Item #24

Pinellas County

315 Court Street, 5th Floor
Assembly Room
Clearwater, Florida 33756

Staff Report

File #: 17-311A, **Version:** 1 **Agenda Date:** 3/7/2017

Subject:
Proposed settlement in the matter of United States ex rel. Dean v. Paramedics Plus, LLC, Pinellas County Emergency Medical Services Authority, et al., 4:14-cv-203 (E.D. TX).

Recommended Action:
Approval of the proposed settlement in the matter of United States ex rel. Dean v. Paramedics Plus, LLC, Pinellas County Emergency Medical Services Authority, et al.

Strategic Plan:
N/A

Summary:
The above-referenced matter is being brought to the Board of County Commissioners for consideration in accordance with the confidential memorandum of February 22, 2017.

Background Information:
N/A

Fiscal Impact:
Unknown.

Staff Member Responsible:
James L. Bennett, County Attorney
Donald S. Crowell, Managing Assistant County Attorney

Partners:
N/A

Attachments:
N/A

CLIENT MEMORANDUM

CONFIDENTIAL ATTORNEY-CLIENT PRIVILEGED COMMUNICATION

TO: The Chairman and Members of the Board of Pinellas County Commissioners sitting as the Pinellas County Emergency Medical Services Authority

FROM: A. Brian Albritton, Esq.
Blake Adams, Esq.
Phelps Dunbar LLP

THROUGH: James L. Bennett, County Attorney JLB

DATE: February 22, 2017

RE: **Executive Summary** of Analysis of Potential False Claims Act Exposure and Evaluation of Settlement Offer in *United States ex rel. Dean v. Paramedics Plus, LLC, Pinellas County Emergency Medical Services Authority, et al.*, 4:14-cv-203 (E.D. TX)

In April 2014, a former employee of Paramedics Plus, Stephen Dean ("Relator"), filed a *qui tam* False Claims Act suit, under seal, in the U.S. District Court for the Eastern District of Texas, *United States ex rel. Dean v. Paramedics Plus, LLC et al.*, 4:14-cv-203, wherein Relator alleged that Paramedics Plus and Pinellas County Emergency Medical Association ("PEMSA") violated federal and Florida False Claims Acts. This document is an executive summary of a more extensive analysis of the claims and background concerning this suit along with our recommendation regarding the proposed settlement with the U.S. Attorney for the Eastern District of Texas and with the Florida Attorney General's Office ("the Government").

During 2004 to 2015, PEMSA exclusively contracted with Paramedics Plus to provide all emergency and non-emergency ambulance transportation services for the County-wide District. PEMSA negotiated payments to Paramedics Plus for these services, and one component of the payment formula was a "profit cap." Proposed publicly by Paramedics Plus in 2004 and incorporated into the Agreement, the profit cap provision capped "earnings before taxes at nine percent (9%) [and] utilized profits in excess of nine percent (9%) for the EMS system." Since 2004, the profit cap was only triggered once in FY 2013, resulting in a payment of $35,600 to the EMS system in FY 2014.

Essentially, the Government and Relator claim that PEMSA violated the Anti-Kickback Statute, 42 U.S.C. § 1320a–7b(b)(1)(B), which makes it illegal to knowingly and willfully solicit or receive any remuneration such as a kickback, bribe, or rebate "in return for purchasing . . . any good, facility, service . . . for which payment may be made . . . under a Federal health care program." The Government chiefly claims that PEMSA's decision to contract with Paramedics Plus in 2004 was improperly influenced by the offer of a profit cap and that the profit cap

qualifies as an illegal kickback or rebate of profits. These alleged kickback violations, the Government claims, tainted each claim for ambulance services submitted by PEMSA to Medicare, Medicaid, or Tricare during the 11-year term of the Agreement, and therefore each PEMSA claim for federal or state reimbursement for ambulance services amounted to a violation of the Florida and federal False Claims Acts.

On behalf of the United States and HHS-OIG, the U.S. Attorney has offered to fully settle PEMSA's alleged state and federal False Claims Act liability, without any admission of liability by PEMSA, for a total amount of: $92,700 - $71,200.00 in alleged damages and $21,500 in the Relator's attorneys' fees - which the federal and state False Claims Acts require PEMSA to pay. The settlement also gives rise to indirect costs: once the agreement is executed by all parties and becomes effective, the settlement requires that PEMSA forgo any further collections of Medicare, Medicaid, and TriCare claims (including co-pays and deductibles) that arose prior to September 30, 2015 *and that remain uncollected as of the date of the settlement*. (This does not affect collections for charges incurred on or after October 1, 2015). PEMSA, however, has collected nearly all it can for this period, including most of 2015's federal reimbursements – approximately $275,000,000 overall. Based on historical projections for collecting aged accounts receivable relating to ambulance transports, the County estimates that the actual amount of revenue that PEMSA would have realistically collected on such remaining claims using reasonable methods of collection would have been around $500,000 or .18% of overall amount collected for the period. Finally, the settlement includes a release of civil and administrative liability under the False Claims Act and related statutes, but that release does not extend to criminal sanctions or to individuals.

Although we question whether PEMSA's contract with Paramedics Plus amounted to an actual violation of the Anti-Kickback statute, and believe that PEMSA may have one or more meritorious defenses to Relator's *qui tam* suit, we recommend PEMSA accept the Government's settlement offer for the following reasons:

1) The False Claims Act creates catastrophic financial exposure for PEMSA due to its treble damages provisions and statutory penalties of between $5,500 and $11,000 *per claim* submitted. The aggregate possible exposure for PEMSA could easily be in excess of $1,000,000,000. Even if the matter did not proceed to trial and settled, the potential catastrophic damage exposure would likely result in an oppressive settlement amount as well.

2) The litigation costs to defend this suit would be enormous and would likely exceed $2,000,000 prior to trial. Additionally, unless PEMSA were able to obtain a change of venue, the proceedings would be conducted in the federal court for the Eastern District of Texas.

3) By agreeing to the settlement offer, PEMSA will be able to definitively and finally resolve and obtain a release of these allegations for a relatively modest sum certain, rather than facing potentially large but uncertain future litigation costs.

4) The Government's refusal to include releases of individual liability does not reflect any intent to bring a future prosecution or FCA action. Rather, the Government does not include individual releases in FCA claims as a matter of policy. In turn, we simply do not find any real basis for a criminal prosecution or continued FCA claim against any individual.

In sum, based on our analysis of all the factors discussed above, we recommend accepting the Government's settlement offer.

CLIENT MEMORANDUM

CONFIDENTIAL ATTORNEY-CLIENT PRIVILEGED COMMUNICATION

TO: The Chairman and Members of the Board of Pinellas County Commissioners sitting as the Pinellas County Emergency Medical Services Authority

FROM: A. Brian Albritton, Esq. ABA
S. Blake Adams, Esq.
Phelps Dunbar LLP

THROUGH: James L. Bennett, County Attorney JLB

DATE: February 22, 2017

RE: Analysis of Potential False Claims Act Exposure and Evaluation of Settlement Offer in *United States ex rel. Dean v. Paramedics Plus, LLC, Pinellas County Emergency Medical Services Authority, et al.*, 4:14-cv-203 (E.D. TX)

As explained more fully below, a "relator" has brought a state and federal False Claims Act *qui tam*[1] against Pinellas County Emergency Medical Services Authority ("PEMSA") and Paramedics Plus, LLC, the company with whom PEMSA contracts for ambulance services, in federal court in the Eastern District of Texas.[2] The *qui tam* alleges, among other things, that PEMSA solicited or received illegal kickbacks while contracting for ambulance services and as a result submitted

[1] The False Claims Act ("FCA") permits either the Attorney General or a private party to initiate a civil action alleging fraud on the federal government. A private enforcement action under the FCA is called a *qui tam* case, and the private party who brings it on behalf of the government is referred to as the "Relator." When a Relator initiates an FCA action, the United States is given a period of time (at least 60 days) to investigative the claim, under seal, and decide whether it will intervene and proceed with the action. In this case, the United States has chosen not to intervene as to PEMSA, and therefore unless this matter is settled, the Relator has the right to continue its *qui tam* against PEMSA on behalf of the United States. *U.S. ex rel Eisenstein v. City of New York*, 129 S.Ct. 2230, 2232 (2009). 31 U.S.C. §3730(c)(1). As explained below, the Florida False Claims Act has a similar *qui tam* provision.

[2] The suit also includes allegations and claims that Paramedics Plus and its parent company paid kickbacks to other ambulance authorities in other states. These claims are unrelated to PEMSA.

false claims to the Medicare, Medicaid, and/or Tricare programs. Together with the Pinellas County Attorney's Office, we have negotiated a draft settlement agreement on behalf of PEMSA with the U.S. Attorney for the Eastern District of Texas and with the Florida Attorney General's Office, Medicaid Fraud Control Unit.

As set forth in more detail below, we believe that it is unclear - at best - whether PEMSA's conduct in including a profit cap in its 2004 contract with Paramedics Plus could form the basis for a violation of the federal Anti-Kickback Statute and result in the submission of false claims. However, because of the potentially catastrophic damages and penalties arising under the federal and state False Claims Acts, the likely massive litigation costs to defend against these claims, and the relatively modest settlement offer from the government, we recommend PEMSA accept the Government's settlement offer and draft settlement agreement.

BACKGROUND FACTS

PEMSA's Ambulance Services Agreement with Paramedics Plus

PEMSA is a special district and authority created in 1980 by a special act of the Florida legislature for the purpose of providing a county-wide emergency medical services system within Pinellas County, Florida (herein "the District"). PEMSA is governed by the Pinellas Board of County Commissioners which sits as the Board of PEMSA (herein "the Board") and utilizes a "public utility model" to provide, among other things, emergency and non-emergency transportation services within Pinellas County, Florida.

PEMSA operates a contracted ambulance service under the Pinellas County tradename "Sunstar Paramedics." PEMSA has, since 2004, exclusively contracted with Paramedics Plus to provide ambulance services for PEMSA. PEMSA is responsible for handling a large volume of ambulance services. For example, in FY 2015/2016, PEMSA provided a combined total 172,802 emergency/non-emergency transports.[3]

In 2004, PEMSA issued a request for proposal for providing ambulance services to the District, and three proposals were received and scored according to several different criteria. Two different committees evaluated the proposals. They

[3] www.pinellascounty.org/publicsafety/ems_overview.htm

both scored Paramedics Plus as the highest of the three and recommended that PEMSA accept Paramedics Plus's proposal. The Board of County Commissioners, sitting as the board of PEMSA, adopted that recommendation.

An "Ambulance Service Agreement" ("Agreement") was negotiated in 2004 with Paramedics Plus. The Agreement was renewed and amended, most recently on October 1, 2014, and its term ended on September 30, 2015.[4] To be operated under the County's "Sunstar" trade name, the Agreement provided that Paramedics Plus was responsible for providing all emergency and non-emergency ambulance transportation in the District. PEMSA, in turn, provided certain negotiated payments to Paramedics Plus for providing these services. PEMSA, however, remained responsible for the overall operation of Sunstar, as well as for billing patients and third-party payors, including Medicare and Medicaid, for ambulance and other related services that were provided.

One component of the payment formula included in the Agreement, both initially and as amended, was a "profit cap."[5] When negotiating the Agreement with PEMSA in 2004, Paramedics Plus proposed a profit cap whereby it would cap "earnings before taxes at nine percent (9%) [and] utilize profits in excess of nine percent (9%) for the EMS system." PEMSA accepted Paramedic Plus's profit cap provision, which was openly and publicly disclosed at the time,[6] and it was incorporated into the Agreement. During the course of the Agreement, the profit cap was only triggered once, resulting in a payment of $35,600 to the EMS system in FY 2014.

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[4] As a result of a 2014 request for proposal, PEMSA entered into a new contract with Paramedics Plus effective October 1, 2015 and running through September 30, 2020. The proposed settlement does not apply to the new contract with Paramedics Plus.

[5] PEMSA's most recent ambulance agreement with Paramedics Plus that commenced on October 1, 2015 does not include a profit cap. The cap provision was eliminated in the 2014 request for proposal, *before* PEMSA learned that an FCA suit against it and others had been filed underseal.

[6] For example, in addition to the profit cap being incorporated as a specific term on the face of the Agreement, a 2004 memo prepared by the directors of Pinellas County's Purchasing Department and EMS and Fire Administration Department repeatedly referenced the profit cap. This memo can be found on the web at www.pinellascounty.org/purchase/ARCHIVED_BIDS/034_283_P(AM)AGENDA.pdf

False Claims *Qui Tam* Filed Against PEMSA in Eastern District of Texas

On or about April 3, 2014, a former employee of Paramedics Plus, Stephen Dean ("Relator"), filed a False Claims Act action, under seal,[7] in the United States District Court for the Eastern District of Texas captioned *United States ex rel. Dean v. Paramedics Plus, L.L.C.*, et al., 4:14-cv-203, pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b) and the Florida False Claims Act, Fla. Stat. § 68.083, against several defendants, including Paramedics Plus and PEMSA. Other than Paramedics Plus, the Complaint's allegations against other defendants in other states are unrelated to PEMSA.

With respect to PEMSA, the Complaint alleged that PEMSA violated the federal False Claims Acts, 31 U.S.C. § 3729, because PEMSA allegedly had solicited or accepted illegal remuneration – kickbacks - from Paramedics Plus in violation of conditions for payment governing the reimbursement of Medicare claims. Relator also alleged that PEMSA violated the Florida False Claims Act, Fla. Stat. § 68.08, with respect to Medicaid claims for ambulance related services based on these same kickback allegations. The Relator alleged that the Agreement's profit cap qualified as a kickback offered by Paramedics Plus in return for PEMSA awarding it an exclusive contract. Comp. ¶ 63.

In support of his position, the Relator cited to a nonbinding, though authoritative, U.S. Department of Health and Human Service-Office of Inspector General ("HHS-OIG") Advisory Opinion No. 13-18 (November 27, 2013). In that Advisory Opinion, HHS-OIG addressed the scenario of a city that issued an RFP for emergency ambulance services and as part of that RFP, required that the RFP's successful bidder provide the City with certain free and specified services.[8] Of this arrangement, the Advisory Opinion observed:

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[7] Section 3730(b)(2) of the FCA provides that a *qui tam* complaint is filed "in camera" and "remain under seal" until the Court permits otherwise. This case remained under seal until January 17, 2017, and PEMSA and its counsel were not authorized to reveal its existence until it was unsealed.

[8] In PEMSA's contract with Paramedics Plus, PEMSA alone is responsible for billing, including the billing of Medicare/Medicaid. In the cited Advisory Opinion scenario, however, "the successful bidder will bill patients and their respective third-party payors, including Federal health care programs, for emergency ambulance services rendered."

> The items and services that the City would require the successful bidder to provide at no charge or pursuant to a nominal value lease - the Services, the Equipment, and the Training - are particularly suspect. These items and services are, and would remain, solely the City's expenses to incur, regardless of its decision to contract with a private ambulance supplier for the provision of emergency ambulance services in the City. Thus, the provision of these items and services at nominal or no cost to the City in exchange for the opportunity to be the City's exclusive supplier of emergency ambulance services, including those payable by Federal health care programs, would fit squarely within the language of the anti-kickback statute.

Settlement Discussions and Preparation of Draft Settlement

Several months ago in 2016, the U.S. Attorney's Office for the Eastern District of Texas contacted the Pinellas County Attorney's Office to discuss settlement of this matter. The U.S. Attorney informed us while it did not wish to intervene and purse this action against PEMSA, it did wish to settle the matter. During this time and up until January 17, 2017[9], the case remained under seal in federal court in Texas, and we and the Pinellas County Attorney's Office were restrained by federal law and the Court for disclosing the suit's existence. In fact, the Court only partially lifted the seal so that the U.S. Attorney could approach PEMSA.

On behalf of the United States and HHS-OIG, the U.S. Attorney proposes to fully settle PEMSA's alleged state and federal False Claims Act liability for a settlement amount of $71,200.00, which represents double the amount that was paid by Paramedics Plus to EMS for the one year the profit cap was exceeded. Additionally, in conjunction with the federal and state False Claims Acts, PEMSA is required to pay the Relator's attorneys' fees which are $21,500. Hence, the total amount that PEMSA will be responsible to pay in the event the Board agrees to the settlement is $92,700.

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[9] The Court's order lifting the seal on the case and complaints was issued on January 17, 2017. See Dkt. 26, E.D. TX, 4:14-Cv-203-ALM.

Among its many provisions, the settlement also requires that PEMSA suspend all further efforts to collect Medicare, Medicaid, and TriCare reimbursement for ambulance services provided by PEMSA/Paramedics Plus prior to September 30, 2015. PEMSA, however, has already collected the vast amount of federal health care billings (including co-pays and deductibles) for ambulance services provided during the 2004 – 2015 period: approximately $275,000,000 for the entire period. PEMSA is not required to reimburse or pay back the federal government or Florida for any payments received to date by Medicare, Medicaid, or Tricare for services previously provided by PEMSA during this 11 year time period.

According to its terms, the draft settlement does not constitute an admission of liability and PEMSA denies the allegations that it violated the False Claims Act. The draft settlement includes a release of PEMSA's civil and administrative liability under the False Claims Act and related statutes, but that release does not extend to criminal sanctions or to individuals. As explained below, we simply do not believe there is any likelihood of criminal prosecution or further civil action against any individual.

Together with the Pinellas County Attorney's Office, we negotiated the settlement over several months. Much of that negotiation concerned our efforts to either extend the releases, better define the release conduct, challenge the requirement to suspend all further efforts at collections for Medicare, TriCare, and Medicaid billings that arose before September 2015. The U.S. Attorney's Office for the Eastern District of Texas and attorneys for the Department of Health and Human Services agreed to almost none of our proposed changes to the draft agreement, and therefore, with very few exceptions, almost all of the draft language derives from them and reflects their standard (and one-sided) provisions for such agreements.

FEDERAL ANTI-KICKBACK STATUTE AND FALSE CLAIMS ACT OVERVIEW

1. Federal Anti-Kickback Statute

The Medicare and Medicaid Anti-Kickback Statute ("Anti-Kickback Statute"), 42 U.S.C. § 1320a-7b, prohibits the knowing and willful offer or payment

of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind to induce (i) the referral of patients for services covered under any federal health care program, including Medicare or Medicaid, or (ii) the purchasing, leasing, ordering or arranging for, or recommending the purchase, lease or order of any good, facility, service, or item covered under a federal health care program. In addition to the prohibition of the "offer or payment" of remuneration, the knowing and willful solicitation or receipt of remuneration related to these activities is also prohibited.

The term "any remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind,[10] and the term "to induce" connotes an intent to exercise influence over the reason or judgment of another in an effort to cause the referral of federal health care program-related business.[11] An actual agreement to refer is not required.

The statute has been broadly interpreted to cover any arrangement *where one purpose* of the remuneration is to obtain money for the referral of services or to induce further referrals. For example, if one purpose of the payment to a physician is to induce patient referrals, courts have ruled that such payments violate the Anti-Kickback Statute even if another purpose of the payment is to compensate the physician for professional services or the payment serves another legitimate purpose.[12] In short, a violation of the Anti-Kickback Statute generally requires a determination that something of value has been given to physicians or other persons or entities for the purpose of inducing their referrals of patients for services covered under a federal health care program.[13]

The Anti-Kickback Statute punishes the intent to induce or reward referrals for services that are paid for by federal health care dollars. In *U.S. v. McClatchey*, the Court of Appeals for the Tenth Circuit explained improper intent as follows:

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[10] *See* OIG Advisory Opinion No. 03-15 (December 18, 2003).

[11] *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995).

[12] *See U.S. v. Davis*, 132 F.2d 1092 (5th Cir. 1998); *U.S. v. Kats*, 871 F.2d 105 (9th Cir. 1989); *U.S. v. Greber*, 760 F.2d 68 (3d Cir. 1985).

[13] A "federal health care program" includes any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the U.S. Government (other than the Federal Employees Health Benefit Program), as well as state health programs such as Medicaid. *See* 42 U.S.C. § 1320a-7b(f) and (h). Specifically, as applied to this analysis, the term includes Medicare, Medicaid, and TriCare.

> [I]n order to sustain its burden of proof against the hospital executives for the crime of violating the Anti-Kickback statute, the government must prove beyond a reasonable doubt that the defendant under consideration offered or paid remuneration for the specific criminal intent "to induce" referrals. To offer or pay remuneration to induce referrals means to offer or pay remuneration with the intent to gain influence over the reason or judgment of a person making referral decisions. The intent to gain such influence must, at least in part, have been the reason the remuneration was offered or paid. (emphasis in original).

The *McClatchey* court continued:

> . . . McClatchey cannot be convicted merely because [he] hoped or expected or believed that referrals may ensue from remuneration that was designed wholly for other purposes. Likewise, mere oral encouragement to refer patients or the mere creation of an attractive place to which patients can be referred does not violate the law. There must be an offer or payment of remuneration to induce, as I have just defined it.[14]

HHS has developed "safe harbor" regulations (in addition to the statutory safe harbors) specifying payment practices that do not violate the Anti-Kickback Statute.[15] For a business arrangement to comply with one of the safe harbors, each provision of the safe harbor must be met. The safe harbor regulations cover, among other arrangements, investments in entities in underserved areas, hospital/physician ambulatory surgical centers, space rental, equipment rental, personal services and management contracts, and *bona fide* employees.

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[14] *U.S. v. McClatchey*, 217 F.3d 823 (10th Cir. 2000). In 2010, the Patient Protection and Affordable Care Act clarified that the government need not prove that the parties intended to violate the statute, but merely that the parties knowingly entered into an arrangement with the intent to induce referrals. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f)(2).

[15] *See* 42 C.F.R. § 1001.952.

Arrangements that do not fit within a safe harbor do not necessarily violate the Anti-Kickback Statute. If an arrangement does not comply with a safe harbor, the OIG analyzes the arrangement to determine whether the Anti-Kickback Statute is violated based on the facts and circumstances of the matter. Where individuals and entities have entered into arrangements that implicate the Anti-Kickback Statute and where the arrangements do not fully comply with a safe harbor regulation, the arrangements are subject to scrutiny by the OIG and may be subject to civil or criminal enforcement action.

Penalties for violation of the Anti-Kickback Statute can include criminal (felony) penalties, administrative fines, and exclusion from federal health care programs.[16] These penalties include fines of up to $25,000 per violation, imprisonment for up to five years, or both. Most importantly for our purposes, violations of the Anti-Kickback Statute can qualify as violations under the False Claims Act, as set forth below.

2. False Claims Act Overview

The FCA provides that a false claim to the Government arises when:

> (a) (1) . . . any person . . .
>
> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or]
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim . . . . .

31 U.S.C. § 3729. Thus, for each false claim, a defendant is subject to a civil penalty of $5,500 to $11,000 as well as three times the amount of "damages" i.e., the reimbursed amount of the health care claim, which the Government sustained because of the violation.

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[16] Violations of either the Anti-Kickback Act or the False Claims Act can result in "exclusion from all Federal health care programs," Medicare Learning Network, Medicare Fraud & Abuse: Prevention, Detection, and Reporting (October 2016). An excluded entity cannot receive any payments from federal health care program (Medicare/Medicaid/Tricare) for services provided by the excluded entity to patients insured by those programs.

The False Claims Act contains a *qui tam* provision allowing private whistleblowers, subject to certain conditions, to bring FCA actions on behalf of the United States. 31 U.S.C. § 3730. The Government may decide to intervene in the case and prosecute it, or it may decline to intervene, and the Relator is then allowed to prosecute the case on behalf of the Government. If a Relator prevails, a FCA defendant is also liable for the Relator's costs and attorney's fees in addition to the fines and penalties discussed above.

In general, false claims under the FCA may be "factually false" or "legally false." "Factually false" claims could be understood to be those claims involving actual fraud, such as those cases where false statements are made to obtain government benefits. "Legally false" claims are generally based upon either an express or implied false certification made by the provider or company that provided the medical service to the patient. Essentially, when submitting a bill for reimbursement by Medicare/Medicaid/TriCare, medical providers and suppliers "certify" that they have complied with applicable laws and regulations governing payment of such claims. If the provider or supplier knows that the Medicare claims they submitted for reimbursement did not comply with applicable laws governing the payment of claims, then their "false certification" of compliance causes them to submit "false" claims for payment.

Alleged violations of the Anti-Kickback Statute by a healthcare provider may be used by *qui tam* relators as a springboard upon which to base violations of the FCA.[17] Plaintiffs in healthcare FCA actions frequently contend (as the Relator does here) that defendants violate the FCA by falsely certifying - either expressly or implicitly - their compliance with the Anti-Kickback Statute. For example, as referenced by the Relator in ¶38 of the Complaint, the Medicare 855B form (used to enroll in the Medicare program) contains a statement wherein the supplier is required to affirm that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to [me] . . . I understand that payment of a claim by Medicare is conditioned upon the claims and the underlying transaction complying with

[17] The Affordable Care Act specifically amended the Anti-Kickback Statute to provide that a "a claim that includes items or services resulting from a violation of [the Anti-Kickback Statute] constitutes a false or fraudulent claim for purposes of [the FCA]." 42 U.S.C. § 1320a-7b(g).

> such laws . . . included but not limited to the federal anti-kickback statute.[18]

For legally false claims arising from allegedly false certifications, the Government most often claims that a medical provider who falsely certifies compliance is not entitled to any reimbursement, *even if the provider did, in fact, provide the service to the patient and the service was medically necessary.* For example, according to the Government, if the medical service - such as an ambulance ride - was provided by a Medicare provider or supplier who had paid (or received) a kickback for the contract to provide medical services (such as ambulance rides), then that provider is not entitled to any reimbursement, even if the provider did not charge anything additional beyond the reimbursement rate for providing the service; it was the patient who "self-referred" by calling an ambulance, and in fact, the patient really required ambulance service. The Government's position in these cases is that it would not have paid these charges if it had known the provider's certification was false.

THE GOVERNMENT'S THEORY OF LIABILITY

As we understand it, the Government's theory of liability for PEMSA under the FCA is premised on an underlying violation of the Anti-Kickback Statute, specifically 42 U.S.C. § 1320a–7b(b)(1)(B) which makes it illegal to:

> knowingly and willfully **solicit or receive any remuneration** (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind -
>
> (A) . . . or
>
> (B) **in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program**. (emphasis added).

[18] CMS Form 855-B.

According to the Government's theory, PEMSA's decision to award the exclusive Ambulance Services Agreement for 2004 – 2015 to Paramedics Plus was improperly influenced by Paramedics Plus's offer of remuneration, *i.e.*, the profit cap and offer to rebate profits in excess of 9% back to EMS - to PEMSA. Additionally, the Government claims that from January 1, 2014 through September 30, 2015, Paramedics Plus improperly offered and paid certain corporate overhead costs to Pinellas EMSA as part of the Agreement. Therefore, according to the Government, the offer and payment of the "profit cap" as well as overhead allocations constituted "remuneration" which was "solicit[ed] or receive[d]" in return for purchasing ambulance services "for which payment may be made in whole or in part under a Federal health care program." As we understand the Government's theory, each claim for ambulance services submitted by PEMSA to Medicare, Medicaid, or Tricare during the entire term of the Agreement with Paramedics Plus was "tainted" by the alleged kickback violation and therefore constitutes a false claim.

Along with the HHS-OIG Advisory Opinion No. 13-18 cited above, the Government relies on "OIG Compliance Program Guidance for Ambulance Suppliers" wherein OIG previously stated back in 2003 that "[a]mbulance suppliers should not offer anything of value to cities or other EMS sponsors in order to secure an EMS contract."[19]

In our analysis, the Government's and Relator's FCA theory against PEMSA relies on an overly expansive interpretation of the term "remuneration" under the Anti-Kickback Statute. We are of the opinion that the profit cap is just one part of the overall contractual consideration agreed upon by PEMSA for the ambulance contract. In addition, we understand that Paramedics Plus's promise to return profits in excess of 9% to EMS was simply PEMSA, as a governmental body, extracting a concession to benefit its overall mission to taxpayers.

The Government, however, views the profit cap provision in isolation, and it essentially claims - regardless of all other factors - that the promise to accept no more than a 9% profit and return any excess to EMS is a remuneration paid by

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[19] 68 *Federal Register* 14245, 14252 (Mar. 24, 2003). Neither the Advisory Opinion nor the "Program Guidance" qualify as binding legal statutes or regulations. Rather, both documents reflect HHS-OIG's interpretation of the Anti-Kickback Statute when applied to ambulance service contracts and should be considered nonbinding authoritative guidance.

Paramedics Plus to obtain the contract from PEMSA. The Government appears to be taking this position in large part because it believes there are other jurisdictions where ambulance companies have unlawfully enticed municipalities and districts to refer them Medicare-reimbursed services in return for payments. By obtaining a settlement from PEMSA, we believe that the Government wishes to send a clear message to municipalities, special districts, and counties who contract for ambulance services that rebate or profit cap arrangements violate the Anti-Kickback Statute.

Overall, we believe that in the event this matter proceeded, the Government and/or the Relator would have difficulty proving that PEMSA and those who evaluated the contract and recommended its approval had the requisite intent to violate the Anti-Kickback Statute. *See, e.g. United States ex rel. Jamison v. McKesson Corp.*, 900 F. Supp. 2d 683, 695 (N.D. Miss. 2012) (finding no anti-kickback violation - and thus no FCA violation - where service agreements between the parties were reached "in business negotiations that were fair, reasonable, and warranted under the facts of this case."). Moreover, PEMSA may have additional defenses to Relator's suit, such as the "public disclosure bar" because the so-called incriminating facts of the profit cap were subject to widespread public dissemination since 2004.[20]

Finally, this case also differs from a "typical" kickback arrangement in that PEMSA - the entity accused of receiving prohibited remuneration - is also the entity that both bills and receives the payments from governmental payors. The alleged "kickback" here is arguably nothing more than PEMSA negotiating for lower prices for contracted services from a vendor.

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[20] The "public disclosure" bar is found at 31 U.S.C. § 3730(e)(4). Prior 2010, the public disclosure bar provided that unless the Relator was an "original source" of the allegations of fraud contained in their *qui tam* False Claims Act suit, a court was without jurisdiction to hear that *qui tam* suit if substantially the same allegations of fraud had been publically disclosed prior to the Relator filing suit. Moreover, as defined by the FCA, a "public disclosure" only occurred if the allegations of fraudulent conduct had been previously revealed or disclosed in a criminal, civil or administrative hearing, in a congressional, administrative or [GAO] report, hearing, audit or investigation, or from the news media. Amended in 2010, the public disclosure bar of the False Claims Act was narrowed substantially. It remains as a defense to a Relator's *qui tam* suit, but it is no longer jurisdictional and the Government can now elect to prevent a *qui tam* from being dismissed on the basis of a prior public disclosure.

In short, we question the Government's theory of PEMSA's liability for alleged Anti-Kickback violations and whether it can and should be applied to PEMSA's Agreement with Paramedics Plus. Notwithstanding our serious misgivings about the Government's legal position (which we made known to the Government), for the reasons set forth below we recommend PEMSA accept this settlement given its small financial impact when compared to the huge costs in attorney's fees, not to mention exposure to potentially catastrophic civil penalties, that would cost PEMSA to fight it.

PEMSA'S POTENTIAL EXPOSURE UNDER THE FCA

If the Government's theory of Anti-Kickback liability were accepted by a Court, PEMSA's exposure under the draconian fines and penalty structure of the FCA could be a financial catastrophe.

a. Treble Damages Provision

As stated above, the FCA provides if a person commits one of the enumerated statutory violations, that person is liable to the Government for "3 times the amount of damages which the Government sustains because of the act of that person." In the context of FCA cases involving kickback violations (or analogous violation of the *Stark* law), *courts have routinely held that the proper measure of the Government's damages is the entire amount of the Government's payment for the tainted claims.*[21]

Therefore, if the Government's and Relator's theory of liability were accepted, PEMSA would likely be liable to the Government (or the Relator) for three times the total amount of ambulance service related payments received from Medicare, Medicaid, or Tricare during the 11 year time period when the alleged violations occurred. As we understand it, PEMSA received approximately $275,000,000 in federal healthcare program payments during the relevant 11 year time period, **which would result in approximately $825,000,000 in liability to the Government** under this damages provision alone.

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[21] *See, e.g. United States v. Rogan,* 517 F.3d 449 (7th Cir. 2008) (Violation of Stark law); *Freedman v. Suarez-Hoyos*, 2012 WL 4344199, at *4 (M.D. Fla. Sept. 21, 2012) (damages resulting from the payment of false claims tainted by a kickback arrangement equals the "full amount that Medicare paid on such claims"); *Drakeford v. Tuomey*, 976 F. Supp. 2d 776, 787 (2013), aff'd 792 F.3d 386 (4th Cir. 2015).

b. Statutory Penalties

As stated above, along with treble damages, the FCA imposes civil penalties for each false claim submitted of not less than $5,500 and not more than $11,000 *per claim*.[22] Courts have construed each "claim" under the FCA to be synonymous with each individual Medicare claim (CMS-1500 form or electronic equivalent) submitted for payment – essentially each event of ambulance service provided by PEMSA and reimbursed by a federal payor.[23]

As stated above, in FY 2015/2016, PEMSA provided approximately 172,802 emergency/non-emergency transports. Approximately 60% of these total ambulance transports were provided to federal health care beneficiaries (Medicare, Medicaid, TriCare): 103,681 transports. **Even applying the minimum penalty amount of $5,500 per claim to this one year, that could result in FCA liability of approximately $570,245,500 in penalties alone.** PEMSA would be facing similar catastrophic penalties for each year back to 2004.[24]

SETTLEMENT AGREEMENT RECOMMENDATIONS

The Government has offered to settle and fully resolve *with PEMSA* the Anti-Kickback violations for the sum of $71,200.00, and the Relator has separately

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[22] 81 *Federal Register* 42491, 42494 (June 30, 2016). For violations occurring after November 2, 2015, the penalty per claim has been increased to $10,781 to $21,563 per claim.

[23] *See e.g. United States v. Krizek*, 111 F.3d 934 (D.C. Cir. 1997); *United States ex rel. Walker v. R&F Properties of Lake County*, 433 F.3d 1349, 1352-53 (11th Cir. 2005) ("These claims are made on HCFA 1500 forms in electronic form, as required by the Medicare regulations . . . [Defendant] further concedes that the submission of the HCFA 1500 forms constitutes the presentation of claims for purposes of the False Claims Act"); *United States ex rel. Antoon v. Cleveland Clinic Foundation*, 978 F. Supp. 2d 880, 890 (S.D. Ohio 2013) ("Each submission of the HFCA-1500 or an electronic equivalent meets the first two elements of an FCA action because it qualifies as a claim made to the United States Government."); *United States v. Rogan*, 459 F. Supp. 2d 692 (N.D. Ill. 2006) (holding each UB-92 submitted constituted a "claim" based on certification of compliance with the Stark and Anti-Kickback statute contained on the hospital cost report)

[24] The statute of limitations for the FCA may range from six to ten years, depending on the facts of the case. 42 U.S.C. § 3731(b)(1) and (b)(2). As noted in footnote 16 above, a violation of the False Claims Act can also result in exclusion from participation in (and the right to receive payment from) Medicare, Medicaid, and Tricare.

agreed to the payment of $21,500 in attorney's fees. Hence, PEMSA would be responsible for an upfront settlement payment of $92,700.

The indirect costs of the settlement are minimal when contrasted with the overall collections to date: as of the effective date of the settlement, PEMSA must forgo any further collections of Medicare, Medicaid, and TriCare claims (including co-pays and deductibles) that arose prior to September 30, 2015 and remain uncollected. Since 2004, PEMSA has collected approximately $275,000,000, nearly all PEMSA can for this period, including most of 2015's federal reimbursements. Therefore, the County estimates that based on historical projections for collections of aged accounts receivables relating to ambulance transports, foregoing any further collections will cost it approximately $500,000 in anticipated revenue.[25] That is, the actual amount PEMSA would have realistically collected on such remaining claims using reasonable methods of collection, and it represents .18% of overall amount collected for the period.

Although we question whether PEMSA's contract with Paramedics Plus amounted to an actual violation of the Anti-Kickback statute, and believe that PEMSA may have one or more meritorious defenses to Relator's *qui tam* suit, we recommend accepting the Government's settlement amount because of the potentially catastrophic exposure which could result from even a partial victory by

[25] The net lost revenue was calculated as follows. Historically, over a six year period PEMSA collects approximately 70% of the total charges/billings for ambulance related services provided to patients who are covered by federal payers such as Medicare, Medicaid, and Tricare; 30% are found to be uncollectable. The uncollectable portion consists mainly of co-pays, deductible, and non-covered charges owed by the patients. PEMSA's past due accounts are sent to collections, but of the 70% collected by, PEMSA, 98.6% of the total collections come in the first two years, 84.9% in the first year alone; only 1% of the outstanding amount is collected in years 3 – 6. The 30% of charges that are found to be uncollectable are essentially ignored or written off as bad A/R, and are excluded from the annual audited financial statement that covers PEMSA. As of mid-December 2016, the running five year balance for the FY11- FY15 period (which is the five year statute of limitations for PEMSA to legally enforce collections) in uncollected amounts from federal payers was $13,764,556. With PEMSA having already collected over 95% of what it anticipated it would collected for this 5 year period, PEMSA estimated as of mid-December 2016 that it only will collect 4.2% of this outstanding A/R or $578,318. As any settlement cannot be final before March 2017, this net amount will decrease further due to collections during this interim period.

the Relator, large litigation costs to defend this claim, and the Government's modest settlement request.

First, as set forth above, False Claims Act liability creates massive financial exposure for PEMSA. If the Government and/or Relator prevailed, PEMSA could be forced to repay up to three times the total amount of federal healthcare program payments it has received from any claims tainted by the kickback arrangement, as well as a statutory penalty of between $5,500 and $11,000 per claim submitted. As we understand it, the aggregate possible exposure for PEMSA could be easily in excess of a $1,000,000,000. Even if the matter did not proceed to trial and settled, if PEMSA did not win on a motion to dismiss, then the potential catastrophic damage exposure would likely result in an oppressive settlement amount as well.

Second, even though the Government has declined to intervene against PEMSA, should PEMSA reject the settlement offer, the Relator would still be able to proceed with the *qui tam* suit. The litigation costs to defend this suit could be enormous, and would likely exceed $2,000,000 prior to trial. Additionally, unless PEMSA were able to obtain a change of venue, the proceeding would be conducted in the federal court for the Eastern District of Texas, which is known as a friendly forum for *qui tam* plaintiffs. Yet, by agreeing to the settlement offer, PEMSA will be able to definitively and finally resolve and obtain a release of these allegations for a relatively modest sum certain, rather than facing potentially large but uncertain future litigation costs.

As we note above, an additional factor to consider is that the Government has steadfastly refused *as a matter of policy*[26] to provide a release of individual liability for PEMSA's board members, managers, directors, or employees. Thus, while we would have liked to include such releases, we do not believe that such a release is necessary for the settlement of this matter. While it is, at best, *theoretically* possible that the Government could bring individual civil or criminal charges against individuals at PEMSA for alleged violations of the Anti-Kickback Statute or the FCA, we strongly believe there is no likelihood that will ever occur. The

[26] In 2015, the U.S. Department of Justice issued a policy statement regarding "Individual Accountability for Corporate Wrongdoing," and referred to as the "Yates Memo," authored by DOJ Deputy Attorney General, Sally Yates. The Yates memo sets forth guidance to be used by DOJ civil and criminal attorneys "in any investigation of corporate misconduct" in order to "hold to account the individuals responsible for illegal corporate conduct."

Government's refusal to include releases does not reflect any intent to conduct a future prosecution or FCA action – indeed, except for the purposes of settlement, it is not even intervening in this action. Rather, as noted above, the Government does not include individual releases as a matter of policy.

In turn, there is really is no basis for a criminal or FCA case against an individual affiliated with PEMSA: no individual at PEMSA, the Board, or the County profited as a result of the profit cap. No one got anything; there is no individual wrongdoing. Indeed, we do not see any evidence that anyone at PEMSA, the Board, or the County ever realized there was anything suspect, let alone illegal, about the Agreement's profit cap. It was openly discussed in public documents, incorporated in a contract that was subject to public review, and it was reviewed by a number of people who never objected to the profit cap. We simply do not find any real basis for a criminal prosecution or continued FCA claim against any individual.

In sum, based on our analysis of all the factors discussed above, we recommend accepting the Government's settlement offer.