



## ISSUE BRIEF # 4

### KEY IMPACTS OF THE AFFORDABLE CARE ACT, OTHER RECENT FEDERAL POLICIES & STATE FISCAL CONDITIONS ON HOSPITALS

#### BACKGROUND

As the federal government and states move forward with implementation of the Affordable Care Act (ACA)<sup>1</sup>, community health centers are pursuing new partnerships to achieve their shared goals of increasing access to care, enhancing quality of care through patients centered medical homes and contributing to the overall transformation of our nation's health care system. Evolving models of partnership and business relationships between health centers and hospitals are central to this effort.

To assist primary care associations and health centers in planning for and participating in discussions with hospitals, this brief provides a basic overview of the major realities and opportunities that hospitals face. The realities stem from a variety of sources, chief among them ACA implementation and state fiscal conditions. All hospitals that currently receive Medicare, Medicaid or other public funds confront these realities now and will continue to face them in the days, months and years ahead. For those hospitals that choose to become "early adopters" of new governance and service delivery models, ACA and state innovation efforts make available many opportunities.

#### REALITIES: REVENUES AND RATE PRESSURES

Hospitals face downward pressure on their traditional revenue streams and rates from a variety of sources. While some of these pressures may be viewed as "normal" business patterns and can be managed by internal management and quality efforts, others will be best managed by a combination of internal strategies and new partnerships with health care entities outside of the hospital walls including community health centers.

#### Medicare

The ACA included several provisions that affect Medicare hospital reimbursement.

Beginning in October 2012, the ACA provides that hospital payments are reduced up to 1% in 2013, 2% in 2014 and 3% in 2015 and beyond based on their **rate of "excess" or preventable hospital readmissions**.<sup>2</sup> A preventable hospital readmission is defined as admission to the same or other applicable hospital within a period of time specified by the Secretary – suggested as 30 days. Critical access hospitals are exempted from this provision. Individual readmission rates will be published on the Hospital Compare web site<sup>3</sup> and the Secretary is required to establish a quality improvement program to assist hospitals in improving their readmission rates.

A **value-based purchasing program** required under the ACA will mean a portion of hospital payments will be directly tied to their performance on a set of quality measures specified by the Secretary beginning in FY2013 (October 1, 2012).<sup>4</sup> At a minimum, quality measures must be utilized for the following conditions: acute myocardial infarction, heart failure, pneumonia, surgeries and healthcare associated infections. On January 13, 2011, HHS issued proposed rules<sup>5</sup> to implement the VBP Program.

Beginning in 2014, **Medicare disproportionate share hospital (DSH) payments are scheduled to be reduced** by 75% of what would otherwise have been paid plus an "add-on" based on factors related to the level of DSH reduction, number of uninsured under age 65 and level of uncompensated care.<sup>6</sup>

Hospitals face reductions of 1% based on their **rates of hospital-acquired conditions** beginning in 2015. The reduction will apply to hospitals in the top 25<sup>th</sup> percentile of rates of hospital-acquired conditions. This information will also be available to the public, after the hospitals have had an opportunity to review and submit corrections.<sup>7</sup>

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### Medicaid

The ACA Medicaid provisions that will affect hospital revenue and rates are as follows:

Effective July 1, 2011, Federal Medicaid **payments to states are prohibited for services related to health care acquired conditions, which must be defined consistent with Medicare definition of hospital acquired conditions.**<sup>8</sup>

The law includes a requirement that HHS **reduce Medicaid Disproportionate Share Hospital (DSH) payments** beginning in 2014; annual reductions range from \$500 million in FFY 2014 to a high of \$5.6 billion in FFY 2019. Reductions will be allocated across states based on a specified “DSH Health Reform Methodology” with the largest reductions targeted on states with the lowest uninsured rates and those states which have not targeted their DSH payments to hospitals with high Medicaid volume and high levels of uncompensated care.<sup>9</sup>

Additional rate pressures are emanating from **state executive and legislative budget balancing decisions in the context of severe state revenue declines.** States traditionally have three levers they can use to manage their Medicaid budgets –

- Eligibility – who they serve;
- Benefits – what they provide; and
- Rates – what they pay providers.

Maintenance of effort (MOE) requirements in the American Reinvestment and Recovery Act (ARRA)<sup>10</sup> and ACA<sup>11</sup> restrict states making modifications to their eligibility and benefit levels. While reducing or eliminating optional benefits is allowed, the savings are not sufficient to manage the shortfalls states face leaving rates the primary “tool” to balance budgets.

**Hospitals along with all other Medicaid providers face rate reductions.** These reductions are often contentious and have resulted in legal challenges in several states. The U. S. Supreme Court has agreed to hear cases from the State of California regarding what discretion states do or do not have in making provider rate reductions. On May 6, 2011, CMS released draft proposed rules giving direction to states on demonstrating and monitoring “meaningful access” requirements when setting or modifying provider payments.<sup>12</sup>

One strategy that providers, including hospitals, have developed with state executives and legislatures to

partially or fully mitigate these rate reductions is imposing “**provider taxes**” or “**assessments**” to generate additional federal Medicaid funding.

In FY 2011, 46 states and the District of Columbia have adopted this strategy. Hospital assessments are in place in 29 states. Provider taxes and assessments face on-going scrutiny and federal law has imposed limitations on their use.<sup>13</sup>

### REALITIES: TRANSPARENCY PROVISIONS

For hospitals operating as a 501(c)(3) “**charitable hospital organization**”, the ACA adds some additional requirements to maintain that status. Among those requirements are:

- Conducting a “**community health needs assessment**” at least every 3 years. This assessment must “take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health”. The assessment must also be publicly available and the facility must adopt an “implementation strategy to meet the community needs identified” and provide information on how it is addressing the needs identified as well as needs not being addressed and the reasons why they are not;
- Having a written “**financial assistance policy**” meeting specific requirements and widely publicizing the policy;
- A written policy requiring the facility to provide **emergency medical care** to individuals regardless of their qualification under the financial assistance policy;
- Facility must “**limit amounts charged** for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy ...to not more than the amounts generally billed to individuals who have insurance covering such care: and “prohibit the use of gross charges”.<sup>14</sup>

While the effective date is not specified, the ACA amended the Public Health Service Act<sup>15</sup>, Sec. 2718 to require all hospitals to “**establish (and update) and make public** (in accordance with guidelines developed by the Secretary) a list of the **hospital’s standard charges for items and services** provided by the hospital”.

### OPPORTUNITIES

Specific ACA provisions will encourage innovation and transformation of how hospitals both lead and participate in new models of health care delivery. Value-Based Purchasing, as discussed earlier, will impose a Pay for Performance component on all Medicare hospitals in connection with treatment of acute myocardial infarction, heart failure, pneumonia, surgical care and health care associated infections. Both Bundling and Accountable Care Organization ACA provisions establish large-scale voluntary demonstrations that hospitals may elect to qualify for. HHS will test and evaluate both methodologies for further potential development and implementation.



Additionally ARRA Electronic Health Record Incentives offer significant opportunity for hospitals to establish or further develop their HIT connectivity.

## **Pay for Performance (P4P)/Value-Based Purchasing**

ACA requires a Medicare Value-Based Purchasing (VBP) program under which a portion of a hospital's payment from Medicare is P4P. While the VBP does not go in to effect until October 1, 2012 (FY2013), the initial performance period begins July 1, 2011; hence hospitals are likely preparing now.

The Inpatient Quality Reporting (IQR) is not new to hospitals. The Medicare Prescription Drug Improvement and Modernization Act<sup>16</sup> mandated hospitals to start collecting a subset of this data in 2003. Under this program payment was tied to the reporting of quality data, but not the outcomes revealed. The ACA now requires that the hospital's payment be tied not only to reporting but also to actual outcomes. Over time the full 45 measure reporting requirements have been instituted. As a result, hospitals should now be well aware of areas of weakness.

A number of the 45 IQR measures used in the VBP are claims based measures that assess quality of care (with respect to acute myocardial infarction, heart failure, pneumonia, surgical care improvement, and health care associated infections) as measured by 30-day mortality and readmission rates. These are likely areas in which coordination with health centers post discharge would represent value to hospitals.

Highest scoring hospitals could receive up to a 1.8% increase added on to base diagnosis-related group (DRG) payments per discharge each fiscal year. It is expected that roughly half of the participating hospitals will receive a net increase and half will receive a net decrease. Perhaps equally motivational to hospitals, all data will be available on Hospital Compare, so that the public has access to hospital performance information.

## **Bundled Payment Demonstrations**

These demonstrations incentivize providers to be jointly accountable for an entire episode of care centered on a hospitalization.

HHS will initiate **Medicaid bundled payment demonstration programs** in up to eight states

beginning in January 2012 and running for five years. Bundled payments will be made for episodes of care and will cover hospital services, concurrent physician services and other services proposed by states and the Secretary. Participating hospitals must have robust discharge planning programs to assure access to post-acute care.<sup>17</sup>

HHS will also initiate a 5-year **Medicare bundled payment pilot program** by January 2013 to test effective coordination of acute and post-acute care for 10 specific conditions to be selected by the Secretary. Bundled payments will cover acute care hospital services, physicians' services, hospital outpatient services and post-acute services and will incorporate transition support services such as care coordination. Payments will be made for episodes of care defined as 3 days prior to hospital admission, hospital length of stay, and 30 days following discharge. Providers must bid to participate, and are expected to offer Medicare a discount off of fee for service delivery of care for the 10 conditions.<sup>18</sup>

These ACA pilots build on a current three-year CMS demonstration, started in 2009. The Acute Care Episode (ACE) demonstration<sup>19</sup> is evaluating the use of bundled payments for specific cardiovascular and orthopedic procedures at 5 sites in Texas, Colorado, Oklahoma and New Mexico. CMS pays providers a lump sum covering all Part A and Part B services incurred during hospital stay.

In addition, many hospitals across the country are already or beginning to enter in to bundled payment arrangements with private payers. These are proposed for high cost, prevalent procedures and may or may not include costs of care pre and post discharge. The inclusion of post discharge services in the ACA demonstrations represents a new opportunity for health centers.

## **Accountable Care Organizations (ACO) / Shared Savings Models**

The ACO demonstration<sup>20</sup> goes further than the Bundling demonstration in that it aims to evaluate groups of providers as they coordinate and are accountable for all of the part A and part B services for a minimum of 5,000 Medicare beneficiaries.

On April 7, 2011, CMS issues a proposed rule<sup>21</sup> on the Medicare Shared Savings Program and ACOs. Based on this guidance, this program will enable groups of providers that meet certain criteria to be recognized as ACOs and thereby share with Medicare any cost savings achieved. These programs are to begin January 1, 2012. Medicare will set a per-beneficiary cost benchmark, adjusted by certain beneficiary characteristics, that represents a discount off of average total fee-for-service costs associated with Medicare Parts A and B. If an ACO meets this benchmark or threshold in the care of beneficiaries assigned to it, as well as upholds quality standards, it will receive an annual shared saving payment.

Selected provider groups must commit to minimum of three years of participation. An eligible ACO must among other criteria have mechanisms for payment receipt and distribution to participating



providers of services and supplies, for joint decision-making, robust clinical information systems, evidence-based medicine processes, and have a sufficient number of primary care clinicians relative to number of Medicare assignees.

### **Additional Demonstration Programs**

HHS is authorized under the ACA to establish **demonstration programs to reduce hospital re-admissions by providing improved transition services through the Community-based Care Transition Program**<sup>22</sup> beginning in October 2011 and running for 5 years. Eligible entities are hospitals with high re-admission rates and community based organizations that partner with them to provide transition services. Preference will be given to those entities serving medically underserved populations, small communities and rural areas.<sup>23</sup>

### **Electronic Health Record (EHR) Incentive Programs**

The Health Information Technology for Economic and Clinical Health Act (HITECH) of ARRA<sup>24</sup> provides for Medicare and Medicaid incentives for EHR adoption for eligible health care professionals and eligible hospitals.

Medicare eligible hospitals include acute care facilities, where the average length of stay is 25 days or less and Critical Access Hospitals (CAHs). Participation may begin as early as 2011.

Medicaid eligible hospitals include acute care hospitals with at least 10% of their patient base covered by Medicaid, children's hospitals and CAHs. Participation may begin as early as 2011 depending on the state. States can voluntarily decide when and if EHR Medicaid incentive programs begin.

Hospitals must demonstrate "meaningful use" of EHR technology in order to qualify for EHR incentives. The three main components of meaningful use are (1) use of a certified EHR in a meaningful manner, such as e-prescribing, (2) use for electronic exchange of health information to improve quality, and (3) use to submit clinical quality and other measures. Hospitals are required to report on 14 core measures and 5 of a menu set of ten additional measures, for a total of 19 measures. In addition, hospitals must report on 15 clinical quality measures.

The meaningful use standards are being implemented in three phases. Stage 1 (2011-2012) sets the baseline for data capture and sharing. Stages 2 (expected to be implemented in 2013) and 3 (expected to be implemented in 2015) will continue to expand on the baseline and be developed through future rulemaking.

The incentives are based on a base payment of \$2 million per hospital and are adjusted by year of transition and number of Medicare or Medicaid discharges.<sup>25</sup> Unlike EHR incentive eligible professionals, eligible hospitals may qualify for both Medicare and Medicaid incentives. Medicare acute care hospitals not achieving Meaningful Use by 2015 will have negative payment adjustments made. There is no such penalty for the Medicaid EHR program.

Health centers are also looking to take advantage of the connectivity and EHR incentives associated with HITECH. Great efforts are being made to have existing systems "talk" with one another, so it is wise for centers to be aware of which certified systems and vendors are in use at their local hospitals and which of the menu set of core measures hospitals are choosing to report.

### **CONCLUSION**

Overall, hospitals face a great degree of uncertainty and change. While the fewer number of uninsured as a result of the ACA suggest hospitals will likely experience a decrease in the amount of uncompensated care delivered, many of the rate pressures discussed herein are more certain. In addition, the nature of new payment methodologies will now require hospitals to incorporate more primary care, and complement inpatient care with a broad array of services not regularly managed by hospitals.

Opportunities for health centers and hospitals to work together are abundant. PCAs and health centers can explore new or expand existing partnerships with their local hospitals in a variety of ways including:

- Participating in Accountable Care Organizations/shared savings models and other managed care initiatives;
- Partnering on an Emergency Room Diversion or care coordination program;
- Exploring ways to leverage additional federal Medicaid dollars by partnering with hospitals on strategies such as provider assessments, ensuring both the hospitals and health centers benefit;
- Understanding which EHR systems are in use at local hospitals and partner on information exchange and connectivity;
- Sharing health information technology resources by way of donation between hospitals and health centers.<sup>26</sup>

## References:

- <sup>1</sup> Public Law 111-148 revised by Public Law 111-152
- <sup>2</sup> ACA Section 3025
- <sup>3</sup> [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
- <sup>4</sup> ACA Section 3001
- <sup>5</sup> 42 CFR Parts 422 and 480. Medicare Programs; Hospital Inpatient Value-Based Purchasing Program; Proposed Rule.
- <sup>6</sup> ACA Section 3133
- <sup>7</sup> ACA Section 3008
- <sup>8</sup> ACA Section 2702
- <sup>9</sup> ACA Section 2551
- <sup>10</sup> P.L.111-5, Section 5001(f)(1)
- <sup>11</sup> ACA Section 2001(b)
- <sup>12</sup> 42 CFR Part 447. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services. Centers for Medicare & Medicaid Services (CMS), HHS. Proposed rule.
- <sup>13</sup> NCSL, "Health Care Provider and Industry Taxes/Fees", February 2011.
- <sup>14</sup> ACA Section 9007
- <sup>15</sup> 42 USC Ch.6A
- <sup>16</sup> P.L.108-173
- <sup>17</sup> ACA Section 2704
- <sup>18</sup> ACA Section 3023
- <sup>19</sup> <http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=cms1204388>
- <sup>20</sup> ACA Section 3022
- <sup>21</sup> 42 CFR Part 425. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice
- <sup>22</sup> <http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=cms1239313>
- <sup>23</sup> ACA Section 3026
- <sup>24</sup> P.L.111-5
- <sup>25</sup> 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
- <sup>26</sup> On October 11, 2005, the OIG and CMS each published proposed regulations that would protect certain donations of electronic prescribing (e-Prescribing) and electronic health records (EHR) technology from prosecution under the Federal Anti-kickback statute (70 *Fed. Reg.* 59015; 42 C.F.R. § 1001.952(x)) and violation of the Stark physician self-referral law (70 *Fed. Reg.* 59181; 42 C.F.R. § 411.357(v)-(x)).

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### **About NACHC**

Established in 1971, the National Association of Community Health Centers (NACHC) serves as the national voice for America's Health Centers and as an advocate for health care access for the medically underserved and uninsured.

### **NACHC's Mission**

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.