SPECIAL BULLETIN

October 29, 2009
This bulletin is four pages.

HOUSE UNVEILS REVISED REFORM BILL

House leaders today released H.R. 3962, the "America's Affordable Health Choices Act of 2009." The blended bill is the merger of the products of three key House committees: Ways & Means, Energy & Commerce and Education & Labor. While we are still awaiting formal numbers from the Congressional Budget Office, the bill is expected to expand coverage to approximately 96 percent of those legally residing in the U.S. and cost slightly less than $900 billion. Responding to concerns from AHA and its members, the bill's public insurance option would reimburse providers using negotiated rates within parameters (rather than Medicare rates) and would extend Medicaid to 150 percent of the federal poverty level (FPL).

We're still working through the almost 2,000-page bill, and will get you additional details as necessary. Meanwhile, here are some of the key provisions that affect hospitals. (Click here for the *AHA Advisory* on the previous draft version of the bill).

Hospital Payment Update: Market basket reductions over 10 years. Reduces Medicare payment updates by a measure of productivity growth for inpatient hospital, outpatient hospital, long-term care hospital, inpatient rehabilitation facility, psychiatric hospital, skilled-nursing facility, hospice, ambulance, home health agency, ambulatory surgical center and laboratory services beginning in 2010.

Public Option: Provides a public insurance option as part of a national exchange. The commissioner of the exchange has discretion to expand the exchange to large employers (100 employees or more) in year three, thus making the public option available to employees of large entities. Provider payment rates would be negotiated within corridors, with a floor of no lower than aggregate Medicare rates and a ceiling of no greater than aggregate average rates paid by plans within the insurance exchange**.** Allows Medicare providers, including hospitals, to opt out of participation in the public option.

Medicaid Expansion: Beginning in 2013, Medicaid is expanded to 150 percent of FPL, up from 133 percent FPL. The federal government will fully finance the first two years of the expansion. In 2015, federal funds will drop to 91 percent with states paying 9 percent for the newly expanded populations.

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Medicaid DSH: Beginning in 2017, federal spending is reduced $10 billion over three years ($1.5 billion in 2017, $2.5 billion in 2018, $6 billion in 2019). No later than 2016, the Secretary must report to Congress with recommendations on the appropriate targeting of DSH payments within states, and the appropriate distribution across states. The methodology for cuts would depend on state rates of uninsurance, and use of DSH money, which would be measured by uncompensated care and hospital Medicaid volume.

Medicaid Graduate Medical Education (GME) Payments: The costs of GME are recognized in statute as legitimate Medicaid costs with state-level reporting requirements.

Medicare Disproportionate Share Hospitals (DSH): Beginning in 2017, would gradually reduce Medicare DSH payments to hospitals if there is a reduction in the number of uninsured between 2012 and 2014. Medicare DSH payments could be partially restored for some hospitals based on the amount of uncompensated care the hospital provides.

Readmissions: Reduces payments in 2012 to hospitals, including critical access hospitals, with actual readmission rates higher than their expected 30-day readmission rates for three conditions. Beginning in 2013, expands the policy to other conditions. Reduces payments to post-acute providers as well. Does not differentiate between unplanned readmissions that are related to the initial admission and all other readmissions.

Bundling: Calls for the HHS Secretary to develop a *plan* to reform Medicare payment for post-acute care services. The legislation also would convert the current Acute Care Episode (ACE) demonstration to a pilot program by January 1, 2011, and expand the pilot program to include post-acute care and other services. If the ACE bundling program is found to improve quality and reduce costs, the Secretary is directed to expand the pilot broadly to other providers on a voluntary basis.

Value-Based Purchasing: The legislation does not include a provision related to value-based purchasing for hospitals. However, value-based purchasing can be utilized by Centers Medicare & Medicaid's (CMS) newly created Innovation Center.

Accountable Care Organizations (ACOs): Establishes voluntary pilots where groups of qualifying physician practices could form ACOs and share in Medicare cost savings. **The legislation does not allow hospitals to take a leadership role in the formation of ACOs**, but they may be included as part of an ACO.

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Geographic Adjustment: Calls for two Institute of Medicine (IOM) studies. The first IOM study on geographic variation is to determine the accuracy of the geographic adjustment factors in the hospital and physician payment systems. Provides $8 billion over two years (FY 2012-FY 2013) to implement IOM's recommendations. Beginning in FY 2014, adjustments to the payment systems would be budget neutral. The second IOM study would examine growth in intensity and services in per capita health spending and whether payments systems should be modified to incentivize "high value" care. Mandates a fast-track process through Congress for implementation.

Innovation Center: Creates a center for Medicare and Medicaid Innovation (CMI) within CMS by January 2011 to test innovative payment and service delivery models to improve coordination, quality and efficiency of health services.

Physician Payment: The legislation does not include a fix to the Sustainable Growth Rate (SGR) formula as proposed in an earlier version of the House bill. Physician payment rates will be addressed through separate legislation.

Self-Referral: Eliminates the exception for physician-owned hospitals under the whole hospital and rural provider exceptions under the Stark law, but grandfathers those with a Medicare provider agreement in place by January 1, 2009. Existing facilities are subject to growth restrictions.

Healthcare-Associated Infections (HAI): Requires hospitals and ambulatory surgical centers to report data on HAIs to the Centers for Disease Control and Prevention.

Healthcare-Acquired Conditions: State Medicaid programs are required to include policies that do not allow higher payments to a hospital if a patient gets a HAI during the hospital stay, similar to the Medicare hospital-acquired conditions policy.

Medicare GME: The legislation does not include cuts to indirect medical education. Makes the following changes to Medicare GME: redistributes unused residency slots, increases training in nonprovider settings, changes the rules for counting resident time and improves the accountable of approved medical residency training.

Rural Providers: Extends Section 508 reclassifications, the outpatient hold-harmless provision, the floor on the work geographic practice cost index for physician payment, the rural ground ambulance add-on, and the grandfathering that allows independent laboratories to continue to directly bill, under the physician fee schedule, for pathology technical component services.

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Comparative Effectiveness: Creates a new Center at the Agency for Healthcare Research and Quality to conduct, support and synthesize comparative effectiveness research. The Center will be supported by a combination of public and private funding.

340B: Expands the 340B program to outpatient drugs for children's hospitals, cancer hospitals, critical access hospitals, Medicare-dependent hospitals, sole community hospitals and rural referral centers. Does not expand the 340B program to inpatient drugs for any hospital type as in previous versions of the legislation.

Long-Term Care: Creates a new, voluntary long-term care insurance program financed by payroll deductions to provide a cash benefit to help individuals with community-based services.

Medicare Commission: The legislation does not include the creation of a Medicare Commission.

Revenue: The bill imposes a 2.5 percent tax on the first taxable sale of any medical device. “First taxable sale” means other than for resale after production, manufacture, or importation. Hospitals purchasing directly from a device manufacturer would pay this tax in addition to the purchase price.

Among other provisions, H.R. 3962 would impose a 5.4 percent tax on individuals with adjusted gross incomes in excess of $1 million (married filing a joint return) and $500,000 (single), and imposes an excise tax of 2.5 percent on medical devices used in the United States.

NEXT STEPS: House leaders hope to hold a floor vote on the bill in the near future. The AHA will continue to work for improvements in this bill.