Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: December 20, 2007
Rudra Sabaratnam and Robert I. Bourseau,	
Petitioners,	Civil Remedies CR1660 App. Div. Docket No. A-08-9
- v. -	Decision No. 2139
Inspector General.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Rudra Sabaratnam, M.D., and Robert I. Bourseau (Petitioners) appealed the September 25, 2007 decision of Administrative Law Judge (ALJ) Richard J. Smith. Rudra Sabaratnam and Robert I. Bourseau, DAB CR1660 (2007) (ALJ Decision). The ALJ upheld the determination by the Inspector General (I.G.) proposing to exclude Mr. Bourseau for 15 years from participation in Medicare, Medicaid, and all other federal health care programs. The ALJ upheld the I.G.'s exclusion of Dr. Sabaratnam but reduced the period of exclusion from 15 to ten years.

The I.G. excluded both Petitioners pursuant to section 1128(b)(7) of the Social Security Act (Act), based on his determination that Petitioners had committed acts described in section 1128A of the Act by submitting Medicare cost reports in 1998 and 1999 on

behalf of a hospital that they knew or should have known included false or fraudulent claims.[1]

Petitioners assert that the ALJ made two legal errors. First, they argue that the ALJ erred by concluding that the I.G. was not required to obtain authorization from the Attorney General of the United States prior to initiating a section 1128(b)(7) exclusion. Second, they argue that the ALJ erred by concluding that the hospital cost reports at issue were "claims" as that term is defined by section 1128A(i)(2) of the Act.

For the reasons discussed below, we uphold the ALJ Decision.

Standard of review

We review an ALJ decision involving an I.G. exclusion to determine whether the decision is erroneous as to a disputed issue of law and whether the decision is supported by substantial evidence in the record as a whole as to any disputed issues of fact. 42 C.F.R. § 1005.21(h).

Applicable Legal Authority

Section 1128(b)(7) authorizes the Secretary of the Department of Health and Human Services to exclude an individual who he "determines has committed an act which is described in section 1128A, 1128B, or 1129" from participation in federal health care programs, including Medicare and Medicaid.[2] Section 1001.901 of 42 C.F.R., which is titled "False or improper claims," provides in pertinent part that the I.G. "may exclude any individual or entity that it determines has committed an act described in section 1128A of the Act."

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[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

[2] Section 1128A(j)(2) authorizes the Secretary to delegate his authority to impose exclusions, civil monetary penalties and assessments to the I.G, and the Secretary has done so. 53 Fed. Reg. 12,993 (April 20, 1988) and 48 Federal Register 21,662 (May 13, 1983). Therefore, although the Act speaks in terms of the Secretary's authority, we refer to the I.G.'s authority in discussing these penalties.

Petitioners were excluded on the basis of the I.G.'s determination that they had committed acts described in section 1128A(a)(1)(A) and (B) of the Act. Those sections provide in pertinent part:

> (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5) of this section) that--
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> (1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof . . . a claim (as defined in subsection (i)(2) of this section) that the Secretary determines
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> (A) is for a medical or other item or service that the person knows or should know was not provided as claimed . . .,
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> (B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,
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> * * *
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> shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty . . . . In addition, the Secretary may make a determination in the same proceeding to exclude the person from participating in the Federal health care programs . . .

Section 1128A(i)(2) defines "claim" for purposes of section 1128A as "an application for payments for items and services under a federal health care program (as defined in section 1128B(f)."

Section 1128A(i)(3) defines "item or service" and provides:

> The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

Factual Background and ALJ Decision

On June 14, 2005, the I.G. notified each Petitioner that the I.G. proposed to exclude him, pursuant to section 1128(b)(7) of the Act, from participation in Medicare, Medicaid, and all other federal health care programs for a period of 15 years. I.G.

Exclusion Notice of June 14, 2005.[3] As the basis for the exclusions, the I.G. informed Petitioners that he had made a determination that they had engaged in conduct described in section 1128A(a)(1)(A) and (B) of the Act by "caus[ing] to be submitted cost reports to the Medicare program . . . for Bayview Hospital and Medical Health Systems (Bayview) that [they] knew or should have known included false or fraudulent claims for medical or other items or services." Id. The cost reports at issue were for 1998 and 1999 and included, according to the I.G., false and fraudulent claims for the costs of interest, legal fees, management fees, rent, and square footage. The exclusion was to be effective 65 days after the date of the letter, unless Petitioners appealed the I.G.'s determination.

On May 6, 2003, which was prior to the I.G.'s action in this case, the United States Department of Justice filed an action against Petitioners in the United States District Court for the Southern District of California for damages and civil penalties under the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733.[4] The

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[3] The information in this section is drawn from the ALJ Decision and the record before the ALJ and is undisputed. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact and conclusions of law.

[4] The FCA, 31 U.S.C. § 3729, provides in relevant part:

> False claims
> (a) Liability for certain acts.--Any person who-
> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
> * * *
> (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> is liable to the United States Government for a

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FCA action alleged that Petitioners, through corporations they owned and managed, presented false claims to Medicare in the form of hospital costs reports for Bayview for the years 1997, 1998, and 1999. United States v. Bourseau, et al., 2006 WL 2961105, at 1 (S.D. Cal. 2006). Petitioners entered appearances in the FCA action, and it was still pending when the I.G. issued the June 14, 2005 exclusion notices.

Both Petitioners appealed the I.G.'s actions by filing ALJ hearing requests.[5] Pursuant to the ALJ's direction, the parties filed briefs and exhibits.[6] The ALJ set a hearing for October 30, 2006. However, on September 29, 2005, the District Court, after a six-day bench trial, issued Findings of Fact and Conclusions of Law in the FCA case, concluding that Petitioners violated the FCA by causing Bayview to submit false or fraudulent claims to Medicare in Bayview's 1997, 1998, and 1999 Medicare cost reports. Bourseau, 2006 WL 2961105. Judgment was entered against Petitioners imposing $31,000 in civil penalties in addition to treble damages. Id. The damages initially imposed were subsequently reduced from $7,925,444 to $5,219,195, and the total judgment for treble damages was reduced from $23,776,332 to $15,657,585. Order Granting Plaintiff's and Defendants' Rule

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[4](...continued)
civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

The FCA action brought against Petitioners also included as defendants RIB Medical Management Services, Inc., a single-employee corporation controlled by Bourseau, and Navatkuda, Inc., a single-employee corporation controlled by Sabaratnam. These corporations were the general partners of California Psychiatric Management Services (CPMS), a California Limited Partnership. CPMS owned and operated Bayview. Petitioners, through RIB and Navatkuda, ran CPMS doing business as Bayview Hospital. U.S v. Bourseau et al., 2006 WL 2961105, at 1 (S.D. Cal. 2006).

[5] The appeals were docketed by the Civil Remedies Division as C-05-520 and C-05-521. The ALJ consolidated the appeals by order of April 4, 2006.

[6] The ALJ admitted the following exhibits into evidence: I.G. Exhibits 1-232, Petitioner Exhibits 1-8, and ALJ Exhibits 1-3.

59(e) Motions to Alter or Amend the Judgment, 2006 WL 39491169 (S.D. Cal. Dec. 1, 2006).[7]

After the court issued its decision, the ALJ cancelled the hearing, and Petitioners and the I.G. moved for summary judgment. The ALJ granted summary judgment in favor of the I.G. The ALJ Decision adopted the findings of fact and conclusions of law recited in Bourseau. ALJ Decision at 10. These findings and conclusions concerned the 1997, 1998, and 1999 cost reports filed by Petitioners to Medicare on behalf of Bayview. As to the 1998 cost report, the court concluded that Petitioners had submitted unallowable and false claims for interest, bankruptcy fees, management fees, fictitious rent, and square footage. As to the 1999 cost report, the court concluded that Petitioners had submitted unallowable and false claims for interest, bankruptcy fees, management fees, and square footage. Relying on the doctrine of issue preclusion, also known as collateral estoppel, the ALJ concluded that Petitioners had committed an act described in section 1128 by knowingly filing false claims for Medicare reimbursement.

Analysis

Petitioners do not object to the ALJ's application of the doctrine of issue preclusion in this proceeding nor do they contest the factual findings based on the FCA action.[8] Rather,

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[7] The court's Findings of Fact and Conclusions of Law and Judgment is at ALJ Exhibit 2, and the court's Order amending the Findings of Fact and Conclusions of Law and Judgment appears at ALJ Exhibit 3. These orders have been appealed to the United States Court of Appeals for the Ninth Circuit and are pending as Nos. 06-56741 and 06-56743.

[8] The ALJ relied on the FCA judgment pursuant to the doctrine of issue of preclusion, also known as collateral estoppel. ALJ Decision at 13-18. The ALJ also concluded that 42 C.F.R. § 1001.2007(d) "bar[red] either Petitioner from challenging the basis for the exclusion." ALJ Decision at 18. Our decision should not be construed as upholding that conclusion. Section 1001.2007(d) applies to derivative exclusions, i.e., exclusions "based on the existence of a criminal conviction or a civil judgment . . ., a determination by another Government agency, or any other prior determination where the facts were adjudicated and a final decision was made." (Emphasis added.) As the ALJ

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Petitioners argue that the ALJ committed legal error by concluding that the I.G. was not required to obtain prior authorization from the Attorney General for this exclusion action and by concluding that the cost reports at issue constituted claims. We reject both of Petitioners' allegations of error.

1. The ALJ correctly concluded that the I.G. may initiate an exclusion action under section 1128(b)(7) without obtaining authorization from the Attorney General of the United States.

Section 1128(b)(7) authorizes the I.G. to exclude an individual who the I.G. "determines has committed an act which is described in section 1128A, 1128B, or 1129." The I.G. sought to exclude Petitioners under section 1128(b)(7) based on his determination that Petitioners had committed an act described in section 1128A(a). The I.G. did not seek to impose any remedies other than an exclusion.

Petitioners argue that the "plain language" of section 1128A(c)(1) requires the I.G. to obtain authorization from the Attorney General prior to initiating any section 1128(b)(7) exclusion. P. Br. at 3-4. In reviewing the plain language of sections 1128 and 1128A, particularly subsections 1128(b)(7) and 1128(c)(1), we come to the opposite conclusion. We first discuss the respective roles of sections 1128 and 1128A. Then we discuss why we conclude that this was a proceeding under section 1128, that proceedings under section 1128 and section 1128A are not subject to identical procedural requirements, and that the requirement for obtaining the Attorney General's authorization is unique to section 1128A proceedings. Finally, we discuss why our construction is supported by legislative history and by other provisions of these statutes.

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[8](...continued)
recognized, a section 1128(b)(7) exclusion is <u>not</u> a derivative exclusion. ALJ Decision at 16-17. Rather, a section 1128A(b)(7) exclusion is <u>based on the I.G.'s determination</u> that an individual has committed an act described in section 1128A. Thus, based on his determination, the I.G. sought to impose these exclusions even prior to the existence of the FCA judgment.

The I.G. had the burden of proving Petitioners committed an act described in section 1128A. 42 C.F.R. § 1005.15(b)(2). As the ALJ held, however, the I.G. may seek to do so by relying on the doctrine of issue preclusion.

Section 1128 of the Act sets out the grounds on which the I.G. must (in the case of mandatory exclusions) and may (in the case of permissive exclusions) exclude individuals or entities from federal health care programs. Section 1128(f) sets out requirements the I.G. must follow in imposing exclusions "under" section 1128. In a section 1128 proceeding, the only remedy the I.G. has the authority to impose is an exclusion.

Section 1128A describes conduct that may result in the imposition of civil monetary penalties (CMPs) or assessments and authorizes the I.G. to impose such remedies. When seeking to impose a CMP/assessment, the I.G. proceeds under section 1128A. Additionally, the last paragraph of section 1128A(a) gives the I.G. the option of seeking to impose an exclusion remedy in a CMP/assessment proceeding. It states:

> In addition, the Secretary may make a determination in the same proceeding to exclude the person from participation in Federal health care programs . . . .

(Emphasis added.) This provision promotes judicial economy by allowing the I.G., in any proceeding he brings to impose a section 1128A CMP or assessment, to also impose an exclusion. Finally, section 1128A(c) sets forth procedural requirements for a proceeding under section 1128A, including that the I.G. "may initiate a proceeding to determine whether to impose a civil money penalty, assessment or exclusion under subsection (a) or (b) only as authorized by the Attorney General pursuant to procedures agreed upon by them."

In other words, section 1128 and section 1128A establish two procedural alternatives, either of which may be used by the I.G. if he determines that an individual has committed an act described in section 1128A.

In support of its argument that the I.G. was required to obtain the authorization of the Attorney General prior to seeking to exclude Petitioners under section 1128(b)(7), Petitioners rely on the fact that section 1128A(c)(1) refers to "a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) . . . ." (Emphasis added.)

We conclude that the plain language of section 1128A(c)(1) does not support Petitioners' position, for the following reasons:

- Petitioners are being excluded under section 1128(b)(7) based on the I.G.'s determination that they "committed an act which is described in section [1128A]." This

citation to section 1128A is merely an efficient means of avoiding repetition by incorporating by reference a lengthy description of conduct. There is no language in either section 1128 or section 1128A to indicate that Congress, by referring to an act described in section 1128A, intended to apply section 1128A procedural standards to section 1128 proceedings in section 1128(b)(7) exclusions.

- Section 1128A(c)(1) requires the I.G. to obtain the Attorney General's authorization when initiating "a proceeding . . . **under subsection (a)**" of section 1128A. Section 1128A(a) authorizes the I.G. to impose a CMP and/or assessment, and, "in addition," an exclusion "in the same proceeding." Since the I.G. is not seeking to impose a CMP or assessment on Petitioners, this is not a proceeding "under" section 1128A(a), and the I.G. is not subject to the authorization requirement in section 1128A(c)(1).

- The use of the disjunctive "or" in section 1128A(c)(1) merely recognizes that the I.G. has a choice of remedies when proceeding "under subsection (a) or (b)" of section 1128A and is not required to impose all three remedies. This language does not convert a proceeding under section 1128(b)(7) into a proceeding under section 1128A.

Petitioners also argue that the ALJ's construction would allow the I.G. to "avoid seeking authorization from the Attorney General . . . simply by characterizing the proceedings as one being brought pursuant to [section 1128]" and that "such an interpretation renders meaningless the requirement for obtaining Attorney General authorization . . . ." P. Br. at 6-7. This argument misdescribes the I.G. actions and reflects Petitioners' failure to understand the function of the section 1128(c)(1) authorization requirement. First, the I.G. is not simply "characterizing" the proceeding one way or another. Rather, Congress established two alternative procedures – section 1128 for when the I.G. is seeking to impose only an exclusion and section 1128A for when the I.G. is seeking to impose CMPs and/or assessment, and, if he chooses, an exclusion. Because the I.G. here seeks only to impose an exclusion remedy, this is a section 1128 proceeding. Second, since the conduct described in section 1128A may also (as here) be subject to civil penalties under the FCA, the section 1128A(c)(1) authorization requirement prevents two federal agencies from trying to impose similar remedies on the same person for the same conduct. In contrast, in a section

1128 proceeding where the only possible remedy is an exclusion, such a coordinating mechanism is unnecessary because the Attorney General is not authorized to exclude individuals from federal and state health care programs.

Our construction of the plain language of section 1128A(c)(1) is supported by the legislative history, which makes clear that Congress regarded sections 1128 and 1128A as separate and distinct procedures and that an exclusion could be brought under either one for the same act. The Medicare and Medicaid Patient and Program Protection Act of 1987 (MMPPPA), Public Law No. 100-93, added section 1128(b)(7) of the Act and amended section 1128A. The accompanying Senate Report explained:

> Under the bill, the Secretary's authority to exclude a person against whom a civil monetary penalty or assessment is imposed would be relocated from section 1128 to section 1128A . . . to make explicit the policy that the Secretary may use a single administrative procedure both for imposition of penalties and assessments and for exclusions.
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> The Committee bill, in the new section 1128(b)(7), would also authorize the Secretary to exclude an individual or entity who commits an act that would be a basis for a civil monetary penalty under section 1128A. **Thus, the Committee bill would give the Secretary two alternative procedures for exclusion. The Secretary could use section 1128, which does not involve civil monetary penalties, or could use section 1128A, which combines actions for exclusion and civil monetary penalties.** It is the Committee's intent, however, that the Secretary not subject an individual or entity to both procedures on the same set of facts.

S. Rep. No. 109, 100th Cong., 1st Sess. 16 (1987)(emphasis added).

Further, other provisions of these two sections show that Congress did not intend for the procedural requirements of the two sections to be identical. For example, subsection 1128(f)(1) provides that an individual excluded "under this section" is entitled to judicial review of the Secretary's final decision after a hearing "as is provided in section 205(g)" of the Act.

In contrast, section 1128A(e) provides for appeal to federal courts of appeal for adverse decisions "under this section."[9]

Additionally, Congress indicated when it intended for a procedural requirement in one type of proceeding to apply to the other. For example, subsection 1128(c)(1) adopts notice and effective date requirements for "an exclusion under this section or under section 1128A"; subsection 1128(c)(3)(A) provides what the Secretary must specify about the period of the exclusion in the "written notice under [subsection 1128(c)(1)] and the written notice under section 1128A"; and subsection 1128(d) requires the Secretary to exercise his authority "under this section and section 1128A" in a manner that results in the individual's exclusion from state health care programs such as Medicaid. Similarly, Congress indicated when a provision of section 1128A

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[9] The I.G. attached to his response brief a Memorandum of Points and Authorities filed by Petitioners in Case No. CV 07-07430 CAS (PJWx) before the United States District Court of the Central District of California. In that action, Petitioners seek injunctive relief to prevent the I.G. from excluding them from federal and state health care programs. P. Memorandum at 1. (The I.G. represents that Petitioners agreed to withdraw their application for a temporary restraining order for a period of 60 days, and the I.G. agreed to delay the imposition of the exclusions for the same period of time. I.G. Br. at 6.) In the federal court application, Petitioners argued that the fact the I.G. does not dispute that the six-year statute of limitations in section 1128A(c)(1) applies to section 1128(b)(7) exclusions establishes that the Attorney General authorization requirement also applies. Id. at 14.

We disagree. The Board held in Wesley J. Hammer, DAB No. 1693 (1999) that, in a section 1128(b)(7) exclusion, the I.G. may not rely on acts committed prior to the six-year limitation in section 1128(c)(1). However, this conclusion was based on specific language in these sections and legislative history indicating that, by "an act which is described in section 1128A," Congress meant an act committed within six years of initiation of the exclusion action. The specific language the Board relied on in Hammer is not relevant to construing the scope of Attorney General authorization requirement. We also note that, in dicta, the Board indicated in Hammer that the authorization requirement of section 1128A did not apply to section 1128 proceedings. Hammer, at 19-20.

applies to section 1128. For example, section 1128A(j)(2) provides –

> The Secretary may delegate authority granted under [section 1128A] and under section 1128 to the Inspector General of the Department of Health and Human Services.

Thus, there is no basis to infer that a procedural requirement unique to section 1128A, such as the Attorney General authorization requirement, applies to a section 1128 proceeding.

For the reasons discussed above, we conclude that the ALJ correctly concluded that the I.G. was not required to obtain authorization from the Attorney General when seeking to impose a section 1128(b)(7) exclusion in a section 1128 proceeding.

2. The ALJ did not err in concluding that the entries on the hospital cost reports at issue constituted false claims under 1128A(a).

The I.G. proposed to exclude Petitioners pursuant to section 1128(b)(7) based on his determination that they had committed acts described in section 1128A(a). I.G. Notices of Exclusion. Relying on the federal court's findings in the FCA action, the ALJ concluded the I.G. had shown that Petitioners committed acts described in section 1128A(a). ALJ Decision at 11-12. Petitioners do not except to the ALJ's reliance on the court's findings, which included the following facts. CPMS (Petitioners' corporation that managed Bayview) retained a consultant to prepare and transmit cost reports for Bayview to Medicare for the years 1998 and 1999. Bourseau, 2006 WL 2961105, at 3. The consultant prepared cost reports based on the actual costs incurred by Bayview; each cost report showed that Bayview's total actual costs for that year were substantially less than the total amount of Medicare interim payments CPMS had received over the course of the cost reporting year. Id. at 6-7. In order to reduce the amount CPMS was obligated to repay Medicare, Petitioners instructed the consultant to include in the cost report other costs, such as interest, professional bankruptcy fees, management fees, and space costs that were unrelated to the operation of Bayview and therefore unrelated to care of its patients. Id. As to the majority of these costs, the consultant advised Petitioners that the costs were unrelated to Bayview and should not be included on the cost reports, but the costs were included over the consultant's objections. Id.

Petitioners raise several arguments in support of their position that the ALJ erred by concluding that entries on these cost

reports constituted actionable "claims" within the scope of section 1128A(a). First, Petitioners argue that a cost report is not a "claim" under section 1128A(a). P. Br. at 9. Petitioners point to the definition of "claim" in section 1128(i)(2) ("an application for payments for items and services under a Federal health care program") and the definition of "item or service" in section 1128A(i)(3) ("the term 'item or service' includes . . . in the case of a claim based on costs, any entry in the cost report, books of account, or other documentation supporting such claim" (emphasis added)). Petitioners assert that a cost report is not an application for payment but, rather, "a report consisting of schedules and other data gathering form on which a provider records the costs and other relevant statistics and data." Id.

We first note that, although Petitioners raised the same argument below, the ALJ did not directly address it. His statement (in Finding of Fact and Conclusion of Law (FFCL) 12) that the legal issues before him were "identical to those alleged and proven" in the FCA proceeding implies that he considered the court's conclusion in that proceeding that Petitioners had knowingly caused the submission of false claims under the FCA to be determinative. ALJ Decision at 10. Since the FCA was written to apply to a broad range of false claims against the federal government, liability under the FCA attaches to a much wider range of acts than those described in section 1128A(a).[10] The reach of section 1128A(a), therefore, is not co-extensive with the reach of the FCA, and the court's conclusion that Petitioners had caused the presentment of "false claims" for purposes of the FCA action would not necessarily preclude a determination that Petitioners had not committed acts described in section 1128A(a). Despite the differences in the scope of the two statutes, however, the ALJ correctly concluded, based on the facts as found by the court in the FCA action, that Petitioners had committed acts described in section 1128A(a).

[10] Under the relevant provisions of section 1128A(a) (and by reference under section 1128(b)(7)), a person is liable if that person "knowingly presents or causes to be presented . . . , a claim (as defined in subsection (i)(2)) that the Secretary determines – (A) is for a medical or other item or service that the person knows or should know was not provided as claimed . . . [or] (B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent."

Petitioners' acts clearly fall within section 1128A)(a) and within the definitions set forth in sections 1128A(i)(2) and (3), contrary to what Petitioners argue. To understand why, it is important to first understand the relevant Medicare reimbursement system, and the role of Medicare cost reports in that reimbursement system. As explained in Bourseau, during the relevant time period, Medicare reimbursed psychiatric hospitals based on the reasonable costs of services. Bourseau at 9. Under the reasonable cost reimbursement system, to qualify for Medicare reimbursement, a cost must be (1) for a Medicare-covered service, (2) related to patient care at the hospital, and (3) reasonable.[11] Section 1814(b) of the Act; 42 C.F.R. § 413.9. Because it is impractical to determine reasonable reimbursable costs on a contemporaneous basis, Medicare makes interim payments to hospitals throughout the reporting period based on their estimated reimbursable costs. 42 C.F.R. § 413.60(a). Within five months after the end of the hospital's reporting period, the hospital is required to file a cost report which presents a final accounting of its actual costs during that period. 42 C.F.R. § 413.24(f)(2). That cost report is used to determine the amount of Medicare reimbursement to which the hospital is entitled for services provided to beneficiaries during the cost reporting period. Federal regulations provide –

> Interim payments are made on the basis of estimated costs submitted by the hospital to Medicare. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services furnished to program beneficiaries during that period.

42 C.F.R. § 413.64(f) (emphasis added). Let us assume, for example, that a hospital charges Medicare for five days of inpatient hospital services provided to Patient A during the cost reporting period, and Medicare pays the hospital for those five days at the hospital's interim per diem rate. After the end of the reporting period, the hospital files its cost report reflecting its actual costs of providing services during that

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[11] A reasonable cost is a cost actually incurred by the hospital for the service and excludes any part of the cost that is unnecessary in the efficient delivery of needed health services. Section 1861(v)(1)(A) of the Act.

period and other relevant information. Medicare recalculates the rate for a day of service based on these actual costs. If the hospital's actual costs were higher than the costs used to calculate the interim rate, the rate for a day of service would increase, and the hospital would receive additional reimbursement for the five days of inpatient service for Patient A. If the actual costs were less, the hospital would reimburse Medicare for the difference between the interim rate and the final rate for a day of service for those five days.

Thus, contrary to Petitioners' assertion that a cost report is merely "a report . . . on which a provider records the costs and other relevant statistics and data," a cost report is the mechanism by which Medicare determines the amount of the final payments to which a hospital is entitled for the cost reporting period. See, e.g., 42 C.F.R. §§ 413.20; 413.64(f). Entries on a cost report therefore constitute a "claim" within the meaning of section 1128A(i)(2). See Thomas M. Horras and Christine Richards, DAB No. 2015 (2006) (holding that entries on a home health agency's home office cost reports of costs that were then allocated to the branch office cost reports and submitted to Medicare were claims within the meaning of section 1128A(i)(2)), aff'd, Leavitt v. Thomas H. Horras, 495 F.3d 894 (8th Cir. 2007) (holding that entries on the agency's home office costs reports "result[ed] in an 'application for payment for items and services'" under section 1128A(a)).

Petitioners also argue that the definition of "item or service" at section 1128A(i)(3), stating that "the term 'item or service' includes . . . in the case of a claim based on costs, any entry in the cost report . . . supporting such claim," indicates that a cost report is not a claim. Petitioners state:

> If a 'cost report,' itself, were a 'claim,' Congress would not have used 'cost report' in the same sentence it used 'claim.' In other words, if a cost report were, in fact, intended to be a claim, then it makes no sense to describe an entry in a cost report as 'supporting a claim.' Rather, 'claim' would be defined to include a cost report itself. Obviously, the term 'cost report' and the term 'claim' are intended to have different meanings.

P. Br. at 9. Petitioners' argument has no merit. Inserting the relevant language from section 1128A(i)(3) into the text of section 1128A(i)(2) shows that Congress intended to attach liability to cost-based providers for each false or fraudulent entry on a cost report. Section 1128A(i)(2), read together with

section 1128A(i)(3), defines a claim as an application for payment for an item or service under a Federal health care program, including "(A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report . . . supporting such claim." By entering an item, device, medical supply, or service on an itemized bill for services (such as billing for a specified number of days of inpatient psychiatric hospital services provided to a specific beneficiary), a provider is applying for payment. A cost report submitted by a cost-based institutional provider such as a psychiatric hospital supports such a claim because the cost report is used in establishing the final rate for any covered services an itemized bill lists as having been provided in the cost reporting period. So, in the example given above, the hospital submitted a claim for an item or service when it billed Medicare for five days of inpatient hospital services for Patient A, and the entries on the cost report for that period support that claim by providing the basis for establishing the per diem rate to which the hospital is entitled for those services. That the entry on the cost report supports the itemized bill does not mean, however, that presenting the cost report, with the entry, cannot also reasonably be considered to be presenting a claim. Instead, it is reasonable to consider submission of a Medicare cost report to <u>also</u> be applying for payment for each entry on the cost report because, by entering those underlying costs on the cost report, a cost-based provider is seeking to have those costs considered in determining the final reimbursement rate for the Medicare-covered services for that cost reporting period. Thus, the statutory reference to a cost report entry as "supporting a claim" is not inconsistent with the ALJ's conclusion that Petitioners committed acts described in section 1128A(a) when they caused to be presented to Medicare false entries on cost reports.

On the other hand, Petitioners' construction of sections 1128A(i)(2) and (3) would put the knowingly false or fraudulent statements of cost report-based providers (such as hospitals and nursing homes) regarding costs to be included in determining the amount of payment to which they are entitled beyond the reach of sections 1128(b)(7) and 1128A(a). Plainly, this result would be contrary to the purpose of the MMPPPA, which is to increase the I.G.'s ability to protect federal health care programs from fraud and abuse.[12] S. Rep. No. 109, 100th Cong., 1st Sess. 1-2 (1987).

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[12] The legislative history specifically indicates

(continued...)

Second, Petitioners argue that even if entries on cost reports are considered to be claims, these particular entries were not "actionable" claims because they were not "application for payments" as required by section 1128(i)(2). P. Br. at 10. Petitioners argue:

> Bayview's 1998 and 1999 cost reports do not request payment from the fiscal intermediary. Rather, they show an "amount owing" the Medicare program by Bayview. Thus, rather than being an application for payment, at

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[12](...continued)
that Congress intended section 1128(i)(3) (then section 1128A(h)(3)) to reach all cost-based providers. The Committee Report states:

> The Committee notes a clarification of intent with respect to the definition of "item or service" in section 1128A(h)(3) of the current statute. Since the enactment of the civil monetary penalty statute, the Congress has enacted the prospective payment system (PPS) for inpatient hospital services furnished under Medicare (section 1886 of the Social Security Act). Consequently, hospitals now bill Medicare for a hospital inpatient stay and receive a payment that encompasses all the hospital inpatient services furnished during that stay. This change in the mechanism and documentation by which hospitals make claims for services under PPS does not affect their status as claims for items or services within the meaning of section 1128A. Other examples of information that hospitals provide under PPS that may constitute a claim include diagnostic and procedural information, cost reports, reports on the numbers and time allocation of interns and residents, and length of stay information.

S. Rep. No. 109, 100th Cong., 1st Sess. 15-16 (1987) (emphasis added). We note that this history indicates that Congress intended section 1128A(a) to cover entries on cost reports, even under prospective reimbursement systems, in which the relationship of the entries to payment amounts is not as direct as under the reasonable cost, retrospective system at issue here.

> most, they are a report of money tentatively owing the Medicare program by Bayview. And, the allegedly erroneous entry in the cost reports decreased the sum showed owing.

P. Br. at 10.

We reject Petitioners' argument. As discussed above, entries on a Medicare cost report are representations that a provider has incurred specific allowable costs in providing covered services to Medicare beneficiaries during the cost reporting period. Thus, each entry is an "application for payment" based on the reported cost. The fact that the entries collectively also establish the total final amount of payments to which a provider is entitled for the cost reporting period, which may be more or less than the total payments made on an interim basis, does not change their nature as applications for payment under Medicare. Moreover, an entry in the cost report which falsely reduces the amount a provider must repay Medicare has the same effect as an entry which falsely causes Medicare to make a payment. They both result in the provider receiving Medicare reimbursement to which it was not entitled. Since Petitioners' construction would shield a class of fraudulent cost report transactions from the protective purposes of section 1128 and 1128A(a), it is contrary to congressional intent of enabling the I.G. to protect Medicare, and is not a reasonable reading of the statute.

Finally, Petitioners rely on the "reverse false claim" provision of the FCA, which provides that a person is liable under the FCA if he/she--

> (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government . . . .

31 U.S.C. § 3729(a)(7). Petitioners argue that the fact that section 1128A(a) "does not have a reverse false claims provision analogous to the federal FCA" supports is position that the 1998 and 1999 cost reports are not "actionable" claims under section 1128A(a). P. Br. at 10.

We reject Petitioners' argument. First, the federal court expressly found that Petitioners were liable under 31 U.S.C. §§ 3729(a)(1) and (2) in addition to subsection (7). Order Granting Plaintiff's and Defendants' Rule 59(e) Motions, 2006 WL 3949169 (S.D. Cal. Dec. 1, 2006), at 1. Subsections (1) and (2)

involve "direct" false claims.[13] Thus, the court was not relying solely on the reverse false claim provision.

Further, even if the Bourseau judgment had been based solely on subsection (7), the absence of a reverse false claim provision in section 1128A(a) is not a basis for concluding that Congress did not intend section 1128A(a) to cover Petitioners' acts. We conclude this based on the following considerations:

- Petitioners may have intended their acts to decrease the total amounts Bayview was obligated to repay Medicare, but that does not alter the nature of their acts as the presentment of claims falsely representing that Bayview was entitled to final Medicare reimbursement based on the costs entered in the cost reports. Petitioners used unallowable costs to establish final Medicare reimbursement rates which (while lower than the interim rates) would still be higher than if those unallowable costs were not considered.[14] Thus, the fact that their acts might also qualify as "reverse false claims" under the FCA does not preclude a finding that Petitioners committed acts described in section 1128A(a).

- Section 1128A(a) must be construed in the context of congressional attempts to protect federal healthcare programs from fraud and abuse. In that context, it is not reasonable to conclude that Congress intended to make liability for false cost report entries depend on whether any interim payments for the cost reporting period were higher or lower than the final payment amounts. The impact on the program is the same – the provider receives money to which it was not entitled.

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[13] Under subsection (1), liability attaches to any person who, among other things, "knowingly presents, or causes to be presented, . . . a false or fraudulent claim for payment or approval," and under subsection (2) liability attaches to any person who "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government." 31 U.S.C. §§ 3729(a)(1) and (2).

[14] Moreover, cost reports may be used to set future rates, on an interim or final basis, so false entries are likely to result higher payment in future periods. See, e.g. 42 C.F.R. § 413.64(e).

- Reading the absence of a specific "reverse false claim" provision in section 1128A(a) as precluding liability in situations such as this would be inconsistent with the fact that section 1128A(a) does not require the I.G. to show that the false claim caused the government to make actual payment or exposed it to making such a payment. Rather, section 1128A(a) focuses on the act of presenting false claims or causing them to be presented, as opposed to falsely receiving federal funds. This focus on claiming is reflected in the penalty provisions. Section 1128A(a) assessment penalties are based on the "amount claimed." In contrast, the FCA imposes penalties of "3 times the amount of damages which the Government sustains because of the act of that person." 31 U.S.C. § 3729(a).

- Finally, the reverse false claim provision on which Petitioners rely was enacted in response to court decisions (involving other government programs) that refused to apply the FCA to false statements that reduced amounts owed. At the time Congress adopted the reverse false claim provision, it indicated that it viewed these decisions as unduly restricting application of the FCA.[15] Therefore, the fact Congress that added a

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[15] The accompanying committee report stated that the reverse false claim provision was being enacted to address "differing judicial interpretations" as to reverse false claims, i.e., "claims to avoid a payment to the Government." S. Rep. No. 99-345, 18 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5283. The Committee stated that, while some courts refused to apply the FCA to reverse false claims, a decision in "a better reasoned result" found that the FCA did apply. The Committee concluded --

> The Supreme Court's opinion in United States v. Neifert-White Co., 390 U.S. 228 (1968), indicated that the False Claims Act 'was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government.' The Committee strongly endorses this interpretation of the act and, to remove any ambiguity, has included this amendment to resolve the current split in the caselaw relating to such material misrepresentations.

(continued...)

> reverse false claim provision to the FCA is not a basis to restrict to scope of section 1128A(a).

Accordingly, we conclude that the ALJ correctly concluded that Petitioners filed "claims" as that term is defined in section 1128(i)(2) and that Petitioners committed acts described in section 1128A(a). To conform the FFCLs with the discussion herein, we modify FFCL 12 as follows:

> 12. On September 29, 2006, the United States District Court for the Southern District of California entered findings of fact and conclusions of law in *United States v. Bourseau, et al.*, No. 03-cv-907-BEN (WMC). In that FCA litigation, the factual issues before me now are identical to those alleged and proven in the United States District Court; those issues were litigated in the United States District Court action by the parties against whom preclusion is asserted here, Petitioners Sabaratnam and Bourseau; the FCA issues have been determined or resolved by a valid and final judgment in the United States District Court; and the determination of the FCA issues in the FCA litigation was a critical and necessary part of the judgment in the FCA action. Because the United States District Court reached its final, full determination of identical factual issues after they had been fully litigated, and because its resolution of all those issues was essential to the United States District Court's valid final judgment, its resolution of those issues precludes Petitioners from relitigating those issues here. *United States v. Bourseau, et al.*, 2006 WL 2961105.

We adopt the following additional FFCL:

> 12A. The facts proven in the FCA litigation establish that Petitioners are persons who committed acts described in section 1128A(a) by presenting or causing to be presented to Medicare claims for items or services when these items or services were not provided as claimed or were false and fraudulent and that Petitioners knew or should have known that the items or services were not provided as claimed or that the claims were false and fraudulent.

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[15](...continued)
Id. at 5283-5284.

Conclusion

For the reasons explained above, we affirm the ALJ Decision with the modifications noted directly above.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member