Chapter 8: 
Fraud and Abuse

1. Introduction

Attempts to defraud the government and abuse of government health care programs are pervasive problems in the U.S. health care system. Mindful of these problems, Congress has enacted numerous laws that specifically target health care fraud and abuse. With these laws, the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) have a variety of tools at their disposal — both at the administrative and judicial level — to hold health care providers to an appropriate standard of accountability.

These tools, though, can cause financial ruin for providers that become a target of an investigation. When the Office of the Inspector General (OIG) of the HHS or another federal or state agency begins an investigation, the investigators have ample time and resources to seek out a pattern of misconduct. For a provider, the ramifications of this investigation can come in several forms. First, providers can expend a significant amount of their own time and resources while defending against allegations of fraud and abuse. This expenditure of time and resources cannot be recaptured, even if the provider is ultimately exonerated. Second, the sanctions that may be imposed on a provider, including suspensions and exclusion from the Medicare and Medicaid programs, can significantly impair the affected provider’s operating performance and cash flow. Since reimbursements from these programs often constitute a significant portion of a provider’s revenues, an interruption of payments for an indefinite period of time can impair liquidity and, in some instances, threaten the affected provider’s ability to continue as a going concern. Third, a conviction for fraud and abuse can result in steep civil fines totaling hundreds of thousands of dollars or more. All in all, these ramifications can be devastating for a provider as it seeks to survive in the market, especially if the provider is already a distressed entity.

Consequently, distressed providers may look to the bankruptcy courts for a fresh start. Under some circumstances, the provider may be able to obtain protection from its creditors. Through either liquidation or reorganiza-
tion, the provider may attempt to utilize the protections of a bankruptcy filing in an effort to resolve some of its debts and improve its financial position.

In many cases, however, traditional bankruptcy protections such as the automatic stay will not apply to the government when the government alleges fraud and abuse. Specific exceptions in the Bankruptcy Code protect the government’s interest in preventing harm to the health care system; however, these exceptions are not without limits. The relevant provisions of the Bankruptcy Code permit in many instances a balancing of the competing interests of creditors and debtors, and, where appropriate, limit certain government enforcement actions. Therefore, bankruptcy attorneys and health care professionals should be mindful of the principal fraud and abuse laws impacting providers, and the way in which these laws intersect with the procedural and substantive course of bankruptcy proceedings.

Successor entities in bankruptcy should also be aware of the ramifications of these fraud and abuse laws. While a properly structured acquisition should limit the successor entity’s liability for the fraud and abuse of its predecessor, the case law in this area continues to develop. Therefore, successor entities need to take steps before and during negotiations to protect themselves against unforeseen liabilities.

Over the past decade, the fraud and abuse laws relevant to this discussion have been in a constant state of flux. The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA) made one notable change regarding Medicare exclusions. More recently, on March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010. Though PPACA is known for its landmark provisions relating to health care access and delivery, PPACA also added numerous provisions that amend the fraud and abuse statutes. For example, the law amends both the Anti-Kickback Statute and False Claims Act and, in effect, will make it easier for the government to prove violations of these laws. PPACA also strengthens the government’s enforcement mechanisms by broadening its ability to suspend Medicare payments and by increasing the penalties for health care fraud convictions. In turn, these PPACA provisions have the potential to create further ripple effects in bankruptcy proceedings. 

289 During the 2011-12 term, the Supreme Court heard several constitutional challenges to
This chapter first outlines the principal fraud and abuse laws that affect providers. It then discusses how the enforcement of these laws intersects with the Bankruptcy Code, and how debtors and creditors might respond most appropriately to the effects of these enforcement actions. The chapter then turns to issues affecting successor entities. Finally, the chapter concludes with an overview of other laws that can affect health care providers. Although used less frequently, these laws can still result in significant civil and criminal liabilities and thus affect parties in bankruptcy proceedings.

2. Fraud and Abuse Laws Impacting Providers

A number of federal and state statutes impose liability on providers who engage in fraudulent tactics that are harmful to the health care system. Penalties for violations of these laws can include, but are not limited to, fines, sanctions and jail time. Furthermore, PPACA added amendments that provide HHS with additional funding and expanded authority to enforce these fraud laws. The effects of these changes on providers range from minor to potentially significant. With this in mind, the following section is intended to provide bankruptcy and health care professionals with a general understanding of the workings and scope of these laws.

a. The Stark Law: Limitation on Certain Physician Referrals

The Stark Law\(^{290}\) prohibits physician self-referrals for certain services paid for by Medicare and Medicaid. Unless an exception applies, the Stark Law sets forth two primary limitations where a physician (or an immediate family member of a physician) has a financial relationship with an entity. First, the physician may not make a referral to that entity for the furnishing of designated health services for which payment otherwise may be made under Medicare and Medicaid. Second, the entity may not present (or cause to be presented) a claim to the government or a bill to any individual.

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\(^{290}\) 42 U.S.C. § 1395nn.

PPACA. On June 28, 2012, the Court upheld the law, concluding that PPACA’s key provision, the individual mandate, is constitutional under Congress’s taxing power. The Court also held that while the Medicaid expansion provisions in PPACA are constitutional, states can refuse to participate in the expansion without losing all Medicaid funding. Notably, none of the new fraud and abuse provisions was at issue. \textit{Nat’l Fed’n of Indep. Bus. v. Sebelius}, 567 U.S. ___ (2012).
or entity for those designated health services that were furnished pursuant to the prohibited referral.\textsuperscript{291}

The Stark Law was originally enacted in 1989 under the Ethics in Patient Referrals Act, with the goal of preventing physicians from making referrals based on financial gain. Such prohibitions help reduce overutilization and cost increases.\textsuperscript{292} Since its enactment, the law has undergone significant amendments. Since 1995, the Centers for Medicare and Medicaid Services (CMS) within HHS has published a series of corresponding and comprehensive regulations to implement the statutory prohibitions.\textsuperscript{293}

Since the passage of the Stark Law, the subsequent revisions and regulations have helped specify which services constitute “designated health services” and which relationships constitute a “financial relationship” under the statute. Currently, there are 12 types of services enumerated in the statute as “designated health services.”\textsuperscript{294} The regulations provide further explanation of these services, and in some cases include the corresponding insurance billing codes.\textsuperscript{295} The statute’s reference to “financial relationships” includes ownership interests, investment interests and compensation arrangements.\textsuperscript{296} The law, however, contains numerous exceptions to accommodate legitimate referral arrangements and financial relationships, such as referrals through a prepaid health plan and ownership of certain publicly traded securities.\textsuperscript{297}

\begin{itemize}
\item\textsuperscript{291} 42 U.S.C. § 1395nn(a)(1)(A)-(B).
\item\textsuperscript{292} See Jennifer Staman, Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview, CONG. RESEARCH SERV. 5 (2010) [hereinafter Health Care Fraud and Abuse Laws].
\item\textsuperscript{293} The law was actually enacted in several parts: Stark I in 1989 and Stark II in 1993. Id. Phase III regulations were also passed in 2007 and can be found at 42 C.F.R. §§ 411.350 et seq.
\item\textsuperscript{294} See 42 U.S.C. § 1395nn(h)(6). The designated health services include: clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans and ultrasounds services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; inpatient and outpatient hospital services; and outpatient speech-language pathology services.
\item\textsuperscript{295} CMS includes updated code lists for designated health services on its website, www.cms.gov/PhysicianSelfReferral/40_List_of_Codes.asp.
\item\textsuperscript{296} 42 U.S.C. § 1395nn(a)(2)(A)-(B).
\item\textsuperscript{297} 42 U.S.C. § 1395nn(b)-(e).
\end{itemize}
PPACA made several noteworthy changes to the statute. For example, PPACA limits the scope of one of the statute’s most important exceptions, the “whole hospital” exception. Under the old law, physicians were allowed to refer patients to hospitals in which they held an ownership interest in the entire facility. The hospitals could then submit claims for designated health services as long as the referring physician was authorized to perform services at the hospital. Under the new law, a hospital must have received its Medicare provider number before Dec. 31, 2010, for the exception to apply (i.e., essentially a grandfathering statute, with new hospitals prohibited). Ultimately, physicians will now have less latitude in referring to hospitals in which they hold particular ownership interests and in making investments in new hospital projects.298 The law also adds several new disclosure and reporting requirements, such as requiring manufacturers and group purchasing organizations to disclose ownership and investment interests held by physicians.299

Violations of the Stark Law can result in denial of payment for the relevant services, a required refund for the services or civil monetary penalties.300 Though the statute is a strict liability statute, i.e., intent need not be proven, monetary penalties of up to $100,000 for each arrangement or scheme may be imposed if the physician or entity “knows or should know” that the referral constitutes a violation of the statute.301

b. The Anti-Kickback Statute

The Federal Anti-Kickback Statute302 prohibits any person from knowingly and willfully offering, paying, soliciting or receiving any remuneration in cash or in kind in return for referrals for any services under a federal health care program.303 As enacted, the statute is intended to limit certain profit incentives that can lead to high costs and overutilization for patients.304 Beyond medical services, the statute also covers other goods and services that are remunerable under Medicare or Medicaid. Thus, it is illegal to offer or pay anything of value in return for the purchase, lease or order of

298 See Staman, Health Care Fraud and Abuse Laws, at 6-7.
299 Id. at 7-8.
300 42 U.S.C. § 1395nn(g).
301 42 U.S.C. § 1395nn(g)(4).
302 42 U.S.C. § 1320a-7b(b)
304 See Staman, Health Care Fraud and Abuse Laws, at 3.
these goods and services, or to arrange for, or recommend the purchase, lease or order of these goods and services.305

The Anti-Kickback Statute includes a number of statutory exceptions. The statute, for instance, does not consider certain price discounts or wages from a bona fide employment relationship as illegal “kickbacks.”306 In its regulations, HHS has also identified several safe harbors that will protect providers from liability. If a specific contract or arrangement does not fall within a safe harbor, HHS may still consider whether the contract and arrangement is tailored to prevent overutilization.307

PPACA recently clarified the intent requirement under the statute. Previously, courts had split on whether “knowingly and willfully” meant that the person has actual knowledge of the Anti-Kickback Statute and specific intent to disobey the law.308 The statute now explicitly provides that actual knowledge of the statute and specific intent to commit a violation are not prerequisites.309 In effect, this amendment should lower the burden for future prosecutions under the statute.

Prosecutions under the law can result in, among other things, criminal fines of up to $25,000 per act, exclusion from the Medicare/Medicaid programs and imprisonment of up to five years.310 Liability under the Anti-Kickback Statute could also trigger a “false” claim under the False Claims Act, which is discussed below. This designation could lead to civil penalties of up to $50,000 per act plus additional penalties of up to three times the remuneration amount.311

306 42 U.S.C. § 1320a-7b(b)(3).
308 Compare Hanlester Network v. Shalala, 51 F.3d 1390 (9th Cir. 1995), with United States v. Starks, 157 F.3d 833 (11th Cir. 1998).
309 42 U.S.C. § 1320a-7(b)(h).
310 42 U.S.C. § 1320a-7(b).
c. The Civil False Claims Act

i. Government Actions

The Federal False Claims Act (FCA)\(^{312}\) is a generally applicable law that is invoked frequently against health care providers. The law imposes civil liability on persons who knowingly submit false or fraudulent claims to the government, or who engage in particular types of wrongdoing in connection with federal government money or property.\(^{313}\) In the health care context, common violations include, but are not limited to: billing for services not rendered, filing false cost reports, increasing the level of care simply to obtain a higher reimbursement, and submitting duplicate billings. Though the government can also bring suit under the Criminal False Claims Act, it may prefer a civil action for various reasons. For example, the government can benefit from the lower “preponderance of the evidence” burden of proof with a civil suit.

In an effort to combat fraud, Congress has made several amendments to the statute. The Fraud Enforcement and Recovery Act of 2009 (FERA) altered some of the statute’s language because Congress was concerned with narrow interpretations of the original language by the courts.\(^{314}\) With the 2009 amendments, the scope of the law is now broader; for example, it is now easier to bring claims against contractors and subcontractors who are not paid directly by the government but who nevertheless receive government funds for false claims.\(^{315}\) PPACA has also expanded the reach of the statute. The new amendments provide a 60-day window for providers to report overpayments from Medicare or Medicaid after the overpayments have been identified.\(^{316}\) Any overpayment retained after the 60-day deadline could be deemed an improper retention of an “obligation” under the FCA. And as mentioned above, the FCA now overlaps with the Anti-Kickback Statute in that some violations of the latter statute may trigger “false” claims under the FCA.

\(^{312}\) 31 U.S.C. §§ 3729-3733.

\(^{313}\) 31 U.S.C. § 3729.


\(^{315}\) Previously, Allison Engines held that a defendant must “intend that a claim be paid...by the Government and not by another entity.” Id. at 671.

\(^{316}\) PPACA § 6402(d), 42 U.S.C. §§ 1301 et seq.
Violations of the FCA can result in a treble damage award for the government. Furthermore, an additional penalty of not less than $5,000 and not more than $10,000 will be imposed for each false claim filed.\textsuperscript{317}

\textit{ii. Qui Tam Actions}

The government’s fraud-combating efforts are also augmented by a provision in the FCA that allows private actors (“relators”) to file a complaint on behalf of both themselves and the U.S. government.\textsuperscript{318} As a preliminary matter, the relator must be the first to file the complaint or else the action is barred.\textsuperscript{319} Assuming the action can proceed, the DOJ will then investigate the merits of the claim and decide whether it wants to join or decline to join the \textit{qui tam} action. Successful relators may be awarded 15 to 25 percent of the proceeds if the government intervenes and 25 to 30 percent if the government does not intervene.\textsuperscript{320} Therefore, this \textit{qui tam} provision can provide employees of providers with a substantial incentive to act as whistleblowers and report fraud and abuse.

The FCA places limitations on which parties may bring \textit{qui tam} actions. But recent amendments in PPACA altered these limitations, perhaps paving the way for an upsurge in the volume of these suits. Before 2010, the “public disclosure bar” of the FCA barred actions where both the allegations had been publicly disclosed and the \textit{qui tam} relator was not an original source of the information. Under the revised law, the public disclosure bar may be lifted where the federal government opposes an action’s dismissal.\textsuperscript{321} PPACA also clarifies which reports constitute “public disclosures” by only including federal reports, not state reports.\textsuperscript{322} Finally, the new amendments potentially expand the pool of \textit{qui tam} relators. For example, individuals only need to have knowledge that “materially adds” to the publicly disclosed allegations, rather than the previous requirement of “direct knowledge.”\textsuperscript{323}

\textsuperscript{317} 31 U.S.C. § 3729(a)(1).
\textsuperscript{318} 31 U.S.C. § 3730(b).
\textsuperscript{319} 31 U.S.C. § 3730(b)(5).
\textsuperscript{320} 31 U.S.C. § 3730(d)(1)-(2).
\textsuperscript{322} 31 U.S.C. § 3730(e)(4)(A)(ii). Under the old language, state reports were considered to be part of the public disclosure bar. \textit{See Graham County Soil & Water Conservation Dist. v. United States ex rel. Wilson}, 130 S.Ct. 1396 (2010).
\textsuperscript{323} 31 U.S.C. § 3730(e)(4)(b).
d. Federal Civil Monetary Penalties

Federal civil monetary penalties may be imposed for a variety of situations in which providers engage in fraudulent practices. Some of the fraudulent practices that trigger the penalties include: knowingly presenting claims to the government for services that were not provided as claimed; knowingly retaining an overpayment; knowingly providing false or misleading information to a provider that could influence the decision of when to discharge an individual from the hospital; and knowingly engaging in fraudulent practices during a period when the person was excluded from the federal health care program.

Though ostensibly focused only on monetary penalties, the statute can result in both civil penalties and administrative penalties, such as exclusion from the Medicare and Medicaid programs. Further, these penalties are in addition to any that may be prescribed by law. Therefore, violations of other fraud and abuse laws, such as the Stark Law, can lead to additional civil monetary penalties.

e. Federal Health Care Fraud

Although the Social Security Act contains several of the principal statutes related to health care fraud — such as the Stark Law and Anti-Kickback Statute — the U.S. Criminal Code also specifically addresses federal health care fraud offenses. The health care fraud provision prohibits persons from knowingly and willfully executing, or attempting to execute, schemes to defraud any health care benefit program. It also prohibits persons from obtaining, by means of false or fraudulent pretense, representation or promises, any of the money or property owned by, or under the custody or control of, any health benefit program. Recently, PPACA added an amendment clarifying that to prove its fraud case, the government need not show an individual’s actual knowledge of the criminal fraud provision or specific intent to violate the statute. Rather, a lower threshold of proof will suffice. In its most com-

324 42 U.S.C. § 1320a-7a.
325 42 U.S.C. § 1320a-7a(a)(1)-(12).
326 42 U.S.C. § 1320a-7a(a).
327 Id.
mon usage, the criminal health care fraud provision acts as an important tool for prosecutors who are investigating providers engaging in Medicare and Medicaid fraud.

Punishment under the statute varies with the severity of the crime. Though violators are generally subject to a fine and/or imprisonment of not more than 10 years, imprisonment can increase to 20 years if the violations resulted in serious bodily injury. Should death result from the violation, the term of imprisonment can be increased to life. Currently, pursuant to PPACA, the U.S. Sentencing Commission is amending the federal sentencing guidelines to increase sentences for federal health care fraud offenses.

f. State Fraud and Abuse Laws

States have also enacted laws that address physician self-referrals, kickbacks and false claims. Where applicable, these laws can result in additional penalties for providers and should be analyzed in order to assess the full scope of a debtor’s liabilities.

3. Effect of Fraud and Abuse Actions on Bankruptcy Proceedings

When the government concludes that a provider has violated one or more of the laws listed above, enforcement actions follow. The ensuing administrative and judicial actions have the potential to jeopardize a provider’s business, especially if HHS suspends Medicare and Medicaid reimbursements, or if a court imposes heavy fines. The suspension or exclusion from such programs, or even the threat thereof, may cause a provider to consider filing a petition for relief in order to stay the government’s suspension or exclusion actions. Bankruptcy protections, however, are limited in certain cases where the government is investigating fraud and abuse. This section will discuss the types of enforcement actions available to HHS and the DOJ, and will then analyze how these actions interact with the debtor protections set forth in the Bankruptcy Code.

a. Types of Enforcement Actions

i. Administrative Actions

Administrative actions against providers take three main forms: exclusion proceedings, termination proceedings and suspension of program payments.

Exclusion. Exclusion from participation in Medicare and Medicaid programs can be potentially disastrous for a provider because payments from these programs often constitute a substantial portion of the provider’s operating revenue. Some exclusions are mandatory; under four sets of circumstances, the OIG is required by law to exclude the provider. These four sets of circumstances include: (1) convictions for crimes related to the Medicare and Medicaid programs; (2) convictions relating to patient abuse and neglect; (3) felony convictions for other health care-related fraud; and (4) felony convictions relating to controlled substances. 332 The length of a mandatory exclusion is a minimum of five years.333

Under other circumstances, the OIG may grant permissive exclusions. The Medicare statutes provide 16 grounds for imposing a permissive exclusion.334 For example, the OIG has the discretion to exclude a provider from Medicare and Medicaid for other convictions relating to fraud, license revocation or suspension, the provision of unnecessary services, and failure to provide required information.335 Recently, PPACA both clarified and expanded HHS’s power to permissively exclude providers. HHS, which already had the power to exclude providers for the obstruction of a criminal investigation, can now exclude providers for the obstruction of program audits. Also, the sixteenth and newest ground allows for exclusion based on a provider’s knowing misrepresentations on enrollment applications.336 The benchmark duration period for permissive exclusions is generally three years, but the duration of each individual case can vary.337

332 42 U.S.C. § 1320a-7(a).
334 42 U.S.C. § 1320a-7(b)(1)-(16).
335 Id.
336 42 U.S.C. § 1320a-7(b)(2), 7(b)(16).
337 42 U.S.C. § 1320a-7(c)(3)(D).
Termination. Termination proceedings occur when HHS either decides to terminate a provider agreement or refuses to renew the agreement.\textsuperscript{338} Termination can occur for various reasons, including a provider’s failure to comply with program requirements. This remedy, however, is not permanent because the provider may reapply if the deficiencies warranting termination have been corrected.\textsuperscript{339} Nevertheless, in the short-term, providers can experience a significant decrease in operating revenue if their Medicare and Medicaid agreements are terminated.

Suspension of Payments. HHS has the authority to suspend Medicare payments to providers if HHS identifies a previous overpayment, payments to be made that are incorrect, or instances of fraud.\textsuperscript{340} As will be discussed in more detail in Chapter 10 of this Manual, the determination of whether a suspension for overpayments is characterized as a “setoff” or a “recoupment” can have implications for the automatic stay in bankruptcy. Courts have reached different conclusions depending on the facts surrounding the overpayments.\textsuperscript{341}

The most salient issue with respect to fraud and abuse in health care involves the PPACA amendments to the HHS’s powers, which could expand HHS’s ability to suspend payments for suspected fraud. Whereas past regulations required the existence of “fraud or willful misrepresentation,” the new regulations authorize HHS to suspend payments when a “credible allegation of fraud” exists.\textsuperscript{342} Under the regulations, allegations are considered to be credible if they have “indicia of reliability.”\textsuperscript{343} Examples in the regulations include allegations from fraud hotline complaints, provider audits and false claims cases.\textsuperscript{344} While the new regulations do include an exception where there is “good cause not to suspend payments,” they have the potential to lead to more payment suspensions and more financial uncertainty for affected providers.\textsuperscript{345} The regulations will also likely require courts to determine which types of allegations satisfy the “indicia of reliability” requirement.

\textsuperscript{338} 42 U.S.C. § 1395cc(b)(2).
\textsuperscript{339} 42 U.S.C. § 1395cc(c)(1).
\textsuperscript{340} 42 C.F.R. § 405.371.
\textsuperscript{342} 42 C.F.R. § 405.371(a)(2).
\textsuperscript{343} 42 C.F.R. § 405.370(a).
\textsuperscript{344} Id.
\textsuperscript{345} 42 C.F.R. § 405.371(a)(2).
ii. Judicial Actions

The government may also institute civil and criminal actions in federal court against providers for violations of the fraud and abuse laws. Though these actions are generally brought by the DOJ, in some cases, such as with FCA actions, *qui tam* plaintiffs file suit against the provider on behalf of the government. Whether the government decides to intervene in the *qui tam* action can have an effect on the automatic stay in bankruptcy proceedings, as discussed below.


When a debtor makes a properly authorized bankruptcy filing, the automatic stay under § 362(a) of the Bankruptcy Code comes into effect. The stay is a form of statutory injunction that is intended to stop virtually all collection efforts by the debtor’s creditors, including actions by governmental units.346 The automatic stay is one of the fundamental protections provided by the Bankruptcy Code. Yet the automatic stay is also subject to a series of exceptions codified in § 362(b) of the Bankruptcy Code.

i. The Police and Regulatory Power Exception to the Automatic Stay

The most important exception to the automatic stay in the area of fraud and abuse is the police and regulatory power exception set forth in § 362(b)(4) of the Bankruptcy Code. This provision states that the automatic stay does not apply to “the commencement or continuation of an action or proceeding by a governmental unit...to enforce such governmental unit’s police and regulatory power.”347

The government frequently invokes this exception when a debtor requests relief from actions that could jeopardize the pool of resources avail-

347 11 U.S.C. § 362(b)(4). When this exception was amended in 1999 to include government organizations operating under the Chemical Weapons Convention, the reworking of the language “created apparently unintentional ambiguities” that threatened to eviscerate the exception’s purpose. In re Nelson, 240 B.R. 802, 804 n.5 (Bankr. D. Me. 1999). Courts have since referenced the pre-amendment version to resolve these ambiguities. See id.; see also United States ex rel. Doe v. X Inc., 246 B.R. 817, 818 (E.D. Va. 2000) (omitting the language from the 1999 amendment while explaining the exception).
able to creditors during reorganization. When this exception is invoked, courts will look to see whether the government is actually acting pursuant to its police and regulatory power or instead merely protecting its status as a creditor. On this point, courts will apply two tests — the “pecuniary advantage” test and the “public policy” test — which are essentially “opposite sides of the same coin.”

Under the “pecuniary advantage” test, the court will look to whether the action will give the government a pecuniary advantage over other creditors of the debtors’ estate. Under the “public policy” test, the court will “distinguish...between proceedings that effectuate public policy and those that adjudicate private rights,” with the former excepted from the automatic stay. Also, although some courts used to apply a “pecuniary purpose” test, which took a narrower approach to the applicability of § 362(b)(4) of the Bankruptcy Code, this test has been all but phased out in favor of the “pecuniary advantage” test.

The police and regulatory power exception has been analyzed in the context of a variety of administrative actions and has resulted in a variety of judicial outcomes. First, HHS has used this exception while attempting to exclude a debtor from the Medicare and Medicaid programs. Although an amendment in 2005 in BAPCPA specifically addresses exclusion actions, even pre-BAPCPA cases had suggested that the government could in certain circumstances exclude a provider from Medicare or Medicaid under the police and regulatory power exception. The existence of fraud, moreover, was an important factor in determining whether the government could pass the pecuniary-advantage test. Therefore, these cases, together with the BAPCPA amendment, make it clear that exclusion actions based on fraud and abuse can be excepted from the automatic stay.

348 In re Medicar Ambulance Co., 166 B.R. 918, 926 (Bankr. N.D. Cal. 1994).
349 In re Commonwealth Cos., 913 F.2d 518, 524 (8th Cir. 1990).
350 Id. at 524 n.6.
351 See, e.g., United States ex rel. Fullington v. Parkway Hosp. Inc., 351 B.R. 280, 285-87 (E.D.N.Y. 2006) (noting that a number of courts have adopted the broader “pecuniary advantage” and concluding that it is more consistent with the statutory language).
353 In re Psychotherapy, 195 B.R. at 533 (“Clearly, if HHS had determined that the debtor should be excluded...by reason of...fraud or other criminal activity, then the court should not prevent HHS’s exclusion of the debtor.”); In re Rusnak, 184 B.R. at 465 (highlighting that HHS had not alleged any fraud, but rather was trying to recover loan payments).
Second, HHS has invoked the police-and-regulatory-power exception in cases where it has suspended payments to the debtor/provider for alleged fraud. The existing case law on this issue has reached differing conclusions. For instance, one court has held that the suspension of payments violates the stay. The court in this case reasoned that a suspension is more akin to an enforcement action for a monetary claim. As such, it is distinguishable from other valid regulatory actions, such as an exclusion action or an action to simply determine the amount of civil penalties but not enforce them. But two years later, another court was not willing to find that HHS violated the stay when the agency suspended Medicare reimbursement payments to the debtor on the ground of suspected fraud. The court concluded that the application of the automatic stay in this context could completely frustrate Congress’s desire to combat fraud. It also distinguished the prior case based on a concession made by HHS in the previous case.

Nevertheless, the new regulations instituted by PPACA could tip the scales in HHS’s favor in future cases. Given that HHS is now explicitly authorized to suspend payments where there is a “credible allegation of fraud,” HHS may now have a stronger argument that these suspensions are well within its regulatory powers. If so, debtors will have to rely on other protections in the Bankruptcy Code discussed below. In the alternative, the debtor could try to show that the allegation does not contain any “indicia of reliability.” It should be noted, though, that some bankruptcy courts require debtors to exhaust their administrative remedies before they will entertain such arguments. Therefore, the debtor may have to file rebuttals and appeals to suspensions at the agency level before the court will exercise jurisdiction over the merits of the claim.

Courts have also applied the police-and-regulatory-power exception to pending civil actions in court. For example, both inside and outside the health care context, courts have applied § 362(b)(4) of the Bankruptcy Code

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354 In re Medicar Ambulance Co., 166 B.R. at 927 ("[I]nasmuch as the suspension is an attempt to enforce a monetary claim, it exceeds the scope of the police power exception.").
355 Id.
356 In re Orthotic Ctr. Inc., 193 B.R. 832, 835 (N.D. Ohio 1996) ("The policy behind the police or regulatory exception to the automatic stay is to prevent the bankruptcy court from becoming a haven for wrongdoers.").
357 Id. at 834.
358 See, e.g., United States v. James, 256 B.R. 479, 481 (W.D. Ky. 2000) (concluding that it had no jurisdiction over debtor’s claims regarding his participation in Medicare).
to pending lawsuits under the FCA. Absent rare exceptions, the FCA lawsuits have been permitted to proceed, notwithstanding the automatic stay. These cases have also relied heavily on legislative history from the passage of the police and regulatory power exception, which explicitly mentions the prevention of fraud as an action within the regulatory power. Nevertheless, the use of the exception is subject to an important limitation: Entry of judgment in the fraud action is permitted, but enforcement of the judgment may still be deemed to violate the automatic stay. In other words, if the government prevails on its fraud claim, then its claim for damages is merely an unsecured claim against the debtor. Otherwise, the government would fail the pecuniary-advantage test because conversion into a secured or priority claim would arguably constitute an advantage in the bankruptcy proceedings.

Finally, the applicability of the police-and-regulatory-power exception does depend on whether the government is truly a party to the civil suit. Thus, qui tam actions are only exempt from the automatic stay where the DOJ has either elected to intervene or where its decision to intervene is pending. If the DOJ has declined to intervene, then the qui tam action is subject to the automatic stay, regardless of any fraud-combating objectives. Further, if the qui tam relator attaches other claims to his or her FCA claim, then only the FCA claim will be eligible for exemption from the automatic stay and all other claims will be stayed.

359 See In re Mickman, 144 B.R. 259, 262 (E.D. Pa. 1992) (permitting continuation of litigation of FCA claim involving a telemarketing scheme to defraud Medicare); see also Commonwealth Cos., 913 F.2d at 525 (excepting FCA claim targeting bid-rigging).
360 See In re HealthEssentials Solutions Inc., No. 05-31218(1)(11), 2007 Bankr. LEXIS 1635, at *3-6 (Bankr. W.D. Ky. May 17, 2007) (staying FCA claim where purpose of lawsuit was only to gain pecuniary advantage against dissolved business and not to prevent or stop fraud).
361 Commonwealth Cos., 913 F.2d at 522-23.
362 Id. at 524; In re Mickman, 144 B.R. at 261.
363 Commonwealth Cos., 913 F.2d at 524.
364 See Fullington, 351 B.R. at 281 (exempting FCA action where the government intervened); Doe, 246 B.R. at 818, 821 (exempting FCA action where government had not yet completed its investigation related to its decision to intervene).
366 See Fullington, 351 B.R. at 281 (refusing to apply exception to relator’s other claims).
ii. The HHS Exclusion Exception to the Automatic Stay

BAPCPA added a specific exception to the automatic stay that addresses HHS exclusion actions. Section 362(b)(28) of the Bankruptcy Code states that the automatic stay does not apply to “exclusion by [HHS] of the debtor from participation in the Medicare program or any other federal healthcare program.” After its passage, commentators debated whether this provision would enlarge the HHS’s powers in bankruptcy proceedings and whether its scope could be extended to termination proceedings. To date, courts’ analyses of this exception have been scarce. Given that the police-and-regulatory-power exception may already have provided sufficient basis to except exclusion actions from the automatic stay, it makes sense that the new exception has not yet been extensively litigated. Yet it is unclear how many debtors have altered their bankruptcy filing plans based on the existence of this exception. Also, while no court has addressed whether the exception can be extended to termination proceedings, the absence of language related to terminations would seem to support the argument that termination proceedings continue to be subject to the automatic stay.

iii. The Anti-Discrimination Provision

In several cases involving exclusion actions by HHS or similar state agencies, debtors have argued that these actions violate the Bankruptcy Code’s anti-discrimination provision. Under § 525(a) of the Bankruptcy Code, government entities are prohibited from discriminating against debtors on the basis of discharged debts. Although § 525(a) of the Bankruptcy Code has helped debtors successfully defeat exclusion actions, none of these cases involved an exclusion resulting from fraud and abuse. Therefore, if fraud is alleged, then the anti-discrimination provision will likely only apply in rare

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369 See Lacktman and Owens, Health Care Providers at 4.
371 See, e.g., In re Berkelhammer, 279 B.R. 660, 670 (Bankr. S.D.N.Y. 2002) (applying § 525(a) of the Bankruptcy Code to find that an exclusion prohibited discrimination based on debtor’s failure to repay overpayments).
circumstances. For example, where the government excludes a debtor for failure to pay debts pursuant to an agreement settling fraud claims, the protections of § 525(a) of the Bankruptcy Code might apply because the basis for exclusion is essentially a discharged debt, not fraud.372

iv. Injunctive Relief

Though the government retains broad powers to combat fraud and abuse in the face of an automatic stay, injunctive relief may still be available. Under § 105 of the Bankruptcy Code, bankruptcy courts have the discretion to issue injunctions if they are “necessary or appropriate to carry out the provisions of [the Bankruptcy Code].”373 In several cases involving fraud claims and FCA actions, the court has either granted relief under § 105 of the Bankruptcy Code or noted that it is available if the debtor can show necessity.374 This latter burden can be achieved if (1) the debtor shows that the balance of irreparable harm weighs in his or her favor; (2) the debtor shows a likelihood of success on the merits; and (3) the public interest favors injunctive relief.375 Granted, the injunction would likely only be temporary. But temporary injunctions may give debtors sufficient time to propose a plan of reorganization, or, in the case of suspended payments, it may provide time to develop a defense explaining why the government’s allegations of fraud are not “credible” or why there is “good cause” not to suspend payments. As an indispensable part of this showing, the debtor would certainly need to provide assurance that fraud and abuse would not continue during the pendency of the injunction.

In sum, debtors should first identify the type of enforcement proceeding at issue. They should then analyze whether the enforcement action can validly fit within an exception to the automatic stay. In some cases, the automatic stay will still apply. For example, *qui tam* actions on behalf of only

372 See *Psychotherapy*, 195 B.R. at 534 (noting that exclusion in this situation would be impermissible under § 525(a) of the Bankruptcy Code).


374 See, e.g., *In re Richmond Paramedical Servs. Inc.*, 94 B.R. 881, 882-86 (Bankr. E.D. Va. 1988) (enjoining HHS from excluding a provider that was convicted on 10 counts of misrepresentation in commercial dealings); see also *Commonwealth Cos.*, 913 F.2d at 527 (highlighting the availability of injunctive relief); *In re Selma Apparel Corp.*, 132 B.R. 968, 970 (S.D. Ala. 1991) (same).

375 *Richmond Paramedical*, 94 B.R. at 884.
the relator cannot be brought under the police-and-regulatory-power exception, and termination proceedings most likely cannot be excepted from the automatic stay under the HHS exclusion exception. Likewise, government attempts to enforce a monetary judgment would not be excepted from the automatic stay because they would place the government at an advantage over other creditors. Finally, debtors should analyze whether other forms of relief are available, such as protection under §§ 525(a) or 105 of the Bankruptcy Code. Injunctive relief under § 105 of the Bankruptcy Code may be especially useful for debtors who can show that an administrative action, such as a suspension of payments, would cause irreparable harm.

4. Issues Involving Successor Liability and Fraud and Abuse Laws

During reorganization, purchasers of health care facilities must be cognizant of how existing Medicare agreements will be assigned and whether outstanding liabilities will carry over from the previous business. Regulators are wary of sham transfers that evade liability. As a result, when a provider facility undergoes a Change of Ownership (CHOW), the existing provider agreement is typically assigned to the new owner, who is then responsible for all outstanding or future overpayments.376 Alternatively, the new owner can refuse assignment of the existing provider agreement. In this case, there would be no CHOW, but the new owner would have to seek new certification into the Medicare program, which can cause significant delays.377

Fortunately for successor entities, existing case law and regulations suggest that liability for overpayments and civil penalties will not be transferred to the new owner when fraud is involved. In the nonfraud context, several circuit and district courts have required successor entities to pay Medicare overpayments and civil monetary penalties that were previously the responsibility of the debtor.378 The rationale behind successor liability in

376 42 C.F.R § 489.18.
378 See, e.g., Deerbrook Pavilion LLC v. Shalala, 235 F.3d 1100, 1104 (8th Cir. 2000); United States v. Vernon Home Health Inc., 21 F.3d 693, 696 (5th Cir. 1994); Delta Health Group, 459 F. Supp. at 1223; see also Cedar Hill Manor LLC v. Dep’t of Soc. Servs., 145 S.W.3d 447, 454 (Mo. Ct. App. 2004).
these cases is threefold: It helps to replenish Medicare funds when the debtor is judgment-proof, it deters sham transfers, and it encourages successor entities to perform due diligence. Yet CMS’s manual on CHOWs specifically states that new owners assume all penalties and sanctions “unless fraud was involved.” The same is true for overpayments. Responsibility for the overpayments stays with the old provider. Admittedly, it should be noted that to date no successor entity has successfully invoked this exception for fraud. But courts have highlighted the availability of this exception in cases where the successor claimed fraud where none actually existed.

Successor entities should nonetheless take steps to protect themselves from successor liability, because the case law is still developing on this issue. Best practices begin with a successor’s own due diligence. If a successor becomes aware of potential liabilities, then it should try to negotiate a lower purchase price to offset the risk of liability that it might be assuming. Also, the successor entity should consider the costs of new certification into the Medicare program against the benefits of avoiding potential liabilities. If certification can be achieved with minimal delay and costs, then the successor may prefer this route to a CHOW. Finally, the successor may want to consider the likely post-transfer financial condition of the previous owner. The more likely that the previous owner is going to be judgment-proof, the harder it may be to convince a court that previous liabilities should not transfer to the successor.

5. Other Fraud and Abuse Laws Impacting Providers

In addition to the principal fraud and abuse laws affecting debtors and successor entities listed above, Congress has enacted a handful of other health care fraud laws. Although these laws are invoked less frequently, providers must still adhere to their prohibitions. On occasion, prosecutors have also used general criminal statutes against providers, such as statutes aimed at unlawful conspiracies. This section briefly summarizes these other statutes that can affect providers. Importantly, any criminal actions based on these statutes

379 Delta Health Group, 459 F. Supp. at 1223.
381 Id.
would likely fall under the police and regulatory power to the automatic stay because they involve attempts by the government to enforce its police power.

a. Additional Health Care Fraud Laws

i. False Statements Relating to Health Care Matters

The False Statements statute prohibits persons from knowingly and willfully misrepresenting or concealing any material fact or making false statements in connection with the delivery of or payment of health care benefits. Penalties can include fines and/or imprisonment of up to five years.\(^{383}\)

ii. Theft or Embezzlement in Connection with Health Care

This statute prohibits persons from knowingly and willfully embezzling, stealing or converting the monies, funds, securities, premiums, credits, property or assets of a health care benefit program.\(^{384}\) Violations are subject to a fine and/or imprisonment of up to 10 years.

iii. Obstruction of Criminal Investigation of Health Care Offenses

Any person who prevents, obstructs, misleads or delays the communication of information or records to a criminal investigator in the context of an investigation for a federal health care offense is subject to a fine and/or imprisonment of up to five years.\(^{385}\)

b. General Criminal Laws Potentially Affecting Providers

i. Racketeer Influenced and Corrupt Organization Act (RICO Act)

The RICO Act\(^ {386}\) provides both civil and criminal sanctions for acts performed as part of an ongoing criminal organization.\(^ {387}\) Though the statute

\(^{385}\) 18 U.S.C. § 1518(a).
is well known for its applicability to organized crime, it can also be used against providers who engage in complex fraudulent schemes. Violators are subject to fines and/or imprisonment of up to 20 years (or for life if the violation is based on a racketeering activity for which the maximum penalty includes life imprisonment).388

ii. False Claims Conspiracy to Defraud the Government

This statute prohibits persons from conspiring to enter into an agreement, combination or conspiracy to defraud the federal government by obtaining or aiding in the obtaining of a payment or allowance by any false, fictitious or fraudulent claim. Violators are subject to a fine and/or imprisonment of up to 10 years.389

iii. Criminal Fictitious False Claims

Commonly known as the “Criminal False Claims Act,” this statute prohibits persons from knowingly making false, fictitious or fraudulent claims “upon or against the United States or any department or agency thereof.” Violators are subject to a fine and imprisonment of up to five years.390

iv. Obstruction of a Federal Audit

This criminal statute prohibits persons with intent to deceive or defraud the government from influencing, obstructing or impeding a federal auditor in the performance of official duties relating to that person.391 Importantly, the statute only applies where a person or entity receives in excess of $100,000 from the government in any year. But given that providers often receive Medicare reimbursements in excess of this amount, this statute can apply to audits directed at providers. Violations are subject to a fine and/or imprisonment of up to five years.

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v.  Mail Fraud

The mail fraud statute prohibits persons from using the postal system to further any scheme to defraud or obtain money or property through false or fraudulent representations. Violators are subject to fines and/or imprisonment of up to 20 years.\textsuperscript{392}

vi.  Wire Fraud

The wire fraud statute prohibits persons from devising or intending to devise any scheme to defraud by transmitting or causing to be transmitted by way of wire, radio or television communications in interstate or foreign commerce any writings, sounds, signals or pictures.\textsuperscript{393} Violators are subject to fines and/or imprisonment of up to 20 years.

6. Conclusion

The government has numerous tools to combat health care fraud and abuse, especially in light of the recent amendments in PPACA. For any provider, enforcement actions stemming from these fraud and abuse laws can be damaging because reimbursement payments often make up a substantial portion of operating revenue. For distressed providers in bankruptcy, these actions can be particularly troublesome as the automatic stay does not always protect debtors from these actions. Though the trend is toward an expansion of enforcement powers, the Bankruptcy Code still contains limits. Therefore, both before and during reorganization, health care professionals and their attorneys should always consider the scope of the automatic stay’s exceptions, the availability of injunctive relief, and any relevant issues involving successor liability.

\textsuperscript{392} 18 U.S.C. § 1341.
\textsuperscript{393} 18 U.S.C. § 1343.