James L. Holly, M.D.

Health Care Reform: What is in the bill?
By James L. Holly, MD
Your Life Your Health
The Examiner
April 1, 2010

The coincidence of the date of this article's publication and of its subject is not lost on the author. As a preamble to this article, it needs to be stated that we will not deal with the short-term or long-term fiscal issues created by this bill. Whether or not the country can afford all of the provisions of this bill will be left for another discussion. Whether or not the insurance industry will survive the provisions of this bill and/or whether the intent of the bill is that insurance companies should not survive will be left for another discussion. There are many provisions in this bill which this writer personally thinks are ill-advised and potentially harmful to the future of our country. Hopefully, these can be corrected in future legislation.

However, there are also provisions in this bill, which, if employed properly, can help SETMA and even press SETMA to expand our vision of improving health care and achieving excellence in both the processes of healthcare delivery and in the outcomes achieved by those processes. I am encouraged by the thought that no child, no senior citizen, or no truly disabled or dependent person will not have access to their personal healthcare provider, who through a "health home" will have their health nurtured and who will be empowered to achieve the degree of health they have determined to have. However anyone may feel about other aspects of this bill, we can all embrace this part of it.

The issues of significant interest to SETMA are:

1. **Accountability of Care organization organizations** – ACOs are teams or groups of physicians who have 5,000 or more Medicare beneficiaries in their practice who then provide coordinated care to improve the quality of care, the patient satisfaction with care while at the same time controlling the cost of care.
2. **Health Home** – this is the emerging term for Patient-Centered Medical Home – as you know SETMA will submit an application on April 9th to NCQA for recognition as a Health Home and subsequently to AAAHC (American Association of Ambulatory Health Care) for certification as a Health Home. Health Home is coordinated care for all patients in a practice regardless of the funding agency.
3. **The changes in Medicare Advantage** – this is the HMO part of Medicare. The bill reduces the payments for Medicare Advantage. It is hoped that it will be possible to mitigate the benefits reduction for Medicare Advantage beneficiaries as a result of the reduction of support.
4. **New initiatives for developing and implementing quality measures**, both process measures and outcomes measures – While many would argue with the methods and means of the bill, no one argues with its intent to improve the quality of care while reducing and controlling the cost of that care. In quality measures,

"process measures" related to whether a needed service or test was done, i.e., did the patient with diabetes have an HgbA1C. "Outcomes measures" addresses what the result of the HgbA1C was and whether or not the patient's diabetes is well controlled or not. Both are important. The bill provides initiatives for designing new quality measures which will allow providers and patients to determine the quality of care which is being received.

5. **Medicare reimbursement** – While some physicians have never treated Medicare beneficiaries because of the traditionally low payments for those services, only recently have mainstream healthcare providers begun to worry about whether they would be able to continue treating Medicare patients. Recent press reports addressed the Mayo Clinic in Arizona's decision to stop seeing Medicare patients.

The bill also provides for the formation of an "Independent Payment Advisory Board (IPAB)," which has the following powers:

- The Independent Payment Advisory Board is to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing cost-growth, improving quality of care, and reducing national health expenditures
- Commission proposals will be automatically implemented unless Congress acts in opposition
- Proposals to modify payments will be effective for payment years 2015 and beyond (2020 for hospitals)

Don't miss the provision that the IPAB's decision will become law unless acted upon by Congress. Obviously, there are concerns that the IPAB may have telescopic vision which focuses only on controlling cost of care without being attentive to the needs of organizations which are charged with providing that care. The IPAB will be a powerful board and it is imperative that it have a diverse and expert makeup which will include all stakeholders in healthcare delivery, including consumers.

April 1, 2010, 21% Reduction in Medicare Reimbursement

Unrelated to the health reform bill but not unrelated to the proposed decreases in reimbursement for Medicare services is a 21.2% Medicare pay cut will take effect April 1, 2010, after the Senate failed to pass a bill extending the effective date to May 1 before lawmakers recessed for 2 weeks. The 21.2% reduction in reimbursement does not necessarily mean that physicians will experience the Medicare meltdown everyone has dreaded. When Congress goes back to work on April 12, Senate Democrats will try to pass the 1-month extension again and make it retroactive to April 1. The Centers for Medicare and Medicaid Services has announced that it will freeze payments on physician Medicare claims for the first 10 business days of April and then pay the full amount — as if the reduction never occurred — once the 1-month extension passes in the Senate.

That very scenario played out just weeks ago when the pay cut took effect on March 1, and the Senate voted the next day to delay it until April 1 (the House had approved that measure the week before). The Centers for Medicare and Medicaid Services did not process physician claims for the first 10 business days of the month to spare physicians the impact of smaller

checks.

Summary of Parts of the Healthcare Reform BIll

The following summary is taken from the bill's section on the issues addressed above:

- **Accountable Care Organizations(ACOs)** ---HHS to establish the Medicare Shared Savings Program to promote accountability and coordination of Medicare Parts A and B services

    - would allow groups of providers who meet certain statutory criteria to be recognized as ACOs and be eligible to share in the cost-savings achieved by the Medicare program
    - eligible ACOs would be groups of providers and suppliers who have an established mechanism for joint decision making, including: practitioners in group practices; networks of practices; partnerships or joint ventures between hospitals and practitioners; hospitals employing practitioners; and such other groups are determined eligible by HHS
    - HHS may give priority to ACOs currently operating within other payer arrangements; program must be established by January 1, 2012

- **Annual Wellness Visit --** beneficiaries will have access to a comprehensive health risk assessment, effective 2011
- **Bundled Payments** -HHS required to develop a national, voluntary bundled payment pilot program to provide incentives for providers to coordinate care, effective 2013 program may be expanded after January 1, 2016
- **Center for Medicare and Medicaid Innovation Center --**creates the Center for Medicare and Medicaid Innovation to test, evaluate, and expand different payment structures and methodologies
  -established by 2011
- **Medical Home** -HHS to award grants to fund medical home models -the Independent Medicare Advisory Board would test medical home models
- **Preventive Services Cost-Sharing --** waives cost-sharing for preventive services, effective 2011
- **Reimbursement for Primary Care Services --** provides a 10% bonus payment on select primary care services and general surgeons providing care in health professional shortage areas, effective 2011-2016

Medicaid

The provision in the bill which addresses Medicaid reimbursement states: "Payment rates to physicians providing primary care services must equal at least 100% of the Medicare payment rate in 2013 and 2014 and that the federal government to fund the cost of this requirement." This has engendered significant discussion within SETMA. Some of that discussion, speaking of those covered by Medicaid, states:

1. "The problem is they CAN'T pay for their procedures or meds, but if we truly

become a health home we will find creative ways of finding resources for them.
2. "We need to hire and train a 'health-needs Scrounger;' remember the movie *The Great Escape*?!!
3. "What a reason to get up in the morning 'to help the helpless and give hope to the hopeless'. Now that's something worth giving your life and soul to.
4. "Our challenge is to take people who:

    a. "…distrust the system -- sometimes with good reason –
    b. "…have years of neglected treatment,
    c. "…are often medically illiterate,
    d. "…have little experience with the concept of 'hope', i.e., that 'a change will make a difference' in their life and
    e. "…whose principle pleasures in life are destructive to their health and
    f. "…then we must change the trajectory and then the direction of change in their heath."

The Future

Recently, SETMA's partners spent a day in a "strategic planning" session. We discussed our strengths, our weaknesses, the opportunities we face and the threats which confront us. The healthcare reform bill provides opportunities and threats. It essentially coalesces with our strengths but as an organization's weaknesses often mirror its strengths, the bill also challenges us to deal with our weaknesses.

We face the future will all systems in place which are needed to meet those challenges. We have no debt and we have partners, colleagues and staff committed to meeting the healthcare needs of our patients.
SETMA is committed to our employees and to our patients. We have plans in place, we think, to deal with the potential challenges of decreasing reimbursement without abandoning our principles and our commitments, and especially without abandoning our patients. We hope to participate in the ongoing healthcare discussion in this country and to contribute to the direction of that discussion.

We remain confident that this is a great time to be involved in healthcare and that the future, while uncertain, will be bright. There has never been a time when we can do more for our patients than at present. Curiously, it is that fact which has helped create many of the issues which produced the current healthcare reform movement. We believe that the outcome of healthcare reform will ultimately be positive, even though the process of that reform has only begun.