McManis Consulting

MEMORANDUM

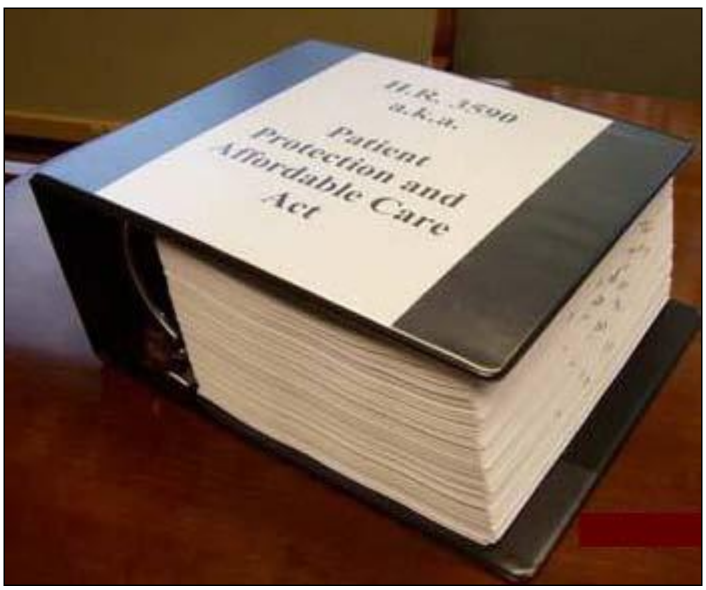
TO: Friends of McManis

FROM: Keith Moore and Dean Coddington

SUBJECT: HR 3590 (as amended): A First Read

DATE: April 5, 2010

Our office copy (see below) is already a bit worse for wear. Undoubtedly, it will become far more tattered over time.



This memo provides a brief overview of selected provisions of the new health care reform law, focusing on aspects that directly affect health systems and physicians.

We address five groups of initiatives that are intended to:

1. Change Medicare and/or Medicaid reimbursement practices, lower the total cost of hospital and physician care, and facilitate and incentivize improvements in quality and patient satisfaction (the "Triple Aim");

2. Improve overall health status;

3. Affect the way the market for health care services functions (e.g., by providing better information and/or further defining the playing field for not-for-profits, for-profits and physician-owned organizations);

4. Improve the supply and/or quality of health care professionals, especially primary care;

5. Enhance children's hospitals and services.

The first part of the memo is intended to be descriptive. (What is in the legislation? Where is it located within the document?) This is followed by several observations.

Elements of the Legislation

<u>Group 1: Initiatives intended to change reimbursement practices, lower the total cost of hospital and physician care, and facilitate and incentivize improvements in quality and patient satisfaction (the "Triple Aim")</u>

a) **Development of a national strategy on health care improvement.** "The Secretary . . . shall establish a national strategy to improve the delivery of health care services, patient health outcomes and population health" (pp. 693-694). This overall strategy is due to be completed in January of 2011 and is to be updated each year. This strategy is to cover a broad range of issues – including patient-centered care, health status/outcomes, and coordination of care. This includes a directive to coordinate public and private sector payer strategies.

b) **Establishment of a framework for global Medicare budgeting** (pp.1000-1052). The new law establishes an independent Health Care Advisory Board. A key purpose of this board is to extend Medicare solvency (p. 1006). It will make recommendations that improve the health care delivery system and health outcomes -- including the promotion of integrated care, care coordination, prevention and wellness, and quality and efficiency improvement (p. 1006).

   This commission has a more comprehensive role in determining the future cost of the Medicare program than MedPAC has now. In theory, this board has the power to effect global budgeting for Medicare. HR 3590 establishes a Medicare per capita growth rate made up of the average of the CPI, the medical component of the CPI and the nominal GDP plus 1%.

Pages 1015-1016 describe how this would work, and how it would lead to a slow down of the growth of Medicare spending. The formula incorporates <u>both</u> the price and quantity of services delivered.

c) **Initiation of value-based incentive Medicare payments for hospitals** (pp. 622-635). DRG payments will be decreased each year; the amounts are on page 634. However, hospitals restore part of the reduction by meeting certain quality and patient satisfaction performance measures.

d) **Establishment of a mechanism for pay for performance for physicians under Medicare** (pp. 681-684). The bill directs the establishment of a value-based payment modifier; this provides differential payment to physicians based on quality of care and health outcomes.

e) **Establishment of Accountable Care Organizations (ACOs) and the Medicare shared savings program** (pp. 739-753). "The ACO shall be willing to become accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it" (p. 743). Also, "The ACO shall have in place a leadership and management structure that includes clinical and administrative systems" (p. 742). And, ACOs will share in the savings (p. 746).

f) **Substantial funding for improving quality measures** (p. 708). $75 million a year for four years will be spent on this initiative.

g) **Authorization to feed back performance data to physicians and groups of physicians** (pp. 658-663). The Secretary is authorized to provide confidential reports to individual physicians and (at the Secretary's discretion) to groups of physicians regarding their performance under various incentive structures and payment mechanisms.

h) **Directive for research on overall health care delivery system performance improvement** (pp. 1053-1062). "The Center shall support such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services" (p. 1057).

i) **Establishment of a "Center for Medicare and Medicaid Innovation" within CMS** (pp. 723-739). "The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care." The center will also test various payment and delivery models (p. 725). The bill talks about "Promoting broad payment and practice reform, including patient-centered medical home models." Page 726 says, "Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment." Sounds like moving in the direction of payment reform!

j) **Payments for "Healthcare Innovation Zones" that include a teaching hospital** (p. 731-732). The law establishes a comprehensive payment to these zones, which consist "a group of providers that include a teaching hospital, physicians and other clinical entities, that through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services …" (p. 731). This initiative also emphasizes electronic medical records and team-based approaches (p. 732).

k) **Further pilot programs and potential extension of payment bundling** (pp. 751-764). In 2016, "the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of care and reducing spending" (p. 763).

l) **Establishment of episode of care groupers** (p. 660-663). The Secretary is directed to develop groups of separate but clinically related items and services into episodes of care by January 1, 2012. This is intended to facilitate data feedback and payment approaches based on episodes of care.

m) **Patient-centered medical homes** (pp.1067-1074). Grants are to be made available to the states for medical homes. Roles for and requirements of interdisciplinary "health teams" working in support of primary care are defined in this section.

n) **Global capitation model for Medicaid safety net hospitals** (p. 543). This is an extension of payment reform to the safety net program.

o) **Additional funding for federally qualified health centers** (pp. 1508-1510). The amounts are substantial -- $3.0 billion in FY 2010 increasing to $8.3 billion in FY 2015 (p. 1508). If these centers partner with other providers, including critical access or small hospitals, they can share in this funding (p. 1509).

p) **Capitated payment available to federally qualified health centers** (pp. 1446-1448). These centers will have to submit information in order for the Secretary to "develop and implement the prospective payment system" (p. 1447).

q) **Preference for managed care in health plans offered through State exchanges** (pp. 204-205). These plans shall try to contract with "managed care systems, or with systems that offer as many attributes of managed care as are feasible in the local market area" (p. 205).

r) **Quality assurance grants** (pp. 1062-1067). It appears that almost any health care provider will be eligible for these grants.

Group 2: Initiatives intended to improve overall health status.

a) **Prevention and public health fund** (pp. 1141-1142). This fund is to "provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." The funding for this starts at $500 million in FY 2010 and increases to $2 billion in FY 2015 and each fiscal year thereafter.

b) **Wellness demonstration projects in 10 states** (p. 91). Please note the large wellness grants listed in the previous section.

c) **Commission on Key National Indicators** (pp. 1518-1528). The indicators are not identified but we assume they deal with quality of life and other health-related indices. There are several pages about how the commission will function. The budget is $7.5 million a year (p. 1528).

Group 3: Initiatives intended to affect the way the market for health care services functions (e.g., by providing better information or further defining the playing field for not-for-profits, for-profits and physician-owned organizations).

a) **Establishment of an Institute to promote better information for informed health care decisions.** A not-for-profit "Patient-Centered Outcomes Research Institute" is created (pp. 1651-1680). Twenty nine pages are devoted to describing this entity and its funding levels. A new not-for-profit, the Institute's purpose is "to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions . . ." (pp. 1651-1652). HR 3590 says that the Institute will identify national priorities for research (p. 1652) so it appears to be clinically oriented. It will establish a research agenda (p. 1653). In contrast to the Commission on National Indicators, described above, the planning for this entity appears to be further along. The budget for the Institute is described on pages 1688-1690; funding will increase from $10 million in FY 2010 to $150 million in subsequent years.

b) **Development of standardized benefits** (p. 19). There will be a serious effort over the next 12 months to develop a standardized benefit package for use in the State exchanges. This is also discussed on p. 103.

c) **Planning grants for establishing health plan exchanges in each state** (p. 128). On page 179 it says that $6 billion is set aside for this work.

d) **Limitations on, and reporting and disclosure requirements for, physician-owned facilities and services** (pp. 1529-1542). Section 6001 (as amended by section 10601 of the Manager's Amendment to the Senate bill and Section 1106 of the reconciliation bill) prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010 to participate in Medicare. Physician-owned hospitals that have a provider agreement prior to December 31, 2010, could continue to participate in Medicare; however, conflict of interest, bona fide investments, and patient safety issues are discussed in detail. There are new requirements for disclosures to patients and reporting to CMS. There are also expansion limitations.

e) **Reduced payments for imaging** (pp. 852-857). This part of the legislation is directed at reducing excessive imaging utilization and/or costs by lowering payment, or margins. Savings are projected at $3 billion between now and 2019 (pp. 856-857).

f) **Increased funding for fraud and abuse prevention** (pp. 1741-1747). There was an additional $10 million each year to fight fraud and abuse in HR 3590. This was substantially increased in HR 4872 (the Reconciliation bill) to $95 million in FY 2011, $55 million in FY 2012, and declining to $20 million in FY 2016 (pp 79-80).

g) **Requirements for community health care needs assessments by not-for-profit hospitals** (pp. 2002-2010). This applies to not-for-profit hospital and indicates that they need these studies at least once every three years (p. 2003). Page 2007 is relatively specific on what is required.

h) **Reporting requirements for health plans** (pp. 30-37). A process is established for the Secretary to review commercial health plans' premium increases on an ongoing basis. Insurers are required to provide reports justifying their increases. In the event of continuing unjustified increases, the Secretary is authorized to recommend exclusion of the offending health plan from the applicable State Exchange. $250 million in grants are authorized for states to monitor insurance premium increases.

i) **Unique health plan identifier and other standardization process related to electronic commerce in health care** (pp. 75-77). The bill causes the establishment of a unique identifier (long a stumbling block in facilitating data analysis and electronic transactions) by October 1, 2012. Other provisions establish standards for electronic funds transfers and electronic claims attachments.

j) **Efforts to reduce paper work** (p. 59). "The Secretary shall seek to reduce the number and complexity of forms and data entry required by patients and providers" (p. 59).

Group 4: Initiatives intended to improve the supply and/or quality of health care professionals.

a) **State health care workforce grants** (1297-1309). There will be planning grants, we assume for each state, in the amount of $150,000 (p. 1298).

b) **Enhanced payments to strengthen primary care** (pp.1440-1446). "In the case of primary care services ... in addition to the amount of payment that would otherwise be made for such services ... there shall also be paid a monthly or quarterly basis an amount equal to 10 percent of the payment amount for the service under this part" (p. 1440). This is for Medicare, Medicaid and those covered by the new program.

c) **Primary care residency programs** (pp. 1486-1490). This is described as grants to "teaching health centers" (described on p. 1488) of up to $500,000 for three years to expand primary care residency programs (p. 1486). We don't see any limit on the number of such grants.

d) **Graduate nurse education demonstration** (pp. 1500-1507). There will be five of these grants where participants will be reimbursed for their costs. These are referred to as advance practice nurses and include nurse practitioners. The funding is large – $50 million per fiscal year (p. 1504).

e) **Establishment of a National Health Service Corps** (p. 1333). The funding is $320 million in FY 2010 and up to $1.2 billion in FY 2015 and subsequent years. This appears to be intended to increase the supply of primary care physicians as well as meeting the health needs of people living in areas where there are physician shortages.

f) **Health care workforce education and training** (p.1339-1346). This is a grant program encouraging primary care; funding will be available to medical schools and some hospitals.

g) **Primary care extension program** (pp. 1431-1439). Funding is $120 million for FY 2011 and 2012 with indications that funding will be continued. A new term: "The Secretary shall award competitive grants to states for the establishment of state- or multistate-level Primary Care Extension Program State Hubs" (p. 1433). Dr. Atul Gawande wrote about this in his 2009 *New Yorker* article; it appears to be patterned after the Agricultural Extension Service.

Group 5: Initiatives directed at children's hospitals and services.

a) **Pediatric accountable care organizations demonstration project** (pp. 544-546). States may make competitive applications for the demonstration project. Participating states are to establish minimum levels of savings (over what would be spent on Medicaid and CHIP.) The demonstration project is authorized for the period 2012 through 2016.

b) **Extension of the "Wakefield Emergency Medical Services for Children Program"** (pp. 1514-1515). Funding levels are $25 million in FY 2010 up to $30.4 million in FY 2014 (p. 1515).

Observations

Taken together, the *Group 1 initiatives* in this legislation (those that are intended to reduce costs and incentivize quality and service) represent a paradigm shift as to how hospitals and physicians will be paid. Even a quick reading of the new law makes several points clear:

- If the intent of this legislation is realized, the proportion of Americans who receive care under fee-for-service medicine will decline. The amount physicians and hospitals receive for a given service will increasingly be based, not only on the service provided, but on the achievement of other cost, quality and outcomes objectives. Payment will be "value based".

- A very large burden, and ultimate responsibility for making this group of initiatives a success or a failure, lies on those responsible for implementation.

- Over time, as a group, we believe these initiatives do have the potential to "shift the cost curve" downward.

- Many of the most important aspects of this legislation will have to be worked out through experimentation and pilot programs. This will require a process of iterative, coordinated decision-making-- involving CMS, hospitals and health systems, physicians, other health care providers, states, and commercial payers that is well beyond what these organizations are accustomed to. Are they up to it?

There isn't much in this plan that benefits specialists or standalone hospitals. Safety-net hospital revenues may go up, but many hospitals are unlikely to experience increased revenues from price increases. As noted above, there will be reductions in DRG payments that can be partially offset if certain quality and outcomes standards are met.

Our brief review of HR 3590 suggests that implementing this plan will be a gigantic undertaking. Henry Aaron of the Brookings Institution and Robert Reischauer of the Urban Institute offer sobering advice at the end of "The War Isn't Over," in *The New England Journal of Medicine*, March 24, 2010: "Far from having ended, the war to make health care reform an enduring success has just begun. Winning that war will require administrative determination and imagination and as much political resolve as was needed to pass the legislation."

Taken together, the *Group 2 initiatives* point to a determination to reduce clinical variation and improve the health status of Americans as a whole. As with Group 1, however, these initiatives amount to the early skirmishes in a long war to achieve national goals. These initiatives should shine a brighter light on the problems.

Taken together, the *Group 3 initiatives* should create "more efficient markets "in health care. Patients should end up with better information on differences in quality and cost, individual purchasers' process of shopping for a health plan should become much easier, and electronic transactions should be easier. This group of changes also makes it much more difficult to initiate (and even to sustain) physician owned specialty hospitals.

Taken together, the *Group 4 initiatives* will help soften what will almost inevitably be a severe supply/demand mismatch for primary care physicians and allied health professions. The "dye is cast", however. The shortages will become acute before these remedies can kick in.

The *Group 5 initiatives* raise some of the same issues for children's hospitals and physicians as are raised on the adult side. This legislation as a whole shows considerable respect for children's health issues. It also raises new questions as to how children's services can be most coordinated with adult services in a way that works well for the child, the family, the child health care delivery system, and the adult delivery system.

A lot of work lies ahead. As we carry out this work, we must plan for unintended consequences. This brief memorandum has focused primarily on the intent of the legislation. Future memos and white papers will focus on implementation issues, including those areas where market-driven outcomes will likely differ from policy-driven intent.