

June 3, 2010

## **Medical Practice Action Alert**

As you know, the federal healthcare reform legislation is very complex, and contains many changes to Medicare and Medicaid payments for physicians. Details of the new payment programs are still under development, and will be for some time; but the outlines are already clear, and the time to prepare for them is now. The purpose of this Memorandum is to set forth some of the steps that physicians and other practitioners should take.

The federal government has dramatically shifted away from "fee-for-service" medicine toward "payment for performance." Many of the new law's key elements are designed to do one thing—provide financial incentives to those who can demonstrate they are moving toward a new delivery model that satisfies six key requirements:

- 1. Compliance with **evidence-based utilization protocols** (which may be developed locally);
- 2. **Coordination of care** in all settings by a primary care practitioner;
- 3. Avoidance of adverse outcomes (e.g. hospital-acquired infections);
- 4. Active management of **chronic illness**;
- 5. **Preventive care and wellness** incentives to both patients and providers; and
- 6. **High value of care rendered** in comparison to peer providers.<sup>1</sup>

These six elements are reflected in the authority given to the Secretary of Health and Human Services to

- revise Medicare and Medicaid payments models to transition physicians away from fee-forservice based reimbursement and align payment incentives with nationally recognized, evidence-based guidelines;
- develop performance-based Medicare payment systems for "accountable care organizations" ("ACOs"), as early as January 1, 2012, as well as pediatric ACO systems for state Medicaid programs;
- make grants to and contract with interdisciplinary "health teams" that support primary care
  practices (including OB/GYN practices) who agree to serve as their patients' "medical
  home" by being accountable for providing integrated, accessible services that meet a large
  majority of the patients' health needs through a sustained partnership with patients;

<sup>&</sup>lt;sup>1</sup> These six elements will be applied to reform the Medicare and Medicaid payment systems; however, since the information developed by the federal and state governments will be shared with the public, it is expected that private insurers and health plans will be quick to follow in order to remain competitive.

- start reporting to physicians their costs of utilization of resources per episode of care in comparison to their peers, commencing in 2012;
- integrate reporting requirements concerning the meaningful use of electronic health records into the Physician Quality Reporting System ("PQRS") by January 2012;
- establish payment penalties for physicians who fail to file PQRS reports, starting in 2015;
- develop a system of "value-based payment modifiers" for physicians as early as 2015;
- require state Medicaid programs to pay primary care physicians no less than 100% of the Medicare payment rate, for 2013 and 2014;
- convert the hospital payment system to a "value-based" system for fiscal years starting on or after October 1, 2012, creating a "zero-sum game" under which Medicare payments will be shifted from hospitals that underperform their peers to the other hospitals; and
- establish a voluntary program to pay hospitals a bundled amount for all care rendered to a Medicare beneficiary for an episode of care (including care rendered during the period 30 days after discharge) regardless of setting.<sup>2</sup>

Of course, many practitioners question this approach because they have limited ability to influence how "quality," appropriateness" and "value" are defined. Fortunately, the new law is designed to permit the local medical community to play a major role. This will be achieved primarily through the formation of ACOs, which can be composed of any combination of providers and suppliers of healthcare services. Physicians and other providers will continue to bill under the existing Medicare payment system, but if the ACO meets certain cost and quality criteria, a portion of the shared savings will be paid to the ACO (and through it to the providers).

The legal criteria to qualify as an ACO are sketchy, and will be further clarified by HHS. The law states that an ACO must have a "mechanism for shared governance"; be set up to receive payments from Medicare and distribute payments to providers under contractual arrangements; take responsibility for the "quality, cost and overall care" of at least 5000 Medicare fee-for-service beneficiaries for a period of at least three years; and include enough primary care professionals to meet the needs of those patients. The ACO must also "coordinate care" and "define processes that promote evidence-based medicine and patient engagement." It is too early to tell what legal structures will make the most sense, because several agencies are still addressing key issues, including HHS, the IRS, the Federal Trade Commission and the Department of Justice. Nonetheless, time is of the essence, and we recommend that all physician clients begin considering what entities (hospitals, physician groups and others) to partner with in order to start developing the necessary resources to participate in the ACO program.

If you have questions, please call Dennis Witherell or Jenifer Belt in Toledo (800-444-6659), Ron Christaldi or Erin Aebel in Tampa (800-677-7661), or Ed Emerson in Columbus (614-628-4418).

This newsletter is designed to provide general information on matters of interest to health care providers and practitioners and is not intended to constitute legal advice.

<sup>&</sup>lt;sup>2</sup> This law will result in many other changes to the relative value unit ("RVU") payment amounts for physician services and other services in physician offices. For example, the practice-expense RVU amounts for certain office-based imaging services are based on an assumed 50% utilization rate, but in 2011 this will change to a 75% rate.