



## BNA's Health Care Fraud Report<sup>TM</sup>

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**14 HFRA 307**

### **Experts Say Burdens to Increase With New Disclosure, Transparency Provisions**

Disclosure and transparency issues are central to the new fraud and abuse provisions in the recently signed Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and providers and suppliers can expect new compliance burdens, Richard P. Kusserow, chief executive officer of Strategic Management, Alexandria, Va., told BNA.

The reconciliation bill, the Health Care and Education Reconciliation Act of 2010, was signed March 25 and became Pub. L. 111-152 (*see related item in BNA Insights*).

"There is going to be a real increase in work for providers and suppliers to develop programs to meet the disclosure standards, such as mandated compliance programs," Kusserow said. "You're creating an affirmative duty to disclose."

Kusserow, who served as the Inspector General for the Department of Health and Human Services from 1981 to 1992, said that in the past, providers and suppliers could get away with fairly pro-forma compliance plans.

Under the new health care law, compliance plans will have to be certified, mostly likely by someone in a leadership position, as opposed to a compliance officer.

"Providers and suppliers who were flying under the radar before won't be able to anymore," Kusserow said.

Long-term care is one industry sector that will most likely have an increased workload staying in compliance with the disclosure and transparency provisions, Kusserow said. Under the new law, he said, they will have to take responsibility for the people they hire.

"Hospitals have been doing this, but long-term care really hasn't. Nursing homes have the highest job turnover in the industry, and they haven't put a lot of effort in performing background checks for new hires. Now, they will have to," Kusserow said.

As efforts gear up to implement the new law, much remains to be worked out, Kusserow said.

"It's a huge undertaking, with possibly 50,000 pages of regulations that need to be written. The Centers for Medicare & Medicaid Services is really going to have to flog the troops to get this done," he said.

In terms of the mandated compliance programs, for example, Kusserow said that CMS still needs to let providers and suppliers know what the standards are and who should certify them.

"It will take a major effort by CMS in the next five years to get the health care reform law up and running," he said.

### **Enrollment and Screening**

Disclosure burdens will also increase due to new provider enrollment and suspension provisions, Kevin G. McAnaney, an attorney with the Law Office of Kevin G. McAnaney, Washington, told BNA

While this will predominately hit durable medical equipment suppliers, home health providers, and small providers, it will affect the entire industry, he said.

The new law boosts enrollment and screening provisions in a number of ways, Jana Kolarik Anderson, an attorney with Nelson Mullins Riley & Scarborough, Washington, told BNA.

"The provisions include additional provider/supplier screening procedures for both Medicare and Medicaid, which include, at a minimum, a licensure check, and may include a criminal background check, fingerprinting, unscheduled and unannounced site visits (including pre-enrollment site visits), and database checks (including checks across states)," Anderson said.

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***Richard P. Kusserow, chief executive officer,  
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As the enhanced screening procedures get under way, Medicare providers and suppliers should expect related enrollment fees, Anderson said, and all providers and suppliers will be required to establish compliance programs with core elements designed by CMS and the Department of Health and Human Services Office of Inspector General, she said.

"With an increased focus on enrollment disclosure, there are clear penalties for misrepresentations. CMS may also institute a temporary moratorium on the enrollment of new providers/suppliers if necessary to prevent or combat fraud, waste or abuse," Anderson said.

The health reform legislation also makes a change to the permissive exclusion statute, giving the OIG the right of permissive exclusion for any individual or group that misrepresents material facts on any application, agreement, bid, or contract associated with a federal health care program, Anderson said. The permissive exclusion statute grants the OIG the power to exclude providers from federal health care programs.

McAnaney said that compliance burdens on the entire health care industry will grow due to increased pressure on the Department of Justice, OIG, and CMS to eliminate fraud and abuse. A result of the increased pressure could be more marginal cases being brought by the government, as well as dysfunction at CMS as it tries to implement the new law, McAnaney said.

"There will be much more aggressive enforcement. With the use of contractors, the government will be going after money, and they will push for more," Kusserow said.

### **Increased Information Flow**

Enhanced disclosures will also apply to Medicare/Medicaid, the Department of Veterans Affairs (VA), and the Department of Defense, Anderson said, with an increased flow of information between the agencies regarding any adverse actions against providers and suppliers. This could include information on loss of licensure, exclusion from federal programs, and other related issues.

"As part of that increased flow of information, CMS will create an Integrated Data Repository with claims and payment data from Medicaid, Medicare (Parts A, B, C, and D), the State Children's Health Insurance Program, the VA, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Indian Health Service (IHS) to share and match data between the agencies to detect fraud. Transparency is king," Anderson said.

The health care reform legislation also requires full disclosures of any financial relationships between pharmaceutical and device manufacturers and physicians and teaching hospitals, Anderson said. This idea is similar to the Physician Sunshine Act, a bipartisan bill that has been brought up in the Senate for several years.

"In addition to transfers of value, manufacturers and group purchasing organizations must disclose ownership or investment interests held by physicians," Anderson said. Noncompliance can result in a number of civil monetary penalties that increase with the failure to report, she said. "These 'transparency reports' will be publicly available," Anderson said.

Also important, the health reform provisions amend the intent requirement under the federal anti-kickback statute, noting that "a person need not have actual knowledge of this section or specific intent to commit a violation of this section."

"What is concerning regarding the amendment is that although most health care providers and

suppliers seek to fit their arrangements into anti-kickback safe harbors, it is not always possible," Anderson said. "This amendment makes that failure to meet a safe harbor more risky."

### **Self-Disclosure Protocol**

Anderson also highlighted the creation of a CMS self-referral disclosure protocol (SRDP) for actual or potential violations of the federal physician self-referral law (42 USC 1395nn), also known as the Stark law.

The Stark law prohibits referrals of Medicare and Medicaid patients to entities with which physicians or their immediate family members have a financial relationship if the referral is for the furnishing of designated health services.

The protocols are supposed to be in place within six months of enactment of the new law and authorize CMS to reduce the amount due and owing for all Stark law violations to amounts less than those specified in Section 1877 (g) of the Social Security Act, which set the original list of sanctions for Stark law violations.

Attorneys, providers, and suppliers have been eager to see such a protocol for some time, Anderson said.

The addition of an SRDP has been in the works for months, Ankur J. Goel, an attorney with McDermott Will & Emery LLP in Washington, told BNA. "This gives CMS the authority to enter into Stark law resolutions. It is a clear grant of authority, and it will help resolve all the head-scratching that providers have had on how to handle self-referral situations."

Goel said the disclosure provisions would be a win for providers and suppliers, giving them a clear path to resolve any Stark law issues. "The particulars remain to be seen, but CMS does understand this issue," he said.

### **Increased Recovery Programs**

Another transparency provision of the health care reform law expands the Recovery Audit Contractor program into Medicaid, William Mahon of Mahon Consulting LLC said. Previously, the RAC program had been confined to Medicare.

RACs are tasked with recovering improper payments. A demonstration program ran from 2005 to 2008, and the RAC program expanded to cover the entire country in January of 2010 (13 HFRA 816, 10/21/09).

Mahon said that the RAC expansion could potentially duplicate the efforts of the Medicaid Integrity Program (MIP), which was created in 2005 (10 HFRA 553, 7/19/06).

The program authorizes contractors, known as Medicaid Integrity Contractors (MICs), to perform provider claims audits and identify fraud and abuse, as well overpayments. Unlike RACs, MICs do not work on a contingency-fee basis.

"A lot of what the White House has been promoting is tied to fraud and abuse, but RACs don't handle fraud cases, at least not now. It doesn't seem like a very thought out program expansion," Mahon said.

Mahon also discussed the parallels between the MIC and RAC programs, and said that official guidance will be needed eventually to sort out any issues the two programs might have with each other.

"Just last year Congress was awarding MIC contracts," Mahon said. "It's hard to believe that they created MICs and then forgot about them. Somewhere down the line, these two parallel programs [RACs and MICs] will need to be reconciled."

Mahon said that it would take awhile for Medicaid RACs to be operational, indicating that the Medicare RACs are still getting up to speed. Referring to reconciling MICs and RACs, he said, "I don't expect that Congress will revisit this issue anytime soon."

Kusserow said that the government has been trying to bring increased accountability to Medicaid for some time now. "Medicaid accountability is where Medicare was in the 1970s," he said.

However, transitioning RACs to Medicaid will be no simple feat, he said. "There are a lot of issues," he said. "Where's the appeals process for RACs? Will it be a standardized federal appeals process? Will

providers be hit by state Medicaid agencies and federal RACs?"

*By James Swann*

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