The Real Measure of Health Reform Success?
CHANGING OPPOSITION TO APPROVAL

HP Enterprise Services, an arm of Hewlett-Packard, the American multi-national information technology corporation that contracts to operate Medicaid Management Information Systems in Arkansas and several other states, hosted a one-day healthcare symposium in May for its clients and a few other invited guests. The highlight of the day was back-to-back appearances by former Senate Majority Leader Tom Daschle and former Massachusetts Governor Mitt Romney, both of whom offered their takes on the recent health reform legislation.

The presentations, though separate, brought to mind the old point/counterpoint segments which occupied the closing slot on CBS’s 60 Minutes for a few years during the 1970s. Daschle aptly filled the role of Newsweek columnist (no, not communist) Shana Alexander, who always expressed a more liberal voice, and Romney did a fine job of channeling the conservative viewpoint of James J. Kilpatrick, a columnist at the time for the now-defunct Washington Star.

Daschle and Romney weren’t on stage together, so there was none of the catty back-and-forth that characterized the on-tube relationship between Alexander and Kilpatrick (“Oh, come on, Jack!” “Now, see here, Shana!”). But, like the two writers on so many issues, and particularly like the American people on the subject of health reform, their views of the law were so diametrically opposed that you had to wonder if the pols were both talking about the same thing.

Knowing the divisive nature of the debate over reform during the past year, it’s more than likely that, had the barbs been thrown, they might have taken on an air of those exaggerated Saturday Night Live point/counterpoint parodies where Jane Curtin first presented the liberal side of an issue before Dan Aykroyd began his response saying, “Jane, you ignorant slut.” Curtin’s lead-in to a defense of her position would be, “Dan, you pompous ass.” It would have been like a mini health reform town hall meeting.

One thing which both men agreed on is that in spite of the legislation, health reform is a work in progress. Success or failure, security or intrusion, balance or disproportion: those things lay in the hands of the secretary of HHS, who eventually will attach many working parts onto the legislative framework. The phrase “the secretary shall” appears regularly throughout the law – more than 1,000 times by some counts – often followed by a directive to develop regulations for everything from coverage and affordability to delivery system changes, quality and transparency. That translates into a lot of new rules and regulations. The devil really is in the details.

It remains to be seen whether the general public will eventually warm to the idea of health reform in the years ahead, but the fact is that the status quo – 46 million uninsured, arbitrary coverage denials and the prospects that health costs could surpass 34 percent of GDP in a matter of years – is clearly unacceptable. There’s an odds-on chance that even folks most adamantly opposed to the law today would never let go of their coverage benefits down the road. If the reform measures prove to reduce the deficit significantly over the next 20 years, as predicted, then all the better.

During the symposium, Sen. Daschle told a story about the 1908 Democratic National Convention in Denver where William Jennings Bryan received his third and final presidential nomination. At the time, the U.S. was bogged down fighting an insurgency in a distant land (the Philippines), Americans were worried about the flood of immigrants (from Europe), and greedy Wall Street bankers were getting the blame for a tanking economy.

Bryan supposedly commented during the gathering that he wished he could return in 100 years to see how the nation survived. Had he been able to attend the 2008 convention in Denver 100 years later, he would have found the U.S. bogged down fighting insurgencies in two distant lands, Americans worried about the flood of immigrants and a tanking economy, with greedy Wall Street bankers still footing the blame.

But, he also would have found an America strengthened through fights to preserve freedom in two World Wars, Korea, Vietnam, Iraq and Afghanistan, the Great Depression, a battle over civil rights, the assassination of one president, the resignation of another and the impeachment of yet another, and too many political scandals to count.

And, Bryan may have been surprised at current day programs like the Federal Reserve, Social Security, Medicare and Medicaid. All were controversial in the beginning for their perceived insidious nature. But, they were later not only accepted, but embraced by the same people who once fought them tooth and nail. Don’t be surprised if a similar fate awaits healthcare reform.
Health Reform Highlights

The year-long national debate over health reform ended in March, when President Obama separately signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA), which made modifications to the PPACA. Together, this historic legislation constitutes the largest change to America’s healthcare system since the creation of Medicare and Medicaid.

The law addresses changes to be made over the next decade in the following areas;

Consumers and Purchasers: The PPACA expands coverage to 32 million people through a combination of public program and private-sector health insurance expansions. Key insurance reforms include a mandate for individuals to have insurance; employer responsibility to provide or contribute to health insurance; low-income subsidies to help individuals purchase insurance; an expansion of Medicaid eligibility; and the creation of state-based health insurance “exchanges.”

Payment and Revenue: A number of steps will be taken to reduce the rate of increase in Medicare and Medicaid spending through reduced payment updates, decreases in disproportionate share hospital payments, and financial penalties. Additional financing is provided through a combination of taxing high-premium health insurance plans, raising the Medicare tax for high-income individuals and imposing annual fees on the pharmaceutical, medical device, clinical laboratory and health insurance industries.

Delivery System Reform and Quality: Key delivery system reforms are employed to better align provider incentives to improve care coordination and quality and reduce costs. These reforms include value-based purchasing; pilot projects to test bundled Medicare payments; voluntary pilot programs where qualifying providers - including hospitals - can form Accountable Care Organizations and share in Medicare cost savings; and financial penalties for hospitals with “excessive” readmissions.

Wellness and Work Force: Grants and loans will enhance work force education and training to support and strengthen the existing work force and to help ease healthcare work force shortages. Public and private insurers to cover recommended preventive services, immunizations and other screenings with zero enrollee cost sharing (no co-payment or deductible). It also initiates policies to encourage wellness in schools, workplaces and communities, and takes steps to modernize the public healthcare system.

Other: The law includes provisions to reduce waste, fraud and abuse in the Medicare and Medicaid programs, and new reporting requirements are imposed on tax-exempt hospitals. In addition, the law also incorporates several oversight programs including new requirements for physician-owned hospitals.

Historic Health Reform Law:
What it Means to Local Hospitals


The historic legislation contains an individual coverage mandate, low-income subsidies, an expansion of Medicaid, insurance reforms and the creation of state-based health insurance exchanges.

The law also calls for new, non-profit, consumer-operated and -oriented plans (or co-ops), as well as multi-state health plans overseen by the federal Office of Personnel Management, to compete with other private health plans in the insurance exchanges.

Financing includes taxing high-premium health insurance plans, raising the Medicare tax for high-income individuals and imposing annual fees on the pharmaceutical, medical device, clinical laboratory and health insurance industries, as well as reducing Medicare and Medicaid provider payments.

Among its many provisions, the healthcare reform package:

- Expands access to coverage to 32 million individuals by 2019 through a combination of Medicaid expansions and private sector health insurance reforms. That means many patients who currently have no health insurance will have a source of payment for care they receive.
- Decreases Medicaid DSH payments by $14 billion and Medicare DSH payments by $22.1 billion, with reductions beginning in fiscal year (FY) 2014.
- Reduces hospital Medicare PPS payment updates by approximately $112.6 billion over 10 years. For 2010 (effective April 1) and 2011, the hospital payment update would be reduced by 0.25 percentage point. Beginning in 2012, the market basket would be reduced by an estimate of productivity, with added reductions of 0.1 percentage point in 2012 and 2013, 0.3 percentage point in 2014, 0.2 percentage point in 2015 and 2016, and 0.75 percentage point in 2017, 2018 and 2019. In 2020 and beyond, hospital payment updates would be reduced by productivity. The final bill eliminates a provision in the Senate bill
calling for the reductions not to occur if certain coverage targets are not met in 2014-2019.

• Establishes the following programs tied to hospital payments:
  1. A national, voluntary, five-year pilot program on bundling payments to providers around 10 conditions. If successful, the Secretary of Health and Human Services (HHS) may expand the pilots after 2015;
  2. Financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay for reporting program (excluding critical access hospitals [CAH] and post-acute care providers);
  3. A Value-Based Purchasing (VBP) program for hospital payments beginning in FY 2013 based on hospitals’ performance in 2012 on measures that are part of the hospital quality reporting program. The program is budget neutral, with 1 percent of payments allocated to the program in FY 2013, growing over time to 2 percent in 2017 and beyond; and,
  4. An additional 1 percent penalty for hospitals in the top quartile of rates for hospital acquired conditions.

• Includes $400 million for payments for FYs 2011 and 2012 to section 1886(d) hospitals located in counties that rank in the lowest quartile for age, sex and race adjusted per enrollee spending for Medicare Parts A and B. The payments would be proportional to each hospital’s share of the sum of Medicare inpatient PPS payments for all qualifying hospitals.

• Eliminates the exception for physician-owned hospitals under the Stark Law and grandfathered existing hospitals with a Medicare provider number as of Dec. 31, 2010. But, it provides limited exceptions to the growth restrictions for grandfathered physician-owned hospitals, including a new exception for hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

• Creates a new, independent board that would make binding recommendations on Medicare payment policy and non-binding recommendations for changes in private payer payments to providers. It excludes Medicare PPS hospitals (but not CAHs) through 2019.

• Extends eligibility for the 340B drug discount outpatient program to children’s, cancer and CAHs, as well as certain sole community hospitals and rural referral centers. It does not expand the program for existing 340B hospitals to cover inpatient drugs, and it exempts orphan drugs from required discounts for new 340B entities.

• Sustains and improves access to care in rural areas through these various improvements:
  1. Extending the outpatient hold-harmless payments for certain hospitals in rural areas
  2. Improving payments for low-volume hospitals
  3. Ensuring that CAHs are paid 101 percent of costs for all outpatient services regardless of the billing methods elected
  4. Extending and expanding the Rural Community Hospital Demonstration Program
  5. Extending the Medicare Dependent Hospital program for one year
  6. Extending the Medicare Rural Hospital Flexibility Program through 2012
  7. Extending reasonable cost reimbursement for laboratory services in small rural hospitals

• Extends for two years selected long-term acute care hospital (LTCH) provisions in the Medicare, Medicaid and SCHIP Extension Act of 2008. It further delays full implementation of the 25 percent Rule, the short-stay outlier cuts, and the one-time budget-neutrality adjustments planned by CMS. Extends current moratorium on new LTCH beds and facilities, with exceptions.

  • Creates a 3 percent add-on to payments made for home health services to patients in rural areas. The add-on applies to episodes ending on or after April 1, 2010, through Dec. 31, 2016.

  • Extends the exceptions process for outpatient therapy caps (see Section 3103). Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after Jan. 1, 2010, through Dec. 31, 2010. The therapy caps are determined on a calendar year basis, so all patients began a new cap year on Jan. 1, 2010. ●