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in the news

Health Policy Monitor

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Health Reform and Related Health Policy News

In this Issue:

An executive summary of political, legal and regulatory issues that may impact your business, prepared by Polsinelli Health Care legal and Public Policy professionals.

Top News

Sebelius: No More Health Law Delays; No Enrollment Extension

On March 12, the U.S. Department of Health and Human Services' (HHS) Secretary Kathleen Sebelius testified before the House Ways and Means Committee that there would be no further delay of the Affordable Care Act's individual mandate, which requires individuals to obtain acceptable health insurance by March 31, 2014.

CMS Announces Innovative Hospice Care Model

The Centers for Medicare & Medicaid Services (CMS) recently launched an initiative to develop innovative payment systems to improve care options for beneficiaries by allowing greater beneficiary access to comfort and rehabilitative care in Medicare and Medicaid. The Medicare Care Choices Model will test improvements to certain Medicare beneficiaries' quality of life while they are receiving both curative and palliative care.

Medicare beneficiaries are currently required to forgo curative care in order to receive access to palliative care services offered by hospices. This model will test whether Medicare beneficiaries who qualify for coverage under the Medicare hospice benefit would elect to receive the palliative and

supportive care services typically provided by a hospice if they could continue to seek services from their curative care providers.

Parties interested in applying must be a Medicare certified and enrolled hospice. Eligible hospice organizations interested in participating in this model must submit application materials no later than June 19, 2014.

View the release here.

State News

17 States and D.C. Implementing SHOP Health Insurance Exchanges for Small Businesses

According to a Commonwealth Fund study, 17 states and the District of Columbia are operating their own Small Business Health Options Program (SHOP) market places which allow small employers to purchase health insurance, while the federal government is operating SHOP marketplaces in the remaining 33 states. States with their own SHOP marketplaces seek to encourage small-business participation, focusing on features generally unavailable outside of SHOP exchange, such as offering employees a choice of plans and setting predicable contribution toward coverage. "States creating their own SHOP marketplaces understood what small business owners wanted and worked to make their marketplaces attractive to them," said Georgetown's Sarah Dash, the lead author of the study.

SHOP marketplaces are intended to improve access to health coverage for small business owners and their employees and are open to employers with 50 or fewer full-time employees. According to the study, nearly all the states' SHOP exchanges include enough competition to offer small-business owners and their employers a choice of insurers and plans. Depending on the state, employers may enroll in the SHOP exchanges online, directly with insurers or through agents and brokers.

View the press release here.

Arkansas "Private" Medicaid Plan

Arkansas implemented a "private Medicaid option" that utilizes federal Medicaid funds to purchase private insurance for low-income individuals. The private option was approved last spring as an alternative to expanding Medicaid under the Affordable Care Act, which is viewed by many conservatives as broken and inefficient. The law recently survived a defunding attempt in the Arkansas state legislature and will continue to operate.

The private option allows those below 138 percent of the federal poverty line to enroll in plans like Blue Cross and Blue Shield through Arkansas' state insurance exchange. Nearly 100,000 Arkansans are enrolled under Arkansas' private option and around 250,000 individuals are eligible. This type of program is currently being explored in other states, including Iowa, Pennsylvania, New Hampshire, Utah and Virginia.

View the press release here.

Missouri Medicaid Work Requirement

The Missouri Legislature recently passed legislation (HB 1901) requiring many adult Medicaid recipients to work and pay a premium of at least one percent of their income to receive health care coverage. Missouri is remodeling their Medicaid program to reflect private-sector insurance and the work requirement is part of the broad proposal.

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The House Government Oversight and Accountability Committee Chairman Jay Barnes said: "I think it's reasonable to expect people on Medicaid, if they are able to work, to actually get out there and work." Others advocated against the adoption of the work and premium requirements. Jen Bersdale, the executive director of Missouri Health Care for All said "these two requirements… actually impose unnecessary and really harmful barriers to care for all people who are living in poverty."

If the federal government approves the work and premium requirements, Medicaid coverage in Missouri will be expanded to hundreds of thousands of lower-income adults. According to Saint Louis University law professional Sidney Watson and Joel Ferber of Legal Services for Eastern Missouri, the work requirement does not appear to be authorized by Medicaid laws, and HHS is unlikely to approve such requirement..

View the press release here.

Nearly One Million More Individuals Signed up for Obamacare Plans in February, But Only One Quarter are Young Adults

Around 4.3 million Americans have signed up for private health plans via health insurance exchanges, with enrollment increasing by nearly one million people in February. This enrollment rate varies dramatically by state. In the first two months of 2014, Florida's enrollment increased by 180 percent, Texas by 149 percent, California by 74 percent, and New York by 56 percent.

However, of the 36 states served by the federal marketplace, only one quarter of the individuals who signed up for coverage in February were between the ages of 18 and 34. Insurance premiums sold in the health exchanges this year are based on the insurer-set benchmark of 40 percent young adults, which is higher than the actual enrollment reflects. The impact on 2015 premiums is unclear. Gary Cohen, a top HHS official said he believes insurance will have enough young adults to balance out the insurance premiums pools and insurers will not have to significantly raise premiums in 2015. Conversely, Brendan Buck, spokesman for House Speaker John Boehner said: "Young adults--those who the White House repeatedly said are critical--are deciding the health care law is a bad deal."

View the press release here.

The State of New York and CMS Reach Agreement in Principle on Medicaid Waiver

New York State and CMS reached an agreement in principle on the state's Medicaid waiver request. This will provide New York with $8 billion over 5 years for improvements to the New York health care system and allows New York to spend part of the estimated $17 billion dollars savings achieved through a major restructuring of its Medicaid Program. Governor Andrew M. Cuomo said: "While the State will be reviewing the terms and conditions of this agreement, it is clearly the biggest step forward towards a positive conclusion for our communities, particularly in Brooklyn, that have suffered from diminishing health care services. Securing this waiver will address those needs, allowing us to increase access and improve the quality of care for New Yorkers while making New York's health care system a model for the entire nation."

View the press release here.

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Regulatory News

Settlements and Judgments

Over the past few weeks, there have been several significant settlements and convictions based on healthcare fraud and abuse allegations. For more information, see the individual press releases below:

- Memorial Hospital (Ohio) settles FCA claims for $8.5 million. View the press release here.
- Jury convicts seven defendants in $97 million Medicare fraud scheme. View the press release here.
- Halifax Hospital Medical Center settled FCA and Stark allegations for $85 million. View the press release here.
- Teva Pharmaceuticals USA and its subsidiary IVAX LLC agreed to a $27.6 million settlement regarding alleged FCA violations. View the press release here.
- Omnicare (Ohio) agreed to a $4.19 million dollar settlement regarding alleged FCA and kickback violations. The press release is available here.
- Skagit County, Washington, became the first county government to settle alleged HIPAA violations, agreeing to a $215k settlement. View the press release here.

Record-breaking Year for Healthcare Fraud Recoveries

On February 26, 2014, Attorney General Eric H. Holder and HHS' Secretary Kathleen Sebelius released a joint statement regarding the success of fraud and abuse enforcement efforts. For every dollar spent on enforcement over the last 3 years, the government has recovered an average of $8.10—the highest 3-year rate of return in history. In fiscal year 2013, these efforts resulted in $4.3 billion dollars in repayments. To view the full press release, click here.

HHS Releases Next Edition of EHR Technology Certification Criteria

On February 26, 2014, HHS' Office of the National Coordinator for Health Information Technology issued a proposed rule for the next edition of EHR technology certification criteria. This is the first set of criteria proposed separate from CMS' meaningful use regulations. To view the full press release, click here. To see the proposed rule, click here.

CMS Adds Physician Quality Data to Physician Compare

As of February 21, 2014, CMS has added physician quality measures to the Physician Compare website, which allows consumers to find out information about physicians and other health care professionals in order to make smarter decisions about their care. In the site's first year of operation, 66 group practices and 141 accountable care organizations have reported quality data. To learn more, click here.

CMS Seeks Input on Next Phase of DMEPOS Competitive Bidding Program

CMS announced that it would seek public comment regarding its expansion of the DMEPOS Competitive Bidding Program established by the Medicare Modernization Act. Specifically, CMS requests comments regarding

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simplification of the payment rules and enhancement of beneficiary access to items and services. To view the fact sheet regarding this request for comment, click here. To view the Advanced Notice of Proposed Rulemaking, click here.

Additional Reading

- *Kaiser Health News:* House GOP Votes To Expand Health Law Religious Exemptions
- *Bloomberg BNA:* No Mandate Delay, No Extension Past March 31 for Enrollments, Sebelius Says
- *Congressman Jim Renacci Press Release:* Renacci Introduces Bipartisan Bill To Provide Relief For Hospitals Treating Our Nation's Most Vulnerable Patients
- *Government Accountability Office:* Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care
- *American Hospital Association:* Statement on H.R. 4188 Establishing Beneficiary Equity in the Hospital Readmissions Program
- *American Medical Association:* AMA Welcomes High Court Review of Federal Infringement on States' Powers
- *Bloomberg BNA:* ACA Insurers Will Have to Cover Same-Sex Spouses Under U.S. Rules
- *Bloomberg BNA:* House Republicans Unveil Plan to Fund 'Doc Fix' by Delaying Individual Mandate

Federal Register

HHS Releases Rules on 90-day Waiting Period for Eligibility for Group Health Plans

The Affordable Care Act required amendments to the set of laws governing group health plans. Included in these amendments is the requirement that group health plans (or health insurance companies offering group health plans) may not require a waiting period of longer than 90 days prior to a new member's eligibility to participate. The proposed rule alters the definition of reasonable and bona fide employment-based orientation to conform with these requirements. Comments are due by April 25, 2014. To view the final rule, click here. To view the proposed rule, click here.

HHS Releases Final Rule Establishing the Basic Health Program

Another requirement of the Affordable Care Act, the Basic Health Plan (BHP) is intended to give states the flexibility to establish a health insurance program for low-income individuals who would otherwise be eligible to purchase coverage through the Affordable Insurance Exchange. The final rule establishes the framework for BHP eligibility and enrollment, benefits, delivery of services, transfer of funds to participating states, and federal oversight. To view the entire rule, click here.

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For More Information

For questions regarding any of the issues covered in this Alert, please contact:

- Matthew J. Murer | *Practice Area Chair* | 312.873.3603 | mmurer@polsinelli.com
- Jane E. Arnold | *Practice Area Vice Chair* | 314.622.6687 | jarnold@polsinelli.com
- Colleen M. Faddick | *Practice Area Vice Chair* | 303.583.8201 | cfaddick@polsinelli.com
- Erin Fleming Dunlap | *Author* | 314.622.6661 | edunlap@polsinelli.com
- Samuel H. Jeter | *Author* | 816.572.4686 | sjeter@polsinelli.com
- Ryan B. Thurber | *Author* | 303.583.8252 | rthurber@polsinelli.com
- Joseph T. Van Leer | *Author* | 312.873.3665 | jvanleer@polsinelli.com

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About Polsinelli

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