IMPACT OF HEALTHCARE REFORM Bill on the Practice of Nephrology

The AFFORDABLE CARE ACT of 2010

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The Patient Protection and Affordable Care Act aka Affordable Care Act

- Passed March 23, 2010
- Bill is 906 pages
- Despite one’s politics, no one can say with certainty how the bill will turn out.
- More about Health Insurance coverage than health care delivery reform
- Goal:
  - Affordable Health Insurance for All
  - Improved Access to Primary Care
  - “Bend the Cost Curve”

Impact on Nephrologists in particular Interventional Nephrology

- Relatively Limited
- Coverage Expansion Could Cause Significant Growth of CKD Population
- Bonus Payments to Primary Care Physicians
- New Center for Medicare Innovation (CMI) to Be Incubator for Policy Development and
- Shared Savings Program will foster new models of care
  - Creation of Accountable Care Organizations (ACO)
  - Patient-centered Medical Home/Neighborhood (PCMH/N)
  - Bundled Payments
- Fraud and Abuse Issues

Components of ACA

- Increased Medicare payments by 10% to primary care physicians
- Other provisions to increase Primary Care work force (non for specialists)
- Increased numbers of insured patients i.e. potential increase work load
  - 50% covered by Medicaid (tab picked up by Feds)
  - Other half, by private Insurance offered via state health exchanges
- Improved Medicaid reimbursement rates (minimum is Medicare rates)
- New models of healthcare delivery: ACO, PCMH/N

POTENTIAL IMPACT

- ISSUES OF FRAUD AND ABUSE
  - Stark Law Changes
  - Anti-kickback Statute changes
  - False Claims Act Changes
  - I AM NOT A LAWYER

Stark Law Changes

- Establishment of Medicare Self-referral Disclosure Protocol (section 6409);  
  - Establish protocols to permit providers and suppliers to voluntarily disclose potential Stark Law violations
  - Allows CMS to negotiate settlements
  - Disclosure for in-office Ancillary Services “…any designated health services in the radiology service category“ (Section 6003)
  - informs patient in writing that patient can get services elsewhere etc.
Anti-Kickback Statute Changes

- Claims from anti-kickback statute are considered false claims for purposes of the federal False Claims Act (section 6402 (f)(1))
- Lowered Criminal Intent Standard (6402 (f))
  - “a person need not have actual knowledge of or specific intent to commit a violation”
- A violation of Anti-kickback Statute is a “federal health care offense” (Sect. 10606)

Other Issues

- Mandatory requirement to return Overpayments in 60 days.
  - Must provide explanation of reason for overpayment
  - Subject to False Claims Act
  - Imposes civil Monetary penalty
- Maximum period for submission of Medicare claims reduced to not more than 12 months
- Others......

COMPONENTS OF ACA

*Healthcare delivery reform*

- Accountable Care Organization($§3022)
- Patient-Centered Medical Home/Neighborhood ($§3023)
- Bundling of payments ($§3502) (beware)
- Readmission Reduction Program($§3025)
- Hospital-Acquired Conditions(3008)

Why Bundled Payment?

Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform

Definition of ACO

- An *organization of health care providers* that agrees to be accountable for the quality, cost and overall care of the Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to the organization.
Driving Forces for ACO

- Out of control spending in a fee-for-service environment
- Gaps in Quality Care
- Potential Waste in system
- Current system fragmented

Accountable Care Organizations: More than Insurance Reform and Reimbursement Model

- Model for delivery-system reform
- ACO model emphasizes the alignment of incentives and accountability for all providers
- ACOs can include provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population
- Current design is Primary care based within an Integrated Health Systems. Other: PHO, IPA etc. Specialty ACOs are not listed and would need to be an exception.

What do you have to do to be an ACO?

- Program begins in 2012
- Commit for 3 years
- Have a formal legal structure that would receive and distribute shared savings to participating providers.
- Have a sufficient number of primary care physicians that can care for a minimum of 5,000 Medicare beneficiaries assigned to the ACO
- Develop defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care using telehealth, remote patient monitoring, etc.
- Meet patient-centeredness criteria such as the use of patient assessments or individualized care plans
- Will require legal and regulatory relief

Chronic Kidney Disease is ideally suited to fall within an ACO

- Increasing CKD population
- Increasing and disproportionate costs
- Gaps in Quality Care
- Potential Waste in system
- Inadequate reimbursement to providers
- Current system fragmented
- Nephrologist provides comprehensive care

Accountable Care Organizations: More than Reimbursement Model

- ACO are not HMOs nor insurance risk entities but are based on the risk of controlling clinical performance
- Would assume risk and the potential financial rewards
- Could utilize gain-sharing models to get access to savings and would finally tackle the Part A-B barriers
- Potential payment methodologies
  - could receive fee-for-service payment and share in any cost savings achieved relative to a risk-adjusted projected spending target for their patient population; bonuses for co-ordination of care.
  - alternatively, payment could be partially or fully capitates, with risks and gains both being shared by all providers

Nephrologists and ACO

- Kidney Care is ideally suited for an ACO
- Nephrologists would act as principle care physician, coordinating care with PCP
- Nephrologists and dialysis providers could form the ACO
- Demonstration Projects provide background
- Data collection and track record for reporting quality data.
What if no specialty ACOs?

- Nephrologists and providers need to work with ACO addressing needs of the CKD population
- Avoid being peripheralized
- Concern about owned physicians practices including hospital based interventional programs vs. independents.

Patient Centered Medical Home/Neighborhood

Patient Center Medical Home(PCMH)

- Concept of coordinated, integrated, patient centric care
- Predominately Primary care driven
- Requires personal physician who coordinates care including housing data, consults etc
- Current model allows specialist to be a PCMH if fulfill criteria

Patient-Centered Medical Neighbor

- RPA and ASN along with other specialists have weighed in on concept and ACP has written a position paper addressing the role of specialist(www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf)
- Encourages co-management
- Define accountability and expectations
- **Nephrologists would be Principle Care Physician with PCP involvement**
- As principle care physician, nephrologist would co-ordinate care not necessarily do it.
- Bonus payments layered on fee-for-service.
- More to come.

CONCLUSIONS

- Current Healthcare Reform has limited impact on interventional nephrology
- Accountable Care Organizations are coming and nephrologist may be playing a major role
- ACOs are likely to be health system based and nephrologists will need to position them selves within those systems (bundling of vascular access services a tenable model)
- Nephrologists need to take a lead role.