# Anti-Kickback Statute and False Claims Act Enforcement

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Good afternoon. Thank you all for joining us.

I'm glad to be joined today by Attorney General Holder and members of our department's senior leadership to provide an update on our efforts to stamp out waste and fraud in our health care system, protect consumers, and safeguard taxpayer dollars.

## *HHS Secretary Kathleen Sebelius*

"*My message to them today is this: there has never been a worse time to try to steal Americans' health care dollars.*"

"*What these criminals may not know is that the Affordable Care Act is not just about making our health insurance system work better for families. It's also contains some of the strongest anti-health care fraud provisions in American history.*"

## *HHS Secretary Kathleen Sebelius*

*"First, we're going to strengthen the screenings for health care providers who want to participate in Medicaid or Medicare. The days when you could just hang a shingle and start submitting claims are over.*

*Next, we're going to make it easier for law enforcement to see health care claims data from different government agencies in one place. Under the old system, it was as if police officers in one town weren't talking to the officers in the next town over. Giving law enforcement agents access to the big picture will help them identify suspicious patterns in claims data that can indicate fraud.*

*Third, we're going to increase the penalties for fraud. When you commit Medicare or Medicaid fraud, you're stealing from every US taxpayer and you should be punished accordingly.*

*Fourth, we're going to provide new resources to get more boots on the ground to fight fraud in communities across the country – altogether, we're adding an extra $600 million over the next ten years. When experts have studied our anti- fraud programs, they've found that they actually pay for themselves in money returned to taxpayers – often may times over. That means going after fraud is one of the best investments we can make."*

***HHS Secretary Kathleen Sebelius***

*"Added together, here's what the changes look like from the perspective of a potential criminal: …..*

*…… it will be harder to submit false claims; you're more likely to get caught if you do; and when you get caught, you're going to get a much tougher punishment."*

***HHS Secretary Kathleen Sebelius***

*"To learn more about this agenda and our results, I encourage you to visit our website www.stopmedicarefraud.gov."*

## *US Attorney General Eric Holder*

*"Today's report shows the success of our collaborative efforts to prevent, identify and prosecute the most egregious instances of health care fraud."*

*"We know that as long as health care fraud pays and goes unpunished, our health care system will remain under siege."*

*"These crimes harm all of us – government agencies and programs, insurers and health care providers, and individual patients. But we are fighting back, and will use the expanded capabilities that the Affordable Care Act provides to stop health care fraud in its tracks."*

## *US Attorney General Eric Holder*

*In fiscal year 2009, anti-fraud efforts resulted in $2.51 billion being deposited to the Medicare Trust Fund, a $569 million, or 29 percent, increase over FY 2008. In addition, over $441 million in federal Medicaid money was returned to the Treasury, a 28 percent increase from FY 2008."*

*"The Affordable Care Act will build on innovative strategies to fight fraud, such as Project HEAT, the joint operation between DOJ, CMS and the HHS Office of Inspector General that has unleashed special strike forces in six states to target health care fraud hot spots like South Florida, New York, Texas, California, Louisiana and Michigan."*

# The Affordable Care Act (ACA)

***New Tools to Fight Fraud, Strengthen Medicare and Protect Taxpayer Dollars***

# The False Claims Act

The False Claims Act (FCA) provides that anyone who knowingly submits false claims to the government is liable for damages up to 3 times the amount of the erroneous payment plus mandatory penalties for each false claim submitted.

(31 U.S.C. § 3729 *et seq.*)

## The False Claims Act

The ACA amended two key definitions under the FCA:

"public disclosure" and "original source"

(31 U.S.C. § 3730(e))

## "Public Disclosure"

The ACA:

(1) abolishes the "public disclosure" bar, and,

(2) narrows the definition of "public disclosure" --

these changes now permit a whistleblower to bring a *qui tam* action that is based on allegations previously disclosed through state proceedings or private litigation.

## “Original Source”

The ACA also broadens the exception for whistleblowers claim to be the “original source” of the publicly disclosed allegations.

## “Original Source”

Previously, if there had been a public disclosure of the information upon which the *qui tam* suit was based, a whistleblower had to be the “original source” of the information, meaning that he or she had to have “direct and independent knowledge” of the allegations.

## “Original Source”

Now, the whistleblower need not have direct knowledge, but instead must provide information to the government prior to the public disclosure, and the information must be independent of and materially add to the publicly disclosed allegations.

## Impact of FCA Changes

These amendments to the FCA will likely serve to increase the number of qui tam lawsuits that involve public disclosure issues.

**Amendments to The False Claims Act Can Help Consumers Reap Millions As Whistleblowers**

*"The new healthcare law recently passed by Congress and signed by president Obama includes significant changes and expansions of the federal False Claims Act ("FCA"), making it easier for whistleblowers to file a claim and potentially earn millions of dollars helping the government fight healthcare fraud…..*

# Class Action Blog (Con't)

*If you are aware of Medicaid and/or Medicare fraud being committed against the United States government by a city, doctor, hospital, clinic, pharmacy and/or medical supply company, you may be entitled to a multi-million dollar award. You can help hardworking taxpayers from being cheated -- and earn millions of dollars in the process -- by blowing the whistle on Medicaid and Medicare fraud.*

*If you know or suspect that Medicaid and/or Medicare fraud is being committed anywhere in the country, please contact us to discuss your legal options."*

- Posted on April 26, 2010 by Jerome Noll (http://classactionblog.mdpcelaw.com/articles/qui-tam-actions)

## Expansion of OIG Exclusion Authority

The ACA expands the OIG's permissive exclusion authority to include providers and suppliers who are not truthful in the enrollment or participation application process.

(SSA §1128(b)(16))

## Expansion of OIG Exclusion Authority

The ACA expands the OIG's permissive exclusion authority to include providers who fail to supply payment information

……previously limited to those who furnish items and services, now includes those who order, refer for furnishing, or certify the need for such items and services.

(SSA §1128(b)(11)) [Eff. 1/1/2010]

## Enhanced Civil Monetary Penalties

The OIG can seek "civil monetary penalties" (CMP) for various types of conduct, many of which are listed in the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a).

The amount of the potential CMP varies depending on the violation.

## Items or Services ordered or prescribed by an excluded person

New CMP - Any person that orders or prescribes a medical item or service during a period in which the person was excluded from a Federal health care program and the person "knows or should know" that a claim for payment for the medical item or service will submitted.

Penalty - up to $10,000 for each item or service, plus an assessment of not more than 3 times the amount claimed for each item or service.

(42 U.S.C. § 1320a-7a(a)(8))

## False Statements on Applications

New CMP - Any person that "knowingly" makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program…."

Penalty - up to $50,000 for each false statement as well as an assessment of not more than 3 times the total amount claimed.

(42 U.S.C. § 1320a-7a(a)(9))

## Overpayments

New CMP - Any person "that knows of an "overpayment" and does not report and return the overpayment in accordance with the new law.

Penalty – up to up to $10,000 for each item or service, plus an assessment of not more than 3 times the amount claimed for each item or service.

(42 U.S.C. § 1320a-7a(a)(10))

## False Records or Statements

New CMP – Any person that "knowingly" makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services.

Penalty – $50,000 for each false record or statement.

(42 U.S.C. § 1320a-7a(a)(8))

## Delaying Inspections

New CMP - Any person that fails to grant timely access, upon reasonable request to the OIG for the purpose of audits, investigations, evaluations, or other statutory functions of the OIG.

Penalty - $15,000 for each day of the failure.

(42 U.S.C. § 1320a-7a(a)(9))

## The Anti-Kickback Statute

The Anti-Kickback Statute (AKS) makes it a criminal offense to "knowingly and willfully" offer, pay, solicit, or receive any remuneration to induce, or in return for, referrals of items or services paid for by a Federal health care program.

The ACA amends the AKS in two important respects:

## The Anti-Kickback Statute

The ACA amended the AKS to provide that a violation of the AKS constitutes a "false or fraudulent" claim under the False Claims Act.

(42 U.S.C. § 1320(a)-7b(g))

## The Anti-Kickback Statute

The ACA amended the AKS to provide that "specific intent" is not required to establish a violation of the AKS.

(42 U.S.C. § 1320(a)-7b(h))

## The Stark Law

The Stark Law prohibits a physician from referring a patient for certain designated health services to an entity with which he or she has a financial relationship, unless an exception applies.

And, the entity that furnishes the referred designated health services is prohibited from billing for those services.

(42 U.S.C. §1395nn)

## In-Office Ancillary Services Exception

Any physician practice that provides MRI, CT and PET Imaging services must notify its patients that he or she may obtain such services from other providers and provide the patient with a list of such other providers in the community.

(Section 6003 of the ACA)

[Eff. 1/1/2010]

## In-Office Ancillary Services Exception

The Secretary of HHS is also authorized to expand the disclosure requirement to include other services.

(Section 6003 of the ACA)

[Eff. 1/1/2010]

## Whole Hospital Exception

The ACA amended the Stark Law to further restrict the ability of physicians to own interests in hospitals to which they refer.

(42 U.S.C. §1395nn(d)(3)(D)(i))

## Self-Referral Disclosure Protocol

As ***intent*** is not an element to establish a violation under the Stark Law, the ACA directs the Secretary of HHS to develop a process allowing providers and suppliers to disclose actual or potential Stark Law violations.

This process is referred to as the "Self-Referral Disclosure Protocol".

(Section 6409 of the ACA)

## Self-Referral Disclosure Protocol

The ACA further authorizes the Secretary of HHS to reduce the amount due and owing for "all violations" of the Stark law and lists the factors the Secretary may consider in making such reductions.

## SRDP Factors

The factors the Secretary may consider in making a reduction include:

1. the nature and extent of an improper or illegal activity;
2. the timeliness of the self-disclosure;
3. the degree of cooperation of the disclosing party; and
4. any other factors deemed appropriate.

## SRDP Regulations

The ACA requires the Secretary of establish the Self-Reporting Disclosure Protocol no later than September 23, 2010.

And, to report on the effectiveness of the Protocol no later than March 23, 2012.

## Obligation to Report and Return Overpayments

The ACA requires health care providers to report and return any overpayment within 60 days of either the date the overpayment is identified or the date a corresponding cost report is due, whichever is later.

An overpayment that is retained after this date becomes an obligation under the FCA, regardless of whether the overpayment was received as a result of a false claim.

*(SSA §1128J(d))* [Eff. 3.23.10]

## Other Health Fraud Amendments

The ACA amended certain federal criminal laws related to health care fraud in title 18 of the USC to take into account the changes made to the AKS.

"Specific Intent" not required to prove a violation under the Health Care Fraud Statute (18 USC §1347).

"Federal Health Care Offense" defined to violations of the AKS (18 USC §1349).

## Federal Sentencing Guidelines

The ACA directs the Sentencing Commission to increase the Federal sentencing guidelines for health care fraud offenses by 20-50% for crimes that involve more than $1,000,000 in losses.

(Section 10606(a) of the ACA)

# Suspension of Payments

The ACA allows the Secretary to suspend Medicare and Medicaid payments otherwise owed to a provider or supplier if there is a "credible allegation of fraud" against the provider or supplier.

The Secretary is required to consult with the OIG in determining whether a "credible allegation of fraud" exists.

The Secretary is required to promulgate regulations governing the use of such payment suspensions.

(Section 6402 of the ACA)

# Expanded Recovery Efforts

The ACA expands the RAC initiative beyond Medicare.

The Secretary is provided new authorities to identify and recover overpayments through the expansion of RAC to Medicaid, Medicare Advantage and Part D (the Medicare drug benefit).

(Section 6411 of the ACA)

# Sharing Data to Fight Fraud

The ACA requires the Secretary to expand CMS integrated data repository to include information from Medicaid, Veterans Administration, Department of Defense, Social Security Disability Insurance, and Indian Health Service, and enhances data matching agreements among Federal agencies.

These agreements will make it easier for the Federal government to share data, identify criminals and prevent fraud. The DOJ and Office of the Inspector General (OIG) both receive clearer rights to access CMS claims and payment databases.

The Secretary also now has authority to require States to report additional Medicaid data elements with respect to program integrity, program oversight and administration.

(Section 6402 of the ACA)

# Compliance Programs

The ACA requires every skilled nursing facility and long term care facility to adopt a "compliance and ethics program" for the prevention and detection of criminal, civil and administrative violations and promoting quality of care no later than March 23, 2013.

(Section 6102 of the ACA)

## Compliance Programs

The ACA also permits the Secretary to require all other types of providers or suppliers to establish compliance programs as a condition of enrollment.

## Medicaid Provider Terminations

The ACA requires a state Medicaid program to terminate a provider participation if the provider is terminated by Medicare or another State Plan.

The ACA further requires a state Medicaid program to exclude an individual if the individual owned or managed an entity with unreimbursed overpayments.

(Section 6501 and 6502 of the ACA)

## CMS Center for Program Integrity

The newly established Center for Program Integrity at CMS will use state-of-the-art methods to implement provisions of the ACA that detect fraud and prevent improper payments.

The Center will also work with the private health care sector to better target fraud and abuse.

## Funding for Enforcement Efforts

The ACA provides an additional $350 million over the next ten years to help fight fraud through the Health Care Fraud and Abuse Control Account (HCFAC) from FY 2011 through 2020.

The Act also allows these funds to support the hiring of new officials and agents that can help prevent and identify fraud.

## Greater Oversight of Private Insurance Abuses

The ACA also provides enhanced tools and authorities to address abuses of multiple employer welfare arrangements and protect employers and employees from insurance scams. It also gives new powers to the Secretary and Inspector General to investigate and audit the health insurance Exchanges. This, plus the new rules to ensure accountability in the insurance industry, will protect consumers and increase the affordability of health care.