American Hospital Association
Health Care Reform Legislation
Key Issues* Side-by-Side

Updated 1-12-10

Key Policy	House Reform Bill	Senate Reform Bill	AHA Position
Issues Impacting All Hospitals			
Coverage Expansion	Coverage of those "legally" residing in the United States – 96% by 2019. 18 million individuals will remain without coverage (an increase of 36 million individuals covered compared to 2010 levels).	Coverage of those "legally" residing in the United States – 94% by 2019. 23 million individuals will remain without coverage (an increase of 31 million individuals covered compared to 2010 levels).	Maintain or exceed the level of coverage in House bill and begin coverage in 2013. Hospitals' contribution to reform of $155 billion must be reduced if coverage targets do not meet or exceed the House level.
Medicaid Expansions	Expands Medicaid eligibility to those up to 150% of the federal poverty level.	Expands Medicaid eligibility to those at or below 133% of the federal poverty level.	Adopt Senate provision and include the original House funding approach that would provide all states 100% federal funding through 2019 for the expanded population.
Public Plan Option	Creates a broad public plan that would negotiate rates with providers within corridors linked in part to Medicare rates.	No public plan; creates non-public, non-governmental health care co-operatives and non-public, multi-state health plans.	Adopt the Senate approach.
Hospital Payment Updates	Reduces hospital payment updates by $119 billion over 10 years. Applies productivity cuts to the hospital market basket update starting in 2010 – an estimated reduction of 1.3% each year.	Reduces hospital payment updates by $102.7 billion over 10 years. Reduces hospital updates by 0.25 percentage point in 2010 and 2011. Beginning in 2012, market basket reduced by productivity adjustments and added reductions of 0.1 percentage point in 2012 and 2013 and 0.2 percentage points in 2014 through 2019.	Minimize reductions in FYs 2010 through 2013 unless coverage is extended in those years. Support the Senate approach to minimizing market basket reductions in FYs 2010 and 2011. Oppose the permanent annual productivity reductions in the Senate and House bills by sunsetting the productivity adjustment after FY 2019.

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Readmissions	Calls for similar approach as the Senate and reduces hospital payments by $9.3 billion over 10 years. Includes a maximum penalty after transition of 5% and also penalizes post acute care providers by 1% per readmission. The policy includes critical access hospitals.	Imposes financial penalties for so-called "excess" readmissions when compared to "expected" levels of readmissions. Reductions would amount to $7.1 billion over 10 years with a maximum penalty after transition of 3% applied to all DRGs. Excludes critical access hospitals and post acute care providers.	Revise both House and Senate approaches. A final policy should be refined to address only truly avoidable and unplanned hospital readmissions related to the original admission.
Hospital-Acquired Conditions (HACs)	Requires reporting of hospital-acquired infection data through the CDC's national infection database.	Adds a 1 percent penalty to hospitals in the upper quartile of rates of HACs, resulting in reductions of $1.5 billion over 10 years.	Reject the Senate provision and urge that any collection and public reporting of HACs be done through CMS' Hospital Compare program.
Independent Payment Advisory Board (IPAB)	No provision. (The House leadership opposes a Medicare board.)	Creates a new Independent board that would make binding recommendations on Medicare payment policy, and make non-binding recommendations for changes in private payer payments to providers. Does not apply to hospitals until 2020.	IPAB or a similar board should be excluded from the final bill. If this proposal is adopted, hospitals, including critical access hospitals, must be permanently exempt.
Medical Device Tax	Establishes a 2.5% excise tax on medical devices sold for use in the U.S. that would likely be passed along to hospitals. The tax applies to "first sale" of all devices, is effective in 2013 and would raise $20 billion over 10 years.	Charges an annual fee to medical device companies, beginning with $2 billion per year in FY 2011 and increasing to $3 billion per year in FY 2018 for a total savings of $20 billion over 10 years. Fee would be assessed based on device manufacturers' market share.	Adopt the Senate approach and support the House's effective date of 2013.
ARRA Medicaid FMAP Extension	Extends the temporary FMAP increase established in the American Recovery and Reinvestment Act of 2009 (ARRA) for an additional six months.	No provision.	Include House provision.

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Priorities Affecting Certain Hospitals			
Medicaid Disproportionate Share Hospital (DSH) Payments	The Secretary would study the DSH program and gives the Secretary authority to reallocate dollars based on hospital levels of uncompensated care. Allotment reductions of $10 billion would begin in 2017. There would be no trigger and there would be no state DSH floor.	Reductions of $18.5 billion would be made against state DSH allotments with no reallocation criteria. States would be categorized based on whether they are a low-DSH state and how much of their previous DSH allotments they spent. The allotment methodology would remain the same. Reductions would be made by reducing the yearly allotment. Differs from the House in that it makes no changes in the distribution of DSH funds. A trigger would be set at a 45% reduction in the uninsured within a state and this can begin as soon as 2015. A DSH floor would be set limiting the reductions in state DSH allotments to 50 percent of 2012 allotments.	Urge the acceptance of a combination of Senate and House approaches. Accept House savings number of $10 billion over the period of Jan. 1, 2017 through FY 2019. Prefer Senate approach of not providing HHS with the authority to change the current program.
Medicare Disproportionate Share Hospital (DSH) Payments	In FY 2017 and beyond, the Secretary would make reductions to Medicare DSH payments, taking into account the empirical justification for DSH payments. The Secretary would then increase Medicare DSH payments for a hospital by an amount based on the amount of uncompensated care the hospital provides, excluding bad debt. Savings would equal $10.3 billion. A trigger would be set for when the national rate of uninsurance sees a decrease of more than 8 percentage points for the under-65 population from 2012 to 2014.	In FY 2015 and beyond, DSH payments would be reduced to the "empirically justified" amount – 25% of the current amount. However, in FY 2015 and beyond, a portion of the lost DSH funds would be used to create a new payment to hospitals to reflect their continuing uncompensated care costs. Savings would equal $24.4 billion. The amount of money that would be available for the "new" payment for uncompensated care would be the amount of the reduction in DSH payments described above times one minus the percent reduction in the uninsured for that year.	Urge acceptance of House savings number of $10.3 billion and the timeframe beginning in 2017.

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340B Drug Program	Expands the 340B program to outpatient drugs for critical access hospitals, sole community hospitals, Medicare-dependent hospitals (MDHs), and rural referral centers.	Expands access for existing 340B hospitals to cover inpatient drugs and adds to the inpatient and outpatient programs children's, cancer and critical access hospitals as well as certain sole-community hospitals and rural referral centers.	Strongly support the Senate provision to expand 340B discounts to include inpatient drugs. While AHA supports the Senate provisions expanding eligibility to additional hospitals, we prefer the hospital expansion provisions in the House bill that cover more rural hospitals, including MDHs.
Long-Term Care Hospitals (LTCHs)	No provision.	Extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2008*. Would further delay full implementation of the 25% rule, the short-stay outlier cuts, and the one-time budget-neutrality adjustments planned by CMS. Extends current moratorium on new LTCH beds and facilities, with exceptions.	Support Senate approach.
Accountable Care Organizations (ACOs)	Creates pilot program for ACOs with limited opportunity for hospital leadership.	Allows hospitals, in cooperation with physicians, to provide leadership in voluntary ACOs, which would be responsible for managing the care of certain beneficiaries, and allow the HHS Secretary to share some of the savings from improved care management with providers.	Support the Senate provision that allows hospitals, in cooperation with physicians, to provide leadership in an ACO. Additionally, support the House approach of creating ACO pilots that allow for testing and evaluation instead of the outright adoption of an ACO program.
Physician Self-Referral	Eliminates the exception for physician-owned hospitals but would grandfather those facilities with a Medicare provider agreement in place by Jan. 1, 2009. Such facilities would be required to meet certain disclosure and patient safety requirements and adhere to a set of rules that ensure bona fide ownership and investment.	Same as the House but with grandfathering beginning August 1, 2010.	Strongly support limitations on self-referrals to physician-owned hospitals and urge the use of the House bill's trigger date of January 1, 2009 for grandfathering existing physician-owned facilities.

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Medicare Extenders	Includes two-year extensions of certain Medicare provisions: • Outpatient hold-harmless payments for certain hospitals in rural areas. • Section 508 wage index reclassifications. • Increasing the work geographic index to 1.0. • Grandfathering direct billing for anatomic pathology technical component services. • Add-on payment for ground ambulance. • Outpatient therapy caps. • 5% increase in physician payment for certain psychiatric therapeutic procedures. • Cost-based payment for brachytherapy.	Includes one-year extensions of certain Medicare provisions: • Outpatient hold-harmless payments for certain hospitals in rural areas. • Section 508 wage index reclassifications. • Increasing the work geographic index to 1.0. • Grandfathering direct billing for anatomic pathology technical component services. • Add-on payment for ground ambulance. • Outpatient therapy caps. • 5% increase in physician payment for certain psychiatric therapeutic procedures. • No provision on brachytherapy.	Support House two-year extension for certain existing rural programs. Support Senate language on Sec. 508 reclassification and extend for two years.
Rural Hospital Provisions	No comparable provisions.	Sustains and improves access to care in rural areas through various improvements: • Improves payment for low-volume hospitals. • Ensures that CAHs are paid 101% of costs for all outpatient services regardless of the billing methods elected. • Extends and expands the Rural Community Hospital Demonstration Program. • Extends the MDH program for one year. • Extends the Medicare Rural Hospital Flexibility Program through 2012. • Extends reasonable cost reimbursement for laboratory services in small rural hospitals.	Support the Senate provisions that would help sustain and improve access to care in rural areas.

*Please note that this side-by-side is a summary of key issues. For information on other issues for which AHA is advocating, please refer to the AHA's 27-page letter sent to congressional leaders on January 7, 2010 or our summaries of the House and Senate bills. To view a copy, visit www.aha.org.