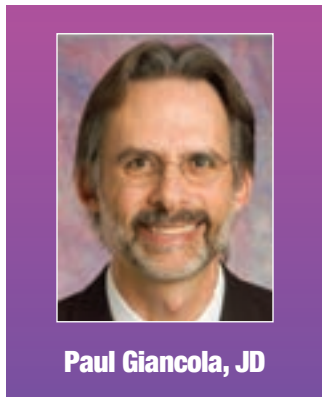




Health Care Reform Expands Physicians' Liability

The Patient Protection and the Affordable Health Care Act ("ACA") is designed to reduce the cost of health care and to improve quality of care. To achieve these goals, the ACA relies, in part, on Accountable Care Organizations ("ACO's") in which physicians, hospitals and other health care pro-



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viders contractually agree to coordinate high quality care and to share in the saving. The ACA also seeks to achieve savings through increased scrutiny of and accountability of physician financial relationships and overpayments. The ACA provisions that impact the daily practice of medicine include:

- **Mandatory Compliance Plans**
Since 2000, compliance plans for medical practices have been voluntary. The Centers for Medicare and Medicaid Services ("CMS") is in the process of developing rules to require compliance programs as a provider condition for Medicare enrollment.
- **Physician Payment Sunshine Act**
The ACA's Physician's Payment Sunshine Act Final Rule requires manufacturers of drugs and medical devices to annually report to CMS financial relationships with physicians and teaching hospitals and payments made to them. There are civil penalties for violations. However, the disclosure of payments does not necessarily protect the parties from liability under other fraud and abuse laws, such as the Anti-Kickback Statute and the False Claims Act.

The ACA has expanded physician liability as part of the effort to reduce cost.

- **Anti-Kickback Statute**
The Anti-Kickback Statute ("AKS") is a criminal statute that prohibits the knowing and willful offer, payment or solicitation or receipt of remuneration to induce (or reward) the referral of federal health care program patients or business. In recognition of the of the broad range of transactions potentially implicated by the AKS, the HHS Office of Inspector General ("OIG") has allowed "safe harbors" to protect certain identified transactions, such as ambulatory surgery centers, employment, and leasing of space and equipment, that fall within the parameters of

the safe harbors. For years courts have struggled with the "intent" requirement of "knowing and willfully" under the AKS. The ACA has clarified the ambiguity surrounding the intent requirement by adding a provision that states that "actual knowledge" of an AKS violation or "specific intent" to commit a violation of the AKS is not necessary for a conviction under the statute. The government must still show that the defendant intended to violate the law, but not AKS itself.

- **Overpayments**
The ACA requires physicians to report and return overpayments no

later than 60 days after the date on which the overpayment was identified or by the date any corresponding cost report is due, if applicable. After 60 days have passed, overpayments that have not been reported and repaid subject physicians to false claims liability (also known as a “reverse false claim”). A physician cannot avoid having actual knowledge of the overpayment by acting in reckless disregard or deliberate ignorance of the overpayment.

Penalties under the False Claims Act (“FCA”) include civil penalties of between \$5,500 to \$11,000 per violation, plus triple damages. There may also be liability under the Civil Monetary Penalties Law, and possible exclusion from federal healthcare programs.

• **False Claims Act**

The FCA imposes liability on physicians who knowingly submit a false or fraudulent claim for payment. The ACA amended the FCA to provide FCA liability for the retention of overpayments, by making it easier for private individuals known as “qui tam relators” to bring FCA cases against providers, and by changing the language

of the AKS to provide that claims submitted in violation of the AKS may also constitute false claims under the FCA.

• **ACO’s**

Although the ACA sanctions ACOs, physician and hospital members are still governed by state and federal fraud and abuse laws and regulations under the AKS, FCA, and the Stark law.

• **Stark Law**

The ACA contains several provisions that impact the Stark law (Physician Self-Referral Law). The ACA amends the Stark law in-office ancillary services exception by requiring physicians, who order imaging services that can be provided by their office, to provide the patient with a written list of suppliers who also provide such services in the area. The ACA also imposes new limitations on the Stark exception that allows physicians to have ownership interests in physician owned hospitals. Finally, the ACA required the Secretary of HHS to develop a Self Referral Disclosure Protocol (“SRDP”) and to compromise payment and penalty amounts owed under Stark. The SRDP was published in September, 2010.

• **Recovery Audit Contractors**

The ACA expanded the Medicare Recovery Audit Contractor (“RAC”) program to Medicaid and has required each state Medicaid program to establish a RAC Program. RACs are tasked with identifying improper payments to Medicare and Medicaid providers.

also includes an additional \$350 million dollars for the Health Care Fraud and Abuse Control Program (“HCFAC”). Consequently, the ACA has expanded physician liability as part of the effort to reduce cost. Physicians should therefore be cautious in their approach to billing federal health care programs for their services. **AM**

Conclusion

The ACA provides a variety of additional tools and resources for the government to fight perceived fraud and to potentially reduce health care costs. To boost their efforts, ACA

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