Health Care Reform: Affordable Care Act (ACA) What is it? How will it affect Doctors/Hospitals and Patients?

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Trends Post ACA

- Physicians
  - Physicians Increasing difficult to stay in private practice
  - Move toward Hospital integration through employment or other Joint Ventures
  - Move toward large single specialty groups
  - Decrease in large multispecialty groups
  - Hospitals will assume more administrative burdens for physicians
  - Medical License tied to products or enrollment in Medicare/Medicaid

Trends Post ACA

- Reimbursement
  - Rate reduction – Continued use of Medicare Sustainable Growth Rate (SGR)
  - Quality Measures – focus on outcomes and tied to reimbursement
  - Reduction of Medicare and Medicaid disproportionate share payments (DSH) to reflect decrease in uninsured population
  - ACO introduction (Waivers for ACO structures?)
  - Global or bundled payment projects

ACA failures

- SGR – current extension set to expire November 30, 2010 (23.5% Reduction by Centers for Medicare and Medicaid Services (CMS) in reimbursement of claims – includes the 2.2% Temp increase set by Congress)
  - Additional cuts in SGR (Approx. 6%) set to take affect on January 1, 2011
  - Total cut SGR could reach 30% by January 1, 2011
- Tort Reform
- Neither SGR or Tort Reform are addressed in ACA

Medicare SGR – what is it?

- 1965 Medicare Program Created
- 1965 – 75 Physicians paid on basis of charges and allowed to balance bill patients
- 1975 – Physician increases capped by Medical Economic Index
- 1992 – Adoption of Fee Schedule, updated annually
- 1998 – Introduction of SGR

Medicare SGR

- Goal of SGR was to predict expenditures and ensure access to physician services while control federal spending.
- Relative Value Unit (RVU)
  - Physician payment = RVU x conversion factor (SGR)
  - RVU (measurement of cost to provide physician services)
    - Physician work component
    - Practice expense
    - Professional liability component
  - SGR – physician services/national economy – targeted growth
- Problems with SGR
  - 23.5% cut in November 30, 2010 – Congress has done nothing
  - Medicaid (some states) tie payments to Medicare Fee Schedule

Medicare SGR

- Result
  - Inadequate access to care for patients
  - Private Plans payment based on Medicare fee schedule – decreased reimbursement
  - Effect of Independent Payment Advisory Board (IPAB) (Created by ACA)
    - Begins on January 14, 2014
    - Makes recommendations to Congress cutting Medicare spending growth.
    - If Congress doesn't pass either IPAB's or its own legislation to meet the IPAB spending reductions within six months, HHS must implement the recommendations.

ACA and Medicaid

- Pre –ACA
  - Medicaid
    - Low income children, disabled and elderly
    - No requirement to cover "able body" adults under 65
    - Children's Health Insurance Program (SCHIP)
    - Premium Assistance Program (2006) permissible under SCHIP
- Post – ACA
  - Medicaid – Newly eligible (Numbers are somewhere 16-17 million added)
    - Individuals eligible if <133% of federal poverty level
    - Below 65
    - Not pregnant
    - Not eligible for Medicaid or enrolled in Medicare Part A/B
    - Benchmark benefits

ACA and Medicaid

- Medicaid Funding – ACA – Health Care Reconciliation Act 2010
  - January 1, 2014 – December 31, 2016 – 100% (Federal)
  - 2017 – 95%
  - 2018 – 94%
  - 2019 – 93%
  - 2020 – 90%

ACA and Medicaid

- Medicaid Issues
  - Takes up approx 20% of State's budget
  - ACA will increase administrative burdens for physicians
  - Physician payments by Medicaid don't cover costs
  - Access to care – Who will treat the newly covered?

Medicaid Demonstration Project (§2704)

- Quality Improvement demonstration projects evaluating integrated care around hospitalization (2012 – 2016 – 8 states)
  - Episode of care that includes hospitalization
  - Concurrent physician services provided during hospitalization
  - Quality focus while reduction of expenditures
  - Bundled payments to hospitals and physicians
    - Evaluation of quality outcomes and spending of hospitals receiving bundled payment

Medicare Payments - Bonus (§5701)

- PCP shortage for newly covered patients
  - Lack of OB/GYN, Peds, Family practitioners, and internists
  - General surgery – more specialists driven by revenue/reimbursement/salary
  - Medicare bonus of 10% for physicians in health professional shortage areas
  - Five year program paid monthly or quarterly
  - Medicaid payments to PCP can be no less than 100% of Medicare Part B during 2013 and 2014
- Value Based Payment Modifier (§3007)
  - Budget neutral system for physician payments – quality and costs established by HHS – used as an additional differential toward payment for physicians
  - Published in 2012 – effective 2015
  - No administrative or judicial review

Medicare Value Based Payment Modifier (§3007)

- Quality of care
  - Established by physicians/physician groups
  - Reflect health outcomes
  - Risk-adjusted
- Cost
  - Comparison of expenditures for physicians
  - Eliminates geographic adjustments in payment
  - Accounts for risk factors

Medicare Spending

- Reduction of DHS payments by 75% in 2014.
- Saves $22.1 million over 10 years beginning in 2014
- Subsequently increase payments based on the percent of the population of uninsured and the amount of uncompensated care
- Value Based Purchasing (VBP) programs
  - Transition from pay for reporting to pay for performance (P4P)
  - Inpatients payments will be modified based on quality measures
    - Include Acute MI; Heart failure; Pneumonia; surgeries, and health care related infections – MRSA

Medicare Spending

- Value Based Purchasing (VBP) programs (Cont.)
  - HHS Secretary sets the performance standards and hospitals will receive a score
  - Achievement and improvement scores
  - Highest scores receive VBP incentive payments
  - Lowest scores receive reduction in payments
  - Budget neutral
  - Pool for payments increases annually:
    - 2013 – 1%
    - 2014 – 1.25%
    - 2015 – 1.5%
    - 2016 – 1.75%
    - 2017 and beyond – 2.0%

Medicare Spending

- Payments for excess hospital readmits (Reduction of payments)
  - Effective 2012
  - Admission of a patient to the same hospital from which the patient was discharged or to another hospital within a time period specified by HHS
  - 2012 – 2014 – Conditions include acute MI, heart failure and pneumonia
  - 2015 – HHS can expand to include COPD, percutaneous transluminal coronary and other vascular procedures
  - Reduction = great of
    - 1 minus the ratio of aggregate payments for excess readmissions and aggregate payments for all discharges; or
    - Floor adjustment – 2013(.99); 2014 (.98) and 2015 (and beyond) (.97)

Medicare Spending

- Payments for Hospital Acquired Conditions
  - Reduce payments by 1% for hospitals In the top quartile of hospitals acquired conditions – effective 2015
  - Only applies to acute care hospitals reimbursed under IPPS and Maryland waiver hospitals
  - HHS will report to Congress on how the policy can be expanded to other provides exempt from IPPS, including: IP Rehab facilities, LTACs, Hospital Outpatient Dept., SNFs and ASCs.

Medicaid Spending

- Medicaid DSH
  - 2009 Federal share = $11,337,262,543
- Reduce state allotments for Medicaid DSH starting in 2014 by:
  - 2014 - $.5 billion
  - 2015 - $.6 billion
  - 2016 - $.6 billion
  - 2017 - $1.8 billion
  - 2018 - $5 billion
  - 2019 - $5.6 billion
  - 1010 - $4 billion

Medicaid Spending

- Medicaid DSH
  - Reductions will target states with lowest percentage of uninsured and those that do not target DSH payments based on Medicaid inpatients and uncompensated care.
  - Methodology imposes a smaller percentage reduction on low DHS states

Other ACA Provisions

- Fraud and Abuse
  - More funding for enforcement under Medicare and Integrity Program
    - More RACs – Medicaid, Medicare Parts C and D
    - Increased spending of $300 million over 10 years
  - Mandatory reporting of overpayments within 60 days of discovery (§6402)
    - What is discovery?
      - Clock starts date overpayment is known or corresponding cost report is due
      - Effective immediately
- Requirements for Physician Enrollment in Medicare (§6405)
  - Physicians or eligible professionals ordering DME (durable medical equipment) or home health services must be enrolled
  - HHS may extend required enrollment to other services
  - Effective July 1, 2010

Other ACA Provisions

- Twelve Month Submission deadline for Medicare Claims (§6404)
  - Previous law was three years after date of service
  - Applies to Medicare Parts A and B
  - Effective January 1, 2010

Physician Perspective

Changes and Trends post ACA

Trends in Physician Integration

- Physicians are considering moving towards consolidation with other physicians as well as hospitals
  - Due to declining reimbursement rates
  - ACA
  - Higher reimbursement for and demand to invest in EHRs
  - Quality Data Reporting Requirements
  - Higher malpractice premiums
  - Increased potential liability and risk due to Government Audits and increased regulatory requirements (RAC audits, ACA fraud and abuse amendments, higher HIPAA penalties and audits, etc.)
  - Likelihood of increased patient volume due to ACA
  - Death of Specialty Hospitals
    - ACA – December 31, 2010 deadline; limitations on size; ownership interest etc.

Physician Reimbursement Issues

- No permanent fix for Physician Payment Cuts Yet (i.e., SGR)
- ACA
  - Modified the Physician Quality Reporting Initiative
    - Incentives extended through 2014 (extra .5% in 2011-2014)
    - Reductions if don't report starting in 2015
  - HHS to establish a budget-neutral payment modifier that provides for differential payment to a physician or a group of physicians based upon the quality of care furnished compared to cost
    - Begins for certain physicians/groups as of 1/1/2015
    - Begins for all physicians/groups as of 1/1/2017
  - Quality payment modifier
  - Improvements to Physician Feedback Program
    - Will be expanded to provide individualized by 2012
  - Public reporting of physician performance information

Increased Pressure to Adopt EHRs

- HITECH Act authorizes incentive payments under Medicare and Medicaid for physicians (and other eligible professionals) who demonstrate the “meaningful use” of certified EHRs
- Proposed rules on “meaningful use” issued in January 2010
- HHS recently issued temporary certification rules for EHRs, which will sunset on December 31, 2011
- Beginning in 2011, Medicare will pay incentive payments to physicians under Medicare Part B
- Also beginning in 2011, state Medicaid programs will make incentive payments (No downward incentives)
- Downward payment adjustments begin in 2015 for physicians who are not meaningful users of certified EHRs

ACOs

- What are ACOs?
  - Groups of providers and suppliers who work together to manage and coordinate care
  - Must meet quality performance standards established by HHS to be eligible for shared savings
- What is the benefit of an ACO under ACA?
  - Able to participate in a shared savings program to promote accountability for a patient population, coordination of Medicare items or services, and encouragement of investment in infrastructure and redesigned care processes for quality and efficient service delivery
  - Providers in ACOs are rewarded with a share of the savings program relative to a spending benchmark
- Exact structure of various ACO models is still to be determined

HOSPITAL PERSPECTIVE

Predictions on the Impact of Reform on Hospitals

- Consolidation of hospitals into bigger systems
- Vertical integration—hospitals will acquire other providers
- Hospitals will employ physicians

Many Features Of ACA Will Foster Horizontal Integration

- Governmental Payors Reimbursement Reductions
  - –Reductions in Medicare and DSH
  - –Reductions in Medicaid, coupled with growth in Medicaid population
  - –Timing difference between cuts and new paying patients

Many Features Of ACA Will Foster Horizontal Integration (cont.)

- Private Payors Payment Reductions
  - New underwriting rules
  - Rates pegged to Medicare
  - Annual fees from payors

Many Features Of PPACA Will Foster Horizontal Integration (cont.)

- Hospitals Struggling with Electronic Mandates
  - EMR
  - Quality initiatives
  - Value-based purchasing
  - Emphasis on cost reductions

Many Features Of ACA Will Foster Horizontal Integration (cont.)

- Sectors Where Activity Expected
  - Struggling not-for-profits acquired by for-profits
  - Not-for-profits consolidating
  - Institutions investing in for-profits
  - Private equity firms buying hospitals

Many Features of ACA Will Foster Vertical Integration

- Integrated delivery systems are simpler to operate if hospital owns all providers
- Bundling that covers an episode of care will case vertical integration

Many Features of ACA Will Foster Physician Employment by Hospitals

- Bundled payments
- Accountable Care Organizations
- Reduced payments based on readmission rates and hospital acquired conditions
- EMR mandates
- Looming physician shortage
- Restrictions on the "whole hospital exception"
- Downward pressure on Medicare reimbursements rates for physicians

Questions or Comments?

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