

Medicare Reimbursement in 2012

Navigating Significant Changes in Reimbursement Methods

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February 14, 2012



Today's Presenters



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PPACA Medicare Policies in 2012

- Introduction – Welcome
- Health Reform Law consists of two acts:
 - Patient Protection and Affordable Care Act (PPACA)
 - Health Care Education Reconciliation Act (Reconciliation Act)
 - We refer to both as the Health Reform Law or “PPACA”



Medicare Laws – Major Reforms Now and in Future – How Do We Cope?

- Today's presentation – continuing PPACA changes to the Medicare laws:
 - Continuation of experiments and fundamental changes
 - New and continuing CMS initiatives
 - Congress and the Administration using Medicare payment policy to shape national health policies



Pay for Quality (Value-Based Purchasing)

- Pay for good quality, penalize for bad quality
- Starts with pay for reporting
- Strategy: Reform quality monitoring, but also
 - Change medical records
 - Billers must be involved with charting quality in medical records/other reports
 - Spillover effect on private payors
- Next level strategy – enhance physician/hospital affiliation strategies to maximize payment and publicize results on these new measures



Medicare Value-Based Purchasing

- Health Reform Law significantly increases link between Medicare payments to providers and quality of services furnished, and patient outcomes
 - Payment adjustments added
 - Additional evaluations of quality reporting and payment adjustments added
 - Future measures will be added



VBP - Acute Care Hospitals

- Effective for discharges on and after 10/1/2012, Secretary of Health and Human Services (HHS) will make value-based incentive payments
- Effective for discharges on and after 10/1/2013, Secretary must also include efficiency measures, including amount of Medicare spending per beneficiary.
- CMS expanded Inpatient Quality Reporting (IQR) program, which collects quality data.



VBP – Acute Care Hospitals

- Starting in 2014, VBP program will have four domains: clinical process of care, patient experience of care, outcomes and efficiency.
- The VBP Program applies beginning in FY 2013 to payments for discharges occurring on or after October 1, 2012. The performance period for calculating a hospital's FY2013 reimbursement begins on July 1, 2011.



VBP - Acute Care Hospitals

- Get incentive payment if meet or exceed performance standards.
- Higher the score, greater the incentive payment.
- Reductions in payments for low scores.
- Incentive payment is budget neutral.
- Payments will be reduced by 1 percent in FY 2013; 1.25 percent in FY 2014; 1.5 percent in FY 2015; 1.75 percent in FY 2016; and 2 percent in FY 2017 and beyond.



VBP - Physicians

■ PPACA:

- Incentive payments for reporting data extended through 2014.
- In 2015, payments for physician whose quality data is unsatisfactory will be reduced.
- 2015 reduction is 1.5%.
- 2016 and later years, reduction is 2.0%.



VBP - Physicians

- FY 2015 start date of VBP for physicians is mandated by law.
- CMS proposed in regulations to use a 2013 reporting period to determine how pay will be adjusted for some physicians in 2015.



VBP - Physicians

- 1/1/2012: CMS outlines steps for establishing the modifier.
- 1/1/2013 – 12/31/2013: CMS starts measuring physician services to determine modifier adjustments in 2015. CMS begins implementing the modifier through the physician fee schedule rulemaking process.
- 1/1/2015: CMS starts applying the modifier to specific physicians and groups.
- 1/1/2017: CMS starts applying the modifier to all physicians and groups.



LTCHs, Inpatient Rehab Facilities, Inpatient Psych Hospitals, Hospices

- Quality reporting required to be implemented.
- Quality measures must be published by 10/1/2012.
- Reduction effective 7/1/2013 or 10/1/2013 for long term care hospitals (LTCH), inpatient psych hospitals and psych units, inpatient rehab facilities, and hospices.
- Failure to submit quality data will result in 2.0% reduction in Medicare payment updates.



PPS-Exempt Cancer Hospitals

- Quality reporting required to be implemented with quality measures published by 10/1/2013.
- Providers failing to submit data will be subject to 2.0% reduction in Medicare payment updates.



SNFs, HHAs, ASCs

- Secretary must submit to Congress a plan to implement value-based purchasing programs for above providers by 9/30/2012.



Public Information on Quality

- Quality data reported to CMS or its agents is gradually being made available to public.
- Providers should consider including their published quality data in marketing, public relations, government relations.
- Level of focus on quality will be highest on published data; less on non-published indicators.
- Hospital Compare website is at:
<http://www.hospitalcompare.hhs.gov>
- Quality is starting to be shown, e.g., for hospitals, not yet for physicians



Hospital-Acquired Conditions

- Secretary will identify hospitals in top quartile of all hospitals, relative to national average, of hospital-acquired conditions for certain high-cost and common conditions.
- Starting on 10/1/2014, such hospitals will see reduction in Medicare payments.
- Challenge: How to respond to data on hospital-acquired conditions.



Conditions Acquired in Other Providers

- Secretary must submit a report to Congress by 1/1/2012 regarding appropriateness of establishing health care acquired condition policies in other provider types.
- Listed are nursing homes, inpatient rehab facilities, long-term care hospitals, outpatient hospital departments, ASCs and health clinics.



Hospital Readmission Reductions

- Beginning on 10/1/2012 hospitals with a high rate of potentially preventable Medicare readmissions will incur Medicare payment reductions.
- FY 2012 final rule adopted readmission conditions for first year to include: 1) acute myocardial infarction 30-day risk standardized readmission measure; 2) heart failure 30-day risk standardized readmission measure; and 3) pneumonia 30-day risk standardized readmission measure.



Hospital Readmissions

- Hospital's readmission rate compared with expected readmission rate.
- Reduced payment for “excess readmissions.”
- Medical records are critical in defending readmissions.



Three/One Day Payment Window

- CMS clarified that 3-day payment window (1-day payment window for LTCHs and certain other non-IPPS hospitals) applies to both preadmission diagnostic and non-diagnostic services furnished to a patient at physicians' practices that are wholly owned or wholly operated by the admitting hospital.



Gainsharing

- Gainsharing demonstration will be continued with increased funding.
- Demonstrations to evaluate physician/hospital arrangements designed to improve quality and efficiency of care provided to beneficiaries.
- Gainsharing is one useful physician/hospital alignment tool.



Accountable Care Organizations (ACOs)

- Secretary has established Medicare Shared Savings Program that uses ACOs to
 - Promote accountability for a patient population
 - Coordinate services and items under Medicare Parts A and B
 - Encourage investment in infrastructure and redesigned care processes for high quality and service delivery



Payment Bundling

- Secretary developed voluntary pilot program for hospitals, doctors, and post-acute care providers to improve patient care and achieve Medicare savings through bundled payment modes.
- Program must be established 1/1/2013 for 5 year period.
- Secretary to test and report on payment bundling.



Other Responses to Medicare Changes

- Service line clinical co-management agreements
- Increased employment/contracting with physicians (primary and specialist) by hospitals
- Physician recruitment by hospitals
- Formation of larger physician group practices
- Physician groups expanding ancillary services, e.g., using in-office ancillary services exception to Stark
- Physician/hospital joint ventures
- On-call arrangements



Medicare Disproportionate Share Hospital Payments

- Significant decrease, effective October 1, 2013.
- DSH payments will be reduced to 25% of the amount that otherwise would have been paid under current law.
- DSH hospitals may be entitled to additional amounts based on a complex formula that includes the following factors:
 - Aggregate amount of reduction in total DSH payments
 - Percentage change in uninsured under-65 population
 - Hospital's level of uncompensated care.
- No administrative or judicial review of Secretary's estimates.
- Based on expectation that fewer patients will be uninsured.



Medical Education Payments - Distribution Of Unused Medical Residency Slots

- Comparison of hospital's resident cap to highest resident level for 3 most recent cost reports.
- Hospital's resident cap will be reduced by 65% of unused slots.
- Hospitals may apply for redistribution of unused slots, must commit to use 75% of additional slots for primary care or general surgery training.
- Effective July 1, 2011.



Medical Residency Programs in Nonprovider Settings

- Current law requires hospital to pay all or substantially all of the cost of training program in a nonprovider setting in order to claim residents training there. All or substantially all defined in the regulations as at least 90% of the total of the residents' salaries and fringe benefits and the portion of teaching physicians' salaries attributable to nonpatient care direct GME activities.



Medical Residency Programs in Nonprovider Settings

- Health Reform Law relaxes requirements, and allows hospitals to claim residents training in nonprovider settings for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) if the hospital incurs the cost of the stipends and fringe benefits for the residents during their nonprovider site rotations.
- Effective for cost reporting periods beginning on and after July 1, 2010.



Medical Education Payments – Jointly Operated Residency Proposals

- Current law has been interpreted by CMS to provide that one hospital must pay all or substantially all of the costs of a residency program in a nonprovider location. Under CMS' interpretation, if two or more hospitals pay such costs, no hospital can claim residents. This issue is under appeal.
- PPACA will allow two or more hospitals to pay such costs and to claim a proportional share of residents.
- Hospitals must enter into written agreement.
- Effective July 1, 2010.



Medicare Prescription Drug Program

- “Donut Hole” will gradually be eliminated beginning in 2011.
- Donut Hole to be entirely eliminated by 2020.



Medicare Donut Hole in 2012

- **Deductible** increased by \$10 to \$320.
- **Initial Coverage Limit** increased \$2,930.
- **Out-of-Pocket Threshold** increased to \$4,700.
- **Coverage Gap (donut hole)** begins once enrollee reaches Medicare Part D plan's initial coverage limit (\$2,930) and ends when enrollee spends a total of \$4,700.
- **in 2012**, Part D enrollees will continue to receive a 50% discount on the total cost of their **brand-name** drugs while in the donut hole. The full retail cost of the drugs will still apply to getting out of the donut hole even though 50% was paid for by the pharmaceutical manufacturers. Enrollees will pay a maximum of 86% co-pay on **generic** drugs while in the coverage gap.



Conclusions: What Does This Mean for Patients and Providers?

- More (all?) people will have health insurance.
 - *Will deductibles and co-insurance go up?*
 - *Losses of other sources to cover bad debt/charity care*
- Quality of care will improve.
 - *Major quality improvements will require close working relationship between physicians and hospitals, and other providers as well.*
- Emphasis on patient centered care, medical homes, nurse navigators, etc.
- Costs?



Conclusions: What Does This Mean for Patients and Providers?

- Is health reform in final form?
 - *No. Needs many regulations, additional statutes, completion of mandated studies, conversion of successful demonstration projects and pilot programs into program policy, etc.*
- The “good old days” were so much better than now.
- “Those who cannot remember the past are condemned to repeat it.” – Santayana



What is the Future Of the Health Reform Law

- Will the Supreme Court of the United States, uphold the law, or overturn the law in part or in whole?
- What will Congress and President do make substantive changes before the next Presidential election in 2013?
- What is the future of the individual mandate?
- Trustees of the Medicare trust funds 2011 annual report: projected date of Medicare HI Trust Fund exhaustion is 2024.
- Will Medicare payments be reduced to reduce budget deficits (remember OBRA 1997)?



Provider Reimbursement Appeals

- Provider Reimbursement Review Board (PRRB) continues to have backlog of thousands of appeals.
- Hospital appeal issues include the following:
 - Medicare Disproportionate Share Hospital (DSH) payments
 - Graduate Medical Education (GME)
 - Indirect Medical Education (IME)
 - Medicare Bad Debts



Medicare DSH Adjustment

- The DSH adjustment is a payment to account for the costs incurred by hospitals that serve a disproportionate number of low-income patients.
- Add-on payment to the standardized payment per discharge under PPS.
- DSH adjustment based on two fractions:
Medicare fraction (SSI percentage), and Medicaid fraction.
 - Medicare fraction – Medicare SSI days/total Medicare days. Computed annually by CMS for each DSH hospital.
 - Medicaid percentage – Medicaid days for which patient was not entitled to Medicare Part A/total patient days.



Medicare DSH Appeals

- Appeals regarding Medicare DSH include the following:
 - DSH-SSI Percentage
 - Medicare+Choice Days – whether Medicare HMO, Medicare Advantage or Medicare+Choice days should be included in the Medicare fraction or the Medicaid fraction.



Medicare DSH Appeals - SSI Percentage

- Providers prevailed in Baystate Medical Center in District Court (2008).
 - After the PRRB ruled in providers' favor, the CMS Administrator reversed the PRRB decision.
 - Providers took case to District Court for District of Columbia.
 - District Court held that CMS calculation of Medicare fraction (SSI percentage) was not based on valid data.
 - Numerous errors in data that CMS obtained from Social Security Administration.
 - Court required CMS to recalculate DSH SSI percentage for hospitals in case.



Medicare DSH - CMS Hold on Issuance of NPRs

- On April 28, 2010, CMS issued CMS Ruling CMS-1498-R.
 - Ordered that all DSH SSI calculations under appeal or for pending audits remanded to CMS for recalculation of DSH SSI percentage.
 - Applies to cases before PRRB, and to NPRs that had not been issued.
 - CMS placed hold on issuance of hospital NPRs, except for non-DSH hospitals. Hold continues in effect.
 - Unknown when CMS will release recalculated SSI percentages.



Medicare DSH Appeals – Medicare+Choice Days

- Many persons eligible for Medicare Part A elect to participate in Medicare+Choice under Medicare Part C.
- Question is whether the days for these persons should be included in the numerator of the Medicare fraction or the numerator of the Medicaid fraction.
- In Northeast Hospital Corporation v. Sebelius (DDC 2010), the court held that once a beneficiary elects Medicare Part C, the beneficiary is no longer entitled to receive benefits under Part A. Therefore, Medicare+Choice days should be included in numerator of Medicaid fraction.



Medicare DSH Appeals – Medicare+Choice Days

- Intermediaries continue to take position that Medicare+Choice days must be included in numerator and the denominator of the Medicare fraction, and not in numerator of Medicaid fraction.
- Partners 2002-2004 DSH Medicare+Choice Groups (PRRB Dec. No. 2011-D37) – PRRB on July 30, 2011 ruled that Medicare+Choice days are not counted in the Medicare fraction, and must be included in numerator of Medicaid fraction.
- CMS Administrator reversed PRRB Decision.
- Appears that providers will have to continue pursuing these appeals at PRRB and in federal court.



GME/IME Appeals

- Many appeals involve residents training in nonhospital settings.
- Hospital may receive GME and IME payments for the time residents spend training in nonhospital settings as long as the residents are performing patient care activities, there is a written agreement between the hospital and the nonhospital site that meets applicable requirements, and the hospital incurs “all or substantially all” of the costs of training the resident in the nonhospital sites.



GME/IME Appeals

- Definition of “all or substantially all,” and the requirement regarding the time that payment must be made, have changed over time.
- The PRRB and the courts have issued several decisions in past year.



GME/IME Appeals

- Medcenter One Health Systems case – involved two North Dakota hospitals that jointly operated a training program with nonhospital sites.
 - At the PRRB, the providers and the intermediary stipulated that the written agreement was met. Issue was whether the “all or substantially all” requirement could be met when two hospitals shared the cost of the offsite program.
 - PRRB ruled in favor of providers.
 - CMS Administrator reversed, holding that a single hospital must incur “all or substantially all” of the cost of the offsite program in order to claim the residents.
 - District Court in 2009 reversed CMS Administrator Decision, and held that two hospitals could not share the cost.
 - Eighth Circuit ruled in 2011 that written agreement requirement was not met, and did not address the issue of whether two hospitals can share the cost of an offsite program.



GME/IME Appeals

- Borgess Medical Center/Bronson Methodist Hospital (PRRB Dec. No. 2011-D46)
 - PRRB ruled on September 27, 2011 that written agreement requirement was met, and that two hospitals can share cost of training in nonhospital sites.
 - CMS Administrator reversed on November 22, 2011, finding that written agreement requirement was not met, and that a single hospital must incur “all or substantially all” of the cost of the training program in nonhospital site.
 - Result of CMS Administrator Decision is that neither hospital can be reimbursed for any of the residents who rotated to nonhospital sites.
 - Case has been appealed to District Court.



Medicare Bad Debts

- Medicare reimburses providers for unrecovered costs attributable to bad debts resulting from deductible and co-insurance amounts which are uncollectible from Medicare beneficiaries.
- Current Medicare payment is 70% of uncollectible bad debts.
- To be allowable, bad debts:
 - Must be related to covered services, and derived from deductible and coinsurance amounts.
 - Provider must be able to establish that reasonable collection efforts were made.
 - Debt actually uncollectible when claimed as worthless.
 - Sound business judgment established that there was no likelihood of recovery at any time in the future.



Medicare Bad Debts – Use of Collection Agency

- If a provider uses a collection agency for its non-Medicare bad debts, it must also refer its Medicare deductible and coinsurance amounts to the collection agency.
- CMS contends that a deductible or coinsurance amount cannot be claimed as bad debt until collection agency formally returns it to the hospital and ceases collection efforts.
- Providers rely on presumption on noncollectibility in the Medicare Provider Reimbursement Manual, which states that an account may be considered uncollectible if the provider has pursued collection efforts for 120 days.



Medicare Bad Debt Appeals – Use of Collection Agency

- Lakeland Regional Medical Center (PRRB Dec. No. 2012-D3)
 - PRRB on December 14, 2011 ruled in provider's favor, finding that intermediary's imposition of requirement that accounts be returned by collection agency prior to claiming them as bad debts violates the Bad Debt Moratorium that Congress imposed in 1987, and which it amended in 1988 and 1989.
 - PRRB relied on Foothill Hospital case from District Court for District of Columbia, in which the court found that Bad Debt Moratorium applies to CMS' policies. The court in Foothill Hospital ruled that the Bad Debt Moratorium prohibits a change in CMS policy to require that bad debts be returned by the collection agency prior to claiming.
 - Case currently before CMS Administrator on review.



Medicare Bad Debt Appeals – Use of Collection Agency

- Several other cases in which PRRB ruled, similar to Lakeland Regional Medical Center case, that bad debts were properly claimed if provider had pursued collection efforts for at least 120 days, even if bad debts had been referred to a collection agency. The CMS Administrator reversed all of these PRRB decisions.
 - Universal Health Services (PRRB Dec. No. 2011-D30)
 - George Washington University Hospital (PRRB Dec. No. 2011-D31)



Medicare Bad Debt Appeals – Crossover Bad Debts

- Bad debts for Dual Eligibles – States have an obligation to pay deductible and coinsurance amounts for services that are within the scope of the State Medicaid Plan.
- Many states limit Medicaid obligation for deductible and coinsurance, and do not pay Medicare bad debts if provider has already received payment from Medicare that is equal to or greater than the amount that Medicaid would pay for the same service to a Medicaid patient.



Medicare Bad Debt Appeals – Crossover Bad Debts

- Genesis Health Care Corporation (PRRB Dec. 2011-D12)
 - Intermediary relied on “must bill” policy set forth in Joint Signature Memorandum 370 (August 10, 2004). JSM 370 states that providers must bill State Medicaid programs for deductibles and coinsurance for Medicare/Medicaid crossover patients, and must receive a remittance advice from the State, prior to claiming the amounts as Medicare bad debts.
 - The PRRB found that the intermediary’s imposition of an absolute requirement that providers obtain Medicaid remittance advices prior to claiming Medicare bad debts is unsupported by statute, regulations, manual provisions and case precedent. The PRRB found that the “must bill” policy has no foundation in law or regulation and is beyond the requirements of the regulations and manuals.
 - The CMS Administrator reversed, based on the providers’ failure to follow the “must bill” policy. Held that providers must bill even when the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts.



Accountable Care Organizations (ACOs)

- ACOs are vehicle through which Shared Savings Program will be implemented.
- ACOs are a cutting edge tool for physician/hospital alignment.
- Detailed requirements in health reform law for group of providers to qualify as ACO:
 - Agree to three year participation
 - Agree to be accountable for quality, cost and overall care of at least 5,000 Medicare fee for service population



ACOs

- Establish formal legal structure allowing ACO to receive and distribute shared savings payments to its participants
- Include enough PCPs to care for Medicare fee for service population assigned to ACO
- ACO must have in place leadership and management structure that includes clinical and administrative services



ACOs

- ACO is responsible for defining processes to promote evidence-based medicine and coordinate care through use of telehealth, remote patient monitoring and other enabling technologies.
- ACO providers bill Medicare same way as if they weren't in ACO.
- ACO may receive additional percentage (defined by Secretary) of “shared savings” achieved by ACO.



ACOs

- Secretary authorized to waive Civil Monetary Penalties, Anti-Kickback Statute, any provisions of Title XVIII including Stark Law. Regulations were issued in October 2011.



ACOs

- One of most valuable tools in physician/alignment toolkit
- Extremely complex to create
- Contracts among all providers in ACO are required
- Clinical integration and/or financial integration is necessary to achieve quality improvement and overall cost savings
- Physician leadership is crucial in developing protocols, clinical pathways, enforcement mechanisms, payor arrangements



ACOs

- Current antitrust guidance prohibits joint negotiation of payor contracts by competing providers (including physicians) without clinical and/or financial integration.
- Exclusive contracting by ACO is problematic.
- Fully mature clinically integrated group can achieve remarkable quality improvements and overall cost reductions.
- Effect of ACO on private health insurance market.



Payment Bundling

- Payment bundling puts a premium on developing ACO or similar integrated group of providers.
- Without clinical/financial integration among otherwise competing providers, the providers cannot successfully achieve goals of ACOs, payment bundling or gainsharing or many other physician/alignment strategies.
- A vibrant physician-developed and physician-operated clinically integrated group can achieve all of above goals, plus major reduction in overall cost of health care while quality is improved at same time



“Under Arrangements”

- 2012 IPPS rules made changes to “under arrangements” requirements.
- Medicare permits hospitals to bill and be paid for certain services that are provided to inpatients under arrangements with an outside entity.
- Final rule limits the services that can be provided under arrangements with an outside entity to therapeutic and diagnostic services.
- Routine services, such as room and board, nursing services, and ICU services can be furnished by another entity but only if they are provided in the hospital where patient is an inpatient
- If a provider satisfies the “provider-based” requirements, it may often bill for services performed in a provider-based facility even if not in the hospital's main campus.



Center for Medicare and Medicaid innovation

- Center for Medicare and Medicaid Innovation created within CMS.
- To test innovative payment and service delivery models to reduce Medicare expenditures while preserving or enhancing quality of care.
- CMMI must seek input from interested parties, and is to consult with representatives of federal agencies, and clinical and analytical experts with expertise in medicine and health care management.



CMMI

- CMMI is to test payment and service delivery models to determine the effect of applying them to Medicare or Medicaid.
- CMMI is to select models to be tested where there is evidence of deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.
- CMS must report to Congress in 2012 and at least every other year thereafter, describing the models tested and providing recommendations as it believes appropriate.



Independent Payment Advisory Board

- New independent, 15-member Board created.
- Must present annually recommendations to Congress on actions that could improve quality and constrain the rate of healthcare cost growth in private sector.
- Board must make non-binding Medicare recommendations to Congress in years when Medicare growth rate is below targeted growth rate.



IPAB

- In years when Medicare growth rate is projected to exceed targeted growth rate, Board's proposals will take effect unless Congress passes an alternate measure that achieves same level of savings.
- Starting in 2020, Board may make binding recommendations to Congress only every other year if growth of overall health spending exceeds targeted growth rate.



IPAB

- Will take years to fully implement.
- Query – Will Congress want to cede its rate-setting authority, even in part, to an independent entity?
- Does this provision pass constitutional muster?
- What effect will Medicare Trust Fund solvency or lack thereof have?



Questions and Answers

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