

# RATH YOUNG PIGNATELLI

New Hampshire MGMA – April 14, 2010 - LEGAL UPDATE

Providers are curious, anxious, hopeful and concerned about state and federal health care reform initiatives. What do they mean to the licensed practitioner? Only time will tell, however, we provide the following interim advice:

- *Stay Focused on Patient Care – Do not get distracted from your care mission; as licensed practitioners, continue to provide quality care to your patients as efficiently and effectively as possible.*
- *Anticipate Economics – Understand reimbursements are not going to rise; be as productive as possible.*
- *Engage in Discussions About Quality of Care Initiatives – Practitioners must play an imperative role in developing and implementing any new care models structured around quality of care; be active participants.*
- *Be Collaborative – Assess your strategic and clinical relationships.*

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## 1. HEALTH CARE REFORM BILL

### TIMELINE OF CERTAIN KEY PROVISIONS

#### Effective January 1, 2010:

**State Law Notification:** Physicians must comply with new patient disclosure requirements for MRI, CT and PET services provided as in-office ancillary services. (See details below at Paragraph 4).

**Medicare Claims Filing:** The maximum period for submission of Medicare claims performed on or after January 1, 2010 is reduced to not more than 12 months.

**Certification for DME & Home Health:** Secretary may revoke enrollment for a period of not more than 1 year for each act by a physician or supplier who fails to maintain or does not provide access to documentation relating to written orders or requests for payment for DME, certifications for home health services or referrals for other items or services as specified by the Secretary. Physicians are required to have face-to-face encounters with patients prior to certification or re-certification for home health services or DME under Medicare.

**Comparative Clinical Effectiveness:** Establish a private, non-profit institute to identify national priorities and to provide research on comparative effectiveness of health treatments and strategies.

**Small Business Tax Credits:** First phase of small business tax credit (up to 35% of employer's contributions to health insurance for employees). Small employers can receive a credit for contributions to purchase health insurance for employees.

#### Effective in March, 2010:

**HPSA Designations:** Secretary, in consultation with stakeholders, must establish a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas.

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The Healthcare Practice Group provides a wide range of regulatory, corporate and litigation support to healthcare providers and suppliers throughout New England and nationally.

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### **Fraud & Abuse:**

**Intent:** Government will now be held to a lesser showing of intent in federal health care fraud cases, instead of a specific intent – now a general intent.

**Enforcement:** Medicare Administrative Contractors are allowed to perform additional reviews to limit fraud and abuse. Secretary may suspend Medicare and Medicaid payments to a provider or supplier pending an investigation of fraud. Health Care Fraud and Abuse Control program funding is increased by \$10 million each year for 10 years.

**Overpayment Returns:** Any person who knows of an overpayment is required to return the overpayment to the Secretary, the state or Medicare contractor within 60 days.

**Sentencing:** Sentences under federal sentencing guidelines are increased for health care fraud.

**Statutory Expansion:** The Anti Kickback Statute was amended to state that items and services resulting from AKS violations are false claims as well.

**Background Checks:** Secretary must establish a nationwide program for national and state background checks on direct patient access employees of certain long-term supports and services facilities or providers.

**Non-Profits:** Additional requirements established to qualify as a 501(c)(3) charitable hospital organization, including conducting a community needs assessment. (See details below at Paragraph 3).

**Student Loans:** Amounts received under any state loan repayment or loan forgiveness program intended to provide for increased availability of health care services in underserved or health professional shortage areas are excluded from gross income.

### **Effective April 1, 2010:**

**Voluntary Medicaid Expansion:** States are allowed to cover parents and childless adults up to 133% of federal poverty level and an increase in the FMAP match.

### **Effective May 23, 2010:**

**High Risk Pool:** Creation of a temporary federal high-risk pool for those who have been uninsured for 6 months and have a pre-existing condition.

**Early Retiree Coverage:** Creation of temporary reinsurance program to reimburse employers for part of the cost of providing health benefits to early retirees.

### **Effective September 23, 2010:**

**No Rescission:** All individual and group plans are prohibited from rescinding a policy once enrolled except for fraud or intentional misrepresentations, and with prior notice to enrollee.

**No Lifetime Limits/Restrictions on Annual Limits:** All insurers are prohibited from imposing lifetime limits, and new individual and all group plans are prohibited from imposing unreasonable annual limits on benefits for all plans. Annual limits are prohibited beginning in 2014. New individual and group plans must cover preventive and wellness services and immunizations without cost-sharing.

**Cover up to 26 Years Old:** All individual and group plans must extend dependent coverage to individuals up to age 26 who are unmarried and not covered by another plan.

**No Pre-existing Exclusions:** Pre-existing conditions exclusions prohibited for dependents on all employer and new individual plans. (This will apply to adults in 2014).

**Administration:** Plans must implement effective appeal procedures. Non-discrimination rules will apply to fully insured plans.

**Hospital Transparency:** Hospitals are required to publicize a list of standard charges, including DRGs.

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**Stark Violation Disclosures:** Secretary is required, within 180 days, to develop a mechanism for providers to voluntarily disclose specific information regarding actual and potential Stark violations.

**Effective October 1, 2010:**

**Community Health Centers:** Funds are provided to build new, and expand existing, community health centers.

**Effective December 31, 2010:**

**No New Physician Owned Hospitals:** Prohibition on physician ownership in hospitals that did not exist by agreement prior to December 31, 2010. Stark law whole hospital exception eliminated going forward.

**RAC Expansion:** Not later than December 31, 2010, Recovery Audit Contractor program is expanded to Medicaid and Medicare Parts C and D. RACs are required to ensure that Medicare Advantage and Prescription Drug Plans implement anti-fraud plans.

**Tanning Tax:** Imposes 10% tax on amounts paid for indoor tanning services.

**Effective January 1, 2011:**

**W-2 Reporting:** Beginning in 2011, employers will be required to disclose the value of health coverage provided on Form W-2.

**Bonus for Rural Doctors:** Primary care providers and general surgeons practicing in health professional shortage areas are given 10% Medicare bonus payment for five years.

**Insurer Transparency:** Health plans must annually report on share of premium dollars spent on medical care.

**Medical Loss Ratio:** Institution of medical loss ratio requirements of 85% for large groups and 80% for small groups (with rebates to enrollees if medical spending is below this amount).

**Medicare Wellness Visits:** Coverage under Medicare is added for an annual wellness visit where individuals are provided personalized prevention plan services.

**NPI Use Mandate:** Secretary is required to promulgate a regulation no later than January 1, 2011 requiring all providers and suppliers that qualify for a national provider identifier to include the identifier on all applications for enrollment.

**HSA Tax:** The tax on HSA and Archer MSA withdrawals prior to age 65 that are used other than for qualified medical expenses is increased to 20 percent.

**P.A. Scope of Practice:** Physician assistants are authorized to order skilled nursing care services for Medicare beneficiaries beginning in 2011.

**Rebates for Donut Hole:** \$250 rebate check for Part D enrollees who enter the “donut hole.” In 2011, a 5% discount on brand-name drugs will be instituted and generic drug coverage will be provided in the donut hole. The gap will be filled by 2020.

**Effective July 1, 2011:**

**Medicaid Never Events:** Federal payments to states for Medicaid services related to Health Care-Acquired Conditions are prohibited.

**Effective January 1, 2012:**

**ACO's:** Secretary must establish a shared savings program that will reward Accountable Care Organizations that take responsibility for the costs and quality of care received by their patient panel. Pilot program to begin 2012. Shared savings payments made to ACOs for meeting quality performance and cost savings. May be limited to organizations with shared governance.

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**Quality of Care Payments:** Secretary must establish value-based payment modifier that provides for differential payment to physicians and physician groups under fee schedule based on quality of care furnished compared to cost during a performance period.

**Effective January 1, 2013:**

**Payroll Tax Increase:** Increase in Medicare payroll tax rate of 0.9% for individuals earning over \$200,000 or couples earning over \$250,000. Tax is also expanded to include a 3.8% tax on net investment income in case of taxpayers earning over \$200,000 individually or \$250,000 as a couple.

**Payment Reform:** Establishment of 5-year national, voluntary pilot program on payment bundling for hospitals, physicians and post-acute care providers.

**Cafeteria Plan Contributions:** Salary contributions to FSAs under a cafeteria plan are limited to \$2,500. However, the itemized deduction for medical expenses will increase to 10%.

**Medicaid Increases:** Medicaid payments for primary care services provided by a physician with a primary specialty designation of family medicine, general internal medicine or pediatric medicine will be reimbursed at 100% of payment rate that applies to such services under Medicare Part B in 2013 and 2014. 100% FMAP to states for meeting this requirement.

**Effective March 31, 2013:**

**Medical Device Disclosures:** On the 90<sup>th</sup> day of each year after this date, any covered drug, device, biological or medical supply manufacturer that provides payment or value to a physician or teaching hospital must report certain information to the Secretary for each preceding year. There will also be a 2.3% excise tax on the sale of medical devices.

**Effective July 1, 2013:**

**Multi-State Plan Requirements:** Secretary, in consultation with NAIC, must issue regulations on health care choice compacts, which will allow multiple states to enter into agreements allowing health plans to be offered in all compact states but be subject only to laws of state in which plan was written.

**Administrative Simplification:** Beginning in 2013, health plans must adopt and implement uniform standards for exchange of PHI.

**Effective January 1, 2014:**

**Insurance Market Reforms:** Imposition of annual fee on health insurers. Requires insurers to issue and renew policies regardless of health status. Eliminates pre-existing condition limitations; premium rates can only vary based on age (with a maximum 3:1 ratio); geography, family size and tobacco use; eliminates annual and lifetime benefit limits on essential benefits.

**Exchanges:** Secretary must set standards for establishment and operation of exchanges and qualified health plans; establishment of health insurance exchanges in each state for purchase of qualifying policies by individuals and small groups in accordance with standards; transitional reinsurance program created for 2014, 2015 and 2016, which requires states to contract with nonprofit reinsurance entity that is funded by fees collected from insurers and provides payments to insurers covering high-risk individuals.

**Individual Mandate and Credits:** Requires most uninsured individuals to obtain insurance or pay penalty (\$95 in 2014, \$325 in 2015, \$695 or 2.5% of income in 2016 and indexed thereafter (with caps on penalties based on the cost of the lowest tier exchange plans). Tax credits are available for individuals and families above Medicaid eligibility and below 400% of federal poverty standard and reduced cost sharing for individuals and families between 100% and 400% of federal poverty standard.

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**Employer Mandate:** Employers with 50 or more employees that do not offer coverage must pay \$2,000 annually for each full-time employee in excess of 30 employees, as long as at least one employee received premium assistance tax credits. If employer does offer coverage but has at least one employee receiving the premium assistance tax credit, the employer must pay \$3,000 for each employee receiving the tax credit up to an aggregate cap of \$2,000 per employee.

**Increasing Medicaid Access:** Medicaid eligibility increases to 133% of federal poverty level of all non-elderly individuals; the federal government will pay 100% of cost of covering newly eligible individuals for 2014, 2015 and 2016.

**Presumptive Eligibility:** All hospitals that participate in Medicaid are permitted to make presumptive eligibility determinations.

**DSH Reductions:** DSH Medicaid payment reductions apply to states beginning in FY 2014; Medicare DSH payments are reduced as the number of uninsured patients is reduced, effective FY 2014.

**Hospital Pay for Performance:** Beginning in 2013, hospitals will have 1% withholds, phased up to 2% in 2017 and beyond; CMS will evaluate reporting programs and pay for performance phased in for LTCHs, IRFs, hospice, cancer hospitals and inpatient psych hospitals.

**Effective January 15, 2014:**

**Payment Advisory Panel:** A 15-member Independent Payment Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. Beginning in 2020, the Independent Payment Advisory Board is required to make binding biennial recommendations to Congress if the growth rate in overall health spending exceeds the growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare. Hospitals and hospice exempt through 2019.

**Effective January 1, 2017:**

**Large Group Exchanges:** States are allowed to permit large group coverage to be offered through exchanges.

**Medicaid Expansion Support:** Federal government support for Medicaid expansion of 95% of additional costs in 2017. Federal government support for Medicaid expansion of 94% of additional costs in 2018. Federal government support for Medicaid expansion of 93% of additional costs in 2019.

**Effective January 1, 2018:**

**Excise Tax on “Cadillac Plans”:** Excise tax is imposed on insurers if aggregate value of employer-sponsored health coverage per employee exceeds certain thresholds.

## 2. SOURCES OF REVENUE/MEDICARE AND MEDICAID REDUCTIONS

### A. Sources of Revenue:

<b>Source of Revenue</b>	<b>10 Year Impact from Source<sup>1</sup></b> (eff. date of implementing provision)
Medicare payroll tax increases	\$210 B (2013)
Industry fee on health insurers	\$60 B (2014)
Other/non-healthcare revisions	\$47 B
40% excise tax on high cost health plans	\$32 B (2018)

<sup>1</sup> 10-year estimates from Bank of America Merrill Lynch

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Industry fee on drug companies	\$27 B (2011)
2.3% excise tax on medical devices	\$20 B (2013)
Increase floor on medical expense deductibility (to 10%)	\$15 B (2013)
Limit FSAs to \$2,500	\$13 B (2013)
Revise definition of HSA/MSA expenses	\$5 B (2011)
Eliminate deduction for drug benefit subsidies	\$4.5 B (2013)
10% excise tax on indoor tanning	\$2.7 B (2010)
Increase tax on non-medical HSA distributions	\$1.4 B (2011)

### B. Medicare/Medicaid Reductions:

Reduction Provision <sup>2</sup>	10 Year Impact of Reduction <sup>1</sup> (eff. date of implementing provision)
Medicare provider MB reductions	\$157 B (2010)
Medicare Advantage payment reductions	\$136 B (2011)
Medicare Advantage interaction with FFS cuts	\$70 B (2012)
Medicare home health payment reforms/cuts	\$40 B (2011)
Medicaid drug rebate increases	\$38 B (2010)
Adjustment in calculation of Part B premiums	\$25 B (2011)
Medicare DSH reductions	\$22 B (2014)
Independent payment advisory board	\$16 B (2015)
Medicaid DSH reductions	\$14 B (2014)
Part D premium increases for high income	\$11 B (2011)
Follow-on biologics	\$7 B (2014)
Hospital readmission reductions	\$7 B (2013)
LTC pharmacy utilization reductions	\$5.7 B (2012)
Medicare imaging reforms	\$2.3 B (2011)

### 3. SUMMARY OF CHANGES FOR 501(c)(3) HOSPITALS

The health care reform bill made several changes to the Internal Revenue Code as it applies to 501(c)(3) state-licensed hospitals or organizations having hospital care as their principal purpose or function. These changes are as follows:

**A. Community Health Needs Assessment.** Tax-exempt hospitals will now need to conduct a community health needs assessment at least once every three years. The assessment must take into account input from those who represent the broad interests of the community served by the hospital, including persons having specialized knowledge or expertise in public health, and must be made available to the public. The hospital must also adopt an implementation strategy to meet the needs identified in the assessment. Hospitals that fail to comply with the community needs assessment provisions will be subject to a tax of \$50,000 per tax year. This requirement becomes effective for tax years beginning after March 23, 2012.

**B. Financial Assistance Policies.** Effective upon the first tax year beginning after March 23, 2010, hospitals must have written financial assistance policies that include (a) eligibility criteria, and whether care will be provided free of

<sup>2</sup> The provision closing the Medicare Part D “donut hole” adds an estimated \$43 B in costs over 10 years. This provision takes effect in 2010.

charge or at a discount, (b) the basis for calculating patient charges, (c) the method of applying for financial assistance, (d) if the hospital does not have a separate billing and collections policy, the actions the hospital may take in the event of non-payment, and (e) measures to widely publicize the policy within the community served by the hospital. Hospitals must also have a written policy requiring the provision of emergency care on a non-discriminatory basis, without regard to eligibility under the hospital's financial assistance policy.

**C. Limitations on Patient Charges.** Effectively immediately, hospitals must limit the amounts charged to patients qualifying for financial assistance to not more than the amounts generally billed to insured patients, and may not use gross charges.

**D. Limits on Collection Practices.** Effective immediately, hospitals may not use extraordinary collection actions before making reasonable efforts to determine whether a patient is eligible for assistance under the hospital's financial assistance policy (with "reasonable efforts" to be the subject of future regulations).

**E. Form 990 Changes.** Hospitals will need to include as part of their 990 annual returns, a description of how they are addressing the needs identified in their community health needs assessment and, as to needs not being addressed, an explanation as to why. Hospitals will also now be required to include audited financial statements with their returns, which will be subject to public disclosure along with the rest of the return

#### 4. PHYSICIAN DISCLOSURES FOR MRI

The health care reform legislation actually amends, effective January 1, 2010, the in-office ancillary services exception contained in the Stark legislation. The amendment requires a new mandatory notice for physicians who work for Medicare patients for MRI, CT or PET services. The notice must be provided at the time of the referral and in writing explaining that the patient may obtain such services from providers other than the physician making the referral to his or her group practice. The referring physician must also provide the patient with a written list of suppliers who furnish such services in the service area in which the patient lives.

Physicians who wish to rely on the in-office ancillary services exception to permit referral of Medicare patients to owned and operated MRI, CT and PET services should begin providing such notices immediately to patients. Physicians who own diagnostic services which are not considered in-office ancillary already must provide such notices to patients in writing pursuant to State law, RSA 125:25-a through 25-c.

#### 5. ILLINOIS HOSPITAL'S TAX EXEMPT STATUS DENIED

In 2006, the Illinois Department of Revenue denied Provena Covenant Medical Center's tax exempt status. Provena is a not-for-profit Illinois corporation that holds 501(c)(3) status under the Internal Revenue Code. Provena Hospitals operates Provena Covenant Medical Center's campus in Urbana. On March 18, 2010, the Supreme Court of Illinois upheld the Department of Revenue's decision.

The Supreme Court took a fairly broad position with respect to what an entity must do to be entitled to a charitable real estate property exemption under Illinois law. The Illinois property tax code provides real estate property tax exemptions for land that meets the following purposes: (1) owned by a public charitable institution; (2) it's actually exclusively used for charitable purposes; (3) the charitable institution has no capital, stock or shareholders; (4) the charitable institution earns no profits or dividends and holds all funds in trust for the purpose expressed in its charter; (5) the charitable institution dispenses charity to all who need it and apply for it; (6) the charitable institution does not provide gain or profit in a private sense to any person; and (7) the charitable institution does not appear to place any obstacle in the way of those who need and would avail themselves of its charitable benefits. Specifically the Court found that there were few charitable donations to the institution and there was no evidence that Provena dispensed charity to all who needed it.

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The Hospital did not advertise charitable care; balances left unpaid were automatically forwarded to collection agencies and waived only if a patient could prove that no other source of payment was available.

### 6. INDEPENDENT LAB BILLING

Independent labs can continue to bill for the technical component of physician pathology services furnished to the patients in hospitals for claims with dates of service on or after January 1, 2010 through December 31, 2010. The health care reform bill extends a moratorium which allows for such billing. This means the prohibition published in the November 2, 1999 Federal Register that would allow hospitals to bill for the technical component of physician pathology services furnished to hospital patients will not be enforced for a while longer.

### 7. THERAPY CAP EXCEPTIONS

NHIC Corp. issued an e-mail on April 1, 2010 explaining that for out-patient therapy services provided on or after January 1, 2010 through December 31, 2010, OT service providers may continue to submit claims with the KX modifier if an exception to the therapy cap is appropriate. Therapy caps are determined on a calendar year basis so all patients begin a new cap year on January 1, 2010. NHIC explains that for physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,860, and for OT services the limit is \$1,860.

### 8. PHYSICIAN FEE SCHEDULE UPDATE

There continues to be controversy over the physician fee schedules. NHIC Corp. has notified providers in New Hampshire that it will hold claims containing services paid under the Medicare Physician Fee Schedule including anesthesia services, for the first ten (10) business days of April. This hold will only affect claims with the dates of service April 1, 2010 and forward. NHIC concludes that the hold should have a minimum impact on provider cash flow because under the current law electronic claims are not paid any sooner than 14 calendar days after the date of receipt. Currently there is no legislation that directly repeals or revises the sustainable growth rate methodology for setting Medicare reimbursement to physicians. Absent congressional action, the SGR will result in a 21.2% reduction when the current extension expires in April 2010. Congress returns from break on April 12 and will consider H.R. 4851, which extends implementation of the cuts.

### 9. TORT REFORM

The Federal Reform legislation does not include any substantive reform to malpractice claims or litigation. For example, there are no provisions which suggest or encourage caps on non-economic damages such as was suggested by the American Medical Association and other physician groups. One section of the law does provide grant funding for state demonstration models to evaluate alternatives to current tort liability litigation. The models would be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. One provision does extend protection from liability contained in the Federal Tort Claims Act to certain free clinics, however, this will not benefit many physicians.

Currently in New Hampshire, the courts are split on whether unanimous panel decisions may be admitted as evidence to the jury. In addition, the state budget cuts will affect the judicial system and providers can expect delays in trial dates.

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### 10. COBRA EXTENSION

The U.S. Department of Labor has again updated model notice packages for group health plans and employers to provide appropriate notice on COBRA coverage premium reductions available through March 31, 2010. To qualify for the 35% subsidy of eligible individual COBRA premiums, individuals must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment. The involuntary termination must occur during the period that began September 1, 2008 and now ends on March 31, 2010. In addition, an involuntary termination of employment that occurs on or after March 2, 2010 but by March 31, 2010 and follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through March 31, 2010, is also a qualifying event. Premium reduction applies to periods of health coverage that began on or after February 17, 2009 and last for up to 15 months.

### 11. NH HEALTH AND HUMAN SERVICES RULEMAKING

#### A. Ambulatory Surgical Centers:

There will be a public hearing on new licensing regulations for ambulatory surgical centers (He-P 812) on April 19, 2010 at 1:30 pm in the Brown Building, Room 232. The proposed regulations include many requirements taken directly from the Medicare Rules of Participation. They are significantly more onerous and detailed than the current licensing regulations.

#### B. Quality Assurance:

Regulations implementing quality assurance policies and committees for physician practices were heard on Friday, April 9, 2010 at 11:00 am in the Brown Building. The comment period ends April 19, 2010. These regulations, He-P 401, are not significantly different than those that have been in effect for a period of time. The regulations outline what is required for a physician practice to develop and implement a quality assurance program and how to ensure that information discussed and submitted to the Quality Assurance Committee is not discoverable during litigation.

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