



How Should Physicians Prepare for Health Reform and Accountable Care?

CLIENT ADVISORY

The landscape of healthcare in the United States dramatically shifted on March 23, 2010. Fee-for service and volume-based care are now moving towards a bundled or capitated payment system that rewards quality and value. The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Reform Act"), which are extending healthcare coverage to an additional 30 million individuals, have accelerated this transition. The Health Reform Act will have a significant impact on patients, providers and suppliers, including physicians and physician organizations.

From a provider-standpoint, much of the Health Reform Act focuses on value and quality in the delivery of care, and encourages coordination among providers. As many of the details are left to regulations, the ultimate impact of the legislation may not be realized until those regulations are proposed and enacted. While the changes will be implemented over the course of several years, physicians should begin to evaluate their practices now to prepare themselves for these changes.

Focus on Primary Care

The availability of primary care physicians in the United States has not kept pace with demand. Some

have suggested that this may be due, at least in part, to a perceived frustration with longer hours, a lack of prestige in comparison to some specialists and a compensation shortfall. For instance, in 2009 the Medical Group Management Association ("MGMA") reported that the average compensation paid to primary care physicians totaled approximately 55% of the average compensation paid to specialists in 2008.¹ Earlier this year, the Advisory Board indicated that U.S. medical school graduates filled only 42% of family medicine residency slots as opposed to 85% for anesthesiology.²

Massachusetts implemented legislation in 2006 with the intent of providing universal healthcare coverage throughout the state. Last year, the Massachusetts Medical Society reported that family medicine and internal medicine physician shortages were critical and severe.³ Based upon this increased demand and short supply, that same report also indicates that physician office appointment wait times have increased while the percentage of primary care physicians accepting new patients has continued to decrease.⁴ In expanding health insurance coverage nationwide through the Health Reform Act, the results in Massachusetts may help to predict the nationwide impact of this

¹ MEDICAL GROUP MANAGEMENT ASSOCIATION, PHYSICIAN COMPENSATION AND PRODUCTION SURVEY: 2009 REPORT BASED ON 2008 DATA 11 (2009). "Primary care" includes Family Practice (without OB), Internal Medicine and Pediatrics/Adolescent Medicine.

² See ADVISORY BOARD, BLUEPRINT FOR THE MEDICAL HOME (Jan. 2010), quoting data from the National Residency Match Program, March 19, 2009.

³ MASSACHUSETTS MEDICAL SOCIETY, 2009 MASSACHUSETTS MEDICAL SOCIETY PHYSICIAN WORKFORCE STUDY 2 (Sept. 2009).

⁴ *Id.* at 3-4.



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legislation on primary care.

In response to these concerns, the Health Reform Act includes some measures intended to address the primary care physician shortage and the increasing emphasis on primary care:

- ⇒ Section 1202 increases the fee for service rate paid by Medicaid to primary care physicians in 2013 and 2014 to equal the Medicare rate.
- ⇒ Section 5501 provides for a 10% bonus payable by the Medicare program to primary care physicians, and also provides for a bonus for general surgeons who perform certain surgical procedures in health professional shortage areas.
- ⇒ Section 3107 extends the 5% add-on Medicare physician fee schedule payment for certain mental health services through December 31, 2010.

Delivery of Care

The Health Reform Act includes various pilot programs and demonstration projects to introduce models to shift governmental healthcare away from traditional fee-for-service reimbursement to payments based on quality and episodes of care. This payment shift will likely push physicians towards clinically integrating with other providers who can offer various levels of care to patients. Some of these programs are described below:

Section 3023 of the Health Reform Act establishes a voluntary pilot program in 2013. Those who participate in the five-year program will receive one bundled payment for an episode of care provided to a patient. An episode of care starts three days prior to an inpatient admission and ends 30 days after discharge. The single payment will

cover all acute care inpatient hospital services, physician services, outpatient services, post-acute services and inpatient long-term acute care hospital services provided during the episode. The pilot program will only apply to certain specified conditions. Those providers who are organized to deliver care in a more efficient and coordinated manner should have better results in this program than those who do not. No later than 2016, the Secretary of the Department of Health and Human Services ("HHS") must submit a plan to Congress on the expansion of this program if it improves quality and reduces costs.

Section 3022 of the Health Reform Act establishes a voluntary "shared savings program" for Medicare. The Secretary of HHS must issue regulations to establish the program by 2012. The Health Reform Act provides for HHS to enter into agreements with eligible accountable care organizations ("ACOs") for the ACOs to manage care for groups of Medicare beneficiaries for a three year period. Physician groups and joint ventures of physicians and hospitals are among the healthcare providers that may establish eligible ACOs. The Health Reform Act allows the Secretary to structure the program to include capitated arrangements and shared risk models, but under the original primary provisions, participants in the ACO would still be reimbursed under the fee-for-service model, but would be eligible for bonus payments if certain thresholds for quality and cost savings were achieved. Current fraud and abuse laws and other legal standards present challenges for ACOs, but large multi-specialty group practices, physician-hospital organizations and independent practice associations that are able to clinically integrate best positioned to succeed as ACOs.

Section 3024 of the Health Reform Act requires the Secretary of HHS to establish an "independence at-home



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demonstration program” by 2012 to facilitate the provision of primary care services to Medicare beneficiaries with multiple chronic conditions who receive care at home. Similar to the shared savings program for ACOs, certain “health teams” could be eligible for shared savings if they achieve high-quality outcomes, high patient satisfaction and cost savings. HHS will develop per capita benchmarks for program costs. A participating practice will be eligible to receive an incentive payment based on actual savings achieved in comparison to the benchmark.

Pursuant to Section 3502 of the Health Reform Act, the Secretary is required to provide grants or enter into contracts with eligible entities to establish “community health teams” to support patient-centered medical homes and primary care practices (including obstetrics and gynecology practices). The team must consist of various healthcare professional in various specialties. HHS will make capitated payments to primary care providers for services rendered to program patients based upon criteria established by HHS. The community health teams will assist in wellness activities and the prevention and management of chronic diseases. The design involves a more comprehensive approach to care based upon the patient’s needs.

Finally, Section 3021 of the Health Reform Act creates a new “Innovation Center” within CMS (starting in 2011) to test, evaluate and expand different payment structures and methodologies in certain areas to reduce governmental program expenditures and preserve or enhance quality. This “think tank” may propose and develop new models, pilot programs or projects to meet these goals.

Physicians who may be interested in participating in a pilot program or a demonstration project should start evaluating whether they are suitable candidates. For practices that decide not to participate, self-evaluations

should still be performed based upon the underlying transition in the manner in which governmental programs will pay for healthcare. Also, some commercial payors may already have similar pilot programs in place that may be appropriate for some practices.

Practical Considerations

Physicians can take a few proactive measures now to prepare for the Health Reform Act’s changes. The first step involves an evaluation of how the practice is currently structured to determine its strengths and weaknesses. The second step involves evaluating various options to prepare for the changes that will be implemented through the Health Reform Act. This self-evaluation may include the following:

- **Practitioners** – How many physicians are employed by the practice? How many mid-level practitioners? Are these numbers optimal?
- **Service Lines** – Is the practice a single or multi-specialty practice? Should this be changed? Different options will apply based upon the size of the practice and the clinical service lines it offers.
- **Relationships** – What current relationship does the practice have with other healthcare providers? Some of these may include:
 - Hospital affiliations and partnerships
 - Equity-based joint ventures
 - Physician Hospital Organizations & Independent Practice Associations
 - Cross-coverage agreements
 - Professional service agreements
 - Shared space, equipment or personnel arrangements
 - Patient safety organizations
 - Peer review organizations



Lawyers at HDJN have diverse backgrounds and varying specialties and represent decades of experience in providing legal advice to health care providers.

- Patient Demographics – What is the practice's service area and where does it obtain most of its patients? Based upon the increase in the insured population, how will this impact the practice based on its patient demographics? Does the practice have the right practitioners, service lines and relationships to best address this?
- Competitors / Opportunities – Who are the competitors and what steps are they taking to move towards accountable care? Is there an unmet healthcare need in the community? How can the strengths of the practice be used to meet that need? What other resources are necessary?
- Electronic Health Records – Does the practice use an electronic medical records system with e-prescribing capability? Is the system interoperable with other systems to allow for greater clinical integration with other providers?
- Payor Mix – Does the practice understand its current payor mix? Does it suggest that the practice will likely receive additional patients through the Health Reform Act who were not previously insured? How will this affect the bottom line? Do any of the practice's commercial payors have pilot programs or demonstration projects similar to those described in the Health Reform Act? Should the practice pursue participation in those programs or projects?
- Equipment – Should the practice acquire diagnostic imaging equipment based upon its patient base and service lines? Could it do so through acquiring, or partnering or merging with another provider?
- Billing and Collection Efforts – How efficient is the practice in documentation, capturing charges and accurately billing for procedures? Does it have a collections policy that is uniformly applied?
- Performance – Does the practice track productivity and quality metrics? How are costs tracked? Are practitioners held accountable for the cost of care? Metrics should be developed in each of these categories to identify strengths, weaknesses and opportunities for the practice.
- Financial Status – Does the practice have the financial resources to make any necessary changes to better position itself for accountable care? Should it expand or reduce offices or service lines?

Another step involves accepting the changes contemplated by the Health Reform Act, regardless of ideology. As practitioners will treat a wide variety of patients with different opinions concerning the Health Reform Act, the focus should remain on how the practice will adjust for the changes and how such changes will affect the manner in which patient care is delivered.

The Health Reform Act will create new opportunities for many healthcare providers. HDJN can help with determining how your practice may better prepare itself for these reform measures. Specifically, we can help with describing these changes in more detail, evaluating your practice's options for moving toward accountable care, determining the impact of these requirements on your organization and developing a plan to implement any necessary changes. If you have any questions or if we can be of assistance, please contact Jim Daniel (jdaniel@hdjn.com), Mike Newby (mnewby@hdjn.com), or Bill Hall (bhall@hdjn.com) at 866-967-9604.



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