For years, prosecutors in a number of jurisdictions have been extracting False Claims Act settlements from nursing homes that are accused of providing less than adequate care. It was only a matter of time until private plaintiffs started litigating their own quality of care grievances against nursing homes and other health care entities under the FCA's qui tam provisions. See, e.g., United States ex rel. Foundation Aiding the Elderly v. Horizon West, Inc., 265 F.3d. 1011 (9th Cir. 2001). Although there is certainly unanimity on the need to protect the elderly and frail from abusive -- and even simply substandard -- nursing home conditions, many have questioned the appropriateness of using the FCA to address medical quality of care issues. See Mark Taylor, Targeting Hospitals: False Claims Act Cases Could Be Next, Prosecutor Says, MOD. HEALTHCARE, June 30, 2003, at 25; John T. Boese, Can Substandard Medical Care Become Fraud? Understanding an Unfortunate Expansion of Liability Under the Civil False Claims Act, 29 THE BRIEF 30 (A.B.A. Tort & Ins. Practice Section, 2000).

The poor fit between quality of care grievances and the purposes of the False Claims Act were recognized by a Federal district court in California that recently granted summary judgment for defendants. United States ex rel. Swan v. Covenant Care, Inc., No. CIVS99-1891 DFL JFM, 2003 WL 22037752 (E.D. Cal. Aug. 5, 2003). In Swan, relator alleged that defendant falsified patient records in order to conceal the fact that it did not meet minimum quality of care standards for participating in the Medicare and Medicaid programs. Id. at *1. Relator provided witness declarations corroborating her allegations that defendants falsified forms to indicate that patients received care, including turning, bathing, feeding, and wound treatment, that was never actually provided. Id. at *2. The court accepted these allegations as true, but held -- in a lengthy, reasoned opinion -- that they failed to state a cause of action under the False Claims Act under either of the two primary theories of liability asserted by relator.

"Worthless" Services

Two years ago the Ninth Circuit stated, in the context of a laboratory services quality of care case, that knowingly or recklessly billing for "worthless services" may be actionable under the False Claims Act. See United States ex rel. Lee v. SmithKline Beecham, Inc., 245 F.3d 1048, 1053 (9th Cir. 2001). However, a panel of the Second Circuit, citing SmithKline, held that under a "worthless services" theory of FCA liability, the service must be so deficient as to be equivalent to no performance at all. United States ex rel. Mikes v. Straus, 274 F.3d 687, 703 (2d Cir. 2001).

Citing Mikes approvingly, the Swan court held that because relator did not allege that defendant's care was so poor that it was equivalent to no care at all, the services provided were not alleged to be worthless. The court noted that payment to the defendant was based on a per diem rate that included a bundle of services including not only the allegedly deficient care, but also room, board, and other routine nursing home services. Swan,
Thus, so long as some value is provided to the government, a worthless services theory of liability must fail under the FCA.

**Express and Implied False Certifications**

The *Swan* decision is also significant because of its treatment of relator's express and implied false certification theories of liability. In false certification cases, it is alleged that the defendant either expressly or implicitly certified its compliance with certain statutes, regulations, or contract terms when requesting payment from the government.

The *Swan* court noted that the false implied certification theory of liability has not been accepted in the Ninth Circuit, and it questioned the validity of decisions from other jurisdictions which have held that submitting Medicare or Medicaid claims for substandard services can give rise to a viable FCA claim. *Id.* at *1 n.2, *6 n.12. Indeed, the court referred to these earlier decisions (*United States v. NHC Healthcare Corp.*, 115 F. Supp. 2d 1149 (W.D. Mo. 2000) and *United States ex rel. Aranda v. Community Psych. Ctrs. of Okla., Inc.*, 945 F. Supp. 1485 (W.D. Okla. 1996)) as containing “questionable holdings [that] have not been adopted by the Ninth Circuit.” *Id.* at *6. The relator in this case provided no evidence that payment was conditioned on an express certification of regulatory compliance, and summary judgment for defendant was therefore appropriate. *Id.* at *6, 8.

**The Role of the Governing Agency**

Perhaps the most important aspect of *Swan* is that it is one of a growing number of decisions in which courts recognize the significance of the governing agency's remedies for, and responses to, the regulatory, statutory, or contractual violations that are alleged to give rise to FCA liability. This trend is occurring in both *qui tam* actions and in cases initiated by the Justice Department. See, e.g., *United States ex rel. Costner v. URS Consultants, Inc.*, 317 F.3d 883 (8th Cir. 2003); *United States v. Southland Mgmt. Corp.*, 326 F.3d 669 (5th Cir. 2003) (en banc).

In *Swan*, the court noted that the Department of Health and Human Services has discretion to impose a variety of sanctions for substandard care in nursing homes, and denial of payment is only one of several remedies for the alleged regulatory violations. Penalties are not automatically assessed whenever a regulatory violation occurs. *Id.* at *7. Therefore, the court held that "[t]o allow FCA suits to proceed where government payment of Medicare claims is not conditioned on perfect regulatory compliance--and where HHS may choose to waive administrative remedies, or impose a less drastic sanction than full denial of payment--would improperly permit *qui tam* plaintiffs to supplant the regulatory discretion granted to HHS under the Social Security Act, essentially turning a discretionary denial of payment remedy into a mandatory penalty for failure to meet Medicare requirements." *Id.*

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