

GREATER NEW YORK HOSPITAL ASSOCIATION

HEALTH CARE REFORM TIMELINE

When Federal fiscal year (FY) 2013 begins on October 1, 2012, the ongoing transformation of the way America's hospitals deliver care—and are reimbursed for that care—will significantly accelerate. For GNYHA members, these changes will occur at both the Federal and State levels, largely via the Affordable Care Act (ACA) and the recommendations of New York's Medicaid Redesign Team (MRT).

GNYHA developed the Health Care Reform Timeline to give member hospitals a convenient, chronological checklist of select, important Federal and State changes to the health care delivery system.

GNYHA will continue to provide comprehensive support and guidance as its members work to improve the health of the population, enhance the patient care experience, and reduce health care costs.

Kenneth E. Raske, President
September 2012

CALENDAR YEARS 2012–2014

OCTOBER 1

2012

VALUE-BASED PURCHASING (VBP) BEGINS

Medicare begins its VBP program, which will pay hospitals based on their performance on select quality measures.

VBP will be financed by withholding a percentage of inpatient payments—excluding indirect medical education (IME), disproportionate share hospital (DSH), outlier, direct graduate medical education (GME), and other “policy” payments—as follows:

FY 2013	1%	FY 2014	1.25%	FY 2015	1.5%	FY 2016	1.75%	FY 2017	2%
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Hospitals can “earn back” an incentive payment based on their performance, with high performers able to receive payments higher than the withheld amount. Low performers cannot lose more than the withheld amount.

MEDICARE READMISSIONS PENALTY BEGINS

Hospitals with higher-than-expected 30-day readmission rates for specific conditions will be penalized.

The ACA caps each hospital's aggregate penalty at a percent of its total Medicare base operating payments for inpatient acute care as follows:

FY 2013	1%	FY 2014	2%	FY 2015	3%
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For FY 2013, three conditions are included in the readmissions penalty program: acute myocardial infection, congestive heart failure, and pneumonia.

Note: Combined, the VBP Program and Readmissions Rate Cut could result in a 2% cut to hospitals in FY 2013.

ADDITIONAL HOSPITAL-ACQUIRED CONDITIONS (HACS) TO BE PENALIZED IN MEDICARE

The Centers for Medicare & Medicaid Services (CMS) will add two more HACs—surgical site infection following cardiac implantable electronic device procedures and iatrogenic pneumothorax with venous catheterization—to the current HAC payment provision, which prohibits higher payments when a HAC is found to occur after admission to a hospital.

OCTOBER 1 *cont.*

MEDICARE GME POLICY UPDATE ON CLOSED HOSPITAL RESIDENT SLOTS

In redistributing resident slot positions from closed teaching hospitals to other hospitals interested in receiving a permanent increase in their resident caps, CMS' first priority area starting in FY 2013 will be the same or a contiguous area as where the closed hospital was located, followed by the same state, then the same region of the country, then the rest of the country. Applications will now be due 90 days after CMS issues a public notice indicating the availability of resident slots from a closed teaching hospital.

MEDICARE BAD DEBT PAYMENTS REDUCED

Medicare bad debt payments to hospitals and other providers will be reduced to 65% (down from 70% for hospitals) starting in FY 2013. The reduction to 65% for providers currently reimbursed at 100%, such as dialysis centers and federally qualified health centers, will be phased in over three years.

2012
cont.

JANUARY 1

MEDICARE PAYMENT BUNDLING PILOT

The ACA includes a five-year pilot program on payment bundling for 10 conditions. CMS will provide episode-of-care payments for services provided three days prior to admission, during the hospital stay, and 30 days post-discharge.

The deadline for implementing the bundling pilot is January 1, 2013, and its duration and scope may be expanded at any time after January 1, 2016, if it is determined that the expansion would reduce Medicare spending and improve quality.

DUAL ELIGIBLE FEE-FOR-SERVICE MODEL (NEW YORK STATE)

New York State begins a managed fee-for-service (FFS) model to integrate care and financing for individuals dually eligible for Medicare and Medicaid, combined with an expanded Health Home program, which will target 127,000 dual eligibles statewide who have multiple chronic and mental health conditions but do not require extended long term care services. While Health Homes will provide care coordination services for this population, all health care services will continue to be reimbursed on an FFS basis.

A managed capitation model for dual eligibles begins in New York State on January 1, 2014 (see Dual Eligible Managed Capitation Model).

INCREASED MEDICAID PRIMARY CARE RATES

To promote primary care services and improve primary care availability for enrollees, state Medicaid programs will be required to reimburse primary care physician services at the applicable Medicare rate for two years. The Federal government will provide 100% of the funding for any rate increases. Medicaid managed care plans are exempt from this requirement.

2013

JANUARY 2

SEQUESTRATION CUTS

"Sequestration" is the term for the automatic, across-the-board spending cuts resulting from the failure of the Joint Select Committee on Deficit Reduction to reach agreement on a deficit reduction plan. The cuts, which are equally divided between defense and non-defense programs, are intended to reduce the deficit by at least \$1.2 trillion.

Under sequestration, Medicare payments to providers will be cut by 2%, for a total cut of \$123 billion from FYs 2013–21. Hospitals will be cut by \$41 billion over that span. Medicaid is exempt from sequestration.

As sequestration nears, Congress may take steps to avoid or modify many of the sequestration cuts—with one scenario being an even larger Medicare cut, and/or Medicaid cuts.

SEPTEMBER 15

COMMUNITY SERVICE PLAN (NEW YORK STATE), COMMUNITY HEALTH NEEDS ASSESSMENT REQUIREMENTS

New York State requires hospitals to submit comprehensive community service plans (CSPs) by this date. Hospitals must review and amend CSPs every three years, and must prepare (and make public) an implementation report in each of the two years following the submission of the CSP.

At the Federal level, the ACA requires hospitals to conduct a community health needs assessment (CHNA), the requirements of which are similar to CSPs, at least once every three taxable years. Hospitals are subject to the CHNA requirement in the first hospital taxable year after March 23, 2012. The Internal Revenue Service (IRS) has issued interim guidance and will issue regulations that govern CHNAs. New York State is seeking to coordinate CSP requirements with IRS rules.

OCTOBER 1

MEDICAID DSH CUTS

The ACA mandates approximately \$22 billion in aggregate Medicaid DSH cuts over 10 years beginning in FY 2014, and the Physician Fix Bill of 2011 extended the cuts through 2021. The cuts will be implemented as follows:

FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
\$500 million	\$600 million	\$600 million	\$1.8 billion	\$5 billion	\$5.6 billion	\$4 billion	\$4 billion

By 2016, Medicaid DSH payments to hospitals are likely to be about half of current levels. The methodology for implementing cuts to state DSH allotments is expected to be the subject of future rulemaking.

MEDICARE DSH CUTS

Currently, Medicare DSH payments are based on a complex formula that pays hospitals based on their percentage of Medicare beneficiaries on Supplemental Security Income and their percentage of Medicaid beneficiaries. Under the ACA, starting in FY 2014 hospitals will receive only 25% of their current Medicare DSH payment amount, as well as a distribution from a pool based on each hospital's share of national "uncompensated care." The definition and reporting of uncompensated care for this purpose have not yet been defined and are likely to be the subject of future rulemaking.

VBP EXPANSION

The VBP program, which pays hospitals based on their performance on select quality measures, will add 30-day risk-adjusted mortality measures. CMS will also increase the inpatient base operating payment withhold from 1% to 1.25%.

QUALITY REPORTING PROGRAM FOR INPATIENT PSYCHIATRIC, INPATIENT REHABILITATION, AND LONG TERM CARE HOSPITALS

These hospitals will be required by CMS to report on certain quality measures, and will be subject to a 2% penalty if they do not report. The reporting period begins at the start of FY 2013, and results will impact payments starting in FY 2014.

MEANINGFUL USE STAGE 2

"Meaningful use" (MU) Stage 2 requirements will begin in FY 2014. In FY 2014 only, hospitals transitioning to Stage 2 can use one quarter for their MU reporting period (instead of the previously proposed full-year reporting requirement).

Medicare providers that do not achieve MU are subject to a payment penalty in FY 2015. If a hospital demonstrates MU in FY 2013, it will avoid payment penalty in FY 2015. Likewise, in years subsequent to FY 2015, hospitals must have achieved MU in the FY two years before to avoid the penalty. An exception exists for hospitals demonstrating MU for the first time in the FY immediately preceding the penalty year. For example, if the first demonstration year is FY 2014, the hospital will still avoid a penalty as long as it successfully registers and attests to MU by July 1, 2014.

HEALTH BENEFIT EXCHANGES

Health Benefit Exchanges become operational and begin accepting applications for subsidized coverage to be effective January 1, 2014. The Federal government will operate Exchanges in states that choose not to establish them or are still in the implementation stage.

DECEMBER 1

UPDATED HOSPITAL INPATIENT RATE (NEW YORK STATE)

The New York State Department of Health is required to update, from 2005 to a more recent year, the base year data used to compute inpatient rates.

JANUARY 1

DUAL ELIGIBLE MANAGED CAPITATION MODEL (NEW YORK STATE)

The managed capitation model builds off the mandatory managed long term care program that began on July 1, 2012, requiring the passive enrollment of this population into Fully Integrated Dual Advantage plans in New York City and Nassau, Suffolk, and Westchester counties by January 1, 2014. Enrollees will receive all Medicare and Medicaid benefits through managed care plans that participate in both programs. The target population is approximately 124,000 downstate dual eligibles who are over 21 and require extended community-based long term care services.

2014
cont.

JANUARY 1 *cont.*

MEDICAID VOLUNTARY EXPANSION

Federal minimum Medicaid income eligibility levels will be increased to 133% of the Federal Poverty Level (FPL).

States will receive 100% Federal funding for covering newly eligible populations for 2014–16, including adults not previously covered, children, pregnant women, parents, childless adults, and the disabled. Federal funding will decrease starting in 2017. States that have already provided coverage for childless adults will begin receiving enhanced Federal funding for this population.

INSURANCE SUBSIDIES AND MANDATES

Individuals earning between 100% and 400% of the FPL become eligible for subsidized health insurance through Health Benefit Exchanges. Penalties begin for individuals who do not obtain coverage. Penalties begin for employers with more than 50 employees that do not offer coverage.

BASIC HEALTH PLAN (BHP)

BHP coverage begins for states that choose to cover individuals between 133% and 200% of the FPL in separate programs outside the Exchanges.

HOME HEALTH PAYMENT REBASING BEGINS

The U.S. Department of Health and Human Services (HHS) Secretary is directed to rebase home health payments to reflect the number and mix of services, intensity level of services, and the average cost of providing care. The new reimbursement system will be phased in over four years and fully implemented in calendar year 2017.

JULY 1

ADMINISTRATIVE SIMPLIFICATION

Health plans must adopt operating rules for health claims or equivalent encounter information, health plan enrollment/disenrollment, health plan premium payment, referral certification, and authorization transactions by July 1, 2014, so that they are effective no later than January 1, 2016.

OCTOBER 1

VBP EXPANSION

For FY 2015, CMS will include Medicare spending per beneficiary (adjusted for age, sex, race, and severity of illness) as the first VBP efficiency measure.

MEDICARE READMISSIONS PENALTY

CMS will add four new categories to the list of conditions for which hospitals with higher-than-expected 30-day readmission rates will be penalized. The maximum penalty will be capped at 3% of base operating payments.

IMPROVED ELECTRONIC TRANSMISSIONS

Hospitals must establish new requirements for administrative transactions between providers and payers of health claims.

MEDICARE ELECTRONIC HEALTH RECORD (EHR) PENALTY

Hospitals that have not yet demonstrated meaningful use of EHRs will be penalized a percentage of their annual market basket update as follows:

FY 2015	35%	FY 2016	50%	FY 2017	75%	Each year thereafter	75%
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Since the penalties are not cumulative, hospitals have an ongoing incentive to meet meaningful use.

IMPLEMENTATION OF ICD-10, HEALTH PLAN, AND OTHER ENTITY IDENTIFIERS

HHS will adopt the International Classification of Diseases, 10th Revision, Clinical Modification and Procedure Coding System (ICD-10 CM and ICD-10 PCS).

HHS will require health care payers to obtain a national unique health plan identifier or other entity identifier. The implementation date will be November 2016.