



Comments
To
Legislative Health and Human Services Committee
July 7, 2011
Taos

Let's be clear, although the country remains divided over the issue of healthcare reform, hospitals are responding to the many moving parts of the Patient Protection and Affordable Care Act, the federal health reform law. Hospitals are trying to anticipate the final rulings and prepare for reform's impending impact. But many of those pieces are yet to be defined or will be implemented in the future.

Whether or not the ACA survives in its current form, it is clear that transformational change in health care financing and delivery will continue. Hospitals and health systems will be:

- More accountable for the quality and cost of the care they provide
- More integrated with physicians and other providers along the continuum of care
- More at-risk financially for the patient populations they serve.

Hospitals are embracing these changes in their daily operations and the New Mexico Hospital Association is committed to work with legislators and the Executive to develop sound public policy.

Pressures from employers, government, and consumers to control unsustainable increases in health care spending will persist. New payment and delivery models - such as value-based purchasing, bundling, penalties for readmissions and health care acquired conditions, health homes and accountable care organizations (ACOs) - will

drive providers to redesign care processes, improve care coordination, and reduce fragmentation.

I'll briefly address some of these areas but first I think it is important explain the current operating environment faced by New Mexico hospitals.

Hospital *Medicare* payment reductions are the primary means for the federal government to fund expanded Medicaid coverage and subsidized commercial coverage through health insurance exchanges. Nationwide, hospitals are absorbing \$155 billion in Medicare cuts over 10 years. The impact in New Mexico is \$765 million over 10 years. Hospitals strongly believe that movement toward universal coverage is a good thing for patients, payers and providers alike. We were willing to agree to these cuts because of the promise of expanded coverage and the potential for lowering the uncompensated care burden on hospitals. But the cuts started in 2010 and the coverage doesn't start to phase in until 2014. On top of that, the House Budget Committee proposal would keep the cuts but strip the coverage out of the reform law. There is still a great deal of uncertainty about how reform will play out.

The Medicare picture pales in comparison to the impact of recent cuts in Medicaid payments to hospitals. We estimate that hospitals will be impacted at a level of \$200 million *annually* by the advent of a new outpatient payment system that went into effect last November. This represents half of all the cost containment measures being implemented by HSD.

Medicaid is currently the top-of-mind concern of hospital administrators. Given the relative magnitude of the Medicaid program in New Mexico, reduced provider payments, expansion in enrollment due to the economy, expansion in coverage due to ACA and HSD redesign efforts all combine to make it very difficult to effectively plan for services with any sense of stability.

Hospitals are faced with unprecedented Medicare and Medicaid payment reductions and combined with the cost challenges of providing an adequate health professional

workforce, the pressures have never been greater. It's no surprise that 30% of the hospital CEOs have turned over in the last year.

Medicaid payment cuts to hospitals and HSD's Medicaid modernization initiative are complicating hospital efforts to address the broader reform timeline. We have developed guiding principles and talking points which we will share tomorrow with the redesign contractor, Alicia Smith. These principles include the following support statements:

- We support efforts to simplify processes, contracting and program duplication
- We support a very transparent State Plan Amendment process
- We support the open use and publication of quality and performance metrics for all stakeholders in the Medicaid program to include HSD, MCOs, providers and recipients alike.
- We support HSD's efforts to seek administrative efficiencies in the program. We urge the Department to utilize the savings from such efficiencies to enhance the direct care of recipients.

Lastly, we urge state policy makers to keep in mind the significant economic contribution made by New Mexico's hospitals. Hospitals sustain over 28,000 full- and part-time jobs representing \$1.8 *billion* in direct payroll and benefit expense. It's estimated that the total ripple effect impact on the economy is \$6.7 *billion*.

The following is a brief sample of some of the key elements of the health reform law that hospitals are addressing or preparing for:

Medicare shared savings Accountable Care Organizations (ACOs), as described in Section 3022 of ACA, are slated to begin in January 2012. A typical Medicare ACO would include a hospital, primary care physicians, specialists and potentially other medical professionals. Services would still be billed under fee-for-service, but the organization's members would coordinate care for their shared Medicare patients with the goal of meeting and improving on quality benchmarks. Because ACO

members are held jointly accountable for this care, they would share in any cost savings that stem from the quality gains.

The proposed rules are problematic and the concerns being raised should be considered by New Mexico Medicaid redesigners. The following AHA comment to the proposed rule clearly states the core problem:

“The AHA recognizes that in crafting the proposed regulation, CMS attempted to achieve a balance between offering incentives for providers to participate in the ACO program and fulfilling CMS’ obligation to protect taxpayers and the Medicare Trust Fund. However, as proposed, this balance is misaligned. The proposed rule places too much risk and burden on providers with little opportunity for reward in the form of shared savings, especially in light of the significant start-up and operating costs that providers must bear with little or no assistance. In order for hospitals to participate in the program in a meaningful way, a more appropriate balance is needed.”

Many hospitals aren’t *creating* an accountable care organization; they are *becoming* one in spite of the regulatory environment. This issue also raises a point on how New Mexico Medicaid should coordinate efforts with Medicare. It’s reasonable to look to Medicare first for redesign ideas that might work in Medicaid. But the populations served are very different. Care should be taken to use the best models from Medicare while addressing the unique needs of the Medicaid population in New Mexico.

Hospital Value-Based Purchasing stems from the congressional intent to begin to pay hospitals for “value not volume”, meaning value as defined by quality performance on certain measures versus straight payments for the volume of services provided. Beginning in October 2012, hospitals will be paid incentive payments based on their performance on various conditions and procedures as well as the national patient satisfaction survey of Medicare patients.

Bundled Payment The law calls for the establishment of a national pilot program on payment bundling for the Medicare program by 2013 and a Medicaid bundling demonstration program by 2012. The pilot, which will be administered by a new Center for Medicare and Medicaid Innovation (CMI), is a voluntary, five-year pilot program that will test bundle payments. Pilots may involve hospitals, including Long Term Care Hospitals and inpatient rehabilitation facilities, physician groups, and skilled nursing facilities and home health agencies for an episode of care that begins three days prior to a hospitalization and spans up to 30 days post-discharge.

The stated purpose of the program is to improve the coordination, quality, and efficiency of services around a hospitalization in connection with one or more of eight conditions to be selected by the Secretary of Health and Human Services. The health reform law holds a lot of promise for the expansion of bundled payment by authorizing the Secretary to expand the program after the pilot phase, based on performance.

Hospital Readmissions Reduction Program (HRRP) contained in Section 3025 goes into effect in October 2012. CMS has issued proposed rules but hospitals believe they should be revised to properly exclude planned and unrelated readmissions. In addition, socio-economic characteristics of the patient population, including income levels, education, and cultural variations result in differences in patient needs and treatment patterns, and therefore potential readmissions. CMS should include adjustments that account for the socio-economic characteristics of the patient population.

New Mexico hospitals have very low readmission rates and are below national averages. The payment penalties would affect less than half of the hospitals.

Health Care Acquired Conditions (HACs) are discussed in Section 2702. On July 1, 2011, Medicaid payments for HACs will be prohibited. This is an example of where it has been prudent for the State to follow the lead of the feds. Rep. Heaton considered including such a provision in statute 2 years ago but local definitions would have undoubtedly been out of sync with the new federal requirements. But here again, there are cautions in the federal statute. We're seeking changes because hospitals have a

“double jeopardy” for health care acquired infections in both the Value-Based Purchasing section and the Health Care Acquired Condition sections of ACA.

Under Section 2703, States have new options to support “**Health Homes**” for Medicaid beneficiaries with chronic conditions. HSD has expressed interest in Health Homes as a tool in Medicaid redesign. We would like to work with the Department to determine the best mechanisms for encouraging hospital interaction with health home designated providers.

Tort reform never saw its way into ACA. Proponents of tort reform wanted to see the usual talking points appear in the bill: caps on the amount of money juries can award a patient, letting jurors consider a patient’s other sources of income when making an award and assigning damages based on how much a physician and/or hospital contributed to an injury. These principles of traditional tort reform did not make it into the law.

Instead, ACA includes two small provisions related to tort reform:

- The “Sense of Senate” in Section 6801 states that “health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance.” The health care act encourages states “to develop and test alternatives to the civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court.”
- The second, and more substantive, provision of the law is Section 10607 which authorizes \$50 million over a five-year period for demonstration grants, or pilot projects, to states for the “development, implementation and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.” NMHA was supportive of a grant application made by the UNM Health Sciences Center to explore an “Administrative Compensation / Safety System” which would, among

other things, create an opportunity for early compensation for birthing injuries through a schedule approach.

Beyond this sampling, we are also closely monitoring the development of the two HIE's – health *insurance* exchange and health *information* exchange. Furthermore, it's generally assumed that a robust Electronic Health Record will provide the underpinning of many health reform elements. In that regard, both hospitals and doctors will try to maximize the use of Medicare and Medicaid EHR incentive payments to achieve “meaningful use” of the new systems they are putting into place.

While health reform – big H – is unfolding, hospitals are engaged everyday in health reform – little H.

With that, I'll be glad to stand for questions.