Federal Changes in the Delivery of Health Care

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"The future ain't what it used to be"
Baseball Hall of Fame Player and Former New York Yankees Coach Yogi Berra

There may be a few people in the country that don't know about the recent enactment of the comprehensive health care system reform law, otherwise known the Patient Protection and Affordable Care Act (PPACA) of 2010. This new law, to be implemented over the next few years, includes several future Medicare hospital and cardiovascular physician payment policy changes, along with the imposition of new medical device tax on manufacturers of cardiovascular equipment and supplies used by perfusionists in the operating room.

The AmSECT Government Relations Committee has and is focused on perfusionist state credentialing for protection of clinical practice entry requirements to better ensure patient safety and the competent delivery of perfusion services. However, knowledge about other public policy changes that indirectly impact the profession is also valuable. Examples are the safety and effectiveness of medical devices used by perfusionists and regulated by the Food and Drug Administration (FDA), changes in Medicare CMS (CMS-Center for Medicare and Medicaid Services) coverage, and reimbursement policies impacting hospitals and physicians for providing high cost surgical procedures.

The members of the Government Relations Committee share the opinion that knowledge regarding such matters should not be excluded from a perfusionist's day-to-day clinical practice. Perfusionists grow wise in the science, techniques, and technologies in their own profession, but they need to have some fundamental understanding regarding the "external" governmental influences and factors impacting their work environments. These regulatory issues are important whether perfusionists are employed by hospitals, surgeon groups, or independent contract providers of services. With this in mind, the following overview highlights some of the coming changes in Medicare payment policy. Other health care reform changes will be discussed in *AmSECT Today* with future concise GRC articles.

Medicare Bundling of Physician and Hospital CABG and Heart Valve Replacement Case Payment

In the 1990's the Medicare Participating Heart Bypass demonstration project found that bundling of hospital Diagnosis Related Group (DRG) payments and Medicare Physician Fee Schedule (PPS-Prospective Payment System for physicians) payments could reduce Medicare costs for these types of

high cost cardiovascular procedures. In 2008, the Medicare Physician Advisory Committee (MEDPAC) recommended to the Congress, and the Congress approved a two-year pilot program for these types of cases. Five hospitals were selected from different parts of the country to participate.

At these pilot project hospitals, each hospital would receive a combined payment amount that included the DRG payment amount and the cardiovascular surgeon PPS payment amount. To get Medicare beneficiaries to use these hospitals, they would receive an incentive payment that could be used as they saw fit. The pilot project Medicare cost data collected showed a combined 5% cost savings reduction for CABG and Heart Valve cases done in these five hospitals.

In the Medicare sections of the Patient Protection and Affordable Care Act (PPACA) (PL 111-148), the CMS has been given the regulatory authority to expand the pilot program to a two year Regional Demonstration program starting in 2011, and authority to convert this to a national payment system in 2013, or there after, based on the collection of more cost and utilization data.

Two adjustments when converting to a national payment system would also come into play. First, university and teaching hospitals would be exempt from the "global fee" payment for hospital and physician services. Second, rural based hospital global fee reimbursement amounts would be adjusted to reflect a surgical case index number. Under current Medicare hospital DRG payments, rural based hospitals already receive a percentage increase from what is paid to urban hospitals to reflect the higher cost of hospital care, due to unique manpower and demographic issues in less populated areas.

Physician/Cardiovascular Surgeon Reaction

In the June 2008 report and recommendation to Congress on bundling of high cost surgical procedures, not just CABG and heart valve cases, the MEDPAC argued that even though hospital DRG payments were already a bundled payment. They felt that extending the concept to physicians would encourage doctors and hospitals to work together to control Medicare program costs and improve patient quality of care. Of course, cardiovascular physicians and other medical specialty physicians took issue with the concept of giving hospitals too much control over physician payment rates. Sending a lump sum payment might potentially provide an incentive to skimp on medical care services to maximize hospital profits.

While these arguments were generally rejected during the Congressional and public debate over the Medicare reimbursement reforms promulgated and subsequently enacted into law, a post passage financial analysis was performed by the CMS covering the complete range of Medicare payment system reforms. It showed that hospitals and hospital administrators will be facing tough challenges as well. Without delving into the other major payment policy changes directly impacting the financial viability of

hospitals in the future, the CMS has estimated that one in six hospitals in the country (15%) could very well go bankrupt over the next ten years. For example, the hospital DRG payment rate for 2011, as now scheduled, will be further reduced by 2.9%. This reduction will be included in the bundled payment rate for the global fee paid to hospitals for high cost surgical procedures.

Indirect Impact on Perfusion Practice and Future Income Potential

Reimbursement changes by the Federal Government are not the only change we will see. There is a newly enacted medical device tax on manufacturers of cardiovascular equipment and supplies used by perfusionists and all other health care professionals. The Health Information Technology for Economic and Clinical Health (HITECH) enacted in 2009 mandates hospitals to have a seamless interoperable patient medical record information system by 2014 or face Medicare payment penalties. It remains to be seen how these new laws will affect perfusionists, regardless of how they are employed or conduct their clinical practices. The impact on salaries, benefits, and the ability to continue to provide innovation in the delivery of patient care are largely unknown. This is not only true of the perfusionist community, but also every other health care professional.

These changes upon us clearly demonstrate what a famous New York Yankees Coach said many years ago – “The future ain't what it used to be”. The health care industry in the United States is likely to be one of constant change for the foreseeable future.