

A GIs Guide to Health-Care Reform

With passage of the Patient Protection and Affordable Health Care Act, American medicine entered a new era. The AGA was an active participant in the health-care reform debate and supports increased access for the millions of uninsured patients in the U.S. However, there remain serious concerns with many provisions of this legislation and how they will impact gastroenterology.

Many health-care reform provisions will be implemented over the next several years through the regulatory process. AGA plans

to work with federal agencies to influence the process with the goal of improving policies that impact the gastroenterology field. We anticipate that lawmakers on



Capitol Hill will write a technical corrections bill, which is common after comprehensive legislation of this magnitude. AGA will advocate for provisions that improve the health-care system for gastroenterologists.

The AGA will keep members updated on the process and provide tools to help gastroenterologists adjust in the new health-care environment. As a first step, we offer this brief chronological guide outlining parts of the bill important to gastroenterology.

Patient-Directed Provisions

Increased Access to Colorectal Cancer Screenings

Beginning immediately, new private sector health-care plans that are issued on or after Sept. 23, 2010, will be required to provide a minimum benefits package and cover colorectal cancer (CRC) and other preventive screenings with no cost sharing for the patient. For example, if a patient's plan period begins on Jan. 1, 2011, the screening benefit would not be effective until the date of the new plan.

In 2011, Medicare and Medicaid will no longer charge copayments for proven preventive screenings such as CRC screenings. Medicare will also waive the deductible for CRC screenings regardless if a polyp or lesion is found. However, the copayment is not waived when a screening colonoscopy becomes therapeutic and AGA has been aggressively lobbying to change this inequity.

Improved Access to Insurance Coverage

Immediate access to high-risk pools must be provided for people who have no insurance because of pre-existing conditions.

In addition, the legislation bars insurers from denying people coverage when they get sick and bans insurers from imposing lifetime caps on coverage. It also bars insurers from denying coverage to children who have pre-existing conditions, and requires insurers to allow young people to stay on their parents' health insurance until they are age 26.

In 2014, no insurer would be allowed to deny coverage to a patient with a pre-existing condition.

Physician Reimbursement Provisions

Imaging Services

Effective immediately, the law would change the utilization rate assumption to 75 percent for advanced imaging equipment (CT, PET and MRI), whereby Medicare assumes that a provider is using imaging equipment 75 percent of the time in order to be fully reimbursed.

Physician Workforce

Effective immediately, a National Health Care Workforce Commission will be established to provide comprehensive information and recommendations to Congress on the nation's workforce priorities. Beginning in 2011, unused graduate medical education (GME) slots would be re-distributed to help increase the training of primary care physicians.

Misvalued Codes

Effectively immediately, the law gives the secretary of HHS the authority to adjust codes that are deemed misvalued or overvalued,

and specifically mentions codes that have experienced high volume and have not been subject to review since the implementation of the Resource Based Relative Value System, the so-called "Harvard codes," which contain many endoscopy codes. AGA will be monitoring this process closely as this will be part of the 2011 Medicare physician fee schedule rule and could potentially have a devastating impact on reimbursement for gastroenterology.

Comparative Effectiveness Research

Effective immediately, the act establishes a Patient Center Outcomes Research Institute, an independent institute governed by patients, providers, government officials and other stakeholders. This institute would focus on clinical effectiveness research, not on cost effectiveness and ensures that CMS will not misuse CER results in ways to

The American Gastroenterological Association is the trusted voice of the GI community.

Founded in 1897, the AGA has grown to include 17,000 members from around the globe who are involved in all aspects of the science, practice and advancement of gastroenterology. www.gastro.org



overlook differences in patient needs or discriminate against the elderly or people with disabilities. The act also clarifies that findings published by the institute do not include practice guidelines, coverage, payment or policy recommendations. The institute will have a Board of Governors to oversee the research findings, including a strong physician representation since it states that out of the seven providers, four need to represent physicians. AGA will monitor opportunities for research in GI and integrate the AGA Digestive Health Outcomes Registry™ with this process.

Physician Quality Reporting System (PQRS)

The Act extends the incentive payments for successful reporting to 1 percent in 2011 and .5 percent in 2012-2014. Beginning in 2015, however, physicians who do not report on quality measures to the PQRS will receive a 1.5 percent cut in Medicare reimbursement and a 2 percent cut in payments in 2016 and thereafter. **The AGA will continue to work with the AMA's Physician Consortium for Performance Improvement (PCPI) to further expand relevant quality measures that enable our members to participate in PQRS and help improve the outcome of GI care.**

The Act requires CMS to create an appeals process for physicians and to provide timely feedback for participating physicians, two positive changes to the program for which the AGA and the Alliance of Specialty Medicine advocated.

Physician Compare Web Site

Beginning in 2011, HHS would develop a Web site on which to host information on Medicare providers and those physicians who participate in the PQRS program. The Web site will be designed to provide the public with information on quality, patient experience and assessment of patient outcomes. Comparable physician quality information will be incorporated on the Web site by 2013.

Ambulatory Surgery Centers

The HHS Secretary would be required to submit a plan by Jan. 1, 2011 for value-based purchasing for ambulatory surgery centers (ASC), under which their payment would be based on quality and efficiency measures. AGA will monitor this process closely and integrate the AGA Digestive Health Outcomes Registry with this new plan.

Effective 2011, an ASC productivity adjustment would be applied to reimbursement similar to the productivity adjustment that is used in the calculation in the Medicare physician fee schedule where productivity is measured compared to the private sector.

Medical Liability Provisions

Effective 2011, the law appropriates \$50 million over five years to provide grants to states to conduct demonstration projects on alternative medical liability reform programs. The HHS Secretary would be required to submit reports to Congress on these pilots and MedPAC would conduct independent reviews of these pilot programs.

Physician Feedback Program

Beginning in 2012, physicians would receive individual reports on their resource use compared with their peers who see a similar patient base.

Accountable Care Organizations

Beginning in 2012, physicians would be encouraged to join accountable care organizations through which they would be eligible for enhanced payment incentives based on quality and efficiency improvement. All physicians are eligible to participate, and the AGA will work to integrate the AGA Digestive Health Outcomes Registry to assist those physicians who choose to participate in such pilots.

Bundling

Effective 2013, the HHS Secretary would be required to establish a pilot program on payment bundling to encourage providers to improve care coordination to achieve savings for the Medicare program.

Value-Based Payment Modifier

The law implements a new budget-neutral value-based modifier through which physicians would be reimbursed based on the cost and quality of care that they deliver. Beginning in 2013, and likely to be part of the 2013 Medicare physician fee schedule, the HHS Secretary would solicit input for quality outcomes measures on which to base the quality modifier; the new payment system would be implemented in 2015. AGA will keep a close eye on this process and will be working to integrate the AGA Digestive Health Outcomes Registry and its measures.

Physician Sunshine Provisions

Effective March 31, 2013, drug, device, biological and medical supply manufacturers would be required to report any transfers of value to any physician, group practice or teaching hospital and disclose any ownership or investment that the physician may have with the manufacturer. These provisions do not appear to apply to CME programs.

Independent Payment Advisory Board

The law creates an Independent Payment Advisory Board (IPAB), which would be comprised of 15 members tasked with making recommendations to Congress on lowering costs to the Medicare program. The recommendations would take effect unless Congress rejects the proposal and offers a recommendation that achieves the same savings. The board would be prohibited from making decisions that ration care, increase beneficiary premiums or eliminate benefits, thus leaving physicians more vulnerable to potential cuts. Effective 2015, IPAB would submit a recommendation to Congress. **AGA does not support implementation of IPAB and will support legislation that abolishes it.**