HEALTHCARE**LEGAL**NEWS

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CARROT OR STICK?: E-PRESCRIBING "INCENTIVE" PROGRAM - FINAL RULE ANNOUNCED

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The Medicare Electronic Prescribing Incentive Program (Program) commenced on January 1, 2009. This Program was authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to provide a combination of incentives and payment adjustments for eligible medical professionals deemed to be "successful electronic prescribers." Recently, CMS announced the Final Rule regarding incentive payments and penalties for calendar years 2012 to 2014.

"The Carrot"

Under the Program, medical professionals who are "successful electronic prescribers" will receive an incentive payment in the amount of 1.0% for calendar year 2012. In comparison, for calendar year 2013, the "incentive payment" will be reduced to 0.5%, and there will be no "incentive payment" for the 2014 calendar year. These "incentive payments" will be paid to medical professionals above what they would otherwise be entitled to under Part B of Medicare.

"The Stick"

Within the same Rule, CMS provides that eligible medical professionals who fail to meet the Program's electronic prescription requirements or obtain a hardship exemption will receive a 1.0% payment reduction for 2012. The reduction in payments under the Program will increase to 1.5% for calendar year 2013 and to 2.0% for 2014. Once again, these reductions will apply to all payments under Medicare Part B.

Nevertheless, individual medical professionals can avoid the 2012 payment reduction if they meet criteria set forth in the Final Rule such as if the eligible medical professional is not a physician (M.D., D.O. or Podiatrist), nurse practitioner, or physician assistant and does not have prescribing privileges. Likewise, group practices (defined as 2 or more medical professionals), may also avoid the payment reduction if they reported in 2011 a significant hardship through correspondence to CMS providing specific and required information regarding the group practice

and stating the group practice's participation in the 2011 Program. Further, either an individual medical professional or group practice may be able to avoid the penalty if it becomes a successful electronic prescriber for purposes of the 2012 Program.

Finally, individual medical professionals and group practices can request CMS grant them a "significant hardship exemption." Applications for this exemption are reviewed by CMS on a case by case basis and are subject to an annual renewal. The deadline for hardship exemption applications for the 2012 calendar year is November 1, 2011 for both individual medical professionals and group practices.

HEALTHCARE REFORM NEWS

SQUEEZE PLAY: WILL INSURANCE BROKERS BE FORCED OUT OF THE MARKET TO INCREASE THE MEDICAL-LOSS RATIO OF HEALTH INSURERS?

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The Patient Protection and Affordable Care Act (PPACA), among other things, requires that health insurance companies pay a minimum percentage of premiums on health care, commonly referred to as the medical-loss ratio. Specifically, PPACA requires that insurers in the individual and small group market spend at least 80% of premiums on medical care, and in large group markets, the requirement goes up to 85%.

However, the fees and commissions paid by health insurers to insurance brokers may not be included in the percentage spent on medical care as announced by HHS in the interim final rule published in December of 2010. This rule was based upon a recommendation regarding medical-loss ratio calculations by the National Association of Insurance Commissioners (NAIC).

One potential unintended side effect of the rule appears to be that many insurance brokers may be forced out of the market as their fees and commissions are reduced or eliminated by health insurance companies in their attempt to meet their medical-loss ratio obligations under the Act. In fact, UnitedHealthcare has already announced that it will no longer pay commissions to brokers for policies sold to large employers in Texas and Florida, two of the largest states in the nation.

While it is unknown at this time whether the final rule to be promulgated by HHS will include these commissions and fees as part of the amount spent on medical care, it will be interesting to see if other health insurers follow UnitedHealthcare's lead. Should enough other health insurers follow UnitedHealthcare, the insurance industry could gain momentum to squeeze HHS into changing the medical-loss ratio rule. At this stage, it is too early to tell who will be winners and losers.

REIMBURSEMENT NEWS

FEDERAL LEGISLATION INTRODUCED TO BENEFIT KIDNEY TRANSPLANT PATIENTS

By Ralph Levy, Jr., who is Of Counsel in Dickinson Wright's Nashville office, and can be reached at 615.620.1733 or rlevy@dickinsonwright.com

In late September, legislation was introduced that if enacted by Congress, would eliminate the current cutoff of Medicare's payment for immunosuppressive drugs for kidney transplant patients. At present, Medicare pays for these drugs only for a period of 36 months after the date of transplant. Once this time period expires, unless a transplant patient has private insurance that covers these drugs, they must be paid for either out of pocket by the patient or through discounted purchase programs sponsored by the pharmaceutical manufacturers of these drugs. Both the House and Senate versions of this proposed legislation allow kidney transplant patients to enroll in Medicare solely to obtain these benefits.

The economic rationale for elimination of this artificial cutoff date is that even if a transplant patient takes the anti-rejection drugs for life after receipt of a kidney transplant, the $15,000 to $20,000 anticipated annual cost to CMS for continued payment for these drugs is far less than the cost of another transplant ($100,000 to $125,000 for each transplant) or a return to dialysis at a cost in excess of $70,000 per year.

"BEWARE THE BUNDLE": MEDICARE ANNOUNCES PILOT PROGRAM FOR BUNDLED PAYMENTS TO HEALTHCARE PROVIDERS

By Ralph Levy, Jr. • rlevy@dickinsonwright.com

In late August, CMS invited providers to submit letters of intent as to their willingness to participate in a pilot program designed to test a new payment methodology by which CMS would make a single "bundled" payment for all types of healthcare services related to a hospital stay for a single illness or course of treatment such as a specific surgical procedure (an "episode of care"). Depending on which of the four payment models that define differently what services are included in the episode of care that CMS ultimately adopts after the end of the pilot program, this single payment could cover all hospital care, laboratory testing and durable medical equipment provided to the patient during the hospital stay and the services provided by physicians and other providers while hospitalized and for a specified time period thereafter.

CMS anticipates significant cost savings and improved quality of care once this bundled payment system is rolled out after completion of its testing of the payment methodology and development of the

accompanying quality incentives and requirements. Although the focus of this new program is a single hospital stay, it could be expanded to additional healthcare services in the future.

Based on the author's experience in the dialysis industry, it is highly likely that CMS can adapt and utilize reimbursement methodologies now being used to pay for dialysis services for use in payment for episodes of care and other healthcare services. For example, starting January 1, 2011, CMS began compensating dialysis providers under a new bundled payment method that included in a single "per treatment" payment previously separately billable laboratory services and treatment-related drugs. This new system for reimbursement of dialysis providers includes positive adjustments based on the acuity of the patient and negative adjustments if certain minimum quality indicators ("quantification of quality standards") are not met by the dialysis provider. It is likely that the bundled payment system for hospital stays will include quantification of quality standards and other elements that are taken into account in payment for dialysis services.

After CMS approves entities that submit nonbinding letters of intent, it will provide them with data to enable those still interested in participation in the pilot program to submit applications for participation in the pilot program by either October 21, 2011 or March 15, 2012 depending on which program is applied for.

HEALTHCARE IT NEWS

THOUGHTS FROM HIMSS 10TH ANNUAL PUBLIC POLICY SUMMIT

By Brian R. Balow, who is a member in Dickinson Wright's Troy office, and can be reached at 248.433.7536 or bbalow@dickinsonwright.com

On September 14 and 15, my colleague, Tatiana Melnik and I, attended the HIMSS (Health Information Management Systems Society) 10th Annual Policy Summit in Washington, D.C. The Summit focused on HIMSS' policy initiatives pertaining to health information technology (HIT), and included in-depth analysis of the underlying HIT issues from subject matter experts representing a wide variety of disciplines. The Summit is timely based in light of the ongoing uncertainty in the HIT legal and regulatory arena, particularly as to the various financial incentives for health care industry adoption of electronic health records systems.

As part of a four person Michigan delegation, Tatiana and I visited the offices of Senator Debbie Stabenow (D - MI) and Senator Jon Kyl (R – AZ) to discuss the following HIMSS policy initiatives:

- In order to improve the quality of your constituents' health care while also reducing its costs, such as through elimination of duplicative care, Congress should continue its strong bipartisan support for Health Information Technology.
- Congress should preserve the investment being made in the Medicare and Medicaid Electronic Health Records Meaningful Use Incentive Program as an essential tool that is critical to the healthcare transformation process.
- In order to ensure that your constituent is the right person getting the right healthcare at the right time, Congress should support the development of a nationwide patient identity solution by lifting the current statutory prohibition to allow HHS to address this issue along with other health IT policy enhancements.

It was clear that both sides of the aisle support and desire to continue to support HIT given the long term financial and services level improvements in implementing technology. Nonetheless, neither side could make any promises given the pending legislative fight in Congress.

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