HEALTHCARE**LEGAL**NEWS

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IN THIS ISSUE

"DOUBLE JEOPARDY": THE CONTRACTUAL ENFORCEMENT OF HEALTHCARE LAWS AND REGULATIONS IN PAYOR AGREEMENTS

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In a recent review of a client's proposed payor agreement with a state agency, I found several disturbing provisions that were buried deep within the "boilerplate" provisions under a "Special Requirements" category. By signing the proposed renewal agreement, the client agreed to comply with several federal healthcare laws and regulations. Despite its being required to comply with the referenced statutes anyway, because the client incorporated these new provisions into its renewed payor agreement, the client will also be in default with this agreement if it fails to comply with the federal provisions. Even though this payor agreement was the annual renewal of an expiring agreement for the same client with the same governmental agency, these provisions were new and were not found in the expiring agreement.

As a result, my client is subject to "Double Jeopardy". If it violates the healthcare laws and regulations that are incorporated into the agreement, my client will not only be subject to the federally imposed consequences of violation of the regulations and laws, but also could be further financially penalized by loss of revenues from the payor agreement since a violation of the contractual requirements to comply with these laws could result in termination of the client's payor agreement with the state agency.

Examples of the federal statutes that my client must comply with under the payor agreement include requirements to comply with HIPAA, HITECH, the Drug Free Workplace Act of 1988 and the Federal Funding Accountability and Transparency Act, each of which has its own set of penalties for noncompliance. In addition, the client is contractually required to file an annual cost report with the state agency to enable the state to claim reimbursement for a portion of the cost of payments under the client's payor agreement.

In summary, for this client, the additional provisions in the payor agreement increased the focus it must give to compliance with several federal healthcare statutes and regulations.

TAX AND EXEMPT PROVIDER NEWS

IRS ANNOUNCES REQUIREMENTS FOR TAX-EXEMPT HOSPITALS TO CONDUCT COMMUNITY HEALTH NEEDS ASSESSMENTS

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On July 7, the IRS proposed requirements for tax-exempt hospitals to conduct community health needs assessments (CHNA) every three years as required by the Patient Protection and Affordable Care Act (ACA) and gave the public until September 23 to comment on the draft requirements.

If these provisions are adopted in final form, a hospital organization that operates multiple hospital facilities can conduct a single CHNA for all of its facilities, but implementation of the assessment and documentation of its implementation must take place on a facility by facility basis.

In addition, the Board of Directors or other governing body of the hospital organization that conducts the CHNA (or a committee of the Board) must approve and adopt an implementation strategy before the end of the year in which the CHNA is adopted.

Each hospital organization that fails to comply with these requirements faces a $50,000 excise tax for each facility it operates.

HEALTHCARE REFORM NEWS

SEVERAL INITIATIVES ANNOUNCED UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT

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Within the past thirty days, the HHS announced several initiatives under the ACA that are designed to improve the efficiency of the healthcare system by enabling healthcare providers and payors to redirect time to increase direct patient care by reducing the administrative time in the billing process.

For example, on June 30, HHS announced an initiative to standardize data requirements for inquiries by a healthcare provider about a patient's insurance eligibility or the status of a healthcare claim that had been previously submitted to an insurer. These new operating rules attempt to provide greater uniformity of information and transmission formats and to facilitate automation of these processes. Health plans, healthcare clearinghouses and certain healthcare providers must comply by January 1, 2013.

Additionally, on July 5, HHS announced the launch of two demonstration programs - one to test two new financial models designed to help states improve quality and share in cost savings resulting from coordinated care and another to improve the quality of care for beneficiaries in nursing homes. HHS also announced the development of a technical resource center to help states improve care for high-need, high-cost beneficiaries. These three programs are aimed at lowering the cost of care for beneficiaries eligible for both the Medicare and Medicaid programs.

On another front, while states continue to fight the implementation of mandated insurance exchanges as required by the ACA, HHS is moving forward. On July 11, HHS unveiled two anxiously anticipated rules that outline some of the requirements for these exchanges. One rule outlines the requirements for the establishment of exchanges, qualified health plans and for implementing the Small Business Health Options Program (SHOP). The other proposed rule provides guidance on premium stability for plans and enrollees participating in an exchange. HHS has not yet released the details of the essential health benefits package or how the federal fallback exchange will operate in states that do not implement their own exchanges. In addition, on August 12, HHS issued proposed regulations on eligibility determinations for exchange participation and insurance affordability programs and standards for employer participation in SHOP.

On one hand, those affected by the ACA- providers, insurers, states, businesses and individual consumers- continue to monitor closely the issuance and finalization of rules for the implementation of the significant initiatives contemplated by the ACA. On the other hand, these same constituents monitor legal attempts to invalidate or ameliorate the impact of the broad and far ranging reforms to the healthcare system that are contained in the ACA.

REIMBURSEMENT NEWS

CMS ISSUES FINAL RULE TYING MEDICARE PAYMENTS TO QUALITY OF CARE

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On August 1, 2011, CMS issued a final rule with respect to Medicare payments to general acute care hospitals and inpatient stays for long term care hospitals for fiscal year 2012. Specifically, Medicare payments to acute care hospitals are projected to increase by 1.1% or $1.13 billion as compared to fiscal year 2011. In comparison, Medicare payments to long term care hospitals are expected to increase by 2.5% or $126 million relative to fiscal year 2011.

In addition to finalizing Medicare payments for fiscal year 2012, this rule also implements readmission measures for three conditions: acute myocardial infarctions (heart attacks); heart failure; and pneumonia. Under the Affordable Care Act, CMS was required to institute a Hospital Readmissions Reduction Program which would reduce payments to hospitals having excess readmissions for certain conditions. The purpose of this program is to provide hospitals with an incentive to reduce "preventable" readmissions to the hospital and improve the coordination of care. According to Dr. Donald M. Berwick, CMS Administrator, "[t]he final rule continues a payment approach that encourages hospitals to adopt practices that reduce errors and prevent patients from acquiring new illnesses or injuries during a hospital stay," and is "intended to reduce overall costs by improving how care is delivered."

The Hospital Readmissions Reduction Program will begin reducing payments in fiscal year 2013 for patients discharged on or after October 1, 2012 based on "preventable" hospital readmissions with respect to the three identified medical conditions outlined above.

LICENSING, FRAUD AND ABUSE AND COMPLIANCE NEWS

CMS' NEW FRAUD DETECTION SYSTEMS QUESTIONED

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The Government Accountability Office (GAO) has found that CMS has failed to fully implement two IT systems that were expected to integrate claims information and improve CMS' ability to detect fraud, waste, and abuse in the Medicare and Medicaid programs.

CMS initiated the Integrated Data Repository (IDR) and One Program Integrity (One PI) to combat fraud, waste, and abuse, which is estimated to be about $70 billion in fiscal year 2010. IDR is intended to function as a central data repository, while One PI is a Web-based portal that is used to access data contained in IDR as well as tools for analyzing the data.

GAO found that while IDR has been operational and in use since September 2006, it does not include all the data that was planned to be incorporated by fiscal year 2010. Similarly, while One PI was developed and deployed, CMS has trained few program integrity analysts to use the system. While officials planned for 639 analysts to be using the system by the end of fiscal year 2010, as of October 2010, only 41 analysts were actively using the system. According to program officials, data was not incorporated into IDR due to technical and funding obstacles and training has fallen behind due to insufficient training plans.

As IT becomes more important in various healthcare projects, we can expect to see additional similar findings from the GAO.

HEALTHCARE IT NEWS

HIPAA 5010, MOST NOT READY FOR CONVERSION

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In mid-August, I attended an event sponsored by the Michigan Center for Rural Health at which my colleague, Brian Balow, and I spoke on legal issues for rural healthcare providers. At that event, a representative from the Michigan Department of Community Health (MDCH) also spoke and told the attendees that most providers are not ready for the HIPAA 5010 implementation.

While most in the industry already knew that many are not prepared, the statistics are staggering. Conversion testing is required. In Michigan, similar to many other states, providers are required to test with the state health department, the MDCH, prior to being approved. **According to the presenter, only about half of the Michigan billing agents have begun testing and, of those, ONLY 2 have passed.** This is surprising given that there are only about 4 months remaining before the January 1, 2012 deadline. MDCH plans to post the names of the organizations that passed online.

Many believe that CMS will push back the deadline. Not so, we were told. CMS is holding firm and beginning January 1, 2012, all electronic transactions will convert to the HIPAA version 5010. Health care providers, billing agents and clearinghouses currently submitting version 4010A1 electronic transactions will be required to submit using version 5010. *Claims not meeting this standard will be rejected.*

All healthcare providers who submit claims must convert. Providers should call their information technology departments, software vendors and partners to check whether they are ready to submit claims using the 5010 standards and, if not, their preparation status. Providers should inquire whether they must incur any additional charges for the conversion, whether the upgrade will include transaction acknowledgements, and when the provider can begin testing. Providers should also take this opportunity to review their contact terms for adherence with federal mandates. Finally, all communications regarding HIPAA 5010 compliance between the provider and the billing agent, vendor or other partner should be adequately documented in case disputes arise among them based on failure to update their systems as required.

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