State

Providers and Patient Groups Speak Out About the Impact of the House and Senate Budgets

As state lawmakers recessed for the July 4 holiday, representatives from provider and patient groups expressed their concerns to legislators about the potential impact of the House and Senate Health and Human Services budget proposals on their constituencies.

House and Senate budget writers have different plans for Medicaid reform, taxes, and education spending, and advocacy groups, like the North Carolina Hospital Association, say those differences can have a huge impact on healthcare in the state.

Hospitals

Cody Hand, Vice President and Deputy General Counsel of the North Carolina Hospital Association, said there were numerous provisions in the Senate budget that were “troubling” and harmful to hospitals across the state.

Those provisions, he said, include Medicaid reform, the sales tax refund cap, the Certificate of Need (CON) repeal, and the elimination of the Graduate Medical Education (GME) add-on to inpatient hospital base rates.

Additionally, Hand said hospitals must now absorb nearly $2 billion in state and federal cuts, saying, “Patients are paying as much as they can. What do we do to absorb almost $2 billion in cuts? Do we eliminate a service?"

Local Management Entities and Managed Care Organizations

Leza Wainwright, CEO of Trillium Resources, and Mary Hooper, Executive Director of N.C. Council of Community Programs, explained to lawmakers how the Senate’s proposed changes to their funding structure would affect the services they provide to more than 100,000 uninsured or underinsured North Carolina residents each year.
At issue, they say, is the Senate’s proposed reduction in funding of $185.6 million a year for two years, the requirement to transfer operating cash to the Medicaid Risk Reserve equaling 15 percent, and discontinuing the state’s 2 percent contribution to the LME/MCO, once it reaches the 15 percent required in the Medicaid Risk Reserve.

Certificate of Need Repeal
Senate budget writers have called for the phased elimination of the state’s Certificate of Need (CON) program, with the complete repeal of the law occurring on January 1, 2019. They propose a plan that, effective January 1, 2016, CON laws will not apply to the establishment of beds or a change in bed capacity at facilities such as acute care hospitals, inpatient psychiatric hospitals, and inpatient rehabilitation hospitals.

Nor would a Certificate of Need be required to offer bone marrow transplants, burn intensive care services or open heart surgery, or to acquire a lithotripter or gamma knife equipment.

The construction, development, establishment, increase in number, or relocation of any operating room or gastrointestinal endoscopy suite in a licensed health service facility could also happen without getting a CON.

Medicaid Reform
House and Senate chambers disagree on many provisions of Medicaid reform. Each has ideas about who should manage the program, whether to form an independent agency to oversee Medicaid and where it should be housed, and the timeline for implementation.

The House makes Provider-Led Entities (PLEs) responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, all claims processing, care management, case management, appeals, and other necessary administrative services.

The House plan calls for PLEs to manage and coordinate the care for enough program aid categories to cover at least 90 percent of Medicaid recipients and to be phased in over five years from when the bill is enacted.

Medicaid would remain in the state Department of Health and Human Services (DHHS), under the House plan. In fact, DHHS would administer and manage all aspects of Medicaid, including negotiating contracts with PLEs and working with them to establish benchmarks and standards.

Under the Senate plan, managed care and other organizations, run by physicians and hospital networks, would run the program through three statewide networks and six regional networks.
An independent, eight-member board, the Health Benefits Authority, would administer and negotiate the contracts, set policy and standards, and make program and other course-corrections without having to get approval from the General Assembly, as long as the mid-year changes kept Medicaid within state budget and didn’t violate any federal guidelines.

The Senate sets an “aggressive” timeline in which to implement Medicaid reform, enrolling the first patient in April 2017.

**Behavioral Health**

John Nash, Executive Director of The Arc of North Carolina, complimented House budget writers for protecting optional services for intellectually disabled patients, not cutting provider rates, and providing funding for targeted case management for people who are on the innovations waiver waitlist.

Nash cautioned, though, that there was an ongoing funding crisis for group homes that left many patients and families being afraid of an “unstable, unpredictable future.”

Jack Register, Executive Director of the National Alliance on Mental Illness NC, expressed concern about the consequence of creating more psychiatric beds in rural areas without the required staff to go with it. In addition, Register said his organization was concerned about the speed at which the Senate budget made changes to the LME/MCO system, suggesting the changes could make the system unstable.

A mental health advocate pressed the committee to devote more funding for state hospital beds rather than community-based services. The advocate reported that Rex Hospital was recently at risk for losing its federal funding because it had to restrain a patient who attacked seven hospital workers and was waiting for 17 days for a bed at Cherry Hospital.

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**Federal**

**Hospitals in 75 Metro Areas Targeted for New Medicare Mandatory Bundling**

The Centers for Medicare & Medicaid Services (CMS) late last week released a proposed rule that would bundle payments for knee and hip replacements for 75 metro areas. *The Comprehensive Care for Joint Replacement (CCJR) Model for Acute Care Hospitals* would bundle all related care for a 90-day episode. Among other provisions, under certain circumstances, the three-day stay in a skilled nursing facility rule can be waived in this model. It is a five-year test beginning January 1, 2016.

"We believe that by requiring the participation of a large number of hospitals with diverse
characteristics, the proposed model would result in a robust data set for evaluation of this bundled payment approach, and would stimulate the rapid development of new evidence-based knowledge,” CMS said in its proposed rule. Comments on the proposed rule are due by September 8, 2015.

**CMS Modifies 2-Midnight Rule**
The Centers for Medicare & Medicaid Services (CMS) has proposed changing several aspects of the 2-midnight rule, which might take some of the steam out of Congress’ interest in repealing the rule altogether. The proposal also contains changes to the Chronic Care Management payment program that started in January.

**New Payment Structure for Home Health Proposed**
The Centers for Medicare & Medicaid Services (CMS) last week released a proposed rule for the Home Health Prospective Payment System for calendar year 2016, which would reduce home health payments by 1.8 percent. Additionally, CMS has randomly selected nine states – Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington – in which to start a new value-based payment model for home health. CMS is also requiring the reporting of new data as part of the IMPACT requirements passed last year.

**Aetna, Humana Deal Prompts More Scrutiny While Hospitals are Well Prepared for Deal**
The plan between Aetna and Humana to merge is likely to receive intense scrutiny from the Federal Trade Commission and Department of Justice, according to a variety of interests closely following the developments.

By taking over Humana, Aetna will take over Humana’s extensive Medicare Advantage enrollment, which some analysts and the Kaiser Family Foundation say will increase its market share in some states – most notably Iowa, Kansas, Missouri and West Virginia – by more than 50 percent. Alone, Humana currently controls more than 50 percent of the market in Kentucky (Senate Majority Leader Mitch McConnell’s home state) Louisiana, Mississippi and Virginia, while Aetna currently rules the market in Alaska.

As for the merger’s impact on hospitals, Fitch Ratings released a new report saying hospitals are well positioned to manage this and other insurer consolidations.

**21st Century Cures Passes House**
The House last week passed the 21st Century Cures bill by a vote of 344-77. The package is pared-down from the legislation that received a unanimous vote out of the Energy and Commerce Committee in late May. Costly parts of the Act were trimmed, because leaders were unable to overcome objections to the use of several controversial offsets for the roughly $12 billion package. Durable medical equipment makers take a $2.5 billion hit in payments to help pay for the package. The Senate is expected to move similar legislation early next year.
Precision Medicine Initiative Moves Forward
The Obama administration reported last week new steps that will help advance the Precision Medicine Initiative that it launched earlier this year. The Administration is pushing for the development of guidance materials and partnerships with federal agencies – including the Office of the National Coordinator for Health IT (ONC) and the Office for Civil Rights (OCR) – to address barriers that prevent patients from accessing their health data. Additionally, the Department of Veteran Affairs announced its plan to reward four grants to researchers who will use its vast Million Veterans Program database to support advancing the Precision Medicine Initiative. The private sector also announced commitments to the program.

GAO Medicaid Analysis May Foretell Congressional Reform Action
The General Accounting Office (GAO) is out with a new report that identified four key issues facing the Medicaid program – access to care, transparency and oversight, program integrity, and federal financing. The report may help provide some insight into the direction Congress may take the program as it discusses healthcare payment reform.

Meanwhile, a report from The Pew Charitable Trusts examines efforts to expand Medicaid in the 19 states that have thus far refused.

Slavitt Gets Official Nod for CMS Post
President Obama has nominated Andrew Slavitt to be the next administrator of the Centers for Medicare & Medicaid Services. Slavitt, who is serving as acting administrator, has also held positions with Optum and Ingenix, both units of UnitedHealth Group. He would replace Marilyn Tavenner, who stepped down from the post in February.