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How Health Care Attorneys Can Discern Vernon, Successor Liability and Settlement Issues

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HOW HEALTH CARE ATTORNEYS CAN DISCERN *VERNON*, SUCCESSOR LIABILITY AND SETTLEMENT ISSUES

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I. INTRODUCTION

In the last few years, two notable trends have emerged in health care: (1) the United States government has made it a priority to minimize fraud, waste, and abuse in the federal health care programs;[1] and (2) health care entities have consolidated and merged.[2] As these two trends continue to grow, several mergers and consolidations will involve health care providers that are either under investigation or have resolved their overpayment and/or False Claims Act liability.[3] As a result, an increasing number of health care attorneys will be asked to assess their clients' Medicare liability before those clients enter into a corporate transaction to buy a health care provider that owes the government Medicare overpayments, civil fines, or penalties.

Part II of this article provides a summary of why these emerging trends will continue to flourish. Part III summarizes the pertinent successor liability law affecting the structuring of corporate transactions. Proceeding from that

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1. *See* United States Attorney General Janet Reno, *Address to the American Hospital Ass'n* [hereinafter Reno Address] (visited Jan. 18, 2000) <http://www.usdoj.gov/ag/speeches/1998/0202_ag_aha.htm> (transcript of Attorney General Janet Reno's Feb. 2, 1998 speech on the government's fight against health care fraud); *infra* notes 5-10 and accompanying text.

2. *See* Alice G. Gosfield, *The New Playing Field*, 41 ST. LOUIS U. L.J. 869, 875 (1997); *infra* notes 32-55 and accompanying text.

3. *See* Robert J. Pristave & Elizabeth Birt, *White Coats, Dark Deeds: Accountability v. Fraud*, 6 BUS. L. TODAY 24 (1997) (reporting that many large health care providers are being investigated by the government).

discussion, Part IV provides an analysis of how courts and the government will likely view Medicare successor liability issues in the future.[4]

II. EMERGING AND CONTINUING TRENDS IN HEALTH CARE

A. The Government's Effort to Curtail Health Care Fraud and Abuse

The federal government is unlikely to decrease its fervent enforcement efforts to reduce the proliferation of health care fraud and abuse.[5] First, Attorney General Janet Reno has placed health care fraud alongside violent crime as a top enforcement priority of the Clinton Administration.[6] The Department of Justice ("DOJ") and United States Attorney's Offices throughout the country are working closely with the Office of Inspector General for the United States Department of Health and Human Services ("OIG") and other federal and state law enforcement agencies to pursue criminal and civil remedies in health care fraud matters.[7] In fiscal year 1999, 483 *qui tam* cases were filed and over $458 million was returned to the United States Treasury.[8] At the very least, health care fraud enforcement will remain a top priority during the second term of the Clinton administration.[9]

4. Medicare is a federal health care program created by the Social Security Amendments of 1965. Pub. L. No. 89-97, 79 Stat. 286 (1965). There are similarities between the Medicare and Medicaid programs, which make much of the discussion in this article applicable to Medicaid. However, it is beyond the scope of this article to discuss the Medicaid program.

5. *See generally* Reno Address, *supra* note 1.

6. Kim H. Roeder & Sara Kay Sledge, *Concentrated Government Efforts to Prosecute Fraud, and Corporate Sentencing Guidelines, Make Compliance Programs Necessary For Health Care Organizations*, NAT'L L.J., Oct. 14, 1996, at B5.

7. James G. Sheehan, *The Office of Inspector General: Health Care Financing Administration Projects*, in HEALTH CARE M & A 1998, at 747, 902 (PLI Corp. Law & Practice Course Handbook Series No. B4-7234, 1998). *See also* Kip Betz, *Special Report: FBI Using More Funding, Staffing to Proactively Fight Fraud Schemes*, 3 Health Care Fraud Rep. (BNA) 522 (June 16, 1999).

8. Taxpayers Against Fraud, *Qui Tam Statistics* (last modified Nov. 1999) <http:\www.taf.org/taf/docs/qtstats99.html>. In fiscal year 1997, a record 534 *qui tam* cases were filed and over $625 million was recovered by the DOJ. *Id.*

9. *See id. See also* Stuart M. Gerson, *Will New Federal Guidelines Arrest Overzealous Use of False Claims Act?*, 13 WHITE-COLLAR CRIME REP. 3 (1999). The False Claims Act is the subject of debate in the health care provider community because the industry believes the government is overreaching in its health care enforcement efforts. *Id.* In response to a growing demand for reform of the False Claims Act and lobbying pressure from the provider community regarding the government's treatment of health care providers in recent national initiatives, the Department of Justice and OIG separately issued national guidelines to ensure that health care providers are treated in a fair and even-handed manner. *See* Memorandum from Eric H. Holder, Jr., Deputy Attorney General, "Guidance on the Use of the False Claims Act in Civil Health Care Matters" (June 3, 1998); Memorandum from June Gibbs Brown, Inspector General, "National Project Protocols-Best Practice Guidelines" (June 3, 1998) (on file with author). *See also*

Second, the government continues to report on astonishing losses by the federal health care programs.[10] For example, an OIG audit of fiscal year 1998 estimated improper payments for Medicare fee-for-service benefits totaled $12.6 billion.[11] Although the OIG's fraud and abuse initiatives had a significant impact in reducing improper payments by the federal health care programs,[12] and the 1998 audit was $7.7 billion less than the fiscal year 1997 estimate of $20.3 billion, the OIG still believes $12.6 billion to be an unacceptable loss to the government and stresses that continued enforcement efforts are needed.[13]

Third, Congress enacted extensive legislation specifically to eliminate fraud, waste, and abuse in health care.[14] The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was enacted to bolster health care fraud and abuse prevention and enforcement.[15] HIPAA increased the potential liability for false claims by revising the administrative penalties for false claims.[16] HIPAA also increased the civil monetary penalties from $2,000 to $10,000 per false claim, and raised the amount of authorized assessments from double to triple the amount claimed.[17] HIPAA additionally provided significant improvements in health care fraud enforcement including a stable source of funding for health care fraud efforts, additional OIG agents, FBI agents and prosecutors, and private sector alternatives to detect health care fraud.[18]

GENERAL ACCOUNTING OFFICE, REP. NO. HEHS-98-195, MEDICARE: APPLICATION OF THE FALSE CLAIMS ACT TO HOSPITAL BILLING PRACTICES (1998) (discussing the guideline's effects on the provider community's impression of health care enforcement by the government).

10. *FY 1998 Financial Statement Audit Health Care Financing Administration (HFCA): Hearing Before Subcomm. On Gov't Management, Information and Technology of the House Comm. on Gov't Reform*, 104th Cong. 3 (1999) [hereinafter *FY 1998 Financial Statement Audit*] (statement of Inspector General June Gibbs Brown, Inspector General). *See also HHS IG Estimates Medicare Overpaid $22 Million for Improper PPS Readmissions*, 3 Health Care Fraud Rep. (BNA) 421 (May 19, 1999); *IG Reports Savings of $6.8 Billion in Most Recent Semiannual Report*, 3 Health Care Fraud Rep. (BNA) 498 (June 16, 1999).

11. *FY 1998 Financial Statement Audit*, *supra* note 10, at 3.

12. *Id.*

13. *Id.* at 3, 7.

14. *See generally* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) [hereinafter HIPAA]; Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997).

15. *See* HIPAA, 110 Stat. at 1936.

16. HIPAA § 212, 110 Stat. at 2004.

17. HIPAA § 215(a), 110 Stat. at 2006. For a summary of the Civil Monetary Penalties Law, see Lewis Morris, *Role of OIG/OLC CMPL, Exclusions, Global Settlements*, in CORPORATE COMPLIANCE SUPP. 1996, at 81, 83-84 (PLI Corp. Law & Practice Course Handbook Series No. B7-6958, 1996).

18. HIPAA required the U.S. Department of Health and Human Services and the Department of Justice to establish a fraud and abuse control program to achieve several goals: (1)

Congress added more health care law enforcement authorities by enacting the Balanced Budget Act of 1997 ("BBA").[19] BBA provided the authority to expand regulations "to fight waste, fraud, and abuse in the Medicare and Medicaid programs."[20] BBA includes several of the President's proposed anti-fraud and abuse initiatives, including the issuance of Stark Law[21] advisory opinions, exclusion of convicted felons from the federal health care programs, and new civil monetary penalties for anti-kickback law violations.[22]

The government plans on the continued use of the recently enacted health care fraud legislation.[23] For example, the OIG plans to finalize regulations that will implement a new and revised civil monetary penalty authority delegated to the OIG and promulgate regulations for implementing the civil monetary penalty authority applicable to Medicare+Choice organizations.[24] With such additional resources and tools, the government can continue its diligent pursuit of health care fraud violations.[25]

Finally, the number of *qui tam*[26] suits filed under the False Claims Act[27] has increased exponentially.[28] Health care fraud accounts for the majority of

coordinate federal, state and local law enforcement programs to control fraud and abuse with respect to health plans; (2) conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States; (3) facilitate the enforcement of the civil, criminal and administrative statutes applicable to health care; (4) provide industry guidance, including advisory opinions, safe harbors, and special fraud alerts relating to fraudulent health care practices; and (5) establish a national data bank to receive and report final adverse actions against health care providers. *See* HIPAA § 201(a), 110 Stat. at 1992 (establishing a fraud and abuse control program).

19. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997).

20. Balanced Budget Act of 1997, 111 Stat. at 319.

21. The Federal Self-Referral Statute ("the Stark Law") prohibits physicians from referring certain "designated health services" to entities in which the physician or a member of his/her family has an ownership or compensation interest, and also prohibits the entity from presenting a Medicare claim for the services. 42 U.S.C. § 1395nn (1994 & Supp. III 1997). For a discussion of the Stark Law, see Greg Radinsky, *Defining a Group Practice: An Analysis of the Stark I Final Rule*, 41 ST. LOUIS U. L.J. 1119 (1997); Jo-Ellyn Sakowitz Klein, *The Stark Laws: Conquering Physician Conflicts of Interest?*, 87 GEO. L.J. 499 (1998).

22. Balanced Budget Act of 1997, 111 Stat. at 271.

23. *See* OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH & HUMAN SERVICES, WORK PLAN: HEALTH CARE FINANCING ADMINISTRATION PROJECTS, FISCAL YEAR 1999, at 44 (1999); *see also IG Red Book Outlines Cost-Saving Recommendations for Medicare, Medicaid*, 3 Health Care Fraud Rep. (BNA) 422 (May 19, 1999).

24. U.S. Dep't of Health & Human Services, *supra* note 23, at 44. *See also HHS IG Planning Final Rules on Safe Harbors, HIPAA Civil Penalties*, 2 Health Care Fraud Rep. (BNA) 870 (Nov. 18, 1998); *HHS IG, AOA Develop Performance Measures to Monitor Fraud-Fighting Grants*, 2 Health Care Fraud Rep. (BNA) 321 (May 6, 1998).

25. *See Regulatory Agenda Sets Goals for HHS IG Rules in Next Six Months*, 3 Health Care Fraud Rep. (BNA) 388 (May 5, 1999).

26. A *qui tam* suit is filed by a person ("relator") on behalf of the government to recover damages and penalties under the False Claims Act. 31 U.S.C. § 3730 (b)(1) (1994). Depending

the new *qui tam* cases.[29] The percentage of *qui tam* cases involving HHS as the client agency has increased from twelve percent to sixty-one percent over the past twelve years.[30] The False Claims Act stipulates that the government must review each *qui tam* suit filed and decide whether it is worthwhile to pursue.[31] As a result, the government will continue to be kept busy as more *qui tam* suits are filed each year. For the foregoing reasons, health care providers will continue to be challenged by government enforcement initiatives to deter fraud and abuse.

B. Consolidation and Merger of Health Care-Entities

Consolidation and mergers are rampant in the health care industry today.[32] These corporate acquisitions are taking multiple forms, including mergers of health insurance companies and health maintenance organizations, health care

on whether the government decides to intervene, the relator can recover between fifteen and thirty percent of the proceeds plus reasonable expenses and attorney fees. *Id.* § 3730 (d)(1). *See also DOJ Relator's Share Guidelines*, 11 TAF Q. REV. 17 (1997) (discussing how Department of Justice determines the percentage of the relator's share).

27. 31 U.S.C. § 3729 (1994). Congress enacted the civil False Claims Act, also known as the "Lincoln Law," to deter and detect "rampant fraud" in federal defense contracting during the Civil War. S. REP. NO. 99-345, at 7 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5285-86 (explaining the history of the False Claims Act). The False Claims Act was significantly amended in 1986 to combat all forms of government procurement and contracting fraud, including fraud with respect to the federal health care programs. *See generally* S. REP. NO. 99-345.

28. Taxpayers Against Fraud, *Qui Tam Statistics* (last modified Nov. 1999) <http:\www.taf.org/taf/docs/qtstats99.html>. In November 1999, the Department of Justice reported that total *qui tam* recoveries amounted to approximately $2.9 billion after the False Claims Act was amended in 1986. *Id.*

29. *Id.*

30. *Id.*

31. 31 U.S.C. § 3730(b)(1) (1994). This section states that *qui tam* actions may be dismissed "only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting." *Id.* The False Claims Act provides the government at least sixty days to review each case. 31 U.S.C. § 3730(b)(2) (1994). However, because the government routinely seeks extensions for review, seals on *qui tam* cases are frequently extended for several months or even a year or more. *See* JOHN T. BOESE, CIVIL FALSE CLAIMS AND QUI TAM ACTIONS 4-101 to 4-104 (1993 & Supp. 1999).

32. *Trends in the Profession*, 62 TEX. B.J. 19 (1999). *See also* Russell C. Coile, Jr., *[A] Healthcare 2001: Transitions, Transactions and Transformations [B] Healthcare Forecast [C] Healthcare Trends: Jan. 1997, 1998*, in HEALTH CARE M & A 1998, at 323, 361 (PLI Corp. Law & Practice Course Handbook Series No. B4-7234, 1998). The federal government treats a merger and a consolidation as a separate and distinct transaction. The Health Care Financing Administration ("HCFA") regulations define merger as "a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving" and consolidation as "the combination of two or more corporations resulting in the creation of a new corporate entity." 42 C.F.R. § 413.134(k)(2)-(3) (1998).

systems acquiring hospitals, and physician management companies acquiring physician practices.[33] There are two primary events that explain why the consolidation and merger of health care providers are likely to continue to occur in the future.

First, the movement toward managed care has prompted many health care providers to consolidate or merge.[34] In today's economic climate, the health care industry is focused on delivering health care services in the most efficient and cost-effective manner.[35] The government and the health care industry regard managed care organizations, which often use capitation,[36] as an effective method of controlling the costs of medical care.[37]

Consolidation has been essential for managed care companies: (1) to provide national coverage; (2) to enhance their product line; (3) to achieve economies of scale; and (4) to augment their bargaining leverage in negotiating capitation arrangements.[38] Tenet Healthcare Corporation, one of the largest hospital chains, recognizes this trend and has made acquiring more of the growing managed care market a top priority.[39] It is likely that the managed care market will continue to grow and estimates suggest that eighty percent of Americans will receive health care from some form of managed care by the year 2000.[40] As a result, health care corporations must consolidate to continue competing effectively in the managed care marketplace.[41]

Second, the continued implementation of the prospective payment system ("PPS") to reimburse health care providers for services and supplies rendered to Medicare beneficiaries will compel health care providers to consolidate. In 1983, the Medicare program implemented its PPS for most inpatient hospital stays to award efficient hospitals for cost-effective delivery of health care

33. Coile, *supra* note 32, at 361.

34. *See Trends in the Profession*, *supra* note 32, at 19-20.

35. *See* Nancy A. Peterman, *Protecting Patients' Rights in Health Care Bankruptcies*, 17 AM. BANKR. INST. L.J. 10 (1998); James T. Markus & John F. Young, *Anti-Discrimination Provisions- Do They Have Any Real Meaning?*, 17 AM. BANKR. INST. L.J. 14 (1998).

36. Capitation is a method of payment whereby the health care provider is paid a fixed amount on behalf of a group or individual to provide a specified set of health care services. James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Healthcare Marketplace: Life in the Healthcare Speakeasy*, 22 AM. J.L. & MED. 205, 210-13 (1996).

37. *Id. See also* Patrick O'Neill, *Doctor Fee Plan May Cure High Costs, But Opponents Decry Side Effects*, PORTLAND OREGONIAN, Sept. 25, 1996, at A1 (stating "capitation has won widespread favor in the health care industry and in government as a way to control runaway medical costs").

38. Paul T. Schnell & Teresa M. Andresen, *Managing Managed Care Mergers and Acquisitions*, 2 M & A LAW., Sept. 1998, at 1.

39. *See* TENET HEALTH CARE CORP., 1998 ANNUAL REPORT 4 (1999).

40. Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1219-20 (1997).

41. *See Aetna to Acquire Prudential Healthcare, Become Largest Health Care Provider in U.S.*, MEALEY'S INS. L. WKLY., Dec. 14, 1998, at 4.

services.[42] PPS limits the amount of reimbursement to those hospitals by predetermining a fixed price for a particular diagnostic related group.[43] This payment system accounts for a substantial portion of hospital revenue and has an overall effect of making hospitals more cost-efficient because actual reimbursements are based upon a fixed rate rather than the actual cost of each provided service.[44]

This change in the payment system resulted in reduced reimbursement levels for many hospitals.[45] As a result, several hospitals chose to consolidate to reduce operating costs and increase profits by operating on a larger scale.[46] This trend is likely to continue as more types of health care providers, such as skilled nursing facilities, are reimbursed under the new Medicare PPS that took effect January 1, 1999.[47] It is uncertain whether these health care providers will be able to remain solvent under the new Medicare reimbursement system.[48] PPS has had a far greater impact than any financial analyst or policymaker expected.[49] For example, Vencor Inc. and Sun Healthcare Group, two of the nation's largest nursing homes chains, are in dire financial straits.[50] Many other health care companies are experiencing similar problems and have

42. BARRY R. FURROW ET AL., HEALTH LAW § 13-10, at 574-75 (1995).

43. *Id.* § 13-10, at 574

44. *Id.* at 575.

45. *See* Stephen H. Siegel, *Consolidation of Physicians and Other Noninstitutional Providers*, 72 FLA. B.J. 18 (1998). *See also* John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions: The Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L.J. 1, 45-49 (1996-1997); Rob Daumeyer, *Tight Market Forces Hospitals to Examine Consolidations*, CIN. BUS. COURIER, Mar. 28, 1988, at 14.

46. *See* Siegel, *supra* note 45, at 18.

47. *See, e.g.*, Ann Saphir, *SNFS Face Prospect of Major Upheaval*, MOD. HEALTHCARE, Jan. 4, 1999, at 32; Karen Pallarito, *More Financial Pain: Market Gyrations Deal Another Blow to Healthcare Stocks*, MOD. HEALTHCARE, Sept. 14, 1998, at 72. Home health agencies are expected to reimbursed under the new Medicare PPS in the near future; however, these health care providers currently are being reimbursed under a transitional "interim payment system." *Id.*

48. *See* Saphir, *supra* note 47, at 72. *See also* Howard W. Dickstein, *PPS Isn't Working*, NURSING HOMES, Feb. 1, 1999, at 9.

49. *See Outcry Grows Over Nursing Home PPS Losses, But Some Are Doing Fine*, MED. & HEALTH, Apr. 23, 1999, *available in* 1999 WL 10391841; Lyn Danninger, *Fed Regulations Threaten Home Health Services*, PAC. BUS. NEWS, Apr. 23, 1999, at 1, *available in* 1999 WL 8090148; Rachel Kamuf & Eric Benmour, *Vencor's Restructuring Options Vary, Analysts Say*, BUS. FIRST-LOUISVILLE, Apr. 12, 1999, at 1, *available in* 1999 WL 8382756.

50. Kamuf & Benmour, *supra* note 49. Vencor Inc. and Sun Healthcare's financial problems were not caused exclusively by the change in the federal health care programs' reimbursement system. Both these companies are highly leveraged companies as a result of rapid growth through acquisitions. *See Corporate Loan Ratings: Moody's Assigns Four New Ratings—Sun Healthcare*, 21 BANK LETTER, July 7, 1997, *available in* 1997 WL 12156157; *Vencor Wrestles with Leverage, Regulatory Changes* 22 BANK LETTER, June 15, 1998, *available in* 1998 WL 20367319; *Investors Buy Up Bargains Caused by Shaky Market*, DAILY OKLAHOMAN, Sept. 4, 1998, at 23.

either closed their businesses or are on the verge of filing for bankruptcy.[51] As a result, many skilled nursing facilities and home health agencies may need to consolidate to survive or augment profits. Consolidation would allow them to reduce their administrative costs while improving market leverage.[52] Some of these distressed companies, including Vencor, are also under investigation by the federal government for possible fraudulent conduct.[53] Accordingly, expanding health care corporations may decide to purchase these distressed companies through an "asset sale" to insulate themselves from the liabilities of the seller.

As managed care and PPS continue to expand, consolidation in the health care industry will continue unless Congress passes legislation that changes the dynamics of the federal health care programs' reimbursement system to allow smaller corporations and less financially secure corporations to remain in business. Thus, the government is using great vigilance in investigating and prosecuting health care fraud violations. At the same time, there is a growing trend for health care organizations to consolidate, merge and purchase each other's assets.[54] Therefore, it is important to address the liability of the new and surviving corporate entity.

III. SUCCESSOR LIABILITY LAW

A. Successor Liability at Common Law

Corporate health care transactions are usually structured as an asset purchase, rather than a stock purchase or a merger, to insulate the buyer from the seller's liabilities. When a corporation sells or otherwise transfers all of its assets, the general common law rule indicates that the buyer does not assume

51. *See* Kamuf & Benmour, *supra* note 49.

52. Other factors resulting in the consolidation of smaller health care entities into larger regional and national operators are the increased complexity of medical services provided, growing regulatory and compliance requirements and the increasingly complicated reimbursement systems. Smaller entities often lack the financial resources to efficiently and effectively deal with the various laws, governmental policies and economic forces that are changing the health care industry. *See, e.g.*, Sun Healthcare Group, Inc. SEC 10-K Form (visited Jan. 18, 2000) <http://www.sec.gov/Archives/edgar/data/904978/0001047469-98-003752.txt>.

53. *See* Andy Miller, *Stock of Atlanta-Based Nursing Home Operator Falls after Deal Canceled*, KNIGHT-RIDDER TRIB. BUS. NEWS, Apr. 6, 1999, *available in* 1999 WL 14824638 (stating that "Federal investigators, in a five-year campaign against health care fraud, are looking at possible Medicare billing problems at other long-term care companies, such as Beverly Enterprises and Vencor."); Vickie Chachere, *U.S. Attorney Investigating Vencor*, TAMPA TRIB., Nov. 19, 1998, at 1.

54. For the convenience of reference, when the term "consolidate" is used, it is often used collectively to mean consolidate, merge and asset purchase.

the corporation's liabilities.[55] This general rule is based upon the premise that when one corporation sells its assets, it transfers an interest distinct from that of the corporate entity itself.[56] However, this general rule is subject to the following four exceptions: (1) an expressed or implied assumption of liability;[57] (2) a transaction that amounts to a de facto merger;[58] (3) a mere continuation of the transferor corporation by the transferee;[59] and (4) a transaction that was fraudulent.[60]

Additionally, some courts will impose liability when dictated by matters of public policy, or where there has been an attempt to frustrate a federal statute. For example, in *Upholsterers' International Union Pension Fund v. Artistic Furniture of Pontiac*, the Seventh Circuit exceeded the traditional exceptions

55. *See, e.g.*, Forest Labs., Inc. v. Pillsbury Co., 452 F.2d 621, 625 (7th Cir. 1971); Bud Antle, Inc. v. Eastern Foods, Inc., 758 F.2d 1451, 1458 (11th Cir. 1985); Conn v. Fales Div. of Mathewson Corp., 835 F.2d 145, 146 (6th Cir. 1987); Wallace v. Dorsey Trailers Southeast, Inc., 849 F.2d 341, 343 (8th Cir. 1988).

56. *See id.*

57. Under this exception, the successor corporation or buyer must have either expressly or impliedly assumed the liabilities pursuant to the contractual agreement that created the successor corporation. *See, e.g.*, Oppenheimer v. Prudential Sec. Inc., 94 F.3d 189, 193-94 (5th Cir. 1996).

58. The sale of assets will transfer the seller's liabilities to the purchasing entity when the transaction amounts to an express or "de facto" merger. Courts consider the following factors in determining whether a "de facto" merger exists: (1) continuity of shareholders, management, personnel and location of assets before and after the transaction; (2) prompt dissolution of the selling corporation; and (3) the buyer's assumption of the seller's ordinary business obligations. *See* Louisiana-Pacific Corp. v. Asarco, Inc., 909 F.2d 1260, 1264 (9th Cir. 1990); Knapp v. North Am. Rockwell Corp., 506 F.2d 361, 365 (3d Cir. 1974); Shannon v. Samuel Langston Co., 379 F. Supp. 797, 801 (W.D. Mich. 1974).

59. Courts typically have considered the following factors in applying the "mere continuation" exception: (1) only one corporation exists after the transaction; and (2) an identity of stock, stockholders, and directors exists between the two corporations. Mozingo v. Correct Mfg., 752 F.2d 168, 174-75 (5th Cir. 1985). In the past decade, a number of courts have begun to deviate from this traditional rule. *Id.* at 175. Courts may begin to apply the "continuity of enterprise," also referred to as the "substantial continuity" theory, in health care cases. Under the "substantial continuity" approach, the court weighs the following factors: (1) retention of same employees; (2) retention of the same supervisory personnel; (3) retention of the same production facilities and location; (4) production of the same products; (5) retention of the same name; (6) continuity of assets; (7) continuity of general business operations; and (8) whether the successor holds itself out to be a continuation of the previous enterprise. United States v. Carolina Transformer Co., 978 F.2d 832, 838 (4th Cir. 1992). *See also Mozingo*, 752 F.2d at 175; United States v. Distler, 741 F. Supp. 637, 642-43 (W.D. Ky. 1990). This test differs from the "mere continuation" approach in that it does not require a continuity of shareholders or directors between the predecessor and successor corporation.

60. Andrew J. Lubrano & Stephen B. Straske II, *Mergers, Share Exchanges, and Sale of Assets*, FLA. B. HANDBOOK 1999, § 10.54, at 58-59 (1999). Under the fraudulent transaction exception, the successor corporation may be held liable for the predecessor's liabilities if the transaction is conducted merely to escape liability.

to the common law rule in assessing liability to a successor corporation.[61] Regarding the four general exceptions, the court stated that "the Supreme Court and this Circuit have imposed liability upon successors beyond the bounds of the common law rule in a number of different . . . contexts to vindicate important federal statutory policies."[62] The courts are willing to ignore the corporate entity and assess liability to a successor corporation and/or individual shareholders[63] in situations where it is apparent that an attempt to avoid liability has been made, or when liability is expressly assumed. Judicial application of any or all of the above noted theories depend upon case specific facts.

B. Successor Liability under Medicare Statutes

The case law on Medicare successor liability is limited. On June 1, 1994, the United States Court of Appeals for the Fifth Circuit issued the leading decision in the context of an overpayment. In *United States v. Vernon Home Health, Inc*., a corporation that purchased the assets of a home health agency was obligated under the Medicare regulations to repay approximately $30,000 in Medicare overpayments made by the government to the prior owner even though it assumed no liabilities in the purchase agreement.[64] The Fifth Circuit held that a purchase of the assets of a home health provider, including the seller's provider agreement and provider number, subjected the buyer to liability for Medicare overpayments made to the seller prior to the sale.[65]

The court rejected the buyer's arguments that under Texas corporate law the buyer of assets does not assume liabilities.[66] Rather, it held that Medicare regulations preempt Texas corporate law regarding successor liability, and based its decision on the applicable regulation.[67] The Medicare regulation

61. Upholsterers' Int'l Union Pension Fund v. Artistic Furniture of Pontiac, 920 F.2d 1323, 1326 (7th Cir. 1990) (imposing liability on a successor corporation for inadequate pension funds provided for by its predecessor, illustrating the court's willingness to apply the concept of successor liability when dictated by matters of public policy). *See also* Sullivan v. J.S. Sales Plumbing, Inc., No. 92 C 7393, 1994 WL 55659, at *3 (N.D. Ill. Feb. 23, 1994); Central States, S.E. and S.W. Areas Pension Funds v. Hayes, 789 F. Supp. 1430 (N.D. Ill. 1992).

62. *Upholsterers' Int'l*, 920 F.2d at 1326. In product liability cases, successors have been found liable for defective products where they have taken over the predecessor's lines of business and the predecessor no longer exists to provide relief. *See* 63 AM. JUR. 2D *Products Liability* § 116 (1996).

63. *See, e.g.*, Beverly Enter. v. Califano, 460 F. Supp. 830 (D.D.C. 1978) (holding a buyer of the stock owned by corporate owners of a nursing home liable for Medicare overpayments to corporation).

64. United States v. Vernon Home Health, Inc., 21 F.3d 693, 694, 696 (5th Cir. 1994).

65. *Id.* at 696.

66. *Id.* at 695-96.

67. *Id.* The court reasoned that:

governing provider agreements mandates that an assigned agreement be subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued.[68] The court stated that when the assets of the home health provider were purchased, the provider agreement was automatically assigned, but noted that the buyer could have rejected the automatic assignment and applied for a new provider agreement.[69] Thus, the Fifth Circuit held that the buyer was liable for the seller's overpayment liability because the buyer did not apply for a new provider agreement.[70]

In late 1994, HCFA ratified the result in *Vernon* in a memorandum from the Director of the Office of Survey and Certification ("Tirone Memorandum").[71] In addition, HCFA repeatedly proposed a rule that would in effect codify *Vernon*.[72] However, the proposed rule has not been adopted.[73]

> The controlling regulation is Title 42 C.F.R. § 489.18(d) which requires: "An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued . . . ." Thus, any purchase of assets that involves the assignment of the provider agreement is subject to the relevant statutory and regulatory conditions. One of these conditions is that adjustments are made for overpayments, pursuant to 42 U.S.C. § 1395g(a): "The Secretary shall periodically determine . . . necessary adjustments on account of previously made overpayments . . . ." *See* Beverly Enters. v. Califano, 460 F. Supp. 830 (D.D.C. 1978) (holding buyer of stock of corporate owners of nursing home liable for Medicare overpayments to corporation); *In re* Metro. Hosp., 131 B.R. 283, 291 (E.D. Pa. 1991) (holding that the Secretary's right to offset overpayments is mandated by 42 U.S.C. § 1395(g), which serves as a limitation on the assignment in bankruptcy of the provider payments).

Id.

68. *Id.* at 696.

69. *Vernon*, 21 F.3d at 696.

70. *Id.* The court stated "[b]y accepting that assignment, *Vernon* II [the buyer] agreed (albeit unknowingly) to accept the terms and conditions of the regulatory scheme. Thus, it is liable for the overpayments." *Id.*

71. *See* OFFICE OF SURVEY AND CERTIFICATION, BUREAU OF HEALTH STANDARDS AND QUALITY, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH & HUMAN SERVICES, MEMORANDUM ON COMMERCE CLEARING HOUSE REPORT OF COURT RULING REGARDING TRANSFER OF PROVIDER AGREEMENT 15-20 (1994) [hereinafter Tirone Memorandum].

72. *See* Nov. 1995 & 1998 Semi-Annual Regulatory Agenda.

73. Health care providers who have defrauded and abused the federal health care programs may file for bankruptcy to avoid paying fines or returning overpayments. By declaring bankruptcy, providers get (1) an "automatic stay," blocking creditors from trying to recover money owed; and (2) discharged financial debts, including overpayments and fines. Unfortunately, previous bankruptcy bills have failed to include any language providing relief to federal health care programs. *See Vice President Gore Announces New Efforts to Fight Health Care Fraud and Abuse*, U.S. NEWSWIRE, Mar. 25, 1999, *available in* 1999 WL 4636036; Katherine E. Harris, *Bankruptcy Bills Fail to Close Loophole That Shields Providers From Fraud Liability*, 3 Health Care Fraud Rep. (BNA) 420 (May 19, 1999). However, a new bill unveiled recently would force bankrupt health care providers to pay fines and overpayments and make it easier to exclude these providers from federal health care programs. *See* Katherine E. Harris,

HCFA initially indicated that a successor to a provider agreement would be liable for all Medicare penalties and sanctions owed by the old owner, unless otherwise stated in the change of ownership.[74] However, HCFA later revised this statement, concluding that the successor would be liable for overpayments incurred by the previous owner by mere acceptance of the provider agreement, regardless of what is stated in the sales agreement.[75] To further expound upon the implications of accepting assignment of a provider agreement, HCFA recently noted that "[i]n accordance with the decision in Vernon, we believe that in accordance with the regulations, all liabilities, including overpayments, of the old owner should be transferred to the new owner when the new owner accepts assignment of the provider agreement."[76]

IV. SUCCESSOR LIABILITY FOR OVERPAYMENTS, FALSE CLAIMS ACT DAMAGES AND PENALTIES, AND CORPORATE INTEGRITY OBLIGATIONS

When a buyer acquires another corporation, it may not know if the seller is subject to a *qui tam* suit and a government investigation.[77] Regardless of the

New Bill Would Force Bankrupt Providers to Pay Fines, Overpayments, 3 Health Care Fraud Rep. (BNA) 577 (June 30, 1999).

74. Effect of Change of Ownership on Provider and Supplier Penalties, Sanctions, and Overpayments, 59 Fed. Reg. 20,387 (proposed Apr. 25, 1994); Effect of Change of Ownership on Provider and Supplier Penalties, Sanctions, and Overpayments, 59 Fed. Reg. 57,596 (proposed Nov. 14, 1994).

75. *See* Tirone Memorandum, *supra* note 71, at 18-19.

76. DISABLED AND ELDERLY HEALTH PROGRAMS GROUP, CENTER FOR MEDICAID AND STATE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH & HUMAN SERVICES, MEMORANDUM ON TREATMENT OF UNDERPAYMENTS AND OVERPAYMENTS IN CHANGE OF OWNERSHIP SITUATIONS 1 (1999).

In an unpublished decision, a federal court recently adopted the reasoning of *Vernon*. *See* Deerbrook Pavilion v. Shalala, No. 98-4179-CV-SOW-ECT (W.D. Mo. Nov. 5, 1999). In *Deerbrook Pavilion*, the court held that a buyer would be liable for a civil monetary penalty which was originally assessed on the previous owner of a provider agreement. The court stated:

> Plaintiff was automatically assigned the provider agreement its predecessor held, the same agreement under which the predecessor incurred civil monetary penalties. These penalties were assessed pursuant to relevant federal statutes providing for the imposition of 'a civil money penalty . . . for each day of noncompliance' with certain regulations. 42 U.S.C. § 1395i-3(h)(2)(B)(ii) (penalties under Medicare); *see* 42 U.S.C. § 1396r (h)(2)(A)(ii) (analogous penalties under Medicaid). An assigned agreement remains subject to all relevant statutes, regulations, terms and conditions under which it was originally issued. 42 C.F.R. § 489.18(d). Therefore, adopting the reasoning of *Vernon*, it follows that plaintiff is properly subject to the civil money penalties imposed on it by HCFA.

Deerbrook Pavilion, No. 98-4179-CV-SOW-ECT, slip. op. at 7. This court did not address the issue of False Claims Act liability.

77. Corporations are required to disclose any government investigations to the Securities and Exchange Commission when they file their 10Ks. However, it is possible that many corporations will be unaware of any investigation while a *qui tam* complaint remains under seal. *See supra* note 31.

seller's status, the buyer's financial liability will depend largely upon whether the transaction was an asset or stock purchase. The term "asset purchase" has become a convenient label in the legal arena because of the significant benefits an asset purchase can bring a buyer in a corporate health care transaction. Accordingly, courts and the federal government are likely to apply an expansive interpretation of the law and look behind the transaction's actual documents to see whether the transaction was in fact a sale of assets or merely an attempt to avoid liability.

A. Overpayments

Vernon provides valuable guidance to attorneys on how other courts and the government will view Medicare successor liability issues. However, it is important to note that *Vernon* has limited applicability. First, the case is only binding authority in the Fifth Circuit. In addition, *Vernon* is limited to its specific facts. *Vernon* involved a home health agency that was a Medicare Part A ("Part A") provider.[78] Under Part A, a participating provider's rights and obligations arise upon execution of a Medicare Provider Agreement.[79] In contrast, Medicare Part B ("Part B") "suppliers" do not enter into provider agreements with HCFA.[80] In fact, reflecting the absence of a contractual relationship under Part B, the regulations define "supplier" as "a physician or other practitioner, or an entity other than a provider, that furnishes health care

78. *Vernon*, 21 F.3d at 694. The Medicare program is comprised of two separate and distinct parts, each of which is funded by a separate trust fund. Part A is financed by contributions from employees, employers, and the self-employed and provides traditional hospital insurance by reimbursing in-patient hospital, skilled nursing, hospice, and home health services. Part B, a voluntary insurance program for the aged and disabled, provides Supplementary Medical Insurance by paying for physician and other medical and health services, as opposed to the primarily institutional type of services covered by Part A. Part B is financed through premiums paid by beneficiaries and through federal government appropriations. *See* FURROW ET AL., *supra* note 42, § 13-1, at 562.

79. *See* 42 U.S.C. § 1395cc (1994 & Supp. III 1997). The Medicare regulations define "provider" as "a hospital [or other healthcare institution] that has in effect an agreement to participate in Medicare." 42 C.F.R. § 400.202 (1998). During the life of the agreement, a Part A provider furnishes medical care to program beneficiaries. In return, the provider is reimbursed from the Federal Hospital Insurance Trust Fund under the Prospective Payment System ("PPS"), which conditions government payment to patient discharge. At the end of its fiscal year, a Part A provider must submit a cost report to a Medicare fiscal intermediary to determine whether the provider was underpaid or overpaid. *See* FURROW ET AL., *supra* note 42, §§ 13-8 to -10.

80. Part B participants (either suppliers or beneficiaries) submit claims for payment to, and receive reimbursement from, a carrier. Payments for physician services under Part B are made from the Federal Supplementary Medical Insurance Trust Fund on the basis of fee schedules. *See* FURROW ET AL., *supra* note 42, §§ 13-21, 22. Payments for other services, such as outpatient services, are based on the Part B program's traditional reasonable cost reimbursement practice. *Id.* § 13-25.

services under Medicare."[81] Since the Fifth Circuit's analysis focused on the contractual arrangement of the Part A provider, *Vernon* is not applicable to transactions involving Part B "suppliers."[82]

The *Vernon* court established that a buyer is liable for overpayments to a seller when the buyer accepts the automatic assignment of the Medicare provider agreement.[83] Because the court held that applicable federal law preempts any state corporate law, *Vernon* does not discuss the issue of whether the transaction constitutes an asset purchase.[84] However, the *Vernon* court noted that the key factor in its determination was that the buyer accepted the automatic assignment of the seller's provider agreement rather than incurring a break in service and applying for a new provider agreement.[85] When Part A providers are involved, it is possible that other courts will impose overpayment liability when the buyer accepts automatic assignment of the seller's provider agreement, based upon the Fifth Circuit's reasoning in *Vernon*.[86]

However, the Fifth Circuit may have reached the same conclusion had *Vernon* involved a Part B supplier. The court would likely have conducted an analysis of the applicable state law regarding successor liability, predicated

81. 42 C.F.R. § 400.202 (1998).

82. *Vernon*, 21 F.3d at 693.

83. *Id.* at 696.

84. *Id.* at 695.

85. *Id.* at 696. As a practical matter, the buyer did not want to obtain a new provider agreement because it would result in a delay in Medicare certification. There is often an interim period between the date that the new owner begins to provide services to Medicare patients and the date on which the new provider is eligible to receive payment for such services. As a result, the purchasing corporation would have forfeited significant Medicare payments for services it provided during this interim period. *See* Tirone Memorandum, *supra* note 71, at 15-18.

86. The *Vernon* court held that federal law "preempted" the relevant state law because a nationwide federal program was at issue. *Vernon*, 21 F.3d at 695-96. After the *Vernon* decision, there has been a growing body of Supreme Court and federal case law disfavoring the use of federal policy concerns to override well established state corporate law principles governing successor liability. *See, e.g.*, O'Melveny & Myers v. FDIC, 512 U.S. 79, 85 (1994) (concluding "[the Court] of course would not contradict an explicit federal statutory provision . . . [or] adopt a court-made rule to supplement federal statutory regulation that is comprehensive and detailed; matters left unaddressed in such a scheme are presumably left subject to the disposition of state law."); Atherton v. FDIC, 519 U.S. 213, 214 (1997) (noting that "a federal court may fashion federal common-law rules only upon a specific showing that the use of state law will create a significant conflict with, or threat to, some federal policy or interest.").

Arguably, the regulatory language that "[a]n assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued" upon which the *Vernon* court based its decision, does not specifically address any issues relating to state corporate successor law; accordingly, it is not in conflict with state corporate law. Thus, it is possible that future courts could hold that state successor liability law could be the applicable standard when the federal authority is vague or silent. As the following discussion notes, however, this would not change the end result. *See infra* notes 87-89 and accompanying text.

upon the fact that state corporate law does not directly conflict with federal law regarding assessment of liability against a Medicare Part B supplier. The Fifth Circuit may have considered whether the buyer's purchase of the seller's assets in *Vernon* gave rise to a de facto merger.[87]

The Fifth Circuit would have conducted a factual analysis to see whether the transaction constituted a de facto merger. For example, to assess whether the buyer assumed the seller's ordinary business obligations, the Fifth Circuit may have noted if the buyer applied for new provider numbers for each federal health care program to which the buyer submits claims.[88] A new entity is permitted to use the seller's Part B provider number, but must notify Medicare by filing a change of ownership notice.[89] The Fifth Circuit and other courts may well have assessed liability to a buyer who accepted a seller's provider number if the courts viewed the buyer's acceptance as assuming the seller's ordinary business obligations. Accordingly, future courts could decide that the corporate transaction is a de facto merger rather than an asset sale.

Alternatively, even though a Part B supplier does not execute a formal contract with HCFA, provider numbers for Part B suppliers arguably correspond to Part A provider agreements.[90] Thus, a court may impose liability based upon a contractual analysis similar to the Fifth Circuit's reasoning in *Vernon*. Accordingly, when a supplier purchases the assets of another supplier, it should apply for a new provider number to create a corporeal barrier between previous business practices and ongoing billing.

87. *See supra* note 58 and accompanying text (listing the factors courts typically look at when considering whether a de facto merger exists).

88. All health care providers and suppliers are required to submit a provider/supplier enrollment application, known as HCFA 855, for enrollment in any federal health care program. *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, HEALTH CARE PROVIDER/SUPPLIER APPLICATION, GENERAL APPLICATION-HCFA 855 (1/98) (visited Jan. 18, 2000) <http://www.wellmedicare.com/forms/hcfa855198.pdf>.

89. *See* DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, HEALTH CARE PROVIDER/SUPPLIER APPLICATION, CHANGE OF INFORMATION FORM-HCFA 855C (1/98) (visited Jan. 18, 2000) <http://www.wellmedicare.com/forms/hcfa855c198.pdf>.

90. *Compare* 42 C.F.R. § 424.55 (1998), *with* 42 U.S.C. § 1395cc. In general, this would not be an issue for Part B suppliers such as physicians and practitioners because when they sell their practices they cannot assign the rights to future billing by the acquiring individual or entity; individual provider numbers are nonassignable since they are based on individual qualifications. *See* Medicare and Medicaid Guide (CCH) ¶ 11,150, at 4633-5 to 4633-6 (1996). However, under limited circumstances, a physician could assign outstanding receivables to a successor or execute a reassignment of benefits. In addition, Part B group provider numbers may be assigned provided the individual physicians who constitute the group do not change. Members of the group practice may change, but Medicare requires notice of these changes and for this reason, successor liability issues are similar to the issues discussed for individuals.

B. Liability Under the False Claims Act

HCFA took advantage of the *Vernon* ruling, and ratified the result in the Tirone Memorandum.[91] The Fifth Circuit's opinion in *Vernon* was silent on the issue of whether the buyer would be liable for Medicare damages and penalties.[92] Nonetheless, HCFA indicated that a successor to a provider agreement would be liable for all Medicare damages and penalties of the previous owner.[93]

HCFA's position is not absolute. The Tirone Memorandum has never been promulgated as a proposed or final rule. Moreover, it is uncertain whether a court would uphold HHS's position on imposing False Claims Act liability in a successor liability transaction. It is easier to recoup an overpayment than to impose civil damages and penalties upon a successor because liability for an overpayment requires no culpability.[94] Conversely, the False Claims Act and the Civil Monetary Penalties Law only impose penalties on those who "knowingly" participate in the wrongdoing.[95]

Even so, the federal government will likely argue that the buyer is responsible for the seller's False Claims Act liability.[96] Based upon the above analysis regarding overpayment liability, the government could determine that the buyer contractually accepted the seller's False Claims Act liability by accepting the seller's provider agreement.[97] While the False Claims Act enables the government to receive treble damages and penalties of up to $10,000 per false claim to deter fraud and abuse, a court may find it more equitable to assess damages above the overpayment amount to recoup the interest the government lost on the improperly submitted claims and to deter other providers from committing fraudulent acts.[98] In addition, the primary

91. Tirone Memorandum, *supra* note 71, at 15-18.

92. *See supra* notes 83-86 and accompanying text.

93. *See* Tirone Memorandum, *supra* note 71, at 20.

94. *See* 42 C.F.R. § 405.371(c) (1998).

95. *See* 31 U.S.C. § 3729(a)-(b) (1994). *See also* 42 U.S.C. § 1320a-7a (1994 & Supp. III 1997) (law regarding Civil Monetary Penalties). HIPAA clarified the standard of knowledge required to impose liability under the Civil Monetary Penalties Law by adding "knowingly" before "presents," *see* HIPAA § 231(d), 110 Stat. at 2013, and by defining the term "should know" to encompass acting with "deliberate ignorance or reckless disregard" of the truth or falsity of the claims submitted. *Id*. HIPAA also expressly included "no proof of specific intent to defraud is required." *Id.* at 2014. This language reflects the same standard of knowledge required for False Claims Act violations. Previously, the False Claims Act did not have a definition of the "knowledge" requirement until the Act was significantly amended in 1986. *See generally* S. REP. NO. 99-345.

96. *See* Tirone Memorandum, *supra* note 71, at 15-18.

97. *Id.* at 15-18.

98. The False Claims Act prohibits the knowing filing of a false or fraudulent claim for payment to the United States, and the knowing use of a false record or statement to obtain payment. Persons violating these provisions of the statute are subject to civil penalties of not less

purpose of the False Claims Act is to enhance the government's ability to recover losses sustained as a result of fraud against the government.[99] When it is unclear as to whether the transaction is an asset sale or a de facto merger, the court may be compelled to assess liability to the buyer to vindicate important federal statutory policies.[100]

In a stock sale or merger, courts may even be more willing to assess some False Claims Act liability to the buyer. In a typical stock sale or merger, a successor corporation expressly undertakes all the liabilities of its predecessor, including any potential claims for Medicare penalties and sanctions.[101] The rationale behind imposing liability on the buyer in this type of transaction is to prevent a corporation from escaping liability because of a mere formality.[102] The buyer likely paid a lower price for the seller's corporation than had the corporation complied with all the applicable federal health care programs' rules and regulations. Therefore, a court will likely find it equitable to impose some liability on the buyer. However, the amount of liability may depend on whether the buyer was fully aware of the seller's False Claims Act liability.

C. Corporate Integrity Obligations

The OIG may take a similar approach in addressing succession issues with its Corporate Integrity Agreements ("CIA").[103] In the context of a global

than $5,000 and not more than $10,000, plus treble damages, for each such claim filed. 31 U.S.C. §§ 3729-3733 (1994).

99. S. REP. NO. 99-345.

100. *See supra* text accompanying notes 61-62. The government will have a harder time seeking damages from the buyer where the buyer only accepted a provider number. As discussed previously, the court's assessment in this situation will depend upon whether the court concludes that the transaction is in fact an asset purchase. If a court does not conclude that the transaction is an asset purchase, it will impose some liability upon the buyer. This is especially true where it is apparent that an attempt to avoid liability has been made.

101. *See* discussion *supra* Part III.A.

102. *Id.*

103. A CIA is an agreement entered into between a health care provider and the government in conjunction with a civil settlement related to a fraud and abuse investigation. It is a government-imposed plan, usually entered into as an alternative to other administrative remedies, such as exclusion from the federal health care programs. *See* Criteria for Implementing Permissive Exclusion Authority under Section 1128(b)(7) of the Social Security Act, 62 Fed. Reg. 67,392, 67,392-93. CIAs are different from Compliance Programs. Compliance Programs are programs voluntarily designed and implemented by health care providers. They are not government imposed. There are no absolute requirements as to what elements, structure or resources should be incorporated into a voluntarily created compliance plan. However, if the government as part of an investigation examines a compliance plan, proof of its effectiveness by the provider may be a key factor in its acceptability as a mitigating factor. *Id.* at 67,393-94. *See generally* OFFICE OF INSPECTOR GENERAL'S COMPLIANCE GUIDANCE FOR HOSPITALS (Feb. 1998); OFFICE OF INSPECTOR GENERAL'S COMPLIANCE GUIDANCE FOR CLINICAL LABORATORIES (Aug. 1998); OFFICE OF INSPECTOR GENERAL'S COMPLIANCE GUIDANCE FOR

settlement to resolve False Claims Act liability, if the OIG is willing to waive its permissive exclusion authority and the provider has not agreed to voluntarily withdraw from the federal health care program, then the OIG customarily will require some contractual assurances of future compliance.[104] The OIG will typically ask the health care provider to implement certain corporate integrity obligations under a CIA.[105]

In a typical situation, a corporation may have purchased a health care company that is subject to a CIA. Each CIA has a specific provision that states it "shall be binding on the successors, assigns and transferees" of the provider.[106] In addition, the OIG requires that a provider notify the OIG promptly after a company enters into a binding agreement to transfer or sell part of its business.[107]

Thus, a successor corporation would be required to implement all applicable provisions of a CIA. In this situation, it would be prudent for the buyer to carefully consider the CIA's effect on its operations prior to entering

HOME HEALTH AGENCIES (Aug. 1998). For materials developed by the OIG as part of its effort to identify and curb health care fraud see *Department of Health & Human Services, Office of Inspector General, Compliance Program Guidance* (last modified Nov. 16, 1999) <http://www.dhhs.gov/progorg/oig/readrm/index.htm> (click on "Compliance Guidance").

104. *Id*. The OIG has broad authority to exclude providers from participation in federal health care programs. 42 U.S.C. § 1320a-7 (1994 & Supp. III 1997). For certain offenses, OIG's exclusion authority is mandatory, while for others it is discretionary. *Id.* Permissive exclusions may be derivative in form. For example, permissive exclusions may be based on action previously taken by a court, state licensing board, or other federal or state agency. In those cases the OIG is not required to reestablish the factual or legal basis for the underlying sanction. Permissive exclusions may also be non-derivative. For example, the OIG may be required to make a prima facie showing that improper conduct occurred. *Id.* The regulations governing exclusions are found at 42 C.F.R. Pt. 1001 (1998).

105. *Department of Health & Human Services, Office of Inspector General, Corporate Integrity Agreements (CIA's)* (last modified Nov. 10, 1999) <http://www.dhhs.gov/progorg/oig/readrm/index.htm> (click on "Corporate Integrity Agreements"). Settlement agreements with CIA obligations were first imposed in 1994. Early CIAs had fewer stringent measures that only required providers to develop policies and procedures, attend training, and provide a certification to the OIG. Over the last few years, CIAs have become much more comprehensive. While each CIA is tailored to the specific provider and deals with the specific facts of the conduct at issue, most CIAs typically are in effect for five years and require a provider to implement the following provisions: (1) hire a compliance officer/establish a compliance committee; (2) develop written standards and policies including a code of conduct; (3) implement a comprehensive training program; (4) audit billings to the federal health care programs; (5) establish a confidential disclosure program; (6) restrict employment of ineligible persons; and (7) submit a variety of reports to OIG. *Id.*

106. A copy of a Corporate Integrity Agreement can be obtained by submitting a Freedom of Information Act request to: HHS Freedom of Information Officer, Office of the Inspector General, Room 645-F, Hubert Humphrey Building, Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201.

107. *See id.*

into the transaction. Each CIA is tailored to the specific provider and deals with the specific facts of the conduct at issue. Accordingly, the company may decide to keep the seller's company as a wholly owned subsidiary. Under this structuring, the OIG would not likely impose the CIA obligations to the buyer's entire corporation, but only to its new subsidiary.

In an asset sale, a health care corporation might argue that the CIA liability does not transfer to the buyer. However, the corporation must seriously weigh the benefits of continued compliance with the seller's CIA obligations, even in an asset purchase. The OIG's analysis to impose liability on the successor corporation will likely be similar to a court's assessment. The OIG might conclude that that the asset purchase agreement is a guise to shield liability and is, in fact, a stock purchase or merger. The OIG could subsequently find that the buyer failed to comply with the seller's compliance obligations and materially breached the CIA. A buyer who materially breaches the CIA is subject to exclusion[108] -- a death sentence to any corporation doing business with federal health care programs.[109] It may therefore be prudent for a buyer contemplating a transaction to agree to continued compliance with a less burdensome CIA than risk being excluded from the federal health care programs. The OIG may only require the buyer in this situation to assume corporate integrity obligations until the seller's facilities are no longer operational.

V. CONCLUSION

As the government continues its efforts to curtail health care fraud and abuse, and more companies continue to consolidate, more health care attorneys will be confronted with assessing their clients' Medicare successor liability issues. In light of *Vernon* and the various HCFA publications, careful consideration should be given when a health care provider accepts an assignment of a Medicare provider agreement or number in an asset sale. The health care corporation should seriously weigh the benefits of assuming the prior owner's Medicare provider agreement or number or accepting a delay in receiving a new provider agreement or number. Likewise, in the event of a stock sale or merger, the buyer or the surviving corporation should carefully weigh the benefits of the transaction against the potential liabilities. It is the

108. *Id.* The parties to a CIA agree that a material breach of the CIA constitutes an independent basis for the provider's exclusion from participation in the federal health care programs. *Id.*

109. Private payors are known to review the OIG's "List of Excluded Individuals/Entities" when deciding whether to retain, contract with, or renew a contract with a health care provider. *See List of Excluded Individuals/Entities* (last modified Jan. 7, 2000) <http://www.dhhs.gov/oig/cumsan/1999/index.htm>.

attorney's job to advise clients on the ramifications resulting from a failure to structure a true "asset sale."

If, however, the client decides to structure the transaction as an "asset sale," there are other steps health care corporations can take to minimize their liability. The buyer can insist that the contract includes a provision indemnifying the buyer from pending and/or existing Medicare overpayments, fines, and penalties for the time period preceding the execution of the transaction. Further, prior to an asset purchase, it is prudent for the buyer and the appropriate federal officials to agree on the total amount of Medicare liability involved in the transaction. Having a firm figure in hand allows the buyer to calculate the capital needed to discharge the debt owed to the federal health care programs; thus, the buyer is in a better position to negotiate an appropriate purchase price for the corporation. If possible, the buyer should try to obtain a favorable legal opinion from the seller's counsel. Finally, and most importantly, the buyer should effectively communicate with the government to clarify any questions surrounding the transaction. A brief phone call or simple letter to the government may reveal an unanticipated problem.

The applicable law on Medicare successor liability issues is relatively straightforward. Courts assess liability to the buyer when they believe the transaction is not an asset purchase but rather an artifice to avoid liability. The difficulty lies in the correct judicial application of law to the facts in determining whether the transaction is actually an asset sale, or instead, a de facto merger.