

## HEALTH REFORM IMPACT

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### **Another Serving of Alphabet Soup: Newly Created Entities Could Play Major Role in Shaping Healthcare Delivery and Payment**

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The Patient Protection and Affordable Care Act (the "Act") directs the establishment of a number of new entities that could have a major impact on the future of healthcare payment and delivery. The Independent Payment Advisory Board ("IPAB"), the Center for Medicare and Medicaid Innovation (the "CMI"), and the Patient-Centered Outcomes Research Institute ("PCORI") are three particularly important new bodies among the alphabet soup of entities created by the Act. In this issue of *Health Reform IMPACT*, we will highlight ways that these three entities may shape the healthcare landscape in the coming years.

#### **Independent Payment Advisory Board (IPAB)**

One of the initial major goals of healthcare reform was to slow the growth of healthcare spending in the United States. Although the Act as eventually passed does not contain as many direct cost control measures as some had hoped, Section 3403 of the Act does establish the IPAB (or, the "Board"), which in the coming years could potentially play a major role in limiting the growth of Medicare spending.

The purpose of the Board, as stated in the Act, is to "reduce the per capita rate of growth in Medicare spending." In structuring the role of the Board, Congress took the unusual step of allowing an independent body outside of Congress and the Centers for Medicare and Medicaid Services ("CMS") to impose Medicare payment changes or restrictions. Each year beginning in 2014, if projected per capita Medicare spending exceeds targeted growth rates, the Board is responsible for providing recommendations for limiting Medicare spending the following year. The Secretary of the Department of Health and Human Services (the "Secretary") is required to adopt the recommendations of the IPAB unless Congress makes an alternate proposal that would result in the same or greater savings.

To achieve cost savings, the Board will almost certainly have to reduce payments for some items or services because the Act prohibits the Board from using many other means to save money. The Board may not submit proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements, or reduce low-income subsidies under part D. In addition, prior to 2019, the Board may not recommend changes in payment to providers and suppliers that are scheduled to receive a reduction in their payment updates if that reduction exceeds a reduction due to productivity adjustments, as specified in the Act. By contrast, from the outset in 2014, the IPAB is specifically permitted to recommend reductions in Medicare payment under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans.

There is to be no judicial or administrative review of the Secretary's implementation of the Board's recommendations. The Board is to submit an initial draft of its proposal each year to the Secretary and to the Medicare Payment Advisory Commission (MedPAC) for review and comment.

The IPAB will consist of 15 individuals appointed by the President and confirmed by the Senate. Board members are to be nationally recognized experts in various areas of healthcare, and each individual is to serve full time for a six-year term. A 10-member consumer advisory council will also be established to advise the Board on the impact of payment policies on consumers.

The Act appropriates \$15 million to the Board beginning in 2012 to carry out its duties and functions. In addition to its cost control functions, the IPAB will be required to produce annual reports addressing health care costs, access to care, quality of care, utilization of services, and comparisons by types of providers and by region.

### **Center for Medicare and Medicaid Innovation (CMI)**

A second entity that is to be created under the Act is the Center for Medicare and Medicaid Innovation ("the CMI"). The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care. If some of the tested programs prove successful in reducing spending and improving the quality of care, then the Secretary is authorized to expand the programs nationwide without Congressional approval.

The Act includes a list of 18 payment or delivery models that the Secretary could test, including:

- Payment for patient-centered medical homes
- Contracting for services on a risk-based comprehensive payment plan
- Using geriatric assessments and comprehensive care plans to coordinate care for elderly persons with physical or mental impairment
- Transitioning payments away from fee-for-service
- Using health information technology (including home telehealth) to help the chronically ill
- Establishing appropriateness criteria that would impact payment to physicians who order diagnostic tests
- Using medication therapy management services
- Establishing community-based health teams
- Paying providers and suppliers for using patient decision support tools
- Allowing states to test fully integrating care for dual-eligibles, i.e., those persons eligible for both Medicare and Medicaid
- Allowing states to test all-payer payment systems
- Aligning evidence-based guidelines for cancer care with payment incentives
- Promoting post-acute care through continuing care hospitals
- Funding home health providers who offer chronic care management services

- Developing a collaborative of high-quality, low-cost healthcare institutions
- Facilitating electronic communication so that off-site medical specialists can provide care for patients at local hospitals
- Promoting greater efficiencies and timely access to outpatient services such as physical therapy
- Establishing comprehensive payments to Healthcare Innovation Zones<sup>1</sup>

Unlike the IPAB, the CMI will not be an independent body, but rather will be an entity within the CMS. The CMI is to begin carrying out its duties by January 1, 2011. The Act allocates \$10 billion in funding for the CMI's programs from 2011 through 2019.

Although there have been a number of other demonstration programs authorized and implemented in the past, the CMI's programs have greater potential to become permanent given the fact that: (i) a significant amount of funding has been made available; (ii) the programs do not initially have to be budget neutral; (iii) the CMI has a great deal of flexibility, and, perhaps most importantly; (iv) CMS is authorized to expand successful programs nationwide without Congressional approval.

### **Patient-Centered Outcomes Research Institute (PCORI)**

A third important new entity is the Patient-Centered Outcomes Research Institute. The PCORI (or the "Institute") is to be a nonprofit corporation designed to set a national agenda for comparative effectiveness research ("CER") efforts. CER involves the comparison of healthcare treatments to determine which work best for which patients and which pose the greatest benefits and harms. By analyzing the outcomes of comparable therapies, drugs, and medical devices, comparative effectiveness research is intended to help providers and payers make informed decisions to increase quality and reduce wasteful spending.

CER is not a new concept, and in fact \$1.1 billion was allocated for such research as part of last year's stimulus package (the American Recovery and Reinvestment Act of 2009). The Institute is intended to now play a lead role in setting a national agenda for CER by setting priorities, evaluating existing studies and conducting its own studies. The Institute may enter into contracts with other entities for the management of funding and conduct of research, including federal agencies, academic research institutions, private sector research, and bodies such as the National Institutes of Health, and the Agency for Healthcare Research and Quality.

The Act does not force payers or providers to make payment or treatment decisions based on the Institute's findings. In fact, the Act specifies that the Institute's data should not be construed as "mandates for practice guidelines, coverage recommendations, payment, or policy recommendations." CMS is permitted to take the Institute's findings into consideration when making coverage determinations, but CMS cannot rely solely on the Institute's findings, and it must provide an opportunity for public input.

The PCORI is to be governed by a 19-member board of individuals appointed by the Comptroller General of the United States. Board members will serve six-year terms, and are to represent various groups including doctors, drug makers, hospitals, patients, medical device manufacturers, government officials,

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<sup>1</sup> "Healthcare Innovation Zones" consist of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity, deliver a full spectrum of integrated and comprehensive healthcare services to applicable individuals while also incorporating innovative methods for the clinical training of future healthcare professionals.

insurers, and health experts. Money for the Institute is to come through a trust that is funded by the government and by a fee on health insurance and self-funded plans. This trust will provide increasing amounts of funding to the PCORI beginning with \$10 million in fiscal year 2010 and increasing to more than \$150 million by fiscal year 2013.

If you have any questions about this issue of *Health Reform IMPACT*, please contact one of the attorneys in our Healthcare Practice Group listed below.

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