KING & SPALDING

Health Headlines

July 25, 2011

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CMS and Center for American Progress Release Bundled Payment Report – On July 18, the Center for American Progress issued a report sponsored by CMS entitled *"Bundling" Payment for Episodes of Hospital Care* (CAP Report), which contained recommendations for bundled payment pilot programs to be initiated by CMS in the near future. The Patient Protection and Affordable Care Act (PPACA) mandated that, by 2013, CMS create a program that would bundle payment for hospital services and other post-acute care services that were provided as part of the same episode of illness. It is anticipated that the initial pilot programs will focus on acute, rather than chronic, care and will involve retrospective, rather than prospective, payment.

Nancy-Ann DeParle, the White House Deputy Chief of Staff, was present at the release of the CAP Report and stated that providers could begin implementing models described in the CAP Report before the end of this year.

The CAP Report includes the following recommendations, among others:

- Pilots should have "clear conditions for participation and clear standards for performance," but leave flexibility for providers to adapt their own "operational details."
- Pilots should strive for "extensive…participation" by providers, be time-limited, and if possible, involve the participation of private insurers.
- Pilots should target medical conditions or diagnoses that are high volume, subject to "substantial variation in treatment patterns and expenditures" and for which there exist well-established, evidence-based interventions.
- Pilots should offer payment designs that incorporate both single bundled payments to a single coordinating provider and alternative designs.
- To ensure broad participation, pilots should begin using existing Medicare DRG rates and constrain rate growth in subsequent years to achieve savings.
- Pilot payments should be tied to quality performance.
- Patients should be informed of a provider's participation in a bundled payments program and be allowed the freedom to seek non-participating providers without financial penalty.

Though not certain, it is likely that CMS's design of the pilot program(s) will be consistent with the recommendations of the CAP Report.

The report and video of Ms. DeParle's remarks can be found **here**.

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DC Circuit Rules Equitable Tolling is Available for Medicare Cost Report Appeals – On June 24, 2011, the Court of Appeals for the D.C. Circuit ruled that equitable tolling may be applied in cases involving provider appeals of Medicare cost reports. *Auburn Regional Medical Center, et al. v. Sebelius,* No. 1:07-cv-02075, 2011 WL 2507853 (D.C. Cir. June 24, 2011). The issue arose in the context of provider appeals of the SSI Ratio component of the disproportionate share hospital (DSH) adjustment for fiscal years 1987-1994. The providers did not appeal the SSI Ratio issue to the Provider Reimbursement Review Board (PRRB) until they learned of the issue in 2006 (as a result of the *Baystate* litigation), more than a decade after the 180-day window for appealing their Medicare cost reports had passed.

The providers argued that the 180-day time limit for appealing Medicare cost report disputes should be equitably tolled because CMS "knowingly and unlawfully failed to disclose that the DSH payments had been understated"; therefore, that statute of limitations for appealing the SSI Ratio issue should not begin until the point in time when the providers learned of the issue. The PRRB held that because it lacked the power to toll the limitations period, the providers' claim was not timely and the PRRB was without jurisdiction to rule on the providers' appeal.

The D.C. District Court ruled that 42 USC 1395oo, the jurisdictional statute governing provider cost appeals, does not allow for equitable tolling. In reversing the district court's decision, the DC Circuit noted the general rule that all limitations periods are subject to equitable tolling unless tolling would be inconsistent with the relevant statute and held that the jurisdictional statute at 42 USC 1395oo(a) "is straightforward and readily amenable to tolling." And although it found that equitable tolling is generally available under 42 USC 1395oo(a), the DC Circuit did not actually apply it; instead, it remanded the case to the district court to determine whether equitable tolling is appropriate under the facts specific to *this* case.

The DC Circuit's ruling is good news for providers, as there may be potential for after-the-fact appeals based on the date that CMS mistakes are revealed (as opposed to the date of the Notice of Program Reimbursement), which could occur many years after the affected fiscal year. It remains to be seen how broadly CMS will apply this equitable tolling doctrine. The decision is available by clicking **here**.

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HHS Inspector General Recommends Replacing Average Wholesale Pricing For Drugs – In a report dated July 18, 2011, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) recommended that the Centers for Medicare & Medicaid Services (CMS) develop a national drug pricing benchmark in order to save on Medicaid pharmacy reimbursement costs paid to pharmacies for prescription drugs. OIG Report: "Replacing Average Wholesale Price: Medicaid Drug Payment Policy," (OEI-03-11-00060). According to OIG, the methodology currently used by most states to calculate reimbursement rates, which is based upon Average Wholesale Price (AWP), is "fundamentally flawed," because it overstates a pharmacy's true cost by not taking into account discounts, rebates, or other price reductions available to the pharmacy.

In light of this concern and the fact that First DataBank (the private publishing source relied upon by most states under the current reimbursement methodology) will discontinue providing pricing information in September 2011, the OIG surveyed all fifty states and the District of Columbia in January to determine how they intend to change their reimbursement methodologies once First DataBank no longer publishes AWP data. Of the forty-five states that use AWP-based reimbursement methodologies, twenty indicated that they had not yet made plans as to how they would calculate reimbursement rates after September 2011. Fifteen states indicated that they had "relatively well-developed plans" to switch to a new methodology. Ten other will continue using AWP to set reimbursement rates at least in the short term.

Notably, forty-four states said that they would like CMS to develop a national benchmark to set Medicaid reimbursement for prescription drugs, according to the report. Of these forty-four states, twenty-four specified that they want a benchmark based on pharmacy Average Acquisition Costs (AACs). As noted in the report, CMS concurs and is contracting with a vendor to develop a survey of retail prices and acquisition cost information. CMS expects to use these data to develop an estimate of AAC.

To view the OIG's report, please click **here**.

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