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BLOG

DOJ Settles with BAYADA for $17 Million in Latest in a String of Enforcement Actions Against Home-Health Agencies

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On September 8, 2021, the U.S. Department of Justice (DOJ) announced that it reached a $17 million settlement with BAYADA, a Moorestown, New Jersey-based home-health company, and certain of its affiliates (collectively referred to as BAYADA) for alleged violations of the False Claims Act (FCA) and Anti-Kickback Statute (AKS). The settlement resolves claims arising out of a *qui tam* complaint filed against BAYADA by the company's former director of strategic growth alleging that the company billed federal payors for services tainted by alleged kickbacks.

BAYADA provides nursing, assisted-care, and related services to patients in private homes and residential facilities around the country. In 2014, BAYADA purchased two home-health agencies in Arizona from an unnamed retirement community operations company. The government alleges that BAYADA made the purchases to induce the seller to refer residents of the retirement communities that it managed to BAYADA, in violation of the AKS. In the government's view, the claims that BAYADA submitted to federal payors for services to patients referred by the seller's retirement communities violated the FCA because they "resulted from" the asset purchases allegedly underlying the AKS violation.[1] The government did not allege that BAYADA failed to provide necessary or medically appropriate services; rather, the government claims that those services were tainted because the underlying patients for whom the services were rendered were obtained through kickbacks.

BAYADA denied the DOJ's allegations but agreed to pay $17 million to settle the claims. The settlement agreement provides for a payment of approximately $3 million to the relator, as well as $695,000 in legal fees, expenses, and costs to the relator's counsel. While DOJ did not publicly disclose the number of allegedly unlawful claims at issue, the substantial settlement reflects an acknowledgment that BAYADA faced potentially devastating financial consequences if this case had gone to trial (e.g., treble damages plus significant penalties of between $11,803 and $23,607 per claim).

The settlement agreement expressly excludes from the release certain of the relator's claims, which remain under seal, leaving open the possibility that the relator may yet pursue non-intervened claims for relief against BAYADA. The government also reserved the rights to bring criminal prosecutions in connection with the conduct alleged in the settlement agreement, to seek to have BAYADA excluded from federal health care programs, and to pursue liability from any individuals who may have been involved.

A CONTRAST FROM A RECENT DISMISSAL OF FCA CLAIMS AGAINST BAYADA

The settlement marks an important distinction from another *qui tam* complaint against BAYADA, brought by the same whistleblower, which was dismissed by a federal judge in New Jersey earlier this year.[2] In that case, BAYADA allegedly violated state lobbying regulations when purchasing a home-health agency from a county board of health.[3] The whistleblower alleged that every claim submitted to a federal payor by the "fraudulently" acquired home-health agency was thus a "tainted" false claim.

The court disagreed, citing the Supreme Court's guidance in the famous *Escobar* case that the FCA "is not an all-purpose antifraud statute, or a vehicle for punishing garden-variety breaches of contract or regulatory violations."[4] The court dismissed the complaint upon finding that it failed to adequately plead how BAYADA's acquisition of a home-health agency by a county-level entity "touches or concerns the United States, or induced action on its part." The court further found that the complaint did not plausibly allege that federal payors would not have reimbursed the claims had they known about the allegedly improper lobbying activity. In other words, even if BAYADA's claims to federal payors were rendered "false" by improper lobbying, such falsity was not material to the government's decision whether to reimburse, and thus the claims were not actionable under the FCA.[5]

Although there is no substantive court ruling associated with the government's September 8 settlement with BAYADA, the underlying allegations reflect a marked contrast from the allegations underlying the claims dismissed in the New Jersey case. As discussed above, the United States' theory in the settled case was that BAYADA caused false claims to be submitted to federal payors because its purchase of home-health agencies allegedly induced the seller to refer patients to BAYADA that it would not have referred otherwise, in violation of the AKS. The upshot is that an alleged fraudulent act on the part of a health care provider who bills to federal payors does not necessarily give rise to FCA liability unless there is some connection between the alleged fraud and the federal payor—in particular, whether the payor's knowledge of the fraud would have affected its willingness to pay the claim.

OTHER RECENT GOVERNMENTAL ACTION TOWARD HOME-HEALTH AGENCIES

The BAYADA settlement comes on the heels of a summer of heavy governmental scrutiny of companies providing home-health services and equipment. In July and August alone, the government announced the following actions against home-health agencies or their principals in connection with alleged waste, fraud, and abuse schemes or other billing-compliance issues:

- In July, DOJ announced that it had obtained a guilty plea from the owner of home-healthcare and hospice agencies for allegedly paying kickbacks to health care-facility employees to induce them to refer patients to his companies. In turn, the defendant's agencies allegedly billed Medicare approximately $2 million for services to patients referred to them through the purported kickback scheme. The defendant agreed to pay or forfeit over $5 million as part of his guilty plea. He also faces up to 15 years in prison and a fine of up to $250,000 or twice the gross gain or loss associated with each of the two charges to which he pleaded guilty.
- In August, DOJ announced that it had reached an agreement with a provider of home respiratory services and durable medical equipment to resolve FCA claims brought by a *qui tam* whistleblower, a respiratory therapist who had worked for the company. The government alleged the company submitted false claims by billing Medicare and Medicaid for ventilator services that were not medically necessary or reasonable for the patient's treatment. The company agreed to pay $3.3 million to settle the claims.
- In August, the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) released a report of an audit that it had conducted of a home-health agency that found that the company had received overpayments of at least $5.9 million over a two-year period. HHS-OIG alleged that the home-health agency incorrectly billed Medicare for services provided to beneficiaries who were not homebound or who did not require skilled services and that it made claims with incorrect payment codes or inadequate supporting documentation. The company disputed nearly all of HHS-OIG's findings. It remains to be seen whether the government will pursue any enforcement action for suspected FCA violations or other claims.

KEY TAKEAWAYS

- The potential for substantial monetary rewards remains a powerful incentive for company insiders to report suspected fraud through the filing of a *qui tam*

- The home-health industry currently seems to be under particular scrutiny, with at least four major announcements of governmental efforts to enforce compliance with billing requirements involving home-health companies in recent months.
- Reimbursement claims submitted to federal payors for services actually performed for the patient may nevertheless constitute false claims under the FCA where the claims were tainted by fraud. An alleged act of fraud on the part of a health care company does not necessarily mean that all claims submitted to federal payors will be actionable under the FCA, e.g., where the alleged fraud had no connection to the federal government or its decision to reimburse a claim. On the other hand, claims for federal reimbursement that "result from" an alleged violation of the AKS constitute false claims for purposes of the FCA, according to the express language of the AKS.

If you have any questions or need further assistance, please contact **Christopher Man** (Partner, White Collar, Regulatory Defense, and Investigations), **Chase Cooper** (Associate, Complex Commercial Litigation), or your Winston & Strawn relationship attorney.

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[1] The AKS expressly states that claims for payment "resulting from" an AKS violation constitute a false claim for FCA purposes. 42 U.S. Code § 1320a–7b(g).

[2] *United States ex rel. Freedman v. Bayada Home Health Care, Inc.*, No. 3:19-cv-18753, 2021 U.S. Dist. LEXIS 90524 (D.N.J. May 12, 2021).

[3] *Id.* at *13–14.

[4] *Id.* at *13 (quoting *Universal Health Servs., Inc. v. United States ex. rel Escobar*, 136 S. Ct. 1989, 2003 (2016)).

[5] *Id.* at *20–24.

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