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in the news

Health Policy Monitor

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Health Reform and Related Health Policy News

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An executive summary of political, legal and regulatory issues that may impact your business, prepared by Polsinelli Health Care legal and Public Policy professionals.

Top News

The Congressional Agenda is Light as the Focus Shifts to the Midyear Elections

Congress has adjourned until after the November elections. Before adjourning, Congress passed a Continuing Resolution to fund the government from the start of the 2015 fiscal year on Oct. 1 until December 11, 2014. The Continuing Resolution will fund the government at an annualized rate of $1.012 trillion. In addition, the resolution includes $88 million for government efforts to fight the Ebola virus. Due to the expiration date, the lame-duck Congress will need to either finalize FY 2015 spending or pass another continuing resolution. Polsinell's Public Policy team will continue to monitor the situation.

As the Continuing Resolution only funds government operations through mid-December, federal agencies will begin the 2015 fiscal year without a clear idea of their funding levels. As a result, agencies are expected to delay entering new contracts or filling vacancies. How Congress will address FY 2015 appropriations largely is dependent on the November elections. If Republicans take control of the Senate in the next Congress, they may push for a second short term continuing resolution to defer spending decisions until that have control. However, some senior Republican senators may push to finalize FY 2105 appropriations during the lame-duck to provide budgetary certainty to the federal agencies.

Physician Supervision Requirement for Small and Rural Hospitals

Both the House and Senate have passed legislation to permit non-physician providers at small, rural hospitals to provide outpatient services

without physician supervision. The Senate passed a bill sponsored by Senator Jerry Moran (R-KS) earlier this year, and last week the House passed legislation, sponsored by Representative Lynn Jenkins (R-KS) to extend the moratorium of the CMS physician supervision rule through the end of 2014. However, a spokesperson for Jenkins said the Senate will need to pass the House bill before the legislation can move forward.

Supporters of a permanent fix to the physician supervision requirements believe that the legislation, if signed by the president, would give Congress enough time to enact legislation, such as the Protecting Access to Rural Therapy Services Act (H.R.2801/S.1143), that would create a default standard of "general supervision" for outpatient therapeutic services. CMS has enforced the supervision requirement since January 1, 2014 and has said that it ensures patients have access to safe care.

CMS Offers Hospitals Temporary Relief from ALJ Case Backlog

CMS is offering hospitals an "administrative agreement" to select hospitals that are willing to accept a partial payment in exchange for agreeing to resolve their pending appeals. The effort is intended to reduce the backlog of claims pending in the appeals process, particularly at the Administrative Law Judge (ALJ) level. The offer is open to acute care hospitals, critical access hospitals, and Maryland waiver hospitals. To be eligible, a claim must have dates of admissions prior to October 1, 2013 and have been denied by a Medicare contractor on the basis that an inpatient admission was not necessary. The claim must be on appeal or within the administrative timeframe to request an appeal.

During a call with providers and stakeholders, CMS provided more details of the settlement offer:

- Hospitals that agree to withdraw their pending appeals will receive 68 percent of the net allowable amount.
- The claims covered by the settlement will not be included in the hospital's inpatient day count, which factor into disproportionate share hospitals payments, 340B eligibility, etc.;
- A hospital may not choose to settle some claims and continue to appeal others;
- The claims remain subject to OIG review

CMS is encouraging hospitals to submit their initial settlement request on or before October 31, 2014. Additional details are available here.

In response to the settlement offer, House Ways and Means Health subcommittee chair Kevin Brady (R-TX) sent a letter to HHS that sought clarification on the statutory authority for the settlement process. Brady questioned why the settlement is an "all or nothing" approach and requested details on how the settlement rate of 68 percent was selected. The letter is available here.

MedPAC Commissioners Discuss Short Hospital Stays, Consider Least-Costly Alternative for Part B Drugs

The Medicare Payment Advisory Commission (MedPAC) met in September and discussed a number of topics that may be incorporated in its Report to Congress in March 2015. The commissioners discussed the controversial short term hospitals stays and payment options, the potential to eliminate the three-day qualifying inpatient stay for covered nursing home care, and reforming hospital rebilling policy so it is aligned with the Recovery Audit Contractor (RAC) look-back period.

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MedPAC commissioners also are considering a proposal to reinstate the "least costly alternative" approach to paying for Part B drugs. CMS previously used a least costly alternative policy to reimburse certain Part B drugs, but a federal court struck down the policy in December 2009. MedPAC is considering three options to for a least-costly alternative policy. First, Congress could authorize CMS to use the earlier least-costly alternative policy, under which CMS would group clinically comparable products together and apply the price of the cheapest one to all of the products in that group. Second, drugs could be grouped by Healthcare Common Procedure Coding System codes and each drug in the group would be paid the average price of drugs in each HCPCS code. The third option would be to use an illness-based bundle. Additional details are available here.

Congressional Focus

Houses Votes to Allow Non-ACA Compliant Group Plans until 2018

The House passed legislation (HR 3522) that would allow insurers to continue to offer insurance plans in the group market that do not meet Affordable Care Act requirements. To qualify for the extension the plans must have been in effect in 2013. "This is a necessary tool for America's workers," Rep. Joe Pitts (R-Pa.), chairman of the Energy and Commerce Health Subcommittee, said during floor debate on the bill Sept. 10. "American workers who like their health-care plan should be able to keep it." Senate action on the bill is unlikely and the White House has said it would veto the bill. Additional details are available here.

House, Senate Pass IMPACT Act

The House and Senate each passed the Improving Medicare Post-Acute Care Transformation Act ("IMPACT Act"). The bill is an effort to modernize post-acute care Medicare payments by requiring a standardized patient assessment across post-acute care ("PAC") settings. The bill also requires PAC providers to report standardized patient assessment data, quality measures, and data on resource use. The bill also requires MedPAC to evaluate and recommend to Congress a payment system for post-acute care that is based on patient characteristics rather than setting. In addition, the bill reduces the SNF market basket update by 2 percent for facilities that do not report assessment and quality data. The President is expected to sign the legislation. Additional details are available here.

Regulatory Roundup

District Court Dismisses AHA Re-billing Lawsuit

A federal district court dismissed a lawsuit brought by the American Hospital Association that challenged a CMS policy that prohibited hospitals from rebilling under Medicare Part B claims that were denied under Part A. The court dismissed the suit on the basis of lack of jurisdiction. AHA is considering an appeal of the dismissal. After AHA filed the lawsuit, CMS partially revised its rebilling policy. Under the revised policy, CMS allowed some ancillary services that were denied payment under Part A to be rebilled under Part B. The rebilled claims would need to meet a timely billing requirement. This requirement, which required the claim to be rebilled within one year of the date of service, created an impossible situation for hospitals, as RAC audits and claim denials frequently occur past the timely filling deadline. Such claims would be ineligible for rebilling under the revised policy. Additional details on the rebilling policy are available here.

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HHS Secretary Reorganizes Department

Shortly after being confirmed as HHS Secretary, Sylvia Burwell began overhauling the management structure of the Department of Health and Human Services , particularly in regard to the operation and management of the Affordable Care Act's health insurance exchanges. Burwell created a new position of Marketplace Chief Executive Officer ("CEO") and Chief Technology Officer just for the insurance exchanges. The CEO is responsible for heading the federal marketplace, managing relationships with state marketplaces, and running the Center for Consumer Information and Insurance oversight ("CCIIO"). CMS has named Kevin Counihan, former CEO of the Connecticut Insurance Exchange, as the CEO. CMS is actively recruiting for the Chief Technology Officer position.

In a recent speech, Burwell said she intended to bring a new management style to the department. "Transparency builds trust and it is something we take very seriously. Even if the numbers aren't quite where we want them to be on something, we're going to tell you about it," Burwell said. Additional details are available here.

HHS Awards $60 Million in ACA Navigator Grants

HHS recently awarded $60 million in Navigator grants to organizations that will help facilitate enrollment through federal and state-partnership health insurance exchanges. Ninety organizations received the grants, which will fund enrollment activities for 2014 and 2015. Navigator grantees must maintain a physical presence in their service-area in order to provide consumers with face-to-face assistance. The three largest grants were awarded to organizations in Florida, Texas and North Carolina. Additional details are available here.

CMS Blocked from Awarding New RAC Contracts

A federal appeals court has blocked CMS from awarding new contracts for Recovery Audit Contractors (RACs), pending an appeal. In issuing the injunction, the court ordered that new contracts cannot be awarded until the lawsuit challenging the RAC contracting process makes its way through the court. CMS earlier intended to award four RAC contracts, but there were multiple protests over the decision. One protest, filed by CGI Federal, is still pending. Based on a lower court ruling that sided with CMS, the agency planned to move forward with the contracting process. The latest ruling regarding CGI's protest, however, will prevent CMS from awarding new contracts. This could delay the RAC contract process for up to a year. Meanwhile, CMS is initiating modifications to the current RAC contracts to allow the contractors to restart some reviews. Most reviews will be conducted on an automated basis. Additional details on the RAC process are available here.

CMS Finalizes Meaningful Use Certification Requirements, Provides Additional Year for Compliance

CMS recently finalized a rule that delays the deadline for compliance with Stage 2 of the meaningful use program. The final rule will allow eligible professionals, hospitals and critical access hospitals to use the 2011 Edition certified EHR technology or a combination of 2011 and 2014 Edition certified EHR technology for the 2014 EHR reporting period. CMS also is delaying the start date for Stage 3 from January 1, 2016 to January 1, 2017. The rule indicated that the delay would help more providers participate in the program; however, CMS did not offer a 90-day reporting period during any quarter for Stage 2 in 2015. Instead, the final rule includes a year-long reporting period for Stage 2 in 2015. Additional details are available here.

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CMS Finalizes 2015 Health Plan Re-Enrollment Rule

CMS finalized a rule (CMS-9941-F) that will allow consumers to re-enroll automatically in health plans that are offered through federally-facilitated exchanges. Consumers in federally-facilitated exchanges will be notified before the open enrollment period for 2015 that they will be automatically enrolled in the same plan with the same premium tax credits if they do not elect to shop for a different plan. They are, however, encouraged to use the exchange to ensure they are receiving all the financial assistance they qualify for and to shop for the plan that best meets their needs. "We are committed to providing a simple, familiar process for consumers to renew their coverage next year," said CMS Administrator Marilyn Tavenner. "Consumers should use this time to evaluate their health needs, browse other options, and see if they qualify for additional financial assistance. However, consumers who are happy with their plan and have no changes to their income or family situation can be auto-enrolled in their same plan next year, similar to how it is done in the employer insurance market today." Additional details are available here.

In other health exchange news, in the next two weeks tax subsidies will be eliminated for about 360,000 people if they do not offer proof of their income. Those enrollees who fail to confirm their incomes could lose their tax credits and face higher premiums or deductibles. In addition, CMS is preparing to terminate coverage for about 115,000 people who purchased coverage through Healthcare.gov but who have missed a deadline to confirm they are legal residents. Additional details are available here.

State Summary

Kansas, Missouri Clinics Receive $9.6 Million in HRSA Funding

Twenty-five health centers in Missouri and 16 in Kansas have been awarded $9.6 million in federal funds to expand primary care services. The HRSA funding, which is part of the Affordable Care Act, will help the clinics hire staff, expand their operating hours, and provide oral health, mental and behavioral health, pharmacy and vision services. Missouri clinics will receive about $6 million and Kansas clinics will receive about $3 million. Additional details are available here.

California Sued over Medicaid Application Backlog

A coalition of health care advocates has filed a lawsuit against Medi-Cal, California's Medicaid program, that alleges the state is failing to process enrollment applications in the timeframe required by law. Applications are required to be processed within 45 days, but the lawsuit alleges that some applicants have been waiting since the end of 2013. The suit is seeking Medicaid enrollment for the pending applications while their incomes are verified. Current, there is a backlog of 350,000 applications. Additional details are available here.

Federal Register

The FY 2015 Inpatient Prospective Payment System final rule is available here.

The FY 2015 Skilled Nursing Facility final rule is available here.

The FY 2015 Outpatient Prospective Payment System is available here.

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[1] Based on the number of American Health Lawyers Association members in the firm (AHLA Connections, June 2014)
[2] Based on a blended score of health care lawyers employed in 2013 and AHLA membership (June 2014)

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* Law360, March 2014
** The American Lawyer 2013 and 2014 reports

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