



2009 Brought Big Changes to Fraud and Abuse Law

What you need to know for 2010

As 2010 begins, it has never been more important for healthcare organizations to carefully monitor their compliance activities and stay on top of the evolving obligations imposed on them under federal law. Healthcare providers now have more hurdles than ever in complying with the rules and regulations associated with the Medicare program. Last year brought significant changes to the federal government's two biggest means of recovery for Medicare costs – the False Claims Act and the Medicare Secondary Payer Act. This article outlines these new potential pitfalls and what actions you can take to protect your organization.

The False Claims Act (FCA) is the government's primary enforcement vehicle for prosecuting Medicare fraud and abuse. 31 U.S.C. § 3729 et seq. The FCA allows the government to recoup payments it has made in response to fraudulent activity, and allows private whistleblowers with knowledge of such action to also bring claims. While this statute was originally passed during the Civil War to prevent contractors' fraudulent dealings with the Union army, today it impacts nearly every industry in the country. The 2009 amendments to the FCA are only the second major overhaul of this enforcement scheme since the 1880's. These changes drastically expand the reach of the statute's civil penalties, which can include treble damages and fines up to \$11,000 per false claim (as well as criminal penalties in some circumstances).

The changes to the FCA were, ostensibly, enacted for the purpose of reaching possible fraud associated with institutions seeking TARP funds and other stimulus programs created by the federal government. Perhaps coincidentally, the new language in the FCA works to specifically overturn recent court decisions which limited the government's right to recovery in certain situations. These new amendments affect every business that deals with federal funds, whether through contracts, grants, sub-contracts, entitlement programs or other transactions. Because of these changes, FCA liability will be much broader and easier to assert. Some

estimates forecast these changes to increase government false claims recoveries to more than \$2 billion annually. In recent years, the healthcare industry has accounted for more than half of all FCA recoveries.

The major changes to the FCA include the following:

- **Elimination of the “intent” requirement:** The FCA amendments reverse the recent decision of the Supreme Court in *Allison Engine Co. v. U.S. ex rel. Sanders*, 128 S. Ct. 2123 (2008). In *Allison Engine*, the Court made clear that a defendant subject to liability under the FCA must intend for the government itself to directly pay the claim. The decision would require the government to show a clear link between the defendant's submission of a false claim and payment by the government. Although the *Allison Engine* court warned that limiting this requirement would turn the FCA into a “boundless” and “all-purpose anti-fraud statute,” Congress effectively overruled the warnings of the court in the new version of the FCA by removing language in § 3729(a)(2) which required defendant to intend to get its claim paid “by the government.” This change in the FCA scheme potentially broadens liability to any transaction in a chain of events that may involve federal dollars at some level. Specifically, it paves the way for the federal government to attempt to expand the reach of its enforcement ability to Medicaid claims.

- **Liability for overpayments:** This is potentially the most troubling aspect of the FCA amendments for the healthcare industry. In the past, in order to establish liability for a “reverse false claim” under the FCA, a defendant must have taken some affirmative action to improperly conceal, avoid, or decrease an obligation to repay the government. The 2009 changes to the FCA remove any requirement of affirmative action by the defendant – it is now arguably enough to simply have possession of an overpayment to incur liability. Now, a healthcare company may arguably be subject to FCA liability for violations of any number of other statutory reimbursement obligations if it has failed to take reasonable steps to identify and return funds owed to the federal government – even if those overpayments were made through no fault or affirmative action of the healthcare provider. There are significant unresolved questions surrounding the parameters of this new language (e.g., how often must an entity check for overpayments, how should they be reported, and how quickly must they be returned?). Healthcare providers

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(and their lawyers) should monitor court decisions that may help define their obligations under this new language.

• **Retaliation:** Under the prior version of the FCA, only employees of the company alleged to have defrauded the government were protected from retaliation or firing for reporting the misconduct. The 2009 changes to the Act expand this protection to independent contractors and other agents of the defendant. In addition, the whistleblower protections now cover lawful efforts to stop violations of the FCA even if no formal FCA action is ever filed. These changes are likely to provide disgruntled employees with additional grounds to contest terminations that are unrelated to FCA issues.

To ensure compliance with these new provisions, the Obama Administration has appropriated \$532 million over the next two years toward enforcement efforts. As part of this enforcement initiative, the Administration has created a series of “Healthcare Fraud Prevention & Enforcement Action Teams” (HEAT) and expanded the Medicare Fraud Strike Force. The HEAT task forces are a combined effort of the Department of Health & Human Services (HHS) and with the Department of Justice (DOJ), and they promote inter-agency collaboration to root out potential Medicare fraud. In addition, the recent changes to the FCA give DOJ increased flexibility in gathering and sharing information related to FCA investigations. The federal government’s renewed focus on enforcement makes clear that companies dealing with federal funds in any respect should expect increased scrutiny for the foreseeable future.

What can you do to minimize your organization’s liability exposure under the False Claims Act? Here are a few ideas for your organization to proactively protect itself from the expanded dangers of False Claims Act liability: (1) Assess your highest risk areas for potential compliance problems – this would likely include billing and refund procedures, record retention policies, certifications and reporting practices, and contracts with outside vendors that rely on the accuracy of claims data; (2) Either strengthen or create systems for identifying and refunding potential overpayments; and (3) Update employment and compliance policies – ensure that your employees understand these obligations and the steps they need to take to avoid compliance issues.

2009’s other major change to federal laws dealing with

the Medicare program is the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). The MMSEA became effective January 1, 2010, and imposes several important procedures for healthcare entities involved in personal injury (e.g., medical malpractice) litigation. The MMSEA adds certain procedural requirements to the existing Medicare Secondary Payer Act (MSP) which established that Medicare will not pay for the healthcare costs of its beneficiaries when some other source of payment is available. The MSP was originally enacted in 1980 and was designed to recoup proceeds from automobile liability insurance when motor vehicle accidents cause injuries to Medicare beneficiaries. As it has evolved, the scope of these reimbursement obligations has continually grown and in 2003 Congress enacted amendments which purport to require Medicare beneficiaries, their lawyers, and some civil defendants to reimburse Medicare for medical expenses that are awarded in lawsuits (either by settlement or judgment). Now under the MSP, Medicare has a right to institute legal proceedings to recoup its payments from anyone that received settlement funds that cover “items and services” previously paid by Medicare, as well as against certain parties that pay a beneficiary for those costs as a result of an underlying lawsuit.

The purpose of the MMSEA is to provide the Centers for Medicare & Medicaid Services (CMS) with information regarding these settlements and judgments arising from personal injury lawsuits, and thereby assist CMS in recovering payments it has made for those injuries. The MMSEA creates three affirmative obligations for an entity that is the subject of a claim that includes medical expenses. First, the statute requires a defendant to ascertain whether Medicare has paid for any of the plaintiff’s healthcare related to the injury at issue. Second, a defendant must register with CMS as a “Responsible Reporting Entity” (RRE) if it may have an obligation to pay for a Medicare beneficiary’s healthcare costs (or otherwise compensate them for a personal injury). Last, once registered, the RRE must report to CMS certain information about any “settlements, judgments, awards, or other payments” made

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to a Medicare beneficiary.

The process of enrolling for and making these reports to Medicare is completely electronic and quite onerous. However, many outside vendors in the market are available to assist with these logistical challenges. Organizations need to diligently adhere to these new requirements because there are severe penalties for failing to comply with the reporting requirements of the MMSEA. If you are an RRE, and you fail to report all information related to your payments to a Medicare beneficiary within the time specified by the MMSEA, you are subject to a fine of \$1,000 per day for each claimant who is unreported. In light of this penalty, any healthcare organization that finds itself a defendant in personal injury litigation needs to carefully consider

Medicare's interest during the discovery process and when considering settlement.

There are a number of practical issues that have been created by the MMSEA and remain unaddressed by CMS. Chief among these concerns is the ability of CMS to deal with the onslaught of data, and whether litigating parties will be able to receive timely information from CMS regarding its interests in a beneficiary's claims. These uncertainties will make the management of litigation and risk assessment very difficult, and healthcare organizations involved in personal injury litigation should make sure their legal counsel has taken these issue into account in all new and pending cases.

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HFMA Region V is proud to introduce our new campaign to help you get certified!

In January, the Certification Chairs from each state in our region gathered to officially kick-off a campaign for a revamp of the Region V State Chapters efforts to increase certification among its members. We wanted to develop a message of what certification is and the importance to a member's career development.



In the upcoming months, look for email and phone messages announcing the campaign along with a redesign of the certification portion of the State Chapter web site. The site will have an FAQ section about certification and the commitment to it, sample test questions, study materials and certified member testimonials. We want to make it as seamless as possible to invite our members to learn about, sit for and successfully pass the certification process.

Additionally, members of each States' Certification Committee will have a visible presence at upcoming educational conference's including the Dixie in February. Please be sure to take a few minutes to speak with them about becoming certified and let them know how they can help you make this a worthwhile process.

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