The following is a summary of the major hospital and health system provisions included in the Finance Committee bill, the America’s Healthy Future Act of 2009.

Coverage

The Chairman’s mark would expand coverage to 94% of people residing in the U.S. through Medicaid expansions and an individual mandate to purchase insurance with low-income subsidies for people with incomes below 300% of the federal poverty level. The plan would create state-based insurance “exchanges” to expand access to affordable insurance products and create new non-profit co-ops instead of a public plan.

Medicare Provider Reimbursement Rate Reductions ($106.3 Billion Over Ten Years for Hospital-Based Providers):

**Hospital and Continuing Care Marketbasket Updates:** The provision would reduce annual marketbasket updates for inpatient and outpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, and inpatient psychiatric facilities by 0.25% in 2010 and 2011. Updates would be reduced by 0.20% annually from 2012 through 2019. The update reductions from 2014 through 2019 could be restored if the previous year’s total percentage of insured population is more than five percentage points below projections.

The provision would reduce updates for home health agencies by 1.0% in 2011 and 2012; and for hospice providers by 0.5% in 2013 through 2019.

**Productivity Adjustments for All Providers:** This provision would reduce updates for all Medicare Part A and B providers who are subject to a marketbasket or Consumer Price Index (CPI) update to reflect estimated gains in productivity. This cut would be in addition to the marketbasket reductions described above. Beginning in 2012, a full productivity adjustment would be applied to inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and nursing homes. Hospice providers would receive a productivity reduction beginning in 2013 and home health providers would begin in 2015. All other productivity reductions for Part B providers would begin in 2011.

**Home Health Agency Payments:** The Secretary of Health and Human Services (HHS) would be directed to reduce payments through rebasing the home health payment rates. Reduced payments would be phased in over four years beginning in 2013. Beginning in 2011, the Secretary would establish a 10% outlier cap on the amount of reimbursement a home health provider can receive from outlier payments. In addition, the provision would provide a 3% add-on payment for rural home health providers from 2010 through 2015.

Disproportionate Share Hospital (DSH) Payments

**Medicare DSH ($22.9 Billion Over Ten Years):** Starting in 2015, hospitals’ Medicare DSH payments would be reduced to reflect lower uncompensated care costs relative to increases in the
number of insured. CMS would determine payment based on two components. CMS would continue to make an “empirically justified” base disproportionate share payment that is equal to 25% of the DSH payments that would otherwise be made. The 75% of funds above this empirically justified base are considered to be tied to uncompensated care costs. For every percentage point reduction in the uninsured in each period evaluated, the percent of funding available for this amount would be proportionally reduced.

Medicaid DSH ($24.9 Billion Over Ten Years): A state’s DSH allotment would be reduced by 50% once the number of uninsured individuals in the state is reduced by 50% compared to an initial uninsured rate on the date of enactment. Thereafter, the state’s DSH allotment would be further reduced at a rate that corresponds with any further reduction in the rate of uninsured. A state’s DSH allotment could not fall below 35% of the total allotment in 2012, adjusted for inflation.

Medicare Readmissions ($2.1 Billion Over Ten Years): This provision would direct the Centers for Medicare and Medicaid Services (CMS) to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for eight conditions selected by the Secretary. Starting in federal fiscal year (FFY) 2013, hospitals with risk-adjusted readmission rates above a certain threshold for the selected conditions would have payments for the original hospitalization reduced by 20% if a patient is re-hospitalized with a preventable readmission within seven days or by 10% if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days to any hospital. The policy could be expanded to include other conditions after three years.

Beginning in FFY 2011, the legislation would also provide $500 million over three years to fund a Community Care Transitions Program for hospitals with high readmission rates and partnership organizations to implement care transitions using evidence-based interventions for targeted high-risk beneficiaries.

Medicare Value-Based Purchasing (VBP) and Quality Reporting for Additional Care Settings

Inpatient Hospital VBP (Budget-Neutral): The proposal would establish a Medicare VBP program for hospitals, to begin in FFY 2012, with data collection/reporting and payment adjustments beginning in FFY 2013. Under this program, a percentage of hospital payments would be tied to performance improvement or attainment on quality measures from the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The HHS Secretary would have authority to expand the VBP measures starting in FFY 2014 and would be required to include efficiency measures (including adjusted Medicare spending per beneficiary) at that time. The proposed VBP program would be funded by Medicare inpatient payment reductions that would be phased in beginning with a 1% reduction in FFY 2013 and increased by 0.25% each year until the reduction reaches 2% for FFY 2017 and subsequent years. The program would be budget-neutral, meaning that each year’s funding pool must be returned to hospitals in that same year. The legislation provides hospitals with an appeals process, something for which HANYS strongly advocated. The proposal also calls for the establishment of demonstration projects to test VBP models for Critical Access Hospitals.

Physician VBP: This provision would make improvements to the Physician Quality Reporting Initiative (PQRI) program, including requiring all eligible health professionals to participate by 2011, establishing payment incentives for physicians to appropriately order high-cost imaging services, expanding the Medicare physician feedback program, and penalizing physicians who utilize significantly more resources than their peers.
SNF and HH VBP: This provision would direct the HHS Secretary to submit a plan to Congress by 2011 outlining a VBP system for home health and a plan for skilled nursing facilities (SNFs) by 2012.

IRF, LTCH, and Hospice Pay-for-Reporting: This provision would implement quality reporting programs for long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and hospice providers in 2013. Providers that do not successfully participate in the program would be subject to a two percentage point reduction in their annual marketbasket update.

Medicare IPPS Exempt Cancer Hospital Quality Reporting: The HHS Secretary would be required to select quality and efficiency measures for Inpatient Prospective Payment System (IPPS)-exempt cancer hospitals by FFY 2013, with mandatory quality reporting for these providers to begin FFY 2014.

Other: Additional resources would be provided to HHS to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. Specifically, the Secretary would be directed to develop a national quality strategy; establish an interagency working group on health care quality; provide additional resources for quality measure development and endorsement; and establish a process for HHS to work with external stakeholders, such as the National Quality Forum, to select quality measures to be included in Medicare VBP and pay-for-reporting programs.

Hospital-Acquired Conditions (HACs) ($1.2 Billion Over Ten Years): Hospital HAC data would be publicly reported in FFY 2013. Starting in FFY 2015, hospitals in the top 25th percentile of rates of HACs for certain high-cost and common conditions would be subject to a 1% payment penalty under Medicare. This payment reduction is in addition to current CMS payment adjustments for HACs.

Medicare Payment Bundling and Accountable Care Organization Pilot Programs and Other New Patient Care Models

Medicare Payment Bundling: This provision would direct the HHS Secretary to implement a national, voluntary pilot program in 2013 to encourage hospitals, doctors, and post-acute care providers to test alternative means of improving collaboration and coordination of patient care. CMS would select eight conditions to be included in the pilot program. The bundled service would start three days prior to hospital admission and extend through 30 days following discharge; and would cover all acute care inpatient, outpatient, physician, and post-acute care services during the episode. Participating providers could share in savings achieved by the Medicare program.

Accountable Care Organizations (ACOs): This provision would establish a voluntary program that would allow groups of providers to be recognized as ACOs and be eligible to share in the cost savings they achieve for the Medicare program. ACOs could include group practice arrangements, networks of practices, partnerships or joint-venture arrangements between hospitals and practitioners, and hospitals employing practitioners.

CMS Innovation Center: This provision would establish an Innovation Center at CMS that would be authorized to test and evaluate payment structures and methodologies that aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The Innovation Center’s funding would be set at $10 billion.
Independent Medicare Payment Commission ($22.6 Billion Over Ten Years): This provision would establish an independent Medicare Commission that would submit proposals to Congress that would, beginning 2015, reduce Medicare spending by targeted amounts (0.5 percentage point reduction in 2015 increasing to a 1.5 percentage point reduction in 2018), if it is determined that there is excess cost growth in the Medicare program. This is aimed at extending Medicare solvency and slowing the growth of the Medicare program. A process would be established for Congress to review, modify, and pass an alternative to the proposals, but Congress would be required to maintain the targeted level of Medicare savings for a particular year. The Commission’s original proposal would be implemented if Congress does not consider the Commissions proposal. Any proposed reductions from the Commission would not affect providers, such as hospitals and hospice, that are scheduled to receive a reduction to their marketbasket update in excess of a reduction due to productivity.

Graduate Medical Education (GME):

Graduate Medical Education Improvements: GME training positions for primary care would be increased through a slot re-distribution program. The provision would redistribute 80% of currently unused training slots. Hospitals could apply to receive up to 75 additional residency positions and would be required to use at least 75% of the increase for primary care or general surgery residency and to maintain their number of primary care residents. Priority would be given to hospitals located in states with low resident-to-population ratios; to hospitals located in a state that is among the top 25 states in the ratio of the total population living in a Health Professional Shortage Area (HPSA); and to hospitals located in rural areas.

The proposal would also encourage additional training in outpatient settings and ensure communities retain training slots if a hospital closes. It would establish a Workforce Advisory Committee made up of external stakeholders tasked with working with HHS and other relevant federal agencies to develop and implement a national workforce strategy.

Medicare Wage Index: The Secretary would be required to report to Congress by December 31, 2011 with recommendations for comprehensive reform of the Medicare wage index system. The plan would be required to take into account the Medicare Payment Advisory Commission (MedPAC) wage index report, including proposed use of Bureau of Labor Statistics data and recommended redefinition of wage areas.

Tax-exempt Status: The proposal does not establish thresholds hospitals and health systems must meet to attain or maintain their tax-exempt status. Instead, the proposal establishes new requirements applicable to Section 501(c)(3) hospitals including the required implementation of strategies to meet the community needs based on the findings of periodic health needs assessments, and the adoption of financial assistance, billing, and debt collection policies. Other disclosure and reporting requirements would apply.

Medical Malpractice: The proposal would encourage states and the Congress to consider demonstration projects to test alternatives to the current civil litigation system as a means to reducing the financial burden to providers of medical liability insurance.

Section 508 Wage Index Reclassifications: The Section 508 reclassifications that are set to expire on September 30, 2009 would be extended through September 30, 2011.

Recovery Audit Contractors (RAC): The RAC program, which currently audits Medicare Part A and Part B claims, would be extended to include Medicare Parts C and D and to Medicaid.
Medicare Rural Provisions

Extension of Outpatient Hold-Harmless Payments: This provision extends payments to small rural hospitals and sole community hospitals (SCHs) to 85% of the payment difference if their outpatient payments under the PPS are less than under the prior reimbursement system for calendar year (CY) 2010 and CY 2011.

Clinical Diagnostic Laboratory Services: This provision reinstates that rural hospitals with less than 50 beds will be paid at reasonable cost for clinical diagnostic laboratory services from July 1, 2010 through July 1, 2012.

Rural Community Hospital Demonstration Program: This provision extends the demonstration program for an additional two years and increases the number of participating hospitals from 10 to 30. In addition, this provision expands eligible sites to rural area in all states until January 1, 2012.

Medicare Dependant Hospitals (MDHs): The MDH classification, which is set to expire on September 30, 2011, would be extended for an additional two years, through September 30, 2013.

Medicare Rural Hospital Flexibility Program: This provision extends the FLEX program an additional two years through 2012. This would allow Small Rural Hospital Improvement (SHIP) grant program funding to be used to support small rural hospitals’ participation in the delivery system reform programs outlined in this legislation (such as VBP, bundling, and accountable care organizations).

Medicare Payments for Rural Areas: This provision requires MedPAC to review payment adequacy for rural health care providers serving the Medicare program and to provide a report to Congress by January 1, 2011.

Community Health Integration Models in Rural Areas: This provision strikes the limitation on the number of eligible counties that may participate in the demonstration project on community health integration models in certain rural counties within the qualifying states. In addition, it deletes references to rural health clinic services and replaces it with the requirement that physician services may also be included within the scope of the demonstration project.

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.

Improving Transparency of Nursing Home Information: Nursing homes participating in Medicaid and Medicare would be required to report certain information pertaining to operations and staffing.