



The following summarizes the major hospital and health system provisions included in the U.S. House of Representatives health reform bill, the Affordable Health Care for America Act, released October 29.

State Fiscal Relief [Section 1749]

The bill would extend for six months the temporary increase to the Federal Medical Assistance Percentage (FMAP) provided in the federal stimulus bill. This would mean \$3.4 billion in additional federal funding to New York State.

Coverage Expansion [Sections 310, 323, 324, 341, 342, 343, 344, and 1701]

The Congressional Budget Office (CBO) projects the House bill would provide insurance coverage to 96% of all Americans; up to 36 million individuals would newly access coverage. Eighteen million individuals would remain uncovered in 2019. Coverage expansion would be achieved by increasing federal support for Medicaid eligibility up to 150% of the federal poverty level (FPL) and by offering subsidies to moderate-income Americans to buy insurance either through private plans in a new federal or state-based health insurance exchange, or through a new government-run public plan. The bill would also allow for the establishment of non-profit health insurance co-operatives, accessed through the exchange.

Expansion of Federal Support for Medicaid Eligibility up to 150% of FPL: The bill would raise the threshold for mandatory Medicaid coverage to 150% of FPL. A federal matching rate of 100% would be provided to states for the cost of the expansion in 2013 and 2014. The federal matching rate for 2015 and beyond would be 91%.

Subsidies for Health Insurance Coverage: Affordability premium credits would be provided on a sliding scale to individuals and families. Premium limits as a percentage of income would start at 1.5% of income for those at or below 133% of FPL and phase out at 12% of income for those at 400% of FPL. A cap on annual out-of-pocket costs is also provided to individuals and families that fall into these income categories.

Establishment of a Government-Run Public Insurance Plan and Non-Profit Health Insurance Co-operatives (Co-ops): The bill would require the Secretary of Health and Human Services (HHS) to develop a new government-operated public health insurance option to compete with private health insurance plans, and offer this option in the new federal- or state-based health insurance exchange in 2013. Also, federal funding for start-up loans and grants would be provided to qualified organizations to assist in the establishment of non-profit, member-run health insurance co-ops that would offer health insurance through the health insurance exchange.

Payment Rates to Providers under the Public Plan and By Co-ops: For the provision of services to individuals with coverage under the newly established public health insurance plan and co-ops, health care providers would either negotiate payment rates with the HHS Secretary (for public plan) or directly with the co-op.

Under the public plan, the law would require that rates negotiated with the Secretary are not lower than aggregate average Medicare rates; and not higher than aggregate average rates of private health insurance plans offering insurance through the exchange.

The Secretary would have the authority to adjust payment rates under the public option to promote better quality and more efficient care. Any payment changes considered by the Secretary must seek to reduce cost for enrollees, improve health outcomes, reduce health disparities, address geographic variation in the provision of medical services, prevent or manage chronic illnesses, or promote integrated patient-centered care.

Medicare Update Factor Reductions [Sections 1101, 1102, 1103, 1131, 1153, and 1155]

Productivity Offsets: The update factor for all Medicare Part A and B providers who are subject to a marketbasket or Consumer Price Index (CPI) update would be reduced, but not below zero, to reflect estimated gains in productivity. Beginning in 2010 or 2011, a full productivity adjustment of about 1.3% would be applied to inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, nursing homes, home health providers, and hospice.

Additional Marketbasket Reductions: In addition to the productivity offset, the annual marketbasket updates would be eliminated for inpatient rehabilitation facilities and nursing homes in the second, third, and fourth quarters of 2010. The marketbasket update for home health providers would be eliminated for 2010.

Disproportionate Share Hospital (DSH) Payment Reductions [Sections 1112 and 1704]

Medicare DSH Report: This provision would require the Secretary to report to Congress by January 1, 2016 on the appropriateness of Medicare DSH payments, taking into account the impact of the health care reform measures that reduce the number of uninsured people.

Maintains Current Medicare DSH Payment Levels Through 2016: Adjustments to Medicare DSH will occur if there is a significant decrease in the national level of the uninsured that exceeds eight percentage points from 2010 to 2014, beginning in 2017. Medicare DSH payments “shall take into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size,” and the amount of uncompensated care, excluding bad debt. These new DSH payments could not be greater than 50% of the estimated DSH savings.

Medicaid DSH Report: This provision would require the Secretary to report to Congress by January 1, 2016 on the appropriateness of Medicaid DSH payments, taking into account the impact of the health care reform measures that reduce the number of uninsured individuals.

Maintains Current Medicaid DSH Payment Levels Through 2016: Beginning in 2017, federal DSH funds are reduced by \$10 billion nationwide: a \$1.5 billion reduction in 2017, \$2.5 billion reduction in 2018, and \$6 billion reduction in 2019. By 2016, the Secretary must recommend to Congress appropriate targeting of DSH payments within states and appropriate distribution across states. The methodology for cuts would depend on states’ rates of uninsured and use of DSH money, which would be measured by uncompensated care and hospital Medicaid volume.

Establishment of a Medicare Readmissions Payment Policy [Section 1151]

Acute Care Hospitals Including Critical Access Hospitals (CAHs): Beginning in federal fiscal year (FFY) 2012, acute care hospitals and CAHs determined to have higher than expected readmission rates in any of

three medical condition categories would receive reduced Medicare payments for all Medicare discharges. Medicare payments would be reduced by the lower of a hospital-specific readmissions adjustment factor or a pre-determined floor (1.0% in FFY 2012, increasing to 5.0% in FFY 2015 and thereafter). The policy would first apply to readmissions related to heart failure, heart attack, and pneumonia; in FFY 2013, the Secretary would be required to expand the list of applicable conditions to include chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA), and other vascular procedures—per the Medicare Payment Advisory Commission’s (MedPAC) June 2007 recommendation to Congress. The Secretary also would have the authority to expand the policy to additional conditions in future years, including all-cause readmissions.

Readmission rates would be risk-adjusted using a methodology endorsed by the National Quality Forum (NQF). The Secretary would be required to provide financial assistance to certain hospitals to help them address specific patient noncompliance issues that may be causing high readmission rates, especially provision of transitional care services. Beginning in FFY 2014, the Secretary would be authorized to modify the adjustment methodology based on hospitals’ readmissions performance compared to a national ranking of hospitals.

Post-Acute Care Providers: Creates an interim readmissions policy for post-acute providers beginning in FFY 2012. For discharges from a post-acute care provider that are readmitted to an acute care hospital or CAH within 30 days of the initial post-acute discharge, the policy would reduce Medicare payments by 0.4% in FFY or rate year (RY) 2012, 0.7% in FFY or RY 2013, and 1.0% in FFY or RY 2014. The bill would require the Secretary, on or after the start of FFY 2015, to develop readmission measures and implement a Medicare readmissions payment policy for post-acute providers similar to the Medicare acute care hospital readmissions payment policy.

Physicians: The Secretary would be required to conduct a study and issue a report within one year after enactment on how a Medicare readmissions payment policy could apply to physicians.

Establishment of Medicaid Health Care-acquired Conditions Payment Policies [Section 1751]

Beginning with discharges on or after January 1, 2010, this bill would require state Medicaid programs to adopt policies ensuring that higher Medicaid payments are not made to hospitals for cases in which one of a select number of secondary diagnoses identified under the Medicare program was not present on admission and therefore considered health care-acquired. It also requires state Medicaid program to adopt policies for non-payment for any health care-acquired condition determined to be a non-covered service under the Medicare program. States could include additional health care-acquired conditions for non-payment in their Medicaid programs.

Establishment of Delivery System Reform Pilot Programs and Demonstration Projects [Sections 1152, 1301, and 1907]

Medicare Payment Bundling: The provision would require the Secretary to develop, within three years of enactment, a detailed plan for bundling payments for post-acute services, defined as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), home health agencies, and hospital-based outpatient rehabilitation facilities. The plan must consider how and whether or not to include acute care hospitals and physicians in the bundle, the scope of the included services, and the payment methodology.

The Secretary is required to expand the current Acute Care Episode (ACE) bundled payment demonstration project to include post-acute care services and to include additional sites, additional geographic areas, and additional conditions by January 1, 2011. The current demonstration is testing bundled payments for a limited number of procedures and includes only hospitals and physicians. The expansion would be a voluntary pilot program and the Secretary could choose to apply the ACE bundled payments to:

- hospitals and physicians;
- hospitals and post-acute care providers;
- hospitals, physicians, and post-acute care providers; or
- combinations of post-acute providers.

If it is determined that the ACE demonstration has improved quality and reduced costs, the Secretary is given unlimited authority to expand it.

Accountable Care Organizations (ACOs): The bill would establish a voluntary program allowing physician practices to qualify as ACOs and share in the cost savings they achieve for the Medicare program. Hospitals and other providers could participate only if affiliated with the physician group. The ACO would qualify to receive incentive payments if Medicare expenditures for beneficiaries in the ACO are less than a target spending level or a target rate of growth. In addition, the Secretary is given authority to develop other ACO payment models, including partial capitation, and to expand use of ACO models that are found to increase quality and reduce cost.

CMS Innovation Center: This would establish a Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services. It would give preference to testing models for which there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. Models could be tested for up to seven years. After testing, the Secretary could expand the scope of a model or implement it on a national basis. CMI funding would be \$350,000,000 for FFY 2010, \$440,000,000 for FFY 2011, \$550,000,000 for FFY 2012, and, for each subsequent year the prior year amount adjusted for overall Medicare expenditure growth.

Addressing the Geographic Variation in Health Spending [Sections 1159 and 1160]

The bill would direct the Institute of Medicine (IOM) to analyze the geographic variation in per capita health care spending among Medicare, Medicaid, privately insured, and uninsured populations and require IOM to consider the extent to which geographic variation can be attributed to differences in:

- input prices;
- health status;
- practice patterns;
- access to medical services;
- supply of medical services;
- socio-economic factors;
- provider and payer organizational models, and
- various other important factors including physician and practitioner discretion, patient preference and compliance, and other issues the IOM deems appropriate.

Based on its findings, IOM would be required to develop and recommend to the Secretary by April 15, 2011 payment changes under parts A and B of the Medicare program—excluding add-ons for Graduate Medical Education (GME) DSH, and Health Information Technology (HIT)—to address geographic variation in Medicare spending. In making its recommendations, IOM could consider the development and adoption of a “value index” based on appropriate measures of quality and cost to adjust provider payment levels on a regional or provider-level basis.

Based on the findings and recommendations from IOM, the Secretary would present Congress with a plan for implementation by 2013. The provisions would not allow Congress to modify the proposal in any way; and it would be effective unless Congress passes a joint resolution to reject it. The President would have the authority to veto congressional disapproval.

Medicare Hospital Wage Index Reform [Sections 1157 and 1158]

The bill would direct IOM to report to the Secretary and Congress within one year of enactment on the validity and effects of the Medicare wage index for hospitals and the geographic practice cost index (GPCI) for physicians, and make recommendations for improving both. Based on the analysis, the Secretary may propose policies to adjust these factors and increase Medicare payment levels by up to \$4 billion per year for two years prior to 2014. Beginning in 2014, the new money/hold-harmless provision expires. Any changes the Secretary wants to continue making to the wage index/GPCI beyond 2014 would be budget-neutral, and therefore, redistributive.

Medicare GME Provisions [Sections 1501, 1502, 1503, 1504, and 1744]

Redistribution of Unused Resident Slots: GME training positions for primary care would be increased through a slot redistribution program. The provision would redistribute 90% of currently unused training slots. Hospitals could apply to receive a maximum of 20 residency slots in the redistribution, and all added slots must be used for primary care residents. Preference for the acquisition of new slots would be given to teaching hospitals currently training physicians above their Medicare GME cap, hospitals with three-year primary care residency programs, hospitals that emphasize training in non-hospital settings or in health professional shortage areas, and in states with low resident-to-population ratios.

Resident Training in Non-Provider Settings: Allows hospitals to be paid for resident training in non-hospital settings if the hospital incurs the costs of the stipends and fringe benefits of the resident. This eliminates current requirements for compensating supervising physicians in non-hospital settings.

Resident Didactic Time: Allows hospitals to count time spent by a resident in non-patient care activities such as didactic conferences and seminars.

Preservation of Resident Slots from Closed Hospitals: Resident slots from a closed hospital will be redistributed using a process to be determined by the Secretary, with priority given to other hospitals within the same state. This would include hospitals closed up to two years prior to enactment.

Medicaid GME: Specifies that GME is covered by the Medicaid program and eligible for federal matching funds, an issue that addresses positively an attempt by the prior administration to end such funding. Directs the Secretary to issue a report on program goals for the use of GME funds based on workforce needs and requires states to submit information on use of these funds.

Medicare Home Health Agency Payment Reductions [Section 1154]

Accelerates the regulatory adjustment for case mix currently scheduled for 2011 so that it occurs in 2010. Allows for adjustments higher than current scheduled if data show payment increases to be higher. Rebases the home health prospective payment system for 2011, taking into account changes in the average number and types of visits per episode, change in intensity of visits, and growth in cost per episode. Requires 5% reduction to payments in 2011 if rebasing is not ready, along with reconciliation of 2011 once the rebasing plan is ready.

Medicare Skilled Nursing Facility Payment Reductions [Section 1111]

The bill requires a reduction in the FFY 2010 Resource Utilization Group (RUG) weights to account for payment increases resulting from transition from 44 RUGs system to 53 RUGs on January 1, 2006. The FFY 2010 Medicare SNF Prospective Payment System (PPS) final rule included this provision.

Beginning on or after January 1, 2010, SNFs would receive an increase in payments by 10% for non-therapy ancillary services (NTAs) and a decrease of 5.5% for the therapy case-mix component. For payments beginning FFY 2011, a separate payment rate would be implemented in a budget-neutral manner to isolate the payment for NTAs which include such things as intravenous medications, respiratory therapies, and drugs. To ensure the accuracy of payment for NTAs, analyses will include indicators for age, physical and mental status, length of stay, ability to perform activities of daily living, diagnoses, and broad RUG category.

Payment for such things is currently included in the nursing component; this change would pay more for patients requiring more of these services (similar to the separation of non-routine medical supplies in the 2008 Home Health PPS).

For payments beginning 2011, indicators shall also be used to modify the current payment component for therapy services.

Establishes an outlier payment adjustment for NTAs and therapy services only. Payment pool not to exceed 2% of total SNF PPS payments.

Other Hospital and Health System Provisions [Sections 1192, 1193, 1145, and 2501]

Extension of Outpatient Hold-Harmless Payments: The bill would extend for two years, through December 31, 2011, outpatient hold harmless payments at the 85% level to hospitals located in rural areas with 100 or fewer beds and Sole Community Hospitals (SCHs).

Extension of Special Section 508 legislative Medicare Wage Index Reclassifications: The bill would extend for two years, through FFY 2011, Section 508 Medicare hospital wage index reclassifications.

Updating Outpatient Payments for PPS-Exempt Cancer Hospitals: The Secretary would be required to conduct a study to determine if the outpatient costs incurred by PPS-exempt cancer hospitals exceed the costs incurred by other hospitals reimbursed under outpatient PPS. If appropriate, CMS would provide an adjustment for services furnished starting January 1, 2011.

340B Drug Discount Program Expansion: Extends access to 340B outpatient drugs for children's, CAHs, Medicare-dependent Hospitals, Sole Community Hospitals (SCHs), and Rural Referral Centers.

Medical Liability Reform [Section 2531]

Would authorize the Secretary to make incentive payments, in an amount determined by the Secretary, to states that adopt an effective alternative medical liability law. State alternatives to medical malpractice litigation must consist of certificate of merit, early offer or both and may not limit attorneys' fees or impose caps on damages. Any incentive payments received by states must be used to improve health care in the state.