Federal & State Legislative Update

Issues Facing Health Care Stakeholders

22 November 2013
Central Ohio HFMA

Agenda

• Health care reform – quick review heading into 2014
• Political Landscape & Developments in Ohio
• The Federal Budget mess
• Challenges for Health Care providers
• The Future
• Questions and Discussion

Central Ohio HFMA
November 2013
Health Care Reform Heading into 2014

Key Elements of the ACA

- Mandate/personal responsibility to carry coverage, with certain hardship exemptions and tax credits.
- “Pay or play” rule for some large employers; exemptions and tax breaks for smaller ones.
- Insurance market reforms – medical loss ratio, guaranteed issue, no rescissions, premium rules, etc.
- State-based health benefits exchanges or marketplaces.
- Expands Medicaid eligibility (and federal funding) in all states that choose to do so.
All private health insurance plans sold on the Exchange must comply with one of four benefit tiers with specified actuarial values:

- **Platinum**: 90%
- **Gold**: 80%
- **Silver**: 70%
- **Bronze**: 60%

State Decisions on Exchanges

Source: National Conference of State Legislatures, February 18, 2013
Ohio’s Exchange/Marketplace

• “Federally Facilitated” (but Ohio Dept. of Insurance retains current areas of authority)
• 12 health insurers filed to participate in Ohio’s Exchange, offering 200+ plans
• Premium rates finalized by mid-September
• Open enrollment: Oct 1 through March 31
• What will the premiums be at each tier? What about provider payment rates?

Navigators vs. Counselors

Navigators—Created in the ACA to assist consumers in enrollment in health plans through state/federal exchanges
  – Federal grant-funded, 30 hours of training required
  – Conduct education/outreach, assist with enrollment
Ohio HB 3 imposes additional requirements on Navigators in Ohio
  – Certification and Training by ODI (incl. HIPAA), criminal records check
  – Prohibits hospitals from being Navigators
Ohio Department of Insurance
  – “Safe harbor” allows hospitals, FQHCs, local gov’t entities, some other non-profits to provide information to the uninsured without having to comply with Navigator requirements
  – But, must not “hold itself out” as a Navigator
Role of Hospitals in Marketplace

- Help patients understand available options and find a health plan
- Can voluntarily become “Certified Application Counselors”
- CACs must receive training (free, 5 hrs)
- Must work in best interests of client and adhere to rules regarding objectivity, confidentiality, etc.
- Must disclose potential conflicts of interest
- CACs receive no federal funding, nor can they charge fees for assistance


Other ACA Provisions Starting 1/1/2014

- Coverage requirement for most adults begins
- Most rules on health plans for adults begin
- Electronic payment standards take effect; plans must certify compliance; Medicare payments fully electronic
- Medicaid providers can make “presumptive eligibility” determinations for patients
- Firms with 200+ employees that offer health benefits must automatically enroll employees (folks still can opt out)
The YouToons Get Ready for Obamacare: Health Insurance Changes Coming Your Way Under the Affordable Care Act

http://kff.org/health-reform/video/youtoons-obamacare-video/

The Political Landscape & Developments in Ohio
Political Landscape in Ohio

• Since the November 2012 election:
  – Ohio House: 59 Republicans / 33 Democrats
  – Ohio Senate: 23 Republicans / 10 Democrats
  – Legislature more conservative

• Impact of term limits:
  – Less relationship-building across aisle
  – In a hurry to leave a legacy

• Impact of Gerrymandering:
  – Safe seats, less compromise
  – Fear primary election more than general election

Look Ahead: Ohio Issues Likely in 2014

• JobsOhio
• Municipal Income Tax Reform
• Ballot issues:
  – Internet Cafes
  – Same-sex Marriage
  – Medical Marijuana
  – Right to Work/union issues
  – Personhood (anti-abortion)

• Who is the next Ohio House Speaker?
2013 Focus: State Budget

• Governor’s Budget Priorities:
  – Medicaid Expansion
  – K-12 Education Funding
  – Higher Education Funding
  – Tax Reform, incl. Fracking/Severance Tax (also including income tax reduction, sales tax broadening)

2013 Focus: State Budget

• Governor’s Priorities--What Happened:
  – Medicaid Expansion—NO (More on this later)
  – K-12 Education Funding—NO
  – Higher Education Funding—YES!
  – Fracking Tax/Tax Reform—NO (but a little “Yes”)

Unusual for Governor not to gain support for budget priorities from a Legislature whose majority is the same party as the Governor.
Hospitals’ State Budget Goals

- Support the expansion of the Medicaid program in Ohio
- Preserve and protect the Hospital Care Assurance Program
- Preserve the hospital franchise fee and appropriate matching funds
- Protect hospital, physician and other practitioners’ Medicaid reimbursement

Ohio House Bill 139

- Sponsored by Ohio Rep. Anne Gonzales (R-Westerville).
- Would permit approved APRNs and physician assistants to admit patients to hospitals.
- Supported by OHA, nurse executives, and others.
- Unanimously passed Ohio House in early October.
- Action in Ohio Senate possible in 2013.
Ohio House Bill 276

- Sponsored by Ohio Rep. Peter Stautberg (R-Cincinnati).
- Provides certain medical liability reforms to protect caregivers from inappropriate lawsuits.
- Health care providers’ statements of apology, error, or fault (“I’m sorry”) would be inadmissible in a civil claim.

Ohio Senate Bill 214

- Sponsored by Ohio Sen. Peggy Lehner (R-Kettering).
- Prohibits non-licensed, non-certified individuals from engaging in surgical technology.
- Defines surgical technology as prepping on OR, readying surgical equipment, etc.
- Must be a physician, RN, LPN, PA, or a certified surgical tech to do so.
- Allows for certain exceptions and waivers.
Medicaid Reform

- **Multiple bills** introduced in General Assembly.
- SB 206 (Burke) and HB 317 (Sears) are among the most comprehensive.
- Themes center on:
  - Stabilizing/reducing state’s Medicaid costs.
  - Centralizing **legislative oversight** and research into Medicaid policy.
  - Improving outcomes, efficiencies, safety.
  - Addressing disparities, drug abuse, mental health.
- **Stay tuned** – opportunity for stakeholders to be involved over the next few months.

Coverage Expansion under Medicaid: Why did Ohio have the debate?

- US Supreme Court Decision, 2012
  - Largely upheld the constitutionality of the ACA...
  - ...But concluded it was coercive to make a state’s ongoing receipt of Medicaid funds conditional on expansion of the program
  - Essentially made coverage expansion optional for states; has created 50 debates around country
Coverage Expansion Under Medicaid:

How was it approved?

• Legislature did not include it in the state budget, but...
• ...Supporters began a ballot initiative, and...
• ...CMS approved the Governor’s Medicaid plan.
• State Controlling Board acted:
  – 7 member board (6 legislators; 1 Gov. staff)
  – Provides legislative oversight over certain expenditures by state agencies; authorizes transfers of federal funds
  – Has authorized expenditure of federal stimulus funds in recent past
  – Approved Governor’s Medicaid plan 5-2
• Legal challenge pending before Ohio Supreme Court
  – Decision likely in December 2013

Coverage Expansion Under Medicaid:

Who does it cover?

• Adults up to 138% Federal Poverty Level (FPL)
  – About $16,000 individual; $27,000 family of 3
  – About 275,000 uninsured Ohioans
  – Mostly childless adults
• Existing eligibility categories:
  – Kids up to 200% FPL
  – Pregnant women up to 200% FPL
  – Parents of dependent children up to 90% FPL
  – Disabled workers up to 250% FPL
  – Disabled non-workers up to 64% FPL
Coverage Expansion Under Medicaid: How will it affect health care financing?

- Reduces hospitals’ uncompensated care by $1.1 billion through SFY 2015.
- Most uninsured will move to Medicaid Managed Care payment levels.
- Administration likely to reduce Medicaid base rate and capital payment rates.
- Will impact hospitals’ Upper Payment and DSH limits.
- Will require reform of DSH distribution model. Goals:
  - Fairness & equity
  - Avoid need for redistributions
The Federal Budget Mess

U.S. House of Representatives

- Of the 234 districts held by Republicans, 206 are rated as “solid Republican.”
- Of the 201 districts held by Democrats, 163 are rated as “solid Democratic.”
- Just 36 districts (8%) are competitive, of which only 9 are true “tossups” (2%).
- Fear of a primary election drives lawmakers.
- Political center is evaporating in US House.
**US Senate**

- Current balance: **54** Democrats, **46** Republicans
- **35** seats up in 2014 (**20D, 15R**)
- **11** are competitive at this point (**9D, 2R**)...
- ...but **5** of these due to retiring Senator (**4D, 1R**)  

**Jonathan’s Prediction (as of 8/2013):**

2015 US Senate balance will be within 2 seats, and probably within 1.

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**Ohioans in Key Positions**

- **US Senate Finance Committee**  
  - Sherrod Brown (D)  
  - Rob Portman (R)
- **US House Ways & Means Committee**  
  - Jim Renacci (R)  
  - Pat Tiberi (R)
- **US House Energy & Commerce Committee**  
  - Bob Latta (R)  
  - Bill Johnson (R)
- **Republican Study Committee**  
  - Jim Jordan (R) – Past Chair
- **Speaker of the US House of Representatives**  
  - John Boehner (R)
Federal Budget - Key Dates

January 1: Fiscal Cliff averted; doc fix passed
March 21-23: FFY 2013 shutdown averted; US House & Senate passed FFY 2014 blueprints
April 1: Sequester hit Medicare providers

**October 1:** FFY 2014 begins (Shutdown vs “Continuing Resolution”)

**October 17:** Default on nation’s debt obligations
Beyond the Debt Ceiling “X Date”

Without action by Congress after Feb. 7, 2014, Treasury Dept. only can spend revenues that come in each day.

• **Option 1 = Prioritize Programs**
  – Prioritized programs would be paid in full and on time, others would not. **Who picks?**

• **Option 2 = Delayed Payments**
  – Pay all programs one day at a time, once enough revenue accumulates. **Backlog!**

• Are these options really feasible? Legal?

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Lessons Learned: A Shutdown’s Implications for Providers

• Medicare and Medicaid claims will continue to be processed …for maybe 60-90 days.

• CMS, FDA, CDC, HRSA suspend “non-urgent” inspections, surveys, certifications, grants, etc.

• Congress, HHS furlough “non-essential” personnel (about 50% of staff).

• **BOTTOM LINE:** The longer a shutdown lasts, the more frustrations for nurses, hospitals & patients.
Interest Rates for Treasury Bills Maturing
Oct 17, 2013
10/4-10/16/2013

We're not going to be disrespected. We have to get something out of this. And I don't know what that even is.

-US Rep Marlin Stutzman (R-IN)
October 2, 2013
Sunk Cost Fallacy

• Justifying the act of continuing to invest in a hopeless undertaking by irrationally focusing on what one already has invested – and irrevocably lost – in the effort.

“We took an unpopular law and chose a more unpopular tactic to deal with the law."

-US Senator Lindsey Graham (R-SC)

October 9, 2013
Approval Ratings of the President & Congressional Parties

Source: NBC News/Wall Street Journal survey

Continuing Appropriations Act of 2014

- Enacted 17 October 2013
- **Extended Treasury’s authority to pay debts** until 7 February 2014 (really March? April?)
- **Ended govt. shutdown**; current funding maintained through 15 January 2014
- Requires **bipartisan, bicameral Budget Conference Committee**:
  - Discuss replacing sequester cuts
  - Report due 13 December 2013
Very Different Budget Priorities...

<table>
<thead>
<tr>
<th>House</th>
<th>Senate</th>
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</thead>
<tbody>
<tr>
<td>Structure</td>
<td>Structure</td>
</tr>
<tr>
<td>Reduces deficit $5.7 trillion and reaches balance over 10 years</td>
<td>Reduces deficit $1.8 trillion over ten years to 2.2 percent of GDP</td>
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<tr>
<td>Taxes</td>
<td></td>
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<tr>
<td>Assumes budget neutral reforms</td>
<td>$900 billion in new revenue</td>
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<td>Sequester</td>
<td></td>
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<tr>
<td>Maintains</td>
<td>Eliminates</td>
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<tr>
<td>ACA coverage expansions</td>
<td>Repeals</td>
</tr>
<tr>
<td>Maintains</td>
<td></td>
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<tr>
<td>Medicare reductions</td>
<td></td>
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<tr>
<td>Additional $127 billion (premium support and structural changes)</td>
<td>Additional $265 billion (unspecified)</td>
</tr>
<tr>
<td>Medicaid reductions</td>
<td>Block grants and cuts $756 billion</td>
</tr>
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Key Dates Ahead

- **13 December**: Report from Budget Conference (sequester fix?) – *providers vulnerable!*
- **31 December**: Medicare physician payment cut (current law) – *how to pay for a fix?*
- **15 January**: Current funding ends for federal programs, 2nd year of sequester begins
- **7 February**: Treasury Dept. forced to use “extraordinary measures” to pay debts
Challenges for Providers

Hospital Cuts by FFY2014 Budget Proposal

<table>
<thead>
<tr>
<th>Issue (Medicare)</th>
<th>US Senate (D)</th>
<th>US House (R)</th>
<th>President</th>
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</thead>
<tbody>
<tr>
<td>Keep or worsen IPAB</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Keep other ACA cuts</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Keep or worsen Sequestration cuts</td>
<td></td>
<td>✔️</td>
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<tr>
<td>Cut Critical Access Hospitals</td>
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<td>✔️</td>
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<tr>
<td>Cut Graduate Medical Education</td>
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<td>✔️</td>
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<tr>
<td>Cut Post-Acute (SNF, Rehab, LTCH)</td>
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<td>✔️</td>
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<tr>
<td>Cut Bad Debt</td>
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<td>✔️</td>
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<tr>
<td>&quot;Site Neutral&quot; Outpatient Cuts</td>
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<td>✔️</td>
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<tr>
<td>New PPS Coding Offsets*</td>
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<td>✔️</td>
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</tbody>
</table>

*Not included in spring budget proposals, but likely to be part of joint budget committee deliberations.
Hospital Cuts by FFY2014 Budget Proposal

<table>
<thead>
<tr>
<th>Issue (Medicaid)</th>
<th>US Senate (D)</th>
<th>US House (R)</th>
<th>President</th>
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<tbody>
<tr>
<td>Block Grant &amp; Cut States’ Funds</td>
<td></td>
<td>√</td>
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<tr>
<td>Repeal ACA’s Medicaid Expansion</td>
<td></td>
<td>√</td>
<td></td>
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<tr>
<td>Keep ACA’s Medicaid DSH Cuts</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Restrict States’ Use of Provider Assessments*</td>
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*Not included in spring budget proposals, but likely to be part of joint budget committee deliberations.

Potential Cuts to US Hospitals

- “Site-neutral” outpatient cuts ($6-25 B/10yrs)
- Smaller payments for post-acute ($70 B)
- Medicaid provider assessment caps ($22 B)
- Less aid for low-income seniors ($20 B)
- Graduate Medical Education cuts ($10 B)
- Medicare “coding offsets” ($8 B)
- Cuts to Critical Access Hospitals ($2 B)
“Site-Neutral” Payment Proposals

- Evaluation & Management codes (pay hospitals at physician office levels) – national estimate: ($10b)/10yrs
- Pay for 66 procedures performed in APCs at APC level: ($9 billion)/10yrs
- Pay for 12 procedures performed in ASCs at ASC level: ($6 billion)/10yrs

Other Federal Options on Table...

- Proposals to cut Critical Access Hospitals:
  - Cutting payments from 101% to 100% of costs
  - Limit eligibility based on proximity to other hospitals
  - Remove “necessary provider” designation
- Medicare readmissions penalties & regs
- Health information technology incentives and regulations
- 340b Medicare drug discount program
- Fundamental reforms to Medicaid, Medicare
**Impact of Sequester Cuts**

- **Military**
  - $43 billion in cuts
  - 7.8% of $550 billion
  - President Obama has said he will not allow cuts to affect military personnel.

- **Domestic programs**
  - No cuts
  - $50 billion
  - Includes health, education, drug enforcement, national parks, hurricane disaster relief and other programs.

- **Mandatory spending**
  - Medicare
  - No cuts
  - $165 billion
  - Includes funding for Pell Grants and programs run by the Department of Veterans Affairs.

- **Other**
  - Social security, Medicare, veterans, benefits, federal retirement benefits, nutrition and other low-income programs.

Chart Source: New York Times

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**“Two Midnight” Rule (IPPS 2014)**

- CMS’ attempt to limit use of observation & clarify when hospitals can start getting paid for inpatient care.
- Requires treatment span “two midnights” to qualify for Medicare Part A payment.
- Positive aspects:
  - Honors physician judgment, case complexity
  - Limits RAC review to info available at time of admission
  - Delayed enforcement
- Negative aspects:
  - Limited clarity
  - Difficult to implement
- AHA considering regulatory, legislative, judicial fixes
We’re Playing Offense, Too

- **Rural Hospital Access Act** (HR 1787/S 842) -- Continue MDH/LVA funding through FFY2014
- **Medicare Audit Improvement Act** (HR 1250/S 1012) – RAC relief for hospitals
- **DSH Reduction Relief Act** (HR 1920) – 2-yr delay to Medicare & Medicaid DSH cuts
- **HR 2053** – return Wage Index to pre-“Bay State Boondoggle” levels (+$20m/yr Ohio)

Medicare RAC Relief

- AHA leading lawsuit on rebilling for denied claims (pending)
- Legislative goals (HR 1250 / S 1012):
  - Limit medical requests
  - Require physician review of denials
  - Increased transparency from RACs
  - Require medical necessity audits to focus on widespread payment errors
  - Allow denied inpatient claims to be billed as outpatient when appropriate
### Forecast: Medicaid DSH Cuts 2013-2021

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Projected Annual Medicaid DSH Cut</th>
<th>Projected Cumulative Medicaid DSH Cut</th>
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<tbody>
<tr>
<td>2013</td>
<td>$0</td>
<td>-</td>
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<tr>
<td>2014</td>
<td>($23,409,393)</td>
<td>($23,409,393)</td>
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<tr>
<td>2015</td>
<td>($26,593,670)</td>
<td>($50,003,063)</td>
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<tr>
<td>2016</td>
<td>($23,484,407)</td>
<td>($73,487,470)</td>
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<tr>
<td>2017</td>
<td>($75,148,136)</td>
<td>($148,635,606)</td>
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<tr>
<td>2018</td>
<td>($197,637,663)</td>
<td>($346,273,269)</td>
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<tr>
<td>2019</td>
<td>($229,316,278)</td>
<td>($575,589,547)</td>
</tr>
<tr>
<td>2020</td>
<td>($151,067,472)</td>
<td>($726,657,019)</td>
</tr>
<tr>
<td>2021</td>
<td>($150,420,040)</td>
<td>($877,077,059)</td>
</tr>
</tbody>
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### A Medicare “Cleanup” Bill?

- Certain rural hospital payments expired 10/1/13.
- Current physician payment rates expire 12/31/13.
- Proposals on table to extend both.
- **How to pay for it?**
- Debate could roll into early 2014.
Transitioning From Volume to Value

- Volume-Based First Curve
  - Fee-for-service reimbursement
  - High quality not rewarded
  - No shared financial risk
  - Acute inpatient hospital focus
  - IT investment incentives not seen by hospital
  - Stand-alone care systems can thrive
  - Regulatory actions impede hospital-physician collaboration

- Value-Based Second Curve
  - Payment rewards population value: quality and efficiency
  - Quality impacts reimbursement
  - Partnerships with shared risk
  - Increased patient severity
  - IT utilization essential for population health management
  - Scale increases in importance
  - Realigned incentives, encouraged coordination
New Measures of Productivity & Financial Mgmt

Current Measures
- Staffing ratios
- Cost per inpatient stay
- Operating margin
- Length of stay

New Measures
- Expenses per episode
- Performance-based contracts
- Targeted cost reduction goals
- Management to Medicare margin

New Measures of Hospital-Physician Alignment

Current Measures
- Number of physicians
- Profit and loss from employed physicians
- Hospitalist utilization
- Number of contracts

New Measures
- Number of aligned physicians
- Contracts that include quality and efficiency incentives
- Availability of non-acute services
- Distribution of shared savings and gains
- Number of providers in hospital leadership
Care System of the Future

- Redefinition of health care delivery and institutions (more proactive, less reactionary)
- Many integrated players in collaboration; team-based approaches
- Satellite points of care linked by technology
- Coordination will be key (Medical Homes, etc.)
- Patients more involved, literate

“In times of change, ‘Learners’ inherit the Earth, while ‘The Learned’ find themselves beautifully equipped to deal with a world that no longer exists.”

-Eric Hoffer
(from Gary Kaplan, by way of James Orlikoff)
Questions & Discussion

THANK YOU!!

Jonathan Archey
Director, Government Affairs