

Health Care Reform Journey Continues as Supreme Court Ponders Law's Fate

Highlights

- ✓ Progress in the private health insurance market as ACA is implemented
- ✓ Most states have taken some action to implement the reform law
- ✓ Providers start process of establishing ACOs for Medicare
- ✓ Fraud and abuse prevention under reform law steps up

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More than two years have passed since the enactment of the Patient Protection and Affordable Care Act and its companion bill, the Health Care and Education Reconciliation Act of 2010 (collectively, ACA). During that time, the three federal agencies responsible for implementing the law (IRS, EBSA, HHS) have issued a plethora of regulations, guidance, notices and model forms on many of the law's provisions. In addition, the agencies have delayed the implementation of some provisions, and Congress has repealed others. States have been active during the past two years as well, enacting various types of reform-related laws. All of these reform-related activities—and others—continue as the nation awaits the Supreme Court's decision on the law's fate.

The following briefing is divided into two main sections. The first examines the aspects of ACA that primarily impact the private insurance market, employers, and individuals seeking to purchase health insurance. The second part primarily focuses on the Medicare and Medicaid programs. In both parts, the analysis goes beyond explaining the law as it stood in March 2010 but emphasizes the specific ways the ACA has been implemented at both the federal and state levels.

Private Insurance Market, Employers, and Individuals

Market reforms

Adult child coverage. A well-known provision of the ACA that took effect September 23, 2010, was the extension of dependent coverage. Group health plans or issuers that make available dependent coverage of children must make such coverage available for children until they reach 26 years of age. Group health plans may not use student status, marital status, residency, or financial support from a parent to deny or restrict dependent coverage to children. The tax exclusion for employer-provided health benefits has been extended to include an adult child who, as of the end of the taxable year, has not attained age 27.

Comment: *Because the ACA did not amend Code Sec. 223, which governs Health Savings Accounts (HSAs), it appears that HSAs cannot reimburse medical expenses for adult children on a tax-free basis unless the child otherwise qualifies as a tax dependent of the account holder (in other words, the law before health reform). Any HSA reimbursements for medical expenses of adult children would be treated as nonqualified reimbursements subject to income inclusion and penalties.*

Since September 2010, the percentage of adults ages 19 to 25 covered by a private health insurance plan has increased significantly, with approximately 2.5 million more young adults with insurance coverage compared to the number of young adults who would have been insured without the ACA, according to data released from the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC). These estimates show that from September 2010 to June 2011, the percentage of young adults ages 19 to 25 with insurance coverage increased from 64% to 73%.

Annual and lifetime limits. Another provision that has been in effect since September 23, 2010, is the prohibition on lifetime or annual limits on the dollar value of benefits for any participant or beneficiary. However, the annual limit prohibition on the dollar amount of benefits that are “essential health benefits” is being phased in for plan years beginning prior to January 1, 2014. Interim final rules establish the following minimum limits:

- \$1.25 million, for a plan year beginning on or after September 23, 2011, but before September 23, 2012; and
- \$2 million, for plan years beginning on or after September 23, 2012, but before January 1, 2014.

Comment: *A list of the “essential health benefits” is located at Sec. 1302 of the ACA. Although the agencies have not issued regulations on this provision yet, on December 16, 2011, HHS released a bulletin describing the approach it plans to take in future rulemaking about essential health benefits. Subsequently, it released 22 frequently-asked-questions (FAQ) that arose from the bulletin ([Frequently Asked Questions on Essential Health Benefits Bulletin](#)).*

The restriction on annual limits does not apply to flexible spending accounts (FSAs), HSAs or medical savings accounts (MSAs). Health reimbursement arrangements (HRAs) also have been exempted from the annual limit restrictions.

Rescissions. The ACA also limited the extent to which a group health plan or health insurance issuer can rescind — or retroactively cancel or discontinue — coverage. Rescission may occur only when an individual seeking coverage (or a person or group plan seeking coverage on behalf of that individual):

- commits fraud;
- makes an intentional misrepresentation of material fact (as prohibited by the terms of the plan or coverage); or
- fails to timely pay required premiums.

The rule provides a “federal floor” with respect to what types of rescissions may occur. If state laws are more protective of individuals — for example, if rescissions are permitted only in cases of fraud — such a law would not conflict with the federal standard and would apply.

Within months after ACA’s enactment, the agencies issued regulations providing rescission examples. One example is as follows:

ACA’s preventive care provision provided approximately 54 million Americans with at least one new free preventive service in 2011.

Inadvertent failure to disclose. John Doe seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires John to complete a questionnaire regarding his prior medical history, which affects the rate set by the health insurance issuer. John inadvertently fails to list that he visited a psychologist on two occasions, six years previously. John is later diagnosed with prostate cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about John’s visits to the psychologist, which was not disclosed in the questionnaire.

Under the ACA, the plan cannot rescind John’s coverage because his failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Preventive care. ACA’s preventive care provision provided approximately 54 million Americans with at least one new free preventive service in 2011 through their private health insurance plans, according to HHS. The provision also generated controversy over contraceptive coverage.

Group health plans and issuers must provide coverage (without any cost sharing) for certain preventive health services including, at minimum:

1. evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). Services with a rating of A or B include screening and counseling to reduce alcohol misuse, aspirin therapy for certain men age 45 to 79 years and women age 55 to 79 years, assorted pregnancy-care screenings, screening for depression, cholesterol abnormalities, anemia, hypothyroidism, obesity, colorectal cancer, tobacco use, and visual acuity in children;
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. with respect to women, any additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

Pursuant to HRSA guidelines, new health plans must include the following preventive services for women without cost sharing for insurance policies with plan years beginning on or after August 1, 2012:

- well-woman visits;
- screening for gestational diabetes;
- human papillomavirus (HPV) DNA testing for women 30 years and older;
- sexually-transmitted infection counseling;
- human immunodeficiency virus (HIV) screening and counseling;
- FDA-approved contraception methods and contraceptive counseling;
- breastfeeding support, supplies, and counseling; and
- domestic violence screening and counseling.

Group health plans sponsored by certain religious employers are exempt from the requirement to provide contraceptive services. However, the definition of “religious employer” is narrow and excludes some nonprofit employers, such as religious hospitals and universities. For these nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan, the HHS has provided time to comply with the contraceptive services provision. These employers have until the first plan year that begins on or after August 1, 2013, but must provide certification that they qualify for the delayed implementation. (Similar coverage for preventive care applies to Medicare beneficiaries; see discussion below in the Medicare section.)

Medical loss ratio. In the summer of 2012, health insurance enrollees might notice the effect of one of ACA’s provisions on their wallets. Health insurance issuers must submit data on the proportion of premium revenues spent on clinical services and quality improvement; ACA calls this the medical loss ratio (MLR). They must issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% or 85% of premium dollars on medical care. Estimates indicate that up to 9 million Americans could be eligible for rebates worth up to \$1.4 billion, according to HHS. Rebates are expected to go to almost one-third (31%) of consumers in the individual market. Among employers, about one-quarter (28%) of the small group market and 19% of the large group market is projected to receive rebates, according to an analysis from the Kaiser Family Foundation.

Reporting and disclosure

Appeals process. Although ACA’s new standards for health care internal claims and appeals and external review took effect six months after the law’s enactment, the EBSA provided an enforcement grace period until plan years beginning on or after January 1, 2012. But now, plans – including some non-ERISA plans (such as plans for employees of state and local governments and church groups) – must comply with the standards.

Group health plans and health insurers must have an “effective” process for appeals of coverage determinations and claims, including an internal claims appeal process and employee notification. This appeals process must include, at a minimum, the following:

- an established internal claims appeal process;
- a notice to participants, in a “culturally and linguistically appropriate manner,” of available internal and external appeals processes, including the availability of assistance with the appeals processes, such as an applicable office of health insurance consumer assistance or ombudsman; and
- a provision allowing an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeals process.

Comment: *The new rules expand on the themes reflected in the old ERISA rules, according to Edward Fensholt, JD, and Mark Holloway, JD, Directors of Compliance Services, Lockton Benefit Group of Lockton Companies, LLC. The rules require the explanation of the decision on the claim or the appeal to include more information. The*

new rules also prohibit making hiring, compensation or promotion decisions regarding claim payers (or medical experts consulted in the context of adjudicating claims) contingent on the likelihood that they'll deny the claim.

SBC. Compliance with another of ACA's new reporting and disclosure requirements is on the horizon. Beginning on September 23, 2012, group health plans and health insurers must provide a Summary of Benefits and Coverage (SBC) that clearly and accurately describes the benefits and coverage under the applicable plan or coverage. The summaries must be in a uniform format, using easily understood language, and must include uniform definitions of standard insurance and medical terms. The explanation also must describe any cost-sharing, exceptions, reductions, and limitations on coverage, and use examples to illustrate common benefits scenarios.

In February 2012, the agencies issued a final rule implementing the SBC requirements and also published templates, instructions and a *uniform glossary*, which group health plans and issuers must make available to participants and beneficiaries.

Comment: *During the first year of applicability, the agencies will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations, according to FAQs About Affordable Care Act Implementation Part VIII, Q2.*

Forms W-2. To provide useful and comparable consumer information to employees on the cost of their health coverage, employers must report the aggregate cost of applicable employer-sponsored coverage on employees' 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers are generally required to give employees by the end of January 2013 and then file with the SSA). Note that the IRS made this informational reporting requirement optional for 2011 Forms W-2. In addition, reporting is not required for 2012 Forms W-2 for any employer required to file fewer than 250 2011 Forms W-2.

Exemptions

Grandfathered plans. While many plans have been scrambling to comply with ACA's provisions, some plans have been trying to remain exempt from the law. Certain group health plans and health insurance coverage that were in effect as of ACA's enactment and that make no

prohibited changes in plan provisions are subject only to certain provisions of the ACA. These plans are called grandfathered health plans.

Only one-third of employers have maintained grandfathered status despite a desire to remain grandfathered, according to *The Health Care Reform Survey 2012* released by the Willis Human Capital Practice. The rate at which respondent employers have lost grandfathered status has far out-paced HHS' expectations for 2012, the survey found.

Waivers. To protect coverage for workers in limited benefit plans and mini-med plans until more affordable and more valuable coverage is available in 2014, the ACA provided HHS with the authority to issue temporary waivers from the annual limit requirements. Plans that received waivers must comply with all other provisions of the law and must alert consumers that the plan has restrictive coverage and includes low annual limits. Additionally, these waivers are temporary and after 2014, no waivers of the annual limit provision are allowed.

As of January 6, 2012, HHS had provided annual limit waivers to 1,722 organizations covering more than 3.3 million employees. This was the last round of waivers that will be granted, and these waivers will extend through the end of 2013.

Delays and repeals

Nondiscrimination rules. In addition to some of the enforcement delays mentioned previously, the IRS has delayed the application of the nondiscrimination requirements in the ACA until regulations are issued. Insured group health plans and plans that are not grandfathered must comply with the Code Sec. 105(h) nondiscrimination requirements, including rules that the plan does not discriminate in favor of highly compensated individuals as to eligibility to participate. In addition, the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals.

CLASS program. The ACA established the Community Living Assistance Services and Supports (CLASS) program, which was intended to be a national voluntary insurance program for purchasing community living assistance services and supports. In a letter to Congressional leaders on October 14, 2011, Kathleen Sebelius, the HHS Secretary, indicated that the CLASS program will not be implemented. According to Sebelius, actuarial analysis presented to Congress "does not identify a benefit plan that I can certify as both actuarially sound for the next 75 years and consistent with the statutory requirements."

Free choice vouchers. The ACA also had included a provision requiring employers who offer minimum essential coverage under the law to employees, and who pay any portion of the cost, to provide free choice vouchers to each qualified employee. Employees who are exempt from ACA's individual mandate, but who do not qualify for premium subsidies, would have been eligible for a voucher equal to the amount the employer would have spent on individual or family coverage.

However, the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) repealed the free choice voucher provision.

1099 reporting. On April 14, 2011, President Barack Obama signed into law a bill repealing the Form 1099 reporting requirement contained in the ACA. The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (P.L. 112-9) repealed expanded information reporting on Form 1099 for certain business payments and rental property expense payments. The law also contains an offset provision to pay for the cost of repeal, estimated at approximately \$25 billion over 10 years.

The ACA included among its revenue raisers an expansion of business information reporting. Section 9006 of the ACA required businesses, charities and government entities to file a Form 1099 when they make annual purchases aggregating \$600 or more to a single provider of goods, other than to a vendor that is a tax-exempt organization, for payments made after December 31, 2011, and reported in 2013 and thereafter. The ACA also repealed the long-standing reporting exception for payments made to corporations. P.L. 112-9 repeals the expanded information reporting requirements for business payments as if Section 9006 of the ACA had not been enacted.

States

Almost all of the states have begun implementing parts of the ACA, according to a report from the Commonwealth Fund. Forty-nine states plus the District of Columbia have either (1) passed new legislation, (2) issued a new regulation, (3) issued new subregulatory guidance (such as a bulletin), or (4) are actively reviewing insurer policy forms for compliance with the early market reform protections of ACA.

Twelve states passed new legislation or issued new regulations that addressed all ten of the reforms in the Patient's Bill of Rights (i.e., the early market reforms, such as the extension of dependent coverage). The District of Columbia and 11 states passed a new law or issued a new

regulation on at least one early market reform. Only one state, Arizona, did not take any of the four actions listed, according to the Commonwealth Fund.

Medicare and Medicaid

The Patient Protection and Affordable Care Act (ACA) included 165 provisions affecting the Medicare program. These provisions were designed to reduce costs, increase revenues, improve certain benefits, combat fraud and abuse, and initiate a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce its costs to Medicare.

The ACA also included several provisions affecting Medicaid, including expanding benefits, streamlining the process for enrolling in Medicaid, and expanding programs to fight fraud and abuse. The discussion below highlights only some of the programs for which additional regulations or guidance has been issued to implement the law.

Accountable Care Organizations

The Centers for Medicare and Medicaid Services (CMS) created a shared savings program to promote accountability for a patient population, coordinate items and services under Parts A and B, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Accountable care organizations (ACOs), composed of a group of providers, will be rewarded with a share of this savings program for providing high quality of care and/or care at lower costs relative to a spending benchmark.

CMS issued a Final rule on November 2, 2011 (76 FR 67802), implementing the ACO program. ACOs can participate in a "one-sided shared savings-only" model where savings only are shared in the first two years and both savings and losses in the third year for the entire length of their first agreement period. After the minimum savings rate is met, the one-sided risk model provides a maximum sharing percentage of 50 percent for ACOs, but the maximum sharing percentage is 60 percent for ACOs in the "two-sided" model where both savings and losses are shared for all three years. There is no minimum threshold for two-sided models, and their payment cap is 10 percent of an ACO's benchmark.

Alternatively, should the per capita cost per beneficiary exceed two percent above the benchmark, shared losses would result to ACOs. There is a cap on the amount

of shared losses an ACO would be liable for, that being five percent of the benchmark for the first year of the program, 7.5 percent in the second year, and 10 percent in the third. ACOs will be required to meet certain quality performance standards.

The following types of groups of providers of services and suppliers are eligible to participate: (1) ACO professionals in group practice arrangements; (2) networks of individual practices of ACO professionals; (3) partnerships or joint venture arrangements between hospitals and ACO professionals; (4) hospitals employing ACO professionals; (5) rural health clinics (RHCs); (6) federally qualified health centers (FQHCs); (7) certain critical access hospitals (CAHs); and (8) other groups of providers of services and suppliers as the Secretary determines appropriate.

Comment: *As of April 2012, there are 65 ACO initiatives operating across the country. These include 32 Pioneer Model ACOs that were announced in December 2011, six Physician Group Practice Transition Demonstration organizations that started in January 2011, and 27 ACOs operating in 18 states under the shared savings program detailed above.*

Value-based purchasing program

A value-based purchasing (VBP) program for hospitals participating in Medicare will launch in fiscal year 2013. This program will link Medicare payments more closely to health care quality. A percentage of hospital payment will be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program will be developed and chosen with input from external stakeholders.

The law also called for VBP programs for critical access hospitals, skilled nursing facilities, ambulatory surgical centers, psychiatric hospitals, rehabilitation hospitals and physicians. Implementation for these VBP programs has not progressed for these entities as far as it has for inpatient hospitals.

Comment: *CMS published a Final rule implementing this program on May 6, 2011 (76 FR 26490); the program will start at the beginning of fiscal year 2013 (October 1, 2012). In FY 2013, an estimated \$850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction. The Final rule includes a list of 13*

measures for which hospitals will have to demonstrate that they have followed best clinical practices and enhanced patients' experiences of care to qualify to receive incentive payments. The list includes 12 clinical process of care measures, as well as the requirement that hospitals collect data through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey.

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Payment bundling

The Secretary of HHS will develop a national voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. The program will begin by January 1, 2013, for a period of five years.

CMS started accepting applications to participate in this demonstration program in August 2011 (Notice, 76 FR 53137, August 25, 2011). Four broadly defined models of care will be used by the CMS Innovation Center during the demonstration project. Three models involve a retrospective bundled payment arrangement and one model would pay providers prospectively.

In the retrospective bundled payment models, CMS and providers would set a target payment amount for a defined episode of care. Participants would propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the original Medicare fee-for-service (FFS) system, but at a negotiated discount.

At the end of the episode, the total payments would be compared with the target price and participating providers would then be able to share in those savings. The bundled payments across providers for multiple services would act as an incentive for providers to coordinate and ensure continuity of care across settings.

In the prospective bundled payment model, CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians and other practitioners. Under this model, physicians and other practitioners would submit “no pay” claims to Medicare and will be paid by the hospital out of the bundled payment.

Hospital readmissions reduction program

Beginning in fiscal year 2012, inpatient prospective payment system (IPPS) hospital payments will be adjusted based on the dollar value of each hospital’s percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum.

This program was implemented by the fiscal year 2012 inpatient hospital prospective payment Final rule (76 FR 51476, August 18, 2011). Beginning FY 2013, with discharges on or after October 1, 2012, hospitals that have excess readmissions for acute myocardial infarction (or heart attack), heart failure, and pneumonia will see their Medicare payments reduced. The program is designed to provide hospitals with an incentive to reduce preventable hospital readmissions and improve care coordination.

Comment: “Readmission” means admission to an acute care hospital (ACH) within 30 days of a discharge from that same ACH. The readmission adjustment factor could potentially cause a 0.3 percent reduction in overall payments to hospitals, amounting to \$300 million in savings.

Related to this program, physician assistants working in collaboration with a physician are now authorized to certify the medical necessity for post-hospital skilled nursing care services. *Medicare Benefit Policy Manual*, Pub. 100-02, Transmittal No. 153, January 13, 2012, and *Medicare General Information, Eligibility, and Entitlement Manual*, Pub. 100-01, Transmittal No. 76, January 13, 2012, both implemented this provision

Center for Medicare and Medicaid Innovation

A new Center for Medicare and Medicaid Innovation (CMI) was created to test innovative payment and service delivery models in an effort to reduce program

expenditures while preserving or enhancing the quality of care furnished to individuals.

CMI was launched in November 2010; its website is <http://innovations.cms.gov>. In its first year, CMI met with hundreds of outside innovators, held 10 regional meetings with over 4,000 attendees, and received nearly 500 significant proposals for improving health care payment and delivery through the “Innovation Portal” on its website. CMI’s first projects include two demonstrations testing Advanced Practice Primary Care. Eight states have been selected to participate in a test of an integrated health home model in which Medicare, Medicaid and some private insurers will compensate physicians and other healthcare professionals for coordination and integration of care across the health care system. When fully implemented, this Multi-Payer Advanced Primary Care Practice Demonstration is expected to serve one million Medicare beneficiaries through 1,200 medical homes.

A similar demonstration will test the use of teams of healthcare professionals in federally qualified health centers (FQHCs) to provide care for low-income patients. This demonstration is expected to involve 500 FQHCs and serve about 195,000 patients.

Comment: By March 2012, CMI had started almost 20 initiatives. In May 2012, CMI announced the first 26 Health Care Innovation award winners. These awards support projects at the community level designed to improve health care, strengthen the health care workforce, and save money.

Independent Medicare Advisory Board

The Independent Medicare Advisory Board (IMAB) was established to reduce the per capita rate of growth in Medicare spending and to make recommendations to Congress on how changes should be implemented to maintain or enhance beneficiary health care access.

Comment: In March 2012, the House of Representatives approved and sent to the Senate HR 5, which would repeal the IMAB. The Senate has not taken up the legislation.

Fraud and Abuse

Provider screening and other enrollment requirements. New and existing providers of medical or other items or services and suppliers participating in Medicare, Medicaid, and the Children’s Health Insurance Program

(CHIP) will be subject to new enrollment and revalidation requirements.

CMS issued a Final rule with comment period (76 FR 5862, February 2, 2011) to implement this section. Effective March 25, 2011, all providers participating in Medicare, Medicaid or the Children's Health Insurance Program will undergo screening before initial enrollment and will be required to revalidate their compliance with enrollment requirements every five years (every three years for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)). CMS may require any provider to revalidate and undergo screening, at any time. Three levels of risk are established (limited, moderate and high) and each type of provider is assigned to one of the three risk categories.

Comment: *CMS may suspend payments to any provider based on a "credible allegation of fraud," which may include calls to the hotline, law enforcement requests and data mining. Beginning March 25, 2011, providers initially enrolling in Medicare were required to pay an application fee. Current providers will have to pay the fee when they revalidate.*

Enhanced program integrity measures. CMS will include claims and payment data from various programs in its integrated data repository to combat fraud and abuse, in addition to overpayment and identifier requirements to enhance program integrity.

Under an Interim final rule with comment period, (75 FR 24437, May 5, 2010) providers are required to include their Medicare National Provider Identifier (NPI) on their Medicaid enrollment forms filed with the state. Claims for durable medical equipment prosthetics, orthotics and supplies (DMEPOS) may be made only if the written order for the item has been communicated by the ordering physician and the claim submitted by the supplier of the DMEPOS identifies the ordering physician by his or her legal name and NPI. Further, the physician or eligible professional who orders or refers must have Medicare-approved status in the Provider Enrollment, Chain and Ownership System (PECOS), even if he or she is enrolled only for the purposes of ordering or referring. PECOS is the national Medicare fee-for-service provider and supplier repository and contains verified credentials.

Comment: *Claims failing to contain the relevant NPI will be denied. A denial will be issued, instead of rejecting the claims, so that appeal rights may be preserved.*

Physician self-referral disclosure protocol. Within six months of enactment, the Secretary of HHS, in cooperation with the HHS Office of Inspector General, was required to establish a self-referral disclosure protocol (SRDP) to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.

CMS may suspend payments to any provider based on a "credible allegation of fraud," which may include calls to the hotline, law enforcement requests and data mining.

CMS released the protocol in September 2010, and then updated it in May 2011.

Comment: *Since February 2011, CMS has announced settlements in eight SRDP cases involving hospitals and physician groups.*

Physician-owned hospitals. Physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, are prohibited from participating in Medicare. Such hospitals that have a provider agreement prior to December 31, 2010, may continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, patient safety issues, and expansion limitations. Inpatient acute care hospitals have new requirements to qualify under either the rural provider or hospital ownership exceptions to the kind of physician ownership or investment interest that would result in prohibition of referrals by the physician to that entity.

The Final rule with comment period, (76 FR 74122, November 30, 2011), regarding the outpatient hospital prospective payment system for 2012, set forth the process for a hospital to request an exception to the prohibition on expansion of facility capacity.

Expansion of the RAC program. States must contract with recovery audit contractors (RACs) by December 31, 2010, and the RAC program will be expanded to include Medicare Parts C and D by that date as well.

CMS has issued letters and transmittals since ACA was enacted providing further guidance to states and private entities involved in Medicare Parts C and D on the expansion of the RAC program.

Physician Compare

The Secretary of HHS was charged with creating a Physician Compare website that contains information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative.

The Physician Compare Web site was launched December 30, 2010. It serves as a healthcare professional directory on Medicare.gov, the official U.S. Government Site for people with Medicare. The site currently allows individuals to search for a physician or other healthcare professional by specialty, type of professional, and location. Additional search criteria allow the user to search by gender and whether or not the healthcare professional accepts the Medicare-approved amount as payment in full on all claims.

Miscellaneous provisions

- Primary care practitioners and general surgeons practicing in health professional shortage areas will be provided with a 10 percent Medicare payment bonus for five years, for services rendered on or after January 1, 2011, and before January 1, 2016.
- ACA extended to the end of 2010 exceptions to limitations on medically necessary therapy and bonus payments made by Medicare for ground and air ambulance services in rural areas; these payments were further extended by later laws. It is unclear how these payment changes would be impacted if ACA was overturned.
- The law extended to the end of 2012 payment rules for long-term care hospital services and the moratorium on the establishment of certain hospitals and facilities.
- Similar to the provision noted above about preventive health services offered by private health insurers, the ACA defined preventive services and removed barriers to Medicare beneficiaries' use of such services

by waiving coinsurance and deductibles for most preventive services. Preventive health services for Medicare beneficiaries include screening and preventive services, preventive physical examinations, and personalized preventive plan services.

- Effective January 1, 2011, if a pharmacy's sales of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) have been less than 5 percent of its total pharmacy sales during the previous three calendar years, fiscal years, or other periods specified

Physicians practicing in health professional shortage areas will be provided with a 10 percent Medicare payment bonus for five years.

by the Secretary of HHS, or if the pharmacy has been issued a provider number by the Centers for Medicare and Medicaid Services as a supplier of DMEPOS for at least five years, then the pharmacy will not be subject to DMEPOS accreditation requirements. Pharmacies that wish to sell DMEPOS, but do not have such exemptions, must submit evidence of accreditation by January 1, 2011. *Medicare Program Integrity Manual*, Pub. 100-08, Transmittal No. 346, June 25, 2010, implemented this provision.

- Finally, there are many other provisions of ACA that are not directly related to either the insurance mandate or the expansion of Medicaid related to Medicare Program Integrity and enforcement activities such as mandatory compliance programs, recovery of overpayments, enhancements of the Office of Inspector General to exclude individuals who have violated the law that were implemented upon enactment. In addition, there are other provisions, which, by statute, will be implemented after 2012 and so far have had little further action taken on them.