HEALTH CAPITAL Topics
Volume 17
Issue 3
March 2024
Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

False Claims Act Recoveries Reach Historic High

Introduction

On February 22, 2024, the U.S. Department of Justice (DOJ) announced their recovery of $2.68 billion in settlements and judgments from civil cases related to the False Claims Act (FCA) for fiscal year (FY) 2023.[1] The FY 2023 overall recoveries were slightly higher than the FY 2022 recoveries of $2.2 billion.[2] Of the $2.68 billion recovered, over $1.8 billion was recouped from the healthcare industry alone, and included recoveries from managed care providers, hospitals, pharmacies, laboratories, physicians, and long-term care facilities.[3] These recoveries reflect the DOJ's focus on new enforcement priorities, including violations of cybersecurity requirements in government-funded grants and contracts and fraud in pandemic relief programs.[4]

Substandard Care & Unnecessary Services

The DOJ pursued a number of cases related to providers allegedly billing federal healthcare programs for unnecessary medical services.[5] Such services waste taxpayer money and can potentially expose patients to harmful treatments or procedures.[6] Various DOJ claims for unnecessary medical services were ultimately settled during FY 2023, including with the following organizations:

- **Smart Pharmacy Inc., SP2 LLC, and Gregory Balotin** paid $7.4 million to resolve allegations that they unnecessarily added an antipsychotic drug (aripiprazole) to topical pain creams to increase federal reimbursement for the creams, and waived patient co-payments. The DOJ alleged that the defendants crushed aripiprazole pills, which were only approved for oral usage, and included them in the creams used for pain treatments, knowing there was no clinical reason to do so.
- **Cornerstone Hospital Medical Center** and related entities paid $21.6 million to resolve allegations that the medical center (formerly a long-term acute care facility) knowingly submitted claims for services furnished by unauthorized and unlicensed students, as well as for services that were effectively worthless or not actually provided.
- **Saratoga Center for Rehabilitation and Skilled Nursing Care**, related entities, and individual owners and operators (Leon Melohn, Alan Schwartz, Jeffrey Vegh, and Jack Jeffa) agreed to pay $7.1 million to resolve allegations that Saratoga Center delivered services that were worthless to residents, which resulted in unnecessary falls, medication errors, and the development of pressure ulcers. Additionally, the facility's physical conditions had deteriorated to such a degree that there was not an adequate linen inventory or disposal of solid waste, and the facility did not consistently maintain hot water.[7]

Unlawful Kickbacks

Several lawsuits were filed in 2023 related to unlawful kickbacks. For example, the DOJ filed suit against multiple office-based labs owned by **Modern Vascular**, its affiliated companies, and its owner, Yury Gampel.[8] The suit alleged that the defendants offered referring physicians various forms of remuneration, including the opportunity to invest in Modern Vascular's labs with the potential for large monetary distributions, specifically to induce them to refer patients to the labs for the treatment of peripheral arterial disease.[9] The complaint also alleged that Gampel pressured interventional radiologists and vascular surgeons employed at the labs to increase the number of invasive surgical procedures.[10] Additionally, **Cardiac Imaging Inc.**, and its founder and CEO, Sam Kancherlapalli, agreed to pay $85.5 million to resolve allegations that, with Kancherlapalli's approval and oversight, Cardiac Imaging paid kickbacks to cardiologists in the form of above-fair market value (FMV) supervision fees, in order to induce the physicians to refer their patients to Cardiac Imaging for PET scans.[11] The DOJ asserted that the fees substantially exceeded FMV for the physician services, and included times the physicians were not physically on-site or in the mobile scanning units.[12]

The DOJ also filed lawsuits involving kickbacks relating to electronic health records (EHR). **NextGen Healthcare Inc.** agreed to pay $31.2 million to resolve allegations that they misrepresented the capabilities of their EHR software by using a product that was designed specifically to meet government criteria for certification, but which otherwise lacked functionality.[13] The DOJ further alleged that NextGen provided unlawful remuneration in the form of credits – often worth up to

(Continued on next page)

$10,000 – as well as tickets to entertainment and sporting events, to customers whose recommendations of the software led to a new sale.[14] The DOJ settled a case with **Modernizing Medicine Inc.**, which agreed to pay $45.4 million to resolve federal allegations that it solicited and received kickbacks from a lab company in exchange for arranging and recommending that Modernizing Medicine's users utilize the lab company's pathology services, conspired with the lab company to improperly donate Modernizing Medicine's EHR to providers, and paid kickbacks to influential sources and customers to recommend their technology and refer customers to Modernizing Medicine.[15] The DOJ also alleged that Modernizing Medicine knew their technology did not allow physicians to record medical records with the appropriate vocabularies, thereby causing certain users to submit false claims for incentive payments under the Department of Health and Human Services (HHS) EHR Incentive Programs.[16]

Additionally, **Carter Healthcare LLC**, a for-profit home health provider, as well as its affiliates, president, and chief operations officer, agreed to pay $22.9 million to settle allegations that Carter Healthcare improperly paid remuneration to physicians under the guise of medical directorships, which in turn induced referrals of home health patients.[17] The DOJ also resolved numerous matters involving laboratories and their recruiters, which allegedly provided physicians kickbacks disguised as legitimate payments.[18] Ten individuals and five corporate entities paid $2.6 million to settle allegations of kickbacks in exchange for laboratory referrals, which included fake investment distributions from management service organizations (MSOs).[19]

Medicare Advantage Fraud

In addition to pursuing cases related to unlawful kickbacks, the DOJ intervened in cases related to Medicare Advantage (MA) (also known as Medicare Part C) plans. Because MA pays providers a set amount per enrolled patient, which amount is then adjusted by several risk factors that affect expected healthcare expenditures (i.e., a plan with more higher-risk patients would receive more reimbursement), the government has a strong interest in ensuring that providers do not manipulate the risk adjustment process. One case was filed against **Cigna,** and other cases continue to be litigated against **UnitedHealth Group**, **Independent Health Corporation**, **Elevance Health**, and the **Kaiser Permanente group**.[20]

Pandemic-Related Fraud

During the COVID-19 pandemic, Congress authorized emergency funding to provide financial assistance directly to state, local, and Tribal governments, as well as to businesses and individuals. The DOJ has pursued cases involving improper payment from the Paycheck Protection Program (PPP), which provided forgivable loans to small businesses (both healthcare and non-healthcare) for payroll, rent, and other operational costs. In FY 2023, the department resolved 270 FCA matters related to improper PPP loans, recovering $48.3 million.[21] The DOJ also pursued cases against other fraud related to the pandemic, including schemes to profit from the pandemic by billing for unnecessary services and tests.[22]

Conclusion

Money recovered by the DOJ through healthcare fraud enforcement is crucial in returning assets back to federally-funded programs such as Medicare, Medicaid, and TRICARE. Of the $2.68 billion recovery, $2.3 billion resulted from lawsuits that were filed under the *qui tam* provisions of the FCA.[23] The FCA's *qui tam*, or whistleblower, provision allows any private citizen to enforce the FCA by filing a complaint, on behalf of the federal government, alleging fraud against the government. The DOJ assumes primary responsibility for prosecuting the claim if it believes the claim has merit, and the whistleblower is entitled to share in a portion of any recovery in the case, whether or not the government becomes involved.[24] The number of lawsuits filed under the *qui tam* provisions has grown significantly since 1986, with 712 *qui tam* suits filed in FY 2023, an increase from the 652 *qui tam* suits filed in FY 2022.[25] Nevertheless, the DOJ's continued active interest and involvement in fraud and abuse cases in 2023 suggests that FCA enforcement will remain high going forward.

Going forward, DOJ Principal Deputy Assistant Attorney General Brian Boynton noted that the DOJ would continue its prosecutorial focus on fraud (specifically as relates to financial relationships under the Stark Law and Anti-Kickback Statute), nursing homes, participants in the MA program (including vendors, plans, and providers), and pandemic spending.[26] Boynton also mentioned the DOJ's interest in third parties (i.e., EHR software providers and coding consultants and private equity investors) and their impact on federal program spending and patient care delivery.[27]

(Continued on next page)

1 "False Claims Act Settlements and Judgments Exceed $2.68 Billion in Fiscal Year 2023" Office of Public Affairs, Department of Justice, February 22, 2024, https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-268-billion-fiscal-year-2023#:~:text=Settlements%20and%20judgments%20under%20the,Associate%20Attorney%20General%20Benjamin%20C (Accessed 2/29/24).
2 *Ibid.*
3 *Ibid.*
4 *Ibid.*
5 *Ibid.*
6 *Ibid.*
7 *Ibid.*
8 *Ibid.*
9 *Ibid.*
10 *Ibid.*
11 *Ibid.*
12 *Ibid.*
13 *Ibid.*
14 *Ibid.*
15 *Ibid.*
16 *Ibid.*
17 *Ibid.*
18 *Ibid.*
19 *Ibid.*
20 *Ibid.*
21 *Ibid.*
22 *Ibid.*
23 *Ibid.*
24 "Civil Actions for False Claims" 31 U.S.C. § 3730.
25 Office of Public Affairs, Department of Justice, February 22, 2024; "False Claims Act Settlements and Judgments Exceed $2 Billion in Fiscal Year 2022" Office of Public Affairs, Department of Justice, February 7, 2023, https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-2-billion-fiscal-year-2022 (Accessed 2/29/24).
26 "DOJ and OIG Actions: 2023 Enforcement Trends Recap" By Tony Maida, Monica Wallace, and Emily Jane Cook, McDermott Will & Emery, February 28, 2024, https://www.mwe.com/insights/doj-and-oig-actions-2023-enforcement-trends-recap/ (Accessed 3/6/24).
27 *Ibid.*

(Continued on next page)

HEALTH CAPITAL CONSULTANTS

(800) FYI -VALU

Providing Solutions in an Era of Healthcare Reform

- Firm Profile
- HCC Services
- HCC Leadership
- Clients & Projects
- HCC News
- Upcoming Events
- Contact Us
- Email Us

- Valuation Consulting
- Commercial Reasonableness Opinions
- Commercial Payor Reimbursement Benchmarking
- Litigation Support & Expert Witness
- Financial Feasibility Analysis & Modeling
- Intermediary Services
- Certificate of Need
- ACO Value Metrics & Capital Formation
- Strategic Planning
- Industry Research

LEADERSHIP

Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 28 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer (American Bar Association); Physician Leadership Journal (American Association for Physician Leadership); The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner (NACVA); and QuickRead (NACVA). She has previously presented before the American Bar Association (ABA), the American Health Law Association (AHLA), the National Association of Certified Valuators & Analysts (NACVA), the National Society of Certified Healthcare Business Consultants (NSCHBC), and the American College of Surgeons (ACS).

Janvi R. Shah, MBA, MSF, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

For more information please visit: www.healthcapital.com