Healthcare Reform Act of 2010

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Healthcare Reform Act 2010 Over 2000 Pages

- This legislation will effect the totality of the Doctor-Patient Relationship once it is effectuated through regulations.
  - In the past the doctor-patient relationship was contractual in nature with Professional Responsibilities establishing the basis of the relationship.
  - Now the relationship will be much more dominated by government regulations.
  - The government will be involved in defining insurance contracts and the provisions which they contain.

A Sample of the Reform
WE ARE NOT GOING TO READ ALL OF THESE

- TITLE I--QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
- Subtitle A--Immediate Improvements in Health Care Coverage for All Americans
- Sec. 1001. Amendments to the Public Health Service Act.
- "PART A--Individual and Group Market Reforms
- "SUBPART II--IMPROVING COVERAGE

SKIMMING THROUGH A Sample of the Reform --- Nor Read This

- Subtitle C--Quality Health Insurance Coverage for All Americans
- PART I--Health Insurance Market Reforms
  Sec. 1201. Amendment to the Public Health Service Act.
- "SUBPART I--GENERAL REFORM

SKIMMING THROUGH A Sample of the Reform - - - Nor Read This

- Subtitle D--Available Coverage Choices for All Americans
- PART I--Establishment of Qualified Health Plans
- PART II--Consumer Choices and Insurance Competition Through Health Benefit
- Exchanges
- PART III--State Flexibility Relating to Exchanges
- PART IV--State Flexibility to Establish Alternative Programs

SKIMMING THROUGH A Sample of the Reform --- We Won't Read This

- PART V--Reinsurance and Risk Adjustment
- Subtitle E--Affordable Coverage Choices for All Americans
- PART I--Premium Tax Credits and Cost-sharing Reductions
- SUBPART A--PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS
- SUBPART B--ELIGIBILITY DETERMINATIONS

SKIMMING THROUGH A Sample of the Reform – And Not This

- PART II--
- Subtitle F-
- PART I-
- PART II-
- TITLE II-
- Subtitle A-
- Subtitle D-

ETC, ETC, ETC

SKIMMING THROUGH A Sample of the Reform – A lot Not To Read

- PART III--Indian Health Care Improvement
- Subtitle D--Provisions Relating to Title IV
- Subtitle E--Provisions Relating to Title V
- Subtitle F--Provisions Relating to Title VI
- Subtitle G--Provisions Relating to Title VIII
- Subtitle H--Provisions Relating to Title IX
- TITLE I--QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Those Are Just Some of The Major Topics

There Are Over 2000 Pages of It?

You Just Want To Practice Medicine

In the future the government will more intrusively determine how you practice medicine (not just Medicare) based upon payment structures and regulations.

You have a choice for your future

- 1- Fly Blind and Accept What Might Happen to Come Your Way
- 2- Or Learn About the New Programs: the Rewards and Benefits By Adjusting To and Accommodating To Them While Practicing Your Profession

- Choice No. 1

- Choice No. 2

SEC 3008 UNDER THE HEALTHCARE REFORM ACT PROVIDES THAT THERE ARE MEDICARE PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS

- These Are In Addition To Those Already Being Applied Pursuant To The Deficit Reduction Act of 2005.
- That Means That Hospitals Better Identify All Diagnosis Upon Admission Or Possibly Be Held Accountable As If The Subsequent Diagnosis Had Been Acquired In The Facility

IN GENERAL.--In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital [in inpatient hospitals in the upper 25% rate of facilities with certain high cost and common conditions] occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under Medicare for their discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges.

Reports As To Hospital's Status Of Acquired Conditions Are To Be Prepared And Made Public

- (B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.--The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections as to the information to be made public with respect to the hospital prior to such information being made public.

LIMITATIONS ON REVIEW.--There shall be no administrative or judicial review concerning the provision of reports to applicable hospitals and the information made available to the public beyond submitting responses to the Secretary.

Criminals Have Rights Of Judicial Review But Hospitals Do Not Have Any Right Of Judicial Or Administrative Review Concerning Devastating Information To Be Released.

What Do You Think Will Happen Once These Reports Go Public?

- Having a single percent of reimbursement reduced for discharges will be a minor cost compared to the increase in professional liability insurance rates for the hospital and all practitioners who admit patients to the facility.

ARE HOSPITALS THE ONLY ONES BEING AFFECTED BY REFORM ACT?

- NO! The Reform Act Has A Special Place For Physicians and the Public. The Administration Promised That It Could Save $500 Billion From Waste, Fraud and Abuse In Order To Pay For The Reform. Where Do You Believe That It Is Coming From?

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

- Medicare is amended so as to ESTABLISH A VALUE-BASED PAYMENT MODIFIER.
- IN GENERAL.--The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the Medicare fee schedule based upon the quality of care furnished compared to cost during a performance period.

Conceptual Implications: Payment based upon performance with weighing of quality of care in comparison to cost of care.

- This program change is to be characterized by BUDGET NEUTRALITY.--The payment modifier established under this subsection shall be implemented in a budget neutral manner.
- This means by the time it is implemented there will be winners and losers. There will be fewer winners and more losers because the revenue saved will be split between the winners and the government. The money will come from the losers.

Sounds good for some but could be devastating to others.

- Government intends to push more work and variety of work on PCPs; thus, saving revenues paid to specialists. If the Government Is to push the work from the specialists, can the PCPs trust the Government?

GLOBAL OFFICE VISIT

- Expect to see more testing and procedures performed by PCPs where sophistication is not required in interpretation and undertaking. Possibly more simple procedures by PCPs in comparison to those by specialists, assuming the procedure permits. Good for PCPs but bad for specialists? However, PCPs might find themselves on the front line of mass production medicine and the Global Office Visit.

Could be devastating for everyone: Specialist, PCPs and Patients Could All Suffer.

- Government intends to cut back on use of and reimbursement to specialists and encourage PCP to assume more responsibility for basic testing and procedures. This would theoretically enhance quality to cost ratios, assuming a PCP can appropriately undertake and interpret the tests performed and procedures undertaken.

What tests and procedures will be assigned to the PCPs and what tests will be referred out to specialists?

- Will government only cut back on reimbursements for specialist testing and procedures without adequately compensating PCP for testing and procedures? Will the Government imposed upon PCPs the responsibility to tests and undertake procedures all under a simple Global Office Visit code?

Why Not If You Are CMS?

- If you are Medicare and attempting to save $500 Billion dollars, which the administration assured the public that it could save from fraud, waste and abuse in order to pay for Health Care Reform, then why not impose more responsibility upon the least paid segment of our health care community and pay them less than you would pay the higher paid segments of the community and cut those higher costs.

Any Winners?

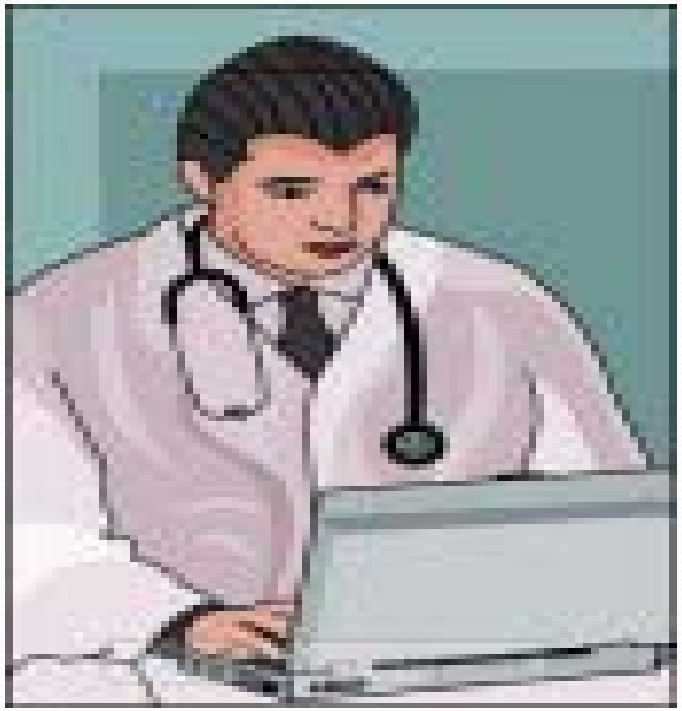
- If Medicare regulatory structure is not adjusted to adequately compensate for services performed and recognized as specialized skills, then all can be losers, including the patients and PCPs.
- Patients could have extensive wait times to see specialists who have available specialized testing equipment and skills.

This can also be imposed by regulation into the private insurance sector. No one and no where is immune from government intrusion!

How Can Specialists Offset Their Lost Income?

- How can specialists offset this loss of work and income? Moonlighting? If so, then only the wealthy can afford the type of healthcare that we are currently use to today?
- How can an Accountable Care Organization assist those involved by providing volume work and reduced overhead? [What is an ACO and how can it assist you?] We shall see.

Medicare will now encourage SYSTEMS-BASED CARE



SYSTEMS-BASED CARE

- The Secretary will now apply a payment modifier in a manner that promotes systems-based care. One such system base care entity would be an HMO. However, the Reform Act is not requiring everyone join an HMO. A system based care organization is identified in the Act itself. The Act recognizes the new creature of the Accountable Care Organization.

Accountable Care Organization?

Accountable Care Organization

- The Reform Act establishes a Medicare SHARED SAVINGS PROGRAM which provides for Accountable Care Organizations [ACO]. This is a program which is established for you to become more efficient in a manner defined by the government and as a result of that efficiency you will have more profit which you are able to share with the government. The government will be potentially generous(?) with HMOs and similar organizations. The ACO is just a new player on the block. The kicker is that the government will be generous with the results of providers' own investment and efficiency efforts.

The Reform Act Provides

- Secretary shall establish a Medicare shared savings program that promotes:
- ***accountability*** for a patient ***population***
- ***coordinates*** items and services under parts A and B,
- encourages ***investment*** in ***infrastructure*** and ***redesigned*** care processes for high quality and efficient service delivery. i.e., that is with your money and investment!

The Reform Act Provides

- ***groups*** of ***providers of services and suppliers*** meeting criteria specified by the Secretary ***may work*** together ***to manage and coordinate care*** for Medicare ***fee-for-service*** beneficiaries through an ***accountable care organization*** (referred to as an 'ACO'); and

The Reform Act Provides

- ACOs ***that meet quality performance standards*** established by the Secretary are eligible to ***receive payments for some of its shared savings*** under the Act. The Secretary takes the rest of the savings.

The Reform Act Provides

- IN GENERAL.--Subject to the requirements of the Reform Act and its regulations, the following groups of providers of services and suppliers, which have established a mechanism for shared governance, are eligible to participate as ACOs under the Medicare program:

The Reform Act Provides

- ACO professionals in group practice arrangements.
- Networks of individual practices of ACO professionals.
- Partnerships or joint venture arrangements between hospitals and ACO professionals.
- Hospitals employing ACO professionals.
- Whichever other suppliers and providers the Secretary determines appropriate.

An ACO shall meet the following requirements:

- The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to as the 'agreement period').

An ACO shall meet the following requirements:

- The ACO shall have a formal legal structure.
- The ACO shall include primary care ACO professionals that are of sufficient number.
- The ACO shall provide the Secretary with information regarding ACO professionals participating in the ACO.

An ACO shall meet the following requirements:

- The ACO shall have in place a leadership and management structure.
- The ACO shall define and implement certain processes.
- The ACO shall demonstrate that it meets patient-centeredness criteria.

AN ACO SHALL HAVE

- QUALITY AND OTHER REPORTING REQUIREMENTS –
- clinical processes and outcomes;
- patient and, where practicable, caregiver experience of care; and
- utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

PAYMENTS.-- Under and ACO Program

- IN GENERAL.--Under the program, subject to certain provisions, payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under the Reform Act.

PAYMENTS.-- Under and ACO Program

The ACO must meet quality and other performance standards established by the Secretary in addition to meeting saving standards established by the Secretary to be eligible for such shared savings payments.

PAYMENTS.-- Under and ACO Program

- DETERMINING SAVINGS.--In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary

CANNOT AVOID AT-RISK PATIENTS

- MONITORING AVOIDANCE OF AT-RISK PATIENTS.--If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

LIMITATIONS ON REVIEW

- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—
- the specification of criteria under subsection (a)(1)(B);
- the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

LIMITATIONS ON REVIEW

- the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);
- the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

What are some of the implications of this system.

- There will be winners and there will be losers. The winner will get onto the ground floor of the changes and control his/her destiny. The loser will be swept by the tides of change with limited control over his/her destiny. A Specialist who gets in on the ground floor of an ACO can make money but he/she becomes one of the excess Specialist without an ACO or other similar organization to affiliate with. Then he/she can find him/herself to be on the low end of the feeding chain. The PCP can find him/herself to now be in demand.

Once Again the Government Controls You, The Results of Your Sweat and Toil And You Have No Right of Appeal As to Many of the Issues Facing You.

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- Dedicated To All Of The Dedicated Physicians Who Have Fallen To The System

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