Health Update

Apr 27, 2015

Phoebe Putney: A Collision of Federal Antitrust and State Certificate of Need Laws

Antitrust Update: New Developments in the St. Luke’s Case and New Controversy After the FTC/DOJ Workshop

Understanding the Potential Role Web Brokers Can Play in State-Based Marketplaces

Compliance Programs: Evolving and Expanding Compliance Obligations

Keeping Personal Health Information Safe: The Importance of Good Data Hygiene

Passage of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): The "Doc Fix"


Phoebe Putney: A Collision of Federal Antitrust and State Certificate of Need Laws

Authors: Ashley Anfer, Associate, Healthcare Industry | Lisl Dunlop, Partner, Litigation

On March 31, 2015, the Federal Trade Commission (FTC) announced that it had entered into a consent agreement with Phoebe Putney Health System, Inc., the Hospital Authority of Albany-Dougherty County and HCA, Inc. This agreement settled a four-year battle arising out of the FTC’s allegations that the Hospital Authority’s acquisition of Palmyra Park Hospital from HCA, Inc., Phoebe Putney’s only competitor in Albany, and its lease to Phoebe Putney would reduce competition for acute care hospital services in Albany, Georgia, in violation of federal antitrust laws.

The FTC’s usual approach in transactions that it believes will lessen competition is to seek to prevent the transaction from closing, or, if the transaction is consummated, seek divestiture of the acquired business to restore competition. In this case, although the FTC would have preferred that Phoebe Putney divest Palmyra Park, Georgia’s Certificate of Need (CON) laws precluded such a remedy, because any proposed purchaser of Palmyra Park could not obtain CON approval to operate the hospital independently.

The Phoebe Putney Case: An Overview

Although divestiture was an available remedy when the FTC commenced this case in 2011, the FTC ultimately was left with no choice but to challenge the transaction after it had closed. The transaction was held open for several years through federal litigation, in which the district and appellate courts thwarted the FTC’s attempts to challenge the transaction, finding that the transaction was protected from federal antitrust scrutiny under the state action doctrine and refusing to hold the transaction open pending further appeal. In a seminal ruling in June 2013—after the transaction had closed—the U.S. Supreme Court ultimately ruled that state action protection did not apply, and the FTC resumed its proceeding challenging the transaction.

In August 2013, the FTC and the parties agreed upon a settlement based on the FTC’s understanding that Georgia’s CON laws would preclude a divestiture of the Palmyra Park Hospital, even assuming the FTC ultimately found that Phoebe Putney’s acquisition of Palmyra was anticompetitive. One month later, however, the FTC withdrew its provisional acceptance of the settlement in response to new information...
received through public comments.

The public comment in question raised doubts that Georgia’s CON laws would bar a divestiture. Following withdrawal of the FTC’s acceptance of the settlement, in March 2014, a newly formed entity filed a formal request with the Georgia Department of Community Health (DCH), inquiring whether Georgia’s CON laws would permit it to acquire and operate Palmyra Park Hospital. In June 2014, DCH issued an initial determination indicating that the acquisition would not require CON review and approval. However, in October 2014, DCH reversed its initial determination and issued a written finding that the CON laws would apply to the proposed acquisition.

The FTC accepted that Georgia’s CON laws would ultimately preclude sale of Palmyra Park Hospital to an independent third party. The consent agreement that was eventually entered:

- Contains a stipulation that the effect of the transaction was to substantially lessen competition within the relevant markets at issue;
- Requires Phoebe Putney and the Hospital Authority to provide the FTC with prior notice of transactions to acquire any part of a general acute-care hospital, or controlling interest in any inpatient, outpatient clinic or facility, or physician group practice in the Albany area; and
- Prohibits Phoebe Putney and the Hospital Authority from opposing CON applications for general acute-care hospitals in the Albany area for up to five years.

State CON Laws

Generally speaking, CON laws and programs seek to reduce healthcare costs by requiring state approval before construction of certain new health facilities or capital improvements of certain existing health facilities, based on community need. The underlying rationale is that excess capacity—for example, in the number of inpatient beds or the number of expensive devices—artificially increases healthcare costs.

Many states established CON programs in response to federal legislation issued in 1974. When this mandate was repealed in 1987, several states discontinued their programs. Notwithstanding this, a majority of states today—36 plus the District of Columbia—still have some sort of CON program, though the scope and focus of these programs vary. Debate about the future of state CON programs is ongoing.³

FTC Opposition to State CON Laws

The Phoebe Putney case is not the first time that the FTC has raised concerns about the inconsistency between federal antitrust policy and state CON laws and programs. In 2008, the FTC and the Antitrust Division of the U.S. Department of Justice issued a Joint Statement to the Illinois Task Force on Health Planning Reform, arguing that Illinois’s CON laws impede the efficient performance of healthcare markets.⁴ In the joint statement, the agencies set forth several arguments against CON laws:

- The market cost-control rationale, which initially drove adoption of CON laws, no longer applies, because costs are negotiated. In fact, CON laws have not controlled market costs.
- CON laws impose additional costs and may even facilitate anticompetitive behavior, because they interfere with the entry of firms that could provide higher-quality services than incumbents. CON laws also can be subject to abuse by incumbents who use the ensuing lengthy regulatory processes to delay entry of new competition (through diversion of competitors’ time and resources), preserving the anticompetitive status quo.
- There are several examples where the CON process itself facilitated the establishment of anticompetitive agreements.
- CON laws do not protect incumbent hospitals’ financial investments and resources and maintain revenue that can be put to charitable use. Instead, CON laws stifle competition that could otherwise encourage incumbents to improve performance and efficiency.
- The agencies advocate for more narrowly tailored policies, targeted at specific social needs (such as charity care) in lieu of broad-sweeping CON policies.

The Phoebe Putney case further highlights the tension between federal
antitrust and state CON laws. In the FTC’s statement concerning the
settlement, the FTC noted that because Georgia regulators deemed the
Albany region to be “over-bedded,” it was unlikely that any divestiture
buyer could obtain the necessary CON approval to operate an
independent hospital. By rendering the FTC’s remedy infeasible in this
case, state CON laws effectively “tied the hands” of federal regulators in
their efforts to preserve market competition, to the detriment of both the
competitive environment and healthcare consumers.

Looking Ahead

The tension between federal antitrust policy and state CON laws, as
demonstrated in the Phoebe Putney case, is an issue that is likely to
continue to arise in cases where the FTC challenges consummated
hospital mergers. An overwhelming majority of states still have CON laws
or programs in place, even though the federal mandate was withdrawn
almost two decades ago.

In unconsummated mergers under review by the FTC, CON laws may be
cited as a barrier to entry that may count against arguments in favor of
consolidation. Conversely, as was the case in the Phoebe Putney
acquisition, CON laws also may prevent divestiture of healthcare entities
by larger conglomerates, preventing market innovation and harming
consumers. The FTC’s inability to restore competitive market conditions in
the Phoebe Putney case may prompt states to reconsider their CON
programs in the future.

1 Statement of the Federal Trade Commission, In the Matter of Phoebe Putney Health
System, Inc. et. al., Docket No. 9348 (Mar. 31, 2015), available at
https://www.ftc.gov/public-statements/2015/03/statement-federal-trade-commission-
matter-phoebe-putney-health-system-inc.

2 The state action doctrine was implicated in this case due to the manner in which the
transaction was structured, whereby the Hospital Authority of Albany-Dougherty
County, a state agency, would first acquire title to Palmyra Park Hospital from HCA,
and would subsequently transfer all management control of Palmyra to Phoebe
Putney under a long-term lease arrangement. As a result, although a state agency
technically acquired the hospital, effectively, it was acquired by a private entity.

2011, updated July 2014), http://www.ncsl.org/research/health/con-certificate-of-need-
state-laws.aspx.

4 Joint Statement of the Antitrust Division of the U.S. Department of Justice and the
Federal Trade Commission Before the Illinois Task Force on Health Planning Reform
(Sept. 15, 2008), available at https://www.ftc.gov/policy/policy-actions/advocacy-

5 Statement of the Federal Trade Commission, In the Matter of Phoebe Putney Health

Antitrust Update: New Developments in the St. Luke’s Case and New Controversy After the FTC/DOJ Workshop

Author: Lisl Dunlop, Partner, Litigation

In the last two issues of Manatt Health News, we reported on two recent antitrust developments:

The 9th Circuit’s decision in the St. Luke’s merger case and

The FTC and DOJ’s healthcare workshop.

Since those reports, there have been some further developments worth noting.

St. Luke’s Applies for a Rehearing

The defendants in St. Luke’s have applied for an en banc rehearing (a hearing by the full bench of the court) of the 9th Circuit decision. On April 7, a group of prominent antitrust professors filed an amicus brief supporting the rehearing. Their brief expressed concern that the 9th Circuit panel’s positions on proof of efficiencies—for example, showing that the merger would allow St. Luke’s to serve patients more effectively was insufficient, and that the district court at most concluded that the hospital might provide better service post-merger—are contrary to the antitrust agencies’ Horizontal Merger Guidelines and may deter transactions that otherwise would promote consumer welfare.
We are waiting with interest to see whether the 9th Circuit takes on the efficiencies argument. Continue to watch Manatt’s “Health Update” for the latest developments.

Hospital Associations Criticize FTC/DOJ Healthcare Workshop

Following the Federal Trade Commission’s (FTC) and Department of Justice’s (DOJ) “Examining Healthcare Competition” workshop in February this year, several hospital associations wrote to the FTC and DOJ criticizing the lack of hospital representation over the two-day hearing, which they claim was hostile to hospital interests.1 In particular, the associations raised concerns about the workshop’s characterizing hospitals as seeking leverage over health insurers and increases in Medicare payments, while overlooking quality and other key reasons for hospital collaboration and consolidation.

The agencies responded, stating that the workshop team consulted with numerous stakeholders in the healthcare industry, but the 14 hospital systems or representative organizations that the staff reached out to either declined to speak to them or to participate in the workshop.2 The agencies also pointed to the presence of several panels that did include hospital perspectives.


back to top

Understanding the Potential Role Web Brokers Can Play in State-Based Marketplaces

Authors: Joel Ario, Managing Director | Allison Garcimonde, Manager

Editor’s note: In an issue brief for the Robert Wood Johnson Foundation’s State Health Reform Assistance Network, summarized below, Manatt Health examines how State-Based Marketplaces (SBMs) can benefit from the experience of Web brokers, who have been using the Internet to enroll consumers in health plans since 1997. The paper defines who Web brokers are, chronicles the evolution of the federal Web broker policy and offers two models for how SBMs and Web brokers can work together. Click here to download the full issue brief free.

_________________________

The Affordable Care Act (ACA) is greatly expanding health insurance coverage, particularly among lower-income, uninsured individuals. Sustaining this expansion is neither easy nor inexpensive and requires ongoing public-private partnerships. One important partnership opportunity is with Web brokers—private distribution channels that, similar to the Marketplaces, offer a choice of health plans from multiple insurers, relying primarily on Web sites and call centers for customer service.

In March 2012, the U.S. Department of Health and Human Services (HHS) provided the opportunity for Marketplaces to capitalize on Web broker experience by authorizing them to partner with Web brokers in enrolling individuals (including those eligible for subsidies), as long as those Web brokers met certain consumer protection standards. The Federally-Facilitated Marketplace (FFM) embraced the Web broker policy in May 2012, and the Centers for Medicare and Medicaid Services (CMS) began signing contracts with Web brokers in July 2013. Since then, the agency has signed agreements with more than 30 brokers. Some leading Web brokers are seeking similar partnerships with states. States could benefit from leveraging the experience of Web brokers as they seek to craft sustainable models for reaching as many consumers as possible.

Who Are the Web Brokers?

Web brokers come in different flavors but share a common goal with the Marketplaces—using the Internet as a distribution channel that makes it easier, faster and cheaper to purchase health insurance in a consumer-oriented Marketplace. Partnerships between Web brokers and Marketplaces are mutually beneficial. Marketplaces have achieved considerable public awareness and may attract issuers that Web brokers hope to represent, while Web brokers can provide technology tools,
consumer-friendly innovations and marketing and sales capacity that are of increasing value to Marketplaces looking to become self-sustaining.

Working in tandem, Marketplaces offer Web brokers access to subsidized coverage to sell, and Web brokers are organized to process many individual buyers efficiently. Public Marketplaces are projected to double the size of the individual market nationally, so Web brokers have a powerful incentive to tap into that growth.

The 30-plus Web brokers that have signed agreements with CMS reflect a broad diversity of business models. Many of them, in fact, may end up collaborating with other Web brokers rather than working independently with the Marketplaces. Five examples of leading Web brokers (profiled in detail in the issue brief) are:

**eHealth, Inc.** Founded in 1997, eHealth (aka eHealthInsurance) offers more than 10,000 products from 180 insurance companies, has affinity relationships with almost 1,000 businesses and reports having enrolled 4 million individuals in health insurance as of last year. The company focuses on providing a self-executing online experience for web-savvy consumers.

**GetInsured.** Founded in 2005, GetInsured’s national web-based platform supports more than 110 carriers and 6,748 health plans. GetInsured also has contracted as an information technology vendor with several states and offers “off-the-shelf” solutions for both the individual and small business Marketplaces.

**GoHealth.** Since 2002, GoHealth has operated a “consumer health insurance exchange,” assisting individual purchasing online, via its agent network or directly, through a major health insurance company. GoHealth was an early partner of the FFM, using its combination of online and call center capabilities.

**OneExchange.** Towers Watson’s exchange division includes ExtendHealth, the largest Medicare exchange, and Liazon Corporation, a leading private exchange for midsized employers. The company is particularly interested in part-time and other employee classes that may be best served by individual coverage.

**Quotit.** Part of Word & Brown Companies, Quotit is an Internet application service provider that has relationships with over 300 insurance carriers representing more than 40,000 plan designs in the health, life, dental and visual insurance markets. Quotit’s software enables independent brokers and retail consumers to generate insurance quotes.

**Evolution of Federal Policy Web Brokers**

The federal government first established a Web broker policy for public Marketplaces—and then adopted an “open competition” version of that policy for the FFM and the 36 states that operated as FFM states in 2014. Under federal regulation, Web brokers can enroll consumers through their own Web sites only if they meet two criteria. First, they must be appropriate connections to the relevant state or federal Marketplace. Second, the Web broker must sign an agreement and abide by the following consumer protections:

- Registers with the Exchange and receives training in the range of Qualified Health Plan (QHP) options;
- Complies with the Exchange’s privacy and security standards;
- Complies with state laws, including laws related to confidentiality and conflicts of interest;
- Meets all standards for disclosure and display of QHP information;
- Provides consumers with the ability to view all QHPs offered through the Exchange and displays all QHP data provided by the Exchange;
- Provides consumers with the ability to withdraw from the process and use the Exchange website instead at any time; and
- Maintains electronic records for audit purposes for at least 10 years.

In July 2013, Web brokers began signing agreements with CMS. By late 2013, CMS had entered into agreements with 30 Web brokers. The “double redirect” technology used to connect the FFM with Web brokers and carriers for direct enrollment, however, proved difficult to use without assistance during the enrollment process. Because consumers were
redirected from the Web broker’s site to the FFM for eligibility
determination, then back to the Web broker’s site to shop and choose a
QHP, there were many opportunities for delays and disruptions. Web
brokers estimate that relatively little of this traffic succeeded in achieving
electronic enrollment. Most Web brokers did not rely on the automated
enrollment process, preferring to provide telephone assistance to
customers.

CMS has considered a set of Web services that would be built on top of
the double redirect process and provide a seamless enrollment
experience for consumers enrolling through Web brokers. The new
services, which are referred to as the Eligibility Verification as a Service
(EVaS) application program interface (API), would be an enhancement to
the direct enrollment capacities, improving consumers’ experiences and
their ability to connect electronically to the FFM. The new services are
targeted to be developed and tested in time for the 2017 enrollment
process.

State Options for Working with Web Brokers

There are two potential models for how SBMs can work with Web brokers:

- **Open competition.** The Marketplace contracts with all web-based
etities that meet basic consumer protection and operational
performance standards.

- **Managed contracting.** The Marketplace contracts selectively and/or
in special partnerships with one or more Web brokers to achieve
specific goals.

The case for open competition started with optimizing consumer choice
and maximizing enrollment. Consumer buying habits vary, so offering
people as many ways as possible to shop for coverage options will make
it easier for them to enroll. Public Marketplaces will have strong appeal to
certain types of consumers, but private Web brokers will appeal to others.
In addition, private Web brokers may be able to experiment with
consumer shopping enhancements in ways that public agencies find
more difficult. In essence, open competition boils down to giving those
that qualify for subsidized coverage the same access to multiple
distribution channels as all other consumers.

The case for managed competition started with the fact that SBMs offer a
unique benefit—Advanced Premium Tax Credits (APTCs). Therefore,
SBMs are in a position to select and partner with Web brokers who are
most aligned with their objectives. Some SBMs may find that selective
contracting offers more value than offering a “vanilla” contract to all Web
brokers that meet minimum standards of consumer protections and
interoperability.

Moreover, public Marketplaces and Web brokers “compete” for
unsubsidized enrollees. The substantial value that public Marketplaces
offer Web brokers suggests that they should bargain for significant
marketing commitments. For example, an SBM might structure a bid
process in which Web brokers propose marketing resources aimed at
tough-to-reach segments.

Now that they have open enrollment experience, SBMs are in a better
position to set longer-term objectives, perhaps using different goals to
suggest different approaches to Web brokers:

- To learn from as many different Web brokers as possible to reach
enrollees, attract as much enrollment as possible and avoid any
suspicion of favoritism. This objective suggests the value of casting a
wide net for Web brokers.

- To leverage tax credits, brand awareness and a wide range of
participating issuers to make the Marketplace the primary destination
for all individual payers, whether subsidized or not. This objective
suggests favoring Web brokers that agree to place subsidized and
non-subsidized individual business through the Marketplace.

- To target for special outreach efforts, particularly linguistic,
professional or demographic groups (e.g., Hispanics, Native
Americans, entrepreneurs). This objective suggests partnering with
selected Web brokers—for example, matching the Web broker’s
spend for targeted advertising and community events.

- To help bridge discontinuities and different rules between Medicaid
and QHPs for the lower-income applicants who may turn out to be
eligible for Medicaid. This objective suggests partnerships with
While Marketplaces may initially gravitate toward one strategy, both
Marketplace needs and Web broker capabilities will evolve over time.
Therefore, Marketplace strategies should evolve as well. For example, a
Marketplace may initially want to learn from as many Web brokers as
possible so may follow the open competition model. Over time the same
Marketplace may find a better return from selectively partnering only with
those Web brokers that make a major commitment to promoting the
Marketplace and its priorities.

Compliance Programs: Evolving and Expanding
Compliance Obligations

Author: Robert Hussar, Counsel, Healthcare Industry

As the web of healthcare providers and entities becomes even more
entangled, so too are compliance-related obligations, interactions and
relationships. The advent of federal and state Accountable Care
Organizations (ACOs), the expansion of Medicare and Medicaid
managed care plans, and the implementation of other state Medicaid
redesign initiatives, including Delivery System Reform Incentive Payment
(DSRIP) programs, are dramatically expanding the breadth, scope and
magnitude of compliance programs. In this article, we highlight the
increased compliance obligations of providers who partner in
collaborative arrangements, with a particular focus on DSRIP compliance
considerations.

The Eight Elements of New York’s Mandatory Compliance
Requirements

States across the country are defining more specific and stringent
regulations around compliance. New joint ventures and initiatives (such
as ACOs, Medicaid managed care expansion and DSRIP) require new
and different compliance approaches.

For this article, we’ll examine New York as one example of how state
compliance programs are evolving—and the kinds of requirements that
need to be kept in mind during execution. Although regulators have
stopped short of requiring Performing Provider System (PPS) leads to
assume the compliance responsibilities of their partners or participants,
there is a clear expectation that the PPS leads should monitor the actions
and compliance efforts of the providers in their networks.

PPS leads must determine how to fulfill their more expansive role without
confusing their employers or partners, duplicating efforts or expanding
their potential liability. They must figure out how to integrate new
requirements with existing compliance efforts, as well as execute them
across all partners and participants.

To implement the new oversight expectations effectively in New York,
PPS leads need to understand and consider all eight elements of the
state’s mandatory compliance requirements:

1. Policies and Procedures

The compliance requirements state that policies and procedures must:

   - Address issues unique to DSRIP funds and processes,

   - Distinguish between policies with provider-specific versus PPS-wide
     applicability,

   - Be easily accessible and regularly updated and maintained,
2. Compliance Officers/Compliance Committees

Recently released guidance emphasizes an established requirement that compliance officers be employees of the Medicaid provider, in this case the PPS lead or one of its wholly owned subsidiaries. The required reporting structure ensures both independence and access to leadership.

New York also addresses compliance committee membership, laying out the composition and participation requirements for both formal and informal groups. Committees must include representatives from across the network’s various affiliates, partners and participants. They also must collect and review data showing measurable evidence that the program is effective.

3. Open Lines of Communication

To meet requirements, compliance programs must have communications initiatives in place that:

- Notify individuals throughout the network of existing hotlines for reporting potential issues and problems.
- Explain which hotline or entity to contact for guidance on specific issues.
- Support the appropriate sharing of information among partners and participants to ensure that all relevant parties are fully informed of emerging issues and prepared to respond in a timely manner.

4. Education

The requirements detail the educational programs needed to support compliance. PPS leads must develop training programs to ensure staff at all partner and participating entities are knowledgeable about compliance regulations, as well as their responsibilities in ensuring those regulations are strictly followed. While the PPS need not train all partners and participants itself, it must have processes in place to confirm training was provided at each performing provider. The programs must include content specific to DSRIP policies and risks and should be developed centrally and compatible across entities to ensure consistency of content while avoiding duplication of efforts.

5. Discipline

Discipline becomes more complicated and potentially politically sensitive as regulations broaden to include requirements for nonemployees and business associates. The most important considerations in any discipline plan are that it encourages good faith participation in the compliance program by all performing providers and is applied consistently.

6. Risk assessment and auditing

Traditionally, risk assessment has focused on four issues: medical necessity, documentation, coding and billing. PPS leads responsible for compliance oversight must also now have processes in place for meticulously and continually evaluating:

- Adherence to the implementation plan;
- The distribution, use and accounting of funds; and
- The completeness and accuracy of quality, cost and other data that may need to be aggregated and delivered to the Centers for Medicare & Medicaid Services (CMS) or the state.

7. Corrective Action

PPS leads are responsible for ensuring that effective corrective action is swiftly implemented for any identified issues. Their required role also includes communicating the corrective action plan and tracking progress against established goals. The New York requirements detail specifically when and to whom PPS leads are able to delegate any of these duties to others in their organizations.

8. Nonintimidation and Nonretaliation

Clearly communicate all rules, requirements and processes, and include language in any existing compliance plan that expands current compliance requirements and initiatives to DSRIP.
PPS leads implement and enforce a policy of nonintimidation and nonretaliation. PPS leads should monitor all disciplinary actions to ensure they can’t be perceived as retaliatory. They also need to ensure that disciplinary actions are being applied equally across the entire PPS.

Looking Ahead

Beyond traditional fee-for-service compliance self-monitoring initiatives, future processes will incorporate oversight procedures that managed care organizations and ACOs have utilized to monitor their downstream entities and participants, respectively. The scope and frequency of communications, adherence to the implementation plan, distribution and appropriate utilization of funding, and accuracy of reporting by partners and participants all will take on increasing significance—and ultimately comprise the central focus of monitoring efforts. Moving forward, oversight likely will consist of some combination of contractual obligations, auditing/monitoring and attestations of compliance. The PPS leads' annual Office of Medicaid Inspector General (OMIG) Compliance Certification will be expanded to encompass activities not only of certifying providers but also of their partners and participants.

Until recently, it would have been hard to imagine that a compliance officer would look back fondly on the good old days of a simpler, perhaps stand-alone compliance program that operated within, and focused on, the operations and risks of a single healthcare entity. The changes highlighted above are significant and can be reasonably expected to have a profound impact not only on compliance officers and their departments but also on the daily operations of providers.

As integration continues, inevitably the reach and complexity of compliance programs will expand exponentially. Payers and providers will be well-served to strategize on how best to coordinate and integrate their plans and programs, not only within their own organizations but also in concert with their participants and partners in an ongoing effort to maximize both efficiencies and effectiveness.

Keeping Personal Health Information Safe: The Importance of Good Data Hygiene

Authors: Deven McGraw, Partner, Healthcare Industry | David Blumenthal, M.D., President, The Commonwealth Fund

Editor’s Note: In a new article in the Journal of the American Medical Association (JAMA), Manatt partner Deven McGraw teams with Dr. David Blumenthal, president of The Commonwealth Fund and former head of the Office of the National Coordinator for Health IT, to examine the vulnerability of personal health information—and what to do to help make health data safe. Key points are briefly summarized below. Click here to read the full article.

Personal health information (PHI) in the United States is not safe, and it needs to be. A nationwide electronic health information system has the potential not only to improve the care of individuals but also to create major new sources of health data for research and healthcare quality improvement. But if patients have concerns that their digitized PHI will be compromised, they will resist sharing it via electronic means, reducing its value in their own care and its availability for research and performance measurement. They also may withhold information about sensitive issues, such as mental health or substance abuse—which surveys suggest already may be happening.

What Should Be Done to Improve PHI Safety?

Part of the responsibility for PHI security lies with clinicians, healthcare organizations and insurers—the primary custodians of health data. Although malicious hacking gets the bulk of media attention, more than 80% of data breaches result from the failure of these entities to observe good data hygiene by implementing basic precautions, such as:

- Encrypting health data;
- Prohibiting the storage of personal information on employees' personal devices, which are vulnerable to loss and theft; and
- Using sound practices for authenticating authorized users.

Policymakers also bear part of the responsibility to protect patients’
healthcare data. Enacted before the Internet and current electronic methods for recording and transmitting data, the Health Insurance Portability and Accountability Act (HIPAA) is antiquated and inadequate to protect patients’ healthcare privacy and security. For example, the law does not regulate the use of PHI companies, such as Apple, Google, Facebook and Twitter, that are already collecting (intentionally or not) health-related data on patients and could become major custodians of health data in the future.

Beyond the adequacy of HIPAA, the security of the nation’s health information systems is inextricably linked to the ability to fend off cyber threats more generally. National policy on this larger question remains nascent.

Conclusion
The stakes associated with the privacy and security of PHI are huge. Threats to the safety of healthcare data need much more focused attention from both public and private stakeholders.

---

Passage of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): The "Doc Fix"

Author: Annemarie Wouters, Senior Advisor

Editor’s Note: The President has signed into law the bipartisan bill H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which permanently repeals the flawed Sustained Growth Rate (SGR) formula and replaces it with a stable Medicare payment system. In a new report, summarized below, Manatt Health takes a close-up look at this “doc fix” and its key provisions. Click here to download the full report.

MACRA introduces a Medicare payment system that rewards physicians for providing high-quality, high-value healthcare. Without this new law, physicians would have faced a 21.2 percent decrease in Medicare payment rates scheduled to take effect on April 1, 2015.

MACRA replaces the SGR formula with positive rate increases for 4.5 years and implements a long-term Medicare value-based payment approach that harmonizes the features of the Physician Quality Reporting System (PQRS), Meaningful Use (MU), and the Value-Based Payment Modifier (VBM). It also incentivizes physicians to participate in Alternative Payment Models (APMs). Additionally, the law includes provisions to continue several other policies that, unless extended, would expire soon (often referred to as extenders).

The new law goes into effect immediately to address Medicare payment rates to physicians for services rendered April 1, 2015.

Key Provisions of the “Doc Fix”
The following describes the main provisions of the new law.

Permanent SGR repeal: The SGR formula is permanently repealed, averting the 21.2 percent cut scheduled to take effect April 1, 2015, and any future SGR adjustments.

Long-term schedule of updates: From January 2015 through June 2015, physicians will see a zero percent update. For the next 4.5 years, from July 2015 through 2019, physicians will be guaranteed a 0.5 percent update. From January 2020 through 2025, the law includes a zero percent update, i.e., the rates will remain at the 2019 level, but providers will be subject to adjustments. For 2026 and beyond, the update will be 0.75 percent for eligible APM participants and 0.25 percent for all others.

The Merit-based Incentive Payment System (MIPS) quality program: The PQRS, MU, and VBM programs continue as currently designed from 2015 through 2018. Starting in 2019, the law sunsets these programs and incorporates elements of them in the MIPS. MIPS-eligible professionals are evaluated using a composite score that results in positive or negative performance adjustments (budget neutral in aggregate). The composite score includes four factors: quality, resource use, meaningful use, and clinical practice improvement activities.

The Secretary of the Department of Health and Human Services (HHS) will establish an annual list of quality measures from which MIPS-eligible professionals may choose for purposes of assessment. The Secretary
also will establish performance standards that consider historical performance, improvement and the opportunity for continued improvement.

MIPS-eligible professionals include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and other groups of healthcare professionals. The MIPS includes both bonuses and penalties that are calculated using a sliding scale based on being above or below performance thresholds.

The Government Accountability Office (GAO) is to perform an evaluation of the MIPS program (not later than October 2021), examine alignment of quality measures used in public and private programs (not later than 18 months after enactment of the law), and conduct a study on whether entities that pool financial risk for physician entities can play a role in supporting physician practices that participate in two-sided risk payment models. The study is to examine all practices, but especially small physician practices, and must be conducted not later than January 1, 2017.

Incentives for physician participation in Alternative Payment Models: The law provides incentives for physicians to participate in ongoing and future new payment models such as accountable care organizations (ACOs), patient-centered medical homes, and initiatives under Section 1115 waivers. Qualifying participants will receive annual bonuses of 5 percent for services in 2019-2024 and not be subject to MIPS requirements. The provision also establishes a Technical Advisory Committee to review and recommend physician-developed APMs based on criteria developed through an open comment process. Not later than July 2016, the Secretary is to submit to Congress a study that examines the feasibility of integrating APMs in the Medicare Advantage payment system.

Establishment of Physician-Focused Payment Model Technical Advisory Committee: The law establishes an 11-member committee that will meet to provide comments and recommendations to the Secretary on physician-focused payment models. No later than November 1, 2016, the Secretary shall establish criteria for physician-focused payment models that the committee can use for making comments and recommendations.

Medicare Payment Advisory Commission (MedPAC) reports on utilization of and expenditures on physician services: MedPAC is to deliver several reports from 2017 to 2021, including one that examines the relationship between physician utilization and expenditures (including rates of increase) and utilization and expenditures in Parts A, B, and D (including rates of increase).

Development of care episode groups, patient condition groups, and classification code systems: To support both MIPS and APMs, the law calls for the development of healthcare episodes groups, patient condition groups and classification codes. These groups will include resources from Medicare Parts A and B, and possibly Part D (per Secretary’s determination).

Funding for quality and resource use measure development, and technical assistance to small practices: The law appropriates $15 million per year, from 2015 to 2019, for quality measure development. It also appropriates $20 million per year from 2016 through 2020 to assist practices of up to 15 professionals to participate in the MIPS or transition to new payment models.

Interoperability of electronic health records by 2018 year-end: The law sets a goal of interoperability of EHR systems by December 31, 2018.

Care management for patients with chronic care needs: The law establishes payment for chronic care management when performed by a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife.

Medical malpractice liability: Quality program standards of PQRS, MU and others cannot be used as a “standard of care” in medical liability actions.

Public information on physician services: Physician utilization and payment data, including data from Physician Compare, will be publicly released on an annual basis. Qualified entities will have broader authority to sell and provide nonpublic reports with explicit protections.

Reports on physician-hospital gainsharing and telemedicine: The law requires the Department of Health and Human Services (HHS) to make
recommendations on amending existing fraud and abuse laws to permit
gainsharing or similar arrangements between physicians and hospitals. It
also requires a report from the GAO on barriers to telemedicine and
remote patient monitoring.

Electronic Health Records interoperability: In the law, Congress
declares that a national objective will be to achieve the widespread
exchange of health information by December 31, 2018.

Highlights of Medicare and Other Extenders

The law includes provisions to temporarily continue ten Medicare provider
payment provisions that, unless extended, would expire soon. For
example, the law extends funding for the National Quality Forum to
review, endorse and maintain quality and resource use measures through
2017.

Eleven other extenders are included as part of the law. Among these are
two that will be permanently extended:

1. The Qualifying Individual Program, a program that assists Medicare
beneficiaries with incomes between 120 percent and 135 percent of
poverty in covering the cost of their Medicare Part B premiums, and

2. The Transitional Medical Assistance program (TMA), a program
that allows low-income families to maintain their Medicaid coverage
for up to one year as they transition from welfare to work.

Extension of the Children’s Health Insurance Program (CHIP)

The law gives a two-year extension to CHIP—a program that covers more
than 8 million children and pregnant women in families that earn income
above the Medicaid eligibility levels. While CHIP is authorized through
2019, no new funding is available after FY 2015. This provision preserves
CHIP funding through FY 2017 and also extends related services, such as
Express Lane Eligibility.

Key Provisions of Offsets

The law waives pay-as-you-go procedures that would otherwise apply. It
includes the following offsets, which address some, but not all, of the
estimated outlays.

Eliminates Medigap first-dollar coverage: Beginning in 2020, new
Medigap plans will limit coverage to costs above the amount of the Part B
deductible (currently $147 per year).

Adds income-related premium adjustment for Parts B and D:
Beginning in 2018, this policy will increase the percentage that Medicare
beneficiaries with modified adjusted gross income between $133,501 and
$160,000 ($267,001-$320,000 for a couple) will pay from 50 percent to 65
percent. Beneficiaries that earn $160,001 and above ($320,001 and
above for a couple) will pay 80 percent.

Post-acute provider market basket updates: Medicare payments to
skilled nursing facilities, inpatient rehabilitation facilities, home health
agencies, hospices, and long-term care hospitals will be limited to
increases of no more than 1.0 percent in FY 2018.

Medicaid Disproportionate Share (DSH) cuts: The new law will increase
net state allotments in 2017 through 2020 and decrease net allotments in
2021 through 2025.

Phased adjustment to inpatient hospital payment rates: Instead of
receiving a single-year 3.2-percentage-point increase in FY 2018,
inpatient hospitals paid under Medicare’s Inpatient Prospective Payment
System will see the increase phased in over six years (0.5 percent per
year) beginning in FY 2018.

Levy on Medicare providers for nonpayment of taxes: This provision
increases the levy from 30 percent to 100 percent against Medicare
service providers with tax delinquencies.

Conclusion

This bipartisan agreement ends the cycle of annual short-term fixes,
which have occurred 17 times since 2001. The law fully repeals the SGR
formula and replaces it with a gradual evolution to a new value-based
physician payment system. It also extends several Medicare and other
policies that would have expired without congressional intervention.

Click here, and Enter Promo Code LGAEXT100 to Register Free. Join Us on April 29 from 1:00 – 2:30 p.m. ET, and Earn CLE Credit.

For a generation more likely to seek health information online than see a doctor, social media is playing an increasingly critical role in healthcare decisions. Today, more than 40% of consumers say that the information they read in social media affects how they deal with their health—and two-thirds of doctors use social media for professional purposes.

With statistics like these, it’s not surprising that a growing number of healthcare entities are incorporating social media into their communication plans. But how can you effectively harness social media’s power to reach and influence your target audiences? And how can you be sure you minimize the risks that often accompany an active social media presence?

In a new webinar for Bloomberg BNA, “Best Practices for Using Social Media in Healthcare,” Manatt answers those crucial questions. First, we will present emerging approaches to inform, engage and motivate patients and physicians. Then, we will take a detailed look at execution risks—both generally and specific to healthcare—and provide clear, actionable strategies for safeguarding your organization. During the session, you will:

- Explore how patients and providers are using social media in healthcare—and the role it plays in healthcare decisions.
- Discover the most effective social media techniques within healthcare for both consumer and professional audiences.
- Benefit from the cross-fertilization of ideas, learning how innovations from other sectors can be adapted to healthcare.
- Examine the issues around the Health Insurance Portability and Accountability Act (HIPAA)—and ensure your social media programs are in compliance.
- Find out how you can avoid liability for content posted by others.
- Learn the regulatory requirements around endorsements/testimonials, hashtags, re-tweeting of third-party content and other key challenges—and be prepared to meet them.

Don’t miss this chance to examine the full gamut of issues—from ensuring privacy to avoiding liability—and understand how to run a high-impact social media campaign without putting your organization in legal jeopardy. Even if you can’t make the April 29 date, register now, and we’ll send you a link to view the program on demand.

Presenters: Jon Glaudemans, Managing Director | Linda Goldstein, Partner and Chair, Advertising, Marketing and Media Division

NOTE: CLE credit is available for this program.

1Source: Mediabistro

2Source: EMR Thoughts