

**Walden University
Q & A continued from Webinar
Todd Linden**

General Note: The answers to these questions are my opinion. The mountain of rules and regulations that will be produced from this legislation will certainly impact the answers to these questions. For example, the first round of ACO regs our due out any week. Based on the information available today, I did my best to offer answers to these excellent questions.

5) Although you mention that payment systems are being reviewed for various collaborative medical scenarios, but what about prevention programs and interventions? Will there be some sort of way to extend payments for healthcare providers who practice strong prevention services? RE: "Optimal Healing Environments", how much will the FED allow for Medical professionals to charge for preventative and educational interaction and how much time per visit will be permit

5) There is a great deal of money in the ARA for prevention...literally billions of dollars. Most of it is in the form of grants, rather than as part of the reimbursement system for providers. However, imbedded in the concept of the accountable care organization is the idea of reducing the expected cost of care for a defined group of Medicare patients? Any savings from what would have been the historic cost for that group is shared with the provider. So if the providers utilizes disease registries and health coaches for example to institute more preventive care and that does indeed reduce the cost of care as all the current evidence suggests, then providers will be rewarded for this behavior.

There is also opportunity for a lot of experimentation on payment systems to reduce cost and improve quality of care utilizing the billions of dollars slated for the CMS Center for Innovation. I believe there will be many ideas tested using optimal healing environments, expansion of the medical home models, and preventive medicine techniques to reduce cost and improve health.

7) While the ACOs and bundling sounds as though it may lower costs, how do you get specialty care physicians to cooperate in a system that will force them to lower their current addictive and pleasant profit margin? Is it not more likely that specialty doctor will continue to support the lobby against such controls?

7) In theory, both ACOs and bundled payment require all the various providers to come together to better coordinate care and look for ways to improve quality and reduce cost. I believe it is very likely that the power shifts to the primary care providers as gate keepers to ensure the appropriate care gets delivered and the use of specialty care be closely controlled. I also think that when the ACOs get established, the numbers of specialists will be limited in the first

place. One simply does not need as many specialists when a defined patient population is established. In reality, there is not much to be very happy about in the ACA for physicians in general and specialty physicians specifically. Incomes will likely go down, unless physicians find ways to dramatically reduce overall costs by employing strategies that reduce overused testing and limit therapies or procedures that do not have evidenced based efficacy.

13) Today, in a system of fee for service and mostly uncoordinated care, the specialists make more money based on volume and often patients wanting "all" medicine has to offer driving care to specialists. That dynamic changes with these new models of payment.

Please note that we are expecting the first set of rules to come out about ACOs in the coming weeks and this should shed some light on exactly how they are going to work going forward.

How will reform impact public health outreach?

13) The reform legislation clearly starts to move us toward population health. In other words, instead of a system that largely cares for people after they are sick or injured, we are now responsible for keeping a group of defined patients (in an ACO) healthy. Some of the greatest improvements in improving health over the past century have not come from modern medicine, but rather in public health measures. Immunizations, safe drinking water, and preventive health are all examples of successful public health activities. I believe it will be public health initiatives that will have some of the biggest impact on both improving health and reducing cost.

Simply consider the epidemic of obesity in this country and the staggering cost it has on the current system. It will not be medical intervention that solves this problem, but rather public health initiatives such as more nutritious school lunches and eliminating junk food machines from schools all together.

24) In some places nurse patient ratio is already at a critical level. How do you think we will be able to keep pace with more people with access and the nursing shortage? And how do you see the quality issue that might be compromise with the worsening of the nurse patient ratio?

24) The ACA expands healthcare coverage dramatically and most people believe with this greatly expanded coverage will increase demand well beyond our current capabilities. So the question is a good one and there is growing concern about clinical workforce shortages not able to keep pace with the increased demand. Quality could suffer if these shortages grow.

31) US citizens and legal residents will incur tax penalty if they do not gain coverage. What about illegal residents. Who will bear the current burden of health care for these individuals?

31) Many people believe not addressing the illegal resident issue in the ACA was a shortcoming. Others believed adding this hotly contested issue to the already partisan healthcare reform debate may have threatened passage of the bill. And so to answer the question; we all will bear the costs for providing care to illegal residents as we do today.

32) It appears that hospitals will be at an additional risk with all these new limited insurance policies e.g. \$5000.00 cap offered by companies that never offered policies before. Wouldn't that be more detrimental to hospital systems?

32) We have recently seen hospital bad debt increase significantly as more and more employers have shifted increasing healthcare costs to employees in the form of higher co-pays and deductibles. There is no question that an increase in high deductible plans anticipated with the state sponsored health insurance exchanges will accelerate this trend. Of course there are other factors that will influence hospital finances...negatively with lower Medicare payment in the out years of the legislation and positively with more people with some coverage currently uninsured and receiving charity care.

35) How do you see the Healthcare Reform affecting the practice of public health and public health nursing specifically?

35) This is an expansion of question 13. As noted I see public health practice expanding under reform. Specifically, I believe public health nursing will also take on greater significance given the focus on population health. There will be no shortage of demand for nurses of all kinds for the seeable future!

37) Do you think that the set payment might discourage doctors from trying more expensive treatments, even when those treatments are truly needed? Or do you think we will see a decrease in cost in many treatments?

37) Although there may well be a financial incentive to reduce the number of expensive treatments under a fully developed "risk sharing" ACO where the goal is to provide care for a defined population at a capitated rate; the initial "shared cost savings" model described in the answer to question 7 is risk adjusted. So, in the early years there will be more reimbursement for people with illnesses and Medicare will continue to take the risk. In the future, when the risk is shifted to the providers, there will be more incentive to reduce the use of expensive procedures.

Today, Medicare has a set payment for inpatient care called diagnostic related groups (DRGs) and to deal with potential gaming the system the government monitors the care provide using a variety of tools and audits. Providers holding back care are penalized. I suspect a similar system will be incorporated in the future when ACOs are fully developed.

The pressure will be on the healthcare system to find ways to bring down the cost of treatments. I think we will likely see costs come down and providers may try to make up for these losses in revenue with the new volume anticipated with more people getting coverage.

One last note here, I do think that patients with money will opt for insurance coverage that more fully covers all treatments. We will likely see a growing "two-tiered" system with basic coverage for those in Medicare, Medicaid and other mandated coverage and another affluent group of patients paying more for the care they desire.

38) Will the implementation of Free Medical Clinics become an option as one of the Models of care for the uninsured and underinsured?

38) Theoretically, we will not need free medical clinics because most Americans will be covered through this legislation. Charity care as we know it and the use of free care clinics in today's system will not continue to exist.

42) With Readmission Penalties how can the hospitals be sure that the patient will go home and continue their recommended therapy/medication in order to not return with the same issue later? It seems like that policy is placing more responsibility on the healthcare provider and none on the patient. What is the patient responsibility in this situation?

42) This is indeed a very good question. Many people believe the ACA was very short on adding patient responsibility to the system. Currently, there are readmission standards. If a Medicare patient is readmitted for the same diagnosis within 30 days of discharge, the hospital is not paid for the second hospitalization. In most cases this is because the patient did not follow discharge instructions, often relating to taking medications as prescribed. Hospitals such as ours are now sending nurses into the homes of chronic disease patients following discharge to ensure patient compliance with physician orders. This is reducing readmissions and I believe the government will be accelerating this activity in the reform legislation to further expand this practice. However, it would be an enhancement for there to be more incentive for the patient to also have added incentive to follow physician orders. For that matter, I believe it would have been nice to have had more incentive for greater patient accountability for living healthier lifestyles in general.

44) How will the FED 'GUARANTEE' !!!!!!! protection of privacy against hacking patient data, loss of patient security and misuse of patient data by government and private enterprise when computerized medical files is required?

44) There is no way to "guarantee" privacy from hackers. Hopefully the good guys will stay ahead of the bad guys with security! It is important to also note, that the current paper-based system has plenty of opportunity for people to snoop and files can get lost in mountains of paper and to fire. In my opinion, the benefits to electronic health records far outweigh the concerns about hackers. Disease registries,

chronic disease management, faster research methods using EHRs are just a few of the benefits. EHRs also create the ability for the "personal health record" giving us all better access and accountability for our own health through better data management.

47) You mention that readmissions will not be paid for by the new program; however won't the hospital simply bill the individual. What is the point in having this penalty for the hospitals; it's more of a penalty against the individual patient. Could you explain this further?

47) The hospital currently cannot bill the patient for anything not covered by Medicare or Medicaid. By participating in these programs, hospitals agree to accept what the government pays. Going forward, this basic payment premise continues, except in a greatly expanded manner.

49) Won't the readmission provision give providers an incentive to put off patient care until they can receive payment? Example: A patient is released and develops a new illness; the healthcare provider could make an appointment for the 31st day instead of treating immediately and losing payment.

49) As noted in question 37, the government audits the care provided. If care is withheld when determined necessary, the provider is penalized. If the provider acts in an irresponsible manner, it is possible to be expelled from the Medicare/Medicaid programs and can also be both criminally and civilly punished in egregious situations.

I do however believe that it does not make sense to deny payment for a totally unrelated illness for a patient if admitted within 30 days of admission. It appears that for example, that if a patient is admitted for pneumonia and discharged and a week later falls and breaks a hip, the second admission is not reimbursed. That does not seem fair.