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Rosanna J. Willis 248.267.3276

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Thomas H. Van Dis 269.383.5816

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Thomas H. Van Dis 269.383.5816

HEALTH CARE REFORM

The Patient Protection and Affordable Care Act of 2010 (PPACA), signed into law by President Obama this past Spring, and legislatively modified by the Health Care and Education Reconciliation Act of 2010, marks a historic step in the overhaul of the U.S. health care system.

PPACA's sweeping provisions impact every aspect of, and player in, the health care arena. Although some changes are effective immediately, many of PPACA's provisions will be implemented incrementally through 2014 and beyond and will be subject to numerous regulations yet to be issued by the Secretary of Health and Human Services. In short, while the debates surrounding the language of the bill may be over, the work relating to implementing and understanding PPACA has just begun.

The primary goal of PPACA is to cover all uninsured Americans with some basic form of health coverage by 2019. Under the legislation, most Americans will be required to have a "minimum essential" package of health insurance by 2014 or pay a penalty based on their level of income. To help defray the cost of private health insurance, the law sets forth parameters for government subsidies to individuals based on income levels. To assist individuals with purchasing private health insurance, online insurance "exchanges" will start in 2014, where individuals may search for and purchase health insurance.

PPACA places responsibility on some employers to offer health insurance to employees. Large employers will face penalties in certain situations if they do not offer health insurance to their full time employees by 2014. Qualifying small employers who choose to

offer health insurance to their employees would be eligible for tax credits to assist with purchasing this coverage.

Some provisions of PPACA are immediately significant as they were either effective upon passage of PPACA or will be effective in 2010. These provisions include, for example, a prohibition on insurers denying coverage to children with pre-existing conditions and also the creation of a "temporary high-risk pool" to assist adults with pre-existing conditions to obtain affordable health insurance. Also in 2010, insurers will be banned from setting lifetime coverage limits on health insurance. Further, insurers will be required to permit unmarried adults younger than 26 to stay on their parent's health insurance starting in 2010.

The cost of implementing PPACA will be paid for, in part, by increased taxes and fees placed on certain medical industries. Starting in 2013, high income individuals will be required to pay a Medicare payroll tax. Also in 2013 and 2014, medical device manufacturers will be required to pay a 2.3% tax on sales. Furthermore, health insurance providers will be required to pay an allocable portion of a total annual fee starting in 2014 (\$8 billion for 2014) and escalating each year thereafter.

PPACA also contains tools to assist the government with combating potentially fraudulent, wasteful, or abusive practices in the health care industry. All health care providers that bill a Federal Health Care Program will be required to develop and implement compliance programs that are effective in combating fraudulent and abusive practices.

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HEALTH CARE REFORM

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After 2010, physicians will be prohibited from owning an interest in a hospital and those hospitals with physician ownership prior to 2011 will be prohibited from expansion. Physicians and group practices that rely on the in-office ancillary services exception to the Federal Stark Law to refer certain services to entities in which they have ownership interests will be required to disclose certain information to the patient in writing. Also, PPACA amended the "intent" requirement in the Anti-Kickback Statute, providing that "specific intent" is not required to violate the statute, making it easier to prosecute providers and suppliers under the Anti-Kickback Statute. PPACA also imposes additional obligations on non-profit, tax exempt hospitals, relating to community health needs assessments and financial assistance policies, among others.

Although the passage of PPACA is considered a major step toward health reform, full implementation of the law will not be complete for many years as thousands of pages of regulations still need to be issued by the Secretary. Thus, the majority of the work in implementing and understanding the full and practical impact of the legislation will come through 2014 and beyond. Miller Canfield's health law attorneys are dedicated to staying continuously informed of all newly issued regulations, rules, and notices relating to PPACA to ensure that our clients in the health care industry are well-versed in how this law impacts their business practices.

Health Law
Rosanna J. Willis 248.267.3276



STARK LAW COMPLIANCE

Section 6003 of PPACA amends the in-office ancillary services exception of the Stark Law to require physicians who refer patients for MRI, CT, PET, and certain other imaging services to inform the patient at the time of the referral that he/she may obtain the service from suppliers other than the referring physician or the physician's group practice. Section 6003 further requires referring physicians to provide the patient with a list of alternative suppliers in the area in which the patient resides.

Section 6003 contains ambiguities which leave important aspects of these requirements open to interpretation. However, on July 13, 2010, CMS, a branch of HHS, issued a proposed regulation (Proposed Rule) which, if adopted, will provide helpful clarifications.



Primarily, despite the January 1, 2010, effective date provided for under Section 6003, CMS proposes a January 1, 2011, effective date. Further, CMS indicates that it is not inclined to expand the requirement to services other than MRI, CT, and PET, and clarifies what must be included in the list of alternative suppliers.

The Proposed Rule requires that a copy of the notification, signed by the patient, be maintained in the patient's medical record. The comment period on the Proposed Rule ends August 24, 2010. If you would like more information or would like us to file comments with CMS on behalf of your organization, please contact the author or Billee Lightvoet Ward at 269.383.5860.

Health Law
Thomas H. Van Dis 269.383.5816

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HEATING UP



The Medicare Fraud Strike Force, known as the Health Care Fraud Prevention & Enforcement Action Team or HEAT, is a joint task force comprised of state and local investigators and senior leaders from the U.S. Departments of Justice (DOJ) and Health and Human Services (HHS) to investigate and prosecute health care fraud.

Strike Forces around the country have been extremely successful at prosecuting offenders, resulting in cases against hundreds of individuals and leading to the recovery of millions in court-ordered restitution.

TYPES OF FRAUD

The types of fraud investigators are looking for include false statements on Medicare forms, kickbacks in exchange for Medicare referrals, and billing fraud, which includes billing for services never provided, billing for unnecessary tests, and double-billing. Investigators use computer technology and quantitative analysis of data to detect fraud. Investigators also rely on community self-policing, anonymous tips, and interviews with Medicare beneficiaries.

RED FLAGS SUGGESTING FRAUDULENT ACTIVITY

- A single diagnosis or same treatments for all patients
- Rare and expensive treatments or services
- A lack of follow-up care
- Geographic disparity among patients
- Inconsistent diagnoses for the same patient
- A doctor treating too many patients

PROTECT YOUR PRACTICE

Honest practitioners may find themselves the subject of an investigation if a red flag is falsely raised. Practical suggestions for proactively protecting your practice.

- Implement detailed recordkeeping for ordered services to ensure they are necessary and actually rendered.
- Specify in writing why services or tests were ordered. Do not leave this to the Medicare provider who files the claim.
- Personally complete all information on certification forms, and never sign blank forms. Never certify the need for medical services or supplies for a patient you have not personally examined.

SELF-REPORTING FRAUD

If an organization suspects that it has committed fraud, it should conduct an internal investigation with the assistance of counsel and, based on the outcome of the investigation, the organization may decide to make a self-disclosure, as outlined by the HHS to Medicare authorities. Self-disclosure may help avoid costs and disruptions associated with a government-directed investigation.

CREATE A COMPLIANCE CULTURE

A good corporate compliance plan is essential even if an organization has not knowingly or otherwise committed fraud. Staff at all levels should receive training on how to recognize fraud and how to report it. Additionally, creating a compliance culture, such as by rewarding self-reporters or having a tip hotline, may go a long way in avoiding becoming the subject of a health care fraud investigation.

WHAT IF YOU'RE INVESTIGATED?

If an organization suspects fraud or becomes the subject of a government investigation, important decisions regarding strategy should be made from the outset. Outside counsel can advise on whether to testify and how to preserve applicable privileges (such as the Fifth Amendment privilege against self-incrimination). If you're a target of an investigation or you'd like to learn more about how to protect your practice, call our office.

Health Law
Pamela C. Enslin 269.383.5806

Associate Aimee J. Jachym
contributed to this article.

Red Flags Rule: The Deadline is Looming... Again

The Federal Trade Commission is further delaying enforcement of the Red Flags Rule (the Rule) until December 31, 2010, for financial institutions and creditors subject to enforcement by the FTC. The delay is again at the request of Members of Congress while Congress considers legislation that would affect which entities would be covered by the Rule.

Since the issuance of the Rule in November 2007, the Rule's applicability to health care providers has been the source of much debate among various medical associations, led by the American Medical Association (AMA), and the Federal Trade Commission (FTC). This debate has accounted, at least in part, for the FTC's prior delays in enforcing the Rule from the initial November 1, 2008, deadline. The FTC first extended the enforcement deadline to May 1, 2009, issued subsequent extensions to August 1, 2009, November 1, 2009, and June 1, 2010, and, most recently, delayed enforcement to December 31, 2010.

The FTC has indicated that, if legislation limiting the scope of the Rule goes into effect before December 31, 2010, enforcement will begin as of the effective date of such legislation. Therefore, providers should be prepared to comply with the Rule — and continue to monitor the ongoing debate.

Health Law
Billee Lightvoet Ward 269.383.5860

A HOSPITAL WANTS TO BUY YOUR PRACTICE

WHAT DO YOU DO?

The mid 1990s saw a wave of physician practice acquisitions by hospitals. Some worked out well; many didn't — and the trend died out — until recently.

USA
MICHIGAN
Detroit
+1.313.963.6420
Ann Arbor
+1.734.663.2445
Grand Rapids
+1.616.454.8656

Kalamazoo
+1.269.381.7030
Lansing
+1.517.487.2070
Saginaw
+1.989.791.4646
Troy
+1.248.879.2000

ILLINOIS
Chicago
+1.312.460.4200

NEW YORK
New York
+1.212.704.4400

OHIO
Cincinnati
+1.614.203.7800

CANADA
Toronto
+1.416.599.7700
Windsor
+1.519.977.1555

CHINA
Shanghai
+86.21.6103.7000

MEXICO
Monterrey
+52.81.8335.0011

POLAND
Gdynia
+48.58.782.0050
Warsaw
+48.22.447.4300
Wroclaw
+48.71.722.5090



QUESTIONS,
COMMENTS AND
TO SIGN UP FOR
E-HOT POINTS:

silkworth@millercanfield.com

millercanfield.com

Physicians are an attractive target for hospitals because their relationships with patients make them a major influence on where patients are referred for services.

CONTEMPLATING SELLING OR MERGING YOUR PRACTICE?

Consider how the new arrangements will affect the day-to-day conduct of your practice. Personal and professional satisfaction is important. Don't assume all your practice management problems will end if you sell. You will no longer have to manage your practice, but you will have to manage the hospital relationship. Like a good marriage, a good business relationship requires considerable time and effort.

Health care laws require that the sale price be limited to fair market value, which is generally established by an independent third party valuation of your practice. The sale comprises the more standardized elements of the overall transaction. **It is the structure of the post-sale arrangements that separates the good deals from the bad.**

POST-SALE BUSINESS ARRANGEMENTS

For a solo practitioner or small group, the alternatives are very limited. The physicians will probably have to become employees. Employment agreements with guaranteed compensation arrangements and benefits for as long a term as reasonably possible are essential.

Multi-specialty groups and certain large or well-situated single specialty practices can often negotiate more favorable arrangements. Such groups should consider keeping their PC intact and having it enter into a Professional Services Agreement (PSA) with the hospital. This is a huge advantage over individual employment agreements, which the hospital can change at will once the term of the agreements expire. The chief advantage of a PSA is that it provides a mechanism for the physicians to bargain collectively with the hospital.

PROTECTIONS

- PSAs provide contractually guaranteed compensation arrangements.
- PSAs have 10 to 20-year terms. Some physicians negotiate an option to terminate the PSA at intervals (every five years) so the hospital will be responsive to the needs of the physicians.
- The PSA can provide a legally guaranteed voice in hospital decisions affecting the physicians.
- Hospitals generally want non-compete agreements from the physicians; this is reasonable. However, what if the physician group elects to terminate the PSA as described in bullet point two above? The PSA can provide that the non-compete provisions do not apply if the entire group chooses to disaffiliate from the hospital.
- If the hospital wishes to hire new physicians in practice areas relevant to the group, the PSA can grant the group a first refusal to hire the new physicians and have them covered by the PSA. This helps maintain the size and bargaining power of the group.



If you can't strike an acceptable deal with the hospital, consider other alternatives

- Sell to a multi-specialty practice. Such practices usually offer enhanced revenue from cross referrals, better rates and terms with payers due to the group's size, and additional revenues in the form of ancillary service income (e.g. ambulatory surgery center, physical and occupational therapy, lab, imaging, etc.).
- Join together with other groups to form a new multi-specialty group.

Consider your options carefully, seek experienced professional help, and above all, be realistic. The "new normal" applies to hospitals and physicians alike.

Health Law
Thomas H. Van Dis 269.383.5816