

# The RAP Sheet

## Table of Contents

<b>The Future Is Now: Medicare Pay for Performance for Inpatient Hospital Services Has Arrived</b> <i>Amy Kearbey, Esq. Jessica Roth, Esq. Eric Zimmerman, Esq.</i> .....	1
<b>Chair's Corner: Reimbursement Predictions for 2013</b> <i>Barry Alexander, Esq.</i> .....	5
<b>In Case You Missed It . . .</b> .....	7
<b>Office of Medicare Hearings and Appeals: "Growing Pains" as Appeals Workload Increases to Record Levels</b> <i>Judith Waltz, Esq.</i> .....	8
<b>Medicaid Enrollment Update</b> <i>Jeanne Vance, Esq. Nathaniel Lactman, Esq. Ross Sallade, Esq. Emily Towey, Esq.</i> .....	11



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—from a declaration of the American Bar Association

## The Future Is Now: Medicare Pay for Performance for Inpatient Hospital Services Has Arrived

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Two key pay-for-performance (P4P) programs created by the Patient Protection and Affordable Care Act of 2010 (PPACA)—the Hospital Value-Based Purchasing Program (VBP Program) and Hospital Readmissions Reduction Program (HRRP)—went into effect October 1, 2012. The VBP Program rewards hospitals for achieving certain levels of performance against specific performance measures, and the HRRP penalizes hospitals with higher than expected readmissions for patients with certain conditions. Together, these programs mark the beginning of Medicare P4P for inpatient hospital services.

### Overview of the VBP Program

#### Background

The VBP Program was created by Section 3001(a)(1) of PPACA<sup>1</sup> and provides for the payment of value-based incentives to hospitals that meet performance standards. The VBP Program reflects the next step toward replacing a fee-for-service model with one that incentivizes and rewards quality and effectiveness. For several years, the Centers for Medicare & Medicaid Services (CMS) has rewarded and penalized providers for reporting quality data through programs such as the Physician Quality Reporting System and the Hospital Inpatient Quality Reporting (IQR) program. These pay-for-reporting programs were widely understood to be a logical precursor to a full-fledged P4P program. In the Deficit Reduction Act of 2005, Congress expressly instructed CMS to prepare a report to Congress regarding potential value-based purchasing programs. This report ultimately shaped what became the VBP Program enacted as part of PPACA. With the implementation of the VBP Program, CMS takes the next step from its pay-for-reporting programs and, for the first time, rewards and penalizes hospitals based on their performance.

## Program Specifications

VBP payments are funded through reductions to base operating diagnosis-related group (DRG) amounts: 1% in fiscal year (FY) 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016, and 2% in FY 2017 and each subsequent year. Hospitals can then earn back these reductions by reaching various performance benchmarks. Although the program is effective beginning with discharges on or after October 1, 2012, actual payment adjustments will not begin until January 2013, at which time hospitals will begin receiving operating DRG payment amounts for each discharge that are adjusted by the net result of the 1% reduction and the hospital's incentive payment adjustment. CMS was to reprocess claims from October 2012 through December 2012.

To evaluate hospital performance, CMS defines a threshold and a benchmark level for each measure. The threshold is the median of hospital performance (i.e., 50th percentile), and the benchmark is the mean of the top decile of hospital performance during the baseline period. For FY 2013, the baseline period is July 1, 2009-March 31, 2010.

Hospitals can achieve points for both *achievement* relative to other hospitals and *improvement* against the hospital's own baseline—ten points for meeting or exceeding the benchmark and a linear scale of one to nine points for scores between the threshold (or baseline) and the benchmark. No points are earned when a hospital performs below the threshold (or baseline). Hospital performance is measured during the performance period, which, for FY 2013, is July 2, 2011-March 31, 2012. CMS uses the higher of the achievement score or the improvement score to calculate the total performance score.

CMS has finalized measures for FYs 2013, 2014, and 2015. Measures are classified into domains, and each domain accounts for a specified portion of the hospital's overall performance score. For FY 2013, the VBP Program includes a clinical process of care domain with twelve measures and a patient experience of care domain based on performance on the Hospital Consumer Assessment of Healthcare Providers and Systems survey. The clinical process of care domain accounts for 70% of the overall performance score, and the patient experience of care domain accounts for the remaining 30%. For FY 2014, CMS added an outcome domain comprised of three mortality measures. The outcome domain will account for 25% of the overall score, and the clinical process of care and patient experience of care domains will be reduced to 45% and 35% of the overall score, respectively.

The final rule for the FY 2014 VBP Program had initially included an efficiency domain based on the Medicare Spending Per Beneficiary (MSPB) measure, consistent with PPACA's express instruction that the VBP Program include efficiency measures beginning during FY 2014.<sup>2</sup> However, under pressure from stakeholders who argued that including the MSPB measure in the FY 2014 VBP Program failed to meet the statutory requirement that measures be posted on the Hospital Compare website for at least one year before being used in the VBP Program, CMS subsequently removed the efficiency domain from the FY 2014 VBP Program. For FY 2015, having now met the one-year posting requirement, CMS finalized the addition of the efficiency

domain, which will account for 20% of the overall patient score. The patient experience of care and outcome domains will each account for 30% of the overall score, and the clinical process of care domain will count for 20%.

The sole measure in the efficiency domain will be MSPB. A hospital's performance on this one measure will thus account for 20% of the hospital's overall performance score for FY 2015. Some stakeholders have objected, asserting that it is inappropriate to afford such a high weight to a single measure. CMS acknowledged these concerns, but stated that the inclusion of only one measure in the efficiency domain underscores "the relative importance of efficiency in the health care sector."<sup>3</sup> Moreover, CMS explained that the relative weighting of the domains has shifted from the initial emphasis on the clinical process of care domain toward measures of outcomes and efficiency as these are the areas of focus for quality improvement.<sup>4</sup>

The performance benchmarks and thresholds have also raised concerns regarding a potential "cliff effect" on payment for very small differences in performance. For measures that have a benchmark score of 1.0, 100% compliance is required to receive the full ten points, resulting in a loss of points for missing just one or two cases. Similarly, for several measures the distance between the threshold and the benchmark is less than 0.1. For these measures, very small differences in performance from hospital to hospital will result in large differences in scoring and, as a result, payment.

Hospitals have very limited appeal rights under the VBP Program. With respect to the measure rate calculations, CMS will provide each hospital with a confidential report detailing the hospital's claims-based measure rate calculations and accompanying discharge level information.<sup>5</sup> Hospitals will have 30 days to review and submit corrections regarding the calculations in their reports. Corrections are limited to calculation errors; hospitals may not submit corrections relating to the underlying claims data or add new claims to the performance period data set. This process aligns with the existing review and corrections procedures in place in the Hospital IQR Program.

## Overview of the HRRP

The HRRP was created by Section 3025 of PPACA.<sup>6</sup> Under the HRRP, hospitals with higher-than-expected readmissions rates will have their Medicare inpatient payments reduced. Readmissions occur when a discharged patient is readmitted to the same or another acute care hospital within 30 days, for any reason (except for a very few excluded "planned" readmissions) when the initial admission has a certain principal discharge diagnosis. Thus, for example, if a patient is discharged after being treated for a heart attack, and then is subsequently admitted within 30 days to any hospital, including the one initially treating and discharging the patient, for injuries following an auto accident, that readmission would count against the original admitting hospital despite the lack of any causal nexus between the initial admission and the readmission.

For FY 2013, CMS will track readmissions for patients treated for three conditions: acute myocardial infarction (AMI), heart failure,

**Table 1. Key Statistics Regarding VBP, HRRP, and Combined Adjustments**

	VBP	HRRP	Combined
<b>Mean</b>	0.01%	-0.28%	-0.27%
<b>Median</b>	0.00%	-0.13%	-0.20%
<b>Minimum</b>	-0.78%	-1.00%	-1.78%
<b>Maximum</b>	0.91%	0.00%	0.91%

and pneumonia. To measure hospital readmissions, CMS adopted the three National Quality Forum-endorsed, hospital risk-standardized readmission measures that are currently included in the Hospital IQR Program: AMI 30-day Risk Standardized Readmission Measure; Heart Failure 30-day Risk Standardized Readmission Measure; and Pneumonia 30-day Risk Standardized Readmission Measure.

For each hospital, CMS calculates an “excess readmission ratio” for each condition that compares the total adjusted actual readmissions at the hospital to the number that would be expected for an average hospital with similar patients.

This ratio is used to calculate an adjustment factor by applying the ratio to the hospital’s aggregate payments for all claims that list the condition and comparing these payments to total payments for all discharges. The adjustment factor is then applied against the wage-adjusted DRG operating payment, subject to an annual cap of 1% in FY 2013, 2% in FY 2014, and 3% thereafter.

Because the penalty is based on a ratio comparing actual readmissions to expected readmissions, the impact of unrelated readmissions (e.g., the auto accident scenario described above) should theoretically be mitigated. In other words, the expectation is not zero readmissions. To the contrary, the program, by design, allows for some expected level of readmissions. The penalties apply only when a hospital’s actual rate of readmissions exceeds the expected level.

The excess readmission ratio used to calculate the payment adjustment factor is adjusted for certain patient demographics, coexisting medical conditions, and indicators of patient frailty. There is no adjustment, however, for race, language, life circumstances, environmental factors, and socioeconomic factors. Stakeholders continue to press CMS on the appropriateness of incorporating an adjustment for socioeconomic factors, and the Medicare Payment Advisory Commission (MedPAC) has indicated that it believes an adjustment for socioeconomic status (SES) would be appropriate. CMS’ own analysis, however, indicates that hospitals that treat a large proportion of patients of low SES can and do perform well on readmissions measures, and that the existing risk-adjustment for patient demographics likely addresses much of the effect of SES.

The HRRP is expected to expand to include admissions for four additional conditions that were identified in MedPAC’s June 2007 report to Congress on Payment Policy for Readmissions: chronic obstructive pulmonary disease, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, and other vascular conditions.

The statute expressly precludes judicial or administrative review of the determination of base operating DRG payment amounts and the methodology for determining the adjustment factor, including the excess readmissions ratio, as well as measures for readmissions.<sup>7</sup> The statute also provides that a hospital must have the opportunity to review, and submit corrections for, information regarding the hospital’s readmission rate prior to the publication of such information. To that end, in similar fashion to the VBP Program, CMS will provide hospitals with a confidential report detailing their excess readmission ratio and accompanying discharge-level information, as well as the risk factors for the discharges that factored into the calculation of the excess readmission ratio.<sup>8</sup> Hospitals would have 30 days to submit corrections to the information in the report. Corrections are limited to calculation errors; hospitals may not submit corrections relating to the underlying claims data or add new claims to the data extract through this process.

**Winners and Losers**

Although the basic tenets of the program have been well defined through rule-making, until recently it was unclear what the impact of the VBP Program and the HRRP might be to individual hospitals. Data available from CMS now allow us to understand the impact (as a percent of revenue as well as total dollars) of each program separately, but also together.

Based on these data, the mean hospital VBP adjustment is a positive adjustment of 0.01%, and the mean hospital HRRP adjustment is -0.28%. Thus, the average combined adjustment across both programs is -0.27%. In other words, overall, the average hospital will lose -0.27% of their base operating DRG payments under both the VBP Program and the HRRP. Table 1 (above) provides additional information regarding actual provider adjustments under each program separately as well as together.

Because adjustments are determined using base operating DRG payments, or the hospital’s standardized amount adjusted only for the area wage index, certain hospital payments such as indirect

**Table 2. Overall Impact of Combined VBP and HRRP Adjustments**

	Combined
<b>Mean</b>	-0.23%
<b>Median</b>	-0.17%
<b>Minimum</b>	-1.56%
<b>Maximum</b>	0.91%

**Table 3.**

	VBP	HRRP	Combined	Per Discharge
<b>Mean</b>	\$ (645.76)	\$ (85,224.30)	\$ (85,870.06)	\$ (19.98)
<b>Median</b>	\$ -	\$ (14,687.18)	\$ (21,723.70)	\$ (15.07)
<b>Minimum</b>	\$ (1,028,723.90)	\$ (3,025,658.54)	\$(4,054,382.45)	\$ (164.11)
<b>Maximum</b>	\$ 634,945.73	\$ -	\$ 634,945.73	\$ 138.27

medical education and disproportionate share adjustments, as well as hospital-specific payments, are held harmless with respect to these adjustments. Because these payments are not subject to adjustment, the combined impact of the VBP Program and the HRRP to a hospital's bottom line might be less than the sum of the individual program adjustments. Table 2, at the bottom of page 3, indicates the combined impact of the VBP and HRRP adjustments as a percent of total revenue, including indirect medical education, disproportionate share, and hospital-specific payments.

As Table 2 indicates, the impact of the VBP Program and the HRRP is further diluted when payment adjustments are considered relative to total DRG payments rather than base operating DRG payments.

On a dollar basis, the average adjustments under the VBP Program, the HRRP, and the combined programs are (\$646), (\$85,220), and (\$85,870), which equates to an average combined loss of approximately \$20 per discharge. While losses under the two programs are small on average, a few hospitals are losing large sums. For FY 2013, losses will be most substantial under the HRRP program. Table 3 provides additional detail regarding hospital gains and losses under the VBP and HRRP programs.

A closer analysis of hospital performance under the VBP Program and the HRRP does not reveal clear patterns of winners and losers. There is, however, a weak relationship, as measured using Pearson's correlation coefficient, between performance under the HRRP and factors such as bed size, teaching status (as measured by a provider's indirect medical education (IME) adjustment), disproportionate patient percentage, case mix index, and percent Medicare. For most of these variables, the relationship between the HRRP adjustment and the variable is negative. That is, as the

variable increases, the HRRP adjustment decreases or becomes more negative. The one exception is case mix index (CMI). Between CMI and the HRRP adjustment factor there is a weak positive relationship, which suggests that as CMI increases the HRRP adjustment factor increases (or becomes less negative).

With respect to VBP, only a hospital's disproportionate patient percentage has any relationship to a hospital's performance under the program and this relationship is negative, such that as a hospital's disproportionate patient percentage increases there is a decrease in the hospital's VBP adjustment factor.

### What Does this All Mean?

Although the immediate impact of the VBP and the HRRP are limited, the impact of these programs will expand as each program is phased in over the next several years. In addition, PPACA requires CMS to implement a payment adjustment for hospital-acquired conditions beginning in FY 2015. When all three programs are fully implemented in FY 2017, 6% of a hospital's base operating revenue will be at risk based on a provider's ability to provide safe, cost-effective quality care as measured by a hospital's ability to meet performance standards relating to the process of delivering care, patient outcomes and satisfaction, Medicare spending, and prevention of hospital-acquired conditions.

- 1 42 U.S.C. § 1395ww(o).
- 2 Social Security Act § 1886(o)(2)(ii).
- 3 77 Fed. Reg. 53258, 53594 (Aug. 31, 2012).
- 4 77 Fed. Reg. at 53505-06.
- 5 77 Fed. Reg. at 53579.
- 6 42 U.S.C. § 1395ww(q).
- 7 Social Security Act § 1886(q)(7).
- 8 77 Fed. Reg. at 53399.

**Table 4. Correlation Coefficients for the VBP and HRRP Adjustment Factors and Various Independent Variables**

	HRRP Adj. Factor	Est. VBP Adj. Factor
<b>HRRP Adjustment Factor</b>	1	
<b>Est. VBP Adjustment Factor</b>	0.060595	1
<b>Urban</b>	0.05971	0.032094
<b>Rural</b>	-0.05971	-0.03209
<b>Beds</b>	-0.12042	-0.07374
<b>IME</b>	-0.13219	-0.09441
<b>DSH</b>	-0.15766	-0.18479
<b>CMI</b>	0.177941	0.097644
<b>Medicare Share</b>	-0.18476	0.011287

# Chair's Corner

## Reimbursement Predictions for 2013

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It was the best of times, it was the worst of times—thus wrote Charles Dickens in his classic, *A Tale of Two Cities*. For the daily sojourner in healthcare, last year's election brought about certainty of one thing—the Affordable Care Act (ACA) is here to stay. Now, as we welcome the turning of another calendar year, the inauguration of President Barack Obama, the University of Alabama's football dynasty (with much sympathy to our Notre Dame colleagues and friends), and the survival of the world's end according to the Mayan calendar, here are some predictions in healthcare almost certain to come true:

### No More "Fiscal Cliff"

The annual list of "Words to be Banished from the Queen's English for Misuse, Overuse and General Uselessness" is compiled each year by Lake Superior State University in Michigan from nominations received from readers throughout the year. Right after the last-minute work of Congress appeared to avert it, "fiscal cliff" easily topped this year's lineup. Ironically, another phrase on this year's list was "kick the can down the road." Well, it seems that term describes exactly what Congress did and continues to do on issues such as the physician Sustainable Growth Rate. Another year and, again, we will face 25% to 30% cuts at the end of December right—but, right under the mistletoe, Congress will line up for that final shot into goal, and, bam, we will move the issue to 2014. Care to bet me?

### More Winners and Losers Under New Payment Systems

The end of 2012 ushered in the first reports of hospitals "winning" and "losing" under Medicare's new payment incentives for value-based purchasing (VBP) and readmission penalties. For the current federal fiscal year (FFY) 2013 running through September 30, 2013, 1,427 hospitals were penalized based on their VBP score and 1,557 hospitals received increased payments based on their VBP score. In addition, a total of 2,217 hospitals have been assessed readmission penalties in the current FFY 2013, with 307 hospitals receiving the maximum possible penalty of 1% of their Medicare reimbursement.<sup>1</sup> This feels like quality with a bite. So, as we rush onward to a world of new burgers with grilled onions at every fast food joint in America, it appears that the intersection of

quality and payment have finally introduced themselves to each other. Sort of like, "Hi, I'm Quality—I would really like to get to know you, Payment, but, I am not sure you really know what to pay for and I always carefully screen my suitors." Well, in any event, I predict that 2013 will see an increase in clinical and financial focus on the areas affected by these incentive payments.

### Did You Say Appeals Anyone?

Medicare appeals provide a constant flow of activity and interesting issues, but 2013 could be a record year. For cost report appeals, the huge backlog of notices of program reimbursement is finally starting to loosen and is almost certain to lead to a record number of new appeals filed with the Provider Reimbursement Review Board. Recovery audit contractors (RACs), zone program integrity contracts, qualified independent contractors (QICs), and other program integrity contractors are in marching full speed ahead in an effort to combat fraud—yet, an August 22, 2012, report prepared by the American Hospital Association showed that 75% of appealed RAC decisions are ultimately reversed.<sup>2</sup> In addition, a November 2012 U.S. Department of Health & Human Services, Office of Inspector General (OIG) report found that for 56% of appeals, the administrative law judges (ALJs) reversed QIC decisions and decided in favor of appellants—the OIG concludes, among other findings, that the Centers for Medicare & Medicaid Services (CMS) and the Office of Medicare Hearings and Appeals should: (1) develop and provide coordinated training on Medicare policies to ALJs and QICs; (2) identify and clarify Medicare policies that are unclear and interpreted differently; (3) standardize case files and make them electronic; (4) revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence; (5) seek statutory authority to establish a filing fee for appeals; and (6) implement a quality assurance process to review ALJ decisions.<sup>3</sup> While many in the industry may disagree with the perspective of these findings, I predict we will see significant continuation of audits and appeals and, most likely, additional Congressional hearings on the entire Medicare appeal process. (My second prediction, however, is that Congress may listen, but, will most likely "kick the can.")

### Medicaid Expansion

As most folks are aware by now, the U.S. Supreme Court's June 2012 ruling on the ACA permits states to "opt out" of the law's Medicaid expansion provisions, leaving each state's decision to participate in the hands of governors and state leadership. According to the latest data, 17 states and the District of Columbia have elected to participate in the Medicaid expansion and four states are leaning toward participation. On the other side, 10 have announced that they are not participating and five are leaning toward not participating, leaving the remaining 14 states as "undecided." Given the fact that the ACA will likely

not be repealed by the next Congress, every state will face pressure to participate in the expansion given the financial impact on their largest constituents, hospitals, and the growing pressure of providing indigent care. I predict in 2013 many of the undecided states will “opt in” to the Medicaid expansion and that, at least a handful of states on the fence will also join the Medicaid party.

## More ACOs, More Shared Savings Program Participants

Well, for all those hospitals and physicians waiting for Godot, the Supreme Court has ruled. We want to move forward with healthcare reform. So . . . for all of those hospitals and physicians that had adopted the “wait and see” approach—well, it’s time to run, not walk. How is your accountable care organization (ACO) doing? Has it been approved by CMS? In 2012, there were 32 participants in CMS’ Pioneer ACO program and 116 participants in the Medicare Shared Savings Program. In the first week of January 2013, CMS approved another 100 ACOs across the country. In 2013, those numbers will increase as the train to payment reform leaves the station.

## More Physician Integration

I find myself often telling the “young” healthcare lawyers in the firm, well, we did this a few years ago (buying physician practices) and then we tore it apart. Is it different this time? According to the recently released 2012 edition of AHA Hospital Statistics, the number of physicians employed by hospitals has grown by 32% since 2000. Today, hospitals employ approximately 212,000 physicians or about 20% of all physicians in the United States. Employment varied by region, with 56% of New England physicians reportedly employed or under contract compared with 29% in the West South Central Region. Impediments to direct employment models exist in states with active corporate practice of medicine laws—such as California and Texas—however, even in California, the report notes an increase in the number of foundations that employ physicians.<sup>4</sup> While some systems pursue employment, others clinical affiliations and co-management structures; one thing is certain in 2013—we will continue to see an increasing number of hospital-physician transactions of all flavors and shapes. (And, my third prediction is that, this time, with well-integrated, sophisticated, and really expensive electronic medical record platforms, we will not be tearing this house down anytime soon).

My final prediction for the year relates to health law and health lawyers. We will be busy. From appeals to audits; from transactions by and between healthcare systems to deals and ventures

between hospitals and physicians; from fraud and abuse enforcement to Medicare payment policy changes—there will be plenty of work in 2013 and opportunities. Within the Regulation, Accreditation, and Payment Practice Group (PG) and AHLA broadly, we continue to seek volunteers to join our mission quest. To write, to speak, to assist planning, and to edit (clearly, I could have used some assistance toning this one down). We are also looking for the next generation of leaders in the association—the premier health lawyers organization in the United States (in my humble opinion). Don’t be shy in 2013. Join us. Don’t just join the PG—take a role in our PG. I can make this final prediction—we will have plenty for you to do in 2013.

- 1 Kaiser Health News, “Medicare Revises Hospitals’ Readmission Penalties” (Oct. 2, 2012).
- 2 American Hospital Association, “Exploring the Impact of the RAC Program on Hospitals Nationwide” (Aug. 22, 2012).
- 3 “Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals,” OEI-02-10-00340 (November 2012).
- 4 2012 AHA Hospital Statistics.



## In Case You Missed It . . .

One of the Regulation, Accreditation, and Payment Practice Group's (RAP PG's) most active ongoing educational features is the timely release of email alerts. In this issue of *The RAP Sheet*, we provide a list of links to the PG's most recently issued email alerts. All of the RAP PG's email alerts can be found on the group's [Email Alerts](#) webpage.

- [CMS Releases Final Regulations for National Physician Payment Transparency Program](#)  
February 4, 2013
- [CMS Announces Healthcare Organizations Selected to Participate in the Bundled Payments for Care Improvement Initiative](#)  
February 1, 2013
- [CMS Announces Expansion of DMEPOS Competitive Bidding Program](#)  
January 31, 2013
- [HHS Announces HIPAA Settlement](#)  
January 7, 2013
- [Impact of the American Taxpayer Relief Act of 2012 on Healthcare Providers](#)  
January 4, 2013
- [CMS Issues Final Decisions on Outpatient Supervision Levels for Select Services Based on Hospital Outpatient Payment Panel](#)  
December 7, 2012
- [The Joint Commission Expands Performance Measurement Requirements Effective January 1, 2014](#)  
December 5, 2012
- [HIPAA Privacy Rule Guidance and De-Identification of PHI](#)  
November 30, 2012
- [CMS Publishes Final Rule Related to Home Health Agencies](#)  
November 26, 2012
- [2013 Final Physician Fee Schedule Issued](#)  
November 14, 2012
- [CMS Issues Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Final Rule](#)  
November 6, 2012
- [CMS Issues Final Rule for Increased Medicaid Reimbursement for Primary Care Physicians](#)  
November 2, 2012
- [American Hospital Association and Others Sue HHS for Claim Denials](#)  
November 2, 2012
- [Medicare Therapy Coverage: The Improvement Standard Disavowed and Discontinued in Proposed HHS Class Action Settlement](#)  
November 1, 2012
- [U.S. Supreme Court Set to Hear Arguments in Decision Reviving Hospitals' DSH Challenge](#)  
October 25, 2012

## Update on CMMI Initiatives from Dr. Gilfillan

Regulation, Accreditation, and Payment Practice Group Mid-Year Luncheon

*Sponsored by Dixon Hughes Goodman LLP*

March 20, 2013

### **Institute on Medicare and Medicaid Payment Issues**

Baltimore Marriott Waterfront Hotel  
Baltimore, MD

**REGISTER**

The Director of the Center for Medicare and Medicaid Innovation (CMMI), Dr. Richard Gilfillan, will provide an update on CMMI activities and initiatives, such as the bundled payment initiatives, Pioneer ACO, and future payment system and healthcare service delivery models.

CMMI was established as part of the Affordable Care Act for the purpose of testing innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program benefits. CMMI is currently focused on the following priorities:

- Testing new payment and service delivery models;
- Evaluating results and advancing best practices; and
- Engaging a broad range of stakeholders to develop additional models for testing.

## Office of Medicare Hearings and Appeals: “Growing Pains” as Appeals Workload Increases to Record Levels

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The Office of Medicare Hearings and Appeals (OMHA) administers hearings on claims, coverage, and beneficiary enrollment determinations. OMHA was created by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and opened its doors on July 1, 2005.<sup>1</sup> OMHA is currently facing a dramatically increasing workload based in large part on appeals ensuing from the Recovery Audit Contractor (RAC) initiatives. As of the time it prepared its fiscal year (FY) 2013 budget request, OMHA expected to receive 35,000 RAC appeals in FY 2012, following the expansion of the RAC initiative to all fifty states.<sup>2</sup> OMHA has also absorbed other new workloads not contemplated at the time of OMHA's establishment, as well as an influx of new Medicare beneficiaries. With its increasing workload, OMHA is currently “operating over capacity for the number of manageable claims which [Administrative Law Judge] teams can adjudicate within ninety days.”<sup>3</sup>

Significant changes may soon ensue at OMHA. The FY 2013 budget request estimates a 57% increase in total claims caseload for FY 2013 (estimated at 368,000 appeals), for which OMHA has requested a budget increase of \$12 million, to \$84 million.<sup>4</sup> As discussed in more detail below, this budget increase will allow OMHA to hire additional staff (both administrative law judges (ALJs) and thirty-six additional junior staff attorneys) and provide for its continuing focus on improving technology, assuming the budgetary requests are allowed.

In addition, the Centers for Medicare & Medicaid Services (CMS) responded positively to a recent U.S. Department of Health & Human Services Office of Inspector General (OIG) report which included ten recommendations for OMHA improvements with which CMS concurred in part or in full.<sup>5</sup> Adopting OIG's recommendations could result in substantive operational changes, including additional clarifications and training on Medicare policies for both OMHA and the qualified independent contractors (QICs), which handle reconsiderations (the appeal level below the ALJ level), with a goal of increased consistency in the QIC reconsiderations and in the ALJ decisions. In addition, OIG recommended that CMS and OMHA develop policies to handle suspicions of appellant fraud, and that they provide ALJs with more (and presumably more limiting) guidance as to the acceptance of new evidence at the hearing level.

### Background of OMHA and the FY 2013 Budget Request

OMHA's ALJs conduct new (de novo) reviews for Level 3 of the Medicare claims appeal process, following redeterminations by the Medicare contractors (Level 1) and reconsiderations by the

QICs (Level 2).<sup>6</sup> ALJ decisions may be appealed to the Medicare Appeals Council, and from there to the district court. Each of the four administrative appeal levels conducts a new, independent review of the evidence and is not bound by prior determinations or decisions of the prior levels of appeal.

In addition to the traditional fee-for-service claims appeals, OMHA now also hears prescription drug benefit appeals, Part B income-related monthly adjustment amount appeals, and claims relating to dual-eligibles in a growing number of states (the issue being whether Medicare or Medicaid should pick up the cost of appealed items or services).<sup>7</sup> By statute, OMHA is required to adjudicate certain types of cases within ninety days. OMHA's ALJs decide some cases on the record, hear cases in person, and utilize telephone hearings and video conferencing to assist in meeting statutory adjudication deadlines and to offer expanded access for appellants.

OMHA's operations are run through four field offices (located in Arlington, VA; Cleveland, OH; Irvine, CA; and Miami, FL) and a headquarters office. According to the budget request, because it began processing cases on July 1, 2005, OMHA has received more than one million claims for adjudication.<sup>8</sup> OMHA currently has 65 ALJ teams. Each ALJ team is comprised of an ALJ, staff attorney, paralegal, and hearing clerk. Actual appeal adjudications in FY 2011 were approximately 234,000; projected adjudications for FY 2012 were 314,000 and 368,000 for FY 2013. The average number of claims to be handled per ALJ team in FY 2011 was 3,896, up from 2,789 in FY 2010.

### The OIG Report

OIG's report represents an analysis of all ALJ appeals decided in FY 2010. Its review of data and statistics was supplemented with interviews of ALJs and OMHA staff, QICs, and CMS staff, as well as a review of CMS policies, procedures, and other documentation. A summary of OIG's most significant findings follows.

### Changes to the ALJ Appeals Process Since 2005

The OIG report summarizes some significant changes to the Medicare ALJ appeals process since the creation of OMHA.

- Prior to 2005 (when OMHA opened its doors), ALJs were bound by Medicare laws, regulations, and national coverage determinations, but were not bound by local coverage determinations (LCDs) or Medicare guidance (e.g., Medicare manuals). After 2005, a new regulation required that ALJs give “substantial deference” to LCDs and CMS program guidance, and the ALJ's decision must explain the reasons why the policy is not followed in a particular case.<sup>9</sup>
- Prior to 2005, appellants could submit new evidence to the ALJ without significant restriction. Since 2005, by regulation an appellant must provide “good cause” for the submission of new evidence at the ALJ level.<sup>10</sup>
- Since 2005, CMS or its contractors have been allowed to participate in ALJ appeals as a participant or as a party, at its choice. As a participant, CMS or the contractor can submit position papers and provide testimony, but cannot call witnesses or cross-

examine the witnesses of a party to the hearing.<sup>11</sup> When CMS or its contractor participates in an ALJ hearing, the agency or its contractor may not be called as a witness during the hearing. As a party to a hearing, CMS or the contractor may file position papers, provide testimony to clarify factual or policy issues, call witnesses, or cross-examine the witnesses of other parties. CMS or its contractor(s), when acting as parties, may also submit additional evidence to the ALJ within the time frame designated by the ALJ.<sup>12</sup> CMS is not allowed to enter an appeal as a party if the beneficiary is unrepresented.

## OIG's Findings Regarding 2010 Appeals

OIG's analysis provides significant insight into OMHA operations and suggests certain appeal strategies. During FY 2010, 40,682 appeals were decided, and it was this universe that OIG reviewed. The most significant findings are summarized below.

- **Who Are the Appellants?** Providers filed 85% of 2010 appeals, while beneficiaries filed 11%, and state Medicaid agencies filed 3%. OIG found that providers filed the vast majority of ALJ appeals, with a small number of providers accounting for nearly one-third of all appeals.
- **Reversal Rates.** Based on all 2010 appeals, the ALJs fully reversed QIC decisions in 56% of cases decided, and partially reversed an additional 6%. An additional 14% were dismissed, remanded, or escalated. Only 24% of the decisions were fully unfavorable to the appellant. Reversal rates were highest for Part A hospital appeals (72%), and lowest for Parts C and D appeals (18% and 19%, respectively). Other Part A providers were at 62% fully favorable decisions for home health/hospice appeals and 51% for skilled nursing facility appeals. For Part B, the overall reversal rate was 59%, led by transportation appeals at 67%, diagnostic testing at 63%, and practitioner services at 48%. Appeals of claims relating to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) were reversed at a 53% rate.
- **Variation in Policy Interpretations.** There were significant differences in the ways that the QIC and the ALJ interpreted Medicare policies, with ALJs perceived as being less strict in their interpretations. ALJ staff indicated that ALJs often decided in favor of appellants when "the intent, but not the letter," of a Medicare policy was met.<sup>13</sup> In contrast, the QICs said they tried to follow Medicare policy strictly, with one QIC indicating that it expects to uphold prior-level determinations unless there is "compelling" evidence to reverse.<sup>14</sup> One example of the different approaches by the QIC and the ALJ related to a denial of home health services by the QIC based on lack of homebound status, while the ALJ found the services to be covered as medically necessary and reasonable without the limiting focus on the homebound requirement. A second example related to application of an LCD, where the QIC denied the claim when only nine out of ten criteria were met, but the ALJ allowed the claim because of a finding that the beneficiary met the broader intent of the policy. Variations in decisions were also noted for unclear Medicare policies, for example, those with vague definitions of the qualifying criteria.
- **Subject Matter Specialization.** ALJs and their staff suggested that specialization in a particular Medicare program area could make their process more efficient rather than the random assignment process currently utilized.
- **Medical Experts.** In contrast to the QICs, ALJs do not have staff members who serve as medical directors and clinicians. ALJ staff said that as a result, ALJs tend to rely on testimony and other evidence from treating physicians, and give deference to the treating physician's opinions.
- **Variation in ALJ Philosophy Results in Variation in Results.** Amongst ALJs, reversal rates varied between 18% and 85%. OIG concluded that this variance seemed to reflect a variation in ALJ philosophies as opposed to any difference in case mix. Also varying was the rate of on-the-record decisions, ranging from 1% to 65% for different ALJs.
- **CMS Participation Impacts Results.** CMS participated in 10% of total 2010 decided appeals (CMS does not participate in Part C or D appeals). This included 18% of DMEPOS appeals, 9% of Part A appeals, and 5% of Part B appeals. In 61% of the appeals in which CMS participated, it provided testimony; in the remaining 39% it submitted position papers. CMS rarely appeared as a party, appearing instead as a participant, but staff indicated that CMS had plans to appear more often as a party in the future. When CMS participated in the appeals, ALJ decisions were less likely to be favorable to the appellants (44% of appeals were in favor of appellants versus 60% when CMS did not participate), with the greatest difference being in DMEPOS appeals (30% versus 58% in favor of appellant when CMS did not participate).
- **Admission of New Evidence by ALJs and other Case Administration Issues.** As noted above, new evidence is only supposed to be accepted at the ALJ level upon a showing of good cause. Notwithstanding that regulatory limitation, most ALJ staff interviewed by OIG indicated that the ALJs typically accepted new evidence when submitted. In addition, file discrepancies (organizational structure and electronic versus paper files) between the QIC and the ALJ levels resulted in inefficiencies in process.
- **Suspicious of Fraud.** Nearly all ALJ staff reported having suspected appellants of Medicare fraud. OMHA has no written policies as to how such suspicions should be addressed. Staff noted that ALJs were inconsistent in how they handled these cases, ranging from reports to supervisors or law enforcement to no reports at all. ALJs also differed in their decisions relating to appeals where fraud was suspected, with some ALJs finding the evidence lacked credibility but others presuming that the evidence submitted was reliable without looking behind it. A concern was raised by CMS about cases which were both pending review on appeal and under investigation for fraud, indicating a fear that the appeals system might be manipulated to influence the fraud investigation.

## OIG's Recommendations

OIG concluded that its findings highlighted inconsistencies and inefficiencies in the Medicare appeals process that must be addressed by OMHA and CMS. It proposed ten recommendations for actions to be taken by OMHA and/or CMS:

1. OMHA and CMS should develop and provide coordinated training on Medicare policies to ALJs and QICs. In response to the OIG report, CMS indicated that ALJ training has already started on a wide range of Medicare policies and emerging issues. CMS has also invited OMHA to participate in its annual conference for contractor medical directors.
2. OMHA and CMS should identify and clarify Medicare policies that are unclear and interpreted differently. In response to this OIG recommendation, CMS noted the value of tracking appeals to identify which Medicare policies are most often at issue and, if necessary and appropriate, to clarify a particular policy.
3. OMHA and CMS should standardize case files and make them electronic. OMHA reported that it is working with CMS to develop a memorandum of understanding regarding standardizing case files and to determine whether current information systems can accommodate an electronic file.
4. CMS should revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence. In response to this recommendation, OMHA promised to review the existing regulations regarding new evidence and develop guidelines and training; CMS added that it would explore options for providing additional guidance on this issue.
5. CMS and OMHA should improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary. On this issue, OMHA and CMS did not concur that ALJ decisions should be postponed, but agreed to discuss how best to approach these types of cases. OIG responded to that position by clarifying its view that postponement should only be considered after weighing all concerns, and that agencies should make decisions to postpone appeals only after receiving a request from law enforcement. In OIG's opinion, postponement decisions should not be made by ALJs or others who are directly responsible for deciding appeals.
6. OMHA should seek statutory authority to establish a filing fee (to address those appellants who file appeals frequently and not apply to beneficiary-filed appeals). OMHA indicated it would consider whether such an authority is appropriate and, if so, seek authority to assess one.
7. OMHA should implement a quality assurance process to review ALJ decisions (to address the discrepancies in reversal rates and policy interpretations). OMHA indicated it has already started such a program based upon peer review of ALJ decisions.
8. OMHA should determine whether specialization among ALJs would improve consistency and efficiency. OMHA said it is not convinced this would improve case-processing, but will conduct further evaluation.
9. OMHA should develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly. OMHA responded that it has conducted such training and continues to develop policies with respect to handling suspicions of fraud.
10. CMS should continue to increase CMS participation in ALJ appeals. CMS indicated that it plans to increase participa-

tion in the appeals by the agency's contractors, and will also enhance participation guidelines for contractors and monitor the results of participation.

## Conclusions

As OMHA approaches its eighth year of operation, it faces a burgeoning workload and a need to process cases in a more efficient manner. Based upon responses to the OIG reports, it appears certain that represented appellants will face more participation by CMS in ALJ hearings, making those hearings more adversarial in nature and with a likely decline in reversal rates (based on OIG's 2010 findings). Appellants likely will face stricter adherence by the ALJs to the regulation that limits the introduction of new evidence to those situations where good cause for the delay can be established. With more training and guidance from CMS and OMHA on Medicare's interpretations of its policies, ALJs may become more consistent in their decisions and perhaps less sympathetic to appellants who meet the spirit but not the letter of those policies. In short, appellants will face a tougher road at OMHA just as more appeals are filed as a result of the full implementation of the RAC initiatives.

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- 1 Pub.L. 108-173, § 931.
  - 2 U.S. Department of Health & Human Services (HHS), FY 2013 Budget in Brief, available at [www.hhs.gov/budget/budget-brief-fy2013.pdf](http://www.hhs.gov/budget/budget-brief-fy2013.pdf). OMHA is funded entirely from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds.
  - 3 HHS, FY 2013, Justification of Estimates for Appropriations Committees, at 14. Available at [www.hhs.gov/budget/hhs-general-budget-justification-fy2013.pdf](http://www.hhs.gov/budget/hhs-general-budget-justification-fy2013.pdf). OMHA has a 90-day deadline for adjudicating certain types of cases, as required by Section 521 of the Benefits Improvement Protection Act (BIPA) Pub. L. No. 106-554. See Section 1869(d) of the Social Security Act.
  - 4 HHS, FY 2013, Justification of Estimates for Appropriations Committees.
  - 5 HHS Office of Inspector General, "Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals," OEI-02-12-00340 (Nov. 2012).
  - 6 Available at [www.hhs.gov/omha/about/index.html](http://www.hhs.gov/omha/about/index.html) (last accessed Dec. 16, 2012).
  - 7 OMHA does not handle Medicare provider/supplier enrollment appeals, which are handled by the Departmental Appeals Board and subject to different procedures.
  - 8 Available at [www.hhs.gov/budget/budget-brief-fy2013.pdf](http://www.hhs.gov/budget/budget-brief-fy2013.pdf), p. 105.
  - 9 Section 405.1062 provides as follows:  
*Applicability of local coverage determinations and other policies not binding on the ALJ and MAC [Medicare Appeals Council].*  
 (a) ALJs and the MAC are not bound by LCDs, LMRPs, or CMS program guidance, such as program memoranda and manual instructions, but will give substantial deference to these policies if they are applicable to a particular case.  
 (b) If an ALJ or MAC declines to follow a policy in a particular case, the ALJ or MAC decision must explain the reasons why the policy was not followed. An ALJ or MAC decision to disregard such policy applies only to the specific claim being considered and does not have precedential effect.  
 (c) An ALJ or MAC may not set aside or review the validity of an LMRP or LCD for purposes of a claim appeal. An ALJ or the DAB may review or set aside an LCD (or any part of an LMRP that constitutes an LCD) in accordance with part 426 of this title.
  - 10 42 C.F.R. §§ 405.1018(c) and 405.1028. Note that the limitation does not apply to unrepresented beneficiaries, and does not include testimony provided at the administrative hearing.
  - 11 42 C.F.R. § 405.1010.
  - 12 42 C.F.R. § 405.1012.
  - 13 OIG, *supra* note 5 at 11.
  - 14 *Id.*

# Medicaid Enrollment Update

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This piece is part of a series that will appear in the *RAP Sheet* over its next several issues that summarizes hot topics in Medicaid enrollment on a state-by-state basis. In this issue, we bring you California, Florida, North Carolina, Virginia, and West Virginia.

Largely speaking, the states are in various stages of implementing federal healthcare reform requirements for provider enrollment that were enacted as part of the Patient Protection and Affordable Care Act of 2010 (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) issued implementing regulations that began to apply to Medicaid enrollment effective March 25, 2011.<sup>2</sup> These federal requirements expanded the provider types subject to federally required enrollment onsite agency reviews, required the payment of Medicaid enrollment fees, and provided new mechanisms for the establishment of Medicaid enrollment moratoria.<sup>3</sup> In addition, the federal rules introduced fingerprinting to the Medicaid enrollment process.<sup>4</sup> The states we are featuring are in various stages of implementation of PPACA's Medicaid enrollment requirements. In addition, state Medicaid programs are also now required to suspend Medicaid payments if the state agency receives a "credible allegation of fraud"<sup>5</sup> while the investigation is pending.

## California

California recently passed legislation authorizing its Department of Health Care Services (DHCS) to implement the vast majority of PPACA requirements on January 1, 2013.<sup>6</sup> Providers should have expected additional guidance from DHCS about implementation, including Provider Regulatory Bulletins and new enrollment forms, prior to this date.<sup>7</sup>

## Enrollment Screening Levels

DHCS will, consistent with federal law, implement the Medicaid program's requirement to classify providers engaged in enrollment matters as "limited," "moderate," and "high" categorical risks, with varying levels of enrollment scrutiny to be afforded to



each provider category.<sup>8</sup> The categorical screening levels assigned by Medicaid will, at a minimum, mirror the screening levels used for Medicare provider enrollment.<sup>9</sup>

California will expand its use of pre-enrollment and post-enrollment site visits to apply to all moderate- and high-risk providers,<sup>10</sup> and collect fingerprints and conduct criminal background checks on 5% direct and indirect owners of high-risk providers.<sup>11</sup> DHCS indicated that fingerprinting would not be implemented on January 1, 2013, until DHCS received additional implementing instructions from CMS. DHCS' Audits and Investigations Division will undertake the site visits.<sup>12</sup>

Beginning in 2013, DHCS will increase a provider's categorical risk level for enrollment purposes from limited or moderate to high if any of the following occur: Medicaid payments have been suspended based on a "credible allegation of fraud, waste or abuse"; the provider has an existing Medicaid overpayment; the provider has been excluded by the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) or another state's Medicaid program within the previous ten years; or the provider is applying as a provider that would have been subject to a Medicaid enrollment moratorium within the last six months.<sup>13</sup>

## Requirements for Enrollment of Ordering and Referring Physicians

All ordering and referring physicians and other professionals providing services under the Medi-Cal program will need to become enrolled as participating providers and, thus, be subject to the scrutiny of the Medicaid enrollment process.<sup>14</sup> According to DHCS, final forms to so enroll providers were published January 1, 2013, although drafts were distributed in advance at public meetings; thus, Medi-Cal payment edits to preclude payments for services ordered or referred by physicians who are not enrolled in the Medicaid program will not implement right away. DHCS has not, at the time of submission of this article, published a date at which time these edits will apply.

## Revalidation

In addition, Medicaid programs are currently required to screen all providers at least every five years.<sup>15</sup> DHCS will be able to use CMS Medicare enrollment revalidation data to fulfill these obligations when it is available.<sup>16</sup> For those providers that do not have such information on file, DHCS is developing a short-form application for this purpose.

## Enrollment Application Fees

DHCS began collecting Medi-Cal enrollment application fees from healthcare providers seeking to enroll (except for physicians, other individual practitioners, providers enrolled in the Medicare program or another state's Medicaid programs, or providers that have paid the applicable application fee to a Medicare contractor or another state Medicaid program) commencing January 1, 2013.<sup>17</sup>

## Enrollment Moratoria

California has a longstanding tradition of implementing moratoria on the enrollment of new providers into the Medi-Cal system—it has had in effect for some time moratoria on enrollment for clinical laboratories, adult day healthcare centers, durable medical equipment providers, and certain pharmacies.<sup>18</sup> California will, effective in 2013, additionally implement enrollment moratoria for providers that HHS identifies as risky to the Medicaid program; DHCS will implement these requests unless DHCS identifies that the moratoria will adversely impact Medi-Cal beneficiary access to care.<sup>19</sup>

## Payment Suspension Based Upon Credible Allegation of Fraud

Effective January 1, 2013, DHCS began suspending Medi-Cal payments to providers if DHCS received a “credible allegation of fraud” while the investigation is pending.<sup>20</sup> DHCS is required to notify the provider of the payment suspension between five and 90 days after the payment suspension begins.<sup>21</sup>



## Florida

Like many states, Florida has implemented new Medicaid provider enrollment rules in light of the PPACA requirements. In April 2012, the Florida Agency for Health Care Administration (AHCA) amended its Medicaid provider agreements to incorporate many of the Medicaid changes required under PPACA. Under the new provider agreements, institutional providers must undergo re-enrollment every three years and non-institutional providers now must undergo re-enrollment every five years (previously, it was every 10 years).<sup>22</sup> Re-enrollment packets are automatically mailed approximately 90 days prior to the expiration date of the Medicaid provider agreement.

The Florida Medicaid provider agreement requires the enrolling provider to attest that all statements and information furnished by the prospective provider are true and complete. Filing a materially incomplete, misleading, or false application renders the enrollment application and provider agreement voidable at the option of

AHCA and is cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.<sup>23</sup> On its face, the provider agreement does not mandate automatic termination for failure to meet this requirement.

Florida now requires criminal history background screening for enrolling and re-enrolling Medicaid providers which involves a fingerprint check of state and federal criminal history information conducted through the Florida Department of Law Enforcement and the Federal Bureau of Investigation. The following individuals must submit to a criminal history check unless otherwise exempt: (1) all partners or shareholders with an ownership interest of 5% or more; (2) all officers; (3) all members of the board of directors; (4) the financial records custodian; (5) the medical records custodian; (6) all billing agents who are employees of the provider; (7) all managing employees or affiliated persons, including pharmacy managers; and (8) all individuals authorized to sign on the account used for electronic funds transfer. These rules became effective in August 2011.<sup>24</sup>

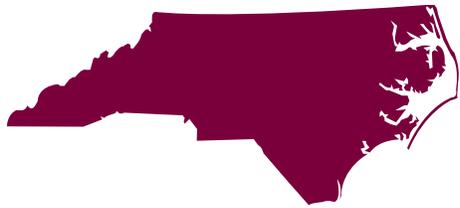
AHCA is required to deny an application for Medicaid enrollment or re-enrollment if one of the individuals has a criminal history of a disqualifying offense.<sup>25</sup> The statute does offer an exemption process, but providers with a problematic criminal history should be proactive and seek an exemption prior to enrollment or re-enrollment.

Medicaid providers must notify AHCA within five business days after a Medicare suspension or disenrollment, and failure to do so may result in sanctions,<sup>26</sup> and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider. If a provider has been suspended or terminated from participation in the Medicaid program or the Medicare program, Florida statutes require AHCA to “immediately suspend or terminate, as appropriate, the provider’s participation in this state’s Medicaid program for a period no less than that imposed by the federal government or any other state, and may not enroll such provider in this state’s Medicaid program while such foreign suspension or termination remains in effect.”<sup>27</sup> Florida law requires AHCA to immediately suspend or terminate, as appropriate, a provider’s participation in Florida Medicaid if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5% or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program.

The Florida Medicaid provider agreement requires the enrolling provider allow the government to access “all Medicaid-related information . . . and other information pertaining to services or goods billed to the Medicaid program.”<sup>28</sup> The provider agreement does not mandate automatic termination for failure to meet this requirement.

## North Carolina

There are many recent developments in the North Carolina Medicaid program (NC DMA). The two biggest are: (1) the incongruence of the current Medicaid enrollment applications



with state Medicaid policy as it relates to changes of ownership (CHOWs) and as it relates to the completion of the “Exclusion/Sanction Information” section; and (2) implementation of new processes mandated under PPACA.

**CHOWs**

There are inconsistent definitions of what constitutes a CHOW under various North Carolina policy pronouncements. Basic Medicaid and N.C. Health Choice Billing Guide<sup>29</sup> and instructions to In State/Border Organization Provider Enrollment Application<sup>30</sup> (Documents) are out of synch with NC DMA policy as to which transactions constitute CHOWs. Specifically, the current Documents define CHOWs to include, among other things, stock purchases. However, Session Law 2011-399/Senate Bill 496, which added Chapter 108C to the North Carolina General Statutes, specifically excludes such stock transfers from the definition of CHOWs.<sup>31</sup> Following recent conversations with the NC DMA Recipient and Provider Services Department regarding a specific stock purchase transaction, it was confirmed that in fact, NC DMA does not consider these changes to constitute CHOWs.

Instead, similar to the Medicare program, NC DMA considers such changes to be changes of information that are reportable as simple file updates.<sup>32</sup>

Rather than require the new shareholders in a stock purchase transaction to submit a new enrollment application, and the previous shareholders to submit a Medicaid Provider Change Form terminating participation due to a CHOW, all that was required at least in one recent instance was to provide NC DMA with a detailed letter describing the relevant changes and providing copies of the relevant pages from the NC DMA provider enrollment application depicting such changes. These documents would then be maintained in the provider’s file.

While NC DMA did indicate that both Documents will undergo revision, no indication as to when to anticipate such changes was provided. More importantly, because the current Documents reflect an entirely different process, anyone undergoing a CHOW for a Medicaid provider in North Carolina should discuss the transaction with Provider and Enrollment Services well in advance in order to receive the most up-to-date process and requirements.

**Exclusion/Sanction Information**

As with CHOWs, the questions currently posed in the Exclusion/Sanction section of the In State/Border Organization Provider Enrollment Application<sup>33</sup> are out of synch with current NC DMA policy. Notably, the current questions embodied in the Exclusion/Sanction Information section exceed what is needed by NC DMA.

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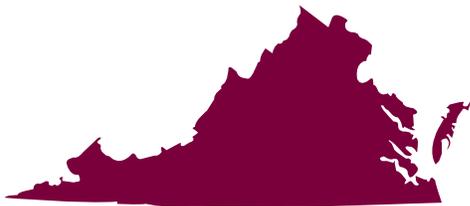


As it stands today, the Exclusion/Sanction Information section of the provider enrollment application asks questions relating not only to the applicant, but also to the applicant's agents, owners, managing employees, etc. However, unlike the Medicare program, NC DMA's questions go a step further and also inquire as to any entity such individuals are or were either an agent, owner, or managing employee of, back to the beginning of time. Responding to questions such as these can be extremely difficult when the applicant is owned and operated by a provider with nationwide or even multi-state operations and with owners, agents, and managing employees with ties to such providers.

Following conversations with the NC DMA Provider and Recipient Services Department we were recently informed that NC DMA does not expect multi-state or national providers and their owners, agents, managing employees, etc., to respond to these questions beyond North Carolina. Instead, they indicate that a global statement with regards to their knowledge of matters with former entities, but then respond in depth, to the extent necessary, with regards to the providers' operations in North Carolina. Unfortunately, as with the current policies regarding CHOWs, the policy with regards to the Exclusion/Sanction Information questions is not yet reflected in the Documents and no indication was provided as to when to anticipate such changes.

## PPACA Mandates

With regards to PPACA mandates, the NC DMA program has begun instituting a wide variety of new measures. Just to name a few, NC DMA has instituted a three-year provider re-credentialing validation program that is currently underway.<sup>34</sup> Similar to the Medicare revalidation program, failing to timely respond to requests for re-credentialing can result in termination of enrollment.<sup>35</sup> In another instance, NC DMA is requiring enrolling providers to undergo screenings and attend trainings for things such as: common billing errors and how to avoid them; audit procedures; how to identify beneficiary fraud; how to report suspected fraud or abuse; and beneficiary due process and appeal rights.<sup>36</sup> Lastly, NC DMA has instituted an enrollment fee for initial enrollments and re-credentialing.<sup>37</sup>



## Virginia

The Virginia Department of Medical Assistance Services (DMAS) has not formally announced changes to its Medicaid provider enrollment and screening requirements. Nevertheless, DMAS recently sought input from a small group of affected parties, asking whether mandatory web-based electronic submission of provider enrollment applications, and other enrollment-related documents, would be appropriate and supported by Virginia Medicaid

providers. In response, one affected party discouraged DMAS from making web-based enrollment mandatory. Though many providers are embracing optional web-based Medicare enrollment through the Provider Enrollment, Chain, and Ownership System (PECOS), the alternative paper application reduces provider anxiety with the new system and accommodates the few providers who do not have the technology or know-how to submit electronic applications. Providers have expressed that a similar arrangement would be ideal for Virginia Medicaid enrollment.

Also, a 2012 Virginia budget amendment<sup>38</sup> indicates that “[i]t is the intent of the General Assembly that [DMAS] exercise the full extent of federal flexibility in excluding and removing providers as needed to ensure Medicaid program integrity in compliance with federal and state statutes.” The amendment also required DMAS to develop a plan to implement programmatic changes that comply with the heightened federal screening requirements, and to report on the plan to the House Appropriations and Senate Finance Committees by December 1, 2012.

More details about Virginia Medicaid provider enrollment should be issued soon.



## West Virginia

West Virginia has made significant strides toward updating its Medicaid provider enrollment procedures and screening requirements. Molina Medicaid Solutions (Molina) and the West Virginia Bureau for Medical Services (BMS) offered a provider workshop in March of 2012 to announce upcoming changes,<sup>39</sup> and BMS recently placed a draft of its Provider Participation Requirements manual online for comment.<sup>40</sup> The following topics outline the announced changes:

### Reenrollment Under PPACA

Molina is finalizing its web-based Provider Enrollment Application (PEA) that will accommodate newly enrolling and re-enrolling providers. PEA is currently undergoing testing and was slated to be available in 2012.

BMS also confirmed that it currently has access to PECOS, the web-based Medicare enrollment system. With this access, BMS will determine which providers and suppliers have paid the Medicare enrollment application fee and will waive the Medicaid screening fee for providers whose payment has been confirmed. BMS has, and will continue to have “read-only” access to PECOS.

This means BMS may only view the information available on PECOS. It may not edit the information.

## Reenrollment Timeline

To initiate re-enrollment for an *existing* provider, BMS will mail the provider a general notice 60 days prior to its re-enrollment start date. Within those 60 days, BMS will mail the provider another letter that will contain a unique reenrollment access code for the new PEA. The provider will then have 30 days from the scheduled re-enrollment start date to complete the re-enrollment. Providers who fail to timely submit their re-enrollment application may be placed on pay hold by BMS.

To initiate enrollment for a *new* provider, the provider will be required to contact Molina for a PEA access code.

## Risk Levels

Re-enrollment will be phased-in by provider type and risk level based on the federal determinations (e.g., home health and DMEPOS are considered high-risk provider types). A schedule of provider types with risk levels and re-enrollment dates will be placed on the Molina web portal and banner pages when it is finalized.

## Screening Requirements

Screening of high-risk level provider types will include criminal background checks and fingerprinting of each person with an ownership or control interest or who is an agent or managing employee of the provider.

Screening of high-risk and moderate-risk providers will require unannounced pre- and post-enrollment site visits. BMS is currently working on the site visit survey form, which providers may request once it is completed.

For all providers, BMS will conduct regular checks of federal and state databases to confirm the identity and determine the exclusion status of providers and any person with an ownership or controlling interest. Molina has updated its web portal to include links to the West Virginia list of excluded providers and OIG's List of Excluded Individuals and Entities.<sup>41</sup>

Also, it is important to recognize that the above screening requirements are the minimum required by federal law. It is possible that BMS will choose to subject all provider types to site visits and/or other screening procedures.

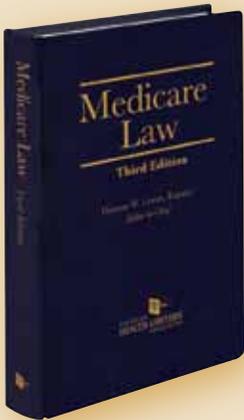
The PEA system was expected to be available before the end of 2012, along with an updated Medicaid manual for Provider Participation Requirements.

*\*If you practice in the Medicaid enrollment area and your state is not represented in this article, please share any interest you may have in contributing to a future piece by emailing Accreditation, Certification, and Enrollment Affinity Group Chair Jeanne Vance at [jvance@salemgreen.com](mailto:jvance@salemgreen.com).*

- 1 Pub. L. No. 111-148 (2010); Pub. L. No. 111-152 (2010).
- 2 76 Fed. Reg. 5862 (Feb. 2, 2011).
- 3 *Id.*
- 4 42 C.F.R. § 455.434.
- 5 42 C.F.R. § 455.23.
- 6 S.B. 1529, ch. 795 (approved by the Governor Sept. 29, 2012; filed with the Secretary of State Sept. 29, 2012); also, Tanya Homman, Chief, Provider Enrollment Division, Comments to author Sept. 14, 2012 (hereinafter *Homman Comment*).
- 7 DHCS confirms that enrollment applications that are pending will continue to be processed on the pre-January 1 forms so long as they are received by DHCS during 2012. Providers applying in 2013 will need to do so on the new forms. *Homman Comment*.
- 8 42 C.F.R. § 455.518; Cal. Welf. & Inst. Code § 14043.38 (forthcoming Jan. 1, 2013).
- 9 *Id.*
- 10 Cal. Welf. & Inst. Code § 14043.38(b) (forthcoming Jan. 1, 2013).
- 11 *Id.*
- 12 *Homman Comment*.
- 13 Cal. Welf. & Inst. Code § 14043.38 (forthcoming Jan. 1, 2013).
- 14 42 C.F.R. § 455.410; Cal. Welf. & Inst. Code § 14043.1(b) (forthcoming Jan. 1, 2013).
- 15 42 C.F.R. § 455.414 (forthcoming Jan. 1, 2013).
- 16 *Homman Comment*.
- 17 Cal. Welf. & Inst. Code § 14043.55(d) (forthcoming Jan. 1, 2013).
- 18 See [http://files.medi-cal.ca.gov/pubsdoco/prov\\_enroll.asp#Forms](http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp#Forms).
- 19 Cal. Welf. & Inst. Code § 14043.55 (forthcoming Jan. 1, 2013).
- 20 Cal. Welf. & Inst. Code § 14107.11(a) (forthcoming Jan. 1, 2013).
- 21 *Id.*
- 22 See Florida Medicaid Provider Agreement § 4.
- 23 See Florida Medicaid Provider Agreement § 5(o).
- 24 See Fla. Stat. § 409.907(8)(a).
- 25 See Fla. Stat. Chapter 435.
- 26 See Florida Medicaid Provider Agreement § 5(q); Fla. Stat. § 409.908(24).
- 27 Fla. Stat. § 409.913(14).
- 28 See Florida Medicaid Provider Agreement § 5(e).
- 29 See Basic Medicaid and N.C. Health Choice Billing Guide, § 4
- 30 See In State/Border Organization Provider Enrollment Application, available at [www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications](http://www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications).
- 31 See North Carolina Session Law 2011-399/Senate Bill 496, adding N.C. Gen. Stat. § 108C-10(a) (providing in relevant part, “. . . Transfer of corporate stock . . . shall not constitute change of ownership.”).
- 32 By way of contrast, it should be noted, that in the case of LLCs, the withdrawal or removal of a member or acquisition of a membership interest will constitute a CHOW. See North Carolina Session Law 2011-399/Senate Bill 496, adding N.C. Gen. Stat. § 108C-10(a) (providing in relevant part, “In the case of a Limited Liability Company (LLC), the withdrawal or removal of a member, or when a person acquires a membership interest from the LLC . . .”).
- 33 See In State/Border Organization Provider Enrollment Application, available at: [www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications](http://www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications).
- 34 See Basic Medicaid and N.C. Health Choice Billing Guide, § 4; see also, Medicaid Bulletin, December 2011.
- 35 See *Id.*
- 36 See *Id.*; see also, North Carolina Session Law 2011-399/Senate Bill 496, adding N.C. Gen. Stat. §§ 108C-3, 108C-9(d).
- 37 See North Carolina Session Law 2009-451, § 10.58A; see also, Medicaid Bulletin, December 2011; see also, [www.ncdhhs.gov/dma/provenroll/index.htm](http://www.ncdhhs.gov/dma/provenroll/index.htm).
- 38 Budget amendment 310 #1h is available at <http://leg2.state.va.us/WebData/12/amend30.nsf/0/b61f461cde8d74e3852579ab0057ff56?OpenDocument&Click=>.
- 39 Materials from the workshop are available at [www.dhhr.wv.gov/bms/news/Pages/pw.aspx](http://www.dhhr.wv.gov/bms/news/Pages/pw.aspx) (log-in information required).
- 40 Only certain sections of the manual are open for comment, and the comment period closed on October 26, 2012. The Provider Participation Requirements Manual Section 300 is available at [www.dhhr.wv.gov/bms/news/Documents/Chap300ProvPartReq30day.pdf](http://www.dhhr.wv.gov/bms/news/Documents/Chap300ProvPartReq30day.pdf).
- 41 The list of excluded providers is available at [www.wvmmis.com/provider\\_enrollment.screen](http://www.wvmmis.com/provider_enrollment.screen).

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