

# HEALTH CARE REFORM: STEERING YOUR CLIENTS THROUGH THE SEA CHANGE

November 18, 2011

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**These materials are for instructional purposes only, and are not to be relied on for legal advice. Legal counsel should always be consulted for specific problems or questions.**

# How Can We Help Our Clients?

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1. Educate ourselves on new payment and delivery reform concepts
2. Advise clients in responding to payer offers, making counteroffers, charting a course
3. Review future contracts and regulations with extra caution

*Q: Will payers and providers become less adversarial or more?*

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# AFFORDABLE CARE ACT: WHEN YOU TRY TO PLEASE EVERYONE....

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- ❑ [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h3590enr.txt.pdf](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
  - ❑ Legal challenges centered primarily on insurance side, not healthcare, though severability issue could affect
  - ❑ 906 pages as published in the Congressional Record (Don't hit PRINT unless you really mean it!)
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# AFFORDABLE CARE ACT – continued

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- ❑ 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** CLASS 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.*

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# ARKANSAS: FIRST IN SOMETHING?

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## Health Payment Improvement Initiative:

- Health Homes
  - Provider “Partnerships”
  - Bundled Payments for Episodes-of-Care
  - Private Plans and Medicare invited to join
  - All-Payer Database/Uniform Pricing Policy
  - Wellness and preventative care
  - Implementation to begin July 1, 2012
  - Dependent upon approval by HHS through SSA 1115 Demonstration Waiver? or 1115A Innovation Waiver?
  - Not dependent upon federal health care reform law
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# WHAT'S WRONG WITH STATUS QUO?

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- ❑ **Fee-for-service** – “Unsustainable.” Paying for each test or procedure creates incentive to do more without necessarily improving quality.
- ❑ **Fragmentation** – “Nightmare to navigate” -- feels less like a system than a confusing, expensive, unreliable, and often impersonal disarray of services (Picker Survey).

In the U.S. 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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# GIVE ME SOME "VALUE-BASED PURCHASING"

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- ❑ Federal government and states trying to shift from fee-for-service to "value-based purchasing."
  - ❑ Trying to avoid the much-publicized problems of capitation in the 1990s in which cost was the main driver.
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# THAT ELUSIVE THING CALLED "QUALITY"

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- ❑ Value = Quality ÷ Costs
  - ❑ Quality difficult to measure
  - ❑ Approaches vary:
    - measure directly (PGP, ACO Shared Savings)
    - alter incentives (bundled payments)
    - hybrid (altered incentives checked by quality measures)
  - ❑ Lesson from PGP Demo: Improving quality easier than cost savings
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# GIVE ME A MEDICAL HOME

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- ❑ More of a concept than one physical location
  - ❑ Person-centered care
  - ❑ Facilitates access to care across all settings
  - ❑ Enhances coordination and integration of care, especially for chronic conditions
  - ❑ Improves quality and clinical outcomes
  - ❑ Improves the patient care experience
  - ❑ Reduces costs through more efficient care
- (Kaiser)
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## MEDICAL HOMES – Continued

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- ❑ A way of managing all aspects of a patient's care, not just treatment. (NCSL)
  - ❑ Medical homes are PCP-driven while health homes include the whole neighborhood, esp community-based providers
  - ❑ Most work is done by nurses and other non-physician staff
  - ❑ Requires highly organized or integrated network that is supported by sophisticated HIT
  - ❑ NCQA, Joint Commission, et al
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## MEDICAL HOMES – Continued

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- ❑ Aimed primarily at fragmented delivery. Can be used with FFS or other payment models.
  - ❑ Typically payor makes separate PMPM payment for medical home services, plus start-up costs.
  - ❑ 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)
  - ❑ ACA incentives: Sections 1001; 2010; 2703; 2706; 3021; 3502.
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# GIVE ME A HOME IN ARKANSAS

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- Early model: Arkansas Medicaid's ConnectCare (AFMC) PCP program. Physicians receive about \$36 per patient per year
  - Starting to see some movement in private sector:
    - ABCBS piloting medical homes in 7 primary care clinics
    - Ark Academy of Family Physicians and Blue & You piloting 3 others
  - A key part of Ark Health Payment Improvement Initiative
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# MAKE ME ACCOUNTABLE: ACCOUNTABLE CARE ORGANIZATIONS

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- ❑ 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
    - FQHCs and RHCs
    - “Other” as determined by Secretary
  - \*ACO professionals = physicians, PAs, NPs, Clinical Nurse Specialists
  - ❑ But other providers may join the ACO as “participants.”
  - ❑ States decide whether and how to license/regulate ACOs.
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# ACOs – Continued

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- ❑ 3-year agreement
  - ❑ Formal legal structure
  - ❑ Must include PCPs
  - ❑ At least 5,000 beneficiaries
  - ❑ Evidence-based medicine
  - ❑ Patient-centered
  - ❑ HIT strongly encouraged
  - ❑ Two-tracks: (1) Upside risk only; or (2) Upside and downside risk with enhanced upside reward. After first 3 years, all ACOs must follow Track 2.
  - ❑ Shared savings potential roughly 50 to 60%, depending on which track.
  - ❑ Final Rule: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> (76 FR 67802 Nov. 2, 2011)
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# BUNDLE ME: EPISODES AND MORE

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- ❑ Bundled Payment: A fixed prepayment made to multiple providers for multiple services for a particular treatment, condition, or period of time.
  - ❑ Small bundles like DRG or flat fee paid to OBs for all care over the course of a pregnancy and delivery.
  - ❑ Episode-of-care covers an episode of illness or medical condition, such as a heart attack, hip replacement, or diabetes.
  - ❑ Global payments cover all care for all conditions for a group of patients. Basically capitation with greater emphasis on quality, not just cost.
  - ❑ Bundling avoids risk of overutilization within an episode but adds incentive to diagnose more episodes. Also risk of “stinting”
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# BUNDLED PAYMENTS – Continued

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## Bundled Payment Continuum



**Probability risk:** Payer (insurance risk)

**Technical risk:** Provider (clinical skills, potentially avoidable complications)

*Bundling multiple services of same provider easier than bundling multiple services of multiple providers.*

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# BUNDLED PAYMENTS – Continued

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- ❑ ACA (3023) – Medicare 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
  - ❑ CMI Pilot (four models) announced Aug. 23, 2011
  - ❑ PROMETHEUS, Geisinger are examples
  - ❑ Centerpiece of Ark Health Payment Improvement Initiative
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# BUNDLED PAYMENTS – Key Questions

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- ❑ 1. To which conditions should bundled payments be applied?
- ❑ 2. What providers and services should be included in the bundled payment?
- ❑ 3. How can provider accountability be determined?
- ❑ 4. What should be the timeframe of a bundled payment?
- ❑ 5. What capabilities are needed for an organization to administer a bundled payment?
- ❑ 6. How should payments be set?
- ❑ 7. How should the bundled payment be risk-adjusted?
- ❑ 8. What data are needed to support bundled payment?

*[Bundled Payment: AHA Research Synthesis Report, May 2010]*

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# COMPARE ME: ALL-PAYER CLAIMS DATABASE

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

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- ❑ 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 HIT in general and specific incentives to accelerate adoption of EHR systems among providers (e.g., “meaningful use” incentives).

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## HIT – Continued

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- ❑ Medicare “meaningful use” incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to be actively utilizing EHR in compliance with the “meaningful use” definition or be subject to financial penalties. Physicians and hospitals only.
  - ❑ Also allows states to award incentive payments through Medicaid. Physicians, physician extenders and hospitals only.
  - ❑ Providers in Medicare and Medicaid will receive \$43,000 to \$64,000 (for individual physicians) and up to \$11 million (for hospitals) in cash incentives over four to six years if they engage in “meaningful use” of EHR.
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# HIT – Continued

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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 EHRs.
  - ❑ \$4.7 billion for National Telecommunications and Information Administration's Broadband Technology Opportunities Program.
  - ❑ \$2.5 billion for the U.S.D.A.'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), NIH, and 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 VA.
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# HIT ARKANSAS

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- ❑ “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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# My Way: Patient-Centered Care

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- ❑ Moving from provider-centered to patient-centered
  - ❑ Involves patient in every decision
  - ❑ Treats patient with dignity, not paternalism
  - ❑ Respects patient's preferences
  - ❑ Tension with Evidence-Based Practices
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# ART OR SCIENCE?: EVIDENCE-BASED PRACTICES

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- ❑ Integrates clinical expertise with clinical evidence from systematic research
  - ❑ Clinical practice guidelines, protocol, practice parameters
  - ❑ Paying only for what works or rationing care?
  - ❑ Regulations may increasingly leave little room for practitioner judgment
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# FINE ME, JAIL ME

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- 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 FCA and CMP violations.
    - Enhanced penalties under CMP –now \$50,000 for each false record or statement.
    - Compliance programs emphasized
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# INVENT ME: CENTER FOR MEDICARE AND MEDICAID INNOVATION

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- ❑ 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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# INNOVATION – Continued

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- 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.

*CMI 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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# ACA OPTIONS OF PARTICULAR INTEREST TO HEALTHCARE PROVIDERS

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## Health Homes for Individuals with Chronic Conditions (Section 2703)

- ❑ Effective January 1, 2011.
  - ❑ Provides enhanced Federal match of 90% for two years.
  - ❑ Beneficiaries must have either (1) two chronic conditions; (2) one chronic condition and at risk for a second; or (3) one serious and persistent mental health condition.
  - ❑ Non-exclusive list in statute includes:
    - mental illness
    - substance abuse disorder
    - asthma
    - diabetes
    - heart disease
    - overweight (BMI > 25)
  - ❑ Arkansas: \$500,000 grant, health home coordinator
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# ACA OPTIONS OF PARTICULAR INTEREST TO HEALTHCARE PROVIDERS

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## Community First Choice Option (HCBS)

- ❑ Adds Section 1915(k) to SSA
  - ❑ Available as of October 1, 2011
  - ❑ Increases FMAP by 6%
  - ❑ State Plan amendment (not a waiver).
  - ❑ Beneficiaries up to 150% FPL without regard to institutional LOC (or same income as for institution--300% SSI--if qualifies for institutional LOC)
  - ❑ Statewide, without regard to type of disability
  - ❑ First year state must spend same or more on services for elderly and disabled
  - ❑ HCBS attendant services and supports to assist with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, cueing, and related supports, but not R&B
  - ❑ Consumer-controlled model
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# ACA OPTIONS OF PARTICULAR INTEREST TO HEALTHCARE PROVIDERS

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## Balancing Incentives (Section 10202)

- ❑ \$3 billion. Available Oct. 1, 2011 - Sept. 30, 2015.
  - ❑ States compete for enhanced match of 2% for states like Arkansas (currently 25%-50% of total LTC expenditures)
  - ❑ State must:
    - Target a goal of 50% expenditure on HCBS by Oct. 1, 2015.
    - Use funds for new or expanded services
    - Not make eligibility requirements for non-institutional LTC services and supports more restrictive than those on 12/31/2010
    - Have in place 3 structural changes within 6 months of application:
      - “No Wrong Door—Single Entry Point System”
      - “Conflict-Free Case Management Services”
      - “Core Standardized Assessment Instruments”
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# ACA OPTIONS OF PARTICULAR INTEREST TO HEALTHCARE PROVIDERS

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## Removing Barriers to HCBS

(Section 2402—amends SSA 1915(i))

- ❑ HCBS without a waiver
  - ❑ Breaks the “eligibility link” between HCBS and institutional care for those up to 150% of FPL (appears to still require for those above that income)
  - ❑ Less stringent needs-based criteria than institutional care (150%)
  - ❑ Independent evaluations and assessments
  - ❑ Individualized care plans
  - ❑ States can target specific populations and vary benefit packages
  - ❑ States cannot use waiting lists. May tighten eligibility if projected enrollment is exceeded, but must grandfather those already enrolled
  - ❑ Cannot limit geographically
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# CHARTING THE COURSE AHEAD

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- ❑ Destination – higher quality; lower cost; patient-centered; less fragmented; more coordinated.
- ❑ Nobody knows how to get there.
- ❑ If 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.

*Supreme Court ruling on ACA unlikely to stop this trend.*

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## CHARTING THE COURSE AHEAD – Continued

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- ❑ Equal Access 42 U.S.C. 1396a(a)(30)(A)
    - may not apply, depending on what is waived
    - Ark. Medical Society v. Reynolds* Consent Decree
    - *Douglas v. Independent Living Center of Southern Calif.* now before Supreme Court
    - “Methods for Assuring Access to Covered Medicaid Services,” Proposed Rule, 76 FR 26342 (May 6, 2011)
  - ❑ Contract negotiations will be crucial in private sector
  - ❑ Eventually statutes and regulations in public sector
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## CHARTING THE COURSE AHEAD – Continued

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- ❑ Don't bite off more than you can chew.
  - ❑ Bundled payments are complex and nuanced. After three years, PROMETHEUS pilot sites have yet to make a single bundled payment!
  - ❑ Arkansas providers not sufficiently large or integrated for most proposals
  - ❑ PGP Demo indicates quality measures easier to satisfy than cost savings, but much depends on benchmarks/targets.
  - ❑ Quality OUTCOMES may be different story.
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# CHARTING THE COURSE AHEAD – Continued

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## Offer payers transitional approach:

- Bundle multiple services of same provider
  - Consider shared savings with no downside risk
  - Request bonus incentives for quality outcomes
  - Adjustments for beneficiary population
  - Focus on HIT, urge payers to take lead
  - Medical/health homes require large capital investment
  - Insist on administrative simplification in APCDB
  - Payers are open to wellness reimbursement
  - Request good data up front – if payers can't provide it, they likely won't be able to manage payment model
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# Additional Information

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- ❑ Peter S. Hussey et al, *The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems in Implementing New Payment Models*, 30 Health Affairs 2116 (2011)
  - ❑ David Ivers, *Transformation and Tribulations: The Barriers to Arkansas' Healthcare Reform and Possible Ways to Overcome Them*, Journal of Arkansas Medical Society (October 2011), available at [http://www.mitchellblackstock.com/PDF/Arkansas Healthcare Reform Article Pt 1.pdf](http://www.mitchellblackstock.com/PDF/Arkansas_Healthcare_Reform_Article_Pt_1.pdf).
  - ❑ Harold D. Miller, *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*, Center for Healthcare Quality and Payment Reform, available at <http://www.chqpr.org/downloads/TransitioningtoAccountableCare.pdf>.
  - ❑ *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, Institute of Medicine (March 1, 2001), available at <http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx>.
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