Repeal of health care reform

- Republicans needed to follow-thru on campaign promise... and take the vote
- Largely symbolic
- Passed House
- Didn’t have 60 votes in the Senate
  - FAA reauthorization bill
Repeal of health care reform

- Republicans needed to follow-thru on campaign promise...and take the vote
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- Doesn’t have 60 votes in the Senate
- President would veto anyway
Republicans needed to follow-through on campaign promise...and take the vote

- Largely symbolic
- Passed House
- Doesn’t have 60 votes in the Senate
- President would veto anyway

- Next Steps
A Plan to Repeal & Replace the Government Takeover of Health Care

- We will repeal the job-killing health care law
- We will replace it with real reforms, with a plan to:
  - Enact medical liability reform
  - Grant consumers the freedom to purchase coverage across state lines
  - Expand Health Savings Accounts
  - Strengthen the doctor-patient relationship
  - Ensure access for those with pre-existing conditions
- We will permanently prohibit taxpayer funding of abortion
Republican health reform

• Camp Bill

• Key Elements
  – Tax credits for individuals and small business to encourage coverage
  – Health insurance reforms
  – Purchasing health insurance across state lines
  – High risk insurance pools
  – Expansion of health savings accounts
  – State innovation grants
  – Medical liability reform

Rep. Dave Camp (R-MI)
Chairman
Ways and Means Committee
Health for Life

Focus on Wellness. Good health – physical, mental and oral – is essential for a productive and vibrant America. A focus on wellness must be integrated into the lifecycle, from birth to death and be encouraged in our homes, schools, workplaces and communities.

The Most Efficient, Affordable Care. America will not be satisfied until and until the cost of insurance and the cost of health care are affordable.

The Highest Quality Care. Motivates doctors, nurses, hospitals, nursing homes and others to work together and team up with patients and families to make sure the right care is given at the right time and in the right setting.

The Best Information. Good information is the gateway to good care.

Health Coverage for All. Paid for by All. Health coverage for all is a shared responsibility. Everyone – individuals, business, insurers and governments – must play a role in both expanding coverage and paying for it.

Within each element, the framework contains a set of initiatives that – over the span of several years – will improve our nation’s health care system by fundamentally reshaping care delivery and realigning incentives. Some improvements will require changes in public policy – in the laws and regulations that shape how care is provided. Others can be made today through the leadership and commitment by hospitals, physicians, and other providers... and hundreds of efforts are underway. AHA’s Hospitals in Pursuit of Excellence initiative provides a growing portfolio of resources to accelerate the transformation of care and work to achieve excellence in clinical, operational and financial performance.

In July 2007, AHA’s leadership approved this framework for sharing, discussion and further modification. Health for Life continues to embrace our guiding principles for necessary changes to achieve better health and health care in America and will continue to be the standard by which we judge any legislative or regulatory efforts to transform the health care delivery system.

Focus on Wellness
- Invest in the provision of primary care services
- Promote healthy pregnancies and newborns
- Invest in America’s public health
- Provide incentives to encourage healthy choices and behaviors
- Provide a national investment in school and community-based health
- Call for a national media campaign focusing on healthy lifestyles
- Provide support and coaching needed to change unhealthy behaviors
- Enhances health professionals education to include a focus on wellness
- Focus on chronic care management
- Create an objective, trusted source of consumer health information and education

Most Efficient, Affordable Care
- Simplify the working of public and private insurance
- Create a better alternative to today’s liability system
- Test payment redesign to reward quality providers who follow recommended “best practices”
- Redesign roles for workers to meet future care needs
- Renovate the education of health care professionals and the broader health care workforce
- Make available to consumers meaningful information on the quality, price, use and comparative effectiveness of health care services
- Analyze the comparative effectiveness, risks and benefits of new technologies, medicines, practices and procedures for individual conditions
- Expand educational capacity and emphasize early math and science learning to meet current and future health care workforce needs
- Test payment redesign to give provider groups a single amount to manage the entire episode of a patient’s care and better coordinate care
- Adequately fund national performance improvement measurement

Highest Quality Care
- Modernize laws and regulations to allow doctors, hospitals and others to work together in teams or “networks”
- Create a national investment to research the best evidence in patient care and effective quality improvement strategies; develop methods for spreading the adoption of these methods within the field
- Clinical integration
- Integrate physical and mental health care delivery
- Expand options for end-of-life care at home
- Require everyone to complete, and providers to honor, a summary of wishes regarding life-sustaining treatment
- Adequately fund national performance improvement measurement
- Redesign coverage and payment to guarantee party
- Reduce health disparities and inequity in health care delivery

Best Information
- Speed the creation of electronic health records and personal health records by selecting and using “interoperable” health standards
- Drive the secure exchange of clinical information among and across different providers of care
- Encourage private sector creation and use of unique, confidential health information identifiers to accurately and securely link patients to their health records
- Fundamentally reform the payment model to encourage specific IT adoption by health care professionals and hospitals
- Provide incentives for health care suppliers and insurers to enable the use of IT
- Conduct research and development of the market requirements and business models needed to create the next generation of systems and technologies
- Allow providers and community partners to share information exchange capabilities
- Establish national models for data use that will facilitate community health improvement

Health Coverage for All, Paid for by All
- Every individual must have and contribute to the cost of health care coverage
- Every employer must take responsibility for providing health care coverage for their employees and contribute to the cost
- Every insurer must guarantee access to coverage that is affordable, gives consumers the protection they need and delivers value
- Governments must maintain their current responsibility for coverage for seniors, disabled and certain low-income people
- Collective financing will be needed

For more information, visit Health for Life at www.aha.org.
ACA strategic directions

- Coverage
- Insurance reforms
- Delivery system reforms
- Payment reforms
- Transparency
- IT

What is NOT in the law

- Movement away from fee-for-service...toward 'integration'
- Emphasis on value vs. volume
- Emphasis on quality vs. quantity

American Hospital Association
ACA strategic directions

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- Accountable care organizations
- Bundling
- Medical homes
- Gain-sharing
- Value-based purchasing
- Comparative effectiveness
- Performance improvement
- CMS Center for Innovation
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What is NOT in the law

FEDERAL RATE REVIEW

- Movement away from fee-for-service...toward ‘integration’
- Emphasis on value vs. volume
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## Coverage Model

<table>
<thead>
<tr>
<th>Employer Provided Health Coverage</th>
<th>State Health Exchanges (Private Plans)</th>
<th>Public Programs</th>
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<td>Medicare</td>
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Coverage

“Shared Responsibility”

• Employer responsibility
• Individual responsibility
• Taxpayers
• Providers
• Other stakeholders
ACA strategic directions

- Coverage
- Insurance reforms
- Delivery system reforms
- Payment reforms
- Transparency
- IT

What is NOT in the law

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- Accountable care organizations
- Bundling
- Medical homes
- Gain-sharing
- Value-based purchasing
- Comparative effectiveness
- Performance improvement
- CMS Center for Innovation
What is NOT in the law

• No new public program
• No requirement that private insurance plans in state insurance exchanges pay Medicare or Medicaid rates
• No expansion of Medicare to age 55 to 65
• No problematic provisions on spending variation
• No charity care requirement/formula to qualify for tax-exempt status
• No cuts in the indirect medical education adjustment
• No cuts for CAHs and exemptions from penalties
• No jurisdiction of Independent Board over (PPS) hospitals
Accountable Care Organizations

Primary Care Physicians
Specialty Care Physicians
Outpatient Hospital Care and ASCs
Inpatient Hospital Acute Care
Long Term Acute Hospital Care
Inpatient Rehab Hospital Care
Skilled Nursing Facility Care
Home Health Care

Acute Care Bundling

Medical Home

Demonstrations and Pilots

Post Acute Care Episode Bundling

Acute Care Episode with PAC Bundling
Fitting It All Together

Medical Homes

ACOs

VBP

Center for Innovation

Readmissions
“We have a lot on our collective plates. We have to prepare to convert to new IT systems and improve the quality of safety of patient care, and we have to reduce the cost of health care while we do those things. We have to find new and better ways to align the interests of hospitals and physicians without inviting the ire of the Justice Department...we have to continue delivering care under the existing model as we try to leave it behind.”

Thornton Kirby
President and CEO
South Carolina Hospital Association
July 16, 2010
Preparing for Reform...

STRATEGIC ISSUES FOR HOSPITAL LEADERS

Success in the post-reform era will require work on many strategies simultaneously, requiring strong and creative leadership to guide hospitals and health systems as they begin their journey toward success under health care reform. Educating boards on strategies and activities also will be critical.

KEY ACTIONS FOR HOSPITALS:

- Enhance efforts to improve quality and patient safety and reduce variation in care within your organization.
- Increase clinical and operational efficiencies.
- Increase efforts to improve patient satisfaction.
- Reduce avoidable readmissions.
- For tax-exempt hospitals, identify community partners and conduct community needs assessment as now required.
- Assess and strengthen your plan for health information technology and electronic health records.
- Collect standardized race and ethnicity data to reduce health disparities in your organization.
- Examine readiness for episodic payment and care redesign, and explore organizational capacity to manage care across the continuum.
- Develop new organizational competencies for clinical integration and foster better alignment with physicians.
- Assess the insurance benefits your hospital offers employees in light of health reform.

THE ROAD AHEAD:
Transforming Health Care
Positioning for reform

- Achieve solid hospital-physician (clinical) alignment
- Measure, report and deliver superior outcomes
- Attain a favorable cost position
- Strategic alliances
The AHA’s Health Care Reform: Moving Forward is meant as a resource for hospital leaders seeking to understand and plan for the changes prescribed by health care reform.

This resource is divided into five sections: Understanding Reform, Communicating Reform, AHA Tools & Resources, What Others are Saying, and Opportunities to Get Involved. Click on each section header for a deeper dive.

- **Understanding Reform** includes an AHA overview of the major aspects of reform, as well as a timeline of key implementation dates and a summary highlighting the impact of insurance provisions on hospitals in their role as employers. It also includes regularly updated links to reports on various aspects of reform, from accountable care organizations to health insurance exchanges, from many different sources.

- **Communicating Reform** was designed to provide you with tools you can use to explain the reform law and its impact when speaking with groups in your community, including your staff.

- **AHA Tools and Resources** is updated regularly as the AHA develops new synthesis reports and advisories on various aspects of reform, as well as other tools you may find helpful as you grapple with upcoming changes.

- **What Others are Saying** offers quick links to various other health care and governmental organizations.

- **Opportunities to Get Involved** includes a summary of grant opportunities of interest to hospitals and will be regularly updated as additional opportunities are made public.
Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides

ACHI Community Health Assessment Toolkit
A Practical Guide to Planning, Leading, and Using Community Health Assessments

Health Care Leader Action Guide on Implementation of Electronic Health Records
July 2010

The HRET Disparities Toolkit
A Guide for Collecting Race, Ethnicity, and Primary Language Information from Patients

Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project
Tools and Guides

Accountable Care Organizations

AHA RESEARCH SYNTHESIS REPORT

JUNE 2010

American Hospital Association Committee on Research

AHA Research Synthesis Reports are periodic reports that synthesize literature on key issues related to the 2010 to 2012 AHA Research Agenda as part of Hospitals in Pursuit of Excellence. The AHA Committee on Research developed the 2010 to 2012 AHA Research Agenda, which was approved by the AHA Board in November 2009.

For more information, contact Maulik Joshi at mjoshi@aha.org or 312-422-2622.

Bundled Payment

AHA RESEARCH SYNTHESIS REPORT

MAY 2010

American Hospital Association Committee on Research

Bundled Payment – AHA Research Synthesis Report
Health Care Leader Action Guide to Reduce Avoidable Readmissions

January 2010

A Guide to Achieving High Performance in Multi-Hospital Health Systems

March 2010
EXECUTIVE SUMMARY

Variation in spending per Medicare beneficiary has long been documented. Researchers at Dartmouth have gone as far as to assert that their work on variation suggests that nearly 30 percent of health care spending could be unnecessary or wasteful. Not surprisingly, in the search to find ways to bend the cost curve, the Obama administration and Congress have seized on reducing variation as a key target. In the fall of 2009, the AHA Board of Trustees convened the Task Force on Variation in Health Care Spending to examine this issue.

The task force spent significant time educating itself on the current research and the many perspectives on the issue. It found that variation goes beyond just measures of spending and arises from many interrelated factors, some within and some beyond the control of the health care system. Not all variation is undesirable or inappropriate. Variation can be appropriate when it is due to the characteristics of the population served (e.g., age or gender) or the varying circumstances of providers (e.g., special missions, costs of doing business, rural/urban location). Other variation is inappropriate, such as when providers fail to adhere to established medical practice resulting in the over, under, or misuse of services. Variation also can be due to broader social issues, such as when a population has poor health status due to poverty or adverse living conditions.

Distinguishing among the types of variation is critical to arriving at a reasonable set of recommendations for action and a fair set of policies for holding providers and other stakeholders accountable for their results.

Despite this complexity, the task force concluded that a significant portion of variation is under the control or influence of hospitals and other providers, and that the time for action is now. Many aspects of health care reform are pushing the field to address variation, and pressures will accelerate as the drive to bend the cost curve intensifies. Addressing variation is a key imperative to success in the current environment and not addressing it is a huge vulnerability for the future.

The task force urged the AHA to issue a bold call to action on the topic of variation that is inherently a hospital business. Hospitals, in conjunction with physicians, other clinicians, and other care partners, must be aggressive and start to reduce the variation that is within their control; collaborate with other parts of the health care system, insurers, and employers to address inappropriate variation across the care continuum; and provide leadership in bringing together other stakeholders to deal with broader societal issues that affect health behavior and health status. The role of the AHA is to work to ensure that hospitals have the appropriate data, tools, and information to be successful in these efforts; to advocate for well-structured policies to ensure accountability and reward success; and to continue to advocate for the removal of the existing barriers to clinical integration.
New political environment

**GOP Priorities**

- Cut spending
- Roll back ACA
- Regulatory relief
Political environment

• Legislative gridlock likely on major issues
  – Not just Democrats vs. Republicans…but Republicans vs. Republicans
  – Still need 60 votes in the Senate
  – White House holds veto pen
Political environment

• New emphasis on deficit reduction…and zero-sum game on policy adjustments
  – “Cut-go”
• Health care reform
  – *Defensive* strategy to preserve positive elements of reform
  – *Offensive* strategy to:
    ➢ Shape key provisions during implementation process
    ➢ Make improvements in priority areas
  ✓ Political challenge
Legislative brinksmanship

“Must Do” Measures

• Funding the government
  – Continuing Resolutions on Appropriations
    ➢ Vehicle for reducing discretionary spending
Legislative brinksmanship

“Must Do” Measures

- Funding the government
  - Continuing Resolutions on Appropriations
    ➢ Vehicle for reducing discretionary spending

- Debt limit extensions
  - Vehicle for longer term deficit reduction

- Expiring provisions
  - Taxes
  - Unemployment compensation benefits
  - Medicare physician payment cuts
Current budget issues

• Rest of this year (FY 2011)
  – Seven months remaining

• Next year (FY 2012)
  – Starts October 1
“It’s a leverage moment for Republicans”

Rep. Eric Cantor (R-VA)
House Majority Leader

Politico
Friday, January 14, 2011
“I can’t wait for the blood bath in April...when debt limit time comes, they’re going to look around and say ‘What the hell do we do now? We’ve got guys who will not approve the debt limit extension unless we give ‘em a piece of meat, real meat’, meaning spending cuts. And boy, the blood bath will be extraordinary...there will be hair and eyeballs all over the floor”

Alan Simpson
“We’re going to have to deal with it as adults...whether we like it or not, the federal government has obligations, and we have obligations on our part.”

Rep. John Boehner (R-OH) Speaker of the House
**COVERAGE**
- EMTALA regulations (inpatient transfers and specialty care)
- Individual responsibility requirement protection
- Mental health services (coverage, parity and access)
- Undocumented immigrants
- ACA legal challenges
- ACA implementation:
  - Enroll America
  - Health insurance exchanges (basic benefit package, subsidies, etc.)
  - Health insurance reforms
  - Medicaid coverage reforms

**DELIVERY SYSTEM IMPROVEMENTS**
- Access to capital
  - FHA Expansions (Section 242 program)
- Clinical integration
  - Legal barriers
  - Medicare Conditions of Participation
- Corporate practice of medicine (state)
- ICD-10 implementation
- Indian Health Service contract services
- Medical liability reform
- Treatment of federally qualified health centers
- ACA implementation
  - Accountable care organizations
  - Administrative simplification
  - Bundling
  - Center for Innovation
  - Gain-sharing
  - Medical homes
  - Medical liability reform (demonstration projects)
  - Physician self-referral
  - Price transparency
    - Medical data reimbursement centers

**EXPIRING PROVISIONS**

**FEDERAL BUDGET**
- Platforms
  - President’s budget
  - Congressional budget resolution
  - Debt limit extension
  - Offsets to finance other programs (cut-go)
  - Other deficit reduction initiatives
  - Annual appropriations
- ACA implementation funding

**HEALTH INFORMATION TECHNOLOGY**
- Certification/grandfathering
- Eligibility for HIT funding (cancer; post-acute; psychiatric; and Puerto Rico)
- Health information exchanges
- Meaningful use/flexibility (Stage I/Stage II)
- Multi-campus

**MEDICARE**
- Annual regulations
  - Clinical laboratory services
  - Home health services
  - Hospice care
  - Inpatient services
    - Coding offset
  - Rehabilitation hospital services
  - Outpatient services
    - Physician supervision (possible legislation)
    - Cancer hospitals (possible legislation)
    - Reductions for multiple therapy services
  - Physician services
  - Psychiatric services
  - Skilled nursing facilities
- Annual MEDPAC recommendations
- Other key payment issues
  - Area wage index*
  - DME competitive bidding
  - LTCH participation criteria
  - Medicare service authorization issues
    - Physician/non-physician practitioners face-to-face encounter to receive home health services
    - Physician signature requirement on lab requisitions (home health/SNF)
  - Observation status
  - Premium support*
  - Rural package
  - Urban Medicare dependent hospitals adjustment

**EXPIRING PROVISIONS**

**PERFORMANCE IMPROVEMENT**
- Care at the end of life
- Medicare Conditions of Participation
  - (deeming requirements)
- Patient safety organizations
- Patient safety initiatives
- Public reporting of quality data
- Quality improvement organizations
- Spending variation (spending variation)
- ACA implementation:
  - Disparities in care (reporting requirements)
  - Hospital acquired conditions (legislation)
  - National quality strategy
  - Patient centered outcomes research/initiatives
  - Quality reporting
  - Readmissions (legislation)
  - Spending variation (studies)
  - Value-based purchasing

**PREVENTION & WELLNESS**
- ACA implementation
  - National Prevention, Health Promotion and Public Health Council
  - Prevention and public health fund

**REGULATORY RELIEF**
- Misuse of False Claims Act
  - Defibrillator implantation
  - Kyphoplasty
- Recovery audit contractors

**TAX**
- Tax-exempt status
  - ACA implementation
    - Community benefit assessment
    - Discounts for uninsured patients
  - Form 990/Schedule H data collection project
- Other (ACA) provisions:
  - Medical device tax (offset)
  - 1099 reporting/compliance (offset)

**WORKFORCE**
- Health manpower supply
  - Foreign physician and nurse supply
  - Increased Medicare GME slots
- NLRB, DoL and other regulatory initiatives
- Scope of practice (state)
- ACA implementation:
  - National Workforce Commission
**2011 ADVOCACY AGENDA**

**HEALTH INFORMATION TECHNOLOGY**
- Certification/grandfathering
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**NOTES**
- § Medical data reimbursement centers

**EXPIRING PROVISIONS**
- 340 expansions
- Audit rule implementation
- Hospital payment protections
- Long-term reform
- Presumptive eligibility of hospital patients
- Waiver process improvements
- ACA implementation:
  - DSH reductions
  - Recovery audit contractors

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- NLRB, DoL and other regulatory initiatives
- Scope of practice (state)
- ACA implementation:
  - National Workforce Commission
RURAL PACKAGE

- Allow hospitals to claim the full cost of provider taxes as allowable costs
- CAH exemption from IPAB
- Ensure that CAH’s are paid at least 101 percent of costs by Medicare Advantage plans
- Ensure adequate reimbursement for CRNS and stand-by services for rural hospitals
- Provide CAH’s flexibility in bed size depending on average daily census
- Provide small, rural hospitals with cost-based reimbursement for outpatient lab and ambulance services
- Reinstate CAH necessary provider status
- Remove unreasonable restrictions on CAH’s ability to rebuild
## Coverage
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## Expiring Provisions

## Federal Budget
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- Congressional budget resolution
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- Offsets to finance other programs (cut-go)
- Other deficit reduction initiatives
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## 2011 Advocacy Agenda

### Health Information Technology
- Certification/grandfathering
- Eligibility for HIT funding (cancer; post-acute; psychiatric; and Puerto Rico)
- Health information exchanges
  - Meaningful use/flexibility (Stage I/Stage II)
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- Patient safety organizations
- Patient safety initiatives
- Public reporting of quality data
- Quality improvement organizations
- Spending variation (spending variation)
- ACA implementation:
  - Disparities in care (reporting requirements)
  - Hospital acquired conditions (legislation)
  - National quality strategy
  - Patient centered outcomes research/initiatives
  - Quality reporting
  - Readmissions (legislation)
  - Spending variation (studies)
  - Value-based purchasing

## Prevention & Wellness
- ACA implementation
  - National Prevention, Health Promotion and Public Health Council
- Prevention and public health fund

## Regulatory Relief
- Misuse of False Claims Act
  - Defibrillator implantation
  - Kyphoplasty
- Recovery audit contractors

## Tax
- Tax-exempt status
  - ACA implementation
    - Community benefit assessment
    - Discounts for uninsured patients
  - Form 990/Schedule H data collection project
- Other (ACA) provisions:
  - Medical device tax (offset)
  - 1099 reporting/compliance (offset)

## Workforce
- Health manpower supply
  - Foreign physician and nurse supply
  - Increased Medicare GME slots
- NLRB, DoL and other regulatory initiatives
- Scope of practice (state)
- ACA implementation:
  - National Workforce Commission
ANNUAL APPROPRIATIONS

- Children’s graduate medical education
- Emergency readiness
- Health information technology
- Health services research
- Maternal and child health block grant
- National Quality Forum
- Nursing and health professions education and training
- PPACA prevention and wellness programs
- Rural health programs
- Substance abuse/mental health block grant
- Trauma systems
COVERAGE
• EMTALA regulations (inpatient transfers and specialty care)
• Individual responsibility requirement protection
• Mental health services (coverage, parity and access)
• Undocumented immigrants
• ACA legal challenges
• ACA implementation:
  -- Enroll America
  -- Health insurance exchanges (basic benefit package, subsidies, etc.)
  -- Health insurance reforms
  -- Medicaid coverage reforms

DELIVERY SYSTEM IMPROVEMENTS
• Access to capital
  -- FHA Expansions (Section 242 program)
• Clinical integration
  -- Legal barriers
  -- Medicare Conditions of Participation
• Corporate practice of medicine (state)
• ICD-10 implementation
• Indian Health Service contract services
• Medical liability reform
• Treatment of federally qualified health centers
• ACA implementation
  -- Accountable care organizations
  -- Administrative simplification
  -- Bundling
  -- Center for Innovation
  -- Gain-sharing
  -- Medical homes
  -- Medical liability reform (demonstration projects)
  -- Physician self-referral
  -- Price transparency
    ✓ Medical data reimbursement centers

EXPIRING PROVISIONS

FEDERAL BUDGET
• Platforms
  -- President’s budget
  -- Congressional budget resolution
  -- Debt limit extension
  -- Offsets to finance other programs (cut-go)
  -- Other deficit reduction initiatives
  -- Annual appropriations
• ACA implementation funding

2011 ADVOCACY AGENDA

HEALTH INFORMATION TECHNOLOGY
• Certification/grandfathering
• Eligibility for HIT funding (cancer; post-acute; psychiatric; and Puerto Rico)
• Health information exchanges
  Meaningful use/flexibility (Stage I/Stage II)
• Multi-campus

MEDICARE
• Annual regulations
  -- Clinical laboratory services
  -- Home health services
  -- Hospice care
  -- Inpatient services
    ✓ Coding offset
  -- Rehabilitation hospital services
  -- Outpatient services
    ✓ Physician supervision (possible legislation)
    ✓ Cancer hospitals (possible legislation)
    ✓ Reductions for multiple therapy services
-- Physician services
-- Psychiatric services
-- Skilled nursing facilities
• Annual MEDPAC recommendations
• Other key payment issues
  -- Area wage index*
  -- DME competitive bidding
  -- LTCH participation criteria
  -- Medicare service authorization issues
    ✓ Physician/non-physician practitioners face-to-face encounter to receive home health services
    ✓ Physician signature requirement on lab requisitions (home health/SNF)
-- Observation status
-- Premium support*
-- Rural package
-- Urban Medicare dependent hospitals adjustment

MEDICAID
• 340 expansions
• Audit rule implementation
• Hospital payment protections*
• Long-term reform*
• Presumptive eligibility of hospital patients
• Waiver process improvements
• ACA implementation:
  -- DSH reductions
  -- Recovery audit contractors

PERFORMANCE IMPROVEMENT
Care at the end of life
• Medicare Conditions of Participation (deeming requirements)
• Patient safety organizations
• Patient safety initiatives
• Public reporting of quality data
• Quality improvement organizations
• Spending variation (spending variation)
• ACA implementation:
  -- Disparities in care (reporting requirements)
  -- Hospital acquired conditions (legislation)
  -- National quality strategy
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  -- Spending variation (studies)
  -- Value-based purchasing

PREVENTION & WELLNESS
• ACA implementation
  -- National Prevention, Health Promotion and Public Health Council
  -- Prevention and public health fund

REGULATORY RELIEF
• Misuse of False Claims Act
  -- Defibrillator implantation
  -- Kyphoplasty
• Recovery audit contractors

TAX
• Tax-exempt status
  -- ACA implementation
    ✓ Community benefit assessment
    ✓ Discounts for uninsured patients
  -- Form 990/Schedule H data collection project
• Other (ACA) provisions:
  -- Medical device tax (offset)
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WORKFORCE
• Health manpower supply
  -- Foreign physician and nurse supply
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• NLRB, DoL and other regulatory initiatives
• Scope of practice (state)
• ACA implementation:
  -- National Workforce Commission
Priorities – To Do (Offense)

- Expiring Provisions
- Medical Liability Reform
- Regulatory Relief
- ACA Implementation
- ACA Fixes
Regulatory relief

• Clinical integration
• Medicare Conditions of Participation
• Misuse of False Claims Act
• Recovery audit contractors
• Health information technology
  – Certification
  – Health information exchanges
  – Eligibility for funding
  – Meaningful use/flexibility
  – Multi-campus

American Hospital Association
Priorities – To Do (Offense)

1. Expiring Provisions
2. Medical Liability Reform
3. Regulatory Relief
4. ACA Implementation
5. ACA Fixes
ACA Fixes

- IPAB (exemption for CAH)
- Readmissions (2013)
- Hospital acquired conditions (2015)
- Disproportionate share reductions (2014)
- 340B expansions
- GME (health care workforce)
Priorities – To Do (Offense)

- Expiring Provisions
- Medical Liability Reform
- Regulatory Relief
- ACA Implementation
- ACA Fixes
Implementing reform

“The Secretary shall”
ACA Implementation

• Becker Committee
• Rules and regulations
• Enroll America
• Field leadership… performance improvement
Priorities – To Do (Offense)

- Expiring Provisions
- Medical Liability Reform
- Regulatory Relief
- ACA Implementation
- ACA Fixes
Priorities – Challenges (Defense)

**ACA**
- Hearings and investigations
- Legal challenges
- Defunding
- Potential legislative amendments

**Coding Offset**
- Medicare Inpatient PPS regulation (proposed rule in Spring)

**Federal Budget**
- President’s budget
- Congressional budget resolution
- Debt limit extension
- Offsets to finance other programs (cut-go)
- Other deficit reduction alternatives
Potential legislative amendments

- 1099 reporting (offset)
- Medical device tax (offset)
- Coverage expansions
  - Medicaid expansions
  - Individual mandate
  - Employer responsibility
- Physician self-referral
- Comparative effectiveness
- Center for Innovation
Politics of deficit reduction

• Initial focus on discretionary funding
  – FY 2008 levels
  – Earmarks
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President’s FY 2012 Budget

Health Care

• $62 billion for two year patch on Medicare physician payment reductions
  – Funded by specific savings from:
    ➢ Medicaid
      ➢ Reducing ability of states to use Medicaid provider taxes in 2015 ($18.3 billion)
      ➢ Rebase/extend Medicaid DSH allotments in 2021 ($4.1 billion)
      ➢ Limit Medicaid DME payment to Medicare levels ($6.4 billion)
    ➢ Pharmaceutical proposals ($12.8 billion)
    ➢ Program “integrity” ($13.9 billion)
    ➢ Program “efficiencies” ($6.4 billion)
  – Savings do not go to reducing the deficit
President’s FY 2012 Budget

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  – Savings do not go to reducing the deficit
Other Highlights

• Children’s GME ($317 million in FY 2012)

• No major changes to restructure entitlement programs such as Medicare, Medicaid or Social Security
White House Releases FY 2012 Budget Proposal

Proposal would cut Medicare/Medicaid spending by $62 billion to fund two-year doc fix

Monday, February 14, 2011

The White House today released its budget proposal for fiscal year (FY) 2012. The proposal does not include major reductions to hospitals under Medicare or restructuring of the Medicare program. However, it does include significant Medicaid payment reductions to providers which are of great concern. The $62 billion in cuts over 10 years fund a two-year extension of physicians’ Medicare payments at the current level. The cuts are as follows.

Medicaid ($28.8 billion): Among other changes, reduces the ability of the states to use Medicaid provider taxes beginning in 2015 and rebases Medicaid disproportionate share hospital payments in 2021.

Children’s Graduate Medical Education (GME) ($318 million): Eliminates GME payments for children’s hospitals.

Program Integrity ($13.9 billion): Expands the Centers for Medicare & Medicaid Services’ program integrity authority, including strengthening third-party liability under Medicaid, recovering payments made in error to Medicare Advantage plans, and dedicates a portion of funds recovered by Recovery Audit Contractors to efforts to prevent improper payments and fraud.

Program Efficiencies ($6.4 billion): Makes a series of changes to the Quality Improvement Organization (QIO) program to improve efficiency, such as expanding the pool of eligible contractors, lengthening the QIO contract period and examining the geographic scope of QIO contracts.

Pharmaceuticals ($12.8 billion): Among other changes, makes a series of changes to shorten the time period in which drug manufacturers maintain exclusivity for new drugs and prohibits drug companies from delaying generic forms of pharmaceuticals.

“While we are pleased that the President’s budget does not include any new major reductions in payments for hospitals services to Medicare beneficiaries, we are deeply disappointed that today’s budget reduces Medicaid, which funds services to our most vulnerable patients such as the poor and disabled,” AHA President and CEO Rich Umbdenstock said. “Moreover, at a time when hospitals have already been asked to absorb big cuts at the state level, and state budgets are already stretched, it is unwise to ask states to continue to do more with less. In addition, we are also disappointed to see elimination of funding for the children’s graduate medical education program at a time when there is a need for an expanded physician workforce. While we fully support eliminating future reductions to physicians, the answer to the physician payment issue is not cutting one provider to reimburse another.”

Overall, the White House estimates that the cuts contained in the $3.7 trillion dollar spending proposal will reduce the national deficit by $1.1 trillion over the next 10 years. The deficit is projected to reach $1.6 trillion this year. The budget proposal can be found at http://www.whitehouse.gov/omb/budget.
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Potential hospital risks

• Indirect medical education adjustment
• Medicare bad-debt
• Independent Provider Advisory Board Expansion
• Acceleration of ACA provisions
• Elimination of Medicaid provider taxes
• Medicare premium support
• Selective contracting
• “Global budgets”… spending caps with enforcement mechanisms
• Tax-exempt status
Politics of deficit reduction

- Initial focus on discretionary funding
  - FY 2008 levels
  - Earmarks

- Medicare and Social Security reform not possible without support from President Obama
  - Republicans have no mandate for reform
  - Polls show most voters opposed
  - Would alienate seniors in 2012 elections

- Previous GOP efforts have failed without Democratic support:
  - Ronald Reagan and Social Security in 1981
  - Newt Gingrich and Medicare in 1995
  - George W. Bush and Social Security in 2005

- In addition…other GOP challenges in taking on Medicare:
  - Were critical of Medicare cuts in ACA
  - “Death panel” issue

- Significant reforms will not generate short-term savings because of necessary grandfathering requirements
Politics of deficit reduction

Bipartisan Senate Group

- Democrats
  - Kent Conrad (ND)*
  - Dick Durbin (IL)*
  - Mark Warner (VA)

- Republicans
  - Mike Crapo (ID)*
  - Tom Coburn (OK)*
  - Saxby Chambliss (GA)
Potential hospital risks

• Indirect medical education adjustment
• Medicare bad-debt
• Independent Provider Advisory Board Expansion
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• Tax-exempt status
Our strategy

• Impact analysis

• Alternatives

• Coalitions

• Telling the Hospital Story
Our strategy: alternatives

- Liability reform
- “Real” comparative effectiveness
- Care at the end of life
- Administrative simplification
- Medicare cost sharing restructuring
- Adjusting Medicare eligibility age
- Tax incentives for long-term care
- Revenues
  - Junk food taxes…obesity
  - Medicare (FICA) rate adjustments
  - Limiting deductibility of health insurance premiums
Our strategy: coalitions

• External
  – Providing policymakers support to make tough choices
  – Spending caps

• Internal
  – Graduate medical education
  – Medicare bad-debt
  – Provider taxes
  – DSH
Our strategy

Telling the Hospital Story

- Challenges in the “cost of caring”
- Community benefit contributions
- Performance improvement focus
- Financial state of America’s hospitals
- Hospitals as economic engines
- Coalition
Timetable

**State of the Union Address**
- **January 25**

**President’s Budget**
- **Week of February 14**

**Congressional Budget Resolution**
- **April 1**

**CR Expires**
- **March 4**

**Congressional Budget Resolution**
- **March - May**

**Medicare Inpatient Final Rule**
- **Early August**

**AHA Annual Meeting**
- **Late April 9-12**

**Medicare Inpatient Proposed Rule**
- **Late April**

**Debt Limit Expires**
- **March - May**

**Medicare Inpatient Final Rule**
- **December 31**

**Physician payment fix and extenders expires**

**Federal Fiscal Year Begins (FY 2012)**
- **October 1**
Your can make a difference

• Political Action
• Grassroots participation
• Telling the Hospital Story