Health Care Alert - May 6, 2015

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Sustainable Growth Rate (SGR) Limitation on Medicare Physician Reimbursement Repealed

On April 14, Congress passed **H.R. 2**, the Medicare Access and CHIP Reauthorization Act of 2015. Acknowledging the **"bipartisan achievement,"** it was signed into law by the President in a "Rose Garden" ceremony late in the day on April 16, 2015. Common "doc-fixes" will no longer be necessary under the new law.

Most importantly, for the period from July 1 through December 31, 2015, the law increases physician payments by 0.5 percent and then annually thereafter beginning in 2016 through 2019. However, beginning in 2020 and running through 2025, it appears that no increases are scheduled. Then, starting in 2026, increases will be based upon two conversion factors:

- One applies to physicians who have met the combined requirements for meaningful use of electronic health records, quality reporting, and alternative payment models ("APM"), and,
- The other applies to physicians who have not met the APM requirements. Physicians qualifying for APM treatment will receive a 0.75 percent update, while all others will receive a 0.25 percent increase.

As might be expected, certain other Medicare provisions are addressed and it delays the so-called "two midnight rule" until September 30, 2015. Two of the several expiring Medicare provisions addressed are: special payments or adjustments to Medicare-dependent hospitals and low-volume hospitals; and funding for development of quality measures.Among some of the other noteworthy provisions addresses enforcement of the "two-midnight rule" concerning inpatient hospital services which is delayed until September 30, 2015 and Medicaid benefits for certain "qualified individuals" is now made permanent as is the "transitional medical assistance program."

Update to Inpatient Rehab Facility Rates and Quality Measures

On April 27, 2015 CMS released the proposed 2016 payment and policy rule for Medicare inpatient rehabilitation facilities ("IRFs"). Here are the key points from the proposed rule:

- Update the IRF federal prospective payment rates to use updated FY 2014 IRF claims and the most recent available IRF cost report data.
- Adopt an IRF-specific market basket that will be used to determine the market basket update and labor-related share. This IRF-specific market basket will reflect the cost structures of only IRF providers.
- Phase in the revised wage index changes.
- Revise and update quality measures and reporting requirements under the IRF QRP.

The updated payment rates will be effective for discharges occurring on or after October 1, 2015. CMS estimates that the net revenue impact of the proposed rule on all IRFs is to increase estimated payments by approximately 1.7%.

The Affordable Care Act established the quality reporting program for IRFs and requires a 2% reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. The following are the quality measures previously finalized and currently used in the IRF quality reporting program. These will affect FY 2017 adjustments to the IRF PPS Annual Increase Factor and Subsequent Year Increase Factors:

NQF Measure ID	Quality Measure Title	Data Submission Mechanism
NQF #0138	National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	CDC NHSN
NQF #0431	Influenza Vaccination Coverage among Healthcare Personnel	CDC NHSN.
NQF #0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay).	IRF-PAI.
NQF #0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)	IRF-PAI
NQF #2502	All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Inpatient Rehabilitation Facilities.	Claims-based
NQF #1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure.	CDC NHSN.
NQF #1717	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure.	CDC NHSN

The Proposed Rule re-proposes the following quality measures for the FY 2018 payment determination and subsequent years:

1. Quality Measure To Reflect NQF Endorsement: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From IRFs (NQF #2502). CMS proposes to adopt this measure for the FY 2018 payment determination and subsequent years to reflect that it is NQF-endorsed for use in the IRF setting as of December 2014.
2. Quality Measure Addressing the Domain of Skin Integrity and Changes in Skin Integrity: Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

CMS also proposes to adopt 6 new quality measures beginning with the FY 2018 payment determination.

1. Quality Measure Addressing the Domain of the Incidence of Major Falls: An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674);
2. Quality Measure Addressing the Domain of Functional Status, Cognitive Function, and Changes in Function and Cognitive Function: Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review);
3. IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review);
4. IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review);
5. IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review);
6. IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review).

CMS intends to publicly report some of the quality data for rehabilitation facilities beginning in fall 2016. However, before the quality data's release, facilities will have an opportunity to review and correct information.

Public comments will be accepted until June 22, 2015. The proposed rule can be viewed here: **http://www.gpo.gov/fdsys/pkg/FR-2015-04-27/pdf/2015-09617.pdf**

Please contact Brian Heaton at **bheaton@kdlegal.com** or Meghan McNab at **mmcnab@kdlegal.com** if you have any questions.

Medicare Releases Individual Prescriber Data

On May 1, 2015, the Centers for Medicare & Medicaid Services (“CMS”) released Medicare Part D prescription drug data that individual physicians, nurse practitioners, physician assistants, and

other health care providers prescribed in 2013. This release of data follows various releases aimed at creating more transparency within the health care. For example, the Sunshine Act released payment information between drug and medical device manufacturers to physicians and teaching hospitals. Further, CMS released payment data to physicians and other health care providers on April 9, 2014. Although this data is a push for more transparency, it could represent a significant risk to health care providers.

The data released, contains individual data for each prescriber and drug. This amounts to more than one (1) million individual health care providers who prescribed approximately $103 billion in prescription drugs under the Part D program in 2013. CMS provided the following chart highlighting the higher number of prescribers by specialty:

Average Costs and Number of Unique Drug Products for Specialties with the Highest Number of Prescribers, 2013

Specialty	Number of Prescribers	Average Total Costs	Cost per Claim	Average Number of Unique Drug Products Prescribed
Internal Medicine	130,640	$205,923	$63	65.7
Dentist	124,322	$855	$14	2.1
Family Practice	105,413	$211,977	$56	74.9
Nurse Practitioner	97,722	$67,708	$78	24.2
Physician Assistant	69,180	$47,405	$70	18.7
Emergency Medicine	43,664	$16,822	$41	9.5
Organized Health Care Education/Training Program - Student	42,307	$8,036	$67	5.6
Obstetrics/Gynecology	35,979	$15,953	$85	6.2
Psychiatry	25,906	$174,274	$104	28.3
Optometry	25,654	$17,501	$99	4.8

It should be cautioned that such data is not indicative of a specific providers prescribing patterns; however Medicare Part D equals billions per year in government reimbursements. Further, for providers or organizations that see a high proportion of Medicare patients, this data may be used in ways that could increase risk to your organization. This includes risks related to prescribing practices, forms of prescription fraud, or even technical non-compliance with prescribing documentation issues.

It is advised that providers and organizations should analyze this data carefully to ensure that any risks associated with this data being published are properly analyzed from both an operational and legal perspective.

If you have any questions or concerns related to the Medicare Part D program, or this recent release of data, please feel free to contact **Robert A. Wade** at (574) 485-2002.

New Guidance Issued for Health Care Boards Regarding Compliance Oversight

Are hospital and health system boards aware of compliance within your organization? On April 20th, the Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services ("HHS"), in collaboration with various healthcare and legal compliance organizations, published a report advising health care organizations that compliance needs to be an integral issue for health care boards. Specifically, HHS published the report titled, **Practical Guidance for Health Care Governing Boards on Compliance Oversight** (the "Report"). The Report addressed various issues relating to a board's oversight and review of compliance program functions.

The Report states that one of the first areas boards should focus on relates to understanding the actual expectations the government has with respect to board oversight of compliance program functions. Although the Report notes that a board must make inquiries to ensure information and reporting systems exist, the board must also confirm that the reporting system is adequate to ensure compliance issues are presented to the board. Further, the Report explains that boards must develop a formal plan to keep informed of regulatory and compliance changes.

One method to ensure the board is able to analyze and understand compliance related issues is to utilize the expertise of others to assist in fulfilling this duty. Specifically, the Report advises that an expert to the board can assist the board in identification of risk areas, provide insight into best practices in governance, and provide consultations on other substantive or investigative matters. While there is no one-size fits all standard for health care organization boards, the Report indicates that boards have a responsibility to ensure they understand compliance functions, are aware of compliance issues within the organization, and receive expert advice to ensure the board can act upon those issues.

The Report also discusses various issues of which boards should be aware. This includes the roles and relationships between the audit, compliance, and legal functions. With respect to each of these areas, HHS believes health care boards should be able to evaluate the adequacy and performance of such functions on a periodic basis. Further, boards are expected to set and enforce expectations related to receiving compliance information from various functions within an organization. One issue that is stressed within the Report is the need for regular reports from an

independent perspective. Finally, the Report addresses the need for boards to understand active monitoring of risk areas as well as encouraging accountability and compliance as an enterprise-wide responsibility.

Krieg DeVault has significant experience in this area as Partner and Health Care Practice Group Leader **Bob Wade** is currently the Compliance Expert to the Board of Halifax Health, a 678-bed hospital system based in Daytona Beach, Florida. In March 2014, Halifax Health signed a Corporate Integrity Agreement ("CIA") with the OIG as part of an $85 million settlement with the U.S. Department of Justice over alleged illegal contracts with physicians, that violated the Stark Law as well submitting false Medicare claims to the federal government. This settlement is the largest Stark Law settlement involving a hospital system to date. Under their CIA, the OIG mandated a Compliance Expert to the Board. This Report, and Bob Wade's recent appointment, highlight that the OIG and HHS are insisting on enterprise-wide compliance from the board level.

If you have any questions or concerns related to the health care organization board compliance, or the Report, please feel free to contact **Robert A. Wade** at (574) 485-2002.

Changes to Advanced Practice Nurse and Physician Assistant Laws

Utilization of advanced practice nurses, such as nurse practitioners, and physician assistants has been increasing over the past few years. Laws with respect to these health care providers have also changed, both on a Federal and State level. On May 4th, Governor Mike Pence signed into Indiana law House Bill 1183 which included changes for both advanced practice nurses and physician assistants. Further, on April 16th President Barack Obama signed into federal law H.R. 2 which included various changes for nurse practitioners. These changes are outlined below.

Physician Assistant

Physicians assistants engage in a dependent practice with physicians in which the physician delegates authority to the physician assistant. Nevertheless, House Bill 1183 substantially changes many requirements related to physician supervision. These changes include that a supervising physician no longer is required to name each drug or drug classification in which the physician assistant has been delegated authority to prescribe, a supervising physician does not need to cosign any prescriptions ordered by a physician assistant, and patient encounters between a patient and a physician assistant should be reviewed by the supervising physician within ten (10) days as opposed to seventy-two (72) hours. Another large change relates to chart reviews. Previously a supervising physician had to review at least 25% of the physician assistant's patient charts. Now, this is required only in the first year of employment and thereafter the physician can determine a specific number of charts that needs to be reviewed. Finally, a supervising physician can now supervise a maximum of four (4) physician assistants at any time as opposed to two (2).

Advanced Practice Nurses/Nurse Practitioners

An advanced practice nurse includes a nurse practitioner, nurse midwife, a clinical nurse specialist, or a certified registered nurse anesthetist. Advanced practice nurses are independent members of the health care team that make independent decisions related to the health care of patients. For advanced practice nurses that seek prescriptive authority, a collaborative agreement is required with a physician. House Bill 1183 had one change that is applicable to both advanced practice nurses and physician assistants. Both are now able to prescribe and treat patients with a Schedule III and Schedule IV controlled substance for the purpose of weight reduction or to control obesity. Although advanced practice nurses have been able to prescribe Schedule II through IV controlled substances, they now can offer treatment for weight loss. H.R. 2 now authorizes nurse practitioners to document the face-to-face encounter required for durable medical equipment orders. Previously, a physician needed to be involved to document such an order.

These changes may have a significant impact on how your organization utilizes these healthcare professionals.