2010's Health Care Reform Refresher: Revisiting Day-to-Day Provider Obligations that Stem from the Patient Protection and Affordable Care Act

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President Donald Trump's action to repeal 2010's Patient Protection and Affordable Care Act (ACA) should not be a surprise. After all, President Trump, along with many other candidates for office, made repeal of the ACA a significant campaign promise. On January 20, 2017, the day of President Trump's inauguration, he signed an executive order that gives the U.S. Department of Health and Human Services (HHS) and "other executive departments and agencies" the authority and discretion to roll back certain aspects of the ACA.[1] What may surprise those in the health care industry is the vast number of day-to-day operational requirements that stem from the ACA and the regulations promulgated under the statute. Because these requirements may change or terminate in the relatively near future, this article will describe some of these provisions and provide a look into the impact of certain provisions of the ACA on providers.

I. Elder Justice Act and Patient Safety and Abuse Prevention Act

Embedded within the ACA is the Elder Justice Act (EJA) and the Patient Safety and Abuse Prevention Act (PSAPA). The EJA focuses on new reporting requirements for elder abuse while the PSAPA focuses on the establishment of a nationwide system to run background checks and screening for employees of long-term care providers.

The EJA is intended to increase coordination at the federal level of elder abuse, neglect, and exploitation prevention efforts.[2] Under the EJA, facilities are required to report any reasonable suspicion of crime against a resident to HHS and one or more local law enforcement entities. If the suspicious incident resulted in serious bodily injury, the facility is required to report the incident no later than 2 hours after forming the suspicion. If the incident does not result in serious bodily injury, the facility is required to report the suspicion within 24 hours. Under the EJA, violations of these reporting requirements will result in civil monetary penalties (CMPs) up to $300,000 and possible exclusion from participation in federal health care programs.

The PSAPA, on the other hand, is intended to address potential elder abuse, neglect, and exploitation before it occurs by preventing the hiring of workers identified as potential risks. Prior to the PSAPA, background checks on long-term care employees were typically a function of state law, which potentially contributed to problems in crime detection across state lines. The PSAPA not only prohibits the hiring of abusive workers, it also requires HHS to establish a program to identify procedures for long-term care facilities or providers to conduct nationwide criminal background checks on direct patient access employees. In order to further incentivize compliance, facilities found in violation of the requirements are subject to penalties.

Since enactment of the PSAPA, the Centers for Medicare & Medicaid Services (CMS) has awarded more than $64 million to 26 States for purposes of designing comprehensive national background check programs for direct patient access employees.[3] In a report issued by the Office of Inspector General (OIG) in 2012, the agency reported that 94% of facility administrators were conducting background checks on prospective employees and that only 4%of those administrators encountered

1 See the text of the Executive Order at https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and. (Last accessed February 4, 2017.)
2 ACA, Subtitle H, §§ 6701-6703.
3 https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/BackgroundCheck.html. (Last accessed February 4, 2017.)

individuals who were unwilling to undergo a background check.[4] In 2010 alone, 9 states received funds from the federal government to design background check programs, and many more states have received funds since that time. The last grant disbursement reported by CMS was in October 2016 to the State of West Virginia.[5]

II. Fraud & Abuse

The ACA also includes a number of health care fraud and abuse prevention measures. One of the most prominent measures relates to provider screening requirements that are based on provider type.[6] In 2010, then HHS Secretary Kathleen Sebelius stated "[u]sing these new fraud prevention measures, CMS will be able to move from a 'pay and chase' approach to one that makes it harder to commit fraud in the first place."[7] As a result of ACA provisions, providers and suppliers are assessed based on their risk for fraud, waste, and abuse and assigned to one of the following three risk categories:

- **Limited Risk**
  The limited risk category includes, among others, physicians, non-physician practitioners, group practices, medical clinics, hospitals, ambulatory surgical centers, end-stage renal disease facilities, critical-access hospitals, and skilled nursing facilities. Limited risk providers are subject to verification that the provider meets applicable federal regulations or state requirements for their specific provider-type, state licensure verification, and database checks, such as the OIG's List of Excluded Individuals/Entities, both before and after enrollment in order to ensure that applicable enrollment criteria are met.

- **Moderate Risk**
  The moderate risk category includes IDTFs, hospices, ambulance service providers, community mental health centers, comprehensive outpatient rehabilitation facilities, and independent clinical laboratories. Currently enrolled home health agencies and DMEPOS providers/suppliers are also classified in the moderate risk category while those that are newly enrolling are categorized as high risk. In addition to those screening procedures that are conducted under the limited risk category, these providers and suppliers are subject to unscheduled and unannounced site visits both prior to and after enrollment.

- **High Risk**
  The high risk category includes home health agencies and DMEPOS suppliers newly enrolling or enrolling a new practice location. In addition to those screening procedures that are conducted under the limited and moderate risk categories, these providers and suppliers are subject to criminal background checks and fingerprinting. These measures are required for owners, authorized or delegated officials, or managing employees.

Additional fraud prevention measures that stemmed from the ACA include HHS's ability to suspend payments to a provider/supplier during an investigation of a credible allegation of fraud, impose a temporary moratorium on the enrollment of new providers, and cross terminate from other state Medicaid programs a provider who has had Medicare billing privileges revoked or been terminated by a single state Medicaid program. The law also increased federal sentencing guidelines for health care fraud by 20-50% for crimes with over $1 million in losses and provides the OIG with the authority to impose stronger CMPs on providers who have committed fraud, including $50,000 for each false statement or misrepresentation of a material fact and $50,000 or triple the amount of the claim involved for providers who know of any overpayment but do not return it.

In addition to the changes to the CMP amounts themselves, the ACA includes requirements related to the timeline for return of overpayments, new recapture provisions, and modifications to the Recovery Audit Contractor (RAC) program:

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4 Find link to report at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/BackgroundCheck.html. (Last accessed February 4, 2017.)
5 *Id.*
6 ACA, § 6401.
7 http://www.agg.com/CMS-Proposes-New-Medicare-Enrollment-Requirements-Aimed-to-Prevent-Fraud-and-Abuse-10-20-2010/.(Last accessed February 4, 2017.)

- The law requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report is due, whichever is later. Fines and penalties are assessed in instances where providers did not meet the 60-day timeline.[8]
- The ACA makes it easier for the government to recapture any funds acquired through fraudulent practices.
- The law requires states to establish contracts with one or more RAC. These state RAC contracts are intended to identify underpayments and overpayments and to recoup overpayments made for services provided under State Medicaid plans as well as State plan waivers. The law also expands the RAC program to Medicare Parts C and D.[9]

III. Physician Payment Sunshine Provisions of the ACA

Manufacturer reporting obligations under the Physician Payments Sunshine Act ("Sunshine Act") are also included in the ACA.[10] The Sunshine Act was designed to increase transparency around the financial relationships between physicians, teaching hospitals, and manufacturers of drugs, medical devices, and biologics. High level requirements included:

- Applicable manufacturers of covered drugs, devices, biologicals, and medical supplies are required to report payments or other transfers of value they make to physicians and teaching hospitals to CMS.
- Applicable manufacturers and applicable group purchasing organizations (GPOs) are required to report to CMS certain ownership or investment interests held by physicians or their immediate family members.
- Applicable GPOs are required to report to CMS payments or other transfers of value made to physician owners or investors if they held ownership or an investment interest at any point during the reporting year.

IV. Bundled Payment Initiatives

The ACA promoted the goal of lowering health care costs while improving the quality of care through certain bundled payment initiatives. The law implemented a demonstration project to study the use of bundled payments for physician and hospital services under Medicaid.[11] In addition to evaluating bundled payments, the ACA implemented a pilot program on bundling, which required HHS to develop a national, voluntary pilot program that encourages certain providers to improve quality of care while lowering cost for the Medicare program through bundled payment models.

V. Nursing Home Transparency

The ACA significantly expanded provider disclosures and increased the distribution and accessibility of facility information to the federal and state government as well as patients. For example, the ACA expanded Medicare provider ownership disclosure requirements and added disclosure obligations for new categories of entities and individuals, including managing employees, trustees, and "additional disclosable parties."[12] Directors of nursing, business managers, and consultants are also potentially captured in the ownership disclosure requirements. Disclosures required to be made include the following:

- Corporation – officers, directors, and shareholders of the corporation who have an ownership interest in the corporation of 5% or more
- LLC – members and managers of the LLC, including, if applicable, the percentage of ownership interest each member and manager has of the LLC
- General Partnership – the partners
- Limited Partnership – the general partners and any limited partners who have a 10% or greater ownership interest in the LP
- Trust – the trustees
- Individual – contact information

8 ACA, § 6402.
9 ACA, § 6411.
10 ACA, § 6002.
11 ACA, § 2704.
12 ACA, § 6101.

- Other persons or entities - determined by HHS

Along with the increased disclosure requirements came increased costs for provider screening, which led to the $500 fee that must be submitted with Medicare enrollment forms.[13] In 2017, that fee increased to $560 (in accordance with the consumer price index).

In addition to the expanded government disclosure requirements, the ACA also mandates significantly increased transparency with changes to the Nursing Home Compare web site, which provides certain quality information to current and prospective patients.[14] Changes to the web site included:

- Additional data regarding staffing
- Links to state internet websites with information regarding state survey and certification programs
- Links to state inspection reports and plans of correction and instructions for interpreting inspection reports
- Standardized complaint form
- Summary of information regarding substantiated complaints
- Information regarding criminal violations by a facility and its employees
- Survey and certification information must be updated quarterly[15]

In addition, the ACA requires that states submit survey and certification to HHS no later than the date on which the state sent such information to the facility. In addition to the expanded disclosure requirements associated with Nursing Home Compare, nursing facilities are also required to have survey, certification, and complaint investigation reports, made during the three preceding years, available to any individual upon request. Facilities are also required to prominently post notice of the availability of these reports in a public area.

VI. Nursing Home Penalty Assessment and Process; Closure

The ACA also modified CMP assessments. The statute permits reduction of CMPs when levied against a nursing home because of a survey deficiency by up to 50 percent if the facility self-reports and promptly corrects the issue that led to the deficiency. The ACA requires that the facility correct the issue within 10 calendar days of the date of imposition of the CMP or 15 calendar days from the date of the circumstance or incident that later resulted in a finding of noncompliance, whichever occurs first.

In addition to CMP changes, the ACA also modified the informal dispute resolution process for CMP cases.[16] As a result of the ACA, CMS can collect CMPs cited at a level of actual harm or immediate jeopardy and hold the funds in an escrow account if the informal dispute resolution process extends longer than 90 days. However, if the facility successfully appeals the penalty, the CMP (plus interest) would be returned to the facility. If the appeal is unsuccessful, CMS can allow some portion of the CMP amount collected and held in escrow to be used in support of activities that would benefit facility residents.

The ACA also added specific obligations that a nursing home must take if it ceases operations. For example, per the ACA, the facility must notify HHS, the state long-term care ombudsman, residents, and legal representatives of residents at least 60 days prior to the date of closure. The notification is required to include a specific plan for the transfer and relocation of the residents. Once the notice is issued, no new residents may be admitted to the facility.[17]

VII. Conclusion

As of the date of this publication, the future of the ACA is unclear, and it remains to be seen whether all or only certain of its provisions will be repealed. Regardless, a refresher of the day-to-day operational obligations that stem from

13 ACA, § 6401.
14 See https://www.medicare.gov/nursinghomecompare/. (Last accessed February 4, 2017.)
15 ACA, § 6103.
16 ACA, § 6111.
17 ACA, § 6113.

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