American Hospital Association®

Eliminating Barriers to Care Coordination

AHA View

The Anti-kickback and Patient Referral laws should be revised to foster, rather than hinder, integrated relationships that help hospitals and physicians work together to better coordinate care for patients.

Background

As the health care field explores new payment and delivery system models that emphasize value over volume and the Triple Aim of improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care, hospitals are actively exploring clinical integration – a move away from working in silos toward emphasizing teamwork to coordinate care. Increasingly, public and private payers are holding hospitals accountable for reducing costs and improving quality in ways that can be accomplished only through teamwork with physicians and other health care professionals within and across sites of care, including the alignment of financial incentives. However, hospitals attempting to achieve the care coordination required by these new payment and delivery system models face significant legal barriers. Chief among these are outdated rules governing relationships between hospitals, physicians and other caregivers – portions of the Anti-kickback Statute and the Ethics in Patient Referral Act (also known as the "Stark law") and the Civil Monetary Penalty (CMP) law.

Congress recently acknowledged the need for change to the CMP law to remove impediments to improving care for patients and remedy the government's problematic interpretation of the law. The recently passed Medicare Access and CHIP Reauthorization Act of 2015 limits the scope of this prohibition, which had prohibited hospitals from offering physicians incentives to follow evidence-based care guidelines, so that a hospital or critical access hospital is only subject to CMPs for making payments to reduce or limit *medically necessary* care. The AHA advocated for this change and is pleased that the Congress has lifted this significant barrier to hospital "gainsharing" arrangements with physicians.

Key Priorities

The AHA recommends two additional, specific changes to enhance hospitals' ability to improve health and health care. They are:

- Creating an anti-kickback safe harbor for clinical integration programs; and
- Refocusing the Stark law on its original intent.

Creating an Anti-kickback Safe Harbor for Clinical Integration Programs
The Anti-kickback law's main purpose is to protect patients and federal health programs from fraud and abuse. The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health program business – including Medicare and Medicaid – can be held accountable for a felony. Today, the law has been stretched to cover any financial relationship between hospitals and doctors. For example, if a hospital rewards a physician for following evidence-based clinical protocols, the reward could be construed as violating the Anti-kickback law, since technically such a reward could

influence a physician's order for treatment or services. In acknowledgement that there are cases where the Anti-kickback statute thwarts good medical practices, Congress has periodically created "safe harbors" to protect those practices. Congress should create a safe harbor for clinical integration programs. The safe harbor should allow all types of hospitals to participate, establish core requirements to ensure the program's protection from anti-kickback charges, and allow flexibility in meeting those requirements so the programs can achieve their health goals.

Refocusing the Stark Law on its Original Intent

The Stark law was originally enacted to ban physicians from referring patients to facilities in which they have a financial interest (known as self-referral). However, a tight web of regulations and other prohibitions that have grown around the law can now prevent arrangements that encourage hospitals and physicians to work together to improve patient care. Specifically, the law prohibits hospitals from making payments to physicians that are tied to achievements in quality and efficiency – rather, payments must be for hours worked only. For example, if a hospital pays a physician to help patients manage their diabetes according to a well-designed medical protocol, both the hospital and physician risk being in violation of the Stark law. Congress should return the Stark law to its original focus of regulating self-referral to physician-owned entities by removing compensation arrangements from the definition of "financial relationships" subject to the law.