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MEDICARE: THE PERPETUAL BALANCE BETWEEN PERFORMANCE AND PRESERVATION

*Craig B. Garner**

“Confusion is a word we have invented for an order which is not understood.”¹

Passed by Congress and signed by President Lyndon Johnson into law in 1965, Medicare² has weathered storms from all directions, growing to be the preeminent standard for health insurance in the United States.³ The idea of losing Medicare as a vital public benefit still remains the single greatest fear with which each passing generation of Americans must contend, and yet, these challenges over the past fifty years, designed to fortify Medicare’s foundation and ensure its longevity, continue to take a toll on the program.⁴

The most recent climate of reform includes changes implemented by the Patient Protection and Affordable Care Act (“PPACA”).⁵ The PPACA is designed to expand coverage for a broader group of people, yet it adds unprecedented layers of complexity such that it may be but a matter of time before the confusion experienced by today’s providers proves to be

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1. HENRY MILLER, *TROPIC OF CAPRICORN* 176 (Grove Press, Inc. 1961).

2. Originally Title 18 of the Social Security Act.

3. See, e.g., MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 30 (Mar. 2014), available at http://medpac.gov/documents/Mar14_EntireReport.pdf (“Because of its size and because other payers use its payment methods, Medicare has an important influence on the nation’s health care delivery system and its evolution.”). The Medicare Payment Advisory Commission (“MedPAC”) is an independent congressional agency established by the Balanced Budget Act of 1997, Pub. L. No. 105-33 (codified at 42 U.S.C. § 1395b-6).

4. *Seniors Fear Hit to Medicare*, WASH. TIMES, Apr. 1, 2010, <http://www.washingtontimes.com/news/2010/apr/01/seniors-worry-health-care-law-will-hurt-them/>.

5. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

Medicare's undoing altogether. The decades of trial and error upon which health care in the United States have been built, at least from the point of view of both physicians and lawmakers who watch from the sidelines, may give way to confusion and disruption industry-wide as a result of newly enacted regulations.⁶

Today, Medicare is the preeminent standard for health insurance in the United States, expanding despite fluctuations in the economic, political and social climate since its initial passage. However, in its struggle toward sustainability, the Medicare Program must understand the resulting consequences as it distances itself further and further from its original simplicity in 1965.⁷

Medicare's original cost-based system gave way in the 1980s to the Prospective Payment System ("PPS"),⁸ an event noted by many with great concern.⁹ Under PPACA, the Medicare system takes another monumental step as it incorporates elements of performance into the PPS.¹⁰ Formulaic and confusing, Medicare's recent approach to provider reimbursement has been likened to *Finnegan's Wake* by James Joyce,¹¹ a book that some critics

6. Compare Herrymon Mauer, *The M.D.'s Are Off Their Pedestal*, FORTUNE MAG. 138, Feb. 1954, with Kevin Vachon, *Confused and Disengaged About Health Care*, PORTLAND DAILY SUN (May 15, 2013, 4:04 PM), <http://www.portlanddailysun.me/index.php/opinion/columns/9355-confused-and-disengaged-about-health-care>.

7. In Medicare's early years, "unrestricted cost reimbursement became the modus operandi for financial American medical care." Rick Mayes, *The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System*, 62 J. HIST. MED. & ALLIED SCI. 21, 24 (2007). According to Sheila Burke, Chief of Staff of Former Senator Robert Dole: "Medicare's traditional model of cost reimbursement was insanity. On the face of it, it encouraged people to do more; it *paid* them to do more and not in any particularly rational way." *Id.* at 22 (emphasis in original).

8. First, the Tax Equity and Fiscal Responsibility Act ("TEFRA") directed the Secretary of Health and Human Services to develop a proposal for legislation that would provide for reimbursement "on a prospective basis." Pub. L. No. 97-248, § 101(c), 96 Stat. 324, 335 (1982). The following year, Congress created the "Prospective Payment System" ("PPS"), which hospitals first became subject to on October 1, 1983, and was phased in over a period of four years. *Alvarado Cnty. Hosp. v. Shalala*, 155 F.3d 1115, 1119 (9th Cir. 1998) (citing 42 U.S.C. § 1395ww(d)(1)(A)(i) (2012)).

9. See, e.g., Ross Mullner & David McNeil, *Rural and Urban Hospital Closures: A Comparison*, 56 HEALTH AFFAIRS 131 (1986).

10. See, e.g., Matthew J. Press, *Limits of Readmission Rates in Measuring Hospital Quality Suggest the Need for Added Metrics*, 6 HEALTH AFFAIRS 1083 (June 2013).

11. See, e.g., *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 841 F. Supp. 2d 270, 270, 270 n.1 (D.D.C. 2012), *rev'd by* 718 F.3d 914 (D.C. Cir. 2013) (comparing James Joyce's *Finnegan's Wake* to the Medicare statute, and calling it "among the most completely impenetrable texts within human experience.") (quoting Rehab. Assn' of Va. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994)).

warn requires “skeleton keys” to understand.¹² In many ways, the need for hospitals and physicians to understand these performance-based measures may seem less important when fear of Medicare insolvency looms in the distance,¹³ especially as it relates to Medicare Part A (hospital insurance benefits for inpatient services) and Medicare Part B (supplemental insurance for outpatient services, among other things).¹⁴ Irrespective of the fleeting grasp providers may have over PPACA’s new Medicare system, hospitals and physicians alike are mindful that the PPS as they once knew it is gone, replaced in part with the beginnings of a performance-based Medicare in which they may lose precious revenue, one percentage point at a time.¹⁵

I. MEDICARE’S MODERN DAY STRUGGLE TO SUSTAIN GUARANTEED HEALTH INSURANCE

In its initial form, Part A of the Medicare Act provided coverage for inpatient hospital costs and other similar expenses to all persons 65 years of age or older who could satisfy the legal residency requirements.¹⁶ Part B, on the other hand, created a voluntary program for qualifying low-income

12. See, e.g., ELOISE KNOWLTON, JOYCE, JOYCEANS, AND THE RHETORIC OF CITATION 3 (The University Press of Florida 1998). One example from *Finnegan’s Wake* is the word “bababadalgharaghtakamminarronkonnbronntonnerronntuonnthunntrovarrhouna wnskawntooohooorderenthurnuk!,” JAMES JOYCE, *FINNEGAN’S WAKE* 3 (The Viking Press 1939), which critics note may mark the downfall of Adam and Eve. See Michael Chabon, *What to Make of Finnegan’s Wake?* N.Y. REV. OF BOOKS, July 12, 2012, <http://www.nybooks.com/articles/archives/2012/jul/12/what-make-finnegans-wake/?pagination=false>.

13. See, e.g., MEDICARE PAYMENT ADVISORY COMM’N, A DATA BOOK: HEALTH CARE SPENDING & THE MEDICARE PROGRAM 8 (June 2012), <http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf> (“Beginning in 2010, the aging of the baby-boom generation, an expected increase in life expectancy, and the Medicare drug benefit are likely to increase the proportion of economic resources devoted to Medicare.”).

14. See, e.g., *Abraham Lincoln Mem’l Hosp. v. Sebelius*, 698 F.3d 536, 541 (7th Cir. 2012).

15. See, e.g., *id.*

16. See, e.g., *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 506 (1994) (“Medicare is a federally funded health insurance program for the elderly and disabled.”). Originally Title 18 of the Social Security Act, as amended by Pub. L. No. 89-97, 79 Stat. 286 (1965). When President Lyndon B. Johnson signed Medicare into law on July 30, 1965, he credited Harry S. Truman as the one who “planted the seeds of compassion and duty” that resulted in Medicare. President Lyndon B. Johnson, Remarks at the Signing of the Medicare Bill (July 30, 1965) [hereinafter Johnson, Remarks at Signing], available at <http://www.trumanlibrary.org/anniversaries/medicarebill.htm>.

individuals to insure against costs from physician and other specific outpatient services and supplies.¹⁷

After signing this historic act into law, President Johnson commented:

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.¹⁸

The foundational coverage provided by Medicare's Part A includes ninety consecutive days (known as a "Benefit Period"), subject to certain deductibles and obligations.¹⁹ Although there is no limit on the number of Benefit Periods to which a Medicare beneficiary is entitled, as a general rule there must be sixty consecutive days *between* any two Benefit Periods, where the beneficiary does not receive any inpatient hospital or other qualifying care under Medicare.²⁰

A. Negation, Disjunction, and Conjunction

With its nearly fifty-year history, Medicare's evolution has been surprisingly marginal in comparison to other public programs, while still serving the health insurance needs for those sixty-five years of age or older.²¹ Perhaps the most significant change occurred in the 1980s under the

17. See Title 42, Ch. 7 (Social Security), Subchapter XIX (Grants to States for Medical Assistance Program).

18. Johnson, Remarks at Signing, (Jul. 30, 1965), *supra* note 16.

19. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT [hereinafter "CMS MANUAL"], Ch. 3, §§ 10.4, 10.4.1, 10.4.2, 10.4.3, 10.4.3.1, 10.4.4. (Nov. 15, 2013), <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf>.

20. *Id.* at Ch. 3, § 10.4.2.

21. See, e.g., Pub. L. No. 92-603, 86 Stat. 1329 (1972) (expanding Medicare eligibility to people under the age of 65 with certain long-term disabilities as well as those with kidney disease); Health Maintenance Organization Act, Pub. L. No. 93-222, 87 Stat. 914 (1973) (creating a partnership of sorts between the Federal Government and certain health care providers as they eased Medicare's increasing burden); Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, 100 Stat. 82 (1986) (codified at 42 U.S.C. § 1395dd) (requiring hospitals that receive federal funding to treat any patient with an emergency condition in such a way that, upon the patient's release,

Reagan administration with the introduction of the PPS and Diagnosis-Related Groups (“DRGs”).²² Restructuring the Medicare system by reimbursing hospitals “at a fixed amount for each patient discharged regardless of the costs incurred by the hospital,”²³ DRGs to this day remain at the center of the Medicare system.²⁴

The changes recently introduced by PPACA reach Medicare’s core, although implementation has just begun and will continue for decades to come.²⁵ PPS introduced the notion of efficiency to the Medicare system, and with PPACA comes the era of performance.²⁶ With thirty years separating the PPS and PPACA, each reform raised the threat of catastrophic operating losses for hospitals unable to meet the demands to change. DRGs have been generally successful in keeping hospitals within any fiscal objectives, and, as an added benefit, DRGs have also shown their influence in creating a hospital dynamic that forces physicians to align with these new hospital efficiencies, lest the hospital be put in the position of having to exclude physician participation whenever possible.²⁷

Over time, however, DRGs have evolved to such an extent that their current level of complexity may be seen as counterintuitive to their original

“no further deterioration of the condition is likely”); Health Insurance Portability and Accountability Act (“HIPAA”), Pub. L. No. 104-191, 110 Stat. 1936 (1996) (creating a national standard for electronic health care transactions and national identifiers for health insurance plans, providers and employees); Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997) (establishing the “Medicare Advantage” option for beneficiaries sometimes referred to as “Part C” and previously known as “Medicare + Choice”); Medicare Prescription Drug, Improvement and Modernization Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (creating “Part D” and also establishing in part a network of Recovery Audit Contractors (“RACs”) to detect and correct improper payments within Medicare); Deficit Reduction Act, Pub. L. No. 109-171, 120 Stat. 4 (2005) (expanding the RAC program to the state level through a Medicaid Integrity Program); Health Information Technology for Economic and Clinical Health Act (“HITECH”), Pub. L. No. 111-5, 123 Stat. 115 (2009) (protecting patient confidentiality by expanding provider liability under HIPAA).

22. Mark B. McClellan, *Medicare Reimbursement and Hospital Cost Growth*, in *ADVANCES IN THE ECONOMICS OF AGING* 149 (David A. Wise ed. 1996); GAIL R. WILENSKY, *THE ECONOMICS OF DRG-BASED PHYSICIAN REIMBURSEMENT* (Cent. for Health Affairs 1985).

23. *Alvarado Cmty. Hosp.*, 155 F.3d at 1119.

24. *See, e.g.*, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates, 78 Fed. Reg. 50,496 (Aug. 19, 2013).

25. *See, e.g., id.*

26. *See, e.g.*, 42 C.F.R. § 412.160.

27. *See generally* David M. Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 *YALE L. J. ON REG.* 273 (1993).

intent. By 2008, DRGs splintered into Medicare Severity Diagnosis Related Groups (“MS-DRGs”), which focus on patients with similar clinical conditions and correlating fixed reimbursements.²⁸ Moreover, certain MS-DRGs are linked to complications or comorbidities (“CCs”) as well as major complications or comorbidities (“MCCs”), thereby transforming the relatively simple 1982 system of 467 DRGs into a modern day labyrinth that not only includes additional acronymic descriptors introduced in 2008,²⁹ such as the applicable DRG “w/CC,” “w/o CC,” “w/MCC,” and “w/o MCC,” but also a set of 2014 regulations that further define 1,622 MCCs and 3,529 CCs.³⁰ As each variation alters the expected reimbursement, nearly any error in a patient’s hospital bill may result in a false claim, which constitutes a criminal offense under federal law.³¹ At its core, the Federal

28. 42 C.F.R. § 412.4.

29. Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, 72 Fed. Reg. 47,130 (Aug. 22, 2007); *but see* Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates, 74 Fed. Reg. 24,080, 24,092 (May 22, 2009) (“We believe that revisions to the DRG system to better recognize severity of illness and changes to the relative weights based on costs rather than charges are improving the accuracy of payment rates in the IPPS.”).

30. 78 Fed. Reg. 50,496 (Aug. 19, 2013). The proposed regulations for 2015 contain similar DRG numbers. 79 Fed. Reg. 27,978 (May 15, 2014).

31. *See, e.g.*, Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241, 247 (2004) (“The abstract contours of fraud and abuse principles must be translated into practical requirements to which health care providers can adhere—and against which their compliance can be measured.”). The primary body of law under which liability may arise in health care transactions is the Federal False Claims Act (“FCA”). 31 U.S.C. § 3729(a) states:

(1) [A]ny person who— (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G); (D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property; (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true; (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or

False Claims Act (“FCA”) imposes liability on anyone who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.”³²

B. Codifying the Confusion

In its attempt to provide a more solid groundwork for American healthcare, PPACA did what may have been previously considered impossible by making Medicare reimbursements even more complicated, escalating the process to a level where the system of guaranteed health insurance can only be explained through algorithms.³³ Each year the Centers for Medicare & Medicaid Services (“CMS”) publishes updated

property to the Government, is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000 . . . plus 3 times the amount of damages.

32. See 31 U.S.C. § 3729(a)(1)(A). Over the years Congress passed many laws focusing on fraud and abuse, including: Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) (regulating Medicare provider fraud and abuse, as well as over utilization and unnecessary referrals); Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, Pub. L. No. 95-142, 91 Stat. 1175 (1977) (expanding the scope of prohibited conduct under Medicare to include practically any remuneration for a physician from the referral of a Medicare or Medicaid beneficiary); Civil Monetary Penalties Law of 1981, Pub. L. No. 97-35, 95 Stat. 357 (authorizing the federal government to assess fines as well as enforce program exclusions against providers who submit false, fraudulent or otherwise inappropriate claims to Medicare or Medicaid); Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680 (1987) (enlisting the aid of the Office of Inspector General (“OIG”) to regulate inappropriate provider arrangements); Ethics in Patient Referral Act of 1989, Pub. L. No. 101-239, 102 Stat. 2106 (commonly known as the first of three “Stark” laws, Congress passed regulations directed at physician referrals for clinical services to an entity in which the physician has a financial interest); Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993) (Stark II) and the 2007 modifications to Stark II (informally known as Stark III); Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 1617 (2009) (expanding the reverse false claim provision significantly so that it now prohibits “knowingly conceal[ing] or knowingly and improperly avoid[ing] or decreas[ing] an obligation to pay” the United States; see also 31 U.S.C. § 3729(a)(1)(G); Section 6402 PPACA (establishing a new requirement for “Reporting and Returning of Overpayments” within 60 days of identifying the overpayment). Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of Inspector General's Civil Monetary Penalty Rules, 79 Fed. Reg. 27,080 (May 12, 2014) (clarifying the OIG’s civil money penalty authority from the PPACA).

33. See *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 916 (D.C. Cir. 2013) (noting that the statutory language for calculating a hospital’s Medicare disproportionate patient percentage (“DPP”) “is downright byzantine and its meaning not easily discernible”).

regulations for the Medicare Program, and in particular the Inpatient Prospective Payment Systems (“IPPS”) for Acute Care Hospitals. Effective October 1 of each year (the start of the Federal Government’s fiscal year), the IPPS regulations set forth in copious detail what hospitals can expect from the Medicare Program in the forthcoming fiscal year. With the 2014 final rules weighing in at 546 triple-columned pages from the Federal Register,³⁴ these annual updates average about half the size of PPACA itself, and address nearly everything a hospital needs to know about changes to the Medicare program for the following year.³⁵

Some of the more intricate topics include the MS-DRG adjustments,³⁶ the Hospital Value Based Purchasing Program (“VBP”) (for fiscal years 2014 through 2019),³⁷ Hospital Readmissions Reduction Program (“RRP”),³⁸ Hospital-Acquired Conditions (“HAC”) and Healthcare-Associated Infections (“HAI”),³⁹ as well as a total reconfiguration of Medicare Disproportionate Share Hospital (“DSH”) payments.⁴⁰ These regulations continue to cause “dread” for any Medicare enthusiast, “for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.”⁴¹ Indeed, poor

34. 78 Fed. Reg. 50,496 (Aug. 19, 2013). The proposed rules for 2015 are a mere 408 triple-columned pages in comparison. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates, 79 Fed. Reg. 27,979 (May 15, 2014).

35. CMS’s objective is to “transform Medicare from a passive payer of claims to an active purchaser of quality [health care] for its beneficiaries.” Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2,454-2,455 (Jan. 13, 2011).

36. 78 Fed. Reg. at 50,506.

37. *Id.* at 50,677.

38. *Id.* at 50,653.

39. *Id.* at 50,523.

40. *Id.* at 50,613; *see also Catholic Health Initiatives Iowa Corp.*, 718 F.3d at 916.

41. *Rehabilitation Ass’n of Va. v. Kozlowski*, 42 F.3d 1444, 1449 (4th Cir. 1994). An advanced degree in mathematics may also be useful in understanding Medicare. *See, e.g.*, 78 Fed. Reg. at 50,602.

In the FY 2010-based IPPS market basket, NAICS 55 expenses that were subject to allocation based on the home office allocation methodology represent 5.650 percent of the total operating costs. Based on the home office results, we are apportioning 3.503 percentage points of the 5.650 percentage points figure into the labor-related share and designating the remaining 2.147 percentage points as non labor-related. In sum, based on the two allocations mentioned above, we apportioned 4.804 percentage points into the labor-related share. This amount is added to the 0.696 percentage point of

performance in 2014's more complex topics could potentially force a hospital out of business.⁴²

C. The Hospital VBP

Well into its second year, the Hospital VBP Program is nothing short of an epic restructuring of the Medicare Program, as it places performance rather than costs at center stage for determining hospital reimbursements.⁴³ On October 1, 2012, its first day in operation, the Hospital VBP Program reduced hospital reimbursements by one percent across the board, thereby creating a "bonus pool" for those successful in this new program, based upon each individual hospital's Total Performance Score ("TPS").⁴⁴ This initial reduction increases each year, and is presently capped at two percent for 2017.⁴⁵

Calculation of a hospital's TPS includes determining performance in addressing specific clinical conditions or procedures⁴⁶ (seventy percent of the TPS) and patient satisfaction (thirty percent of the TPS).⁴⁷ CMS then "converted each hospital's TPS into a value-based incentive payment

professional fees that we already identified as labor-related, resulting in a professional fees: Labor-related cost weight of 5.500 percent.

42. See e.g., 42 U.S.C. § 1395ww(o)(7)(c)(5)(2013) (Hospital Value Based Purchasing Program, wherein reductions to the base operating DRG for hospitals increases to two percent in 2017); 42 U.S.C. § 1395ww(q)(3)(C)(iii) (2013) (Hospital Readmission Reduction Program, wherein reductions to the base operating DRG for hospitals can increase to as much as three percent in 2015); 42 U.S.C. § 1395ww(p)(1) (2013) (Hospital-Acquired Conditions, which can decrease hospital Medicare revenue by one percent starting in 2015); Lisa Rosenbaum, *The Whole Ball Game—Overcoming the Blind Spots in Health Care Reform*, 368 N. ENGL. J. MED. 959 (2013) ("If we focus on physicians and patients separately, we lose any sense of how their goals match up and whether patients value care that the evidence indicates is necessary."); Karen Kane, *What Does Quality Cost? Analyzing the Patient Protection and Affordable Care Act's Value Based Purchasing Provision and How It Could Affect the Delivery of Care by Hospitals*, 14 DUQ. BUS. L. J. 69, 78-80 (2011); Michelle Nicole Diamond, *Legal Triage for Healthcare Reform*, 43 COLUM. HUM. RTS. L. REV. 255, 272 (2011).

43. See 78 Fed. Reg. at 50,677 (May 10, 2013).

44. 42 U.S.C. § 1395ww(o)(7)(C) (2012).

45. *Id.*

46. See 42 U.S.C. § 1395ww(o)(2)(B)(i)(I) and (for fiscal year 2013) and 42 U.S.C. § 1395ww(o)(2)(B)(ii) (for fiscal year 2014). These quality measures include (1) Acute Myocardial Infarction (two measures); (2) Heart Failure (one measure); (3) Pneumonia (two measures); (4) Healthcare-Associated Infections through the surgical care improvement project (seven measures) which focuses on reducing surgical complications; and (5) in 2015, efficiency measures "include measures of Medicare spending per beneficiary." *Id.*

47. See 78 Fed. Reg. 50,677 (May 10, 2013).

percentage using a linear exchange function [1.8363054116⁴⁸] and then converted the value-based incentive payment percentage into a per discharge value-based incentive payment amount.”⁴⁹ For 2013 and 2014, CMS regulations for the Hospital VBP Program include twelve clinical processes of care measures, eight patient experience of care dimensions (identified from the Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”) survey), and three outcome measures.⁵⁰ In Fiscal Year 2015, Medicare regulations will add two new outcome measures and an efficiency measure that tracks Medicare spending per beneficiary.⁵¹

Familiarizing oneself with these new measures and their descriptions, however, is only the beginning. To fully understand how the Hospital VBP Program will impact a hospital’s reimbursement in 2016, it is imperative to pay careful attention to the achievement threshold and benchmark figures, which do not include the numerical values that result when the performance standards are calculated. The 2016 finalized performance standards for outcome domain measures, with achievement thresholds and benchmarks, include:

| Measure ID | Measure Description | Achm’t⁵² | Benchmark⁵³ |
|----------------------|---|----------------------------|-------------------------------|
| (Percentages) | | | |
| MORT-30-AMI | Acute Myocardial Infarction (AMI) 30-day mortality rate | 0.847472 | 0.862371 |
| MORT-30-HF | Heart Failure (HF) | 0.881510 | 0.900315 |

48. See 78 Fed. Reg. 61,197, 61,200 (Oct. 3, 2013) (correcting the original number published in the Federal Register on August 19, 2013 (1.8363321306) to read “1.8363054116”).

49. See 78 Fed. Reg. 50,496 (Aug. 19, 2013).

50. See *id.* To summarize, the 2014 Hospital VBP Program quality measures include: (1) Acute Myocardial Infarction (two measures); (2) Heart Failure (one measure); (3) Pneumonia (two measures); (4) Healthcare-Associated Infections through the surgical care improvement project (seven measures), which focuses on reducing surgical complications; and (5) Patient experience of care dimensions. *Id.*

51. See *id.* In 2016, Medicare will again add new measures to the Hospital VBP Program. *Id.*

52. The achievement threshold means the median (fiftieth percentile) of hospital performance on a core measure during a baseline period for a particular fiscal year.

53. The benchmark means the arithmetic mean of the top decile of hospital performance on a measure during a baseline period for a particular fiscal year. 42 C.F.R. § 412.160.

30-day mortality rate

| | | | |
|------------|---|----------|----------|
| MORT-30-PN | Pneumonia (PN) 30-day mortality rate | 0.882651 | 0.904181 |
| PSI-90 | Complication/patient safety for selected indicators (composite) | 0.622879 | 0.451792 |

The finalized clinical process of care, outcome and efficiency domain measures for 2016, for example, include:

| Measure ID | Measure Description | Achm't | Benchmark |
|----------------------|---|---------------|------------------|
| (Percentages) | | | |
| IMM-2 | Influenza Immunization | 0.90607 | 0.98875 |
| PN-6 | Initial Antibiotic Selection For CAP in Immuno-Competent Patient | 0.96552 | 1.00000 |
| SCIP-Inf-2 | Prophylactic Antibiotic Selection for Surgical Patients | 0.99074 | 1.00000 |
| SCIP-Inf-3 | Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time | 0.98086 | 1.00000 |
| SCIP-Inf-9 | Urinary Catheter Removed On Postoperative Day 1 or Postoperative Day 2 | 0.97059 | 1.00000 |
| SCIP-Card-2 | Surgery Patients on Beta- Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative | 0.97727 | 1.00000 |

| | Period | | |
|------------|---|----------------|----------------|
| SCIP-VTE-2 | Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery | 0.98225 | 1.00000 |
| CAUTI | Catheter-Associated Urinary Tract Infection | 0.801 | 0.000 |
| CLABSI | Central Line-Associated Blood Stream Infection | 0.465 | 0.000 |
| SSI | Surgical Site Infection | | |
| | <ul style="list-style-type: none"> • Colon • Abdominal Hysterectomy | 0.668 0.752 | 0.000 0.000 |

| HCAHPS Survey Dimension | Floor | Achm't | Benchmark (Percentages) |
|----------------------------------|--------------|---------------|------------------------------------|
| Communication with Nurses | 53.99 | 77.67 | 86.07 |
| Communication with Doctors | 57.01 | 80.40 | 88.56 |
| Responsiveness of Hospital Staff | 38.21 | 64.71 | 79.76 |
| Pain Management | 48.96 | 70.18 | 78.16 |
| Communication About Medicines | 34.61 | 62.33 | 72.77 |
| Hospital Cleanliness & Quietness | 43.08 | 64.95 | 79.10 |
| Discharge Information | 61.36 | 84.70 | 90.39 |
| Overall Rating of Hospital | 34.95 | 69.32 | 83.97 |

Although the 2014 Regulations provide examples that extend through 2019, the information set forth above is consistent with the CMS approach that “is well understood by patient advocates, hospitals, and other stakeholders because it was developed during a lengthy process that involved extensive stakeholder input, and was based on a scoring methodology [CMS] presented in a report to Congress.”⁵⁴

D. Hospital RRP

The Hospital RRP penalizes hospitals for certain excess readmissions, including acute myocardial infarction, heart failure and pneumonia.⁵⁵ Starting in October 2014, while Medicare will exclude planned readmissions, the total amount for which a hospital may be penalized increases to two percent (up from one percent in 2013).⁵⁶ Moreover, in 2015 Medicare will introduce four new measures for inclusion in the Hospital RRP: (1) coronary artery bypass grafts (“CABG”) surgery; (2) chronic obstructive pulmonary disease (“COPD”); (3) percutaneous coronary intervention (“PCI”); and (4) other vascular conditions.⁵⁷

For 2014, the formula employed by CMS to calculate the readmissions penalty, or readmission adjustment factor, is:

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmission Ratio for AMI-1)] + [sum of base operating DRG payments for HF x (Excess Readmission Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmission Ratio for PN-1)] + [sum of base operating DRG payments for COPD x (excess readmission ratio for COPD-1)] + [sum of base operating payments for THA/TKA x (excess readmission ratio for THA/TKA -1)].

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges.

Ratio = $1 - \frac{\text{Aggregate payments for excess readmissions}}{\text{Aggregate payments for all discharges}}$ ⁵⁸

54. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates, 78 Fed. Reg. 27,486, 27,616-17 (May 10, 2013) (Interim Rule).

55. 42 U.S.C. § 1395ww(q) (2012).

56. *Id.* at § 1395ww(q)(3)(C).

57. 78 Fed. Reg. at 50,653. The regulations for 2015 may also include Total Hip Arthroplasty (“THA”) and Total Knee Arthroplasty (“TKA”). 79 Fed. Reg. at 27,988.

58. *Id.* See also *Readmissions Reduction Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service->

The Readmission Adjustment Factor for 2014 is the higher of the ratio or 0.9800, all of which is based on claims data from July 1, 2009 to June 30, 2012.⁵⁹ In response to the RRP, hospitals have focused considerable attention toward discharge and post-discharge care, in some instances informally extending a hospital stay beyond its clinical conclusion,⁶⁰ or at other times not admitting a return patient for “inpatient” status but rather keeping the patient in “observation.”⁶¹ Because the program targets elderly hospital patients, the debate over the RRP’s value continues.⁶²

E. Medicare DSH

Starting in Fiscal Year 2014, hospitals that usually receive Medicare DSH payments will receive these monies in two separate payments: (1) Twenty-five percent of the amount the hospital previously received under Medicare DSH, and (2) “an additional payment for the DSH hospital’s proportion of uncompensated care, determined as the product of three factors.”⁶³ These three factors, which now make up seventy-five percent of the Medicare DSH funds to which a hospital may be entitled, include:

- (1) 75% payment of the payments that would otherwise be made [under the old DSH methodology]
- (2) 1 minus the percentage change in the percent of individuals under the age of 65 who are uninsured (minus 0.1 percentage points for FY 2014, and minus 0.2 percentage points for FY 2015 through FY 2017); and
- (3) a hospital’s uncompensated care amount relative to the uncompensated care amounts of all DSH hospitals expressed as a percentage.⁶⁴

II. MAKING SENSE OF THE FUTURE

The projected efficiency with which Medicare will operate under the 2014 regulations serves as a basis to justify the nature and complexity of PPACA’s newfound annual regulations. Even those programs designed to reallocate Medicare funding to hospitals operating at higher levels of

Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html (last visited July 9, 2014).

59. 42 U.S.C. § 1395ww(q).

60. See 42 C.F.R. § 419.22(n) (defines services that support an inpatient admission and Part A as appropriate, notwithstanding the length of stay).

61. See OFFICE OF THE INSPECTOR GEN., HOSPITALS’ USE OF OBSERVATION STAYS AND SHORT INPATIENT STAYS FOR MEDICARE BENEFICIARIES (July 29, 2013).

62. See *generally* Press, *supra* note 10.

63. 42 U.S.C. § 1395ww(r).

64. 78 Fed. Reg. at 50,613.

efficiency are estimated to reduce initial payments by as much as \$1.1 billion.⁶⁵ The early stages alone of this current reconfiguration are expected to force a reduction of more than five percent for any particular hospital.⁶⁶ If such cutbacks are applied across the healthcare spectrum, the anticipated reductions alone would result in a \$30 billion cut. With hospital profit margins facing a national crisis, it remains to be seen if hospitals can afford this loss of revenue.⁶⁷

If successful, this redistribution of Medicare funding among hospitals is only the beginning of what may soon become a total reconfiguration of the Medicare program. From its humble origins in 1965, when it cost beneficiaries \$3.00 per year for coverage under Part B,⁶⁸ Medicare has grown to become anything but modest when viewed in terms of its ever-evolving infrastructure, and it is far too early to predict the fate of programs such as Hospital VBP or the RRP. Nevertheless, from its inception PPACA has been structured to strive toward long-term goals,⁶⁹ and while the Federal Government believes that the effects of recent changes such as those addressing the Hospital VBP Program will directly impact the improvement of patient outcomes, safety, and the patient's overall experience.⁷⁰ This same government, however, acknowledges that there is no concrete way to "estimate these benefits in actual dollar and patient terms"⁷¹ because the programs do not begin until the following fiscal year. Only time will tell if modern healthcare's recently added complexities will fortify America's healthcare structure or create a series of financial cracks to weaken the foundations upon which it was built.

65. *Id.* at 50,507.

66. *Id.* This, of course, does not take into consideration reductions in revenue from sequestration (2%), see 2 U.S.C. § 900(c)(2), as well as inpatient quality reporting (2%), see 42 C.F.R. § 412.140, and outpatient quality reporting (2%), see 42 C.F.R. § 419.46. Together these three additional items can raise reductions from five percent to eleven percent.

67. See generally Mark G. Harrison & Cecilia C. Montalvo, *The Financial Health of California Hospitals: A Looming Crisis*, 21 HEALTH AFFAIRS 120 (Jan. 2002); *Declining Operating Margins Show U.S. Hospitals Still Face Challenges*, HEALTHCARE FIN. MGMT. (Feb. 1, 2006), available at <http://www.allbusiness.com/health-care-social-assistance/864684-1.html>.

68. See Marian E. Gornick, et al., *Thirty Years of Medicare: Impact on the Covered Population*, 18:2 HEALTH CARE FIN. REV. 183 (1996).

69. See *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2642 (2012) (Scalia, J., Kennedy, J., Thomas, J., and Alito, J., dissenting).

70. See 78 Fed. Reg. at 50,677.

71. 78 Fed. Reg. 27,882 (May 10, 2013).