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Reimbursement changes under health care reform: Are you prepared?

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Health care reform will bring about significant change to how providers are paid, and payment changes will necessitate changes in how care is delivered. A primary objective of health reform is to integrate a fragmented health care delivery system to reduce costs and improve both the quality of care and the overall health of populations.

Hospitals are very familiar with Medicare's traditional payment methodology for hospital services (i.e., a diagnosis related group [DRG] payment for inpatient care, and an ambulatory payment classification [APC] payment, for outpatient care) and with Medicare's volume-based or fee-for-service payment methodology for physician services. Under the current payment structure, doctors determine the care that is to be provided in hospitals, yet bear no financial consequence for the cost of that care. Compounding this divide is the fact that hospitals and physicians are motivated by different—and often adverse—financial incentives, and neither the hospital nor the physician payment model rewards consistent high quality and low-cost care. A goal of health care reform is to align these misaligned incentives between hospitals and physicians through new payment models, thereby improving quality, reducing costs, and improving patient outcomes.

This article will provide hospitals with an overview of the variety of new payment and delivery models included in the Patient Protection and Affordable Care Act of 2010 (PPACA) and other recent laws and regulations to better prepare hospitals for fundamental changes in the way they are paid. It will also discuss the importance of establishing different relationships between hospitals and physicians, and the common structures to achieve those relationships, which are necessary if hospitals are to perform well under the payment models of the future.

Value Based Purchasing

With the passage of PPACA, Congress implemented the Value Based Purchasing (VBP) program first developed by the Centers for Medicare and Medicaid Services (CMS) in 2007. VBP is a payment model that directly ties reimbursement to performance. Section 3001 of PPACA enacts VBP for hospitals for discharges occurring on or after October 1, 2012 (FY 2013). Hospitals subject to VBP under PPACA are generally "subsection (d) hospitals" which includes most acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), but does not include psychiatric

hospitals, rehabilitation hospitals, childrens hospitals, or long-term care hospitals. However, PPACA excludes VBP for hospitals that:

- do not participate in Hospital IQR program;
- have been cited for deficiencies that pose immediate jeopardy to the health and safety of patients during the performance period;
- do not have a minimum number of applicable measures for the performance period; or
- do not have a minimum of cases for the applicable measures for the performance period.

VBP evolved from the existing Medicare Hospital Inpatient Quality Reporting program (Hospital IQR program), formerly known as the Reporting Hospital Quality Data for the Annual Payment Update program (RHQDAPU). Under VBP, a hospital's reimbursement from CMS will directly depend on its performance under certain quality targets and not simply for reporting them. Beginning October 1, 2012, the hospitals' risk based on performance will be limited to 1% of their DRG Medicare payments, with the risk increasing each year to a maximum of 2% by 2017. The total amount of payments available to hospitals under VBP must be equal to the total amount of reduced payments for all hospitals in that fiscal year (i.e., the VBP payments are budget neutral). This means that high performing hospitals stand to earn more reimbursement under VBP, and low performing hospitals likely will lose. The VBP payment will be earned based on the hospital's reported performance on metrics related to five specific conditions: acute myocardial infarction, heart failure, pneumonia, surgeries, and health care-associated infection. The measures CMS initially proposed to adopt for the program are a subset of the measures that have already adopted for the Hospital IQR program. In FY 2014 and after, the metrics must also include efficiency measures, including Medicare spending per beneficiary.

On May 6, 2011, CMS released its final rules[1] for implementing VBP for hospitals pursuant to PPACA (the VBP proposed rule). Under the final rules, CMS will use 13 measures that it already uses for the Hospital IQR program for reporting quality data already in place (12 of the proposed measures are clinical process measures and one measure is a patient experience measure with eight components). CMS has noted that all 45 measures specified under the Hospital IQR program (with the exception of readmission measures) are "candidate measures" for use in VBP going forward.

For the clinical process measures, CMS will use a performance period of July 1, 2011 through March 31, 2012 for the FY 2013 payment determination. A hospital's performance during the performance period will be measured against its performance in a baseline period of July 1, 2009 to March 31, 2010. CMS also will add three outcome measures for FY 2014 that use an 12-month performance period from July 1, 2011 to June 30, 2012 and that would be compared to a baseline of July 1, 2008 to June 30, 2009. Therefore, a hospital's baseline for the first year of the VBP program has already been established, and performance that will impact payments under VBP began on July 1, 2011.

Under the final rules, a hospital's performance will be measured based on the higher of the hospital's achievement score and its improvement score for each applicable measure. A total score would be calculated for each hospital by combining the greater of the hospital's achievement or improvement "points" for each measure, then weighing the measure (for FY 2013, 70% clinical process measures, 30% patient experience measures) and adding together the weighted scores (see table 1 on page 32). VBP measures must be announced no later than 60 days prior to the beginning of a performance period.

CMS has proposed to adopt a "linear exchange function" for the purpose of translating the total

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Table 1: Example of hospital VBP score calculation provided by CMS in the VBP Proposed Rule.

Domain	Condition	Achievement points	Improve-ment Points	Earned points (higher of achieve-ment or improvement)	Domain Score
Clinical Process of Care	HF-1	8	9	9	67.5
	HF-2	0	5	5	
	PN-2	0	3	3	
	PN-7	10	10	10	
Patient Experience of Care	HCAHPS Base Score	60	40	60*	69
	HCAHPS Consistency Score				
Total Performance Score					0.6795

** The Patient Experience of Care or HCAHPS earned points are calculated by summing the higher of achievement or improvement points across all eight HCAHPS measures.*

performance score to the VBP incentive payment earned by the hospital. This means a hospital with a total performance score of zero will not receive any incentive payment, while a hospital with a higher total performance score will receive an amount corresponding to its performance taken from the aggregate amount of the base operating DRG payment amounts withheld from all hospitals (1% in FY 2013).

Although VBP is expected to move the dial toward improving quality, some limitations of the VBP payment model are that it continues to keep separate the incentives for hospitals and physicians, and it does not directly address total cost or quality of care. Nonetheless, a hospital's success under VBP is directly tied to the performance of its physicians, because the quality targets that form the basis of the hospital VBP are largely driven by physician rather than hospital performance. Therefore, if they have not done so already, hospitals need to engage physicians to comply with quality initiatives, especially the VBP-related metrics that could effect payment.

Accountable Care Organizations

It is hard to avoid hearing about Accountable Care Organizations (ACOs) in the health care industry press these days. The goal of ACOs is to improve both the quality of care and the patient experience while decreasing cost for a defined population of patients. ACOs may be comprised of physicians, hospitals, and other providers and suppliers who are structured to work together to achieve these goals. The ACO concept originated from the Physician Group Practice Demonstration Project (PGP) established by CMS in 2005. The PGP was a pay-for-performance demonstration project for physicians mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. The goal of the demonstration

was to reduce the separation between payment for Medicare Part A and Part B services to improve both the cost efficiency and health outcomes of patients. In the demonstration, physician groups continued to receive fee-for-service payments, but were eligible for bonuses when they demonstrated cost savings and met quality performance targets. CMS distributed bonuses to some of the participating physician groups, which has contributed to provider interest in ACOs.[2] (CMS recently released its proposed rules on ACOs; however, an analysis of the proposed rules is beyond the scope of this article and will be provided in a future issue of **Compliance Today**.)

ACO structures may be flexible and may include integrated delivery systems, physician hospital organizations (PHOs), independent practice associations (IPAs), partnerships of PHOs or IPAs, hospitals, large group practices, joint ventures owned by physicians, hospitals and others, or any variation as long as a legal structure is in place to allow the participants to share a single payment.

PPACA imposes eight requirements that an ACO must meet before it can receive a shared savings payment from CMS. These requirements include:

- a commitment to provide patient centered care;
- participation as an ACO for at least 3 years;
- a formal legal structure to allow the ACO to receive and distribute shared savings to participants;
- primary care and other health care professionals are included for at least 5,000 Medicare beneficiaries;
- an appropriate leadership and management structure is in place; and
- appropriate clinical and administrative systems are implemented, including technology that can define and implement processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care through care management.

Becoming an ACO has potential financial benefits to its participants. The shared savings payment model sustains current reimbursement for each participant (DRG or APC payments for hospitals; fee-for-service payments for physicians), but also allows the ACO participants to share an incentive bonus if they are successful in reducing the total cost of the care for a defined population below a target established by CMS based on previous expenditures, while improving quality and the patient experience. Importantly, however, ACOs will require not only new legal relationships between hospitals and physicians to achieve cost effective, high-quality, and high-satisfaction care, but also a new mindset from hospitals looking to maximize their potential shared savings.

Patient-centered medical homes

A principal objective of health care reform is to encourage patient-centered care. Indeed, patient-centered care is a statutory requirement for ACOs. Patient-centered care is best facilitated through a Patient Centered Medical Home (PCMH). PPACA includes pilot projects designed to explore the effectiveness of PCMHs to reduce cost and improve quality of care. The inclusion of PCMHs into ACOs is widely recognized as essential to ACO viability.

PCMHs are team-based models of care led by primary care physicians who maximize health outcomes by providing continuous and coordinated care throughout a patient's lifetime. In a PCMH, each patient's personal physician is responsible for meeting or overseeing all of a patient's health care needs. The primary care physician in a PCMH works with a network of health professionals (e.g., nurses, therapists, hospitals, and other physicians) to provide a full range of health care to meet the specific needs of each patient. The primary care physician in a PCMH is uniquely positioned to avoid unnecessary or duplicate care for a patient, and to assist the patient in navigating the health care system. PCMHs provide patients with greater resources through collaboration among the primary care physicians and other

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health professionals; better access to primary care though improved scheduling and enhanced methods of patient communication; care coordination; and enhanced health information technology systems for tracking tests, results, screens, and preventative care.

As early as the 1960s, PCMHs first emerged to provide pediatric care to children with special needs. Eventually, PCMHs expanded from the pediatric setting to family care. PCMHs were first tested by seven national family medicine organizations in 2002 under The Future of Family Medicine: A Collaborative Project of the Family Medicine Community. Pursuant to the Tax Relief and Health Care Act of 2006, Congress mandated a demonstration to test the PCMH model for Medicare, and CMS recently completed its open solicitation period for participants.

PCMHs will very likely be a key component of ACOs because of the role that primary care will play in a patient's inclusion in a particular ACO. Given this important incorporation of primary care, any physician-hospital alignment strategy that is part of an ACO should place special emphasis on primary care in order to fully take advantage of the new payment models.

Bundled payments

Bundled payment under PPACA is a pilot program defined as "comprehensive [payment], covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary)." Bundled payments are currently the subject of the Acute Care Episode (ACE) demonstration conducted by CMS at five organizations. ACE started in 2009 and is examining the bundled payment methodology's ability to improve the quality of care while reducing costs for discreet episodes of care.

Under a bundled payment system, hospitals and physicians receive a single payment for an "episode" of care, rather than for each isolated treatment. PPACA requires CMS to establish a "national pilot program on payment bundling" by January 1, 2013. Like many of the payment models designed to align hospital and physician financial interests, bundled payments will require hospitals to examine their current structure in order to best navigate yet another new method of reimbursement, specifically one where hospitals and physicians will be required to share a single payment.

Pay-for-reporting and other notable incentive programs

Besides programs though which a hospital might see their traditional reimbursement structure affected, CMS continues to implement several programs, begun prior to health care reform but continuing thereafter, where hospitals will be required to report on various quality metrics or implement certain health information technology, such as electronic health records (EHRs), in order to receive incentive payments or avoid payment penalties.

CMS continues to operate the Hospital IQR program which penalizes hospitals that fail to report on quality data applicable to required quality targets. The program has been in place for several years. Under the Deficit Reduction Act of 2005, the penalty that applies for a failure to report is a 2% downward adjustment to the hospital's the annual market basket update. Additionally, CMS enacted the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) in 2009, which is modeled after Hospital IQR and also imposes a 2% reduction to a hospital's annual market basket update for outpatient services for failing to report certain outpatient-specific metrics. As of 2011, hospitals are required to report on 45 inpatient and 11 outpatient quality metrics as part of Hospital IQR and HOP QDRP, respectively, or face the annual market basket reduction.

CMS also has implemented an analogous pay-for-reporting program for physicians, referred to as the

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Physician Quality Reporting Initiative (PQRI). The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. The PQRI was further modified as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). In 2011, the program name was changed to Physician Quality Reporting System, although it is still commonly referred to as PQRI.[3]

Under the Physician Quality Reporting System, physicians are eligible to receive a bonus if they report on certain quality metrics applicable to their practice. The program has been expanded so that currently there are 190 individual measures for physician reporting. For physicians, the PQRI uses a financial "carrot" rather than the "stick" approach used under the Hospital IQR or HOP QDRP program for hospitals. Initially, just for participating in PQRI and making the report, physicians received a bonus equal to 2% of their Medicare Physician Fee Schedule payments received during the applicable reporting period. Beginning in 2011, a physician's bonus opportunity is reduced to 0.5% and can be achieved by submitting data on PQRI quality measures for an entire 12-month reporting period, either as an individual physician or as a member of a selected group practice, and by participating in the PQRI's Maintenance of Certification program by completing a practice assessment program.

Electronic Prescribing Incentive program

Similarly, Medicare recently established an incentive program focused on electronic prescribing by physicians. Section 132 of MIPPA authorized a new and separate incentive program called the Electronic Prescribing (eRx) Incentive program for eligible professionals who are successful electronic prescribers. The eRx Incentive program began on January 1, 2009 and is separate from and in addition to the PQRI. Eligible professionals do not need to participate in PQRI to participate in the eRx Incentive program. For each program year, CMS implements the eRx Incentive program through an annual rulemaking process published in the Federal Register.

The eRx Incentive program is similar to PQRI in that it is based on the Medicare Physician Fee Schedule for covered professional services furnished by the eligible professional during a reporting period. For the 2009 and 2010 eRx Incentive program year, the incentive payment amounts were equal to 2% of the total estimated allowed charges by the eligible professional; for 2011 and 2012 the incentive payment amount will be equal to 1% of the total estimated allowed charges; and for 2013, the incentive payment amount is reduced to 0.5%. Beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment or penalty, applied to all of the eligible professional's professional services under the Medicare Physician Fee Schedule. Specifically, for 2012 through 2014, if an eligible professional is not a successful electronic prescriber for the reporting period for the year, the Medicare Physician Fee Schedule amount for covered professional services will be reduced by 1% for 2012, 1.5% for 2013, and 2% for 2014.

To be eligible for the eRx Incentive program, the eligible professional must meet the criteria for being a successful electronic prescriber as outlined in the annual rulemaking process. For example, in 2011 a physician would need to adopt a qualified eRx system that includes the capability to:

- generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers, if available;
- select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts;

- provide information related to lower cost, therapeutically appropriate alternatives, if any; and
- provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

Meaningful use

Hospitals and physicians also now may receive incentive payments for not just reporting on certain clinical metrics, but also for implementing certain levels of EHRs and achieving "meaningful use." On July 13, 2010, pursuant to the American Recovery and Reinvestment Act of 2009 (ARRA), CMS released the Final Rule for the Medicare and Medicaid Electronic EHR Incentive Programs (the EHR Incentive Program). Simultaneously, the Office of the National Coordinator for Health Information Technology (ONCHIT), pursuant to the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), released its final rule on the initial standards, implementation specifications, and certification criteria for EHRs and health information technology in the EHR Incentive Program. These two EHR Incentive Program final rules establish what criteria and technical standards constitute the "meaningful use" of EHR technology required for a provider to be eligible for incentive payments, and have been discussed in detail in prior articles in **Compliance Today**.

The significant incentive programs and payment changes targeted at measuring the care delivered by providers, all established in a relatively short period of time, clearly demonstrate CMS's motivation to change the way care is measured, reported, reimbursed, and ultimately delivered. At a fairly quick pace and in multiple areas, providers will be faced with increasing financial pressure from CMS to both report and improve on the way they deliver care.

Structuring hospital-physician alignment

Although it cannot be disputed that hospitals and physicians must structure their relationship differently to succeed under these new payment and delivery models, the exact structure they pursue is largely variable and can depend on the unique characteristics of the current relationship among them and the market in which they practice. The new payment changes will arrive soon, and hospitals and physicians need to select their structure and implement it prior to the payment changes so they are positioned to succeed in the new payment paradigm. Except for ACOs which may receive relief, hospitals and physicians remain constrained by the fraud and abuse laws; however, a number of legal structures are available today to align physicians and hospitals without running afoul of these laws.

Employment model

Hospitals may directly employ physicians; provide all of the facilities, equipment, and staff to support the physicians' practice; and bill and collect for the physicians' services. This is a highly integrated structure where the hospital is responsible for and bears the entire financial risk of the physicians' practice. The physicians are paid by the hospital for all of their professional services, and hospitals may also pay incentives to promote efficiencies and improve quality. In an employment model, hospital-supplied access to all necessary facilities and staff to perform services greatly benefits the physician, and the hospital benefits through an easier path to meeting regulatory requirements when dealing with employed physicians, compared to dealing with a physicians in a less integrated structure. The hospital often purchases the physician's practice in advance of employment, which may or may not include restrictive covenants that keep the physician loyal to the hospital through non-compete agreements.

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Under the new models of care, employment by itself will not result in the health care delivery changes that are required to perform well under VBP or bundled payment. Shared savings will not be achieved unless the hospital successfully engages a broad group of physicians (employed or not) who redesign care processes to provide evidenced-based medicine, meet quality imperatives, and achieve efficiency in providing services. However, employment does provide a legal structure that would allow for payment of incentives to the physicians if the delivery changes can be implemented.

Tax-exempt affiliated entity model

One step removed from the hospital employing physicians, a tax-exempt entity affiliated with the hospital may provide physician services for the hospital, and this separate entity either can employ or contract with physicians or physician groups to provide all physician services for the system. This structure also results in a high degree of integration between the hospital and the physicians. Similar to the employment model, the tax-exempt affiliated entity typically acquires the physicians' practice; provides all of the facilities, staff, and equipment to support the physicians' practice; and bills and collects for the physicians' services. To establish a tax-exempt affiliated entity, IRS tax-exemption requirements will affect the structure of the affiliate's board and the role that the physicians can play in setting compensation and other financial aspects of the affiliate's operations.

Hospitals in states with strict corporate practice of medicine prohibitions often can use tax-exempt affiliate models to align physicians, because the corporate practice prohibition prevents them from employing physicians directly. However, the model may still be used in states where direct employment by the hospital is not prohibited due to several benefits of the tax-exempt affiliated entity model. First, the model can achieve a high degree of alignment between physicians and the hospital while providing the physicians a sense of independence and autonomy. Often, the physicians retain their corporate organization under state law and then contract with the tax-exempt entity through a professional services agreement, although individual contracts and employment (where permitted) also can occur. Additionally, using a separate tax-exempt entity may help separate the billing, malpractice liability, etc. for the physicians' professional services from the hospital. The tax-exempt model may also make compliance with the fraud and abuse laws easier if the affiliate, and not the hospital, provides the incentive to control costs.

Pay-for-quality model

In a 2008 Advisory Opinion, the Office of Inspector General endorsed a pay-for-quality structure. The structure involves the creation of a new legal entity which all physicians who have been on the hospital's active medical staff in relevant departments for at least one year may join. The entity then contracts with the hospital to provide various tasks and services to improve quality and promote efficiency. Payment to the new legal entity can be based on a percentage of pay-for-performance and VBP dollars earned by the hospital (up to 50%) and then distributed to the physician-owners on a per capita basis. As a result, the structure incentivizes multiple physician specialties, regardless of a physician's employment status, to deliver the care necessary to improve the hospital's performance under VBP and may serve as the legal structure necessary to support an ACO.

Under the pay-for-quality model, the hospital does not have to expend significant capital to purchase multiple physician practices or to assume the financial risk of operating those practices. This structure retains the physicians' private practices and aligns the physicians financially with the hospital on metrics focused on quality and efficiency, the key focus of the payment and delivery model changes described above. Moreover, both employed and non-employed

physicians may be engaged to promote quality, resulting in improved quality and reduced cost, and this model provides a legal structure that is sufficient to distribute either bundled or shared savings payments as an ACO. The principal disadvantage of the structure is that the fraud and abuse laws discussed above are more difficult to navigate.

Joint ventures and physician-hospital organizations

Joint ventures between hospitals and groups of physicians also create a mechanism for addressing the new payment methods and achieving higher quality of care. Joint ventures remain subject to the various regulatory requirements that govern physician-hospital relationships in other contexts and may provide for integration without the physicians giving up total control to either the hospital or an affiliated entity. Risk and rewards may also be shared between hospitals and physicians under joint ventures, and the joint venture may qualify as the legal structure necessary to distribute shared savings or bundled payments as an ACO. State law, such as the corporate practice of medicine or professional corporation requirements, potentially impact the ability of hospitals and physicians to jointly own physician practices, however.

Physician-hospital organizations (PHOs) are a form of hospital/physician joint venture that traditionally exists for managed care contracting and physician network development. Nonetheless, these organizations also could function as the vehicle to distribute shared savings or bundled payments as an ACO. PHOs of the past typically did not actually deliver care, therefore a PHO likely would need to do more than just contracting and network development to achieve the delivery system changes needed to be successful under the new payment models. However, PHO use is becoming more common, particularly if they can achieve "clinical integration" to allow for collective negotiation of managed care contracts by the participants under the anti-trust laws.

Conclusion

Health care reform will bring about significant change to both how providers are paid and how care is delivered. The new structures are focused on rewarding improved quality and reduced cost and will require the development of new relationships between hospitals, physicians, and other providers across the care continuum. Although existing laws create a maze of regulation through which providers must navigate to restructure their legal relationships, the models described above can be developed under the current regulatory requirements. Creating these new legal relationships now is essential if hospitals and physicians are to succeed once the new payment and delivery models become effective. ■

1. The VBS Final Rule can be downloaded at http://www.federalregister.gov/articles/2011/05/06/2011-10568/medicare-program-hospital-inpatient-value-based-purchasing-program
2. For performance Year 4, five physician groups participating in the demonstration received performance payments totaling $31,700,000 in bonus payments based on a portion of the savings realized by Medicare. Also, during the first four performance years, physician groups increased their quality scores an average of 10 percentage points on 10 diabetes measures; 13 percentage points on the 7 heart failure measures; 6 percentage points on the 7 coronary artery disease measures; 9 percentage points on the 2 cancer screening measures; and 3 percentage points on 3 hypertension measures.
3. PPACA directs the Secretary of HHS to develop and implement a VBP program for physicians beginning in 2015.

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