

Preparing for an Uncertain Future

Chapter FastFACTS

- 1. For-profit businesses perceive money-making opportunities in health reform.**
- 2. The law instructs HHS to implement a voluntary shared-savings program that will serve a defined Medicare fee-for-service population.**
- 3. The ACA expands Medicaid to a national floor of 133% of the federally defined poverty level.**
- 4. Starting in 2013, Medicaid will equal Medicare's rates for evaluation and management services and immunizations provided by primary care physicians.**
- 5. The Association of American Medical Colleges projects there will be a shortfall of about 60,000 doctors between now and 2015.**

Despite various efforts in Congress, state legislatures, and the courts to stop health reform in its tracks, it is the law of the land; and many in government, the medical profession, and the private sector are working assiduously to implement its many provisions. Many analysts believe that the law ultimately will remain in force, but in a modified form. Moreover, its core access requirement—the mandate that all American citizens and legal residents acquire health insurance (with a few exceptions mostly for financial hardship and religious objection) —is the portion that is most at risk. (For other at-risk

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Date _____ Time _____ F/U Appt
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 Phone Number _____ AM PM
 Chief Complaint _____
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Discuss and advise **Action**
 Rx to Pharmacy _____
 order lab work _____
 call for office visit in _____ days/weeks
 Other _____

Coding
 _____ minutes spent in telephone medical discussion
 billable not billable

Telephone service	Physician	NPP
5-10 minutes	99441	98966
11-20 minutes	99442	98967
21-30 minutes	99443	98968
Online encounter	99444	98969

Signature _____

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sections, see “Watching Court Cases, Political Debate.”)

Although no one can accurately predict how the U.S. Supreme Court may ultimately rule when the various court challenges to the ACA make their way to the top bench in a year or more, many legal scholars have been quoted as saying they do not believe that striking down the individual mandate requirement means necessarily voiding the entire law.

Bullish on Health Reform?

Meanwhile, money talks; and big business remains generally bullish on healthcare reform, with Wall Street seeing potential profits in the idea that millions more Americans will be holding health insurance cards over the next decade. Still, health insurers, like many in the business of healthcare, are lobbying hard to revise specific sections of the law or to change timetables for implementation, but not, in large part—or publicly, at least—working for repeal.

“I am optimistic because through all the political noise, without health reform we will still have problems with quality, safety, and reliability of healthcare,” Dr. Silbaugh says. “Big players know we have to be ready to go to a different payment system, not fee-for-service, and we have to be able to prepare for having more people with financial coverage. Essentially, [companies in the business of healthcare] are saying, ‘We’re preparing and we don’t want to walk away from 30 million new enrollees.’”

Like Dr. Silbaugh, few health reform experts think that Congress will focus in the foreseeable future on many of the cost-control, delivery system transformation, or quality-inducing sections of the law. “There is a perception of paralysis among people who only read what’s in their local newspaper. They know the Republicans don’t like the healthcare reform bill and the Republicans got elected, so fill in the blanks,” Dr. McGeeney says. “The reality is that there is a fairly broad consensus in D.C. around the main pillars of health reform—that everybody should have some basic level of healthcare in this country, that costs are too high, that quality needs to be better, that care needs to be coordinated and managed better, and that you need to pay doctors differently. You need to pay them for the job they are doing and not for their volume.”

New Delivery Systems

One part of the law that many expect to have a great effect on healthcare delivery—and on physicians in particular—is the pro-

Watching Court Cases, Political Debate

As of press time, of the nearly two dozen legal challenges filed on the federal health reform law, there have been five court rulings: Three rulings have upheld the law, and they were from judges appointed by Democratic presidents. Two courts have struck down part or all of the law, and the judges in those cases were appointed by Republican presidents. All have considered the same provisions, constitutional clauses, and court precedents. A Supreme Court decision looms, but not before a year or two.

The part of the ACA most at risk—both of possible repeal and at the court level—is the individual mandate to buy health insurance, which requires most U.S. citizens and legal residents to have health insurance by 2014 or pay a penalty; but Republicans have also specifically targeted these aspects of the law that they say are most vulnerable:

Independent payment advisory board. This 15-member board, which will be nominated by the president and confirmed by the Senate, will recommend ways to reduce the growth of Medicare spending. Its recommendations will be automatically implemented in 2015 unless Congress comes up with its own solution. Many Republicans and Democrats are opposed to having an independent board with so much control over Medicare.

Healthcare spending accounts. The law caps the maximum contributions to these accounts at \$2,500 a year starting in 2013 and limits their use in purchasing over-the-counter medications or healthcare products. The money saved by the government is intended to help fund healthcare reform, but many oppose the change.

CLASS. This new voluntary insurance program, short for Community Living Assistance Services and Support, is designed to help people stay in their own homes if they become disabled by paying them \$50 a day to help pay for non-medical care expenses, such as a home health aide or household modifications. Opponents say this may become an unaffordable entitlement.

Taxes on insurers. To raise money to help fund health reform, starting in 2018, a fee will be imposed on health insurers that offer so-called “Cadillac” or “gold-plated” plans, meaning those that have excessive premium costs. Opponents of that provision say that healthcare inflation is likely to continue, so that what is now considered a high-cost plan may be more the norm. The fee is now set as a 40% excise tax on top of any amount that exceeds a premium cost of \$27,500 for family plans or \$10,200 for individual plans.

motion of new integrated delivery systems, such as ACOs. The law instructs HHS to implement, no later than Jan. 1, 2012, a voluntary shared savings (accountable care) program that will serve a defined Medicare fee-for-service population. By 2013, HHS is supposed to have in place a national pilot program focused on payment bundling that aligns incentives to promote integrated care and joint responsibility among providers. To share in savings, ACOs must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care, according to an analysis of the law by the Kaiser Family Foundation. Many private insurers expect to have the ACOs take risk for their patients as well.

What ACOs are and how they are going to function are still very much up in the air, with new draft regulations just promulgated at the end of March and currently subject to comment; however, 74% of hospital chief executives queried this winter in the HealthLeaders Media Industry Survey say they are either planning to become ACOs in the next five years or already have necessary components in place to be considered an ACO.

Surveyed hospital executives also say overwhelmingly that they believe the percentage of employed physicians in their organizations will grow over the next three years. Currently physicians and hospitals cannot share bundled payments unless physicians are employed by the hospitals; but the draft ACO regulations broaden the concept of what constitutes adequate integration, short of total financial integration, in order to avoid running afoul of antitrust and fraud-and-abuse problems later.

Expanded Medicaid

In addition to its provisions to expand access to private insurance, the ACA greatly expands Medicaid to a national floor of 133% of poverty level (about \$14,400 for an individual and \$29,300 for a family of four) and opens it up to non-Medicare-eligible adults under age 65 without dependent children who are currently not eligible for Medicaid.

Under the law, the federal government will pay the bulk of the increase, but states are required to maintain eligibility; and

enrollment has been growing significantly since the recession started in 2007. About 7 million more people have enrolled in Medicaid since the summer of 2007, a total of more than 50 million low-income people, the highest number in the program's history. That rise—coupled with any increase in costs that they will be responsible for under health reform—is prompting states, particularly those with Republican governors and large budget deficits, to take aim at the program. Some Republican analysts have said these state efforts to cut, rather than expand their Medicaid programs, could be the new tactic for resisting or undoing health reform.

The Congressional Budget Office estimates that the health reform law will increase Medicaid coverage by 16 million people by 2019 at a cost to the federal government of \$434 billion and a state cost of \$20 billion.

In addition to Medicaid, health reform promises to increase coverage for those people who cannot afford now to buy health insurance or who work at jobs that do not provide insurance. State Health Benefit Exchanges, to be established by 2014, will offer subsidies to Americans who are not eligible for Medicaid but whose incomes are below 400% of the poverty level, to help them buy affordable insurance.

Increasing access by expanding Medicaid raises a red flag for many physicians, who have shied away from participating in Medicaid in growing numbers due to its low payment rates. Tennessee internist Dr. Ralston remembers what happened when his state's TennCare program quickly extended coverage to an additional 500,000 people in the mid-1990s by making access to its plans easy and affordable, but nearly bankrupted the state in the process. The program became a victim of its own success; it had reduced the state's uninsured population to only 6%, but it had become so expensive that Tennessee was forced to scale it back in 2005. It also paid health providers less than private insurance plans, prompting much cost-shifting to private insurers and convincing many physicians to stop accepting TennCare patients at all. "We had a disaster here, and I'm not sure that many people with existing practices are going to be willing to expand and count on having the cost of their expansion covered by the Medicaid program," Dr. Ralston says. "That's a real concern."

Recognizing that low reimbursement rates have discouraged many physicians from accepting Medicaid patients, starting in 2013 the law raises Medicaid rates for evaluation and management services and immunizations provided by primary care physicians to levels equal with Medicare. It also lets states establish medical homes for Medicaid patients with chronic illnesses.

Private Sector Initiatives

Another unknown is what is going to happen in the private sector as a result of health reform. “The law puts together a framework, but within that there is going to be a lot of innovation,” Dr. Martin says. In fact, many private insurers and states have already imposed or mandated some of the same reforms the federal government is now proposing under health reform. Many private payers already are paying incentives for quality reporting, for instance; and some states are imposing financial penalties on hospitals with above-average infection rates and hospital-caused complications.

Workforce Supply Concerns

How will the mismatch between supply and demand affect access, cost, quality, and delivery system reform? The Association of American Medical Colleges projects that between now and 2015, the country will have a shortfall of about 60,000 doctors across all specialties. Its estimates are based on U.S. Census Bureau projections of a 36% growth in the number of Americans over 65, an assumption that nearly one-third of all physicians are expected to retire in the next decade, and the fact that Congress has not allocated funding for additional residency training slots.

Whatever happens, Dr. Silbaugh says, health reform “is an incredible opportunity for physicians” who have felt they’ve had to produce more and more faster and faster. “As the system changes from rewarding volume to rewarding value,” he says, physicians will be able to return to their roots as knowledge workers, with unique skills that are valued by the public.