KING & SPALDING

Health Headlines

April 18, 2011

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Budget Deal Includes Cuts to Spending Under PPACA – On April 14, 2011, the U.S. House of Representatives and the Senate passed a continuing resolution, which may be read **here**, that will keep the government funded until the end of the 2011 fiscal year (September 30) and makes approximately $40 billion in spending cuts. The continuing resolution (H.R. 1473), which passed the House of Representatives by a 260-167 vote and the Senate by an 81-19 margin, was signed by President Barack Obama on April 15.

According to a summary of the resolution from the House Appropriations Committee, which may be read **here**, the sections of H.R. 1473 related to Labor, Health and Human Services, Education and related agencies contain a total of $157.7 billion, roughly a $5.5 billion, or 3.36%, reduction from fiscal year 2010 levels. The resolution also cuts funding to the Consumer Operated and Oriented Plan Program (CO-OP), a program funded under Section 1322 of the Patient Protection and Affordable Care Act (PPACA). As described in PPACA, the CO-OP was created to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans." Under PPACA, $6 billion was appropriated for the CO-OP. As set forth in the continuing resolution passed by Congress, "[o]f the funds made available for the Consumer Operated and Oriented Plan Program under Section 1322(g) of the Patient Protection and Affordable Care Act, $2,200,000,000 are hereby permanently cancelled." The continuing resolution also terminates entirely the free voucher program created under PPACA, a program that would have taken effect in 2014, stating "Subsections (a), (b), (c), (d), and (e) of section 10108 of the Patient Protection and Affordable Care Act are repealed."

Reporter, *Christina Gonzalez*, Houston, +1 713 276 7340, cagonzalez@kslaw.com.

CMS Announces Partnership for Patients Initiative to Improve Patient Care and Reduce Costs – On April 12, 2011, Health and Human Services (HHS) Secretary Kathleen Sebelius and CMS Administrator Donald Berwick announced the formation of the "Partnership for Patients" initiative, which will bring together the federal and state governments, major hospitals, employers, health plans, physicians, and clinicians to reduce medical errors as well as the cost of care through a public-private partnership.

Secretary Sebelius said in a press release accompanying the announcement of the initiative, "Working closely with hospitals, doctors, nurses, patients, families, and employers, we will support efforts to help keep patients safe, improve care, and reduce costs." The objective of the Partnership is to improve health outcomes by reducing instances of preventable, hospital-acquired conditions by 40 percent and by reducing the number of hospital readmissions by 20 percent within three years. CMS estimates that the Partnership could save 60,000 lives and save as much as $35 billion for the healthcare system, including $10 billion in Medicare savings by 2013.

To support the Partnership, HHS announced $1 billion in federal funding to be made available under the Patient Protection and Affordable Care Act. The new Community-based Care Transition Program at the CMS Innovation Center,

discussed in more detail in the article below, will provide $500 million in funding to community-based organizations that partner with eligible hospitals for certain care transition services. Applications for Partnership funds may be made by eligible community-based organizations and acute care hospitals that partner with community-based organizations. Funding awards will be made on an ongoing basis by CMS. Interested applicants should visit the CMS Medicare Demonstrations website, **here**, for more information regarding eligibility requirements and application materials.

Additionally, CMS will dedicate up to $500 million in funding though its Innovation Center to test different models of improving patient care and collaboration in order to reduce hospital-acquired conditions, including the prevention of adverse drug reactions, pressure ulcers, childbirth complications, and surgical site infections. The goal of the Innovation Center initiative is to help hospitals adopt evidence-based care improvements on a local level and then share these approaches among public and private partners across the country.

For more information about "Partnership for Patients", click **here**. For a fact sheet about the initiative, click **here**.

Reporter, *J. Austin Broussard*, Atlanta, +1 404 572 4723, jabroussard@kslaw.com.

CMS Releases Solicitation for Proposals for Participation in the Community-based Care Transitions Program (CCTP) – CMS is accepting applications for participation in the Medicare Community-based Care Transitions Program (CCTP). The CCTP, mandated by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high-risk Medicare beneficiaries. As stated in the solicitation, the goals of the CCTP "are to improve the quality of care transitions, reduce readmissions for high risk Medicare beneficiaries, and document measurable savings to the Medicare program by reducing unnecessary readmissions."

Entities eligible to participate in this program are statutorily defined under section 3026 of the Affordable Care Act to include subsection (d) hospitals with high readmission rates that partner with community-based organizations (CBOs) or CBOs that provide care transition services. CBOs are defined as community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals and whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers.

While the CCTP will run for five years, beginning April 11, 2011, participants will be awarded two-year agreements that may be extended on an annual basis for the remaining three years based on performance. The solicitation indicates that proposals will be accepted on a rolling basis and that "a competitive process will be used to select eligible organizations." In selecting CBOs to participate in CCTP, the Affordable Care Act requires that preference be given to eligible entities that are Administration on Aging grantees that provide concurrent care transition interventions with multiple hospitals and practitioners or entities that provide services to medically-underserved populations, small communities, and rural areas. In addition, the solicitation indicates that consideration will also be given to organizations that have established similar care transition interventions with State Medicaid programs and organizations that have established relationships with Medicare Advantage plans and commercial health plans as part of a comprehensive all-payer approach to readmission reduction.

As outlined in the solicitation, applicants must: (1) identify root causes of readmission and define their target populations and strategies for identifying high-risk patients; (2) specify care transition interventions (including strategies for improving provider communications and patient activation); and (3) provide a budget including a per eligible discharge rate for care transition service, an implementation plan with milestones, and demonstrated prior experience with effectively managing care transition services and reducing readmissions. For further details on the CCTP and the application process, please click **here** to access the solicitation.

Reporter, *Lora L. Greene*, New York, +1 212 556 2174, lgreene@kslaw.com.

DOJ Secures Guilty Pleas From Owners of Mental Health Corporation in $200 Million Medicare Fraud Scheme – On April 14, 2011, Lawrence Duran and Marianella Valera, the owners of American Therapeutic Corporation (ATC), pleaded guilty to all counts in a superseding indictment charging Duran with 38 felony counts and Valera with 21 felony counts for a scheme that resulted in the submission of over $200 million in fraudulent claims to Medicare over eight

years. The investigation and prosecution were brought as part of the Medicare Fraud Strike Force operations in Miami.

According to the superseding indictment, the defendants "paid kickbacks to owners and operators of assisted living facilities (ALFs) and halfway houses and to patient brokers in exchange for delivering patients to ATC and ASI [American Sleep Institute]," a related company. Press Release, Department of Justice, Two Owners of Miami-Area Health Care Corporation Plead Guilty to Orchestrating $200 Million Medicare Fraud Scheme (Apr. 14, 2011). They then "billed Medicare for mental health services that were illegitimate or never provided." *Id.* To conceal the scheme, they set up complex money laundering operations to hide the proceeds and caused the alteration of patient files to make it appear that patients qualified for and were being treated for mental health services at their facilities. *Id.*

The indictment charged Duran and Valera with "conspiracy to commit health care fraud, health care fraud, conspiracy to pay and receive illegal health care kickbacks, conspiracy to commit money laundering, money laundering and structuring to avoid reporting requirements." *Id.* Sentencing is set for July 13, 2011. The case is captioned *United States v. Duran*, 10-20767-CR-King (S.D. Fla. pleas Apr. 14, 2011), and the Department of Justice's press release is accessible by clicking **here**.

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King & Spalding Upcoming Roundtable on Environmental Management for Health Care Facilities on April 29, 2011 – On Friday, April 29, 2011, we will be hosting a new Roundtable focused on environmental management for the healthcare industry from 1:00 p.m. to 2:30 p.m. Eastern. By ensuring compliance with mandatory requirements imposed by state and federal regulators, a properly executed Environmental Management System (EMS) will minimize the risk of incurring significant fines and penalties. Furthermore, because implementation strategies usually include minimizing waste, an EMS will often produce substantial efficiencies and cost-savings. You can register to attend in person or by Webinar by clicking **here**. Lunch will be provided between 12:00 p.m. and 1:00 p.m. if you would like to arrive early for that.

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