Hospital Value Based Purchasing and the Bundled Payment Initiative Under the Affordable Care Act: A Good Start, But is it Good Enough?

Nita Garg
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I. INTRODUCTION

The United States spends more per capita on health care than any other nation; yet, the U.S. does not achieve better health care outcomes compared to other developed nations.¹ Many of the discussions on how to reform the health care industry have focused on how to best contain these escalating costs. One frequent suggestion as how best to accomplish these goals would be to end the traditional healthcare payment model of fee-for-service. This model has contributed to the overuse of tests and treatment by providers for the sake of higher profits,² and moreover, this reimbursement model has no real relationship with provider performance and patient outcome.³ One of the proposed solutions to this problem is a reimbursement model that ties payment to providers with patient outcome in an attempt to simultaneously decrease healthcare costs and improve healthcare quality.

Under the Patient Protection and Affordable Care Act (PPACA),⁴ Medicare will utilize two new outcome-based reimbursement models. Over seven million Medicare beneficiaries experienced more than 12.4 million inpatient hospitalizations in 2009.⁵ Another study concluded that one in

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³ Id.


seven Medicare patients will experience an “adverse” event such as a preventable illness or injury while in the hospital. One in three Medicare beneficiaries who leave the hospital today will be readmitted to the hospital within a month. Additionally, every year, close to 100,000 Americans die from medical errors in hospital care. These errors lead to significant and unnecessary healthcare spending. Medicare spent an estimated $4.4 billion in 2009 to care for these errors, and subsequent readmissions cost Medicare another $26 billion.

In response to these staggering statistics, the federal government has responded by proposing two demonstration projects under PPACA that attempt to use payment incentives as a way to improve quality while reducing unnecessary costs. The first project, Hospital Value Based Purchasing, utilizes a pay for performance payment model, while the second project, the Bundled Payment Initiative, utilizes an episodic payment model. Providers under these arrangements would be rewarded for meeting quality measures and reducing cost. This is a fundamental change from the fee-for-service model of reimbursement, which financially rewards providers for providing more services, regardless of the quality, or outcome, of those services.

Pay for performance (commonly referred to as “P4P”) is a payment model that rewards healthcare providers for meeting performance measures for quality and cost efficiency. While there are clearly incentives to improve quality and reduce cost, the effectiveness of pay for performance models on a large scale has not been conclusively proven.

The episodic payment model is a reimbursement model where payment is for all services associated with an episode of care, such as a hospital admission. This goes beyond hospital diagnosis-related groups (DRGs) by bundling hospital, physician, and other clinical services into a single rate.

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6. Id.
7. Id.
8. Id.
9. Id.
10. Id.
11. Id.
12. Id.
14. Id. at 523.
“It would also increase accountability for outcomes by extending the episode to a period of perhaps thirty days beyond the hospital discharge.”

Payers would develop rates based on the resources needed to provide care that is consistent with established clinical guidelines.

While this move by Medicare into the realm of outcome-based payment will be the first large-scale shift away from the fee-for-service reimbursement model in health care, the private and public sector have already tried to respond to increasing healthcare costs, coupled with concerns over quality, with mixed results. The Federal government is placing considerable faith in the Hospital Value-Based Purchasing program and the Bundled Payment Initiative to solve the conundrum of cost and quality. While these two programs are currently Medicare-based, the hope is that these programs will not only prove successful in Medicare, but ultimately change the way health care is delivered in the Medicaid and private health care industries as well. This paper will explore how these two programs created by the Federal government are structured and whether there is a need for change if these programs are to meet the high expectations that have been placed on them to reduce cost and improve quality. Unfortunately, the Federal government has proposed reimbursement models that will prove to be inadequate and ineffective at accomplishing their stated goals. Consequently, these two programs must undergo significant changes before any dramatic difference will be seen in both the cost and quality of health care in the United States.

In Section II, this paper will provide a brief background on how the current state of health care has led to interest in simultaneously reducing cost and improving quality. Healthcare costs in the United States are significantly higher than other developed nations, yet there has not been a corresponding increase in positive healthcare outcomes.

Section III of this paper will explore the Medicare Hospital Value-Based Purchasing program, the first large-scale value-based purchasing program. This section will examine how this reimbursement model is structured and look into what the Medicare program, and thus the Federal government, hopes to accomplish by implementing this reimbursement model next year. After looking at value-based purchasing, Section III will continue by exploring the Bundled Payment Initiative. Launched under a new branch of the Center for Medicare and Medicaid Services (CMS), the Center for Medicare and Medicaid Innovation, this program shifts payment from a traditional fee-for-service reimbursement model to a model that provides

16. Id.
payment to cover an entire “episode of care.” This section will look into how this reimbursement model is structured and what CMS is hoping to accomplish with this demonstration program.

Section IV will investigate the potential flaws of these two federal demonstration projects by looking into the weaknesses of these programs and possible unintended consequences. This section will examine the validity of the potential criticisms and whether the benefits of these programs will outweigh the criticisms. In this section, the paper will also explore possible modifications that could be made to the current programs. While the Value-Based Purchasing Program and the Bundled Payment Initiative are steps in the right direction, their current structure is too narrow in scope and with far too many weaknesses to make fundamental changes in how health care is reimbursed and in the quality of health care being delivered.

II. BACKGROUND

A. The Statistics

The United States spends more on health care than other developed countries. In 2006, the United States spent $2.1 trillion, the equivalent of sixteen percent of the national GDP, on health care. This translated to a per capita rate of $7,026 annually. Unlike other developed countries that provide near-universal coverage, the United States has a significant uninsured population. In 2006, close to fifty million people, (over sixteen percent of the U.S. population) were without health insurance coverage, and, therefore, likely without consistent access to health care services.

According to a report from the Robert Wood Johnson Foundation, “the increased attention to health care costs is merited and likely reflects the recent trend of health insurance premiums—the most visible indicator of healthcare costs—growing at a much faster rate than workers’ earnings.”

Data from the Kaiser Family Foundation-Health Research and Educational

18. As this paper is not intended to delve deeply into why health care costs are rising, but rather, explore the programs intending to deal with this concern, there will only be a brief discussion of the reasons behind, and the future of, high health care costs.
21. Id.
22. Id.
23. Id.
Trust Annual Employer Survey and the U.S. Department of Labor indicates that premiums for employment-based private insurance increased 114% from 1999 to 2007, while earnings increased twenty-seven percent, leaving a gap of seven percentage points per year, on average.

The gap between health spending trends and income trends likely has led to a sharp increase in the proportion of the population concerned about their ability to afford health insurance in the future. When health care spending grows at much faster rates than GDP or workers’ earnings, health insurance becomes less affordable—and more people become uninsured. Those who can continue to afford coverage are finding that premiums and payments for medical care not covered or paid for by insurance are becoming increasingly large over time in relation to income.

What is behind these escalating health care costs? In a 2008 report, the Congressional Budget Office identified seven key factors driving the historical growth of health care spending: (1) an aging population; (2) changes in third-party payment; (3) personal income growth; (4) health sector prices; (5) administrative costs; (6) defensive medicine and supplier-induced demand; and (7) technology-related changes in medical practice. Researchers have identified the latter as a leading factor, responsible for anywhere from one-third to two-thirds of the growth in real per capita health care spending.

B. Spending Projections

According to the most recent annual National Health Expenditure (NHE) projection by the CMS Office of the Actuary, released in 2010, NHE reached $2.6 trillion in 2010 and has grown 3.9 percent, down from 4.0 percent in 2009. Spending growth in 2010 was slow in response to


26. DEMYSTIFYING, supra note 20, at 1.

27. Id.


29. DEMYSTIFYING, supra note 20, at 11.

declines in both the employment rate and private health insurance coverage resulting from the recession.\textsuperscript{31} GDP growth in 2010 was projected to have been 3.8\%, nearly the same growth rate as the NHE.\textsuperscript{32} The health share of GDP is expected to have remained constant between 2009 and 2010 at 17.6 percent.\textsuperscript{33}

Both private health insurance and out-of-pocket spending were projected to grow between 2011 and 2013.\textsuperscript{34} Private health insurance spending is projected to grow close to five percent in 2013, up from close to three percent in 2010.\textsuperscript{35} This growth is a result of expectations of employer-sponsored insurance enrollment increasing with gains in employment.\textsuperscript{36} Out-of-pocket spending is projected to grow by nearly four percent in 2013, up from close to two percent in 2010, as growth in household incomes is expected to lead to related growth in health care spending and as it is anticipated that employers will increase cost-sharing requirements in employer-sponsored insurance plans.\textsuperscript{37} In 2014, health care spending is projected to grow 8.3\%.\textsuperscript{38} The projected acceleration in the growth rate is most likely a result of coverage-related expansions.\textsuperscript{39} Under PPACA, Medicaid eligibility requirements in 2014 will include persons under age sixty-five in families with income up to 138\% of the Federal Poverty Level.\textsuperscript{40} Consequently, “Medicaid enrollment is expected to increase by 19.5 million people and spending is projected to grow 20.3\%.”\textsuperscript{41} The new state Health Insurance Exchanges are expected to cover nearly fourteen million people in 2014 and “contribute to 9.4-percent growth in private health insurance spending.”\textsuperscript{42}

According to the CMS Office of the Actuary, forecasts for periods much longer than ten years are implausible, as the extrapolation of current trends would project nearly the entire United States GDP directed toward health

\textsuperscript{31} Id.
\textsuperscript{32} Id.
\textsuperscript{33} Id.
\textsuperscript{34} Id.
\textsuperscript{35} Id.
\textsuperscript{37} Id.
\textsuperscript{38} Id.
\textsuperscript{39} Id.
\textsuperscript{40} Id.
\textsuperscript{41} Id.
care costs. As a result, longer-term projections “work from the other direction, [by] considering how much health spending growth society will tolerate.” As such, the forecasters conclude that both private and public sectors will eventually take more aggressive actions to control spending than has been the experience to date. The Congressional Budget Office (CBO) recently published a forecast also questioning the long-term sustainability of the upward trend in health care spending. Under the CBO predictions, health care spending will reach “forty-nine percent of GDP in 2082. This implies that between 2018 and 2082, health spending would increase only 1 percentage point,”—quite a shift from the current trend.

The rising cost in health care is understandably a significant cause for concern for all health care payers, but more so for the federal government, as Medicare is the largest single payer of health care services in the country. With spending projections forecasting rising costs without an end in sight, there has been added pressure to find a way to stunt the growth in spending. As will be discussed in the next section, an added layer to this concern is the increase in costs has not seen a subsequent increase in quality of care received by patients.

C. Concerns about Quality

While rising health care costs are a significant part of the health care conundrum, just as important, if not more important, are concerns about the quality of health care being provided in the United States. As mentioned in the introduction, the United States has a mortality rate higher than other developed countries. This is especially surprising when considering that the Unites States also spends significantly more on health care than these other developed countries. At the beginning of the new millennium, the World Health Organization ranked the health systems of close to 200 nations. France and Italy ranked first and second while the United States ranked

43. DEMYSTIFYING, supra note 20 at 5.
44. Id.
45. Id.
46. Id.
thirty-seventh, a showing that the New York Times referred to as “dismal.” More recently, the Commonwealth Fund compared the United States with other advanced nations through surveys of patients and doctors and analysis of other data. Its latest report, issued in May of 2007, “ranked the United States last or next-to-last compared with five other developed nations on the majority of performance measures, including quality of, and access to, care.” In that same report, the Commonwealth Fund ranked the United States first in providing the “right care” for a given condition as defined by standard clinical guidelines. The United States scored highly for preventive care services, such as pap smears and mammograms, as well as blood tests and cholesterol checks. But the United States scored poorly “in coordinating the care of chronically ill patients, in protecting the safety of patients, and in meeting their needs and preferences.” All of these poor showings drove the overall quality rating down to last place for the country.

According to a New York Times article covering the Commonwealth Fund report, “American doctors and hospitals kill patients through surgical and medical mistakes more often than their counterparts in other industrialized nations.” Estimates indicate that nearly 100,000 patients die each year in the United States from preventable medical errors. At the same time, patient safety measures have worsened by nearly one percent each year for the past decade. Health care associated infections significantly drive up the cost of health care by nearly $28 to $33 billion per year.

As state and federal governments, payers, and consumers recognize both the enormity of quality concerns and financial pressures, and the connection between the former and the latter, the public and private sectors have responded in various ways in an attempt to reduce costs and improve quality. The two programs analyzed in the next section, Medicare Hospital Value Based Purchasing Program, and the Bundled Payments for Care Improvement Initiative, each take varying approaches to accomplish the same goals: reducing cost and improving quality.

50. Id.
52. Id.
53. Id.
56. Id. at 7.
III. PROGRAMS UNDER PPACA

A. Medicare Hospital Value Based Purchasing Program

The Hospital Value-Based Purchasing Program (hereinafter referred to as the “Program”) is a CMS initiative under PPACA that will reward acute-care hospitals with financial incentives for improvements in the quality of care they provide to Medicare beneficiaries. The Program marks the first time hospitals will be paid for inpatient acute care services directly based on care quality, not only for the quantity of the services they provide, a stark change from the fee-for-service reimbursement model that Medicare currently utilizes. However, “it has sparked less discussion than has another experiment to change Medicare’s payment system through accountable care organizations, where a select group of doctors and hospitals get bonuses if they find ways to save money.” This is somewhat surprising considering that the accountable care initiative will affect fewer providers than will be impacted by the Program.

Under the final rule, Medicare will cut payments to the included hospitals by 1 percent, setting that money aside for a “bonus pool.” In the 2013 Fiscal Year, the Program will distribute the funds in the bonus pool, an estimated $850 million, to hospitals based on their overall performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. These incentive payments will be taken from what Medicare otherwise would have spent for hospital stays, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance. The bonus pool will increase to two percent of Medicare payments in October 2016. This bonus pool can result in significant additional reimbursement for high performing hospitals.

Proponents of the Program believe that this change in the reimbursement scheme will lead to improvement in care quality, while simultaneously

57. This Section will focus on the structure of the Program and the Initiative. The next Section will delve into an analysis and criticism of both.
61. RAU, supra note 59.
62. Id.
63. Id.
64. Id.
resulting in significant savings over time. According to CMS, the Program measures will focus on how closely hospitals adhere to the best clinical practices and how well hospitals improve their patients’ care experiences.\(^\text{65}\) When hospitals follow these effective best practices, CMS believe that patients will receive higher quality care and see better outcomes. As a result of patients healing without complication, this reimbursement model can improve health and ultimately reduce health care costs.\(^\text{66}\)

The Program is anticipated to affect more than 3,000 acute care hospitals, each having their payments adjusted beginning October 2012.\(^\text{67}\) However, there is also a lengthy list of hospitals that will be excluded from these Medicare requirements, including: (1) Hospitals subject to a penalty under the Hospital IQR program;\(^\text{68}\) (2) Hospitals receiving immediate jeopardy sanctions; (3) Hospitals with too few cases or measures; (4) Critical access hospitals;\(^\text{69}\) (5) Inpatient rehabilitation facilities; (6) Long-term care hospitals; (7) Children’s hospitals; and (8) Specialty hospitals.\(^\text{70}\)

As mentioned, reward payments will be linked for achievement or improvement in quality of care and financial efficiency. Quality will be judged based on measures set under the Program, with additional measures being added each fiscal year. The scoring process utilizing these metrics attempts to turn clinical and patient experiences into statistics that CMS in turn can use to rank the performances of participating hospitals. CMS has said the goals of the scoring method are to create a process that is transparent, reflective of true differences in performance, eliminates unintended consequences, considers improvement and achievement, and uses the most currently available data.\(^\text{71}\)

B. Bundled Payments for Care Improvement Initiative

Created under PPACA, the Bundled Payments for Care Initiative (hereinafter referred to as the “Initiative”) is a program aimed at physicians,

\(^{65}\) HEALTHCARE.GOV, supra note 5.

\(^{66}\) Id.

\(^{67}\) Id.

\(^{68}\) Id. (Since 2004, CMS has collected quality and patient experience data from acute care hospitals on a voluntary basis under the Hospital Inpatient Quality Reporting Program (IQR). The vast majority of hospitals now choose to participate in the IQR program in order to be eligible for the full annual percentage increase in reimbursements each year, as a result of legislation requiring Medicare to reduce the annual percentage increase for hospitals that did not participate in the reporting program).

\(^{69}\) Id. (Although critical access hospitals are currently excluded from the Program, CMS is required to conduct reports on critical access and smaller hospitals, implying there is a high potential that these hospitals will be taken off the excluded list in the future).


\(^{71}\) HEALTHCARE.GOV, supra note 5.
hospitals, and other health care providers to help improve care for patients while they are in the hospital and after they are discharged. Under the Initiative, payments will be aligned for services delivered across an entire episode of care. This bundled payment method of reimbursement thus differs from the current model, which provides payment for each service separately. The Initiative, therefore, goes well beyond hospital diagnosis-related groups (DRGs)\textsuperscript{72} by bundling hospital, physician, and other clinical services into a single rate.

According to the Department of Health and Human Services (HHS), the bundled payment method of reimbursement under the Initiative will give health care providers new incentives to coordinate and improve the quality of care, while saving money for Medicare.\textsuperscript{73} Department Secretary, Kathleen Sebelius, says of the Initiative, “Patients don’t get care from just one person – it takes a team, and this initiative will help ensure the team is working together. The Bundled Payments initiative will encourage doctors, nurses and specialists to coordinate care. It is a key part of our efforts to give patients better health, better care, and lower costs.”\textsuperscript{74} HHS believes that by bundling payment across providers for the multiple services involved in one episode of care, health care providers will have a greater incentive to coordinate care amongst each other, ensuring continuity of care across settings and providers, thus resulting in better outcomes for patients.\textsuperscript{75} In describing the Initiative, CMS noted that one Medicare heart bypass surgery bundled payment demonstration saved $42.3 million (roughly ten percent of expected costs) and saved patients $7.9 million in copayments while improving care and lowering hospital mortality.\textsuperscript{76}

This better coordinated care could theoretically reduce duplication of services, preventable medical errors, and adverse outcomes for patients, while simultaneously lowering costs due to providing more efficient care. Former CMS administrator Donald Berwick, M.D., explains the impetus behind moving away from a fee for service payment model and toward the

\textsuperscript{72} The prospective payment system is a per-case reimbursement mechanism under which inpatient admission cases are divided into relatively homogeneous categories called diagnosis-related groups (DRGs). In this DRG prospective payment system, Medicare pays hospitals a flat rate per case for inpatient hospital care so that efficient hospitals are rewarded for their efficiency and inefficient hospitals have an incentive to become more efficient. This is opposed to a fee for service (FFS) model, in which services are unbundled and paid for separately.


\textsuperscript{74} Id.

\textsuperscript{75} Id.

\textsuperscript{76} Id.
fee-for-episode-of-care model:

From a patient perspective, bundled payments make sense. You want your doctors to collaborate more closely with your physical therapist, your pharmacist and your family caregivers. But that sort of common sense practice is hard to achieve without a payment system that supports coordination over fragmentation and fosters the kinds of relationships we expect our health care providers to have.77

Under the Initiative, providers can apply to participate in one of four models (discussed below), all of which group different services together for bundled payments. Providers are defined broadly, and include physician’s groups, hospitals, physician-hospital organizations, nursing homes, and others.78 To participate in the Initiative, physicians and hospitals design their own models of bundled payment under the four general types of payment models. Providers then submit bids to The Center for Medicare and Medicaid Innovation. The bids must propose a target price for an episode of care; participants would receive discounted payments under the fee for service system, and at the end of the episode the total payments for the care would be compared to the target price. Those involved in providing the patient’s care could share in any savings generated to Medicare.

As mentioned, there are four available models for providers to design their program.79 The first three models involve retrospective payments. In these models, CMS and providers set a target payment amount for a defined episode of care.80 Applicants would propose a target price, which would be set by applying a reduction to total costs for a similar episode of care (to be determined based on historical data).81 While participants in these models would be paid under the traditional fee-for-service system, this payment would be at a negotiated discount.82 At the conclusion of an episode, the total payment amount would be compared with the target price.83 Participants may share the profits resulting from this theoretically more efficient care model.84

77. Id.
79. Id.
80. Id.
81. Id.
82. Id.
83. Id.
In Model 1, an episode of care would be defined as an inpatient stay in a hospital.\textsuperscript{85} Medicare will provide the hospital a discounted payment based on the rates established under the Inpatient Prospective Payment System (IPPS).\textsuperscript{86} Medicare will pay physicians independently for services rendered under the Medicare Physician Fee Schedule. Hospitals and physicians will then be allowed to share gains resulting from this improved coordination of care.\textsuperscript{87}

In Model 2, the episode of care would include the inpatient stay and post-acute care and would end, at the applicant’s option, either a minimum of thirty or ninety days after discharge.\textsuperscript{88} In Model 3, an episode of care would begin at the start of post-acute care with a participating Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH) or Home Health Agency (HHA) within thirty days of discharge from the inpatient stay and would end no sooner than thirty days after the start of the episode.\textsuperscript{89} In both Models 2 and 3, the bundle would include services provided by physicians, post-acute provider care, any related readmissions, and other Part B services proposed in the definition of an episode definition (such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and Part B drugs).\textsuperscript{90} The target price will be reduced from an amount based on the applicant's typical fee for service payments for the episode of care.\textsuperscript{91} Payments will be made at the usual fee for service rates, however, after, the aggregate Medicare payment for the episode will be reconciled against the target price.\textsuperscript{92} Any decrease in costs beyond the discount reflected in the target price will be given to the participants to share among the participating providers.\textsuperscript{93}

Finally, in Model 4, CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians and other practitioners. Physicians and other practitioners would “submit “no-pay” claims to Medicare and would be paid by the hospital out of the

\textsuperscript{85} Id.
\textsuperscript{86} Id.
\textsuperscript{87} Id.
\textsuperscript{88} Id.
\textsuperscript{89} Id.
\textsuperscript{90} Id.
\textsuperscript{91} Id.
\textsuperscript{92} Id.
\textsuperscript{93} Id.

bundled payment.\textsuperscript{94}

While CMS has undertaken similar initiatives in the past, those projects focused on inpatient services related to surgeries.\textsuperscript{95} The new Initiative is much broader, as “it will encompass both in-hospital and post-discharge care and can include chronic disease and other medical admissions, as well as surgeries.”\textsuperscript{96}

IV. ANALYSIS

While the Hospital Value-Based Purchasing Program and the Initiative represent a step in the right direction, there are quite a few problems with the current structure of these programs. While it is clear that increasing health care costs dictate that fundamental changes must be made to the current health care reimbursement scheme, the Program and the Initiative have weaknesses that must be addressed before they can accomplish their goals. Although the weaknesses in both the Program and the Initiative are quite problematic in their impact on the potential effectiveness of these new reimbursement models, they could both represent a good starting point to reduce costs and improve quality. For the Program and Initiative to make any sort of meaningful impact, though, there will have to be significant changes to the structure and scope of both. More importantly, there will likely have to be fundamental changes to the federal government’s regulatory scheme for health care.

A. Worsening Disparities for Vulnerable Populations

Studies, including one discussed below, have shown that rewarding physicians for providing better care to patients could end up widening medical disparities experienced by the most vulnerable populations: lower income and minority groups. These studies demonstrate that under a typical pay for performance reimbursement model, providers serving vulnerable populations would likely receive lower payments than other providers.\textsuperscript{97} This discrepancy is due in part to the gaps that already exist in the quality of health care received by patients depending on their demographics. The studies also suggest, however, that these pay for

\textsuperscript{94} Id.


\textsuperscript{96} Id.

performance models “could divert resources away from medically needy communities, further eroding the quality of medical care rather than driving improved quality.”

A study published in “Health Affairs suggests that if low-quality, high-cost hospitals are financially penalized [through a system of performance-based payments], disparities in care are likely to worsen.” A disproportionally higher number of elderly Black, Hispanic, and Medicaid patients receive care in low-quality, high-cost hospitals in the South. “Given that low-quality hospitals often have lower margins than average, the impact on them could be particularly striking,” writes Ashish K. Jha, MD, a professor of health policy at the Harvard School of Public Health.

The authors of the study found that small public or for-profit institutions in the South were considered the “worst” hospitals nationally because of both low quality and high costs. The “best” hospitals were more likely to be in the Northeast, nonprofit, and have a cardiac intensive care unit. The best hospitals also had a higher average proportion of Medicare patients and a smaller proportion of elderly Hispanic patients. The worst hospitals had twice as many elderly black patients as the best hospitals. “Elderly Hispanic and Medicaid patients accounted for 4% and 23% of patients, . . . in the worst hospitals, but only 1% and 15% at the best hospitals.”

Overall, “patients cared for in the worst hospitals had a 12% to 19% higher chance of dying in the hospital, and patients with an acute myocardial infarction or pneumonia were 7% to 10% more likely to die than those cared for in the best hospitals.” The authors concluded:

“Our findings have important implications for Medicare’s forthcoming value-based purchasing program. The worst institutions in particular will have to improve on both costs and quality to avoid incurring financial penalties and exacerbating

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98. Id.
100. Jha, supra note 99.
102. Id.
103. Id.
104. Id. (clarifying that best was defined as having the lowest cost and highest quality).
105. Id.
106. Id.
disparities in care. As the United States embarks on efforts to improve hospital care using value-based purchasing principles, we will need to help hospitals improve quality and efficiency simultaneously and to monitor the results of their efforts, so that we do not inadvertently worsen disparities in care.

In the same study, researchers also found that average-sized physician practices serving the highest proportion of vulnerable populations would annually receive about $7,100 less than other practices under a pay for performance program. That disparity has the potential to be even larger if greater amounts of money are at stake. As it stands already, there are relatively fewer health care providers located in communities with large medically vulnerable populations. The authors of the study posit that “if these providers receive lower reimbursements than other providers, new resources may be diverted elsewhere, making it difficult to reverse existing disparities.”

Blair Childs, an executive with Premier, an alliance of more than 2,500 hospitals, said it best:

“The powerful thing about value-based purchasing is that it’s going to continually raise the bar. The bad thing is that if you start behind and you’re penalized financially and there are costs associated with doing all the programs you need to do, you run the risk of being in a death spiral.”

Taking this information into account, any pay for performance program must be structured to account for the payment shortfalls that would exacerbate these gaps. One approach could be to award grants to providers caring for the vulnerable populations that would be negatively impacted by these shortfalls. These grants, if targeted properly, could offset potential financial and quality disparities. In addition, such grants could provide another benefit by maintaining the financial incentive to improve the quality of care for these populations. Physician Mark Friedberg, a researcher who studies pay for performance programs says, “[w]e found that practices that treat vulnerable populations have room for performance improvement, so it’s important to preserve the incentive to improve quality of care while taking steps to prevent an increase in disparities.”

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108. Id. at 1910.
109. RAND CORPORATION, supra note 97.
110. Id.
111. Id.
112. Rau, supra note 59.
113. RAND CORPORATION, supra note 97.
B. Participation

One of the major weaknesses to both the Initiative and the Program is the narrow scope with regard to which providers are included in these new reimbursement model schemes. Perhaps the most noticeable gap in participation would be how both the Program and the Initiative apply exclusively to the Medicare program. While the Medicare program does represent the largest expenditure by the federal government on health care, and the largest payor of health care in the United States, there are still other large payors in the health care system that are not being included under this provision of PPACA. Medicaid, other federal and state government health programs, employer-sponsored health plans, and private health plans are being excluded from both the Program and the Initiative. While the hope for proponents of both reimbursement models is that the success of these programs will translate into providers and other payors choosing to utilize value based purchasing and bundled payment models, there is no guarantee that providers and payors will voluntarily choose to do so. Providers may opt not to volunteer for either model with another payor as they likely realize that the current fee-for-service payment model would provide them with a higher reimbursement rate. Other payors may opt not to pursue these reimbursement models due to the resources and capital involved in completely overhauling how providers are reimbursed for their services. Even then, to get to the point where other payors utilize these payment models, there would have to be definitive proof that these programs work at reducing cost like they promise.

Another problematic exclusion in the Initiative is the voluntary nature of the program. The Bundled Payment Initiative is entirely voluntary for providers. Those providers who determine that fee-for-service would yield a higher reimbursement would likely not opt to switch to the bundled payment model, where the benefits of any financial incentives could easily be negated by taking a few extra patients under a fee-for-service payment model. Thus, the Initiative may have limited impact on “bending the cost curve” if it does not spread or providers choose to opt out. While the Hospital Value-Based Purchasing Model is mandatory for acute care hospitals participating in Medicare, participation in Medicare itself is not mandatory for all hospitals. (However, participation is mandatory for tax-exempt hospitals.) Although Medicare has historically had significantly higher participation rates than lower-reimbursed Medicaid, there has been repeated discussion of significantly reducing Medicare reimbursement rates for physicians. With these inevitable rate cuts, Medicare, like Medicaid,

114. This, of course, would not include those previously mentioned hospitals that have been excluded from having to participate in the Program.
will likely see a drop-off in physicians and non tax-exempt hospitals willing to participate in the Medicare program.

C. Conflicting Aims of the Current Federal Regulatory Scheme

The Program and the Initiative suffer not only from weaknesses inherent in their current structure, but also suffer as a result of the federal regulatory scheme under which both projects must function. Fraud and abuse, antitrust, and tax regulations make the successful implementation of the Program and the Initiative quite difficult.\textsuperscript{115}

An explanation of how far a law interferes with the Program and Initiative goals is instructive. The Office of the Inspector General at the Department of Health and Human Services (OIG) may impose civil penalties and assessments on a provider or entity that engages in various types of improper conduct with respect to federal health care programs.\textsuperscript{116} One provision of the Civil Monetary Penalty makes it illegal to provide payments to induce reduction of limitation of services, known as the “Gainsharing Provision.”\textsuperscript{117} If a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to beneficiaries of a federal health program that are under the direct care of a physician, the hospital will be in violation of the law. In addition, any physician who accepts any such payment will also be in violation of the law. Of course, encouraging physicians to focus on utilization and cost are predicates to the Program and Initiative being successful.

Further, the Physician Self-Referral law, commonly referred to as the Stark Law, prohibits physicians from referring Medicare and Medicaid patients for the provision of certain designated health services to a provider with which the physician (or an immediate family member) has a financial relationship.\textsuperscript{118} Providers may not bill the federal health care programs for any service that has been provided in violation of the law.\textsuperscript{119} The Stark Law was intended to prohibit physician ownership of certain ancillary services, such as clinical laboratories, diagnostic imaging facilities, and so forth as a response to numerous studies showing that such ancillary services were subject to overutilization when the referring physician had a financial interest.

\textsuperscript{115} For purposes of this paper, this discussion will mostly be limited to fraud and abuse regulation concerns.
\textsuperscript{116} 42 U.S.C. § 1320a–7a(b) (2006).
\textsuperscript{117} 42 U.S.C. § 1320a–7a(b) (2006).
\textsuperscript{119} Id.
Unfortunately, the actual impact of the Stark Law has been not only to limit physician ownership of ancillary services, but also to make difficult certain beneficial relationships between physicians and hospitals. The American Health Lawyers Association (AHLA) found that, even though the Stark Law was intended to be directed at physicians, the impact of the Stark Law falls primarily on hospitals and other institutional providers to which physicians refer patients.120 If a hospital accepts patient referrals in violation of the Stark Law, it “could be required to return Medicare reimbursement payments and to pay additional penalties under the False Claims Act, even if the violations were unintentional and inadvertent.”121 A violation that goes undetected for a significant period of time can lead to substantial fines for the provider.122

Furthermore, the Stark Law makes it difficult for providers to work together to voluntarily develop or implement various arrangements designed to improve health care quality and control costs, including arrangements such as integrated delivery systems, pay for performance arrangements, gainsharing arrangements, or bundled payments. According to a practice update from the Akerman law firm, “The regulatory structure of the Stark Law, if left unchanged, will be a direct impediment to two principal objectives of the current health care reform initiative – improving quality and managing costs.”123 Cooperative arrangements among various providers could be the key to improving the quality of care provided and reducing the cost of care provided to patients.124 The Stark Law assumes that cooperative arrangements among providers may create incentives for over-utilization of services.125 As such, the Stark Law must be altered as to allow the type of cooperative arrangements among health care providers that are necessary to both improve the health care quality and reduce health care costs.126

While Accountable Care Organizations (ACO) created under the Shared Savings Program will receive fraud and abuse waivers that would insulate the ACO and the providers from risks and liabilities under the Stark Law,127 the anti-kickback statute, and the Gainsharing Prohibition under the Civil

121. Id.
122. Id.
123. Id.
124. Id.
125. Id.
Monetary Penalty,\textsuperscript{128} these waivers have not been extended to other providers that are making changes to their health care delivery model in an attempt to reduce cost and improve quality.\textsuperscript{129} These waivers should apply to providers participating in the Program and the Initiative. With the Initiative being voluntary, the waivers may be the extra push that providers need to opt into the program.

Furthermore, the Civil Monetary Penalty Law should be rewritten to ensure that providers who are effectively and successfully participating in an episodic payment or pay for performance reimbursement model will not be penalized for participating in a program that reduces costs and improves quality. The Stark Law also should be rewritten so that the scope of the Stark Law will be limited, and compliance be made easier, by revising the Stark Law to prohibit only certain specified relationships, such as physician ownership of clinical laboratories, outpatient diagnostic imaging facilities, and similar ancillary services which may be particularly subject to over-utilization. The current version of the Stark Law, with its blanket prohibition of referrals on almost all types of services, can unnecessarily punish hospitals and discourage cooperative agreements among various providers that may be critical to reducing costs and improving quality in health care. The financial penalties under the Civil Monetary Penalty and the Stark Law should not be trebled unless there has been shown to be intentional violation or bad faith by the provider. These hefty fines unnecessarily drive up costs. Likewise, financial penalties beyond restitution should not apply under Stark Law when the services provided were medically necessary.

D. Self-Serving Behavior by Providers

One of the major problems with these programs is that they ignore the human nature of providers. Arguably, the Value-Based Purchasing Program does a better job of acknowledging this problem by reducing payments to those participants who do not meet predetermined quality and cost benchmarks. Even then, the bonus pool is still only one percent of total payments.\textsuperscript{130} While hospitals often run on razor thin profit margins,\textsuperscript{131} the time, effort and money required to meet or exceed all of these benchmarks might wipe out any significant profit from pay for performance

\textsuperscript{128} See 42 U.S.C. §§ 1320a-7(a)(5); 42 U.S.C. §§ 1320a-7a(b); 42 U.S.C. §§ 1320a-7b(b)(1); 42 U.S.C. §§ 1395nn.

\textsuperscript{129} 42 C.F.R. § 425 (2012).

\textsuperscript{130} RAU, supra note 59.

\textsuperscript{131} Maggie Fox, Update 1-US Hospital Profits Fall to Zero, \textsc{Reuters} (Mar. 3, 2009), http://in.reuters.com/article/2009/03/02/hospitals-usa-idINN0242705020090302.
programs.

This problem is exacerbated by the voluntary nature of the Initiative. While groups may receive extra payment if they provide care that is much more efficient in the new model, there is no guarantee under the programs that a participating provider would see significantly higher reimbursements under either a bundled payment model or value based purchasing model.132 As one physician said, regarding payment models that reward quality and cost efficiency, “We should stop reimbursing so much for stuff we’d like to discourage. To put it another way, I think if we stopped paying so much for procedures, we would do less procedures. If I can see 20 patients a day, and you offer to increase my pay 5% if I do an awesome job, I could work harder, hire people, and try to make 5% more. Or, I could just see 21 patients a day. Guess which I’ll do. And the latter will INCREASE costs.”133

The lack of penalties will also become apparent when selectively choosing patients becomes a concern. Critics worry that remodeling the reimbursement scheme to financially reward cost efficiency could lead to physicians and hospitals picking only the healthiest patients as sicker patients tend to be more costly to treat.134 A related practice, “dumping,” is when providers choose to end care for difficult, costly or otherwise unwanted patients.135 The increased use of payment models that reward outcomes and cost-efficiency, such as episodic payment and pay for performance reimbursement models, raises concern that providers may increase these cherry-picking and dumping behaviors and deny care to those most in need, further driving health care costs upward.136 A related concern is that the widespread use of electronic medical records will make cherry-picking and dumping behaviors easier by providing physicians with easy to use tools for data mining to determine which patients will be more profitable.137

Indeed, cherry-picking by some Medicare HMOs has been documented.138 Many Medicare HMOs are known to actively recruit

132. See generally the statutes and regulations associated with the Program and Initiative.
135. Id.
136. Id.
137. Id.
138. Id.
clinical practices and patients in more affluent neighborhoods, offering healthy seniors free meals and other inducements to switch from traditional Medicare to their private HMO option.\footnote[139]{Id.} Unsurprisingly, few recruitment events occur in low-income neighborhoods.\footnote[140]{Id.}

Another problem is that if Medicare sticks with the same quality metrics for too long of a period of time and doesn’t keep revisiting and revising these standards, then the program risks encouraging an overly simplified model of care.\footnote[141]{Luna S. Hines, et al., Agency for Healthcare Research and Quality, AHRQ Publication No. 08-0022, Becoming a High Reliability Organization: Operational Advice for Hospital Leaders 104 (2008).} Hospitals could become complacent and simply try to hit the benchmarks on the small set of indicators that Medicare rewards, without thinking about how to put in place the infrastructure to improve quality of care across the board.\footnote[142]{Id.} In response, the federal government plans to continually add other indicators over time, and it will rotate out indicators when the great majority of hospitals have achieved a high level of performance on them.\footnote[143]{Id.} Still, Medicare must carefully monitor the effect of the program to ensure that hospitals do not achieve a high level of performance simply by diverting resources from other unrewarded, but nonetheless important areas of care.

E. Rethinking How to Treat Costly Patients

Neither the pay for performance nor the episodic payment reimbursement models take into account recent research on the predictability of chronic illness. Physician Jeffery Brenner, brought to the spotlight by Atul Gawande’s New Yorker article, “The Hot Spotters,” created a pilot model of health care in Camden, New Jersey that attempted to improve quality while simultaneously reducing costs.\footnote[144]{Atul Gawande, The Hot Spotters, The New Yorker, Jan. 24, 2011, at 42.} His model was a result of a fairly simple observation: that sick people with chronic (and costly) diseases tended to be clustered in certain areas of the city.\footnote[145]{Id.} Surprisingly, the sickest parts of the city were not necessarily the poorest as well.\footnote[146]{Id.} Brenner, with hospital admission data, plotted the location of patients with the highest health care costs.\footnote[147]{Id.} As suggested by Gawande’s
title, Brenner found “hot spots” of disease in unsafe nursing homes, or housing projects with poor access to proper nutrition. Brenner responded to his discovery by providing special attention to these costly patients. This special attention included more frequent medical visits, a “health coach” of sorts to ensure these patients were taking their medication regularly, and social workers to assistant with problems of insurance or access to food. The results of the program on costs and health of the patients involved were astounding. The thirty-six “super utilizers” averaged sixty-two hospital and E.R. visits per month before joining the program and thirty-seven visits after—a forty-per-cent reduction. Their hospital bills averaged $1.2 million per month before and just over $500,000 dollars after—a fifty-six-per-cent reduction.151

Gawande holds that “the critical flaw in our health-care system that people like . . . Brenner are finding is that it was never designed for the kind of patients who incur the highest costs.” Oftentimes, the sickest, poorest, and most costly patients in the United States are using the emergency room as the “primary mechanism of service.” Now, this is not to say that the doctor’s office and the hospital emergency room do not serve a necessary role in health care delivery. According to Gawande, though, the problem arises when the patients are those with complex problems, such as

“the forty-year-old with drug and alcohol addiction; the eighty-four-year-old with advanced Alzheimer’s disease and a pneumonia; the sixty-year-old with heart failure, obesity, gout, a bad memory for his eleven medications, and half a dozen specialists recommending different tests and procedures. It’s like arriving at a major construction project with nothing but a screwdriver and a crane.”154

This demonstration project brings to the forefront the question of whether shifts in reimbursement schemes can actually impact the cost and quality of care being delivered. In this situation, costs were considerably reduced and patient health drastically improved, but not as a result of changing how providers were reimbursed. Rather, it seems that a change in how treatment was provided, which individuals are provided treatment, and the holistic nature of the treatment is what made a difference. This raises the

148. Id.
149. Id.
151. Id. at 44.
152. Id. at 46.
153. Id.
154. Id.
question of whether the Program and the Initiative will make a meaningful difference without shifting how we treat health problems. Of course, this also raises the question of the role of prevention and amelioration of behavior driven illness, such as obesity and diabetes. Solving these will require significant resources.

F. Providing Care That Will be More Cost Effective

Both the Program and the Initiative plan to reduce costs by changing how health care services are reimbursed, seemingly in hopes that in addition to reducing payment, an indirect result will be that providers will alter their behavior to reduce the use of unnecessarily expensive services as a personal measure to increase their profits. However, both the Program and the Initiative ignore the fact that providers are self-interested in providing services that will yield them a profit. A prime example of how this self-interest increases cost is the higher reimbursement rates for specialist physicians as compared to primary care physicians.155 Often, specialist physicians will provide services or procedures within the scope of practice of a provider who could be reimbursed at a lower rate.156

Both the Program and the Initiative can benefit from learning lessons from reimbursement models that utilize the “gatekeeper” method of keeping costs down, such as Health Maintenance Organizations.157 With the gatekeeper method, patients are prevented from seeing costlier specialists until a primary care physician has vetted them to determine if they actually do require the services of a specialist.158 Not only do the Program and the Initiative fail to discourage the use of expensive specialists, any other project that only rethinks the reimbursement model would be working within the confines of a healthcare system that does not encourage the utilization of primary care as a cost-reduction method.

The Program and the Initiative do not attempt to modify the American health care system to reduce the use of specialists. A major factor in medical students choosing to pursue specialties, in addition to the prestige, is the considerably higher pay associated with specialty areas of medicine.159 However, Medicare can, in fact, influence the number of primary care physicians versus specialty physicians. The Federal

155. See generally the CPT Code to compare reimbursement rate for primary care visits versus procedures performed by specialists and surgeons.
156. Id.
government, through the Medicare program, funds post-graduate Medical training in the form of residencies. As such, the Medicare program can help increase the number of primary care physicians by reducing the number of specialty residencies, thus increasing the number of primary care specialties. Another way for Medicare to encourage cost-effective services would be to lower reimbursement for specialty procedures. Lowering surgical reimbursement in particular might be important, because surgery tends to be costly and most prone to medical errors and adverse outcomes.

Even then, some studies have shown that merely increasing the number of primary care physicians will likely not solve this problem. In a study appearing in Health Affairs, RAND Corporation researchers concluded that the best way to strengthen primary care in the United States would be to reorient the focus of the health system rather than solely focusing on training more primary care providers. There is an emerging consensus that strengthening primary care will provide Americans with better health care and help restrain the growth of health care spending, exactly what the Program and the Initiative are aiming to accomplish. RAND researchers reviewed existing studies about primary care and its impact on health care quality, outcomes and costs. “There is limited evidence that simply increasing the number of primary care physicians in the nation will improve health and slow the growth of health care costs unless we also reorient the system to focus on primary care,” said Dr. Eric Schneider, a senior natural scientist at RAND and an author of the study. Important steps that should be a part of any health system reorientation include encouraging patients to use primary care providers as coordinators of their health care, shifting investment from high-technology services to instead support community-based primary care, and improving communication between specialists and primary care providers.

G. Experience in the United Kingdom

Finally, we can look at previous experience to learn much about the

161. See KOHN ET AL., supra note 54.
163. Id.
164. RAND CORPORATION, supra note 97.
165. Id.
166. Freidberg, supra note 162, at 770.
utility of quality payment incentives.\textsuperscript{167} A similar program in the United Kingdom a few years ago that utilized financial incentives to reduce costs and improve quality proved not to be as successful as anticipated.\textsuperscript{168} Granted, physicians in the United Kingdom who work for the National Health Service (NHS) typically work on a salary basis,\textsuperscript{169} rather than a fee-for-service basis; however, there are some applicable lessons for the United States. Starting in 2004, NHS committed more than $3 billion toward a program that would pay physicians bonuses of as much as twenty-five percent of their total income.\textsuperscript{170} To qualify for this bonus, physicians had to meet or exceed some or all of the 135 quality benchmarks that were predetermined by NHS.\textsuperscript{171}

Researchers at Harvard studied this UK program to see if they could learn any lessons about the effectiveness of pay for performance on a national scale. Rather than look at all 136 quality measures, the researchers choose to focus on only a few pertaining to hypertension, one of the most undertreated, expensive, and common diseases.\textsuperscript{172} The results were disappointing, to say the least. After reviewing close to 500,000 primary care patient records, researchers determined that the NHS’ pay for performance program had no effect on outcomes.\textsuperscript{173} Patients were not any healthier than they would have been if the financial incentive program hadn’t existed.\textsuperscript{174} Surprisingly, the physicians were not motivated (or perhaps unable) to change their behavior with regard to costs and quality in response to financial incentives.\textsuperscript{175}

Unfortunately, the study did not offer suggestions of how exactly financial incentives could be used to positively alter physician behavior. “Money by itself doesn’t buy health,” concluded Stephen Soumerai, co-

\textsuperscript{167} While there have been pay for performance success stories in health care, these have been in the private sector and on a much smaller scale. As such, the successes and lessons learned from those models cannot necessarily be applied to the Program and the Initiative. See Gosden T. Forland, et al., Capitation, Salary, Fee-for-Service and Mixed Systems of Payment: Effects on the Behaviour of Primary Care Physicians., COCHRANE DATABASE OF SYSTEMATIC REVIEWS 3 (2006).


\textsuperscript{170} Pickert, supra note 168.

\textsuperscript{171} Id.

\textsuperscript{172} Id.

\textsuperscript{173} Id.

\textsuperscript{174} Id.

\textsuperscript{175} Id.
VI. CONCLUSION

While the Hospital Value Based Purchasing Program and the Bundled Payment Initiative are much-needed steps in a large-scale shift away from the traditional, and flawed, fee for service reimbursement model, they will likely not be the “magic pill” to cure what ails health care in the United States. The Program and the Initiative reach too few providers, only reach one payer, and have to work within the confines of a health care system and federal regulatory scheme that work against both programs’ ability to reach their full potential in meeting the grand expectations that have been placed on them. The Program and the Initiative are somewhat effective in that they are bringing to the forefront the notion that fundamental changes must be made to how providers are reimbursed for their services if escalating health care costs are to be stopped. This is certainly a key piece of the puzzle.

By giving the Program and the Initiative the best chance possible at meeting their goals of reducing cost and improving quality, valuable lessons can be learned and then applied to other key players and aspects in the health care world. For example, the clinical integration necessary to effectively participate in the Initiative could easily spread to other providers and payers if the Initiative is able to demonstrate that this integration can drastically reduce costs for both providers and payers, and improve the patient experience. The cost consciousness required for both the Program and the Initiative could fundamentally alter how payers and providers think about health care delivery, and, in particular, encourage the shifting the delivery of some care to “lower rung” providers, such as physician assistants or nurse practitioners, as a method of cost reduction.

The weaknesses inherent in the current structure of both the Program and the Initiative lessen the likelihood that either Medicare response will lead to the dramatic changes in cost and quality that their creators so desire. While the Program and the Initiative should not be scrapped (their usefulness in being the first large-scale shift away from the costly and ineffective fee for service model should not be underestimated), without correcting these glaring weaknesses, the Program and Initiative will fail. Worse yet, if the Program and Initiative fail, other payers and providers will likely be discouraged from proceeding with their own major shifts in how health care is financed and delivered in this country.

176. Id.
177. Id.
The Beazley Institute for Health Law and Policy  
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