

Puerto Rico False Claims Act: Perspectives and Implications to your Compliance Program

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May 16, 2019
 A Presentation for the HCCA San Juan Regional Compliance Conference
 San Juan Marriott Resort & Stellaris Casino

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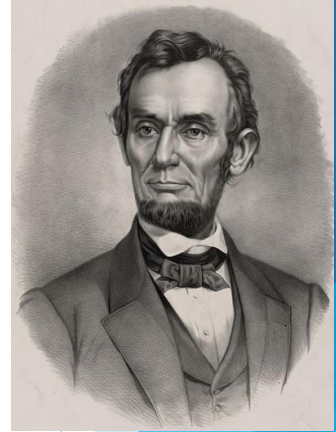
Overview

- A. **Federal** False Claims Act
- B. Puerto Rico False Claims Act
- How does the Enactment of the Commonwealth False Claims Act **benefits** Puerto Rico and what are we **missing**?
- C. **Comparison**: Federal FCA vs. Puerto Rico FCA
- D. Establishment of the **Medicaid Healthcare Fraud Unit** at a Glance
- E. What **type of cases** are prong to State False Claims Act Investigation / Litigation?
 1. Hospital
 2. Managed Care
 3. Pharmacy
 4. Nursing Facilities
 5. Other
- F. **Implications** for your Compliance Program

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▶ A. FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

- President Lincoln signed the False Claims Act (FCA) in response to scoundrels who sold the Union Army “gunpowder” kegs full of sawdust, uniforms sewn with used rags that disintegrated when wet, and boots made of cardboard that fell apart when worn.
- The FCA allows persons and entities with evidence of fraud against federal programs or contracts to sue the wrongdoer on behalf of the United States Government.
- *Qui tam* is short for *qui tam pro domino rege quam pro si ipso in hac parte sequitur* – that is, that “who sues on behalf of the king as well as for himself.”
- It provides for treble damages, with a percentage of those damages payable exclusively to the relator: 15-25% if the government joined in prosecuting the case and up to 25-30% if the relator handled the case without government support.



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▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

A violation of the FCA occurs when there has been:

- (1) a false statement or fraudulent course of conduct;
- (2) made or carried out with **knowledge** of the falsity;
- (3) that was **material**; and
- (4) that involved a **claim** (i.e., a request or demand for money or property from the United States).

See United States v. Bollinger Shipyards, Inc., 775 F.3d 255, 259 (5th Cir. 2014).

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▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

What Actions Are Considered Violations under the False Claims Act?

- ❑ Knowingly **presenting** (or causing to be presented) to the federal government a false or fraudulent claim for payment;
- ❑ Knowingly **using** (or causing to be used) a false record or statement to get a claim paid by the federal government (includes Implied Certification Theories);
- ❑ **Conspiring** with others to get a false or fraudulent claim paid by the federal government;
- ❑ Knowingly using (or causing to be used) a false record or statement to **conceal, avoid, or decrease** an obligation to pay money or transmit property to the federal government.
- ❑ **Reverse False Claim: Retaining** an “overpayment” from a government program.

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▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

FY	Settlements and Judgements			
	Non-Qui Tam	Qui Tam		
	Total	Where U.S. Intervened or Pursued	Where U.S. Declined	Total
2013	188,376,772	2,796,819,362	200,298,056	2,997,117,418
2014	1,676,608,226	4,386,812,989	81,378,451	4,468,191,440
2015	738,442,487	1,897,040,808	514,160,695	2,411,201,503
2016	1,896,930,624	2,925,411,797	108,298,069	3,033,709,866
2017	280,997,308	2,585,063,111	599,038,273	3,184,101,384
2018	767,115,453	1,994,733,622	118,671,636	2,113,405,258

As in all previous years since DOJ first published its fraud statistics, *qui tam* actions in FY 2018 constituted the large majority—84 percent—of the new matters. Non *qui tam* actions, and those qui tam matters where the Government intervened, yielded the overwhelming majority of the funds recovered by the Government.

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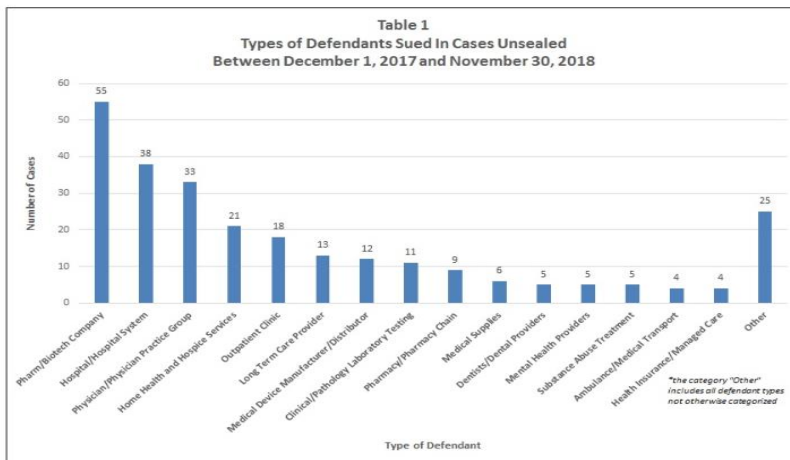
▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

Four Year Trends in Source of Annual Fraud Recovery Amounts

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Percentage of Total Annual Fraud Recovery Attributable to HHS	39.59%	67.5%	55.3%	63.0%	87.3%
Percentage of Total Annual Fraud Recovery Attributable to DoD	1.22%	9.0%	2.4%	6.4%	3.7%
Percentage of Total Annual Fraud Recovery Attributable to Other Agencies	59.19%	23.5%	42.3%	30.6%	9.0%

The bulk of fraud recovery since FY 2015 continues to be realized in connection with the healthcare industry. In FY 2018 Health and Human Services (“HHS”)–related fraud constituted a larger portion of the total amount of annual fraud recovery (87.25%) than HHS-related fraud represented in the two preceding years (63% and 55.25%).

▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)



Source: Mintz Qui Tam Database

▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

2018: Largest Settlements - DEVICE MANUFACTURER

On October 1, 2018, a wholesale drug manufacturer and its subsidiaries agreed to pay **\$625 million** to resolve allegations that they improperly repackaged and distributed overfill oncology drugs. Last year, one of the subsidiaries pled guilty to illegally distributing misbranded drugs that were not registered with the FDA, and agreed to pay \$260 million to resolve criminal charges. This year's settlement resolves the parent's civil liability **for submitting purportedly false claims for the allegedly illegally repackaged drugs and allegedly providing kickbacks to induce physicians to purchase the repackaged drugs**. The whistleblower will receive approximately \$93 million of the civil settlement.

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▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

2018: Largest Settlements - MANAGED CARE PLAN

On October 1, 2018, a Medicare Advantage provider agreed to pay **\$270 million** to resolve allegations that it provided inaccurate information that resulted in Medicare Advantage Plans receiving inflated Medicare payments.

The settlement also resolves allegations made by a whistleblower that HealthCare Partners engaged in **"one-way" chart reviews** in which it scoured its patients' medical records for diagnoses its providers may have failed to record. It then submitted these "missed" diagnoses to MAOs to be used by them in obtaining increased Medicare payments. At the same time, **it ignored inaccurate diagnosis codes that should have been deleted and that would have decreased Medicare reimbursement** or required the MAOs to repay money to Medicare.

The whistleblower will receive approximately \$10.1 million of the settlement.

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▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

2018: Largest Settlements - HOSPITAL

On September 25, 2018, a Florida-based hospital chain, and a Pennsylvania-based subsidiary, agreed to pay over **\$260 million** to resolve criminal and civil charges for allegedly **billing for inpatient services that should have been billed as outpatient services, remunerating physicians for referrals, and inflating claims for emergency department fees**, as well as allegations **Hospital administrators and executives** set mandatory admission-rate benchmarks and pressured physicians to meet them by admitting patients in non-medically necessary cases. **A portion of the recovery will go to participating state programs.** The allegations resolved by the settlement were originally brought in eight whistleblower law suits. Two whistleblowers will receive \$15 million and \$12.4 million of the recovery; the other whistleblowers' shares have not yet been determined.

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▶ FALSE CLAIMS ACT AT A GLANCE (31 U.S.C. Sections 3729 through 3733)

2018: Largest Settlements - "HONORABLE" MENTION

On December 6, 2018, a California-based pharmaceutical company agreed to pay \$360 million to settle claims that **it used a non-profit foundation** as an illegal conduit to pay copays of Medicare patients taking its drug, in violation of the AKS, based on allegations that, ***rather than allowing financially needy Medicare patients to participate in the company's free drug program***, it referred them to the foundation, which paid their copays, resulting in claims to Medicare ***for the remaining cost.***

See also: April 4, 2019; U.S. Department of Justice
Three Pharmaceutical Companies Agree to Pay a Total of Over \$122 Million to Resolve Allegations That They Paid Kickbacks Through Co-Pay Assistance Foundations.

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B. PUERTO RICO FALSE CLAIMS ACT, Act. No. 154-2018

➤ Proper Name:

False Claims to Government of Puerto Rico Programs, Contracts, and Services Act

➤ Basic Premises:

- It is not limited to Medicaid fraud; it also applies to other types of claims made to and contracts entered into by the Puerto Rican government;
- Creates the Puerto Rico Medicaid Fraud Control Unit;
- Provides forum for Commonwealth FCA Litigation;
- Establishes qui tam provisions and whistleblower rights;
- For purposes of whistleblower anti-discrimination, it is tied to Title IV of Act No. 2-2018, known as the “Anti-Corruption Code for a New Puerto Rico,” **and the applicable Federal Laws.**

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B. PUERTO RICO FALSE CLAIMS ACT, Act. No. 154-2018

INTERACTION BETWEEN ANTI-CORRUPTION CODE AND PUERTO RICO FCA?

➤ **Anti-Corruption Code for a New Puerto Rico Act:**

“The most common type of corruption is abuse of a public authority to obtain undue advantage, generally secretly and privately. Other forms of corruption are the improper use of privileged information, patronage, bribery, influence peddling, extortion, fraud, embezzlement, malfeasance in office, quid pro quo, cronyism, co-optation, nepotism, impunity, and despotism.”

➤ **False Claims to Government of Puerto Rico Programs, Contracts, and Services Act:**

“In Puerto Rico, there are state programs that benefit thousands of Puerto Ricans on a daily basis. Unfortunately, there are individuals and/or program participants who submit false information in order to receive such benefits, whether as a service provider or a beneficiary of the program”.

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How does the Enactment of the Commonwealth False Claims Act benefits Puerto Rico?

- Additional **state tool**, backed by the federal government to fight Fraud, Waste and Abuse in State/Commonwealth Programs.
- HR 1832, known as the Bipartisan Budget Act of 2018, will provide an additional \$1.2 Billion in Medicaid Assignment upon establishment of the Medicaid Fraud Control Unit (**MCFU**) in Puerto Rico.
- Yearly additional funding for the MFCU from the Federal Government (75% matching the remaining 25% from PR).

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What are we missing?

➤ INCREASE IN MATCHING FUNDS RECOUPMENT

- ❑ States who can demonstrate to the Federal Government that their State FCA complies with certain requisites will receive an additional 10% of the amounts recovered based on their matching funds formulas.
- ❑ For example, if a litigation ensues where Medicaid funds are recovered, in a state with a matching Medicaid funds formula of 60% State v. 40% Federal, the State will receive 70% of the recovered amount, whereas the Federal Government's take will be decrease to 30% .
- ❑ **Puerto Rico's Medicaid funds are not based upon a matching formula: it is a pre-determined block. Where do we stand?**
 - ❑ For a good explanation and analysis of Puerto Rico Medicaid Federal Funding, see "[Puerto Rico's Medicaid Program Needs an Ongoing Commitment of Federal Funds](#)", by Judith Solomon published on April 22, 2019.

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C. Comparison: Federal FCA vs. Puerto Rico FCA

	Civil FCA	Criminal FCA	Puerto Rico FCA
Cause of Action: Element	Presents or causes to be presented a false or fraudulent claim for payment or approval	Same	Presents or causes to be presented a false or fraudulent claim for payment or approval
Element	Makes or uses a false or fraudulent record or statement	Same	Makes or uses a false or fraudulent record or statement
Element	By the federal government or its agent	Same	Conspire to present false claim or use a false statement
Element	Has possession, custody, or control of property or money used, or to be used by government and delivers or causes to be delivered less than all of the payment		Make, use, or cause to be used a false statement or record that is essential to an obligation to pay the government
Element			Tied to payment from the government or its agent

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C. Comparison: Federal FCA vs. Puerto Rico FCA

	Civil FCA	Criminal FCA	Puerto Rico FCA
Definitions: Knowingly	Person has actual knowledge, acts in deliberate ignorance, or acts with reckless disregard of truth or falsity of information - intent to defraud is not necessary	Same	Person has actual knowledge or acts in deliberate ignorance of truth or falsity of information
Material	A natural tendency to influence, or be capable of influencing, the payment or receipt of money or property	Same	Same
Claim	Any request or demand for money or property that is presented to the United States or its agent	Same	any communication for money or property, if the money or property is to be spent or used on the Government's behalf
Obligation	An established duty arising from any relationship, or from the retention of an overpayment	Same	An established duty, arising from a contractual relationship between the government and another entity/person or retention of an overpayment

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C. Comparison: Federal FCA vs. Puerto Rico FCA

	Civil FCA	Criminal FCA	Puerto Rico FCA
Citation	31 U.S.C. § 3729-33	18 U.S.C. § 287	32 PR. Laws Ann. Tit. 32 § 2931
Limitations	6 years or 9 years if material facts should have been known by government	N/A	6 years or 9 years if material facts should have been known by government; if conspiracy, time lapses beginning on the last fraudulent act
Maximum Penalties	Treble damages, attorney fees, and Civil Monetary Penalty between \$11,463 and \$22,927 PER CLAIM, plus 3 times the amount of total damages to the government,	5 years prison, \$250,000 for individual and \$500,000 for corp. if felony - \$100,000 to \$200,000 if misdemeanor	Treble damages, attorney fees, and Civil Monetary Penalty between \$11,463 and \$22,927 PER CLAIM, plus 3 times the amount of total damages to the government, Up to 5 years in prison and fine of treble damages OR \$1000, whichever is greater
Exclusion from Medicare/Medicaid	Yes	Yes	Yes
Intent	Knowingly	Same	Knowingly

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C. Other Important Provisions of the Puerto Rico FCA

§ 2934a. Civil action: Who can present it?

- Any person may bring a civil action and file a complaint in his capacity as Relator for a violation of the PR FCA in the name of the Government (except personnel of the MFCU, ASES and other government contractor acting as investigators).
- Dismissal Without Prejudice can only occur with the consent of the Secretary.
- The Secretary must be served with a copy of the Complaint and has 60 days to determine if intervention will proceed (may be extended with good cause).
- **FIRST COMES FIRST GETS:** Except for the Government, no one else can intervene or file a similar case because of the same facts;
- If the Government intervenes: 1) it takes control of the litigation; it may request the dismissal of the case; 3) it may settle the case (all notwithstanding original relator's position).
- If the Government does not intervene, Relator may continue the action, but any settlement or pay-out must be approved by the Secretary.

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C. Other Important Provisions of the Puerto Rico FCA

§ 2934b. Compensation

- ❑ **IF GOVERNMENT INTERVENES**: Relator gets between 15% and 25% - Court decides what the percentage is, lacking an agreement between Relator and Government.
- ❑ **IF GOVERNMENT DOES NOT INTERVENE**: Relator gets between 25% and 30% - Court decides what the percentage is.
- ❑ **IF RELATOR IS FOUND TO HAVE BEEN A CO-CONSPIRATOR AT ANY MOMENT**: Reduction of 5% under any scenario above;
- ❑ **IF CRIMINAL CHARGES ARE PRESSED AGAINST THE RELATOR**: Dismissal from the action and no remuneration.

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C. Other Important Provisions of the Puerto Rico FCA

§ 2934c. Collateral impediment

- ❑ In no event may a person bring an action which is based upon allegations or transactions which are or were the subject of a civil suit or an administrative civil money penalty proceeding **in which the Government was already a party.**
- ❑ The court shall dismiss an action if the allegations or transactions as alleged in the action or claim, series of events, or actors are substantially the same. In these cases, the Government may bring the action at its discretion.

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C. Other Important Provisions of the Puerto Rico FCA

§ 2934d. Rights of the Relator (Whistleblower Protection)

- ❑ Any person, employee, contractor, or agent shall be entitled to bring a complaint as Relator if he knows of the existence of a violation (except personnel of the MFCU, ASES and other government contractor acting as investigators).
- ❑ If such employee, contractor, or agent is discharged, demoted, suspended, threatened, or otherwise discriminated against in the terms and conditions of employment for bringing an action, such employee shall be entitled to the protections of Title IV of Act No. 2-2018, known as the “Anti-Corruption Code for a New Puerto Rico,” and the applicable Federal Laws.

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C. Other Important Provisions of the Puerto Rico FCA

Section 4.5 of the Anti-Corruption Code.- Civil Actions, states:

- ❑ Any person alleging a violation of the provision of Section 4.2 of this Act may bring a civil action against the person acting contrary thereto and seek compensation for damages, mental anguish, **triple back pay (different from Federal FCA which is double)** , as well as any other benefit that such person would have earned and attorneys’ fees.
- ❑ The action shall be initiated within three (3) years after the occurrence of said violation or after the person became aware of such fact (same as Federal FCA).
- ❑ Burden of Proof: Similar to Puerto Rico Employment Discrimination Cases-
 - **Prima Facie**: proof that he is cooperating or has cooperated with any investigation of government corruption that affects or affected any person with whom the plaintiff had any tie or relationship

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D. Establishment of the Medicaid Healthcare Fraud Control Unit at a Glance

- MFCUs investigate and prosecute Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities.
- MFCUs operate in 49 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.
- MFCUs is usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors;
- Must be separate and distinct from the State Medicaid agency.
- Federal regulations prohibit the Units from pursuing recipient fraud, unless there is a conspiracy with a provider.

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D. Establishment of the Medicaid Healthcare Fraud Control Unit at a Glance

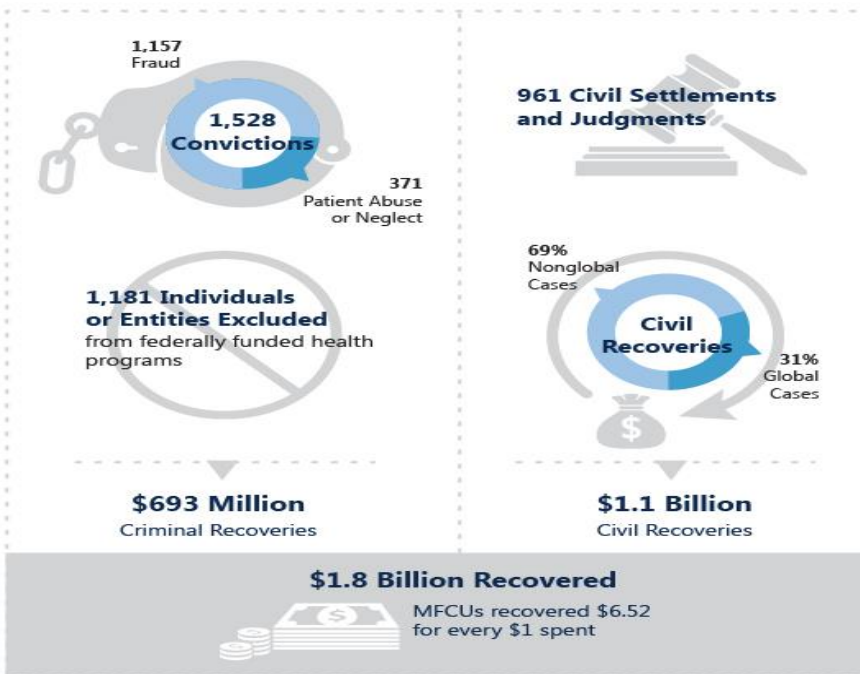
- Section 1128(b)(5) of the Social Security Act specifies that providers who are suspended or excluded from participation or otherwise sanctioned for reasons bearing on professional competence, professional performance, or financial integrity by state Medicaid agencies are subject to a permissive exclusion by the OIG.
- The MFCU has jurisdiction to investigate Medicare fraud only with the consent of the OIG and only if the case as a whole is primarily related to Medicaid.

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Medicaid Fraud Control Units Statistical Data for Fiscal Year 2018



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E. What type of cases are prong to State FCA Investigation and/or Litigation? - **HOSPITAL**

Aurora Health Care, Inc. Agrees to Pay \$12 Million to Settle Allegations Under the False Claims Act and the Stark Law

December, 2018.

- The US and Wisconsin allege that, during a 2 year period, Aurora entered into compensation arrangements with two physicians that did not comply with the Stark Law. The United States and the State of Wisconsin allege that Aurora nonetheless submitted claims for services ordered by those physicians to Medicare and Medicaid, in violation of the False Claims Act.
- The investigation that discovered the allegedly improper compensation arrangements resulted from a whistleblower lawsuit filed under the *qui tam* provisions of the Federal False Claims Act **and the State of Wisconsin False Claims Act**. Consequently, the whistleblowers will recover a share of the settlement amount.
- As part of the settlement, the United States, the State of Wisconsin, and the whistleblowers will ask the district court to dismiss the *qui tam* complaint.

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E. What type of cases are prong to State FCA Investigation and/or Litigation? - **MANAGED CARE**

Managed Care Fraud: Against the Plan / By the Plan

Managed Care Plans are at the unique intersection of Healthcare Fraud and Abuse in two broad categories:

FRAUD AGAINST THE PLAN

- * Up-coding
- * Double Billing
- * Overutilization/Overtreatment
- * Retention of overpayments by providers (with Potential applicability of 60-Day Rule)

FRAUD BY THE PLAN

- * Manipulation of risk adjustment data
- * Retention of overpayments
- * Inducement of Beneficiaries
- * Enrollment of ineligible/non-existing beneficiaries
- * Cherry-picking beneficiaries

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E. What type of cases are prong to State FCA Investigation and/or Litigation? - PHARMACY

Walgreen Co. to Pay \$60 Million to Settle Medicaid False Claims Act Allegations

January 22, 2019.

- 46 states and D.C. have joined with the federal government to reach an agreement in principle with Walgreen Co. (Walgreens) to settle allegations that Walgreens violated the False Claims Act by billing Medicaid at rates higher than its usual and customary (U&C) rates. As a result, Walgreens will pay the states \$60 million dollars, all of which is attributable to the States' Medicaid programs.
- The investigation revealed that Walgreens submitted claims to the States' Medicaid programs in which it identified U&C prices for certain prescription drugs sold through the PSC program that were higher than what Walgreens actually charged for those drugs. In doing so, Walgreens' obtained more money in reimbursements from the States' Medicaid program for sales of such drugs than it was entitled to receive.

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E. What type of cases are prong to State FCA Investigation and/or Litigation? - NURSING FACILITIES

South Florida Health Care Facility Owner was convicted for Role in Largest Health Care Fraud Scheme Ever Charged by The Department of Justice, Involving \$1.3 Billion in Fraudulent Claims.

- **April, 2019.** A federal jury found a South Florida health care facility owner guilty for his role in the largest health care fraud scheme ever charged by the Justice Department, involving over \$1.3 billion in fraudulent claims to Medicare and Medicaid for services that were not provided, were not medically necessary or were procured through the payment of kickbacks.
- From approximately January 1998 through July 2016, convicted Esformes led an extensive health care fraud conspiracy involving a network of assisted living facilities and skilled nursing facilities that he owned. Esformes bribed physicians to admit patients into his facilities, and then cycled the patients through his facilities, where they often failed to receive appropriate medical services, or received medically unnecessary services, which were then billed to Medicare and Medicaid.

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E. What type of cases are prong to State FCA Investigation and/or Litigation? -SERVICE PROVIDER

March 2019: Guilty plea in a health care fraud matter.

- The investigation revealed that PURNELL was the owner, operator, manager and/or CEO of Extended Reach Day Treatment for Children and Adolescents ("Extended Reach"), a Medicaid provider of behavioral health services, including "day treatment" services. From on or about October 1, 2013, through October 26, 2016, PURNELL engaged in a scheme to defraud Medicaid by "adding" units of Day Treatment services not actually provided to Medicaid recipients in Extended Reach's billed claim submissions.
- The defendant engaged in an extensive and systematic scheme to fraudulently bill "added" unit claims for "day treatment" services provided to Medicaid recipients.

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E. What type of cases are prong to State FCA Investigation and/or Litigation? - MANUFACTURER

ABBOTT TO PAY \$25 MILLION TO RESOLVE OFF-LABEL MARKETING AND KICKBACK ALLEGATIONS RELATED TO TRICOR

October 26, 2018.

- 49 states and D.C. have joined with the federal government to reach an agreement with Abbott Laboratories to settle allegations that the company paid kickbacks and engaged in off-label marketing tactics to improperly promote its drug, TriCor. Abbott, an Illinois based manufacturer and supplier of prescription drugs, will pay the states and the federal government \$25 million dollars, **of which \$4,024,609.00 will go to the Medicaid programs**, to resolve civil allegations that Abbott's unlawful promotion of TriCor caused false claims to be submitted to the government health care programs.

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F. Implications for your Compliance Program

Perspective on Compliance Programs

From the “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans”

“CMS strongly believes that in order to contract with a state, the MCO or PHP should have administrative and management arrangements and procedures that **include a mandatory compliance plan** that is designed to guard against fraud and abuse. The Medicaid Alliance for Program Safeguards realizes that organizations vary in size and structure which affect the make-up of the organization’s compliance program. However, there are some common elements that should be present regardless of the type or the size of a compliance program”.

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F. Implications for your Compliance Program

- Policies and Procedures
 - Update to include the new local requirements
- Training
 - Provide training to all your employees and subcontractors
- Effective Lines of Communications
 - Ensure you provide different ways in which an employee can refer concerns
 - Encourage employees to report potential problems
- Enforcement
 - Investigate all concerns received
 - The more that you enforce your own internal procedures, the less likely you will appear on an MFCU’s radar for Medicaid fraud.

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QUESTIONS?

