The Federal Landscape

After Fixing SGR, What’s Next in DC?

MO and IL HFMA Chapters
May 13, 2015
St. Louis, MO
Presentation Overview

• The Setting in DC

• The SGR Fix

• Other Federal Advocacy Agenda for Hospitals
Welcome to day 544...

...of the 2016 election season...

(see http://www.270towin.com/2016-countdown-clock/)
Presidential Candidates:

...Republican: 19?
Ted Cruz*
Rand Paul*
Marco Rubio*
Jeb Bush
Chris Christie
Carly Fiorina
Lindsey Graham
Bobby Jindal
John Kasich
George Pataki
Rick Perry
Rick Santorum
Democratic Presidential Candidates:

...Declared: Sec. of State and former U.S. Sen. Hillary Clinton; and Sen. Bernie Sanders (D-VT)
Potential Democratic Presidential Candidates

Lincoln Chafee, Gov of RI
Martin O'Malley, Gov of MD
Jim Webb
Joe Biden
Bernie Sanders
Paul Strauss, Sen. DC
Jack Markell
Chris Murphy
Janet Napolitano
Brian Schweitzer
Meanwhile...

...a Republican-controlled Congress is open for business; ...the Supreme Court works on King v Burwell; and ...SGR bill gets passed!
3/26 (vote of 392 v 37), the House passed a bill to permanently replace the Medicare physician sustainable growth rate (SGR) formula.

4/14 (92 v 8), the Senate passed the same bill.

4/17, President Obama signs the bill.
Modern Healthcare’s Cover Photo...
Key Provisions of HR 2

- Cost: $210 billion with offset of only $70 billion
  - Reductions to payments to hospitals other providers
  - Limiting coverage under Medigap plans to costs above the Part B deductible starting 2020
  - Means-testing premiums for Parts B and D
HR 2 rejects…

- Reductions to:
  - Outpatient hospital services (so-called “site-neutral” cuts);
  - Medicare bad debt payments; and
  - Graduate medical education;

- Rejects:
  - Changes to critical access hospital program;
  - Changes to certain services provided in inpatient rehabilitation facilities;
  - Further delays to the ICD-10 program; and
  - Changes to current law related to physician-owned specialty hospitals.
Critical provisions impacting hospitals

- Adjustment to Inpatient Hospital Rates
- Post-acute Care Provider Market Basket Reductions
- Medicaid Disproportionate Share Hospital (DSH) Changes
- Adjustments to Physician Payment Rates
- Extensions of Certain Programs
- Interoperability of EHRs
- Other Provisions
Adjustment to Inpatient Hospital Rates

- Instead of restoring the entire 3.2% FY 2018, this legislation restores 3% over 6 years.
- Therefore, hospitals will receive over 90% of the amount due over a longer period.
- Also, prevents a 0.55% offset for the cumulative documentation and coding effect through FY 2010.
Post-acute Care Provider Market Basket Reductions

- One percent update in FY 2018 to long-term care hospitals, inpatient rehabilitation facilities, home health agencies, skilled-nursing facilities and hospices
- Updates fully replace the current law updates, i.e., not subject to additional productivity or other reductions
Medicaid DSH Changes

• Eliminates Medicaid DSH cuts in FY 2017 (the first year in which the program is currently scheduled to be reduced)
• Lowers the Medicaid DSH cuts in current law in Fys 22018 through 2020
• Increases the Medicaid DSH cuts in current law in FYs 2021 through 2024
• Extends Medicaid DSH cuts into FY 2025
Adjustments to Physician Payment Rates

• 0.5 % update through 2019 and a 0 percent update from 2020 through 2025 for physicians and other health care professionals under the physician fee schedule
• After 2025, physicians and professionals who participate in a qualifying alternative payment model, such as the Medicare Shared Savings Program, would receive an annual update of 1% while all other physicians and professionals would receive an annual update of 0.5 %
• Consolidates the current-law physician quality reporting system, EHR, and value-based modifier programs into one
• Incentivizes care coordination efforts for patients with chronic care needs
• Expands the use of Medicare data for transparency and quality improvement
• Partial enforcement delay of Medicare’s “two-midnight” policy through Oct. 1, 2015
• Medicare-dependent Hospital program through Oct. 1, 2017
• Rural low-volume adjustment through Oct. 1, 2017
• Children’s Health Insurance Program through Oct. 1, 2017
• Ground ambulance add-on payments, including for “super rural” areas through Jan. 1, 2018
• Outpatient therapy caps exceptions process through Jan. 1, 2018
• Home health rural add-on through Jan. 1, 2018
• Physician work geographic practice cost index (GPCI) floor through Jan. 1, 2018
Interoperability of EHRs

- Bill declares interoperability of EHRs a national objective and establishes an expectation that the country will achieve widespread interoperability by Dec. 31, 2018.

- Outlines policies to further interoperability including prohibitions against “information blocking” by providers, as well as secretarial discretion to increase meaningful use penalties and decertification of EHRs if widespread interoperability is not achieved.
Other Provisions

- Remove “gainsharing” civil monetary penalty (CMP) barrier created by OIG thereby assuring that hospitals and physicians can work together to provide “medically necessary” services to improve patient care without the threat of a CMP.
- $60 M in each of FYs 2016 and 2017 for the Teaching Health Center Program which expanded residency training in community-based settings and was set to expire at the end of FY 2015.
- Requiring each Medicare Administrative Contractor to establish a program to educate providers and suppliers about ways to reduce improper payments and attempts to encourage greater reporting by individuals of fraud and abuse in the Medicare program by enhancing the incentives or rewards for doing so and extending the program to encompass Medicaid as well as Medicare.
Hospital issues beyond SGR

- Offset to other programs
  - Sequestration cushions

- Political protection for extending the debt limit

- Life of trust funds

- Entitlement reform
• GOP sets congressional agenda:
  – Still need 60
  – But, only need 50 for budget mandating reconciliation process (platform for reforms?)
    ➢ Tax policy
    ➢ Entitlement reform
    ➢ Deficit reduction
    ➢ ACA repeal
Continued attacks on ACA

• No consensus
  – Incremental:
    ➢ Repeal medical device tax
    ➢ Change definition of full-time employee
    ➢ Repeal IPAB
      ❑ Has Democrat support
    ➢ Delay employer mandate
    ➢ Repeal individual mandate
    ➢ Repeal restrictions on physician-owned hospitals
  – Comprehensive repeal of ACA, but no GOP alternative
President’s Budget

Key Medicare Provisions

• Cancel sequester
• Strengthen IPAB (-$4.1 billion)
• Hospitals (and hospital related)
  – Reduce bad debt to 25 percent (-$25.5 billion)
  – Reduce GME (IME) payment by 10 percent (-$10.9 billion)
  – Critical access hospitals
    ➢ Reduce payment from 101 to 100 percent of cost (-$1.43 billion)
    ➢ Eliminate designation for hospitals located fewer than ten miles from nearest hospital (-$690 million)
  – Reduce update factors for SNFs, LTCHs and IRFs (-$70 billion)
  – Implement site-neutral payments for certain procedures treated in SNFs and IRFs (-$1.95 billion)
  – Raise 60 percent IRF threshold back to 75 percent (-$2.5 billion)
  – Waste, fraud and abuse (-$400 million)
President’s Budget

Key Medicare Provisions

• “Other providers”
  – Rx reimbursement reductions ($-140 billion)
  – Medicare Advantage ($-20 billion)
  – Reduce SNF payments for readmissions ($-2.21 billion)
  – Bundle post-acute care payments ($-8.1 billion)
  – Modernize clinical laboratory payments ($-9.4 billion)

• Beneficiaries
  – Increase Part B and D premiums related to income: ($-53 billion)
  – Encourage use of generic Rx ($-6.7 billion)
  – Discourage seniors from purchasing first-dollar coverage/Medigap ($2.9 billion)
  – Home health copayments ($-739 million)
Key Medicaid Provisions

- **No** F-FMAP blending
- **No** restrictions on provider assessment programs
- Delay DSH cuts for one year
- "Rebase" Medicaid DSH in 2023 (-$3.6 billion)
- Improve Rx rebates (-$8.8 billion)
- DME payment limitations (-$4.4 billion)
- Waste, fraud and abuse (-$3.6 billion)
President’s Budget

Other Key Health Provisions
(Discretionary – FY 2014)

• Reduce Graduate Children’s Medical Education by $177 million
• Reduce Hospital Preparedness program by $125 million
• Reduce Rural Hospital Flexibility grant program by $15 million
• Additional $235 million for mental health services
Next fiscal cliff

June 2015

Debt Limit Extension

THE UNITED STATES WILL RUN OUT OF MONEY

DEBT CEILING AHEAD
Other AHA Advocacy

- DSH payment
- RAC relief (litigation)
- Two midnight enforcement (September 30, 2015)
  - CAH 96 hour rule
- Readmissions adjustment (socioeconomic)*
- HAC penalty program changes*
New challenges

340B “Mega-rule”

- Hospital eligibility
- Patient definition
- Contract pharmacy
- Drug diversion
- GPO exclusion

www.aha.org

AHA Advocacy Alliances™
Meanwhile: King V Burwell

Section 1321 provides that if a state does not establish an exchange under Section 1311, ...HHS “shall...establish and operate such exchange within the state.”

DEPENDS ON WHAT THE MEANING OF THE WORD “SUCH” IS

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
At stake: Subsidies

Here’s Where People Could Lose Their HEALTH INSURANCE SUBSIDIES

KEY:  
- States that use Healthcare.gov, the federal health insurance marketplace. People in these states are at risk of losing the subsidies they receive through the ACA. (36 states)
- States where the state runs the health insurance marketplace. (14 states)

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
Decision

• Late June
• Then what?!
  • Timing?
  • Plan B?
Potential next steps

- ACA political negotiation?
- Switch to state exchange
- Other workarounds
Beyond the decision…

• Communications activities

• Tool kit to members
  – Directing actions via state associations (where appropriate)
Top AHA Priorities

Regulatory Radar Screen

• Ebola funding
• RAC reform
• Two mid-nights alternative
  – CAH 96 hour rule
• Shaping 340B “mega-rule”
• ACO/MSSP
• Medicare Advantage
• Physician supervision
• Moving forward on ICD-10
• IT meaningful use
• VA Choice program implementation
Moving to Value

• Triple Aim:
  – Better Care
  – Smarter Spending
  – Healthier People

• Moving from volume to value
  – Pay-for-performance initiatives
  – Alternative payment models

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- 2016:
  - 85% FFS linked to quality (Categories 2-4)
  - 30% Alternative payment models (Categories 3-4)

- 2018:
  - 90% FFS linked to quality (Categories 2-4)
  - 50% Alternative payment models (Categories 3-4)
CMS’ Framework

Traditional FFS

Value-Based (Link to Quality)
- Hospital VBP
- Physician VM
- Readmissions
- HACs
- Quality Reporting

Alternative Delivery Models
- ACOs
- Medical homes
- Bundled payment
- Comprehensive Primary Care initiative
- Comprehensive ESRD

Population Health/At Risk
- Eligible Pioneer ACOs in years 3-5
- Maryland hospitals

Volume ➞ Value
HHS Health Care Payment Learning and Action Network

- Forum for stakeholders to discuss move to alternative payment models
- Independent contractor will convene meetings, disseminate information to Network participants, and lead learning sessions where participants can share best practices
AHA Governance Poll: Please indicate the approximate percentage of your organization's net patient revenue for each of the following payment mechanisms (N= 191 responses)

- Fee for Service - DRG, Per Diem or Percent of Charges: 88%
- Fee for Service plus shared savings: 8%
- Bundled payments (inpatient plus physician or inpatient, physician and post acute): 2%
- Partial and Global capitation payments: 5%
What are the challenges in moving towards a new payment system that rewards better value, efficiency and integrated care? (N= 191 responses)

- Do not have the systems (information technology, financial, data, etc.) in place or competencies for operating successfully in a new payment model: 32% of respondents rate this as a major challenge, while 24% rate it as less of a challenge.
- Infrastructure cost is too high for implementing new payment model: 34% of respondents rate this as a major challenge, while 15% rate it as less of a challenge.
- Payers are not willing to move to new payment models: 27% of respondents rate this as a major challenge, while 15% rate it as less of a challenge.
- Do not have sufficient population to operate in a new payment model: 20% of respondents rate this as a major challenge, while 20% rate it as less of a challenge.
- Do not have or have access to physician delivery arrangements that would successfully operate in a new payment model: 24% of respondents rate this as a major challenge, while 14% rate it as less of a challenge.
- Do not provide enough scope of services to operate in a new payment model: 17% of respondents rate this as a major challenge, while 10% rate it as less of a challenge.
What are challenges not listed above that you think are significant? (Common themes)

- Model poses difficulties because of our type of facility (for example, Rural, CAH, Rehabilitation, low population).
- Financial concerns and risks the facility takes on, associated with a new payment model.
- Insufficient access to data; including patient data and data to make informed decisions about risk and benefits.
- Uncertainty with future of the Affordable Care Act.
- Cultural shift in a consumer directed environment is difficult.
- Patient/consumer involvement, cooperation, and compliance to their health and outcomes is challenging.
- There is a lack of education, understanding, and buy-in of the model, both internally and externally.
ACOs

• CMS Medicare Shared Savings Program (MSSP) began in 2012
  – Lots of interest
  – Not much shared savings
  – Few organizations taking downside risk

• Proposed Rule in Dec. 2014
ACOs

AHA Advocacy Positions

• Better balance risk vs. reward
• Modify assignment process to better account for where beneficiaries are receiving primary care
• Adopt payment waivers for ALL ACOs
• Modify ACO targets so they do not have to compete against their own best performance to generate savings
• Provide better and timelier data
BPCI program began in 2013
Lots of interest; not a lot of participation
  – Model 1: Acute care hospital/gainsharing
    • 15 participants/providers
  – Model 2: Acute care hospital + physician + PAC
    • 60 participants/112 providers
  – Model 3: PAC only
    • 20 participants/106 providers
  – Model 4: Acute care hospital + physician
    • 10 participants/providers
• Health care field undergoing dramatic change
• Moving from volume to value
• Pressure to innovate and redefine payment and care delivery
• Transition period
  – Many starting points
  – Many potential paths
  – Many potential speeds
1. **Redefine** to a different care delivery system (i.e., more ambulatory or long-term care oriented)

2. **Partner** for greater horizontal or vertical reach, efficiency and resources for at-risk contracting (i.e., through a strategic alliance, merger or acquisition)

3. **Integrate** by developing a health insurance function or services across the continuum (e.g., behavioral health, home health, post-acute care, ambulatory care)

4. **Experiment** with new payment and care delivery models (e.g., bundled payment, accountable care organization or medical home)

5. **Specialize** to become a high-performing and essential provider (e.g., children’s hospital, rehabilitation center)
Inner City Urban Hospitals

- Often serve as medical safety net
- May be independent, private
- Typically have unfavorable payer mix
- Face many social challenges
- Often struggle financially
- Provide services community depends upon
Rural Hospital Challenges

- Older population
- Greater percent living in poverty
- Low-patient volumes
- More outpatient, SNF & home health
- Limited workforce
- Lack of access to capital
- On average, 60% hospital revenue is from public programs, that underpay

But typically largest employer
AHA Behavioral Health Task Force

Recommendations

Six areas of focus

– Community Needs Assessment
– Hospital Behavioral Health Plan
– Community Collaboration
– Adequate Financing
– Employer Practices
– Advocacy
Let’s De-stigmatize Mental Illness

Rich Umbdenstock, AHA President and CEO

Mental illness and addictive disorders are all too common in every community. They cause suffering in the adults and children affected and their families, and they have a significant economic and social impact. Treatment works, but the stigma often associated with behavioral health disorders keeps people from getting the care they need. With local collaboration, hospitals can play a central role in building understanding and awareness and increasing access to behavioral health services. This week, I sent a letter to the White House that describes some of the innovative collaborations of our hospitals to address this issue. Please add your stories to the case examples we have compiled so we can continue to learn from one another and remove the obstacles that keep our neighbors from seeking behavioral health care.
This toolkit is a user-friendly “how-to” guide to help accelerate the elimination of health care disparities and ensure our leadership teams and board members reflect the communities we serve.

Whether your organization is beginning this journey or is already deeply engrained in this work, the compendium was created in response to your many requests to gather best practices in one convenient resource.

www.equityofcare.org
After the SGR fix, what’s next in DC?

Kim Byas, Sr., PhD, MPH, FACHE
Regional Executive
312-422-2885
kbyas@aha.org