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Washington Update
APPD Meeting
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Association of
American Medical Colleges

Topics

What's happening on Capitol Hill?

What's CMS doing?

- ACOs
- Pioneer ACOs
- Bundled Payment Demonstration
- Health Insurance Exchanges
- And More!

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SGR – Physician Updates

1/1/12: unless Congress acts a **29.5% decrease** to physician payment

Cost of fixing the problem:

- $300 billion for 10 year solution
- 1-2 year "fix" more likely @ $12-31 billion (38 % cut on 1/1/ 2014)

In Congress:

- Hearings in House Energy & Commerce and Ways &Means Committees; no Senate activity

Physician advocacy community:

- Urges Congress, including the Joint Select Committee on Deficit Reduction, and the Obama Administration to address **permanent** SGR reform in the Medicare physician payment system

If not fixed in deficit bill, could be separate legislation

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MedPAC's Proposal

- 2 conversion factors:
  - Primary care (pc services make up 60% of Medicare charges): 10 year freeze
  - All others: 3 years at -5.9%, then 7 years of a freeze
- This will yield $200B in savings

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MedPAC ‘cont

Offsets for remaining $235B for SGR fix:

- 21% post acute care
- 5% Medicare Advantage
- 9% labs
- 11% hospitals
- 32% prescription drugs
- 6% durable medical equipment
- 14% from beneficiaries through higher cost sharing (limits from non-par physicians)

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Joint Select Committee on Deficit Reduction

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Avoiding Sequestration

1. Passage by Congress of balanced budget amendment to the Constitution
2. Joint Committee comes up with a bill that passes both houses and is signed by the President

BUT

If bill passes that reduces deficit by less than $1.2T, automatic cuts will be triggered

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If no bill or target not reached. . .

•Social Security, Medicaid, and CHIP not subject to automatic cuts

•Medicare:

- No change in benefits for enrollees
- Maximum cut of 2%
- Cuts would have to come from physicians, hospitals, and other providers
  - Estimated cut per practice plan: $4-5 m
  - Estimated cut per teaching hospital: $4-5m

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Potential Medicare Targets

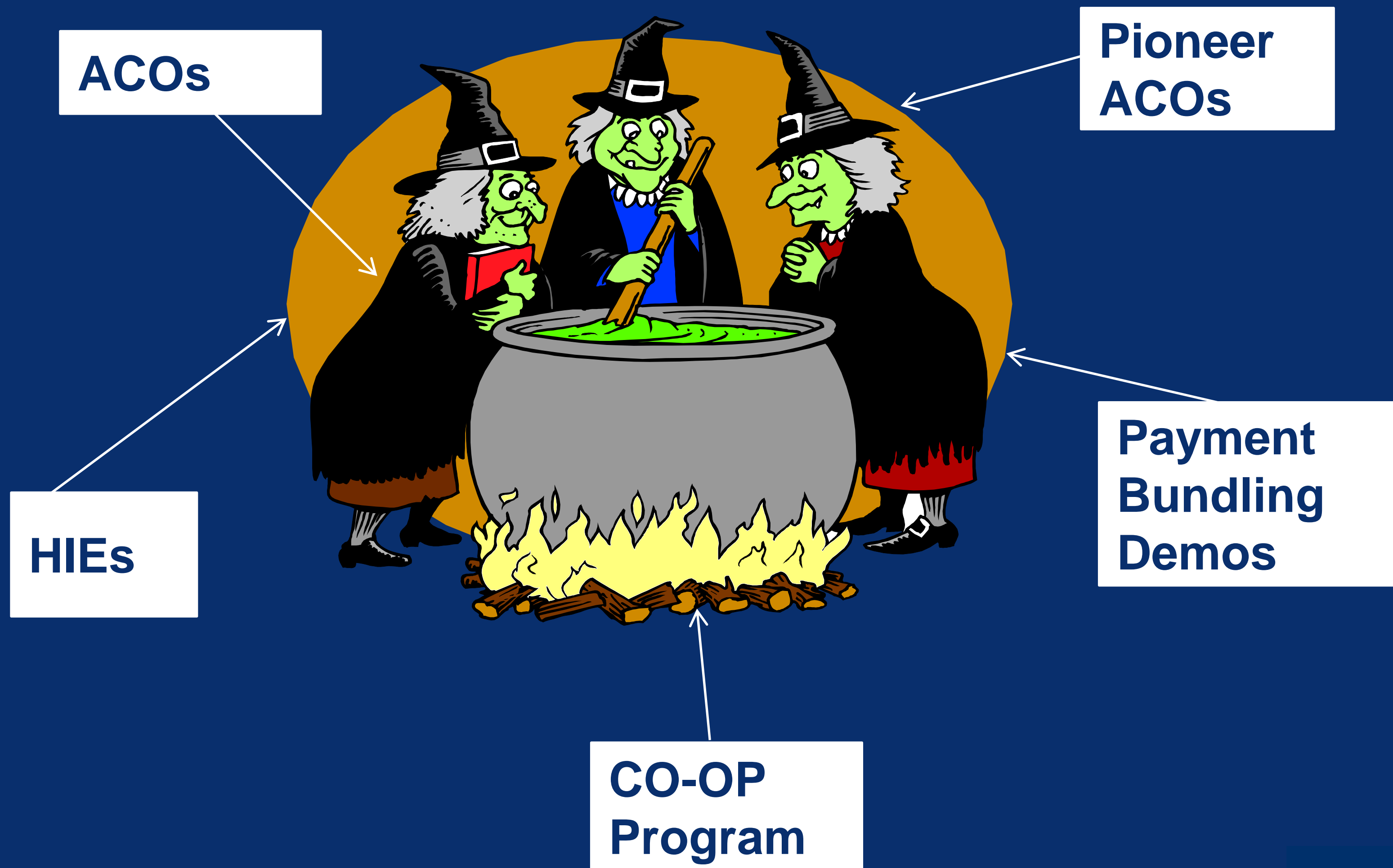
Indirect Medical Education

Direct Graduate Medical Education

Bad debts

Special treatment of critical access hospitals, Medicare dependent hospitals, sole community hospitals, rural hospitals

What's in the CMS Pot?



ACOs

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ACO Proposed Rule

- Released March 31
- OIG, DOJ/FTC and IRS released companion documents same day (limited waivers and antitrust "safety zones")
- Will we ever see a final rule?
- What's the rush?

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Proposed Rule Overview Cont.

- ACOs would enter into 3 year agreements as early as January 1, 2012

- Cannot participate in both ACO program and Center for Medicare and Medicaid Innovation (CMMI) shared savings pilots

- Participants continue to receive FFS payments through agreement period

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Who Can Be an ACO?

- Physician group practices
- Networks of individual practices
- Partnerships/joint venture arrangements between hospitals and physicians
- Hospitals employing physicians
- Other providers, such as FQHCs, can participate in ACOs but cannot independently form ACOs

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ACO Stumbling Blocks

Prospective beneficiary attribution

Risk too high; potential shared savings too small

Too much micromanagement—governance structure

IME, DGME, DSH not removed

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From CMS to CMMI

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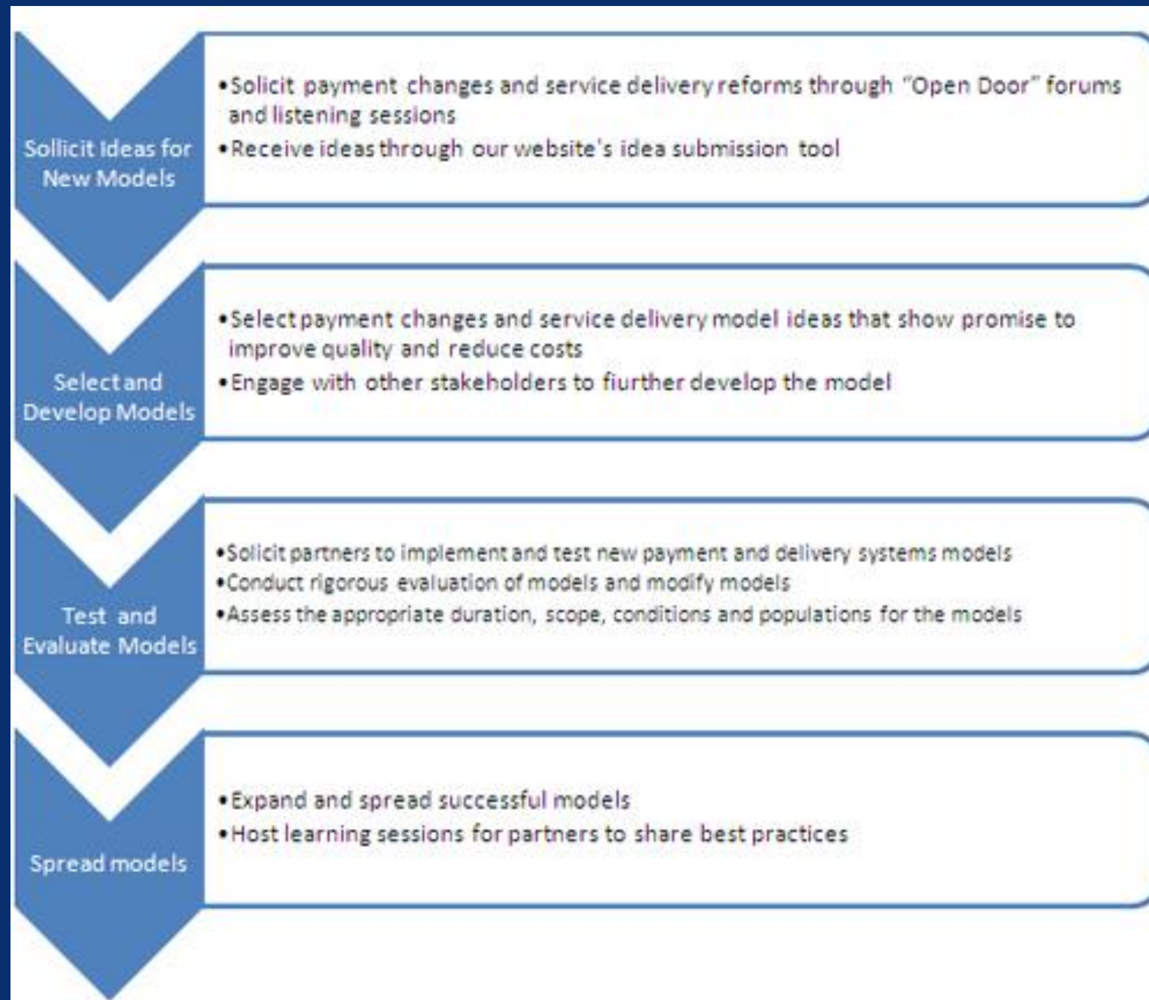
CMMI Process



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Pioneer ACOs

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CMS Objective for Pioneer ACOs

- To design an ACO program for more advanced systems: those organizations already experienced in coordinating care for a significant portion of patients under risk sharing contracts who will be able to more rapidly transition to an ACO model

- The Pioneer ACO will complement the MSSP ACO and inform MSSP ACO development, providing a platform for CMMI to test new ideas and concepts that could eventually be incorporated into the MSSP

Timeline/Key Dates

- Notice of Request for Applications (RFA): Released May 17
- Letter of Intent (and Data Use Agreement): Due **June 30** to PioneerACO@cms.hhs.gov
- Pioneer ACO Model Application: Postmarked on or before **August 19**
  - CMS will only consider applications from organizations that have submitted letters of intent
- Interview of Semi-Finalists: **1-2 months after application deadline**
- Program Tentative Start: **3rd or 4th quarter of 2011** (CMS says it will provide "comfortable interval" between acceptance into program and program start date)

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Pioneer ACO vs. MSSP ACO

	Pioneer ACO	MSSP ACO
Administered Through	CMMI	CMS
Type of Program	Demo/pilot, CMMI expects to initially partner with 30 Pioneer ACOs	Program (i.e. option under Medicare program like Medicare Advantage)
Participation Period	Up to 5 years	3 years
Maximum Shared Savings	Up to 75% of savings	Up to 60% of savings
Minimum Beneficiaries	15,000	5,000
Beneficiary Attribution Method	Prospective or retrospective	Retrospective
Role of Specialists in Attribution	Hybrid primary care and specialty attribution	Primary care only
Other Payer Involvement	By end of 2013 perf. period majority of all ACO revenue (including M'care) will come from "outcomes-based contracts"	Encouraged but not required
Minimum Savings/Loss Rate	1% and share in first dollar savings/losses	2.0-3.9% and share in savings after 2.0% (1-sided); 2.0% and share in first dollar savings/losses (2-sided)

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Hybrid Attribution Model: Primary Care and Specialty

- Beneficiaries will first be aligned with the <u>group</u> of primary care providers (same as MSSP, but including NPs and PAs) who billed for the <u>plurality of primary care allowed charges</u> during combined 3 year period
    - Group=NPIs under a TIN; thus one physician may not have the plurality, but if that physician's group has the plurality the beneficiary will be assigned
- If a beneficiary had less than 10% of E&M allowed charges billed by primary care physicians (*in or out of the ACO*), alignment will be with the <u>group of eligible specialists</u> who billed for the plurality of allowed charges
- Eligible specialties: nephrology, oncology, rheumatology, endocrinology, pulmonology, neurology, and cardiology
- Beneficiaries will be assigned each year

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Payment Methodology

- Multiple payment arrangements:
  - Core Payment Arrangement as set forth in RFA
    - Core Arrangement, Core Option A, and Core Option B
  - Alternative Payment Arrangements: CMS encourages applicant Pioneer ACOs to propose alternative payment models
    - CMS will distill and synthesize these suggestions to develop the Alternative Payment Arrangement(s) which Pioneer ACOs can select instead of one of the Core Payment Arrangement options

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Core Payment Arrangement

	Performance Period 1	Performance Period 2	Performance Periods 3, 4, 5
Core Arrangement OR	Up to 60% shared savings and shared losses 10% maximum*	Up to 70% shared savings and shared losses 15% maximum	Population-based payment, with up to 70% shared savings and shared losses 15% maximum
Core Option A	Up to 50% shared savings and shared losses 5% maximum	Up to 60% shared savings and shared losses 10% maximum	Same as Core Arrangement
Core Option B	Up to 70% shared savings and shared losses 15% maximum	Up to 75% shared savings and shared losses 15% maximum	Population-based, up to 75% shared savings and shared losses 15% maximum

Source: RFA p. 10

***The max amount of shared savings or losses received /incurred is capped at a set percentage of an ACO's total Parts A and B spending.**

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Expenditure Benchmark

- Based on weighted prior 3 year average of actual expenditures for each of ACO's aligned beneficiaries, most recent year weighted most heavily (60%, 30%, 10%)
- Includes IME and DSH, but not DGME payments
- This baseline will be increased by average percentage growth rate (50%), and absolute dollar equivalent of growth rate (50%) for a national reference population ("matched cohort")
  - The national reference population will have beneficiary characteristics that are similar to the Pioneer ACO's population
  - It will be adjusted for age, sex, and potentially other characteristics

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Performance Periods 3 through 5

- If ACO generates minimum annual average savings over years 1 and 2 (which will vary based on whether ACO is in a high or low cost state):
  - Payment will transition to population-based payment in year 3
    - ACO providers will receive 50% of FFS payment on submitted claims; the remainder will be provided to the ACO as per-beneficiary-per-month payment based on projections

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Payment Bundling

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4 Payment Bundles to Be Tested

Model 1: Acute Stay

- Hospital inpatient only

Model 2: Acute Stay plus Post-Acute Care (PAC)

- Inpatient, physician, all post-acute services , readmissions

Model 3: PAC

- Physician, all post-acute services, readmissions

Model 4: Acute Stay

- Single payment for all hospital and physician services associated with an inpatient stay

IME, DSH and capital payments are excluded from bundle calculations

All bundle models must include quality measures

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Timelines

- Providers propose the details of the bundle (within CMMI guidelines)
- Nonbinding Letter of Intent
  - Model 1: Sept 22, 2011
  - Models 2-4: Nov 4, 2011
- Applications
  - Model 1: Oct 21, 2011
  - Models 2-4: March 15, 2012
- Agreements
  - Performance period of 3 years, with potential to extend an additional 2 years

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Beneficiary Choice

- Beneficiaries have complete freedom of choice
- All models must include description of patient notification process (implementation & documentation)
- Awardees must have a proposed plan for beneficiary engagement & education
  - CMS will monitor & evaluate to ensure beneficiaries receive needed care

Bundling: Comparison Overview

	Model 1	Model 2	Model 3	Model 4
Name	Retrospective Acute Care Stay (similar to Gainsharing Demo)	Retrospective Acute Care Stay and PAC	Retrospective PAC	Prospective Acute Care Stay (similar to ACE Demo)
Services in bundle	Part A inpatient services	Inpatient (initial admission), physician, readmissions, LTCH, IRF, SNF, home health, outpatient, therapy, lab, DME, Part B drugs	Physician, readmissions, LTCH, IRF, SNF, home health, outpatient, therapy, lab, DME, Part B drugs	Inpatient (initial admission), physician services, readmissions

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Bundling: Episode Definitions

	Model 1	Model 2	Model 3	Model 4
Description	Retrospective Acute Care Stay	Retrospective Acute Care Stay and PAC	Retrospective PAC	Prospective Acute Care Stay
Episode Start	Admission for any MS-DRG	Admission for selected MS-DRGs (to be proposed)	Initiation of selected post acute care services within 30 days following discharge for selected MS-DRGs (to be proposed)	Admission for selected MS-DRGs (to be proposed)
Episode End	Discharge	Option 1: 30-89 days post discharge Option 2: min 90 days post discharge	Min 30 days	Discharge
Post-Episode Period	30 days post episode	30 days post episode	30 days post episode	30 days post episode
Quality Reporting	Inpt quality reporting plus additional measures to be proposed	To be proposed, but standardized set will be agreed to by CMS and awardee	To be proposed, but standardized set will be agreed to by CMS and awardee	To be proposed, but standardized set will be agreed to by CMS and awardee

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Bundling: Payment

	Model 1	Model 2	Model 3	Model 4
Description	Retrospective Acute Care Stay	Retrospective Acute Care Stay and PAC	Retrospective PAC	Prospective Acute Care Stay
Payments to Providers	Hospital: Discounted FFS	Traditional FFS for all providers – reconcile to target	Traditional FFS for all providers - reconcile to target	Single payment to hospital; MDs paid by hospital
Minimum Medicare Discount	Mo 1-6: 0% Mo 7-12: 0.5% Yr 2: 1% Yr 3: 2% For Part A Services	2-3% on allowed Part A & B services depending on length of episode	To be proposed	3% on allowed Part A & B services
Additional risk/reward during episode	Risk if total A&B costs > historical trend	If episode costs< target → Medicare pays If episode costs>target → Awardee pays	If episode costs< target → Medicare pays If episode costs>target → Awardee pays	Must repay any services paid separately by Medicare
Additional Risk	For all models, awardee at risk if total Part A&B spend during post-episode is above historical trend.			

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Health Insurance Exchanges

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Exchange Rules Overview

- HHS has issued two proposed rules providing the framework for the establishment of Health Insurance Exchanges (HIEs):
  - Establishment of Exchanges and Qualified Health Plans, July 15, *Federal Register*
    - Comments Due: September 28
  - Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, July 15, *Federal Register*
    - Comments Due: September 28
- HHS also released a proposed ruled, Establishment of Consumer Operated and Oriented (CO-OP) Program, July 20, *Federal Register*
  - Comments Due: September 16

Establishment of an Exchange

- States may establish an Exchange to provide coverage to individuals and small businesses (Small Business Health Options Program "SHOP")
  - Should the State not elect to establish its own Exchange, the Secretary must establish a federally administered Exchange in that State
- NPRM would offer states significant flexibility, including decisions surrounding governance, network adequacy, and certification of qualified health plans

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Functions of an Exchange

- Enrollment: single, streamlined process; the Exchange is responsible for determining eligibility for both Exchange products and Medicaid/CHIP
- Consumer Support: call center; website offering plan comparison tools and enrollment opportunities; Exchange “Navigators” to assist with education, and enrollment assistance
- Exchange Model: Approach can range from insurance clearinghouse (e.g. “the Travelocity option”) to active purchaser

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CO-OP Program

Consumer Operated and Oriented Plan (CO-OP) Program

- Provides Federal loans to foster development of consumer-governed, private, nonprofit health insurance issuers to offer QHPs in the Exchanges
- Only loan recipients are eligible to become a CO-OP
- As proposed, any organization associated with a State University system (e.g. hospital, provider group) is ineligible to participate in the CO-OP program
- CMS will begin awarding loans in late 2011 or early 2012

There's More!

- Physician Quality Reporting Programs
- E-prescribing
- Meaningful Use
- HIPAA
- 5010, ICD-10
- Our research colleagues:
  - COI final rule
  - ANPRM on revisions to the Common Rule

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