Targeting Fraud and Abuse in the Health Care Reform Era

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The price tag on health care reform is expected to be paid for, in part, by eliminating fraud and abuse. As a result, the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care Education Reconciliation Act, contains many provisions targeting potentially fraudulent practices. These are not merely hollow threats; the government has allocated an additional $250 million for fraud and abuse enforcement activities over the next six years. As a result, providers need to expect aggressive enforcement of fraud and abuse regulations by the government. This article is intended to highlight some changes to fraud and abuse regulations.

Enhanced Screening of Providers

The first line of defense in preventing fraud and abuse under PPACA is keeping fraudulent providers out of the system. Therefore, PPACA requires the Department of Health and Human Services (HHS) to develop a new, stronger screening process for providers enrolling in Medicare, Medicaid and CHIP. These provisions require licensure checks and may include criminal background checks, fingerprinting, unannounced site visits, database checks and other screening that HHS deems appropriate. These new procedures will be developed by the end of September and will roll out for new providers on March 23, 2011 and existing providers on March 23, 2012. They will apply to revalidation of enrollment beginning in September of this year. By 2013, no provider will be enrolled in Medicare, Medicaid or CHIP unless that provider has gone through this enhanced screening.

Limitations on Physician Ownership of Hospitals

Congress chose to severely limit the Stark exception for physician ownership of hospitals, commonly referred to as the "whole hospital exception". Physician-owned hospitals with a Medicare provider agreement in place before December 31, 2010 will retain their Stark exception; however, physician-owned hospitals will not be able to enroll in Medicare after that date and comply with Stark. Additionally, the percentage of ownership by physicians is frozen as of March 23, 2010.

PPACA placed additional, cumbersome requirements on physician-owned hospitals. As just one example, these hospitals cannot increase the number of operating rooms, procedures rooms or beds after March 23, 2010. While HHS will create a process under which these hospitals can apply for increases, this will severely restrict the ability of these hospitals to expand. Moreover, physician-owned hospitals will now be subject to disclosure requirements and additional restrictions. This section also limited the Stark exception for rural hospitals. Physician-owned and rural hospitals must consider the impact of these new regulations on their business model.

Disclosure Requirements for In-Office Ancillary Services

Congress also chose to amend the Stark law exception related to in-office ancillary services for certain advanced imaging (MRI, CT, PET). Now, any provider that is referring for these services under the in-office ancillary services exception must give written notice to each patient at the time of referral stating that the patient may obtain the advanced imaging services from a different supplier. The provider must also give the patient a list of other suppliers in the area where the patient lives. This provision is especially confusing as it became retroactively effective on January 1, 2010, even though retroactive compliance is impossible. For providers

who refer to MRI, CT and PET imaging under the in-office ancillary services exception to Stark, it is important look into establishing a compliance program for this revised Stark exception.

Creation of a Self-Referral Disclosure Protocol

In the past, providers who have discovered Stark violations have been in a precarious predicament. Even a technical violation (such as the realization that one party had not signed a lease) would result in, at minimum, the return of one hundred percent of the Medicare billings for the prohibited relationship. To rectify this situation, Congress has ordered HHS to develop a Self-Referral Disclosure Protocol by September 23, 2010. PPACA specifically authorizes HHS to reduce the amount owing for Stark violations highlighting the three factors that HHS should consider in determining whether to reduce the amount. These factors are: (1) "The nature and extent of the improper or illegal practice;" (2) "The timeliness of such self-disclosure;" and (3) "The cooperation in providing additional information related to the disclosure." In the case of a potential Stark violation, a provider may want to contact counsel to determine the proper course of action.

Strengthening of the Anti-Kickback Statute

Previously there has been some uncertainty as to what intent was necessary to violate the Anti-Kickback Statute. PPACA has clarified that violation of the Anti-Kickback Statute neither requires actual knowledge of the statute nor specific intent to commit a violation of the statute. PPACA has further clarified that a violation of the Anti-Kickback Statute can be a basis for a False Claims Act lawsuit. Both of these changes strengthen the government's ability to successfully prosecute providers for violating the Anti-Kickback Statute, thereby increasing the risk for providers who have arrangements that may violate the Anti-Kickback Statute.

Therefore, providers may want to assess their risk of Anti-Kickback violations and determine whether they need to unwind any of their relationships.

Failure to Return Overpayments Creates a False Claims Act Violation

PPACA demands that providers must report and return all overpayments and provide notice in writing of the reason for overpayment. The failure to comply with this section within 60 days of discovering the overpayment creates a violation of the False Claims Act which can be prosecuted. This requirement went into effect on March 23, 2010. Therefore, if a provider has any known overpayments, that provider should immediately contact counsel to determine the proper course of action under PPACA.

Entering this New Era

As a result of PPACA, the government will have more tools and more money to fight fraud and abuse while simultaneously limiting the relationships providers can have. That Congress did this at the same time as testing new delivery and payment systems makes these changes confusing and, in some cases, contradictory. Therefore, providers must acknowledge the increased risk in this new era and take this opportunity to make sure their relationships are in compliance and minimize the risk of coming under government scrutiny.

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