**From:** Barbara Gay [mailto:BGay@leadingage.org]
**Sent:** Tuesday, September 20, 2011 8:03 AM
**To:** Barbara Gay; execforum@lyris.leadingage.org
**Subject:** RE:[execforum] LeadingAge update - deficit reduction

President Obama has submitted the Administration's proposals for reducing the federal budget deficit to the congressional Joint Select Committee on Deficit Reduction. The full text of the President's proposal may be read here:
http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.

The Joint Committee will not necessarily adopt the Administration's proposals in drawing up legislation to reduce the federal budget deficit, as required under the Budget Control Act. But it is possible that some of the Administration proposals will be contained in the deficit reduction plan the joint committee must produce by November 23.

We have urged the Joint Committee to make every effort to strengthen Medicare, Medicaid and other programs serving elders and to take this population's needs into account in developing the deficit reduction plan.

Some of the Administration proposals of interest to long-term services and supports providers:

**Bad debt**: "Align Medicare policy with private sector practice in coverage of bad debts. For most eligible provider types, Medicare currently reimburses generally 70 percent of bad debts resulting from beneficiaries' non-payment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. This proposal will align Medicare policy more closely with private sector standards by reducing bad debt payments to 25 percent for all eligible providers over three years starting in 2013. This will save approximately $20 billion over 10 years."

**Adjust payment updates for certain post-acute care providers.** MedPAC analysis indicates that Medicare payment significantly exceeds the cost of patient care in post-acute care settings, resulting in high Medicare margins.This proposal would gradually realign payments with costs through adjustments to payment rate updates in 2014 through 2021 for these providers.These adjustments build on recommendations from MedPAC's March 2011 Report to the Congress, in which they recommended that the Congress eliminate payment updates for each of these provider types in 2012.This proposal will save $33 billion over 10 years. [note: these reductions would be in addition to the cuts nursing homes and other post-acute care providers already have received from CMS.]

**Equalize payments for certain conditions commonly treated in IRFs and SNFs.** Post-acute care related to a number of conditions, including hip and knee replacements, hip fractures, and certain pulmonary diseases are currently provided in both IRFs and SNFs, although Medicare payments are significantly greater when treated in IRFs.This policy would reduce the differences in payment for treatment of specified conditions to encourage care in the most clinically appropriate setting beginning in 2013.This proposal will save approximately $5 billion over 10 years.

**Adjust SNF payments to reduce hospital readmissions.** The Affordable Care Act created payment adjustments for inpatient hospitals with high rates of readmissions, many of which could be avoided through better care. However, a comparable adjustment does not exist for SNFs.MedPAC analysis shows that nearly 14 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided. To promote high quality care in SNFs, this proposal reduces SNF payments by up to three percent beginning in 2015 for facilities with high rates of care-sensitive, preventable hospital readmissions. This proposal will save approximately $2 billion over 10 years.

**Reduce the Medicaid provider tax threshold beginning in 2015.** Many States impose taxes on health care providers to help finance the State share of Medicaid program costs. However, some States use those tax revenues to increase payments to those same providers, and use that additional spending to increase their Federal Medicaid matching payments. The Administration proposes to limit these types of State financing practices that increase Federal Medicaid spending, by phasing down the Medicaid provider tax threshold, from the current law level of 6 percent in 2014, to 4.5 percent in 2015, 4 percent in 2016, and 3.5 percent in 2017 and beyond. By delaying the effective date until 2015, the proposal protects States from reductions in the short term. This proposal is projected to save $26.3 billion over 10 years.

**Prohibit States from using Federal funds as the State share of Medicaid or CHIP, unless specifically authorized by law.** This proposal would prohibit States from using Federal funds as the State share of Medicaid or CHIP unless funds are specifically provided for that purpose under law.

**Apply a single blended matching rate to Medicaid and CHIP starting in 2017.** Under current law, States face a patchwork of different Federal payment contributions for individuals eligible for Medicaid and CHIP. Specifically, State Medicaid expenditures are generally matched by the Federal Government using the Federal medical assistance percentage (FMAP); CHIP expenditures are matched with enhanced FMAP (eFMAP); and the Affordable Care Act provides increased match for newly-eligible individuals and certain childless adults beginning in 2014.Beginning in 2017 this proposal would replace these complicated formulas with a single matching rate specific to each State that automatically increases if a recession forces enrollment and State costs to rise.This proposal is projected to save $14.9 billion over 10 years.

**Introduce home health co-payments for new beneficiaries.** Medicare beneficiaries currently do not make co-payments for Medicare home health services. This proposal would create a home health copayment of $100 per home health episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay.This would apply to new beneficiaries beginning in 2017.This proposal is consistent with a MedPAC recommendation to establish a per episode copayment. MedPAC noted that "beneficiaries without a prior hospitalization account for a rising share of episodes" and that "adding beneficiary cost sharing for home health care could be an additional measure to encourage appropriate use of home health services." This proposal will save approximately $400 million over 10 years.

**Introduce a Part B premium surcharge for new beneficiaries that purchase near first-dollar Medigap coverage.** Medigap policies sold by private insurance companies provide

beneficiaries additional support for covering healthcare costs by covering most or all of the cost sharing Medicare requires. This protection, however, gives individuals less incentive to consider the costs of health care services and thus raises Medicare costs and Part B premiums.Of particular concern are Medigap plans that cover substantially all Medicare copayments, including even the modest co-payments for routine care that most beneficiaries can afford to pay out of pocket. To encourage more efficient health care choices, the Administration proposes a Part B premium surcharge equivalent to about 15 percent of the average Medigap premium (or about 30 percent of the Part B premium) for new beneficiaries that purchase Medigap policies with particularly low cost-sharing requirements, starting in 2017.Current beneficiaries and near-retirees would not be subject to the surcharge. Other Medigap plans would be exempt from this requirement while still providing beneficiaries options for protection against high out-of-pocket costs. This proposal will save approximately $2.5 billion over 10 years.

**Strengthen the Independent Payment Advisory Board (IPAB) to reduce long-term drivers of Medicare cost growth.** Created by the ACA, IPAB has been high-lighted by economists and health policy experts as a key contributor to Medicare's long term solvency. Under current law, if the projected Medicare per capita growth rate exceeds a predetermined target growth rate, IPAB recommends to the Congress policies to reduce the rate of Medicare growth to meet the target. IPAB recommendations are prohibited from increasing beneficiary premiums or cost-sharing, or restricting benefits. To further moderate the rate of Medicare growth, this proposal would lower the target rate from the GDP per capita growth rate plus 1 percent to plus 0.5 percent. Additionally, the proposal would give IPAB additional tools like the ability to consider value-based benefit design… [note: because the ACA prohibits policies to reduce the rate of Medicare growth from affecting beneficiary costs or benefits, all cuts would have to come at the expense of providers. This proposal lowers the target growth rate that would trigger the requirement that IPAB come up with Medicare spending reduction policies.]

**Limit Medicaid reimbursement of durable medical equipment (DME) based on Medicare rates.** Under current law, States have experienced the same challenges in preventing overpayments for DME that previously confronted Medicare. The Medicare program is in the process of implementing innovative ways to increase efficiency for payment of DME through the DME Competitive Bidding Program, which is expected to save the Medicare program more than $17 billion and Medicare beneficiaries approximately $11 billion over 10 years. This proposal extends some of these efficiencies to Medicaid, starting in 2013, by limiting Federal reimbursement for a State's Medicaid spending on certain DME services to what Medicare would have paid in the same State for the same services. This proposal is projected to save $4.2 billion over 10 years.

**Strengthen third-party liability for Medicaid beneficiary claims.** This proposal would affirm Medicaid's position as a payer of last resort by removing exceptions to the requirement that State Medicaid agencies reject medical claims when another entity is legally liable to pay the claim, starting in 2013.Specifically, the Administration wants to allow States to avoid costs for prenatal and preventive pediatric claims when third parties are responsible, allow providers to collect medical child support for children with health insurance through a non-custodial parent, and allow Medicaid to recover costs from beneficiary liability settlements. This proposal is projected to save $1.3 billion over 10 years.

Barbara Gay

Director of Advocacy Information

LeadingAge

(202) 508-9489