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## Survival Guide to Health-System Reform

By: SHARON H. FITZGERALD

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### Where Do Providers Focus Their Attention First?

So, *now* what?

The massive health-system reform legislation dubbed the Patient Protection and Affordable Care Act is law, enacting the most sweeping changes in America's health system since Medicare. Experts say now is the time providers should take a deep, cleansing breath, then jump into action with short-term strategies that could pay off down the road.

"There will be pain before we start seeing a gain for providers," acknowledged Ron Wince, president and CEO of Arizona-based Guidon Performance Solutions, a consulting firm that specializes in performance improvement and cultural transformations in the healthcare industry. Guidon's clients include The Mayo Clinic and Cleveland Clinic. He likened the transformation process, especially early on, as

"two steps forward and one step back," adding, "The reform after the reform. That's really where the big stuff is going to hit everybody. We've got to figure out the 'how' piece." And Wince predicted that the level of change won't slow for four or five years.

The good news, he added, is that providers will see a net increase in patient volume versus the net decrease of the past couple of years. "I think the increase in volume could be a net positive economically for a lot of the providers," he said.

### EMRs Top Priority

While this may sound like a broken record, physicians must work doubly hard to ensure an electronic medical records solution is implemented in their practices – and the sooner the better. While this provider obligation harkens back to the mandates inherent in last year's HITECH Act, much of the reforms targeted in the new law are tied to easily accessible and easily shared patient data.

Thus, according to Wince, EMRs should be providers' No. 1 short-term goal. "There are some efficiency gains if you do it right. The EMRs can be a net positive, and there are some financial benefits to offset the costs," he said. To stave off reimbursement cuts, EMRs must be in place by 2015 and demonstrate "meaningful use."

Moreover, providers also need to brace themselves for transparency requirements, making available their prices and "quality measures based on adherence to the evidence," said Paul Keckley, executive director of the Deloitte Center for Health Solutions in Washington, D.C.

### Kumbaya Time?

Mike Segal, a partner in the Miami office of Florida law firm Broad and Cassel, predicted that the EMR burden will prompt "a significant and inevitable consolidation in the delivery of healthcare services." The chair of Broad and Cassel's Health Law Practice Group, Segal said he sees EMR implementation "as being a significant reason why small physician practices will become a dinosaur." Indeed, more and more hospitals are buying practices, especially those in the primary-care arena, he said.

Yet Segal's recommendation isn't necessarily mergers. "Instead of merging, skip that and let's form integrated networks, not just loosey-goosey networks, tight networks tied together with the same electronic information," he suggested. As opposed to forming a new, large medical group, physicians should consider integrating clinically and financially. Beware of Stark, anti-kickback and anti-trust regulations, he noted.

Keckley said providers should expect increased scrutiny regarding conflicts of interest. "They are going to exponentially increase, because Congress has concluded that in many cases physicians have taken advantage of the system to benefit themselves financially. They believe that especially to be the case with imaging facilities, with physician-owned hospitals and, to a lesser extent, in-office and ambulatory surgery. It's in that order," he said. He suggested that physicians evaluate the

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structure of their agreement with a hospital because they are precluded from benefiting directly or indirectly from their own referrals.

Integration of hospitals and providers "is clearly in the bill" and tied to participation in bundled payments and gain-sharing programs, Keckley said. In fact, cooperation and coordination of patient care is a hallmark objective of reform. While working together across specialty lines is a sea change from today's delivery model, doctors must ready themselves for the "team approach," Keckley said. "It's very easy for legislators, consumers and employers to understand. The ones who seem not to understand it are doctors."

The new law encourages the concept of the "medical home," with the patient's personal physician leading a team of practitioners who collectively take responsibility for the overall care provided. That means breaking down long-standing walls, and Wince doesn't believe that's an easy sell. "It's very difficult for somebody who is as capable as a physician not wanting to be in a position of control," he said. "I think we've got a big cultural hurdle to get over before this medical home thing is going to work, at least on the providers' side. I don't think physicians are ready for one kumbaya group."

### Reimbursement Woes

The "most imminent" issue for providers is to improve the model by which physicians are paid, Keckley said. Consideration on the issue is delayed through October, he added. As a result of the reform measure, physicians already can expect less from Medicare Advantage Plans.

"The reimbursement stuff is going to be a mess, I think, for a while," Wince said. "There are a lot of questions around what the implications are." Meanwhile, occasional news stories crop up about a physician group or clinic refusing to accept Medicare or Medicaid because of declining reimbursements and increasing patient numbers. In fact, The Mayo Clinic has made some minimal moves in that direction for some patient populations.

Segal said another payment issue inherent in the reform act – and one that providers must learn to embrace – is a shift away from fee-for-service. "It incentivizes the wrong way – the more services you do, the more you get paid – rather than being incentivized to keep people well," he noted.

### Time for Logic

With 30 years in academic medicine and healthcare research, Keckley said, "The truth is, we have to fix the system." While he recognized that the reform act may create more questions than it answers, at least it acknowledges the need for a seismic shift in the way medicine is delivered in America.

Then he bemoaned what he called the "mass hysteria" that has clouded debate and understanding. "It has digressed to sound bites and pandering to fears. That's exactly what's happened. The reality of the system, coming out of this 14-month health-reform process, is unknown to most people because it was buried in politick, in cable media and in partisan bickering that escapes logic."

Segal had this to say, "I don't think anybody can tell right now how it's all going to end up, but I do know this: When they passed Medicare, even though that was a little more bipartisan, there were a lot of people willing to secede from the union then, too."

*Editor's note: Beginning in June, Medical News will have a three-part series looking at the timeline of implementation, issues and actions*

### What Your Patients Want to Know

The 2010-2011 health-reform changes most noticeable to consumers will be:

- Drug, medical device industry fees: A 2.5 billion per year on drug companies.
- Medicaid expansion: States may increase eligibility threshold to 133 percent of the federal poverty level (mandated by 2014).
- Doughnut hole: Seniors enrolled in Part D will receive a rebate for up to \$250 and, in 2011, will start seeing discounts up to 50 percent for brand name.
- medications (doughnut hole eliminated by 2020).
- Tax credits for small businesses: Businesses with 25 or fewer employees and average wages of less than \$50,000 can qualify for a tax credit of up to 35 percent of the cost of their premiums
- Dependent coverage: Parents are allowed to keep children on their health insurance until age 26 if the child is ineligible for coverage through an employer
- High-risk pools: During the first 90 days, individuals with pre-existing conditions that left them uninsurable for the last six months may enroll in a new high-risk insurance program subsidized by the federal government and administered by the states.
- Risk assessments and preventive health plans for seniors: Effective 2011, Medicare enrollees will be provided comprehensive risk assessments and personalized prevention plans as part of the program.
- Insurance industry regulatory changes: Lifetime caps eliminated, rescission of coverage for other than fraud eliminated, mandatory reporting of medical loss ratios, and elimination of pre-existing condition as a basis for coverage for children under 2 years of age.
- Physician bonuses: Primary care and general surgeons who practice in underserved areas will be eligible for 10 percent bonuses.
- Federal subsidies for retiree health costs: Through 2013, the federal government covers 80 percent of retiree medical claims of more than \$15,000, capped at \$90,000 — at which point the employer's plan will pay the rest.
- Long-term care: In 2011, the provisions of the CLASS act funding long-term care services through

providers need to know to meet the reform challenges ahead.






voluntary premiums (without a federal subsidy) begins; includes provisions for individuals with disabilities and cognitive impairment to receive coverage.

*\* Information from the Deloitte Center for Health Solutions*

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