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CMS outlines plan to implement PPACA reductions in state allocations for DSH payments

CMS has proposed the Disproportionate Share Hospital Reduction Methodology (DHRM) to implement the reductions in allocations to states for Medicaid payments to disproportionate share hospitals (DSH) as required by Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) sec. 2551. The proposed DHRM would be effective for federal fiscal years (FFYs) 2014 and 2015; CMS would evaluate the available data generated during these first two years of the reductions in order to make adjustments to the formula for the remaining period of the reduction.

PPACA requirements

Because millions of previously uninsured individuals will become eligible for Medicaid on January 1, 2014, the costs to hospitals of furnishing uncompensated care to these individuals is expected to drop dramatically. Therefore, section 2551 of PPACA amended Soc. Sec. Act sec. 1923 by adding paragraph (f)(7), which requires CMS to reduce the allocations to states for DSH payments each year from FY 2014 through FY 2020. The statute specifies the aggregate amount of the cuts for each year and directs CMS to consider certain factors as it calculates the reductions to each state's allotment. Smaller cuts should be made to the allocations of low DSH states, states with populations that include higher percentages of uninsured individuals, and those that target their DSH payments to hospitals with higher rates of Medicaid inpatient care utilization and uncompensated care costs.

The proposed DHRM

First, CMS would divide the states into two groups, low and "non-low" DSH states. The statute defines low DSH states as those that reported in 2003 that they spent more than zero but less than 3 percent of their Medicaid expenditures on DSH payments in 2000. Then CMS would calculate each of the specified factors separately for each group. The low DSH factor (LDF) would be calculated by comparing each state's DSH expenditures as a percentage of its total Medicaid expenditures, determining the average percentage for each group, and dividing the average percentage for the low DSH states by the average for the non-low states. The LDF would be multiplied by the aggregate reduction specified in the statute. That amount would be subtracted from the total reduction and distributed among the low DSH states; the remainder of the aggregate cuts would be distributed among the other states.

CMS would determine the uninsured percentage factor (UPF) for each state using data from the American Community Survey, which is more precise than other census data. The calculations would account for both the absolute numbers of uninsured and their percentage of the state population. The hospitals with high volumes of Medicaid inpatients would be determined by applying the statutory definition, *i.e.,* those with percentages at least one standard deviation from the average for their group, the low or non-low DSH states. The methodology also would include the percentage of states' DSH

payments that were made to hospitals that did not have high Medicaid volume.

Uncompensated care costs

States already are required to calculate and report the hospitals' costs of furnishing uncompensated care. CMS would use these reports, Medicare cost reports, and other information to calculate the uncompensated care factor, which will be used to mitigate the effects of the reduction of the states' DSH allocations.

Budget neutrality factor

The proposed rule would apply an additional factor to states that were approved to use their DSH allotments to operate Medicaid expansion demonstrations under Soc. Sec. Act sec. 1115 to achieve the budget neutrality required by the statute. The portion of the allotment diverted to the Medicaid expansion demonstration would not be reduced.

Effect of Medicaid expansion decision

Congress assumed that all states would be required to expand their Medicaid programs under PPACA. The Supreme Court's decision in *National Federation of Independent Business v Sebelius* made the expansion optional. The proposed rule does not provide specifically for the effect of states' decisions whether to expand Medicaid; however, CMS anticipates that states that do not expand their Medicaid programs will have more uninsured adults in proportion to their population and would not experience the reduction in the costs of uncompensated care provided by expansion.

Comment period

CMS will accept comments on the proposed rule until 5:00 p.m. on July 12, 2013. ■

Proposed rule, 78 FR 28551, May 15, 2013, ¶220,890

RAC recoveries hit $1.37 billion in FY 2013: CMS

From October 2012 through March 2013, the first six months of fiscal year 2013 for the Medicare program, recovery audit contractors (RACs) collected $1.371 billion in overpayments from Medicare providers, according to CMS. RACs also returned $65.4 million in underpayments to providers.

Since October 2009, RACS have collected $4.5 billion from providers and returned $333.6 million in overpayments.

Major issues

Three of the four RACs reported the same major issue for the period January 2013 through March 2013—medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed. The fourth RAC reported as its major issue instances where minor surgery and other treatment that should have been considered outpatient procedures for coverage purposes were instead billed as inpatient stays.

Changes in RAC program

In April, CMS announced changes to the limit on the number of additional document requests (ADRs) that Recovery Audit Contractors (RACs) may make to providers. Effective April 15, 2013, no more than 75 percent of the documents requested may be from any one type of claim. The claim types include inpatient prospective payment system (IPPS), outpatient PPS (OPPS), skilled nursing facility (SNF), inpatient psychiatric facility (IPF), inpatient rehabilitation facility (IRF), ambulatory surgical center (ASC), and physician claims. Interim and final bills are treated as one claim. ■

CCH Chicago Bureau, May 9, 2013

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HHS will fund enrollment assistance in health centers nationwide

On May 9, 2013, HHS Secretary Sebelius announced that the agency will offer $150 million in new funding to allow community health centers to assist consumers with enrollment in health insurance coverage options. Community health centers, supported by the U.S. Department of Health and Human Services (HRSA), are community-based, patient-directed organizations located in designated Medically Underserved Areas (MUAs) or serving designated Medically Underserved Populations (MUPs). There are currently about 1,200 such centers across the country operating nearly 9,000 delivery sites and serving roughly 21 million patients each year.

As more uninsured consumers seek to enroll in plans, the centers will help them understand coverage options, determine their eligibility, and enroll in selected options by providing unbiased information about available plans. The new funding will allow centers to train existing staff, as well as hire new staff and conduct education activities, including community outreach events. The HRSA website allows health centers to determine whether they are eligible for funding and provides information about applying for funding.

The administration is making an effort to ease the health coverage enrollment process, recently releasing a one-stop application for enrolling in health insurance, Medicaid, and the Children's Health Insurance Program (CHIP). It views this new funding as an additional step in the process of ensuring Americans "access to affordable health care." ■

CCH Chicago Bureau, May 9, 2013

GAO suggests modifying federal medical assistance percentage formula

The Government Accountability Office (GAO) has suggested modifying the federal medical assistance percentage (FMAP) formula to promote more equitable allocation of federal funding to the Medicaid program. The GAO emphasized that the modifications must take into account demand for services, geographic cost differences, and state resources to result in both beneficiary and taxpayer equity; suggestions include replacing the use of per capita income (PCI) in the FMAP formula with total taxable resources (TTR). The report also suggested federal data sources that could be used to develop various measures.

Considerations of equity

The federal government matches most state expenditures for Medicaid based on the FMAP, which, itself, is based on a comparison of a state's PCI to the national PCI. The lower a state's PCI compared to the national average, the more the federal government pays; the higher a state's PCI, the less the federal government pays. The GAO believes that a more equitable formula can be reached by seeking beneficiary and taxpayer equity. Beneficiary equity, which ensures that funds are distributed to adequately serve the needy, must consider the demand for services within each state based on the size and characteristics of its population, and geographic cost differences, particularly the cost of personnel that provide services. Taxpayer equity, which ensures that all states receive sufficient funding to provide a comparable level of services while contributing roughly the same proportion of their resources, must consider state resources and include all taxable income, not simply that which is actually taxed.

PCI shortcomings

PCI fails to consider these factors. For example, states with similar PCIs may have different numbers of low-income residents; those residents may vary in their need for services, as the elderly and disabled often require more care than younger adults and children. In fiscal year (FY) 2010, for example, Medicaid spent roughly $17,000 on each disabled beneficiary and $15,000 on each elderly beneficiary, but only $4,000 for each non-disabled adult under 65 and $3,000 per non-disabled child. PCI also ignores geographic cost differences and state resources, including income generated in the state but not received by state residents.

New data sources

The report suggested utilizing federal data sources, such as the U.S. Census Bureau's American Community Survey (ACS) and Current Population Survey (CPS), to begin tracking demand for services; the Bureau of Labor Statistics' (BLS) Occupational Employment Statistics (OES) survey to track geographic cost differences; and TTR to account for state resources. Unlike PCI, TTR includes other forms of taxable income, such as money generated within a state but not received by state residents, resulting, in FY 2010, in a 42 percent larger measure than PCI. ■

GAO Report, GAO-13-434, May 10, 2013, ¶68,131

Insurer need neither defend nor indemnify management services organization subject to FCA suit

A Washington district court granted an insurer's motion for summary judgment against a management services organization, MSO Washington, Inc., (MSO) that sued the insurer, alleging wrongful denial of coverage, failure to provide a defense, negligence, breach of duty of good faith, and violation of state statutes. MSO was the subject of a False Claims Act (FCA) lawsuit and ultimately settled the case with the federal government for $600,000. The court determined that MSO's fraudulent billing practices were not covered by the policy.

Insurance policy

MSO is a management services organization that contracts with providers to provide various services, including billing and collection services. MSO took out an insurance policy for 2008-2009 from RSUI Group, Inc., RSUI Indemnity Company, Inc., and Landmark American Insurance Company (collectively RSUI), in which it listed its professional services as a medical outpatient facility and its professional activities and specialty as "primary care, medical outpatient facility." RSUI agreed to cover MSO for professional negligence, provided that any claim against MSO occurred during the policy period and was timely reported to RSUI. The policy included an exclusion for dishonesty.

FCA complaint

On August 3, 2006, an FCA *qui tam* complaint was filed, under seal, against MSO and others, alleging that the company knowingly submitted false or fraudulent claims related to Medicare and Medicaid to the federal government, and knowingly made or used false records or statements to get the claims paid or approved. Specifically, the complaint alleged that MSO provided medical care in non-office settings, but coded up services and places of service to codes that cost more, using "canned entries" to overrepresent services supplied to patients. The HHS Inspector General served MSO with a subpoena, notifying it of the complaint on May 5, 2008. The case eventually settled for $600,000.

MSO timely notified RSUI of the claim and RSUI responded that it would view the subpoena as a potential claim, but reserved its rights, noting that no duty to defend or indemnify had yet been triggered. RSUI eventually denied all coverage. MSO filed suit, alleging wrongful denial of coverage, failure to provide a defense, negligence, breach of duty of good faith, and violations of state statutes. It also sought a continuance to allow discovery.

Court analysis

Under Washington law, an insurer must defend where an insurance policy could "conceivably" cover allegations in a complaint, but must only indemnify if the policy actually covers liability. RSUI's 2008-2009 policy only covered negligence in the rendering or failure to render the professional services listed in the contract. Although MSO argued that billing was its primary professional service, it listed its primary professional service as "medical outpatient facility" in the policy. Furthermore, case law holds that submitting billing claims under the FCA is not a professional service. As a result, the court held that RSUI did not have a duty to defend or indemnify MSO. Additionally, the FCA does not cover allegations of negligence, whereas RSUI's policy only covered negligence. Liability under the FCA naturally includes dishonesty, which was excluded under the policy. Therefore, the court dismissed the claims for wrongful denial of coverage and failure to provide a defense.

The court similarly dismissed MSO's claims for bad faith and negligence, and for violations of Washington's Insurance Fair Conduct Act and Consumer Protection Act, reiterating that RSUI had no duty to defend or indemnify MSO. It further noted that the FCA claims arose prior to the effective dates of additional RSUI policies, so RSUI could not be liable for coverage under those policies. Finally, it determined that MSO's desire for additional discovery lacked merit, as no additional information could make RSUI liable for coverage. As a result, the court granted RSUI's motion for summary judgment as to all claims and dismissed them with prejudice. ■

MSO Washington, Inc. v. RSUI Group, Inc., W.D. Wash., May 8, 2013, ¶304,447

Single state agency requirement prevents managed care organization from appealing preliminary injunction

The Fourth Circuit refused to hear a managed care organization's interlocutory appeal of a preliminary injunction where the single state agency charged with administering North Carolina's Medicaid program did not appeal the decision. The single state agency requirement promotes both efficiency and responsibility, both of which would be thwarted by allowing another agency to change or disapprove an administrative decision. Furthermore, any decision would have served as nothing more than an advisory opinion, since it would not be binding on the state agency.

Single state agency

The Medicaid statute requires the designation of a single state agency "to administer or supervise the administration" of its Medicaid program (42 U.S.C. sec. 1396(a)(5)). HHS regulations state that related agencies will not have "authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment . . . with respect to the application of policies, rules, and regulations issued by the Medicaid agency" (42 C.F.R. sec. 431.10(e)(3)).

Factual background

The North Carolina Department of Health and Human Services (NCDHHS) is the single state agency charged with administering North Carolina's Medicaid program. It contracted with Piedmont Behavioral Healthcare (PBH), a managed care organization, to provide care to 675 disabled individuals as part of the North Carolina Innovations waiver program, which provided services to individuals with chronic intellectual and developmental disabilities that qualified them for institutionalization, but allowed them to live in community environments. Enrollees in the program and their guardians meet annually with their physicians and a PBH employee to design and submit a plan to PBH for approval. Once PBH approves a plan it must provide enrollees with certain notice and appeal rights should it reduce or terminate those services. After changing the system by which it assigned base budget amounts to enrollees, PBH notified many enrollees by mail that their base budgets would be reduced. One autistic enrollee, for example, received a letter stating that his annual budget would be gradually reduced from $47,588.22 to $18,799.60.

A group of named plaintiffs filed suit against the NCDHHS Secretary, PBH, and PBH's director, seeking injunctive relief forcing the agencies to return services to previously authorized levels and comply with notice and hearing requirements of the Medicaid statute and the Fourteenth Amendment. The district court determined that PBH had taken an action without providing proper notice and appeals rights and granted a preliminary injunction. PBH and its director appealed 14 days before the deadline; NCDHHS did not take any action.

Fourth Circuit analysis

The Fourth Circuit dismissed PBH's appeal, finding that it was specifically intended to change or disapprove an administrative decision. Having been ordered to comply with injunctive relief by the district court, NCDHHS made the decision not to appeal the order, effectively adopting as policy the reinstatement of services to prior levels. Hearing PBH's appeal would destroy the efficiency intended by the single state agency requirement, allowing multiple agencies across a state to litigate numerous decisions made by the single state agency. It would also effectively release the single state agency from responsibility for Medicaid decisions, allowing it to simply defer to actions taken by other agencies in the state. The court found that litigation decisions, particularly those "tantamount to a substantial policy choice," can be classified as administrative decisions. Furthermore, even if the court were to have granted PBH's appeal, it could not have any binding effect. The district court ruling bound NCDHHS, and therefore PBH, as a subsidiary agency. The Fourth Circuit could not reverse a decision against a party that did not appeal it.

More than 10 months after the notice of appeal expired, the Secretary of NCDHHS filed a motion asking the court to suspend the rules of appellate procedure, noting that she was not aware that her decision not to appeal would preclude an appeal by PBH. The court dismissed the argument, noting that the agency was put on notice years previously of the requirement when it was a defendant in another case, that the agency never responded to a timely brief filed by the plaintiffs arguing that NCDHHS' failure to appeal prevented PBH from appealing, and that NCDHHS was represented by the North Carolina Attorney General and could simply have joined PBH's appeal. The court denied the Secretary's motion as a change of strategy resulting from political change. ■

In re K.C. v. Shipman, 4th Cir., May 10, 2013, ¶304,451

$50 million in tax refunds from health care fraud penalties awarded to provider

One of the world's largest providers of kidney dialysis products and services, Fresenius Medical Care Holdings Inc. is entitled to an income tax refund of $50.4 million plus interest on a portion of a health care fraud penalty the Internal Revenue Service (IRS) disallowed as a business expense deduction. Fresenius entered into a $486 million settlement agreement with the Department of Justice in 2000 to resolve claims against its subsidiary, National Medical Care Inc. (NMC). The claims were brought to the government's attention under the "whistle blower provisions" of the False Claims Act, and NMC pled guilty to engaging in a conspiracy to defraud Medicare and other federal health care programs. The majority of the fraud occurred prior to NMC becoming a wholly owned subsidiary of Fresenius.

Taxes on the settlement agreement

Included in Fresenius' settlement agreement was a $385 million civil penalty under the False Claims Act (FCA),

which the IRS determined to be approximately 50 percent compensatory and deductible as a business expense. Fresenius challenged the IRS decision, contending that the IRS had improperly taken the position that half of the $385 million the company paid in civil settlements were in fact punitive and therefore not deductible. Then, Fresenius reached a settlement with the IRS on the deductibility of $65.8 million paid to the whistleblower in the fraud case, but still contended that the remaining $126.8 million previously disallowed by the agency should be deductible.

Jury verdict upheld

In August of 2012, a jury found that an additional $95 million were ordinary and necessary expenses paid in carrying on a business, and were compensatory and therefore deductible. According to the judge, based on the large amount of pre-judgment interest necessary to make the government whole on losses incurred by the fraud, it was reasonable for the jury to conclude that a vast majority of the settlement payments were compensatory. However, because Fresenius could not present a "precise accounting of pre-judgment interest owed to the government, and there was evidence to show that some portion of payments were made to settle Fresenius' liability in the form of mandatory penalties under the FCA," it was also reasonable that the jury allowed Fresenius only part of its requested deduction.

Accordingly, the judge upheld the jury verdict for and granted Fresenius's motion for final judgment in accordance with that verdict, for a refund of $50.4 million plus interest for the taxes it paid on the $95 million. ■

Fresenius Medical Care, Inc. v. U.S., D. Mass., May 10, 2013, ¶304,452

OTHER DECISIONS AND DEVELOPMENTS

CMS Manuals

Quarterly Healthcare Common Procedure Coding System Drug/Biological Code Changes - July 2013 Update. *Medicare Claims Processing Manual*, Pub. 100-04, Transmittal No. 2695, May 2, 2013, ¶160,434.

Reporting of principal and interest when returning previously recouped money – Analysis. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1225, May 2, 2013, ¶160,435.

Update to the Common Working File Qualifying Stay Edit for skilled nursing facility and wing bed providers. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1227, May 2, 2013, ¶160,436.

Debts referred to Treasury through the Healthcare Integrated General Ledger Accounting System (HIGLAS). *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1228, May 2, 2013, ¶160,437.

National Coverage Determination for Transcatheter Aortic Valve Replacement (TAVR) - Implementation of Mandatory Reporting of Clinical Trial Number. *Medicare Claims Processing Manual*, Pub. 100-04, Transmittal No. 2689, May 3, 2013, ¶160,438.

New Non-Physician Specialty Code for Complimentary Insurer. *Medicare Claims Processing Manual*, Pub. 100-04, Transmittal No. 2697, May 3, 2013, ¶160,439.

Modification to change request CR7254. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1211, May 3, 2013, ¶160,440.

MCS prepayment review report. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1212, May 3, 2013, ¶160,441.

Updating the shared system and common working file to no longer create veteran affairs "I" records in the Medicare secondary payer auxiliary file. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1213, May 3, 2013, ¶160,442.

Medicare system update to include line level National Provider Identifier (NPI) Sanction editing on Critical Access Hospital (CAH) Method II outpatient claims. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1214, May 3, 2013, ¶160,443.

VMS prepayment review report. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1215, May 3, 2013, ¶160,444.

Applying multiple procedure payment reductions to therapy cap amounts for critical access hospital claims. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1216, May 3, 2013, ¶160,445.

CWF editing for vaccines furnished at hospice. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1217, May 3, 2013, ¶160,446.

Phase lll ERA enrollment operating rules. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1224, May 3, 2013, ¶160,447.

Common Working File (CWF) Informational Unsolicited Response (IUR) or Reject for a new patient visit billed by the same physician or physician group within the past three years. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1231, May 3, 2013, ¶160,448.

New non-physician specialty code for complimentary insurer. *Medicare Financial Management Manual*, Pub. 100-06, Transmittal No. 219, May 3, 2013, ¶160,449.

American Recovery and Reinvestment Act of 2009 Electronic Health Record (EHR) Incentive: New critical access hospital banking information file transfer for eligible professional Payment. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1218, May 3, 2013, ¶160,450.

National Competitive Bidding Program (CBP): Instructions for processing CBP oxygen and capped rental item claims with the start of the round one recomplete. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1219, May 3, 2013, ¶160,451.

Billing social work and psychological services in Comprehensive Outpatient Rehabilitation Facilities (CORFs). *Medicare Claims Processing Manual*, Pub. 100-04, Transmittal No. 2690, May 3, 2013, ¶160,452.

Health Insurance Portability and Accountability Act (HIPAA) EDI front end updates for October 2013. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1220, May 3, 2013, ¶160,453.

New Healthcare Common Procedure Coding System (HCPCS) codes for customized durable medical equipment. *One Time Notification Manual*, Pub. 100-20, Transmittal No. 1232, May 6, 2013, ¶160,454.

Medicare Part A—Coverage

FY 2014 hospice wage index and payment rate. CMS' proposed amendments to the hospice wage index, daily payment rates, and quality reporting requirements for federal fiscal year (FY) 2014 would result in a net increase of 1.1 percent over the FY 2013 rates, raising total Medicare payments for hospice services by $180 million. CMS also proposes to replace the two quality measures required to be reported with two other measures, change the way that hospice patients' diagnoses are reported, and add a caregiver survey on the hospice experience after the hospice services have ended. *Proposed rule*, 78 FR 27823, April 29, 2013, ¶220,887.

Medicare Part B—Coverage

MedEnvios Healthcare, Inc., submitted claims for diabetic testing supplies without the KL modifier in accordance with Medicare billing requirements. A recent Office of Inspector General (OIG) report found that the audited durable medical equipment supplier operated in accordance with Medicare billing requirements 100 percent of the time, and as a result the OIG had no recommendations to provide. The OIG determined that MedEnvios Healthcare Inc. (Medenvios), a durable medical equipment supplier, properly submitted claims for diabetic testing supplies without the KL modifier in accordance with Medicare billing requirements. The KL modifier denotes when diabetic testing supplies were provided via mail-order. *OIG Report*, No. A-09-12-02053, May 7, 2013, ¶60,880.

Coverage Decisions and Exclusions

Medicare Secondary Payer Act liability. Sanctions against a truck company for failure to disperse settlement funds weren't warranted because it was reasonable for the truck company to wait for the proper information on Medicare Secondary Payer Act liability, per the terms of the contract. There was a dispute over the terms of a settlement and whether the settlement contained a provision regarding liability under the Medicare Secondary Payer Act. It was proper for the court to consider the facts and circumstances surrounding the settlements and conclude that the sanctions against the truck company's counsel were inappropriate. *Robinson v. Penske Truck Leasing Co.*, Pa. Super. Ct., May 10, 2013, ¶304,453.

Prospective Payment Systems

Adjustment of dialysis payments for anemia management drug utilization. CMS could have saved $529 million in 2011 if it had properly adjusted payments for dialysis services under the end-stage renal disease prospective payment system (ESRD PPS) to reflect actual anemia management drug utilization, according to a report from the HHS Office of Inspector General. *OIG Report*, No. A-01-12-00522, May 10, 2013, ¶60,882.

FY 2014 IPPS for Acute Care Hospitals and the LTC PPS Rates. Approximately 3,400 acute care hospitals would receive a net 0.8 percent reimbursement increase, including sequestration cuts, but may face penalties for new categories of readmitted patients, and new measures in quality incentive pay beginning October 1, 2013, according to the Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System proposed rule, released by CMS. LTCHs would receive a $62 million increase in payments,

or 1.1 percent, under the proposal. Within the proposed rule, CMS has provided clarification on which patient stays qualify as legitimate hospital admissions, an effort to resolve confusion that has resulted in hospitals placing 8 percent of its patients in "observation" status, up from 3 percent in 2006, and absorbing less than half of the payment it would normally receive for a patient officially admitted. The proposed rule would also exempt certain planned admissions from the readmissions penalty. *Proposed rule*, 78 FR 2486, May 10, 2013, ¶229,027.

HIPAA and HITECH

Medical loss ratio. The Internal Revenue Service (IRS) has issued proposed regulations that provide guidance to Blue Cross and Blue Shield organizations and other health insurance companies on computing and applying the medical loss ratio added to the federal tax code by sec. 9016 of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148). The regulations would apply to tax years beginning after December 31, 2013. *Proposed rule*, 78 FR 27873, May 13, 2013, ¶220,889.

Preventive services mandate. Geneva College's challenge to the preventive services mandate for group health insurance coverage in the Patient Protection and Affordable Care Act will proceed notwithstanding the Court's previous ruling that the claim was not yet ripe for Adjudication. Because the college was in the process of negotiating its group insurance contracts for the plan year beginning August 1, 2013, and the HHS Secretary would probably not issue a final rule before the contract was finalized, the court considered the agency's proposed rule "sufficiently final" to allow it to decide the case on the merits. Therefore, the college's claims that the HHS rules are arbitrary and capricious, were promulgated in violation of the notice and comment requirements of the Administrative Procedure Act, and violate its rights under the First Amendment and the Religious Freedom Restoration Act, will proceed. *Geneva College v. Sebelius*, W.D. Penn., May 8, 2013, ¶304,448.

Medicare--Notices; Determinations; Appeals

Failure to exhaust administrative remedies. A federal district court granted two Medicare contractors' motion to dismiss claims filed against them by a home health agency because the agency failed to exhaust its administrative remedies. The agency was attempting to appeal the contractors' suspension and ultimate denial of payments. The court rejected the agency's argument that administrative appeal would be futile and denied its request for injunctive relief. *MJG Management Associates, Inc. v. NHIC Corp.,* D. Mass., May 9, 2013, ¶304,450.

Medicare--Program Integrity; Fraud and Abuse

Special advisory bulletin on the effect of exclusion from participation in Federal health care programs. *OIG Report*, May 8, 2013, ¶60,881.

Medicaid—Eligibility

Determination of attorney's fees was upheld in case involving transfer of property for Medicaid eligibility. *Jackson v. Selig*, E.D. Ark., May 10, 2013, ¶304,449.

Medicaid--Payment to Providers

340B Drug Pricing Program. The Aids Healthcare Foundation (AHF), a nonprofit corporation that furnishes outpatient drugs to its Medicaid (Medi-Cal) patients and voluntarily participates in the 340B Drug Pricing Program, was granted a permanent injunction preventing Toby Douglas, Director of the California Department of Health Care Services (Department) from applying a state law that, in most cases, reimburses 340B providers less than non-340B providers for dispensing the same drugs to Medi-Cal beneficiaries. AHF initiated an action against the Department in response to the state's enactment of sec. 14105.46 of the California Welfare and Institutions Code, which imposed new requirements on prescription drug providers that participate in the 340B program (see 42 U.S.C. sec. 256b). The court found that the state failed to obtain federal approval before enacting a state plan amendment (SPA) as required by federal law and concluded that sec. 14105.46 is preempted under the Supremacy Clause of the U.S. Constitution (Article VI, Clause 2). The court determined that the law conflicted with the requirements of 42 U.S.C. sec. 1396a(a)(30)(A) (Sec. 30(A)) in multiple respects. *AIDS Healthcare Foundation v. Douglas*, C.D. Cal., May 3, 2013, ¶304,446.

Medicaid--Administration and Financing

Medicaid waiver. The Florida Agency for Persons with Disabilities (APD) improperly reduced the level of services authorized for Moreland under the state's waiver program for persons with developmental disabilities from Tier One to Tier Three because it failed to consider whether he needed the Tier One services to avoid institutionalization. The agency bore the burden of proof that the lower level of services would meet Moreland's needs and avoid institutionalization. Because the hearing officer found that Moreland had intense needs for medical and adaptive services and was in danger of institutionalization without the Tier One services Fla. Admin. Code R. 65G-4.0026 required the agency to consider the other services authorized under his cost plan rather than limiting its analysis to the personal care services authorized under the waiver. The matter was remanded to the agency for further consideration. *Moreland v. Agency for Persons with Disabilities*, Fla. App. Ct., ¶304,454.

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