CCH BRIEFING *Special Report*

U.S. Supreme Court Concludes Hearings on Health Reform Law; Implementation of Many Provisions Rolls On

Highlights

- ✔ U.S. Supreme Court heard arguments on Anti-Injunction Act, the Individual Mandate, Severability and Medicaid Expansion
- ✔ Many PPACA provisions are already in effect
- ✔ Details about new regulations relating to PPACA explained

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Introduction

The U.S. Supreme Court has now concluded three days of hearings on three separate cases related to the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148). This Special Report provides a summary of the four major issues the Court will consider over the next few months before it releases a decision, likely in late June or early July 2012.

The Court heard arguments on the following cases –

- March 26—*HHS v. Florida* (11-398), whether the Anti-Injunction Act regarding the federal collection of taxes applied to this case;
- March 27—*HHS v. Florida* (11-398), whether the individual mandate to purchase health insurance was unconstitutional;
- March 28 (morning)—*National Federation of Independent Business v. Sibelius* (11-393), concerning the severability of the individual mandate, *e.g.*, if the Court decided that the individual mandate was unconstitutional, whether the entire law would have to be struck down.
- March 28 (afternoon)—*Florida v. HHS* (11-400)—whether the expansion of Medicaid coverage under PPACA is coercive to the states.

The issues discussed during oral arguments relate to parts of the law that generally do not go into effect until 2014, although the federal government and some states have begun laying the groundwork to implement the law.

This Special Report also examines Medicare issues that were not part of the oral arguments considered by the Court, but have been law for two years, and have been implemented in whole or in part by federal agencies. Although this briefing does NOT examine the possible outcomes of various Supreme Court decisions, which may range from upholding the entire law, striking down part of it, or striking down all of it, highlighting the existing Medicare aspects of PPACA is a reminder of the possible changes that could impact the program if the entire law is struck down.

Anti-Injunction Act

The first matter presented on Monday, March 26, in the arguments in *HHS v. Florida* (11-398) was whether the penalty imposed under PPACA, starting in 2014, for any individual who did not purchase a health insurance policy with minimum essential coverage, was a tax. Robert Long, an attorney tapped by the Court to present the case for "penalty equals tax" because neither the government nor the states wanted to make that case, noted that the "Anti-Injunction Act (AIA) imposes a pay first, litigate later rule that is central to Federal tax assessment and collection. The Act applies to essentially every tax penalty in the Internal Revenue Code. There is no reason to think that Congress made a special exception for the penalty imposed" by PPACA.

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If the Court considered the penalty to be a tax, then, under the AIA, it could not make a ruling in the case because the AIA provides that "no suit for the purpose of restraining the assessment of collection of any tax maybe maintained in any court by any person." If the penalty is a tax, a person would have to pay the tax first and then litigate the matter, including using all administrative hearings before going to the courts. In this case, no tax would be or could be paid until after 2014, most likely not until 2015, at the earliest. As such, the AIA would prohibit this case from being heard until that date.

Neither the Obama administration nor the states believe that the AIA applies in this case. The Obama administration maintained that the AIA does not apply because PPACA does not impose a tax, therefore, the AIA is not relevant. Solicitor General Donald Verrilli, the attorney for the U.S. government, in response to a line of questioning from Justice Alito, argued that Congress has the authority to use its taxing power to enact a measure not labeled a tax, and that the court has ruled, in licensing cases, for example, there can be an exercise of taxing power although there is no tax. The government argued that there are no jurisdictional issues in this case for the Court to decide. Even if the penalty is an exercise of taxing power, it is not a tax. As such, the AIA prohibition against maintaining a case is not relevant.

Gregory Katsas, representing the states, argued that the "purpose of this lawsuit is to challenge a requirement — a Federal requirement to buy health insurance. That requirement itself is not a tax." For that reason alone, he argued that the Anti-Injunction Act does not apply.

When is a mandate a mandate? Chief Justice Roberts questioned how a mandate can be a mandate if there is no enforcement mechanism such as a tax or penalty. "It's a command. A mandate is a command. If there is nothing behind the command, it's sort of well what happens if you don't file the mandate? And the answer is nothing. It seems very artificial to separate the punishment from the crime."

Katsas argued that "because Congress reasonably could think that at least some people will follow the law precisely because it is the law," those people will begin preparations to be compliant with the law. In response to a line of questioning from Justice Kagan, who asked how those individuals would have standing to bring a suit, Katsas said that the mandate is the "forced acquisition of an unwanted good," and the injury is an economic one, one to the pocketbook, that it starts with preparations to be compliant.

Katsas then pointed out how the law exempts some people, the very poor, from the penalty, but not the mandate. The people who are exempt will not have to pay the penalty, but they are required to purchase insurance, which he argues is the problem–the requirement to purchase whether or not there is a penalty. The injury in this case is to the states that would have to plan and prepare to add these individuals to their Medicaid programs.

The Court was concerned about granting equitable exceptions to the AIA's prohibition against courts hearing cases about taxes before they were collected and was worried that giving the government the discretion to waive the AIA prohibition was a bit arbitrary. Justice Sotomayor, however, identified four cases for which the AIA was waived by the government and a tax case that was allowed to be heard before the collection of a tax, making it seem like granting an exception could be a possibility in this case.

Individual Mandate to Purchase Health Insurance

On the second day of oral arguments regarding *HHS v. Florida,* the Court turned to the constitutionality of the provision requiring all individuals to obtain health insurance coverage or face a penalty. The government, through General Verrilli, stated that health insurance is the predominant method of payment in the health care industry, yet effective access does not exist for 40 million Americans. Those not covered under employer-sponsored health insurance and not qualified for Medicare or Medicaid are left to purchase coverage from the individual market at the going-rate rather than at the heavily subsidized rate that employees pay.

Some of the major sources of contention related to the individual mandate include (1) whether the government can force individuals to participate in a market and whether the mandate involves the insurance market or the health care market, (2) whether there is a limit to Congress' commerce power, and (3) whether the fee required for violating the mandate is a tax.

The respondents, represented by Paul Clement, argued that individuals are being forced to participate in commerce and there is no limiting principle in place.

What is the market? Verrilli argued that PPACA instituted "reforms of the insurance market, directed at the individual insurance market, that preclude … discrimination based on pre-existing conditions, that require guaranteed issue and community rating. And … the minimum coverage provision is necessary to carry into execution those insurance reforms."

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Unwilling participants. The government's argument was that all individuals participate in the health care market whether or not they use health care services at any given point because, arguably, everyone will need health care at some point. Justices pounced on both sides of the issue, responding affirmatively, that as humans, we are at a risk for needing health care and are not able to predict when that will be (Breyer) and negatively, that the government shouldn't be able to regulate those individuals that have chosen not to participate in the market.

The Justices compared the individual mandate requirement to paying for funeral services after your death, a cell phone service to assist in an emergency, or insurance for your automobile. The heart of the government's argument is that those individuals that do not have insurance coverage and require emergency services are able to obtain such services from an emergency department, and individuals with insurance coverage subsidize the cost of that emergency treatment through higher premiums.

What comes next? Chief Justice Roberts expressed concern that if Congress could create a mandate to purchase health insurance, it could create a mandate in other areas of commerce. He said, "once we say that there is a market and Congress can require people to participate in it … it seems to me that we can't say there are limitations on what Congress can do under its commerce power." He added, "we can compel people to do things — purchase insurance, in this case; something else in the next case — because we've accepted the argument that this is a market in which everybody participates."

Is it a tax? The Court was concerned about the term used to describe the fee that individuals violating the individual mandate will have to pay. When asked why the government chose to call the fee a "penalty" rather than a "tax," General Verrilli responded that Congress believed it would be more effective in accomplishing its objective by calling it a penalty. The government further argued, however, because the penalty is paid on an IRS form (1040), on April 15th each year, that it is a tax.

Severability

The Wednesday morning session was devoted to arguments in *National Federation of Independent Business v. Sebelius* (11-393). Given the level of skepticism demonstrated by some of the Justices in their questioning about the individual mandate, it is not beyond the realm of possibility that the mandate will be struck down. That, of course, leads to the question: What then is the fate of the legislation's hundreds of other provisions?

Justice Ginsberg summed up the Court's inquiry best: If the mandate fails, is the treatment of the remaining provisions "a wrecking operation" that dismantles the entire law or "a salvage job" that attempts to save the provisions that can operate independently of the mandate?

A hollow shell. Attorney Paul Clement, who represented the National Federation of Independent Business, contended that the remainder of the health reform law would be "a hollow shell" without the individual mandate, comparing it to a wheel that still had its spokes, but lacked the hub that connected them. He argued that Congress' intent was for the rest of PPACA's provisions to operate around the mandate, and that if the mandate was not enforced, the other provisions would be meaningless.

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Justice Scalia seemed to agree with Clement, stating that, "My approach would be to say that if you take the heart out of this statute, the statute's gone." Scalia found it unrealistic to expect the Court to go through 2,700 pages of legislation and evaluate each provision individually to determine whether it could operate independently of the mandate. Known for injecting humor into his questioning, Scalia even went as far as to invoke the Eighth Amendment barring cruel and unusual punishment.

Attorney Edwin Kneedler, who represented the Obama Administration, claimed that only two other provisions depended on the constitutionality of the individual mandate: (1) the prohibition of insurers from turning away applicants, and (2) the prohibition of insurers from taking account of pre-existing conditions. He reasoned that insurance costs would increase otherwise because the insurance pool would be full of

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those who waited until they were sick to obtain coverage and would not contain the healthy individuals who were not required to obtain insurance.

Justice Kagan seemed to find this option favorable, stating that "half a loaf is better than no loaf." Justice Roberts pointed out that many of PPACA's provisions were added as incentives for lawmakers to go along with the politically unpopular mandate; however, he added that many of the law's provisions are completely unrelated to the mandate.

Return it to Congress. In a third position, argued by private court-appointed counsel, the Court also considered whether it could simply strike the mandate and return the law to Congress to let it sort out the legitimacy of the rest of the provisions. Justices Kennedy and Scalia acknowledged the sharply partisan-divided Congress that is currently in power and questioned whether it was capable of completing this task. Kennedy inquired whether this would be accomplished by "the real Congress or the hypothetical Congress."

Scalia bluntly stated, "You're not going to get 60 votes in the Senate to repeal the rest. It's not a matter of enacting a new act. So you're just put to the choice of, I guess, bankrupting insurance companies and the whole system comes tumbling down or else enacting a federal subsidy program to the insurance companies, which is what the insurance companies would like, I'm sure."

Medicaid Expansion

The implications of the Court's decision on the Medicaid expansion issue may reach much further than health care reform into other areas of federal regulation such as education and environment. Needless to say, federalists are watching this issue closely. At issue is whether Congress exceeded its authority to require states to expand their Medicaid rolls with individuals that qualify under PPACA's new criteria, which will include adults with annual incomes up to 133 percent of the federal poverty line.

The government cited Article I of the U.S. Constitution which gives Congress the power to "lay and collect . . . taxes to pay the debts and provide for the common defense and general welfare of the United States" and to "regulate commerce . . . among the several states." No federal court has ever found that states have been unlawfully coerced when they accept conditions attached to federal money. Clement argued that this law is fundamentally unique in comparison with past cases because participation in the Medicaid program is directly tied to a nonvoluntary mandate and the state's willingness to receive the extra federal funds may affect whether it can continue to receive existing federal Medicaid funds.

Losing Medicaid funding. Justice Breyer challenged Clement by pointing out that PPACA does not affirmatively state that states would lose their pre-existing Medicaid funding if they elect not to expand their Medicaid enrollment. As the law stands, it would be left to the Department of Health and Human Services (HHS) Secretary's discretion, and she is bound by existing administrative law, which requires her to act reasonably. If she does not act reasonably, he contended, the states can challenge her actions in federal court.

Clement countered that while PPACA does not guarantee that the Secretary would take away current funding from nonparticipating states, it does leave the possibility open. That possibility serves as coercion to the states to expand their programs or risk losing all federal funding for their Medicaid programs, which no state will be willing to do, he argued. He stated that the government has had numerous opportunities since this case was introduced to clarify that they would not take such action, but it has chosen not to clarify its position.

Chief Justice Roberts seemed to side with Clement, adding that, "The concern is that the Secretary has total and complete say" whether to take away states' Medicaid funding for refusing to expand programs . . . Why not be concerned about the authority the federal government is exercising?"

Justice Kennedy agreed that, essentially, states have "no realistic choice" but to expand their programs, indicating that he agrees the statute is coercive.

Justice Kagan had a different interpretation of the provision, asking, "Why is a big gift from the federal government a matter of coercion . . . there is no matching funds requirement . . . it's just a boatload of federal money." She pointed out that the federal government would pay for 90 percent of the cost of expansion.

Solicitor General Donald Verrilli similarly argued that providing hundreds of billions of dollars to states to expand health care for the poor was hardly coercive. Each state is merely expected to front 10 percent of the cost and administer the program.

Clement maintained that, despite the federal government's "gift," the power of the states was undermined by threatening the cut-off of all Medicaid funding.

What Wasn't At Issue Before the Court: Medicare Provisions

PPACA included several provisions related to the Medicare program that are not directly connected to either the

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health insurance mandate or the Medicaid expansion. For the last two years, CMS and other government agencies have been diligently implementing dozens of other provisions of the law that never came up during the oral arguments before the Court. One of the unanswered questions is what happens to all the new regulations and programs that have been put in place since March 2010 if the Court strikes down the entire law.

Here are highlights of some of the original PPACA provisions and where they stand today.

Accountable Care Organizations (PPACA Sec. 3022) A shared savings program was created 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 is 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 2 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 ten percent in the third. ACOs will be required to meet certain quality performance standards.

ACO types. 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.

There are also a number of other requirements that must be met to participate as an ACO, such as: (1) accountability; (2) participation agreements; (3) legal structure and governance; (4) distribution of savings; (5) minimum number of primary care providers and beneficiaries; (6) reporting; (7) leadership and management; (8) promotion of new processes and methods; (9) patient-centeredness; (10) marketing guidelines; and (11) program integrity. ACO participants will continue to receive traditional payment under the original Medicare fee-for-service program under Parts A and B. Should an ACO meet certain quality and savings requirements, however, the ACO would qualify for shared savings, based on the quality score of an ACO.

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CMS has a list of FAQs relating to ACOs available at http://www.cms.gov/sharedsavingsprogram/Downloads/MSSP_FAQs.pdf.

Value-based purchasing program (PPACA Sec. 3001(a)). 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 (and in all other quality programs in this title) will be developed and chosen with input from external stakeholders.

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

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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.

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 entitites as far as it has for inpatient hospitals.

Physician Compare (PPACA Sec. 10331) 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.

Inpatient Rehabilitation Facilities (PPACA Sec. 3004(b)) Quality reporting measuring programs will be implemented for inpatient rehabilitation facilities (IRFs). Providers who do not participate in the program will be subject to a 2.0 percent reduction in their annual market basket update, starting in 2014.

CMS issued a Final rule on August 5, 2011 (76 FR 47836), to implement this program. The Secretary of HHS is required to select quality measures for the IRF quality reporting program from those that have been endorsed by the consensus-based entity that holds a performance measurement contract; this contract is currently held by the National Quality Forum (NQF). Under Soc. Sec. Act §1886(j)(7)(D)(iii), the Secretary is required to publish the measures that will be used in FY 2014 no later than October 1, 2012.

Center for Medicare and Medicaid Innovation (PPACA Sec. 3021) 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.

By March 2012, CMI had started almost 20 initiatives.

Payment bundling. (PPACA Sec. 3023 and 10308) 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.

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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. (PPACA Sec. 3025) 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 certain selected conditions will see their payments reduced under the program. Readmissions measures are finalized for the three conditions—acute myocardial infarction (or heart attack), heart failure, and pneumonia—as well as the methodology that will be used to calculate excess readmission rates for these conditions. The program is designed to provide hospitals with an incentive to reduce preventable hospital readmissions and improve care coordination.

Physician assistants and skilled nursing facilities. (PPACA Sec. 3108) Physician assistants working in collaboration with a physician are 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.

Pharmacy accreditation requirements. (PPACA Sec. 3109) 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 by the Secretary of Health and Human Services, 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 that 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.

Independent Medicare Advisory Board (PPACA Sec. 3403) The Independent Medicare Advisory Board 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.

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.

Physician-owned hospitals. (PPACA Sec. 6001(a)) 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.

Provider screening and other enrollment requirements. (PPACA Sec. 6401(a)) 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. CMS may

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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 will be required to pay an application fee. Current providers will have to pay the fee when they revalidate. Providers who participate in Medicaid only will pay the application fee to the state agency. Those participating in Medicare will pay the fee only for Medicare participation, and state agencies will rely on the Medicare determination of compliance.

Enhanced Program Integrity Measures (PPACA Sec. 6402) 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.

Physician self-referral disclosure protocol. (PPACA Sec. 6409) Within six months of enactment, the Secretary of Health and Human Services (HHS), in cooperation with the HHS Office of Inspector General, was required to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.

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

Expansion of the RAC program. (PPACA Sec. 6411) 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 PPACA was enacted providing further guidance to states and private entities involved in Medicare Parts C and D on the expansion of the RAC program.

Miscellaneous provisions. PPACA included many other provisions that went into effect immediately. For example, for 2010 PPACA partially closed the "donut hole" coverage gap for beneficiaries who received prescription drug coverage under Part D by a $250 rebate, if, as of the end of a calendar quarter in 2010, has incurred costs for covered Part D drugs exceeding the initial coverage limit. PPACA 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 PPACA 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.

Finally, there are many other provisions of PPACA 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, and enhancements to the authority 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.

Conclusion

The U.S. Supreme Court is expected to hand down its decision in the three cases it considered in March sometime in late June or early July. Guessing how the Court will decide is just that . . . a guess. It could uphold all, some, or none of the health reform law. It could provide specific direction to Congress as to next steps . . . or not. Depending on the Court's decision, Congress may be charged with taking quick action . . . or not.

In the hearing on severability, Paul Clement, in making the argument that the entire law should be struck down if the individual mandate is struck down, noted "if you strike down only the individual mandate, Congress could say the next day, well, that's the last thing we ever wanted to do; so, we're going to strike down the rest of the statute immediately and then try to fix the problem. So, whatever you do, Congress is going to have options."

Justice Ginsburg replied, "It's a choice between a wrecking operation, which is what you are requesting, or a salvage job. And the more conservative approach would be salvage rather than throwing out everything."

In the meantime, CMS, other government agencies, and the states will proceed with implementing the law as it stands in March 2012.

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