Our Conversation Today

✓ What we *did* (ACA)
✓ What we’re *doing*
✓ Where we’re *going*
2010: ACA and Stimulus Bill

- 32 million more people with health insurance
- Shared responsibility - Individual mandate, employer “play or pay,” government subsidies
- Expands public programs

- HIT Medicare/ Medicaid Incentive programs (ARRA)
- Expansion of broadband technology (ARRA)
- Funding for HIT infrastructure (ARRA)

- Public/Private comparative effectiveness institute with steady funding
- Hospital Value-Based Purchasing (VBP)
- Enhanced public reporting
- Numerous provisions to reduce health disparities
- National quality center

- $12.9 billion prevention and public health fund
- Increases access to preventive services
- Zero cost sharing for recommended preventive services (public & private insurance)
- Annual Medicare wellness visits
- Grants for workplace wellness programs
- Creates a national public health council with advisory groups

- Pilot programs on payment bundling
- Accountable Care Organizations (ACOs)
- Center for Medicare and Medicaid Innovation (CMI)
- Independent Payment Advisory Board (IPAB)
- Administrative Simplification

American Hospital Association
The Past Year

• 1 government shutdown
• 1 healthcare.gov meltdown
• 2 debt limit extensions
• 2 physician payment patches
• 2 sets of Medicare extensions
• 3 enforcement delays of two-midnight policy
• 2 delays of Medicaid DSH cuts
• 3 changes to the sequester (out-year)
• 1 VA health care crisis
Fiscal cliffs and deadlines

December 10, 2014

- Federal budget...appropriations
Beyond election day...

Control of Senate

- Louisiana
- Kansas
- Maine
2014 lame duck prospects

• House Ways and Means Republicans...”hospital bill”

• If the Senate flips:
  – Possible desire to “dispose” of certain items (physician payment fix)
Fiscal cliffs and deadlines

December 31, 2014

- Medicaid physician payment “cliff”
Fiscal cliffs and deadlines

- December 10, 2014
  - Federal budget...appropriations

- December 31, 2014
  - Medicaid physician "cliff"

- April 1, 2015
  - Medicare physician payment "cliff"
    - Prospects for reform
Fall/Winter Priority Advocacy

- Demanding responsible regulation
  - RACs, ALJs
  - Hospital inpatient short-stay policy
  - IT meaningful use

- Protecting vulnerable populations
  - Limit Medicare DSH cuts
  - Adjustments to hospital readmissions reduction program (socioeconomic adjustment)
  - Adjustments to hospital acquired conditions penalty program
  - Medicaid physician payment cliff

- Ensuring access to care in rural communities
  - Medicare extenders (April 1, 2015)
    - Low volume adjustment
    - Dependent hospital program
    - Ambulance payment add-on
    - Outpatient therapy cap exemption
  - Access to outpatient therapeutic services

- Need for budget predictability
Need for budget predictability

- Prospective coding offsets ($8 billion)
- Site neutral payment policies
  - E&M code/HOPD ($10 billion)
  - 66 additional APCs procedures ($9 billion)
  - 12 procedures performed in ASCs ($6 billion)
- Hospital bad-debt reductions ($20 billion)
  (Assistance for low income Medicare beneficiaries)
- GME reductions ($10 billion)
- CAH: payment reductions and qualification criteria ($2 billion)
- Post acute care ($70 billion)
- IPAB expansion ($4.1+ billion)
- Medicaid:
  - State provider assessments ($22 billion)
- 340B

October 1, 2014 = FY 2025 Savings
Ensuring a Healthier Tomorrow

The Problem:
The current growth rate for health care spending is a central area of focus for policymakers. A number of factors contribute to the rise in spending, including changing demographics and the aging of the baby boom generation, the growth in chronic illness, advances in medical technologies and system inefficiencies. Achieving a sustainable level of health care spending may require reducing both the cost of individual services and the use of total services. If health care spending is not slowed, the effects will be profound and affect everyone — health care providers, the government, insurers and employers, and individuals.

In times of fiscal crisis, the federal government repeatedly turns to cutting Medicare and Medicaid spending, almost exclusively through reductions to provider payments. This will not put us on a sustainable path for the future. Numerous studies have found — and the flawed physician sustainable growth rate confirms — that reducing provider payment rates does not result in reduced Medicare spending on services. Ratcheting provider payments will not put us on a sustainable path for the future; we need real targeted reforms, not blunt cuts to provider payment.

Future growth in Medicare and Medicaid represents a serious challenge.

- Today, Medicare covers more than 48 million people. Baby boomers are now reaching the eligible age of 65 at the rate of 10,000 a day.
- The Medicare program currently costs about $560 billion annually, and over the next decade, the Congressional Budget Office (CBO) projects Medicare costs will almost double — totaling more than $1 trillion by 2022.
- The 2012 Medicare Trustees Report projects that the ratio of workers-to-beneficiaries will decline from four workers per beneficiary in 1965 (the start of the Medicare program) to slightly less than three workers per beneficiary in 2011, to two workers per beneficiary in 2040.
- The Urban Institute reports that the average couple will receive $387,000 in Medicare benefits but only pay $122,000 in Medicare taxes over their lifetime.

These major demographic shifts and trends create a significant — and unsustainable — burden for future generations.

The Solution:
The AHA’s vision is a society of healthy communities where all individuals can reach their highest potential for health. Health coverage is critical to fulfilling this vision. The Patient Protection and Affordable Care Act (ACA) expanded access to health care coverage, enacted significant insurance reforms and put in place opportunities to reform the delivery system. To help expand health care coverage to millions, the hospital field will undergo changes that will stretch Medicare and Medicaid dollars further.

As policymakers grapple to rein in federal spending, they should focus on the following two interconnected strategies that will improve the health care system, ensure the short- and long-term financial viability of the Medicare and Medicaid programs, and tackle the federal debt and deficit:

- Promote and reward accountability. We need to restructure the system in a way that promotes and rewards accountability — to patients, their families and their communities.
- Use limited health care dollars wisely. We need to focus on using limited health care dollars more wisely — in ways that eliminate inefficiency and improve quality of care for patients.

Each strategy has six priority recommendations. Each recommendation has a list of suggested actions that providers, the government, insurers and employers, and individuals can take to strengthen our health care system and our nation’s finances. Everyone bears some responsibility and everyone must contribute to the solution. To speed success, our efforts must be aligned.
1. Promote + Reward Accountability

- Payment and delivery system reform
- Eliminate preventable infections / complications
- Engage individuals in health, health care
- Better manage advanced illness
- HIT / electronic health records
- Transparency on quality and pricing
2. Use Limited Health Care $ Wisely

- Eliminate non-value added treatments
- Revamp care for vulnerable populations
- Promote population health
- Modernize federal programs
- Simplify administrative and regulatory processes
- Reform medical liability system
Medicare Suits

- DRG
- Reduce LOS
- RACs / 1-day stays
- Can’t rebill
- Appeals and observation
- 2-midnight rule
- ALJ delays and moratorium
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* AHA Suits
Medicare Suits

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- ALJ delays and moratorium * # (68%)

* AHA Suits
# CMS changes
Medicare Suits

- DRG
- Reduce LOS
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- Can’t rebill * # (can under B / 1 year) X
- Appeals and observation
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- ALJ delays and moratorium * # (68%)

* AHA Suits
# CMS changes
X Court ruling