BROUSE McDowell

Eight District Academy of Osteopathic Medicine & Surgery, Touchdown to CME 2014

"The Affordable Care Act, Impact on Health Care Providers"

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COLLECTIVE EXPERIENCE . COLLABORATIVE CULTURE . CREATIVE SOLUTIONS

TABLE OF CONTENT

I. INTRODUCTION
AFFORDABLE CARE ACT (ACA)

- Affordable Care Act (ACA), *aka* Patient Protection and Affordable Care Act (PPACA) or ObamaCare
- Enacted on March 23, 2010
- Despite numerous legal challenges, PPACA remains the law of the land
- PPACA places emphasis on:
  - 1. "New" payment models: Bundling, provider incentives, provider payments tied to quality measures, capitation, etc.
  - 2. Enforcement to (1) recoup funds and (2) prevent fraud and abuse
  - 3. New care delivery models (accountable care organizations, medical homes, etc.)
- Major investment in health information infrastructure as a foundation and strategic tool → EHRs, telemedicine, electronic payments

II. PHYSICIAN PERSPECTIVE ON THE ACA

- Physician surveys:
  - Impact on patient care – Patient/Physician relationship
  - Healthcare costs
  - Independent Payment Advisory Board (IPAB)
- Practice changers:
  - Insurance status
  - Sunshine Act
  - Newly-insured patients:
    - Higher complexity
    - Quality measures
    - Physician extenders

III. MANDATORY COMPLIANCE PROGRAMS

- **"CORE ELEMENTS"**
  1. Design & scope
  2. Governance & Leadership
  3. Feedback, Data Systems, and Monitoring
  4. Performance Improvement Projects (PIPs)
  5. Systematic Analysis and Systemic Action
- **APPLICATION TO NURSING FACILITIES (NFs and SNFs) AND MEDICAL DIRECTORSHIP ACTIVITIES**
  - Deadline for NFs and SNFs to comply has passed (03/23/2012)
  - No regulations yet
  - No timeline for other providers or suppliers yet.
- **TIPS FOR SUCCESS: CONTINUOUS EFFORTS REQUIRED**
  - Start from the top and create a "culture" of compliance
  - Document your compliance efforts and all compliance communications
  - Periodically discuss compliance with your employees, training
  - Conduct compliance surveys
  - Conduct and document exit interviews

III. MANDATORY COMPLIANCE PROGRAMS (CONT'D)
CMS REQUEST FOR COMMENTS IN SPECIFIC AREAS, I.E. PITFALLS

- Use and implementation of the 5 core elements
- Applicability to hospitals and LTC facilities
- Costs and benefits
- Types and costs of tracking systems
- Interplay with state or other compliance requirements
- Application to different types of providers and suppliers
- Effectiveness
- Use of third party resources
- Identification of responsible staff
- Reasonable timelines for implementation

IV. MEDICARE – FRAUD AND ABUSE: INCENTIVE REWARD PROGRAM, PROPOSED NEW RULES

- **2013 ENFORCEMENT NUMBERS**
  - Expected recoveries
  - Program exclusions
  - Return on investment (ROI)

- **EXISTING INCENTIVE REWARD PROGRAM**
  - Qui tam actions (whistleblowers)
  - HIPAA Section 203(b)(2): Reward is 10% of the first $10,000 of overpayments recovered or $1,000 whichever is less

- **ADDITIONAL NEW RULES PROPOSED**
  - Bring in line with IRS incentives
  - 15% of final amount collected applied to the first $66,000,000 for the sanctionable conduct

V. MEDICARE – FRAUD AND ABUSE: PROVIDER ENROLLMENT, EXISTING REQUIREMENTS

- **ACA SECTION 6402, "**Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP"
- **PROVIDER ENROLLMENT REQUIREMENTS: 42 CFR PART 424, SUBPART P**
  - New Medicare providers: Enhanced screening and enrollment requirements up front
  - All providers were required to be screened by March 23, 2013
    - Automated provider screening (APS)
    - Revalidation project: 2 phases
    - **Revalidation cycle:**
      - DMEPOS: 3 years
      - Providers: 5 years
      - Any-time-revalidation if CMS requires , including site visits
  - Implementation of Fingerprint-based background checks

V. MEDICARE – FRAUD AND ABUSE: PROVIDER ENROLLMENT (CONT'D), PROPOSED NEW RULES

- **ADDITIONAL NEW RULES PROPOSED**: "Requirements for the Medicare Incentive Reward Program (IRP) and Provider Enrollment"
  - Published April 29, 2013; Final rule target date 04/29/2016
  - Goal: Ensure that fraudulent entities and individuals do not enroll in or maintain enrollment in Medicare

- **PROVIDER ENROLLMENT PROPOSED RULES**
  - Debts to Medicare
  - Felony Convictions
  - Abuse of billing privileges
  - Post-revocation submission of claims
  - Effective date of billing privileges
  - Effective date of re-enrollment bar
  - Corrective action plans (CAPs)

VI. MEDICARE COMPLIANCE, 60-DAY RULE & SELF-DISCLOSURE PROTOCOL

- **BILLING, 60-DAY RULE (CMS-6037-P)**
  - Proposed rule published 02/16/2012; No final rule yet.
  - Requires the reporting and returning of overpayments by the later of 60 days from the ***identification*** of the overpayment or the date of the corresponding cost report
  - Look-back period: 10 years

- **UPDATED SELF-DISCLOSURE PROTOCOL (SDP)**
  - Published on October 30, 1998 by OIG and HHS
  - OIG updated on April 17, 2013:
    - Information on how the SDP has worked to date
    - Procedural guidance
    - Clarification regarding penalties
    - Still no word on how DOJ would view the self-disclosure (DOJ not bound by SDP)
  - Results
  - Look-back period: "The time during which the disclosing party may not have been in compliance"
    - → Indefinite! Must disclose all non-compliant periods

- **INTERPLAY BETWEEN 60-DAY RULE AND SDP**
  - SDP update suggests that the SDP may mitigate potential exposure under the CMS proposed 60-day rule

VII. PHYSICIAN PAYMENTS SUNSHINE ACT

- **GOAL:** Public transparency into industry-physician financial relationships
- **SUNSHINE ACT requires public disclosures of**:
  - **(1) Financial transfers**
    - **Direct payments** to physicians and/or teaching hospitals
    - 12 exceptions
    - **Third party payments**
    - **Indirect financial transfers**
  - **(2) Ownership**

- **PREPARING FOR THE SUNSHINE ACT:** Check information for accuracy; Annual 45 day review period to correct inaccuracies

- **TECHNOLOGY**: CMS issued two "Apps" for data tracking assistance
  - Open Payments Mobile for Physicians
  - Open Payments Mobile for Industry

VII. PHYSICIAN PAYMENTS SUNSHINE ACT, CONT'D

- **CMS PORTAL**
- **CONTENT OF REPORT**
- **PENALTIES for manufacturers and GPOs' failure to report, and knowing failures to report**: Maximum combined annual total $1,150,000
- **KEY DATES FOLLOWING INCEPTION**: Final regulations published February 2013
  - August 1, 2013: Applicable manufacturers and GPOs must begin data collection
  - Industry (manufacturers and GPOs):
    - Phase 1 User Registration - March 31, 2014
    - Phase 2 – June 1 through 30, 2014
  - Physicians:
    - Phase 1 User Registration – starts June 1, 2014 (CMS Enterprise Portal)
    - Phase 2 - July 2014
  - September 30, 2014: CMS releases reports to public
- **PREPARING FOR THE SUNSHINE ACT**:
  - NPI
  - Request ongoing notice
  - Update disclosures periodically
  - Set-up internal procedures to check system periodically
- **CMS FAQs**: https://questions.cms.gov/faq.php?id=5005&rtopic=2017&rsubtopic=7803

VIII. PHYSICIAN SHORTAGE, THE PERFECT STORM

- ACA is biggest expansion of health coverage in 50 years
- Medicaid: 4.8 million people added since October 2013
- Low Medicaid rates
- **PHYSICIAN SHORTAGE NATIONWIDE:** 91,500 by 2020; 130,600 by 2025
  - Shortage without the ACA would be 64,100
  - Key factors: (1) Technical difficulties and (2) only half the states expanded Medicaid
  - But the surge is coming!

- **NEED TO ENCOURAGE GREATER MEDICAID PARTICIPATION AMONG PHYSICIANS**
- **CONSEQUENCES & CONSIDERATIONS FOR HEALTH CARE PROVIDERS**:
  - Clinical reimbursements
  - Expect more federal dollars towards streamlining the healthcare delivery system and evidence-based innovations
  - Consider enrolling in Medicaid if you are providing "PCP services."

VIII. PHYSICIAN SHORTAGE (CONT'D), CONSEQUENCES & TRENDS FOR PROVIDERS

- **RECRUITING**
  - Emphasis on preventative services
  - Design attractive compensation packages
  - Retention

- **RETAIL HEALTH CLINICS** (examples: CVS Caremark Corp., Walgreens, Target, WalMart)
  - Will more than double by 2015
  - New competition and complement for health care providers
  - Retail clinics target physician extenders
  - →Provider employment contracts: non-compete clause; "moonlighters"

- **TELEMEDICINE**:
  - Increased use of telemedicine for all compatible specialties with physician shortage

- **MENTAL HEALTH CARE**: Additional 2.3 million individuals will gain mental health coverage, a specialty traditionally lagging in insurance coverage
  - Medicaid rates
  - ACA mandates coverage of depression screening
  - Incidence on employers' bottom line

VIII. PHYSICIAN SHORTAGE (CONT'D), THE ACA FIX: MEDICARE/MEDICAID PARITY

- **PARITY:** Medicaid reimbursements (fee-for-service and managed care) must rise to the level of Medicare payments for "PCP services."
  - "PCP services" include some specialist services
  - Not applicable to Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs)
- **FUNDING:** Federal dollars for 2 years ($11.8 billion)
- **RESULT:** Average Medicaid reimbursement increase of 64% nationally (76% in Ohio)
- **WHEN:** Dates of service on or after 01/01/2013 through 12/31/2014
- **DELAYS** in increasing the rates and paying physicians retroactively
- **RISK:** Overpayments. Two potential sources of overpayments:
  - Billing processes
  - Specialty reported during self-attestation process

VIII. PHYSICIAN SHORTAGE, THE ACA FIX: MEDICARE/MEDICAID PARITY (CONT'D)

- **ELIGIBILITY** – Two options to qualify:

  → **Board certification and/or 60% of "PCP services"**

  1. Eligible specialty or subspecialty; and/or
  2. 60% of the provider's Medicaid claims for the E&M codes specified in the regulation.

- **1. SPECIALTIES AND SUB-SPECIALTIES ELIGIBLE, as defined by:**
  - American Board of Medical Specialties (ABMS)
  - American Board of Osteopathic Association (AOA)
  - American Board of Physician Specialties (ABPS)
  - → See next slide for all eligible specialties
- **2. PCP SERVICES:**
  - Applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine
  - "General internal medicine" encompasses internal medicine and all subspecialties recognized by the ABMS, AOA, and ABPS

VIII. THE ACA FIX, MEDICARE/MEDICAID PARITY (CONT'D): WHAT ARE "PCP SERVICES?"

- ACA specifies increased payments for 3 primary care medical specialties: Family Medicine, General Internal Medicine and Pediatrics
- Includes some subspecialties with a relation to the original three

- **QUALIFYING SUBSPECIALTIES UNDER THE ABMS**
  - **Family Medicine** – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine
  - **Internal Medicine** – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; etc.
  - **Pediatrics** – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; etc.

- **QUALIFYING SUBSPECIALTIES UNDER THE AOA**
  - **Family Physicians** – No subspecialties
  - **Internal Medicine** – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology
  - **Pediatrics** – Adolescent and Young Adult Medicine; Neonatology; Pediatric Allergy/Immunology; Pediatric Endocrinology; Pediatric Pulmonology

- **QUALIFYING UNDER THE ABPS**
  - ABPS does not certify subspecialists
  - **Eligible certifications**: American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine

VIII. THE ACA FIX, MEDICARE/MEDICAID PARITY (CONT'D): WHAT ARE "PCP SERVICES?" - EXAMPLES

- **Board-certified "general surgeon" practicing as a general family practitioner**
  - Does the physician qualify under either prong of the 2-part test?
    - Board certification: No
    - PCP services: Perhaps
      - Yes, if 60% of Medicaid claims for prior year were for E&M codes specified in the regulations
      - No, if less than 60% of Medicaid claims for prior year were not PCP services in accordance with the regulations
- **Physician with a certification in Family Medicine Obstetrics under the ABPS**
  - Does the physician qualify under either prong of the 2-part test?
    - Board certification: Yes
- **Physician with a certification in Obstetrics under the ABMS or AOA**
  - Does the physician qualify under either prong of the 2-part test?
    - Board certification: No
    - PCP services: Perhaps (60% PCP services rule)

IX. ACA IMPACT ON MEDICARE PAYMENTS TO PHYSICIANS AND HOSPITALS

- **Independent Payment Advisory Board (IPAB)**
- **Primary care physicians incentives**
  - → 10% bonus 2011 through 2016
- **Medicare payment sustainable growth rate (SGR):** Implementation delays continue
- **Quality/Cost payment**
  - → Payment modifier applicable in 2015
- **Physician quality reporting system (PQRS)**
- **Imaging reimbursement cuts**
- **Reduction for inpatient hospital prospective payment system**
  - Clinical measures, efficiencies, patient outcomes may increase or decrease a hospital's reimbursement

X. ELECTRONIC PAYMENTS

- **New operating rules for how electronic transactions are conducted**
  - Goal: To create consistency, enhance reliability, increase efficiency, lower administrative/operating costs, and strengthen security
  - Potential savings

- **Phase 1 - January, 2014:** Compliance with electronic payment rules
  - 100% of claims payments
  - All payors must be able to pay electronically if the provider requests it

- **Phase 2 - January, 2016:** Compliance with other rules

- **Obstacles to overcome before going electronic:**
  - Lack of provider awareness
  - Expense
  - Enrollment volume
  - Security - Concern about giving out banking information
  - Not understanding the benefits
  - Need for training

- **Preparing for the new operating rules:**
  - Educate yourself
  - Work with your bank
  - Contact health plans
  - Change systems and manage

XI. ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

- **ACO "Classic" model:** Medicare ACO or Medicare Shared Savings Program (MSSP)
  - 123 Medicare ACOs nationwide
- **GOAL**
- **NEW EMERGING ACO MODELS**
  - **Advance Payment Model:**
    - 35 nationwide; 1 in Ohio
  - **Pioneer ACO Model:**
    - 32 nationwide; none in Ohio
- **YEAR-ONE RESULTS (2012-2013):**
  - $380 million savings from Medicare ACOs and Pioneer ACOs
  - Medicare ACOs: 114 total, 54 showed lower spending growth
  - Pioneer ACOs: 23 total, 9 showed lower spending growth
- **SPECIALTY OR DISEASE-SPECIFIC ACOs:** Specific chronic diseases ACOs, such as cancer, chronic kidney disease, and end stage renal disease
  - E.g.: Comprehensive ESRD Care Model
- **PEDIATRIC ACOs** at the state level (Children's Hospital)

XII. PATIENT-CENTERED MEDICAL HOMES (PCMH) AKA "PRIMARY CARE MEDICAL HOMES"

- **PCMH** is an enhanced primary care delivery model that strives to achieve better access, coordination of care, prevention, quality, and safety, and to create a strong partnership between the patient and primary care physician.

- **PCMH CORE FUNCTIONS and GOALS:**
  - Patient-centered orientation
  - Proactive, comprehensive, team-based care
  - Care coordinated across health care system
  - Superb access by patient to care
  - Commitment to quality and safety

- PCMH acts as the medical home; ACO serves as the medical neighborhood
- Incentive payments to providers

XII. PATIENT-CENTERED MEDICAL HOMES (PCMHS), CONT'D

- **PAYMENT METHODOLOGY**
- **→ 10% INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES**
  - Additional payment for "primary care services" provided by a "primary care practitioner"

- **AGENCIES INVOLVED**:
  - Agency for Healthcare Research and Quality (DHHS)
  - CMS
  - DOD (TriCare)
  - Health Resources and Services Administration (DHHS)
  - Substance Abuse and Mental Health Association (SAMHSA)

- **PCMHs ARE NOT ACOs**
  - PCMHs and ACOs both focus on improving health outcomes through care coordination and primary care
  - ACOs are comprised of many "medical homes"
  - ACOs are accountable for the cost and quality of care both within and outside of the primary care relationship.
  - ACOs are larger

XIII. MEDICARE ADVANTAGE PLANS MAKEOVER

- **MEDICARE ADVANTAGE PLAN, AKA "PART C" OR "MA PLAN"**
  - Plan offered by a private company that contracts with Medicare to provide Part A (hospital) and Part B (medical) benefits. Most also offer Part D (drugs)
  - Types
  - Reimbursements

- **ACA PROVISIONS TARGET "WASTEFUL" MEDICARE SPENDING**
  - MA plans received on average 13% more per enrollee
  - Bring in line MA payments with traditional Medicare payments
  - ACA does not eliminate MA plans or reduce extra benefits
  - **New medical loss ratio (MLR) requirements recently finalized** (Effective July 22, 2013)
    - "80/20 rule" or profits
    - Several levels of sanctions

- **MA PLANS CONTINUE TO GROW – DESPITE ACA/ANALYSTS' PREDICTIONS**
  - 41% growth (4.6 million increase)
  - 30% seniors enrolled nationwide
  - 1.3 million more beneficiaries enrolled (nearly 10% year-over-year increase)
  - Total enrollment: 15.7 million (2014)

XIII. MEDICARE ADVANTAGE PLANS MAKEOVER (CONT'D)

- **REGIONAL DISPARITIES**
  - Rise in premiums not applicable in all states
  - HMOs versus PPOs
  - Some markets have "super concentration" at the top
    - Contrast with Ohio: Top 3 plans represent 67% total MA enrollees: Humana, Inc. (26%); BCBS Wellpoint (24%); Aetna (16%)

- **IMPLICATIONS FOR PROVIDERS**:
  - MA plans will pass along cuts to providers and consumers
  - Proposed cuts vs. heavy lobbying
  - Average out-of-pocket costs have risen significantly.
  - Share of plans with limits above $5,000 has doubled
  - Concentration at the top
  - Providers must enroll and manage contracts with many plans

- **→ ANALYZE YOUR MEDICARE DATA**

XIV. OIG'S AUTHORITY EXPANDED UNDER THE ACA

- **Proposed Rule**: Expands the OIG's Civil Monetary Penalties (CMP) authority
- **Goal**
- **Delegation**
- **5 new violations**
  - Failure to grant OIG timely access to records
  - Ordering or prescribing items or services that the person knows or should know may be paid for by a federal health care program while excluded
  - Making false statements, omissions, or misrepresentations in an enrollment application
  - Failure to report and return a known overpayment
  - Making or using a false record or statement that is material to a false or fraudulent claim
- **Medicare Advantage plans**
- **Factors evaluated for assessing penalty and/or period of exclusion:**
- **Emergency Medical Treatment And Labor Act (EMTALA)**
- **RECOMMENDATION FOR PROVIDERS:** Review OIG Work Plan <u>every year</u>

XV. OIG WORKPLAN 2014

- Full report (101 pages) available at online

- **AREAS OF FOCUS**

- **KEY AREAS FOR PROVIDERS TO EVALUATE AND REVISE, AS APPLICABLE:**
  - New inpatient admission criteria
  - Outpatient evaluation and management (E&M) services billed at "new patient" rates
  - Medical necessity of high cost diagnostic radiology tests
  - Physicians' place-of-service coding errors
  - Security of personal devices containing personal health information (PHI)
  - Improper Medicare payments for beneficiaries with other health care coverage (Medicare Secondary Payer, MSP)
  - Kwashiorkor diagnostic (malnutrition) and treatment

XVI. QUESTIONS & ANSWERS

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