Health Care is Not a Simple Matter

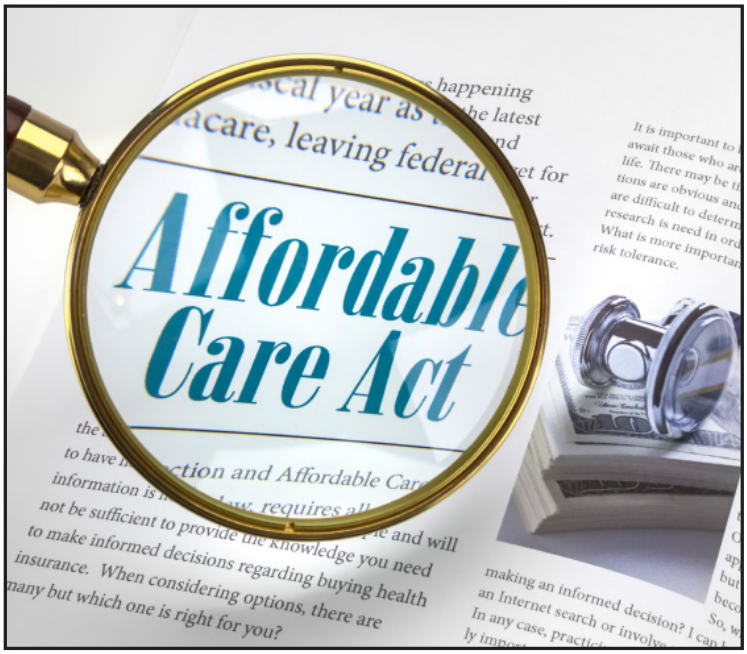
Understanding the Complexities in a Changing Environment

BY GARY R. PANNONE
Managing Partner

PLDW
PANNONE LOPES DEVEREAUX & WEST LLC
counselors at law

Health care and health insurance are evolving and becoming increasingly more fragmented because of the enactment of the Patient Protection and Affordable Care Act (ACA). The Centers for Medicare and Medicaid Services (CMS) continues to administer Medicare for persons age 65 and older and works in conjunction with the states in the administration of Medicaid for a significant portion of the low income population. Private health insurance on the other hand is regulated at the state level.

In the United States, primary care physicians make up approximately one third of the doctors practicing medicine, and although many remain self-employed, the current trend is toward the aggregation with other physicians in small, medium sized and large groups that also include physician assistants, nurses and other clinical staff. Patients generally have ability to choose their own doctor, depending upon their insurance plan and are usually not required to register with a primary care practice.



Primary care doctors have no formal gatekeeping function, except within some managed care plans. Specialist doctors can work in both private practice and hospitals. Physicians are paid through a combination of methods, including negotiated fees (private insurance), capitation (private insurance), and administratively set fees (public insurance). Physicians often receive financial incentives based on various performance criteria. Insured patients are generally directly responsible for some portion of physician payment, and uninsured patients are nominally responsible for all or part of physicians' charges, although those charges frequently are reduced or waived (with the extent of charity care varying substantially among providers).

Physician practices are mostly small (with fewer than five physicians) and single-specialty, although multi-specialty practices are not uncommon. Nurses and other non-physician staff often provide and assist in managing patient care, although their scope of practice varies by state. The government and private insurance companies are funding many initiatives aimed at shifting from a specialist-focused health system to one that is primarily care-focused. The Patient-Centered Medical Home (PCMH) model, in which a patient receives targeted, accessible, continuous, coordinated, and family-centered care from a personal physician is becoming a standard of practice to improve quality of care.

Prior to the enactment of the ACA, a majority of U.S. citizens maintained primary health insurance coverage either directly or through the Medicare/ Medicaid programs. A significant segment of the population remains uninsured; however, the claim of the ACA is that there will be a significant reduction or elimination of the uninsured population in less than a decade. The type of insurance will include inpatient and outpatient hospital and physician services with an emphasis on preventative care. Private insurance plans often have restricted networks of providers, with limited or no coverage if patients receive out-of-network care. Medicare is either open-network on a fee-for-service basis or what is called Medicare Advantage in which the federal government pays a private insurer for a network-based plan.

The public portion of the health insurance programs in the U.S. is financed through payroll taxes, premiums, and federal reimbursement, while Medicaid is a tax-funded, joint federal-state health insurance program that is administered by the states within guidelines established by the federal government. States receive matching funds from the federal government at rates that vary based on the per capita income of their populations. The expansion of Medicaid under the ACA will be fully funded by the federal government for the initial three years followed by a phase out of this subsidy. Provider reimbursement rates under the Medicare program are typically determined according to a fee schedule, with various regional adjustments (e.g., based on cost of living). Reimbursement under the Medicaid program varies by state, while private health insurers typically negotiate payment rates with providers.

> The patient-centered medical home model whereby a patient receives targeted, accessible, continuous, coordinated, and family-centered care from a personal physician is becoming a standard of practice to improve quality of care.

The ACA outlines national goals and priorities relating to quality improvement efforts and the Center for Medicare and Medicaid Innovation (CMMI) conducts testing for payment and service delivery models designed to reduce spending and improving the quality of care with an emphasis on reducing hospital-acquired infections and preventable readmissions The ACA also created the Patient-Centered Outcomes Research Institute (PCORI) to fund research that will provide providers and patients with evidence-based information to make health care decisions.

CMS is governed by the Department of Health and Human Services (HHS) which is the principal federal agency involved with health care services. The Institute of Medicine (IOM), an independent, nonprofit organization that works outside of government, acts as an adviser to policymakers and the private sector on improving the nation's health. It undertakes many studies in response to specific mandates from Congress and requests from federal agencies or independent organizations. Stakeholder associations (e.g., the American Medical Association) comment on and lobby for policies affecting the health system.

CMS has moved toward increased public reporting with Hospital Compare, a service that reports on process of care, outcome of care, and patient experience measures at over 4,000 hospitals. In addition, states have developed additional public reporting systems and measures, including some that address ambulatory care. Medicare has developed a variety of pay-for-performance programs. As of October 2012, Medicare has tied hospital reimbursement rates to performance indicators that include process, outcomes of care, and patient experience measures. For example, payments to hospitals with high 30-day readmission rates are reduced and the majority of private insurance providers also have pay-for-performance programs.

The creation of Accountable Care Organizations (ACOs) is a direct result of the passage of the ACA. ACOs are networks of providers, including hospitals and physicians agreeing to be responsible for providing a defined population with care that meets quality targets. In exchange, they are able to share in the savings that constitute the difference between forecasted and actual health care spending for their population. ACOs are held responsible for providing high-quality care to their attributed population of patients, with incentives for keeping those patients healthy.

Medicare, Medicaid, and various private purchasers, including employer groups, are also experimenting with new payment incentives that reward higher quality and more efficient care. In addition to pay-for-performance, strategies being implemented include "bundled" payments, under which a single payment is made for services from a number of providers related to a single episode of care. A significant segment of the population of physicians and hospitals use some form of electronic medical record system. The financial incentives for physicians and hospitals are tied to the attainment of benchmarks for the "meaningful use."

To summarize, the ACA and the reforms that have been initiated are not a simple matter and will impact the insurance and health system for many years.

Summary of ACA and reform initiatives impacting the insurance and health system:

- expanding Medicaid to include everyone with incomes below 133 percent of the federal poverty level
- establishing state-based insurance marketplaces for individuals and small businesses called exchanges
- providing insurance subsidies for low- and middle-income individuals and tax credits for small businesses
- instituting a series of insurance regulations that include guaranteed issue and community rating
- eliminating copayments for recommended preventive services and immunizations
- instituting a mandate for individuals to have health insurance or pay a fee
- establishing the Center for Medicaid and Medicare Innovation to develop and test payment models for improving quality and lowering costs
- establishing the Independent Payment Advisory Board, with a mandate to reduce the growth of Medicare expenditures through payment reforms
- creating a shared savings program in Medicare for ACOs that take responsibility for efficiently providing care to a defined population and meeting quality targets
- increasing Medicare and Medicaid payments for primary care

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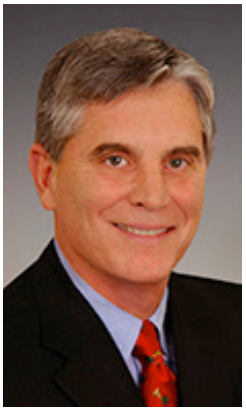

GARY R. PANNONE
Managing Partner

Gary R. Pannone is the Managing Partner of Pannone Lopes Devereaux & West LLC and has been representing closely held business owners for thirty years. He is an experienced business lawyer specializing in the areas of business formations, corporate restructuring, mergers, acquisitions, corporate compliance and health care. His practice includes the representation of nonprofit organizations with respect to consolidations, mergers and acquisitions.

PLDW

PANNONE LOPES DEVEREAUX & WEST LLC

counselors at law

317 Iron Horse Way, Suite 301 Providence, RI 02908
tel 401 824 5100