

# Health care reform: What every physician should know

By Sidney S. Welch, J.D., M.P.H., and Jennifer Blakely, J.D., M.P.H., Arnall Golden Gregory LLP

**O**n March 23, 2010, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA) (Pub. L. No. 111-148). Subsequently, on March 30, 2010, President Obama signed a companion bill, H.R. 4872, to amend certain provisions contained in H.R. 3590 and to reconcile the Senate and the House versions of the legislation. This article provides a summary of the significant provisions of PPACA related to physicians and their practices.

**Elimination of Physician Ownership of Specialty Hospitals.** (Section 6001). PPACA includes strict limits and restrictions to the Physician-Self Referral Law (Stark) exception that allows physicians to have ownership interests in hospitals as long as their interests are in the whole hospital (Whole Hospital Exception) and effectively bars future physician investment in specialty hospitals. Notably, this provision grandfathers existing hospitals that had physician investment and a provider agreement in place as of December 31, 2010 and prohibits existing physician-owned hospitals from increasing either (a) the percentages of the total value of the ownership interests held in the hospital by physicians; or (b) the number of operating rooms, procedure rooms, and beds with some limited exceptions. These provisions also require the hospital to issue an annual report to the Secretary of the Department of Health and Human Services (HHS) identifying the owners/investors and the nature and extent of their ownership/investment interests. This information will be made publicly available on Center for Medicare and Medicaid Services' (CMS) Web site. Failure to make this disclosure may result in civil money penalties ranging from \$1,000 to \$1,000,000 or, if greater, 0.1 percent of the total annual revenues of the hospital. HHS will begin auditing for these requirements no later than May 1, 2012.

**Patient Notices Required for MRI, CT, PET Referrals.** (Section 6003). Stark generally prohibits physicians from referring patients for certain designated health services to an entity where the physician has a financial relationship. One of the exceptions to this general prohibition is where the referral is for "in-office ancillary services," which entails certain requirements.<sup>1</sup> PPACA amends this exception to include a requirement that, as of January 1, 2010, the referring physician must inform patients in writing, at the time of a referral, that the patients may obtain specified imaging services (MRI, CT, and PET), or other designated health services as designated by HHS (yet to be determined), from a person other than the referring physician or his/her group practice. Specifically, the referring physician must provide the patient with a written list of suppliers that furnish such services in the area in which the patient resides.

**Stark Self-Disclosure Protocol.** (Section 6409). PPACA instructs HHS to develop and implement a disclosure protocol for actual and potential Stark violations by September 23, 2010. HHS must collaborate with the OIG in developing this protocol, which it must display on the CMS Web site. PPACA also gives HHS the authority to compromise or adjust payment and penalty amounts due and owing for violations of the Stark Law based on factors such as the nature and extent of the improper or illegal practice, the timeliness of a disclosure, the provider's cooperation in supplementing information as needed, and any other factors HHS deems appropriate. Physicians should stay tuned for the more detailed instructions, which should be posted by the September 2010 deadline.

**Reporting of Gifts from Manufacturers.** (Section 6002). The Physician Payments Sunshine provisions of PPACA require that, by March 31, 2013, manufacturers that make a "payment or another transfer of value" to a physician or teaching hospital to report annually, in electronic form, specified information on such transactions to HHS. A "payment or transfer of value" is defined broadly to mean a transfer of anything of value, including but not limited to, consulting fees, honoraria, gifts, entertainment, food, travel, compensation for serving as faculty but does not include (a) a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service, where the applicable manufacturer is unaware of the identity of the covered recipient; or (b) where the transfer is valued at \$10 or less. These provisions do not supersede any corresponding state laws.

**Reporting of Ownership/Investment Interests in Manufacturers and Group Purchasing Organizations.** (Section 6002). In addition, beginning on March 31, 2013, manufacturers and group purchasing organizations (GPOs) must submit information to HHS identifying any ownership or investment interests (other than interests in a publicly traded security or mutual fund) held by a physician (or the physician's immediate family member) in the manufacturer or GPO during the preceding year. These provisions do not supersede any corresponding state laws.

**Compliance Programs Are Mandatory.** (Section 6401). PPACA requires providers and suppliers to establish a compliance program by a date to be determined by HHS and to include elements established by the Secretary of HHS. For physicians, the requirements may include some of the elements of the OIG Compliance Program for Individual and Small Group Physician Practices.<sup>2</sup>

**Provider Screening for Enrollment/Re-Enrollment.** (Section 6401). HHS is required to determine the appropriate level of screening for each category of provider/supplier. At a minimum,

(continued on page 24)

<sup>1</sup>See 42 C.F.R. § 355(b).

<sup>2</sup><http://oig.hhs.gov/authorities/docs/physician.pdf>

Do you *really*  
need a law firm  
with an office  
in Dubai?



While we don't have an office in Dubai,

### **Here's what we *do* have...**

- Over 130 attorneys, including one of the nation's largest teams of healthcare-dedicated attorneys
- More than 60 years of delivering practical, value-based business solutions
- Many of the country's best healthcare lawyers, as recognized in *The Best Lawyers in America*, *Super Lawyers*, *Chambers USA* and other independent peer ratings
- Extensive experience helping healthcare clients throughout the country face an array of complex regulatory and industry-related challenges

We believe prudent companies today are seeking quality over quantity and experience over extravagance.

**AGG... when you need the right lawyer.**

attorneys at law  
[www.agg.com](http://www.agg.com)  
404.873.8500



(continued from page 22)

all providers and suppliers will be subject to licensure checks, and HHS may impose additional screening measures, such as fingerprinting, criminal background checks, multi-state database inquiries, and random or unannounced site visits. HHS is also required to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their National Provider Identifier (NPI) on enrollment applications.

**More Money to Fight Fraud.** (H.R. 4872 Section 1303) Perhaps not surprisingly, as of 2011, PPACA provides additional funding to the tune of \$250 million for enforcement activities under the Medicare and Medicaid Integrity Program.

**Mandatory Obligation to Report Overpayments in 60 Days.** (Section 6402(d)). As of March 23, 2010, PPACA imposes a 60-day timeframe for a provider to report any overpayment to HHS, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, including the reason for the overpayment – both of which are significant changes. The clock starts to run as of the date the person knows of the overpayment or the date any corresponding cost report is due, if applicable. PPACA also imposes penalties for retention of the overpayment past this time deadline, as discussed herein.

**New, Shorter 12 Month Deadline for Submission of Medicare Claims.** (Section 6404). As of January 1, 2010, PPACA reduces the time period for filing a written request for payment from three calendar years to one calendar year for services provided under Medicare Parts A and B, with certain exceptions that HHS may specify.

**Physicians Who Order Items or Services Must be Medicare Enrolled Physicians or Eligible Professionals.** (Section 6405). For written orders and certifications made on or after July 1, 2010, PPACA requires physicians or eligible professionals who order DME or home health services to be enrolled in the Medicare program, otherwise, the Medicare contractor will reject the claim. This change strives to ensure that (1) orders and referrals will be written by qualified physicians and eligible professionals whose credentials would be verified as part of the Medicare provider/supplier enrollment process; and (2) certain abusive practices of falsely reporting identifiers in claims as being assigned to a specific ordering or referring physician or eligible professional when they are not, will be eliminated.

**Expansion of Civil Monetary Penalties.** (Sections 6402, 6408). PPACA provides additional grounds for civil monetary penalties, including penalties for making false statements on supplier enrollment applications; knowingly ordering or prescribing a medical item or service during a period of exclusion; knowingly fail to report and return an overpayment; knowingly submit false statements material to a false claim submitted for payment; and delaying inspections.

**Other Penalties.** (Sections 6406, 6402, 6501, 6502). PPACA gives HHS other disciplinary authority, including the ability to disenroll providers that fail to maintain and provide access to written orders or requests for payment for durable medical equipment (DME), certification for home health services, or referrals for other items and services to HHS. The same provision gives OIG permission to exclude individuals or entities

that order, refer, or certify the need for health care services and fail to provide adequate documentation to HHS to verify payment. PPACA also requires Medicaid agencies to exclude individuals or entities if they own, control, or manage an entity that: (1) has failed to repay overpayments during the period as determined by HHS; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation. Sections 6501 and 6502 of PPACA require States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program or if they own, control or manage an entity that has failed to repay overpayments during the period as determined by HHS; is suspended, excluded, or terminated from participation in any Medicaid program; or is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

**Fee-for-Service Being Transitioned to Values-Based Payments.** (Section 3007 as modified by Section 10327). PPACA contains a number of provisions regarding value-based payments for physicians. PPACA requires HHS to develop and implement a budget-neutral payment adjustment (i.e., payment modifier) that will vary Medicare payments to physicians and physician groups based on the quality and cost of the care they deliver. Quality of care would be evaluated on a composite of risk-adjusted measures of quality established by HHS, such as measures that reflect health outcomes. Costs, defined as expenditures per individual, would be evaluated based on a composite of appropriate measures of costs established by HHS that eliminate the effect of geographic adjustments in payment rates and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals and other factors determined appropriate by HHS).

**Modifications to the Physician Quality Reporting Initiative (PQRI)**<sup>3</sup>. (Section 3002). PPACA provides an additional 0.5 percent Medicare payment bonus to physicians who successfully report quality measures to CMS via a qualified Maintenance of Certification program. Eliminates the MA Regional Plan Stabilization Fund.

**Bundling Pilot Program.** (Section 3023). PPACA directs HHS to develop a national, voluntary pilot program encouraging hospitals, physicians, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. PPACA also requires HHS to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, HHS is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending.

**Sustainable Growth Rate (SGR).** PPACA did not address SGR payment fixes. Separate legislation is expected to address SGR.

**Payment for Imaging Services.** (Section 3135). PPACA reduces the equipment utilization rate, used for calculating Medicare Part B payments for advanced diagnostic imaging, from 90 percent to 75 percent, effective 2011. The equipment utilization percentage is used for setting practice expense relative value units. As to

single-session imaging, for services furnished on or after July 1, 2010, the multiple procedure payment reduction applicable to the technical component for imaging will be increased from 25 percent to 50 percent. Further, PPACA contains a provision for additional reduction in payment for multiple imaging procedures.

**Payment Increases for Primary Care Physicians and General Surgery Services.** (Section 5501). PPACA provides several incentives to strengthen the primary care workforce. Beginning on January 1, 2011, primary care practitioners (defined as physicians with a primary specialty designation of family, internal, geriatric, or pediatric medicine, or a nurse practitioner, clinical nurse specialist, or physician assistant, for whom primary care services accounted for at least 60 percent of allowed charges) are provided with a 10 percent Medicare payment bonus for five years for services relating to specified evaluation and management codes such as 99201-99215, 99304-99340, and 99341-99350. Further, all general surgeons who perform major procedures (with a 10- or 90-day global service period) in a health professional shortage area will be eligible for a 10 percent bonus payment for these services from 2011–2016. Section 1202 of H.R. 4872 provides that Medicaid payment rates to primary care physicians providing primary care services can be no less than 100 percent of Medicare Part B payment rates for 2013 and 2014 and further provides 100 percent federal funding for the incremental costs incurred by states in meeting this requirement.

**Geographic Adjustment Under the Medicare Physician Fee Schedule.** (Section 3102, H.R. 4872 Section 1108). The national average “floor” on Medicare’s geographic payment adjustment (commonly known as the GPCI) for physician work expired at the end of 2009. PPACA re-establishes that floor in 2010. In 2010 and 2011, Medicare will also reduce the GPCI adjustment for physician practice expenses in rural and low-cost areas. Further, beginning in 2011, the practice expense GPCI adjustment will be brought up to the national average for “frontier” states (Montana, North Dakota, South Dakota, Utah and Wyoming). Physicians in 56 localities in 42 states, Puerto Rico and the Virgin Islands will benefit from these geographic payment adjustments.

**Graduate Medical Education.** (Section 5508). PPACA authorizes the redistribution of current unused GME residency slots to qualifying hospitals to address physician shortages in rural and other underserved areas, especially in the areas of primary care and general surgery. PPACA also includes provisions that would provide more flexibility in the GME program to allow for training in outpatient settings and would preserve GME positions from closed hospitals based on certain criteria. Further, PPACA authorizes qualified teaching hospitals to be eligible for GME payments and would allow for teaching health centers development grants to enable newly accredited or to expand primary care medical residency programs meeting certain criteria. PPACA also establishes a graduate nurse education demonstration program in Medicare.

**Independent Payment Advisory Review Board.** (Section 3403 as modified by Section 10320). PPACA establishes an Independent

Payment Advisory Board (IPAB) to reduce Medicare payment updates for physicians and other providers under a new spending target system and fast track legislative approval process. The purpose of the IPAB is to provide Congress comprehensive proposals to reduce cost growth and improve quality of care for Medicare beneficiaries. The IPAB will be appointed by the President and confirmed by the Senate. Significantly, the IPAB is prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare standards for benefit, eligibility, and cost-sharing.

**Medicare Shared Savings Program/Accountable Care Organizations (ACOs).** (Section 3022). PPACA provides for the establishment of ACOs, which are groups of providers established to work together to manage and coordinate care for Medicare fee-for-service beneficiaries. ACOs that meet quality performance standards are eligible to receive payments for shared savings. HHS must establish appropriate measures to assess the quality of care in determining which organizations qualify for shared savings. These measures may incorporate reporting requirements and incentive payments related to the PQRI, including requirements and payments related to electronic prescribing, EHR, and other similar innovations.

**Medical Liability.** (Section 6801). PPACA provides that it is the sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance and states should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of

*(continued on page 26)*

## **Melvin M. Goldstein, P.C.** **ATTORNEY AT LAW**

**248 Roswell Street  
Marietta, Georgia 30060**

**Telephone 770/427-7004**

**Fax 770/426-9584**

**[www.melvinmgoldstein.com](http://www.melvinmgoldstein.com)**

- **Private practitioner with an emphasis on representing healthcare professionals in administrative cases as well as other legal matters**
- **Former Assistant Attorney General for the State of Georgia and Counsel for professional licensing boards including the Composite State Board of Medical Examiners**
- **Former Administrative Law Judge for the Office of State Administrative Hearings**

<sup>3</sup>PQRI includes an incentive payment to eligible professionals who satisfactorily report data on quality measures. MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5 percent of total allowable charges under the physician fee schedule in 2007 and 2008 to 2 percent in 2009 and 2010.

(continued from page 25)

prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. PPACA further provides that Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

**Donut Hole Coverage.** With respect to the prescription drug coverage, H.R. 4872 provides a \$250 rebate for all Medicare Part D enrollees who enter the "donut" hole (i.e., where the beneficiary must pay for all prescription drug spending out of pocket) in 2010, and will receive their payment no later than the 15th day of the third month following the end of the quarter. Each enrollee is limited to one payment.

**Other Miscellaneous Provisions.** In addition, PPACA contains several other provisions that impact physicians such as the following:

- Physician assistants are permitted to order post-hospital extended care services. (Section 3108).
- Payment for dual-energy x-ray absorptiometry services (i.e., bone density tests) in 2010 and 2011 is restored to 70 percent of the Medicare rate paid in 2006. (Section 3111).
- A physician must have a face-to-face encounter with a patient before the physician may certify eligibility for home health services or durable medical equipment. (Section 6407).

- Beginning January 2011, PPACA provides complete coverage under Medicare for annual personalized prevention plan services beginning after a beneficiary's initial year of enrollment. (Section 4103 as modified by Section 10402).
- Medicare will begin to cover the entire cost of most preventive health care services beginning in January 2011. Beneficiary coinsurance requirements and deductibles will be waived for personalized prevention plan services and covered preventive services when such services are recommended by a grade A or B by the U.S. Preventive Services Task Force in all settings. (Section 4104 as modified by Section 10406).

---

*Sidney S. Welch, J.D., M.P.H., is a partner at Arnall Golden Gregory, LLP who concentrates on representing physicians and physician groups in all legal aspects of their practices on a national basis. She can be reached at [sidney.welch@agg.com](mailto:sidney.welch@agg.com).*

*Jennifer S. Blakely, J.D., M.P.H., is an associate at Arnall Golden Gregory, LLP who concentrates her practice on health care regulatory and compliance issues, representing physicians and physician groups, and representing pharmaceutical and medical device companies. Blakely can be reached at [jennifer.blakely@agg.com](mailto:jennifer.blakely@agg.com).*

*This is a paid advertorial.*



**MICA BILLING SERVICES AND SUITEMED INTELLIGENT  
MEDICAL SOFTWARE EMR/PMS SUITE**

**“A WINNING COMBINATION”**

**CALL TODAY FOR A FREE PRICE QUOTE AND DEMONSTRATION  
1-800-344-6422**

Get your stimulus money here:  
[www.micamedical.com](http://www.micamedical.com) • [sales@micamedical.com](mailto:sales@micamedical.com)