

## Impact of Health Reform: Academic Medical Centers and Public Teaching Hospitals

Academic medical centers (AMCs) and public hospitals will be affected by all of the health reform provisions that impact hospitals more generally such as market basket adjustments, quality payment provisions, penalties for readmissions, Sustainable Growth Rate, physician payment provisions, etc.

AMCs and public teaching hospitals will be impacted by changing and expanding coverage of the uninsured. The un- and under-insured populations have typically been cared for by public teaching hospitals in many cities and regions because they do not represent an attractive patient population for other hospitals and physician groups. Those that are newly insured either through employers or through state insurance exchanges may now be more attractive to other providers and AMCs may need to be more aggressive in ensuring that they are meeting patients' needs in order to retain the patient population.

For those that receive health care coverage through Medicaid expansion, the new system will provide some coverage for the formerly uninsured but at payment rates inadequate to cover provider costs. Development of new care models that are primary care focused and include effective chronic disease management will continue to be important for this patient population.

### DSH Payments

AMCs are, in many cases, also public safety net hospitals. The Reconciliation Act outlined final disproportionate share hospital (DSH) payment reductions and authorized the Secretary of Health and Human Services to target Medicaid DSH reductions across states based upon rates of uninsured and costs of uncompensated care.

Medicare DSH payments will be cut by \$22.1 billion beginning in 2014 if uninsured rates decrease. A portion of the cuts are to be returned to hospitals with high uncompensated care costs.

The aggregate Medicaid DSH reductions (from an estimated base of \$13 billion in 2014) are as follows:

Year	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Reduction	\$500M	\$500M	\$600M	\$1.8B	\$5B	\$5.6B	\$4B

### Grants

The new health reform law also provides grant funding for the establishment of “collaborative care networks” across community health centers, safety net hospitals, public health departments, etc.

### Graduate Medical Education (GME) Funding

The Health Reform law provides very modest, and less than hoped for relief to the national caps on GME slots eligible for Medicare funding.

- Redistribution of 65 percent of unused slots
- 70 percent of the redistributed slots will be given to hospitals in states with resident-to-population ratios in the lowest quartile
- 30 percent of redistributed slots will go to hospitals in the 10 states with the highest proportion of the population in a Health Professional Shortage Area (HPSA) and to rural hospitals

- An individual hospital is limited to 75 new slots
- At least 75 percent of the new slots must be used for primary care or general surgery for at least 5 years

Most academic medical centers will not benefit from this reallocation and will continue to struggle with the demand for additional physicians and a growing number of medical school graduates but no additional residency and fellowship training slots.

### **Health Innovation Zones**

The Reform law allocates \$10 billion to the newly-established Center for Medicare and Medicaid Innovation (CMI). The CMI is intended to test payment and delivery models that can improve quality and slow the rate of Medicare cost growth. One option that CMI may consider testing is the Health Innovation Zone (HIZ) concept, which was developed by the Association of American Medical Colleges (AAMC). HIZs are essentially an integrated delivery network with an AMC at its core, which encompasses the full spectrum of comprehensive and community care. The goal of an HIZ is to build new collaborative relationships focused on development of new and innovative care delivery models such as accountable care organizations (ACOs) or medical homes to be tested by the HIZ with the ultimate goal of enhanced clinical practice and improved health.

### **Grants to Develop Teaching Health Centers (THCs) (Sec. 5508(a))**

In an effort to increase the size of the primary care workforce, the Health Reform laws authorize \$25 million in FY 2010, \$50 million each in FYs 2011 and 2012, and “such sums as may be necessary” in subsequent years to encourage teaching health centers (THCs) to expand or establish new primary care residency programs. For purposes of this section, primary care residency programs are defined as approved programs in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics. Of the total funding, up to \$5 million per year may be spent on “technical assistance program grants,” a term that is not defined in the statute and that will have to be explained through regulation.

The law defines a THC as an entity that (1) is a community-based, ambulatory patient care center, and (2) operates a primary care residency program.

### **Other**

AMCs and public teaching hospitals should be in a unique position to participate in the various pilot programs created through the health reform laws.

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