The Supreme Court’s Decision on the ACA and Its Impact on Strategic Planning

Western COD Meeting

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ACA Refresher—As Approved by The Supreme Court

ACA Legislation Highlights
ACA Implementation Timeline
Upcoming Regulations
Supreme Court’s Decision on the ACA

Putting All Medicaid Funds at Risk is Coercive & Unconstitutional

Medicaid Expansion is Constitutional Because Penalty Severed
  • Individual Mandate is Constitutional under the Taxing Power
  • Medicaid Expansion is Constitutional

Entire Act Should Fall

Anti-Injunction Act Does NOT Bar Review of Case
Hospital Issues on Horizon

- Medicare/Medicaid cuts to hospitals = $155B/10 yrs
- Hospital price transparency
- Community benefit reporting requirements/IRS
- Readmissions policies FY 2013
- Value based purchasing FY 2013
- Medicaid voluntary expansion CY 2014
- Exchange establishment (fed/state) CY 2014
- Hosp Acquired Conditions reductions FY 2015
- Will coverage levels be adequate (96%)
Physician Issues on Horizon

- Changes to geographic adjusters in payment
- Quality reporting mandatory for physicians
  - Physician pay ‘value’ modifier
- Public reporting (‘physician compare’)
- Medicaid payment rates
  - 2013-14: Rates not lower than Medicare for primary care services (proposed rule)
- Medicare payments
  - 2011-15: bonuses to pc practitioners and general surgeons
- What to do about the SGR
ACA Implementation Timeline

- **Medicare Reforms**
  - Pilot programs to change how doctors are paid, cost controls

- **Insurance Reform**
  - Young adults on parents’ plan, rate review, no lifetime limits

- **Insurance Reforms**
  - Individual mandate, guaranteed issue, community rating

2012

2014

2015

- **Everything Else**
  - Indian Health Service, restaurant menu labeling, breastfeeding rules, prevention fund, free preventative screenings, etc.

- **Medicaid Expansion**
  - Intended to broaden entitlement to everyone under 133% of federal poverty limit in some states

- **Exchanges and Tax Credits**
  - Sets up a marketplace to buy insurance and helps middle income Americans pay their premiums

- **Doctors paid according to quality of care**
Upcoming Regulations

From existing guidance*, the AAMC anticipates upcoming regulations to include:

- Guidance on essential health benefit implementation in Medicaid
- Further comment to consider amending the final rules regarding Medicaid eligibility determinations made by Exchanges
- QHP quality reporting requirement and quality reporting and disclosure requirements for all Exchanges
- Draft and final notice of benefit and payment parameters including user fee, risk adjustment, risk corridor, and reinsurance methodologies

* Essential Health Benefits Bulletin (12/16/11) and Federally-Funded Exchange Guidance (5/16/12); current regulations available at [http://cciio.hhs.gov/resources/regulations/index.html#hie](http://cciio.hhs.gov/resources/regulations/index.html#hie)
Medicaid/Exchange Issues

Exchange Strategies

DSH Strategies

Voluntary Medicaid Expansion

Current State Policies
Exchange: Key Dates

- **Summer 2012**: Publish regulations on 2014 insurance reforms
- **Sept 30 2012**: Deadline to select benchmark Essential Health Benefits plan.
- **Oct 1 2013**: Proposed open enrollment begins.
- **Nov 16, 2012**: Request federal certification for Exchange operations.
- **Jan 1 2014**: Exchange goes live.
- **July 1 2013**: Finalize QHP contracts.
- **Dec 31 2014**: Exchanges must be self-sustaining.
- **Aug 15, 2012**: First of ten new opportunities to apply for Exchange grants.
- **Jan 1 2013**: Receive conditional or full exchange certification from Secretary.
- **Nov 2014**: Last Exchange Establishment application deadline.

From: Manatt Presentation
ACA Medicaid Changes: Key Dates

Affordable Care Act Provisions

Q3 - Q4 2012

Q1 – Q2 2013

Q3 – Q4 2013

Q1 – Q2 2014

Q3 – Q4 2014

Q1 – Q2 2015

Q3 – Q4 2015

Medicaid expansion to 133% FPL (100% fed. funds)

Maintenance of Effort for Adults

Maintenance of Effort for Children (until 2019)

Primary care payment increases (100% federally funded)

DSH reductions begin

Redesigned eligibility & enrollment systems launch

Basic Health Plan launches (for states opting in)

From: Manatt Presentation
DSH Strategies
ACA and Medicare DSH

• $22 billion in aggregate Medicare DSH cuts over 10 years
• Implemented as per-hospital cuts:
  ▪ Starting in FY 2014, each hospital receives 25% of the Medicare DSH payments calculated under the current formula
    ➢ Law states that 25% represents MedPAC’s “empirically justified” Medicare DSH amount (March 2007 Report)
• Aggregate annual savings is re-directed to eligible hospitals
  ▪ Additional payments will reflect the hospital’s DSH Payment Percentage, the % change in uninsured, and a hospital’s uncompensated care costs
    ➢ The Medicare DSH formula does not currently account for uncompensated care costs.
ACA and Medicaid DSH

- $18 billion in aggregate Medicaid DSH cuts over 10 years.
  - FY 2014: $500 million
  - FY 2015: $600 million
  - FY 2016: $600 million
  - FY 2017: $1.8 billion
  - FY 2018: $5 billion
  - FY 2019: $5.6 billion
  - FY 2020: $4 billion

- Cuts occur regardless of coverage levels.
- In FY 2021, allotments equal FY 2020 levels (ie, reduced levels), plus an inflation update.
  - Approved as a $4 billion offset for 2012 legislation providing SGR relief and the extension of tax cuts and unemployment benefits.
ACA Methodology for Achieving Medicaid DSH Cuts

To achieve aggregate annual savings under ACA, HHS Secretary must implement a “DSH Health Reform Methodology” that must:

• Impose the *largest percent reductions* on states that:
  ✓ Have the lowest percentages of uninsured individuals
  ✓ Do *not* “target” DSH payments on hospitals with high Medicaid inpatient volume
  ✓ Do *not* “target” DSH payments on hospitals with high levels of uncompensated care (excl. bad debt)
DSH Methodology (cont’d)

• Impose *smaller percent reductions* on Low-DSH states.
  ✓ Historically, has included Alaska, Arkansas, Delaware, Idaho, Iowa, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Wisconsin, Wyoming.
  ✓ ACA awarded Hawaii status as a Low DSH state.

• Account for the extent to which a state’s Medicaid DSH allotment was included in a budget neutrality calculation for coverage expansions approved under Sec. 1115 waivers (as of July 31, 2009).
Also in Play...


• Revises current definition of “uninsured” to include both:
  ✓ Patients with no health coverage
  ✓ Insured patients that lack coverage for a specific service

• AAMC submitted comments:
  ✓ Supports the “service-specific” definition
  ✓ Make the definition retroactive to 2008 (when Medicaid DSH established an individual-specific definition of “uninsured”)
  ✓ Also include in the DSH limit calculation:
    ➢ Unpaid coinsurance and deductibles
    ➢ Costs of services provided after coverage is exhausted (esp. for patients requiring lengthy hospital stays)
Voluntary Medicaid Coverage Expansions 2014

Federal Poverty Level

- 100%
- 133%
- 250%
- 400%

Medicaid
Expands to include adults not previously covered (i.e., low-income women, pregnant women, disabled)

Cost Sharing Subsidies for Exchanges to 250% FPL

Premium Subsidies for Exchanges (133-400% FPL)
Governor Jack Markell (D-DE)
NGA Chairman, 2012-2013
DGA Chair, 2010

On the Voluntary Medicaid Expansion:

- “Math is math. It’s not Democratic or Republican.”
- “We want to make it clear that if the deal changes, and the federal government reduces its commitment, that we’re not going to be left holding the bag.”
- “The best role NGA can play is to recognize that different governors from different states will make their own decisions.”

Current State Policies
Medicaid Eligibility for Working Parents by Income, January 2012

- < 50% FPL (17 states)
- 50% - 99% FPL (16 states)
- 100% FPL or Greater (18 states, including DC)
Medicaid for Childless Adults

Coverage of Low-Income Adults by Scope of Coverage, January 2012

- **No or Limited Coverage (43 states)**
- **Medicaid Comparable Coverage (8 states, including DC)**
Since ACA Passed...

• **Budget Actions**
  
  o Proposed GME cuts
    ▪ President’s budget FY 2013
    ▪ Ryan’s budget FY 2013
    ▪ Simpson-Bowles resurrected
  
  o Sequestration

• **Selected provisions implemented**
  
  o Bad Debt reimbursement cut
  o MSSP (ACOs)
  o Value Based Purchasing
  o CMMI
President’s FY 2013 Budget

- GME Cuts: $9.7B/10 yrs
- Phase-Down Bad Debt Payments: $35.9B/10 yrs
- Strengthen IPAB: (no budget impact)
- Single Blended FMAP Rate: $17.9B/10 yrs
- Phase-Down Medicaid Provider Tax: $21.89B/10 yrs
- Rebase Medicaid DSH Allotments: $8.3B/10 yrs
Paul Ryan’s FY 2013 Budget

- Achieves $2.5 trillion reduction in health care spending over 10 years:
  - Repeals ACA but retains the $500 billion in Medicare reductions included in ACA
  - Converts federal Medicaid funding into block grants - $810 billion
  - Converts Medicare into a premium support model - $205 billion

- Discretionary spending cap at $1.028 trillion
  - $19 billion below BCA cap ($1.047 trillion)
  - Assumes 3% cut to discretionary health spending overall
    - For example: NIH, Title VII, CHGME
Paul Ryan’s FY 2013 Budget (con’t)

• Replaces sequestration with reconciliation
  
  o Directs 6 House committees to identify necessary savings by April 27 to avert sequestration
  
  o Includes nearly $97 bill/10 yrs in reductions from Energy & Commerce Committee and $53 bill/10 yrs from Ways & Means Committee
  
  o Options to achieve reductions include health care spending, means-testing entitlement programs and medical liability reform
Simpson, Bowles Revisit Plan

“Authors of the Simpson-Bowles deficit reduction plan are rewriting their $4 trillion proposal to include an aggressive plan to control health care spending.”

CQ Today, 7/17/2012
Simpson-Bowles Plan Resurrected

• Reform Medicare SGR
  o Freeze physician payments 2012-2020

• Reduce medical education payments
  o Limit DGME to 120% nat’l avg/resident in 2010
  o Reduce IME from 5.5% to 2.2%

• $6B/yr cut to teaching hospitals

• Phase out Medicare payments for bad debts
  o Saves $23 billion over 10 years

• Phase out Medicaid provider tax mechanism
  o Saves $44 billion over 10 years
## FY 2013 AAMC Priorities

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<td>$30.623 B</td>
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<td>$30.723 B</td>
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<td>Title VII ¹</td>
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<td>$256 M</td>
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<td>Title VIII ¹</td>
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<td>$231 M</td>
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<td>AHRQ ² (w/ transfers)</td>
<td>$369 M ($405 M)</td>
<td>Eliminates AHRQ and rescinds $150 million from PCORTF</td>
<td>$364 M ($438 M)</td>
<td>- 1.4% (8.1%)</td>
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<td>Children’s GME</td>
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<td>$275 M</td>
<td>3.8%</td>
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<tr>
<td>NHSC ³</td>
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<td>$300 M</td>
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<tr>
<td>CDC ⁴</td>
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<td>$5.697 B</td>
<td>0.7%</td>
<td>$5.714 B</td>
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1 Includes proposed transfers from the PHS Evaluation tap and the Prevention and Public Health Fund.
2 AHRQ is scheduled to receive $24 million from the Patient-Centered Outcomes Research Trust Fund (PCORTF) and $12 million from the Prevention and Public Health Fund (PPHF) in FY 2012. Expected transfers in FY 2013 include $62 million from the PCORTF and $12 million from the PPHF.
3 Includes $295 million (FY 2012) & $300 million (FY 2013) from the ACA’s NHSC Fund.
4 CDC totals do not include transfers from the Prevention and Public Health Fund (PPHF). CDC received $825 million in FY 2012. The Senate Committee recommends an $858 million transfer to CDC. The House Subcommittee rescinds $1 billion in FY 2013 from the PPHF. As a result, overall funding to CDC in FY 2013 would drop by $814 million (11.7 percent) compared to FY 2012.
Looking Forward to Congressional Actions

The Fiscal Cliff/Debt Ceiling
Sequestration
Deficit Reduction
GME, NIH, Title VII, and Other Federally-Funded Programs
FY 2013 Appropriations

Tax Cuts

Payroll Tax Holiday

Extended Unemployment Benefits

AMT “Patch”

SGR (“Doc Fix”)

Sequestration

Debt Limit Extension
Change in Budget Deficit Under Current Law

Δ = $560 billion

Source: CBO, May 2012
Breaking Down the Sequester

$1.2 Trillion Sequester (2013-2021)

$984 Billion Sequester (split evenly over 9 years, $109 bn/yr)

Assumed Debt Service Savings $216 bn

Defense Cuts $492 bn

Lower Annual Discretionary Funding $492 bn

Non-Defense Cuts $492 bn

Lower Annual Discretionary Funding $322 bn

Medicare 2% Cut $116 bn

PPACA* Exchange Subsidy Cuts $7 bn

Other Mandatory Cuts $41 bn

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<th>Resources Before Sequestration</th>
<th>Sequestration</th>
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<td></td>
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<td>Dollar reduction</td>
<td>Percent reduction</td>
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<td><strong>Defense</strong></td>
<td>$726</td>
<td>$54.7</td>
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<td>Military personnel funding, assumed to be exempt (est.)</td>
<td>136</td>
<td>0</td>
<td>0.0%</td>
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<td>Other non-war funding for 2013</td>
<td>410</td>
<td>38.0</td>
<td>9.3%</td>
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<td>Subtotal, amount subject to caps</td>
<td>546</td>
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<td>War funding, outside of caps (estimated)</td>
<td>90</td>
<td>8.3</td>
<td>9.3%</td>
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<td>Unobligated balances from prior years (estimated)</td>
<td>90</td>
<td>8.3</td>
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<td><strong>Non-defense discretionary (NDD) programs</strong></td>
<td>501</td>
<td>38.6</td>
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<tr>
<td>Non-exempt programs</td>
<td>423</td>
<td>38.5</td>
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<td>Veterans’ health and Pell grants, exempt (estimated)</td>
<td>72</td>
<td>0</td>
<td>0.0%</td>
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<td>Health centers and Indian health, 2% limit (estimated)</td>
<td>6</td>
<td>0.1</td>
<td>2.0%</td>
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<td><strong>Non-exempt mandatory programs</strong></td>
<td>605</td>
<td>16.1</td>
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<tr>
<td>Medicare payments to providers and plans, 2% limit</td>
<td>542</td>
<td>10.8</td>
<td>2.0%</td>
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<tr>
<td>Other non-exempt mandatory programs</td>
<td>63</td>
<td>5.2</td>
<td>8.2%</td>
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FY13 Sequester Falls Almost Entirely on Smallest Pieces of the Budget

Impact of Sequestration

Spending cuts beginning Jan. 2, 2013 will:

• Reduce nation’s GDP by $215 billion; and

• Cost the U.S. economy 2.14 million jobs
  o Increase unemployment by as much as 1.5 percentage points
  o Nearly 50 percent of job loss from non-DOD cuts

Impact of Sequestration on NIH

“NIH would expect to lose 7.8 percent of the budget, about $2.4 billion….
[That] would result in roughly 2,300 grants that we would not be able to award in fiscal year '13….

“[T]hat represents almost a quarter of our new and competing grants that would result in success rates… falling to historically low levels….

“And I think the burden would hit particularly heavily upon first time investigators….”

NIH Director Francis Collins, M.D., Ph.D., Senate Labor-HHS-Education Appropriations Subcommittee, 3/28/12
So What Happens Next?

• Conventional wisdom is nothing happens before the election, but

• House Republican leaders talking about short-term continuing resolution (CR) to get them into 2013

• Will Congress and the Administration negotiate a deal during the “lame duck” session following the election – or –

• Will the “winners” in November refuse to negotiate with the “losers” and everything gets kicked into the 113th Congress
HOPD
Moratorium Options

• Any HOPD in existence as of a certain date would not be subject to the E/M reductions, OR

• Limit the number of E/M claims paid at the full rate to the number of E/M visits paid in a previous year, OR

• Define the moratorium by looking at square footage that is currently serving as a provider-based clinic.
Exemption Option

• For hospitals that meet either one of the conditions below:
  o Any HOPD located on the campus of a [teaching] hospital, OR
  o Any HOPD operated by a [teaching] hospital that has a DSH patient percentage (DPP) greater than (25%? 20%).
Mitigation Options

• Available for HOPDs not covered by the exemption(s) selected from the above list, OR

• Provide stop-loss protection, OR
  ▪ Based on losses in outpatient revenues only (preferred)
  ▪ Based on total losses, but exclude special payments (DSH, IME, DGME)

• Phase-in the reduction over a period of > 3 years, OR

• Limit the amount of the reduction.
  ▪ Instead of making the HOPD amount equal to the physician office visit, set the HOPD amount at X% of the difference between the physician office visit rate and the OPPS rate.
Medicare’s Investment in GME

DGME as a % of Medicare

IME as a % of Medicare
Medicare Covers 23% of Direct Costs

- DGME Cost per trainee (Medicare cost reports)
  - $145,000 per trainee, per year on average
  - Medicare uses PRA of about $94,000 a year

- Direct costs of training in US teaching hospitals
  - $13 billion per year

- Current Medicare DGME payments
  - $3 billion per year
  - $2 billion per year underpayment for Medicare’s share
### Special Federal Funding Streams

<table>
<thead>
<tr>
<th>Stream</th>
<th>Source</th>
<th>Amount</th>
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<tbody>
<tr>
<td>IME – Medicare</td>
<td>Medicare</td>
<td>$6.5 billion</td>
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<tr>
<td>DGME – Medicare</td>
<td>Medicare</td>
<td>$3.0 billion</td>
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<tr>
<td>GME – Medicaid</td>
<td>Medicaid</td>
<td>$3.2 billion</td>
</tr>
<tr>
<td>DSH – Medicare</td>
<td>Medicare</td>
<td>$9.8 billion</td>
</tr>
<tr>
<td>DSH – Medicaid</td>
<td>Medicaid</td>
<td>$11.1 billion</td>
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</table>
How Do These #s add up?

Average COTH Medicare margin about -3%
Average losses on Medicaid higher
COTH provides $8 billion charity care/yr
NIH, other grants don’t pay full costs of research
GME is only partially funded by gov’t
No explicit payments for standby care
Many clinical service lines lose money
All of the missions are inter-related and dependent upon clinical revenue…which is declining.
Unless GME Positions Grow, Someone Likely to be Squeezed Out

Projected Growth in MD and DO Entrants into GME

26,000 Currently Available Residency Positions

MD GME Entrants

DO GME Entrants

IMG GME Entrants

Sources: 2008: AAMC Dean’s Enrollment Survey
2008: AACOM Enrollment Analysis

Preliminary Data Prepared by: Center for Workforce Studies (SAS) 7/09

THE MAYANS!

ARMAGEDDON 2012