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in the news

Health Policy Monitor

May 2013 Issue 1

Health Reform and Related Health Policy News

In this Issue:

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

HHS Releases Hospital Pricing Data in Transparency Effort; Results Show Significant Variation

On May 8, 2013, in an unprecedented effort to provide transparency to health care consumers, the Department of Health and Human Services (HHS) released hospital pricing data from approximately 3,400 hospitals that receive payment from Medicare for inpatient services. The data, which compares charges for services provided during the 100 most common inpatient stays, reveals that hospital charges for similar services can vary significantly -- even within the same geographic area. For example, a fact sheet from the Centers for Medicare and Medicaid Services (CMS) shows that charges to treat heart failure range from $21,000 to $46,000 within the Denver, Colorado, area. Although Medicare does not actually pay the amount that a hospital charges, this data is likely to reignite the debate over medical costs and hospital pricing methodology. More information about the transparency initiative can be found here, and the actual pricing data is available on CMS' website here.

States Divided on Medicaid Expansion

With all eyes on the final hours of many state legislative sessions, it appears states will be almost equally split on whether to expand Medicaid eligibility. According to data from Avalere Health, as of May 6, 2013, twenty states and the District of Columbia will expand Medicaid, and fifteen states will not. Of the remaining fifteen states, only four are leaning toward expansion.

Current focus is on Florida, as local lawmakers are urging Florida Gov. Rick Scott to call a special session to address the issue, though other states in the limelight include Arizona, Louisiana, Kansas, Connecticut, and Oklahoma.

While there is no established deadline for states to expand their Medicaid programs, if states do not expand, they will likely forego lucrative financial incentives included under the Affordable Care Act. Given the uncertainty about the legislative battles still being fought, it is difficult to predict how many states will expand their Medicaid programs come January 1, 2014. For more information and specific state data, please click here.

CMS Issues FY 2014 Proposed Rules for Acute-Care and Long-Term Care Hospitals, Skilled Nursing Facilities, Inpatient Rehab Facilities, and Hospice

In a flurry of activity, the Centers for Medicare and Medicaid Services (CMS) recently released several proposed rules affecting Medicare Part A providers, including acute-care hospitals and long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and hospice providers. Additional information about each proposed rule is available below.

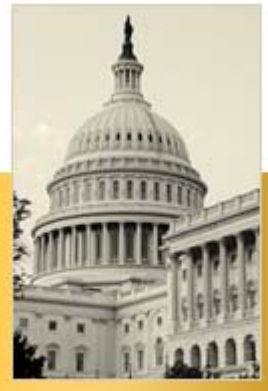
Inpatient Prospective Payment System (IPPS) Proposed Rule

On April 26, 2013, the Centers for Medicare & Medicaid Services released a proposed rule that would update the Medicare payment policies and rates for general acute care and LTCHs effective October 1, 2013.

Under the proposed rule, general acute care hospitals paid under the inpatient prospective payment system that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program would see operating rates for inpatient stays increased by 0.8 percent; those that do not successfully participate in the IQR Program would receive a 2.0 percentage point reduction from the proposed increase. The projected increase for these payments, which include capital and operating payments, is $27 million. The proposed rule would also increase Medicare payments to LTCHs by 1.1 percent, or approximately $62 million.

Other significant provisions of the proposed rule include the following:

- Revisions to the Direct Graduate Medical Education policy addressing inpatient labor and delivery days in the inpatient Medicare utilization calculation.
- Clarification of admission and medical review criteria for hospital inpatient services.
- A negative 0.8 percent recoupment adjustment to recoup documentation and coding overpayments for prior years.
- Guidance regarding implementation of a variety of Affordable Care Act provisions, including the



Hospital-Acquired Conditions (HAC) Reduction Program and a new payment methodology to calculate Disproportionate Share Hospital adjustments.

A fact sheet that discusses major payment provisions of the proposed rule is available here. A separate fact sheet related to quality is available here. The proposed rule will be published in the May 10, 2013 Federal Register, with comments due by June 25. CMS expects to issue the final rule by August 1, 2013. The display copy of the proposed rule can be downloaded from the Federal Register here.

The SNF Proposed Rule

CMS issued the 2014 SNF prospective payment system proposed rule on Monday, May 6, 2013. Among other technical changes, the rule includes a 1.4% market basket update to SNF payments for 2014 and invites suggestions to identify reimbursement alternatives for therapy services under the SNF PPS. CMS will accept comments on the proposed rule until July 1, 2013. The text of the proposed rule is available here and appeared in the May 6 Federal Register.

IRF Proposed Rule

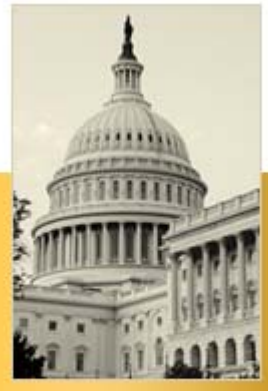
Released in the May 8 edition of the Federal Register, the IRF prospective payment system proposed rule would increase IRF payments by 2% for fiscal year 2014. The rule also outlines proposed changes to the so-called "60% rule," under which a hospital must demonstrate that at least 60% of its patients meet the IRF criteria in order to be excluded from the hospital inpatient prospective payment system. Specifically, the rule would revise the list of diagnosis codes used to identify patients "presumptively" in need of intensive rehabilitation. Comments on the proposed rule are due by July 1, 2013. The proposed rule is available here.

Hospice Proposed Rule

Under the proposed rule for hospice, CMS would provide a 1.1% increase in hospice payments for FY 2014. In addition, the proposed rule provides guidance for reporting diagnoses on hospice claims, including recommendations that hospices pay more attention to reporting multiple diagnoses, avoid "adult failure to thrive" and "debility" as principal diagnoses, and, for patients electing hospice within three days of a hospital discharge, list the inpatient care diagnosis on the hospice claim. The rule also contains changes to the hospice quality reporting program, which will subject hospices to a two percent payment reduction if they fail to report certain quality data. The proposed rule will be published in the May 10, 2013 Federal Register, with comments due by July 9. A display copy is available here.

Appeal of Ruling on Plan B Contraception

On May 1, 2013, one day after the FDA approved over-the-counter use of Plan B for women 15 and older, the Department of Justice appealed the order of a U.S. District Court judge to have the Food & Drug Administration (FDA) make Plan B One-Step (Plan B), an emergency contraceptive, available without age restrictions within thirty days of the judge's April 5th ruling.



The move drew immediate criticism from reproductive rights groups and various medical associations, including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Health and Medicine, which issued a collective statement opposing the decision of the Department of Justice to appeal the court order. However, the appeal is supported by anti-abortion groups such as the Susan B. Anthony List.

State News

Pennsylvania Insurance Department Approves Highmark's Takeover of West Penn Allegheny Health System

On April 29, the Pennsylvania Insurance Department approved the proposed takeover of West Penn Allegheny Health System (West Penn), a seven-hospital health system largely operating in the Pittsburgh area, by Highmark Inc., a health insurance company. Proposed in 2011, the landmark transaction is contingent upon compliance with a number of conditions intended to protect consumers and preserve competition. Specifically, the Insurance Department is requiring a firewall between Highmark's insurance entities and any providers in the newly-named Allegheny Health Network. In addition, if West Penn's financial stability comes into question at any point, Highmark is required to submit a corrective action plan to the state. Highmark also is prohibited from requiring a most-favored-nation clause, which would require West Penn to offer it the hospital's best payment rate or terms given to any other insurer. For more information, the Pennsylvania Insurance Department's "Approving Determination and Order" is available here.

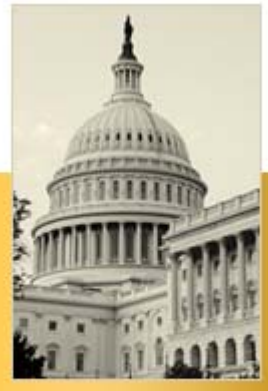
OIG Calls for Refund of $7.3 Million from New York Medicaid

According to an April 15 report published by the HHS Office of the Inspector General (OIG), the New York Department of Health (Health Department) improperly sought at least $7.3 million in federal Medicaid reimbursement for patients enrolled in managed care organizations. The OIG found that the Health Department failed to make proper eligibility determinations and, in some instances, allowed beneficiaries to have more than one Medicaid identification number, resulting in duplicate monthly payments to the managed care plans. In addition, the OIG estimated that the Health Department claimed $546,000 in Medicaid reimbursement where applicants did not provide a valid Social Security number (SSN) or where there was no case file documentation to support the eligibility determination. The OIG's full audit report is available here.

Regulatory News

CMS Delays Implementation of Phase 2 Ordering and Referring Denial Edits

Citing technical issues, CMS will delay implementation of Phase 2 edits that would have denied certain claims with missing or incorrect information



regarding an approved or opted-out physician or non-physician provider. Specifically, this review would have targeted: (a) Medicare Part B claims from labs, imaging centers, and DMEPOS suppliers that have an ordering or referring physician/non-physician provider; and (b) Part A home health agency claims requiring an attending physician provider. CMS will advise providers of the new implementation date in the near future.

CMS Revises Interim Guidance for Part B Rebilling

On April 19, 2013, CMS issued revised temporary instructions for billing for Part B services on types of bills 12x and 13x. This technical guidance, available here, follows the March 13 CMS Ruling 1455-R, which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a claim for an inpatient admission as not reasonable and necessary.

HHS Issues Guidance on Brokers and Agents in Exchange Marketplaces.

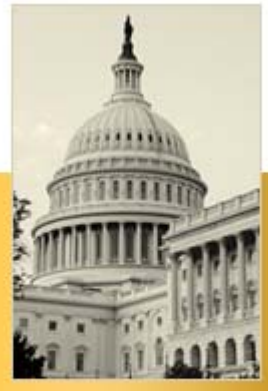
On May 1, the HHS Center for Consumer Information and Insurance Oversight (CCIIO) issued guidance related to the role of brokers and agents in assisting consumers to enroll in health plans through Federally-facilitated exchanges, State Partnership exchanges, or State-based exchanges. Among the highlights, CMS will allow State-based exchanges to establish rules on how much insurers can pay brokers (either by direct compensation from the exchange or by having issuers continue to pay commissions), but the Federally-facilitated exchanges will not establish commission schedules or pay commissions directly to such brokers. The full HHS guidance document is available here.

Additional Reading

- *pcori:* PCORI Awards $88.6 Million in Funding for Comparative Effectiveness Research Projects
- *Kaiser Health News:* A Shorter Exchange Application. But Is It Simpler?
- *MedPage Today:* Medicare: Cost-Cutters on Hold
- *Senate Finance Committee:* Finance Committee Approves Marilyn Tavenner to Lead Medicare, Medicaid
- *Kaiser Health News:* Harkin Lifts Hold On Tavenner Nomination To Lead CMS
- *Kaiser Health News:* Advocates Head to Court to Overturn Medicare Rules for Observation Care
- *The Hill:* Unified Medicare Benefit Would Save Billions, Study Says

Federal Register

CMS published a proposed rule revising the Incentive Reward Program provisions of 42 C.F.R. § 420.405 and certain provider enrollment requirements in 42 C.F.R. § 424, Subpart P. The proposed rule specifically modifies the reward amount for information regarding individuals or entities engaged in potentially fraudulent behavior from 10 percent of the overpayment or $1,000,

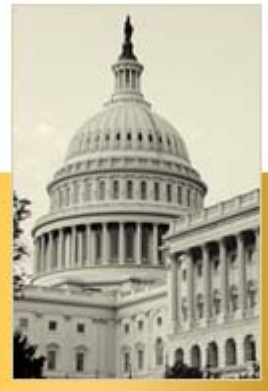


whichever is less, to 15 percent of the final overpayment amount collected. In addition, the rule would expand CMS' bases for denying or revoking a provider or supplier's enrollment, including allowing revocation upon a determination that a provider or supplier has a "pattern or practice" of submitting claims that fail to meet Medicare requirements. Comments will be accepted until June 28, 2013. The proposed rule was published in the Federal Register on April 29, 2013, and is available here.

CMS published a proposed rule that would increase Medicare reimbursement for hospice providers by 1.1% for fiscal year 2014. The rule would also amend the existing quality-reporting requirements for hospices and, beginning July 1, 2014, would require hospices to being collecting and submitting new patient-data forms – called Hospice Item Sets – designed to measure certain aspects of patient care upon admission and discharge. Comments are due by July 9, 2013. The proposed rule is available here and will appear in the May 10 Federal Register.

IRS published a Notice of Proposed Rulemaking (NPRM) regarding the health insurance premium tax credit made available by the Affordable Care Act and related statutes. The regulations generally provide guidance for determining whether health coverage under an eligible employer-sponsored plan provides minimum value (MV) and affects employers offering health coverage and their employees. Comments will be accepted through July 2, 2013. The NPRM is available here and appeared in the May 3 Federal Register.

FDA put on display a notice announcing and requesting comments regarding a regulation that would clarify how FDA determines the organizational entity within FDA assigned to have primary jurisdiction for the premarket review and regulation of products that are comprised of any combination of: (1) a drug and a device; (2) a device and a biological product; (3) a biological product and a drug; or (4) a drug, a device, and a biological product. The regulation would also establish a procedure whereby an applicant could obtain an assignment or designation determination by submitting certain information to FDA. Comments are due July 1, 2013. The notice is available here and appeared in the May 2 Federal Register.



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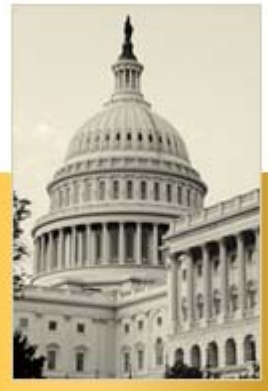

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* *Inc.* Magazine, September 2012

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