Washington Report – February, 2015
(Covers activity between 2/1/15 and 2/28/15)
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Short Term Fix for SGR Likely

With the current SGR fix expiring on March 31st, momentum for a short-term fix for the Medicare Sustainable Growth Rate (SGR) before this deadline is building in Congress. Speaking to the American Medical Association, House Budget Committee Chairman Rep. Tom Price (R-GA) said that he believes that Congress will pass a short-term fix before again attempting to pass a permanent fix. Senate Finance Committee Chairman Sen. Orrin Hatch (R-UT) also believes that Congress will have to rely on another short-term fix to avoid a 21% cut in Medicare Physician Fee Schedule Payments to providers if no action is taken before the March 31st deadline.

Last year, Congress had a bipartisan, bicameral legislative framework for permanently repealing the Medicare SGR however it never came to fruition due to the inability of both chambers of Congress to find a way to pay for it. This measure is still widely supported by legislators, however they are no closer to finding a way to offset its cost than they were last year.

Chairman Price stated that he thinks a permanent repeal will be brought up by the end of the fiscal year (September 30th) and that the permanent fix will be tied to extending funding for the Children's Health Insurance Program (CHIP) which also expires on September 30th. Chairman Price offered no details as to what the potential offsets will be.

The House only has 12 legislative days in Washington scheduled for the month of March, with the last scheduled legislative work day being March 26th. The Senate is scheduled to be in Washington every week day in March through the 27th.

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Burwell: No ACA Subsidy Contingency Plan

On March 4th, the Supreme Court is scheduled to hear oral arguments in the case King V. Burwell. A decision by the court is expected in June.

Under King V. Burwell, King argues that the federal tax subsidies available to individuals purchasing health insurance through an Exchange are only available to individuals if they purchase insurance through an Exchange established and operated by a state. More specifically, King asserts, that the Internal Revenue Service, in promulgating regulations outlining the process for obtaining federal tax subsidies, went beyond the intent of Congress when it concluded that ALL individuals purchasing insurance through an Exchange – whether federal or state – were entitled to a tax subsidy if they qualified.

There is no dispute that the clear, unambiguous language of the ACA states that the subsidies are available to individuals purchasing insurance through an exchange operated by the state. However, the Obama Administration (and their allies) argue that Congress did not literally mean the subsidies should only be available for state operated exchanges. Instead, they maintain, that you have to read the language in context and at worst, it is a typographical error by Congress and the Administration has the latitude to draft and implement regulations that reflect the "intent" of Congress even when that may appear to be contrary to the "clear unambiguous" language of the statute.

So, what happens if the Supreme Court rules in favor of King and concludes the tax subsidies that have been available and paid to everyone who qualifies, regardless of whether they purchased through a federal or state exchange are invalid for most of those individuals? Will those who purchased insurance through a federal Exchange and received a subsidy have to pay it back? Will, the Obama Administration try to use an Executive Order to "fix" this problem? Will the Obama Administration ask Congress to pass legislation making the subsidies available to all, regardless of the type of exchange? Will states who deferred to the federal government, revisit the issue and seek to set up a state-operated exchange in order to make the subsidies valid in those states?

In a February 24th letter to Senator Orrin Hatch (R-UT), Chairman of the Senate Finance Committee, HHS Secretary Sylvia Matthews Burwell stated that her agency "does not have a contingency plan" for dealing with a Supreme Court decision invalidating the tax subsidies for individuals purchasing health insurance via the Federal health exchange. Her letter was in response to one from Chairman Hatch asking about such a contingency plan.

The exchange between the two comes as rumors are flying around Washington that HHS does in fact have a contingency plan. In testimony before the House Energy and Commerce Committee's Health Subcommittee, Burwell reiterated what she told Hatch in the letter - she is unaware of the existence of this rumored document.

Despite this testimony, the general consensus in Washington is that someone in the Department has put together a contingency plan in the advent the Court's decision is unfavorable to the Administration. It is also understandable that Administration Officials would not want to discuss a possible contingency plan.

Several officials from previous administrations (Republican and Democrat) have said that when they were in similar situations, they had developed contingency plans depending upon the outcome of court cases but like the Obama Administration, they, too, did not want to discuss those plans publicly for various reasons.

If the court rules the federal exchange subsidies to be invalid, it would have enormous consequences for millions of consumers, employers and insurance companies. 37 states opted not to establish their own exchanges resulting in the federal government operating that state's exchange. About 8.6 million consumers have signed up for health insurance for 2015 through a federal exchange and about 87% of those consumers qualify for subsidies. Without this financial assistance, most, if not all of those consumers will not be able to afford their monthly premiums and will discontinue their coverage. Insurance companies will not only have to continue to cover these consumers for 90 days, but they will end up having to increase premiums for all of their insurance products by as much as 50% to compensate.

Finally, should the court invalidate the tax subsidies in the 37 states with federally operated exchanges, it would also have the effect of invalidating the employer mandate in those states as well. Why? Remember, the enforcement mechanism for the employer mandate is that one employee sought and obtained tax subsidized insurance through an exchange. If there are no tax subsidies in states with federally operated exchanges, then there is no way to trigger the enforcement of the employer mandate.

As with previous court cases involving the ACA, the oral argument in March will be watched closely and you can be sure that every talking head in America will be trying to interpret every question, every body movement, eyebrow adjustment or physical reaction during the court's proceedings.

Stay Tuned!

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CMS Delays Publishing Final Rule on Overpayments

On February 13th, the Centers for Medicare and Medicaid Services (CMS) announced a one-year delay in the publication of a final rule that, once adopted, will likely require providers to repay Medicare overpayments within 60 days of discovering them. The original proposed rule was released for public comment in mid-February, 2012.

By law, CMS must publish a final rule within three years of the publication of the proposed rule – unless the agency cites extenuating circumstances that prevent the agency from meeting three-year maximum for consideration of public comments. Failure to meet the deadline would require the agency to reissue a new proposed rule and once again solicit the public for comments.

By asserting that the complexity of the issue was preventing adherence to the deadline, CMS can get a one-year extension. That is what has been done in this instance. CMS cited "the complexity of the rule and the scope of comments" as its reasons for delaying publication of the final rule until no later than February 16, 2016. HBMA was one of the organizations submitting comments on this proposed rule.

The controversy at the time – and still was not over the 60-day reporting requirement. Rather it was over a proposal by CMS that providers retain medical records for at least 10 years in order to allow for a look-back for the identification of billing errors that may have occurred in previous years.

HBMA, in its comments, cited numerous operational and policy problems with this proposed change. The HBMA comments stated,

> **"HBMA believes strongly that requiring providers to retain records for ten years or have no confidence in the finality of claims decisions for a minimum of ten years is excessive and burdensome to providers. We strongly recommend that CMS clarify that the 10-year look-back proposal does NOT change current Medicare record retention or payment review policies."**

And, with respect to identifying past billing errors, HBMA said,

> **"… HBMA recommends that CMS clarify that the new policy does not require providers to affirmatively conduct a review of all past billing but simply states that in the normal course of business, should a provider uncover an overpayment, the provider has an obligation to report and refund that money within the designated timeframe."**

Although the overpayment final rule was delayed, CMS makes clear in the announcement that even without a final rule, providers still face penalties and potential False Claims Act liability for failing to return Medicare overpayments.

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Medicare Now Covers Certain Cancer Screening

On February 5th, the Centers for Medicare & Medicaid Services (CMS) released a National Coverage Determination (NCD) that effective immediately, Medicare will cover lung-cancer screening with low-dose computed tomography (LDCT).

According to a press release issued by CMS, this NCD marks the first time the program has covered lung cancer screening. Medicare now covers lung cancer screening with LDCT once per year for Medicare beneficiaries who meet certain risk criteria:

- They are age 55-77, and are either current smokers or have quit smoking within the last 15 years;
- They have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years); and
- They receive a written order from a physician or qualified non-physician practitioner (PA, NP, etc.) that meets certain requirements.

The new benefit also includes a visit for counseling and shared decision-making on the benefits and risks of lung cancer screening.

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February a Busy Month for ICD-10

February continued to be a busy month for ICD-10. In addition to the House Energy and Commerce Health Subcommittee hearing on the new coding system, CMS released the results of the first round of end-to-end testing and posted the dates for a new round of front-end testing. Finally, HBMA conducted and reported the results of their member-only ICD-10 Readiness survey.

The results of end-to-end testing were considered a success by CMS (although some in the industry found them disappointing). A press release issued by CMS reported an 81% claims acceptance rate from a total of 14,929 test claims that were submitted.

It should be noted that significant industry concern about possible payment disruptions remain because there has been far less evidence of ICD-10 end-to-end testing amongst commercial payers and state Medicaid agencies.

However, due to the relative success of this first round of end-to-end testing, it is less likely that Congress will intervene to prevent the October 1, 2015 effective date from happening.

Over 600 providers and billing companies participated in this round of testing. According to the results, most of the rejected claims were not accepted for reasons unrelated to ICD-10:

- 3% - Invalid submission of ICD-9 diagnosis or procedure code
- 3% - Invalid submission of ICD-10 diagnosis or procedure code
- 13% - Non-ICD-10 related errors, including issues setting up the test claims (e.g., incorrect NPI, Health Insurance Claim Number, Submitter ID, dates of service outside the range valid for testing, invalid HCPCS codes, invalid place of service).

CMS declared that "Testing demonstrated that CMS systems are ready to accept ICD-10 claims."

Two more end-to-end testing weeks will be held before the October 1, 2015, effective date for mandatory ICD-10 use:

- April 27 through May 1
- July 20 through July 24

Testers who participated in the January testing are automatically eligible to test again in April and July.

Along with the results, outgoing CMS Administrator Marilyn Tavenner weighed in on the results in a CMS blog post praising the results. She also clarified that only claims for services provided on or after October 1, 2015 must be submitted with ICD-10 codes.

All claims for services prior to October 1, 2015 must be submitted with ICD-9 codes. Some stakeholders continue to advocate for a dual-coding phase in of ICD-10 since payers will have to maintain their ICD-9 systems through September 30, 2016. With nothing but confidence coming out of CMS, this idea has been gaining momentum as an alternative to another delay for stakeholders who oppose the upcoming implementation.

The results of ICD-10 testing mirror a recently published GAO report affirming that CMS is prepared for the ICD-10 transition and is taking measures to help alleviate challenges for some providers. The report cites the widely known problem small providers are having with their preparation and discusses the Agency's steps to work with some of these providers to help ensure readiness for the October implementation. The report also surveyed a handful of stakeholders on their reaction to other CMS training materials such as the Road to 10 website.

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House Hearing on ICD-10 Implementation

On February 11th, the House Energy and Commerce Health Subcommittee held a hearing on ICD-10 readiness. Although some members of the Committee expressed concern about the transition to ICD-10, the overall consensus of the

Committee seemed to be move ahead with implementation. While most Members were averse to another delay in implementation, some were concerned with the negative affect the new system could have on physicians.

Rep. Joe Pitts (R-PA), Chairman of Energy and Commerce Committee's Subcommittee on Health, said both providers and payers have already made significant investments toward the ICD-10 transition, and "any further delays would incur additional costs associated with re-training employees and maintaining the existing ICD-9 system." Rep. Gene Green (D-Texas), the panel's Ranking Member, also said he supports ICD-10 implementation and that there should be no more delays.

Originally scheduled to be implemented by October 1, 2013, ICD-10 has been delayed twice. In 2012, the Centers for Medicare and Medicaid Services (CMS) delayed implementation until October 1, 2014 in response to broad stakeholder concerns, and in 2014, Congress mandated a delay as part of the Protecting Access to Medicare Act of 2014, signed by President Barack Obama in April 2014. That language delayed the implementation again until no later than October 1, 2015.

Despite a resounding call for no further delays, those Members of Congress who favor a delay were not shy about expressing their opinions. Rep. Morgan Griffith (R-VA), who represents constituents in more rural areas with smaller health care providers, said ICD-10 could lead to an increase in physician paperwork. He argued that mandating ICD-10 would have a range of negative effects, including less time for physicians to meet with patients and early retirement for physicians who are unable to keep up with rising costs of implementing the new system.

Witnesses invited to present at the hearing, were almost uniformly in support of transitioning to ICD-10 by October 1, 2015. This alone was considered a signal that the Committee had no intention of authoring legislation mandating another delay. Of the seven witnesses invited to testify, only one, Dr. William Terry, a urologist from Mobile, Alabama expressed outright opposition to ICD-10 implementation.

Dr. Terry said the new system would lead to poorer quality of care due to less physician consultation time with patients. More time, he argued, would be spent training for the system and inputting a larger set of codes due to specificity of the new coding system. Terry said Congress should support legislating a dual ICD-9/ICD-10 option so that physicians will have time to transition to the new coding system.

While another outright delay in the effective date is unlikely, a number of provider groups continue to argue in favor of either another delay or, an outright repeal of the ICD-10 mandate.

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Anthem Hack Compromises Info for 80 Million Customers

Personal information for nearly 80 million individuals were compromised after hackers broke into a database for Anthem, Inc., the nation's second-largest health insurance company. Information regarding names, email addresses, and Social Security member identification numbers were compromised. The personal information that was compromised is separate from data protected under HIPAA. The origin of the attack is currently unknown.

Impacted plans and brands include Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue shield of Georgia, Empire Blue Cross and Blue Shield, Amerigroup, Caremore, Unicare, Healthlink and DeCare. According to Anthem, all those impacted will receive notification via mail advising them of offered protections and next steps.

The incident arrives on the heels of President Barack Obama's State of the Union address, which touted cybersecurity as a top priority. While the president's cybersecurity plan is not specific to the health industry, it calls for increased sharing of information on cyberthreats from the private sector with the Department of Homeland Security's National Cybersecurity and Communications Integration Center, other federal agencies and private-sector operated Information Sharing and Analysis Organizations. The plan also calls for a single notification requirement that would standardize the existing patchwork of state laws currently in place.

Anthem has been working with the Health Information Trust Alliance (HITRUST) to share hack-related information with the organization. HITRUST has also endorsed the President's cybersecurity plan.

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Providers Given Extension for 2014 Meaningful Use Attestation

The Centers for Medicare and Medicaid Services (CMS) announced they are extending the EHR Incentive Program 2014 reporting year. Eligible providers now have until 11:59 p.m. ET on March 20, 2015 to attest to meaningful use. Under the EHR Incentive Program, eligible providers who fail to attest to 2014 meaningful use will receive a 1% reduction in their Medicare payments for 2015. The deadline was supposed to be February 28th. The extension comes at the request of many providers seeking more time to properly attest. According to CMS data, as of Feb. 1, just 127,815 of the more than 500,000 providers eligible to participate in the program have attested to meeting the meaningful use requirements for the 2014 reporting year.

Reporting Method	**Submission Period**	**Submission Deadline Time (All Times are Eastern)**
EHR Direct or Data Submission Vendor that is certified EHR technology (CEHRT)	1/1/15 - 3/20/15	8:00 p.m.
Qualified clinical data registries (QCDRs) (using QRDA III format) reporting for PQRS and the clinical quality measure (CQM) component of meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program	1/1/15 - 3/20/15	8:00 p.m.

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Slavitt Putting Imprint on CMS Management

In January, CMS Administrator Marilyn Tavenner announced she would be departing CMS at the end of February. As Tavenner was putting the last pieces of tape on the moving boxes in her office, her interim replacement, Andy Slavitt, we busy assembling his management team. Although Slavitt has been officially announced as the “Interim Administrator”, it is quite possible that Slavitt will serve as “Interim CMS Administrator” for the remaining 22 months of the Obama Administration.

In mid-February, Slavitt announced that Dr. Patrick Conway would assume Slavitt's old post and act as principal deputy administrator. Next, it was announced that Dr. Mandy Cohen would serve as the CMS Chief of Staff.

Conway is currently the Chief Medical Officer for CMS and he is expected to retain that title as well as continue to lead the Center for Medicare and Medicaid Innovation and the Center for Clinical Standards and Quality.

In making the announcement, Slavitt said that Dr. Conway “will continue to lead our strategic initiatives on delivery system reform," Conway is tasked with meeting goals set out by HHS Secretary Sylvia Mathews Burwell regarding the move toward rewarding quality rather than volume of care.

Cohen's role will be overseeing the day-to-day activities at CMS. Unlike Conway, who will continue to retain his previous positions within the agency, Cohen will no longer serve as the Principal Deputy Director of the Center for Consumer Information and Insurance Oversight.

Additional staff changes resulting from Tavenner’s departure will be announced in the coming months.

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CMS – An Independent Agency?

Since the creation of the Medicare program in 1965, the agency that oversees the operation of the program has been part of a Cabinet Department. The names may have changed - HHS was previously the Department of Health Education and Welfare – and – CMS was previously called the Health Care Financing Administration (HCFA) - the line of authority always remained the same.

Now, an influential voice in how the Medicare program is run has raised the prospect that CMS could be removed from HHS and established as a stand-alone "Independent Agency" of the federal government. In raising this issue, Senator Orrin Hatch (R-UT) Chairman of the Senate Finance Committee, which has oversight authority over Medicare and CMS, suggested he was motivated by a desire to "remove politics" from the governance of the Medicare and Medicaid programs. More specifically, he wanted to keep the White House from "having too much influence over its (CMS) operations."

In making this suggestion, Hatch noted that more than 2/3 of the HHS budget goes to CMS so in some respects, one could argue that CMS is larger than HHS and as a stand-alone agency, would have the 2nd largest budget of the federal government – second only to the Department of Defense.

As an Independent Agency, analogous to the Food and Drug Administration (FDA) or the Federal Trade Commission (FTC), the agency overseeing the Medicare and Medicaid program could exercise greater independence from the White House – whoever the occupant. But even as an independent agency, CMS would still be dependent upon Congress for the dollars necessary to run the program. And, the Administrator of the agency would still be appointed by the President and subject to confirmation by the Senate.

Removing an agency the size of CMS from the Department is not unprecedented. In 1994, Congress and the Clinton Administration agreed to remove the Social Security Administration from HHS. At that time, SSA's budget represented 51% of the total HHS budget – far less than what CMS accounts for within HHS today.

Of course, it cannot go unnoticed that by diminishing the Administration's influence over the Agency, Hatch's proposal would likely increase Congressional influence over the agency's policies and programs and mission.

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ACA Enrollment for 2015 Exceeds 11 Million

In a February 19th blog post, the Obama administration announced that about 11.4 million people signed up for health coverage during this year's open enrollment period. In general, the 2015 open enrollment period lasted from November 15, 2014 until February 15, 2015. A few state-run Exchanges were granted the authority to continue enrolling individuals after February 15th and, it was announced that due to some glitches in the tax penalty phase of the program, the Federal Exchanges would reopen to afford certain individuals some additional time to sign up and avoid penalties.

The total number of enrolled individuals includes both those who newly signed up and those who were automatically re-enrolled into their plan from last year. Approximately 8.6 million people purchased a Qualified Health Plan through HealthCare.gov (the Federal Exchange) and about 2.8 million people obtained qualified coverage from a state-based marketplace.

This enrollment total exceeds the Department of Health and Human Services' (HHS) revised goal of enrolling 9 million people in 2015. However, it still falls short of the agency's originally stated enrollment goal of 13 million.

After the February 15th close of the Exchanges, the Obama administration announced a special enrollment period that will begin March 15th and end April 30th to help consumers avoid tax penalties for not obtaining health insurance coverage this year as required by the ACA's individual mandate. To qualify for special enrollment, people will need to self-attest that they had to pay a penalty for not having coverage in 2014. For 2015, the penalty is $325 per uninsured person or 2% of household income, whichever is larger.

It was also announced in late February that the Internal Revenue Service (IRS) had sent out approximately 800,000 incorrect tax forms to consumers who purchased health insurance on the Federal Exchange. These 1095-A forms provide a monthly accounting of the subsidies consumers received to help pay their health insurance premiums.

The issue with these forms is that they were overly generous in terms of specifying the amount of money consumers were entitled to upon reconciling this subsidy data with the individual's actual income from the entire year.

It should be remembered than when people enrolled in health plans last year (2014) and submitted the financial data for determining their health plan subsidies, most based their enrollment "income" attestation on their 2013 tax return. In many instances, that income was lower than what the taxpayer's employer reported on their 2014 W-2 statements. This discrepancy caused the taxpayer to receive an ACA tax subsidy higher than what it should have been. Now that the IRS has accurate 2014 income information, they are informing taxpayers that the 1095-A information was incorrect and that the taxpayer received subsidies higher than what they were entitled to. Most taxpayers will have to refund the money to the federal government.

But of the 800,000 people affect by this, some are getting an unanticipated "tax holiday" from the Obama Administration. The Administration announced that approximately 50,000 tax filers had filed their taxes before the IRS realized the problem. Rather than asking them to refile their taxes, the Administration is giving them a "free pass". However, for the 750,000 individuals who had not filed their taxes by the time the IRS discovered the problem, they will have to pay back the money.

It should also be noted that there may be some taxpayers who are entitled to a greater subsidy then they had previously expected. These would be taxpayers who had an income lower in 2014 than was attested to for purposes of calculating the subsidy. These taxpayers can file an amended tax return if, after receiving the revised 1095-A, they are eligible for more money than they received.

For the remaining 750,000 affected individuals who haven't yet filed, they are being told to wait for corrected forms to arrive in March before filing their tax returns for 2014.

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New CBO Director Selected

The House and Senate Budget Committees have selected Keith Hall, a former Commissioner of the Bureau of Labor Statistics (BLS) under the George W. Bush administration, to become Director of the Congressional Budget Office (CBO). Hall will be replacing current Director, Doug Elmendorf whose term expired in January. Elmendorf has stayed on as Director until his successor was selected and he will continue to serve as Director until Hall's term begins on April 2nd. Hall's four-year term will expire on January 3, 2019.

After Republicans took control of both houses of Congress this year, it was unclear if they would renew the Democrat-appointed Elmendorf's term or select their own director.

After serving as Commissioner of the BLS, Hall worked as a senior research fellow at the Mercatus Center at George Mason University and he is currently the Chief Economist at the U.S. International Trade Commission.

The CBO is a non-partisan agency of Congress that is responsible for providing objective budget and economic analysis for both Chambers. The CBO scores the economic impact and costs of introduced legislation and provides broad economic information to Congress which helps to serve as a guide for Congressional priorities.

Hall's choice has been praised by many in Congress and related Federal agencies. The BLS is responsible for studying many key economic indicators such as the monthly jobs report. Many feel that Hall's tenure at the helm of BLS means he is well prepared to take over the CBO.

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Enrolling in Medicare for Part D Prescribing

Section 6405 of the Affordable Care Act (ACA) requires that physicians and eligible professionals (PAs, NPs, etc.) who **order** durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) or **certify** home health care for beneficiaries, be enrolled in Medicare. The ACA also permits the Secretary of Health and Human Services (HHS) to extend these Medicare enrollment requirements to physicians and eligible professionals (EPs) who **order or certify** all other categories of Medicare items or services, including covered Part D drugs.

Until now, the Secretary has not exercised the discretionary authority to expand the applicability of the ordering/certifying requirements to other areas beyond DME and home health.

However, beginning in June of this year, CMS will require that physicians and eligible professionals **who write prescriptions for covered Part D drugs must be enrolled in Medicare**, or have a valid record of opting out of Medicare for their prescriptions to be covered under Part D.

This requirement is intended to ensure that Part D drugs are only prescribed by "qualified" individuals. This provision is effective June 1, 2015.

CMS is also adding the authority to revoke a physician's or eligible professional's Medicare enrollment if:

- CMS determines that he or she has a pattern or practice of prescribing Part D drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or the pattern or practice of prescribing otherwise fails to meet Medicare requirements; or
- The physician/EPs Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked; or
- The applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs.

CMS believes that the authority to revoke such prescribers' Medicare enrollment will help protect beneficiaries and the Medicare Trust Fund from fraud, waste and abuse.

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First Results of the Value Modifier Program

The Medicare Value Modifier (VM) program provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period. Under the VM program, a physician or group of physicians can receive a positive adjustment, a negative adjustment or no adjustment at all based upon their PQRS reporting for previous years.

CMS believes that by providing meaningful and actionable information to physicians, they can improve the care they deliver to Medicare beneficiaries. In 2014, CMS made quality data available to all physicians in the form of feedback reports. These reports included information about the quality and the cost of care. For physician groups with 100 or more eligible professionals that are subject to the Value-Based Payment Modifier (VM) in 2015, the physician feedback reports include information about their VM adjustment.

In this initial round of the VM program payment adjustments; medicare limited participation to groups of 100 or more physicians. A total of 1,272 groups could have been eligible to participate in the VM program. For a variety of reasons the vast majority of these groups either were exempt or chose not to participate. In the end, only 10% of the large groups eligible for VM for 2015 participated (127 groups of 100 or more physicians).

The base year used for the adjustment calculations was 2013 and CMS used the PQRS filings for that year to make the determination.

The results of the VM Program reporting for large group practices have been announced.

A total of 14 of the qualifying group practices were awarded a 1% positive adjustment to their Medicare Fee-For-Service payments this year under the VM program. These groups represented 7,000 total physicians. By comparison, a total of 11 groups will see a decrease this year of either 0.5% or 1%. The remaining 103 groups will receive no adjustment.

By law, VM program payments are budget neutral, meaning that the amount given in bonuses must be equal to the amount given in penalties.

In FY 2016, the VM program will be expanded to physician groups of 10 or more and will be based upon PQRS data reported in 2014.

The VM program will expand to solo practitioners and groups with fewer than 10 physicians in 2017; however, these solo and small group practices will not be subject to downward adjustments in their first year of participation.

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Medicare Fraud Bill Passes House Committee

On February 26, 2014, the House Ways and Means Committee passed the Protecting the Integrity of Medicare Act (PIMA) of 2015 and sent it on for further consideration. The legislation was jointly referred to the House Energy and Commerce Committee so that Committee can choose to consider the bill prior to full House consideration.

The legislation, was originally introduced by Representative Kevin Brady (R-TX) and Jim McDermott (D-WA), respectively the Chairman and Ranking member of the House Ways and Means Health Subcommittee, and is intended to strengthen Medicare fraud prevention.

Key provisions in the bill include

- Removing Social Security numbers from Medicare beneficiary cards;
- Giving Medicare beneficiaries the option to receive a Medicare summary notices (MSN) electronically;
- Strengthen efforts to prohibit incarcerated felons and deceased individuals from filing for Medicare benefits;
- Requiring the Secretary of Health and Human Services (HHS) to examine the use of Beneficiary Smart Card;
- Requiring each Medicare Administrative Contractor (MAC) to establish an improper payment outreach and education program;
- Expanding the types of professionals who can perform the required face-to-face encounter for Medicare DME prescriptions;
- Expanding the voluntary non-emergency ambulance transfer prior authorization program to additional states;
- Identification by the RACs of the most frequent and expensive payment errors, a notice to providers of new topics that have been approved for audits by RACs, as well as specific instructions to providers on how to correct and avoid errors and audit issues.

HHS would retain up to 15% of recovered money to go toward implementing corrective actions to help reduce the error rate of payments. The bill also contains a provision that would require CMS to use the National Provider Identifiers (NPIs) as the only prescriber identifier for the Medicare prescription drug program.

Most of the provisions in this Bill were previously introduced at least once in prior Congresses.

The House Energy and Commerce Committee has not announced what they intend to do with the legislation. They can, reject the bill, approve the bill as approved by the Ways and Means Committee or seek to mark up/amend the legislation and pass their own version. Although House leadership has not scheduled a vote for this bill; it appears to be on a fast track and enjoys broad bi-partisan support in the House.

While there is always an appetite among Senators for fighting fraud and abuse, the Senate has yet to make this bill a similar priority.

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Medicare Transmittals

Centers for Medicare & Medicaid Services uses transmittals to communicate new or changed policies or procedures that will be incorporated into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes. The following Transmittals were issued in the month of February.

Transmittal Number	Subject	Effective Date
R578PI	Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15	2015-05-15
R1472OTN	International Classification of Diseases, 10th Revision (ICD-10) Testing - Acknowledgement Testing with Providers	N/A
R3199CP	Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims	2015-04-21
R3201CP	Healthcare Provider Taxonomy Codes (HPTCs) April 2015 Code Set Update	2015-07-06
R3202CP	Common Edits and Enhancements Modules (CEM) Code Set Update	2015-07-06

Transmittal Number	Subject	Effective Date
R134SOMA	Revisions to State Operations Manual (SOM) Exhibit 138 EMTALA Physician Review Worksheet revisions	N/A
R3198CP	Instructions for Downloading the Medicare ZIP Code File for July 2015	2015-07-06
R467PR1	Part 1, Chapter 14, Reasonable Cost of Therapy and Other Services Furnished by Outside Suppliers	N/A
R3203CP	Automation of the Request for Reopening Claims Process	2015-10-06
R3204CP	National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers	2015-07-06
R179NCD	National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers	2015-07-06
R1471OTN	Renaming PPS-FLX6- PAYMENT Field in the Inpatient Prospective Payment System (IPPS) Pricer Output	2015-07-06
R1469OTN	Develop Rough Order of Magnitude (ROM) for Appeals Workload in Preparation for Implementation of International Classification of Diseases-10th Revision (ICD-10)	2015-03-16
R3195CP	Final MSN Redesign-Related Update to Chapter 21 of the Medicare Claims Processing Manual	2015-04-16
R31COM	Update of IOM Pub. 100-09, Chapter 6, section 30.2.11 to include the requirements for implementing Quality Assurance Monitoring at the Medicare Administrative Contractors.	2015-02-20
R203BP	Payment Repairs to Capped Rental Equipment Prior to the End of the 13-Month Cap	2015-07-06
R3196CP	Payment Repairs to Capped Rental Equipment Prior to the End of the 13-Month Cap	2015-07-06
R1470OTN	Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP): Additional Instructions for Grandfathered Items Subject to CBP	2015-07-06
R3194CP	Update to the Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) - Recurring File Updates	2015-04-06
R1468OTN	Identification of Obsolete Shared System Maintainer (SSM) Reports	2015-07-06
R1467OTN	Reporting Force Balance Claim Payment on the Electronic Remittance Advice (ERA) 835 and Cross Over Beneficiary (COB) 837 Claim Transactions	2015-07-06
R1466OTN	Use of Modifiers KK, KG, KU, and KW under the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program	2015-07-06
R575PI	Incorporation of Revalidation Policies into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15	2015-05-15

Transmittal Number	Subject	Effective Date
R90GI	Rescinds/Replaces CR 7468 - Updated Instructions for the Change Request Implementation Report (CRIR) and Technical Direction Letter (TDL) Compliance Report (TCR)	2015-05-25
R133SOMA	Revisions to the State Operations Manual (SOM) - Appendix PP – Guidance to Surveyors for Long-Term Care Facilities	2015-02-06
R3187CP	Language Only Update to Pub 100-04, Chapter 30 for ASC X12 and Claim References	2015-03-06
R3190CP	CY 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	2015-01-05
R1462OTN	Identifying “No Documentation” Medical Necessity Denials for Claims Flagged for Recovery Auditor Review	N/A
R1463OTN	Identification of Obsolete Shared System Maintainer (SSM) On-Request Jobs	2015-07-06
R3189CP	Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens	2015-04-24
R567PI	New Timeframe for Response to Additional Documentation Requests	2015-04-06
R568PI	Review Timeliness Requirements for Prepay Review	2015-03-01

Correction: In a March 3, 2015 *Legislative Alert* memo to the HBMA membership on SGR, Rep. Kevin McCarthy (R-CA) was identified as being from Texas and the Chairman of the House Ways and Means Health Subcommittee. Rep. McCarthy is from California and he is the House Majority Leader. We apologize for any confusion this may have caused.