

How Will Hospitals Be Affected by Health Care Reform?

Timely Analysis of Immediate Health Policy Issues

July 2010

Robert Berenson and Stephen Zuckerman

Given how many sectors make up the hospital industry, including nonprofit and for-profit community hospitals, teaching hospitals, and safety net hospitals, it is likely that the effects of reform will not be felt uniformly across all hospitals. Some types of hospitals have historically provided more care to uninsured patients, and these hospitals are likely to gain the most in terms of revenue increases for the mostly uncompensated care they have been providing to these patients. Analysis we have done based on results from an Urban Institute microsimulation model suggests that the roughly 30 million newly insured Americans would generate approximately \$40 billion in new revenues for all hospitals by 2019.¹ However, the coverage expansions were paid for, in part, by hospitals agreeing to accept slower growth in Medicare payment rates and to forgo certain special payments that have been made under Medicare and Medicaid to offset the costs of uncompensated care. The Congressional Budget Office's (CBO) projections of the amount of these forgone revenues suggests that, as a group, hospitals will not be giving up very much more, if any, revenues than they will gain from newly insured patients (discussed below).

Some criticism of the legislation as it relates to hospitals, e.g., from leadership at the Mayo Clinic,² has focused on the lack of broad-based and decisive change in payment

Improved quality of care and changes in payment will likely result from reform, but most hospitals won't see much difference in their bottom line.

approaches under Medicare, particularly related to not altering the basic inpatient payment method based on diagnosis-related groups. Although there are a number of mandated pilots of new payment models, for the most part, they would build on established payment methods and provide incentives at the margin for altering behavior, e.g., for reducing rates of readmissions while still receiving payment for the readmissions.³ Even under the mandated "shared savings" approach to testing accountable care organizations (ACOs), hospitals remain profit centers with a strong business case for keeping beds full and employing service-line strategies for generating volume, contributing to what some have called a "medical arms race."

Payment Changes in Medicare and Medicaid

The basic agreement referred to above reduces Medicare's annual market basket updates for a range of providers, including hospitals, home health, skilled nursing facilities, hospices, inpatient rehabilitation and other providers. (Hospitals in some cases include these other provider types.) Across all of these providers, CBO projects that Medicare will save \$40.5 billion relative to the current

payment baseline in 2019 as a result of limiting the annual updates.⁴ The policy theory underlying these reduced updates was to take savings based on an assumption of economy-wide productivity improvements. Hospitals account for a little less than 50 percent of Medicare spending, excluding physician services and prescription drugs. This implies that hospitals will receive roughly \$20 billion less in Medicare revenues in 2019 than they would under current rules, about half our projected increase in hospital revenues from the coverage expansion.

An Independent Payment Advisory Board (IPAB) will be established in 2014 and will recommend policies to reduce Medicare spending in any year in which the Medicare *per capita* spending growth rate exceeds a target growth rate. These recommendations would most likely be related to adjusting payment rates and would become law unless Congress passed an alternative proposal that achieved the same level of budgetary savings. Of particular note and consistent with the role the hospital industry played in negotiating with policy makers, hospitals and certain other provider types that experienced significant reductions in their market basket updates in the legislation are exempt



Robert Wood Johnson Foundation



from the Board's jurisdiction through 2019. This would limit the potential impact of IPAB during its early years.

Effective 2014, Medicare Disproportionate Share Hospital (DSH) payments will be reduced initially by 75 percent and subsequently adjusted based on the percent of the population uninsured and the amount of uncompensated care provided. Beginning also in 2014, Medicaid DSH will be reduced starting with relatively small amounts—\$0.5–0.6 billion in aggregate from 2014 to 2016 and increasing to \$5.6 billion in 2019.⁵ Effective in October 2011, the U.S. Secretary of Health and Human Services (the Secretary) is to develop a new Medicaid DSH allocation method to accomplish a number of policy objectives, consistent with financing the expanded coverage under the Act. This new method is supposed to take into account the percentage of the state's population that is uninsured, current levels of DSH spending, and the use of DSH funding in Medicaid waiver programs. Given that current DSH allocations are not explicitly related to the size of the state's uninsured population, this could lead to a substantial reallocation in Medicaid DSH payments across states.

New Payment Incentives

Although Medicare's hospital payment system remains in place and does not substantially alter payment incentives, there were some changes. Two provisions of the law would give hospitals a greater incentive to promote high quality care and avoid unnecessary readmissions. Specifically, starting in 2013, Medicare payments will be reduced for hospitals with high rates of potentially preventable readmissions, initially for three conditions: acute myocardial infarction, heart failure, and pneumonia, the three conditions

with risk-adjusted readmission measures currently endorsed by the National Quality Forum. The hospital's actual readmission rate for these conditions will be compared to its expected readmission rate, and the hospital will be subject to a reduction in Medicare payment for its "excess readmissions." The Secretary will make the information on each hospital's readmission rates available to the public after hospital review for accuracy. CBO estimates that this payment adjuster would save \$7.1 billion over 10 years. In addition, the law would continue the policy of denying Medicare payment for treatments associated with hospital-acquired conditions and extend this policy from Medicare to Medicaid. This should encourage hospitals to create systems that would lower the incidence of hospital-acquired conditions and, thereby, improve quality of care. CBO estimates this would save \$1.4 billion, but that none of this would come from Medicaid.

Pilot Programs for Improving Quality and Health System Performance

Effective in 2012, hospitals may participate in ACOs, which are intended to develop approaches to providing high quality care while allowing providers to share in the cost savings they achieve for the Medicare program. ACOs can be thought of as a set of providers, including primary care physicians, specialists, and/or hospitals, who bear responsibility for the cost and quality of care delivered to a subset of traditional Medicare program beneficiaries.⁶ This entity would have to control traditional Medicare spending by providing financial rewards for good performance based on comprehensive monitoring of quality and spending. Any Medicare savings that emerge

from these ACOs would be shared with the providers. Although many details of this policy need to be worked out, CBO projected that Medicare would save \$4.9 billion as a result of this "shared savings" model that is built on standard program payments. However, the Centers for Medicare and Medicaid Services (CMS) may also test other payment models for ACOs, including partial capitation.

Several provisions aimed at improving efficiency could begin building a structure that would contain costs in the future, but were not scored by CBO as producing savings during the first 10 years of reform. CMS is to start a pilot program in Medicare to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and extends to 30 days after discharge. As a pilot, if it is proved successful at reducing spending without compromising quality, CMS can extend the program broadly as early as three years after initiation of the pilot, which is to begin by 2013. The law also requires that the Secretary develop approaches to value-based purchasing that provide incentives to hospitals and physicians who achieve certain pre-set quality targets.

Two new demonstration projects affecting hospitals will also take place in Medicaid: paying bundled payments for episodes of care that include hospitalizations and making global, capitated payments to safety net hospital systems.

Graduate Medical Education

Some hospitals will also be affected by provisions for increasing the number of Graduate Medical

Education (GME) training positions by redistributing currently unused slots under the cap set in the Balanced Budget Act of 1997, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios, effective 2011. The law also allows for flexibility in using GME funding to permit residency programs to promote more training in ambulatory care settings, effective 2010. These provisions would add about \$1.1 billion to government spending over 10 years.

Requirements for Nonprofit Hospitals

Given increasing concern about whether nonprofit hospitals provide the kind of community benefits commensurate with their nonprofit status and the coverage expansion that will take place, the law imposes additional requirements on nonprofit hospitals to conduct community needs assessments every three years and to adopt an implementation strategy to meet the identified needs. The law also contains a number of provisions that guide hospitals' adoption and application of financial assistance policies, including limiting charges to uninsured patients.

Conclusion

For the most part, the payment changes that affect hospitals are related to somewhat reduced payment updates based on current payment methods and the introduction of new, marginal incentives designed to move in the direction of rewarding better performance. In this way, there is a modest move in the direction of paying for value rather than volume. More substantial payment change, such as using forms of global payments that should produce more fundamental alteration in hospitals' business model which relies on filling beds, will be tested in pilots and demonstrations. And with hospitals exempt from IPAB's jurisdiction over budget cutting until 2019, most hospitals will likely benefit financially because of the coverage expansions.

Notes

¹ Our microsimulation model indicates that each newly insured person will spend, on average, \$2,000 more than they had when they were uninsured (in 2010 dollars). If we inflate this by the CMS actuaries' 73.2 percent projection of aggregate growth in personal health care spending, we find \$3,464 in new spending by each newly insured person. Since hospital spending will account for roughly 37 percent of personal health care spending in 2019, each newly insured person should add a little less \$1,300 dollars to hospital revenues. Using CBOs projection of 32 million fewer uninsured people suggests that hospital revenues would increase by roughly \$40 billion.

² Mayo Clinic, *A Perspective on Current Health Reform Issues from Mayo Clinic*, March 19 2010, <http://healthpolicyblog.mayoclinic.org/2010/03/19/mayo-clinic-health-reform-legislation/>.

³ A summary of the new health reform law is available at <http://www.kff.org/healthreform/8061.cfm> (Kaiser Commission on Medicaid and the Uninsured).

⁴ Congressional Budget Office, letter to the Honorable Nancy Pelosi providing an analysis of the reconciliation proposal, March 20, 2010, <http://cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

⁵ Congressional Budget Office, March 20, 2010. All subsequent cost estimates of the various provisions in the Patient Protection and Affordable Care Act are drawn from this source.

⁶ Kelly Devers and Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, Urban Institute Policy Brief, October 2009.

The views expressed are those of the authors and should not be attributed to any campaign or to the Robert Wood Johnson Foundation, or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgments

Robert Berenson, M.D., is an institute fellow and Stephen Zuckerman is a senior fellow in the Health Policy Center of the Urban Institute.

This research was funded by the Robert Wood Johnson Foundation. The authors would like to thank John Holahan for his input on estimating the impact of health reform on hospital revenues and helpful comments he provided on earlier drafts of this brief.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 35 years, the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.