

To: AHCA State Affiliates  
AHCA Board of Governors  
Council for Post-Acute Care  
Regional Multifacility Council & CEOs  
Not for Profit Council  
Independent Owner Council  
Finance Committee  
Survey/Regulatory Committee  
AHCA Advocacy Department

From: David Hebert

Subject: **Unresolved Issues in Health Care Reform Bills**

Date: December 14, 2009

Recent communications have focused on the main issues facing our industry and key items of market basket updates, RUG IV, Medicaid, the Wyden amendment, and transparency. Recent communications have also shared detailed analysis of the bills as they impact our industry.

While we would like to have as many of these items “fixed” as possible, this memo will outline some outstanding issues apart from our main priorities in both the House-passed bill, the *Affordable Health Care for America Act* (H.R. 3962) and the Senate bill currently under consideration, the *Patient Protection and Affordable Care Act* (drafted as an amendment to H.R. 3590). While we will continue to work to make the bills better, we wanted you to be aware of the other problematic issues.

*Independent Medicare Advisory Board.* The Senate bill would create an independent Medicare advisory board which would make recommendations for cutting Medicare spending. These recommendations would be considered by Congress under expedited procedures and would be implemented if Congress failed to act. AHCA/NCAL has concerns about this provision and believes Congress should remain involved in Medicare payment decisions. AHCA/NCAL also believes that both the proposed new commission and MedPAC must take Medicaid and other payers into consideration when making recommendations. **AHCA/NCAL is also concerned that certain providers, such as hospitals, would not be subject to cuts based on recommendations by the board while others, including SNFs, would be.**

#### Duties of IMAB

From 2015-2019, IMAB is required to recommend changes to the Medicare program to limit the rate of growth in the program if the Medicare Trustees project that the program's spending per beneficiary is growing more rapidly than a measure of inflation (average of growth rates of CPI for medical services and the overall CPI for urban consumers). After 2019, recommendations are required if the projected rate of growth exceeds the rate of increase in National Health Expenditures (NHE).

### Scope of IMAB authority

The Board's actions are limited. It is prohibited from modifying eligibility or benefits. Its proposals cannot ration care; raise taxes or Part B premiums; change Medicare benefits, eligibility, or cost-sharing standards; or reduce payments for providers whose payments have already been reduced by the bill's market-basket adjustments. **The legislation does authorize the board to recommend changes that would affect hospitals and hospices beginning in 2020.**

The Board would be allowed to reduce spending under Medicare C and D (such as premium subsidies and performance bonuses to MA and PDPs). CBO concludes then that the Board's recommendations will focus on reductions in subsidies for non-Medicare benefits offered through MA plans and changes to payment rates for services furnished in the fee-for-service sector by providers other than hospitals, physicians, hospices, and suppliers of durable medical equipment offered through competitive bidding.

### Adoption of Recommendations

The IMAB recommendations do not need to be approved by Congress to take effect. The recommendations, along with legislative implementation language, go to the President who then submits them as a legislative proposal to Congress. The House and Senate then consider that legislative proposal under a fast-track process. The House and Senate can amend the proposal, *but unless Congress waives the requirement by a 3/5 vote, any changes must still achieve the same cost-savings required by the IMAB proposal.* While Congress can waive the requirement to adopt comparable savings, the legislation passed by Congress remains ordinary legislation that must be signed into law by the President. If legislation is not signed into law by August 15, the Secretary is required to implement the original IMAB proposal. In other words, in any given year, either the IMAB proposal or legislation passed by the House and Senate and signed by the President that achieves the same cost-savings targets will be implemented (with the exception that Congress could waive the cost-savings requirements by a 3/5 vote, pass legislation that does not meet the IMAB targets, and have that law signed by the President).

### Score

The CBO scored the Board as saving \$23.4 billion over 10 years. Last week's report by the CMS Actuary on the Reid bill found that the reductions in Medicare growth rates through the IMAB may be "difficult to achieve in practice."

Civil Monetary Penalties. The House bill gives the Secretary the authority to increase CMPs for deficiencies at all levels of scope and severity. While CMP reductions are possible for self-reported deficiencies, the bill states that they may not be reduced by more than 50 percent. Reductions would not be made for deficiencies citing an immediate jeopardy or actual harm violation, or if the deficiency is a repeat deficiency. The Secretary is also authorized collect CMPs immediately, place them in an escrow account until completion of the IDR process, or the date that is 90 days after the date of the imposition of the CMP. AHCA opposes the increase of civil money penalties as unnecessary and punitive and we believe that such increases will not serve as a motivation for improving facility behavior. AHCA is particularly concerned that increasing monetary fines for deficiencies at all levels of scope and severity drains the facility of resources available for patient care.

Reimbursement for Background Checks. Both the House and the Senate bills establish a nationwide program requiring long term care facilities and providers to conduct screening and criminal and other background checks on prospective direct access patient employees based on the pilot program created under the Medicare Modernization Act of 2003. AHCA/NCAL is concerned that implementation of the program will result in additional fees for providers and thereby increased costs. The House bill contains a provision, added at our request, encouraging states to reimburse providers for the costs of conducting these checks, while the Senate bill does not. AHCA/NCAL will continue to push so that at least the House language, and preferably stronger language, will be included in the final package.

Transparency. The House and Senate bills contain extensive nursing home transparency requirements: disclosure mandates including information on SNF/NFs' officers, directors, trustees, managing partners, additional disclosable parties, 5 percent ownership interests. In the House bill, facilities are required to certify to the Secretary and the Inspector General that the information submitted upon request is "accurate and current." AHCA/NCAL believes that it is appropriate to disclose parties that have operational control over the facility and those who are directly responsible for various aspects of patient care; however, these provisions go far beyond what is reasonable or useful to consumers.

Both bills also expand information that must be included on Nursing Home Compare, including information on Special Focus Facility Program. AHCA/NCAL believes that Including Special Focus Facility Program information on Nursing Home Compare would be extremely cumbersome and difficult for a consumer to understand and digest.

Fraud and Abuse. The Senate and House bills contain extensive Medicare and Medicaid program integrity provisions, including enhanced penalties for health care fraud. The Senate bill requires the Secretary, in consultation with the OIG, to screen all providers and suppliers before granting Medicare, Medicaid, and CHIP billing privileges and at time of revalidation. An application fee of \$200 for individual practitioners, adjusted for inflation beginning in 2011, and \$500 for institutional providers and suppliers adjusted for inflation beginning in 2011, would be imposed to cover the costs of screening each time they re-verify their enrollment (every five years). AHCA/NCAL is opposed to additional fees and unfunded mandates being placed on providers for the screening processes.

Tort Reform. The House bill permits the Secretary to make incentive payments to each State that has an alternative medical liability law. The Secretary is responsible for determining the amount of each payment and whether or not a State has an alternative medical liability law in compliance with the bill requirements. However, a State will not be eligible for incentive payments if it limits attorneys' fees or imposes caps on damages in a law related to alternative liability, even if the caps are part of existing State alternative liability law. AHCA/NCAL opposes these restrictions on the contents of medical liability laws related to incentive payments and believes that any tort reform provision in the Bill must permit States to craft their own requirements without penalization.

Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Settings. Both the House and the Senate bills would require Medicare Part D prescription drug and Medicare Advantage prescription drug plans to employ utilization management techniques, such as weekly, daily or automated dose dispensing, when providing medications to beneficiaries residing in long-term care facilities in order to reduce waste associated with 30-day fills. AHCA/NCAL is concerned about the impact of this provision on facilities and is working with Congressional staff to clarify the language.

Maximum Period for Submitting Medicare Claims. Both the House and Senate bills reduce the period for Medicare claims submission under Parts A, B, C, and D from 36 months to 12 months to try and combat fraud and abuse. The Senate bill has an earlier effective date, January 1, 2010, while the House would begin a year later on January 1, 2011. In addition, the Senate provision would also apply to any service furnished before January 1, 2010. AHCA/NCAL is monitoring this very closely regarding any potential detrimental impact on SNFs.

Bundled Payments. Both the House and Senate bills contain provisions that would establish bundled payments, including post-acute care- details below. However the Senate bill also contains a Medicaid bundled payment provision, which is more limited and primarily focused on the Hospital and Physician services, although it still includes post-acute care services. While AHCA has concerns about post-acute bundling and would prefer to see a demonstration project as opposed to a pilot, as in the House version, since a pilot can more easily become permanent, we believe that the requirement in the bill that the Secretary submit a plan to Congress before it becomes permanent is appropriate. We are also concerned that post acute providers may not be the “bundler” under the Senate Medicaid provision.

- Medicare
  - Senate- Will require the Secretary to implement a national, voluntary pilot program coordinating care for Medicare beneficiaries not covered under Part C during an entire episode of care for eight conditions to be specified by the Secretary by January 1, 2013. Services to be included in the bundle are: acute care inpatient hospital services; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, post acute care services (PAC) including home health, skilled nursing, inpatient rehabilitation, and long term care hospital; and other services that the Secretary determines appropriate. The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate for purposes of the pilot. The Secretary must decide which patient assessment tool as well as which quality measures, for both episodes of care and post acute care, are to be used in the pilot. The post-acute care quality measures must be site neutral. The Secretary would develop policies to ensure the traditional fee-for-service program provides payment for PAC services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge. Any Medicare provider, including hospitals, physician groups, or post-acute entities interested in assuming responsibility for the bundled payment would be able to apply to participate in the pilot program. Any entity assuming responsibility for the bundled Medicare payment would be required to have an arrangement with an acute hospital for initiation of bundled services. All services provided under the bundle would be required to be provided or directed by Medicare-participating providers. Eligible entities would receive the bundled payment for each patient served, regardless of whether patient receives certain levels of physician or post acute care. The pilot must be conducted for five years, and if it improves patient outcomes, reduces costs and improves efficiency, then the Secretary would be required to submit a plan to Congress to make the program permanent.

- Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending.
- House- Directs the Secretary to submit to Congress a detailed plan on how to implement post-acute bundled payments. Contains requirements for the Secretary to consult with stakeholders and to take specific issues into consideration, including protections for consumers to preserve access to care and patient choice. The plan shall include detailed specifications for a bundled payment for post acute care (PAC) services and may include other approaches. The plan shall include the consideration of certain enumerated issues, such as the nature of payments under a post acute care bundle, how cost-sharing for a post acute care bundle should be treated relative to existing cost-sharing, the nature of relationships required between hospitals and providers of post acute care service to facilitate bundled payments (e.g., anti-kickback).It also contains requirements for data collection and analysis. Converts the existing Acute Care Episode demonstration project to a pilot program and expands the program so that it may include bundling of payments for hospitals and post-acute providers, effective January 1, 2011 The Secretary may only expand the pilot program, if the Secretary finds that the demonstration and pilot maintain or increase quality of care and reduce program expenditures and yield a certain level of savings.
- Medicaid. The Senate bill contains a bundled payment demonstration project, to be established in eight states to begin on January 1, 2012 through December 31, 2014. Services included would encompass acute care hospital, concurrent physician, and post acute care services. Hospitals would receive a single bundled payment for integrated care delivered to a Medicaid beneficiary during a hospitalization and 30 days post-discharge. We will continue to monitor this project, since at this time, a PAC provider cannot be the bundler.

Recovery Audit Contractors. The Senate bill would expand the Recovery Audit Contractors (RACs) Program to Medicare Parts C and D, as well as Medicaid. AHCA/NCAL is concerned about these provisions, since the pilot program for Parts A and B was problematic for SNFs.

Medicaid Presumptive Eligibility Determinations by Hospitals. This provision in the Senate bill would allow any hospital the option, based on preliminary information, to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

AHCA/NCAL believes this could potentially include individuals discharged from the hospital to a nursing facility. In other words, the period of presumptive eligibility for Medicaid could include the individual being discharged from the hospital to the nursing facility. The provision specifies that the Secretary will release guidance; therefore, we will know more when the guidance is released. AHCA will work to clarify the potential impact of this provision.

Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliation. Under this provision in the Senate bill, individuals or entities are temporarily excluded from participating in Medicaid if the entity has unpaid overpayments. This exclusion extends to affiliated entities under management, control, or ownership of entities that are excluded from participation. AHCA/NCAL believes this is already covered by provisions in the current exclusion law, specifically Section 1128 of the Social Security Act. This provision appears to be redundant and unnecessary.

Medicaid Global Payment System Demonstration. In the Senate bill, a Medicaid Global Payments demonstration project would be established in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a global capitated payment structure. AHCA/NCAL will work to ensure that SNFs are not impacted by this provision.

Home and Community Based Services and Assisted Living. Both the House and the Senate bill have extensive provisions to improve support for home and community based services. AHCA/NCAL will work to ensure that assisted living is included in the definition of home and community based services.

Elder Justice Act. Unlike the House, the Senate bill includes the entire text of the Elder Justice Act (S. 795), which establishes a new Elder Justice program at HHS. Among others, this provision requires each individual owner, operator, employee, manager, agent, or contractor of an LTC facility must report to the Secretary and local law enforcement entities any reasonable suspicion of crimes occurring in such facility. Additionally the owner or operator of such an LTC facility must notify the Secretary and the appropriate state regulatory agency of a facility's impending closure, as well as establish a plan for the transfer and adequate relocation of facility residents. While AHCA/NCAL supports the *Elder Justice Act* overall, we have significant concerns about the existing language and have sought clarifying changes regarding the definitions of neglect, crimes, and covered individual in addition to reducing the scope of reporting to only those facilities participating in Medicare and Medicaid and the level of CMPs assessed.

Employer Mandate.

- House
  - *Play or Pay.* As of January 1, 2014, employers with more than 50 employees not offering minimum essential health coverage will be required to pay \$750 for each employee.
  - If an employer offers unaffordable coverage, where employee premiums exceed 9.8% of their income or the actuarial value is less than 60%, employees are eligible to access the exchange.
  - Employers whose employees receive a tax credit must pay the lesser of \$3,000 for each employee accessing the tax credit or \$750 for each full-time employee.
  - Employers who impose a waiting period would be required to pay \$400 for any FTE during a 30-60 day waiting period and \$600 for any FTE during a 60-90 day waiting period.
  - Requires employers who offer coverage but whose employees receive tax credits to pay for each worker receiving a tax credit up to a cap of \$400 per FTE.
  - Employers with 200 or more employees must automatically enroll new employees into health insurance plan offered. Employers must provide adequate notice and opportunity for employees to opt out. Penalty amounts will be adjusted for inflation after 2014. Exempts employers whose workforce exceeds 50 FTE for 120 days or fewer/year with seasonal workers.

- Senate
  - *Play or Pay*. Employers not offering health coverage or contributing at least 72.5% of the lowest cost qualified health plan for an individual and 65% for a family will pay an 8% fee based on average payroll. Exempts small businesses with payrolls less than \$500,000/year.
  - Establishes a graduated rate of contribution requirements for employers with payrolls of \$500,000 to \$750,000 not offering health coverage between 2% and 6% of annual payroll.

Union Friendly-Provisions. AHCA/NCAL is working closely with the U.S. Chamber of Commerce to try and either modify these provisions or have them removed altogether.

- Protections for Employees. The Senate bill sets up new protections for workers and an express mechanism to resolve complaints under the *Fair Labor Standards Act (FLSA)*. The provision is designed to ensure that no employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has received a premium tax credit; has provided or caused to be provided information relating to a related violation; has testified or is about to testify about such violation; has assisted or is about to assist in such a proceeding; or has objected to or refused to participate in an activity the employee reasonably believes to be in violation.
- Discrimination. The Senate bill contains a provision reiterating that existing discrimination laws (the *Civil Rights Act*, the *Education Amendments Act*, the *Age Discrimination Act*, and the *Rehabilitation Act*) apply regarding exclusion from participation in or denial of benefits under any health program or activity.
- Reinsurance. The House and Senate bills both would establish a temporary reinsurance plan for certain retiree health benefit plans covering retirees 55 ages old or older and not eligible for Medicare. The provision would apply to voluntary employees' beneficiary associations (VEBAs) and employer-provided plans. Eligible plans would apply to the Secretary to participate. Participating employment-based plans would submit claims for reimbursement to the Secretary, and the Secretary would reimburse 80% of claim costs between \$15,000 and \$90,000 (adjusted based on CPI). Requires plans to use the funds to lower costs borne by plans and beneficiaries.
- Compulsory Unionization of Health Care Workers. The House bill allows the Secretary to establish "conditions of participation for health care providers" under the public option provision, which gives the Secretary wide latitude to create rules for providers, and possibly health care workers, who participate in the public option. Although some national groups have stated that this provision could require compulsory union membership for all employees participating under the public option, we understand that is not the case since such a requirement is likely to be precluded by the National Labor Relations Act.