

HEALTH LAW UPDATE

April 15, 2010

HEALTH REFORM -- THE DEVILISH DETAILS

As discussed in the [April 1, 2010, issue of the Health Law Update](#), the enactment of the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively, PPACA) is a significant legislative milestone that seeks to reorganize the health insurance market and transform the healthcare delivery system. To that end, the following articles focus on some of the "devilish details" involved in directly linking Medicare payment to quality, providing items and services to Medicare and Medicaid beneficiaries under the new exceptions to CMP Law, assessing key transitional issues and coverage changes for employers and the impact of the tax changes on business.

Directly Linking Payment to Quality

PPACA made sweeping changes designed to improve the quality of care by healthcare providers. Perhaps the most significant change directly links the amount a provider is reimbursed to the quality of the services furnished by the provider as measured by CMS. Never before have providers had so much reimbursement dependant on the determination of how their services are furnished (as compared to whether such services were furnished).

First, Congress expanded its payment "penalty" on hospital-acquired conditions (HACs). In the Deficit Reduction Act of 2005, Congress modified the diagnosis related group (DRG) payment system for hospitals to eliminate payment for certain conditions that were not present at the time of a patient's admission. CMS adopted ten conditions that generally represented preventable hospital accidents or infections and, beginning in fiscal year 2008, stopped paying for them if they were acquired during a patient's stay. PPACA continues this trend and authorizes CMS to adopt additional preventable conditions to the list. In addition, PPACA requires that the HAC program be expanded to Medicaid populations and conditions by July 1, 2011, and requires CMS to study and report on the expansion of the HAC payment elimination program to a wide variety of other providers by January 1, 2012. Moreover, Congress enacted a one percent payment penalty for hospitals that, relative to the national average, are in the top quartile of HACs during the prior applicable time period (e.g., cost reporting year). This one percent payment reduction would be in addition to any other reductions in payment for quality-related issues (described below), and would apply to all discharges (i.e., not just ones involving patients with HACs).

Congress also enacted a program designed to reduce payments to hospitals with higher than expected readmission rates. Such hospitals will face payment reductions for all discharges up to one percent in 2013, increasing to three percent in 2015 and beyond. The reductions would be based on the hospital's performance in 30-day "risk adjusted" readmission rates for three conditions: heart attack, heart failure and pneumonia. Readmission rates higher than "expected" would result in a payment reduction to the hospital based on a formula utilizing the ratio of actual readmissions to expected readmissions. CMS would be authorized to develop new conditions to

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add to the three original conditions identified in the law. The program becomes effective October 1, 2012.

While the HAC and readmission programs provide substantial incentives to focus on quality, nowhere is the direct quality-to-payment link more apparent than the establishment of the value-based purchasing (VBP) programs adopted (or directed to be adopted) under PPACA. The Medicare DRG payment system is dramatically overhauled by the new law to require prospective payment hospitals to *earn back* a growing portion of their total DRG payments for a fiscal period. The VBP program begins by creating a one percent "incentive pool" in 2013 and gradually increases the incentive pool to two percent of DRG payments by 2017. In other words, the VBP program is not funded by additional payments to hospitals, but instead involves a redistribution of DRG payments between hospitals based on quality performance.

The VBP program utilizes the current Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program as its foundation. Using the RHQDAPU quality measures (currently 44, but there will be 70 in 2012) each hospital will be "scored" for a performance period based on its achievement (or improvement from the prior performance period) in each of the quality measure categories. (Examples of quality measure categories include provision of aspirin on admission for AMI patients, providing discharge instructions for heart failure patients, etc.). The hospital's performance for each measure (presumably the percentage such measures were performed for patients during the performance period) would be totaled to derive a VBP score that would then be used to determine how much, if any, VBP incentive pool payments are allocated to the hospital. PPACA requires that the higher quality hospitals (based on the performance scores) receive the higher amounts of the VBP incentive payments. Presumably, the high performing hospitals would actually receive more than the base DRG payment for each discharge in the fiscal year following a successful performance period, while low performing hospitals may not receive a full base DRG payment for discharges during the fiscal year following a poor performance period.

Thus, the VBP program will operate to redistribute base DRG payments among competing hospitals based on their quality performance. The program begins with hospitals in 2013, but a report on a VBP program for physicians is due on May 1, 2010. Further, Congress required CMS to adopt a plan for VBP for skilled nursing facilities, home health agencies, and ambulatory surgery centers by January 1, 2011. In other words, the VBP model is set to expand, and the trend toward directly linking payments to quality is only at its dawn. Healthcare providers face both challenges and opportunities in this new payment system and early efforts to develop models for successfully functioning in the new systems likely will be rewarded.

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New Exceptions to Remuneration Under the CMP Law

A provision within the Civil Money Penalties Law or CMP, commonly referred to as the beneficiary inducement provision, prohibits any person from offering or transferring "remuneration to any individual eligible for benefits [under Medicare or Medicaid] that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made in whole or in part under [Medicare or Medicaid]." Under the CMP, "remuneration" includes "transfers of items or services for free or for other than fair market value." Prior to PPACA, there existed a few, limited exceptions to the types of items and services deemed "remuneration" under the CMP. If a provider desired to provide free items or services that did not meet one of these exceptions, it still could do so as long as the items or services were deemed to have only "nominal value" (i.e., be less than \$10 each and \$50 in the aggregate per year).

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While the "nominal value" test still exists, PPACA establishes the following four new exceptions to the definition of remuneration, giving providers much greater flexibility in providing items and services to beneficiaries:

1. Remuneration which promotes access to care and poses a low risk of harm to patients and federal healthcare programs (as determined by the Secretary of HHS);
2. Items or services that (i) consist of coupons, rebates or other rewards from a retailer; (ii) are offered or transferred on equal terms available to the general public, regardless of health insurance status; and (iii) are not tied to the provision of items or services reimbursed in whole or in part by Medicare or Medicaid;
3. Items or services that (i) are not offered as part of any advertisement or solicitation; (ii) are not tied to the provision of services reimbursed in whole or in part by Medicare or Medicaid; (iii) are reasonably connected to the medical care of the individual; and (iv) are provided after determining in good faith that the individual is in financial need; and
4. Waiver by a PDP sponsor of a prescription drug plan under Medicare Part D, or a Medicare Advantage organization offering an MA-PD plan under Medicare Part C, of any copayment for the first fill of a covered part D drug, as long as it is a generic drug.

While some of these new exceptions may be difficult for providers to rely upon until regulatory interpretation is available, it is clear that PPACA intends to significantly loosen the CMP restraints on providing free items and services to Medicare and Medicaid beneficiaries.

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Employer Advisory

PPACA radically changes the way health, accident and sickness insurance is to be bought, sold and provided in the U.S., principally by reorganizing the commercial health insurance marketplace, generally starting June 21, 2010, and ending December 31, 2013. Then, effective January 1, 2014, PPACA will require most employers to provide employment-based health insurance coverage -- or pay a potentially substantial penalty. For all but the largest employers, providing health insurance coverage will involve purchasing group coverage from a newly-reorganized health insurance marketplace. In the interim, employers must cope with a number of transitional issues and coverage changes without losing sight of the bigger changes headed everyone's way in 2014. Baker Hostetler's Employee Benefits Team prepared an [Employer Advisory](#) that provides a series of assessments and identifies key issues employers should address to avoid being caught out of position. Its focus is on what employers need to do before 2014 arrives.

For more information, please contact John J. McGowan Jr., jmcgowan@bakerlaw.com or 216.861.7475, or Jennifer A. Mills, jmills@bakerlaw.com or 216.861.7874, if you have questions about this Advisory, or your regular Baker Hostetler contact if you have questions about the recently-enacted healthcare reform legislation.

Overview of Main Tax-Related Provisions

In order to partially fund the numerous changes to the healthcare system (projected to cost approximately \$940 billion), PPACA establishes a variety of new taxes and fees expected to generate about \$428 billion of revenue.

Baker Hostetler's Tax Group prepared an [Executive Alert](#) summarizing these principal new taxes and fees. Although some of the provisions became effective at passage, most have delayed effective dates. As a result, there may be opportunities for you to minimize the negative tax effects associated with PPACA with some advance planning. There also will undoubtedly be continuing legislative efforts to make technical corrections to PPACA, as well as the need for detailed implementing regulations.

If you have questions on how any of these tax changes may affect you or your business, or would like to discuss whether advance tax-planning opportunities may be available for you, please contact Paul M. Schmidt, pschmidt@bakerlaw.com or 202.861.1760, Jeffrey H. Paravano, jparavano@bakerlaw.com or 202.861.1770, Christopher J. Swift, cswift@bakerlaw.com or 216.861.7461, Edward G. Ptaszek, eptaszek@bakerlaw.com or 216.861.7497, Christina Novotny, cnovotny@bakerlaw.com or 216.861.7295, or your regular Baker Hostetler contact.

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