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The FCA and Commercial Insurance Claims in Private Equity Health Care Transactions

Bill Eck
Leon Rodriguez
John Shire
Dr. Ty Treutelaar

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Seyfarth Shaw LLP

Speakers

Bill Eck
Partner
Washington, DC

Leon Rodriguez
Partner
Washington, DC

John Shire
Partner
Washington, DC

Dr. Ty Treutelaar
Founder
The Private Compliance Group, Inc.

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02 Impact on Private Equity Deals

03 How to Conduct a Proper Reimbursement Analysis

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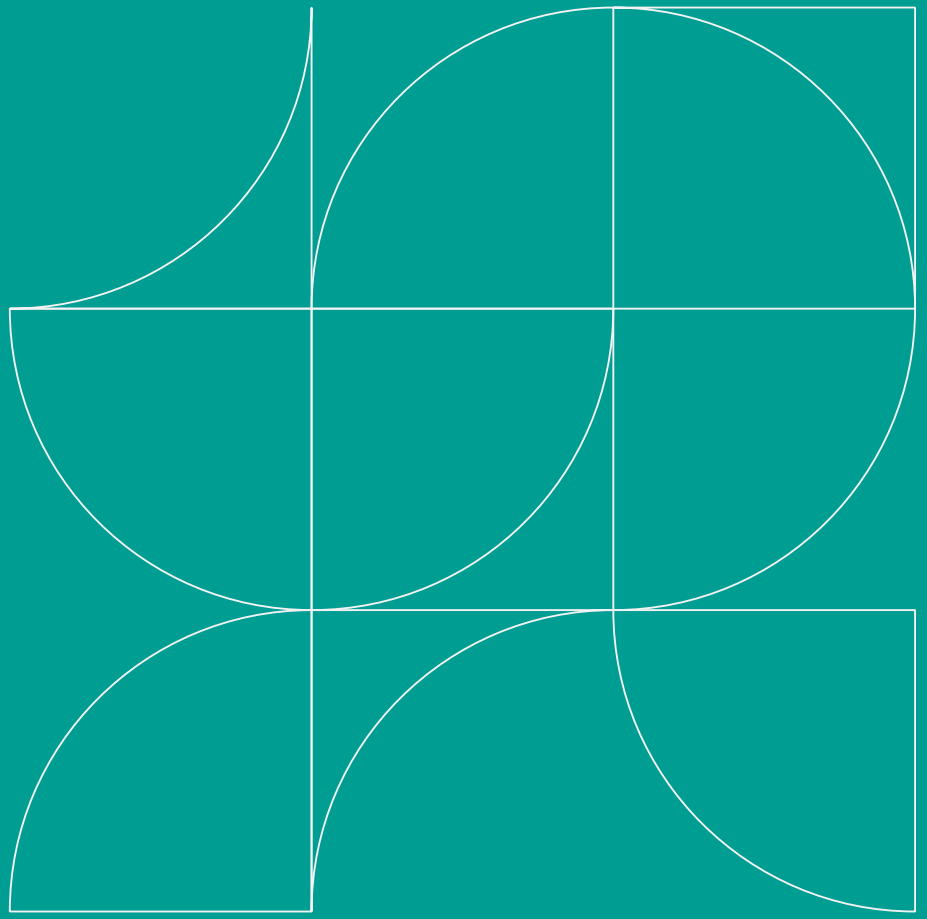
06 Q&A

1. Introduction to FCA



The False Claims Act in a Nutshell

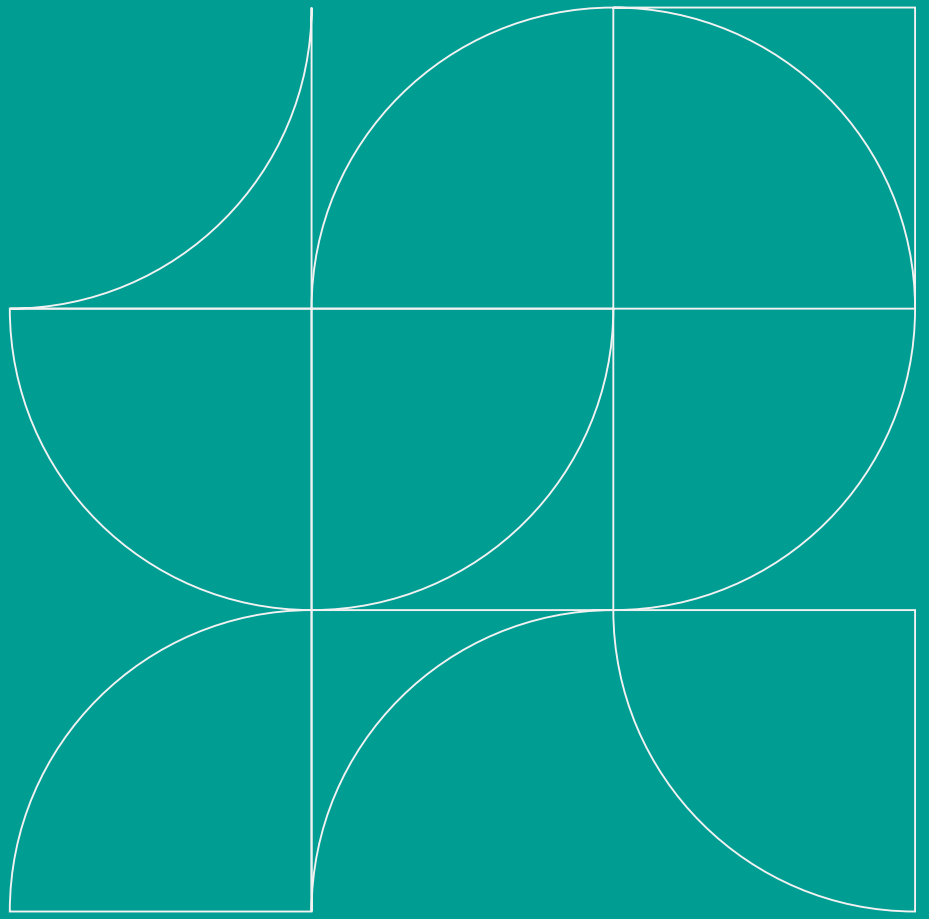
- Applies to an entity or person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval
- Penalties between $5K and $10K per claim
- + treble damages
- Qui Tam whistleblower provisions, filed under seal

More on the False Claims Act

- Government investigations conducted by:
  - Department of Justice
  - FBI
  - Department of Health and Human Services, Office of the Inspector General

- Implied Certification Theory upheld by U.S. Supreme Court in Universal Health Services, Inc. v. United States ex rel. Escobar (2016)

2. Impact on Private Equity Deals



Impact on Private Equity Deals

2(a) – Typical Investment and Acquisition Process

- Value assessment beyond the P/L
  - Cash flows
  - Organizational structure
  - Assessment of management team
  - Historical data
- Follow the money
- Follow the paper trail

Impact on Private Equity Deals

2(b) – Why Health Care and Claims Diligence Matters

- **Standard Compliance Diligence**
  - Stark
  - Anti-Kickback Statute
  - HIPAA
  - EMTALA
  - Licensure
- **Successor Liability**
  - Stock purchases and mergers
  - Asset purchases
  - Continuing practices
  - FCA risk
- **Claims Diligence**
  - Overpayment risk
  - Going forward EBITDA and earnings
  - FCA risk

Impact on Private Equity Deals

2(c) – Discussion of Impact Examples

Impact on Private Equity Deals

2(d) – "Transactional Diligence" and How This Differs

Industry term meaning

- Deep evaluation of:
  - Whether the target entity demonstrates:

(a) Compliance Guide documents

(b) Data supporting historical claims

(c) Concurrent/retrospective review

(d) Comparison of claims submitted versus cash receipts

(e) Verbal understanding of coverage guidelines

Impact on Private Equity Deals

2(e) – Typical P/L Accounting Diligence

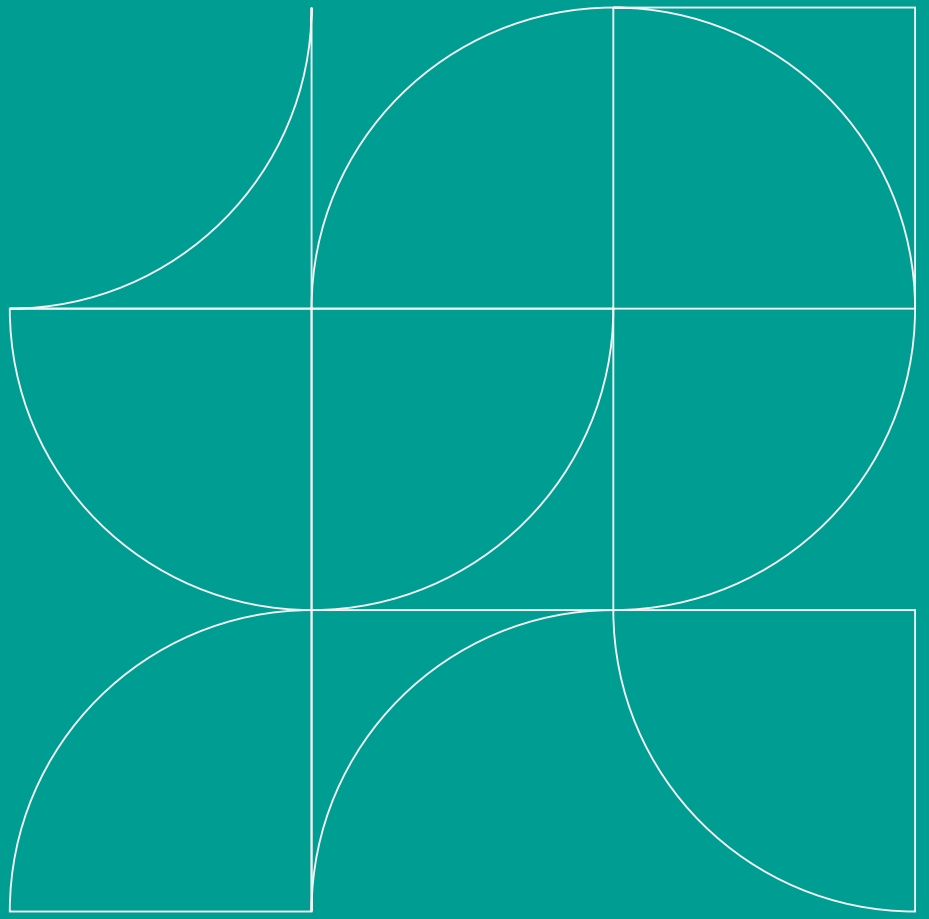
- Analysis of the target's revenue and expenses
- Analysis of the accuracy and sustainability of EBITDA and earnings
- Analysis of contributions to revenue
  - By payor
  - By service
  - By physician (where appropriate)
- Analysis of one-time events
- Review of material contracts and sales data
- Testing financial statements
- In addition, transactional claims diligence is critical.

Impact on Private Equity Deals

2(f) – Why Reimbursement Analysis is the Key to Successful Transactions

- The importance of third-party payors in health care cannot be overstated.
- Material impact on EBITDA and earnings
- Compliance with payor requirements has a potentially significant impact on EBITDA and earnings.
- There is also a potentially significant exposure to overpayment and FCA liability.
- The requirements of Medicare and other payors, regarding services and claims, are complex and technical.
- To determine accuracy and sustainability of EBITDA and earnings requires a statistical analysis of claims and records for compliance with these requirements.

3. How to Conduct a Proper Reimbursement Analysis



How to Conduct a Proper Reimbursement Analysis

3(a) – Compliance Guide

- Coding Claims
  - Level of service
  - Preconditions satisfied (NCDs / LCDs)
  - Indications satisfied (NCDs / LCDs)
- Documentation
  - Producible
  - Dates are consistent
  - Services are supported
  - Diagnoses are supported
  - Medical necessity is supported
  - Provider signature is present and timely

How to Conduct a Proper Reimbursement Analysis

3(b) – Documentation

- Rules of the game:

  (a) Payor guidelines: govt/commercial

  (b) Coverage decisions: local & national

  (c) Medicare policy bulletins

  (d) OIG pronouncements

    - Compliance guidance/industry
    - Enforcement initiatives

How to Conduct a Proper Reimbursement Analysis

3(b) – Documentation (continued)

- Hard copy of compliance guide
  - Hand over to government in an enforcement action
  - Review and update annually
  - Training module
  - Document training by staff

How to Conduct a Proper Reimbursement Analysis

3(b) – Documentation (continued)

- List of codes
  - Actual billed codes
  - Codes by grouping
  - Metrics analysis by codes billed
- Signature documentation
  - Parent/guardian
  - Qualified professional
  - Physician
  - “In and out” times or “start and stop” times

How to Conduct a Proper Reimbursement Analysis

3(b) – Documentation (continued)

- Payor Results
  - Actual payment on codes by claims
  - Differential analysis by payment versus claim
  - All correspondence with payors
    - Government recoup notices and outcomes
    - Commercial carrier letters and notices

How to Conduct a Proper Reimbursement Analysis

3(c) – Payor Review

- Payor Mix
- Payor Reports

How to Conduct a Proper Reimbursement Analysis

3(d) – Coding

Payor Guidelines

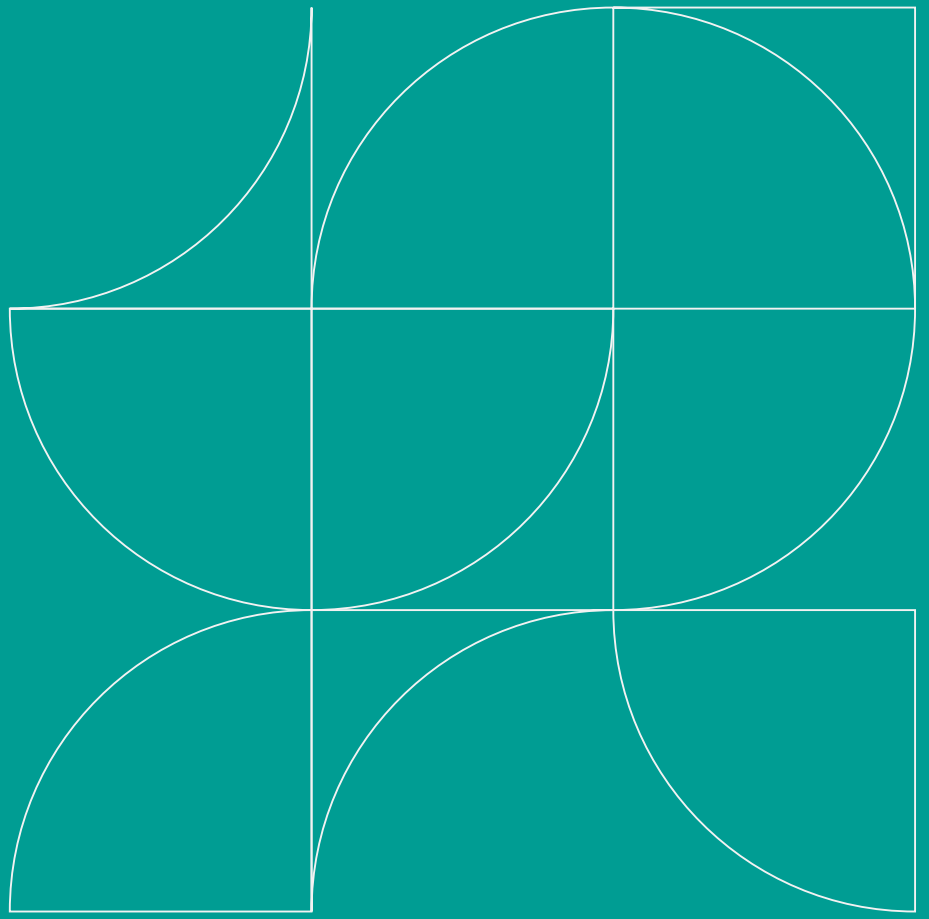
- Government
- Commercial
- Local coverage decisions
- National coverage decisions
- Software check with third parties

How to Conduct a Proper Reimbursement Analysis

3(e) – Claims/Record Review & Attorney Client Privilege

- Probe sample
- Determine confidence level and precision interval
- Use of RAT-STATS and or other statistical software
- Determine Attribute Error Rate and convert to Financial Error Rate
- Extrapolate to universe of sampled claims
- This requires an individual with expertise in statistics and medical review policy.
- This can yield quantitative information about past billings, or A/R, or both.

4. Measures



Measures

4(a) – Baseline Documentation and Procedures

Identify the point in time, the date certain, when you can state with 100% certainty that your organization is following a protocol that is compliant with all applicable laws, regs and guidelines.

This date is the baseline.

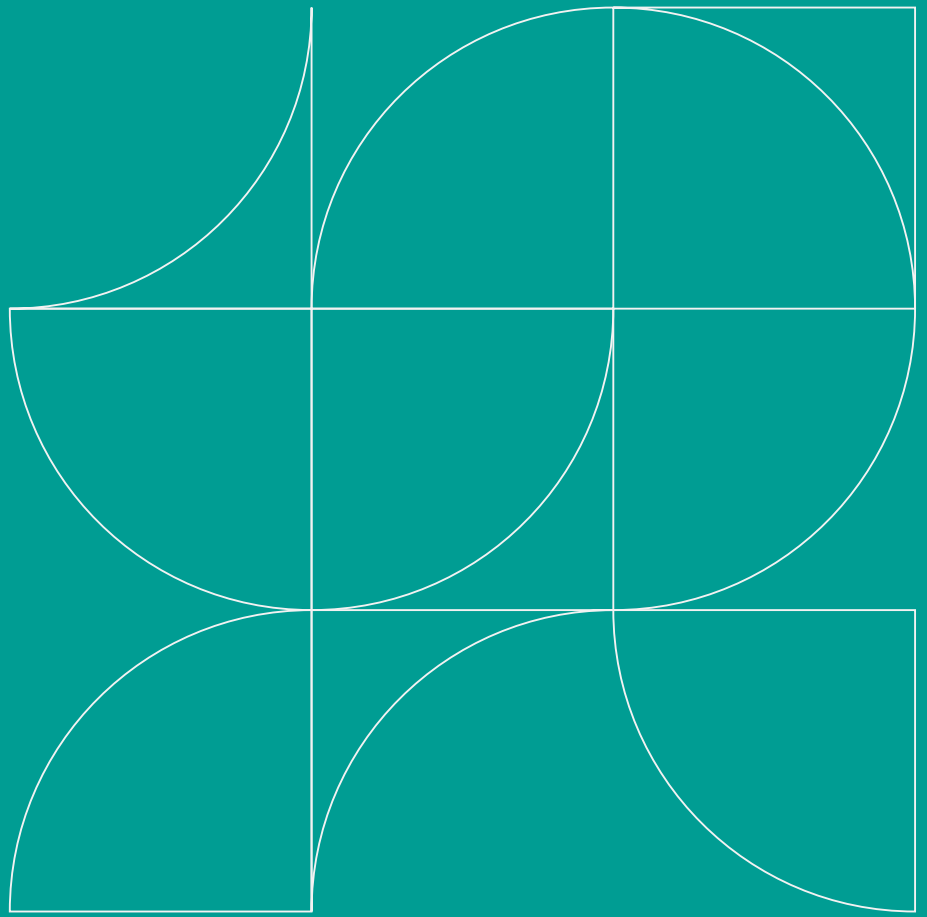
For internal audits, work backwards from the baseline.

Measures

4(b) – Representation and Warranty Insurance

- Presently there are insurers who will write representation and warranty insurance without health care carve outs.
- May include coverage for defense costs and penalties
- Limitations: 10-20% of enterprise value
  Deductibles: 1-2% of enterprise value
  Premium: 3-4%
  3-year survival (match non-fundamental representations)
- BUT, health care, and billing in particular, is carved out
- When there is due diligence with claims analysis as described in this webinar, the risk can be included.

5. FCA in the Wake of COVID-19



COVID-Related Relief Funding and False Claims Act Risk

- Substantial funding/lending flowing to health care providers through:
  - Paycheck Protection Program and Health Care Enhancement Act
  - Coronavirus Aid, Relief, and Economic Security (CARES) Act
  - $570 Billion between the two Acts
- https://www.seyfarth.com/news-insights/update-paycheck-protection-program-and-health-care-enhancement-act-increases-funds-available-to-hospitals-and-health-care-providers.html (Bill Eck)
- Anti-Fraud Provisions
  - HHS-OIG workplan issued May 2020; signals concentrated focus on use of COVID-related funding

Goal 2: Protect Funds

OIG oversight and enforcement activities protect HHS funds from fraud, waste, and abuse and promote transparency of, and accountability for, HHS spending. As of mid-May 2020, HHS was appropriated $251 billion for COVID-19 response and recovery, which includes $175 billion for the Provider Relief Fund and $76 billion for the HHS Office of the Secretary and certain Operating Divisions to prevent, prepare for, and respond to coronavirus. In addition, the Department is expending substantial funds from other appropriations for activities related to the COVID-19 public health emergency, including increases in the Federal match for Medicaid and in reimbursement for some Medicare services. Ensuring accurate payment in accordance with program requirements is a longstanding HHS management challenge, and OIG's work will address contracts, grants, program payments, and other payment mechanisms.

Objective A: Prevent, detect, and remedy waste or misspending of COVID-19 response and recovery funds

- Conduct audits and evaluations of HHS's oversight, management, and internal controls for awarding, disbursement, and use of funds.
- Audit fund recipients to assess whether they met use, reporting, and other requirements, and, where appropriate, recommend recovery of misspent funds.
- Participate on, and coordinate closely with, the PRAC to prevent and detect fraud, waste, abuse, and mismanagement, and to mitigate major risks that cut across program and agency boundaries.

Objective B: Fight fraud and abuse that diverts COVID-19 funding from intended purposes or exploits emergency flexibilities granted to health and human services providers

- Identify and investigate suspected fraud, in coordination with Federal, State, local, and Tribal law enforcement partners, and exercise OIG's administrative enforcement authorities when appropriate.
- Conduct audits and evaluations to identify program integrity vulnerabilities and recommend safeguards.
- Alert HHS, enforcement partners, and industry stakeholders to potential fraud risks or schemes to steal funds.

https://oig.hhs.gov/about-oig/strategic-plan/COVID-OIG-Strategic-Plan.pdf

Thank you

Questions?