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## HEALTH CARE REFORM – THE TRANSLATION

Enactment of the Patient Protection and Affordable Care Act ("PPACA" or the "Act"),<sup>1</sup> as amended by the reconciliation act,<sup>2</sup> has consultants, lawyers and policy think tanks scrambling to educate the public, the health industry and payors about the most far reaching piece of legislation in the nation's history. The size and breadth of the law is overwhelming. The number of pages is intimidating enough. However, the provisions of this Act are so far reaching that they touch almost every person, hospital, physician, healthcare provider, payor, employer, government-sponsored health program, supplier, pharmacy, and taxpayer.

The only way to begin to understand PPACA is to first step back and understand the various components of the Act in the context of the whole Act. There is very significant change coming to the way we provide healthcare, the way we pay for healthcare, and the way we think about healthcare. We will get to each of the detailed provisions as they are rolled out. First, let's examine the big picture of what really got enacted.

There are ten titles to the Act. Titles I and II have gotten almost all the news coverage, but even taken together, they are only about 25% of the entire Act. These two titles deal with insurance issues. Title I expands coverage in the private side: there will be no more pre-existing conditions on a phased in schedule; there are mandates for individuals and employers to provide insurance coverage; it establishes the insurance exchanges and provides for state flexibility; and it permits young adults to remain on their parents' insurance until age 26, etc. Title I (the mandates) is the primary basis for the lawsuits which have been filed challenging the Constitutionality of the Act. Title II expands the roles of public coverage: it expands Medicaid coverage; it changes Medicaid prescription drug coverage; it establishes a Federal Coordinated Health Care Office to address coordination of payment for dual eligible individuals; and it establishes a new option for states to provide long-term home and community-based services and supports.

Beginning with Title III through Title VII inclusive, fully 50% of the Act relates to quality improvement and cost efficiency. These are the sections that will impact providers the most, and these are the sections we will focus on in depth in subsequent health reform articles and seminars. This discussion is not intended to cover each and every aspect of the legislative reform package, but to provide a glimpse into the breadth of what has been enacted.

The Medicare program is the largest purchaser of healthcare items and services in the country. It is also the program over which Congress and the federal government have direct control. As a result, the first obligations for initiating quality improvement and changes in the

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reimbursement system will happen within the Medicare program. These changes include linking payment to meeting quality and cost targets; implementing a hospital value-based purchasing program; creating accountable care organizations (“ACO”), which will assume risk and share rewards in Medicare savings; and introducing bundled payments for a broad range of services designed to be provided to a single individual over an entire episode of care.

ACOs are qualifying groups of providers, including hospitals, which are established to share in Medicare cost savings above a certain threshold. The exact payment models may include a partial capitation arrangement or some other payment model that would reward improvements in quality and efficiency. Several demonstration projects will be initiated and expanded as part of the planning phase of the ACO initiative.

A CMS Innovation Center will be established by 2011 to design, implement, test, evaluate, and expand payment models and methodologies for the governmental health programs, including Medicare, Medicaid, and CHIP.

In Title IV, Congress focuses on chronic disease and improving public health. For providers who serve special needs populations, this is the section of the Act for you to study. New committees are created, and new studies and grants are authorized to focus on prevention, chronic disease, wellness, nutrition, etc. Funding is authorized for Community-Based Collaborative Care Networks to provide comprehensive (from preventive care through hospitalizations and as much in between as can be included) to low-income populations. States can receive grants to establish interdisciplinary teams to support medical homes and provide coordination of care. These interdisciplinary teams may include (in addition to primary care physicians) specialists, nutritionists, social workers, mental health providers, and alternative medicine providers. Additionally, Title IV addresses modernizing disease prevention; increasing access to clinical preventive services at schools and generally in the community; conducting research and data collection about geographic disparities in care; and funding for childhood obesity projects among others.

Title V addresses methods of bringing additional healthcare workers into the workforce. A new commission will be authorized to assess workforce needs, there are sections on medical student loans and recruitment efforts, there are educational and training grants and changes to graduate medical education. For example, the Act redistributes 65% of unused residency slots to increase primary care and general surgery residencies. Decisions on the redistributed slots will also consider the likelihood of a particular hospital participating in an innovative delivery model to promote quality of care.

Title VI marries transparency in the healthcare system with program integrity. This is the “carrot and stick” title. It creates new rules that require transparency for physicians, nurses, and the pharmaceutical industry. In addition, Title VI creates a private comparative effectiveness research (CER) entity. CER will compare, for example, one drug against another drug to determine which has the broadest efficacy for addressing particular symptoms. This is very different from current drug testing which compares the effectiveness of the studied drug to a placebo. CER asks “is this drug or treatment better than other drugs or treatments commonly prescribed for a certain set of

symptoms” rather than “is this drug or treatment better than nothing?” Of course, the outcomes of such studies will depend on what questions are asked and, at present, the research centers around what questions are most appropriate. Even when CER provides a completed analysis of a particular drug or treatment, any conclusion will be open for additional testing as more data changes the scope or level of importance of the questions used in the study.

Title VI also adds fraud and abuse updates and, in the space of a few pages, all but eliminates the Stark exception for whole hospital ownership by physicians. In addition, Title VI expands the Recovery Audit Contractor (RAC) program, which is just now being implemented across the country.

Title VII is about improving access to innovative drugs and therapies. This is an area of special interest to safety net hospitals such as children’s hospitals, sole community hospitals, and cancer hospitals. It deals principally with the 340B program.

Title VIII is a relatively short title instituting a long-term care insurance program that can be paid for through payroll deductions.

Title IX addresses revenue sources to help pay for the reform package (in not quite 100 pages out of over 2400 total). Of course, other areas of the Act include measures that are intended to provide cost savings. This title also addresses additional fees and excise taxes that are intended to offset the cost of reform, including excise taxes on high cost insurance plans; imposition of annual fees on branded prescription pharmaceutical manufacturers and importers and medical device manufacturers and importers; additional requirements for charitable hospitals, including performing community health needs assessments, maintaining a financial assistance policy which includes methods for providing financial assistance or free care, maintaining a policy on providing emergency assistance, and billing and collection requirements relative to charity care patients.

Title X contains corrective revisions to the prior 9 titles.

This article is intended only as an overview to illustrate the breadth of the Act, to provide a general view of the areas it addresses, and to demonstrate how the primary focus of the legislation on quality care and changing the business of providing healthcare. As some pundits in Washington have noted, the Act dramatically affects how the medical community will interact when treating patients. Success in this environment will be determined by how effectively physicians, clinicians, and service providers embrace a collaborative approach to treating their patients.

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<sup>1</sup> Patient Protection and Affordable Care Act, HR 3590, Pub. L. 111-148 (Mar. 23, 2010).

<sup>2</sup> Health Care and Education Reconciliation Act of 2010, HR 4872, Pub. L. 111-152 (Mar. 29, 2010).

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