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Health Reform's New Bundles of Joy: Value-Based Purchasing and Payment Bundling Initiatives

May 6, 2010

The Patient Protection and Affordable Care Act (the "Act") directs the establishment of a number of value-based purchasing programs and payment bundling initiatives that impact providers across the healthcare spectrum, including physicians, hospitals, skilled nursing facilities, home health agencies, and ambulatory surgery centers, among others. In this issue of *Health Reform IMPACT*, we will highlight some of the most significantly affected healthcare industry sectors.

Value-Based Purchasing Programs

Hospitals. Slated to begin in 2013, the value-based purchasing program for hospitals will affect payments made to hospitals under the inpatient prospective payment system. The program will provide value-based incentive payments to hospitals meeting certain performance standards (although note that there is a corresponding decrease in diagnosis-related group (DRG) payments to all hospitals, even those meeting the performance standards, as will be discussed in more detail below).¹ Initially, the program shall include at least measures for acute myocardial infarction, heart failure, pneumonia, surgeries, and health-care associated infections. Over time, the program is to incorporate efficiency measures, including measures of spending per Medicare beneficiary. The Act excludes measures of readmissions from this program and instead provides payment reductions for excessive readmission rates in a separate section of the legislation (to be addressed in a later issue of *Health Reform IMPACT*).

To fund the hospital value-based purchasing program, the Secretary of Health and Human Services (the "Secretary") will reduce DRG payments for all hospitals, whether or not they are eligible for an incentive payment. Specifically, the base operating DRG payment for all inpatient discharges will be reduced by a percentage that will gradually increase from one percent (1%) in FY 2013 to two percent (2%) in FY 2017 and subsequent years. The amounts saved from these reductions will be used to fund the incentive payments to reward those hospitals that meet or exceed the quality performance measures. For those hospitals earning incentive payments, the payment varies based on the degree of performance (i.e.,

¹ Furthermore, even if hospitals meet the value-based purchasing performance standards, they will not receive any incentive payments if they do not submit certain mandated data on quality measures that are required under separate provisions of the Social Security Act.

hospitals achieving the highest performance scores will earn the largest value-based incentive payments).

Some hospitals are excluded from the value-based purchasing program described above due to insufficient numbers of measures and cases. However, the Act calls for a separate value-based purchasing demonstration program for these hospitals to be established within two (2) years of enactment of the Act. The Act similarly calls for a value-based purchasing demonstration program for critical access hospitals within the same time frame.

Skilled Nursing Facilities, Homes Health Agencies and Ambulatory Surgery Centers. The Act directs the Secretary to develop plans for value-based purchasing programs for Medicare payments to skilled nursing facilities (SNFs), home health agencies (HHAs), and ambulatory surgery centers (ASCs). In the case of SNFs and HHAs, such plans are to be submitted to Congress by October 1, 2011, and in the case of ASCs, the plan is due January 1, 2011.

Physicians and Physician Groups. The Act requires the Secretary to establish a payment modifier that provides for differential payment to physicians under the physician fee schedule based on the quality of care furnished as compared to cost. This payment modifier is to be budget-neutral. By January 1, 2012 the Secretary is required to publish: (1) the applicable measures of quality and cost,² (2) dates for implementation of the payment modifier, and (3) the initial performance period for application of the payment modifier.

Initial implementation of the payment modifier shall begin through the rulemaking process during 2013, but its actual application is to begin January 1, 2015 for selected physicians and physician groups (as determined by the Secretary) and no later than January 1, 2017 for all physicians and physician groups. In applying the payment modifier, the Secretary may account for (1) promoting systems-based care, and (2) the special circumstances of physicians and physician groups in rural areas and underserved communities. The Secretary must also coordinate the existing Medicare Physician Feedback Program with the provisions for value-based payment modifiers.

By January 1, 2011, the Secretary is charged with developing a Physician Compare Website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative. This Physician Compare Website is to be implemented by January 1, 2013. In developing the plan for the Physician Compare Website, the Secretary shall, as appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners already mandated under the Medicare Improvements for Patients and Providers Act of 2008.³

And that's not all. The Act mandates pilot programs to test the implementation of value-based purchasing for Medicare payments to psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs. These pay-for-performance pilot programs are to be implemented by January 1, 2016, and may eventually be expanded if certain

² Quality of care and cost will be evaluated, as practical, based on a composite of measures (which shall be risk-adjusted and standardized).

³ Public Law 110-275, Section 131.

conditions are met, including the Secretary's determination that such expansion is expected to improve the quality of care and reduce spending.

Payment Bundling Initiatives

Medicare. The Act directs the establishment by January 1, 2013 of a national pilot program on payment bundling that will encourage hospitals, physician groups, SNFs, and HHAs to improve the coordination, quality and efficiency of healthcare. The program may eventually be expanded if the Secretary determines that the program maintains or increases quality of care while reducing spending.

Bundled payment under the pilot program will be based on an episode of care provided to an applicable Medicare beneficiary surrounding a hospitalization. The payment will be comprehensive and will cover the costs of acute inpatient services, physicians' services delivered in and outside the acute care setting, outpatient hospital services, and post-acute services, including home health and skilled nursing services, and other services the Secretary deems appropriate.

The program will be focused on a maximum of ten (10) medical conditions to be selected by the Secretary and will include quality measures. As practical, data relating to quality measures is to be submitted through the use of qualified electronic health records. The Secretary is directed to consult with representatives of small rural hospitals (including critical access hospitals), regarding participation in the pilot program taking into consideration any difficulties in doing so (i.e., low volume). The Secretary must also apply the provisions of the pilot program so as to separately test the continuing care hospital model.⁴

Medicaid. The Act provides for a demonstration project in up to eight (8) states to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary. Such bundled payments would be for an episode of care that includes a hospitalization and for physician services provided during such hospitalization. This demonstration program will begin on January 1, 2012 and end December 31, 2016. A report to Congress on the results of the demonstration is due one year after completion of the demonstration.

Implications

It is clear from these and similar provisions of the Act that the alignment of government payments with quality health care and cost efficiency is a continuing trend. Given the potential future impact of these initiatives on payments, it is in providers' best interest to participate in the initial process of selection of measures for the value-based purchasing initiatives.

Moreover, the making public of quality data, such as through the Physician Compare Website, is another way that the government works to hold providers accountable for the quality of care that they provide. As such, providers should work with the government to ensure that the quality measures selected accurately reflect quality of care provided.

⁴ The term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides, under common management, the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units, long term care hospitals, and skilled nursing facilities that are located in a hospital.

If you have any questions about any aspect of these value-based purchasing or payment bundling initiatives, please contact any of the attorneys listed in our Healthcare Practice Group listed below.

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