KING & SPALDING

Health Headlines

February 14, 2011

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President's FY 2012 Budget Includes Two-Year Fix to Physician Payment – President Obama announced his proposal for the FY 2012 budget today, proposing to reduce the budget deficit by $1.1 trillion over the next 10 years. Notably, the budget proposes to pay for two years of reimbursements to Medicare physicians at the current payment levels and to offset this cost with $62 billion in specific health savings. In December, the President worked with Congress to prevent a 25 percent cut to Medicare physician payment rates for 2011.

The President's budget allocates $79.9 billion in discretionary spending for the Department of Health and Human Services (HHS), the principal federal agency charged with protecting the health of Americans. Actual discretionary expenditures by HHS in 2010 totaled $82.3 billion. For FY 2012, the budget allocates approximately $485 billion in mandatory expenditures for Medicare and $279 billion for Medicaid and the Children's Health Insurance Program (CHIP).

In addition, the President's budget provides $581 million in discretionary program integrity funding to implement activities to reduce payment error rates and enhance civil and criminal enforcement for Medicare, Medicaid, and CHIP. This funding is in addition to the $53 million allocated by the budget for the operations of the HHS Office of Inspector General (OIG) and $47 million for the HHS Office of Civil Rights (OCR) for FY 2012.

The administration's fact sheet regarding the FY 2012 budget for the Department of Health and Human Services is available by clicking here. An overview of the FY 2012 budget is available by clicking here.

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CMS Finds High Error Rate on Pacemaker Implants Meeting CMS Coverage Policy – Through its Comprehensive Error Rate Testing (CERT) Program, CMS discovered a large number of errors related to the implantation of cardiac pacemakers. The CERT Program randomly selects a small sample of Medicare fee-for-service claims to produce a national error rate and a provider compliance error rate. In the case of cardiac pacemaker implantation, the CERT Program revealed that patients who had an indication for a single-chamber pacemaker nevertheless often received dual-chamber devices. In response, CMS issued a fact sheet on the topic, available by clicking here.

The CERT review of cardiac pacemaker implantations revealed two common errors. First, claims often lacked documentation to support the choice of a dual-chamber, rather than a single-chamber, pacemaker. CMS noted, "Physicians must clearly state, in the patient's medical record, the reasons for choosing a dual-chamber pacemaker rather than a single-chamber pacemaker." Second, claims often revealed the implantation of a dual-chamber pacemaker in patients with a clear contraindication, such as chronic atrial fibrillation.

The CMS fact sheet lists four indications for a dual-chamber pacemaker that are listed in the Medicare National Coverage

Determinations Manual, available by clicking here:

- Patients in whom a single-chamber pacemaker elicits a drop in blood pressure, retrograde conduction, or discomfort;
- Patients who have already experienced significant symptoms of pacemaker syndrome;
- Patients in whom even a small increase in cardiac efficiency will improve quality of life (*e.g.* patients with congestive heart failure despite adequate other medical measures); or
- Patients in whom pacemaker syndrome is anticipated (*e.g.* young and active patients).

CMS Pub. 100-03, ch. 1, § 20.8. In addition, the fact sheet notes that dual-chamber pacemakers are never covered when certain conditions are present. These overriding contraindications, which include all other indications for which CMS has not specifically indicated coverage, are:

- Ineffective atrial contractions;
- Persistent or frequent supraventricular tachycardias, except when the pacemaker is specifically for the control of the tachycardia;
- A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood of prolonged pacing needs; or
- Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was second-degree and/or third-degree AV block in association with bundle branch block.

Hospitals should take CMS's instructions on pacemaker coverage seriously. In a very similar area—Medicare coverage for implantable cardiac defibrillators—there is a large number of ongoing investigations where the government presumably is considering penalties under the False Claims Act. It is important that hospitals be mindful of CMS's coverage policy for pacemakers (and all other services) to minimize compliance risk.

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ONC Announces New EHR Funding to Aid Rural Providers – On February 8, 2011, the Office of the National Coordinator for Health IT (ONC) announced an increase of $12 million in HITECH Act funding for regional extension centers to provide technical and educational assistance to critical access hospitals (CAHs) and rural hospitals as those facilities work to qualify for Medicare and Medicaid incentives as "meaningful users" of EHR technology.

This latest infusion of funds comes after an initial $20 million awarded by ONC to regional extension centers in September 2010 to provide onsite support to CAHs and rural hospitals with fewer than 50 beds. ONC will direct the additional $12 million to 48 regional extension centers that serve CAHs and small rural hospitals. ONC stated in its February 8 announcement, available by clicking here, that the geographic and financial challenges facing these facilities require additional funding to overcome. The complete list of regional extension centers receiving the new funds is available by clicking here.

Reporter, *Christopher Kenny*, Washington, D.C., +1 202 626 9253, ckenny@kslaw.com.

Secretary Sebelius Sends Letter to Governors Outlining Potential Cost-Saving Measures for State Medicaid Programs – On February 3, 2011, the Secretary of Health and Human Services (HHS), Kathleen Sebelius, sent a letter to state governors outlining potential methods for states to reduce their Medicaid costs. The Secretary's letter was submitted in response to concerns raised by governors about the Medicaid program's substantial drain on their states' dwindling state budgets. At the outset of the letter, the Secretary reaffirmed the Obama Administration's commitment to assist states in balancing their budgets while still providing critical health care services to those who need them. The Secretary pointed out that the Administration had already provided support to states to address such concerns by working with Congress to pass and later to extend the enhanced Medicaid federal match (*i.e.*, Federal Medical Assistance Percentage or FMAP) provisions of the American Recovery and Reinvestment Act. The Secretary acknowledged, however, that the enhanced FMAP provisions are scheduled to expire June 2011 and that states are continuing to face substantial budgetary

constraints as a result of, among other things, rising Medicaid costs.

Responding to these concerns, the Secretary outlined the following potential cost saving measures to assist the management of their Medicaid programs:

- **Modify Medicaid Benefits.** The Secretary pointed out that states have flexibility to change or limit optional benefits under the Medicaid program (*e.g.*, prescription drugs, dental services, and speech therapy) through a Medicaid state plan amendment, particularly for higher-income enrollees. States also have the ability to increase cost-sharing for certain enrollees.
- **Manage Care for High-Cost Enrollees.** Noting that 25 percent of Medicaid expenditures are spent on one percent of enrollees, the Secretary indicated that states could reduce expenditures for such enrollees through the implementation of initiatives to, among other things, strengthen systems for providing long-term care, provide better primary and preventative care, and lower the incidence of low birth weight babies.
- **Efficiently Purchase Drugs.** The Secretary pledged HHS's commitment to ensure that states have accurate information regarding the costs of drugs to facilitate "prudent purchasing decisions." For example, HHS has undertaken a national survey to create a database of actual acquisition costs.
- **Assure Program Integrity.** Emphasizing that the three-year weighted average national error rate for Medicaid is 9.4 percent (*i.e.*, $33.7 billion), the Secretary indicated that there were new options available to states to address Medicaid program integrity. These include, among others, HHS's Medicaid Integrity Institute webinars, a new federal portal identifying excluded providers, the use of federal audit contractors, and the use of predictive modeling and analytics which are now being developed for the Medicare program.

The Secretary indicated that this letter and the above cost-saving measures were "just the beginning" of HHS's discussion with states on how they can better manage their Medicaid programs and navigate their budget crises. HHS stated that it would host a series of "virtual" meetings with state health policy advisors and Medicaid directors to share additional Medicaid cost-saving initiatives.

The Secretary's letter appears to suggest that there will be significant changes by states to their Medicaid programs. As states attempt to address budgetary constraints and the rising costs of their Medicaid programs, the scope and benefits offered under the states' Medicaid programs will likely change. This letter also seems to underscore the Obama Administration's intent to be much more actively involved in the management of state Medicaid programs, particularly as health reform is rolled out.

A copy of the Secretary's letter is available by clicking here.

Reporter, *Adam Robison*, Houston, +1 713 276 7306, arobison@kslaw.com.

King & Spalding Upcoming Roundtable to Discuss Medicare and Medicaid Program Contractors – On February 23, 2011, King & Spalding will be hosting a Roundtable in its Atlanta office entitled "Taking Charge of Contractor Chaos." The Roundtable will offer a discussion of the various Medicare and Medicaid program contractors (including RACs, MACs, MICs, PSCs and ZPICs) and how they operate, overlap and differ, as well as how providers can prepare themselves for contractor audits. Please be on the lookout for additional communications regarding further program details and registration information.

King & Spalding 20th Annual Health Law and Policy Forum – King & Spalding's 20th annual Health Law and Policy Forum will be held this year on March 14 at the Four Seasons Hotel in Atlanta. Please be on the lookout for additional communications soon that will provide details on the specific content of the program.

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