HEALTH REFORM – NEW ACTIVITY AND EXPIRED DEADLINES

Administration Introduces Plan; Holds Bipartisan Summit on Healthcare Reform

In anticipation of his White House Reform Summit, President Obama released an 11-page summary of the administration’s $950 billion health reform plan that proposes to extend insurance coverage to more than 31 million Americans. While the President’s plan was substantially based on the Senate’s Patient Protection and Affordable Care Act (H.R. 3590), it “incorporates the work the House and the Senate have done and adds additional ideas from Republican members of Congress.”

Additions reflected in the administration’s proposal include a new Health Insurance Rate Authority charged with providing "needed [federal] oversight" of insurance market behavior, 100 percent Federal Medicaid Assistance Percentage (FMAP) to the states through 2017 for expanding Medicaid and nine new anti-fraud and abuse proposals including technology for real-time claims data and payment analysis. Other important elements include a delay in the excise tax on high-cost “Cadillac” plans until 2018, a new 2.9 percent assessment on unearned income in the Medicare payroll tax for individuals and families making more than $200,000 and $250,000, respectively, and increased tax credits for health insurance premiums.

The administration’s proposal set the stage for a bipartisan Summit on Healthcare Reform held by the President on February 25, 2010. During the televised event moderated by President Obama, issues central to insurance reforms, cost containment, coverage expansion and deficit reduction were debated by the invitees that included congressional leaders from both sides of the aisle. Although clarifying the philosophical divide between the parties over the role of government in healthcare, the daylong Summit ended without achieving a bipartisan accord. By letter to Congress, the President expressed a willingness to accommodate certain Republican policy initiatives -- tort reform, Medicaid payment, health savings accounts and enhanced fraud deterrence -- discussed during the Summit in his final health reform bill. Reconciliation has emerged as the preferred path forward by congressional Democrats for passing a comprehensive health reform bill in the face of continuing Republican opposition.

House Moves on Insurer Antitrust Bill

In what could be a parallel strategy to convert certain segments of the House and Senate health reform bills into a series of bite-size initiatives, the House of Representatives acted to repeal the antitrust exemption for health insurance companies from the McCarran-Ferguson Act with a robust bipartisan vote (406-19). Citing the need for this legislation because "95% of health insurance markets are highly concentrated," the bill’s sponsors, Reps. Tom Perriello (D-Va.) and Betsy Markey (D-Colo.) characterize the Health Insurance Industry Fair Competition Act (H.R. 4626) as “a very important step for fiscal responsibility.” While the House reform measure contains a similar provision, the Senate version does not. As a result, subsequent passage of the Health Insurance Industry Fair Competition Act in the Senate likely will face tougher sledding.
Expired Deadlines Prompt Action by Congress and CMS

Meanwhile, a provision passed under the U.S. Department of Defense Appropriations Act to delay a 21 percent payment cut for physicians mandated by the Medicare sustainable growth rate formula expired February 28, 2010. See the January 21, 2010, issue of the Health Law Update. The Centers for Medicare & Medicaid Services (CMS) has instructed its contractors to hold claims for services paid under the Medicare Physician Fee Schedule (MPFS) for the first ten business days of March “to avoid disruption in the delivery of health care services and payment of claims.” The MPFS claims hold will affect only those claims with dates of service March 1, 2010, and forward, according to the agency.

This week, President Obama signed into law the Temporary Extension Act of 2010 (H.R. 4691) as a stopgap measure to forestall lapsing deadlines affecting unemployment and COBRA healthcare subsidies. Relevant for physicians, non-physicians and other providers of services paid under the MPFS, the new law delays the 21.2 percent payment reduction until the end of the month. Other deadlines temporarily extended by the new law include COBRA premium assistance subsidies signed into law by President Obama under the American Recovery and Reinvestment Act (ARRA) and the cap on Medicare Part B outpatient therapy services that became effective January 1, 2010.

New legislation introduced by Senate Majority Leader Harry Reid (D-Nev.) and Finance Committee Chair Max Baucus (R-Mont.) on March 1, 2010, would further delay cuts in the MPFS to September 30, 2010. The proposed American Workers, State, and Business Relief Act of 2010 (H.R. 4213), introduced as a substitute amendment to the Tax Extenders Act passed by the House last year, additionally would (1) continue the increased FMAP for states made available by ARRA for an additional six months from January 1, 2011, to June 30, 2011, (2) reverse the outpatient cap on Medicare Part B outpatient therapy services until the end of the year, and (3) extend COBRA premium assistance subsidies through December 31, 2010.

For more information, please contact Susan Feigin Harris, sharris@bakerlaw.com or 713.646.1307 or Kathleen P. Rubinstein, MPA, Policy Analyst, krubinstein@bakerlaw.com or 713.276.1650.

WYDEN- Gregg Bill Proposes to Eliminate Tax-Exempt Bonds

While fundamental tax reform has not created the same headlines as health reform, a bill introduced in the Senate last week has added to the concerns of hospital and health system CFOs. The Bipartisan Tax Fairness and Simplification Act of 2010 (S. 3018), commonly referred to as the “Wyden-Gregg Bill” after the bill’s sponsors, Sens. Ron Wyden (D-Oreg.) and Judd Gregg (R-N.H.), seeks to simplify the current federal income tax system through a number of fundamental changes. Among them is the elimination of tax-exempt bonds beginning in 2011 in favor of a tax credit program coupled with a prohibition on advance refunding of bonds.

Senator Wyden, a member of the Senate Finance Committee, reportedly was the primary proponent of the provisions concerning tax-exempt bonds. According to a joint statement issued by the Senators: “Wyden-Gregg changes tax-exempt bonds to tax-credit bonds as part of its overall effort to lower tax rates by broadening the tax base. This was a sensible option for not only broadening the base but for making the tax code more equitable, because -- unlike a tax exemption -- a tax credit allows taxpayers at all income levels to realize the same tax benefits.”

Spokespersons for several organizations that represent various segments of the tax-exempt bond market quickly announced their opposition to these provisions. Baker Hostetler does not anticipate that the Wyden-Gregg Bill will become a legislative priority in the immediate future.
The Healthcare Industry, Government Policy and Tax Groups will continue to monitor the Wyden-Gregg Bill. For further information on tax-exempt bond provisions, contact Thomas W. Kahle, tkahle@bakerlaw.com or 513.929.3414, or for more information on the bill generally or other tax provisions, contact Paul M. Schmidt, pschmidt@bakerlaw.com or 202.861.1760.

FEDERAL SENTENCING GUIDELINES -- PROPOSED AMENDMENTS

The U.S. Sentencing Commission (Commission) recently proposed a series of changes to the Federal Sentencing Guidelines (Guidelines) that are used to determine a defendant's punishment for federal crimes, including healthcare fraud. The Guidelines focus primarily on two factors -- the criminal conduct and the defendant's criminal history. The proposed changes, if enacted, may require providers to re-evaluate their ethics and compliance policies, their compliance officer's reporting relationships and how the organization responds to detected violations.

Remediation of Harm

The proposed amendment would change the Guideline’s commentary to clarify the remediation efforts needed to satisfy the requirement for an effective compliance and ethics program. The amendment would require that an organization's response to detected criminal conduct include remedying the harm caused to identifiable victims and paying restitution to victims. The clarification also suggests that organizations consider, in light of the offense, whether any modifications to the compliance plan should be made and whether an independent monitor should be engaged to assure implementation of the modifications.

Compliance Officer Board Reporting

The proposal also requested comments on whether compliance officers should be encouraged to report directly to an organization's governing body. In most instances, this change should not be as significant for providers who have followed the Office of Inspector General's recommendation that comprehensive compliance programs should include designating a chief compliance officer and other appropriate bodies, e.g., a corporate compliance committee that reports directly to the CEO and the governing body. See, e.g., OIG Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987, 8989 and 8993 (Feb. 23, 1998) and Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858, 4875 (Jan. 31, 2005).

Probation Terms

The proposed amendment to Guideline Section 8D1.4 eliminates the current distinction between conditions of probation imposed solely to enforce a monetary penalty and conditions of probation imposed for other reasons, and eliminates preconditions for the implementation of certain probation requirements. Under the revised rule, a court may consider, if appropriate (1) employee and shareholder notification of the conduct; (2) imposition of an independent monitor with appropriate qualifications; (3) reporting of financial condition, subsequent criminal prosecutions, material civil litigation or administrative proceedings, and any governmental investigation or inquiry and material adverse business changes; and (4) conducting unannounced examinations of the entity's books, records and facilities and “interrogation[s]” of knowledgeable individuals.

The proposed amendment also clarifies that the independent monitor must be independent and properly qualified. This change was proposed in response to complaints regarding the use of politically-favored monitors, such as former Attorney General Ashcroft’s reputed 18-month, $52 million engagement for monitoring orthopedic supplier Zimmer Holdings of Indiana and proposed legislation, including the Accountability in Deferred Prosecution Act of 2009 (H.R. 1947).

Document Retention Policy

The proposed amendments will require that high-level personnel and employees be aware of their organization's document retention policies and conform those policies to meet the goals of an effective compliance program.

Effect of Board and High Level Management Involvement

This proposed amendment questions whether the Guidelines should be expanded to provide punishment mitigation where high-level personnel are complicit in a violation in which (1) the compliance officer reports directly to the Board; (2) the compliance program detected the violation; and (3) the organization promptly reported the offense to appropriate authorities.
These changes to the Guidelines should be monitored as they may, if implemented, require modifications to providers’ ethics and compliance policies, their compliance officer’s reporting relationships and how the organization responds to detected violations. Providers cannot simply pay lip service to compliance by relying on a written code of ethics that is not vigorously implemented. The Commission is accepting comments on the proposals until March 22, 2010.

For more information, please contact Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327.

IME / GME PAYMENTS – COURT FINDS LACK OF CLARITY IN CMS INSTRUCTIONS

On February 16, 2010, the U.S. District Court for the District of Columbia ruled that the Secretary of the U.S. Department of Health and Human Service (HHS) did not provide sufficient notice that the claim-filing time limits for Medicare Part A claims would be applied to the submission of data necessary to calculate the hospital’s graduate medical education (GME) and indirect medical education (IME) costs attributable to Medicare+Choice (M+C) beneficiaries. The decision (Loma Linda Univ. Med. Ctr. v. Sebelius, No. 08-1520 (D.D.C. Feb. 16, 2010) reversed CMS’s determination that its regulation and the instructions it supplied to the fiscal intermediary implicitly put the hospital on notice of the agency’s claim-filing requirements for GME/IME payments for M+C enrollees.

A consultant discovered in 2003 that the hospital had not filed for or received IME and GME payments for a large number of M+C patients. The consultant gathered the data regarding these patients, and the hospital sent it to the intermediary with a request for payment. The data was not submitted on the standard UB-92 claim form used for filing Part A claims and was rejected by the intermediary on the ground that it was not in the proper format. Further, both CMS and the intermediary stated that, even if the data had been submitted on UB-92 claim forms, it would have been rejected as untimely. According to CMS, the hospital should have known, based on a rule it issued in 1998 and a later Program Memorandum issued to intermediaries, that a UB-92 claim form would be required to claim GME/IME for services to M+C enrollees and that the general rules for timeliness of claims would be applied to such claims.

The court found that CMS’s rationale could not be supported by the administrative record. The court noted that there was no language in any of the agency’s rule-making guidance regarding time limits, nor was there any mention of the regulation governing the submission of Part A claims. The court found that the hospital became aware of the filing deadlines when it sought payment in 2003 for unbilled claims and was informed by the fiscal intermediary that its request was untimely. The court remanded the case to CMS to determine whether the data that the hospital submitted to the intermediary in lieu of the standard UB-92 claim form could be used to calculate the IME/GME payments.

The case presents a positive result for Medicare providers who are held to standards that are not set forth in the published regulation and guidance of the agency. The Loma Linda court did not seem willing to let the agency get by with "implicit instructions” tucked within the meaning of its rules.

If you have any questions regarding the decision or with respect to challenges to CMS actions, please contact Gregory N. Etzel, getzel@bakerlaw.com or 713.646.1316.

SSI RATIO – COURT HOLDS NO JUDICIAL RECOUSE FOR UNTIMELY APPEAL

On February 26, 2010, the District Court for the District of Columbia ruled against a group of providers who attempted to capitalize after the fact on the provider-friendly ruling in the Baystate case (in which the Provider Reimbursement Review Board (PRRB or Board) held that the SSI Ratios used to compute providers’ disproportionate share hospital (DSH) adjustments were systemically flawed). Auburn Regional Medical Center, et al. v. Sebelius, 2010 WL 675053 (D.D.C. 2010). In Auburn, the providers appealed their fiscal year 1987-2004 notices of program reimbursement (NPRs), alleging that their DSH payment adjustments were understated because they had been calculated using inaccurate SSI Ratios. However, because the providers did not meet the 180-day deadline for filing appeals to the Board, the Board ruled that the providers’ appeals were untimely. The providers readily admitted that they had not met the 180-day appeal deadline, but argued that because they did not learn of the inaccurate SSI Ratios until the Board’s decision in Baystate was issued, equitable tolling should apply and the providers should be given 180 days from the Board’s decision in Baystate (as opposed to 180 days from issuance of their NPRs) to file their appeals.

The Board denied the providers’ appeals, stating that it had no authority to grant a request for equitable tolling. The providers appealed the Board’s decision to the D.C. District Court, arguing that (1) equitable tolling should apply; (2) the court should order the use of accurate SSI Ratios through a grant of mandamus; and (3) if judicial review is not available under the Medicare statute’s grant of jurisdiction, then federal court jurisdiction is appropriate under 28 USC § 1331. With
respect to the providers’ first argument, the court held that it was obligated to follow the D.C. Circuit’s precedent in Athens Comm. Hosp. v. Schweiker, which held that the Board’s dismissal of an untimely provider appeal is not a "final decision" within the meaning of 42 U.S.C. § 1395oo(f), and therefore, is not subject to judicial review. With respect to the providers’ mandamus request, the court ruled that the absence of a requisite "duty" on the part of the defendant and the failure of the providers to exhaust administrative remedies precluded the court from granting mandamus relief. Finally, the court held that Congress did not intend to allow judicial review of Medicare claims under 28 U.S.C. § 1331. The lesson to be learned from this case is that the law and courts are not sympathetic to providers’ untimely attempts to appeal Medicare reimbursement determinations.

For more information, please contact Krista M. Barnes, kbarnes@bakerlaw.com or 713.646.1352.

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TEXAS FREESTANDING EMERGENCY FACILITIES -- PROPOSED LICENSING RULES

The Texas Department of State Health Services recently published detailed proposed rules on the construction and operation of freestanding emergency medical care facilities. 35 Tex. Reg. 1568 (Feb. 26, 2010). The rules define a freestanding emergency medical care facility as a facility that is structurally separate and distinct from a hospital and which provides evaluation and stabilization services for medical conditions that would lead a prudent layperson to believe that failure to get immediate medical care could place the person's health in serious jeopardy or result in serious bodily impairment, dysfunction or disfigurement or serious jeopardy to the health of a fetus. Under the proposed rules, most freestanding emergency medical care facilities would be required to be licensed by September 1. Comments on the proposed rules are due on or before March 29, 2010.

For more information, please contact Robert M. Wolin, rwolin@bakerlaw.com or 713.646.1327.

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CHRIS SWIFT NAMED BEST LAWYER OF THE YEAR

For 2010, Best Lawyers, the oldest peer-review publication in the legal profession, has named Chris Swift "Cleveland Tax Lawyer of the Year." After more than a quarter of a century in publication, Best Lawyers is designating "Lawyer of the Year" in high-profile legal specialties in large legal communities. Only a single lawyer in each specialty in each community is being honored as the "Lawyer of the Year." Best Lawyers compiles its lists of outstanding attorneys by conducting exhaustive peer-review surveys in which thousands of leading lawyers confidentially evaluate their professional peers. The current, 16th edition of The Best Lawyers in America (2010) is based on more than 2.8 million detailed evaluations of lawyers by other lawyers. Those honored as "Lawyer of the Year," have, during the past two surveys, received particularly high ratings by earning a high level of respect among their peers for their abilities, professionalism and integrity. Steven Naifeh, Managing Editor of Best Lawyers, said, "We continue to believe -- as we have believed for more than 25 years -- that recognition by one's peers is the most meaningful form of praise in the legal profession."

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EVENTS CALENDAR

March 17-18

Cleveland partner Steve Eisenberg will speak on "Developing Best Practices for a Breach Assessment Process" at the HIPAA Compliance Congress: Data Protection and Privacy Compliance under the HITECH Act sponsored by the American Conference Institute at The Helmsley Park Lane in New York, New York.

March 22

Cleveland partner Steve Eisenberg will speak on "Imaging Center Acquisitions and Plans for Consolidations in 2010" at Imaging 100 sponsored by The Summer Group taking place at the Chateau Elan in Atlanta, Georgia.

March 24

Cleveland partner Steve Eisenberg will speak on "Accountable Care Organizations and Other Offshoots of Health Care Reform" at the Health Care Law Section Meeting of the Cleveland Metropolitan Bar Association in Cleveland, Ohio.
April 8

Houston partner Susan Feigin Harris will speak on "Healthcare Reform, Part II; Delivery System Reform and the Market Response -- How Will It Affect Providers?" at the University of Texas Health Law Conference at the Four Seasons Hotel in Houston, Texas.

Houston partner Greg Etzel will speak on "All Eyes on Quality: The Increasing Role of Quality in Federal Program Payment and Enforcement Policies" at the University of Texas Health Law Conference at the Four Seasons Hotel in Houston, Texas.

April 9

Houston partner Donna Clark will speak on "Stark and Fraud and Abuse Hot Spots: Self-Reporting, Disclosure and Compliance Issues" at the University of Texas Health Law Conference at the Four Seasons Hotel in Houston, Texas.