NOTEWORTHY

New CBO Director
The new CBO Director, Keith Hall, will give his first congressional testimony before the Senate Budget Committee, which is holding an oversight hearing on that nonpartisan agency. Mr. Hall, who took the helm in April in place of director Doug Elmendorf, is a former White House Council Chief Economist and Commissioner of the Bureau of Labor Statistics.

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FEDERAL

House Ways and Means Committee Holds Hearing on Removing Ban on Physician Self-Referral

On May 19, the House Ways and Means Health Subcommittee, held a hearing in which testimony was provided by Rich Umbdenstock, President and CEO of the American Hospital Association (AHA), on how necessary it is to preserve the ban on physician self-referral to new physician-owned hospitals and maintain restrictions on the growth of existing physician-owned hospitals. In his testimony, Mr. Umbdenstock described the conflict of interest that is inherent in self-referral, and urged lawmakers to "reject efforts to change the carefully crafted compromise contained in law and help protect community hospitals and access to care for all who need it." Specifically, he said the AHA recommends three statutory changes to enhance hospitals' ability to...
improve health and health care:

- Create an Anti-kickback safe harbor for clinical integration programs
- Refocus the Stark law on ownership arrangements
- Standardize the merger and review process between the two federal antitrust agencies

Hearing on Hospital Observation Stays - Medicare Audit Improvement Act (H.R. 2156)

The Senate Special Committee on Aging held a hearing to examine "solutions to the hospital observation stay crisis." Testimony provided by Jyotirmaya Nanda, M.D., system medical director for informatics and physician compliance at the Center for Clinical Excellence and Corporate Responsibility at St. Louis-based SSM Health Care, emphasized that the distinction between inpatient and observation services is a payment distinction set forth by the Centers for Medicare & Medicaid Services, not a clinical distinction. Dr. Nanda noted how difficult it is for hospitals to comply with Medicare payment policies while addressing the confusing and often difficult issue of patient status with patients and their families, leaving them in an untenable position.

"On the one hand, they risk loss of reimbursement, monetary damages and penalties from auditors and prosecutors when they admit patients for short, medically necessary, inpatient stays. On the other hand, they face criticism from certain patients and CMS over the perceived use of observation services instead of inpatient admission." Dr. Nanda said that Medicare auditors, especially Recovery Audit Contractors (RAC), second guess physician judgment, sometimes years after a patient was seen and often with additional retrospective information on the patient's condition, undermining the physician's medical judgment by denying inpatient claims. He said the Medicare Audit Improvement Act (H.R. 2156) would go a long way toward ensuring the RAC program "is more accurate and fair for the Medicare program, providers and beneficiaries."
Covered California, the state's Exchange program, has released a proposed budget of about $332.9 million for fiscal 2016, marking a 15 percent reduction from last year's funds. The drop is largely due to shifting much of the cost for the state's eligibility and enrollment system to the state's Medicaid department, as well as reducing marketing and outreach. The budget also reflects lessons learned from earlier years, including data that indicate about 80 percent of exchange enrollees, rather than the expected 85 percent, pay their premiums.

While California’s exchange enrollment increased only 1 percent this year, Covered California’s Executive Director Peter Lee pointed out that the 495,000 people who enrolled are still just slightly below the "medium" enrollment projections of 500,000 for this year. For 2016, Covered California’s projected enrollments range from a low of 1.36 million to a high of 1.52 million.

The budget also includes $100 million in funds that the federal government allowed through a grant extension, and that the exchanges stresses "will be used in accordance with federal rules that allow marketplaces to use grant funds for establishment costs for design, development and implementation, but not to support ongoing operations."

While Covered California continues to use federal grant establishment funding, the exchange is streamlining its operations and banking the fees collected from contracted health plans to "ensure the exchange's ongoing financial health," according to the exchange. Covered California collects a $13.95 per-member per-month fee from plans participating in the exchange.

The exchange says it is on "solid financial footing" and expects to end fiscal 2015 with nearly $194 million in unrestricted reserve money, or more than six months' worth of operating funds. The exchange also projects having more than $150 million in reserves at the beginning of fiscal 2017. Despite budget cuts of 33 percent, which will impact marketing and outreach, Covered California will still propose $120 million in outreach.

Another reason for the smaller budget is a change in the cost allocation for the California Healthcare Eligibility and Enrollment Retention System (CALHEERS). The proposed budget calls for a 48 percent decrease
in Covered California's spending on CALHEERS, so the exchange would be responsible for 14 percent of costs while the state's health department, which oversees Medicaid, would cover the remaining 86 percent. A spokesman notes that this is because 11 million of those enrolled through the system are in Medi-Cal, while only 1.4 million are in the exchange.

The official also clarifies that CALHEERS can receive the enhanced 90 percent federal match for developing eligibility systems that CMS recently extended without an end date, but only for the portion of the system allocated to Medi-Cal.

Mr. Lee also said that the state has not been discussing the potential to lease its system or create a regional exchange with other states in advance of a Supreme Court decision in King v. Burwell. The idea of regional exchanges (or borrowing a successful state exchange's technology) has been floated as a solution should subsidies cease to flow through states using Healthcare.gov. Mr. Lee said they have been concentrating on preparing for their third year in open enrollment which begins November 1.

**Florida**

**CMS Offers Preliminary LIP Funding Level**

In a [letter](#) dated May 21, Director of CMS's Center for Medicaid and CHIP Services, Vikki Wachino, discusses funding for Florida's Low Income Pool (LIP) for 2015-2016. The LIP pool is intended to help hospitals pay the cost of providing care to low-income patients. The letter notes that CMS has yet to make "a final determination on LIP" and hints that the $1 billion would come from a combination of federal and state funds. The $1 billion funding rate for 2015-2016 would be consistent with the LIP funding level prior to 2014.

Earlier this year, the state of Florida submitted, for CMS's review, an annual $2.2 billion LIP funding request through June 2017, with roughly $1.3 billion annually from the federal government and the remainder from state and local dollars.
Special Session Called
Senate President Andy Gardiner (R) and House Speaker Steve Crisafulli (R) issued a joint special session proclamation that specifies issues to be considered during a three-week session starting June 1. Both leaders have agreed to pass a new state budget while at the same time debate legislation covering health care, Medicaid, tax cuts, and environmental policy. Also included in the proclamation is the Senate’s modified version of Medicaid expansion, a health insurance exchange that would expand health care to 800,000 uninsured residents using federal Medicaid money, a good signal that the Senate is agreeing to debate the issue again.

The regular legislative session came to an abrupt close in late April after House members abruptly adjourned early due to a stalemate with the Senate over whether to expand health care coverage to 800,000 Floridians. That session ended without a new state budget.

State government could be shut down if a new budget is not passed by June 30. Governor Rick Scott has warned state agencies about the possible shutdown and this week ordered them to come up with a list of the state's most critical needs in case legislators had problems passing a new budget.

The divide between the two chambers was sparked by the likely loss of more than $1 billion in federal aid to hospitals that is set to expire June 1. Federal officials had told the state that in lieu of funding their low-income pool (LIP) for 2016, that Medicaid expansion would cover more residents for fewer dollars. On May 21, Federal official announced that Florida can likely expect $1 billion in the budget year beginning July 1 for the Low Income Pool (LIP), and that coupled with state Medicaid options outlined in the announcement, the state would be able to retain Medicaid investment in the state at or above the current $2.6 billion level of LIP funding.

Legislative leaders have also agreed to discuss other health care changes that would affect doctors, nurses, and hospital operations. The agreement also states that tax cuts will be considered as well. The House passed nearly $700 million worth of tax cuts, but the bill was never taken up by the Senate because of the health care standoff. Senate Budget Chief Tom Lee cautioned that there is no guarantee any of the proposals will pass.