HINSHAW

Alerts

Patient Protection and Affordable Care Act Introduces Numerous Programs Focused on Quality and Delivery of Health Care

May 20, 2010
Health Care Alert

This is the 11th in a series of health care alerts that Hinshaw & Culbertson LLP will publish on the topic of health care reform.

The recently enacted Patient Protection and Affordable Care Act (PPACA) includes several elements designed to improve the quality and delivery of health care and support by linking payment to better quality outcomes. Following are summaries of a number of the programs to be established under the new legislation.

In 2013, the United States Secretary of Health and Human Services (Secretary) will establish a hospital value-based purchasing program, under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards. At least five such conditions or procedures are contemplated under the Act, and they include: acute myocardial infarction (AMI), heart failure, pneumonia, surgeries, and health care associated infections. In the case of a hospital that is found to have met or exceeded the performance standards for the performance period for a fiscal year, the Secretary is to increase the base operating diagnosis related group (DRG) payment amount for the hospital for each discharge occurring in each such fiscal year by the value-based incentive payment amount.

Not later than March 23, 2012 (two years after enactment), the Secretary is to establish a demonstration program providing for a value-based purchasing program under Medicare for inpatient critical access hospitals. The demonstration program is to be conducted for a three-year period.

The Secretary is also to establish a national strategy for quality improvement in health care. In so doing the Secretary is to identify national priorities for improvement and what will have the greatest potential for improving health care outcomes and efficiency for all populations. The Secretary is to collaborate, coordinate and consult with state agencies responsible for administering Medicare and the Children's Health Insurance Program with respect to developing and disseminating strategies, goals, models and time tables that are consistent with national priorities identified.

Among the pilot programs to be developed will be the creation within the Center

Attorneys

Roy M. Bossen

for Medicare and Medicaid Services of a Center for Medicare and Medicaid Innovation (CMI). The purpose of CMI is to test innovative payment and service delivery models, to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. The Secretary will give preference to models that also improve the coordination, quality and efficiency of health care services furnished to applicable individuals. The Secretary is to ensure that the CMI is carrying out the duties described above not later than January 1, 2011.

The Secretary is also to establish a shared saving program that promotes accountability for patient populations and coordinates items and services under Medicare Parts A and B. This program is designed to encourage investment in infrastructure and redesign care processes for high quality and efficient service delivery. Under such a program, groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (ACO). ACOs that meet quality performance standards established by the Secretary will be eligible to receive payments for shared savings. Groups of providers of services and suppliers will have to establish a mechanism for shared governance to be eligible to participate as an ACO. ACOs may include the following:

- Group practice arrangements involving physicians and physician extenders;
- Networks of individual and group practices;
- Partnerships or joint venture arrangements between hospitals;
- Integrated delivery systems or integrated organizations of hospitals and their employed physicians and ancillary providers; and
- Such other groups or providers of services and suppliers as the Secretary determines appropriate.

An ACO must be willing to become accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it. Additionally, the ACO must enter into an agreement with the Secretary to participate in the program for not less than a three-year period. The ACO will have a formal legal structure that is to allow the organization to receive and distribute payments for shared savings to participating providers. The ACO is to include primary care providers and other professionals that are sufficient in number to provide service to beneficiaries assigned to the ACO. At a minimum, the ACO is to have at least 5,000 such beneficiaries assigned to it, to be eligible to participate in the ACO program. The ACO is to have in place a leadership and management structure that includes clinical administrative systems. It must also define processes to: (1) promote evidence-based medicine and patient engagement; (2) report on quality and cost measures; and (3) coordinate care, such as through the use of telehealth, remote patient monitoring, and such other enabling technologies.

The Secretary is to establish benchmarks for each agreement period for each ACO, utilizing the three most recent available years of pre-beneficiary expenditures for Medicare Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. An ACO that meets the appropriate requirements (a percent that is still to be determined by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year under the ACO, and such benchmark for the ACO, may be paid to the ACO as shared savings.

Another program is the Independence of Home Medical Practice Demonstration Program. It is designed to test a payment incentive and service delivery model that utilizes physician-and nurse practitioner-directed home-based primary care designed to reduce expenditures and improve health outcomes. It will be designed to test whether the model will result in reducing preventable hospitalizations, preventing hospital readmission, reducing emergency room visits, improving health outcomes commensurate with the beneficiary's stage of chronic illness, improving the efficiency of care, reducing the cost of health care services covered, and achieving beneficiary and family caregiver satisfaction.

For further information, please contact Roy M. Bossen or your regular Hinshaw attorney.

This alert has been prepared by Hinshaw & Culbertson LLP to provide information on recent legal developments of interest to our readers. It is not intended to provide legal advice for a specific situation or to create an attorney-client relationship.