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Sweeping Changes Proposed Through The Health Care Fraud Enforcement Act of 2009

Law Would Bring More Enforcement, Stronger Criminal Sanctions, New Definition Of 'Willful Conduct' Fraud, and Clarification On Illegal Kickbacks And False Claims

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Following an October 28, 2009, Senate Judiciary Committee hearing on "Effective Strategies for Preventing Health Care Fraud," Senator Ted Kaufman (D-DE) introduced Senate Bill 1959, "The Health Care Fraud Enforcement Act of 2009" ("S. 1959" or "Act"),[1] aimed at assuring that those who "steal" from the federal government's investment in health care face swift prosecution and substantial punishment.[2] According to Senator Kaufman, fraud costs both public and private health plans between $72 billion and $220 billion annually, which translates into higher premiums and an increase in the cost of medical care.[3] S. 1959 is designed, in the Senator's words, to "strengthen the government's capacity to investigate and prosecute waste, fraud and abuse in both government and private health insurance."[4] S. 1959 is co-sponsored by Judiciary Committee Chairman Leahy (D-VT) and Committee members Specter (D-PA), Kohl (D-WI), Schumer (D-NY), and Klobuchar (D-MN). S. 1959 has been referred to the Senate Judiciary Committee.

Prosecuting Waste, Fraud and Abuse is a Top Obama Administration Priority

In keeping with the Obama Administration's promise to prosecute waste, fraud and abuse, and in addition to the HEAT initiatives already underway,[5] S. 1959 would increase the offense level in the federal sentencing guidelines, redefine the health care fraud offense, declare all kickbacks as "false" for purposes of the federal False Claims Act, reduce the bar necessary to prove intent under the Health Care Fraud Statute and increase funding for health care fraud prevention and enforcement efforts. Indeed, S. 1959 would authorize the "modest" annual appropriation of an additional $20 million for 2011 through 2016 to be used in investigating and prosecuting health care fraud. S.

1959 specifically allocates an additional $10 million per year to the United States Attorneys' Offices and $5 million each to the Civil and Criminal Divisions of the Department of Justice ("DOJ").

In addition to the additional annual appropriations, S. 1959's specific provisions increase the potential sanctions, including criminal sanctions, that can be imposed upon health care entities while at the same time lowering the scienter requirement. The specific provisions include:

- Proposed amendments to the Federal Sentencing Guidelines, which would authorize increased sentences for persons convicted of federal health care offenses in two ways:

    - Increase the offense level range by two to four levels for health care offenses according to the following tiers of monetary loss: a 2 level increase for losses of $1 million or more, a 3 level increase for losses of $7 million or more, and a 4 level increase for losses of $20 million or more;

    - Allows for the aggregation of the amount of all claims "submitted" as a method for calculating intended loss. This proposed "clarification" is in protest to courts that have limited intended loss to the amount actually paid by the government, or payable under government fee schedules.[6]

- Proposed amendments to 18 U.S.C. § 1347, the Health Care Fraud Statute, which would add a definition of willful conduct that does not require proof that the defendant acted with actual knowledge of the law in question or specific intent to violate that law. Under S. 1959, the willful intent requirement would be met if a defendant "acts voluntarily and purposefully to do what the law forbids." This provision parallels the language in the Senate Finance Committee health care reform bill ("America's Healthy Future Act of 2009")[7] amending the definition of willful conduct under the Anti-Kickback Statute.[8]

- Proposed amendments to 42 U.S.C. § 1320a-7b, the law that enumerates criminal penalties for acts involving federal health care programs, including the Anti-Kickback statute, which provide that all claims submitted in violation of this law constitute a false or fraudulent claim under the False Claims Act. Importantly, if adopted, a tainted claim will constitute both a prohibited kickback and a false claim even when the claims are submitted by someone other than the payor or recipient of the kickback.

- Proposed amendments to 18 U.S.C. § 24(a), the provision defining federal health care offenses, which would add to the definition of "federal health care offense" violations of the Anti-Kickback statute as well as health care-related offenses under the federal Food, Drug and Cosmetic Act ("FDCA") and ERISA. Violations of the newly included sections would allow the proceeds of these offenses to be subject to criminal forfeiture, render obstruction of an investigation a crime, include these offenses as specified unlawful activity for purposes of money

laundering and authorize the use of administrative subpoenas to investigate such violations.

S. 1959 Augments Earlier Health Care Fraud Enforcement Initiatives

Introduction of the Health Care Fraud Enforcement Act augments earlier federal government efforts to intensify health care fraud enforcement, including the Fraud Enforcement and Recovery Act of 2009 ("FERA"),[9] which President Obama signed into law on May 20, 2009. Specifically, FERA already expanded the scope of the False Claims Act ("FCA")[10] in significant ways, including:

- Eliminating the presentment requirement and requiring only a nexus to the government. Under FERA, the definition of "claim" was revised to include any request or demand made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the government's behalf or to advance a government program or interest and the government provides or reimburses any portion of the money or property. Yet, the government does not define either of the key phrases "used on the government's behalf" or "to advance a government program or interest."

- Incorporating a materiality requirement that adopts the weaker standard. With respect to FCA liability for submission of false records or statements, FERA now specifies that the false record or statement must be material to the government's payment decision, and defines "materiality" as having a natural tendency to influence or be capable of influencing, the payment or receipt of money or property.

- Expanding the "reverse false claim" provision to expressly include retention of an overpayment. FERA imposes FCA liability for knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the government. "Obligation" is defined broadly to include an established duty, whether or not fixed, arising from certain relationships, statutes, regulations, or the retention of an overpayment.

- Authorizing government intervention complaints to relate back to the date of the original compliant. FERA provides statute of limitation extension in qui tam cases where the government intervenes or amends the relator's complaint, so long as the government claim arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth in the relator's complaint. Given the delay already inherent in government investigations, this amendment dramatically affects a defendant's ability to defend itself for business conduct dating back many years.

The Health Care Fraud Enforcement Act of 2009 is the latest in a series of Congressional initiatives this year to provide additional tools for the government to investigate and prosecute claims of health care fraud. This is in anticipation of the greater role of government funds in providing more people access to health benefits

should federal health reform be enacted. This also is in anticipation of the growing number of new Medicare beneficiaries and Medicaid recipients in the near term as a result of demographics and economical conditions.

In this heightened enforcement climate, health care entities are likely to face increased government scrutiny. Therefore, it is critical that health care entities continually review, adapt and audit their compliance programs and policies to ensure they adequately address the issues identified by these enforcement efforts.

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[1] S. 1959, 111th Cong. (2009).

[2] Health Care Fraud Enforcement Act of 2009, Section-by-Section Justification, available at: http://kaufman.senate.gov/press/press_releases/release/?id=5e8767a9-e711-4f7a-8a52-27ad23e8fb53.

[3] Press Release, Senator Ted Kaufman, Kaufman Introduces Bill to Protect Americans from Health Care Fraud (Oct. 28. 2009), http://kaufman.senate.gov/press/press_releases/release/?id=5e8767a9-e711-4f7a-8a52-27ad23e8fb53.

[4] *Id.*

[5] Earlier this year, Attorney General Eric Holder and Health and Human Services ("HHS") Secretary Kathleen Sebelius announced the creation of a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), to combat Medicare fraud. See http://www.hhs.gov/news/press/2009pres/05/20090520a.html. The HEAT initiative was promoted as an effort to strengthen existing programs to combat fraud, and invest new resources and technology. Announced HEAT team efforts include the expansion of joint DOJ-HHS Medicare Fraud Strike Force teams to Detroit and Houston (other teams are operating in South Florida and Los Angeles). These teams use a data-driven approach to identify unexplainable billing patterns and investigating these providers for possible fraudulent activity.

[6] Health Care Fraud Enforcement Act of 2009, Section-by-Section Justification.

[7] S. 1796, 111th Cong. (2009).

[8] 42 U.S.C. § 1320a-7b(b).

[9] Pub. L. No. 111-21, 123 Stat. 1616 (2009).

[10] 31 USC § 3729-3733.