Health Care Reform and the Road Ahead for Gastroenterology

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The Supreme Court has weighed in on the constitutionality of the Patient Protection and Affordable Care Act (ACA). Few people predicted that the individual mandate to purchase insurance would be upheld because of Congressional authority to levy a tax. Fewer still predicted the ruling on Medicaid expansion. In this month’s “Practice Management: The Road Ahead” segment, 4 of us have tried to outline (within editorial word limits) the potential implications of the Supreme Court ruling. Although we await election results, make no mistake—the ACA will move forward, and it will have profound implications for gastroenterology. Our training programs and safety net hospitals will suffer (see Taylor IL and Clinchy RM. Clinical Gastroenterology and Hepatology 2012;10:828–830), colorectal cancer screening paradigms may change as accountable care organizations develop, and each practice will be challenged to understand their state’s reaction to Medicaid expansion. The American Gastroenterological Association will continue to monitor the national landscape, educate you about The Road Ahead, and advocate for our numbers and patients.

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The Patient Protection and Affordable Care Act, along with the Health Care and Education Reconciliation Act (collectively, ACA), was signed into law on March 23, 2010. The ACA is the nation’s most sweeping health care legislation since the establishment of Medicare and Medicaid. Soon after its passage, numerous states, organizations, and individuals challenged the ACA in state and federal courts. The Supreme Court granted judicial review to portions of 3 cross-appeals of the Eleventh Circuit’s opinion: one by the federal government (of Health and Human Svcs. v Florida), one by the states (Florida v U.S. Dept. of Health and Human Svcs.), one by the federal government (U.S. Dept. of Health and Human Svcs. v Florida), and one by the National Federation of Independent Business (Nat’l Fed. of Independent Bus. v Sebelius), and dedicated 3 days in March 2012 to hear arguments, which is the most time allotted to a single case since Brown v Board of Education in 1954. This article briefly reviews the high court’s ruling on June 28, 2012, and then considers the road ahead for health care reform and its impact on gastroenterology.

The Supreme Court Rules

In a 5 to 4 vote, Chief Justice John Roberts joined with the court’s 4 more liberal members to uphold most of the ACA including the “individual mandate” that requires all Americans to purchase insurance or pay a penalty. In the majority opinion, Justice Roberts wrote, “The Affordable Care Act’s requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax.” Roberts added, “Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.” By upholding the individual mandate, the Court ensured that the bulk of the ACA, which includes numerous provisions intended to expand access to care, control costs, and improve quality, would stand. Yet in a 7 to 1 decision, the court ruled that the federal government cannot require states to participate in the ACA’s planned expansion of Medicaid, and that states electing not to comply with expansion may do so without being stripped of their existing Medicaid funds. Roberts emphasized that the court considers only the constitutionality and not the wisdom of legislation. “We do not consider whether the Act embodies sound policies,” he wrote. These decisions “are entrusted to our nation’s elected leaders, who can be thrown out of office if the people disagree with them.”

The Affordable Care Act

The ACA contains numerous provisions that will be implemented during the course of several years. To date, more than 40 ACA provisions have taken effect, many of which impact patients with digestive diseases and gastroenterologists. This article will focus on 4 specific areas of the law: patient protections, access, payment reform, and performance measure-
ment. After discussing how each will impact gastroenterology, we conclude by discussing how they further the 5 trends in health care reform introduced in “The Road Ahead” by John I. Allen.2

**Patient Protections**

Under the ACA, insurance companies are prohibited from rescinding coverage during illness or imposing annual or lifetime limits on coverage. Health plans are barred from basing premiums on medical history and imposing excessive premium rate increases and must now spend at least 80%–85% of collected premiums on medical care. Children may no longer be denied insurance coverage for preexisting conditions, and for adults, this protection will take effect in 2014.

**Expanding Access to Care**

The ACA will enable many currently uninsured patients to obtain health coverage and care for digestive diseases. Under the individual mandate, every citizen must obtain health insurance through their employer, the private market, or Medicaid. Low-income individuals not qualifying for Medicaid will receive federal tax credits and cost-sharing subsidies on a sliding scale. The ACA will also establish insurance exchanges to enable individuals and small businesses to pool risk and purchase health coverage at a lower cost. It was originally projected that these measures would expand health coverage to 32 million of the currently 50 million uninsured Americans. However, much uncertainty about the individual mandate, insurance exchanges, and Medicaid expansion remains after the Supreme Court ruling, and the actual number who will receive insurance coverage will probably be lower than previously estimated.

It is not clear how effective the individual mandate will be. ACA protections against insurance industry abuses will certainly lower barriers to health insurance. However, if the financial penalty for not obtaining insurance under the individual mandate is not sufficient to motivate healthy individuals to comply, a significant number may choose to remain uninsured. Without the contributions of these individuals to help finance the insurance pool and spread risk, premiums would rise and push other individuals out of the insurance market.

As of July 2012, states have made variable progress toward establishing health insurance exchanges. Fourteen states and the District of Columbia have passed legislation authorizing exchanges, and more than 20 states have authored similar bills. Several states including California and Maryland have not only passed legislation but are moving forward to install computer systems and set up administrative structures for their exchanges. Other states including Louisiana, Florida, Wisconsin, and Alaska are refusing to set up any insurance exchanges. In between are states that are debating how quickly to move and whether it would be easier to wait until after the November 2012 elections or simply allow the federal government to establish and operate exchanges as permitted by the ACA. Under current law, insurance exchanges must be operational by January 1, 2014, but because implementation was stalled while waiting for the Supreme Court decision, many states may not meet this deadline.

The most uncertainty surrounds Medicaid, the major source of new coverage. With the Supreme Court barring the federal government from removing existing funding from noncompliant states, some states will decide to opt out of Medicaid expansion for budgetary, cultural, or political reasons. Individuals in these states who do not qualify for Medicaid under current eligibility criteria but with incomes still below the ACA’s cutoff for receiving federal subsidies (133% of federal poverty level) may remain uninsured.3 Thus, the number of uninsured Americans who will obtain health coverage under the ACA’s Medicaid expansion may end up being significantly lower than the 17 million originally predicted before the Supreme Court ruling.

From the gastroenterology perspective, the ACA will lower barriers to colorectal cancer (CRC) screening and expand health coverage to millions of currently uninsured Americans. Medicare, Medicaid, and private health plans are required to cover CRC screening without charging patients deductibles or copayments. The law waives cost-sharing for colonoscopy, sigmoidoscopy, and fecal occult blood testing. However, under Medicare’s current payment rules, if a patient is referred for a positive fecal immunochemical test or undergoes polyp removal during a screening colonoscopy, the procedure becomes reclassified as a therapeutic procedure, and beneficiaries must pay an out-of-pocket cost. Cost-sharing for polyp removal may discourage usage of CRC screening.

With regard to coverage expansion, although the actual number of patients obtaining health insurance will probably be lower than first estimated, the newly insured will have greater opportunity than ever before to access care from gastroenterologists. Low-income patients with debilitating chronic diseases including chronic liver disease, hepatitis B and C, inflammatory bowel disease, and gastrointestinal malignancies will experience the greatest benefit.

Gastroenterologists practicing in low-income areas, safety-net hospitals, or academic medical centers, which generally see the highest number of uninsured patients, will experience the greatest benefit from the ACA’s coverage expansions. However, gastroenterologists practicing in states refusing to participate in Medicaid expansion will encounter a higher number of uninsured individuals. Because reimbursement rates for many newly insured patients, particularly those covered by Medicaid, will be low, many gastroenterologists may be unable to accept them.4 In addition, a nationwide shortage in the supply of gastroenterologists predated the ACA. For these reasons, there may not be enough gastroenterologists to fully meet the increased demand for services, which may lead to greater acceptance of the use of mid-level providers to perform CRC screening.5

**Payment Reform**

The fee-for-service (FFS) model will remain the primary reimbursement system for most gastroenterologists in the short-term. The ACA does not address the sustainable growth rate (SGR) formula that guides FFS reimbursement for Medicare and most other insurance plans. The SGR was introduced in 1998 with good intentions to control Medicare spending but attempts to reduce reimbursement without accounting for growth in the complexity and volume of health services and does not incentivize individual providers to control costs. The SGR is simplistic; if actual medical spending exceeds a preset
spending target linked primarily to overall economic growth, then reimbursement is cut. There is evidence that the payment cuts proposed by the SGR may significantly undermine access to care for seniors. Congress has averted deep payment cuts mandated by the SGR each year since 2003, but there is no guarantee that it will continue to do so. The Medicare Payment Advisory Commission recommended to Congress in October 2011 that the SGR be repealed and replaced with a modern and more sustainable physician fee schedule. However, as long as the SGR remains law, gastroenterologists and other procedure-based specialties remain vulnerable to large reimbursement cuts.

Although the ACA leaves SGR intact for now, FFS reimbursement will undergo 2 significant modifications. The ACA authorizes the Secretary of Health and Human Services to adjust “misvalued” fee schedules for procedures and services that have experienced high growth rates or advances in technology. Anatomic pathology, upper endoscopy, colonoscopy, and endoscopic retrograde cholangiopancreatography are among the numerous procedures under review, and Medicare reimbursement for these services will probably decrease.

By 2017, Medicare will begin adjusting FFS reimbursement for physicians, hospitals, and ambulatory surgical centers (ASCs) with “value based purchasing modifiers” (VBPMs) that reward performance over volume. Gastroenterologists and other physicians providing high quality of care and improved outcomes relative to cost may receive bonuses, whereas those providing services judged to be of poor value will be penalized. Under the current proposed VBPM system, reimbursements are adjusted up or down for the top and bottom 5% of providers submitting quality metrics. The majority of providers who elect to submit data under the Physician Quality Reporting System (PQRS) will see little change in reimbursement based on the VBPM. Those who elect to forgo participation in both PQRS and Meaningful Use will see a 5% cut in Medicare reimbursement.

Gastroenterology services constituted 33% of all ASC claims in 2009, the largest category by volume, and endoscopic procedures were 3 of the 5 most common surgical procedures.6 During the next few years, Medicare will begin to make value-based adjustments to ASC reimbursement based on performance relative to national benchmarks.

Over the long-term, the ACA facilitates a vision first outlined a decade ago, gradually shifting reimbursement for all Medicare services from FFS to systems rewarding improved patient care, higher efficiency, innovation, and value. The ACA has established an Innovation Center at the Centers for Medicare and Medicaid Services (CMS) and provided $10 billion in funding for the next decade to develop and test more effective payment and care delivery systems.7 A major initiative of the Innovation Center is to develop bundled payment systems that would pay for entire episodes of care across multiple care teams and settings rather than for discrete services by individual providers. Proponents believe that this approach would create incentives for higher quality and more cost-effective care and improve care coordination. Because reimbursement would no longer increase for each additional procedure or hospitalization, gastroenterologists may be incentivized to coordinate care more closely with colleagues, use expensive tests and procedures more rationally, and develop innovative ways to improve care for patients with chronic digestive diseases. It remains to be determined how exactly to define each episode of care and how to divide reimbursement across primary care physicians, surgeons, pathologists, radiologists, and other providers who will also share responsibility for gastrointestinal patients. One might envision that a bundled payment for colonoscopy, including payment for professional services, facility costs, anesthesia, and pathology, as well as complications related directly to the procedure (e.g., perforation, bleeding, repeat study because of poor preparation), could become considered as part of a bundled payment initiative. Although bundling and other payment reforms clearly have great potential to change incentives and improve health care delivery, it is important to note that gastroenterologists will not be able to provide high-quality care if reimbursement levels are below the cost of providing care.

Expanding Quality Measurement and Evaluation of Clinical Effectiveness

To inform and help drive the payment reforms discussed above, the ACA expands national quality reporting systems and research on clinical effectiveness. The ACA has extended the PQRS under which gastroenterologists who voluntarily report select performance measures by using Medicare Part B claims, a qualified registry, or an electronic health record can receive a 0.5% bonus payment. Current PQRS measures include CRC screening (measure 113), surveillance rates after removal of adenoma (measure 185), as well as the treatment and management of inflammatory bowel disease (measures 269–275) and hepatitis C (measures 83–87, 89–90, and 183–184). For 2013, CMS has proposed a new measure for CRC screening intervals after a normal screening colonoscopy. Starting in 2015, gastroenterologists who do not participate in PQRS will experience a 1.5% cut in their Medicare reimbursement that will increase to 2% in 2016 and higher percentages beyond.

The ACA also aims to make patients more informed consumers of health care. A Physician Compare Web site is publicly available and can be used to search for physicians who participate in PQRS and the Electronic Prescribing Incentive Program. CMS will incorporate data on physician performance by 2013.

The ACA has established the Patient-Centered Outcomes Research Institute (PCORI), which has been charged with evaluating the relative effectiveness of different medical therapies to “give patients a better understanding of the prevention, treatment, and care options available, and the science that supports those options.”9 The Institute of Medicine has identified 100 high-priority areas for comparative effectiveness research including CRC screening methods, upper endoscopy surveillance strategies in gastroesophageal reflux disease, biological therapy for inflammatory bowel disease, and alternative management strategies for hepatitis C. Responding to concerns that this work may encourage health care rationing, the ACA prohibits PCORI from conducting cost-effectiveness analyses or using findings to deny care to patients.

As policymakers focus increasingly on aligning payment systems with quality and cost of care and defining health care value, these efforts will expand. The American Gastroenter-
ological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), and the American College of Gastroenterology (ACG) have identified a subset of the National Quality Forum's National Performance Measure Set applicable to gastroenterologists. The AGA developed the Digestive Health Outcomes Registry to collect performance measure data, and the ACG and ASGE partnered on the GI Quality Improvement Consortium to capture colonoscopy data. The AGA has recently announced the Digestive Health Recognition Program, developed in conjunction with Bridges to Excellence, and Practice Improvement Modules developed with the American Board of Internal Medicine. The AGA's suite of quality programs provides a coordinated pathway for gastroenterologists to address emerging requests from payers, purchasers, providers, and patients to demonstrate value and to meet and exceed requirements to maintain specialty certification.

Conclusions

We believe that there are 5 trends in health care reform that will influence how gastroenterology will be practiced in the coming decade: performance measurement, population management, aggregation, cost, and accountability. Each of these concepts is contained in some form within the ACA. They support a nationally agreed-upon agenda to enhance value by improving the health of both individual patients and patient populations while reducing costs. So how should gastroenterologists respond?

Gastroenterologists will be successful if they build practices with a culture of leadership, learning, and team-based care incorporating systems engineering tools and health information technology. This will provide the foundation for care coordination, performance measurement, and quality improvement needed to enhance, document, and report value of care delivered in what will become an increasingly value-sensitive health care marketplace. Practices should maintain a critical eye toward operations, how to be more efficient, and whether each step in the care process is truly adding value to the patient experience. Independent gastroenterologists will need to closely monitor their referral base as payers and hospitals acquire primary care practices and be prepared to adapt to the practice transformation these partners will inevitably undergo under health reform. Gastroenterologists should also remain open-minded to new partnerships and ventures with hospitals, ambulatory facilities, and medical groups, not only to diversify revenue sources but also to explore new opportunities for innovation and improving their practice. In meeting the challenges of health care reform, gastroenterologists will play an important role in helping to build a higher performing and more accessible American health care system and also help to set a new standard of care for millions of patients with digestive diseases.

References

8. PCORI. About us. Available at: http://www.pcori.org/about/.

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Conflicts of interest

The authors disclose no conflicts.