

## HEALTH LAW UPDATE

December 9, 2010

### HEALTH REFORM'S UNTOLD STORY -- RESTRUCTURING PRECEDES REGULATION

Since March 23, 2010, the date the new Patient Protection and Affordable Care Act (PPACA) was signed into law, the healthcare industry and its many consultants and advisors were thrust into a new era of healthcare financing, delivery, payment and structure, not to mention creating yet another set of new acronyms for which the industry is well known.

A new concept emanating from the law -- the Accountable Care Organization (ACO) -- has leaped onto the scene with warp speed, resulting in a daily barrage to the industry of e-mails and invites for ACO-focused seminars and how-to meetings. Yet, in Washington D.C. and around the nation, we are confronted with repeated and vehement messages about the reform law's repeal and replacement efforts.

The prognosis, as confirmed by many on Capitol Hill, is that PPACA will not be overturned in its entirety. The law's unbounded scope, with numerous interlacing provisions aimed at altering federal, state and local healthcare systems, is far too complex for total dismantling. Instead, efforts to tweak, defund and overturn targeted provisions by lawmakers will be the order of the day in the year ahead.

Federal and state budget woes are certain to impact funding for government-sponsored healthcare programs as the reform law phases through implementation. In the political arena, the need to assure that deficit spending is being checked or reduced will necessitate that the scored savings of any PPACA provision targeted for change will not be adversely affected. As a result, the reimbursement uncertainties that currently plague the Medicare and Medicaid programs, most notably a sustainable "fix" for the Medicare physician fee schedule, likely will continue.

As for the states, budget deficit headaches and escalating Medicaid costs have prompted serious study and debate over invoking the "nuclear option" -- complete withdrawal from the Medicaid program. Changes to Medicaid programs around the nation appear likely, as states grapple with attempts at budget certainty and calls for maximizing state flexibility over the program's administration and design. To that end, Sens. Ron Wyden (D-Oreg.) and Scott Brown (R-Mass.) recently introduced the "Empowering States to Innovate Act" (S. 3958), legislation that would allow the states to immediately pursue healthcare coverage innovation waivers under PPACA.

While the debate by lawmakers over the future of PPACA has garnered much publicity, what is less well known are the transformative changes that are occurring in the delivery of healthcare, spurred on by the provisions in the reform law that seemingly have taken on a life of their own! One year ago, few in the healthcare industry were aware of the ACO concepts being promoted by the Centers for Medicare and Medicaid Services (CMS) via demonstration project. Yet, within nine short months since the enactment of PPACA, every healthcare system wants to be an ACO, is dubbing itself an ACO or desires to jump on the ACO bandwagon -- all this, without any regulations or guidance from the U.S. Department of Health and Human Services!

Delivery system reform, spurred on by PPACA, is where the healthcare industry is focused and there are no signs that Congress intends to change or defund or remove the PPACA provisions on ACOs. Providers are awaiting regulations on the shared savings

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concepts and demonstration programs, as well as more guidance on creating patient-centered medical homes, bundled payment demonstration programs and extending the gainsharing demonstration program. It is clear to the industry and to this attorney, that the redesign and restructure by the Medicare and Medicaid programs with regard to payment for quality, bundled payment, penalties for hospital readmission and the steady drive to eliminate fee-for-service reimbursement is the untold story of the health reform law.

CMS is expected to release ACO regulations sometime in mid-January 2011. The absence of regulatory guidance has prompted a flurry of activity as providers work to strategically position their institutions, systems and practices for the future. Both the American Medical Association and the American Hospital Association have submitted comments to CMS and issued white papers urging the agency to define ACOs as provider-driven entities.

This hasn't stopped the health plans, however. While ACOs are primarily defined as affiliations or cooperatives between hospitals and physicians, health plans are struggling with where they fit into this equation. Health plans argue that they have the infrastructure to track the health of large populations and to monitor the health of patients enrolled in networks. They argue that they are the only entities qualified and licensed to bear the financial risk that may be required when taking on the care of a large cohort of patients, as anticipated in the ACO.

On the other hand, the ACO has not been defined as an entity in which payment will be made by capitation, with risk. In fact, no one knows at this juncture whether patients may or may not be aware that they belong to an ACO.

Meanwhile, the commercial insurance market has been barreling ahead, "creating" in some markets what they call an "ACO" or enticing providers into their ACO. Providers are either calling themselves ACOs, if they have a sufficiently integrated network, or are seeking to acquire primary care practices and other downstream providers to create an integrated network of providers that can receive a form of accountable payment. Hospitals have taken the lead in creating these new entities, driven largely by healthcare reform, demanding larger and integrated regional networks.

As increasing numbers of physicians opt for affiliating with hospitals as a means to stay competitive, others are contending with the reality that solo and small physician practices may soon be things of the past. For many such practices, the capital funding necessary to achieve electronic medical record connectivity can be accomplished only via affiliation, and trends show that physicians are looking to hospitals for this infrastructure. As for the larger physician groups, many openly agree that fee-for-service medicine is unsustainable and that, even without PPACA, the current changes make sense given the prospects for producing better outcomes and enhancing patient care.

Healthcare lawyers are actively seeking guidance from the regulators, as clients move forward with a frenzy of consolidation options, but the laws and regulations are not keeping pace with the realities of the market. To accommodate this brave new world, a series of existing laws, both state and federal, will need to be redefined, relaxed, eliminated or waived. This is the real story of healthcare reform: that the structural changes occurring in the healthcare industry are outpacing regulation and the law.

Providers should carefully move toward a model that best embraces their internal culture and the realities of their local market. Baker Hostetler remains thoroughly engaged with healthcare providers, CMS and Congress with regard to PPACA. We actively represent providers who seek guidance from CMS and who wish to promote a demonstration project concept with the CMS Centers for Innovation.

If you wish to discuss any of these issues with us, please do not hesitate to call Susan Feigin Harris, [sharris@bakerlaw.com](mailto:sharris@bakerlaw.com) or 713.646.1307 or any member of the [Baker Hostetler Healthcare Industry Team](#). Kathleen P. Rubinstein, MPA, Healthcare Policy Analyst, contributed to this article.

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