

HEALTH CARE REFORM 101: WHAT YOU REALLY NEED TO KNOW

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MITCHELL • BLACKSTOCK

Mitchell • Blackstock • Ivers • Sneddon • PLLC

David Ivers

Mitchell Blackstock Ivers & Sneddon Law Firm

1010 W. Third St.

Little Rock, AR 72201

501 519-2072

divers@mitchellblackstock.com

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FEDERAL LAW: WHEN YOU TRY TO PLEASE EVERYONE....

- ❑ http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf
 - ❑ Patient Protection and Affordable Care Act – enacted March 23, 2010
 - ❑ Amended by Health Care and Education Reconciliation Act – enacted on March 30, 2010.
 - ❑ Sometimes referred to as PPACA, more commonly as **Affordable Care Act** or ACA or “health care reform,” or derisively as “Obamacare.”
 - ❑ 906 pages as published in the Congressional Record. (Don’t hit PRINT unless you really mean it!)
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FEDERAL LAW: WHEN YOU TRY TO PLEASE EVERYONE....

- The Congressional Budget Office (CBO) estimates net effect of ACA will be a reduction in the deficit of \$143 billion by 2019, of which \$124 billion will derive from the healthcare provisions.
- Title I Quality, Affordable Care for All Americans (insurance reform)
- Title II Role of Public Programs (Medicare/Medicaid/CHIP)
- Title III Improving the Quality and Efficiency of Health Care
- Title IV Prevention of Chronic Disease and Improving Public Health
- Title V Health Care Workforce
- Title VI Transparency and Program Integrity
- Title VII Improving Access to Innovative Medical Therapies
- Title VIII CLASSS Act (long-term care insurance)
- Title IX Revenue Provisions

Comment: Complexity reflects political compromises, trying to provide health insurance to everyone without using a government-run plan. Regardless of the Supreme Court decision on individual mandate, the law provides unprecedented – but time-limited -- funding opportunities for Medicaid and Medicare projects.

ARKANSAS: TRANSFORMATION OR TIGHTROPE?

- ❑ Medicaid Transformation Proposal:
 - ❑ --Health Homes
 - ❑ --Provider "Partnerships"
 - ❑ --Episodes-of-Care
 - ❑ --Private Plans and Medicare invited to join
 - ❑ --All-Payer Database/Uniform Pricing Policy
 - ❑ --Implementation to begin July 1, 2012; "long-term care" (including DD) by July 1, 2013
 - ❑ --Dependent upon approval by HHS and 1115 Demonstration Waiver
 - ❑ --Not dependent upon the federal health care reform law.
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GIVE ME SOME “VALUE-BASED PURCHASING”

- ❑ Federal government and states trying to shift from fee-for-service to “value-based purchasing.”
 - ❑ “A concept that links payment directly to the quality of care provided, and is a strategy that can help transform the current payment system by rewarding providers for delivering high quality, efficient clinical care.” (*CMS, Medicare Shared Savings Program/Accountable Care Organizations; Proposed Rule, March 31, 2011*)
 - ❑ Driven largely by fact that in the United States we spend more money per person on health care than any other country but lag behind other countries in health measures such as life expectancy and infant mortality.
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THAT ELUSIVE THING CALLED 'QUALITY'

Variations on a theme:

- Health Homes/Medical Homes
- Evidence-Based Practices
- Shared Savings
- Episodes-of-Care
- Global Payment
- Pay-for-Performance
- Care Coordination
- Care Management
- Case Management
- Trying to avoid the much-publicized problems of managed care in the 1990s in which cost was the main driver.

Comment: Assumption that quality-driven care is less-expensive care.

THE GOLDEN AGE OF EXPERIMENTATION

- ❑ We know the destination – higher quality; lower cost; patient-centered; less fragmented; more coordinated.
- ❑ But nobody knows how to get there.
- ❑ Consensus seems to be that FFS is not sustainable. What will replace it?
- ❑ Current system is fragmented both at provider level and payer level. How to make it seamless and consistent across silos?
- ❑ Expect change, confusion, success, failures, until the path becomes clear.

Comment: Supreme Court ruling on ACA unlikely to stop this trend.

GIVE ME A HOME: MEDICAL HOMES/HEALTH HOMES

- ❑ More of a concept, than one physical location.
 - ❑ A way of managing all aspects of a patient's care, not just treatment. It is coordinated, comprehensive, efficient and personalized. Evidence-based. Aims to improve patient self-management skills. (NCSL)
 - ❑ PCPs work with case management nurse; specialists; hospitals; post-acute care facilities; community providers. How the money gets divided up is not clear.
 - ❑ Goal: Stop fragmented, inefficient care; reduce hospital admissions and ER visits; improve overall health and satisfaction.
 - ❑ Cost: The cost of setting up a medical home ranges from \$60 to \$1,800 per person per year, while gross savings have been estimated at \$250 pppy. (NCSL)
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GIVE ME A HOME IN ARKANSAS

- ❑ Requires highly organized or integrated network that is supported by sophisticated health information technology.
- ❑ Starting to see some movement in private sector with insurance companies, hospitals, and physician clinics.
- ❑ A key part of Arkansas Medicaid Transformation proposal.
- ❑ Early model: Arkansas Medicaid's ConnectCare (AFMC) PCP program. Physicians receive about \$36 per patient per year.

Comment: May need "state action" antitrust exemption to facilitate joint provider activities.

I WANT TO BE AN ACO: ACCOUNTABLE CARE ORGANIZATIONS

- ❑ Similar to PHOs and other models from the 1990s, but supposedly without payer involvement.
 - ❑ ACA (Section 3022) – ACOs are the chosen vehicle for Medicare **“Shared Savings Program.”**
 - ❑ ACO – Group of providers who form a legal entity and agree to become accountable for the quality, cost, and overall care of the Medicare beneficiaries assigned to it.
 - ❑ Eligible to form ACOs:
 - ❑ --Networks of “ACO professionals.”*
 - ❑ --Joint ventures between hospitals and ACO professionals.
 - ❑ --Hospitals employing ACO professionals.
 - ❑ --“Other” as determined by Secretary
 - ❑ *ACO professionals = physicians, PAs, NPs, Clinical Nurse Specialists
 - ❑ But other providers may join the ACO as “participants.”
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I WANT TO BE AN ACO: ACCOUNTABLE CARE ORGANIZATIONS

- ❑ ACO Conditions:
 - ❑ 3-year agreement
 - ❑ Formal legal structure
 - ❑ Must include PCPs
 - ❑ At least 5,000 beneficiaries
 - ❑ Evidence-based medicine
 - ❑ Patient-centered
 - ❑ Use of health information technology
 - ❑ Two-tracks: (1) First two years, upside only model; third-year includes downside risk; or (2) two-sided model from the start, but with enhanced upside reward.
 - ❑ Shared savings potential roughly 50 to 60%, depending on which track.
 - ❑ Proposed regs: <http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf> (March 31, 2011)
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BUNDLE ME: GLOBAL PAYMENTS

- ❑ A fixed prepayment made to a group of providers for all care for all conditions for a population of patients. (NCSL)
 - ❑ Like episode-of-care, since in both cases payment is bundled. Main difference is that global payments cover all care for all conditions for a group of patients, while episodic payments cover only an episode of illness or medical condition, such as a heart attack, hip replacement, or diabetes.
 - ❑ Similar concept as capitation. Some important differences in that today's global payments include incentives for quality improvement, adjustments for health status and chronic conditions, and more sophisticated use of technology to manage care.
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BUNDLE ME: EPISODE-OF-CARE

- A single payment for all care to treat a patient with a specific illness, condition, or medical event, as opposed to a fee for each service (NCLS)
- ACA (3023) – Pilot program on payment bundling. “Episode” defined as:
 - Three days prior to admission to hospital for applicable condition
 - Length of hospital stay;
 - 30 days post-discharge
- ACA (2704) -- Medicaid episode-of-care demonstration projects around hospitalization in up to 8 states.

Comment: Episode-of-care is cornerstone of the Arkansas Medicaid Transformation proposal.

PERFORMANCE ANXIETY: PERFORMANCE-BASED PAYMENTS (P4P)

- ❑ Payments to providers for meeting pre-established quality benchmarks for a group of patients. (NCSL)
 - ❑ Medicare Shared Savings Program is an example.
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COMPARE ME: ALL-PAYER CLAIMS DATABASE

- A statewide repository of health insurance claims information from all health care payers – government programs, private plans, and employer-sponsored plans.
 - Facilitates easy comparisons.
 - May reduce administrative burdens for providers.
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HIT ME: MAKING SENSE OF HIT, HIE, EHR, EMR

- ❑ HIT = Health Information Technology
 - ❑ HIE = Health Information Exchange
 - ❑ EHR/EMR = Electronic Health Records/Electronic Medical Records
 - ❑ HITECH = Health Information Technology for Economic and Clinical Health Act (HITECH), part of American Recovery and Reinvestment Act of 2009 (ARRA).
 - ❑ HITECH contains incentives promoting health care information technology in general and specific incentives to accelerate adoption of electronic health record (EHR) systems among providers (e.g., “meaningful use” incentives).
 - ❑ Medicare meaningful use incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing EHR in compliance with the “meaningful use” definition or they will be subject to financial penalties under Medicare. Physicians and hospitals only.
 - ❑ Also allows states to award incentive payments to Medicaid providers, mainly physicians and hospitals.
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HIGH DOLLARS IN HITECH

- ❑ \$20.819 billion in incentives through the Medicare and Medicaid reimbursement systems to assist providers and organizations in the adoption of electronic health records.
 - ❑ \$4.7 billion for National Telecommunications and Information Administration's Broadband Technology Opportunities Program.
 - ❑ \$2.5 billion for the U.S. Department of Agriculture's Distance Learning, Telemedicine, and Broadband Program.
 - ❑ \$2 billion for the Office of the National Coordinator (ONC).
 - ❑ \$1.5 billion for construction, renovation, and equipment for health centers through the Health Resources and Services Administration.
 - ❑ \$1.1 billion for comparative effectiveness research within the Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), and the Department of Health and Human Services (HHS).
 - ❑ \$500 million for the Social Security Administration.
 - ❑ \$85 million for health IT, including telemedicine services, within Indian Health Services.
 - ❑ \$50 million for information technology within the Veteran's Administration.
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HIT ARKANSAS

- “The Arkansas Health Information Exchange (HIE) Project is the collaborative effort of public and private stakeholders to plan a technology-based, secure Health Information Exchange system that will improve the health care experience for patients, providers and insurers.” <http://recovery.arkansas.gov/hie/>
 - Will ultimately allow health information to follow you whenever and wherever you go in the health care system in order to:
 - improve access and quality of healthcare
 - reduce inefficiencies and avoidable costs
 - create better health outcomes
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FINE ME, JAIL ME

- ACA – numerous provisions targeted at stopping fraud and abuse:
 - Medicaid Recovery Audit Contractors (RACs), like the Medicare RACs
 - Affirmative obligation to report overpayments (funds received or retained to which you are not entitled after “applicable reconciliation”), within 60 days of “identifying” the overpayments or the due date for cost report, whichever is later. Intentional failures to pay can serve as basis for False Claims Act and Civil Monetary violations.
 - Enhanced penalties under CMP –now \$50,000 for each false record or statement.
 - Compliance programs emphasized
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INVENT ME: CMS CENTER FOR MEDICARE AND MEDICAID INNOVATION

- ❑ The purpose of the CMI is to test innovative payment and service delivery models to reduce costs while improving quality.
 - ❑ Models tested must address “a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.”
 - ❑ May include models that feature:
 - Broad payment and practice reform in primary care, including patient-centered medical home models for high-need individuals.
 - Contracting directly with groups of providers, such as through risk-based comprehensive payment or salary-based payment
 - Care coordination among providers that transitions away from FFS to salary-based payment.
 - Care coordination for chronically ill individuals at high risk of hospitalization through a provider network supported by health information technology.
 - Medication therapy management.
 - Community-based health teams to support small-practice medical homes in chronic care management.
 - Patient decision-support tools.
 - Others.
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INVENT ME: CMS CENTER FOR MEDICARE AND MEDICAID INNOVATION

- ❑ Need NOT be budget neutral, but to be adopted and expanded, must improve quality without increasing cost, or reduce cost without reducing quality, or improve quality and reduce cost.
 - ❑ Funding: \$5 billion for startup costs; \$10 billion for ongoing expenses through 2019.
Comment: CMS will consider any idea, large or small. Almost any idea that doesn't fit other parts of ACA could fit here.
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