

# Healthcare Reform: Neurosurgery's Perspective

## Neurosurgery's Key Healthcare Reform Priorities

- Cover uninsured
- Lower health care costs
- Insurance reforms
- No single payer
- No interference in doctor/patient relationship
- Ensure direct access to specialty care by doctor of patient's choice, including right to privately contract
- Address workforce shortages in surgery
- No government regulation of residency training
- Loan repayment program for pediatric specialists
- Improve emergency care system
- Quality determined by profession
- Establish independent comparative effectiveness research institute w/appropriate safeguards
- Medical liability reform
- Repeal SGR
- No budget neutral primary care bonus payments
- No independent payment advisory board
- Continue to allow physician ownership of imaging equipment, specialty hospitals and ASCs

## Neurosurgery's Reaction to Health Reform Law

### "Good" News:

- No public option or single payer
- Elimination of 5% payment cut for "outlier" MDs
- Elimination of *budget neutral* bonus payment to primary care
- Extended gainsharing demonstration program
- Enhances relevance of clinical data registries
- Improvements in comparative effectiveness research provisions
- Funding for emergency care regionalization pilot projects
- Funding for federal EMS-Trauma Program
- Loan repayment program for pediatric surgeons
- Physician "sunshine" provisions not too onerous w/some federal preemption

### Bad News:

#### Medicaid

- Expands Medicaid to all individuals under age 65 with incomes up to 133 percent of the federal poverty level
- Increases payments for primary care services provided by primary care physicians to 100 percent of the Medicare payment rates for 2013 and 2014 – setting up reimbursement battle in a couple of years
- Quality improvement initiatives including the development of quality measures for Medicaid eligible adults, prohibits Medicaid payment for services related to health care acquired condition, and establishes several Medicaid demonstration projects to study the use of bundled payments

for hospital and physician services, global payments and pediatric accountable care organizations

### ***Linking Payment to Quality Outcomes in Medicare***

- Mandatory/punitive Physician Quality Reporting Initiative (PQRI) whereby beginning in 2015, physician payments will be reduced if they do not successfully participate in the PQRI program. The penalty is 1.5% in 2015 and 2% in subsequent years. Silver Lining: Physicians who participate in a qualified Maintenance of Certification Program may fulfill the PQRI requirements.
- Expands Medicare's physician resource use feedback program.
- Establishes a value-based payment modifier under the physician fee schedule, which will be implemented in a budget-neutral manner and will adjust Medicare physician payments based on the quality (measures that reflect health outcomes) and cost of the care they deliver.

### ***Health Care Quality***

- Authorizes \$75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). New measures will assess, among other things, health outcomes and functional status of patients. HHS will publicly report on patient outcomes measures.
- Provides \$20 million to support the endorsement and use of endorsed quality and efficiency measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.
- Requires HHS to collect and aggregate data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information.

### ***New Patient Care Models***

- Establishes within the CMS a Center for Medicare & Medicaid Innovation. Concerned with following payment models:
  - global payments to groups of providers
  - accountable care organizations,
  - varying payments to physicians who order advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria
- Establishes a Medicare shared savings program for accountable care organizations. ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.
- Establishes a national, voluntary pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models.
- Establishes a hospital readmissions reduction program whereby payments for hospitals would be reduced by 1% in 2013, 2% in 2014 and 3% in 2015 and beyond if hospitals do not meet readmission criteria.

### ***Medicare Payment Changes***

- The Secretary of HHS is directed to regularly review fee schedule rates to identify misvalued codes under the physician fee schedule. This review will focus on codes for which there has been the fastest growth; codes that have experienced substantial changes in practice expenses;

codes for new technologies or services; multiple codes that are frequently billed in conjunction with furnishing a single treatment and codes which have not been subject to review since the implementation of the RBRVS including services that have experienced high growth rates. The Secretary would have enhanced authority to adjust fees schedule rates that are found to be misvalued or inaccurate.

- The equipment utilization factor for advanced imaging services will be increased from 50 to 75% in 2011.

#### ***Independent Payment Advisory Board***

- Creates a 15-member Independent Payment Advisory Board (IPAB) 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, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board is required to make non-binding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate.
- Hospitals are exempt from cuts through 2019.
- Board members will essentially be full-time employees of the IPAB.

#### ***National Health Care Workforce Commission***

- Establishes a 15 member National Health Care Workforce Commission tasked with reviewing health care workforce and projected workforce needs.
- The majority of the commission must be non-providers, and is required to include at least one representative of consumers and one of labor unions. No slotted seat for surgeon.
- The Commission shall submit recommendations to the Congress, the Department of Labor and the Department of Health and Human Services about improving safety, health and worker protections in the workplace for the health care workforce. Concern: This could be camel's nose under the tent to regulate resident duty hours.

#### ***Primary Care Services and General Surgery***

- Beginning in 2011, provides primary care practitioners and general surgeons (but not other surgical subspecialties) practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years. This bonus is no longer budget-neutral (initially the provision would have offset half of the cost of the primary care and general surgery bonuses with reductions in all other physician services). However: Sets up a future reimbursement battle at the end of 5 year period.

#### ***Medicare GME Changes***

- Beginning July 1, 2011, directs the Secretary of HHS to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians.

#### ***Prohibition on physician-owned hospitals***

- Prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, to participate in Medicare.

- Provides a limited exception to the growth restrictions for grandfathered physician owned hospitals, which is not likely adequate.

#### ***Industry-Physician Relations***

- Requires drug, device, biological and medical supply manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. (Note: this provision does not apply to industry support of professional associations)
- Duplicative State or local laws would be preempted by Federal law; however, Federal preemption would not occur for State or local laws that are beyond the scope of this section.

#### ***Medical Liability Demonstration Program***

- Authorizes HHS to Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. Plaintiffs may opt out of the demonstration program at any time.

### **Issues not Adequately Addressed in the Health Reform Law:**

#### ***Medicare Physician Payment Reform***

- The new health law failed to repeal Medicare's flawed sustainable growth rate (SGR) formula. While Congress continues to pass temporary measures to prevent payment cuts (22% in 2010 and cumulative cuts of over 40% over the next several years), lawmakers have not yet taken action to permanently fix the payment system.

#### ***Medical Liability Reform***

- Despite findings by the Congressional Budget Office (CBO) that comprehensive medical liability reforms that include an effective cap on non-economic damages would save the federal government \$54 billion over 10 years, Congress did not include proven medical liability reforms, based on California or Texas models, in the new health law.

#### ***Private Contracting***

- The new health law does not guarantee patients and physicians the right to privately contact without penalty. Under current Medicare law, physicians must opt-out of Medicare for 2 years in order to engage in private negotiations with Medicare patients for services provided.

#### ***Graduate Medical Education***

- The new health law does not remove or modify the current caps on federally funded residency slots.