Strategies for Coping With Changes to Medicare Payment Policies

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Medicare – Major Reforms Now and in Future – How Do We Cope?

- Introduction – Welcome
- Health Reform Law consists of two acts:
  - Patient Protection and Affordable Care Act (PPACA)
  - Health Care and Education Reconciliation Act (Reconciliation Act)
  - Reconciliation Act signed by President on March 30, 2010
  - We refer to both as the Health Reform Law or "PPACA"

Vast Scope of Health Reform Law

- The Health Reform Law changes many areas including:
  - Health insurance reform
  - Increased access to health insurance
  - Establishment of "Exchanges"
  - Premium tax credits and cost-sharing reductions
  - Individual responsibility to maintain coverage

Vast Scope of Health Reform Law (cont.)

- Employer responsibilities
- Medicaid program expansion and changes
- Primary care emphasis
- Children's Health Insurance Program expansion
- Medicaid prescription drug coverage
- Improving quality of Medicaid
- Maternal and child health services

Vast Scope of Health Reform Law (cont.)

- Linking payment to quality outcomes under Medicare*
- National strategy to improve health care quality*
- Encouraging development of new patient care models*
- Improving Medicare for patients and providers*
- Rural protections
- Improving payment accuracy*
- Part C Medicare Advantage changes

* covered by this program

Vast Scope of Health Reform Law (cont.)

- Changes to Part D, Medicare prescription drug plans*
- Ensuring Medicare sustainability*
- Health care quality improvements*
- Health care work force*
- Transparency and program integrity – Foley's Friday Focus topic last week

*covered by this program

Vast Scope of Health Reform Law (cont.)

- Improving access to innovative medical therapies
- Revenue provisions, including
  - Excise tax on high cost employer-sponsored health coverage
  - Additional requirements for charitable hospitals
  - Taxes on pharma, medical devices, health insurers
  - Elimination of deduction for Part D expenses
  - Additional hospital insurance tax on high-income taxpayers
  - Excise tax on indoor tanning services

Vaster scope yet?

- Strengthening quality, affordable health care for all Americans
- Phases out the Part D "donut hole"

- Today we're only discussing provisions affecting Medicare directly and indirectly
- Foley has a large series of programs to cover other aspects of Health Reform Law – see www.foley.com/HCReform

Medicare Laws – Major Reforms Now and in Future – How Do We Cope?

- Today's presentation – changes to the Medicare laws:
  - Some experiments with fundamental changes
  - Enhancements of existing CMS initiatives
  - Congress and the Administration using Medicare payment policy to shape national health planning

Pay for Quality (Value-Based Purchasing)

- Pay for good quality, penalize for bad quality
- Starts with pay for reporting
- Strategy: Reform quality monitoring, but also
  - Change medical records
  - Billers must be involved with charting quality in medical records/other reports
  - Spillover effect on private payors
- Next level strategy – enhance physician/hospital affiliation strategies to maximize payment and publicity results on these new measures

Medicare Value-Based Purchasing

- Health Reform Law significantly increases link between Medicare payments to providers and quality of services furnished, and patient outcomes
  - Payment adjustments added
  - Additional evaluations of quality reporting and payment adjustments added
  - Future measures will be added

Hospital Value-Based Purchasing Program

- Medicare already requires hospitals to report on quality measures.
- Failure to timely report to CMS agent = reduction in hospital's market basket index payment update.
- Health Reform Law: Medicare will tie payment to acute care hospital to its performance on designated quality standards.

Acute Care Hospitals

- Effective for discharges on and after 10/1/2012, Secretary of Health and Human Services (HHS) must develop value-based incentive payments on at least five specific conditions or procedures.
  - Acute MI
  - Heart failure
  - Pneumonia
  - Surgeries
  - Healthcare-associated infections
- Effective for discharges on and after 10/1/2013, must also include efficiency measures, including amount of Medicare spending per beneficiary.

Acute Care Hospitals

- Get incentive payment if meet or exceed performance standards.
- Higher the score, greater the incentive payment.
- Reductions in payments for low scores.
- Incentive payment is budget neutral.

Physicians

- Incentive payments for reporting data extended through 2014.
- In 2015, payments for physician whose quality data is unsatisfactory will be reduced.
- 2015 reduction is 1.5%.
- 2016 and later years, reduction is 2.0%.

LTCHs, Inpatient Rehab Facilities, Inpatient Psych Hospitals, Hospices

- Quality reporting required to be implemented.
- Quality measures must be published by 10/1/2012.
- Reduction effective 7/1/2013 or 10/1/2013 for long-term care hospitals (LTCH), inpatient psych hospitals and psych units, inpatient rehab facilities, and hospices.
- Failure to submit quality data will result in 2.0% reduction in Medicare payment updates.

PPS-Exempt Cancer Hospitals

- Quality reporting required to be implemented with quality measures published by 10/1/2013.
- Providers failing to submit data will be subject to 2.0% reduction in Medicare payment updates.

SNFs, HHAs, ASCs

- Secretary must submit to Congress a plan to implement value-based purchasing programs for above providers by 9/30/2012.

Public Information on Quality

- Quality data reported to CMS or its agents will be made available to public.
- Providers should consider including their published quality data in marketing, public relations, government relations.
- Level of focus on quality will be highest on published data; less on non-published indicators.

Hospital-Acquired Conditions

- Secretary must identify hospitals in top quartile of all hospitals, relative to national average, of hospital-acquired conditions for certain high-cost and common conditions.
- Starting on 10/1/2014, such hospitals will see reduction in Medicare payments.
- Challenge: How to respond to data on hospital-acquired conditions.

Conditions Acquired in Other Providers

- Secretary must submit a report to Congress by 1/1/2012 regarding appropriateness of establishing health care acquired condition policies in other provider types.
- Listed are nursing homes, inpatient rehab facilities, long-term care hospitals, outpatient hospital departments, ASCs and health clinics.

Hospital Readmission Reductions

- Beginning on 10/1/2012 hospitals with a high rate of potentially preventable Medicare readmissions will incur Medicare payment reductions.
- First three conditions: heart attack, heart failure, pneumonia.
- Hospital's readmission rate compared with expected readmission rate.
- Reduced payment for "excess readmissions."
- Medical records are critical in defending readmissions.

Gainsharing

- Gainsharing demonstration will be continued with increased funding.
- Demonstrations to evaluate physician/hospital arrangements designed to improve quality and efficiency of care provided to beneficiaries.
- Gainsharing is one useful physician/hospital alignment tool.

Accountable Care Organizations (ACOs)

- Secretary must establish by 1/1/2012 Shared Savings Program to
  - Promote accountability for a patient population
  - Coordinate services and items under Medicare Parts A and B
  - Encourage investment in infrastructure and redesigned care processes for high quality service delivery

ACOs

- ACOs are vehicle through which Shared Savings Program will be implemented.
- ACOs are a cutting edge tool for physician/hospital alignment.
- Detailed requirements for group of providers to qualify as ACO:
  - Agree to three year participation
  - Agree to be accountable for quality, cost and overall care of at least 5,000 Medicare fee for service population

ACOs

- Establish formal legal structure allowing ACO to receive and distribute shared savings payments to its participants.
- Include enough primary care physicians to care for Medicare fee for service population assigned to ACO.
- ACO must have in place leadership and management structure that includes clinical and administrative services.

ACOs

- ACO is responsible for defining processes to promote evidence-based medicine and coordinate care through use of telehealth, remote patient monitoring and other enabling technologies.
- ACO providers bill Medicare same way as if they weren't in ACO.
- ACO may receive additional percentage (defined by Secretary) of "shared savings" achieved by ACO.

ACOs – Legal Issues

- Secretary authorized to waive Civil Monetary Penalties, Anti-Kickback Statute, any provisions of Title XVIII including Stark Law.
- No discussion of waiving antitrust law, state laws.
- May have significant effect on private payor contracting.

ACOs – Strategic Considerations

- One of most valuable tools in physician/alignment toolkit
- Extremely complex to create
- Contracts among all providers in ACO are required
- Clinical integration and/or financial integration is necessary to achieve quality improvement and overall cost savings
- Physician leadership is crucial in developing protocols, clinical pathways, enforcement mechanisms, payor arrangements

ACOs – Strategic Considerations

- Current antitrust guidance prohibits joint negotiation of payor contracts by competing providers (including physicians) without clinical and/or financial integration.
- Exclusive contracting by ACO is problematic.
- Fully mature clinically integrated group can achieve remarkable quality improvements and overall cost reductions.
- Effect of ACO on private health insurance market.

Payment Bundling

- Secretary must develop voluntary pilot program for hospitals, doctors, and post-acute care providers to improve patient care and achieve Medicare savings through bundled payment modes.
- Program must be established 1/1/2013 for 5 year period.
- Secretary to test and report on payment bundling.

Payment Bundling

- Payment bundling puts a premium on developing ACO or similar integrated group of providers.
- Without clinical/financial integration among otherwise competing providers, the providers cannot successfully achieve goals of ACOs, payment bundling or gainsharing or many other physician/alignment strategies.
- A vibrant physician-developed and physician-operated clinically integrated group can achieve all of above goals, plus major reduction in overall cost of health care while quality is improved at same time.

Other Responses to Medicare Changes

- Service line clinical co-management agreements
- Employment of physicians (primary and specialist) by hospital
- Physician recruitment by hospitals
- Formation of larger physician group practices
- Physician/hospital joint ventures
- On-call arrangements

The Future of Medicare

- Are we going to repeat the past, or enter a brave new world?
- "Beauty is in the eye of the beholder."
  - Margaret Wolfe Hungerford
- We often wish for the "good old days."

Medicare Disproportionate Share Hospital Payments

- Significant decrease, effective October 1, 2013.
- DHS payments will be reduced to 25% of the amount that otherwise would have been paid under current law.
- DSH hospitals may be entitled to additional amounts based on a complex formula that includes the following factors:
  - Aggregate amount of reduction in total DSH payments
  - Percentage change in uninsured under-65 population
  - Hospital's level of uncompensated care.
- No administrative or judicial review of Secretary's estimates.
- Based on expectation that fewer patients will be uninsured.

Medical Education Payments - Distribution Of Unused Medical Residency Slots

- Comparison of hospital's resident cap to highest resident level for 3 most recent cost reports.
- Hospital's resident cap will be reduced by 65% of unused slots.
- Hospitals may apply for redistribution of unused slots, must commit to use 75% of additional slots for primary care or general surgery training.
- Effective July 1, 2011.

Medical Residency Programs in Nonprovider Settings

- Current law requires hospital to pay all or substantially all of the cost of training program in a nonprovider setting in order to claim residents training there. All or substantially all of the cost is defined in the regulations as at least 90% of the total of the residents' salaries and fringe benefits and the portion of teaching physicians' salaries attributable to nonpatient care direct GME activities.

Medical Residency Programs in Nonprovider Settings

- Health Reform Law relaxes requirements, and allows hospitals to claim residents training in nonprovider settings for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) if the hospital incurs the cost of the stipends and fringe benefits for the residents during their nonprovider site rotations.
- Effective for cost reporting periods beginning on and after July 1, 2010.

Medical Education Payments - Jointly Operated Residency Proposals

- Current law has been interpreted by CMS to provide that one hospital must pay all or substantially all of the costs of a residency program in a nonprovider location. Under CMS' interpretation, if two or more hospitals pay such costs, no hospital can claim residents. This issue is under appeal.
- PPACA will allow two or more hospitals to pay such costs and to claim a proportional share of residents.
- Hospitals must enter into written agreement.
- Effective July 1, 2010.

Physician Payments

- Incentive payments for primary care services provided by primary care practitioners
- Primary care practitioners include physicians with a primary specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine
- Primary care practitioners also include nurse practitioners, clinical nurse specialists and physician assistants
- Practitioner's primary care services must account for at least 60% of allowed Medicare charges
- 10% bonus payment
- Effective January 1, 2011 to December 31, 2015

Medicare Prescription Drug Program

- "Donut Hole" will gradually be eliminated beginning in 2011.
- $250 rebate in 2010.
- Beneficiaries will receive 50% discount on brand name drugs.
- Donut Hole to be entirely eliminated by 2020.

Center For Medicare and Medicaid Innovation

- Center for Medicare and Medicaid Innovation created within CMS.
- Must be in place by January 1, 2011.
- To test innovative payment and service delivery models to reduce Medicare expenditures while preserving or enhancing quality of care.
- CMI must seek input from interested parties, and is to consult with representatives of federal agencies, and clinical and analytical experts with expertise in medicine and health care management.

Center for Medicare and Medicaid Innovation

- CMI is to test payment and service delivery models to determine the effect of applying them to Medicare or Medicaid.
- CMI is to select models to be tested where there is evidence of deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.
- CMS must report to Congress in 2012 and at least every other year thereafter, describing the models tested and providing recommendations as it believes appropriate.

Independent Payment Advisory Board

- New independent, 15-member Board created.
- Must present annually recommendations to Congress on actions that could improve quality and constrain the rate of heathcare cost growth in private sector.
- Board must make non-binding Medicare recommendations to Congress in years when Medicare growth rate is below targeted growth rate.

Independent Payment Advisory Board

- In years when Medicare growth rate is projected to exceed targeted growth rate, Board's proposals will take effect unless Congress passes an alternate measure that achieves same level of savings.
- Starting in 2020, Board may make binding recommendations to Congress only every other year if growth of overall health spending exceeds targeted growth rate.

Independent Payment Advisory Board

- Will take years to fully implement.
- Query – Will Congress want to cede its rate-setting authority, even in part, to an independent entity?
- Does this provision pass constitutional muster?

Conclusions: What Does This Mean for Patients and Providers?

- Many more people will have health insurance.
  - *Will deductibles and co-insurance go up?*
  - *Loss of other sources to cover bad debt/charity care*
- Quality of care may improve.
  - *Major quality improvements will require close working relationship between physicians and hospitals, and other providers as well.*
- Emphasis on primary care.
- Cost – Not comprehensively addressed.

Conclusions: What Does This Mean for Patients and Providers?

- Perceived abuses in insurance contracts prohibited: pre-existing conditions, lifetime maximums, cancellation of policy after costly medical event.
  - *What will be added cost of above?*
- Is health reform in final form?
  - *No. Needs many regulations, additional statutes, completion of mandated studies, conversion of successful demonstration projects and pilot programs into program policy, etc.*

Questions and Answers

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