

# UPDATES FROM BARATZ & ASSOCIATES, P. A. FOR THE HEALTHCARE INDUSTRY

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## CONTINUED EXPANSION OF ANTI-FRAUD AND ABUSE EFFORTS

### Federal Update

The federal False Claims Act ("FCA") is a Civil War-era statute that prohibits individuals or companies from making demands for payment or withholding money from the United States government that they are not entitled to receive or withhold. The FCA requires a violator to pay back to the government three times the amount improperly received or withheld, plus a penalty of between \$5,500 and \$11,000 for each violation of the Act. Amendments to the Act in 1986 significantly increased the incentives for whistleblowers to initiate lawsuits by giving them a share of the funds recovered by the government or by whistleblowers on behalf of the government. This Act has become a major force used by the Department of Justice to prosecute healthcare fraud and abuse. A movement in Congress to expand the capabilities of this Act has been ongoing for quite awhile and on April 28, 2009 the Senate overwhelmingly passed (92-4) the Fraud Enforcement and Recovery Act of 2009 (FERA) (S.386). A similar bill, False Claims Correction Act of 2009, is also reported out of committee by the House Judiciary Committee. The support is strong for this legislation and many believe that a bill will be signed in the near future with most, if not all, provisions of these bills intact.

Although these bills are primarily targeted at potential fraud involving recipients of economic stimulus funds in the financial services industry, they include other very significant changes to the FCA. FERA would authorize the provision of a total of \$245 million per year over the next two years for the DOJ to hire prosecutors, and for the DOJ, FBI, and other law enforcement agencies to hire investigators, forensic analysts and support staff to enhance the fraud enforcement effort. FERA is projected to cost \$490 million over the next five years but proponents such as Senator Patrick Leahy (D-VT) has noted that the government recovers more than \$20 for every dollar spent on criminal fraud litigation. Since 1986, more than \$21 billion has been recovered under the FCA. Some proposed changes include:

- Eliminating the requirement that false claims be presented directly to the government. This expands the line of potential targets through contracted relationships with subcontractors and suppliers to direct contractors;
- Eliminating the intent requirement for a false statement;
- Eliminating the intent requirement for conspiracies.

House proposed legislation that could be included in a final bill may include:

- Eliminating public disclosure defense;
- Permitting government employees to be relators;
- Exempting Qui Tam relators from pleading requirements of pleading claims of fraud with particularity and specificity. This may allow relators to go on fraud "fishing expedition" claims;
- Expanding anti-retaliation protection to contractors and other third parties;
- Imposing liability for failure to disclose overpayments even where the failure was not "knowing". This could have significant consequences for medicare providers;
- Expanding the statute of limitations period from six years to eight years;
- Various retroactive consequences.

It seems that, regardless of what the final signed bill looks like, there will be one and it will likely increase the number of lawsuits brought by relators under the qui tam provisions of the FCA; thereby, substantially increasing the risks and potential cost of doing business with the government. Continued emphasis on robust compliance programs at healthcare providers is critical to reduce the chance for errors and oversights leading to significant liability.

(The above includes information from several reporters on this topic including: R. Hurwitz, Esquire, Sheppard Mullin (4/9/09), Steven R. Jenkins, Esquire, Day Pitney, LLP (3/31/09), AHLA Fraud and Abuse Practice Group (5/1/09), Reed Smith, LLP Life Science Group (5/5/09)

## New Jersey Institutes First Medicaid Inspector General

At a recent conference presented by the American Bar Association in Philadelphia, PA., a round table discussion was held that included several fine speakers on healthcare fraud and abuse enforcement issues. One of those was former prosecutor from the Eastern District U.S. Attorney Office, Mark Anderson, who provided insight as to the approach that he expects to take in the initial stages of developing this new office.

The state implemented this program through the Medicaid Program Integrity Act establishing the Office of Medicaid Inspector General. The plan is to oversee, recommend and investigate various aspects of the medicaid program to identify possible fraud and abuse. Although Mr. Anderson stated that the office has limited resources at this point (less than 10% of the people resources that the NY OMIG program has) they intend to begin by identifying the most significant recipients of state medicaid funds and begin to review the use of those monies. Based on the success of the program in NY State run by another former Federal Prosecutor, James G. Sheehan (\$263 million in fraud recoveries in 2008), I would anticipate that success in NJ may follow a similar blueprint. The NY OMIG recently became sophisticated enough to issue the first Medicaid Work Plan that includes some 70 pages of detail on initiatives of the department, areas of concern, details of investigative resources and programs. This is similar to the U.S. Department of Health and Human Services OIG work plan that has been available for years at the federal level. What this says to me is that continued expanded enforcement in the healthcare industry is here to stay at both federal and state levels and it is critical that healthcare providers understand the area that they work in and all of the related laws and regulations.

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