2012
Minnesota Rural Health Conference
Duluth, MN

Life In Washington

- Parties are more Polarized
- Media likes to stir things up
- Media outlets are more numerous
- News cycle are very abbreviated

It’s an Election Year!

We will be electing:

- A President
- All 435 Members of the House
- 33 United States Senators:10 open seats – 3R, 6D, 1I

What Will or Must Get Done this Year?

Judicial?

Legislative?

Executive?

Judicial

Supreme Court ruling on the individual mandate included in the Affordable Care Act.

Legislative

Bush Tax Cuts – Extend or discontinue?

Payroll Tax Cut – Extend or discontinue?

SGR “fix” – Extend or discontinue?

Medicare extenders - Extend or Discontinue?

Unemployment – Extend or Discontinue?

Appropriations Bills

Legislative

Across the board budget sequestration cuts mandated by the Deficit Control Act of 2011.

Executive

Rules and Regulations implementing the ACA and other federal initiatives.

Legislative?

Congressional Schedule over the next 4 1/2 months

- 18 possible work weeks
- Currently scheduled to be **out** of Washington for 11 of those weeks.
- Approximately 45 work days between now and the election

Legislative

Bush Tax Cuts – Extend or discontinue?
Payroll Tax Cut – Extend or discontinue?
SGR “fix” – Extend or discontinue?
Medicare extenders - Extend or Discontinue?
Unemployment – Extend or Discontinue?
13 Appropriations Bills
Sequestration

SGR

Where are we and where are we going?

Short term fix?

Medium term fix?

Permanent fix?

Projected SGR cut for 2013

It is estimated that the SGR related cut that will occur on January 1, 2013, absent Congressional intervention will be approximately 32%

SGR Options

Short-term (2-3 month) extension of the current Conversion Factor (CF). Effective January 1, 2013 through February 28 or March 31, 2013.

Medium Term extension of the current CF (12 months to two years)

Permanent fix the SGR problem

Most Likely?

Short Term 2 – 3 month fix

Long-term SGR fix option?

MedPAC

Primary Care: 10 Year Freeze in the CF

Non-Primary Care: 3-year cut (5.9% per year) followed by a 7 year freeze in the CF.

Why hasn’t a permanent fix been adopted by Congress?

Cost of an SGR fix?

3 Month Fix - $10 Billion

20 Month fix - $90 - $100 Billion

Permanent fix - $300+ Billion

Doing nothing – **Priceless!**

Debt Limit Deal (Sequestration)

Last August, Congress and the President reached an agreement to raise the federal debt ceiling thereby avoiding a technical default on government loans.

The Debt Limit deal requires significant cuts in FUTURE federal spending – both discretionary AND entitlement programs.

The total amount cut as a result of the debt limit deal is approximately $2.0 Trillion. A “Super Committee” was charged with coming up with the remaining $1.5 Trillion.

Debt Limit Deal

Because the Super Committee failed to make recommendations that were enacted, then automatic cuts of $1.2 Trillion are mandated to be equally divided between defense and non-defense spending via a process called “sequestration”.

What is Sequestration?

More importantly, why should YOU and your clients, care?

Sequestration

Sequestration is a process whereby the Office of Management and Budget is authorized to make across the board cuts in federal spending WITHOUT the need for specific Congressional approval of those cuts.

Sequestration

In general, sequestration will result in cuts of approximately 3% in non-defense domestic spending. However, the budget deal limits the amount of cuts in Medicare due to sequestration to **2%** of program costs

Sequestration

Congress further stipulated that if sequestration should be necessary, money “saved” in Medicare cannot come from higher Medicare taxes or increases in beneficiary copays or deductibles.

Congress also exempted Medicaid from the sequestration process.

Can Sequestration be avoided?

Yes, if Congress agrees to spending cuts between now and January 2013, the amount of federal spending subject to sequestration can be limited or eliminated altogether.

Is that Likely?

Are Medicare cuts on the table?

Provider Payments?	YES
Eligibility?	YES
Medicare tax hike?	NOT LIKELY

SGR and the Budget Deal

The current budget ASSUMES that the SGR related cut scheduled to take effect on January 1, 2013 will go into effect.

So any SGR fix that is not “paid for” would only increase the amount of money that would have to be cut to meet the Budget Deal target.

Judicial

The Supreme Court heard legal challenges to the Affordable Care Act March 26th, 27th, and 28th.

The Supreme Court will likely rule on the constitutionality of the ACA by this month. (June).

Judicial

Can the federal government require an individual to purchase health insurance?

Can the federal government unilaterally expand (dramatically) Medicaid coverage?

Other Issues Before the Court

- Are the challenges permissible?
- What are the remedies in the event the Court determines the mandate is unconstitutional?

Healthcare Reform and Care Innovation (and the Supreme Court)

If the Supreme Court rules the individual mandate unconstitutional, will this derail the move towards changes in the delivery and payment for healthcare services?

… we believe that would be a brief pause because the main driver of the consolidation wave is overall payment reform, revenue reductions, and reimbursement pressures. Whether or not the mandate stands, the reimbursement pressure is going to continue."

Moody's Investor Services

Predictions?

The Court will…

Healthcare Reform

Next Steps

Effective 1/1/2014

Medicaid Expansion occurs – 133% of Poverty – everyone. The Federal Government will cover 100% of the cost of those newly covered then gradually reduce this to 90%.

Medicare-Medicaid Payment Equalization

Effective 1/1/2013, States are required to increase Medicaid fee-for-service payments to a level equivalent to what Medicare would have paid for that service. This payment equalization policy remains in effect through 2014.

The Federal government assumes 100% of the cost of increasing these payments.

Health Exchanges

Health Insurance Exchanges will go into effect on 1/1/2014. At that time, the individual mandate and employer mandates will also take effect.

It will be illegal to sell an insurance policy with a pre-existing condition clause in the contract.

Guiding Principles of Innovation

CMS has identified what it calls the Triple Aim of Innovation:

Better Health

Better Care

Lower Cost

What About

A different aim of Reform? What about a healthcare delivery system that is Triple A!

Affordable

Accessible

A+ Quality

What is the Goal?

1. Shift financial risk from the payer (government or commercial insurer) to the provider of care.

2. Link provider payments to quality rather than volume.

3. Move away from fee-for-service as the primary payment mechanism for physician services.

ACO – Accountable Care Organization

What is an ACO?

Vertically integrated, multi-specialty entity that encompasses inpatient and outpatient services.

ACOs and Rural

CMS changed the final ACO rules to make it easier for rural providers to participate in these innovative delivery models IF the provider wishes to participate.

Participation is voluntary AND CMS can continue to pay rural providers affiliated with an ACO on a cost-basis.

Quality and Cost and ACOs

ACOs will be required to meet dozens of quality markers on an annual basis. Many of the quality markers track with the EHR reporting requirements for “meaningful use.”

How Will ACOs affect rural and other safety net providers?

- Rural Health Clinics, FQHCs small rural hospitals and CAHs can be part of an ACO.
- Patients whose primary place of service is an RHC or FQHC can be “assigned” or “attributed” to an ACO.
- Rural Health Clinics, FQHCs and CAHs that are part of an ACO can continue to receive cost-based reimbursement from Medicare

ACOs and Rural

Although rural providers will be allowed to form ACOs, as a practical matter this will not be possible under the current formulas for MOST rural providers.

ACOs and Rural

- Minimum of 5,000 Medicare beneficiaries "assigned" to the ACO.

- In order for a patient to be "assigned" he or she MUST have been seen by a primary care physician* at least once during the previous 12 months

Accountable Care Organizations (ACOs)

Are ACOs just a dressed up version of HMOs?

Will ACOs lead to the “Walmartization” of American Health Care or truly reform the healthcare delivery system in a way that is beneficial to patients?

What About?

Bundled Payments

Value Based Purchasing

Other Issues

ICD-10

In 2009, HHS announced that ALL providers must use ICD-10 CM on health insurance claims or the payer could deny that claim.

What they said then…

"The rumors that the Centers for Medicare & Medicaid Services (CMS) will delay implementation of the new ICD-10 coding systems don't hold water."

CMS Official, May, 2011

ICD-10

HHS has announced that the original effective date for use of ICD-10 – October 1, 2013 - will be rescinded. No new date for the mandatory use of ICD-10 has been announced. A Notice of Proposed Rulemaking was issued in May and a final announcement is expected “soon” on the new effective date.

Will ICD-10 Happen?

Medicare Bad Debt

A proposal was put forward by the Obama Administration to reduce the amount of bad debt RHCs and CAHs can claim on their cost report.

Language was included in the SGR “fix” legislation adopted a few weeks ago that would:

Bad Debt Limits

Limit Bad Debt claimed by RHCs and CAHS to 88% of amount allowable – effective for CY 2013.

Limit Bad Debt claimed by RHCs and CAHS to 76% of amount allowable – effective for CY 2014

Limit Bad Debt claimed by RHCs and CAHs to 65% of amount allowable – effective for CY 2013 and subsequent years.

Independent Payment Advisory Board

There is established an independent board to be known as the Independent Payment Advisory Board.

It is the purpose of this Board to reduce the per capita rate of growth in Medicare spending.

Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program.

The report may include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations.

If the Chief Actuary of CMS determines Medicare spending is too high, the proposal shall include recommendations that will result in a net reduction in total Medicare program spending.

Proposals submitted by the Board must be considered by the Congress under expedited procedures and Congress must either adopt the recommendations of the Board or adopt alternative recommendations that achieve the same level of “savings” in the Medicare program as recommended by the Board.

The Board is prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards including deductibles, coinsurance, and co-payments.

So what's left?

Oh Yeah, Provider Payments!

Shortage Area Designation Proposed Changes

In 2008, the Health Resources and Services Administration issued a proposed rule proposing numerous changes in the way the federal government designates underserved areas.

Due to the controversial nature of that proposal, the agency withdrew the proposal and went back to the drawing board.

The Patient Protection and Affordable Care Act (Healthcare Reform) legislation, mandated that the Secretary of HHS appoint a “Negotiated Rulemaking” Committee to consider possible changes in the methodology used to designate areas as medically underserved or health professional shortage areas.

Shortage Area Designations

New criteria for designating boundaries?

New providers counted (NPs and PAs)?

New exceptions for certain “safety net” providers?

New provider-population ratios?

Increased Provider Audits

Recovery Audit Contractors

- CMS is expanding the Recovery Audit Contractor initiative in 2012.
- States are adopting a RAC process for state Medicaid programs.