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## *Healthcare Reform: Impact on Hospitals*

The Patient Protection and Affordable Care Act (ACA) amended by the Health Care and Education Reconciliation Act (Reconciliation Act), collectively referred to as healthcare reform, will implement many significant changes affecting hospital providers. Several of these changes will be discussed below.

In response to increased criticism that tax-exempt hospitals are not fulfilling their charitable missions, the ACA aims to increase transparency concerning the special benefits and incentives tax-exempt hospitals receive by imposing additional requirements when qualifying for 501(c)(3) status.[1] In addition, the ACA requires tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three years to better demonstrate that they are meeting the particular needs of the patient community they serve.[2] Tax-exempt hospitals will also be required under the ACA to establish a written financial assistance policy which would include, among other things: (1) the criteria for eligibility for financial assistance; (2) the basis for calculating amounts charged to patients; and, (3) the steps to be taken in the event of nonpayment.[3] Other provisions in the ACA will require tax-exempt hospitals to increase their accountability for the quality of care provided to patients. Failure to comply with any requirement of the CHNA can result in a penalty of up to $50,000.[4]

To promote the goals of lowering healthcare costs and increasing the quality of patient care, two payment systems are being established with the goal to directly tie reimbursement to performance: value-based purchasing and bundled payments. Effective October 1, 2012, the ACA mandates a value based purchasing model (first initiated by The Centers for Medicare and Medicaid (CMS) in 2007) for all hospitals.[5] Value – Based Purchasing (VBP) is a model whereby incentive payments are given to hospitals that meet or exceed certain performance benchmarks set by CMS.[6] In the past, hospitals were rewarded for simply reporting their performance in certain areas.[7] Under the ACA, and the VBP reimbursement model, such reporting is mandatory, with a percentage of Medicare reimbursement tied directly to achieving certain quality benchmarks.[8] The benchmarks will take various aspects of care into consideration, including certain efficiency and patient satisfaction metrics.[9] Beginning in FY 2013, the clinical measures for these incentive payments will include achieving certain quality metrics related to such clinical conditions as heart failure, pneumonia and hospital-related infection, with more conditions to be considered after that time.[10]

In addition to the VBP reimbursement model, various pilot programs were created by the ACA to promote efficiency and accountability by healthcare providers. Perhaps most notably is the bundled payment pilot program, whereby a single bundled reimbursement is provided for an episode of care, beginning three days before admission to the hospital and ending thirty days after the patient is discharged.[11] The Secretary of CMS has been charged with establishing a national pilot program for bundled payments by January 1, 2013,[12] with one of the goals being to correct the inefficiency of the current "fee-for-service" model, as well as to lower hospital readmission rates[13] The ACA's bundled payment system, if fully implemented, will greatly impact hospitals, as both hospitals and physicians would share a single payment.[14] For more information on bundled payments see Health Capital Topics October 2010 issue, "*Emerging Healthcare Organization Series, Bundled Payments*."

With already overwhelmed waiting areas, hospitals with emergency departments have started implementing new approaches to handle overcrowding in anticipation of the nearly 34 million uninsured that will enter the market in 2014 under the ACA insurance mandate. There organizational changes range from differing intake procedures based on severity of care needed; more efficient use of bed space; and, lowering re-admission rates.[15] In addition, new healthcare delivery structures and arrangements promoted by the ACA, such as Accountable Care Organizations (ACOs), will affect the current organizational structure of many hospital enterprises. Under the various existing enterprises recognized as primary candidates for ACOs, the hospital controlled model is one of the most popular.[16] However, certain state limitations on the corporate practice of medicine may pose barriers to the implementation of this model.[17]

This article highlights a few of the myriad changes that hospitals will experience as a result of the ACA. Common themes in all of these reforms are accountability, efficiency, and quality – three of the cornerstones that are driving healthcare reform efforts. The next article in this series will explore the impact of healthcare reform on physician providers.

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[3] "Patient Protection and Affordable Care Act", § 9007(a)(4), Pub. L. 111-148, 124 Stat. 856, March 23, 2010.

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[6] "Patient Protection and Affordable Care Act" § 3001, Pub. L. 111-148, 124 Stat. 856, March 23, 2010.

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[17] "Herding Cats? What Health Care Reform Means for Hospital-Physician Alignment and Clinical Integration" By Daniel H. Melvin and Chris Jedrey, McDermott, Will & Emery (October 13, 2010), p.38.



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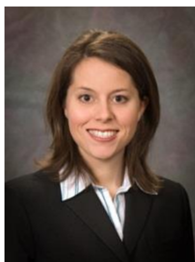

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