Health Law Alert: “One Purpose Test” for Anti-kickback Statute Violations Adopted by Yet Another Judicial Circuit

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In a recent case, the Seventh Circuit Court of Appeals joined four other judicial circuits in adopting the "one purpose test" for assessing business arrangements under the Anti-kickback Statute (AKS). This test provides that if any "one purpose" of an arrangement is to induce or reward referrals reimbursable by federal health care programs, the AKS has been violated. Viewed in light of changes 2010's Affordable Care Act (the ACA) made to the AKS, along with increased enforcement by regulators and skyrocketing numbers of False Claims Act (FCA) cases filed by qui tam whistleblowers, proactive efforts to ensure compliance with the AKS have never been more vital.

The Anti-kickback Statute

The AKS prohibits paying or receiving anything of value, regardless of form (gifts, certain discounts, cross-referrals between parties), for the purpose of inducing or rewarding another party for referrals of services paid for by Medicare, Medicaid, and other programs. It also prohibits exchanging anything of value to induce or reward purchasing, ordering, leasing or arranging for the purchase, leasing, or ordering of services paid for by these programs.

The AKS requires that an individual's actions be made "knowingly or willfully." While many observers take the position that the AKS, as a criminal law, requires some degree of specific intent for a violation to occur, regulators have argued that a party does not have to intend to break the law, but rather must have only intended its actions. The government may prosecute AKS violations criminally or seek to impose civil penalties. Penalties are harsh—including fines of up to $25,000 and prison terms of up to five years—and can be imposed on both the payer and recipient of benefits impermissibly exchanged for referrals.

The AKS' broad scope means that it applies to almost all business arrangements where payments flow between referral sources, including arrangements that have perfectly legitimate purposes. Regulators have historically taken the position that any payment arrangement that exceeds fair market value impliedly seeks to induce referrals and that the burden is on the party charged to prove that payment is fair market value for the services provided.

The 7th Circuit Decision: United States v. Borrasi

The 7th Circuit adopted the "one purpose" test in United States v. Borrasi. In a classic example of bad facts making bad law, Borrasi involved a psychiatric hospital that paid bribes to a group of physicians in return for their referrals to the hospital. The physicians were placed on the hospital payroll under false titles and job descriptions in order to conceal the bribes. The physicians would then submit false time sheets and were paid for that recorded time. Although the physicians testified to attending occasional meetings, they stated that they performed none of the job duties for which they submitted time. Further, there was apparently never any expectation that the physicians would need to accomplish these duties.

The court stated that paying any value for referrals is illegal. While only part of the payments were "intended to induce" the physician to refer patients to the hospital, the statute was violated, even if the payments were also intended to compensate for other legitimate professional services. In adopting the "one purpose" test, the court concluded that the payment for referrals does not have to be the primary purpose of the payments received; it only had to be one purpose of the business arrangement.

Amendments to the AKS

Most providers would never engage in the blatant conduct at issue in Borassi. Nevertheless, the importance of ensuring scrupulous compliance with the AKS by all organizations has been enhanced by two amendments made to the law in 2010. First, under the ACA, regulators arguably do not need to prove that an individual had actual knowledge of a violation or the specific intent to violate the AKS. The ACA seems to have eliminated the last remnants of the argument that specific intent is required to violate the AKS. While health care attorneys have long argued that some degree of prohibited intent is required to demonstrate a violation, the Office of Inspector General has long held that the "one purpose" test is the rule.

Second, the ACA provides for the first time in any federal statute or regulation that a claim submitted for items or services, the provision of which resulted from a violation of the AKS, are false under the FCA. This change is significant due to the crippling penalties that can be imposed under the FCA. Violators must repay the government three times the amount of the fraud, and are also liable for civil penalties of $5,500 to $11,000 per false claim. The whistleblowers who file FCA claims on behalf of the government can receive significant financial incentives (between 15 percent and 30 percent of the government's recovery). Since 1986, over $28 billion has been recovered by the federal government in judgments and settlements under the FCA.

These changes underscore the importance of taking steps to regularly review business arrangements that implicate the AKS. A wide range of activities—from discounts to referral fees to marketing practices—can be considered kickbacks. The extremely broad application of the AKS, coupled with the lower levels of knowledge and intent requirements, make the AKS and FCA extremely potent weapons.

Reducing the Risk of AKS Violations in Business Arrangements

The 7th Circuit is only the latest jurisdiction to adopt the OIG's "one purpose" test. In spite of the ambiguity of this standard, and the difficulty of reconciling its application to an industry where there is almost always an expectation that a business arrangement may result in additional services, it has never been more important for providers to evaluate their business arrangements for purposes of AKS compliance. The following are some basic steps that providers can take to help ensure compliance:

- Carefully document and track services provided under contracts. One of the easiest angles for regulators to take is to base their AKS argument on defendants' inability to show that services were actually provided.
- Document the need for business arrangements. For example, while the AKS does not prohibit a hospital from paying for the services of a medical director, it would prohibit a hospital from paying for medical directors that are not actually needed.
- Consider using a central database to track contracts, including when they are amended, terminated, or reach their date of expiration. Most common AKS safe harbors and Stark Law exceptions require that a written agreement be in place. Services performed between referral sources without a contract in place are low-hanging fruit for regulators.
- Be careful with fair market value documentation. In recent years, regulators have been drilling down into the technical basis for parties' conclusion that payment is at fair market value.

Enforcement of AKS and Stark Law violations continues to increase. Given the budgetary constraints faced by Medicare and Medicaid, and the significant financial rewards available to qui tam whistleblowers, there is little chance this trend will abate any time soon. Taking care to ensure that business arrangements are current will aid providers in complying with these important laws.

If you have questions regarding this alert or the Anti-kickback Statute, please contact Jesse Berg at 612.632.3374 or jesse.berg@lathropgpm.com.