KING & SPALDING

Health Headlines

March 28, 2011

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Home Health Face-to-Face Encounter Requirement – Effective April 1, 2011, as a condition of payment for home health agencies, Medicare beneficiaries are required to see a physician 90 days before or 30 days after starting home health services. See 42 C.F.R. § 424.22(a). The face-to-face encounter must be performed by the certifying physician or by a nurse practitioner, a clinical nurse specialist, a certified nurse midwife, or a physician assistant (as authorized by state law) and document that the patient is in need of homebound services.

In the preamble discussion to the CY 2011 Home Health Prospective Payment System final rule, CMS stated that the goal of the requirement is "to achieve greater physician accountability in certifying a patient's eligibility and establishing a patient's plan of care. We believe these goals can be achieved better if the face-to-face encounter occurs closer to the HH start of care, increasing the likelihood that the clinical conditions exhibited by the patient during the encounter are related to the primary reason the patient comes to need HH care." 75 Fed. Reg. 70372, 70427 (Nov. 17, 2010).

The face-to-face documentation requirement is in addition to a physician's current responsibilities of prescribing home health care and verifying a plan of care (generally developed by the home health agency). Several entities within the home health agency community have expressed concern with the new rule due to the potential imposition on a patient to leave home for increased physician visits when one of the purposes of home health care is to cut back on such visits.

The final rule is available by clicking here.

Reporter, *Juliet M. McBride*, Houston, +1 713 276 7448, jmcbride@kslaw.com.

CMS Releases Preview of Meaningful Use Attestation Process for Medicare EHR Incentives Program; ONC Issues HIT Strategic Plan – On March 25, 2011, CMS announced on its Web site that the agency will begin accepting provider attestations of Stage 1 meaningful use measures on April 18, 2011. Eligible providers must attest that they have satisfied each meaningful use measure in order to qualify for Medicare EHR incentives under the HITECH Act. CMS has posted a series of screenshots that walk eligible providers through the attestation process. An eligible provider will be required to answer a series of questions attesting that the provider has met each meaningful use measure. Providers will make attestations in the form of a yes/no response, or by entering a numerator and denominator value for those measures that require providers to exceed a certain percentage threshold. Providers will submit attestations for all of the required "core measures" and five of ten "menu measures." After a provider submits all attestations, CMS will produce a "Summary of Measures" page informing the provider whether the attestations have been accepted. CMS's announcement states that a successful online submission through the attestation system will qualify a provider for incentives funding. The screenshots are available here.

Also on March 25, the Office of the National Coordinator for Health IT (ONC) released its Health IT Strategic Plan. The

Plan outlines ONC's goals for development of a national health IT infrastructure through 2015. Of note, ONC states that meaningful use criteria for Stages 2 and 3 of the Medicare and Medicaid Incentives Programs will focus less on process measures and more on clinical outcomes. Furthermore, ONC states that it is working with private payors to develop parallel EHR incentives programs to accelerate widespread EHR deployment. The Plan also emphasizes the development of real-time personal health records available to patients through provider web portals and other sources. ONC will accept comments on the Plan through April 22, 2011. The Plan is available for viewing by clicking here.

Reporter, *Christopher Kenny*, Washington, D.C., +1 202 626 9253, ckenny@kslaw.com.

GAO Report Identifies Alternatives to Individual Mandate – On February 25, 2011, the GAO issued a report that identifies several different alternatives to the individual mandate under the Patient Protection and Affordable Care Act (PPACA). Senator Benjamin Nelson had asked the GAO to identify potential alternatives to the individual mandate due to "the possibility that legislative or judicial action could result in a change to, or elimination of, the mandate." The report discusses nine different alternatives that would encourage, but not require, individuals to obtain private health insurance coverage. GAO interviewed 41 officials from 21 organizations in the healthcare field in connection with the report. The report notes that the alternatives are generally presented in the order of frequency they were discussed by the experts who were interviewed, and further notes that GAO does not recommend one approach over the other. The nine alternatives are:

- Modify open enrollment periods and impose late enrollment penalties
- Expand employers' roles in autoenrolling and facilitating employees' health insurance enrollment
- Conduct a public education and outreach campaign
- Provide broad access to personalized assistance for health coverage enrollment
- Impose a tax to pay for uncompensated care
- Allow greater variation in premium rates based on enrollee age
- Condition the receipt of certain government services upon proof of health insurance coverage
- Use health insurance agents and brokers differently
- Require or encourage credit rating agencies to use health insurance status as a factor in determining credit ratings.

A full copy of the report is available here.

Reporter, *Harry Richards*, Washington, D.C., +1 202 626 9126, jrichards@kslaw.com.

King & Spalding Assembles Healthcare Reform Task Force – King & Spalding has formed an interdisciplinary healthcare reform task force of over 40 lawyers and other professionals with expertise in the key legal issues affecting healthcare providers, manufacturers, pharmacies, investment banks, and employers of all types.

Our task force members who work with healthcare industry clients will collaborate actively with our employee benefits professionals in assessing the ways in which reform will affect the marketplace for healthcare services and insurance. They will bring their active involvement in physician and hospital services integration over the last 20 years, and more recent experiences such as supporting health information technology adoption, to assist healthcare providers of all types in preparing for payment reforms such as bundled pricing, medical homes and accountable care arrangements.

More information about King & Spalding's Healthcare Reform Task Force, including a listing of its working groups, is available by clicking here.

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Dennis M. Barry
dbarry@kslaw.com
+1 202 626 2959