LEADERSHIP MATTERS

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Supreme Court Rules on Healthcare Reform Law

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On June 28, 2012 in one of the most anticipated decisions in many years, the United States Supreme Court voted by a 5-4 majority to uphold major provisions of The Patient Protection and Affordable Care Act of 2010 (PPACA). Led by Chief Justice John Roberts, the Supreme Court concluded that the "individual mandate," one of the most controversial aspects of the law, was constitutional as a valid exercise of the Federal government's taxing power. In addition to upholding the requirement that all individuals maintain some sort of insurance coverage, the Court also sanctioned the expansion of Medicaid provided under the PPACA. Importantly, however, the Court held that the Federal government could not withhold Medicaid funds from States that choose not to expand Medicaid coverage pursuant to the PPACA. How that aspect of the Court's ruling impacts Medicaid expansion will likely be a State-by-State issue. The stage is now set for the PPACA to continue to be one of the key issues in the upcoming Presidential and Congressional elections.

In upholding the PPACA, the Court ensured that healthcare reform under the Act will continue, at least until the Federal elections this November. This removes some of the uncertainty under which healthcare providers have been acting while the legal challenge was pending.

Healthcare providers should now proceed with the expectation that the PPACA will be implemented according to schedule. While the upcoming election could change things, it would take a Republican sweep of the Presidency and both Houses of Congress to even begin the process of repealing provisions of the PPACA.

In order to best prepare financially, hospitals should pay special attention to the following areas as the PPACA is fully implemented. Now is the time for improved clinical and financial collaboration to be proactive in improving patient care delivery models while minimizing financial penalties today and in future years.

1. The Hospital Readmission Reduction Program commences on October 1, 2012. The initial focus will be on readmissions related to heart attack, heart failure and pneumonia. Hospitals with higher than expected readmission rates will experience reductions in their Medicare rates. It is expected that the Federal Fiscal Year (FFY) 2013 financial impact of the Readmission Reduction Program totals $300 million nationally. Hospitals can also expect up to a 2% reduction in base DRG rates in 2014 and up to a 3% reduction in base DRG rates in 2015. CMS will expand the program to include COPD, CABG, PTCA and other vascular procedures. It is estimated the readmission payment reductions will total $7.1 billion over ten years. There are very few hospitals nationally that will not experience a payment reduction. Hospitals focused on the reduction of readmissions are best positioned to limit the financial impact of this program.

2. The Value Based Purchasing (VBP) program will reward hospitals that deliver high quality care with value based incentive payments to hospitals that meet specified performance standards. These standards will begin with a subset of the measures in the current Pay for Reporting program but will be expanded to include efficiency and outcome measures. Effective October 1, 2012, all hospitals will experience a 1% reduction in base DRG rates. Incentive payments will then be made to the qualifying providers. In other words, hospitals will need to "earn their money back".

3. Beginning in FFY 2012, CMS publically reported the first eight hospital acquired conditions under the inpatient quality reporting program. Beginning October 1, 2014, hospitals in the top quartile with respect to national HAC rates will experience a 1% payment reduction in base DRG rates.

4. Hospitals should prepare for changes to Medicare Disproportionate Share Hospital Reimbursement, which under the PPACA is set to begin on October 1, 2013. Those changes will reduce Medicare DSH payments to 25% of their current levels.

5. Hospitals should pay greater attention to the Medicare Cost Report Worksheet S-10, which reflects uncompensated care provided by a hospital. In conjunction with the decrease in Medicare DSH payments, an uncompensated care fund is being created. Although it is unclear exactly how the Centers for Medicare and Medicaid Services will determine how to allocate that fund, it is likely that the S-10 will pay a role in that allocation. The S-10 also is a significant determinant of Electronic Health Record payments to hospitals.

6. State-by-State changes in Medicaid will likely accelerate following the Supreme Court's decision. Many States had held up implementing Medicaid changes and expansion until a final decision on the PPACA's constitutionality was issued. Now that the constitutionality has been settled, expansion measures will become more prominent. Hospitals should work with their Associations and other advocates to attempt to shape these expansion efforts to ensure that providers' views are considered in the expansion. Once the specifics of each State's expansion become clearer, hospitals will have to work with consultants and internal staff to adjust to those changes.

7. Some States have stated that despite the Supreme Court's ruling, the State will not implement various provisions of the PPACA. This puts hospitals in a very precarious position. With DSH funding scheduled to be reduced, if a State does not take steps to implement the PPACA, it is possible that hospitals in such a State will also be excluded from the new uncompensated care pool. The impact on hospital funding could be substantial. Hospitals should work closely with their advocates to ensure that any State that wants to register its continuing objection to the PPACA does so in a manner that does not hurt hospitals and other providers in the State.

Hospitals will experience Medicare payment reductions in just a few months. Additional reductions will continue over the next few years. It will imperative for hospitals to focus on these areas to minimize the financial impact wherever possible.

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