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THE HOSPITAL & HEALTHSYSTEM
ASSOCIATION OF PENNSYLVANIA

# Testimony

## Submitted on behalf of The Hospital & Healthsystem Association of Pennsylvania

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Before the

**Pennsylvania House Insurance Committee and House Democratic Policy Committee**

Presented by:

Timothy L. Ohrum
Director, Legislative Services
The Hospital & Healthsystem Association of Pennsylvania

Pittsburgh, PA
July 21, 2010

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**Statement of The Hospital & Healthsystem Association of Pennsylvania**

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**Director, Legislative Services**
**The Hospital & Healthsystem Association of Pennsylvania (HAP)**

**Pittsburgh, Pennsylvania**
**Wednesday, July 21, 2010**

I am Tim Ohrum, Director, Legislative Services, for the Hospital & Healthsystem Association of Pennsylvania (HAP).

HAP represents and advocates for more than 250 acute and specialty care hospitals and health systems across the state, and the patients they serve. We appreciate the opportunity to present the views of our member hospitals and health systems regarding the impact that the Patient Protection and Affordability Act will have on health care delivery, as well as HAP's perspective on the state's priorities for successful implementation of the federal reforms. I have divided my remarks into two segments, first how reform impacts Pennsylvania hospitals, and second, implementation priorities.

## Health Reform Impact on Hospitals

I have attached a summary of the major provisions of importance to hospitals in the reform package for your review. However, in an effort to be sensitive to the committee members' time, I will focus on the delivery system reforms that will have the most significant implications for hospitals.

Delivery system reforms include Accountable Care Organizations, Bundling of Payment, Readmissions Policy, Value Based Purchasing, and Medical Homes, all of which provide a very different way of thinking for physicians who treat patients, and for hospital leaders who must reconfigure existing care models. No longer can the two groups work independently of one another. Moving forward hospital and physician reimbursements will be tied to quality as opposed to the number of procedures they order—quality over quantity.

To better understand these delivery system reforms I will provide you a very brief explanation of each.

**Value Based Purchasing (VBP):**
The law establishes a VBP program to begin in FY 2013 to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures. The VBP program applies to all acute-care prospective payment system hospitals except certain ones which do not have a sufficient number of patients with related conditions. A demonstration project will be created for critical access hospitals (CAH), which is important to Pennsylvania since we have thirteen federally qualified CAHs.

Measures will be selected from those used in the Medicare pay-for-reporting program, including measures for heart attack, heart failure, pneumonia and surgical care, and measures assessing a patient's perception of care. The Health and Human Services (HHS) Secretary is directed to include measures on health care-associated infections, and measures assessing efficiency, including measures of Medicare spending per beneficiary, which will be adjusted for differences in age, sex, race, severity of illness and other factors.

**Payment Bundling:**
Beginning in FY 2013, the HHS Secretary will establish a national voluntary pilot program on bundling of payment in order to improve the coordination, quality and efficiency of health care services. The pilot program will be conducted initially for five years and can be continued longer if the Secretary determines the program does not reduce quality, but does reduce cost. Entities comprised of groups of providers including hospitals, impatient rehabilitation facilities, long term care hospitals, physician groups, skilled-nursing facilities, and home health agencies may apply to participate in the pilot.

**Accountable Care Organizations (Shared Savings Program)**
Beginning in January of FY 2012, groups of qualifying providers, such as physician group practice arrangements, networks of practices, hospital-physician joint ventures, and hospitals employing physicians and other clinical professionals (physician assistants, nurse practitioners or clinical nurse specialists), will have the opportunity to form Accountable Care Organizations (ACO's) and share in the cost savings they achieve for the Medicare program.

To earn incentive payments, ACO's must meet certain quality thresholds. Reporting measures will be set by the HHS Secretary and include:

1. Clinical processes and outcomes.
2. Patient and caregiver perspectives on care.
3. Utilization and costs.

The ACO will then be able to share in the savings generated to the Medicare program at a rate determined by the Secretary

**Hospital Readmissions**
Beginning in FY 2013, inpatient prospective payment system (IPPS) hospitals with higher than expected readmissions rates will experience decreases in Medicare payments for <u>all</u> Medicare discharges. This provision is to be enacted two years from the legislation's passage, which is March 23, 2012. Prior to that time, the HHS Secretary will make available a program for eligible hospitals to improve their readmission rates through patient safety organizations. Performance

evaluation will be required on the 30-day readmission measures for heart attack, heart failure, and pneumonia, which are currently part of the Medicare pay-for-reporting program. In 2015 the HHS Secretary may expand the list of conditions to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures, as well as any other condition or procedure the Secretary chooses.

**Health Homes for Medicaid Enrollees with Chronic Conditions:**
The health reform law requires the HHS Secretary to award State Planning Grants to establish a Health Home Program for eligible enrollees by January 1, 2011. Eligible participants must have at least two chronic conditions, such as asthma, diabetes or mental health issues, and must select a designated provider to serve as a health home. States will provide payment for the health homes except during the first eight fiscal year quarters in which the FMAP is at 90 percent. States also may propose alternative methods of payment. States must include the following in their proposal:

1. Requirement for hospitals to refer participants who seek emergency care to his/her health home provider.
2. Plan for coordinating with the Substance Abuse and Mental Health Services Administration.
3. Methodology for tracking readmissions.
4. Proposal for using health IT.
5. Report quality measures.

## State Implementation Priorities

While states vary in the ways in which they approach public policy issues, all states will be confronting many of the same challenges and asking many of the same questions. The National Academy for State Health Policy has published a briefing paper that identifies and describes ten aspects of federal health reform that states must "get right" if they are to be successful in reform implementation. Not all are specifically targeted to hospitals, but all are important in ensuring Pennsylvania has a high quality, cost efficient health care delivery system. The ten areas are:

1. Be Strategic with Insurance Exchanges.
2. Regulate the Commercial Health Insurance Market Effectively.
3. Simplify and Integrate Eligibility Systems.
4. Expand Provider and Health System Capacity.
5. Attend to Benefit Design.
6. Focus on the Dually Eligible.
7. Use your Data.
8. Purse Population Health Goals.
9. Engage the Public in Policy Development and Implementation.
10. Promote and support quality and efficiency initiatives of the health care system.

Expanding provider and health system capacity may be the most difficult issue for hospitals to address, and certainly has the ability to impact patient access to high quality health care.

Studies have determined that on average people without health insurance use about 60 percent of the health care services. Expanding coverage will increase demand for services, which will strain the capacity of those parts of the health care system that are already under pressure. Of particular concern is primary care, internal medicine, obstetrics/gynecology, general surgery, orthopedic surgery, radiology, cardiology, emergency department care, and pediatrics.

Pennsylvania faces a significant shortage of physicians. Studies demonstrate that Pennsylvania needs to take steps now to ensure an adequate supply of physicians on an ongoing basis. Physician workforce levels in Pennsylvania are not nearly sufficient to meet the increased demand for physician services that will result from our aging population, and increased insurance coverage. The fact that there is also evidence that the nation faces a physician shortage makes the challenge for Pennsylvania even greater.

If physician supply and use remain the same, the United States will experience a shortage of 124,000 full-time physicians by 2025, according to the Association of American Medical Colleges. This is largely driven by population growth, an aging population and aging physicians, and increased physician visits. In Pennsylvania the difficult medical liability environment further complicates and worsens the problem.

One of every four physicians in Pennsylvania is 60 years or older; only one in five is under the age of 40 with the average age being 48.9 years. One out of every three physicians who completed their medical degree in Pennsylvania remained in the state to practice, ranking Pennsylvania 32$^{nd}$ among all states. It also is worth highlighting that twenty percent of those primary care physicians in the state say they will leave Pennsylvania in five years or less.

What can the General Assembly do to improve access to quality physicians in Pennsylvania:

1. Retire the MCARE fund.
2. Expand loan forgiveness programs.
3. Make Pennsylvania "physician-friendly" by offering incentives to encourage physicians to practice in the state's rural areas and develop programs that encourage more residents who are training in Pennsylvania to remain in the state as clinical practitioners.
4. Make Pennsylvania a leader among states in the delivery of high-quality health care services through the use of health information technology, including in physician practices.
5. Raise physician fees paid by Medicaid and commercial insurers so Pennsylvania is as competitive as other states nationwide.

## Summary

HAP continues to carefully analyze the Patient Protection and Affordability Act, and is working closely with Pennsylvania hospitals to implement the key priorities I have outlined today. We are committed to helping policymakers understand key consequences in the reform bill such as the potential shortage of quality physicians, and identifying ways in which you can assist in helping address these problems.

Thank you for this opportunity to testify and to provide the hospital community's perspective on the Patient Protection and Affordability Act. I am happy to answer your questions.

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**Summary of Major Provisions of Importance to Hospitals in the Reform Package (The Patient Protection and Affordable Health Care Act and the Reconciliation Act of 2010)**

**Coverage Expansion:**

- Beginning in January 1, 2014, all U.S. citizens and legal residents would have to obtain coverage or face a tax penalty.
- Expands access to coverage to 32 million individuals by 2019, through a combination of public program expansions and private sector health insurance reforms.
- Individuals with employer-based coverage will be able to retain their coverage. Those without employer plans can obtain coverage through newly formed "health insurance exchanges."
- Subsides are available to assist low-income individuals with the purchase of health insurance premiums, and Medicaid would be expanded to provide coverage for the poor.
- While employers are not required to provide coverage, large employers will be charged a "free rider" assessment if their employees purchase health care coverage through the exchange with federal premium subsidies.

**Medicaid:**

- Beginning in 2014, requires all state Medicaid programs to cover individuals up to 133 percent of the federal poverty level (FPL).
- States will receive federal funds to pay for the newly expanded populations starting with 100 percent federal financing for 2014-2017 and scaled down to 90 percent for 2020 and thereafter. States that have already covered this population will receive additional federal assistance.

**Medicaid Disproportionate Share (DSH) Payments:**

- Decreases Medicaid DSH payments by $14 billion with reductions beginning in fiscal year (FY) 2014.
- DSH reductions are not directly tied to increases in the level of insurance coverage, and the final bill directs the Health and Human Services Secretary to develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions. In making DSH reductions, the Secretary is instructed to look at a state's percentage of reduction in the uninsured, and whether a state targets DSH funds to hospitals with high Medicaid volumes or uncompensated care.

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**Medicare Disproportionate Share (DSH) Payments:**

- Decreases Medicare DSH by $22.1 billion beginning in FY 2014.
- The final package would continue to reduce Medicare DSH payments by 75 percent to eliminate DSH payments that are above the "empirically justified" level, as determined by the Medicare Payment Advisory Commission.
- A portion of the 75 percent would then be returned to hospitals depending on the amount of uncompensated care they provide. This amount is subject to a trigger, and would be phased down if coverage increases.

**Hospital Payment Updates:**

- Reduces hospital Medicare payment updates by approximately $112.6 billion over ten years. For 2010 (beginning April 1) and 2011, the hospital payment update would be reduced by 0.25 percentage point.
- Beginning in 2012, the market basket would be reduced by an estimate of productivity; *with added reductions* of 0.1 percentage point in 2012 and 2013; 0.3 percentage point in 2014; 0.2 percentage point in 2015 and 2016; and 0.75 percentage point in 2017, 2018, and 2019. In 2020 and beyond, hospital payment updates would be reduced by productivity.
- The reconciliation bill eliminates a provision in the Senate bill calling for the reductions not to occur if certain coverage targets are not met in 2014-2019.

**Health Insurance Exchanges:**

- Beginning in 2011, requires states to establish health insurance exchanges through which individuals and small businesses can purchase qualified private health insurance coverage.
- A Federal Employee Health Benefit Plan (FEBHP)-like, multi-state health insurance plan will be offered through the exchanges with oversight by the federal Office of Personnel Management.
- Consumer Operated and Oriented Plans (CO-OPS) will be created to foster non-profits, member-run health insurance cooperatives. There is no government-run program.

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**Health Insurance Reforms:**

- Establishes, within 90 days of enactment, temporary mechanisms to provide coverage to individuals with pre-existing conditions and for non-Medicare eligible retirees over age 55.
- Within six months of enactment, it prohibits insurers from setting annual and lifetime limits, dropping coverage (except in cases of clear fraud), and excluding coverage to children based on a pre-existing condition.
- Within six months of enactment, would allow parents to include dependent children up to age 26 on their health insurance.
- Beginning in 2014, health insurers would be prohibited from excluding coverage based on pre-existing conditions for adults, would have limits imposed on premium ratings, and would have to guarantee the issuance of coverage for anyone who seeks it.

**Administrative Simplification:**

- Provides for 11 specific expansions of the administrative simplification provisions under HIPAA by HHS, as well as periodic reviews (beginning January 1, 2012, and every three years thereafter) of where greater uniformity would further improve operation of the health care system and reduce administrative costs.
- The process requires input from the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, the Health Information Technology Standards Committee, standard setting organizations, and stakeholders.

**Bundling:**

- Beginning in 2013, requires the Secretary to establish a national, voluntary, five-year pilot program on bundling payments to providers around ten conditions.
- If the voluntary pilot program is successful, the Secretary may expand the pilots after 2015.

**Readmissions:**

- Beginning in federal fiscal year 2013, imposes financial penalties on hospitals for so-called "excess" readmissions when compared to "expected" levels of readmissions based on the 30-day readmission measures for heart attack, heart failure, and pneumonia that are currently part of the Medicare pay-for-reporting program.

- Critical access hospitals and post-acute care providers are excluded from these provisions.

**Accountable Care Organizations (ACO):**

- Beginning in 2012, allows hospitals, in cooperation with physicians, to provide leadership in voluntary ACOs, which would be responsible for managing the care of certain beneficiaries, and allows the Secretary to share some of the savings from improved care management with providers.

**Value-Based Purchasing (VBP):**

- Establishes a VBP program for hospital payments beginning in federal fiscal year 2013 based on hospitals' performance in 2012 on measures that are part of the hospital quality reporting program.
- The program is budget neutral, with 1 percent of payments allocated to the program in FY 2013, growing over time to 2 percent in 2017 and beyond.

**Hospital-Acquired Conditions (HAC):**

- Beginning in federal fiscal year 2015, adds a 1 percent penalty to hospitals in the top quartile of rates of HACs, resulting in reductions of $1.5 billion over ten years.

**Geographic Variation:**

- Includes $400 million for payments for federal fiscal years 2011 and 2012 to section 1886(d) hospitals located in counties that rank in the lowest quartile for age, sex and race adjusted per enrollee spending for Medicare Parts A and B.
- The payments would be proportional to each hospital's share of the sum of Medicare inpatient PPS payments for all qualifying hospitals.
- Includes a commitment by the Secretary to commission two Institute of Medicine (IOM) studies and convene a national summit on geographic variation, cost, access, and value in health care. One study will evaluate hospital and physician geographic adjustment factors, looking at their validity as well as the methodology and data used to create them. Allowable changes will be implemented by December of 2012. The second study will examine geographic variation in the volume and intensity of health care services and recommend ways to incorporate quality and value metrics into the Medicare reimbursement system.

- The Secretary also will convene a national summit on geographic variation, cost, access, and value in health care later this year.

**Innovation Center:**

- Creates a Center for Medicare and Medicaid Innovation (CMI) within CMS by 2011 to test innovative payment and service delivery models that improve quality and reduce program expenditures within certain limited geographic areas.

**Physician Self-Referral:**

- Eliminates the exception for physician-owned hospitals under the Stark Law and grandfathers existing hospitals with a Medicare provider number as of December 31, 2010. It requires compliance with disclosure, patient safety, bona fide investment, and growth restriction rules.
- The legislation also provides limited exceptions to the growth restrictions for grandfathered physician-owned hospitals including a new exception for hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

**Physician Payment:**

- The final bill does not address the physician payment issue.
- A short-term, temporary fix for the scheduled reduction in physician payment for the remainder of calendar year 2010 is currently being debated in separate legislation.

**Primary Care Physicians:**

- Requires states to increase Medicaid payment rates to primary care providers in 2013 and 2014 only to Medicare levels, and provides 100 percent federal funding for the incremental costs to states.

**Independent Payment Advisory Board (IPAB):**

- Creates a new, independent board that would make binding recommendations on Medicare payment policy and non-binding recommendations for changes in private payer payments to providers.
- The recommendations exclude providers such as hospitals (but not critical access hospitals) through 2019.

**340B Program:**

- Extends eligibility for the 340B drug discount outpatient program to children's, cancer, and critical access hospitals, as well as certain sole community hospitals and rural referral centers.
- It does not expand the program for existing 340B hospitals to cover inpatient drugs, and it exempts orphan drugs from required discounts for new 340B entities.

**Medical Education:**

- Contains no reductions in indirect medical education (IME) payments.
- Redistributes 65 percent of unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. Qualified hospitals would be able to request up to 75 new slots.

**Long-Term Care Hospitals (LTCH):**

- Extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2008.*
- Further delays full implementation of the 25 percent rule, the short-stay outlier cuts, and the one-time budget-neutrality adjustments planned by CMS.
- Extends current moratorium on new LTCH beds and facilities, with exceptions.

**Rural Hospital Provisions:**

- Extends the outpatient hold-harmless payments for certain hospitals in rural areas.
- Improves payments for low-volume hospitals.
- Ensures that CAHs are paid 101 percent of costs for all outpatient services regardless of the billing methods elected.
- Extends and expands the Rural Community Hospital Demonstration Program.
- Extends the Medicare Dependent Hospital program for one year.
- Extends the Medicare Rural Hospital Flexibility Program through 2012.
- Extends reasonable cost reimbursement for laboratory services in small rural hospitals.

**Medicare Extenders:**

- Includes one-year extensions of certain Medicare provisions, including Section 508 wage index reclassifications; increasing the work geographic index to 1.0; grandfathering direct billing for anatomic pathology technical component services; add-on payments for ground ambulance; outpatient therapy caps; and a 5 percent increase in physician payment for certain psychiatric therapeutic procedures.

**Liability:**

- Provides $50 million in appropriated funds for medical liability demonstrations.

**Fraud and Abuse:**

- The final legislation contains significant additional funding to fight fraud and abuse, with increased financial penalties for existing policies, as well as new requirements and penalties for providers, suppliers, and others.

**Excise Tax on High-Cost Health Plans:**

- Creates an excise tax beginning 2018, for insurers of employer-sponsored health plans and sets the threshold for the tax at $10,200 for individual coverage and $27,500 for family coverage.

**Medical Device Tax:**

- Beginning 2013, implements a 2.3 percent excise tax on medical device manufacturers.
- Exempts from the tax any device of a type that is generally purchased by the public, such as eyeglasses and hearing aids.

**Other Revenue Provisions:**

- Includes an assessment of $67 billion on health insurers beginning in 2014.
- Includes an assessment of $33 billion on brand-name pharmaceuticals beginning in 2011.