KING & SPALDING

Health Headlines

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OIG's Spring 2011 Semiannual Report To Congress – The Office of Inspector General (OIG) at the Department of Health and Human Services has released its semiannual report describing OIG's reviews, recommendations, and investigative activities during the first half of FFY 2011. OIG reports expected recoveries of about $3.4 billion resulting from audits and investigations, including 349 criminal actions and 197 civil actions. Items of special interest include:

- Wisconsin Physicians Service (WPS) made incorrect Medicare payments in excess of hospital charges for outpatient services for calendar years (CYs) 2004 through 2007, including overpayments not refunded totaling $9.2 million. Overpayments were identified through OIG's audit of claims where Medicare payment exceeded the provider's billed charges for outpatient services. The incorrect payments involved excessive units of service, incorrect HCPCS codes, unallowable services, and lack of supporting documentation.

- Intermediaries made an estimated $6.6 million in overpayments to ambulatory surgical centers (ASCs) for services provided to beneficiaries during covered Part A stays in skilled nursing facilities (SNFs) during CYs 2006 through 2008. Under the "consolidated billing rules," payment for the ASC services was deemed to be included in the SNFs' Part A payments.

- OIG recommends closer monitoring by CMS of SNFs billing for higher-paying resource utilization groups (RUGs), like ultra-high level therapy, due to concerns that the payment system incentivizes SNFs to bill for more therapy than is needed.

- OIG identified 20 high-utilization counties whose per-beneficiary spending on outpatient therapy was more than 72 percent above the national average. OIG recommends that the Centers for Medicare and Medicaid Services (CMS) review outpatient therapy claims in high-utilization areas and revise the therapy cap exception process.

- According to OIG, CMS should focus on error-prone providers for review and corrective action. OIG recommends that CMS use available error rate data from the Hospital Payment Monitoring Program and the Comprehensive Error Rate Testing (CERT) program to identify error-prone providers, require them to develop corrective action plans, and share error rate data with intermediaries to assist in identifying improper payments.

- Santa Clara Valley Medical Center paid $4.3 million to resolve its False Claims Act liability for improper billing of 1-day hospital admissions that did not meet "medical necessity" criteria for inpatient services and should have been billed as outpatient observation services. This is the only item in the OIG's Semiannual Report on this issue.

- OIG has released educational materials for new physicians on how to avoid Medicare and Medicaid fraud and abuse. The Roadmap for New Physicians, which summarizes the five main fraud and abuse laws, is available by

clicking **here**.

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

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Proposed Rule Allows Medicare Claims Data To Be Used By "Qualified Entities" To Publish "Comprehensive Performance Reports" For Providers And Suppliers – CMS issued a proposed rule, with comment period, implementing Section 10332 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, which requires the Centers for Medicare and Medicaid Services (CMS) to disclose standardized extracts of Medicare claims data under Parts A, B, and D to "qualified entities" for the evaluation of the quality performance of providers and suppliers. The qualified entities must combine the Medicare data with claims data from other payers and make "comprehensive performance reports" available to the public. According to CMS, this statutory provision is "intended to make Medicare data available to those already working with other claims data in order to increase sample sizes used to calculate measures and evaluate the performance of providers of services and suppliers."

The proposed rule sets forth stringent requirements that an entity would have to meet to qualify as a "qualified entity," including having an "established track record" of "handling claims data and calculating performance measures" for providers and suppliers. CMS is not planning to limit the number of qualified entities in any geographical area, however, raising the possibility that "in certain circumstances providers of services and suppliers might receive multiple reports from different qualified entities."

Qualified entities would use Medicare and non-Medicare claims data to assess provider and supplier performance on "standard" or "alternative" quality measures. Standard quality measures are measures that are endorsed by the National Quality Forum (NQF) or already used by CMS in other quality reporting initiatives. CMS may adopt additional "alternative" measures if the qualified entity can show that the "alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by the standard measures." CMS will consider proposed alternative measures annually in notice and comment rulemaking prior to the start of the next calendar year. Approved alternative measures would be available for use by all qualified entities. Qualified entities must use all measures as approved "including all numerator and denominator inclusions and exclusions, measured time periods, and specified data sources."

Qualified entities must then create quality reports that include "an understandable description of the measures, rationale for use, methodology (including risk-adjustment and physician attribution), data specifications and limitations, and sponsors." Under the proposed rule, the qualified entity must make the quality reports available to the provider or supplier at least 30 days before the report is made publicly available. They must give providers and suppliers at least 10 days from receipt of the report to request the underlying documentation or seek an appeal of errors. CMS stated, however, that the public disclosure of reports will not be delayed because of a pending appeal. Instead, the qualified entity must simply note on the report if an appeal is pending.

CMS will be accepting comments until August 8, 2011. We encourage providers and suppliers to review the rule, which would add eleven new sections to the Code of Federal Regulations (42 C.F.R. §§ 401.701 - 401.711), and consider submitting comments. Among several areas for possible comment, the proposed appeal procedures appear woefully inadequate. Besides giving a provider or supplier only 10 days to review its reports and request corrections, and making reports available to the public notwithstanding an ongoing appeal, CMS imposes no real requirements on the qualified entity's appeal process. Instead, CMS merely "encourage[s] qualified entities to dedicate appropriate resources . . . to resolving good faith questions regarding performance results." Providers and suppliers have no further recourse should this process be inadequate. The proposed rule is available **here**.

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Health IT Policy Committee Work Group Recommends Delay Of Stage 2 Meaningful Use Criteria – In a draft letter released June 8, 2011, the Meaningful Use Work Group of the Health IT Policy Committee recommended a one-year

delay in the implementation of Stage 2 meaningful use criteria. Under the Medicare and Medicaid electronic health records (EHR) Incentives Programs, hospitals and eligible professionals must demonstrate meaningful use of certified electronic health records in order to receive incentives funding. The work group recommended delaying implementation until 2014 so that hospitals and eligible professionals will have another year to successfully implement the Stage 1 criteria set forth in the Centers for Medicare and Medicaid Services' (CMS) January 2010 Meaningful Use Rule. CMS is scheduled to issue its Stage 2 Meaningful Use Rule in June 2012, for implementation by eligible hospitals during federal fiscal year 2013.

While the work group expresses support for gradually increasing the standards and criteria necessary for hospitals to demonstrate meaningful use (indeed, the work group requested public comment on potential Stage 2 criteria earlier in 2011), the work group states that implementing the next set of criteria in 2013 will not give hospitals enough time to adapt to the new requirements. The work group states that maintaining the current schedule will present "a nearly insurmountable timing challenge for those who attest to [Stage 1 of] meaningful use in 2011."

The work group addressed its letter to Dr. Farzad Mostashari, head of the Office of the National Coordinator for Health IT (ONC), who is also the chairman of the Health IT Policy Committee. If the work group's recommendations are approved by both the full Health IT Policy Committee and ONC, the recommendations are then submitted to CMS as it crafts the Stage 2 Meaningful Use Rule. Ultimately, CMS is responsible for setting the Stage 2 criteria and may modify or disregard the recommendations.

The work group's draft letter is available **here**.

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CMS Issues Final Rule Banning Medicaid Payment For Preventable Illnesses And Injuries – On June 6, 2011, the Centers for Medicare and Medicaid Services (CMS) published a final rule implementing Section 2702 of the Patient Protection and Affordable Care Act (PPACA) that requires the Department of Health and Human Services to adopt Medicaid payment adjustments for health care-acquired conditions. The new rule requires state Medicaid agencies to stop reimbursing providers for provider-preventable conditions, which are defined to include health care-acquired conditions, in an effort to address and reduce the occurrence of preventable conditions. Although the Deficit Reduction Act of 2005 required CMS to adjust payments to hospitals for certain hospital-acquired conditions, it did not address adjustments to Medicaid payments. Thus, until PPACA, states relied on guidance from CMS in State Medicaid Director Letter #08-004 dated July 31, 2008, that *permitted* - but did not require - states to amend their state plans if they desired to implement hospital-acquired condition nonpayment policies.

In the final rule, provider-preventable conditions are comprised of health care-acquired conditions and other provider-preventable conditions. Health care-acquired conditions apply to Medicaid inpatient hospital settings and include the full list of Medicare's hospital-acquired conditions with the exception of deep vein thrombosis following total hip or knee replacements for certain patients. Other provider-preventable conditions apply broadly to Medicaid inpatient and outpatient health care settings and include, at a minimum: surgery on the wrong patient, the wrong surgery, and wrong site surgery. States are permitted to expand other provider-preventable conditions to settings other than inpatient hospitals with CMS approval if states identify events that occur in other settings for which payment should not be made. States are also permitted to expand other provider-preventable conditions based on specified criteria and subject to CMS approval.

Therefore, the final rule establishes the minimum standards for nonpayment that states are required to adopt, but grants states the option to expand the nonpayment ban to additional other provider-preventable conditions, with CMS approval. According to CMS, twenty-one states already have adopted health care-acquired conditions-related nonpayment policies, most of which identify at least Medicare's hospital-acquired conditions for inpatient hospitals. The new federal rule expands the nonpayment ban nationwide, however, and mandates nonpayment of federal matching funds for health care-acquired conditions. Those states currently without nonpayment policies for preventable conditions are required to submit amendments to their state Medicaid plans. States with such policies in place should review the policies to ensure that they comply with the new rule. All states must also implement provider self-reporting through existing claims systems.

Although the final rule is effective July 1, 2011, CMS states in the final rule that it intends to delay compliance action

until July 1, 2012 to give states time to implement the final rule.

To view the final rule, click **here**.

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