

## ACA's Efforts to Make Healthcare More Affordable

The first installment of this three-part Health Capital Topics series, which focused on the decreasing marginal utility in healthcare, discussed the substantial growth in U.S. healthcare spending, which has failed to yield significantly better health outcomes. As a result, the U.S. may not be receiving sufficient “value per dollar” spent on healthcare. The second segment of this three-part series explored the potential causes of decreasing marginal utility in the U.S. healthcare system by identifying the primary causes of waste in healthcare spending. This third and final installment of this series will examine various provisions of the *Patient Protection and Affordable Care Act (ACA)* that are designed to combat wasteful spending and make healthcare more affordable.

Several provisions of the ACA are designed to provide financial incentives for achieving better health outcomes, with the objective of reducing waste that results from poor delivery and coordination of healthcare. Section 3001 of the ACA established the *Hospital Value-Based Purchasing (VBP) Program* to reward acute-care hospitals by linking incentive payments to quality outcomes.<sup>1</sup> Under the Hospital VBP Program, the *Centers for Medicare & Medicaid Services (CMS)* provides incentive payments to hospitals based on how the hospital scores on a predetermined set of measures.<sup>2</sup> The VBP payments for the 2014 fiscal years are determined based on three sets of measures:

- (1) Thirteen *Clinical Process of Care measures*, which rate how often hospitals adhered to clinical best practices;
- (2) Eight *Patient Experience of Care measures*, which are based on patient surveys in which patients rate the responsiveness of staff and overall experience; and,
- (3) Three *30-Day Outcome Mortality measures*, which are based on a hospital's mortality rates for specific conditions, while patients are in the hospital or within 30 days after discharge.<sup>3</sup>

The program is funded through a reduction of *Diagnosis-Related Group (DRG)* payments to participating hospitals for the applicable fiscal year.<sup>4</sup> The reduction in 2014 was 1.25%, and will increase to 2% by 2017.<sup>5</sup> Those withheld funds are then redistributed to hospitals based on their *Total Performance Score (TPS)*, which represents the hospital's total weighted score based on the foregoing measures.<sup>6</sup>

The *Medicare Shared Savings Program (MSSP)*, established in Section 3022 of the ACA, is another program aimed at reducing waste resulting from poor care coordination.<sup>7</sup> The MSSP is designed to improve quality of care by:

- (1) Promoting accountability for the care of Medicare beneficiaries;
- (2) Requiring coordinated care for all services provided under Medicare; and,
- (3) Encouraging investment in infrastructure and redesigned care processes.<sup>8</sup>

The program provides financial incentives to eligible *Accountable Care Organizations (ACOs)* to meet specified quality performance standards to receive payments for shared savings.<sup>9</sup> Under the MSSP, an eligible ACO accepts responsibility for the overall quality, cost, and care of a defined group of Medicare beneficiaries.<sup>10</sup> The ACO's financial incentive payments are determined by comparing the ACO's annual incurred costs to benchmarks established by CMS.<sup>11</sup> This program encourages participating ACOs to facilitate coordination and cooperation among its providers to improve quality of care and reduce unnecessary costs. The *Congressional Budget Office (CBO)* estimates that the establishment of the MSSP could save Medicare \$4.9 billion between 2010 and 2019.<sup>12</sup>

Another provision aimed at reducing waste by improving the quality and coordination of care is the *Hospital Readmissions Reduction Program*, established in Section 3025 of the ACA.<sup>13</sup> Before the enactment of the ACA, hospitals had little incentive to reduce preventable hospital readmissions, which accounted for a large portion of wasteful spending.<sup>14</sup> The *Readmissions Reduction Program* requires CMS to reduce payments to hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.<sup>15</sup> A qualifying “readmission” is defined as an admission to a hospital within 30 days of a discharge from the same hospital, or a different hospital.<sup>16</sup> Currently, CMS has adopted readmission measures for Acute Myocardial Infarction, Heart Failure, and Pneumonia.<sup>17</sup> Under this program, a hospital's readmission rates for these conditions are compared to its expected readmission rates, and the hospital is subject to penalties for its excess readmissions.<sup>18</sup>

In addition to targeting waste that results from poor care delivery and coordination, the ACA also targets

*administrative complexity*, a category of waste resulting from the inefficient and overly bureaucratic procedures of health insurers and accreditation.<sup>19</sup> The ACA establishes *health insurance exchanges*, which are centralized online marketplaces for health insurance, where shoppers can view side-by-side comparisons of qualified health insurance plans to ensure they receive the best deal.<sup>20</sup> The exchanges: (1) lower the costs of administering a health plan by reducing the need for marketing and sales services;<sup>21</sup> and, (2) increase competition among health plans and eliminate their ability to “*cherry pick*” low-risk patients.<sup>22</sup> Thus, in order to remain competitive, health plans would have to renegotiate pricing with providers and reduce excessive administrative costs.<sup>23</sup>

Finally, in response to concerns regarding the proliferation of fraud and abuse, the ACA includes initiatives aimed at increasing transparency and improving federal enforcement tools. The ACA incorporates the *Physician Payments Sunshine Act*, which requires extensive reporting and public disclosure of financial arrangements between certain providers and manufacturers of medical devices and pharmaceuticals.<sup>24</sup> The transparency requirement was intended to address the concern that industry payments to physicians, estimated at \$20 to \$57 billion each year, may influence the physicians’ choice of treatment.<sup>25</sup>

The ACA also amends enforcement authority to create a significant expansion of potential liability for providers under federal healthcare laws, including the federal Anti-kickback statute (AKS), the False Claims Act (FCA), and the federal physician self-referral law (Stark Law). For example, Section 6402 of the ACA requires that any person who receives overpayments from Medicare or Medicaid report and return such overpayment to an appropriate Secretary, state, intermediary, carrier, or contractor within 60 days after the date the overpayment was identified,<sup>26</sup> and failure to do so may give rise to liability under the FCA.<sup>27</sup> Additionally, the law broadens the intent requirement under the AKS, providing that “*a person need not have actual knowledge of [the AKS] or specific intent to commit a violation of [the AKS]*” for the government to prove a violation of the law.<sup>28</sup>

The fraud and abuse amendments to the ACA have contributed to substantial health fraud recoveries by the *Department of Justice (DOJ)* and *Office of Inspector General (OIG)* in recent years. The DOJ announced in February 2014 that it recovered a record-breaking \$4.3 billion in fiscal year 2013 from individuals and companies who attempted to defraud federal healthcare programs.<sup>29</sup> For every dollar spent on healthcare fraud and abuse investigations in the past three years, the federal government recovered \$8.10.<sup>30</sup>

Despite the recent flattening of U.S. healthcare expenditures per capita, policymakers have made it a major priority to reign in these costs in order to make healthcare more affordable. Several provisions in the ACA aim to curb wasteful spending by incentivizing better quality and coordination of care among hospitals and providers; reducing administrative complexity; increasing competition among health insurance plans; and, investing more resources into combating fraud and

abuse violations. However, it remains to be seen whether these provisions will reign in wasteful healthcare spending.

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- 4 *Ibid.*
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- 6 *Ibid.*, “The total performance score information,” Medicare.gov, <http://www.medicare.gov/hospitalcompare/data/total-performance-scores.html> (Accessed 5/16/2014).
- 7 “Medicare Shared Savings Program,” Patient Protection and Affordable Care Act § 3022, Pub. L. 111-148, 124 Stat. 119, H.R. 3590 (March 23, 2010).
- 8 *Ibid.*
- 9 *Ibid.*
- 10 *Ibid.*
- 11 *Ibid.*
- 12 “Table 5: Estimate of the Effects of Non-Coverage Health Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate,” Congressional Budget Office, Letter to Nancy Pelosi (March 20, 2010), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf> (Accessed 4/23/2014).
- 13 “Hospital Readmissions Reduction Program,” Patient Protection and Affordable Care Act § 3025, Pub. L. 111-148, 124 Stat. 119, H.R. 3590 (March 23, 2010).
- 14 See “Causes of Wasteful Spending in the U.S. Healthcare System,” Health Capital Topics, Vol. 7, Issue 4 (April 2014).
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- 21 “How Does the ACA Control Health Care Costs?” Robert Wood Johnson Foundation, July 2011, [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf71451](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71451) (Accessed 4/2/2014).
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- 23 *Ibid.*
- 24 “Health Care Reform: Substantial Fraud and Abuse and Program Integrity Measures Enacted,” McDermott Will & Emery (April 12, 2010), <http://www.mwe.com/info/news/wp0410a.pdf> (Accessed 4/23/2014).
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- 26 “Enhanced Medicare and Medicaid Program Integrity Provisions,” Patient Protection and Affordable Care Act § 6402(c)(2), Pub. L. 111-148, 124 Stat. 119, H.R. 3590 (March 23, 2010).
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- 28 *Ibid.*
- 29 “Departments of Justice and Health and Human Services Announce Record-Breaking Recoveries Resulting from Joint Efforts to Combat Health Care Fraud,” Department of Health and Human Services Press Release, February 26, 2014, <http://www.hhs.gov/news/press/2014pres/02/20140226a.html> (Accessed 4/23/2014).
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**Robert James Cimasi**, MHA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS (HCC)**, a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institution of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: “*Accountable Care Organizations: Value Metrics and Capital Formation*” [2013 - Taylor & Francis, a division of CRC Press], “*The Adviser’s Guide to Healthcare*” – Vols. I, II & III [2010 – AICPA], and “*The U.S. Healthcare Certificate of Need Sourcebook*” [2005 - Beard Books]. His most recent book, entitled “*Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services*” was published by John Wiley & Sons in March 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious “*Shannon Pratt Award in Business Valuation*” conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).



**Todd A. Zigrang**, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives, and serves as President of the St. Louis Chapter of the American Society of Appraisers (ASA). He has co-authored “*Research and Financial Benchmarking in the Healthcare Industry*” (STP Financial Management) and “*Healthcare Industry Research and its Application in Financial Consulting*” (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser’s Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.



**Matthew J. Wagner**, MBA, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas of valuation and financial analysis. Mr. Wagner has provided valuation services regarding various healthcare related enterprises, assets and services, including but not limited to, physician practices, diagnostic imaging service lines, ambulatory surgery centers, physician-owned insurance plans, equity purchase options, physician clinical compensation, and healthcare equipment leases.



**John R. Chwarzinski**, MSF, MAE, is a Vice President of **HEALTH CAPITAL CONSULTANTS (HCC)**. Mr. Chwarzinski holds a Master’s Degree in Economics from the University of Missouri – St. Louis, as well as, a Master’s Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. Mr. Chwarzinski’s areas of expertise include advanced statistical analysis, econometric modeling, and economic and financial analysis.



**Jessica L. Bailey**, Esq., is the Director of Research of **HEALTH CAPITAL CONSULTANTS (HCC)**, where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law and Policy.