Craig Boyd Garner A Professional Law Corporation

ARE WE FIGHTING THE RIGHT HEALTH CARE BATTLE?

Though the United States Supreme Court may have finally put to rest any constitutional disagreements over the Affordable Care Act (ACA), the debate over health care is far from settled. Finding critics of the landmark decision is as easy as surveying the Court itself, since each of the eight remaining justices took issue in one way or another with the majority opinion set forth by Chief Justice John Roberts.

It therefore comes as no surprise that the aftereffects of the Court's 5-4 split have already trickled down through nearly every aspect of federal and state politics, providing more than 100 pages of partisan fodder that will ensure both sides have an ample supply of rhetoric to flame this debate for years to come. For this reason, now is the time to ask ourselves if the nation is focusing on the wrong questions. If so, the answers over which we now debate are of little value.

In many ways, the ACA is a trillion dollar gamble with a trifold agenda that attempts to address the future. At its core, the bill seeks to improve the long term health of Americans by promoting innovation in the delivery of medicine, placing stronger emphasis on the prevention of disease and enhancing education in the adoption and maintenance of healthier lifestyles.

More often than not, however, such laudable goals are overshadowed by the fact that it also seeks to expand accessibility to the 50 million who are currently uninsured. In this light, the ACA becomes a theory without guarantee, and its success is in large part contingent upon the woefully deficient system it seeks to replace. Whether or not the United States can afford to look so far ahead in its current economic climate plays an understandably overwhelming role in this debate.

Without adequate funding for the ACA's collection of pilot programs, preventative health care services and forward thinking research, the only remaining viable option for Congress is to reduce provider reimbursement until such time as American health care can endure. Should this occur, it will be difficult for medical schools to graduate those willing and able to honor the Hippocratic Oath with the same degree of skill and integrity exhibited by physicians today. Indeed, our newfound entitlement to health care will have little meaning if in the future there is no one left to deliver it.

While the ACA is far reaching, its primary flaws are that it lacks any meaningful mechanism to instill a sense of pride for individual health, and it fails to educate the people that they must respect their right to health care. Though Americans will likely never come to a consensus on such ethical topics as when life begins or when it should come to an end, surely few will disagree that from a practical standpoint the best way to reduce the burden on health care is to collectively live healthier lives requiring less of a demand on the system.

The alternative to this option will be the creation of a health care infrastructure that is unsustainable, resulting in fewer doctors providing inferior care. Such a fear should have been central to the health care debate from the beginning, rather than the primarily political issue of whether the individual mandate is a tax or penalty.

Now that health care reform has at last received the attention it deserves, we as a nation might consider spending less time defining lines drawn between political parties and more time examining the symbiosis between patient and provider. For thousands of years, patients have relied upon physicians to extend lives, cure disease and promote well-being. With the ACA comes a shifting of this burden from provider to patient, whose willingness to accept or reject responsibility for his or her own health may now determine the future through the ways in which we respect the right to health care.

READMISSIONS REDUCTION PROGRAM

Starting October 1, 2012, the Hospital Readmissions Reduction Program (HRRP) reduces a hospital's base operating Medicare diagnosis-related group (DRG) payments with respect to readmissions for three conditions, including:

(1) acute myocardial infarction; (2) heart failure; and (3) pneumonia.

Are You Prepared?

Contact us today for additional information

(310) 458-1560 / Craig@CraigGarner.com / www.craiggarner.com

AN OVERVIEW OF THE HOSPITAL VALUE-BASED PURCHASING PROGRAM

Section 3001(a) of the Affordable Care Act (ACA) established the hospital Value-Based Purchasing (VBP) Program. Under the VBP Program, beginning October 2012 hospitals will face a 1% reduction overall on Medicare payments under the Inpatient Prospective Payment System (IPPS), as these funds will be used to pay for performance bonuses under the VBP Program. By 2015, hospitals that continue to show poor performance ratings will not only be excluded from the bonus pool, they will also face additional cuts in reimbursement.

ELIGIBILITY

Under the ACA, the Centers for Medicare & Medicaid Services (CMS) must establish a minimum number of cases, measures and surveys for hospital eligibility in the VBP Program. For Fiscal Year (FY) 2013, CMS created specific minimum reporting requirements for the number of cases, measures and surveys. Success in the VBP Program is based on a hospital's performance in 12 Clinical Process of Care measures and 8 Patient Experience of Care dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The HCAHPS survey, the first national, standardized, publicly reported survey of patients' perspectives of hospital care, is a survey instrument and data collection method for measuring patients' perceptions of their hospital experience.

To receive a Clinical Process of Care score, hospitals must report a minimum of 10 cases per measure and at least four applicable measures during the performance period. Clinical Process of Care Measures include: (1) Acute Myocardial Infarction (AMI); (2) Heart Failure (HF); (3) Pneumonia (PN); and (4) Surgical Care Improvement Project (SCIP).

To receive a Patient Experience of Care score, hospitals must complete at least 100 HCAHPS surveys during the performance period. Patient Experience of Care Dimensions include: (1) communication with nurses; (2) communication with doctors; (3) responsiveness of hospital staff; (4) pain management; (5) communication about medicines; (6) cleanliness and quietness of hospital environment; (7) discharge information; and (8) the overall rating of the hospital.

Also for FY 2013, a hospital's performance in the VBP Program will be based on *how it scores* in the 12 Clinical Process of Care measures and 8 Patient Experience of Care dimensions of the HCAHPS survey. A hospital's Total Performance Score (TPS) will be composed: (1) 70% from the 12 clinical measures above; and (2) 30% from the 8 patient experience of care dimensions.

Hospitals will receive two scores on each measure and dimension: one for *achievement* and one for *improvement*. The *achievement score* measures how a hospital performed compared to other hospitals. The *improvement score* measures how much a hospital has improved compared to its own previous performance.

Both scores are determined based on a hospital's performance compared to achievement and improvement ranges for each clinical measure and HCAHPS dimension. CMS will use the greater of either achievement or improvement scores on each measure and dimension to calculate a hospital's TPS. Like the Clinical Process of Care measures, the 8 Patient Experience of Care dimensions are scored using the greater of improvement or achievement points. However, the Patient Experience of Care domain also includes a Consistency Score.

Two scores—*Base* and *Consistency*—are calculated for this domain. The *Base* score is the greater of improvement or achievement points for the 8 Patient Experience of Care dimensions. *Consistency* points are awarded based on a hospital's lowest HCAHPS dimension score during the performance period relative to the scores of other hospitals from the baseline period. A hospital that does not receive a domain score in both the Clinical Process of Care and Patient Experience of Care domains will not receive a TPS or an incentive adjustment.

ADDITIONAL INFORMATION ABOUT THE VBP PROGRAM CAN BE FOUND AT WWW.CRAIGGARNER.COM.

A TIME TO FOCUS ON COMPLIANCE

When it comes to the Affordable Care Act, there is no shortage of topics upon which the nation can disagree. As patients lobby to make medical services a constitutional right, providers share a much different perspective on modern American health care. To practitioners and non-clinical professionals alike, participation in government sponsored health care programs is in many ways akin to joining the freemasons or pledging a fraternity, the exclusion from which is nothing less than a modern day blackballing by the not-so-secret society known as the Office of the Inspector General (OIG).

While Medicare regulations can be difficult to decipher, there is no shortage of hospitals participating therein. The exclusion from federally funded programs such as Medicare and Medicaid can mean the end for a facility, while for hospital executives, directors, officers, managers and in-house counsel the repercussions from such an act can amount to the end of a career in health care altogether. The nexus between hospital punishment and individual culpability can be tenuous at times, and a negative ruling against a hospital may not insulate individuals from prosecution and even exclusion under the Responsible Corporate Officer Doctrine (RCO), sometimes referred to as the "Park" doctrine, after the United States Supreme Court decision *United States v. Park,* where the Court held:

> "The concept of 'responsible relationship' to, or a 'responsible share' in, a violation . . . indeed imports some measure of blameworthiness; but it is equally clear that the Government establishes a prima facie case when it introduces evidence sufficient to warrant a finding by the trier of fact that the defendant had, by reason of his position in the corporation, responsibility and authority either to prevent in the first instance, or promptly to correct, the violation complained of, and that he failed to do so."

The origins of the RCO can be traced to cases involving the Federal Food, Drug and Cosmetic Act of 1938, and subsequently to cases of environmental, public health and safety concerns. To be sure, granting authority for the Federal Government to criminally prosecute individuals for the actions of the entity is nothing new in health care. Today, 42 U.S.C. Section 1320a-7 is the statutory authority upon which the OIG relies when excluding individuals and entities from participation in Medicare and Medicaid. Subsection (a) sets forth the ***mandatory*** exclusion provisions and subsection (b) sets forth the ***permissive*** exclusion provisions.

Mandatory exclusions include: (1) conviction of a health care program related crime; (2) conviction involving patient abuse; (3) felony conviction related to health care fraud; or (4) felony conviction involving a controlled substance. The list of permissive exclusions is much longer, including for example: (1) conviction of a criminal misdemeanor related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct both relating and unrelated to health care; (2) conviction related to obstruction of an investigation or audit; (3) license revocation or suspension by a state licensing authority; (4) and claims for excessive charges or unnecessary services.

The OIG has encouraged health care compliance programs, noting that such covenants within an institution help hospitals and other health care providers develop effective internal controls that promote adherence to applicable state and federal laws. Indeed, the OIG believes a hospital may gain important additional benefits by voluntarily implementing a compliance program. Such benefits include: (1) demonstrating the hospital's commitment to honest and responsible corporate conduct; (2) increasing the likelihood of preventing, identifying and correcting unlawful and unethical behavior at an early stage; (3) encouraging employees to report potential problems to allow for appropriate internal inquiry and corrective action; and (4) minimizing any financial loss to government and taxpayers through early detection and reporting, as well as any corresponding financial loss to the hospital.

Hospitals, governing boards, executives, managers, directors and physicians are direct targets as the Federal Government ramps up its efforts to eliminate fraud in modern American health care. Although not a technical requirement for hospitals under state or federal law, all hospitals would be well advised to give serious consideration to adopting a proactive, comprehensive compliance program.

While a compliance program may never completely insulate a hospital from potential liability, in the event of an allegation under the Federal False Claims Act or a related state claim, the existence of a meaningful compliance program can protect a hospital and those individuals in charge from substantial civil and/or criminal penalties, possible exclusion from the Medicare or Medicaid programs, and the need to adopt an entirely new and unfamiliar compliance program on an expedited basis. Compliance programs should not be thought of as an insurance policy, but rather a show of commitment to the industry in which health care professionals serve.