CMS and ACA Implementation: Status and Implications for Providers
March 25, 2014
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Principal, FaegreBD Consulting
Agenda

► CMS and its Priorities for 2014
► Status of CMS Projects
► Implications for Health Care Providers
CMS and its Priorities for 2014
Pre-ACA Priorities

- **Core business**
  - Fee for Service (FFS) and Medicare Advantage (MA) delivery system
  - Paying FFS claims
  - Program Integrity (prevent fraud and abuse)
  - 1-800-Medicare consumer assistance
  - Medicare program operations
  - Medicaid program operations
Post-ACA Priorities

• **Continue Core Business**
  - Paying FFS claims
  - Program Integrity (prevent fraud and abuse)
  - 1-800-Medicare consumer assistance
  - Medicare program operations
  - Medicaid program operations

• **Evolve to New Payment Systems**
  - Implementing ACA provisions
  - Innovating health care delivery and payment systems
    - Imposing risk on FFS providers
    - Ensuring MA plans are paid appropriately (i.e., paid less)
  - Implementing ICD-10
  - Implementing Meaningful Use
  - Implementing Sunshine Act
Implementation—CMS Obligations and Process

SAMPLE Regulation/Guidance Timeline

*This timeframe assumes the agency started rulemaking on the day legislation was enacted.
ACA Implementation Status: 
A Changing Law of the Land
What has Happened Already?

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td>- Coverage for kids with pre-existing</td>
<td>- Limits on non-medical spending by health plans</td>
<td>- Hospital readmission penalties</td>
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<tr>
<td>conditions</td>
<td>- Physician quality reporting</td>
<td>- Accountable Care Organizations (ACOs)</td>
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<td>- Coverage for young adults under 26</td>
<td>- CMS Innovation Center</td>
<td>- Hospital value-based purchasing program</td>
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<tr>
<td>- Small business tax credit takes effect</td>
<td>- Community Based Care Transitions Program</td>
<td>- Pharmaceutical fees</td>
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<tr>
<td>- Federal Pre-existing Condition Insurance Plan (PCIP) takes effect (delayed)</td>
<td>- Medicare Advantage payment changes</td>
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<td>- Coverage for preventive care</td>
<td>- Medical Health Homes</td>
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<td>- Medicaid FMAP</td>
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<td>- Comparative effectiveness research</td>
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### What is Happening or Should Soon be Happening?

<table>
<thead>
<tr>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>Medicare Bundling Pilot</td>
<td>Essential benefits package</td>
<td>Employer coverage mandate takes effect for large (&gt;100) employees</td>
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<tr>
<td>Flexible spending limits</td>
<td>Insurance industry fee</td>
<td>(delayed from 2014)</td>
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<tr>
<td>Additional CHIP funding</td>
<td>Premium subsidies and cost-sharing benefits</td>
<td>Basic Health Program takes effect</td>
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<tr>
<td>Preventive services in Medicaid</td>
<td>Medicaid expansion</td>
<td>(delayed from 2014)</td>
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<tr>
<td>Electronic Exchange Standards</td>
<td>Medicare managed care plans</td>
<td>Small Business Health Options Plan (SHOP Act) takes effect</td>
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<tr>
<td>Medical device excise tax</td>
<td>Coverage begins in health insurance marketplace exchanges, including e-</td>
<td>(delayed from 2014)</td>
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<tr>
<td>Sunshine provisions</td>
<td>eligibility</td>
<td>Limits on out-of-pocket costs for consumers take effect</td>
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<tr>
<td>Open enrollment in health insurance marketplace begins (Oct. 1)</td>
<td>Yearly dollar limits on essential benefits eliminated</td>
<td>(delayed from 2014)</td>
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<tr>
<td></td>
<td>Maximum small business tax credit increases</td>
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<td></td>
<td>PCIP coverage ends (extended through April 2014)</td>
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<tr>
<td></td>
<td>Open enrollment through March 31</td>
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</tbody>
</table>

- Employer coverage mandate takes effect for large (>100) employees (delayed from 2014)
- Basic Health Program takes effect (delayed from 2014)
- Small Business Health Options Plan (SHOP Act) takes effect (delayed from 2014)
- Limits on out-of-pocket costs for consumers take effect (delayed from 2014)
**CLASS Act**
- Repealed

**Independent Payment Advisory Board (IPAB)**
- Cut $20 million
- Nominations delayed

**IRS**
- Budget frozen and then cut $350 million to hinder ACA implementation

**Congress**
- Increased federal subsidies allowed for Congress and staff

**Premium Subsidy**
- Eligibility calculations altered, saving $13 billion
- Requirements for income verification rolled back

**Prevention and Public Health fund**
- Cut $9 billion

**Medicaid**
- “Louisiana Purchase” cut $3.2 billion
- State Medicaid waivers
- Supreme Court decision and 25 states decline full expansion
- Delayed state Medicaid agency e-reporting requirements

**Employer Mandate**
- Employer mandate delayed to 2016 (2015 for >100 employees)
- Employer reporting delayed to 2015
- Form 1099 information reporting requirements REPEALED
- SHOP exchanges delayed to 2015

**Insurance Coverage**
- Pre-Existing Condition Insurance Plan (PCIP) enrollment suspended, coverage extended through 4/2014
- Funding for new health insurance cooperatives eliminated
- 3-month insurance enrollment extension
- Limits on some out-of-pocket costs for consumers
- Basic Health Plan Option delayed until 2015
- Consumers
ACA Implementation Status

Responding to budget and quality pressures by innovating health care delivery and payment systems
Failure to pass legislation triggered “across-the-board” automatic reductions of $1.2 trillion in discretionary and direct spending.

- **10% reduction for defense**
  - *8% in 2013*

- **8% reduction for non-defense**
  - *5% in 2013*

- **2% reduction max for Medicare**
  - *(up to $150-200 billion)*
  - *April 1*

- **0% reduction for Medicaid**
Taming the Budget

Discretionary
- Health examples: FDA, NIH, CDC, AHRQ, CMS IT/FTEs
- 5-8% non-defense cuts (2013 sequester)
- Additional cuts possible (2015 debt ceiling and final budget)

Entitlement
- Health examples: Medicare, Medicaid, ACA subsidies
- 2% Medicare (sequester)
- Additional cuts or reforms (as part of “biggish bargain”)

Revenues
- Health examples: ACA mandate tax, industry taxes
- Increased taxes:
  - individual rates
  - corporate rates, or
  - “loophole” reform

Deficit Reduction
Possible Entitlement Cuts

Overall potential target:
- $500 billion total, roughly allocated by industry as in ACA

Medicaid far less likely to be cut or changed but House very motivated
- MOE and partial expansion remain high interest

Medicare fee for service cuts remain high interest
- Generally avoid beneficiary impact
- Greatest impact on providers
- Plenty of collateral impact
- “Bad guys” remain targets: post-acute care (SNFs, IRFs, home health), DME, imaging, labs

Premium Subsidies
- Generosity of subsidy
- Income eligibility
### Medicaid Savers/Reforms

<table>
<thead>
<tr>
<th></th>
<th>Device</th>
<th>Drug</th>
<th>Hospital</th>
<th>Provider</th>
<th>Insurer/Plan</th>
<th>Beneficiary</th>
<th>State</th>
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</thead>
</table>
| **Eliminate state provider taxes**
($20 - $50B) |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |
| **Extend/rebase DSH cuts in FY ’24**
($3.3B)         |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |
| **Reduce state flexibility / maintenance of effort (MOE) (TBD)** |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |
| **Blended FMAP rate**
($17B)             |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |
| **DME Medicare rate caps**
($3B)             |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |
| **Move duals to managed Medicaid**
($12-$153B)       |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |
| **End primary care pay bump**
(Approx. $15B)    |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |
| **Increase fraud control**
($1-40B)         |  ●     |  ●   |  ●       |  ●       |  ●            |  ●          |  ●    |

Note: all savings occur over 10 years

- ● = More likely to happen
- ○ = Could happen
- ● = High impact
- ○ = Moderate impact
- ● = Limited impact

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### Medicare Savers/Reforms – Patient Cost Share Changes

<table>
<thead>
<tr>
<th>Means testing ($20-$55B)</th>
<th>Device</th>
<th>Drug</th>
<th>Hospital</th>
<th>Provider</th>
<th>Insurer/Plan</th>
<th>Beneficiary</th>
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<tbody>
<tr>
<td>Raise eligibility age to 67 ($125-$148B)</td>
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<td>Co-insurance for home health ($40-224B)</td>
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<td>Combined Part A/B cost share ($110B)</td>
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<td>Medigap reform ($38-54B)</td>
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<tr>
<td>Generics / brand cost-share ($8.5B)</td>
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- = More likely to happen
- = Less likely to happen
= Limited impact
= Moderate impact
= High impact

Note: all savings occur over 10 years
### Medicare Savers/Reforms – Drug & MedTech Changes

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<tr>
<th></th>
<th>Device</th>
<th>Drug</th>
<th>Hospital</th>
<th>Provider</th>
<th>Insurer/Plan</th>
<th>Beneficiary</th>
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<tbody>
<tr>
<td>MA Competitive Bidding</td>
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<td>($20-$60B)</td>
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<td>Imaging Cuts</td>
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<td>($1-5B)</td>
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<td>Expand prescription drug rebates for dual eligibles</td>
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<td>(Approx. $112-$135B)</td>
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<td>Increase fraud control</td>
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<td>($1-40B)</td>
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<td>Generics / brand cost-share</td>
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<td>($8B)</td>
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<td>ASP 103% for Part B drugs</td>
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<td>($7B)</td>
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<td>Accelerate Donut Hole rebates</td>
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- = Could happen
- = Moderate impact
- = High impact
- = Limited impact
- = Less likely to happen

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### Medicare Savers/Reforms – Provider Changes

<table>
<thead>
<tr>
<th>Payment cuts or freezes (Approx. $175B)</th>
<th>Device</th>
<th>Drug</th>
<th>Hospital</th>
<th>Provider</th>
<th>Insurer/Plan</th>
<th>Beneficiary</th>
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<tbody>
<tr>
<td>Eliminate bad debt payment ($24-$36B)</td>
<td>•</td>
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<tr>
<td>Extend 2% Medicare cut</td>
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<tr>
<td>Reduce GME/IME payment ($50-69B)</td>
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<tr>
<td>Increase fraud control ($1-40B)</td>
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<tr>
<td>SGR reform (Costs $12-15B)</td>
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<tr>
<td>Post-acute cuts/bundled pay (Approx. $9-98B)</td>
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</tbody>
</table>

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- Red = More likely to happen
- Black = High impact
- Yellow = Could happen
- Green = Less likely to happen
- Blue = Limited impact
- Orange = Moderate impact

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Budget and Quality Pressures on CMS

Payor agencies (Medicare, Medicaid) under substantial cost-cutting pressure, and pressure to improve care quality

Cost reduction: “Bend the curve of growth”
- Control spending both in public programs and commercial insurance
- Shift from traditional fee-for-service (dis)incentives and move toward managed care and shared risk; patient-centered approaches
- Utilize lowest-cost settings and providers
- Use market approaches

Focus on quality, outcomes, efficiency, appropriateness
- Coordinate care
- Measure performance to standards
- Impact within-episode and across-continuum care

Recognize inherent link and tension between cost reduction and quality improvement
Agency Strategies to Address the Fiscal Crisis

Value Based Purchasing
- Hospital VBP
- Physician Quality Reporting Initiative (PQRI) and VB Modifier
- Hospital Readmissions
- Healthcare Acquired Infections
- MA Star Ratings
- Never Events
- CMS Study on HHAs
- SGR Reform Incentives
- Post-Acute Care VBP

Bundled Payments/Aligning Incentives/Care Coordination (Episode-based)
- Care Transitions (CTTP)
- Acute Care Episode (ACE) Demo
- Gainsharing Demo
- CMMI Bundled Payment Initiative
- National Payment Bundling Demo?
- CMMI Innovation Challenge
- Post-Acute Care Bundle

Bundled Payments/Aligning Incentives/Care Coordination (Non-Episode)
- Accountable Care Organizations (Shared Savings)
- Pioneer ACOs
- Special Needs Populations (SNPs)
- Medical Homes
- CMMI Innovation Challenge
- Dual Eligibles

Diversion
- State Balancing Incentives Program
- Medicaid Home and Community Based Services State Option Plan
- Community First Choice Option
- Money Follows the Person Rebalancing Demo
- Program of All Inclusive (PACE)
- Independence at Home Demo

Competitive Bidding
- Medicare DME
- Medicare Part D
- Medicare Advantage
- Medicare Advantage Cuts
- Medicare Advantage
- Medicare "Premium Support"?

Payment Cuts
- Independent Payment Advisory Board (IPAB)
- Medicare Advantage Cuts
- Market Basket Updates – Productivity Adjustments
- Disproportionate Share Hospital Cuts
- Sequestration (2% Medicare Cut)
- Medicaid FFS
- Post-Acute Care cuts
SGR Status

Background

- SGR formula intended to control Medicare Part B reimbursement to physicians; imposes cuts on reimbursement if spending growth exceeds plan
- Formula is overly constraining and so Congress has deferred cuts annually for 6 years using "budget gimmick" that kicks cuts "down the road"
- Current planned cuts of 30% will occur March 31, 2014

New value-based payment policy has been agreed on by Congress

- Repeals SGR and provides a period of predictable, statutorily-defined payment rates
- Establishes value-based payment approach instead of automatic cuts
- Incentive payments for physicians who perform well on quality measurements
- House and Senate, Democrats and Republicans, agree on the approach

Cost of repeal is the lowest in memory
SGR Status

However, Congress disagrees on how to proceed

House
- Intends to kick the can again for 9-12 months; and protect physician reimbursement
- Wants to pay for the cuts with delay of ACA individual mandate or other provider cuts

Senate
- Intends to kick the can again for 9-24 months; and protect physician reimbursement
- Either won't pay for the cuts (increases the deficit) or will pay for budget gimmick (use "savings" from ending the wars in Iraq and Afghanistan)

Cost of deferral of cuts
- ~ $15 billion for 9 months
- ~ $135 billion for 10 years

Next opportunity for resolution: lame duck session late in 2014 or next year with the debt ceiling
Implications for Health Care Providers
Implications for Providers and Industry Customers

- Providers increasingly put “at risk”
  - Bundled payments, care coordination
- Providers increasingly subject to quality measures
  - Reporting and value-based systems
- Providers using most efficient settings and staff are advantaged
- Consolidation increasingly valued by providers for its efficiency or ability to control referrals, networks, and prices
- Employee providers increasingly valued for its efficiency
- Disruptive technologies and services become essential
Recommendations

► Be aware of the full range of opportunities and threats associated with access to “old” fee for service system
► Consider proactively moving with the federal program toward “new” payment methods wherever possible
► Care coordination; bearing risk; use of care extenders and efficient site of care…all are viewed as high value
► Integrate social service solutions with health care solutions
► Take into account state law and actions (Medicare, health reform, and exchanges)
► Demonstrate cost impact on federal system
► Demonstrate favorable quality/patient outcomes
► Develop evidence – as robust as possible but don’t let the perfect be an enemy
► Consider pilots/demos or narrower scope where there is pushback
► Develop scalable solutions
ACA Implementation Status
New Data Collection Tools
ICD-10 Implementation

Background:

► 10th version of the International Classification of Diseases
► Provides additional codes covering essential conditions, supplies, services, procedures
► Important Florida-related examples:
  ► V9542XA (Forced landing of spacecraft injuring occupant, initial encounter)
  ► V9027XA (Drowning and submersion due to falling or jumping from burning water-skis, initial encounter)
► 17,000 codes under ICD-9; 155,000 under ICD-10
► Long supported by CMS as a tool to get better insight into health care utilization
► Now supported by CMS as a tool to constrain spending, developing new payment methods
► Considered by CMS to be "the foundation for health care reform"
► Long feared by providers
  ► Costly systems upgrades, and training
  ► Slower claims filing
  ► No code, no payment; wrong code, no payment
ICD-10 Implementation (cont.)

CMS Status:

► Implementation dates
  ▪ Long-delayed (since 2006)
  ▪ Now set for October 2014
  ▪ No sign of further delays
► Limited end-to-end testing
  ▪ Only a small group of providers in summer of 2014

Provider Status

► As many as 75% of providers have done nothing to prepare
► Large health systems are generally implementing training and computer updates in February
► 20 of 50 states have not updated their systems
Meaningful Use Implementation

► $20 billion in incentives to providers to use electronic medical records
► Included in 2009 stimulus bill; started in 2011 and continues through 2016 (extension to 2017). Medical professionals can participate for up to 5 continuous years.
► CMS views it as essential tool to improve patient care and interoperable exchange of data
  ▶ some appreciation for potential to improve quality of patient care
  ▶ concern for cost and delays with utilization
  ▶ technology challenges are serious
  ▶ promise of interoperability remains remote
► The last year to begin participation (without penalties) is 2014
► Penalties for not demonstrating meaningful use begin in 2015 (1% reduction increasing annually to 5%)
► Dec 2013 CMS proposed extending Stage 2 through 2016 and beginning Stage 3 in 2017 (for providers that completed two or more years of Stage 2)
Sunshine Act

Background:
- Requires disclosure of relationships with medical product manufacturers (drugs and devices)

Implementation timeline:
- Web-based reporting system due March 30, 2014
- Same company as the one that built the federal health care exchanges
- Manufacturer files initial reports
- Providers provide comments/edits where the reports are not accurate
- CMS provides public access September 30, 2014

CMS Status:
- Web-based system not on time (surprise!)
- Email-based system will be used
- CMS still intends to provide public access as scheduled
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