Summary of Certain Provisions in the Patient Protection and Affordable Care Act of 2010 That Are Noteworthy for Continuing Care Providers

Ari J. Markenson, JD, MPH
Benesch Friedlander Coplan & Aronoff LLP
White Plains, NY

The Patient Protection and Affordable Care Act of 2010[1] (Health Reform Bill) is full of new issues for continuing care providers. This article summarizes just a few provisions worth noting and does not represent a comprehensive overview of the Health Reform Bill. The issues summarized in this article relate to transparency and disclosure of ownership, mandatory compliance programs, face-to-face practitioner encounter requirements, and new claims-submission timeliness requirements for long term care providers.

Nursing Home Transparency and Disclosure of Ownership

The Health Reform Bill contains significant disclosure of ownership and related transparency provisions for skilled nursing facilities (SNFs) and nursing facilities. Under Section I, Title VI, Subtitle B, Part I, the Health Reform Bill enacts a series of additions and changes to existing law.

The changes generally require facilities to disclose ownership and control interests, managing employees, and individuals or entities that exercise operational control beyond current disclosure requirements. They also add requirements to disclose individuals or entities that lease or sublease the real property to the facility, provide management or administrative services, or provide management or clinical consulting services to the facility.

These new disclosure requirements are significant and reach well beyond the existing ownership and control disclosure requirements found in 42 C.F.R. Part §424 Subpart P and the CMS 855 form.

Section 6101 of the Health Reform Bill provides that beginning on the date of enactment and ending when the information is provided to the appropriate government agencies, providers must have available for inspection the following information:

(ii) The identity of and information on—

I. each member of the governing body of the facility, including the name, title, and period of service of each such member;

II. each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

III. each person or entity who is an additional disclosable party of the facility.

(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

An "additional disclosable party" is defined in Section 6101 as:

any person or entity who—

i. exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

ii. leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

iii. provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

"Organizational structure" is defined in Section 6101 as:

in the case of—

i. a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

ii. a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

iii. a general partnership, the partners of the general partnership;

iv. a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

v. a trust, the trustees of the trust;

vi. an individual, contact information for the individual; and

vii. any other person or entity, such information as the Secretary determines appropriate.

The U.S. Department of Health and Human Services Secretary (HHS Secretary) must promulgate final regulations implementing these requirements within two years of the Health Reform Bill's enactment.

In order to comply with the new statutory provisions, providers have to begin evaluating what information must be retained and made available to government agencies in the interim period between the bill's enactment and when regulations are promulgated specifying how the information is to be reported.

Mandatory Compliance Programs for Nursing Homes

The Health Reform Bill includes provisions requiring SNFs and nursing facilities to have a compliance and ethics program in place that is effective in preventing and detecting criminal, civil, and administrative violations, and in promoting quality of care consistent with regulations developed by the HHS Secretary, working jointly with the Office of Inspector General.

Title VI, Subtitle B, Part 1 of the Health Reform Bill provides that the compliance and ethics program regulations must be promulgated not later than two years after the Health Reform Bill's enactment.

The term "compliance and ethics program" is defined in Section 6102 as a program that:

(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care; and

(B) includes at least the required following components:

1) The Provider must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations.

2) Specific high-level employees must be assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

3) The Provider must use due care not to delegate substantial discretionary authority to individuals whom the Provider knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations.

4) The Provider must take steps to effectively communicate its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

5) The Provider must take reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents can report violations by others within the organization without fear of retribution.

6) The standards must be consistently enforced through appropriate disciplinary mechanisms, including, discipline of individuals responsible for the failure to detect an offense.

7) After an offense has been detected, the Provider must take all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations.

8) The Provider must periodically undertake reassessment of its compliance and ethics program to identify changes necessary to reflect changes within the organization and its facilities.

This compliance and ethics program mandate is significant in that compliance programs for SNFs and nursing facilities will now be required by statute and regulation. SNFs and nursing facilities that have not already done so should begin the process of establishing a compliance and ethics program, taking into account the size and operations of their specific organization. Those that have a compliance and ethics program in place will want to review it to make sure it includes the components required by the new legislation.

Face-to-Face Practitioner Encounter Requirements

The Health Reform Bill includes statutory provisions requiring face-to-face practitioner encounters for home health certifications and prior to the provision of orders for durable medical equipment (DME).

In the home health context, Title VI, Subtitle E, Section 6407(a) of the Health Reform Bill amends 42 U.S.C. §1395f(a)(2)(c). The amendment adds a condition to the existing conditions for payment. The new condition provides that prior to making a certification that a patient meets the criteria for Medicare-covered home health services, the physician "must document that the physician himself or herself has had a face-to-face encounter with the [patient] within a reasonable timeframe as determined by the Secretary." At some point in the near future, the Centers for Medicare & Medicaid Services (CMS) will likely publish regulations defining "reasonable timeframe."

In the DME context, Title VI, Subtitle E, Section 6407(b) of the Health Reform Bill amends 42 U.S.C. §1395m(a)(11)(B). The amendment adds a condition to the existing conditions for payment. The new condition provides that prior to providing an order for DME under the Medicare program, "a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist [must have] had a face-to-face encounter with the [patient] during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary." To the extent that CMS wants to redefine the timeframe, it will likely publish regulations in the future.

Additionally, Title VI, Subtitle E, Section 6407(d) of the Health Reform Bill provides that the encounter requirements shall apply

to similar home health certifications or orders for DME in the Medicaid program.

Home health agencies and DME providers need to start thinking about how they are going to implement these new requirements and either develop or revise their policies and procedures accordingly. Training of staff and practitioners also will be an important part of implementing the changes.

Medicare Claims Filing Timeliness Requirements

Section 6404 of the Health Reform Bill changes the long-standing rules relating to the timeliness of filing Medicare claims.

Historically, providers and suppliers relied on rules that were based upon the date of service for a claim in any given year. The shortest maximum filing timeframes were approximately eighteen months from the date of service, and in some cases claims could be filed well beyond eighteen months.

Section 6404 changes the timeliness requirements to provide that all claims by providers and suppliers must be filed with a Medicare contractor twelve months from the date of service. Additionally, all claims for dates of service prior to January 1, 2010, must be filed by December 31, 2010.

Providers and suppliers should evaluate whether they will be affected by the catch-up in 2010 that requires all claims prior to January 1, 2010, to be filed by the end of the year. Additionally, to the extent necessary, providers and suppliers should ensure that billing software and billing cycles are adjusted to address the new limitations.

* * * *

As mentioned, the four issues summarized above are just a small piece of the overall Health Reform Bill. The legislation's impact will become clearer as health law practitioners and the industry continue to sift through the bill and follow new regulatory issuances and the implementation of the bill's provisions.

1 Pub. L. No. 111-148.

Long Term Care, Senior Housing, In-Home Care, and Rehabilitation Practice Group Leadership

Barbara J. Duffy, Chair –
Lane Powell PC
Seattle, WA
(206) 223-7944
duffyb@lanepowell.com

John Camperlengo, Vice Chair – Research and Website
Gentiva Health Services
Atlanta, GA
(770) 951-6387
john.camperlengo@gentiva.com

Thomas J. Kapusta, Vice Chair – Membership
Evangelical Lutheran Good Samaritan Society
Sioux Falls, SD
(605) 362-3256
tkapusta@good-sam.com

Jennifer L. Hilliard, Vice Chair – Educational Programs
American Association of Homes & Services for the Aging
Washington, DC
(202) 508-9444
jhilliard@aahsa.org

Joanne R. Lax, Vice Chair – Strategic Activities
Dykema Gossett PLLC
Bloomfield Hills, MI
(248) 203-0816
jlax@dykema.com

Ari J. Markenson, Vice Chair – Publications
Associate General Counsel
Benesch Friedlander Coplan & Aronoff LLP
White Plains, NY
(914) 682-6822
amarkenson@beneschlaw.com

Richard E. Gardner, III – Discussion List Moderator
Arnall Golden Gregory LLP
Atlanta, GA
(404) 873-8148
richard.gardner@agg.com