Healthcare Reform Law: Issues Affecting Hospitals and Health Systems

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The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (the Healthcare Reform Law), includes substantial changes that will affect how hospitals of all types are reimbursed under the Medicare program. These changes reflect a number of trends, such as (a) movement toward linking provider payment to quality, (b) encouraging growth in the primary care workforce, and (c) movement away from indirect payment mechanisms for treating the indigent through disproportionate share hospital payments, in light of the expected decrease in the numbers of uninsured. This LawFlash briefly summarizes these major payment changes and how they may influence hospitals.

Very few of the provisions in the Healthcare Reform Law will be self-implementing; many of the details will be fleshed out in further guidance and rulemaking. Moreover, the Centers for Medicare & Medicaid Services (CMS) will have a tremendous amount of discretion in developing the implementing rules. Therefore, continued monitoring of the implementation of these provisions by hospitals and health systems is warranted, and proactive involvement in the rulemaking process is recommended for most institutions in order to be as prepared as possible for the coming changes enacted by the Healthcare Reform Law.

Morgan Lewis will continue to monitor the various reimbursement and payment developments of significance to the hospital industry created by the Healthcare Reform Law.

A. Market Basket Updates and Other Payment Changes

Section 3401 of the Healthcare Reform Law provides for a reduction in the annual market basket update for inpatient prospective payment system (IPPS) hospitals by 0.25%, for federal fiscal years (FYs) 2010 and 2011. For subsequent FYs, the annual market basket update for IPPS providers is reduced by the following percentages:

FY 2012-2013: 0.1%
FY 2014: 0.3%
FY 2015–2016: 0.2%
FY 2017–2019: 0.75%

The reduction in the annual market basket update for IPPS hospitals mirrors that for outpatient prospective payment system (OPPS) hospitals, except that the reduction will be applied pursuant to the

calendar year for OPPS hospitals. Beginning in fiscal and calendar years 2012, the Healthcare Reform Law subjects the market basket update for IPPS and OPPS hospital providers to a "productivity adjustment," which potentially means further reductions in payment. The productivity adjustment is the 10-year moving average of changes in economy-wide private nonfarm business productivity, as projected by the Secretary of Health and Human Services (the Secretary). These productivity adjustments may result in a negative market basket update, with a concomitant reduction in payment rates.

The Healthcare Reform Law includes similar market basket update reductions and productivity adjustments for long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals. Section 3004 of the Healthcare Reform Law further mandates quality reporting for long-term care hospitals and inpatient rehabilitation facilities, beginning in fiscal or rate year 2014. Failure to report the required data will result in a reduction in the hospital's annual market basket update to its standard federal rate.

B. Quality Initiatives

1. Value-Based Purchasing

Section 3001 of the Healthcare Reform Law establishes a hospital value-based purchasing program (VBP) applicable to acute care hospitals paid under IPPS. Under the VBP program, inpatient payments to these hospitals, beginning in FY 2013, will be modified based on a hospital's performance with respect to certain quality measures.

For the first year, the Secretary will select measures that cover at least the following five conditions or procedures: (1) acute myocardial infarction (AMI), (2) heart failure, (3) pneumonia, (4) surgeries, and (5) healthcare-associated infections. Other selected measures must relate to the Hospital Consumer Assessment of Healthcare Providers and Systems Survey. All such quality measures will have been initially implemented through the existing Medicare pay-for-reporting program. For FY 2014 and beyond, the Secretary will expand the measures to include ones focused on efficiency, for example measures of Medicare spending per beneficiary.

The Secretary will establish performance standards for the selected measures and each hospital will receive its own performance score comprised of an achievement score and an improvement score. Those hospitals with the highest total performance scores will receive the largest VBP incentive payments, while those with the lowest scores will receive a reduction in their payments.

Payment incentives and reductions will be budget-neutral, with an increasing amount of the inpatient funding pool allocated to VBP, as follows:

FY 2013: 1.0%
FY 2014: 1.25%
FY 2015: 1.5%
FY 2016: 1.75%
FY 2017 and future years: 2.0%

To get a sense of how the Secretary will likely implement this statutory authority, hospitals and health systems can review CMS's report to Congress on VBP, *available at*

https://www.cms.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf. Many of the provisions in the Healthcare Reform Law build off of concepts laid out in CMS's report.

2. *Hospital Acquired Conditions*

Pursuant to Section 3008 of the Healthcare Reform Law, beginning in FY 2015, Medicare will reduce payments to hospitals that are in the top quartile with respect to national rates of hospital acquired conditions (HAC). Specifically, Medicare will limit a hospital's reimbursement to 99% of the amount of payment that it would have otherwise received for the discharge prior to the payment-reduction policy's taking effect. A HAC is defined as a condition subject to payment restrictions under IPPS payment rules and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital.

The 1% payment-reduction policy will apply to acute-care hospitals paid under IPPS and Maryland waiver hospitals. However, on or before January 1, 2012, the Secretary will report to Congress on how this policy can be expanded to other providers that are currently exempt from IPPS, such as inpatient rehabilitation facilities, long-term care hospitals, hospital outpatient departments, skilled nursing facilities, and ambulatory surgical centers. The Secretary is required to publicly report hospital-specific information on HACs on the Hospital Compare website (www.hospitalcompare.hhs.gov).

3. *Readmissions*

Section 3025 of the Healthcare Reform Law requires the Secretary to calculate the actual and predicted "readmission" rates to hospitals for several different health conditions that are associated with a high number of readmissions or high costs. The Healthcare Reform Law defines a "readmission" as the admission of a patient to the same hospital from which the patient was discharged or to another hospital within a time period specified by the Secretary from the date of the patient's discharge.

For FYs 2012 through 2014, conditions subject to this provision are AMI, heart failure, and pneumonia, and the readmission period is 30 days. Beginning in FY 2015, the Secretary is authorized to expand this policy to cover four additional health conditions identified by the Medicare Payment Advisory Commission (MedPAC) in its report to Congress in June 2007. The four conditions are: chronic obstructive pulmonary disease, coronary artery bypass graft, percutaneous transluminal coronary, and other vascular procedures. Thus, starting in October 1, 2012, hospitals with high readmission rates for patients with these conditions will have their Medicare payments adjusted by the greater of a "ratio" or a "floor adjustment factor." The "ratio" is equal to 1 minus the aggregate payments attributable to excess readmissions with respect to a hospital divided by the aggregate payments from all discharges from that hospital. The "floor adjustment factor" will be 0.99 in FY 2013; 0.98 in FY 2014; and 0.97 in FY 2015 and subsequent years.

The Healthcare Reform Law also requires the Secretary to publish hospital readmission rates on the Hospital Compare website. In addition, the Secretary must calculate and report on the readmission rates for all patients for a hospital for an applicable condition, and post this information on the Hospital Compare website.

4. *Other Quality Initiatives*

For additional information on other quality initiatives included in the Healthcare Reform Law that may have an impact on hospitals, please visit Morgan Lewis's Healthcare Reform Law portal at http://www.morganlewis.com/healthcarereform.

C. Graduate Medical Education

In the Healthcare Reform Law, Congress has weighed in on nearly every graduate medical education (GME) topic that has been of any significance over the past several years. The legislation also mandates "Round II" of the residency redistribution program, though, by some estimates, there are fewer than 1,000 residency slots left to redistribute to hospitals. Some of the key GME provisions are summarized below.

1. Residency Redistribution Program

Section 5503 of the Healthcare Reform Law requires the Secretary to implement a new residency redistribution program. Since 1998, hospitals have been subject to a cap on the number of full-time equivalent (FTE) residents for which they can be reimbursed under Medicare. While the FTE resident counts at most hospitals significantly exceed their FTE caps, there are some hospitals that are below their caps. The first redistribution resulted from the Medicare Modernization Act of 2003. This second one resembles the initial redistribution, but with several key differences.

The redistribution program has two key facets: reducing the FTE caps for hospitals with FTE resident counts below their existing caps and increasing FTE caps for certain hospitals with FTE resident counts above their caps. To determine whether a hospital will incur a cap reduction, the Secretary must look at the FTE count for the three most recent cost-reporting years and assess which one has the highest FTE count. If this highest count is lower than the hospital's FTE cap, the hospital will incur a reduction of 65% of the difference between the FTE count and the FTE cap. Certain hospitals are exempted from these reductions, such as rural hospitals with fewer than 250 beds. The reduction takes effect on July 1, 2011.

The FTE slots are to be redistributed according to certain priorities. Greatest consideration is given to hospitals located in areas with the lowest ratios of residents to the population. Rural areas and jurisdictions that have a high percentage of their area in a health professional shortage area also take priority. Within these areas, hospitals must be able to show a demonstrated likelihood of filling the new residency slots within three years. Hospitals also are given credit for having rural resident training tracks. No hospital can receive more than 75 residents. Any hospital receiving new residency slots must maintain the current level of primary care FTEs for at least five years. Additionally, during this five-year period, 75% of the slots received must be used for primary care or surgery residents.

2. Nonhospital Site Costs Borne by Hospital

Currently, CMS requires that hospitals pay preceptor physicians in freestanding clinics and physician offices for their supervisory services before time spent by residents at these sites can be included in the hospital's FTE resident count for both direct and indirect medical education payments. Pursuant to Section 5504 of the Healthcare Reform Law, effective with discharges occurring on or after July 1, 2011 (for IME) and cost reporting periods beginning on or after July 1, 2011 (for direct GME), hospitals need to incur only resident salaries and fringe benefits as a precondition to including these rotations in the hospital's FTE count.

3. Didactic and Research Time

CMS policy has been to exclude time spent by residents in didactic activities and research from the FTE count for both indirect medical education payments and training at nonhospital sites (both for direct GME and indirect medical education payments). Section 5505 of the Health Reform Law requires that time spent by residents in didactic activities be included in the FTE resident count. However, research remains excluded. These provisions apply to direct GME payments from July 1, 2009. The effective date for indirect medical education payments is October 1, 2001.

D. Disproportionate Share Hospitals

To account for the expected decrease in the numbers of uninsured, Section 3133 of the Healthcare Reform Law provides for a downward adjustment in the payments received by Medicare disproportionate share hospitals (DSH). Starting in FY 2014, Medicare DSH payments to acute care hospitals paid under IPPS will be reduced to 25% the amount that would otherwise be paid. This reduction represents the empirically justified amount specified by MedPAC in its March 2007 report to Congress.

Hospitals will receive an additional payment for FY 2014 and each subsequent FY based on the product of three factors:

Factor One: The difference between the aggregate amount of payments made to hospitals before and after the DSH reduction;

Factor Two: 1 minus the percent change in the percent of individuals under 65 who are uninsured in the most recent period for which data is available compared to 2013, minus 0.1 percentage points for FY 2014 and minus 0.2 percentage points per year for FYs 2015 through 2017; and

Factor Three: The percent of uncompensated care for each hospital compared to all hospitals.

Starting in FY 2018, the Healthcare Reform Law provides that Factor Two will be 1 minus the percent change in the percent of individuals who are uninsured in the most recent period for which data is available compared to 2013, less an additional 0.2 percentage points per year for FYs 2018 and 2019.

E. Charitable (Tax-Exempt) Hospitals

Under the provisions of Section 9007 of the Healthcare Reform Law, hospitals must satisfy additional requirements in order to qualify as section 501(c)(3) charitable hospital organizations. In particular, charitable hospitals must conduct a community needs assessment and adopt an implementation strategy to meet the needs identified in the assessment. Charitable hospitals also must develop a written financial assistance policy that includes the following: (1) the eligibility criteria for financial assistance, (2) the basis for calculating amounts charged to patients, (3) a method for applying financial assistance, and (4) the actions that will be taken in the event of nonpayment if the hospital does not have a separate billing and collection policy. In addition, charitable hospitals must develop policies that provide that care will be furnished for emergency conditions regardless of the patient's eligibility under the hospital's financial assistance policy.

Other requirements applicable to charitable hospitals include a mandate to limit the amounts charged for emergency or other medically necessary care to the amounts generally billed to individuals who have

insurance, and a prohibition on the use of "gross charges." The Healthcare Reform Law also requires charitable hospitals to make reasonable efforts to determine a patient's eligibility for financial assistance before engaging in extraordinary collection efforts. Failure to meet these new requirements for any taxable year will subject charitable hospitals to a $50,000 tax.

F. Independent Payment Advisory Board

Section 3403 of the Healthcare Reform Law establishes an Independent Payment Advisory Board (IPAB), composed of 15 members appointed by the President—including the Administrators of CMS and the Health Resources and Services Administration. The IPAB is required to submit recommendations to the President and Congress on slowing the growth in total Medicare spending and extending the solvency of the Medicare program. Specifically, the IPAB will address ways reduce the rate of per capita Medicare spending by targeted amounts. If Congress fails to act on the IPAB's recommendations, the Secretary is directed to implement the recommendations.

Hospitals, health systems, and other stakeholders may be interested in Morgan Lewis's analysis of major fraud and abuse provisions in the Healthcare Reform Law. This information is summarized at http://www.morganlewis.com/pubs/FraudAbusePrgmIntegrityProvisions.pdf and a detailed discussion is available at http://www.morganlewis.com/pubs/WashGRPP_PrgmIntegrityProvisions_LF_31mar10.pdf.

If you have any questions or would like more information on any of the issues discussed in this LawFlash, please contact the authors of this LawFlash, **Al Shay** (202.739.5291; ashay@morganlewis.com) and **Andrew Ruskin** (202.739.5960; aruskin@morganlewis.com), or any of the following key members of our cross-practice Healthcare Reform Law resource team:

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