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Driving Provider Integration: Implications for Hospitals and Health Systems of the Patient Protection and Affordable Care Act

I. Introduction

On March 23, 2010, President Obama signed into law the most sweeping health care legislation since Medicare was enacted in 1965. The Patient Protection and Affordable Care Act[1] (the "Act") seeks to transform the American healthcare delivery system through a variety of cutting-edge initiatives and by amending a series of existing laws. The law has been described as allowing the "biggest transformation of government since World War II"[2] in its effort to provide increased healthcare coverage to millions of Americans while also seeking to control the spiraling cost of healthcare.

The law will impact hospitals and health systems in numerous ways as it seeks to achieve the two goals of increased coverage and controlling costs. Hospitals will face increased demands for primary and preventive care from an increasing number of patients. At the same time, hospitals will see reimbursement changes, increased reporting requirements relating to quality outcomes and experimentation with new payment models. The result of these changes, assuming the Act is implemented,[3] will be an increased drive toward integration of hospitals and healthcare systems as they, along with physicians and other providers, react to this massive transformation of the U.S. healthcare delivery system.

[1] H.R. 3590, the "Patient Protection and Affordable Care Act" (P.L. 111 - 148, 124 Stat. 119) was subsequently amended by H.R. 4872, the "Health Care and Education Reconciliation Act of 2010" (P.L. 111 – 152, 124 Stat. 1029), as part of the budget reconciliation process.

[2] *The New York Times*, April 18, 2010, interview with David Cutler, Harvard economist and President Obama's chief campaign adviser of health policy.

[3] For an essay on the work facing the Obama Administration as it strives to implement the Act, *see The New Yorker*, "Now What?" by Atul Gawande (April 5, 2010)

The Act seeks to achieve this transformation through the amendment of several existing statutes. They are:

- The Public Health Service Act ("PHSA");
- The Fair Labor Standards Act;
- The Social Security Act;
- The Internal Revenue Code;
- The Employee Retirement Income Security Act of 1974 ("ERISA"); and
- The Deficit Reduction Act of 2005

Accordingly, a number of regulatory agencies, such as the Department of Labor and the Treasury Department, will play significant roles in the implementation of the Act. However, the biggest role will be played by the Department of Health and Human Services (HHS), which will be faced with developing the regulations necessary to carry out the Act's provisions.[4]

The Act is structured into 10 Titles that impact discrete areas of healthcare reform. Combined, the Titles in the Act touch upon almost every sector of the healthcare delivery system in the United States. The Reconciliation Act, passed one week later, makes technical and conforming changes to the Act. The Act's Titles are:

Title I – Quality, Affordable Health Care for All Americans[5]

Title II – Role of Public Programs[6]

Title III – Improving the Quality and Efficiency of Health Care

Title IV – Prevention of Chronic Disease and Improving Public Health

Title V – Health Care Workforce

Title VI – Transparency and Program Integrity

Title VII – Improving Access to Innovative Medical Therapies

Title VIII – CLASS Act[7]

Title IX – Revenue Provisions

Title X – Strengthening Quality, Affordable Health Care for All Americans[8]

[4] President Obama has already assembled a high-level team to carry out key elements of the law and is considering moving faster than the new law requires putting them in action. *The New York Times*, "Obama Gets Law Moving" (April 18, 2010)

[5] The repeated use of the word "Americans" throughout the Act in lieu of the word "patients" or "consumers" is intentional in that the Act specifically does not include the undocumented, of which there are approximately 10.8 million, according to a 2009 estimate by the Department of Homeland Security.

[6] This Title describes changes to the Medicaid, CHIP and other public programs.

[7] Title VIII is a voluntary, national long-term care insurance program.

[8] This Title contains changes to earlier Titles in the Act.

II. Expanded Health Care Coverage

A. Increased Primary Care Demands

Under the Act, hospitals and health systems will face greater demand for primary care services by increased numbers of patients. According to some estimates, an additional 32 million Americans will have health insurance coverage – in Texas alone the number may reach as high as 6.1 million.[9]

Title I of the Act makes several amendments to the PHSA that will result in greater access to primary care services.[10] Section 1001 of the Act prohibits lifetime or annual limits on care, and provides that insurers cover preventive health services, to include immunizations, and women's and children's preventive services without any cost sharing (payment of co-pays or deductibles).[11]

A number of community health and wellness initiatives are also included in the Act, which will almost certainly push the demand for greater access to primary care

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[9] *Texas Hospital Association*, Health Care Reform Bill Talking Points, available at http://www.tha.org/HealthCareProviders/Issues/HealthCareCoverage/THA%20talking%20points%20on%20the%20health%20reform%20bill.pdf

[10] A frequent criticism of the Act is that health insurance coverage does not equal access to health care services. Anticipating greater demand for primary care coverage as a result of the reforms under the Act, Section 5501 provides primary care practitioners with a 10% Medicare payment bonus for 5 years. However, this may not address lower Medicare rates in effect due to the Sustainable Growth Rate (SGR) formula, contained in the Balanced Budget Act of 1997. Since 2001, Medicare rates have dropped by approximately 21% since 2001, in inflation-adjusted dollars. Additionally, Section 1202 of the Reconciliation Act provides that Medicaid payments rates to primary care doctors for furnishing primary care services will be no less than 100% of Medicare rates in 2013 and 2014. However, increasing historically low Mediacid reimbursement rates to Medicare rates is no guarantee that physicians will see these patients. The Houston Chronicle reported that record numbers of physicians, especially primary care physicians, in Texas are dropping out of Medicare due to low reimbursement rates. *Houston Chronicle*, May 17, 2010 "Texas doctors opting out of Medicare at alarming rate" Available at: http://www.chron.com/disp/story.mpl/metropolitan/7009807.html Thus, increasing low rates to rates that are encouraging physicians to leave the Medicare program does not appear to be a viable solution to the physician shortages looming in primary care.

Nonetheless, the Act contains other provisions designed to provide for more primary care physicians; however, tangible results of these provisions may be years away. The Act adds primary care residency positions, adjusts rules concerning medical residency programs, increases teaching capacity in primary care residency programs and establishes demonstration projects in graduate nurse education, among others. *See* Sections 5501- 5509.

[11] Section 1001 of the Act amends the following sections of the PHSA:

- Section 2711 of the PHSA, as further amended by Section 10101of the Act, prohibits plans from establishing lifetime limits, and annual limits beginning in 2014, on the dollar value of benefits. Prior to 2014, plans may only establish restricted annual limits as defined by the Secretary of Health and Human Services (HHS), ensuring access to needed services with minimal impact on premiums; and
- Section 2713 of the PHSA is amended to require all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, certain child preventive services recommended by the Health Resources and Services Administration (HRSA), and women's preventive care and screening recommended by HRSA, without any cost-sharing.

services. Among the provisions of the Act are childhood obesity demonstration projects,[12] clinical and community preventive services,[13] oral health activities,[14] and education and outreach campaigns. [15] The Act also authorizes a grant program for the development and operation of school-based health clinics to provide comprehensive and accessible preventive and primary health care services to medically underserved children and families. [16]

Increased demand for primary and preventive care will also result due to the Act's removal of barriers for Medicare beneficiaries to obtain preventive services [17] and Medicare coverage of annual wellness visits, with no co-pay or deductible. [18] The Act

[12]The Children's Health Insurance Program Reauthorization Act of 2009 included several provisions designed to improve the quality of care under Medicaid and CHIP. This law directed the Secretary to initiate a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity. Section 4306 of the Act appropriates $25 million for the childhood obesity demonstration project and adjusts the demonstration time period to fiscal years 2010 through 2014.

[13] Section 4003 of the Act expands the efforts of, and improves the coordination between, two task forces that provide recommendations for preventive interventions. The U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services such as colorectal cancer screening or aspirin to prevent heart disease, and develops recommendations for their use. The Community Preventive Services Task Force uses a public health perspective to review the evidence of effectiveness of population-based preventive services such as tobacco cessation, increasing physical activity and preventing skin cancer, and develops recommendations for their use.

[14] Section 4102 establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women and creates demonstration programs on oral health delivery and strengthens surveillance capacity.

[15] Section 4004 directs the Secretary to convene a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities to promote health and prevent disease across the lifespan. In addition, the Secretary will provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each State would be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services.

[16] This section also appropriates $50 million each year for fiscal years 2010 through 2013 for expenditures for facilities and equipment. Section 10402 of the Act adds vision services to the list of health services for which a School Based Health Center should provide referrals.

[17] Section 4104 waives beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force. Section 10406 clarifies that Medicare beneficiaries do not have to pay coinsurance (including co-pays and deductibles) for preventive services delivered in all settings.

[18] Section 4103 provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. Such services would include a comprehensive health risk assessment. The personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition. Section 10402 clarifies that Medicare beneficiaries are eligible for the initial preventive physical exam in their first year of Medicare coverage and for personalized prevention services annually thereafter.

further provides for expanded Medicaid coverage for diagnostic, preventive and rehabilitation services, [19] comprehensive tobacco cessation services for pregnant women,[20] and grants to states to provide incentives to prevent chronic diseases.[21]

B. Increased Demand for Other Health Services

In addition to providing for increased access to primary care, the Act extends coverage for other services, such as the Black Lung survivors, [22] freestanding birth centers, [23] maternal and early childhood home visiting programs, [24] postpartum depression,[25] emergency psychiatric programs, [26] trauma centers, [27]emergency medical centers for children,[28] and women's health programs.[29]

Reforms made to existing health insurance plans will also bring in more patients

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[19] Section 4106 changes the current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.

[20] Under Section 4107, States would be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Such services would include diagnostic, therapy and counseling services, and prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration for cessation of tobacco use by pregnant women. This section would also prohibit cost-sharing for these services.

[21] Pursuant to Section 4108, States are eligible for grants to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

[22] Section 1556 provides for improvements to the Black Lung Benefits Act.

[23] Coverage of services provided by free-standing birth centers is required by Section 2301.

[24] Section 2951 provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

[25] Section 2952 provides support services to women suffering from postpartum depression and psychosis and also helps educate mothers and their families about these conditions. Provides support for research into the causes, diagnoses, and treatments for postpartum depression and psychosis.

[26] Section 2701 requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

[27] Section 3505 reauthorizes and improves the trauma care program, providing grants administered by the HHS Secretary to States and trauma centers to strengthen the nation's trauma system. Grants are targeted to assist trauma care centers in underserved areas susceptible to funding and workforce shortages.

[28] Section 5603 awards grants to States and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment.

[29] Sec. 3509 provides for women's health offices at various Federal agencies to improve prevention, treatment, and research for women in health programs.

seeking care. Among those plan changes are requirements that all plans offering dependent coverage allow individuals until age 26 to remain on their parents' health insurance, [30] immediate access to insurance for people with a preexisting condition, [31] and protection of the ability of Americans and legal aliens to obtain and keep health insurance that contains a list of defined essential benefits.[32] Moreover, any individual enrolled in any form of health insurance has the right to maintain their coverage as it existed on the date on March 23, 2010. [33]

Furthermore, patients will be able to freely select their primary care and OB

[30] Section 1001 of the Act amends Section 2714 of the PHSA to require all plans offering dependent coverage to allow individuals until the age of 26 to remain on their parents' health insurance. Section 2301 of the Reconciliation Act eliminates the requirement that adult children be unmarried. This requirement does not, however, extend to an insured's grandchildren under the age of 26.

[31] Section 1101 of the Act enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition, ensures premium rate limits for the newly insured population, and provides up to $5 billion for this program, which terminates when the American Health Benefit Exchanges are operational in 2014. Also establishes a transition to the Exchanges for eligible individuals.

[32] Section 1201 of the Act provides the following amendments to the PHSA:

- Sec. 2702. Guaranteed availability of coverage. Each health insurance issuer must accept every employer and individual in the State that applies for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.
- Sec. 2703. Guaranteed renewability of coverage. Requires guaranteed renewability of coverage regardless of health status, utilization of health services or any other related factor.
- Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status. No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past.
- Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status. No group health plan or insurer offering group or individual coverage may set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability – including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 percent for employee participation in certain health promotion and disease prevention programs. Authorizes a 10-State demonstration to apply such a program in the individual market.
- Sec. 2707. Comprehensive health insurance coverage. Requires health insurance issuers in the small group and individual markets to include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all health plans to comply with limitations on allowable cost-sharing.
- Sec. 2708. Prohibition on excessive waiting periods. Prohibits any waiting periods for group coverage that exceeds 90 days. Section 10103 clarifies that waiting periods do not apply to the individual market.
- Sec. 2709. Coverage for individuals participating in approved clinical trials. As added by Section 10103, prohibits insurers from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

[33] Section 1251 allows any individual enrolled in any form of health insurance to maintain their coverage as it existed on the date of enactment. Section 10103 applies the requirements for medical loss ratios and uniform coverage documents to grandfathered plans. Section 2301 of the Reconciliation Act applies the requirements for excessive waiting periods, lifetime limits, rescissions, and extension of young adult coverage to grandfathered plans. Also, applies requirements relating to pre-existing coverage exclusions to

providers,[34] while reducing the cost sharing for individuals enrolling in qualified health plans for those falling below certain income levels.[35] Additionally, insurers will have fewer grounds upon which to deny coverage. Both the OIG and HHS will monitor insurers' actions in this arena.[36]

Medicare benefit levels will be maintained[37] and Medicaid coverage will be expanded to include the lowest income populations.[38] Increased demand for other healthcare services will also be driven by greater access to therapies under Medicare[39] and in the future, Medicare will make available more evidence-based preventive care services.[40]

III. The Drive Toward Quality

A. Increased Reporting Requirements

group health plans, applies requirements regarding adult child coverage to group health plans only if the adult child is not eligible to enroll in an employer-sponsored plan.

[34] Section 2719A of the PHSA is amended by Section 1001 of the Act (and further amended by Section 10101 of the Act to require that a plan enrollee be allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care provider. Precludes the need for prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers. Plans are precluded from requiring authorization or referral by the plan for a patient who seeks coverage for obstetrical or gynecological care by a specialist in these areas.

[35] Under section 1402 of the Act, the standard out-of-pocket maximum limits ($5,950 for individuals and $11,900 for families) would be reduced to one-third for those between 100-200 percent of poverty, one-half for those between 200-300 percent of poverty, and to two-thirds for those between 300-400 percent of poverty.

[36] Section 1562 of the Act directs the GAO to study the rate of denial of coverage and enrollment by health insurance issuers and group health plans.

[37] Section 3601 reaffirms that Medicare guaranteed benefits will not be reduced and that any savings generated for the Medicare program will extend the solvency of the Medicare trust funds, reduce Medicare premiums and cost-sharing, and improve or expand guaranteed Medicare benefits or protect access to providers. Section 3602 reaffirms that benefits guaranteed to Medicare Advantage plan participants will not be reduced or eliminated.

[38] Section 1331 allows States to contract, through a competitive process that includes negotiation of premiums, cost-sharing, and benefits, with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have income below 200 percent of the Federal Poverty Level (FPL). Also, Section 2001 of the Act (as amended by Section 10201) creates a new State option to provide Medicaid coverage through a State plan amendment beginning on April 1, 2010. Eligible individuals include all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). This section also creates a new mandatory Medicaid eligibility category for all such "newly-eligible" individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014.

[39] Section 1554 of the Act prevents the Secretary from promulgating certain regulations limiting access to health care services.

[40] Section 4015 authorizes the Secretary to modify the coverage of any currently covered preventive service in the Medicare program to the extent that the modification is consistent with U.S. Preventive Services Task Force recommendations and the services are not used for diagnosis or treatment. The Secretary will also conduct a provider and beneficiary outreach program regarding covered preventive services. This section also authorizes a Government Accountability Office (GAO) study of the utilization of and payment for Medicare covered preventive services, the use of health information technology in coordinating such services, and whether there are barriers to the utilization of such services.

Hospitals – and also physicians – must be prepared for a new paradigm in which quality outcomes will be required by both insurers and the government. The new reporting requirements are part of a two-step process in which payments will be linked to outcomes. However, before that happens, both the federal government and insurers will need access to greater data. As these requirements for data increase, many providers – most likely physicians in solo practices or small groups – will seek consolidation with other physician groups or seek integration with hospitals and health systems.

The reporting requirements in the Act are extensive and will rely heavily on developing systems to measure various quality outcomes that are risk adjusted. Likewise, such reporting requirements will be tied to the usage of electronic medical records.

The Secretary of HHS is required to develop and publicly report on patient outcomes measures.[41] The Secretary must also collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information.[42]

Moreover, the Act requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions, improve patient safety, and promote wellness and health.[43] Furthermore, the following reporting requirements will be put in place by virtue of the Act:

- Adult health quality measures;[44]
- Long-term hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals and hospice programs; [45] and
- PPS-exempt cancer hospitals;[46]

[41] The federal government will be spending $95 million over the next five years to develop these reporting systems. Section 3013 of the Act authorizes $75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). Quality measures developed under this section will be consistent with the national strategy. Section 3014 of the Act provides $20 million to support the endorsement and use of endorsed quality and efficiency measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.

[42] Section 3015, as amended by Section 10305.

[43] Section 2717.

[44] Section 2701 directs the Secretary of HHS to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measurement program for children enacted in the Children's Health Insurance Program Reauthorization Act of 2009. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis.

[45] Section 3004 establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update. Section 10322 also establishes a quality measure reporting program for inpatient psychiatric hospitals beginning FY2014.

[46] Section 3005 establishes a quality measure reporting program for PPS-exempt cancer hospitals beginning in FY2014. Providers under this section who do not successfully participate in the program

The reporting requirements will be equally applied to physicians under the Act, which provides incentives to physicians who report quality data to Medicare.[47] Pursuant to the physician quality reporting initiative (PQRI), an appeals and feedback processes for participating professionals in PQRI will be created. Additionally, a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine will be established. Beginning in 2014, physicians who do not submit measures to the PQRI will have their Medicare payments reduced. Section 10327 of the Act provides an additional 0.5 percent Medicare payment bonus to physicians who successfully report quality measures to CMS via the new Maintenance of Certification program and eliminates the MA Regional Plan Stabilization Fund.

Beginning in 2012, Medicare will provide reports on physicians that will compare their per capita utilization to other physicians who see similar patients.[48] Reports will be risk-adjusted and standardized to take into account local health care costs. The Act also requires the Secretary of HHS to develop a "Physician Compare" website where Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures, provided that such information provides an accurate portrayal of physician performance.[49]

While not a reporting requirement, the Act will also release and use standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy and in accordance with other requirements.[50]

B. Moving From Reporting to Paying for Quality Outcomes

As mentioned previously, reporting of quality metrics is only the first of a two-step process in which the government will begin to pay providers – both hospitals and physicians – based upon outcomes. Various provisions throughout the Act provide payment mechanisms for quality-based payments. One of the most noticed provisions will prohibit Medicaid payment for services related to a health care-acquired condition.[51]

The Act calls for an establishment of a hospital value-based purchasing program in fiscal year 2013.[52] Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program (and in all other quality programs in this title) will be developed and chosen with input from external stakeholders. Section 10335 of the Act clarifies that the program will not

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would be subject to a reduction in their annual market basket update.

[47] Section 3002 creates improvements to the physician quality reporting initiative (PQRI).

[48] Section 3003 of the Act provides for improvements to the physician feedback program.

[49] Section 10331.

[50] Section 10332.

[51] Section 2702, contains the payment adjustment for health care-acquired conditions. The Secretary of HHS will develop a list of health care-acquired conditions for Medicaid based on those defined under Medicare as well as current State practices.

[52] Section 3001.

include measures of hospital readmissions.

Starting in FY2015, hospitals in the top 25th percentile of rates of hospital-acquired-conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare.[53] This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a health care-acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.

Beginning in FY2012, the Act will adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum.[54] The Secretary of HHS also has the authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.

Pay-for-quality extends to physicians under the Act. The Secretary of HHS will develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver.[55] Quality and cost measures will be risk-adjusted and geographically standardized. The Secretary will phase-in the new payment system over a two-year period beginning in 2015.

III. Payment Reform: Exploring New Payment Models

A. Introduction

One of the goals of the Act is to contain healthcare costs. It contains a variety of mechanisms in an attempt to achieve this, which will impact hospitals differently, depending on the hospitals' location and patient and payor mix. Overall, a new bureaucracy will be created with the Independent Payment Advisory Board, an independent 15-member tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries.[56] In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. The Board will be required to make annual recommendations to the President, Congress, and private entities on actions they can take to improve quality and constrain the rate of

[53] Section 3008.
[54] Section 3025. Section 10309 makes a technical correction to the hospital readmissions payment policy establishing in the underlying section.
[55] Section 3007.
[56] Section 3403, as amended by Section 10320.

cost growth in the private sector. The Board must also make non-binding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate. The Board is prohibited from making recommendations that would reduce premium supports for low-income Medicare beneficiaries. Beginning in 2020, the Board's binding recommendations to Congress are limited to only every-other-year if the growth in overall health spending exceeds growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare.

Specific Reimbursement Rates

The Act contains a number of specific reimbursement changes targeting selected providers and geographic regions. Payments to Federally Qualified Health Centers (FQHCs) by qualified health plans are guaranteed to be at least as high as payments to FQHS as Medicaid.[57] The Act also provides some relief to hospitals adversely impacted by the work geographic index floor and the practice expense geographic adjustment under the Medicare physician fee schedule. [58] Certain market basket updates are revised to include a productivity adjustment,[59] an extension is allowed for processing exceptions to limitations on medically necessary therapy caps,[60] and future reforms of the hospital wage index calculations[61] are additional specific reimbursement measures contained in the Act.

Cancer hospitals that are exempt from the inpatient prospective payment system are to be studied to determine if their outpatient prospective payment system costs exceed costs of other hospitals.[62] Urban hospitals that are Medicare-dependent will also be studied to determine if they need additional Medicare payments under the inpatient prospective payment system.[63] The Act further extends the PHSA Section 340B discount drug pricing system to certain childrens, cancer, critical access and sole community hospitals.[64]

Rural Hospital Payments

Rural hospitals particularly benefit from a wide range of reimbursement assistance found mostly in Title III of the Act. These include additional payments for clinical pathology services,[65] air and land ambulance services,[66] and certain clinical diagnostic tests.[67] Additionally, rural hospitals benefit from a number of improvements to

[57] Section 10104.
[58] Section 3102.
[59] Section 3401.
[60] Section 3103.
[61] Section 3137.
[62] Section 3138.
[63] Section 3142.
[64] Section 7101.
[65] Section 3104.
[66] Section 3105.
[67] Section 3122.

hospital payment methodologies designed to ensure their financial viability. These include adjustments for low-volume hospitals,[68] critical access hospitals,[69] and the Medicare hospital wage index floor.[70] The Act also provides for further study on Medicare payments to healthcare providers in rural areas[71] and special demonstration projects to test new models of community health integration.[72]

The Flex Grant program for rural hospitals, which supports rural hospital's efforts to implement alternative payment methodologies, such as value-based purchasing and bundled payments, is extended through 2012.[73] The Act also establishes hospital wage index and geographic expense floors in rural states where at least 50 percent of the counties are "frontier."[74]

DSH Payments

Perhaps one of the biggest changes to the reimbursement paradigm in federal funding of hospitals is the gradual diminution of the Medicare and Medicaid disproportionate share hospital (DSH) payments. Because one of the Act's goals is to increase insurance coverage of Americans, both the Medicare and Medicaid DSH payments to hospitals will be decreased to reflect the supposed decrease in charity care that hospitals will have to provide. As amended by Section 1104 of the Reconciliation Act, Section 3133 of the Act reduces Medicare DHS payments by $3 billion over 10 years, beginning in 2014. Under Section 2551 of the Act, as amended by Section 1203 of the Reconciliation Act, federal Medicaid DSH payments will be lowered from $18.1 billion to $14.1 billion, beginning in fiscal year 2014.

This payment change could have a serious effect on those hospitals that currently rely on such payments if the Act is not implemented as originally envisioned. Hospitals could conceivable see their charity care levels remain steady – or decrease only slightly – but have to contend with drastically reduced federal assistance through the DSH program. Moreover, because the Act does not extend protections to the undocumented, those hospitals, especially in States that border Mexico could still be forced to provide care to those individuals without health insurance. This portion of the Act will likely be re-examined in the coming years and adjusted or modified to better reflect the actual rate of implementation. Also yet to be decided is how the nation's struggle over the immigration issue affects financing of healthcare for the undocumented.

[68] Section 3125.
[69] Section 3128.
[70] Section 3141.
[71] Section 3127.
[72] Section 3126.
[73] Section 3129.
[74] Section 10324.

Global, Capitated Payments for Episodic Care

Part of the transforming nature of the Act lies in new payment models that -- while having been used elsewhere previously – have been adopted for use on a federal level. The Act also seeks to allow innovation in new healthcare delivery models through the use of demonstration projects. This transformative nature of the Act stems from the belief that healthcare costs cannot be constrained unless the highly fragmented nature of the industry is driven toward integration. To that end, at least three different attempts at changing the nature of reimbursement are explored in the Act.

First, the Act allows for a demonstration project to evaluate integrated care around a hospitalization.[75] This project can be employed in up to eight states to study the use of bundled payments for hospital and physician services in the Medicaid program. Additionally, the Secretary of HHS is directed in the Act to develop a national, voluntary pilot program to encourage hospitals, doctors and post-acute care providers to improve patient care and achieve savings for he Medicare program through bundled payment models. [76]

Second, the Act establishes a Medicaid global payment demonstration project in up to five states that would allow participating states to adjust their current payment structure for safety net hospitals from a fee-for service to a global capitated payment structure. [77] Finally, the Act allows an extension of the gainsharing demonstration initially authorized under the Deficit Reduction Act of 2005.[78]

Expanded Fraud & Abuse Enforcement

With the unprecedented amount of money that will finance the expansion of health services under the Act, it should come as no surprise that there is a significant expansion of fraud and abuse prevention initiatives in the Act. Most of the fraud and abuse provisions can be found in Title VI, though there are other provisions found elsewhere throughout the Act. The Reconciliation Act increased the funding to fight fraud and abuse by $350 million over the next ten years, with funds used to fight fraud indexed to the increase in the Consumer Price Index.[79] Additionally, the Act Enhances the fraud sentencing guidelines, changes the intent requirement for fraud under the anti-kickback statute, and increases subpoena authority relating to health care fraud.[80] New auditing, reporting and other compliance requirements for the PHSA 340B drug pricing program are included in the Act.[81]

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[75] Section 2704.
[76] Section 3023
[77] Section 2705.
[78] Section 3027.
[79] Sections 1301 and 1303 of the Reconciliation Act.
[80] Section 10606.
[81] Section 7102.

The Act also requires States to implement fraud, waste, and abuse programs before January 1, 2011.[82]

The Act further provides for enhanced screening of providers, increased disclosure and required compliance programs.[83] An integrated data repository (IDR) claims and payment data from various federal health programs would be established to allow inter-agency use of data for investigations.[84]

Very importantly, Section 6402 of the Act also requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

Providers and suppliers will be subject to permissive exclusion for providing false information on any application to enroll or participate in a Federal health care program and expands the use of Civil Monetary Penalties (CMPs) to excluded individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to CMPs of up to $50,000.

The Secretary of HHS under the Act has the authority to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary. The Secretary is also authorized to suspend payments to a provider or supplier pending a fraud investigation. As amended by Section 1304 of the *Reconciliation Act*, allows a 90-day period of enhanced oversight and withholding of payment in cases where the HHS Secretary identifies a significant risk of fraud among DME suppliers. Section 6408 of the Act also provides for significantly enhanced penalties for persons who fail to grant HHS OIG timely access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions. Further, enhanced penalties are provided for making false statements to a federal health care program.

Hospitals and other providers also need to be aware of new rules governing the submission of claims for Medicare. Beginning January 2010, the maximum period for submission of Medicare claims would be reduced to not more than 12 months.[85]

Other initiatives designed to detect and prevent fraud and abuse include:

- Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank;[86]
- Requirement that physicians who order items or services be Medicare enrolled physicians or eligible professionals;[87]
- Requirements for physicians to provide documentation on referrals to programs at high risk of waste and abuse;[88]

[82] Section 6508.
[83] Section 6401.
[84] Section 6402.
[85] Section 6404.
[86] Section 6403.
[87] Section 6405.
[88] Section 6406.

- Face-to-face encounters with patients required before physicians may certify eligibility for home health services or durable medical equipment under Medicare;[89]
- Expansion of the Medicare self-referral disclosure protocol to include reporting of violations of the physician self-referral prohibition;[90]
- Expansion of the Recovery Audit Contractor (RAC) program;[91]
- Termination of provider participation under Medicaid if terminated under Medicare or other State plan;[92]
- Medicaid exclusion from participation relating to certain ownership, control, and management affiliations; [93]
- Billing agents, clearinghouses, or other alternate payees required to register under Medicaid;[94]
- Requirement to report expanded set of data elements under MMIS to detect fraud and abuse;[95]
- Prohibition on payments to institutions or entities located outside of the United States;[96] and
- Mandatory State use of national correct coding initiative.[97]

Restrictions on Physician Investment in Healthcare Entities

The Act contains significant expansions of the Stark Law, which seeks to limit physician investment in entities to which they refer. These restrictions could force physicians to sell their interests in these entities to hospital and health systems as they seek to exit these arrangements rather than face heightened penalties. These restrictions will also eliminate competition that hospitals have faced from physicians who invest in ancillary and surgical services.

The Act prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, to participate in Medicare.[98] Such hospitals that have a provider agreement prior to December 31, 2010 could continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, and patient safety issues, and expansion limitations. There is a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

[89] Section 6407.
[90] Section 6409.
[91] Section 6411.
[92] Section 6501.
[93] Section 6502.
[94] Section 6503.
[95] Section 6504.
[96] Section 6505.
[97] Section 6507.
[98] Section 6001. As amended by Section 1106 of the Reconciliation Act, this provision takes effect December 31, 2010.

Physicians that continue to invest in ancillary services will face greater disclosure and reporting requirements that will certainly add to the administrative burden they face, not to mention the exposure to false claims act cases as a result of not following the myriad of new laws. The Act adds an additional requirement to the Medicare in-office ancillary exception that requires the referring physician to inform the patient in writing that the individual may obtain the specified service from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice.[99]

Moreover, the Act requires drug, device, biological and medical supply manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital.[100]

These reporting and disclosure requirements, combined with enhanced penalties for violations, will likely serve to diminish the number of physicians who own or have financial relationships with covered services.

IV. New Patient Care Models Will Drive Integration

The Act will encourage provider integration into order to provide coordinated care that results in better outcomes at lower costs. Consequently, there are several and frequent mentions of new patient-centered care models that rely heavily on primary care provided in a "medical home" setting. This, combined with the push toward bundled payments for episodic care and global payments for hospitalization is likely to encourage physicians and hospitals to integrate in ways not seen since the widespread introduction of managed care in the early 1990's.[101]

The Act establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation,[102] the purpose of which is to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. The

[99] Section 6003.
[100] Section 6002.
[101] The effects of the Act on provider integration are already being felt in at least two states that have restrictions against the corporate practice of medicine. In Texas, the state legislature has begun hearings on repealing state laws that restrict employment of physicians by corporate entities. On May 13, 2010, The Texas Senate Intergovernmental Relations Committee heard testimony on whether hospitals should be allowed to directly employ physicians. Even the Texas Medical Association agreed that more physicians today are receptive to employment. Charles Bailey, General Counsel of the Texas Hospital Association, suggested that the Act reinforced the need for a change in the restrictions against the corporate practice of medicine.

In California, the Hospital Association of Southern California is proposing to create a multi-hospital foundation to supply small and medium-sized hospitals with physicians, in an attempt to deal with health reform and California's restriction against the corporate practice of medicine. *Wall Street Journal*, May 14, 2010.
[102] Section 3021.

Act also embraces the idea of Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time.[103] Under the Act, such ACOs can share in cost savings they produce.[104] ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. The Act provides additional flexibility to the Secretary of HHS to implement innovative payment models for participating Accountable Care Organizations, including models currently used in the private sector.[105]

Under the Act, States are encouraged to enroll Medicaid beneficiaries with chronic conditions into a health home.[106] Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. Moreover, the Act creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.[107]

V. Conclusion

The Patient Protection and Affordable Care Act of 2010, if implemented, will truly represent one of the biggest transformations of federal government in its attempt to overhaul the healthcare system in the United States. It will be years before the full effects of the legislation on our healthcare system are fully known. However, as this discussion of the Act's impacts on hospitals and health systems demonstrates, providers will be faced with greater demands for care, shifting reimbursement models, and incentives to integrate to provide coordinated care. Consolidation is inevitable as providers join forces to cope with the advent of healthcare reform that has – after years of debate and discussion – finally arrived.

[103] Section 3022.

[104] Section 2706 of the Act extends the concept of ACOs to Pediatric ACOs and establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

[105] Section 10307.

[106] Section 2703.

[107] Section 3502. Section 10321 clarifies that nurse practitioners and other primary care providers can participate in community care teams.