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Paying Patients Part of Medicare Savings Proposal

Incentive payments to Medicare patients that encourage them to improve their health are one of the ideas floated as a way to spur doctors and hospitals to take more accountability for patients' health costs.

Under a proposal released Aug. 9, the Centers for Medicare & Medicaid Services is considering ways to persuade coordinated care groups to take on more financial risk for their patients' health-care spending. The proposed rule (RIN:0938-AT45) would provide incentives through waivers for some Medicare requirements and changes to how performance measures are calculated for these organizations, known as accountable care organizations or ACOs.

Accountable care organizations are groups of doctors, hospitals and providers who coordinate care for patients and are rewarded for providing high-quality care while creating savings for Medicare. ACOs can share in the savings to Medicare if they meet certain quality standards. Right now most ACOs share in savings, but a small minority are actually sharing in financial risk, often called downside.

''When ACOs are willing to take on more downside risk, CMS is willing to provide more flexibility in how they provide services,'' Josh Seidman, senior vice president at the Washington health-care policy consulting firm Avalere Health, told Bloomberg Law Aug. 10.

There are 561 ACOs in the Medicare Shared Savings Program, and all would be affected by this rule, according to the CMS. Those ACOs serve 10.5 million beneficiaries in Medicare. The program was set up under the Affordable Care Act.

Some of the top-performing ACOs include the Palm Beach ACO LLC., Illinois-based Advocate Physician Partners Accountable Care Inc., and Hackensack, N.J.-based Hackensack Alliance ACO, according to CMS data.

Comments are due Oct. 16 on the proposal. When final, the rule will go into effect July 1, 2019. The ACOs that are already operating will have their agreements with the government extended until June 30, 2019, instead of the usual Jan. 1 expiration date.

Incentives for Good Health Most Medicare beneficiaries in an ACO are unaware their care is being coordinated under such an organization. With the proposal, the CMS is trying to improve how health-care providers communicate with patients about the ACO and its goals and benefits, Seidman said.

The proposal would require providers to notify beneficiaries that their provider is in an ACO.

The rule would also allow providers in ACOs that take on risk to give beneficiaries a $20 incentive payment for each qualifying primary care service they receive. The voucher is an ''incentive for taking steps to achieve and maintain good health'' for patients, according to the rule. The voucher could be used for preventive care items or services or advance a health goal for the beneficiary.

The beneficiary incentives will allow providers to ''engage with beneficiaries in a different way and to keep them engaged,'' Aisha Pittman, senior director of payment policy at Premier Inc., told Bloomberg Law Aug. 10. Premier is a health-care alliance that unites hospitals and other health-care providers across the U.S.

By keeping patients engaged, doctors and other providers can help them understand changes in care and better manage their care, which Pittman said will ultimately lower costs over time.

If providers have more flexibility in how to engage beneficiaries initially, it may prevent high cost use later, Seidman said.

Waivers ACOs are already waived from certain provisions of the physician self-referral law known as the Stark law, which prevents physicians from referring patients to medical facilities where they or their immediate family members have financial interests. They also have waivers from the anti-kickback statute, which prohibits payments for recommending products or services to patients covered by Medicare or Medicaid.

The new proposed rule would give ACOs that take on financial risk a waiver from the skilled nursing facility three-day rule. The rule requires a patient to stay three days in an inpatient hospital, acute care hospital, or critical access hospital prior to admission to a skilled nursing facility.

Health-care providers that take on risk would get Medicare payments for telehealth services starting Jan. 1, 2020, even if the beneficiaries don't meet geographic limitations for telehealth.

Benchmark Setting The CMS calculates financial benchmarks for each ACO to assess its financial performance. That benchmark is used to calculate how much of the savings the ACO will be able to share in.

There is concern from some providers and researchers that current ACO benchmarks may be underestimating the savings ACOs provide to Medicare.

The way benchmarks are calculated now don't reflect the actual patient population, Pittman said. Premier is happy the CMS is willing to change that to make them more reflective.

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The proposal would make changes to the methodology for determining the benchmarks by including regional and national spending growth rates. The rule would also change the methodology for risk adjusting by reflecting changes in health status of beneficiaries over the length of the agreement period.

The CMS is recognizing there is a disincentive for providers to participate without including regional measures in the benchmarks, Seidman said.

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