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Allina Health Services v. Sebelius: Implications for Providers' DSH Payments

By Tracy Jessner, Esq.

The federal District Court for the District of Columbia, in *Allina Health Services, et al. vs. Kathleen Sebelius*, No. 1:10-CV-1463 (D.D.C. Nov. 15, 2012), issued an opinion that, if upheld on appeal, will likely result in increased Medicare Disproportionate Share Hospital (DSH) reimbursement for many acute care hospitals.

The *Allina* case involves how Medicare Part C inpatient hospital days should be counted for DSH purposes. Hospitals that serve a disproportionate share of low-income patients receive additional fees based on a calculated DSH percentage. This percentage is the sum of two fractions, commonly called the Medicare/SSI fraction and the Medicaid fraction. The statute defines the Medicare/SSI percentage as the number of patient days for patients "entitled" to benefits under Part A as well as SSI benefits, divided by the total patient days for patients "entitled" to benefits under Part A. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Medicaid fraction is defined as the patient days for patients eligible for Medicaid but not "entitled" to benefits under Part A, divided by the total number of patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)

Medicare Part C, formerly known as the Medicare+Choice (M+C) program and currently known as the Medicare Advantage program, gives beneficiaries an alternative to the traditional Part A program, and allows them to enroll in a managed care plan. In order to enroll in Part C, a beneficiary must be "entitled to benefits under part A. . . and enrolled under part B." 42 U.S.C. § 13952-21(a)(3)(A). However, once enrolled in Part C, beneficiaries are no longer entitled to benefits under Part A. The Centers for Medicare and Medicaid Services (CMS) pays the plans directly for those beneficiaries, and the plan pays the providers.

When the Part C program was initially implemented, CMS routinely excluded Part C patient days from the Medicare/SSI fraction and included such days, if the beneficiaries were "dual eligible," in the numerator of Medicaid fraction. In 2003, CMS issued a Notice of Proposed Rule Making (NPRM), addressing the issue of whether Part C patient days belonged in the Medicare/SSI fraction. In the NPRM, CMS proposed to clarify that, once a beneficiary elects Part C, those patient days should not be included in the Medicare/SSI fraction and should be included, as applicable, in the Medicaid fraction. However, in 2004, CMS declined to adopt its previously proposed policy, and instead, adopted the contrary policy that Part C patient days would be included in the Medicare/SSI fraction and would not be included in the Medicaid fraction. Despite CMS stating that it would adopt this new policy, the applicable regulation was never amended until 2007, when CMS issued a "technical correction" to the regulation. CMS stated it had "inadvertently" forgotten to amend the regulation to conform to the 2004 policy change, and therefore waived notice and comment for the 2007 regulatory amendment, viewing the amendment as a technical correction for the oversight of not having done so in 2004.

CMS began applying the new DSH calculation retroactively. Northeast Hospital Corporation appealed the inclusion of Part C patient days in the Medicare/SSI fraction in prior fiscal years. The D.C. Court of Appeals, in *Northeast Hospital Corp. v.. Kathleen Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), held that CMS's interpretation was arguably permissible under Chevron analysis, which is a legal doctrine concerning the level of deference owed to administrative agencies, but the policy was impermissibly retroactive when

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applied to the provider's fiscal years 1999-2002.

In the meantime, a group of providers, including Allina Health Services, appealed the inclusion of Part C patient days in the Medicare/SSI fraction in later fiscal years. A year after the *Northeast* decision was issued, the D.C. District Court in *Allina* issued a ruling in favor of the providers that vacated CMS's 2004 policy and 2007 regulation amendments. The court determined that CMS violated the notice and comment provisions of the Administrative Procedure Act (APA) and the Medicare Act. The court noted that CMS may only publish a final rule that differs from a proposed rule if the final rule is a "logical outgrowth" of the proposed rule. Otherwise, CMS must treat the new provision as a proposed regulation, and allow the public the opportunity for notice and comment. Therefore, the court held that, because the 2004 policy was the polar opposite of the 2003 NPRM, the 2004 policy and 2007 regulation amendments were procedurally flawed. Additionally, the court found that CMS's explanation of the 2004 policy failed to provide a reasoned analysis for the change in policy, and accordingly held that CMS had acted arbitrarily and capriciously in violation of the APA. CMS subsequently filed an appeal to the D.C. Court of Appeals.

Despite the D.C. District Court's ruling, CMS has continued to include Part C days in the Medicare/SSI fraction. Although the *Allina* appeal is still pending, providers should file cost report appeals challenging the Medicare program's inclusion of the Part C days in providers' SSI fractions, as well as the exclusion of "dual eligible" Part C days in the Medicaid fraction. It should be noted that there is reason to believe that the Provider Reimbursement Review Board (PRRB) considers the Medicare/SSI fraction issue and the Medicaid fraction issue as two issues that each need to be appealed separately. If providers wish to pursue these appeals, they should file their appeals with the PRRB within 180 days of the dates of their NPRs in order to preserve their right to challenge the improper DSH calculations.

CMS has suggested that if the *Allina* appeals case ultimately is decided in favor of the providers, CMS will issue reopening notices to "correct" the DSH calculation. This suggestion has been included in reopening notices accompanying or following recent NPRs. However, the outcome of the case, the terms of any judicial orders, and the extent of the potential reopenings are all uncertain at this point. Given this uncertainty, providers that may be considering whether or not to pursue these appeals are cautioned against relying solely on potential reopenings, or otherwise waiting for the outcome of the Allina appeal, and should instead file their own appeals.

To further complicate matters, President Obama's budget proposal for fiscal year 2014, released April 10, 2013, included a proposal to "clarify" that Part C patient days be included in the calculation of the Medicare/SSI fraction of the DSH calculation. Although such a statutory amendment could moot providers' DSH Part C days related appeals, it is uncertain whether the proposal will be considered seriously by Congress, and if so, whether it would be enacted, and to what extent it would affect providers' previous DSH calculations and payments.

Hooper, Lundy & Bookman has begun filing independent group appeals and common interest related party (CIRP) group appeals with the PRRB for providers who have received their NPRs. Providers should evaluate whether the exclusion of Part C days in the Medicare/SSI fraction, as well as the inclusion of "dual eligible" Part C days in the Medicaid fraction, would positively impact their reimbursement. If so, providers are encouraged to contact HLB as soon as possible to discuss their appeal options.

For additional information, please contact Laurence Getzoff, John Hellow or Tracy Jessner in Los Angeles at 310-551-8111, Felicia Sze in San Francisco at 415-875-8500, or Robert Roth in Washington D.C. at 202-580-7700.

PRRB Revises Rules Effective March 1, 2013

By Nina Adatia, Esq.

The Provider Reimbursement Review Board (the Board or PRRB) has revised its rules, effective March 1, 2013. Many of the changes formally require providers to follow what were generally considered to be "best practices" under the previous version of the rules. Most notably, under this new version of the Rules, the Board requires providers to supply specific documentation when filing certain types of appeals to demonstrate that (a) the Board has jurisdiction over an appeal and (b) the appeal filing requirements established by the reg-

HLB Briefs

- HLB is pleased to announce that San Diego attorneys Kitty Juniper and Stephen Treadgold have been recognized by San Diego Magazine's *Best Lawyers in San Diego.*
- HLB is pleased to announce that an interview with Los Angeles attorney Linda Kollar was recently featured in the Los Angeles Times in an insert titled *Women Leaders in the Law.*

ulations have been met. The Board has also updated its Model Forms to incorporate the changes made to the Board Rules. The Board has confirmed that while use of the Model Forms is still not mandatory, a provider's submission must contain all of the information called for by the corresponding Model Form. The revised Rules and Model Forms are available in the Downloads section of the Centers for Medicare and Medicaid Services' PRRB webpage at: http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

Below is a summary of the significant changes, and, in italics, our commentary and specific guidance to assist providers in assuring they follow these revised rules.

Rule 3.3: The Board now requires that all correspondence sent to the Board also be sent to the opposing party (*i.e.*, the Intermediary/Medicare Appeals Contractor (MAC) and the appeals support contractor. *Generally, the specific contact information for both entities can be found in the cover letter to the provider's Notice of Program Reimbursement (NPR). The current appeals support contractor is Blue Cross Blue Shield Association.*

Rule 5.1: Rule 5.1 puts an affirmative obligation on the Provider Representative to ensure that its contact information that is on file with the Board is kept current. *The Board frequently issues correspondence, including appeal acknowledgment letters containing critical due dates and notices of hearing, by e-mail. Accordingly, maintaining a current e-mail address with the Board is imperative.*

Rule 5.4: The Board now explicitly requires that a provider's designation of representation letter reflect the particular fiscal year being appealed.

Rule 7.1: A provider appealing from an RNPR is now required to submit additional documentation to the Board with its initial appeal request. Specifically, a provider is required to include the RNPR, the NPR immediately preceding the RNPR, the reopening request that preceded the RNPR (if applicable), the Intermediary's reopening notice, the RNPR workpapers relating to the appealed issue(s), and any applicable cost report worksheets.

Rule 7.2: With regard to self-disallowed items, if the provider claims that the item being claimed was not claimed on the cost report because some legal authority predetermined that the item would not be allowed, the provider is required supply specific information to the Board with its initial appeal. Specifically, the provider is now required to include a concise issue statement of the self-disallowed item(s), the reimbursement or payment sought for the item(s), and the authority that predetermined that the claim would be disallowed. Further, the Board explicitly requires that effective for cost reporting periods ending on or after December 31, 2008, items not being claimed based on some legal authority must be adjusted through the protested cost report process, and the provider must follow the applicable procedures for filing a cost report under protest as described in the Provider Reimbursement Manual (CMS Pub. 15). As published, the Rule states that these procedures are outlined in CMS Pub. 15-1, Section 115. The Board has since clarified that the correct citation for this reference is CMS. Pub. 15-2, Chapter 1, Section 115.

Rule 7.4: The Board has also established additional requirements for providers appealing based on an Intermediary's failure to timely issue a final determination. Specifically, the provider must provide a copy of: (1) the certification page of the perfected or amended cost report; (2) the certified mail receipt evidencing the Intermediary's receipt of any as-filed or amended cost reports; (3) the Intermediary's acknowledgment of the as-filed and any amended cost reports; (4) evidence of the Intermediary's acceptance or rejection of the as-filed or amended cost reports; and (5) the documentation required by Rule 7.2 if the appeal involves a self-disallowed item.

Rule 11.1: A provider may add an issue to an existing individual appeal by filing a request with the Board no later than 60 days following the expiration of 180 days from the date of the NPR (i.e., within 240 days of the NPR date). When doing so, the provider must provide specific documentation with its add request, including a statement of the issue, and if being filed by someone other that the provider, a valid letter of representation (if not already on file with the Board).

Rule 16.1: A provider may join an existing group by transferring the relevant issue from an existing individual appeal to the group or by appealing directly from a final or revised determination into the group. Rule 16.1 now requires that specific supporting documentation must be submitted with such requests. When transferring an issue from an individual appeal to a group appeal, the provider must attach the following documents to its transfer request: (1) a copy of the relevant NPR or RNPR, (2) documentation showing that the issue is currently part of the appeal from which it is being transferred (i.e., the initial appeal request or the request to add the issue); and, (3)if the provider is appealing from an RNPR, the documents identified in Rule 7.1. When a provider is appealing an issue directly from a final determination into a group, the provider must attach a copy of the NPR or RNPR and, if the provider is appealing from an RNPR, the documents identified in Rule 7.1. *While the Board has always required that the issue being transferred properly reside in the appeal from which it was being transferred, the previous version of this Rule did not require the provider to provide evidence to demonstrate that fact.*

Rule 20.1: Within 60 days of full formation of a group, the Group Representative must prepare two schedules of providers and two sets of supporting jurisdictional documentation. One copy is to be sent to the Board, and the second copy is to be sent to the lead intermediary. An additional copy of the schedule or providers, without supporting jurisdictional documents, is to be sent to the appeals support contractor. Thus, the Group Representative is not only responsible for maintaining evidence of providers that join a group, but also for knowing when the group is complete, so that it can timely notify the Board and provide the required documentation to the lead intermediary and appeals support contractor.

Rule 21: With its revisions to this Rule, the Board has made significant changes to the information and supporting documentation to be submitted with the schedule of providers. With regard to the schedule itself, the Board now specifically requires that a provider appealing from an RNPR include an "R" after the "date of final determination" listed in the schedule. For the "date of hearing request" column, the provider is required to list the date the initial request was filed with the Board, and, if the issue under appeal was added subsequent to the initial request, to include the date that the request to add the issue was filed. The PRRB further clarifies that when the provider lists the "number of days" in the schedule of providers, it should calculate the number of days between the issuance of the final determination (not including the 5-day presumption for mailing time) and the date the hearing request was filed. Further, if the issue was added to the appeal on a later date, the provider should also include a second calculation for the number of days between the final determination (again, not including the 5 day presumption) and the date the add request was filed. For the "prior case number(s)" column, the Rule now requires that the provider identify each case in which the issue resided before it was added to the present case. The full history of transfers and any restructuring must be reflected in this column. If the provider was added directly to the group appeal, the provider should instead indicate "Direct Add" in this column. Finally, in the "dates of direct add/transfer" column, the provider must identify the date the issue was transferred from each case to the next, in chronological order. *In order to be jurisdictionally valid, the figure in the "number of days" column should be 185 or less (for the original appeal request) or 245 or less (for the add request). If the figure is between 181 and 185 (for the original appeal request) or between 241 and 245 (for the add request), the provider should include footnote and indicate that the Board will take into account the 5-day presumption.*

The Board also made changes to the requirements for the supporting documentation to be provided with the schedule of providers. Supporting documentation for the "final determination" column must include the dated cover page of the NPR (or RNPR, as applicable) or a copy of the other final determination from which the provider is appealing. When a provider is appealing the Intermediary's failure to timely issue an NPR, the provider must supply copies of all the documentation required by Rule 7.4 (i.e., the documentation filed with the initial appeal request). For the "date of hearing request" column, the provider must supply a copy of the relevant pages from the initial appeal request, as well as the request to add. For appeals filed after August 21, 2008, the provider must also supply a copy of the proof of delivery for both items. For the "audit adjustment number" column, providers must provide a copy of the matter being appealed (such as the audit adjustment report). If appealing from an RNPR, the provider must also provide copies of the documentation required under Rule 7.1. If appealing a self-disallowed item, the provider must submit a narrative describing the challenged authority and a copy of the cost report protested item page. If the cost reporting period ended on or after December 31, 2008, the provider must also submit evidence of protest. For the "dates of direct add/transfer" column, the provider must supply the letter(s) or form(s) documenting each transfer of the issue, in chronological order. If the cases were restructured, the provider must also include a copy of the Board's letter restructuring the case. Finally, the Board now requires that the provider's supporting documentation for the schedule of providers include a copy of a valid letter(s) of representation for the providers identified in the schedule.

Rule 24.3: If a case representative does not receive a hearing notice within 30 days of submission of a proposed joint scheduling order (JSO), the representative should contact the Board to ensure the JSO was received and processed.

Rule 27.6: Rule 27.6 explains that five additional copies of a final position paper should be received by the Board 7-10 business days prior to the hearing, and not at the time of filing of the final position paper. *Under the previous version of this Rule, the five additional copies were to be received by the Board 3-5 days prior to the hearing.*

For additional information, please contact Nina Adatia, Jordan Keville or John Hellow in Los Angeles at 310.551.8111; Robert Roth in Washington, D.C. at 202.550-7700; or Felicia Sze in San Francisco at 415.875.8500.

Medi-Cal, The Exchanges, and Bridge Plans

By Katrina Pagonis, Esq. & Felicia Sze, Esq

On March 7, 2013, California's Health Benefits Exchange (Covered California) announced that it will seek Federal approval for so-called Bridge Plans.1 "Bridge Plans" would create a "bridge" for individuals who transition between Medi-Cal and purchasing health insurance through Covered California. Under the proposal, Medi-Cal Managed Care Plans would be eligible to be certified as low-cost "Bridge" Plans offered through Covered California. Enrollment in bridge plans would be restricted to individuals that lose their Medi-Cal eligibility due to a moderate increase in income and the parents of children enrolled in the Healthy Family Programs. California State Senator Edward Hernandez, O.D., has already introduced Bridge Plan legislation, and, on March 6, 2013, he amended SBX1 3 to include proposed Bridge Plan amendments to California's Exchange laws.

Coverage for Individuals whose Income Fluctuates, Affecting their Medi-Cal Eligibility

The Bridge Plan proposal is intended to minimize the disruption and fragmentation of care that might otherwise occur when individuals transition from Medi-Cal to Exchange plans and when family members are split between Healthy Families and Exchange plan coverage. It is estimated that in a given year, "churn"—shifts in eligibility between Medicaid and the Exchange—might affect as much as 50 percent of adults with family incomes below 200 percent of the federal poverty level.[2] The U.C. Berkeley Center for Labor Research and Education estimates that 15.1 percent of Medi-Cal eligible individuals will experience an increase in income that makes them ineligible for Medi-Cal within 12 months.[3] This churning risks disrupting continuity of care as individuals transition between networks of providers contracting with Medi-Cal managed care plans and Exchange plans. Allowing continued access to Medi-Cal managed care plans may also facilitate the coordination of care within families when a family's income exceeds the Medi-Cal eligibility requirements for adults, but not for children.

Bridge Plan Offering

Under the Exchange's proposal, a Bridge Plan would be a new type of Exchange plan that would be offered through Covered California, but would only be available to individuals that lose Medi-Cal eligibility or share a household with Healthy Families enrollees. This is referred to as the "narrow" bridge.[4] Only Medi-Cal managed care plans would be able to offer Bridge Plan products. Covered California intends that the Bridge Plans would be the most affordable Exchange plans offered at the silver metal tier (an actuarial value of 70 percent). According to the Board recommendation brief, this might be achieved through a sequential bidding process under which Bridge Plan issuers would bid on premiums after the premiums for other Exchange plans had been set.

Federal Subsidies

The target populations for Bridge Plans would be eligible for Federal Exchange subsidies—namely premium tax credits and cost-sharing reduction payments. These subsidies lower the cost of premiums, deductibles, copayments, and coinsurance and reduce out-of-pocket maximums for households earning up to 200 percent of the federal poverty level ($47,100 for a family of four in 2013).[5] These subsidies would ensure that a Bridge Plan product priced as the lowest cost silver plan would cost less than $118 in monthly premiums for a family of four earning just above the Medicaid eligibility threshold (from 138 up to 150 percent of the federal poverty level). At this income level, Federal cost-sharing reduction payments would eliminate the plan's deductible, would substantially decrease copayments (e.g., $3 for a primary care visit and $6 for an urgent care visit) and coinsurance (e.g., 10 percent for a hospital stay), and would lower the out-of-pocket maximum to $4,500 for a family.

Implementation and Expansion

In order for the Bridge Plan proposal to be implemented, California will need Federal approval. Section 1331 of the Patient Protection and Affordable Care Act (ACA) requires HHS to establish a basic health program under which states can enter into contracts to offer standard health plans for low-income individuals not eligible for Medicaid.[6] HHS, however, has delayed implementation of the basic health program, indicating that the program will be operational in 2015 for interested states.[7] In the interim, HHS will work with interested states to "identify similar flexibilities to design coverage systems for 2014" and has specifically indicated that bridge plans may be approved.[8] Given the time needed for approval and implementation, Covered California aims to begin enrollment in April 2014.

If the Bridge Plan proposal is adopted, Covered California estimates that between 670,000 and 840,000 individuals would be eligible to enroll in a Bridge Plan in 2014. Over the coming years, the Exchange might conduct further research and discussions focused on potentially expanding Bridge Plan to non-Medicaid eligible individuals earning less than 200 percent of the federal poverty level. If this "broad" bridge is implemented, it could draw much of the subsidy eligible population away from typical Exchange plans and onto Bridge plans.

Network Adequacy and Provider Reimbursement

For providers, the proposal raises network adequacy and reimbursement concerns. The approved proposal suggests that enrollment would be closed to non-Bridge enrollees if the network is only adequate to handle the Bridge population. Because network adequacy is already an area of concern with Medi-Cal managed care plans, opening these networks to new enrollees could magnify network adequacy issues.

By design, the Bridge Plans will be offered at below-market premiums, based on the sequential bidding process. We anticipate that these below-market premiums would magnify the already significant downward pressure on provider reimbursement rates. The board recommendation brief on the Bridge Plan assumes that typical Exchange plans would carry average reimbursement rates set at 120 percent of Medicare rates and projects a 5 percent reduction in provider reimbursement by Bridge Plans (i.e., 114 percent of Medicare).[9] We note that this estimate of provider rates for Bridge Plans may still be higher than the rates ultimately offered to providers in light of the troubling provider reimbursement rates being pushed by potential Exchange plans.

For additional information, please contact Katrina Pagonis or Felicia Sze in San Francisco at 415.875.8500, or Lloyd Bookman in Los Angeles at 310.551.8111.

HLB Highlights of Recent Activity

The healthcare industry continues to experience sweeping changes. As a result, Hooper, Lundy & Bookman, PC (HLB) has expanded to meet the challenges of health care reform and the changing industry landscape. As healthcare organizations evolve, we are taking this time to provide an overview of highlights of our recent activities to better serve clients going forward.

- **HLB ARGUES BEFORE THE U.S. SUPREME COURT**: The U.S. Court of Appeals for the D.C. Circuit reversed the decision of the lower court and ruled that (a) District Courts have jurisdiction to review Medicare reimbursement appeals that are dismissed by the Provider Reimbursement Review Board (PRRB) because the provider allegedly did not file its appeal within 180 days after receiving its Medicare NPR, and (b) the 180-day appeal deadline can be extended under the theory of equitable tolling. After a spirited oral argument in which HLB served as lead and arguing counsel, the Supreme Court reversed the equitable tolling decision. However, because the Secretary did not seek review of the decision on the jurisdiction of District Courts to hear appeals of PRRB dismissals based on failure to meet the 180-day appeal deadline, that decision remains good law. *Sebelius v. Auburn Regional Medical Center, et al.*, No. 11-1231 (Decided January 22, 2013).

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[1] Covered California, Press Release, Bridge Plans Improve Continuity & Affordability of Care (March 7, 2013), *at* http://www.healthexchange.ca.gov/Documents/Bridge%20Plan%20Authorization-Final6.pdf.

[2] Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility may Move Millions Back and Forth Between Medicaid and Insurance Exchanges,* 30 HEALTH AFF. 228 (2011).

[3] Covered California, Board Recommendation Brief, Bridge Plan: A Strategy to Promote Continuity of Care & Affordability through Contracts with Medi-Cal Managed Care Plans at 3 (Feb. 23, 2013).

[4] Covered California has also announced its intention to pursue a "broad" Bridge Plan, through which individuals earning less than 200% of the Federal Poverty Level would be qualified to enroll in a Bridge Plan.

[5] Households earning between 200 and 250 percent of the federal poverty level ($47,100 to $58,875 for a family of four in 2013) are eligible for reduced premiums and lower out-of-pocket maximums; at 250 to 400 percent of the federal poverty level ($58,875 to $94,200 for a family of four), households are eligible for premium assistance only.

[6] 42 United States Code § 18051.

[7] HHS, Questions and Answers: Medicaid and the Affordable Care Act (February 2013), at http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/ACA-FAQ-BHP.pdf.

[8] *Ibid*.; HHS, Frequently Asked Questions on Exchanges, Market Reforms and Medicaid at 6 (December 10, 2012), at http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

[9] Covered California, Board Recommendation Brief, Bridge Plan: A Strategy to Promote Continuity of Care & Affordability through Contracts with Medi-Cal Managed Care Plans at 6 (Feb. 23, 2013).

- **HLB ADDS A GOVERNMENT RELATIONS GROUP**: Based in the firm's Washington, D.C. office, HLB's new Federal Government Relations and Public Policy Department is led by Martin A. Corry and includes veteran health care lobbyist, Kelly L. Lavin and economic policy advisor, Alex M. Brill. In addition to almost 30 years as a federal lobbyist, Mr. Corry is the former Special Assistant to the Administrator of the Centers for Medicare and Medicaid Services (CMS) where he served from 2002-2007. At CMS, Mr. Corry was involved with a wide range of matters ranging from implementing the Medicare Modernization Act (MMA) to the annual issuance of CMS payment rules in coordination with the Office of Management and Budget. HLB's Federal Government Relations and Public Policy Department is immediately available to assist the firm's health care clients with a full complement of services, including: legislative and regulatory advocacy, proposed legislation development and monitoring, strategic planning and risk assessment, assistance with funding and grant applications and coalition building.

- **OVER $700 MILLION SETTLEMENT FOR HOSPITALS**: The U.S. Department of Health and Human Services (HHS) entered into a settlement agreement for more than $700 million for the benefit of over 500 of HLB's hospital clients regarding the underpayments to these hospitals relating to the Medicare Rural Floor Budget Neutrality (RFBN) adjustment. Under the settlement agreement, HHS agreed to pay the settling hospitals amounts associated with the RFBN adjustment error for fiscal years 1999 through 2011. The settlement was the result of HLB actions on behalf of these hospitals over several years, including administrative appeals through the Provider Reimbursement Review Board and federal court litigation.

- **EIGHT-FIGURE JURY VERDICT FOR HOSPITALS' "BILLED CHARGES"**: After a lengthy trial, HLB's hospital client won a jury verdict in its favor for $10.7 million. The jury verdict found that the hospital's billed charges were the reasonable and customary value for post-stabilization services rendered to Medi-Cal managed care beneficiaries. The insurance company defendant was also ordered to pay the hospital's costs and interest at the Knox-Keene rate of 15 percent per annum.

- **COMMENTS RESULT IN ALMOST $2 BILLION IN FEDERAL GOVERNMENT CONCESSIONS**: HLB leads the annual comments set for a national hospital organization regarding the Inpatient Prospective Payment System Rates Rule. This year, two issues on which HLB led comments resulted in significant impact: (1) CMS listened to HLB's comments and downwardly adjusted the outlier threshold for FY 2013. The change between the proposed and final rule netted hospitals a bit more than $1 billion. (2) Through an intensive analysis of patient acuity and coding trends, HLB demonstrated to CMS that a documentation and coding adjustment authorized by Congress was unnecessary. The net additional reimbursement to hospitals from Medicare for FY 2013 was about $800 million.

- **ALMOST $2 MILLION REIMBURSEMENT FOR RESIDENT SUPPLIES**: Eight related skilled nursing facilities were disallowed costs of acquiring supplies for residents on grounds the supplies were provided by a related party supply company. At hearing, HLB argued the costs of the supplies should be allowed in full because the supply company met the exception to the related party rule: i.e., the supply company was a *bona fide* separate company; the supply company transacted a significant portion of its business with unrelated parties; the services of the supply company were normally obtained on the open market; and the supply company charged the related party fair market rates. The financial impact of the decision was almost $2 million.

- **DSS WITHDRAWS ACCUSATION**: California Department of Social Services withdrew an Accusation seeking to exclude a young therapist from working in a non-profit with at-risk youth for the rest of his life because 10 years ago he was detained (but never arrested). When it was pointed out to DSS that the Accusation was based on illegally acquired evidence and that DSS sought to illegally preclude employment based on this evidence, they withdrew the Accusation.

- **AMENDMENTS TO COORDINATED CARE INITIATIVE**: HLB drafted amendments to the Governor's Coordinated Care Initiative (Senate Bill 1008) that established significant protections for skilled nursing facilities participating in California's dual-eligible demonstration program. The protections include rate protection in the form of statutory language ensuring that the current Medi-Cal and Medicare rate for skilled nursing services will serve as rate floors and electronic claims submission and payment.

- **HOSPITAL DEFEATS WRIT OF ATTACHMENT**: HLB successfully represented a hospital in opposing an

application for writ of attachment, which would have created a lien against the hospital for over $4.7 million dollars. In a breach of contract dispute between a hospital and one of its former vendors, the vendor filed for a writ of attachment. HLB opposed the application by arguing the amount in controversy was not readily ascertainable, a necessary requirement for a writ of attachment to be issued, due to the vendor's numerous billing errors, The court agreed and denied the vendor's application.

- **FULL REIMBURSEMENT FOR ADMINISTRATOR COSTS**: A skilled nursing facility was denied reimbursement by the Department of Health Care Services for the full costs of employing its administrator based on a 1999 state survey updated for inflation. HLB took a writ to Superior Court challenging the survey because it did not meet the factors enumerated in the Provider Reimbursement Manual. The court agreed. The Department revised its administrator compensation tables and reimbursed the client the full costs of employing its administrator.

- **CLIENT GETS HEALTH PLAN LICENSE**: HLB assisted a health system client achieve its goal of launching a new health plan in Southern California, including providing strategic advice, negotiating and drafting the transactional documents, and assisting with all aspects of navigating the complex filing requirements to become a licensed health plan. The new plan was formed to support Medi-Cal managed care members and to prepare for the California Children's Services demonstration project, which targets children with certain diseases and ongoing medical conditions.

- **MERGER & ACQUISITION TRANSACTIONS**: Reflective of the increasing M&A activities in the healthcare industry, HLB was actively involved in representing buyers and sellers in many, varied acquisition transactions, including transactions for hospitals, long-term care facilities, surgery centers, DME companies, home health and hospice providers, and others in the industry.

- **FINANCING TRANSACTIONS**: HLB assisted many providers in connection with various types of financings and re-financings, including acquisition and working capital financings and tax-exempt bond financings.

- **DISMISSAL FOR OPPONENT'S FAILURE TO PROSECUTE**: HLB successfully moved to dismiss an arbitration demand filed against a hospital system client, and its management company, by a physician and his medical group. This dismissal was obtained on "failure to prosecute" grounds after the plaintiffs and their counsel failed to prosecute the case or communicate with the Arbitrator for just over one year. HLB also successfully defended Plaintiffs' attempt to have the Superior Court reverse the Arbitrator's order.

If you would like additional information regarding any of these activities, please contact report authors Michael Houske, Linda Kollar or Devin Senelick in Los Angeles at 310-551-8111; Regulatory Department Chair John Hellow; Business Department Chair David Henninger, or Litigation Department Chair at 310.551.8111; or office managing partners Mark Reagan in San Francisco at 415.875.8500; Mark Johnson in San Diego at 619.744.7300; or Robert Roth in Washington, D.C. at 202.580.7700.

Calendar

April	**10**	**CAHF Nurse Leadership Conference, Anaheim** Mark Johnson speaks on *Informed Consent*
	12	**CSHA Annual Meeting & Spring Seminar** Hope Levy-Biehl presents *HIPAA & HITECH Update*
	18	**MasterCare Services Client Conference, Anaheim** Mark Johnson speaks on *ZPICs*
	23	**CHA Webinar - Coordinated Care Initiative: Dual Eligibles Demonstration** Lloyd Bookman and Felicia Sze present *Strategic and Operational Considerations for Hospitals.*
	25	**Los Angeles County Bar Association Meeting** Mark Johnson presents *California's Dual Eligibles Demonstration Project*
May	**9**	**ABA Long-term Care Webinar** Mark Johnson presents *Compliance Programs for LTC Facilities*
	15-17	**ABA 23rd Annual Institute on Health Care Fraud, Miami Beach** Robert Roth presents *The Foundations of Health Care*
	30	**CAMSS Annual Education Forum, San Diego** Jennifer Hansen presents *Physician Behavior Contracts*

CHA Hospital Compliance Manual New Edition Released

The California Hospital Association has just released the new edition of the California Hospital Compliance Manual, which is co-authored by Hooper, Lundy & Bookman attorneys.

The new edition has been updated to reflect changes through Jan. 1, 2013 to Medicare and Medi-Cal reimbursement requirements, including physician supervision, repeat admissions, same-day readmissions, leaves of absence and much more.

New to the 2013 edition is Chapter 14, "Hospital Signage Requirements," which describes 80 different state and federal signage requirements for California health facilities in a useful chart format. The chart contains the name of the required sign; who must comply; a description of the requirement; any signage requirements that specify where in the facility the sign must by posted; sign size, font size, or foreign language requirements in the law; and the name of sample signs.

To order the manual and view a complete list of contents, visit www.calhospital.org/compliance

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