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MEDICAID-RATE SETTING AFTER BOREN

by: Kimber L. Latsha, Esquire

In 1980, Congress passed the Boren Amendment to the Social Security Act. The intent behind the Amendment was to grant states greater flexibility in complying with the Health Care Finance Administration’s oversight of state Medicaid programs, and to help move states away from the inflationary nature of cost-based reimbursement. One of the effects of the Boren Amendment was to create a federal cause of action against states if Medicaid rates were not reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with applicable laws and regulations, as well as applicable quality, safety, and health standards. Because the Boren Amendment failed to fulfill its main objective, the Amendment was repealed by the Balanced Budget Act of 1997, and its substantive and procedural provisions were replaced by a new public notice and comment requirement.

Among the chief concerns in the post-Boren landscape is that substantive challenges to a state’s rate-setting methodology or challenges to the adequacy of the rates will no longer be viable. States rely on portions of the legislative history of the Balanced Budget Act, which suggest that no provision of the Social Security Act which formerly contained the Boren Amendment should be interpreted to give providers a right of action to challenge Medicaid rate adequacy. However, the Balanced Budget Act changed only a few isolated parts of the section formerly containing the Boren Amendment, therefore possibly leaving the door open to providers’ substantive challenges.

(See **MEDICAID**, p.3)

PROACTIVE AND PROGRESSIVE COLLECTIONS

by: Jason L. Swartley, Esquire

The most effective collection tools are due diligence and persistence. The only thing worse than owing a creditor money is being a creditor trying to collect money. Often, creditors have difficulty collecting money because they don’t fully understand the benefits of a collection system. A well-developed collection system identifies delinquent balances and facilitates prompt action by the creditor. This is called due diligence.

Due diligence assists the creditor in the identification of delinquencies while also enabling the creditor to take the next progressive step in the collection process. For example, if a 30-day delinquency is identified, a polite collection letter is warranted. On the 45th day of delinquency, a phone call may remind the responsible individual of the delinquency. Once the delinquency reaches 60 days, a harsher and more demanding letter is necessary. On the 90th day of delinquency, referral for legal action is prudent. Such a collection system assists the creditor in the collection of the outstanding balance in several ways. First, progressively more aggressive collection steps will ensure that the debtor knows the creditor is serious about the collection of the debt while identifying for the debtor the increasingly severe penalties for non-payment. Second, a general principle of conflict resolution and management is that each conflict should be resolved individually lest a larger, more unmanageable conflict result.

Collection of a debt involves conflict! A large \$50,000 conflict occurring over 24 months may start as merely a \$1, \$100, or \$1,000 conflict. In many instances,

(See **COLLECTIONS**, p.3)

ENFORCEMENT SANCTIONS ARE EXPECTED TO INCREASE

by: *Edward G. Cherry, Esquire*

The Health Care Financing Administration ("HCFA") has made changes to the federal certification enforcement process that may make it easier for nursing facilities to incur sanctions. There are two reasons for the expected increase in sanctions: 1) HCFA has recently changed the method of designating a facility as a "Poor Performing Facility"; and 2) HCFA has instituted a new type of civil money penalty ("CMP").

On September 22, 1998, HCFA issued memoranda to the Regional Administrators and State Survey Agency Directors relating to the designation of Poor Performing Facility. If a facility has at least one deficiency which is a "G" or higher on the Enforcement Grid during the current survey, and the facility had at least one deficiency that was a "G" or higher on the previous survey, then the facility will be classified as a Poor Performing Facility. Previously, the facility was not designated as a Poor Performing Facility unless it was cited for Substandard Quality of Care on the current survey and Substandard Quality of Care on at least one of the previous two standard surveys. HCFA will phase in the change. Currently, HCFA is only looking at deficiencies classified as "H" or higher. HCFA will phase in the "G" deficiencies (i.e., an isolated finding where there is actual harm) this spring.

This change significantly expands the possibility of receiving the designation of Poor Performing Facility, and thus, the possibility of receiving immediate sanctions. The word from HCFA is that the new Poor Performing Facility definition utilizing "H" deficiencies or higher has not had a significant impact on the number of Poor Performers. That may be the case, but there should be an increase in the sanctions that facilities receive when the "G" deficiencies are phased into the process. As most facilities know, it is very easy to have consecutive surveys with an isolated deficiency that constitutes actual harm. Facilities should strongly consider challenging improper

"G" deficiencies through the Informal Dispute Resolution process even when the facility had a good survey because of the increased exposure on the subsequent survey.

HCFA also *suggests* that the State Survey Agencies look at multi-facility chains as a whole. If a facility is found to have deficiencies during a survey, and the state is aware that another facility in the same chain has been designated as a Poor Performing Facility, HCFA recommends that the facility that is currently being surveyed also be designated a Poor Performing Facility. As such, a Poor Performing Facility's compliance history can be imputed to every other facility in a chain in that state.

In addition to the increased possibility of being designated a Poor Performing Facility, effective May 17, 1999, a facility may be assessed an episodic CMP for each instance of noncompliance found during a survey. An "instance" is defined in the preamble to the regulation as a single deficiency identified by a tag number. The episodic CMP will be imposed at the time that noncompliance is documented. Unlike the traditional CMP, there will be no time period during which a facility may bring itself into compliance before the penalty is imposed.

The minimum episodic CMP will be \$1,000, and the maximum for one instance of noncompliance will be \$10,000. HCFA or the state may impose as many episodic CMPs as they deem necessary, but the limit for one facility for one survey will be \$10,000. The amount of the episodic CMP will be determined by three factors: 1) use of scope and severity to determine magnitude of noncompliance, including a determination of actual harm; 2) the facility's degree of culpability; and 3) the facility's history of prior offenses, including repeat deficiencies.

It is important to note that HCFA or the state may impose either a traditional CMP or an episodic CMP, but not both, per survey.

INSIDE THE FIRM

LATSHA DAVIS & YOHE, P.C. is pleased to announce three new additions to the firm:

Robert E. Slavkin, Esquire became associated with LATSHA DAVIS & YOHE, P.C. in February 1999. Mr. Slavkin graduated from the University of Pittsburgh School of Law, where he earned his Juris Doctorate. Prior to joining the firm, Mr. Slavkin worked as an associate with Buchanan Ingersoll, P.C., and also with the Department of Public Welfare as an assistant counsel. His primary practice area is medical assistance reimbursement.

Jason L. Swartley, Esquire joined LATSHA DAVIS & YOHE, P.C. in March 1999. Mr. Swartley graduated from the Dickinson School of Law of Pennsylvania State University, where he earned his Juris Doctorate. Prior to joining the firm, he served as staff counsel with the Pennsylvania Higher Education Assistance Agency. Mr. Swartley's practice areas include health care regulatory issues, creditor and collection law, employment law, and litigation.

Jonathan M. Crist, Esquire joined LATSHA DAVIS & YOHE, P.C. in March 1999. Mr. Crist served as a navigator in the United States Air Force. He graduated from the Dickinson School of Law, where he earned his Juris Doctorate, and Temple University, where he received his L.L.M. in taxation. Prior to joining the firm, Mr. Crist worked for several small firms in the Harrisburg area. Most recently, he worked as a sole practitioner. Mr. Crist concentrates his practice in the areas of taxation, real estate development, and litigation.

OIG ISSUES IMPORTANT ADVISORY OPINION ADDRESSING ANCILLARY PROVIDER/SNF CONTRACTING ISSUES UNDER PPS

by: David C. Marshall, Esquire

The Department of Health and Human Services Office of Inspector General (“OIG”) has released an Advisory Opinion regarding a proposed ambulance contract that contains pronouncements pertinent to potentially all ancillary provider relationships. In Advisory Opinion 99-2 (a copy of which can be found on the OIG’s web site <http://www.dhhs.gov/progorg/oig/>), released on March 4, 1999, the OIG reviewed a proposed arrangement between an ambulance company and a SNF, where the ambulance company discounted its rates attributable to the transport of PPS-covered Medicare Part A SNF residents by 50%, and then billed Part B services provided to SNF residents based on its usual and customary charges. The OIG initially concluded that the “discount” offered for Part A transportation did not fit within the Discount Safe Harbor, as the arrangement constituted “a price reduction applicable to one payor but not to Medicare or a State health care program.” More importantly, however, the OIG raised significant concerns that the “discount” offered on PPS-covered transports was provided to obtain referrals for other “Federal health care program business” (i.e., Part B-covered services). The OIG was troubled by the fact that the discounts offered for Part A transports were made simply to generate additional referrals that would be paid under the more profitable Part B program. To the OIG, this practice constitutes “swapping,” or using a SNF’s Part A residents as leverage to negotiate more profitable contractual arrangements. In conclusion, the OIG stated that if the “knowing and willful” intent requirements of the Anti-Kickback Statute could be proven, then it was possible that this relationship, and other relationships of this type, would be violations of the Statute.

This position may have significant implications for SNFs as they renegotiate their relationships with ancillary providers. The OIG’s analysis would appear to impact on all arrangements where the compensation for PPS-covered services is based on a discount against the Medicare fee screens or the ancillary provider’s usual and customary charges. Thus, to the extent that a “discount” arrangement is contemplated, the arrangement should be structured to fit within the Discount Safe Harbor. Alternatively, the use of a flat, per diem compensation arrangement that is consistent with fair market value and economically consistent with the facility’s overall PPS rate, would appear to be acceptable to the OIG. The OIG’s Advisory Opinion requires providers to be more careful than ever in establishing contractual arrangements with ancillary providers. We recommend that before entering into any relationship, the terms of that relationship be reviewed against the requirements contained in the applicable federal and state fraud and abuse laws.

(MEDICAID, cont. from p. 1)

Even if the repeal of the Boren Amendment allows states to thwart substantive rate challenges, procedural protections still exist that may enable providers to challenge the rate-setting methodology and adequacy of rates. For example, Boren regulations containing a public process requirement, not unlike the new public notice and comment requirements under the Balanced Budget Act, still exist. Federal courts have consistently enforced the public process requirements under Boren, which suggests that the Balanced Budget Act public process requirements will provide avenues of recourse to providers. Also, pursuant to the new public notice and comment requirements of the Balanced Budget Act, providers may be able to challenge the state’s rate-setting methodologies and adequacy of rates in a similar manner as they would have done under Boren.

Other means also exist for providers to challenge the adequacy of Medicaid reimbursement. Providers are still protected by the Equal Access Requirements of the Social Security Act. Also, states are still required to provide an appeal mechanism in their state plans, as well as maintaining a Medical Care Advisory Committee for the purpose of advising the state Medicaid Agency about health care services.

Providers may also be able to challenge state rate setting by challenging collateral elements of the state plan that may be impacted by the rate change. The Social Security Act contains numerous requirements pertaining to state plans. For instance, states must provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients. An

argument can be made that reductions in state reimbursement rates will have a detrimental effect upon the safeguards needed to ensure the best interests of the recipients. Also, a provider may challenge a state’s rate-setting methodologies if the effects of the state plan result in disparate impacts among recipient groups.

The new amendments to Medicaid rate-setting issues included in the Balanced Budget Act were intended to provide greater rate-setting flexibility to the states. Although the Boren Amendment has been repealed and replaced within the Social Security Act, the regulations promulgated pursuant to Boren with regard to state plan requirements are still in effect. These requirements include general state plan requirements for content, plan amendment and proposed effective dates, as well as specific requirements pertaining to rate making. Although this area of the law remains unsettled and uncertain, providers still have remedies available to challenge inadequate rate-setting by state Medicaid agencies.

(COLLECTIONS, cont. from p. 1)

a debtor may resist collection efforts because there is an underlying perception by the debtor that he or she did not receive goods or services worth the amount of the obligation. Efforts to collect money from debtors who perceive a lack of value received in relation to the amount of the debt must begin with the education of the debtor. Many times, success in the collection of a debt depends upon the creditor’s ability to convince the debtor that: 1) there is a legal obligation to pay the debt; and 2) that value was received.

The best collection tools are due diligence and persistence. If these two tools are used properly there will be far fewer \$50,000 conflicts requiring legal intervention.

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✓ **MARK YOUR CALENDARS!**

Our Long-Term Care Compliance Compendium, Fall 1999, will be held:

- November 9, 1999** - Sheraton Inn Pittsburgh North, Mars
- November 11, 1999** - West Shore Country Club, Camp Hill
- November 12, 1999** - Hilton Valley Forge, King of Prussia

March 16, 1999 - Kimber L. Latsha and Edward G. Cherry co-presented at PHCA's Mid-Year Conference. The session was entitled "Understanding Medicare +Choice."

March 16, 1999 - Kimber L. Latsha and David C. Marshall co-presented at PHCA's Mid-Year Conference. The session was entitled "Medicare PPS - Can Facilities Deny Admission Based on Insufficient Payment for Cost of Care for High-Acuity Residents?"

March 17, 1999 - Kimber L. Latsha, Edward G. Cherry, and Dale Van Wieren co-presented at PHCA's Mid-Year Conference. The session was entitled "Update on the Federal Certification Process and Deficiency Challenges."

March 18-19, 1999 - Kimber L. Latsha presented at PBI's 5th Annual Health Law Institute. The session was entitled "Long-Term Care Update."

March 25, 1999 - Glenn R. Davis and David C. Marshall co-presented at American College of Health Care Administrators. The sessions were entitled "Fraud & Abuse and Criminal Background Checks" and "PPS Consolidated Billing."

March 26, 1999 - Kimber L. Latsha presented at AHLA's Medicaid/Medicare Institute Conference. The session was entitled "Reimbursement for Long-Term Care."

May 4, 1999 - Kimber L. Latsha and Douglas C. Yohe will be co-presenting at PANPHA's Annual Conference. The session is entitled "Affiliations, Consolidations and Mergers: The Next Wave for Providers."

May 6, 1999 - Edward G. Cherry will be presenting at MANPHA's Annual Conference. The session is entitled "Update on the Federal Certification Process and Challenging Deficiencies."

May 6, 1999 - Kimber L. Latsha and Douglas C. Yohe will be co-presenting at MANPHA's Annual Conference. The session is entitled "Affiliations, Consolidations and Mergers: The Next Wave for Providers."

May 26, 1999 - Kimber L. Latsha, David C. Marshall and Theo Tamborlane will be co-presenting at NJANPHA. The session is entitled "Corporate Compliance & Current Government Enforcement Activities."

June 8, 1999 - Kimber L. Latsha and Mary Frances Grabowski will be co-presenting at the PICPA Annual Seminar. The session is entitled "Point/Counterpoint."

