

Alphabet Soup

ACA, ACO, HIPAA, COBRA/ EMTALA

Christopher H. Howard, J.D.
Albert C. Weihl, M.D.
Wailea Marriott
December 9, 2011

Overview

- Federal laws and regulations are having an ever increasing impact on the local practice of medicine and the business of medicine

Health Care 2011

- Coverage/Access
- Quality Issues
- Costs

The numbers

- Resident population of the United States **11/8/11**

312,575,986

- One birth every..... 7 sec
- One death every..... 12 sec
- One international migrant (net) every..... 37 sec
- Net gain of one person every..... 13 sec

Health Care 2011

- Population numbers

- US total population ~310,000,000
 - Medicare 45,000,000
 - Medicaid 60,000,000
 - Uninsured 45,000,000
 - Employer based insurance 160,000,000

Health Care 2011

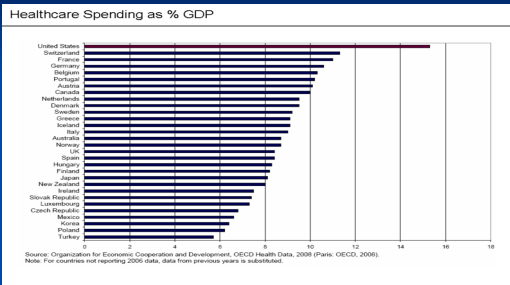
- Coverage/Access

- 45+ M uninsured for a full year - ~15% of population
 - Actually closer to 60 M uninsured at any point in time - ~20% of population
- Many more underinsured
- Rescissions when become sick—cancel policy
 - “pre-existing conditions” discovered; e.g., acne not mentioned on application
- Pre-existing condition exclusions

Health Care 2011- US

- Costs - staggering
- Largest business in the world
 - \$2.7+ T per year (projected \$4.3 T 2018)
 - \$225 B/mo
 - \$7.5 B/day
 - \$310 M/hr
 - \$5.2 M/min
 - \$8,700/person (projected \$13,100 by 2018)
- Unsustainable
- 17.6% GDP spent on healthcare (2009)
 - 13.5 million workers in HC – 9% of workforce
 - 4.4% of overall population

Healthcare \$\$\$ as % GDP



GDP (2009) vs US Healthcare

- | GDP (millions USD) | Healthcare \$\$\$ |
|--------------------|---------------------|
| ■ EU 16,414,697 | |
| ■ US 14,119,050 | |
| ■ JP 5,068,894 | |
| ■ CH 4,984,731 | |
| ■ DE 3,338,675 | |
| ■ FR 2,656,378 | US 2,473,300 (2009) |
| ■ UK 2,178,856 | 2,600,200 (2010) |
| ■ IT 2,118,264 | |
| ■ BR 1,574,039 | |

The Patient Protection and Affordable Care Act (ACA)

- The Patient Protection and Affordable Care Act contains nine titles:
 - I: Quality, affordable health care for all Americans
 - II: The role of public programs
 - III: Improving the quality and efficiency of health care
 - IV: Prevention of chronic disease and improving public health
 - V: Health care workforce
 - VI: Transparency and program integrity
 - VII: Improving access to innovative medical therapies
 - VIII: Community living assistance services and supports
 - IX: Revenue provisions

Title I: Quality, Affordable Health Care

- Immediate Improvements:
 - • Eliminate lifetime and unreasonable annual limits on benefits
 - • Prohibit rescissions of health insurance policies
 - • Provide assistance for those who are uninsured because of a pre-existing condition
 - • Require coverage of preventive services and immunizations
 - • Extend dependent coverage up to age 26

Title I: Quality, Affordable Health Care

- Immediate Improvements:
 - • Develop uniform coverage documents so consumers can make apples-to-apples comparisons when shopping for health insurance
 - • Cap insurance company non-medical, administrative expenditures
 - • Ensure consumers have access to an effective appeals process and provide consumers a place to turn for assistance navigating the appeals process and accessing their coverage
 - • Create a temporary re-insurance program to support coverage for early retirees
 - • Establish an internet portal to assist Americans in identifying coverage options
 - • Facilitate administrative simplification to lower health system costs

Title II: The Role of Public Programs

- **Medicaid Expansion:** States may expand Medicaid eligibility as early as January 1, 2011. Beginning on January 1, 2014, all children, parents and childless adults who are not entitled to Medicare and who have family incomes up to 133 percent FPL will become eligible for Medicaid.
- **Children's Health Insurance Program:** States will be required to maintain income eligibility levels for CHIP through September 30, 2019.

Title III: Improving the Quality and Efficiency of Health Care

- **Linking Payment to Quality Outcomes in Medicare**
- **Strengthening the Quality Infrastructure:**
- **Encouraging Development of New Patient Care Models:** Accountable Care Organizations (ACOs) that take responsibility for cost and quality received by patients will receive a share of savings they achieve for Medicare.

Title III: Improving the Quality and Efficiency of Health Care

- **Ensuring Beneficiary Access to Physician Care and Other Services**
- **Rural Protections**

Title III: Improving the Quality and Efficiency of Health Care

- Improving Payment Accuracy
- Medicare Advantage (Part C)
- Medicare Prescription Drug Plan Improvements (Part D)

Title III: Improving the Quality and Efficiency of Health Care

- Ensuring Medicare Sustainability
- Health Care Quality Improvements

Title IV: Prevention of Chronic Disease and Improving Public Health

- Modernizing Disease Prevention and Public Health Systems

Title IV: Prevention of Chronic Disease and Improving Public Health

- **Increasing Access to Clinical Preventive Services:** The Act authorizes important new programs and benefits related to preventive care and services:
 - • To provide Medicare coverage – with no co-payments or deductibles – for an annual wellness visit and development of a personalized prevention plan.
 - • To waive coinsurance requirements and deductibles for most preventive services, so that Medicare will cover 100 percent of the costs.

Title IV: Prevention of Chronic Disease and Improving Public Health

- **Creating Healthier Communities:** Grants to eligible entities to promote individual and community health and to prevent chronic disease.
- **Support for Prevention and Public Health Innovation:** Funding for research in public health services and systems to examine best prevention practices.

Title V: Health Care Workforce

- **Innovations in the Health Care Workforce:** National commission to review health care workforce and projected workforce needs.
- **Increasing the Supply of the Health Care Workers:** The federal student loan program will be modified to ease criteria for schools and students, shorten payback periods, and to make the primary care student loan program more attractive.

Title V: Health Care Workforce

- **Enhancing Health Care Workforce Education and Training:** New support for workforce training programs is established in these areas: Family medicine, general internal medicine, general pediatrics, and physician assistantship.

Title V: Health Care Workforce

- **Supporting the Existing Health Care Workforce:** Program for minority applicants for health professions, expands scholarships for disadvantaged students who commit to work in medically underserved areas.
- **Strengthening Primary Care and Other Workforce Improvements:** Redistribute unfilled residency positions, redirecting those slots for training of primary care physicians.
- **Improving Access to Health Care Services:** Expanded funding for federally qualified health centers.

Title VI: Transparency and Program Integrity

- **Physician Ownership and Other Transparency:** Physician-owned hospitals that do not have a provider agreement prior to February 2010 will not be able to participate in Medicare. Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital.
- **Nursing Home Transparency and Improvement:** Require that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available information on ownership.
- **Targeting Enforcement:** Reduce civil monetary penalties for facilities that self-report and correct deficiencies.

Title VI: Transparency and Program Integrity

- **Improving Staff Training:** Dementia management and abuse prevention training as part of pre-employment training for staff.
- **Nationwide Program for Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers:** National and state background checks of direct patient access employees of certain long-term supports and services facilities or providers.
- **Patient-Centered Outcomes Research:** Establish a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private board appointed by the Comptroller General to provide for the conduct of comparative clinical outcomes research.

Title VI: Transparency and Program Integrity

- **Medicare, Medicaid, and CHIP Program Integrity Provisions:** Screen providers and suppliers participating in Medicare, Medicaid, and CHIP.
- **Enhanced Medicare and Medicaid Program Integrity Provisions:** CMS will include in the integrated data repository (IDR) claims and payment data from Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).

Title VI: Transparency and Program Integrity

- **Sense of the Senate Regarding Medical Malpractice:** The Act expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

Title VII: Improving Access to Innovative Medical Therapies

- **Biologics Price Competition and Innovation:** Establish a process under which FDA will license a biological product that is shown to be biosimilar or interchangeable with a licensed biological product.
- **More Affordable Medicines for Children and Underserved Communities:** Drug discounts through the 340B program are extended to inpatient drugs and also to certain children’s hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

Title VIII: Community Living Assistance Services and Supports

- Establishment of national voluntary insurance program for purchasing community living assistance services and support (CLASS program).

■ This program has been abandoned

Title IX: Revenue Provisions

- **Excise Tax on High Cost Employer-Sponsored Health Coverage:** New excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan with an annual premium that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage.
- **Increasing Transparency in Employer W-2 Reporting of Value of Health Benefits:** Disclose the value of the benefit provided by the employer for each employee’s health insurance coverage on the employee’s annual Form W-2.
- **Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin:** Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the medical expense itemized deduction. Over-the-counter medicine obtained with a prescription continues to qualify as qualified medical expenses.

Title IX: Revenue Provisions

- Increase in Additional Tax on Distributions from HSAs and Archer MSAs Not Used for Qualified Medical Expenses:
- Limiting Health FSA Contributions: This provision limits the amount of contributions to health FSAs to \$2,500 per year.

Title IX: Revenue Provisions

- Corporate Information Reporting:
- Pharmaceutical Manufacturers Fee:
- Medical Device Manufacturers Fee:
- Health Insurance Provider Fee:
- Eliminating the Deduction for Employer Part D Subsidy:
- Modification of the Threshold for Claiming the Itemized Deduction for Medical Expenses:

Title IX: Revenue Provisions

- Tax on Elective Cosmetic Surgery:
- Executive Compensation Limitations:
- Additional Hospital Insurance Tax for High Wage Workers:
- Special Deduction for Blue Cross Blue Shield (BCBS):
- Simple Cafeteria Plans for Small Businesses:

ACOs Accountable Care Organizations

- A way to incent Physicians and other providers to save CMS money by offering to let them share in the savings
- Authorized by the Affordable Care Act
- Final rules came out October 20, 2011

“What Providers Need to Know”

- From the Department of Health and Human Services:
http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN907406.pdf
- Shared savings final rule:
<http://www.ofr.gov/inspection.aspx>

ACO

- A group of providers and suppliers that will work together to coordinate care for the Medicare Fee-For-Service payment system
- Different providers receive different, disconnected payment
- Patient-centered

Who may participate

- Practitioners in group practice arrangements
- Networks of individual practitioners
- Joint ventures of hospitals and practitioners
- Hospital employing ACO practitioners
- Other Medicare providers and suppliers
- Certain critical access hospitals, federally qualified health centers and rural health clinics

To Participate

- Providers must come together, apply to CMS and be accepted
- Must meet all eligibility requirements
- Must serve at least 5,000 Medicare Fee-For-Service patients
- Must agree to participate at least three years
- Must establish governing body including providers, suppliers and Medicare patients

Why?

- To share in the savings
- 2 models:
 - Share savings only
 - Share up to 50%
 - Share savings and losses (with minimum savings and maximum losses) for more experienced ACOs
 - Share up to 60%

Also

- ACO Quality and Performance standards and
- Exemptions and waivers from various other requirements

HIPAA

- Healthcare Insurance Portability and Accountability Act
 - (the “P” does **NOT** stand for Privacy)
 - National privacy standards
 - National security standards
 - National billing coding standards
 - Portability (limiting pre-existing condition exclusions)

HIPAA

- Overview/Reminder:
- Created as the AGREED part of Clinton’s healthcare reform initiative
- Created Federal standards for
 - Limiting pre-existing condition exclusions
 - Coding (for billing)
 - And, to do that
 - Privacy
 - Security

HIPAA Breaches

- A new area of compliance/enforcement under HIPAA in combination with the HITECH Act Privacy and Security Rules
 - 2/17/09 part of the stimulus package

HIPAA Breaches

- Per “hipaa.com” as of 10/25/11, OCR reported 345 breaches involving 11,959,488 individuals
- Two more known at that point with another 6.5 million individuals
- Breach Notification and Enforcement Rules are pending (any day) and compliance required in 2012

Privacy

- New rule (proposed May 31, 2011):
 - Everyone would have a right to get a report on who accessed their protected health information “PHI” electronically

COBRA/EMTALA

- Overview
- Recent regulatory developments
- Recent litigation

In case you forgot

- Anti-dumping statute
- Federal pre-empts state law
- Political in genesis and amended in response to political events
- Primary risk: penalties which may be imposed on hospital or physician
- Lawsuits rare (usually only if state has a shorter statute of limitations)

Requirements

- Screening exam
- If emergency condition, either:
 - Provide treatment, or
 - Stabilize and transport.
 - If transfer rejected, must inform of risks and benefits.

Requirements, continued

- If not stabilized, may not transfer unless:
 1. Written request to transfer, after risks and benefits explained
 2. A physician has signed the certification summarizing the risks and benefits
 3. If physician not physically present, a qualified medical person may sign after consulting with the physician who has decided the risks and benefits outweigh staying. Physician must later co-sign

Recent (Relatively) OIG Comments

- An on-call physician generally must come to do an exam when called
- May be sent to physician office for exam if in hospital-owned facility on contiguous land

2011 CMS Clarifications

- In March 2011 CMS clarified changes from laws passed in 2009:
 1. Community call plans
 2. Emergency waiver of EMTALA allowed by Secretary of HHS during times of emergency
 3. Clarification regarding hospitals with specialized capabilities

2010 Proposed Rule

- A rule that would have required a hospital with specialized capability, and capacity, to accept a patient was not adopted
- CMS clarified that the potential receiving hospital is not exposed to EMTALA liability if the patient is admitted elsewhere
- If patient not admitted to first hospital, then there is potential EMTALA exposure to the second hospital

EMTALA Suits?

- Rare, but
- 2011, Nurse filed wrongful termination/ whistleblower suit
 - Claiming fired in retaliation for reporting EMTALA violation
 - Mass. Dept of Public Health Inspector agreed the transfer violated regulation and found four other violations, hospital exposed to \$250,000 in fines
 - RN fired the same day CMS sent a team to investigate

Penalties

- Civil fines up to \$50,000/day
(\$25,000/day in hospitals with < 100 beds)
- May be imposed against hospital, ED Physician and/or on call physician
- AND, potential exclusion from Medicare
