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Health Reform for Hospitals and Health Systems

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On March 23, 2010, the president signed into law the Patient Protection and Affordable Care Act, Public Law 111-148 (H.R. 3590) (PPACA). One week later, the president signed into law a set of proposed changes to PPACA, the Health Care and Education Affordability Reconciliation Act (H.R. 4872) (the Reconciliation Act). These two pieces of legislation combined (referred to here as the law) constitute the current efforts to reform healthcare in the United States.

The law will have a profound impact on healthcare in the United States, and almost every provision will have some impact on hospitals and health systems, albeit indirect in many instances. Examples of provisions of the law having a significant, but indirect, impact on hospitals are those aimed at increasing insurance coverage across the uninsured and underinsured, expanding Medicaid programs, and improving healthcare workforce training and development.

The purpose of this article is to identify and briefly discuss those provisions of the law that directly impact hospitals. Many of the provisions solidify previous legislative and regulatory efforts, and involve concepts that are likely familiar to hospital executives. Others may involve initiatives not previously encountered and represent a change from business as usual. The discussion below is divided into five key areas: (1) hospital finance and governance, (2) Medicare payment changes, (3) Medicaid payment changes, (4) care delivery and payment reform, and (5) residency and medical education.

1. Hospital Finance and Governance

Hospitals Required to Publish Charges – Tucked into a section of the law primarily directed toward insurance plans, the law requires each hospital operating within the United States to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups. The effective date of this change is not specified in the law. (PPACA, Sec. 2718, as amended by Sec. 10101)

Charitable Hospitals – The law establishes new requirements for hospitals with Section 501(c)(3) tax-exempt status including completing community health assessments at least every three years, publicizing financial assistance policies, and limiting charges to patients qualifying for financial assistance. For a more thorough discussion of this section of the law, please see <http://www.mcguirewoods.com/news-resources/item.asp?item=4670>. (PPACA, Sec. 9007)

2. Medicare Payment Changes

Medicare Hospital Value-Based Purchasing Program (VBP) – The law establishes a value-based purchasing program for hospitals under the Medicare Inpatient Prospective Payment System (IPPS) to be effective in 2013. This is similar to the VBP currently being evaluated by CMS as required by the Deficit Reduction Act of 2005. Under the VBP, a percentage of the payments to hospitals will be tied to a hospital's performance on a number of quality measures selected by the Secretary of Health and Human Services (secretary), relating to at

least the following conditions or procedures for 2013: acute myocardial infarction, heart failure, pneumonia, surgeries, and healthcare associated infections.

On the up side, where a hospital meets or exceeds the performance standard for the performance period, the base operating Diagnosis Related Group (DRG) payment amount is increased by a percentage for the fiscal year subsequent to the performance period. On the down side, where a hospital falls below the performance standard for the performance period, the base operating DRG payment amount is decreased by a percentage for the fiscal year subsequent to the performance period.

The amount of the payment increase percentage is to be determined by the total amount of payment decreases for all hospitals – the law requires the cost of paying for the increase in payment for those hospitals that exceed the performance standard to be offset by the reduction in payment for those that fall below the performance standard in a cost-neutral manner. The applicable payment decrease percentage is set forth in the law as 1% beginning in 2013, increasing .25% each year through 2017, to a maximum of 2%. (PPACA, Sec. 3001, as amended by Sec. 10335)

Medicare Penalty for High Rates of Hospital-Acquired Conditions – The law takes the Centers for Medicare and Medicaid Services (CMS) current rules on changes to payment for hospital-acquired conditions under the IPPS a step further by subjecting hospitals in the top 25th percentile of rates of hospital-acquired conditions to a 1% reduction in payment the hospital would have otherwise received, starting in 2015. The law also provides that a report on hospital-acquired conditions will be provided to hospitals and will be made available to the public. (PPACA, Sec. 3008)

Hospital Readmissions Reduction Program – The law establishes a reduction in payments beginning in 2012 for hospitals paid under the IPPS, based upon a ratio of the payments for all preventable readmissions to the payments for all discharges. The secretary is to determine what conditions are to be included and what amounts to a readmission, but the law suggests that a readmission could be an admission to the same hospital within 30 days of the date of discharge. The law also provides that a report on readmission rates will be provided to hospitals and made available to the public. (PPACA, Sec. 3025)

Disproportionate Share Hospital (DSH) Payments – The law requires the secretary to change Medicare DSH payments to better reflect a hospital's uncompensated care costs. Beginning in 2014, hospitals will receive 25% of DSH payment the hospital would have otherwise received, plus an additional payment amount that factors in the reduction in DSH payment, the change in the number of uninsured individuals under 65, and the amount of uncompensated care. The law specifically excludes the secretary's estimates on these factors from judicial or administrative review. (PPACA, Sec. 3133, as amended by Sec. 10316 and Reconciliation Act, Sec. 1104)

Medicare Wage Index Improvement – The law extends through 2010, current hospital reclassifications for purposes of the Wage Index. These reclassifications were previously authorized under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), but were set to expire Sept. 30, 2009.

The law also requires the secretary to submit to Congress by Dec. 31, 2011, a plan for reforming the Wage Index, and in so doing, the secretary is required to take into account

the recommendations set forth in the Medicare Payment Advisory Commission June 2007 report titled "Report to Congress: Promoting Greater Efficiency in Medicare." In addition, the law requires that the Wage Index reclassifications continue to be determined based upon the figures contained in the 2010 Inpatient Prospective Payment System Final Rule (74 Fed. Reg. 43754, Aug. 27, 2009), so long as a higher Wage Index reclassification results. (PPACA, Sec. 3137, as amended by Sec. 10317)

Market Basket Updates – The law reduces the market basket update for hospitals beginning in 2012 by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (as projected by the secretary for the 10-year period ending with the applicable period). The law provides that the adjustment could result in a 0% market basket and, if negative, could result in a reduction in payment rates from year to year. In addition to the productivity adjustment, the market basket will be reduced by .25% for both 2010 and 2011, by .1% in 2012 and 2013, by .3% in 2014, by .2% in 2015 and 2016, and by .75% in 2017, 2018, and 2019. (PPACA, Sec. 3401, as amended by Sec. 10318 and Reconciliation Act, Sec. 1105)

3. Medicaid Payment Changes

Medicaid DSH Payments – The law makes reductions in DSH allotment to states for the years 2014 through 2020, and requires the secretary to develop a methodology for implementing the reductions in a manner that makes the greatest cuts in states that direct the lowest amount of DSH allotments and the lowest percentage of uninsured. The law specifies aggregate amounts by which DSH payments must be reduced beginning in 2014 continuing through 2020. (PPACA, Sec. 2551, as amended by Reconciliation Act, Sec. 1203)

Payment Reductions for "Health Care-Acquired Conditions" – This law adopts changes similar to the changes made to the IPPS designed to prevent higher payment in cases where a patient acquires complications or co-morbidities in a hospital stay that are not present on admission. The law will prohibit state Medicaid plans from paying for services related to "health care-acquired conditions" (defined in the law as a medical condition for which an individual was diagnosed that could be identified by a secondary diagnosis code). Implementing regulations by the secretary are to be finalized and effective as of July 1, 2011. (PPACA, Sec. 2702)

4. Care Delivery and Payment Reform

Accountable Care Organizations/Shared Savings (Medicare) – The law requires the secretary to establish, no later than Jan. 1, 2012, a mechanism to share savings (meaning the reduction in the per capita Medicare expenditures below a benchmark determined by the secretary) with Accountable Care Organizations (ACOs). ACOs are defined by the Medicare Payment Advisory Commission as a set of physicians and hospitals that accept joint responsibility for the quality of care and the cost of care received by the ACOs patients.

The payment for shared savings for ACOs that meet the performance standards will be equal to the difference between the estimated per capita Medicare expenditures and the benchmark. The ACOs would continue to receive the same payments they receive under the current fee-for-service system, and shared savings would be an additional payment

amount. The law establishes minimum requirements for eligible ACOs and quality and other reporting requirements for ACOs. (PPACA, Sec. 3022, as amended by Sec. 10307)

Bundled Payments for Hospitals, Physicians, and Post-Acute Care (Medicare) – The law requires the secretary to establish by Jan. 1, 2013, a five-year pilot program for integrating care across hospitals, physicians, and post-acute care providers during an episode of care for certain medical conditions. The episode of care will include three days prior to admission, the length of stay in the hospital, and the period 30 days following discharge from the hospital.

Entities composed of a hospital, a physician group, a skilled nursing facility, and a home health agency can apply to participate in the program. Bundled payments will be paid to the entity participating in the program. The secretary is to establish quality measures for the program that include functional status improvement, reductions in hospital readmissions, and rates of discharge to the community. (PPACA, Sec. 3023, as amended by Sec. 10308)

Extension of Gain Sharing (Medicare) – The law extends through Sept. 30, 2011, a demonstration project established by the Deficit Reduction Act of 2005 designed to evaluate gainsharing arrangements between hospitals and physicians aimed at reducing costs and improving efficiency. The law does not specify whether additional participants will be allowed. (PPACA, Sec. 3027)

Hospital and Physician Bundled Payment (Medicaid) – The law establishes a demonstration project to study bundled payment under Medicaid for hospital and physician services. Similar demonstration projects have been pursued under Medicare. The five-year demonstration project, to begin Jan. 1, 2012, targets hospitals with robust discharge planning programs for placing patients in post-acute care settings. (PPACA, Sec. 2704)

Global Payment System for Safety Net Hospitals – The law establishes a demonstration project to study changes in healthcare quality and outcomes in large safety net hospital systems or networks under a global payment methodology. The project is to be conducted in the years 2010 through 2012. (PPACA, Sec. 2705)

5. **Residency and Medical Education**

Distribution of Additional Residency Positions - The law provides that, for cost reporting periods on or after July 1, 2011, if a hospital's resident level is below the resident limit, the limit will be reduced by 65% of the difference between the resident level and the limit that would otherwise apply. The resident slots reduced can be redirected to hospitals applying for an increase in residents, so long as the level of full-time equivalent primary care residents does not drop below specified levels over a five-year period beginning on the date of the increase. If a hospital fails to meet the requirements, the secretary can reduce the hospital's resident limit and redistribute. (PPACA, Sec. 5503)

Counting of Resident Time in Outpatient Settings and Jointly Operated Residency Training Programs – The law changes the rules for calculating resident time for purpose of indirect medical education (IME) and direct graduate medical education (DGME) payments to allow time outside the hospital. For cost reporting periods beginning July 1, 2010, all time spent by a resident is included in determining full-time equivalency, without regard to the setting, so long as the hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident is in the setting. Where a hospital shares these costs, the

hospital can count a proportion of the time, based upon a written agreement with the party sharing the costs. (PPACA, Sec. 5504)

Counting of Resident Time for Didactic and Scholarly Activities - The law changes the rules for calculating resident time for purposes of indirect medical education (IME) and direct graduate medical education (DGME) payments to allow time spent in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient. (PPACA, Sec. 5505, as amended by Sec. 10501)

Aside from these provisions that directly impact general acute care hospitals, there are a number of provisions directed toward rural hospitals, cancer hospitals, sole community hospitals, critical access hospitals, and other specific provider types.

McGuireWoods' Healthcare Department will continue to monitor the law and those provisions that are of importance to hospitals and health systems and will keep you informed of significant developments. We have also undertaken similar efforts in other segments of the healthcare industry including long term care, ambulatory surgical centers, and physicians and physician practices. If you have any specific questions about how the law will affect your organization, please contact a member of the Healthcare Department.

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