

# HEALTH POLICY MONITOR



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## Update for April 2013

### Top News

#### Large Hospital Systems Settles for \$25.5 Million for False Claims Act Allegations

On April 3, 2013, the United States Department of Justice (“DOJ”) announced it had entered into a settlement agreement with Utah-based Intermountain Health Care, Inc. (“IHC”) for \$25.5 million based on IHC’s alleged violations of the False Claims Act, Civil Monetary Penalties Law and the Stark Law.

The settlement arose out of: (1) improper compensation arrangements between IHC’s subsidiary medical group and several physicians where their bonus formulas may have taken into account the volume and value of their referrals to IHC; (2) office space leases with physicians that were not set

out in writing or executed by the parties and may have had fair market value issues; and (3) other services agreements between IHC and physicians that were not set out in writing or executed by the parties.

In announcing the settlement, the DOJ indicated IHC approached the DOJ to resolve the issues addressed in the settlement.

To read the entire DOJ press release, click [here](#).

#### Catholics’ Challenge to Contraceptive Coverage Mandate Dismissed As Not Ripe

On March 22, 2013, the United States District Court for the Southern District of Ohio dismissed claims by



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two Roman Catholic organizations that challenged the constitutionality of the contraceptive coverage mandate under the Affordable Care Act.

In their challenge, the Catholic organizations argued, among other things, that laws requiring employee health plans to cover patient education and abortion counseling, sterilization procedures and contraceptive methods violate their deeply held religious beliefs. The government moved to dismiss the claims, and the court held the plaintiffs' action was unripe due to the harms alleged being unlikely to "ever come to pass." In affirming its decision, the Court pointed to a temporary safe harbor provision which prevents the government from enforcing the mandate against certain nonprofit groups until after January 1, 2014, the date in which many states' plans begin.

Industry experts note this will not be the last of challenges to the contraceptive mandate the court will hear.

To read the entire opinion, click [here](#).

## States News

### Tennessee Rejects Traditional Medicaid Expansion

On March 27, 2013, GOP Governor Bill Haslam rejected Medicaid expansion under the traditional program. The Tennessee governor stated he plans to leverage federal funds to help Tennessee residents purchase plans through insurance exchanges—similar to plans proposed by Ohio and Arkansas.

Haslam stated in his speech to the state legislature that Tennessee will leverage available federal funds to allow residents to purchase private health insurance. Haslam further commented that he was opposed to expanding coverage under TennCare—the state's Medicaid program—as, in Haslam's opinion, CMS has failed to fully outline costs and alignment reforms.

Brad Palmtree, the head of a Tennessee consumer advocacy group, expressed his deep disappointment in Haslam's decision, calling for the governor to reconsider his position. Palmtree adds that by rejecting Medicaid expansion, "Tennessee will continue to have hundreds of thousands of uninsured residents who do not receive the health care they need."

Currently, TennCare provides coverage to 1.2 million residents. Surveys estimate that an additional 175,000 Tennesseans would have been added to this figure under traditional Medicaid expansion.

To read more click [here](#).

### Maryland Passes Medicaid Expansion Bill

On March 27, 2013, after a three year effort to create a health insurance exchange for state residents, the Maryland General Assembly approved legislation to expand its Medicaid program. The expansion bill, which was approved by a 35-11 Senate vote and 93-43 vote in the House of Delegates, is expected to extend coverage to 147,000 previously uninsured Marylanders by January 1, 2014.

The expansion bill has several targeted components. It serves to authorize creation of a state reinsurance program, use existing premium taxes for funding purposes, allow enrollees from high-risk pools access to the exchange, and set continuity of care requirements for providers. For Medicaid recipients,



eligibility will be expanded to children ages 6 to 18 and adults under 65 with household incomes up to 133 percent of the federal poverty level.

Maryland Lieutenant Governor Anthony Brown remarked that passage of this historic bill ensures that Maryland “will be among the first states in the country to bring the full benefits of the Affordable Care Act to individuals, families, and small businesses.” Open enrollment in Maryland’s Health Benefit Exchange is slated to begin October 1, 2013.

To read more click [here](#).

### Minnesota Receives Grant to Focus on Overused Medical Tests

Minnesota’s largest physician group, the Minnesota Medical Association, received a \$50,000 grant from the Robert Wood Johnson Foundation. The grant, which is aimed at educating doctors about overused medical procedures and tests, is one of almost two dozen grants awarded to health entities across the United States.

Dr. Robert Meiches, CEO of the medical association, stated the grant is part of a nationwide campaign entitled “Choosing Wisely,” which serves to bring awareness to doctors [and patients] that an exorbitant amount of unnecessary medical care is being provided throughout the United States. Meiches says the additional care being provided is not supported by evidence, does not increase quality, and ultimately serves to boost costs adding to the financial burden our health care system already endures.

Since launching nearly a year ago, Choosing Wisely has helped over 25 medical specialty societies deem tests and procedures as either unnecessary or overused.

To read more about the campaign and grant, click [here](#).

### Physician Supervision of Kentucky PA’s Relaxes

Kentucky Governor Steve Beshear (D) signed into law H.B. 104 which reduces the time that a physician assistant (PA) must be directly supervised by a doctor from 18 months of medical practice to 3 months. Under the current law [KRS 311.860], which is in effect until May 31, 2014, a newly graduated PA is not able to practice medicine in a location that is separate from their supervising physician until that PA has at least 3 months of continuous experience. PAs may, however, perform services in a location separate from the supervising physician so long as the supervising physician is “continuously available via telecommunication” and a waiver has been granted by the Kentucky Board of Medical Licensure.

Beginning June 1, 2014, the requirement of 3 months of continuous service in a non-separate location will be removed. The rationale behind this change stems from the autonomous decision-making that PAs already employ in carrying out a broad range of duties. The Academy of Physician Assistants (AAPA) commented on the new law stating, “in rural areas, the PA may be the only health care provider on-site, working elsewhere through telecommunication.” In addition to relaxing the supervision requirement, the law aims to encourage PAs trained in Kentucky to stay in Kentucky for the duration of their practice.

For more information, read the text of [H.B. 104](#) here.



## Regulatory News

### U.S. District Court Finds Hospitals Qualify as Federal Subcontractors

The United States District Court for the District of Columbia recently found three hospitals affiliated with the University of Pittsburgh Medical Center qualified as federal “subcontractors” by providing services to a health maintenance organization that had a prime contract with the federal government.

The ruling is important because as federal subcontractors, such hospitals must comply with regulations of the United States Department of Labor’s Office of Federal Contract Compliance Programs, which require that federal subcontractors abide by certain equal opportunity standards and develop and implement affirmative action plans. Failure to comply with these requirements may result in substantial fines on such federal subcontractors.

To read the full case, click [here](#).

### House Releases Second Draft of Plan to Fix Sustainable Growth Rate (SGR) Formula

On April 3, 2013, the House Energy and Commerce and Ways and Means Committee released a second draft of a proposal to permanently fix the sustainable growth rate (“SGR”) formula with the intention of bringing the final proposal to the House floor this summer.

The second draft proposes a three phase approach to fixing the SGR formula including repealing the SGR formula and freezing physician payment rates in the first phase, linking payment updates to quality and clinical improvement activities in the second phase, and reforming Medicare’s fee for service reimbursement system to promote cost efficiency in the third phase. The second draft indicated the ultimate proposal must be budget neutral, but it did not include details on how the proposal

would be paid for. Further, the second draft did not include any specific legislative language and commentators noted it was devoid of many specific proposals.

For more information, read the [Commentary](#) and [Official SGR Proposal](#).

### Despite Federal Delay, States Moving Forward with Employee-Choice Exchanges

While the federal government has delayed the use of Small Business Health Option (“SHOP”), or “employee-choice,” health insurance exchanges until 2015, some states are moving forward with and planning to immediately offer the employee-choice option when their state-run health insurance exchanges open to the public later this year or early next year.

The employee-choice option allows employees whose employers choose to purchase coverage through a health insurance exchange to choose their own coverage as opposed to employers choosing coverage for their employees. Employees pay for the coverage with a contribution provided by the employer. Some states have indicated the employee-choice option was key to their support of state-run health insurance exchanges and rather than wait for the federal government to offer the option, states are taking the lead in offering it to businesses that use state-run health insurance exchanges.





For a full article on states' efforts to offer the employee-choice option for their health insurance exchanges, click [here](#).

### Sixth Circuit Overturns False Claims Act Ruling Regarding Physician Supervision of Imaging Procedures

The United States Sixth Circuit Court of Appeals recently overturned a Tennessee District Court's \$11 million judgment that MedQuest Associates' use of unapproved physicians to provide supervision of diagnostic imaging tests and an old billing code to bill Medicare resulted in the submission of false claims to Medicare. The Sixth Circuit indicated that the requirements at issue were conditions to participate in the Medicare program, rather than conditions of payment, and that the substantial fines and penalties under the False Claims Act were inappropriate for the violation of the technical and local program requirements at issue in the case.

For more information, click [here](#).

### CMS Reverses Course on Medicare Advantage Rates

CMS announced this week that rather than assume cuts to the Medicare payment rate for physician services this year, it will assume there will be a zero percent change in the Medicare reimbursement for physician services, resulting in close to a 3 percent increase in the Medicare Advantage growth rate for 2014.

CMS had initially proposed the Medicare Advantage growth rate would decrease by 2.3 percent based on the impending reductions to the Medicare physician fee schedule ("MPFS") under the SGR. However, CMS now assumes Congress will fix or otherwise delay the impact of the SGR, resulting in a zero percent change in the MPFS. This changed assumption will result in a 2.96 increase in the Medicare Advantage growth rate for contract year 2014.

To read CMS' Annual Medicare Advantage rate announcement, click [here](#).

### MedPAC Discusses Concerns with Accountable Care Organizations

MedPAC expressed concern this past week with accountable care organizations ("ACOs") as one of the vehicles created under the Affordable Care Act to reduce volume-based growth in health care costs. MedPAC indicated that ACOs may compete with Medicare Advantage plans but may not have the same ability to steer patients to more efficient providers. Further, MedPAC was concerned with the effect of notices providers give to Medicare beneficiaries who are assigned to an ACO, believing such beneficiaries may not understand that assignment to an ACO does not limit their choice of providers. MedPAC was also concerned that Medicare beneficiaries may be reluctant to participate in an ACO where the providers, rather than the beneficiaries, share in cost savings.

For more information, click [here](#).

### Physician Payment Sunshine Act Final Rule Released

On February 8, 2013, CMS published a final rule ("Rule") for what is commonly referred to as the Physician Payment Sunshine Act ("Act"), which was passed as Section 6002 of the Affordable Care Act. The



Act requires certain manufacturers of medical drugs, biologicals, and devices and certain group purchasing organizations (defined in the Rule as “applicable manufacturers” and “applicable GPOs”) to report to CMS payments or other transfers of value made to certain physicians and teaching hospitals (defined in the Rule as “covered recipients”) and certain physician owners or investors. CMS will make these reports available for public review. The Act is part of CMS’ efforts to create greater transparency between medical manufacturing companies and providers, whose relationships have historically drawn scrutiny from CMS and other governmental agencies. The Rule requires applicable manufacturers and applicable GPOs to gather reportable data beginning on August 1, 2013 and submit their first reports on March 31, 2014. CMS will release the data publicly by September 30, 2014.

The Rule finalizes a number of key definitions and other provisions, including who must submit the required reports to CMS, what data must be submitted in the reports, what the process is for submission and review, how affected parties can dispute submissions, how the public can access the reports, and what the penalties are for failing to submit the reports.

## Additional Reading

- **Medical Device Tax Repeal Proposal Stalls in the House**

Efforts to repeal the much-debated medical device tax imposed by the Affordable Care Act have stalled in the U.S. House of Representatives, jeopardizing the reality the tax will be repealed at all.

For more information, click [here](#).

- **DOJ Announces Multiple Settlements with Health Care Providers for ADA Violations**

The DOJ issued a press release listing eight settlements with health care providers over the past

year, for alleged violations of the Americans with Disabilities Act, and in particular, denying access to care to individuals with hearing disabilities.

For more information, click [here](#).

- **Kaiser Health News: [IG Report Slaps Medicare For Not Recouping More Overpayment For Equipment](#)**
- **Inside Health Policy: [CMS Set To Release Guidance Implementing New Hospital Rebilling Policy](#)**
- **Kaiser Health News: [Walgreens Becomes 1<sup>st</sup> Retail Chain To Diagnose, Treat Conditions](#)**
- **Kaiser Health News: [Health Law Coverage Expansion Will Help Ex-Felons](#)**

## Federal Register

### IRS Releases Additional Guidance Regarding Community Health Needs Assessments

On April 5, 2013, the Treasury Department issued a proposed rule that provides additional guidance to tax-exempt hospitals regarding community health needs assessments (“CHNAs”). Tax-exempt hospitals must conduct CHNAs every three years as required by Section 501(r) of the Internal Revenue Code, which was



implemented as part of the Affordable Care Act. The Internal Revenue Service has previously issued additional guidance regarding CHNAs in Notice 2011-52 and other requirements of Section 501(r) in subsections (r)(4)-(r)(6), including the requirements that tax-exempt hospitals maintain a financial assistance policy, limit charges to individuals eligible for financial assistance and not engage in extraordinary collections efforts, in proposed regulations issued by the Treasury Department in June, 2012.

The proposed rule issued on April 5 primarily gives further guidance on CHNAs, including which tax-exempt hospitals must conduct CHNAs (by making minor amendments to the definitions of “hospital facility” and “hospital organization”) and the consequences tax-exempt hospitals may face for failing to meet the requirements of 501(r). The proposed rule does not provide additional guidance on the requirements in Sections 501(r)(4)-(6). The Treasury Department will be accepting comments to the proposed rule through July 5, 2013.

To read the proposed rule, click [here](#).

### CMS Issues Proposed Rule to Strengthen Oversight of Accreditation Organizations

On April 5, 2013, CMS issued a proposed rule that revises the survey, certification and enforcement procedures related to its oversight of national accreditation organizations. The proposed rule also clarifies and strengthens CMSs’ oversight of new organizations that apply for and are granted status as an accreditation organization.

To read the proposed rule, click [here](#).

### HHS Releases Proposed Rule for Exchange Navigators

On April 3, 2013, CMS released a [proposed rule](#) to outline the use of health insurance Navigators. Navigators are organizations and individuals whose roles were created

under the Affordable Care Act, for the purpose of providing consumers with unbiased information regarding coverage options.

CMS, recognizing that millions of Americans in 2014 will be eligible for new coverage opportunities, said that Navigators will “serve an important role in ensuring people understand the health coverage options available to them.” Specifically, Navigators will help orient consumers who are not familiar with health insurance and guide individuals living with disabilities, or those with limited English literacy.

In a recent news release, CMS said the proposed rule serves to clarify earlier program guidance and provides criteria that the Navigators in federally-facilitated and state partnership exchanges must meet. CMS further pledged that Navigators will be impartial, appropriately trained, and will provide information in an accessible manner.

The proposal (CMS-9955-P) was published in the April 5th Federal Register and comments are due May 6.

### CMS Finalizes Rule to Cover Costs of Newly-Eligible Medicaid Beneficiaries

On Monday, April 2, 2013, CMS finalized a proposed rule to reimburse states for 100 percent of their costs for “newly eligible” Medicaid beneficiaries, beginning January 1, 2014. The final rule implements



sections 2001(a)(3) (B) and 10201(c) of the Affordable Care Act related to the availability of increased FMAP rates under the Medicaid program with respect to the new adult eligibility group. While the published rule is final, CMS will accept comments for sixty days on certain provisions of the rule and reserves the right to modify the rule.

The final rules defines a “newly eligible individual” as “an individual determined eligible for Medicaid in accordance with the requirements of the adult group described in [42 C.F.R. §] 435.119, would not have been eligible for Medicaid under the State’s eligibility standards and methodologies for the Medicaid State plan, waiver or demonstration programs in effect in the State as of December 1, 2009, for full benefits or for benchmark coverage described in [42 C.F.R. § 440.330(a), (b) or (c)] or benchmark equivalent coverage described in [42 C.F.R. § 335] that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in [42 C.F.R. § 440.330(a), (b), or (c)], or would have been eligible but not enrolled (or placed on a waiting list) for such benefits or coverage through a waiver under the plan that had a capped or limited enrollment that was full.” 42 C.F.R. § 433.204.

States will receive full reimbursement for newly eligible individuals beginning January 1, 2014 and extending through 2016 after which reimbursement will

gradually decrease each year down, to 90 percent for calendar years 2020 and beyond.

For more information, click [here](#).

## Two National Data Banks Combine Under New HRSA Final Rule

On April 4, 2013 the Department of Health and Human Services Health Resources and Services Administration (“HRSA”) released a final rule which combines all data from the Healthcare Integrity and Protection Data Bank (“HIPDB”) into the National Practitioner Data Bank (“NPDB”). The final rule has the effect of permanently abolishing the HIPDB.

In addition to transferring all HIPDB data into the NPDB, the final rule also implements [Section 6403 of the Affordable Care Act](#) which was established to mitigate duplicate reporting obligations between the two databases. Additionally, Section 6403 calls for supplementary reporting and querying requirements, including requiring each state to create a reporting system for certification and licensure actions taken against a practitioner by that state’s licensing agency.

The final rule was published in the April 5 Federal Register and takes effect May 6, 2013. For more information read the [final rule](#).





## For More Information

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## About Polsinelli Shughart's Health Care Group

The Health Care group has vast national resources and strong Washington, D.C. connections. With highly trained, regulatory-experienced attorneys practicing health care law in offices across the country, we are familiar with the full range of hospital-physician lifecycle and business issues confronting hospitals today. A mix of talented, bright, young attorneys and seasoned attorneys, well known in the health care industry, make up our robust health care team.

Polsinelli Shughart is the 10th largest health care law firm in the nation, according to the 2010 rankings from Modern Healthcare magazine. The publication annually ranks law firms based on their total membership in the American Health Lawyers Association. With one of the fastest-growing health care practices in the nation, Polsinelli Shughart has the depth and experience to provide a broad spectrum of health care law services.

## About

### This Publication

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