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A timeline for change: A discussion of Affordable Care Act provisions

» Be aware of reimbursement changes and the timeline driven by the Affordable Care Act to take steps to preserve reimbursement to the extent possible.

» By 2015, up to 6% of hospital reimbursement will be at risk for poorly performing hospitals.

» EHR incentive payments are available until 2015, then hospitals will be subject to penalties.

» The Value Based Purchasing program has already started and reimbursement will decline, commencing October 1, 2012, unless hospitals can perform well.

» CMS will implement another penalty, based on the hospital readmission rate for certain discharges, starting October 1, 2012.

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The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act or ACA) were enacted in March of 2010, thus adopting into law many quality-related initiatives aimed at transforming our health care system from one based on volume to one based on value. Although these programs directly resulted from Congress enacting the ACA, some of the initiatives discussed in this article had foundations laid long before health care reform became law.

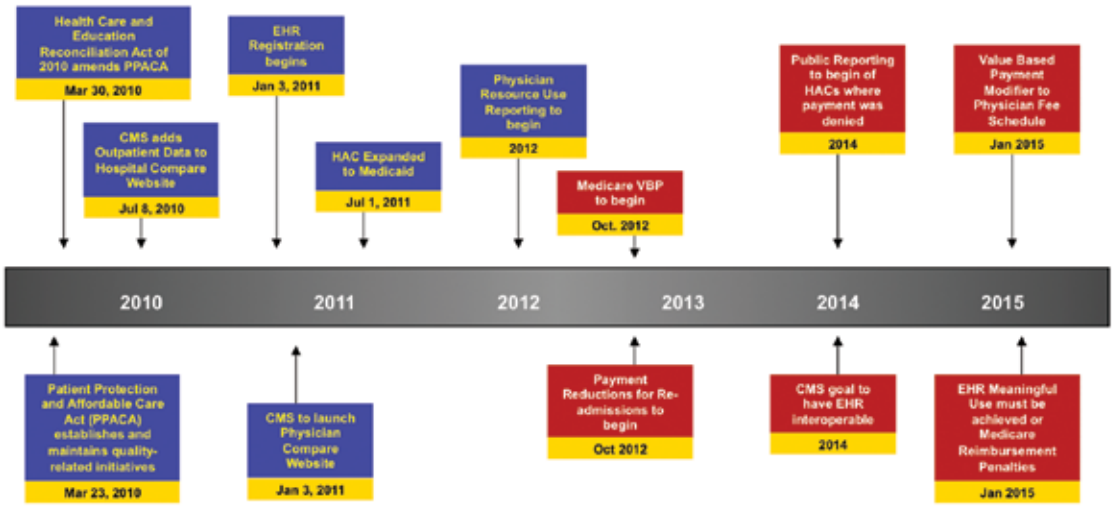
The ACA contains important changes, many of which are the subject of much public debate, including the health insurance mandate, creation of state-based insurance exchanges, and expansion of Medicaid eligibility to 133% of the federal poverty level, thereby increasing access to affordable health insurance. However, this article will focus on other ACA provisions that are less controversial and may not be known to the general public. These provisions implement certain quality-of-care initiatives most likely to directly affect how health care providers will deliver and get paid for the care they render to patients in the future.

Anderson

Van Leer

This article will describe many of the ACA's quality-of-care provisions applicable to hospitals, based on their implementation schedule. We will address each of these provisions according to the federal fiscal year in which they will be implemented, which runs from October 1 through September 30. This means that, for initiatives that commence at the beginning of a federal fiscal year, the change actually occurs October 1 of the preceding calendar year (e.g., federal fiscal year 2013 begins on October, 2012). The timeline (see figure 1, page 20) shows the

Figure 1: Timeline for implementation of various ACA programs



CMS=Centers for Medicare & Medicaid Services; DRA=Deficit Reduction Act; IOM=Institute of Medicine; MMS=Medicare Prescription Drug, Improvement and Modernization Act; QI=Quality Improvement;

implementation schedule for many of these programs.

FY2012

Bundled Payments

Starting on January 1, 2012 and running through December 31, 2016, CMS initiated a new Medicare demonstration project using bundled payments for episodes of care that may include hospitalizations, post-acute care, and physician services. Under the bundled payment pilot program, providers can opt to receive a single payment for an entire episode of care. Bundled payments align the financial incentives of those delivering care, and is intended to improve quality, reduce cost, and eliminate the fragmented delivery of care for medical conditions for which a bundled payment is used.

In order to participate in the program, providers must have submitted letters of intent no later than November 2011. Providers must then submit an application. The application for Model 1 was due November 18, 2011. The application for Models 2, 3, and 4 became available online on April 23, 2012 and must be submitted by June 28, 2012. The program will utilize four models, which vary as to scope and type of payment. These include:

- Model 1 — Retrospective bundled payment for the acute inpatient stay only
- Model 2 — Retrospective bundled payment for hospitals, physicians, and post-acute providers for an episode of care
- Model 3 — Retrospective bundled payment for post-acute care where the bundle does not include the acute inpatient hospital stay
- Model 4 — Prospective bundled payment for hospitals and physicians for the acute inpatient hospital stay only

Models 1, 2, and 3 use a retrospective payment to allow for the payment of the traditional fee-for-service amounts while care is being delivered. CMS will reconcile the retrospective payment against a pre-determined target amount for the entire episode after the episode is completed. The target price would consider the base diagnosis-related group (MS-DRG) payment including payment adjustments and outlier payments. Model 4, which uses a

prospective payment, substitutes a bundled payment instead of the traditional fee-for-service payment for the entire episode of care. The episode of care may be defined by the provider seeking to participate in the bundled payment initiative and may vary, depending on the model. In some cases, applicants may define both the length of the episode and types of beneficiaries included.

Bundled payments allow providers to share gains from efficiency improvements with those who partner with them to redesign care. In the retrospective models, CMS expects providers to discount their charges initially and increase the discounts each year. In addition, providers must adhere to certain quality measures determined by CMS before any shared savings will be distributed.

Providers and suppliers selected for bundled payments will be required to enter into agreements for a period of 3 years, with the possibility of an additional 2-year extension. A recent report issued by the Congressional Budget Office indicates that bundled payments can result in significant savings to the Medicare program.[1] CMS has published a Request for Application which includes more detail on the models and their specific criteria and can be found at *http://innovations.cms.gov/initiatives/Bundled-Payments/index.html*.

Accountable Care Organizations

One of the most talked-about components of health care reform was the implementation of accountable care organizations (ACOs). Although the industry largely rejected the proposed rules issued by CMS in April, 2011, the final rules issued in November, 2012 contain several improvements that may make the program more attractive.

Beginning in 2012, health care organizations may apply to become ACOs. ACOs are intended to be integrated, shared savings programs where participants agree to be accountable for the quality and the cost of care provided to Medicare fee-for-service beneficiaries. If they succeed, the participants in the ACO will be rewarded for keeping costs down while achieving quality and patient satisfaction goals, and they can share in a portion of the savings achieved by the ACO.

An ACO may consist of many independent providers and suppliers, including hospitals, physicians, post-acute care providers, etc. However, there must be at least 5,000 beneficiaries who receive most of their primary care services from a physician participating in the ACO. Several safe harbors grant relief to the ACO and its participants from fraud and abuse, antitrust, and tax-exemption concerns.

In the first year, an ACO's receipt of shared savings will be tied to its reporting on 33 quality measures, but in years after, the ACO's high performance on some or all of the quality measures will be required. Additionally, for the first 3-year contract term, ACOs can choose one of two tracks. The one-sided model allows the ACO to have an upside share savings opportunity without downside risk; however, the shared savings opportunity is less under this model (50% of the excess shared savings up to a cap). The two-sided model requires the ACO to share in 60% of both savings and losses, up to a cap.

ACOs cannot succeed without significant buy-in from all participants, including hospitals, physicians, post-acute care providers, etc. It is expected that the program, if successful, could result in further consolidation throughout the health care industry.

Electronic Health Record Incentive program

The Medicare and Medicaid EHR Incentive program provides payments to eligible hospitals and eligible professionals to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology. CMS will utilize the Stage 1 Meaningful Use requirements in FY2012.

Incentive payments under the Medicare program are available to eligible hospitals in 2012 (the payments actually began in 2011) if the hospital achieves meaningful use. The amount of the payment is based on a number of factors, but begins with a $2 million base payment. Hospitals still can earn the maximum pay-out for the full 4-year opportunity if they begin in 2012, but the total payments will decrease for hospitals that start receiving payments in 2014 and later. Hospitals also may participate in both the Medicare and Medicaid programs, if they meet the criteria to do so.

Assessment of community health needs

For tax years beginning after March 23, 2012, tax-exempt hospital organizations must conduct a community health needs assessment (CHNA) every three years. The assessment must include a description of the community served by the hospital facility and the health needs identified for the community. A hospital or organization that fails to satisfy the requirements related to the conduct of CHNA will be penalized through a $50,000 excise tax which, for health systems, can apply to each individual facility in the system.

FY2013

Inpatient and Outpatient Quality Reporting programs

The Inpatient and Outpatient Quality Reporting programs (IQR and OQR, respectively) were enacted by Congress to improve data collection on quality of care for hospitals. Although the programs have been around for several years, CMS will expand upon them in several significant ways in 2013. The program reduces payments by 2% of the Inpatient Prospective Payment System (IPPS) market basket update and 2% of the increase to the Outpatient Prospective Payment System (OPPS) fee schedule conversion factor for hospitals that do not successfully report on the required quality metrics. For FY2013, several new metrics have been added, and hospitals must successfully report on 57 IPPS measures and 23 OPPS measures.

Besides adding more metrics to the required reporting, beginning in FY2014, CMS plans to add a metric that evaluates spending-per-beneficiary. This metric aggregates the total spending for Medicare beneficiaries (adjusted for age, severity of illness, and other factors) using an episode of care that runs from three days prior to an inpatient admission (called an "index hospitalization") through 30 days post-discharge. The spending calculation will take into account all related and unrelated Part A and Part B services provided to Medicare beneficiaries during the episode, with some limited exceptions, such as statistical outliers and transfers from one acute care hospital to another. Although transfers from one acute care hospital to another will be excluded at first, CMS will consider inclusion of such transfers at a later date.

CMS will allocate the costs that occur during an episode, including costs attributed to a readmission during an episode of care (and any transfers to another hospital that occur during a readmission), regardless of whether the readmission is related to the index hospitalization. CMS will also attribute costs for transfers to sub-acute facilities (e.g., a skilled nursing facility or a long-term acute care hospital) to the index hospitalization.

To calculate a hospital's per-beneficiary spending amount, CMS will divide the sum of all adjusted Medicare Part A and Part B payments during each episode attributed to an index hospitalization by the total number of episodes for that hospital. The operative metric used to report a hospital's spending-per-beneficiary is the "spending-per-beneficiary ratio," which is calculated by dividing the hospital's spending-per-beneficiary amount by the median spending-per-beneficiary for all hospitals nationally. CMS will post the data for the

beneficiary spending measure on the Hospital Compare website.

Value Based Purchasing

Beginning in FY2013, Medicare's Value Based Purchasing program (VBP) officially begins, changing the diagnosis-related group (DRG) payment rates for hospitals for discharges occurring on or after October 1, 2012. Using measures already reported under the IQR, CMS will measure a hospital's level of performance to readjust DRG payment rates, rewarding high performing hospitals while penalizing those that do not perform as well.

The payments under the VBP program will come from an across-the-board reduction in hospital's DRG payments. In FY2013, a hospital's DRG payments will be reduced by 1% with an opportunity to "earn back" this amount or more, based on the hospital's total performance score (TPS). CMS will categorize measures into domains. The amount at risk under the VBP grows annually thereafter, reaching a cap of 2% by FY2017. For FY2013, CMS identified two domains that will be measured — the Clinical Process of Care domain and the Patient Experience of Care domain.

The measures in each domain will be reviewed during both a baseline period and a performance period. The baseline period is the time period CMS will use to establish both a "threshold" score and a "benchmark" score. The threshold score is the median score for all hospitals nationally during the baseline period, and the benchmark is the score for the top 10% of hospitals nationally during the same baseline period. A hospital's own baseline score is also measured, and that will be used to determine how much the hospital improved during the performance period. The baseline period for the first two domains for FY2013 is July 1, 2009 to March 31, 2010.

The performance period is the time period used to judge the hospital's performance for purposes of adjusting its DRG payments. A hospital is judged both on its improvement from its own baseline score (improvement score) and on its achievement as compared to the national threshold and benchmark (achievement score). The performance period for the Clinical Process of Care domain and Patient Experience of Care domain started on July 1, 2011 and ended March 31, 2012. Thus, hospitals will soon learn how their DRG rates for FY2013 will be changed, based on their value-based performance.

For FY2013, the Clinical Process of Care domain includes 12 measures selected from the IQR program. Some of these measures include:

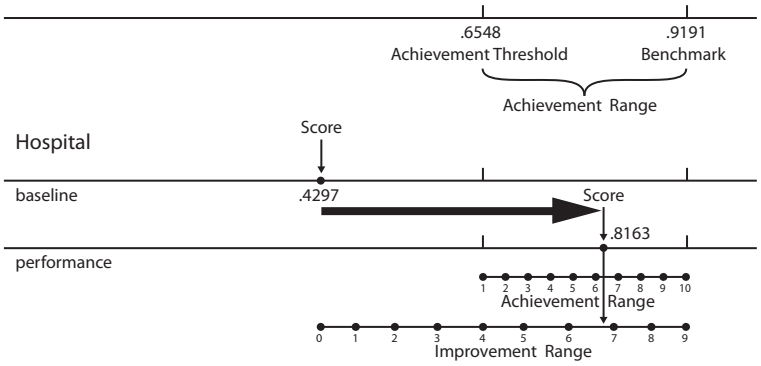
- Fibrinolytic therapy received within 30 minutes of hospital arrival for heart attack patients
- Prophylactic antibiotic selection for surgical patients
- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Blood cultures performed in the Emergency Department prior to receiving an initial antibiotic in hospital

Also for FY2013, the Patient Experience of Care domain includes eight measures from the Hospital Consumers Assessment of Healthcare Providers Survey (HCAHPS). Some of these measures include the HCAHPS' survey questions regarding:

- Communication with doctors
- Responsiveness of hospital staff
- Discharge information
- Quietness of the hospital environment

A scoring example is provided (see figure 2, page 25). Here, Hospital 1's performance improved from 0.4297 to 0.8163 in the performance period, and its achievement score is 0.8163. This puts the hospital's score above

Figure 2: Measure: AMI-7a — Fibrinolytic Therapy



Hospital earns: 6 points for achievement
7 points for improvement
Hospital score: maximum of either achievement or improvement
= 7 points on this measure

the threshold but below the benchmark, and CMS will use a formula to determine the score with that range. Thus, in the example, the hospital earns an achievement score of 6 and an improvement score of 7. CMS awards the hospital the higher of its achievement score or its improvement score. Accordingly, Hospital 1 would receive 7 points for this measure.

DRG payment rates are changed based on the hospital's TPS which aggregates the total points for each domain and divides the total earned points by the total possible points to determine the domain score. CMS will then weight each domain using a pre-set weighting methodology to determine the TPS. For FY2013, the TPS will be calculated using a weighting methodology of 70% for the Clinical Process of Care domain and 30% for Patient Experience of Care domain.

CMS conducted a "dry run" of the FY2013 VBP program in February and March 2012. There is not much a hospital can do now to influence its final DRG payment rates for FY2013, because the performance period concluded March 31, 2012, and hospitals are expected to learn of their actual DRG payment rate for FY2013 by November 1, 2012. However, the program continues each year thereafter, increasing the amount at risk for the hospital based on its performance. Thus, hospitals would be well-advised to take steps now to inject quality controls into their operations so that they can be assured of high performance going forward.

Readmissions Reduction program

The ACA established the Medicare Hospital Inpatient Readmissions Reduction program, which will further reduce DRG payments for acute care hospitals that have higher-than-expected readmission rates for certain conditions. Under the program, CMS will reduce hospitals' base operating DRG payments by an adjustment factor that accounts for excess readmissions. The payment reduction is capped at 1% in FY2013, but increases to 3% by FY2015. The measures that will be evaluated for excess readmissions for the first year of the program include the 30-day risk standardized readmission measures for acute myocardial infarction (AMI), heart failure, and pneumonia.

For purposes of this program, readmissions are those that occur within 30 days from a discharge, which is the same timeframe currently used for readmission measures under the IQR program. Notably, all related readmissions within this timeframe will be counted, unless

they meet some limited exceptions. Many of the details of the program are undefined, and CMS plans to finalize the remaining details of the program in its FY2013 rule-making cycle.

Independent Payment Advisory Board

One of the more controversial provisions of the ACA was the creation of the Independent Payment Advisory Board (IPAB) which was designed to stem the growth of Medicare spending. The IPAB is intended to be responsible for recommending reductions in spending growth. Although IPAB is prohibited from recommending changes that would ration care or increase taxes, cost-sharing requirements, or beneficiary premiums, many fear that these limitations will not be followed, and there is widespread concern that too much authority is delegated to the IPAB.

The ACA requires the 15-member IPAB board to make specific recommendations annually to reduce spending growth if the projected Medicare growth rate exceeds the projected annual target determined by the chief actuary of CMS. These recommendations must be given to Congress and the President by January 15 each year. Congress can either adopt the IPAB's recommendations or enact changes that result in the same savings for Medicare. If Congress fails to act, however, Health and Human Services (HHS) *must* implement IPAB's proposals by August 15 of the same year, without any further review by either the courts or the Executive branch of government. Thus, in the absence of Congressional action, recommendations by the IPAB automatically become law. The ACA requires that the IPAB begin its work in 2013, with 2015 targeted as the first year that its recommendations would be implemented.

The future of the IPAB is presently uncertain, as several proposals have been made to repeal its creation.[2] In fact, the Medicare Decisions Accountability Act of 2011, approved by the House Energy and Commerce Committee, includes among its provisions the repeal of the IPAB. In addition, President Obama has not appointed any members of the IPAB yet, and the Secretary of HHS indicated that it is unlikely IPAB will make recommendations before 2018.

Electronic Health Record Incentive program

Full incentive payments are still available to eligible hospitals in 2013, but they begin to be phased down, using a transition factor over a 4-year period beginning in 2014. On February 23, 2012, CMS released the proposed rule for Stage 2 Meaningful Use rules, which CMS plans to implement in FY2013 for many providers who are to advance to Stage 2. However, in the proposed rule, HHS announced that it may delay implementation of the Stage 2 requirements for providers that began participation in 2011.

FY2014

Value Based Purchasing

Beginning in FY2014, 1.25% of DRG payments will be at risk under VBP. CMS also will add a new Outcomes domain to the VBP, which will consist of three mortality measures using a baseline period of one year (from July 1, 2009 to June 30, 2010), and a similar year-long performance period of July 1, 2011 to June 30, 2012. The scoring and other metrics under the VBP are not expected to change for FY2014, but CMS will adjust the weighting of the domains as follows:

- Clinical Process of Care domain — 45%
- Patient Experience of Care domain — 30%
- Outcomes domain — 25%

Payment cuts

In FY2014, the individual mandate under the health reform law begins, which is expected to reduce the amount of uncompensated care for most hospitals. Thus, in FY2014, the Medicare Disproportionate Share Hospital

(DSH) payments will be cut across the board, but the DSH payments to a specific hospital may increase subsequently, based on the percent of the population that is uninsured and the amount of uncompensated care that the hospital provides. This is meant to compensate hospitals that do not see the expected reduction in uncompensated care and thus shoulder a larger proportion of the burden of providing uncompensated care. Similarly, the ACA also mandated a reduction in state Medicaid DSH allotments. HHS is required to develop a methodology for distributing these DSH reductions in manner that imposes the largest reductions for those states with the lowest percentage of uninsured.

DSH payments are based on a complex statutory formula meant to give additional compensation to hospitals that provide a high percentage of care to indigent patients. These reductions are anticipated to total $22.1 billion over 10 years. The cuts are meant to offset increases in insured individuals as a result of the individual mandate and Medicaid expansion taking place in FY2014. Many hospitals are concerned about the impact these reductions may have on their bottom-line. This is particularly true for public hospitals and other safety-net providers.

Electronic Health Record Incentive program

EHR incentive payments to eligible hospitals also continue in 2014; however, CMS will apply a transition factor that reduces the incentive payment to 75% of what otherwise would have been paid, as if 2014 were the second payment year for the hospital. Thus, hospitals beginning participation in 2014 will not realize optimal payments under the EHR incentive program.

FY2015

Value Based Purchasing

In FY2015, 1.5% of hospital DRG payments will be at risk under the VBP program. There

Timeline Takeaways

The focus on changing payment policy in the name of value and improving patient outcomes will likely pose difficulties for many providers, because these changes are occurring rapidly. Nevertheless, many of these initiatives, albeit challenging, are expected to make valuable improvements to our health care delivery system. These policy changes, like many others, can also cause hospitals a significant loss of revenue, unless they have taken steps to perform well under them. This requires constant vigilance to learn about the changing rules and active efforts to change how care is delivered to ensure high-level performance.

- 2012
  - Bundled Payment program begins
  - ACOs and Shared Savings program begin
  - Hospitals may be eligible for full payout of the EHR incentive
  - A community health needs assessment is required every three years, or a $50,000 penalty may be assessed
  - 2% Medicare market basket update payment reduction (IPPS) for failing to report IQR measures
  - 2% Medicare market basket update payment reduction (OPPS) for failing to report OQR measures
- 2013
  - 2% Medicare market basket update payment reduction (IPPS) for failing to report IQR measures
  - 2% Medicare market basket update payment reduction (OPPS) for failing to report OQR measures
  - Hospitals must begin demonstrating meaningful use of EHR this year to receive full pay-out
  - IPAB program begins
  - 1% decrease in Medicare DRG payments (to fund VBP program)
  - 1% penalty (decrease in base operating DRG payment) for hospitals with higher-than-expected readmissions

(continued on next page)

Timeline Takeaways *(continued)*

- 2014
  - 2% Medicare market basket update payment reduction (IPPS) for failing to report IQR measures
  - 2% Medicare market basket update payment reduction (OPPS) for failing to report OQR measures
  - Hospitals may still begin participation in the EHR Incentive program, but payments will be subject to a 25% reduction
  - 1.25% decrease in Medicare DRG payments (to fund VBP program)
  - 2% penalty (decrease in base operating DRG payment) for hospitals with higher-than-expected readmissions
  - 1% penalty for hospitals in top 25% for HACs
  - DSH payment cuts begin
- 2015
  - 2% Medicare payment reduction (IPPS) for failing to report IQR measures
  - 2% Medicare payment reduction (OPPS) for failing to report OQR measures
  - 1% penalty for hospitals in the top 25% for HACs
  - 3% penalty (decrease in base operating DRG payment) for hospitals with higher-than-expected patient readmissions
  - Hospitals may still receive reduced EHR incentive payments if they begin participation in 2015, but payments will be reduced by 50%. Hospitals that do not successfully demonstrate meaningful use will be subject to a 25% reduction market basket update.
  - 1.5% decrease in Medicare DRG payments (to fund VBP program)

are also certain hospital-acquired conditions (HAC) measures and Agency for Healthcare Research and Quality (AHRQ) patient safety indicators, inpatient quality indicators, and composite measures that had been proposed by CMS to be added to the Outcomes domain for FY2014, but then were withdrawn. It is likely that CMS may include these measures in future years, possibly as early as FY2015.

Furthermore, CMS intends to incorporate a fourth, Efficiency domain, which is expected to be included by 2015. This domain will likely consist of the spending-per-beneficiary measure added to the IQR program in FY2013, which CMS proposed to add to the VBP for FY2014, but then was withdrawn.

Electronic Health Record program

Hospitals may still receive an EHR incentive payment in 2015, but it will be subject to a reduction factor of 50%, due to the application of the transition factor. Hospitals that do not successfully demonstrate meaningful use will incur a 25% reduction of their market basket update. This penalty increases each year thereafter if meaningful use is not achieved, until, by 2017, 75% of the market basket update is at risk.

Hospital-acquired conditions

One component of lowering health care costs and improving outcomes is penalizing hospitals if a patient experiences a complication that is deemed to be reasonably preventable and was not present on admission. Thus, under current payment policy, hospitals do not receive the additional payment for treating a patient's complications if one of several hospital-acquired conditions (HACs) occurs during a hospital admission.

Starting in FY2015 (beginning with discharges on or after October 1, 2014), hospitals will incur a 1% penalty of their total Medicare payment if the hospital ranks in the top 25% nationally for HACs. This information will also be posted publicly. A hospital will be compared with the national average to determine if it falls in the top quartile.

1. Lyle Nelson: Congressional Budget Office, Lessons from Medicare's Demonstration Projects on Value-Based Payment (2012). Available at http://www.cbo.gov/publication/42925