2011 Health Care Regulatory and Compliance Update

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Key Hospital Fraud Enforcement Provisions of the Patient Protection and Affordable Care Act

- Sets 60 day deadline for returning overpayments to CMS
- Establishes a protocol for self-disclosure of Stark violations to the OIG
- No new physician-owned hospitals as of December 31, 2010

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Key Hospital Fraud Enforcement Provisions of the Patient Protection and Affordable Care Act

- Relaxes the intent requirements of the AKS—"repeals" the Hanlester case
  - Old test: Violation occurs if
    - "one purpose" of payment is to induce an illegal referral;
    - actual knowledge of the AKS's prohibitions;
    - specific intent by inducing the referral to violate the AKS
  - New test: Violation occurs if
    - "one purpose" of payment is to induce an illegal referral; no longer necessary to prove specific intent to violate the AKS

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- Increases funding — over $700 million during the decade — to fight Medicare fraud and abuse
- Tax-exempt hospitals, effective March 23, 2012, must perform a "community health needs assessment" every three years, and are required to develop a financial assistance policy, including criteria for assistance for discounted care, billing and collection
- Establishes a national health care fraud and abuse data collection program for reporting adverse actions against providers, information to the NPDB
- Establishes new grounds for terminating and excluding persons or entities from Medicaid who own or manage entities that fail to repay overpayments, that are excluded from Medicaid, or that are affiliated with excluded persons or entities

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Key Hospital Fraud Enforcement Provisions of the Patient Protection and Affordable Care Act

- Knowing falsity is grounds for program exclusion
- Expands grounds for CMPs for: excluded providers and; falsities made in Medicare or Medicaid enrollment applications
- Suspension of program payments pending investigation of “credible allegations of fraud”

Separate from any California reform legislation

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