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HIGHLIGHTS OF THE DEFICIT REDUCTION ACT OF 2005

Signed into law on February 8, 2006, the Deficit Reduction Act of 2005 (the "DRA") is designed to significantly reduce Medicare and Medicaid spending in the coming years. As set forth below, the new law makes important changes, among others, to reimbursement rates for out-of-network emergency services paid by Medicaid managed care payors and to caps on reimbursement for therapy services by Medicare, and also mandates that providers educate their employees about fraud and abuse.

MEDICAID DEFAULT RATES

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In a section of the DRA that appeared by stealth, the Conference Committee adopted a Medicaid fee-for-service (FFS) "default rate" provision for emergency services rendered to enrollees of non-contracted Medicaid managed care organizations (MCOs). Section 6085 of the DRA pertinently amends § 1932(b)(2) of the Social Security Act to state: "Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full the amounts (less any payments for indirect costs of medical education and direct costs of graduate education) that it could collect if the beneficiary received Medical Assistance under this Title other than through enrollment in such an entity."

Accordingly, hospitals that treat emergency patients enrolled in Medicaid MCOs with which they do not have a rate agreement will be required to accept as payment in full the Medicaid FFS that would apply if the

patient was enrolled in the regular Medicaid program, less any reimbursement for medical education expenses. It is widely estimated that Medicaid programs, including Pennsylvania's, pay only about 80% of the average costs of hospitals. As a consequence of this new law, hospitals effectively will be forced to subsidize Medicaid managed care plans, including for-profit entities, by providing emergency services to enrollees of those entities for less than actual costs. This federal law will override favorable state laws and state court decisions, such as the recent decision in HAP v. DPW, in which the Pennsylvania Supreme Court invalidated a provision of the Pennsylvania General Appropriations Act that required hospitals to accept Medicaid FFS rates from MCOs for noncontracted emergency services. (In striking that budgetary provision, the Pennsylvania Supreme Court recently stated that paying Medicaid FFS rates did not amount to covering the "reasonable costs" of emergency care as required by Pennsylvania's Act 68.) This provision also raises grave concerns from a policy standpoint, as it affords MCOs enormous leverage in negotiating contracts with hospitals. Thus, MCOs may be incented to contract only with lower cost or community hospitals, knowing that sophisticated emergency care can be obtained from academic medical centers on a noncontracted basis at "bargain rates."

These forced "discounts" to charges do not directly benefit the government (which pays MCOs on a capitated basis), but, rather, will go into the "pockets" of managed care companies, which will now be entitled by law to pay amounts that, especially for tertiary level or academic medical centers, are below the institutions' actual costs of providing services. As a result, this provision is suspect and may be susceptible to challenge under the Takings Clause of the U.S. Constitution. As the federal default rate provision does not take effect until January 1, 2007, this delay should afford representatives of the hospital sector an opportunity to seek its repeal, and make a case to Congress that this budgetary provision serves only to "rob Peter to pay Paul."

THERAPY CAPS

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The DRA should provide some relief to providers grappling with the newly implemented caps on Medicare therapy services. As background, the Balanced Budget Act of 1997 established annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. Subsequent legislation, however, imposed moratoria and suspended application of the payment limits (with the exception of 1999 and a brief period in 2003) through December 31, 2005.

Despite much controversy, Congress declined to extend the most recent moratorium. Thus, on January 1, 2006, Medicare therapy services became subject to two annual caps: (1) a combined $1,740 cap for outpatient physical therapy and speech language pathology and (2) a separate $1,740 cap for occupational therapy. The caps apply to outpatient Part B therapy services in all settings, except outpatient hospital and hospital emergency rooms.

Individuals and providers received some relief from the caps, however, with the passage of the DRA, which directed CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006.

On February 15, 2006, CMS released Transmittal 855 in the Medicare Claims Processing Manual, which describes the exceptions process. According to CMS, the process allows for two types of exceptions to caps for medically necessary services. First, an "automatic exception" will be allowed, without a written request, for a beneficiary with a certain medical condition or "clinically complex situation" who requires services in excess of the caps. While only certain conditions or diagnoses automatically qualify (see http://www.cms.hhs.gov/transmittals/downloads/R855CP.pdf), certain clinically complex situations can also justify an automatic exception for any condition that requires skilled therapy services. Both conditions or complexities, however, must have a "direct and significant impact on the need for the course of therapy being provided" to qualify the beneficiary for the exception. Further, as in all exceptions, the above-the-cap services must be documented, covered by Medicare, and medically necessary.

Second, a "manual exception" requires submission of a written request by the beneficiary or provider and medical review by the contractor responsible for processing the claims. This exception will apply to a patient who does not have a condition or complexity that allows automatic exception but nonetheless requires above-the-cap medically necessary services. The beneficiary or provider may fax a letter, with documentation that justifies the request, requesting up to fifteen (15) treatment days of service beyond the cap. The contractor has ten (10) business days to make a decision on the number of treatment days he/she determines are medically necessary. If the contractor fails to make a decision within that timeframe, the exception will be deemed granted.

In its February 15 transmittal, CMS stated that the exceptions process is effective retroactively to January 1, 2006. Thus, providers whose claims have already been denied due to the caps should contact their carrier to request a review of the claim to determine if the beneficiary would have qualified for an exception. Providers who have not yet submitted claims for services provided on or after January 1, 2006 that qualify for an exception should submit the claims for payment and refund to the beneficiary any excess private payment.

EMPLOYEE EDUCATION REQUIREMENTS

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The DRA is the first law to require that certain Medicaid providers implement important aspects of a compliance program. Specifically, through an addition to the mandatory components of a Medicaid State Plan, the DRA requires any entity that receives or makes annual Medicaid payments of $5 million or more to establish written policies that provide "detailed information" to its employees and contractors as to the role of the federal False Claims Act and similar State laws in preventing and detecting fraud and abuse in federal health care programs. The policies must also describe the whistleblower protections available under those laws, as well as how the entity itself undertakes such prevention and detection. Because the new law makes compliance a "condition of receiving" Medicaid payments, an entity that continues to seek Medicaid reimbursement without enacting the required policies could be liable for violating the False Claims Act. These employee education provisions generally take effect on January 1, 2007.

Best practices have long dictated that health care providers establish compliance programs that incorporate essential elements for an effective program derived by the Office of Inspector General from the federal Sentencing Guidelines for Organizations. These essential elements include, among others, implementing written policies and procedures, conducting effective training and education, and developing effective lines of communication. In response to the Sarbanes-Oxley Act, the Sentencing Commission strengthened its compliance program criteria in amendments to the Guidelines enacted in November 2004. The amendments, for example, made compliance and ethics training an explicit requirement that extended to high-level personnel within the organization, and also made clear that the training obligation was ongoing, requiring periodic updates. The DRA continues this trend toward promoting specific corporate compliance activities by mandating, for the first time, that as a condition of continuing to receive Medicaid payments, providers establish written policies and procedures, and educate their employees and agents as to relevant fraud and abuse laws, including how these laws protect them from retaliation if they report potential violations.

"LAWYERS IN THE SPOTLIGHT"

Mark Gallant will be presenting an "Annual Medicaid Litigation Update" at the American Health Lawyers Association's (AHLA's) Medicare and Medicaid Reimbursement Conference in Baltimore in March 2006. Mark will also be speaking on "Out of Network Services" at the Pennsylvania Bar Institute's Health Law Institute in Philadelphia on March 15.

John Washlick presented "Hot Topics in Physician Recruitment" as part of an AHLA teleconference on January 29, 2006 and the "Do's and Don'ts of Contractual Joint Ventures" at an AHLA conference in Ft.

Lauderdale, FL on February 9, 2006. John will also be making presentations on "Sarbanes-Oxley: Best Practices v. Practical Implementation" at a Healthcare Financial Management Association (HFMA) conference in Chattanooga, TN on February 22, 2006 and on "Physician Recruitment, Retention and Recruitment Incentives" as part of a joint AHLA/HFMA teleconference on April 11, 2006.

Kate Layman taught a 3 hour, 1 night course on "Accreditation and Regulation" in January/February of 2006 as part of a seminar on Hospital Law at Widener Law School.

Sal Rotella and **Kate Layman** conducted a training session for attorneys on Medicare Part D Compliance Issues at Cozen O'Connor on December 19, 2005.

Brad Rostolsky will be presenting "Electronic Medical Records" at the Lorman Seminar on Medical Records Law in Wilkes Barre, PA on February 28, 2006 and will be conducting a client seminar on HIPAA issues in New York City on March 23, 2006.

If you have questions about any of the topics discussed in this *E-lert* or any of the other numerous issues raised by the DRA, please contact any of the above authors or either of the following:

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