HEALTH CARE LAW
May 2010

Fraud, Abuse, and Transparency Provisions of Health Care Reform Law

This is the third in a series of Barnes & Thornburg LLP alerts on the subject of health care reform

The Healthcare Department of Barnes & Thornburg has prepared the attached summary of significant provisions of the Patient Protection and Affordable Care Act (Act). This summary is intended to assist health care providers in interpreting the many changes to the law that affect Medicare and Medicaid providers. The Act imposes a number of new affirmative requirements on providers related to payment, referrals, and physician ownership. It also includes significant changes to the government’s primary enforcement tools to pursue fraud, abuse, and overpayments.

The attached chart describes the major fraud and abuse and “transparency” provisions of the Act and provides detail on the following topic areas:

- Requirement for physicians referring patients to their own groups for radiology services to provide a written list of alternative radiology providers at the time of referral.
- Revisions to the intent requirement of the Anti-kickback law.
- New requirement that overpayments must be reported and returned within 60 days.
- Changes to the time period for submission of claims.
- Reporting requirements for drug, device, and medical supply manufacturers as well as group purchasing organizations (GPOs) to identify payments to physicians and teaching hospitals.
- Reporting of drug sample distribution by manufactures.
- Additional transparency requirements for nursing homes and pharmacy benefit managers (PBMs).
- Amended intent requirement under the Anti-kickback law.
• Strengthening of fraud enforcement tools through changes to the False Claims Act, Civil Money Penalty law, sentencing guidelines, exclusion authority, subpoena power.
• Dedication of more than $250 million for fraud and abuse enforcement.
• Affirmative obligation for certain health care providers to maintain a formal compliance plan.
• Increased reporting required in connection with Medicare provider/supplier enrollment.

The Department of Health and Human Services is required to promulgate regulations that will interpret and expand on many of these new provisions. The Barnes & Thornburg Healthcare Department will continue this series of alerts with in-depth explorations of each of these provisions. A detailed summary of the fraud and abuse provisions of the Act relevant to health care providers is below, and can also be downloaded as a separate attachment by clicking on the link at the top of this page. You can also download a PDF of the summary by clicking on the following url: http://tinyurl.com/266bmcd

For further information, please contact Healthcare Department chair Mark Rust at 312-214-8309 or mark.rust@btlaw.com or your usual Barnes & Thornburg attorney. This alert was prepared by Ellen Layton (ellen.layton@btlaw.com), Katherine O’Brien (katherine.obrien@btlaw.com), and Laura Seng (laura.seng@btlaw.com). Visit us online at www.btlaw.com/healthcare.

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**HEALTH CARE REFORM – FRAUD AND ABUSE SUMMARY FOR HEALTHCARE PROVIDERS**

**PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) & HEALTH CARE AND EDUCATION RECONCILIATION ACT (HCERA)**

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| **Stark Law – Limitations on Referrals by Physicians, Transparency and Reporting Requirements** | Previously, the Stark Law included a “whole hospital exception” that allowed physicians to refer to hospitals in which they hold an ownership interest (so long as the ownership interest is in the entire facility and not merely a department or division). Under the new law, the “whole hospital” exception will only apply to protect physician ownership in hospitals that have a Medicare provider number before December 31, 2010. Among other things, PPACA as modified by HCERA: | March 23, 2010  
Sec. 6001 PPACA  
Sec. 1106 HCERA  
42 U.S.C. § 1395nn |
| Physician Ownership in Hospitals | - Amends the Stark Law exception to prohibit new physician-owned hospitals.  
- Allows physician-owned hospitals that have a provider agreement in place with Medicare before December 31, 2010 to continue to participate in Medicare (and use the “whole hospital” exception), subject to limitations on expansion and physician ownership.  
  - There is no mechanism in the new law to grandfather hospitals under construction. To use the Stark Law exception, the hospital must have a Medicare provider agreement as of December 31, 2010.  
  - The percentage of physician ownership of the hospital in place as of March 23, 2010 cannot increase.  
  - Expansion in the number of operating rooms, procedure rooms and beds beyond those in place as of March 23, 2010 is allowed only in very limited circumstances. Certain “high-Medicaid facilities” will be able to expand their number of beds.  
- Requires hospitals to notify HHS annually of the identity of each physician owner and the nature and extent of the physician’s ownership in the hospital. This information will | |
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| **Overpayments** | Overpayments must be reported and returned within 60 days of identity or the date a corresponding cost report is due, whichever is later. Repayments may be made to the carrier, contractor or intermediary.  
  - Any overpayment retained after the 60-day deadline is deemed an “obligation” for purposes of the False Claims Act. | March 23, 2010  
Sec. 6402 PPACA  
42 U.S.C. § 1301 et. seq. |
| **Self Referral Disclosure Protocol** | Within six months from the date of enactment (March 23, 2010), HHS and the OIG shall establish a protocol for health care providers and suppliers to disclose an actual or potential violation of the Federal Physician Self-Referral Law (the Stark Law).  
  - The Self Referral Disclosure Protocol (SRDP) will include (i) instructions for health care providers and suppliers on the specific person, official, or office to whom such disclosures shall be made; and (ii) instructions on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements. The SRDP and instructions will be posted on the CMS website.  
  - PPACA authorizes HHS discretion to reduce the amount due and owing for all violations under the Stark Law to an amount less that that specified in the statute. In establishing the amount due, the following factors may be considered:  
    - Nature and extent of the improper or illegal practice;  
    - Timeliness of such self-disclosure;  
    - Cooperation in providing additional information related to the disclosure; and  
    - Such other factors as the Secretary of HHS considers appropriate. | Sec. 6409 PPACA |
| **Physician Ownership Transparency/Disclosure** | Physicians that provide in-office MRI, CT and PET services (and other designated health services as determined by the Secretary of HHS) must, at the time of the referral, inform patients in writing of alternative suppliers of the services.  
  - The list of alternative supplies must be in the area where the individual resides. | January 1, 2010  
Sec. 6003 PPACA |
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<tr>
<td>Self Referred Imaging Services</td>
<td>• This amendment to the Stark in-office ancillary services exception applies to services furnished after January 1, 2010.</td>
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| Physician Payment Reporting (Sunshine Provisions) | **Physician Compensation.** Manufacturers of drugs, devices, biologicals or medical supplies must submit an annual report to HHS of all payments or other transfers of value made to a physician or teaching hospital (a “covered recipient”). This does not include payments to physician employees of the manufacturer. The reports will be made publically available.  
**Physician Ownership.** Manufacturers and group purchasing organizations must make similar annual reports regarding ownership or investment interests held by a physician (or immediate family member). This reporting requirement does not include physician ownership/investment in a publicly traded security or mutual fund.  
• Medical supplies include any product for which payment is available under a federal health care program [e.g., Medicare and Medicaid] or a waiver of such a plan.  
• The first report is due March 31, 2013 (and on the 90th day of each calendar year thereafter) and covers all activity during the prior calendar year.  
• Delayed reporting is allowed for product research or development agreements and clinical investigations.  
• The report to HHS includes physician/covered recipient identity, payment amounts, descriptions of non-cash payments (e.g., items, services, stock and stock options), description of the nature of the payment (e.g., consulting fee, gift, entertainment, honoraria, research, education, charitable contribution), name of the drug, device, biological or supply (when payment related to marketing, education or research), and other information as the Secretary of HHS determines to be appropriate.  
• The definition of “payment or other transfer of value” excludes certain types of compensation such as low value items, educational materials, patient samples, discounts and rebates, among others.  
• Penalties for failure to report include civil monetary penalties of not less than $1,000 but not more than $10,000 for each payment or other transfer of value or ownership/investment interest that is not reported (not to exceed $150,000). Also, civil monetary penalties of not less than $10,000 but not more than $100,000 may be imposed for each payment or other transfer of value or ownership/investment interest that a manufacturer or group purchasing organization knowingly fails to report (not to exceed $1 million). | First report due March 31, 2013 (for activity beginning 1/1/2012)  
Sec. 6002 PPACA                                                                                                        |
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<td>Prescription Drug Sample Transparency</td>
<td>• The new law does not preempt any state laws that require the reporting or disclosure of information that falls outside the scope of the above requirements.</td>
<td>April 1, 2012</td>
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<td>No later than April 1 of each year beginning in 2012, each manufacturer and authorized distributor of record of prescription drugs for which payment is available under Medicare or Medicaid, must submit a report to HHS of all drug samples distributed to practitioners. The report will identify the practitioner and provide the identity and quantity of drug samples distributed.</td>
<td>Sec. 6004 PPACA</td>
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<td>Pharmacy Benefit Manager Transparency</td>
<td>Pharmacy Benefit Managers (PBM) for health benefit plans that provide pharmacy benefits, Medicare Advantage drug plans or plans offered through exchanges must report information about prescription percentages provided through retail and mail order pharmacies, generic drug use, rebates and other price concessions. These reports can only be disclosed by the Secretary for specific purposes and in a form that does not disclose the identity of the PBM, plan, or prices charged for drugs.</td>
<td>Sec. 6005 PPACA</td>
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| Anti-Kickback Statute                             | A claim that includes items or services resulting from a violation of the Anti-Kickback Statute (AKS) constitutes a false or fraudulent claim for purposes of the False Claims Act.  
• A person need not have actual knowledge of the AKS nor specific intent to commit an AKS violation. | March 23, 2010               |
| Anti-Kickback Statute – Beneficiary inducements   | With regard to the prohibition on beneficiary inducements, the definition of “remuneration” under the Anti-Kickback Statute (AKS) does not include:  
• Any remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs and as designed by the Secretary’s regulations.  
• Offer or transfer by a retailer of coupons, rebates or other rewards if certain conditions are met (e.g., pharmacy chain coupons).  
  ─ offer must be made to the general public and regardless of patient insurer  
  ─ offer must not be tied to other items reimbursed under Medicare  
• Unadvertised provision of items or services for free or less than fair market value based on a good faith determination of financial need where there is a reasonable connection | March 23, 2010               |
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| False Claims Act – Public Disclosure Bar to Qui Tam Actions | Under the previous requirements of the False Claims Act, a court did not have jurisdiction over a “qui tam” or whistleblower lawsuit if the allegations had been publicly disclosed and the qui tam relator was not an original source of the information (with direct and independent knowledge of the alleged activity). The amendments to the False Claims Act make the following changes:  
• Public disclosure no longer bars jurisdiction but the amendments do subject a qui tam lawsuit to possible dismissal if the government declines to intervene and the allegations were publicly disclosed and the relator is not an original source.  
• The DOJ may oppose dismissal of an action even where the allegations were publicly disclosed and the relator is not an original source. The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were “publicly disclosed” …unless the person bringing the action is an original source of the information.”  
• “Public disclosures” are now defined to mean a disclosure: (i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party; (ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or (iii) in the news media  
• State proceedings, state audit reports and private litigation are not qualifying “public disclosures” that bar jurisdiction  
• Expands the definition of “original source” by eliminating the “direct knowledge” requirement, making it easier to maintain jurisdiction in these cases. Under the new definition, an original source is an individual who either:  
  ─ prior to a public disclosure has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or  
  ─ who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing a qui tam action. | March 23, 2010  
Sec. 10104(j) PPACA  
31 U.S.C. § 3730(e)(4) |
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| Health Care Fraud Offenses  
- Intent  
- Sentencing Guidelines | PPACA amends the U.S. Criminal Code to deem certain criminal offenses “federal health care fraud offenses.” If a particular offense is defined as a “federal health care fraud offense,” convictions for violation may be punishable by longer prison terms and/or higher fines.  
- The list of federal health care fraud offenses was expanded to include:  
  - Certain criminal ERISA violations (section 501 of ERISA)  
  - Violations of the Anti-Kickback Statute  
  - Violations of Section 1349 of the U.S. Criminal Code (attempting or conspiring to commit a criminal offense)  
  - Violations of Section 301 of the Federal Food, Drug and Cosmetic Act  
PPACA also amends the criminal health care fraud statute (18 USC §1347) to provide that “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.”  
The U.S. Sentencing Commission is now required to review and amend the federal sentencing guidelines related to federal health care fraud offenses. The Federal Sentencing Guidelines were amended to provide a two to four fold increase in the offense level for defendants convicted of Federal health care violations involving a Governmental loss of $1 million or more. | March 23, 2010  
Sec. 10606 and 6402  
PPACA  
18 U.S.C. § 1347  
18 U.S.C. § 24(a) |
| CMS Civil Monetary Penalties | Civil Monetary Penalty (CMP) liability was expanded to include the following:  
- Any person who orders or prescribes a medical or other item or service during a period in which the person was excluded from participation in a Federal health care program, if the person knows or should know that a claim for such medical or other item or service will be made.  
- Knowingly making or causing to be made any false statement, omission, or misrepresentation of a material fact in any Federal health care program application (e.g., provider enrollment form), agreement, bid or contract.  
- Knowing retention of an overpayment and failure to report and return such overpayment.  
- Knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program (Penalty: $50,000 for each false record or statement) | March 23, 2010  
Sec. 6402 and 6408  
PPACA  
42 U.S.C. §1320a-7a(a) |

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<td>Permissive Exclusion -- - Obstruction of Program Audits - Knowing misrepresentation on enrollment application</td>
<td>Failing to grant timely access, upon reasonable request, to the HHS Inspector General for audits, investigations, evaluations or other statutory functions (Penalty: $15,000 for each day of delay). HHS may permissively exclude a person or entity from participation in Federal health care programs based on obstructing an investigation or audit (under previous law, permissive exclusion was limited to obstructing a criminal investigation). HHS may permissively exclude any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program.</td>
<td>January 1, 2010 Sec. 6402 and 6408 PPACA 42 U.S.C. § 1320a-7(b)(2)</td>
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<td>HHS- OIG Subpoena Authority Expanded</td>
<td>PPACA extends the HHS testimonial subpoena authority to investigations related to exclusion from Federal health care program participation and authorizes the Secretary of HHS to delegate this subpoena authority to the HHS Inspector General.</td>
<td>March 23, 2010 Sec. 6402 PPACA 42 U.S.C. § 1320a-7(f)</td>
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<td>Inter-Agency Privileged Communications</td>
<td>PPACA amends ERISA to authorize the Secretary of Labor to promulgate a regulation to “provide an evidentiary privilege for, and provides for confidentiality of communications” between or among certain federal and state agencies (include the state insurance department, state attorney general, DOJ and HHS). Any privilege that is established will apply to communications related to an investigation, audit, examination or inquiry conducted by any of the agencies.</td>
<td>To be effective after the regulations are promulgated. Sec. 6607 PPACA 42 U.S.C. § 1134(d)</td>
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<td>Suspension of Payments Pending Investigations of Fraud</td>
<td>Medicare and Medicaid payments may be suspended pending investigation of “credible allegation of fraud” unless HHS determines there is good cause not to suspend payments. The Secretary of HHS shall consult with the OIG to determine if there is a “credible allegation” of fraud with respect to any particular investigation.</td>
<td>March 23, 2010 Sec. 6402 PPACA 42 U.S.C. § 1396(b)(i)(2)</td>
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<td>Fraud and Abuse Enforcement Funding</td>
<td>PPACA appropriates an additional $10 million for each of fiscal years 2011 through 2020 to the Health Care Fraud and Abuse Control Account, and provides a permanent consumer price index adjustment. HCERA appropriates $250 million for FY 2011 through 2016 for costs of the administration and operation of the Health Care Fraud and Abuse Control Program and the</td>
<td>March 23, 2010 Sec. 6402 PPACA Sec. 1303 HCERA</td>
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<td>Medicare Integrity Program</td>
<td>Medicare Integrity Program ($95 million for FY 2011; $55 million for FY 2012; $30 million for each of FY 2013 and FY 2014; and $20 million for each of FY 2015 and FY 2016)</td>
<td>42 U.S.C. § 1395i(k)</td>
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| **OIG Authority to Obtain Information**       | In order to protect the integrity of the Medicare and Medicaid programs, the OIG may obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—  
- is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or  
- directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program regardless of how the item or service is paid for, or to whom such payment is made.  
The OIG may obtain any supporting documentation necessary to validate claims for Medicare or Medicaid payment, including a prescribing physician’s medical records for an individual who is prescribed an item or service, and “any records necessary for evaluation of the economy, efficiency, and effectiveness of the Medicare and Medicaid programs.” | March 23, 2010  
Sec. 6402 PPACA  
42 U.S.C. § 1301                                                                                      |
| **Time Period to Submit Medicare Claims**     | Under the previous Medicare rules, a provider could submit claims for payment within three (3) calendar years following the date of service.  
Under PPACA, Medicare claims must be submitted within the period ending one (1) calendar year after the date of service (beginning with services furnished on or after January 1, 2010). The Secretary of HHS may provide for exceptions to this rule.  
For services furnished before January 1, 2010, a bill or request for payment must be filed no later than December 31, 2010. | January 1, 2010  
Sec. 6404 PPACA                                                                                       |

**Compliance Plans and Provider Enrollment**

| Provisional Enrollment Period for New Providers and Suppliers | Under the PPACA, a provisional enrollment period may apply to new providers and suppliers. During this period, CMS will have increased authority regarding pre-payment and payment caps. | March 23, 2010  
Sec. 6401 PPACA  
42 U.S.C. § 1395cc(j); 42 U.S.C. § 1396a(a) |
<p>| Compliance | Certain providers and suppliers will be required to implement compliance plans as a condition of | Secretary to determine |</p>
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<tr>
<td>Programs for Providers and Suppliers</td>
<td>enrollment. The required elements for the compliance plans will be determined by HHS in consultation with the OIG through the implementation of regulations.</td>
<td>timeline for implementation Sec. 6401 PPACA</td>
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<td>Disclosure of Affiliations</td>
<td>The PPACA requires new providers and suppliers to disclose current or previous affiliations with providers or suppliers that have uncollected debts, have been excluded from participation in a federal health care program, have had their payments suspended, or have had their billing privileges revoked.</td>
<td>Sec. 6401 PPACA</td>
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| Provider and Supplier Screening | Providers and suppliers will be subject to new screening requirements for enrollment and re-enrollment.  
  • The Secretary and OIG will establish regulations governing the screening of providers and suppliers.  
  • All providers and suppliers will be subject to licensure checks.  
  • The following screening checks may be imposed on suppliers and providers  
    ─ Fingerprinting  
    ─ Finger Original background checks  
    ─ Finger Multi-state database inquiries  
    ─ Finger Surveys and site visits  
  • Screenings for new providers and suppliers must occur within the first year following enactment of the law.  
  • Screenings for existing providers must occur within two years of enactment of the law. | Sec. 6401 PPACA |

**Databases and Reporting**

| **Integrated Data Repository** | Under the PPACA, CMS is required to include integrated data repository claims and payment data from specific Federal health care programs in the Integrated Data Repository. As part of the Integrated Data Repository initiative, government agencies, such as the Department of Veterans Affairs and Department of Defense that contribute to the data repository will also have access to the data. | March 23, 2010 March 23, 2010 Sec. 6402 and Sec. 6403 PPACA 42 U.S.C. § 1301 |
| **Sharing of Provider and Program Related Data Between** | In addition to the integrated data repository, information sharing between governmental entities will be increased. Governmental units will have increased access to information reported by providers and beneficiaries. Such information sharing initiatives will include the following:  
  • States are required to establish a system to report formal license proceedings. | First day after the final day of the transition period. Sec. 6402 PPACA |
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| **Governmental Entities** | • A national health care fraud and abuse data collection program will be established to report certain final adverse actions to the government and to make reported information available to the National Practitioner Data Bank.  
• HHS Inspector General and the Attorney General will have access to claims and payment databases for purposes of conducting law enforcement and oversight activities.  
• Increases the number of data elements that states must submit under the Medicaid Management Information System (MMIS) to protect program integrity oversight and administration.  
• Beginning with contract years on or after January 1, 2010, including data already submitted, entities that contract with state Medicaid managed care organizations must provide patient encounter data to the state. | 42 U.S.C. § 1301 et. seq.  
Sec. 6504 PPACA  
42 U.S.C. §1396b(r)(1)(F) and 42 U.S.C. §1396b(m)(2)(A) (xi) |
| **Model Uniform Report Form** | The PPACA requires the National Association of Insurance Commissioners and HHS to develop a model uniform reporting form for private insurance companies to use to report suspected cases of fraud and abuse. | March 23, 2010  
Sec. 6603 PPACA  
42 U.S.C. § 300gg-93 |
| **Medicare and Medicaid Program Integrity** | Entities that contract with the Medicare and Medicaid Integrity Programs must provide certain statistics to HHS and OIG including information related to overpayments and fraud referrals. | March 23, 2010  
Sec. 6402 PPACA  
42 U.S.C. § 1395ddd;  
42 U.S.C. § 1396u-6(c)(2) |

**Medicaid**

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| **Enrollee Encounter Reporting** | The PPACA prohibits states from collecting federal matching payments for medical assistance to those individuals for whom the state does not report enrollee encounter data to Medicaid Management Information Systems (MMIS) promptly. | March 23, 2010  
Sec. 6402 PPACA |
| **Recovery Audit Contractor (RAC) Program** | The PPACA expands the RAC program to cover more government healthcare programs including:  
• Requiring states to contract RACs to identify underpayments and overpayments and recoup overpayments for Medicaid services. The deadline for states to contract with RACs is December 31, 2010.  
• Expanding the RAC program to include Medicare Parts C and D  
• Requiring each Medicare Advantage Program and Part D prescription drug program to | March 23, 2010  
Sec. 6411 PPACA  
42 U.S.C. §1396a(a)(42), 1395ddd(h) |
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<td>Medicaid Coding Initiative</td>
<td>Requires that states implement coding methodologies that are compatible with the National Correct Coding Initiative for Medicaid claims.</td>
<td>Applies to claims filed on or after October 1, 2010</td>
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<td>Sec. 6507 PPACA 42 U.S.C. §1396b(r)</td>
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<td>Changes to Increase Medicaid Program Integrity</td>
<td>State Medicaid Programs are required to implement certain changes designed to increase the integrity of the program. These changes include:</td>
<td>January 1, 2011 unless state legislation is required</td>
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<td>• Termination of provider participation in the Medicaid program upon termination from participation in the Medicare or other state program.</td>
<td>Sec. 6501 PPACA 42 U.S.C. §1396a(a)(39)</td>
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<td>• States must terminate enrollment of individuals or entities if the individuals or entities are terminated from Medicare or another state’s Medicaid program.</td>
<td>Sec. 6502 PPACA 42 U.S.C. §1396a(a)</td>
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<td>• Individuals or entities that are affiliated with a suspended, excluded or terminated individual or entity shall be excluded from Medicaid.</td>
<td>Sec. 6503 PPACA 42 U.S.C. §1396a(a)</td>
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<td>• Billing agents, clearinghouses, or other alternate payees that submit claims on behalf of providers to the Medicaid program must register with the state and HHS. Additional regulations are required to implement this provision.</td>
<td>Sec. 6505 PPACA 42 U.S.C. §1396b(a)</td>
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<td>• Medicaid may not make payments for items or services to any financial institution or any entity outside of the United States.</td>
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<td>Increased Disclosure and Reporting Requirements for Nursing Homes, Long Term Care Facilities and Skilled Nursing Facilities</td>
<td>New requirements regarding nursing homes and long term care facilities are designed to increase the transparency of information related to these types of providers. Examples of changes designed to achieve these objectives include:</td>
<td>Sec. 6101 and Sec. 6102 PPACA Various dates</td>
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<td>• Disclosure of ownership information and information of other parties with certain financial or other interests in the facility</td>
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<td>• Increased disclosure regarding a facility’s ownership structure</td>
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<td>• Increased disclosure requirements for individuals involved in governance including trustees, managing employees, officers and directors</td>
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<td>• Increased accountability requirements for skilled nursing facilities and nursing facilities</td>
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<table>
<thead>
<tr>
<th>PROVISION</th>
<th>SUMMARY OF REQUIREMENT</th>
<th>EFFECTIVE DATE AND CITATIONS</th>
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<td>including establishment of quality programs and compliance plans</td>
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| Durable Medical Equipment (DME) | The PPACA increases prescribing requirements applicable to Durable Medical Equipment (DME) and home health services. These increased requirements include:  
  • Physicians who prescribe DME or home health services must be enrolled in the Medicare Program. (applies to orders and certifications made on or after July 1, 2010)  
    — HHS can expand this requirement to other services and items.  
  • For orders, certifications, and referrals made on or after January 1, 2010, HHS can revoke a Medicare physician’s enrollment, for a maximum of one year for each violation, for providers for do not maintain and provide access to required documentation related to DME payment and home health service certifications, or referrals for other items and services.  
  • Physicians and other authorized professionals must have a face-to-face encounter with a patient before certifying eligibility for home health services after January 1, 2010.  
  • Physicians and other authorized professionals must have a face-to-face encounter with a patient prior to providing a written order for DME (effective March 23, 2010).  
    — These requirements apply to both Medicare and Medicaid beneficiaries | Sec. 6405, 6406, 6407 PPACA  
  Various dates |
| Surety Bonds | HHS must take into account the volume of billing when determining the amount of a surety bond for a home health agency or a DME provider. | March 23, 2010  
  Sec. 6402 PPACA |