O. Health Reform 2014 – Are We There Yet?

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What ACA-related topics are we going to cover today?

- How can hospitals get paid under the presumptive eligibility rules?
- What are the legal issues involved in acting as a CAC?
- Can hospitals subsidize premiums for those eligible for the Exchanges?
- What is the PSO contract requirement for hospitals?
- How should hospitals implement the most recent notices under Section 501(r) and revisions to 2013 Schedule H?
- What is happening with the contraceptive mandate issue?
ACA: What is in place already

- Adult children up to 26 can stay on parents’ policy
- Kids w/ pre-existing conditions cannot be denied coverage
- No lifetime limit on benefits (soon no annual limits)
- Companies must prove fraud to cancel a policy; must allow appeals for claims denial
- Preventive services available without a co-pay
- Medicare ‘Doughnut Hole’ closed
- 35% tax rebate for small businesses
- Insurance companies must spend most $ on care

ACA: What are the key challenges for 2014 that will impact hospitals?

- Exchanges
- Medicaid Expansion
- Enrollment
**State Marketplaces -- Status**

- **17 States Running Own Exchange:**
- **7 States Using Federal-State Partnership Exchange:**
- **27 States Defaulting to Federally-Facilitated Exchange**

Source: Kaiser Family Foundation

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**Medicaid Expansion -- Status**

- **26 States Participating**
- **22 States Not Participating**
- **3 States Continuing Debate**

Source: Kaiser Family Foundation
Two-thirds of the uninsured live in 13 states

Uninsured by State

<table>
<thead>
<tr>
<th>Number of Uninsured</th>
<th>&lt;230K</th>
<th>230K - 600K</th>
<th>600K - 1.1M</th>
<th>1.1M+</th>
</tr>
</thead>
</table>

67% of uninsured live in 13 states

Presumptive Eligibility for Medicaid

- Starting in 2014, hospitals will have a new opportunity to better connect eligible patients to Medicaid.

- Using presumptive eligibility (PE), hospitals will be able to immediately enroll patients who are likely eligible for Medicaid, without waiting for an eligibility determination.

- A person can stay temporarily enrolled until the end of the month following the month when the presumptive eligibility determination was made (up to 60 days).

- The hospital will receive payment for the services provided during the temporary enrollment period, just as if the patient were already enrolled in Medicaid.
Statutory Authority and Related Federal Rules re: Presumptive Eligibility

- **Statutory authority:** Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), as modified by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (March 30, 2010), Title 2, Subtitle A, Section 2001(a)(4)(B) and Title 2, Subtitle A, Section 2202.

- **Federal regulations:** *Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa, 42 CFR 435.1110 (2013).*

- **Medicaid State Plan Amendment Template and Implementation**

Source: Enroll America Presumptive Eligibility Toolkit for Hospitals

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What do the federal rules allow hospitals to do?

- ACA and subsequent regulations allow "qualified hospitals" to make presumptive eligibility determinations.

- A "qualified hospital" is one that participates in Medicaid either through a state plan or a Section 1115 waiver.

- Qualified hospitals may determine an individual to be presumptively eligible for Medicaid based on basic preliminary information provided by the individual.

Source: Enroll America Presumptive Eligibility Toolkit for Hospitals

Who can be determined to be Presumptively Eligible?

- Hospitals that elect to make presumptive eligibility determinations may use it for income-based Medicaid eligibility for children, pregnant women, parents and caretaker relatives, and other adults (populations for which eligibility is based on modified adjusted gross income (MAGI)).

- Hospitals are permitted to make PE determinations for the above groups regardless of for whom a state allows PE determinations to be made.

- States also may allow hospitals to use PE for additional groups of individuals as well, including those whose eligibility is not based on MAGI (such as people eligible through a disability-related pathway or through a Medicaid 1115 waiver).

Source: Enroll America Presumptive Eligibility Toolkit for Hospitals
**How will a hospital be paid when providing services to those determined presumptively eligible?**

- Hospitals will be paid at regular Medicaid rates.

- Payment for services is guaranteed for a hospital during an individual’s presumptive eligibility period, even if the person fails to complete the full Medicaid application or is ultimately determined to be ineligible for Medicaid.

- States will not be permitted to recoup money from the hospital for services rendered during the presumptive eligibility period.

**What do hospitals have to do comply with the PE Regulations?**

- A hospital must inform the state Medicaid agency that it intends to make presumptive eligibility determinations and that it agrees to follow the state’s policies and procedures.

- Hospitals must tell individual patients how to apply for and obtain a full Medicaid application. A state also can establish policies that require hospitals to assist those individuals in completing the full Medicaid application.

- Hospitals must notify PE applicants of:
  - Their PE determination
  - The length of the PE period
  - If PE is denied, the reason for the denial and that a full, formal Medicaid application may still be submitted

- Hospitals must notify the state within 5 days of a PE determination

*ACA § 2202, § 435.1110*
What are State obligations under PE Regulations?

**States must:**
- provide qualified entities with the policies and procedures applicable to PE.
- provide qualified entities with the application forms for Medicaid and information on how PE entities should assist individuals in completing and filing such forms. (§ 435.1110(b)(2))
- identify those fields/information required for PE determination if regular Medicaid application is to be used.

**States may:**
- develop proficiency standards, trainings, and audits with which hospitals must comply.
- adopt policies that would require individuals to attest their immigration and residency status to a hospital before being given a presumptive eligibility determination. (§ 435.1102(d))
- impose corrective action for hospitals not following state policies or meeting established standards, including termination if other measures fail. (§ 435.1110(d)(1))

**States may not**
- require verification of any PE eligibility factors as a condition of PE
- impose other conditions on PE

Resources on Presumptive Eligibility

- July 15 Final Regulation:  

- Enroll America Toolkit:  
  [http://www.enrollamerica.org/toolkits/pe/home.html](http://www.enrollamerica.org/toolkits/pe/home.html)
Legal Issues for Certified Application Counselors

- Then Certified Application Counselor (CAC) program uses community-based organizations, including hospitals, to help enroll consumers in QHPs. ACA requires a CAC program in every state, regardless of whether an FFM, SBM or SFP.

- Hospitals that want to be involved in the CAC program must apply to become a CAC Designated Organization (CDO) and, in FFMs, must enter into a CDO contract with CMS. Key terms of the model CMS/CDO contract include:
  - One year term, with auto renewal.
  - Either party may terminate on 30 days’ notice
  - CMS can terminate on 14 days’ notice for breach
  - Services cannot be assigned or subcontracted
  - CMS can amend contract on 30 days’ notice. CDO can reject and terminated.
  - CMS has right to audit
  - CDO must certify at least one staff member or volunteer to serve as a CAC at the location

Legal Issues for Certified Application Counselors

- CDO must enter into written contract with each CAC (CMS has drafted model CDO/CAC contract) requiring CAC to:
  - Register and complete CMS approved CAC training
  - Disclose conflicts of interest with any QHP
  - Comply with privacy and security standards
  - Agree to act in best interest of applicants assisted
  - Inform consumers of the functions and responsibilities of a CAC
  - Obtain Authorization Form from each consumer (CMS has drafted model Authorization Form)
  - Maintain record of Form and permit consumer to revoke at any time
  - Not impose any fee on consumer
  - Prominently display her/his CAC certificate
  - Provide consumer with full range of QHP and Insurance Affordability Programs (No steerage)
Legal Issues for Certified Application Counselors

- CDO must establish procedures to:
  - Maintain a CAC registration process and method to track performance of CACs – must “screen” CACs
  - Oversee and monitor all CACs to ensure compliance with contractual responsibilities
  - Disclose all CAC conflicts of interest
  - Ensure all consumers are informed of CAC responsibilities
  - Establish procedures to withdraw certification of CACs who do not comply with terms of contract
  - Establish procedures to comply with the specific privacy and security standards developed for Consumer’s Personally Identifiable Information (PII)


Premium Subsidies

- **Issue**: Can hospitals subsidize payments for health plans purchased on the Exchanges for individuals in need of assistance?

- **Anti-Kickback Statute (AKS) Issues**
  - Conflicting views from HHS:

- **Tax-Exemption Issue**
  - Would the IRS view such payments as an acceptable form of “financial assistance” and “community benefit” or an impermissible “private benefit”?
Hospitals and PSOs Under ACA

“Section 1311. Affordable choices of health benefit plans. [Establishing state-based health insurance exchanges]

(h) Quality Improvement.—

(1) Enhancing patient safety.—Beginning on January 1, 2015, a qualified health plan may contract with—

(A) a hospital with greater than 50 beds only if such hospital—

(i) utilizes a patient safety evaluation system (PSES) as described in part C of title IX of the Public Health Service Act; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

Under Title IX, part C of the Public Health Service Act, PSES means “the collection, management, or analysis of information for reporting to or by a patient safety organization (PSO).”

• In early December 2013, CMS published proposed rules on a variety of issues related to the QHPs. The proposed rules, recognizing the amount of work that would be needed for hospitals to meet the January 1, 2015 deadline, delayed the January 2015 implementations date and proposed a phased-in approach through the use of temporary alternatives.

• In Phase One, hospitals, in lieu of full PSO participation, can qualify for QHP contracts by meeting the Medicare Conditions of Participation (either Medicare-certified or Medicaid-only). Phase One is intended to last two years or until further guidelines are issued.

The PSO proposed regulations can be found at:
Hospitals and PSOs Under ACA

• In the proposed rule, CMS requested comments on the following questions about Phase Two:
  – What core aspects should be included in hospital patient safety programs?
  – What should a comprehensive hospital discharge planning program require for each patient?
  – What health care quality improvement activities should be implemented by health care providers?
  – How can QHP issuers track patient safety information

• Hospital sector commented that there should be several options for complying with the PSES condition, not just contracting with a PSO.

New 501(r) Notices and Changes to 2013 Schedule H

• On December 30, 2013, the IRS issued two notices related to Section 501(r).

• As a reminder, Section 501(r) requires tax-exempt hospitals to:
  – Limit charges
  – Establish and disclose financial assistance policies
  – Abide by reasonable billing and collection requirements
  – Perform a community health needs assessment every 3 years.

• Notice 2014-2 confirms that tax-exempt hospitals may rely on both the proposed regulations issued on June 26, 2012 and those issued on April 5, 2013 pending the publication of final regulations or other applicable guidance.

• This Notice cleared up confusion regarding whether organizations could rely on both sets of proposed regulations.
New Section 501(r) Notices and Changes to 2013 Schedule H

- Notice 2014-3 contains a proposed revenue procedure that provides correction and disclosure procedures under which certain failures to meet Section 501(r) will be excused for purposes of Sections 501(r)(1) and (2)(B) (failure to meet the requirements of Section 501(c)(3)).

- Such will not apply to a failure that is willful or egregious, including a failure due to gross negligence, reckless disregard or willful neglect. A hospital’s correction/disclosure of a failure does not create a presumption that it was not willful or egregious.

- Even if a failure is excused for purposes of Sections 501(r)(1) and (2)(B), excise taxes could still apply.

New Section 501(r) Notices and Changes to 2013 Schedule H

- The proposed revenue procedure contains four correction principles:
  1. **Restoration of affected person** - To the extent reasonably feasible, each affected person should be returned to the position they would have been in had the failure not occurred.
  2. **Reasonable and appropriate correction** – Depending on the failure, there may be more than one reasonable and appropriate correction
  3. **Timing** - The correction should be made as promptly as is reasonable given the nature of the failure.
  4. **Implementation of Safeguards** – If the hospital has not established practices and procedures that are reasonably designed to achieve compliance with Section 501(r), such should be established as part of the correction.

- To the extent that a hospital’s practices and procedures comply with Section 501(r), but the practices or procedures failed, the hospital should determine if changes are needed to reduce the likelihood of the same failures recurring and to assure prompt identification and correction of any such failures.
New Section 501(r) Notices and Changes to 2013 Schedule H

• The proposed revenue procedure also requires a hospital to disclose failures on its Form 990, Schedule H in the year the failure is discovered. The disclosure must include:
  – A description of the failure, including type, date, number affected, $$ involved, cause;
  – A description of the discovery, including how it was made and the timing of the discovery;
  – A description of the correction made, including whether all persons were restored; and
  – A description of the revised or newly implemented practices and procedures.

• Minor and inadvertent omission and errors due to reasonable cause that are corrected in accordance with Section 1.501(r)2(b) of the 2013 proposed regulations are not failure to meet a requirement of Section 501(r) and do not need to be disclosed.

New Section 501(r) Notices and Changes to 2013 Schedule H

• On December 19th, the IRS posted draft instructions for the 2013 Form 990, Schedule H, with a link to provide comments. However, even though the key hospital associations filed comments, the draft became final shortly thereafter, with no changes.

• Most of the changes are fairly minor. However, there were two substantive changes to the Schedule H that are potentially problematic:
  – Schedule H now requires hospitals to net funds received as restricted grants against its community benefit expense. (Reversal of 5 year position.)
  – Now, to be able to check “Yes” to Schedule H, Part V, line 19, the hospital must not only have a written policy that requires compliance with EMTALA, but also have a policy that prohibits debt collection activities from occurring in the emergency department or in other hospital venues where such activities could interfere with the treatment of emergency medical conditions without discrimination.
Contraceptive Mandate Update

**LEGAL CHALLENGES to the HHS Mandate**

U.S. Supreme Court to hear Hobby Lobby and Conestoga

91 CASES FILED
Over 300 PLAINTIFFS
The Becket Fund for Religious Liberty led the charge against the unconstitutional HHS mandate. There are now a total of 91 cases.

FOR-PROFIT 46
NONPROFIT 45
CLASS ACTION 2

*Not indicates a case has been filed in that state.*

Source: http://www.becketfund.org/hhsinformationcentral/

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Contraceptive Mandate Update

**RULINGS ON THE MERITS**

FOR-PROFIT
- 33 Injunctions Granted
- 6 Injunctions Denied

NON-PROFIT
- 19 Injunctions Granted
- 1 Injunction Denied

Source: http://www.becketfund.org/hhsinformationcentral/

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