Key Payment Provisions of the
Federal Health Reform Law

(HR 3590 as modified by HR 4872)

Summary

Medicare Payment

Physicians

- **Increased payments for primary care physicians.** Beginning January 1, 2011 and continuing for five years, primary care providers will receive 10% bonus payments for evaluation and management services.

- **Increased payments for general surgeons practicing in physician shortage areas.** Beginning January 1, 2011, the bonus payment program for physicians practicing in physician shortage areas will be extended to include a 10% bonus for general surgeons on major procedure codes (in addition to the existing 10% bonus for primary care physicians practicing in shortage areas).

- **Quality-based payment adjustments for physicians in Medicare**.
    - Physicians will continue to be paid a bonus to report quality data through 2014; beginning 2015 physicians will be penalized for not reporting the data.
    - Beginning in 2013, physician base payments will modified based to reward quality, according to risk-adjusted measures of health outcomes and costs.

- **Feedback to physicians on resource use.** CMS must develop an episode grouper to allow measurement of resource utilization by physicians for episodes of care and must make the methodology public.

- **Geographic adjustments to physician payment.** CMS must revise the practice expense adjustment to the physician base payment to more accurately reflect practice expense variations by 2012. In the meantime, the amount by which payments are modified downward to reflect lower than average practice expense under the current formula will be reduced by 50%. This affects Oregon physicians outside the Portland payment area because their practice expense under the current formula is 93% of the national average. Portland area physicians are unaffected because the geographic modifiers raise their payments above the base. In addition, the legislation re-instated the physician work floor, which means that the physician work adjustment will continue to be used only to upward adjust physician payments—not to downward adjust them in communities where professionals are paid less than average.

Hospitals

- **Hospital inpatient payment adjustments for high readmission rates.** Base payments will be reduced for hospitals with higher than expected risk adjusted readmission rates for conditions identified by CMS, beginning with heart attacks, heart failure and pneumonia. Reductions cannot exceed 1% in fy 2013, 2% in fy 2014, and 3% in fy 2015. Readmission rates will be posted on the CMS website.

- **Hospital inpatient payment adjustments for high incidence of hospital acquired infections.** Base payments will be reduced 1% for hospitals in the top quartile for incidence of hospital acquired infections beginning fy 2014. Rates will be made public.

- **Quality-based payment adjustments for hospital inpatient services ("Hospital Value-based Purchasing Program").** CMS must develop a program of incentive payments that would hold back a percentage of the base rate (1% in federal fiscal year 2013 and increasing to 2% in 2017) and use those funds to reward hospitals that meet quality and efficiency standards. The program does not apply to critical access hospitals or hospitals with insufficient numbers to measure quality, but requires CMS to conduct demonstration programs to test systems for rewarding quality in such hospitals.

- **Geographic adjustments to hospital payments.** CMS must revise the hospital wage index to address specified issues.

- **Bonus payments for hospitals in low cost communities.** Medicare will spend $200 million each year in fy 2011 and 2012 to increase hospital payments in counties that rank in the lowest quartile for Medicare fee for service spending. Assuming Oregon hospitals qualify, they are likely to receive increases to their base pay of something less than one-half of one percent each year.

- **Reduces Medicare disproportionate share hospital payments beginning fy 2014.**

Other facilities and providers

- **Accountable Care Organizations (ACOs)**. Beginning in 2012, CMS must have in place rules to designate ACOs and a shared savings payment model. To be eligible for shared savings payments, ACOs must meet eligibility and reporting criteria determined by the secretary, contract with Medicare for a minimum of 3 years and care for a minimum of 5,000 Medicare beneficiaries.

- **Prospective payment system for federally qualified health clinics.** CMS must develop a payment neutral prospective payment system for FQHCs and implement it in 2012.

- **Quality reporting and payment programs for other facilities and providers.** CMS must begin quality reporting programs for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals, cancer hospitals, and hospice programs by fy 2014. CMS must submit a plan for value-based purchasing for skilled nursing facilities and home health programs by fy 2012.

Medicare Advantage

- **Reduced Medicare Advantage payments.** Beginning in 2012, payments for Medicare Advantage plans will be calculated under a new formula. Benchmarks, which are the basis of payments, have averaged 116% of fee for service cost are old law and have resulted in payments to MA plans well above the cost of covering fee for service beneficiaries). Under the new law the benchmarks will be no higher than 115% of fee for service cost after a six-year phase-in period. Benchmarks will be set as high as 115% of fee for service cost for counties with low fee for service costs and as low as 95% of fee for service cost for counties with high fee for service costs. [Benchmarks are the

maximum Medicare will pay a plan to provide Medicare covered services. Plans that "bid" (contract with Medicare) to provide services at less than the benchmark receive the bid amount plus "rebates" (additional payments) equal to 75% of the difference between the benchmark and the bid. The average benchmark rate for Oregon plans has been well-above the new 115% cap, so MA payments will be reduced under the new law.]

- **Minimum loss ratios for Medicare Advantage plans.** Beginning in 2014, Medicare Advantage plans must have a minimum loss ratio of 85%.

Medicare Payment-setting Process

- **Independent Payment Advisory Board**. Beginning in 2014, a new Independent Payment Advisory Board will provide Congress savings plans if Medicare spending exceeds targets. The plans will go into effect if not overridden by Congress. Reductions cannot be achieved by "rationing care," increasing beneficiary premiums or cost-sharing, or (until 2019) reducing payments for most hospitals.

Medicaid Payment

- **Increased payments for primary care in Medicaid.** During calendar years 2013 and 2014, primary care physicians must be paid 100% of Medicare rates for evaluation and management and immunization services. The incremental costs for increasing the reimbursement rate over what it was in July 2009 will be 100% federally funded.

- **Primary Care Homes.** Beginning in 2011, states with an approved state plan amendment to pay for medical homes for enrollees with >1 chronic disease will receive a 90% federal match for primary care home services. The 90/10 match will remain in effect for the first 8 fiscal quarters from the date a state's plan amendment is approved.

- **Reduces Medicaid disproportionate share hospital payments beginning fy 2014.**

Pilots and Demonstrations

- National Medicare **pilot on payment bundling** addressing chronic and acute conditions involving select providers
- National Medicaid demonstration beginning January 1, 2012 in eight states for **episode-based payment**
- National two-year Medicaid demonstration beginning October 1, 2011 in five states for **global capitated payments** to safety net hospitals or networks.
- National shared savings pilots 2012-2016:
    - Medicaid – **accountable care organizations** taking responsibility to care for children receive incentive payments if they exceed minimum savings levels established by CMS and the applicant state
- Center for Medicare and Medicaid Innovation funding for payment innovation.

Implications for the Payment Reform Subcommittee

The Subcommittee may wish to consider:

- Whether to recommend all payer adoption of pay for performance adjustments and/or payment methods adopted in the Medicare program (e.g. creation of Accountable Care Organizations);
- Whether to recommend Oregon action to align with and prepare for federal payment reform opportunities;
- Whether Oregon should seek to participate in any of the pilot and demonstration programs initiated by the bill.