





Provider Based Facilities

- Bipartisan Budget Act 2015, Section 603
 - Section 603 amends the Medicare statutory provisions for hospital OPPS payments
 - General rule – Items and services furnished on or after January 1, 2017 in *new* "off campus outpatient departments of a provider" generally will not be paid under the Medicare OPPS but rather under other payment systems if the requirements for such payment are otherwise met
 - "Off-campus outpatient department of a provider" means the department of a provider that is not located on a hospital's "campus" (as defined in the provider-based regulations) or within 250 yards from a "remote location of a hospital" (also as defined in the provider-based regulations)

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Provider Based Facilities

- Bipartisan Budget Act 2015, Section 603 (cont.)
 - General rule does not apply to "dedicated emergency departments," or departments of a provider that were billing under OPDS with respect to covered outpatient department services furnished prior to November 2, 2015 (grandfathered facility)
 - Hospitals are required to provide to the Secretary information deemed appropriate to implement Section 603, including codes/modifiers on claim forms and information about off-campus outpatient departments on Medicare enrollment forms
 - No administrative or judicial review

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Provider Based Facilities – Transactional Issues

- Change of Ownership
 - Acquisition of a provider-based facility and retention of grandfathered status is permissible
 - Must be in conjunction with the change of ownership of the main provider
 - Cannot acquire a provider-based facility through change of ownership separate from the main provider and retain grandfathered status
- Relocation
 - Relocation of a grandfathered provider-based facility to another off campus location and retention of grandfathered status is not permitted
 - Exception for extraordinary circumstances outside of the hospital's control
 - Relocation to an on-campus location permitted (these facilities would be outside of the section 603 payment limitation)
- Addition of service lines
 - CMS will not currently limit expansion of services, but retained the possibility of doing so

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Co-location/ Shared Space Arrangements

- Co-location/shared space arrangements and Conditions of Participation and provider-based status payment implications
 - CMS policy that any co-location of a hospital, including HOPD, with another entity raises questions whether the hospital can meet the Medicare CoPs and certain provider-based status requirements
 - CMS is enforcing its "no shared space" position via attestation denials and state agency/accreditation organization education in the context of LSC/architectural evaluations
 - Issues include shared physical space and shared personnel/operations
 - Purported upcoming revisions to the Medicare State Operations Manual "manualizing" its "no shared space" policy

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Telemedicine Services / Arrangements

- Location of patient (originating site) must be:
 - outside a Metropolitan Statistical Area (MSA) or in a rural census tract
 - limited to certain facilities, including physician offices, hospitals, CAHs, RHCs, FQHCs, hospital-based ESRD, SNFs
- Medicare covers only telemedicine services using synchronous, interactive telecommunications systems
 - includes real-time video and audio interaction between the healthcare provider at the distant site and the patient at the originating site
 - excludes most store-and-forward applications

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Telemedicine Services / Arrangements

- Eligible provider types include physicians, PAs, NPs, nurse-midwives, clinical nurse specialists, clinical psychologists, clinical social workers, registered dietitians or nutrition professionals
 - state licensing, credentialing and privileging requirements apply (ordinarily at the originating site)
- Eligible type of services include office or other outpatient visits, professional consults, psychotherapy, pharmacology, transitional care management and alcohol and other substance abuse counseling and treatment.

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Medicaid Reimbursement for Telemedicine

- Federal Medicaid statute does not recognize telemedicine as a distinct service
- States may determine:
 - whether or not telehealth services are covered,
 - what services are covered in what geographic areas,
 - which practitioners are reimbursed, and
 - how much services are reimbursed
- Differs from state to state, though the states must still satisfy the federal requirements of efficiency, economy and quality of care

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CONNECT for Health Act

- Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act
 - “Bridge” Demonstration Waiver program consistent with the MACRA MIPS program
 - Program participants would not be subject to the Medicare payment limitations on site or technology
 - Extended demonstration waivers to qualifying alternative payment models (APM) participants
 - data reporting obligations under both waiver program and APM model
- Expands originating sites to include ESRD facilities, facilities where stroke evaluation or management services are provided via telehealth, Indian Health Service facilities
- Distant sites expanded to include RHCs and FQHCs

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CONNECT for Health Act

- Improved Medicare coverage for remote patient monitoring services
 - available for patients:
 - with 2 or more Medicare-covered chronic conditions
 - at least 2 inpatient or ER visits in previous year
 - reimbursement available for renewable 90-day periods of remote patient monitoring
- Permits Medicare Advantage plans to use telehealth or remote patient monitoring services to provide benefits under the original Medicare fee for-service program option.
 - includes items or services furnished to treat medical or behavioral health conditions

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Expanding Capacity for Health Outcomes (ECHO) Act

- HHS is instructed to examine technology-enabled collaborative learning and capacity building models and their impact on:
 - addressing mental and substance use disorders, chronic diseases and conditions, prenatal and maternal health, pediatric care, pain management, and palliative care;
 - addressing health care workforce issues, specialty care shortages, primary care workforce recruitment, retention, and training;
 - the implementation of infectious disease and public health surveillance programs;
 - the delivery of health care services in rural areas, HPSAs and MUAs, and to medically underserved populations and Native Americans

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Expanding Capacity for Health Outcomes (ECHO) Act

- The ECHO Act sponsors the analysis of:
 - the use and integration of technology-enabled collaborative learning and capacity building models by health care providers;
 - the impact of models on health care provider retention;
 - the impact of models on the quality of, and access to, care for patients;
 - the barriers faced by health care providers, States, and communities in adopting models;
 - the impact of models on the ability of local health care providers and specialists to practice to the full extent of their education, training, and licensure, including the effects on patient wait times for specialty care; and
 - efficient and effective practices used by communities that have adopted models, including potential cost-effectiveness

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Fraud & Abuse Considerations

- Anti-kickback: equipment exchange between providers
 - OIG evaluated telemedicine-specific models in 1998, 1999, 2004 and 2011, which focused on the value of the most often free consultative telemedicine services to both the referring and consulting practitioners, and evaluated any equipment exchange arrangements to determine inducement of referrals
 - June 2015 OIG Fraud Alert on Physician Compensation Arrangements
- Stark Law
 - New exception for timeshare arrangements (42 CFR 411.357(y))
 - In-office ancillary services exception (42 CFR 411.355(b)) issues

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Medicare Access and CHIP Reauthorization Act of 2015

- MACRA provides physicians with 2 alternatives:
 - Physicians can participate in the MIPS program, with relatively flat reimbursement rates as compared to present payment methodology, with upward or downward payment adjustments based on compliance with MIPS quality and cost reporting requirements.
 - Physicians participating in an APM may be excluded from MIPS reporting and payment, and will be eligible for a 5% incentive payment for the year.

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**Medicare Access
and CHIP Reauthorization Act of 2015**

- Physicians electing the MIPS side will potentially receive payment adjustments (upward or downward) of 4% in 2019, which increases to 9% in 2022
- Physician fee schedule updates according to the following schedule:
 - 0.5% update 2015 through 2019
 - 0% update 2020 through 2023
 - Payment updates resume after 2023, with differential updates for MIPS and APM participants

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**Medicare Access
and CHIP Reauthorization Act of 2015**

- Performance will be based on 4 categories:
 - Clinical quality
 - Resource utilization
 - Meaningful use of EHR Technology
 - Clinical practice improvement
- Physician performance in each of these categories will contribute towards a composite score, and each physician will be ranked on a scale of 0 to 100
- Composite scores will differentiate between the best and worst performers with respect to these metrics
- Payment under MIPS will be zero-sum, so the expectation is that incentives will be offset by penalties

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**Medicare Access
and CHIP Reauthorization Act of 2015**

- Instead of participating and reporting under the MIPS program, physicians can participate in an alternative payment model (APM).
- The 5% APM incentive will be offered from 2019 to 2024.
- Beginning in 2026, the APM incentive will take the form of a 0.75% fee schedule update, whereas MIPS program participants will receive a 0.25% fee schedule update in comparison.

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Advanced APM Requirements

- MACRA Final Rule's implementation of statutory requirements of Advanced APMs:
 - I. must require participants to use certified EHR technology
 - The Advanced APM must require >50% of eligible clinicians to use CEHRT
 - Special criterion exclusively for MSSP ACO's deems this element satisfied through one quality measure that assesses meaningful use of EHR technology (which affects the ACO's shared savings/losses)
 - II. provides for payment based on quality measures comparable to those in MIPS
 - CMS liberally interpreted this requirement, permitting non-MIPS measures such as those "endorsed by a consensus-based entity" or even "any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid"
 - At least one outcome measure is generally required
 - III. entails "more than nominal" financial risk for monetary losses, or is a medical home model
 - For 2017/2018, the following minimum amounts must be at risk by the APM Entity:
 - Revenue-based standard: 8% of the average estimated total Medicare A/B revenues, OR
 - Benchmark-based standard: 3% of the expected expenditures for which the APM Entity is responsible
- Determined on a track/option basis

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MACRA Considerations

- The alignment model selected will raise issues about the extent of support provided and the financial terms under which it is provided.
 - Employment (Stark, AKS)
 - Leased or Contracted Services (Stark, AKS)
 - MSSP ACO membership (Waivers)
 - MSO (Stark, AKS)

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MACRA Implications for ACO Development

- The financial benefits accruing to physicians from participating in a successful MIPS or Advanced APM program create an important additional incentive to join an ACO.
- These benefits would be in addition to the other less certain financial benefits offered by ACO participation.
 - Sharing in MSSP Awards (if a MSSP ACO and if awarded)
 - Sharing in improved private payor reimbursement through better contracts (sometimes slow to develop)
 - Health System's quality and performance program payments (can vary based on System engagement)

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Macra Implications For Health Systems

- Like success under the MSSP ACO Program, success under MACRA in the form of higher reimbursement to physicians will likely be at the cost of FFS in-patient revenue that would have accrued to the Health System.
- As health systems change their strategy from relying on FFS as their leading revenue driver to relying on performance-based revenues, careful management and development of MACRA-based programs will be necessary.

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Issues Related to Acquisition of Providers

Hospital Value Based Purchasing

- Adjusts Medicare payments to hospitals based on a formula taking into account each hospital's performance on a designated set of quality measures.
- Beginning in fiscal year 2013, the HVBP program provides bonuses and penalties based on a hospital's performance on a subset of Inpatient Quality Reporting program measures.
- Designed to be budget neutral – bonuses are paid from fixed PPS payment reductions (increased from 1% in 2013, 1.75% in 2016, to 2% in 2017)
- CMS estimates \$1.8 billion in FY 2017 incentives

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Hospital Value Based Purchasing

- Program participation available for IPPS participating subsection (d) hospitals
- Hospitals excluded from the HVBP program are not subject to the 2% reduction and are not eligible to receive incentives.
- Excluded hospitals:
 - hospitals subject to IQR payment reductions
 - hospitals cited for immediate jeopardy deficiencies
 - hospitals not meeting minimum patient volume and domain score threshold (3 of 4) requirements

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Hospital Value Based Purchasing

- The domains for the FY 2017 HVBP program and the weighting for these domains are:
 - Clinical Care (30%)
 - Outcomes (25%)
 - Process (5%)
 - Patient and Caregiver Centered Experience of Care/ Care Coordination (25%)
 - Safety (20%)
 - Efficiency and Cost Reduction (25%)

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Hospital Value Based Purchasing

- "Modest effects on Medicare payments and no apparent change in quality-of-care trends."
- Bonuses and penalties received by ~3,000 eligible hospitals amounted to less than 0.5% of applicable Medicare payments each year.
 - In each of the HVBP program's first three years, a large majority of hospitals—between 74 percent and 93 percent—received a bonus or penalty of less than 0.5%.

GAO-16-9 Hospital Value-Based Purchasing

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Hospital Value Based Purchasing

- Most annual bonuses or penalties were less than \$50,000.
 - FY 2015 - 52% of hospitals received bonuses or penalties that led to payment adjustments < \$50,000
 - 72% had payment adjustments < \$100,000
- Aggregate redistribution - \$140 million

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Hospital Value Based Purchasing

- Small urban hospitals had higher median payment adjustments each year than hospitals overall.
 - 60 beds or fewer had the highest median payment adjustments (0.38%)
 - 201 beds and above had the lowest median payment adjustments
- Hospitals with better financial performance generally had higher payment adjustments.
 - Hospitals with net income > 5.0% received the highest median bonuses
 - Hospitals with net losses > 5.0% had lowest median

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Hospital Value Based Purchasing

- Small rural hospitals' median payment adjustments were similar to hospitals overall in the first two years and higher in the most recent year evaluated (2015)
- Safety net hospitals consistently had lower median payment adjustments, including both smaller bonuses or larger penalties, than hospitals overall.
- GAO found no apparent shift in quality performance trends during the first three years of the HVBP program.
- Preliminary analysis of information from 2013 and 2014 shows that it did not noticeably alter the existing trends in hospitals' performance on any of the quality measures used to determine HVBP payment adjustments that we examined.

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Hospital Readmissions Reduction Program

- Penalizes hospitals with an excess readmission ratio, as compared to the national average for hospitals for patients with comparable conditions
- Readmissions include admissions within 30 days of discharge, to any hospital
- Hospitals must have 25 cases per condition evaluated
- The HRRP penalty is calculated across 3 years of readmissions data

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Hospital Readmissions Reduction Program

- HRRP payment adjustment:
 - The HRRP participating hospital's base operating DRG payment amount is adjusted for each discharge occurring during the fiscal year.
 - The payment adjustment for each discharge is determined by subtracting the product of the base operating DRG payment amount for such discharge by the hospital's readmission payment adjustment factor for the fiscal year from the base operating DRG payment amount for such discharge.
- Applies to patients admitted for:
 - acute myocardial infarction
 - heart failure
 - Pneumonia
 - COPD
 - elective total hip and/or total knee replacement
 - coronary artery bypass graft

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Hospital Readmissions Reduction Program

- FY 2016 results:
 - 3400 HRRP-participating hospitals
 - ~ 76% of hospitals will receive some penalty
 - 38 received the maximum penalty (3%)
- FY 2017 results:
 - ~ 80% of hospitals will receive some penalty
 - 49 hospitals will receive the maximum 3% penalty
 - MedPAC estimates \$526 million in aggregate penalties

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Hospital Readmissions Reduction Program

- MedPAC concerns regarding HRRP payments:
 - Readmission penalties exceed the cost of readmissions
 - penalties should be a constant multiple of the costs of readmissions
- HRRP penalties, being comparative among participating hospitals, could continue to maintain penalty levels as readmissions decrease overall
- Heart failure readmission rates are inversely related to heart failure mortality rates
 - MedPAC recommends use of an all-condition measure, which has less of a negative correlation
- Low-volume hospitals do not have much incentive to invest in reducing readmissions

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Hospital Readmissions Reduction Program

- Readmissions increased by an estimated 0.5 per 10,000 discharges per year before ACA
- Readmissions decreased by 76.6 per 10,000 discharges per year after ACA
- Readmission rates decreased by 92.4 per 10,000 discharges per year among hospitals receiving 0.99% or greater penalty
- Readmission rates decreased by 69.0 per 10,000 discharges per year among hospitals receiving no readmission penalty

Annals of Internal Medicine 12/27/2016

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Medicare Site Neutral Payment Policy

- Principle is Medicare should not pay more for care in one setting than in another if the care can be safely and efficiently provided in a lower cost setting
- MedPAC recommends that Congress align Medicare OPPS payments with freestanding physician group/clinic payments
- MedPAC also recommends site neutral payments for some medical services in IRFs and SNFs
- Bipartisan Budget Act of 2015, Section 603
 - All services
 - Only off-campus
 - Exceptions
 - Grandfathered facilities

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Medicare Site Neutral Payment Policy

- Government Accountability Office Report "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform" (December 2015)
 - Medicare pays more than necessary for evaluation and management (E/M) services
 - CMS lacks the statutory authority to equalize total payment rates between hospital outpatient departments and physician offices and achieve Medicare savings
 - GAO recommends that Congress direct the Secretary to equalize payment rates between settings for E/M office visits and other services that the Secretary deems appropriate and return the savings to the Medicare program
- Effective January 1, 2016, hospitals must include modifier –PO on UB-04 for services performed in off-campus HOPDs
- Physicians must include on 1500 either POS 22 (on-campus HOPD) or POS 19 (off-campus HOPD)

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Medicare Site Neutral Payment Policy

- LTCH will receive LTCH PPS only if (immediately preceding LTCH discharge):
- Short-term acute care hospital stay included at least three days in an intensive care unit (subsection d hospital); or
- The discharge is assigned to the Medicare severity long-term care DRG based on the receipt of mechanical ventilation services for at least 96 hours
- Site-neutral payments to be phased in this fiscal year based on facility cost report date:
 - FY 2016 and 2017 blended rate for cases that miss criteria
 - FY 2018 – 100 percent site-neutral payments

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Bundled Payments for Care Improvement Initiative

- Model 2
- Episode of care includes inpatient stay and a 30-90 day post-acute care period, related readmissions included.
- Participants in the program define the bundled services to be included, which may include post-acute, physician, clinical laboratory, DME services and drugs.
- 2-3% discount target rate applies, depending on the post-acute services proposed. Program participants receive a bonus equal to any savings beyond the target price. If payments exceed the target price, program participants share in down-side risk.

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BPCI Fraud and Abuse Waivers

- Model 2 features the following waivers from fraud and abuse scrutiny:
 - Savings Pool Contribution Waiver
 - Incentive Payments Waiver
 - Group Practice Gainsharing Waiver
 - Patient Engagement Incentive Waiver

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Comprehensive Care for Joint Replacement

- Effective April 1, 2016, bundled payments for hip and knee replacement surgeries became mandatory for hospitals in 67 MSAs under the Comprehensive Care for Joint Replacement (CJR) program
- CJR program is in context of CMS's goal of tying 50% of Medicare provider payments to alternative payment models by 2018
- CJR applies to MS DRG 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities (MCC)) and MS DRG 470 (Major joint replacement or reattachment of lower extremity without MCC)
- Hospital that performs a lower extremity joint replacement (LEJR) surgery is accountable for the "episode" of care cost, which begins at the time of surgery and ends 90 days after discharge
- During five-year CJR model, providers of LEJR services will receive their ordinary Medicare payments with a true up at the end of the year
- Bonus/penalty – difference between target price and actual episode spending, up to specified cap

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Comprehensive Care for Joint Replacement

- Will Medicare increase bundling?
- How likely is CMS to continue promoting/encouraging providers to participate in the BPCI program?
- As CJR program results begin to be analyzed, will data be used to refine target price methodology to ensure it is achieving savings, or will the data instruct other results?

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Comprehensive Care for Joint Replacement

- August 17, 2017 proposed rule:
 - Certain CJR model participants permitted a onetime option to remain or withdraw
 - Hospitals in 34 of 67 geographic areas remain under mandatory participation
 - low-volume and rural hospitals excepted
 - Hospitals in remaining 33 areas permitted to withdraw
- MSAs with the highest average wage-adjusted historic lower-extremity joint replacement episode payments proposed for continued mandatory participation
- What does this proposed rule signify for the future of bundled payment models generally?

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Takeaways from Bundled Payment Programs Generally

- Success or failure may be driven largely on access to data (outcomes, financial) and the timeliness of that data.
- The two examples addressed here have varying motivations to negotiate – providers should be aware of those power dynamics and respond accordingly.
- Successful bundled payment program participants to-date are those vertically integrated systems that already have control over post-acute and physician care. Consider the risks and benefits of integration in light of the future of bundled payment initiatives.

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Enforcement Initiatives – Report and Return Overpayments

- Affordable Care Act provided:
 - An overpayment must be reported and returned by the later of --
 - The date which is 60 days after the due date on which the overpayment was identified; or
 - The date any corresponding cost report is due, if applicable.
- Significant challenges around the interpretation of this provision
- Final Rule published on Reporting and Returning Overpayments in February 2016
- Effective March 14, 2016

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Enforcement Initiatives – Report and Return Overpayments

• **Final Rule Provisions:**

- **Identification** – “A person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment”
- **Lookback** – 6 year lookback period
- **Reporting** – Provides additional avenues for self-reporting of overpayments

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Enforcement Initiatives – Report and Return Overpayments

- New “*reasonable diligence*” standard replaces proposed “*actual knowledge*,” “*reckless disregard*,” and “*deliberate ignorance*” standards
- Means an affirmative duty to proactively determine whether overpayments have been made
- 60-day time period for report and return begins when:
 - Completion of reasonable diligence (including determination of the overpayment amount) or
 - Receipt of credible information of a potential overpayment if the person failed to conduct reasonable diligence and in fact received an overpayment

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Enforcement Initiatives – Report and Return Overpayments

- No overpayment is too small; CMS expressly declined to adopt a *de minimis* threshold
- Even a single payment triggers a duty to investigate
- Shortened lookback of 6 years; consistent with the False Claims Act’s standard statute of limitations; longer than the 4-year timeframe set forth in the reopening regulations
- Interplay of requirements = any evidence of an overpayment requires a thorough review for the preceding 6 years
 - E.g., after resolving a third-party or internal audit, providers will need to expand the scope to cover the 6-year timeframe, unless there is a reason (like a change in the law) not to do so

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Enforcement Initiatives – Report and Return Overpayments

- “Reasonable diligence” includes (1) identifying the existence of an overpayment and (2) quantifying the amount
 - More practicable for both providers and the contractors or other entities who may otherwise receive a series of partial refunds
- Nevertheless, providers cannot idle or delay in review
- Benchmark of 6 months for timely investigation
 - More concrete than the proposed rule’s language of “all deliberate speed” – the standard for implementing desegregation under *Brown v. Board of Education* associated with endless delay

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Enforcement Initiatives – Report and Return Overpayments

- Congress in ACA created FCA liability and CMP penalties for improper retention of overpayments
- A person who “knowingly conceals or knowingly and improperly avoids or decreases an obligation” to refund an overpayment is liable for treble damages and penalties under FCA
- Overpayments become “obligations” 60 days after they have been “identified” (or when next cost report is due, whichever is later)
- *U.S. ex rel. Kane v. Continuum Health Partners* – Federal court held that an overpayment is identified (starting 60-day clock) when a hospital is “put on notice of a potential overpayment, rather than the moment when an overpayment is conclusively ascertained”
- Obligation to return an overpayment can be suspended under CMS and OIG protocols for self-disclosures

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