Children’s Hospital Affinity Group Brown Bag

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Healthcare Reform and Its Impact on Children’s Hospitals

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Introduction

- This is a broad overview!
- Citations to health reform law:
  - P.L. 111-148: Patient Protection and Affordable Care Act (PPACA)
  - Manager’s Amendment- Section 10,000s
  - P.L. 111-152: Health Care and Education Affordability Reconciliation Act of 2010 (HCERA)
- Focus on issues of significance to children’s hospitals
- Due to time constraints, will not cover insurance market reforms
Overall Approach

- The Patient Protection and Affordable Care Act attempts to extend health insurance to most U.S. citizens and legal residents
  - Expansion of the Medicaid program
  - Creation of new market through Exchanges – small group and individual
  - Employer coverage; individual / employer incentives and penalties
- The most ambitious element comes on line Jan. 1, 2014
- During 2010 – 2014, the law seeks transformation of the U.S. health delivery system from pay-for-procedures to paying for quality
- Relies heavily on the states to expand Medicaid and establish Exchanges
Give Me a Baker’s Dozen, Please!

- Expansion of coverage
  - Individual and employer “mandate”
- Expansion of public programs
- Tax changes
- Exchanges
- Changes to private insurance coverage
- State implementation
- Cost containment initiatives

- Quality / improve health system performance
- Invest in prevention / wellness
- Workforce
  - Invest in primary care delivery
- Improvement to Medicare
- False Claims Act and fraud
- Physician ownership exception / Stark Law
Reform Issues of Significance to Children’s Hospitals During the Debate

- CHIP reauthorization
- Medicaid FMAP support to states
- Medicaid DSH
- Pediatric physician reimbursement rates – specialists
- Medicaid delivery reform initiatives
- Enhanced workforce support for pediatric training
- 340B drug and orphan drug inclusion
PPACA Implications on Children’s Hospitals

- Increased coverage and demand for pediatric care
  - Anticipated 8 M currently uninsured children accessing system by 2014 with significant proportion covered by children’s hospitals

- Financial and delivery system reform
  - Will potential efficiencies positively impact academic medical center and children’s hospitals sufficient to offset other decreases
  - Pediatric ACO demonstration

- Medicaid reimbursement
  - Increase for primary care
  - Decreases in facility reimbursement; APR-DRGs

- Medicaid DSH reduction
Pediatric Coverage

- CHIP & Medicaid serve as major insurers for pediatric population
  - According to the Robert Wood Johnson Foundation, the number of uninsured among children dropped from 12.5% in 1999 to 9.9% in 2008 due to gains in Medicaid / CHIP

- Children’s hospitals rely on Medicaid / CHIP payment for a large proportion of admissions
PPACA / Medicaid and Kids

- States prohibited from cutting eligibility for Medicaid / CHIP between now and 2019 – Maintenance of Effort provisions (cuts will result in loss of all federal Medicaid funding)
- CHIP is maintained through 2019
- CHIP block grant $$ must be reauthorized post 2015
- Private insurers must offer coverage for children with pre-existing conditions – 9/23/10
- 1 in 3 kids eligible for either CHIP or Medicaid but unenrolled in 2007
- In 2014, children below 133% FPL must be in Medicaid
- Exchange: role in future of Medicaid / CHIP
Medicaid / CHIP

- CHIP authorized and funding extended through 9/30/2015 (as opposed to 2013)
- States that run out of CHIP allotment required to screen for Medicaid coverage
- States required to use Modified AGI for Medicaid
  - No longer permitted to apply income disregards or assets tests
- States required to continue MOE in place as of enactment (3/23/10)
- Permits hospitals to make presumptive eligibility determinations for Medicaid populations (eff. Jan. 2014)
Medicaid / CHIP

Enhanced FMAP for Medicaid and CHIP

- Education Jobs and Medicaid Assistance Act (P.L 111-226) 8/10/10
  - Extends increased FMAP under ARRA through 6/30/11
- 23% increase in FMAP for CHIP up to 100% of costs in 2015
- Physician reimbursement increased to 100% of Medicare payment rates for 2013 – 2014. Payment will be 100% of matching funds for difference in payment above state’s rates for services in place 7/1/09
  - Applies to primary care, defined to include family medicine, general internal medicine and pediatrics
- Medicaid and CHIP Payment Advisory Commission (MACPAC)
  - Created under CHIPRA
  - Funded and expanded under PPACA
Recessionary Impacts on State Medicaid Programs

- Will FMAP be extended beyond 6/30/11?
- Budget crisis in most Medicaid programs
  - Medicaid caseload and growth high
  - State revenues weak
- Within Medicaid agencies, fiscal, administrative and provider capacity to implement health reform is growing concern
- Bundled or fixed payments → need to seek control over more $$
- Commercial payors – reductions in costs and escalation in desire to push off risk
- Talent / training shortages
- Increased competition
Medicaid Delivery Reform

- Payment adjustment for HACs (§ 2702)
- State option to provide medical homes for chronic conditions (§ 2703)
- Demonstration project to evaluate integrated care around hospitalization (§ 2704)
- Medicaid global capitated payment model (§ 2705)
- Pediatric ACO (§ 2706; cross-ref. to § 3022)
Medicaid Delivery Reform

- HACs
  - Secretary shall identify current state practices that prohibit payment for healthcare-acquired conditions
  - Eff. 7/1/11
  - Prohibition of payments to states
  - May use Medicare program as guide, but make program-appropriate exclusions

§ 2702
Medicaid Delivery Reform

Health Homes

- Jan. 1, 2001, a state may provide a “team of healthcare professionals” as a “health home”
- Payments will be made to a designated provider or team
- May be tiered
- May be capitated or alternative model
- Monitoring: state must include method to track avoidable hospital readmissions and calculate saving resulting from improved care coordination and management; and HIT
- Providers must report on quality measures developed by Secretary, as condition for payment
Medicaid Delivery Reform

- **Global Payment Demonstration Project**
  - Participating states shall adjust payments to eligible safety net hospital systems or networks from FFS to global capitated payment model
  - 2010 – 2012; 5 states
  - Evaluation component by CMS Innovations Center to evaluate healthcare quality outcomes and spending
Elements of Pediatric ACOs

- Secretary to establish demonstration project
- January 1, 2012 – 2016
- Secretary consults with states and pediatric providers in establishing pediatric quality guidelines
- Minimum level of savings in expenditures for items and services in Medicaid and CHIP
- 3 year period
Elements of ACOs (§ 3022)

- Accountable care organizations (ACOs)
  - Must have a group of providers who have established a method for shared governance
  - Qualifying criteria, bundled payment and bonus structure aimed at encouraging greater clinical integration by providers, physicians and suppliers
  - Who qualifies?
    - ACO professionals in a group practice
    - Networks of individual practices of ACO professionals
    - Partnerships or J / V between hospitals and ACO professionals
    - Other groups as Secretary determines
Elements of ACOs (§ 3022)

Accountable care organizations (ACOs) (cont’d)

- Opportunities and challenges include
  - Assessing risk capacity, organization and restructuring issues
  - Aligning incentives through coordination and cooperation
  - Implementing evidence-based quality and efficiency measures
  - Developing arrangements / transactions across provider types
  - Instituting effective board, executive and operational oversight
  - Managing compliance with new and existing laws

- Applicable to Medicare and Medicaid
ACOs / Medical Homes

- CMS seeks provider input in ACO Open Door Forum where development of pediatric ACOs discussed
- ACO workshop to focus on antitrust, AKS self-referral and CMP issues – Oct. 5th, hosted by FTC, CMS and OIG
- State action re: development of ACOs as model
- Commercial market incentives
PPACA Pediatric Workforce Funding Options

- Children’s hospitals are essential in training pediatricians
  - ACGME accredited programs train majority of pediatricians in U.S.

- Pediatric recruitment and retention programs
  - Specialty loan repayment program for pediatric medical and surgical specialties and child and adolescent mental behavioral health
  - Amends the Public Health Service Act
  - Recipients must agree to provide services in health professional shortage area, medically underserved area or medically underserved population.
  - $30 M for 2010 – 2014
PPACA Pediatric Workforce Funding Options

- **Investment in training for general pediatrics, family medicine and internal medicine**
  - Eligible entities include nonprofit private hospitals and schools of medicine
  - Need-based financial assistance for trainees
  - To plan, develop and operate programs generally and in community based settings
  - Training in new competencies
  - Work with National Health Care Workforce Commission (§ 5101)
    - May include programs to provide training within patient-centered medical homes
    - To support joint degree programs in infectious disease control, disease prevention and health promotion

- **Priority given to those who have a record of training the greatest percentage of providers; provide training to vulnerable populations such as children, child abuse victims, HIV / AIDS and individuals with disabilities**
340B Drug Discounts

- DRA ’05 added freestanding children’s hospitals to access outpatient drug discounts
- PPACA included a technical fix on 340B to permanently include freestanding children’s hospitals in eligibility for discounts
- Orphan drug prohibition added in reconciliation compromise (HCERA) inadvertently included children’s hospitals
- Huge adverse impact on children’s hospitals – estimates are that loss of orphan drug discount under 340B will cost a participating hospital between $1-3 M / year
- Changes to the orphan drug prohibition are being pursued through NACH
Public Health in PPACA for Children

- Childhood obesity initiatives (§ 4004)
- Childhood obesity demonstration project through CHIPRA funded in PPACA at $25 M
- National Prevention, Health Promotion and Public Health Council creation
- School-based health centers (§ 4101)
- Immunizations – CDC demonstration program to improve immunization rates in children
- Wakefield Emergency Medical Services for Children program reauthorized (§ 5603)
Workforce Investment

Medical education

- Generally increases GME training positions for primary care through a redistribution program for currently unused training slots (§ 5503)
- Increases training in nonprovider settings (§5504)
- Establishes initiatives aimed at aligning education for medical workers with health system needs
- Grants / loan forgiveness programs for resident and fellows in pediatrics, general internal medicine, physician assistants for training or focusing on health professional shortage areas, focusing on pediatric specialty or subspecialty training, including pediatric dentistry
Tax Changes – Requirements for Charitable Hospitals

- Adds 4 specific additional requirements that hospitals must satisfy to maintain tax-exempt status under § 501(c)(3) of the Internal Revenue Code (IRC)

1. Community needs assessment
   - Every two years
   - Adopt implementation strategy
Tax Changes – Requirements for Charitable Hospitals

2. Financial assistance policy

- Each hospital must adopt and make widely available a written financial assistance policy with the following:
  - Eligibility criteria for financial assistance and whether such assistance includes free or discounted care
  - The basis for calculating amounts charged to patients
  - The method for applying for financial assistance
  - Collection policy or action that a hospital may take in connection with nonpayment
  - How the hospital will publicize the policy
Tax Changes – Requirements for Charitable Hospitals

3. Limitations on charges
   - Hospital must limit charges for emergency or medically necessary care provided to patients who qualify under financial policies to “not more than the amounts generally billed to individuals who have insurance covering such care”
   - Joint Committee on Taxation request for comments and interpretation

4. Billing and collection
   - May not engage in “extraordinary collection practices” until reasonable efforts have been made to determine whether a patient qualifies for financial assistance under hospital policies
Tax Changes – Requirements for Charitable Hospitals

- **Excise tax**
  - $50,000 excise tax for failure to satisfy the community health-needs assessment

- **Agency reports**
  - Treasury Secretary in consultation with HHS will report to Congress annually on
    - Levels of charity care, bad debt and certain unreimbursed costs of taxable, tax-exempt and government hospitals
    - Costs incurred by tax-exempt hospitals for community benefit activities
  - Treasury and HHS also must report on community benefit related trends within 5 years of enactment
Medicaid DSH

- Disproportionate Share Hospital (DSH) payment reductions – supplemental payments to providers to help compensate for underpayments in governmental programs if threshold of patients is large enough to meet statutory formulas
  - Medicare – $22 B reduction over 10 years beginning 2014
  - Medicaid – fewer uninsured = reduced need for DSH payments
    - Beginning 2014, $500 M
    - 2015=$600 M
    - 2016=$600 M
    - 2017=$1.8 B
    - 2018=$5 B
  - Calls on Secretary to develop a methodology to recognize those states with low percentage of uninsured or that target DSH funds to hospitals with high Medicaid volumes or uncompensated care
  - Lowers cuts from those initially proposed
Physician Ownership

- Physician-owned hospitals prohibited
  - Grandfathers physician-owned hospitals with Medicare provider numbers prior to 12/31/10
  - Subjects existing facilities to growth restrictions on date of enactment for hospitals with existing license or Medicare provider enrollment agreement granted
    - Number of beds, operating rooms, procedure rooms
    - Grandfathered hospitals have to file annual report to identify MD owners; disclose hospital is physician-owned to patients
Physician Ownership

- **In office ancillary services disclosure**
  - MRI, PET, CT
  - MD must provide patient with written list of suppliers (Jan. 1, 2010 effective date)

- **Self-disclosure process outlined**
  - Protocol was eliminated a year ago
  - Obligates CMS to develop protocol within 6 months of enactment
Fraud and Abuse

- Furthers the march to eliminate waste, fraud and abuse in Medicare and Medicaid
- Broadening liability under False Claims Act
  - Any claim under Anti-Kickback Act can be “false claim” under FCA
  - Revisions to whistleblower provisions
  - New provisions related to overpayment
  - New sanctions, criminal and civil penalties
  - Suspension of payments pending investigation
End Stage Renal Disease


- Comments re: use of adult prevalent co-morbidities to adjust base rate and request for specific pediatric co-morbidities

- Use same statistical regression methodology for adults
End Stage Renal Disease

- Adjustment for use of resources
- Resulting final rule adopted some of comments by adoption of higher average composite rate payment / treatment in 2007 base year – 10.5% higher for pediatric ESRD
- Rejected use of more accurate co-morbidities
Opportunities and Threats

- Funding opportunities exist for development of pediatric training programs / collaboratives
- Pediatric ACO project – monitor and effect development of pediatric quality measures currently being developed; stay abreast of updates
- Look into development of medical home models
Opportunities and Threats

- DSH reductions will challenge bottom line
- Coverage expansion
  - Estimated that an additional 8 M children currently uninsured will be funneled into system by 2014
  - Children’s hospitals and affiliated providers will provide a significant portion of care
- Work with states – be proactive
Questions?
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