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Vinson & Elkins L.L.P.

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Health Care Fraud and Abuse: New Weapons, New Penalties, and New Fears for Providers Created by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Colleen M. Faddick*

INTRODUCTION

Health care fraud and abuse cost an estimated $20 billion to $100 billion per year.¹ With so many government programs vying for limited dollars, it is not surprising that Congress has relented neither in its pursuit of Medicare and Medicaid program reforms, nor in its desire to severely thwart fraud and abuse in government health care programs. Thus, Congress passed and the President signed into law the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),² substantially increasing the government’s tools for detecting and weapons for fighting fraud and abuse.³

The cost of fraud in health care is not only the underlying theme of federal fraud and abuse attacks, but the basis for expecting large recoveries resulting from expanded government and private programs to detect fraud and abuse and produce settlements. However, the new programs under HIPAA come

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* Colleen Faddick is an associate in the Health Industry Group of the Houston office of Vinson & Elkins L.L.P. She received her Bachelor of Arts from the University of Colorado, and her Juris Doctor from the University of Houston Law Center.

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1. Alwyn Cassill, Cop: Fed Fraud Police Yourself or We'll Get You, AHA News, Feb. 3, 1997, at 1 (stating that the U.S. General Accounting Office estimates health care fraud and abuse to be as high as 10% of the $1 trillion spent annually on health care); GAO Official Says Program Fraud Could Be as High as $20 Billion, 3 BNA's HEALTH CARE DAILY 2, Mar. 5, 1997 (estimating Medicare fraud and waste to range from $6 billion to $20 billion per year).


3. Although HIPAA also contains provisions regarding health care insurance access, portability, and renewability, this article focuses only on the numerous sections of Title II of HIPAA that relate to the prevention of health care fraud and abuse.
with a substantial price tag. In 1997, the Medicare trust fund is expected to contain at least $157 million for the Secretary of the Department of Health and Human Services ("Secretary" or "HHS") and the Federal Bureau of Investigation ("FBI") to conduct the various fraud-fighting programs created by HIPAA. Under the new legislation, the fraud-fighting budget will swell to $310 million by the year 2002, and then level off thereafter, without any sunset provision. HIPAA also provides significant funding for the new Medicare Integrity Program for the private detection of health care fraud, described below. Settlements, criminal fines, civil monetary penalties, and other penalties or damages recovered from individuals and entities involved in health care fraud and abuse are also to be appropriated into these funds.

The government intends for its well-funded and expanded fraud and abuse programs to combat health care fraud and abuse. Although it is difficult to argue with the government's lofty goal of eradicating fraud and abuse from the health care system, the practical application of many of HIPAA's provisions may prove harmful to many health care providers by producing the unintended consequences of fewer settlements, more court battles, and the entanglement of the innocent in the intricacies of the government's new and very broad punishment tools.

This article focuses on three provisions of HIPAA: the expansion of permissive exclusions, the broadened array of civil monetary penalties, and the new health care fraud crimes provisions. Section I of this article explains the new tools and weapons available to combat fraud and abuse. Section II describes HIPAA's creation of new health care fraud crimes, its addition of permissive exclusion from the federal health care programs for individuals associated with entities that violate fraud and abuse laws, and its expansion of civil monetary penalties. Section III outlines the purposes and basic elements of a corporate compliance plan, a tool that may be useful in preventing or lim-

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4. For 1997, HIPAA appropriates at least $104 million to the total fraud-fighting efforts of the Secretary of HHS and the Attorney General. At least $60 million is earmarked for the HHS's Office of the Inspector General ("OIG"), and $47 million is appropriated to the FBI. HIPAA § 201(b) (to be codified at 42 U.S.C. § 1320a-7c).

5. HIPAA § 201(b) (to be codified at 42 U.S.C. § 1395i).

6. HIPAA § 262 (to be codified at 42 U.S.C. § 1320d to 1320d-8) requires all health care providers and health plans (except worker's compensation plans) to use a single set of uniform standards for the electronic exchange of health care administrative and financial information.
iting individual and corporate liability under the fraud and abuse laws. This article concludes that, while many of the new provisions of HIPAA are necessary and meaningful to prevent health care fraud and abuse, the expanded criminal liability and the broad permissive exclusion provision, coupled with the new and confusing civil monetary penalties provision, emphasize the need to mitigate exposure to civil and criminal sanctions.

As of this writing, many commentators have reported that President Clinton and some members of Congress wish to amend the Act.7 This article analyzes the law as it stands in spring 1997.

I. FRAUD AND ABUSE LAWS BEFORE AND AFTER HIPAA

HIPAA represents one of the most expansive changes to federal fraud and abuse laws. Some of the more noteworthy changes include the establishment of three major programs: a Fraud and Abuse Control Program, a Medicare Integrity Program, and a Beneficiary Incentive Program. In addition, HIPAA amends the permissive exclusion provisions, provides certain minimum exclusion periods, expands the scope of civil monetary penalties, instructs the Secretary to issue advisory opinions, protects certain risk-sharing arrangements from illegal remuneration (anti-kickback) penalties, creates new crimes relating to health care fraud, and establishes a data base to house reports of adverse actions relating to the delivery of health care services. (The table found in the Appendix to this article summarizes the Act’s changes to federal fraud and abuse laws.)

A. Fraud and Abuse Control Program

HIPAA establishes a Health Care Fraud and Abuse Control Program (“Control Program”) to coordinate federal, state, and local health care anti-fraud enforcement programs.8 Specifically, HIPAA funds the Control Program for criminal, civil, and administrative enforcement; for conducting investigations, financial and performance audits, inspections, and evaluations; and for establishing and modifying safe harbors, issuing advisory opinions, and maintaining a public data base. This new Control

8. HIPAA § 201(a) (to be codified at 42 U.S.C. § 1320a-7c).
Program will be jointly administered by the Attorney General and the Secretary of HHS, acting through the OIG. Appropriations from a new Health Care Fraud and Abuse Control Account, instituted within the Medicare Hospital Insurance (Part A) Trust Fund, will fund the new program. Fines, penalties, and other fraud and abuse recoveries are also expected to contribute to the Control Program's funding. Appropriations for the first year of the Control Program (fiscal year 1997) may not exceed $104 million and may be increased by fifteen percent for each year thereafter through fiscal year 2003, at which point level funding is expected. Further, appropriations may be made from the new account to fund the cost of the FBI's activities in this area.

B. Medicare Integrity Program

The Medicare Integrity Program, established under HIPAA, authorizes HHS to contract with private companies to carry out fraud and abuse detection, cost report audits, utilization review, and provider payment determinations. The Medicare Integrity Program is also charged with provider, beneficiary, and public education, as well as the development of a list of durable medical equipment ("DME") items subject to prior HHS payment authorization. HHS is allowed to remove Medicare payment integrity activities from current Medicare contractors.

HHS is required to issue a proposed ruling with respect to how it plans to implement the new program. The new rules were slated for publication during July of 1997, but were not available as of the date of this writing. The Medicare Integrity Program will be administered by the Secretary. It will be generously funded by amounts appropriated from the Medicare (Part A) Trust Fund, receiving in 1997 between $430 million and $440 million, and bulging up to $720 million for each year after 2002.


10. HIPAA § 201(b) (to be codified at 42 U.S.C. § 1395i).

11. HIPAA § 202(a) (to be codified at 42 U.S.C. § 1395ddd). The DME list is created by the Secretary and predetermines that payment will not be made for certain equipment that, in the Secretary's payment experience, is frequently subject to unnecessary utilization. 42 U.S.C. § 1395m(a)(15) (1995).

12. HIPAA § 202(b) (to be codified at 42 U.S.C. §§ 1395h & 1395u(c)).

13. HIPAA § 201(b) (to be codified at 42 U.S.C. § 1395i).
C. Beneficiary Incentive Program

To enlist Medicare beneficiaries and others to help identify fraud and abuse, HIPAA created the Beneficiary Incentive Program, offering incentive payments to beneficiaries for providing information that leads to monetary recoveries or other criminal or civil sanctions under the Medicare program.\(^{14}\) The Secretary must establish programs to encourage individuals to report incidents of fraud and abuse against the Medicare program, though discourage reporting frivolous or irrelevant information,\(^{15}\) and must solicit suggestions from beneficiaries to improve the program's efficiency.\(^{16}\) To help increase beneficiary awareness of any potential improprieties, the program requires the Secretary to provide each beneficiary with an explanation of benefits for every item or service paid for by Medicare.\(^{17}\) Individuals whose reports lead to the recovery of at least $100 (exclusive of criminal penalties) or efficiency savings may receive a share of the recovery or savings.\(^{18}\)

D. Permissive Exclusion and Minimum Exclusion Periods

As described more fully in section II(A), HIPAA expands the activities that may form the basis for exclusion from the Medicare and Medicaid programs. In addition to the many actions previously subject to this devastating sanction, exclusion from Medicare and Medicaid is now available for violations of the new crimes added by HIPAA and convictions for *misdemeanor* controlled substance violations, as well as for officers or managing employees of a sanctioned entity and those who control a sanctioned entity and knew or should have known of the prohibited activity. Minimum periods for certain permissive exclusions and a mandatory five-year exclusion from Medicare and Medicaid for *felony* convictions relating to health care fraud and controlled substances replace the Health Care Financing Administration's prior discretion in setting exclusion periods.\(^{19}\)

\(^{14}\) HIPAA § 203 (to be codified at 42 U.S.C. § 1395b-5).

\(^{15}\) HIPAA § 203(b)(1).

\(^{16}\) HIPAA § 203(c)(1).

\(^{17}\) HIPAA § 203(a).

\(^{18}\) HIPAA § 203(b)(2) & (c)(2).

\(^{19}\) HIPAA § 211 (to be codified at 42 U.S.C. § 1320a-7).
E. Civil Monetary Penalties

As explained in detail in section II(B) below, Congress expanded the programs subject to civil monetary penalties to include any federally funded or state-funded health care program, excluding the Federal Employee Health Benefit Plan, and made substantial changes to the civil monetary penalties provisions. First, HIPAA clarifies the level of intent required for the imposition of civil monetary penalties by adding the requirement that a person must knowingly present a claim or make misleading statements to induce payment for a claim that falls within one of the prohibited categories.

Second, HIPAA increases the maximum civil monetary penalty from $2000 per item or service to $10,000 per item or service. Civil monetary penalties may now be assessed for upcoding, claiming medically unnecessary services or items, or offering remuneration. The latter includes waiving coinsurance and deductible amounts or providing free or discounted services to Medicare/Medicaid beneficiaries to influence their choice of provider, practitioner, or supplier. However, civil monetary penalties may not be assessed for waiving coinsurance and deductible amounts if the waiver (1) is not routine, (2) is not offered as part of any solicitation or advertisement, (3) was based on financial need, (4) resulted notwithstanding reasonable collection efforts, or (5) is permitted under current law. Also excluded from the prohibition are differentials in coinsurance and deductible amounts that constitute a plan’s benefit design, such as a plan incentive designed to promote the delivery of preventive care.

Third, physicians who falsely certify Medicare beneficiaries for home health care are subject to a civil monetary penalty of $42 U.S.C. § 1320a-7a (1995).

21. HIPAA clarifies that knowledge of information is imposed upon one who knows or acts on information actually possessed as well as information that should have been possessed but for the "deliberate ignorance or reckless disregard of the truth or falsity of the information." HIPAA § 231(d) (to be codified at 42 U.S.C. § 1320a-7a(j)(7)). This standard is similar to that required for liability under the federal False Claims Act ("FCA"). For a comparison of the knowledge standards of the FCA as well as the fraud and abuse prohibitions, see Robert Salcido, Mixing Oil and Water: The Government's Mistaken Use of the Medicare Anti-Kickback Statute in False Claims Act Prosecutions, 6 ANNALS HEALTH L. 105 (1997).
22. HIPAA § 231(c) (to be codified at 42 U.S.C. § 1320a-7a(a)).
23. HIPAA § 231(h) (to be codified at 42 U.S.C. § 1320a-7a(a)(i)(6)).
not more than three times the amount of payments or $5000, whichever is greater.24

Fourth, those who have a control interest or who are managers or officers of a violating entity may be subject to civil monetary penalties.25

F. Safe Harbors and Advisory Opinions

HIPAA requires the Secretary to establish a procedure to solicit recommendations at least annually, to publish proposals to modify existing and add new safe harbors under the anti-kickback provision of the Social Security Act,26 and to issue special fraud alerts. The Secretary must publish proposed safe harbors with a sixty-day comment period and may issue final rules implementing new or modifying existing safe harbors as necessary.27

HIPAA also requires the Secretary, in consultation with the Attorney General, to issue advisory opinions regarding compliance with the anti-kickback provision.28 Advisory opinions must be rendered within sixty days of a request. This provision became effective on February 21, 1997, and will sunset on February 21, 2001. On February 19, 1997, the OIG issued a final interim rule setting the procedural requirements for issuing advisory opinions.29 Although the President's proposed budget for 1998 contains a provision repealing the authority to issue advisory opinions,30 the Secretary is moving forward pursuant to HIPAA's requirements. The advisory opinions will be made available to the public, although they are binding only on the Secretary and the requesting party. While advisory opinions regarding the anti-kickback provision are a welcomed addition, Congress did not require the Secretary to issue advisory opinions about situations with potential implications under the Stark law, which prohibits self-referrals for certain "designated health services" paid for by Medicare and Medicaid. In addition, advisory opinions are not available for issues relating to the fair market value of any goods, services, or property, or regarding the

24. HIPAA § 232 (to be codified at 42 U.S.C. § 1320a-7a(b)(3)).
25. See infra section II(B).
27. HIPAA § 205 (to be codified at 42 U.S.C. § 1320a-7d(a)).
28. HIPAA § 205 (to be codified at 42 U.S.C. § 1320a-7d(b)).
30. 1998 Budget of the President, Ch. 5, at 52.
status of an individual as an "employee" as defined in section 3121(d)(2) of the Internal Revenue Code.31

G. Risk-Sharing Arrangements

HIPAA creates an exception to the anti-kickback provision for risk-sharing arrangements.32 An arrangement for items or services between a Medicare HMO or Competitive Medical Plan and an individual or entity does not result in illegal remuneration if the arrangement is pursuant to a written agreement.33 Also not illegal remuneration are arrangements for items or services between health plans and an individual or entity if pursuant to a written agreement that places the individual or entity at substantial financial risk for the costs or utilization of the items or services that the individual or entity is obligated to provide.34 While the exception is in effect, the Secretary has failed to issue in a timely fashion standards relating to this amendment.

The Secretary is required to expedite the establishment of risk-sharing standards through a negotiated rule-making process in consultation with the Attorney General and other interested parties, including representatives from the health care industry. HIPAA requires consideration of the following factors when creating the new standards: (1) the level of risk appropriate to the size and type of arrangement, (2) the frequency of assessment and distribution of incentives, (3) the level of capital contribution, and (4) the extent to which the arrangement provides incentives to control the cost and quality of health care services.35 In May of 1997, the Secretary issued proposed rules calling for a series of meetings to begin the negotiated rule-making

31. One of the exceptions to the anti-kickback provision is for remuneration paid by an employer to an employee in a bona fide employment relationship with such employer. 42 U.S.C. § 1320a-7b(b)(3)(B). Although status as an employee is crucial to this exception, that status may be determined only by the Internal Revenue Service and the Secretary will not issue opinions on that subject.

32. HIPAA § 216 (to be codified at 42 U.S.C. § 1320a-7b(b)(3)(F)).

33. See Peter A. Pavarini, Physician Networks & Other Organizational Models for Managed Care Contracting, in NATIONAL HEALTH LAW. Ass’n, ALIGNING THE NEW HEALTH CARE SYSTEM (Mar. 13-15, 1997).

34. HIPAA does not define substantial financial risk, but leaves the determination to the Secretary through negotiated rule making with the Attorney General. Congress declined to include in this provision all of the acceptable risk arrangements offered in the House version of the bill, excluding incentive pools and per diem payments. See H.R. CONF. REP. NO. 104-736, at 251, reprinted in 1996 U.S.C.C.A.N. 2064.

35. HIPAA § 216(b) (to be found at 42 U.S.C. § 1320a-7b note).
process in June, 1997. The Secretary intends to complete the process and publish interim final rules by year-end 1997.36


By adding new federal crimes, HIPAA criminalizes various activities relating to health care benefit programs, including fraud,37 theft or embezzlement,38 false statements,39 obstruction of criminal investigations,40 and money laundering.41 Health care benefit programs are defined to include any public or private plan or contract, thus providing private payers with additional weapons to fight fraud.42 Persons and organizations convicted under these provisions are subject to fines, imprisonment, or both. HIPAA further authorizes investigative demand, or administrative subpoena, procedures for the Attorney General or the Attorney General’s designee, including the FBI,43 forfeiture of property,44 injunctive relief,45 and qualified immunity for persons who provide information to law enforcement officials.46 However, the authority of the Secretary of Labor to investigate violations related to ERISA plans is not affected by this provision.47 HIPAA also establishes a new criminal penalty for those who knowingly and willfully dispose of assets to gain eligibility for Medicaid benefits, subjecting them to fines and jail time if convicted of violating this provision.48

I. Data Collection

HIPAA requires the Secretary to establish a national health care fraud and abuse collection program (to be coordinated with the National Practitioner Data Bank). Under the collection program, federal and state government agencies and health

37. HIPAA § 242 (to be codified at 18 U.S.C. § 1347).
39. HIPAA § 244 (to be codified at 18 U.S.C. § 1035).
40. HIPAA § 245 (to be codified at 18 U.S.C. § 1518).
41. HIPAA § 246 (to be codified at 18 U.S.C. § 1956(a)(1)).
42. HIPAA § 241 (to be codified at 18 U.S.C. § 24).
43. HIPAA § 248 (to be codified at 18 U.S.C. § 3486).
44. HIPAA § 249 (to be codified at 18 U.S.C. § 982(a)).
45. HIPAA § 247 (to be codified at 18 U.S.C. § 1345(a)(1)).
46. HIPAA § 248 (to be codified at 18 U.S.C. § 3486(d)).
47. HIPAA § 250. For more information about the Secretary of Labor’s ability to investigate ERISA violations, see 29 U.S.C. § 1134 (1995).
48. HIPAA § 217 (to be codified at 42 U.S.C. §1320a-7b(a)(6)).
plans must report at least once each month all “final adverse actions” taken against a health care practitioner, provider, or supplier. HIPAA defines final adverse actions, as related to the delivery of items or services, as the following: (1) civil judgments, (2) federal or state criminal convictions, (3) revocation or suspension of licensure, (4) reprimand, censure, or probation, (5) exclusion from participation in any federal or state health program, (6) any other negative action or finding by such federal or state agency that is publicly available, and (7) any other adjudicated decisions that HHS identifies by regulation. Federal and state government agencies as well as health plans may tap into the information in the data base for a reasonable fee. Providers, suppliers, and licensed practitioners may, under regulations to be issued by HHS, request disclosure of their own information, and may dispute the accuracy of the report. HHS is responsible for establishing procedures designed to protect the privacy of individuals receiving health care services when disclosures are made under the new reporting system.

II. THE INTRICACIES OF HIPAA

Preventing health care fraud and abuse is the theme of a significant portion of HIPAA. As discussed above, several provisions reinforce the government’s anti-fraud position and provide enhanced methods through which the government and private citizens may wage the war against health care fraud. However, HIPAA contains three interrelated anti-fraud weapons of particular importance to the government’s arsenal against fraudulent activities. These interrelated weapons, although placed throughout HIPAA, can financially penalize violators through exclusion from participation in the Medicare and Medicaid programs, increased civil monetary penalties, and criminal prosecution and/or the imposition of extraordinary fines for violations of the newly created health care fraud crimes. For example, one act or omission could subject an individual to prosecution for a fraud crime, which can result in imprisonment or large fines, which in turn could cause the individual to be excluded from the Medicare and Medicaid programs, which then could cause the individual’s employer to be excluded from the programs.

49. HIPAA § 221(a) (to be codified at 42 U.S.C. § 1320a-7e(g)(1)(A)(i)-(v)).
50. HIPAA § 221(a) (to be codified at 42 U.S.C. § 1320a-7e(d)).
51. HIPAA § 221(a) (to be codified at 42 U.S.C. § 1320a-7e(c)).
Amendments under HIPAA to existing laws have created a variety of permutations.52

A. The Permissive Exclusions: Mandatory Lengths and Imputed Responsibility

Prior to HIPAA, individuals and entities were subject to either mandatory or permissive exclusion from the Medicare and Medicaid programs for any one of fourteen acts or omissions. HIPAA operates to clarify some of those acts, specifying mandatory exclusion for certain felony convictions and providing for permissive exclusion for misdemeanor convictions and other activities. Although permissive exclusion for such acts has been an option for the Secretary of HHS, the period of exclusion was usually left to the Secretary’s discretion. Now, a minimum period of exclusion is prescribed for certain offenses, subject to the Secretary’s determination that a shorter or longer period is appropriate based on mitigating or aggravating circumstances. In addition, as mentioned above, HIPAA expands the group subject to possible exclusion to include individuals who control a sanctioned entity.

The new permissive exclusion for individuals who control a sanctioned entity is intended to provide HHS with a weapon to penalize individuals who own or operate Medicare- and Medicaid-participating entities that commit acts that subject the entities to various sanctions. Prior to this provision, these individuals could not be held personally accountable for the actions of the entities they controlled. A sanctioned entity is one excluded from the Medicare or Medicaid program or convicted of a felony or misdemeanor relating to Medicare and Medicaid, patient abuse, health care felony fraud,53 or felony manufacturing, distributing, prescribing, or dispensing of a controlled substance.54 HIPAA subjects an individual to permissive exclusion if the individual (1) maintained a direct or indirect ownership or control interest in a sanctioned entity and knew or should have

52. For example, an entity may commit an act for which it may be excluded, prosecuted for health care fraud, and/or assessed a civil monetary penalty, which in turn may cause an individual(s) associated with the entity to be excluded from Medicare and Medicaid and be assessed civil monetary penalties. (This scenario is described in detail in section II(B) below.) Of course, the sanctions and penalties described above are in no way exhaustive. Other actions may lie under the anti-kickback provision, the federal False Claims Act, Stark law, and other federal or state laws.

53. See infra section II(C).

54. HIPAA § 213 (to be codified at 42 U.S.C. § 1320a-7).
known of the action constituting the basis for the sanction, or (2) was an officer or managing employee\textsuperscript{55} of the sanctioned entity, even without a showing of knowledge. The knowledge standard applicable to those with ownership and control interests charges those who act in deliberate ignorance or in reckless disregard of the truth or falsity of the information with knowledge of the action; no proof of specific intent to defraud is required.\textsuperscript{56}

Although the permissive exclusion for individuals who control a sanctioned entity is new, the theory of penalizing an individual or an entity based on a relationship or association with another individual or entity is well established under the Social Security Act ("SSA").\textsuperscript{57} Since the 1980s, the government has had the option to exclude an entity that was controlled by a sanctioned individual.\textsuperscript{58} However, there are important differences between the 1980s provision—imputing to the entity the actions of the individual—and HIPAA's provision—imputing to the individual the actions of the entity. First, the 1980s provision established a five percent floor when determining if an individual has a con-
control interest in an entity;\textsuperscript{59} HIPAA contains no floor. Second, under the 1980s provision, entities may be excluded based on the controlling individual’s (1) conviction of felony or misdemeanor Medicare and Medicaid crimes or for patient abuse, (2) felony convictions for health care fraud or violations relating to controlled substances, (3) assessment of a civil monetary penalty under sections 1128A and 1129 of the SSA, or (4) exclusion from Medicare or Medicaid. However, under HIPAA, an individual may be excluded only if the entity’s acts fall within (1) and (2) above. Third, under the 1980s provision, exclusion of an entity controlled by a sanctioned individual does not depend on the culpability of either the entity or the individual, while under HIPAA, exclusion of an individual who controls a sanctioned entity requires a showing of the individual’s knowledge of the actions, unless the individual is an officer or managing employee of the entity.

Accordingly, individuals and entities must be cautious and selective when choosing their affiliates. Individuals at the officer or management level who join entities previously sanctioned may be subject to permissive exclusion, despite having no relationship with the entity at the time of the activities giving rise to the sanction. Of course, an entity faces similar challenges in determining whether its officers, directors, agents, or managing employees may fall within the category of sanctioned individuals who may expose the entity to permissive exclusion. This result is particularly discouraging for sanctioned entities that wish to clean house and bring in new officers and managers to operate the entity according to Medicare and Medicaid laws and regulations. Because of these challenges for organizations and their management, it is increasingly important for organizations to establish methods to promote compliance with federal and state laws to minimize civil and criminal exposure for both the organization and its management personnel.

\textsuperscript{59} 42 U.S.C. § 1320a-3(a)(3) (1995) defines a “person with an ownership or control interest” as a person who:

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or
(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or
(B) is an officer or director of the entity, if the entity is organized as a corporation; or
(C) is a partner in the entity, if the entity is organized as a partnership.
B. Civil Monetary Penalties Are Applied to Those Excluded from the Programs

The provision in HIPAA allowing the government to impose civil monetary penalties requires careful study. In addition to the changes in the intent standard and the amount of the penalty the government may assess, as described in section I(E) above, this section of HIPAA subjects a new group of individuals to these penalties. Specifically, the government may assess civil penalties against an individual (1) who is excluded from the Medicare or Medicaid programs pursuant to the civil monetary penalties provisions or the permissive or mandatory exclusion provisions, and (2) who, at the time of a violation of the civil monetary penalties provisions, (a) retained “a direct or indirect ownership or control interest in an entity” participating in the Medicare or Medicaid programs, and who knew or should have known “of the action constituting the basis for the exclusion,” or (b) is “an officer or managing employee . . . of such an entity . . . .”

While this language sounds similar to that found in the new permissive exclusion section, several phrases in the civil monetary penalties provision do not appear in the permissive exclusion section, creating confusion regarding the provision’s meaning and application. Often the legislature drafts an act

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60. Under the civil monetary penalties provision, the individual may be subject to a $10,000 penalty for each day the prohibited relationship occurs. HIPAA § 231(c)(2) (to be codified at 42 U.S.C. § 1320a-7a(a)).

61. Exclusion from the Medicare and Medicaid programs is an option available in the same proceeding as the assessment of civil monetary penalties. 42 U.S.C. § 1320a-7a(a) (1995).

62. Id. § 1320a-7 (1995).

63. HIPAA § 231(b) (to be codified at U.S.C. § 1320a-7a(a)(4)).

64. The exact language is as follows:

Any person (including an organization, agency or other entity, but excluding a beneficiary, as defined in subsection (i)(5) of this section) that

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(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII [of the Social Security Act] or a State health care program in accordance with this subsection or under section 1128 [42 U.S.C. § 1320a-7] and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b) [42 U.S.C. § 1320a-5(b)]) of such an entity; . . . .
that when read carefully is subject to a variety of interpretations. This is true of HIPAA. Given the various interpretations of the civil monetary penalties provision, providers and their owners, officers, and managing employees may feel uncertain with regard to their exposure to these penalties.

First, it seems that the government can impose penalties upon an individual who has been excluded from the Medicare and Medicaid programs based upon a violation of the civil monetary penalties provisions or the permissive or mandatory exclusion provisions. Second, there must be a violation of the civil monetary penalties provisions. However, it is unclear whether the civil monetary penalty is in addition to the violation for which the individual was excluded from the programs. If two separate violations are not necessary, then the government can impose these penalties for the same violation that led to its excluding the individual. If only one violation is needed, it is curious that HIPAA describes that violation inconsistently: first as an exclusion from the Medicare and Medicaid programs based upon a violation of either the civil monetary penalties provision or the permissive or mandatory exclusion provisions, and then as a violation of only the civil monetary penalties provision, omitting the references to the permissive and mandatory exclusion provisions. Also, because the owner must know (or have imputed knowledge) of the action constituting the basis for the exclusion, it would appear that the knowledge requirement in the civil monetary penalties provision pertains to the activity causing the individual’s predicate exclusion, rather than any secondary violation of the civil monetary penalties provisions; in other words, there is no required second violation. However, this analysis would make the knowledge clause of the civil monetary penalties provision superfluous—the individual has been excluded, and thus the individual’s knowledge (actual or imputed) of the violative action has been established; there is no need to reaffirm knowledge of the same action. It is possible, however, that the knowledge requirement applies to an action causing a second violation of the civil monetary penalties provision by either the individual or the entity that the individual owns or in which the individual maintains a control interest.

This new civil monetary penalties provision can lead to various results based upon these various interpretations. For example, the provision could serve as a bar, or at a minimum a severe

HIPAA § 231(b)(4) (to be codified at 42 U.S.C. § 1320a-7a(a)(4)).
financial deterrent, to the retention of any ownership or control interest in any entity participating in Medicare or Medicaid by an individual who has been excluded from the programs. This result follows an interpretation that the violation of the civil monetary penalties provision and the knowledge clause pertain to the individual's predicate exclusion. Such a result could be particularly harmful to, for example, an individual who owns several Medicare DME supply entities, only one of which committed acts that formed the basis for its exclusion from the Medicare program. According to the new permissive exclusion described in section II(A) above, the individual may be excluded for retaining an ownership interest in the sanctioned entity. Under one interpretation of HIPAA, the government may subject the individual to penalties totaling $10,000 for each day the individual retains an ownership interest in each of the other Medicare DME supply entities, despite the fact that the other supply entities have not committed any violations.65

Although not clear from the language of the civil monetary penalties provision, a fairer interpretation of the new provision is possible. An excluded individual is subject to penalties for each day the individual retains an ownership or control interest in an entity that, subsequent to the individual's exclusion, violated the civil monetary penalties provisions, if the excluded individual knows or should know of the action constituting the basis for the entity's subsequent violation. Although the actual language of the amended civil monetary penalties provision does not clearly state this, this reasonable construction could not be deemed unduly harsh. An excluded individual who retains an ownership interest in a Medicare- or Medicaid-participating entity that then violates the civil monetary penalties provision cannot complain, particularly if the individual knew or should have known of the action constituting the basis for the entity's violation of the civil monetary penalties provision.

The expanded civil monetary penalties provision may lead to the assessment of significant and broad-based penalties against excluded individuals. Until the meaning and application of this new section becomes clear, counsel must alert organizations and their owners, officers, and managing employees of the various possible interpretations.

65. Of course, these other supply entities also may be excluded from the Medicare and Medicaid programs if the now-excluded ("sanctioned") individual's ownership interest amounts to five percent or more. 42 U.S.C. § 1320a-7(b)(8) (1995).
C. Federal Health Care Offenses: The Creation of New Fraud Crimes

Prior to HIPAA, criminal prosecution of offenses relating to Medicare and Medicaid fraud was limited to those anti-kickback and criminal false claims offenses delineated in the SSA or general fraud crimes, such as mail fraud, wire fraud, and false statements. Many of these statutes only apply to Medicare and Medicaid offenses and cannot be used to prosecute crimes against other payers, such as private payers. In filling this void, HIPAA substantially broadened the base of statutes available to prosecute a variety of crimes relating to health care and extended their applicability to any health care benefit program. Accordingly, HIPAA’s amendments protect all payers, not just Medicare, Medicaid, and other federal health care programs. Indeed, the potential breadth of these statutes cannot be overstated, as frauds committed on Medicare and Medicaid are also likely to be charged as violations of the new provisions under HIPAA, including health care fraud, embezzlement, false statements, obstruction, and money laundering.

1. Health Care Fraud

This new offense of health care fraud criminalizes the knowing and willful execution or attempted execution of “a scheme or artifice to defraud any health care benefit program” as well as the obtaining by false pretenses of any money or property “owned by, or under the custody or control of, any health care benefit program, in connection with the delivery or payment for health care benefits, items, or services . . . .” Violations are punishable by fine or imprisonment for up to ten years. If the violation results in serious bodily injury, the term of imprisonment increases to twenty years; if it leads to death, the term is life in prison. The language of this statute is similar to that of the mail/wire fraud statutes and, thus, it is likely that the case

67. A health care benefit program is defined to include any public or private plan or contract under which medical benefits, items, or services are provided to any individual. HIPAA § 241(a) (to be codified at 18 U.S.C. § 24(b)).
68. HIPAA § 242 (to be codified at 18 U.S.C. § 1347).
69. HIPAA § 242.
law broadly interpreting those provisions will apply to this new statute. Fines paid pursuant to a conviction under this section will go to the Medicare Hospital Insurance (Part A) Trust Fund.71

2. Embezzlement of Health Care Funds

Any person who knowingly and willfully embezzles, steals, or converts or intentionally misapplies any of the funds, assets, or property of a health care benefit program violates this provision. Offenses are punishable by fine or imprisonment of up to ten years, but if the value of the embezzled property does not exceed $100, the term of imprisonment is not more than one year.72

3. False Statements Relating to Health Care

Any person who, in any matter involving a health care benefit program, (a) knowingly and willfully falsifies, conceals, or covers up a material fact, or makes a false statement or representation regarding a material fact, or makes or uses any materially false document knowing it to be false (b) in connection with the delivery of or payment for health care benefits (c) shall be fined and/or imprisoned for up to five years.73 Modeled on the False Statements Act,74 this statute is extremely broad. Intent to defraud is not an element of the offense; the only criminal intent required is the knowing and willful making of a false statement relating to health care benefits or services intended to induce action by the person to whom the statement is made. As with the False Statements Act, this new statute has broad implications and, in the context of health care, may have unintended consequences.

4. Obstruction of Criminal Investigations of Health Care Offenses

Any person who willfully prevents, obstructs, misleads, delays, or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a federal health care offense to a criminal investigator shall be

71. HIPAA § 242(b).
72. HIPAA § 243(a) (to be codified at 18 U.S.C. § 669).
73. HIPAA § 244 (to be codified at 18 U.S.C. § 1035).
fined and/or imprisoned for up to five years. A "criminal investigator" is defined as any person authorized by a federal agency to conduct or engage in investigations of potential health care violations. This statute is likely to be used by investigators and/or prosecutors to impede attempts by health care providers and their attorneys to "manage" government investigations. Therefore, health care providers should be counseled to think twice about instructing employees not to cooperate with federal investigators and to be scrupulous about preserving records once an investigation has commenced or is likely to commence. Of course, legitimate efforts to limit the scope of a subpoena, keep investigators within the bounds of a search warrant, or inform employees about their rights and obligations in dealing with government investigators should not run afoul of this statute.

5. Money Laundering of Proceeds of Health Care Offenses

This provision brings federal health care offenses within the definition of a "specified unlawful activity" in the money laundering statute. A person commits a money laundering offense by engaging in a financial transaction involving the proceeds of "specified unlawful activity," knowing of the source of the proceeds, with the intent to (1) promote the unlawful activity, (2) conceal the source of the proceeds, or (3) evade federal tax laws or currency reporting requirements. Money laundering may have broad application to the field of health care. For example, reinvesting funds acquired by a violation of the anti-kickback provision in a medical practice could potentially be prosecuted on a money laundering theory.

6. Injunctive Authority Relating to Health Care Offenses

This provision authorizes a federal prosecutor to bring a civil action to enjoin a person or entity committing or about to commit a federal health care offense. In addition, the Attorney General may bring a civil action to freeze the assets of a person or entity engaged in committing a federal health care offense to

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75. HIPAA § 245(a) (to be codified at 18 U.S.C. § 1518(a)).
76. HIPAA § 245(a) (to be codified at 18 U.S.C. § 1518(b)).
77. HIPAA § 246 (to be codified at 18 U.S.C. § 1956(c)(7)(F)).
79. HIPAA § 247(a)(1)(C) (to be codified at 18 U.S.C. § 1345(a)(1)(C)).
prevent the dissipation or alienation of assets potentially subject to fines or forfeiture.\(^{80}\)

7. Administrative Subpoena Authority Relating to Health Care Investigations

This provision authorizes the Attorney General to issue a subpoena for documents, records, or other tangible things in an investigation of a federal health care offense. Also, a records custodian may be compelled to testify regarding the production and authentication of documents.\(^{81}\) Unlike a grand jury subpoena, however, this administrative subpoena is not self-executing. If challenged, the prosecutor must seek enforcement of the subpoena in court.\(^{82}\) Failure to obey a court order enforcing the subpoena is punishable as contempt.\(^{83}\) Persons who comply in good faith with a subpoena issued pursuant to this provision are immune from civil liability for disclosure of information,\(^{84}\) and individualized health information disclosed pursuant to such a subpoena must be kept confidential.\(^{85}\) However, there does not appear to be any minimum cause threshold for issuing a subpoena. Thus, the new authority resulting from this provision may be used to engage in “fishing expeditions,” which courts view with disfavor. In essence, this provision gives the Department of Justice and the FBI the same administrative subpoena power as the OIG.

III. CORPORATE COMPLIANCE PLANS

As illustrated above, a violation of the fraud and abuse provisions as amended by HIPAA can carry with it devastating results. Now, more than ever, it is important for a health care entity to institute a corporate compliance plan.\(^{86}\) A corporate compliance plan that is properly conceived, implemented, and enforced can provide health care entities with a useful tool to avoid penalties and possible exclusion from the Medicare and

\(^{80}\) HIPAA § 247(b) (to be codified at 18 U.S.C. § 1345(a)(2)).

\(^{81}\) HIPAA § 248(a) (to be codified at 18 U.S.C. § 3486(a)).

\(^{82}\) Compare 18 U.S.C. § 3484, FED. R. CRIM. P. 17(g), with HIPAA § 248(a) (to be codified at 18 U.S.C. § 3486(c)).

\(^{83}\) HIPAA § 248(a) (to be codified at 18 U.S.C. § 3486(c)).

\(^{84}\) HIPAA § 248(a) (to be codified at 18 U.S.C. § 3486(d)).

\(^{85}\) HIPAA § 248(a) (to be codified at 18 U.S.C. § 3486(e)).

\(^{86}\) For an explanation of a corporate compliance plan, see Thomas E. Bartrum & L. Edward Bryant, Jr., The Brave New World of Health Care Compliance Programs, 6 ANNALS HEALTH L. 51 (1997).
Medicaid programs, and to help assure that the entity’s employees and representatives are complying with applicable laws. Despite the benefits of a corporate compliance plan, many entities fear that any documents or findings generated from the corporate compliance plan are not privileged.87 A health care entity must weigh the pros and cons with counsel to determine the best course. Now with HIPAA, the pros may greatly outweigh the cons.

A corporate compliance plan is a formal and comprehensive set of policies and procedures designed and implemented to ensure that an organization and its employees consistently comply with all applicable laws and regulations pertaining to its business activities. Corporate compliance plans may take many forms, ranging from a single policy statement to a detailed procedural manual. The specific purposes and benefits of a corporate compliance plan vary among organizations, but generally include:

1. providing an organization with a formal means to monitor and control employee behavior;
2. protecting the financial security for employees and the organization by identifying and correcting conduct that might otherwise carry severe financial consequences;
3. furnishing a mechanism or structure to disseminate quickly and efficiently information relating to changes in government regulations;
4. educating the organization on the manner in which it conducts its business, which can foster the development of strategies to reduce the costs of providing services;
5. improving the ability of the organization to respond to a claim that it has failed to comply with applicable laws;
6. establishing a structure that encourages employees to report internally their concerns; and
7. creating a mechanism to collect, retain, and disseminate information, and to preserve the attorney-client privilege.88

Regardless of the form or the variety of benefits available from a corporate compliance plan, many organizations implement a plan for the primary purpose of minimizing exposure to both civil and criminal liability and sanctions. However, an or-

organization may not attain this goal without a comprehensive and systematic method of identifying and addressing areas of risk, educating personnel, auditing or measuring the plan's effectiveness, solving problems as they arise, enforcing the plan, reporting violations, and swiftly disciplining violators. These plans not only can assist the health care entity in avoiding both criminal and civil violations, but, as explained below, can serve as a basis for a reduced criminal penalty if a violation occurs.

A. Criminal Liability

The United States Sentencing Guidelines ("Guidelines") offer a strict structure for federal judges to sentence individuals or entities convicted of federal crimes, giving judges very little discretion in determining the sentence. However, the Guidelines allow the court to reduce criminal sanctions—that is, corporate probation and fines—against a corporation that maintains an effective corporate compliance plan. For example, a court can order corporate probation (for a felony, from one to five years) if, among other things, an organization having fifty or more employees does not have an effective corporate compliance plan. Corporate probation may consist of court-ordered (1) publication of the nature of the offense in the format and media specified by the court; (2) institution of a corporate compliance plan in a form determined by the court; and (3) submission by the organization to unannounced examinations of its books and records and interrogation of "knowledgeable individuals" within the organization. Thus, the existence of an effective corporate compliance plan can prove extremely helpful at the time of sentencing.

With regard to the court's imposition of fines, corporate compliance plans play an important role. The Guidelines establish a range of fines for each offense, the calculation of which involves a base fine multiplied by a culpability score; this score can be lower if the corporation maintains an effective corporate compliance plan. That base level corresponds to a particular fine. To establish the range of fines the court can impose, the base fine is multiplied by minimum and maximum multipliers, which relate to the entity's culpability level. Each entity begins with a culpability level of five, which requires that the base fine be

90. Id. at § 8D1.1(3).
91. Id. at § 8D1.4.
multiplied by one and by two to obtain the minimum and maximum fines available for the offense. However, the culpability level may be increased for aggravating circumstances, corresponding to higher minimum and maximum multipliers, or decreased for mitigating circumstances, corresponding to lower minimum and maximum multipliers. Mitigating circumstances include the existence of an effective program to prevent and detect violations of law (a corporate compliance plan) or the willingness of the corporation to report its own violation (self-reporting). For example, a conviction of filing false Medicare claims that caused a loss to the Medicare program totaling $2000 would correspond to a base fine level of twelve. The base fine for this action would be $40,000. Without an effective corporate compliance plan, and assuming no aggravating or mitigating circumstances, the entity would receive a culpability score of five, with a minimum-maximum multiplier range of one to two. The fine would be no less than $40,000 and no more than $80,000. If the entity had an effective corporate compliance plan in place, its culpability score would drop from five to two, which provides for a minimum multiplier of 0.4 ($16,000) and a maximum multiplier of 0.8 ($32,000). Thus, the existence of an effective corporate compliance plan could reduce the criminal fine by as much as sixty percent.

Only a corporate compliance plan that is an “effective program to prevent and detect violations of law” can be used to as a mitigating circumstance. The Guidelines state that it must be reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal conduct. The hallmark of an effective program is that the organization exercises due diligence in its attempt to prevent and detect criminal conduct by its employees and other agents.  

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92. Aggravating circumstances include involvement in or tolerance of criminal activity by high-level personnel, prior criminal history, violation of a judicial order, and obstruction of justice. FEDERAL SENTENCING GUIDELINES MANUAL § 8C2.5(b)-(e).
93. Id. § 8C2.5(f)-(g).
94. Id. § 8A1.2. The existence of an effective corporate compliance plan will not reduce criminal fines if high-level personnel or an individual responsible for the administration or enforcement of the corporate compliance plan participated in, condoned, or willfully ignored the offense. “Participation in an offense by an individual within substantial authority results in a rebuttable presumption that the organization did not have an effective program to prevent and detect violations of law.” Id. § 8C2.5(f).
95. Id.
Due diligence requires at a minimum that the organization take the following steps:

1. The organization must establish compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal conduct;

2. Specific high-level personnel of the organization must be assigned overall responsibility to oversee compliance with such standards and procedures;

3. The organization must use due care not to delegate substantial discretionary authority to individuals who the organization knew or should have known through the exercise of due diligence had a propensity to engage in illegal activities;

4. The organization must take steps to communicate effectively its standards and procedures to all employees and other agents by, for example, requiring participation in training programs or disseminating publications that explain in a practical manner what is required;

5. The organization must take reasonable steps to achieve compliance with its standards by, for example, using monitoring and auditing systems reasonably designed to detect criminal conduct by its employees and other agents and having in place and publicizing a reporting system that allows employees and other agents to report criminal conduct by others within the organization without fear of retribution;

6. The standards must be consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, adequate discipline of individuals responsible for the failure to detect an offense; the form of discipline that is appropriate is case specific; and

7. After an offense is detected, the organization must take all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modifications to its program to prevent and detect violations of law.96

The new crimes created by HIPAA, in addition to the existing Medicare and Medicaid crimes, grant prosecutors ample ammunition to punish both individuals and organizations convicted of health care fraud crimes involving both public and private payers. By following these due diligence steps in designing, implementing, and enforcing a corporate compliance plan, health care

96. Id.
entities can benefit in two ways. First, a corporate compliance plan should decrease the risk of criminal activity by establishing an environment in which violations of law are not tolerated and all employees are encouraged and advised that, as a condition of employment, immediate and internal reporting of all indiscretions is required. Second, as explained above, the existence of an effective plan may mitigate the criminal sanctions to be imposed.

B. Civil Liability

While there exists no specific guideline, regulation, or statute that provides for a reduction in civil penalties based upon the existence of a corporate compliance plan, an effective plan built and enforced along the principles of the Guidelines could minimize the organization's exposure to various civil liabilities and sanctions. Even if a violation occurs, counsel can argue that just as with criminal penalties, civil penalties should be reduced, an argument that may prove fruitful in negotiations.

CONCLUSION

Due to the existence of fraud and abuse in the health care industry, Congress expanded the weapons available to fight fraud and reduce waste. Nonetheless, the severe liability and sanctions created by HIPAA's permissive exclusions, civil monetary penalties, and fraud crimes should give pause to all health care providers. HIPAA's new fraud-fighting mechanisms address interrelationships whereby violations committed by an individual or entity can trigger a domino effect of exclusion, assessment of civil monetary penalties, and criminal prosecution of affiliated individuals and entities.

Given the areas of subjective interpretation and the harsh penalties, health care provider organizations should consider the benefits of a corporate compliance plan to limit overall civil and criminal liability exposure to the organization and the dindividu-als with whom they associate. An effective plan that prevents and detects violations of law may serve to minimize a variety of activities that could lead to civil liability or criminal punishment. In addition, an effective plan is considered a mitigating factor

97. Among the civil liabilities that may be avoided or minimized through the implementation and enforcement of a corporate compliance plan are federal False Claims Act (31 U.S.C. § 3729 (1995)) and Racketeer-Influenced and Corrupt Organizations Act (18 U.S.C. § 1964 (1995)) liabilities.
that operates to reduce criminal fines pursuant to the Guidelines. If the sanctions available under prior law have failed to inspire a health care organization to implement a corporate compliance plan, HIPAA should provide sufficient motivation.
## APPENDIX

### HIPAA’S CHANGES TO THE FRAUD AND ABUSE LAWS

<table>
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<tr>
<th>Subject</th>
<th>Before HIPAA</th>
<th>After HIPAA</th>
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</thead>
<tbody>
<tr>
<td>Programs subject to the laws</td>
<td>Medicare and state health care programs</td>
<td>All federally and state-funded health care programs except the Federal Employee Health Benefit Plan</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Mandatory exclusion from Medicare for conviction of certain crimes (state or federal)</th>
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<tbody>
<tr>
<td>Programs subject to the laws</td>
<td>Medicare-related crimes</td>
<td>Adds: Health care fraud felony crimes created by HIPAA</td>
</tr>
<tr>
<td></td>
<td>Patient abuse crimes</td>
<td>Crimes relating to the unlawful manufacturing, distributing, prescribing, or dispensing of controlled substances</td>
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</tbody>
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<tr>
<th>Permissive exclusion from Medicare for conviction of certain crimes (state or federal) or other related state action</th>
<th>Permissive exclusion for those who are subject to the following state or federal actions or for those entities that are controlled by those who are subject to the following:</th>
<th>Adds permissive exclusion for those who commit any of the following, for those who control a sanctioned entity and knew or should have known of the action that is the basis for the conviction of the entity, or for those who are officers or managing employees of the sanctioned entity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs subject to the laws</td>
<td>Finding of guilt for: Fraud Obstruction of investigation Prohibited manufacture, distribution, prescription, or dispensing of controlled substance Excessive charges or charges for unnecessary services Kickbacks under SSA §§ 1128A, 1128B, 1129 Failure to disclose required information Failure to supply information on subcontractors and suppliers Failure to supply payment information Failure to grant immediate access to the Secretary Failure to take corrective action</td>
<td>Health care fraud misdemeanor crimes created by HIPAA Misdemeanor controlled substances violations Felony controlled substances violations now require exclusion</td>
</tr>
</tbody>
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<tr>
<th>Length of permissive exclusion</th>
<th>At the Secretary’s discretion</th>
<th>Mandatory exclusion periods:</th>
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<tbody>
<tr>
<td></td>
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<td>Minimum exclusion of three years for convictions of fraud crimes, obstruction violations, or controlled substances violations</td>
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<td></td>
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<td>Minimum exclusion of the same time as a license revocation</td>
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</tbody>
</table>
### HIPAA's Changes to the Fraud and Abuse Laws (Continued)

<table>
<thead>
<tr>
<th>Subject</th>
<th>Before HIPAA</th>
<th>After HIPAA</th>
</tr>
</thead>
</table>
| **Civil Monetary Penalties**     | *Amount:*
|                                  | • $2000 per item claimed                                                    | • Minimum one year exclusion if convicted for excessive charges or unnecessary services |
| Those subject to penalties:      | • Violators of the penalties provisions                                      |                                                                              |
| Intent Standard:                 | • Knew or should have known of the actions constituting the violation        |                                                                              |
| **Illegal Remuneration/anti-kickback Exceptions** | Exception for qualified group purchasing arrangements and bone fide employment relationships | Adds exception for risk-sharing arrangements, as defined by HIPAA |
| **Penalties against beneficiaries under Medicare or Medicaid for criminal false claims** | Technically within anti-kickback and/or criminal false claims | Criminal penalty for fraudulent disposition of assets to qualify for Medicaid |
| **Adverse Action Data Collection** | None                                                                         | Data base to report final adverse actions such as civil judgments, criminal convictions, license revocation, and exclusion from Medicare/Medicaid |
| **Specific Federal Health Care Fraud Crimes** | Anti-kickback provisions and criminal false claims under SSA | Adds new federal crimes for fraud, theft, embezzlement, false statements, obstruction of investigation, and money laundering relating to both public and private health care programs |
| **Fraud and Abuse Control Program** | None                                                                         | Control program coordinates federal, state, and local health care anti-fraud programs |
| **Medicare Integrity Program**    | None                                                                         | Allows HHS to contract with private entities to carry out fraud and abuse detection |
| **Beneficiary Incentive Program** | None                                                                         | Monetary incentive for beneficiaries to report fraudulent activity and provide program efficiency suggestions |
| **Manner by which Safe Harbors are Established** | At the Secretary's discretion pursuant to the Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, § 14, 42 U.S.C. § 1320a-7b. | Secretary must solicit and create new safe harbors and fraud alerts |
| **Availability of Advisory Opinions** | None                                                                         | OIG must issue advisory opinions covering anti-kickback issues |