HEALTHCARE REFORM
What’s next?

Vice President of Corporate Responsibility
Regional Health

Healthcare Reform
HEALTHCARE REFORM

- March 23, 2010
- Cost $940 billion over 10 years
- Reduce the deficit by $143 billion
- Provide covers for 32 million more Americans
HEALTHCARE REFORM

"Reform Law Delivers Ammo to Battle Fraud"

Modern Healthcare, March 29, 2010

HEALTHCARE REFORM

- Financial Environment
  - Mandated 0.25% market-basket cut 2011
    - Estimated $201 million
    - $157 billion over 10 years
  - Proposed 0.1% cut in hospital IP rates
  - Increased medical-device reimbursement
    - 5 devices (determined 8-1-10)
    - Add-on payments
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Financial Environment

- Patients choosing to utilize OP/ASC
- Severely ill are left for hospitals
- Physician practices:
  - MPFS 90% to 75% utilization effective 2011 for CT’s & MRI’s
  - >1 diagnostic imaging
    - 1st test 100% reimbursement
    - 2nd test from 75% now 50% effective 7-1-10

Financial Environment

- Funding for fraud enforcement by $350 million over 10 years.
- HHS has authority to suspend payments on questionable claims
- Penalties relating to:
  - High readmission rates effective 2013
  - HAI effective 2015
HEALTHCARE REFORM

- Financial Environment
  - Doctors could benefit under the Medicaid program
    - PCP = 100% of Medicare payment rates
  - Disproportionate Share Hospital
    - $36 billion reduction 2014

Healthcare Reform

**PPACA**
- CP is mandatory
- Condition of enrollment
- Boards are expected to be active
- Increase Board accountability

**Costs**
- Impact to CP
- CO at the table
- Board operations vs. oversight
- Quality of Care & Compliance
HEALTHCARE REFORM

- Strategic assessment of readiness
  - Cost controls
  - Inefficiencies
  - Base DRG reductions
    - 1% in 2013
    - 2% in 2017
  - Paradigm shift from crisis-driven to preventive health maintenance

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- Strategic assessment for readiness
  - Uncompensated care will decrease
  - 2019 expansion
    - 32 million with additional coverage
    - ½ anticipated to be Medicaid
    - Shift in insurer mix
    - Decrease in overall reimbursement per patient
HEALTHCARE REFORM

- Strategic assessment for readiness
  - Manage clinical costs
    - Effective admission to discharge
    - Construct efficient patient flow
    - Establish process to intervene and proactively manage
  - NEW covered lives
    - Lacked preventive care previously
    - Anticipated higher cost per member
  - Nurses in greater demand

HEALTHCARE REFORM

- 2014 all US citizens to maintain essential health coverage or face a penalty.
- Penalties begin at 1% of taxable income
- Exemptions and rebates when paying 8% of income
State...of Confusion

US District Judge
...rejected the claim that requiring Americans to buy health insurance is unconstitutional.

State...of Confusion

U.S. District Judge Vinson
...believes it has yet to be determined whether the mandate requiring people to buy health insurance is constitutional or not...

Associated Press
October 18, 2010
State...of confusion

Judge Vinson:
Members of Congress who voted in favor of the bill never actually referred to the penalties for not buying insurance as "taxes" perhaps to minimize any backlash they might receive from constituents.

Healthcare Reform

- Hearing scheduled 12-16-10
- 20 states
- National Federation of Independent Business
  - Congress intentionally unclear when penalties were created
  - Congress is overstepping constitutional authority
More confusion????

- Taxpayers must wait until 2014 when changes take effect to file lawsuits.
- Opponents of reform are turning to the courts
  - Social Security Act
  - Civil Rights Act
  - Voting Rights Act

Lawsuits

- Alabama, Arizona, Colorado, Georgia
- Indiana, Idaho, Louisiana, Michigan
- Mississippi, Nebraska, Nevada, North Dakota
- Pennsylvania, South Carolina, South Dakota
- Texas, Utah and Washington
Healthcare Reform

Logic
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- Women’s & Children’s Health
  - Lifetime limit ban: 2010 <$750,000
  - Essential health benefits: Maternity
  - Rescissions of Coverage (benefit 15 million)
  - Cover preventive services
    - Breast and cervical cancer, osteoporosis, colorectal, blood pressure, cholesterol, etc.
    - Screenings for infants, children, adolescents
  - Immunizations

Healthcare Reform

- Quality of care for better outcomes
- Reduce costs
- Increase pay-for performance
- Increase penalties for non-compliance or substandard care
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Nurse managed community care clinics
- underserved
- vulnerable population
- no regard to insurance or income
- affiliated with qualified health center

§5316 Demonstration Project
- $600,000
- 1-year training program for recent graduated nurse practitioners
$200 million in grants, 4 years
- Funds maternal, infant, early childhood visitation programs to low income women
- Better outcomes
HEALTHCARE REFORM

- Fee-for-service volume-based model to improved outcomes or value

- Five-year pilot to test alternative payment methodologies
  - Payment bundling (8 conditions)
  - Incentives to coordinate care from diagnosis to discharge, rehab or HH

Healthcare Reform
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- Compelling assessment to partner
  - Re-evaluate accounting and finance
  - Review technology applications to track revenue
  - Understand ability to report quality
  - Volume shifts for Medicaid “health homes” from acute to non-acute settings

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- “Health Homes” for Medicaid
  - At least 2 chronic conditions OR
  - 1 chronic & serious mental health
    - Provider is approved by HHS
    - Established infrastructure to provide service
    - Comprehensive care management
      - Reduce readmission
      - Improve chronic care coordination
  - Procedures for referring Medicaid patient seeking treatment in ED to a HH Provider
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- “Health Homes” for Medicaid
  - Re-examine business model to prepare for volume shifts
  - Consider strategic alliances
- Compliance Considerations

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- Medicaid Exclusion from Participation
  §6502
  - Any entity that owns, controls or manages an entity or is owned, controlled or managed by an individual or entity that has unpaid overpayments, is suspended or excluded from participation or is affiliated with an entity that has been suspended or excluded.
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- Quality measures & technology
  - Value-based purchasing incentives
    - October 2012 discharges
  - Provides incentive payments
  - Hospital Compare public in 2012
  - HACs public in 2015
  - Hospital readmissions
    - Reduce payment October 2012
    - More conditions to come in 2015

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- Quality measures & technology
  - HITECH Act expanded HIPAA with CE’s and BA’s to enhance safeguards for privacy
    - Stimulus funds for EHR
    - Medicare reimbursement reduction for failure to adopt
  - Quality reporting increases
    - Administrative burdens
    - Require new or enhanced IT systems to track and report
HEALTHCARE REFORM

- Accountable Care Organizations
  - Contract to manage care and curb spending
  - Share of savings for quality and cost-control
  - Economic and legal challenges
    - Bonuses vs. payment for service
    - Prohibitions on self-referral
    - Collusion
    - State insurance regulators
    - Anti-trust
    - COI

ACO Basics

Accountable care organizations, soon to be a part of Medicare, pay bonuses to networks of doctors and hospitals that achieve quality goals and slow healthcare spending. Policymakers have proposed three types of ACO networks in journal articles.

<table>
<thead>
<tr>
<th>Level one</th>
<th>Level two</th>
<th>Level three</th>
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</thead>
<tbody>
<tr>
<td>• No financial risk for providers</td>
<td>• Risk for spending that exceeds targets</td>
<td>• Risk for full or partial capitation</td>
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<tr>
<td>• Shared savings bonus</td>
<td>• Greater shared savings bonus</td>
<td>• Additional quality bonuses</td>
</tr>
<tr>
<td>• Basic quality, efficiency and patient-experience measured</td>
<td>• Quality, efficiency and patient-experience measured</td>
<td>• Expanded reporting of quality, efficiency and patient-experience measures</td>
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- Government oversight
  - Establishes the Independent Payment Advisory Board (IPAB)
  - Background screenings required prior to billing Medicare
  - Overpayments reported/returned 60 days
  - Expands sunshine rules
    - Disclose ownership
    - Bans new physician-owned hospitals

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- Government oversight
  - CMS directed to reduce the fee-for-service payment error rate in half by 2012
    - November 2009 12.4% or $35.4 billion
  - HEAT (Health Care Fraud Prevention and Enforcement Action Team)
    - HHS & DOJ joint effort
  - Requires data-sharing among federal agencies.
  - Expanded RAC to Medicaid, Medicare Part D
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- Distribution of primary resources
- Government oversight
  - Expanded RAC to Medicaid, Medicare Part D and Medicare Advantage
  - Enhanced screening and oversight of providers and suppliers
- Voluntary self-disclosure protocol

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- Title VI Transparency and Program Integrity Section 6002
  - Amends SSA manufactures must report pymt or transfer of value to providers >$10
  - Applies to pharmaceutical, biotech and medical device manufacturers
  - Reporting begins 3-31-13 to preceding year
  - Manufacturers to post information searchable and downloadable
HEALTHCARE REFORM

- Title VI Transparency and Program Integrity Section 6002
  - Failure to report $1,000-$10,000 for each payment or transfer (not to exceed $150K)
  - CMP’s
  - Additional compliance requirements

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- Conflict of Interest Management
  - Review and assess institution’s COI policies and procedures
  - Consider data base for collection of disclosures
  - Develop auditing/monitoring
  - Identify COI Committee for the institution
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- Insurance Mandate
  - Congressional Budget Office predicts 4 million to pay a fine
    - $4 billion IRS
    - 2016 $695 or % of household income
  - Predict that majority of fines will come from those making more than 400% of poverty level

End of Life Decisions

- Lack of timely response
- Lack of response
- Altering (or destroying) documents
- Ignoring issues
- Misleading the government
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