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A Health Reform Workaround

Law360, New York (March 04, 2010) -- Although the general sentiment is that health reform is on its last leg, certain elements keep propelling us forward:

- 1) severe budgetary shortfalls are squeezing Medicaid funding in every state;
- 2) momentum for delivery system reforms are continuing despite grid-lock in Congress;
- 3) a 21 percent cut in payments to Medicare physicians is looming unless Congress acts to change it; and
- 4) program integrity efforts assume center stage as Congress and the administration work to shore up the public fisc.

With comprehensive reform at an impasse following Scott Brown's, R-Mass., assumption of the Senate seat held by a Democrat for 47 years, providers are wondering how best to respond strategically in such a fluid political environment.

In what could be an alternative strategy to incorporate provisions from the House and Senate reform bills into a diffuse array of legislative initiatives and regulatory measures, President Obama introduced his FY 2011 federal budget proposal on Feb. 1, 2010.

Characterizing health care costs as "the single biggest threat to our nation's fiscal future," the administration's \$3.8 trillion budget request to Congress assumes enactment of specific provisions from the now-stalled reform legislation, saving an anticipated \$150 billion over 10 years.

With regard to the immediate concerns of state Medicaid budgetary shortfalls, Obama's budget proposal extends the temporary Federal Medical Assistance Percentage (FMAP) increase provided by the American Recovery and Reinvestment Act of 2009 (ARRA) for six months, resulting in an additional \$25.5 billion to the states. It also provides for a 10-year fix to the statutorily mandated payment reduction under the Medicare physician fee schedule.

With the fate of comprehensive health reform legislation still in question, the president's budget proposal underscores the administration's intent to pursue a number of health care payment and delivery system reforms.

To that end, President Obama's budget document allocates \$268 million for comparative effectiveness research (CER) and an increase of \$110 million to the Centers for Medicare and Medicaid Services (CMS) for "modernizing the Medicare and Medicaid programs by making CMS a leader in value-based purchasing."

With regard to CER, the Obama administration currently is soliciting research grant applications, funded by ARRA, for studies to measure the benefit of treatments produced in routine clinical practice.

For a preview of how a value-based purchasing (VPB) system could be implemented by the administration, one needs to look no further than the Senate reform legislation.

Reimbursement under the Medicare inpatient prospective payment system (IPPS) would be reduced under the Senate's reform proposal by one percent in 2013, two percent in 2017, and thereafter to fund incentive bonus payments to hospitals achieving certain quality-based performance scores.

Medicare payments to hospitals would be reduced for readmission rates related to specified conditions after 2012. A penalty applicable to hospitals that score poorly with respect to hospital-acquired conditions (HAC) would be instituted in 2015.

Building on these VBP initiatives, expect to see efforts by the Obama administration aimed at testing and implementing payment bundling programs and alternative reimbursement methodologies that promote care coordination and reward providers for comprehensive patient care management.

For example, discussions currently are underway by the Medicare Payment Advisory Commission (MedPAC) as to how an Accountable Care Organization (ACO) model could function as a means for controlling cost growth and improving quality under the Medicare program. Alternatives under consideration by MedPAC include whether ACO implementation should be pursued using a voluntary or mandatory path.

Similarly, CMS has announced that it is moving forward with an administration-initiated demonstration project whereby Medicare would partner with existing multipayer medical home pilots to improve the delivery of care. This demonstration, titled the Multi-Payer Advanced Primary Care Practice Demonstration, is slated for implementation sometime this year.

While the administration's budget proposal for FY 2011 does not appear to contemplate additional cuts in Medicare, the president has asked Congress to create "a bipartisan fiscal commission charged with identifying additional policies to put our country on a fiscally sustainable path ... by 2015."

To that end, President Obama signed an executive order on Feb. 18, 2010, establishing an 18-member bipartisan National Commission on Fiscal Responsibility and Reform tasked with recommending solutions to the federal deficit, including changes and/or reductions to entitlement programs.

With analysts projecting an unprecedented 17.3 percent share of the nation's gross domestic product for health care, expect Medicare spending cuts to remain high on the administration's policy agenda in the coming years.

On Jan. 28, 2010, HHS and the U.S. Department of Justice brought together law enforcement, private and public sector leaders and health care experts for a "National Summit on Health Care Fraud," the first national gathering of this kind and an initiative of the Health Care Fraud Prevention & Enforcement Action Team (HEAT).

Reiterating the president's "zero tolerance" policy on health care fraud, administration officials outlined an aggressive prosecution and prevention approach that includes bolstering HEAT, expanding the Medicare Fraud Strike Force to other geographic areas, enhanced budgetary investments and regulatory reforms.

On the same day, Sen. Charles Grassley, R-Iowa, introduced a 100-plus-page fraud and abuse deterrence bill "comprised of reforms with bipartisan support" from the Senate reform bill.

The proposed "Strengthening Program Integrity and Accountability Act in Health Care" (S. 2964) would enhance civil monetary penalties and provider screening and enrollment efforts, impose deadlines for reporting and returning overpayments, require payment suspension periods, expand the Recovery Audit Contractor (RAC) program and require HHS to establish a physician self-referral disclosure protocol.

New provisions affecting the federal False Claims Act in the proposed legislation include a two-year statute of limitations for the filing of claims alleging retaliation against whistleblowers and amendments to the "original source" exception to the public disclosure bar.

The president's budget echoed efforts of the Justice Department and Sen. Grassley in his budget by including revenue enhancers that focus on healthcare fraud prevention and program integrity, described as a "top priority for the president."

The budget document provides \$561 million in HCFAC discretionary funding and infuses the joint HHS-DOJ HEAT task force with an additional \$250 million for investigative and enforcement initiatives.

With HCFAC funding levels at \$1.7 billion for FY 2011, it is clear that the administration intends on making significant inroads on fraud prevention and program integrity during the next fiscal year.

Reforms? Yes, they are coming still and likely will surface in a multitude of vehicles — not only via the budget and "must pass" legislation, but also through regulation, demonstration projects and by executive order.

As a result, the health care industry should not sit back and breathe a collective sigh of relief. Rather, providers should be positioning themselves, strategically, to address growing downward financial pressures, the call for innovations involving greater physician-hospital integration, and the establishment of new models for delivery aimed at creating medical homes for patients.

Providers must heed the call for enhanced quality in exchange for payment and recognize that their institutions will be subject to enhanced scrutiny with regard to coverage, payment and compliance under the Medicare and Medicaid programs.

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