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The New Health-Care Law and What It Means for Clinical Gastroenterology

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On 23 March 2010, President Obama signed the Patient Protection and Affordable Care Act (HR 3590, or PPACA) into law, Public Law 111-148. One week later, the president signed into law the Health Care and Education Reconciliation Act of 2010 (HR 4872, or Reconciliation Act), Public Law 111-152, which made certain politically required modifications to PPACA.

Background

PPACA (HR 3590) was the version of comprehensive health reform drafted in the Senate and passed on 24 December 2009 by a vote of 60–39. On 21 March 2010, the House of Representatives passed HR 3590 by a vote of 219–212, but only after receiving assurances from the Senate leadership that the Senate would vote on a "package of fixes," structured as a budget-reconciliation bill, to amend HR 3590. By crafting the legislation in such a way, it allowed the Senate to pass the bill with a simple majority vote instead of the traditional 60 votes necessary to overcome a filibuster.

What does this mean for practicing physicians—and gastroenterologists in particular? While health-reform legislation is now law, the *implementation* of health reform will strongly influence the impact on our specialty; and the Secretary of Health and Human Services (HHS) is just beginning to develop these policies. For many years to come, physicians and practice groups will be required to follow a series of new rules and regulations dealing with the changes enacted by health-care legislation. Physicians will also be faced with a changing payer landscape that will affect the practice of medicine.

The brief description below as well as the detailed list of key health-reform provisions in **Table 1** explain how the changes will impact you and your patients.

Health reform and provider reimbursement

While multiple provisions of the new health-reform legislation aim to reduce Medicare costs by controlling reimbursement policies, it must be noted first that the legislation fails to address the existing flaws in the physician-reimbursement scheme regarding the sustainable growth rate (SGR) formula. In other legislative vehicles, Congress has delayed the 21% reimbursement reduction scheduled to go in effect January 2010 with temporary one-month patches. However, as long as the current reimbursement system is in place, delaying the 21% cut only exacerbates the cuts next year and beyond. Congressional leaders have said that they will attempt to permanently reform the SGR formula in separate legislation; unfortunately, a permanent fix to this problem is unlikely in the near future, because of the significant budgetary cost and the lack of political appetite for additional health-care legislation.

The overall goal of the health-reform legislation was to provide more individuals with increased access to high-quality and cost-effective health care. Although the legislation will provide enhanced access to government health programs and federally subsidized individual and group insurance plans, beginning in large measure in 2014, providers should be wary as to how the law will determine "cost-effective" health care. In Medicare, for example, the law requires the Secretary of the HHS to adjust reimbursement for certain physicians by a "value-based modifier" in 2015, which will adjust Medicare physician payments in a budget-neutral manner based on the quality and cost of the care they deliver. By January 2017, this provision will apply to all physicians and physician groups. The issue of "budget neutrality" is at the root of this pattern of reimbursement cuts to gastroenterology over the past decade, and it preserves a system that unfortunately creates winners and losers across specialties. The new health-reform law also requires the Secretary to review and adjust reimbursement for certain "misvalued" codes, including codes experiencing high-volume growth. This provision could have significant consequences for providers performing colonoscopy and colorectal cancer screening as other provisions in the law aim to *increase* screening utilization rates. The key provisions designed to turn back years of reimbursement cuts for gastrointestinal procedures that are contained in legislation supported and advanced by the American College of Gastroenterology—the Supporting Colo-Rectal Examination and Education Now (SCREEN) Act—were not included in the final bill, although efforts to deal with these issues as part of the battle on the SGR will continue.

Another provision in the new law extends reporting measures aimed at increasing quality of care. The Physician

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Quality Reporting Initiative (PQRI) is extended through 2014, with incentive payments ranging from 0.5% to 1.0% from 2011 to 2014. However, beginning in 2015, physician payment will be tied to successful PQRI reporting. This is important, and potentially problematic, because PQRI reporting measures to date are largely for primary care and not for specialties, as the Centers for Medicare & Medicaid Services (CMS) notes in the 2010 Medicare Physician Fee Schedule Final Rule. Physicians will soon know whether they are perceived as quality providers, because the new law requires HHS to create, beginning in 2011, a "physician compare" website to grade and compare providers enrolled in the Medicare program and others participating in the PQRI program. Also, HHS must have a plan to include other quality-of-care data for public consumption by 2013. Specialties such as gastroenterology should take note of this because the public will probably initially judge their performance by their participation in PQRI, although this may be misleading. Furthermore, by 2012 the Secretary will be providing physicians with a "physician feedback" report, which compares gastroenterologists and other providers caring for similar patients based on quality measures such as PQRI.

It is troubling to look at these provisions on reimbursement that require providers to demonstrate their value through more reporting and scrutiny but also provide little in the way of incentives or payment enhancements. The most telltale sign that Congress may be looking to provider reimbursement as a key source of reduction in health-care costs in Medicare is the newly authorized Independent Payment Advisory Board (IPAB). This

Table 1. Key provisions of the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act

Issue	Description	When does it start?
Provider reimbursement and reporting		
Sustainable growth rate and Medicare physician pay reform	The health-reform law does not address Medicare physician reimbursement or sustainable growth rate (SGR) reform	Congress has been passing temporary "fixes" that prevent the 21% reimbursement cut that was scheduled to take effect in January 2010
Physician feedback program	*Physician feedback program.* Expands Medicare's physician resource use feedback program to provide for development of individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) with those of other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health-care costs	Effective 2012
Public reporting of physician performance information	*A "physician compare" website.* Requires the Secretary of HHS to develop a website with information on providers enrolled in the Medicare program and others participating in the PQRI program. The website will provide public, comparable information on quality measures, patient experience, and assessment of patient outcomes	Requires the Secretary to publish the measures of quality of care and costs, the dates of implementation of the payment modifier, and the initial performance period no later than 1 January 2012 The Secretary shall develop the website by January 2011 and implement a plan to incorporate comparable information on the website regarding quality of care by January 2013 The Secretary is required to report to Congress on the "physician compare" website by 1 January 2015 The Secretary will apply the payment modifier beginning on 1 January 2015
Physician Quality Reporting Initiative	*Improvements to the Physician Quality Reporting Initiative:* Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRI Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine	Incentive payments for successful reporting are 1% (2011) and 0.5% (2012–2014) Beginning in 2015, physicians who do not submit measures to PQRI will have their Medicare payments reduced by 1.5% for 2015 and 2% for 2016 Beginning in 2012, the Secretary is required to develop a plan on integrating clinical reporting measures with "meaningful use" of health IT. (CMS is phasing in an incentive program on health IT "meaningful use" with the ultimate goal of tying payments to health IT in 2015)
"Misvalued" codes	*Misvalued codes under the Physician Fee Schedule.* Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have undergone high growth rates. Strengthens the Secretary's authority to cut reimbursement fee schedule rates that are found to be "overvalued" or "inaccurate"	Effective when bill signed into law

Table 1. Continued

Value-based payment modifier	*Value-based payment modifier under the Physician Fee Schedule.* Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized	Requires that the Secretary publish the measures of quality of care and costs, the dates of implementation of the payment modifier, and the initial performance period not later than January 2012 The Secretary will phase in the new payment system over a 2-year period beginning in 2015
Extension of work geographic index floor	*Extension of the Work Geographic Index Floor and revisions to the Practice Expense Geographic Adjustment Factor under the Medicare Physician Fee Schedule.* Extends a floor on geographic adjustments to the work portion of the fee schedule through the end of 2010, with the effect of increasing practitioner fees in rural areas. Also provides immediate relief to areas negatively impacted by the geographic adjustment for practice expenses	Requires the Secretary of HHS to improve the methodology for calculating practice expense adjustments beginning in 2012
Sunshine provisions	*Transparency reports and reporting of physician ownership or investment interests.* Requires drug, device, and biological and medical supply manufacturers to report transfers of value made to a physician, a physician medical practice, a physician group practice, and/or a teaching hospital. Duplicative state or local laws would be pre-empted by federal law; however, federal preemption would not occur for state or local laws that are beyond the scope of this section. Directs any applicable manufacturer or group purchasing organization to submit to the Secretary information relating to any ownership or investment interest held by a physician in the applicable manufacturer or group purchasing organization. Noncompliance by the manufacturer or group purchasing organization will result in civil money penalties of not less than $1,000 and not more than $10,000 for each violation. Information reported to the Secretary will be made available to the public	Effective 31 March 2013 and on the 90th day of each calendar year beginning thereafter
Imaging services and self-referral of imaging services	*Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services.* Amends the in-office ancillary exception of the Stark Law to include a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services, as determined by the Secretary, the referring physician must inform the individual at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or a person who is directly supervised by the physician or by another physician in the group practice. The individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides	Effective when bill is signed into law
	Utilization factor: Modification of equipment utilization factor for advanced imaging services Increases the utilization rate assumption for advanced diagnostic imaging equipment	Utilization rate changes: 50% to 65% for 2010–2012, to 70% for 2013, and to 75% for 2014 and subsequent years
	Payment for imaging services: Sets the utilization rate assumption for expensive diagnostic imaging equipment (equipment priced over $1 million) at 75% for 2011 and subsequent years. This change would be exempt from the traditional budget neutrality for Part B services	
Independent Payment Advisory Board	Creates a 15-member Independent Payment Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress will be allowed to consider an alternative provision on a fast-track basis. The Board will be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards[a]	The Independent Payment Advisory Board will make proposals to Congress and the President beginning in 2014, and annually thereafter for years when growth exceeds target growth

15-member board will be tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries beginning in 2014. In years when Medicare costs are projected to be unsustainable, i.e., greater than a target growth rate, the board will be required to submit proposals to Congress that will become law unless Congress passes an alternative measure achieving the same level of savings. The board is prohibited from making proposals that "ration care," raise taxes or Part B premiums, or change Medicare benefit eligibility or cost-sharing standards. Moreover, the board is prohibited from recommending polices impacting payments for hospice and hospitals before 2018. However, there is no restriction on the board from modifying physician reimbursement rates beginning in 2014.

Ambulatory surgical centers (ASCs) and physician-ownership issues are also impacted by health reform. Effective January 2011, the Secretary is required to develop a plan to reimburse ASCs

Table 1. Continued

Payment bundling	*National pilot program on payment bundling.* Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute-care providers to improve patient care and achieve savings for the Medicare program through bundled payment models	Requires the Secretary to establish this program by 1 January 2013 for a period of 5 years. Before 1 January 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending
Additional provisions		
Medical malpractice reform	*State demonstration programs to evaluate alternatives to current medical tort litigation.* Authorizes states to conduct demonstration programs to evaluate alternatives to current medical tort litigation. Grants may be awarded for no more than 5 years. Alternatives to tort litigation should allow for resolution of disputes and promote a reduction of health-care errors by encouraging the collection and analysis of patient safety data related to disputes resolved by organizations that engage in efforts to improve patient safety and the quality of health care	Appropriates $50,000,000 for the 5-year fiscal year period beginning with fiscal year 2011 The Secretary shall submit to Congress an annual compendium of the annual reports submitted to the Secretary from states. MedPAC and MACPAC shall conduct independent reviews of the alternatives to current tort litigation implemented by the states and submit reports to Congress not later than 31 December 2016
Ambulatory surgical center productivity adjustments	*Productivity adjustments.* Applies a productivity reimbursement adjustment to ASC services based on quality and efficiency[b]	Effective 1 January 2011
Payment adjustment for hospital-acquired conditions	*Hospital-acquired conditions.* Certain high-cost and common hospital-acquired conditions would be subject to a payment penalty. Requires the Secretary to recommend to Congress a policy on hospital-acquired conditions in the ASC and outpatient setting	Penalty payment for hospitals (inpatient) effective 2015 Recommendation to Congress must be made by January 2012
Ambulatory surgical center value-based purchasing plan	*Plan for a value-based purchasing program.* Requires the Secretary of HHS to develop a plan to reimburse ASCs based on the quality and efficiency of care delivered in ASCs	The Secretary must submit the plan by 1 January 2011
Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals	Prohibits physician-owned hospitals that do not have a provider agreement prior to 31 December 2010 from participating in Medicare. Such hospitals that have a provider agreement prior to 31 December 2010 could continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, patient safety issues, and expansion limitations The Secretary shall make information submitted by hospitals relating to physician ownership and investment available to the public. The Secretary shall establish policies and procedures to ensure compliance with such provisions. This may include unannounced site reviews of hospitals	Effective immediately. Not later than 1 May 2012, the Secretary shall conduct audits to determine whether hospitals are in violation of such reporting provisions
Beneficiary components		
Preventive health services	*Coverage for preventive care without cost sharing.* Requires individuals and group health insurance plans to cover, and not impose cost sharing on, preventive services recommended with A or B rating by the US Preventive Services Task Force, including colonoscopy	6 months after bill is signed into law, except grandfathered plans Effective 2014 for all plans in the health insurance exchanges
Waiver of coinsurance for preventive services	*Removal of barriers to preventive services in Medicare.* Waives coinsurance in all settings (copayment and deductible) for certain preventive and screening services. Such services are those recommended (rated A or B) by the US Preventive Services Task Force, for any indication or population	Effective 1 January 2011

on the basis of value and efficiency. It is unclear what data the Secretary will use when implementing a "value-based purchasing program" or when determining a reimbursement "productivity adjustment," as ASCs currently do not report quality or cost information, nor are there new requirements mandating that they do so. CMS even noted in its 2010 hospital outpatient and ASC payment rule that it would be burdensome for ASCs to report cost and quality data. ASC payments are currently pegged to a percentage of the hospital outpatient department (HOPD) payment rate, with gastroenterology services in the ASC setting reimbursed at roughly 59%–60% of the HOPD rate. Additionally, the IPAB can propose and implement policy changes affecting ASC procedures and reimbursement rates.

Another mechanism purportedly intended to control Medicare costs prohibits new physician-owned hospitals without a provider agreement as of December 2010 from participating in the Medicare program entirely. Existing physician-owned or physician-invested facilities will be subject to greater scrutiny, as the law requires new compliance, reporting, and audit policies to monitor physician ownership and investment.

Physicians also should note that, effective immediately, the Stark Law "in-office ancillary services" exception is amended and now also requires physicians referring patients for magnetic resonance imaging, computed tomography, and positron emission tomography services to inform the patient at the time of referral that the patient may obtain these imaging services from another provider. The referring physician must also provide the patient with a written list of local service providers. As background, the Stark Law prohibits certain referrals in which the referring physician has an ownership/investment interest in or compensation arrangement with the entity providing the services unless the physician or physician group is providing other, unrelated physician services in that same building or group practice (the "in-office ancillary services" exception). Although there is no current guidance from CMS on this change, providers and office staff should implement an office policy in order to be in compliance with this provision. The law also changes payment rates for imaging services by setting the utilization-rate assumption for high-cost diagnostic imaging equipment (equipment priced over $1 million) at 75% beginning in 2011.

Key impacts on patients

The impact of the new health-reform law on gastroenterology patients, especially in colorectal cancer screening, is more positive than the impact on providers. The law mandates that all new group and individual health plans as of September 2010 provide patients with coverage for preventive services rated A or B by the US Preventive Services Task Force (USPSTF). For colorectal cancer screenings, the USPSTF provides an A recommenda-

Table 1. Continued

Waiver of coinsurance for colorectal cancer screening tests	*Removal of barriers to preventive services in Medicare.* Provides that the waiver of coinsurance for colorectal cancer screening shall apply regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test	Effective 1 January 2011
Improved access to preventive services in Medicaid	*Improving access to preventive services for eligible adults in Medicaid.* The current Medicaid state option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include (i) any clinical preventive service recommended with a grade of A or B by the US Preventive Services Task Force, and (ii), with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices and its administration. States that elect to cover these additional services and vaccines, and also prohibit cost sharing for such services and vaccines, would receive an increased federal medical assistance percentage (FMAP) of one percentage point for these services (Sec. 4106)	Effective 1 January 2013
Private insurance lifetime limits	*No lifetime limits.* Restricts and prohibits individual plans from establishing lifetime or annual coverage limits	Effective 6 months after bill is signed into law
Private insurance annual limits	*Regulated, restricted annual limits on benefits, effective 6 months after bill is signed into law; ban on annual limits beginning in 2014*	Restricted annual limits effective 6 months after bill is signed into law; then banned beginning in 2014
Preexisting conditions	*Prohibition of preexisting-condition and health-status exclusions.* Prohibits private insurers from imposing insurance exclusion based on a preexisting condition or health status	Effective 6 months after bill is signed into law for children; effective 2014 for all

ASC, ambulatory surgical center; CMS, Centers for Medicare & Medicaid Services; HHS, Department of Health and Human Services; IT, information technology; MACPAC, Medicaid and CHIP Payment and Access Commission; MedPAC, Medicare Payment Advisory Commission; PQRI, Physician Quality Reporting Initiative.

[a]The only major item left to reduce costs is lowering provider payments. [b]Note there are no cost-reporting requirements.

tion for colonoscopy, fecal blood testing, and sigmoidoscopy in adults, beginning at age 50 and continuing until age 75. This is consistent with the American College of Gastroenterology's recommendations on colorectal cancer screenings, although the College maintains that African Americans should begin getting screened at age 45. This provision has been part of the College's screening legislation initiatives, the SCREEN Act, along with increases in reimbursement that have not yet been adopted but continue to be a major priority for the College.

All health insurers participating in newly created state or regional-based health insurance "exchanges" (similar to the current Massachusetts Commonwealth Health Connector system) will be required to cover these preventive services and will be prohibited from imposing cost sharing on beneficiaries (i.e., copayments and deductibles). Insurers are also prohibited from imposing lifetime limits (effective September 2010), restricted in their ability to impose annual limits (effective September 2010, then prohibited beginning in 2014), and prohibited from imposing exclusions based on a preexisting condition or health status (beginning September 2010 for children, and beginning in 2014 for all).

Currently, an estimated 31 states mandate coverage for colorectal cancer screenings. The health-reform law requires all insurers in every state to provide coverage for colorectal cancer screening. This is a vast improvement in the fight against colorectal and other gastrointestinal-related conditions that the College has been waging at the state level.

For Medicare beneficiaries, the law also eliminates cost sharing (copayment and deductible) for colorectal cancer screenings regardless of procedural code or diagnosis. This becomes effective January 2011. This provision has also been part of the SCREEN Act and the College's legislative initiatives. Current law waives cost sharing for screening colonoscopy, but not when a screening turns into a diagnostic colonoscopy. This is good news for Medicare beneficiaries, as they routinely wake up from a colonoscopy to find that they owe money for a preventive service that saved their life and saves the Medicare program money. Current colonoscopy utilization rates among Medicare beneficiaries, however, are relatively low, with an estimated 52% of beneficiaries getting some form of screening. Hopefully, eliminating cost sharing will improve utilization. This is important because Medicare may experience an increase in colorectal cancer incidences due to the fact that obesity is expected to be a major chronic condition among Medicare beneficiaries as the Baby Boomer generation ages into the program.

The law also encourages states to cover preventive services such as colorectal cancer screenings in their Medicaid programs. The federal government generally reimburses or matches 50%–75% of the cost for a state's Medicaid expenses, depending on the average per capita income of the state. Beginning in 2013, the federal government would increase by 1% its Medicaid matching rate for states choosing to cover these preventive services and waive beneficiary coinsurance.

Overall, health-care reform does much to increase access to health insurance and necessary preventive services. For this, Congress should be congratulated for its efforts in passing the bill. The College membership can take pride in its role in getting these important patient-focused provisions of the College's legislative agenda included in the law.

Looking forward

Congress and President Obama have designed and created the blueprint of health reform, but the Secretary of HHS and the policy makers at CMS are now responsible for implementing these programs and policies. Congress gave the Secretary a tremendous responsibility as well as an extensive to-do list. The silver lining in this approach is that medical societies will be able to comment on proposals and have influence over the final rules.

Now that the signing ceremonies are over and the media have shifted focus to the next "breaking news" alert, you can be assured that the American College of Gastroenterology will remain focused on the impact of this law as CMS and HHS begin finalizing the details and enacting the provisions of health reform. Furthermore, the College will continue to pursue every legislative and regulatory opportunity to increase reimbursement for gastroenterology and reverse the trend of cuts that began almost a decade ago.

In many respects, health-care reform has just begun.

CONFLICT OF INTEREST

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