26th Annual Update in Physical Medicine & Rehabilitation

Healthcare Reform & PMR
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Overview of Presentation

• 2012 Calendar.

• Conference on Payroll tax / UI / Medicare “Extenders.”

• Update on SGR & Other Physician Issues.

• Debt Ceiling: The Deal – “Sequestration” – Potential Cuts.

• Health Reform Trends, Incentives & Implementation.

• Essential Health Benefits & Medical Necessity.

• Supreme Court Review of Health Reform.

• Regulating Health Reform’s New Delivery Models.
2012 Milestones:

Jan 24 – President’s State of the Union (SOTU) address.
Feb 13 – President releases his FY 2013 budget.
Feb 29 – Payroll/UI/Medicare “Extenders” agreement.
Mar 26 – Supreme Court to Consider Health Reform Laws.
Apr 1 – Deadline for release of House/Senate budgets.
Aug - Sep – Republican & Democratic conventions.
Oct. 1 – Deadline for completion of FY 2013 appropriations bills.
Nov. 6 – Presidential Elections.
Nov - Dec – Lame-Duck Session likely.
Jan 1, 2013 – Sequestration cuts begin ($1.2 trillion/10 years).
Payroll Tax/ UI / SGR Extension:

Health Care “Extenders:” (extended through Dec. 31, 2012)

- Physician Payment Update (SGR): 0.0% update to the conversion factor;
- Extends Therapy Caps “exceptions” process; caps extended to HOPD;

Pay-Roll Tax Relief: (extended through Dec. 31, 2012)

- Extends the 2% payroll tax cut for employees.
- Impact on Social Security Trust Fund.

Unemployment Insurance: (extended through Dec. 31, 2012)

- Extends Federal unemployment insurance programs at reduced levels.
Payroll Tax/ UI / SGR Extension: (cont.)

Offsets / “Pay-fors:” (each over 10 years)

- Medicare hospital / SNF “bad debt” payments: $6.9 billion:
  - $1.2 billion to come from nursing homes.
- Rebasing the Medicaid DSH payments: $4.1 billion;
- Cutting clinical lab payments by 2%: 2.7 billion;
- Cutting the prevention and wellness fund from health reform: $5 billion; (1/3rd of overall fund)
- Eliminates the “Louisiana Purchase” (Medicaid matching rate for “Federal Disaster”): $2.5 billion.
SGR – Long-Term Prospects:

- **Timing is unclear.** (Current extension expires January 1, 2013)
  - No action yields 32% payment cut.
  - Action in lame-duck session v. early 2013?
  - More short-term updates v. long-term update?

- **Growing perception: permanent SGR fix will feature:**
  - Several years of fixed legislative payment updates.
  - Transition period to test a new payment system.

- **Cost an issue** – 10-year freeze at current levels is $316 billion – possibly paid for by various proposals:
  - Unspent funds from Iraq / Afghan wars.
  - Raising Medicare eligibility age from 65 to 67.
  - Reform of Medicare programs; cuts to other Medicare providers.
Specific SGR Reform Proposals:

- **House Democrats**: “CHAMP” HR 3162, 110th Congress
  - Start with an update floor; then apply 6 new silos/target growth rates.
- **House Democrats**: HR 3961, 111th Congress
  - Now only 2 silos / target growth rates: E/M – all other services.
- **MedPAC** (Oct 2011):
  - Repeal SGR; 10-year payment freeze for primary care; specialists cut 5.9% for 3 years followed by 7-year freeze; CMS to test new models.
- **Sen. Stabenow**: (111th Congress) Repeal SGR; new physician payment baseline; 10-year freeze; CMS to test new models.
- **Rep. Schwartz**: Repeal SGR; 2012 freeze; 4-year transition period (2.5% update for primary care; 0.5% for specialists); CMS to test new models.
- **AMA**: Repeal SGR, 5-year stable payments, transition to new model(s).
- **AMA**: Forms “Innovator Committee” – research new payment models.
Physician Issues:

Primary Care: 10% bonus for physicians and general surgeons in Health Professions Shortage Areas (for 5 years starting in 2011).

Quality Reporting: Requires participation; bonus payments up to 2014; penalties for not participating in/after 2015.

Physician Value-Based Payment Modifier:
- Differential payment based on quality measures (to include outcomes).
- Initial development underway at CMS for possible inclusion in 2013 rule and for implementation in 2015 (partial) and 2017 (full).

Independent Payment Advisory Board: (IPAB)
- Suggests new quality/solvency cost-cutting proposals to Congress.
- In budget deficit years, IPAB proposals take effect unless Congress acts.
- Opposed by organized medicine.

Center for Medicare and Medicaid Innovation: (CMMI)
- Tests new payment/delivery models to reduce cost, enhance quality.
Physician Issues: (cont.)

Fraud & Abuse: Review status of RAC and MAC appeals.

“Sunshine Act:” Requires Annual public reporting of any drug / device manufacturer payments to physicians. (as of March 31, 2013)

Medical Malpractice:

• H.R. 5 – Broad bills pass House Energy & Commerce and Judiciary Cmtes. in 2011.

• No Action on Senate Companion bills or other action since then.

Graduate Medical Education: (GME/IME) Congress considering cuts as part of deficit “sequestration.”

PCORI: Creation of PCORI (Patient Centered Outcomes Research Institute) and boost in federal commitment to CER research.

• ‘09 Stimulus ($1 trillion); ‘10 ACA (over $450 million annually).

• PCORI just released first draft of National Priorities for Research and Research Agenda, comments due March 15, 2012.
Debt Ceiling

Aug 2, 2011: Congress foregoes larger deal ($4 trillion+); passes last second deal averting default due to $14.3 trillion debt limit.

THE DEAL: Stage One

- Immediately raised limit by $400 billion. Next $500 billion subject to Vote of Disapproval.
- Caps total discretionary spending for next ten years (2012 – 2021) to decrease deficit by about $917 billion.
- Medicare & Medicaid programs (entitlements) protected in Stage 1.
- Other HHS Programs subject to Stage 1 cuts (ex.: NIH and CDC).
Debt Ceiling Deal

THE DEAL: Stage Two

- Bipartisan Joint Congressional Committee [*Failed to Achieve Goal*]
  - Goal: Cut $1.5 trillion/10 years from federal deficit (through entitlement reform and/or taxes) = $1.5 trillion debt limit raise.
  - Committee Missed Nov. 23 and Dec. 23 Deadlines.

- Failure ➔ “Sequestration” (i.e., across-the-board program cuts).
  - $1.2 trillion/10 years to both discretionary and mandatory programs (in order to generate $1.2 trillion debt limit raise).
  - Split 50/50 between defense and non-defense programs.
  - Medicaid / Social Security exempted.
  - Medicare sequestration cuts limited to 2% (& not from benefits or cost-sharing).

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Debt Ceiling:


• But, Congressional leaders have already suggested replacing cuts as specified by Deficit Deal.
  • GOP Members propose bill to void cuts to defense programs;
  • Proposals to void other cuts expected to be introduced, including elimination of 2% Medicare provider cuts.
  • Any adjustments likely to occur either earlier in 2012 or during “lame duck” session.
  • Harder to achieve consensus the closer the Congressional calendar gets to the November elections.
Debt Jeopardized Programs

Potential Program Cuts to Medicare Providers (over 10 years)

Graduate Medical Education (GME/IME):

- Biden-Boehner: $14 billion in “reform to DGME and IME payments.”
- Bowles-Simpson: $60 billion by “reducing excess payments for medical education.”

Bad Debt:

- Biden-Boehner: $14-26 billion from phasing out/eliminating bad debt payments.
- Bowles-Simpson: $23 billion by cutting bad debt payments.

Rural Hospitals:

- Biden-Boehner: $14 billion from “reforming rural hospital programs.”

DSH Payments:

- Biden-Boehner: $4 billion from “rebasing Medicaid DSH in 2021.”

Hospital Coding:

- Biden-Boehner: $3 billion from “recouping hospital coding intensity adjustment.”
Debt Jeopardized Programs

Potential Program Cuts to Medicare Providers (over 10 years)

Durable Medical Equipment:
- Biden-Boehner: $5 billion from “Medicaid DME Payments.”

Physicians:
- Biden-Boehner: $1.8 billion from “validating phys. orders for high-cost/fraud risk services.”

Larger Proposed “Biden/Boehner” Savings/Cuts:
- $50 billion from SNF/home health co-pay and payment reductions,
- $100 billion from Medicaid FMAP reform,

Other Bowles-Simpson Proposals: (no specific savings)
- Aggressively Implement and Expand Payment Reform Pilots (ACOs, payment bundling)
- Eliminate Provider Carve-Outs from IPAB (hospitals).
Debt Jeopardized Programs – IRFs

Additional Potential Program Cuts to Medicare Providers (over 10 years)

Inpatient Rehabilitation Facilities (IRF):
Primarily from President Obama’s FY 2013 budget and deficit plan, includes:

- Proposed cuts to Future Investment in Rehabilitation Services. ($32 billion)
  - Cuts in annual inflation updates for certain post-acute care providers.

- Site-Neutral Payment Proposals. ($4 billion)
  - Equalize/reduce payments to IRFs at the SNF level plus a portion of the IRF payment for patients with hip fractures, joint replacements and other conditions as determined by the Secretary.

- 75% Rule for IRFs. ($3 billion)
  - Raise current 60% threshold back up to 75% threshold.
Debt Jeopardized Programs – MedPAC

Additional Potential Program Cuts to Medicare Providers (over 10 years)

**MedPAC Deficit Proposals:** (Fall 2011)

- Apply offset to DME categories not subject to competitive bidding. ($8 billion)
- Pre-payment review of power wheelchairs. ($0.2 billion)
- Bundled payment for hospital and physician during admission. ($1 billion)
- Validate physician orders for high cost services. ($2 billion)
- Pay E&M visits in HOPD at physician fee schedule rates. ($10 billion)
- No IRF update in FY 2013. ($1 billion)
- Raise 60% Rule compliance threshold for IRFs to 75%. ($3 billion)
- No LTCH Update for FY 2013. ($1 billion)
- Rebase HH in 2013 and no update in 2012. ($10 billion)
- Rebase SNF payment rates. ($23 billion)
- Apply Readmissions Policy to SNFs, HH, LTCHs, and IRFs. ($4 billion)
Debt Jeopardized Programs – IRFs

But, Rehabilitation is NOT a Medicare Cost-Driver:

• According to data, Medicare IRF expenditures are flat or decreasing in recent years in contrast to many other acute and post-acute spending.

• IRF spending was $6.4 billion in 2010 – the same as in 2004.

• IRF was 2.2% of overall Medicare spending in 2003 and 1.3% in 2010.

• IRFs have declined from 1,231 in 2005 to 1,169 in 2011.

• Versus HH & SNF, IRF is just 11% of total post acute care spending.
Impending Train-wreck

Lame-Duck Soup.

- FY 2013 Appropriations.
- SGR and Other “Extenders” – expire end of 2012.
- Unemployment Benefits; Payroll Tax Cut – expire 2012.
- Debt Ceiling Rises Again – starts January 2013.
Intended Trends of Health Reform Law

• **Winners:**
  - Preventive care;
  - Chronic care coordination;
  - Coverage of mental illness;
  - Transitional care (reducing re-hospitalizations);
  - Primary care;
  - Home and community based care;
  - Integrated care.

• **Losers:**
  - Fee for service reimbursement;
  - Managed care.
Overall Trends (cont.)

- Extensive innovation will continue regardless of legal / political outcome of ACA.
- Team approach and coordination of care amongst providers.
- Consolidation: Insurers / hospitals buying physician practices.
- Cost containment: bundled payments and capitation models rather than fee for service.
- More administrative burdens for providers.
  - Tracking and reporting of quality measures.
  - Payment modifiers.
Healthcare Reform Refresher

• Enactment of PPACA in March 2010 has major implications for people with disabilities:
  • Prohibition of discrimination based on health status in private health insurance
  • Guaranteed issue and renewability
  • Prohibition of preexisting condition exclusions
  • Prohibition of coverage/policy rescissions
  • Premium Rating Protections
  • Prohibition of Lifetime and annual dollar limits on essential health benefits
Healthcare Reform Refresher (Cont.)

• Risk adjustment
  • Transitional reinsurance program and risk corridors for individuals and group markets between 2014-2016
  • Risk adjustment and chronic care coordination will shift focus from risk avoidance to competition (chronically ill / disabled)

• Includes “disability” as a health disparity category

• Accessible medical diagnostic equipment & tech

• Essential health benefits include:
  • Rehabilitation and habilitation services & devices
  • Mental health parity/ behavioral health/ chronic care coordination
  • Nondiscrimination protections
Healthcare Reform Refresher (Cont.)

• In defining essential health benefits the Secretary must:
  • Ensure essential health benefits reflect an appropriate balance so specific benefit categories are not unduly benefited.
  • Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals due to disability.
  • Take into account the health care needs of diverse segments of the population, including persons with disabilities.
  • Ensure that established essential health benefits cannot be denied on the basis of the individual’s present or predicted disability, degree of medical dependency or quality of life.
  • Periodically review and update the essential benefits based on changes in medical evidence or scientific advancement.
EHB: IOM Report Findings

• Start with the typical small employer plan.

• Expand beyond that plan to include services normally not covered but included in the statute, like habilitation, mental health services, and chronic disease management.

• If the typical small employer plan does not have the experience to define habilitation, look to NAIC & Medicaid for guidance.

• “The scope of benefits eligible for coverage should be guided by scientific evidence about which screening, diagnosis, treatment, management and monitoring interventions are effective in improving or maintaining people’s health and functioning.”
Essential Health Benefits (EHB) Bulletin

• Non-binding HHS guideline for regulating the EHB.

• AAPM&R comments submitted Jan. 31. Proposed regulation coming “soon.”

• Each state given great flexibility to define a “benchmark” plan.

• State’s choose from one of four options:
  • Any of the state’s 3 largest small group plans; or
  • Any of the 3 largest state employee health plans; or
  • Any of the 3 largest federal health plan (FEHBP) options; or
  • The largest insured commercial non-Medicaid HMO in the state.

• First option would permit federal government to cover expense of state mandates in 2014–2015.
EHB Bulletin (cont.)

• State-selected “benchmark” plan would then be “enhanced” to include statutory benefit categories, including rehabilitation and habilitation, behavioral health, and chronic care coordination.

  • In addition, mental health parity applies.

  • States would then apply ACA non-discrimination protections.

  • Plans would be able to make actuarially equivalent substitutions within statutory categories.

  • Subsequent HHS guidance also states that specific dollar limits on benefits are prohibited but non-dollar (scope and duration) limits can be imposed in an actuarially equivalent manner.

    • i.e.: 20 PT and 10 OT visits = 10 PT visits and 20 OT visits.
“Medical Necessity”
Victory for PMR Community

• Aug. 2011 Proposed Rule—Uniform Insurance Terms:
  • referenced NAIC definition of “medical necessity.”

  “Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.”

• Coordinate coalition to include recognition of cognitive conditions.

• Feb. 2012 Final Rule: “Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

• Adding “condition” is crucial as it captures cognitive / congenital conditions where “illness, injury or disease” alone would not.
HHS Actively Implementing ACA

• HHS is motivated by statutory deadlines but also by political calculation of 2012 election.

• Examples of key regulations issued to date:
  • State high risk pools for people with pre-X conditions.
  • Insurance on parents’ policy until age 26.
  • Exchanges and state implementation of new markets.
  • Mental Health Parity.
  • Medical Loss Ratio Requirements.
Supreme Court to Hear ACA Cases

Four Legal Issues to be Presented:

- **Individual Mandate** *(HHS v. Florida)*
  - Is it constitutional (in relation to commerce clause) to require everyone to buy health insurance?

- **Severability** *(Florida v. HHS; NFIB v. Sebelius)*
  - Does striking Mandate negate rest of ACA reform bill?

- **Medicaid Expansion** *(Florida v. HHS)*
  - Is it coercive and does it exceed Congress’ spending power to require that States must accept expansion in order to continue receiving federal Medicaid funding?

- **Jurisdiction** *(HHS v. Florida)*
  - Can the law be constitutionally challenged before tax (individual mandate penalties) has been collected?
Supreme Court Timing

Brief Submission Dates:
- Early Jan. – Original and Amicus briefs due.
- Early Feb. – Opposing briefs due.
- Early Mar. – Replies to Opposing briefs due.

SCOTUS Consideration: March 26-28.

Arguments (6 Hours):
- 2 hours – Individual Mandate;
- 1.5 hours – Anti-Injunction Law (jurisdiction);
- 1.5 hours – Severability;
- 1 hour – Medicaid Expansion.
Medicaid

• Tremendous Medicaid funding pressures in states.

• Governors seek more flexibility (including block grants) and release from MOE provisions of ACA.

• Benefit cuts, including cuts to mental health and rehab benefits, payment cuts, and cuts to covered individuals (i.e.: eligibility) are all possible.

• Budget discussions continue to include Medicaid provisions but it is protected from sequestration.
Medicaid

• 2014: 16 million new beneficiaries joining Medicaid.

• Obama Administration offered $65 billion in cuts in recent recommendations to Super Committee;
  • $55.7 billion in FY 2013 budget proposal.
  • Blend Medicaid matching rate between Medicaid and SCHIP funding, and other funding decreases.

• Acceleration of Medicaid managed care for all Medicaid beneficiaries, including people with significant disabilities is an idea that will not go away.
Medicaid Case at U.S. Supreme Court

- Douglas v. Independent Living Centers of So. Cal. (3 cases).
- Decision rendered on Feb. 22, 2012 (5 to 4 decision).
- Case could have eliminated ability of beneficiaries and providers to use Supremacy Clause to sue Medicaid for adequate rates to ensure equal access to care.
- Supreme Court remanded case to 9th Circuit essentially refusing to invalidate an individual’s right to sue a state for Medicaid rate cuts.
- Outcome is confused and sends mixed signals on right of individuals to sue states for other Medicaid infractions (e.g., Olmstead).
Delivery System Reform: Medicare Regulatory Activity

• Hospital Readmissions Reduction Program.
• Accountable Care Organizations.
  • Pioneer ACO’s.
• RFP for “Bundling” care – 4 different models.
• Continuing Care Hospital (CCH).
• Independence at Home Demonstration Project.
## ACOs: Proposed Versus Final Rule

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<tr>
<th>PROPOSED RULE</th>
<th>FINAL RULE</th>
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<td>2 tracks that specifically establish shared savings rates.</td>
<td>2 tracks made simpler and with higher shared savings rate in exchange for sharing risk.</td>
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<tr>
<td>Retrospective attribution.</td>
<td>Prospective attribution.</td>
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<tr>
<td>66 quality measures.</td>
<td>33 quality measures (one addresses “function”).</td>
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Pioneer ACOs

• Fearing that ACO final rule’s significant changes would delay final rule, CMS (CMMI) created the “Pioneer” ACO program in summer 2011.

• More accommodating Pioneer rules signaled significant changes to final ACO rule.

• CMS allows prospective attribution of patients.

• Permits advance payments out of anticipated shared savings to reduce barriers to entry without repayment.

• CMS also expected to help subsidize new ACOs.

• Attraction of being among the first ACOs to be recognized by CMS as a “Pioneer.”

ACOs focused on primary care of Medicare population.
CMS Bundling Announcement

Bundled Payments for Care Improvement Initiative

• CMS request for applications from Medicare providers on bundling care and related payments.

• A three-part strategy by CMS, with the first phase focused on redesign of acute care with providers already making the transition, while also working on a systems-wide switch to bundled payment and developing a plan to extend episode payments into chronic care.

• Currently, four models for payments for an episode of care in the acute, post acute, and the two together; four additional models planned for the future, which will include chronic care.
Continuing Care Hospital (CCH)

A Bundling Concept

- A new delivery system for rehabilitation therapy programs
- Virtual/actual facility providing all required post-acute care
- Physician decides whether to admit and level of care
- Each CCH may accept highest patient complexity allowed by state licensure.
- Episode of care: full period of stay + 30 days post-discharge
- Paid on a per episode basis using new PPS system which will account for projected medical and functional resources
  - New PPS created using Post Acute Care Payment Reform Demo
  - Outlier payment methodology to account for extraordinary situations