Medicare and Outpatient Spine:

Love affair or nightmare?

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What is Medicare?

- It was created by President L.B. Johnson in 1965 under the Social Security Act and began operating in 1966
- The program began by operating on Medicare Volume Performance Standards
- It assumed a 12% increase in people entering the Medicare program
- If program spending exceeded a pre-set standard, fees for services would decrease
- Standards varied across geographical areas and high-volume areas

Source: http://www.aaos.org/news/aaosnow/dec12/cover1_f1.pdf

What is Medicare?

- In 1997, established the Sustained Growth Rate formula under the balance budget act
- In 2001, healthcare costs growth exceeded economic growth
- The escape mechanism activated and necessitated a cut in reimbursements
- Every year or so, Congress would pass a temporary patch or fix

Remember the SGR?

- The SGR is calculated using these factors:

  1) The estimated percentage change in fees for physicians' services.

  2) The estimated percentage change in the average number of Medicare fee-for-service beneficiaries.

  3) The estimated 10-year average annual percentage change in real GDP per capita.

  4) The estimated percentage change in expenditures due to changes in law or regulations.

What are the payment factors?

- Physician reimbursements are adjusted using a Conversion Factor
  - Determined by 3 factors
    - Medicare Economic Index
    - Performance Adjustment
    - Various other adjustments
- Geographic Adjustment
  - Based on 6 factors – Physician, Practice, and Liability Insurance RVUs and Geographic Price Indices,

Medicare Access and CHIP Reauthorization Act of 2015

- Signed into law April 2015
- The only measure the RAND corporation found that *modestly* reduced healthcare spending (vs. ACOs and P4P)
- Will change the way we are all paid, if nothing else

What is MACRA

- The Medicare Access and CHIP Reauthorization Act of 2015
  - Aka MACRA
  - Repealed the SGR
  - Physician payment increases by 0.5% for 2015-2018.
  - Replaces PQRS and Hi-TECH with a Merit-based Incentive Program – MIPS
  - APMs are alternatives to the MIPS

http://www.healthcare-informatics.com/article/breaking-president-obama-signs-sgr-repeal-legislation-shifting-medicare-physician-payment-in

MACRA Timeline

MACRA ready
The Shift to Value-Based Payment

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Medicare Part B Baseline Payment Updates											
	+0.5%[A]	+0.5%	+0.5%	+0.5%	+0.%						+0.25%* +0.75%**
					*Non-qualifying APM Conversion Factor **Qualifying APM Conversion Factor						
Merit-Based Incentive Payment System (MIPS)											
	PQRS, Value-based Modifier, and Meaningful Use[B]			*Quality, Resource Use, Meaningful Use, and Clinical Practice Improvement Activities*							
	-6%	-9%	-9%	+/-4%	+/-5%	+/-7%	+/-9%				
Qualifying Alternative Payment Model (APM) Participant											
				5% Incentive payment							
				APM Participants Exempt from MIPS							

Bundled Payments

- Major caveats
  - High turnover rate in carrier populations – how do we track and how do we get paid when a patient moves or changes insurance?
  - What happens when a patient has a major, expensive complication – no more money comes in but expenses continue?
  - Eliminating episodes of necessary care in order to save money?

Analysis of Bundled Payments
The RAND Corporation Report TR-562/ 20

How will ASCs work in the post-SGR world?

- An ASC could participate in the program and most likely will.
- APMs are not available as of right now and everyone will be in the MIPs until they are available.
  - APMs fits into things like Medicare Shared Savings Programs and ACOs
- APMs could end up being the better alternative as it offers a 5% lump sum bonus on your CMS payments for 2019-2024
- By 2026 ¾% increase in payments each year

Bundled Payments and Spine in the ASC: more questions than answers

- Potentially lucrative if you are in an APM
- The future?
- Will hospitals be more motivated to purchase or co-own ASCs
  - Uhm – yeah
- How can you stay profitable?
- Will ANYONE be out of network?

Eligible ASC Spine Procedures

CPT Code	Description	RVU	Reimbursement ($)
22551	Neck spine fuse & remove below c2	25.00	895.03
22554	Neck spine fusion	17.69	633.32
22612	Lumbar spine fusion	23.53	842.40
22614	Spine fusion extra segment	6.43	230.20
63020	Neck spine disk surgery	16.20	579.98
63030	Low back disk surgery	13.18	471.86
63042	Laminotomy single lumbar	18.76	671.63
63045	Removal of spinal lamina (cervical)	17.95	642.63
63047	Removal of spinal lamina	15.37	550.27
63056	Decompress spinal cord (far lat. disc)	21.86	782.62

How far will they go?

- In 2011, Medicare spent $549B; approximately $158B were for inpatient services.
- 36 million patients per year admitted to the hospital; 42% are Medicare patients (with Medicare paying for 90% of their expenses) (Debt.org)
- Big pressure to cut spending
- Healthcare costs represented 17.1 % of our 2013 GDP
  - Australia – 9%
  - Denmark -10.6%
  - Germany – 11.3%
  - Israel – 7.2%
  - Philippines – 4.4%
  - Russia – 6.5%
  - South Africa – 8.9%

(Debt.org)

What About Waste?

- Medicare audit revealed approximately $120 million on spinal fusions was improperly spent
- From 1998 and 2008, spinal fusions rose by over 50% (175K to over 410K)
- My opinion: There is a very strong possibility that Medicare will resist continuing to pay for outpatient fusions if there is a serious uptick in frequency of the procedure
- New studies refuting utility of fusion

Spinal fusion costs spur insurance changes, but can Medicare follow?
Tampa Bay Times, June 20, 2014

Suggestions if you start

- Coding, Coding, Coding
- JNS study in 2014 reviewing 178 lumbar fusions completed at the Brigham
  - Only 48.4% of the primary ICD-9 code matched the actual diagnosis
  - If both the primary and secondary were considered 79.4% matched the actual indication for fusion

J Neurosurg Spine. 2014 Dec;21(6):984-93

Tools for Assessing Patients for Surgery

- http://riskcalculator.facs.org/PatientInfo/PatientInfo
- Its important to consider the *worst case scenario* for all case
  - What if all goes wrong?
- Make sure there is a transfer agreement with a nearby hospital where to surgeon is privileged

What about implant costs?

- Bear in mind that implants represent a major cost center.
- Biologics can be extraordinarily expensive
- Carefully vet the case with your surgery scheduler/finance specialist
- A special note about Medicare and disc arthroplasty
  - In California, Medicare (under Noridian) has a non-coverage policy
  - Most other regions DO cover cervical disc arthroplasty
- In some states, Medicare DOES cover Coflex technology
  - Alabama, Georgia, Tennessee (Cahaba GBA regions) (International Business Times, January 7, 2013)

Recommendations

- Judge each case on its own merits
- Carefully screen the patients
- Understand your exit strategy
- Recruit people for the case with whom you are familiar
- Instrumented cases will be more expensive
- Understand bundled payments - ?
- Start slow

THANK YOU