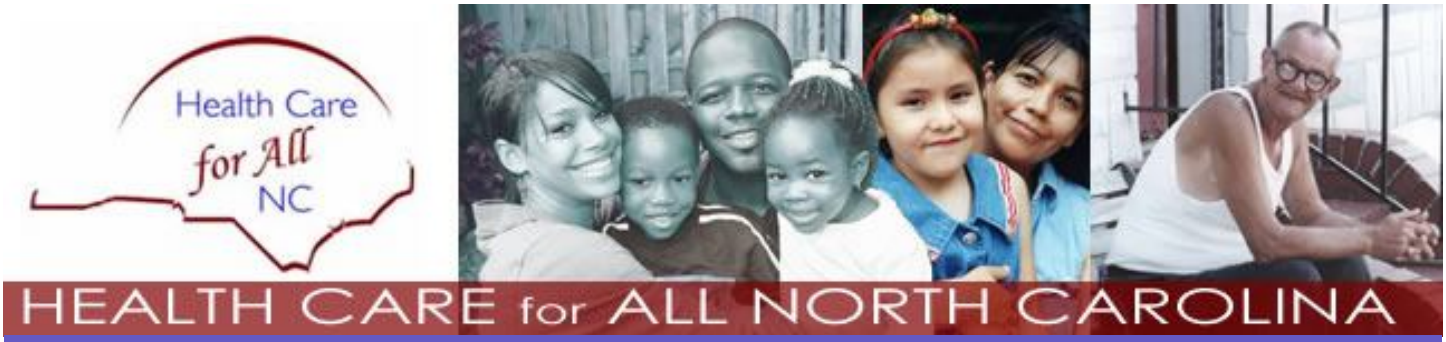

Health Care for All NC

www.healthcareforallnc.org

Inside the newsletter you will learn about:

- **PPACA's Game Changer – the 60 Day Rule for Returning Overpayments to CMS**
- **Medicaid Reform and Medicaid Expansion**
- **The experiences of a Downeast Affordable Care act Navigator**
- **A synopsis of the November 2013 Physicians for a National Health Program Annual Meeting*: Protecting Caregiving from the Market: A Road Map to Single Payer*.**

Most important, we want your ideas and suggestions about your newsletter and ways to bring a better health care system to North Carolina. Please send your suggestions to info@healthcareforallnc.org

Sincerely,
Editorial Staff, Mandie Carlson, Mysha Sissine & Jonathan Michels

Hold the Dates

December 23
Mass Moral Monday *in Raleigh*

January 12, 1 PM
HCFA-NC Annual Meeting
228 Rosenau Hall
Gillings School of Global Public Health
135 Dauer Drive, Chapel Hill, NC 27599

February 8
HKonJ (Historic Thousands on Jones Street) *in Raleigh*

Health Care for All NC
PO Box 2235 - Chapel Hill, NC 27515-2235
info@healthcareforallnc.org

PPACA's Game Changer – the 60 Day Rule for Returning Overpayments to CMS

By Erin Shaughnessy Zuiker, JD, MPH

For years the federal government has been working hard to recapture any improperly paid Medicare and Medicaid funds, but until recently the effort has been largely ineffective. Section 6402 of the Patient Protection and Affordable Care Act ("PPACA") creates an affirmative obligation for a health care provider to return an overpayment to the Centers for Medicare and Medicaid Services ("CMS") within 60 days of "identification." Since 2010 providers have speculated about what precisely is meant by the term "identified" in the context of the 60 day requirement; on February 16, 2012, CMS provided its answer in proposed rules regarding the reporting and refunding of overpayments.[1] CMS's Proposed Rule provides: "[A] person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment."[2]

The passage of PPACA, combined with the False Claims Act (FCA) and the Fraud Enforcement and Recovery Act of 2009 ("FERA"), has significantly enhanced the federal government's arsenal to recoup monies improperly paid to providers. Historically, a key distinction between fraud and abuse, on the one hand, and mistake, on the other, has been intent. However, for purposes of health care fraud involving Medicare and Medicaid, the distinction may no longer be meaningful with respect to claims submitted to the federal and state governments.

This is achieved because the FCA imposes liability when the claimant acts "knowingly" with respect to an obligation. However, "knowingly" does not require that the person submitting the claim have actual knowledge that the claim is false. The definition of "knowing" or "knowingly" does not include a requirement that the provider intended to defraud the government.[3] In addition, FERA amended the FCA, such that any person who knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government may be held liable under the FCA. In turn, "obligation" was defined as "an established duty, whether or not fixed . . . arising from the retention of an overpayment."[4] Thus, failing to repay the government in a timely fashion can result in liability under the FCA.

How does PPACA play into all of this? The reporting and refunding of an overpayment is now expressly required—thus creating an "established duty" for purposes of FCA liability. Therefore, any overpayment retained beyond the 60 days from "identification" creates an "obligation" for purposes of the FCA and may result in FCA liability, with the possibility of treble damages and fines, if the provider demonstrates a "knowing and improper" failure to return the overpayment. While the FCA penalties are mandatory, PPACA has added discretionary civil monetary penalties ("CMPs") up to $10,000 for each item or service, plus treble damages. The CMPs are triggered by the Office of Inspector General ("OIG"), but may be applied in addition to any FCA penalties. The voluntary and prompt refunding of overpayments is thus a significant obligation of providers with serious consequences for failure.

For too long the government's efforts to combat fraud within the Medicare and Medicaid programs were insufficient. As a result, the government has paid billions to providers who have billed the programs in excess of the services they provided or for services that were never provided. It is in everyone's interests that these fraudulent activities are stopped and the individuals involved are prosecuted. Mistakes are inevitable however, and with the passage of PPACA, the stakes for those providers who are trying to properly bill the Medicare and Medicaid programs for the services they provide have increased significantly. In the past, a provider who submitted a bill in error took efforts to correct the mistake. Now, failure to timely correct a billing error and repay the government any funds improperly paid to the provider may create both civil and criminal liability.

In an era of strained resources and rising costs, providers are diligently working to provide health care services to Medicare and Medicaid patients. And while it is in all our interests to protect the Medicare Trust Fund, it is shortsighted for the government to be overly zealous in its effort to handle improper payments. As the issue of access continues to be debated, it is important to remember that

healthcare reform cannot be funded on the backs of the very providers who are delivering the services. Providers work hard day in and day out to care for their patients and in good faith submit claims for their services to the Medicare and Medicaid programs. Criminalizing mistakes may lead more providers to refuse to accept Medicare and Medicaid patients, which in the end will limit access to the very people PPACA intends to benefit.

Notes:
1. See 77 FR 9179, published February 16, 2012.
2. Id. at 9182 (emphasis added).
3. 31 U.S.C. § 3729(b)(1).
4. 31 U.S.C. § 3729(b)(3).

Medicaid Expansion: NC's Delayed First Effort toward Single Payer Healthcare

By Gary Greenberg

In 2009, during the legislative healthcare debate, controversy targeted many topics hotter than Medicaid . Disputes about National v State-wide competition, a Public option, and the Individual Mandate caused strident division and name-calling. At NC-4th District Congressman Price's only townhall meeting (where a fist-fight broke out in the balcony of NCCU's overflowing auditorium) Medicaid wasn't even mentioned.

Even after the Affordable Care Act passed, its Medicaid component wasn't particularly controversial. Most Americans (including clinicians) thought that Medicaid already covered the poor, so didn't find the removal of categorical qualifications a radical proposal. It's still poorly recognized that N. Carolina offers NO Medicaid, even to very low-income adults unless they are pregnant, disabled, elderly or parents-of-very-young-children.

For our own HCfA-NC organization, where a Single Payer, Medicare-for-All structure is endorsed, many didn't notice that Medicaid is exactly that: a governmental program with comprehensive coverage for all (poor), delivered at standard prices by the patient's chosen commercial health provider.

In June 2012, when the Supreme Court affirmed the Individual Mandate but struck down coercive states' acceptance of the Medicaid Expansion, controversy was unexpected. Full Federal support (tapering to 90%) would motivate even red states to accept reduced costs and expanded coverage. In November's gubernatorial election, neither candidate expressed positions on Medicaid.

In February 2013[1], when the NC-Senate's Republicans' SB-4 barred any participation in the ACA, and chose to ignore the Institute of Medicine's detailed analysis[2] (and scores of clinician advocates in the gallery), Gov. McCrory's position wasn't known, and for several weeks he remained non-committal. Now that he's signed the ban confirmed by both houses, rejection seems immutable (strengthened by legislature's reversal of his other tepid vetoes).

So how can the situation improve?

- **Mass education and protests have begun. Many HCfA-NC's members participated (and some were arrested) at NAACP-NC's Moral Mondays, where Medicaid Expansion was a priority topic (among so many!). These efforts continue. The "Hundred Thousand on Jones St." (HKoJ[3]) will be February 8, 2014, to show endorsement for Federal support for unemployment and Medicaid.**
- **County and city councils recognize a need to provide for low income citizens and to support local health institutions. Durham City[4] and Mecklenburg County[5] passed a resolution[6] endorsing the expansion, and provided an opportunity for clinicians to achieve media attention for these points.**
- **Grassroots efforts can publicize this decision's effects, narrating examples of economic and humanitarian damage. Reversal will require legislative action, but Governor McCrory is a necessary first step, to call an early special session and to lead a more thoughtful legislative review. A press event[7] on the steps of the Capital in October with the Democratic leader of the House and a Triangle-based Senator was well covered (but quickly refuted[8] by the Governor).**
- **Policy[9] and advocacy[10] groups are often looking for credentialed and articulate experts on these issues, to supplement discussion and personal narrative about this issue.**

Supporting Medicaid Expansion offers a target toward developing a direct Single Payer resource for North Carolina, and can reverse a spiteful denial of a critical national opportunity.

Notes:
1. http://www.wral.com/news/state/nccapitol/video/12064530/#/vid12064530
2. http://www.nciom.org/wp-content/uploads/2013/01/Final-ExecSumm-FINAL.pdf
3. http://hkonj.com/
4. http://www.wncn.com/story/23052801/durham-council-urges-state-to-expand-medicaid
5.http://www.charlotteobserver.com/2013/10/15/4391361/commissioners-to-legislature-reconsider.html#.UqzzAPRDuyU
6. http://www.healthcareforallnc.org/advocacy/resolutions/Dur-MCD-resolution.docx
7. http://pulse.ncpolicywatch.org/2013/10/28/lawmakers-advocates-call-for-special-session-to-expand-medicaid/
8. http://www.newsobserver.com/2013/10/28/3320821/supporters-of-medicaid-expansion.html
9. http://www.ncjustice.org/?q=node/114
10. http://progressnc.org/

Health Care Reform Today

By Vana Prewitt, Ph.D.

The present state of the healthcare reform effort is disappointing, given all of the efforts to create a single payer, universal health care law. Choices made by Federal and State agencies put North Carolina (NC) in a position of having no effective support for rollout east of I-95 (Down East). Of all the people in NC, this group needs the most help. Remote, isolated, and often without computers at home, they cannot begin to unravel the mystery of enrolling. In desperation, I became a Blue Cross insurance agent. It was the only way I could get the necessary training and privileged insurance company information.

I met with county agencies in September to discover that, despite being listed as Navigators on the Federal website, they could be of no help since they were untrained and understaffed. I made connections with Enroll America, a volunteer group, who believed a Navigator would train them to be Certified Application Assistants. I joined a broker, Carolina Benefits Specialists (CBS), in Greenville believing they would enact a plan. I left this group last week due to their unethical practices.

- **The mayor of Greenville is a former insurance agent and consultant to the CBS brokers but he introduces himself as "the mayor of Greenville" which makes it seem he is introducing an official function of the Affordable Care Act.**
- **NC Enroll (sounds a lot like Enroll America, yes?) was introduced by the mayor to many community groups and churches, leading them to believe a coordinated rollout effort was coming. We are still waiting.**
- **They said enrollment required an insurance agent, which is untrue.**
- **Insurance agents are required by law to inform subscribers that they are paid a commission, are not official Navigators, and that individuals can enroll themselves at Healthcare.gov. CBS has not passed this on to the agents and discouraged agents from telling subscribers about the national website.**
- **CBS claimed to be hiring and training dozens of Navigators for this area. There were three in Jacksonville, me in New Bern, and nobody to cover Pamlico, Carteret, or Beaufort counties.**
- **They asked me to be a team leader (responsible for actions of others) but would not introduce me to the team members (as it turned out, there were none).**
- **Agents were told not tell anyone that NC Enroll is part of CBS because they primarily write group policies. Their current customers are unhappy about the ACA and would be unhappy if they knew CBS was selling the policies.**
- **Without a functioning enrollment database, agents are collecting personal information on paper for later enrollment. CBS has collected over five hundred such applications but not a one is actually enrolled.**

Community groups have reported that they were initially fooled by NC Enroll's tactics. The volunteers from Enroll America, Interfaith Connections, a local sorority, the African American community, and Merci Clinic (free) are coming together to build a coordinated plan with agents they can trust. The lack of coordination, a functioning system, and mass public confusion has handicapped us. Our next move is to schedule large public events at the library weeks in advance and make sure the announcements get into the church bulletins, newspaper, flyers, and public service announcements.

Notes:
Vana Prewitt, Ph.D. will gladly share resources, information, and educational materials vprewitt@moc.edu

PNHP Meeting Annual Meeting

By Jay Walsh

The following is a brief synopsis of the November 2, 2013 PNHP (Physicians for a National Health Program) Annual Meeting*: Protecting Caregiving from the Market: A Road Map to Single Payer*.

The *Welcome* was given by the PNHP immediate past-president, Garrett Adams, MD, and the current PNHP president, Andrew Coates, MD. Their remarks set the stage for our continued focus throughout the day: how to achieve a new and improved Medicare for all.

The first presentation was a *Health Policy Update* session by Steffie Woolhandler, MD, MPH, and David Himmelstein, MD, co-founders of PNHP. They addressed the likely course from the ACA (Affordable Care Act) and ACOs(Accountable Care Organizations) to single payer.

There are many unknowns about this politically charged process. The only safe, long-term prediction is that it will fail. It clearly was not designed to work as it is far too complex and keeps the "fox" of the health insurance industry guarding the "hen house" of healthcare.

Next, Adam Gaffney, MD described the *Impact of Austerity on European Health Systems*. As expected, the impact can only be described as disastrous. As long as financial resources are shifted from the poor and middle class to the rich, care will deteriorate as necessary services are underfunded.

An *Update from Massachusetts*, the model for the ACA, was given by Rachel Nardin, MD, board adviser, PNHP. It never ceases to amaze me how the mainstream media doesn't get this right. The rosy picture they paint proves that the system is not financially sustainable, as Dr. Nardin indicated. Those who need the services are still suffering, both physically and financially.

This year's keynote speaker was Vermont Governor Peter Shumlin. He described how Vermont has positioned itself as the most likely state to achieve something close to a Single Payer system. Shumlin also indicated that he knew he would need the help of PHNP since groups that oppose single payer will attempt to undo his efforts.

The Luncheon presentation was given by Marcia Angell, MD, past editor-in-chief, New England Journal of Medicine. She discussed *Patients and Profits* in her usual witty but completely accurate way.

During the afternoon, multiple workshops were given by various presenters (all of the subjects/ names are available by request– just email me at jaywalsh@thistle-cottage.com).

After Andrew Coates, MD, gave the Closing session entitled *In Defense of Caregiving*, there were the Social Hour and various Ad hoc meetings, including one attended by some members from the "Southern States: Jonathan Kotch, MD, Jessica Saxe, MD, and myself.

Finally, the Dinner session, entitled *The Medicare Crisis – Real or Imagined?,* was presented with the introduction by Oliver Fein, MD, past president, PNHP and Bruce Vladeck, past administrator, CMS (Centers for Medicare and Medicaid Services.) This was followed by a brief recognition of Leadership Training participants. Dr. Claudia Fegan reflected on the 50th Anniversary of the March on Washington for Jobs and Freedom in the *Closing Remarks.*

Meet the Editor: Mandie Carlson

Mandie has always been dedicated to the issue of high level wellness for all. This includes access to health care. For the past 4 years, Mandie has found herself in the position of having no health insurance. She also has the dubious distinction of income that is too low (yes, low) to qualify for a subsidy if she bought health insurance through the Affordable Care Act. Since then, she has stopped taking medications, stopped going to doctors, and she has discovered the community acupuncture clinic. In case of emergency,

she carries around her living will and is considering having DNR (do not resuscitate) tattooed on her wrist so the hospitals don't get her daughter's inheritance. She is, and has always been, strongly in favor of single payer health care.

Mandie attended University of Virginia School Nursing where she obtained her BSN with a Wellness Focus. Her Masters in Public Health in Maternal and Child Health is from UNC. She has worked as a school nurse, a public health researcher, and a preschool teacher.

Recently, Mandie fufilled her dream of moving to the mountains of Western North Carolina. There she became active on the leadership council of the Blue Ridge Holistic Nurses. Currently, she is an integrative health coach, a freelance editor (papers, applications and resumes), and teaches young children at the YMCA.
In her leisure time, Mandie loves going for lunch with her daughter, walking her dog around Beaverdam Lake, hiking, creating art, and enjoying drumming circles.

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- Make a donation for the right to health care : http://www.healthcareforallnc.org/
- Be a HCFA-NC Volunteer, write to: info@healthcareforallnc.org