Healthcare Reform

Physicians Should Act Today To Save Tomorrow

Healthcare reform is now a reality, and those reforms create a very different medical practice environment. Although many of the changes will not be implemented immediately, physicians should begin now to position themselves to take advantage of opportunities the law offers and to protect themselves against potential pitfalls; they can act today on measures which will enable their practices to benefit from incentives that will become available as reforms are implemented. Attorneys can help strategically and with legal issues, but physicians can take steps to help themselves. This article focuses on steps that can be taken in three areas: fraud and abuse, creating value, and physician-hospital relationships.

Fraud and Abuse Enforcement

It is no secret that the government has identified fraud and abuse enforcement as a fundamental priority of the healthcare reform legislation. Fraud, waste, and abuse is one of the major components of the Patient Protection and Affordable Care Act (PPACA). The number of auditors and investigators has increased, and whistleblower actions arguably are more attractive. Violations of the Anti-Kickback Statute (AKS) and Stark Statute (Stark) now are subject to sanctions under both the Civil Money Penalties Law and the Federal False Claims Act (FCA).

Of particular interest to physicians, PPACA requires providers (and suppliers and health plans) to "report and refund" any "overpayment" within 60 days after the overpayment is "identified" or the date any corresponding cost report is due, whichever is later. An "overpayment" is defined as any funds received or retained under Medicare or Medicaid to which the provider, supplier, or plan is not entitled after an "applicable reconciliation." A provider also must specify "the reason for the overpayment."

Reporting and repaying any overpayment is an "obligation" under the FCA, so failure to report and return an overpayment within the applicable deadline may constitute a violation. Potential monetary penalties range from $5,500 to $11,000 per claim, plus treble damages. PPACA also amends the Civil Monetary Penalty statute to establish monetary penalties for failure to report and repay overpayments. "Unpaid overpayments" also are grounds for Medicaid program exclusion. The new laws will apply to earlier overpayments that are only now discovered — not just those occurring after the effective date of PPACA.

PPACA does not provide specific guidance about when an "overpayment" is considered "identified" and, thus, the repayment deadline triggered. The OIG historically has taken the position in the self-disclosure context that an overpayment is not "identified" until a provider has completed its internal investigation of an overpayment. The treatment of this issue under PPACA is not yet clear.

This increased focus on fraud and abuse enforcement means that physician practices should ensure that their billing, documentation, credit balance review and repayment procedures, reports to government, as well as Stark, Anti-Kickback, and other financial relationships are in compliance with the new laws. Taking the following steps now will save time, energy, money, and administrative burden later when auditors appear or in the event of a whistleblower action:

1. Review the practice's compliance program and make any recommended updates or corrections. If the practice does not have an effective compliance program (as defined by the OIG), adopt one and implement it immediately. Legal counsel can assist with adoption and implementation, but ultimately, it is the practice's responsibility to ensure that the program is followed.

PHYSICIANS SHOULD TAKE ACTION TODAY ON THE MEASURES THAT WILL ENABLE THEIR PRACTICES TO BENEFIT FROM INCENTIVES THAT WILL BE AVAILABLE IN THE HEALTHCARE SYSTEM AS HEALTHCARE REFORMS ARE IMPLEMENTED.

2. Review the practice's internal compensation formula to confirm that it is Stark-compliant.

3. Make sure all financial relationships with referral sources are as close to an AKS safe harbor as possible.

4. Make sure all financial relationships with providers to which Stark-designated health services are referred, or from which referrals for Stark-designated health services are received, fall within a Stark exception.

5. Obtain a baseline audit of the practice's documentation accuracy. Legal counsel should assist with this task, and both counsel and the practice should take appropriate steps to evidence an intent that the audit work and the outcome be protected by the attorney-client privilege and/or treated as attorney work product.

6. Develop an annual auditing and monitoring schedule based on the identified risk areas for the practice.

Measuring and Improving Quality

The healthcare reform legislation includes a national strategy to improve the delivery of healthcare services, patient health outcomes, and population health through measurement, more transparency, and value-based purchasing. Quality measures are being developed by the government that will allow assessment of:

1. Health outcomes and functional status of patients;

2. Management and coordination of healthcare, including care transition across multiple care episodes and the continuum of providers, healthcare settings, and health plans;

3. The quality of information given to patients by healthcare providers, and whether and how that information is used in making healthcare decisions;

4. Meaningful use of health information technology;

5. The safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

6. The efficiency of care;

7. The equity of health services (including addressing health disparities across populations and geographic areas);

8. Patient experience and satisfaction; and

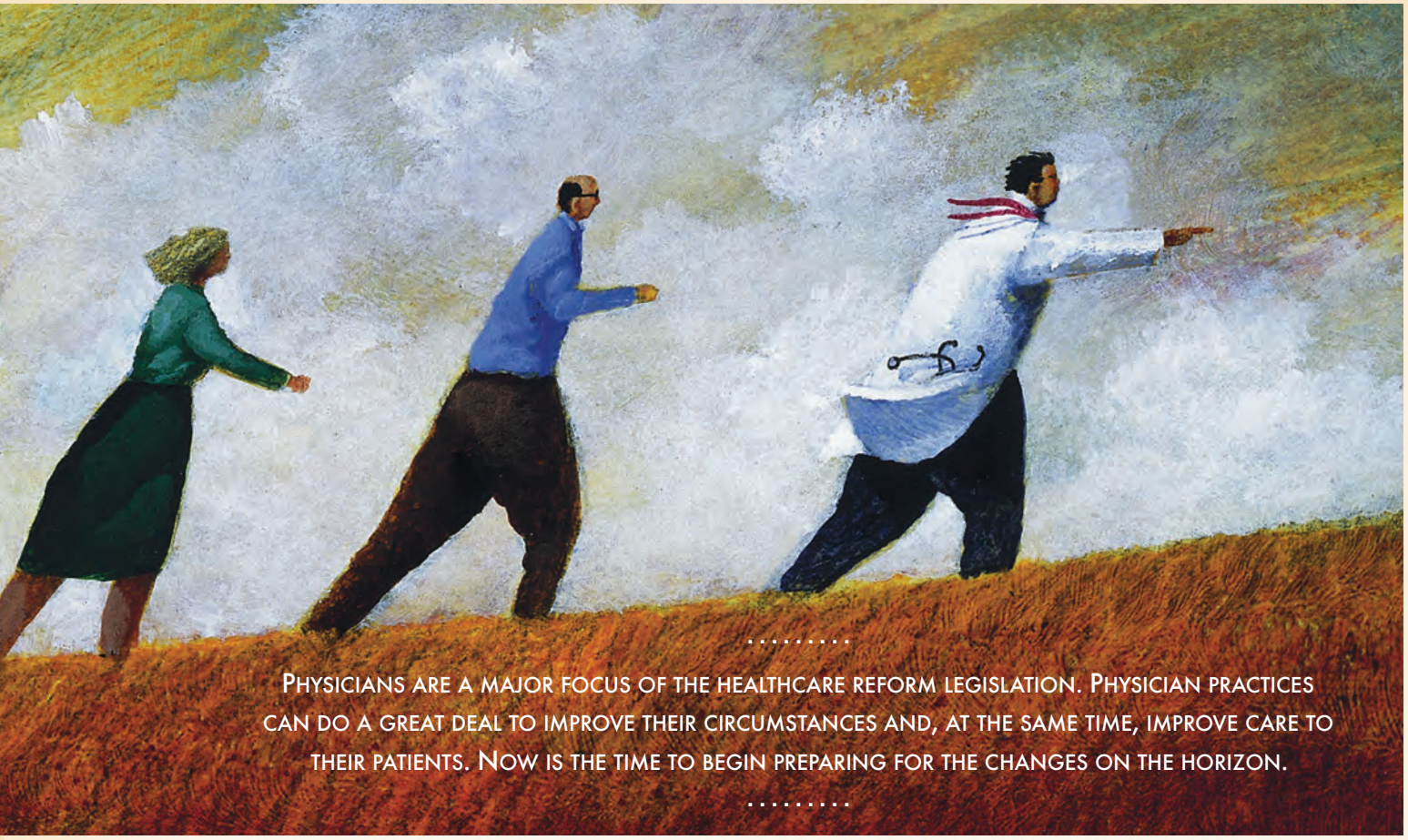
9. Use of innovative strategies and methodologies.

By 2012, measures will be published to establish a Medicare payment modifier that provides for differential payment to physicians based on quality of care.

The physician practice must be able to measure its quality and costs if it is to demonstrate and improve quality in the future. Physician practices must adopt standardized clinical processes, to the extent possible, to succeed in the highly measured environment. Clinical integration within a practice allows the practice to become more efficient and standardized in patient care delivery. Acting now to integrate clinically and standardize care and to measure quality, outcomes, and costs will help ensure success when additional Medicare payments are available based on quality of care. Many of the following steps can also improve the practice's financial margins:

1. Consider possible methods of clinical integration within the practice.

2. Analyze existing behaviors and habits



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among the physicians in the practice and in relationship to staff that do not directly and measurably contribute to improved quality, financial margins, or patient experience.

3. Require each physician in the practice to measure his or her own performance and make changes based on data.

Physician-Hospital Relationships

Physicians will be subject to value-based purchasing in Medicare beginning in 2012. Efficiency standards and performance measures will be established. It is likely that the measures adopted will be applied to performance data from 2011 (only a few months away). The physician value-based purchasing program will be coordinated with the hospital value-based purchasing program, which also begins in 2012. Hospitals and physicians have a short timeframe to agree on a common goal to improve their performance, with the ability to achieve and demonstrate improved quality and efficiency as the endpoint. On their side of the equation, physician practices can:

1. Review information regarding alternatives available for hospital-physician relationships;

2. Consider the best way to approach hospital representatives about solidifying the relationship in ways that will improve quality to the benefit of the physician practice, the hospital, and patients.

Anti-Kickback and Stark Revisions

PPACA also includes a number of changes to the AKS and Stark laws, some of which become effective soon. For example, when a physician refers a patient to an entity with which the physician has a financial relationship for MRI, CT, PET and other services still to be identified by DHHS, the referring physician must inform the patient in writing at the time of the referral that he or she may obtain services from another provider. In addition, the physician must provide the patient with a written list of providers in the area.

PPACA also amends the rural provider and "whole hospital" ownership exceptions to Stark. Future physician investment in hospitals, effectively, is barred. Hospitals with existing physician investment are grandfathered if a provider agreement is entered by December 31, 2010. A number of limitations apply to the grandfathered hospitals, however. For example, the aggregate percentage of physician investment in the hospital, or an entity with ownership in the hospital, cannot be increased. There are also restrictions regarding the expansion of hospital services or beds.

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[1] The United States Department of Health and Human Services (DHHS) Office of Inspector General (OIG) reported, in 2009, savings and expected recoveries of $20.97 billion, including $4 billion in investigative receivables.

[2] This statute may be invoked by the Inspector General without a referral to the Justice Department.

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