KING & SPALDING

Health Headlines

September 19, 2011

Health Headlines

DC Circuit Court Issues Decision in *Northeast* on Treatment of M+C Days in the DSH Calculation – On September 13, 2011, the D.C. Circuit Court of Appeals issued its decision in the Northeast Hospital case regarding whether Medicare+Choice (M+C) days are days "entitled to benefits under Part A" for purposes of the DSH payment calculation for cost reporting periods 1999-2002. *See* ***Northeast Hospital Corp. v. Sebelius****,* No. 10-5163, (D.C. Cir., Sept. 13, 2011). The district court had determined that the Secretary's policy of including M+C days, which are administered under Part C of Medicare, as days "entitled to benefits under Part A," violated the plain language of the statute. The three judge panel all agreed with the district court's *outcome*, but two of the three judges disagreed with the district court's finding that the plain language of the statute prohibited the Secretary's current interpretation. Instead, they upheld the district court's outcome in favor of the hospital for its 1999-2002 fiscal years because they determined that the Secretary was bound by her prior policy, in place until October 1, 2004, of *not* counting M+C patients as entitled to benefits under part A. The majority opinion expressly left open the question of whether or not the Secretary's policy of including M+C days in the Medicare Part A fraction beginning October 1, 2004, is reasonable under the statute. The concurring opinion, by contrast, agreed with the district court and argued that the Secretary's current policy violates the plain language of the statute and is therefore invalid whether before or after the 2004 policy change.

For providers, the upshot of the court's decision is that CMS cannot add M+C days to the SSI fraction of the DSH calculation for any cost reporting period beginning before October 1, 2004. In addition, hospitals that have valid appeals pending on the issue for these pre-October 1, 2004 periods should be allowed to add M+C days to the numerator of the Medicaid fraction to the extent they are also Medicaid eligible days. While the court did not address how other days for which Medicare Part A did not make payment, such as Part A exhausted days or Medicare secondary payer days, should be treated, it would seem that court's reasoning would apply with equal force to these categories of days. How M+C days, or any other days for which Medicare Part A did not make payment, should be treated for periods beginning October 1, 2004, is a question the court left open for a future case. Each side has 60 days in which to file a petition for rehearing.

Reporter, *Daniel J. Hettich*, Washington, D.C. +1 202 626 9128, dhettich@kslaw.com.

CMS Issues Final Rule for Medicaid RACs – On September 16, 2011, the Centers for Medicare and Medicaid Services (CMS) published the final rule in the *Federal Register* which implements the Medicaid Recovery Audit Contractor (RAC) program, as required by § 6411 of The Patient Protection and Affordable Care Act (PPACA). States are required to fully implement their Medicaid RAC programs by January 1, 2012. CMS estimates that the Medicaid RAC program will result in net savings to the Medicaid program of $110 million in fiscal year (FY) 2012, $330 million in FY 2013, $480 million in 2014, $580 million in 2015, and $630 in FY 2016.

The final rule addresses many of the provisions included in the proposed rule released on November 10, 2010. For example, States may contract with *one or more* Medicaid RACs, and States are not required to adopt new administrative review processes to accommodate the Medicaid RACs. Medicaid RACs are reimbursed on a contingency fee basis for the

identification of overpayments and States have the discretion to establish the timing of Medicaid RAC contingency fee payments. The final rule provides that "States must adequately incentivize the detection of underpayments."

It appears that CMS has attempted to apply some of the "lessons learned" from the Medicare RAC Demonstration Project by establishing a three-year look back period for the Medicaid RACs (unless the State receives CMS approval) and requiring that the Medicaid RACs hire at least one full-time Medical Director who possesses the credential of a Doctor of Medicine or Doctor of Osteopathy. Medicaid RACs are also required to issue overpayment findings within 60 calendar days. While CMS does not establish a medical record request limit in the final rule, States are required to establish such limits based on the number and frequency of medical record requests.

The final rule requires States—not Medicaid RACs—to report instances of potential fraud to the state Medicaid Fraud Control Unit (MFCU) or appropriate law enforcement officials. CMS emphasizes in the final rule that Medicaid RACs are not intended to replace current Medicaid program integrity or audit efforts. CMS also makes it clear that it does not expect to release a Medicaid RAC Statement of Work or have significant oversight of the Medicaid RAC program after its implementation. A significant concern in the provider community involves the potential for overlapping audits, given the number of government contractors authorized to audit Medicaid claims. The final rule provides that the Medicaid RAC "should not" audit claims that are currently under review or have been reviewed.

The Medicaid RAC final rule is available by clicking **here**.

Reporters, *Sara Kay Wheeler*, Atlanta, +1 404 572 4685, skwheeler@kslaw.com and *Stephanie F. Johnson*, Atlanta, +1 404 572 4629, sfjohnson@kslaw.com.

CMS Releases Updated Statement of Work for Medicare Recovery Audit Contractors – On September 1, 2011, CMS released on its website an updated Statement of Work for the Medicare Parts A and B Recovery Audit Contractor (RAC) Program, which replaces the Statement of Work previously issued in 2007. The Statement of Work is an "umbrella" document which is incorporated into each Medicare RAC's Task Order and outlines the scope of authority of those contractors in conducting program audits. The new Medicare RAC Statement of Work includes several important revisions of which providers should be aware.

New Name for the RAC Program

- A noticeable update in the new Statement of Work is that CMS has changed the name of the Medicare "Recovery Audit Contractor Program" to the "Recovery Audit Program" and consequently modified all references to "RACs" to "Recovery Auditors." However, for the sake of simplicity, this article will refer to RACs as opposed to Recovery Auditors.

Clarifications to Medicare RAC Audit Parameters

- The new Statement of Work emphasizes the Medicare RACs' responsibility to review *all* claim and provider types for overpayments and underpayments that have a high propensity for error based on Comprehensive Error Rate Testing (CERT) results and other CMS analysis. At the same time, however, it admonishes the Medicare RACs to ensure that processes are developed to minimize provider burden to the greatest extent possible when identifying Medicare improper payments. This may include refining audit parameters to select only those claims with the greatest probability of impropriety and that the number of additional documentation requests (ADRs) to the provider do not impact the provider's ability to provide care. On the other hand, *the Statement of Work now "encourages" Medicare RACs to use extrapolation techniques for certain claim types*, indicating that "extrapolation may be cost effective for low dollar claims that require complex review that have a history of having a high error rate."

New Claims Review Process: Semi-Automated Review

- The updated Statement of Work also acknowledges a new type of claims review process that may be conducted

by Medicare RACs. In addition to existing "automated reviews" and "complex reviews," a Medicare RAC may now engage in a "semi-automated review" which is "to be used in [cases where] a clear CMS policy does not exist but in most instances the items and services as billed would be clinically unlikely or not consistent with evidence-based medical literature."

- The Statement of Work describes the semi-automated review as a two-part review. First, the Medicare RAC identifies any billing aberrancies which have "high indexes of suspicion to be an improper payment" through an automated review using claims data. Second, the RAC sends a notification letter to the provider explaining the potential billing error that is identified. The letter must indicate that the provider has forty-five days to submit documentation to support the original billing. If the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the provider's claims processing contractor for adjustment and a demand letter will be issued.

Required Timing and Effect of the Demand Letter

- Other issues addressed by the new Statement of Work include clarification regarding the required timing and effect of a Medicare RAC's demand letter. The new Statement of Work clarifies that the Medicare RAC is responsible for issuing the demand letter *on the same date* the provider receives its remittance advice from the Medicare Administrative Contractor (MAC) because the remittance advice and demand letter begin interest accrual, inform the provider of its appeal rights, and begin the appeal/recoupment timeframes. If the Medicare RAC fails to issue timely demand letters, the Statement of Work indicates that CMS may suspend recovery audit activity in that RAC's jurisdiction. However, this process will change beginning January 1, 2012 due to a recent update to the Medicare Financial Management Manual at Chapter 4, Section 100.5, which transfers responsibility for issuing demand letters from the RACs to MACs. For more information about MAC-issued demand letters, as outlined in CMS Transmittal 192, click **here**.
- All providers receiving a demand letter (and/or review results letter) from the Medicare RAC are now availed an opportunity to discuss the improper payment with the RAC in a "discussion period." The discussion period will be used to determine if the provider has other information relevant to the payment of audited claims. The Medicare RAC must respond to written requests for a discussion period within thirty days of receipt, *but the RAC need not respond if it is notified that the provider has initiated an appeal*. This means that a provider may have a difficult time simultaneously pursuing both informal discussions with the RAC and an appeal within the 30-day limitation on recoupment timeframe.

New Time Limits and Requirements Regarding Interactions with Providers

- Some of the more subtle updates outlined by the new Statement of Work include changes to certain policies that may be of practical consideration to many providers. Many of these updates establish timeframes in which the Medicare RACs must communicate or interact with audited providers. For example, Medicare RACs will not receive their contingency fee in cases where more than sixty days have elapsed between receipt of the medical record documentation and issuance of its review results letter to the provider, unless granted an extension by CMS. Medicare RACs must now also respond to all e-mail inquiries within two business days of receipt, including requests from CMS as well as inquiries from providers and other external entities. In addition, CMS may now institute a maximum payment amount per medical record that a RAC would be required to pay the provider.

The updated Medicare RAC Statement of Work may be downloaded **here**.

Reporters, *Sara Kay Wheeler*, Atlanta, +1 404 572 4685, skwheeler@kslaw.com and *J. Austin Broussard*, Atlanta, +1 404 572 4723, jabroussard@kslaw.com.

CMS Extends Deadlines for Model 1 of Bundled Payment Initiative Demonstration – The Centers for Medicare & Medicaid Services (CMS) indicated that it has received a great deal of interest and a large number of inquiries about the Bundled Payments for Care Improvement initiative released on August 23, 2011. Originally, the deadline for submitting an application for Model 1 of the Bundled Payment Initiative was September 22, 2011, but CMS has been responsive to requests for additional time to prepare applications. Based on the feedback CMS has modified the two deadlines for

Model 1 as follows:

- **Letters of intent are now due on October 6th, 2011**
- **Applications are now due on November 18th, 2011**

For more information, visit the CMS Innovation Center website by clicking **here**.

Reporter, *Gregory N. Etzel*, Houston, +1 713 751 3280, getzel@kslaw.com.

Congressional Budget Office Issues Report on the Budget Control Act's Automatic Budget Enforcement Procedures – Pursuant to the Budget Control Act of 2011 (Public Law 112-25), the Congressional Joint Select Committee on Deficit Reduction (the Super-Committee) had its first meeting last week. The Super-Committee is charged with proposing legislation to cut budget deficits by at least $1.5 trillion between 2012 and 2021. If the Super-Committee is unable to propose such legislation that is passed by Congress no later than December, automatic procedures for cutting both discretionary and mandatory spending will take effect. On September 12, 20011, the Congressional Budget Office (CBO) released a report estimating the impact of these potential automatic cuts.

CBO's report notes that the automatic cuts would be equally divided between defense and non-defense spending, starting in 2013. The automatic cuts would be achieved by lowering the caps on discretionary budget authority specified in the Budget Control Act and by automatically cancelling budgetary resources (a process known as "sequestration") for some programs and activities financed by mandatory spending. Some programs, however, such as Social Security and Medicaid, would be exempt from automatic budget cuts.

With respect to Medicare, CBO notes that the automatic cuts would include reductions of 2 percent each year in most Medicare spending. CBO estimates that, under the current law, the 2 percent limit would apply to approximately $6.1 trillion of Medicare spending over the nine-year period, for a total of $123 billion in savings. However, CBO notes that estimating automatic reductions for nondefense programs such as Medicare is "complicated" and "subject to a considerable degree of uncertainty."

CBO also expects that reductions in budgetary resources for certain parts of Medicare would offset some of the automatic savings; for example, premiums for Part B of Medicare are set to cover a fraction of that program's costs, and if those costs are reduced, receipts from premiums will be lower. This could result in $31 billion less collected in Part B premiums through 2021, according to CBO.

A copy of the CBO's report is available by clicking **here**.

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

Compliance Deadline Approaching for New Health Care Electronic Transactions Standards – On October 1, 2013, the ICD-9 code sets used to report medical diagnosis and inpatient procedure codes will be replaced by ICD-10 code sets. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the health care industry to use standard formats for electronic claims and claims-related transactions. To accommodate the ICD-10 code structure, the current versions of the transaction standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions and the National Council for Prescription Drug Programs [NCPDP] Version 5.1 for pharmacy transactions) were modified under the Modifications to HIPAA Electronic Transaction Standards Final Rule, (see 74 Fed. Reg. 3296 (Jan. 16, 2009) and 74 Fed. Reg. 3328 (Jan. 16, 2009)). The current versions were replaced with Version 5010 and Version D.0, respectively. All those engaging in standard transactions, including providers, billing services, and health insurers, must implement Version 5010 and Version D.0 by January 1, 2012.

The CMS Fact Sheet is available **here** and the CMS webpage on Transactions and Code Sets Regulations is available **here**.

Reporter, *Juliet M. McBride*, Houston, +1 713 276 7448, jmcbride@kslaw.com.

King & Spalding LLP Co-Sponsoring 4th Annual Healthcare Deal Making Summit – King & Spalding is co-sponsoring the 4th Annual Healthcare Deal Making Summit—dedicated to M&A deal making activity for non-profit and for-profit providers. The summit will be held at the Union Station Hotel in Nashville, Tennessee on October 3-5, 2011. Topics of the summit include:

- Implications of healthcare reform and industry consolidation of healthcare provider M&A transactions
- Market intelligence on deal making activity and pricing from the leading equity investors, financiers, and investment bankers
- Opportunities for non-profit and for-profit providers to facilitate deal making in a strategic business environment with the gathering of financiers and dealmakers under one roof

For more information, please visit: **4th Annual Deal Making Summit**.

To register, please visit **Healthcare Deal Making Summit Registration**. Please contact **Jay Harris**, **Paul Quiros**, or **Bill Spalding** at +1 404 572 4600 for more information on this event.

King & Spalding Starts New Distribution List for CMS's Bundled Payment Demonstration Project – King & Spalding's Healthcare Industry Group is creating a distribution list of clients and others who would like to receive updates from us on CMS's Bundling Demonstration project. We will include on this list all those who were signed up for our September 12 Roundtable (subject, of course, to opt out) and others who request to be included. Please respond by e-mail to healthcare@kslaw.com if you would like to be on our Bundling Distribution List. We will distribute the slides we used for our Roundtable presentation, and also will distribute the list of questions that we are submitting to CMS on the Bundling Demonstration.

Health Headlines – Editor:

Dennis M. Barry
dbarry@kslaw.com
+1 202 626 2959

The content of this publication and any attachments are not intended to be and should not be relied upon as legal advice.