VEDDERPRICE®

Chicago ■ New York ■ Washington, D.C.

May 2010

Health Law Bulletin

Changes to the Health Care Fraud and Abuse Laws Enacted as Part of Health Reform Legislation

After more than a year of intense debate, President Obama and the 111th Congress have succeeded in enacting comprehensive health care reform legislation. The legislation is composed of two separate laws—the Patient Protection and Affordable Care Act (PPACA), which was signed into law by President Obama on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), amending certain provisions of the PPACA, which was signed into law on March 30, 2010.

This bulletin, the second in a series of bulletins for health care providers and other Vedder Price clients in the health care industry, discusses changes in federal laws concerning health care fraud and abuse, including the False Claims Act, the Medicare and Medicaid Anti-Kickback Statute, and the Civil Monetary Penalties provisions of the Social Security Act.

The False Claims Act

The False Claims Act generally provides that a person can be subject to a fine and/or imprisonment for up to five years when he or she, in any matter involving a health care program, "knowingly and willfully (1) falsifies, conceals, or covers up by a trick, scheme, or device a material fact; or (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses a materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry." The False Claims Act was amended in 2009 by the Fraud Enforcement and Recovery Act of 2009 (FERA), to provide that knowingly failing to pay an obligation owing to the government is sufficient to constitute a false claim.

The PPACA adds an overpayment reporting obligation to the Social Security Act, requiring any person who receives an overpayment to report it to the Department of Health and Human Services (HHS) and repay the amount of the overpayment before the later of (i) the date that is 60 days after the overpayment is identified or, (ii) if applicable, the date any corresponding cost report is due. With this change, an overpayment is now an obligation to the government, and therefore failing to return the overpayment constitutes a false claim under the False Claims Act (as amended by FERA).

The Anti-Kickback Statute

The Anti-Kickback Statute prohibits the knowing and willful offer, payment, solicitation or receipt of remuneration to induce or reward the improper referral of items or services reimbursable by a federal health care program. Most courts have held that an arrangement is in violation of the Anti-Kickback Statute where any purpose of the arrangement is to induce or reward referrals, regardless of whether there are additional, legitimate reasons for the arrangement. Prior to the enactment of the PPACA, however, courts were split as to what constitutes a "knowing" payment, solicitation or receipt of remuneration.

Most courts have long held that the "knowing and willful" criterion is satisfied if the defendant engaged in the payment, solicitation or receipt of remuneration in exchange for referrals with the knowledge that such conduct was illegal. In contrast, the Ninth Circuit and other courts have held that the government or plaintiff

must prove that the defendant knew that his or her conduct was a violation of the Anti-Kickback Statute and acted with specific intent to violate the law. The PPACA resolves this issue by adding a new provision which states that "a person need not have actual knowledge of [the Anti-Kickback Statute] or specific intent to commit a violation" of the Anti-Kickback Statute to constitute a violation.

The PPACA further clarifies that a claim which originates from a referral in violation of the Anti-Kickback Statute constitutes a "false claim." Accordingly, in addition to direct liability under the Anti-Kickback Statute itself, a violation of the Anti-Kickback Statute can be the basis for liability under the False Claims Act.

Administrative Sanctions—Civil Monetary Penalties and Exclusion

Health care providers engaging in fraudulent or abusive activities are subject to a number of administrative sanctions, including exclusion from participation in Medicare and Medicaid, and the imposition of civil monetary penalties for each claim deemed improper. The so-called "CMP Statute" authorizes HHS to impose civil monetary penalties (CMPs) for presenting or causing to be presented a claim that falls into any of a number of categories of "improper" claims. "Improper" claims include, among others, any claim that is false or fraudulent, is in violation of the anti-assignment rule or involves the transfer of funds to a Medicare or state health plan beneficiary to induce the beneficiary to improperly order or receive services from a particular institution, physician or other practitioner.

Exclusion, pursuant to which a provider is barred from receiving any payment from Medicare or any state health care program, including Medicaid, is mandatory for providers convicted of certain crimes relating to health care fraud, patient abuse or misuse of controlled substances, and for providers who have defaulted on Health Education Assistance Loan obligations. In addition, the Office of the Inspector General (OIG) has the discretionary authority to exclude health care providers (known as "permissive exclusion").

The PPACA expands the bases under which the OIG is authorized to impose civil monetary penalties and, at its option, exclude from participation in federal health care programs the following:

- Knowingly making, using or causing to be made or used a false record or statement material to a false claim for payment under federal health care programs ($50,000 per false record or statement);
- Failing to grant timely access to the Inspector General upon the IG's reasonable request for the purpose of audits, investigations, evaluations or other statutory functions of the OIG ($15,000 per day);
- Ordering or prescribing a medical or other item or service during a period in which the person was excluded, where the person knows or should know the claim for such service will be made to a federal health care program ($10,000 plus three times the amount of the potential claim);
- Making false statements in connection with provider enrollment; and
- Knowingly failing to report and return an overpayment within the required timeframe.

In a rare example of a change in the fraud and abuse laws that benefits providers, the PPACA added a number of exclusions from the definition of "remuneration," including:

- An incentive that "promotes access to care and poses a low risk of harm to patients and the Federal health care programs";
- The provision of items or services for free or below fair market value, in connection with a rebate, coupon or similar program, provided that the items or services are made available to all individuals without regard to health insurance status, and are not tied to the provision of other items or services reimbursable by Medicare or a state health program; or
- The provision of items or services for free or below fair market value, if the item or service is reasonably connected to the medical care of the individual, and the discount is granted based upon a good faith determination of financial need.

Implementing regulations will no doubt have a significant effect on the scope of these changes and the actions necessary to maintain compliance. In addition, we can expect an increasing governmental focus on fraud and abuse in the health care industry in the form of new laws and the dedication of additional resources to their enforcement. We will monitor these developments as they occur.

VEDDERPRICE®

222 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60601
312-609-7500 FAX: 312-609-5005

1633 BROADWAY, 47th FLOOR
NEW YORK, NEW YORK 10019
212-407-7700 FAX: 212-407-7799

875 15th STREET NW, SUITE 725
WASHINGTON, D.C. 20005
202-312-3320 FAX: 202-312-3322

www.vedderprice.com

About Vedder Price

Vedder Price P.C. is a national business-oriented law firm with more than 250 attorneys in Chicago, New York and Washington, D.C.

Health Law Services

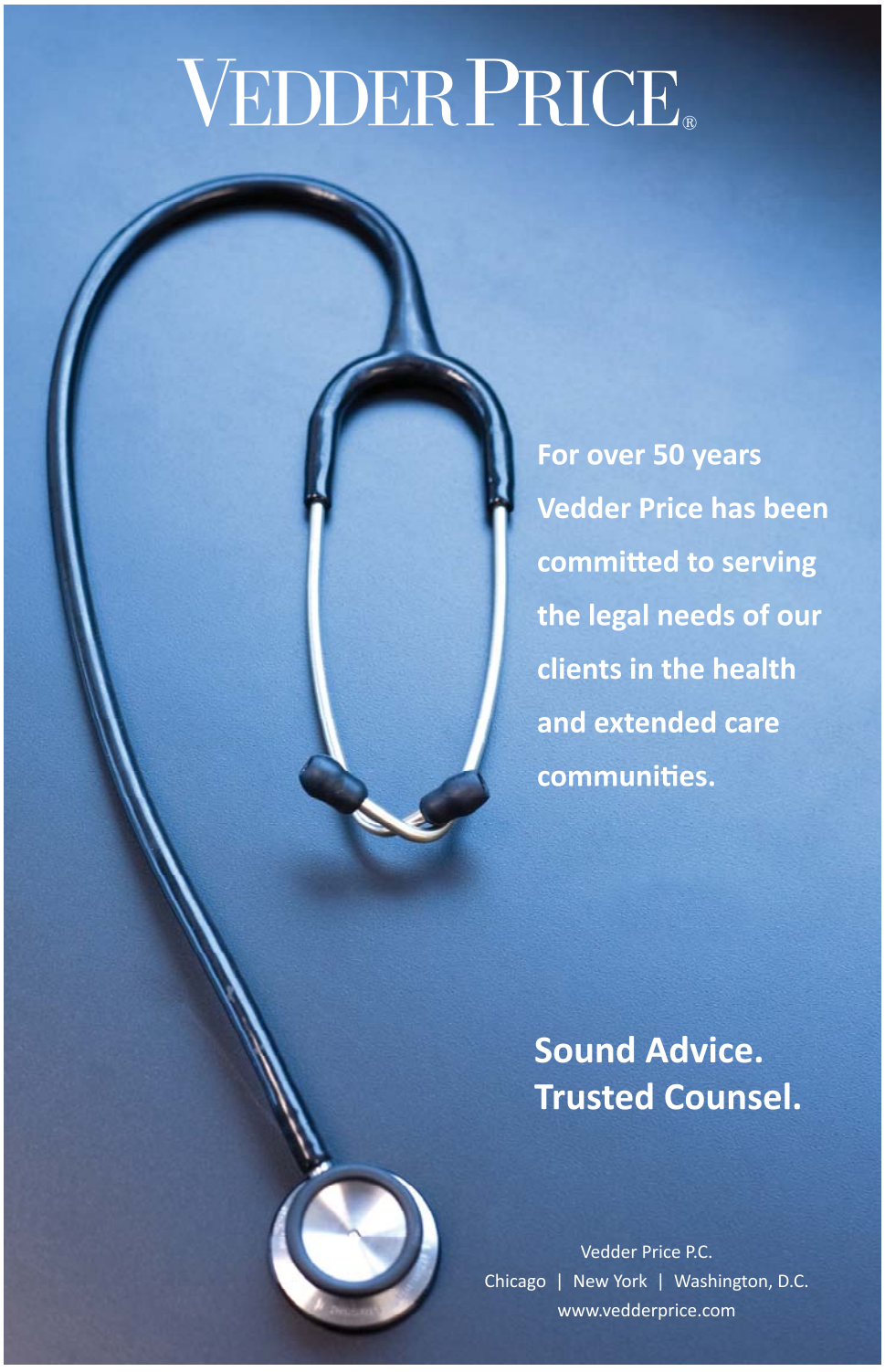
For over 60 years, the attorneys of Vedder Price P.C. have counseled and advocated on behalf of a broad spectrum of clients in the health care industry, including major health care provider institutions and health care systems, physician organizations, managed care organizations, individual and group health care practitioners and practices, professional membership associations, and a variety of other not-for-profit organizations and foundations and for-profit enterprises.

Our full-service health law practice provides a wide array of legal services, including:

- Health Care Financing
- Medicaid and Medicare Reimbursement
- State and Federal Tax
- Professional Associations
- Medical Records Retention and Maintenance

Principal Members of the Health Law Group

Thomas G. Abram 312-609-7760
Thomas A. Baker 312-609-7507
David E. Bennett..... 312-609-7714
Nicholas S. Harned..... 312-609-7870
Robert J. Moran..... 312-609-7517
Michael E. Reed 312-609-7640
Richard H. Sanders 312-609-7644
Thomas E. Schnur..... 312-609-7715
Kathryn L. Stevens 312-609-7803
Gregory G. Wrobel..... 312-609-7722


VEDDER PRICE®
For over 50 years Vedder Price has been committed to serving the legal needs of our clients in the health and extended care communities.
Sound Advice.
Trusted Counsel.
Vedder Price P.C.
Chicago | New York | Washington, D.C.
www.vedderprice.com