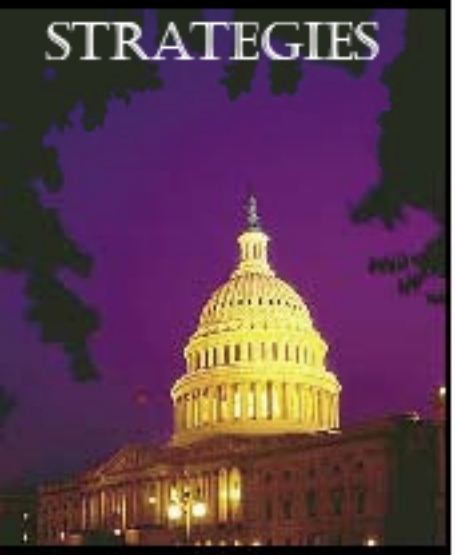
HART HEALTH HH STRATEGIES



Health Policy Briefing

November 5, 2012

Medicare, Medicaid, PPACA At Stake in Tuesday's Election; CMS Issues Final Pay Rules

Election To Shape Budget Deal and Regulation on Health Issues

Tuesday's presidential election appears to be a dead heat with just a few states set to determine the outcome and the lame-duck congressional agenda on avoiding the "fiscal cliff" and raising the federal debt ceiling. While a re-elected **President Obama** has indicated his interest in pursuing a "grand bargain" to ameliorate the effect of sequestration and reduce future federal deficits, a newly elected **President Romney** would likely try to persuade Congress to make a short-term deal and push off long-term decisions in order to allow the Romney administration to structure its own comprehensive tax and spending plan. If campaign promises are pursued, the Romney plan would seek to restructure Medicare (allowing younger taxpayers to choose private health plans in the future), provide states with block-grant funding for Medicaid and scale-back the main components of the PPACA (including the individual mandate and $ 716 billion in Medicare cuts).

Regardless of the presidential outcome, the Obama Administration will likely rush to issue regulations that OMB has bottled up for political reasons. The Administration has also delayed issuing the upcoming regulatory agenda on key health issues as well as details on the effect of sequestration on federal health programs. The lack of key PPACA regulations have hampered the ability of states to properly structure their health insurance exchanges, of health insurers to finalize their benefit plans and of employers to make coverage decisions for next year and for the critical 2014 year when the PPACA mandates become effective. If Obama is reelected, The House Oversight and Government Reform Committee is readying a "resolution of disapproval" which would strip the IRS of its regulatory decision to provide federal subsidies for individuals who obtain health insurance under the default federally administered health exchange (or even all such subsidies). The committee's chairman, **Rep. Darrell Issa,** has threatened the IRS with a subpoena for documents related to

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the IRS decisions after the agency cited "confidentiality interests" as the reason for not complying with an earlier request for information. If Mitt Romney prevails, the House will likely defer action on this and other health matters until next year and attempt to use the budget reconciliation process to halt the implementation of various PPACA provisions.

HHS to Unveil Two Nationwide PPACA Health Plans

OPM has been silent on health related regulatory matters, but raised the veil briefly to say that OPM will negotiate with insurers to establish two new nationwide health insurance plans (one a non-profit) that will be offered in both state-run health insurance exchanges and the federal default exchange. If the Administration limits the offerings available under the federal exchange to the two nationwide plans, this move would greatly simplify the operation of the federal exchange. It remains unclear whether the plans would have to abide by state insurance law as well as the rules under the PPACA.

CMS Releases Final Payment Rules

Last week CMS released the 2013 Medicare Physician Fee Schedule (MPFS) final rule which will take effect next year. Comments are due within 60 days. The rule includes a cut of nearly 27% that is scheduled for more than a million physicians under the SGR (unless Congress mitigates the cut legislatively). The rule also addresses other changes to the physician fee schedule (RVU, PE, geographic cost indices, etc.), quality provisions (PQRS, e-prescribing, EHR and the VBPM), and payments for Part B drugs, etc. The rule also implements provisions of the PPACA by establishing face-to-face encounters as a condition of payment for certain durable medical equipment (DME) items. In addition, it implements statutory changes regarding the termination of non-random prepayment review.

CMS also released the 2013 Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems (OPPS/ASC) final rule that includes provisions related to QIOs. Under the rule, OPPS payments will increase by about 1.8% and ASC payments will increase by about 0.6%.

Under a final CMS rule for home health agencies, payments are estimated to decrease by about $10 million or .01%. The rule contains provisions to ensure quality and establishes a new hospice quality reporting program.

A final CMS rule for Medicare reimbursements to end-stage renal disease treatment facilities will increase payments by 2.3% in 2013 to about $8.4 billion. The rule also includes reporting on clinical measures and expands the scope of the ESRD Quality Incentive Program (QIP) reporting requirement to cover a broader range of patients who receive dialysis care.

Codifying a provision of the Middle Class Tax Relief and Job Creation Act, the rule reduces to 65% certain bad debt payments for several Medicare provider groups as an intended revenue source for a future Medicare doc fix. A final CMS Medicaid payment rule provides for increased payments in only 2013-14 for primary care services delivered by a physician in family medicine, general internal medicine or pediatric medicine as well as for related sub specialists. The rule allows states to either lock-in rates at the level of the Medicare physician fee schedule in effect at the beginning of 2013 and 2014 or modify the rates in alignment with all updates by Medicare. In addition to value-based payments, family physicians would likely see increases of about 7% while other physicians providing family care services would see their rates increase by about 3-5%.

MedPAC Approves Recommendations to Congress

Last week the Medicare Payment Advisory Commission voted to approve several Medicare payment policy changes. The recommendations on therapy caps requested by Congress would: reduce the certification period for outpatient therapy plan of care from 90 to 45 days; develop national guidelines for therapy services, implement payment edits at the national level based on guidelines that target implausible amounts of therapy and use PPACA authority to target high-use geographic areas and aberrant providers; reduce the cap for physical therapy and speech-language pathology services combined and the separate cap for occupational therapy to $1,270 in 2013 and update the caps annually by the Medicare Economic Index; direct HHS to implement a manual review process for requests to exceed cap amounts and provide the resources to CMS for this purpose; permanently include services delivered in hospital outpatient departments under therapy caps; apply a multiple procedure payment reduction (MPPR) of 50% to the practice expense portion of therapy services provided to the same patient on the same day; prohibit the use of V-codes as principal diagnoses on therapy claims; and collect functional status information on therapy users using a streamlined, standardized assessment tool that reflects factors such as a patient's demographic information, diagnosis, medication, surgery and functional limitations to classify patients across all therapy types. The recommendations on Medicare physician payment work adjustments would provide for adjustments to reflect geographic differences across labor markets for physicians and other health professionals. However, MedPAC said Congress should allow the geographic practice cost index (GPCI) floor to expire as under current law and adjust payments for the work of physicians and other health professionals only by the current one-quarter GPCI. HHS should be directed to develop an adjuster to replace the current one. As to current three temporary add-on payments for ambulance services, MedPAC recommended that they be allowed to expire this year. MedPAC also recommended that HHS "rebalance" ambulance payments in a revenue neutral way to pay less for basic life support and to pay more for other ground services. MedPAC also discussed but could not resolve whether or not to recommend a penalty on home health care agencies whose patients are admitted to hospitals at an unusually high rate. The commission also discussed, without resolution, making several changes with respect to MA special needs plans, such as to permanently reauthorize institutional needs plans and D-SNP plans covering dual eligibles if they assume clinical and financial responsibility for integrated benefits. However, they are considering the current authority for chronic care plans to expire.

HHS OIG Approves Flat Rate Compensation

In an advisory opinion released by the HHS Office of Inspector General, the agency said that the practice by hospitals to pay flat or per diem fees to specialty physicians for providing on-call services in hospitals is ok if the arrangements meet certain conditions, including an independent review of set rates paid for actual and necessary services.

NIH Creates National Down Syndrome Registry

NIH has provided a contractor with $300,000 to develop and operate a national Down syndrome patient registry to facilitate care coordination and information sharing among families and researchers. Individuals with Down syndrome and their families would be able to access the registry to create a customized profile, access the patient's health history, input and update contact information, select which patient data should be displayed, receive reminders about the patient's medical care and compare the patient's medical information with anonymous data on other registry participants.

Health Legislation Recently Introduced

H.R. 6580 (VETERANS' HEALTH), to amend Title 5, United States Code, to allow veterans who receive health care from the Department of Veterans Affairs to be eligible for supplemental dental and vision insurance under the Federal Employees Health Benefits Program; FUDGE; jointly, to the committees on Oversight and Government Reform and Veterans' Affairs, Oct. 26.