HALL RENDER'S THIS WEEK IN WASHINGTON – JULY 8, 2016

CMS RELEASES PROPOSED PAYMENT CHANGES FOR OPPS AND ASC PAYMENT SYSTEM

On July 6, CMS issued its annual proposal for updating payment rates and policies in the Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") payment system. The proposed rule would also implement Section 603 of the Bipartisan Budget Act of 2015, which requires most hospital outpatient departments ("HOPDs") not billing under the OPPS before November 2, 2015 to bill under the Physician Fee Schedule ("PFS") or ASC payment systems. Those HOPDs billing OPPS before that date are excepted from the prohibitions in Section 603.

However, the proposed rule goes further than what is found in Section 603 by prohibiting excepted HOPDs from billing under the OPPS for services "beyond those within the clinical families of services furnished and billed prior to" November 2, 2015. In addition to the expanded services prohibition, CMS is also proposing that an excepted HOPD lose its excepted status if it changes location. The agency appears to justify these proposals by noting in its accompanying press release that MedPAC, the HHS Office of Inspector General ("OIG") and some lawmakers have expressed concern in the past over the number of off-campus physician practices being bought by hospitals.

The proposed rule would also shorten meaningful use reporting requirements under Medicare's Electronic Health Records Incentive Program from a full calendar year to a 90-day period to increase flexibility and reduce reporting burdens for hospital providers. New quality measures, including hospital visits following outpatient surgery and emergency department visits for patients undergoing chemotherapy, would be added to the OPPS and ASC reporting programs that focus on care experience and patient outcomes.

Another provision in the proposed rule would remove the pain management dimension of patient survey questions under the Hospital Value-Based Purchasing Program to reduce financial pressure that providers may face to overprescribe opioids and other pain medications. CMS projects the proposed rule would increase Medicare OPPS payments by 1.6 percent and ASC payments by 1.2 percent in 2017. The agency will accept comments on the proposed rule through September 6.

HOUSE PASSES MENTAL HEALTH REFORM BILL

On July 6, the House overwhelmingly voted to pass a mental health reform bill (H.R. 2646). Despite the strong House vote (422-2), the Senate currently has no plans to take up its mental health reform legislation (S. 2680), even though that measure passed out of committee and has been waiting for floor action since March. With Congress set to adjourn next week until after Labor Day, there is little time for the Senate to act.

The measure passed by the House would establish a new leadership position within HHS to direct federal mental health and substance abuse programs. The bill would reauthorize existing treatment and suicide prevention programs and create new ones, including a minority fellowship program for mental health providers and a training program that teaches clinicians how to better comply with HIPAA. The legislation would also require HHS to clarify conditions under which covered entities may release protected mental health information and codify a Medicaid managed care regulation allowing optional state coverage of Institutions for Mental Disease care for adults.

APPROPRIATIONS COMMITTEE ADVANCES LABOR-HHS FUNDING BILL

On July 7, the House Subcommittee on Labor, HHS and Education advanced the FY 2017 appropriations bill. The bill provides a total of $73.2 billion for HHS, an increase of $2.6 billion above last year's enacted level. Of note, the bill recommends $3 billion for CMS program management and operations, which is $576 million below the 2016 enacted level.

The bill includes over $6.1 billion for the Health Resources and Services Administration, a cut of $218 million from FY 2016. However, within the HRSA account, the State Offices of Rural Health received a $1 million increase over the FY 2016 level. Also within the HRSA account is $300 million for the Children's Hospital Graduate Medical Education program, which is $5 million more than FY 2016. The bill also provides nearly $1.5 billion for Community Health Centers, which is the same as FY 2016.

WAYS AND MEANS ADVANCES BILL DELAYING PHYSICIAN-SUPERVISION RULE

On July 7, the House Ways and Means Committee voted to advance the Continuing Access to Hospitals Act (H.R. 5613) authored by Rep.

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Lynn Jenkins (R-KS). The bill delays CMS enforcement of the physician supervision requirement for outpatient therapy services at critical access hospitals through 2016. It allows physicians and other qualified clinicians to provide general, rather than direct, supervision over most outpatient therapeutic services.

Earlier in the week, Sen. John Thune (R-SD) introduced a companion bill in the Senate (S. 3129). While the House is expected to pass H.R. 5613 next week, Senate leadership has not yet indicated that it will take action on the issue before the seven-week district work period starts July 15. Instead of moving the Thune bill, the Senate could pass H.R. 5613 right after it comes over from the House, which would send it to the President for signature as lawmakers leave town.

CMS RELEASES PROPOSED PHYSICIAN FEE SCHEDULE RULE

On July 7, CMS released its annual proposed changes to the PFS. The proposal updates payment policies, payment rates and quality provisions for services provided in CY 2017. CMS indicates that physician payment rates will decrease less than 1 percent next year. The proposed rule contains several proposals intended to improve how Medicare pays for services provided by primary care physicians and other practitioners for patients with multiple chronic conditions and mental and behavioral health issues, as well as cognitive impairment or mobility-related impairments. The proposed rule would also pay for new telehealth services, such as critical care consultations, ESRD-related services for dialysis and advanced care planning services. Starting in 2018, providers will be able to bill Medicare for diabetes prevention services. It also requires that providers who contract with Medicare Advantage be screened and enrolled in Medicare. CMS will accept comments on the proposed rule until September 6, 2016.

CMS ISSUES FINAL RULE FOR ACCESS TO MEDICARE CLAIMS DATA

Late on July 1, CMS released a final rule expanding the use of Medicare data by qualified groups. The rule expands the number of organizations approved by CMS to access claims data to include government entities and contractors or business associates of authorized users that purchase the information.

Under the rule, qualified entities are able to buy Medicare claims and other federal data at a price equal to the cost incurred by the government for processing the data. Entities are able to combine the information provided by CMS with patient data from insurance companies and providers and then resell that data to organizations such as insurers, medical device makers and employers. Qualified entities are not allowed to sell data to insurers for an area in which they do not provide coverage. The new rule also requires entities receiving claims data to use patient security protections under HIPAA.

HEALTH-RELATED BILLS INTRODUCED THIS WEEK

Rep. Markwayne Mullin (R-OK) introduced a bill (H.R. 5626) that would amend Title XIX of the Social Security Act to eliminate the requirement for three months of retroactive coverage under the Medicaid program.

Sen. Ed Markey (D-MA) introduced a bill (S. 3130) that would amend Title XVIII of the Social Security Act to provide for a permanent Independence at Home medical practice program under the Medicare program.

NEXT WEEK IN WASHINGTON

The House and Senate return on July 11 for their final week of work prior to the national political conventions and summer district work period. On June 12, the Senate Finance Committee will hold a hearing on the need for Stark Law reform, which comes after the committee majority released a 19-page white paper outlining potential reforms to the Stark Law. The white paper follows a discussion held in December 2015 by the majority side of the Senate Finance and House Ways and Means committees where Hall Render shareholder Gregg Wallander participated in a small roundtable of outside Stark Law experts.

On June 13, the Senate Finance Committee is also scheduled to hold a hearing on MACRA implementation, during which Acting CMS Administrator Andy Slavitt is expected to testify. CMS proposed the rule for implementing MACRA earlier this year, and the deadline for commenting on the rule was June 27.

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