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June 2013

Capitol Briefs

MedPAC’s Report to Congress Considers Hospice Payment, Accountability
On June 14, the Medicare Payment Advisory Commission (MedPAC) released its June report to Congress, focusing on a number of policies related to Medicare and delivery system reform. (Read the executive summary and access a fact sheet on the report.) In a chapter devoted to hospice policy, commissioners examine long stay patients, live discharges and hospice care in the nursing home setting and reiterate previous recommendations for hospice payment reform.

Congress Seeking Stakeholder Input on Post-Acute Care by Aug. 19
In a letter to post-acute care providers, Senate Finance Committee and House Ways and Means Committee leaders are inviting suggestions on ways to “ensure that Medicare beneficiaries receive the right post-acute care, in the right setting at the right time with the highest level of quality.” The lawmakers are seeking policy proposals to improve payment accuracy, combat fraud, and address variation in utilization. In addition, the committees have requested that stakeholders provide information and ideas on the types of reforms that will help to advance the goal of improving patient quality of care and care transitions, while rationalizing payment systems and improving program efficiency. Comments should be sent by August 19, 2013, to postacutecarereform@mail.house.gov and postacutecarereform@finance.senate.gov.

GOP Opposition to IPAB May Leave HHS in Control of Medicare Cuts
Republican leaders in Congress are refusing to offer nominees for the Independent Payment Advisory Board (IPAB), a 15-member expert panel created under the Affordable Care Act (ACA) to propose Medicare reimbursement cuts should per-person spending on the benefit rise above a certain rate. Republicans oppose the IPAB, arguing that it will serve to ration care and result in fewer providers accepting Medicare patients. However, the ACA requires that Medicare spending be reduced, and if the IPAB is not constituted or otherwise fails to produce recommended cuts, then the responsibility falls to the Secretary of Health and Human Services. In a May 9 memo to Senator Tom Coburn (R-OK), the Congressional Research Service explained that both the IPAB’s recommended cuts or, if necessary, the Secretary’s recommendations would be subject to fast track rules. The cuts would automatically take effect unless Congress identified similar savings elsewhere in the federal budget or blocked them by a two-thirds vote in the Senate. Read more at FierceHealthcare.

The Academy Weighs In

AAHPM Suggests Reforms as Senate Finance Committee Examines Medicare Physician Payment
In May, AAHPM submitted comments in response to a request by the Senate...
Finance Committee that stakeholders in the provider community provide input as the committee examines ways to eliminate the Sustainable Growth Rate formula and restructure Medicare physician payment. The lawmakers were seeking ideas for reforms to the physician fee schedule and fee-for-service system that would lay the foundation for a performance-based payment system and ensure stability in physician reimbursement. The Academy offered suggestions for payment, policy and incentive reforms that would advance patient access to high-quality palliative care and drive patient- and family-centered outcomes.

AAHPM Profiles Practitioners Working in Innovative Models of Care
On June 18, AAHPM’s Emerging Payment and Delivery Models Working Group launched a new bi-monthly series titled *Hospice and Palliative Medicine Profiles in Innovation*. These short profiles feature programs or initiatives that are integrating palliative care in evolving systems, such as patient-centered medical homes, accountable care organizations, or integrated health systems. Check out the June profile that features insights from Academy member David Wensel, DO FAAHPM, who serves as medical director for a Program of All-inclusive Care for the Elderly (PACE) in Topeka, KS. The Working Group, chaired by Phil Rodgers, MD FAAHPM, was formed under the Academy’s Public Policy Committee in order to track, examine and communicate changes in care delivery and payment models and guide the Academy in advocating for hospice and palliative care in the post-reform landscape.

AAHPM Offers Input As State Lawmakers Craft Guidelines for Curbing Opioid Abuse
The National Conference of Insurance Legislators (NCOIL) is drafting guidelines for states undertaking reforms aimed at stemming opioid abuse. The organization of state lawmakers, spurred to action by the escalating costs of abuse, is expected to suggest best practices that address drug monitoring programs, funding, prescribing practices, and data sharing, among other things. AAHPM reached out to NCOIL staff in June to encourage the group to consider the unique needs of patients with serious illness when crafting the guidance. The Academy urged NCOIL to strike the proper balance between mitigation and patient access to needed medications and not legislate the practice of medicine. Rather than focus on prescribing practices, AAHPM suggested model policy should target the sources of drug diversion -- such as forgery, pharmacy thefts, and improper prescribing -- and focus on prescriber and patient education. The legislators are preparing the guidelines for review during their July meeting.

News From CMS

**CMS: Hospitals Readmissions Down in 2012**
In a newly reported analysis of 30-day, all-cause hospital readmission rate patterns from 2007-2012, the Centers for Medicare & Medicaid Services found rates for all Medicare fee-for-service beneficiaries dropped noticeably during 2012. Investigators discuss the possible reasons behind the reduction but note further investigation is warranted.

**Medicare Trustees Release Annual Report**
Slower growth in health care expenditures means the Medicare hospital trust fund is expected to be solvent through 2026, two more years than the last estimate. While spending is projected to continue to grow more slowly than the overall economy for the next several years -- thanks to cost controls implemented in the Affordable Care Act, the 2013 Medicare Trustees’ report points out that long term program viability is still a concern, particularly in light of a growing elderly population. Observers also note that positive projections for Medicare’s supplemental insurance fund -- which covers parts B and D -- are based on faulty assumptions, such as a 25 percent reduction in 2014 Medicare physician payment as prescribed by the sustainable growth rate formula. In recent
years, Congress has passed a "doc fix" to eliminate or postpone such cuts. Read more in [USA Today](#).

**OIG: Inaccurate Medicare Provider Data Puts Program at Risk**

The U.S. Department of Health & Human Services Office of Inspector General examined provider information maintained in two databases -- the National Plan and Provider Enumeration System and the Provider Enrollment, Chain and Ownership System -- and found the data to be largely inaccurate, incomplete, and inconsistent. In a report to CMS, the OIG makes recommendations to improve program integrity and allow for better detection of waste, fraud and abuse. Read more at [MedPage Today](#). (Requires free subscription.)

### In the States

**PPSG Releases Progress Report on State Pain Policy**

A new report from the University of Wisconsin Pain & Policy Studies Group (PPSG) evaluates states’ CY 2012 policies governing the medical use of opioids and uses evidence from policy research to grade states from A to F, according to whether laws enhance or impede pain management. The PPSG analysis also includes laws and regulatory policies governing nursing practice. A companion guide explains evaluation methods and criteria and discusses achieving balance in state and federal pain policy.

**State Adoption of POLST Now Widespread**

Physician orders for life sustaining treatment (POLST) -- patient-directed medical orders with greater detail and greater force and effect than a "do not resuscitate" order or other advance directive -- are becoming increasingly common as state-sanctioned policy, a development that appears to be supporting closer adherence to patient preferences. Following approval this year of POLST in Indiana and Nevada, they are now utilized in 43 states, and many states are moving to integrate them into electronic health records. Still, some disability groups and religiously-oriented organizations are arguing against POLST. Read more in the Pew Charitable Trust's [Stateline](#).

**Efforts to Reduce Prescription Drug Abuse Advance in California**

A package of bills aimed at curbing prescription drug abuse in California has passed the State Senate with overwhelming support and will move forward for consideration by the state's General Assembly. The legislation would provide for mandatory reporting by coroners of all deaths involving a prescription drug, proactive investigation and easier suspension of prescribers, and an upgrade for the California Substance Utilization, Review and Evaluation System (CURES), the state's prescription monitoring program. The changes to CURES were ultimately less ambitious than initially proposed, and reforms to be funded by a new tax on pharmaceutical and biotech companies were ultimately scrapped in order to advance the remainder of the proposal. At the same time, the legislature has put pressure on the Medical Board of California, which has been blamed for poor oversight of prescribers and contributing to a spike in abuse-related deaths. Lawmakers have threatened to disband the Board unless it can demonstrate significant reforms. The [Los Angeles Times](#) has more on the legislative package and developments related to the medical board.

**Montana Organization Questions Medical Board's Approach to Physician Aid in Dying**

An organization called Montanans Against Assisted Suicide has filed suit in state court. The group is requesting judicial review of the Montana Board of Medical Examiners' position paper on the practice of physician-assisted death. The position states that it will approach complaints against physicians in cases involving assisted death in the same way it approaches cases involving any other medical intervention. Montanans Against Assisted Suicide argues this position wrongly
presents physician-assisted death as a legal act, whereas a 2009 Montana Supreme Court ruling found that the act is not explicitly illegal under the state's laws. Read more in the Missoulian.

**Oregon NPs Earn Dispensing Privileges**
The Oregon legislature has unanimously passed legislation that will allow nurse practitioners to dispense prescription medications, including controlled substances. The right to dispense will be granted to NPs who apply to the Oregon Board of Nursing and undergo relevant training, and it will only allow the distribution of prepackaged medications. Previously, NPs were required to show their patients faced difficulty in accessing pharmacies. Read more in The Lund Report.

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### Reports & Resources

**Report Tracks Care of Chronically Ill Medicare Beneficiaries Near End of Life**
Medicare spending for chronically ill patients at the end of life increased more than 15 percent from 2007 to 2010, according to a new brief from the Dartmouth Atlas Project. The data (available for download) also shows that Medicare patients spent fewer days in the hospital and received more hospice care in 2010 than they did in 2007. Investigators note the findings may signal that patient preferences are carrying greater weight in end-of-life care decision-making. However, for Medicare beneficiaries with chronic illness near the end of life, health care quality, outcomes, and cost vary greatly across regions and hospitals. Read more from the Medicare NewsGroup.

**AHA Survey: Medicare RAC Reviews Increasing**
According to the American Hospital Association's RACTrac survey, 91 percent of responding hospitals experienced claim denials or medical records requests from a Medicare recovery audit contractor (RAC) in the first quarter of 2013. The 44 percent of hospitals that appealed denials were successful 72 percent of the time, but they faced extensive delays when doing so. In fact, the survey showed that three-fourths of all appealed claims were still sitting in the appeals process. The Medicare Audit Improvement Act (H.R.1250/S.1012), introduced this year in Congress by Rep. Sam Graves (R-MO) and Sen. Roy Blount (R-MO), aims to address many RAC practices highlighted in the June report, including large record requests, medical necessity determinations by non-expert reviewers serving as the basis for complex audit denials, and significant delays in decisions on hospital appeals. Read more about the AHA survey at FierceHealthFinance.

**GAO Examines HHS Progress in Setting Up Insurance Exchanges**
State health insurance exchanges created under the Affordable Care Act -- expected to serve nearly 9 million people -- are slated to be operational in a little over three months. Across the country, state and federal policymakers are racing to complete the required infrastructure and make the technical, administrative, and regulatory changes necessary to address data integration, review of insurance products, fraud prevention, and training and certifying of consumer aides. However, a new Government Accountability Office (GAO) report, casts doubt on whether small business and individual consumer insurance exchanges will be finished on time, as 44 percent of the projects supporting their implementation are now behind schedule. Read about states' progress on exchanges in Stateline. Kaiser Health News has more on the GAO report.