Ralph Levy, Jr.

"Back to the Future": Implications of Recent Developments in Physician Payment Methodologies

Providers Need to Step Up Their Efforts to Monitor Future Trends and Manage Patient Treatment

Ralph Levy, Jr. is of counsel in the Nashville, Tenn. office of Dickinson Wright PLLC. He can be reached at 615/620-1733 or by email at rlevy@dickinsonwright.com. Dickinson Wright PLLC is a full-service law firm with almost 300 attorneys with offices in Michigan, Tennessee, Arizona, Nevada, Ohio, Washington, D.C., and Toronto, Ontario.

Recent announcements by the Centers for Medicare & Medicaid Services (CMS) as to physician payment changes for 2013 and the adoption and implementation of new methods to compensate primary care physicians for patients covered by private health plans are important "early indicators" of dramatic future changes in physician reimbursement. The CMS announced changes in physician compensation include the implementation of policy changes to "improve patient care and lower health care costs long term" (quoting Marilyn B. Tavenner, who is the CMS Acting Administrator, in a July 6, 2012 announcement of the proposed 2013 Medicare payment changes to physicians).

The changes that are being initiated by private insurers are driven by the realization that, because improvement of the overall health care of their policy beneficiaries will decrease the costs of medical care for their insured population, health insurers should encourage their patients to seek preventative care. These recent developments indicate that methodologies in payment for physicians will likely change rapidly and dramatically in the future and that governmental payers and private insurers may "revert to the past" by emphasizing primary patient care of their beneficiaries to prevent the onset of diseases and other expensive medical conditions.

Back to the Future Event #1:

CMS Announces Payments in 2013 and 2014 for Certain Primary Care Services Provided to Medicaid Patients

In early May, CMS issued a proposed rule that implemented a provision in the Affordable Care Act that increases payments during 2013 and 2014 to certain phy-

sicians who provide primary care services to Medicaid patients. CMS will make these payments to physicians who specialize in family medicine, general internal medicine, or pediatric medicine and related subspecialties. Only primary care services provided by these physicians will be eligible for these supplemental payments, the purpose of which is to make certain that eligible physicians are compensated for these services provided to Medicaid beneficiaries in an amount at least equal to the rate payable by CMS if they were furnished to Medicare program beneficiaries.

Because the financial responsibility for these supplemental payments will be borne initially by the states that administer the applicable Medicaid programs, CMS will compensate these states for 100 percent of the costs incurred by the states in making these payments. All services billed under the eligible physician's Medicaid provider number, including primary care services rendered by nurse practitioners under the supervision of the eligible physician, are eligible for payments under this program, which also covers patients enrolled in Medicaid managed care plans. States are given options to determine the rates of reimbursement for these services, which are initially based on payment rates for 2013 and 2014 primary care physician services provided to Medicare patients.

In large part because of the scrutiny over the constitutionality of the legislation as a whole in the case recently decided by the Supreme Court, this Affordable Care Act provision that calls for increased payments for Medicaid primary care physician services has received little publicity. However, the concept of "equalizing" payments for primary care services provided by physicians to Medicaid and Medicare patients is a potential "back to the future" trend for two reasons.

First, the limitation of these supplemental payments to primary care services only is an early indicator of a potential "future trend" — emphasis on primary care services and preventive care in particular. This might indicate a preference to primary care physician services over services provided in the treatment of known medical conditions by specialists such as surgeons and anesthesiologists. Although it is likely that preferential treatment of primary care physician services will continue through Congressional action or by CMS policy decisions that are designed to improve preventative care, it remains to be seen whether special payment provisions for primary care physician services will result in patients' enhanced usage of the services of primary care physicians. If so, this trend is reminiscent of the prior physician practice pattern in which a patient uses the services of only one physician as occurred in years past.

The second important aspect of this proposed rule as to payment for certain physician services provided to Medicaid patients is the elimination of a payment disparity in payments for primary care services provided by physicians to Medicaid and Medicare patients. Although these additional equalizing payments for such services do not eliminate other distinctions in program benefits to Medicaid and Medicare beneficiaries or in governmental payments for other types of physician and other health care services provided to these patients, a single reimbursement rate for similar services provided to both Medicare and Medicaid program participants could be a very small first step toward a single payer health system as is prevalent in other countries.

It will be interesting to monitor future governmental physician payment changes to identify the continuation of what appears to be a trend toward encouraging primary care physician use and equalizing payments to providers of services to Medicaid and Medicare patients.

Back to the Future Event #2:

CMS Announces Medicare Payment for Discharge Transition Care Provided by Certain Primary Care Physicians and Details about Voluntary Program for

Quality-Based Payment Initiatives to Physician Groups

On July 6, 2012, CMS announced proposed changes to the Medicare Physician Fee Schedule (MPFS) for services furnished by physicians during calendar year 2013. Included within these changes are 7 percent payment increases to family physicians and increases to other primary care physicians of between 3 percent and 5 percent. However, 2013 payments to physicians with certain other specialties will be reduced (for example, anesthesiologists and cardiologists will incur a 3 percent payment *reduction*).

The major component of the proposed increased payments to primary care physicians is a new separate payment to a patient's community physician or practitioner for coordination of care of the patient during the first 30 days after discharge from a hospital or nursing home stay. This represents the first time that CMS has proposed to pay for the care required of patients as they transition back into the community after a stay at a hospital or skilled nursing home.

This discharge transition care payment represents 5 percent of the proposed 7 percent payment increase to family physicians. In the announcement that accompanied the proposed regulations, CMS noted that this payment for discharge transition care management dovetails with the Affordable Care Act mandated program that seeks to reduce payments to hospitals that have excess readmissions for certain medical conditions.

Also included within the proposed rules are changes to several previously implemented quality reporting initiatives and, as authorized by the Affordable Care Act, a voluntary program through which payments to physicians are adjusted based on the quality and cost of care they provide to their patients. Groups with 25 or more physicians that elect not to participate in the physician quality reporting program will eventually incur a 1.0 percent payment reduction.

With the July announcement as to 2013 payments for physician services to Medicare patients, CMS indicated its willingness to encourage through a new payment stream the care by physicians of patients as a means to reduce hospital readmissions after discharge from a hospital or nursing home stay for treatment of certain conditions. This is quite a different form of a payment-driven solution to a specific problem — excessive hospital readmissions — than the use of a bundled payment that compensates all providers of services during a single hospital admission and for a specified time period after discharge. (See this author's article entitled *Beware the Bundle: Medicare Announces Pilot Program for Bundled Payments to Providers*, which appeared in the May-June 2012 issue of this publication that described a pilot program launched by CMS to enable it to develop a single bundled payment to all providers for a single "episode of care" — a hospital stay.)

Only time will tell if the discharge transition care payment will remain in effect beyond 2013 and, if so, whether it will continue as a separate payment or as an additional element of a bundled payment that includes compensation for post-discharge physician services. Physician groups and other health care providers should monitor the potential for expansion of this "to the future" trend to both hospital stays and in other areas.

Although the details of the program by which physician groups can elect to be compensated for improved quality of care provided to patients as compared to the assumed costs for those services and the potential for payment reductions to physician groups that decline to participate in this "voluntary" program are beyond the scope of this article, this program is yet another example of a policy change in which providers (in this case, physicians) are "paid for performance" as compared to being "paid for each service." In other words, physicians and other providers of services to Medicare patients will soon have to "quan-

tify quality" and can expect that in the future their payments for services will be partially dependent on the quality and cost of services they provide to their patients.

It remains to be seen if the recently announced quality of care initiative is a harbinger to a future capitated payment model in which primary care physicians and possibly other physicians receive a specified payment per month for each patient under care that is only partially adjusted for the actual services provided such patients or for their acuity. This "to the future" trend is also one worth watching.

Back to the Future Event #3:

Exploration of New Payment Models — "Direct Primary Care" Physician Services and Payment for Enhanced Primary Care Services by Private Insurers

Turning to recent physician reimbursement changes prompted by private payers rather than CMS, two areas are worth watching. The first is one in which physician groups provide primary care services on a "capitated" basis to all employees of a business. Under this model, employers separately contract with a physician group for primary care services at a fixed price per employee payable to the physician group that varies only based on the number of covered employees. The employees of the business obtain better access to care without having to submit insurance claim forms or worry about deductibles or copayments.

The hope of the employer is that as a result of this program, its employees will be more likely to seek preventative care, which ultimately will result in savings for medical costs and a limit on health insurance plan premium increases. Most employers that adopt the direct primary care model also maintain high deductible health insurance plans to cover the costs of hospitalizations and visits to specialists by their employees. Thus, an employer that uses this new model for its business has two categories of expenses: monthly payments to the primary care group that provides direct primary care and monthly premiums payable for its high-deductible health insurance plan.

Due to Medicare program participation limitations, physicians that participate in such a program cannot treat any patient who is Medicare eligible. Whether programs such as the direct primary care program described above will reduce the number of primary care physicians who treat Medicare-eligible patients remains to be seen. To avoid a further decline in the number of physicians who treat Medicare patients, the other possible "future trend" is whether CMS will consider the direct patient care model as it explores changes in payment methodologies for health care in order to control costs. If so, it is likely that this model will first be tried in pilot or demonstration programs before being rolled out program wide.

In a related development, on June 6, 2012, CMS announced a new initiative, called the Comprehensive Primary Care (CPC) initiative, by which CMS will partner with 45 commercial, federal, and state insurers in seven different markets to provide enhanced primary care services to patients that participate in the program. For the first two years of the four year program, CMS will pay the 75 primary care practices in each of the seven designated markets a payment on average $20.00 for each Medicare or Medicaid patient per month (called by CMS a per-beneficiary-per-month care management fee or PBPM). Although the PBPM payment from CMS will be reduced to approximately $15.00 per month in the third and fourth years of the CPC initiative, the primary care practices will have the opportunity to share in savings from the cost of care provided to their patients during the second, third, and fourth years of the CPC initiative.

In return for the PBPM payment from CMS, the primary care practices that participate in the CPC initiative must provide enhanced primary care services (such as longer and more flexible hours, the use of

electronic health records, coordination of care with other health care providers, and individualized enhanced care for patients with multiple chronic diseases) to their patients. The other payers that participate in the program also will pay the practice groups that elect to participate in the program a monthly amount that will vary market by market.

According to CMS, the objective for these additional payments is to "allow [the practice groups] to integrate multi-payer funding streams to strengthen their capacity to implement practice-wide quality improvement." It will be interesting to see whether a sufficient number of primary care practice groups submit applications to participate in the CPC initiative. (Applications were due to be submitted by July 20, 2012.)

In summary, it is highly likely that payment methodologies for physician services will continue to change rapidly and dramatically in the future regardless of whether services are being provided to patients with governmental health insurance (Medicare or Medicaid) or to those with private insurance coverage. Regardless of whether or not the payment models that are adopted in the future include capitated payments (per patient per month), enhanced payment for primary care and other preventative care services or other as yet unspecified methodologies, it remains to be seen if physicians will have the option (*i.e.*, will not be required) to participate in shared savings programs using either the carrot (bonus payments based on improved quality of care and reduced cost of services) or the stick (payment reductions for failure to achieve quality of care indicators or markers). In addition, it will be interesting to see if the returned focus on primary care physician services continues (the reversion to a practice pattern for physician care as in years gone by, *i.e.*, the "back" in "back to the future").

What is certain is that physician groups (and other health care providers as well) need to be conscious of the need to monitor the future trends and changes in payment methodologies. At the same time, they should continue to invest in their ability to manage on a real-time basis patient-related health and treatment information, which information will be required in order to receive compensation for services rendered regardless of payment methodology.

Reprinted from Journal of Health Care Compliance, Volume 14, Number 5, September-October 2012, pages 59-63, with permission from CCH and Aspen Publishers, Wolters Kluwer businesses.
For permission to reprint, e-mail permissions@cch.com.