OUTLOOK 2015: Physician Payments, Managed Care Quality, RACs Top List

Physician and hospital reimbursement policies lead the list of expected Medicare hot topics in 2015, according to comments from knowledgeable stakeholders and Advisory Board members for BNA’s Medicare Report. Health-care providers and attorneys also will need to keep an eye on developments with Recovery Audit Contractors (RACs), Accountable Care Organizations, Medicare Advantage quality measures and payment and Part D plans’ use of preferred pharmacies.

On the legal front, Advisory Board members say to watch for action in litigation involving disproportionate share payments, jurisdictional issues surrounding the Provider Reimbursement Review Board and the backlog of Medicare claim appeals at the administrative law judge level.

On the Hill

Republicans begin 2015 in control of both the House and Senate after electoral victories in November 2014, and as in 2014, one potential major legislative development would be action to permanently replace the troubled Medicare physician reimbursement system.

Analysts and stakeholders say even with Republican control in both houses of Congress, the odds haven’t improved for passing a permanent fix for Medicare’s sustainable growth rate (SGR) formula.

Although there was bipartisan, bicameral support for a permanent fix earlier in 2014, with the proposed SGR Repeal and Medicare Provider Payment Modernization Act (H.R. 4015), lawmakers couldn’t agree on how to pay for it. The bill passed the House but didn’t advance in the Senate.

The most recent patch will expire March 31, and most experts and government agencies, including the Congressional Budget Office, assume Congress will pass another patch in the new session that will maintain current payment levels for Medicare doctors.

Each year, the SGR formula calls for deep cuts in Medicare physician pay rates that are routinely canceled by Congress with a temporary patch known as the “doc fix.”

Even with bipartisan, bicameral support for a permanent solution, political differences between the two parties has kept lawmakers from reaching agreement on how to pay for full reform.

Top 10 Medicare Issues in 2015

According to members of BNA’s Medicare Report’s Advisory Board, these are the top 10 issues to watch in 2015:

1. Permanent revision to the SGR physician payment formula or continuation by Congress of temporary fixes.
2. Regulatory and legislative refinements to the Accountable Care Organization/Medicare Shared Savings Program.
3. Changes to the Medicare Advantage program: quality ratings, payment refinements.
4. Legislative, legal action to resolve hospital observation status controversy.
5. Congressional action to repeal/refine the Affordable Care Act and implementation of ACA Medicare provisions.
6. Impact of growing backlog of Medicare appeals regarding Recovery Audit Contractor program.
7. Whether CMS will provide any financial relief resulting from the Allina DSH Medicare Part C days case.
8. Inclusion of hospice services in Medicare Advantage.
9. Potential court decision in HealthFirst case concerning the 60-day overpayment rule.
10. Annual Medicare Trustees report on Medicare program health and number of years before projected insolvency.

There have been 17 patches to the program since 2003, which the Congressional Budget Office has estimated cost $146 billion. The total cost of repeal rose in December 2014 to $148 billion from fiscal years 2015 to
2024, a jump from the $138 billion, 10-year estimate that the CBO made in early 2014.

**Same Legislation in 2015.** Analysts and stakeholders believe the same legislation from 2014 will be brought up again in 2015, with the same results.

“How do you pay for it?” Joseph Antos, an analyst at the American Enterprise Institute, said to Bloomberg BNA. He predicted lawmakers would pass another short-term fix, but “the pay-fors are going to kill them.”

Figuring out how to pay for a permanent fix is a “bi-partisan pain,” Antos said in a late 2014 interview, because the money for physicians has to come from some other sector. “It’s never going to be easy” to find the money, he said.

Rep. Phil Roe (R-Tenn.), chairman of the Republican Doctors’ Caucus, told Bloomberg BNA he supports the policies in H.R. 4015 and doesn’t feel they need to be renegotiated anew 2015, especially because of bipartisan support.

“I think both sides of the aisle understand that [physician payment reform] needs to get done. We need to replace it with a sustainable system that hopefully will lower costs for people.”

—Rep. Phil Roe (R-Tenn.)
chairman, Republican Doctors’ Caucus

“I’m not saying there wouldn’t be a tweak or something, but I’m satisfied with the policy,” Roe said. “Once you’ve got a grand slam home run like that one was—an agreement on policy—I don’t think you’ll revisit that.”

Roe acknowledged there’s a chance the negotiations will get caught up in acrimonious politics over the ACA but said he hopes that isn’t the case.

The last SGR bill “was done in a real bipartisan way,” Roe said. “I think both sides of the aisle understand that it needs to get done. We need to replace it with a sustainable system that hopefully will lower costs for people.”

‘Incremental’ Funding. Chris Jennings, who was a senior adviser on health care to both President Barack Obama and President Bill Clinton, said in a December 2014 briefing that the funding for changes in the SGR could be made incrementally.

Health-care costs have dropped significantly since the ACA was enacted, making it less expensive to fund SGR adjustments. Otherwise, it would be too difficult for Congress to make necessary cuts in Medicare to finance SGR changes, Jennings said.

SGR proposals move the health-care delivery system away from fee-for-service toward value-based purchasing, which many believe is necessary, he said. Insisting on “dollar-for-dollar offsets, I think we may actually be making a very, very penny-wise, pound-foolish decision.”

Roe said despite some efforts to pass a full SGR repeal without offsets, he would insist on paying for at least some of it. Roe wouldn’t specify if any other law-
Martin Corry, chairman of the government relations and public policy department of Hooper, Lundy & Bookman, PC in Washington, told Bloomberg BNA if Republicans decide to pursue reconciliation as a policy vehicle, it needs to be a balancing act between advancing favored policies and “making sure that what you’re running through won’t get vetoed at the end of the day,” especially if lawmakers want to show they can govern.

Getting through the reconciliation process consumes a lot of time on the legislative calendar, Corry said, and time is at a premium for most senators, especially those that face re-election in 2016. If lawmakers want to use reconciliation for a wholesale repeal of the Affordable Care Act, they could use up lots of time “and get nowhere.”

Rep. Paul Ryan (R-Wis.), the new chairman of the House Ways and Means Committee, has said he may use reconciliation for tax reform purposes but hasn’t said if he’d use it for Medicare or Medicaid changes.

Republicans won the Senate majority in part by opposing the Affordable Care Act, so a vote to repeal the law is likely to be one of the first votes of the 114th Congress.

Aside from full-scale ACA repeal, Republicans may try targeted repeals of provisions in the law. Senate Majority Leader Mitch McConnell (R-Ky.) has stated he wouldn’t be able to repeal the entire health-care reform law, but he has identified three provisions of the law that are “extremely unpopular with the American public.”

Those items, he said, are likely to be targets of Republican action: the excise tax on medical devices, the individual mandate, and the law’s definition of full-time work as 30 hours a week.

Keith Fontenot, a visiting scholar at the Brookings Institution and managing director of the government relations and public policy department of Hooper, Lundy & Bookman, said holding a full-scale repeal vote in the context of reconciliation “would involve an enormous amount of effort and meet with a certain veto.”

He said Congress may have a better chance at getting a package of more targeted changes under reconciliation that might “pass muster” with the administration by avoiding a repeal of the entire law.

Fontenot said passing a separate SGR fix, an extension of primary care and community health center funding and a Children’s Health Insurance Program reauthorization in a reconciliation bill would “give members something positive to vote for in the context of a lot of other pain.”

He said a challenge would be the Byrd rule of reconciliation, which he said limits “extraneous, non-budgetary, provisions.” The Byrd rule, named after former Sen. Robert Byrd (D-W. Va.), amended the Congressional Budget Act of 1974 to allow senators to block legislation if it would significantly increase the federal deficit.

Entitlement Reform. Congress in 2015 may also look at ways to trim health-care costs. Recent hearings and comment requests from lawmakers show they believe health-care spending is unsustainable and are looking for ways to reduce spending without affecting beneficiary care.

Some lawmakers have said that savings may be found by decreasing spending on ACA programs, and by reforming Medicare and Medicaid.

Some indication of that occurred during a House Energy and Commerce Committee hearing in December 2014 that hinted at future battles over ACA provisions, including premium assistance in the insurance exchanges and the federal matching rate paid to states as part of the expansion of Medicaid coverage.

Fontenot, who had been the health-care director at the White House Office of Management and Budget, said he wouldn’t be surprised if Medicaid becomes a target for lawmakers, especially if it’s used by Republicans as a pay-for when they attempt to repeal parts of the ACA.

The House budget put forward by Ryan in 2014 included proposals that would have replaced Medicaid with a block grant program, along with other provisions to rein in entitlement spending.

Fontenot said that while he still expects a “conservative budget” from new House Budget Committee Chairman Rep. Tom Price (R-Ga.), some of Ryan’s proposals could be moderated as Price will be guided by House leadership “with an eye towards what can get done.”

The House and Senate “don’t have to pass the same resolution, but they would like to,” Fontenot said, as it may lead to a reconciliation bills that stands more of a chance of being enacted.

On the Senate side, Fontenot said Sen. Mike Enzi (R-Wyo.), the new chairman of the Senate Budget Committee, faces an even more daunting challenge in part due to the Byrd rule.

“Enzi is definitely a conservative,” Fontenot said. “You shouldn’t expect [the budget resolution process] to be easy going, but he has a reputation of being able to work across the aisle.”

Hospital, Part A Issues

Similar to 2014, many stakeholders predicted Medicare hospital short-stay policies, like those found in the two-midnight rule, and concerns related to the work of Recovery Audit Contractors (RACs) will be major issues for hospitals and other Part A providers in 2015.

Furthermore, some stakeholders said home health issues, such as changes to the Medicare face-to-face encounter requirement, will be important in 2015.

Under the two-midnight rule, which the CMS adopted in 2013, a Medicare beneficiary is not considered inpatient unless the admitting physician expects that beneficiary to need care in the hospital for a period spanning two midnights.

Hospital and other health-care groups say the two-midnight rule shortchanges hospitals because it leads to incorrect reimbursements by the CMS.

In addition, many in the health industry worry that the two-midnight requirement increases costs for Medicare beneficiaries and has caused providers to increasingly classify patients under outpatient observation, even when they are admitted to a hospital to receive care (25 MCR 969, 8/8/14).

Despite opposition from hospital and other health groups, the two-midnight rule took effect Oct. 1, 2013 (24 MCR 1338, 11/15/13).

Priya Bathija, a senior director of health policy at the American Hospital Association, told Bloomberg BNA that her organization will continue to work on the
short-stay issue in 2015. She said the AHA believes the policy doesn’t provide accurate payment to hospitals for beneficiaries who need inpatient care but don’t meet the two-night threshold.

Bathija said the AHA will work with the CMS to fix problems with the two-midnight rule, but could not say if those fixes would happen soon. The AHA is hopeful that the CMS will at least provide an idea of how it will address problems with the two-midnight rule in fiscal 2016 rulemaking.

Bathija also said the AHA isn’t the only stakeholder that would like to see changes to the policy. The House Ways and Means Committee has taken an interest in changing the policy, and Bathija said the AHA will work with the committee to fix it.

Furthermore, Bathija said the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment policies, has expressed an interest in seeing the policy changed. In November 2014, MedPAC commissioners discussed ways to alter several hospital short-term stay policies, which may affect how RACs operate.

### RAC Audits

RAC work to detect overpayments in the Medicare program and have drawn the ire of the hospital industry, which wants the program reformed.

During a November 2014 presentation, MedPAC staff said RACs “have focused their audits on [the] appropriateness of 1-day inpatient stays.” Because of this, it said, “hospitals have increased use of outpatient observation” (25 MCR 1388, 11/14/14).

Different stakeholders said the RAC program could continue to be a major Medicare issue in 2015. The number of RAC denials has created a backlog of appeals and a recent congressional report estimated 750,000 appeals are in the backlog.

**Appeals Backlog.** Michael Lutz, a director at the consulting firm Avalere Health, a health-care consulting firm, told Bloomberg BNA the backlog isn’t likely to decrease in 2015.

“With increases in the number of Medicare beneficiaries and the increasing use of medical management and pharmacy management approaches, we can expect the number of Medicare appeals to continue to increase, thus leading to increased volume of appeals,” Lutz said.

Likewise, Kenneth Marcus, an attorney with Honigman Miller Schwartz and Cohn LLP, Detroit, said, “There is no reason to believe that the backlog will improve.”

The large appeals backlog received attention from providers and regulators in 2014. To reduce the volume of denied patient status claims pending in the appeals process, the CMS in August 2014 offered an “administrative agreement” to certain hospitals willing to resolve their appeals in exchange for a timely partial payment.

Specifically, the CMS said any acute-care hospital or critical access hospital that elects the administrative agreement option to resolve their pending patient status appeals will receive a partial payment equal to 68 percent of the net payable amount (25 MCR 1115, 9/12/14).

**Questioning Partial Payment.** The CMS has yet to say how many providers pursued the administrative agreement, but during a November 2014 event, several officials from state hospital associations said many of their members decided to participate in the agreement to settle Medicare patient status appeals and receive a partial payment.

However, Joe Schindler, vice president of finance at the Minnesota Hospital Association, said at the time he mostly heard that his group’s member hospitals weren’t going to take the settlement because they thought the payment amount was too low.

“Had the settlement offer been in the 75 to 80 percent level,” at least a few more providers might have considered it, he said.

Providers in a good cash position were willing to hold out on the offer “partly because they thought another offer could come down the pike,” Schindler said. However, he said it was unclear whether the CMS will extend another patient status appeals offer (25 MCR 1415, 11/21/14).

**Providers Want RAC Changes.** In addition, the Office of Medicare Hearings and Appeals at the Department of Health and Human Services in October 2014 issued a request for information to gather suggestions about how it could reduce the appeals backlog (25 MCR 1335, 11/7/14).

Comments on the RFI showed that hospitals think the RACs are the cause of the backlog and they want significant reforms of the program (25 MCR 1502, 12/19/14).

The AHA’s Bathija told Bloomberg BNA that the appeals backlog won’t get any better in 2015 unless the CMS and Congress address problems with the RAC program.

Marcus said if the RAC program is reformed in 2015, it should temper a RAC’s ability to disallow claims.

“The appeals process is gridlocked,” he said, “and the only solution short of dramatically increasing the ALJ ranks is to reduce the ability of the RAC’s to generate appealable issues.”

Health-care consultant Larry Goldberg, Oakton, Va., said “nothing will change” in regard to the program as long as the RACs are uncovering legitimate errors.

**RAC Group Expects More Pressure.** The American Coalition for Health Care Claims Integrity (ACHCI), a group that represents the RACs, told Bloomberg BNA that in 2015, it will continue to support the RAC program even as it expects pressure against the RACs to continue.

“We understand that auditing can be unpopular with providers, but the backlash against auditing has interfered with the implementation of good government programs” like the RAC program, ACHCI told Bloomberg BNA.

“Providers continue to push back on Medicare oversight efforts, including oversight from the Office of the Inspector General (OIG),” the ACHCI said. “Given the traction the AHA and AMA have gained thus far in sidelined the RAC program, we expect even more vocal pressure from those groups in 2015.”
“Providers continue to push back on Medicare oversight efforts. We expect even more vocal pressure from those groups in 2015.”

—AMERICAN COALITION FOR HEALTH CARE CLAIMS INTEGRITY

The ACHCI said it “looks forward to continuing our efforts to educate lawmakers and American seniors about the effectiveness of Recovery Auditing and the ongoing threats to Medicare solvency posed by the provider community’s lack of accountability for their improper billing.”

The group said that as 2015 progresses, it hopes to see “greater transparency and more consistent application of Medicare policy in the appeals process.”

The coalition said it remains concerned “about the increasing amount of wasteful spending in Medicare and the impact that the loss of those funds will have on the program’s future.”

In particular, the ACHCI said it suspects that the results of the comprehensive error rate testing (CERT) program will continue to climb in 2015. The CMS agency calculates the Medicare fee-for-service (FFS) improper payment rate through the CERT program.

Citing figures from the Department of Health and Human Services fiscal 2014 Agency Financial Report, the coalition said, “the percentage of Medicare FFS improper payments has steadily risen from 8.5% in FY 2012 to 10.1% in FY 2013 and has increased again to 12.7% in FY 2014.”

Moreover, the ACHCI said, “This latest error rate equates to a loss of $46 billion in FY 2014 alone. With decision makers under pressure by the provider industry to further scale back oversight, Medicare is hemorrhaging resources, causing grave concerns about the longevity of the Trust Fund.”

The group told Bloomberg BNA it anticipates the CMS “will continue their good work to improve the RAC program for all stakeholders, including important enhancements planned in the new contracts that should be awarded next year.”

ACO Pilot Program

Some stakeholders interviewed by Bloomberg BNA predicted the Pioneer Accountable Care Organization (ACO) pilot program will undergo changes in 2015.

The Pioneer ACO model is designed for health-care organizations and providers that have experience coordinating care for patients across care settings. As of Dec. 19, 2014, there were 19 providers participating in the Pioneer ACO program, according to the CMS.

The Pioneer ACO program faced scrutiny in 2014 as several providers left the program and some stakeholders interviewed by Bloomberg BNA said that scrutiny will continue in 2015 (25 MCR 1207, 10/3/14).

CMS Evaluating Pioneer ACOs. Joshua Raskin, a health-care analyst at Barclays, predicted the demise of the program.

The CMS “has a long history of pilot programs that were implemented in such a poor fashion that success was almost impossible,” he told Bloomberg BNA. “I think the Pioneer program is going to simply end in 2016.”

However, Raskin said that ACOs “are being much more effectively managed in the private sector and predicted that ACOs will be much more effective in Medicare Advantage than in Medicare fee-for-service.

Others, however, didn’t see the program ending soon, but did predict changes.

For example, Hooper Lundy’s Fontenot and law firm colleague Corry, said the CMS “has tried to make the program more flexible for providers with different capabilities, easing the transition to two-sided risk for those less able to manage costs, and allowing systems further down the learning curve to begin to do things that come close to enrollment of beneficiaries.”

They said those changes, along with attempts to respond to many of the criticisms of the Pioneer ACO program, “will help stabilize the program and reduce dropouts.”

However, others offered more pessimistic views of the program. Goldberg said the Pioneer ACO program doesn’t offer sufficient rewards for providers that choose to participate in it, saying, “CMS is not giving enough of a real carrot for organizations to participate.”

Marshfield Clinic’s Miller struck a similar note.

“Pioneers and ACOs in low payment regions of the country will continue to withdraw from the program because the costs of participation exceed what might be recaptured in incentive payments,” Miller said.

ACOs in general may be further implemented in the private sector. Marcus said he sees the ACOs morphing and resembling health maintenance organizations. That is, he said, the ACOs will be “co-opted by the establishment health insurers.”

The CMS Dec. 1, 2014, released a proposed rule (79 Fed. Reg. 72,760; CMS-1461-P) making changes to another ACO initiative known as the Medicare Shared Savings Program (MSSP). The rule includes a new risk model for use by participating accountable care organizations (25 MCR 1433, 12/5/14). In addition, the agency Dec. 22, 2014, said 89 new providers will join the MSSP ACO program as of Jan. 1.

The CMS said it will have a total of 405 ACOs participating in the Shared Savings Program in 2015, serving more than 7.2 million beneficiaries. The agency also said when combined with the Innovation Center’s 19 Pioneer ACOs, the CMS will have a total of 424 ACOs serving over 7.8 million beneficiaries (26 MCR 4, 1/2/15).

Home Health Issues

Several home health issues may impact providers and Medicare in 2015. In particular, William Dombi, vice president for law at the National Association for Home Care and Hospice (NAHC), told Bloomberg BNA there may be resolution to a lawsuit his organization filed in June 2014 against the CMS challenging the agency’s face-to-face encounter requirement.

The NAHC’s lawsuit seeks to block a regulation by the CMS that requires physicians to provide a written narrative of why a Medicare beneficiary is receiving home-health services (N.A. For Home Care & Hospice, 1/25/15).
The NAHC said the Medicare health-care provider (25 MCR 1504, 12/19/14). In a survey of 1,000 medical groups released in October 2014, the MGMA said the majority of physician practices don’t believe Medicare’s quality reporting programs enhance their ability to provide high-quality patient care and that the requirements are either “very” or “extremely” complex.

Negatively affected are practice efficiency, support staff time, and clinician morale, a significant majority of respondents indicated, the MGMA said. “Instead of providing timely, meaningful, and actionable information to help physicians treat patients, this has become a massive bureaucratic reporting exercise,”

Part B Reimbursement

Another topic to watch in 2015 that could have significant impact on Medicare providers is what happens to physician Part B payments. Doctors now face penalties for failing to participate in Medicare quality reporting programs, and their trade associations are less than pleased as the CMS moves forward with value-based payments.

The move is being met with trepidation. Several doctor groups have told the CMS that its expansion of quality measurement programs is happening too fast and the programs are overly complicated.

“Medicare Advantage overall remains an attractive program for many retirees, and enrollment is projected to remain strong on both the plan and beneficiary side.”

—MARTIN A. CORRY AND KEITH J. FONTENOT
HOOPER Lundy & BOOKMAN

The Medical Group Management Association, which represents medical practices, told the CMS that the “complexity of these programs, and resulting physician frustration, has reached an all-time high.” The MGMA called 2015 “a critical year for medical group practices participating under Medicare Part B quality reporting programs” because of the penalties.

Cut to Reimbursements. Starting in 2015, physicians and other Part B professionals will receive a 1.5 percent cut to their 2015 service payments under the physician fee schedule if they didn’t satisfactorily report under the Physician Quality Reporting System (PQRS) for 2013. The PQRS is a pay-for-reporting program that uses both payment incentives and cuts to promote reporting of quality information by eligible professionals. To link Medicare reimbursements to quality of care, doctors report measures for the CMS to evaluate.

The incentive payments for past years were issued separately as a single payment in the following year for providers who reported satisfactorily. However, the ACA authorized incentive payments only through 2014. The agency sent letters in November 2014 to those who will receive 98.5 percent of their reimbursements for services. Providers have until Feb. 28 to ask for a review if they believe the impending cut to be in error.

In a survey of 1,000 medical groups released in October 2014, the MGMA said the majority of physician practices don’t believe Medicare’s quality reporting programs enhance their ability to provide high-quality patient care and that the requirements are either “very” or “extremely” complex.

Negatively affected are practice efficiency, support staff time, and clinician morale, a significant majority of respondents indicated, the MGMA said. “Instead of providing timely, meaningful, and actionable information to help physicians treat patients, this has become a massive bureaucratic reporting exercise,”

The NAHC is concerned with the rating system’s design to classify most home health agencies as three-star providers. While a three-star rating would be considered good under that system, Dombi said most consumers wouldn’t see it as a good rating since the system, in theory, would allow providers to earn up to five stars.

Moorhead said she didn’t know when the CMS will implement the program but told Bloomberg BNA her group wants to work closely with the agency to offer feedback on the five-star rating program.

The CMS home health payments final rule for 2015 (79 Fed. Reg. 66,032; CMS–1611–F) eliminated the face-to-face narration requirement. However, its elimination wasn’t retroactive, so the NAHC continued with its lawsuit (25 MCR 1332, 11/7/14).

Dombi told Bloomberg BNA there’s a reasonable chance that his group and the CMS will reach a compromise on this narration requirement issue before the new rule takes effect although that chance, he said, isn’t “better than even.”

He said he has no hints as to which way the judge is leaning, and the CMS has asked the case be dismissed.

Face-to-Face Changes. Dombi said he expects a great deal of confusion surrounding the new face-to-face encounter provisions slated to begin in 2015 and that his group will educate members about the new rule. He also expects the CMS to provide education for physicians about the new requirements.

Tracey Moorhead, the president and chief executive officer of the Visiting Nurses Association of America (VNAA), told Bloomberg BNA that her group asked the CMS to delay changes to the face-to-face encounter rules. She said the agency is considering the VNAA’s request.

Moorhead also said her organization has asked the CMS for more clarification about the new face-to-face provisions; for example, how home health agencies can collaborate better with physicians to meet documentation requirements.

Home Health Ratings. Dombi and Moorhead separately spoke about their groups’ respective concerns with a plan by the CMS to introduce a website rating system for home health agencies.

The CMS Dec. 11, 2014, said it’s proposing a star rating system under Medicare for home health agencies in 2015 that would allow consumers to identify differences in quality and use the information when selecting a health-care provider (25 MCR 1504, 12/19/14).

Dombi said the NAHC sees the CMS moving quickly to implement the home health five-star rating system, possibly putting it into effect in 2015.

The NAHC is concerned with the rating system’s design to classify most home health agencies as three-star providers. While a three-star rating would be considered good under that system, Dombi said most consumers wouldn’t see it as a good rating since the system, in theory, would allow providers to earn up to five stars.

Moorhead said she didn’t know when the CMS will implement the program but told Bloomberg BNA her group wants to work closely with the agency to offer feedback on the five-star rating program.

The NAHC is requesting that the court declare the regulation invalid and is asking for a preliminary injunction blocking its enforcement (25 MCR 712, 6/13/14).

The CMS home health payments final rule for 2015 (79 Fed. Reg. 66,032; CMS–1611–F) eliminated the face-to-face narration requirement. However, its elimination wasn’t retroactive, so the NAHC continued with its lawsuit (25 MCR 1332, 11/7/14).

Dombi told Bloomberg BNA there’s a reasonable chance that his group and the CMS will reach a compromise on this narration requirement issue before the new rule takes effect although that chance, he said, isn’t “better than even.”

He said he has no hints as to which way the judge is leaning, and the CMS has asked the case be dismissed.

Face-to-Face Changes. Dombi said he expects a great deal of confusion surrounding the new face-to-face encounter provisions slated to begin in 2015 and that his group will educate members about the new rule. He also expects the CMS to provide education for physicians about the new requirements.

Tracey Moorhead, the president and chief executive officer of the Visiting Nurses Association of America (VNAA), told Bloomberg BNA that her group asked the CMS to delay changes to the face-to-face encounter rules. She said the agency is considering the VNAA’s request.

Moorhead also said her organization has asked the CMS for more clarification about the new face-to-face provisions; for example, how home health agencies can collaborate better with physicians to meet documentation requirements.

Home Health Ratings. Dombi and Moorhead separately spoke about their groups’ respective concerns with a plan by the CMS to introduce a website rating system for home health agencies.

The CMS Dec. 11, 2014, said it’s proposing a star rating system under Medicare for home health agencies in 2015 that would allow consumers to identify differences in quality and use the information when selecting a health-care provider (25 MCR 1504, 12/19/14).

Dombi said the NAHC sees the CMS moving quickly to implement the home health five-star rating system, possibly putting it into effect in 2015.

The NAHC is concerned with the rating system’s design to classify most home health agencies as three-star providers. While a three-star rating would be considered good under that system, Dombi said most consumers wouldn’t see it as a good rating since the system, in theory, would allow providers to earn up to five stars.

Moorhead said she didn’t know when the CMS will implement the program but told Bloomberg BNA her group wants to work closely with the agency to offer feedback on the five-star rating program.

The NAHC said the Medicare regulation requiring physicians to explain why a Medicare beneficiary is home bound has introduced unnecessary complexity to providing health services and resulted in retroactive reimbursement denials based not on a patient’s medical needs but a lack of proper paperwork.

The NAHC is requesting that the court declare the regulation invalid and is asking for a preliminary injunction blocking its enforcement (25 MCR 712, 6/13/14).

The CMS home health payments final rule for 2015 (79 Fed. Reg. 66,032; CMS–1611–F) eliminated the face-to-face narration requirement. However, its elimination wasn’t retroactive, so the NAHC continued with its lawsuit (25 MCR 1332, 11/7/14).

Dombi told Bloomberg BNA there’s a reasonable chance that his group and the CMS will reach a compromise on this narration requirement issue before the new rule takes effect although that chance, he said, isn’t “better than even.”

He said he has no hints as to which way the judge is leaning, and the CMS has asked the case be dismissed.

Face-to-Face Changes. Dombi said he expects a great deal of confusion surrounding the new face-to-face encounter provisions slated to begin in 2015 and that his group will educate members about the new rule. He also expects the CMS to provide education for physicians about the new requirements.

Tracey Moorhead, the president and chief executive officer of the Visiting Nurses Association of America (VNAA), told Bloomberg BNA that her group asked the CMS to delay changes to the face-to-face encounter rules. She said the agency is considering the VNAA’s request.

Moorhead also said her organization has asked the CMS for more clarification about the new face-to-face provisions; for example, how home health agencies can collaborate better with physicians to meet documentation requirements.

Home Health Ratings. Dombi and Moorhead separately spoke about their groups’ respective concerns with a plan by the CMS to introduce a website rating system for home health agencies.

The CMS Dec. 11, 2014, said it’s proposing a star rating system under Medicare for home health agencies in 2015 that would allow consumers to identify differences in quality and use the information when selecting a health-care provider (25 MCR 1504, 12/19/14).

Dombi said the NAHC sees the CMS moving quickly to implement the home health five-star rating system, possibly putting it into effect in 2015.

The NAHC is concerned with the rating system’s design to classify most home health agencies as three-star providers. While a three-star rating would be considered good under that system, Dombi said most consumers wouldn’t see it as a good rating since the system, in theory, would allow providers to earn up to five stars.

Moorhead said she didn’t know when the CMS will implement the program but told Bloomberg BNA her group wants to work closely with the agency to offer feedback on the five-star rating program.
Anders Gilberg, MGMA senior vice president of government affairs, told the CMS.

Value Modifier Phase-In. Also on Jan. 1, the CMS began the phase-in of its value modifier, a calculation that provides for different payments to a physician or group based on the quality of care compared to the cost of that care during a performance period.

The American Medical Association said that physicians are “largely unaware” of the value modifier and has complained to the CMS about the “tsunami of rules and policies surrounding the penalties.”

The value modifier, which was part of the ACA, rates doctors through PQRS quality measures. The phase-in begins with large groups. In 2015, physicians in groups of 100 or more who submit claims to Medicare under a single tax identification number are subject to the value modifier, based on their performance in 2013.

To have avoided the 1 percent payment reduction this year, those large groups were required to have self-nominated and participated in a PQRS group reporting method, such as a registry, in 2013.

Exemptions to this program are for those participating in the Comprehensive Primary Care Initiative, an initiative designed to test practice redesign models, or accountable care organization programs—either the Medicare Shared Savings Program or the Pioneer ACO program.

Also, if the large doctor groups opted for “quality-tiering,” calculation of the value modifier could result in an upward or neutral adjustment based on 2013 performance.

Quality tiering is an analysis that determines if a group practice’s performance is statistically better, the same, or worse than the national mean.

It determines the type of adjustment—upward, downward or neutral—to Part B service payments based on quality and per capita cost measures. Groups receive a “quality of care composite score” and a “cost composite” score to arrive at the value modifier amount.

Reporting in 2015. During 2015, doctors’ quality reporting will impact reimbursements in 2017 under the value modifier. The CMS will begin applying the value modifier in 2017 to all physicians, including solo practitioners, a requirement that some groups asked be delayed.

“Many providers do not understand how the [value modifier] is calculated, and it is extremely difficult to determine how the quality data will affect each” practitioner’s score, the American Society of Cataract and Refractive Surgery told the CMS on Dec. 23, 2014.

The group asked the CMS to hold off on the expansion to individual doctors until a greater number are successfully reporting under PQRS.

The AMA recommended that penalties for the value-based purchasing programs not be increased and that the CMS ask Congress to provide a longer phase-in period to implement the value modifier.

The MGMA asked CMS to put in place a “single-harmonized Medicare quality improvement initiative that standardizes reporting and supports physicians in their efforts to improve care for their patients.”

Managed Care Plans

Despite the conclusion of the CMS’s quality bonus demonstration, which gave extra funds to mid-ranking Medicare Advantage plans, and another year of phased-in ACA payment reductions, the 2015 MA contract year is anticipated as generally positive for marketplace stability and enrollment.

A total of 309 new plans will enter markets in 2015, according to the Kaiser Family Foundation (KFF), a nonprofit organization focusing on national health issues. The overall number of MA plans will be similar to that in 2014, declining by 3 percent from 2,014 to 1,945 in 2015, according to the KFF.

In terms of stability, 84 percent of 2015 plans were also available in 2014. While some have terminated their contracts with Medicare, most have decided to continue operating, and others are launching new plans across the country in 2015, according to KFF.

The 2015 Landscape. For the 2015 contract year, plans debuted and MA organizations expanded throughout the nation.

As a sampling: Highmark started an MA health maintenance organization in western Pennsylvania and Aetna introduced one in northern New Jersey. In the Midwest, UnitedHealthcare launched its first MA plan in DuPage County, Ill. Blue Cross Blue Shield of Michigan expanded its service areas to additional counties. Humana expanded offerings in North Carolina.

The launch of specialty needs plans (SNPs) that focus on service to beneficiaries eligible for Medicare and Medicaid included those by Anthem Blue Cross and Blue Shield in Wisconsin, Ohio and Missouri and by Amerigroup in Tennessee.

Funding Changes. The 2015 MA county rates reflect the continued phase-in of the ACA funding cuts that will reduce MA funding by more than $200 billion in years 2010-2019.

The purchase of physician groups by hospitals is driving up MA premiums and making contractual negotiations more difficult.

—GEORGE STRUMPF, EMBLEMHEALTH

The ACA also tied MA plan quality to reimbursement through the CMS’s one-to-five-star rating system.

The CMS’s three-year quality bonus demonstration, which allowed for extra payments to MA contracts with three and 3.5 stars, ended Dec. 31, 2014. The program reverted to the ACA requirement that only those contracts achieving an overall rating of at least four stars may receive a boost in county rates.

With the CMS’s reporting that 60 percent of MA plan contracts will have less than four stars and consulting firm Avalere’s conclusion that the average enrollment-weighted star rating for MA plans that offer the prescription drug benefit (MA-PDs) was 3.92 for 2015, there are predictions of shifting marketplace dynamics.

Relative Impact. Barclays’ Raskin said that the conclusion of the CMS’s quality bonus demonstration will have a large impact on MA plans but on a relative basis. A four-star plan has a major advantage over a three-star plan because of the increased reimbursement, he said.
Five-star plans have an even bigger advantage because they aren’t restricted to enrolling beneficiaries during the open enrollment season, he said. The CMS allows beneficiaries to switch to a five-star MA plan or Part D plan in their area anytime during the year.

Those privileges “could make it more challenging for plans with fewer stars to compete with higher-rated plans that receive higher rebates and, for some, continuous enrollment,” the KFF said.

In fact, Hooper Lundy’s Corry and Fontenot, said in a joint e-mail that the pressure is “not just those below four stars, as the benchmark caps are squeezing quality incentive payments to plans above four stars.”

However, they added: “Medicare Advantage overall remains an attractive program for many retirees, and enrollment is projected to remain strong on both the plan and beneficiary side.”

**Enrollment Growth.** Enrollment predictions are for more growth despite previous speculation to the contrary.

“Some questioned whether the Medicare Advantage market would shrink in response to the reductions in payments to Medicare Advantage plans included in the ACA,” the KFF said.

Instead, “companies may have adjusted their business strategies and tightened their belts in response to the changes in the ACA and the sequestration of Medicare spending put in place under the Budget Control Act of 2011,” it said.

Raskin predicted more MA growth despite the continued reimbursement pressure. “As we look at 2015, I believe that growth could be very similar to the 10 percent growth seen in 2013 and 2014,” he told Bloomberg BNA.

Of the two biggest MA companies, Humana and United said they expect their MA membership in 2015 to grow 8 percent.

**Potential Problems Ahead.** However, Avalere’s Lutz said that shrinking reimbursements could affect “plans’ ability to enhance benefits or remain viable in some markets.”

He told Bloomberg BNA that he expects to see consolidation in the number of benefit plans that MA organizations offer in each marketplace.

Another encroaching issue for MA, according to EmblemHealth’s George Strumpf, is “provider consolidation in large urban areas where the majority of MA members are now enrolled.”

The purchase of physician groups by hospitals is driving up MA premiums and making contractual negotiations more difficult, he said.

“Restoration of any of the MA payment reductions is unlikely and the combination of provider consolidation, payment cuts and the health insurance tax will reduce margins and gradually cause exits from the program,” Strumpf predicted.

**Change in the Senate.** However, the new bicameral Republican majority in Congress led Corry and Fontenot to comment that “Republicans in general have been more favorable to MA, seeing it as a better alternative than the traditional fee for service system.”

Xavier Baker, a counsel in Crowell & Moring’s Health Care Group, pointed out that after some congressional pressure, the CMS raised 2015 MA rates from a proposed 1.9 percent decline in February 2014 to a 0.4 percent increase in its final Call Letter in April 2014.

Several Republican senators, including McConnell and new Majority Whip John Cornyn (R-Texas), gave speeches on the Senate floor denouncing the 1.9 percent cut, saying it would “increase premiums, reduce choices, and cause America’s seniors to lose access” to benefits.

**Steped-Up Enforcement.** Lynn Shapiro Snyder, with Epstein Becker & Green in Washington, predicted that in addition to increased consolidation of players, “there will be increased enforcement for non-compliance.”

Similarly, Christine M. Clements, with Crowell & Moring in Washington, said that another challenge for plans is the CMS’s compliance oversight and enforcement activities. The agency views the MA and Part D prescription drug plan program as “mature” and has become increasingly impatient with plan missteps, she said.

---

**In addition to increased consolidation of players,**

“there will be increased enforcement for noncompliance.”

—LYNN SHAPIRO SNYDER, EPSTEIN BECKER & GREEN

**Network Terminations.** In 2015, the CMS is expected to exercise sharper scrutiny of MA provider terminations.

“As MA plans attempt to narrow their networks, similar to the trends in exchange and group plans, they will need to make sure they do so in accordance with the network requirements established for the program,” Lutz said.

A CMS spokesman told Bloomberg BNA the agency is “developing an audit model to test plans sponsors’ network adequacy.”

Following complaints about UnitedHealthcare and other MA organizations dropping doctors from their contracted networks, the CMS in its 2015 Call Letter, published in April, required plans to provide the agency with 90 days’ notice of any significant network changes.

In addition, starting in 2015, the CMS will allow enrollees to switch plans when MA organizations initiate midyear provider terminations.

This special enrollment period is available on a case-by-case basis when the CMS determines that changes to a network that occur outside of the routine contracting are significant.

**Congressional Activity.** Legislation introduced by Sen. Sherrod Brown (D-Ohio) and Rep. Rosa DeLauro (D-Conn.) in the 113th Congress would place more restrictions on MA organizations that want to eliminate doctors from their provider networks.

Both members plan to reintroduce their bills in the 114th Congress.

Lauren Kulik, a spokeswoman for Brown, told Bloomberg BNA that the legislation might be revised. “We also plan to ask CMS to do some of these things via regulation, since not all of these protections require legislative action,” she said.
Raskin said the opt-out rate is running higher than expected because of “less than scrupulous behavior” by certain providers.

“This is a complex set of individuals that will take time to manage,” he told Bloomberg BNA. “That said, it is too important to fail.”

Both the federal government and the states “cannot afford to allow these individuals to remain unmanaged,” he continued. “We could see over 500,000 duals in managed care plans in 2015 and that is a solid start.”

**Part D Drug Benefit**

The potential benefit of preferred pharmacies, locking in certain beneficiaries to one or two pharmacies and new requirements for pharmaceutical prescribing, are among the policy issues involving the Medicare Part D drug benefit as it enters its ninth year.

The number of PDPs shrunk between 2014 and 2015. In 2015, a total of 1,001 prescription drug plans (PDPs) will be offered nationwide, down by 14 percent from the 1,169 PDPs offered in 2014 and the lowest number of PDPs in program history, the KFF said.

**The reduction in PDPs is largely driven by consolidation of offerings by a number of top plan sponsors, including Aetna, Cigna, CVS and UnitedHealth.**

—AVALERE HEALTH

The lower number of plans reflects the impact of mergers and CMS policies that encourage plan sponsors to eliminate low-enrollment plans and ensure there are meaningful differences among plan offerings, the KFF said.

According to Avalere Health, the reduction is largely driven by consolidation of offerings by a number of top plan sponsors, including Aetna, Cigna, CVS and UnitedHealth.

Despite those activities, the average number of PDPs by region will be 29 in 2015, according to the KFF.

**Preferred Pharmacies.** The debate over Part D preferred pharmacies—in which enrollees must fill their prescriptions from a subset of network pharmacies to receive lower cost sharing—won't stop in 2015.

The share of PDPs with this type of pharmacy network grew from 7 percent in 2011 to 72 percent in 2014, the KFF said, and a CMS study released at the end of 2014 put the issue back in the spotlight.

The study showed that some Medicare Part D plans’ use of preferred pharmacies may not allow for consistent access to those lower-cost pharmacies for all plan enrollees, particularly in urban areas, according to CMS staff.

Yet the Pharmaceutical Care Management Association, a strong proponent of preferred pharmacies, said its own study showed that in urban and suburban areas, the average Medicare beneficiary need only travel about one extra mile to use a preferred retail pharmacy to save $20-$40 on monthly cost sharing.

The study showed that some Medicare Part D plans’ use of preferred pharmacies may not allow for consistent access to those lower-cost pharmacies for all plan enrollees, particularly in urban areas, according to CMS staff.

Yet the Pharmaceutical Care Management Association, a strong proponent of preferred pharmacies, said its own study showed that in urban and suburban areas, the average Medicare beneficiary need only travel about one extra mile to use a preferred retail pharmacy to save $20-$40 on monthly cost sharing.

The study showed that some Medicare Part D plans’ use of preferred pharmacies may not allow for consistent access to those lower-cost pharmacies for all plan enrollees, particularly in urban areas, according to CMS staff.

Yet the Pharmaceutical Care Management Association, a strong proponent of preferred pharmacies, said its own study showed that in urban and suburban areas, the average Medicare beneficiary need only travel about one extra mile to use a preferred retail pharmacy to save $20-$40 on monthly cost sharing.

The study showed that some Medicare Part D plans’ use of preferred pharmacies may not allow for consistent access to those lower-cost pharmacies for all plan enrollees, particularly in urban areas, according to CMS staff.

Yet the Pharmaceutical Care Management Association, a strong proponent of preferred pharmacies, said its own study showed that in urban and suburban areas, the average Medicare beneficiary need only travel about one extra mile to use a preferred retail pharmacy to save $20-$40 on monthly cost sharing.

The study showed that some Medicare Part D plans’ use of preferred pharmacies may not allow for consistent access to those lower-cost pharmacies for all plan enrollees, particularly in urban areas, according to CMS staff.

Yet the Pharmaceutical Care Management Association, a strong proponent of preferred pharmacies, said its own study showed that in urban and suburban areas, the average Medicare beneficiary need only travel about one extra mile to use a preferred retail pharmacy to save $20-$40 on monthly cost sharing.

The study showed that some Medicare Part D plans’ use of preferred pharmacies may not allow for consistent access to those lower-cost pharmacies for all plan enrollees, particularly in urban areas, according to CMS staff.

Yet the Pharmaceutical Care Management Association, a strong proponent of preferred pharmacies, said its own study showed that in urban and suburban areas, the average Medicare beneficiary need only travel about one extra mile to use a preferred retail pharmacy to save $20-$40 on monthly cost sharing.
**CMS’s Position.** The CMS’s latest study findings were in line with the agency’s general stance that preferred cost sharing may not be beneficial to all of a plan’s enrollees.

In its 2015 Call Letter, the CMS said that instead of passing on lower costs available through economies of scale, some plans with preferred cost sharing charge higher negotiated prices.

When the latest study was released, CMS staff said that a next step could be indicated in the proposed 2016 Call Letter, to be released in February.

The issue also may be pushed forward by Congress.

A bill (H.R. 4577) in the 113th Congress, introduced by Rep. Morgan Griffith (R-Va.), would have required PDPs in medically underserved areas to extend to any pharmacy “the option to be an in-network pharmacy.”

The National Community Pharmacists Association, a supporter of the legislation, said the bill, which had 80 co-sponsors, will be reintroduced in the 114th Congress.

The NCPA’s position is that independent community pharmacies are often excluded by PDPs from such arrangements, causing some enrollees to change pharmacies or pay higher copays.

The NCPA’s “any willing provider” stance is that discounted copays should be offered at any pharmacy that is willing to accept the insurance plan’s terms and conditions.

**Pharmacy Lock-In.** In another area that will be continuing in 2015, legislation is expected to be reintroduced that would give beneficiaries determined to be at risk for prescription drug abuse access to a limited number of pharmacies.

In December 2014, the bipartisan leadership of the House Ways and Means Subcommittee on Health introduced a bill (H.R. 5780) that would place limits on at-risk beneficiaries regarding the purchase of certain opioids and similar drugs.

Those enrollees would be allowed a choice of a pharmacy and provider to fill their prescriptions for the problem drugs.

The provision is one section of a wide-ranging fraud bill that garnered 21 co-sponsors in the waning days of the 113th Congress. It would also give states the authority to share information in an effort to prevent prescription drug abuse across state borders.

**Committee Attention.** In the Senate, the concept, known as pharmacy lock-in, has caught the attention of the Committee on Homeland Security and Governmental Affairs.

A spokeswoman told Bloomberg BNA that Sen. Tom Carper (D-Del.), former committee chairman in the 113th Congress, plans to work with colleagues in the 114th Congress on efforts to reduce Medicare waste, fraud and abuse, including measures that would curb so-called doctor and pharmacy shopping.

The drug abuse topic was also discussed by the Medicare Payment Advisory Commission in October 2014 and may be so again in the spring when Congress’s Medicare advisers look at other aspects of Part D medication use, such as contraindicated drug combinations and polypharmacy, or the use of multiple or excessive prescriptions, according to commission staff.

The CMS said that, in June 2014, of the 40 million Part D enrollees, 22,000 had been identified as potentially overusing opioids.

In the first half of 2014, 233 Part D plan contracts submitted 4,299 overuse issues to the CMS’s Medicare Part D Overutilization Monitoring System.

**Updated Regulation.** Speculation abounds on the status of provisions of a CMS regulation proposed a year ago.

In January 2014, the CMS proposed a wide-ranging update rule for Medicare Parts C and D that contained a variety of controversial changes to the MA and Part D programs, including those to criteria for protected drug classes, preferred pharmacies, noninterference and the medication therapy management programs.

After protest from lawmakers, beneficiaries, providers and various trade groups, CMS Administrator Marilyn Tavenner said that, due to the complexities of the issues and stakeholder input, the agency wouldn’t finalize most of the proposals at this time.

When the rule was finalized in May 2014 (RIN 0938-AR37, CMS–4159–F), it contained a list of more than 40 provisions that wouldn’t be made final at that time but could be addressed later.

Others were withdrawn, including the provision on classes of clinical concern. “We are not finalizing any new criteria and will maintain the existing six protected classes,” the final rule said.

Among the provisions that the CMS put on hold were:

- a two-year limitation on submitting a new bid in an area where an MA organization has been required to terminate a low-enrollment plan;
- termination of contracts of MA organizations offering the drug benefit for failing for three consecutive years to achieve three stars on the Part C and Part D summary star ratings in the same contract year;
- expansion of quality improvement program regulations;
- strategies for the medication therapy management program; and
- agent and broker training and testing requirements.

**Profound Impact.** A “question is whether CMS will repropose the provisions,” Rosato of the Academy of Managed Care Pharmacy, told Bloomberg BNA. Some of the provisions, she added, such as changes to preferred networks and a medication therapy management expansion, “could have a profound impact on plans and beneficiaries if implemented.”

Testifying in September 2014 during a hearing of the House Committee on Oversight and Government Reform, Tavenner was asked to confirm that she wouldn’t put forth a “rule that is similar in nature” to the gutted regulation.

“I’m not interested in bringing back the pieces that we pulled,” she responded.

Rosato told Bloomberg BNA that a recent federal regulatory agenda, however, suggests that CMS might reconsider at least some of the provisions.

The HHS’s fall 2014 regulatory agenda listed several Medicare rules including “the remaining policies not finalized” for 2015 under the MA and Part D programs.

“If CMS proposes and finalizes provisions for 2016, plans will have a short time-frame to prepare,” Rosato said.
Prescriber Enrollment. Although the CMS didn’t finalize controversial issues in its proposed rule, one of the provisions that stayed still resulted in some controversy.

The section required physicians and other eligible professionals who write prescriptions for Part D drugs or supplies to be enrolled in Medicare, or have a valid opt-out affidavit on file for their prescriptions to be covered under Part D, effective June 1.

However, following an outcry by providers who said that beneficiaries could be put in jeopardy if they are unable to fill a subscription, the CMS extended the effective date to Dec. 1 “to allow adequate time to address outstanding issues associated with the new provision.”

As of that date, claims are to be denied if the prescriber lacks an active and valid national provider identifier (NPI) to be contained on the claims and isn’t enrolled in or opted out of Medicare.

Despite the rollback of the effective date, the CMS wants clinicians who haven’t enrolled in Medicare to submit their enrollment applications or opt-out affidavits to their Medicare Administrative Contractors by June 1.

“For many years, the Medicare Part D program has sought effective ways to ensure that prescribers enroll in the system, but has had limited success.”

—EDITH ROSATO, CEO, ACADEMY OF MANAGED CARE PHARMACY

Arthur Lerner of Crowell and Moring LLP, Washington, called the requirement “a compliance headache for Part D stand-alone plans.”

Rosato said that “for many years, the Medicare Part D program has sought effective ways to ensure that prescribers enroll in the system, but has had limited success.” She said that “plans are concerned about the implementation process to ensure that beneficiaries continue to receive their medications in a timely manner.”

Observation Status v. Inpatient Status

Litigation is continuing in Bagnall v. Sebelius (2d Cir., 13-4179, oral arguments 10/23/14), in which the Center for Medicare Advocacy (CMA) is arguing for the right of notice and procedure review for Medicare beneficiaries who are placed in observation status, not inpatient status. The CMA also executed a settlement with the HHS on Oct. 23, 2013, and are awaiting a decision.

Hospitals Litigating Two-Midnight Rule

Litigation is continuing in two separate cases filed by the AHA against the HHS concerning different aspects of the two-midnight rule (25 MCR 451, 4/18/14). In Am. Hosp. Ass’n v. Sebelius (D.D.C., No. 1:14-cv-00609, filed 4/14/14), the AHA is challenging an August 2013 HHS policy which states a physician must expect that a patient’s care will require treatment over two consecutive midnights to be an “inpatient” for purposes of Medicare reimbursement.

In Am. Hosp. Ass’n v. Sebelius (D.D.C., No. 1:14-cv-00607, filed 4/14/14), the AHA is challenging the 0.2 percent rate cut to Medicare reimbursement rates for hospital discharges included in the two-midnight rule on the grounds that hospitals won’t see the increase in reimbursements that the rate cut was intended to offset because overall reimbursements will actually decrease, costing hospitals nationwide more than $200 million in 2014.

The parties are litigating motions for summary judgment filed by the AHA in both two-midnight cases and a motion to dismissed filed by the HHS in the case dealing with inpatient status.

Additionally, House Ways and Means Subcommittee on Health Chairman Kevin Brady (R-Texas) released a discussion draft of a proposed bill that would alter several aspects of the two-midnight rule. Brady’s proposed bill calls for the removal of the 0.2 percent Medicare rate cut and alterations to reimbursement rates for short hospital stays, as well as changes to the RAC program (25 MCR 1450, 12/5/14).

MSP Beneficiary Notice Changes

The CMA also executed a settlement with the HHS on Nov. 5, 2014, that resulted in the dismissal of Haro v. Johnson (D. Ariz., No. 4:09-cv-00134, settlement 11/5/14).

The CMA unsuccessfully challenged the HHS’s policy of demanding up-front payments of Medicare Secondary Payer (MSP) claim disputes after a U.S. Court of Appeals for the Ninth Circuit ruling in September 2013 that the CMA plaintiff beneficiaries failed to adequately pursue administrative remedies (24 MCR 1125, 9/13/13).

However, the settlement did effectuate several changes to several MSP notices to beneficiaries involved in claim disputes that are due to take effect no later than 180 days after the settlement’s effective date. According to the terms of the settlement, the CMS is required to make specified changes to the Medicare Secondary Payer Rights and Responsibilities letter, the Conditional Payment Notice letter, the Demand letter.
and the Intent to Refer letter that clarify the rights of beneficiaries who have MSP claims.

In addition, the CMS agreed to remove references to “Medicare liens” from Medicare manuals and its website, clarifying that MSP claims aren’t Medicare liens.

**ALJ Backlog Litigation Continues**

The burgeoning backlog of Medicare claim appeals at the ALJ level became the subject of active litigation in 2014 and promises to continue in 2015 with the filing of two lawsuits against the HHS: one filed by the CMA (Lessler v. Burwell, D. Conn., No. 14-cv-1230, filed 8/26/14) and another filed by the AHA (Am. Hosp. Ass’n v. Sebelius, D.D.C., No. 14-cv-00851, filed 5/22/14)(25 MCR 656, 5/30/14).

The parties in Lessler are litigating a motion to dismiss filed by the HHS on Nov. 17, 2014. The class action lawsuit asks the court for a declaratory judgment that the secretary of health and human services is in violation of the statutory 90-day ALJ decision time limit and to force the HHS to issue ALJ decisions within the 90-day time limit (25 MCR 1097, 8/29/14).

The U.S. District Court for the District of Columbia granted the HHS’s motion to dismiss the AHA’s action on Dec. 19, 2014, calling the dispute one of budget and politics that’s best left to Congress and the HHS to work out.

The AHA said it disagreed with the ruling and expected to appeal the decision (26 MCR 19, 1/2/15).

**HHS Not Giving Up Allina Fight**

Ligation between a collection of hospitals and the HHS over the disproportionate share hospital (DSH) payments and how Medicare Part C patient days should be accounted for continues in Allina Health Services v. Burwell (D.D.C., No. 1:14-cv-01415, filed 8/19/14), despite the U.S. Court of Appeals for the District of Columbia Circuit’s ruling in favor of the hospitals in April 2014 (25 MCR 400, 4/4/14).

While the D.C. Circuit agreed with the plaintiff hospitals that the HHS’s rule treating Part C days as part of the SSI fraction in DSH calculations was arbitrary and invalid, it didn’t set out a specific remedy for the plaintiffs.

The hospitals filed a subsequent lawsuit on Aug. 19, 2014, that asks the U.S. District Court for the District of Columbia to order the HHS not to treat Part C days as Part A days for the purposes of DSH payment calculations for periods prior to Oct. 1, 2013, and to recalculate the plaintiff hospitals’ DSH payments prior to that date and make any additional payment needed.

Robert L. Roth at Hooper, Lundy & Bookman PC in Washington, said he was watching the current Allina litigation, stating it was important to determine “whether lawsuits challenging a final rule based on APA deficiencies will result in tangible relief for hospitals when successful.”

The HHS has filed a motion to dismiss for lack of jurisdiction, and the hospitals filed a motion for summary judgment.

**Possible Settlement in Sutter Health.** Another DSH payment dispute that might soon be resolved in 2015 is a lawsuit filed by 29 hospitals claiming Ruling 1498-R violates several prior court rulings by requiring Medi-care Administrative Contractors (MACs) to include certain noncovered inpatient hospital days in DSH calculations (Sutter Health v. Sebelius, D.D.C., No. 14-cv-00850, filed 5/22/14) (25 MCR 657, 5/30/14).

According to a Dec. 9, 2014, status report filed by the HHS, the parties are making progress on continued settlement discussions, and the parties were due to file another status report on Jan. 7.

**PRRB Jurisdictional Bar Disputes**

Roth also said PRRB jurisdictional decisions would be a big source of litigation in 2015 for Medicare providers “addressing the apparent significant increase in PRRB jurisdictional dismissals.”

Honigman’s Marcus agreed with that assessment, noting that “there have been numerous reported PRRB jurisdictional decisions, some of which will make their way into federal court.”

Both Roth and Marcus cited the February 2014 PRRB decision in Danbury Hospital v. Blue Cross Blue Shield Ass’n (PRRB, No. 2014-D3, 2/11/14), as illustrating the issue.

The PRRB ruled it had no jurisdiction to hear a provider claim that its intermediary didn’t make an adjustment for Medicaid eligible days within the notice of program reimbursement because the provider didn’t show any impediment to identifying or verifying the Medicaid eligible days itself before filing its cost report (25 MCR 494, 4/25/14).

**Pushback Against Self-Disallowance Regulation.** A group of hospitals is challenging the HHS’s “self-disallowance regulation” in Banner Heart Hosp. v. Burwell (D.D.C., 1:14-cv-01195-BAH, filed, 7/15/14), which involves another PRRB jurisdictional bar to provider appeals.

The 11 plaintiff hospitals argue in their complaint that the self-disallowance rule, which requires a Medicare provider to self-disallow an item on its cost report if it believes that the item may be denied reimbursement to preserve a later right to appeal, violates a provider’s statutory right to Medicare claim appeals.

The HHS filed an answer in the Banner Heart Hospital case, but litigation hadn’t progressed much further by the end of 2014.

The HHS settled a separate lawsuit over the self-disallowance regulation on Nov. 24, 2014, for $32.5 million, which represented 98 percent of the plaintiffs’ total Medicare reimbursement claims in dispute (Charleston Area Med. Ctr. v. Sebelius, D.D.C., No. 13-cv-766, settlement announced 11/24/14) (25 MCR 1457, 12/5/14).

An earlier injunction ordered by the Charleston Area Med. Ctr. court allowed the hospital plaintiffs in that case and plaintiffs in two other cases (Lee Mem. Hosp. v. Burwell (D.D.C., No. 13-643) and Denver Health Med. Ctr. v. Sebelius (D.D.C., No. 14-553)) to pursue appeals of Medicare reimbursements that were dismissed by the PRRB for lack of jurisdiction.

The PRRB dismissals were based on the hospitals’ failure to file a self-disallowance notice that it was protesting a reimbursement decision in annual cost reports.
U.S. Supreme Court APA Ruling

An upcoming decision in a pair of consolidated U.S. Supreme Court cases has implications for Medicare regulation (Perez v. Mortg. Bankers Ass’n (U.S., No. 13-1041, argued 12/1/14) and Nickols v. Mortg. Bankers Ass’n (U.S., No. 13-1052, argued 12/1/14)), according to Marcus.

The cases involve regulations issued by the Department of Labor concerning overtime eligibility under the Fair Labor Standards Act, but more broadly deal with the issue when a federal agency is required to provide a notice and comment period under the Administrative Procedure Act when revising existing regulations.

By James Swann, Eric Topor, Nathaniel Weixel, Michael D. Williamson, and Mindy Yochelson

To contact the reporters on this story: James Swann in Washington at jswann1@bna.com, Eric Topor in Washington at etopor@bna.com, Nathaniel Weixel in Washington at nweixel@bna.com, Michael D. Williamson in Washington at mwilliamson@bna.com, Mindy Yochelson in Washington at myochelson@bna.com

To contact the editors responsible for this story: Brian Broderick at bbroderick@bna.com, Kendra Casey Plank at kcasey@bna.com, Ward Pimley at wpimley@bna.com, Lisa M. Rockelli at lrockelli@bna.com, Steve Teske at steske@bna.com