6,000 Whistleblowers and Still Counting

DOJ Reports $3.8 Billion in Settlements and Recoveries in 2013

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In 2013, the U.S. Department of Justice (DOJ) reported having secured $3.8 billion in settlements and judgments from civil cases involving fraud against the government.[1] This was the second largest annual recovery and fourth year in a row that the DOJ has recovered more than $3 billion. In fact, 2013 was only surpassed by last year's nearly $5 billion figure.

Since January 2009, over $17 billion has been recovered through this process and is nearly half the total recoveries since the Act was amended 27 years ago in 1986. Most of these cases were brought under the "whistleblower" or *qui tam* provisions that allow individuals to file lawsuits alleging false claims on behalf of the government. If the government prevails in the action, the whistleblower, known as a relator, receives up to 30 percent of the recovery.

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The Evolving False Claims Act (FCA) and Whistleblowers

The FCA was passed during the Civil War to combat the fraud perpetrated by companies that sold supplies to the Union Army. It contained *qui tam* provisions that allowed private citizens to bring action on the government's behalf against those defrauding the government; however, in 1943, Congress reduced the whistleblower reward to the point that it fell into virtual disuse. In the mid-1980s, frustrated with the DOJ's inability to respond effectively to outrageous charges and other improper billing behavior by government defense contractors, Congress moved to revise the FCA to bring back a more robust *qui tam* incentive to encourage more whistleblowers.[2]

Amendments were sponsored by Senator Charles Grassley and Representative Howard Berman that re-established significant whistleblower rewards up to 15 to 30 percent of the amount recovered by the

government in cases brought by them. This unleashed a new generation of whistleblowers. It is worth noting that the FCA continues to be modified, as it was in the Fraud Enforcement and Recovery Act of 2009 to expand the reach of the law and by the 2010 Patient Protection and Affordable Care Act.[3]

The 1986 whistleblower amendments have led to more investigations and greater recoveries. At a Congressional Hearing, Congressman Berman, a classmate of mine from UCLA, called for two government witnesses, a representative of the DOJ and me, as Inspector General of the U.S. Department of Health and Human Services (HHS). The DOJ was defensive of its prerogatives in determining what cases warranted investigation and took a position against the amendments. The fact that whistleblowers could proceed without the DOJ took its monopoly in decision-making away. The DOJ considered the amendments a rebuke of its performance in managing contractor fraud. I was the other witness, as HHS Inspector General, and endorsed the proposals with qualifications that some of the provisions that permitted whistleblowers to benefit from reporting be eliminated.

Health Care Fraud

The driving force for the 1986 FCA amendments was to address Department of Defense procurement fraud; however, it had application to many government programs, including veterans benefits, federally insured loans and mortgages, transportation and research grants, agricultural supports, school lunches, and disaster assistance, among others. The interesting result is that the reality is that while passing legislation focusing on defense procurement fraud, the legislation created a huge shift toward health care providers. No one anticipated that the largest recoveries would come from health care fraud to the Medicare and Medicaid programs, but that is what happened.

Of the $3.8 billion reported by DOJ last year, there was $2.6 billion in health care fraud recoveries — or more than two thirds of the total. Procurement fraud, primarily in defense contracts, the original primary target by Congress, accounted for $890 million, or roughly 28 percent. The predominance of health care FCA cases is not new; for the past four years, more than $2 billion in recoveries came from cases involving health care fraud.

The Rise of Whistleblowers

Since passage of the 1986 amendments, there has been a growing awareness of the FCA. The number of whistleblower lawsuits has grown steadily to a level of more than 6,000 *qui tam* cases to date. Whistleblower lawsuits have been in the range of three to four hundred per year from 2000 to 2009, when they began their climb from 433 lawsuits in fiscal year 2009 to 752 lawsuits in fiscal year 2013, 100 more than the record set the previous fiscal year.

More than 70 percent of the recoveries under the FCA in 2013 were from lawsuits filed under the *qui tam* provision of the law. That translated to $2.9 billion of the $3.8 billion the department recovered in fiscal year 2013. *Qui tam* relators received as their share more than $345 million. *Qui tam* recoveries exceeded $2 billion for the first time in fiscal year 2010 and have continued to exceed that amount every year since. *Qui tam* recoveries this past fiscal year bring the department's totals since January 2009 to $13.4 billion. During the same period, the department paid out $1.98 billion in whistleblower awards.

The Drivers in *Qui Tam* Cases

There were two different areas in health care where the FCA has been applied most often: (1) pharmaceutical/medical device industries, and (2) the health care provider sector. Of the $2.6 billion in federal health care fraud recoveries, $1.8 billion were from alleged false claims for drugs and medical devices under federally insured

health programs with an additional $443 million for state Medicaid programs. Many of these settlements involved allegations that pharmaceutical manufacturers improperly promoted their drugs for uses not approved by the Food and Drug Administration (FDA) — a practice known as "off-label marketing." Examples include Abbott Laboratories Inc. that paid $1.5 billion in a settlement and Amgen Inc. that paid the government $762 million. Other cases involve corrupt arrangements with physicians to influence the sale of products that violate the anti-kickback statute.

In the health care provider sector, the number of cases was much larger, but the average size of the settlements was much smaller. The driver for the great majority of cases is not traditional false claims found through audits but as a result of corrupt arrangements with referral sources (physicians) that implicated the anti-kickback statute and/or Stark laws.[4] All claims arising from a corrupt arrangement under these laws are considered false and fraudulent. That brings them under the FCA.

The largest such case in 2013 was a $237 million judgment against Tuomey Healthcare System Inc. for violating the Stark law and the FCA in submitting claims to Medicare for patients referred to the hospital by physicians who had a prohibited financial relationship with the hospital.[5] Another example cited by the DOJ in 2013 involved Dr. Steven J. Wasserman, MD, a Florida dermatologist who paid $26.1 million in settlement in connection with an illegal kickback arrangement with Tampa Pathology Laboratory. It was one of the largest settlements in history for an individual.[6]

Avoiding Implicating the FCA

The common denominator between the two major categories of DOJ cases relates to physician arrangements. It has been for a number of years, and continues to be, the highest enforcement priority of the DOJ and the Office of Inspector General (OIG). For the provider community, the best way to avoid getting enmeshed in the FCA is to have effective ongoing monitoring and auditing of arrangements with physicians. Monitoring should be done by the program managers responsible for developing and managing physician arrangements. This includes setting up a process; establishing controls in the form of policies and procedures; and verifying that they are being followed consistently.

Ongoing auditing reviews should be conducted by parties outside the program areas. This may involve the compliance office, internal auditors, outside experts,[7] or any combination thereof. The purpose of the operational audits is to make sure that program managers are meeting their ongoing monitoring obligations and that the controls in place are effective. The OIG also urges in its compliance guidance and mandates in its corporate integrity agreements (CIAs) that hospitals and other institutional providers with physician arrangements develop a database that sets forth processes and controls to avoid violating the law.

Despite all the evidence provided herein, the strange fact remains that ongoing monitoring and auditing of arrangements is among the most neglected areas by compliance officers. Primarily, this is the case because the compliance officers have trepidation of reviewing an area that has been the province of legal counsel, internal and/or external. The feeling is that the attorney is best qualified to determine what passes muster with the law. If all this were true, there wouldn't be 6,000 whistleblowers that brought cases to the DOJ, and the billions of dollars in settlements would not have been realized each year.

Endnotes:

1. www.justice.gov/opa/pr/2013/December/13-civ-1352.html.
2. False Claims Act (FCA), 31 U.S.C. §§3729-3733, provides for civil actions by the U.S. government to recover damages and civil penalties for false claims for payment. The *qui tam* provisions [3730(b)-(h)], authorize private citizens, acting as whistleblowers and designated as relators, to initiate FCA actions to benefit the federal government and to share in any recoveries.

3. Public Law 111-148, Patient Protection and Affordable Care Act.
4. www.compliance.com.
5. Tuomey Case: AO 450 (SCD 04/20/10 Judgment in a Civil Action filed 9/30/13, entry number 881-2.
6. www.justice.gov/opa/pr/2013/December/13-civ-1352.html.
7. www.compliance.com/services/physician-arrangements-reviews.

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