PPACA and Physicians: Payment, Quality, Program Integrity

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AAMC Teleconference
April 27, 2009
Agenda

- Physician Payment & Quality Provisions
- Program Integrity and Fraud and Abuse
- Physician Sunshine Act

- Slides available at www.aamc.org/reform
PHYSICIAN PAYMENT AND QUALITY ISSUES
Physician Provisions

• No SGR fix
• GPCI adjustments
• Primary care/general surgery bonus
• Focus on QUALITY and COST
  • PQRI incentives through 2014; then penalties
  • Feedback report on resource use
  • Value-based modifier
• Payment demonstrations and pilots
Physician Fee Schedule Update

• 2010 Fee Schedule update—
  • 21% cut delayed multiple times
  • “Continuing Extension Act of 2010” (HR 4851) extends freeze through May 31

• No fix in PPACA

• Options …..
Geographic adjustments

GPCI work floor extended through 12/31/10

GPCI PE changes

• 2010-11:
  • Blend ½ national, ½ local
  • increases if <1
  • hold harmless if reduction

• By 1/1/12: modify methodology; budget neutral

• 1/1/11: Establishes ongoing 1.0 floor for frontier states (ND, SD, WY, MT, UT)
Additional Medicare bonus

1/1/11-12/31/15: 10% bonus to:

- Primary care practitioners (family med; IM; geriatrics; peds; NP; clinical nurse specialist; PA) if primary care services (office, skilled nursing, and home visits) at least 60% of allowed charges

- General surgeons for major surgical procedures (use 10- or 90-day global period) in HPSAs
Medicaid Primary Care

2013-14: Medicaid payments to primary care physicians (family med, general IM, and peds) for primary care services **not lower than** Medicare fee schedule
• Extends incentives; adds penalties
  • 2011 incentive payment: 1%
  • 2012-14 incentive payment: .5%
  • 2015: 1.5% reduction
  • 2016 and later: 2% reduction
• Add Maintenance of Certification option
  • additional 0.5% incentive 2011-2014
• Integrate with meaningful use reporting requirements (by 2012)
• Other: informal appeal; timely feedback
Maintenance of Certification (MoC)

• “...continuous assessment program such as qualified American Board of Medical Specialties Maintenance of Certification program or equivalent...”
2011-14: 0.5% increase in PQRI payment if do the following:

- Satisfactorily submit data on quality measures for 1 year
- Have data submitted through an MoC
- More frequently than is required to qualify for or maintain board certification:
  - Participate in MoC for a year and
  - Successfully complete MoC program practice assessment

2015 and beyond: may incorporate requirements above into composite quality measures
Physician Value-Based Purchasing

MIPPA 2008

• established Physician Feedback Program
  • confidential reports on resource use (cost)
  • per capita and per episode measurement
• mandated a plan to transition to value-based purchasing for physician
  • report due to Congress May 2010

PPACA 2010

• Modifies Feedback Program
• Establishes value-based modifier
Feedback Program Changes

By 1/1/12: Develop public episode groupers

• Combine separate but clinically related items and services into an episode of care

In 2012: reports to physicians that compare patterns of resource use of individual physicians to other physicians

• Adjust for socioeconomic and demographic characteristics, ethnicity and health status

Coordinate Feedback Program with VBP initiatives
VBP Modifier under PFS

Payment modifier under fee schedule based on quality of care compared to cost

• Based on a composite of measures, such as measures that reflect health outcomes. Measures to be risk-adjusted

• Costs to be based on a composite of appropriate measures of costs that eliminate geographic adjustments and take into account risk factors
VBP Modifier ‘cont

By 1/1/12: measures of quality and costs to be published

2013: Implementation of modifier to begin through PFS rulemaking

1/1/15: payment modifier for specific physicians and physician groups

Not later than 1/1/17: modifier with respect to all physicians and physician groups

Physician VBP program to be coordinated with other VBP programs
## Incentive Programs

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<th>2011</th>
<th>2012</th>
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<tbody>
<tr>
<td>PQRI</td>
<td>1.0%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
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<tr>
<td>OR</td>
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<tr>
<td>PQRI – MoC option</td>
<td>1.5%</td>
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<tr>
<td>E-prescribing</td>
<td>1.0%</td>
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<td>0.5%</td>
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<tr>
<td>OR</td>
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<tr>
<td>EHR Meaningful Use</td>
<td>Varies</td>
<td>Varies</td>
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*Penalties for not e-prescribing: 1.0% reduction in 2013; 1.5% reduction in 2015*

Note: Incentives are lump payments. Percents on Medicare total allowed charges for applicable period

### Other Medicare Incentives

- 10% bonus (quarter or annual) on primary services by primary care practitioners (2011-2015)
- 10% bonus (quarter or annual) on surgeries by general surgeons in HPSAs (2011-2015)

### Medicaid Incentive

Rates for primary care services not less than Mcare Fee Schedule (2013-2014)
**Reductions applied to the CF**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<tbody>
<tr>
<td>PQRI</td>
<td>1.5%</td>
<td>2.0%</td>
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<td>EHR Meaningful Use*</td>
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<td>2.0%</td>
<td>3.0%</td>
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<tr>
<td>Value based modifier</td>
<td>TBD (increase or reduction)</td>
<td>TBD (increase or reduction)</td>
<td>TBD (increase or reduction)</td>
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</tbody>
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* If 75% or fewer of eligible professionals are not meaningful EHR users, a 1% decrease in fee schedule may continue for 2018 and beyond, not to exceed a total reduction of 5%.

At least 5% of Fee Schedule at Risk by 2017!
Public Reporting

• 2011 - Physician Compare website
• 2013 - “implement plan” to make performance data publicly available
• Can include
  • Quality measures, assessments of quality, efficiency, patient satisfaction, safety…
• Data prior to 2012 not included
Demonstration Projects

AAMC TELECONFERENCE MAY 13

Centers for Medicare and Medicaid Innovation (CMI) – includes option for AAMC-supported HIZ

Payment bundling pilot

Shared savings (Accountable care organizations)
Other Fee Schedule Items

• Misvalued RVUs
  • identify RVUs that are potentially misvalued
  • authority to bundle or modify RVUs

• Imaging –
  • changes utilization assumption for advanced diagnostic imaging from 90% to 75% (starting 2011)
  • increases TC reduction for multiple procedures in same session from 25% to 50% (starts 7/1/2010)

• Extends Mental Health Add-on to 12/31/2010
MISC. PHYSICIAN PAYMENT ISSUES
Other Physician Issues

Medicare:

• Enrollment required for billing for DME and home health (effective 1/1/10)
• Requirement can be extended to other services
• Failure to provide access to documentation for referrals to DME, home health, and other items or services (effective 1/1/10) can result in revocation of enrollment

Medicaid: all ordering or referring physicians or other professionals must be enrolled under Medicaid; NPI required
Other physician issues ‘cont

Medicare claims must be submitted within 1 calendar year after date of service

Applies to services furnished on or after 1/1/10

Exceptions possible
IPAB
IPAB

Independent Payment Advisory Board

• Work starts 2014
• Purpose: to reduce growth in per capita growth rate of Medicare spending
• Initially targets Parts C & D
• Hospitals and hospices excluded until 2020
• Recommendations to consider effects on providers with actual or projected negative margins or payment updates
IPAB ‘cont

What’s not allowed:

• Rationing of health care
• Raising premiums
• Increasing cost sharing
• Restricting benefits or modifying eligibility
IPAB ‘cont

Compare per capita growth rate to savings target:

Savings target = total Medicare spending X applicable percent:

2015: 0.5 percent
2016: 1.0 percent
2017: 1.25 percent
2018 and later: 1.5 percent
By 1/15/15 and at least every 2 years after: report to Congress and the President on recommendations to slow the growth in national health care expenditures while preserving or enhancing quality of care.
RESEARCH AND REIMBURSEMENT
CCER and Coverage Decisions

Can’t deny coverage “solely on the basis of” CCER

No lower value on extending the life of an elderly, disabled, or terminally ill person

Can’t preclude or discourage treatment choice based on how an individual values tradeoff between extending life and risk of disability

Can’t use of a dollars-per-quality adjusted life year to establish what type of health care is cost effective or recommended, or for coverage, reimbursement or incentive programs (can’t devalue disability)
CER and Coverage ‘cont

Can only use CCER for Medicare coverage if use “iterative and transparent process,” including public comment and consideration of effects on subpopulations

CER can be used to:

• Determine coverage, reimbursement or incentive programs based on comparison of difference in effectiveness of alternative treatment in extending a life due to age, disability, or terminal illness

Allows differential copayments based on factors such as cost or type of service
Payment for Clinical Trials

Begins 2014

Amends Public Health Service Act NOT SSA

Insurers may not:

1. Deny participation of a “qualified individual” in a clinical trial

2. Deny coverage of routine patient costs for items and services furnished in connection with participation in the trial, or

3. Discriminate against individual on the basis of participation in the trial
Clinical trials ‘cont

Routine costs: items and services consistent with plan’s coverage that is typically covered for a qualified individual not enrolled in a clinical trial

Not covered:

• Investigational item, device, or service itself

• Items and services solely to satisfy data collection and analysis and that are not used in the direct clinical management of the patient

• Service clearly inconsistent with widely accepted and established standards of care
Clinical trials ‘cont

If there’s an in-plan provider participating in the trials, can require participation through that provider

But coverage can’t be denied if the qualified individual is in an out-of-state trial

Insurers aren’t required to cover out-of-network providers unless out-of-network benefits are otherwise provided
Clinical trials ‘cont

Definition of “approved clinical trial”

• Phase I, II, III, or IV for prevention, detection, or treatment of cancer or other life-threatening disease or condition
• Federally funded trials
• Study or investigation conducted under an IND reviewed by the FDA
• Study or investigation is exempt from having an IND application
Clinical trials ‘cont

Life threatening condition: likelihood of death is probable unless the course of the disease or condition is interrupted

Applies to Federal employee health insurance, but not to other Federal health programs

Does not preempt state laws that have additional requirements
PROGRAM INTEGRITY AND FRAUD AND ABUSE
First, Medicaid and CHIP

In 6 months: procedures for provider screening

• Level of screening depending on risk of fraud, waste and abuse
• Includes licensure check
• May include: criminal background check, fingerprinting, unscheduled and unannounced site visits (including pre-enrollment), and database checks
• 2 years after enactment applies to current providers
• No screening, no enrollment
More Medicaid and CHIP

Enhanced oversight for new providers

• Procedures to provide for provisional enrollment period of 30 days to 1 year, during which provider is subject to prepayment review and payment caps

Temporary moratorium on enrollment of new providers can be imposed if necessary to prevent or combat fraud, waste or abuse
Program Integrity

By 12/31/10: RAC expansion to Medicare Parts C and D; Medicaid

Compliance programs required for enrollment in Medicare, Medicaid, or CHIP.

  • Must contain “core elements”

Medicare self-disclosure protocol for actual or potential violations of Stark law within 6 months
Integrating Data Repository

At a minimum claims and payment data from:

- Medicare (A, B, C, D) and Medicaid
- CHIP
- VA health-related programs
- DoD health-related programs
- Federal old age, survivors, and disability benefits
- Indian Health Service
Even More Data for OIG/DOJ

HHS OIG and DOJ to have access to claims and payment data from HHS and contractors for Medicare, Medicaid, and CHIP
Overpayments

After reconciliation, Medicare and Medicaid overpayments to be returned within later of: 60 days from discovery or date next cost report due

- Written notification of reason for overpayment
- Failure to do so = obligation = FCA violation
Beginning 1/1/11: all Medicare and Medicaid claims and enrollment applications must include NPI (rulemaking required)
Suspension before conviction

Can suspend Medicare and Medicaid payments pending investigation of a credible allegation of fraud

• Consult with OIG to make determination
Money for Fighting Fraud

2011: $105m
2012: $65m
2013-14: $40m
2015-16: $30m
2017-2020: $10m
“Enhanced Penalties”

Enhanced penalties may be triggered by:

- Failure to grant timely access upon reasonable request by OIG for audits, investigations, evaluations, or other statutory functions: $15,000 per day penalty

- If knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services: $50,000 for each record or statement
There’s More: NPDB and HHS

HHS to report information to NPDB on final adverse actions (except those with no findings of liability) related to health care fraud and abuse
AKS and FCA

For anti-kickback law, no need to have actual knowledge or specific intent to commit a violation

FCA: To be an “original source”:

- Prior to public disclosure voluntarily discloses information on which allegations are based or
- Has knowledge that is independent of and materially adds to publicly disclosed allegations or transactions
MALPRACTICE
A Brief Word on Malpractice

- States should be encouraged to develop and test alternatives to civil litigation system
- Congress should consider establishing a state demonstration program to evaluate alternatives
SUNSHINE ACT
Physician Payment and Ownership Sunshine Provisions [6002]

Requires annual reporting of payments, other transfers of value to physicians and teaching hospitals from manufacturers of drugs, devices, biological, or medical supplies for which payment is available under Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP)

Also requires reporting of physician ownership or investment interests in such manufacturers

Reporting begins March 31, 2013

Secretary to post reports on public Web site
Physician Payment and Ownership Sunshine Provisions

Excludes payments of less than $10 unless annual aggregate to a recipient exceeds $100

Requires description of the nature of the payment
  • consulting fees;
  • compensation for services other than consulting;
  • honoraria;
  • gift;
  • entertainment;
  • food;
  • travel (including the specified destinations);
• education;
• research;
• charitable contribution;
• royalty or license;
• current or prospective ownership or investment interest;
• direct compensation for serving as faculty or a speaker for a medical education program;
• grant; or
• any other nature of the payment or other transfer of value (as defined by the Secretary).
Definition of physician:

• Allopaths
• Osteopaths
• Dentists
• Podiatrists
• Optometrists
• Chiropractors
Upcoming Calls

**Topic:** Hospital-related provisions (includes fraud and abuse, GME, quality, community benefit)

**Date:** April 29, 2-3:30pm EDT

**Topic:** GME (includes redistribution of unused Medicare resident cap slots; counting didactic and other time in hospital and non-hospital settings; permanently distributing cap slots from closed hospitals)

**Date:** May 3, 2-3:30pm EDT

**Topic:** Student Loans (closed call; only financial aid administrators)

**Date:** May 4, 2-3:30pm EDT
Upcoming Calls (Cont.)

**Topic:** Quality Provisions (includes quality reporting and performance-based payments for hospitals and physicians)

**Date:** May 10, 2-3:30pm EDT

**Topic:** Workforce, Title VII, Public Health, and Disparities

**Date:** May 12, 2-3:30pm EDT

**Topic:** Demonstration Projects and the CMS Innovation Center

**Date:** May 13, 2-3:30pm EDT
Learn
Serve
Lead