KING & SPALDING

Health Headlines

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Physician Payment and Therapy Relief Act of 2010 Extends 2.2 Percent Medicare Physician Fee Schedule Update Through December 31, 2010 – President Obama signed into law the Physician Payment and Therapy Relief Act of 2010 last Tuesday, November 30th, which extended the 2.2 percent update to the Medicare Physician Fee Schedule (MPFS) until December 31st of this year. The 2.2 percent update has been in effect for MPFS claims with dates of service from June 1, 2010 to November 30, 2010.

H.R. 5712, which became Public Law 111-286 after the President's signature, delays a 23 percent reduction in Medicare physician payments until December 31. In order to maintain the current MPFS payment rate until December 31, 2010 and to remain budget neutral, the law reduces Medicare payments for certain outpatient therapy services by $1 billion by imposing a 20 percent multiple payment procedure reduction (MPPR) to the "practice expense" component for the second and any subsequent outpatient therapy services paid under the fee schedule that are furnished in an office setting.

To remain budget neutral, the law modified the multiple payment procedure reduction (MPPR) finalized by the Centers for Medicare and Medicaid Services (CMS) on November 18, 2010 by applying a 20 percent reduction rather than a 25 percent reduction to the "practice expense" component for the second and any subsequent outpatient therapy services paid under the fee schedule that are furnished in an office setting.

The text and a summary of the Physician Payment and Therapy Relief Act of 2010 is available by clicking here.

Reporter, *J. Austin Broussard*, Atlanta, +1 404 572 4723, jabroussard@kslaw.com.

CMS Removes Invalidated Medicaid Federal-State Cost-Sharing Rule – On November 30, 2010, the Department of Health and Human Services (HHS) announced that it was removing provisions of a final rule published on May 29, 2007 (Final Rule), pursuant to a decision of the United States District Court for the District of Columbia in *Alameda County Med. Ctr. v. Leavitt*, 559 F. Supp. 2d 1 (2008). The Final Rule had modified the regulatory requirements pertaining to federal and state funding of the Medicaid and State Children's Health Insurance Program (SCHIP) programs. Included within the Final Rule were provisions that, among other things, clarified that only units of government could finance the non-federal share of Medicaid expenditures and limited Medicaid reimbursement to government-operated health care providers to the provider's cost in providing services to Medicaid beneficiaries.

In *Alameda County Medical Center*, the D.C. District Court vacated the Final Rule after finding that HHS had improperly promulgated the Final Rule by ignoring a Congressional moratorium on the regulation enacted as part of the U.S. Troop Readiness, Veterans Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007 (later extended by the Supplemental Appropriations Act of 2008). As part of the American Recovery and Reinvestment Act of 2009, Congress subsequently expressed its sense that the Final Rule should not be adopted. Through the regulation issued on November

30, 2010, HHS removed all provisions of the Final Rule from the Code of Federal Regulations and reinstated the regulatory language that existed prior to the issuance of the Final Rule. These changes affect rules in Parts 433, 447, and 457 of Title 42 of the Code of Federal Regulations.

The Final Rule is available by clicking here.

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CMS Selects 800 Hospitals for Calendar Year 2012 Outpatient Record Validation Under the Hospital Outpatient Data Quality Reporting Program – On December 1, 2010, CMS published its list of the 800 hospitals selected for chart validations under the hospital outpatient prospective payment system data quality reporting program (HOP QDRP). CMS had formerly requested outpatient quality data from all hospitals, but has now determined to review data from only 800 randomly selected hospitals. The results of this validation will affect the payment rates for only the 800 hospitals for calendar year 2012.

The HOP QDRP is a quality data reporting program implemented by CMS under Section 109(a) of the Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA), which corresponds to Section 1833(t) of the Social Security Act. Under the HOP QDRP, hospitals report data using standardized measures of care in order to receive the full annual payment update (APU) to their outpatient prospective payment system payment rate. Hospitals that fail to report data to CMS incur a 2.0 percentage point reduction to their APU, which applies to the payment year to which the survey data relates.

In its Proposed Rule published on August 3, 2010, CMS proposed to validate data submitted by 800 hospitals for purposes of the CY 2012 HOP QDRP payment determination. CMS also proposed to retain the 11 quality measures for CY 2012 determination as well as to add one new structural measure and three new claims-based imaging efficiency measures. In its Final Rule published on November 24, 2010, CMS finalized its proposal to review medical records from only 800 of the HOP QDRP participating hospitals. CMS also decided to adopt its proposal regarding the addition of the four new HOP QDRP reporting for calendar years 2012.

For the CY 2012 payment update, CMS decided to validate data for only 800 hospitals out of the approximately 3,200 HOP QDRP participating hospitals. CMS commented that this approach would produce a more reliable estimate of whether a hospital's submitted data has been abstracted accurately; would provide more statistically reliable estimates of the quality of care delivered in each selected hospital as well as at the national level; and would reduce overall hospital burden because most hospitals will not be selected to undergo validation each year. CMS will request no more than twelve medical records per hospital per quarter from the 800 selected hospitals.

The Proposed Rule regarding the number of hospitals selected for the CY 2012 HOP QDRP payment determination can be found at 75 Fed. Reg. 46170, 46360-83, 46458-59 (Aug. 3, 2010) and by clicking here. The Final Rule can be found at 75 Fed. Reg. 71800, 72064-72110, 72132-33 (Nov. 24, 2010) and by clicking here. The list of the 800 selected hospitals is available by clicking here.

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CMS Launches New Provider Compliance Webpage – CMS recently launched a new Provider Compliance webpage for Medicare fee-for-service (FFS) providers. The webpage is available at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp. According to CMS, the agency intends for the webpage to contain educational information for Medicare FFS providers about dealing with and avoiding improper activities and billing errors. The webpage maintains a list of, and access to, the CMS Medicare Learning Network (MLN) products that relate to provider compliance as well as National Education Products developed by CMS and CMS's new publication for providers, the Medicare Quarterly Provider Compliance Newsletter.

The agency intends for the Medicare Quarterly Provider Compliance Newsletters to describe the "top" issues for the quarter that CMS has discovered through activities and reviews conducted by the Office of Inspector General, Recovery Audit Contractors, Program Safeguard Contractors, Zone Program Integrity Contractors, and Medicare Administrative Contractors related to billing errors or other areas of noncompliance. CMS intends to use the newsletters to inform providers of the steps that CMS has taken to make providers aware of the described issues and provide recommendations to providers for managing and/or avoiding the issue. The first of these newsletters published in October 2010 discusses issues common to various provider types, such as failure to submit requested documentation, billing for the incorrect number of units and failure of the medical record to provide sufficient documentation. The October 2010 issue is available by clicking here. CMS notes, however, that future issues may focus on issues appropriate to a particular Medicare FFS provider type or set of items or services.

Providers should consider the new webpage as an additional resource providing insight into CMS's expectations of providers, and therefore, providers should periodically refer to the new webpage for information.

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King & Spalding Hosts Managed Care Roundtable – On Friday, December 10, 2010, King & Spalding will host a Roundtable in its Atlanta offices featuring speakers from the Washington, D.C. and Atlanta managed care and antitrust practices on current developments in the managed care industry relevant to providers and payors. For more information and to register, please click here.

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