

What Long-Term Care Providers Need to Know about Health Care Reform, Right Now!

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Introduction

- Health care reform – what happened?
- The “Big 3” near-term issues for LTC providers
 - New overpayment rules
 - New CMP provisions
 - Transparency / reporting requirements
- Beyond the “Big 3”: Other important reforms that will hit LTC providers in the next 12-18 months

Health Care Reform – What Happened?

- March 23, 2010 – President Obama signs the Patient Protection and Affordable Care Act (“PPACA”)
- Lots of press about “insurance reforms”
 - Most won’t take effect until 2014
- Less emphasis on the Act’s fraud and abuse and transparency measures
 - Many effective NOW

Health Care Reform – What Happened?

- Big themes in the PPACA
 - Expanding insurance coverage
 - ❖ Employer requirements
 - ❖ Individual mandates
 - Imposing price controls on insurers
 - Pilot programs to test theories of integrated care
 - ❖ Bundled payments
 - ❖ ACOs / gainsharing
 - ❖ Medical home
 - CLASS Act
 - **Huge section on combating fraud and abuse**
 - **Increased transparency and reporting requirements**
- These last two categories are where we'll focus today

Health Care Reform – “Big 3” Issues for LTC Providers

- If you only remember three things about health reform over the next 12 months:
 - New rules for reporting/repaying overpayments are important – noncompliance could lead to false claims exposure
 - Expanded CMPs for failures to report suspected crimes against residents, plus a new “escrow” option for OBRA CMPs could create cash flow concerns
 - Transparency provisions will require you to have extensive ownership and investment interest information available, starting now

The “Big 3”: New Overpayment Rules

- Overpayments must be **reported** and **returned** within the later of
 - 60 days of identification of the overpayment
 - The date the corresponding cost report is due
- Repayments made to the applicable payor
- Any overpayment retained after the deadline is an “obligation” for FCA purposes
 - 2009 FERA amendments to FCA expanded definition of “obligation” to include retention of an overpayment where “established duty” to repay existed
 - PPACA now establishes that duty expressly
- Effective: March 23, 2010

The “Big 3”: New Overpayment Rules

- Unless overpayment subject to an “applicable reconciliation process,” you have 60 days from the date you “identify” the overpayment to return/report it, or else you have a potential false claim
 - Cost report reconciliation
 - Other reconciliation processes (self-disclosure protocols)?
- Critical to remain diligent about identifying and analyzing potential overpayments
- Creates a need to develop/refine internal processes for “triaging” potential overpayments

The “Big 3”: CMPs and Escrow

- Two kinds of new CMP provisions to understand
 - CMPs specific to LTC providers
 - ❖ Elder Justice Act
 - ❖ OBRA CMP changes / escrow
 - CMPs that apply to all providers
 - ❖ False statement-related fines
 - ❖ Failure to cooperate with OIG investigations

The “Big 3”: CMPs and Escrow

- Specific to LTC providers
 - **Elder Justice Act – Abuse reporting requirements**
 - ❖ Applies to facilities receiving >\$10k in federal funds annually
 - ❖ Mandates reporting of “reasonable suspicion” of crime against a resident to HHS Secretary and local law enforcement
 - 2 hours to report if “serious bodily injury” involved
 - 24 hours to report otherwise
 - ❖ **Up to \$200k CMP, possible exclusion** for failure to report
 - ❖ **Up to \$300k CMP, possible exclusion** if failure to report exacerbated harm to resident
 - ❖ Mandatory notification of obligations to “covered individuals”
 - Must also post employee right/process to file complaint for violation
 - ❖ Penalties for retaliation: \$200k CMP, 2 year exclusion, or both
 - ❖ Same appeals process as for OBRA appeals
 - ❖ Effective: March 23, 2010

The “Big 3”: CMPs and Escrow

- Mandated reporting requirements – comparison

Source	What to report	Who reports	How soon	To whom
42 CFR 483.13	Alleged violations involving abuse or misappropriation of resident property	Facility	ASAP, no later than 24 hrs (unless shorter state rule)	Administrator and other officials in accordance with State law
Health & Saf. 1418.91	Incidents of alleged abuse or suspected abuse of a resident	Facility	ASAP, no later than 24 hours	CDPH
Welf. & Inst. 15630	Incident that reasonably appears to be / is reported as involving physical abuse, neglect, abandonment, abduction, isolation, or financial abuse	Individual	Immediately / ASAP (verbal); 2 working days (written)	LTC ombudsman OR local law enforcement
SSA Sec. 1150B	Reasonable suspicion of a crime (as defined by state/local law) against LTC facility resident	Individual AND facility	2 hours (if serious bodily injury), else 24 hours	HHS Sec. AND 1 or more law enforcement authorities

The “Big 3”: CMPs and Escrow

- Specific to LTC providers
 - **SNF general / quality of care requirements (OBRA)**
 - ❖ Existing law
 - Up to \$10k CMP per day/instance for noncompliance
 - CMPs not collected until final disposition
 - ❖ New law: Secretary may reduce CMP by up to 50% where facility self-reports / promptly corrects deficiency within 10 calendar days
 - ❖ Limits on applicability of reductions
 - ❖ Forthcoming regs to define a 30-day IDR process (pre-collection)
 - ❖ Secretary may collect/place CMP into an escrow account
 - Earlier of date IDR complete or 90 days after imposition of CMP
 - If appeal succeeds, provider receives refund plus interest
 - ❖ Effective: March 23, 2011
 - **Escrow represents a significant change from existing practice - potential cash flow disruption if large CMP**

The “Big 3”: CMPs and Escrow

- Applicable to all providers
 - **\$50k + treble damages** for knowingly making false statements, omission, misrepresentation of a material fact in any federal healthcare program application, bid, or contract
 - **\$50k for each false record or statement** used for payment from federal healthcare program (FCA-type provision)
 - **\$15k per day** for failure to grant timely access, upon reasonable request, to OIG for audits, investigations, evaluations, etc.
 - Effective: March 23, 2010

The “Big 3”: Transparency

- New disclosure requirements for ownership and “additional disclosable parties” information
- Prior law required Medicare providers to disclose limited ownership/investment interests (855A)
- New law expands information LTC facilities must provide:
 - Organizational structure of the facility
 - Additional information on officers, directors, trustees, and managing employees of the facility
 - ❖ Names, titles, start dates of service
 - ❖ “Managing employee” broadly defined
 - Information on any “additional disclosable party” of the facility

The “Big 3”: Transparency

- “Additional disclosable party” requirement may generate some heartburn
 - Defined as any person or entity that
 - ❖ exercises operational, financial, or managerial control over the facility, or provides policies or procedures for the operations of the facility, or provides financial or cash management services to the facility
 - ❖ leases or subleases real property to the facility, or owns a whole or partial interest equal to or exceeding 5% of the total cash value of such real property
 - ❖ provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility
- This will require disclosure of the structure and relationships of parent-subsidiary and related organization relationships (e.g., real estate holding companies and administrative service companies)

The “Big 3”: Transparency

- Beginning March 23, 2010, facilities must have this information **available for submission**
- By March 23, 2012, Secretary must issue regulations requiring the information to be reported to the Secretary in a standard format
 - Will require certification that information is “accurate and current” (best of facility’s knowledge)
- Within 1 year after final regulations issued, facilities will be required to make information available to the public
- Taken in conjunction with new mandatory Medicaid exclusion provisions for persons or entities “affiliated” with an excluded entity or individual, transparency requirements could provide more opportunities for government authorities to seek exclusion

Beyond the “Big 3”

- The PPACA also contains many other reforms that will hit long-term care in the next 12-18 months
 - Reimbursement
 - ❖ Payment rates
 - ❖ Claims submission
 - ❖ Cost reports
 - Regulatory Enforcement
 - ❖ New/expanded enforcement authorities and penalties
 - ❖ Provider enrollment and transparency requirements
 - ❖ Elder Justice Act grants to LTC facilities
 - Fraud and Abuse
 - ❖ Overpayments
 - ❖ False Claims / Healthcare Fraud
 - ❖ Stark / Anti-Kickback

Reimbursement: Payment Rates

- Revisions to SNF PPS provisions for FY 2011 (§ 10325)
 - No market basket update reduction
 - Delays implementation of RUG-IV until 10/01/11
 - Remaining provisions of FY 2011 PPS on track
- Extension of therapy caps exception (§ 3103)
 - Extended until 12/31/10

Reimbursement: Claims Submission

- Time period to submit Medicare claims (§ 6404)
 - Old rule: 3 calendar years following year in which service performed
 - **New rule: 1 calendar year after the date of service**
 - Applies to all services furnished on or after 01/01/10
 - Services furnished before 01/01/10 – bill or request for payment must be filed by 12/31/10
- NPI requirements (§ 6402)
 - NPI must be included on all Medicare/Medicaid program applications and claims starting 01/01/11

Reimbursement: Cost Reports

- Expenditure reporting requirements (§ 6104)
 - Applies to cost reporting periods beginning March 23, 2012
 - Facilities must separately report expenditures for wages/benefits for direct care staff
 - Must break out RNs, LPNs, CNAs, other medical and therapy staff
 - Will provide greater transparency for staffing levels as well as wage and benefit data

Regulatory Enforcement: New and Expanded Authorities and Penalties

- Expansion of the RAC program (§ 6411)
 - Medicare Parts C and D
 - Medicaid (by Dec. 31, 2010) – what about MICs?
 - Yet another contractor – establish points of contact with existing MIC / RAC in advance of disputes
- Expanded OIG subpoena authority (§ 6402)
 - Grants OIG broad authority to obtain information for purposes of program integrity, including supporting documentation necessary to validate federal program payments
 - Consider employee training on rights/responsibilities in the event of an investigation
- Repeal of Medicare Prepayment Medical Review Limitations (§ 1302)
 - Greater potential for random governmental audit/review

Regulatory Enforcement: New and Expanded Authorities and Penalties

- New grounds for mandatory exclusion from Medicaid (§ 6501)
 - If terminated by Medicare or other Medicaid program
 - For individuals/entities that own, control, or manage an entity that
 - ❖ Has delinquent unpaid overpayments
 - ❖ Is suspended, excluded, or terminated from participation
 - ❖ Is **affiliated** with a suspended, excluded, or terminated individual or entity
 - Effective: Jan. 1, 2011

Regulatory Enforcement: New and Expanded Authorities and Penalties

- New grounds for permissive exclusions (§§ 6402 and 6408)
 - Knowing false statement, omission, or misrepresentation of material fact in any application, agreement, bid, or contract to participate or enroll in a federal healthcare program
 - ❖ Increased importance on verifying enrollment applications and provider agreement data
 - Obstruction of program audits and investigations
 - ❖ Prior law applied only to obstructing criminal investigations
 - ❖ Consider employee training about proper cooperation

Regulatory Enforcement: New and Expanded Authorities and Penalties

- Suspension of payments pending investigation of fraud (§ 6402)
 - HHS can suspend Medicare/Medicaid payments pending a “credible investigation of fraud,” unless “good cause” exists
 - Allows HHS to go over the heads of States to some degree
- U.S. Federal Sentencing Guidelines (§ 10606)
 - Increase of 2-4 levels for federal healthcare offenses involving >\$1M
 - Translation: an extra 6-12 months in prison, higher associated fines for high dollar-value healthcare fraud offenses

Regulatory Enforcement: Provider Enrollment and Transparency

- LTC-specific provisions
 - Nationwide program for national/state background checks on direct patient access employees (§ 6201)
 - Compliance and ethics program must be in place and operational by March 23, 2013 (§ 6102)
 - ❖ Standards likely similar to existing OIG guidance
 - Required registration under Medicaid of any agents, clearinghouses, other alternate payees that submit claims on behalf of healthcare providers (§ 6503)
 - ❖ Must register with the state and the HHS Secretary

Regulatory Enforcement: Provider Enrollment and Transparency

- Nursing Home Compare Website (§ 6103)
 - Requires Secretary to include certain data on site
 - ❖ Staffing data (incl. census and nhppd, turnover/tenure)
 - ❖ Links to websites with information about state survey and certification programs and inspection reports (incl. 2567s)
 - ❖ Summary info on number, type, severity, and outcome of substantiated complaints
 - ❖ Number of adjudicated instances of criminal violations by a facility
 - Secretary must require most data not later than March 23, 2011. Staffing data reporting requirements effective by March 23, 2012
 - More public access to staffing data, including by potential plaintiffs under state nurse staffing ratio / unfair competition laws

Regulatory Enforcement: Provider Enrollment and Transparency

- Provider screening and other enrollment requirements (§ 6401)
 - Applies to all Medicare/Medicaid providers
 - Expanded provider screening procedures
 - Enhanced oversight for new providers/suppliers
 - Increased disclosure requirements for new providers/suppliers
 - Authorizes HHS to satisfy past due obligations by adjusting payments to providers/suppliers with the same TIN
 - ❖ Prevents licensee from divesting its way out of CMP-laden facility
 - Establishment of compliance program is a condition of enrollment

Regulatory Enforcement: The Elder Justice Act

- First introduced 6 years ago as stand-alone bill
- Enacted as a subtitle of PPACA
- Several provisions related to establishing various bodies, advisory boards, and investigating entities regarding “elder justice”
- CMP provisions discussed above for failures to report “reasonable suspicion” of abuse
- **\$67.5M over 4 years in grants** to enhance long-term care, focused on
 - recruiting, training, retention of staff
 - Improving management practices
 - adoption of certified EHR technology

Regulatory Enforcement: The Elder Justice Act

- Staffing grants
 - Grants to eligible entities to carry out programs that
 - ❖ Offer continuing training and varying levels of certification to direct care employees, based on observed clinical care practices and the amount of time the employees spend providing direct care
 - ❖ Provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program
- Management grants
 - Grants to eligible entities to carry out programs that provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as
 - ❖ Establishment of standard HR policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews
 - ❖ Establishment of motivational and thoughtful work organization practices
 - ❖ Creation of a workplace culture that respects and values caregivers and their needs
 - ❖ Promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals
 - ❖ Establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are CNAs
- Potential for facilities that do well under AB 1629 to receive grants?

Regulatory Enforcement: The Elder Justice Act

- Technology grants
 - Authorizes grants to LTC facilities for the purpose of assisting such entities in offsetting costs related to purchasing, leasing, developing, and implementing certified EHR technology designed to improve patient safety and reduce adverse events and healthcare complications resulting from medication errors
 - Funds provided under such grants may be used for any of the following:
 - ❖ Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies
 - ❖ Making improvements to existing computer software and hardware
 - ❖ Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing
 - ❖ Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information
 - Grant recipient shall, where available, participate in its state's electronic health information exchange program
- All three grant programs will need to be further defined by the Secretary

Fraud and Abuse: Overpayments

- In addition to the new “60-day rule,” Section 6506 provides States more flexibility in timeframes for investigations
 - Extends period for States to repay overpayments to federal government from 60 days to 1 year where ongoing judicial/administrative process in play
 - If overpayments due to fraud, state repayments not due until 30 days after date of final judgment
 - Applies to overpayments discovered on/after March 23, 2010

Fraud and Abuse: False Claims and Healthcare Fraud

- FCA – Public disclosure bar to qui tam actions (§ 10104(j))
 - Public disclosure no longer jurisdictional, DOJ has discretion to oppose dismissal even if relator is not original source
 - Limits public disclosure to federal sources (news media still count)
 - Expands definition of “original source”
- Healthcare Fraud Offenses (§ 10606)
 - Reduces intent required to establish violation of the criminal healthcare fraud statute (18 U.S.C. § 1347)
 - ❖ “Knowing and willful” does not require proof of actual knowledge of the healthcare fraud statute or specific intent to violate the statute
 - Expands definition of “healthcare fraud offense” to include AKS, FDCA, and certain ERISA violations

Fraud and Abuse: Stark and Anti-Kickback

- Medicare Self-Referral Disclosure Protocol (§ 6409)
 - Old law: OIG self-disclosure protocol requires a colorable AKS violation – no free-standing process for self-disclosing Stark violations
 - New law: establishes a self-referral disclosure protocol (SRDP) for healthcare providers and suppliers to disclose an actual or potential Stark violation
 - Authorizes HHS discretion to reduce the amount due and owing for all Stark violations to an amount less than that specified in the statute
 - Effective: No later than September 23, 2010, HHS Secretary to establish SRDP procedures in consultation with OIG

Fraud and Abuse: Stark and Anti-Kickback

- Amendments to the federal Anti-Kickback Statute (§ 6402)
 - A claim that includes items/services resulting from an AKS violation now constitutes a false or fraudulent claim for FCA purposes
 - A person need not have actual knowledge of the AKS nor specific intent to commit an AKS violation (overruling *Hanlester*)
- More important than ever to make sure your current provider/supplier contracts (e.g., medical director agreements) have been reviewed for compliance with AKS
 - FMV
 - Timekeeping requirements

Conclusions

- Substantial changes regarding fraud and abuse and transparency are effective now and may require operational changes today
- Examples of possible action items to address in the near-term:
 - Develop a potential overpayment processing strategy
 - Review reporting processes for incidents of suspected abuse / crimes against residents
 - Compile ownership / investment transparency data
 - Develop / implement a meaningful ethics and compliance program
 - Train employees about best practices for responding to government investigations
 - Evaluate whether your facility may be eligible for training and technology grants under the Elder Justice Act
 - Review provider/supplier agreements for Stark/AKS compliance
- Stay tuned for forthcoming regulations and guidance that further define the PPACA's provisions

Questions?

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