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CLIENT ADVISORY

Health Reform 2010: Highlights for Hospitals

The following are a list of selected changes for hospitals that come out of the Patient Protection and Affordable Care Act of 2010 (J.R. 3590; Pub. L. 111-148) and its subsequent amendment through passage of the Health Care and Education Reconciliation Act of 2010 (H.R. 4872). Approximate dates of implementation, the applicable section in the PPACA or HCERA, and regulation citations are reflected in parenthesis:

Medicare Payments

- Establishes a value-based purchasing program (VBP) for hospitals under the Inpatient Prospective Payment System (IPPS). Under the VBP, a percentage of the payments to hospitals will be tied to a hospital's performance on a number of quality measures relating to a number of conditions. Payments will be adjusted depending on whether a hospital meets, exceeds, or falls below the performance standard (effective 2013) (Sec. 3001, 10335)
- Requires new regulations to change Medicare Disproportionate Share Hospital (DSH) payments to better reflect a hospital's uncompensated care costs (beginning 2012) (Sec. 3133, 10316 and HCERA Sec. 1104)
- Extends current hospital reclassifications for purposes of the Wage Index through 2010 (Sec. 3137, 10317)
- Reduces the market basket update for hospitals beginning in 2012 by a productivity adjustment. The adjustment could result in a 0 percent market basket and, if negative, could result in a reduction in payment rate 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 the years 2017 through 2019 (Sec. 3401, 10318 and HCERA Sec. 1105)
- Provides for 10 percent incentive payments to primary care physicians whose Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges (effective Jan. 1, 2011 to Jan. 1, 2016) (Sec. 5501)
- Provides for 10 percent incentive payments to general surgeons performing major surgery in health professional shortage areas (effective Jan. 1, 2011 to Jan. 1, 2016) (Sec. 5501)
- Re-establishes the national average "floor" on Medicare's geographic payment adjustment (commonly known as the GPCI) in 2010 (Sec. 3102)

- Beginning in 2011, the practice expense GPCI adjustment will be brought up to the national average for "frontier" states (Montana, North Dakota, South Dakota, Utah and Wyoming) (Sec. 10324)
- Extends Medicare quality reporting incentives to 1 percent in 2011 and 0.5 percent from 2012 to 2014 for voluntary participation in Medicare's Physician Quality Reporting Initiative (PQRI). An additional 0.5 percent incentive payment will be made to physicians who participate in a qualified Maintenance of Certification Program (quality practice-based learning programs through specialty boards). Beginning in 2015 physician payments will be reduced if they do not successfully participate in the PQRI program. In 2015, the penalty will be 1.5 percent; in subsequent years it will be 2 percent (Sec. 3002).
- Requires CMS to establish a national, voluntary pilot program encouraging hospitals, physicians and post-acute providers to improve services and achieve savings through bundled payments (by 2013). CMS will be authorized to expand this pilot by 2016 if it appears to be achieving its goals (Sec. 3023)
- Establishes a penalty for high rates of hospital-acquired conditions. Hospitals in the top 25th percentile of rates of hospital-acquired conditions will be subjected to a 1 percent reduction in payment. A report on hospital-acquired conditions will be provided to hospitals and will be made available to the public (beginning 2015) (Sec. 3008)
- Reduces payments to hospitals paid under the Inpatient Prospective Payment System (IPPS) based on a ratio of the payments for preventable readmissions to the payments for all discharges. Forthcoming regulations will determine what conditions are to be included and what amounts to a readmission. A report on readmission rates will be provided to hospitals and made available to the public (Beginning 2012) (Sec. 3025)
- Extends through September 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 (Sec. 3027)

Medicare Shared Savings Program

- Establishes a shared savings program that will allow providers to manage and coordinate care for Medicare beneficiaries through Accountable Care Organizations (ACOs) (beginning 2012) (Sec. 3022)
- Providers participating in an ACO would continue to bill and receive payment under the normal fee-for-service system, but would be eligible to receive additional payments from Medicare if costs per beneficiary are lower than Medicare's estimated per capita cost (Sec. 3022)

- ACOs must meet certain quality performance standards and reporting requirements (Sec. 3022)

Medicaid Payments

- Reduces the Disproportionate Share Hospital allotment to states between 2014 and 2020 (Sec. 2551, HCERA Sec. 1203)
- Increases Medicaid payment rates to primary care physicians to at least 100 % of Medicare rates in 2013 and 2014. The law does not mention payment rates beyond 2014 (HCERA Sec. 1202)
- Prohibits Medicaid payment for services related to a "health care-acquired" condition (effective July 1, 2011) (Sec. 2702)
- Requires CMS to establish a national, voluntary pilot program encouraging hospitals, physicians and post-acute providers to improve services and achieve savings through bundled payments (by 2013). CMS will be authorized to expand this pilot by 2016 if it appears to be achieving its goals (Sec. 2704)

Medicaid Expansion

- Beginning in 2011, states would have the option to provided Medicaid coverage to all low-income individuals through a state plan amendment. States would have to cover individuals with incomes at or under 133 percent of the federal poverty level (beginning in 2014) (Sec. 2001)
- The Federal government would pay 100% of the cost for the newly eligible from 2014 to 2016. Federal funding would decrease in subsequent years to between 82.3% and 95% of the additional cost to states. (Sec. 2001)

Medicare Prescription Drug Coverage Expansion

- Provides a $250 rebate for Medicare patients whose prescription expenses reach the Medicare Part D "doughnut hole" in 2010 (Sec. 3315, HCERA Sec. 1101)
- The beneficiary co-insurance rate for this coverage gap will be narrowed in phases from the current 100 percent to 25 percent in 2010 (HCERA, Sec. 1101)

Preventive and Screening Benefit Expansions

- Requires private health plans to provide minimum level of coverage without cost-sharing for preventive services such as immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women (beginning 2010) (Sec. 1001)
- Requires Medicaid to cover tobacco cessation services for pregnant women (beginning 2010) (Sec. 4107)

- Eliminates cost-sharing for certain preventive services in Medicare and Medicaid (beginning 2011) (Sec. 4106)

Waste/Fraud/Abuse Measures

- Requires CMS to develop procedures for screening health care providers participating in Medicare and Medicaid that at minimum would include licensure checks, but which could also include criminal background checks, fingerprinting, multi-state database inquiries, and random or unannounced site visits. Application fees of $200 for individual providers and $500 for institutional providers would be imposed each time they verify their enrollment (every five years) (by August, 2010) (Sec. 6401)
- Maximum period for submission of Medicare claims reduced to twelve months from date of service (effective now, exceptions pending) (Sec. 6404)
- Requires that Medicare home health services and DME be ordered by a health care professional or doctor enrolled in Medicare. The order must be in writing based on a face-to-face encounter between the doctor/health care professional and the beneficiary (effective July 1, 2010) (Sec. 6405, 6407)
- Expands the number of metropolitan statistical areas to be included in round two of the competitive bidding program for DME, prosthetics, orthotics and supplies (effective now) (Sec. 6410)
- Expands the recovery audit contractor (RAC) program to state Medicaid programs and to Medicare Parts C and D (Dec. 31, 2010) (Sec. 6411)
- Requires State agencies to exclude from participation any individual or entity that owns, controls, or manages an entity that has unpaid overpayments, is suspended or excluded from participation, or is affiliated with an individual or entity that has been suspended or excluded (effective now) (Sec. 6502)
- Requires providers, physicians, and other supplies to provide documentation on referrals to programs at high risk of waste and abuse. Interim regulations require documentation and access to documentation related specifically to orders and referrals for covered home health, laboratory, imaging, and specialist services, in addition to the current documentation and access requirements for durable medical equipment prosthetics, orthotics, and supplies. Both the provider or supplier who furnishes the ordered/referred services and the physician or eligible professional who ordered/referred the services are required include their NPIs and to maintain documentation for seven years from the date of the order. Such documentation includes both written and electronic documents. Both the provider or supplier and the physician or eligible professional must provide access to the

documentation upon the request of CMS or a Medicare Contractor (effective July 6, 2010) (interim final rule revising 42 C.F.R. sec. 424.516(f))

Malpractice

- Authorizes grants to States to test alternatives to civil tort litigation. These models would be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients would be able to opt-out of these alternatives at any time (Sec. 6801)

Physician Ownership-Referral

- Prohibits physicians from referring patients to hospitals they own and provides a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county) (effective Dec. 31, 2010) (HCERA Sec. 1106)

Physician Self-Referral

- Creates new disclosure requirements for the in-office ancillary services exception for certain imaging services, including MRI and radiologic imaging. Patients must be informed that they may receive services for which they are referred from a different provider and given a list of supplies in their area that furnishes services. The compliance date in the law is retroactive to Jan. 1, 2010, but there is a disagreement over whether physicians are required to comply now or after the Secretary promulgates regulations clarifying the requirements (Sec. 6003)

Employer Requirement to Offer Coverage

- Requires employers with more than 50 employees with at least one full-time employee who receives a premium tax credit to offer health insurance coverage or be assessed a range of fees, beginning at $2000 per each full-time employee, excluding the first 30 employees from the assessment (effective Jan. 1, 2014) (Sec. 1513, HCERA Sec. 1003)
- Requires employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit to pay the lesser of $3000 per each employee receiving the tax credit or $2000 per full-time employee (effective Jan. 1, 2014) (Sec. 1513, HCERA Sec. 1003)
- Provides a range of small business tax credits for employers contributing at least 50 percent of the costs of coverage for their employees, with credits phasing out as firm size and average employee wages increase (effective 2010) (Sec. 1421)

- Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage (effective now, subject to forthcoming regulations) (Sec. 1511)

Medical Education and Residency

- Increases the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011) (Sec. 5503)
- Changes the rules for calculating resident time for GME to allow time outside the hospital in patient care. 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 the hospital shares the costs, the hospital can count a proportion of time, based upon a written agreement with the party sharing the costs (beginning July 1, 2010) (Sec. 5504)
- Changes the rules for calculating resident time for GME to allow time spent in non-patient care activities, such as didactic conferences and seminars, but not including research not associate with the treatment or diagnosis of a particular patient (beginning July 1, 2010) (Sec. 5505)
- Establishes Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs (beginning 2010) (Sec. 5508)
- Increases healthcare workforce supply and supports training of health professionals through scholarships and loans, increasing teaching capacity, and other provisions (beginning 2010) (Sec. 5201 through 5509)

Conclusion

As the federal health reform legislation is implemented via the regulatory process, there will be significant additional work for hospitals and health systems seeking to keep up with changes in legal and operational requirements. The legislative changes are complex and extend over the next decade. The regulatory changes implementing the legislation will be substantial as well. If our firm can be of assistance in further identifying and interpreting these changes for you, please let Peter Mellette, Harrison Gibbs or Nathan Mortier know.