Federal Update

December 24, 2009

HANYS
Healthcare Association
of New York State

Congressional Activity on Reform

Senate

Patient Protection and Affordable Care Act passed the Senate 12-24-2009.

House

Affordable Health Care for American Act passed the House 11-7-2009.

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Process

Senate

Approved reform bill on December 24

House

Approved reform bill on November 7

Option 1

Conference Committee: An informal House-Senate conference among Democratic leaders will reconcile differences between the two bills.

Final Passage of Consensus Bill: Consensus bill, or "Conference Report," developed by the conference committee will need to be passed by each chamber.

President's Signature: Consensus bill approved by both chambers sent to President for signature in early 2010.

Option 2

Alternatively, the Senate bill could be sent to the House for a vote. Any changes to it would be sent back to the Senate. The "ping-pong" would cease when the identical bill passed each chamber.

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Critical Issues to Achieving a House-Senate Compromise

- Public Plan
- Coverage levels
- Cost-containment
- Abortion
- Financing
- Access to coverage for undocumented individuals

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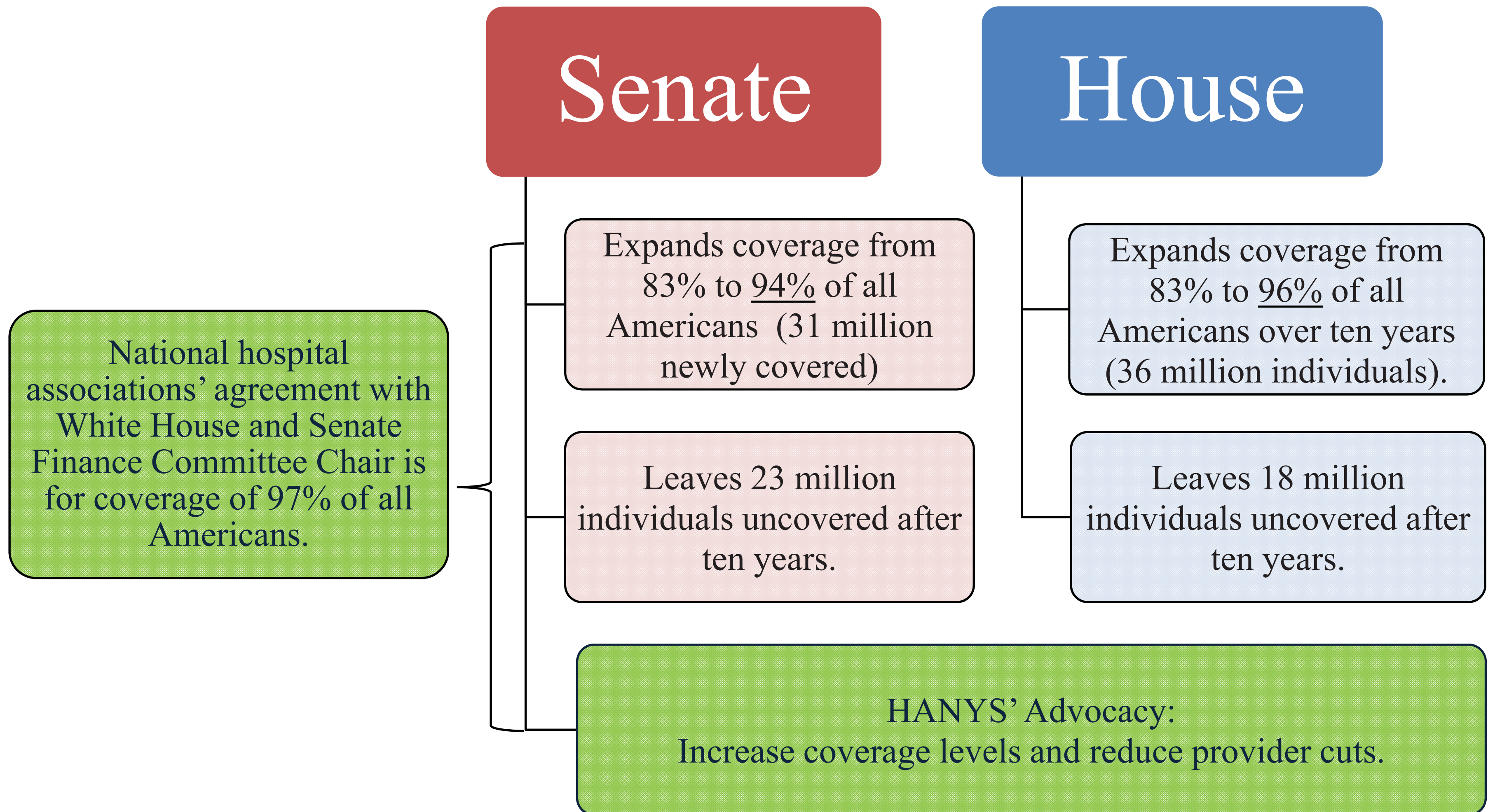
Comparing Reform Proposals

Coverage Expansion



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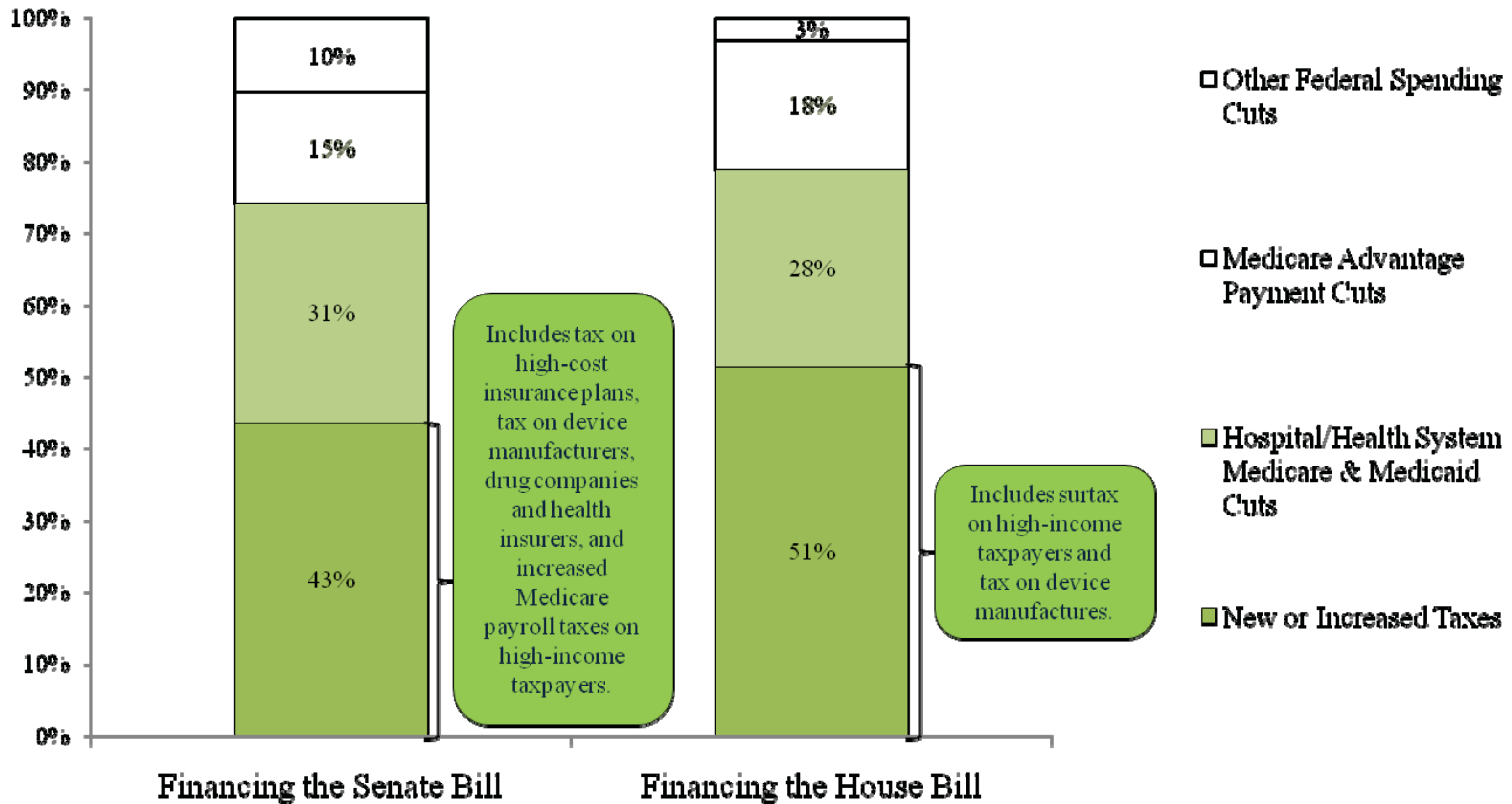
Coverage Expansion–How?

Health Insurance Exchanges	• **House**: National exchange. States can also establish exchanges. • **Senate**: State-based exchanges.
National Public Health Insurance Option	• **House**: Establishes national public plan with negotiated rates with floor tied to Medicare. • **Senate**: No national public plan. As an alternative, Office of Personnel Management (agency that oversees the Federal Employee Health Benefit Plan) to oversee a new system of national health insurance plans offered by private insurers, available via state exchanges.
Non-Profit Health Insurance Co-ops	• Established with federal start-up loans and grants.
Medicaid Expansion	• **House**: Up to 150% of Federal Poverty Level (FPL). • **Senate**: Up to 133% of FPL.
Subsidies	• Available to moderate-income Americans to buy insurance coverage in exchange (up to 400% FPL).
Employer and Individual Responsibility	• **House**: Individual and employer mandates. • **Senate**: Weaker individual mandate and employer responsibility.

Major Financing Components

Senate: Cost = $871 billion. Fully offset over ten years. *

House: Cost = $1.052 trillion. Fully offset over ten years. *



* Reflects gross cost of coverage expansions based on Congressional Budget Office (CBO) scores.

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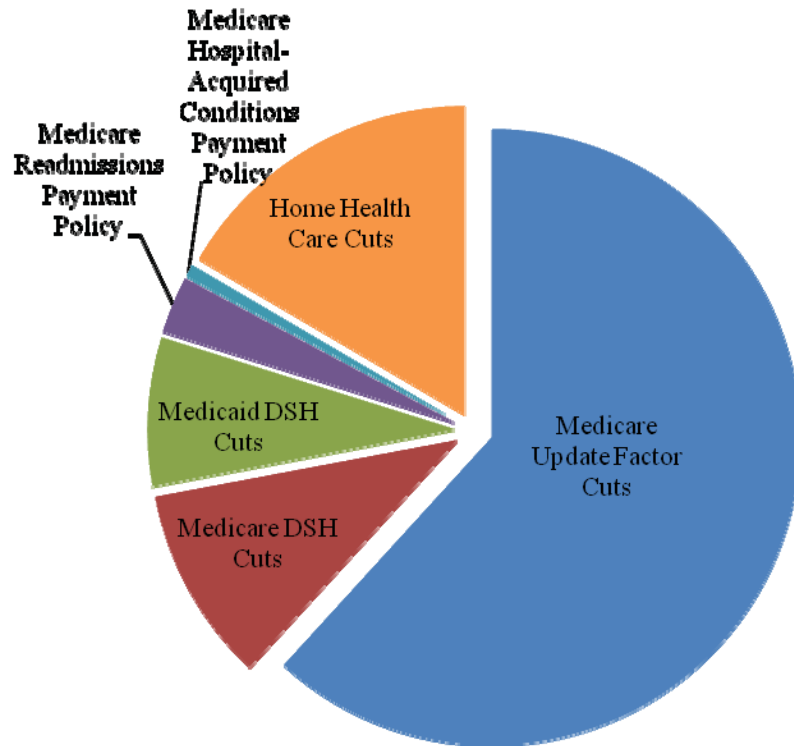
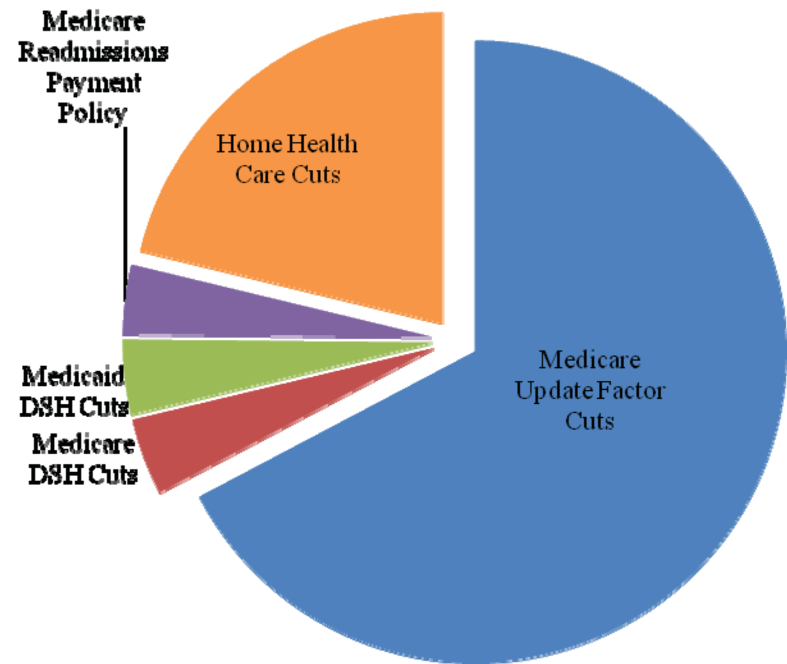
Hospital and Health System Reductions

Senate: $238 billion over ten years.

House and Senate are generally consistent on the level of inpatient hospital cuts, with approximately $155 billion in Medicare and Medicaid reductions over ten years—about $13 billion to New York State.

House: $258 billion over ten years. *





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Key Hospital and Health System Provisions

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Medicare Update Factor Reductions

Senate

- Update factor cuts to all care settings would begin in 2010.
- $147 billion in payment cuts over ten years.
- $8.0 billion in cuts to New York hospitals and health systems.
- Does not sunset.
- Does not protect updates from going below zero.

House

- Update factor cuts to all care settings would begin in 2010.
- $173 billion in payment cuts over ten years.
- $10.7 billion in cuts to New York hospitals and health systems.
- Does not sunset.
- Protects updates from going below zero.

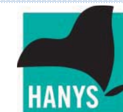
DSH Reductions

Senate

- Beginning as early as 2015, $43 billion in Disproportionate Share Hospital (DSH) payment cuts over ten years.
- $24.4 billion in cuts to Medicare DSH; $18.5 billion to Medicaid DSH. As much as $5.5 billion in cuts to New York hospitals.
- Medicare cuts tied to level of uninsured and "empirically" justified amount with portion of DSH funding maintained for hospitals with high levels of uncompensated care.
- Medicaid cuts triggered once a state reduces uninsured by 45%. Level of Medicaid DSH cuts would vary by state (either 17.5%, 25%, 35% or 50%) based on the amount of Medicaid DSH funding distributed to states and how much of its DSH allotment each state has spent over the past several years. DSH allotments could not fall below 50% of current levels.
- NY would face either 35% or 50% reduction.

House

- Beginning in 2017, $20 billion in DSH payment cuts over ten years. As much $2.6 in cuts to New York hospitals.
- Cuts split about equally between Medicare and Medicaid.
- Medicare cuts triggered by reduction in uninsured with portion of DSH funding maintained for hospitals with high levels of uncompensated care.
- Medicaid cuts tied to level of uninsured, uncompensated care and hospital Medicaid volume.



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Hospital Readmissions

Senate

- Beginning in federal fiscal year (FFY) 2013, $7 billion in cuts over ten years ($800 million to New York hospitals).
- Would reduce Diagnosis Related Group (DRG) payments for Prospective Payment System (PPS) hospitals with higher than anticipated readmission rates.
- 30-day window.
- Does not differentiate between unplanned readmissions related to the initial readmission and all other readmissions.
- Establishes assistance program for hospitals with high readmissions.

House

- Generally the same as the Senate, but would begin in FFY 2012 and would apply to Critical Access Hospitals (CAHs), $9 billion in payment cuts over ten years. ($1.1 billion to New York hospitals).

Hospital Value-Based Purchasing

Senate

- Beginning in FFY 2013, would establish a budget-neutral program for all PPS hospitals.
- Would establish demonstration project to test value-based purchasing (VBP) model for CAHs.
- Up to 2.0% of Medicare inpatient hospital payments would be reallocated based on quality performance.
- Efficiency measures to be added (approach to address geographic variation in spending).
- Prohibits use of readmissions measures.

House

- No provision.

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Geographic Variation

Senate

- Would require the inclusion of efficiency measures in new inpatient hospital VBP purchasing by FFY 2014.
- Measures must include Medicare per-beneficiary spending.
- Efficiency measures must be adjusted for age, sex, race, severity of illness, and other factors the Secretary of Health and Human Services (HHS) deems appropriate.

House

- Based on findings from an Institute of Medicine (IOM) study, the HHS Secretary must develop a plan to implement a budget-neutral application of a "value index" to Medicare payments by 2013.
- IOM is to include numerous input prices in its analysis of variations in spending, volume, and intensity of services.
- Congress would have no authority to modify the proposal in any way.
- Proposal would become effective unless Congress passed a joint resolution to reject it; resolution subject to Presidential veto.

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Wage Index

Senate

- Would require HHS Secretary to report to Congress by 2012 on plan to comprehensively reform the hospital wage index system.
- Would establish, with new funding, a hospital wage index floor of 1.0 for inpatient and outpatient services and a practice expense floor of 1.0 for physicians in "frontier" states (Montana, Nevada, North Dakota, South Dakota and Wyoming).

House

- Changes to the hospital wage index/physician Geographic Practice Cost Index (GPCI) based on IOM study.
- Up to $8 billion in new funding may be made available in 2012 and 2013.
- Budget-neutral changes based on IOM study in 2014 and thereafter.

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Graduate Medical Education (GME)

Senate

- No cuts to GME payments to hospitals.
- Program enhancements for counting residency time in non-hospital settings.
- Redistributes unused Medicare-funded residency slots.
  - Redistributes 65% of currently unused training slots.
  - Priority order for redistribution would be given to hospitals located mainly outside of New York State.

House

- Generally the same as the Senate.
- Would redistribute 90% of currently unused residency slots.

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Independent Payment Advisory Board

Senate

- Would establish IPAB to submit proposals to Congress and the President beginning in 2015 to reduce Medicare spending by targeted amounts (0.5 percentage point reduction in 2015 increasing to a 1.5 percentage point reduction in 2018).
- Congress could modify or pass an alternative to the proposals, but would be required to maintain the targeted level of Medicare savings for the year.
- IPAB's original proposal would be implemented if Congress does not consider the board's proposal.
- Excludes targeting reductions to hospitals for ten years.
- IPAB to make non-binding recommendations on system wide costs.

House

- No provision.

501(c)(3) Tax-Exempt Status

Senate

- Would not establish thresholds hospitals must meet to attain or maintain tax-exempt status.
- Would establish the following additional criteria in order for hospitals to maintain their tax-exempt status:
  - Implementation of strategies to meet community needs based on the findings of periodic health needs assessments;
  - Adoption of financial assistance policy with criteria to qualify, basis for payment, collection policies defined;
  - Limitation of charges for those who qualify for financial assistance to not more than the amounts generally billed to those with insurance, and prohibits the use of gross charges; and
  - Requirement that 501(c)(3) hospitals not engage in extraordinary collection actions.
- In addition to needing to meet all four reporting requirements to maintain tax-exempt status, a $50,000 excise tax would apply if a hospital fails to meet the community health plan requirements.

House

- No provision.

340B Drug Discount Program

Senate

- **340B Expansion**
  - Would expand the 340B drug discount program to inpatient drugs.
- **340B Extension**
  - Beginning January 1, 2010, would extend access to 340B program to certain:
    - CAHs, Sole Community Hospitals (SCHs), and Rural referral Centers (RRCs).
    - Children's hospitals.
    - Cancer hospitals.

House

- **340B Expansion**
  - No provision.
- **340B Extension**
  - Same as Senate, but would begin upon enactment and include in the program extension, Medicare-Dependent Hospitals (MDHs).

State Fiscal Relief

Senate

- No provision

House

- Would extend for six months the temporary increase to the Federal Medical Assistance Percentage (FMAP) provided in the federal stimulus bill.
- $3.4 billion in additional federal funding to New York State ($23.5 nationwide).
- *Similar extension--in addition to extension approved in House reform bill– approved by House in jobs bill prior to December recess. Senate action next year.*

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Key Hospital and Health System Pilots and Demonstrations

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Medicare Payment Bundling

Senate

- Would establish a five-year, national pilot program for bundling payments by 2013. The HHS Secretary could extend program if costs are reduced and quality maintained.
- Participation would be voluntary.
- An entity comprised of providers including a hospital, physician group, skilled nursing facility, and home health agency could submit an application to join the pilot program.
- The bundled payment would be for all acute and post-acute services three days prior to hospital admission and extend through 30 days following discharge for eight conditions.
- The HHS Secretary would develop the bundled payment rates and could test payments based on bids submitted by the entities.
- Establishes a separate continuing care hospital (CCH) bundle pilot.

House

- Would expand the current, voluntary, Acute Care Episode (ACE) bundled payment demonstration by 2011. (The ACE demo is testing bundled payments for a limited number of procedures and includes only hospitals and physicians.)
- Participation would be voluntary.
- Would require the expansion to include additional sites, geographic areas, conditions, and post-acute care providers.
- HHS Secretary would have authority to expand the demonstration, if it is determined the program improved quality and reduced costs.
- Would require the HHS Secretary to develop a plan for bundling payments for post-acute services and must consider how and whether to include acute care hospitals and physicians in the bundle.

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Accountable Care Organizations (ACOs)

Senate

- Would establish a voluntary, national pilot program in 2012 that would allow groups of providers to be recognized as ACOs.
- Hospitals could take the lead in formation an ACO.
- Hospitals and other providers of the ACO could share in Medicare cost savings they achieve.
- The Secretary would reset spending benchmarks after three years.

House

- Would establish a voluntary, national pilot program by 2012 that would allow groups of physicians to be recognized as ACOs.
- Hospitals cannot take the lead in forming an ACO.
- Hospitals and other providers <u>must be affiliated</u> with the physician group to participate and share cost savings.
- CMS would have the authority to allow ACOs to continue as long as they are improving quality and maintaining costs or reducing costs while maintaining quality.

Medicaid Payment Demos

Senate

- The HHS Secretary would be authorized to conduct the following Medicaid demonstrations:
  - Medicaid bundled payment demonstrations to evaluate integrated care around a hospitalization in up to eight states.
  - Medicaid global payment demonstrations for safety net hospitals in up to five states.
  - Pediatric ACO demos.
  - Medicaid emergency psychiatric demonstrations.

House

- The HHS Secretary would be authorized to conduct the following Medicaid demonstrations :
  - Medical home pilot.
  - ACO pilot.

Center for Medicare and Medicaid Innovation

Senate

- Would provide funding to establish within CMS, a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services.
- After testing, the HHS Secretary could expand the scope and duration of a model.
- Allows the Secretary to limits test of innovative payment and service delivery models within certain geographic area.

House

- Generally the same as the Senate but would slightly different funding levels.

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Additional Provisions in House and Senate Bills

Medicare hospital-acquired conditions reporting and payment policy.

- $1.5 billion in savings and would require the Secretary to publicly report on measures for hospital-acquired conditions that are currently utilized by CMS (Senate only).

Extension of special Section 508 legislative Medicare wage index reclassifications.

- One-year extension and requires CMS to recalculate the wage index values for these hospitals (Senate) / Two-year extension (House).

Extension of outpatient hold-harmless payments to hospitals located in rural areas with 100 or fewer beds and SCHs.

- One-year extension (Senate) / Two-year extension (House).

Medical liability reform.

- Modest proposals that would provide grant funding to states to encourage alternatives to the current civil litigation system.

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Key Issue Not Fully Addressed in Reform: Medicare Physician Payment Cut

21.5% physician Medicare payment cut scheduled for March 1, 2010.

Cost of a permanent, payment formula fix = $239 billion over ten years.

House: Removed physician fix from health reform bill, the cost of which needed to be offset. Instead, House has passed freestanding legislation to provide a permanent fix with no spending offsets and has also approved a short-term 60-day fix as part of Defense Appropriations bill.

Senate: Majority Leader Harry Reid has removed one-year physician fee fix from the Senate health reform bill. Not enough votes in Senate to approve freestanding legislation that is not offset. Senate has approved the short-term 60-day fix included in the Defense Appropriations bill.

Permanent fix likely to prove elusive. Expect a short-term fix included in health reform bill.