COMMENTARY

What Health Care Reform Could Really Mean

Amid considerable discussion of the potential impact of Congress's 2010 health care legislation on hospitals, insurers, pharmaceutical companies, and patients, very little has been written about its effect on physicians. Partly, that may be because the effect has been barely perceptible so far, but mostly it's because, as usual, we are at the bottom of everyone's priority list.

JOSEPH S. EASTERN, M.D.

While it is true that most physicians will see few changes in the near term, that paucity of change is part of the problem, since both of the essential changes sought by physicians – tort reform and revision of the ill-conceived Medicare compensation rules that threaten to cut payments by 25% every few months – were never addressed.

That said, many of the early provisions of the law do favor physicians in the short term. Beginning this year, insurers can no longer cancel policies already issued, nor can they exclude children with preexisting conditions. Adults who were previously uninsurable because of chronic ailments will have access to insurance as well. Lifetime coverage limits are prohibited, and dependents may remain on their parents' policies until they are 26 years old. Early retirees will not have to risk going uninsured until they qualify for Medicare, and Medicare's infamous "doughnut hole" will gradually close. Small businesses will receive tax-credit incentives to insure their workers.

All of this adds up to more paying patients, with better insurance.

However, as additional provisions come online starting in 2012, the long-range potential impact on private practitioners becomes more uncertain, and more ominous.

"Physician payment reforms" will begin to appear. Although no one yet knows exactly what that means, the law mandates the formation of accountable care organizations to "improve quality and efficiency of care." The buzzword will be outcomes – the better your measurable results, the higher your reimbursements. This is supposed to reward quality of care over volume of procedures, but the result could be exactly the opposite if less-motivated providers cherry pick the quick, easy, least-risky cases and refer anything time consuming or complex to tertiary centers.

In 2013, Medicare will introduce a national program of payment bundling. A single hospital admission, for example, will be paid with a single bundled payment that will have to be divided among the hospital and treating physicians. The idea, ostensibly, is to encourage physicians and hospitals to work together to "better coordinate patient care," but arguments over how to divide the pie could, once again, have the opposite effect.

Hospitals will get most of the new patients under the Medicaid expansion in 2014 and will hire even more physicians away from private practice to treat them.

It won't take long for hospitals to figure out that they can keep the whole pie if the partnering physicians are their employees. Look for hospitals to absorb more private offices.

By 2014, states will have to set up "SHOP Exchanges" (Small Business Health Options Program), allowing small businesses (defined as 100 employees or less) to pool their resources to buy health insurance. Most people will, by then, be required to have health insurance coverage or pay a fine if they don't. Employers not offering coverage will face fines and other penalties, and health insurance companies will begin paying a fee based on their market share, which will no doubt be passed along to those they insure, nullifying some of the savings garnered by the SHOP Exchanges, which are already predicted to be marginal.

The big Medicaid expansion will be in place by 2014 as well, but few physicians are likely to accept more Medicaid patients unless Medicaid compensation increases. That is unlikely to happen without substantial reductions in the states' woeful budget deficits – and probably not even then, since state governments already complain about their Medicaid budgets. Hospitals, with their deeper pockets, will get most of the new Medicaid patients and will hire even more physicians away from private practice to treat them.

If this sounds like a large potential problem for private practice as we know it, it is. Then again, it's too early for reliable predictions: There is a lot of potential leeway in the new law's future specifications, and a lot can happen between now and full implementation, from modifications and amendments to outright repeal. Only time will tell. ■

DR. EASTERN *practices dermatology and dermatologic surgery in Belleville, N.J. To respond to this column, e-mail Dr. Eastern at our editorial offices at clinicalneurologynews@elsevier.com.*

Congress Addresses Fraud in 'Exploitable' Medicare System

BY FRANCES CORREA

FROM A HEARING OF THE OVERSIGHT SUBCOMMITTEE OF THE HOUSE COMMITTEE ON WAYS AND MEANS

WASHINGTON – The new Center for Program Integrity and the Medicare Fraud Strike Force are among federal efforts aimed at combating fraud and abuse in the Medicare and Medicaid programs, top federal officers testified at a hearing of the subcommittee.

Subcommittee Chairman Charles W. Boustany (R-La.) said that he called the hearing because "without action, the problem is only going to get worse. Every dollar lost to health care fraud is a dollar not spent on patient care."

Key among new federal efforts is the Center for Program Integrity. Created by the Affordable Care Act, the Center for Program Integrity is now one of the Centers for Medicare and Medicaid Services.

Among the center's first tasks is to implement, risk-based screening for new Medicare- and Medicaid-participating providers, according to its deputy administrator and director, Peter Budetti.

The new rule holds high-risk providers and suppliers to a higher degree of scrutiny, based on their level of past interaction with the Centers for Medicare and Medicaid Services and law enforcement agencies. Certain characteristics, including exclusions by the Department of Health and Human Services' Office of Inspector General, could bump a provider to the high-risk level, Mr. Budetti said.

The subcommittee also heard from Lewis Morris, chief counsel to the Department of Health and Human Services' Office of Inspector General. Mr. Morris discussed the Medicare Fraud Strike Force, also created by the Affordable Care Act. The strike force is a collaboration of the Centers for Medicare and Medicaid Services, the Office of Inspector General, and the Department of Justice.

Since 2009, the Medicare Fraud Strike Force has brought charges against more than 1,000 defendants, recovering nearly $2.3 billion and shortening investigation time to a few weeks.

Since its inception in 2009, the strike force has brought charges against more than 1,000 defendants, recovering nearly $2.3 billion and shortening investigation time from up to a year to a few weeks, Mr. Morris testified.

The strike force is currently working toward securing legislation to close the current system loophole that prevents charging executives for committing fraud if they leave the company.

"The amendment of our discretionary exclusion authority would give us the ability [to charge executives] and be able to say to that corporate executive: 'You're out of our program because you're not treating our [participants] the way we expect you to,' " Mr. Morris said.

The subcommittee also listened to testimony delivered by Aghaegbuna "Ike" Odelugo, who pled guilty in August 2010 to fraudulently billing Medicare for close to $10 million. Mr. Odelugo worked in billing for 14 different health care companies and, from 2005 to 2008, ran the fraud scheme in conjunction with patients and doctors.

"This system has a number of weaknesses which are easily exploitable," Mr. Odelugo said, adding that all he needed was a basic knowledge of data entry and people to recruit patients and falsify patient data.

"This is a nonviolent crime and is often committed by very educated people including business people, hospitals, doctors, and administrators," Mr. Odelugo testified.

"It reaches across all ethnic and racial lines. It relies on an often unsuspecting victim base of Medicare recipients and other physicians who long for attention and care."

Mr. Odelugo testified that he volunteered to cooperate with authorities and testify before the subcommittee in an effort to help his case.

Subcommittee members noted that antifraud efforts must be protected from efforts to cut federal expenditures.

"It just seems intuitive then that this is an area where further budget cuts may end up costing us more in the long run, if we're taking away that enforcement capability or investigative capability," Rep. Ron Kind (D-Wis.) said at the hearing.

According to Mr. Morris, money spent on pursuing fraudsters yields a $6.80 return on the dollar.

To capitalize on that return, President Obama has proposed a 10-year $370 billion plan using funds from fraud recovery as a 2-year fix for the Sustainable Growth Rate formula. ■

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