Health Care Reform Task Force Meets

The Arkansas Health Reform Legislative Task Force, created under Act 46 of 2015, held its organizational meeting on March 10. Senator Jim Hendren and Representative Charlie Collins were named as the chairmen. Vice Chairs are Senator Cecile Bledsoe and Representative Reginald Murdock. The next meeting time was set for tomorrow, Tuesday, March 17, 2015, upon adjournment of both chambers. While the Task Force members are all legislators, plans call for an advisory group comprised of various healthcare organizations, including the Arkansas Hospital Association, which will be heavily involved in the work to come. Arkansas Surgeon General Dr. Greg Bledsoe will head that advisory panel. Arkansas hospital representatives should continue to reach out to individual Task Force members (below) about the needs of the state’s hospitals, healthcare facilities, the healthcare system and patients.

Arkansas Health Reform Legislative Task Force

Senator Cecile Bledsoe, Rogers  
Representative Justin Boyd, Fort Smith  
Senator Linda Chesterfield, Little Rock  
Representative Charlie Collins, Fayetteville  
Senator John Cooper, Jonesboro  
Representative Joe Farrer, Austin  
Senator Jim Hendren, Gravette  
Representative Deborah Ferguson, West Memphis  
Senator Keith Ingram, West Memphis  
Representative Michelle Gray, Melbourne  
Senator Jason Rapert, Conway  
Representative Kim Hammer, Benton  
Senator Terry Rice, Waldron  
Representative David Meeks, Conway  
Senator David Sanders, Little Rock  
Representative Reginald Murdock, Marianna

Ex Officio: Dr. Greg Bledsoe, Arkansas Surgeon General

Special Enrollment Period for Healthcare.gov

The Centers for Medicare & Medicaid Services (CMS) recently announced a special enrollment period (SEP) for individuals and families which did not have health coverage in 2014 and are subject to the fee or “shared responsibility payment” when they file their 2014 taxes in states that use federally-facilitated marketplaces (FFM). This special enrollment period will allow individuals and families who were unaware or did not understand the implications of this new requirement to enroll in 2015 health insurance coverage through the FFM.

CMS will provide these consumers with an opportunity to purchase health insurance coverage from March 15 through April 30. If consumers do not purchase coverage for 2015 during this special enrollment period, they may have to pay a fee when they file their 2015 income taxes.

Those eligible for this special enrollment period live in states with a FFM and:

- Currently are not enrolled in coverage through the FFM for 2015.
• Attest that when they filed their 2014 tax return they paid the fee for not having health coverage in 2014.
• Attest they first became aware of, or understood the implications of, the shared responsibility payment after the end of open enrollment (February 15) in connection with preparing their 2014 taxes.

The special enrollment period begins on March 15 and ends at 11:59 p.m. ET on April 30. If a consumer enrolls in coverage before the 15 of the month, coverage will be effective on the first day of the following month.

This year’s tax season is the first time individuals and families will be asked to provide basic information regarding their health coverage on their tax returns. Individuals who could not afford coverage or met other conditions may be eligible to receive an exemption for 2014. To help consumers who did not have insurance last year determine if they qualify for an exemption, CMS also launched a health coverage tax exemption tool (https://www.healthcare.gov/exemptions-tool/#/) on www.HealthCare.gov and www.CuidadodeSalud.gov.

Americans who do not qualify for an exemption and went without health coverage in 2014 will have to pay a fee – $95 per adult or 1% of their income, whichever is greater – when they file their taxes this year. The fee increases to $325 per adult or 2% of income for 2015. Individuals taking advantage of this special enrollment period will still owe a fee for the months they were uninsured and did not receive an exemption in 2014 and 2015. This special enrollment period is designed to allow such individuals the opportunity to get covered for the remainder of the year and avoid additional fees for 2015.

Consumers seeking to take advantage of the special enrollment period can find out if they are eligible by visiting https://www.healthcare.gov/get-coverage. Consumers can find local help at www.Localhelp.healthcare.gov or call the FFM call center at (800) 318-2596. TTY users should call (855) 889-4325. Assistance is available in 150 languages.

AHA Board Highlights

During its regular monthly meeting at the Arkansas Hospital Association (AHA) building on March 13, the AHA board of directors covered the following agenda items:

Remarks from Dr. Greg Bledsoe: The new Arkansas Surgeon General reviewed with the board a brief biography of his education and experiences and the events that led to his appointment by Governor Hutchinson. He noted his most recent position as the head of emergency care with a hospital in rural Alabama, which, he said, provided him with a better understanding and concern for rural healthcare challenges. Dr. Bledsoe will serve as an ex officio member of the new legislative task force charged with developing recommendations about the future of the Medicaid program and the continued coverage of people who now have Private Option health plans. He will also chair an advisory panel to the task force comprised of representatives from various provider groups.

Washington Update: The current authorization for continuing the sustainable growth rate formula which governs Medicare physician fees expires on March 31. Taking some type of action either to continue the SGR for a period of time or to replace it with another methodology is a top priority in Congress. That puts Medicare hospital payments at risk again, particularly for reductions related to some outpatient procedures if Congress chooses to enact provisions for site-neutral payments. Such a move would equalize payments for those services regardless of whether they are provided in a physician’s office or a hospital.
**Medicaid Update:** The Arkansas Hospital Association will be conducting a follow-up to its recent survey aimed at measuring the impact on hospitals from new subsidized and Private Option health plans. The information will be needed as the legislative task force to study the future of Medicaid and the Private Option begins to develop recommendations for the governor.

**Outstanding VA Claims:** Senator John Boozman’s office in Little Rock is working with the AHA to set up a meeting at which representatives from the VA’s Jackson, MS administration center will discuss the matter of unpaid claims for services provided to VA patients by local non-VA hospitals. The meeting is being planned for early April.

**Legislative Update:** The Arkansas General Assembly continues its 2015 regular session. March 9 was the final day for bills to be introduced and more than 500 were filed. A bill establishing requirements for licensure as community paramedics has passed the House and is on the Senate calendar. The AHA worked with other groups to defeat a move by the Highway Department to obtain more state general revenues for its budget. If approved, the bill could have had a negative impact on other state programs such as Medicaid.

**Arkansas Insurance Marketplace:** About 65,000 Arkansans had purchased federally subsidized health plans through the Arkansas Insurance Marketplace as of March 1. The updated figures for Private Option health plans has not been released.

**AHA Education Activities:** The Summer Leadership Conference will be held June 17-19 in Nashville, TN. Upcoming educational workshops include an April 23 session on key compliance issues and a series of workshops on ICD-10, which will run April 29-September 10.

**AHA Quality Program:** The AHA is in the final stages of proposal preparation with the American Hospital Association’s Health Research and Education Trust for the HEN 2.0 work which is anticipated to begin later this year upon award of a contract. March 18 is the deadline to submit the final list of hospitals with an interest to participate in the HEN effort. Also, more than 70 participants turned out for the February 26 Pharmacist Led Collaborative.

**NewsNotes About Arkansas Folks:**
Correction: Last week’s issue of The Notebook contained information that Rick Holloway, MD, had been named chief medical officer (CMO) for Ozark Health Medical Center in Clinton. However, Dr. Holloway was named CMO for Ozarks Medical Center in West Plaines, MO. We apologize for the error.

**The AHA Calendar**

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Information on all AHA educational programs and activities is available at [http://www.arkhospitals.org/events](http://www.arkhospitals.org/events).
Final Thoughts by Paul Cunningham

There was a time when hospitals across the country could spend the better part of a year mustering the troops and support to rally against potential Medicare payment cuts. Typically, those efforts played out over the course of a spring and summer, as CMS prepared its final sets of prospective payment system rules and regulations or Congress approached looming fiscal cliffs that coincided with the end of the federal fiscal year. That’s no longer the case. These days, the route to the next fiscal year usually is a narrow mountain road with budgetary fiscal cliffs just around the next bend. And, so it is this year, with the shelf-life of the existing “patch” for the Medicare sustainable growth rate (SGR) due to expire on March 31.

For those who might not recall, the SGR, a formula-based approach which ties physician payments to growth in the national economy, was put into place under the Balanced Budget Act of 1997. Intended as the means by which CMS could objectively regulate spending on Medicare physician services, it has fallen far short of expectations.

In the late 90s, the SGR formula produced moderate annual increases in physician payments. Everyone was happy until the quick onset of the harsh reality found in a Robert Burns verse, “The best laid plans of mice and men oft go awry.”

In 2001, the combination of a recession in the overall economy and dramatically increasing medical costs led to an SGR-induced cut of 4.8% in Medicare physician rates for 2002. So much for the back-slapping. The SGR never again has called for an increase in rates. Therefore, to avoid a repeat of the 2002 reductions, some truly excessive, Congress has decided to override the formula 17 times with a temporary patch. This year, if Congress does not act by March 31, payments to Medicare physicians will be reduced by 21.2%.

The series patches have kept increases in physician payments below the general inflation rate for the past dozen years, but have also resulted in a huge gap between the actual level of Medicare physician-related spending and the SGR targets. The cost of a permanent fix to the SGR, which everyone agrees is needed, has grown every year and now borders $140 billion. It’s no surprise that a permanent solution is still lacking. But, there’s also been a cost to the temporary fixes, much of which has been borne by hospitals that have seen Congress find clever ways to divert multiple billions of dollars from Medicare hospital payments to physicians.

Today, discussions continue on Capitol Hill on both a permanent SGR fix and another short-term patch to avoid the cut to physician payments set to take effect April 1. Payments for hospital care are again at risk as a potential offset. Cuts to payments for hospital outpatient care (so-called site-neutral cuts), cuts to graduate medical education, Medicare bad debt payments, changes to the critical access hospital (CAH) program, the two-midnight policy, readmissions, Medicare extenders, inpatient rehabilitation facilities (IRFs) and others are in the mix in either context.

The brief time frame makes it all the more important that Arkansas hospital officials continue working the state’s congressmen and senators to drive home the point that further cuts will only increase hospitals’ challenges and could in turn limit patients’ access to care. Particularly, urge them to reject any move that would limit reimbursements for hospital outpatient care to the level of less intensive care sites. Note the recent American Hospital Association study (http://www.brookings.edu/blogs/health360/posts/2015/02/sgr-medicare-physician-payment-primer-fontenot) that found hospital outpatient departments treat sicker and poorer patients in need of more extensive care and resources than do physician offices.

Hospitals are also vulnerable to reductions in payments for Independent Rehabilitation Facilities (IRF) and critical access hospitals. Some in Congress are discussing the possibility of equalizing the rates paid to IRFs and skilled nursing facilities (SNFs) for Medicare patients with selected conditions as one way to cover part of the cost of the next Medicare physician payment fix. Others want to put CAH reimbursements back to 100% of costs, versus 101% that in now allowed.

Arkansas hospitals are already on the hook for more than $2.5 billion in reductions to their future Medicare payments as a result of laws and rules put in place since 2010. Don’t assume there won’t be more. The message to Congress is pretty simple: Enough is enough.