

Health Care Reform 101: For Hospitals

Law360, New York (June 18, 2010) -- Although much of the Patient Protection and Affordable Care Act will not come into effect for several years, and regulations further defining its provisions have yet to be drafted, it is clear that hospitals must begin to think strategically now about how to best position themselves to provide care under this new regulatory structure.

To make the scope of PPACA manageable, we have identified five things that hospitals should do now to prepare for the coming reality of health care reform.

1) Reinforce the Culture of Compliance

Commitment to compliance has always mattered to hospitals. Reform will cause them to recommit to their culture of compliance. And here is why: PPACA provides an additional \$250 million in the first five years for fraud and abuse enforcement and has clarified some of the requirements of the Anti-Kickback Statute, making it easier for the government to convict and the consequences more severe for providers.

For example, under PPACA, the Anti-Kickback statute does not require actual knowledge of the violation or specific intent to violate the statute. PPACA explicitly allows for violations of the Anti-Kickback Statute to be a basis for a False Claims Act suit. PPACA also contains changes to the Stark Law, including the development of a self-disclosure protocol for certain violations of Stark.

These changes make it even more important for hospital systems to have well-developed fraud and abuse compliance programs to encourage individuals to come forward with concerns in order to limit liability and determine if and when self-disclosure is necessary. In addition, in order to meet PPACA's goals of budget neutrality, PPACA assumes that over 10 years, \$500 billion will be recovered through elimination of waste, fraud and abuse in the Medicare program.

PPACA also expands the Recovery Audit Contractor ("RAC") program to Medicaid and shortens the overpayment return period to 60 days after the discovery of an overpayment. The result of these changes is that hospitals can expect more audits and will need to be able to review and return overpayments quickly or face False Claims Act liability.

Ultimately hospitals will need to ensure their procedures encourage compliance with Medicare regulations to avoid overpayments and to make the RAC audit process go smoothly. With the significant financial investment in fraud and abuse enforcement, the expectation that such enforcement will result in substantial savings, and an expectation of disclosure and expedited return of overpayments, hospitals will be under significant pressure to maintain an effective and efficient compliance program.

Compliance officers and in-house counsel of hospitals should (1) update their compliance programs to reflect PPACA's changes and priorities; (2) increase compliance training to re-emphasize the importance of compliance across their systems in this environment of heightened scrutiny; (3) ensure there is a clear process for individuals to come forward with compliance concerns in order to limit liability and determine if and when self-disclosure is necessary; and (4) value and reward those who are committed to the culture of compliance.

2) Prepare the Care Platform

PPACA will provide health insurance coverage to almost 34 million people that are currently uninsured. Hospitals will need to consider how this change will affect the utilization of their services, and review their care platforms in light of those changes, considering both where newly insured patients will be treated and where they were treated when uninsured, to properly allocate resources.

For example, hospitals should consider whether there will be increased demand for primary care services from these patients, but should also consider whether there will be changing demand for or use of emergency room or urgent care services. This changing demand will challenge hospitals to use their resources efficiently and consistently to provide high quality care.

PPACA has a number of programs that will incentivize hospitals to deliver cost-effective, quality care. Effective for hospital discharges after Oct. 1, 2012, under the hospital value-based purchasing program, Medicare will link payments for certain high-cost procedures to meeting certain quality measures.

Starting in 2013, under the pilot Bundled Payment Program, Medicare will reimburse hospitals for a group of services that are normally provided to a patient with a specific diagnosis, rather than reimburse for each service provided. Each hospital will assume the risk that it will go un-reimbursed for patient services exceeding the bundled payment; however, the hospital will keep any excess payment for patients that are treated without using all of the services covered in the bundled payment.

In 2012, the Accountable Care Organization ("ACO") pilot program will provide additional shared-savings payments to qualifying ACOs. An ACO is an official arrangement between a wide variety of providers that will provide integrated care to Medicare beneficiaries, with the goal of reducing costs through better coordination of care.

Under PPACA, among other things, an ACO must have: (1) a sufficient number of primary care providers to care for the patients for whom the ACO is accountable; (2) leadership, management and access to specialists and processes (such as the use of telemedicine technologies and use of Web sites to promote best practices within the ACO) necessary to promote evidence-based medicine and to coordinate care; and (3) a legal structure able to distribute financial incentives related to meeting quality performance measures.

The manner in which Medicare will reimburse ACO providers will help drive coordinated care. The act combines existing fee-for-service payments with shared savings incentive payments for achieving certain quality performance measures and for reducing Medicare expenditures within the ACO by a certain percentage below a predetermined benchmark.

The secretary of HHS also has the flexibility of paying ACOs other than through the traditional fee-for-service and shared savings bonus. The act specifies that one of the alternative payment models could be a partial capitation model in which the ACO would be at financial risk for some, but not all, of the Part A and B services provided. However, only "highly integrated" ACOs or ACOs otherwise capable of bearing risk, such as integrated hospital systems, would be eligible to participate in a capitation or other risk-based reimbursement model.

To prepare for the move toward a reimbursement system demanding coordinated care and consistent delivery of quality care, hospitals will have to determine whether their existing care platform of providers is sufficient to effectively coordinate the delivery of care across the service spectrum. If a hospital has to improve its care platform, a hospital will have to consider not only the means of expanding its platform, e.g., acquisition, employment, or joint ventures with other providers to create an ACO, but how to integrate new providers into its system of delivering care.

3) Prepare the Infrastructure Platform

Both the compliance and integrated care programs of PPACA discussed above require system-wide programs that help hospitals coordinate patient care, track quality reporting, develop documentation, and identify compliance concerns. An electronic health record (“EHR”) system will be a critical component of such system-wide programs.

The American Recovery and Reinvestment Act (“ARRA”) provided additional Medicare and Medicaid funding for hospital systems that are “meaningful users” of “certified EHR technology.” However, reimbursement is only available between the years of 2011 and 2016, and hospitals that wish to maximize reimbursement must have implemented the EHR by 2013.

Further, hospitals that are not “meaningful users” by 2015 will face reduced Medicare reimbursement. Consequently, hospitals should assess their current EHR systems now to determine whether they will be entitled to the ARRA payments. Implementing “certified EHR technology” is not sufficient to obtain the ARRA payment; the hospital must also be a “meaningful user” of the technology.

Although the definition of “meaningful use” is still being developed, hospitals can begin to assess whether or not their EHR is being used by practitioners, what barriers may prevent practitioners from being meaningful users, and how the EHR can be better integrated into practice.

Additionally, hospitals should consider how the EHR system can be expanded and integrated into other hospital information systems. For example, hospitals should consider how the EHR supports the billing system, whether it could be developed to help automate the RAC Audit process, and how best practices can be implemented via EHR system to coordinate care.

4) Reassess the Ability to Meet Community Needs and Comply with Charitable Status Requirements

PPACA creates a new Internal Revenue Code Section 501(r) clarifying certain responsibilities for tax-exempt hospitals. Although tax-exempt hospitals have long been required to complete a community needs assessment, PPACA requires this process more frequently and adds the requirement to implement a strategy to meet the identified need.

Under the new Code section, within three years, and once every three years thereafter, tax-exempt hospitals will need to assess community health needs and develop and implement plans to meet those needs. The community-needs assessment must take into account input from persons who represent the broad interests of the community served, especially those of public health, and must be made available to the public.

Failure to conduct the community-needs assessment or to adopt plans to meet those needs can result in a \$50,000 excise tax or the revocation of the hospital’s tax-exempt status. Although tax-exempt hospitals will have conducted a community-needs assessment in the past, they will need to review their procedures to be prepared to collect data and make regular assessments and implementation plans. As the process progresses, hospitals will need to track the outcomes of the implementation plans to make sure that the plans do in fact address the community needs.

In addition, hospitals must have a written financial assistance policy to ensure that the hospital provides non-discriminatory emergency medical care regardless of whether a person is eligible for financial assistance, and prohibits hospitals from taking “extraordinary collection actions” until the hospital makes “reasonable efforts” to determine whether a patient is eligible for assistance under the policy. As with the community-needs provisions, most hospitals will have a financial assistance policy and a policy on collections. Now is the time to re-examine those policies and how employees are implementing them.

5) Revisit Financial Planning

Most of PPACA’s changes, including expansion of Medicaid, increased regulatory scrutiny, reduction in annual market basket adjustments resulting in lower reimbursement and changing payment structures will create additional financial challenges for hospitals. On top of the regulatory and reimbursement challenges, hospitals may need (and may struggle to find) access to credit to fund capital expenditures to adjust to the needs of reform amid changes to, and possible decline in, operational revenue.

Hospitals should review their finances to determine whether they have the capital to support these changes in the immediate future and to understand how changing revenue streams will impact long-term financial viability. The review should focus on how these changes will impact the hospital financially, and how it can leverage existing resources (or those that it can acquire) to take advantage of new opportunities that PPACA creates.

Conclusion

Overall PPACA focuses on making hospitals accountable for providing efficient integrated care. It provides payment incentives to hospitals that can meet these challenges and facilitates more stringent enforcement against waste, fraud and abuse. Even though much of PPACA is still undefined, hospitals can act now by thinking strategically about how to manage the benefits and challenges of reform.

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