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Weekly Washington Healthcare Update

This Week: Upcoming Congressional hearings on Medicare/Medicaid reforms... Administration delays ACA's employer mandate requirement... Proposed rule would reduce dialysis payments

JULY 8, 2013

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1. Congress

House of Representatives

District Work Period -- No Votes

Upcoming Energy and Commerce Hearing on Medicaid Reform

The Energy and Commerce Health Subcommittee has announced it will hold a hearing entitled "Making Medicaid Work for the Most Vulnerable" on Monday, July 8, 2013, at 4 p.m. in 2123 Rayburn.

Witnesses:

Nina Owcharenko
Director, Center for Health Policy Studies
Heritage Foundation

Tarren Bragdon
President & Chief Executive Officer
Foundation for Government Accountability

Alan Weil
Executive Director
National Academy for State Health Policy

For more information, or to view the hearing, please visit: energycommerce.house.gov

Senate

State Work Period -- No Votes

Finance Committee Hearing on Medicare Payment Reform

The Senate Finance Committee has announced it will hold a hearing entitled "Repealing the SGR and the Path Forward: A View from CMS," on Wednesday, July 10 at 10 a.m. in Room 215, Dirksen Senate Office Building.

Witnesses:

Mr. Jonathan Blum
Acting Principal Deputy Administrator and Director
Center of Medicare, Centers for Medicare and Medicaid Services

For more information, or to view the hearing, please visit: www.finance.senate.gov

2. Administration

HHS

Employer Mandate Requirement Delayed One Year

The Administration has announced it will delay a provision of the Affordable Care Act that would have required businesses with more than 50 employees to provide affordable health care or pay a fine of up to $3,000 per employee, beginning in 2014. Citing concerns that the reporting requirements under the Affordable Care Act (ACA) are too complicated for businesses to reasonably implement, the announcement also specified that, until 2015 when the employer mandate will now take effect, businesses will not be penalized if they do not provide worker health insurance. The delay is an attempt to address complaints from employer groups and others that feel the current requirements will put an undue administrative burden on businesses. The Administration has said that it is still encouraging insurers and employers to voluntarily implement the proposed rules as a way to provide real testing of the reporting systems. The

American Hospital Association said the employer mandate delay is "troubling" and "further erodes the coverage that was envisioned as part of the ACA."

CMS

Office of the National Coordinator for Health IT Plan Released

On July 2, the Office of the National Coordinator for Health Information Technology (ONC) released plans for reducing medical errors caused by electronic health records and other health IT tools. The Health IT Patient Safety Action and Surveillance Plan was a joint effort by ONC and the Agency for Healthcare Research and Quality at the Department of Health and Human Services to promote the reporting of health IT-related patient safety incidents and hazards through the use of EHR systems to reduce the rate of occurrence, ONC said in a release.

The plan centers on leveraging ONC's EHR certification program to create a closer relationship between health IT vendors and patient safety organizations. ONC also will propose standards and certification criteria for generating incident reports from EHR systems later this year.

3. State Activities

Pennsylvania Medicaid Expansion

It wasn't long after the Pennsylvania Senate approved Medicaid's expansion in their state by a bipartisan 40-10 vote, that Republicans in the House stripped the bill of its expansion language, and sent it back to the Senate. With the House now in recess for the remainder of the summer, any hopes for Medicaid's expansion lie in the hands of state senators. A number of observers believe that this action by the House will likely be enough to push the issue to the fall.

Iowa Exchange Receives Six Insurer Applications

Six insurers within the state have decided to join the Iowa exchange: Coventry Health Care of Iowa, CoOportunity Health, Avera Health Plans, Gunderson Health Plans, Sanford Health and Health Alliance Midwest. Absent from the list was Wellmark Blue Cross Blue Shield — Iowa's largest health insurer. Though it has opted out of selling during the first year, according to the CEO of the insurer, John Forsyth, they do intend to apply to be able to list their policies for the following year, 2015. More information: www.liveinsurancenews.com

4. Regulations Open for Comment

NEW - IRS Proposed Rule For Tax Credits Issued on Exchanges

On June 28, the IRS issued a proposed rule on specific information regarding premium tax credits the insurance exchanges must report to IRS and to the person receiving the tax credit. Under the proposed rule, IRS explains what specific information regarding the tax credits the exchanges must report to IRS and to the person receiving the tax credit. Under ACA, tax credits can be made available to eligible recipients each month. The proposed rule would require the exchanges to report the required information to the IRS on a monthly basis and to the recipient on an annual basis. The information the exchanges must report would include, among other things, the name, address, taxpayer identification — i.e., Social Security — number (or date of birth if a taxpayer ID number is not available), the monthly premium for the applicable benchmark plan used to compute the tax credit and the monthly premium for the plan or plans in which a taxpayer, responsible adult or family member enrolls, without reduction for advance credit payments. According to the proposed rules, the exchange would report the information to the IRS on or before the 15th day following each month of coverage. The exchange must also send the tax credit recipient an annual statement including the same information on or before Jan. 31 of the year following the calendar year of coverage. Comments are due Aug. 31.

NEW - CMS Proposed Dialysis Payment Rule

CMS has issued the proposed End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) rule for renal dialysis services furnished to beneficiaries on or after Jan. 1, 2014. CMS projects the updated calendar year (CY) 2014 ESRD bundled market basket increase will be 2.9 percent, which is reduced by an estimated multi-factor productivity (MFP) adjustment for CY 2014 of 0.4 percent, for a projected update of 2.5 percent to the ESRD PPS base rate in CY

2014. Section 632(a) of the American Taxpayer Relief Act of 2012 requires the Secretary to make reductions to the ESRD PPS base rate to reflect the Secretary's estimate of the change in the utilization of ESRD-related drugs and biologicals by comparing per patient utilization data from 2007 with such data from 2012. This adjustment results in an overall 12 percent reduction in Medicare payments for CY 2014. The rule seeks comment on whether this change should be phased in over more than one year.

As a result of the application of the ESRD bundled market basket update reduced by the MFP adjustment, the wage index budget-neutrality adjustment and the drug utilization adjustment, CMS projects the proposed updates for CY 2014 would decrease total payments to all ESRD facilities by 9.4 percent compared with CY 2013.

The rule also proposes changes to the ESRD Quality Incentive Program (QIP) for payment year (PY) 2016.

The proposed rule also addresses issues related to the coverage and payment of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), including clarification of the definition of routinely purchased DME; clarification of the grandfathering provision related to the three-year minimum lifetime requirement; and implementation of budget-neutral fee schedules for splints, casts and intraocular lenses (IOLs) inserted in a physician's office.

View the proposed rule. CMS will accept comments on the proposed rule until Aug. 30, 2013.

Proposed Rule on Home Health Payments

On June 27, CMS published a proposed rule to update Medicare's Home Health Prospective Payment System (HH PPS) payment rates and wage index for calendar year (CY) 2014. The rule proposes rebasing adjustments, with a four-year phase-in, to the national, standardized 60-day episode payment rates, the national per-visit rates and the NRS conversion factor. Payments to home health agencies (HHAs) are estimated to decrease by approximately 1.5 percent, or $290 million in CY 2014, reflecting the combined effects of the 2.4 percent HH payment update percentage ($460 million increase); the rebasing adjustments to the national, standardized 60-day episode payment rate; the national per-visit payment rates; the NRS conversion factor ($650 million decrease); and the effects of ICD-9 coding adjustments ($100 million decrease). This proposed rule would also establish home health quality reporting requirements for CY 2014 payment and subsequent years and proposes to specify that Medicaid responsibilities for home health surveys be explicitly recognized in the State Medicaid Plan, which is similar to current regulations for surveys of Nursing Facilities (NF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID). Comments must be received by Aug. 26.

Final CMS Rule on Improving Coordination Between Long-Term Care Hospitals and Hospices

CMS issued a rule June 26 that aims to improve care coordination between long-term care (LTC) hospitals and hospice facilities; the new rule, which goes into effect Aug. 26, 2013, clearly defines the role of each provider in delivering and maintaining the continuity of care for each patient. Because LTC facilities and hospitals provide many of the same services, there is a high possibility that residents could receive duplicative and/or conflicting services. In general, LTC facilities are usually responsible for nursing services, dietary services, physician services, dental service, pharmacy services, specialized rehabilitative services and, when necessary, laboratory and social services. The new rule mandates that LTCs that choose to arrange for the provision of hospice care enter into written agreements with Medicare-certified hospice providers of the specific services to be provided by each entity in order to reduce overlap. "We believe that a clear division of responsibilities and increased communication required by this rule will help eliminate duplication of and/or missing services," CMS said in the rule. As the rule stands, the written agreement of care will unanimously be applied to all residents within the LTC facility, not individual patients. Criticisms of the new rule are largely based on the extra burden to providers, as it will take staff time to develop the language for the one written agreement describing the allocated care services. It is estimated that the burden associated with first-year implementation of this rule is 80,695 hours or $5.5 million for the 16,139 LTC facilities affected.

Proposed Rule to Clarify Long-Term Care Ombudsman Program

The Administration on Aging (AoA) of the Administration for Community Living (ACL) within the Department of Health and Human Services (HHS) has issued a Notice of Proposed Rulemaking, with request for comments, to implement provisions of the Older Americans Act, the State Long-Term Care Ombudsman program. This proposed rule replaces AoA's 1994 Notice of Proposed Rulemaking. The proposed rule contains two main parts, both related to the ombudsman program:

An amendment to existing regulations promulgated under the Older Americans Act at 45 C.F.R. Part 1321, and a new Part 1327, which would be added to the existing regulations. The proposed amendment to existing regulations addresses responsibilities of state agencies housing long-term care ombudsman offices not to disclose the identity of any person sending a complaint to the ombudsman or the identity of any resident of a long-term care facility. In addition, the proposed amendment would extend the disclosure protections to include "files, records, and other information" instead of only "files" as the existing rule provides.

The newly proposed Part 1327 would define the following terms included in the Older Americans Act, including "immediate family," "office of the state long-term care ombudsman" and "representative of the office of the state long-term care ombudsman." Comments are due Aug. 19.

Program Integrity Guidelines for Exchanges, Premium Stabilization Program

CMS has released a proposed rule outlining program integrity guidelines for the Health Insurance Marketplace (Marketplace) and premium stabilization programs. The proposed rule sets forth financial integrity and oversight standards with respect to Affordable Insurance Exchanges; Qualified Health Plan (QHP) issuers in federally facilitated exchanges (FFEs); and states with regard to the operation of risk adjustment and reinsurance programs. It also proposes additional standards with respect to agents and brokers. These standards, which include financial integrity provisions and protections against fraud and abuse, are consistent with Title I of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. The proposed rule says that in states running only the SHOP exchange while HHS operates the exchange for the individual market, data sharing requirements between the SHOP and individual exchange won't apply. There's only one state that plans to have such an arrangement -- Utah -- and the data issue was a key concern. The rule would also allow the state to set up a navigator program for the SHOP exchange, exclusively for outreach to small businesses, that is completely separate from the one for the individual exchange. Comments must be submitted by July 15.

Pre-Existing Condition Insurance Plan (PCIP) Interim Final Rule

CMS has issued an interim final rule with comment period sets the payment rates for covered services furnished to individuals enrolled in the Pre-Existing Condition Insurance Plan (PCIP) program administered directly by HHS beginning with covered services furnished on June 15, 2013. The rule sets most reimbursement rates in federally administered PCIPs at Medicare levels. This interim final rule also prohibits facilities and providers who, with respect to dates of service beginning on June 15, 2013, accept payment for most covered services furnished to an enrollee in the federally-administered PCIP from charging the enrollee an amount greater than the enrollee's out-of-pocket cost for the covered service as calculated by the plan. The rule also bans "balance billing" enrollees of the federal-run PCIPs to protect them "from having to potentially shoulder significant costs that could be shifted to them as a result of this new payment policy." Comments will be accepted through July 22.

Disproportionate Share Hospital Proposed Rule

CMS has issued a proposed rule on Disproportionate Share Hospital (DSH) payment reductions required by the ACA, applying a methodology that would not distinguish between states that have chosen to expand their Medicaid programs, pursuant to the ACA. According to the proposed rule, data reflecting the effects of the decision to implement the new coverage group may not be available to consider the impact of a state's decision to expand or not until 2016.

Once finalized, this rule will go into effect on Oct. 1, unless Congress enacts the president's budget proposal to begin the Medicaid DSH allotment reductions in fiscal year 2015 instead of FY 2014, while retaining the same total amount of reductions through 2020. The Affordable Care Act requires aggregate reductions to state Medicaid DSH allotments annually from FY 2014 through FY 2020. Comments on the proposed rule are due July 12.

Tanning Bed Warning Label Proposal

The FDA issued a proposal that would elevate tanning beds from a low-risk to high-risk medical device and would add a warning label to them. If the order is finalized, manufacturers would have to submit a pre-market notification (510(k)) to the FDA for these devices, which are currently exempt from any pre-market review. Manufacturers would have to show that their products have met certain performance testing requirements, address certain product design characteristics and provide comprehensive labeling that presents consumers with clear information on the risks of use. The order proposes to include a contraindication against use on people under 18 years old, and the labeling would have to include a warning that frequent users of sunlamp products should be regularly screened for skin cancer.

The FDA will take comments on the proposed order until Aug. 7.

5. Reports

HHS-OIG

Medicare Contractor Uncollected Overpayments Total $543 Million

According to the HHS-OIG, Medicare contractors reported $543 million in currently not collectible (CNC) provider overpayments for 2010, with detailed information on only seven of the 39 contractors that pay and process claims. Those seven contractors were only responsible for 71,000 CNC overpayments, or 22 percent of payments for the fiscal year 2010. For the seven contractors, 97 percent of FY 2010 CNC overpayments were not recovered. According to contractors, inaccurate provider contact information delays or prevents some overpayment demand letters from reaching providers. In order to improve information on CNC overpayments, the Office of the Inspector General has recommended that the CMS ensure that all CNC overpayments include provider type, that correct addresses are on file when sending overpayment demand letters and that tax identification numbers are used to keep track of providers who receive government payments.

GAO

$3.7 Billion Awarded to Establish Insurance Exchanges

According to a GAO report released July 1, HHS has awarded about $3.7 billion to states to establish health insurance exchanges; however, states had drawn down only about $380 million in health exchange funding as of February. Among states that have received exchange grants, the amount of funding provided ranges from $0.8 million (Wyoming) to about $911 million (California). Approximately half the states were awarded less than $30 million in exchange grant funding, while 10 states were awarded more than $100 million. GAO's review of a subset of exchange grantee financial reports indicated that nearly 80 percent of expenditures have been for contracts and consulting services, much of which states spent on key activities for developing exchange information technology systems. HHS also awarded about $159 million in rate review grants to 46 states and the District of Columbia, much of which has funded five key activities, including expanding the scope of rate review programs and enhancing the transparency of the rate review process.

If you have any questions, please contact Stephanie Kennan, Senior Vice President, or Brian Looser, Assistant Vice President, at McGuireWoods Consulting.

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