HONIGMAN ALERT

Health Care Department **March 18, 2011**

If you have questions regarding the information in this alert or would like to receive further information regarding our Health Care Department, please contact:

Jennifer L. Benedict
313.465.7326
jbenedict@honigman.com

Ann T. Hollenbeck
313.465.7680
ahollenbeck@honigman.com

Matthew R. Keuten
313.465.7510
mkeuten@honigman.com

Kenneth R. Marcus
313.465.7470
kmarcus@honigman.com

Erica D. Partee
313.465.7528
epartee@honigman.com

Linda S. Ross
313.465.7526
lross@honigman.com

Angela Epolito Sprecher
313.465.7540
asprecher@honigman.com

Health Care Fraud and Abuse Update

The federal government has become increasingly active and successful in pursuing health care fraud, often winning and touting significant judgments and recoveries. The developments described in this Alert reflect the government's stepped up efforts and success in combating health care fraud and abuse at all levels. Providers should review these developments carefully and take steps to minimize their exposure under the fraud and abuse laws. All providers should structure and review their contracts, arrangements and practices on a regular basis to ensure that they comply with applicable rules, regulations and laws governing health care. Additionally, they should promptly and thoughtfully address any compliance issues discovered as a result.

Government's Health Care Fraud and Abuse Recovery Totaled a Record $4 Billion in 2010

The federal government recovered a record $4 billion through fraud and abuse enforcement actions in 2010, according to a joint report issued on January 24, 2011 by the Department of Health and Human Services (HHS) and the Department of Justice (DOJ). The report, entitled *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010*, notes that approximately $2.5 billion was won or negotiated in health care fraud judgments and settlements. In 2010 alone, the DOJ opened more than 1,000 new health care fraud investigations and HHS excluded over 3,000 individuals and entities from participation in the Medicare program. In a press release announcing the report, HHS Secretary Kathleen Sebelius acknowledged that the report marks 2010 as the most successful year to date for the government's efforts in combating health care fraud. You can view this report at http://oig.hhs.gov/publications/hcfac.asp.

The report provides specific examples of significant settlements, prosecutions and achievements of HHS and DOJ through 2010, and also highlights ongoing collaborative efforts among governmental departments. For example, the Medicare Fraud Strike Force serves as a joint enforcement team of the HHS and DOJ and has prosecution teams operating in Baton Rouge, Brooklyn, Chicago, Dallas, Detroit, Houston, Los Angeles and Tampa. The Medicare Fraud Strike Force combines the data analysis capabilities of HHS and the investigative resources of the FBI with the prosecutorial resources of the DOJ. In 2010, the Medicare Fraud Strike Force filed charges against 284 defendants and accounted for the imprisonment of 146 defendants. The report signifies the growing attention and resources the government plans to devote to identifying and prosecuting fraud and abuse in health care. In addition, the DOJ and HHS are holding fraud and abuse summits in various cities around the country to focus attention on health care fraud and the efforts being undertaken to eliminate it using enhanced tools available to them under the Affordable Care Act.

Recent Settlement Agreements

It has become commonplace to read about prosecutions, convictions and settlements resulting from fraud and abuse investigations initiated by the government on its own, as a result of a qui tam action or in response to a self-disclosure. The potential unlawful conduct is wide ranging. For example, in a recent settlement agreement resulting from a self-disclosure, the alleged unlawful conduct involved improper financial relationships with referring physicians, which could have implicated the False Claims Act (FCA), the Anti-Kickback Statute (AKS) and the Stark Law (Stark). Examples of the potential improper financial relationships include (1) office leases and independent contractor arrangements that may have been inconsistent with fair market value, or not commercially reasonable, or which were not memorialized in writing, (2) business courtesies extended to physicians that may have exceeded permissible limits, and (3) the provision of signage and various marketing materials for physicians on terms that may not have been commercially reasonable or on fair market value terms. In another recent instance involving a qui tam action, the settlement resolved allegations of AKS and FCA violations related to professional services agreements entered into with cardiologists in exchange for the ongoing referral of lucrative cardiac procedures. The cardiologists allegedly received payment for EKG reads well in excess of amounts paid to their peers and received other payment under the agreement wholly unrelated to their EKG reading duties.

These settlement agreements are noteworthy for several reasons beyond the multiple millions of dollars recovered. In some cases, the settlement agreement resolves potential violations under FCA, AKS and Stark against one but not all of the parties involved. For example, a hospital system recently disclosed potentially unlawful conduct involving physicians on its medical staff and named the involved physicians. The named physicians were not a party to the settlement agreement and were not released under that agreement. Therefore, the physicians have potential exposure under the fraud and abuse laws for the disclosed conduct. Any physicians listed in a settlement agreement need to understand how the settlement agreement affects their interests, determine the extent to which they have exposure to any liability under federal or state law and how best to address that exposure. All physicians who have business relationships with hospitals entering into settlement agreements with the government should review the settlement agreements to determine if they are implicated in any way. Physicians whose names appear in any such settlement agreement should immediately contact the hospital to obtain an understanding of the details of the settlement agreement as it pertains to business arrangements involving the physician and what steps have been taken so far to correct the alleged improper conduct. Physicians also should retrieve and review all documentation in their files pertaining to the business arrangements identified in the settlement agreement and should request copies of all documentation in the hospital's files as well. Physicians should work with their own legal counsel to evaluate any potential exposure under FCA, AKS and Stark, and to determine the appropriate course of action to best protect their interests.

Hospitals and other health care providers also should note the recent settlement agreements and take steps now to review their business relationships with physicians and physician groups and the manner in which those relationships and agreements are structured and monitored. While many hospitals conduct periodic self audits, such audits often focus on topics identified by CMS or OIG as areas of concern rather than on the more technical or routine aspects of facilitating ongoing compliance with

AKS and Stark. Both are important. Thus, while monitoring timely renewals of expiring contracts and obtaining all required signatures on agreements can be time consuming and burdensome, such activities enable providers and their legal counsel to reduce their risk of noncompliance and to promptly address any business arrangements that do not comply with AKS and Stark.

CMS Announces New Rule to Prevent Fraud in Medicare, Medicaid and S-CHIP

The Centers for Medicare and Medicaid Services (CMS) recently issued a new final rule to proactively prevent healthcare fraud in public health programs by increasing provider screening and enforcement measures aimed at keeping potentially fraudulent providers from entering Medicare, Medicaid and state Children's Health Insurance Programs (S-CHIP). The rule implements provisions of the Patient Protection and Affordable Care Act and imposes requirements related to initial enrollment, revalidation and billing, which affect every type of supplier or provider enrolled in Medicare, Medicaid or S-CHIP.

The final rule, entitled *Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, provides for the following:

- More stringent enrollment and screening measures for all Medicare providers and suppliers, and especially for those considered high risk. Providers who fall into categories identified as high risk may undergo fingerprinting, criminal background checks and unannounced site visits;
- Allows CMS to suspend payments to providers and suppliers while investigating a credible allegation of fraud;
- Grants CMS authority to impose a temporary moratorium on enrollment of certain categories of Medicare providers and suppliers in a geographic area if there is significant potential for fraud;
- Requires states to screen providers who service Medicaid beneficiaries to determine past instances of fraud and to exclude all providers from Medicaid and the S-CHIP if the provider has been excluded from Medicare or another state's Medicaid program;
- Imposes an application fee of $500 for initial Medicare enrollment or revalidation of Medicare 855 applications; and
- Allows CMS to analyze data with predictive data software to detect healthcare fraud.

The provisions of the final rule become effective March 25, 2011. Providers and suppliers who participate in government health programs should familiarize themselves with the requirements of the final rule and seek counsel if CMS takes any adverse action against them under the new rule.

OIG Issues Most Wanted Health Care Fugitives List

To enhance its enforcement efforts, the OIG has, for the first time, published a Most Wanted Fugitives list to focus public attention on healthcare fraud and abuse crimes. The list names the OIG's top ten suspects from a list of 170 fugitives allegedly responsible for about $124 million in fraudulent claims against federal healthcare programs. The Most Wanted Fugitives list appears on the OIG's website and includes photographs and brief profiles of each individual. Those with information regarding any of the

fugitives are asked to complete an online fugitive tip form or call the OIG hotline for reporting fugitive related information. The site also indicates changes to each fugitive's status, including when he or she is captured. You can view the OIG's Most Wanted Fugitives list at http://oig.hhs.gov/fugitives.

For questions regarding fraud and abuse or assistance in implementing an effective compliance monitoring program, please contact any member of the Honigman Health Care Department.