# Provider Reimbursement Changes in Healthcare Reform Law

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The new healthcare reform law – Public Laws (PL) 111-148 and 111-152 – make numerous changes to the ways Medicare and Medicaid reimburse healthcare providers. Such changes were designed not only to help pay for the expansion of health insurance coverage to 32 million new individuals, but also to create more efficiency within the healthcare system.

The following report breaks down several notable reimbursement changes within major sectors of the industry. Such changes will largely be implemented and administered in the coming months and years by the Centers for Medicare and Medicaid Services (CMS).

## HOSPITALS

As the various provisions of the new law are implemented, hospitals will likely need to make a variety of operational changes, but as a whole the industry fares reasonably well under the new law.

### Readmissions Policy

Under Section 3025, a new Medicare readmissions policy will subject hospitals with readmission rates over a certain threshold to payment penalties. Slated to begin in FY 2012, the expected impact of this section on hospitals is approximately $7 billion.

This provision would adjust payments for hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) based on the dollar value of each hospital's percentage of potentially preventable readmissions for the three conditions with risk-adjusted readmission measures that are currently endorsed by the National Quality Forum – acute myocardial infarction, heart failure, and pneumonia.

### Value-Based Purchasing

Under Section 3001, a new value-based purchasing program for hospitals will require a percentage of Medicare payments for some common, high-cost procedures (such as cardiac, surgical and pneumonia care) to be tied to quality. The program begins in FY 2013, and quality measures included in the program will be developed and chosen with input from external stakeholders.

Funding for the program will come via reductions in Medicare IPPS payments of 1% in FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016 and 2% in FY 2017 and beyond.

### Disproportionate Share Hospitals

The majority of the reimbursement cuts that will affect hospitals are in the Disproportionate Share Hospital (DSH) payment system that pays hospitals based on their volume of charity care. Cuts are slated to begin in FY 2014, and the Medicare and Medicaid DSH reductions will equal approximately $36 billion over 10 years.

However, it is important to note that these reductions will not materialize until after the number of insured individuals has increased, and that reducing DSH payments will be directly based on lower levels of uncompensated care costs. The law directs the Secretary of Health and Human Services (HHS) to develop the methodology for reducing DSH allotments to all states in order to achieve the mandated reductions. More information will be available when these regulations are proposed.

### Hospital-Acquired Conditions

Section 3008 requires Medicare reimbursement penalties to begin in FY 2015 for hospitals with high rates of conditions or infections acquired while in the hospital (those hospitals in the top 25th percentile). The expected impact on the industry is $1.4 billion.

This provision also requires the HHS Secretary to submit a report to Congress by 2012 on the establishment of a healthcare acquired condition policy related to other Medicare providers, such as ambulatory surgical centers, nursing homes, long-term care facilities, health clinics, outpatient hospital departments and inpatient rehabilitation facilities.

**Market Basket Reductions**

The healthcare reform law reduces annual market basket payment updates for hospitals, in addition to inpatient rehabilitation facilities, nursing homes, home health providers and others. The slated reductions are 0.25% in FY 2010 and FY 2011, 0.2% in FY 2012 and FY 2013, 0.3% in FY 2014, 0.2% in FY 2015 and FY 2016, and 0.75% in FY 2017 through FY 2019. In addition, hospitals and other providers face the instatement of a "productivity adjustment" to the market basket update, estimated to be about a one percentage point reduction in the market basket update each year beginning in 2015.

In total, hospitals will see more than $100 billion in market basket reductions.

## POST-ACUTE CARE

Home care and hospice providers will not fare as well as hospitals under the new healthcare reform law. In a nutshell, they will not see any direct expansions but will face Medicare cuts of nearly $40 billion over 10 years.

**Market Basket Reductions**

Similar to the reductions that hospitals will face, home health providers will face a reduction in the home health market basket update by one percentage point in 2011 – 2013, and will face the same "productivity adjustment" to the market basket update, estimated to be about a one percentage point reduction in the market basket update each year beginning in 2015.

Section 3131 of the law will direct the HHS Secretary to improve payment accuracy through rebasing home health payments starting in 2014, based on an analysis of the current mix of services and the intensity of care provided to home health patients. This provision will also place a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments.

**Independence at Home Program**

On a more positive note, Section 3024 of the new healthcare law establishes the Independence at Home demonstration program, which will allow for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician-directed home-based primary care teams that aim to reduce expenditures and improve health outcomes.

## LAB COMPANIES

Lab companies avoided an industry tax in healthcare reform due to their upfront agreement on Medicare payment reductions. Clinical labs will see a 1.75% reduction in their payments over the next five years and, on a more positive note, lab companies will see a one-year exemption from the recommendations of the newly established Independent Payment Advisory Board (see below).

## INDEPENDENT PAYMENT ADVISORY BOARD

2015 will see the establishment of an Independent Payment Advisory Board to develop and submit proposals to Congress aimed at reducing excess cost growth and improving quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Such alternative provisions could be considered by Congress on a fast-track basis.

Once established, the recommendations of this board will have implications throughout the various sectors of the healthcare industry, as reimbursement reductions will likely be recommended in order to keep the Medicare program on a sustainable course.

As CMS and HHS begin the arduous task of implementing the aforementioned reimbursement adjustments, in addition to the remainder of the 2,000+ page healthcare law, we will continue to monitor this detail-oriented process and provide updates as notable developments occur.