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Medicare's Doc Pay Plan Has Hospitals Eyeing Bottom Line

By **Jeff Overley**

Law360, New York (July 15, 2013, 8:45 PM ET) -- Medicare's new proposal to pay primary care physicians for managing the sickest patients without requiring face-to-face interaction carries hidden financial implications for hospitals, potentially helping them duck readmission penalties but also eating into their income by preventing admissions in the first place, experts say.

In a proposed rule issued last week, the Centers for Medicare and Medicaid Services said that starting in 2015, it intends to allow doctors to bill for an array of services provided to patients with two or more chronic diseases. Characterized as "advanced primary care," covered services would include the development and revision of a treatment plan, communication with other practitioners and the evaluation of medication a patient is taking.

To the extent chronically ill patients are at some point also treated by a hospital for one of five common ailments that can trigger readmission penalties, that extra care by physicians might help keep them from quickly returning for more inpatient treatment.

"That increased intensity on the part of the physician is definitely going to have a spillover effect on the hospital side," said Alex M. Brill, an economic policy adviser at Hooper Lundy & Bookman PC.

Right now, hospitals can be dinged if patients return within 30 days of treatment for heart attacks, heart failure or pneumonia. Next October, the agency will also look at readmissions related to hip or knee replacements and chronic obstructive pulmonary disease.

The current 1 percent readmissions penalty will rise to 2 percent in October before leveling off at 3 percent the following year.

Hospitals have complained that readmissions are very difficult to prevent when it comes to extremely ill patients, and by incentivizing primary care doctors to step up their involvement, CMS is effectively giving hospitals a helping hand, said Andrew Ruskin, a health partner at Morgan Lewis & Bockius LLP.

"If you allow patient management to get reimbursed, it should be easier to help keep them out of the ER, which would mean that the hospitals that are trying to keep their readmissions low [would benefit]," Ruskin said.

The policy shift seems to represent another layer in the Obama administration's bet that prevention and coordinated care are key to improving outcomes and preventing the nation's health care spending from spiraling completely out of control.

It also would join other incentives for physicians treating very ill patients, including reimbursement for overseeing care plans for people in hospices and a payment code created last year for services aimed at helping a patient transition back into the community after a stay at a hospital or long-term care venue.

Jason B. Caron, a partner at McDermott Will & Emery LLP, cautioned against expecting too much out of paying doctors for chronic care management, saying that while "there is some promise" in the idea, "you always have a tricky dynamic with coordinating care."

Indeed, CMS' proposed rule contains several provisions that could give pause to any observers hoping for dramatic results. For one thing, it requires a doctor to spend at least 60 minutes on coordinating a single patient's care in order to qualify for extra compensation. That prevents CMS from having to shell out cash for small bits of work that are perhaps less likely to pay great dividends for a patient, but also potentially discourages smaller investments of time that could still show results.

"Maybe 30 minutes of care coordination is important but doesn't get reimbursed," Brill said.

Further, only one payment per patient is allowed every 90 days, and payments in subsequent 90-day periods would only be allowed if there was a need for a "substantial revision of the care plan," CMS wrote.

And in order to be permitted to bill for chronic care management, physicians are required to provide "24-hour-a-day, seven-day-a-week beneficiary access to the practice," regulators proposed.

All that said, assuming that real coordination does emerge, then "it could definitely have an impact on hospital admissions and readmissions," Caron said.

That seems to be CMS' goal, as the agency wrote in the proposed rule that "successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs — for example, through reductions in hospitalizations, use of post-acute care services and emergency department visits."

And by specifying cost-cutting as a goal, CMS showed that the policy could cut both ways by keeping patients from visiting hospitals in the first place. That would take readmissions penalties off the table, but those savings could be dwarfed by lost income from inpatient visits that never materialize, said Thomas S. Crane, a health member at Mintz Levin Cohn Ferris Glovsky & Popeo PC.

"I think it's more likely that it will reduce admissions overall," Crane said. "I think it's going to have a minor impact on reducing unnecessary readmissions."

It's also possible that the overall impact could be virtually a wash — admissions decline, but chronically ill patients continue to frequently require hospital outpatient services, partly offsetting lost revenue from inpatient visits.

On the whole, the initiative seems likely to improve patient care, and so hospitals should take the unusual step of publicly advocating for a proposal related to primary care reimbursement, Ruskin said, arguing that while income is important, hospitals will be happy to see other providers helping to manage the toughest patient cases.

"On the margins, there will be cases that would have gone to the hospitals that won't," Ruskin said. "[But] they're not looking for a constant revenue stream from the same patient cases."

--Editing by John Quinn and Chris Yates.