

LEGISLATIVE CHANGE: CONGRESSIONAL ACTIONS AFFECTING HEALTH CARE PROVIDERS

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Today's Presentation

- A View from Capitol Hill
 - The 115th Congress & The Senate Finance Committee
 - Legislative Process Overview
- Recent Legislative & Policy Changes Affecting Physician Practices
 - Brief Medicaid Overview
 - Medicaid Reform and Per Capita Caps
 - CMS Audits and Appeals Program
 - Stark Law

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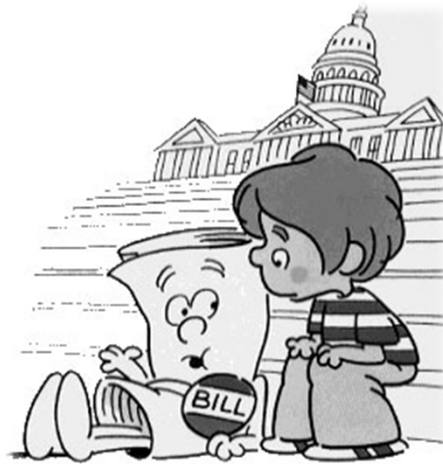
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The comments expressed by Kimberly Brandt are her own opinions and ideas, and do not reflect the opinions of the

Senate Finance Committee
or Chairman Orrin G. Hatch

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A View from Capitol Hill



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Standing Committees

Agriculture, Nutrition, and Forestry
 Appropriations
 Armed Services
 Banking, Housing, and Urban Affairs
 Budget
 Commerce, Science, and Transportation
 Energy and Natural Resources
 Environment and Public Works
Finance
 Foreign Relations
 Health, Education, Labor, and Pensions
 Homeland Security and Governmental Affairs
 Judiciary
 Rules and Administration
 Small Business and Entrepreneurship
 Veterans' Affairs

Special, Select, and Other

Indian Affairs
 Select Committee on Ethics
 Select Committee on Intelligence
 Special Committee on Aging

Joint

Joint Committee on Printing
 Joint Committee on Taxation
 Joint Committee on the Library
 Joint Economic Committee

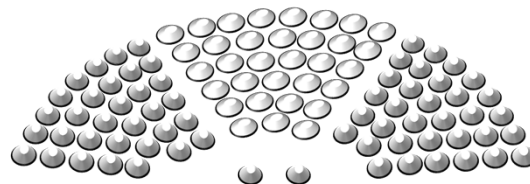
115th Congress - Senate



52 Republicans

46 Democrats

2 Independents



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UNITED STATES SENATE COMMITTEE ON FINANCE

What is it and What does it do?

Finance Committee Jurisdiction:

- Tax matters
- Social Security
- Medicare & Medicaid
- Supplemental security income
- Family welfare programs
- Social services
- Unemployment compensation
- Maternal and child health
- Revenue sharing
- Tariff and trade legislation
- Oversees 50% of Federal Budget

History

- During the 14th Congress (1815–1817), the Senate created the Select Committee on Finance to handle some of the proposals set forth in President James Madison's message to Congress
- On December 10, 1816, the Senate established the Committee on Finance as a standing committee of the Senate

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UNITED STATES SENATE COMMITTEE ON FINANCE

Committee Leadership



Chairman Orrin Hatch



Ranking Member Ron Wyden

Democrats

Debbie Stabenow

Maria Cantwell

Bill Nelson

Robert Menendez

Tom Carper

Ben Cardin

Sherrod Brown

Michael Bennett

Robert Casey, Jr.

Mark Warner

Claire McCaskill

Republicans

Chuck Grassley

Mike Crapo

Pat Roberts

Mike Enzi

John Cornyn

John Thune

Richard Burr

Johnny Isakson

Rob Portman

Pat Toomey

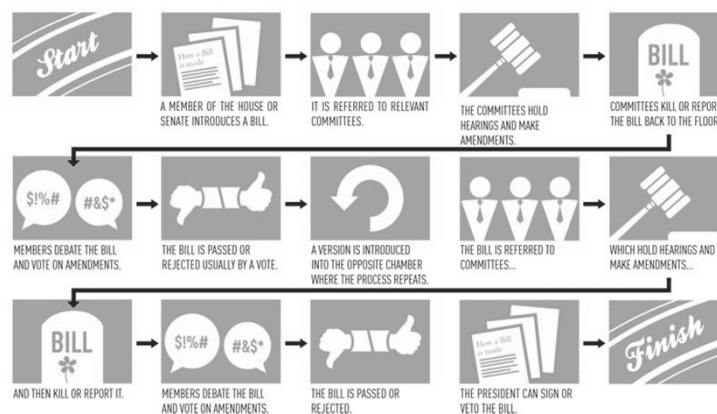
Dean Heller

Tim Scott

Bill Cassidy

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How a Bill Becomes a Law - Simplified



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Recent Legislative & Policy Changes Impacting Health Care Reform



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Brief Medicaid Overview

- Medicaid is dually-financed by the federal government and states; however, the program is administered by states within the parameters of federal law
- Under the current system, federal Medicaid financing for states is done via an open-ended model that places no caps on the amount of beneficiary spending
- Medicaid provides a guarantee to states for federal matching payments with no predetermined limit. The federal share of Medicaid is determined by a formula set in statute that is based on a state's per capita income
 - Using the current matching formula, the federal government pays an increasingly higher amount to states with larger occurrences of poverty
 - The federal matching assistance percentage (FMAP) varies by state from a floor of 50% to a high of 74%

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Program Eligibility

- Medicaid and the Children’s Health Insurance Program (CHIP) cover over 74 million low-income Americans, who fall into four main groups:
 - Infants and children;
 - Pregnant women, parents, and other nonelderly adults;
 - Individuals of all ages with disabilities; and
 - Low-income seniors
- Medicaid covers many—but not all—poverty stricken Americans
 - States can opt to provide Medicaid for children with significant disabilities in higher-income families to fill gaps in private health insurance and limit out-of-pocket burden
 - Medicaid assists 1 in 5 Medicare beneficiaries with their Medicare premiums and cost-sharing, and provides many of them with benefits not covered by Medicare (e.g. long-term care, dental care, and vision care)

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Effect of ACA on Medicaid Enrollment

- Prior to the Affordable Care Act (ACA), most able-bodied low-income adults did not qualify for Medicaid coverage
 - The ACA was established to expand coverage for uninsured, able-bodied Americans with incomes up to 138% of the federal poverty level (FPL). The ACA provided federal funding for the vast majority of the cost of the Medicaid expansion
 - As of January 2017, 32 states—including DC—had expanded Medicaid, and 19 states had not. In the non-expansion states, 2.6 million adults with income below 100% FPL have fallen into a “coverage gap” because their income exceeds their state’s cutoff for Medicaid
- Since the ACA’s expansion, the Medicaid program has become unsustainable and increasingly expensive to maintain

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Per Enrollee Spending

- Total federal and state Medicaid spending was about \$532 billion in FY 2015 (third-largest domestic program in the federal budget)
- Medicaid is the second-largest item in state budgets, accounting for 18.7% of state general revenue spending and 28.2% of total state general revenue spending
- Although per-enrollee costs are relatively low, total Medicaid costs are high due to a large amount of people in the program and the exceedingly high costs of a minority of beneficiaries
 - Seniors and people with disabilities make up 1 in 4 beneficiaries, but account for almost two-thirds of Medicaid spending
 - Medicaid plays a large role in state budgets, states have an interest in cost containment and program integrity

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Beneficiary Outcomes

- Historically, Medicaid has faced one significant challenge—maintaining physician participation
 - Medicaid beneficiaries reside disproportionately in underserved communities—with a lack of primary care providers—which places stress on the hospital ER's that care for uninsured patients
 - Low provider compensation rates mean that many primary care physicians are unwilling to accept new Medicaid patients, as the costs of care outpace the reimbursement rates
- Factors that contribute to this problem include:
 - Complex program requirements;
 - Payment delays; and
 - Concerns about managing the care of patients with high levels of health and social risk
- Although the ACA expanded coverage to millions of previously uninsured Americans, this didn't translate into better outcomes for beneficiaries

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Medicaid Program Integrity

- Estimated improper payments totaling more than \$29 billion in fiscal year 2015
- The lack of complete and reliable data on states' spending and financing of the non-federal share of the program hinders federal oversight
- CMS does not have the data needed to understand payments states make to individual providers, nor a standard process for assessing whether payments are economical and efficient as required by law
- There have been cases where the state's Medicaid payments exceeded the hospital's total operating costs
 - States are not required to limit Medicaid payments to Medicaid costs, but payments that greatly exceed Medicaid costs raise questions about whether those payments are economical and efficient, and ultimately used for Medicaid purposes

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Proposed Medicaid Financing Reform

- The House bill is mainly devoted to reforming the Medicaid program, attempting to take the best elements of the ACA and merge them with an innovative approach to provide essential coverage.
- The American Health Care Act (AHCA) transitions federal Medicaid funding to a per-capita cap basis by 2020, transforming the nature of the Medicaid program
- Amongst other changes, the AHCA will address:
 - State authority to make presumptive eligibility determinations;
 - The ACA's Medicaid expansion by limiting enhanced funding;
 - Incentives for states to re-determine eligibility for Medicaid more often; and
 - Medicaid eligibility issues

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Senate Reform Efforts

- Prior to the AHCA, the Committee sought guidance from numerous groups and organizations, including:
 - **Governor's Roundtable**—In early January, Republican governors from 11 states were invited to participate in a governor's roundtable. This meeting provided context for the flexibility that many across the nation had been requesting in their state Medicaid programs
 - **1-on-1 Meetings**—Realizing the value of seeking guidance from private organizations, the Senate Finance Committee organized meetings with numerous groups that are responsible for providing care to Medicaid beneficiaries
 - **Letter to Governors**—To inform the Committee of the issues that states face in administering Medicaid programs, a letter was sent to governors to solicit opinions and suggestions for improvements
- States are the best administrators of their Medicaid programs—they know the specific needs of their population. Proactively seeking advice for Medicaid reform from numerous parties has expanded the Committee's understanding of the key issues facing the current system

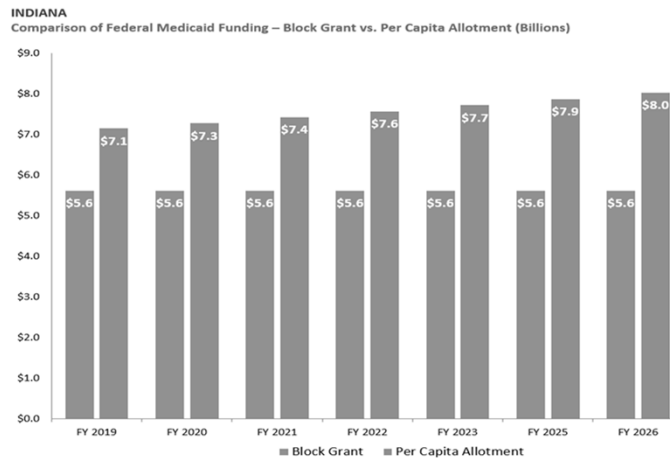
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Per Capita Cap Reforms

- What Is a Per Capita Cap?
 - A per capita cap is a limit on per enrollee spending
 - The upper limit on spending is the per capita amount
- Why Does A Per Capita Cap Save Money?
 - This policy saves money because:
 - Growth rate is set as something such as Consumer Price Index Medical (CPI M)
 - Practically, there will also be State incentives to be more efficient
- Why Do States/Governors Prefer A Per Capita Cap Over Block Grant?
 - States receive more money as enrollment grows and less as it falls (large portions of Medicaid enrollment are generally countercyclical to the economy)
 - This policy approach recognizes the difference between different patient populations

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Illustrative Impact of PCC vs. Block Grant Approach



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Per Capita Caps Simplified

- Using a per capita cap with Medicaid there is an upper limit in how much the federal government would reimburse states
 - The cap could be calculated, by a total user or by group population, for a base year
 - Each subsequent year, the per enrollee cap would be adjusted based on a growth rate
 - This would be used to calculate the state's total federal Medicaid funding limit based on the following product:
 - $(\text{base year per capita amount}) \times (\text{growth rate percentage}) \times (\text{enrollment})$
- Through this method of calculating payments to states would reflect changes in enrollment but would simply set an upper limit of funding

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Understand the Per Capita Cap Approach

Simplified overview

- Establish the base year for Medicaid enrollees (2016)
- Take the base and grow it by a given inflator (ex. CPI-M)
 - Calculate the 2019 provisional Per Capita Limit
- Calculate the Adjustment Ratio for 2019 Per Capitas
 - Adjust the separate enrollee groups Per Capitas
- Grow the 2019 Adjusted Per Capitas
- Reduce any federal payments for any over spending

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Audits and Appeals



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Overview of CMS's Audit Program

What is it?

- CMS's Audit Program is designed to fight fraud, waste, and abuse by identifying and recovering improper payments made on claims for services provided to Medicare beneficiaries

History

- The program is the product of a demonstration that ran between 2005 and 2008 and resulted in over \$900 million in overpayments being recovered and returned to the Medicare Trust Fund and nearly \$38 million in underpayments returned to health care providers

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Recovery *Audit* Contractors (RACs)

Who are they?

- Four private companies that run Medicare's Recovery Audit Program

What do they do?

- Identify improper payments from Medicare Part A and B claims
- Analyze claims and review those most likely to contain improper payments, which may include:
 - payment for items or services that do not meet Medicare's coverage and medical necessity criteria;
 - payment for items that are incorrectly coded; and
 - payment for services where the documentation submitted did not support the ordered service
- Request and analyze provider claim documentation to ensure services provided were reasonable and necessary

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Controversy



What's the big deal?

- RACs are paid on a contingency-fee basis
- CMS coding standards are complex and constantly changing
- RACs can audit healthcare providers for up to three years

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Understanding the RACs Appeals Process

The five-levels of appeal include:

- Redetermination by the Fiscal Intermediary
- Reconsideration by a Qualified Independent Contractor;
- Administrative Law Judge Hearing;
- Medicare Appeals Council Review; and
- Judicial Review in U.S. District Court

Problems with the process:

- Overloaded system, causing at least a two-year delay at the ALJ level
- High cost of RAC appeals

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Potential Solutions

President's Budget Proposal for FY 2016 Includes Several Medicare Appeals Legislative Proposals:

- Provide Office of Medicare Hearings and Appeals and Departmental Appeals Board Authority to Use Recovery Audit Contractor Collections
- Establish a Refundable Filing Fee
- Sample and Consolidate Similar Claims for Administrative Efficiency
- Remand Appeals to the Redetermination Level with the Introduction of New Evidence
- Increase Minimum Amount in Controversy for Administrative Law Judge Adjudication of Claims to Equal Amount Required for Judicial Review
- Establish Magistrate Adjudication for Claims with Amount in Controversy Below New Administrative Law Judge Amount in Controversy Threshold
- Expedite Procedures for Claims with No Material Fact in Dispute

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Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM)

- **On June 4, 2015, the U.S. Senate Finance Committee passed AFIRM**
 - The bill was introduced in December 2015
- **Purpose:** Seeks to increase coordination and oversight of government audit contractors while implementing new strategies to address growing number of audit determination appeals that delay taxpayer dollars from reaching the correct source

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AFIRM Act

• Proposed Changes—

- Improve oversight capabilities for HHS/CMS that increase the integrity of the Medicare auditors and claims appeals process
- Coordinate efforts between auditors and CMS to ensure that all parties receive transparent data regarding audit practices, improved methodologies, and new incentives/disincentives to improve auditor accuracy
- Establish voluntary alternate dispute resolution process to allow for multiple pending claims with similar issues of law or fact to be settled as a unit, rather than as individual appeals
- Ensure timely and high quality reviews, raise amount in controversy for review by an ALJ to match amount for review by District Court
- Allow for use of sampling and extrapolation, with the appellant's consent, to expedite the appeals process

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Fraud and Abuse



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Physician Self-Referral Law (“Stark Law”)

“[If a physician (or an immediate family member of such physician) has a financial relationship with an entity . . . then the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made]” under Medicare and to some extent Medicaid

Social Security Act § 1877; 42 U.S.C. § 1395nn

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Stark Law Problems & Potential Solutions

PROBLEMS

- Complex and rigid law with difficult exceptions
- Diverged from original intent
- Not aligned with health care delivery reform

SOLUTIONS

- **H.R. 2914 (2013)** – limiting scope of DHS and narrowing in-office ancillary services exception
- **H.R. 3776 (2013)** – reducing penalties for technical violations
- Expanding Medicare Shared Savings Program Waivers

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Other Stark Law Proposals

Legislation:

- **Medicaid Physician Self-Referral Act of 2015** (Rep. McDermott, D-WA)
 - Amends Social Security Act Title XIX to clearly apply Stark-like prohibitions
 - Creates direct False Claims Act liability for Stark Law violations

Other Changes:

- **Obama Administration Proposed FY 2016 Budget**
 - Excludes radiation therapy, therapy services, advanced imaging, and anatomic pathology services from the in-office ancillary services Stark Law exception unless a practice is “clinically integrated” and demonstrates cost containment

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Committee Work on Stark Law

- **December 2015** – Senate Finance Committee and House Ways and Means Committee host roundtable to hear from Stark Law experts
- **February 2016** – Reviewing submissions and preparing a white paper on proposed legislative fixes for the law
- **June 2016** – Issued white paper on potential Stark solutions
- **July 2016** – Committee Hearing on issues with Stark law – 3 witnesses, great discussion of issues

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Physician-Owned Distributorships (PODs)



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What are PODs?

HHS Office of the Inspector General (OIG), “Special Fraud Alert: Physician-Owned Entities” (2013)

- “Physician-owned entities that derive revenue from selling, or arranging for the sale of, implantable medical devices ordered by their physician-owners for use in procedures the physician-owners perform on their own patients at hospitals or ambulatory surgical centers (ASCs).”

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Latest POD Developments

- **June 2011** – Senate Finance Committee Report on Physician-Owned Entities
- **March 26, 2013** – OIG Special Fraud Alert on PODs released
- **October 23, 2013** – OIG's Report on PODs (per Congressional request)

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POD Developments

- **November 2014** – U.S. DOJ filed two False Claims Act complaints against a Michigan neurosurgeon, a spinal implant company, two of its distributorships, and the companies' owners
- **May 2015** – A Michigan neurosurgeon, previously involved in a FCA complaint, pleaded guilty to \$11 million in fraud for unneeded surgeries and patient harm
- **November 2015** – Finance Committee PODs hearing examining pros and cons of issue
- **May 2016** – Finance Committee issues updated report on marketplace impact of PODs post OIG fraud alert
- **January 2017** – Surgeon involved in POD sentenced to nearly 20 years in prison for patient harm and unnecessary surgeries.

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Questions?



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