Medicare Fraud and Abuse and Qui Tam: The Dynamic Duo or the Odd Couple?

Kaz Kikkawa

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# NOTE

**MEDICARE FRAUD AND ABUSE AND QUI TAM: THE DYNAMIC DUO OR THE ODD COUPLE?**

*Kaz Kikkawa†*

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† J.D., Case Western Reserve University School of Law, 1997.
I. INTRODUCTION

"ACCORDING TO THE GENERAL ACCOUNTING Office (GAO), ten percent of every health care dollar spent in this nation is lost to fraudulent and wasteful provider claims. Applying this estimate to all health care spending means that more than $100 billion, or over $274 million a day, was lost to fraud and abuse in fiscal year 1995."\(^1\) Moreover, anecdotal testimony suggests that official action recoups only a portion of this loss because "[t]he relatively small amount of each false bill, technical rules, and the paper trail needed to build a successful case limit public prosecutions of health care abuses."\(^2\)

To combat fraud in the health care market, there are three major federal statutes in place designed to protect the purses of Medicare and Medicaid:\(^3\) the Social Security Act's section pertaining to fraud and abuse of federal health care programs\(^4\) (Fraud and Abuse statute), the 1981 Civil Monetary Penalties Law,\(^5\) and the Stark legislation.\(^6\) In addition to the protections...
given specifically to Medicare and Medicaid, the federal treasury is generally protected from contractor fraud by the False Claims Act (FCA). 7

This Note addresses the narrow question of whether an alleged violation of the anti-kickback portion of the Fraud and Abuse statute, by itself, renders a Medicare claim 8 "false" for purposes of FCA. This has recently been addressed by two federal district courts, each reaching a different result. In United States ex rel. Pogue v. American Healthcorp. Inc., the Middle District of Tennessee held that a claim alleging FCA liability premised on a violation of the anti-kickback portion of the Fraud and Abuse statute can survive a summary judgment motion. 9 On the other hand, the Southern District of Texas held in United States ex rel. Thompson v. Columbia/HCA Healthcare Corp. that an anti-kickback violation does not create a per se false claim under the FCA upon which such relief may be granted. 10

7. Stark I prohibits physicians from referring Medicare patients to clinical laboratories in which the physician has an ownership interest. Stark II expands the prohibition against self-referral to additional health care services such as radiology services, prosthetics, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services. See Andrea Tuwiner Vavonese, Comment, The Medicare Anti-Kickback Provision of the Social Security Act: Is Ignorance of the Law an Excuse for Fraudulent and Abusive Use of the System?, 45 CATH. U.L. REV. 943, 955 (1996); Joseph Avanzato & David A. Wollin, Health Care Fraud: Potential Pitfalls for Health Care Providers, R.I. B.J., Jan. 1996, at 9, 13-14 (outlining the basic tenets of the Stark legislation).

8. This Note addresses liability surrounding claims for payment submitted to Medicare and/or Medicaid. However, in the interest of clarity, this Note refers only to Medicare. While the programs are undoubtedly different in many respects, it should be assumed that when liability for a claim submitted to Medicare is discussed, the same liability would apply to a claim submitted to Medicaid.


An analogous question is whether FCA liability can be predicated upon a violation of Stark I or Stark II. While this Note does not specifically address the question of FCA liability for violations of the Stark laws, it appears that the answer becomes clearer when dealing with prohibited physician self-referrals. As Ralph W. Mello, the attorney who represented the plaintiff in the Pogue case points out, "a claim submitted in violation of [Stark I or Stark II] is a false claim" under the FCA since:

Both Stark I and Stark II, in addition to prohibiting the referral, expressly prohibit the entity that receives the illegal referral from presenting, or causing to be presented a claim to Medicare for the services furnished pursuant to a prohibited referral. 42 U.S.C. § 1395nn(a)(1)(B) . . . . Additionally, 42 U.S.C. § 1395nn(g)(1) expressly
The answer has tremendous consequences for health care providers. While violations of the Fraud and Abuse statute can only be prosecuted by the government, claims under the FCA can be brought both by the government and by private individuals under the FCA's "qui tam" provisions.11

The qui tam provisions of the FCA enable private individuals to sue those perpetrating fraud against the government.12 These provisions encourage individuals to report fraud by allowing those who do come forward to share in the government's recovery after a defendant is successfully prosecuted or settles.13 If a violation of the anti-kickback statute creates a per se viable claim under the FCA, private individuals will essentially be able to enforce the anti-kickback statute. Moreover, since those who bring suit are eligible to receive a generous bounty proportionate to the award they bring,14 such enforcement will hardly be lacking.

The purpose of this Note is to examine whether a violation of the anti-kickback statute should constitute a per se viable claim under the FCA. While much has been written about the anti-kickback statute and the qui tam provisions of the FCA individually, it was not until the Pogue and Thompson decisions that the interplay of these two statutes became a consideration. This Note is unique because it is the first to focus on this interplay and to address the question of whether a violation of the anti-kickback statute should constitute a per se viable claim under the FCA. Part II of this Note contains a brief summary of each statute and the provisions at issue. Part III

provides that the government cannot pay any claim submitted for services that are furnished pursuant to a prohibited referral.


13. See id. § 3730(d).

14. See id.
analyzes the conflicting decisions in *Pogue* and *Thompson*. Part IV examines the relevant policy considerations in choosing a default rule. In Part V, this Note concludes that the default rule should be that a violation of the anti-kickback statute does not constitute a per se viable claim under the FCA.

## II. SUMMARY OF THE STATUTES

### A. The False Claims Act


The False Claims Act (FCA) prohibits individuals from knowingly submitting a false claim to the government for money. It was originally enacted in 1863 "in response to cases of contractor fraud perpetrated on the Union Army during the Civil War." It allows the U.S. Attorney General to bring civil suit against those who violate its provisions. Private individuals are also authorized to bring civil suit against violators under the Act’s qui tam provisions.

In order to establish a violation of the FCA, the party bringing the suit must prove that the defendant knowingly presented, or caused to be presented, a false claim to the government.

15. *Id.* §§ 3729-3733.
18. *Id.* § 3730(b)(1). See also Michael Lawrence Kolis, *Settling for Less: The Department of Justice’s Command Performance Under the 1986 False Claims Amendments Act*, 7 ADMIN. L.J. AM. U. 409, 414 n.20 (1993) (citing P. David Richardson, *Private Law Enforcement: Qui Tam Actions and Shareholder Suits, in LAWYERS’ DESK BOOK ON WHITE-COLLAR CRIME* 173, 174 (Milton Eisenberg ed., 1991)). When the False Claims Act was signed into law in 1863, "Congress thought it necessary to enact the qui tam provisions . . . because, during a huge military buildup at the height of the Civil War, [the Department of Justice] had just come into existence, the Federal Bureau of Investigation did not exist, and the War Department did not have any investigative arm. Therefore, the United States simply did not have the resources to control the fraud and waste of the growing military industry." *Id.* Now, "[t]he legislative intent underlying the qui tam mechanism is to provide incentives for ‘whistleblowers’ to assist the federal government in the discovery and prosecution of fraudulent claims by offering them a ‘bounty,’ i.e., a percentage of any monies recovered from the defendant in an FCA suit." Thomas F. O’Neil, III et al., *The Buck Stops Here: Preemption of Third-Party Claims by the False Claims Act*, 12 J. CONTEM. HEALTH L. & POL’y 41, 44-45 (1995).
19. 31 U.S.C.A. § 3729(c) (West 1997) defines "claim" as: any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.
government for payment or made a false statement or representation in order to obtain payment from the government.20 The statute defines "knowingly" as "(1) ha[ving] actual knowledge of the information,"21 (2) "act[ing] in deliberate ignorance of the truth or falsity of the information;"22 or (3) "act[ing] in reckless disregard for the truth or falsity of the information."23 While that section also states that "no proof of specific intent to defraud is required,"24 courts routinely have found innocent mistake and mere negligence as valid defenses to FCA liability.25 However, "considerable disagreement centers on determining when one is acting with 'deliberate ignorance' or 'reckless disregard' rather than being 'merely negligent.'"26

20. See id. § 3729(a). Specifically, that section states:

A) LIABILITY FOR CERTAIN ACTS. 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 payment or approval;

2) 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;

3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

7) 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, is liable to the United States Government . . . .

Id.

21. Id. § 3739(b)(1).
22. Id. § 3739(b)(2).
23. Id. § 3729(b)(3).
24. Id. § 3729(b).
26. Robert Salcido, Application of the False Claims Act "Knowledge" Standard: What One Must "Know" to be Held Liable Under the Act, 8 HEALTH LAW, Winter 1996, at 1, 2. Salcido states that the legislative history of the FCA and its amendments provide little definitive guidance since they "[speak] in metaphors and generalities." Id. at 5. Salcido points to the following examples: 132 Cong. Rec. 29322 (Oct. 3, 1996) (statement of Rep. Berman), "While the Act was not intended to apply to mere negligence, it is intended to apply to situations that could be considered gross negligence where the submitted claims to the Government are prepared in such a
Persons found guilty of violating the FCA face "a civil penalty of not less than $5000 and not more than $10,000 [per claim], plus three times the amount of damages which the government sustains because of the act of that person." Since courts have interpreted this language as creating a mandatory formula to be applied after a violation of the act is found, most defendants face strong incentives to settle false claims actions brought against them. It should also be noted that when a defendant actively cooperates with the government's investigation, a more lenient method of calculating penalties is available.

sloppy or unsupervised fashion that resulted in overcharges to the government. The Act is also intended not to permit artful defense counsel to require some form of intent as an essential ingredient of proof. This section is intended to reach the 'ostrich-with-its-head-in-the-sand' problem where government contractors hide behind the fact they were not personally aware that such overcharges may have occurred." Id. at 5. See also S. Rep. No. 99-345, at 5-6 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5273. "Those doing business with the Government have an obligation to make a limited inquiry to ensure the claims they submit are accurate." Id.

27. 31 U.S.C.A. § 3729(a) (West 1997). "It is important to note that the damages are now structured to make litigation worthwhile for the plaintiff. If the defendant has made only one or a few claims, but they are of large amounts, the damages portion of the statute which requires the defendant to pay three times the amount of the fraudulent claim has some bite. If the defendant has regularly made a great number of claims for small dollar amounts, the civil penalty of not less than $5,000 per claim makes it financially worthwhile for the plaintiff to bring a suit." Carolyn J. Paschke, Note, The Qui Tam Provision of the Federal False Claims Act: The Statute in Current Form, Its History and Its Unique Position to Influence the Health Care Industry, 9 J.L. & HEALTH 163, 169 (1994) (footnotes omitted).

28. See Harry R. Silver & Sanford V. Teplitzky, The False Claims Act: A Potent Weapon in the War on Health Care Fraud, HEALTH CARE LITIG. REP., Apr. 1996, at 5 (citing United States v. Lorenzo, 768 F. Supp. 1127 (E.D. Pa. 1991)). For example, United States v. Lorenzo involved an FCA violation charged by the government against a dentist. "The dentist had performed routine dental examinations, which are not reimbursable by Medicare, and characterized a portion of each examination as 'cancer examination of the oral cavity, head/neck' in order to obtain Medicare reimbursement. The court determined that this was fraud and that 3,683 separate false claims had been submitted. Even though each of the false claims was for $35.50, which amounted to total overcharges of $130,719.10, the court ruled that it was required by the FCA to impose a civil penalty of $5,000 for each of the 3,683 separate false claims. This amounted to $18.4 million in mandatory civil penalties." Id. The statute allows for such an outcome:

[B]oth § 3729(a)(1) and § 3729(a)(2) may apply to a given situation. However, the number of counts can vary, depending on which section is charged. Assume for example, a sub-contractor submits fifty false claims to a contractor who, unaware of the falsity, includes the invoices when submitting a claim to the government for reimbursement. The sub-contractor could be charged under § 3729(a)(2) with fifty counts for causing submission of fifty false statements to get a claim paid. Or, the subcontractor could be charged under § 3729(a)(1) with one count for causing submission of a false claim.

Bucy, supra note 25, at 701-02 (illustrating options for prosecutorial discretion). See supra note 20 for the exact wording of § 3729(a)(1) and § 3729(a)(2).

29. 31 U.S.C.A. § 3729(a)(7)(A-C) (West 1997) states that if: (A) the person committing
2. Qui Tam Actions

a. Standing and Procedure

The qui tam provisions of the FCA enable private individuals to sue those perpetrating fraud against the government. They encourage and reward individuals for reporting fraudulent behavior by allowing those who do come forward to share in the government’s recovery after a successful prosecution or settlement. Individuals who come forward under the qui tam provisions are called “relators” since they relate or inform the government of the fraud in question. While the qui tam provisions essentially allow anybody with knowledge of prohibited behavior to have standing as a relator, the statute carves out certain situations where private individuals are not allowed to bring suits.

First, “[i]n no event may a person bring an action ... which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.” Second, “[n]o court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news

the violation turns himself in and provides to the government “all the information known to such person about the violation within thirty days after [he] first obtained the information;” (B) the relator “fully cooperated with any Government investigation of such violation;” and (C) “at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation” then “the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of the person.”

30. Id. § 3730(b)(1).
31. See generally id. § 3730. (establishing civil actions for false claims).
33. “The ‘public disclosure’ restriction has proven to be the greatest jurisdictional barrier for qui tam relators,” William E. Kovacic, Whistleblower Bounty Lawsuits As Monitoring Devices in Government Contracting, 29 LOY. L.A. L. Rev. 1799, 1815 (1996). “The majority interpretation of the public disclosure bar views qui tam actions as ‘based upon’ a public disclosure whenever the factual basis for the relator’s suit has been revealed in the public domain, regardless of whether the relator in fact derived knowledge of the facts from that disclosure.” Id. at 1815 n.67 (citations omitted).
media, unless the action is brought by the Attorney General or the person bringing the action is an 'original source' of the information. Once a qui tam action has been filed, "no one other than the government or the original relator can intervene or bring any case based on the facts of the original action." "In other words, no copy cat suits are allowed, and the first case bars all others based on the same facts." If a latter-filed case alleges some facts that are contained in the original case and other facts that are not, the overlapping factual allegations are stricken from the latter-filed complaint, while original allegations are allowed to stand.

The basic procedural rules for bringing a qui tam suit are relatively straightforward. A private plaintiff files a complaint. The complaint is kept under court seal for sixty days to allow the government to investigate the claim without the defendant's knowledge. After the expiration of the sixty-day period, the government must choose whether or not to join the action. If the government joins the action it has "the primary responsibility for prosecuting the action." While the original private party plaintiff has the right to continue as a co-party to the action, his rights can be severely limited by the court upon a showing that the party's participation will interfere with or delay the prosecution, or would be repetitious, irrelevant, or

34. An "original source" is defined as one who has "direct and independent knowledge of the information" and who voluntarily provides it to the government before filing the qui tam action. 31 U.S.C.A. § 3730(e)(4)(B) (West 1997). While courts are split on what constitutes 'direct and independent' knowledge, "[t]he majority of courts that have considered the original source requirement [have found] that the relator must obtain 'direct knowledge' of the fraud without the benefit of an intermediary who introduces the information to the relator. Similarly, courts characterize a relator's knowledge as 'independent' when the information is not acquired through public disclosure or, in some instances through the government." Francis E. Purcell, Comment, Qui Tam Suits Under the False Claims Amendments Act of 1986: The Need for Clear Legislative Expression, 42 CATH. U.L. REV. 935, 963 (1993).


37. See id. at 132 n.21 (citing several cases including Erickson ex rel. United States v. American Inst. of Biological Sciences, 716 F. Supp. 908 (E.D Va. 1989)).

38. See id. § 3730(c)(1).


40. See id.

41. Id. § 3730(c)(1).
harassing. Moreover, the government may settle or dismiss the case over the objections of the relator. If the government does not join the action, the relator has the right to continue the suit on his own. However, the government retains the reserved right to intervene and join the action at a later date.

b. Potential Awards

If after investigating the relator’s claim the government decides to take up the action, the relator is entitled to receive “at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action.” But, where the information provided by the relator is not a “substantial contribution,” “the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation.” Regardless of the amount of recovery the action yields or whether the information provided is a “substantial contribution” under the statute, private plaintiffs “shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys’ fees and costs” from the losing parties.

A relator is able to challenge the government in court if it considers inadequate a settlement between the government and a defendant. Towards this end, a relator may have the right to conduct discovery in order to find out the elements of a settlement where the relator has been excluded from such negotiations.

42. See id. § 3730(c)(2).
43. See id.
44. See id. § 3730(c)(3).
45. See id.
46. Id. § 3730(d).
47. Id.
48. Id.
49. Ryan, supra note 36, at 132 n.23 (noting that several relators have been successful in such challenges).
50. Id. (citing United States ex rel. McCoy v. California Medical Review, Inc., 133 F.R.D. 143 (N.D. Cal. 1990)).
If the government does not take over the action and the private party continues the suit on its own, it is entitled to a greater share of the recovery if it prevails. If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses fees and costs shall be awarded against the defendant.  

On the other hand, if the defendant prevails and the court finds "that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for harassment" then the court may award the defendant reasonable attorneys fees and expenses.

3. The Rise of Qui Tam

While the FCA has been in force for over a century, it has only recently begun to garner more attention from health care providers. In the mid-1980s, in the midst of rising concern for the federal budget deficit and increased discoveries of government contracting fraud, particularly in the military, Congress decided to re-vamp the FCA as its primary tool for fighting fraud perpetrated against the government. Recognizing that courts had not been applying the Act as rigorously as was originally intended, Congress made significant amendments

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52. Id. § 3730(d)(4).
53. See Kolis, supra note 18, at 414 n.44 (citing Kenneth D. Brody, Recent Developments in the Area of 'Qui Tam' Lawsuits: A New Weapon For Challenging Those Who May Be Submitting False Claims to the Government, 37 FED. B. NEWS & J. 592, 592 (1990)). See also Silver & Teplitzky, supra note 28 (stating that news reports that defense contractors "were selling $400 hammers and $800 toilet seats to the military" influenced Congress to amend the FCA in 1986).
to the FCA in 1986. The 1986 amendments increased the penalties assessed against violators, raised the percentage of recovery available to plaintiffs, lowered the burden of proof required to prove a claim, and allowed plaintiffs to continue with the suit themselves if the government decided not to take over the prosecution. Also, "under the former statute, a relator had to prove actual knowledge. The more liberal post-1986 version . . . extends liability to virtually anybody involved with the claim to make sure there has been no mistake or fraud."

As a result of the 1986 Amendments, there has been a dramatic increase in the number of qui tam suits filed, with large recoveries by both the government and plaintiffs. "From 1943 to 1986, there were only three qui tam cases recovering a total of $54,000 . . . since the passage of the [1986] amendments, there have been 1,386 qui tam filings with recoveries of over $1 billion." Moreover, the predominant target


56. "The civil penalty was increased from double the amount of the damages sustained to triple the amount. The [per claim] forfeiture amount was increased from $2000 to [$5000-$10,000]." Frank LaSalle, Note, The Civil False Claims Act: The Need for a Heightened Burden of Proof as a Prerequisite for Forfeiture, 28 AKRON L. REV. 497, 500 n.21 (1995) (citing 31 U.S.C. § 3729(a) (1988)).

57. Prior to the 1986 amendments, relators could only receive up to ten percent of the award when the government intervened and took over the suit. See Purcell, supra note 11, at 945. See generally 31 U.S.C.A. § 3730(d) (West 1997) (listing the recovery percentages currently available to plaintiffs).

58. Prior to the 1986 Amendments, there was some ambiguity as to the requisite standard of proof with "some courts [erroneously] employ[ing] a clear and convincing standard, an essentially criminal standard, to the FCA, a basically civil statute." Kolis, supra note 18, at 424 n.72 (citing False Claims Reform Act: Hearings on S.1562 Before Subcomm. on Administrative Practice and Procedure of the Senate Comm. on the Judiciary, 99th Cong., 35 (1985) (statement of Jay B. Stephens, Deputy Associate Attorney General, U.S. Dept. of Justice)). Now, the statute is clear: "The essential elements of the cause of action, including damages [must be proved] by a preponderance of the evidence." 31 U.S.C.A. § 3731(c) (West 1997).

59. Under the 1986 Amendments, relators are now able to continue their claims if the government decides not to pick it up. As will be discussed, this provision is one of the most hotly contested changes to the FCA under the 1986 Amendments. See infra pp. 114-15.

60. Paschke, supra note 27, at 168.

61. "Despite its long history and several amendments, the [FCA] was little more than a dusty lance in the government's armory until the past decade." O'Neil et al, supra note 18, at 43 (describing the large increase in the number of qui tam suits filed since the 1986 amendments to the FCA). See also Park, supra note 11, at 1061-62 (citing Bruce Fein, Bounty Hunters Unleashed, WASH. TIMES, Aug. 22, 1989, at F1).

62. BUREAU OF NAT'L AFF., INC., Study Predicts Increase in Federal Health Fraud, Private Recovery Actions, BNA MEDICARE REP., Nov. 15, 1996 (citing a September 1996 study by The False Claims Legal Act Center in Washington, D.C.). See also Thomas F. O'Neil & Adam
of qui tam suits has shifted from defense contractors to health care providers and other federal program suppliers. In fact, "[m]ore than 20% of the qui tam cases filed since the 1986 amendments have involved allegations of fraud against the United States Department of Health and Human Services." It should also be noted that the changes to the qui tam provisions instituted by the 1986 amendments are highly controversial. Before their passage, the Department of Justice strenuously opposed them. Since their passage, their constitutionality has been challenged on several grounds, but without success.

B. The Medicare and Medicaid Fraud and Abuse Statute

The Medicare and Medicaid fraud and abuse statute imposes criminal penalties on those who defraud the Medicare and Medicaid programs. The purpose of this statute is not only to punish wrongdoers, but also to prevent the over-utilization of services and to contain the costs of these programs. The statute is divided into two major parts.

Part (a) prohibits essentially the same conduct as covered by the False Claims Act. Its most general provision punishes...
anybody who "knowingly and willfully makes or causes to be made a false statement or representation of any material fact in any application for any benefit or payment under a federal health care program." Examples of offenses under this part include billing for services not actually provided or falsely claiming that services provided were medically necessary in order to obtain government reimbursement. Part (b) is the anti-kickback portion of the fraud and abuse statute ("anti-kickback" statute). This part:

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,
(4) having made application to receive such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,
(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a federal health care program and knows that the individual who furnished the service was not licensed as a physician, or
(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under §1396p(c) of this title, shall [be guilty of a violation].

Id. 69. Id. § 1320a-7(b)(a)(1).
71. 42 U.S.C.A. § 1320a-7b(b) (West 1997). The statute specifically provides in pertinent part:

b) ILLEGAL REMUNERATIONS
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 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 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
prohibits the knowing and willful solicitation, offer, payment, or receipt, directly or indirectly, of any remuneration (including kickbacks, bribes or rebates), either in cash or in kind in return for patient, product, or service referrals whenever payment from either the Medicare or Medicaid program is involved. [The] statute applies to any type of referral, including sales of products such as prescriptions, and applies both to the payer and the recipient of the kickback.\footnote{72}

The main purpose of the anti-kickback provision is to reduce health care costs rather than punish "wrongdoers."\footnote{73} The underlying rationale is that "[i]f providers are paid for referrals, they have an incentive to overrefer, thereby increasing utilization and costs. Adding insult to injury, including the referral in the charge to Medicare or Medicaid would further increase costs."\footnote{74}

The fact that the anti-kickback provisions prohibit a broad scope of conduct and provider arrangements has been discussed extensively since the last major amendments to the Fraud and Abuse statute in 1986.\footnote{75} Nonetheless, courts have continually refused to narrow the scope of conduct that the statute prohibits.\footnote{76} The leading case, United States v. Greber, held that if one purpose of a payment was to induce future reciprocal

\begin{footnotes}

\footnote{72} Avanzato & Wollin, supra note 6, at 9.
\footnote{74} Id.
\footnote{75} See, e.g., John J. Farley, Note, The Medicare Antifraud Statute and Safe Harbor Regulations: Suggestions for Change, 81 GEO. L.J. 167, 173 (1992) (stating that critics have argued that financial arrangements beneficial to patient care have been prohibited by the statute); Ellen L. Janos & M. Daria Niewenhous, White Coat Crime or Hospital-Physician Financial Relationships in the 90's, BOSTON BJ., May-June 1996, at 8 (discussing the breadth of conduct covered by the anti-kickback law).
\footnote{76} See Avanzato & Wollin, supra note 6, at 9-11 (describing how courts interpret anti-kickback provisions).
\end{footnotes}
referrals, the payment violates the anti-kickback law. "Under Greber, the breadth of the prohibition of the fraud and abuse law is truly startling. It calls into question numerous routine practices in the health care industry as the industry consolidates and otherwise seeks to rationalize and make more efficient the delivery of services." Furthermore, the breadth of prohibited conduct could have the opposite effect of that intended by the statute's drafters.

Greber makes illegal much restructuring in the health care marketplace that is appropriate in the rationalizing of the health care industry. In the current environment, it is a truism that the fraud and abuse law is being violated routinely but that those violations are acknowledged as not threatening the public interest. Indeed, they further the public interest and are needed to improve the functioning of the health care marketplace. Lack of prosecution leaves the industry living with economically and socially appropriate conduct . . . . In sum, the modern health care industry is akin to a speakeasy — conduct that is illegal is rampant and countenanced by law enforcement officials because the law is so out of sync with the conventional norms and realities of the marketplace and because respected leaders of the industry are performing tasks that, while illegal, are desirable in improving the functioning of the market.

This sentiment has been voiced by other scholars and health law practitioners alike.

78. Blumstein, supra note 73, at 213.
79. Id. at 218.

Although the statute was an effective and logical response to fraud and abuse under a cost-based system, it may be inappropriate to apply the same rules to the newly competitive health care environment. The statute is broadly worded and appears to prohibit many arrangements that pose little risk to the integrity of the program or the quality of medical care.

Id. at 1135. See, e.g., Robert Fabrikant, Health Care Reform: The Use of the Anti-Kickback Statutes in Private Litigation, and the Need for an Antitrust-Type Approach, in HEALTH CARE REFORM LAW INSTITUTE 453, 455 (PLI Commercial Law and Practice Course Handbook Series No. 700, 1994) (proposing that anti-kickback statutes may retard the development of relationships between providers that are necessary for healthcare reform). See also Sheldon Krantz & Stan Soya, Courts Restrict Creative Enforcement of Health Care Fraud Laws, 6 LEGAL OPINION LETTER, Dec. 18, 1996, (Wash. Legal Found., Wash., D.C.).

While 'kickback' sounds like an evil thing, existing statutory language reaches
One Circuit Court has adopted a narrower interpretation of the anti-kickback statute than the "one purpose" test originated in Greber. In Hanlester Network v. Shalala,81 the Ninth Circuit limited the scope of prohibited conduct under the anti-kickback statute by strictly reading the statute's scienter requirements. The court construed 'knowingly and willingly' as requiring that the defendant knew that the statute prohibited offering or paying remuneration to induce referrals, and then engaged in prohibited conduct with the specific intent to disobey the law.82 "Thus, a good faith belief that one's conduct was not prohibited by the anti-kickback provision would constitute a defense."83

The heightened scienter requirement put forth in Hanlester has been widely debated in the literature. While many commentators appear ready to adopt it,84 the obvious downfall of the holding is that the heightened scienter requirement would make criminal convictions more difficult to obtain. "Although the Ninth Circuit's rulings are not binding on federal courts in other circuits, the Hanlester decision resulted from a 'test case' and thus could have considerable impact on subsequent federal jurisprudence. In addition, many states . . . have enacted statutes that are substantially similar to the anti-kickback provision, and those states may look to Hanlester for guidance."85

activities that fall far short of nefarious conduct . . . Improper kickbacks and bribes cannot be condoned and should be dealt with harshly. Because the anti-kickback statutes and regulations, on their face, also proscribe many activities that should not be the subject of criminal prosecution or even civil enforcement, they have to be used with caution to avoid undue interference with the marketplace.

Id.

81. Hanlester Network v. Shalala, 51 F.3d 1390, 1399-1400 (9th Cir. 1995) (requiring the government to satisfy the "knowingly and willfully" scienter requirement of the anti-kickback statute, 42 U.S.C. § 1320a-7(b)(b)(1-2), by establishing that the defendant knew his conduct was unlawful and acted anyway).
82. See id. at 1400.
83. Avanzato & Wollin, supra note 6, at 12.
85. Avanzato & Wollin, supra note 6, at 12.
Nonetheless, other courts have not adopted this interpretation.

Recognizing the effect the over-expansiveness of the statute was creating on the healthcare market, in 1987 Congress directed the Secretary of Health and Human Services to create regulations immunizing certain specific practices which would otherwise be illegal under the statute.\textsuperscript{86} While thirteen "safe harbors" have since been issued,\textsuperscript{87} many commentators feel they offer little guidance in structuring provider arrangements when compared with the vast scope of prohibited conduct under the fraud and abuse statute.\textsuperscript{88} These technically illegal but immunized exceptions are referred to as "safe harbors." Shortly after the first safe harbors were issued, former Inspector General of the United States Department of Health and Human Services, Richard Kusserow, explained these safe harbors and indicated that additional guidance as to the proper interpretation of the anti-kickback statute could be found in Fraud Alert bulletins issued by the Department of Health & Human Services, forthcoming "interpretive rules" which the Office of the Inspector General (OIG) planned on issuing, and from published administrative and judicial decisions as more violations are prosecuted.\textsuperscript{89} Unfortunately, the guidance provided by the

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\item \textsuperscript{87} See 42 C.F.R. § 1001.952 (1994).
\item \textsuperscript{88} See Blumstein, supra note 73, at 224.
\item The present safe harbor regulations carefully delineate thirteen payment practices that are not criminal offenses or civil violations. The safe-harbor regulations set forth with particularity practices which, if adhered to strictly, are not fraud and abuse offenses .... The narrowly drawn cast to the safe harbors means that in many situations the safe harbors give little real guidance ... [while] failure to fall within a safe harbor puts providers at peril when devising innovative arrangements that use financial incentives.
\item Id. See also Kusserow, supra note 84. The safe harbor regulations are codified in 42 C.F.R. § 1001.952 (1994). In addition to these, eight additional safe harbors have been proposed by the Department of Health and Human Services. See Health Care Programs: Fraud and Abuse; Additional Safe Harbor Provisions Under the OIG Anti-Kickback Statute, 58 Fed. Reg. 49,008 (1993) (proposing additional safe harbors) (to be codified at 42 C.F.R. pt.1001) (proposed Sept. 21, 1993); Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the OIG Safe Harbor Anti-Kickback Provisions, 59 Fed. Reg. 37,202 (1994) (summarizing and describing proposed changes to the safe harbor provisions) (to be codified at 42 C.F.R. pt.1001) (setting forth various standards and guidelines for safe harbor provisions designed to protect certain health care programs). While these proposed safe harbors do not create definite boundaries between legal and illegal behavior, they give fairly broad guidance.
\item Kusserow, supra note 84, at 62-63. "In contrast to the safe harbor regulations which
OIG has been minimal, and legal precedent is sparse, as settlements are commonplace. Because of the limited guidance, providers have been left on their own to navigate the vast prohibitions of the anti-kickback statute.

Congress has recently addressed the ambiguity of the Fraud and Abuse statute with the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).90

Section 205 of the Act sets forth a three-pronged program intended by Congress to help assist providers in the understanding of the fraud and abuse laws, which are frequently criticized for being vague and overly broad. In addition to provisions requiring the OIG to solicit and respond to proposals for modifications to the Safe Harbor regulations on an annual basis, and mandating a formal process under which so-called “Fraud Alerts” may be requested, the law enacts a compulsory process for seeking and issuing advisory written opinions.91

While these provisions are a good step toward clarifying the scope of prohibited conduct under the Fraud and Abuse statute, the actual effect these provisions will have in the future is questionable as their passage has been fought by enforcement agencies. Especially contentious is the provision requiring the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) to issue advisory opinions to individual providers on whether a proposed business venture violates the Fraud and Abuse Anti-Kickback statute.92

specify conduct immune from prosecution, the Fraud Alerts highlight areas where OIG has particular concerns because of the impact of certain practices on the health care programs.” Id. The planned interpretive rules were to “clarify ambiguities in a particular safe harbor or a conflict between two or more safe harbors. [They will not] address whether a specific fact situation falls within a safe harbor, but rather will explain terms or resolve other questions of more general applicability.” Id.


92. Id. See also Republicans Reject Democratic Concerns Over Health Bill, Push For Quick Action, BNA HEALTH CARE DAILY 2, July 30, 1996.

The advisory provisions of [proposed HIPAA] has outraged Justice officials, who say it would weaken their hand substantially in prosecuting violations if they had given advance approval, even if the proposals were based on misleading or incomplete information from the providers. Attorney General Janet Reno has appealed personally to House Ways and Means Health Subcommittee Chairman Bill Thomas (R-Calif) to drop the provision, according to White House and congressional sources.
Moreover, debating the potential effectiveness of the advisory opinion provision may be moot since there have already been proposals to repeal it. President Clinton's proposed budget for 1998 suggested repealing this provision because of the belief that the advice-giving process would hinder the ability to prosecute providers. The underlying fear is that some providers would obtain favorable advisory opinions under false pretenses and then hide behind them later to defraud the Medicare and Medicaid programs. Furthermore, in March of 1997, Health and Human Services Inspector General, June Gibbs Brown, stated that the administration would soon release legislation proposing the repeal of HIPAA section 205. In opposition to these efforts, health care providers, including the American Medical Association, have strongly supported the advisory opinion provision. While HIPAA section 205's fate remains unclear at this point, even if the section remains in force, one has to wonder how anxious HHS and the DOJ will be to give such guidance after having fought so strenuously against such a provision in the past.

Despite the questionable future of section 205, HIPAA's overall effect on the Fraud and Abuse statute is not clear. In January of 1997, the Bureau of National Affairs advisory board, which consists of twenty attorneys who specialize in

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Id. Before HIPAA was passed, the Department of Justice (DOJ) had been able to prevent the passage of such a provision in the past with the argument that “fact-based rulings are inappropriate in relation to a statute the application of which ultimately hinges on the intent of individuals.” Thomas S. Crane et al., supra note 91 (discussing fraud and abuse provisions in HIPAA). “The HHS Office of Inspector General has also expressed its vehement opposition to the plan, noting that the ‘enormous resources’ required to implement HIPAA’s advisory opinion requirement threaten to undermine the ongoing project of government downsizing.” Scott D. Godshall & Michael H. Friedman, New Options on the Anti-Kickback Laws: Getting Advice That’s Worth the Effort, BNA MEDICARE REP. 33, Sept. 20, 1996.


94. See id.


health law, published the results of its annual survey.⁹⁷ Several of its members stated that HIPAA “raises as many questions as it answers.”⁹⁸ Marilou M. King, executive vice-president of the National Health Lawyers Association, went so far as to say that “[i]t’s going to take years to sort out the new fraud and abuse rules.”⁹⁹ In short, it appears that providers are going to face the same uncertainties in navigating the broad scope of conduct prohibited by the Fraud and Abuse statute as they did before the passage of HIPAA.

III. CONFLICT IN THE COURTS

Last year, two federal district courts grappled with the question of whether a violation of the anti-kickback statute constitutes a viable claim under the FCA.¹⁰⁰ Specifically at issue was whether a claim for payment submitted to Medicare by a provider who is or was in violation of the anti-kickback statute is rendered a “false claim” for FCA purposes by the fact of the anti-kickback violation alone. The two courts came to opposite conclusions.

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⁹⁸. Id.
⁹⁹. Id.
¹⁰⁰. The first case to address this issue was United States ex rel. Roy v. Anthony, 914 F. Supp. 1504 (S.D. Ohio 1994). However, the court in Anthony allowed the plaintiff’s qui tam action to withstand a motion for dismissal without explaining the interplay between the FCA and the Fraud and Abuse statute. The court merely held that “[u]nder the facts alleged, the plaintiff could produce evidence that would show that the kickbacks allegedly paid to the defendant physicians somehow tainted the claims for Medicare. Additionally, the plaintiff may establish that the claims for Medicare were constructively false or fraudulent.” Id. at 1506-07. As such, Roy v. Anthony offers little insight into the question at hand. However, the court did state that “[m]erely pointing to violations of the Fraud and Abuse statute will not suffice” to establish that the defendants committed violations of the False Claims Act. Id. at 1506. See also United States ex rel. Pogue v. American Healthcorp Inc., 914 F.Supp. 1507, 1510 (M.D. Tenn. 1996) (stating that “[u]nfortunately, the court [in Anthony] gave little explanation for its decision”).
A. United States ex rel. Pogue v. American Healthcorp Inc. 101

1. Case Summary

In this case, the plaintiff, A. Scott Pogue, alleged that his former employer, Diabetes Treatment Centers of America (DTCA), and its parent company, American Healthcorp, Inc. (AHC), along with the West Paces Medical Center and several other individual physicians and hospitals were involved in a scheme by which individual physicians would refer their Medicare and Medicaid patients to West Paces Medical Treatment for treatment in violation of the federal anti-kickback and self-referral statutes. 102

Pogue alleged that a violation of Medicare anti-kickback and self-referral laws constitutes a violation of the FCA since “participation in any federal program involves an implied certification that the participant will abide by and adhere to all statutes, rules and regulations governing that program.” 103 In other words, Pogue did not “alleg[e] that the Defendants overcharged Medicare or charged it for services not rendered, [rather, he argued] that Defendants’ failure to comply with Medicare laws prohibiting kickbacks and self-referrals [in and of itself] rendered the Medicare claims submitted by the defen-

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101. 914 F. Supp. 1507. Pogue initially had his suit dismissed under FED. R. CIV. P. 12(b)(6) for failure to state a claim upon which relief can be granted. The decision initially dismissing the case, United States ex rel. Pogue v. American Healthcorp, Inc., No. 3-94-0515, 1995 WL 626514 (M.D. Tenn. Sept. 14, 1995) (memorandum) is not officially reported and contains additional material regarding the facts of this case.

102. See Pogue, 914 F. Supp. at 1508. Mr. Pogue had a high-level position at the Diabetes Treatment Centers of America (DTCA) as the Director for Marketing and Director of Development. See United States ex rel. Pogue v. American Healthcorp, Inc., 1995 WL 626514, at 1 (M.D. Tenn. Sept. 14, 1995). He held that position for 18 months before being fired. See id. Shortly after his termination, Pogue hired an attorney to negotiate a covenant not to sue with DTCA whereby he subsequently agreed to “release and forever discharge for himself, his heirs successors, administrators and assigns, the Company, its agents, directors, officers or employees from any and all legal claims, causes of action, agreements, obligations, liabilities, damages and or demands whatsoever at law or in equity, in any federal or state court or before any federal or state commission, agency or board” in return for $13,000 and “the right to receive bonuses on certain projects underway at the time . . . .” Id. at 2. Although Pogue actively considered bringing a qui tam action while he and his attorney were negotiating the release, the court found the subsequent covenant not to sue unenforceable as against public policy. See id. at 3. The court reasoned that enforcement of such a release with respect to qui tam actions would subvert the purposes of the False Claims Act. See id. at 4.

103. Pogue, 914 F. Supp. at 1509.
While the Pogue court recognized other court decisions finding FCA liability based on violations of other statutes, rules, and regulations, the court hesitated to immediately hold that violations of the Medicare anti-kickback and self-referral laws could support an FCA claim because of apparent inconsistency in Supreme Court precedent. The court stated:

Obviously the language of the False Claims Act and its legislative history have created a great deal of confusion among the courts regarding the Act's applicability to claims that are not themselves false but were derived through fraudulent conduct. The Supreme Court may have only added to this confusion with its somewhat conflicting holdings in Neifert-White that the False Claims Act extends "to all fraudulent attempts to cause the Government to pay out sums of money" and McNinch, that the False Claims Act "was not designed to reach every kind of fraud practiced on the Government."

After considering the above-mentioned precedent and the FCA's legislative history, the Pogue court concluded that "the False Claims Act was intended to govern not only fraudulent acts that create a loss to the government, but also those fraudulent acts that cause the government to pay out sums of money to claimants it did not intend to benefit." Using this reasoning, the court allowed Pogue's case to survive defendant's motion to dismiss because of Pogue's allegation that the government would not have reimbursed the defendants' Medicare claims had it known of the defendants' anti-kickback and self-referral violations.

104. Id. at 1510.
105. Specifically, the court cited and discussed the following two cases: Ab-Tech Constr., Inc. v. United States, 31 Fed. Ct. 429 (1994) (finding an FCA violation after the defendant deliberately withheld from the Small Business Association knowledge of a prohibited contract arrangement with a non-minority-owned enterprise), aff'd 57 F.3d 1084 (Fed. Cir. 1995), and United States v. Incorporated Village of Island Park, 888 F. Supp. 419 (E.D.N.Y 1995) (finding that defendants were liable under the FCA for engaging in a tenant pre-selection scheme by which they gave preferential treatment to white resident applicants for housing in violation of the regulations governing the administration of a Community Development Block Grant Program subsidized by the government with Housing and Urban Development (HUD) funds). See Pogue, 914 F. Supp. 1507, at 1510-11.
2. Case Analysis

The weakness in the *Pogue* court's reasoning is that it ignores the role of prosecutorial discretion in enforcing a statute that is over-expansive in the scope of conduct that it prohibits.\(^{108}\) As discussed, many providers today are operating in technical violation of the anti-kickback statute because of the lack of guidance as to what behavior is legal or illegal under the anti-kickback statute.\(^{109}\) Moreover, while many providers are in technical violation of the statute, their violations sometimes result in actual savings to the Medicare and Medicaid programs, more efficient delivery of health care, or an increase in the quality of health care.\(^{110}\) While it would be naïve to say that all of those in violation of the anti-kickback statute are "good violators," it would be equally naïve to say that there are no "bad" violators (i.e., providers who deliberately break the anti-kickback provisions with the primary intention of lining their own pockets) in the marketplace. Under the *Pogue* holding, these "good violators" are subject to the same FCA liabilities as "bad violators."

Likewise, prosecutors are given broad discretion in their power to enforce the Fraud and Abuse statute when a violation is found or suspected.\(^{111}\) Prosecutors can make the distinction between "good" and "bad" violators and enforce the statute accordingly. The shortcoming of the *Pogue* holding is that it assumes that the government will refuse to reimburse a defendant's Medicare claims if the government learns that the defendant has violated the anti-kickback provisions in any way. In other words, it ignores the fact that a prosecutor's discretion could lead her to refuse to prosecute an anti-kickback violation which she believes does not harm the Medicare or Medicaid programs or the public interest in general.\(^{112}\) The effect of

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109. See *supra* text accompanying notes 69-74.
110. *Id.*
111. See Blumstein, *supra* note 73, at 218.
112. It should be noted that there is no safe harbor or other exception for providers who can prove that their technical violation of the anti-kickback statute actually results in savings to the government. See Blumstein, *supra* note 73, at 210 (stating that "it is not a defense to prove that program costs are being reduced [since] [n]o statutory (or administrative) safe harbor based on the reduction of Medicare and Medicaid program costs exists"); Hyman & Williamson, *supra* note
this shortcoming is to essentially allow any private individual to enforce the broad prohibitions of the fraud and abuse provisions via the FCA's qui tam provisions for their own personal gain. This, along with the increased incentive to bring suit resulting from the 1986 Amendments to the FCA, will serve to increase the potential liability of providers, forcing them to undertake various costly, preventive measures.\textsuperscript{113}

B. \textit{United States ex rel. Thompson v. Columbia/HCA Healthcare Corporation}\textsuperscript{114}

1. Case Summary

Seven months after the Middle District of Tennessee's decision in \textit{Pogue},\textsuperscript{115} the U.S. District Court in the Southern District of Texas ruled on essentially the same claim brought by a physician in private practice, James M. Thompson, against his competitor, Columbia/HCA Healthcare Corporation.\textsuperscript{116}

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  \item[80] at 1193-96 (suggesting that conduct which does not result in harm to the Medicare or Medicaid programs or beneficiaries should not be illegal).
  \item[113] See infra pp. 114-15.
  \item[116] Id. at 400. Pogue and Thompson's claims are similar in so far as they allege the False Claims Act was violated because the defendants submitted claims to Medicare and Medicaid while in violation of the Medicare and Medicaid anti-kickback laws and/or the Stark prohibitions on physician self-referrals. Thompson specifically alleged that Columbia/HCA Healthcare Corporation violated the statutes prohibiting referrals by:
    \begin{enumerate}
      \item Offering physicians in a position to refer patients an exclusive opportunity not available to other qualified investors to invest in "partnerships" to own defendants' hospitals, and receive profits therefrom;
      \item Offering loans or providing assistance in obtaining bank loans to invest in these "partnership's;"
      \item Repayment of capital investments disguised as "consultation fees;"
      \item Free and below market rent for offices near defendant's hospitals;
      \item Expense-paid vacations and educational opportunities for physicians and medical technicians in a position to refer patients;
      \item Payments to physicians and medical technicians in positions to influence referrals based on the number and amount of patient-days used, or procedures scheduled;
      \item Creating lucrative financial arrangements with physician-owned entities which induce physicians to practice at defendants' hospitals;
      \item Making payments to physicians and physicians' groups in the form of "rent" for vacant space, or space "rented" at an excessive rate;
      \item Forgiveness of the cost of above-standard leasehold improvements to space occupied by physicians in defendants' Medical Office Building;
      \item Income guarantees to physicians who agree to practice at the defendants' hospitals.
    \end{enumerate}
  \item[Id. at 401.] Thompson alleged that Columbia/HCA violated the FCA "by fraudulently concealing their illegal actions under the anti-kickback statute and Stark laws by filing false certificates of
Specifically, Thompson asserted that Columbia/HCA had submitted Health Care Financing Administration (HCFA) Form 2552s which contained fraudulent certifications. These forms not only specifically warn those completing the form of possible liability from misrepresenting or falsifying any information on them, but also specifically direct the completer to the anti-kickback prohibitions. Thompson further claimed that this compliance certificate also "requires the hospital administrator to execute a statement certifying that he is familiar with the laws and regulations regarding the provision of healthcare services and that the services identified in the cost report were provided in compliance with the anti-fraud statute."

In response to Thompson's allegations, Columbia/HCA argued that even if it did violate the anti-kickback or Stark laws and it did submit a Form 2552 for Medicare reimbursement which contained false information, the filing of the false certification did not, by itself, render the related claims for payment false or fraudulent. It asserted that "even if [they] have violated the anti-kickback laws or Stark laws the government would have paid the Medicare claims since there is no allegation that the services rendered were not medically necessary or otherwise false or fraudulent. In other words, . . . even if the alleged kickbacks and prohibited financial relationships might cause a doctor to refer a patient to one hospital rather than another, that does not mean the services rendered to the patient were unnecessary or the resulting Medicare claim was false or fraudulent."

117. According to the Thompson court, form 2552 contains the following warning: Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative fines and/or imprisonment may result.

118. Thompson, 938 F. Supp. at 406.

119. See id. at 402-03.

120. Id. In essence, Columbia/HCA argued that "a false statement is not coterminous with a false claim." Id. at 406. In support of this proposition, Columbia/HCA cited United States v. Hill, 676 F.Supp. 1158, 1174 (N.D.Fl. 1987). Id. at 406.
The parties in Thompson argued the same precedent that was argued in Pogue. The court in Thompson, similarly, cited much of the same language from those cases as did the court in Pogue. However, unlike the court in Pogue, the court in Thompson was constrained to follow the holding of United States ex rel. Weinberger v. Equifax, Inc., and to reach the opposite conclusion. The court stated:

In Equifax, the Fifth Circuit held that there is no indication that the FCA is intended to be used as a private enforcement device for the Anti-Pinkerton Act. By the same reasoning, the FCA would not be intended to be used as a private enforcement device for the Medicare Anti-Kickback statute and Stark laws. Despite the rash of district court decisions outside the Fifth Circuit that hold to the contrary, this Court must follow Fifth Circuit law that still requires that a claim itself be false or fraudulent in order for liability under the FCA to exist. 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.

On October 23, 1997, the Fifth Circuit granted new life to Thompson's claim. Recognizing its previous decision in Equifax and the Ninth Circuit's approach in United States ex rel. Hopper v. Anton, the court stated that "where the government has conditioned payment of a claim upon a claimant's certification of compliance with, for example, a statute or regulation, a claimant submits a false or fraudulent

References:

121. See cases cited supra notes 105-06.
122. Thompson, 938 F. Supp. at 403-04.
123. 557 F.2d 456 (5th Cir. 1977), cert. denied, 434 U.S. 1035 (1978).
124. United States ex rel. Weinberger v. Equifax Inc. [hereinafter Equifax] was cited in both Pogue and Thompson as authority supporting the proposition that "the False Claims Act was not designed to reach every kind of fraud practiced on the government." 557 F.2d 456, 460 (5th Cir. 1977) (quoting United States v. McNinch, 356 U.S. 595, 599 (1958)).
127. 557 F.2d 456 (5th Cir. 1977).
128. 91 F.3d 1261 (9th Cir. 1996).
claim when he or she falsely certifies compliance with that statute or regulation.” With regards to Thompson’s claims, the court was "unable to determine . . . whether, or to what extent, payment for services identified in defendants’ annual cost reports was conditioned on defendants’ certifications of compliance.” As such, the Fifth Circuit vacated the district court’s dismissal of Thompson’s claim and remanded this issue back to the district court "for further factual development.”

It should be noted that Thompson, in his district court case, had alleged that the defendants had submitted claims for medically unnecessary services in his Second Amended Complaint. Thompson’s evidence to support this claim consisted of statistical studies which concluded that forty percent of the Medicare claims for services rendered by Columbia/HCA’s physicians who were in arrangements violating the anti-kickback statute were for services that were medically unnecessary. However, the district court found that Thompson had not met his pleading burden under Rule 9(b) of the Federal Rules of Civil Procedure, which requires that averments of fraud be pleaded “with particularity.” While the district court recognized its right to allow Thompson to replead these allegations in compliance with Rule 9(b), the court refused to do so and dismissed the case.

129. Thompson, No. 96-40868, 1997 WL 619314, at n.4.
130. Id.
131. Id.
133. See id. at 406-07.
134. See id. at 406. FED. R. CIV. P. 9(b) states “[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity.” The court in Thompson stated:

Thompson has not met his pleading burden with respect to his allegation that the FCA was violated due to the submission of claims for services that were not medically necessary since he has not alleged that any specific physicians referred patients for such services or that any specific claims were filed for such services. Thompson did not assert that the defendants were submitting claims for services which were not medically necessary until the filing of his Second Amended Complaint, which was after defendants filed their initial motions to dismiss.

Thompson, 938 F. Supp. at 407.

135. Thompson, 938 F. Supp. at 407. (“So while leave could be granted for Thompson to replead in compliance with Rule 9(b), the Court declines to do so since this allegation appears to be a last minute effort by Thompson to avoid dismissal of the case based on the statutory violations of Medicare.”).
While Thompson's appeal in the Fifth Circuit was pending, several large constituencies loaned support to their respective interests in the case.\textsuperscript{136} Regardless, the Fifth Circuit affirmed the district court's decision that on this issue, Thompson's complaint failed to satisfy the requirements of Federal Rule of Civil Procedure 9(b).\textsuperscript{137} The court stated that "Thompson provided no factual basis for his belief that defendants submitted claims for medically unnecessary services other than his reference to statistical studies. There is no indication, however, that these studies directly implicate defendants."\textsuperscript{138}

2. Case Analysis

While the decision in Pogue illustrates the shortcomings in

\textsuperscript{136} The American Hospital Association (AHA) filed an amicus brief to the Fifth Circuit asking that the district court decision be affirmed. See Stark Seeks DOJ Intervention in Columbia/HCA False Claims Case, BNA HEALTH CARE DAILY 6, Apr. 24, 1997. The AHA maintained that "use of the False Claims Act in cases where there is no injury to the public fisc, as in cases alleging violations of the anti-kickback and self-referral law, is 'abusive' and 'beyond the scope of the Act.'" Id. In opposition to this, Rep. Fortney H. Stark (D-Calif) filed an amicus brief asking the Fifth Circuit to reverse its decision and conclude that violations of the Medicare anti-kickback statute and the Stark prohibitions constitute FCA violations. See Stark, Koop, Todd, Relman File Amicus Briefs in False Claims Case, BNA HEALTH CARE DAILY 2, Jan. 2, 1997. Likewise, former U.S. Surgeon General C. Everett Koop, Harvard Medical School Professor Arnold S. Relman, and James S. Todd, former executive vice-president of the American Medical Association, also filed amicus briefs to the Fifth Circuit asking for reversal of the decision. See id. "Their brief stated that it did not seek to offer any additional insights into the construction of the False Claims Act or its application to the factual allegations of the case ...." Id. In the brief they maintained that the "self-referral and compensation arrangements at issue in ... [Thompson] threaten to erode traditional medical ethics, undermine public trust, and create irreconcilable conflicts of interest at a time when the public at large will be ill served thereby." Id.

\textsuperscript{137} United States \textit{ex rel.} Thompson v. Columbia/HCA Healthcare Corp., No. 96-40868, 1997 WL 619314, at n.5 (5th Cir. Oct. 23, 1997). The Fifth Circuit stated: At a minimum, Rule 9(b) requires that the plaintiff set forth the "who, what, when, where, and how" of the alleged fraud. Williams \textit{v.} WMX Tech., Onc., 112 F.3d 175, 179 (5th Cir. 1997). Thompson argues, however, that the pleading requirements of Rule 9(b) are relaxed where, as here, the facts relating to the alleged fraud are peculiarly within the perpetrator's knowledge. Although we have held that fraud may be pled on information and belief under such circumstances, we have also warned that this exception "must not be mistaken for license to base claims of fraud on speculation and conclusory allegations." See Tuchman \textit{v.} DSC Communications Corp. 14 F.3d 1061, 1068 (5th Cir. 1994). In addition, even where allegations are based on information and belief, the complaint must set forth a factual basis for such belief. Kowal \textit{v.} MCI Communications Corp., 16 F.3d 1271, 1279 n.3 (D.C. Cir. 1994); Neubronner \textit{v.} Milken 6 F.3d 666, 672 (9th Cir. 1993).

\textit{Id.}

\textsuperscript{138} \textit{Id.}
finding that a violation of the anti-kickback statute renders a claim for payment to Medicare a per se false claim for FCA purposes, the district court’s decision in Thompson exposes the weakness of the opposite rule. In Thompson there appeared to be convincing evidence that Columbia/HCA was a “bad violator” of the anti-kickback statute. If we adhere to the rule that a violation of the anti-kickback statute does not render a claim to Medicare or Medicaid a per se false claim for FCA purposes, we may allow “bad violators” to go unpunished, as such fraud may not be uncovered absent the private enforcement mechanism of the FCA’s qui tam provisions.

IV. ANALYSIS

Should a violation of the anti-kickback statute constitute a per se viable claim under the FCA? The optimal result would be to amend the anti-kickback statute in a way that clearly delineates prohibited and lawful behavior and which tolerates provider arrangements designed for competition in the prospective payment era.139 However, in light of our experience with the Fraud and Abuse statute and with the new HIPAA, the only thing that seems clear is that more guidance on the anti-kickback statute is unlikely to come soon.140 The alternative to amending the Fraud and Abuse statute is amending the FCA. However, this alternative is unlikely to yield a substantially better result since tinkering with the FCA involves considerations extending beyond the scope of health law, let alone the scope of the anti-kickback provisions. In the absence of ambitious legislative overhaul, we are currently left with two potential default rules. This section examines the pros and cons of

139. As mentioned earlier, the weaknesses in the Fraud and Abuse statute have been extensively discussed in the literature.
140. However, the U.S. Supreme Court is currently considering the issue of whether “a relator could assert a cause of action under the False Claims Act for a regulatory violation even if the alleged violation did not and could not cause a financial loss to the United States.” AHA, AMA, AAMC File Amicus Brief in Supreme Court Whistleblower Case, BNA HEALTH CARE DAILY 8, Dec. 13, 1996. The case under consideration originated in the Ninth Circuit and is labelled Hughes Aircraft Co. v. United States ex rel. Schumer, U.S. Sup. Ct., No. 950-1340. The result could have significant implications for health care providers since it, in effect, would create a safe harbor for conduct which saved money under Medicare and Medicaid so far as FCA claims are concerned. As discussed, there currently is no such safe harbor under the Fraud and Abuse statute. 42 U.S.C.A. § 1320a-7b (West 1997).
A. Why A Violation of the Anti-Kickback Statute Should Per Se Constitute a Viable FCA Claim.

There are several reasons that explain that a violation of the anti-kickback statute constitutes an FCA claim. First, the amount of fraud that occurs within our nation’s health care system is enormous. If private individuals are allowed to help combat this fraud through the qui tam provisions, the amount of health care fraud would be reduced because, presumably, more violators would be caught or exposed, and likewise, more potential fraud perpetrators would be deterred. Given the large increase in the number of qui tam suits that have been filed since the 1986 Amendments to the FCA, such a result appears likely.

Moreover, anti-kickback violations are arguably more difficult for the government to detect when compared to false claims for services that were not medically necessary or were not performed. False claims premised on anti-kickback violations result from the structure of financial arrangements among providers. The only way these can be detected would be for the Attorney General to open a provider’s books and examine that provider’s organizational structure and its related contracts. Without any reasonable cause to investigate or a starting point for investigation, such access and information is difficult for enforcement officials to obtain.

However, false claims premised on the submission of claims for medically unnecessary procedures or for unperformed procedures could be found by examining the claims received from providers. In other words, from an enforcement standpoint, a private cause of action through qui tam may be better suited to detecting anti-kickback violations than false claims. As such, qui tam actions are especially valuable in the anti-kickback context because, in uncovering fraud, the government relies more on information provided by relators.

Second, although relying on prosecutorial discretion could

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141. See supra pp. 81-82.
142. See supra notes 61-64 and accompanying text.
ostensibly protect "good violators" of the anti-kickback statute, prosecutorial discretion is prone to abuse and could be used to protect "bad violators." In other words, by not allowing an anti-kickback violation to constitute a per se viable claim under the FCA, enforcement of the statute is limited to those providers whom the Attorney General or the OIG chooses to pursue. While enforcement officials could use this discretion to prosecute only those persons in serious violation of the anti-kickback statute, this discretion can also be abused to harass those who commit minor violations or to protect those in flagrant violation of the statutes.

Third, as discussed previously, one of the most significant criticisms of the anti-kickback statute is the lack of guidance as to what conduct is legal and what is illegal. If qui tam suits based on allegations of anti-kickback violations are allowed, the judicial precedent interpreting the anti-kickback statute presumably would be expanded and developed. By adding to the judicial interpretation of the anti-kickback statute, qui tam suits in this area could help providers navigate the breadth of the statute's prohibitions.

B. Why A Violation of the Anti-Kickback Statute Should Not Constitute a Per Se Viable FCA Claim

For every reason in support of allowing qui tam suits based on violations of the anti-kickback statute, there is a more convincing reason to not allow these suits.

1. Providers who are in technical violation of the anti-kickback statute may be trying to reduce program costs instead of trying to defraud Medicare

While the problem of health care fraud is admittedly great, many commentators believe that much of the conduct prohibited by the anti-kickback statute is actually beneficial to the Medicare and Medicaid systems, helps to reduce overall health

143. See supra notes 108-113 and accompanying text.
144. See Blumstein, supra note 73, at 218 (discussing how demands of the marketplace require industry leaders to perform illegal tasks that improve the market).
145. See supra notes 71-99 and accompanying text.
care costs, or improves the quality of health care.\textsuperscript{146} Since reduction of health care costs is the primary rationale behind the Fraud and Abuse statute,\textsuperscript{147} we should hesitate to allow all violations of the anti-kickback statute to be actionable under the FCA's qui tam provisions. Prosecutors recognize that due to the expansiveness of the anti-kickback provisions, some providers' "illegal" conduct is more egregious than others. Allowing any private individual to bring a qui tam claim would subject those in "mild" violation to liability when the government itself would not prosecute such behavior.

2. There is no need for additional private fraud enforcement efforts

While one could argue that the government may not prosecute all violations of the anti-kickback statute because of limited governmental resources, this is not entirely convincing in light of the newly enacted Health Insurance Portability and Accountability Act:\textsuperscript{148}

The Act delivers extraordinary resources to the Department of Health and Human Services Office of Inspector General and the Federal Bureau of Investigation, and intermediaries and carriers. Specifically, without further appropriations, the OIG will receive $60-$70 million in funding for 1997 which will increase to $150-$160 million through the year 2000 for Medicare and Medicaid program activity; the FBI will receive $47 million for 1997 and up to $114 million for 2002, and intermediaries and carriers will receive $430-$440 million for 1997 and up to $720 million for 2002 for program integrity functions. These funds are, however, merely a deposit into the kitty because the Act creates a bounty system for investigators. Funds collected from providers for violations of the law and from settlements and asset forfeitures are to be placed into the Fraud and Abuse Control Account to be recycled for new fraud and abuse busting activities.\textsuperscript{149}

Given the way the damages provisions of the FCA are struc-
tured, there is no reason why the government should refuse to prosecute a valid claim for lack of resources since any government victory would clearly pay for itself.\textsuperscript{150} Similarly, the federal government’s commitment to fighting health care fraud is well-established. Health care fraud “is the second priority of the United States Department of Justice, after violent crime. A criminal and civil health care fraud coordinator is now present in every United States Attorney’s Office.”\textsuperscript{151}

3. Allowing Qui Tam Opens the Door to Many Frivolous and Retributive Suits

Furthermore, the argument that more violations of the anti-kickback statute would be flushed out by private enforcement is mitigated by the fact that the wrong people would presumably be the ones bringing the qui tam actions. At least one commentator has suggested that qui tam suits are often brought only to harass and has provided some admittedly crude empirical evidence to support his assertion.

Some relators have filed qui tam actions merely to harass their former employer or to add personal leverage to [another] personal claim . . . . From fiscal year 1987 through Sept. 10, 1996, 1,434 qui tam actions were filed. The government intervened in only 209 cases. Recoveries have occurred in only 39 cases where the government chose not to intervene, and the total amount recovered in those cases represents only 1\% of the government’s total recoveries under the FCA during the same period. The large number of cases declined by the government suggests that there have been many frivolous cases filed, like \textit{Millner}, for the purpose of harassing a defendant or attempting to leverage a larger settlement on a personal claim [concurrently filed with the qui tam action].\textsuperscript{152}

\textsuperscript{150} See 31 U.S.C.A. § 3730 (West 1997).

\textsuperscript{151} Bucy, supra note 25, at 693-94 (citing Medicare & Medicaid Fraud & Abuse: Hearings before the subcommittee on Human Resources and Intergovernmental Affairs of the House Comm. on Govt. Reform and Oversight, 104th Cong., 1st Sess. *2 (June 15, 1995) (statement of Gerald M. Stern, Special Counsel, Health Care Fraud, Department of Justice), available in 1995 WL 360342).

\textsuperscript{152} Mark R. Troy, \textit{Qui Tam Settlements: Is the Government Being Shortchanged?}, ANDREWS HEALTH CARE FRAUD LITIG. REP. 3, Dec. 1996 (citing \textit{Millner} v. ITT Corp., No. 1:92cv9, unpublished order (N.D. Ind. Sept. 27, 1995)). According to Troy, in \textit{Millner}, “the court held that the qui tam action was frivolous and was ‘calculated to harass ITT and cause it as much harm as possible.’” \textit{Id.}
It should be noted that the plaintiff in *Pogue* was a disgruntled employee who brought suit after he was fired. The plaintiff in *Thompson* was a local physician who brought suit against his large competitor, Columbia/HCA. The qui tam provisions are structured to encourage whistleblowers to come forth and report behavior that defrauds the government by giving them a large bounty if a violation is found. In passing the 1986 Amendments, Congress realized that many of the people bringing qui tam claims would be current or former employees of the defendant, since only an employee would have the detailed knowledge of the fraud to bring the claim in the first place. Presumably, a portion of the generous bounty afforded to such individuals is calculated to help compensate these individuals for any future retribution taken against them by current or former employers. Thus, insofar as the relator is concerned, the qui tam provisions are structured to provide a shield for coming forward and reporting the fraud. If, in reality, the qui tam provisions are actually being used as a sword against former employers and competitors, the spirit of the qui tam statute is being violated, since the relator is not attempting to make the government whole, but rather is merely trying to punish the defendant. Likewise, if the majority of qui tam actions that are brought in spite of the government's refusal to prosecute the claim are frivolous as the statistics above suggest, it is difficult to believe that allowing this private cause of action is truly flushing out more fraud.

4. Allowing Qui Tam Places Large Costs on Providers

The threat of a qui tam suit forces providers and other government contractors to assume costs beyond those associated with defending or settling a suit. We have already seen that the penalty provisions of the FCA encourage defendants to settle. In addition to the expense of threatened litigation and the potential catastrophic penalties that could be faced if litigation were to proceed unsuccessfully, there is always the

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153. *See supra* note 103.
cost of negative publicity inherent in going to court, especially where allegations of fraud are involved. Furthermore, the mere threat of a qui tam suit could raise costs for providers that undertake preventive measures.

"Firms may adopt costly safeguards to reduce the likelihood of a qui tam suit," such as employment screening to identify employees with personality and character traits suggesting strong tendencies toward conformity and loyalty. This not only increases the costs of hiring and promotion but also may shape the employer's workforce in an undesirable way by disfavoring creative or assertive individuals. Also, "qui tam monitoring may increase the importance of consensus as a decision-making objective because achieving consensus reduces the possibility that individual employee will believe that favored approaches were improperly rejected." While achieving consensus is expensive and time-consuming in and of itself, it can also yield decisions that "are suboptimal in their tendency to incorporate compromise positions which satisfy potential holdouts but fail to make needed choices or respond adequately to specific, [difficult] problems."

Another way that providers have attempted to address potential qui tam liability for anti-kickback violations is through the establishment of corporate compliance programs. These programs are aimed at preventing and detecting violations of federal and state law through employee participation. One of the main impetuses behind creating these programs is the fact that "the sentencing guidelines award substantial credit to a corporation convicted of a crime if the company had a corporate compliance program in place before the offense occurred and if the company reports the offense to the U.S. Attorney's Office as soon as possible." The cost of

156. Kovacic, supra note 33, at 1827.
157. See id.
158. Id.
159. Id.
160. See Jeannine Mjoseth, Health Attorneys See Rapid Growth in Adoption of Compliance Plans, 5 BNA HEALTH L. REP. 33 (1996) (detailing the need for and characteristics of recent health care organizations' compliance plans). "Health care attorneys are seeing 'tremendous growth' in the development of compliance plans by health care providers, driven by high profile fraud settlements and numerous qui tam suits . . . ." Id.
161. New Fraud, Abuse Laws 'Real Sleeper,' Show Need for Good Compliance Plans, BNA HEALTH CARE DAILY 2, Aug. 27, 1996 (quoting Illene Nagel, commissioner of the U.S.
these programs is presumably high due to the employee hours involved and the fact that outside counsel should coordinate the compliance program in order to take advantage of attorney-client privilege in case of an investigation and to keep any investigation “under the direction of an attorney if something discoverable were to take place.” On the other hand, the costs for developing these plans is tax deductible. However, as discussed in the next section, the potential for lucrative windfalls from successful qui tam suits may outweigh the benefits of these programs.

5. Allowing Qui Tam Frustrates Providers’ Own Attack Against Fraud

“...A compliance program reduces the likelihood of civil and criminal wrongdoing, gives a realistic view of the company, establishes a structure to disseminate legal and policy changes quickly, maximizes use of the attorney/client privilege, and speeds responses to lawsuits and investigations.” Regardless, these benefits to the provider can be undermined by the lucrative benefits the qui tam provisions offer to employees.

Qui tam enforcement can undermine internal compliance mechanisms in two ways. First, an employee may choose to file a qui tam suit instead of going through any internal anti-fraud mechanism the provider may have established. Similarly, the provider’s internal compliance officials may deliberately avoid correcting any fraud in order to lay the foundation for their own, larger qui tam actions. In short, the luctriveness of the qui tam action itself is more persuasive than participation in an employer’s anti-fraud mechanism, thus reducing the effectiveness of such mechanisms.


162. Charles Pereyra-Suarez & Carole A. Klove, Ring Around the White Collar: Defending Fraud and Abuse, 18 WHITIET L. REV. 31, 36 (1996) (discussing how some corporate clients prefer to have compliance coordinated by outside counsel in order to avoid internal investigation).


164. Id.

165. Kovacic, supra note 33, at 1831.

166. See id.

167. See id.
6. Allowing qui tam frustrates the government's fight against fraud

When the 1986 Amendments to the FCA were being debated in Congress, the Department of Justice itself opposed an amendment to the Act that would allow a private individual to continue pursuing their claim after the government refused to pick it up and prosecute it.\textsuperscript{168} The DOJ gave several reasons for its opposition. The DOJ believed that:

Absent the absolute right to control litigation, DOJ could not completely direct the course of litigation, including the right to settle certain issues or dismiss claims against particular parties. Therefore, DOJ would lose its prosecutorial autonomy. Forced to compromise with a stubborn relator harboring a different agenda, DOJ would be unable to negotiate settlements favorable to the government and to consider other factors, such as its own time and resources. Instead, DOJ might be forced to litigate claims to judicial resolution, satisfying relators' agenda for a guilty verdict, but wasting government resources for marginal government gains.\textsuperscript{169}

Furthermore, "[w]hen DOJ is informed of a qui tam suit, it must do more than decide whether a claim is meritorious and worth pursuing: it must also decide whether to intervene in a case that has already been brought . . . . [This] compromises DOJ's autonomy, because DOJ must pick up and investigate that case within sixty days to determine how the government will handle it."\textsuperscript{170}

In addition to noting the differing objectives of the government and relators, the DOJ also opposed allowing private citizens to continue qui tam claims without the government

\textsuperscript{168} See Kolis, supra note 18, at 413 (citing FALSE CLAIMS REFORM ACT: HEARINGS ON S.1562 BEFORE THE SUBCOMM. ON ADMINISTRATIVE PRACTICE AND PROCEDURE OF THE SENATE COMM. ON THE JUDICIARY, 99th Cong., 1st Sess. 2 (1985) at 20 (testimony of Jay B. Stephens, Deputy Associate Attorney General, U.S. Department of Justice)). "The Department of Justice (DOJ) believed that the qui tam provisions, created originally during an era when the United States did not have true investigative bodies, were superfluous in modern times . . . . Further, DOJ felt that only occasionally would a qui tam relator unearth an instance of fraud that otherwise might never have been discovered." \textit{Id.} at 427 (citing FALSE CLAIMS REFORM ACT: HEARINGS ON S.1562 BEFORE THE SUBCOMM. ON ADMINISTRATIVE PRACTICE AND PROCEDURE OF THE SENATE COMM. ON THE JUDICIARY, 99th Cong., 1st Sess. 2 (1985), at 44 (testimony of Jay B. Stephens, Deputy Associate Attorney General, U.S. Department of Justice)).

\textsuperscript{169} Kolis, \textit{supra} note 18, at 429-30.

\textsuperscript{170} \textit{Id.} at 435.
since doing so would subvert the DOJ’s role as a case manager in the fight against fraud. In other words, instead of systematically bringing suits as part of a larger fight against fraud, the DOJ would have to attend to and examine the multitude of unrelated cases brought by numerous and varied private individuals. In effect, the DOJ felt that it would be “forced to prosecute fraud in the ad hoc manner mandated by numerous qui tam relators.”171 Ten years after the passing of the 1986 Amendments the DOJ’s fears appear to come true. In May of 1996, Lewis Morris, a deputy associate general counsel in the Office of the Inspector General of the Health and Human Services Department stated that the quality of the allegations that qui tam relators have brought forth is “all over the place.”172 He further stated that the volume of qui tam cases “is significantly distorting the investigative priorities” of the OIG and “distorts [the OIG’s] attempt to have a systematic approach to dealing with fraud and abuse.”173

Finally, the DOJ also believed that if relators were allowed to continue as co-parties in the government’s suit against a defendant, “some relators might file qui tam suits and insist on remaining in the case only to engage in collusive litigation. A DOJ co-party, truly aligned with the defendant, could stay in the case and tip-off the defendant, deliberately interfere with the proceedings, or negatively influence the outcome of the suit.”174 While this scenario does not appear to have arisen so far, the possibility is not precluded by the statute.

171. Id. at 430 n.97.
172. Government Officials Grouse About Burden of Investigating Complaints, BNA HEALTH CARE DAILY 7, May 13, 1996 (commenting on how the proliferation of qui tam claims consumes the OIG’s investigative resources, and as a result, prevents the OIG from focusing on other areas).
173. Id. Mr. Morris also indicated that the OIG wants an increased focus on managed care, but cannot pursue it because the OIG is “busy chasing down qui tam claims.” Id.
7. Allowing Qui Tam Will Not Create More Judicial Precedent Clarifying the Fraud and Abuse Laws

Allowing qui tam suits as a means of developing precedent clarifying the scope of conduct prohibited under the Fraud and Abuse statute is not worthwhile for several reasons. As discussed previously, negative publicity, the large potential penalties involved, and availability of reimbursement of attorneys fees all encourage the settlement of claims. Few cases are litigated to completion, thus creating little judicial precedent.

Moreover, even if these cases routinely went through to trial, without any legislative guidance, precedent could develop in an *ad hoc* and inconsistent manner. This could just create more confusion. In short, there is no guarantee that the development of precedent will clarify the scope of conduct prohibited by the Fraud and Abuse statute.

**V. CONCLUSION**

When considered individually, the impact of the FCA’s qui tam provisions and the impact of the anti-kickback provision on health care providers and on the fight against health care fraud is debatable. But, when a claim submitted to Medicare is considered false for purposes of the FCA by the mere fact that it was submitted while the provider was allegedly in violation of the anti-kickback law, the combination of these statutes tilts the legal playing field to the disadvantage of health care providers.

The FCA’s generous, bounty-oriented award structure strongly encourages plaintiff/realtors to bring suit. When combined with the broad and vague scope of prohibited conduct that providers face under the fraud and abuse laws, providers are left facing potentially unlimited liability. Furthermore, notwithstanding the costs of defending against such litigation, providers face additional costs in developing and implementing more secure internal compliance programs. Moreover, the effectiveness of these efforts can be undermined by the sheer lucrativeness of a qui tam suit itself to the individual plaintiff/realtor. In addition, *ad hoc* private enforcement of the anti-kickback statute under qui tam can undermine the government’s own coordinated fraud-fighting efforts.
In the absence of ambitious legislative overhaul, courts are left to help providers navigate the broad scope of prohibited conduct under the fraud and abuse statute. While the facts of each case should guide any decision, considerations from equity and public policy indicate that courts should begin their own analyses from a position that a qui tam claim cannot rest solely on an alleged anti-kickback violation. Nonetheless, the weakness of adhering to this position as a blanket rule is illustrated by analysis of the *Pogue* and *Thompson* decisions. As such, as the guiding lights in this area of law, courts should carefully tailor their decisions to specific evidentiary factors and give as specific direction as possible.