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Health Policy Briefing

August 19, 2013

Disputes over Affordable Care Act May Stymie Other Legislation When Congress Returns

President Spurns Republican Attempts to Shut Down Government Over Health Reform Law

The President used a White House press conference to chide Republicans over any attempt they may make to use the fiscal year (FY) 2014 appropriations process to defund the Patient Protection and Affordable Care Act (PPACA). He said "The idea that you would shut down the government unless you prevent 30 million people from getting health care is a bad idea…." Although **House Speaker John Boehner (R-OH)** has not voiced support for the efforts of 66 House Republicans and **Senators Mike Lee (R-UT) and Marco Rubio (R-FL)** to include the defunding provision in the continuing resolution (CR) to be taken up when Congress returns in September, several alternative routes may be considered by the Republican conference in the House next month. One would be to include the PPACA defunding provisions in the House FY 2014 CR and leave it to Senate Democrats to send the CR back without the provision, thus forcing a conference on spending levels as well as PPACA defunding. Another approach Republicans might take is to pass a "clean" CR without the PPACA provision and defer to using the upcoming need to increase the federal debt limit as leverage to defer the individual mandate until 2015 (and/or repealing the Independent Payment Advisory Board, medical device tax, etc.). Regardless of the approach, a significant hurdle to reaching a House/Senate agreement over spending will be the extent to which to continue beyond September the lower spending levels mandated under the sequestration elements of the Budget Control Act (BCA).

Inside

PPACA Health Reform Update

Concerns Over PPACA Delays

Republicans continued their attacks on the PPACA over the congressional recess, renewing concerns over the "grace period" delay until 2015 of the requirement that "grandfathered" and certain other group health plans/insurers cap out-of-pocket costs ($6,350 for individuals and $12,700 for families) and comply with the employer mandate. House Speaker John Boehner encouraged the Senate to take up the House-passed bill (H.R. 2668) which would also delay the individual mandate and said "This is the bottom line: if the president's health care law is too complex and costly for big businesses and insurance companies to figure out, American families deserve a break from it as well." Senator Lamar Alexander (R-TN) said that the "most sensible course is to dismantle and replace this historic mistake and replace it with a step-by-step plan to transform our health care delivery system." Nonetheless, the Department of Health and Human Services (HHS) said many consumers, including individuals and small businesses, who obtain health insurance under PPACA exchanges will benefit from the cap. Senate Minority Leader Mitch McConnell (R-KY) also sent a letter to the Centers for Medicare and Medicaid Services (CMS) asking the agency to delay the October 1st launch of open enrollment under the PPACA Health Insurance Exchanges over concerns raised by the HHS Office of Inspector General (OIG) that the multi-agency data hub might not be fully functional to secure the personal and financial information shared with the state-run and federally-run exchanges. The Internal Revenue Service (IRS) also released a final rule spelling out how the agency will share taxpayer income and Social Security information with the exchanges. As to the same matter, Senator Orrin Hatch (R-UT) asked the Government Accountability Office (GAO) for a report on the risks the data hub presents in breaching the privacy and identity of exchange participants. Senator Roy Blunt (R-MO) also wrote to HHS Secretary Kathleen Sebelius requesting that the agency release by September the premium rates for health plans to be offered under the federally-run exchanges. Chairman Darrell Issa (R-CA) and Rep. James Lankford (R-OK) of the House Committee on Oversight and Government Reform also threatened Treasury/IRS to comply by August 29 with their request for information on how the agencies arrived at their decision to provide tax credits to individuals under the federally-run exchanges or become subject to a subpoena for the information.

HHS Grants to PPACA Navigators

HHS announced that 105 different navigator groups have been awarded $67 million to help individuals obtain information and enroll under federally-run and state-partnership exchanges/marketplaces.

Request for HHS Written Plan for Stark Self-Referrals

Rep. Jim McDermott (D-WA), the author of the so-called Stark self-referral provisions under the PPACA, sent a letter to CMS asking the agency to submit a detailed plan by October 15th for revising the protocol for the self-disclosure by physicians of actual and potential violations and for reducing the backlog of unresolved disclosures. In a busy week, the congressman also sent a letter to the GAO requesting the agency to investigate recent hospital consolidations which he says may result in less competition and higher costs. The letter is attached and can be found on page 4.

Medicare/Medicaid/Public Health Services Corner

Expanded Medicare Coverage for Certain Pacemakers

CMS released a decision memorandum under which Medicare will allow for the coverage of single chamber or dual chamber pacemakers for treatment of nonreversible symptomatic bradycardia due to sinus node dysfunction and second- and/or third-degree atrioventricular block.

Veterans' Mental Health Initiative

The President unveiled a $100 million grant program which will fund various research center initiatives to find better treatment regimens for veterans with brain injuries and mental health conditions.

Upcoming Committee Health Hearings

House Education and the Workforce Health, Employment, Labor and Pensions Subcommittee: will hold a field hearing titled "Health Care Challenges Facing Kentucky's Workers and Job Creators." 10 a.m. Aug. 27, Farish Theater, Central Library Branch, Lexington Public Library, 140 E. Main.

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Congress of the United States
House of Representatives
Washington, DC 20515

August 13, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Tavenner:

As the lead author of the Self-Referral Disclosure Protocol (the "**Protocol**") found in Section 6409 of the Affordable Care Act, and as Ranking Member of the Ways and Means Subcommittee on Health, I am concerned about the implementation of this provision. While I am pleased that CMS implemented this provision quickly, and met the required date under the statute for delivering its *Report to Congress*, I continue to have concerns about how long it is taking the agency to resolve disclosures. It is my understanding that while CMS has received nearly 300 submissions under the Protocol since it was published in September 2010, the agency has settled fewer than 30. Some submissions have taken nearly a year to process, creating enormous uncertainty for those who have submitted disclosures under the Protocol.

Clearly, CMS is overwhelmed by the number of disclosures it has received through the Protocol. Accordingly, the process that CMS is using to resolve disclosures must be modified. As you know, providers and suppliers often utilize the Protocol when a violation of the Self-Referral law is discovered during the course of due diligence. While I commend CMS for expediting its review of this subset of submissions, it is important to me that all providers and suppliers that avail themselves of the Protocol receive prompt dispensation of their submissions.

I recognize that CMS is underfunded and understaffed. In particular, sequestration has done a great deal of harm to the agency and its ability to fulfill its mission. Notwithstanding that fact, CMS should consider promptly modifying the Protocol so that disclosures can be settled more promptly. As CMS considers how to revise the Protocol, it is important to ensure that CMS

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continues to have the latitude to administer the Protocol as the agency sees fit. Furthermore, I recognize that as we move to alternative payment models, the following statements are true: (a) fee for service will be with us for some time until new payment models have evolved on a widespread basis; and (b) many of the alternative payment models contemplated, including accountable care organizations, for example, are built squarely on the foundation of fee for service. As such, it is important to ensure CMS retains flexibility in addressing noncompliance with the Self-Referral law to combat newly emerging fraud schemes, as we are still operating in a fee for service environment. Accordingly, I do not seek to prescribe any particular way that CMS must handle disclosures under the Protocol. I do, however, provide the following recommendations, which may help alleviate the backlog and improve timely processing of submissions going forward:

1. Consider revising the Protocol to include guidance on time parameters to ensure providers and suppliers have some certainty when making submissions under the Protocol.

2. Consider modifying the internal deliberative process that is used to make determinations about the amounts due and owing to more easily resolve disputes. This may involve, for example, requiring information back from each of the CMS components involved in the administration of the Protocol more quickly so that there is less turnaround time in processing disclosures.

3. Consider making certain, limited information related to CMS's internal deliberative process public. This would be akin to the recent modification to the OIG's Self Disclosure Protocol ("**SDP**") whereby OIG modified its SDP to make certain information related to its calculation of damages available to the public. Such a modification to the Protocol would allow providers and suppliers to better understand whether the Protocol is the appropriate avenue for resolving a particular violation, or whether another avenue is more appropriate, including, without limitation, refunding the overpayment to the Medicare Administrative Contractor ("**MAC**"), or working with the local U.S. Attorney's Office ("**USAO**") to resolve the actual or potential violation of the Self-Referral law. Some subset of disclosures would then likely be siphoned either to the MAC or to the USAO, thus alleviating some of the backlog and/or reducing the number of disclosures received under the Protocol going forward.

4. Consider more readily transferring some number of cases that may be more serious and involve potential violations of the Anti-Kickback Statute to the Office of the Inspector General. Once such cases are identified, they should be rapidly dispensed with in this manner. Perhaps some front end modifications can be made to the Protocol to ensure agency staff can promptly identify the universe of submissions that should be more immediately transferred to OIG.

5. It is my understanding that providers and suppliers have done a better job with getting CMS the information it needs at the front end to allow CMS to make its determinations. This is in large part due to CMS's excellent education efforts in this regard. However, if the quality of the submissions is still problematic such that the agency continues to receive incomplete submissions and is spending time going back and forth with providers to obtain the information required under the Protocol, CMS may need to modify the Protocol to incent providers to supply an initial complete submission. This could be accomplished by moving providers and suppliers with repeat difficulties in submitting required information to the "back of the line." Or, the Protocol could be modified to state that a provider's obligation to report and return an overpayment under Section 6402 of the Affordable Care Act would no longer be tolled for incomplete submissions under the Protocol.

Again, I appreciate your efforts in faithfully administering the Protocol. However, it is important that providers and suppliers have some level of certainty that a submission made through the Protocol will be acted upon in a timely manner. It simply is not sustainable to continue as CMS is currently operating if there is a one year backlog in resolving submissions.

I will continue to monitor this situation to ensure that the backlog is remediated in a reasonable manner, and that CMS administers the Protocol in a manner that allows for some degree of certainty. I ask that you contact my staff no later than **October 15, 2013**, with a written, detailed plan for addressing the backlog of disclosures the agency has received under the Protocol, as well as your initial thoughts related to revising the Protocol to address submissions going forward.

Thank you in advance for your attention to this matter. Should you have any questions, please do not hesitate to contact Tiana Korley on my staff at (202) 225-3106 or Tiana.Korley@mail.house.gov.

Regards,

Jim McDermott
Member of Congress

cc: Matthew Axelrod, Esq., Associate Deputy Attorney General,
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