

**DuaneMorris**

**The Impact of the Federal Healthcare Reform Law on Healthcare Providers**

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**PPACA**

- Patient Protection and Affordable Care Act ("PPACA") was signed on March 23, 2010
- In April 2010, Health Care and Education Reconciliation Act of 2010 adopted numerous changes to PPACA
- Currently being challenged by a majority of the states
- Implementation timeline: From enactment through 2018
- "Coverage law"

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**Today's Topics**

- Insurance Reform
- Changes to False Claims Act/Enforcement
- New Rules for Tax-Exempt Hospitals
- New Rules for Providers as Employers
- Impact on Payment Issues
- Update on Legal Challenges

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Insurance Reform

- Private Insurance Policy Reforms
- High Risk Pools/Pre-Existing Conditions
- Wellness
- Any Willing Provider
- New Insurance Markets for Individuals & Small Employers
- Individual/Family Premium Subsidies
- Coverage Mandate

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Private Insurance Policy Reforms

- Certain health insurance policy provisions are now required for all health insurance policies (except for grandfathered plans), including:
  - ✓ Prohibition on lifetime limits or aggregate annual limits
  - ✓ Prohibition on non-renewal of coverage, except for fraud or breach of policy
  - ✓ Prohibition on pre-existing condition exclusions
  - ✓ Extension of coverage to adult dependents up to age 26, under parents' policies
  - ✓ Mandatory coverage of certain preventative care (immunizations for children, etc.)
  - ✓ Prohibition on offering different types of coverage based on employees' salaries, which favor high-salaried employees

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Private Insurance Policy Reforms (cont.)

- Secretary of HHS to develop standards for summary of benefits and coverage explanation, to enable "apples to apples" comparisons by consumers (starting March 2012)
  - ✓ Proposed regulations/templates were published in August 2011
- States must track and publish all complaints and problems with health insurers and educate consumers on their rights and obligations under health insurance policies
- Grants available to states to establish offices of health insurance consumer assistance

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Private Insurance Policy Reforms (cont.)

- Secretary of HHS and states must monitor and report on excessive premium increases. Health insurers must give rebates to insureds if their administrative costs exceed 15% of premium for large group health insurance policies and 20% for individual and small group policies
- PPACA imposes limitations on surcharging individual and group premiums for the small group market
  - ✓ Policies may only consider rating individuals by individual or family, the community in which the insured is located, the age of each insured and whether they use tobacco

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High Risk Pools/Pre-Existing Conditions

- Federal government has established a high risk pool program ("Pre-existing Condition Insurance Plan (PCIP)") for individuals who:
  - ✓ Have not been covered for 6 months prior to applying for coverage through the high risk pool
  - ✓ Have a pre-existing condition defined by the Secretary of HHS
  - ✓ Are U.S. citizens
- States or non-profit entities may apply for federal funding to become qualified high risk pools
- As of August 31, 2011, 33,958 individuals were enrolled in PCIP programs (PA had the most – 3,926)
- Will be superseded in 2014, by insurance exchanges

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High Risk Pools/Pre-Existing Conditions (cont.)

- Group health plans and health insurance issuers offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll, based on any of the following health status-related factors:
  - ✓ Health status
  - ✓ Medical condition (including physical and mental)
  - ✓ Claims experience
  - ✓ Receipt of health care
  - ✓ Medical history
  - ✓ Genetic information
  - ✓ Evidence of insurability
  - ✓ Disability
  - ✓ Any other health status-related factor determined appropriate by the Secretary of HHS

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**Wellness**

- Employers may reduce premiums by up to 30% for employees that participate in smoking cessation programs, join and participate in a fitness center, undertake periodic health education seminars and participate in other programs that encourage prevention
- PPACA also provides funding for states to provide demonstration wellness programs

**Any Willing Provider**

- PPACA requires insurers to contract with any provider willing to accept the rates and other conditions offered by the insurer's health plan

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**New Insurance Markets for Individuals & Small Employers**

- PPACA provides for creation of insurance exchanges, which are state marketplaces for sale of health insurance policies for individuals and group market for small employers
- Each exchange will have to offer a set of standard health insurance policies that assume a different percentage of risk and are sold at four different price points:
  - ✓ "bronze" plan (covers 60% of the risk)
  - ✓ "silver" plan (covers 70% of the risk)
  - ✓ "gold" plan (covers 80% of the risk)
  - ✓ "platinum" plan (covers 90% of the risk)

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**New Insurance Markets for Individuals and Small Employers (cont.)**

- Each policy covers minimum set of benefits, within at least the following categories:
  - ✓ Ambulatory patient services
  - ✓ Emergency services
  - ✓ Hospitalization
  - ✓ Maternity & newborn care
  - ✓ Mental health & substance use disorder services, including behavioral health treatment
  - ✓ Prescription drugs
  - ✓ Rehabilitative & habilitative services and devices
  - ✓ Laboratory services
  - ✓ Preventive & wellness services and chronic disease management
  - ✓ Pediatric services, including oral & vision care

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**New Insurance Markets for Individuals and Small Employers (cont.)**

- Exchanges must pay providers for improved outcomes and according to pay-for-performance formulas
- Each exchange must have a "navigator" that provides mandated consumer information including an online portal

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**New Insurance Markets for Individuals and Small Employers (cont.)**

<http://www.statehealthfacts.org> (as of November 9, 2011), on Exchange Status:

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**Individual/Family Premium Subsidies, Coverage Mandate**

- PPACA provides for reduced out-of-pocket expenses and premium credits for individuals with incomes up to 400% of the federal poverty level
- Premium subsidies will limit premium costs to between:
  - ✓ 2% of household income, for families and individuals at 133% of poverty level, and
  - ✓ 9.5% of household income, for families and individuals at 400% of poverty level
- Individuals who remain uninsured for more than three months must pay yearly penalty of the greater of 2.5% of household income or \$695 per person (max. of \$2,085/family)
- Penalties phased in from 2014 to 2016

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Changes to the False Claims Act/Enforcement

PPACA made changes to the False Claims Act:

- Changes to the "Public Disclosure Bar"
- Changes to definition of "Original Source"
- Increased actionable claims

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Changes to the False Claims Act/Enforcement

Changes to the "Public Disclosure Bar"

- Prior to the PPACA, courts did not have jurisdiction to hear *qui tam* lawsuits based on information that was publicly disclosed unless the whistleblower was an "original source" of the information.
- Now, a court shall dismiss a *qui tam* action based on publicly disclosed information where the whistleblower is not an original source of the information *unless the government opposes the dismissal*.

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Changes to the False Claims Act/Enforcement

Changes to Definition of "Public Disclosure"

- Information from state proceedings and private actions eliminated.
- Public disclosure is now limited to information "(i) in a *Federal* criminal, civil or administrative hearing *in which the Government or its agent is a party*; (ii) in a Congressional, Government Accountability Office, or other *Federal* report, hearing, audit or investigation; or (iii) from the news media. (emphasis added).

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Changes to the False Claims Act/Enforcement

Changes to Definition of "Original Source"

- Previously, direct and independent knowledge of the information was required
- PPACA expands the definition to be someone who either:
  - voluntarily discloses the information to the government prior to the public disclosure ;or
  - who has "knowledge that is independent of and materially adds to the has publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action . . . ."

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Changes to the False Claims Act/Enforcement

Increase in Actionable Claims under the FCA:

- A violation of the Anti-kickback Statute now constitutes a false or fraudulent claim under the FCA.
- Now it is easier to violate the Anti-kickback Statute – actual knowledge of the statute or intent to commit a violation are no longer required.
- Delaying the refund of a known overpayment beyond 60 days can result in liability under the FCA.

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Changes to the False Claims Act/Enforcement

Examples of Enforcement/Program Integrity

- Increased funding to fight fraud and abuse in Medicare and Medicaid
- Monitoring of Federal healthcare programs for evidence of fraud and abuse
- Recovery Audit Contractor (RAC) Program expanded
- Mandatory compliance programs for providers and suppliers
- Enhanced penalties

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**Changes to the False Claims Act/Enforcement**

**Examples of Enhanced Penalties:**

- Up to three times the amount claimed for any false statement, omission, or misrepresentation of a material fact in an application, bid, or contract to participate in a Federal healthcare program as a provider or supplier
- Up to \$50,000 for each false record or statement material to a false or fraudulent claim for payment for items or services furnished under a Federal healthcare program
- Up to \$15,000 for each day timely access is denied to HHS for the purposes of an audit, investigation or evaluation

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**New Rules for Tax-Exempt Hospitals**

**Section 501(c)(3) of Internal Revenue Code**

- Creates a category of organizations that:
  - ✓ Are exempt from federal income tax
  - ✓ Can receive charitable contributions that are deductible by the donor
  - ✓ Are eligible for tax-exempt bond financing
- Applies to several sub-categories of exempt organizations: one is "hospitals"

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**New Rules for Tax-Exempt Hospitals**

**PPACA creates new Section 501(r) of IRC**

- Affects Section 501(c)(3) hospitals
- Basic provisions of IRC § 501(r):
  - ✓ Community Health Needs Assessments
  - ✓ Financial Assistance Policy
  - ✓ Limitation on Charges
  - ✓ Billing and Collection Requirements

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### New Rules for Tax-Exempt Hospitals

- Community Health Needs Assessment
  - ✓ Must be conducted every three years
  - ✓ Hospital must adopt implementation strategy to meet needs identified in assessment
  - ✓ Take into account input from persons who represent broad interests of community, including public health experts
  - ✓ Must be made widely available to public
  - ✓ Organizations with multiple hospitals:
    - Must perform assessment for each hospital facility
    - Will not be treated as exempt for any facility that does not comply

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### New Rules for Tax-Exempt Hospitals

- Written Financial Assistance Policy
  - ✓ Eligibility for financial assistance (free or discounted care)
  - ✓ Basis for calculating amounts charged
  - ✓ Method for applying for financial assistance
  - ✓ Actions taken in event of nonpayment (e.g., collections actions or reporting to credit agencies)
  - ✓ Measures to widely publicize in community

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### New Rules for Tax-Exempt Hospitals

- Limitation on Charges
  - ✓ Amounts charged for emergency or other medically necessary care to individuals eligible for financial assistance cannot exceed "lowest amount generally billed" to individuals with insurance coverage
  - ✓ Cannot use "gross charges"
  - ✓ What is the "lowest amount generally billed"?
    - Lowest rate paid by commercial insurance
    - Average of three lowest commercial rates
    - Medicare rate
    - Cannot use "chargemaster" rates

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### New Rules for Tax-Exempt Hospitals

- **Billing and Collection Requirements**
  - ✓ Prohibits using "extraordinary collection efforts" before making "reasonable efforts" to determine eligibility for financial assistance under policy
  - ✓ What are "extraordinary collection actions"?
    - Lawsuits
    - Liens on residences
    - Arrests
  - ✓ What are "reasonable efforts"?
    - Notification of financial assistance policy upon admission
    - Written and oral communications about the bill
    - Must occur before collection action or report to credit agencies

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### New Rules for Tax-Exempt Hospitals

- **Penalties for Non-Compliance**
  - ✓ \$50,000 excise tax for failure to perform community needs assessment
  - ✓ Loss of tax exemption
- **Effective Dates**
  - ✓ Community health needs assessment: Tax years beginning on or after April 1, 2012
  - ✓ Everything else: Tax years beginning on or after April 1, 2010

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### New Rules for Providers as Employers

#### Overview of Changes

- Employers will be required to make changes to their health plans in order to comply with the insurance reforms
- Employers will be incentivized to provide insurance to employees

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**New Rules for Providers as Employers**

**Affordable Insurance Options for Small Employers**

- New insurance markets for small employers to increase affordable options.
- Establishes state-based Small Business Health Options Programs ("SHOP")
  - In 2014, small businesses with up to 100 employees can purchase qualified coverage in a SHOP.
  - In 2017, states will have the option of allowing business with more than 100 employees to participate.

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**New Rules for Providers as Employers**

**Penalties and the Provision of Insurance**

- No mandate that employers provide health insurance for their employees
- But, certain employers that do not offer coverage or offer coverage that does not meet certain minimum requirements will face penalties starting in 2014

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**New Rules for Providers as Employers**

**Penalties and the Provision of Insurance**

- Penalties for large employers that do not offer coverage and have at least one full-time employee that receives a tax credit or cost sharing reduction toward a plan purchased through an Exchange
  - Large employers – at least 50 full-time equivalent employees in the prior calendar year
  - Penalties will be \$2,000 multiplied by the number full-time employees, excluding the first 30 employees

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**New Rules for Providers as Employers**

**Penalties and the Provision of Insurance**

- Penalties for large employers that do offer coverage but have at least one full-time employee that receives a tax credit or cost sharing reduction toward a plan purchased through an Exchange will face penalties
  - Penalties will be \$3,000 multiplied by the number of employees who received a tax credit or cost sharing reduction
  - Maximum penalty of \$2,000 multiplied by the number of full-time employees, excluding the first 30 employees

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**New Rules for Providers as Employers**

**Increase in Employer Responsibility for the Provision of Insurance**

- Automatic enrollment
  - Applies to employers with more than 200 full-time employees that offer a health insurance plan starting in 2014
- Written notice to employees
- Reporting of information to the government

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**New Rules for Providers as Employers**

**Tax Credits for Small Businesses that Provide Insurance**

- Small employers that cover at least 50 percent of the cost of health insurance coverage for their employees are eligible to receive a tax credit to offset the cost of providing coverage
  - A small employer is defined as an employer with no more than 25 full-time equivalent employees with average annual wages of \$50,000.

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**New Rules for Providers as Employers**

**Tax Credits for Small Businesses that Provide Insurance**

- Maximum credit is 35 percent of a small business's premium contributions in 2010 and 50 percent in 2014
  - 25 and 35 percent respectively for tax-exempt businesses
- Maximum credit goes to employers with 10 or fewer full-time equivalent employees and average annual wages of less than \$25,000
- Credit phases out for other small employers

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**Impact on Payment Issues**

- Accountable Care Organizations (Medicare Shared Savings Program)
- National Pilot Program on Payment Bundling
- Value-Based Incentive Payments to Hospitals under Inpatient Prospective Payment System ("PPS")
- Nonpayment for Readmissions
- Disproportionate Share Hospital ("DSH") Adjustment
- Physician Payments

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**Accountable Care Organizations (Medicare Shared Savings Program) ("ACOs")**

- Program is to commence on January 1, 2012
- ACO is a group of providers of services and suppliers working together to manage and coordinate care for Medicare fee-for-service beneficiaries
- Providers of services and suppliers that are part of an ACO can continue to receive traditional Medicare fee-for-service payments, and are eligible for additional payments based on meeting specified quality and savings requirements
- "Three-part aim":
  - ✓ Better care for individuals
  - ✓ Better health for populations
  - ✓ Lower growth in expenditures

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**Accountable Care Organizations (cont.)**

- Key elements of ACO model involve:
  - ✓ A team of hospitals, physicians and other professionals
  - ✓ A designated Medicare fee-for-service population that accepts the ACO as its caregiver
    - Patients are assigned to an ACO based on their primary care physician
    - A primary care physician may only participate in a single ACO; specialists may participate in multiple ACOs
  - ✓ A set of performance and quality benchmarks against which the ACO's financial performance is measured
  - ✓ A formula for sharing savings among the professionals when the ACO performs better than the agreed-upon performance and quality benchmarks
- Participation in an ACO is completely voluntary

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**Accountable Care Organizations (cont.)**

- Entities that are eligible to form an ACO include:
  - ✓ Professionals in group practice arrangements (i.e., physicians, nurse practitioners, physician assistants and other healthcare practitioners)
  - ✓ Networks of individual practices or independent practice associations
  - ✓ Partnerships or joint ventures between hospitals and physicians and other professionals
  - ✓ Hospitals employing physicians and other professionals
  - ✓ Critical Access Hospitals (CAHs)
  - ✓ Rural Health Clinics (RHCs)
  - ✓ Federally Qualified Health Centers (FQHCs)

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**Accountable Care Organizations (cont.)**

- ACOs must:
  - ✓ Enter into a 3-year agreement with the Secretary of HHS
  - ✓ Create a structure that is legally authorized to receive and distribute payments for shared savings to professionals, hospitals and other service providers
  - ✓ Have the necessary leadership and management structure that includes clinical and administrative systems
  - ✓ Define processes that promote evidence-based medicine and patient engagement
  - ✓ Collect data on cost and quality
  - ✓ Coordinate the delivery of patient care using telehealth, remote patient monitoring and other types of distance medicine
  - ✓ Perform patient and caregiver assessments to demonstrate to the Secretary of HHS that the ACO is patient-centered

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Accountable Care Organizations (cont.)

- Two different "tracks" for organizations wishing to become ACOs:
  - ✓ "One-sided risk model": Sharing of savings only for all 3 years, but no sharing of losses
  - ✓ "Two-sided risk model": Providers and government share in savings and losses for all 3 years (but shared savings payments to ACO are greater than in one-sided model)
  - ✓ ACO may choose either model, but may not switch between models
  - ✓ After initial 3-year period, all ACOs will be under "two-sided model"
- ACOs must also collect data and report on utilization and costs, clinical processes, clinical outcomes and patient and caregiver care experience

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Accountable Care Organizations (cont.)

- Proposed ACO regulations were released in late March 2011, with 60-day comment period
- Reaction was mainly negative, with many large providers stating that they would not participate in ACO formation unless major changes were made
- General sense was that shared savings payments were not enough to overcome the high costs of establishing an ACO
- Final regulations were released in October 2011
- Fairly significant changes were made based on comments received
- On November 10, CMS released the Medicare Shared Savings Program Application for 2012
  - ✓ Applications for 4/1/12 start date are due by 1/20/12
  - ✓ Applications for 7/1/12 start date are due by 3/30/12

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National Pilot Program on Payment Bundling

- PPACA requires the Secretary of HHS to establish, by January 1, 2013, a pilot program for "integrated care during an episode of care provided to a beneficiary around a hospitalization"
- Goal is to improve coordination, quality and efficiency of health care services
- Hospital will receive a "bundled" payment covering all care provided to the patient during the period starting 3 days before admission and ending 30 days after discharge
- Payment is intended to cover:
  - ✓ Acute inpatient care
  - ✓ Physician services
  - ✓ Post-acute care services, such as nursing home, skilled nursing and inpatient rehabilitation services

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**Value-Based Incentive Payments to Hospitals Under Inpatient Prospective Payment System ("PPS")**

- PPACA provides for additional payments to hospitals based on performance on measures selected by Secretary of HHS, beginning in federal FY 2013
- Measures must cover at least:
  - ✓ Acute myocardial infarction
  - ✓ Heart failure
  - ✓ Pneumonia
  - ✓ Surgeries
  - ✓ Healthcare-associated infections
- For each federal FY, Secretary is to establish performance standards for measures

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**Value-Based Incentive Payments to Hospitals Under Inpatient Prospective Payment System (cont.)**

- Hospital that meets or exceeds performance standards for performance period will receive additional payment for each discharge
- Additional payment is determined by multiplying the base operating diagnosis-related group ("DRG") payment by the hospital's value-based incentive payment percentage, which is based on hospital's performance score
- Value-based incentive payments are funded by reducing base operating DRG payment amounts by specified percentage that increases each year during FYs 2013-17

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**Nonpayment for Readmissions**

- Hospitals paid under Medicare PPS will be subject to reductions in Medicare payments beginning October 1, 2012, if they are unable to prevent certain Medicare patients from being readmitted
- Payments to hospitals will be reduced when patients with three specific "high volume" and "high cost" conditions (i.e., heart attack, heart failure and pneumonia) are readmitted for those conditions
- Base DRG payments could be reduced by as much as 1% in 2012, 2% in 2014 and 3% in 2015 and thereafter if hospitals are unable to prevent such readmissions

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**Disproportionate Share Hospital ("DSH") Adjustment**

- PPACA revises the formula for computing Medicare DSH adjustment payments to hospitals
- DSH payments are made to hospitals that provide a disproportionately high amount of uncompensated care
- Beginning in federal FY 2014, a hospital will receive 25% of the amount of payment it would otherwise have received under the existing DSH adjustment statute
- But, hospital will receive an additional DSH payment based on the product of the following factors:
  - ✓ Reduction in hospital's DSH payment
  - ✓ Change in number of uninsured individuals under age 65
  - ✓ Amount of uncompensated care provided by hospital, relative to other DSH hospitals

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**Physician Payments**

- Physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for office, nursing facility and home visits comprise at least 60% of their total Medicare charges will be eligible for 10% bonus payment for these services from FYs 2011-2016
- General surgeons who operate in a health professional shortage area ("HPSA") will also be eligible for 10% bonus payment for their services from FYs 2011-2016
- Incentive payments of 1% in FY 2011 and 0.5% from FY 2012 to 2014 will continue, for voluntary participation by physicians in the Physician Quality Reporting System (formerly known as the "Physician Quality Reporting Initiative" or "PQR")
- Beginning in FY 2015, a physician's payments will be reduced if the physician does not successfully participate in the PQRS program (in 2015, the penalty will be 1.5%, and in subsequent years 2%)

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**Update on Legal Challenges**

**District Court and Appellate Level Challenges To Healthcare Reform Law**

- The most frequently challenged provision is the law's individual mandate provision
- Court decisions have varied in their interpretation of the constitutionality of the law
  - Some courts have found part of or all of the law unconstitutional
  - Some courts have upheld the law as constitutional
  - Some courts have dismissed challenges based on a finding that the court lacked jurisdiction

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Update on Legal Challenges

Overview of Appellate Level Challenges

- 6 cases in the circuit courts have been decided
- Fourth (two cases), Ninth and Third Circuits dismissed challenges based on lack of standing or jurisdiction
- Circuit split in the Eleventh and Sixth Circuits regarding the law's constitutionality under the Commerce Clause
  - U.S. Supreme Court review likely

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Update on Legal Challenges

11<sup>th</sup> and 6<sup>th</sup> Circuits Split on Constitutionality

- *Florida v. U.S. Dep't of Health and Human Servs.*, No. 11-11021 (11th Cir. Aug. 12, 2011)
  - Holding: The individual mandate provision is an unconstitutional exercise of Congress' power under the Commerce Clause of the United States Constitution
  - Court refused to hold the entire Act unconstitutional, ruling instead that the individual mandate provision is severable from the rest of the Act

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Update on Legal Challenges

11<sup>th</sup> and 6<sup>th</sup> Circuits Split on Constitutionality

- Eleventh Circuit Analysis:
  - Act is unprecedented, expansive in scope, and does not contain cognizable limits
  - Not a sufficient nexus between decisions to abstain from purchasing health insurance and commerce
  - "what Congress cannot do under the Commerce Clause is mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die"

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Update on Legal Challenges

11<sup>th</sup> and 6<sup>th</sup> Circuits Split on Constitutionality

- *Thomas More Law Ctr. v. Obama*, No. 10-2388 (6th Cir. June 29, 2011)
  - Holding: The individual mandate provision is constitutional under the Commerce Clause.
  - On July 26, 2011, petition for certiorari filed
  - Analysis:
    - The provision regulates an economic activity—the practice of self-insuring for the cost of healthcare
    - Congress had a rational basis for determining that such a practice, in the aggregate, substantially affected interstate commerce

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Update on Legal Challenges

Other Circuit Court Decisions

- *Virginia ex rel. Cuccinelli v. Sebelius*, No. 11-1058 (4th Cir. Sept. 8, 2011)
  - Holding: Virginia did not have standing to challenge the individual mandate provision
    - Constitutionality not considered
  - Analysis
    - The individual mandate did not impose obligations on the sole plaintiff, Virginia
    - The individual mandate did not threaten the enforceability of the Virginia Health Care Freedom Act

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Update on Legal Challenges

Other Circuit Court Decisions

- *Liberty University, Inc. v. Geithner*, No. 10-2347 (4th Cir. Sept. 8, 2011)
  - Holding: The court did not have jurisdiction because the lawsuit amounted to a "pre-enforcement action seeking to restrain the assessment of a tax"
    - Challenge to the individual and employer penalties
  - Analysis:
    - The penalties constituted a tax under the Internal Revenue Code
    - The Anti-Injunction Act prohibits lawsuits that attempt to restrain the assessment or collection of a tax

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Update on Legal Challenges

Other Circuit Court Decisions

- *Baldwin v. Sebelius*, No. 10-56374 (9th Cir. Aug. 12, 2011)
  - Holding: The court held that plaintiffs did not have standing to challenge the Act
  - Analysis:
    - Baldwin did not show injury in fact—he did not allege that currently lacks health insurance or claim that he must save money to purchase insurance
    - The Pacific Justice Institute did not allege that the individual mandate provision applied to it

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Update on Legal Challenges

Other Circuit Court Decisions

- *New Jersey Physicians Inc. v. Obama*, No. 10-4600 (3d Cir. Aug. 3, 2011)
  - Holding: The plaintiffs did not have standing to challenge the individual mandate provision
  - Analysis:
    - There were no allegations that the patient was presently affected or that the physician would be affected by the Act
    - The association had identified only one member, the physician, who himself had not experienced any injury

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Update on Legal Challenges

U.S. District Court for the Middle District of Pa.

- *Goudy-Bachman v. U.S. Dep't of Health and Human Servs.*, No. 10-cv-763 (M.D. Pa. Sept. 13, 2011)
  - Holding: The individual mandate provision is unconstitutional
  - The court ruled that the provision is severable from the rest of the Act and therefore did not strike down the entire Act

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**Update on Legal Challenges**

**U.S. District Court for the Middle District of Pa.**

- Analysis
  - Rejected the distinction between regulation of activity or inactivity in its Commerce Clause analysis
  - An "anticipatory mandate"
    - "a mandate in anticipation of the receipt of health care services that forces individuals to become market participants prior to entering the market or engaging in any conduct, activity or transaction in that market."
  - Commerce Clause does not allow Congress to reach "a pre-transaction stage"

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**Update on Legal Challenges**

**Challenges to Other Provisions**

- *Physician Hospitals of America v. Sebelius*, No. 6:10-cv-277 (E.D. Tex. March 31, 2011).
  - The case challenged the provision limiting the ability of physician-owned hospitals to bill Medicare for services provided to patients referred by a physician owner
    - Raised due process, equal protection, void for vagueness, and takings arguments
  - Holding: The provision is not unconstitutional and Congress acted with a rational basis
  - Appeal pending in the Fifth Circuit

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**Questions?**

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