Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Goodwill Home Healthcare, Inc.,
(O.I. File No. 5-09-4-1027-9),

Petitioner,

v.

The Inspector General.

Docket No. C-15-718

Decision No. CR4073

Date: July 27, 2015

DECISION

The Inspector General (IG) of the United States Department of Health and Human Services notified Goodwill Home Healthcare, Inc. (Petitioner) that it was being excluded from participation in Medicare, Medicaid, and all other federal health care programs for a minimum period of five years based on its conviction for a crime under the Anti-Kickback Statute. Petitioner requested a hearing to dispute the exclusion. For the reasons stated below, I conclude that the IG has a basis for excluding Petitioner from program participation and that the five-year exclusion is mandated by law.

I. Background

By letter dated November 28, 2014, the IG notified Petitioner that it was being excluded from participation in Medicare, Medicaid, and all federal health care programs for the minimum statutory period of five years pursuant to 42 U.S.C. § 1320a-7(a)(1) because of its conviction in the United States District Court, Northern District of Illinois, of a criminal offense related to the delivery of an item or service under Medicare or a state health care program, including the performance of management or

administrative services relating to the delivery of items or services, under any such program. IG Exhibit (Ex.) 4. On December 17, 2014, Petitioner, through counsel, filed a request for a hearing (RFH) to dispute the exclusion.

On January 21, 2015, I convened a consolidated pre-hearing telephone conference in this case and in two other cases, Marilyn Maravilla a/k/a Marylin Maravilla v. the Inspector General, C-15-717, and Junjee L. Arroyo v. the Inspector General, C-15-732. The substance of the prehearing conference is summarized in my Order and Schedule for Filing Briefs and Documentary Evidence (Order) dated January 23, 2015. *See* 42 C.F.R. § 1005.6. In compliance with the Order, the IG submitted a brief (IG Br.) together with six exhibits (IG Exs. 1-6). Petitioner submitted a response brief (P. Br.) and four exhibits marked P. Exs. A-D. Petitioner requested that its co-owner, Marylin Maravilla, and twelve other witnesses testify. P. Br. at 3-4. The IG filed a reply brief (IG Reply Br.). The IG objected to Petitioner's proffered testimony, arguing it was a collateral attack on the underlying conviction as well as being irrelevant. IG Reply Br. at 5-6.

I directed Petitioner to submit the written direct testimony of Ms. Maravilla. *See* 42 C.F.R. § 1005.16(b). As to Petitioner's other proposed witnesses, I sustained the IG's objection and did not permit their testimony because it would have been in the nature of character testimony relating to Ms. Maravilla, which is not relevant to the narrow issue I must decide in this case. *See* 42 C.F.R. § 1001.2007(a). I am required to exclude irrelevant and immaterial evidence. 42 C.F.R. § 1005.17(c). I provided the IG with the opportunity to object to Ms. Maravilla's testimony and/or request to cross-examine Ms. Maravilla. Petitioner submitted the affidavit of Ms. Maravilla (Maravilla Aff.). The IG elected not to cross-examine Ms. Maravilla and had no objection to her affidavit.

II. Decision on the Record

Neither party objected to any of the proposed exhibits. Therefore, I admit IG Exs. 1-6 and P. Exs. A-D into the record. The IG indicated that he does not think that an in-person hearing is necessary and did not have any witness testimony to offer. IG Br. at 5; IG Reply at 5. In my May 15, 2015 Order permitting Petitioner to submit written direct testimony, I stated that if the IG did not seek to cross-examine Ms. Maravilla, I would decide this case on the written record following the final submissions of the parties. Therefore, I decide this case on the written record.

III. Issue

Whether the IG has a basis for excluding Petitioner for five years from participating in Medicare, Medicaid, and all other federal health care programs under 42 U.S.C. § 1320a-7(a)(1). *See* 42 C.F.R. § 1001.2007(a)(1)-(2).

IV. Jurisdiction

I have jurisdiction to adjudicate this case. 42 U.S.C. § 1320a-7(f)(1); 42 C.F.R. §§ 1001.2007, 1005.2

V. Findings of Fact, Conclusions of Law, and Analysis[1]

The IG must exclude an individual or entity from participation in Medicare, Medicaid, and all other federally-funded health care programs if that individual or entity has been convicted of a criminal offense related to the delivery of an item or service under Medicare or a state health care program. 42 U.S.C. § 1320a-7(a)(1); 42 C.F.R. § 1001.101(a).

A. Petitioner pled guilty in the United States District Court for the Northern District of Illinois (District Court) to one count of Conspiracy to Commit Offense or to Defraud the United States, and the District Court issued a Judgment in a Criminal Case adjudicating Petitioner guilty of that crime.

Petitioner was a provider of home health care services located in Lincolnwood, Illinois. IG Ex. 1 at 2. Petitioner submitted claims to Medicare for reimbursement for those home health services. On August 9, 2012, a federal grand jury indicted Petitioner and five individuals on 29 counts, alleging violations of 18 U.S.C. § 371 and 42 U.S.C. §§ 1320a-7b(b)(1)(A) and 1320a-7b(b)(2)(A). IG Ex. 1. Petitioner was charged in 17 of the 29 counts. According to the Indictment, from on or about August 2008 through on or about July 2010, Petitioner and the other individuals conspired to offer and pay illegal kickbacks to nurses, marketers, and other home health care workers in exchange for the referral of patients to Petitioner for home health services that were billed to Medicare. IG Ex. 1 at 4, 5. The Indictment alleged that Petitioner billed Medicare for over $5,000,000 of home health care services purportedly provided to patients that Petitioner obtained as a result of paying approximately $400,000 in illegal kickbacks. IG Ex. 1 at 5-6. Count One of the Indictment alleged, in relevant part, that Petitioner and the other individuals conspired:

> to knowingly and willfully offer and pay remuneration, and cause [Petitioner] to offer and pay remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, to nurses, marketers, and others known and unknown to the Grand Jury to induce such persons to refer patients to [Petitioner] for the furnishing and arranging for the furnishing of services for which payment may be made in

[1] My findings of fact and conclusions of law are set forth in italics and bold font.

> whole and in part under Medicare, in violation of Title 42, United States Code, Section 1320a-7b(b)(2)(A); and
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> . . . to knowingly and willfully solicit and receive remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, from [Petitioner] in return for referring patients to [Petitioner] for the furnishing and arranging for the furnishing of services for which payment may be made in whole and in part under Medicare, in violation of Title 42, United States Code, Section 1320a-7b(b)(1)(A).

IG Ex. 1 at 4-5.

On November 12, 2013, Petitioner entered into a plea agreement in which it agreed to plead guilty to Count One of the Indictment and admit it violated 42 U.S.C. § 1320a-7b(b)(2)(A) and 18 U.S.C. § 371. IG Ex. 2.

On June 17, 2014, the District Court entered a Judgment in a Criminal Case in which the court acknowledged Petitioner's guilty plea to Count One of the Indictment and indicated Petitioner was "adjudicated guilty" of violating 18 U.S.C. § 371 ("Conspiracy to Commit Offense or to Defraud the U.S."). IG Ex. 3 at 1. The District Court sentenced Petitioner to four years of probation and an assessment of $400. IG Ex. 3 at 2-3; IG Ex. 5 at 118. The District Court also entered a forfeiture order of $264,447 against Petitioner. IG Ex. 3 at 4; IG Ex. 6.

B. Petitioner was convicted of a criminal offense for the purposes of 42 U.S.C. § 1320a-7(a)(1).

Under 42 U.S.C. § 1320a-7(a)(1), Petitioner must be "convicted of a criminal offense" before it can be excluded. An individual or entity is considered "convicted" when a judgment of conviction has been entered by a federal, state, or local court, or a plea of guilty or no contest has been accepted in a federal, state, or local court. 42 U.S.C. § 1320a-7(i)(1), (3). In the present matter, Petitioner entered a plea of guilty to a charge of violating 18 U.S.C. § 371, and the District Court "adjudicated [Petitioner] guilty" of that crime. IG Ex. 2; IG Ex. 3 at 1. I conclude, based on these facts and Petitioner's admission that it was convicted of a criminal offense (P. Br. at 1), that Petitioner was convicted of a criminal offense.

C. Petitioner's conviction of conspiracy to defraud the United States through payment of kickbacks for the referral of Medicare beneficiaries is a criminal offense related to the delivery of an item or service under Medicare.

An individual or entity must be excluded from participation in any federal health care program if the individual or entity was convicted of a criminal offense related to the delivery of an item or service under Medicare. 42 U.S.C. § 1320a-7(a)(1); 42 C.F.R § 1001.101(a). The requirement that the conviction be "related to" the delivery of health care items or services simply means that there must be a nexus or common sense connection. *See Quayum v. U.S. Dep't of Health & Human Servs.*, 34 F. Supp. 2d 141, 143 (E.D.N.Y. 1998); *see also Friedman v. Sebelius*, 686 F.3d 813, 820 (D.C. Cir. 2012) (describing the phrase "related to" in another part of section 1320a-7 as "deliberately expansive words," "the ordinary meaning of [which] is a broad one," and one that is not subject to "crabbed and formalistic interpretation" (internal quotes omitted)).

Although Petitioner admits that it violated the Anti-Kickback Statute, it disputes that its conviction was related to the delivery of an item or service under Medicare or a state health care program. Petitioner argues that its criminal acts involved no loss to the Medicare or Medicaid programs; its patients did not suffer any harm or receive unnecessary services; and there was no fraudulent billing. RFH at 2-3; P. Br. at 2-3.

Petitioner's arguments are without merit. As discussed below, I conclude that an obvious nexus exists between Petitioner's conviction and the delivery of an item or service under Medicare. Petitioner was convicted of conspiring to offer and pay kickbacks, in violation of 18 U.S.C. § 371. Petitioner was involved in a conspiracy to induce the referrals of Medicare beneficiaries to its business through illegal kickbacks, and then billed Medicare for services provided to those Medicare beneficiaries. It is instructive to examine the specific provision of the Anti-Kickback Statute referred to in Count One to which Petitioner pled guilty of conspiring to violate, which states:

> Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program . . . shall be guilty of a felony . . . .

42 U.S.C. § 1320a-7b(b)(2)(A). Therefore, based on the statutory language, it is clear that Petitioner's criminal conspiracy has a nexus to the delivery of an item or service under a federal health care program. Moreover, Petitioner admitted the following factual basis in its plea agreement:

> Beginning in or about August 2008, and continuing through in or about July 2010, at Lincolnwood, in the Northern District of Illinois, Eastern Division, and elsewhere,

> [Petitioner] conspired with co-defendants . . . and [other individuals] to knowingly and willfully offer and pay kickbacks, directly and indirectly, overtly and covertly, to outside marketers, to induce such persons to refer patients to [Petitioner] for the furnishing and arranging for the furnishing of services for which payment may be made in whole and in part under Medicare, in violation of [42 U.S.C. § 1320-7b(b)(2)(A)].
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> As [Petitioner] knew, Medicare provided free and below-cost health care benefits, including medically necessary in-home health care services for persons who were deemed homebound due to illness or injury that restricted their ability to leave their place of residence. In addition, [Petitioner] . . . was a licensed provider of home health care services that submitted reimbursement claims to Medicare for services provided to its clients.
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> . . .
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> [Petitioner], through [co-defendants and others], provided home health care services to patients. [Petitioner] also contracted with [other individuals and a separate entity] to act as marketers. It was part of the conspiracy that, beginning in or about August 2008 and continuing through in or about July 2010, [Petitioner] agreed with [co-defendants] and others to make payments to outside marketers . . . in exchange for the referral of patients to [Petitioner] for home health services for which [Petitioner] sought reimbursement from Medicare, knowing that it was illegal to make these payments.
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> . . .
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> In furtherance of the conspiracy, . . . [Petitioner], through [a co-defendant], knowingly and willfully offered and paid approximately $2,000 to [a co-defendant], in exchange for [the co-defendant's] referral of four patients to [Petitioner] for home health services for which [Petitioner] sought reimbursement from Medicare.

IG Ex. 2 at 2-5.

Petitioner admitted further that "between approximately September 2006 and July 2010, [Petitioner] paid a total of $109,685 to [other individuals and an entity] in exchange for referral of patients to [Petitioner] for home health services for which [Petitioner] sought reimbursement from Medicare, knowing that it was illegal to make those payments." Petitioner also admitted that during the same time frame, it paid $298,163 to other individuals that were based on patient starts of care or recertification of patients for which it sought reimbursement from Medicare. Petitioner admitted that it "billed Medicare for services provided to all of these patients and that Medicare paid [Petitioner] approximately $2,291,000 for these services." IG Ex. 2 at 6.

The admissions Petitioner made as part of its plea agreement thus conclusively demonstrate the required nexus between Petitioner's criminal conduct and the delivery of items or services under Medicare. I note, moreover, that decisions of the Departmental Appeals Board have held that a conviction for violating the Anti-Kickback Statute is a program-related conviction. *Dinesh Patel, M.D.*, DAB No. 2551 at 6 (2013) (citing *Boris Lipovsky*, M.D., DAB No. 1363 (1992) and *Niranjana B. Parikh, M.D.*, DAB No. 1334 (1992)).

In its defense, Petitioner makes several arguments, with the primary argument being that the IG has not properly applied the exclusion statute in this matter. In excluding Petitioner, the IG proceeded under the mandatory exclusion authorities of 42 U.S.C. § 1320a-7(a)(1) based on Petitioner's conviction; however, Petitioner asserts that its criminal conduct falls instead under the permissive exclusion provision of 42 U.S.C. § 1320a-7(b)(7), which permits exclusion when the Secretary of Health and Human Services determines that an individual violated 42 U.S.C. § 1320a-7b (the Anti-Kickback statute). RFH at 1-2; P. Br. at 5-6. Petitioner notes that under 42 U.S.C. § 1320a-7(b)(7), the IG has the discretion not to impose any exclusion at all, and thus argues that various "factors" show that no exclusion is warranted in its case. RFH at 1-2; P. Br. at 5-6.

Petitioner's argument is fundamentally flawed because the IG's exclusion under 42 U.S.C. § 1320a-7(a)(1) is derivative of Petitioner's conviction, whereas a permissive exclusion under 42 U.S.C. § 1320a-7(b)(7) is an original action in which the IG would need to prove that Petitioner violated 42 U.S.C. § 1320a-7b by a preponderance of the evidence. Because Petitioner was already convicted of conspiracy to defraud the United States through payment of kickbacks for the referral of Medicare beneficiaries, the IG no longer needed to prove such a violation in order to exclude Petitioner.

A federal court addressed this issue in detail.

> Plaintiff first contends the ALJ's imposition of a period of exclusion under the mandatory exclusion provision of 42 U.S.C. § 1320a–7(a)(1) was an erroneous application of

law, and the ALJ should have applied the permissive exclusion provisions of 42 U.S.C. § 1320a–7(b)(7).

. . .

Plaintiff was convicted of conspiracy to commit kickback violations, in violation of 18 U.S.C. § 371 and offering and paying bribes in violation of 42 U.S.C. § 1320a–7b(b), one of the statutes expressly referenced in the permissive exclusion provision of 42 U.S.C. § 1320a–7(b)(7).

. . .

Pursuant to the plain language of 42 U.S.C. § 1320a–7(a)(1), the mandatory exclusion provision applies to individuals *convicted* of *program-related crimes,* that is crimes *related to the delivery of an item or service.* On the other hand, 42 U.S.C. § 1320a–7(b)(7) provides that the permissive exclusion provision Plaintiff references applies to individuals *that the Secretary determines has committed an act* described in certain statutes, including the Anti–Kickback Statute. Obviously, if a jury has convicted an individual of committing a program-related crime, the Secretary need not make a determination that the individual has engaged in the underlying conduct; a jury has found beyond a reasonable doubt that the person has committed the conduct. Mandatory exclusion thus applies to those convicted of program-related crimes, while permissive exclusion applies to those the Secretary has determined (in an administrative proceeding) have committed certain acts described in specific statutes.

If legislative intent was not apparent from the plain language of the statute, the ALJ could have resorted to legislative history. But the legislative history does not support the interpretation urged by Plaintiff. The legislative history explains that § 1320a–7(b)(7) is a very different exclusion authority than the exclusion authority of § 1320a–7(a)(1) for program-related convictions. Exclusion authority under § 1320a–7(b)(7) rests on a determination by the Secretary that the individual has committed an act described in §§ 1320a–7a, 1320a–7b, or 1320a–8. A permissive exclusion proceeding under § 1320a–7(b)(7) is initiated by Defendant's Office of Inspector General, and the respondent has the right

> to a pre-exclusion hearing in which the Office of Inspector General must introduce evidence to establish, by a preponderance of the evidence, that a violation of any of the enumerated sections has occurred. The legislative history of section 1320a–7(b)(7) indicates it was enacted as an alternative to criminal prosecution or where a program-related conviction does *not* exist.

Anderson v. Thompson, 311 F. Supp. 2d 1121, 1124-1127 (D. Kan. 2004) (emphases in original). Based on this analysis, I reject Petitioner's argument.

Although Petitioner does not dispute that it was convicted of conspiring to defraud the United States through the payment of illegal kickbacks, it nevertheless emphasizes that its actions did not harm any patients or negatively impact Medicare or Medicaid. Moreover, Petitioner asserts that no fraud was involved. RFH at 2; P. Br. at 2. In her affidavit, Petitioner's President and co-owner, Marylin Maravilla, asserts that the District Court judge who sentenced Petitioner in the criminal case "concluded that none of [her] conduct was fraudulent, that there was no loss to Medicare or Medicaid, with any referrals for home health services being based on sound medical judgment, and that there was no harm to patients." Maravilla Aff. ¶ 27.

Ms. Maravilla's statements appear to be more an attempt to explain Petitioner's criminal conduct rather than an attack on its conviction. However, even if Ms. Maravilla was suggesting that the illegality of Petitioner's actions should be minimized, I would consider such an argument to constitute an impermissible collateral attack on its conviction. Under the regulations, Petitioner is explicitly prohibited from re-litigating its criminal offense before me. 42 C.F.R. § 1001.2007(d); *see also Travers v. Shalala*, 20 F.3d 993, 998 (9th Cir. 1994); *Anderson*, 311 F. Supp. 2d at 1128.

Moreover, the fact that Petitioner did not commit any fraud through its kickback activity is irrelevant to my analysis. There is nothing in the statutory language of 42 U.S.C. § 1320a-7(a)(1) that requires that an individual or entity be convicted of a criminal offense involving fraud. All that is required for a criminal offense to be program-related is that there is a nexus between the offense of which one is convicted and the delivery of an item or service under Medicare or a state health care program. I have concluded that a nexus exists in this case between Petitioner's criminal conduct and the Medicare program.

While the sentencing transcript reflects that the District Court judge did not consider Petitioner's crime to be of the most egregious character, the judge nevertheless recognized that Petitioner's criminal acts could potentially have had an adverse impact on the healthcare system. The judge stated, "The crimes that [Petitioner and the other defendants] have pled guilty to in this case arise from a statute which is, in essence, a

prophylactic statute. Payment for referrals on a patient-by-patient basis creates bad incentives and increases the risk of fraud." IG Ex. 5 at 98. Although the judge acknowledged that "[t]here are no fraudulent billings that are attributable to [Petitioner and the other defendants]" (IG Ex. 5 at 98), he noted that "what makes this crime more serious than a technical violation of the rules is the requirement of willfulness. The defendants have admitted that they knew that at least some of their conduct violated the Anti-Kickback law, but they did it anyway." IG Ex. 5 at 101. I note that, as part of its sentence, Petitioner was liable to the United States for a substantial forfeiture judgment – $264,447 – related to the proceeds of its illegal behavior. IG Ex. 6. Regardless of Petitioner's attempt to re-characterize its offense, Petitioner's criminal acts demonstrate that it poses a threat to federal health care programs.

D. Petitioner must be excluded for the statutory minimum of five years under 42 U.S.C. § 1320a-7(c)(3)(B).

Because I have concluded that a basis exists to exclude Petitioner pursuant to 42 U.S.C. § 1320a-7(a)(1), Petitioner must be excluded for a minimum period of five years. 42 U.S.C. § 1320a-7(c)(3)(B); 42 C.F.R. §§ 1001.102(a), 1001.2007(a)(2).

I note that Petitioner also makes what is essentially an equitable argument in claiming that its patients will be forced to seek care elsewhere if it is excluded. Petitioner submitted numerous letters from its patients and their family members, regarding the care received from Petitioner.[2] P. Ex. D. I have no authority to reverse or reduce the five-year exclusion imposed by the IG based upon such equitable considerations. *See Donna Rogers*, DAB No. 2381 at 6 (2011). I have found there is a basis for Petitioner's exclusion pursuant to 42 U.S.C. § 1320a-7(a)(1). The five-year period of exclusion is the minimum period authorized by Congress, and I have no authority to reduce the period of exclusion.

VI. Conclusion

For the foregoing reasons, I affirm the IG's determination to exclude Petitioner from participating in Medicare, Medicaid, and all other federal health care programs for the statutory five-year minimum period pursuant to 42 U.S.C. § 1320a-7(a)(1), (c)(3)(B).

/s/

Scott Anderson
Administrative Law Judge

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[2] These letters primarily attest to the good character of Petitioner's President, Marylin Maravilla, who provided home health care services through Petitioner.