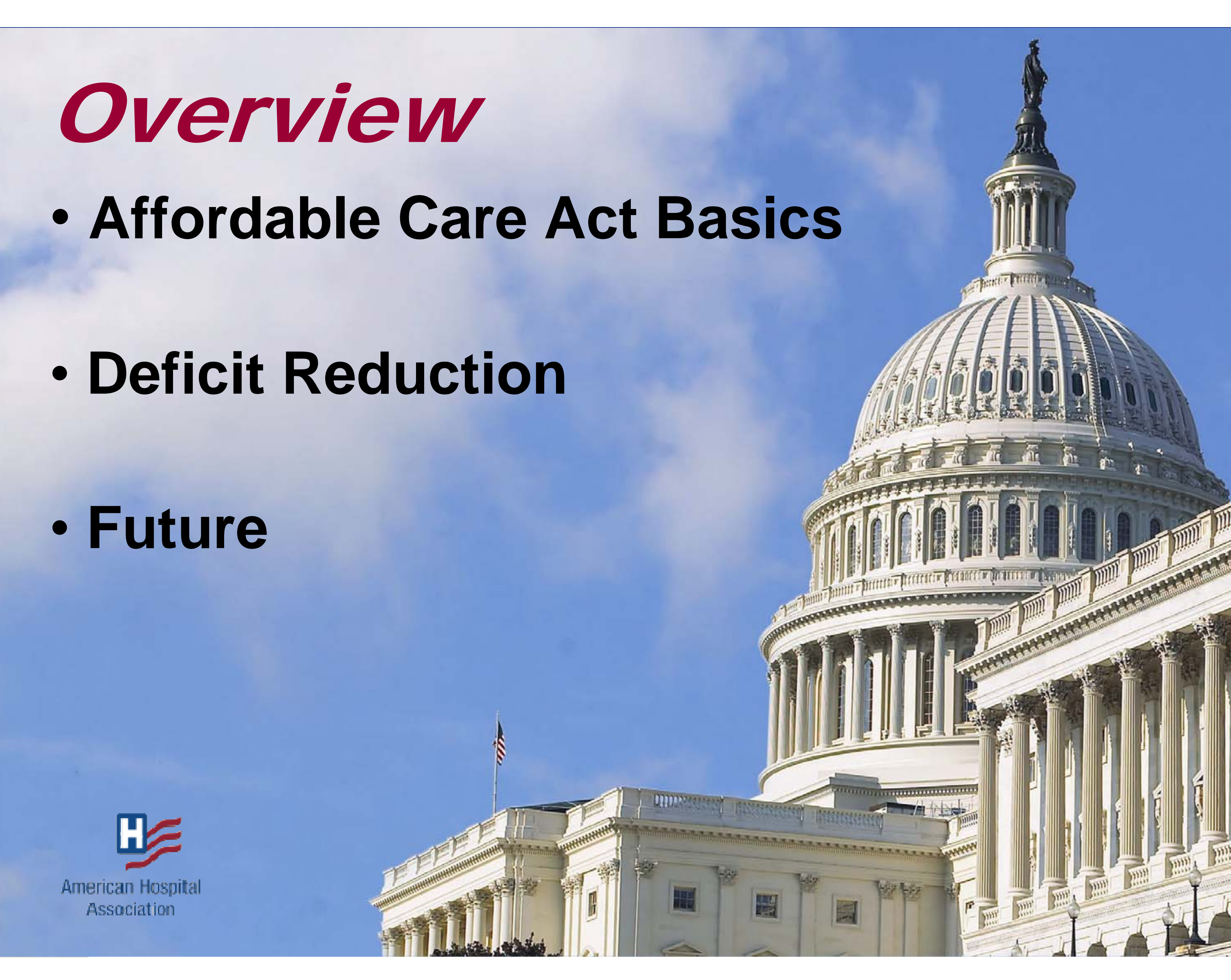
Hospitals and the ACA

NAHEFFA

Fall 2011


Overview
• Affordable Care Act Basics
• Deficit Reduction
• Future
American Hospital
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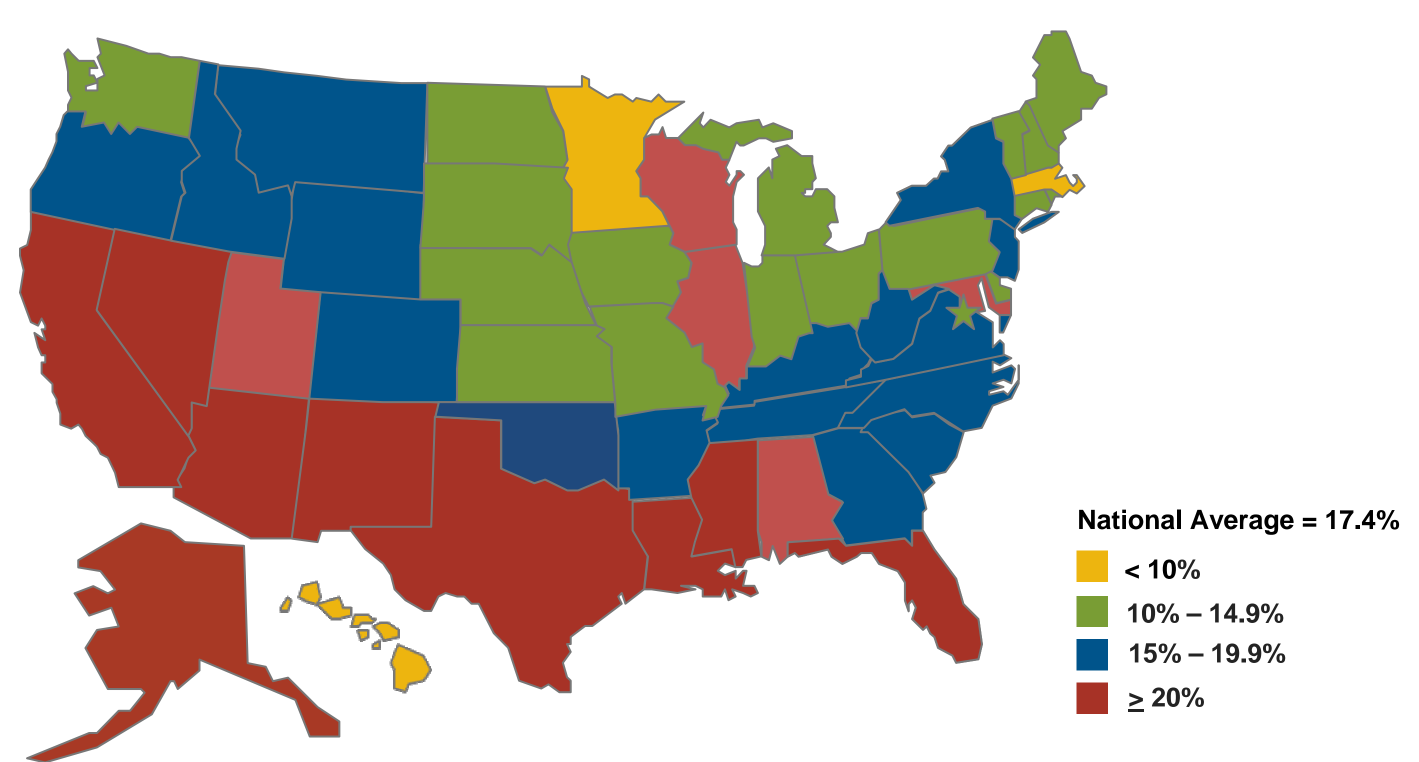
Southwestern states have higher rates of uninsured individuals.

Chart 12: Uninsured Rates for Nonelderly by State, 2007 – 2008



Source: Kaiser State Health Facts. 2009. *Uninsured Rates for the Nonelderly by Age, 2007 – 2008.*
Link: http://www.statehealthfacts.org/comparetable.jsp?ind=139&cat=3.

Agreement

	Current Policy	Agreement	Finance Proposal
Coverage of all uninsured	81 percent	94 percent	91 percent
Coverage of "legals" only	83 percent	97 percent	94 percent
Uncovered	51 million	19 million	25 million
Hospital Reductions	→	$155 billion	$153.3 billion
Reduce Uncomp care	→	$171 billion	$135-$146 billion

- **Hospitals Exempt from IPAB**

$155 Billion Hospital Reduction

MEDICARE AND MEDICAID PAYMENTS

2010-2019

- Reduce Annual Payment Updates
- Penalties for Higher Than Expected Readmissions
- Failure to Report Quality Information
- Hospital Acquired Conditions
- Ban Physician-Owned Hospitals
- Disproportionate Share Payments

Key elements of the bill

- Coverage expansions
- Insurance reforms
- Delivery system reforms
- Payment changes
- Quality
- Workforce
- Wellness and prevention

Coverage Model

Employer Provided Health Coverage	State Health Exchanges (Private Plans)	Public Programs
		• Medicare • Medicaid • Military/ Tri-care • VA • FEHBP

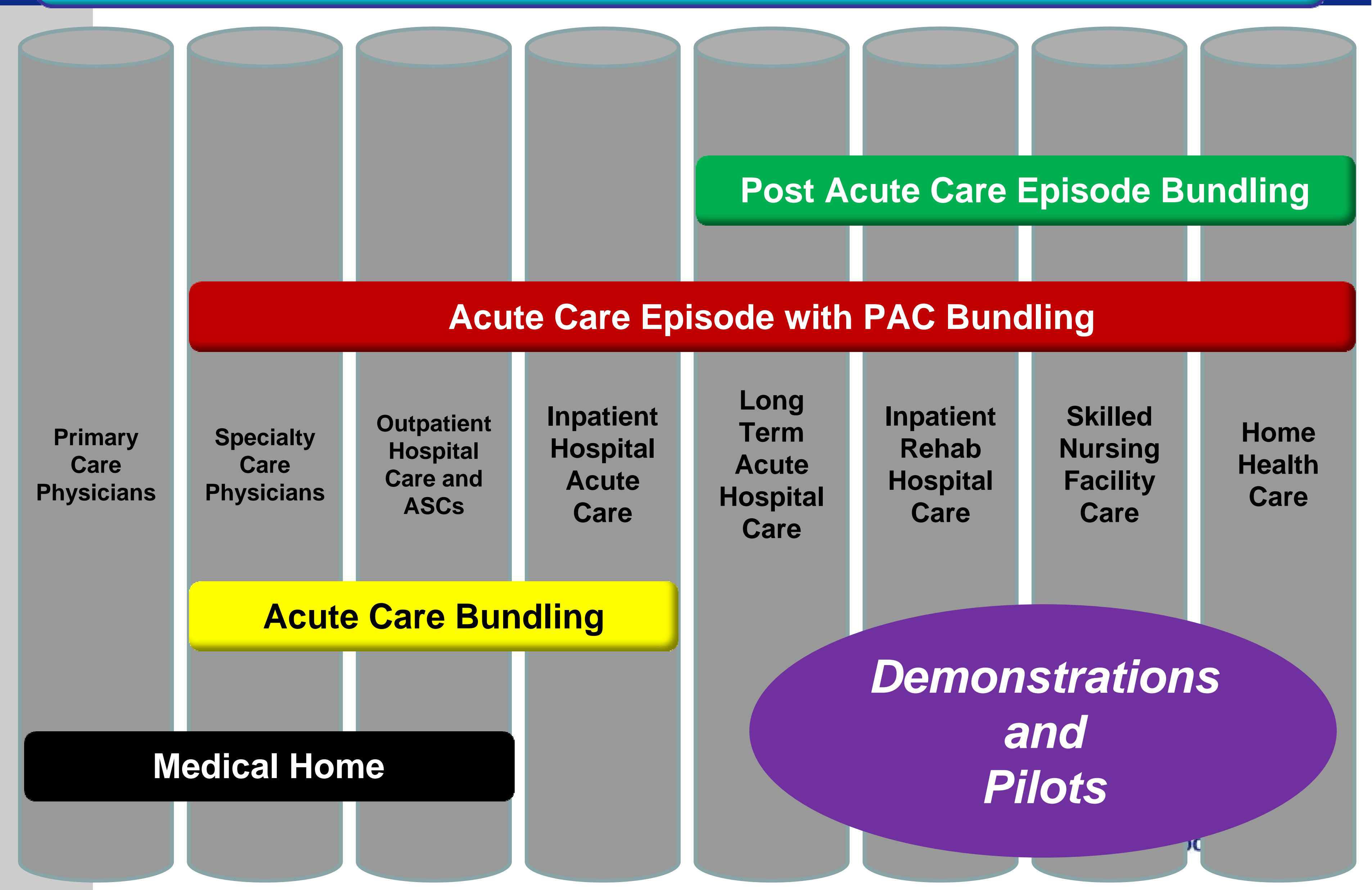
ACA strategic directions

- Coverage
- Insurance reforms
- Delivery system reforms
- Payment reforms
- Transparency

- Movement away from fee-for-service…toward 'integration"
- Emphasis on value vs. volume
- Emphasis on quality vs. quantity

Delivery System Reforms

- Accountable care organizations
- Bundling
- Medical homes
- Gain-sharing
- CMS Center for Innovation
- Value-based purchasing
- Geographic variation
- Demonstration program to expand emergency inpatient psychiatric beds



Accountable Care Organizations
Post Acute Care Episode Bundling
Acute Care Episode with PAC Bundling
Primary Care Physicians
Specialty Care Physicians
Outpatient Hospital Care and ASCs
Inpatient Hospital Acute Care
Long Term Acute Hospital Care
Inpatient Rehab Hospital Care
Skilled Nursing Facility Care
Home Health Care
Acute Care Bundling
Medical Home
Demonstrations and Pilots

ACO Investment

Estimate of ACO Investment	Average*
CMS (based on a range of an estimate of 75-150 ACOs)	$1,800,000
AHA** (200-bed, single hospital system)	$11,600,000
AHA ** (1200-beds, 5-hospital system)	$26,100,000

***Average amounts represent estimated costs for the start-up and ongoing costs for year 1.**

****Includes start-up and ongoing costs for a typical year. Some costs may have already been incurred or be allocable to other budgets.**

American Hospital Association

Some Industry Reaction

WALL STREET JOURNAL

JUNE 19, 2011

The Accountable Care Fiasco

Even the models for health reform hate the new HHS rule.

"The American Medical Group Association…'overly prescriptive, operationally burdensome, and the incentives are too difficult to achieve.' In a survey of its members, 93% said they won't enroll."

Value-Based Purchasing

- Pay for actual performance on quality
- Payment incentives begin FY 2013
- Applies only to PPS hospitals – critical access hospitals are excluded
- Budget neutral

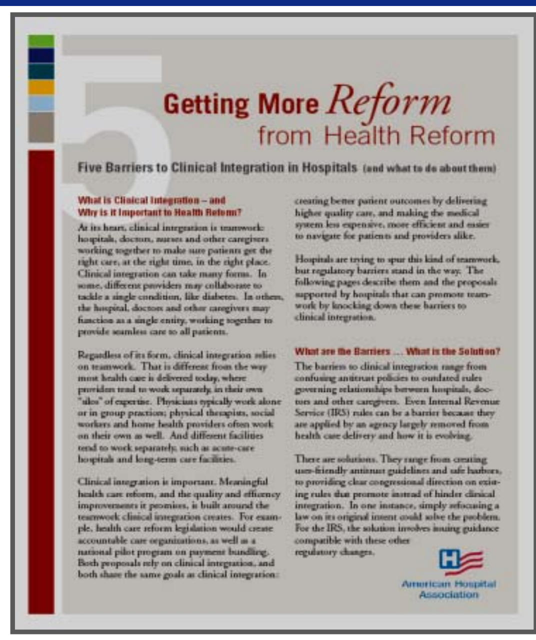
Positioning for reform

- **Achieve solid hospital-physician (clinical) alignment**
- **Measure, report and deliver superior outcomes**
- **Attain a favorable cost position**
- **Strategic alliances**

Removing Barriers to Clinical Integration

- **Collaboration among different providers**

- **Five legal hurdles:**
  - **Antitrust**
  - **Self referral (Stark)**
  - **Civil monetary penalties**
  - **Anti-kickback**
  - **Internal Revenue Code**



Getting More *Reform* from Health Reform

Five Barriers to Clinical Integration in Hospitals (and what to do about them)

What is Clinical Integration – and Why is it Important to Health Reform?

At its heart, clinical integration is teamwork: hospitals, doctors, nurses and other caregivers working together to make sure patients get the right care, at the right time, in the right place. Clinical integration can take many forms. In some, different providers may collaborate to tackle a single condition, like diabetes. In others, the hospital, doctors and other caregivers may function as a single entity, working together to provide seamless care to all patients.

Regardless of its form, clinical integration relies on teamwork. That is different from the way most health care is delivered today, where providers tend to work separately, in their own "silos" of expertise. Physicians typically work alone or in group practices; physical therapists, social workers and home health providers often work on their own as well. And different facilities tend to work separately, such as acute-care hospitals and long-term care facilities.

Clinical integration is important. Meaningful health care reform, and the quality and efficiency improvements it promises, is built around the teamwork clinical integration creates. For example, health care reform legislation would create accountable care organizations, as well as a national pilot program on payment bundling. Both proposals rely on clinical integration, and both share the same goals as clinical integration: creating better patient outcomes by delivering higher quality care, and making the medical system less expensive, more efficient and easier to navigate for patients and providers alike.

Hospitals are trying to spur this kind of teamwork, but regulatory barriers stand in the way. The following pages describe them and the proposals supported by hospitals that can promote teamwork by knocking down these barriers to clinical integration.

What are the Barriers … What is the Solution?

The barriers to clinical integration range from confusing antitrust policies to outdated rules governing relationships between hospitals, doctors and other caregivers. Even Internal Revenue Service (IRS) rules can be a barrier because they are applied by an agency largely removed from health care delivery and how it is evolving.

There are solutions. They range from creating user-friendly antitrust guidelines and safe harbors, to providing clear congressional direction on existing rules that promote instead of hinder clinical integration. In one instance, simply refocusing a law on its original intent could solve the problem. For the IRS, the solution involves issuing guidance compatible with these other regulatory changes.

American Hospital Association

AMERICAN HOSPITAL ASSOCIATION
FEBRUARY 2010

TRENDWATCH

Clinical Integration – The Key to Real Reform

Regardless of what legislation ultimately passes Congress, many policymakers recognize that systemic changes are needed in how health care is delivered in the United States. Anything less than systemic change may alter the health care system around the edges, but will not achieve the meaningful reform that expands coverage, improves quality and care coordination, rewards effective and efficient care, promotes innovation, and helps control cost. And as the AHA's *Health for Life: Better Health, Better Health Care* initiative has described,[1] achieving greater clinical integration in care delivery is essential to the system change needed to achieve these goals.

Some hospitals already are using a broad range of approaches to integrating more closely with physicians and other health care providers. Clinical integration spans the spectrum from initiatives aimed at achieving greater coordination around a single clinical condition or procedure to fully-integrated hospital systems with closed staffs consisting entirely of employed physicians.

Hospitals seeking greater clinical integration first need to overcome the legal hurdles presented by the antitrust, Stark, Civil Monetary Penalty and anti-kickback laws and the Internal Revenue Code. [See page 11 for a chart of barriers to clinical integration.] The case studies discussed here demonstrate the range of clinically-integrated hospital initiatives in existence today and illustrate how arduous and challenging the legal barriers can be. While some of these barriers to clinical integration are surmountable, they can force hospitals and physicians to spend substantial time and expense in implementing solutions.

Clinical integration can improve the quality and efficiency of our health care system; however, current legal barriers frustrate reform efforts. The nation needs laws and regulations that encourage or at least do not impede our progress in improving care and care delivery for patients.

The Growing Importance of Clinical Integration

The U.S. health care delivery system is fragmented in several significant ways. First, most office-based physicians continue to practice in solo or small groups.[2] Moreover, to the extent that physicians are moving to larger practices, it is generally to form single specialty practices, and not the multi-specialty groups that are best able to support care coordination.[3] A study of Medicare claims from 2000–2002 found that

Medicare patients see a multitude of physicians.

Chart 1: Average Number of Physicians Medicare Beneficiaries Visit Annually

Source: Pham, H., Schrag, D., et al. (2007). Care Patterns in Medicare and Their Implications for Pay for Performance. *The New England Journal of Medicine*, 356: 1130-1139.

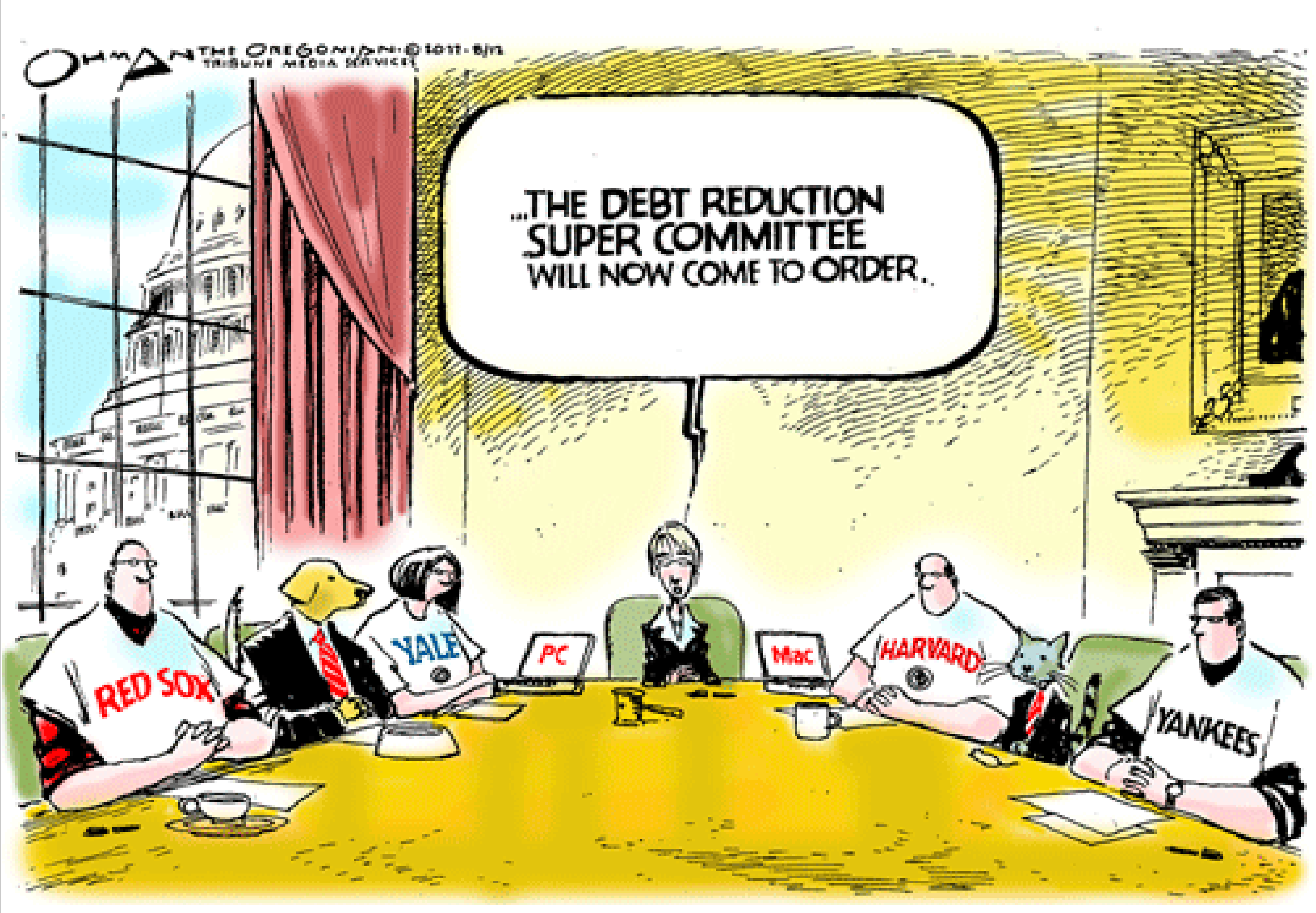
American Hospital Association

Integrated Systems

2011 SDI Top 100 IHNs

Rank	Final Score	IHN Name	City
1	93.17	Sentara Healthcare	Norfolk
2	91.68	ProMedica Health System	Toledo
3	91.05	St John's Health System	Springfield
4	91.03	Intermountain Healthcare	Salt Lake City
5	90.49	Providence Health & Services	Portland
6	89.91	St John's Mercy Health Care	Saint Louis
7	89.55	Banner Health	Phoenix
8	89.36	Multicare	Tacoma
9	89.11	WellStar Health System	Marietta
10	89.07	Advocate Health Care	Oak Brook
11	88.45	Baptist Memorial Health Care Corp	Memphis
12	88.38	Geisinger Health System	Danville
13	87.57	Sharp HealthCare	San Diego
14	87.09	Novant Health	Winston-Salem
15	86.96	Franciscan Health System	Tacoma

The Super Committee



Budget Control Act

Stage II

- **Special bipartisan congressional committee to make additional $1.5 trillion in deficit reduction recommendations by Thanksgiving**
  - Guaranteed up-or-down vote (and no filibuster) on recommendations if majority of panel support recommendations by Christmas
  - Enforcement process…debt limit extended by another $1.5 trillion thru 2012 **IF**:
    - Recommendations of special committee adopted with resolution of disapproval; ***OR***
    - Automatic across-the-board cuts…sequester of $1.2 trillion

Budget Control Act

Potential Sequester Impact: $1.2 trillion

• No revenues	
• Defense	$ 492 billion
• Total non-defense	$ 492 billion
• Medicare	$ 123 billion
– No cuts in benefits	
– 2 percent limit on provider cuts	= $43 billion
• Medicaid exempt	
• Net interest savings	$ 216 billion
TOTAL	$ 1.2 Trillion

Options

- **Medicaid ($100 billion)**
  - Provider taxes/assessments
  - Blending rates/FMAP

- **Medicare**
  - IME ($15 billion)
  - Bad debt ($15-30 billion)
  - IPPS retrospective coding offsets ($5 billion)
  - Rural adjustment cuts ($14-16+ billion)
  - Post acute care services ($50 billion)
  - Expansion of IPAB

President's Budget (3.0)

Overview

- **$3 trillion in savings beyond $917 billion in Budget Control Act**

- **Components**
  - Revenues/tax reform ($1.5 trillion)
  - Military operations ($1.0 trillion)
  - Mandatory programs ($580 billion)
    - Medicare ($248 billion)
    - Medicaid ($72 billion)

President's Budget (3.0)

Key Medicare Proposals

- **Hospitals**
  - Post acute care (total): $42 billion
  - Bad debt: $20 billion
  - IME: $9 billion
  - Rural providers (total): $6 billion
  - Fraud and abuse (total): $5 billion

- **Other stakeholders**
  - Rx reimbursement ($135 billion)
  - Increase Part B and D premiums related to income: $20 billion
  - Medigap ($2.5 billion)
  - Increase Part B deductible ($1 billion)
  - Home health copayments ($400 million)

President’s Budget (3.0)

Key Medicaid Proposals

- Provider assessments/taxes$26.3 billion
- Blending/FMAP: $14.9 billion
- Updating income definition: $14.6 billion
- Extending current DSH policy: $4.1 billion
- Durable medical equipment: $3 billion
- Fraud and abuse: $1.4 billion

Bottom lines

Challenges…Vulnerabilities

- **Rest of 2011**
  - Super committee…sequestration
  - End of year extensions/MD payment fix

- **Next year…2012**

  - If sequester kicks in…deficit reduction package alternative before January 2013
  - Expiration of Bush-Obama tax cuts
- **2013**
  - “Boehner rule”…for future debt limit extensions

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