

HEALTH CARE

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SPECIAL ISSUE: HEALTH CARE AND THE LAW

Avoid Becoming a Target Despite Increasing Government Scrutiny of Michigan Providers

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and local law enforcement agencies have shared information and resources to investigate and prosecute fraudulent health care matters in both the criminal, civil and administrative realms.

On February 17, 2011, 111 defendants were charged in 9 different cities with defrauding Medicare for more than \$225 million, 21 of which are from the Detroit area. This marked the largest coordinated Medicare fraud action ever taken. However, Michigan is no stranger to such actions in recent years. The Healthcare Fraud Prevention & Enforcement Action Team (a/k/a "HEAT") has been active in the Detroit area since March 2009. HEAT is an intra-agency effort whereby agents from the OIG, DOJ, FBI, DEA, and other federal

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Federal Court Judge Rules All Seniors Receiving Social Security Must Participate in Medicare Part A or Forfeit Past and Future Retirement Benefits

A federal District Court judge [Rosemary Collyer] has dismissed a two-and-a-half year lawsuit charging the Social Security Administration (SSA) and Department of Health and Human Services (HHS) with adopting policies that deny otherwise eligible retirees their rightful Social Security benefits if those retirees choose not to enroll in Medicare. The lawsuit, known as Hall v. Sebelius, was originally filed October 9, 2008.

"Anyone concerned with what will happen when the bureaucrats start writing the thousands of pages of rules that will govern the 'Patient Protection and Affordable

Care Act' need only look at what has happened in Hall v. Sebelius," said Kent Masteron Brown, lead attorney in the case. "When they do, they will realize nothing will be optional and there will be no fair, affordable or swift manner to obtain recourse or appeal a decision made by the bureaucracy."

The plaintiffs announced their intent to appeal the decision "even if it takes them two-and-a-half more years to win the right to make their own healthcare choices, rather than be beholden to a bureaucracy that knows and cares nothing about their individual circumstances," Brown said.

Judge Collyer's decision, he said, "provides a novel, new interpretation of what a federal 'entitlement' is. Based on her ruling, an entitlement is now an obligation. If an individual is entitled to certain federal benefits, he or she under this decision would now be obligated to accept them. A low-income family, hypothetically, could be required to accept housing and food assistance if that family qualifies – even if the members of that household have objections to accepting public assistance. That, in

Editor's note: This lead story is just a hint of the legal issues that must be decided in future years regarding major health care topics. This issue of Health Care Weekly Review™ is dedicated to covering these legal decisions.



Judge Rosemary Collyer

effect, is the meaning of this ruling."

The plaintiffs alleged that 1993 and 2002 rules added by the Social Security Administration to its "Program Operations Manual" are illegal. Those rules state, in effect, that any retiree who elects to opt out of Medicare Part A will automatically lose his or her Social Security retirement benefits and will be forced to repay any Social Security benefits received prior to opting out of Medicare Part A.

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While the initial focus was on suppliers of DME, subsequent focus has been on providers of infusion therapy, physical and occupational therapy, and home health services. In addition to incarceration, prosecutors are also seeking forfeiture of criminal proceeds and restitution to the Medicare program. All providers who significantly rely upon Medicare/Medicaid funding should review their practices for compliance with federal regulations and policies to avoid becoming a target.

One of the reasons for increased enforcement actions in Michigan is the availability of additional "tools" to the federal agents to pursue suspected healthcare fraud. In May 2009, the Federal False Claim Act ("FCA") was amended by the Fraud Enforcement and Recovery Act ("FERA") which greatly enhanced the federal government's healthcare fraud enforcement powers. FERA expanded liability under the FCA to entities that indirectly receive government funds such as subcontractors. FERA also eliminated the previous requirement that a party take an affirmative step (e.g., a false representation) to defraud the government. Under FERA, a person/entity can be held liable for simply retaining a federal overpayment even if the overpayment was not caused by their own fraudulent conduct (called a "reverse false payment"). FERA allows for civil investigative demands ("CIDs") to can compel oral testimony, document production and interrogatory answers. FERA also expands the protection of whistleblowers to include contractors and agents (not just employees) and allows even the compliance officer or biller to be a whistleblower.

In addition to FERA, there have been changes to manner in which CMS conducts its provider audits. Not only are RACs scrutinizing Medicare payments for improper payments, CMS also employs MICs to scrutinize Medicaid payments and ZPICs to perform a wide range of medical review, data analysis and Medicare evidence-based policy auditing activities. Of all the current CMS audit initiatives, it is vital that providers facing ZPIC audits immediately and effectively address targeted audit issues as ZPICs focus on the areas deemed to be at the greatest risk for fraud by providers and report all cases to the OIG.

Another reason for increased enforcement actions in Michigan is the availability of additional "tools" to State agents to pursue suspected healthcare fraud. Effective January 6, 2009, our legislature amended the Michigan Medicaid False Claims Act increasing the civil penalties associated with submitting false claims to Medicaid, expanding the definition of "knowingly" to include acting with deliberate ignorance or reckless disregard and allowing for "reverse false claims" similar to the federal FERA provisions. Michigan also now qualifies for an extra 10% of the recovery from the federal government for Medicaid false claims thereby providing increased incentives for the State to investigate and prosecute Medicaid false claim cases.

In light of these increased "tools" of enforcement, what can a healthcare provider in Michigan do to avoid becoming a target? The following is a list of suggested proactive measures to be taken:

- **Develop, implement and maintain a compliance program that includes education and continuing education of billing staff with a focus on proper documentation in accordance with third party payor guidelines;**
- **Identify risk areas through self-audits and review of the applicable third party payor publications and the annual OIG Work Plan; and**
- **Obtain and analyze your practice profiles from third party payors to understand how your practice compares to your peers to determine any aberrant areas of your practice that may need to be addressed.**

Being proactive and spending the resources upfront will be far more cost effective in the long run.

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