Here Comes the Patient Protections and Affordable Care Act: What Does It Mean for Hospitals?

Corridors Spring 2010

04.27.2010

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President Obama's signing of the Patient Protection and Affordable Care Act of 2010 (the Act) into law this past month was welcomed as a historic change to our nation's health care system. The 2,400-page reform bill (H.R. 3590) cleared Congress on March 21, 2010, after a heated and mostly partisan vote. Naturally, hospitals and other health care providers benefit (financially) from the Act's insurance market and coverage reform to the extent these measures increase the number of patients with insurance coverage (an estimated 32 million newly insured individuals) and reduce self-pay and charity care cases. In the event that you haven't had time to digest the voluminous text of the Act, we have identified 10 aspects of the new Act of likely interest to hospitals.

Tracking Hospital Readmission Rates

First, acute care hospitals will be able to participate in a program under Medicare to incentivize improved quality outcomes by tracking hospital readmission rates and offering financial incentives to reduce preventable readmissions. This program authorized by Section 3025 of the Act will track excess readmissions and provide public reports of hospital readmission rates. The Centers for Medicare & Medicaid Services (CMS) will oversee this program, which is anticipated to be established in 2012.

Medicare Pilot Program for Bundling of Hospital and Physician Services

Second, Section 3023 of the Act authorizes another new Medicare nationwide pilot program aimed at the integration of medical care that will affect hospitals starting in 2013. This program will bundle payments to physicians, hospitals and others involved in a patient's treatment during an episode of care involving hospitalization to encourage the coordination, efficiency and quality of specified services among providers. The services subject to the new pilot program identified in the Act include:

- Acute care inpatient services;
- Outpatient hospital services (includes emergency department services);
- Post-acute care services (includes home health, skilled nursing, inpatient rehabilitation, and inpatient hospital services by a long term care hospital);
- Physician services in and outside the acute care setting; and
- Any other service identified by regulation.

The Act details that the pilot program would be limited (at least initially) to beneficiaries having one of eight "applicable conditions" to be identified by the Department of Health and Human Services (HHS) as such conditions that involve six common characteristics including being amenable to a bundled payment and involving an opportunity for providers and suppliers of services to improve the quality of care while reducing expenses.

False Claims Act and Stark Developments

Third, the Act includes a number of initiatives to bolster the government's efforts to fight health care fraud and abuse in Medicare, Medicaid, the children's health insurance program (CHIP), and private insurance. Section 1313 details the applicability of the federal False Claims Act (and its remedies) to claims filed related to the soon-to-be created American Health Benefit Exchanges (by states) to provide consumer choices and health insurance competition. Next, Section 6409 of the Act requires CMS to develop a Stark Self-Referral Disclosure Protocol (SRDP) for actual and potential self-referral violations. The requirement of developing the SRDP comes almost exactly one year after the Office of Inspector General (OIG) stated that self-disclosures of only Stark violations would no longer be accepted under the existing Self-Disclosure Protocol. The Act does not involve any other federal agency (not the OIG or the U.S. Department of Justice) in the development or implementation of the SRDP, although collaboration between agencies seems likely to ensure consistency and full resolution of disputes. Starting this year, Section 6003 of the Act requires referring physicians to provide patients with written lists of suppliers for imaging services or other specified designated health services in the patient's area of residence when the physician is relying on the in-office ancillary services exception to Stark. Finally, Section 6001 of the Act further limits the Stark exception on physician ownership of hospitals to whole hospitals and otherwise places significant restrictions on physician-owned hospitals.

Grants for Training Primary Care Clinicians

Fourth, the several provisions of the Act focus on an enhanced role for primary care and the health care workforce, including a section authorizing multiple federal grants (potentially to eligible hospitals) for enhanced education and training programs for primary care clinicians. These grants may be awarded to hospitals, medical or osteopathic medical schools, other physician training programs, or nonprofit entities that successfully apply for them. The grants for these training and education programs will last up to five years. The training programs must focus on family medicine, general internal medicine or general pediatrics. One of the goals of Section 5301 of the Act is to increase the number of primary care clinicians and encourage this increase through grants and funded programs to hospitals, schools of medicine and others able to make this goal a reality.

Physician Incentive Payments

Fifth, other physician payment-related provisions include a new program aimed at incentivizing physicians based on quality of care versus volume of services and a 10% incentive payment for primary care services to primary care physicians (and allied health professionals) under Section 5501 starting in 2011. General surgeons practicing in health professional shortage areas (HPSAs) are also eligible for a 10% incentive payment on "major surgical procedures" starting in 2011. These incentive payments to primary care clinicians and general surgeons are to end in

2016 unless the funding for the incentives is increased by future legislation.

Preventive Services Provided by FQHCs

Sixth, the Act expands Medicare payments to preventive services provided in federally qualified health centers (FQHCs) by 2011 and calls for the development of a prospective payment system for services furnished by FQHCs. New health plans will be required to cover preventive services with little or no cost to patients. Improved preventive care is associated with fewer acute episodes for medical conditions and therefore reduced expenditures for health care.

List of Hospital's Standard Charges

Seventh, the Act requires each hospital to establish and make public a list of its standard charges for items and services, including by diagnosis-related groups (DRGs). This measure is contained in Section 2718 of the Act and relates to reducing the cost of health care. Not only does this section require clear accounting for costs and the public list of hospital charges, it also strives to "ensure consumers receive value" for their health insurance premiums by mandating a rebate to consumers under specified conditions.

Excise Tax on High-Cost Employer-Funded Health Plans

Eighth, a hospital as an employer will be subject to an excise tax on high-cost employer-provided plans costing over $27,500 for family coverage and $10,200 for individual coverage. Higher thresholds for the imposition of this tax are effective for rescue squad and ambulance crews as high-risk professionals. The Act makes other changes to the required covered services, newly impermissible exclusions and limits, the cost, and other aspects of insurance coverage offered by employers. In addition, the Act imposes a 2.9% excise tax on the sale of medical devices by manufacturers and importers, but generally speaking, this tax should not be applicable to hospitals (or affiliates) reselling medical devices not manufactured or imported by hospitals.

"Independent" Board to Set New Medicare Payment Formulas

Ninth, Section 3403 of the Act authorizes the creation of the Independent Medicare Advisory Board (the Board), which will determine new Medicare payment formulas. The Board is prohibited under the Act from proposing to raise beneficiary premium, ration care and raise revenues. The Board also cannot propose to reduce payment rates for items and services provided prior to December 31, 2019. This Section involves the Chief Actuary of CMS and is intended to reduce Medicare expenditures over time.

Demonstration Project for Development of Alternative Tort Litigation Systems

Finally, Section 10607 of the Act creates a demonstration project under which states are eligible for grants to develop, implement and evaluate alternatives to the current tort litigation system to resolve disputes over injuries allegedly caused by health care providers or organizations. The alternatives under these grants must resolve the disputes as well as promote a reduction in health care errors through the encouragement of reporting patient safety data related to these disputes to patient safety organizations or other entities that "engage in efforts to improve

patient safety and the quality of health care." The government has sought to increase the reporting of patient safety data, especially as it relates to pending malpractice claims, for the purpose of improving care and reducing preventable errors through various initiatives for the past five years. States awarded such grants will be required to report their findings and analysis to the Secretary of HHS.

Conclusion

The Act offers multiple opportunities for hospitals to improve patient care, finances and health care workforce. While the lengthy Act provides details for many opportunities, we can expect further refinements, amendments and explanations in future legislation and regulations. Since much of the Act's implementation will not occur until 2011 to 2014, we also anticipate that some provisions of the Act will substantially change or even be eliminated. Much time and effort will likely be spent in the next decade striving to decipher and then implement the many reform measures of the Act. In the interim, hospitals are encouraged to consult with an attorney or consultant familiar with the Act concerning the Act's applicability to you.

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