Health Care Reform: Today, Tomorrow, and the Next Day

Part III
May 19, 2010

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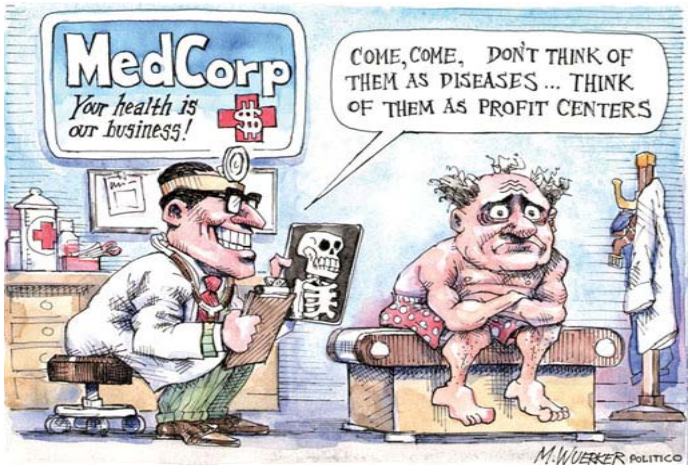
Three-Part Series

- Today (April 21)
  - Overview of PPACA
  - Immediate and short-term impact
- Tomorrow (May 5)
  - Access to adequate and affordable health insurance
  - Health care workforce
- The Next Day (May 19)
  - Strategic planning in response to health care reform

Two Intertwined Goals

- Better health insurance coverage that is more available and affordable for legal residents
- Reform the health care delivery and payment system to provide better care in a more cost-efficient manner



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The First Two Months

- **Children with pre-existing conditions**
  - March 29 agreement by insurance industry not to pursue loophole
- **Small business tax credits**
  - April 1 IRS guidance (with updates)
  - Postcards to 4 million employers
  - May 17 IRS regulation
- **High risk pools**
  - April 2 letter to states concerning participation
  - May 10 applications to states who intend to participate (30 so far)
  - By June 1, state and federal programs operational
- **Medicaid expansion**
  - April 9 CMS letter to state Medicaid directors

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The First Two Months

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- **Insurance rate reviews**
  - April 12 request for public comment (May 14 deadline)
  - May 5 letter to state governors and insurance commissions regarding rate review authority
- **Medical loss ratio**
  - April 12 request for public comment (May 14 deadline)
  - By June 1, NAIC to provide uniform methods for calculation
- **Office of Consumer Information and Insurance Oversight**
  - April 18 Jay Angoff named as director
- **Adult child coverage**
  - April 27 IRS guidance
  - May 11 HHS regulations
  - Voluntary action by insurance companies

The First Two Months

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- **Rescissions**
  - April 28 insurance companies announce early compliance fraud fighting
  - April 30 HHS regulations on program enrollment, timely filing
  - May 11 DOJ/HHS press conference addressing FY 2009 fraud recoveries
- **Early retiree reinsurance program**
  - May 5 HHS regulations
  - By June 1, program launched
- **Web portal**
  - May 5 HHS regulations on information collection
  - By July 1, Phase I introduced
- **Medicare Part D donut hole**
  - By June 15, first $250 checks to be mailed

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Political Landscape

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- Legal challenges to individual mandate
  - 20 state attorneys general + NFIB
- Mid-term elections and Republicans' "Second Opinion" campaign
- States move to implement reform
  - Virginia initiative

Getting from Here to There

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Here	There
Fee-for-service	Outcome-based reimbursement
Provider silos	Integrated provider networks
Fragmented care	Coordinated care
Data is an afterthought	Data is king
Defensive medicine	Evidence-based medicine

Strategic Planning for Reform

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- ***Required*** community health needs assessment
  - All non-profit hospital organizations (including critical access hospitals) must complete by January 1, 2013
  - "takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health"
- ***Strategic*** community needs assessment

"Transforming health care everywhere starts with transforming it somewhere."

Atul Gawande, "Testing, Testing,"
The New Yorker, December 2009

Welcome to River City

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- 35,000 residents
- 90 minutes from major metropolitan area
- Smaller communities in surrounding area
- 4 major local private employers
- State college and technical school

Welcome to River City

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- River City Memorial Hospital
- River City Multi-Specialty Clinic
- Other physician practices (1-3 doctors)
- River City Ambulatory Surgery Center (physician owned)
- Home health and hospice
- Skilled nursing/long-term care facilities
- Local health department
- Federally qualified health center

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Scene I: Memorial Hospital

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- Non-profit corporation
- 150 beds with broad range of inpatient and outpatient services
- Supporting hospital for three CAHs
- Employ hospital-based physicians and other "high end" specialists
- Minimal physician involvement in administration
- Nervous board members
- Overtures by regional health system

Health Reform and the Hospital Bottom Line

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- Medicare payment reductions
  - Automatic
  - Poor performance
- New money
  - More insured, better coverage
  - Medicare payments
    - Value-based purchasing
    - Medicare shared savings program
    - Demonstration projects
- Essential investments
  - Community needs assessment
  - Compliance
  - HIT/HIE

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Automatic Medicare Payment Reductions

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- **FY10**: Reduction in market basket updates (up to 0.75 in FY17)
- **FY12**: Additional reduction resulting from productivity adjustments
- **FY13**: Reductions in base operating DRG amounts to fund value-based purchasing (1% in FY13, ramp up to 2% in FY17)
- **FY 14**: Cuts in Medicare/Medicaid DSH payments (tied to reduction in uninsured)

Payment Reductions Tied to Hospital Performance

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- **Hospital-acquired conditions**
  - Continue current Medicare program (no payment for secondary diagnosis)
  - FY11: Extend to Medicaid
  - FY15: 1% inpatient payment reduction for hospitals in top quartile for HACs
- **Excessive readmissions**
  - FY13: Penalty for excessive readmissions relating to heart attack, heart failure, pneumonia
    - 1% penalty in FY13 up to 3% by FY17
    - FY15: HHS may expand eligible readmissions conditions
    - Public reporting of readmission rates

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Reducing Readmissions

- **Community-Based Care Transition Program**
  - In 2011, funding for high readmission rate hospitals to improve transition care by partnering with community-based organizations
    - Submit application with specific intervention proposal
    - $500 million appropriation
- **Patient Safety Organizations**
  - In 2012, high readmission rate hospitals eligible for assistance from Patient Safety Organizations

More Insured, Better Coverage

- **Immediate reforms expanding coverage**
  - Small business tax credits; high risk pools; early retiree reinsurance program; rescissions; lifetime limits; dependent coverage; kids' pre-existing conditions
- **Immediate reforms enhancing coverage (new plans)**
  - First-dollar coverage for preventive care; no out-of-network penalties for emergency services
- **Significant expansion of coverage in 2014**
  - Private insurance vs. Medicaid
  - Essential health benefits

Medicare Value-Based Purchasing Program

- FY11 and 12: Lump sum payments to hospitals in counties with lowest adjusted Medicare spending
- FY12: VBP demonstration project for CAHs
- FY13: Increase in base-operating DRG payment amount for meeting/exceeding specified performance measures
  - AMI, heart failure, pneumonia, hospital-acquired infections
  - Public reporting of hospital-specific information
- FY14: Include efficiency standards in measures (Medicare spending per beneficiary)

Medicare Shared Savings Program

- New program on line by January 1, 2012
- Provider may participate by joining with other providers to form accountable care organization (ACO)
  - Medicare pays ACO portion of cost savings for assigned patient population if specified quality measures are satisfied
  - ACO allocates payment among participants

What's an ACO?

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- Voluntarily aligned providers jointly held accountable for achieving measured quality improvements and reductions in rate of spending growth for identified patient population
  - Degree of alignment depends on providers' wants and community needs
- PPACA requirements:
  - "have established a mechanism for shared governance"
  - "have in place a leadership and management structure that includes clinical and administrative systems"
  - "define processes to promote evidence-based medicine and patient engagement," quality reporting, and care coordination
  - "have a formal legal structure…to receive and distribute payments for shared savings…."

Shared Savings Payments

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- Three-year commitment
- Each ACO assigned at least 5,000 Medicare beneficiaries
  - Process for patient attribution TBD
  - Prohibitions on cherry picking and lemon dropping
- Providers continue to receive usual fee-for-service payments
- Compare estimated average per capita Medicare expenditures with actual spent for specified time period
- If meet specified performance standards AND reduce costs, ACO receives a portion of the savings

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Evolution of ACOs

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- **Phase I** (Medicare's Shared Savings Program)
  - Legal entity with basic HIT and performance reporting capabilities
  - "Starter set" of quality, efficiency, and patient-experience measures
  - Shared savings for meeting quality and spending targets, no downside risk (continued fee-for-service payments)
- **Phase II** (Other payers?)
  - More advanced HIT and care coordination staff
  - More and stronger performance targets and reporting requirements
  - Downside risk (skin in the game)
    - Larger shared savings balanced by accountability for costs exceeding targets
    - Risk-adjusted partial capitation payments with quality bonuses

ACO Barriers

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- No common definition of ACO
- No experience building and maintaining necessary organizational and legal structures
- Lack of infrastructure to support development of protocols, care coordination
- Lack of experience with quality reporting
- Uncertainty relating to antitrust law, Stark Law, Anti-Kickback Statute, and Civil Money Penalties Act
  - FTC guidance on clinical integration
  - "The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this Act."

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Integration Enablers

- Stark exception for hospital EHR donations to physicians
- Incentive payments for meaningful use of HIT and funding for development of HIE (ARRA)
- National Strategy for Improvement in Health Care
- Patient-Centered Outcomes Research Institute
- Quality measure development
- Comparative effectiveness research
- Quality improvement initiatives
- VBP for other providers

Other Incentives for Integration

- Medicare demonstration projects
  - Extension of current gainsharing demonstration project
  - Independence at home medical practice (by 2012)
  - Payment bundling for episode of care (by 2013)
- Medicaid demonstration projects
  - Global payment system (2010)
  - Pediatric ACO (2012)
  - Integrated care around a hospitalization (2012)
- Center for Medicare and Medicaid Innovation
  - Focus on telehealth projects
- Community Transformation Grants
- Community-Based Collaborative Care Network Program

Can We Get There?

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- Start the conversation *now*
  - Inclusive, not exclusive
  - Providers (*all of them*), employers, and payers
- Define how the ACO will benefit the community
- Explore options
  - Commitment by participants to engage in the process
  - Evaluate current linkages and relationships
  - Consider what's worked elsewhere
- HIT/HIE as first step towards integration
- Development of clinical protocols

Necessary Investments

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- Community needs assessment
  - Delivery of preventive care/wellness programs
- Compliance
  - Mandatory compliance programs
  - Obligation to return overpayments
  - New enforcement tools
- HIT/HIE
  - Assess current capabilities
  - Make financial/human resources commitment
  - Due diligence
  - Monitor meaningful use regulations
  - Monitor statewide HIE initiatives
  - Support for independent practices
- Other "noise"
  - HIPAA transactions standards (2013-17)
  - ICD-10 (October 2013)

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Scene II: River City Physician Clinic

- Multi-specialty physician group practice
  - Family practice/OB, internists, general surgeons, ENT, pediatricians
  - Nurse practitioners and physician assistants
- In-office ancillary services
  - Clinical lab, CT, x-ray, bone density, physical and occupational therapy
- Several physicians hold ownership interest in ambulatory surgery center

Concerns/Obstacles

- Declining revenues
  - Cuts in imaging payments
  - 21 percent cut scheduled for May 31
- Health information technology
  - Cost to implement
  - Time to implement
  - How to manage data
- Pressure to sell to hospital
- Fear loss of autonomy (even if don't sell)
- Legal/compliance concerns

What PPACA Means for Physicians

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- Emphasizes coordination of care across specialties and providers
- Primary care providers play instrumental role
- Emphasis on quality/outcomes/patient-centered care (medical homes)
- Emphasis on "bundling" of payments for multiple providers

What PPACA Means for Physicians

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- Disparate and independent providers may find they have common interests and needs
  - Need to combine resources (*e.g.*, HIT)
  - Need to coordinate quality/performance improvement efforts
  - Need to rely on/coordinate with other specialties
  - Need to be paid

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What to Do?

- Step One: "You gotta know the territory"
- Step Two: Identify PPACA opportunities
- Step Three: Strategic planning
- Throughout the Process: Compliance

Step One
"You gotta know the territory."

- Identify opportunities in the market
  - Who are the other providers?
    - Hospital?
    - Post-acute care providers?
    - PHO?
    - Specialists inside/outside of group?
    - FQHC?
  - Payer mix
  - Employer initiatives

Step One
"You gotta know the territory."

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- Identify Internal Opportunities
  - Status of HIT?
  - Contracts with innovative payers?
  - Using clinical protocols?
  - Participating in Physician Quality Reporting Initiative?
  - Physician leaders?

Step Two
Identify PPACA Opportunities

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- More insureds (immediate)
  - Dependent coverage up to age 26
  - Rescissions of coverage prohibited
  - Reinsurance for employers providing coverage to early retirees over age 55
  - High-risk pool for pre-existing conditions
  - No restrictions on selection of primary care physician

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Step Two
Identify PPACA Opportunities

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- More insureds (2014)
  - Mandate (or tax penalty) for individual coverage
  - Health insurance exchanges and subsidies
  - Mandate (or tax penalty) on employers of >50
  - Expansion of Medicaid

Step Two
Identify PPACA Opportunities

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- More reimbursement
  - GPCI (Geographic Price Cost Index)
  - No lifetime limits on coverage (and restriction on annual limits)
  - No pre-existing condition exclusions for children (extends to everyone in 2014)
  - Insurers must cover certain preventive services and immunizations without cost-sharing

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Step Two
Identify PPACA Opportunities

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- More reimbursement
  - Health plans required to report medical loss ratio (MLR) and pay rebate to insureds
  - Primary care/general surgery Medicare 10 percent bonus payments (2011)
  - PQRI bonuses (2011-2014)
  - Medicaid primary care payment at Medicare rates (2013-2014)

Step Two – Identify PPACA (and Related) Opportunities

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- New Programs and Pilot Projects
  - ACOs
  - Medical home
  - Independence at home
  - Value-based purchasing
  - Payment bundling
  - Center for Medicare/Medicaid Innovation
  - Medicaid pediatric ACO
  - HRSA funding (for community health centers)
  - Community transformation grants
  - Meaningful use payments

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Step Three
Strategic Planning

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- Actions to Take
  - Educate physicians and identify strong physician leaders (internal)
  - Identify strong physician partners (outside group)
  - Strengthen/expand clinical protocols

Step Three
Strategic Planning

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- Actions to Take
  - Evaluate health information technology capabilities and opportunities
    - EMR: Practice? Hospital? Other partners? Interconnectivity?
    - State HIE/HIT
  - Identify other providers to engage as partners
    - Hospital
    - Other physicians
    - FQHC
    - Post-acute care
  - Engage key partners to determine structure/governance

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Step Three
Strategic Planning

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- Identify a Structure or Structures
  - Key characteristics:
    - Sufficient level of clinical integration
    - Ability to receive and administer payment to providers

Step Three
Strategic Planning

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- Identify a Structure or Structures
  - Employment?
  - Physician enterprise?
  - Independent practice association?
  - Clinical co-management or other contractual arrangements?
  - Clinical pathways?
  - Other?
    - Look at successful models: Geisinger, Cleveland Clinic, Mayo Clinic

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Throughout the Process – Compliance

- Stark
  - Applicable exception?
  - Disclosure requirements for in-office ancillary services self-reporting?
- Anti-Kickback
- Civil Money Penalties
- Antitrust
- FERA
- Sunshine Act
- Corporate practice of medicine
- Fee splitting
- HIPAA and state information privacy laws

Scene III
River City Chamber of Commerce

- Mix of larger employers (local and out-of-town) and small employers
- Many, many questions

PPACA's Impact on Employer Health Insurance

- Small business tax credits
- New plan rules = premium increases?
  - New premium review processes
  - Transparency
- Loss of grandfather status
- Gearing up for 2014 (if<50 FTEs)
  - Waiting for regulations
  - Each employer is unique
  - May 14 Congressional Research Service report
  - From fully insured to self-insured?

CLASS Act

- Voluntary long-term care insurance program operated by federal government
- Employers expected – but not required – to allow for payroll deductions and automatically enroll employees
- Effective 2011?

Wellness Programs

- In 2011, grants available to employers with fewer than 100 employees working 25+ hours/week to establish employee wellness programs
- What constitutes a wellness program?
  - health awareness initiatives (health education, preventive screenings, and health risk assessments)
  - efforts to maximize employee engagement
  - initiatives to change unhealthy behaviors and lifestyle choices (counseling, seminars, online programs, self-help materials
  - supportive environment efforts (workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health)
- HHS to provide technical assistance and other resources to evaluate employer-based wellness programs

Wellness Programs

- Beginning in 2014, employers may offer rewards of up to 30 percent of the cost of coverage for participating in wellness program
  - premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided
  - must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet established standards
- Reward limit may be increased to 50 percent if HHS deems appropriate

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Quality Reporting

- By 2012, HHS will develop quality measures for health plans addressing:
  - quality reporting, case management, care coordination, chronic disease management, and medication and care compliance initiatives
  - hospital readmission prevention programs
  - appropriate use of best clinical practices, evidence-based medicine, and health information technology
  - wellness and health promotion activities
    - Smoking cessation, weight and stress management, physical fitness, nutrition, heart disease and diabetes prevention, healthy lifestyle support

Quality Reporting

- Annual reports to Secretary
  - posted HHS website
  - penalties for non-compliance
  - "good job" exceptions
- Make available to enrollees during each open enrollment period

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