The Law Offices of Jason M. Healy PLLC

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A health law firm in the nation's capital

www.HealyLawDC.com

Contact Us:

Jason M. Healy
1667 K Street NW
Suite 1050
Washington, DC 20006
(202) 706-7926
(888) 503-1585 fax

jhealy@healylawdc.com

CONGRESSIONAL BUDGET OFFICE FINDS LITTLE SAVINGS IN MEDICARE DEMONSTRATION PROJECTS

The Congressional Budget Office recently released an issue brief ("CBO Brief") that raises serious questions about the value of Medicare demonstration projects, finding that only *one* out of the ten major demonstrations to enhance the quality and efficiency of fee-for-service care actually reduced Medicare spending.[1] In all other demonstrations, Medicare spent *more* on the services provided, after fees to participating organizations are considered. CBO concluded that the lack of savings was largely attributable to structural impediments built into the existing fee-for-service payment systems, which reward providers for delivering more care and lack the centralization needed for effective care coordination. CBO suggested that "substantial changes to payment and delivery systems will probably be necessary for programs involving disease management and care coordination or value-based payment to significantly reduce spending and either maintain or improve the quality of care provided to patients."[2] However, as discussed below, CBO also provided specific recommendations to improve the cost-effectiveness of Medicare demonstrations.

Disease Management and Coordination of Care.[3] The CBO Brief looked at six major demonstrations that sought to manage chronic diseases and/or coordinate care for chronic disease patients. These models typically used care managers who would be in contact with Medicare beneficiaries and physicians, either personally or by telephone. The models targeted beneficiaries that would potentially benefit most from the coordination of care in a measurable way. The demonstrations sought to reduce Medicare costs by reducing hospital admissions.

Of the 34 programs studied in the 6 models, 18 involved fees that were "at risk," or only earned by the care managers to the extent that they reduced Medicare spending, and 16 involved guaranteed fees. Only two programs, both "at risk" models, reduced Medicare spending enough to offset the fees paid to the care managers. The CBO Brief determined that hospitalizations decreased 7 percent and regular Medicare spending (*i.e.*, not including fees) decreased an average of 6 percent when care managers had direct interactions with physicians. When the care

manager had direct contact with patients, admissions fell 7 percent and regular Medicare spending decreased by an average of 3 percent. Even these more effective models failed to achieve the 13 percent average savings needed to offset the care managers' fees.

Value-Based Payment.[4] The CBO Brief also evaluated four demonstration models that sought to improve quality and efficiency of care by experimenting with alternative payment methods. The models included the Physician Group Practice Demonstration (10 large physician practices could share savings if they reduced total Medicare spending), the Premiere Hospital Quality Incentive Demonstration (278 hospitals could receive bonuses for achieving quality-of-care measures in the top tier of participating hospitals), the Home Health Pay-for-Performance Demonstration (273 home health agencies could share in Medicare savings if they were among the top-rated in their region in quality scores or quality improvement), and the Medicare Participating Heart Bypass Center Demonstration (7 participating hospitals and related physicians agreed to accept a discounted bundled payment for heart bypass surgery).

The first three of these offered bonuses based on quality improvements, Medicare savings, or a combination of both. None of the three resulted in anything more than negligible savings to the Medicare program. The fourth was virtually guaranteed to result in Medicare savings because the discount was pre-negotiated with seven hospitals and their physicians who treat heart bypass patients. However, the CBO Brief notes that the "[h]ospitals and physicians were willing to accept discounted payments because of competitive pressure in their markets," which calls into question whether such a model would be successful if implemented more broadly.[5]

Lessons Learned.[6] In addition to the positive correlative factors noted for the coordination of care models (placing fees at risk and encouraging direct contact between care managers and patients/physicians), the CBO Brief identified five approaches that are also beneficial, including: gathering timely data on use of care and admissions; focusing on transitions in care settings to reduce readmissions; using team-based care with close collaboration; targeting interventions toward high-risk enrollees; and limiting the costs of interventions by keeping bonuses and fees below the program's spending reductions.

For future demonstrations, the CBO Brief recommended using "randomized designs or well-matched comparison groups" to reduce the possibility that a model's Medicare savings would be over- or under-estimated; consistently and promptly reporting evaluation findings; including a large enough number of beneficiaries to obtain sufficiently precise estimates; accounting for the differential in coding practices between demonstration groups and comparison groups; and listing as much information as possible on public information reports.

Takeaways for Providers. The CBO Brief offers a sharp critique of many of the major Medicare demonstrations on payment efficiency and

quality improvement. CBO's findings are potentially significant because many of the same general themes tested – bundled payments, shared savings and shared risk, quality measures, and coordination throughout the episode of care – are the primary features of Accountable Care Organizations (and the related Pioneer ACOs and Advanced Payment Model ACOs) and the Bundled Payment Initiative.[7] They also indicate the features CMS might embrace or avoid when making grants under the Innovation Challenge.[8]

Long-term acute care hospitals and other providers should carefully evaluate demonstration proposals as opportunities to test delivery models and take advantage of offered bonuses and incentives, but know that most demonstrations will not achieve their stated goals or permanently alter the Medicare landscape. If the CBO Brief is any indication, we can expect more Medicare demonstrations to ask participants to agree to reduced payments as part of a bundled payment or otherwise in order to reduce overall Medicare spending.

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1. CONGRESSIONAL BUDGET OFFICE, Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment (Jan. 2012), available at http://www.cbo.gov/ftpdocs/126xx/doc12663/01-18-12-MedicareDemoBrief.pdf.
2. *Id.* at 2.
3. *Id.* at 2-4.
4. *Id.* at 4-7.
5. *Id.* at 6.
6. *Id.* at 7-8.
7. *See* our Long-Term Acute Care Hospital Legal Alert Vol. 1, No. 2 (Pioneer ACOs, June 2011) at http://www.healylawdc.com/images/LTACH_Legal_Alert_-_Pioneer_ACO_-_June_2011.pdf and Long-Term Acute Care Hospital Legal Alert Vol. 1, No. 5 (Bundled Payments Initiative, Sept. 2011) at http://www.healylawdc.com/images/LTACH_Legal_Alert_-_Payment_Bundling_-_Sept_2011.pdf.
8. *See* our Long-Term Acute Care Hospital Legal Alert Vol. 1, No. 6 (Innovation Challenge, Nov. 2011) at http://www.healylawdc.com/images/LTACH_Legal_Alert_-_Innovation_Challenge_-_Nov_2011.pdf.

About Us

The Law Offices of Jason M. Healy PLLC is a health care law firm that focuses exclusively on legal issues affecting health care providers. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations. We also represent health care providers in reimbursement audits, appeals, and litigation. Located in Washington, DC, we are well positioned to provide legal support for advocacy efforts. Our principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.

Please feel free to reach us at the phone number or email address above if we can be of assistance. We look forward to working with you and your company.