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(Covers activity between 5/1/16 and 5/31/16)

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Return To Top

HBMA GR Committee Preparing Comments on MACRA Proposed Rule

The HBMA Government Relations Committee and select HBMA members who volunteered to participate in the process are currently reviewing the 962 page proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) in April that establishes the key details for how the Agency will implement the new Medicare value-based payment systems created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

MACRA repeals the maligned Medicare Sustainable Growth Rate formula (SGR), which provoked a yearly ritual of Congress scrambling to pass short-term bills at the 11th hour to avoid massive cuts to Medicare Part B reimbursements. MACRA replaces the SGR by providing a few years of modest payment updates before giving providers two value-based payment options in which they can participate.

Most providers will participate in the Merit-based Incentive Payment System (MIPS) which consolidates the three existing Medicare quality programs (PQRS, Value Modifier and EHR Meaningful Use) into a new quality reporting and measurement program. MIPS requires

providers to report under several categories and assigns each participating provider a composite score based on their performance in: quality; use of technology; cost of care; and use of clinical practice improvement activities. How an individual provider scores when compared to all other MIPS eligible clinicians will determine whether that clinician receives a positive payment adjustment or a negative payment adjustment.
It is important to note that the MIPS initiative is built on the current fee-for-service platform using the Resource Based Relative Value Scale methodology as the foundation for determining final payment for services.

MACRA also allows providers to participate in Alternative Payment Models (APM) which hold providers accountable for financial risk and quality of care. Providers who meet a participation threshold for APMs that are approved by CMS can be exempt from MIPS reporting and can earn a percent bonus payment claims for each year they meet the APM threshold. Providers in APMs can also earn rewards through the structure of the actual APM.

The HBMA reviewers are conducting an in-depth analysis of the operational and administrative challenges that the new payment models present. For example, how will providers receive feedback on their performance in either MIPS or APMs? Will CMS be open to reducing the MIPS reporting period from one year to 90 days for the first reporting year as providers adjust to the new system? How will CMS specifically adjust a provider's payments under MIPS? Will the patient's cost sharing be based on the MIPS adjusted payment or the underlying fee-schedule amount? The proposed rule is rather vague in those important details.

HBMA intends to incorporate these, and other important questions into formal comments to CMS. HBMA also intends to identify issues that should be more urgently addressed with CMS outside of written comments through either meetings or separate correspondence with the Agency.

If you have any comments or observations about the proposed rule that you would like to bring to the attention of the HBMA GR Committee, please email them to gr@hbma.org.

Return To Top

House Ways and Means Committee Passes Bill Tweaking Several Hospital Payment Policies

In early May, the House Ways and Means Committee put forward a bill that makes some adjustments to several hospital payment policies. The Helping Hospitals Improve Patient Care Act (H.R. 5273), would add clarification to last year's hospital outpatient department site neutral payment policy as well as make some changes to the way hospital readmission penalties are applied. The bill was passed unanimously by the House of Representatives on June 7th.

Last year, when Congress passed the Bipartisan Budget Act (BBA) which set top line spending amounts for the following two fiscal years, they added a provision to the bill that established a

site neutral payment policy for all "new" hospital outpatient departments (HOPD). This provision was intended to rein in the increasingly prevalent purchasing of physician practices by hospitals which would subsequently designate the practice as a HOPD. The HOPD designation made the site eligible for higher reimbursements for providing the same services. The BBA grandfathers existing HOPDs but prohibits "new" HOPDs from being reimbursed at the higher rates. Many hospitals objected to the new law because it did not provide an adequate definition for what constitutes a "new" HOPD. For example, many hospitals were in the process of actively constructing new HOPDs and the financial models for these in-progress projects were based on the expectation that they would receive the HOPD payments. The Ways and Means Committee bill clarifies the term "new" to allow HOPDs which were in the process of being built before the BBA was passed to remain eligible for the HOPD reimbursement rates.

Additionally, the bill would change the way hospitals are evaluated for readmission penalties. Rather than evaluate all hospitals together, the bill would group hospitals together based on the number of Medicare/Medicaid dual-eligible patients they treat for the readmissions penalty. The Committee believes this will create a more even playing field for hospitals that treat very different patient populations. Although this specific provision only applies to hospitals, it is an interesting way of approaching one of the key complaints about quality measurement programs – failure to risk adjust for factors outside the control of the provider. Providers treating large populations of "difficult" to treat patients argue that they are disadvantaged against their peers who see "easier" to treat patient populations.

It will be especially interesting to see the reaction of stakeholders and policy makers to the idea of stratifying providers within a quality performance program based on patient population. If Congress or CMS is willing to implement such a policy in one forum, perhaps they would apply this methodology to other Medicare quality programs such as the Merit-Based Incentive Payment System (MIPS).

Return To Top

Misery Loves Company - Push to Expand RAC Program Gaining Steam

Since 2007 CMS has had a system in place to reduce overspending in Medicare Parts A and B known as the Recovery Audit Contractor (RAC) program. The Recovery Audit Contractor initiative has been one of the most notable program integrity strategies employed by the Centers for Medicare and Medicaid Services (CMS) in the last few years. To date, it has been focused exclusively on auditing Part A and Part B claims and has not been extended to Parts C or D.

For many years, federal law has allowed individuals eligible for Medicare Part A and B to enroll in an approved private health plan (Medicare Part C) instead of traditional Medicare. Medicare Part C approved Health Plans (MA Plans) receive monthly premiums from Medicare and enrolled patients. MA Plans are then responsible for paying for all medically necessary care for enrolled beneficiaries that would have been covered had these individuals enrolled in traditional Medicare. The plans are also authorized to cover services not included in the traditional Medicare A and B benefit package.

In addition to the base premium, MA Plans can receive add-on payments from Medicare if it is determined that a disproportionately high number of "unhealthy" individuals enrolled in that plan resulting in higher than expected costs. The data to determine if a plan has a higher than expected "unhealthy" population is self-reported and some plans have been accused of exaggerating the risk scores for their patients in order to receive the higher payments.

Some outside observers have questioned whether MA plans are up-coding their enrollees in order to justify higher Medicare payments to the Plans.

The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and the Government Accountability Office (GAO), both recently issued reports suggesting that there may be some validity to the "up-coding" allegations.

An OIG commissioned report, authored by Ernst & Young was published on May 12, 2016, and concluded that HHS should implement an expanded RAC program to monitor Medicare Parts C and D payments, particularly these risk adjustment payments. The report recommends that CMS have the Medicare Advantage RAC program in place by FY 2017 (October 1, 2016).

The report by GAO, which was released on May 9th, comes to a similar conclusion as the Ernst & Young report, recommending that CMS establishes a "legally binding RAC program for Medicare Part C.

Although federal law has authorized CMS to expand the RAC program beyond Part A and B claims from its inception, the agency has yet to act on this authority. HHS agreed with each of GAO's recommendations.

There is a concern that by adding MA audits to the RAC scope of work, the backlog of appeal reviews currently seen in the RAC program could get worse. Just as providers subject to RAC audits have challenged those reviews, MA plans can also be expected to appeal the RAC's findings. Critics worry that the logistical issues experienced by Part A and B providers going through a RAC appeal could be exacerbated by an expansion of the RAC program unless additional resources are devoted to the audit appeals process.

Though nothing has been decided yet, the weight of the OIG and GAO reports certainly suggests that momentum towards expanding the RAC program to MA plans is gaining steam.

Return To Top

HHS Wants to Make Medical Bills Easier for Patients to Understand

The Department of Health and Human Services (HHS) announced a new partnership with several organizations to improve medical bills for patients who often have trouble fully understanding them. This initiative, called the "A Bill You Can Understand" challenge, is intended to improve how medical bills explain what services were provided, what services are covered versus what services are not covered and what the patient owes in cost sharing.

The challenge solicits new designs for medical bills from the public and interested stakeholders. It is sponsored by AARP and will be administered by the Mad*Pow design agency. The challenge will issue two awards – one for the innovator that designs the bill that is easiest to understand and a second for the innovator that designs the best transformational approach to improve the medical billing system by focusing on what the patient sees and does throughout the process. Six organizations have committed to test the winning designs. They are:

- Cambia Health Solutions (Portland, OR)
- Geisinger Health System (Danville, PA)
- INTEGRIS Health (Oklahoma City, OK)
- The MetroHealth System (Cleveland, OH)
- Providence Health & Services (Seattle, WA)
- University of Utah Health Care (Salt Lake City, UT)

The challenge will accept submissions until August 10, 2016. Challenge winners will be announced in September 2016 and will receive cash prizes of $5,000 each.

Return To Top

Insurers Submit 2017 Health Exchange Premium Rate Proposals

This month, the public was offered its first glimpse into how much insurers intend to raise premiums for the plans they sell in the health insurance exchanges in 2017. This insight came via rate filings with state and federal regulators. Many of the rate proposals publicized thus far are relatively modest increases however some markets might experiences a dramatic increase in Health Plan premiums for the coming plan year. While premiums generally increase each year, the effects of the many hardships faced by insurers over the past three years is apparent in the proposed premium rate increases for 2017 in certain markets.

There are a number of factors that insurance providers consider in the formulation of their premium proposals. Factors likely to raise premiums in 2017 include:

- The end of the Affordable Care Act (ACA) reinsurance and risk-corridor programs;
- The rising general costs of healthcare; and
- Historically adverse patient mix in the exchanges which see enough younger (healthier) consumers enroll in plans to balance the cost of older (sicker) consumers.

While these factors undoubtedly affect the premium proposals, these rates are not set in-stone immediately upon their proposal. Instead, insurers are required to submit their proposed premium increases to state regulators who either approve or disapprove of the proposal. Further, any proposed rate increase of 10 percent or higher is reviewed by HHS who then has the option to publicize the rates if they deem them unreasonable. However, HHS cannot approve or disapprove of a rate.

While the premium rates will almost certainly not be finalized until November 1st when the rates are published on Healthcare.gov, the proposal filings paint an early picture of 2017's insurance

markets. Thus far it appears premium rates will most likely be higher on average in 2017 than in 2016. The ACA is still providing healthcare subsidies to individuals up to 400 percent above the federal poverty line which will dampen the impact of higher premiums on consumers who are eligible for the subsidies.

A study conducted by Avalere Health on the first nine states to publish premium proposals indicates that premiums for silver-tiered plans will rise by an average of 16 percent. Premium increases ranged from as low as 5 percent in one state to 44 percent in another. A separate study on the previous year's premium changes conducted by the Robert Wood Johnson Foundation found it very difficult to identify a true national average for premiums because each market within each state is so unique.

In some markets, proposed premium rate increases are quite dramatic. For example, Oregon insurers asked for an average 42 percent premium increase across the second-lowest cost silver plans. This is important because this is the level on which the federal subsidies are based. However, New York saw a 25 percent reduction in proposed premiums for second-lowest cost silver plans despite a 7 percent average increase across all silver plans if the proposed rates are approved.

As a rule of thumb, nearly all premium proposals are higher in areas with weak competition, and lower in areas with greater competition. Rates also vary based not just on state, but also on specific markets within states and among each insurer. Though a state might see an overall modest increase in premiums on average, specific markets that only have one or two insurers to choose from could see much higher increases.

The proposed rate increases are not entirely surprising as insurers look to recover from their initial financial challenges and reach a level of consistent profitability on the exchanges. For the time being, without preexisting condition risk pools and the ability to reject coverage for less healthy individuals, narrow networks and high deductible plans are some of the only mechanisms providers have to keep costs down. Nonetheless, HHS has made stabilizing premium rates one of its primary goals moving forward, with the hope of bringing consistency to the marketplaces. Despite highly varied premium rates in 2014 and 2015, the hope amongst all in the healthcare industry is that if rates stabilize, competition will normalize and affordable rates will be the norm.

Return To Top

HHS Clarifies Rules on Charging Patients for Medical Records

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is attempting to clarify its policy for how much a HIPAA Covered Entity can charge patients for access to their medical records. OCR published additional information on its FAQ page addressing confusion over whether or not such a fee would be capped at $6.50.

According to OCR, providers are allowed to charge patients a "reasonable" fee to compensate themselves for providing copies of the patient's personal health information (PHI), including

electronic versions of their medical records. This fee is meant to cover labor and supply costs for providing the records. Providers have three options for determining the fee:

1. **Actual costs:** A provider may calculate actual labor costs to fulfill the request, as long as the labor included is only for copying (and/or creating a summary or explanation if the individual chooses to receive a summary or explanation) and the labor rates used are reasonable for such activity. The covered entity may add to the actual labor costs any applicable supply (e.g., paper, or CD or USB drive) or postage costs. Patients must be made aware of the fee in advance.
2. **Average costs:** In lieu of calculating labor costs individually for each request, a covered entity can develop a schedule of costs for labor based on average labor costs to fulfill standard types of access requests, as long as the types of labor costs included are the ones which HIPAA permits to be included in a fee (e.g., labor costs for copying but not for search and retrieval) and are reasonable. Covered entities may add to that amount any applicable supply (e.g., paper, or CD or USB drive) or postage costs.
3. **Flat fee for electronic copies of PHI maintained electronically:** A covered entity may charge individuals a flat fee for all requests for electronic copies of PHI maintained electronically, provided the fee does not exceed $6.50, inclusive of all labor, supplies, and any applicable postage. Charging a flat fee not to exceed $6.50 is therefore an option for entities that do not want to go through the process of calculating actual or average allowable costs for requests for electronic copies of PHI maintained electronically.

This FAQ section resulted in confusion for providers over whether or not the $6.50 cap for the flat fee option applies to the actual and average cost options as well. OCR is clarifying that the $6.50 cap only applies to the flat fee option and that there is actually no cap for what a provider can charge if they use the actual or average cost options. However, the fee must be "reasonable" in regards to covering labor and supplies.

Return To Top

DOL Increases Threshold for Overtime Payment Eligibility for Salaried Employees

On May 18th, 2016 the Department of Labor (DOL) published its final rule that drastically reforms the regulations regarding overtime pay for employees. Most notably, the final rule expands overtime pay benefits to more employees by increasing the salary eligibility threshold for overtime pay. By raising this threshold, millions of previously ineligible salaried employees are newly eligible to earn overtime pay.

The rule expands overtime pay benefits to salaried employees who make up to $47,476 per year. This threshold is currently set at those who make up to $23,660 per year. The DOL originally proposed a threshold of $50,440. The new cap takes effect on December 1st, 2016.

The final rule expanding overtime payment benefits now grants a projected 4.2 million additional salaried individuals the rights to "time and a half" payment for all hours per week worked

beyond 40. The threshold for overtime eligibility is to be automatically updated every three years, starting January 1st, 2020.

Employers with salaried employees who earn less than $47,476 (including bonuses) should be aware they are now legally obligated to pay their employees time and a half for every hour per week they work beyond the base-line 40 hour mark.

This rule will affect all industries, including healthcare. The DOL estimates the rule will directly affect roughly 200,000 hospital workers, and 300,000 non-hospital health care workers. Health professionals that may be most impacted include nurses, medical technicians and paramedics.

Return To Top

CMS Releases Interim Final Rule in Effort to Save Remaining CO-OPs, Address SEPs

On May 6, 2016 the Centers for Medicare and Medicaid Services (CMS) released an interim final rule which lifts some restrictions on the operations of Consumer Oriented and Operated (CO-OP) health insurers to help keep the remaining CO-OPs financially afloat. The rule also makes changes to the special enrollment periods for exchange-sold health plans.

CO-OPs were created under the Affordable Care Act (ACA) as a means to address the difficulties that often prohibit new health insurers face when trying to enter a market. The CO-OPs are state-based non-profit insurance providers designed to compete with existing large insurers. The ACA authorized billions of dollars in federal start-up loans for the CO-OPs. Over the past two years, many CO-OPs have struggled to gain a foothold in their state markets to the point where more than half of the original 23 have already closed. The financial struggles of the CO-OPs have largely been attributed to a massive shortfall in payments from the risk corridor program that was supposed to protect insurers from unexpected losses for the first few years of the exchanges. Large insurance companies, which have built up their financial stability over many years of existence were able to weather the losses from the risk corridor shortfall. The brand new CO-OPs had not reached that point of financial stability and were therefore forced to close up shop.

In response to the CO-OP failures, CMS released this interim final rule to amend a number of regulations governing CO-OPs in the hopes that easing several regulations will help those that remain, stay solvent. This interim final rule loosens the previous restrictions on the composition of CO-OP boards. Perhaps most significantly, CO-OPs are now allowed to accept investment from private for-profit entities if the CO-OP is in danger of being unable to provide full-coverage for its beneficiaries, or is near or has become insolvent. Additionally, the rule ends the requirement that the majority of CO-OP board members be members of the CO-OP themselves.

CO-OPs were also given temporary relief from the requirement that at least two-thirds of the plans they sell must meet the federal standards to be certified as qualified health plans (QHP) in the individual and small business exchanges. Previously, CO-OPs that did not meet this requirement could be forced to pay back their federal loans earlier than scheduled. The new rule allows for a grace period to meet the two-thirds requirement as long as the CO-OP offers a silver

and gold tiered QHP and provides a specific timetable for how it will meet the two-thirds requirement in the future.

Perhaps as an indication that this rule might be too little too late, only a few weeks after the interim final rule was published, Ohio's CO-OP announced that it will close in 2017 due to a net loss of over $79 million in 2015 combined with early 2016 losses of over $30 million. Ohio's CO-OP claims that it received none of the $47 million in risk corridor payments it was entitled to from 2015. The CO-OP, known as InHealth, provided care to about 20,000 individuals.

The interim final rule also reduces the special enrollment periods (SEPs) established by the ACA. SEPs are specific instances which allow individuals to buy a healthcare plan outside of the open enrollment period with no associated penalties. Examples of SEPs are marriage, adoption, permanent change of residence, etc. Insurance companies, big and small, detest SEPs which they see as easily exploited loopholes in which individuals can game the system to pay for insurance for the few months that they need it as opposed to paying the whole year. The interim final rule increases restrictions on SEPs, most notably by requiring those who use a change in residence to qualify for an SEP to have had valid healthcare for at least one of the prior sixty days to their SEP enrollment. Nonetheless, the new rules governing SEPs still do not require enrollees to have documentation as evidence, a primary complaint of insurance providers about SEPs.

The interim final rule which went into effect on May 11, 2016 is expected to make an immediate impact regarding levels of enrollment in SEPs for small and large insurance providers alike. Additionally, CMS will continue to closely-monitor the remaining CO-OPs operations under the new rules, in the hopes the program will not fail entirely.

Return To Top

HHS Regulatory Agenda Allows CMS to Delay Part B Drug Reimbursement Proposal

On May 18th, the Department of Health and Human Services (HHS) released its regulatory agenda for all pending regulatory actions. The agenda includes the proposed Medicare Part B Drug Payment Model which was proposed in March of this year. However, the agenda lists the date for the final rule's publication as March 11, 2019 – three years after the proposal was introduced. This is not the specific date that CMS intends to publish the rule, but it is the deadline by which it must. This implies that CMS could delay implementation of this controversial proposal for up to three years.

CMS is proposing a two-phased approach to change the way Medicare reimburses physicians under Part B for drugs they administer in their office. Medicare currently reimburses providers at 106% of the average sales price (ASP) of a drug. Phase one of the proposal reduces that payment to 102.5% but adds a flat fee of $16.80 per drug each time a drug is administered. Phase two would implement several value-based purchasing options. CMS is proposing to begin testing phase one of this model during the second half of 2016. Testing of the second phase will begin less than a year later in early 2017.

The proposal cannot go into effect until all comments are considered and a final rule is issued. The public comment period ended in May and it is likely that CMS received an enormous amount of comments that will take longer to review than the Agency expected. Additionally, the Obama Administration is facing an increasingly short window of opportunity to complete its regulatory agenda before the new Administration that might disagree with this proposal is sworn in and withdraws the proposal if it is not yet finalized. It is therefore safe to assume that CMS intends to finalize the rule before the end of the year.

Return To Top

Aetna and Humana Remain Confident About Merger Despite New Challenges

The CEOs of Aetna and Humana continue to express optimism that their proposed merger will be completed by the end of the year despite several new challenges to the mega deal between the two insurance giants. The merger prompts many concerns regarding the effect of the deal on competition, especially in the Medicare Advantage (MA) markets in some states. With Aetna and Human both standing among the top five largest insurers, a consolidation of this magnitude is certain to prompt anti-competition scrutiny.

The deal is currently being examined by several states before it will ultimately have to be approved by the US Department of Justice (DOJ) to ensure that it meets federal anti-trust standards. Thus far, most states that have reviewed the deal have approved it. However, this month, Missouri insurance regulators decided not to approve the proposed merger unless the companies make a significant divestment in the MA market in the state. According to the insurance regulators, if the deal were to be completed today, the new company would be in violation of anti-trust laws and would have to cease doing business in the counties that would be adversely affected until they are in compliance.

The companies were given 30 days to submit a plan on how it will address the State's anti-competition concerns. This will be a key test to see if the companies can "divest" their way to regulatory approval. Even if their response satisfies Missouri's regulator, it is unclear if this has broader implications for how other states and the DOJ will view the merger.

Return To Top

House Committee Holds Hearing on Medicare and Medicaid Program Integrity

On May 24, 2016 the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations held a hearing to address the issue of fraud and abuse within the federal Medicare and Medicaid programs. The hearing, which was chaired by Rep. Tim Murphy (R-PA-18), included three witnesses:

- Dr. Shantanu Agrawal (Deputy Administrator and Director, Center for Program Integrity, CMS, HHS)
- Mr. Seto J. Bagdoyan (Director, Audit Services, Forensic Audits and Investigative Service, GAO)

- Ms. Ann Maxwell (Assistant Inspector General, Office of Evaluation and Inspections, OIG, HHS)

The hearing's underlying theme was that while CMS has made progress in preventing fraud, there is more work to be done. Of course, the hearing's participants were divided on what the remaining work should be.

A point that was made early and often by Dr. Agrawal is that the majority of improper Medicare and Medicaid payments are not a result of fraud, rather they are the result of doctor documentation and coding errors.

A primary focus amongst most of the Committee's members was the comparison between commercial insurance providers and Medicare and Medicaid providers. Rep. Murphy was among the most critical of the 12 percent improper payment rate in fee-for-service (FFS) Medicare, and stated his desire to incorporate and/or mimic more commercial practices to mitigate improper payments. This line of questioning was undertaken by a number of other representatives, each receiving similar responses from the panel that the rate of improper payment was being worked on, and that it was biased to compare the privatized rate of improper payments versus the Medicare and Medicaid percentages.

Another sentiment expressed throughout the hearing by Committee Members as well as by the witnesses was that states need to assume more responsibility in enforcing federal fraud prevention programs. Dr. Agrawal stressed that CMS has attempted to provide states with improved avenues to prevent fraud such as increased access to federal background check programs and direct lines to CMS offices. Nonetheless, OIG witness Ann Maxwell stressed her belief that states are facing significant operational difficulties in addition to resource concerns in their efforts to implement an effective program integrity infrastructure. Therefore, their ability to fully implement the federally requested fraud prevention measures would not be as simple as some of the Committee Members suggested.

A frequently raised example of improper payments during the hearing was the continued existence of a high number of supposed healthcare provider addresses either being defunct or incorrect. Site-visits to verify provider addresses were touted as a measure that had achieved some level success. This tactic led to 1,900 providers being dis-enrolled after site-visits, but some Committee Members expressed dissatisfaction with that number. Some Members also feel that CMS currently employs ineffective background check procedures but pressed hard for advanced screening as an important tool.

A few weeks after the hearing, OIG released its Semiannual Report to Congress which provides an update on the OIG's efforts to combat fraud and abuse over the first half of the 2016 fiscal year. According to the report, OIG recovered $2.77 billion thus far in FY 2016, an increase of almost $1 billion that was recovered over the first half of FY 2015. About $2.2 billion was recovered through investigations while about $555 million was recovered through routine audits. Many of these recoveries are attributed to sizable settlements with large health systems.

According to the report, the number of providers who have been excluded from participating in the Federal Health Programs was 1,662 thus far in FY 2016.

Return To Top

Congress Working to Pass Opioid Addiction and Abuse Legislation

This being an election year, expectations of Congress passing meaningful legislation are low. However, in a rare display of bipartisanship and political willpower, Congress is nearing completion of a bill that addresses the growing opioid addiction and abuse epidemic that is plaguing many parts of the country. Opioid abuse and addiction has been a central election issue in many Congressional races this year which has supplied the motivation to address this issue with legislation despite what should be a generally unproductive period.

On March 10th the Senate passed S. 524, the Comprehensive Addiction and Recovery Act (CARA) of 2015, which focuses on giving state and local governments the resources to combat heroin and prescription pain killer addiction and abuse through better funded prevention and treatment programs. Further, the bill puts a strong emphasis on curtailing the liabilities associated with the emergency administration of opioid overdose medication, in conjunction with promoting the lawful disposal of opioids. CARA also takes steps to provide states and local governments with the means necessary to establish alternative treatment methods for opioid addicted individuals outside of incarceration.

CARA authorizes about $80 million to be appropriated to the Department of Justice (DOJ) for the awarding of grants to state and local governments. The grants will be used to establish new local and state opioid-abuse programs through existing DOJ grant programs and funding streams as opposed to creating a new grant program.

The House passed a package of eighteen of its own anti-opioid bills, illustrating its similar interest in addressing the opioid abuse problem. The bill package passed by the House, which includes the noteworthy H.R. 5046, the Comprehensive Opioid Abuse Reduction Act (COARA), will likely become amendments to CARA during conference. COARA currently stands as the House's most visible counterpart to CARA, and differs from the Senate's opioid abuse legislation in that it calls for the use of $103 million in block-grants to states for prevention and treatment programs. Another one of the bills in the House package, H.R. 4641, would create a federal interagency taskforce to develop best practices for pain management and prescribing opioids.

Though these bills would certainly make a positive impact on the fight against opioid addiction and abuse, Democrats are holding out for an extra $600 million through emergency funding. Republicans are resisting the use of emergency funding in favor of using the traditional appropriations process to provide any additional funding. Both bills are well short of the President's request for $1.1 billion in new funding to address the opioid epidemic.

While the opioid prevention bills have typically received widespread support from both sides of the aisle in the past months, Republicans and Democrats remain divided on the type and amount of funding the anti-opioid programs in these bills should receive.

In response to that frustration Senator Joe Manchin (D-WV) introduced a new piece of opioid abuse legislation that would implement a 1-cent-per-milligram excise tax on opioid distributors, for every opioid pill that they sell. The money from this tax would then go directly towards federal efforts to curb opioid abuse. Despite Manchin's bill having a small chance of becoming law, his proposal represents ongoing Democratic frustration with what they perceive to be a lack of necessary funding and drug-company accountability. Republicans have asserted that there is not enough time for this type of requirement to be successfully incorporated into CARA, and that ensuring CARA is passed close to as it stands now should be the priority.

The two Chambers are in the process of forming a Conference Committee to reconcile the policy and funding differences between the different bills. Currently CARA and the House bill package await joint conference deliberations, and it remains to be seen how the core variations between them will be reconciled.

Return To Top

ONC Publishes Data on Hospital EHR Utilization and Interoperability

The Office of the National Coordinator for Health Information Technology (ONC) has published updated information on EHR adoption and interoperability in non-federal acute care hospitals. The data, which was collected through surveys, shows steady improvements in both adoption and interoperability in 2015.

The study that focused on EHR adoption asserts that 96 percent of hospitals in the U.S. had possession of a certified EHR technology (CEHRT), and 83.8 percent of hospitals had fully adopted the usage of a basic EHR, a noteworthy improvement from 75.5 percent in 2014. Critical Access Hospitals (CAH) reported fully adopting basic EHRs in about 8 out of every 10 responses despite generally having less financial and technological resources than large-market hospitals.

Although the data shows a high percentage of hospitals having adopted an EHR, the level of interoperability between varying EHR products is markedly lower than what would be expected. According to ONC, there are four key domains of interoperability: sending, receiving, finding, and integrating. From 2014 to 2015 the percent of hospitals electronically receiving, sending, and finding key clinical information grew; however, the percent of hospitals electronically using or integrating clinical health information decreased. The percentage of hospitals that are interoperable across all four domains increased marginally from 23 percent to 26 percent. The interoperability study demonstrates at least some improvement from 2014 to 2015.

Despite this overall improvement, the interoperability study demonstrated that only 46 percent of hospitals had necessary patient information electronically available from providers outside their system at the point of care. Most of the major impediments to the full usage of EHR are technical issues such as an information exchange partner's EHR system being incompatible with the hospital's own system (59 percent), or difficulty in finding a provider's address (45 percent). Additional difficulties include fees associated with exchanging information or the exchange partner lacking a certified EHR system.

Congress expressed its desire for full-scale EHR interoperability by the end of 2018 in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As of now, this goal seems unrealistic given the pace of improvements reported in this release.

Return To Top

Congress Divided On How to Address Zika Virus

The Zika Virus has established itself as the U.S.' most significant public health threats of 2016 similar to past concerns over diseases such as Ebola and H1N1. The immediate effects of contracting the Zika infection through a mosquito bite are relatively minor, but according to the Centers for Disease Control and Prevention (CDC), a Zika infection during pregnancy can cause a serious birth defect called microcephaly, as well as other severe fetal brain defects. Zika has ravaged many countries in South America and though there have only been a few reported cases in the US, policy makers are worried that it impact on the US will dramatically worsen during peak mosquito season this summer.

The Obama Administration and Congress recognize the need for federal action to help prevent the further spread of the disease and mitigate the effects of the disease within the U.S. However, as is often the case, there is disagreement on the details of how to address this threat.

Both the House and the Senate have been working on legislation to appropriate federal funds that address the Zika threat. On May 16th the House of Representatives introduced H.R. 5243 – the Zika Response Appropriations Act of 2016 and passed it on May 18th. The bill faced opposition from Democrats who claimed that the $622 million authorized by the bill was not nearly enough to defend against Zika. The amount of $622 million is about one third of the $1.9 billion that the White House requested was necessary to combat Zika back in February.

Additionally, H.R. 5243 would not appropriate the $622 million as emergency funds, which most Democrats and the White House prefer. Instead, it would repurpose $352.1 million leftover in funds to combat the 2014 Ebola outbreak, and utilize $270 million left in the HHS' administrative accounts. This funding strategy minimizes the effect on the federal debt. Democrats in the House have expressed strong disdain towards the passing of H.R. 5243 and President Obama has declared he will veto the bill if it makes it to his desk.

The Senate has taken a different path than the House in handling the Zika appropriations battle, by opting to include Zika funding as an amendment on an unrelated spending bill, as opposed to the standalone Zika funding bill passed by the House. On May 19th a Senate approved an amendment to an unrelated spending bill which allocated $1.1 billion in emergency funding to combat Zika. Senate Republicans were largely split on the amendment with some Senators from states that are likely to face the brunt of a Zika epidemic advocating for the full payment of the President's requested amount. However, other Senators voted against the amendment in the effort to avoid voting for a measure that would contribute to the deficit.

On May 19th the Senate passed the unrelated spending bill that contained the previously-passed Zika appropriations amendment containing $1.1 billion in emergency funding, and passed the bill. The President, nearly all Congressional Democrats, and the CDC alike have expressed their discontent with what they see as inadequate funding in the House's Zika appropriations proposal. The White House has stated it will not veto the Senate's proposal if it is finalized.

The two Chambers formed a Conference Committee to reconcile the differences between the two bills.

Return To Top

CMS Transmittals

The following Transmittals were released by CMS between May 1st and May 31st.

Transmittal Number	Subject	Effective Date
R651PI	Medical Review of Skilled Nursing Facility Prospective Payment System (SNF PPS) Bills	2016-06-28
R3532CP	Annual Update of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)	2016-10-03
R3531CP	July 2016 Update of the Ambulatory Surgical Center (ASC) Payment System	2016-07-05
R3533CP	Payments to Home Health Agencies That Do Not Submit Required Quality Data	2016-08-30
R57QRI	Payments to Home Health Agencies That Do Not Submit Required Quality Data	2016-08-30
R122MCM	Chapter 14 - Contract Determinations and Appeals	2016-06-28
R267FM	Notice of New Interest Rate for Medicare Overpayments and Underpayments -3rd Qtr Notification for FY 2016	2016-04-19
R3530CP	JW Modifier: Drug amount discarded/not administered to any patient	2016-07-05
R1669OTN	Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	2016-10-03
R1670OTN	Shared System Enhancement 2014 – Identification of Fiscal Intermediary Standard System (FISS) Obsolete Reports - Analysis Only	2017-04-03
R3529CP	Instructions for Downloading the Medicare ZIP Code File for October 2016	2016-10-03
R3525CP	Common Edits and Enhancements Modules (CEM) Code Set Update	2016-10-03
R3527CP	Claim Status Category and Claim Status Codes Update	2016-10-03

R3528CP	Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July CY 2016 Update	2016-07-05
R1664OTN	Reporting Medicare Administrative Contractor (MAC) Provider Education Website Analytic Data to the Provider Customer Service Program Contractor Information Database (PCID)	2016-06-14
R222BP	Revisions to Private Contracting/Opt-Out Manual Sections Due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)	2016-08-15
R98GI	Clarification of Inpatient Psychiatric Facilities (IPF) Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification	2016-08-15
R223BP	Clarification of Inpatient Psychiatric Facilities (IPF) Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification	2016-08-15
R3522CP	Update to Internet-Only-Manual Publication 100-04, Chapter 18, Section 30.6	2016-06-14
R3523CP	July 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2016-07-05
R3524CP	July 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.2	2016-07-05
R1665OTN	Coding Revisions to National Coverage Determinations (NCDs)	2016-10-03
R1668OTN	National Provider Identifier Crosswalk System (NPICS) Retirement Analysis Only - Engage Shared Systems Maintainers and Medicare Administrative Contractors (MACs) in Meetings and Correspondence Related to the NPICS Retirement with the Stakeholders	2016-10-03
R3520CP	2016 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List	2016-02-01
R192NCD	Percutaneous Left Atrial Appendage Closure (LAAC)	2016-10-03
R1660OTN	Shared Savings Program (SSP) Accountable Care Organization (ACO) Qualifying Stay Edits	2017-01-03
R3519CP	Corrections to Chapter 1 of the Medicare Claims Processing Manual	2016-08-08
R3515CP	Percutaneous Left Atrial Appendage Closure (LAAC)	2016-10-03
R3518CP	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2016 Update	2016-07-05
R1659OTN	Convert Assembler Code to COBOL or Best Coding Language to Improve MCS System Maintainability and Sustainability - Analysis Only	2016-10-03

Return To Top