

Strategic Implications of the Patient Protection and Affordable Care Act for Academic Health Centers

By Mindy J. Steinberg, MPH

Anticipating behavioral responses by other stakeholders, academic health centers should consider strategies to better position themselves for the new realities of the post-health reform environment.



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The Patient Protection and Affordable Care Act (PPACA, Pub L 111-148), enacted in 2010 and mostly upheld by the Supreme Court in June 2012, embodies the most significant changes in federal health policy in 40 years. Provisions related to hospital reimbursement, reductions in disproportionate share hospital (DSH) payments once reduction in uninsured thresholds are reached, fraud and abuse, quality improvement, research, manufacturers' payments to physicians and teaching hospitals, graduate medical education, student loans, and health workforce will affect academic health centers in ways both anticipated and unanticipated by the drafters of the law.

The Association of Academic Health Centers (AAHC) released a preliminary analysis after PPACA was passed, along with two additional papers focused on specific provisions of the bill that addressed accountable care organizations (ACOs) and graduate medical education (GME). This issue brief provides an updated analysis and reviews the implications of health reform, given the effects of the the Supreme Court decision. The analysis steps back from the details of the legislation in order to assess broader strategic implications of health reform for AAHC member institutions.

OVERVIEW OF SUPREME COURT DECISION

In a 5-4 decision announced on June 28, 2012, the Supreme Court upheld most of the PPACA as constitutional, including the major provision in question: the individual insurance mandate. However, the Court did make one fundamental change to PPACA. The original law included an expansion of Medicaid eligibility to 138% of the federal poverty level (FPL). Included in the Medicaid expansion was a commitment that the federal government would pay 100% of the cost of all additional Medicaid enrollees brought in due to

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the expansion (stepping down to 90% by 2020). The Secretary of Health and Human Services was also given the discretion to withdraw some or all of a state's federal Medicaid dollars if the state did not expand eligibility. The Court ruled that Congress did not have the power to require the eligibility expansion of states, leaving the Medicaid expansion portion of the law optional for states. If states choose not to participate in the expansion, they will continue to receive their current rate of federal Medicaid funding. States that do participate will receive the full 100% for enrollees in the expansion until 2020.

The new optional status of the Medicaid expansion may prove to be problematic because of the potential for significantly higher numbers of people left without insurance coverage. PPACA provides subsidies for people between 138% and 400% FPL to purchase their own private coverage through a state exchange, with the assumption that people who earned 138% FPL or below would be eligible for Medicaid. In those states that choose to opt out of the expansion, some people will have incomes too high to qualify for Medicaid and too low to qualify for subsidies.

It is not yet clear how the optional Medicaid expansion will be operationalized. It will be up to the Department of Health and Human Services (HHS) to determine all of the details, including the process for a state to opt in or out. Perhaps most concerning, it is unclear what HHS' plans are to handle those low-income people in states that opt out of the Medicaid expansion and who do not qualify for subsidies to purchase private insurance.

OVERVIEW OF POLICY CHANGES

Expansion of coverage and the health care system.

In light of changes to the Medicaid expansion, the nonpartisan Congressional Budget Office (CBO) and the Joint Committee on Taxation

(JCT) have adjusted their initial projections of the cost of PPACA, as well as its resulting increase in coverage. It is now estimated that PPACA will result in more than \$1,168 billion in new spending over the next 10 years, an \$84 billion reduction from costs estimated in March 2012.¹ The law includes a mandate on individuals to be covered, a mandate on employers (excluding small employers) to provide health benefits, subsidies for low-income individuals and small businesses, and the aforementioned option to expand Medicaid to 138% of FPL. The CBO and JCT now estimate that the mandates, incentives, and other expenditures are expected to insure approximately 30 million additional people, resulting in expansion of healthcare coverage to 92% of the population by 2022. Virtually every aspect of healthcare financing and delivery will be affected, inevitably altering the mix of public and private payers, increasing demand for services, and stressing supply in many communities.

Downward pressure on reimbursement, increased focus on value.

Changes to Medicare reimbursement policies will directly and indirectly affect payers and providers. Healthcare reform ratchets down Medicare reimbursement of hospitals, nursing homes, home health care, hospice, labs, and other providers; Medicare physician fee cuts are to be addressed separately. Medicare Advantage health plans also face cuts in excess of \$100 billion over 10 years. PPACA opens the door to more fundamental changes to Medicare, however, by introducing economic incentives for primary care physicians, an independent payment advisory board, support for the medical home, a Center for Medicare and Medicaid Innovation (CMMI), and demonstrations or grants related to accountable care organizations, bundled payments, and hospital value based payments.

¹ Congressional Budget Office. (2012). *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (CBO Publication No. 43472). Washington, DC: U.S. Government Printing Office. Retrieved from <http://www.cbo.gov/publication/43472>

Increased emphasis on transparency, fraud and abuse enforcement.

PPACA seeks to strengthen comparative effectiveness research and provide for the development, implementation, and reporting of provider quality measures. In addition, it requires new disclosures relating to nursing home ownership and drug/device company payments to physicians and teaching hospitals. PPACA also increases the size and use of civil monetary penalties and requires providers to implement compliance programs. Among the fraud and abuse provisions most likely to impact academic health centers are requirements to repay overpayments within 60 days and to file claims within one year.

Increased emphasis on health workforce and health professions education.

PPACA creates a new national commission to review health workforce needs, recommend policy changes, and foster development of a national health workforce strategy. Members of the National Health Care Workforce Commission were announced by the Government Accountability Office (GAO) in September 2010. Unfortunately, Congress has yet to appropriate any funds for the Commission, and thus, the Commission has been unable to conduct any business.

PPACA also makes a number of health workforce and health professions education policy changes in advance of the formulation of a coordinated national policy, including (but not limited to):

- **Medicare and Medicaid:** providing incentives/payments for primary care physicians; support for medical homes; expansion of physician assistants' role in Medicare; independence at home demonstration program; reauthorization of patient navigator program.
- **Prevention and Public Health:** establishment of the Prevention and Public Health Fund; school-based health centers grants; pain-care education and training.
- **Health Workforce Innovation:** creation of a national center for health workforce analysis; health workforce development grants.

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- **Health Workforce Supply:** revised HRSA health professions student loan guidelines; nurse student loans; pediatric subspecialty loan repayment program; public health workforce loan repayment; mid-career public health and allied health scholarships; inclusion of allied workforce recruitment and retention program in the Higher Education Act; increased funding for the National Health Service Corps; nurse managed health clinics; ready reserve corps; tax exclusion for NHSC loan repayment, state loan repayment or loan forgiveness programs intended to increase availability of healthcare services.
- **Health Workforce Education and Training:** specifying primary care residency program grants; tuition assistance for direct-care workers; dentistry training; grants for alternative dental providers in rural and underserved areas; geriatric workforce development grants; mental and behavioral health education and training; cultural competency, prevention, and disabilities training; nurse career ladder and retention grants; nurse faculty loans and loan repayment; community health workforce behavioral outreach; public health fellowships; public health sciences track and commissioned corps service requirement; rural-focused education and training grants; preventive medicine and public health training grant program; family nurse practitioner training program.
- **Health Professions:** supporting interdisciplinary innovations; healthcare professions training for diversity; reauthorize Title VII AHEC program; workforce diversity grants for nurse training; a primary care extension program through the Agency for Healthcare Research and Quality (AHRQ).
- **Other Workforce Improvements:** Promoting

Medicare incentive payment for general surgeons; development of prospective payment system for federally qualified health centers; redistribution of unused residency slots; demonstration project to provide low income individuals with support for health professions training; grants to teaching health centers to promote primary care; graduate nurse education demonstration program.

- **Access to Services:** enhanced funding for federally qualified health centers; negotiated rulemaking for designation of health professions shortage areas (HPSAs) and medically underserved methodology; community health center fund for CHCs and the National Health Service Corps (NHSC); three-year demonstration for states providing access to affordable care.

IMPACT OF HEALTH REFORM ON ACADEMIC HEALTH CENTERS

With implementation of PPACA now in full swing, what can academic health centers expect from health reform? The impact of reform on academic health centers will vary with each institution's particular circumstances; AAHC anticipates some common experiences, however, including:

- **Insurer behavioral response.** Facing new restrictions on past underwriting practices and coverage limitations, as well as increased scrutiny of premium increases, insurers are likely to revisit utilization and care management techniques they backed away from following the patient protection backlash in the late 1990s. Some insurers are already aggressively promoting Medicaid

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- **Government behavioral response.** With the Supreme Court challenges decided, the battle moves back to Congress. The 2012 Republican Party platform includes continued support for the repeal of PPACA. However, if election results make repeal impossible, it is likely that those in Congress who oppose PPACA will turn their focus towards the appropriations process and implementation financing. Efforts to defund HHS' ability to implement PPACA should be expected in 2013.

Already under intense fiscal pressure due to economy-driven budget shortfalls, states and the federal government now face the costs associated with health reform's significant expansion of both public and private coverage. If Massachusetts' post-reform experience is a preview of the national experience, the costs may be more, and the savings less, than anticipated:

- *Compliance enforcement:* PPACA, together with other recent legislation, adds a significant new layer of fraud and abuse requirements. There is bipartisan interest in increased fraud and abuse enforcement because it is viewed as paying for itself. Because fraud and abuse enforcement tends to be more cost effective when focused on the largest institutions that generate the most and largest claims, academic health centers are likely to be subject to even greater compliance scrutiny and risks from this point forward.
- *Medicaid managed care redux:* In addition to maintaining, if not deepening, current budget reductions, states looking to reduce healthcare expenditures are once again examining the implications of significantly increased use of managed care within their Medicaid programs. Some states may "privatize" coverage for most or all Medicaid recipients.

- *Negotiated fee schedules:* Following the lead of Massachusetts, which recently began aggressively resisting insurance premium rate increases, a wave of state resistance to health insurance premium increases around the country could follow. Faced with an inability to raise premiums, insurers may ultimately demand some form of negotiated universal fee schedules that could garner support both from employers (who have long viewed themselves as victims of significant cost-shifting by public programs) and state governments reluctant to raise taxes to pay for increasing healthcare expenditures.
- **Patient behavioral response.** Providing chronically uninsured populations healthcare coverage does not, by itself, teach newly covered persons how to effectively use healthcare. Anticipated savings from replacing uncompensated care with insured coverage may not be fully realized where newly-covered patients significantly increase their health care consumption but do so inefficiently (e.g., receiving redundant care from multiple providers who are unaware of each others' interventions), especially in the case of patients with Medicaid coverage that pays significantly below the cost of services provided.
- **Market consolidation.** With some healthcare institutions already struggling financially, the added uncertainty, stress, and disruption associated with reform could lead to closures and/or restructuring, which raises both the possibility of consolidation and the potential for increased antitrust enforcement activities.

ACADEMIC HEALTH CENTERS CAN STRATEGICALLY RESPOND TO THE NEW REALITIES OF HEALTH REFORM

Anticipating these behavioral responses by other stakeholders, academic health centers should consider strategies to better position themselves for the new realities of the post-health reform environment, such as:

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- **Streamlining and standardizing compliance.** The emphasis on fraud and abuse enforcement in PPACA and other recent legislation, and the likely increased compliance risks, should be a clarion call to any academic health center that has not already assessed and reengineered its compliance function to improve efficiency and consistency across the entire institution, as well as for academic health centers collectively to standardize practices across institutions.
- **Becoming significantly more cost competitive and demonstrating greater value.** The healthcare sector lags behind other sectors of the economy in terms of efficiency and productivity. Academic health centers, which typically have higher cost structures than competing providers, will be especially vulnerable financially unless they reengineer themselves to be much more cost competitive and demonstrate superior outcomes.
- **Innovating alternative payment mechanisms.** PPACA contains several provisions that offer academic health centers the opportunity to explore alternatives to traditional fee for service payment (e.g., accountable care organizations, payment bundling, hospital value based payments). Academic health centers should exploit this opportunity to preserve alternatives to future negotiated universal fee schedules.
- **Developing shared data systems to identify and address inefficient healthcare consumption patterns across communities.** As disproportionate providers of last resort compared to for-profit competitors, academic health centers often struggle with wasteful healthcare consumption patterns by uninsured and publicly insured

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patients. Many of the highest cost patients visit multiple providers who are unaware of services already provided. Additionally, income and geographic residence are often highly correlated with healthcare consumption patterns that could be much more effectively and efficiently addressed by community-based care and prevention. Academic health centers should work cooperatively with other service providers to develop shared databases that track care consumption patterns community-wide to identify opportunities for targeted interventions that can be financed by retaining a share of savings realized.

- **Embracing accountability for community health.** Given their unique combination of analytical resources, research capabilities, and patient care expertise, academic health centers are better positioned than either government or their patient-care competitors to take responsibility for addressing behaviorally-driven chronic health conditions. Faced with increased competitive pressure in routine acute care services, academic health centers should explore community health as an opportunity to develop new or expanded roles and funding streams.

CONCLUSIONS

The AAHC's strategic analysis of PPACA suggests that the most profound effects of health reform on academic health centers may come from the behavioral responses to health reform by government, insurers, and patients, rather than from the direct impact of specific provisions of the law. Academic health centers can anticipate these behavioral responses, better positioning themselves for the new realities of the post-reform

environment. As a crucial component of the healthcare safety-net, academic health centers will continue to serve as healthcare providers for the uninsured, even as their numbers decline. Coupled with scheduled cuts in Medicare and DSH payments, caring for the uninsured could have a significant impact on the financial health of academic health centers.

As academic health centers examine ways to increase cost efficiency while maintaining the quality of the services they provide, fundamental changes to the healthcare system will likely precipitate the need to reconsider the current business model that requires the research and education functions to be dependent upon excess clinical revenues for sustainability. Understanding that "collaboration is the new competition," academic health centers should undertake a more collaborative mode to share best practices, investigate new models of organization, and experiment with innovative methods of care delivery that incorporate research and education.

Academic health centers also have an opportunity to strongly influence long-term public perception and policy regarding health reform by speaking out as prominent institutions and as individual practitioners. It is, of course, imperative that academic health centers actively engage their state and federal policymakers, specifically on fiscal issues. AAHC and its member institutions will continue to widely disseminate communications about the financial realities of the academic health center enterprise and the vital economic importance of our institutions. This will be of particular importance, for example, as governors and state legislatures are faced with the decision whether or not to opt in to the Medicaid expansion. In this era of reform and significant change, collaboration among the academic health center community is key to ensuring that the needs of our institutions are considered in policy decisions.



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1400 Sixteenth Street, NW, Suite 720
Washington, DC 20036
202.265.9600
202.265.7514 fax
www.aahcdc.org

*For more information, contact Mindy J. Steinberg, MPH,
Director of Government Relations, msteinberg@aaahcdc.org*

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