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Proposed Rule Implements Fraud Protection Steps for Provider Enrollment

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, Affordable Care Act or ACA), made significant changes to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to reduce fraud, waste, and abuse at the provider enrollment level of program participation. These changes included: . . .

Editor's Note:

On March 23, 2010, and March 30, 2010, President Obama signed into law the two companion pieces of legislation that comprise what is commonly referred to as "Healthcare Reform." In this edition of the *RAP Sheet*, two articles focus on pieces of Healthcare Reform. We expect to include at least one article on Healthcare Reform in future editions of the *RAP Sheet* as well.

Healthcare Reform

CMS Publishes Proposed Rule to Implement Redistribution of Unused Residency Slots Under PPACA*

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In the healthcare reform legislation enacted earlier this year, Congress provided for a one-time reallocation of unused residency slots, effective July 1, 2011.[1] On August 3, 2010, CMS published a proposed rule providing guidelines for the redistribution process.[2] Although the proposed rule has not yet been finalized, there are several important deadlines in the proposal for which teaching hospitals should begin planning now.

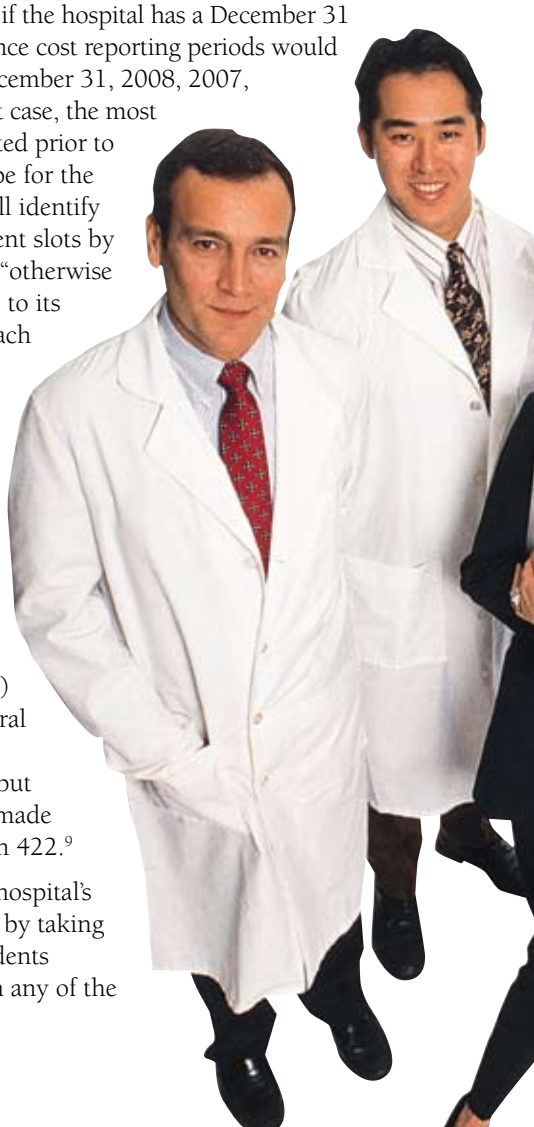
First, the proposed rule established December 1, 2010, as the deadline for hospitals eligible for an increase in the resident cap to submit applications with supporting documentation to the agency.[3] As discussed below, only a limited group of hospitals is eligible to receive an increase to their resident cap, and any hospitals that do not meet the criteria established by the agency need not apply. In the event that there are more resident slots available than the amount that qualifying hospitals request, CMS would initiate another application process after July 1, 2011, through notice and comment rulemaking.[4]

In addition, the proposed rule sets May 1, 2011, as the deadline by which CMS will estimate each teaching hospital's unused resident slots for purposes of calculating full-time equivalent (FTE) cap reductions. CMS will use the resident counts reflected on the hospital's three most recent cost reports that were submitted before March 23, 2010.[5] Importantly, the proposed rule provides that CMS will use non-final estimates to determine the number of unused residents for redistribution and reduction of a teaching hospital's cap, irrespective of whether the hospital has received or appealed from a final determination for one or more of its three most recent cost reporting periods for which the hospital has submitted a cost report prior to March 23, 2010. As was the case in the last FTE reduction process in 2003, as part of the Medicare Modernization Act (MMA), the statute provides that a determination by CMS to reduce a hospital's resident cap is not subject to administrative or judicial review.[6] Further, if a hospital later prevails in an appeal concerning its resident count for one or more of the reference cost reporting periods, any increase in residents because of the appeal will not be applied to readjust the resident cap.[7] Thus, it is important that hospitals with pending appeals concerning their resident counts be cognizant of the May 1, 2011, deadline and be proactive in assembling supporting documentation for their FTE counts. Hospitals should be communicating with the Medicare contractor to reach a determination of the appropriate FTE counts for each of the three reference cost reporting periods.

Resident Cap Reductions

Beginning July 1, 2011, hospitals that do not use all of their allotted resident slots will see their resident caps reduced by 65% of the "unused" slots. CMS' proposed rule defines a hospital's "unused" slots as its fewest number of unfilled slots (below the hospital's existing FTE cap) in any of the hospital's three most recent cost reporting periods for which the hospital has submitted a cost report before March 23, 2010. These are referred to as the "reference cost reporting periods."[8]

For example, for a hospital with a June 30 fiscal year end, the three reference cost reporting periods would be the periods ending June 30, 2009, 2008, and 2007, because the most recent cost report submitted prior to March 23, 2010, would be for the period ending June 30, 2009. However, if the hospital has a December 31 fiscal year end, the reference cost reporting periods would be the periods ending December 31, 2008, 2007, and 2006, because in that case, the most recent cost report submitted prior to March 23, 2010, would be for the 2008 fiscal year. CMS will identify a hospital's unused resident slots by comparing the hospital's "otherwise applicable resident limit" to its number of residents in each of the three reference cost reporting periods. The "otherwise applicable resident limit" is determined based on the hospital's 1996 FTE cap, as adjusted to account for new training programs, mergers, direct graduate medical education (GME) affiliation agreements, rural track training programs, and previous *reductions* (but not increases) that were made pursuant to MMA Section 422.[9]



CMS will determine the hospital's "reference resident level" by taking the highest count of residents training at the hospital in any of the

three reference cost reporting periods.[10] CMS will then compare that reference resident level to the adjusted 1996 FTE cap to determine the hospital's total number of unused resident slots. Sixty-five percent of the hospital's unused slots will be redistributed. CMS will make separate calculations regarding a hospital's GME and indirect graduate medical education (IME) caps.[11] In the event that the hospital's highest resident count in the reference cost reporting periods is the same for two or more years, CMS will determine that hospital's unused slots using the period that has the "least amount of difference between the resident level and the otherwise applicable resident limit."[12] For example, if a hospital had ten, ten, and seven unused slots during the three reference cost reporting periods, its FTE cap would be reduced by an amount equal to 65% of seven.

As noted above, in calculating the cap reductions, CMS will adjust the hospital's 1996 resident cap for a number of different reasons. For example, the FTE cap for a hospital that has entered into a GME affiliation agreement will be the hospital's cap, as adjusted for the GME affiliation agreement. However, if the GME affiliated group as a whole is training above the group's aggregate FTE cap, individual hospitals within that group will still be subject to the cap reduction if the individual hospital's resident count is less than its adjusted cap in the three reference cost reporting periods.[13]

In addition, if a hospital's resident cap was previously reduced pursuant to Section 422 of the MMA, CMS will compare the reference resident level to the reduced FTE cap. However, CMS will not factor into the calculation any FTE cap *increases* that a hospital received under the MMA. CMS notes that to reduce MMA cap increases would be "premature," as hospitals that received cap increases under the MMA "may still be 'building' their residency programs" using the additional slots they received under the MMA.[14]

Hospitals that have recently merged, but who were not merged in any of the three reference cost reporting periods, will be treated as if they were merged during those periods for purposes of determining whether the cap reduction should apply. Thus, those hospitals' FTE counts and caps for the reference cost reporting periods will be combined for purposes of determining the cap reduction.[15]

Certain hospitals will be exempted from the FTE cap reduction altogether. For example, rural hospitals with less than 250 acute care inpatient beds are exempted from the cap reduction.[16] Under the proposed rule, CMS would use data from the rural hospital's most recent cost reporting period ending prior to March 23, 2010, to determine the hospital's bed count.[17] Rural hospitals with 250 beds or more would be subject to a potential reduction in their resident caps.

In addition, the proposed rule would exempt hospitals that have participated at any point in the National Voluntary Residency Reduction Plan (VRRP) or the New York or Utah Medicare GME Demonstration projects, regardless of whether the hospital withdrew from the program prior to completion.[18] In order to claim exemption from the cap reductions on one of these bases, hospitals participating in these three programs would have been required to submit a plan to CMS by December 1, 2010, for filling their unused resident slots by March 23, 2012.[19]

Further, the proposed rule would exempt from the cap reduction any hospitals whose number of residents in the three reference cost reporting periods exceeds the hospital's FTE cap, adjusted for the factors discussed above. [20]

As previously discussed, CMS has proposed May 1, 2011, as the date by which the agency will estimate hospitals' cap reductions, although subsequent audits may occur that result in upward or downward adjustments to the number of slots by which a hospital's cap is actually reduced. Under the proposal, CMS would have until December 31, 2011, to complete their audits, and any cap determinations made would be retroactive to July 1, 2011.[21] The proposed rule notes that hospitals will have "a time-limited opportunity" to review FTE cap reduction determinations for "technical errors" before they are finalized.[22]

CMS and its contractors would use the latest available cost report or audit data available at the time the determinations are made.[23] If a hospital's appeal regarding its FTE count for one of the reference cost reporting periods has been resolved as of the time the Medicare contractor makes its determination, the contractor would use the FTE count that will be used in issuing the subsequent NPR.[24] The proposed rule clearly states, however, that CMS will "not wait for appeals of reference period cost reports to be resolved" before making determinations of whether and by how

much hospitals' resident caps should be reduced.[25] If an appeal is resolved after the cap reduction determination is made, any increase in FTEs will not be applied to readjust the FTE cap. Thus, once the FTE cap reduction is made, that adjustment is permanent and will be in effect for all subsequent years, regardless of a hospital's later success in an appeal of its FTE count for one of the reference cost reporting periods. Thus, it is important that hospitals with pending appeals as to their GME or IME FTE counts attempt to resolve those appeals with the intermediary *before* the agency makes its determinations regarding cap reductions.

Similarly, hospitals whose reference cost reports have not yet been audited or are currently being audited should be proactive in compiling and furnishing their Medicare contractor with documentation supporting their FTE counts to get the contractor comfortable with making a favorable adjustment or, at a minimum, to avoid a negative adjustment. Once the redistribution occurs, effective July 1, 2011, later adjustments to a hospital's FTE count for the reference cost reporting periods as a result of the resolution of an appeal or a reopening will have no effect on the new FTE cap.

Determination of Hospitals That Will Receive FTE Cap Increases

Hospitals that wished to apply for an increase to their FTE caps were required to submit an application on or before *December 1, 2010*. The hospitals eligible for a cap increase under PPACA are limited to rural hospitals and urban hospitals located in a limited group of states. The statute reserves 30% of the redistributed slots for rural hospitals and/or hospitals located in one of the ten states, territories, or districts with the highest proportion of their population living in a health professional shortage area (HPSA)—*see* Figure 1.[26] The remaining 70% of redistributed slots are reserved for hospitals located in a state with a resident-to-population ratio in the lowest quartile—*see* Figure 1.[27] If additional resident slots are available after CMS redistributes residents to qualifying hospitals in accordance with the criteria set forth in the proposed rule, CMS notes that it would initiate another round of applications sometime after July 1, 2011.[28]

In the proposed rule, CMS discusses at length certain additional criteria that will be used to prioritize which hospitals receive redistributions. For example, CMS would prioritize hospitals applying for a redistribution by organizing them into five "priority categories" based on which and how many of the factors discussed above apply to that hospital.[31] Within each priority category, CMS would further rank hospitals based on a point system, with hospitals that score a higher number of points receiving priority for an FTE cap increase.[32]

The statute requires the U.S. Department of Health and Human Services Secretary to take into account the likelihood that hospitals receiving increases in their FTE caps will be able to fill the new slots within their first three cost reporting periods beginning on or after July 1, 2011.[33] In the proposed rule, CMS interprets this provision as a threshold requirement that must be met before the agency will consider a hospital's application.[34] Under the proposal, in order to qualify for a cap increase, a hospital would have to provide documentation showing that it meets at least one of the following "demonstrated likelihood criteria":

Figure 1—States or Territories Eligible for Additional FTE Slots (As Proposed)

Rural hospitals and/or hospitals located in one of the ten states, territories, or districts with the highest proportion of population living in a HPSA (in order) [29]	Hospitals located in a state with a resident-to-population ratio in the lowest quartile[30]
Receive first 30% of redistributed slots	**Remaining 70% of redistributed slots**
Louisiana	Montana
Mississippi	Idaho
Puerto Rico	Alaska
New Mexico	Wyoming
South Dakota	Nevada
District of Columbia	South Dakota
Montana	North Dakota
North Dakota	Mississippi
Wyoming	Florida
Alabama	Puerto Rico
	Indiana
	Arizona
	Georgia

(1) The hospital intends to establish a new residency program that will begin training residents at some point during the first three cost reporting periods beginning on or after July 1, 2011, and does not have sufficient room under its current FTE cap to accommodate those residents;

(2) The hospital intends to use the additional FTEs to expand an existing program within the same three-year period and does not have sufficient room under its current FTE cap to accomplish the expansion; or

(3) The hospital is already training residents at or above its current FTE cap.[35] The proposed rule contains a detailed description of the specific documentation that a hospital would be required to submit in order to meet one of the three demonstrated likelihood criteria.[36]

The proposed rule further provides that each application submitted by a hospital "must be program-specific."[37] In other words, CMS states that hospitals must meet the demonstrated likelihood criteria for *each program* for which they are applying for a cap increase and complete a separate CMS evaluation form for each.[38] However, if a hospital's application for a cap increase is granted, any increase would not be program-specific, but could be applied to any residents that the hospital trains.[39]

Each application must list the total number of resident slots requested by the hospital for *all programs*—GME, IME, or both.[40] In addition, the application must include a completed copy of the CMS evaluation form for each program for which the hospital intends to use the requested cap increase, cost report worksheets for the most recent cost reporting period showing the FTE counts reported by the hospital, and a signed attestation.[41] A sample of the CMS evaluation form is available in the *Federal Register* at 75 Fed. Reg. 46416-19.

In addition to these requirements, hospitals must submit data on the number of residents training in primary care programs for the three most recent cost reporting periods ending before March 23, 2010.[42] The statute requires that hospitals receiving cap increases must ensure that, for the five-year period from July 1, 2011, through July 1, 2016, their number of FTE primary care residents does not fall below their average number of primary care residents during the three cost reporting periods ending prior to March 23, 2010.[43] In addition, the statute requires that hospitals use at least 75% of any FTE increase in a primary care or general surgery residency during this same five-year period.[44] In the proposed rule, CMS interprets this provision to mean that hospitals must both maintain their existing average primary care resident counts and ensure that 75% of any additional slots received go to primary care or general surgery residency programs.[45] Hospitals that do not meet these primary care requirements will lose their additional residency slots.[46]

Conclusion

Although CMS' proposals have not been finalized, hospitals should nevertheless begin preparing now for the implementation of PPACA's redistribution provision. Under the proposal, applications for resident cap increases and supporting documentation must have been received by CMS by December 1, 2010. Hospitals potentially eligible for a cap increase that wait for the final rule may not have adequate time to prepare the required applications and supporting documentation. In addition, hospitals should also begin preparing now for potential cap reductions. As discussed above, it is important that hospitals work with their Medicare contractors to resolve pending appeals with respect to the reference cost reporting periods prior to May 1, 2011, and for those periods that have not yet been or are currently being audited, to provide documentation to the contractor in support of the hospital's position. Hospitals that do not prepare now could be left in the lurch.

**Please note that this article was submitted for publication in November 2010.*

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1 Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § 5503, effective March 23, 2010.
2 75 Fed. Reg. 46170, 46390-421 (Aug. 3, 2010).
3 75 Fed. Reg. at 46399.
4 75 Fed. Reg. at 46409-10.
5 75 Fed. Reg. at 46394.
6 42 U.S.C. § 1395ww(h)(7)(E).
7 75 Fed. Reg. at 46393.
8 75 Fed. Reg. at 46394.
9 75 Fed. Reg. at 46391, 46396.
10 75 Fed. Reg. at 46394.
11 *Id.*
12 *Id.*
13 75 Fed. Reg. at 46395.
14 75 Fed. Reg. at 46396.
15 75 Fed. Reg. at 46395.
16 42 U.S.C. § 1395ww(h)(8)(A)(ii)(I).
17 75 Fed. Reg. at 46391-92.
18 75 Fed. Reg. at 46392.
19 *Id.*
20 *Id.*
21 75 Fed. Reg. at 46394.
22 75 Fed. Reg. at 46393.
23 *Id.*
24 75 Fed. Reg. at 46393-94.
25 *Id.*
26 42 U.S.C. § 1395ww(h)(8)(E)(i)(II).
27 42 U.S.C. § 1395ww(h)(8)(E)(i)(I).
28 75 Fed. Reg. at 46410.
29 75 Fed. Reg. at 46405.
30 75 Fed. Reg. at 46402.
31 75 Fed. Reg. at 46404.
32 75 Fed. Reg. at 46408.
33 42 U.S.C. § 1395ww(h)(8)(C)(i).
34 75 Fed. Reg. at 46398.
35 75 Fed. Reg. at 46397-98.
36 *Id.*
37 75 Fed. Reg. at 46398.
38 *Id.*
39 *Id.*
40 75 Fed. Reg. at 46399.
41 75 Fed. Reg. at 46399-40.
42 75 Fed. Reg. at 46411.
43 42 U.S.C. § 1395ww(h)(8)(B)(ii)(I).
44 42 U.S.C. § 1395ww(h)(8)(B)(ii)(II).
45 75 Fed. Reg. at 46412.
46 42 U.S.C. § 1395ww(h)(8)(B)(ii)(III).

Pandora's Box: Litigation of CMS Ruling 1498-R Begins . . .

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On April 28, 2010, CMS issued Ruling 1498-R (Ruling), which, by any reckoning, effectively dropped a bomb on thousands of hospital appeals challenging the accuracy of Disproportionate Share Hospital (DSH) payments. The Ruling sets forth the Centers for Medicare & Medicaid Services' (CMS') position with respect to appeals before the Provider Reimbursement Review Board (PRRB or Board) that raise any of the following issues related to the Medicare DSH calculation:

1. The accuracy of the Supplemental Security Income (SSI) percentage with respect to the data matching process for Medicare and SSI eligibility data, found to be insufficient in *Baystate Medical Center v. Leavitt*[1];
2. The exclusion from the Disproportionate Patient Percentage (DPP) of non-covered inpatient hospital days (for example, Medicare Secondary Payor days) and exhausted inpatient benefit days for persons entitled to Medicare Part A (which CMS construes to also include Medicare Part C days) for cost reports with patient discharges before October 1, 2004; and
3. For cost reports beginning prior to October 1, 2009, the exclusion from the DPP of labor, delivery, and recovery (LDR) days, with such days to be included, as appropriate, in either the Medicaid fraction or the SSI fraction.

With respect to each of the issues above, the Ruling declares that "CMS' action eliminates any actual case or controversy" regarding previously calculated DSH payment adjustments, and "thereby renders moot each properly pending claim in a DSH appeal."[2] Thus, in one fell swoop, the Ruling purports to dispose of thousands of individual and group appeals and seize control over thousands of individual cost reports, thereby setting the stage for any number of lawsuits challenging its validity. This article briefly summarizes the Ruling itself and then discusses three such actions recently filed in federal district court.[3]

CMS Ruling 1498-R

According to CMS, Ruling 1498-R resolves all jurisdictionally proper appeals pending before the Board on each of the issues described above because the Ruling "eliminates any actual case or controversy" and "thereby renders moot each properly pending claim" before the Board.[4] Each such appeal will be remanded to the Medicare Administrative Contractor/intermediary (intermediary) and CMS for:

(1) A new SSI calculation using a new CMS SSI matching program and a new Medicaid fraction for inclusion of Labor and Delivery (LDR) days if appropriate;

(2) Recalculation of the DSH payment due to the hospital; and

(3) Issuance of a revised notice of program reimbursement (RNPR), from which the hospital can appeal if dissatisfied with the result.[5]

The remand will take place according to a Standard Implementation Process (Board determines if claim is subject to remand under Ruling) or an Alternative Implementation Process (provider requests remand).[6]

Even if a hospital only appealed one of the three issues addressed in Ruling 1498-R, CMS states that its revised data matching process will include the non-covered inpatient hospital days and exhausted benefit days of those entitled to Part A benefits, which CMS also construes to include Part C days,[7] along with any LDR inpatient days for patients who were entitled to Part A benefits.[8] Thus, if a provider appealed only the exclusion from the DPP of non-covered days, those days would be accounted for in the revised DPP as part of CMS' revised data matching process. Alternatively, if a hospital appealed only the SSI data matching issue, the Ruling requires that the SSI fraction also be revised to include non-covered and exhausted benefit inpatient days and qualifying LDR days.[9]

The Ruling, which purports to "eliminate" and "render moot" all properly pending PRRB appeals challenging any of the three DSH issues, raises all sorts of complicated issues, such as:

- Whether CMS may unilaterally deprive the Board of its statutorily granted jurisdiction;
- Whether CMS may review expedited judicial review determinations made by the Board despite an express statutory prohibition against such review; and
- Whether CMS may retroactively impose new rules for determining which inpatient days will be included in the DPP.

Not surprisingly, a number of hospitals have already filed suit in federal court challenging the Ruling's validity.

Baystate and the Genesis of CMS Ruling 1498-R

CMS issued Ruling 1498-R in the wake of the D.C. District Court's finding in *Baystate* that, among other things, CMS did not use the best available data to develop the SSI percentages, and that the MEDPAR process is flawed and produces unacceptably inaccurate data. In the wake of the *Baystate* decision, CMS subsequently revised its SSI data matching process in order to address these deficiencies, which it applied to the *Baystate* hospital cost reporting periods at issue in the appeal. After review, Baystate accepted the new SSI percentages for its four fiscal years at issue, thereby allowing settlement of the case.[10] On August 16, 2010, CMS officially adopted the revised SSI matching process developed pursuant to the *Baystate* decision, which it plans to use to implement the previously announced Ruling.[11] Had the Ruling merely implemented CMS' allegedly improved SSI data matching process for all pending appeals of the SSI percentage issue, hospitals participating in those appeals could have expected to see an increase in DSH payments (or a decrease in any DSH liability) resulting from an increased number of inpatient days included in the numerator of the SSI fraction.

In addition, CMS used the Ruling as a vehicle for implementing a new policy with respect to LDR inpatient days by reversing its prior policy of excluding most LDR days from the DPP for cost reporting periods prior to October 1, 2009.[12] Specifically, the Ruling directs intermediaries to include LDR days in the Medicaid fraction or the SSI fraction as applicable for all properly pending appeals.[13] Although there may be some mothers who had LDR days for which they had Medicare Part A entitlement, they may have already been included in the SSI fraction. In any event, it appears that most inpatient LDR days will likely go into the denominator of the Medicaid fraction, with Medicaid-eligible inpatient LDR days also being included in the numerator. Accordingly, hospitals with appeals seeking inclusion of LDR days in the Medicaid fraction could, similar to hospitals appealing the SSI matching process, expect a positive impact upon recalculation of the DPP.[14]

Instead, however, the Ruling appears to offset and potentially even negate any positive impact of improved SSI matching. The Ruling mandates adding Medicare non-covered (e.g., MSP, exhausted Part A, and Part C) inpatients days in the SSI fraction, rather than adding any Medicare and Medicaid dual-eligible days into the numerator of the Medicaid fraction, or excluding non-covered days from the DPP altogether in the absence of Medicaid eligibility. In order to add such days, however, CMS must violate its own regulation, 42 C.F.R. § 412.106(b)(2)(i)(2003),[15] which expressly limited inclusion in the SSI fraction to covered days, until October 1, 2004, when CMS changed its prior policy via an amendment to the regulation.[16] Recognizing that litigants might characterize this new policy as unlawful retroactive rulemaking, the last sentence of the Ruling states that if it were deemed to implicate retroactive rulemaking issues, retroactive application is necessary to ensure compliance with the Medicare DSH statute.[17]

The SCA Group Appeals

On June 14, 2010, PRRB granted expedited judicial review or "EJR" [18] for three Southwest Consulting Associates (SCA) hospital groups challenging the validity of CMS Ruling 1498-R.[19] EJR allows a hospital or group of hospitals to bypass a PRRB hearing and file suit in federal court to challenge the validity of a statute, regulation, or CMS Ruling.[20] In order to grant EJR, the Board must determine two things: (1) whether it has jurisdiction to decide the matter at issue; and (2) whether it lacks the authority to decide the merits of the matter at issue.[21] By statute, the CMS administrator may not review a Board EJR determination.[22]

The SCA group appeal hospitals challenged whether, for cost reporting periods that began prior to October 1, 2004, non-covered, dual-eligible inpatient days must be included in the numerator of the Medicaid fraction.[23] Just one month following a Board hearing on the dual-eligibles issue in the SCA group appeals, CMS issued Ruling 1498-R. The hospitals requested EJR challenging the validity of the Ruling "which, if valid, purports to render moot and deny the Board's jurisdiction to decide the appeals [previously] heard."[24]

PRRB Decision Granting EJR—June 14, 2010

On June 1, 2010, the Board held oral arguments on the hospitals' EJR request.[25] The hospitals challenged the Ruling's validity for several reasons, including that: it counts dual-eligible days in the SSI fraction and denies their placement in the Medicaid fraction in violation of the Medicare statute and regulations; it retroactively changes a substantive standard without notice and comment in violation of the Medicare statute and Administrative Procedures Act (APA); and it attempts to divest the Board of jurisdiction in violation of the Medicare statute. Office of General Counsel attorneys argued on behalf of CMS, contending that the Ruling did not call for the reopening of cost reports, but rather "vacated" the appealed NPRs and revised NPRs. In a decision issued on June 14, 2010, the Board granted EJR, concluding, among other things, that:

> The Board lacks the authority to make a determination whether the Ruling deprives it of continuing jurisdiction because the challenged substantive provisions of the Ruling are also the foundation for CMS' claim the Board lacks jurisdiction to grant EJR. The Board has no authority to invalidate any provision of the Ruling; EJR is, therefore, appropriate for the Federal Court to make the determination in that EJR preserves the status quo and aids the Board's determining its own jurisdiction.[26]

The Board acknowledged the conflict between the Medicare statute's prohibition against CMS administrator review of a Board EJR determination,[27] and the regulations authorizing administrator review of the jurisdiction component of the Board's EJR determination.[28] The Board noted, however, that "these conflicting provisions create a conundrum the Board is unable to unravel without the aid of a Federal court because it cannot invalidate any of these challenged provisions."[29]

CMS Administrator Decision "Vacating" the PRRB's EJR Determination—August 12, 2010

Following the PRRB's grant of EJR for three of the SCA group appeals, the CMS administrator chose to review the Board's June 14, 2010, EJR decision and determined that EJR was inappropriate.[30] CMS conceded at the EJR hearing that the Board has no authority to invalidate CMS Ruling 1498-R,[31] and thus the administrator reviewed only the Board's jurisdictional determination. With respect to the administrator's review, the Medicare statute authorizes the CMS administrator to "reverse," "modify," or "affirm" Board decisions.[32]

The administrator did not, however, reverse, modify, or affirm the Board's jurisdictional determination as authorized by the Medicare statute. Instead, the administrator "vacated" the Board's decision granting EJR, arguing that CMS Ruling 1498-R itself stripped the Board of its jurisdiction over any of the three issues specifically addressed in the Ruling, including Medicare unpaid or "non-covered" days.[33] In other words, the administrator contends that CMS may grant itself authority to nullify hospital appeals merely by issuing a CMS ruling to that effect, even though the statutory requirements for Board jurisdiction have otherwise been met.

Hospitals Participating in SCA Group Appeals File Suit in Federal Court

On August 12, 2010, hospitals participating in the SCA group appeals covered by the administrator's decision to vacate the Board's June 14, 2010, decision filed suit in the U.S. District Court for the District of Columbia.[34] The hospitals' complaint alleges, among other things, that:

(1) Having met all applicable jurisdictional and procedural requirements, the Ruling improperly divests the hospitals of their statutorily granted appeal rights, and the Board of its jurisdiction, in violation of the Medicare statute;

(2) The Ruling's provision mandating inclusion of non-covered dual-eligible days in the Medicare fraction improperly imposes retroactive substantive standards without notice and comment in violation of the Medicare statute and regulations, and the APA; and

(3) The current regulations authorizing the CMS administrator to review the "jurisdictional component" of a Board EJR determination violate the Medicare statute.[35]

Of particular interest, the SCA hospitals filed an amended complaint on August 26, 2010.[36] The amended complaint states that on August 18, 2010, plaintiffs' counsel received a decision issued by the CMS Administrator finding that the Ruling "prohibits the Board and the Administrator from review and removes jurisdiction to review provider appeals regarding three issues," but nevertheless proceeded to find further that "the issue under appeal by the hospitals is one of the three issues addressed by the Ruling, and that the Ruling, therefore is applicable."[37] The hospitals allege that this most recent decision of the Administrator is also arbitrary and capricious, as it "purports to review and vacate the Board's decision after having found that the issue in the hospitals' appeals to the Board is covered by the Ruling and the Ruling 'prohibits' the Administrator from reviewing appeals on any issue covered by the Ruling."[38]

The Queen's Medical Center Appeal

On July 27, 2010, The Queen's Medical Center filed suit in the United States District Court for Hawaii.[39] Similar to the SCA group appeals, The Queen's Medical Center appeal sought inclusion of dual-eligible, non-covered days in the Medicaid fraction for its cost reporting period ending 1998. In The *Queen's Medical Center* case, however, not only had the Board already conducted a hearing on the issue, it had also issued a decision in favor of the hospital prior to CMS' issuance of Ruling 1498-R.[40] The CMS Administrator subsequently took review, vacated the PRRB's decision, and remanded to the intermediary pursuant to the Ruling.[41] The hospital's complaint alleges, among other things, that: (1) the CMS Administrator's remand determination (a) violates the Medicare statute, which provides only for an affirmance, modification, or reversal of a PRRB decision; (b) violates 42 C.F.R. § 405.1875(f), which allows remands to the PRRB and prohibits remand based on an alternative legal basis; and (c) is arbitrary and capricious; (2) the Ruling's provision divesting the Board of jurisdiction violates the Medicare statute, and numerous federal appellate decisions; and (3) the Ruling violates the DSH regulation in effect for the cost reporting year ending 1998, which only allowed inclusion of "covered" days in the SSI percentage.[42]

So What's Next?

Undoubtedly, the SCA group appeal cases and The *Queen's Medical Center* case represent only the first of what may develop into a wave of litigation challenging the validity and attempted implementation of CMS Ruling 1498-R. In addition to the issues raised by the Ruling, however, other issues remain. For example:

1. Whether the Board will permit hospitals to withdraw their appeals in an attempt to limit losses or avoid incurring additional liability;
2. If the Board allows such withdrawals, will CMS nevertheless attempt to take control over those cost reporting years pursuant to its self-granted authority under the Ruling; and
3. If the D.C. Circuit and the Ninth Circuit eventually split over the issues raised in the currently filed litigation, what effect would such a split in the courts have regarding the Ruling's validity.

In addition, even if the Ruling is ultimately found to be a valid exercise of agency authority, whether in whole or in part, it leaves unresolved other important issues related to the DSH calculation. For example, one issue not resolved by the *Baystate* case involves CMS' longstanding refusal to participate in discovery before the PRRB, thereby depriving hospitals of the ability to confirm the accuracy of their SSI percentages.[43] The Ruling offers no mechanism for hospitals to obtain information regarding the parameters of the new SSI matching process, or the underlying data that will be used by CMS to recalculate the SSI percentages. As a result, hospitals have no means for determining whether the new SSI

matching procedure actually complies with *Baystate* and the Medicare statute.

While it remains to be seen exactly what effects the Ruling will have on hospitals appealing the accuracy of their DSH calculations, a flurry of litigation is almost certain.

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1 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008).

2 CMS Ruling 1498-R at 6, 11, 18, 34, and 35.

3 *See also Salt Lake Reg'l Med. Ctr. v. Sebelius*, (D.D.C.), Case 1:10-cv-01447-ESH (PRRB granted EJR; no prior Board hearing; appeal seeking inclusion of dual-eligible, non-covered days in Medicaid fraction); *Beth Israel Deaconness Med. Ctr. v. Sebelius*, (D.D.C.), Case 1:10-cv-01593-ESH (PRRB granted EJR following hearing; appeal seeking inclusion of dual-eligible, non-covered days in Medicaid fraction).

4 Ruling at 36-37.

5 Ruling at 30-32.

6 Ruling at 18-21; Board Alert 7, Procedures for Implementing CMS Ruling No. 1498-R (May 25, 2010).

7 This issue of whether Part C days are properly included in the SSI fraction is currently the subject of many pending PRRB appeals. At least one federal district court has found that Part C days do not belong in the SSI fraction. *See Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81, 95 (D.D.C. Mar. 29, 2010). Both parties appealed the *Northeast Hospital* decision to the U.S. Court of Appeals for the D.C. Circuit (Case No. 10-5163).

8 Ruling at 33-34.

9 Ruling at 34. Although some have wondered whether CMS will try to reach the SSI percentage even if there are no LDR days at issue related to Part A entitled individuals, the Ruling states that unitary relief will be provided "for properly pending claims in appeals of the LDR day issue, *to the extent that the disputed LDR days were for patients who were entitled to Part A benefits*." Ruling at 33 (emphasis added). As evidenced by the Ruling itself, however, one can never be certain exactly what CMS may do.

10 Ruling at 5.

11 *See* 2011 Inpatient Prospective Payment System (IPPS) Final Rule, 75 Fed. Reg. 50042 (Aug. 16, 2010); Ruling at 5-6.

12 CMS reversed its policy to exclude LDR days from the DPP for cost reporting periods beginning October 1, 2009, by amending the DSH regulation at 42 C.F.R. § 412.106(a)(1)(ii)(B). *See* Ruling at 14. CMS' newly announced policy to include LDR days in the DPP for cost reporting periods prior to October 1, 2009, appears to be in response to a recent court decision in which the Secretary conceded its prior policy was erroneous. *See Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81, 95 (D.D.C. Mar. 29, 2010).

13 Ruling at 15-17, 30-31, and 35.

14 Nevertheless, hospitals should determine, if possible, whether any inpatient LDR days are related to patients entitled to Medicare Part A and whether the published SSI percentage did or did not include such days prior to requesting a remand on this issue. According to the Ruling, if any LDR days represent patients entitled to Medicare Part A, the intermediary will recalculate the entire SSI fraction pursuant to the Ruling's mandate to include non-covered Part A and Part C days, as well as recalculate the SSI percentage using CMS' new matching program. *See* Ruling at 34.

15 The text of 42 C.F.R. § 412.106(b)(2)(i) prior to October 1, 2004 read as follows (emphasis added):

(2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of *covered* patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation; . . .

16 In the FY 2005 IPPS Final Rule, CMS amended 42 C.F.R. § 412.106(b)(2)(i) to remove the term "covered" from the regulation such that inpatient days of a person entitled to Medicare Part A and SSI are included in the numerator and denominator of the SSI fraction, regardless of whether the patient's stay was actually covered under part A. 69 Fed. Reg. 48916, 49246 (Aug. 11, 2004).

17 Ruling at 39.

18 The Medicare statute authorizes providers to bypass a Board hearing and go straight to federal court for issues involving "a question of law or regulations" if the Board determines it is "without the authority to decide." 42 U.S.C. § 1395oo(f).

19 *Southwest Consulting 2004 DSH Dual Eligible Days Group v. BCBSA* (PRRB Dec. 2010-D36, PRRB Cases 07-2626G, 06-2111GC, and 09-2298GC, for cost reporting periods ending 2004) (June 14, 2010).

20 42 C.F.R. § 405.1842(f)(1)(ii).

21 42 C.F.R. § 405.1842(b)(1); 42 C.F.R. § 405.1842(f)(1)(ii).

22 42 U.S.C. § 1395oo(f)(1). Cf. 42 C.F.R. § 405.1842(a)(3) and (g)(1)(ii) (authorizing CMS Administrator review of the Board's jurisdictional finding, but not its authority determination).

23 *Southwest Consulting Group*, PRRB Dec. 2010-D36 at 4.

24 *Southwest Consulting Group*, PRRB Dec. 2010-D36 at 4-5.

25 Of note, oral arguments are not typically conducted for EJR requests.

26 *Southwest Consulting Group*, PRRB Dec. 2010-D36 at 14.

27 *See* 42 U.S.C. § 1395oo(f)(1) ("the [Board's EJR] determination shall be considered a final decision and not subject to review by the Secretary").

28 *See* 42 C.F.R. § 405.1842(a)(3) and (g)(1)(ii).

29 *Southwest Consulting Group*, PRRB Dec. 2010-D36 at 12-13.

30 *Southwest Consulting 2004 DSH Dual Eligible Days Group v. BCBSA* (CMS Adm. Reviewing PRRB Dec. 2010-D36, PRRB Cases 07-2626G, 06-2111GC, and 09-2298GC, for cost reporting periods ending 2004) (Aug. 12, 2010).

31 *Southwest Consulting Group*, PRRB Dec. 2010-D36 at 7.

32 42 U.S.C. § 1395oo(f)(1).

33 *Southwest Consulting Group*, CMS Adm. Dec. at 3-4.

34 *Alegent Health, et al. v. Sebelius*, (D.D.C.), Case No. 1:10-cv-01354-JDB (Dkt. No. 1) (Aug. 12, 2010).

35 *Alegent Health* at 35-40.

36 *Alegent Health, et al. v. Sebelius*, (Dkt. No. 4) (August 26, 2010).

37 *Alegent Health* at 35-36.

38 *Alegent Health* at 40-41.

39 *The Queen's Medical Center v. Sebelius*, (D.C. HI), Case No. 1:10-cv-00434-SOM-LEK (Dkt. No. 1) (July 27, 2010).

40 *Queen's Medical Center* at 15.

41 *Queen's Medical Center* at 15.

42 *Queen's Medical Center* at 16-19.

43 In 2008, CMS issued revised regulations governing provider reimbursement determinations and appeals before the Board. 73 Fed. Reg. 30190 (May 23, 2008). These regulations codified CMS' "longstanding position" that neither the Secretary nor CMS may be a party to an appeal before the Board. 42 C.F.R. § 405.1843; 73 Fed. Reg. at 30215. Additionally, a party may not request discovery from CMS, the Secretary, or any federal agency, 42 C.F.R. § 405.1853(e)(2)(i), nor may the Board issue a subpoena to CMS, the Secretary, or any federal agency. 42 C.F.R. § 405.1857(a)(i); 42 C.F.R. § 405.1853(e)(5)(vii).

Healthcare Reform

Proposed Rule Implements Fraud Protection Steps for Provider Enrollment

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The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010[1] (collectively, Affordable Care Act or ACA), made significant changes to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to reduce fraud, waste, and abuse at the provider enrollment level of program participation. These changes included:

1. Establishing procedures under which more rigorous *screening* is conducted for providers and suppliers;
2. Requiring an *application fee* to be imposed on providers and suppliers;
3. Imposing temporary *moratoria* on enrollment of Medicare, Medicaid, and CHIP providers/suppliers;
4. *Suspending payments* pending credible allegations of fraud;
5. Establishing *compliance programs*; and
6. *Terminating provider participation under Medicaid and CHIP* if terminated under Medicare or another state Medicaid program or CHIP.

On September 23, 2010, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule[2] (Proposed Rule) to implement the above ACA provisions. This article summarizes the Proposed Rule, which vastly expands the ability of CMS and state agencies to monitor the enrollment of providers and suppliers in Medicare, Medicaid, and CHIP, and to combat fraud, waste, and abuse in those programs through a variety of new techniques. Comments to the Proposed Rule were due by November 16, 2010, and the final rule is expected to be released early this year.

Under the Proposed Rule, CMS develops three categories of providers according to the risk of fraud, waste, and abuse—limited, moderate, and high—which in turn affects the level of screening procedures an enrollee will undergo.[3] As proposed, the new risk categories and the related enrollment screening procedures will be applicable to newly enrolling providers and suppliers on March 23, 2011, and to currently enrolled providers and suppliers beginning on March 23, 2012. Although CMS requested comments on what criteria should be considered in making assignments to the different risk categories, the Proposed Rule places providers and suppliers in the different risk categories and screening categories—*see* Figure 1.

Figure 1—Proposed Assignments of Provider Types to Risk Categories (Medicare)

Limited	Moderate	High
• Physicians • Non-physician practitioners • Hospitals, including critical access hospitals • Skilled nursing facilities • Federally qualified health centers (FQHCs) • Medical clinics • Group practices • Publicly traded providers or suppliers • Ambulatory surgical centers • End stage renal disease (ESRD) facilities • Portable x-ray suppliers • Others[4]	• Comprehensive outpatient rehabilitation facilities (CORFs) • Independent diagnostic testing facilities (IDTFs) • Independent clinical laboratories • Currently enrolled (re-validating) home health agencies • Currently enrolled (re-validating) suppliers of DMEPOS • Hospice organizations • Others[5]	• Newly enrolled home health agencies • Newly enrolled suppliers of DMEPOS

CMS proposed to move providers and suppliers from a "limited" or "moderate" risk level to the "high" risk level if the following occurs:

- CMS has evidence from or concerning a physician or non-physician practitioner that another individual is using his/her identity within the Medicare program.
- The provider or supplier has been excluded by the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG), or had its Medicare billing privileges denied or revoked by a Medicare contractor within the previous ten years and is attempting to establish additional Medicare billing privileges for a new practice location or by enrolling as a new provider or supplier.
- The provider has been terminated or otherwise precluded from billing Medicaid.
- CMS lifts a temporary moratorium applicable to such providers or suppliers at which point the move to the high risk level will last for six months after the lifting of the moratorium.[6]

CMS is considering comments on additional criteria that would justify a move from limited or moderate to a high risk category and vice versa.

The Proposed Rule modifies the level of screening depending on the risk category a provider or supplier is assigned—*see* Figure 2. Because of the expense and efficiencies involved, CMS proposed to allow states to rely on the results of the Medicare contractor's screening to meet the provider screening requirements under Medicaid and CHIP. Similarly, state Medicaid agencies could rely on the results of sister state Medicaid programs and CHIP. For Medicaid-only or CHIP-only providers, CMS proposed that states follow the same screening procedures that CMS and its contractors follow with respect to Medicare providers and suppliers.

Application Fee

ACA Section 6401(a) requires the HHS Secretary to impose a fee on each "institutional provider of medical or other items or services or supplier" to cover costs of screening and to carry out screening and other program integrity efforts. "Institutional providers" include any healthcare provider that bills Medicare, Medicaid, or CHIP on a fee-for-service basis, with the exception of Part B medical groups or clinics, physician and non-physician practitioners who submit the CMS 855I to enroll in Medicare.[8] Under the Proposed Rule, the $500 application fee (adjusted yearly based on the CPI for all urban consumers) is nonrefundable and is required with the submission of an initial enrollment application, an application to establish a new practice location, as part of revalidation, or in response to a revalidation request.[9] An application will be rejected and, in the case of revalidations, billing privileges may be revoked if the institutional provider does not submit the application fee or hardship exception.

Because CMS proposed that a state may rely on the results of the screening requirements for participation in a state Medicaid program or CHIP, CMS further proposed that a provider or

supplier enrolled in more than one program (that is, Medicare and Medicaid or CHIP, or all three programs) would only be subject to the application fee under Medicare, and that fee would cover screening activities for enrollment in all programs.[10]

Providers or suppliers can apply for a hardship exemption to the enrollment fee by including a letter with the application.[11] CMS proposed that such hardship requests will be considered on a case-by-case basis, and provided one example that might support a request for hardship exception of a national public health emergency where a provider or supplier is enrolling for purposes of furnishing services required as a result of the national public health emergency situation.[12]

Temporary Moratoria on Enrollment

ACA Section 6401(a) provides that the HHS Secretary may impose a temporary moratoria on the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers, if the HHS Secretary determines such moratoria are necessary to prevent or combat fraud, waste, or abuse. The Proposed Rule establishes that, for the enrollment of new Medicare providers and suppliers, CMS may impose a moratorium in six-month increments in situations where:

(1) CMS indentifies a trend that appears to be associated with a high risk of, or determines there is a significant potential for, fraud, waste, or abuse with respect to a particular provider or supplier type or particular geographic area or both;

(2) A state has imposed a moratorium on enrollment in a particular geographic area or on a particular provider or supplier type; or

(3) CMS, in consultation with OIG or U.S. Department of Justice, identifies a particular provider or supplier type or a particular geographic area as having a significant potential for fraud, waste, or abuse.[13]

Figure 2—Comparing Current Screening Requirements and Proposed Screening Requirements

TYPE OF SCREENING REQUIRED (Medicare)[7]	Current Rule	Proposed Rule– "Limited"	Proposed Rule- "Moderate"	Proposed Rule- "High"
Verification of any provider/supplier-specific requirements established by Medicare	x	x	x	x
Verification of license (may include licensure checks across states)	x	x	x	x
Database checks: • Social Security Number • National Provider Identifier • National Practitioner Data Bank licensure • OIG exclusion • Taxpayer identification number • Tax delinquency • Death of individual practitioner, owner, authorized official, delegated official, or supervising physician	x	x	x	x
Unscheduled or unannounced pre-enrollment or post-enrollment site visits	Only DMEPOS and IDTFs pre-enrollment; ad hoc for others		x	x
Criminal background check—owners, authorized or delegated officials, and managing employees				x
Fingerprinting—owners, authorized or delegated officials, and managing employees				x

Because such decisions are by statute not subject to judicial review, CMS proposed that a provider or supplier may administratively appeal an adverse determination based on the imposition of a temporary moratorium up to and including the Department Appeal Board level of review.

CMS believes that imposing the moratoria will provide time to review and consider additional programmatic initiatives and develop additional regulations. The moratoria would be limited to:

(1) Newly enrolling providers and suppliers; and

(2) The establishment of new practice locations, not a change of practice locations.

The moratoria would not apply in situations involving changes in ownership of existing providers or suppliers, mergers, or consolidations. CMS may lift a moratorium in the case of a presidentially declared disaster, if circumstances warranting the moratorium have abated, if CMS has implemented program safeguards, or if the HHS Secretary determines that it is no longer necessary.

State Medicaid agencies must comply with a moratorium unless an agency determines that compliance would adversely affect Medicaid beneficiaries' access to medical assistance.[14] States also have the authority to impose moratoria (in six-month increments), numerical caps, or other limits for providers that the HHS Secretary identifies as being at high risk for fraud, waste, or abuse. In such cases, the state must first seek CMS' concurrence and provide written details of the proposal, including anticipated duration and a "substantial justification" explaining why disallowing newly enrolling providers would reduce the risk of fraud.[15]

Suspension of Payments

ACA Section 6402(h) provides that the HHS Secretary may suspend payments to a provider or supplier pending an investigation of a credible allegation of fraud, unless the HHS Secretary determines that there is good cause not to suspend payments. Under current Medicare rules, CMS is allowed to suspend payments for 180 days based upon reliable information that an overpayment or fraud or willful misrepresentation exists or that the payments to be made may not be correct.[16] The Proposed Rule would eliminate that 180-day limit in cases of "credible allegations of fraud" from any source.

The Secretary is required to consult with OIG in determining whether there is a credible allegation of fraud. The Proposed Rule defines a "credible allegation of fraud" as an allegation from any source, including but not limited to fraud hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, and law enforcement investigations.[17] Allegations are considered to be credible when they have indicia of reliability. Any issues related to this definition will be evaluated on a case-by-case basis by looking at all relevant factors, circumstances, and issues. The Proposed Rule also adds a provision for when an investigation is resolved, and thus the basis for suspension of payments no longer exists. A "resolution of investigation" occurs when legal action is terminated by settlement, judgment, or dismissal, or when the case is closed or dropped because of insufficient evidence.[18]

In accordance with ACA, CMS can choose not to impose a suspension (or not to continue a suspension) if there is good cause, despite credible allegations of fraud. Circumstances that may qualify as good cause include:

(1) OIG or law enforcement has specifically requested that a payment suspension not be imposed because it may compromise or jeopardize an investigation;

(2) Beneficiary access to items or services would be so jeopardized as to cause a danger to life or health;

(3) Other available remedies implemented by CMS or a Medicare contractor more effectively or quickly protect Medicare funds than would implementing a payment suspension; or

(4) CMS determines that a payment suspension or a continuation of a payment suspension is not in the best interests of the Medicare program.[19]

Although CMS may maintain a suspension for an unspecified period of time, it must evaluate whether there is good cause not to continue a suspension of payments every 180 days after initiation of a suspension.

With regard to the Medicaid program, current regulations provide that a state Medicaid agency may withhold payments to a provider in whole or in part based upon the receipt of reliable *evidence* that the need for withholding payments involves fraud or willful misrepresentation under the Medicaid program.[20] Under the Proposed Rule, payment suspensions are mandatory where an *investigation of a credible allegation of fraud* under the Medicaid program exists— thus, as acknowledged by CMS, adopting a lesser threshold for a payment suspension than is in the current regulation.[21] The "good cause" exceptions in the Medicaid rule are similar to the Medicare rule.[22]

The Proposed Rule requires a state to make a formal, written suspected fraud referral to its Medicaid Fraud Control Unit (MFCU) or, where a state does not have a MFCU, to an appropriate law enforcement agency for each instance of payment suspension as the result of a state agency's preliminary investigation of a credible allegation of fraud. CMS also proposed that on a quarterly basis, a state must request a certification from the MFCU or other law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation or in the course of enforcement proceedings warranting the continuation of the payment suspension.

Compliance Programs

ACA Section 6102 requires a nursing facility to have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations, and in promoting quality of care. Similarly, ACA Section 6401(a) requires providers and suppliers to, as a condition of enrollment in Medicare, Medicaid, or CHIP, establish a compliance program that contains certain "core elements." The HHS Secretary is responsible for developing regulations and core elements for compliance programs. In the Proposed Rule, CMS solicits comments on "core elements" of a compliance program. CMS does not intend to finalize compliance plan requirements when the other proposals in the Proposed Rule are finalized, but will instead do further rulemaking on compliance plan requirements. CMS is most interested in receiving comments on the use of the seven elements of an effective compliance and ethics program as described in Chapter 8 of the U.S. Federal Sentencing Guidelines Manual as the basis for the core elements, but has not limited the core elements to those seven elements.

Effect of Other Program Terminations

ACA Section 6501 requires a state's Medicaid program to terminate an individual's or entity's participation if the individual or entity has been terminated under Medicare or another state's Medicaid program on or after January 1, 2011. State Medicaid programs would terminate a provider only after the provider exhausted all available appeal rights in the state that originally terminated the provider. States would be required to terminate

participation only in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause (i.e, fraud, integrity, or quality issues). Termination would not be mandatory in cases where providers, suppliers, or eligible professionals were terminated based upon a failure to submit claims over a period of twelve months or more, or any other voluntary action taken by the provider to end its participation in the program, unless it was taken to avoid a sanction. States are required to report adverse provider actions to CMS. The Proposed Rule applies these provisions equally to CHIP.[23]

1 Public Law No. 111-148, effective March 23, 2010, as amended by Public Law No. 111-152, effective March 30, 2010.
2 75 Fed. Reg. 58204 (Sept. 23, 2010).
3 *Id*. at 58208 (to be codified at 42 C.F.R. § 424.518).
4 "Limited" risk category also includes histocompatibility laboratories; Indian health service facilities; mammography screening centers; organ procurement organizations; mass immunization roster billers; religious nonmedical health-care institutions; rural health clinics; radiation therapy centers; and public- or government-owned or affiliated ambulance services suppliers. *Id.* at 58209.
5 "Moderate" risk category also includes community mental health centers and nonpublic, nongovernment-owned or affiliated ambulance services suppliers. *Id.* at 58210.
6 *Id.* at 58212 (to be codified at 42 C.F.R. § 424.518(c)(3)).
7 For Medicaid and CHIP, CMS expects states to asses the risk of fraud, waste, and abuse using similar criteria to those used in Medicare; however, CMS does not intend to limit states from engaging in other screening activities or from assigning a particular provider type to a higher risk level than the level assigned by Medicare. Additional requirements related to Medicaid and CHIP screening are discussed at 75 Fed. Reg. at 58214-17.
8 Institutional providers include providers and suppliers who submit a CMS-855A, CMS-855B (but not physician and non-physician practitioner organizations), or CMS-855S or associated Internet-based PECOS enrollment applications. This definition of "institutional provider" will be codified at 42 C.F.R. § 424.502.
9 75 Fed. Reg. at 58218-19; to be codified at 42 C.F.R. § 424.514.
10 *Id.* at 58219.
11 *Id.* at 58219-20.
12 *Id*. at 58219.
13 *Id.* at 58221; to be codified at 42 C.F.R. § 424.570.
14 The Proposed Rule establishes that prior to imposing a moratorium in any state, CMS will consult with the state so that the state may have an opportunity to seek an exception from the moratorium. Additionally, states must provide CMS with written details of the moratorium's adverse impact on Medicaid beneficiaries.
15 75 Fed. Reg. at 58221 (to be codified at 42 C.F.R. § 455.470(a)).
16 42 C.F.R. §§ 405.370-405.379.
17 75 Fed. Reg. at 58239 (to be codified at 42 C.F.R. § 405.370 for Medicare and 42 C.F.R. § 455.2 for Medicaid).
18 CMS is considering comments on an alternate definition of "resolution of investigation" occurring when a legal action is initiated or the case is closed or dropped because of insufficient evidence to support the allegations of fraud.
19 75 Fed. Reg. at 58239 (to be codified at 42 C.F.R. § 405.371).
20 42 C.F.R. § 455.23.
21 75 Fed. Reg. at 58224 (to be codified at 42 C.F.R. § 455.23(a)).
22 42 C.F.R. § 455.23(e).
23 75 Fed. Reg. at 58229 (to be codified at 42 C.F.R. § 455.416).

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Show Me the Money: The Reimbursement Side of "Meaningful Use"

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On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) released the long-awaited Meaningful Use final rule (Final Rule) defining the Stage 1 criteria that eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must meet to qualify for Medicare and Medicaid incentives under the Health Information Technology for Economic and Clinical Health Act (HITECH Act). This rule was published in the July 28, 2010, *Federal Register*.[1] While electronic health record (EHR) and IT professionals focus on the Final Rule's technology and interoperability requirements, financial personnel are busy running reimbursement scenarios. This article focuses on what EPs, EHs, and CAHs must do in order to receive incentive payments under the Medicare and Medicaid EHR incentive programs.

EPs, EHs, and CAHs can qualify for Medicare and Medicaid incentive payments if they adopt certified EHR technology and meaningfully use it to achieve specified objectives and demonstrate measures. The Final Rule creates a new sub-part, Part 495, in the Code of Federal Regulations detailing the requirements for meaningful use and the incentive payments. A "meaningful EHR user" is defined as an EP, EH, or CAH that, for an EHR reporting period during a payment year, demonstrates meaningful use of certified EHR technology by meeting the applicable objectives and associated measures.[2]

To meet the definition of a "meaningful user," EPs, EHs, and CAHs must meet all "core set" objectives and demonstrate the associated measures of the Stage 1 criteria, unless they meet the exclusion criteria for non-applicable objectives.[3] Additionally, the EP, EH, and CAH must meet five of the objectives from the "menu set;" at least one of which must be from the Population and Public Health category. Meaningful use must occur during the entire "EHR Reporting Period," which is defined as any continuous ninety-day period for the first payment year and then for the entire payment year thereafter.[4] For EPs, the payment year is the calendar year beginning with calendar year 2011.[5] For EHs and CAHs, the payment year is the federal fiscal year (FFY) beginning with FFY 2011 (October 1, 2010, through September 30, 2011).[6]

Medicare Incentive Payment Program

Eligible Professional

Under the Medicare EHR incentive program, a qualifying EP (defined as a physician, including doctors of dental surgery, podiatry, optometry, and chiropractors)[7] may receive Medicare EHR incentive payments for up to five payment years, with payments beginning as early as January 2011.[8] In general, the maximum amount of total incentive payments that an EP can receive under the Medicare program is $44,000. Specifically, a qualifying EP can receive an incentive payment as high as $44,000 if their first payment year is 2011 or 2012. For 2011 or 2012, there are five annual incentive payments of $18,000, $12,000, $8,000, $4,000, and $2,000, respectively. If a qualifying EP's first payment year starts in 2013, the EP can only receive a maximum of $39,000 with four annual incentive payments of $15,000, $12,000, $8,000, and $4,000. In 2014, the maximum drops to $24,000 with three annual payments of $12,000, $8,000, and $4,000.[9] Each year, however, an EP who predominantly furnishes services in a geographic Health Professional Shortage Area (HPSA), in the year prior to the payment, is eligible for a 10% increase in the maximum incentive payment amount.[10]

EPs who cannot demonstrate meaningful EHR use by 2015 will be subject to penalties in the form of lower Medicare reimbursement for professional services. Payment reductions of the Medicare physician fee schedule reimbursement for professional services are 99% for 2015, 98% for 2016, and 97% for 2017.[11] However, the U.S. Department of Health and Human Services Secretary (HHS Secretary) can exempt an EP from the payment reductions if the HHS Secretary determines that compliance with the requirement for being a meaningful user would result in a significant hardship for the EP.[12]

Eligible Hospitals

EHs may receive Medicare incentive payments for up to four payment years beginning in FFY 2011 until FFY 2013, provided they are able to demonstrate meaningful use.[13] EHs only receive three payments if the first payment year is FFY 2014, two payments if the first payment year is FFY 2015, and one payment if the first payment year is FFY 2016. EHs may not receive incentive payments after FFY 2016.[14] The initial Medicare incentive payment amount for EHs is equal to the product of the EH's Medicare share fraction multiplied by the amount resulting from one of the following calculations:

- For hospitals with 1,149 acute care inpatient discharges or less = $2 million
- For hospitals with at least 1,150 but no more than 23,000 acute care inpatient discharges = $2 million + [$200 x (number of discharges for the hospital -1,149)]
- For hospitals with more than 23,000 acute care inpatient discharges = $6,370,200

Incentive payments for EHs are phased down over the four-year period using a transition factor that will reduce the initial payment amount by 25% each year after the first year. For EHs receiving their first payment in FFY 2014 or after, payments are reduced by 25% each year beginning with FFY 2014.[15]

Eligible Critical Access Hospitals

Qualifying CAHs may receive Medicare incentive payments for up to four payment years beginning with cost reporting periods that begin in FFY 2011 and ending with a cost reporting period

that begins in FFY 2015.[16] CAHs can receive Medicare incentive payments for the reasonable costs incurred for the purchase of depreciable assets such as computers and associated hardware and software, necessary to administer certified EHR technology, excluding any depreciation and interest expenses associated with the acquisition.[17] A qualifying CAH will receive an incentive payment amount equal to the product of its reasonable costs incurred for the purchase of certified EHR technology and its Medicare share percentage.[18] The Medicare share percentage equals the lesser of: (1) 100%; or (2) the sum of the Medicare share fraction for the CAH and twenty percentage points.[19]

CAHs that cannot demonstrate meaningful EHR use by FFY 2015 are also subject to penalties in the form of downward payment adjustments. Beginning in or after FFY 2015, if a CAH is not a qualifying CAH, then the reasonable costs of the CAH in providing CAH services to its inpatients are adjusted by the following applicable percentages: 100.66% for FFY 2015; 100.33% for FFY 2016; and 100% for FFY 2017 and each subsequent FFY.[20]

Medicaid Incentive Payment Program

The Final Rule gives states the option to provide for payments to Medicaid providers for adopting, implementing, or upgrading certified EHR technology or for meaningful use of such technology. Additionally, the Final Rule provides enhanced federal financial participation (FFP) to states to administer these incentive payments.

Eligible Professional

Medicaid uses a slightly different definition for EPs to include physicians, dentists, certified nurse midwives, nurse practitioners, and a physician assistant in a physician assistant-led federally qualified health center or rural health clinic.[21] Further, Medicaid EPs may not be hospital-based and must meet one of the following criteria:

- Have a minimum 30% patient volume attributable to individuals receiving Medicaid;
- Have a minimum 20% patient volume attributable to individuals receiving Medicaid; and be a pediatrician; or
- Practice predominately in a federally qualified health center or rural health clinic and have a minimum 30% patient volume attributable to needy individuals.[22]

Medicaid EPs who are also eligible as a Medicare EP must choose between the Medicare and Medicaid incentive programs when they register.[23] An EP may change his or her EHR incentive election payment program once. An EP who switches programs is not permitted to collect more than the maximum Medicaid incentive ($63,750) across all payment years.[24]

A Medicaid EP must adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in the first year of participation to qualify for Medicaid incentive payments.[25] Medicaid EPs must then demonstrate meaningful use in years two through six of participation to continue receiving payments.[26] For calendar years 2011-2021, the maximum amount of total incentive payments that a Medicaid EP can receive is $63,750 over six years.[27] The annual incentive payment limits in the first, second, third, fourth, fifth, and sixth years are $21,250, $8,500, $8,500, $8,500, $8,500, and $8,500, respectively.[28]

It is important to note that all Medicare providers will have a payment reduction in 2015 if they are not demonstrating meaningful use in either the Medicare or Medicaid EHR incentive program.[29]

Eligible Hospital

Acute care hospitals, including CAHs, with at least a 10% Medicaid patient volume for each year for which the hospital seeks an EHR incentive payment and children's hospitals, are eligible to receive Medicaid EHR incentive payments.[30] Unlike EPs, hospitals that meet both sets of eligibility criteria may receive incentive payments from both Medicare and Medicaid.[31] The incentive payments provided to critical access hospitals and children's hospitals under the Medicaid incentive program are analogous to those provided to Medicare EPs.[32]

Medicaid EHs and CAHs must adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in the first year of participation to qualify for Medicaid incentive payments.[33] Note that there is no EHR reporting period for adopting, implementing, or upgrading EHR technology for Medicaid EH's and CAH's first payment year. Medicaid EHs and CAHs must demonstrate meaningful use over a ninety-day reporting period during their *second* year of participation and over twelve months for their third and subsequent years.[34] Hospitals that are eligible for both Medicare and Medicaid incentive payments would be well served to plan their ability to demonstrate and report meaningful use, and then strategically register to receive the first Medicaid incentive payment in the year *before* they are able to demonstrate and report meaningful use. This would allow a hospital to adopt, implement, or upgrade EHR and collect the Medicaid Year 1 payment, and then in the next year, the hospital should demonstrate meaningful use for a ninety-day period and collect the Medicaid Year 2 payment and the Medicare Year 1 payment.

Registration for Incentive Payment Programs

Registration for the Medicare EHR Incentive Program will begin in January 2011. Registration for the Medicaid EHR Incentive Program will vary by state. Registration information will be available toward the end of 2010.[35]

Tax Issues for Incentive Payments

EPs, EHs, and CAHs should be aware of the potential tax consequences associated with the Medicare and Medicaid incentive payments they receive. Currently, there are no specific exclusions from gross income for such incentive payments provided in either the HITECH Act or in the Final Rule. Thus, Medicare and Medicaid incentive payments will likely be considered taxable income to the EPs, EHs, and CAHs receiving them.

False Claims Act Implications

Further, EPs, EHs, and CAHs that receive federal incentive payments are subject to the federal False Claims Act. Under the False Claims Act, any person who knowingly presents or causes to be presented to the federal government a false or fraudulent claim for pay is subject to civil monetary penalties.[36] In applying for incentive payments, providers will attest that they have a good-faith belief that they are using a certified EHR system.[37] Attesting to EHR meaningful use is making a claim for payment to a federal program—thus, EPs, EHs, and CAHs are liable for knowingly making false or fraudulent attestations.

1 75 Fed. Reg. 44314-44588 (July 28, 2010).
2 42 C.F.R. § 495.4.
3 42 C.F.R. §§ 495.6-495.8.
4 42 C.F.R. § 495.4.
5 *Id.*
6 *Id.*
7 42 C.F.R. § 495.100.
8 42 C.F.R. § 495.102
9 *Id.*
10 42 C.F.R. § 495.102(c).
11 42 C.F.R. § 495.102(d).
12 *Id.*
13 42 C.F.R. § 495.104.
14 42 C.F.R. § 495.104(b).
15 42 C.F.R. § 495.104(c).
16 42 C.F.R. § 495.106.
17 42 C.F.R. § 495.106(b).
18 42 C.F.R. § 495.106(c).
19 42 C.F.R. § 495.106(c)(3).
20 42 C.F.R. § 495.106(e).
21 42 C.F.R. § 495.304(b).
22 42 C.F.R. § 495.304(c).
23 42 C.F.R. § 495.310(c).
24 42 C.F.R. § 495.10(e).
25 42 C.F.R. § 495.314(a).
26 42 C.F.R. § 495.314(b).
27 42 C.F.R. § 495.310(a).
28 *Id.*
29 42 C.F.R. §§ 495.102(d) and 495.310(a).
30 42 C.F.R. § 495.304(e).
31 42 C.F.R. § 495.310(j).
32 42 C.F.R. § 495.310(f).
33 42 C.F.R. § 495.314(a).
34 42 C.F.R. § 495.314(b).
35 *Available at* www.cms.gov/EHRIncentivePrograms.
36 31 U.S.C. § 3729(a).
37 42 C.F.R. § 495.8.

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In Case You Missed It

Welcome to a new feature of *The RAP Sheet*, referencing email alerts that have been issued by the Regulation, Accreditation, and Payment Practice Group (RAP PG) since the June 2010 issue of *The RAP Sheet*.

Additional RAP PG email alerts have been distributed since the newsletter's submission. Review all of these alerts at the RAP PG Email Alerts page.

- FCC Proposes New Medical Research License to Spur Medical Wireless Research [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/FCCProposesNewMedicalResearchLicensetoSpur.aspx] (December 9, 2010)
- DAB Clarifies Definition of IDTF and Rules on Leasing and Sharing of Practice Locations [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/DABClarifiesDefinitionofIDTFRulesonLeasingandSharingofPracticeLocations.aspx] (December 2, 2010)
- Congress Postpones Medicare Physician Reimbursement Rate Cuts [http://www.healthlawyers.org/Members/PracticeGroups/PO/emailalerts/Pages/CongressPostponesMedicarePhysicianReimbursementRateCuts.aspx] (December 1, 2010)
- Senate Acts to Avert Medicare Physician Fee Cut [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/SenateActstoAvertMedicarePhysicianFeeCut.aspx] (November 22, 2010)
- CMS Promulgates Changes to the Thirty-Six Month Rule for Home Health Agencies in the 2011 Home Health Prospective Payment System Final Rule [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/CMSPromulgatesChangestotheThirty-SixMonthRuleforHomeHealthAgenciesinthe2011HomeHealthProspectivePaymentSystemFinalRule.aspx] (November 19, 2010)
- CMS Issues 2011 Final Payment Rules for HOPDs and ASCs, Physician Services, and HHAs [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/101108_RAP.aspx] (November 8, 2010)
- NCQA Seeking Public Comment on Its Accountable Care Organization Evaluation Criteria [http://www.healthlawyers.org/Members/PracticeGroups/IHC/emailalerts/Pages/NCQASeekingPublicCommentonIts.aspx] (November 1, 2010)

- Decision of District Court Remands Appeal of Administrative Law Judge's Decision [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/DecisionofDistrictCourtRemandsAppealofAdministrativeLawJudge'sDecision.aspx] (October 28, 2010)
- Charity Care Patients Counted for Medicaid DSH Calculation Are Not Countable for Medicare DSH Calculation [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/CharityCarePatientsCountedforMedicaidDSHCalculationAreNotCountableforMedicareDSHCalculation.aspx] (October 21, 2010)
- States Receive Funding from the Affordable Care Act [http://www.healthlawyers.org/Members/PracticeGroups/RAP/emailalerts/Pages/StatesReceiveFundingfromtheAffordableCareAct.aspx] (October 15, 2010)
- Two Important Regulation, Accreditation, and Payment Practice Group Updates – "CMS Administrator Vacates PRRB's Jurisdictional Decision Granting Expedited Judicial Review on CMS Ruling 1498-R Regarding DSH Calculations" and "Seventh Circuit Holds That Hospital Was Entitled to Medicare Indirect Medical Education Reimbursement for Time Spent by Residents in Research Activities Not Related to Patient Care" (September 2, 2010)
- Even Wheelchairs Need Tune-Ups: CMS Releases Final Rule Revising DMEPOS Enrollment and Participation Standards (August 31, 2010)
- CMS Releases Final Rule for Medicaid Eligibility Quality Control and Payment Error Rate Measurement for Medicaid and CHIP (August 17, 2010)
- Seventh Circuit Holds That Secretary May Not Unilaterally Reopen an Administrative Proceeding After Judicial Review Has Been Initiated (August 9, 2010)
- CMS Issues Final IPPS Rules; Interim Final Rule on Three-Day Payment Window (August 4, 2010)
- Ninth Circuit Reverses District Court on the Basis that the PRRB Should Not Have Granted EJR (July 26, 2010)
- CMS Issues Proposed Physician Fee Schedule Rule, Including Stark Disclosure Requirements for Imaging Services; Physician Fee Cut Delay Legislation Signed (June 29, 2010)
- PRRB Grants Expedited Judicial Review on CMS Ruling 1498-R Regarding DSH Calculations (June 21, 2010)
- Another Federal Court Rules Hospice Cost Cap is Invalid Regulation (June 11, 2010)
- CMS Delays Deadline for Joint Commission-Accredited Hospitals to Implement Telemedicine Standards (June 11, 2010)
- Arizona Hospitals Lose DSH Decision in Federal Court (June 10, 2010)

If you would like to volunteer to assist the RAP PG in preparing email alerts, email the Practice Groups staff indicating your interest.

Chair's Corner

Barry D. Alexander, Esquire
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The former British novelist, essayist, and Prime Minister Benjamin Disraeli once said, "change is inevitable . . . change is constant."

For those of us who have chosen to brave the murky waters of Medicare and Medicaid reimbursement and healthcare integration, change is the world we live in. While the Regulation, Accreditation, and Payment Practice Group (RAP PG) leadership, AHLA staff, and our membership have been geared up and remain ready to track the full implementation of the Affordable Care Act (ACA) (note that two articles in this edition of *The RAP Sheet* follow that objective), sweeping changes in state and federal legislative seats following November 2, 2010, virtually guarantee some changes to the healthcare reform implementation, whether it be in timing or content, or both. By the same token, while the future of the individual mandate provisions and health exchange funding may be somewhat in doubt in the next Congress, ACA includes significant changes to a number of Medicare stakeholders—new demonstration projects and a brand new division within the Centers for Medicare & Medicaid Services to implement these new demonstration programs, expanded quality-of-care initiatives and corresponding payment incentives, new wellness benefits, and closing the proverbial donut hole under Part D, to name a few. So, while pundits pontificate over which, if any ACA provisions may be subject to the chopping block, many changes to the Medicare program will be difficult, if not impossible to roll back. These will be the changes that we will continue to watch in 2011 and beyond. These are the changes that will shape the future of the Medicare program.

To our readers and members, I have two specific requests for help. First, get involved and volunteer to help us evaluate and bring the best content to the entire PG membership. AHLA and the RAP PG have a long history of "many hands making the work light." There are so many different ways to volunteer that you can control the amount of time and effort it may require you to offer to the PG. My own seventeen years of volunteering and involvement with AHLA illustrate the broad range of possibilities: articles, email alerts, recruiting other volunteers and luncheon speakers, moderating webinars, speaking at in-person programs, editing *The RAP Sheet*, or just answering a reimbursement question for a fellow member.

I hope you will consider joining the team effort it takes to produce the significant amount of content we strive to deliver. I hope you will consider leadership and other opportunities within AHLA. This association thrives on our members and our members, in turn, make this association and this PG work.

Second, I am reminded that feedback is a gift. As you read this issue, or as you catch another AHLA email alert, or as you listen in on a webinar, or as you peruse a toolkit on the RAP PG website, or as you review a brochure for an in-person program—drop us a quick line and let us know what is working, what is not working, or what is missing from our efforts. Either email me directly at barry.alexander@nelsonmullins.com or to the outstanding AHLA Practice Groups staff at pgs@healthlawyers.org will guarantee that it reaches the RAP PG leadership.

Wishing each and every one of you a happy and healthy New Year.

Barry Alexander

Now is the Time to Volunteer

Did you consider writing an article recently when you saw a compelling court decision come down or a new regulation pop up? Were you listening into an AHLA webinar and thought about your own idea for an AHLA webinar? Have you always been curious about volunteering for the Practice Groups, but never knew who to contact or how to get started?

If yes is the answer to one or more of these questions, all that you need to do is email pgs@healthlawyers.org indicating your interest in volunteering for the Practice Groups. Your email can be as general or as specific as you would like. We will find the right spot for you; we only need to know that you are interested.

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