EPSTEIN BECKER & GREEN P.C.

Physician Transactions that Work: Look for Clinical Integration

Physician Agreements & Ventures
November 1, 2007

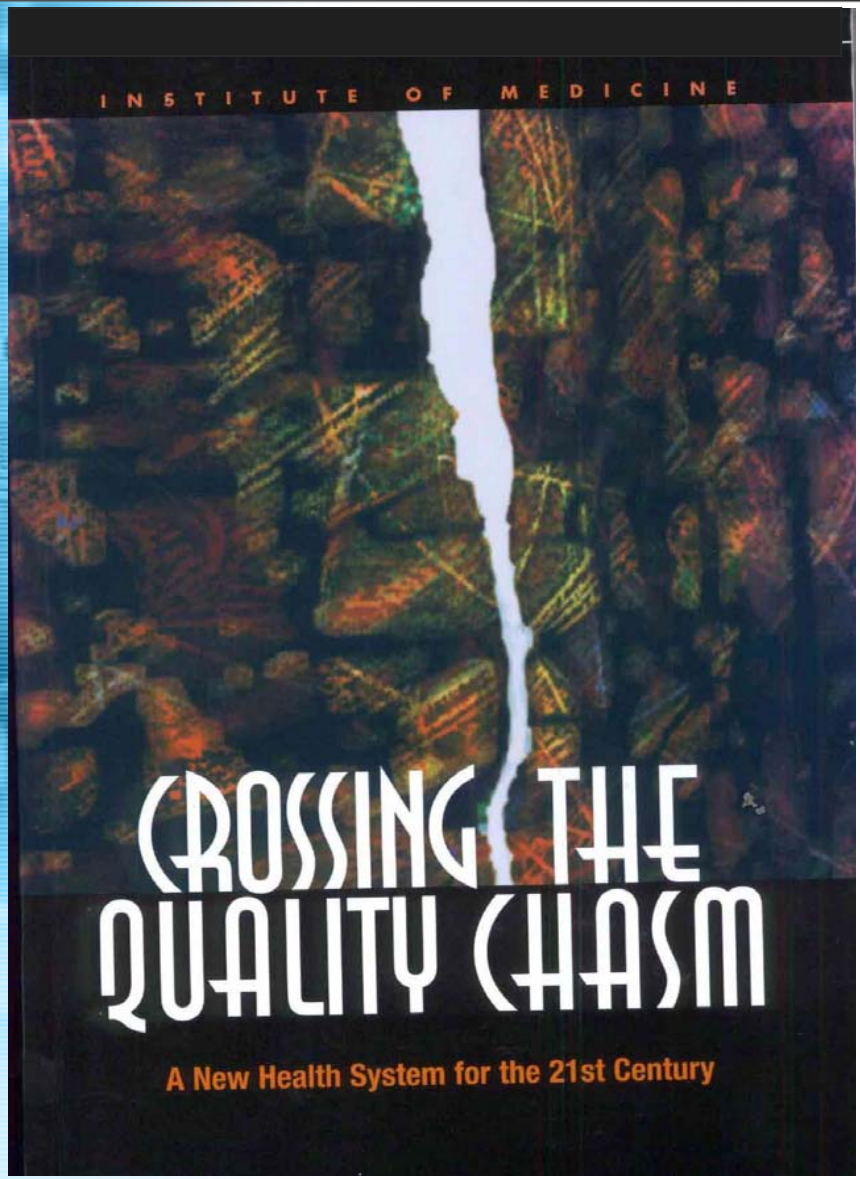
Douglas A. Hastings
Chair, Health Care and Life Sciences Practice
Epstein Becker & Green, PC
Member, Board on Health Care Services, Institute of Medicine

THOUGHT LEADERS IN HEALTH LAW®

EBG

U.S. Healthcare System Realities

- Mixed public and private system
- Health care is driving the U.S. economy
- Health care system is extraordinarily advanced, yet inefficient, uneven and too often unsafe
- Improvement will require collaboration, integrated care and aligned incentives
- Enforcement priorities are not necessarily aligned with policy needs and operational realities



"The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses and health care leaders are concerned that the care delivered is not, essentially, the care we should receive …Quality problems are everywhere affecting many patients. Between the healthcare we have and the care we could have lies not just a gap, but a chasm."

— Institute of Medicine, 2001

The Six Aims

Quality defined as care that is:

- Safe
- Effective
- Efficient
- Patient-Centered
- Equitable
- Timely

Results of Commonwealth Fund Scorecard

- The “National Scorecard on U.S. Health System Performance,” released September 20, 2006, is a comprehensive evaluation of U.S. health care quality, access, equity, outcomes and efficiency
- For 37 key indicators of the five health care system dimensions listed above, overall U.S. score equaled 66 out of a possible 100
- Efficiency was the single worst score among the five dimensions. For example, in 2000/2001, U.S. ranked 16th out of 20 countries in use of EHRs
- We are worldwide leader in costs

Commonwealth Fund Scorecard (cont.)

- U.S. scored 15th out of 19 countries in mortality attributable to health care services
- Basic tools (i.e., Health IT) are missing to track patients through their lives
- We do poorly at transition stages — hospital readmission rates from nursing homes are high; our reimbursement system encourages “churning”
- Improving performance in key areas would save 100,000 to 150,000 lives and $50 billion to $100 billion annually

Commonwealth Fund Recommendations

- Expand health insurance coverage
- Implement major quality and safety improvements
- Work toward a more organized delivery system that emphasizes primary and preventive care that is patient-centered
- Increase transparency and reporting on quality and costs
- Reward performance for quality and efficiency
- Expand the use of interoperable information technology
- Encourage collaboration among stakeholders

Rewarding Provider Performance: IOM Pay-for-Performance Recommendations (September 2006)

- The Secretary of the Department of Health and Human Services (DHHS) should implement pay for performance in Medicare using a phased approach as a stimulus to foster comprehensive and system-wide improvements in the quality of health care

- Congress should create provider-specific pools from a reduction in the base Medicare payments for each class of providers (hospitals, skilled nursing facilities, Medicare Advantage plans, dialysis facilities, home health agencies, and physicians)

IOM Pay-for-Performance Recommendations (cont.)

- Congress should give the Secretary of DHHS the authority to aggregate the pools for different care settings into one consolidated pool from which all providers would be rewarded when the development of new performance measures allows for shared accountability and more coordinated care across provider settings

- Because public reporting of performance measures should be an integral component of a pay-for-performance program for Medicare, the Secretary of DHHS should offer incentives to providers for the submission of performance data, and ensure that information pertaining to provider performance is transparent and made public in ways that are both meaningful and understandable to consumers

IOM Pay-for-Performance Recommendations (cont.)

- The Secretary of DHHS should develop and implement a strategy for ensuring that virtually all Medicare providers submit performance measures for public reporting and participate in pay for performance as soon as possible

- Three years after the release of this report, the Secretary of DHHS should determine whether progress toward universal participation is sufficient and whether stronger actions—such as mandating provider participation—are required

IOM Pay-for-Performance Recommendations (cont.)

- CMS should design the Medicare pay-for-performance program to include components that promote, recognize, and reward improved coordination of care across providers and through entire episodes of illness

- Because electronic health information technology will increase the probability of a successful pay-for-performance program, the Secretary of DHHS should explore a variety of approaches for assisting providers in the implementation of electronic data collection and reporting systems to strengthen the use of consistent performance measures

Quality vs. Cost?

"Right from the start it has been one of the great illusions in the reign of quality that quality and cost go in opposite directions. There remains very little evidence of that. There may be some innovations that raise costs while raising quality, but many, many improvements reduce costs."

— Don Berwick
Health Affairs, October 2005

Porter and Teisberg, Redefining Health Care

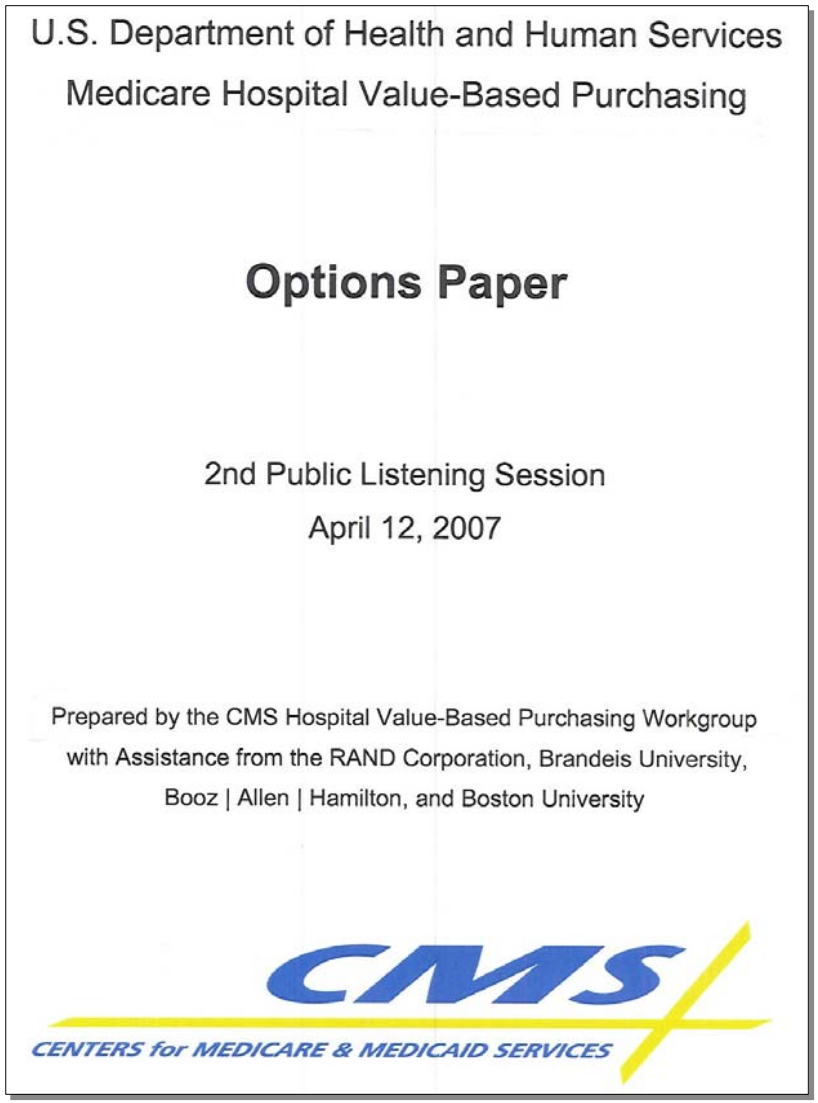
Creating Value-Based Competition on Results

- Integrated care is the goal, not aggregation of boxes
- High quality = less cost = value to patients
- P4P must incent lower costs
- Value must be measured, communicated and compensated

Porter and Teisberg Conclusion

"Value-based competition on results is a positive-sum competition in which all participants can win, so long as they are dedicated and capable. However, those participants that will enjoy the greatest rewards will be those that move early. For anyone in the health care system, the time to act is now."

Value-Based Purchasing



U.S. Department of Health and Human Services

Medicare Hospital Value-Based Purchasing

Options Paper

2nd Public Listening Session

April 12, 2007

Prepared by the CMS Hospital Value-Based Purchasing Workgroup with Assistance from the RAND Corporation, Brandeis University, Booz | Allen | Hamilton, and Boston University

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Opportunities to Improve Quality and Reduce Costs

- Gainsharing-type arrangements
- Ambulatory Surgery Centers
- Service Line Joint Ventures
- Medical Group Consolidation
- Management Contracts and Leasing Arrangements
- “Under Arrangements” Arrangements

But Legal Obstacles Remain

- Stark Law
- Anti-Kickback Statute
- Civil Monetary Penalty Statute
- Medicare Reimbursement
- Exempt Organization Tax Law
- Antitrust Law
- Quality Monitoring and Reporting

Why Clinical Integration Can Solve Business and Legal Issues

- The single entity concept
- Quality is enhanced
- Care is more efficient
- The government recognizes all of this both in law and enforcement policy
- For example, the AMC exception to Stark, employee exceptions to Stark and the Anti-Kickback laws, antitrust guidance on clinical integration

Federal Payment and Enforcement Initiatives

The Carrot:

- Pay for performance
- Gainsharing demonstrations
- Regulatory compliance benefits of “good” quality

The Stick:

- Non-payment for “Never Events”
- Reduced payments for outcomes below benchmarks
- Growing federal enforcement in connection with “bad” quality

Enforcement Meets Quality

- The private sector must continue to educate Congress and the regulatory agencies on the importance of quality as an affirmative element of compliance; the private sector also at times will have to initiate change before the payment system and regulations catch up; but the rewards are potentially very high — in terms of financial and organizational success as well as social benefit

Enforcement Meets Quality (cont.)

- There is an opportunity for the best performers in the industry to create positive change by demonstrating best practices in quality health care to government, private payors and consumers — and then by opening up these best practices through transparency of data and promoting collaboration to spread change