NOTEWORTHY

Update on HealthCare.gov

The Obama administration announced an eight-day extension to the health insurance exchanges' open enrollment period for consumers seeking insurance coverage that would begin on January 1.

HHS previously set the deadline at December 15, but decided to extend it until December 23 in light of the technical difficulties that have prevented many people from enrolling in coverage through the federal health insurance exchange website.

The announcement comes just days after an HHS official said the department will delay by one month the start of open enrollment in the insurance exchanges for coverage that would begin in January 2015.

FEDERAL

What's Taking Place on the Hill Before the Congressional Christmas Recess

The next several days are critical to hospitals as Congress will wrap up business for the year as soon as December 13. Prior to adjourning for the year, the House and Senate will attempt to wrap up key legislation including a budget agreement currently in conference committee and what looks like a temporary physician payment fix (SGR).

Budget Conference Update

The budget conference is attempting to negotiate a small package that would partially relieve the impact of Sequestration in the near future. A physician payment fix remains high on the priority list with the Senate Finance Committee doing a markup of a permanent fix on December 12th. However, a short term fix to the SGR by the House probably on December 13 is more likely the vehicle that
nearly double what it was during
the first month of open
enrollment, according to a recent
analysis by the Commonwealth
Fund.

According to the analysis, about
150,000 individuals enrolled in
plans from November 2 to
November 21, after about 79,000
people had enrolled from
October 1 to November 2.

California has had about 80,000
state residents enroll in coverage,
while New York and Washington
had reported enrollment
numbers in the tens of thousands
by the end of last week.

The report’s authors say the
numbers suggest that the lower-
than-expected enrollment in the
first month was because of
website system problems rather
than lack of interest or demand
for the exchange plans.

will push discussions of a long term fix into 2014.

HCA supports relief from sequestration and a permanent SGR fix; however, we
strongly oppose cuts and policy changes that would be paid for by hospitals to
address either.

Funding Reductions

Nearly a Half Trillion in Cuts are set to be implemented over the next ten years,
including $95 billion enacted in the last three years alone. This includes $45
Billion in Medicare cuts through Sequestration.

Self-Referral to Physician Owned Hospitals

Further, there is an effort by supporters of physician-owned hospitals to repeal or
significantly weaken the ACA’s ban on self-referral to physician-owned hospitals
as part of an amendment or last minute deal on the SGR package. The ability of a
physician to financially gain from referrals to hospitals they own creates an
uneven, anti-competitive playing field threatening patient safety and the health
care safety net provided by full service community hospitals. Conflict of interest is
inherent in these arrangements and to once again allow for their proliferation by
weakening the law would prove to be a giant step backwards for both consumers
and taxpayers.

CMS Issues 2014 Hospital Outpatient Payment Final Rule

The Centers for Medicare and Medicaid Services (CMS) has issued the 2014
Hospital Outpatient Department (HOPD) Prospective Payment System Final
Rule. Under the rule, HOPD payments will increase 1.7 percent, reflecting a 2.5
percent market basket update reduced per the Affordable Care Act by .5 percent
to account for productivity improvements and an additional .3 percent. CMS
projects that total HOPD payments will increase by $4.37 billion, but only $600
million when not accounting for increases in enrollment, utilization, and case-mix
are.

The final rule adopts many, though not all of the major payment policy changes
contained in the proposed rule. CMS finalized its proposal to collapse the current
five levels of Evaluation and Management (E & M) visit codes for clinics into one
new Level II HCPCS code. However, CMS did not finalize its proposal to collapse
visit codes for Type A and Type B emergency departments.

In addition, CMS finalized its policy to create 29 new "Comprehensive" APCs for
the most costly device-dependent APCs, though it is delaying implementation until January 1, 2015, and invites formal comment on its policy. Further, CMS is finalizing, with some limits, its proposals to package various services within APCs and thereby create broader payment bundles. The newly packaged services include, among others, certain drugs used in diagnostic tests and procedures, drugs and supplies used in surgical procedures, and certain clinical diagnostic laboratory tests. For additional resources, see the Fact Sheet.

In addition to the 2014 HOPD final rule, CMS also issued the 2014 Physician Fee Schedule final rule. CMS notes that, absent Congressional action on the SGR, the base unit of payment, or conversion factor, will drop 20 percent, which is less than the earlier estimate of 24 percent. CMS did not finalize its site-neutral payment proposal to cap the physician practice expense payment for procedures furnished in a non-facility setting at the total payment rate for the service when furnished in an ambulatory surgical center or hospital outpatient setting. For additional resources, see the Fact Sheet.

Medicare to Pay Flat Rate for Clinic Visits

The Centers for Medicare and Medicaid Services (CMS) has announced that it intends to pay flat rates for Medicare visits to outpatient clinics instead of payments that vary with the severity of the patient’s condition. It did, however, for the time being, decide not to enact a similar policy for emergency-room visits, recognizing that more study is required in that area. CMS stated that it would do so for emergency room visits to make sure the payment structure “would not underrepresent resources required to treat the most complex patients, such as trauma patients.”

The 1,200-page outpatient prospective payment system rule for 2014, was released in late November, and says the agency is changing its longstanding approach to paying for clinic visits because of a widespread concern that the old system encourages upcoding. The rule means that the 10 procedure codes for outpatient clinic visits will all fall under a single code. The new payment rates will be calculated based on statistical averages in 2012 claims data for the five levels of severity.

Critics argue that moving away from the five-level system contradicts the central notion of Medicare’s severity-based payment system, but CMS officials said the variation in costs between high- and low-complexity patients in clinics was not significant enough to justify the payment differences.

Medicare payments for hospital outpatient services, under the final rule, will
increase 1.7% in 2014 under a final rule. The rate reflects a 2.5% marketbasket update offset by a 0.5% productivity adjustment and a 0.3% adjustment mandated under the healthcare reform law. The productivity adjustment is 0.1% higher than what was proposed in July.

Ambulatory surgery centers (ASCs) will also see a 1.2% payment increase, reflecting an inflation update of 1.7% offset by the 0.5% productivity adjustment. ASCs that do not meet quality requirements could face a 2% payment cut, according to the rule.

The CMS will begin data collection next year for four quality reporting programs that will affect payment rates in 2016. The programs include the level of flu vaccination coverage for healthcare personnel, the follow-up interval for colonoscopy patients with both average risk and a history of polyps, and the visual function of patients 90 days after cataract surgery.

But the rule also removes two quality determination measures: providing a transition record to discharged emergency department patients and providing a patient referral for cardiac rehabilitation. The wide-ranging rule also reduces the number of quality outcomes measures that organ procurement organizations have to meet from three to two.

In addition, it sets the performance and baselines periods for reducing hospital-acquired infections under the value-based purchasing program, and creates a second, independent review process for hospitals that are dissatisfied with the outcome of an administrative appeal.

Comments on the rule are due January 27.

### IRS Releases Final Regulations to Implement ACA Taxes

The Internal Revenue Service (IRS) released several final rules to implement various taxes required by the Patient Protection and Affordable Care Act (ACA). A rule imposing a health insurance tax generally will apply to most health insurers. Some plans, such as self-insured plans that do not use a third party administrator, will be exempt.

The Joint Committee on Taxation has estimated that the health insurance tax will exceed $100 billion over the next 10 years, with $8 billion for 2014; $11.3 billion each for 2015 and 2016; $13.9 billion for 2017, and $14.3 billion for 2018.

The health insurance industry and business groups, such as the Chamber of
Commerce, strongly oppose the fee. Representative Charles Boustany Jr. (R-LA) has introduced legislation, HR 763, that would repeal the fees.

The IRS also released a final rule for the ACA additional Medicare payroll tax, which increases Medicare contributions by 0.9 percent on the amount of income above $200,000 annually. Further, the IRS issued a final rule on the ACA net income investment tax, another tax on those with high incomes to help pay for insurance expansion under the ACA. Both of these rules took effect this year, and are anticipated to total $210 billion in collections over 10 years, as estimated by the Joint Committee on Taxation.

Administration Announces Delay in SHOP

The Obama Administration has announced a one year delay in the SHOP Marketplace on the HealthCare.gov web site. Small business owners who want to apply for new health coverage for their workers through the new marketplaces will have to do so through brokers or paper applications because the online portal will not work for another year, federal officials said. Prior to the announcement there was speculation that an additional delay would occur.

CMS Issues Proposed Rule Related To PSO Participation

The Centers for Medicare & Medicaid Services (CMS) has released a proposed rule to implement section 1311(h) of the Patient Protection and Affordable Care Act (ACA) relating to whether hospitals of more than 50 beds must have an agreement with a Patient Safety Organization (PSO) in order to contract with qualified health plans (QHPs). CMS proposes that, for now, hospitals will not need to contract with a PSO.

CMS proposes two phases for implementation of this ACA requirement. In the first phase, from 2015 to at least 2017, CMS would connect compliance to certain Conditions of Participation (CoPs) for hospitals. Specifically, CMS proposes that a QHP issuer would be able to contract with a hospital of more than 50 beds only if the hospital is Medicare-certified or has a Medicaid-only CMS certification number (CCN). Thus, the hospital would be subject to the CoPs for quality assessment and performance improvement (QAPI) and discharge planning.

CMS does not outline anything concrete for the second phase, but says it is “considering requiring QHP issuers to ensure that their contracted hospitals have...”
agreements with PSOs and comprehensive hospital discharge programs, and that their health care providers implement health care quality activities.”

CMS intends for its PSO-related requirements to apply to all Health Insurance Marketplaces (exchanges), including those that are state-based. CMS’s proposal is included as part of a larger proposed rule implementing mainly insurance-related provisions of the ACA. Comments on this rule are due by December 26.

**STATE**

**Virginia: Election Results**

The state Board of Elections has certified Democrat Mark Herring as the winner of the November 5 election for Virginia Attorney General race. Newly elected Democrat AG Herring beat state Senator Mark Obenshain (R), by 165 votes out of more than 2 million votes cast.

Senator Obenshain has asked for a recount of those votes cast, and because Senator Herring maintained a lead of just .007 percent of the 2.2 million votes, the taxpayers will pay for the recount. A Richmond circuit judge set the statewide recount for December 17-18, but gave heavily populated Fairfax County a one-day head start.

Once localities complete the tally, a three-judge recount court headed by Richmond Circuit Judge Beverly W. Snukals and assisted by Judge Junius P. Fulton III of the 4th Judicial Circuit and Judge Joseph W. Milam Jr. of the 22nd, will convene in Richmond to settle any challenged ballots. Senator Obenshain’s attorney William H. Hurd proposed several measures that would possibly drive up the number of disputed ballots, helping the Republican to close the gap, such as giving election observers the authority to oversee the ballot inspection, and suggest ballots they consider questionable be sent for further review.

**Virginia: Committee Chairs for Virginia House of Delegates’ Standing Committees Announced**

Speaker of the Virginia House of Delegates William J. Howell (R-Stafford) announced the Chairs of the House of Delegates’ Standing Committees, which includes the appointment of seven new Committee Chairs. As Speaker of the
Speaker Howell stated that he felt it was important for the new Chairs to begin their work as early as possible. The following are the list of Chairs with the asterisk denoting new appointments:

- *Agriculture, Chesapeake and Natural Resources: Chairman Ed Scott
- *Appropriations: Chairman Chris Jones
- *Education: Chairman Steve Landes
- *Finance: Chairman Lee Ware
- *General Laws: Chairman Todd Gilbert
- *Science & Technology: Chairwoman Barbara Comstock
- *Transportation: Chairman Tom Rust
- Commerce & Labor: Chairman Terry Kilgore
- Courts of Justice: Chairman Dave Albo
- Counties, Cities and Towns: Chairman Riley Ingram
- Health, Welfare & Institutions: Chairman Bobby Orrock
- Militia, Police & Public Safety: Chairman Scott Lingamfelter
- Privileges & Elections: Chairman Mark Cole

Committee assignments for all members will be announced on January 8, 2014.