MEDICARE READMISSIONS SUMMIT

Legal Issues In Current and Future Readmissions Policy

Presented by

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Davis Wright Tremaine LLP
DEFINING SUCCESS TOGETHER

INCREASING FOCUS ON QUALITY OF CARE, OUTCOMES AND APPROPRIATE SETTING

- IMPROVEMENT OF QUALITY OF CARE
- PUBLIC REPORTING TO INCREASE PATIENT AWARENESS
- PAYMENT ISSUES

IMPACT ON ANNUAL PAYMENT UPDATE TO ADJUST IPPS PAYMENT

versus

PAYMENT DENIALS FOR INDIVIDUAL READMISSIONS

versus

PENALTIES FOR "AVOIDABLE READMISSIONS"

versus

BUNDLING ACROSS INPATIENT AND POST-ACUTE CARE

SOME RECENT CMS ACTIONS INVOLVING READMISSIONS AND INTRODUCING PPACA!

- RHQDAPU MEASURES ADDITIONS
- MEDICARE READMISSIONS PROJECT
- MEDICARE CONDITIONS OF PARTICIPATION REVISIONS
- OIG ACTIVITY AND EXPECTATIONS

AND NOW PPACA

- **OBJECTIVES OF PPACA**
  - PROVIDE MEANINGFUL INSURANCE COVERAGE TO APPROXIMATELY 32 MILLION PEOPLE
  - IMPROVE QUALITY OF CARE
  - REDUCE MEDICAL ERRORS
  - CREATE SAVINGS IN FEDERAL HEALTHCARE EXPENDITURES
  - “BEND” THE COST CURVE

NEW FEDERAL STRATEGY

- **NATIONAL STRATEGY FOR IMPROVEMENT IN HEALTH CARE (JANUARY 1, 2011)**

  DHHS TO ESTABLISH NATIONAL STRATEGY OT IMPROVE DELIVERY OF HEALTH CARE SERVICES, PATIENT OUTCOMES AND POPULATION HEALTH.

- **ESTABLISHMENT OF THE CENTER FOR MEDICARE AND MEDICAID INNOVATION**

  THIS NEW ENTITY WILL TEST NEW PAYMENT AND DELIVERY MODELS THAT IMPROVE QUALITY AND REDUCE COST.

- **ESTABLISHMENT OF PATIENT CENTER OUTCOMES RESEARCH INSTITUTE (FUNDING TO BEGIN IN 2010**)

  COMBINED PUBLIC AND PRIVATE SECTOR REPRESENTATION; PURPOSE IS TO FOSTER EVIDENCE-BASED MEDICINE BY IDENTIFYING RESEARCH PRIORITIES AND CONDUCTING RESEARCH COMPARING CLINICAL EFFECTIVENESS OF VARIOUS TREATMENTS.

SYSTEM REFORM & OUTCOMES – FOCUSED MEDICINE

AREAS OF PRIMARY FOCUS:

- INCREASED IMPORTANCE OF PRIMARY CARE (ROLE AS "GATE KEEPER")
- OVERALL CARE COORDINATION AMONG PROVIDERS/INSTITUTION
  - MOVEMENT TOWARDS CLINICAL INTEGRATION AMONG PROVIDERS
  - ESTABLISHMENT OF A "MEDICAL HOME"
  - ESTABLISHMENT OF ACCOUNTABLE CARE ORGANIZATIONS
- USE AND FURTHER INCREASED USE OF INFORMATION TECHNOLOGY FOR SHARING OF "BEST PRACTICES" AND ACHIEVEMENT OF QUALITY METRICS
- RISK-BASED PAYMENT TO PROVIDERS
  - BUNDLES PAYMENTS
  - SHARED SAVINGS
  - VALUE-BASED PRICING
- STATE EXPERIMENTS WITH PAYMENT REFORM

PAYMENT REFORM

INDEPENDENT PAYMENT ADVISORY BOARD

- 15 MEMBER BOARD TO PRESENT CONGRESS WITH PROPOSALS TO REDUCE MEDICARE PER CAPITA GROWTH RATE AND IMPROVE QUALITY (FUNDING BEGINS 2012; FIRST RECOMMENDATIONS DUE 2014)
- CANNOT MAKE PROPOSALS THAT "RATION" CARE, RAISE TAXES OR MEDICARE PREMIUMS, CHANGE MEDICARE BENEFITS, ELIGIBILITY OR COST SHARING
- IN YEARS WHEN MEDICARE COSTS ARE PROJECTED TO BE UNSUSTAINABLE, PROPOSALS ARE BINDING UNLESS CONGRESS ENACTS EQUIVALENT SAVINGS MEASURES
- THROUGH 2019, HOSPITALS AND HOSPICES ARE EXEMPT FROM REDUCTIONS

PAYMENT REFORM

- **OVERALL REDUCTION IN MEDICARE PAYMENT –** REDUCE MARKET BASKET UPDATES FOR HOSPITALS, HOME HEALTH, SKILLED NURSING FACILITY, HOSPICE AND OTHER MEDICARE PROVIDERS (FOR HOSPITALS, EFFECTIVE 2010)
- **HOSPITAL READMISSIONS –** PAYMENT PENALTY TO HOSPITALS WITH "EXCESS READMISSIONS RATIO" (FOR DISCHARGES COMMENCING OCTOBER, 2012)
- **DSH PAYMENT REDUCTIONS** (EFFECTIVE 2014)
- **HOSPITAL ACQUIRED CONDITIONS –** REDUCED PAYMENTS FOR HOSPITALS WHOSE DATA PUTS THEM IN TOP QUARTILE OF RATES FOR CERTAIN PREVENTABLE HOSPITAL ACQUIRED CONDITIONS (EFFECTIVE 2015)

POSSIBLE MARKET RESPONSES

- CONSOLIDATION – BOTH HORIZONTAL AND VERTICAL
- PROVIDERS AND PAYORS EXITING THE MARKET
- LESS REVENUE / PRICING PRESSURE
- INCREASED DATA GATHERING AND PUBLIC REPORTING – REQUIREMENT TO DEMONSTRATE "VALUE"
- INCREASED IT INFRASTRUCTURE

CURRENT PUBLIC REPORTING

FINANCIAL INCENTIVES TO REPORT QUALITY

- MEDICARE MODERNIZATION ACT OF 2003:
  - CHANGED THE MANNER FOR REFLECTING THE CHANGE IN THE HOSPITAL MARKET BASKET IN IPPS PAYMENTS
  - TIES PAYMENT UPDATES TO QUALITY BY PROVIDING A FINANCIAL INCENTIVE TO HOSPITALS TO REPORT ON QUALITY TO OBTAIN THE ANNUAL PAYMENT UPDATE (APU) THROUGH REPORTING HOSPITAL QUALITY DATA FOR ANNUAL PAYMENT UPDATE (RHQDAPU) INITIATIVE
  - DEFICIT REDUCTION ACT OF 2005: ALSO PROVIDED FINANCIAL INCENTIVES TO HOSPITALS PARTICIPATING IN MEDICARE'S HOSPITAL QUALITY ALLIANCE

CURRENT PUBLIC REPORTING

- ORIGINALLY HOSPITALS SUBMITTED DATA ON 10 QUALITY MEASURES FOR ACUTE MI, HF, AND PNEUMONIA
- FY 2010 IPPS: QUALITY MEASURES EXPANDED FROM 30 TO 44
  - CMS CLAIMS THESE MEASURES ASSESS :
    * QUALITY OF CARE
    * EFFICIENCY OF CARE
    * PROMOTE COORDINATION OF CARE AMONG HOSPITALS AND OTHER PROVIDERS

CURRENT PUBLIC REPORTING

FY 2010:

- THREE READMISSION MEASURES ADDED:
  1. READ-30-HF: HEART FAILURE 30-DAY RISK STANDARDIZED READMISSION MEASURE (MEDICARE PATIENTS)
  2. READ-30-AMI: ACUTE MYOCARDIAL INFACTION 30-DAY RISK STANDARDIZED READMISSION MEASURE (MEDICARE PATIENTS)
  3. READ-30-PN: PNEUMONIA 30-DAY RISK STANDARDIZED READMISSION MEASURE (MEDICARE PATIENTS)
- CMS SAID IN FINAL FY 2009 IPPS RULEMAKING THAT ALL MEASURES FINALIZED FOR FY 2010 WOULD BE NQF ENDORSED
- NQF ENDORSED ALL THREE READMISSION MEASURES

CURRENT PUBLIC REPORTING

- **PROPOSED FY 2011 (MAY 4, 2011): 46 MEASURES**
  - RETAINED 41 MEASURES
  - HARMONIZED 2 MEASURES
  - ADDED 2 CHART-ABSTRACTED MEASURES
  - ADDED 2 STRUCTURE MEASURES

- **RETAINED THE 3 READMISSION MEASURES**

CURRENT PUBLIC REPORTING

- RESPONSIVE TO MedPAC CALL TO DEVELOP READMISSION MEASURES WITH HF AS A PRIORITY

- CMS: HEART FAILURE READMISSION MEASURE IS CMS' FIRST EFFICIENCY OUTCOME MEASURE

CURRENT PUBLIC REPORTING

LOOKS AT "ALL CAUSE" ADMISSIONS WITH THE INDEX HF BECAUSE:

- READMISSION FROM ANY CAUSE IS AN "ADVERSE EVENT" TO THE PATIENT
- MEASURES SHOULD NOT CREATE INCENTIVES TO GAME THE REPORTING OF THE HF BY CODING HF ADMISSIONS WITH A DIFFERENT DIAGNOSIS
- HARD TO EXCLUDE QUALITY AND ACCOUNTABILITY ISSUES BASED ON THE DOCUMENTED CAUSE OF THE READMISSIONS

CURRENT PUBLIC REPORTING

NO DATA SUBMISSION TO THE QIO CLINICAL WAREHOUSE IS REQUIRED

- CALCULATIONS WILL BE BASED ON EXISTING MEDICARE FEE-FOR SERVICES-CLAIMS DATA ALREADY IN CMS' POSSESSION
- REDUCES SUBMISSION ISSUES THAT RESULTED IN ALL OR NOTHING DENIALS OF TOTAL APU FOR PRIOR FYs
  - SOME HOSPITALS WERE DENIED TOTAL APU BASED ON FAILURE TO SUBMIT 1-2 CASES

PAYMENTS

- RHQDAPU:
  - FY 2010: CMS SAYS ELIGIBILITY FOR APU NOT YET BASED ON PERFORMANCE ON THESE MEASURES
  - BUT MUST ALLOW PUBLIC REPORTING

versus

- PAYMENT DENIAL OF INDIVIDUAL CLAIM BASED ON QUALITY OF CARE FACTORS

versus

- PPACA

PPACA

- **HOSPITAL READMISSIONS REDUCTION PROGRAM**
  - FY 2013: Penalty on IPPS Hospitals for avoidable readmissions (within 30 days of discharge date)
    - Special rules for sole community and small rural hospitals
    - The 3 current readmissions measures
  - FY 2015: Conditions may be expanded

- **LIMITED ADMINISTRATIVE AND JUDICIAL RENEW**

PPACA

- **PSO PROGRAM TO ASSIST HOSPITALS WITH HIGH READMISSION RATES TO IMPROVE THEIR READMISSION RATES** (3/23/2012 START DATE)

- **COMMUNITY-BASED CARE TRANSITIONS PROGRAM** (1/1/2011 START DATE)
  - ELIGIBLE HOSPITALS INCLUDE HOSPITALS WITH HIGH READMISSION RATES

PAYMENTS

READMISSIONS ALREADY SUBJECT TO DENIAL OR COMBINATION WITH PRIOR ADMISSION FOR PAYMENT PURPOSES

- SAME DAY READMISSIONS
  - REQUIRED TO COMBINE THE ADMISSIONS IF RELATED TO THE PRIOR STAY'S MEDICAL CONDITION AND USE A SPECIFIC CODE
  - HOSPITAL IS RESPONSIBLE FOR SERVICES RENDERED BY OTHER PROVIDERS DURING A COMBINED STAY.
    - CMS PUB. 100-04 (MEDICARE CLAIMS PROCESSING MANUAL), SECTION 40.2.5

PAYMENTS: 30-DAY READMISSIONS

- IN THE NOT TOO DISTANT PAST QIO: HAD THE AUTHORITY TO REVIEW AND DENY READMISSIONS OR THE PRECEDING ADMISSION NO MATTER HOW MANY DAYS HAD ELAPSED SINCE THE PATIENT'S DISCHARGE
  - QIOs WERE RESPONSIBLE FOR POST PAYMENT UTILIZATION REVIEW AND MEDICAL REVIEW OF INPATIENT FEE-FOR-SERVICE PAYMENTS (HOSPITAL PAYMENT MONITORING PROGRAM)
  - UNDER THE 8TH SOW, QIOs WERE TO AUTOMATICALLY REVIEW HOSPITAL READMISSIONS WITHIN 30 DAYS.

PAYMENTS: 30-DAY READMISSIONS

- AS OF 8/01/08: TRANSITION FROM QIO:
  - MACs, FIs, AND CERT
  - RACs?
    - RACs NOT TO REVIEW CLAIMS ALREADY REVIEWED BY OTHER MEDICARE CONTRACTORS
    - BUT RACs WERE PERMITTED TO REVIEW "SAME DAY" READMISSIONS EVEN IF QIO INITIATED SAME DAY STAY PROJECT
    - RACs MAY BE ABLE TO REVIEW 30-DAY READMISSIONS IF CMS APPROVES AS A NEW ISSUE?
      - NOT SAME CODING ISSUE AS SAME DAY READMISSION
    - RACs PAID ON CONTINGENCY FEE BASIS

CURRENT COMPLIANCE ISSUES

- MEDICAL REVIEWS OF READMISSIONS USE SAME GUIDELINES USED FOR REVIEWING THE APPROPRIATENESS OF ANY OTHER ACUTE OR LTCH CLAIMS. CMS Pub. 100-08 (MEDICARE PROGRAM INTEGRITY MANUAL), SECTION 6.5.7
  - MEDICAL REVIEWS OF READMISSIONS CAN DENY STAYS:
    - IF MEDICALLY UNNECESSARY
    - IF IT RESULTED FROM A PREMATURE DISCHARGE FORM THE SAME HOSPITAL
    - IF IT WAS A RESULT OF CIRCUMVENTION OF PPS BY THE SAME HOSPITAL
  - WHO WILL BE CONDUCTING THE MEDICAL REVIEWS?

CURRENT COMPLIANCE ISSUES

- FIs/MACs TO REFER QUALITY ISSUES, INCLUDING CIRCUMVENTION OF PPS:
  - IF THE ACTION RESULTED IN UNNECESSARY ADMISSIONS, PREMATURE DISCHARGES AND READMISSIONS, REFER TO QIO OR BENEFIT INTEGRITY CONTRACTOR. SSA 1886(f)(2), 42 CFR 476.71; CMS Pub. 100-08, SECTION 6.5.9, CMS 100-10, SECTION 4255
  - IF DISCHARGE IS FOUND TO BE PREMATURE, EITHER OR BOTH CLAIMS FOR THE STAY MAY BE DENIED. CMS Pub. 100-10 (QIO MANUAL), SECTION 4240

CURRENT COMPLIANCE ISSUES

- CIRCUMVENTION OF PPS
  - CMS 100-10, SECTION 4255: IF PROVIDER IS FOUND TO HAVE TAKEN ACTION WITH THE INTENT OF CIRCUMVENTING PPS AND THAT ACTION RESULTED IN INAPPROPRIATE MEDICAL OR OTHER PRACTICES REGARDING BENEFICIARIES OR BILLING, MAY ALSO REQUIRE CORRECTIVE ACTION.
    * LIST OF PROHIBITED ACTIONS THAT CIRCUMVENT PPS INCLUDES READMISSIONS FOR CARE THAT COULD HAVE BEEN PROVIDED DURING THE FIRST ADMISSION

CURRENT COMPLIANCE ISSUES

- FAILURE TO SUBSTANTIALLY COMPLY WITH CORRECTIVE ACTION MAY RESULT IN:
  - TERMINATION OF PROVIDER AGREEMENT PROVIDER
  - EXCLUSION FROM MEDICARE AND ANY STATE HEALTH CARE PROGRAM
- CMS RECOGNIZES THAT A PROVIDER IS GENERALLY ENTITLED TO A HEARING AND JUDICIAL REVIEW OF DENIAL
- CMS CLAIMS THAT LIMITATION OF LIABILITY PROVISIONS NOT APPLICABLE
- BENEFICIARY NOT TO BE CHARGED FOR DENIED SERVICES

CURRENT COMPLIANCE ISSUES

- CMS SEES A DANGER OF HOSPITALS "GAMING" PPS
  - MISREPRESENTING DIAGNOSES TO AVOID CLASSIFICATION AS ONE OF THE 3 READMISSION MEASURES, SO IT IS LOOKING AT READMISSIONS FOR ALL CAUSES
- OIG WORK PLAN FY 2009: OIG TO REVIEW HOSPITALS' CONTROLS FOR ENSURING THE ACCURACY OF DATA REPORTED RELATED FOR QUALITY MEASUREMENT

CURRENT COMPLIANCE ISSUES

OIG ACTIONS AND ACTIVITIES

- OIG WORK PLANS INCREASING FOCUS ON MEDICAL NECESSITY AND QUALITY
- OIG SUPPLEMENTAL COMPLIANCE PROGRAM GUIDANCE FOR HOSPITALS: JANUARY 31, 2005
  - RISK AREAS INCLUDE
    - ADMISSIONS AND DISCHARGES
    - SUBSTANDARD CARE
    - COMPLIANCE WITH QUALITY-RELATED CONDITIONS OF PARTICIPATION AND MONITORING QUALITY OF CARE IN THE HOSPITAL

CURRENT COMPLIANCE ISSUES

- HHS/OIG/AHLA GUIDANCE FOR BOARDS ON GOVERNANCE: 2007 “CORPORATE RESPONSIBILITY & HEALTH CARE QUALITY: A RESOURCE FOR HEALTH CARE BOARDS OF DIRECTORS”
  - *PURPOSE:* TO PROMOTE DIRECTORS TO BECOME INFORMED REGARDING HEALTH CARE QUALITY REQUIREMENTS, MEASUREMENT TOOLS, AND REPORTING REQUIREMENTS AS PART OF FULFILLING THEIR FIDUCIARY DUTIES TO THEIR PROVIDER ORGANIZATION

CURRENT COMPLIANCE ISSUES

- OIG CITES MEDICALLY UNNECESSARY SERVICES AND FAILURE OF CARE/SUBSTANDARD CARE AS PREDOMINANT CRIMINAL AND CIVIL FRAUD THEORIES.
- OTHER THEORIES:
  - EXCLUSIONS BASED ON QUALITY FAILURES
    * SUBSTANTIALLY IN EXCESS OF THE PATIENT'S NEEDS
    * OF A QUALITY WHICH FAILS TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE

CURRENT COMPLIANCE ISSUES

- CIVIL MONEY PENALTIES FOR QUALITY
  - NOT MEDICALLY NECESSARY
  - PROVIDING FALSE OR MISLEADING INFORMATION THAT COULD BE EXPECTED TO LEAD TO PREMATURE DISCHARGE
  - HOSPITAL PAYMENTS TO PHYSICIANS TO REDUCE SERVICES

CURRENT COMPLIANCE ISSUES

- COMPLIANCE WITH MEDICARE CONDITIONS OF PARTICIPATION AND THEIR FOCUS ON OUTCOMES AND QUALITY OF CARE
  - 42 CFR 482:21: GOVERNING BODY
  - 42 CFR 482.21: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM
  - 42 CFR 482.22: MEDICAL STAFF
  - 42 CFR 482.30: UTILIZATION REVIEW
  - 42 CFR 482.43: DISCHARGE PLANNING
- JOINT COMMISSION STANDARDS RE: DISCHARGE

FUTURE EMPHASIS ON ALIGNMENT: GOALS & KEY ELEMENTS

- AVOID UNNECESSARY COSTS
- IMPROVE QUALITY (AS MEASURED BY OUTCOMES)
- COLLABORATION BETWEEN HOSPITAL AND PHYSICIANS
- VOLUNTARY -- PROVIDER (OR PAYOR) INITIATED
- PROVIDE INCENTIVES TO ENCOURAGE CHANGES IN PHYSICIAN PRACTICES AND MORE EFFICIENT USE OF RESOURCES

THE DARK SIDE

- ANTITRUST LAW
- PHYSICIAN INCENTIVE PLAN LAW
- STARK LAW
- ANTI-KICKBACK LAW
- INSURANCE LAW
- CORPORATE PRACTICE OF MEDICINE

ANTITRUST LAW

TRADITIONAL: SHERMAN ACT –

- PER SE ILLEGAL COMPETITOR AGREEMENTS
- BOYCOTTS AND COERCION

REGULATORY ENFORCEMENT (FTC ACT § 5)

- GUIDELINES
- INTEGRATED V. NON RISK SHARING
- MULTI-PAYER COLLABORATION
- COMMON MEASURES V. INDEPENDENT PAYMENT

PHYSICIAN INCENTIVE PAYMENT PROHIBITION SOCIAL SECURITY ACT §1128A(B)(1) (THE "CMP LAW")

(b)(1) IF A HOSPITAL OR A CRITICAL ACCESS HOSPITAL KNOWINGLY MAKES A PAYMENT, DIRECTLY OR INDIRECTLY, TO A PHYSICIAN AS AN INDUCEMENT TO REDUCE OR LIMIT SERVICES PROVIDED WITH RESPECT TO INDIVIDUALS WHO—

(A) ARE ENTITLED TO BENEFITS UNDER PART A OR PART B OF TITLE XVIII OR TO MEDICAL ASSISTANCE UNDER A STATE PLAN APPROVED UNDER TITLE XIX, AND

(B) ARE UNDER THE DIRECT CARE OF THE PHYSICIAN,

THE HOSPITAL OR A CRITICAL ACCESS HOSPITAL SHALL BE SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY LAW, TO A CIVIL MONEY PENALTY OF NOT MORE THAN $2,000 FOR EACH SUCH INDIVIDUAL WITH RESPECT TO WHOM THE PAYMENT IS MADE.

(2) ANY PHYSICIAN WHO KNOWINGLY ACCEPTS RECEIPT OF A PAYMENT DESCRIBED IN PARAGRAPH (1) SHALL BE SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY LAW, TO A CIVIL MONEY PENALTY OF NOT MORE THAN $2,000 FOR EACH INDIVIDUAL DESCRIBED IN SUCH PARAGRAPH WITH RESPECT TO WHOM THE PAYMENT IS MADE.

ANTI-KICKBACK LAW
SOCIAL SECURITY ACT § 1128B(B)

(b)(1) WHOEVER KNOWINGLY AND WILLFULLY **SOLICITS OR RECEIVES** ANY REMUNERATION (INCLUDING ANY KICKBACK, BRIBE, OR REBATE) DIRECTLY OR INDIRECTLY, OVERTLY OR COVERTLY, IN CASH OR IN KIND—

(A) IN RETURN FOR REFERRING AN INDIVIDUAL TO A PERSON FOR THE FURNISHING OR ARRANGING FOR THE FURNISHING OF ANY ITEM OR SERVICE FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART UNDER A FEDERAL HEALTH CARE PROGRAM, OR

(B) IN RETURN FOR PURCHASING, LEASING, ORDERING, OR ARRANGING FOR OR RECOMMENDING PURCHASING, LEASING, OR ORDERING ANY GOOD, FACILITY, SERVICE, OR ITEM FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART UNDER FEDERAL HEALTH CARE PROGRAM,

SHALL BE GUILTY OF A FELONY AND UPON CONVICTION THEREOF, SHALL BE FINED NOT MORE THAN $25,000 OR IMPRISONED FOR NOT MORE THAN FIVE YEARS, OR BOTH.

ANTI-KICKBACK LAW *(CONT'D.)*

(2) WHOEVER KNOWINGLY AND WILLFULLY **OFFERS OR PAYS** ANY REMUNERATION (INCLUDING ANY KICKBACK, BRIBE, OR REBATE) DIRECTLY OR INDIRECTLY, OVERTLY OR COVERTLY, IN CASH OR IN KIND TO ANY PERSON TO INDUCE SUCH PERSON—

(A) TO REFER AN INDIVIDUAL TO A PERSON FOR THE FURNISHING OR ARRANGING FOR THE FURNISHING OF ANY ITEM OR SERVICE FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART UNDER A FEDERAL HEALTH CARE PROGRAM, OR

(B) TO PURCHASE, LEASE, ORDER, OR ARRANGE FOR OR RECOMMEND PURCHASING, LEASING, OR ORDERING ANY GOOD, FACILITY, SERVICE, OR ITEM FOR WHICH PAYMENT MAY BE MADE IN WHOLE OR IN PART UNDER A FEDERAL HEALTH CARE PROGRAM,

SHALL BE GUILTY OF A FELONY AND UPON CONVICTION THEREOF, SHALL BE FINED NOT MORE THAN $25,000 OR IMPRISONED FOR NOT MORE THAN FIVE YEARS, OR BOTH

STARK LAW
SOCIAL SECURITY ACT § 1877

THE BASIC PROHIBITION:

§ 1395nn. LIMITATION ON CERTAIN PHYSICIAN REFERRALS

(a) **PROHIBITION OF CERTAIN REFERRALS**

(1) **IN GENERAL**

[UNLESS AN EXCEPTION APPLIES], IF A PHYSICIAN (OR AN IMMEDIATE FAMILY MEMBER OF SUCH PHYSICIAN) HAS A *FINANCIAL RELATIONSHIP* WITH AN ENTITY [THAT PERFORMS OR CAUSES THE PERFORMANCE OF A DESIGNATED HEALTH SERVICE], THEN—

(A) THE PHYSICIAN **MAY NOT MAKE A REFERRAL** TO THE ENTITY FOR THE FURNISHING OF DESIGNATED HEALTH SERVICES FOR WHICH PAYMENT OTHERWISE MAY BE MADE, AND

(B) THE ENTITY **MAY NOT PRESENT OR CAUSE TO BE PRESENTED A CLAIM** OR BILL TO ANY INDIVIDUAL, THIRD PARTY PAYOR, OR OTHER ENTITY FOR DESIGNATED HEALTH SERVICES FURNISHED PURSUANT TO A REFERRAL PROHIBITED.

STARK LAW – POSSIBLE EXCEPTIONS

- BONA FIDE EMPLOYMENT RELATIONSHIPS
- PERSONAL SERVICE ARRANGEMENTS
- PREPAID PLANS
- RISK SHARING
  - OIG APPROVED?
  - MEDICARE CARVE OUT? (SPILL OVER?)

QUESTIONS?