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Health Care Reform in the Immediate Future – 2011 Implementation

Several provisions of the Affordable Care Act have become effective and several additional provisions will become effective in 2011. Stakeholders at the federal and state levels have begun the preparations for implementing the Act's imminent provisions. For example, Illinois has already begun to develop the parameters of a state insurance exchange, which is mandated by the new law.

This paper focuses on those provisions and programs which will be implemented in the immediate future. It is important to note that, despite recent court decisions which have struck at the individual mandate provision of the ACA, the Obama Administration is confident that the ACA will be upheld by the courts. In this spirit, the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) are continuing to issue guidelines and regulations which will direct the Act's implementation. Therefore, hospitals should continue their preparations for compliance with the Affordable Care Act, even as the numerous anticipated court appeals are litigated.

I. State Insurance Exchange Development

Work has begun to establish an insurance exchange in Illinois, pursuant to the ACA provision that state insurance exchanges must be operational by 2014. The Illinois Department of Insurance is committed to developing a state exchange, in collaboration with a broad group of stakeholders and is working with the Illinois Health Care Reform Implementation Council (Council), a body consisting of state agency directors appointed by the Governor, to solicit input and make recommendations on implementing the federal health care reform law at the state level.

As a preliminary step toward developing the state exchange, the Council recently requested, and the Illinois Hospital Association (IHA) submitted, [comments](#) on health insurance reform and the option of establishing an insurance exchange in Illinois. Some immediate next steps on the exchange development are described here:

Series of Stakeholder Meetings. Department of Insurance Director Michael McRaith is initiating separate meetings with five stakeholder groups: providers, insurers, employers, agents, and patient/family advocates. On December 14, the Department of Insurance convened an introductory meeting for providers. IHA, the Illinois State Medical Society, family physicians, psychiatrists, pediatricians and acupuncturists were among the attendees.

The Director's goal is for these separate groups to reach consensus on major issues that need to be addressed in establishing an exchange, prior to bringing the groups together to hammer out differences. The goal is to have a bill on exchange implementation ready for the General Assembly by early February. The next meeting will be to discuss the exchange governance structure. Director McRaith expressed his preference for governance of the exchange by a semi-autonomous new agency run by a professional with experience in business and insurance that would be free from some of the state's hiring and procurement requirements. Additional meetings will address fiscal sustainability of the exchange, medical loss ratio considerations, compensation reforms, and contracting issues.

Report of Health Care Reform Implementation Council. The Council will produce a high level draft report to the Governor, including recommendations on the exchange. The draft will be the subject of a hearing in January after which the report will be finalized and formally adopted. Any gaps in the report and unanswered questions on the insurance and exchange topics will serve as additional subject matter for the planned combined stakeholder meetings.

Medical Loss Ratio. Effective January 1, 2011, the ACA requires insurers to utilize at least 80% of premiums collected for health care (and not administrative) purposes. The Director is soliciting feedback on this medical loss ratio (MLR) provision. One question is whether Illinois should ask the federal government for an exemption from the immediate 80% MLR requirement, since the Director believes there are currently only two insurers that would probably meet it. There are several that are very close and could probably come into compliance in a reasonable amount of time; but some insurers may never be able to comply. IHA is examining the issue and will be discussing it with the Policy & Advocacy Council at their January 12 meeting.

Reimbursement Reforms. Another discussion item will be compensation reforms for providers, in particular, quality standards that would impact payment. With an eye toward consumer protection, the Director specifically requested input on how provider/payer contracts are changing and voiced concern that contracts could be used to steer markets.

Although this initial meeting was primarily for introduction of topics, IHA was able to highlight its recommendations on workforce needs and network adequacy and approval. Once scheduled, the meeting dates will be circulated.

II. ACA Provisions Effective in 2011

In addition to the medical loss ratio (MLR) provision discussed above, the following key sections of the ACA become effective in 2011:

Medicare Market Basket Adjustment. In keeping with the schedule of Medicare payment reductions that began in 2010, the annual market basket update for 2011 will be reduced by 0.25%. This reduction is applicable to inpatient and outpatient hospital services, inpatient psychiatric facilities and inpatient rehabilitation facilities. Long-term care hospitals will experience a 0.50% reduction in 2011, while a 1.0% reduction will be implemented for home health agencies.

ASC Medicare Productivity Adjustment. Beginning in 2011, the market basket update under Medicare for ambulatory surgery centers will be reduced by a productivity adjustment, currently estimated at 1.3%.

Medicare Advantage Provider Rates. Payment rates to private Medicare Advantage plans will be gradually reduced, beginning with a freeze at 2010 levels.

Closing the Donut Hole. In 2011, the phase-in begins to close the gap in Medicare Part D coverage that occurs when a beneficiary's spending for prescription drugs reaches \$2,830 and Medicare stops paying until the threshold reaches \$4,550.

Removal of Barriers to Preventive Services. Beginning January 1, 2011, the law eliminates Medicare beneficiary co-payments and deductibles for preventive screenings and services receiving a recommendation of "A" (strongly recommends) or "B" (recommends) by the United States Preventive Services Task Force and for all colorectal cancer screenings. Such cost sharing is waived for Pap tests, smoking cessation counseling, and other specified preventive services.

Bonus to Primary Care Practitioners. Primary care services delivered by a primary care practitioner will receive a 10 percent bonus payment (on a monthly or quarterly basis) under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of qualifying evaluation and management codes include office visits, home visits, nursing facility visits and rest home and custodial care services. The bonus will be available only to primary care practitioners in the specialties of family medicine, internal medicine, geriatric medicine, pediatric medicine, and nurse practitioners, clinical nurse specialists, and physician assistants who furnish 60 percent of their services in these codes.

In addition, qualifying practitioners providing care in a health professional shortage area (HPSA) will receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine, though only 10 percent of these visits will count toward the 60 percent threshold above. General surgeons providing care in a HPSA will receive a 10 percent bonus on major procedure codes for five years,

beginning January 1, 2011. The 2011 final Medicare Physician Fee Schedule released in November included these provisions.

Geographic Variation. For FYs 2011 and 2012, the law provides a total of \$400 million to hospitals located in counties that rank in the lowest quartile for Medicare per-beneficiary spending, adjusted by age, sex and race. The amount allocated for 2011 is \$150 million, while the balance of \$250 million will be allocated in 2012. Each hospital will receive funding in an amount that is proportional to its Medicare inpatient hospital payments as a percentage of the Medicare inpatient hospital payments made to all hospitals receiving the funding.

Redistribution of Unused GME Slots. The ACA will redistribute unused and closed hospital residency training positions as a way to encourage increased training of primary care physicians and general surgeons. The allocation formulas and eligibility criteria were finalized in rules issued on November 24 and differ for the respective categories. Application timelines are brief, concluding by January 21 for unused requests and April 1, 2011 for closed hospital positions. Unused positions will be based on cap determinations for cost-reporting periods on or after July 1, 2011 while re-distribution of GME slots from closed hospitals will involve those facilities that have closed their programs up to two years prior to the enactment of ACA. CMS has indicated that they intend to finalize allocation decisions by late 2011.

Medicaid Health Homes and Chronic Disease Prevention. The HHS Secretary will begin to award State Planning Grants to establish a Health Home Program for eligible Medicaid enrollees by January 1, 2011. Eligible Medicaid participants must have at least two chronic conditions and may designate a provider as a health home. States using the option will receive 90% federal matching payments for two years for health home-related services. In addition, the HHS Secretary will award five-year grants to states to provide incentives to Medicaid beneficiaries who participate in healthy lifestyle programs and demonstrate changes in health risk and outcomes.

III. Assessing Readiness to Participate in ACA Activities

With respect to the above aspects of the ACA, hospitals and health systems may assess their readiness to partner with other providers or with the state or federal government by considering the following:

- Are staff considering questions that may be raised during the stakeholder meetings on developing an Illinois insurance exchange?
- Is the organization aware of pilot opportunities to test innovative methods of health care payment and delivery?

- How will Medicare payment adjustments affect the care continuum in your community?
- Are staff exploring potential partnerships with providers along the care continuum to maximize the value of health care expenditures?
- Given that quality standards will increasingly affect reimbursement, what are you doing to transition from a volume-based payment system to one founded on value?
- What tactics and strategies are commercial insurers employing to limit their expenditures and what responses and countermeasures should hospitals employ in light of those tactics and strategies?

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