What Does Health Care Reform Mean For Physicians?

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Last month we saw historic changes made to our nation's health care system when President Obama signed into law the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (together, the "Act"). The Act will require the purchase of health insurance for nearly 95% of our nation's population which equates to roughly 32 million more insured Americans by 2014. Such an increase in insured Americans should spurn an increase in business for many physicians and physician group practices, though it will be quite some time before we fully understand the legislation's impact. Of course, in addition to requiring the purchase of health insurance by so many Americans, the Act also contains provisions that will affect almost every sector of the health care industry in several significant ways, including provisions relating to fraud and abuse, program integrity and quality of care.

This Alert focuses on some of the most significant provisions in the Act that relate to physicians and physician group practices (for purposes of this Alert, all references to "physicians" also apply to physician group practices), including those provisions that impact physicians in connection with their status as employers. It is worth noting that collectively the Act includes approximately 2,000 pages and contains more provisions and changes than can conceivably be covered in a manner that can be digested in a format such as this Alert. Accordingly, we have summarized only those provisions of the Act we believe are the most significant to physicians over the short and medium term, and we invite anyone with questions about other issues not covered in this Alert to contact us directly for more information. Further, we invite you to contact us directly if you have questions relating to the issues covered in this Alert, as in many cases this summary could raise questions not answered herein in the interest of brevity.

> Imaging Services Provided in a Physician's or a Physician Group Practice's Office

The Act requires that physicians providing MRI, CT and PET services in their offices pursuant to the Stark Law exception for in-office ancillary services immediately begin disclosing the identity of alternative providers of such services to their patients. Specifically, referring physicians must inform patients in writing at the time of the referral that the patient may obtain the services from a source other than the physician or the group practice and provide the patient with a written list of alternative suppliers in the area. While there is some debate as to whether the Act requires the disclosure now, as opposed to after regulations are promulgated, we believe the prudent course of action is to make the disclosure immediately. Also, the Act provides that the Secretary of the Department of Health & Human Services ("DHHS") may add other radiology services to this list in the future.

> Referrals for Durable Medical Equipment ("DME") and Home Health Services

Medicare has traditionally covered DME and home health services so long as a physician orders them and certifies that they are medically necessary. The Act tightens these requirements in certain respects. Specifically, in order to be covered under Medicare: (1) a face-to-face encounter between a patient and the ordering physician, nurse practitioner, physician assistant, or certified nurse specialist working in collaboration with the physician is required before DME or home health services are ordered (effective for services ordered or certifications made after January 1, 2010 for home health services and March 23, 2010 for DME); (2) the ordering physician must maintain and provide to DHHS as requested, documentation concerning orders or referrals for DME or home health services (effective for services ordered or physician certifications made after January 1, 2010); and (3) the ordering physician must be enrolled in the Medicare program (effective for DME or home health services ordered after July 1, 2010).

Health Care Reform

> Limitations of Physician Ownership in Hospitals

The Act imposes new strict limitations relating the to Stark Law exception that allows physicians to have ownership interests in hospitals to which they refer patients (commonly referred to as the "whole hospital exception"). The Act effectively bars future physician investment in hospitals, although it grandfathers hospitals that have physician investors as of the enactment date and have a provider agreement in effect as of December 31, 2010. Importantly, in addition to the previously mentioned grandfather requirements, the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physicians in the aggregate does not exceed such percentage as of the enactment date. In light of the preceding, there is some debate, however, as to whether the hospital must have physician investors as of the enactment date or as of December 31, 2010.

In addition, unless certain requirements outlined in the Act can be met, the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the enactment date can be no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of that date. Finally, additional requirements relating to the new limitations of the whole hospital exception include: (1) the submission by each hospital to the Secretary an annual report providing a detailed description of the identity of each physician owner or investor and any other owners or investors of the hospital and the nature and extent of all ownership and investment interests in the hospital; (2) the disclosure by any referring physician owner/investor to any referred patient that he/she has an ownership interest in the hopital; (3) the dis closure by the hospital on any public website of the hospital and in any public advertising for the hospital that the hospital is partially owned by physicians; and (4) before admitting the patient into the hospital, if the hospital does not provide a physician on the premises during all hours in which the hospital is providing services to such patient, the disclosure by the hospital of this fact to the patient and the hospital must receive from the patient a signed acknowledgement that the patient understands that fact.

> Expanding Access to Primary Care Services and General Surgery Services

In addition to the amount of payment that would otherwise be made for primary care services provided by a primary care practitioner on or after January 1, 2001 and before January 1, 2016 to aged and disabled individuals who are enrolled in the Supplementary Medical Insurance Program for the Aged and Disabled, the Act provides there shall also be paid (on a monthly or quarterly basis) an amount equal to 10% of the payment amount for the service, which should be paid from the Federal Supplementary Medical Insurance Trust Fund. Similarly, in addition to the amount of payment that would otherwise be made for major surgical services furnished by a general surgeon after January 1, 2001 and before January 1, 2016 to aged and disabled individuals who are enrolled in the Supplementary Medical Insurance Program for the Aged and Disabled, the Act provides there shall also be paid (on a monthly or quarterly basis) an amount equal to 10% of the payment amount for the service, which should also be paid from the Federal Supplementary Medical Insurance Trust Fund.

> Development of Stark Law Self-Referral Protocol

The Act requires the Secretary of DHHS to collaborate with the DHHS' Office of Inspector General ("OIG") in developing a self-referral disclosure protocol. The self-referral disclosure protocol instructions must be displayed on the Centers for Medicare and Medicaid Services ("CMS") website and must specify (1) the person, officer or office to whom such disclosure is to be made; and (2) the effect of such disclosure on any existing corporate integrity agreements and corporate compliance agreements. The Act also expressly authorizes the Secretary to compromise payment and penalty amounts owed for violations of the Stark Law, which is important because it was not clear whether CMS had the authority to reduce or compromise amounts owed under the Stark Law. Now under the Act, in determining whether to reduce amounts owed, the Secretary must consider the nature and extent of the improper or illegal practice, the timeliness of disclosure, the provider's cooperation and any other factors the Secretary deems appropriate.

> Reporting on Certain Physician Ownership or Investment Interests

Beginning on March 31, 2013, and continuing on the 90th day of each calendar year thereafter, the Act requires drug, DME, biological and medical supply manufacturers to report transfers of value made to physicians to the DHHS. Transfers of value may include consulting fees, compensation for services other than consulting, honoraria, gifts, entertainment, food, travel,

education, research, charitable contributions, royalty or license, current or prospective ownership or investment interest, direct compensation for serving as faculty or as a speaker for medical education programs, grants or other transfers defined by the Secretary. Among other exceptions, transfers of value shall not include gifts under $10, product samples, educational materials, and loans of a device of less than 90 days.

> Physician Quality Reporting Initiative

The Act extends the Physician Quality Reporting Initiative ("PQRI") program until 2014 for physicians reporting quality data to Medicare. The Act provides that an additional .5% Medicare payment bonus will be given to physicians who successfully report quality measures to CMS via the new Maintenance of Certification program, and beginning in 2014 physicians who do not submit those measures will have their Medicare payments reduced. The Act also establishes an informal appeals process for providers seeking review of a denial for unsatisfactory data submission, provides for submitting satisfactory data and establishes a means for participation for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine. The Act seeks to coordinate ongoing PQRI and electronic health records quality reporting efforts. Finally, the Act requires the Secretary to integrate reporting on quality measures with reporting requirements for the meaningful use of electronic health records.

> Medicare Shared Savings Program and Accountable Care Organizations

The Act requires the Secretary to establish a shared savings program ("Program") that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery no later than January 1, 2012. Under the Program, groups of providers and suppliers that meet specific requirements set forth by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization ("ACO"). The ACOs that meet quality-of-care targets and reduce the costs of their patients relative to spending benchmarks will be rewarded with a share of the savings they achieve for the Medicare program.

> Improvements to the Physician Quality Reporting System

The Act requires specified new types of reports and data analysis under the physician feedback program, and expands Medicare's physician resource use feedback program to provide for development of individualized reports by 2012. The reports will compare the per capita utilization of physicians to other physicians who see similar patients, and the reports will be risk-adjusted and standardized to take into account local health care costs.

> Value-Based Payment Modifier under the Physician Fee Schedule

The Act establishes a value-based payment system which will be phased in starting in 2015 that adjusts Medicare fee schedule payments based on the quality of care furnished compared to costs during a given performance period. Pursuant to the Act, measures for quality and cost will be established by the Secretary.

> Required Implementation of Compliance Program

The Act requires providers (including physicians and physician group practices), as a condition of enrollment in Medicare, Medicaid, or CHIP, to establish a compliance program that contains core elements to be established by the Secretary. The Secretary shall determine the timeline for the establishment of the core elements and the date of the implementation of the compliance program.

> Overpayment Liabilities for Medicare Providers

The Act imposes new obligations on Medicare providers (including physicians and physician group practices) to report and return overpayments within the latter of 60 days of the date the overpayment was identified or the date any corresponding cost report is due. The Act also requires the provider to notify the entity to which the overpayment is returned in writing of the reason for the overpayment. Under the Act, an overpayment is defined as "any funds that a person receives or retains under [the Medicare or Medicaid Act] to which the person, after applicable reconciliation, is not entitled." In addition, the failure to report and return an overpayment becomes an "obligation," which, under recent amendments contained in the Fraud Enforcement and Recovery Act, can form the basis of a claim under the False Claims Act. The False Claims Act penalties are potentially severe and include triple the amount of the damage to the government plus penalties of up to $5,500 to $11,000 per claim. Finally, under the Act a failure to pay an overpayment can be grounds for

Health Care Reform

exclusion from the Medicare/Medicaid program.

> Enhanced Medicare and Medicaid Program Integrity Provisions

The Act gives the OIG authority to obtain information from a provider for the purposes of protecting the integrity of Medicare and Medicaid. Such information may include any supporting documentation necessary to validate claims for payment.

> Period for Submission of Medicare Claims Reduced to 12 Months

Beginning January 2010, the Act reduces the maximum period for submission of Medicare claims to not more than 12 months.

> Requirement for Physicians to Provide Documentation on Referrals to Programs at High Risk of Waste and Abuse

Beginning January 1, 2010, the Act give the Secretary of DHHS the authority to revoke enrollment of a physician or supplier (for no more than 1 year) if such physician or supplier fails to maintain and 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 upon request by the Secretary. The OIG has the authority to exclude individuals or entities that order, refer, or certify the need for health care services that fail to provide adequate documentation to verify payment.

> Enhanced Penalties for Failure to Provide the OIG Access to Documents

Under the Act, persons who fail to provide the OIG access to documents for the purpose of audits, investigations, or evaluations in a timely manner is subject to a civil money penalty of $15,000 for each day of failure. Further, persons who knowingly make, use, or cause to be made or used any false statement to a Federal health care program would be subject to a civil money penalty of $50,000 for each violation.

> Small Business Tax Credit

The Act adds a new tax credit to encourage small businesses to offer private health insurance to employees and to pay at least 50% of the cost of that coverage. The credit is available only to employers with 25 or fewer full-time equivalent employees earning an average of $50,000 or less per year. Seasonal employees are not counted for this purpose. For an employer with 10 or fewer full-time equivalent employees, the credit is equal to 35% of the employer's contribution to the cost of the premium. The credit is phased out for employers with more than 10 full-time equivalent employees, but not more than 25. If the premiums for the coverage exceed a "small business benchmark premium" to be determined by the federal government, the credit will be computed by reference to the benchmark premium rather than the actual premium. In addition, the credit is reduced if the average compensation of the qualifying employer's full-time equivalent employees' exceed $25,000. In those cases, the reduction is computed by multiplying the otherwise available credit by a fraction, the numerator of which is the full-time equivalent employees' average compensation in excess of $25,000 and the denominator of which is $25,000.

Under the Act, the credit is not refundable. Rather, it may be applied against the alternative minimum tax liability. Notwithstanding, the credit may be carried back one year and may be carried forward for 20 years.

The credit is available for the years 2010 through 2013. Effective in 2014, the credit will be available only with respect to employers that purchase coverage through a state insurance exchange established under the Act. The credit will increase from 35% to 50%, and will be available through 2016.

> Employer Requirement to Inform Employees of Coverage Options

Under the Act, an employer is required to provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013) written notice which must inform the employee: (1) of the existence of a State insurance exchange established under the Act (an "Exchange"), including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance; (2) that he/she may be eligible for a tax credit under certain circumstances; and (3) that he/she will lose the employer contribution (if any) to any health benefits plan offered

by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes if the employee purchases a qualified health plan through the Exchange.

> Shared Responsibility for Employers Regarding Health Coverage

Under the Act, if a large employer (defined as an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year) fails to offer to its full-time employees (and their dependents) the opportunity to enroll in a minimum essential coverage under an eligible employer-sponsored plan, the employer must pay a penalty equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month. The number of individuals employed by a large employer as full-time employees during any month shall be reduced by 30 for purposes of calculating this payment amount.

In the case of any large employer which requires an extended waiting period (more than 60 days) to enroll an employee in any minimum essential coverage under an employer-sponsored plan, the employer must pay a penalty of $600 for each full-time employee to whom the extended waiting period applies.

If a larger employer offers the opportunity to enroll in an eligible employer-sponsored plan and one or more full-time employees have enrolled in a plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee for any month, then the employer must pay a penalty equal to the number of employees having enrolled in a plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid times $250.00 for such month.

> Reporting of Employer Health Insurance Coverage

The Act requires certain large employers to file a return with the Internal Revenue Service ("IRS") in a form and in a time to be determined that contains the following information: (1) a certification as to whether the employer offers its full-time employees (and their dependents) the opportunity to enroll in employer-sponsored plan meeting certain minimum requirements; (2) the length of any waiting period with respect to such coverage; (3) the months during the calendar year in which coverage was available; (4) the monthly premium for the lowest cost option in each enrollment category under the plan; (5) the employer's share of the total allowed costs of benefits provided under the plan; and (6) such other information that may be required by regulations to be promulgated.

> Protections for Employees

The Act prohibits an employer from discharging or in any manner discriminating against any employee because the employee has: (1) received a tax credit or received any subsidies; (2) provided to the employer, the Federal Government, or an Attorney General of a State information relating to any violation, or any act or omission the employee reasonably believes to be a violation of, any provision of the Fair Labor Standards Act; (3) testified, assisted or participated, or is about to testify, assist or participate in a proceeding concerning a violation of the Fair Labor Standards Act; or (4) objected to, or refused to participate in, any activity that the employee reasonably believed to be in violation of the Fair Labor Standards Act. An employee that believes that he or she has been discharged or discriminated against in this manner may seek relief by filing a complaint with the Secretary of Labor within 180 days of the violation.

> Inclusion of Cost of Employer-Sponsored Health Coverage on Employee's W-2

For taxable years beginning after December 31, 2010, the Act requires employers to include the aggregate cost of applicable employer-sponsored coverage on each employee's W-2.

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