

Healthcare Reform Update

April 1, 2010

Healthcare reform is now law!

- **3/21 - House passed the Senate-passed reform bill**
- **3/21 – House passed budget reconciliation bill that modifies Senate bill**
 - **\$938 B price tag**
- **3/23 – President Obama signed Senate bill into law**
- **3/25 – Senate passed budget reconciliation portion with technical correction, requiring second vote by the House**
- **3/25 – House passed budget reconciliation bill with technical correction**
- **3/30 - President signed final budget reconciliation bill**

Premier alliance preparing for healthcare reform

- **Health Reform Executive Briefings**

- May 17 – Chicago
- May 26 – Dallas
- June 9 – CEO Forum at the Breakthroughs Conference in Washington, DC
- June 24 – Charlotte



- <http://www.premierinc.com/reform/>

- **Federal Affairs Network Meeting**

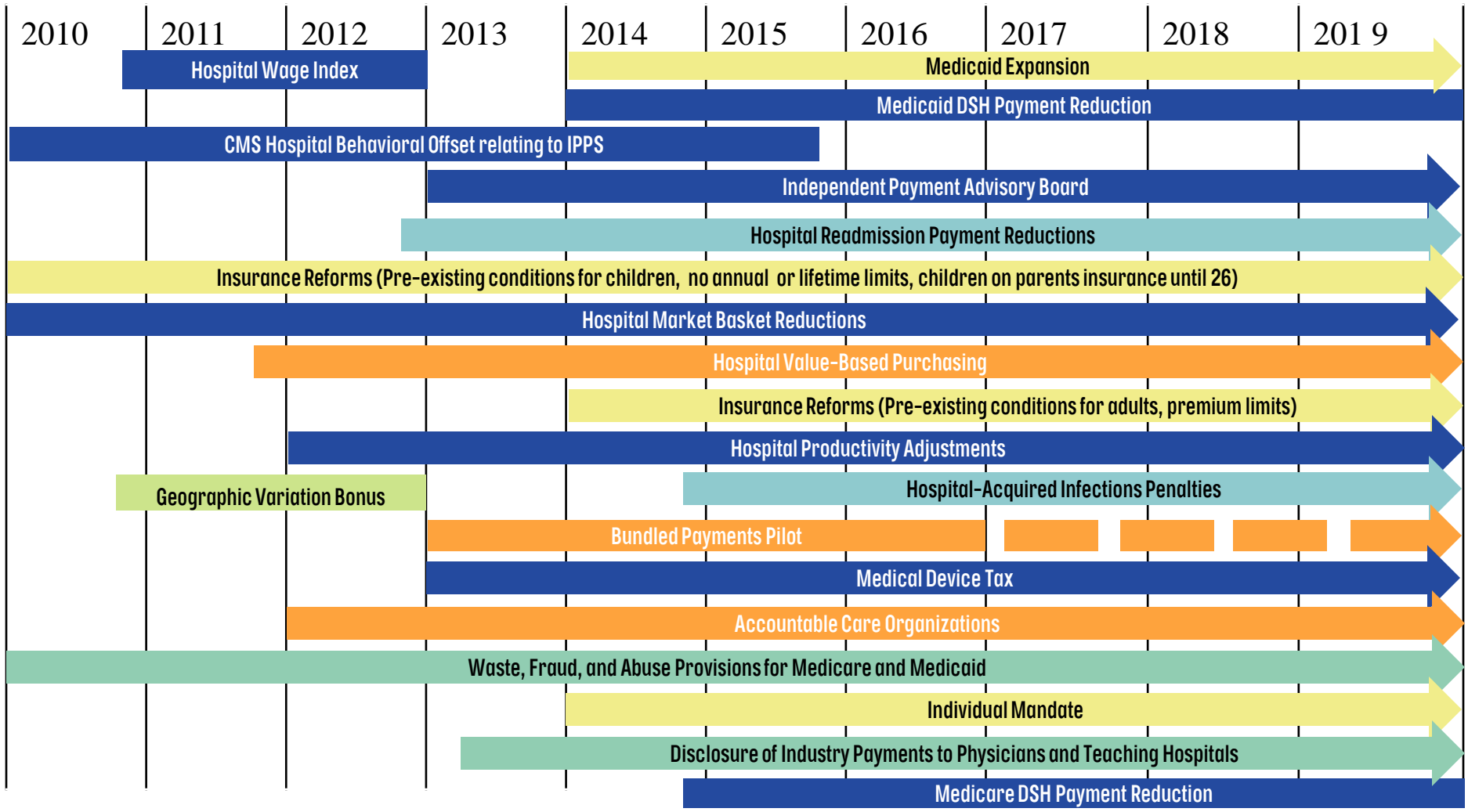
- June 14-15 in Washington, DC

Major components of healthcare reform impacting hospitals

- Expanded coverage
- Payment cuts
- Aligning payment with quality
- Delivery system reforms
- Evidence-based care
- Fraud & abuse
- Other provisions

Health Reform Implementation Timeline

- Key:**
- = Coverage Provisions
 - = Delivery System Provisions
 - = Quality Provisions
 - = Transparency Provisions
 - = Payment Constraint Provisions
 - = Geographic Variation Provision



Coverage

Expanded coverage

Healthcare reform provision

- Medicaid expansion (begins 2014)
 - 133% of FPL
 - 100% federal match for first 3 years, then scales down to 90% by 2020
 - Expands to non-pregnant childless adults (previously uncovered)
 - States maintenance of efforts
 - Medicaid rates to primary care physicians will be the same as Medicare rates, beginning in 2013
- Premium subsidies (through tax or “affordability” credits) for those above new Medicaid income levels but below 400% of FPL
- State-based health insurance “exchanges”
 - All states required to establish exchange by 2014
- Individual & employer (50+ employees) coverage - “pay or play” (beginning 2014)
- Health insurance reforms

Expanded coverage strategic implications

- Reduction in estimated uninsured (32 million)
- Less uncompensated care
- Hospitals treating higher Medicaid population/Greater state Medicaid burden, as 100% federal matching rate is reduced
- How to manage shifts in payer mix
- Strategies for improving patient uptake in Medicaid and health insurance newly offered through state exchanges
- Strategies for improving patient uptake in...
- Analyze shifts in payer mix
 - Changes to revenue cycle focus points
 - Changes in risk with changing population covered
 - Changes in quality outcomes with changing population covered
- Hospitals permitted to make presumptive Medicaid determinations starting January 1, 2014

Payment Cuts

Payment cuts

Healthcare reform provisions

Reductions in market basket updates for inpatient and outpatient services (saves \$156 .6 B over 10 years):

- 0.25% in 2010-2011 (beginning April 1, 2010)
 - 0.1% in 2012-2013
 - 0.3% in 2014
 - 0.2% in 2015-2016
 - 0.75% in 2017-2019



Productivity adjustment for inpat/outpat beginning 2012 (e.g. would have been 1.3% in 2008)



Medicare DSH cuts (saves \$22.1 B over 10 years) beginning in 2015

- 75% reduction in Medicare DSH payments to hospitals
- A significant portion of 75% cut would be distributed back based on each hospital's proportion of national uncompensated care



Medicaid DSH cuts (saves \$14.0 B) beginning 2014

- HHS will develop methodology for reducing federal DSH allotments to states

Payment cuts

Healthcare reform provisions

- Extends Sec. 508 hospital wage index reclassifications through FY 2011
- Independent Payment Advisory Board to propose cost reductions
 - Hospitals exempted until 2020
- Medical device tax (saves \$20 B over 10 years)
 - Imposes 2.3% excise tax on first taxable sale, applied at point of sale beginning 2013
 - Danger of tax being passed on to hospitals
- ❖ CMS behavioral offset to IPPS payments -- 6-8% or more over 3-5 years beginning in FY 2011

Payment constraints

Strategic implications

- Run impact analyses
- Step up patient insurance eligibility efforts
- Achieve greater efficiencies
 - staffing levels/mix,
 - revenue cycle,
 - evidenced-based care delivery,
 - Systems engineering.
- Leverage purchasing negotiation process to:
 - Reduce supply costs, esp. for physician preference items
 - Minimize ability of manufacturers to pass medical device tax on to hospitals
- Engagement in regulatory rulemaking

Aligning Payment with Quality

Medicare value-based purchasing

Healthcare reform provisions

- 1% of DRG tied to performance on quality & outcomes measures (FY 2013)
- Incentive pool scales to 2% of DRGs (FY 2017)
- Budget neutral (unallocated funds kept in the system)
- Quality measures from Hospital Compare measure set
- AMI, heart failure, pneumonia, SCIP, patient satisfaction; efficiency and others
- Reward for attainment (benchmark) and improvement

Value-Based Purchasing – Establish demo for CAHs, and for hospitals excluded from VBP program. (Not later than 2 years after enactment)

Value-Based Purchasing – Establish hospital VBP program under IPPS. Measure hospitals quality performance standards. (2012-10-01)

Value-Based Purchasing – Payments begin to be affected by standards measured in FY2012. (FY2013)

Value-Based Purchasing – Comptroller General submits interim report on program. (FY2015)

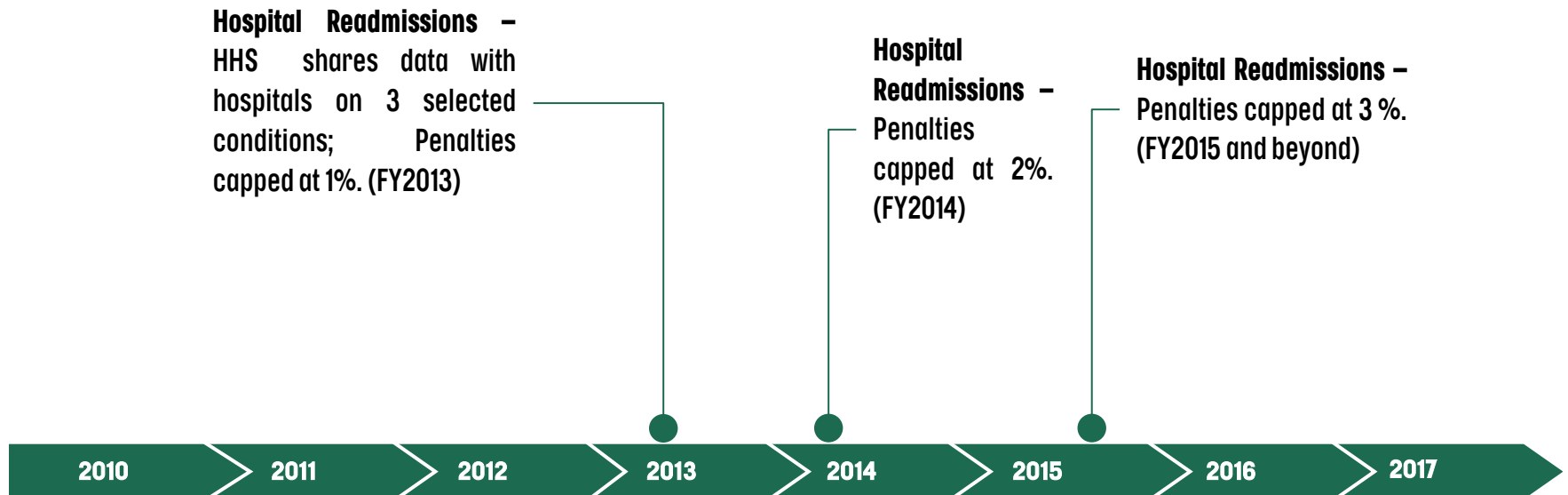
Value-Based Purchasing – Comptroller General submits evaluation. (FY2017)



Readmissions

Healthcare reform provisions

- Up to 3% cut to all DRGs for readmissions over expected
- Up to 1% in FY 2013, 2% in FY 2014, not to exceed 3% in 2015 and beyond
- Initially AMI, CHF, PN
 - Expands to COPD, CABG, PTCA, and other vascular in 2015
- 10 year savings: \$7.1 B



Hospital-acquired conditions

Healthcare reform provision

- Top quartile hospitals penalized 1% of DRGs beginning FY 2015 (\$1.5 billion over 10 years)
- Public reporting of HAIs
- Infection included in VBP (CL-BSI, Cdiff, MRSA, CA-UTI, VAP, SSI)

Hospital Acquired Conditions –
HHS submits report on expanding HAC policy to other providers. (FY2012-01-01)

Hospital Acquired Conditions –
HHS calculates national and hospital specific data on rates of HACs and shares with hospitals; publically reported on Hospital Compare Web site. (FY2013)

Hospital Acquired Conditions –
Hospitals in top quartile of national HAC rates receive 1% reduction in Medicare payments. (2015-10-01)



Efficiency /geographic variation

Healthcare reform provision

- \$400 million for bonuses for hospitals in counties in bottom quartile for lowest adjusted total Medicare per beneficiary spending (\$200 M each for FY 2011 and FY 2012)
- White House commitment to commission two IOM studies:
 1. Evaluate hospital and physician geographic payment adjustments
 - Implement “allowable” changes to physician payment and hospital wage index rates by FY 2012
 2. Geographic variation in volume and intensity of services and availability of services
 - Incorporate quality and value metrics into Medicare reimbursement system
 - New Independent Payment Advisory Commission recommendations by 2014

Aligning Payment with Quality

Strategic implications

- Winners and losers
- Hospital-specific impact analysis
- Participation in HQID an advantage
- Adherence to evidenced-based care must be major focal point of hospitals
- Track measures and benchmark against others
- Coordination with physicians and post-acute care key
- Focus on care management and related technologies
- Engage in regulatory rulemaking

Delivery System Reform

Accountable care organizations

Healthcare reform provision

- Hospitals and Physicians (at minimum) working together to manage total patient cost of care and outcomes
- Providers meeting certain criteria able to share in savings
 - Spending below their benchmark eligible for shared savings
 - Program begins no later than 2012
 - Providers enter into 3-year contracts with government
- Broad range of providers eligible to initiate ACOs
- Allows payment models beyond fee-for-service
- CMS may give preference to those ACOs already contracting with the private market
- Saves \$4.9 B over 10 years

Accountable Care Organizations
- Providers meeting criteria can be recognized as ACOs and can qualify for incentives bonus. (no later than 2012-01-01)



ACO participation requirements

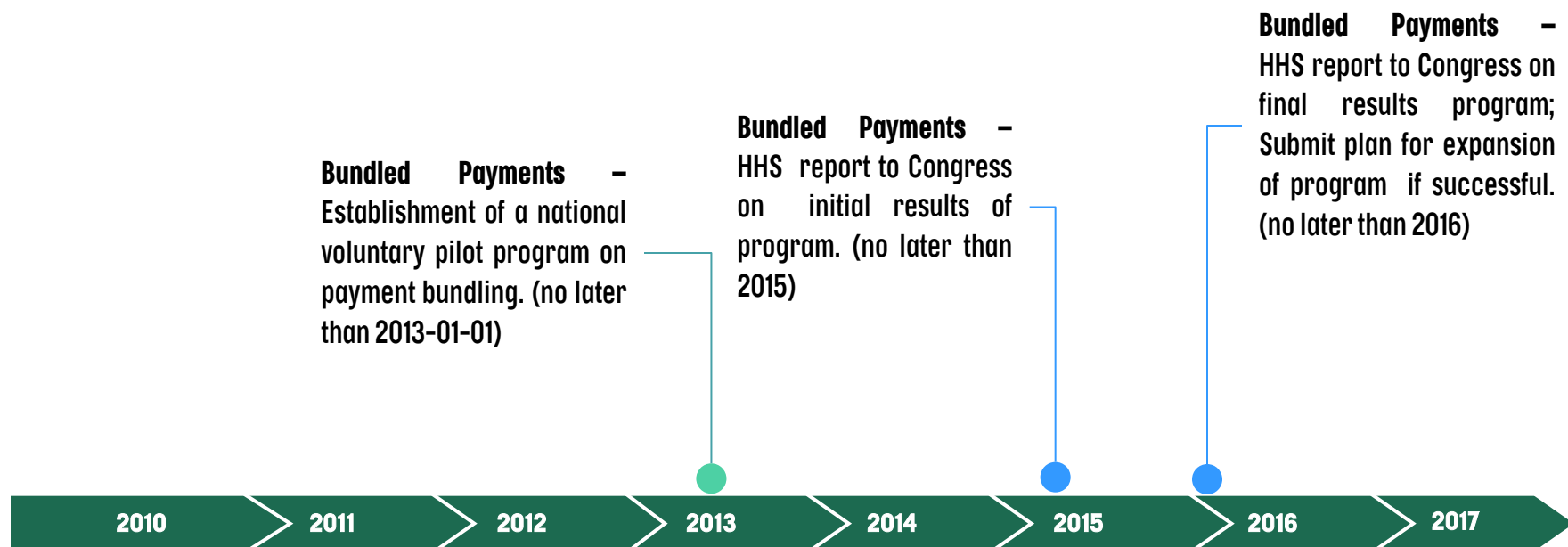
Healthcare reform provision

- Must accept accountability for the total cost, quality and care of beneficiaries assigned to the ACO.
- Three-year participation commitment
- A formal legal structure that would receive and distribute shared savings to participating providers.
- A sufficient number of primary care physicians that can care for a minimum of 5,000 Medicare beneficiaries assigned to the ACO
- Defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care using telehealth, remote patient monitoring, etc.
- Meet patient-centeredness criteria such as the use of patient and caregiver assessments or individualized care plans
- No participation in other government –based shared savings demonstration projects

Bundled payments

Healthcare reform provision

- National voluntary pilot bundled payment in acute inpatient, physician services, outpatient, post-acute (no later than 2013)
- Episode of care: 3 days prior to admission and 30 days following patient discharge for 10 conditions
- Potential to expand pilot program, but remains voluntary



Center for Medicare and Medicaid Innovation

Healthcare reform provisions

- Establishes Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care (no later than 1/1/2011)
 - Priority given to models that address defined population for which there are deficits in care leading to poor clinical outcomes of potentially avoidable expenditures
 - Specifies 20 potential models for testing
 - HHS may expand duration and scope of models that are found successful through rule-making process, but participation is voluntary
 - Waiver authority extends only to testing phase
- Vehicle for various reforms contained in legislation
- Appropriates \$5 million in FY 2010 and \$10 billion for FY 2011 through FY 2019

Delivery System Reform

Strategic implications

- Hospitals must change way care is delivered
 - Move to bigger episodes of care coordinated across the continuum and/or managing population outcomes
- Hospitals will need to build:
 - Network of physicians
 - Potentially vertically integrate
 - IT and data management infrastructure
 - Reimbursement infrastructure
 - Create payer partnerships
 - Align internal incentive arrangements
 - Measure & communicate results
 - ACO management capability
 - Define & drive improvement in population measures of success
 - Legal & governance structure
 - Central medical management capability
 - Build patient centric, value oriented culture of continuous improvement

Waste, Fraud and Abuse

Waste, fraud & abuse

Healthcare reform provisions

- Expansion of CMS program protection authority (2011)
- Penalties for false statement on enrollment, claims applications
- Expansion of RAC program into Medicaid
- Reduction of maximum period for submission of Medicare claims
- Establish Medicare & Medicaid sanctions database
- Limitations on Medicare pre-payment claims reviews

Transparency

Increased pressure for full transparency

Healthcare reform provisions

- Disclosure of industry payments to physicians and teaching hospitals (beginning 2013)
- Prohibition on Medicare participation by physician-owned hospitals (grandfathered to December 31, 2010)
 - Affects qualifications for rural exception

Increased pressure for full transparency

Strategic implications

- Exposes the financial linkage between physician preference products and physicians, enabling greater standardization by Premier members
- Enables Premier alliance members to understand potential conflicts of interest among practicing physicians

Evidence-based care

Focus on evidenced-based care

Healthcare reform provisions

- Creation of Patient-Centered Outcomes Research Institute (comparative effectiveness research)
- National priorities for quality measurement development
- Funding for measurement development entity
- Availability of Medicare data for performance measurement

Evidenced-based care

Strategic implications

- Comparative effectiveness research will arm hospitals with information as to the safety and effectiveness of treatment ***compared*** to other therapies
 - Help in negotiations with physicians over physician preference items
- Increased focus on quality measurement will increase data for continuous quality improvement

Other provisions

Non-profit hospitals

Healthcare reform provisions

- Imposes new standards for the tax exemption of nonprofit hospitals
 - Requires that a hospital complete a community needs assessment once every three years
 - Requires hospitals to adopt and publicize a financial assistance policy
 - Prohibits billing patients who qualify for financial assistance the top rates
 - Prohibits a hospital from taking extraordinary collection actions if the hospital has not made reasonable efforts to notify patients of its financial assistance policy
 - Imposes an excise tax of \$50,000 on a hospital organization that fails to meet the requirements for any taxable year

Other hospital provisions

Healthcare reform provisions

- Hospital wage index (costs \$2 B)
 - Wage index floor of 1.00 for hospitals located in “frontier” states (Wyoming, Montana, North Dakota, South Dakota and Utah)
- Extension of Outpatient Hold Harmless Provision
- Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas
- Extension of the Rural Community Hospital Demonstration Program
- Extension of the Medicare-dependent hospital (MDH) program
- HHS Study on urban Medicare-dependent hospitals
- Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals
- Technical correction related to critical access hospital services
- Extension of and revisions to Medicare Rural Hospital Flexibility Program

340B Drug Pricing Program

Healthcare reform provisions

- Expansion of 340B drug discount program
 - Expands program to include certain children's hospitals, cancer hospitals CAHs, and rural referral centers