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HEALTHCARE  
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What it means for your practice

A SPECIAL REPORT FROM MGMA CONNEXION MAGAZINE

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# Healthcare reform has passed — now what?

**A**fter a lengthy and often rancorous debate, Congress enacted and President Obama signed into law legislation providing for multiple changes and experiments in how healthcare is organized and paid for in the United States. So the question is no longer will we see a healthcare reform bill, but how will reform affect our practices?

Realistically, the legislation passed in March must be viewed as the first step in what is likely to be a process of reform that will extend over several years.

The major changes expand insurance coverage and close a variety of loopholes through which insurance companies often avoided covering people who were most in need of health insurance. A number of demonstration projects on aspects of care delivery, such as medical homes, accountable care organizations and use of comparative effectiveness research were also included. But wide-scale changes to payment mechanisms or other significant cost-containment measures are absent. As a consequence, it seems highly likely that these issues will be revisited in the near future — perhaps as soon as next year.

While predicting the precise impact of this legislation is a bit speculative, examining what happened in Massachusetts after their 2006 reform bill passed can be instructive.

To help the Medical Group Management Association (MGMA) Board of Directors envision the future for the Association and its members, we invited Lynn Nicholas, president and chief executive officer of the Massachusetts Hospital Association, and Alice Coombs, MD, president-elect of the Massachusetts Medical Society, to participate in the February board meeting. Here are a few presentation highlights:

- An already stressed delivery system was strained even further by the influx of some 400,000 newly insured people. Primary care was especially stretched,

and the time required to get a primary care physician appointment was extended. As a consequence, patient volumes in emergency departments surged. Many hospitals adapted by improving triage and adding urgent care capacity.

- The individual mandate worked. Despite predictions that a large number of people would pay penalties for not having insurance, the vast majority got insurance through employers or the new state health insurance exchange. Notably, the penalties for not being insured contained in the new federal legislation are somewhat higher than are those in Massachusetts.
- Because the initial state legislation (like the federal legislation) did little to address spiraling costs, the problem has only gotten worse in Massachusetts. As a consequence, the Special Commission on the Health Care Payment System was created to work on controlling costs. One of its proposals is state-controlled rate setting for hospitals and physicians.
- Because the specter of rate setting is so distasteful to all parties, the level of cooperation between hospital professionals and physicians has never been higher. These professionals are actively working together to create accountable care organizations, coordinate care for patients with chronic diseases, accept financial risk from payers and help solve the problem of rising costs. As Nicholas and Coombs put it, the alternative to hospital-physician cooperation is state control.
- Consolidation and integration of practices is accelerating. And while some large multispecialty groups in Massachusetts are well known (e.g. Fallon Clinic, Lahey Clinic and the Massachusetts General Physicians



By William F. Jessee, MD, FACMPE, president and CEO, Medical Group Management Association American College of Medical Practice Executives and MGMA Center for Research, [wfj@mgma.com](mailto:wfj@mgma.com)

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Organization), most physicians are in small groups. The pace with which those groups are merging, developing integrated independent practice associations and/or integrating with hospitals has picked up considerably to achieve the level of integration required for the new care delivery models that a reformed payment system is likely to require.

Overall, it seems as if the key lessons to be learned from the Massachusetts reforms are all words that begin with the letter "C," including cost control, collaboration, co-operation and coordination of care.

As much as many physicians and practice administrators cherish the freedom and opportunity that small practices have historically enjoyed, it appears that the delivery system of the future is going to be a different animal.

For some practices, making the transi-

tion will create a wealth of new opportunities for physicians and administrators. For others, changes may be painful. In either case, MGMA is your professional resource to help you survive and thrive.

A final thought from Albert Einstein: "The definition of insanity is doing the same thing over and over again and expecting different results." All of us should give careful thought to that advice as we consider how we plan to react to the reform law. 

**join the discussion:** What is your practice doing differently as a result of healthcare reform? Tell us at [mgma.com/connexioncommunity](http://mgma.com/connexioncommunity) or [connexion@mgma.com](mailto:connexion@mgma.com)

**Turn to page 11 to read more about Massachusetts' healthcare reform.**



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# How healthcare reform provisions affect your practice

By the MGMA Government  
Affairs Department,  
govaff@mgma.com

**O**n March 30, President Obama signed H.R. 4872, the Health Care and Education Reconciliation Act of 2010, which modifies the Patient Protection and Affordable Care Act (PPACA), H.R. 3590. Together, these bills serve as the foundation for changes made by Congress to the current healthcare delivery, payment and insurance systems.

Since that time, the MGMA Government Affairs team in Washington, D.C., has fielded hundreds of inquiries from members, media representatives and patients seeking guidance on how the bill will affect them. To cut through the confusion, we have provided a timeline here along with links to an on-demand webinar online hosted by MGMA CEO and President William Jessee, MD, FACMPE.

To recap, MGMA did not support the final healthcare reform legislation because of its failure to reflect the Association's healthcare reform principles.

The following reference implementation timeline focuses on major issues of interest to MGMA members. Some provisions are effective immediately, while others will take years to implement. A significant number of legislative provisions require the secretary of the Department of Health and Human Services (HHS) to develop implementing regulations. MGMA will work with the secretary to make sure that group practice interests are represented throughout the rulemaking process. In addition, we anticipate that the Centers for Medicare & Medicaid Services (CMS) and other federal agencies will issue guidance concerning PPACA provisions that may impact current regulations, and we will keep you abreast of that news.

A detailed listing of important legislative provisions can be found in the reference implementation timeline at [mgma.com/healthcarereform](http://mgma.com/healthcarereform). Find some of the major provisions that impact practices, insurers and patients and the timelines associated with those provisions\*.

2010

- **Imaging:** Payment for the technical component of diagnostic services will be reduced by 50 percent for subsequent procedures on consecutive body parts beginning July 1. This is an increase from the current 25 percent reduction. (Sec. 3135)
- **GPCI work floor:** Extended through Dec. 31, 2010. The Geographical Practice Cost Index (GPCI) work floor expired at the end of 2009. (Sec. 3102)
- **Practice expense GPCI adjustment:** Retroactively effective from Jan. 1, 2010, HHS is required to revise the calculation method of the practice expense (PE) portion of the geographic practice cost index (GPCI). This revision results in increased PE GPCIs for certain rural areas. Implementation of this provision will most likely require CMS to reprocess certain 2010 claims. (Sec. 3102 as modified by Recon. Sec. 1108)
- **Small Business Tax Credit:** Effective calendar year 2010, the law establishes a tax credit of up to 35 percent of an employer's contribution for health insurance premiums for qualified small businesses contributing to their employees' health insurance. There is also a tax credit of up to 25 percent for small nonprofit organizations. Qualified small businesses are defined as employers with 25 or fewer full-time equivalent employees and average wages of less than \$50,000. To be eligible for the tax credit, the employer must also contribute at least 50 percent of the total premium cost or 50 percent of a benchmark premium. (Sec. 1421, as modified by Sec. 10105)
- **Coverage for preventive services and immunizations:** Effective Sept. 23, 2010, individual and new group plans must cover

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- Detailed PPACA implementation guide and link to Jessee's webinar available at [mgma.com/healthcarereform](http://mgma.com/healthcarereform)

certain preventive services and immunizations without cost-sharing. The law does not specify the preventive services and immunizations that must be covered, but it does specify that services with an A or B rating in the current U.S. Preventive Services Task Force will be covered. Covered immunizations are those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. (Sec. 1001)

- **Elimination of pre-existing condition exclusion for children:** Effective Sept. 23, 2010, individual and group health plans are prohibited from imposing pre-existing condition exclusions on children. (Sec. 10103)
- **Extension of dependent coverage to young adults up to age 26:** Effective Sept. 23, 2010, all individual and group health insurance plans are required to allow uninsured children to remain on their parents' health insurance policies through age 26. (Sec. 1001) To date, several major health plans have agreed to implement the rule prior to the required effective date.
- **Elimination of lifetime limits and restriction of annual limits:** Effective Sept. 23, 2010, insurance plans are prohibited from establishing lifetime limits on coverage, and there will be new restrictions on the use of annual limits until 2014. The secretary of HHS will define the restricted annual limits that may be used by plans prior to 2014. After 2014, all plans are prohibited from establishing any lifetime or annual limits on the dollar value of benefits. (Sec. 1001, as modified by Sec. 10101)
- **Imaging/self-referral:** Physicians who refer their patients for magnetic resonance imaging, computed tomography or positron emission tomography (and potentially other radiology services the secretary of HHS deems appropriate) utilizing the "in-office ancillary services" exception to the Stark/physician self-referral law must provide a written notice to their patients at the time of referral. The notice must inform the patient that he or she may obtain the services elsewhere. The patient must also be supplied with a written list of alternative suppliers in the area where he or

she resides. The law makes this requirement effective Jan. 1, 2010; providers should begin complying immediately. (Sec. 6003)

- **Self-referral:** By Sept. 23, 2010, the secretary of HHS must develop a protocol that allows providers and suppliers to self-disclose violations (actual or potential) of the physician self-referral/Stark law. The secretary is authorized to reduce the violations for providers who self-disclose. (Sec. 6409)
- **Physician-owned hospitals:** Existing physician-owned hospitals will be restricted in their ability to expand and still qualify for the physician self-referral exception beginning March 23, 2010. In addition, new physician-owned hospitals must have their provider agreements in place by Dec. 31, 2010, in order to qualify for physician self-referral/Stark law protection. The number of operating rooms, procedure rooms and beds must not exceed the number on March 23, 2010, or the date of the provider agreement, whichever is later, unless a hospital meets the requirements of an exceptions process to be established by the secretary relating to community need. By September 2011, existing hospitals must comply with new requirements, including reporting physician ownership to the secretary of HHS and having procedures in place to disclose physician ownership to patients and the public, among other requirements. (Secs. 6001, 10601 as modified by Recon. Sec. 1106)

## 2011

- **Primary care incentives:** For 2011 through 2016, primary care providers (family medicine, internal medicine, geriatrics and pediatrics physicians or nurse practitioners, clinical nurse specialists and physician assistants) must charge at least 60 percent of their total allowed Medicare charges as office, nursing facility or home visits in order to qualify for a 10 percent bonus payment. This payment will be distributed on a monthly or quarterly basis. (Sec. 5501)
- **General surgery in HPSA incentive:** For 2011 through 2016, general surgeons

## Washington Link

- **General surgery in HPSA incentive:**

For 2011 through 2016, general surgeons furnishing major procedures (10-day or 90-day global service period) in a health professional shortage area (HPSA) will be eligible for a 10 percent bonus payment to be paid on a monthly or quarterly basis. (Sec. 5501)

- **Imaging:** For Medicare physician fee schedules for 2011 and thereafter, the utilization assumption for services using “expensive diagnostic imaging equipment” (currently defined by CMS to include magnetic resonance imaging and computed tomography) will be set at 75 percent. The utilization assumption is used to calculate the practice expense relative value units in the technical component payment. Through 2009, the utilization assumption for such equipment was set at 50 percent. In 2010, CMS increased the assumption to 90 percent to be phased in over four years, which means that the 2010 assumption is roughly 60 percent. By increasing the assumption to 75 percent on Jan. 1, 2011, practices could see a further cut in the technical component payment for services using this equipment. However, beginning in 2012, this cut will be less than it would have been under the 90 percent assumption. (Sec. 3135, as modified by Recon. Sec. 1107)

- **Value-based payment modifier under the physician fee schedule:**

Before 2012, HHS must publish the quality and cost measures, the implementation dates and the initial performance period associated with a new Part B value-based payment modifier. The modifier provides for differential payments to physicians or groups of physicians based on the quality of care furnished compared to the cost of care during a performance period. This modifier begins to affect payments in 2015 based on 2014 performance data. (Sec. 3007)

- **PQRI:** The incentive payment for

successful participation in the 2011 Physician Quality Reporting Initiative (PQRI) will be 1 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. By Jan. 1, 2011, at the latest, CMS must establish an informal appeals process for PQRI participants who did not satisfactorily participate. Beginning in 2011, CMS will offer an additional participation method through a continuous assessment program, such as a qualified American Board of Medical Specialties Maintenance of Certification (ABMS MOC) program. Practices that utilize this new method for PQRI reporting in years 2011 through 2014 will be eligible for an additional 0.5 percent incentive payment. The incentive payment for successful participation in the 2012 through 2014 PQRI will be 0.5 percent of a practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. By Jan. 1, 2012, at the latest, CMS must provide timely feedback to practices participating in the PQRI. In 2015, if a practice does not satisfactorily participate in the PQRI, a 1.5 percent penalty is applied to the practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. In 2016 and beyond, if a practice does not satisfactorily participate in the PQRI, a 2 percent penalty is applied to the practice's total estimated Medicare Part B allowed charges for covered professional services furnished during the reporting period. (Sec. 3002)

- **CMI:** By Jan. 1, 2012, at the latest, CMS must establish a Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models to reduce program expenditures. HHS must provide preference to models that also improve the coordination, quality

and efficiency of healthcare services, and HHS will have the authority to limit model testing to certain geographic areas. (Sec. 3021)

- **Operating Rules for the Eligibility and Claim Status Electronic Transactions:** Operating rules for the HIPAA eligibility verification transaction and the health claim status transaction are required by July 1, 2011 (with an effective date of Jan. 1, 2013), with the goal of creating as much uniformity in the implementation of these electronic standards as possible. The operating rules are to be consensus-based and will reflect the necessary business rules affecting health plans and healthcare providers and the manner in which they operate. The legislation states that these rules “may allow for the use of a machine-readable identification card.” (Sec. 1104)

- **Standardized Health Plan Enrollment and Claim Edits:** The HHS secretary is to seek input by Jan. 1, 2012, on whether the health plan enrollment process could be made electronic and standardized, and whether there could be greater transparency and consistency of the methodologies and processes used by health plans to establish claim edits. (Sec. 10109)

- **Medical liability reform:** States will be eligible to receive grants for the development, implementation and evaluation of alternatives to tort litigation for resolving disputes allegedly caused by healthcare providers or organizations. Grants can be awarded for no more than five years. A total of \$50 million is available. (Sec. 10607)

## 2012

- **Medicare ACO program:** By Jan. 1, 2012, at the latest, HHS will establish a Medicare shared savings program that promotes accountability for a patient population, coordinates items

and services under Parts A and B, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. In this program, groups of service providers and suppliers that meet the criteria specified by HHS may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through a Medicare Accountable Care Organization (ACO). ACOs that meet quality performance and risk-adjusted standards established by the secretary of HHS are eligible to receive payments for shared savings. Among other requirements, the ACOs must enter into an agreement with HHS for at least three years, include a sufficient number of primary care providers to treat at least 5,000 Medicare beneficiaries that HHS assigns to the ACO, have a defined management structure, practice evidence-based medicine and report on quality and cost measures. (Sec. 3022)

- **Health Plan Identifier:** HHS is required to develop a final rule establishing a unique health plan identifier by Oct. 1, 2012. This identifier will simplify the routing of healthcare transactions and the administration of healthcare plan benefits. The effective date is Jan. 1, 2014. (Sec. 1104)

## 2013

- **Medicaid/Medicare payment parity:** Medicaid payments to primary care physicians (specialties designated as family medicine, general internal medicine or pediatric medicine) furnishing evaluation and management services and immunizations are raised to match Medicare rates for 2013 and 2014. Additional federal funds are allocated to states to account for this payment increase. (Recon. Sec. 1202)
- **National Pilot Program on Payment Bundling:** By Jan. 1, 2013, at the

latest, HHS must establish a five year, voluntary pilot program on payment bundling for integrated care by inpatient/outpatient hospital services, physician services and post-acute care services during an applicable episode of care (three days prior to admission and 30 days following discharge) provided to a Medicare fee-for-service beneficiary around a hospitalization. HHS will select 10 chronic, acute, surgical or medical conditions. HHS may extend the pilot after 2016 if certain criteria are met. (Sec. 3023)

## 2014

- **IPAB:** By Jan. 15, 2014, the non-elected Independent Payment Advisory Board (IPAB) may begin to develop and submit advisory reports on matters related to the Medicare program to Congress. The IPAB is given authority to formulate comprehensive regulatory and legislative recommendations to slow the growth in national health spending. In certain circumstances, the IPAB would have the authority to make binding Medicare policy recommendations and nonbinding private payer policy recommendations to Congress. Empowering an IPAB with authority to make binding Medicare policy recommendations based on expenditure targets adds a second expenditure constraint on physicians who are already subjected to the sustainable growth rate formula. No later than July 1, 2014, and annually thereafter, the IPAB shall produce a public report containing standardized information on systemwide healthcare costs, patient access to care, utilization and quality of care that allows for comparison by region, types of services, types of providers and both private and public payers. 2015 is the first year IPAB has the authority to make Medicare cost-reduction recommendations. No later than Jan. 15, 2015, and at least once

every two years thereafter, the IPAB shall submit recommendations for slowing the growth in national health expenditures while preserving or enhancing quality of care to Congress and the president. (Sec. 3403, as modified by Sec. 10320)

- **Health Claims Attachments:** HHS will issue a final rule by Jan. 1, 2014, establishing a transaction standard and a single set of associated operating rules for health claims attachments that is consistent with the X12 Version 5010 transaction standards. The use of standardized electronic claims attachments will significantly accelerate the claims adjudication process and eliminate costs associated with the copying and mailing of supporting documentation. The effective date is Jan. 1, 2016. (Sec. 1104)
- **Operating Rules for Health Claims and Referral Certification and Authorization:** Adoption of operating rules by July 1, 2014 (effective date Jan. 1, 2016), for health claims or equivalent encounter information, referral certification and authorization transactions are required. (Sec. 1104)

Questions about the implementation timeline or healthcare reform?

- Contact the MGMA Government Affairs Department, 877.ASK.MGMA (275.6462) ext. 1300, or e-mail govaff@mgma.com.
- Discuss your questions in the Federal Legislation and Red Tape Forum in the MGMA Member Community. 

\* Citations to the Patient Protection and Affordable Care Act or, where indicated, to the Health Care and Education Reconciliation Act of 2010 (Recon.)



# Healthcare reform: The devil is in the details

## Member Opinion

*The views expressed are those of the MGMA member and are not necessarily endorsed by MGMA, nor do they constitute legal advice.*

**P**assage of the healthcare reform bill is a major milestone for the U.S. healthcare system. And as we unravel the bill, discover the real story and prepare for the consequences of this massive effort – both intended and unintended – we know one thing for sure: The transition will be a long road.

Reform is needed. Soon we will reach the point at which employers have trouble providing affordable health insurance to employees, with the unattractive alternatives of dropping coverage or taking more from employees' pockets. Double-digit healthcare inflation is driving double-digit health premium increases. As a result, we see employers buying plans with increased deductibles and copayments or, worse, dropping employee insurance altogether.

Our hope has been reform that empowers physicians to provide better care and that does not lasso doctors into bureaucratic webs. But if "meaningful use" electronic medical record regulations are any indication, many new regulations may not improve healthcare.

The legislation is not as bad as the Republicans make it out to be. Armageddon is not upon us. And the sun will come up tomorrow. The bill is also not as fabulous as the Democrats claim. In typical liberal fashion, the bill is overly complex and heavily bureaucratic, and its supporters express unjustified faith in governmental competence.

The devil really is in the details considering that a brief summary of this bill runs at 60 pages. Thousands of pages of regulations will be written and phased in for about a decade, and the thrust and direction of those regulations will allow bureaucrats to shape and mold the healthcare system.

The bill will change the healthcare system

to an amazing depth and breadth. And despite proclamations from economists, politicians and policy wonks, we don't know its full impact. The Obama administration talks about health insurance reform, but the legislation clearly intends to reorganize the healthcare system from top to bottom, including physician practice, ancillary services, pharmaceutical companies, long-term care and hospital care.

President Obama has been hammered by the political right for going too far too fast, and by the progressive left of his own party for being timid. The liberals wanted a single-payer system and were willing to settle for a public option, but politicians left the table with only the hope that reform will be reformed.

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The amount of misinformation, overgeneralization and plain old hot air tossed around during the debate makes a calm analysis difficult. And it has left citizens and patients confused and alarmed. The bill, which will ultimately reorganize and redirect one-sixth of our economy, is full of slow phase-ins and long transitions.

A great deal of the debate has focused on the positive or negative impact the bill will have on the deficit over the next 10 years. The Congressional Budget Office estimated a positive deficit impact of about \$140 billion, yet no one has any real idea what the bill will do.



By Tom Ealey, MGMA member and associate professor of business administration at Alma College, Alma, Mich., [tomealey@yahoo.com](mailto:tomealey@yahoo.com) or [ealey@alma.edu](mailto:ealey@alma.edu). Ealey won the Edward B. Stevens Article of the Year award for his February 2009 *MGMA Connexion* article on healthcare reform. See the [mgma.com](http://mgma.com) box below for a link.

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- [mgma.com/healthcarereform](http://mgma.com/healthcarereform)
- The February 2009 issue of *MGMA Connexion* has resources on modeling practice financials. Search back issues of the magazine online at [mgma.com/virtualconnexion](http://mgma.com/virtualconnexion)

do. Anyone who has studied the history of Medicare and Medicaid knows that legislative budget estimates tend to melt in the face of politicking and lobbying.

Many problems need immediate attention. State budgets, hammered by the recession, will have to cut Medicaid benefits. Private insurers and employers will have to adjust quickly to new regulations and cost structures. Major changes in Medicare programming are inevitable.

## Immediate problems

For physician groups, the immediate problem is the Medicare fee schedule. As I write this, the news is not good. It foreshadows future cuts for physicians, while cuts to other providers are already scheduled.

Physicians are already dumping Medicare and Medicaid patients – a rash course of action unless they fully understand the fixed/variable behavior of costs, practice cost-volume-profit structure and have run scenario

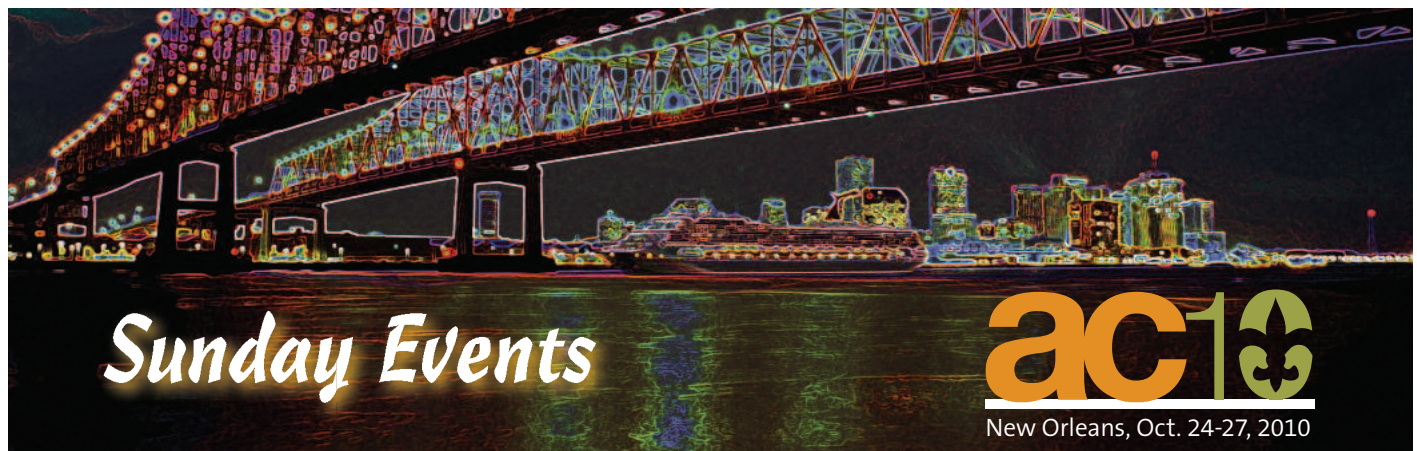
analysis models on the bottom-line impacts of dropping patients.

In the longer run, physician groups will have to examine strategic plans, tactical markets and financial actions as well as assess the benefits of joining integrated systems and perhaps the existence of the group.

Congress and the White House have produced numerous summaries, some objective and some with a political spin, and they are all worth reading. Look to the Medical Group Management Association for focused commentary on the future of physician groups and readable summaries and timelines.

The journey has just begun. We may get to a good place, but not without some bumps and bruises. The United States can improve coverage and contain cost, but will this reform be the proper reform? Only time will tell. 

**join the discussion:** What do you think of this opinion piece? Tell us at [mgma.com/connexioncommunity](http://mgma.com/connexioncommunity) or [connexion@mgma.com](mailto:connexion@mgma.com)



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# Opportunity in crisis

## How your practice can make the most of a reformed healthcare system

**H**ealth reform will forever change patient demographics, demand for professional and ancillary services, payer mix and practice reimbursement. These changes will be troublesome for many medical professionals. At the same time, health reform presents an opportunity for great economic success if practice leaders are prepared for the transformed environment.

The first step in preparing a medical group for the new healthcare system is to separate personal political views from practical assessments of how the law can enable practice owners to gain market share, increase reimbursement, reduce costs and exert greater influence in the medical community.

Perhaps the most controversial aspect of the law, requiring all U.S. citizens and legal residents to have qualifying health coverage, may not take effect until 2014, but most larger businesses are quickly (and quietly) expanding insurance coverage to all full-time employees.

Wal-Mart, the largest corporation in America, has been criticized for not providing reasonably priced health insurance. However, in July 2009, Wal-Mart officials supported the employer insurance mandate and stated that 94 percent of its employees had insurance, either through the company or family members.<sup>1</sup>

Healthcare organizations are moving quickly to expand operations to accommodate a significant increase in demand. On April 13, 2010, CVS Caremark Corp. announced plans to double the number of MinuteClinics over the next five years. Walgreens and Wal-Mart representatives have also indicated a plan to expand in-store medical clinics.<sup>2</sup>

### Increased demand for services

Medical groups also need to prepare for increased demand for services. In the short

term, you need to assess if the current number of physicians in your practice and service mix is appropriate for the transformed healthcare system. You also need to determine if the practice should use more non-physician providers and if current facilities will be adequate for an influx of new patients.

These decisions cannot be made without careful study and deliberation. At the same time, once you put a strategy for managing increased volume in place, you will be well prepared for increased demand in a system constrained by too few providers.

Increased demand can provide opportunities for astute financial managers to rebalance payer mix. Because health reform did not call for a public option for health insurance, the large majority of newly insured patients will have employer-purchased commercial insurance coverage, which will pay rates established by insurance contracts.

Evaluate administrative performance and payment levels for commercial insurers and government payers to identify which insurers pay more quickly, have fewer denials and abide by the terms of their contracts. This analysis will enable you to determine whether you should continue to act as a participating provider or not renew the contract and be reimbursed as a nonparticipating provider. Rebalancing insurance payer mix can substantially improve your practice's revenue and bottom line without a change in volume.

Another strategy that a practice can employ to cope with increased patient demand is to expand hours. Starting earlier and ending later is not only more convenient for patients, but the additional services will boost revenue. Operating costs will increase only slightly since fixed facility costs are already covered. Again, the practice professionals who plan ahead can use the changed environment to their economic advantage.



David N. Gans, MSHA, FACMPE, vice president, MGMA Innovation and Research, dng@mgma.com

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**The first step in preparing a medical group for the new healthcare system is to separate personal political views from practical assessments.**

## Profitable investments

Health reform will present opportunities that an astute manager cannot pass up. Study the legislation, and you will identify numerous opportunities to exploit. The practice manager who reviews internal data, tracking and reporting procedures can evaluate whether the practice has the systems it needs for the new environment.

Health reform will place additional demands on a practice's information systems, and investments in health technologies such as electronic health records, electronic prescribing systems and patient chronic disease registries will pay off with increased "pay-for-performance" payments and better management information.

Practice professionals should also consider opportunities for partnerships with hospitals or other medical groups. Such agreements can enable your practice to qualify for new types of payments, access additional capital and increase organizational clout.

Stanford University economist Paul Romer said, "A crisis is a terrible thing to waste."<sup>(3)</sup> And while health reform will present a crisis of monumental proportions for many medical groups, it also provides an opportunity that will enable some medical groups to prosper beyond their wildest dreams. 

**Join the discussion:** Let us know whether this type of "action plan" is helpful at [mgma.com/connexioncommunity](http://mgma.com/connexioncommunity) or [connexion@mgma.com](mailto:connexion@mgma.com).

### Notes

1. [http://www.usatoday.com/money/industries/insurance/2009-06-30-walmart-insurance\\_N.htm](http://www.usatoday.com/money/industries/insurance/2009-06-30-walmart-insurance_N.htm)
2. <http://www.pbn.com/detail/49166.html>
3. <http://www.nytimes.com/2009/08/02/magazine/02FOBonlanguage-t.html>

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# What Massachusetts learned from healthcare reform

**I**n Massachusetts, the healthcare industry is the second-largest employer — just behind retail. The industry got a total overhaul in 2006 when passage of the Healthcare Reform Law required nearly every person to have healthcare coverage. Two of the women who have been instrumental in sculpting Massachusetts healthcare reform met with the Medical Group Management Association (MGMA) Board of Directors in February to give an overview of the process as well as the challenges ahead.

Using their experience as a benchmark, presenters Alice Coombs, MD, president-elect of the Massachusetts Medical Society, and Lynn Nicholas, FACHE, president and chief executive officer of the Massachusetts Hospital Association, told MGMA board members that by using and analyzing data, doctors will play a more active role in driving quality and performance metrics.

And, while the future holds great promise for healthcare professionals, these new metrics will shine a spotlight on performance.

"It's going to be unforgiving," Nicholas says. "You will get paid for what you do. And in the long run, quality does cost less."

A key message from the presentation was the importance of creating a tight-knit community of medical professionals who recognize the inherent benefits of teamwork and assuming risk entailed in providing care at clinics as well as referrals to hospital systems.

"When we talk about how we successfully enacted our coverage plan, we talk about shared responsibility, but the moral of the story is that it only worked because everybody had real skin in the game," Coombs says.

Within the new system, which has a five-year implementation goal, doctors from different specialty groups — and hospitals — will form alliances to ensure that patients receive appropriate care that may include complementary approaches such as acupuncture and physical therapy before surgery is recommended.

"Sometimes more [care] is not better, but coordination of care should not limit a

patient's access to care," Coombs says.

Global payment is the predominant model envisioned for the new system, though fee for service would still occur in certain situations. One benefit to global payment is that it encourages doctor alignment and more accountable care organizations (ACOs), Coombs adds.

Nicholas concurs. "Transparency for providers and insurers alike is the single most important tool to level the playing field and understand what needs to be changed."

**With an increasing emphasis on referrals — and a doctor's selection of specialists — professional networks will become increasingly important.**

Massachusetts government officials created a Health Care Quality and Cost Council that comprises doctors, state government leaders, administrators and insurance professionals who appreciate the complex landscape and, ultimately, can propose mutually beneficial solutions to the healthcare dilemma, Nicholas and Coombs say.

In addition, Massachusetts Gov. Deval Patrick appointed a 10-member special commission to examine healthcare cost issues as well as best practices. Members of the commission — which included Coombs and Nicholas — recognized that while doctors currently divvy patient care among specialists, few actually coordinate that care. As a result, additional costs are incurred.

They also discovered that changing healthcare settings — and, when appropriate, using community hospitals and community health



*Presenting to the MGMA Board of Directors were Alice A. Tolbert Coombs, MD, FCCP, president-elect of the Massachusetts Medical Society, a critical care specialist at South Shore Hospital and an anesthesiologist with South Shore Anesthesia Associates.*

*Lynn Nicholas, FACHE, joined the Massachusetts Hospital Association as president and CEO in August 2007 bringing more than 30 years of hospital and association experience.*

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centers — can provide significant cost savings.

“By steering patients to the right setting, we can drive costs down,” Nicholas says. The same surgery performed at two different hospitals can represent a 30 percent difference in fees, “yet there was not always a difference in the quality of care provided. We analyzed the metrics,” she adds.

In an ideal scenario, primary care doctors tell patients which hospital to go to within a specific ACO system and are included in risk contracts, which increase the doctor's level of engagement throughout the referral process.

“It's the power of the market,” Nicholas says. “It's all going to be about the physicians and how much risk they take on as well as data, data, data and transparency.”

With an increasing emphasis on referrals — and a doctor's selection of

specialists — professional networks will become increasingly important.

Presenters explained that because Massachusetts-based doctors will assume some of the risk associated with patient care, they have to become more analytical about the care provided at different hospitals. And once data are analyzed, some large hospital contracts will be shifted to different specialists to ensure that the best medicine is provided. In this scenario, knowing which doctors are the best at what they do is a key component of success.

“Aligning physicians is the right thing to do,” Coombs says. “It's the best thing for the patients. Even if it never saves a dime, it's the right way to provide care.”

Judging from the enthusiastic response from insurance companies, Massachusetts professionals are onto something.

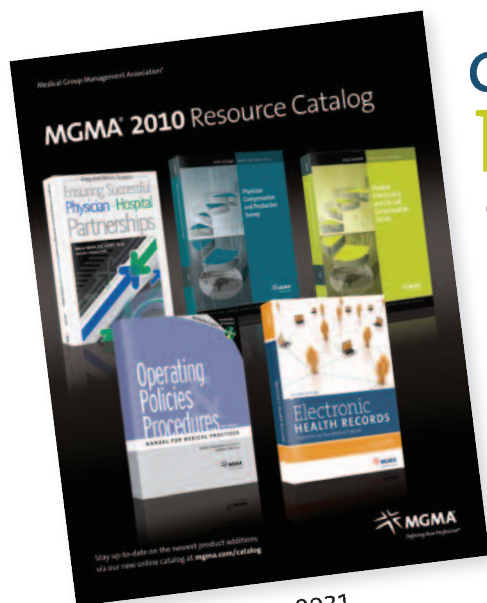
“Insurance companies are exuberant about this,” Coombs says.

Physician groups and hospital professionals also have lots of interest in being the early adopters of this type of reform.

“It's a small way to take back market share,” she adds.

Throughout the healthcare process, which continues to evolve in Massachusetts, medical professionals learned that shared risk and new alliances can produce better care, lower costs and higher levels of patient and doctor satisfaction. State professionals recognize that capitation may not be as profane a concept as once believed and that performance evaluation — and analysis of healthcare locations — is mutually beneficial. 

**join the discussion:** What do you think of the ideas shared here? Tell us at [mgma.com/connexioncommunity](http://mgma.com/connexioncommunity) or [connexion@mgma.com](mailto:connexion@mgma.com).



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