AAMC
Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

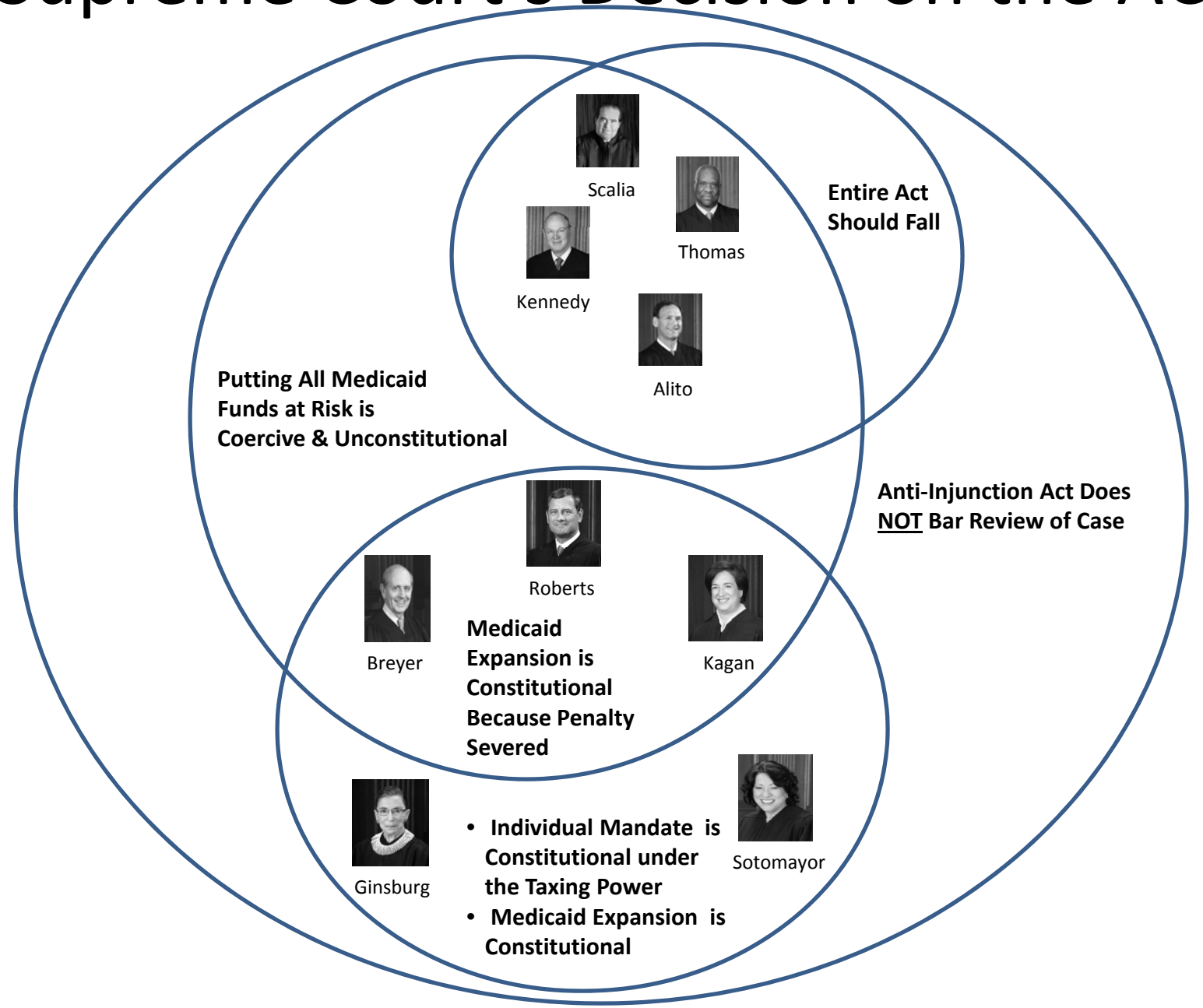
Health Care Reform: What's Next?

AAMC Fly-In Meeting

July 24, 2012
Chicago, IL

Association of
American Medical Colleges

Supreme Court's Decision on the ACA



ACA Refresher

ACA Legislation Highlights

ACA Implementation Timeline

Upcoming Regulations

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Hospital Issues on Horizon

- Medicare/Medicaid cuts to hospitals = **$155** B/10 yrs
- Hospital price transparency
- Community benefit reporting requirements/IRS
- Readmissions policies FY 2013
- Value based purchasing FY 2013
- Medicaid voluntary expansion CY 2014
- Exchange establishment (fed/state) CY 2014
- Hosp Acquired Conditions reductions FY 2015
- Will coverage levels be adequate (96% vs ?)

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Physician Issues on Horizon

- Changes to geographic adjusters in payment
- Quality reporting mandatory for physicians
  - Physician pay ‘value’ modifier
- Public reporting (‘physician compare’)
- Medicaid payment rates
  - 2013-14: Rates not lower than Medicare for primary care services (proposed rule)
- Medicare payments
  - 2011-15: bonuses to pc practitioners and general surgeons
- What to do about the SGR

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Since ACA Passed…

- Budget Actions
  - Proposed GME cuts
    - President's budget FY 2013
    - Ryan's budget FY 2013
    - Simpson-Bowles resurrected
  - Sequestration
- Selected provisions passed or implemented
  - Bad Debt reimbursement cut
  - MSSP (ACOs)
  - Value Based Purchasing
  - CMMI

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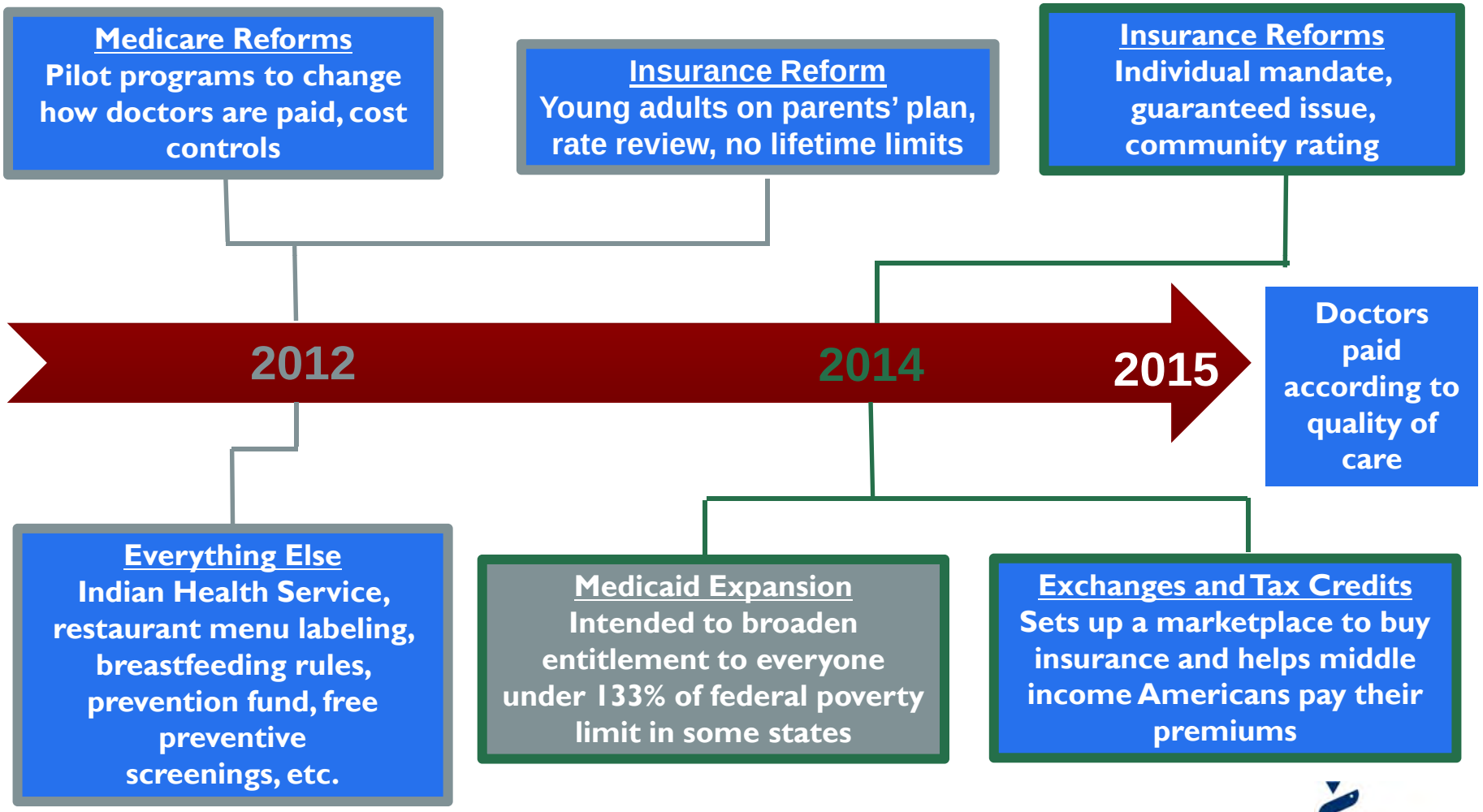
ACA Implementation Timeline



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Upcoming Regulations

From existing guidance*, the AAMC anticipates upcoming regulations to include:

- Guidance on essential health benefit implementation in Medicaid
- Further comment to consider amending the final rules regarding Medicaid eligibility determinations made by Exchanges
- QHP quality reporting requirement and quality reporting and disclosure requirements for all Exchanges
- Draft and final notice of benefit and payment parameters including user fee, risk adjustment, risk corridor, and reinsurance methodologies

* Essential Health Benefits Bulletin (12/16/11) and Federally-Funded Exchange Guidance (5/16/12); current regulations available at http://cciio.hhs.gov/resources/regulations/index.html#hie

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Medicaid/Exchange Issues

Exchange Strategies

DSH Strategies

Current State Policies

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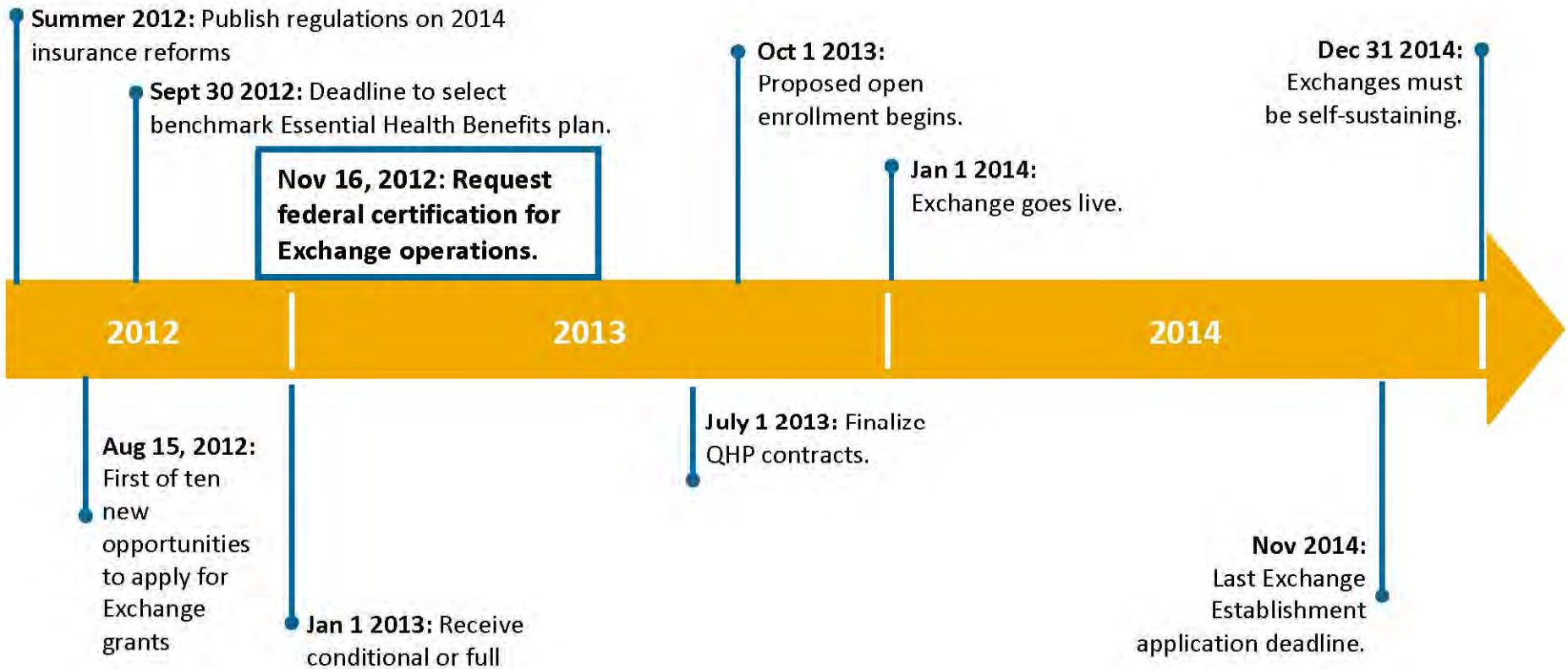
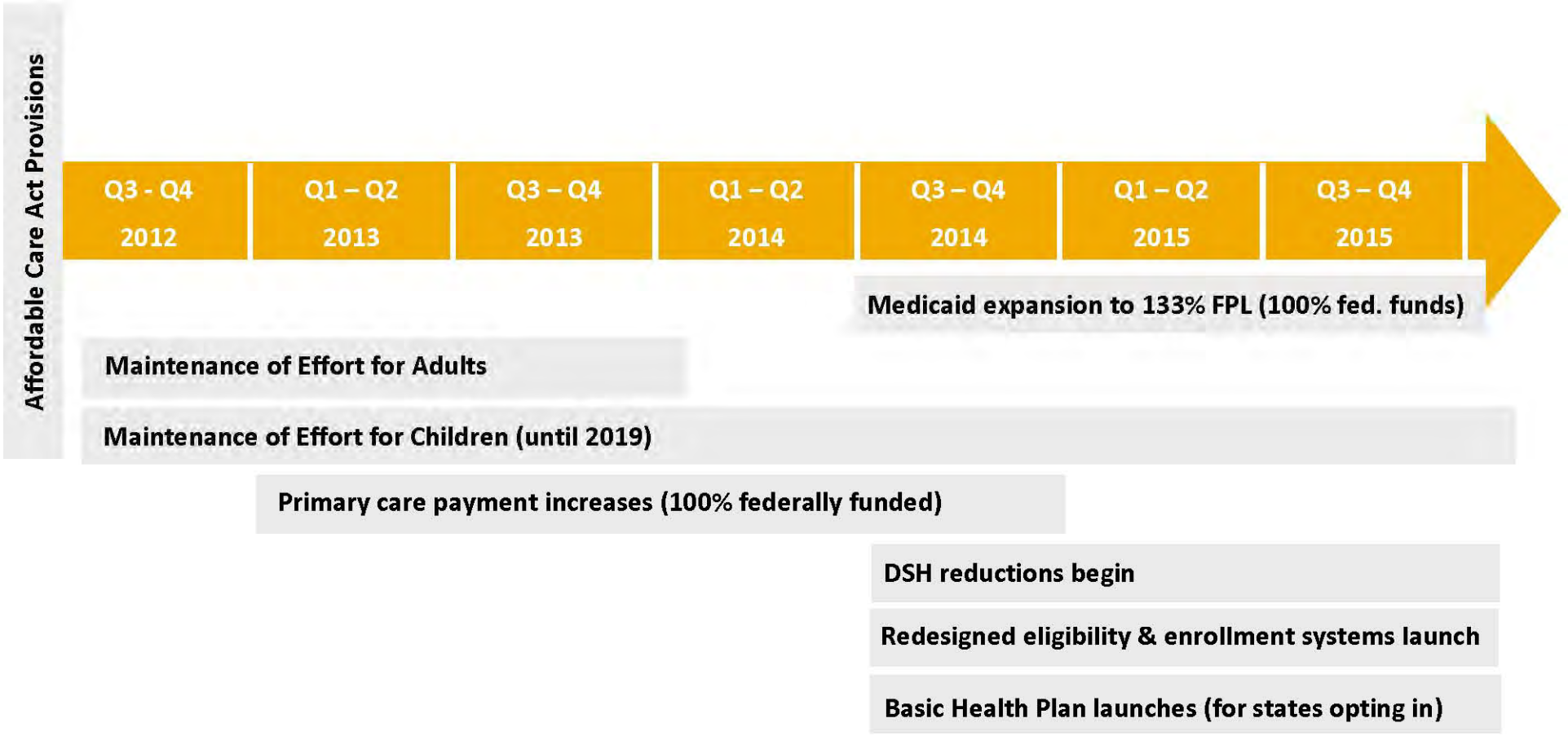
Exchange: Key Dates



From: Manatt Presentation

ACA Medicaid Changes: Key Dates



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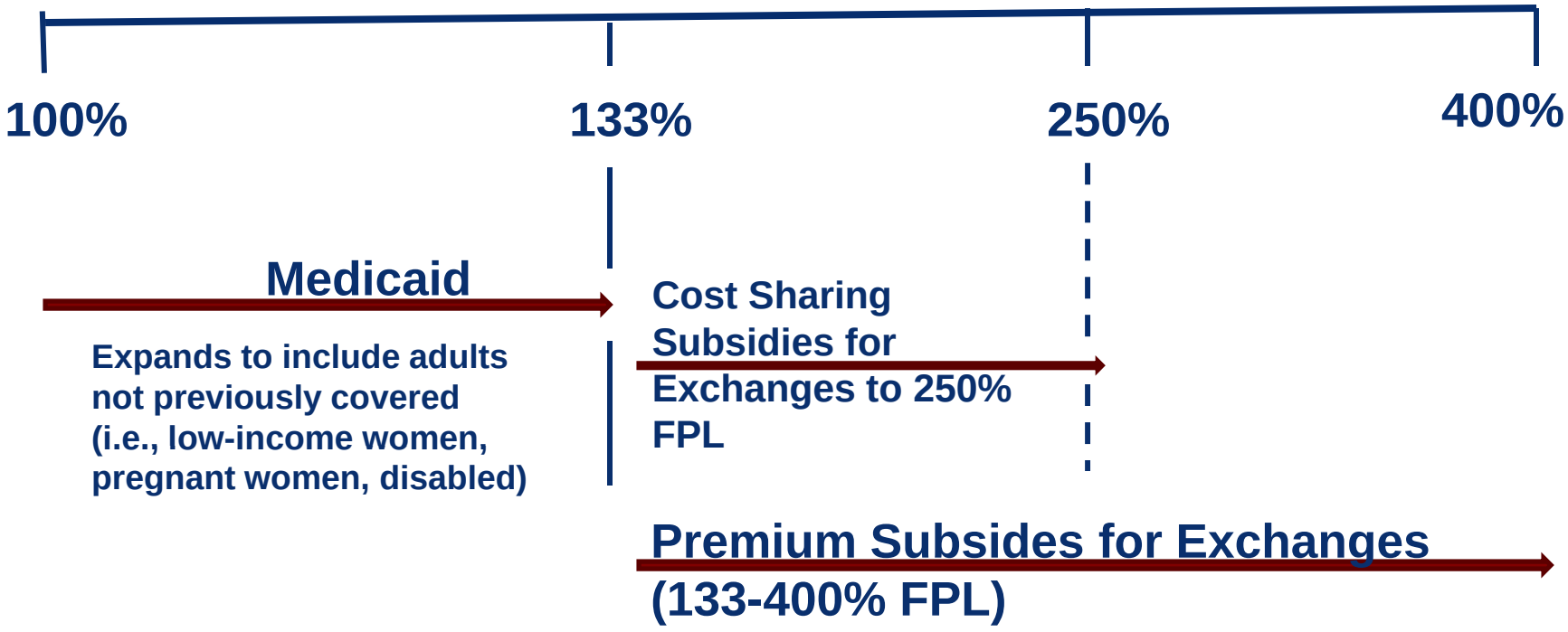
From: Manatt Presentation

Coverage Expansions 2014

Federal Poverty Level



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Governor Jack Markell (D-DE)
NGA Chairman, 2012-2013
DGA Chair, 2010

On the Voluntary Medicaid Expansion:

- "Math is math. It's not Democratic or Republican."
- "The first thing we want to make sure of is our understanding of the math…with respect to what kind of increased reimbursements we'd get."
- "We want to make it clear that if the deal changes, and the federal government reduces its commitment, that we're not going to be left holding the bag."

Source: *Governing* ("FedWatch Blog", July 16, 2012)

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NGA Chairman (*cont'd*)

On the Voluntary Medicaid Expansion:

- "The best role NGA can play is to recognize that different governors from different states will make their own decisions."
- "This is a decision for each governor to make … there doesn't have to be unanimity."

Source: *Governing* ("FedWatch Blog", July 16, 2012)

Medicaid/Exchange Issues

Exchange Strategies

DSH Strategies

Current State Policies

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Medicare DSH Adjustment: General Overview

DSH Payment Percentage (DPP) is per-hospital calculation used to calculate Medicare DSH payments

- Formula (in general; exceptions for certain hospitals):

Medicare Disproportionate Patient Percentage

Disproportionate Patient Percentage = (Medicare/Supplemental Security Income Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)

- Changes in Medicaid inpatient volume under ACA will potentially impact a hospital's DSH Payment Percentage
- Currently, DSH accounts for 12% of all Medicare PPS payments to major teaching hospitals

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ACA and Medicare DSH

- $22 billion in aggregate Medicare DSH cuts over 10 years
- Implemented as per-hospital cuts:
  - Starting in FY 2014, each hospital receives 25% of the Medicare DSH payments under the current formula
    - 25% represents MedPAC's "empirically justified" Medicare DSH amount (March 2007 Report)
- Small portion re-directed to eligible hospitals
  - Additional payments will reflect the hospital's DSH Payment Percentage, the % change in uninsured, **and a hospital's uncompensated care costs**
    - The Medicare DSH formula does not currently account for uncompensated care costs.

By 2016, Medicare DSH payments to hospitals likely to be about half of current levels

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General Overview: Medicaid DSH Payments

- State Medicaid provides payment adjustments/supplements to hospitals serving a disproportionate share of low-income patients (Medicaid and uninsured).
- Medicaid program awards each state an annual Medicaid DSH allotment (total about $11.5 billion annually; aggregate/state total may not exceed 12% of Medicaid spending).
  - ✓ Largest source of federal funding for uncompensated hospital care.
  - ✓ In general, a state's allotment equals the previous year's allotment, updated by inflation.
  - ✓ Significant variation in allotment levels among states.

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Medicaid DSH Overview (*cont'd*)

- States must use allotments to help "DSH hospitals" offset costs of caring for low-income patients when not covered by Medicare, Medicaid, CHIP, or other insurance.
- States must establish:
  - ✓ Criteria for "DSH hospital" designation; and
  - ✓ A DSH payment methodology.
- Under Medicaid statute, all DSH hospitals must have (at minimum) a Medicaid utilization rate of 1% and either:
  - ✓ A Medicaid inpatient utilization rate exceeding one standard deviation above the mean for all hospitals in the state; or
  - ✓ A low-income patient utilization rate exceeding 25%.

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Medicaid DSH Overview (*cont'd*)

A state's DSH payment methodology is closely tied to the hospital's Medicaid and uninsured patient volume. It must either:

- Be tied to the hospital's Medicare DSH percentage (least frequently used option); or
- Tie payments to a DSH hospital's volume of Medicaid and uninsured patients (most frequently used option).
  - ✓ States may use different DSH payment formulas according to hospital "types"

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Medicaid DSH Overview (*cont'd*)

Per-hospital limit on Medicaid DSH payments

- Medicaid DSH payments limited to hospital costs of providing inpatient and outpatient services to Medicaid and uninsured patients, minus any applicable revenues for those services.
- But exactly how does Medicaid define "uninsured"?
  - ✓ A person with no insurance coverage?
  - ✓ A person with insurance that doesn't cover necessary services?

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New Actions on DSH (Not Part of ACA)

January 18, 2012 Proposed Rule: Defining "uninsured" for the purpose of establishing *hospital-specific Medicaid DSH limits*.

- Revise current definition of "uninsured" to include both:
  - ✓ Patients with no health coverage
  - ✓ Insured patients that lack or exhaust coverage for a specific service
- AAMC submitted comments:
  - ✓ Supports adding the "service-specific" component
  - ✓ Make definition retroactive to 2008 (when Medicaid established an "individual-specific" definition)
  - ✓ Add unpaid coinsurance and deductibles to the per-hospital DSH limit calculation
  - ✓ Clarify that the DSH calculation may include the cost of services provided after coverage is exhausted

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ACA and Medicaid DSH

- $18 billion in aggregate Medicaid DSH cuts over 10 years.
  - ✓ FY 2014: $500 million
  - ✓ FY 2015: $600 million
  - ✓ FY 2016: $600 million
  - ✓ FY 2017: $1.8 billion
  - ✓ FY 2018: $5 billion
  - ✓ FY 2019: $5.6 billion
  - ✓ FY 2020: $4 billion
- Cuts occur regardless of coverage levels.
- In FY 2021, allotments equal FY 2020 levels (ie, reduced levels), plus an inflation update.
  - ✓ Approved as a $4 billion offset for 2012 legislation providing SGR relief and the extension of tax cuts and unemployment benefits.

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ACA Methodology for Achieving Medicaid DSH Cuts

To achieve aggregate annual savings under ACA, HHS Secretary must implement a "DSH Health Reform Methodology" that must:

1. Impose the ***largest percent reductions*** on states that:
   - ✓ Have the lowest percentages of uninsured
   - ✓ Do *not* "target" DSH payments on hospitals with high Medicaid inpatient volume
   - ✓ Do *not* "target" DSH payments on hospitals with high levels of uncompensated care (excl. bad debt)

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DSH Methodology (*cont'd*)

2. Impose ***smaller percent reductions*** on Low-DSH states.
   - ✓ States with Medicaid DSH expenditures 0%-3% of total (state and federal) FY 2000 Medicaid spending
3. Account for the extent to which a state's Medicaid DSH allotment was included in a budget neutrality calculation for coverage expansions approved under Sec. 1115 waivers (as of July 31, 2009).

Can give input at federal level on approaches

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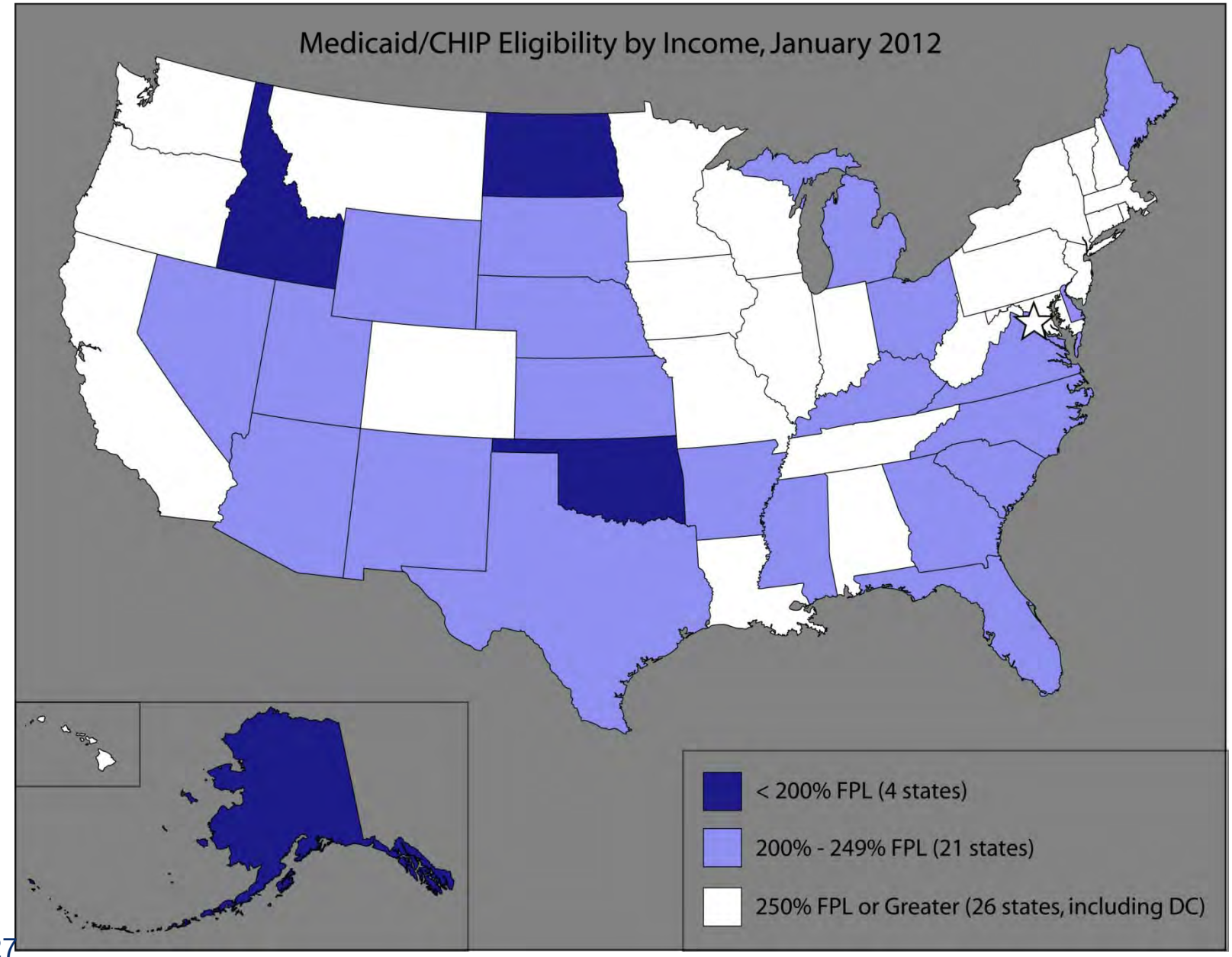
Medicaid/CHIP Eligibility



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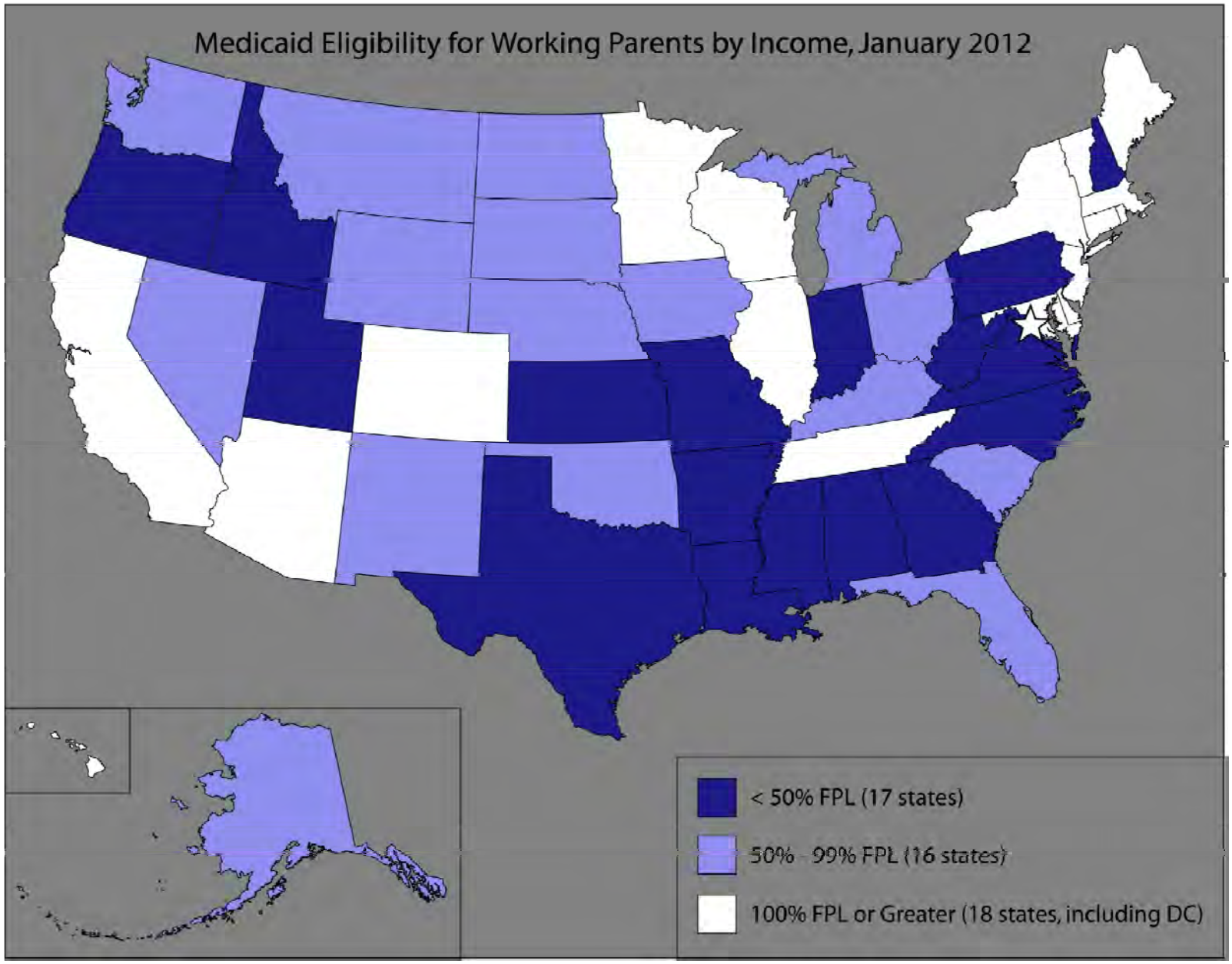
Medicaid for Working Parents



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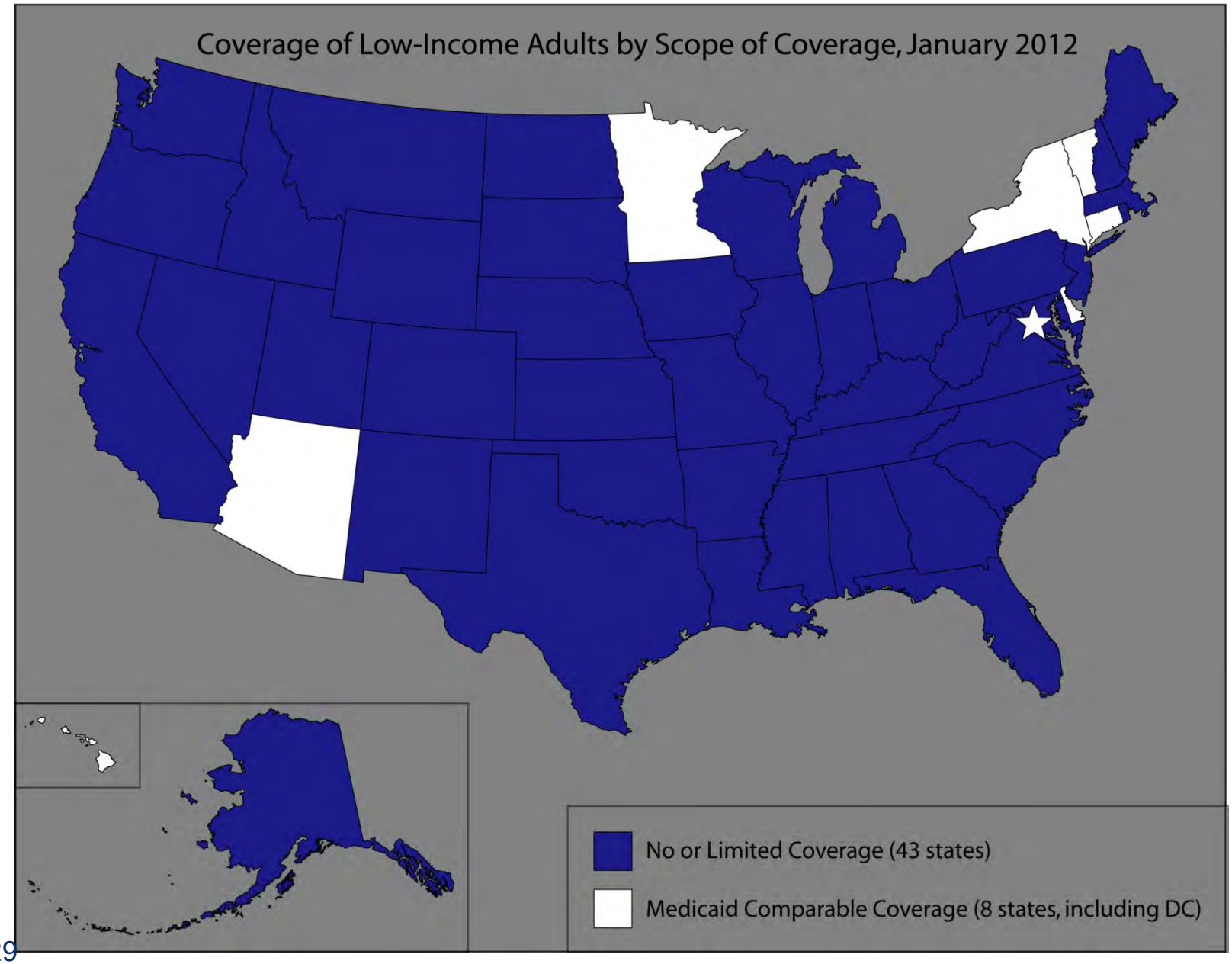
Medicaid for Childless Adults



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What's Happening on the Ground?

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Looking Forward to Congressional Actions

- The Fiscal Cliff/Debt Ceiling
- Sequestration
- Deficit Reduction
- GME, NIH, Title VII, and Other Federally-Funded Programs

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- **FY 2013 Appropriations**
- **Tax Cuts**
- **Payroll Tax Holiday**
- **Extended Unemployment Benefits**
- **AMT “Patch”**
- **SGR (“Doc Fix”)**
- **Sequestration**
- **Debt Limit Extension**

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"But at the same time, I think you also have to protect the recovery in the near term. Under current law, on January 1st, 2013, there is going to be a massive fiscal cliff of large spending cuts and tax increases."

Federal Reserve Chair Ben S. Bernanke, testifying before the House Financial Services Committee, 2/29/12

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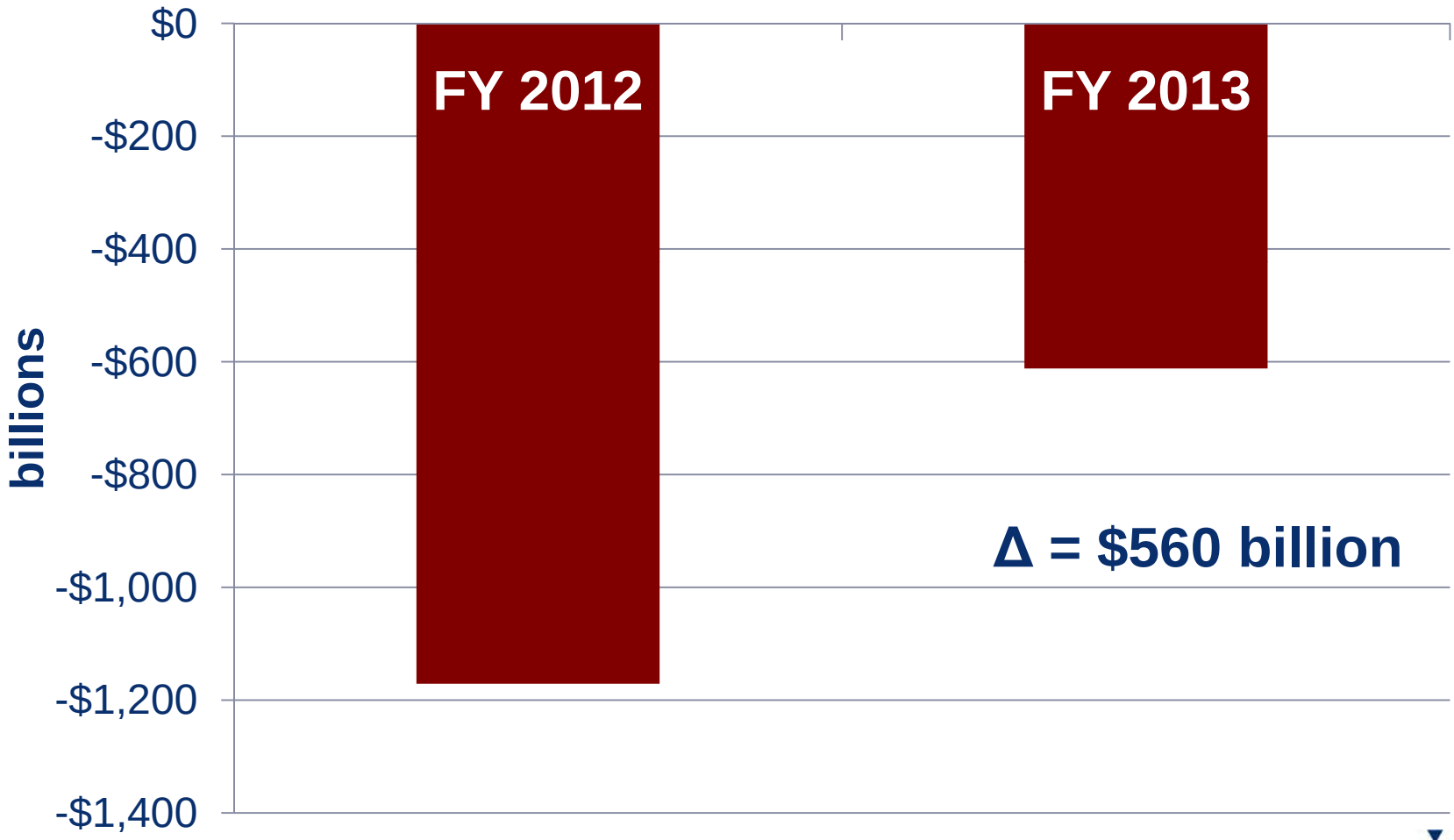
Change in Budget Deficit Under Current Law



Source: CBO, May 2012

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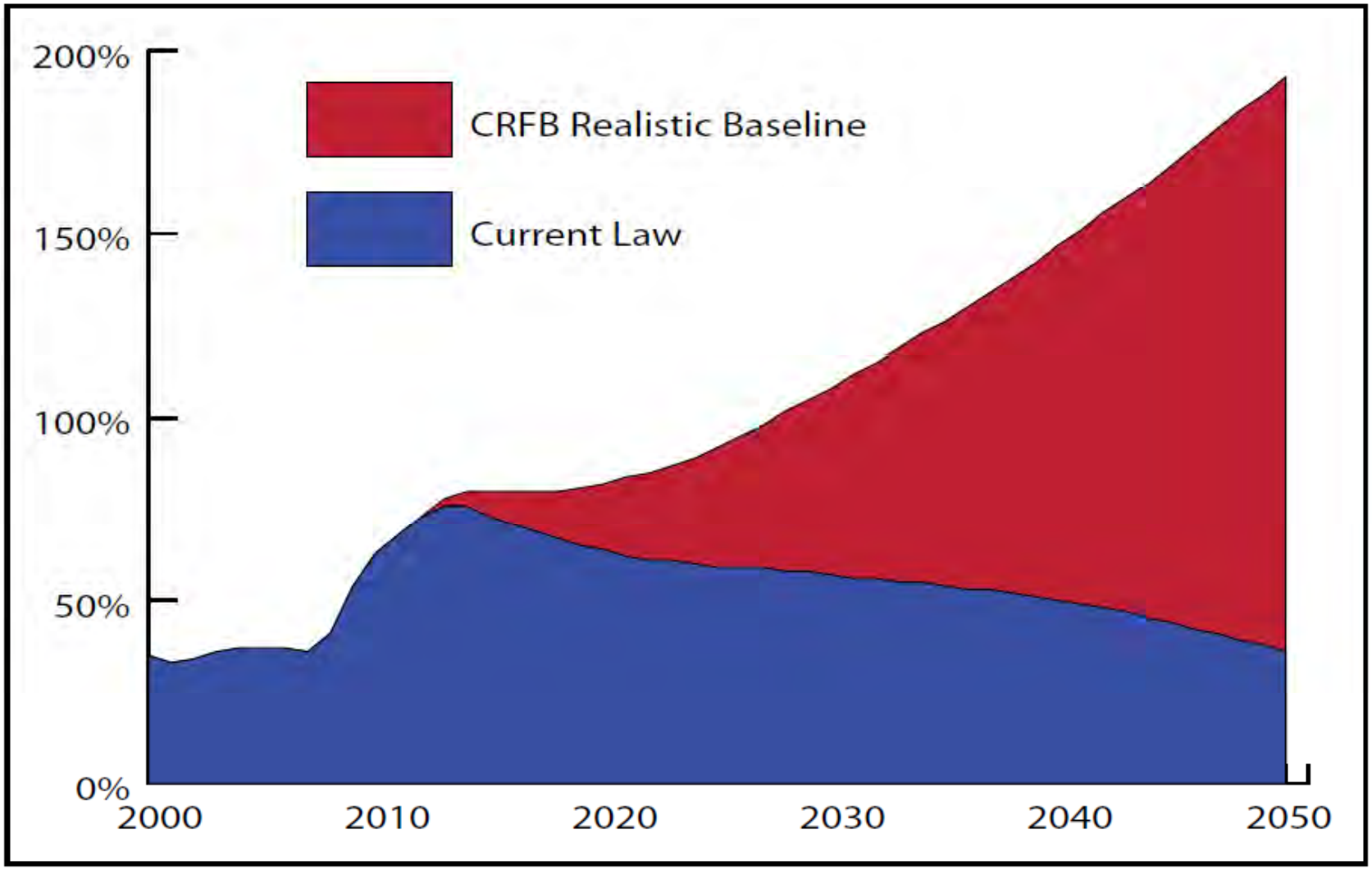
FIG 3. DEBT PROJECTIONS (PERCENT OF GDP)



Source: Committee for a Responsible Federal Budget, *Between a Mountain of Debt and a Fiscal Cliff, 7/16/2012*

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se·ques·tra·tion, *n.*

Loss of blood or of its fluid content into spaces within the body, so that the circulating volume diminishes…

…the cancellation of budgetary resources.

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OMB on the Sequester

"When bipartisan majorities in Congress voted for the BCA, they and the administration knew that this sequester would be destructive…. [T]he sequester wasn't meant to be implemented. It was designed to cause cuts so deep that just threatening them would force members of Congress to agree on a big, balanced package of deficit reduction.

"The truth is that no amount of planning or reports will turn the sequester into anything other than the devastating cut in defense and domestic investments that it was meant to be."

Jeffrey Zients, acting director, Office of Management and Budget, *Politico*, 7/10/12

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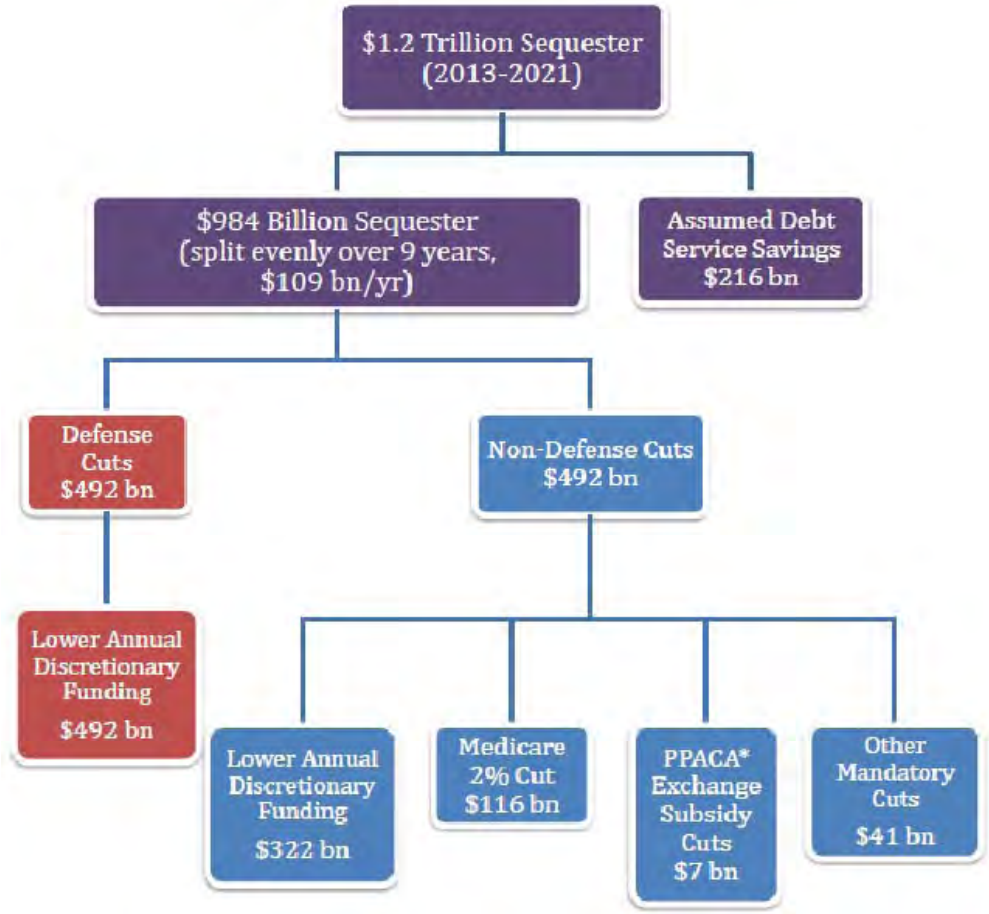
Breaking Down the Sequester



Source: Bipartisan Policy Center, *Indefensible: The Sequester's Mechanics and Adverse Effects on National and Economic Security*, June 2012

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Table 2

Sequestration in 2013 if Appropriations Match 2013 Caps

In billions of dollars

	Resources Before Sequestration	Sequestration	
		Dollar reduction	Percent reduction
Defense	**$726**	**$54.7**	
Military personnel funding, assumed to be **exempt** (est.)	136	0	0.0%
Other non-war funding for 2013	410	38.0	9.3%
Subtotal, amount subject to caps	546		
War funding, outside of caps (estimated)	90	8.3	9.3%
Unobligated balances from prior years (estimated)	90	8.3	9.3%
Non-defense discretionary (NDD) programs	**501**	**38.6**	
Non-exempt programs	423	38.5	9.1%
Veterans' health and Pell grants, **exempt** (estimated)	72	0.0	0.0%
Health centers and Indian health, **2% limit** (estimated)	6	0.1	2.0%
Non-exempt mandatory programs	**605**	**16.1**	
Medicare payments to providers and plans, **2% limit**	542	10.8	2.0%
Other non-exempt mandatory programs	63	5.2	8.2%

Source: ***How the Across-the Board Cuts on the Budget Control Act Will Work,*** **Richard Kogan, Center for Budget and Policy Priorities, 12/2/2011, www.cbpp.org/files/12-2-11bud2.pdf**

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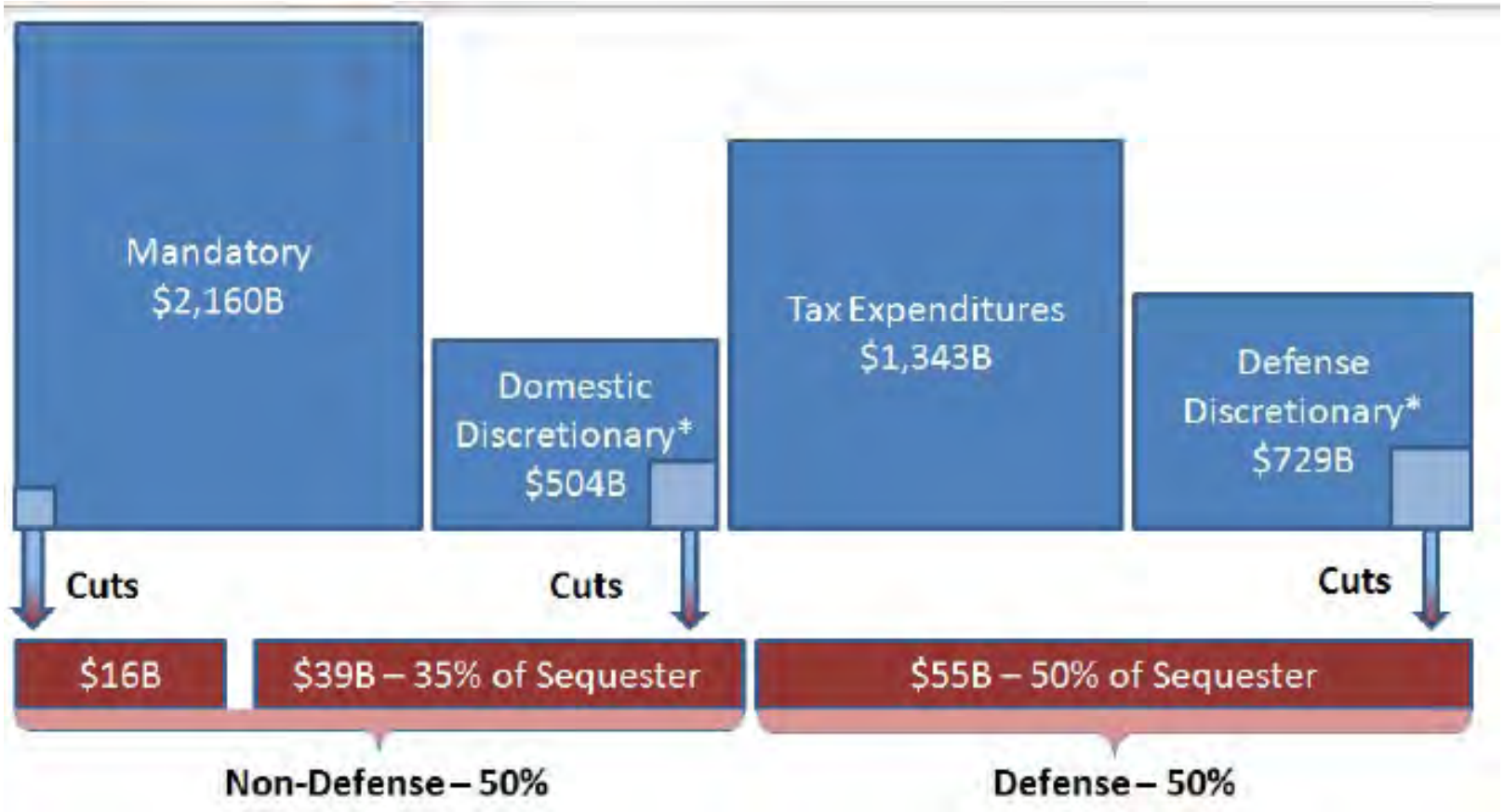
FY13 Sequester Falls Almost Entirely on Smallest Pieces of the Budget



Source: Bipartisan Policy Center, *Indefensible: The Sequester's Mechanics and Adverse Effects on National and Economic Security*, June 2012

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Impact of the Sequester

"My great fear is that medical research, education programs, and investments in the future of our country will be sacrificed in order to preserve nuclear weapons programs, amongst other things that are not needed."

Rep. Ed Markey (D-Mass.), quoted in *Politico*, 7/19/2012

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Impact of Sequestration

Spending cuts beginning Jan. 2, 2013 will:

- **Reduce nation's GDP by $215 billion; and**
- **Cost the U.S. economy 2.14 million jobs**
  - **Increase unemployment by as much as 1.5 percentage points**
  - **Nearly 50 percent of job loss from non-DOD cuts**

Source: The Economic Impact of the Budget Control Act of 2011 on DOD & non-DOD Agencies, Stephen S. Fuller, Ph.D., report prepared for Aerospace Industries Association, July 17, 2012

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Impact of Sequestration on NIH

"NIH would expect to lose 7.8 percent of the budget, about $2.4 billion…. [That] would result in roughly 2,300 grants that we would not be able to award in fiscal year '13….

"[T]hat represents almost a quarter of our new and competing grants that would result in success rates… falling to historically low levels….

"And I think the burden would hit particularly heavily upon first time investigators…."

NIH Director Francis Collins, M.D., Ph.D., Senate Labor-HHS-Education Appropriations Subcommittee, 3/28/12

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Simpson, Bowles Revisit Plan

"Authors of the Simpson-Bowles deficit reduction plan are rewriting their $4 trillion proposal to include an aggressive plan to control health care spending."

***CQ Today*, 7/17/2012**

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National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)

- **Reform Medicare SGR by freezing physician payments from 2012 through 2020, fully offsetting the cost, and recommending CMS develop an improved formula that encourages care coordination.**
- **Reduce excess payments to hospitals for medical education.**
  - **Limit DGME payments to 120% national average resident in 2010**
  - **Reduce IME from 5.5% to 2.2%**
- **$6B/yr cut to teaching hospitals**

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National Commission on Fiscal Responsibility and Reform

- **Phase out Medicare payments for bad debts (*saves $23 billion over 10 years)***
- **Phase out Medicaid provider tax mechanism (*saves $44 billion over 10 years)***

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National Commission on Fiscal Responsibility and Reform

- **Cap discretionary spending through 2020.**
  - **Return spending to "pre-crisis" 2008 levels in real terms in 2013.**
  - **Limit spending growth to half the projected inflation rate through 2020.**
  - **Create bipartisan "Cut-and-Invest Committee" to identify annually 2% of discretionary budget that should be cut, with half of savings redirected into "high-value investments" such as R&D in energy and other critical areas.**

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302(b) Subcommittee Allocations [in billions]

	FY 2012 Enacted	FY 2013 House	FY 2013 Senate
Labor-HHS-ED	**$156.8**	**$150.0**	**$157.7**
Total	**$1,043.0**	**$1,027.9**	**$1,047.0**

Sources: House and Senate Appropriations Committees

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FY 2013 AAMC Priorities

	FY 2012 Final [P.L. 112-74]	FY 2013 House Subcmte.	Percent Change 12-13	FY 2013 Senate Committee	Percent Change 12-13
NIH	$30.623 B	$30.623 B	0.0%	$30.723 B	0.3%
Title VII [1]	$264 M	Unavailable		$256 M	- 3.0%
Title VIII [1]	$231 M	Unavailable		$231 M	0.0%
AHRQ [2] (w/ transfers)	$369 M ($405 M)	Eliminates AHRQ and rescinds $150 million from PCORTF		$364 M ($438 M)	- 1.4% (8.1%)
Children's GME	$265 M	$275 M	3.8%	$265 M	0.0%
NHSC [3]	$296 M	Unavailable		$300 M	0 %
CDC [4]	$5.656 B	$5.697 B	0.7%	$5.714 B	1.0%

1 Includes proposed transfers from the PHS Evaluation tap and the Prevention and Public Health Fund.

2 AHRQ is scheduled to receive $24 million from the Patient-Centered Outcomes Research Trust Fund (PCORTF) and $12 million from the Prevention and Public Health Fund (PPHF) in FY 2012. Expected transfers in FY 2013 include $62 million from the PCORTF and $12 million from the PPHF.

3 Includes $295 million (FY 2012) & $300 million (FY 2013) from the ACA's NHSC Fund.

4 CDC totals do not include transfers from the Prevention and Public Health Fund (PPHF). CDC received $825 million in FY 2012. The Senate Committee recommends an $858 million transfer to CDC. The House Subcommittee rescinds $1 billion in FY 2013 from the PPHF. As a result, overall funding to CDC in FY 2013 would drop by $814 million (11.7 percent) compared to FY 2012.

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It's Déjà vu all over again...

"When the time comes, I will again insist on my simple principle of cuts and reforms greater than the debt limit increase. This is the only avenue I see right now to force the elected leadership of this country to solve our structural fiscal imbalance."

House Speaker John Boehner (R-Ohio), speaking at 2012 Fiscal Summit sponsored by the Peter G. Peterson Foundation, 5/15/12

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When do we hit the debt limit?

"[O]n the current estimates … we're likely to hit the debt limit sometime before the end of the year, but Congress has given the executive branch a set of tools … [that] will probably take us into the early part of 2013, thus separating somewhat the timing of the expiry of the tax cuts and the sequester with the ultimate need for Congress to act on the debt limit."

Treasury Secretary Timothy Geithner, speaking at 2012 Fiscal Summit sponsored by the Peter G. Peterson Foundation, 5/15/12

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So What Happens Next?

- **Conventional wisdom is nothing happens before the election, but**
- **House Republican leaders talking about short-term continuing resolution (CR) to get them into 2013**
- **Will Congress and the Administration negotiate a deal during the "lame duck" session following the election – or –**
- **Will the "winners" in November refuse to negotiate with the "losers" and everything gets kicked into the 113th Congress**

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What to Do When You Go Home

- **Encourage your member of Congress to join the Academic Medicine Caucus**
- **Ask your Senators to cosponsor S. 1627, The Resident Physician Shortage Act of 2011, to increase the number of residency positions eligible for Medicare DGME and IME support**
- **Attend a candidate's town hall meeting and ask questions about issues of concern to academic medicine**

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What to Do When You Go Home

- **Invite your member of Congress, Senators, and staff to visit your campus to learn about the critical role you play in the community and about the ground-breaking medical research you conduct**
- **Consider hosting a Project Medical Education program or a Research Means Hope celebration at your institution.**
- **Talk with your representatives about the need for Congress to increase federal support for doctor training and invest in the future by maintaining funding for NIH research**

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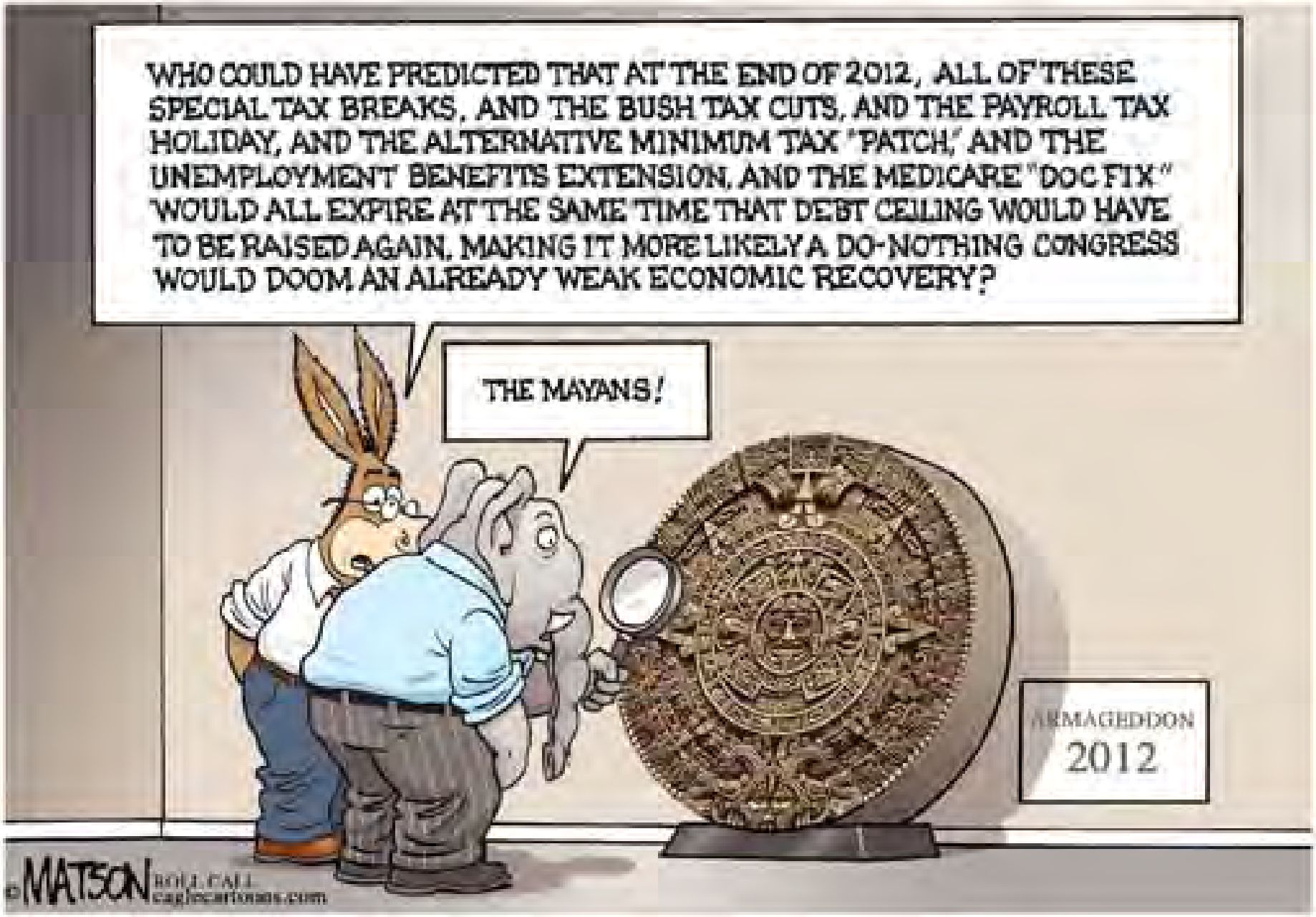
WHO COULD HAVE PREDICTED THAT AT THE END OF 2012, ALL OF THESE SPECIAL TAX BREAKS, AND THE BUSH TAX CUTS, AND THE PAYROLL TAX HOLIDAY, AND THE ALTERNATIVE MINIMUM TAX "PATCH," AND THE UNEMPLOYMENT BENEFITS EXTENSION, AND THE MEDICARE "DOC FIX" WOULD ALL EXPIRE AT THE SAME TIME THAT DEBT CEILING WOULD HAVE TO BE RAISED AGAIN, MAKING IT MORE LIKELY A DO-NOTHING CONGRESS WOULD DOOM AN ALREADY WEAK ECONOMIC RECOVERY?
THE MAYANS!
ARMAGEDDON
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