



# MEDICARE REPORT



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## Medicare in the 21st Century: Achieving Quality and Efficiency Through Payment and Service Delivery Reforms

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### I. Introduction

**N**ow that the much-anticipated health care reform legislation (the "Legislation") has passed, the country's attention will turn away from contentious debates about issues such as the public option, public funding, and coverage for abortion services, and undoubtedly will turn toward the effects of the Legislation on individuals and businesses.

In particular, all sectors of the health care industry should be focusing on the Legislation's provisions intended to increase the quality of care provided by, and the efficiency and accountability of, the Medicare program while decreasing overall costs. These potential changes, along with the restructuring of the health insurance markets, are the cornerstone of health care reform.

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The reasons why Congress sought to make these changes are at least two-fold. First, policy experts have long-pointed to the unsustainable growth projections in Medicare spending, which is expected to increase even more as the nation's baby boomers move toward Medicare eligibility. Second, Medicare reforms tend to drive change through the entire health insurance system. For many years, private insurers have followed Medicare's reimbursement and program policies.

All health care providers and suppliers, even those that do not participate in state or federal health care programs, and others in the health care industry should understand the Legislation's provisions meant to transform the Medicare program and should consider their broad implications.

Sections II-IV of this article discuss the payment mechanisms, demonstration programs, and other steps taken to increase quality and efficiency in the traditional Medicare programs (Parts A and B) while Section V provides an overview of the other significant changes to the Medicare program, including Medicare Advantage (Part C) the Prescription Drug Benefit program (Part D), and revisions to payment methodologies in Part A and Part B.

### II. Changes to Payment Mechanisms Intended to Increase Quality and Efficiency

#### A. MEDICARE PART A

Medicare Part A covers hospital and other institutional care and represents a significant component of all Medicare expenditures. This section focuses on system changes included in the Legislation, including implementation of value-based purchasing programs, quality reporting, penalties associated with hospital-

acquired conditions, and the hospital readmissions reduction program.

### 1. Value-Based Purchasing Programs

Currently, the Medicare Part A payment system does not include a meaningful pay-for-performance (P4P) program, as that term is commonly understood; the closest analog to such a program is a limited initiative that requires hospitals to submit quality data to the Secretary of the Department of Health and Human Services (the Secretary) or face lower prospective payment (PPS) annual updates.<sup>1</sup> The Legislation, however, effectively expands this program to reward hospitals financially based on the quality of services provided through a value-based purchasing (VBP) program.

Starting in federal fiscal year (FFY) 2013, hospitals will be eligible to receive value-based incentive payments directly linked to their own respective performance under the VBP program,<sup>2</sup> which will cover at least five quality measures (including, in later years, efficiency measures), as determined by the Secretary. Notably, measures relating to readmissions are specifically excluded but are addressed elsewhere in the Legislation, as described below. The Centers for Medicare & Medicaid Services (CMS) will assess each hospital's performance under the VBP program's performance standards to determine how much each hospital will earn in VBP program payments.

The VBP program is funded through a modified budget neutrality formula whereby the aggregate amount that the Secretary estimates to be available each year under the VBP program will be based on reductions in Medicare base operating diagnosis-related group (DRG) payment amounts, subject to various adjustments and exclusions.<sup>3</sup> The limitations on the size of the VBP program incentive payments will depend on the aggregate amount of reductions: from 1.0 percent in FFY 2013 up to 2 percent in FFY 2017 and thereafter. In addition, the incentive payments or payment reductions will only apply to the fiscal year at issue, and the Secretary is prohibited from basing future PPS payments to hospitals on such payments or reductions.<sup>4</sup>

Further, the Secretary must make information about each hospital's performance on each measure and the performance standards publicly available so that Medicare beneficiaries can make informed decisions when choosing their providers. Both the Secretary and the Government Accountability Office must conduct a study of the VBP and submit reports to Congress.

The Legislation also requires the Secretary to develop VBP programs and other quality/efficiency demonstration projects for critical access hospitals and certain other hospitals,<sup>5</sup> as well as three additional plans to implement VBP programs for, respectively, skilled nursing facilities (SNFs), home health agencies (HHAs),<sup>6</sup> and ambulatory surgical centers (ASCs).<sup>7</sup> These plans must take into account the following:

- ongoing development, selection, and modification process of measures, to the extent feasible and practicable, of all dimensions of quality and efficiency;
- reporting, collection, and validation of quality data;
- structure of VBP adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment;
- methods for the public disclosure of information on performance; and
- other issues determined appropriate by the Secretary.<sup>8</sup>

The Secretary must submit these plans to Congress by January 1, 2011 for ASCs and by October 1, 2011 for SNFs and HHAs. In addition, by January 1, 2016, the Secretary must establish a pilot P4P program for other facilities such as long term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), hospices, and PPS-exempt cancer hospitals.<sup>9</sup>

### 2. Quality Reporting

The Legislation also directs the Secretary to establish quality reporting programs for LTCHs, IRFs, hospices, and PPS-exempt cancer hospitals, and to publish specific quality measures by October 1, 2012.<sup>10</sup> Once the quality measures are established, the affected facilities will have a 2-year ramp-up period (beginning in rate year (July 1) 2014 for LTCHs and FFY 2014 for IRFs, hospices, and PPS-exempt cancer hospitals) to prepare quality data for submission to the Secretary.<sup>11</sup> If a LTCH, IRF, or hospice does not comply with the quality reporting requirements, it will receive a 2-percentage-point reduction in its annual payment update (an adjustment that could result in an annual update of less than zero) that will cause the base payment to be lower than in the preceding year.<sup>12</sup> Each participating LTCH, IRF, and hospice should therefore use the two-year ramp-up period to establish the infrastructure and data

<sup>1</sup> Social Security Act § 1886(b)(3)(B)(vii)(I)-(viii)(I) (42 U.S.C. 1395ww(b)(3)(B)(vii)(I)-(viii)(I) (2009)) (later amended by Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3001(a)(2) (2010)). The Legislation requires the Secretary starting in fiscal year 2013 to collect quality outcome data with risk adjustments.

<sup>2</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3001 (2010), *codified at* Social Security Act § 1886(o) (42 U.S.C. 1395ww(o)). Certain hospitals and Maryland acute care hospitals may be excluded; Medicare rates for acute care hospitals in Maryland are set under a Medicare waiver by the Maryland Health Services Cost Review Commission. See Health Services Cost Review Commission, Home Page, <http://www.hsrc.state.md.us/>.

<sup>3</sup> Pub. L. No. 111-148, § 3001(a), *codified at* Social Security Act § 1886(o)(7) (42 U.S.C. 1395ww(o)(7)).

<sup>4</sup> Pub. L. No. 111-148, § 3001(a), *codified at* Social Security Act § 1886(o)(9) (42 U.S.C. 1395ww(o)(9)).

<sup>5</sup> Pub. L. No. 111-148, § 3001(b)(1)(A).

<sup>6</sup> Pub. L. No. 111-148, § 3006.

<sup>7</sup> Pub. L. No. 111-148, § 10301, *codified at* Pub. L. No. 111-148, § 3006(f).

<sup>8</sup> Pub. L. No. 111-148, § 3006.

<sup>9</sup> Pub. L. No. 111-148, § 10326.

<sup>10</sup> Pub. L. No. 111-148, § 3004, *codified at* Social Security Act § 1886(m)(5) (42 U.S.C. 1395ww(m)(5)), and § 3005, *codified at* Social Security Act § 1866(m)(5) (42 U.S.C. 1395cc(m)(5)).

<sup>11</sup> *Id.*

<sup>12</sup> *Id.* Medicare pays for inpatient care provided by LTCHs, IRFs, and hospices using prospective payment systems (PPS), and these systems are updated annually using the market basket index, which estimates the change in the purchase price of goods and services at a later time. However, certain cancer hospitals are still paid based on reasonable costs. See generally Social Security Act § 1886 (42 U.S.C. 1395ww).

collection systems necessary to comply with the quality reporting requirements.<sup>13</sup>

### 3. Hospital-Acquired Conditions

For many years, researchers have found that many hospital acquired infections are avoidable, and this issue has garnered much attention in the Medicare context. Starting in FFY 2015, hospitals in the top 25<sup>th</sup> percentile of the national average with respect to hospital acquired conditions will receive 99 percent of the otherwise applicable payment for *all* inpatient stays.<sup>14</sup> A hospital-acquired condition (HAC) is defined as: a) high cost or high volume, or both; b) present as a secondary diagnosis resulting in the assignment to a higher paid MS-DRG; and c) reasonably preventable through the application of evidence-based guidelines.<sup>15</sup> In addition, by January 1, 2012, the Secretary must submit a report to Congress recommending whether to expand the HAC payment adjustment policy to other types of facilities (e.g., IRFs, LTCHs, hospital outpatient services, SNFs, ASCs, etc.).<sup>16</sup>

This change builds upon steps previously taken by CMS to encourage hospitals to reduce preventable HACs and, in turn, to improve the quality of care provided to Medicare beneficiaries by limiting payment. Although payment for a Medicare beneficiary's inpatient stay depends on the primary diagnosis, a secondary diagnosis related to a HAC can result in increased payments to the hospital. In an effort to prevent hospitals from receiving a higher payment in such circumstances, CMS decided not to pay for the increase resulting from the secondary diagnosis as of FFY 2009.

### 4. Hospital Readmissions Reduction Program

Under the Legislation, the Secretary must establish a program to reduce payments to hospitals for discharges on or after October 1, 2012, based on the hospital's percentage of potentially preventable inpatient Medicare readmissions covering three conditions with high volumes and/or high rates (heart attack, heart failure, pneumonia).<sup>17</sup> Information on hospitals' readmission rates will also be made available to the public. The purpose of the Legislation is to reduce hospital readmissions, which many view as an indicator of poor quality of care or a failure to coordinate care appropriately. In 2005, the Medicare Payment Advisory Commission (MedPAC) found that 6.2 percent of Medicare hospital-

izations resulted in readmission within 7 days, 11.3 percent within 15 days, and 17.6 percent within 30 days.<sup>18</sup> MedPAC estimated that these potentially preventable readmissions accounted for \$25 million in Medicare spending.<sup>19</sup>

In addition to reducing Medicare payments based on hospital readmissions, the Legislation directs the Secretary, as of January 1, 2011, to provide funding to eligible hospitals and community-based organizations that furnish evidence-based care transition services to high-risk Medicare beneficiaries (i.e., those who have a minimum hierarchical condition category score) as part of a 5-year Medicare Community Care Transitions Program (CCTP).<sup>20</sup> Participation in the CCTP will require eligible hospitals and community-based organizations to submit a detailed proposal for at least one care transition intervention, such as: a) initiating care transition services for high-risk beneficiaries not later than 24 hours prior to the inpatient discharge; b) arranging timely post-discharge follow-up services to provide beneficiaries with information about responding to symptoms that may indicate additional health problems or a deteriorating condition; c) providing high-risk beneficiaries with assistance to ensure productive and timely interactions with post-acute and outpatient providers; d) assessing and engaging with high-risk beneficiaries using self-management support and information specific to the beneficiaries' conditions; and e) conducting comprehensive medication review and management.<sup>21</sup>

## B. MEDICARE PART B

Although Medicare Part B covers an array of physician and other medical benefits, the focus here is limited to several physician quality improvement programs created or bolstered by the Legislation as well as the Legislation's expansion of covered prevention and wellness services.

### 1. Physician Quality Reporting System

As mandated by the Tax Relief and Health Care Act of 2006, CMS previously established the Physician Quality Reporting Initiative (PQRI), which provides for an incentive payment to eligible professionals<sup>22</sup> who report data on quality measures. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the PQRI a permanent program and extended incentive payments through 2010.

The Legislation further extends the incentive payments for covered services through 2014 and also implements a penalty for professionals who do not re-

<sup>13</sup> The Legislation does not provide for payment adjustments in the event a PPS-exempt cancer hospital fails to comply with the quality reporting requirements. See Pub. L. No. 111-148, § 3005.

<sup>14</sup> Pub. L. No. 111-148, § 3008(a), *codified at* Social Security Act § 1886(p) (42 U.S.C. 1395ww(p)). Certain Maryland acute-care hospitals may be excluded, as the Maryland Health Services Cost Review Commission sets rates for acute care hospitals in Maryland under a Medicare waiver. See Health Services Cost Review Commission, Home Page, <http://www.hsrc.state.md.us/>.

<sup>15</sup> Social Security Act § 1886(d)(4)(D)(iv) (42 U.S.C. 1395ww(d)(4)(D)(iv)).

<sup>16</sup> Pub. L. No. 111-148, § 3008(b).

<sup>17</sup> Pub. L. No. 111-148, § 3025(a) (as amended by Pub. L. No. 111-148, §§ 3001 and 3008), *codified at* Social Security Act § 1886(q) (42 U.S.C. 1395ww(q)). Maryland acute care hospitals may be exempt from this provision, given that the Maryland Health Services Cost Review Commissions sets Medicare rates for these hospitals. See Health Services Cost Review Commission, Home Page, <http://www.hsrc.state.md.us/>.

<sup>18</sup> Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007, at 107, available at [http://www.medpac.gov/chapters/Jun07\\_Ch05.pdf](http://www.medpac.gov/chapters/Jun07_Ch05.pdf).

<sup>19</sup> *Id.* at 108.

<sup>20</sup> Pub. L. No. 111-148, § 3026.

<sup>21</sup> Pub. L. No. 111-148, § 3026(c)(2).

<sup>22</sup> An "eligible professional" is a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian, nutrition professional, physical or occupational therapist, qualified speech-language pathologist, or qualified audiologist. Social Security Act § 1848(k)(3)(B) (42 U.S.C. 1395w-4(k)(3)(B)).

port quality measures for 2015 (or subsequent years).<sup>23</sup> For successful quality reporting, professionals will earn a 1 percent incentive payment in reporting year 2011 and a 0.5 percent incentive payment in each reporting year from 2012 through 2014. An additional 0.5 percent incentive payment will be paid in each reporting year from 2011 through 2014 for meeting the requirements of a Maintenance of Certification Program (MOCP),<sup>24</sup> which is an “ongoing process of education and assessment for certified physicians to improve practice performance” operated by the American Board of Medical Specialties.<sup>25</sup> The penalty for failing to report quality data satisfactorily will be a 1.5 percent reduction in payment in reporting year 2015 and a 2 percent reduction in reporting year 2016 and beyond.

The Secretary currently posts a list of professionals who satisfactorily report quality data pursuant to the PQRI, and, under the Legislation, public reporting will be expanded. By January 2011, the Secretary must develop a Physician Compare Internet website that provides information related to Medicare-enrolled physicians and professionals who participate in the PQRI.<sup>26</sup> Similarly, the Legislation requires the Secretary to implement a plan by January 1, 2013 to publicize Medicare physician performance information that provides comparable information on quality and patient experience measures.<sup>27</sup> The Secretary also must develop a plan by January 1, 2012 to integrate the PQRI with the reporting requirements related to the meaningful use of electronic health records, as established by the American Recovery and Reinvestment Act of 2009.

## 2. Physician Feedback Program

The Legislation expands upon the types of reporting and data analysis required under the Physician Feedback Program, which was created under MIPPA to improve efficiency and control costs. This program uses Medicare claims data to develop confidential reports for physicians that measure the resources used in providing care to Medicare beneficiaries. Specifically, the Legislation provides that, by January 1, 2012, the Secretary must: a) develop an episode grouper that “combines separate but clinically related items and services into an episode of care for an individual;”<sup>28</sup> and b) provide reports to physicians that compare an individual physician’s patterns of resource use to such patterns of other physicians.<sup>29</sup> For purposes of preparing such reports, the Secretary must make adjustments for differences in socioeconomic and demographic characteristics and eliminate the impact of geographic adjustments in payment rates, and, at the same time, establish methodologies that would attribute episodes of care to physicians, identify physicians to compare, and aggregate episodes of care into a composite measure.<sup>30</sup>

<sup>23</sup> Pub. L. No. 111-148, § 3002(a), *codified at* Social Security Act § 1848(m) (42 U.S.C. 1395w-4(m)), and § 3002(b), *codified at* Social Security Act § 1848(a) (42 U.S.C. 1395w-4(a)).

<sup>24</sup> Pub. L. No. 111-148, § 3002(a)(1), *codified at* Social Security Act § 1848(m) (42 U.S.C. 1395w-4(m)).

<sup>25</sup> American Board of Medical Specialties, *ABMS Maintenance of Certification*, Apr. 13, 2010, [http://www.abms.org/Maintenance\\_of\\_Certification/default.aspx](http://www.abms.org/Maintenance_of_Certification/default.aspx).

<sup>26</sup> Pub. L. No. 111-148, § 10331(a)(1).

<sup>27</sup> Pub. L. No. 111-148, § 10331(a)(2).

<sup>28</sup> Pub. L. No. 111-148, § 10331(a)(2).

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

## 3. Value-Based Payment Modifier Under Physician Fee Schedule

The Legislation provides for the Secretary to phase in a separate “value-based payment modifier” to the Medicare Physician Fee Schedule by 2013.<sup>31</sup> This payment modifier provides for differential payments to physicians or groups of physicians based upon the quality of the care that they achieve for Medicare beneficiaries relative to the cost of that care. The modifier will apply in addition to the existing geographic adjustment factors and is intended to promote “systems-based care,” to take into account the special circumstances of rural and other underserved areas, and to be implemented in a budget-neutral manner. The Secretary must publish by January 1, 2012, the required measures of quality and cost, dates of implementation, and performance period and must apply the modifier as early as January 1, 2015, but no later than January 1, 2017.

## 4. Prevention and Wellness

Starting on January 1, 2011, Medicare Part B will cover, without cost-sharing,<sup>32</sup> annual “personalized prevention plan services,” including a comprehensive health risk assessment after the first year of enrollment as well as any other preventive services authorized by Secretary or graded A or B by the U.S. Preventive Services Task Force (USPSTF) within the Department of Health and Human Services (HHS).<sup>33</sup> In addition, the Secretary now will have the authority to make evidence-based coverage modifications to Medicare preventive services. Specifically, the Secretary can withhold payment for covered preventive services graded D (not recommended) by the USPSTF and modify coverage of covered preventive services consistent with the USPSTF’s recommendations.<sup>34</sup>

This change is consistent with recent steps taken to expand the range of preventative services covered by Medicare Part B. Although Medicare Part B previously covered a one-time initial preventive physical exam (IPPE) provided within one year of a beneficiary’s Part B, it did not provide for subsequent coverage of general, routine health examinations.

## III. Entities Created to Assess and Encourage Quality and Efficiency

Recognizing that a detailed review of the Medicare program’s payment and service delivery systems is a necessary step toward improving the quality of care provided while controlling costs, Congress created new entities, such as the Center for Medicare and Medicaid Innovation, Patient-Centered Outcomes Research Institute, and Independent Medicare Advisory Board, to

<sup>31</sup> Pub. L. No. 111-148, § 3007(2), *codified at* Social Security Act 1848(p) (42 U.S.C. 1395w-4(p)).

<sup>32</sup> Pub. L. No. 111-148, § 4103(b), *codified at* Social Security Act § 1861(hhh) (42 U.S.C. 1395x(hhh)). Medicare generally covers 80 percent of the costs of Part B-covered services, and the beneficiary is responsible for the remaining 20 percent of the cost. However, this cost-sharing amount is waived for many, but not all, covered preventive services. See Social Security Act § 1833 (42 U.S.C. 1395l).

<sup>33</sup> *Id.* The USPSTF examines and makes evidence-based, graded recommendations for the use of preventive services. See generally, United States Preventive Services Task Force, <http://www.ahrq.gov/clinic/USpstfab.htm>.

<sup>34</sup> Pub. L. No. 111-148, § 4105, *codified at* Social Security Act § 1834(n) (42 U.S.C. 1395m(n)).

conduct further studies, implement new models of care, and/or recommend changes.

### A. Center for Medicare and Medicaid Innovation

The Secretary has broad authority under the Social Security Act to develop innovative approaches to reimbursement methodology, delivery of health care, and provision of benefits in government-sponsored programs. To that end, the Legislation tasks the Secretary with establishing the Center for Medicare and Medicaid Innovation (CMI) within CMS by January 1, 2011, to test, evaluate, terminate, or expand innovative payment and service delivery models, with the goal of reducing program expenditures under Medicare, Medicaid, and CHIP while preserving and enhancing the quality of care furnished to beneficiaries.<sup>35</sup>

Phase I of the implementation includes the selection, testing, and evaluation of payment and delivery models, and Phase II includes the expansion of the duration and scope of such models. Funding for Phases I and II would come from the Treasury (not otherwise appropriated, generally) beginning in 2010 for an indefinite period of time.<sup>36</sup> Congressional oversight of the CMI begins in 2012, with the Secretary submitting biannual reports to Congress detailing the CMI's activities.<sup>37</sup> The Legislation requires such reports to include: a) a description of the models tested, including the number of Medicare and Medicaid beneficiaries participating in such models; b) payments made on behalf of such beneficiaries; c) any models chosen for expansion; d) evaluation results; and e) any recommendations the Secretary deems appropriate for legislative action to facilitate the development and expansion of successful payment models.<sup>38</sup>

### B. Patient-Centered Outcomes Research Institute

The Legislation also creates a private, independent, nonprofit corporation, to be known as the "Patient-Centered Outcomes Research Institute" to identify priorities for and to conduct comparative clinical outcomes research (CCOR).<sup>39</sup> The stated goal of the Institute is to identify effective and efficient treatment options. During the process leading up to enactment of the Legislation, critics of comparative effectiveness research raised concerns about how CCOR results would be used and the extent to which they would influence coverage and reimbursement policies or would otherwise impact patient care and potentially limit provider and patient treatment choices. In short, the concern was that CCOR results could lead to limited beneficiary choices or "rationing" of care.

Despite such concerns, the Legislation allows the Secretary to use CCOR to make Medicare coverage determinations, so long as the process is iterative and transparent, includes public comment, and considers the effects on subpopulations.<sup>40</sup> CCOR cannot, however, be used in a manner that undervalues extending the life of an elderly, disabled, or terminally ill individual or that would discourage an individual from

choosing health care treatments based on the value of extending the length of his or her life and the risk of disability.<sup>41</sup>

### C. Independent Medicare Advisory Board

Widespread concern had been expressed that policy-driven reimbursement changes had historically been undermined by political pressure on Congress. In one of the more controversial changes in the Legislation, one that reportedly had become an important policy issue to President Obama,<sup>42</sup> Congress created an Independent Medicare Advisory Board (also known as the Independent Payment Advisory Board or "IPAB") to develop and submit comprehensive proposals (in consultation with the Secretary, MedPAC, and the Medicaid and CHIP Payment Access Commission (MACPAC))<sup>43</sup> to the President and Congress relating to Medicare reimbursement rates, with the aim of reducing the rate of growth in Medicare spending and improving the quality of care for Medicare beneficiaries.<sup>44</sup> IPAB's fifteen members, who will be appointed by the President and confirmed by the Senate, must have expertise in health care finance and economics, delivery, and management.

The IPAB must present its recommendations to the President and Congress by January 15th of each calendar year beginning in 2014, except when: (a) the Office of the Chief Actuary determines that the Medicare per capita growth does not exceed a pre-established target per capita growth; (b) the projected percentage increase in the medical care category of the consumer price index (CPI-M) is less than projected increases in the consumer price index for all urban consumers (CPI-U); or (c) for 2019 and thereafter, the per capita growth rate for national health care expenditures exceeds the Medicare per capita growth rate.<sup>45</sup>

In a significant departure from the current process with MedPAC recommendations, any recommendations made by the IPAB related to the Medicare program will become effective immediately unless Congress enacts legislation to prevent their implementation using the expedited review processes specified in the Legislation. As part of the compromises made to accommodate the strong opposition to this new approach, such recommendations cannot propose changes to Medicare payment systems that would ration health care, raise beneficiaries' premiums or cost sharing, restrict benefits, or modify eligibility requirements.<sup>46</sup> In addition, recommendations submitted prior to December 31, 2018 cannot propose reductions to payment rates for items and services furnished before December 31, 2019 by providers that are subject to the market basket reduction in excess of any payment rate reduction due to productivity.

<sup>41</sup> Id.

<sup>42</sup> J. Calmes "After Health Care Passage, Obama Pushes to Get It Rolling", N.Y. Times, April 17, 2010.

<sup>43</sup> MACPAC was created by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). See Pub. L. No. 111-3, § 506(a), 123 Stat. 8, 91 (2009).

<sup>44</sup> Pub. L. No. 111-148, § 3403(a) (as amended by Pub. L. No. 111-148, § 3022), codified at Social Security Act § 1899A (42 U.S.C. 1395 et seq.).

<sup>45</sup> Id.

<sup>46</sup> Id.

<sup>35</sup> Pub. L. No. 111-148, § 3021(a), codified at Social Security Act § 1115A.

<sup>36</sup> Id.

<sup>37</sup> Id.

<sup>38</sup> Id.

<sup>39</sup> Pub. L. No. 111-148, § 6301(a), codified at Social Security Act § 1181 (42 U.S.C. 1301 et seq.).

<sup>40</sup> Id.

## IV. Demonstration/Pilot Programs Focused on Quality and Efficiency

Congress recognized that many potentially high-impact reforms are not yet ready for full implementation but rather need gestation in demonstration and pilot programs. The more significant of these relate to programs for “shared savings,” payment bundling, primary care and care coordination or “medical home,” hospice concurrent care and health lifestyles.

### A. Medicare “Shared Savings” Program

Since 2005, CMS has conducted the Physician Practice Group (PGP) demonstration project, which offers performance payments to 10 large physician groups that improve patient outcomes by efficiently coordinating care for chronically ill and high-cost Medicare beneficiaries. To further promote quality and cost savings, the Legislation introduces an accountable care organization (ACO) model<sup>47</sup> designed to test different payment incentive models within structured provider networks. The Legislation requires that, by no later than January 1, 2012, the Secretary must establish a new Medicare shared savings program (also known as “gainsharing”), that allows groups of providers that meet the Secretary’s criteria to work together, through an ACO, to manage and coordinate care for Medicare beneficiaries. ACOs that satisfy certain quality performance standards (“eligible ACOs”) are eligible to share in the cost savings they achieve for the Medicare program. Such cost savings will be driven by accountability for a patient population, coordination of care, investment in infrastructure, and the redesign of processes for high quality and efficient delivery of care. Eligible ACOs will be limited to the following groups of providers and suppliers:

- ACO professionals in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint venture arrangements between hospitals and ACO professionals,
- Hospitals employing ACO professionals, and
- Such other groups of providers and suppliers deemed appropriate by the Secretary.<sup>48</sup>

The creation of ACOs represents a significant culture shift for Medicare providers and suppliers, who should begin to think about the financial and human resources that will be needed to develop an ACO, the new relationships that will need to be formed, and the added reporting and compliance responsibilities that participation will bring.

### B. National Pilot Program on Payment Bundling

Notwithstanding the increased focus on the supposedly negative incentives of the fee-for-service payment system, the Legislation does not mandate implementation of alternative payment arrangements for Medicare providers and suppliers right away. It does, however, call for a bundled payment pilot program to test such an

alternative approach. Under the program, Medicare would pay a provider a single, comprehensive payment for the full range of applicable care provided during a hospitalization episode. The Legislation focuses on “episodes of care,” a term which is defined generally to include the services rendered during hospitalization as well as three days before admission and 30 days after discharge. The Legislation allows the Secretary to establish different periods for episodes of care, as appropriate.

The pilot program must be established by January 1, 2013, and would be expanded only if it reduces costs while maintaining or improving quality.

### C. Primary Care and Care Coordination “Medical Home” Demonstration Project

Improving the quality and efficiency of care, which is one goal of the Legislation, also requires an emphasis on primary care services and care coordination. The Legislation therefore encourages implementation of the so-called “medical home” model. The name, which is a misnomer to many, does not refer to home health services but rather is primarily intended to convey the idea that care should be coordinated and integrated.

The Secretary must conduct a medical home demonstration project by January 1, 2012, to test the model by using physician and nurse practitioner-directed, primary care teams to reduce expenditures and to improve health outcomes for chronically ill beneficiaries. The model will encompass primary care for patients of all ages, in coordination or partnership with the patient and, as appropriate, the patient’s family.

Congress’s recognition of, and support for, the medical home model arises in part from the ongoing advocacy efforts of primary care providers, who see the medical home model as key to providing efficient, high-quality, coordinated care. For example, In March 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association collectively issued the Joint Principles of the Patient-Centered Medical Home. These principles include:

- Quality and safety through evidence-based medicine and accountability,
- Enhanced access to care, and
- Payment that fairly compensates providers for services, including coordination of care.

The principles also state that fair compensation to providers should foster the use of information technology and communication with patients through email and other means. The medical home model is expected to reduce preventable hospitalizations, hospital readmissions, and emergency room visits while, at the same time, improving health outcomes and reducing the cost of health care services. The foundation of the medical home model is an ongoing relationship with a personal physician who takes the lead in coordinating the patient’s health care.

### D. Medicare Hospice Concurrent Care Demonstration Program

The Legislation also authorized the Secretary to conduct a three-year demonstration program allowing Medicare beneficiaries to receive hospice care and all other Medicare-covered services concurrently. At present, Medicare prohibits such payments. Funding

<sup>47</sup> The Legislation also requires the Secretary, by January 1, 2012, to establish a pediatric ACO demonstration project, under which a participating State would recognize certain pediatric medical providers as ACOs for purposes of receiving incentive payments. See Pub. L. No. 111-148, § 2706.

<sup>48</sup> Pub. L. No. 111-148, § 3022, *codified at* Social Security Act § 1899 (42 U.S.C. 1395 et seq.).

for this demonstration program would come from Medicare funds that would otherwise pay for hospice care.

## E. Promotion of Healthy Lifestyles

The Legislation also emphasizes the need to promote healthy lifestyles by authorizing the Secretary, acting through the Centers for Disease Control, to award grants to state and local health departments and Indian tribes to carry out five-year pilot programs to provide public health interventions, community preventive screenings, and clinical referrals for chronic diseases for individuals who are between 55 and 64 years of age. The Secretary must conduct an annual evaluation of the pilot programs and report to Congress, by September 30, 2013, on the evaluation results and any recommendations to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries.

## V. Other Significant Changes to the Medicare Program

### A. MEDICARE ADVANTAGE PART C

The Legislation will result in significant changes to the Medicare Advantage program by reducing payment amounts, increasing blended benchmarks, repealing the comparative cost adjustment, regulating medical loss ratio, providing additional beneficiary protections, and clarifying the Secretary's authority to deny MA bids.

#### 1. Payment Amounts

The Legislation adopts a new methodology for determining Medicare Advantage (MA) payments that will result in a reduction in payments to MA plans.<sup>49</sup> CMS determines payments to MA plans by comparing a plan's bid, which encompasses the costs of providing required Medicare benefits, to the benchmark, which is the maximum amount Medicare will pay for the required Medicare benefits included in the MA plan's benefit package. Each year, the benchmark increases based on a statutorily specified formula that considers the MA per capita growth percentage and, sometimes, average spending in the traditional Medicare program.

As authorized by the Legislation, benchmarks for 2011 will be held at the 2010 levels. A blended benchmark based on a percentage (95 percent, 100 percent, 107.5 percent, or 115 percent) of a base amount will be implemented in 2012, with the base amount for that year being set at per capita spending in traditional Medicare. Following 2012, base amounts will be adjusted, either by growth in overall Medicare, or per capita traditional Medicare spending in the particular county.

In counties where traditional Medicare spending is highest, the percentage adjustment to the base amount would be the lowest (95 percent) and in counties in which original Medicare spending is the lowest the percentage adjustment will be the greatest (115 percent). The Legislation permits longer phase-in schedules for areas where the benchmark decreases by larger amounts.

<sup>49</sup> Health Care and Education Affordability Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102(b)(2010) (repealing Pub. L. No. 111-148, §§ 3201 and 3203), *codified at* Social Security Act § 1853 (42 U.S.C. 1395w-23).

### 2. Increase in Blended Benchmark for Qualifying Plans

Currently, an MA plan must implement a quality improvement program, but there is no relationship between adherence to the program and payment amounts. Starting in calendar year 2012, an MA plan will have the opportunity to increase its blended benchmark if it can meet certain targets.<sup>50</sup> The Legislation rewards qualifying plans (earning at least four out of five stars) with an increase in blended benchmark, with larger increases for such plans in qualifying areas. Certain other MA plans also are eligible for this increased blended benchmark. In addition, MA plans with lower-than-benchmark bids and with higher quality ratings are eligible to receive rebates from CMS of up to 100 percent of the difference between the benchmark and bid, up from 75 percent. This rebate increase will be phased-in over three years.

### 3. Repeal of Comparative Cost Adjustment and Regulation of Medical Loss Ratio

MA plans now must spend a certain percentage of their revenues on health care services, commonly referred to as the "medical loss ratio," or "MLR." Beginning in 2014, an MA plan that spends less than 85% of its revenue on providing health care services must pay the difference between its MLR and an MLR of 85 percent to the Secretary.<sup>51</sup> Further, if a MA plan has an MLR below 85% for three consecutive years, the Secretary will restrict enrollment in the plan; if the MLR is below 85 percent for five consecutive years, the MA plan will be terminated.

This process takes the place of the Comparative Cost Adjustment (CCA) program created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.<sup>52</sup> The purpose of the CCA program was to examine a possible new MA payment system and implement adjustments to Part B premiums based on a comparison of the cost of providing services under Medicare Part B and Part C.

### 4. Beneficiary Protection and Benefit Simplification

In addition to altering the MA plan payment calculation methodology, the Legislation includes a number of beneficiary protection provisions. For plan years starting on or after January 1, 2011, for services such as chemotherapy treatment, renal dialysis, skilled nursing care, and other services to be identified by the Secretary, an MA plan cannot charge an enrollee a cost-sharing amount greater than such amounts applicable under traditional Medicare for the same services.

The Legislation also seeks to increase beneficiary protection by controlling how a MA plan applies its rebates, bonus payments, and supplemental premiums. As of 2012, an MA plan that earns rebates and bonuses and receives supplemental premiums must use the funds first to reduce cost sharing obligations; then to cover preventative and wellness benefits; and, lastly, to offer other benefits not covered by traditional Medi-

<sup>50</sup> *Id.*

<sup>51</sup> Pub. L. No. 111-152, § 1103, *codified at* Social Security Act § 1857(e)(4)(A) (42 U.S.C. 1395w-27(e)(4)(A)).

<sup>52</sup> Pub. L. No. 111-152, § 1102(f) (repealing § 1860C-1 of the Social Security Act, which established the Comparative Cost Adjustment program); Pub. L. No. 111-152, § 1103, *codified at* Social Security Act § 1857(e) (42 U.S.C. 1395w-27(e)) (setting forth requirements for Minimum Medical Loss Ratios).

care. An MA plan cannot use such funds to reduce or eliminate the Part B premium.

### 5. Simplification of Annual Beneficiary Election Periods

The Legislation alters the period during which Medicare beneficiaries can enroll in and disenroll from an MA plan (and/or Medicare Part D). Currently, Medicare beneficiaries can enroll and change enrollment in an MA plan between November 15 and December 31, with the changes effective January 1. Also, January, February, and March are continuous open enrollment and disenrollment periods, during which Medicare beneficiaries can enroll in an MA plan, switch from MA to traditional Medicare, and change from one MA plan to another.

Starting in calendar year 2011, Medicare beneficiaries will have one coordinated election period for MA and Part D, from October 15th through December 7th. Beneficiaries will no longer have the option of switching from one MA plan to another or moving to MA from traditional Medicare after the benefit year starts. However, beneficiaries can return to traditional Medicare during the first 45 days (January 1st through February 15th) of the benefit year.

### 6. Authority to Deny Bids

The Secretary receives bids from multiple MA plans and has the authority to negotiate and accept a bid only after determining that the bid meets certain standards. Until now, the authority of the Secretary to reject a bid submitted by an MA or Part D plan was an open question. The Legislation answers this question by providing that, effective January 1, 2011, the Secretary does not have to accept a bid submitted by an MA or Part D plan.<sup>53</sup> Further, bid information must be certified by a member of the American Academy of Actuaries.

## B. MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAM Part D

### 1. Closing the “Donut Hole” Coverage Gap

Since the inception of the Medicare Part D prescription drug benefit program, Medicare beneficiaries have been navigating the so-called “donut hole.” The donut hole is a gap in coverage (from \$2,830 to \$6,440 in covered prescription drug costs in calendar year 2010) in which a Medicare Part D enrollee is responsible for the full cost of his or her prescription drugs. Once the enrollee gets through the donut hole, catastrophic coverage begins and cost-sharing amounts are generally limited to 25 percent. The Legislation will phase out the donut hole by calendar year 2020.<sup>54</sup>

Part D enrollees who enter the donut hole as of the last day of a calendar quarter in 2010 will receive a \$250 rebate by no later than the 15th day of the third month following the end of such quarter.<sup>55</sup> As of January 1, 2011, certain Part D enrollees will receive a 50 percent discount for brand name drugs upon reaching the donut hole. The 50 percent discount will be offered by the pharmaceutical manufacturers in return for coverage of

their drugs by Part D plans. Gradually, enrollee cost-sharing obligations will decrease, and, by calendar year 2020,<sup>56</sup> cost sharing obligations while in the gap will equal 25%.

For calendar years 2014 through 2019,<sup>57</sup> an enrollee’s out-of-pocket expenses (which is the metric used to determine when the enrollee reaches catastrophic coverage) will include the value of the discount provided by the pharmaceutical manufacturers, but not the portion covered by Medicare.

### 2. Improvement in Determining Low-Income Subsidy (LIS) Benchmark

In addition to phasing out Part D’s coverage gap, the Legislation changes the calculation of the low-income subsidy (LIS) benchmark. As a result, the number of plans qualifying as low-income benchmark plans may increase.

Currently, a Part D plan can qualify as a low-income benchmark plan if it provides Part D coverage with a premium equal to or less than the regional low-income premium subsidy amount. An MA plan also can qualify as a low-income subsidy plan, and can use rebate payments related to its Part C service, to reduce its Part D premium. The regional benchmarks are calculated using Part D premiums for both stand-alone plans and MA plans.

Inclusion of the MA Part D premiums in the calculation of the regional benchmarks has resulted in stand-alone Part D plans facing artificially low premium bids and a reduced number of qualifying plans. To remedy this situation, MA rebate amounts used to reduce an MA plan’s Part D premium will not be included when calculating LIS regional benchmarks as of January 1, 2011.

## C. REVISIONS TO MEDICARE PARTS A AND B PAYMENT METHODOLOGIES

While many of the changes in the Legislation introduce an array of creative methods and incentives for increasing quality, efficiency, and accountability while reducing costs, the Legislation also includes a number of straightforward changes to Medicare program reimbursement amounts that are worth noting.

### 1. Elimination of Geographic Disparities in Physician Reimbursement Rates

Medicare Physician Fee Schedule payment amounts are adjusted based on the Geographic Practice Cost Indices (GPCIs), which take into account certain geographic factors representing differences in the cost of physician items and services. These factors, which include physician work, practice expense, and medical malpractice insurance, reflect how each geographic area compares to the national average for physician items and services.

Under current law, the Secretary must adjust the practice expense GPCI to reflect the full difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages. However, Congress determined that these geographic differences are not justified and that physicians working in high-cost areas should be working to

<sup>53</sup> Pub. L. No. 111-148, § 3209(a)-(c), *codified at* Social Security Act § 1854(a)(5) (42 U.S.C. 1395w-24(a)(5)).

<sup>54</sup> Pub. L. No. 111-152, § 1101(b) (amending Pub. L. No. 111-148, § 3301), *codified at* Social Security Act § 1860D (42 U.S.C. 1395w-101 et seq.).

<sup>55</sup> Pub. L. No. 111-152, § 1101(a)(1), *codified at* Social Security Act § 1860D-14A(g)(1) (42 U.S.C. 1395w-152(g)(1)).

<sup>56</sup> Pub. L. No. 111-152, § 1101(b), *codified at* Social Security Act Title XVIII Part D (42 U.S.C. 1395w-101 et seq.).

<sup>57</sup> *Id.*

reduce such costs. As a result the Legislation specifies that for services furnished during calendar years 2010 and 2011, the practice expense GPCI will reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of one-half local and one-half national), instead of the full difference currently in effect.<sup>58</sup> In addition, no later than January 1, 2012, for calendar years 2012 and beyond, the Secretary must make appropriate adjustments to the practice expense GPCI to ensure accurate geographic adjustments. Such adjustments must be made without taking into account adjustments made in calendar years 2010 and 2011 and in a budget neutral manner.

## 2. Improvement To The Hospital Area Wage Index

Similarly, when determining the payment methodology for hospitals, the Secretary must adjust the standardized payment amount by taking into account the geographic differences in hospital labor costs. This adjustment factor is referred to as the area wage index or AWI. Certain hospitals that meet specific average hourly wage thresholds are able to reclassify themselves to areas with higher wage index values. Although hospitals could take advantage of this reclassification only until September 30, 2009, the Legislation extends that date for one year. Starting in FFY 2011, the Secretary will make hospital reclassifications determinations using the average hourly wage percentage used in FFY 2009 Medicare Geographic Classification Review Board (MGCRB) decisions.<sup>59</sup>

In addition, Congress repealed a regulatory change implemented in fiscal year starting October 1, 2008 related to the manner in which CMS calculates the budget neutrality effect of the so-called rural floor provisions of section 4410 of the Balanced Budget Act of 1997.<sup>60</sup> In 1997 Congress recognized inequities existed in situations where certain urban areas in a State have unusually depressed wages when compared to the State's rural areas, and as a result Congress required that the wage index for hospitals in an urban area of a given State cannot be less than the AWI received by rural hospitals in that State. In addition, to offset the revenue impact of this rural floor adjustment, Congress required a nationwide budget neutrality adjustment. In the past few years, CMS has taken the position that the rural floor provision was becoming subject to abuse and creating distortions among States. As a result, in a radical departure from past interpretations of its numerous other budget neutrality authorities under PPS, for this budget neutrality adjustment, beginning in fiscal year starting October 1, 2008, such adjustment is being transitioned from a nationwide to a statewide adjustment, with a statewide adjustment fully implemented this federal fiscal year.<sup>61</sup> However, in the Legislation Congress reversed this state-by-state approach to budget neutral-

ity and requires the Secretary to perform this budget neutrality calculation "in the same manner as the Secretary administered" similar provisions found in the PPS, thereby returning to the previous status quo of "a uniform, national adjustment to the area wage index."<sup>62</sup>

## 3. Payment for Imaging Services

Medicare expenditures for advanced diagnostic imaging services, such as diagnostic MRIs and CT scanning, have far outpaced other Medicare cost increases in recent years. Following a MedPAC recommendation on this issue, CMS implemented a change to the formula for calculating Medicare payments for certain imaging services intended to decrease payments for imaging services, beginning in FFY 2010. This change focused on the practice expense component, part of which depends on a presumed utilization rate for the equipment.

Through 2009, CMS based its payment practice expense payments for imaging services on a presumed utilization of 50 percent; however, CMS sought to begin the process of increasing the presumed utilization rate for MRIs and CTs to 90 percent over a four-year period, which would result in lower payments for these services. In response to concerns raised by imaging services providers, the Legislation modified the presumed utilization rates and the length of the transition period by setting the presumed utilization rate assumption to 65 percent through 2012, 70 percent for 2013, and 75 percent for 2014 and beyond.<sup>63</sup>

## 4. Geographic Variations Additional Payments to "Qualifying Hospitals"

Since the late 1970s, health policy researchers have observed that there are significant, largely unexplained variations in health care expenditures and that higher costs areas typically do not achieve better quality of care or improved health outcomes. Even so, relatively little progress has been made in identifying specific care modalities across the cost spectrum that should either be eliminated as worthless or pushed aggressively as best practices. As a result, geographic variations in costs have spurred ongoing policy debates throughout the course of health care reform deliberations.

The resulting political compromise on this issue was one of the last pieces of the puzzle to fall into place with a seemingly innocuous 11<sup>th</sup>-hour amendment to the Reconciliation Bill entitled "Payment For Qualifying Hospitals."<sup>64</sup> This amendment makes \$400 million available from the Medicare Part A Trust fund to increase payments to a "qualifying hospital," which is a hospital located in a county ranked in the lowest quartile for age, sex, and race-adjusted spending under Medicare Parts A and B.<sup>65</sup> The more complete explanation of this amendment, however, is found in the Secretary's March 20, 2010 letter to Congressional leaders pushing this issue, known informally as the "Quality Care Coalition." In this letter, the Secretary agreed that "the current

<sup>58</sup> Pub. L. No. 111-148, § 3102(a) (as amended by Pub. L. No. 111-152, § 1108), *codified at* Social Security Act § 1848(e)(1)(H)(i) (42 U.S.C. 1395w-4(e)(1)(H)(i)).

<sup>59</sup> This requirement would apply until the first fiscal year beginning on or after the date that is one year after the date the Secretary submits the wage index reform plan. *See* Pub. L. No. 111-148, § 3137 (as amended by Pub. L. No. 111-148, § 10317).

<sup>60</sup> Pub. L. No. 111-148, § 3141.

<sup>61</sup> 42 C.F.R. § 412.64(e)(4).

<sup>62</sup> Pub. L. No. 111-148, § 3141.

<sup>63</sup> Pub. L. No. 111-148, § 3135(a) (as amended by Pub. L. No. 111-152, § 1107), *codified at* Social Security Act § 1848 (42 U.S.C. 1395w-4).

<sup>64</sup> Amendment to the Amendment in the Nature of a Substitute for H.R. 4872, § 1109 (2010) (amending Pub. L. No. 111-152, § 1109 (2010)).

<sup>65</sup> *Id.*

geographic variation in Medicare rate is inequitable” and committed the administration to taking certain steps to address the problem, some of which had been included in the unenacted House version of health care reform legislation. These steps include a commitment to commissioning studies from the Institute of Medicine, directing the CMI to test innovative models, seeking appointees to the new IPAB who have expertise in “geographic, value and quality disparities,” and convening a “National Summit” on this issue.

### 5. Reductions in Medicare Disproportionate Share Hospital (DSH) Payments

Starting in FY 2014, the Legislation requires a 75% reduction in Medicare DSH payments made to hospitals based on an assumed reduction in the level of the hospital’s uncompensated care costs because of the anticipated increases in the number of insureds.<sup>66</sup> The reduction is based on findings in the March 2007 MedPAC report that about three-fourths of DSH payments were not empirically justified with respect to higher medical care costs. This change could have an extraordinary impact on hospitals located in low-income areas if the assumptions on which it is based turn out to be faulty.

### 6. Additional Payment Changes

- A 10 percent Medicare bonus available from 2011 through 2016 for physicians and others providing primary care services in health professional shortage areas. Half of the bonuses would be offset through across-the-board reductions in payments for other services.
- A 5 percent increase in the payment rate for psychiatric services through the end of 2010.
- An increase to the payment rate for certified nurse midwives from 65 percent to 100 percent of the rate that would be paid if a physician were performing the service.
- Improvement of payment accuracy through rebasing home health payments starting in 2014 based on an analysis of the current mix of services and intensity of care provided to home health patients.

## VI. Conclusion

The changes discussed in this article as well as others made to the Medicare program by the Legislation are intended to drive reform throughout the entire health care system and to “bend the cost curve.” Throughout the health care reform debate, many questioned whether the then-proposed Medicare changes went far enough.

<sup>66</sup> Pub. L. No. 111-148, § 3133 (as amended by Pub. L. No. 111-148, § 10316 and Pub. L. No. 111-152, § 1104), *codified at* Social Security Act § 1886(r)(1) (42 U.S.C. 1395ww(r)(1)).

While the Legislation unquestionably will have a significant impact on the Medicare program’s payments and service delivery systems, additional action will be necessary to move the modest quality improvement bonuses and demonstration projects into the mainstream of health care delivery.

President Obama appears keenly aware of the need to take decisive action. His recent nomination of Donald M. Berwick, M.D. to serve as the CMS Administrator sends a strong message in this regard. In his announcement of the nomination, the president highlighted Berwick’s experience with cost and efficiency issues: “Dr. Berwick has dedicated his career to improving outcomes for patients and providing better care at lower cost.”<sup>67</sup> Indeed, the organization that Berwick has overseen for a number of years, the Institute for Healthcare Improvement, is known internationally for its ability to challenge current practices.<sup>68</sup> In addition, the Obama administration reportedly is seeking to accelerate implementation of the Legislation<sup>69</sup> and has appointed two experienced White House advisors, Nancy-Ann DeParle (who directed the legislative effort and who served as CMS Administrator under President Clinton) and Pete Rouse, to lead implementation efforts.

Even though the administration has demonstrated a strong commitment to implementing robust health care reform, only time will tell whether changes made to the Medicare program will be sufficiently robust to achieve the Legislation’s goal of improving the quality of care and accountability while decreasing overall costs throughout the health care system and, more specifically, forestalling a looming Medicare funding crisis.

<sup>67</sup> Press Release, The White House Office of the Press Secretary, President Obama Nominates Dr. Donald Berwick for Administrator of the Centers for Medicare and Medicaid Services (April 19, 2010).

<sup>68</sup> <http://www.ihl.org/IHI/About/IHIOverview.htm>.

<sup>69</sup> J. Calmes, “After Health Care Passage, Obama Pushes to Get It Rolling,” N.Y. Times, April 17, 2010.

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