Legislative and Regulatory Update

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Florida Hospital Association
March 13, 2015

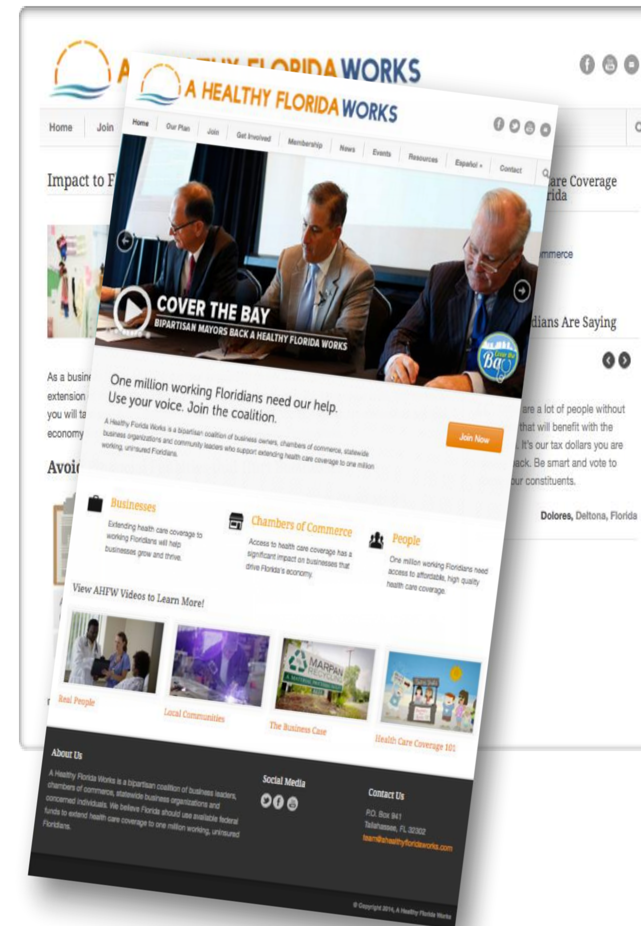
From the State Perspective

Legislative Issues

- Strategic Priorities
  - Extension of health care coverage
- Future for supplemental funding

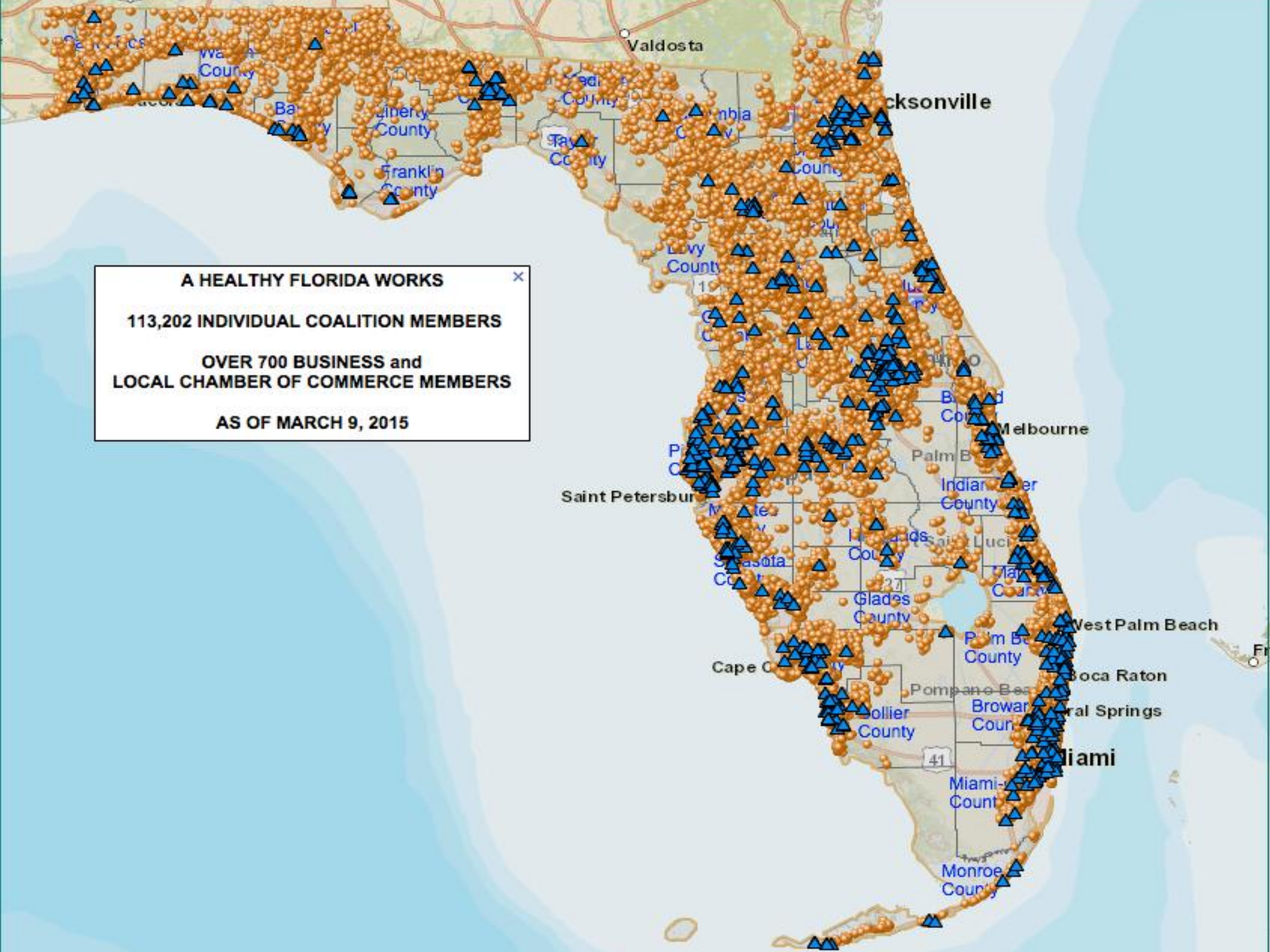
A HEALTHY FLORIDA WORKS

- Launched in August 2013, coalition includes **over 700 businesses, 20 local chambers,112,000 individuals,** Associated Industries of Florida, the Florida United Business Association and FHA.
- Mission is extending health care coverage to approximately one million Floridians through the use of existing federal funds.
- Focused on building and growing membership to educate individuals on business case.



FLORIDA HOSPITAL ASSOCIATION

Mission to Care. Vision to Lead.



A HEALTHY FLORIDA WORKS
113,202 INDIVIDUAL COALITION MEMBERS
OVER 700 BUSINESS and LOCAL CHAMBER OF COMMERCE MEMBERS
AS OF MARCH 9, 2015
Valdosta
Melbourne
West Palm Beach

Where We Are Today: Florida Health Insurance Affordability Exchange Program (FHIX)

- On March 4, AHFW presented draft legislation during Senate Health Policy Committee workshop.
- During the workshop, legislators discussed ideas with experts and constituents from across the state.
- As a result of that workshop, the Senate has filed SPB 7044, "The Florida Health Insurance Affordability Exchange", which includes all of the key components found in the AHFW proposal.
- **The Senate Health Policy Committee heard the bill on Tuesday, March 10.**

Florida Health Insurance Affordability Exchange Program (FHIX)

- Who is covered?
  - All individuals below 138% of the Federal Poverty Level
- How does it work?
  - Creates new state exchange
  - Benefits provided through Medicaid managed care plans
  - Requires participation in job and education requirements for eligibility
  - Cost sharing – premiums on sliding scale and co-pay for non-emergent ER use

Florida Health Insurance Affordability Exchange Program (FHIX)

- 6 month lock out for non-payment of premium
- Program expiration should Federal match drop below 90% in any year
- Funds state share through elimination of Medically Needy Program

Supplemental Funding

Until we get some clarity to this picture on how we are going address healthcare and unreimbursed care in the state of Florida, we are not going to be allocating large chunks of resources to any of the priorities, including individual member priorities.

Everything is on the table, including not being able to get allocations established for conference, and therefore being here in May."

Senator Tom Lee
Budget Appropriations
Chairman

Supplemental Funding

- Federal policy shift in funding for uncompensated care at the state level
- Florida's Low Income Pool to sunset on June 30, 2015
- CMS wants to see considerable reform
- Recent study highlights serious challenges to Florida's Medicaid program and the way it finances hospital care

"CMS and Florida agree that this one-year extension of the LIP will provide stability for providers as Florida transitions to statewide Medicaid managed care, while allowing the state to move toward a significantly reformed Medicaid payment system."

Marilyn Tavenner
CMS Department of Health and Human Services Administrator

From the Federal Perspective

FY2016 Budget Proposal

- Replace sequestration with other savings opportunities
- Implement value-based purchasing for SNF, HHA, ASC, HOPD and CMHCs
- Establish a hospital-wide Readmission measure
- Eliminate the 190-day lifetime limit on IPF services
- Implement bundled payments for post-acute care

FY2016 Budget Proposal (con.)

- Reduce Medicare coverage of bad debts
- Better align GME payments with patient care costs
- Reduce CAH payments from 101 percent of reasonable cost to 100 percent
- Prohibit CAH designation for facilities that are less than 10 miles from the nearest hospital
- Modify the 60 percent rule for IRFs by requiring that 75 percent of IRF patients require intensive rehab services

IRS Final Rule for Tax-Exempt Hospitals

- Changes the requirements for patient notification about the hospital’s financial assistance policy (FAP), including the requirement of offering a paper copy of the summary of the FAP to patients at registration or at discharge and providing information on the availability of financial assistance on billing statements

IRS Final Rule for Tax-Exempt Hospitals (con.)

- Requires hospitals to list in their FAP the providers delivering emergency or other medically necessary care in the facility, and to specify those that are covered by the hospitals FAP and those that are not;
- Requires signage about the FAP;
- Allows hospitals to change the method for calculating the "amount generally billed" (AGB) rather than being locked into a single methodology;

IRS Final Rule for Tax-Exempt Hospitals (con.)

- Requires translation of FAP documents if a limited English proficient group constitutes the lesser of five percent of the community served or 1,000 individuals;
- Clarifies that filing a hospital lien does not constitute an extraordinary collection activity (ECA);
- States that sale of debt is not considered an ECA if certain requirements are met in the contract of sale; and

IRS Final Rule for Tax-Exempt Hospitals (con.)

- States that deferring or denying care, or requiring a down payment, based on previous unpaid bills constitutes ECAs.

Inpatient and Outpatient Hospital Payments: MedPAC

- *Reducing or eliminating the difference between HOPD and Physician fee schedule payments for selected HOPD APCs (66 APCs).* This proposal would reduce HOPD payments by roughly $1.4 billion per year, including $1.2 billion in Medicare payments, and $240 million in beneficiary co-insurance.

Payments for Hospital Care at Risk

- Paying hospitals for E/M services in the HOPD setting at the physician fee schedule amount: $477,096,847
- Paying for APCs that meet specific criteria at the physician fee schedule amount: $334,012,740
- Capping hospital payments for 12 proposed APCs at the ASC rate: $49,915,898
- Total Cut: $861,025,485

Inpatient Rehab Facilities: MedPAC

- *MedPAC calls for implementing a new site neutral payment that would "eliminate the difference in payments between IRFs and SNFs for selected conditions."* The recommendation would not specify the conditions, but, MedPAC has performed analysis on using 22 conditions for site neutral payments. Likely would also recommend a transition period/phase-in for changes.

Other Options for Savings: MedPAC

- Reductions in payments to hospitals for assistance to low-income Medicare beneficiaries (bad debt)
- Reductions to payments for GME
- Reductions to rural hospital programs, including CAH
- Cuts to inpatient rehabilitation and long-term care hospitals
- Changes to the 340B program

Recovery Auditor (RA)

- Program Improvements
  - ADRs limits based on provider's compliance with Medicare rules
    - Providers with low denial rate will have lower ADR limits
  - ADR limits diversified across all claim types
  - Limit RA look-back period to six months from the date of services for patient status reviews
    - In cases where the hospitals submits the claim within three months of the date of service

Recovery Auditor (RA) Changes

- RA will have 30 days to complete complex reviews and notify providers of findings
- RA must wait 30 days to allow for discussion request before sending overpayment to MAC
- RA must confirm receipt of discussion request or other written correspondence within three business days
- RA will not receive contingency fee until after the second level of appeal is exhausted

Recovery Auditor Changes

- CMS will require the RA to broaden their review topics to include topics based on referrals such as OIG reports
- RA will be required to maintain an overturn rate of less than 10 percent at the first level of appeal
- RA will be required to maintain an accuracy rate of at least 95 percent

President’s Budget: RA Changes

- Allowing CMS to retain an increased portion of payments denied by RACs in order to pay for RAC-related appeals
- Establishing a per-claim filing fee for providers and suppliers at each level of Medicare appeal. The fee would be returned to appellants who receive a fully favorable appeals decision.

President's Budget: RA Changes

- Increasing the minimum amount that must be at issue (known as the amount in controversy) for a claim to be adjudicated by an ALJ. The minimum amount in controversy would be the same as that for federal court ($1,460 in 2015).
- Implementing a magistrate adjudication program for claims below the minimum amount in controversy.

President's Budget: RA Changes

- Remanding appeals to the first MAC level of review when new documentary evidence is submitted at the second level of appeal or above
- Allowing HHS to use sampling and extrapolation to adjudicate appeals and to consolidate appeals into a single administrative appeal at all levels of the appeals system.

Questions???

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