

Health Care Reform Goes Live

Day Three in the Current Climate of Reform

Date: October 3, 2013

Time: 2:30 PM to 4:00 PM

Location: Givner & Kaye, a Professional Corporation
12100 Wilshire Boulevard, Suite 445
Los Angeles, CA 90025

Presentation By: Craig B. Garner

MCLE Credit -- 1.00

Craig B. Garner is a State Bar of California approved MCLE provider and certifies that this activity conforms to the standards for approved education activities prescribed by the rules and regulations of the State Bar of California governing MCLE.

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INTRODUCTION

A Brief History of Health Care in the United States

Throughout the 1800s, access to the delivery of care rendered by the few elite hospitals (totaling fewer than 200 in 1873) in cities such as New York, Boston and Philadelphia went hand-in-hand with one's status in society. Most medical care took place in the home.

By the 1920s, the hospital had become a national institution in America, with more than 5,000 facilities appearing across the country. This trend brought with it advances in technology, more trained physicians, and greater quality of care.

As conditions in health care improved, the practice of medicine in the United States shifted from home to hospital. People went to a hospital to get better, benefitting from medical advances and greater availability of care.

A Brief History of Health Care, continued

In 1946, the Hospital Survey and Construction Act (the Hill Burton Act) disbursed approximately \$3.7 billion to hospitals so they could meet the growing needs of the nation. The Hill Burton Act sought to create 4.5 hospital beds per 1,000 people nationwide.

The Hill Burton Act forced hospitals and their communities to work together, combining federal funds with local monies to cover expenses.

By the 1960s, health care in the United States was at a crossroads. Access to treatment had increased, but so had the corresponding price tag. With the passage of Medicare in 1965, our nation solidified its commitment to government sponsored health care.

The Patient Protection and Affordable Care Act

- > On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act into law.
- > The Health Care and Education Reconciliation Act followed a week later.
- > Together, this landmark legislation became the **Affordable Care Act**, also known as the **ACA**.

Who Pays for the Affordable Care Act?

- > Drug manufacturers
- > Health insurers
- > Medical device manufacturers (excise tax starting in 2013)
- > Indoor tanning services
- > Medicare Payroll Tax increases (starting in 2013)
- > Businesses that offer high-end "Cadillac" plans (starting in 2018)
- > Taxpayers, in part through the Individual Mandate (starting in 2014)
- > Companies, in part through the Business Mandate (starting in 2015)

REFORM FROM THE PATIENT'S PERSPECTIVE



- > Essential Health Benefits
- > Individual and Group Market Reforms
- > Improving Coverage
- > Medical Loss Ratio
- > Individual Mandate
- > Employer Mandate

Essential Health Benefits

- > Ambulatory patient services
- > Emergency services
- > Hospitalization
- > Maternity and newborn care
- > Mental health and substance use disorder
- > Prescription drugs
- > Rehabilitative and habilitative services and devices
- > Laboratory services
- > Preventative and wellness services / chronic disease management
- > Pediatric services, including oral and vision care

42 U.S.C. § 18022

Nearly Essential Health Benefits

- > Emergency room visits
- > Ambulance services
- > Diabetes care management
- > Kidney dialysis
- > Physical therapy
- > Durable medical equipment
- > Prosthetics
- > Infertility treatment
- > Organ and tissue transplantation

Institute of Medicine, *Essential Health Benefits*

Individual and Group Market Reforms

Fair Health Insurance Premiums (42 U.S.C. § 300gg)

- > Individual or Family
- > Rating Area (states will decide)
- > Age (but not more than 3 to 1 for adults)
- > Tobacco Use (but not more than 1.5 to 1)

End of Preexisting Condition Exclusion (42 U.S.C. § 300gg-3)

Coverage for Adult Child Until the Age of 26 (42 U.S.C. § 300gg-14)

Guaranteed Availability of Coverage (42 U.S.C. § 300gg-1)

What Are the Levels of Coverage?

- > Bronze (60% of the full actuarial value of the benefits)
- > Silver (70% of the full actuarial value of the benefits)
- > Gold (80% of the full actuarial value of the benefits)
- > Platinum (90% of the full actuarial value of the benefits)
- > Catastrophic (29 years old or younger or exempt from Section 5000A)

42 U.S.C. § 18022(d), (e)

Minimum Medical Loss Ratio

Referred to as the “80/20 provision” of the Affordable Care Act, the Medical Loss Ratio (MLR) applies as follows:

- **Large group market:** An issuer must provide a rebate to enrollees if the issuer has an MLR of less than 85% (subject to adjustments).
- **Small group market and individual market:** An issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80% (also subject to adjustments).

States retain the option to set a higher MLR to ensure that premiums are used for clinical services and quality improvements.

45 C.F.R. Part 158

Minimum Medical Loss Ratio, continued

“[A]n issuer must rebate a pro rata portion of premium revenue if it does not meet an 80 percent MLR for the small group market in a State that has not set a higher MLR. If an issuer has a 75 percent MLR for the coverage it offers in the small group market in a State that has not set a higher MLR, the issuer must rebate 5 percent of the premium paid by or on behalf of the enrollee for the MLR reporting year after subtracting premium and subtracting taxes and fees. . . . In this example, an enrollee may have paid \$2,000 in premiums for the MLR reporting year. If the Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue . . . are \$150 for a premium of \$2,000, then the issuer would subtract \$150 from premium revenue, for a base of \$1,850 in premium. The enrollee would be entitled to a rebate of 5 percent of \$1,850, or \$92.50.”

45 C.F.R. § 158.240(c)(2)

Individual Mandate (How to Maintain Minimum Essential Coverage)

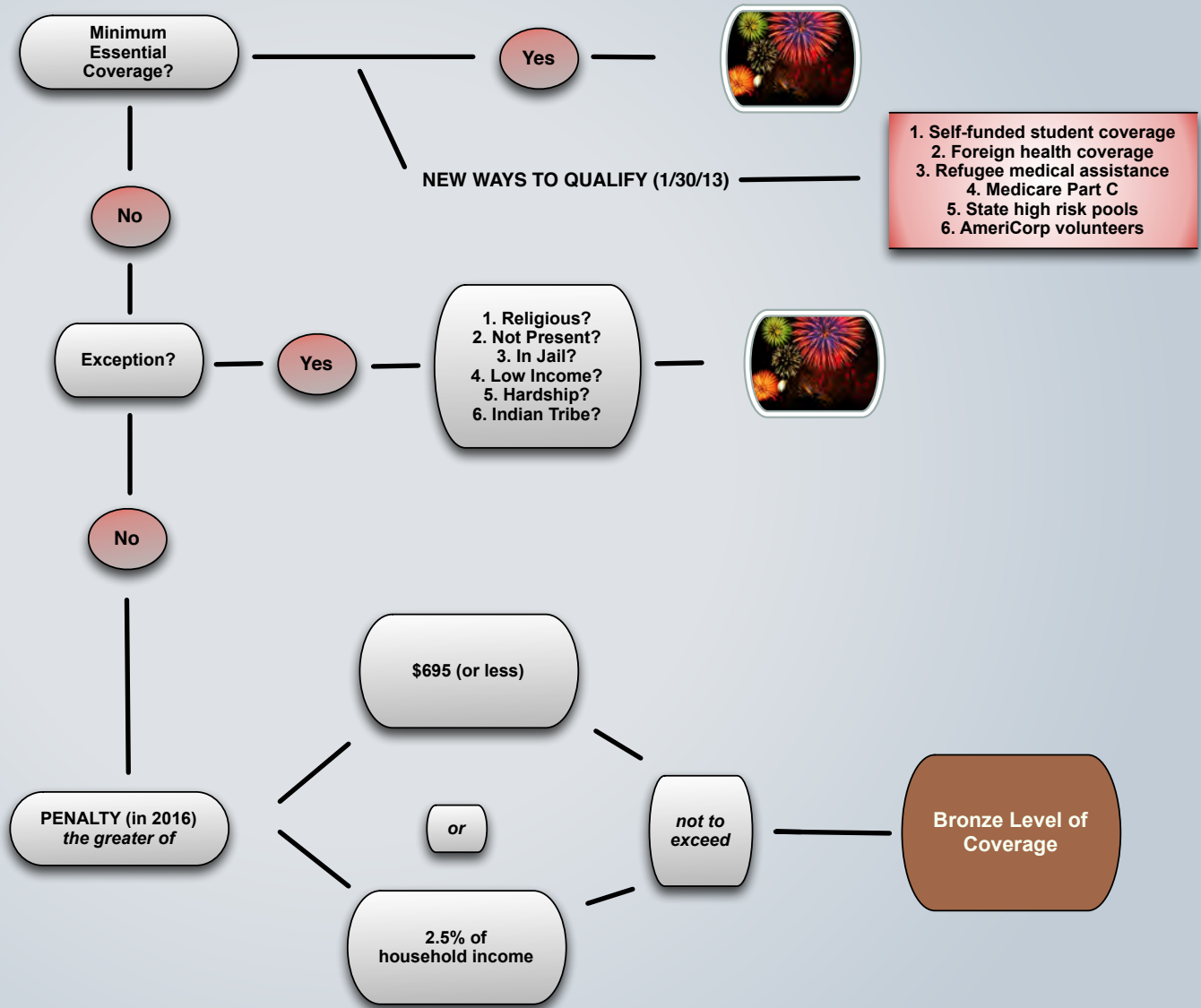
- > Government sponsored programs (Medicare, Medicaid, CHIP, Tricare, Veterans, Peace Corps); or
- > Employer-sponsored plan; or
- > Plans in the individual market (Exchange, Basic Health Program, CO-OPs);
- > Grandfathered health plan; or
- > Other.

26 U.S.C. § 5000A

The Penalty

Collecting the Penalty

- > Waiver of criminal penalties
- > Limitations on liens and levies



Employer Mandate

- > *DELAYED UNTIL 2015*
- > The ACA does not require employers to offer health insurance coverage to their employees.
- > For “large employers” (those with 50 or more full-time employees), however, the ACA imposes a penalty of \$2,000 per employee if any of their full-time employees qualify for and receive federal subsidies.
- > This penalty does not apply for the first 30 employees.

26 U.S.C. § 4980H

Small Business Health Care Tax Credits

For small businesses that are not required to provide health coverage, new tax credits will be available to those with low-paid employees.

- Must pay average annual wages below \$50,000.
- Must have fewer than the equivalent of 25 full-time workers (for example, an employer with fewer than 50 part-time workers may be eligible).
- In 2010 this credit was up to 35% of a small business' premium costs (25% for tax-exempt employers). On January 1, 2014, this rate will increase to 50% (35% for tax-exempt employers).
- Designed to encourage small businesses to provide qualified health insurance for their employees.

Small Business Health Care Tax Credits, continued

In a May 2012 publication, the United States Government Accountability Office (GAO) concluded:

- > Fewer small businesses claimed the Small Employer Health Insurance Tax Credit in 2010 than expected. A total of 170,300 small businesses claimed the tax credit out of an estimated 1.4 to 4 million eligible employers.
- > There were \$468 million in credits claimed, although most claims were limited to partial rather than full percentage credit.
- > Only 8,100 employers claimed the full credit.

Employer W-2 Reporting Requirements

- > For 2012, W-2 forms included the total cost of employer-sponsored health insurance coverage.
- > Required by the Affordable Care Act, the disclosures are designed to raise awareness of health care expenses among employees.
- > These health benefits are still tax free.
- > The new information appears in Box 12 of the standard W-2 form, with the two-letter code DD.

Health Reimbursement Arrangements (HRAs)

An HRA is an arrangement that is funded solely by an employer. It reimburses an employee for medical care expenses (Internal Revenue Code § 213(d)) incurred by the employee, or spouse, dependents and any children who, as of the end of the taxable year, are under 27 years of age.

- > Up to a maximum dollar amount for a coverage period
- > Excludable from the employee's income
- > Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years
- > Includes group health plans

Health Flexible Spending Arrangements (FSAs)

- > A benefit designed to reimburse employees for medical care expenses incurred by the employee, employee's spouse, dependents and any children who, as of the end of the taxable year, are *under 27* years of age.
- > Contributions to an FSA offered through a cafeteria plan do not result in gross income to the employee (subject to other Code provisions).
- > As of January 1, 2011, the cost of an over-the-counter medication was no longer reimbursable from FSAs without a prescription, though this does not apply to insulin, medical devices, eye glasses or contact lenses.

Premium Tax Credit

- > The ACA provides for a premium tax credit to help individuals and families afford health insurance coverage through an Exchange.
- > An employee is not eligible if offered affordable coverage under an employer-sponsored plan that provides minimum value, or if the employee enrolls in an employer-sponsored plan.
- > An employer sponsored plan is affordable if the employee's required contribution does not exceed 9.5% of the employee's household income.



HEALTH INSURANCE EXCHANGES

“The Health Insurance Marketplace is designed to help you find insurance that fits your budget, with less hassle. No matter where you live, you’ll be able to buy insurance. . . . New laws mean plans must treat you fairly and can’t deny you coverage because of pre-existing conditions.”

Source: CMS Toolkit

Sort plans by: Benefits Package

Show Plans. Then choose up to 3 to compare. Click Continue at bottom.

	Monthly Cost	Annual Deductible	Annual Out of Pocket Max.	Doctor Visit	Generic Rx	Emergency Rooms	Hospital Stay
YAP Low no Rx Benefits Package 5 plans available Show Plans About YAP Low no Rx	as low as \$136	\$2,000	\$5,000	\$25 copay	Not applicable	\$250 copay	annual deductible, then 20% co-insurance
YAP Low with Rx Benefits Package 5 plans available Show Plans About YAP Low with Rx	as low as \$163	\$2,000	\$5,000	\$25 copay	\$15 copay	\$250 copay	annual deductible, then 20% co-insurance
YAP High no Rx Benefits Package 5 plans available Show Plans About YAP High no Rx	as low as \$168	\$250	\$5,000	\$25 copay	Not applicable	\$250 copay	annual deductible, then 30% co-insurance
YAP High with Rx Benefits Package 5 plans available Show Plans About YAP High with Rx	as low as \$191	\$250	\$5,000	\$25 copay	\$15 copay	\$250 copay	annual deductible, then 30% co-insurance
Bronze Low Benefits Package 6 plans available Show Plans About Bronze Low	as low as \$219	\$2,000 (ind.) \$4,000 (fam.)	\$5,000 (ind.) \$10,000 (fam.)	annual deductible, then \$25 copay	annual deductible, then \$15 copay	annual deductible, then \$100 copay	annual deductible, then 25% co-insurance
Bronze Medium Benefits Package 6 plans available Show Plans About Bronze Medium	as low as \$224	\$2,000 (ind.) \$4,000 (fam.)	\$5,000 (ind.) \$10,000 (fam.)	\$30 copay	\$10 copay	annual deductible, then \$150 copay	annual deductible, then \$500 copay
Bronze High Benefits Package 6 plans available Show Plans About Bronze High	as low as \$229	\$250 (ind.) \$500 (fam.)	\$5,000 (ind.) \$10,000 (fam.)	\$25 copay	\$15 copay	\$150 copay	annual deductible, then 35% co-insurance
Silver Low Benefits Package 6 plans available Show Plans About Silver Low	as low as \$272	\$1,000 (ind.) \$2,000 (fam.)	\$2,000 (ind.) \$4,000 (fam.)	\$20 copay	\$15 copay	annual deductible, then \$100 copay	annual deductible, then no copay
Silver Medium Benefits Package 6 plans available Show Plans About Silver Medium	as low as \$288	\$500 (ind.) \$1,000 (fam.)	\$2,000 (ind.) \$4,000 (fam.)	\$20 copay	\$15 copay	\$100 copay	annual deductible, then no copay
Silver High Benefits Package 6 plans available Show Plans About Silver High	as low as \$311	None	\$2,000 (ind.) \$4,000 (fam.)	\$25 copay	\$15 copay	\$100 copay	\$500 copay
Gold Benefits Package 6 plans available Show Plans About Gold	as low as \$380	None	None	\$20 copay	\$15 copay	\$75 copay	\$150 copay

How Do Exchanges Work?

- > Make comparison shopping easier
- > Lower barriers for new competition in the insurance market
- > Provide savings and choice through transparency
- > Determine individual tax credits/subsidies
- > Increase competitive advantage for enrollees
- > Focus on the uninsured

State-Based Exchange

Each individual state operates all Exchange activities, but a state may use federal government services for the following areas:

- > Premium tax credit and cost sharing reduction determination
- > Exemptions
- > Risk adjustment program
- > Reinsurance program

State Partnership Exchange

State operates activities for:

- > Plan management (and/or)
- > Consumer assistance

State may elect to oversee directly, or in the alternative rely upon federal government services for the following activities:

- > Reinsurance program
- > Medicaid and CHIP eligibility assessment or determination

Federally-Facilitated Exchange

Operated by HHS, but state may elect to perform certain activities itself. It can use federal government services for the following activities:

- > Reinsurance program
- > Medicaid and CHIP eligibility assessment or determination

Exchange Transparency

As part of the application process, each state should post certain sections from its application on the appropriate state website, including:

- > Exchange board and governance structure
- > Stakeholder consultation plan
- > Outreach and education plan
- > Role of agents and brokers
- > Coordination strategy
- > Pre-Existing Condition Insurance Plan (PCIP) transition
- > Long-term operational cost plan

California Health Benefit Exchange

The California Health Benefit Exchange posts the following vision, mission and value set on its website (www.healthexchange.ca.gov):

- > Consumer-focused
- > Affordability
- > Catalyst
- > Integrity
- > Partnership
- > Results

Basic Health Program

Beginning January 1, 2015, states will have an additional option to establish a Basic Health Program (BHP) for certain low-income individuals who would otherwise be eligible to obtain coverage through the Exchange.

- > Exists *in addition to* Exchanges and Medicaid Expansion
- > Proposed rules published September 25, 2013
- > Regulations encourage coordination between BHP rules and existing rules for Exchanges, Medicaid or CHIP
- > Final rules forthcoming



DELIVERING MEDICAL CARE

- > Accountable Care Organizations
- > Bundled Payments for Care Improvement Initiative
- > Patient-Centered Medical Homes

Accountable Care Organizations

An ACO is a shared savings program that **promotes** accountability for a patient population, **coordinates** items and services under Medicare parts A and B, and **encourages** investment in infrastructure and redesigned care processes for high quality and efficient services.

42 U.S.C. § 1395jjj: *“Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the “program”) that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”*

Accountable Care Organizations, continued

By aligning health care providers that focus on improvement, efficiency, and experience within a particular patient demographic, ACOs connect reimbursement with quality, outcomes, and resource utilization. This is a significant departure from the traditional fee-for-service model that for years has been the standard in American health care.

- > January 10, 2013 -- 106 new ACOs approved by CMS.
- > July 9, 2012 -- 87 new ACOs approved by CMS.
- > April 10, 2012 -- 27 new ACOs approved by CMS.

ACO Application (July 2012)

[S]ubmit a narrative describing how the ACO will . . . implement its quality assurance and improvement program including but not limited to the ACO's processes to promote evidence-based medicine, beneficiary engagement, coordination of care, and internal reporting on cost and quality. Please include a description of remedial processes and penalties (including the potential for expulsion) that would apply for non-compliance.

Submit a narrative describing how the ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics that lets the ACO monitor, give feedback, and evaluate ACO participant and ACO provider/supplier performance.

ACO Application, continued

Submit a narrative describing how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement.

- > ***Evaluate** the health needs of its assigned beneficiary population (including consideration of diversity in its patient population) and **develop** a plan to address the needs of its population.*
- > ***Communicate** clinical knowledge/evidence-based medicine to beneficiaries in a way they can understand.*
- > ***Engage** beneficiaries in shared decision-making in ways that consider beneficiaries' unique needs, preferences, values and priorities.*
- > ***Establish** written standards for beneficiary access and communication, as well as a process for beneficiaries to access their medical records.*

ACO Quality Measures

CMS will measure quality of care using nationally recognized measures in four key domains:

- > Patient/caregiver experience (7 measures)
- > Care coordination/patient safety (6 measures)
- > Preventive health (8 measures)

At-risk population:

- > Diabetes (6 measures)
- > Hypertension (1 measure)
- > Ischemic Vascular Disease (2 measures)
- > Heart Failure (1 measure)
- > Coronary Artery Disease (2 measures)

Other ACO Requirements

- > Eligibility
- > Governance and Leadership
- > Compliance Plan
- > Data Submission
- > Public Reporting and Transparency
- > Audits and Monitoring
- > Assignment of Beneficiaries
- > Data Sharing
- > October 2011 Revisions*

Bundled Payments for Care Improvement Initiative

Model 1: Retrospective Acute Care Hospital Stay Only

- > Episode of care is defined as the inpatient stay.
- > Physicians paid separately.
- > Some gainsharing permitted.

Model 2: Retrospective Acute Care Stay *plus* Post-Acute Care

- > Episode will end either 30, 60 or 90 days after discharge.
- > May include up to 48 different clinical condition episodes.

Bundled Payments for Care Improvement Initiative, continued

Model 3: Retrospective Post-Acute Care Only

- > Triggered by acute care hospital stay and begins at initiation of post-acute care services with a participating skilled nursing facility.
- > Post-acute care services must begin within 30 days of discharge and end either 30, 60 or 90 days after the initiation of episode.
- > May include up to 48 different clinical condition episodes.

Bundled Payments for Care Improvement Initiative, continued

Model 4: Acute Care Hospital Stay Only

- > CMS makes a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the hospital stay by the hospital, physicians and other practitioners.
- > Related admission for 30 days after discharge is included.
- > May include up to 48 different clinical condition episodes.

Included Episodes

Major joint upper extremity; Amputation; Urinary tract infection; Stroke; Chronic obstructive pulmonary disease, bronchitis/asthma; Coronary artery bypass graft surgery; Major joint replacement of the lower extremity; Percutaneous coronary intervention; Pacemaker; Cardiac defibrillator; Pacemaker device replacement or revision; Automatic implantable cardiac defibrillator generator or lead; Congestive heart failure; Acute myocardial infarction; Cardiac arrhythmia; Cardiac valve; Other vascular surgery; Major cardiovascular procedure; Gastrointestinal hemorrhage; Major bowel; Fractures of femur and hip/pelvis; Medical non-infectious orthopedic; Double joint replacement of the lower extremity; Revision of the hip or knee; Spinal fusion (non-cervical); Hip and femur procedures except major joint; Cervical spinal fusion; Other knee procedures; Complex non-cervical spinal fusion; Combined anterior posterior spinal fusion; Back and neck except spinal fusion; Lower extremity and humerus procedure except hip, foot, and femur; Removal of orthopedic devices; Sepsis; Diabetes; Simple pneumonia and respiratory infections; Other respiratory issues; Chest pain; Medical peripheral vascular disorders; Atherosclerosis; Gastrointestinal obstruction; Syncope and collapse; Renal failure; Nutritional and metabolic disorders; Cellulitis; Red blood cell disorders; Transient ischemia; Esophagitis, gastroenteritis and other digestive disorders.

Patient-Centered Medical Homes

Comprehensive Team of Care Providers

- > Physical and mental health needs
- > Physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators
- > Built around the community

Patient Centered (partnering with patients and their families)

Patient-Centered Medical Homes, continued

Coordinated Care During Transitions

- > Specialty care
- > Hospitals
- > Home health care
- > Community Services

Accessible Services

- > Shorter waiting times for urgent needs
- > Enhanced in-person hours
- > 24 hour telephone or electronic access to team member

Quality and Safety

- > Evidence-based medicine
- > Patient satisfaction
- > Sharing data



MEDICAID EXPANSION

What Is Medicaid?

Medicaid is health insurance for individuals who qualify financially, as well as families with dependent children, the aged, blind or disabled.

- > Medi-Cal
- > KanCare
- > SoonerCare
- > Hoosier Healthwise
- > MassHealth
- > SALUD!
- > TennCare

Medicaid Expansion

77 Federal Register 17144 (Mar. 23, 2012)

- > Implemented provisions of the Affordable Care Act related to Medicaid eligibility, enrollment and coordination with the Exchanges, CHIP, and other programs.
- > Simplified the eligibility rules in Medicaid and CHIP.
- > Set the minimum Medicaid income eligibility level of 133 percent of the Federal Poverty Level for most non-disabled adults under age 65.

Medicaid Expansion, continued

Additional Regulations (Jan. 14, 2013)

- > Reflects new statutory eligibility provisions.
- > Proposes changes to provide states more flexibility to coordinate Medicaid and CHIP eligibility, appeals and other administrative procedures.
- > Modernizes and streamlines existing rules.

Medi-Cal

- > Created in California during its 1975 Second Extraordinary Session.
- > CAL. WELF. & INST. CODE § 14000:
“The purpose [of Medi-Cal] is to afford to qualifying health care and related remedial or preventative services, including related social services which are necessary for those receiving health care under [Medi-Cal].”
- > Includes 25% of California’s population.

Medicaid Expansion and the Supreme Court

The United States Supreme Court held that Congress has the authority to offer funding for states to expand Medicaid by 2014 without imposing retroactive financial conditions. *National Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606-07 (2012).

Congress never dreamed that any State would refuse to go along with the expansion of Medicaid. Congress well understood that refusal was not a practical option. (Id. at 2665 (Scalia, Kennedy, Thomas and Alito, JJ, dissenting)).

Status Opposing Medicaid Expansion (as of Sept. 16, 2013)

- > Alabama
- > Alaska
- > Georgia
- > Idaho
- > Indiana
- > Kansas (undecided)
- > Louisiana
- > Maine (undecided)
- > Mississippi
- > Nebraska
- > North Carolina
- > Oklahoma
- > Pennsylvania (undecided)
- > South Carolina
- > South Dakota
- > Tennessee (undecided)
- > Texas
- > Utah (undecided)
- > Virginia
- > Wisconsin
- > Wyoming

Medicaid Expansion by the Numbers

The Federal Government will pay 100% of added expenses for newly eligible beneficiaries through 2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and thereafter.

States must pay “qualified” physicians Medicaid fees at least equal to Medicare rates starting in 2013.

Pay increase applies to family physicians, internists and pediatricians (and in some instances specialists) provided (1) they are Board-certified or (2) at least 60% of the Medicaid codes they billed in the previous year were primary care codes identified in the Affordable Care Act.



PERFORMANCE BASED REIMBURSEMENT

- > Hospital Value-Based Purchasing
- > Physician Value-Based Purchasing
- > Hospital Readmissions Reduction Program
- > Hospital Acquired Conditions
- > Hospital Associated Infections

Hospital Value-Based Purchasing (VBP) Program

- The DRG system will begin to include value-based purchasing.
- CMS will start paying hospitals Medicare “bonuses” based upon overall performance, adherence to quality measures and patient satisfaction.
- This epic change is designed to transform a system that has historically been based on cost into one that focuses primarily on quality and performance.
- Funding for value-based purchasing comes from base operating DRG reductions (1% in 2013, 1.25% in 2014, 1.5% in 2015, 1.75% in 2016, and 2% thereafter).
- Hospitals with poor performance ratings may be excluded from bonus opportunities.

Hospital VBP, continued

The VBP Program is based on a hospital's total performance score (TPS), which includes, in part, 12 Clinical Process of Care measures (70% of the TPS) in the following categories:

- > Acute Myocardial Infarction
- > Heart Failure
- > Pneumonia
- > Surgical Care Improvement Project

Hospital VBP, continued

The TPS also includes 8 Patient Experience of Care dimensions (30% of TPS) from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey:

- > Communication with doctors
- > Communication with nurses
- > Responsiveness of hospital staff
- > Pain management
- > Communication about medication
- > Cleanliness and quietness
- > Discharge information
- > Overall rating

Form Over Substance

Follow HCAHPS Quality Assurance Guidelines

- > Hospitals must continuously collect and submit HCAHPS data in accordance with the current HCAHPS Quality Assurance Guidelines and within the quarterly data submission deadlines.
- > To participate in the collection of HCAHPS data, a hospital must either (1) contract with an approved HCAHPS survey vendor or (2) self-administer the survey, provided the hospital attends HCAHPS training and meets Minimum Survey Requirements.
- > Four approved methods of administering the CAHPS Hospital Survey: (1) mail; (2) telephone; (3) mixed (mail followed by telephone); and (4) active interactive voice response.

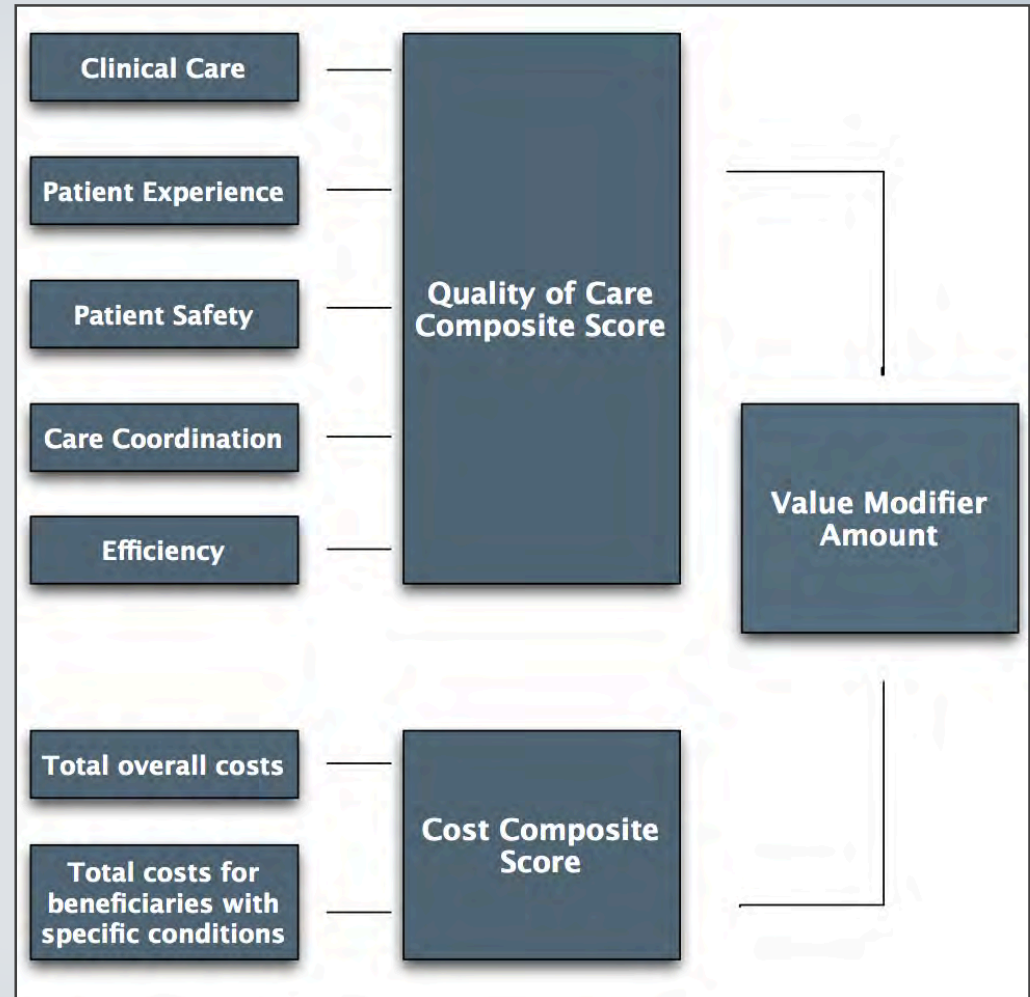
Physician VBP

For groups with 25 or more physicians, CMS recommends that the following outcome measures be used in the calculation:

- > 30-day post discharge visits
- > All cause readmissions
- > Composite of acute prevention quality indicators (pneumonia, UTI, dehydration)
- > Composite of chronic prevention quality indicators (COPD, heart failure, diabetes)

Physician Value Modifier Amount

Combine each quality measure into a quality composite and each cost measure into a cost composite using the following domains:



Hospital 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** (AMI); (2) **heart failure** (HF); and (3) **pneumonia** (PN).

Adjustment Factor: A hospital's "adjustment factor" or readmission payment adjustment is *the greater of* (1) the ratio of a hospital's aggregate dollars for excess readmissions to their aggregate dollars for all discharges or (b) the statutory adjustment maximum for the Fiscal Year (FY). For FY 2013, the number cannot exceed 0.99 (*i.e.*, a 1% reduction). The statutory floor adjustment factor is 0.98 for FY 2014 and 0.97 for FY 2015 and subsequent years.

Hospital Readmissions Reduction Program, continued

Numerator: Adjusted Actual Readmissions

Step 1:

Calculate each patient's predicted probability of readmission = $\frac{1}{1 + e^{-Z_a}}$

$$Z_a = \text{hospital-specific effect} + X\beta$$

↑
intercept + risk-adjustment coefficients

Step 2:

To get the numerator result, add all patients' predicted probabilities of readmission

Denominator: Expected Readmissions

Step 1:

Calculate each patient's expected probability of readmission = $\frac{1}{1 + e^{-Z_e}}$

$$Z_e = X\beta$$

↑
intercept + risk-adjustment coefficients

Step 2:

To get the denominator result, add all patients' expected probabilities of readmission

Hospital-Acquired Conditions

The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payments for certain hospital acquired conditions. CMS has titled the provision “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC & POA).

- Hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (*i.e.*, was not present on admission).
- The case is paid as though the secondary diagnosis is not present.

Hospital-Acquired Conditions, continued

The Inpatient Prospective Payment System (IPPS) Fiscal Year 2013 Final Rule sets forth the applicable HACs:

- > Foreign Object Retained After Surgery
- > Air Embolism
- > Blood Incompatibility
- > Pressure Ulcer Stages III & IV
- > Falls and Trauma (fracture, dislocation, head injury, burn, etc.)
- > Catheter-Associated Urinary Tract Infection

Hospital-Acquired Conditions, continued

Additional HACs:

- > Vascular Catheter-Associated Infection
- > Manifestations of Poor Glycemic Control
- > Surgical Site Infections Following Coronary Artery Bypass Graft and Certain Orthopedic Procedures (spine, neck, shoulder, elbow) as well as Bariatric Surgery and Implantation of Cardiac Electronic Device
- > Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures (total knee and hip replacements)
- > Iatrogenic Pneumothorax with Venous Catheterization



OTHER PROVISIONS

- > Innovation
- > Prevention
- > Fraud and Abuse

Innovation and Prevention

To reduce patient health care expenditures, the Affordable Care Act must rely upon innovation and prevention, hoping to improve upon the delivery of health care in the United States. Some examples include:

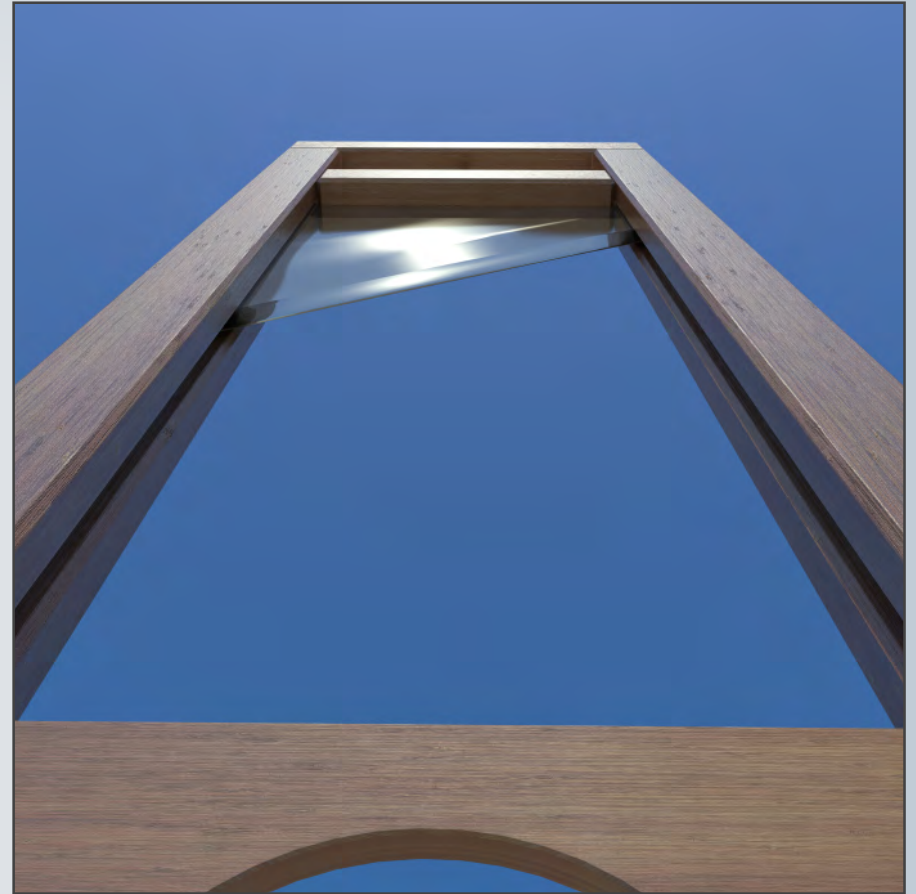
- Center for Medicare & Medicaid Innovation (\$10 billion each decade)
- School-Based Health Center Grants (\$50 million)
- Prevention and Public Health Fund (\$11 billion through 2022)
- Education and Outreach Campaign for Preventative Benefits
- Community Transformation Grants
- Patient-Centered Outcomes Research Institute (PCORI)

Fraud and Abuse

The Affordable Care Act increases the Federal Government's arsenal to combat health care fraud, abuse and waste.

Some examples include:

- > Mandatory Compliance Programs
- > 60 Days to Pay
- > Physician Owned Hospitals
- > Medicaid RACs
- > Physician Payment Sunshine Act



Mandatory Compliance Programs

Section 6401(a)(7) of the Affordable Care Act requires all providers and suppliers who participate in Medicare to adopt a compliance program as a condition precedent.

The Office of the Inspector General (OIG) has encouraged the industry “to exercise due diligence to prevent and detect criminal conduct and otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law” consistent with the Federal Sentencing Guidelines for Organizations (FSGO).

Section 6102 of the Affordable Care Act specifically requires nursing homes to establish “a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations” by March 23, 2013.

60 Days to Pay

Last year the Federal Government made it clear that health care providers must return federal overpayments **within 60 days** from the time the overpayment was first identified.

Failure to follow this new requirement set forth in Section 6402(a) of the Affordable Care Act throughout any ten-year “look-back” period creates potential liability under the False Claims Act.

Providers are held to a standard of actual knowledge or “reckless disregard or deliberate ignorance” for purposes of identifying an overpayment under the new regulations.

Physician-Owned Hospitals

Section 6001 of the Affordable Care Act limits the “whole hospital exception” under the physician self-referral prohibitions, more commonly known as the Stark Laws. This exception applies only to physician-owned hospitals that had physician ownership as of March 23, 2010, and had obtained a Medicare provider number by the end of 2010.

Subsequent regulations clarified requirements for and restrictions on physician-owned hospitals, including but not limited to:

- Requirements for “grandfathered facilities”
- Clarification that “physician ownership” can change but never increase
- Limitations on physical expansion (*i.e.*, total number of beds)

Medicaid RACs

The 2003 legislation that began the Recovery Audit Contractor (RAC) program to detect and correct improper payments within Medicare has since expanded under the Affordable Care Act.

Section 6411 of the Affordable Care Act requires each state to establish its own recovery audit program for Medicaid.

Clarified through November 2010 regulations, the burden to succeed placed on these Medicaid RACs is certain to increase exponentially in 2014 when Medicaid Expansion officially begins.

Physician Payment Sunshine Act

Enacted in February 2013, Section 6002 of the Affordable Care Act (the Physician Payment Sunshine Act) deals primarily with transparency and public disclosure.

It requires disclosures by certain **manufacturers** of drugs, devices, and biological or medical supplies, as well as **group purchasing organizations** (GPOs), including but not limited to: (a) certain physician ownership or investment interests; and (b) certain payment information made by these entities to physicians.

The deadline to collect this information is **August 1, 2013**, and the reporting deadline is **March 31, 2014**.



CHALLENGES

- > **Contraception Controversy**
- > **Debt Ceiling, Fiscal Cliff and Sequestration**
- > **HIPAA, HITECH and GINA**

The Contraception Controversy

When first announced in August 2011, the inclusion of contraceptive care as a mandatory component in the employer promotion of preventative services sparked a First Amendment debate.

Regulations in February 2012 created a temporary enforcement safe harbor for objecting employers.

The February 2013 regulations set the new threshold, allowing employers to:

- > Oppose providing coverage for some or all of the previously required contraceptive services on the basis of religious grounds;
- > Exist as a nonprofit entity; and
- > Represent themselves as a religious entity.

Debt Ceiling, Fiscal Cliff and Sequestration

How will the nation's financial challenges impact the Affordable Care Act?

How many percentage points will it take before a hospital collapses?

- > The **debt ceiling** compromise proved to be the final blow to the Community Living Assistance Services and Supports (CLASS) Program.
- > The **fiscal cliff** disrupted a major portion of the funding for the Consumer Operated and Oriented Plans (CO-OPs).
- > Will **sequestration** prove to be another catalyst for the reduction of provider reimbursement?

HIPAA (Health Insurance Portability and Accountability Act) and **HITECH** (Health Information Technology for Economic and Clinical Health Act)

The most recent privacy regulations were released in January 2013, affecting almost 700,000 health care entities.

The costs involved include:

- Breach notifications -- as much as \$14.5 million (in 2011), not including the estimated initial expense of \$3.9 million to set up the toll-free notification lines.
- Business associates -- as high as \$150 million, including security rule compliance documentation and BAAs.
- Notification to patients of privacy practices (for providers, health insurers and third party administrators -- as much as \$56 million.

The Digital Medical Record

Existing privacy laws require practically every health care related electronic device to employ encryption algorithms, from a home facsimile or copy machine to all institutional servers.

Laptops and other portable devices must default to unreadable ciphertext, a protocol far beyond the ordinary login password.

Last year's release of the Medicare and Medicaid Programs' Electronic Health Record Incentives specified hospital stage two (out of three stages) criteria to qualify for electronic health record incentive payments.

Physicians' Medicare incentive payments can be as high as \$44,000, but the future penalty for not participating is up to 3% of all Medicare payments starting in 2017.



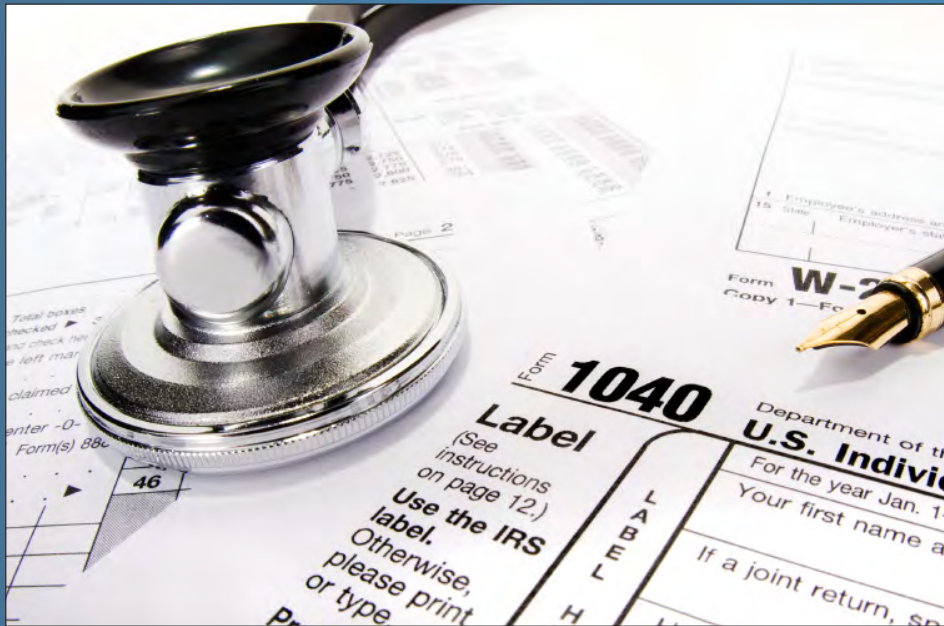
The Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA is the leading federal protection of genetic information, but it only prohibits genetic discrimination in health insurance and employment.

GINA does not regulate access, security or disclosure of genetic or whole genome sequence information across all potential users, nor does it protect against discrimination in other contexts.

State laws vary for similar protections.

Genetic information protections are only briefly mentioned in the Affordable Care Act (42 U.S.C. § 300gg-3(b)(1)(B) (Treatment of Genetic Information)): “*Genetic information shall not be treated as a condition . . . in the absence of a diagnosis of the condition related to such information.*”



TAXES AND REFORM

- > Points of Intersection
- > Additional Medicare Tax
- > Other Taxes

Points of Intersection

The ACA has become inextricably connected to the laws of federal and state taxation. These points of intersection include:

- > Disclosure or Use of Information by Tax Return Preparers
- > Medical Loss Ratio (MLR)
- > Reporting Employer Provided Health Coverage in Form W-2
- > Net Investment Income Tax
- > Additional Medicare Tax
- > Minimum Value
- > Small Business Health Care Tax Credit

Points of Intersection, continued

- > Health Flexible Spending Arrangements
- > Medical Device Excise Tax
- > Health Insurance Premium Tax Credit
- > Individual Shared Responsibility Provision
- > Health Coverage for Older Children
- > Excise Tax on Indoor Tanning Services
- > Adoption Credit
- > Transitional Reinsurance Program
- > Medicare Shared Savings Program

Points of Intersection, continued

- Qualified Therapeutic Discovery Project Program
- Group Health Plan Requirements
- Annual Fee on Health Insurance Providers
- Tax-Exempt 501(c)(29) Qualified Nonprofit Health Insurance Issuers
- Additional Requirements for Tax-Exempt Hospitals
- Annual Fee on Branded Prescription Pharmaceuticals
- Employer Shared Responsibility Payment
- Excise Tax on “Cadillac” Plans
- Patient-Centered Outcomes Research Institute
- Retiree Drug Subsidies

Additional Medicare Tax

- > As of 2013, the 0.9% Additional Medicare Tax applies to income that exceeds a threshold amount of \$250,000 for married taxpayers filing jointly and \$125,000 if filing separately.
- > A \$200,000 threshold applies for all other taxpayers.
- > An employer is responsible for withholding the Additional Medicare Tax from wages or compensation it pays in excess of these limits within a calendar year.

Net Investment Income Tax

- > As of 2013, the 3.8% Net Investment Income Tax applies to individuals, estates and trusts that have certain investment income above threshold amounts.

Indoor Tanning Services Tax

- > As of July 1, 2010, a 10% excise tax on indoor UV tanning services went into effect.

Medical Device Excise Tax

- > As of January 1, 2013, manufacturers and importers paid a new 2.3% medical device excise tax on sales of certain medical devices.

Fee on Branded Prescription Pharmaceutical Manufacturers and Importers

- > Beginning in 2011, the ACA requires an annual fee from certain manufacturers and importers of brand name pharmaceuticals.

Additional Resources

- > www.healthcare.gov (U.S. Government)
- > www.healthreform.kff.org (The Henry J. Kaiser Foundation)
- > www.hhs.gov (The U.S. Department of Health and Human Services)
- > www.cms.gov (Centers for Medicare & Medicaid Services)
- > www.oshpd.ca.gov/reform (Office of Statewide Health Planning & Development)
- > www.chhs.ca.gov (California Health & Human Services Agency)

Craig B. Garner

Craig is an attorney and health care consultant, specializing in issues pertaining to modern American health care and the ways it should be managed in its current climate of reform.

Craig's law practice focuses on health care mergers and acquisitions, regulatory compliance and counseling for providers. Craig is also an adjunct professor of law at Pepperdine University School of Law, where he teaches courses on Hospital Law and the Affordable Care Act.

Between 2002 and 2011, Craig was the Chief Executive Officer of Coast Plaza Hospital in Norwalk, California. Craig is also a Fellow Designate with the American College of Healthcare Executives, a Member of the State Bar of California, Business Law Section, Health Law Committee and a Vice Chair of the Healthcare Reform Educational Task Force of the American Health Lawyers Association.

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