Federal Healthcare Reform: The Push for Quality, Efficiency and Integration

Kathryn Hickner-Cruz, Esq.
Adrienne Dresevic, Esq.
The Health Law Partners, PC, Southfield, MI

By now, most healthcare providers have at least a basic understanding of the recent and broad sweeping federal healthcare reform legislation commonly known as the Affordable Care Act,[1] which was adopted during March, 2010. Although Republicans in Congress are expected to use the "power of the purse" to limit the impact of the Affordable Care Act, it is anticipated that those aspects of the law focusing on reforming the healthcare delivery system will be less constrained than those provisions focusing on health insurance reform.

Among its many facets, the Affordable Care Act functions as a catalyst for integration among health care providers (including anesthesiologists) by mandating that Medicare and Medicaid pay for value (i.e., quality and efficiency) as opposed to volume. Achieving the performance standards imposed by the federal government under the Affordable Care Act will require coordination and cooperation among providers. As a result, the healthcare community is responding to the Affordable Care Act by taking action and preparing for change. Healthcare attorneys across the country are diligently working to organize corporate structures and negotiate relationships to allow their clients to thrive in this uncertain reimbursement environment, while simultaneously ensuring compliance with the complex state and federal healthcare regulations.

This article summarizes certain specific aspects of the Affordable Care Act that encourage integration within the health care industry, including: (1) the Medicare Shared Savings Program, (2) the Center for Medicare and Medicaid Innovation, (3) the National Pilot Program on Payment Bundling and (4) the Hospital Value-Based Purchasing Program.

Medicare Shared Savings Program

One aspect of federal healthcare reform eliciting significant interest among healthcare providers is the Affordable Care Act's Medicare Shared Savings Program, under which Accountable Care Organizations (ACOs) that meet certain quality and efficiency performance standards will be eligible to receive certain financial incentives (enhanced reimbursement).[2] The Secretary of the United States Department of Health and Human Services is required to establish the Shared Savings Program no later than January 1, 2012.

The Shared Savings Program embraces the concept of the patient-centered medical home. Under the Shared Savings Program, each ACO will be assigned at least 5,000 Medicare fee-for-service beneficiaries based upon those beneficiaries' utilization of primary care physicians. In comments by the American Society of Anesthesiologists (ASA) made during December, 2010 to the Centers for Medicare and Medicaid Services (CMS) regarding the Shared Savings Program, the ASA expressed its support for a surgical home model to achieve further coordination of care led by anesthesiologists. Such a model could be adopted in connection with the medical home concept that will be promoted by ACOs.

The Affordable Care Act provides that numerous types of organizations can become ACOs. For example, the various types of models include hospital employment models, group practices, joint ventures, physician organizations, physician hospital organizations and contractual models such as management services arrangements. Notwithstanding such structural flexibility, all ACOs will need to satisfy certain standards, including for example, each of the following: (a) being willing to be

[1] The "Affordable Care Act" refers to the Patient Protection and Affordable Care Act adopted March 23, 2010 ("PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010 adopted on March 30, 2010 ("HCERA").
[2] PPACA Section 3022.

accountable for the quality, cost and overall care of Medicare beneficiaries; (b) contractually committing to participate in the Medicare Shared Savings Program for at least three (3) years; (c) maintaining a management structure that includes clinical and administrative systems; and (d) adopting processes to promote evidence based medicine and patient engagement, report on quality and cost measures, and coordinate care. The Secretary will promulgate regulations to refine each of these broad and amorphous requirements. As a condition of receiving Medicare shared savings payments, ACOs will need to submit information to the Secretary as necessary to determine the quality and efficiency of care furnished by the ACO. Each ACO will need to have the information technology and other electronic health record (EHR) infrastructure in place to maintain, share, retrieve and report meaningful and usable data.

In order to achieve the clinical and administrative coordination and sharing of information that will be necessary to the success of ACOs, physicians, hospitals and other professionals will need to integrate (both clinically and either corporately or contractually) but within the constraints of applicable law. Significant bodies of federal and state law impose numerous barriers to integration among healthcare providers, including the federal Anti-Kickback Statute, the federal Stark Law, and the federal Civil Monetary Penalty Law (all of which are designed to prevent fraud and abuse with respect to the federal healthcare programs), federal tax exempt laws (prohibiting, for example, impermissible benefits to private individuals), the federal and state patient privacy laws, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) (setting forth standards for the security and privacy of patient information) and the state corporate practice of medicine doctrines (adopted, in part, to preserve the unique attributes of the physician-patient relationship). Furthermore, ACOs will need to be designed with sensitivity toward the federal antitrust laws, which are designed to encourage competition and limit market concentration. Many experts envision progressive changes in many of these substantive areas of the law as governmental authorities attempt to reconcile the tensions created between current legal requirements and the integration required to operate a successful ACO.

Additional guidance from CMS regarding the Shared Savings Program is expected to be published soon. As referenced above, during December, 2010 the ASA provided CMS with its comments regarding the Shared Savings Program and its insight with respect to anesthesiologist participation in the Shared Savings Program due to the unique nature of anesthesiology and the limited resources of those anesthesiologists that are solo and small practice providers.

Center for Medicare and Medicaid Innovation

The Center for Medicare and Medicaid Innovation (CMI or the Innovation Center) is charged with exploring innovative payment and service delivery models that improve the quality and affordability of Medicare and Medicaid coverage, focusing especially on those models that address groups of individuals experiencing deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.[3] The Affordable Care Act sets forth twenty models deemed to accomplish these objectives and a list of eight additional considerations for the selection of models. CMI has already announced new initiatives that focus on the "medical home" concept. Because CMI will embrace the principles of patient

centeredness, coordination of care, and the improved quality and efficiency of health care services, the CMI programs are likely to promote bundled payment programs, ACOs and other integrated models. To advance the mission of CMI, the Affordable Care Act provides $10 billion in funding during fiscal years 2011-2019.

National Pilot Program on Payment Bundling

The Affordable Care Act requires that the National Pilot Program on Payment Bundling be established by January 1, 2013 and that it shall continue for a period of at least five (5) years.[4] Groups of providers and suppliers (each of which must include a hospital, physician group, skilled nursing facility and home health agency) will need to organize themselves under a single umbrella for purposes of submitting an application to participate in the Payment Bundling Program. Those participants that are accepted into the program will receive a comprehensive bundled payment covering certain services furnished to an individual during an episode of care with respect to covered medical conditions. For this purpose, an "episode of care" includes: (a) the three days prior to the admission to the hospital for the condition, (b) the length of stay in a hospital and (c) the thirty (30) days following discharge from the hospital. The services included are acute care inpatient services, physician services, outpatient hospital services, post-acute

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[3] PPACA Section 3021.
[4] PPACA Section 3023.

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services and others. By placing risk upon the providers and suppliers participating in the organization that applies for and participates in the program, the Payment Bundling Program seeks to reduce costs. It is anticipated that the necessary collaboration required among providers participating in the Payment Bundling Program will be challenging, even for those providers that have substantial experience with integrated models and the acceptance of risk. Among other hurdles, the organization applying for the program will need to determine how the bundled payment should be allocated among the various providers and suppliers in the group, which is an especially difficult task considering the duration of an episode of care and the wide range of services and providers that are covered by a bundled payment.

Hospital Value-Based Purchasing Program

The Hospital Value-Based Purchasing Program is another example of CMS transitioning itself from a volume-based purchasing program to a value-based purchasing program that compensates providers for quality and efficiency rather than quantity alone.[5] Beginning no later than October 1, 2012, the Value-Based Purchasing Program will provide incentive payments to certain hospitals that receive reimbursement through the inpatient prospective payment system and that achieve certain performance standards relating to various measures. For the 2013 fiscal year, the measures will cover at least acute myocardial infarction (AMI), heart failure, pneumonia, surgeries and certain health care associated infections. The Value-Based Purchasing Program will include only quality standards until 2014, at which time the program will be expanded to also include efficiency standards. The Value-Based Purchasing Program will be funded through a reduction in the base diagnosis related group (DRG) payment amounts for all hospitals (1% for fiscal year 2013; 1.25% for fiscal year 2014; 1.5% for fiscal year 2015; 1.75% for fiscal year 2016 and 2% for fiscal year 2017 and after). Payments made under the Value-Based Purchasing Program will be in the form of increases to base operating DRG payments after the reduction just described. Better performing hospitals will receive larger incentive payments based on the methodology established by the Secretary. In order to achieve the quality and efficiency objectives, hospitals will need to collaborate with their providers and hold them accountable through various mechanisms, which may include, for example, hospital co-management company arrangements, physician hospital organizations (PHOs) and other contractual mechanisms. An example of a contractual mechanism requiring providers to cooperate with the hospital to improve the quality of care are those provisions commonly in exclusive anesthesia services agreements providing that certain compensation or subsidies from the hospital to the anesthesia providers are only payable upon the achievement of certain quality benchmarks (i.e., those provisions providing that certain funds are placed at risk).

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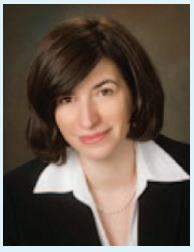
Notwithstanding the uncertainties surrounding federal healthcare reform, groups of physicians, hospitals, and other providers are developing structures and relationships that will allow them to transform themselves into integrated entities and networks so that they may thrive in an evolving health care reimbursement environment. This proactive approach is advisable considering the substantial time and monetary resources that will be required in order to effectively integrate in a manner that allows providers to achieve the quality and efficiency goals being adopted pursuant to the Affordable Care Act. We encourage all providers to reach out to their professional organizations and professional advisors to keep abreast of the continual developments in this area of the law.

[5] PPACA Section 3001.

Adrienne Dresevic



Kathryn Hickner-Cruz

Adrienne Dresevic, Esq. is a founding member of The Health Law Partners, P.C. Ms. Dresevic practices in all areas of healthcare law and devotes a substantial portion of her practice to providing clients with counsel and analysis regarding Stark and fraud and abuse. Ms. Dresevic can be reached at adresevic@thehlp.com.

Kathryn Hickner-Cruz, Esq. is a health care attorney with The Health Law Partners, P.C. Ms. Hickner-Cruz specializes in health care transactional matters and compliance with federal and state health care regulations. She regularly assists her clients by structuring and facilitating corporate reorganizations, mergers, asset acquisitions and divestitures, private placements, and joint ventures. Ms. Hickner-Cruz has expertise in federal and state self-referral laws, including Stark, federal and state anti-kickback laws, HIPAA and state privacy laws, and federal tax exempt laws. She can be reached at (248) 996-8510 or khicknercruz@thehlp.com.