athenainsight

Today's data. Tomorrow's healthcare.

athenainsight.com

A healthcare law held together by duct tape

By Stephanie Zaremba | August 12, 2016

The drive to fix healthcare is full of big ideas — major overhauls of how physicians are paid, patients are insured, health information is documented, and care is coordinated.

But some of the most important fixes might come from focusing on less exciting details. For example: How outdated fraud and abuse laws are squeezing innovation from the system.

Imagine our existing healthcare laws as a building. Ideally, it is well constructed at the outset, regularly maintained, and remains useful for decades into the future.

But when a law becomes riddled with exceptions — and then with addendums to close the loopholes to the exceptions — its integrity starts to fail. Pretty soon, it's dilapidated, having exceeded its useful life, held together with a complex web of duct tape and a door that only opens if you know exactly where to kick it.

Our fraud and abuse laws — specifically, the Stark Laws and Anti-Kickback Statute — were written in the era of fee-for-service. They were essential, at the time, to addressing the fundamentally misaligned incentives created by a payment system that rewards physicians for volume.

The basic premise of the laws is simple: A physician can't receive a financial benefit for referring a patient to another care provider or prescribing a drug, treatment, etc. As patients, we want our providers recommending care based on what is best for our health, not best for their wallets.

But as we shift away from fee-for-service and toward value-based care, Stark and Anti-Kickback are not keeping up. We increasingly see behaviors that are desirable but technically prohibited, such as a hospital paying for the electronic health record used by community physicians. So over time, each law has been subject to a few dozen exceptions and hundreds of advisory opinions carving out specific acceptable behaviors.

Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program receive broad waivers to Stark and Anti-Kickback in recognition of the fact that these laws directly prohibit what is required for ACO success: sharing of costs, infrastructure, and savings.

The Department of Health and Human Services has set aggressive goals for tying payments to value, not volume, and our fraud and abuse laws must be reformed for those goals to be realized. Currently, physicians and hospitals are prohibited from a long list of desirable behaviors under a value-based model: advising patients on the selection of a high quality post-hospital care facility; providing patients with cab rides to appointments or scales to help monitor their weight between visits; and paying for the cost of exchanging patient information electronically, to name a few.

When physicians are financially incentivized to coordinate care, they need a legal framework that encourages innovation around how healthcare providers organize, share costs, exchange information, and engage across the broad continuum of care.

But instead of reform, to date the policy changes necessary to implement this shift are piled on top of a rickety foundation and, as a result, innovation suffers.

The good news is that members of Congress are looking at ways to address problems with the Stark Laws and Anti-Kickback Statute. As they dive in, policymakers need to recognize this crumbling building for what it is: Something that needs comprehensive rebuilding, not another round of patches.

Stephanie Zaremba is director of government and regulatory affairs for athenahealth.