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Health Law Alert

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Court Rules That Noncompliance with Medicare Conditions of Participation Does Not Render Claims "False" Under the False Claims Act

A federal district court judge in Houston, Texas recently issued a decision that should offer hope to health care providers who are subject to lawsuits under the federal False Claims Act ("FCA") based on their participation in the Medicare or Medicaid programs. *See United States ex rel. Rocha v. American Transitional Hosps., Inc.*, No. H-97-2699 (S.D. Tex. Dec. 14, 2005). In dismissing an FCA suit brought against a long-term acute care hospital, the district court in *Rocha* recognized that the hospital's imperfect regulatory compliance did not make its claims for Medicare reimbursement "false" when the underlying regulatory system specifically allowed for the continuation of Medicare payments during periods of noncompliance. The decision's reasoning applies to other types of health care providers whose right to Medicare or Medicaid reimbursement is not conditioned on perfect regulatory compliance. The *Rocha* decision also illustrates that health care providers may use the reimbursement and administrative enforcement provisions of the Medicare and Medicaid programs to stop regulatory noncompliance from turning into a violation of the FCA.

Alleged Misconduct

The *Rocha* case was initiated by two nurses under the qui tam provisions of the FCA that allow private persons, known as "relators," to bring an action on behalf of the federal government. The relators in *Rocha* ("Relators") were former employees of American Transitional Hospitals ("ATH"). The Relators alleged that one of ATH's hospitals fraudulently maintained its certification as a Medicare provider by falsely representing that it complied with Texas regulations regarding emergency rooms. Allegedly, the hospital's "emergency room" was never staffed or used by patients, but instead was used for storage. The Relators asserted that the hospital's failure to comply with state emergency room regulations rendered all of its Medicare claims "false."

The Court's Decision

ATH filed a motion to dismiss Relators' complaint and the court agreed to dismiss the case. In its decision, the court acknowledged the unique nature and purpose of Medicare program requirements, stating:

> Relators direct the Court to no authority suggesting that if a hospital fails to meet a condition of participation in Medicare, the automatic result is that (1) the hospital is ineligible to receive Medicare payments, and (2) all claims thereby submitted by the hospital for Medicare payments are "false" under the FCA. Instead, under 42 C.F.R. § 488.28(c)(1), "[i]f it is determined . . . that a provider is not in compliance with one or more of the standards, it is granted a reasonable time to achieve compliance." In other words, federal regulations contemplate that if a Medicare provider is not in complete compliance with applicable rules and regulations, the provider may continue participation in Medicare – and presumably submit claims for Medicare payment – while the cited deficiency is corrected.

The court noted that certification of regulatory compliance may constitute a violation of the FCA only when the right to payment is conditioned upon regulatory compliance. In the *Rocha* case, however, payment was not conditioned on regulatory compliance.

Implications of the *Rocha* Decision

The U.S. Department of Justice ("DOJ") has increasingly sought to apply the FCA to health care providers' regulatory violations. Despite the questionable merits of this effort, it has undergone very little judicial scrutiny because FCA suits are often settled out of court before the theory is tested.

Providers such as hospitals and nursing homes operate in a regulatory environment in which Medicare payments are typically continued during periods of regulatory noncompliance. Other administrative enforcement mechanisms are used to induce the provider to correct whatever problems have been identified by the government. For example, when a nursing home is found to be out of compliance with Medicare program requirements, the Centers for Medicare & Medicaid Services has the discretion to continue making Medicare payments if the nursing home submits an acceptable plan of correction and returns to substantial compliance with Medicare program requirements in a timely manner.

Nonetheless, providers should note that in some states, including New York, state law conditions the receipt of Medicaid payments on compliance with all statutes and regulations applicable to participants in the Medicaid program. Thus, notwithstanding the ruling in *Rocha*, providers in such states may be liable under the FCA for knowingly submitting false Medicaid claims during a period of non-compliance with an applicable statute or regulation.

Conclusion

The availability of remedies other than non-payment, and the use of such remedies to motivate providers to take corrective action, demonstrates that Medicare and Medicaid payment is not necessarily tied to a provider's "perfect" compliance with program requirements – absent any state law to the contrary. Instead, this regulatory framework demonstrates that periodic noncompliance by providers is anticipated and built into the administration of the Medicare and Medicaid programs. Severing the link between regulatory violations and Medicare/Medicaid payment is an important strategy for health care providers defending themselves against FCA lawsuits. In order to utilize such a defense, however, it is essential that providers utilize counsel who understand the Medicare and Medicaid reimbursement rules applicable to a particular transaction, as well as the administrative remedies available to address noncompliance with Medicare/Medicaid program requirements.

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