HEALTH CARE TEAM

Team Leader/Issue Contact: **Bob Waste, UC Davis Health System, (916) 734-5441, rjwaste@ucdavis.edu**

PROTECT MEDICARE & MEDICAID

Requested Actions:

- Expand "grandfather" provision for hospital outpatient departments "in progress" that will be subject to "site-neutral" reductions under the Bipartisan Budget Act (BBA).
- Influence the finalization of Medicaid Managed Care proposed rule to maintain the flexibility necessary to sustain safety net providers' ability to contract with Medi-Cal managed care plans.
- Protect Medicaid provider fees as a way to support adequate reimbursement and maintain access to providers.
- Support the Establishing Beneficiary Equity in the Hospital Readmissions Program Act, which will create a socio-economic risk adjustment to hospital readmissions penalties.
- Engage in the implementation of the changes to physician payments and quality measures contained in the Medicare Access and CHIP Reauthorization Act (MACRA).
- Protect the 340B Drug Program as an important cost-saving element for treating the most vulnerable in Sacramento.
- Sustain Medicare Advantage rates to support the successful model of coordinated, high quality, cost-saving care to seniors.
- Support the broader availability of safe, convenient, and appropriate telehealth options, including expansion of payment for the provision of services provided.
- Maintain funding levels for Graduate Medical Education (GME) and Indirect Medical Education (IME) to support access to preventive, primary and specialty medical care to the newly insured.

Medicare and Medicaid (Medi-Cal) in the Sacramento Region

Medicare and Medicaid (Medi-Cal) are large payer sources for health systems, hospitals, community clinics, physicians and other providers, all of whom are committed to providing access to affordable, efficient and effective health care to beneficiaries, despite operating in a challenging regulatory environment and difficult reimbursement structure.

Medicare

Bipartisan Budget Act (BBA)

Passed late last year, the BBA established two tiers of reimbursements for hospital outpatient departments (HOPD). Those operational and billing before November 2, 2015 are paid under the

hospital outpatient prospective payment system; those currently planned or under construction will receive lower reimbursement unless the grandfather provision expanded to include HOPDs that are in various stages of development. Many HOPDs in California are "in process" as hospitals scramble to comply with California's stringent seismic compliance mandates. Accommodating these planned outpatient departments will honor agreements and commitments made by hospitals operating under federal rules that have been in place since 2001. Expanding the grandfather provision will also maintain access to services in underserved communities.

Medicare Access and CHIP Reauthorization Act (MACRA) Implementation
After nearly twenty years of temporary "patches" to avoid steep reductions to physician payments, the MACRA was passed and signed into law. Among its key provisions, the legislation repeals the physician sustainable growth rate (SGR) formula and replaces it with a Merit-based Incentive Payment System (MIPS), which tracks physician performance. The measure maintains stable physician payment by providing a 0.5 percent update and transitions to the new payment system beginning in 2019. It also creates incentives for physicians to participate in qualifying alternative payment models (APM), such as the Medicare Shared Savings Program. CMS has begun the regulatory process to develop the MIPS program by issuing requests for information and a plan to develop measures and transition to the MIPS program. We ask Congress to monitor the development of the program to ensure quality measures are coordinated with existing measures across the spectrum of care, are focused on outcomes and do not require burdensome documentation taking physicians away direct patient care.

Readmissions Reduction Program
Created by the Affordable Care Act (ACA), the hospital readmissions program imposes steep penalties on hospitals with higher patient readmissions for specific conditions. Published studies have shown hospitals that serve underserved communities face higher penalty rates than other hospitals. The Readmissions Reduction Program should be updated to create achievable targets for hospitals, and should include a socio-economic adjustment factor to account leveling the playing field for hospitals in underserved communities. The Establishing Beneficiary Equity in the Hospital Readmissions Program Act acknowledges the disparities safety net hospitals experience and incorporates a socio-economic risk factor to adjust penalties for those hospitals, allowing them to maintain the necessary resources to address the needs of the communities they serve.

Medicare Advantage
Since the 1980s, Medicare has served as the backbone of care coordination efforts in Medicare, Medicaid and commercial markets. Through the 5-Star Quality initiative, CMS leads the way in creating important incentives for Medicare Advantage (MA) plans to provide high-quality care to

beneficiaries. The ACA reduced Medicare Advantage payments in the past five years and updates in 2015 and 2016 have essentially been flat while health care costs have increased. Additional

reductions in MA rates would have a destabilizing effect on the program and could create problems for beneficiaries. Payment cuts also have a down-stream effect on providers and can affect access to high-quality care. Regulatory policy changes that affect the program's funding, year after year, are creating disruption and confusion among beneficiaries who are looking for consistency and predictability and can damage a program that offers value for beneficiaries. Further, such disruptions threaten to impede health plans from driving the innovation that has resulted in better coordinated care and improved outcomes for beneficiaries who enroll in Medicare Advantage. An estimated 45% of Medicare beneficiaries in the Sacramento area are enrolled in Medicare Advantage plans. We urge Congress to act to prevent further cuts to the Medicare Advantage rates in 2016 and 2017.

Telehealth
Sacramento is quickly becoming a connected system of care, complete with a comprehensive telehealth network. In fact, hospital systems in Sacramento are leading the state by expanding and training for the utilization of telehealth to meet the needs of patients and communities. Sacramento area providers, health systems, and health plans have the opportunity to scale the provision of telehealth services for beneficiaries, including those on Medicare.

Despite great advancement in this area and studies to show the value telehealth brings to patient outcomes and cost savings, there remains very limited reimbursement for services provided through telehealth. Providers should receive reimbursement for the provision of telehealth services aligned with services performed face-to-face. In addition, patients would benefit from changes to telehealth, such as lifting most restrictions for qualifying participants, permitting the use of remote patient monitoring for certain patients with chronic conditions, and relaxing site and geographic limitations. We encourage members to work with the Senate Finance Committee and other committees with appropriate jurisdiction to consider telehealth legislation that improves the care and outcomes of Medicare beneficiaries with chronic conditions.

340B Drug Program
The 340B program requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to hospitals and other organizations that care for many low-income and uninsured patients. Safety-net hospitals and other providers that qualify for the program are able to purchase drugs at a discount, allowing them to stretch scarce dollars to treat the most vulnerable in our communities. Despite a more than 20-year track record of increasing access to care for vulnerable patients and communities, some want to scale back or eliminate the 340B program. This would hurt

patients and unnecessarily add costs to providers without providing any savings to government programs.

Graduate Medical Education (GME)

Hospitals and other providers receive additional funding for a number of different reasons, including Graduate Medical Education (GME) and Indirect Medical Education (IME). Teaching hospitals and hospitals with residency programs receive GME and IME payments, based on the idea that hospitals should be compensated for the extra steps it takes to train doctors and to reflect the higher cost of treating complex patients. Consistently in budget discussions, GME and IME funding are put at-risk. This is particularly troublesome when the nation faces a severe shortage of primary care providers. The American Association of Medical Colleges (AAMC) estimates primary care physician shortages to range between 12,500 and 31,100 physicians and a non-primary care shortfall between 28,200 and 63,700 physicians over the next decade. Specific to Sacramento, the effect of reductions to GME and IME will have a profound impact on the medical schools and residency programs offered in many facilities. Annually, hospitals in Sacramento take part in training nearly a thousand residents and fellows and more than 700 medical students. We urge Congress to continue funding these vital programs.

Medicaid (Medi-Cal)

California's Medi-Cal program is the nation's largest Medicaid program in terms of the number of people it serves (more than 12.6 million) and in terms of dollars spent (close to $64 billion). Medi-Cal covers one in three Californians, more than one in ten adults under age 65, the majority of people living with HIV/AIDS, and about half of all children in California, while also caring for two-thirds of all nursing home residents. While the cost of the traditional program is shared equally by California and the federal government, the federal government pays 100 percent of the costs of providing health care services to the expanded Medi–Cal population from 2014 through 2016. The federal match is scheduled to phase down to 90 percent by 2020 and beyond. California ranks 47th out of 50 states in reimbursement for Medicaid services, increasingly affecting access to timely, appropriate care for Medi-Cal recipients. An estimated two-thirds of physicians in California simply cannot afford to participate in Medi-Cal. Payments to managed care plans are similarly near the bottom nationally. As a result, Medi-Cal patients report difficulty finding a doctor.

Medicaid Managed Care

Enrollment in California's Medi-Cal managed care delivery system has increased from 55 to 80 percent over the last five years by transitioning numerous populations into Medi-Cal managed care. Over this time, providers have performed well across many areas, including care management, utilization, and overall cost levels, when compared to other states and the U.S. averages. In fact, California's average per capita expenditures have been below U.S. averages, despite a much higher cost of living and cost of doing business. In June 2015, CMS proposed a rule to modernize Medicaid managed care

regulations intended to update regulations to better align them with existing commercial and Medicare Advantage rules. Over the years, with the support and approval of CMS, California has developed a variety of supplemental payment programs to meet identified needs ofpatients and providers. Often, these payments have targeted a subset of providers, typically those with the largest Medi-Cal patient populations, and therefore the greatest reliance on Medi-Cal as a primary source of revenue. While the proposed rule is an important step in aligning rules across the marketplace by creating more transparency in rate setting, and strategies for quality improvement, it lacks the flexibility necessary for managed care plans to extend reimbursement to safety-net providers. Removing this flexibility will severely impact safety-net providers by an estimated $2.5 billion throughout California and will destabilize the Medi-Cal program. We urge Congress to ensure that federal safeguards are in place and are being utilized to provide adequate Medicaid payments to promote high-quality care.

Provider Fee

Hospitals provide care to all patients that come through their doors, regardless of the patient's ability to pay. In response to a severe budget shortfall in 2010, the hospital industry banded together and worked with policymakers to create a Quality Assurance Fee, which allowed the state to draw down federal matching funds otherwise lost due to lack of state funding. The fee stabilized reimbursements to Medi-Cal providers, giving the state some flexibility to normalize its budget. Even with the fee, providers were able to recoup less than half of the shortfall they experienced in Medi-Cal. Since then, the state has passed a longer-term hospital provider fee, which will continue to stabilize Medi-Cal reimbursements to hospital providers for years to come. Congress continues to consider restrictions to or the elimination of Medicaid provider fees. We call on Congress to protect the ability of states to utilize provider fees to stabilize Medicaid funding.