Implementing Federal Health Care Reform—What You Should Know

Whether revered as the solution to affordable health care in the United States or reviled as extensive and overreaching governmental regulation, the historic health care legislation recently enacted is destined to have a profound impact on health care providers across the country.

The first of these laws, the American Recovery and Reinvestment Act of 2009 (ARRA), commonly referred to as the “Stimulus bill,” focused on addressing the crisis in financial institutions and its adverse effects on the U.S. economy. However, one section of the law, known as the Health Information Technology for Economic and Clinical Health (HITECH) Act, provides guidance and incentives around implementing Electronic Health Records (EHRs).

The more recent Patient Protection and Affordable Care Act of 2010 (commonly referred to as ACA) and its subsequent amendment, the Health Care and Education Affordability Reconciliation Act, both enacted in March 2010, are intended to provide Americans with broader access to health insurance coverage and affordable, high-quality health care. While recent repeal efforts by the Republican-controlled House of Representatives may result in some withdrawal of funding of, or changes to, specific ACA provisions, it is unlikely that Congress will be successful in repealing the entire health care reform law. And while several states have filed court challenges to the law’s requirement that everyone carry health insurance, the cases are not expected to reach the Supreme Court for several years. In the meantime, numerous provisions have already been implemented in 2010 and 2011, with the most significant changes slated to take effect by 2014.

This issue of infocus targets some key components of health care reform to help clinicians prepare for and comply with changes under way and understand the impact on their practice. Several articles highlight what health care providers, particularly office-based practitioners, need to know regarding their new obligations and opportunities under the ACA and HITECH laws, as well as the time frames in which they must act. In addition, ”Health Care Reform: Models for Success” offers perspectives from a recent talk on current and future health care reform issues by Dr. Steven M. Sayfer, president and CEO of Montefiore Medical Center in the Bronx.
The Patient Protection and Affordable Care Act of 2010, commonly known as the Affordable Care Act, or ACA, is the centerpiece of current health care reform legislation. This law targets key areas of reform, including: extending health insurance coverage to Americans who currently have little to no insurance, reducing health care spending, curbing the rapid rise in health care costs, and improving quality of care and patient outcomes (see “Projected Savings with Health Care Reform”). To accomplish these goals, the law introduced wide-ranging provisions covering: insurance coverage reforms; employer and employee health plan requirements; expansion of public programs such as Medicare and Medicaid; new payment approaches and health-related tax and funding changes; emphasis on prevention and wellness care; new models for insurance and health care providers, such as state health insurance exchanges, accountable care organizations, and medical homes; and improved quality measurements and reporting, among others.

Given the exhaustive scope of the ACA, the federal government established an aggressive timeline for enactment, which began in 2010 and extends over the next 10 years. The complexity of this legislation has also prompted numerous interpretations and resources providing guidance and information (see “Health Reform Timeline: Physician Resources”). This article highlights some of the ACA provisions and timelines that impact office-based practitioners, with emphasis on their threefold role as physicians, small-business owners, and employers.

Expanded Coverage Improves Economic Outlook

While health care costs and coverage have been perennial topics of policy debate (see infocus Summer 2009, “Health Care Change in a Cost-Constrained World”), the current recession has exacerbated the problem. According to U.S. Census figures, the number of Americans lacking health insurance coverage rose from a rate of 15.4 percent in 2008 to 16.7 percent in 2009, with 50.7 million uninsured.1 This lack of health insurance has a direct effect on physician practice. The American Medical Association estimated that in 2008 physicians provided $24 billion in charity care, much of it to their uninsured patients.2 For related statistics for New York, see “Reforms—How Does New York Measure Up?”

In 2010, the first set of ACA provisions to address the uninsured went into effect, including: ensuring coverage availability for those with pre-existing conditions, prohibiting lifetime limits on benefits or dropping coverage when enrollees get sick, extending dependent coverage to age 26, creating state options to expand Medicaid and Children’s Health Insurance Program (CHIP) coverage benefits, requiring coverage for preventive care, and supporting health coverage for early retirees. Many of the more comprehensive ACA provisions, such as instituting state health insurance exchanges and mandating health insurance for all Americans, are set to take effect in 2014 and beyond. As a result, states have had to create interim pre-existing condition insurance plans (PCIPs) to meet the coverage requirements for people with pre-existing conditions (including newborns) who lack health insurance. For more on the New York State plan, enacted October 1, 2010, see “New York Bridge Plan: Spanning the Coverage Gap.”
The Congressional Budget Office estimates that by 2019 current health care legislation will reduce the ranks of the (non-elderly) uninsured by 32 million people. Beyond providing vital coverage for underserved populations, these measures represent a “win-win” solution for practitioners. The increase in both the number of insured and conditions covered has the potential to swell patient populations for physicians’ practices. Conversely, with fewer uninsured, physicians can expect to see a related drop in their financial burden for uncompensated care.

Your Timeline for Action
As ACA reforms designed to extend health insurance coverage are being phased in, additional provisions have been implemented in 2010 and 2011 that impact or benefit physicians’ practices. These include small-business tax credits, increased payments for preventive and primary care services, changes to Medicare and Medicaid payments, quality-of-care measures and monitoring, and new insurance plans in New York State. Here’s what you need to know about these various provisions.

New Tax Credits for Physician Practices
In addition to serving a growing number of insured patients, many medical practices qualify as small businesses and are eligible for health reform-related tax benefits. For example, one key ACA provision that became effective for the 2010 tax year is a new tax credit for qualified small businesses to help them pay for employees’ health insurance. If a medical practice employs fewer than 25 full-time equivalent workers earning an average salary of less than $50,000 (excluding the salary of the physician owner(s)) and the practice pays 50 percent of the cost of employees’ health insurance premiums, then the practice is eligible for a tax credit of up to 35 percent of the employer’s premium contribution. This credit is based on a sliding scale depending on the number of employees in the practice and their average earnings.

The small-business tax credit of up to 35 percent will be available annually until 2014. After that, the credit will climb to 50 percent of an employer’s premium contribution. Be sure to check your eligibility for this tax benefit in coming years before filing your practice’s income tax return (see “IRS Guide to Small Business Tax Credit”).

Promoting Primary Care—Medicare, Medicaid and More
In addition to assisting physician practices through tax breaks, the ACA is squarely focused on improving the current primary and preventive care model through insurance changes as well as funding incentives. For example, beginning in 2010, all new health insurance plans were required to cover preventive services at no charge to patients and state Medicaid plans began covering tobacco cessation services for pregnant women. Additional improvements in 2011 include increasing coverage for proven preventive health and wellness programs under both Medicare and Medicaid plans.

As part of these incentives, from January 1, 2011, to January 1, 2016, Medicare will also increase reimbursements for designated primary care services by paying a 10 percent bonus to eligible primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants in family, internal, geriatric, and pediatric medicine. To qualify, primary care services must account for at least 60 percent of the practice’s Medicare-allowed amount for two years prior to the bonus payment. The American Academy of Family Physicians (AAFP) estimates that 80 percent of family practitioners will qualify for bonus payments. For additional details, see “What You Should Know About Medicare Primary Care Incentive Payment (PCIP).”

In an effort to broaden access to health care services and encourage more providers to accept Medicaid patients, the ACA will require states to pay for primary care services at the same rate as Medicare by 2013. State Medicaid programs may choose to increase reimbursement for these services above the Medicare-allowed amount, but may not pay less.

Finally, ACA provisions address one of the key issues in primary care, the growing shortage of physicians, by improving training support. This includes adjusting the Medicare graduate medical education (GME) policy (effective July 2011) to expand training access and funding for primary care and increasing primary care residency programs at teaching health centers. In 2011, the Health Care Workforce Augmentation provision will also increase funding for state grants, scholarships, and loans, and investigate other programs in an effort to increase the number of primary care providers.

Extending Quality-of-Care Reporting Bonuses
Another goal of the Affordable Care Act is to improve the overall quality of health care in the United States. This effort relies, in part, on physicians reporting accurate data on health care performance. The Centers for Medicare and Medicaid Services (CMS) recognized this need in 2006 when it started the Physician Quality Reporting Initiative (PQRI), a voluntary program encouraging practitioners to submit quality-of-care data on services covered under the Medicare Physician Fee Schedule (PFS). Essentially, physicians and practices register to participate in the program and then submit evidence of their quality performance as part of their Medicare Part B claims or a qualified registry (on a 6- or 12-month basis) or through an approved electronic health record (EHR) system (on a 12-month basis). Submissions that meet the criteria for a satisfactory rating are considered “successful” submissions, qualifying the physician or practice for financial incentives.

In 2009, more than 162,800 eligible health care professionals reported 2008 quality data to Medicare. However, only 52 percent, or 85,000, of these practitioners met the criteria for satisfactory reporting and qualified for the roughly $92 million in incentive payments. For the remaining physicians and practices, Medicare found their quality data failed to meet the criteria for “successful” reporting. This high rejection rate has many physicians questioning the value of participation (see “Quality Reporting in Question?”).

Despite these concerns, ACA provisions are clearly focused on measures to encourage wider PQRI compliance and success. First, the Group Physician Reporting Option (GPRO) has been expanded for 2011 to enable smaller group practices (with 2–199 practitioners) to participate in quality reporting and related benefits. The current PQRI program, which has been renamed the Physician Quality Reporting System, or PQRS, also extends a “carrot and stick” approach to induce all Medicare-participating physicians and groups to submit data. In 2011, participants are eligible for a 1 percent bonus based on their total Medicare allowed amount (down from the 2 percent of previous years). This bonus declines to 0.5 percent in years 2012–2014. Then, effective in 2015, participation becomes mandatory and Medicare will impose a 1.5 percent penalty on physicians who do not participate in
Projected Savings with Health Care Reform

According to the Congressional Budget Office, current Health Reform legislation is projected to slow growth in health care spending from 6 percent to 5 percent per year. These cuts would reduce the Federal deficit by $143 million in the first 10 years, $1 trillion within the subsequent decade.


IRS Guide to Small Business Tax Credit

The Internal Revenue Service’s Web site at www.irs.gov supplies useful information about the new small business health care tax credit. Click “Business” (top bar) and then scroll down and locate “Affordable Care Act Tax Provisions,” which provides tax information related to a number of ACA provisions. Click “Small Business Health Care Tax Credit for Small Employers” to access a complete set of resources on the tax credit. This Web page provides links to basic information and a video explaining the tax credit, a fact sheet with three simple steps to determine if your business is eligible for the tax credit, frequently asked questions, the new tax Form 8941 and other resources. (You may reach this Web page directly at: www.irs.gov/newsroom/article/0,,id=223666,00.html.)

Affordable Care Act: A Physician’s Timeline for Impact and Action

continued from page 3

the reporting program. The penalty will rise to 2 percent of the total allowed amounts in 2016 and thereafter. For the most current information on PQRS, GPRO, related incentives, and how to qualify and get started, see www.cms.gov/PQRS.

To further reward quality reporting, physicians who submit PQRS data can earn an additional 0.5 percent bonus in 2011–2014 as part of the Maintenance of Certification (MOC) Program Incentive. To qualify for this bonus, physicians must work with an MOC entity, participate in an MOC program more frequently than required, and successfully complete a qualified MOC program practice assessment (for details, see “MOC Program Changes and Incentives”).

Other incentives to encourage quality reporting include plans to enable consumers to compare physicians’ quality metrics online via the new Physician Compare Web site (see “HHS Tackles Physician Compare Web Site”). And by January 1, 2012, PQRS reporting will be integrated with a “meaningful use” incentive program for Electronic Health Records (EHRs). This integration will enable physicians to leverage 22 PQRS measures for EHR “meaningful use” reporting. For more information on EHRs and the financial rewards of the “meaningful use” EHR incentive program, refer to the “HITECH Act and EHRs—Changes on the Horizon” article in this issue.

Increasing Health Insurance Coverage—The Physician’s Role

The ACA aims to increase health insurance coverage by prohibiting certain discriminatory insurance practices, making insurance premiums more affordable, creating new insurance options or exchanges, and establishing requirements for people to obtain coverage. Many of these provisions for expanding insurance coverage go into effect in 2014. Perhaps the most notable provision is one that requires Americans (who can afford it) to either buy health insurance or pay a fee, which would be pooled to help offset the cost of providing care to uninsured Americans. This provision impacts office-based physicians on several levels, as physicians must not only carry health insurance for themselves and their dependents, but may also have certain coverage obligations for their employees.

According to the provision, starting in 2014 all U.S. citizens and legal residents must have health insurance that meets specific coverage criteria. Failure to have health insurance incurs a financial penalty that is phased in as follows: $95, or 1 percent of taxable income, in 2014; $325, or 2 percent of taxable income, in 2015; and $695, or 2.5 percent of taxable income, in 2016. Thereafter, penalties will be increased annually based on the cost-of-living adjustment. To facilitate access to health insurance, state exchanges will be created to provide coverage at a reasonable cost. For those who cannot afford the insurance premiums, cost-sharing subsidies (premium credits) will also be available for individuals with income between 100 percent and 400 percent of the federal poverty level.

From a business perspective, beginning in 2014, employers with more than 50 (full- or part-time) employees are required to provide all full-time workers with health insurance or incur “play or pay” fees. These penalty fees can be considerable. For example, if a business does not offer coverage and employs at least one full-time worker who is eligible for a cost-sharing subsidy, the business will pay penalties of $2,000 for each of its full-time employees in excess of 30. Employers can also be assessed fees if the plans they provide are found to be too costly, i.e., if at least one full-time employee requires a cost-sharing subsidy to pay for the plan. In that case, the penalty would equal $3,000 for each cost-subsidized employee or $2,000 per full-time employee, whichever is less.

Small-business employers with 50 or fewer employees, which includes most office-based physician practices, are not required to provide these health insurance benefits. As previously noted, tax credits will be available to any small business or practice that chooses to provide its employees with health insurance benefits. Special health exchanges will also be available to provide affordable coverage options.
THE PLANS FOR HEALTH INSURANCE EXCHANGES
Recognizing the cost challenges for individuals and small businesses, ACA provisions mandate creation of health insurance exchanges in every state by January 1, 2014. (State plans and models for these exchanges must be in place by January 1, 2013.) To jump-start these efforts, HHS awarded $1 million grants to 48 states, including New York. In March 2011, HHS granted an additional $241 million to “early innovators” (New York and five other states) to develop the technology necessary for consumers to purchase coverage through these state exchanges.2 Two states, Massachusetts and Utah, have also been cited repeatedly for their differing but successful approaches to state health insurance exchanges (see “Health Insurance Exchanges—Differing Approaches”). The Congressional Budget Office (CBO) estimates that by 2019 roughly 38 million people will obtain coverage through health insurance exchanges (either individually or through employer-based plans).10 These new exchanges aim to standardize health insurance benefits and facilitate comparison shopping for a plan. Additionally, exchanges are intended to facilitate enrollment in selected health coverage and qualify individuals for tax credits to help make the premiums more affordable. Two types of exchange plans are required: a Consumer-Operated and -Oriented Plan, or CO-OP, for individuals, and a specialized Small Business Health Options Program (SHOP) for small businesses with up to 100 employees. The intent of SHOP is to counteract cost inequities where small businesses routinely pay 18 percent more in premium costs and three times more for plan administration than larger businesses.11

What is the status of New York State’s readiness for these health insurance exchanges? The state’s first SHOP exchange, New York’s Health Insurance Exchange (NYHIE), was unveiled on November 18, 2010. NYHIE is billed as a “market-driven exchange” with “expansive health insurance choices” for sole proprietors and small businesses and their employees. This exchange has actually been around for more than 16 years and was formerly known as the Long Island Association (LIA) Health Alliance. For more on the new NYHIE, visit the Web site at www.liahealthalliance.com. With its recent infusion of federal funding, the state will likely begin CO-OP development in the near future.

ADDITIONAL PROVISIONS AND FUTURE HEALTH REFORMS
Given the massive scope of health care reform legislation, this article highlights some of the more significant ACA provisions that will impact physicians and their practices over the next few years. Omitted from this discussion are some of the large-scale reforms that will reshape health care over the next decade and beyond. These initiatives include: revamping payment models, such as bundling payments based on episodes of care and quality, value and performance metrics; allowing physicians to form Accountable Care Organizations (ACOs) that integrate primary care services to increase efficiencies, improve quality of care, and reduce costs; and establishing medical homes which provide coordinated care that integrates community-based care with regional trauma and emergency care. Look to future issues of *infocus* to provide more information as these measures and other key initiatives unfold and begin to remake the face of health care as we know it.

RESOURCES:

**New York Bridge Plan: Spanning the Coverage Gap**

The New York Bridge Plan is designed to bridge the gap in health insurance for legal New York State residents (including newborns) who have pre-existing conditions and have not been covered by health insurance for six months or more. This program, run by GHIL Emblem Health Company, will be available until it is replaced by health insurance exchanges and other ACA provisions that take effect January 1, 2014. As of October 2010, only 400 New Yorkers had signed up for this plan (*Crain’s Health Pulse*, “New York Bridge plan gears up,” October 4, 2010, www.crainsnewyork.com/article/20101004/PULSE/101009979).

With the New York Bridge Plan, applicants must submit a doctor’s statement or medical record proving they have an eligible pre-existing condition. Applicants must also provide evidence that they are legal residents in New York and have not had insurance coverage for the previous six months. As policies provide individual not family coverage, multiple family members with pre-existing conditions must apply separately for coverage. In addition, all providers must be in GHIL’s network. To simplify the process, eligible individuals can apply online at: http://www.ghil.com/nybridgeplan/index.html. Enrollment is available on a first-come, first-served basis (a waiting list will be instituted once enrollment is filled).

Once an individual is accepted into the New York Bridge Plan, coverage begins immediately, with no waiting period. The plan provides comprehensive benefits covering primary, specialty, and hospital care as well as prescription drugs, with no deductibles and only a small co-payment for outpatient visits. Monthly premium rates are standardized based on where applicants live; downtown residents pay $421/month and upstate residents pay $362/month. Instructions for applying and details about the insurance benefits can be found by visiting the New York Bridge Plan Web site at: http://www.ghil.com/nybridgeplan/index.html.
**Health Reform Timeline: Physician Resources**

Numerous online resources are available to help physicians make sense of the Affordable Care Act (ACA) provisions and timelines. Here are a few examples:

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<td>Various physician-related resources:</td>
<td>A joint resource developed by the American Medical Association, the American Academy of Family Physicians, and other groups that physicians can share with patients to help with health care decisions; includes ACA information, views by state, and searchable timeline:</td>
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<td>• Summary of health reform law by stakeholder/issues (publication #8061):</td>
<td>Information on HITECH funding, ONC initiatives, and other programs:</td>
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<td>• Timeline of health reform changes (publication #8060):</td>
<td>FEDERAL GOVERNMENT HEALTH CARE SITE</td>
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<td><a href="http://www.kff.org/healthreform/8060.cfm">http://www.kff.org/healthreform/8060.cfm</a></td>
<td>General resources on health care changes:</td>
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**How does New York measure up in terms of needing insurance coverage reforms?** According to a recent New York State Health Foundation (NYSHealth) report, about 2.6 million New Yorkers are uninsured, including: 1.1 million eligible for Medicaid but not yet enrolled, 1.1 million not eligible because of family incomes, and nearly 400,000 undocumented immigrants. The report estimates that with ACA reforms, nearly 1.2 million New Yorkers could be enrolled in Medicaid and an additional one million residents would be able to obtain coverage through the state’s health insurance exchanges with about 70 percent receiving subsidies. With these changes in place, a majority (2.2 million) of the state’s 2.6 million uninsured residents are expected to have health coverage. (See “Implementing Federal Health Care Reform: A Roadmap for New York State,” New York State Health Foundation, August 2010, pp. 1-93, [www.nyshealthfoundation.org/userfiles/file/RoadmapPaper_Aug2010.pdf](http://www.nyshealthfoundation.org/userfiles/file/RoadmapPaper_Aug2010.pdf).)
With the ACA plans for online quality comparisons for physicians, it becomes increasingly important for physicians to participate in the Physician Quality Reporting System (PQRS). However, for many physicians, the trend has been to opt out of this voluntary program. Why the reluctance to participate? According to member surveys conducted on behalf of the American Medical Association (AMA), nearly half of the physicians who submitted quality data using a claims-based reporting method did not receive the necessary satisfactory rating to qualify for bonus payments. Compounding the frustration, physicians were often unable to access the feedback reports or determine why their quality data was rejected.1

Based on these survey results, the AMA and other health care provider associations succeeded in getting the Centers for Medicare and Medicaid Services (CMS) to make changes to the PQRS rules for 2011, which are part of the CMS Final Rule on the 2011 Medicare Physician Fee Schedule (MPFS). These improvements include: reducing the amount of information physicians need to provide by lowering the reporting threshold on claims-based reporting from 80 percent to 50 percent of applicable cases, providing physicians with more timely feedback reports and interim feedback on claims-based PQRS reporting, and developing an informal appeals process enabling physicians to request a CMS review when their reporting does not qualify for a bonus payment.2

Physicians may be able to improve submission accuracy and acceptance by using Electronic Health Records (EHRs) or qualified clinical data registries for PQRS reporting. More than 90 percent of practitioners who followed this approach, instead of the more error-prone claims-based reporting methods, successfully qualified for incentive payments.3

For all other information on PQRS submissions, see www.cms.gov/pqrs.

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**What You Should Know About Medicare Primary Care Incentive Payment (PCIP)**

**WHO QUALIFIES FOR THE PROGRAM?**

Only practitioners with a primary specialty designation of family medicine (code 08), internal medicine (code 11), geriatric medicine (code 38), or pediatric medicine (code 37) qualify for the Medicare Primary Care Incentive Payment (PCIP) program. In addition, primary care services must account for 60 percent of Medicare claims for two years prior to the bonus year, e.g., 2011 qualification is based on your 2009 Medicare claims.

**WHAT PRIMARY CARE SERVICES ARE ELIGIBLE?**

The PCIP bonus applies to HCPCS codes: 99201–99215; 99304–99340; and 99341–99350.

**WHAT IS THE BASIS FOR THE BONUS AMOUNT?**

The PCIP bonus is based on the Medicare-paid portion (typically 80 percent) of allowed charges under Medicare Part B for primary care services provided between January 1, 2011, and January 1, 2016.

**WHAT TO DO WITH THAT EXTRA CHECK?**

While these quarterly PCIP bonuses can be used to reward individual practitioners, some practice managers are choosing to funnel the payments back into the general practice. Another idea is to earmark the funds for Health Information Technology (HIT) investments.

**WHAT IF I AM A NEW PRACTITIONER AND DO NOT QUALIFY IN 2011?**

The Centers for Medicare and Medicaid Services (CMS) will be releasing a provision to accommodate newly enrolled Medicare providers in 2011.

Additional details can be found in the CMS Medicare Learning Network (MLN) article: MLN Matters Number 7060 (www.cms.gov/MLNMattersArticles/downloads/MM7060.pdf).

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MOC Program Changes and Incentives

More than 750,000 physicians in the U.S. are certified by one or more of the 24 Member Boards of the American Board of Medical Specialties (ABMS). In 2006, ABMS introduced its Maintenance of Certification (MOC) program, which “…uses evidence-based guidelines and national standards and best practices in combination with customized continuing education so physicians demonstrate their leadership in the national movement for healthcare quality. MOC also requires proof of continuing education and experience in between testing for re-certification.”

The MOC program requires practitioners to demonstrate leadership in six core competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communications skills, systems-based practice, and professionalism. As part of this demonstration, they must follow a four-part qualification process that entails verifying current licensure and professional standing, continuing education and self-assessment, testing and practice performance evaluations.

Recognizing the synergies between MOC program goals and federal quality measures, the Centers for Medicare and Medicaid Services (CMS) added a 0.5 percent bonus for physicians who during a given year:

- Submit quality-of-care data that meets the criteria for the Physician Quality Reporting System (PQRS)
- Participate in a qualified MOC program
- Successfully complete a qualified MOC practice assessment

Details on program criteria and eligibility are available at www.cms.gov/PQRS, under “Maintenance of Certification Program Incentive.”

In light of recent health reforms, the ABMS is also revamping its MOC program to effectively align with CMS requirements for PQRS reporting and “meaningful use” of Electronic Health Record (EHR) systems. Initially, three ABMS member boards will launch this alignment effort: the American Board of Family Medicine, the American Board of Internal Medicine, and the American Board of Pediatrics. These three boards jointly certify nearly 370,000 practicing physicians in the U.S. The intent is to support one format for MOC and PQRS data, making it easier for physicians to submit and qualify for related CMS bonuses. Other changes include updating practice improvement modules so that physicians can track results using their EHR systems.


HHS Tackles Physician Compare Web Site

Beyond rewarding providers for quality reporting, ACA provisions call for quality measurements to be analyzed to improve health care services, patient outcomes, related costs, and provider payments. A secondary goal is to improve transparency around health care service providers.

Taking a cue from the success of the various comparative Web sites, such as Health Grades “report cards” for hospitals, the Secretary of Health and Human Services (HHS) has launched a Physician Compare Web site at: www.medicare.gov/find-a-doctor. The intent is to provide an online resource that consumers can use to search for and compare performance data for individual providers.

Initially, this searchable Physician Compare Web site provides basic information for each doctor, such as name, practice, address, degree and residency programs, and whether they are participating in the Physician Quality Reporting System (PQRS). Later in 2011, the site will include e-prescribing information for physicians participating in the Electronic Prescribing (ePRX) Incentive Program. And by 2013, the plan is to provide detailed quality and performance information for physicians who submit quality (PQRS) reporting (physicians will be given time to review their own performance data before it becomes public).

What is the impact to physicians? Right now, physicians are advised to visit the site (www.medicare.gov/find-a-doctor) and verify that their information is correct. Changes can be made by clicking the “Note to Providers” tab, which displays a screen with detailed how-to-update instructions. However, looking ahead, once comparative quality data are posted, providers who are not quality reporting may find it puts their practices at a disadvantage. This serves as added impetus for practices to get involved with the PQRS now and even consider implementing certified Electronic Health Record (EHR) systems to facilitate quality reporting and bonus payments.


Medicaid Quality Reporting on the Way

Medicaid quality reporting is on the way as ACA provisions call for the Secretary of Health and Human Services (HHS) to develop the Medicaid Quality Measurement Program to advance quality measurements for adults in Medicaid programs. To date, these measures have been drafted and released for public comment, which was completed March 1, 2011. Final measurements will be published in January 2012, with voluntary state-level reporting expected to begin in January 2013. Watch for more developments as New York State ramps up for this new Medicaid quality reporting. (See Department of Health and Human Services, “Medicaid Program: Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults,” Federal Register, Vol. 75, No. 250, December 30, 2010, pp. 1-3, http://www.gpo.gov/fdsys/pkg/FR-2010-12-30/pdf/2010-32978.pdf.)
Health Insurance Exchanges—Differing Approaches

As states make plans for creating health insurance exchanges, two states have been cited for their current exchanges, which feature differing approaches to the model. In Massachusetts, the Connector exchange is a state-controlled plan where the state negotiates premium prices and benefits and approves insurance companies that wish to be part of the exchange. Conversely, Utah’s Health Exchange plan is market-based. The state sets a minimum standard for plan benefits within the exchange and the participating insurance companies compete on price.

In Massachusetts, where insurance is required, nearly 97 percent of residents had health insurance in 2009. In Utah, where insurance is not required, the 85 percent rate is a little higher than the national average of 83 percent. (R. Pear, “Health Care Overhaul Depends on States’ Insurance Exchanges,” The New York Times, October 23, 2010, www.nytimes.com/2010/10/24/health/policy/24exchange.html.)

Whether states opt for a state-run or market-driven model, the ACA dictates a number of requirements for what exchanges must offer for both consumers and small businesses. Development of state exchanges will also be subject to state legislative approval. The National Academy of Social Insurance (NASI) developed a comprehensive resource covering both topics; see “Designing an Exchange: A Toolkit for State Policymakers,” January 2011, pp. 1-45, www.ksinsurance.org/hbexpplan/files/20110221_gpid1_Designing_an_Exchange.pdf.

HITECH Act and EHRs—Changes on the Horizon

The Health Information Technology for Economic and Clinical Health (HITECH) Act promotes adoption of Health Information Technology (HIT), calling for nationwide use of certified Electronic Health Records (EHRs) by office-based physicians and other health care providers by 2014. These efforts started in 2010 and are being managed through the Office of the National Coordinator for Health Information Technology (ONC); see www.healthit.hhs.gov. Key goals for adopting EHR technology include: improving the quality of care and public health; reducing medical errors and health disparities; increasing prevention efforts and coordinating community resources; and improving the continuity of care across health settings while protecting patient privacy and the security of medical records. (See infocus, Summer 2009 highlight on Dr. David Blumenthal, who was named National Coordinator for Health Information Technology in March 2009.)

Although a majority of hospitals and office-based physicians rely on computer software for administrative functions such as billing and appointments, far fewer providers have installed EHR systems. In a 2010 National Ambulatory Medical Care Survey (NAMCS) of more than 10,000 physicians conducted by the Centers for Disease Control and Prevention (CDC), about half of the physicians reported using some type of EHR or EMR (electronic medical record) system. These results were similar in New York, with around 49 percent of physicians using EHRs. In an effort to increase participation, the HITECH Act supports a combination of financial incentives and penalties to entice health care providers to the EHR table.

Incentives for Using HIT

Starting in May 2011, the federal government was scheduled to begin paying bonuses to doctors, clinicians, and hospitals for using “certified” EHR technology. This is good news for those who have already implemented an EHR system and offers financial impetus for practices considering EHR purchases. The bonus program is designed to promote early enrollment by offering incentive payments of up to $18,000 annually in 2011 and 2012. (Those who delay participation will receive smaller incentive payments.) Over the next five years, participating physicians and other providers can earn up to $44,000 from Medicare or $63,750 from Medicaid if they demonstrate that they are making “meaningful use” of EHR systems. The overall bonus pool has been estimated at $27 billion. To date, more than 18,000 providers have registered for the program. Health care professionals who fail to demonstrate “meaningful use” of “certified” EHRs by the 2014 deadline will see a reduction in their Medicare reimbursement starting in 2016. Links to a complete overview of Medicare and Medicaid EHR incentives, eligibility requirements, and reporting dates are available at: www.cms.gov/EHRIncentivePrograms.

EHRs Must Be Certified

One significant change on the health care horizon is that EHRs must now be certified by the ONC’s Authorized Testing and Certification Body (ATCB) to qualify for incentives. To verify certification, the ONC ATCB tests EHR technology to ensure that it complies with the Centers for Medicare and Medicaid Services (CMS) criteria for “meaningful use.” Essentially, certification confirms that the EHR system or software offers necessary functionality and capabilities, maintains security and confidentiality, and is able to exchange information with other EHR systems. Information on the certification process is provided on the ONC Web site (http://healthit.hhs.gov) under “Certification Programs.” The ONC also maintains a list of certified EHR products that physicians can browse or search to verify that their current EHRs are compliant (see http://onc-chpl.force.com/ehrcert). Finally, recognizing that selecting a certified EHR system can be a challenging process, the ONC has sponsored regional centers to provide health care professionals with advice and technical assistance in EHR selection. As of February 2011, 40,000 providers had signed up for assistance at 62 regional centers. For more information on the resources available for New York–based physicians, see “Helping Physicians with EHRs in New York.”

continued on page 10
Demonstrating Meaningful Use of EHRs

The concept of “meaningful use” is a driving force behind EHR adoption.Providers must meet mandated time frames and standards defining “meaningful use” of certified EHRs in order to be compliant and qualify for monetary rewards. (This includes demonstrating “meaningful use” for a consecutive 90-day period in the first year of participation and for a full 12 months in subsequent years.)

There is considerable interest in what constitutes “meaningful use” of EHRs as evidenced by the 2,000-plus comments submitted during draft review of the regulations for 2011 and 2012. The resulting final rule requires health care professionals to meet 20 of 25 MU (meaningful use) objectives (the 15 core requirements and 5 out of 10 menu set objectives). These MU objectives provide physicians with the tools to qualify and quantify how they are using their EHR technology. Examples include core requirements such as recording patient demographics, maintaining an active medication list, transmitting more than 40 percent of prescriptions electronically; menu set objectives include implementing drug formulary checks, sending patient reminders for preventive or follow-up care, and incorporating clinical lab test results into the EHR. A downloadable list of the MU requirements and the specific objectives for eligible professionals is available on the Web at www.cms.gov/EHRIncentivePrograms, under “Meaningful Use.”

Getting Started

To participate in the EHR incentive program, providers must first register on the CMS Web site. Note that you can register before your EHR is installed. To find out more, check your eligibility, and get started, visit www.cms.gov/EHRIncentivePrograms and click “Path to Payment.” Each individual physician in a practice is eligible to participate and receive annual incentive payments from either Medicare or Medicaid. For 2011, providers will be asked to self-attest (legally state) compliance with the selected “meaningful use” criteria.

Additional Opportunities—eRX Incentive/Penalty Program

Since 2009, the CMS has sponsored an Electronic Prescribing (eRX) Incentive Program to encourage eligible health care professionals to start using a qualified eRX system or eRX functionality as part of their EHR system. This program provides incentives to providers who bill at least 10 percent of their Medicare Physician Fee Schedule (MPFS) charges from eRX denominator codes (representing 100 or more evaluation and management or other services). For 2011, this program is offering a 1 percent bonus on all MPFS-allowed eRX charges for the year to physicians who report at least 25 eRX denominator code services. To earn incentives and avoid penalties, physicians must start using a qualified eRX system to report at least 10 distinct encounters for eRX denominator code services by June 30, 2011. For those who miss this deadline, the CMS will apply a penalty, reducing MPFS payments by 1 percent beginning in 2012. Thereafter, penalties will increase and bonuses will decrease by 0.5 percent each year. Detailed criteria on eRX system and physician eligibility and qualifications, potential hardship exceptions, and information on how to get started can be found at http://www4.cms.gov/ERxIncentive. As with PQRS reporting, multiple physicians in group practices can also claim eRX incentives.

HIT Efforts Prompt Privacy and Security Changes

As HIT moves medical information and health records online, there is growing concern among providers and patients about ensuring the safety of that information. Since 2003, the Health Insurance Portability and Accountability Act (HIPAA) has ushered in many new regulations and procedures for ensuring the privacy and proper handling of protected health information (PHI). It even called for health care institutions and providers to conduct periodic risk assessments to identify potential vulnerabilities. Subsequent HIPAA updates have introduced rules addressing privacy and security issues. More recently, both the HITECH Act and ACA have introduced new rules and proposals protecting patient privacy and governing patient access to their health information. For details on what providers need to know, see “What’s New with HIPAA?”

Next Steps—EHRs and You

With recent health reforms, physicians and other practitioners are facing radical change on the health care horizon. EHR technology appears to be a key enabler of this change. For practices that have not yet implemented EHR systems, now would be an opportune time to do so, thanks to new incentives and penalties, EHR certification opportunities, and HIT support from regional centers. According to a 2010 report from Accenture (with assistance from the New York Academy of Medicine), 58 percent of U.S. physicians surveyed who have practices with fewer than 10 practitioners...
and are not currently using EHRs plan to purchase an EHR system in the next two years. (The number jumps to 80 percent for physicians under age 55.) This study of 1,000 U.S. physicians also found that these EHR purchasing decisions are motivated by the federal incentives (51 percent) and penalties (61 percent). Perhaps more telling, of the surveyed physicians currently using an EHR system, 90 percent feel it has brought value to their practice through efficient retrieval of patient information and quick and accurate data entry, and by enabling their practice to work better. This speaks directly to the ongoing debate among health care providers who question the benefit of EHR systems in physician practices. For more on this topic, see “Is There Value in EHRs for Physicians?”

Regardless of where physicians stand on the EHR debate, change is coming. And with only 50 percent of U.S. physicians using some type of EHR system today, much remains to be done in the drive for nationwide use of HIT and universal electronic medical records for all Americans by 2014.


6 M. Mosquera, “Blumenthal takes issue with EHR adoption naysayers.”


Helping Physicians with EHRs in New York

Selecting the right EHR system from myriad certified products and vendors can present challenges for even the savviest health care professional. To help with this task, two programs are available to provide New York physicians with technical assistance in selecting and using certified EHR software and meeting “meaningful use” requirements:

**NYC REGIONAL ELECTRONIC ADOPTION CENTER FOR HEALTH (NYC REACH) PROGRAM:**

Staff in this program have years of experience assisting primary care providers with EHR systems as part of Mayor Michael Bloomberg’s Primary Care Information Project. For the more than 30,000 physicians based in New York City, this program can provide assistance with all phases of EHR adoption, from vendor selection through “meaningful use” and improved health outcomes. It also has enough funding available to offer subsidized services to 4,500 eligible providers. For more information, visit the NYC REACH Web site at: http://www.nycreach.org.

**NEW YORK eHEALTH COLLABORATIVE (NYeC):**

For New York physicians outside the city, the NYeC Regional Extension Center provides “tailored and personal technical and adoption services” for EHR selection. This includes services to help physicians choose the right EHR for their practice, discounted pricing for preferred vendors, and management of EHR implementation and adoption. For more information, refer to the NYeC Web site at: http://www.nyehealth.org.

Both programs’ Web sites also provide numerous educational resources, including newsletters, webinars, and other events, to further assist health care providers with “meaningful use” of EHRs.

Beyond these provider-targeted services, the NYeC has been engaged in efforts to advance and improve overall HIT use in New York. According to its Web site, the NYeC is working with various Statewide Collaborative Process (SCP) groups, including the New York State Department of Health (NYS DOH), to develop common policies, procedures, technical processes, etc., to improve and standardize New York’s HIT infrastructure. The goal is to develop a statewide HIT network to enable all providers to securely share patient information.
Since 2003, health care providers have been adhering to Health Insurance Portability and Accountability Act (HIPAA) requirements relating to providing patients with standard privacy notices and obtaining patients’ signed consent before disclosing their Protected Health Information (PHI) for certain purposes.

Amendments to HIPAA in 2009 imposed additional requirements. These included an interim final breach notification rule (the highly-criticized rule was withdrawn, but the reporting requirements remain in effect pending issuance of a final rule). The rule requires health care providers and other HIPAA-covered entities, as well as business associates of those entities, to report privacy and security breaches resulting in disclosure of “unsecured” (i.e., unencrypted) PHI to patients, the U.S. Department of Health and Human Services (HHS), and the media if the breach involves 500 or more patients.

Notably, under the 2009 amendments, business associates were for the first time directly covered by HIPAA (as opposed to being required to comply by contract with a HIPAA-covered entity). Thus, business associates are now subject to HIPAA’s monetary and other penalties for non-compliance.

There are also new limitations on the scope of PHI that can be disclosed to health plans, used for marketing and fundraising purposes, and sold without patient authorization.

In addition, new requirements have been imposed relating to Electronic Health Record (EHR) systems to ensure privacy and security around the electronic exchange of PHI. For example, effective January 1, 2011, HIPAA-covered entities and business associates who use EHRs must honor any patient request for information about disclosures of their information for treatment, payment, and health care operations. In addition, the proposed regulations allow patients to demand their personal medical information in electronic form. To assist providers in educating their patients, HHS will be releasing its Patient Health Record (PHR) Model Notice in 2011, to provide patient privacy rights information in plain language.

Final HIPAA rules concerning privacy and security, enforcement, breach notification, and accounting of disclosures of Electronic Health Records (EHRs) are anticipated in late 2011.

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Is There Value in EHRs for Physicians?

While the new Electronic Health Record (EHR) certification and incentive goals are impressive, many physicians question whether there is value in implementing an EHR system in small practices. Based on a recent Health Affairs study, the answer to this question is a resounding “Yes!” After examining more than 4,000 peer-reviewed articles written from July 2007 through February 2010, the study selected 154 that met the stringent parameters required. In the analysis, 92 percent of the articles showed HIT adoption provided positive effects on aspects of care from the perspective of quality, efficiency and provider satisfaction. These benefits pertained to outcomes at health care organizations both small and large.1

Despite its pro-EHR findings, the study also examined a number of negative articles, which largely focused on provider or staff dissatisfaction with HIT implementation or use. As a result, the study concluded that while Health IT (HIT) funding is valuable in spurring EHR adoption by health care providers, it also presents an opportunity for further research on ways to address some of the noted challenges around EHR acceptance.2

Some of the current debate and hesitation around EHR adoption also focuses on cost. According to CMS estimates, physicians can expect to spend about $54,000 for a certified EHR system, with additional expenses related to staff training and transition. While use of an EHR system can qualify physicians for annual incentives, this will rarely cover the full cost. Another concern centers on the return on investment and whether the “meaningful use” of EHR technology can actually deliver patient care quality and efficiency benefits that outweigh the cost.3

According to Dr. David Blumenthal, former director of the Office of the National Coordinator for Health Information Technology (ONC), small practices can indeed reap cost benefits in terms of charge capture, which is more effective with EHR systems. He cites examples where practices were able to increase revenues and deliver better quality patient care through improved EHR management of revenue-generating preventive services such as routine screenings and immunizations. He also stresses the need for practices to recognize and plan for an initial reduction in productivity when implementing a new EHR system. As with any new process or system, training and top-level endorsement are essential for success.4

The hope is that further studies, combined with the new requirements for certification and other HIT efforts, will push EHR vendors to standardize and improve the usability of current EHR products. And with the establishment of regional assistance centers mandated by the ONC, physicians now have access to vital resources and support for effective EHR purchasing decisions.


2 Ibid, p. 470.


The idea of reform is a whitewash; health care reform is needed to address much-needed reform of our “tattered quilt” of health care payment options and delivery systems, Dr. Safer sees hope that this landmark legislation will succeed in providing health care coverage for 32 million Americans. As a start, he cites improved coverage for young adults and those with pre-existing conditions, as well as medical screening and coverage for “donut hole” Medicare Part D recipients. Though the focus of the ACA is insurance reform, not payment or delivery system reform, he believes the ACA will, as with other federal legislation, mature and improve over time.

ADDRESSING PAYMENT AND DELIVERY REFORMS
According to Dr. Safer, “Only 14 pages of the ACA explore opportunities to reform health care delivery and payment systems. The U.S. spends $2.5 trillion on health care each year, with 70 percent of that going to federal and state programs, but we are not getting the ‘bang for the buck.’ Although the U.S. spends twice as much as every Western European country, we still fall below those countries in terms of life expectancy, live births, women’s health, and other key health indicators.”

To truly succeed in our reform efforts, he says, we must move to a single-payer system that includes everyone. He cites a payment rating system currently used in Maryland—as well as systems used in Great Britain, Canada, and France—as examples of successful single-payer approaches using either a public or private provider.

[As an aside to Dr. Safer’s comments, this single-payer approach is gaining momentum in a number of states, from Vermont to California. Proposals have also surfaced in New York in response to Governor Andrew Cuomo’s plans for redesigning the state’s Medicaid program, which currently costs $50 billion and supports 4.7 million residents a year. With Medicaid costs climbing at an unsustainable 6 percent annually, proponents of a single-payer alternative put estimated cost reductions at $10 billion. Savings are projected to come through reduced administrative and insurer costs (such as elimination of the Medicaid eligibility system), improved care coordination and provider spending, and related purchasing efficiencies.1]

Dr. Safer noted the considerably higher costs for malpractice premiums in the Bronx versus other boroughs, such as Manhattan, even though the quality, safety and overall outcomes are on par. He attributed this high cost to the significantly higher settlement rates and volume of cases in the Bronx. While he sees ACA provisions providing “a glimmer of hope for much-needed tort reform,” he puts more stock in other health care system improvements. However, New York State’s budget this year opens the dialogue about the best way to reduce high medical malpractice rates that challenge the ability of doctors to do what they are trained to do. Statewide, and especially in places like the Bronx, obstetricians have stopped delivering babies, as they cannot afford the cost of the premiums.

MODELS OF INSPIRATION
While far from comprehensive, the ACA does support changes to health care delivery models in its push for Accountable Care Organizations (ACOs). According to Dr. Safer, current models that inspired this approach include those fielded by Kaiser Permanente, the Geisinger Health System, and the Mayo and Cleveland clinics. These models feature salaried physicians, “system-ness,” high quality and efficiency, coordinated care, Health IT (HIT), and effective disease management. Two facilities are also aligned with medical schools. Despite the benefits, he notes that many of these touted models have more homogeneous patient populations, take commercial insurance and cash—not Medicare or Medicaid payments—and are classified as “destination” hospitals. The strong financial position of these ACO models makes it difficult for others to emulate them in many health care environments across the U.S., particularly large urban centers.

THE MONTEFIORE MODEL—LESSONS LEARNED FROM THE BRONX
According to Dr. Safer, the Bronx faces many challenges. With close to 1.4 million people, plus an estimated 300,000 uninsured, the Bronx is a county of considerable size and complexity. Twenty-seven percent of households fall below the poverty line (40 percent of children under age 18 reside in households with incomes below the poverty line), and more than 13 percent of...
In the Bronx, there’s a “hunger paradox,” where chronic “food instability” is coupled with high rates of obesity. In the South Bronx, 40 percent of children are overweight or obese. In this economically and health-challenged environment, where annual health care costs have risen to $12 billion, Montefiore Medical Center is delivering a “real world” model for successful, cost-effective, high-quality health care.

At the heart of the Montefiore model is a premier academic medical center providing state-of-the-art medical care, an integrated delivery system, and a commitment to coordinated community care, Dr. Safyer notes. This included 2.5 million ambulatory visits last year in clinics, schools, homeless centers and shelters, as well as home health and public health programs. At Montefiore, physicians are aligned and employed; there is “system-ness” and an emphasis on patient-centered primary care, complex disease management programs, quality and safety. Montefiore is linked together and supported by a call center and secure HIT systems for integrated access to patients’ electronic medical records. Montefiore accepts pre-payment and manages care of 150,000 lives through its Care Management Organization (CMO). The CMO has developed a novel approach to coordinated and managed care, improving outcomes and reducing cost.

In addressing questions of financial solvency, Dr. Safyer noted that Montefiore has been a good steward of limited resources and as a result has been “wildly successful, with a more than 2 percent profit margin” despite a payer mix that is nearly 80 percent Medicare and Medicaid.

While it remains to be seen if Montefiore’s success can be emulated as a model for future ACOs in New York or across the country, Dr. Safyer and others are trying to find out. Plans are under way to conduct a demonstration project to show how the Montefiore model can be scaled to a regional partnership to improve the health of the population and contain escalating costs.

For an in-depth analysis of Montefiore’s program, see the case study prepared by The Commonwealth Fund.1 An article, “It Takes a Village: A Cooperative Model for Health,” was also featured in infocus, Summer 2009.


Two recent initiatives are designed to assist states with health care reform efforts to meet provisions set forth in the Patient Protection and Affordable Care Act (ACA). The first is sponsored by the Robert Wood Johnson Foundation (RWJF) and initially focuses on helping 10 states (including New York) with the “technical assistance, research and monitoring, and consumer engagement” necessary to maximize ACA-related health care insurance and coverage reforms. These states were selected based on diversity in demographics, location, and coverage models, as well as current progress in implementing reforms.

As part of these efforts, a newly formed State Health Reform Assistance Network will provide the 10 states with technical and administrative guidance in areas such as creating state health insurance exchanges, expanding Medicaid, and improving enrollment systems. Another group, Boston-based Community Catalyst (www.communitycatalyst.org), will help the states solicit consumer input as part of state health care policy improvements. The RWJF will support these activities, analyze results, and share collective “lessons learned” with all states to facilitate subsequent reforms.

For the second initiative, the RWJF has teamed with the National Academy for State Health Policy to create the State Refor(u)im (www.statereforum.org). As the name implies, this Web site provides a forum for sharing resources and ideas related to state health care reform. This resource enables visitors to view and compare current statistics as to where each state stands on key indicators and milestones such as coordinated care initiatives, health insurance exchanges, benefit design, public engagement, etc. Members of the health care community may also wish to join this forum to participate in online discussion forums and networking opportunities with other users.