



Alert

Life Sciences and Health Care Client Service Group

To: Our Clients and Friends

March 24, 2010

Health Care Reform Alert: Matters Important to Providers and Suppliers

Late Sunday night, March 21, the House of Representatives took its final step toward comprehensive health care reform by passing the Senate health bill (H.R. 3590) and an accompanying reconciliation bill (H.R. 4872). On Tuesday, March 23, President Obama signed the Senate health bill, making it law (Public Law 111-148). The reconciliation bill is pending in the Senate and, upon passage, will be signed into law. The new law is the most sweeping legislative change to health care law in decades.

The new law's impact on coverage, insurers, tax increases, and employers has been widely reported. This Alert comments on the impact the law will have on providers and suppliers. The Medicare and Medicaid changes are an integral part of this analysis. Summarized below are some provisions of the health reform package that will impact providers and suppliers. These provisions will become effective at various dates, as specified below. Provisions which are only found in the reconciliation bill, and have not yet become law, are italicized.

Waste, Fraud, and Abuse

- Allows HHS to freeze supplier enrollment in categories identified as being at elevated risk of Medicare and Medicaid fraud (effective immediately)
- Requires that all Medicare and Medicaid enrolled providers and suppliers establish compliance programs meeting requirements determined by HHS (effective immediately)
- Increases data sharing among CMS and executive agencies for purposes of discovering fraud and abuse (effective immediately)
- Increases penalties for submitting false claims (effective January 1, 2010)
- Increases funding for anti-fraud investigation activities (effective immediately)
- Requires that manufacturers and group purchasing organizations disclose to HHS financial relationships with physicians (effective March 31, 2013)

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- Requires that physicians referring MRIs, CTs, and PETs to facilities with which they have a financial relationship inform patients in writing that they may obtain services from other suppliers and provide a list of such suppliers in order to qualify for the in-office ancillary services exception (effective immediately)
- Expands the Recovery Audit Contractor (“RAC”) program to Medicare Parts C and D and Medicaid (effective immediately)
- Requires that physicians meet with patients face to face before certifying eligibility for home health services or durable medical equipment under Medicare (effective immediately)
- Amends the Anti-Kickback law intent requirement to provide that a person need not have actual knowledge of the law or specific intent to violate the law (effective immediately)
- *Withholds payment on initial claims by newly enrolled durable medical equipment suppliers for 90 days where the supplier is within a category or geographic area determined by HHS to present a significant risk of fraudulent activity among durable medical equipment suppliers (effective January 1, 2011)*

Payment and Reimbursement

- Reduces Medicare payments to hospitals to account for preventable hospital readmissions (effective October 1, 2012)
- Reduces Medicare payments to hospitals for hospital-acquired conditions by 1% (effective October 1, 2014)
- Prohibits federal payments to states for Medicaid services related to hospital-acquired conditions (effective July 1, 2011)
- Reduces annual reimbursement increases for inpatient hospital, home health, skilled nursing facility, hospice, and other Medicare Part A providers (effective dates vary)
- Establishes performance-based payment program for hospitals (effective October 1, 2012)
- Requires HHS to develop plans to implement performance-based payment programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers (reports due to Congress January 1, 2011)
- Provides a Medicare 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015 (effective January 1, 2011)
- *Reduces Medicare Disproportionate Share Hospital payments by 75% and subsequently increases payments based on the percent of the hospital service area population that is uninsured and the amount of uncompensated care provided (effective October 1, 2013)*
- *Increases Medicaid fee-for-service and managed care payments for primary care services provided by primary care doctors to 100% of the Medicare payment rates for 2013 and 2014 (effective January 1, 2014)*

- *Restructures and reduces payments to Medicare Advantage plans by setting payments at varying percentages of Medicare fee-for-service rates (effective January 1, 2011)*
- *Caps total payments to Medicare Advantage plans at current levels (effective January 1, 2011)*

New Projects and Programs

- Grants providers organized as Accountable Care Organizations that voluntarily meet quality thresholds a share of the cost savings they achieve for Medicare (program to begin January 1, 2012)
- Creates an Innovation Center within CMS to test, evaluate, and expand different payment structures and methodologies (effective January 1, 2011)
- Establishes a Medicare pilot program to develop and evaluate payment for bundled services including inpatient hospital services, physician services, outpatient hospital services, and post-acute care services (program to begin January 1, 2013)
- Creates a Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and the risk of developing another condition, or at least one serious and persistent mental health condition, to designate a provider as a “health home” (a team that provides comprehensive services and care coordination), with the payment method determined by the state (effective January 1, 2011)
- Creates a Medicaid demonstration project to pay bundled payments for episodes of care (effective January 1, 2012)
- Creates an Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home (effective January 1, 2012)

Miscellaneous

- Closes the so-called donut hole in the Medicare Part D Prescription Drug Benefit Program (effective in multiple phases)
- Expands the 340B program to Children’s Hospitals, Critical Access Hospitals, and Rural Referral Centers (effective January 1, 2010)
- Creates a voluntary long term care insurance program financed by payroll deductions (effective January 1, 2011)
- Requires that tax-exempt hospitals conduct community benefit assessments every three years and adopt and implement strategies to meet identified needs (effective for taxable years after March 23, 2010)
- Requires that skilled nursing facilities implement compliance and ethics policies meeting requirements issued by HHS (effective March 23, 2013)
- *Imposes a 2.3% excise tax on the sale of most medical devices (effective December 31, 2012)*

We would be pleased to discuss the impacts of the health care reform legislation on your organization. Feel free to contact any member of the Life Sciences and Health Care Group listed below.

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