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False Claims Act Risks for Bundled Services: Exposure Risks and Damages

The healthcare industry is no stranger to liability threats under the federal False Claims Act (FCA), with the number of cases consistently growing as the government clamors to offset losses in its straining healthcare budget. According to Attorney General Eric Holder, the government is "taking [its] fight against health-care fraud to a new level."[1] The classic example of a false claim involves submitting a request for payment for work that was not performed or a product that was not delivered, but in the healthcare industry, government reimbursement programs frequently use fixed payments for a collective bundle of services, *e.g.,* diagnostic related groups, *per diem* payment rates, bundled services, *etc*. So what level of exposure does a healthcare provider face when just a small portion of the collective service is allegedly false or fraudulent—is it potentially liable for the value of the whole claim or just the portion that was tainted?

The Worthless Service Theory

To maximize damages, the government (and whistleblowers, especially) often asserts what is known as a "worthless service" theory of recovery, alleging that the fraudulent component of the bundled service renders the whole claim invalid. The worthless service theory is based on the notion that some services can be so deficient in quality that they amount to no service at all. A straightforward worthless service claim involves a specific function or test that was performed so poorly that, in effect, it was not done at all. If providers billed for each individual act of care, then application of the worthless service theory would be relatively straightforward—courts could simply compare the acts billed for to the acts actually performed. With bundled service payments, however, providers do not bill separately for individual acts of patient care, such as feeding, changing or bathing. Damages are potentially higher under a worthless service theory for bundled services because the value of the entire claim, not just the tainted portion, is at risk.

The courts have been mixed on how they handle worthless services claims. For example, in a recent nursing home case in Kentucky, a court allowed the government to proceed with its worthless services claims involving allegedly deficient quality of care.[2] The court reasoned that, under a worthless services

1 See Press Release, Department of Justice, "Attorney General Eric Holder Speaks at the Health Care Fraud Takedown Press Conference" (May 2, 2012), available at http://www.justice.gov/iso/opa/ag/speeches/2012/ag-speech-1205021.html..

2 *U.S. v. Villaspring Health Care Center, Inc.*, 2011 WL 6337455 (E.D. Ky. Dec. 19, 2011).

theory, "[i]t is not necessary to show that the services were completely lacking; rather, it is also sufficient to show that patients were not provided the quality of care which meets the statutory standard."

Other courts, however, have been unwilling to find that an entire *per diem* bundled claim becomes poisoned by the tainted portion. In a case from the Northern District of Oklahoma, a plaintiff tried to use the worthless service theory to hold a defendant liable for not complying with minimum weekly therapy requirements.[3] The plaintiff, however, failed to demonstrate that the services received were worthless or even grossly negligent. For example, one patient identified did not receive all of the required weekly therapy hours, but even during the most egregious week the patient still received nine of the twenty-one required therapy hours. Because the patient received at least some of the care for which the defendant billed, the court was unwilling to find that the defendant submitted a false claim. Thus, as another court has commented, "the False Claims Act was not designed for use as a blunt instrument to enforce compliance with all medical regulations."[4]

Damages Exposure in Non-Worthless Services Cases

When the government elects not to pursue a worthless service claim (or when a court has prohibited it from doing so), it may nevertheless still be able to recover if it can substantiate damages for the portion of the allegedly tainted claim under a "benefit of the bargain" theory. Under this measure of damages, the Supreme Court has held that the government's actual damages in substandard product or service cases should be calculated by determining the difference between the market value of the good or service received and the market value of the good or service had it been of the specified quality.[5] Most often, these damages are established through expert testimony detailing the difference in value between what the government paid for and what it received. This process is much more factually and labor intensive than simply recouping the value of the entire bundled claim, which is one of the reasons that the government prefers the worthless service theory. In addition, the government's experts must substantiate their damages analyses with generally accepted methodologies, thereby subjecting them to intense cross examination and attack.

Using a benefit of the bargain analysis in an insurance HMO case, a court allowed the government to introduce expert testimony explaining the difference between the medical loss ratio of the defendant and other comparable HMOs.[6] The government alleged that the defendant sought to exclude pregnant women from its plan, resulting in higher profits to the HMO. Based in part upon the government expert's comparison of the medical loss ratios, the jury awarded $48 million in damages against the defendant, which the court later trebled as required under the FCA. Notwithstanding the defendant's attacks on the government's experts and the methodologies, the court allowed the judgment to stand.

In some circumstances, however, courts will allow the government to recover the entire contract price even where it did receive a benefit from its bargain. For example, in an older case, a court rejected a defendant's

3 *United States ex rel. Sanchez-Smith v. AHS Tulsa Regional Medical Center, LLC*, 2010 WL 4702270 (N.D. Okla. Nov. 10, 2010).
4 *Mikes v. Straus*, 274 F.3d 687, 695 (2d Cir. 2001).
5 *United States v. Bornstein*, 423 U.S. 303 (1976).
6 *United States ex rel. Tyson v. Amerigroup Ill., Inc.*, 488 F. Supp. 2d 719 (N.D. Ill. 2007).

"no harm, no foul" argument asserted by a physical therapist who submitted Medicare claims using his brother's name and provider number.[7] Although the defendant argued that the patients had received services performed by qualified therapists, the court found that the government had been damaged for the full amount.

FCA Penalties

In addition to any actual damages that the government may recoup, the FCA also authorizes penalties of between $5,500 and $11,000 per claim. For providers with high claims volume, these penalties can be exorbitant and can often dwarf the government's actual damages. In bundled services cases, however, the nature of the claims may actually be of some benefit for the providers. Rather than billing for individual service components thereby generating multiple claims, the providers instead submit few actual claims. This is important in potentially reducing (but by no means eliminating) the amount of penalties claimed by the government.

Conclusion

Because the FCA does not include specific damage calculation methodologies, courts will continue to refine their own models, especially as the healthcare reimbursement programs continue to change and evolve. In the face of this ever-changing system, one constant will no doubt remain: the government is laser focused on healthcare fraud, and the resulting damages imposed against providers can be staggering.

7 *Peterson v. Weinberger*, 508 F.2d 45 (5th Cir. 1975).