



Special Bulletin: Health Reform Passes Congress

Summary of Major Provisions in Final House Reform Package

Friday, March 26, 2010

The U.S. House of Representatives late Thursday voted to pass the piece of the landmark health care reform package. President Obama is expected to sign the bill into law early next week. Highlights of provisions of greatest interest to Kansas hospitals are provided below.

Coverage Expansion, Individual Mandate, and Employer Responsibility: Expands access to coverage to 32 million individuals by 2019 through a combination of public program expansions and private section health insurance reforms. Beginning in January 1, 2014, all U.S. citizens and legal residents would have to obtain coverage or face a tax penalty. Individuals with employer based coverage will be able to retain their coverage. Those without employer plans can obtain coverage through newly formed "health insurance exchanges." Subsidies are available to assist low-income individuals with the purchase of health insurance premiums and Medicaid would be expanded to provide coverage for the poor. While employers are not required to provide coverage, large employers will be charged a "free rider" assessment if their employees purchase health care coverage through the exchange with federal premium subsidies.

Medicaid: Beginning in 2014, requires all state Medicaid programs to cover individuals up to 133 percent of the federal poverty level (FPL). States will receive federal funds to pay for the newly expanded populations starting with 100 percent federal financing for 2014-2017 and scaled down to 90 percent for 2020 and thereafter. States that have already covered this population will receive additional federal assistance.

Medicaid Disproportionate Share Hospital (DSH): Decreases Medicaid DSH payments by \$14 billion with reductions beginning in fiscal year (FY) 2014. DSH reductions are not directly tied to increases in the level of insurance coverage, and the final bill directs the Secretary to develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions. In making DSH reductions, the Secretary is instructed to look at a state's percentage of reduction in the

uninsured, and whether a state targets DSH funds to hospitals with high Medicaid volumes or uncompensated care.

Medicare DSH: Decreases Medicare DSH by \$22.1 billion beginning in FY 2014. The final bill would continue to reduce Medicare DSH payments by 75 percent to eliminate DSH payments that are above the "empirically justified" level, as determined by the Medicare Payment Advisory Commission. A portion of the 75 percent would then be returned to hospitals depending on the amount of uncompensated care they provide. This amount is subject to a trigger, and would be phased down if coverage increases.

Hospital Payment Updates: Reduces hospital Medicare payment updates by approximately \$112.6 billion over 10 years. For 2010 (beginning April 1) and 2011, the hospital payment update would be reduced by 0.25 percentage point. Beginning in 2012, the market basket would be reduced by an estimate of productivity, *with added reductions* of 0.1 percentage point in 2012 and 2013, 0.3 percentage point in 2014, 0.2 percentage point in 2015 and 2016, and 0.75 percentage point in 2017, 2018 and 2019. In 2020 and beyond, hospital payment updates would be reduced by productivity. The final bill eliminates a provision in the Senate bill calling for the reductions not to occur if certain coverage targets are not met in 2014-2019.

Health Insurance Exchanges: Beginning in 2011, requires states to establish health insurance exchanges through which individuals and small businesses can purchase qualified private health insurance coverage. A Federal Employee Health Benefit Plan (FEHBP)-like, multi-state health insurance plan will be offered through the exchanges with oversight by the federal Office of Personnel Management. Consumer Operated and Oriented Plans (Co-OPS) will be created to foster non-profits, member-run health insurance cooperatives. There is no government-run program.

Health Insurance Reforms: Establishes, within 90 days of enactment, temporary mechanisms to provide coverage to individuals with pre-existing conditions and for non-Medicare eligible retirees over age 55. Within six months of enactment, it prohibits insurers from setting annual and lifetime limits, dropping coverage (except in cases of clear fraud), and excluding coverage to children based on a pre-existing condition. Also would allow parents to include dependent children up to age 26 on their health insurance. Beginning in 2014, health insurers would be prohibited from excluding coverage based on pre-existing conditions for adults, would have limits imposed on premium ratings, and must guarantee the issuance of coverage for anyone who seeks it.

Administrative Simplification: Provides for 11 specific expansions of the administrative simplification provisions under HIPAA by HHS, as well as periodic reviews (beginning Jan. 1, 2012 and every three years thereafter) of where greater uniformity would further improve operation of the health care system and reduce administrative costs. The process requires input from the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, the Health Information Technology Standards Committee, standard setting organizations, and stakeholders.

Bundling: Beginning in 2013, requires the Secretary to establish a national, voluntary, five-year pilot program on bundling payments to providers around 10 conditions. If successful, the Secretary may expand the pilots after 2015.

Readmissions: Beginning in FY 2013, imposes financial penalties on hospitals for so-called "excess" readmissions when compared to "expected" levels of readmissions based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program. Excludes critical access hospitals and post-acute care providers.

Accountable Care Organizations (ACOs): Beginning in 2012, allows hospitals, in cooperation with physicians, to provide leadership in voluntary ACOs, which would be responsible for managing the care of certain beneficiaries, and allows the Secretary to share some of the savings from improved care management with providers.

Value-Based Purchasing (VBP): Establishes a VBP program for hospital payments beginning in FY 2013 based on hospitals' performance in 2012 on measures that are part of the hospital quality reporting program. The program is budget neutral, with 1 percent of payments allocated to the program in FY 2013, growing over time to 2 percent in 2017 and beyond.

Hospital-Acquired Conditions (HACs): Beginning in FY 2015, adds a 1 percent penalty to hospitals in the top quartile of rates of HACs, resulting in reductions of \$1.5 billion over 10 years.

Geographic Variation: Includes \$400 million for payments for FYs 2011 and 2012 to section 1886(d) hospitals located in counties that rank in the lowest quartile for age, sex and race adjusted per enrollee spending for Medicare Parts A and B. The payments would be proportional to each hospital's share of the sum of Medicare inpatient PPS payments for all qualifying hospitals. Includes a commitment by the Secretary to commission two Institute of Medicine studies and convene a National Summit on geographic variation, cost, access and value in health care. One study will evaluate hospital and physician geographic adjustment factors, looking at their validity as well as the methodology and data used to create them. Allowable changes will be implemented by December of 2012. The second study will examine geographic variation in the volume and intensity of health care services and recommend ways to incorporate quality and value metrics into the Medicare reimbursement system. The Secretary will also convene a National Summit on Geographic Variation, Cost, Access and Value in Health Care later this year.

Innovation Center: Creates a Center for Medicare and Medicaid Innovation (CMI) within CMS by 2011 to test innovative payment and service delivery models that improve quality and reduce program expenditures within certain limited geographic areas.

Physician Self-Referral: Eliminates the exception for physician-owned hospitals under the Stark Law and grandfathers existing hospitals with a Medicare provider number as of

December 31, 2010. It requires compliance with disclosure, patient safety, bona fide investment, and growth restriction rules. The bill also provides limited exceptions to the growth restrictions for grandfathered physician-owned hospitals including a new exception for hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

Physician Payment: The final bill does not address the physician payment issue. A short-term, temporary fix for the scheduled reduction in physician payment for the remainder of CY 2010 is currently being debated in separate legislation.

Primary Care Physicians: Requires states to increase Medicaid payment rates to primary care providers in 2013 and 2014 only to Medicare levels, and provides 100 percent federal funding for the incremental costs to states.

Independent Payment Advisory Board (IPAB): Creates a new, independent board that would make binding recommendations on Medicare payment policy and non-binding recommendations for changes in private payer payments to providers. The recommendations exclude providers such as hospitals (but not critical access hospitals) through 2019.

340B Program: Extends eligibility for the 340B drug discount outpatient program to children's, cancer and critical access hospitals, as well as certain sole community hospitals and rural referral centers. It does not expand the program for existing 340B hospitals to cover inpatient drugs, and it exempts orphan drugs from required discounts for new 340B entities.

Graduate Medical Education: Contains no reductions in IME payments. Redistributes 65 percent of unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. Qualified hospitals would be able to request up to 75 new slots.

Long-Term Care Hospitals: Extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2008*. Would further delay full implementation of the 25% Rule, the short-stay outlier cuts, and the one-time budget-neutrality adjustments planned by CMS. Extends current moratorium on new LTCH beds and facilities, with exceptions.

Rural Hospital Provisions: Sustains and improves access to care in rural areas through various improvements:

- Extends the outpatient hold-harmless payments for certain hospitals in rural areas
- Improves payments for low-volume hospitals
- Ensures that CAHs are paid 101 percent of costs for all outpatient services regardless of the billing methods elected
- Extends and expands the Rural Community Hospital Demonstration Program
- Extends the Medicare Dependent Hospital program for one year

- Extends the Medicare Rural Hospital Flexibility Program through 2012
- Extends reasonable cost reimbursement for laboratory services in small rural hospitals

Medicare Extenders: Includes one-year extensions of certain Medicare provisions, including Section 508 wage index reclassifications; increasing the work geographic index to 1.0; grandfathering direct billing for anatomic pathology technical component services; add-on payments for ground ambulance; outpatient therapy caps; and a 5 percent increase in physician payment for certain psychiatric therapeutic procedures.

Liability: Provides \$50 million in appropriated funds for medical liability demonstrations.

Fraud and Abuse: The final bill contains significant additional funding to fight fraud and abuse, with increased financial penalties for existing policies as well as new requirements and penalties for providers, suppliers and others.

Excise Tax on High-Cost Health Plans: Creates an excise tax beginning 2018 for insurers of employer sponsored health plans and sets the threshold for the tax at \$10,200 for individual coverage and \$27,500 for family coverage.

Medical Device Tax: Beginning 2013, implements a 2.3 percent excise tax on medical device manufacturers. Exempts from the tax any device of a type that is generally purchased by the public, such as eyeglasses and hearing aids.

Other Revenue Provisions: Includes an assessment of \$67 billion on health insurers beginning in 2014, and an assessment of \$33 billion on brand-name pharmaceuticals beginning in 2011.
