 2-3% higher than that of the general community.

In response to these trends, the VA has significantly ramped up its mental health services for veterans, it has prioritized eliminating homelessness among veterans, and it has established the Veterans Justice Outreach (VJO) Initiative. The VJO Initiative seeks to avoid the unnecessary criminalization of mental illness and extended incarceration among veterans by facilitating appropriate mental health and substance abuse services for veterans involved in the criminal justice system. Every VA medical center is staffed with at least one VJO coordinator whose responsibility is to assist local Courts and veteran defendants.

Georgia has three VA Medical Centers (located in Augusta, Decatur, and Dublin) and a number of community-based outreach centers in other locations. Each of Georgia's VA Medical Centers is staffed with VJO coordinators.

To express support for the creation of veterans treatment courts, you may contact the Governor's Office and your representatives in the General Assembly.

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[3] *See* 38 C.F.R. § 17.38(c)(5).

[4] *See* Information Letter, "Information and Recommendations for Services Provided by VHA Facilities to Veterans in the Criminal Justice System," published April 30, 2009 (citing RAND study).

Resources

- To view our proposed legislation for Georgia, visit our blog at http://georgiavetcourt.posterous.com/
- For information about the VA's Veterans Justice Outreach Initiative, visit http://www.va.gov/HOMELESS/VJO.asp
- For information about veterans treatment courts nationwide, visit the website of the National Association of Drug Court Professionals (NADCP) at http://www.nadcp.org/vets
- For information about Georgia Accountability Courts, including the November 2011 report of the Criminal Justice Reform Council, and cost and recidivism comparisons of treatment programs versus incarceration, visit http://w2.georgiacourts.org/gac/
- To refer a veteran to an attorney, you may contact Norman Zoller, Coordinating Attorney, Military Legal Assistance Program, State Bar of Georgia, at (404) 527-8765.
- To assist a veteran in obtaining VA benefits, you may direct him or her to a local office of the Georgia Department of Veterans Service. http://sdvs.georgia.gov/portal/site/SDVS

White House Report: States Progressing Toward Establishing Health Insurance Exchanges

Douglas J. Witten
State of Georgia

On January 18, 2012, the White House issued a report (the "Report")[1] indicating that twenty-eight (28) States and the District of Columbia are moving forward to implement the new Affordable Care Act (the "ACA") driven health insurance exchanges.

The Report summarizes State actions undertaken to establish exchanges, which are intended to be one-stop marketplaces where consumers can choose a private health insurance plan that fits their needs starting in 2014, and focuses on examples of the State legislation and executive actions, public meetings, and other activities in motion to create these new health insurance marketplaces the ACA contemplates. The Report provides a "snapshot" of ten (10) States (Alabama, Colorado, Idaho, Michigan, Minnesota, Mississippi, Nevada, New York, Pennsylvania, and Rhode Island) to illustrate the diversity of approaches and progress each of these is taking to have an exchange functioning by the ACA's 2014 deadline. The Report notes that the States profiled are not necessarily those furthest along in establishing an exchange but, rather, are included to "cut across the spectrum of geography, demographics, and political leadership."

In addition to the focused State profiles, the Report briefly discusses the status of a pair of States, Massachusetts and Utah, which had exchange-like structures in place before the enactment of the ACA, as well as various States that have "indicated an interest in establishing" an exchange with the beginning of 2012 legislative sessions. The Report outlines the Administration's proposals for new options for States reluctant to establish their own exchanges, including participation in a "partnership exchange" and alternatively in a "federally-facilitated exchange" developed by the Department of Health and Human Services ("HHS"). To round out its progress summary, the Report includes a chart depicting "State Affordable Insurance Exchange Actions and Funding," displaying exchange authority and grant amounts for each State and the District of Columbia.

The Report does not include Georgia in its State "snapshots" or related discussion, but the "State Affordable Insurance Exchange Actions and Funding" chart reflects Georgia's "EO for Study" of exchanges and the State's receipt of an HHS exchange planning grant in the amount of $1,000,000.

In fact, on June 2, 2011, Governor Deal signed an Executive Order[2] to establish the Georgia Health Insurance Exchange Advisory Committee (the "Committee") and to assign the Committee certain duties and responsibilities with respect to health insurance exchanges. Among those duties and responsibilities, the Committee was charged with assessing whether Georgia should create a State-based exchange (or multiple exchanges) and delivering recommendations for legislation and a business plan should such an exchange or exchanges be proposed. On December 15, 2011, the Committee submitted its final report[3] to the Governor, expressing support for the development of a type of small business health insurance marketplace, through private or limited quasi-governmental means, that focuses on private-sector, free-market principles. Ultimately, the Committee concluded its assessment by noting that "[c]ontinued review, planning and evaluation by

[1] The Report is entitled "2012 Progress Report: States Are Implementing Health Reform," *available at* http://www.whitehouse.gov/sites/default/files/01-18-12_exchange_report.pdf

[2] http://gov.georgia.gov/vgn/images/portal/cit_1210/21/41/17217485106_02_11_01.pdf

[3] http://healthcarereform.georgia.gov/vgn/images/portal/cit_1210/28/4/179765813GHIX%20Final%20Report%20to%20the%20Governor.pdf

the Governor and the Georgia State Legislature will be necessary."

Recent reports signal that the Georgia General Assembly will not take up health insurance exchange legislation during the 2012 session. Sen. Renee Unterman, chairman of the Senate Health and Human Services Committee, has indicated as of the date of this writing that Republican legislative leadership and Governor Deal have agreed not to push an insurance exchange bill, not wanting to move forward until the Supreme Court has ruled on the constitutionality of the Federal health reform law,[4] though Georgia Democrats contend that there should be no delay in the creation of a Georgia exchange.[5] With additional regulations from Washington, an eagerly-anticipated Supreme Court ruling on the ACA, and the 2012 Presidential election on the horizon, which all have the potential to alter dramatically the health reform landscape as the 2014 exchange deadline approaches, an ongoing debate over exchanges is likely to intensify in the coming months.

[4] Andy Miller, *State Won't Act on Health Insurance Exchange*, Georgia Health News, January 12, 2012, *available at* http://www.georgiahealthnews.com/2012/01/state-act-health-insurance-exchange/#0_undefined,0_

[5] Jeanne Bonner, *Democrats Want Healthcare Exchange*, GPB News, January 13, 2012, *available at* http://www.gpb.org/news/2012/01/13/democrats-want-healthcare-exchange

Turning up the HEAT: A Review of Both the National and Local Federal Health Care Fraud Enforcement Environment

Brian F. McEvoy
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Over the past two years, the Federal Government's approach to health care law enforcement has become significantly more active. This increase in activity has been triggered not only by increased funding for health care fraud enforcement, but also by recent legislative provisions that expand fraud and abuse exposure for health care providers under the False Claims Act ("FCA"). In light of these developments, corporate health care clients are more dependent than ever on competent counsel to investigate potential health care law violations and to defend them if the Government begins an investigation of their own into the client's activities.

However, preventing (or minimizing) institutional health care fraud is the best medicine. To take such prophylactic measures, counsel must be familiar with the current changes in federal health care regulation and recent enforcement initiatives taken by federal law enforcement. This paper will focus on the recent expansion of the FCA, and the Government's recent initiatives in enforcement under the FCA.

Pervasiveness of the Health Care Fraud

On January 28, 2010, at the National Summit on Health Care Fraud, Attorney General Eric Holder described health care fraud as a serious problem whose scope is "simply shocking," noting that more than $60 billion in public and private health care spending is lost to fraud each year. Attorney General Holder also echoed the concerns of HHS Secretary Kathleen Sebelius when he admitted that, due to the size and amount of money involved in the national health care system, "so long as health care fraud pays and these crimes go unpunished, our health care system will remain under siege."[1] However, according to some experts, the $60 billion dollar health care fraud figure cited by Holder may in fact be too conservative of an estimate of the amount of money lost to health care fraud each year.

In May 2009, while testifying before the Senate Committee on the Judiciary: Subcommittee on Crime and Drugs, Malcolm K. Sparrow, a Harvard Professor of Public Management and expert in fraud detection and control strategy, stated:

> The units of measure of losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. We just don't know the first digit. It might be as low as one hundred billion. More likely it is two or three. Possibly four or five. But whatever that first digit is, it has eleven zeroes after it.[2]

Other experts agree with Sparrow's conclusions, putting the estimated annual loss between $70 and $100 billion.[3] Illustrated another way, some 10-

[1] Attorney General Eric Holder, Remarks at National Summit Health Care Summit (January 28, 2010) (transcript available at http://www.stopmedicarefraud.gov/innews/holderremarks.html).

[2] Malcolm K. Sparrow, Testimony at "Criminal Prosecution as Deterrent to Health Care Fraud" before Senate Committee on Judiciary: Subcommittee on Crime and Drugs (May 20, 2009) (transcript available at http://www.hks.harvard.edu/news-events/testimonies/sparrow-senate-testimony) [hereinafter "Sparrow Testimony"].

[3] Rudman, *et al.,* Health care Fraud and Abuse, 6 *Perspectives in Health Information Management* 1 (Fall 2009); Association of Certified Fraud Examiners, Health care Fraud, available at www.acfe.com/resources/fraud-101-health care.asp (last visited February 23, 2009).

20% of the annual Medicare and Medicaid budget is spent on fraudulent or false claims.[4]

Regardless of the actual number, losses from health care fraud are staggering. Statistics like this have motivated law makers to expand exposure of health care providers under the FCA, and have motivated the present administration to increase funding of health care fraud prevention and to expand the use of the FCA to guard against health care fraud.

Recent Expansion of the False Claims Act

On May 20, 2009, President Obama signed into law the Fraud Enforcement and Recovery Act ("FERA"). Less than a year later, on March 23, 2010, the President signed the Patient Protection and Affordable Care Act ("PPACA"). The passing of these two laws within the last two years has significantly expanded the exposure of health care providers that receive federal funds.

Expansion of the FCA resulting from FERA

FERA expanded both the procedural and substantive provisions of the FCA. As to the procedural changes to the FCA, FERA resolved two important areas of ambiguity present in the FCA. First, FERA specifically provides that the Government's complaint-in-intervention, which typically replaces, amends, or adds to the relator's complaint under seal, relates back to the date of the filing of the relator's complaint.[5] FERA also resolved ambiguity relating to the requirement that relators provide the Government with a "written disclosure of substantially all material evidence." Before FERA, it was unclear whether the FCA permitted *qui tam* relators to also assist state and local enforcement agencies while the relator's complaint was under seal. Now, relators are clearly "not preclude[d]" from serving on state or local officials the Complaint, other pleadings and the written disclosure of substantially all material evidence.[6] FERA also expanded the ability of the Government to use civil investigative demands ("CIDs") beyond what is permissible under FERA.[7] Whereas CIDs were only occasionally used in the past, under the Attorney General's new power to delegate the authority to issue CIDs, use of such devices will become common practice. The result of this significant procedural expansion is that the Government may now use interrogatories in the form of CIDs to aid in its civil **or criminal** investigations of whistleblower claims.

Substantively, FERA has eliminated the FCA's prior intent requirement. Before FERA, liability under the FCA existed only where the individual "knowingly" made, used or caused to be made or used, a false record or statement "to get a false or fraudulent claim paid or approved by the Government."[8] FERA the words "to get" and "paid or approved by the Government,"[9] such that health care providers are now liable under the FCA upon a showing that the false statement at issue is material to a false claim.[10]

This significant change is coupled with a more expansive definition of the term "claim," which now means "any request or demand, whether under contract or otherwise, for money or property and whether or not the United States has title to the money or property."[11] This amendment allows the Government to pursue false claims for payment that occur through the submission of indirect false claims for payment, that is false claims to third-party contractors or other intermediaries as opposed to directly to the Government.

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[4] Sparrow Testimony, *supra.*

[5] 31 U.S.C. § 3731(c), which reads:

> For statute of limitations purposes, any such Government pleading shall relate back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the Government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that person.

[6] 31 U.S. C. § 3732(c).

[7] 31 U.S.C. §3733.

[8] 31 U.S.C. § 3729 (1994), *amended by* Pub. L. No. 111-21, § 4, 2009 Stat. 386 (2009).

[9] Fraud Enforcement and Recovery Act, Pub. L. No. 111-21, § 4, 2009 Stat. 386 (2009).

[10] 31 U.S.C. § 3729 (2009).

[11] 31 U.S.C. § 3729(b)(2).

Perhaps most significantly, FERA also expands the "reverse false claims" provisions of the FCA. After FERA, a reverse false claim exists where an individual "knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."[12] This amendment removes the old requirement that the offending person take an affirmative act to conceal, avoid, or decrease their obligation to pay. Now, all that is required is that the offending party "know" that they are in receipt of or have retained money to which they are not entitled, *i.e.* an overpayment. The implications of this amendment are significant; if the recipient were to discover that they received an overpayment because of a systematic or automated flaw in their billing system, the knowledge of this single incident of overpayment would impute knowledge of a potential overpayment to all transactions using that same defective system – resulting in a massive obligation to repay, and if not repaid, a massive reverse false claim (which may include liability for treble damages).

Expansion of the FCA resulting from PPACA

Although FERA's changes also expanded the class of persons protected from retaliation to also include contractors and agents, as opposed to just employees, the bigger changes to the FCA (from the whistleblower's perspective) came from the PPACA. The PPACA has softened the "public disclosure jurisdictional bar," a provision that removed a court's jurisdiction where the relator's suit is based on publicly disclosed information "in a criminal, civil, or administrative hearing" as well as publicly disclosed information in a news media report or any number of other Government reports, hearings, audits, or investigations.[13] This jurisdictional restriction was formerly a defendant's most significant defense to a *qui tam* suit, but has now been significantly limited. Before the PPACA, relators' suits could not rely on publicly disclosed information from federal or state or local entities without stripping the court of jurisdiction over the suit.[14] Now, "publicly disclosed information" includes only information disclosed in federal courts or by federal departments or agencies.[15] Furthermore, the PPACA allows the Government to veto the imposition of a jurisdictional bar, even if the relator has relied solely on information publicly disclosed by federal agencies.[16]

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knowledge that the PPACA had been passed by Congress. Accordingly, the law will only apply to cases pending as of March 23, 2010.

[12] 31 U.S.C. § 3729(a)(1)(G).

[13] 31 U.S.C. § 3730(e)(4) (2009).

[14] *Graham County Soil and Water Conservation District v. U.S. ex rel Wilson*, -- U.S. --, 130 S.Ct. 1396 (2010). It is important to note that this Supreme Court made its holding before the President signed the PPACA into law, but with

[15] 31 U.S.C. § 3730(e)(4)(2009), which now reads:

> (4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed--
>
> (i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;
>
> (ii) in a congressional, Government [FN2] Accountability Office, or other Federal report, hearing, audit, or investigation; or
>
> (iii) from the news media,
>
> unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.
>
> (B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

[16] *Id.*, "The court shall dismiss an action or claim under this section, **unless opposed by the**

Finally, PPACA eliminated the "direct knowledge" requirement contained in the definition of "original source" – greatly expanding the number of persons who can bring *qui tam* actions.[17] Now, a relator is considered an original source, and can avoid the jurisdictional bar, if their knowledge is (1) independent and (2) materially adds to the publicly disclosed allegations. The practical effect of this amendment is that a relator may make allegations based upon indirect or even secondhand knowledge.

Historical Use of the FCA to Enforce of Health Care Fraud

The recent expansions of the FCA have significantly eased restrictions on filing a *qui tam* lawsuit. Not only is liability easier to prove, but the number of people capable of bringing a case and surviving the public disclosure jurisdictional bar will encourage the filing of *qui tam* cases. While the FCA applies to any recipient of Government money, these changes will most significantly affect the health care industry and health care providers. As of 2004, 80% of all *qui tam* cases were related to health care fraud[18] – nearly double the percentage of health care cases just seven years earlier.[19] Accordingly, much of the $2.2 billion in civil enforcement recoveries as well as the criminal prosecutions for health care fraud, described by Attorney General Holder at the National Summit, began with the filing of a *qui tam* complaint.

In terms of *qui tam* suits, whether the Government decides to intervene is the single greatest determinant of success, as well as the size of any recovery. This is apparent based upon data maintained by the Department of Justice's civil division concerning all *qui tam* actions, health care and otherwise, filed from 1986 through 2009.[20]

See Table 1 at the end of this article.

Not only does Government intervention lead to an extraordinarily high success rate, but the Department of Justice data also reveals that Government intervention results in the relator's 15-30% share historically being 28 times higher than if the Government declines to intervene.[21]

Furthermore, according to the chart below,[22] there is evidence that the returns for the Government are also greater where the *qui tam* case originates from a relator, as opposed to the Government's own independent investigation.

See Table 2.

Recent Enforcement Initiatives

Beginning in Miami in 2007, the Department of Health and Human Services ("HHS") and the Department of Justice ("DOJ") began a number of joint undertakings to combat health care fraud. On May 20, 2009, in a joint press release,[23]

Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed-- . . ." (emphasis added).

[17] 31 U.S.C. § 3730(e)(4)(B).

[18] Jack A. Meyer, President, Economic and Social Research Institute, *Fighting Medicare Fraud: More Bang for the Federal Buck*, prepared for Taxpayers Against Fraud Education Fund (July 2006) available at http://www.taf.org/FCA-2006report.pdf (last visited February 27, 2010).

[19] John R. Phillips and Mary Louise Cohen, Failing to report Medicare billing errors: a very risky business, *Journal of the Association of Health care Internal Auditor* (Spring 1997).

[20] Taxpayers Against Fraud, *Fraud Statistics – Overview*, October 1, 1987 – September 30, 2009, Civil Division,, U.S. Department of Justice, available at http://www.taf.org/FCAstats2009.pdf.

[21] One explanation for the extraordinarily high success rate and high rewards is that the Government is able to engage in a more thorough fact investigation than a whistle-blowing relator and, to that end, is able to determine more accurately how good a case is before it decides whether or not to intervene.

[22] Taxpayers Against Fraud, *The 1986 False Claims Act Amendments: A Retrospective Look at Twenty Years of Effective Fraud Fighting in America,* p.5 (2006) (available at http://www.taf.org/retrospective.pdf) (last visited February 27, 2010).

[23] U.S. Dept. of Health & Human Services, Press Release, *Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention and Enforcement Action Team* (May 20, 2009), available at

Attorney General Holder and Secretary Sebelius announced the formal creation of the Health Care Fraud Prevention and Enforcement Action Team, or HEAT Program. This program is characterized by a number of joint Strike Teams through which both HHS and DOJ are committed to engaging in data-focused investigations of potential health care fraud by pooling their data to discover billing trends that are indicative of fraud.

The first such Strike Team, based out of Miami and later dubbed "Phase One," has been a resounding success in its first three years of existence, garnering more than $220MM in court-ordered restitution in 87 criminal cases involving 159 defendants.[24] Along with the creation of HEAT, the proposed budget for fiscal year 2010 called for a 50% increase in spending on fraud and abuse enforcement and prevention, and a total of $1.7BB in projected spending over the next five years.[25] In this manner, HHS and DOJ are seeking to "raise[] the stakes on health care fraud, with increased tools, resources and sustained focus by senior-level leadership."[26] The statement further opined that the HEAT program, along with the increase in proposed spending, could save the United States over $2.7BB over the next five years.[27]

The National Summit on Health Care Fraud, held in January 2010, was another initiative indicative of the new environment of health care fraud enforcement. At this conference, not only were the successes of the HEAT Program publicly announced, but officials from both the public and private sector engaged in closed-door discussions for purposes of determining how best to curb health care fraud throughout the United States. Furthermore, by emphasizing the successes of the Government's new focus on health care fraud, by unveiling proposed budgetary increases, and by inviting leaders in the private sector to participate in the health care fraud discussion, the Government is reminding the private sector that there is more than enough success, and money, to go around.

Such activities, coupled with the strengthening of the FCA, have lead to an increasingly active healthcare fraud and abuse enforcement environment that is nationally coordinated. While certainly individual districts continue to pursue their own healthcare fraud cases,[28] the Department of Justice through the HEAT program, also is coordinating these prosecutions nationally. On September 7, 2011, Attorney General Holder and Secretary Sebelius announced the bringing of charges against "91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing."[29] This "nationwide takedown," as it was described by the press release, involved charges brought in Miami, Houston, Baton Rouge, Los Angeles, Brooklyn, Dallas, Detroit, and Chicago – all cities where there a HEAT strike force has been established. Furthermore, this press release shows that Miami, where the HEAT program began in 2007, continues to be a hotbed for health care fraud and is an area of focus for the government.

The extent to which fraud enforcement will be nationally coordinated in the future is unknown, but in terms of the future of cases brought in the Northern District of Georgia, the recent *Allergan* case may offer some insight into the type of exposure a company may face for health care fraud. In this case, Allergan, the makers of Botox, agreed to pay $600MM and plead guilty to a federal misdemeanor to settle civil and criminal charges that it had illegally promoted and sold Botox for unapproved uses, namely treating

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http://www.hhs.gov/news/press/2009pres/05/20090520a.html. [hereinafter "May 20 Press Release"].

[24] Fact Sheet: Phase One Medicare Fraud Strike Force Miami-Dade County, Fla., p.1 available at http://www.stopmedicarefraud.gov/heatsuccess/heat_taskforce_miami.pdf (last visited February 24, 2010).

[25] John J. Carney and Robert M. Wolin, *Target Health Care Fraud*, NEW YORK LAW JOURNAL, July 13, 2009.

[26] May 20 Press Release, *supra.*

[27] *Id.*

[28] *See* http://www.stopmedicarefraud.gov/HEATnews/index.html for an index, by state, of health care fraud prosecution press releases.

[29] U.S. Dept. Health & Human Services, Press Release, Medicare fraud strike force charges 91 individuals for approximately $295 million in false billing (September 7, 2011), available at http://www.hhs.gov/news/press/2011pres/09/20110907c.html.

headaches. These charges arose out of the initial whistleblower suit, the Government's investigation of which led to allegations of kickback and fraud violations. The *qui tam* suit was resolved for $225MM of the $600MM that Allergan paid as part of the global settlement. From the perspective of the corporate health care client, however, the important take away point is that the bringing of the $225MM civil suit led to an overall payment of $600MM and a criminal conviction.

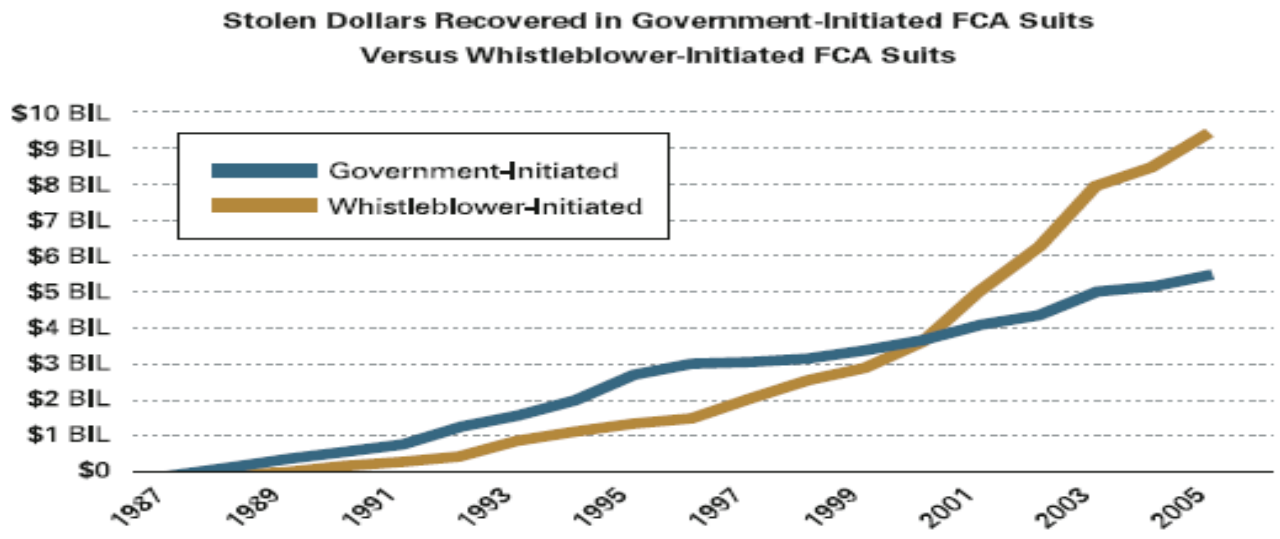
Preventive Measures

In light of the changes to the FCA, from the perspective of corporate health care providers, a key prophylactic measure to limit the corporate client exposure in the new health care enforcement environment is to minimize *qui tam* suits. To do this, corporations must ensure that they have in place policies and procedures designed to address the most recent changes in the FCA. Furthermore, in light of the softened intent requirements of the current FCA, corporations should be more conservative than before on "close" cases where it is unclear that an FCA violation might have occurred. Indeed, many corporate health care providers may consider governing their conduct as if they are *already* operating under a Corporate Integrity Agreement with the Government. This is particularly true in light of the expansion of the "reverse false claims" provisions, under which a false claim exists where an individual simply retains money to which he or she or it knows they are not entitled. Finally, fostering a corporate culture in which compliance is not a secondary concern, but a primary concern, may also aid in preventing the creation of whistleblowers, since such an environment may encourage problems, if they arise, to stay in house and be resolved via a self-report or other less costly measure.

Table 1

From 1986-2009	Settlement or Judgment Reached	Case Dismissed	Total No. Concluded cases	Success rate
DOJ Civil Division Intervened	1,076	58	1,134	**95%**
DOJ Civil Division **Did Not** Intervene	239	3,681	3,920	**6%**
All Cases (regardless of intervention)	1,315	3,739	5,054	**26%**

Table 2



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MESSAGE FROM THE EDITOR
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