Health Care Reform: What’s Next for Academic Medicine?

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AAMC

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What is the AAMC?

- Association of American Medical Colleges
- Not-for-profit association
- Represents:
  - All 141 accredited U.S. and 17 accredited Canadian medical schools
  - Nearly 400 major teaching hospitals and health systems (including 47 Department of Veterans Affairs medical centers)
  - Nearly 90 academic and scientific societies
  - Through these institutions and organizations, 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians
AAMC’s Mission Areas

The AAMC serves and leads the academic medicine community to improve the health of all.

The AAMC’s three mission areas are:

• Research
• Education
• Clinical Care
Health Care Affairs (HCA)

- Health Care Affairs (HCA) lead patient care policy issues related to teaching hospitals and teaching physicians, including:
  - Medicare and Medicaid regulations
  - Care delivery reform and innovation
  - Quality and patient safety
  - Graduate medical education
  - Hospital and physician payment
  - And collaborates with the research and education units of AAMC
AAMC COTH Hospitals are a Safety Net, 2009

COTH Hospitals as a Percent of All Hospitals

- All Other 94%
- COTH 6%

Share of Total Charity Care Costs

- 62%
- 38%

Note: 1) Charity care is that which is provided without expectation of payment, and does not include bad debt.
2) This analysis reflects general, nonfederal, acute care hospitals.
3) AAMC COTH reflects members of the AAMC’s Council of Teaching Hospitals and Health Systems.
### Emerging Themes in Health Care

| Integrated Models of Care – Innovation in Programs | • Accountable Care Organizations  
• Medical Homes  
• Bundling |
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<thead>
<tr>
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<tbody>
<tr>
<td>Expansion of Coverage</td>
<td>• Prevention and wellness, Medicaid expansion, exchanges, nondiscrimination</td>
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<tr>
<td>Refining / Changing Payment Methodologies</td>
<td>• Cuts in payment rates, refinements to payment systems, patient assessment instruments.</td>
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<tr>
<td>Linking Payment to Quality</td>
<td>• Value based purchasing, hospital readmissions policy, electronic health records, registries</td>
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| Program Integrity | • Provider Enrollment  
• Funding Increases for Enforcement  
• Expansion of Audits (RACs) |
Hospital Issues on Horizon

- Medicare/Medicaid cuts to hospitals = $155 B/10 yrs
- Hospital price transparency
- Community benefit reporting requirements/IRS
- Readmissions policies FY 2013
- Value based purchasing FY 2013
- Medicaid voluntary expansion CY 2014
- Exchanges begin CY 2014
- Hosp Acquired Conditions reductions FY 2015
- State decisions on coverage expansion CY2014
Physician Issues on Horizon

• Changes to geographic adjusters in payment
• Quality reporting mandatory for physicians
  o Physician pay ‘value’ modifier
• Public reporting (‘Physician Compare’)
• Medicaid payment rates
  ▪ 2013-14: Rates not lower than Medicare for primary care services (proposed rule)
• Medicare payments
  ▪ 2011-15: bonuses to Primary Care practitioners and General Surgeons
• SGR and Medicare cuts
ACA Implementation Timeline

**Medicare Reforms**
Pilot programs to change how doctors are paid, cost controls

**Insurance Reform**
Young adults on parents' plan, rate review, no lifetime limits

**Medicaid Expansion**
Intended to broaden entitlement to everyone under 133% of federal poverty limit in some states

**Exchanges and Tax Credits**
Sets up a marketplace to buy insurance and helps middle income Americans pay their premiums

**Doctors paid according to quality of care**

**Everything Else**
Restaurant menu labeling, breastfeeding rules, prevention fund, free preventive screenings, etc.

2012

2014

2015
Since ACA Passed...

• Budget Actions
  o Proposed GME cuts
    ▪ President’s budget FY 2013
    ▪ Ryan’s budget FY 2013
    ▪ Simpson-Bowles resurrected
  o Sequestration

• Selected provisions passed or implemented
  o MSSP (ACOs)
  o Value Based Purchasing
  o CMMI Initiatives
General Overview: Medicaid DSH Payments

• State Medicaid payment adjustments/supplements to hospitals serving a disproportionate share of low-income patients (Medicaid and uninsured).

• Each state gets an annual Medicaid DSH allotment (total about $11.5 billion annually; aggregate/state total may not exceed 12% of Medicaid spending).
  ✓ Largest source of federal funding for uncompensated hospital care.
  ✓ In general, a state’s allotment equals the previous year’s allotment, updated by inflation.
  ✓ Significant variation in allotment levels among states.
Medicaid DSH Overview (cont’d)

• States must establish:
  ✓ Criteria for “DSH hospital” designation; and
  ✓ A DSH payment methodology.

• Under Medicaid statute, all DSH hospitals must have (at minimum) a Medicaid utilization rate of 1% and either:
  ✓ A Medicaid inpatient utilization rate exceeding one standard deviation above the mean for all hospitals in the state; or
  ✓ A low-income patient utilization rate exceeding 25%.
ACA and Medicaid DSH

- Per-hospital cuts:
  - Beginning FY 2014, each hospital receives 25% of the Medicare DSH payments calculated under the current formula
    - 25% represents MedPAC’s “empirically justified” Medicare DSH amount (March 2007 Report)
  - Aggregate annual savings is re-directed to eligible hospitals
    - Additional payments will reflect the hospital’s DSH Payment Percentage, the % change in uninsured, and a hospital’s uncompensated care costs
    - Current Medicare DSH formula does not account for uncompensated care costs.
What happens in States that Opt out of Medicaid expansion?

• If states opt out, adults without children and some parents would find themselves in a hole: Ineligible for Medicaid but may not qualify for federal subsidies.

• Without the expansion, the cost of uncompensated care will continue to spiral upward and more costs will be shifted to the insured.

• Both DSH cuts and lack of expanded Medicaid populations would differentially impact AMCs
GME financing under fire

• Reduce excess payments to hospitals for medical education.
  o Limit DGME payments to 120% of the national average resident in 2010
  o Reduce IME from 5.5% to 2.2%
• $6B/yr cut to teaching hospitals
Anticipate Accountability in GME

• MedPAC recommendation is to tie 50% of IME funding to accountability metrics

• Modify the current system of funding for GME to “support medical education that supports skills needed in a delivery system that reduces cost growth while maintaining or improving quality”

• Members of Congress very interested in accountability concept
HOPD E/M Cuts – AAMC Analysis

• Proposed “equalizations” disproportionately affect America’s teaching hospitals (consistent with MedPAC)
  • 69% of the total reductions come from teaching hospitals
  • 45% of the total reductions come from major teaching hospitals

• AAMC members provide disproportionate health care services to challenging patient populations including duals, disabled, and “non-white” patients compared to other hospitals and physician offices
Potential Dollars at Risk for Quality Provisions (% reduction in DRG payments)

**Potential to have 6% of base DRG payments at risk by 2017**

- **VBP**
  - Begin FY 2013
  - 1-2% reduction (phased in over 4 years)
  - Opportunity to recoup full amount and more

- **Readmissions**
  - Begin FY 2013
  - 1-3% reduction cap (phased in over 3 years)

- **Hospital Acquired Conditions**
  - Begin FY 2015
  - 1% reduction
Value-Based Purchasing

• Move from pay-for-reporting to pay-for-performance
• Must meet thresholds based on achievement or improvement to receive incentive payment
• Phased-in reduction to base DRG payment to fund incentive pool: 1% for FY 2013 increasing by quarter increments annually up to 2% in FY 2017
• Applies to base DRG payment only, does not affect IME, DSH and outlier payments
• Budget neutral – all funds are returned to hospitals
• Initial year of program includes process measures and HCAHPS
VBP Domains for FYs 2014 - 15

Domain Weighting
FY 2014

- Process: 45%
- Outcomes: 25%
- HCAHPS: 30%

Domain Weighting
FY 2015

- Process: 30%
- Outcomes: 20%
- Efficiency: 30%
- HCAHPS: 20%
Risks to funding for support for education, uninsured and research

<table>
<thead>
<tr>
<th>Program</th>
<th>Type</th>
<th>Amount</th>
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<tbody>
<tr>
<td>IME</td>
<td>Medicare</td>
<td>$5.7 billion</td>
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<tr>
<td>DGME</td>
<td>Medicare</td>
<td>$2.7 billion</td>
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<tr>
<td>GME</td>
<td>Medicaid</td>
<td>$3.2 billion</td>
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<tr>
<td>DSH</td>
<td>Medicare</td>
<td>$9.8 billion</td>
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<tr>
<td>DSH</td>
<td>Medicaid</td>
<td>$11.1 billion</td>
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<tr>
<td>NIH</td>
<td></td>
<td>$14 billion</td>
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Moody’s bond downgrade for U of M hospitals

“We Challenges: Steep decline in operating cash flow driven by increased expenses of opening the new women's and children's hospitals and implementation of new clinical information technology. In FY 2012, Moody’s-adjusted operating cash flow declined to a very low 2.9% after transfers from a thin 5.2% the prior year. Management anticipates continued operating pressures and has instituted improvement initiatives.

Sizeable transfers to The University of Michigan Medical School to support strategic operating needs and substantial recent capital investment of UM Hospitals weaken operating and debt measures when including transfers in expenses and loans from the university as direct debt, resulting in much lower metrics including peak debt service coverage.

Revenue pressures with shifts from commercial to governmental payers and non-pay patients as well as more moderate rate increases;

Outlook: The stable outlook reflects the strong relationship and oversight by University of Michigan, with a goal to create efficiencies and improve operations. The outlook is further supported by our belief that UM Hospitals will continue to generate good cash flow before transfers to support its rated debt load, while maintaining a good liquidity position. New construction projects will add additional capacity to meet growth in volumes and to provide additional revenues and cash flow.

WHAT COULD MOVE THE RATING UP: Marked improvement in operating cash flow generation and resulting increase in debt service coverage (after transfers); material decline in total debt load.
A Positive Perspective:

There is a view that constructive change is possible and that AMCs will be drivers of that change. Strengths include:

• Inherent Sustainability
• Strong Market Positions
• Resilience
• Experienced Employers of Physicians
• Leaders well matched to a complex future

D. Beckham H&HN Daily 12/15/2011
Immense Pressure for Action in Six-Week Window

- Nov 6, 2012: Election Day
- Nov 13, 2012: Lame Duck Session Begins
- Jan 1, 2013: Lame Duck Ends; Congress Resumes; SGR Patch Expires

Dec 31, 2012:
- Bush-era tax cuts expire
- Emergency unemployment benefits end
- Payroll Holiday Tax ends
- Alternative Minimum Tax exemptions end

Jan 2, 2013:
- Sequester takes effect
  - $55B in mandatory defense cuts
  - $55B in mandatory non-defense cuts
Sustainable Growth Rate (SGR) Patch Set to Expire...

- SGR – instituted in BBA of 1997
- Intended to constrain growth in physician spending to a target. Payment updates determined by difference in spending and target.
  - Overridden by Congress every year except 2002
- If no fix or “patch” by end of year, physician payments will be cut by 27% on 1/1/13

Fixing the problem:

- $245 billion for 10 year freeze
- 1-2 year “patch” more likely @ $18.5 - 48 billion, with a 22 - 26 percent cut on January 1, 2014 or 2015
Breaking Down the Sequester

## OMB Preliminary Annual Sequestration Estimates

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Non-defense Discretionary</td>
<td>8.2 %</td>
<td>$38.0 B</td>
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<tr>
<td>Non-defense Direct</td>
<td>7.6 %</td>
<td>$5.6 B</td>
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<tr>
<td>Medicare</td>
<td>2.0%</td>
<td>$11.1 B</td>
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<tr>
<td><strong>Subtotal, Non-defense</strong></td>
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<td><strong>$54.7 B</strong></td>
</tr>
<tr>
<td>Defense Discretionary</td>
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<tr>
<td>Defense Direct</td>
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<td>$0.1 B</td>
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<tr>
<td><strong>Subtotal, Defense</strong></td>
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<td><strong>$54.7 B</strong></td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>$109.3 B</strong></td>
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*Note: Medicaid, VA, and AHRQ exempt from sequestration.*
# OMB Preliminary Sequestration Estimates for Programs of Interest to Academic Medicine

<table>
<thead>
<tr>
<th>Program</th>
<th>Sequester</th>
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<tbody>
<tr>
<td>Medicare</td>
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<td>Medicaid</td>
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<tr>
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<td>AHRQ</td>
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<td>PCOR Trust Fund</td>
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<tr>
<td>VA Healthcare</td>
<td>Exempt</td>
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Lame Duck Scenarios

- Grand Bargain/Balanced Approach
- "Kick the Can"
  - How long
  - Offsets
- Carve Out Bills
  - Defense, Medicare
- Cancel outright

Note: For the 7 lame duck sessions since 1990, the House has convened an average of six days; the Senate, ten days
“The budget hemorrhaging has hit at scattered teaching hospitals across the country, from San Francisco to Philadelphia. New York's clusters of teaching hospitals are among the biggest and hardest hit, the Greater New York Hospital Association says. It predicts that Medicare cuts will cost the state's hospitals $5 billion and force the closing of money-losing departments and whole hospitals. Dr. Samuel O. Thier, president of the group that owns Massachusetts General Hospital, says, "We've got a problem, and you've got to nip it in the bud, or else you're going to kill off some of the premier institutions in the country."
"If you can’t keep up, we could go broke, then you’d have to bail us out, and that could lead to European-style socialism!"
Average Health Care Spending per Capita, 1980–2009
Adjusted for differences in cost of living

Source: OECD Health Data 2011 (June 2011).
It is not necessary to change. Survival is not mandatory.

W. Edwards Deming