

Health Care Reform's Impact on Physician Practices

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INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) will bring a sweeping overhaul of the United States health care system when it is fully implemented [1]. When one considers the magnitude of the impact this legislation will have on physicians' practices in general and physiatrists' practices in particular, an overview is necessary to help physicians prepare for changes that may need to be made in their medical practices. This overview focuses only on the impact of Medicare and Medicaid payment changes, new statutes to combat fraud and abuse, and selected other pertinent provisions. This guide is not intended to be an all-inclusive one to this immense legislation.

PPACA will result in a significant increase in the number of Americans who will have health insurance coverage. Beginning on September 23, 2010, PPACA will prohibit health plans from placing lifetime limits and unreasonable annual limits, rescinding coverage, and denying coverage to children with preexisting conditions. For adults, preexisting condition exclusions will be prohibited starting in 2014. Also in 2014, PPACA will mandate most Americans to purchase health insurance coverage. Subsidies will be provided to some so that they can purchase coverage through state-based insurance exchanges. These exchanges are "supermarkets" for health insurance, where consumers may comparison shop for affordable coverage, with a standard set of benefits. In addition, large employers will be assessed a penalty if they do not provide affordable coverage to their employees. The Congressional Budget Office estimates that by 2019, PPACA will result in about 32 million additional Americans who have health coverage, resulting in 94% of Americans having health coverage (up from 83%) [2]. Such expansion of coverage will require a more robust health care workforce. The impact to the field of physical medicine and rehabilitation is yet to be determined.

To counterbalance the expanded coverage, PPACA will seek to contain costs. Most notably, there will be approximately \$455 billion in targeted funding reductions in Medicare and Medicaid during the next 10 years. Institutional providers and Medicare Advantage plans will be primarily affected by such cost reductions. Additional cost-containment measures include provisions for combating fraud and abuse and for quality improvement requirements. Some of these measures will directly and/or indirectly impact physicians. These impacts may differ on the basis of one's practice type (inpatient/outpatient), practice entity (solo, single/multi-specialty), and geographic location. Some components of the legislation are presented in this article with suggested questions for physicians' and practice managers' consideration.

MEDICARE PAYMENT CHANGES

Changes to Physician Quality Reporting Initiative (PQRI)

Under the PQRI, providers receive incentive payments for reporting data on quality measures. PPACA extends PQRI incentives with a 1% bonus in 2011 and a 0.5% bonus for each year between 2012 and 2014. An additional 0.5% bonus is available for providers reporting quality measures through a Maintenance of Certification Program (an assessment program provided by a specialty board recognized by the American Board of Medical Specialties) in 2011 to 2014. Beginning in 2015, a penalty will be assessed on providers who do not satisfactorily submit data on quality measures (a 1.5% penalty in 2015 and a 2% penalty for each year thereafter).

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Questions for Consideration. Will the Maintenance of Certification provision affect psychiatrists who are grandfathered with lifetime certification? Will the quality reporting cost your practice more than the penalty? Who is monitoring this for you? How will institution-based physicians be affected?

Value-Based Payment Modifier

The Secretary of Health and Human Services (HHS) has been tasked with developing a payment modifier that provides for differential payment to a physician or group of physicians on the basis of the quality of care furnished compared with cost. The Secretary will be phasing in this modifier during a 2-year period beginning in 2015. These quality measures are yet to be determined.

Questions for Consideration. Will there be quality of care measures pertinent to your practice? Will “function” be part of a quality measure?

Geographic Payment Adjustments

Under the Medicare physician fee schedule, geographic practice cost indices (GPCIs) are used to account for cost variations from locality to locality with regard to physician work, practice expense, and professional liability insurance. With regard to physician work, the law currently provides a “geographic floor” value of 1.0. Such a geographic floor has the effect of increasing the GPCI for any locality having a value less than the national average. This statutory provision was set to expire at the end of 2009 but has now been extended to the end of 2010. The law also changes how the GPCI for practice expense is calculated in 2010 and 2011. These changes will allow certain rural areas, and other localities, to be compensated at a higher rate. For 2012 and subsequent years, the GPCI adjustment for practice expense is to be determined by improved methodology developed by the HHS Secretary. For “frontier states,” (ie, Montana, North Dakota, South Dakota, Utah, and Wyoming), a practice expense “geographic floor” will be implemented in 2011.

Question for Consideration. Will this have an impact on your geographic practice location?

10% Primary Care Services Bonus

Primary care practitioners will receive a 10% bonus for some primary care services furnished from 2011 through 2015. Eligible primary care practitioners include physicians specializing in family medicine, internal medicine, or geriatric medicine, as well as nurse practitioners, clinical nurse specialists, and physician assistants in such practice areas. These primary care practitioners will be eligible if at least 60% of their allowed charges in a given prior period are for primary

care services, which include designated evaluation and management services, that is, Healthcare Common Procedure Coding System codes 99201-99215, 99304-99340, and 99341-99350.

Question for Consideration. In the future will psychiatrists be seen as primary care physicians for patients with specific conditions (eg, spinal cord injury, brain injury, low back pain, etc)?

10% General Surgery Services Bonus

General surgeons who practice in a health professional shortage area will receive a 10% bonus for major surgical procedures (ie, procedures for which a 10-day or 90-day global period is used for payment) furnished from 2011 through 2015.

Question for Consideration. Could the supply and demand for general psychiatrists in specific areas warrant a similar consideration in the future?

Absence of Sustainable Growth Rate Fix

Congress has so far failed to permanently fix the faulty sustainable growth rate methodology that currently is used in part to calculate Medicare physician payments. Until a permanent fix occurs, physicians will continue to face significant potential Medicare payments reductions.

Question for Consideration. Who monitors this continuous moving target for your practice?

MEDICAID PAYMENT CHANGES

In 2013 and 2014, the Medicaid payment rate must equal the Medicare payment rate for primary care services. Physicians specializing in family medicine, general internal medicine, or pediatric medicine are eligible for these increased payment rates for primary care services, which include evaluation and management services, immunization, and administration services. The federal government will provide 100% funding to states for these payments to eligible primary care physicians.

NEW STATUTES TO COMBAT FRAUD AND ABUSE

Return of Overpayments within 60 Days

Providers must now report and return any overpayment within 60 days after it is identified, or by the date a cost report is due, whichever is later. However, there is no guidance on when an overpayment is deemed “identified.” This statutory provision is effective immediately, and providers should develop procedures to flag overpayments. An identified over-

payment that is not returned in a timely manner is subject to penalties under the False Claims Act [3].

Question for Consideration. What is your practice's overpayment policy at present? Who tracks this?

Submission of Medicare Claims within 12 Months

The maximum period for submission of Medicare claims is now reduced from 3 calendar years to 1 calendar year.

Documentation of Referrals

Physicians and suppliers must now maintain and, upon request, provide access to documentation relating written orders or requests for payments for durable medical equipment (DME), certifications for home health services, or referrals for other items and services. Failure to maintain adequate documentation may result in disenrollment from Medicare for a period of 1 year. Moreover, the HHS Office of Inspector General now has authority to exclude providers who fail to maintain documentation from federal health care programs. This provision is particularly important to physiatrists because physiatrists frequently provide care to Medicare patients who need DME or other referral services, such as home care services.

Question for Consideration. Does your current practice follow this guideline? If not, will this add a new administrative or time burden on your practitioners?

Requirement for Face-to-Face Encounter

Before certifying eligibility for home health services or DME under Medicare, a physician must certify that the physician has had a face-to-face encounter with a patient. Alternatively, the physician may certify that such an encounter took place with a nurse practitioner or clinical nurse specialist, working in collaboration with the physician, or a certified nurse-midwife, or a physician assistant under the supervision of a physician.

Question for Consideration. Again, how might this change your present practice?

Disclosure of Alternative Imaging Providers

A referring physician who has a financial stake in an imaging facility must now inform patients in writing that they may obtain magnetic resonance imaging, computed tomography, or positron emission tomography services from a person other than the referring physician or his/her affiliates (ie, they must offer alternatives to the patient). The referring physician

must provide a list of suppliers who offer such services in the area in which the individual resides.

Question for Consideration. Will the number of practices with ownership and/or use of imaging see shifts? How will the "scope of services" and "your area" be defined?

OTHER PERTINENT PROVISIONS

Administrative Simplification

The Secretary of HHS will be adopting uniform standards and operating rules for the electronic transactions that occur between providers and health plans (eg, health claim status and enrollment or disenrollment in a plan). The goal of such national standards is to reduce the number and complexity of forms and data entry required by patients and providers.

Question for Consideration. Will there be a time of increased administrative cost as the result of "inefficiencies" during the transition phase with savings after full implementation? What might be the timing of this for your practice?

Alternatives to Medical Tort Litigation

To test alternatives to the current medical tort litigation system, states will be given grants to develop new models. These models would be required to emphasize patient safety, disclosure of health care errors, and early resolution of disputes.

Question for Consideration. Will interventional practices potentially see a greater cost-benefit to liability rates than non-interventional practices?

Prevention

The PPACA provides several provisions that improve access to preventive services. Under Medicare, preventive services will now be provided without coinsurance. Similarly, private health plans will now be required to cover preventive services without cost-sharing. In addition, incentives are provided to improve access to preventive services for beneficiaries enrolled in state Medicaid programs.

Question for Consideration. In the future what will be included in preventive services?

CONCLUSION

Because the PPACA has not completed its full implementation, its direct and indirect effects are not yet fully understood. Besides the provisions that directly affect physician practices, there are a number of provisions in the law that will likely have some indirect impacts.

For example, the law's requirement for insurers to cover preventive services could cause a dramatic increase in the

number of patients visiting their primary care doctors for check-ups.

Question for Consideration. Will these wellness visits result in the discovery of conditions previously undetected or untreated? Will these new conditions increase the demand for physiatrists' and/or other specialists' services?

Moreover, physiatrists in multi-specialty groups may see the groups' collections increase or decrease on the basis of the mix of general surgeons or primary care physicians of their group.

Question for Consideration. Will this affect your group's overhead distribution?

There are numerous provisions that could have far-reaching effects on physicians' practices and the rest of the health care industry. Therefore, vigilance in monitoring the PPACA implementation rollout and allowing for adequate preparation time to meet new regulations is essential for physicians and anyone else managing a practice during this transition

period. As an example of the need for such vigilance, HHS and other federal agencies have already released administrative rules regarding some of the provisions discussed in this article. Physicians and others will have an opportunity to provide comments and suggestions. However, awareness of these rules is essential in making informed comments on this legislation that will affect all medical practices.

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