KING & SPALDING

Health Headlines

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CMS Final IPPS and LTCH Rule Includes Higher-Than-Proposed Payment Increases – On August 1, the Centers for Medicare and Medicaid Services (CMS) posted a display copy of the final rule governing inpatient prospective payment system (IPPS) for acute care hospitals and the long term care hospital prospective payment system (LTCH PPS). The rule contained two pleasant surprises: a net increase of 1.1% in overall payments to acute care hospitals for FY 2012 over FY 2011 (rather than the proposed decrease of 0.55%) and an increase in payments to LTCHs of 2.5% for FY 2012 over FY 2011 (as opposed to the proposed 1.9% increase). The net 1.1% increase for acute care hospitals is the result of a market basket increase of 3%, an Affordable Care Act (ACA)-mandated reduction of 0.1%, a documentation and coding reduction of 2.0% (as opposed to the 3.15% reduction that was proposed), a 1% productivity reduction, a 1.1% increase designed to correct a rural floor budget neutrality adjustment error brought to light by *Cape Cod v. Sebelius*, No. 09-5447 and another increase of 0.1%.

The following are other highlights from the final rule:

- Hospital Acquired Conditions (HACs): clarifies instructions on Present on Admission (POA) indicator use, adds five new diagnosis codes as CC/MCCs, and announces CMS's decision not to add contrast induced acute kidney injury as a HAC at this time (CMS deferred the decision to a time in the future when improved coding for the condition is available).
- Wage Index: publishes the national average hourly wage (unadjusted for occupational mix) of $36.2784 and explains in detail changes to the pension expense calculation for defined benefit pension plans.
- Hospital Value-Based Purchasing Program and Hospital Inpatient Quality Reporting Program: finalizes establishment of hospital value-based purchasing program and measures for value-based incentive payments for FY 2013 discharges; describes the new spending-per-beneficiary measure, which measures spending from 3 days prior to admission to 30 days after discharge (rather than the proposed 90 days after discharge).
- Hospital Readmissions Reduction Program: discusses general framework of the program, which will reduce payments in FY 2013 for discharges occurring on or after October 1, 2012 to hospitals with excess readmissions for the following three conditions: myocardial infarction, heart failure, and pneumonia. More specifically, the final rule discusses the selection of applicable conditions, the definition of readmission, measures for the conditions chosen for readmission, the methodology for calculating the Excess Readmission Ratio, Public Reporting of readmission data, and the definition of "applicable period." The rest of the rules governing the operation of the program will be discussed in rulemakings in future years.
- DSH & IME: finalizes proposal (without modification) that days relating to patients receiving inpatient hospice services in the inpatient hospital setting be excluded from both the Medicare and Medicaid Fraction components of the disproportionate share hospital (DSH) patient percentage calculation and for purposes of the indirect medical education (IME) adjustment.
- LTCHs: In addition to the 2.5% increase in operating payments, the final rule adopts the following three proposed quality measures to be used in the LTCH Quality Reporting Program for 2014 payment determinations:

new/worsening pressure ulcer, urinary catheter-associated urinary tract infection, and central line catheter-associated bloodstream infections.

- Graduate Medical Education (GME): finalizes the interim final rule (without modification) regarding the treatment of teaching hospitals that are members of Medicare GME affiliated groups for purposes of determining full time equivalent (FTE) cap reductions.

The final rule is available by clicking **here** and is scheduled for publication in the *Federal Register* on August 18, 2011.

Reporter, *Krista Barnes*, Houston, +1 713 751 3273, kbarnes@kslaw.com.

HHS Announces Adoption of New Comprehensive Coverage for Women's Preventive Care – On August 1, 2011, the Department of Health and Human Services (HHS) announced historic new guidelines that will ensure that women receive preventive health services at no additional cost. The guidelines, which were developed by the independent Institute of Medicine (IOM), require new health insurance plans to cover women's preventive services, including well-woman visits, screening for gestational diabetes, breastfeeding support, contraception, and domestic violence screening, without charging a co-payment, co-insurance or a deductible.

Under the Affordable Care Act, women's preventive health care is covered with no cost sharing for new health plans. Last summer, HHS released new insurance market rules under the Affordable Care Act, requiring all new private health plans to cover several evidence-based preventive services like mammograms, colonoscopies, blood pressure checks, and childhood immunizations without charging a co-payment, deductible or co-insurance. The August 1 announcement of the new guidelines for comprehensive coverage for women's preventive care builds upon that progress. "The Affordable Care Act helps stop health problems before they start," said HHS Secretary Kathleen Sebelius. "These historic guidelines are based on science and existing literature and will help ensure women get the preventive health benefits they need." New health plans will need to include these services without cost sharing for insurance policies with plan years beginning on or after August 1, 2012.

The HHS guidelines are available by clicking **here**.

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Congressional Research Service Issues Report on Medicare Program Integrity – On July 29, 2011, the Congressional Research Service (CRS) issued a report entitled, "Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse." The report sets forth an overview of Medicare program activities including discussion on, among other things, the background of Medicare health care fraud, a summary of CMS's program integrity activities, a description of the relationship between private contractors and federal law enforcement agencies in overseeing Medicare program integrity, and recent program integrity initiatives.

The report provides a status update with respect to CMS program integrity contractors and highlights the six core program integrity activities that such contractors coordinate:

1. Provider auditing;
2. Medical necessity claims review;
3. Fraud investigations;
4. Medicare secondary payer activities;
5. Provider education on Medicare billing procedures; and
6. Identification of Medicare and Medicaid improper billing practices (*i.e.*, Medicare-Medicaid Data Match Program).

Once the CMS program integrity contractors identify suspected fraud, they refer the cases to Medicare administrative contractors to address overpayment issues, and where appropriate, to the Department of Health and Human Services Office of Inspector General and the Department of Justice for further investigation and prosecution. Program integrity and anti-fraud resources increased from an estimated \$0.9 billion in FY 1999 to approximately \$1.9 billion in FY 2010,

and the number of fraud enforcement actions for new civil and criminal actions have more than quadrupled through FY 2010.

The report is available by clicking **here**.

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King & Spalding Client Alert Issued Concerning the Enactment of the Budget Control Act of 2011 – King & Spalding's Government Advocacy and Public Policy Practice Group recently issued a Client Alert entitled "The Budget Control Act of 2011--A Crisis Avoided." The Client Alert, issued on August 4, 2011, describes how the default of the U.S. Treasury was avoided through the enactment of the Budget Control Act of 2011 (S. 365; Pub. L. No. 112-25 (2011)), the steps that must be taken in the coming months to reduce the federal spending by an additional $1.5 trillion, and the impact these spending cuts may have on major industries, including healthcare. To view the Client Alert in its entirety, please click **here**.

King & Spalding Upcoming Roundtable on Recent Developments in Managed Care Litigation and Contracting – On Friday, August 26, 2011, we will be hosting a new Roundtable focused on recent developments in managed care litigation and contracting, including discussion about how the Patient Protection and Affordable Care Act (PPACA) is likely to affect managed care disputes. The Roundtable will take place from 1:00 p.m. to 2:30 p.m. Eastern. You can read additional information on the agenda and register to attend the Roundtable by clicking **here**.

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