

What's Next for Health Care?

Understanding the Debate in Washington

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American Reinvestment & Recovery Act (aka Stimulus Package)

Health Care Components:

- \$86.6 billion for Medicaid
- \$24.7 billion to provide a 65 percent subsidy of health care insurance premiums for the unemployed under the COBRA program
- \$19 billion for health information technology
- \$10 billion for health research and construction of NIH facilities
- \$1.3 billion for medical care for service members and their families
- \$1 billion for prevention and wellness
- \$1 billion for the Veterans Health Administration
- \$2 billion for Community Health Centers
- \$1.1 billion for comparative effectiveness
- \$500 million to train healthcare personnel
- \$500 million for healthcare services on Indian reservations



Health IT

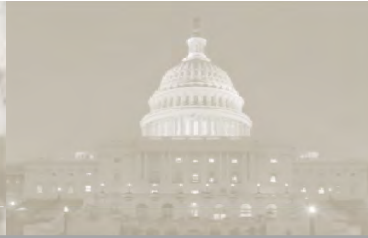
- Beginning in 2011, Medicare physicians who implement and report meaningful use of electronic health records (EHR) will be eligible for an initial incentive payment up to \$18,000.
 - Physicians (non-hospital based) are eligible for Medicare incentive payments based on an amount equal to 75% of the allowed Medicare Part B charges, up to a maximum of \$18,000 for early adopters whose first payment year is 2011 or 2012.
- Development of uniform electronic standards
- Establishes the role and functions of the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS
- Includes a provision that will reduce Medicare payments for physicians who do not use EHR systems that takes effect in 2015



HIT Payments to Physicians

First Payment Year	First Payment Year Amount, and Subsequent Payment Amounts in Following Years	Reduction in Fee Schedule for Non-Adoption/Use
2011	\$18k, \$12k, \$8k, \$4k, and \$2k	\$0
2012	\$18k, \$12k, \$8k, \$4k, and \$2k	\$0
2013	\$15k, \$12k, \$8k, and \$4k	\$0
2014	\$12k, \$8k, and \$4k	\$0
2015	\$0	-1% of Medicare fee schedule
2016	\$0	-2% of Medicare fee schedule
2017 and thereafter	\$0	-3% of Medicare fee schedule

Note: Physicians in rural health professional shortage areas who adopt/use EHRs are eligible to receive a 10% increase on the incentive payment amounts described above.



Comparative Effectiveness

- Administered by AHRQ, NIH, and the Secretary of HHS
- Funding will “be used to conduct or support research to evaluate and compare clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition”
- Signifies preeminence of clinical outcome-based research and analysis (as opposed to research driven by cost analysis)
- Prohibits HHS from including national clinical guidelines or coverage determinations in CER.
- Establishes a new advisory council called the Federal Coordinating Council for Comparative Effectiveness Research.



Senate Finance Options

What are the possibilities?

Infrastructure

- HIT
- Comparative Effectiveness Research
- Quality Measurement
- Physician Payment Transparency
- Physician-Owned Hospitals
- Nursing Home Transparency
- GME
- National Workforce Strategy



Senate Finance Options

What are the possibilities?

- Value-Based Purchasing (Hospital, Home Health, Nursing Home)
- PQRI Improvements
- Transparency of Self Referrals
- Quality reporting for Rehab and Long-Term Care facilities
- Primary Care and General Surgery Bonus
- Payment for Transitional Care
- CMS Chronic Disease Innovation Center
- Hospital Payment Bundling
- SGR Temporary Fix
- Accountable Care Organizations



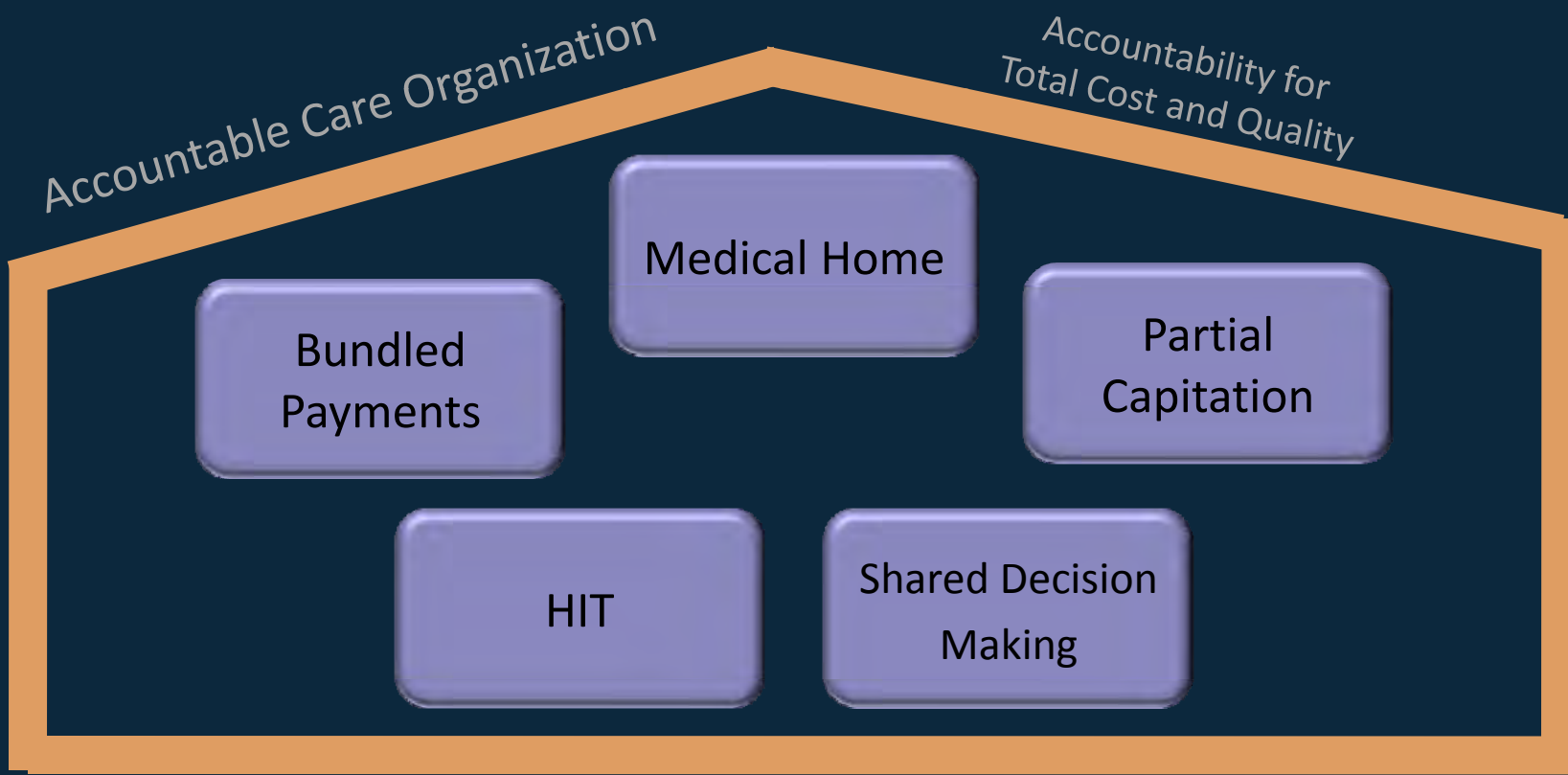
Accountable Care Organizations

Three components of ACO infrastructure

- Local Accountability for Cost, Quality, and Capacity
- Shared Savings
- Performance Measurement



ACO is the overarching structure within which other reforms can thrive





ACOs will look very different, but a few characteristics are essential

1

Can provide or manage continuum of care as a real or virtually integrated delivery system

2

Are of a sufficient size to support comprehensive performance measurement

3

Capable of internally distributing shared savings payments



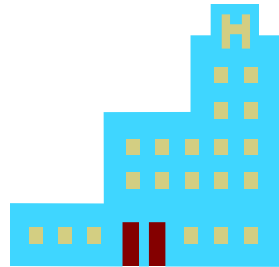
Which providers comprise an ACO? It varies.

Accountable Care Organization

Primary Care



Hospital



Specialists



Other Possible Components:

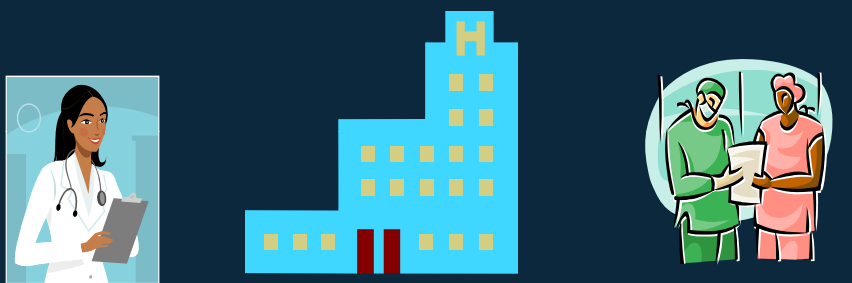
Home Health

Mental Health

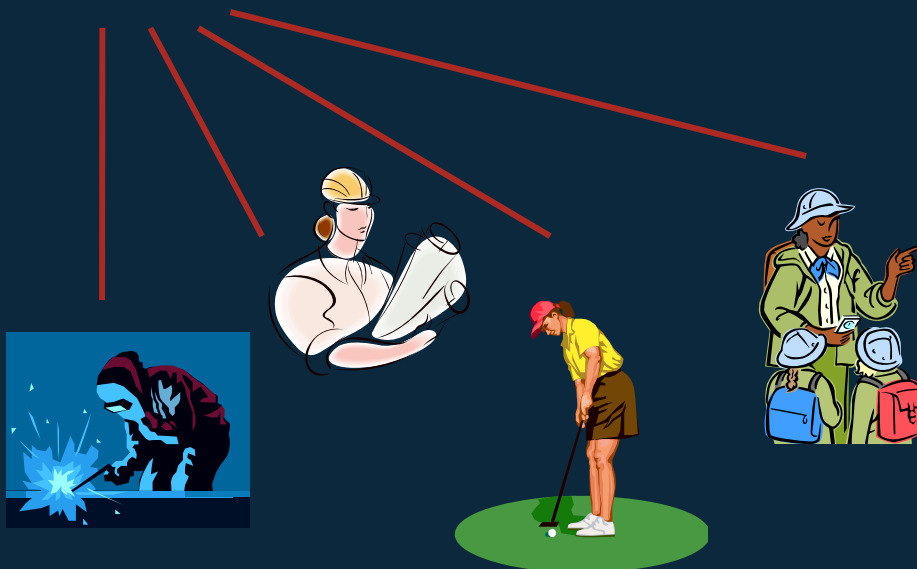
Rehab Facilities



How are patients assigned to the ACO?



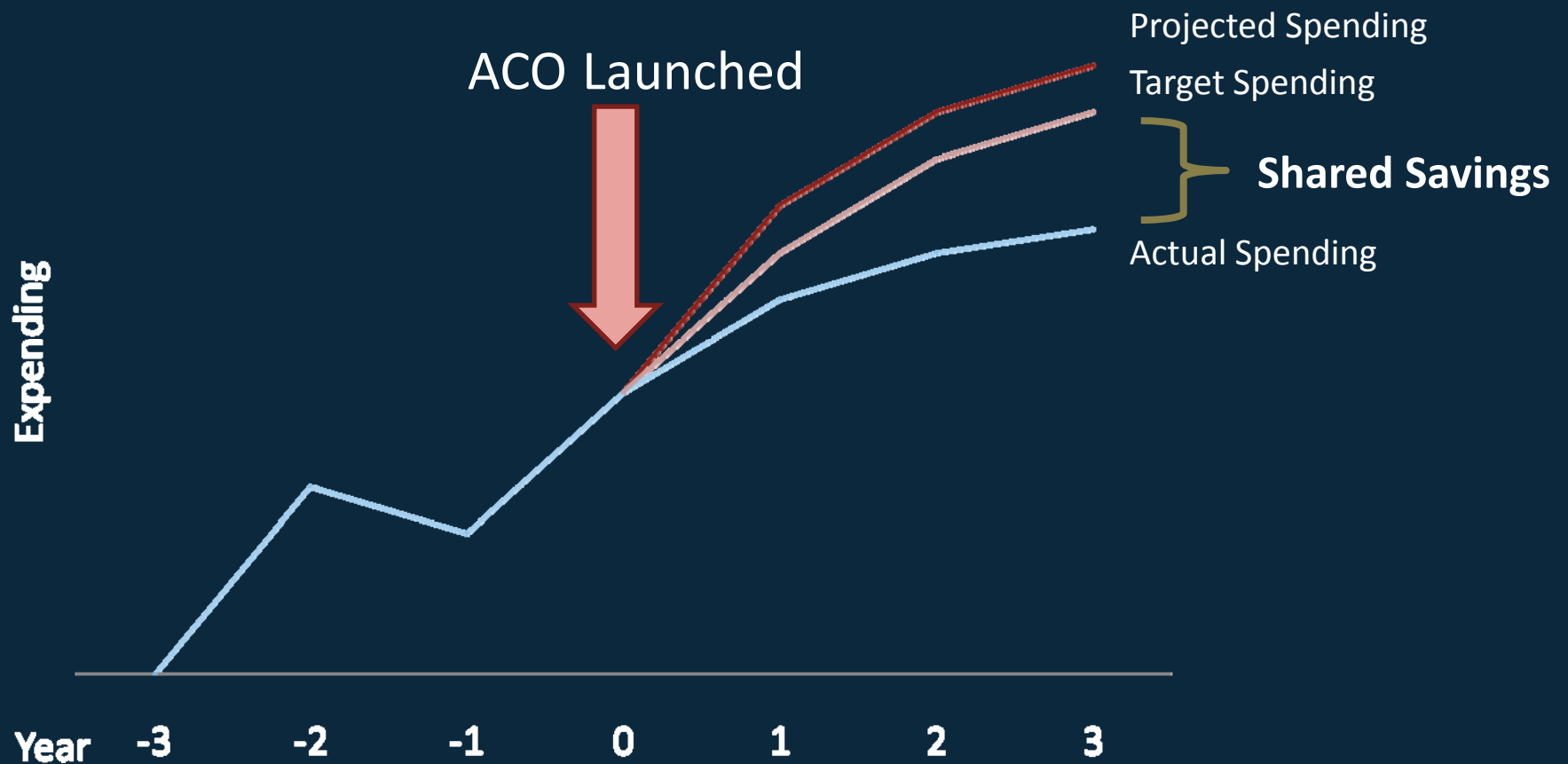
Providers sign agreement to participate with ACO
(PCPs must be exclusive to one ACO; Specialists can be part of multiple ACOs)



Patients are assigned to their PCP based on the majority of their outpatient E&M visits

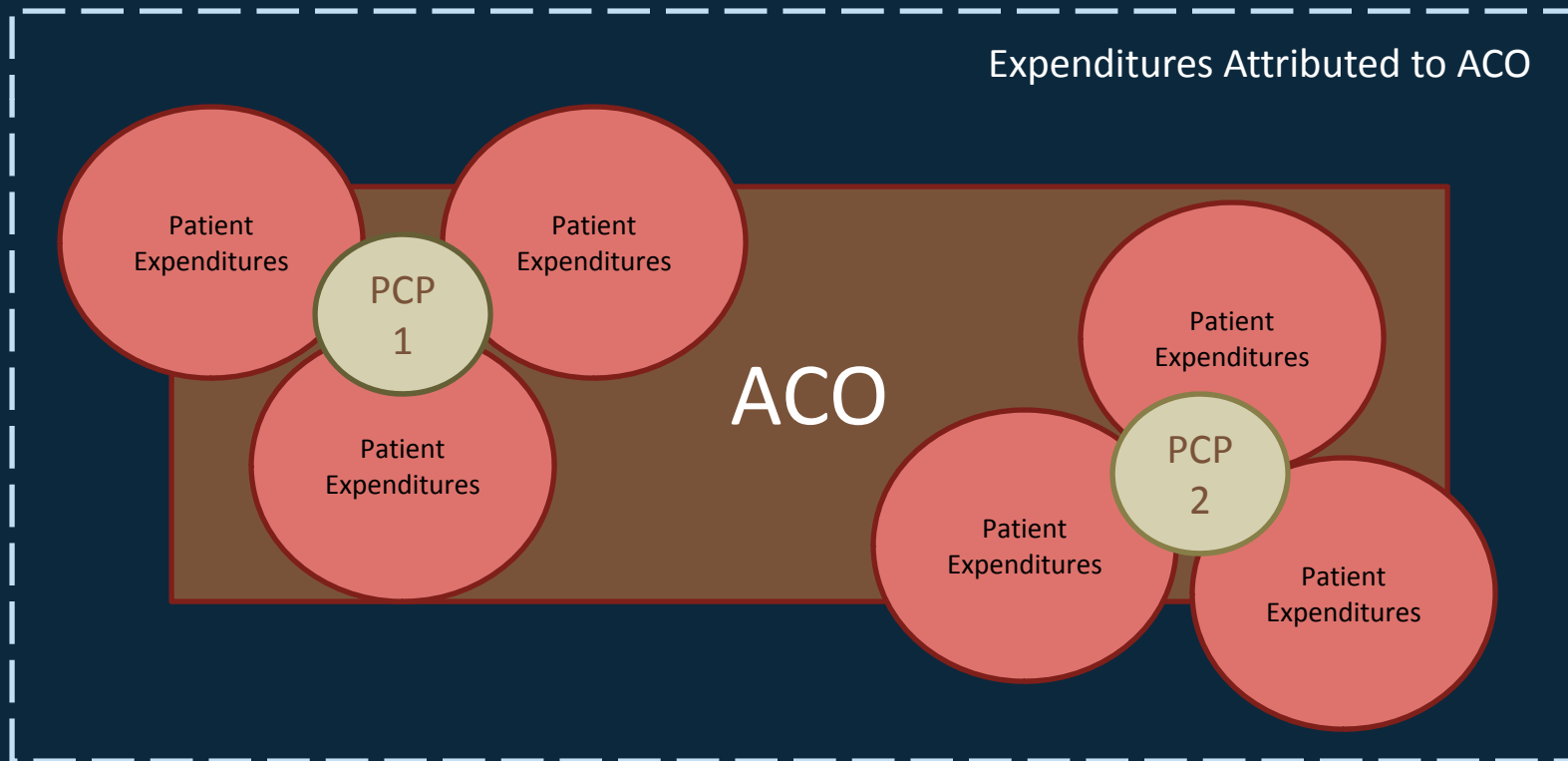


Calculating savings based on spending targets





ACO is responsible for all patient expenditures





Multiple initiatives within the ACO model:

\$800M (Target Expenditures)

- \$525M (Traditional Fee for Service Payments)
 - \$115M (Bundled Payments for Specific Conditions)
 - \$150M (PMPM Payments for Medical Home)
-

\$10M (Available Shared Savings)

(80/20 agreed upon split)



\$8M to the Providers



\$2M to the Payers