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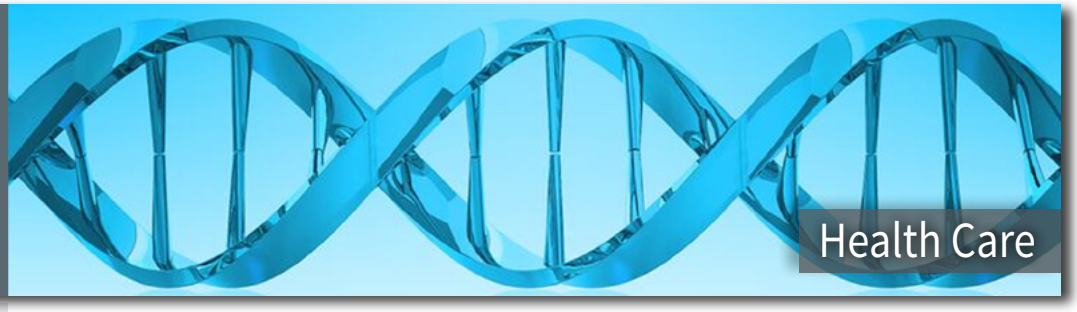

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Continuing Resolution Creates Significant Changes to Medicare and Medicaid Policies

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by Gabriel Scott and Neal Shah

The Bipartisan Budget Act of 2018, commonly referred to as the "Continuing Resolution," was recently signed into law, creating a short-term fix to funding the federal government for six weeks while also raising the debt ceiling for one year and increasing spending limits for two years. The primary purpose of the Continuing Resolution (Pub. L. 115-123) was to authorize federal government spending and renew commitments to programs like the Children's Health Insurance Program (CHIP). **However, the Continuing Resolution, which was signed Feb. 9, also contained a number of legislative changes with important implications for Medicare coverage, fraud & abuse, and value-based payment initiatives. These changes will continue to impact the Medicare program long after the resolution expires.**

The changes include:

Increased Fraud & Abuse Penalties

The Continuing Resolution increased the maximum criminal and civil fines and penalties associated with a number of healthcare fraud statutes.

- Increasing the maximum criminal penalties from $25,000 to $100,000 per claim, and from five years to 10 years in prison for felony violations under 42 U.S.C. § 1320a-7b, including the Anti-Kickback Statute (AKS), prohibitions on false statements associated with federal healthcare program benefits and the condition/operation of institutions, and illegal patient admittance and retention practices.

- Increasing fines under the sections of the Civil Monetary Penalty (CMP) Law concerning "improperly filed claims," including increasing CMPs:

    - From $50,000 to $100,000 for civil penalties for violating the Anti-Kickback Statute, prohibitions on making false records or statements material to false claims, and making false statements in bids or contracts (for example, for Medicare Parts C and D).

    - From $15,000 to $30,000 for providing false information that could reasonably be expected to influence inpatient hospital discharge decisions.

  - From $10,000 to $20,000 for medically unnecessary care, remuneration that could reasonably induce beneficiaries to select a provider, unlicensed physician services, upcoding, certain relationships with excluded individuals, and several other violations.

- Increasing the size of the "Gainsharing CMP" (which prohibits payment by a hospital to induce a physician to reduce or limit medically necessary services) from $2,000 to $5,000, and from $5,000 to $10,000 if a physician in such a situation certifies certain home health eligibility standards.

- The Continuing Resolution also doubled other miscellaneous civil and criminal penalties – for example, increasing the penalty for violating Medicare assignment rules from $2,000 to $4,000.

As with existing CMP authorities, the OIG will increase all of these amounts based on inflation. Virtually all providers who participate in Medicare and Medicaid are subject to one or more of these laws. A**s a result, given these substantial increases in both civil fines and criminal penalties, providers and their advisors should review these revised provisions and continue to focus on AKS and CMP compliance to understand the current risk posed by enforcement actions under these laws.**

Modifications to Stark Law Rules

In the 2016 Medicare Physician Fee Schedule Final Rule, the Centers for Medicare and Medicaid Services (CMS) made a number of interpretive changes to the Stark Law designed to reduce the number of "technical" violations. These violations included problems with holdover leases or other arrangements, missing signatures, and the failure to memorialize an agreement in a single written contract. While these were welcome changes, their legal status was unclear since they were made in CMS's preamble commentary rather than through administrative rulemaking.

The Continuing Resolution represents an extremely positive step by codifying these changes in the text of the Social Security Act. In particular, Congress has now adopted the following positions as a formal part of the legislative text of the Stark Law:

- Allowing parties to demonstrate that an agreement is in writing using a "collection of documents, including contemporaneous documents evidencing the course of conduct between the parties involved."

- Any exception requiring a signature will be satisfied if the document is signed within 90 days following the date of non-compliance.

- Expressly authorizing indefinite holdovers of many agreements (including personal service agreements and leases of space or equipment) so long as they are on the same terms as an initial arrangement lasting one year and continue to meet the standards of the exception (including remaining at fair market value).

Presumably, courts will feel more comfortable applying these rules now that they have been incorporated into the statutory text. As a result, this should reduce the number of inadvertent or "technical" violations that could potentially give rise to Stark Law liability.

Changes to MACRA / QPP

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new value-based payment framework called the "Quality Payment Program." Starting in 2017, CMS began to use certain quality and performance-related measures to calculate bonuses or penalties that would apply to physician and other Medicare Part B professional payments starting in 2019. The Continuing Resolution makes several changes to the Quality Payment Program, particularly to the Merit-based Incentive Payment System (MIPS) that applies to clinicians who do not participate in formal value-based payment programs. These changes include the following:

- Congress established that CMS may not look at the costs of Part B-covered drugs or items in assessing payments or penalties under MIPS.

- CMS is no longer required to set 30 percent of the total MIPS score based on the new Cost category; instead, for 2018-2021 the agency has flexibility to set the weight as low as 10 percent.

- CMS currently has discretion to define a MIPS score that will trigger bonuses or penalties, which it has used to set relatively low "thresholds" protecting many clinicians from penalties. Congress extended this discretionary authority through 2021.

- CMS must publish meaningful information about any cost measures under consideration.

- CMS is no longer required to adopt more stringent meaningful use standards over time regarding the use of electronic health records.

Accountable Care Organization changes

Accountable Care Organizations (ACOs) are Medicare payment models created under the Affordable Care Act to encourage physicians, hospitals and other providers to collaborate to reduce healthcare costs while maintaining or improving care quality. Since their inception in 2011, CMS has initiated a permanent Medicare Shared Savings Program (itself divided into a number of policy tracks with different levels of payment risk and potential bonuses) as well as a Next Generation ACO program administered through the Center for Medicare and Medicaid Innovation (CMMI). The Continuing Resolution makes a number of important changes to CMS ACO initiatives.

- Beginning in 2020, ACOs can receive Medicare reimbursement for telehealth services furnished in beneficiaries' homes, even if they are not located in a rural area.

- Beginning in 2020, CMS must allow participants in all ACO models to determine the beneficiaries assigned to them at the start of the program (known as "prospective attribution").

- For 2018 and all future years, CMS must allow beneficiaries to voluntarily align with ACOs "if a system is available for electronic designation."

- CMS must implement a new program by 2020 allowing ACOs to provide financial incentives to encourage beneficiaries to obtain primary care services through the ACO.

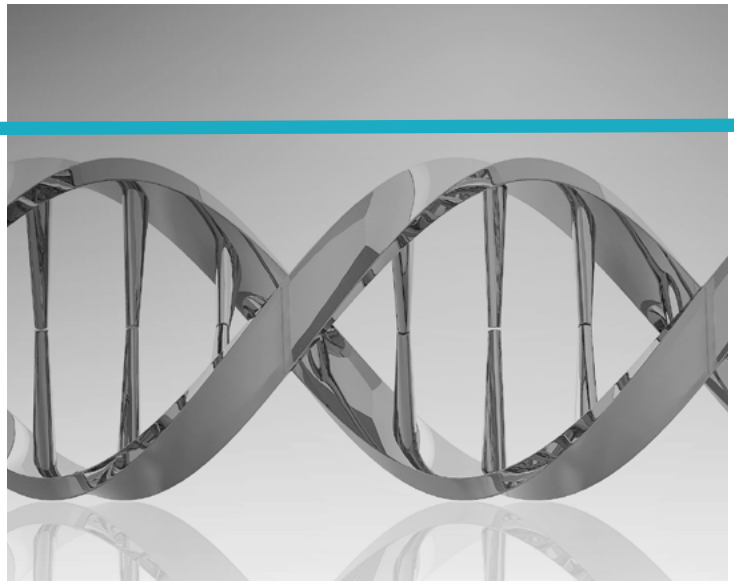
- Requires CMMI to expand its Medicare Advantage Value-Based Insurance Design model nationwide and keep it in place until at least 2022.

Changes to Telehealth Rules

The Continuing Resolution further expands the situations in which providers can obtain Medicare reimbursement for telehealth services. For example, it includes new coverage for telehealth services provided in urban areas for the narrow purpose of stroke care. It also allows Medicare Advantage plans to offer expanded telehealth purposes, which will be treated as original Medicare services for the purposes of calculating payments.

The Continuing Resolution also made a number of technical changes to Medicare coverage and payment standards in areas like ambulance care, therapy services, certain categories of acute care hospitals, dialysis providers, Medicare Advantage plans, and others. While these narrower changes are beyond the scope of this Alert, providers should closely scrutinize the content of the Continuing Resolution.

To learn more about the Continuing Resolution or to discuss potential strategies and opportunities it presents, please contact the authors or your Polsinelli attorney.



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