# Top False Claims Act Developments

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## OVERVIEW

This week's top False Claims Act developments include: DOJ's continued emphasis on FCA cases involving Medicare Part C, DOJ's expanding focus on telemedicine fraud, and a petition to the Seventh Circuit in an FCA case for rehearing en banc.

### 1. DOJ's Continued Focus On FCA Cases Involving Medicare Part C

**Overview:** On September 14, 2021, DOJ intervened (https://www.justice.gov/opa/pr/united-states-intervenes-and-files-complaint-false-claims-act-suit-against-health-insurer) in a *qui tam* action alleging that Independent Health Association and its affiliates violated the FCA by submitting unsupported diagnosis codes for its Medicare Advantage Plan (MA Plan) enrollees in order to receive higher reimbursements (a practice known as "upcoding"). Independent Health's subsidiary DxID LLC allegedly coded conditions that were not documented in patients' medical records and also asked healthcare providers to sign addenda to medical records.

**Medicare Part C:** As explained in prior posts (here (https://www.chamberlitigation.com/FalseClaimsAct3), here (https://www.chamberlitigation.com/FalseClaimsAct4), and here (https://www.chamberlitigation.com/FalseClaimsAct5)), under Medicare Part C, beneficiaries can enroll in Medicare Advantage plans that are administered by private insurers. To receive payments, these companies submit diagnosis data to the

Centers for Medicare & Medicaid Services (CMS), and CMS calculates a "risk score" for each beneficiary, which translates into CMS's monthly payment to these companies per beneficiary. More severe diagnoses typically lead to higher risk scores and larger payments. Allegations of untruthful data submitted to CMS to increase Medicare reimbursements are increasingly forming the basis of FCA claims.

**Our Take:** DOJ's latest intervention follows previous government interventions in six FCA cases involving Medicare Part C insurers (discussed in an earlier post (https://www.chamberlitigation.com/FalseClaimsAct3)), and further illustrates DOJ's intensifying enforcement efforts in this space. As we have recommended (https://www.chamberlitigation.com/FalseClaimsAct5) before, health care providers and private insurers with Medicare Advantage plans should ensure that they have robust compliance programs and measures focused on ensuring accurate diagnosis codes, correcting inaccurate diagnosis codes, and keeping up with overpayment-refund obligations.

### 2. DOJ's Expanding Focus on Telemedicine Fraud

**Overview:** On September 17, DOJ announced (https://www.justice.gov/opa/pr/national-health-care-fraud-enforcement-action-results-charges-involving-over-14-billion) a nationwide health care fraud enforcement action involving over $1.4 billion in alleged losses. The actions targeted more than a hundred defendants, including doctors and nurses, and took place in dozens of different districts around the country.

Most notably, the new actions concentrate on so-called telemedicine fraud, which accounts for over $1.1 billion in allegedly false and fraudulent claims. In many of these actions, DOJ claims that telemedicine executives paid doctors and nurse practitioners to order unnecessary durable medical equipment, genetic and other diagnostic testing, and pain medications, either without any patient interaction or with only a brief telephonic conversation with patients they had never seen. DOJ also asserts that healthcare professionals billed Medicare for sham telehealth consultations that did not occur as represented.

**Our Take:** These enforcement actions further underscore DOJ's pandemic-era focus on perceived telemedicine fraud, where DOJ believes that telemedicine companies work with doctors to issue unnecessary prescriptions at the government's expense. The new

actions illustrate DOJ's willingness to use criminal authorities in addition to the False Claims Act in this space.

### 3. Molina Healthcare Petitions Seventh Circuit for Rehearing En Banc In Post-*Escobar* Case

**Overview:** A month ago, in a 2-1 decision, the Seventh Circuit revived an FCA case against Molina Healthcare, reversing the district court's decision granting Molina's motion to dismiss the case for failure to state a claim and ruling that the relator plausibly alleged that Molina knowingly billed for skilled nursing services that it did not provide.

Molina had contracted with Illinois' Medicaid program to provide managed care services under a "capitation" system where it paid fixed amounts for each beneficiary at specific tiers, based on their care needs. At the highest tier, covering people in nursing facilities, the capitation rate included certain skilled nursing services, which Molina had subcontracted to another company, GenMed, which was founded by the relator. After GenMed canceled the contract, Molina allegedly did not inform the state, which kept paying the full capitation amount even though Molina allegedly did not deliver the services or seek a replacement provider.

In its opinion (https://www.chamberlitigation.com/sites/default/files/US v. Molina Healthcare 7th Circuit Opinion.pdf), the Seventh Circuit majority reached several notable conclusions. Addressing the relator's factual falsity claim, the majority observed that Molina sought capitation payments without disclosing that it allegedly did not provide one of the services required by the contract. By holding that this was enough to state a claim, the majority extended the factual-falsity theory to include omissions as well as affirmative misrepresentations. The majority also held that "[m]aterial omissions can suffice" for purposes of the implied certification theory of FCA liability, even in the absence of specific representations about the goods and services provided. And it allowed the relator to establish knowledge because Molina was allegedly a "sophisticated player[] in the healthcare market." Judge Sykes filed a forceful dissent, arguing that the majority's decision conflicts with *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016), and with circuit precedent.

**Petition for Rehearing En Banc:** On September 2, Molina petitioned for rehearing en banc. The petition (https://www.chamberlitigation.com/sites/default/files/Molina Healthcare Petition for Rehearing En Banc.pdf)

contends that, under *Escobar,* False Claims Act liability attaches to implied false certifications only when the defendant makes specific representations that are material to the government's payment decision.

Quoting the dissent, the petition emphasizes that the "majority moves our circuit law in a different direction," establishing "a new rule" that "a mere request for payment from the government, coupled with material noncompliance with a contractual condition, is a cognizable FCA violation."

The petition also argues that the decision presents questions of exceptional importance because it will subject defendants to "FCA liability for what previously was only a breach of contract," forcing courts to confront "a surge in meritless FCA actions that will now survive valid pleading challenges."

**Our Take:** The Seventh Circuit's decision puts that court on an unexpected post-*Escobar* trajectory. The court's decision on the petition for rehearing en banc will be significant with respect to the requirements for pleading FCA claims under *Escobar*.

* Disclosure: King & Spalding LLP represents Molina Healthcare in this case.

**Also In the News**

**Orlando Cardiologist Settles FCA Allegations.** On September 15, DOJ announced (https://www.justice.gov/opa/pr/orlando-cardiologist-pays-675-million-resolve-allegations-performing-unnecessary-medical) a $6.75 million settlement with Dr. Anish Pal, a cardiologist based in Orlando, Florida, to resolve allegations that he submitted false claims to federal health care programs for medically unnecessary ablations and vein stent procedures.

**Default Judgment Entered Against South Carolina Pain Management Clinics, Drug Testing Laboratories and a Substance Abuse Counseling Center.** On September 3, DOJ announced (https://www.justice.gov/opa/pr/united-states-obtains-140-million-false-claims-act-judgments-against-south-carolina-pain) that the District Court for the District of South Carolina entered a default judgment totaling more than $136 million against Oaktree Medical Center P.C., FirstChoice Healthcare P.C., Labsource LLC, Pain Management Associates of the Carolinas LLC, and Pain Management Associates of North Carolina P.C., in a case alleging that the companies provided financial incentives to providers to induce their referrals of drug tests. The

court had previously entered a default judgment of over $4 million against two other defendants, ProLab LLC and ProCare Counseling Center LLC, which had allegedly billed federal health care programs for unnecessary urine drug tests.

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