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Coppersmith Schermer & Brockelman PLC

What the FCA?

The Civil Fraud and Abuse Provisions of the Patient Protection and Affordable Care Act of 2010

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EXECUTIVE SUMMARY

Much has been made of the fraud and abuse provisions of the Patient Protection and Affordable Care Act of 2010 (PPACA), and rightfully so. But it is a mistake to view the fraud and abuse provisions of PPACA in isolation. They are more appropriately seen as the continuation of an aggressive expansion of the False Claims Act that started last year, with the passage of the Fraud Enforcement and Recovery Act of 2009 (FERA). PPACA's fraud and abuse provisions, while significant, and in some instances even extreme, are merely the latest step in an ongoing expansion of the civil tools available to the government to combat fraud and abuse in the field of health care.

BACKGROUND

To fully comprehend the scope of the fraud and abuse provisions in PPACA, you must first understand the changes made by FERA last year. FERA was introduced on February 5, 2009, in the middle of—according to the legislative history—the "most serious economic crisis since the Great Depression," and at a time when the federal government had "obligated and expended more than $1 trillion in an effort to stabilize the banking system and rebuild our economy."

FERA's sponsors recognized that "one of the most successful tools for combating waste and abuse in government spending has been the False Claims Act, which is an extraordinary civil enforcement tool used to recover funds lost to fraud and abuse." With FERA, Congress expanded the False Claims Act in at least three key ways:

1. **Liability for claims not submitted directly to government.** Before FERA, the U.S. Supreme Court had held that the False Claims Act applied only when the defendant presented a claim for the government itself to pay. FERA extended the reach of the False Claims Act to claims submitted to nongovernmental contractors and subcontractors that pay claims with federal dollars or "on the

government's behalf or to advance a government program or interest." This applies the False Claims Act to, for example, claims submitted to Medicare Advantage plans and Medicaid managed care plans.

2. **Reverse false claims.** FERA expanded liability for reverse false claims, making it a violation of the False Claims Act to retain overpayments by the government.

3. **Lower standard for materiality.** FERA relaxed the standard for materiality, making it easier for the government to prove violations of the False Claims Act. Before FERA, the False Claims Act did not expressly explain when a false statement or document was material to the payment of the claim, triggering liability. The federal circuits therefore developed their own standards for materiality, which varied between circuits. FERA set a low bar for materiality—"having the actual tendency to influence or be capable of influencing the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

RELEVANT PROVISIONS OF PPACA

With the foregoing in mind, we now turn to PPACA.

Initially, PPACA significantly increases the funds and personnel devoted to investigating and ferreting out health care fraud and abuse. Among the key provisions are the expansion of the Recovery Audit Contractor program (RAC) (§ 6411). This provision mandates the expansion of RAC into Medicare by requiring states to contract with one or more RACs to identify underpayments and overpayments and to recoup overpayments for Medicaid services by December 31, 2010. RACs are compensated at least in part by a bounty process that gives them an incentive to aggressively seek out and pursue fraud and abuse.

Beyond that, the most significant substantive provisions are:

Liability for overpayments (§ 6402). PPACA fleshes out the reverse-false-claims provisions of FERA. Health care providers now generally must report and return any overpayment of Medicare or Medicaid funds within 60 days after the overpayment was "identified." PPACA does not explain what it means for an overpayment to be "identified." There will almost certainly be legal battles over the meaning of that term. Any overpayment not reported within 60 days becomes an "obligation" under the False Claims Act, making the provider potentially liable for three times the total amount overpaid, plus $10,000 for each overpayment.

Suspension of Medicare and Medicaid payments during fraud investigations (§ 6402). PPACA allows the Department of Health and Human Services (HHS) to suspend all Medicare payments, and allows states to suspend all Medicaid payments, to a health care provider "pending an investigation of a credible allegation of fraud . . . ." This provision is significant, and will be the subject of a future bulletin in this series.

Amendments relating to the anti-kickback statute (§ 6402). Health care arrangements and transactions related to federal health care programs are governed by the criminal and administrative provisions of the anti-kickback statute. (42 U.S.C. § 1320(a)-7(b)). Under PPACA, a claim that includes items or services resulting from a violation of the anti-kickback statute is now also a false claim under the False Claims Act. PPACA also makes it easier for the government to prove a violation of the anti-kickback statute—the government

does not have to show that the defendant actually knew about the anti-kickback statute, or specifically intended to violate it.

The Stark self-referral disclosure protocol (§ 6409). This provision was the subject of a bulletin issued earlier in this series. PPACA establishes a self-referral protocol for providers and suppliers to disclose potential violations of the Stark law. PPACA also authorizes HHS to reduce amounts due for violations of the Stark law. Previously, Stark violations were strict liability in nature, and the amounts owed could be grossly disproportionate to any conduct associated with the overpayment. The factors that HHS will consider in deciding whether to reduce the amount due are:

- the nature and extent of the improper or illegal practice,
- the timeliness of the self-disclosure,
- any cooperation in providing additional information other than the disclosure, and
- any other factors that the Secretary of HHS deems appropriate.

***Qui tam* relator provisions (§ 10104(j)).** There are several provisions dealing with *qui tam* relators. Public disclosure is no longer a jurisdictional bar, but *qui tam* lawsuits are subject to dismissal if the relator is not an original source of publicly disclosed allegations. News media reports remain a qualifying bar to *qui tam* lawsuits. The definition of original source is also expanded to include an individual who discloses to the government information on which the claims are based before any public disclosures. The definition now also includes an individual who provides separate and independent knowledge that materially adds to the publicly disclosed information before filing an action.

Civil monetary penalties (§ 6402, § 6408). PPACA allows civil monetary penalties for various types of conduct, including:

- Failing to report and return an overpayment by a federal health care program.
- Ordering or prescribing any item or service for which a claim will be made to a federal health care program, when the person or entity ordering or prescribing is excluded from the program.
- Making a false record or statement that is material to a claim for payment under a federal health care program.
- Making a false or misleading statement in "any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program." This specifically includes statements in connection with Medicare Advantage organization, Medicare prescription drug plan sponsors, and Medicaid managed care organizations.
- Failing to grant timely access to the Inspector General of HHS for "audits, investigations, evaluations, or other statutory functions."

These penalties range from $10,000 to $50,000, plus three times the amount of payments at issue, for every violation.

WHAT THIS MEANS FOR HEALTH CARE PROVIDERS

The passage of PPACA is a good opportunity for providers to make sure that they are complying with federal law. PPACA increases the chances that any particular provider will face government scrutiny, and ratches up the penalties for a violation of federal law. That makes this an ideal time for providers to:

- Ensure they are following all required procedures when filing claims with federal health care programs (or entities affiliated with those programs). Providers need to know, with certainty, what items and services are properly billable, and follow the required procedures when submitting claims.
- Identify any potential Stark issues, and discuss with counsel whether and how to disclose them.
- Implement a compliance program that is effective, up-to-date, and that addresses the specific risks that face the providers' business.
- Make sure their employees know how to respond appropriately to a subpoena or other contact by the federal government.

FOR MORE INFORMATION

This Client Alert is the fifth in the "Finding Your Way" advisory series, designed to assist our clients and other health care providers as they prepare to respond to health care reform. Future articles will include discussions regarding the health care reform law's provisions regarding accountable health organizations, health reform pilot projects, and health reform quality initiatives.

For questions about the information contained in this Alert, or any of the fraud and abuse provisions in the health care reform law, please contact any member of our Criminal Defense & Government Investigations Group:

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