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Health Care Regulatory and Legislative Update

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Weekly Health Care Criminal and Civil Fraud Enforcement Round-Up

The following highlights notable health care fraud and abuse news, settlements and enforcement actions from the previous week. The home healthcare industry continues to be targeted by enforcement agencies.

1. Detroit Based Home Health Company Owner Sentenced to 30 Years in Prison for $33M Medicare Fraud Scheme. On October 28, 2016, the Department of Justice (*"DOJ"*) announced that the owner of several Detroit home health care companies was sentenced to 30 years in prison for his role in a Medicare fraud scheme that caused approximately $33 million in losses for the Medicare program. The owner was also ordered to pay $40M in restitution. Evidence showed that the owner paid kickbacks (1) to recruiters who financially induced patients to sign up for unnecessary home health care services and (2) physicians to refer patients to the companies for unnecessary home health care services.
2. Kansas-Based Home Health Company to Pay $1.8M to Resolve False Claims Act Allegations. On October 25, the DOJ announced that Best Choice Home Health Care Agency Inc. (*"Best Choice"*) and its owner, Reginald King, have agreed to pay $1.8 million to resolve allegations that Best Choice and King violated the False Claims Act by paying kickbacks for the referral of Medicaid-covered patients for home and community-based healthcare services from Best Choice. Best Choice is a home healthcare services provider based in Kansas City, Kansas. The government specifically alleged that Best Choice paid an

individual kick-backs for transporting patients from their homes to Best Choice facilities. The case was initially filed by a whistleblower, who will receive a $43,000 reward.

First Circuit Rules That HHS Had Right to Recoup Disproportionate Share Overpayments Payments from Maine Hospitals

Referring to the Medicare reimbursement system as "often surreal" and "among the most arcane known to man," the United States Court of Appeals for the First Circuit reversed a $17 million summary judgment victory for a group of eight Maine hospitals in a fight against the U.S. Department of Health and Human Services (*"HHS"*). In its Friday ruling, the First Circuit found that HHS had the right to recoup disproportionate share payments (*"DSH payments"*) that it accidentally overpaid for Medicare services dating as far back as 1993. Hospitals that serve a significantly disproportionate number of low-income patients are eligible for annual DSH Payments. Generally, the more low-income patients a hospital serves, the higher its annual DSH payment. Safety-net hospitals, which rely on DSH payments and are often already financially squeezed, will find this ruling particularly disappointing.

Vermont's All-Payer ACO Approved by CMS to Begin in January 2017

On October 26, 2016, Vermont received formal approval to proceed with its All-Payer Accountable Care Organization (*"ACO"*) as previously described in our October 11, 2016 update. In CMS's press release, CMS Chief Medical Officer Dr. Patrick Conway stated: "This model is historic in terms of its scope, aiming to include almost all providers and people throughout the state in an all-payer ACO model to drive improved quality, better care coordination, healthier people, and smarter spending." Vermont's All-Payer ACO will begin in January 2017. We will continue to monitor the success of this model, as Vermont's success or failure will likely plan a role in the way other states approach health care delivery system reform.