Summary Recap and Key Takeaways from AHLA's Medicare and Medicaid Payment Issues Conference

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Every year, health lawyers, providers, consultants, and government experts from across the country convene in Baltimore for the American Health Lawyers Association's Institute on Medicare and Medicaid Payment Issues, the most comprehensive program available on legal issues related to health care reimbursement. This program brings together knowledgeable private sector speakers with representatives from various government agencies, including the OIG, CMS, OGC, and DOJ. The highlight this year included a keynote by The Honorable Alex M. Azar, II, Secretary, US Department of Health and Human Services (HHS).

AGG's health care team fielded five attendees at the conference, one of whom presented on payment updates for home health and hospice. Read on for high-level takeaways from a selection of the sessions at this content-rich conference.

- Secretary Azar addressed HHS's "Regulatory Sprint to Coordinated Care" Initiative in his keynote address. Under this initiative, the agency is examining rules that may form a barrier to coordinated care. Among those targeted is Stark law, which, although designed to provide necessary protection under fee-for-service compensation models, may be impeding the switch to value-based compensation arrangements. Accordingly, the agency is seeking comments on a possible exception for advance-payment models, as well as other changes to Stark law. If on Twitter, one can follow updates at #rs2cc.

- During her presentation, Nancy Griswold, Chief Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA), confirmed the agency is continuing to work diligently to clear the ALJ backlog within the timeframe currently mandated by court order (*i.e.*, end of FY 2022). She gave several practice pointers to providers, including a reminder that appellants must submit a request to aggregate claims (as needed to meet the amount in controversy requirements) at the same time as the initial request for hearing. In addition, ALJ Griswold noted that providers should not spend additional time to reorganize or tab medical records in a particular format for submission to the ALJ, as such formatting would not likely be maintained in the file before the ALJ. She noted that OMHA is working on developing an electronic records system which may allow some of the original formatting by providers to be kept in the future, but currently everything is still in paper format and all documents are typically reorganized by OMHA staff upon receipt.

- Bill Dombi, President of the National Association of Home Care & Hospice, provided insights on the new reimbursement model for home care on the horizon for 2020, with the goal of addressing access to care for vulnerable patients and elimination of therapy volume as payment rate determinant. The new model will prohibit therapy volume thresholds for payment amount and will use a 30-day payment unit. Mr. Dombi also discussed implementation and challenges with the new home health Patient-Driven Groupings Model (PDGM), including concerns with the regression-based methodology including therapy volume and the change in costing methodology reducing case weights and, thus, payment amounts. Mr. Dombi concluded with a discussion of the new Review Choice Demo (RCD), a revival of the pre-claim review demo that CMS previously suspended. RCD is slated for five demonstration states for five years, with the option to expand to other states. Under the model, home health agencies will select from three initial choices for claims review: (i)

100% pre-claim review, (ii) 100% post-payment review, or (iii) minimal post-payment review with a 25% payment reduction.

- The Fraud and Abuse Hot Topics panel discussion was led by HHS, OIG, an Assistant US Attorney and outside counsel. CMS hot topics included the need for all providers and suppliers to enroll in the Medicare program in order to receive Medicare payments, and that enrollees should update their information when necessary.[1] Additionally, revocations are being made based on improper prescribing practices,[2] where the DEA or applicable state administrative or licensing body suspends or revokes the ability to prescribe drugs. This is based on a pattern or practice that is abusive, a threat to the health and safety of beneficiaries, or fails to meet Medicare requirements. Another focus of CMS is the reporting and returning of overpayments, which shall be reported or returned by the later of (i) the date which is 60 days after the date on which the overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. Some of the OIG's hot topics included the focus on individual accountability where there used to be a greater focus on companies and entities. The OIG believes this attributes responsibility where it needs to be. Additionally, the OIG is heavily focused on prescribers and pain management facilities and their dealings in opioids. The primary fact pattern is excessive prescribing which has resulted in individuals being excluded for years. Another OIG hot topic was the use of grant funds. HHS is the largest grant issuing federal agency and OIG enforces and protects HHS. Grant monies used for, for example, unallowable operating costs are being pursued. The DOJ highlighted the Civil False Claims Act. Since 1986, there has been $59 billion in recoveries under the FCA, with $32 billion of those recoveries from healthcare. Discussion was had about the Yates memo, where the focus on individuals remains key, as seen in complaints and settlements. November 2018 guidance clarifies that (i) corporations earn credit for providing relevant facts about individuals "substantially responsible for the misconduct," and (ii) there is discretion for civil attorneys to offer some credit even if the company does not qualify for maximum credit. Additionally, there was discussion regarding the cases currently being brought. Much of the government's focus and scrutiny has been on whether patients are being harmed or if there is risk of patient harm, or if patients are vulnerable. Cases highlighted involved drug and device integrity, medical necessity-related cases, patient co-payments, telehealth cases, cases involving electronic medical records, and kickback allegations with continued focus on referrals. The DOJ's criminal enforcement hot topics covered an increase in opioid enforcement, which has been considered a public health emergency, with all stages of the opioid distribution being monitored (manufacturers, distributers, pharmacies, physicians, and dealers).

1 42 C.F.R. 424.505
2 42 C.F.R. 424.535(a)(13) and (14)

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