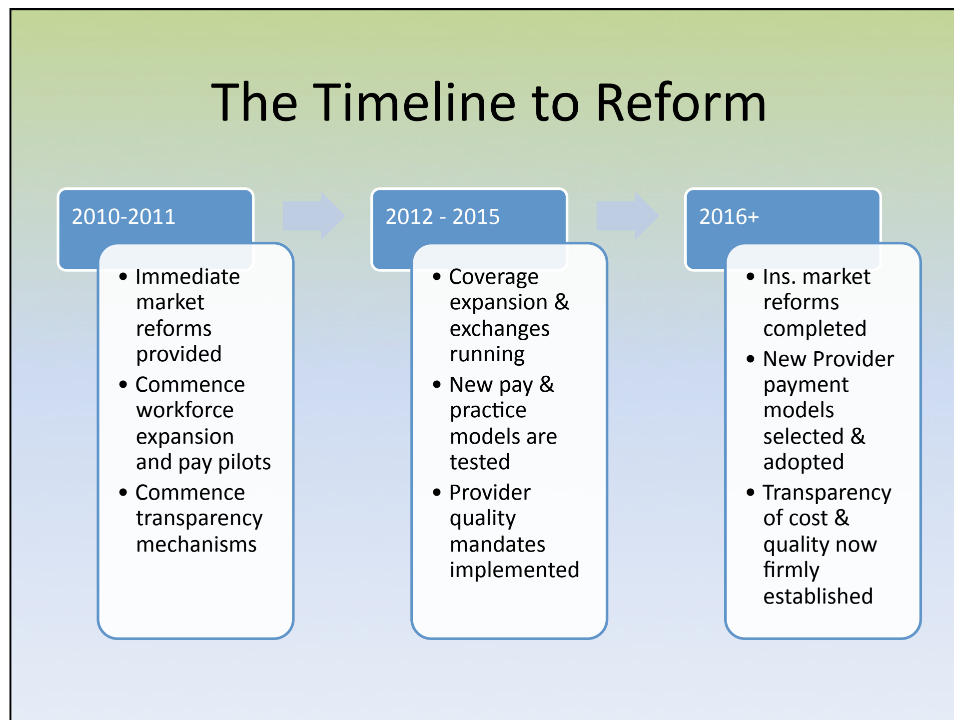
HEALTH REFORM 2010 – How Will it Impact Physicians?

Bill Barcellona © 2010 California Association of Physician Groups

The Old vs. The New

Old Health Care System	New Health Care System
Access	**Access**
• A Privilege	• A Right
Affordability	**Affordability**
• Driven by Insurers	• Driven by the Government
Quality	**Quality**
• Unsubstantiated	• Transparent



Access to Care

- Coverage is expanded to 38 million Americans between 2010 and 2015
- Achieved through a combination of market reforms and premium subsidies
- Uninsured "cost shift" is systematically eliminated through almost universal coverage
- Exchanges are created as one-stop shops for consumers to purchase insurance coverage

Market Reforms

expand coverage

2010

•No pre-ex condition exclusions for kids

•Temporary national exchange for high-risk uninsured opens in 90 days

•Ban on rescissions commences

•Ban on lifetime and annual coverage caps based on dollar amounts

2011

•Medicaid coverage expansion begins

•Free preventive care for seniors

•Small business tax credits

2012

•Early retiree coverage pool begins

•Employers must offer coverage

2014

•State insurance exchanges open

•Individual mandate begins

•Adult Medicaid expansion

The insurance pool will be broadened as far as possible between now and 2017

Cost Controls

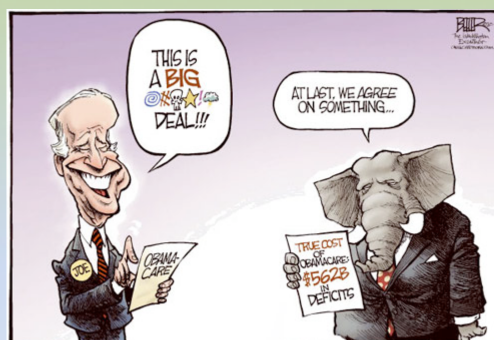
exist in the legislation

•CMS will experiment with a variety of new provider payment models from 2010 to 2016

•Hospitals will face tough curbs on FFS billing & penalties

•Health Plans will have to meet 85% MLR

•Physician payments will evolve from pure fee-for-service



Cost controls are imposed on carriers and providers under PPACA – the Republican plan focused on high-deductible cost shifts to consumers, assuming over-utilization drives the majority of costs in the system, i.e. rationing

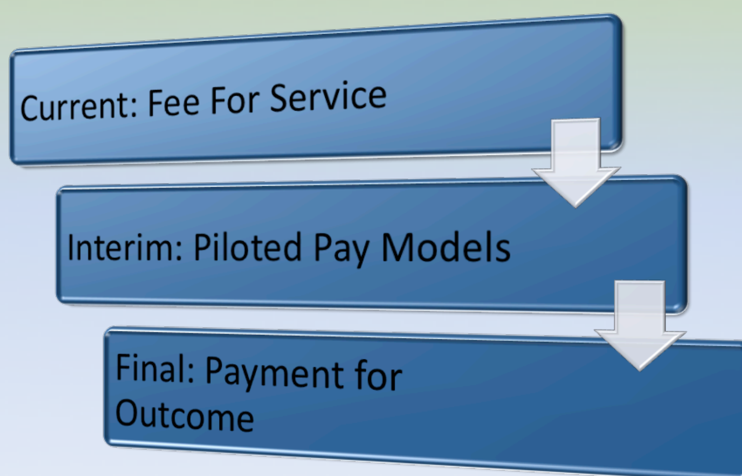
Quality

and transparency

- •CMS will begin to publish physician performance on a new website called “Physician Compare” for Medicare
- •Providers must contribute best practices innovations as a part of qualifying as ACOs
- •New shared decision making tools will be distributed
- •PQRI reporting will be integrated with MU reporting in 2012 – penalties begin in 2015

Evidence-based medicine research will not be applied mandatorily, but as payment for outcomes is established, providers will migrate toward proven clinical pathways to justify payments

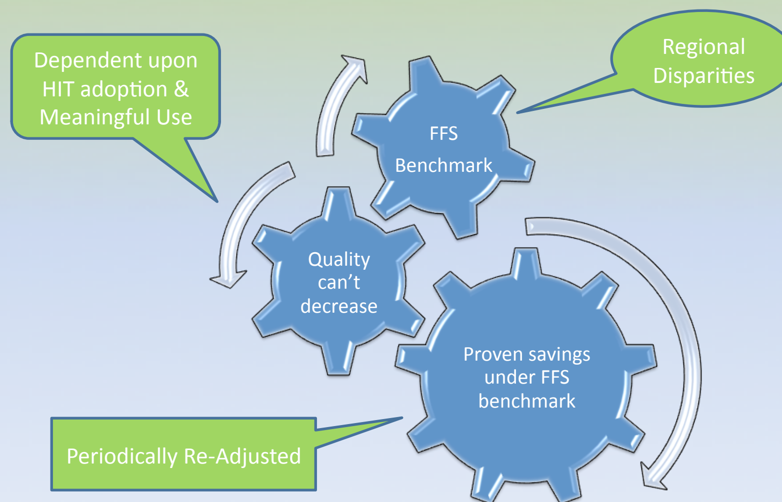
Bending the Cost Trend



Piloted Payment Models Through 2016

- Shared-Savings "Performance Target" Model
- PQRI value-based payment modifier
- Bundled-Payments Model
- Bonus Payments for Quality
- Risk-Adjusted Capitation for Chronic Patients
- Increased Payments for Medi-Cal Primary Care
- Increased Payments for Medicare Primary Care
- Medicare Pay-for-Performance Model

Common Goals of Payment Pilots

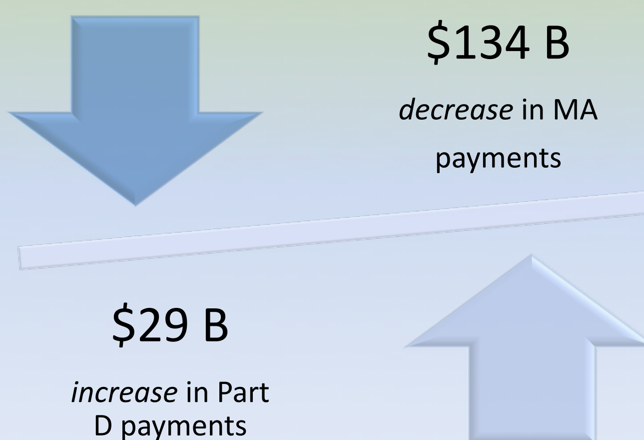


Example: Evolution of PQRI

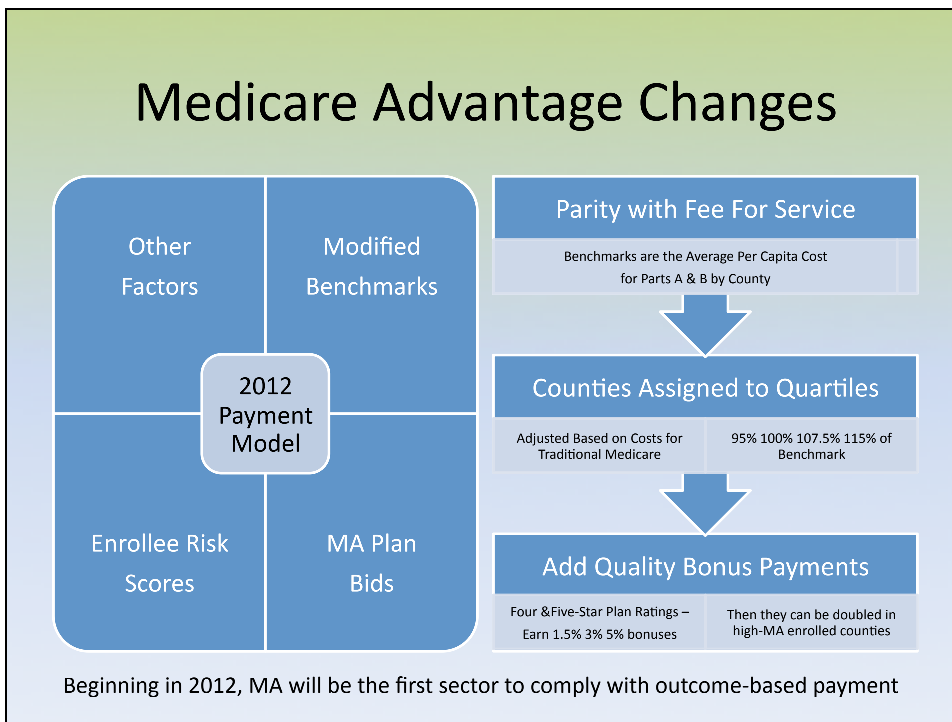
§3001: Link Medicare Payments to Quality Outcomes

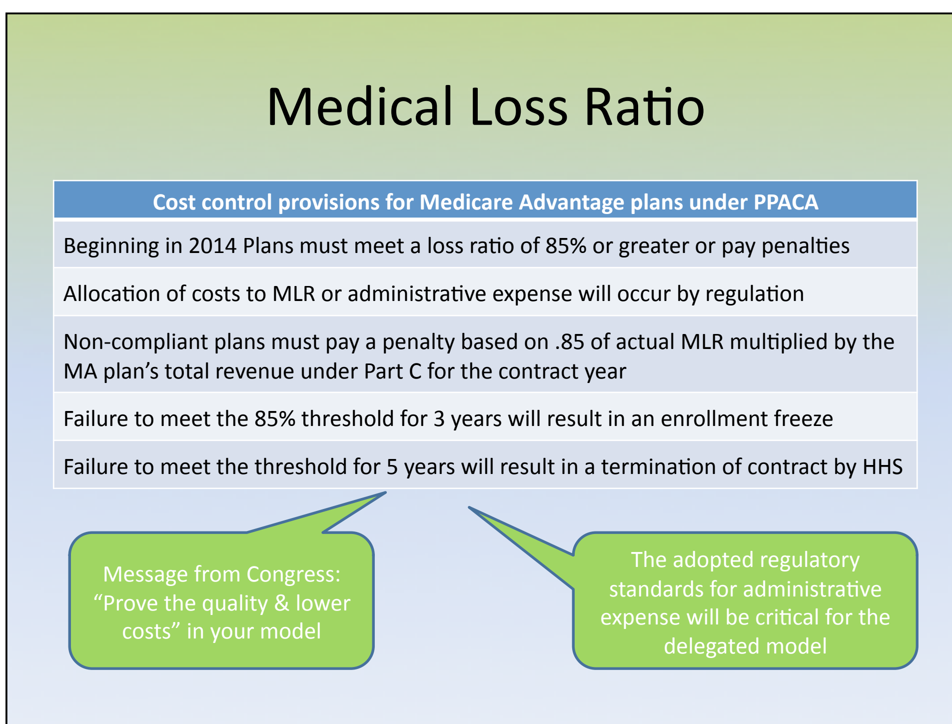
§3002:	§3003:	§3007:
Link PQRI metrics to MU metrics – penalty after 2015 for no reporting	Physician Feedback Program will compare & publicly report episode-based performance of individual doctors	HHS to set a value-based payment modifier under Medicare payment schedule based on quality of care compared to cost

10-Year MA Payment "Reforms"



Congress concluded that Medicare Advantage promised more than it delivered


Medicare Advantage Changes
Other Factors
Modified Benchmarks
2012 Payment Model
Enrollee Risk Scores
MA Plan Bids
Parity with Fee For Service
Benchmarks are the Average Per Capita Cost for Parts A & B by County
Counties Assigned to Quartiles
Adjusted Based on Costs for Traditional Medicare
95% 100% 107.5% 115% of Benchmark
Add Quality Bonus Payments
Four &Five-Star Plan Ratings – Earn 1.5% 3% 5% bonuses
Then they can be doubled in high-MA enrolled counties
Beginning in 2012, MA will be the first sector to comply with outcome-based payment


Medical Loss Ratio
Cost control provisions for Medicare Advantage plans under PPACA
Beginning in 2014 Plans must meet a loss ratio of 85% or greater or pay penalties
Allocation of costs to MLR or administrative expense will occur by regulation
Non-compliant plans must pay a penalty based on .85 of actual MLR multiplied by the MA plan's total revenue under Part C for the contract year
Failure to meet the 85% threshold for 3 years will result in an enrollment freeze
Failure to meet the threshold for 5 years will result in a termination of contract by HHS
Message from Congress: "Prove the quality & lower costs" in your model
The adopted regulatory standards for administrative expense will be critical for the delegated model

An Alternative to Medicare Adv.

Accountable Care Organizations

- §3022 - CMS Pilot project commences in 2012
- ACOs will qualify for assigned Medicare patients

  by offering integrated care management, data reporting on performance metrics and demonstrating cost savings over FFS system
- Primary Care ACOs will be formed in Medi-Cal
- ACOs will provide the infrastructure for doctors to meet new reporting and outcome-based payment structures

Medi-Cal & CHIP Pediatric ACOs

Section	Provision of the PACO Demo (2012 – 2016)
2706(a)(1)	Qualified in the same way as Medicare ACOs under §3022
(c) (1)	HHS secretary sets the performance guidelines in consultation with the States and Pediatric providers
(c) (2)	States set an annual minimal level of savings over FFS expenditures
(c) (3)	Three year minimum participation period required of the ACO
(d)	When the ACO meets the performance target for quality and cost savings under (c) (1), the incentive payment for such year will be equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings

Why ACOs are Important

Increased patient enrollment

- CMS will assign patients to ACOs

ACOs will lead payment reform

- A natural advantage in this process due to your coordinated care model

Bill: "When can I qualify?" Application process not yet established, prob. Early 2011

Medicaid Expansion

- California expects 3 million new Medi-Cal lives by 2014 – *half* of all new patients in California
- Payment rates increase to Medicare levels from 2014 to 2016 – *is this sustainable?*
- Pediatric Accountable Care Organizations and Global Payments Model tested
- Increase in Medi-Cal managed care lives as the State seeks cost-savings over FFS

Medicaid Expansion Provisions

Section	Topic
2001	•Adults under age 65 with gross incomes of less than 133% FPL •States can expand as early as 2010 and cover beyond 133% by 2014 •CMS will pay 100% of expansion from 2014 to 2016 •Increases FMAP from 2014 to 2016 •Requires benchmark to cover prescription drugs and mental health
2002	•Eligibility based on modified gross income for the non-elderly •Exempts from this requirement: (1) individuals eligible for Medicaid through another program; (2) the elderly or Social Security Disability Insurance (SSDI) program beneficiaries; (3) the medically needy; (4) enrollees in a Medicare Savings Program; and (5) the disabled.
2003	•Extends premium assistance subsidy for qualified employer-sponsored coverage to children under age 19 to all individuals, regardless of age. •Prohibits eligibility requirement of enrollment in qualified employer-sponsored coverage.

Medicaid Quality Improvements

Section	Topic
2701	CMMS to adopt a core set of adult health quality measures and create a Medicaid Quality Measurement Program to administer metrics
2702	Adopt regulations to prevent payment for never events
2703	Health home program for chronically ill beneficiaries
2704	Bundled payment hospitalization demonstration project
2705	Medicaid global payment demonstration project
2706	Pediatric ACO demonstration project

Coordination of Dual Eligibles

Section	Topic
2601	Waivers shall be for five years with a five-year extension, unless the Secretary determines otherwise. Up to ***1.1 million new patients*** in California under this category.
2602	Establishes a Federal Coordinated Health Care Office at CMMS to integrate the benefits more closely, and improve coordination between the federal and state governments to ensure that beneficiaries get full access to the services to which they are entitled

Recent Anthem proposal offered to serve Dual Eligibles at 85% of Medicare. CAPG declined to participate

Emerging theme: Will DHCS pay sufficient rates for dual eligibles to be adequately served in managed care? (85% or 115% of Medicare FFS)

CHIP Provisions

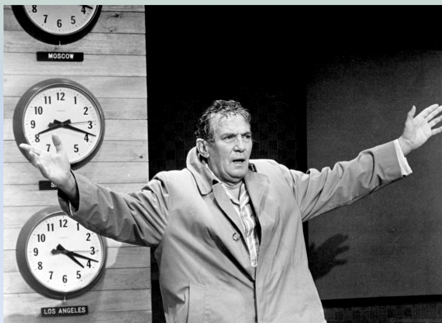
Section	Topic
2101	•Increases FMAP from 2016-2019 subject to a 100% cap. •States prohibited from applying lesser standards prior to 2019 •HHS must accept health plans offered in the exchanges •Requires the Secretary to: (1) review benefits offered whose benefits and cost-sharing are at least comparable to those provided under the particular state's CHIP plan. •Prohibits enrollment bonus payments after 2013. •Requires eligibility based on modified gross income and household income beginning in 2014.
2201	Requires simplification of enrollment application and coordination with state health insurance exchanges via state-run websites for both CHIP and Medicaid

No Cost Controls in PPACA?

- As you can see, PPACA is littered with dozens of cost-control pilots that will be tested over the next 5 years – it's all about saving money
- The 2016-2017 time frame will be critical as HHS determines which mechanisms to adopt permanently
- The Secretary has full authority to experiment with any payment system beyond those listed, so don't count out partial and full-risk capitation

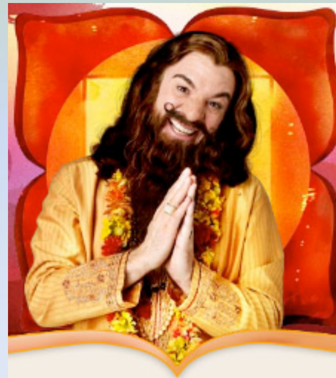
U.S. Physician – Circa 2017

Mad As Hell?



Peter Finch, Network, 1976

Finding Nirvana



CAPG

Stay Tuned

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