

an informational series for hospital leaders

The Illinois Hospital Association Task Force on Health Care Reform

# Implementing Health Care Reform: Challenges and Opportunities for Illinois Hospitals

August 2010

## Historic Change

The Patient Protection and Affordable Care Act (PPACA), effective March 23, 2010, represents the greatest change in U.S. health care since the adoption of the Medicare and Medicaid programs, and holds promise for increased access to care, greater quality, and better value for health care expenditures. While this change presents challenges, it also presents opportunities – especially the opportunity for hospital leaders, in partnership with state and federal officials and other stakeholders, to transform the health delivery system.

As hospital leaders look forward, they are asking:

- What will health care reform mean for my hospital and my community?
- What are the strategic issues that we must consider to thrive in a new environment?
- How will health reform be implemented in Illinois?

This paper is designed to help Illinois hospital leaders find answers to these important questions.



*Under Illinois Senate Bill 3047, the **Health Care Justice Implementation Task Force** is to be created by the State of Illinois. It is charged with monitoring and making recommendations to the Legislature and Governor concerning implementation of federal health reform. The task force will consist of 29 members – to be appointed by the Governor and the legislative leaders. IHA will strongly advocate for hospital representation on the task force.*

## The Current Illinois Environment

In Illinois, the current economic crisis is the most significant environmental factor as the state moves toward implementation of the new law. With a deficit of \$13 billion, and uncertainty about the extension of enhanced federal Medicaid stimulus funding, the state is behind even before it begins to address how to implement federal health reform. If a prolonged recession continues to suppress revenues, and the prompt pay required by the federal stimulus law expires, the state will be challenged to pay hospitals and other providers of critical services in a timely manner. This situation will compound the effects of the \$8.2 billion in Medicare cuts to Illinois hospitals over 10 years that hospitals will begin to experience this year as part of health care reform.

Like many other states, the long-standing financial pressures on Illinois raise concerns about the state's ability to secure and apply the administrative resources (e.g., personnel, data systems, technical expertise) needed to implement the complex regulatory programs planned under health reform. This reality, while challenging, also presents an opportunity for Illinois hospitals to play a leadership role, building on their longstanding partnership with the state, to support and promote the effective implementation of health care reform.

## Six Areas of Focus for Consideration

This paper summarizes likely implications of federal health reform implementation for Illinois hospitals. It is organized into six key issue areas: coverage, reimbursement, quality, delivery system, hospital-physician alignment, and workforce. These issues are interrelated – you cannot discuss one without considering the implications on another. For example, expanding coverage to 1.7 million more Illinoisans will compound demands on an already inadequate health care workforce in this state.

At the end of each section are strategic questions for your organization to consider as you discern next steps in your journey toward an enhanced health care delivery system.

### 1 Coverage

#### Coverage Expansion

By January 1, 2014, the Patient Protection and Affordable Care Act expands Medicaid eligibility to persons with incomes below 133% of poverty; mandates individual coverage; and initiates state “exchanges” to offer affordable commercial coverage. In Illinois, IHA estimates that approximately 540,000 of the 1.7 million currently uninsured Illinoisans will become Medicaid-eligible, and an additional 330,000 individuals are expected to obtain commercial coverage.

However, a significant segment of Illinois' population will likely remain uninsured, most notably the approximately 280,000 unauthorized immigrants not covered by the federal legislation. In addition, as many as 500,000 Illinoisans could remain uninsured because they are exempt from the law's mandate or they simply fail to comply.



Reducing the number of uninsured will benefit hospitals by reducing the amount of uncompensated care. However, the extent of that benefit will depend on several factors that may vary significantly: the number of undocumented immigrants in the community; the proportion eligible for Medicaid instead of commercial coverage; and the rates paid by Medicaid and the commercial plans.

In any event, it will be important for uninsured individuals to enroll in programs for which they are eligible. Hospitals may wish to assist in promoting that enrollment process.

## The Insurance Exchange

By January 1, 2014, states will create “exchanges” to facilitate the purchase of commercial coverage for individuals and small employers. The exchange will become a key platform for health coverage, determining which plans are offered, facilitating enrollment, deciding exemptions, and developing fee schedules that reflect various markets. The exchange will also enroll eligible individuals in Medicaid or other public programs. Given the important role the exchange will play in the structure, operation and enrollment in health plans, it is imperative that hospital interests are represented in the development and operation of the exchange.

## Estimating the Impact of Expanded Coverage

Many factors make it difficult to estimate the impact of expanded coverage: rules have yet to be developed; data is lacking; there is unpredictability regarding individuals shifting within various types of health coverage. However, a rough estimate of the impact is possible, based on a Congressional Budget Office (CBO) analysis applied to the Illinois uninsured population.

**IHA estimates that the potential financial impact, using the CBO assumptions, could range from \$6.7 billion to \$8.1 billion in new revenue for Illinois hospitals over 10 years (2010 – 2019).** However, this estimate will evolve as providers, the public and insurers respond to reform, and as unpredictable changes occur. Additionally, this impact will vary by hospital. For example, a hospital serving a large number of uninsured, unauthorized immigrants may see only a modest increase in patients with coverage, even after reform.

## First Steps

Enrolling eligible individuals in new coverage options will be critical to your hospital realizing the promised benefits of health reform. Strategic considerations include:

- What is the potential impact on your hospital of the expansion in coverage under optimistic and conservative assumptions?  
See IHA’s Coverage Estimator at [www.ihatoday.org](http://www.ihatoday.org).
- What percentage of your community’s currently uninsured will likely continue to be uninsured?
- What percentage of the newly covered will likely be Medicaid recipients?
- What role might the hospital play in enrolling the uninsured in coverage?

*One issue to consider as coverage is expanded is whether employers who currently offer coverage will shift to plans offered via the insurance exchange. These plans may have higher out-of-pocket costs and different reimbursement rates for providers. Based on reports from hospital leaders in Massachusetts – a model for federal reform – this concern has not materialized.*

*Initially, the exchange is only open to individuals and small employers. However, in 2017 the state may admit larger firms into the exchange.*

*Information and resources on health reform are available on the IHA web site at [www.ihatoday.org](http://www.ihatoday.org), including an Excel spreadsheet to estimate the impact of expanded coverage under reform.*

*Click on the “Health Care Reform Resources” logo.*



## 2 Reimbursement

***In the next 12 months, the Illinois Medicaid program is heading toward a financial catastrophe.*** Unless Congress acts, the enhanced Federal Medical Assistance Percentage (FMAP) matching rate expires on December 31, 2010. Extending it for six months, through June 30, 2011, is worth \$750 million to Illinois. The state's budget assumes the six-month extension will occur. Tied to the FMAP extension is the federal law requiring Medicaid to pay hospitals and nursing homes promptly. Without its extension, the payment cycle for hospitals will likely increase dramatically, given the state's financial crisis. Even if the increased FMAP is extended for six months, Illinois will face the loss of \$1.5 billion in federal funds for the state fiscal year that begins on July 1, 2011.

The pressure to “bend the cost curve” while improving quality is a dominant theme of health reform. The PPACA seeks to achieve this goal, as well as to partially pay for coverage expansion, by reducing the projected increases in Medicare and Medicaid spending and by using payment policies based on value instead of volume. Numerous pilot and demonstration programs are authorized as mechanisms for transitioning to a performance-based payment system. Commercial health plans are pursuing similar strategies to contain costs.

### Medicare Changes

Beginning in 2010, the estimated reductions in Medicare payments to Illinois hospitals over 10 years total \$8.2 billion, including reducing Medicare DSH payments by 75% beginning in 2014. However, a portion of these DSH reductions would be returned to hospitals based on their uncompensated care amounts.

Additionally, while other reimbursement changes take place in future years, it will take time to adjust to the new incentives, so work needs to begin now to succeed in the new environment.

- **Readmissions.** Beginning in 2013, Medicare will impose financial penalties on hospitals for “excess” readmissions based on the 30-day readmission measures for heart attack, heart failure and pneumonia. Critical access hospitals and post-acute providers are exempt.
- **Value-based purchasing.** Beginning in 2013, a portion of hospital inpatient payments will be tied to hospital performance on certain quality measures related to cardiac, surgical and pneumonia care.
- **Bundled payments.** Beginning in 2013, a national, voluntary pilot program will be implemented to bundle payments for 10 conditions for inpatient, outpatient, physician, and post-acute services provided up to three days prior to the admission and within 30 days after discharge.

### Medicaid Changes

- **Eligibility.** Beginning in 2014, the Medicaid program will be expanded to cover non-elderly individuals, including parents; children; and childless adults, up to 133% of the federal poverty level. An initial federal matching rate of 100% will be provided for newly eligible individuals that will gradually decrease to 90% after 2019. Adding more than 500,000 individuals to the Illinois Medicaid program will place increased pressure on the state budget.
- **Medicaid DSH reductions.** Beginning in 2014, federal Medicaid DSH allotments will be reduced by \$14.1 billion over 10 years, a 50% reduction from FFY2009. The U.S. Dept. of Health and Human Services (HHS) is to determine the actual reductions for each state based on the number of uninsured in the state and how the state treats hospitals with high Medicaid and uncompensated care volumes.

- **Medicaid hospital-acquired conditions.** By January 1, 2011, the state must adopt policies to ensure higher Medicaid payments are not made for cases covered by the Medicare hospital-acquired condition policy.
- **Medicaid demonstration projects.** The HHS Secretary is authorized to conduct Medicaid demonstration projects including bundled payment demonstrations; global payment demonstrations for safety net hospitals; Pediatric Accountable Care Organization demonstrations; and Medicaid emergency psychiatric demonstration projects.

## Commercial Insurance

The PPACA insurance reform provisions impose numerous restrictions on commercial insurers, such as minimum medical loss ratios, prohibiting rescissions, prohibiting denying coverage to children due to pre-existing conditions, and prohibiting lifetime limits on coverage. In response, many health plans are seeking to either increase their premiums or reduce the amounts they pay to providers, e.g., by adopting Medicare payment rates and methods. Additionally, plans may seek to shift the risk of high cost care to others, such as hospitals and health systems. Finally, many expect that there will be further concentration in the health insurance marketplace, as larger plans will have a greater ability to survive in a more challenging environment.

## First Steps

The implications of these changes and trends include:

- Pressure to “bend the cost curve”;
- Payment will increasingly be based on value, not volume;
- Payment will be more at risk;
- Medicare and Medicaid will constitute a greater percentage of hospitals’ payer mix;
- Commercial payments will seek to mirror Medicare rates and methodologies; and
- There will be increased pressure on the Illinois Medicaid program to contain costs.

Given these trends and implications, strategic considerations include:

- What is the estimated impact of Medicare and Medicaid reductions on your hospital?
- How do you anticipate your payer mix will change?
- What are your strategies for reducing readmissions?
- What are your strategies for achieving efficiencies and savings?
- Are you prepared to share financial risk, e.g., bundled payments? What expertise is needed to do so?
- What partnerships or collaborative arrangements should you consider – health plans, post-acute providers, physicians?

Through the **IHA Quality Care Institute**, Illinois hospitals are pledging to “Raise The Bar” by collaborating to:

- Reduce hospital readmissions; and
- Reduce hospital-acquired conditions and infections.

The IHA Quality Care Institute is a new strategic center that builds on existing quality and patient safety initiatives, designing innovative programs for hospitals to measurably strengthen the quality of health care all across Illinois. Through the Institute, hospitals can access data, tools and best practices from across the state. The Quality Care Institute also provides Illinois hospitals with practical approaches for performance improvement and will actively advocate for the removal of barriers to care coordination.

To learn more, visit:

[www.ihqualitycare.org](http://www.ihqualitycare.org).

Illinois hospitals should consider strategies for participating in improvement efforts through collaboratives and the **Midwest Alliance for Patient Safety**, to reduce adverse occurrences and near misses. The Alliance is the joint venture Patient Safety Organization (PSO) of the Illinois Hospital Association Quality Care Institute and the Metropolitan Chicago Healthcare Council.



## Quality and Value

With its emphasis on value and performance, health care reform increasingly ties reimbursement to quality measures. Several of the performance-based incentives that take effect in FFY2013 (which begins on October 1, 2012) will be based on performance reported in the prior fiscal year. This means that work to succeed under these new incentives needs to begin now. Examples of key PPACA quality-related provisions include:

- Beginning in 2013, Medicare payment reductions for readmissions, based upon 2011 performance;
- Beginning in 2013, Medicare value-based purchasing, based upon performance starting in 2011 on quality measures, patient satisfaction and hospital-acquired conditions;
- Beginning in 2011, Medicaid non-payment for hospital-acquired conditions, based on 2011 claims data;
- Support for comparative effectiveness research in 2010;
- In 2011, establishing the Center for Medicare and Medicaid Innovation (CMI) within CMS to improve coordination, quality and efficiency through programs, such as medical homes.

## Public Reporting and HIT

The demand for public reporting of performance and quality measures, such as on *Hospital Compare* and IHA's *Illinois Hospitals Caring for You* web site ([www.illinoishospitals.org](http://www.illinoishospitals.org)), will only increase. As part of PPACA, the HHS Secretary is charged to develop a national quality improvement strategy that includes a framework to carry out the public reporting of performance information. It is important that such reporting be coordinated and not unduly burdensome.

Investment in Health Information Technology (HIT), such as electronic health records and computer physician order entry, is critical to improving quality and patient safety. The integration of quality, health information technology, and payments will begin in 2011 with incentive payments for the successful integration and implementation of the “meaningful use” of HIT and penalties for non-compliance after 2015 for most providers.

## First Steps

Given the increased importance of quality improvement and value-based purchasing, important strategic considerations for your hospital include:

- How does your hospital compare on key quality measures to other hospitals in your community? In the state? Nationally?
- What unwarranted variations in utilization and outcomes exist within your hospital? What strategies can be employed to reduce these variations among your physicians? Do you have the necessary data systems in place?
- What is your strategy to align physicians with your hospital improvement initiatives? Do your physicians' clinical information systems align with the hospital's information system?

- What strategies do you have to improve performance? What are your key targets? Are you working with other key stakeholders?
- What technology and other resources does your hospital need to advance care, prevent harm, and meet the meaningful use requirements?
- How are you optimizing your technology to advance patient care within your hospital and in your community?

## 4 Delivery System

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The reimbursement and quality provisions described above will spur changes in the delivery system. Several other provisions of PPACA will provide additional incentives to encourage coordination of care, prevention and wellness. While the precise outcome of the changes in the delivery system may be difficult to predict, the general trends described below are likely. In short, hospitals will be more at risk, more accountable and more integrated.

### Accountable Care Organizations

The Accountable Care Organization (ACO) concept contemplates partnerships among hospitals, physicians and other providers in order to assume responsibility for improving the quality of health care and for slowing the growth in health care spending. Experiments with the ACO model are being explored in the private sector and, under PPACA, beginning in 2012, CMS will establish a program to allow groups of providers to organize ACOs and share in the cost savings they achieve for the Medicare program. Since the rules for implementing an ACO under Medicare have yet to be developed (proposed rules from CMS are expected this fall), it is not clear precisely how the organization will be held financially accountable. However, key attributes of ACOs under Medicare will include:

- Sufficient primary care professionals to treat at least 5,000 beneficiaries;
- Agreement to participate in the program for at least three years;
- Leadership and management structure, including administrative and clinical systems;
- Defined processes to promote evidence-based medicine, report on quality and cost measures and coordinate care.

### New Approaches for Providers...

The CMS Center for Medicare and Medicaid Innovation (CMI) will test innovative payment and service delivery models to improve coordination, quality and efficiency of health care services, such as patient-centered medical homes. New models will emphasize primary care and incentives to reduce inpatient hospital care. As financial incentives evolve, hospitals and other providers may assume an expanded responsibility for maintaining the health of populations or communities, in addition to addressing the needs of patients who come to the hospital during an episode of illness.

## ...for Patients

Building on the current trend toward outpatient care, delivery system reforms will likely include the expanded use of telemedicine and delivering care in the patient's home through technology such as home monitoring systems. Consumers will also be more engaged in their health care and demand more quality and cost information. There will be a greater emphasis on personal responsibility for unhealthy behaviors, such as smoking and obesity. The nature and scope of end-of-life care will be reevaluated to enhance the public's knowledge of and access to palliative care at the end of life.

## ...and for Payers

Public and private payers will increase efforts to control health spending. In particular, Illinois' precarious financial condition will heighten pressure to control state spending on Medicaid recipients as well as state employees and retirees. The state will seek new programs that reduce spending through care coordination. As payers strive to control costs, the incentives in the current system to encourage utilization will evolve to incentives based on value. As these incentives change, behavior will change.

## Partners in Care

How care is delivered and by whom (e.g., advanced practice nurses and physician assistants) will be redesigned to respond to workforce shortages and to improve efficiency. "Pre-primary care" will emphasize preventive care and maintaining wellness. This may include partnering with community stakeholders such as local health departments, schools, employers, and social service agencies to encourage healthy lifestyles. Collaborating with other organizations will increase in importance, as providers conduct community needs assessments and demonstrate community benefit. More hospitals may join health systems to more effectively manage care and costs and have access to the capital needed to invest in technology and facilities.

## First Steps

Given the likely changes in the delivery system, key strategic considerations include:

- What's the role of your hospital in serving your community? What assets do you bring to your community?
- Do you want to and are you able to manage the care of populations across the care continuum?
- How will savings targets be established and savings shared? How will quality benchmarks be established?
- Are you able to assume financial risk for a population? What core competencies are needed to do so?
- What partnerships or collaborations should you consider, e.g., with health plans, physicians, other hospitals, post-acute providers?

Close collaboration between hospitals and physicians will provide the essential infrastructure for new delivery system and reimbursement mechanisms, such as ACOs and bundled payments. Recognizing that physicians must drive the clinical changes necessary to improve health care outcomes and efficiencies, hospitals see an imperative to align hospital and physician interests, values and goals, and build the culture of trust that is an essential foundation for a sustainable business arrangement.

## A Collaborative Culture

A collaborative culture – one built on mutual trust and respect – begins with understanding the diverse perspectives of physicians. The environmental challenges they face are significant – inadequate reimbursement, increasing liability costs and regulatory burdens – to name a few. Reflecting that diversity, some physicians have pursued a more autonomous path and are less engaged with the hospital. Others are interested in employment by the hospital. The challenge for many hospitals is to find ways to build relationships with a diverse physician community that will lead to the alignment and clinical integration needed to improve quality and increase efficiency. Success in this complex balancing act will require diverse models of alignment to meet the diverse needs of physicians. One size will not fit all.

## Physician Employment and Other Alignment Models

Models for alignment or clinical integration span a wide range. On one end of the continuum, there are health systems where the hospital and physicians are under common ownership and are fully integrated economically. At the other end of the spectrum, there are examples where a hospital and a group of independent physicians have agreed to work together to reduce costs for a particular procedure, such as hip replacements. In the middle, are hospitals that employ a substantial number, but far less than all, of their physicians. Another mid-range approach is where a hospital and independent physicians have an active physician-hospital organization that is clinically integrated and engages in joint negotiations with health plans. These efforts at alignment and integration require hard work, development of a culture of collaboration and investment in infrastructure. Additionally, many models require careful legal consideration related to potential legal barriers such as the anti-referral, fraud and abuse and antitrust laws.

## First Steps

Given the trends affecting the relationship between physicians and hospitals, key strategic considerations include:

- Do you have an effective physician-hospital relationship? How can it be strengthened? Are you building an effective collaborative culture?
- What is your strategy to recruit and retain needed physicians?
- What are your strategies to improve your alignment with your physicians – employed and independent; specialist and primary care?
- What is your strategy to assure the productivity of employed physicians?
- What is your strategy to use advanced practice nurses and physician assistants to extend the effectiveness of your physicians?

*As the interests of hospitals and physicians become more aligned, especially financially, it will be increasingly important for hospitals to address the needs and concerns of physicians. Examples include:*

- *Hospital reimbursement based on infection rates, patient satisfaction scores and readmissions.*
- *Inadequate physician reimbursement rates under Medicare and Medicaid impact hospital-employed physicians.*
- *Expanded Medicaid eligibility without adequate Medicaid physician rates (for primary care and specialists) will not increase access to care. Patients will still turn to already crowded hospital emergency rooms for care.*

## 6 Workforce

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### Workforce Strategies

The PPACA includes strategies and resources to coordinate federal, state and local workforce development, and to connect workforce education with the delivery of health care services. Grants and loans target individuals, schools and organizations, especially those with interest in low income, underserved and rural areas. Although the new law maintains the current number of Medicare-funded graduate medical education positions, provisions addressing the redistribution of unused slots and those from closed hospitals are intended to maximize training opportunities and primary care resources.

### Supply and Demand

Until the recent economic downturn, the inadequate supply of physicians and other health care professionals was one of the top issues confronting Illinois hospitals. These challenges are widely expected to resurface with the economy's recovery. Illinois' aging health care workforce is of great concern, coupled with increasing demand for health care services for an aging population. Of the estimated 78.2 million baby boomers, the oldest will turn 64 in 2010, while an estimated 35% of active physicians are over 55 and most will retire by 2020. Two-thirds of Illinois licensed professional nurses are over age 46.

### Expanded Role for Midlevel Practitioners

The federal mandate for expanded coverage will increase the need for health care services and exacerbate the already critical shortage of certain health care workers. Both the demand for primary care services and projected physician shortages are likely to prompt an increased need for mid-level providers such as physician assistants and advanced practice nurses. The inadequate number of these professionals is a major concern.

### Training Residents

The reform law's redistribution formula for unused residency positions is based on priority consideration for states with low resident-to-population ratios, and is likely to disadvantage Illinois, which has one of the highest ratios. Aggregate data from Medicare cost reports (2006-2008) indicates that Illinois hospitals have invested in physician residency training exceeding the number of allocated Medicare-funded positions, and the trend is increasing, with hospitals continuing to expend their own funds.

## First Steps

Given the trends affecting the health care workforce, key strategic considerations include:

- How do you anticipate your workforce needs to change in the future?
- What strategies do you employ to recruit and retain your workforce?
- Are you engaged in active discussions with other stakeholders about collaborative efforts to address health care worker education and supply issues?
- What is your strategy to contain salary and benefit costs?
- Do you have an employee health and wellness program?
- What is your strategy to respond to union organizing campaigns?

## Conclusion

The health care delivery system is on the cusp of transformation. Illinois hospitals recognize and support the need to move away from health care delivery that is often uncoordinated and fragmented to a true system of care – one that is coordinated, collaborative and accountable. Achievement of this goal will be incremental and will require hospitals and health systems to assess their readiness, share their expertise, and maintain a steady pace on the road to a re-designed and reformed health care delivery system. The Illinois Hospital Association, your companion on the journey, will be there, to advocate on your behalf and to provide the information, tools and resources you need to continue to serve your patients and community.

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