

Western Region Flex Conference





Federal Update
June 7, 2007
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Federal Update



- Political Environment
- Rural Advocacy Agenda
- Policy Agenda


Political Environment



Congressional Agenda

- Limited legislation will be enacted this year
- Our focus: stopping bad regulations
 - Medicaid IGT/CPE rule
 - Medicare inpatient PPS rule
 - Medicaid GME rule

Legislative Possibilities

- Democrats top priority
 - Medicare Rx negotiations
 - Drug re-importation
 - Stem cell research expansions
- Reauthorizations
 - Prescription Drug User Fee Act (PDUFA)
 - Medical Device User Fee Act (MDUFA)
 - S-CHIP
- Prevent negative outcomes
 - Medicare physician fee fix

Saturday, May 5, 2007


The Washington Post

Democrats' Momentum Is Stalling

In the heady opening weeks of the 110th Congress, the Democrats' domestic agenda appeared to be flying through the Capitol: Homeland security upgrades, a higher minimum wage and student loan interest rate cuts all passed with overwhelming bipartisan support.


But now that initial progress has foundered as Washington policymakers have been consumed with the debate over the Iraq war. Not a single priority on the Democrats' agenda has been enacted, and some in the party are growing nervous that the "do nothing" tag they slapped on Republicans last year could come back to haunt them.

FY 2008 Budget





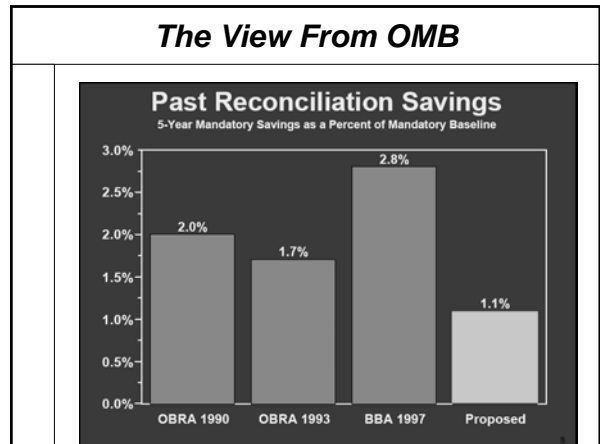
President's Request

[Five-Year Impact in billions of dollars]



	Medicare	Medicaid
Legislative	\$65.6	\$13.0
Regulatory	10.2	12.7
Total Savings	75.8	25.7







Budget Strategy

Action Plan


1. Impact analysis—to generate grassroots response
2. Locked in Reps./Sens. against cuts to *“hospital services for Medicare beneficiaries”* before houses draft budget resolutions
 - “Dear Colleague Letters”
 - House – Neal/English letter - 223 signers
 - Senate – Lincoln/Roberts letter - 43 signers
3. Coalition ads



Status

Budget Resolutions

- Passed both Houses
- Balance budget by 2012
- Punt on most extending expiring tax cuts
- Assume increased revenues
- Key health care elements:
 - Reject President’s Medicare and Medicaid cuts
 - No reconciliation process
 - SCHIP reauthorization and expansion-additional 6 million kids at an estimated \$50 billion
 - 23+ Reserve funds established...with NO money (including IT adoption and for evaluation of medical technologies for effectiveness and value)



Immediate Budget Challenge

SPENDING		
• SCHIP Reauthorization	\$	15 billion
• SCHIP Expansion		50 billion
• Medicare MD Payment Fix		25 billion
• AMT Fix		50 billion
TOTAL	\$	140 billion

OFFSET OPTIONS		
• Tobacco tax increase	\$	35 billion
• Tax enforcement (Emanuel)		10 billion+
• Medicare Advantage		50 billion
• Hospital cuts (President’s budget)		30 billion
TOTAL	\$	125 billion

CongressDailyAM

Thursday, April 26, 2007


Stark charted a hypothetical scenario in which the subcommittee would be required to raise \$10 billion.

“We’ll sit down and take a rough cut. Take two from hospitals. Give three back to the doctors. Take five from [Medicare] Advantage and two from wheelchairs and whatever, and we have our 10.”


To win over committee members, he added, “You keep nudging them and nudging them, and when everybody looks equally unhappy, you drop the gavel.”

Hospital To Do List

"Expiring Provisions"




- Rehabilitation rule at 60 percent
- Physician-owned limited service hospitals
- Direct Medicare payments to independent labs for technical component of pathology services
- Hold-harmless for Medicare outpatient payments to rural and sole community hospitals
- Section 508 reclassifications
- Rural home health 5 percent add-on
- Cost payment payment for rural lab services provided by hospitals with fewer than 50 beds
- Ambulance mileage bonus for transport of rural patients





Physician-owned Limited Service Hospitals

- **CBO Scoring of Savings.**
- **Working with House and Senate Committees.**
- **Tracking reactions from Members of Congress.**
- **Letters from "Friendly" Members of Congress to Committee Leadership**




Clinical Integration

- Outgrowth of Task Force on Delivery System Fragmentation
- Objective: opportunities for hospitals and doctors align incentives to:
 - Improve quality
 - Provide vehicle for hospitals to work more closely with medical staff
 - Prepare for P4P
 - Take responsibility for providing services for entire episode of care or population of patients
 - Bargain collectively with insurance companies
- Guidance sought from FTC to avoid antitrust prosecution

Mental Health Parity Legislation


- **S. 558** – Introduced by Sens. Pete Domenici (R-NM), Edward Kennedy (D-MA) and Michael Enzi (R-WY)
- **H.R. 1424** - Introduced by Reps. Patrick Kennedy (D-RI) and Jim Ramstad (R-MN)
- The Senate & House bills are not companion measures.
- Both pieces of legislation seek to expand on the Mental Health Parity Act of 1996 by establishing parity between mental health and physical health insurance coverage for hospital days, outpatient visits, co-pays, deductibles and out-of-pocket maximums.
- Senate bill passed out of HELP Committee on 2/14/07; it is supported by the AHA and other members of the Coalition for Fairness in Mental Illness Coverage, and for the first time for a MHP bill, business & insurance interests, including the National Retail Federation and AHIP.



Mental Health Parity Legislation


Legislation Comparison:

- Neither bill mandates mental health coverage. The bills follow the 1996 law which is an "if you provide, then you must" format.
- Senate bill preempts state laws governing cost-sharing and treatment limits (substituting federal parity requirements for the state laws). House bill does not preempt this or other state law.
- Both bills preserve existing coverage mandates. If a state requires employers to provide mental health benefits, and/or requires that certain diagnoses be covered (up to and including DSM-IV), neither bill would alter such requirements.
- Neither bill covers employers of fewer than 50 workers (current law).





Mental Health Parity Legislation

- Both bills include substance abuse treatment.
- Both bills extend parity requirements to out-of-network care; House bill requires the provision of out-of-network mental health benefits if plans provide any med/surg OON; Senate bill would allow OON med/surg without requiring the provision of OON MH.
- Senate bill makes the definition of mental health benefits subject to the terms and conditions of the plan; House bill establishes a minimum benefits package that is tied to the conditions covered by the most popular FEHB plan (effectively DSM).
- Both bills allow employers to seek an exemption if they can show cost increases attributable to parity that exceed 2% in the first plan year following enactment and 1 percent thereafter.





Health Information Technology

- 7 House bills introduced
- 8 Senate bills introduced
- Administration-led incentives
- Another expensive initiative
 - Pay-go??

Labor Agenda



- Card Check
 - House passed 241-185
 - Pending Senate Action
 - 60 votes needed
- NLRB decision on “supervisor”
 - House hearing
 - Senate legislation introduced, but no action yet

Our Strategy



Legislation

- Oppose “card check” legislation
- Monitor and take action on other labor initiatives:
 - Overturning NLRB decisions (supervisors)
 - Manual lifting
 - Staffing ratios
 - Mandatory overtime
 - Track state legislative trends



Immigration Reform

- Ability to recruit from abroad
 - U.S. shortages
 - Retrogression
 - Human rights element
- Employment Verification
 - **Reliable**
 - **Quick**
 - **Non-burdensome to health care providers**



Senate Immigration Bill

- Most comprehensive revision of immigration law since 1996
- Replaces current Employment Based “green card” system with a new visa program based on points:
 - Nurses and other health care professionals are disadvantaged at outset
 - Weighted in favor of Master’s, PhDs


Senate Immigration Bill

- Reauthorizes Conrad J-1 Waiver program
- Establishes pilot program to redistribute unused waivers
- Foreign medical residents barred from entering on temporary H-1B visa
- Foreign physicians cannot be admitted unless they complete a service component.

Your Focus for the Next Four Months


- No hospital cuts
- An improved IPPS rule



Federal Budget

What's NOT in the President's or Congress' Budget?


- Medicare physician fix \$330 billion for system like market basket update over 10 years




Legislative Agenda

2007 AHA Advocacy Agenda

- Ensure adequate resources to hospitals
- Improve quality of care and patient safety
- Expand coverage
- Make hospitals employers of choice
- Improve accountability for tax-exempt status
- Ensure that marketplace conduct takes place on a level playing field




AHA 2007 Rural Agenda

Rural Package

- Further efforts to protect critical access hospitals (CAH) such as
 - expanding existing cost-based payment to other settings
 - allowing flexibility for relocation and
 - continuing efforts to ensure that CAH's that contract with Medicare Advantage programs are appropriately reimbursed.
- Cost-based payment for rural hospitals with 50 beds or fewer,
- Efforts to allow CAH's to receive cost-based reimbursement for outpatient labs.
- Expansion of 340B program


Appropriations

- Rural health programs



Expiring Provisions

- The AHA supports the legislative extension of the following:
 - Section 508 wage index reclassifications (9-30-07)
 - Home health 5 percent rural add-on (1-1-07)
 - Cost-based payment for laboratory services provided by hospitals with fewer than 50 beds located in low population density areas (7-1-07)
 - Ambulance mileage bonus for transport of rural patients in low population density areas (1-1-07)
 - Separate billing for technical component of pathology services [12-31-07]



Sole Community Hospitals

Sole Community Hospital Preservation Act (H.R.1177)

Reps. Tanner(D-TN)/Graves(R-MO)

- Permanently Extend Outpatient PPS Hold Harmless
- Target Amount Year Rebasing – Add a more current year to determine target amount



TC Pathology

The Physician Pathology Services Continuity Act (S.458/H.R.1105)

Sens. Lincoln (D-AR)/Thomas (R-WY)
Reps. John Tanner (D-TN)/Kenny Hulshof (R-MO)

- Allows for a permanent extension of the grandfather clause allowing Medicare to make direct payments to independent laboratories for the technical component of pathology services



Medicare Advantage

Rural Health Services Preservation Act (S.630/H.R.2159)

Sens. Coleman (R-MN), Harkin (D-IA) and Durbin (D-IL)
Reps. Ron Kind and Cathy McMorris-Rodgers

Would require MA plans to pay CAH and RHC services, at minimum, what they otherwise would have been paid under Medicare with cost reconciliation, or 103% of interim rates without reconciliation (in or out of network).



CAH Lab Services

Critical Access To Clinical Lab Services Act (S. 1277)

Sen. Ben Nelson (D-NB)

- Work to restore cost-based reimbursement of lab services
- Focus on Congress – Not CMS



FY 08 Rural Appropriations

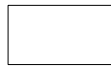
FY 2007 Appropriations at FY 06 Levels
Continuing Resolution, December 2006
(in millions of dollars)

<u>Program</u>	<u>FY 2007 Enacted</u>	<u>FY 2008 President</u>
Rural Health Research/Policy	\$9	\$9
Rural Outreach Grants	\$39	\$0
State Offices of Rural Health	\$8.4	\$8.1
Rural Hospital FLEX Grants	\$64	\$0
NHSC	\$125.5	\$116



Rural Legislative Priorities


- Rural Community Hospital Assistance Act
- 340b Drug Program Expansion
- Rural Home Health Bonus



Rural Community Hospitals

Rural Community Hospital Assistance Act

- CAH 101% cost for SNF, home health
- 101% cost for ambulance services
- “Tweener” 25-50 bed hospitals Inpatient and Outpatient 101% cost reimbursement
- Challenge - Need to make case to Congress




340b Program

Safety Net Inpatient Drug Affordability Act

Sens. Bingaman (D-NM) and Thune (R-SD)


- Expand eligibility for CAHs, RRCs, and SCHs in the 340b program.
- RRCs and SCHs would have to have a DSH percentage of no less than 8%.
- 340b = On average 40% AWP for outpatient drugs
- CAHs not currently allowed without DSH%
- CAHs Cost saver to government



Rural Home Health Bonus

Medicare Rural Home Health Payment Fairness Act

- 5% “ add on” payment expired Dec 31, 2006
- Expect legislation in the 110th to reinstate add-on






Policy Agenda

Medicaid Proposed Rule

Key Provisions


- Restrictions on the use of:
 - Intergovernmental transfers
 - Certified public expenditures
- Proposed rule with 60-day comment period—ended mid-March
- September 1 implementation date
- Estimated savings: \$3.8 billion over five years

Medicaid Strategy

Action Plan

- Regulatory advisory to field
- Garner broad, bipartisan support from Congress to prevent implementation and convince leadership
 - House: Eshoo (D-CA)-King (R-NY) letter 226
 - Senate: Durbin (D-IL)-Dole (R-NC) letter 43*
- Identify legislative vehicle (supplemental, minimum wage, etc.)
 - Prevent CMS from enforcing the rule (“no such funds...”)
- File comment letters...and bottle up from becoming final rule
- National coalition partners
- Litigation options
- GME budget proposal





Medicaid Proposed Rule

Supplemental Appropriations Bill

Emergency Wartime Supplemental *post 1st veto


- Conference agreement:
 - On-year moratorium
 - \$3.8 billion over 5 years
 - Offset within the bill
 - Senator Durbin (D-IL) champion

Medicare Inpatient PPS Rule


Key Provisions

- Behavioral offset of 2.4 percent in FY 2008 and FY 2009 related to the implementation of Medicare-Severity (MS-DRG'S)
 - Reduces hospital payments \$21.9 billion over five years
- Capital payment:
 - Freezes adjustment for urban hospitals (cut of 0.8 percent)
 - Cuts adjustment large urban hospitals (cut of 3 percent)
 - Provides increase of 0.8 percent for rural hospitals
 - Reduces hospital payments by \$2.7 billion over five years
- Comment period closes June 12

 Centers for Medicare & Medicaid Services


Medicare Inpatient PPS Rule

- Patient Safety and Specialty Hospitals:
 - Requirement to disclose physician ownership
 - Requirement to inform patients of physician availability (for all hospitals).
 - Considering strengthening requirements for emergency services capability (for all hospitals—unclear if mean CAHs).



Medicare Inpatient PPS Rule -- FY 2009

- **Quality Measures:** CMS proposes 32 measures in 2009 including:
 - Pneumonia, 30-day mortality
 - Cardiac surgery patient with controlled 6AM postoperative serum glucose
 - Surgery patients with appropriate hair removal
 - Colorectal patients with immediate postoperative normothermia
 - Surgery patients on a Beta-Blocker prior to arrival who received a Beta-Blocker during the perioperative period
- **Hospital-acquired Conditions:** CMS proposes six conditions, out of the 13 they are considering for implementation in FY 2009 including:
 - Catheter-associated urinary tract infections
 - Pressure ulcers
 - Staphylococcus aureus septicemia
 - Object left in surgery
 - Air embolism
 - Blood incompatibility




Our Strategy


Advocacy Action Plan

- Impact analysis to member
- Press release on impact
- Joint HALO letter
- Congressional sign-on letter
- Unified comment letters for field
- Meetings with administrative leaders


NEWS RELEASE
ANA DECRIES BACKDOOR BUDGET CUTS TO SERVICES FOR SENIORS
 CMS Proposal Cuts Resources for Medicare By \$25 Billion


Washington, DC—April 22, 2009—The American Hospital Association (AHA) has today issued a press release and a letter to Congress in response to a proposal by the Centers for Medicare & Medicaid Services (CMS) to cut Medicare payments to hospitals by \$25 billion over five years. The proposal would reduce Medicare payments to hospitals by \$25 billion over five years. The proposal would reduce Medicare payments to hospitals by \$25 billion over five years. The proposal would reduce Medicare payments to hospitals by \$25 billion over five years.





CAH Interpretive Guidelines

CAH Interpretive Guidelines	
	<p>All CAHs: All CAHs that relocate must comply with "75% Test"</p> <ul style="list-style-type: none"> • Overly prescriptive changes to definitions of mountainous terrain and secondary roads such as: <ul style="list-style-type: none"> – Elevation above 3,000 feet – Grades greater than 5 percent – Speed limit of less than 45 mph <p>Approval Process:</p> <ul style="list-style-type: none"> • CAHs must file attestations of compliance in advance • Final determination not made for 1 year after move 

CAH Interpretive Guidelines	
	<p>AHA Strategy:</p> <ul style="list-style-type: none"> • Education through conference calls, news articles, etc • Met with CMS staff and political appointee • House and Senate Dear Colleague letters-- <ul style="list-style-type: none"> – Walden (R-OR) and Pomeroy (D-ND) 60 signatures – Roberts (R-KS) and Harkin (D-IW) 36 signatures • Included comments on the Guidelines in the FY 07 IPPS letter • Stand-alone comment letter on the Guidelines <ul style="list-style-type: none"> – Guidelines go well beyond FY 2006 rule – Mountainous terrain and secondary roads definitions too prescriptive and should be rescinded – 5 mile safe harbor from 75% test • Have meet twice since letter with CMS staff • Legislation? 

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