The Modern American Hospital
Balancing Performance and Compliance in the Current Climate of Reform

ORANGE COUNTY BAR ASSOCIATION
HEALTH CARE LAW SECTION MEETING

Date: April 11, 2013
Time: 12:00 PM to 1:30 PM

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.
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.
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.
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
- Taxpayers, in part through the Individual Mandate
- Companies, in part through the Business Mandate
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)
Precious Metals (January 2013)

- Platinum 30-day average = $1,585
- Gold 30-day average = $1,673
- Silver 30-day average = $31
Taxes and Flexible Spending Accounts in 2013

» Individual contributions to flexible spending accounts for medical expenses can no longer exceed $2,500 per year.

» New regulations limit the itemized deduction for unreimbursed medical expenses (previously 7.5% of adjusted gross income) to 10%.

» Taxes on wages above $200,000 increased by 0.9%.

» Unearned income is subject to a new 3.8% increase.
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); or
- Grandfathered health plan; or
- Other

26 U.S.C. § 5000A
The Penalty

Collecting the Penalty

- Waiver of criminal penalties
- Limitations on liens and levies

Minimum Essential Coverage?

- Yes

NEW WAYS TO QUALIFY (1/30/13)

Exception?

- Yes

1. Religious?
2. Not Present?
3. In Jail?
4. Low Income?
5. Hardship?
6. Indian Tribe?

- No

PENALTY (in 2016)

the greater of

- $695 (or less)

or

not to exceed

- 2.5% of household income

Bronze Level of Coverage
**Employer Mandate**

The Affordable Care Act 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 law imposes a penalty ($2,000 per employee) if any of their full-time employees qualify for and receive federal subsidies.

The large employer penalty does not apply for the first 30 employees.

For small businesses that are not required to provide health coverage, generous new tax credits will be available to those businesses with low-paid employees to encourage them to provide qualified health insurance for their employees.

26 U.S.C. § 4980H
Small Business Health Care Tax Credits

The Affordable Care Act provides tax credits to small businesses with low-paid employees:

- Must cover at least 50% of the cost of health care coverage for some of its workers based on the single rate.
- 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).
- Must pay average annual wages below $50,000.
- 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).
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. 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 among employees of health care expenses.

- 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.
The Affordable Care Act
Year by Year
<table>
<thead>
<tr>
<th>YEAR</th>
<th>SUBJECT</th>
<th>INDIVIDUAL</th>
<th>SMALL GROUP</th>
<th>LARGE GROUP</th>
<th>SELF-FUNDED (ASO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Dependent coverage for adult children to age 26</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>2010</td>
<td>No lifetime or annual dollar limits on essential health benefits</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2010</td>
<td>No lifetime dollar limits on coverage</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2010</td>
<td>100% coverage for in-network preventive care</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2010</td>
<td>No annual dollar limits on certain types of benefits (restricted annual limits allowed until 2014)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2010</td>
<td>No pre-authorization for emergency services (patient protection)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>2010</td>
<td>No higher cost share for out-of-network emergency services (patient protection)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2010</td>
<td>No pre-existing condition exclusions for children</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2010</td>
<td>Revised appeals process</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>2010</td>
<td>Early retiree reinsurance program (fund exhausted 2011)</td>
<td>NA</td>
<td>Y</td>
<td>Y</td>
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<td>2010</td>
<td>MLR requirements</td>
<td>Y (80%)</td>
<td>Y (80%)</td>
<td>Y (85%)</td>
<td>NA</td>
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<tr>
<td>2010</td>
<td>No pre-tax reimbursements from health spending or flexible spending accounts (HSA/FSA) for non-prescribed, over-the-counter medications</td>
<td>NA</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>YEAR</td>
<td>SUBJECT</td>
<td>INDIVIDUAL</td>
<td>SMALL GROUP</td>
<td>LARGE GROUP</td>
<td>SELF-FUNDED (ASO)</td>
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<tr>
<td>2011</td>
<td>20% tax for nonqualified HSA withdrawals</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2012</td>
<td>Reporting value of employer-sponsored coverage on W-2</td>
<td>NA</td>
<td>Optional</td>
<td>Optional</td>
<td>Optional</td>
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<tr>
<td>2012</td>
<td>Summary of Benefits &amp; Coverage (SBC)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2012</td>
<td>60-day notice of material modification</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2012</td>
<td>Women’s Preventative Care</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2013</td>
<td>Reporting value of employer-sponsored coverage on W-2</td>
<td>NA</td>
<td>Transitional relief until 2014</td>
<td>Y (employer responsibility)</td>
<td>Y (employer responsibility)</td>
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<tr>
<td>2013</td>
<td>Employee notification of exchanges, including subsidies and tax credits</td>
<td>NA</td>
<td>Y (employer responsibility)</td>
<td>Y (employer responsibility)</td>
<td>Y (employer responsibility)</td>
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<tr>
<td>2013</td>
<td>Flexible Spending Account contributions limited to $2,500/year</td>
<td>NA</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2013</td>
<td>Patient-Centered Outcomes Research Institute (PCORI)-sponsored comparative effectiveness research fee (CER)</td>
<td>Y (health plan pays)</td>
<td>Y (health plan pays on employers’ behalf)</td>
<td>Y (health plan pays on employers’ behalf)</td>
<td>Y (employer responsible for calculating)</td>
</tr>
<tr>
<td>2013</td>
<td>Free choice voucher required to be provided to qualifying employees</td>
<td>NA</td>
<td>Repealed</td>
<td>Repealed</td>
<td>Repealed</td>
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<tr>
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</tr>
<tr>
<td>2014</td>
<td>Insurer Fee (or Health Insurance Tax)</td>
<td>Y (health plan pays on employer’s behalf)</td>
<td>Y (health plan pays on employer’s behalf)</td>
<td>Y (health plan pays on employer’s behalf)</td>
<td>NA</td>
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<tr>
<td>2014</td>
<td>Transitional Reinsurance Fee</td>
<td>NA</td>
<td>Y (health plan pays on employers’ behalf)</td>
<td>Y (health plan pays on employers’ behalf)</td>
<td>Y (employer encouraged to calculate amount and pay fee directly)</td>
</tr>
<tr>
<td>2014</td>
<td>Essential health benefits (EHB) package required</td>
<td>Y</td>
<td>Y</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>2014</td>
<td>Out-of-pocket maximum limits applied (cumulative for all coverage)</td>
<td>Y</td>
<td>Y</td>
<td>Y (transitional relief until 2015)</td>
<td>Y (transitional relief until 2015)</td>
</tr>
<tr>
<td>2014</td>
<td>No pre-existing condition exclusions regardless of age</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2014</td>
<td>Coverage waiting period not to exceed 90 days</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2014</td>
<td>Employers with 50+ required to offer coverage with minimum value (MV)</td>
<td>NA</td>
<td>Y (dependent on number of employees)</td>
<td>Y (dependent on number of employees)</td>
<td>NA</td>
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<tr>
<td>2014</td>
<td>Auto-enrollment required by employers with 200+ employees</td>
<td>NA</td>
<td>NA</td>
<td>Y (dependent on number of employees)</td>
<td>Y (dependent on number of employees)</td>
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<tr>
<td>2014</td>
<td>Coverage of routine care costs for patients* participating in clinical trials</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>YEAR</td>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>2014</td>
<td>“Small group” redefined as 1-100 (states may defer until 2016)</td>
<td>NA</td>
<td>Y</td>
<td>Y</td>
<td>Y (dependent on number of employees)</td>
</tr>
<tr>
<td>2014</td>
<td>Deductible limits $2,000 individual / $4,000 family</td>
<td>NA</td>
<td>Y</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>2014</td>
<td>HIPAA nondiscrimination rules on wellness programs</td>
<td>NA</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2014</td>
<td>Wellness program maximum incentive increase to 30%</td>
<td>NA</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>2014</td>
<td>Individual mandate</td>
<td>Y</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>2014</td>
<td>Guaranteed issue</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>2014</td>
<td>Rating limitations</td>
<td>NA</td>
<td>Y</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2018</td>
<td>40% excise tax on high-cost “Cadillac” plans</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
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
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 these activities itself, or 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
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)

[Submit 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 and 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
➤ Can 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) (Final Rule)

- 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

Proposed Rule (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


*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).
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
The DRG system will begin to give way to 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
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 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: $$\frac{1}{1 + e^{-z}}$$

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

**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: $$\frac{1}{1 + e^{z}}$$

$$Z = X\beta$$

**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) and Bariatric Surgery and Implantation of Cardiac Electronic Device

➤ Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures (total knee and hip replacements)

➤ Latrogenic 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 healthcare 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.”
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)
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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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