Capitol Briefs

Legislation to Improve Hospice Accountability Signed Into Law

On Oct. 6, President Obama signed into law the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act* (H.R. 4994/ S. 2553). The legislation includes provisions to improve hospice program integrity -- that AAHPM has long supported -- as well as address patient care. The new law requires that hospices be surveyed at least every three years and authorizes funding for the Centers for Medicare & Medicaid Services (CMS) to contract for the additional oversight. These changes track with recommendations from the U.S. Department of Health & Human Services Office of the Inspector General. For programs that reach a yet-to-be-determined threshold of "long stay" patients in hospice care for more than 180 days, the legislation would require a medical review of care provided to these individuals. Finally, the measure includes changes to the hospice aggregate payment cap, updating it by a common inflationary index for a ten-year period. Read more in the *Washington Post* and MedPage Today.

Hydrocodone Combination Products Moved to Schedule II

On Oct. 6, the U.S. Drug Enforcement Administration (DEA) final rule reclassifying hydrocodone-combination products as Schedule II medications under the Controlled Substances Act took effect. Prescriptions for covered drugs can no longer be submitted over the phone, manufacturers and dispensers are subject to more stringent storage and tracking requirements, and prescriptions will be limited to a three-month supply, fillable in sequential 30-day increments. Each refill will now require a visit to a health care provider, however. In some cases, prescriptions issued before Oct. 6, 2014, that have authorized refills may be dispensed, but this will be subject to state law, insurance limitations, and pharmacy operations. Learn more in the AMA Wire, and access this American Medical Association fact sheet suitable as an office reference or handout.

Congressional Proposal Would Give MU Attesters a Break

Legislation introduced in Congress Sep. 16 would reverse a provision in a recent CMS rule that in 2015 will require eligible providers and hospitals to engage in year-round reporting of Meaningful Use of electronic health records (EHR) using 2014 Edition certified technology. Under the *Flexibility in Health IT Reporting (Flex-IT) Act* (H.R. 5481), providers could attest to Meaningful Use during any three-month quarter of the year instead. U.S. Rep. Renee Ellmers (R-NC), who introduced the bill, notes that only 9 percent of the nation's hospitals and 1 percent of eligible health care professionals have demonstrated the ability to meet Meaningful Use Stage 2 requirements using the 2014 Edition technology. Read more in Fierce EMR. The legislation is endorsed by the Healthcare Information and Management Systems Society, which took its annual "Congressional Asks" to advance health IT to Capitol Hill on Sep. 18.

New Controlled Substance Disposal Regs Effective Oct. 9

The DEA has published a final rule implementing the *Secure and Responsible Drug Disposal Act of 2010*. Under the new regulations, "ultimate users" have more options for disposing unused, unwanted or expired controlled substances and now are permitted to deliver such medications to third parties for disposal. The rule specifies that "a member of the hospice patient's household may dispose of the patient's pharmaceutical controlled substances, but the home hospice or homecare provider cannot do so unless otherwise authorized by law (for example, under state law) to dispose of the decedent's personal property." The DEA is expanding its prescription drug take-back program to allow pharmacies and hospitals to accept returns of unused medications. The overall goal is to decrease unused pharmaceutical controlled substances in households so as to reduce the incidence of diversion, misuse and abuse. Read more at FDA Law Blog and in *USA Today*.

MedPAC Considers Challenges Facing Medicare Program

The Medicare Payment Advisory Commission (MedPAC) -- a nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program -- met Sep.11-12. Issues on the agenda included hospital short stay policy and developing payment policy to promote the use of services based on clinical evidence. The commissioners also received an update on Medicare accountable care organizations. Staff reviewed expectations about future health care spending, the drivers of growth, and evidence of health care inefficiency and misspending. They also considered challenges to the Medicare program -- fragmented payment systems, limited tools to restrain fraud and abuse, benefit design, price differences across settings, and under- or overvalued services -- and potential approaches MedPAC might take to address them. Access issue briefs and presentations from the meeting. AAHPM's lobbying and consulting firm, Heart Health Strategies, also prepared this meeting summary for Academy members.

AAHPM Weighs In

AAHPM Comments on CMS Proposals for 2015 Medicare Physician Fee Schedule

On Sep. 2, AAHPM submitted comments on the Centers for Medicare & Medicaid Services (CMS) 2015 Medicare Physician Fee Schedule Proposed Rule. The Academy's Public Policy Committee and its Emerging Payment & Delivery Models Working Group, the Quality Committee, and the Education and Training Strategic Coordinating Committee chair contributed to AAHPM's feedback. The letter addresses concerns about a number of CMS proposals, ranging from the use of hospital cost reports to revise the Medicare physician fee schedule practice expense methodology to the adoption of new chronic care management codes to the CMS Open Payments program. AAHPM also highlighted palliative care measure gaps in the Physician Quality Reporting System and suggested additional codes for inclusion on the list approved for telehealth. CMS is now considering stakeholder input, and a final rule is expected in November.

AAHPM Advocates for CCM Codes in Meeting with Director of Medicare

Phil Rodgers, MD FAAHPM, co-chair of AAHPM's Public Policy Committee, participated in Sep. 12 meeting with Sean Cavanaugh, deputy administrator and director of the Center for Medicare at CMS. AAHPM was one of eight organizations that signed a joint letter to CMS regarding the agency's proposal for a new chronic care management (CCM) code. Medical society representatives, including

Rodgers, previously met with CMS staff to discuss their concerns and a follow-up meeting with Cavanaugh was scheduled to formally present requests relayed in the letter. Rodgers described how care management services could benefit patients with serious illness, while the group expressed concerns that the code described in the 2015 Medicare Physician Fee Schedule would cover services more in line with disease management rather than benefit patients with complex chronic illness. Since a CPT code for CCM services was developed, stakeholder specialty societies have worked together to present the code to the AMA/Specialty Society Relative Value Scale Update Committee (RUC), which recommends values for new or revised CPT codes to CMS, and to advocate for its inclusion in the fee schedule.

AAHPM Joins Coalition Partners in Statement on Media Coverage of Hospice

Concerned that recent media reports provide an unbalanced and sensationalized review of hospices and the care they provide, AAHPM joined with its partners in the National Coalition for Hospice and Palliative Care (NCHPC) to issue a public statement calling for action by hospice and palliative care providers. The NCHPC highlights data that shows how high-quality hospice care is provided each day in the U.S. and urges health care professionals to encourage positive coverage of "the true story of *living* while receiving hospice care" by sharing stories with local media and on social networks.

News from HHS

New Hospice Regulations Effective Oct. 1

Provisions in the Centers for Medicare & Medicaid Services (CMS) final rule updating the hospice wage index and payment rate for fiscal year (FY) 2015 took effect Oct. 1. The rule institutes reforms intended to improve program integrity, beneficiary protection, and quality of care. It also provides an update on hospice payment reform analyses, potential definitions of "terminal illness" and "related conditions," and information on potential processes and appeals for Part D payment for drugs while beneficiaries are under a hospice election. CMS expects payment to all hospices to increase by 1.4 percent, or $230 million, in FY 2015. While per diem rates will increase by 2.1 percent, hospices that do not submit required quality data will be subject to a 2 percent rate reduction. AAHPM submitted comments on the proposed rule in July. See how they track with the final regulations in this "side-by-side" summary prepared for the Academy by Hart Health Strategies. Access a CMS Fact Sheet highlighting key aspects of the rule, and read more in Healthcare Finance News.

Apply for MU Hardship Exemptions through Nov. 30

CMS has announced it will reopen the submission period for hardship exception applications for eligible professionals and hospitals to avoid the 2015 Medicare payment adjustments for not demonstrating meaningful use of Certified Electronic Health Record Technology. The new deadline will be 11:59 PM EST on Nov. 30, 2014. Access additional details and the exemption application on the CMS website. Read more in Modern Healthcare (requires free subscription).

CMS Offers to Settle Hospital Appeals to Reduce Backlog

In a move that could apply to as many as 800,000 cases, CMS has offered to settle pending hospital

appeals of claim denials related to inpatient status. The agency hopes the effort will reduce the large backlog of appeals. Ninety percent of hospitals report waiting more than four months for a hearing before a federal administrative law judge, and it can take upwards of 18 months for cases to be resolved. Under the deal, CMS will pay 68 percent of what acute care and critical access hospitals are asking for in their appeals for cases where a Medicare contractor determined that the care provided was appropriate but doing so under an inpatient status was not. Appeals must be related to admissions with dates before Oct. 1, 2013, and the patient must not have been enrolled in Medicare Advantage. Hospitals that file a settlement agreement must do so by Oct. 31 and agree to settle all pending eligible claims. Read more at FierceHealthcare.

Concerns Remain in Wake of Sunshine Act Data Release

On Sep. 30, CMS posted information on 4.4 million payments -- worth nearly $3.5 billion -- that drug and device makers have made to health care providers and teaching hospitals. Those that registered on the Open Payments website to review data prior to publication disputed 12,579 records, roughly 9,000 of which remained unresolved at the close of the review period. Prior to the launch, trade associations representing the medical device, biotechnology and pharmaceutical industries sent a letter to CMS Administrator Marilyn Tavenner noting their concerns that, unless CMS provides sufficient background information and context regarding industry collaboration with physicians and other health care providers, patients may form mistaken impressions that all transfers of value to physicians are suspect. Read more in Medscape (requires free subscription).

In the States

California Enacts Laws Expanding Access to Palliative Care Services, Information

On Sep. 25, California Gov. Jerry Brown signed into law two measures that will expand patient access to palliative care and hospice services. Under SB 1004, Medi-Cal, the state's Medicaid program, must establish palliative care standards and provide technical assistance to Medi-Cal managed care plans for the delivery of palliative care services to all beneficiaries. This follows the pilot implementation of a pediatric palliative care benefit that was intended to help evaluate whether, and to what extent, such a benefit should be offered broadly under the Medi-Cal program. The other approved bill, AB 2139, requires a healthcare provider, when making a diagnosis of a terminal illness, to notify the patient or the patient's agent of the right to comprehensive information and counseling regarding end-of-life care options and, upon request by a patient or surrogate, to provide that information or make a referral to a hospice provider or other qualified organization who can do so.

FSMB Offers Model Interstate Compact for Multistate Medical Licensure

The Federation of State Medical Boards has produced model legislation that states could adopt in an effort to create a "single stop" mechanism for multistate physician licensure. Requiring at least seven states to sign on, the compact would not replace or preempt the current system of state licensure, but would instead make portability of a medical license easier for board-certified physicians. A physician's state of principal licensure would review his or her application for a multistate license against credentials set forth in the compact. If approved, no further review will be required by other participating states. Observers expect such a system would benefit the practice of telemedicine and

help improve access to care in rural and underserved areas. Read more in Modern Healthcare (requires free subscription).

California Ballot Measure Would Require Random Drug Testing of Physicians

If approved in November, California's Proposition 46 would establish the first law in the nation requiring random drug and alcohol testing of doctors. Positive results would be reported to the state medical board, which would be required to suspend a physician's license pending further investigation. The ballot initiative is drawing a variety of critics. Opponents in organized medicine say that rehabilitation, rather than punishment, would do more to ensure providers get the treatment they require, and that just targeting physicians is not an effective strategy to address increasing abuse among health care workers. Others point out that, while state ballot initiatives are supposed to be limited to a single subject, Proposition 46 would also raise the state's cap on non-economic medical liability damages from $250,000 to over $1 million, as well as require health care practitioners to consult the state's prescription drug monitoring database before prescribing certain controlled substances. Proponents say the distinct provisions all target patient safety. Learn more from Ballotpedia.org and in Fierce Healthcare.

Indiana Hospitals Say Public Reporting of County Employee Pay Hinders Physician Recruiting

A state law that mandates public disclosure of public employees' salaries puts county hospitals at a disadvantage when recruiting physicians, according to the Indiana Hospital Association. The group is fighting the requirement and wants physician compensation removed from the Indiana Gateway for Government Units database. Read more in the *Indianapolis Star* and FierceHealthFinance.

Reports & Resources

Perspectives on IOM EOL Care Report

On Sep. 17, the Institute of Medicine released the report "*Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*." An expert committee, that included a number of AAHPM thought leaders -- including Academy President Jean S. Kutner, MD MSPH FAAHPM, produced the consensus report following a year of work to assess the current state of end-of-life care and "the knowledge gaps, structural problems, and financial disincentives that hamper delivery of optimal care." Read about reactions to the report's findings and recommendations in Medscape (requires free subscription). Kutner offers her perspectives on the report at aahmblog.org.

NIH Report Considers Opioids for Chronic Pain; Submit Comments by Oct. 17

The draft report of the 2014 National Institutes of Health Pathways to Prevention Workshop titled "*The Role of Opioids in the Treatment of Chronic Pain*" summarizes the workshop and identifies future research priorities. Access more information, including the research review that informed the workshop, presentation summaries, and a videocast of the meeting. Submit public comments on the draft report through Oct. 17, 2014.

New Telemedicine Reports Examine States Policies, Impact on Chronic Disease Care

Two new reports released Sep. 8 offer a gap analysis of state telemedicine policies. In the first, the American Telemedicine Association grades states on coverage and reimbursement standards. In the other, the group grades them on physician practice standards and licensure. In another study, published online in the journal *Telemedicine and e-Health*, researchers assess the impact of telemedicine on chronic disease management with regard to cost, quality and access to care. The authors focus their review on congestive heart failure, stroke, and chronic obstructive pulmonary disease.

AMA Develops Priorities for EHR Usability

Building on its 2013 study with RAND Corp. confirming that discontent with electronic health records (EHRs) is taking a significant toll on physicians, the American Medical Association (AMA) has released a set of eight priorities to improve EHR usability. The AMA identified key challenges physicians face with current EHRs and makes recommendations for improving usability to benefit caregivers and patients. Access the priorities document on the AMA website.

Watch *Health Affairs* Briefing on IOM GME Report

On Sep. 10, *Health Affairs* held a briefing on the Institute of Medicine's July report on graduate medical education (GME) governance and financing. Participants expressed support for recommendations that target teaching hospitals' accountability and transparency of GME funding, but other recommendations did not fare as well. Watch a video of the briefing, download the audio, or access slides on the *Health Affairs* website.

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