Top 10 Issues in Health Care for 2012

Kelly M. Jolley, McNair Law Firm, PA
The June 28, 2012 Supreme Court decision essentially made the expansion of the Medicaid program under the ACA a state option.

Under the ACA as enacted but prior to the Court’s ruling, the Medicaid expansion appeared to be mandatory for states that wanted to continue receiving federal matching funds for any part of their Medicaid program.

The Supreme Court held that the Federal government could not penalize states that refuse to expand Medicaid by withholding federal Medicaid dollars.

Many states, including South Carolina, have “opted out” of Medicaid expansion. Many other states have requested guidance from DHHS regarding the sustainability of the program under the ACA.
ACA

• CBO and JCT now estimate that the insurance coverage provisions of the ACA will have a net cost of $1,168 billion over the 2012–2022 period—compared with $1,252 billion projected in March 2012 for that 11-year period—for a net reduction of $84 billion. (Those figures do not include the budgetary impact of other provisions of the ACA, which in the aggregate reduce budget deficits.)

• In 2022, for example, Medicaid and the Children’s Health Insurance Program (CHIP) are expected to cover about 6 million fewer people than previously estimated, about 3 million more people will be enrolled in exchanges, and about 3 million more people will be uninsured.

The Act provides an additional $350 million to fight fraud. These funds supplement a robust $464 million expenditure in fiscal year 2009 for the Health Care Fraud and Abuse Control Account.
Anti-Kickback Statute (AKS) amended to provide that a violation of the AKS constitutes a false or fraudulent claim under the FCA (Sec. 6402(f)) of ACA.

Intent standard revised to “a person need not have actual knowledge of this section or specific intent to commit a violation of this section.”
FRAUD and ABUSE: Self Disclosure Protocol


DHHS filed first report to Congress regarding SRDP effectiveness on March 23, 2012, detailing 150 disclosures CMS received in past year.

Disclosures range from personal service arrangement violations associated with personal service arrangements to physician recruitment arrangements and office space rental.

CMS settled 6 cases during the reporting period (two more have been settled since the report was released) while 110 are either currently under review or pending receipt of additional information. Settlements ranged from $6,700 to $579,000.

The remaining 32 were either dropped, referred to law enforcement or remain on administrative hold. Not the fast track to resolve Stark violations that providers might have hoped for.
FRAUD and ABUSE: Contracts and Referrals

• *U.S. v. Borrasi*, 2011 WL 1663373 (7thCir. 5/4/11)
  • Rejects “primary motivation” doctrine
  • Physician convicted of violating AKS by accepting salary from hospital in exchange for making referral
  • Even if hospital payments to employed doctor were compensation for professional services, AKS violated if “at least part of the payments” were intended to induce referrals
**FRAUD and ABUSE: Exclusive Contracts**

  - 5th Circuit reversed preliminary injunction, finding it a "legislative act of a public entity," supported by rational basis
  - Fear of losing only cardiac surgeon provided rational basis for closing the department
  - "Only those physicians who are contractually committed to the Hospital to participate in the Hospital’s on-call emergency room coverage program shall be permitted to exercise clinical privileges in the cardiology dept."
FRAUD and ABUSE: False Claims Act

- FCA now requires providers to detect and refund overpayments, making self-policing by providers of paramount importance.

- CMS proposed rule for reporting overpayments requires providers to look back further than the current 4 to 6 years and imposes increased obligations to ferret out improper claims.

- McKesson Corp. has agreed to pay $190 million in False Claims Act settlement for inflating pricing information on prescription drugs (3/12)
Physician Payment Sunshine Provision – requires “applicable manufacturers” (drug and device manufacturers) to report information on payments to physicians and teaching hospitals

GPOs must disclose physician or family ownership

All reports will be public on CMS website Hospital error data on CMS website – 4/7/11

Hospital comparison – includes outpatient care measures

Drug/Device “Sunshine” provisions

Manufacturers required to submit “transparency reports” eff. 1/1/12; report 2012 data on physician and teaching hospitals on 3/13/13
“60-Day Rule” to repay overpayments – Pub. Law No. 111-149, § 6402(d)

- Applies to funds that a person is “not entitled” to receive
- Due within 60 days or the date the corresponding cost report is due (when does the “cost report deadline apply?”)
- “Identified” overpayment is not defined
- Review internal organizational definitions

• CMS using overly strict standard to determine Medicare coverage for SNF and HHA care

• Standard: to maintain ability to perform routine tasks or prevent deterioration; does not require improvement
• Hospital Value Based Purchasing Program, 76 Fed. Reg. 26490 (5/6/11)
  • Medicare hospital payments based on quality metrics

• HHS site for ASC Value Based Purchases – https://www.com.gov/ASCPayment/
**Moore v. Reese**, 637 F.3d 1220 (11th Cir. 4/7/11)

- Georgia Medicaid not required to defer to treating physician’s medical necessity determination for in-home care
**Additional Scrutiny for Post-Acute Care for Medicare beneficiaries**
CMS will focus on provider certifications, length of stay, amount of therapy and documentation requirements. Post-acute-care providers should plan accordingly.

**Hospitals must report patient infections or face losing funds**
- Beginning 1/1/11, hospitals must report the number and rate of ICU patients who get catheter-related bloodstream infections
- Non-reporting hospitals lose 2% of Medicare update in 2013
- Next year, requirements expand to surgical site infections

5. REBATES UNDER THE MEDICAL LOSS RATIO

• Effective 2011, large group plans spending less than 85% of premiums on clinical services must provide a rebate to participants

• NAIC report $2 Billion in rebates if in effect in 2010

• Kaiser Foundation reports $1.3 billion in rebates for 2011, due to be paid by August 2012. Can you guess your rebate? Can you improve your reimbursement rate with your private insurance payors?
Considerable increase in HIPAA enforcement by OCR and state Attorneys General – substantial civil monetary penalties in some cases

Report studied 130 data breaches and found average cost of a single breach in the U.S. in 2009 was $6.75 Million

- Average cost of $471 per patient record (Source: http://www.ponemon.org)

Criminal prosecutions have been pursued, including several where the health care providers facing criminal charges did not obtain any financial gain from the unauthorized use of protected health information.
• 4/2012: South Carolina Health and Human Services announced that records of 228,435 Medicaid patients were improperly transferred to an employee’s email account

• Since January 2012 breaches involving the exposure of more than 1.1 million records have been reported in Georgia, New York, Florida, Massachusetts and Utah.

• HHS reports 19.2 million records exposed in 410 breaches since 9/09.
HIPAA:
Privacy and Security Audits

- 150 KPMG HIPAA Audits in 2012
- Extensive documentation requirements
- On-site surveys to review and examine compliance
- HIPAA and Fraud???
- What will the result of the audits be? Probably more audits.
7. ANTITRUST

  - Attacks “most-favored nation” clause
  - Complaint alleges such clauses “inhibit hospitals from negotiating competitive contracts with BC/BS competitors”
  - As a follow-up, DOJ subpoenaed documents from Blues plans in Missouri, Ohio, Kansas, West Virginia, North Carolina, South Carolina and D.C. in March 2011.
    “The antitrust division is investigating the possibility of anticompetitive practices involving MFN clauses in various parts of the country.”
• *City of Pontiac v. BCBS of Michigan* (3/30/12) action was dismissed, finding the “per se” rule inapplicable because there was no horizontal relationship between BCBS of Michigan and the hospital defendants.
8. ACOs

- October 2011, CMS issued final rule on Medicare Shared Savings Program (MSSP) for the formation of Accountable Care Organizations (ACOs)
- Provider-led organizations to manage the full care of a defined population and account for the cost and quality of the care
- Most potentially challenging aspect of healthcare reform
- Ends fee for service
- Note: Although some physicians and hospitals will combine forces to create ACOs, many more will form relationships short of ACOs to align hospital and physician interests.
• “A mechanism of shared governance that provides all ACO participants with an appropriate proportionate control over the ACO’s decision making process.”

• Board must include ACO providers, suppliers and Medicare beneficiaries

• CMS develops “performance benchmarks” for each ACO

• 65 quality measures in six main areas
ACOs: Requirements and Benefits

- OIG notice outlines waivers of certain fraud and abuse laws. 76 Fed. Reg. 19655

- Shared savings arrangements:
  - Track 1 – 50% and no losses shared in year 1 & 2
  - Track 2 – 60% with upside/downside risk in all years

- Minimum 5000 patients

- Safety zones FTC and DOJ. 76 Fed. Reg 21894
ACOs: Reimbursement

- One requirement is that the ACO develop and utilize evidence-based medicine. Utilization of evidence-based guidelines will play a major role in Medicare reimbursement under the ever-increasing “never events” policy.

- Under the ACA’s insurance exchange provisions, the Secretary of the Dept. of Health and Human Services is required to provide guidelines for increased reimbursement to reward the use of “evidence-based” medicine.
ACOs: DOJ, FTC, OIG, CMS, IRS on ACOs

• DOJ and FTC: Policy Statement of Antitrust Enforcement Policy, issued 10/20/11; www.ftc.gov/opp/aco/

• HHS/CMS/OIG: Interim Final Rule re: proposed ACO fraud and abuse waivers;

• IRS Fact Sheet 2011-20: EO participating in ACOs: issued 10/20/11; www.irs.gov/newsroom/article10,,id=248490,00.html

9. RESPONSIBLE CORPORATE OFFICER DOCTRINE

- Several federal agencies responsible for civil and criminal health care enforcement have been aggressively using the “responsible corporate officer doctrine.”

- Corporate officers can be held accountable, both civilly and criminally, for corporate violations of numerous statutes affecting public health, safety and welfare.

- Under the doctrine, the corporate officer does not have to participate in the violation, and indeed, does not even have to know the violation occurred.

- Corporate officer has liability because he or she has responsibility for proper oversight and supervision.
10. TAXATION

- Community Health Needs Assessment required from tax-exempt hospitals under the ACA – Section 501(r) of the IRC – in order to maintain 501(c)(3) status.

- IRS Notice 2011-52 (July, 2011) outlines requirements

- Hospitals must prepare Community Assessments every 3 years beginning with first tax year after March 23, 2012

- Assessments required for federal and state exemptions

- Code Section 4959, IRS may impose a $50,000 excise tax on any hospital that fails to meet the Community Assessment requirements in any taxable year.
11. Disability Discrimination

- July 26, 2012 – “Barrier-Free Health Care Initiative”

- Partnership between DOJ’s Civil Rights Division and U.S. Attorney’s Offices to target enforcement of ADA in healthcare industry. Initial focus is on people with hearing loss.

- Henry Ford Health System in Michigan entered into a settlement agreement with DOJ to ensure effective communication for people who are deaf or have a hearing loss and agreed to pay $70,000 to the complainants.

- Southern New Hampshire Medical Center agreed to pay complainant $5,000 for requiring a deaf patient’s hearing mother to serve as an interpreter for her daughter and entered into consent decree.
Questions?
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Kelly M. Jolley
Special Counsel/Health Care and Litigation
Hilton Head Island, SC
843-785-2171
kjolley@mcnair.net
Office Locations

Anderson, SC
132 East Benson Street
Anderson, SC 29624
(864) 226-1688

Bluffton, SC
The Plaza at Belfair
4 Clarks Summit Drive
Bluffton, SC 29910
(843) 815-2171

Charleston, SC
100 Calhoun Street
Charleston, SC 29401
(843) 723-7831

Charlotte, NC
Two Wells Fargo Center
301 South Tryon Street
Charlotte, NC 28282
(704) 347-1170

Columbia, SC
1221 Main Street
Columbia, SC 29201
(803) 799-9800

Pawleys Island, SC
11019 Ocean Highway
Pawleys Island, SC 29585
(843) 235-4100

Greenville, SC
Poinsett Plaza
104 South Main Street
Greenville, SC 29601
(864) 271-4940

Hilton Head Island, SC
Shelter Cove Executive Park
23-B Shelter Cove Lane
Hilton Head Island, SC 29928
(843) 235-4100

Myrtle Beach, SC
Founders Centre
2411 Oak Street
Myrtle Beach, SC 29577
(843) 444-1107

Lexington, KY
1010 Monarch Street
Lexington, KY 40513
(859) 455-8080