12 Affordable Health Care Act 2010

The Patient Protection and Affordable Care Act (HR3590) (PPACA) was amended by the Health Care and Education reconciliation Act (HCRA) (HR 4872); both are jointly referred to as the Affordable Health Care Act of 2010. This new legislation will affect nearly every aspect of health care, and its implementation will involve the participation of federal and state governments, insurance providers, health care providers such as hospitals and employers.

Federally, the Department of Human Health Services (HHS), the Departments of Education, the Department of Labor and the Department of the Treasury will all be participating in the definitions and implementation of the new legislation.

The legislative intent was to increase access to health insurance. It expands federal private health insurance market requirements, and requires the formation of health insurance exchanges to provide individuals and small employers with access to insurance. Costs are projected to be offset by tax increases, increased revenues and reduced expenditures on Medicare and Medicaid.

Much of the Affordable Care Act (ACA) of 2010 involves insurance reform. Provisions in the legislation that will affect hospitals involve a change in how medical providers and hospitals receive reimbursement for Medicare fee-for-service (FFS) and care delivery systems. Transparency is a key component of the legislation; required program elements, reports and mandates are included to increase transparency in the health care industry. It authorizes mandatory compliance plans for hospitals and other care providers. Hospitals must have written policies and procedures for patient medical records and hospital operation records to assist in compliance according to licensure laws, federal health care program requirements and other statutes and regulations.

Additional provisions affecting hospitals include demonstration projects and grant programs to incentivize and test new methods of care delivery.

Exhibit 12-1
Upcoming Compliance Deadlines

2013	• Decrease HAC by 40 percent • Reduce hospital readmissions by 20 percent
2014	• Medicaid eligibility expands with new uniform federal income limit (33%) and inclusion of childless adults • Health Benefit Exchange required to be fully certified and operational • Lifetime and annual limits are prohibited • End of temporary high risk health insurance pools and transition to the Health Benefit Exchange • Individual mandate goes into effect
2016	• ARRA penalties for not meeting meaningful use requirements for EHRs

Reimbursement Reductions

Reimbursement payments for Medicaid will be reduced to hospitals at the same time as the number of eligible Medicaid-eligible individuals increase, exposing hospitals to the potential for significant financial hardship. Public hospitals and safety-net hospitals which serve large numbers of Medicare and Medi-Cal beneficiaries will have higher exposure to this risk. Hospitals facing the reimbursement reduction in higher income areas may fare better as they have more opportunity for cost-shifting onto their patients with private insurance. General acute care hospitals will be facing mandated payment reforms including:

- *Hospital Readmissions Payment Reductions*
  Estimated to save $8.2 billion in savings for CMS through 2019, hospitals with readmission rates higher than their risk-adjusted expected readmission rates, beginning in 2013, will face reduced DRG payments for Medicare inpatients equal to that paid for the extra readmissions. The reduced

payments will apply to three conditions for the first two years, expand to five in 2015, and can be expanded thereafter.

- *Payment Adjustments for Hospital-Acquired Conditions (HACs)*
  Medicaid will not reimburse hospitals for services related to preventable HACs (10 specific types) and other preventable injuries and illnesses. The ACA set a deadline for implementation for July of 2011 but CMS extended the compliance deadline to July1, 2012. As of 2015, a one percent DRG payment reduction for Medicare services will apply to general acute care hospitals with HAC rates in the top 25 percent of hospitals in the U.S.

- *Hospital Value-Based Purchasing Program*
  Hospitals who meet quality and patient satisfaction measures, and who have established health IT infrastructure that can use patient-specific data for analysis and reporting to CMS, will be paid $850 million in incentives. Additional measures will be added in 2014 and in 2015 Medicare physicians will face a new value-based reimbursement system. All hospitals will experience reduced DRG payments, but only those that voluntarily choose to comply will receive the incentives. Reduced reimbursement will come into effect with one percent in 2013, and will increase by 0.25 percent every year until it reaches two percent in 2017 and remains at that rate thereafter.

- *Medicaid Reimbursement for Primary Care*
  This provision creates a floor for Medicaid payments made to primary care doctors, on a temporary basis, to address the shortage of primary care and specialty physicians in the Medi-Cal program. Medi-Cal has a low participation rate for providers due to low reimbursement rates for primary care; the physician fees are the fourth lowest in the nation and are less than half of Medicare reimbursement for the same services. Additionally this provision expands medical school loan repayment programs and training opportunities.

Delivery System Reforms

Medicaid

The PPACA will raise the threshold of Medicaid eligibility in 2014, expanding coverage to individuals with incomes up to 133 percent of the federal poverty guidelines ($14,404 for an individual and $29,326 for a family of four as of 2009). New measures include a federal uniform guideline for eligibility across the US and will now require states to offer coverage to individuals without children. The legislation will offer federal financing to newly eligible persons (FMAP) on the following schedule: 100 percent for 2014 to 2016, 95 percent for 2017, 94 percent for 2018 and 90 percent for 2020 and beyond. The Centers for Medicare and Medicaid Services (CMS) will oversee the implantation of the Medicaid expansion in 2014.

National Health Service Corps

The National Health Services Corps, a federal workforce program from the ARRA, was reauthorized through 2015 under the PPACA to continue to address healthcare workforce issues such as staff shortages.

Tax Provisions

The excise tax on medical devices enacted by the PPACA was repealed. After 2012 imposes a tax on sales of any taxable medical device by the manufacturer, producer or importer equal to 2.3 percent of the selling price. A "taxable medical device" is any device intended for humans except medical devices generally purchased by the general public at retail, such as eyeglasses, contacts, hearing aids, etc.

The tax deduction for expenses earmarked for the Medicare Part D subsidy is set to be eliminated. The elimination has been delayed until 2013.

The estimated tax payment of corporations with assets of $1 billion or more will be facing increases by 15.75% in the third quarter of 2014.

Pilot Programs

Hospitals are facing more individuals who qualify for Medicare benefits at the same time that they are receiving reduced levels of reimbursement. As such, care delivery and reimbursement reforms and pilot programs are being looked at as a way to offset the costs these hospitals will incur.

Reimbursement and care delivery reforms include:

- *Medicare and Medicaid Payment Bundling Demonstrations*
  A five-year bundling pilot program where a single price is charged for medical services provided during the entire course of the episode, defined as three days prior to a hospital admission to 30 days after discharge. The single payment cannot exceed the cost of the same services outside of the bundling.

- *Partnership for Patients*
  Decrease HAC by 40 percent and reduce hospital readmissions by 20 percent by 2013. CMS estimates savings in the amount of $35 billion over three years. California hospitals are also entering the Partnership for Patients programs.

- *State Demonstrations to Integrate Care for Dual-Eligible Individuals*
  California was one of 15 states who were funded up to $1 million to align service delivery and improve the quality and patient experience for dual-eligible individuals. Successful delivery system reform will be replicated in other states.

- *Medicare Shared Savings Program (MSSP)* The MSSP Accountable Care Organization program allows for the negotiation of other payers who may be in the private sector or with other public programs to negotiate new payments and create care delivery arrangements.

- *Community-based care transitions program (CCTP)* Beginning in 2013, Medicare will stop reimbursement for readmission within a 30 day period. Partnerships between hospitals and Community Based Organizations that provide transition services and with other public health agencies can build new care systems and related infrastructure that can reduce readmissions. Available funds for the program over a five-year period is$500 million and CBOs and any hospital may submit an application to receive funds, regardless of the hospital's current readmission rate. The CCTP program fits in with the Bridge to Reform 1115 waiver.

Bridge to Reform 1115 Waiver

The State of California has come up with provisions to help the state's health care delivery system transition to all the new provisions and mandates. The federal government is granting $8 billion to California over the next five years to be used for the waiver programs. They include:

- Expansion of county-based coverage for up to 500,000 low-income individuals who will become eligible in 2014
- Required enrollment of 380,000 Medi-Cal-only seniors and persons with disabilities into fully managed care for each individual
- The Delivery System Reform Incentive Pool (DSRIP) program: Under the DSRIP program, public hospitals have access to $3.3 billion if they use the funds to improve their HIT, chronically ill patient care and care quality and to try new care delivery models.
- Creation of pilot programs to test new care delivery models for children in the California Children's Services (CCS) program.

National Prevention, Health Promotion, and Public Health Council

Established programs dedicated to promoting health and promoting disease prevention as a part of a national strategy, called the National Prevention and Health Promotion Strategy, to improve public health. These programs will be directed by the Centers for Disease Control and Prevention (CDC), and try to expand the focus of health care to include wellness and prevention instead of focusing solely on sickness and disease. ❖