Health care reform

What it may mean for your practice

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With the passage of The Patient Protection and Affordable Care Act (PPACA), dramatic changes are coming in health care delivery in the United States. Supporters of the new law say that it will improve quality of care and outcomes, provide more accountability in health care, and even reduce costs.

This issue of cost is important. Estimates from 2009 suggest that the United States spent $2.6 trillion (17.3% of gross domestic product) on health care while the average spending in the rest of the world equals just 9% gross domestic product.[1] The numbers can be debated, but the rising cost of health care cannot be sustained. Supporters argued that the law was essential to containing costs.

Will PPACA contain cost? The Congressional Budget Office (CBO) expressed concern that health care costs will remain high even after reform, even as it determined that the PPACA will reduce the federal budget deficit by more than $100 billion over the first decade and by more than $1 trillion between 2020 and 2030.[2] CBO also estimated that the cost of covering the bill would be more than offset by Medicare savings through fraud and abuse efforts, new taxes and fees, tax on high-cost employer-sponsored health plans, and tax on investment incomes of the most affluent Americans.[2]

Now that the legislation has passed, the regulatory work has begun. This is where the language of the bill is put into details by regulatory agencies such as the Department of Health and Human Resources and the Centers for Medicare and Medicaid Services. Debate exists about what the provisions really mean in PPACA, but some facts are generally accepted.

- The CBO estimates that approximately 26 million currently uninsured Americans will be covered by 2019. This will leave 24 million uncovered and about 1/3 of these are estimated to be illegal immigrants.[3]
- Once fully implemented, insurance companies can no longer deny insurance based on preexisting conditions or limit coverage through annual or lifetime caps.[4]
- Insurance companies cannot discriminate based on age or gender.[4]
- The age for children to remain on their parent's insurance is raised to 26 years.
- Insurance exchanges and tax credits will be developed to assist lower income families with obtaining coverage.[4]
- There are funds for Medicare Part D medication coverage to gradually phase out the donut hole gap for seniors, although the hole does not completely close until 2020.[4]
- The national average "floor" on Medicare's geographic payment adjustment is reestablished for 2010 and will be further adjusted in 2011.[4]
- There is a 10% incentive for primary care physicians.[4]

Each of these bulleted items represents potentially positive improvements in the health care delivery system. Many will benefit patients with neurologic diseases, especially provisions affecting preexisting conditions, lifetime caps, and elimination of the prescription drug donut hole. However, there are a number of provisions

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that cause concern and a few that were unfortunately not addressed at all. We discuss some of those issues in the following.

Specifically for physicians, the incentive payments of 10% apply to primary care physicians and general surgeons. Physicians eligible for the primary care incentive are defined by the bill by 2 criteria. First, they must have 60% or greater of their Medicare billings be outpatient evaluation and management (E/M) services. Second, they must also be on the list of eligible physicians, which is internal medicine, and its subspecialties, family practice, geriatrics, and pediatrics. Because neurology is not a subspecialty of internal medicine, we are not eligible for this bonus even if we bill 60% or more on E/M services. Despite strong efforts by the American Academy of Neurology (AAN) and its members, neurology was not added to the list of eligible physicians through an amendment to the bill. Though many in Congress supported neurology's argument, the final issue came down to the political wrangling that occurred in getting the PPACA passed and further amendments were not considered. The AAN continues to lobby for this effort and may still get some language included that would allow us to be eligible. The CBO has estimated the cost of adding neurology to be $300 million over 10 years.

One concern raised about the improved reimbursements to internal medicine physicians is that more graduating medical students will select these fields for their careers and thus not select neurology as a field given its lower reimbursement rates. There are some historical data to support this argument. A study by The Robert Graham Center: Policy Studies in Family Medicine and Primary Care evaluated 20 years of survey data from graduating medical students looking at factors that influenced their choices of careers. The income gap between proceduralists (radiology and orthopedics) is nearly 3 times that of primary care physicians and had an impressively negative impact on choice of primary care fields.[5] Certainly, other factors influence choice of profession as well, but this study clearly found that economic factors played a key role.[5] The point of including the primary care incentive in the PPACA was in response to the argument that students were not choosing primary care fields due to financial disincentives. Comparisons of fill rates for physicians by salary and specialty show neurology at the low end with internal medicine, family medicine, and psychiatry.[6]

Since neurology is not included in the primary care incentive, there is concern our field will be less attractive to medical students. This could translate into fewer neurologists available in the future and lead to a shortage of neurologists. Even if the total number of neurologists does not shrink, an access to care issue may arise due to the millions of new people now covered by health care and now accessing the system. As a result, access to care for neurologic patients could deteriorate. This may translate into longer patient wait times and worsening health conditions before being seen. There are already shortages in certain locations and these will likely worsen.[7-9] Others may turn to less qualified physicians to treat their neurologic conditions.[10] There are no current studies to prove these suppositions but the AAN has taken the proactive position of not waiting until the crisis occurs to try to fix it.

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Quality reporting incentives were continued in the PPACA, so that physicians who participate in these Medicare incentive programs will continue to see bonus payments through 2014. These programs, known as Physician Quality Reporting Incentive (PQRI), were renewed and are to be expanded in the future, but the current voluntary nature expires and penalties will be assessed to those not participating by 2015. This means that if you do not participate in this Medicare quality reporting program starting in 2015 your Medicare payments will be gradually reduced.

PQRI was instituted in 2007 and includes a list of quality measures for which physicians can report. To be eligible for the bonus payment, a participant must report on at least 3 quality measures for at least 80% of the cases in which the measure was reportable. Lists of measures can be found on the CMS website (http://www.cms.hhs.gov/PQRI/15 MeasuresCodes.asp#TopOfPage) or the AAN website (http://www.aan.com/go/practice/pay). Additional incentive programs are available for physicians who participate in maintenance of certification (MOC) programs. The AAN has developed an extensive MOC program which will be available for neurologists requiring recertification, including those grandfathered prior to recertification requirements. Again, more information can be found on the AAN Web site (http://www.aan.com/go/education/certification). There are also Medicare incentives for institution of electronic health records, which the government believes will further improve quality by allowing for medication interaction and side effect checks, better communication between physicians, and real-time data on their patients' care.[2]

One area only minimally addressed was malpractice reform. Despite many physician groups lobbying hard for important changes in malpractice, Congress only supported grants for demonstration projects to explore the issue further. Some states, such as Texas, Illinois, and California, have already implemented tort reform and have experience with measures that work and those that do not work.[11-13] Other states, such as Kentucky or Michigan, have implemented innovative measures to address rising costs of tort reform such as early disclosure and resolution models.[14] The return on investment of more pilot projects seems low. Meaningful tort reform is unlikely to affect our practices in the near future.

One of the more worrisome aspects of this legislation is the development of an Independent Payment Advisory Board (IPAB). This Board is to be a group of impartial experts charged with targeting growth rates for Medicare spending and to ensure that expenditures stay within set limits. The IPAB will make recommendations to Congress on ways to control health care costs in general. Comprised of 15 members appointed by the President, those who are selected are expected to be experts in health finance, payment, economics, actuarial science, and health facility or health plan management. Three members are required to be from the Department of Health and Human Services, but the other appointees are not restricted or specifically defined. There is no requirement for a physician or health care provider to be on the Board.[4]

The IPAB's first recommendations are to be implemented in 2015. Each year the Centers for Medicare and Medicaid Services (CMS) will determine the acceptable Medicare growth rate based initially on the Consumer Price Index and then eventually on the gross domestic product. If it is predicted that Medicare growth will be above these projections, then the IPAB will be required to make recommendations to Congress on how to decrease Medicare spending for the upcoming year. Congress is very limited in its ability to revise these recommendations and if they do not act the recommendations will automatically be implemented.[15] Most agree that the main way for the IPAB to limit spending will be through cuts to provider payments. These annual short-term actions only on cost will have unclear consequences on patient care and will likely have serious consequences on practices.[15] In general, the overall details are sketchy about the IPAB at this point, but one thing is clear, the CBO estimates that the provision will save $15.5 billion over 10 years, which indicates that the impact on physician practices could be dramatic.[3]

Of course the glaring omission for physicians is the absence of Medicare payment fee schedule reforms. Currently, Medicare payments are tied to the sustainable growth rate (SGR) formula. The SGR was initially instituted in 1998 as a means of controlling fees, but this only impacts a certain aspect of health care expenses (e.g., predominantly physician reimbursements and not testing fees or hospital fees), so it has not resulted in cost containment overall. Over the past few years this formula would have resulted in increasingly larger cuts in physician reimbursement. Because each year Congress blocked these cuts but did not fix the formula, the cuts are carried over to the subsequent years. If this correction were to go through it would be accounted for as a cost to the budget and this is concerning to many as adding to the deficit.[2] Through aggressive lobbying efforts, physicians have managed to prevent direct cuts in reimbursement while only achieving flat or a minor increases in payments.

Physicians were hoping to get a permanent fix to the flawed SGR formula but this has remained elusive. This is at least in part because projected costs of permanently fixing the payment schedule are in the billions of dollars. This continues to have the biggest potential impact on neurology practices, and it remains to be seen what is going to happen with this in the long term. As it stands now, without congressional action, the SGR will cause a cut of approximately 23% on December 1, 2010, and another 6.5% on January 1, 2011.

As the famous Chinese proverb says, "May you live in interesting times." In the United States, those of us practicing in health care are doing just that. As the proverb suggests, this is both a curse and a blessing. We have had dramatic improvements in diagnosis, treatment, and life expectancy over the last 50 years. The next 10 years should prove to have equally dramatic changes in health care delivery. Whether these will be improvements or not remains to be seen.

DISCLOSURE

Dr. Jones has received funding for travel or speaker honoraria from the American Academy of Neurology and Medical Education Resources; serves as clinical advisory editor for *Clinical Neurology News*; and serves on the speakers' bureau for Novartis. M. Amery is employed as Legislative Counsel for the American Academy of Neurology.

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