



an informational series for hospital leaders

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Program Integrity Provisions

The Patient Protection and Affordable Care Act (PPACA) includes provisions that enhance the government's effort to combat fraud, waste and abuse. According to the U.S. Dept. of Health and Human Services (HHS) web site, PPACA will "shift the emphasis from the old model of 'pay and chase' to a new model that puts a premium on fraud prevention and program integrity." Recently, the Secretary of Health and Human Services sent a letter to state attorneys general urging them to work with HHS and federal, state, and local law enforcement officials to mount a substantial outreach campaign to educate Medicare beneficiaries on ways to prevent scams and fraud.

A few key PPACA provisions regarding program integrity are effective now, while other provisions will require the Secretary to adopt rules, so compliance will follow the publication of interim final rules. Hospitals should understand these new obligations and risks and take appropriate steps to ensure compliance.

Effective Now:

- **Unintentional violations of the anti-kickback statute.** The anti-kickback statute no longer requires intent, and now states: "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section." (Sec. 6402) The removal of this intent requirement exposes hospitals to much greater risk of violating the anti-kickback prohibition because the government's burden of proving a violation is substantially reduced. *Accordingly, hospitals should review their existing financial arrangements with other providers to make sure that no payments can be viewed as unintentional kickbacks. In addition, hospitals may want to consider subjecting all future financial arrangements with other providers to an "anti-kickback compliance assessment" to document a good faith attempt to comply with the law. Having a well-documented anti-kickback compliance process may persuade federal authorities not to prosecute under this law.*
- **Under the False Claims Act, whistleblowers need not be the original source of the information about a fraud.** More whistleblower lawsuits will be able to go forward now because it will be easier to bring these suits. Previously, a public disclosure of a fraud barred a whistleblower from going forward with an action. Now, certain types of public disclosures will

no longer impede an action. *Therefore, to minimize the chance of a whistleblower lawsuit, hospitals should review whether managers investigate and address employee grievances when employees complain about a hospital practice.*

- **For the first time, disclosure and repayment of overpayments is expressly required by law.** Persons who have received overpayments must report and return the overpayment no later than 60 days after the date on which the overpayment was identified, or the date any corresponding cost report is due. (Sec. 6402) *Hospitals will need to review, and possibly revise, their billing policies and procedures to comply with this new mandate. Policies and procedures must help identify overpayments and implement a process for repaying any overpayments within this 60-day payback period.*
- **The Recovery Audit Contractor (RAC) program is expanded to include audits of Medicaid and Medicare Parts C and D.** (Sec. 6411) *Hospitals that submit Medicare Advantage claims will want to make sure documentation is thorough and that services are medically necessary in order to defend payments from these plans. The PPACA RAC expansion provision indicates that the RACs will be focusing primarily on the plans themselves, but it is likely that the plans, in turn, will request records from providers to substantiate services. Also, it is not clear if the current RAC for Region B (which includes Illinois), CGI Technologies, will be the RAC assigned to review Medicare Part C and Part D. Before a RAC can review any new issue, it must receive approval from CMS and then post the issue on its web site. Given that RAC reviews in Illinois only started this past December on a limited number of hospital issues (i.e., DRG validation) and there are more to come, it is improbable that reviews of Part C and Part D will begin before 2011.*
- **Medicare and Medicaid claims without a National Provider Identifier (NPI) may be rejected.** The simple failure to include a NPI on claims can have substantial financial consequences (e.g., claim rejections and payment delays). *Consequently, hospitals and their affiliated providers should review and revise, if necessary, their procedures to make sure that each Medicare and Medicaid claim includes the NPI and legal name for any provider or supplier required to be included on a claim, in order to receive full and timely payment.*

Other program integrity provisions are not effective until the Secretary publishes rules to implement those provisions. More information will follow as rules are published. For questions regarding the content of this memo, please contact Kathleen Pankau, Assistant General Counsel at 630-276-5598 or kpankau@ihastaff.org.