

The **RAP** Sheet

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—from a declaration of the American Bar Association

Medicaid Provider Enrollment Update: Georgia, Ohio, South Carolina, Washington

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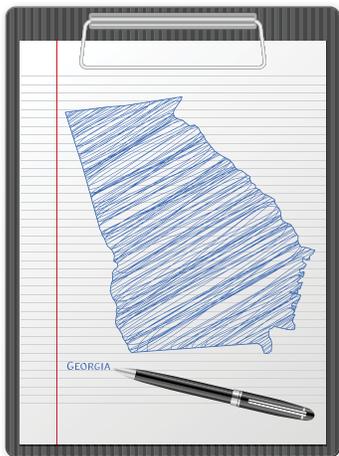
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This is the second piece in a multi-part series examining hot topics in Medicaid provider enrollment on a state-by-state basis. While many states are in various stages of implementing the federal requirements for Medicaid provider screening and enrollment that were enacted as a part of the Patient Protection and Affordable Care Act (PPACA)¹ as amended by the Health Care and Education Reconciliation Act of 2010, Georgia is an example of a state going beyond the federal mandates to more broadly address issues of efficiency and fraud and abuse in the Medicaid program.

The February 2013 issue of *The RAP Sheet* looked at California, Florida, North Carolina, Virginia, and West Virginia. In this installment, we bring you Georgia, Michigan, Ohio, South Carolina, and Washington. Stay tuned for future issues of *The RAP Sheet* and updates on Medicaid enrollment developments in additional states.



Georgia

As Georgia has sought both to position itself for compliance with various mandates of PPACA and address the dynamic healthcare regulatory environment at the state level, the Georgia Department of Community Health (DCH), the state agency that administers the Medicaid program in Georgia, has, over the past couple of years, implemented several new initiatives impacting Medicaid stakeholders, including beneficiaries, providers, communities, and governmental agencies.² Several of these initiatives are designed to directly improve the administration and efficiency of the Medicaid provider enrollment process, and at the same time, more closely monitor potential fraud and abuse in the Medicaid program and enhance the ability of physicians to provide more complete patient care through information availability and sharing measures. While not an exhaustive list, following are a few key items of note Georgia has undertaken:

Medicaid Provider Enrollment Section

In early 2011, DCH transferred the Provider Enrollment Section from DCH's Office of the General Counsel to the Office of Inspector General (OIG). This change will, in part, enable DCH to better control fraud in the Medicaid/PeachCare for Kids programs by monitoring providers from the time of actual enrollment in the Medicaid program. To that end, the Provider Enrollment Section is implementing several new initiatives including background screening processes, enhanced database checks, and re-enrollment of providers every three years.³

Electronic Provider Enrollment

DCH has implemented an electronic enrollment process that has served to reduce the application processing time from several months to a couple of weeks, resulting in an increased number of providers throughout the state and a reduction in administrative challenges faced by providers.⁴ Financial investment in advanced information technology systems is a fundamental necessity for states in order to streamline their eligibility and enrollment processes, which will impact (and benefit) both patients and providers.⁵

New Resource for Enrollment Guidance

DCH has posted on its website as of November 2011 a new, detailed frequently asked questions compilation designed to facilitate the enrollment process for providers. The guidance walks providers through the enrollment process and provides links to related ancillary information needed to complete the application. It also provides important information to enrolled providers regarding the change-of-ownership process and changing electronic funds transfer payee.

Redesign of Georgia Medicaid

In 2011, DCH engaged Navigant Consulting to undertake a comprehensive assessment of Georgia's Medicaid program and to identify options for redesign.⁶ In July 2012, DCH announced that while it was not undertaking a wholesale redesign of the Medicaid program given the then-continued uncertainty of healthcare initiatives at the federal level, it was implementing certain key recommendations, including: (1) continued use of the care management organization (CMO) model to serve Medicaid and PeachCare for Kids populations; (2) transitioning foster children to a single-designated CMO; and (3) implementing a value-based purchasing model.⁷ Of particular interest to providers will be DCH's initiative to create a centralized portal designed to reduce administrative burdens and make it easier for providers to care for their patients by giving providers more comprehensive, accurate, and timely information about their patients, streamlining the credentialing process, providing key performance metrics, and designating areas for improvement. With respect to credentialing specifically, the intent is to provide an avenue for new Georgia Medicaid providers wishing to participate in a CMO to file a single-source application and share credentialing information with each of the CMOs.⁸



Michigan

Provider Screening and Enrollment

Michigan, like other states, is implementing new Medicaid provider screening and enrollment requirements, as required by PPACA. Highlights of these new requirements are described below.

Additional screening of Medicaid providers will be conducted based on the provider's categorical risk level.⁹ The higher the risk level, the more robust the screening activities will be. The Michigan Department of Community Health (MDCH), which administers the Medicaid program in Michigan, adopted the risk categorization established by the Centers for Medicare & Medicaid Services (CMS) for provider types recognized under the Medicare program.¹⁰ For non-Medicare provider types, MDCH establishes the risk level.

There are three risk categories—"high," "moderate," and "limited." Provider types in the high-risk category, and thus subject to the most rigorous screening requirements, are newly enrolling home health agencies and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Screening activities for providers in the high-risk category include unannounced site visits and fingerprint-based criminal background checks.¹¹

Provider types in the moderate-risk category are ambulance services, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent clinical laboratories, physical therapists, revalidating home health agencies, and DMEPOS suppliers.¹² While MDCH does not contemplate criminal background checks for providers in the moderate-risk category at this time, they will be subject to unannounced site visits. All other provider types not in the high- or moderate-risk categories, such as hospitals and nursing homes, are in the limited-risk category. Screening requirements for the limited-risk category include verification of licensure, Social Security number, Taxpayer Identification Number, National Provider Identifier (NPI), and OIG exclusion status.

All providers enrolling in Medicaid, except for individual physicians and non-physician practitioners, are now required to pay an application fee. The fee, which is established by CMS and is \$523 for 2012, will be updated annually; however, providers who are enrolled in or have paid the application fee to Medicare or another state's Medicaid or Children's Health Insurance Program are not required to pay the application fee. Also, providers may request a hardship exception from MDCH.¹³

Providers enrolled in Medicaid will be required to revalidate their Medicaid enrollment information every five years, unless MDCH requires revalidations more frequently. MDCH will contact providers when it is time to revalidate. Medicaid providers should continue to notify MDCH within 35 days of any change to their enrollment information.¹⁴ Revalidation does not change the requirement to provide MDCH with notice of such changes.

MDCH will provide updates as these new screening and enrollment requirements are implemented.

Enrollment of Urgent Care Centers, Physician Assistants, and Nurse Practitioners

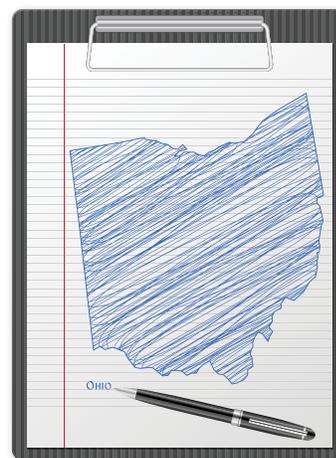
In addition to the changes in provider enrollment and screening discussed above, Medicaid is now enrolling new provider types—

urgent care centers (UCCs), physician assistants (PAs), and nurse practitioners (NPs).

With respect to UCCs, MDCH identified a need to improve access to non-emergency services for Medicaid beneficiaries.¹⁵ Michigan Medicaid defines a UCC as "a medical clinic or office, not located in a hospital emergency department, whose purpose is to provide unscheduled diagnosis and treatment of illnesses for ambulatory beneficiaries requiring immediate medical attention for non-life-threatening conditions."¹⁶ Enrollment of UCCs is expected to provide access to a place of service more appropriate than a hospital emergency room when a beneficiary's primary care provider is not available. Enrollment for UCCs began on October 1, 2012.¹⁷

Also beginning October 1, 2012, licensed PAs and NPs who render, order, or bill for covered services to Medicaid beneficiaries must begin enrolling in Medicaid.¹⁸ As of January 1, 2013, PAs and NPs will no longer bill for services under their delegating/supervising physician's NPI.¹⁹ Rather, NPs and PAs must enroll with an Individual (Type 1) NPI number as a rendering/servicing-only provider.²⁰

PAs and NPs must affiliate themselves with the billing NPI of their delegating/supervising physician, and payment for services provided by NPs and PAs will be paid to the affiliated delegating/supervising physician, group, or billing provider NPI.²¹ However, the enrollment procedures and requirements for NPs who render services pursuant to a formal, written collaborative practice agreement with a physician remain unchanged. These enrolled NPs are eligible for direct payment for NP services provided.²²



Ohio

The Ohio Department of Job and Family Services (ODJFS), the state agency responsible for the Ohio Medicaid program, has implemented various new regulations in 2012 and is in the process of promulgating additional regulations in 2013 to comply with the PPACA requirements for Medicaid provider screening and enrollment.

Enrollment Screening Levels

ODJFS has already implemented regulations, effective as of March 31, 2012,²³ to classify providers into limited, moderate, and high categorical risks, as required by PPACA.²⁴ The category levels reflect the level of enrollment scrutiny to be used for providers in that category. Providers in the limited category are subject to: (1) verification that they meet any applicable Medicaid requirements for their provider type; (2) license verifications, including state licensure verification in states other than Ohio; and (3) database checks on a pre-enrollment and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type. Providers in the moderate category are subject to: (1) all of the requirements for the limited category; and (2) onsite visits, including pre-enrollment and post-enrollment site visits as well as unannounced onsite inspections. Providers in the high category are: (1) subject to all of the requirements for the limited and moderate categories; and (2) each person with a 5% or greater ownership or control interest in the provider is subject to a criminal background check and required to submit fingerprints to ODJFS.²⁵ To be an eligible provider in the Medicaid program, the provider must meet the applicable screening requirements.²⁶ However, the regulation provides that a provider is exempt from this regulation if the provider participates in the Medicare program and has met the Medicare provider screening requirements or if the provider has met screening requirements for another state's Medicaid program.²⁷

Revalidation

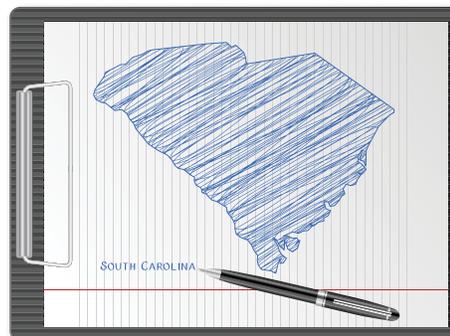
Under current regulations, Medicaid provider agreements may be term limited to seven years.²⁸ To comply with the PPACA requirement that Medicaid programs revalidate the enrollment of all providers at least every five years,²⁹ ODJFS has indicated that it will revise these regulations in 2013 to require revalidation every five years, presumably by shortening the maximum length of term-limited provider agreements. The current regulation also allows for open-ended provider agreements and specifically provides that hospitals, nursing facilities, intermediate care facilities, and managed care organizations utilize open-ended provider agreements.³⁰ It is unclear if these open-ended provider agreements will continue to exist subject to revalidation screening requirements or if these open-ended provider agreements will be converted to term-limited provider agreements.

Requirements for Enrollment of Ordering and Referring Physicians

Previously, ordering and referring physicians did not have to be enrolled in the Medicaid program in Ohio. To satisfy PPACA requirements,³¹ ODJFS will require all ordering and referring physicians and other professionals providing services under the Ohio Medicaid program to become enrolled as Medicaid providers and go through the enrollment and screening process.

Enrollment Application Fees

Effective March 31, 2012, providers will be required to pay an enrollment fee of \$532 at the time of initial enrollment and every five years at the time of revalidation.³² A provider must have paid this application fee to be an eligible provider in the Medicaid program.³³ However, the fee is not required from providers that are enrolled in Medicare or that have paid an enrollment fee in another state's Medicaid program.³⁴



South Carolina

South Carolina began implementation of the changes in provider enrollment mandated by PPACA in August 2012. These changes were finalized in the revised Provider Enrollment Manual published on December 3, 2012, and can be accessed on the South Carolina Department of Health & Human Services (SCDHHS) website at www.scdhhs.gov.

Moratoria

SCDHHS has imposed a temporary moratorium on the enrollment of providers identified as being an increased risk to the Medicaid program by the Secretary of HHS. SCDHHS may also impose a temporary moratorium on new providers or impose numerical caps, or other limits on providers the state identifies as having a significant potential for fraud, waste, or abuse. The moratorium would be for six months and could be extended in six-month increments if documented in writing.³⁵

Ordering or Referring Provider

SCDHHS now requires that all ordering or referring physicians or other professionals providing services under the state plan or any waiver shall be enrolled as participating providers. Qualified providers must be enrolled in South Carolina Medicaid to order or refer services or to bill Medicaid for these services. Ordering or referring providers must submit an application, pay appropriate application fees, and be subject to the same screening process as all providers.³⁶

Enrollment Screening

All providers must be screened by SCDHHS prior to enrollment. The level and type of screening will be based on a categorical risk level of limited, moderate, or high. Limited-risk providers must be in good standing with their licensing board and meet all provider-specific requirements. Moderate-risk providers must meet all standards for limited-risk providers, and agree to an onsite visit by SCDHHS. High-risk providers must meet all standards for limited- and moderate-risk providers, and undergo a criminal background check and submit fingerprinting. SCDHHS will adjust the categorical risk level from limited or moderate to high if one of the following applies:

- Payment suspension occurs based on a credible allegation of waste, fraud, or abuse;
- The provider has an existing Medicaid overpayment;
- The provider has been excluded from another Medicaid program within the past 10 years; or
- An enrollee was under a temporary moratorium within the most recent six months.

South Carolina will conduct both pre- and post-enrollment onsite visits for providers deemed moderate- or high-risk providers.³⁷

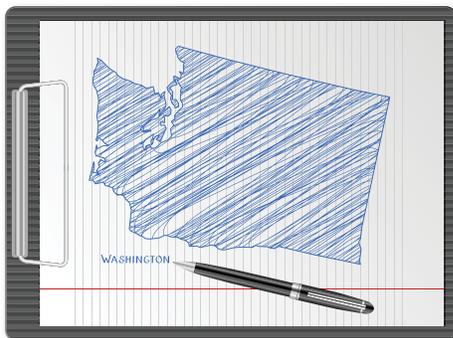
Revalidation

All providers, except DME providers, must have their enrollment information revalidated every five years. DME providers must have their enrollment information revalidated every three years. Providers seeking revalidation must submit a new application and pay a new application fee to continue enrollment in South Carolina Medicaid. Failure to meet these requirements will result in termination.³⁸

Criminal Background Checks

As a condition of enrollment, all providers must consent to a criminal background check, including federal and state databases, if:

- They have 5% or more ownership interest in the provider; or
- They are listed in the moderate- or high-risk categorical levels.³⁹



Washington

Washington has adopted, and continues to develop new Medicaid provider enrollment rules to implement online enrollment capabilities, screen out fraudulent providers upon enrollment or during revalidation, and increase oversight over ordering, referring, and prescribing providers. The following are some of the significant new enrollment measures adopted into the Washington Medicaid program this year.

New Proposed Enrollment Screening Rules

On December 5, 2012, the Washington State Health Care Authority (HCA) released proposed rules that would require applicants to undergo more intensive screening procedures when initially enrolling in the Medicaid program.⁴⁰ If adopted, the new rules would require new provider applicants to disclose detailed information regarding their direct and indirect owners, employees who manage their organization, as well as others who have the ability to exert control over the organization.⁴¹ Applicants would also be subject to new and additional enrollment screening requirements such as license verifications, database checks, site visits, and criminal background checks including fingerprint-based criminal background checks for those providers considered high risk for potential fraud and abuse by Medicare.⁴² The proposed rules would also grant HCA the authority to impose temporary moratoria on the enrollment of new Medicaid providers when either directed or approved by CMS.⁴³

New Revalidation Requirements

The proposed rules released on December 5, 2012 would also introduce new provider revalidation procedures into the Washington Medicaid program. The proposed rule would subject enrolled providers to a revalidation process at least every five years.⁴⁴ The revalidation process would include, but not necessarily be limited to, updating provider enrollment information, submitting any specific forms required by HCA, and undergoing HCA screening protocol for new providers as described above.⁴⁵

New Requirements for Ordering, Referring, and Prescribing Providers

Effective July 1, 2012, HCA began to require all ordering, referring, or prescribing providers to enroll as participating providers with Medicaid.⁴⁶ Thus, as of July 1, 2012, Washington Medicaid will not pay for any healthcare service referred, ordered, or prescribed by a physician or other licensed healthcare professional that is not enrolled in the Medicaid program with a valid enrollment profile in HCA's ProviderOne claims adjudication system.

Services must also be ordered, referred, or prescribed by a professional who has obtained an NPI to be eligible for payment under Washington Medicaid.⁴⁷ If a claim fails to include the NPI of the physician or licensed healthcare professional who ordered

or prescribed the service, or referred the client for the service, HCA will deny the claim.⁴⁸ Any prescribing physician or licensed healthcare provider must include their NPI on any prescription they write to allow the provider filling the prescription to prepare the claim according to the above rules.

Only in limited situations will the enrollment and NPI requirements not apply to ordering, referring, or prescribing providers. For example, claims submitted to HCA's managed care organizations are specifically exempted from this requirement, as are Medicare crossover claims.⁴⁹ However, HCA has specified that in other unique circumstances, the enrollment and NPI requirements will apply to ordering, referring, and prescribing providers. For example, if an ordering provider is enrolled in another state's Medicaid program, the provider must still enroll in Washington for his or her ordered services to be eligible for reimbursement.⁵⁰ The enrollment requirement equally applies when Medicaid is billed as the beneficiary's secondary insurer.⁵¹ Washington Regional Support Network providers also will be required to enroll for their claims to be paid for services, items, or medications billed to Medicaid to be reimbursed.⁵²

HCA has issued specific guidance indicating that the Medicaid program's pharmacy claim submission system, the point of sale system, will reject pharmacy claims unless the claim is written by a Medicaid-enrolled prescriber and submitted with the prescriber's NPI as the prescriber identifier.⁵³ Formerly, HCA would accept pharmacy claims in which the prescriber's U.S. Drug Enforcement Administration number was used in the prescriber's field.⁵⁴ Thus, all pharmacists prescribing for Medicaid beneficiaries, even those dispensing over-the-counter birth control or administering vaccines, must be enrolled in Washington Medicaid.⁵⁵

Enrollment Issues for Durable Medical Equipment Companies

Effective September 1, 2012, HCA adopted special Medicaid enrollment rules applicable to durable medical equipment (DME) companies. To enroll in Washington Medicaid, and to be eligible for payment, new DME providers must already be enrolled in the Medicare program, and must meet Medicare enrollment requirements on an ongoing basis.⁵⁶ All DME providers already enrolled in Washington Medicaid will be required to revalidate their enrollment at some point within the next three years.⁵⁷ If a currently enrolled DME provider is not already enrolled in Medicare, the provider must enroll with Medicare upon revalidation.⁵⁸ Failure to enroll will cause the provider's Medicaid enrollment to fail revalidation, and the DME provider will be terminated from the Washington Medicaid program.⁵⁹ DME providers will receive written correspondence from HCA when they are being requested to revalidate, and HCA will provide the appropriate paperwork to them at that time.⁶⁰

If you practice in the Medicaid enrollment area, and your state was not represented in this or The RAP Sheet's previous article (February 2013), and you are interested in contributing to a future piece on this topic as it relates to your state, please contact Jeanne L. Vance of Salem & Green PC, chair of the Accreditation, Certification, and Enrollment Affinity Group, at jvance@salemgreen.com.

- 1 Patient Protection and Affordable Care Act (PPACA), Pub L. No. 111-148, 124 Stat. 119 (2010) (as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010)).
- 2 Georgia was one of six states included in a study performed by the U.S. Government Accountability Office to review and assess steps taken by states to implement PPACA's reform initiatives. See U.S. Gov't Accountability Office, GAO-12-821, *Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act* (Aug. 2012) (GAO Study).
- 3 See Department of Community Health, Provider Enrollment Section, *available at* www.dch.georgia.gov/provider-enrollment (last visited Dec. 7, 2012).
- 4 See The IT Transformation: Changing the Way DCH Does Business, DCH-i: Vol. 1, Issue 6 (Mar./Apr. 2012), *available at* <http://dch.georgia.gov/dch-i-marchapril-2012-vol-1-issue-6>.
- 5 See GAO Study, *supra* note 2, at 18.
- 6 See Department of Community Health, Medicaid and CHIP Redesign, Executive Summary, Medicaid and PeachCare for Kids® Design Strategy Report (January 23, 2012), *available at* <http://dch.georgia.gov/medicaid-chip-redesign>.
- 7 See Department of Community Health, Press Releases, Department of Community Health Medicaid and CHIP Redesign Moves Forward, *available at* <http://dch.georgia.gov/press-releases/2012-08-28/departement-community-health-medicaid-and-chip-redesign-moves-forward> (last visited July 13, 2012).
- 8 See Department of Community Health, MCAC Meeting Schedule, CMO Network Adequacy, 2nd Quarter 2012 (Nov. 7, 2012), *available at* <http://dch.georgia.gov/mcac-meeting-schedule>.
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- 10 *Id.*
- 11 *Id.*
- 12 *Id.*
- 13 *Id.*
- 14 *Id.*
- 15 Medical Services Administration, MSA Bull. 12-44, Enrollment of Urgent Care Centers (Issued Aug. 31, 2012).
- 16 *Id.*
- 17 *Id.*
- 18 Medical Services Administration, MSA Bull. 12-42, Medicaid Enrollment of Physician Assistants and Nurse Practitioners (Issued Aug. 31, 2012).
- 19 *Id.*
- 20 *Id.*
- 21 *Id.*
- 22 *Id.*
- 23 OHIO ADMIN. CODE 5101:3-1-17.8.
- 24 Screening Levels for Medicaid Providers, 42 C.F.R. § 455.450 (2011).
- 25 OHIO ADMIN. CODE 5101:3-1-17.8.
- 26 OHIO ADMIN. CODE 5101:3-1-17(A)(3).
- 27 OHIO ADMIN. CODE 5101:3-1-17.8(A).
- 28 OHIO ADMIN. CODE 5101:3-1-17.4.
- 29 Revalidation of Enrollment, 42 C.F.R. § 455.414 (2011).
- 30 OHIO ADMIN. CODE 5101:3-1-17.4.
- 31 Enrollment and Screening of Providers, 42 C.F.R. § 455.410 (2011).
- 32 OHIO ADMIN. CODE 5101:3-1-17.8(C).

- 33 OHIO ADMIN. CODE 5101:3-1-17(A)(3).
 34 OHIO ADMIN. CODE 5101:3-1-17.8(A).
 35 South Carolina Medicaid Provider Enrollment Manual 1, Dec. 3, 2012.
 36 *Id.* at 5-9.
 37 *Id.* at pp. 12-15.
 38 *Id.* at p. 9.
 39 *Id.*
 40 WASH. REG. 12-24-088 (Dec. 5, 2012).
 41 *Id.*
 42 *Id.*
 43 *Id.*
 44 *Id.*
 45 *Id.*
 46 WASH. ADMIN. CODE § 182-502-0005(2) (2012).
 47 WASH. ADMIN. CODE § 182-502-0005(3) (2012).
 48 Washington State Health Care Authority, Enrolled Provider Requirements, available at <http://hrsa.dshs.wa.gov/providerenroll/participate.shtml> (last visited Dec. 13, 2012).
 49 Washington State Health Care Authority, New Medicaid Requirements for Ordering, Prescribing, and Referring Provider FAQ, available at http://hrsa.dshs.wa.gov/provider/documents/fs_faorderingprescribingreferringproviders.pdf (last visited Dec. 13, 2012).

- 50 *Id.*
 51 *Id.*
 52 *Id.*
 53 Washington State Health Care Authority, *Provider Notice #12-33*, available at <http://listserv.wa.gov/cgi-bin/wa?A2=ind1205&L=HRSA-PROVIDERS&P=R35520> (last visited Dec. 13, 2012).
 54 *Id.*
 55 *Id.*
 56 WASH. ADMIN. CODE § 182-543-2000(1)(b) (2012).
 57 Washington State Health Care Authority, *Provider Notice #12-62*, available at <http://listserv.wa.gov/cgi-bin/wa?A2=ind1208&L=HRSA-PROVIDERS&P=R2476> (last visited Dec. 13, 2012).
 58 *Id.*
 59 *Id.*
 60 *Id.*

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Medicare Bad Debts Referred to a Collection Agency—Recent Legal Developments

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One of the longstanding areas of disagreement between the Medicare program and its providers involves reimbursement for uncollected Medicare deductible and coinsurance amounts that have been referred to an outside collection agency. The Medicare program reimburses providers for uncollected Medicare deductible and coinsurance amounts as “Medicare bad debts,” and such reimbursement is separate from the amount that the provider is paid under the applicable prospective payment system for the services provided.

In many cases, providers have treated accounts referred to a collection agency as uncollectible bad debts and claimed them in their Medicare cost report for the year when the bad debts were referred to the collection agency. Providers have taken this action based on the fact that collection agencies are generally able to collect only a very small percentage of the accounts referred to them. Simply put, providers have taken the position that the uncollected accounts should be considered worthless, with no likelihood of recovery, in the year when they are referred to a collection agency. Therefore, providers have sought Medicare reimbursement for the uncollected accounts at the time they are referred to a collection agency.

The Centers for Medicare & Medicaid Services (CMS), however, has taken the position that a provider’s action in referring uncollected accounts to a collection agency indicates that the provider still considers the debt to have value and not to be worthless. Thus, CMS contends that accounts referred to a collection agency cannot yet be considered to be actually uncollectible, as there is some likelihood of recovery in the future. Accordingly, CMS has taken the position that if a provider refers an account to a collection agency, the account cannot be claimed for bad debt reimbursement until the collection agency has completed its efforts and returned the account to the provider.

This article discusses two issues regarding bad debts referred to a collection agency. First, this article discusses the litigation between providers and CMS on this issue with respect to cost-reporting periods that began before October 1, 2012. In two decisions, one issued in 2008 and one issued on March 26, 2013, the U.S. District Court for the District of Columbia (D.D.C.) ruled that CMS’ disallowance of uncollected accounts that had been referred to a collection agency is unlawful because it violates the Bad Debt Moratorium that was enacted by Congress in 1987. The Bad Debt Moratorium (discussed in further detail below) prohibits CMS from making changes to the agency’s Medicare bad debt policy that was in effect on August 1, 1987. In both cases, the D.D.C. found that CMS did not have a policy on the issue of bad debts referred to a collection agency in place prior to August 1, 1987, and that CMS was barred by the Bad Debt Moratorium from implementing a new policy providing for the disallowance of bad debts referred to a collection agency.

Second, this article discusses the statutory amendment passed by Congress in 2012, which changed the law for cost-reporting periods beginning on and after October 1, 2012. The amendment provides that the Medicare Bad Debt Moratorium will have no effect for cost-reporting periods beginning on and after October 1, 2012.

Background

In most cases, Medicare beneficiaries who receive services or supplies under the Medicare program are required to pay part of the cost of the service or supply. These copayments include deductibles and coinsurance obligations, and can be either a set dollar amount or a percentage of the charge or other applicable amount. For example, a Medicare beneficiary is charged a fixed deductible amount when he or she receives Medicare-covered inpatient services in a hospital for the first time in a benefit period,¹ and is charged an inpatient coinsurance amount for each day after the first 60 days of an inpatient stay in a benefit period.² The Medicare provider or supplier is required to bill the beneficiary or his or her insurance company for the copayment amount.

The Medicare statute prohibits cost shifting, which means that costs associated with services provided to Medicare beneficiaries cannot be borne by non-Medicare patients, and vice versa.³ In order to prevent cost shifting, providers that submit cost reports can claim the copayment amounts that they are unable to collect



from Medicare beneficiaries as bad debts on their cost reports, and receive a percentage of the unpaid amounts from the Medicare program.⁴

The Medicare regulations provide that to be entitled to Medicare reimbursement of bad debts, four criteria must be met. First, the debt must be related to covered services and derived from deductible or coinsurance amounts. Second, the provider must be able to establish that reasonable collection efforts were made. Third, the debt must be actually uncollectible when claimed as worthless. Fourth, sound business judgment must establish that there was no likelihood of recovery at any time in the future.⁵

The Medicare Provider Reimbursement Manual (PRM) (CMS Pub. No. 15-1) provides CMS' interpretation of these regulatory requirements. Several sections of the PRM are relevant.

First, PRM Section 310 defines a "reasonable collection effort" to collect Medicare bad debts as one that is "similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients."

Second, PRM Section 310.2 sets forth a "presumption of noncollectibility," which establishes that if, after reasonable and customary attempts to collect the unpaid amounts have failed, the debt remains unpaid more than 120 days from the date the first bill was mailed to the Medicare beneficiary, the debt "may be deemed uncollectible."

Third, PRM Section 316 establishes a system to ensure that any debts deemed uncollectible that are later recovered by the provider are subtracted from bad debt reimbursement due to the provider in the reporting period in which those payments are recovered.

CMS has taken the position that uncollected accounts that are referred to a collection agency cannot be claimed for bad debt reimbursement until the collection agency returns the accounts to the provider. After CMS' position became known, many hospitals altered their bad-debt claiming practices and did not claim bad debts until they were returned by the collection agency. However, many other hospitals continued to claim bad debts referred to a collection agency in the year they were referred to the collection agency, based on their conclusion that such bad debts were uncollectible at the time of referral and therefore met the requirements for claiming.

The Bad Debt Moratorium

In 1987, in response to policy changes proposed by the Inspector General of the U.S. Department of Health & Human Services, Congress enacted what became known as the "Bad Debt Moratorium."⁶ This statute prohibits CMS from making any changes to the policies regarding reimbursement for Medicare bad debts that were in effect on August 1, 1987, including any change in the criteria for what constitutes a "reasonable collection effort."

In 1988, Congress amended the Bad Debt Moratorium to prohibit CMS from making any policy change with respect to bad debts referred to an external collection agency.⁷

In 1989, Congress amended the Bad Debt Moratorium again, prohibiting CMS from requiring a hospital to change its bad debt collection policy if the hospital's Medicare intermediary had accepted such policy before August 1, 1987.⁸

The Foothill Hospital Decision

In 2008, the D.D.C. considered the validity of CMS' policy requiring the disallowance of Medicare bad debts referred to a collection agency. In *Foothill Hospital-Morris L. Johnson Memorial v. Leavitt*,⁹ the hospital had claimed bad debts on its Medicare cost report in the year during which the bad debts were referred to an outside collection agency. The Medicare intermediary disallowed the bad debts based on its conclusion that the bad debts could not be considered worthless as long as collection efforts continued. The hospital appealed the intermediary's disallowance to the Provider Reimbursement Review Board (PRRB), which ruled in the hospital's favor.¹⁰ However, the CMS Administrator reversed the PRRB's decision and upheld the intermediary's disallowance of the bad debts.¹¹

In *Foothill Hospital*, the D.D.C. first considered the threshold question of whether the Bad Debt Moratorium limits CMS' ability to change its policies related to bad debts. The court noted that previous cases discussing the Bad Debt Moratorium had focused on providers' bad debt policies, rather than on the government's bad debt policies. The court held that the "plain meaning" of the Moratorium is that CMS "is prohibited from making any changes in the agency's bad debt policy as it existed as of August 1, 1987." The court noted that the Moratorium had been amended to incorporate a prohibition regarding CMS' ability to change an individual hospital's bad debt policy, but that there was nothing to suggest that the amendment was intended to change the meaning of the 1987 Moratorium with respect to CMS' bad debt policies. Thus, the D.D.C. held that the Moratorium prevents CMS from changing the agency's bad debt policies that were in effect on August 1, 1987, regardless of an individual hospital's practices.¹²

The D.D.C. in *Foothill Hospital* next examined whether CMS' policy prohibiting the reimbursement of bad debts referred to an outside collection agency constituted a change in policy that was made after August 1, 1987. CMS argued that its policy is clearly set forth in Section 4198 of the Medicare Intermediary Manual, which provides as follows:

If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.

The D.D.C. concluded that Section 4198 could not be applied against the hospital because it constituted a new rule when it was promulgated in 1989, after Congress had enacted the Bad Debt Moratorium. The court noted that the heading for Section 4198

clearly states “NEW POLICY – EFFECTIVE DATE: For Prospective Payment System (PPS) cost report audits performed after 10/12/89.”¹³

CMS next argued that it was not necessary for the CMS Administrator to rely on the Medicare Intermediary Manual because the regulatory criteria constitute a bar to reimbursement for bad debts held by a collection agency. To support this contention, CMS relied on the district court decision in *Battle Creek Health System v. Thompson*,¹⁴ which upheld a fiscal intermediary’s finding that the regulations prohibit reimbursement for bad debts held by a collection agency. The *Foothill Hospital* court rejected this argument for several reasons. First, *Battle Creek* did not address the applicability of the Bad Debt Moratorium. Second, in 1995 the CMS Administrator issued a decision approving a bad debt claim even though a collection agency was still working on the account.¹⁵ The court found that the CMS Administrator’s decision in *Battle Creek* did not provide any evidence of policies existing before the date of the Bad Debt Moratorium.

The D.D.C. found that several agency sources predating the Moratorium suggested that CMS’ policy denying reimbursement of bad debts referred to a collection agency was contrary to its policy in effect on August 1, 1987. The court thus concluded that the “blanket prohibition against reimbursement while collection efforts are ongoing constitutes a change in policy, for this policy did not exist prior to the effective date of the moratorium.”¹⁶

Therefore, the D.D.C. in *Foothill Hospital* determined that CMS’ prohibition of reimbursement of bad debts referred to a collection agency constituted a change in policy in violation of the Bad Debt Moratorium, and was therefore invalid. CMS filed an appeal of the *Foothill Hospital* decision, but withdrew its appeal prior to briefing.¹⁷

The District Hospital Partners Decision

Despite its loss in the *Foothill Hospital* case, CMS continued to deny reimbursement for bad debts referred to a collection agency until the collection agency returned the bad debts to the provider. On March 26, 2013, the D.D.C. issued a second decision, *District Hospital Partners, L.P. v. Sebelius*,¹⁸ in which it again held that CMS’ policy violates the Bad Debt Moratorium.

The hospitals in the *District Hospital Partners* case sought reimbursement of Medicare bad debts that had been claimed in the hospitals’ 2003, 2004, and 2005 cost reports. The Medicare intermediary disallowed the claimed bad debts, declaring that an ongoing collection effort at an outside collection agency indicated that the bad debts were not yet deemed worthless. The hospitals appealed to the PRRB, which issued a unanimous decision holding that the hospitals properly claimed the uncollectible accounts as bad debts even though the accounts were still at an outside collection agency.¹⁹ The CMS Administrator issued a decision reversing the PRRB and upholding the intermediary’s disallowance of the hospitals’ claimed bad debts.²⁰ The CMS Administrator asserted that CMS has “always required that a provider demonstrate that its collection efforts were reasonable and, therefore, there has been no change in CMS policy.”

The D.D.C. in *District Hospital Partners* concluded, as it did in the *Foothill Hospital* case, that the disallowance of bad debts referred to a collection agency violates the first prong of the Bad Debt Moratorium. The D.D.C. concluded that the CMS Administrator’s finding that the policy was in place prior to the effective date of the Moratorium was not supported by substantial evidence.

In reaching its conclusion, the D.D.C. reviewed the evidence cited by CMS in support of its argument that the bad debt policy existed prior to the enactment of the Bad Debt Moratorium. CMS



first argued that the bad debt regulation, issued in 1966, includes an “inherent” presumption that bad debts referred to a collection agency could not be claimed until returned by the collection agency. The D.D.C. found that the wording of the regulation fails to support such an interpretation.

CMS next argued that the PRM provisions, on their face, require the policy in question. However, the D.D.C. found that the language of the PRM does not set forth any such policy and, in fact, tacitly contradicts it. The D.D.C. noted that the PRM provides that a provider may use a collection agency as part of a “reasonable collection effort.” The D.D.C. further noted that the PRM provides that a bad debt may be claimed if the provider has made “reasonable and customary attempts” to collect a debt for 120 days, and that this provision does not exclude debts that remain at collection agencies.

CMS next argued that the 1989 Medicare Intermediary Manual Transmittal (Transmittal) supported the agency’s position that the policy in question existed before the Bad Debt Moratorium. The D.D.C. noted that the 1989 Transmittal was the first time that the policy actually appeared in writing, and that this was two years after the Bad Debt Moratorium went into effect. The D.D.C. concluded that CMS’ identification of the Transmittal as setting forth “New Policy” contradicted CMS’ argument.

CMS also argued that two memoranda written in 1990 by the Health Care Financing Administration (the same operational entity now known as CMS) supported its argument. The D.D.C. concluded that a close look at the language of the memoranda squarely contradicts CMS’ assertion that its policy was in place in 1990, much less before the Bad Debt Moratorium became effective three years earlier in 1987.

CMS also attempted to rely on a Joint Signature Memorandum (JSM) that was issued on May 2, 2008. The D.D.C. found that the JSM cited no pre-1987 evidence in support of its statement that CMS had a policy disallowing reimbursement of bad debts referred to a collection agency prior to the Bad Debt Moratorium. The D.D.C. stated that “[t]he JSM demonstrates that, twenty years after the Moratorium went into effect, the agency had still not succeeded in adequately communicating or implementing a policy that it claims was in place for over forty years.”

Lastly, the D.D.C. rejected CMS’ argument that various CMS Administrator decisions supported the agency’s position. First, CMS identified six CMS Administrator decisions between 1992 and 1997 which it contended demonstrated that the CMS Administrator had a consistent position that accounts pending at collection agencies cannot be deemed worthless. The D.D.C. noted that all of these CMS Administrator decisions postdate the Bad Debt Moratorium by several years. Furthermore, all of the cases dealt with the separate issue of whether both Medicare and non-Medicare accounts must be sent to a collection agency

for the provider to claim the uncollected Medicare accounts as bad debts, and the cases do not address when in the process a provider can claim such accounts as bad debts.

CMS also contended that three fairly recent CMS Administrator decisions support the agency’s position. However, in addition to the fact that all of these cases significantly post-date the Moratorium, the decisions were either overturned or were upheld without addressing the Moratorium issue.

The D.D.C. in *District Hospital Partners* concluded that CMS had pointed to no persuasive evidence that supported the agency’s position that the prohibition on reimbursement of bad debts referred to a collection agency was in effect prior to the Bad Debt Moratorium. Furthermore, the D.D.C. found that the only pre-1987 evidence that was identified by the parties contradicted CMS’ position. The D.D.C. therefore vacated the CMS Administrator’s decision and remanded the case to CMS for further proceedings consistent with the court’s ruling.

Additional Pending Case

There is at least one additional case in the D.D.C. that involves the same issue that was presented in the *Foothill Hospital* and *District Hospital Partners* cases, i.e., whether the Bad Debt Moratorium bars CMS’ disallowance of bad debts referred to a collection agency.²¹ That case has been fully briefed, and is currently awaiting oral arguments and the issuance of a decision.

Potential Additional Disputes Regarding Cost-Reporting Periods Beginning Before October 1, 2012

There are thousands of hospital cost reports for cost-reporting periods that began before October 1, 2012 that have not yet been audited and settled through the issuance of a Notice of Program Reimbursement by the Medicare intermediary or Medicare administrative contractor. As noted above, some hospitals altered their bad debt practices and only claimed bad debts referred to a collection agency in the year when the bad debts were returned by the collection agency. Those hospitals will likely not be impacted by the decisions in *Foothill Hospital* and *District Hospital Partners*, unless there are some cost-reporting years when they did claim bad debts at the time they were referred to a collection agency.

However, those hospitals that have continued to claim bad debts in the year they were referred to a collection agency may be subject to audit disallowances of the bad debts. At this point, it is unclear whether CMS will continue to instruct its contractors to disallow bad debts that have been referred to a collection agency. If so, there could be many additional appeals involving this issue.

Statutory Elimination of Bad Debt Moratorium Effective for Cost-Reporting Periods Beginning on and After October 1, 2012

In the Middle Class Relief and Job Creation Act of 2012, Congress amended the law to provide that the Bad Debt Moratorium has no effect for cost-reporting periods beginning on and after October 1, 2012. As discussed herein, the decisions in *Foothill Hospital* and *District Hospital Partners* were based on the D.D.C.'s conclusion that the Bad Debt Moratorium prohibited CMS' action. For cost-reporting periods beginning on and after October 1, 2012, providers could no longer rely on the Bad Debt Moratorium, but would have to argue, for example, that CMS' policy is arbitrary and capricious. Courts generally grant CMS substantial latitude in implementing statutory reimbursement principles, so a challenge to the bad debt policy as arbitrary and capricious would present an additional hurdle that was not present in the cases involving earlier cost-reporting periods. In light of Congress' elimination of the Bad Debt Moratorium for cost-reporting periods beginning on and after October 1, 2012, the author recommends that providers claim bad debts referred to a collection agency only when the collection agency returns the bad debts to the provider.

1 42 C.F.R. § 409.82.

2 42 C.F.R. § 409.83.

3 42 U.S.C. § 1395x(v)(1)(A).

4 For cost-reporting periods beginning during federal fiscal years 2001 through 2012, providers are entitled to receive 70% of their allowable bad debts. For subsequent cost-reporting periods, providers are entitled to receive 65% of their allowable bad debts. 42 C.F.R. § 413.89(h)(1).

5 42 C.F.R. § 413.89(e). The Medicare bad regulation was previously found at 42 C.F.R. § 413.80, but was redesignated to 42 C.F.R. § 413.89 in 2004. 69 Fed. Reg. 48916 (Aug. 11, 2004, effective Oct. 1, 2004).

6 As originally enacted in 1987, the Bad Debt Moratorium provided as follows:
(c) CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES. — In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of the U.S. Department of Health & Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort).

Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 § 4008, 101 Stat. 1330 (reprinted in 42 U.S.C. § 1395f note).

7 The 1998 amendment to the Bad Debt Moratorium provides as follows:
Effective as of the date of the enactment of the Omnibus Budget Reconciliation Act "42 USC 1395f note" of 1987, Section 4008(c) of such Act is amended by inserting after "reasonable collection effort" the following: ". . . including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency."
Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647 § 802, 102 Stat. 3342, 3798 (reprinted in 42 U.S.C. § 1395f note).

8 The 1989 amendment to the Bad Debt Moratorium provides as follows:
The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106 (reprinted in 42 U.S.C. § 1395f note).

9 558 F. Supp. 2d 1 (D.D.C. 2008).

10 *Foothill Presbyterian Hosp. v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. No. 2007-D11, Medicare & Medicaid Guide (CCH) ¶ 81,678 (2006).

11 *Foothill Presbyterian Hosp. v. Blue Cross & Blue Shield Ass'n*, CMS Admin. Dec., Medicare & Medicaid Guide (CCH) ¶ 81,681 (Feb. 14, 2007).

12 *Foothill Hosp.*, 558 F. Supp. 2d at 6; see also *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 798 n. 9 (9th Cir. 2003) ("Effective in August of 1987, Congress imposed a moratorium on changes in bad-debt-reimbursement policies, and the Secretary lacked authority in November of 1995 to effect a change in policy.").

13 Medicare Intermediary Manual, Transmittal No. 28.

14 423 F. Supp. 2d 755 (W.D. Mich. 2006). The district court's decision was affirmed by the Sixth Circuit in *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401 (6th Cir. 2007).

15 *Lourdes Hosp. v. Blue Cross & Blue Shield Ass'n*, HCFA Admin. Dec., Medicare & Medicaid Guide (CCH) ¶ 34,410 (Oct. 27, 1995).

16 *Foothill Hosp.*, 558 F. Supp. 2d at 10.

17 *Foothill Hosp.-Morris L. Johnson Mem'l v. Leavitt*, No. 08-5224, 2008 WL 4562209 (D.C. Cir. Sept. 19, 2008).

18 *District Hosp. Partners, L.P. v. Sebelius*, Civil Action No. 11-1717 (D.D.C. Mar. 26, 2013).

19 *Universal Health Servs., Inc. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2011-D30, Medicare & Medicaid Guide (CCH) ¶ 82,729 (2011).

20 *Universal Health Servs., Inc. v. Blue Cross Blue Shield Ass'n*, CMS Admin. Dec., Medicare & Medicaid Guide (CCH) ¶ 82,759 (July 26, 2011).

21 The pending case is *Lakeland Reg'l Health Sys. v. Sebelius*, Case No. 1:12-cv-00600 (D.D.C.).



Hospital Billing under Medicare Part B Following a Denial under Part A

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Introduction

Medicare pays for inpatient hospital services under Part A and for outpatient services under Part B. As is true for all Medicare services, a Part A inpatient stay must be medically reasonable and necessary in order to be payable.¹ Where a recovery audit contractor (RAC) or other contractor reopens a favorable claim determination under Part A for a hospital stay and denies the stay on the basis that it was not necessary for the hospital to have admitted the patient, the hospital may seek to be paid under Part B for services that would have been considered reasonable and necessary had the hospital treated the patient as an outpatient. Many of the same services a hospital furnishes to an inpatient are also payable under the Part B Outpatient Prospective Payment System.

In a frequently asked questions (FAQs) issued in 2008, the Centers for Medicare & Medicaid Services (CMS) prohibited hospitals from rebilling under Part B, except for a limited number of “ancillary services,”² and only “if all claim processing rules and claim timeliness rules are met.”³ The FAQs, which CMS insists reflects longstanding policy, and which hospitals insist was new policy, created a controversy between hospitals and CMS that is still ongoing. Until very recently, hospitals that have appealed the denial of an inpatient stay that was made on the basis that the stay was not reasonable and necessary have been successful in having the administrative law judge (ALJ) or the Medicare Appeals Council of the Departmental Appeals Board (DAB) award full payment under Part B where the ALJ has upheld the denial of the stay. In other words, the ALJs and the DAB have consistently refused to follow the FAQs and have not limited payment to the list of ancillaries. Also, the ALJs and the DAB have not required a new claim to be submitted under Part B and within the timely filing limit, but instead have held that the rules on administrative finality, rather than the rules on timely filing, apply. In March 2013, however, CMS issued a proposed rule that, if finalized, would greatly restrict hospitals’ ability to rebill under Part B.⁴ Concurrent with the proposed rule, CMS issued a CMS Ruling that essentially acquiesces in the ALJ and DAB decisions; however, the CMS Ruling is in effect only until CMS issues a final rule.⁵

This article examines the Part B rebilling issue and offers a critique of the proposed rule and the CMS Ruling.

Background

The decision of whether to admit a patient as an inpatient, or place the patient on [outpatient] observation status can be a difficult one, depending on the patient’s condition, and is made by a physician, not the hospital. Where a patient is admitted, and the hospital is paid by Medicare, and a RAC or other contractor subsequently denies the stay upon review, the hospital can choose to appeal the denial and/or bill Part B for some amount of Part B services. The operative question is, what is the range of services for which a hospital may rebill under Part B?

The question of whether hospitals may receive payment for the full range of Part B services (instead of only the limited range of “ancillary” services discussed below) has been around for a long time (perhaps since the inception of Medicare in 1965) but it has only gained prominence since the advent of the RACs. Some hospitals will say that the recent notoriety is due to a change in policy, whereas CMS insists that its “longstanding” policy has been that, following a denial of a Part A hospital stay as not being reasonable and necessary, hospitals may bill only for a limited amount of services, commonly referred to as the “ancillary” services.

Section 10 of Chapter 6 of the Medicare Benefit Policy Manual states that payment may be made under Part B for physician services and for certain non-physician medical and other health services when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. The listed services, known as the ancillary services, are only a subset of the total range of services that provide to hospital patients that are payable under Part B.⁶ The provision in the Medicare Benefit Policy Manual was originally in Section 3110 of the Intermediary Manual, and appeared as early as July of 1987. CMS also refers to the list of ancillary services as the Part B inpatient services. It is not clear what authority CMS relies on to pay for inpatient services under Part B. Payment for hospital services under Part B is normally only for outpatient services. Provisions in Section 1833 of the Social Security Act (42 U.S.C. Section 1395l) do provide for payment under Part B for certain inpatient hospital services, including “inpatient hospital services designated by the [U.S. Department of Health & Human Services] Secretary,” but payment for such services appears to be limited to situations in which the patient has exhausted his/her entitlement to Part A benefits or was not entitled to Part A benefits in the first place.⁷ It should also be noted that the provisions in Section 1833 of the Social Security Act were added by the Balanced Budget Act of 1997,⁸ whereas, as mentioned above, the list of ancillary services has existed since at least 1987.

In 2005, CMS began the RAC demonstration program that was mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).⁹ Congress directed the Secretary to conduct a three-year demonstration program using RACs to detect and correct improper payments in the Medicare fee-for-

service program. The statute provided that RACs would be paid a contingency fee based on the amount of improper payments. In order to recover payments, the RACs would reopen and revise a favorable claim determination and create an overpayment. The revised determination would be subject to appeal. Under the demonstration, hospitals were allowed to rebill Part B for all reasonable and necessary services. The demonstration operated in New York, Massachusetts, Florida, South Carolina, and California and ended on March 27, 2008.

Even before the RAC demonstration was over, Congress required that the RAC program be made permanent, beginning in 2010.¹⁰ In preparation for the permanent program, CMS issued a FAQs in November 2008 that said that, following a denial of a Part A hospital stay, hospitals would be limited to billing Part B for the list of ancillaries in the Medicare Benefit Policy Manual, and must file the claim within the timely filing limit, as measured from the date of services provided to the beneficiary.

At the time the FAQs were issued, the timely filing period was 15-27 months.¹¹ Even with this extended period for filing claims, it would already be too late, in the great majority of cases, for a hospital to rebill under Part B, because the RAC's reopening would typically occur after the timely filing period had already expired. However, in the Patient Protection and Affordable Care Act (the 2010 healthcare reform statute), Congress limited the timely filing period to 12 months from the date of service (although it also authorized the Secretary to promulgate exceptions to the time limit).¹² Because of the FAQs, hospitals were at risk for not getting paid for services they provided.

The inability to rebill Part B within the timely filing limits forced hospitals into having to appeal the Part A denial.

Litigation

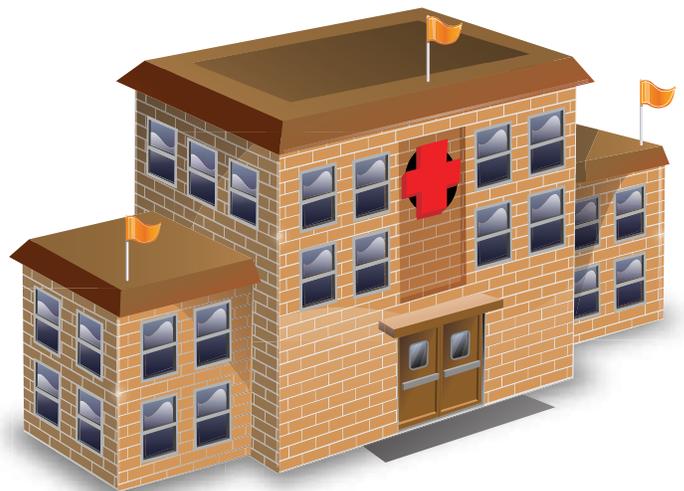
Once the hospitals started appealing the RAC denials, a pattern began to emerge. In some cases, the RAC's denial of Part A coverage would be reversed. In many cases, however, the RAC's denial of Part A coverage would be upheld at the ALJ level of appeal,¹³ and the ALJ would order full Part B payment to be made. In fact, in virtually every case in which an ALJ upheld the denial of Part A coverage, the ALJ ordered that full Part B payment be made. Likewise, in the few cases that have reached it, the DAB has also ordered that full Part B payment be made.¹⁴ The ALJs and the DAB have not interpreted Section 10 of Chapter 6 of the Medicare Benefit Policy Manual as limiting payment to the list of ancillary services. Instead, the ALJs and the DAB have focused on other language in the Manual that says that when a Part A overpayment has been made, Medicare contractors are to ascertain whether the beneficiary is entitled to any Part B payment for the service at issue and, if so, Part B billings should be permitted and/or offset against the Part A overpayment.¹⁵ For example, in the *UMDNJ* case, the DAB stated:

When the intermediary reopened the determinations on the initial claims at issue here, it had the same plenary authority to process and adjudicate each claim as it did when that claim was first presented and paid. The intermediary needed only supplementary information in order to process a Part B claim for the very same items and services identified with specificity on the original Part A claim. As specified in the [Medicare Intermediary Manual], the intermediary should have undertaken any necessary actions needed to process a claim under Part B rather than Part A, and thus offset any Part A overpayment.

UMDNJ—University Hospital v. Riverbend GBA

The ALJs and the DAB also have not found that the limitations of timely filing present a problem. Instead, they have relied on Manual language that says that, where a claim has been reopened, the rules on administrative finality apply, and that under the adjustment bills process, a new claim does not need to be filed, but rather the Part B payment may be made as an adjustment to the original Part A claim.

In response to the number of ALJ decisions that upheld a RAC denial of Part A services but required payment for services under Part B, CMS issued a technical decision letter on July 13, 2012 that clarified that contractors are, in fact, required to follow ALJ rulings and to make payment upon an ALJ's award of Part B payment.¹⁶ The letter indicated that "the ALJ's order is in conflict" with CMS policy as outlined in the Medicare Benefit Policy Manual and that the conflict created by the ALJ decisions has "caused operational difficulties." However, CMS acknowledged that it is "bound to effectuate each individual decision" issued by the ALJ and the DAB. Therefore, the letter instructed claims administration contractors to contact the hospital within



30 calendar days of receipt of the effectuation notice to secure a new replacement claim with appropriate outpatient codes. Under the directions in the letter, a hospital had 180 days after being contacted by the contractor to produce the replacement claim for payment. The letter also explicitly instructed contractors to “bypass or override timely filing requirements” to issue payment, which was a pragmatic acknowledgment that by the time a Part A claim is denied and appealed, the one-year post-treatment filing requirement is likely to have passed.

On November 1, 2012, because of their dissatisfaction with CMS’ policies on the rebilling under Part B where a Part A stay has been denied, the American Hospital Association and four member hospitals brought suit against the Secretary. The plaintiffs claim that hospitals have a statutory right to be paid for reasonable and necessary services and that such right is being denied by CMS’ policies. The suit is pending.¹⁷ Also, in contrast to CMS’ concerns that hospitals may admit patients as inpatients who should instead be given care at the outpatient observation level, beneficiary advocacy organizations have brought a nationwide class action suit against the Secretary contending that the use of observation status violates the Medicare Act, the Freedom of Information Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment to the Constitution, and harms patients who are not admitted and therefore do not have the requisite three-day (at least) inpatient stay necessary to qualify them for post-discharge skilled nursing facility (SNF) benefits.¹⁸

The 2012 Part A to Part B Rebiling Demonstration Project

In November 2011, in response to the continuing controversy over its policy of limiting Part B payment to the list of ancillary services following a denial of a Part A stay, and in an effort to diminish the appeals workload and attendant costs to the hospitals and the contractors, CMS announced a three-year demonstration project related to Part B rebilling. The demonstration was limited to 380 hospitals, on a first-come, first-serve basis, and was to run from January 1, 2012 through December 31, 2014 (but has been terminated early, as noted below). Demonstration participants would be allowed to rebill Part B for the full range of Part B services that were reasonable and necessary, instead of just the list of ancillary services, but would receive only 90% of the payment for such services, and were limited to collecting the lesser of the Part A or Part B co-insurance amounts.¹⁹ More significantly, hospital participants in the demonstration project were required to waive their right to appeal the denial of the Part A stay. Thus, a hospital considering whether to apply for participation in the demonstration was required to weigh the possible benefit of receiving 90% of the payment for the full range of Part B services (instead of the 100% payment for the full range of Part B services it was virtually guaranteed through an ALJ decision, minus the costs of appeal) versus the potential detriment of giving up the possibility of receiving somewhat increased

payment under Part A if the hospital was successful in an appeal of the denial of the Part A stay.

Adding to the consideration of whether to apply for participation in the demonstration was the concern that the RACs would know (through their receipt of their contingency fees) which hospitals were participating in the demonstration, and thereby could make questionable denials of Part A stays without fear that the hospitals could appeal them. It was because hospitals were required to give up their appeal rights that many hospitals chose not to apply for participation in the demonstration.²⁰ Interestingly, CMS usually invokes its demonstration authority in situations where it does not have statutory authority to make payment in the manner provided for under the demonstration, and usually identifies the statutory provision or provisions that prevents it from making payment in such manner absent a demonstration. The fact that CMS did not do so for the Part B rebilling demonstration reinforced hospitals’ beliefs that there was no legal impediment to CMS making a full Part B payment after a Part A stay has been denied.

The 2013 CMS Ruling and Proposed Rule

On March 18, 2013, CMS published CMS Ruling 1445-R²¹ (Ruling) and Proposed Rule 11455-P,²² both of which address billing procedures following denial for Part A inpatient admission due to a finding of a lack of medical necessity. Both the Ruling and the proposed rule diverge from CMS’ professed longstanding position described above that, except for a limited list of so-called Part B inpatient services (also known as the ancillaries), a hospital cannot be paid under Part B following a denial for Part A inpatient admission, even if services were medically necessary and would have been paid if they had been initially billed as outpatient services. However, whereas both the Ruling and proposed rule formally align with outcomes in the appeal process in which hospitals have been largely successful in pursuing payment under Part B following denial under Part A, practically, the proposed rule is unlikely to yield the same results due to the challenges posed by its proposed timeline for rebilling under Part B.

The Ruling provides that when a Part A claim is denied for lack of medical necessity for inpatient admission, the hospital may either pursue payment through the administrative appeals process, or withdraw the appeal and submit claims for coverage of Part B services. If a hospital chooses to pursue administrative appeals and is ultimately unsuccessful on its Part A claim, it may still rebill under Part B. The Ruling provides for a 180-day window within which to file a Part B inpatient claim, and a Part B outpatient claim (for the so-called outpatient-only services that were furnished prior to admission). The 180-day period for submitting Part B claims begins on the date of receipt of the final unfavorable appeal decision or, in the event the appeal is withdrawn, receipt of the dismissal notice. The Ruling does not allow hospitals to resubmit a claim upon the hospital’s internal review indicating an unnecessary inpatient status.

The Ruling is effective upon issuance, but remains in effect only until the effective date of a final rule. It applies to Part A hospital inpatient claims that were denied by a Medicare review contractor because the inpatient admission was determined not reasonable and necessary, provided that the denial was made: (1) while the Ruling is in effect;²³ (2) prior to the effective date of the Ruling, but for which the timeframe to file an appeal has not expired; or (3) prior to the effective date of the Ruling, but for which an appeal is pending. The Ruling explicitly addresses the conflict between previous CMS policy and ALJ/DAB rulings and rejects DAB authority to order payment under Part B following denial of payment for medically unnecessary inpatient services under Part A stating that “an appeals adjudicator’s scope of review is limited to the claim(s) that are before them on appeal, and such adjudicators may not order payment for items or services that have not yet been billed or have not received an initial determination.”²⁴ Therefore, for all appeals to which the Ruling applies, the ALJ and DAB may not order payment of Part B services that a hospital has not yet claimed, discontinuing the method that has proven most successful for hospitals seeking Part B payment after being denied under Part A. In other words, new claims under Part B must be filed.

Substantively, the proposed rule is in sync with the Ruling insofar as both provide a method to seek more Part B payment following Part A denial than what is allowed under current CMS policy. If the proposed rule is finalized as is, however, its implementation may not result in greater Part B payments, largely due to the filing deadlines contained in the proposed rule.

First, unlike the Ruling, the proposed rule would require that, following a Part A denial, a Part B inpatient claim and/or Part B outpatient claim must be filed within the existing claim filing deadline of one year after the date of service.²⁵ Because most Part A denials will occur through a reopening by a RAC or other contractor more than a year after the date of service, hospitals effectively would be denied the ability to file a Part B claim and would no longer enjoy the provider-positive decisions that have been issued during the appeals process. CMS explains in the proposed rule that, because a new claim must be filed, it is not appropriate to use the current adjustment bill process (which does not require a new claim to be filed within the timely filing limit). CMS does not explain why it would not modify its adjustment bill rules, or consider the original Part A claim to be a protective filing for later Part B claims, or amend the regulations to create an exception to the timely filing limits so as not to prevent hospitals from rebilling. In addition, to the extent a hospital wished to ensure some form of payment by filing a Part B claim as provided for under the proposed rule, it would be required to abandon the outstanding Part A appeal. Moreover, like the Ruling, the proposed rule would limit ALJ/DAB authority to compel payment under Part B when faced with a question of Part A coverage determinations.

The second key difference between the Ruling and the proposed rule is that the proposed rule would allow hospitals to submit Part B claims following an internal discovery of an improper Part A

inpatient admission, provided these claims are filed within one year of the date of service. This proposed provision, if adopted, may create an incentive for hospitals to self-audit Part A claims that could be deemed lacking medical necessity, so that they may file timely Part B claims and avoid the risk that they may at some future date receive a denial of the Part A claim by a RAC or other contractor long after the timely filing period has expired.

At the 2013 AHLA Medicare and Medicaid Institute, a CMS representative indicated that the proposed rule would allow hospitals to submit a Part B inpatient bill for ancillary services and a Part B outpatient claim for the other services that were reasonable and necessary and delivered while the patient was an outpatient. However, the proposed rule would *not* allow hospitals to change patient status (outpatient or inpatient) after patient discharge²⁶ as a result of an internal review that reveals an improper Part A inpatient admission. In part, CMS’ position is designed to protect the beneficiary’s right to receive SNF stay coverage, which is only allowed after a minimum three-day inpatient stay.²⁷ However, beneficiary liability is more likely to increase under the proposed rule; currently, when a Part A claim is denied, a beneficiary is refunded any copayments paid for services billed under Part A. Under the proposed rule, the beneficiary would still be refunded any copayments for services billed under Part A, but would be responsible for Part B copayments and the full cost of drugs that are usually self-administered (and therefore, not covered under Part B). Because hospital pharmacies are rarely Medicare Part D (which in most cases should cover these outpatient drugs) network pharmacies, the proposed rule recognizes that beneficiary copayments may be higher under the proposed rules.

Conclusion

Both the Ruling and proposed rule address the ongoing conflict between CMS policy and ALJ/DAB rulings. However, the timely filing restriction in the proposed rule, if adopted in a final rule, may have the effect of reversing the hospitals’ ability to receive Part B payments that they have successfully obtained through the appeals process.²⁸ Although it is too early in the process to be certain of the outcomes of implementing the Ruling or proposed rule, hospitals will undoubtedly urge CMS to revise the proposed rule so that the final rule will not include the timely filing restriction. Alternatively, they may wish that no final rule is ever issued, which would allow the Ruling to stand.

**The authors gratefully acknowledge the thoughtful review by Andrew Wachler of Wachler & Associates PC of a draft of this article.*

1 Section 1862(a)(1)(A) of the Social Security Act (Act), 42 U.S.C. § 1395y(a)(1)(A), provides that “[n]otwithstanding any other provision of [title xviii] no payment may be made under Part A or Part B for any expenses incurred for items or services [that] are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Despite the absolute language of this section, under the limitation of liability provisions of Section 1879 of the Act, 42 U.S.C. § 1395pp, Medicare will pay a provider or supplier for an item or service that is not

- medically reasonable and necessary if the provider or supplier can establish that neither it nor the beneficiary knew or reasonably should have known that the item or service was not payable.
- 2 The list of ancillaries appears in Section 10 of Chapter 6 of the Medicare Benefit Policy Manual (CMS Pub.100-02).
 - 3 FAQ 9462, issued November 2008, stated:
 - Q. If I receive a demand letter from a Recovery Audit Contractor (RAC) because a service didn't meet Medicare's medical necessity criteria for an inpatient level of service, can we re-bill all the services on an outpatient claim?
 - A. Providers can re-bill for Inpatient Part B services, also known as ancillary services, but only for the services on the list in the Benefit Policy Manual. . . . Rebilling for any service will be allowed only if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the national program.
 - 4 CMS-1455-P, 78 Fed. Reg. 16632 (Mar. 18, 2013).
 - 5 CMS-1455-R, 78 Fed. Reg. 16614 (Mar. 18, 2013). Note that the Ruling does not acquiesce in the ALJs' and DAB's treatment, or the treatment of the CMS July 13, 2012 Technical Direction Letter (discussed below), that the inpatient order should be deemed an order for outpatient observation. CMS-1455-R, 78 Fed. Reg. 16614 at 16616 (Mar. 18, 2013).
 - 6 The services listed in the Medicare Benefit Policy Manual are: diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy, including materials and services of technicians; surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations; prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices; leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy; screening mammography services; screening pap smears; influenza, pneumococcal pneumonia, and hepatitis B vaccines; colorectal screening; bone mass measurements; diabetes self-management; prostate screening; ambulance services; hemophilia clotting factors for hemophilia patients competent to use these factors without supervision; immunosuppressive drugs; oral anti-cancer drugs; oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and epoetin alfa (EPO).
 - 7 See Sections 1833(t) (1)(B)(ii), (a)(8) of the Social Security Act, 42 U.S.C. §§ 1395l(t)(1)(B)(ii), (a)(8).
 - 8 Pub. L. No. 105-33.
 - 9 Pub. L. No. 108-173, § 306.
 - 10 Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302.
 - 11 42 C.F.R. § 424.44 (2008).
 - 12 Pub. L. No. 111-148, § 6404(b)(2).
 - 13 The ALJ level is the third level of appeal in the claims determination appeals process. It is preceded by the redetermination and reconsideration levels. Following an ALJ's decision or dismissal, the provider (or supplier) and CMS may ask for review by the Medicare Appeals Council of the DAB. The DAB is the final level of appeal in the administrative appeals process. See 42 C.F.R., Part 405, Subpart I.
 - 14 See, e.g., In the Case of *O'Connor Hosp. v. National Gov't Servs.*, Medicare and Medicaid Guide (CCH), paragraph 122,133 (Feb. 1, 2010) (declining review of ALJ decision), available at www.hhs.gov/dab/divisions/medicareoperations/macdecisions/oconnorhospital.pdf (last visited Apr. 7, 2013); In the case of *UMDNJ – University Hosp. v. Riverbend GBA*, Medicare and Medicaid Guide (CCH), paragraph 120,770 (Mar. 14, 2005), available at www.dhhs.gov/dab/macdecision/umdnj.htm (last visited Apr. 7, 2013).
 - 15 Medicare Financial Management Manual (CMS Pub. 100-06), Ch. 3, § 170.1. See also Medicare Claims Processing Manual, Ch. 29, § 170.1.
 - 16 CMS Technical Decision Letter 12309, 03-28-12 (July 13, 2012).
 - 17 *American Hosp. Ass'n v. Sebelius*, No. 1:12-cv-1770 (D.D.C.). The complaint is available at www.aha.org/content/12/121101-aha-hhs-medicare-com.pdf, last accessed on Apr. 7, 2013.
 - 18 *Bagnall v. Sebelius*, No. 3:11-cv-01703 (D. Conn) (filed Nov. 3, 2011).
 - 19 It is not unusual, upon rebilling under Part B, for the Part B copayments for the full range of Part B services to equal or exceed the Part A copayments for the hospital stay that was denied.
 - 20 Hospitals that chose to apply for, and were accepted for participation in, the demonstration, could cancel their participation at any time.
 - 21 CMS-1455-R, 78 Fed. Reg. 16614 (Mar. 18, 2013). A CMS Ruling is binding on all administrative-level adjudicators, including ALJs and the DAB. See 42 C.F.R. § 405.1063(b).
 - 22 CMS-1455-P, 78 Fed. Reg. 16632 (Mar. 18, 2013). A "condition code" is an entry on the UB-04 claim form, or electronic equivalent, which describes conditions or events that apply to that billing period.
 - 23 Presumably this means that if the denial were to occur prior to the effective date of a final rule, and the hospital were to appeal timely the denial after a final rule became effective, the Ruling's provisions on when a Part B claim must be filed, and not the timely filing restriction of the proposed rule (if adopted) would control. The proposed rule is not clear on this point, however.
 - 24 CMS-1455-R, 78 Fed. Reg. 16614 at 15 (Mar. 18, 2013).
 - 25 Consistent with the Ruling, the proposed rule takes the position that where the Part A stay is denied, the three-day payment window restriction on billing separately Part B services prior to an admission by the same hospital as where the Part B services were furnished would not apply.
 - 26 CMS' Condition Code 44 policy allows hospitals to change the beneficiary's status from inpatient to outpatient if: (1) the change in status is made prior to discharge; (2) the hospital has not submitted a Medicare claim for the admission; (3) both the practitioner responsible for the care of the patient and the utilization review committee concur with the decision; and (4) the concurrence is documented in the medical record. Medicare Claims Processing Manual (CMS Pub. 100-04). Ch.1, § 50.3; MLN Matters article SE0622, Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient," Sep. 2004), available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0622.pdf (last accessed Apr. 7, 2013).
 - 27 Although a beneficiary must have had an inpatient stay of three days or more that was *reasonable and necessary* to qualify for post-discharge SNF benefits, CMS avoids finding the SNF stay to be noncovered, despite the denial of the Part A stay as not being reasonable and necessary, by interpreting a Manual provision as saying that the SNF stay will be permitted unless the hospital's decision to admit the patient was far outside the norm of what constitutes reasonable and necessary. See Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 8, § 20.1.
 - 28 AHA released a statement following the proposed rule that it remains concerned that CMS' proposed rule would limit the ability of hospitals to rebill and would not fully reimburse them for all reasonable and necessary services provided, and that it plans to press ahead with its lawsuit. AHA's Special Bulletin is available at www.aha.org/presscenter/pressrel/2013/130314-pr-rebilling.pdf (last accessed Apr. 8, 2013).

Chair's Corner

Volunteerism and Leadership

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Around the time this *RAP Sheet* is published, AHLA's annual reappointments and changes in leadership within all of its Practice Groups, including the Regulation, Accreditation, and Payment Practice Group (RAP PG), will become effective. I have been given the honor to pen this column as one of my first near-official acts as the new chair of the RAP PG.

It seems apropos to highlight two concepts—volunteerism and leadership. They are the bedrock of AHLA service to its members—without them, there would be no AHLA, no PGs, no educational content. Volunteering and leading are obviously different concepts; yet in practice, they can be almost indistinguishable. One begets the other.

Barry Alexander is a great example. He provided six years of service as a RAP PG vice chair, three years of service as chair, and countless contributions of speaking, moderating, writing, and behind-the-scenes orchestration of high-quality content for RAP PG and other AHLA members. He learned from the best, RAP PG leadership predecessors such as **Andy Ruskin**, **Eric Zimmerman**, and **Dinetia Newman**. Each a great volunteer, each a tremendous leader.

Quick-witted **Ken Marcus** brought many things to the table in his six years of service as a vice chair within the RAP PG. He rotated through each of the vice chair positions and similarly chipped in to the content kitty repeatedly, and was always able to find time for a pun or wise crack. He's not finished either—he's taking his talents to the Steering Committee. Ken has been tapped by AHLA's Membership Committee to be the chair of a new Steering Committee to explore the development of a Lifetime Leadership Council. Volunteerism, leadership, hand in hand.

RAP PG's Volunteer of the Year for 2012-2013, celebrated at the Medicare and Medicaid Institute in Baltimore in March, was **Jeanne Vance**. All she did was *volunteer to lead* the creation and launch of a new RAP PG sub-group, the Accreditation, Certification, and Enrollment Affinity Group (ACE

AG). Through a year of its existence, the ACE AG has put on a webinar and an educational call, and developed a robust webpage of resources (including summaries of 2012 and 2013 Department Appeals Board and Civil Remedies Division decisions affecting provider enrollment, a state-by-state contact list for certification and enrollment agencies, a Medicare and Medicaid provider enrollment toolkit, and state Medicaid enrollment updates appearing in issues of *The RAP Sheet*, including this one). Amazingly, all of this was done in just one year! Of course, Jeanne did not do all of this herself, but she did *lead* a strong team of volunteers, including ACE AG vice chairs **Jennifer Benedict**, **Emily Cook**, **Allen Killworth**, and **Ross Sallade**.

Space will not allow me to adequately feature the efforts of **Judy Waltz** and her team of Editorial Board, Member Briefing, and *The RAP Sheet* volunteers, **Jeff Moore** and his massive band of toolkit authors and editors and monthly email alert updaters, **Claire Miley** and her army of tweeters (you should really be following us on Twitter @AHLA_RAPture), or the wave of speakers and moderators who presented RAP PG's eight-part reimbursement bootcamp webinar series.

Each of these individuals bears the marks of volunteerism, leadership by service and example, and selflessness that make this association great. Ask each of them how it all started, and usually the answer is remarkably simple: volunteering to write an article, do email alerts, or moderate a webinar. Volunteerism becomes leadership. Tomorrow's leaders are probably already off to that simple start.

How do you measure the value of volunteerism and leadership? Moreover, how do you adequately express gratitude for it? Those of us whose lives are tracked in tenths and quarters of an hour can count the number of hours, but that only measures time, not value. Counting the number of presentations, articles, or emails measures output, not value. And even if some value could be ascribed to time or output, it would not capture the effect on the recipients and the example each of these leaders set for those of us who follow them. It is, sadly, impossible to truly measure the value of and adequately express our thanks for all of these efforts.

Thanks to each of you, whether named here or not, for your volunteering efforts and leading the RAP PG—not only for your service but as much for your example.

Jim

Incoming Chair, RAP PG

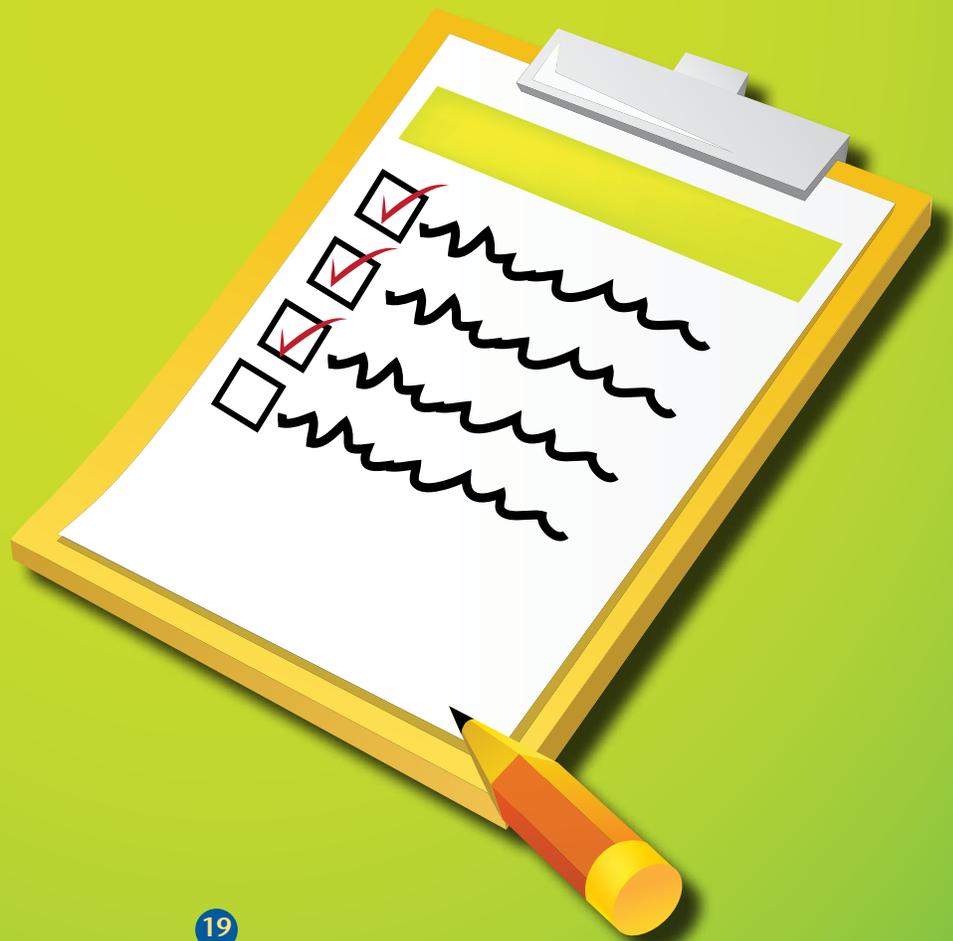
We Need Your Feedback: Survey

Staffing, Spending, and Compensation

The In-House Counsel Practice Group and General Counsel (GC) Metrics LLC invite you to take part in this year's **staffing, spending, and compensation survey**. This free, confidential survey provides benchmarks on legal department staffing and spending, with a page dedicated to health systems. At the **In-House Counsel Program** in San Diego, GC Metrics will present updated benchmarks as well as preliminary compensation results. If you submit your department's data later, you will be sent a subsequent release.

To participate, **access** the survey and simply enter your **six fiscal year 2012 figures on staffing and spending**, and complete the compensation table.

Thank you for your participation!



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