Health Care Reform Advisory: Reforming the Health Care Delivery System through Medicare Payment Reforms

1/11/2010

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While the more hotly contested health care reform issues, such as the public option and immigrant access to coverage, have garnered the most attention over the past few months, one particular aspect of health care reform has gone relatively unnoticed: the proposed transformation of the Medicare program through initiatives meant to increase quality of care, efficiency, and accountability while decreasing overall costs. Given the bipartisan support for these changes, they undoubtedly will appear in any final legislation, which means that Medicare providers and suppliers (collectively, "providers") in all service settings should begin to understand these initiatives and consider their implications.

Hospital Value-Based Purchasing Program (SB 3001)

One of the more creative (though not entirely original) proposed Medicare payment reforms is the Hospital Value-Based Purchasing (VBP) Program. The VBP Program, proposed by the Senate, is intended to improve the quality of care provided by directly linking Medicare payments to performance. Specifically, the Program would provide financial incentives to acute care hospitals that meet or exceed certain performance standards, or those that make improvements on performance relative to a previous performance period. Adjusted payments to qualified hospitals would begin in fiscal year (FY) 2013 and would be funded by reductions in Medicare inpatient prospective payment system payments made to all hospitals. Certain hospitals would be excluded, such as those that fail to report quality measures to CMS, those cited for serious deficiencies in care, and those not having a sufficient number of patients with the qualifying conditions (including heart failure, pneumonia, surgeries, and infections).

Although the House bill does not contain an equivalent proposal, it does require the Institute of Medicine (IOM) to determine whether the Medicare payment system should include incentives for high-level care and to make recommendations on the implementation of any such modifications (for example, on a regional or provider-level basis).

Accountable Care Organizations (SB 3022; HB 1301)

Both the House and Senate bills incorporate accountable care organization (ACO) models to encourage groups of providers (organized as ACOs) to come together to improve the quality of

care provided to qualified beneficiaries, while reducing costs. Under both bills, implementation would begin by January 1, 2012, and when entering into agreements with ACOs, the Secretary of Health and Human Services (the Secretary) could give preference to those organizations already participating in similar arrangements with other payors.

An ACO could continue to receive payment on a fee-for-service basis, but would receive an incentive payment equal to a portion of the savings achieved. The estimated savings and the spending benchmarks would be determined by the Secretary. To qualify for the incentive payment, the ACO would need to meet certain quality performance standards, and the payment amount could be capped by the Secretary. The bills also provide for the use of partial capitation payment models (which may be limited to highly integrated ACOs capable of bearing the risk) and allow the Secretary to develop or use other payment models that would improve quality and efficiency. Regardless of the specific payment model used, the bills do not allow the overall payments to providers to exceed what they would have otherwise been outside of the program.

Creation of ACOs would, to say the least, be a significant culture shift for Medicare providers, who should begin to think about the financial and human resources needed to develop an ACO, the new relationships that will need to be formed, and the added reporting and compliance responsibilities that participation would bring.

Payment Bundling (SB 3023; HB 1152)

Both the House and Senate bills include payment bundling as a Medicare reform tool, though a number of the details vary. In a bundled payment system, Medicare would pay a single provider entity one amount for the full range of care provided during a hospitalization episode. Neither the House nor Senate bill implements a bundled payment program; rather, they both call for a bundled payment pilot program to test the approach.

The House bill focuses on including bundled payments in post-acute care reform (but the bundles may also include some inpatient services), while the Senate bill would cover "episodes of care"—a time period that includes hospitalization as well as the three days prior to admission and the 30 days following discharge. The Senate bill would allow the Secretary to establish a different period for the episode of care, as appropriate. The House bill would require the Secretary's plan to address a number of issues, including (i) patient protections to ensure quality of care and provider choice, (ii) application of existing laws to the relationships required to facilitate bundling, (iii) appropriate quality measures, and (iv) specific payment details.

The pilot program must be established by January 1, 2013 under the Senate bill and by January 1, 2011 under the House bill. The payment bundling program would be expanded only if it reduces costs while maintaining or improving quality.

Reduction of Preventable Hospital Readmissions (SB 3025; HB 1151)

According to Congress, preventable hospital readmissions give rise to excess health care costs. The House and Senate therefore propose to reduce Medicare payments to hospitals based upon a percentage of potentially avoidable Medicare readmissions for certain conditions (such as heart attack, heart failure, and pneumonia) according to a methodology determined by the Secretary, and authorize the Secretary to expand the provision to include additional conditions. As originally proposed by the Senate, the payment adjustment for a discharge in a fiscal year would only apply to acute care hospitals in the highest readmission quartile for the condition for the fiscal year. Any payment reductions would apply only for the fiscal year involved, and would not apply to subsequent fiscal years. The applicable percentage reduction would be 20% for a readmission that occurs within 7 days of the prior discharge, and 10% for a readmission that occurs within 15 days of the prior discharge. The House bill would further authorize the Secretary to monitor hospitals' efforts to avoid high-risk patients in order to reduce the likelihood of readmissions.

Productivity Adjustments/Improvements (SB 3401; HB 1103)

Both the House and Senate bills call for a productivity adjustment to the relevant market basket update for certain Part A and Part B providers (effective dates vary). Generally, a productivity adjustment is a net cut to the market basket rate (cost of living) increase for a fiscal year or cost reporting period, equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity (as published by the Secretary from time to time). The proposed adjustment would apply to payments made to most providers.

The House bill would establish a floor for the rates for inpatient hospitals, outpatient hospitals, and home health services, and would ensure that a productivity adjustment, combined with any other adjustments applied for quality reporting and use of electronic health records, would never reduce the market basket update below zero. The Senate bill proposes a "give back" provision that would make the market basket update in any year contingent on the level of non-elderly insured population relative to the projected level of non-elderly insured at the time of enactment.

In addition to the productivity adjustment, the Senate bill also proposes additional reductions in the market basket. For the years 2014-2019, all providers would see a reduction of 0.2% to the market basket. However, if the level of non-elderly insured falls below projections, the "give back" provision would apply and there would be no 0.2% reduction to the market basket.

Specific Proposed Changes to Medicare Payment Amounts

Although the details differ, the above-referenced provisions in the House and Senate bills introduce an array of creative methods and incentives for increasing quality, efficiency, and accountability while reducing costs. At the same time, the two bills also propose more straightforward changes to Medicare program reimbursement amounts. Highlights include:

- A 0.5% increase in Medicare physician pay in 2010, but a 23% cut for 2011.
- A 10% Medicare bonus for physicians and others practicing in health professional shortage areas for primary care services provided from 2011 through 2016. Half of the bonuses would be offset through across-the-board reductions in other services.
- A 5% increase in the payment rate for psychiatric services through the end of 2010.
- An increase to the payment rate for certified nurse midwives, from 65% of the rate that would be paid were a physician performing the service to the full rate.
- Improvement of payment accuracy through rebasing home health payments based on an analysis of the current mix of services and intensity of care provided to home health patients.
- Starting in 2015, a reduction in hospitals' Medicare disproportionate share hospital (DSH) payments to reflect lower uncompensated care costs relative to increases in the number of insureds.
- An incentive payment for geographic areas with efficient use of Medicare spending.

In addition to specifically outlined payment changes, the bills provide for the continued review and possible adjustment of payments under the Medicare program:

- Secretary to review and identify potentially misvalued Medicare codes and adjust them as appropriate. The bill provides $20 million annually for this activity (HB 1122).
- Medicare Payment Advisory Commission (MedPAC) report to Congress on appropriate Medicare coverage for home infusion services and potential savings (HB 1143).
- MedPAC study and report on bone mass measurements payment rates (HB 1148; compare to SB 3111, which restores payments for bone density tests).
- MedPAC study and report on variations in home health agency margins (HB 1155A).
- MedPAC study and report regarding payments to rural providers and beneficiary access, including recommendations for modification and adjustment in payments and appropriate legislative and administrative action (SB 3127).
- IOM study and Centers for Medicare & Medicaid Services response regarding geographic variation in spending and the use of geographic adjusters (HB 1157-1160).
- HHS study on need for additional payments to Urban Medicare-dependent Hospitals (SB 3142).

Some Proposed Demonstration Projects Relating to Coordinated Care

In addition to the payment and delivery reforms highlighted above, the bills explore other models that may reduce Medicare program costs while improving the quality of care for beneficiaries and/or reducing the risk of hospitalization. These include:

- Independence at Home Medical Practice Demonstration Program (focused on chronically ill Medicare beneficiaries).
- Community-Based Care Transitions Program.
- Gainsharing Demonstration Program (extension through 2011).
- Medicare Hospice Concurrent Care Demonstration Program (which would allow beneficiaries to receive hospice care and all other Medicare covered services concurrently).

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Conclusion

Medicare payment changes undoubtedly will be a core piece of any health care reform legislation that is finally passed, and such changes will have profound financial and operational effects on virtually all Medicare providers. Although many of the details will be determined through the regulatory process or additional legislation (and influenced by the results of ongoing demonstrations, pilots, studies, and reports), the underlying goal—to use the Medicare reimbursement system to promote high quality health care, accountability, and efficiency—will remain the same. Any final legislation likely will include creation of an independent advisory panel that would monitor all payment changes to ensure consistency with, among other things, variations in growth of volume of services, geographic factors, and overall health spending among uninsured, privately insured, and Medicare and Medicaid groups. Still, providers should conduct their own ongoing financial and operational assessment of the effects of any changes. While these reforms may possibly result in improvements to the health care delivery system and lower costs, the changes in reimbursement methodologies will present many challenges for the provider community, and certain segments will fare much better than others.

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