



MEDICARE REPORT



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How Will the PPACA Impact Your Practice? A Physician's Guide to Health Care Reform



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1. Introduction

The Patient Protection and Affordable Care Act ("PPACA")¹ signed into law on March 23, 2010, promises to reshape the way that health care services are delivered and paid for in this country. The impact of the PPACA will be felt in every segment of the health care system. Some of these changes are effective immediately; others will be phased in over the next several years.

Physicians will be impacted both by the delivery system and payment reforms and the expansion of health

¹ H.R. 3590, Pub. L. No. 111-148.

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care coverage to millions more Americans. Some of the reforms described below build on changes that were already in the works; others are entirely new.

Some will present significant challenges to the way physicians practice today; others will create new opportunities. Discussed below are those provisions of the new law which all physicians should be aware of as they face the future.

2. Impact of Coverage Expansion

The PPACA extends health care insurance to an additional 32 million to 34 million Americans by 2014 of whom as many as 20 million may be Medicaid recipients. It also prohibits denying health care based on pre-existing conditions², and prohibits rescission of insurance when due to illness.³ It also mandates expanded coverage of preventive care, including a requirement that private insurers cover preventive services given an A or B rating by the United States Preventive Services Task Force with no cost-sharing.⁴ For physicians, this means more insured patients and a greater Medicaid load. It may also mean, at least initially, sicker patients—those who have deferred health care due to lack of insurance. Caring for this newly insured population will present challenges especially in areas where there are physician shortages.

3. Medicare Payment Changes

- **Primary Care Bonus:** Beginning Jan. 1, 2011, and continuing for five years, Medicare will pay a 10 percent bonus to certain "primary care practitioners" for the provision of "primary care services."

² PPACA section 1201(2)(A), adding new section 2704 to the Public Health Service Act (PHSA).

³ PPACA section 1001(5), adding new PHSA section 2712.

⁴ PPACA section 1001(5), adding new PHSA section 2713.

An eligible “primary care practitioner” is a physician, nurse practitioner, clinical nurse specialist, or physician assistant whose primary specialty designation is Family Medicine, Internal Medicine, Geriatrics, or Pediatrics and for whom 60 percent of Medicare-allowed charges are for “primary care services,” defined as evaluation and management services (excluding inpatient hospital visits). The bonus, which will be paid either monthly or quarterly, only applies to the designated E & M services—it does not include other services. The bonus is not subject to budget neutrality requirements.⁵

- **General Surgery Bonus:** The PPACA provides for a 10 percent bonus for general surgeons working in health professional shortage areas for 2011-2015.⁶
- **Temporary Increase for Psychotherapy Services:** For 2010 only, there is a 5 percent increase for psychiatric services.⁷
- **Therapy Cap Exceptions Extended:** The exceptions to the caps on outpatient physical and occupational therapy are extended through 2010.⁸
- **Geographic Payment Adjustments:** There are a number of changes designed to benefit rural areas whose payments have been depressed as a result of the geographic adjustments to the physician fee schedule. The “geographic floor” on physician work, which had expired in 2010, has been extended to 2011.⁹ In addition, the formula for calculating geographic adjustments on the practice expense portion of the fee schedule payments has been modified to increase payment to rural areas, and there is protection for certain frontier states.¹⁰ Since these changes are budget neutral, this means that the cost of the change will be spread across all services.
- **Imaging Services:** The PPACA changes the formula for calculating payment for advanced imaging services (MRI, CT, PET) by setting the assumed utilization rate at 75 percent beginning in 2011.¹¹ In 2010, CMS increased the utilization rate for these services to 90 percent from 50 percent with a four-year phase-in which impacted 2010 rates. The 75 percent rate mandated by the PPACA is not phased in and thus the entire impact will be felt in 2011. The proposed fee schedule rule to be released this summer will indicate the extent of the reductions. The Act also reduces the discount on imaging services on contiguous body parts on the same day from the current 25 percent to 50 percent.¹²

⁵ PPACA sections 5501(a)(1) and 10501(h), adding section 1833(x) to the Social Security Act (SSA).

⁶ PPACA section 5501(b)(1), adding SSA section 1833(y).

⁷ PPACA section 3107.

⁸ PPACA section 3103.

⁹ PPACA section 3102(a), amending SSA section 1848(e)(1)(E).

¹⁰ PPACA sections 3102(b)(2) and 10324(c), adding SSSA section 1848(e)(1)(H).

¹¹ PPACA section 3135(a)(1)(B) and section 1107(1)(B) of the Health Care and Education Reconciliation Act of 2010 (HCERA), adding SSA section 1848(b)(4)(C).

¹² PPACA section 3135(b)(1), adding SSA section 1848(b)(4)(D).

- **Physician Quality Reporting Initiative (PQRI) Incentives and Penalties:** The Act extends the bonuses for the reporting of quality measures through the PQRI through 2014 with a 1 percent bonus in 2011 and 0.5 percent in 2012-2014.¹³ Physicians can also earn an additional 0.5 percent bonus for participation in a maintenance of certification program.¹⁴ Beginning in 2015 the bonus converts to a penalty of 1 percent in 2015 and 2 percent thereafter for physicians who do not participate in PQRI.¹⁵

4. Preventive Health Services

- **Medicaid:** Beginning on Oct. 1, 2010, Medicaid will cover tobacco cessation services for pregnant women.¹⁶
- **Medicare:**
 - In 2011, cost sharing for preventive services will be eliminated.¹⁷
 - In 2011, new coverage for annual preventive visit including preventive services with an “A” or “B” rating from the United States Preventive Services Task Force.¹⁸

5. Increased Medicaid Payment for Primary Care In 2013 and 2014, Medicaid rates for “primary care services” (to include E & M services and immunizations) provided by family medicine, internists, and pediatricians shall be at equal to Medicare rates for the same services.¹⁹

6. Payment System Reform The PPACA is loaded with provisions that promote “pay for performance” as an alternative to the fee for service payment system. These include new programs, demonstration projects, pilots, grants, and a new Center for Medicare and Medicaid Innovation.

The common thread throughout most of these system reforms is reducing expenditures, increasing quality, care coordination, chronic care management, integration of care, preventive care among others.

- **Accountable Care Organizations/Shared Savings Programs:** The ACO/shared savings program is a new permanent voluntary program established within Medicare beginning 2012.²⁰ An ACO is an entity with a formal legal structure that can be formed by physicians, certain non-physician practitioners, physician group practices, hospitals or hospital/physician joint ventures. The entity must

¹³ PPACA section 3002(a), amending SSA section 1848(m)(1).

¹⁴ PPACA section 10327(a), adding SSA section 1848(m)(7).

¹⁵ PPACA section 3002(b), adding SSA paragraph 1848(a)(8).

¹⁶ PPACA section 4107(a), adding SSA section 1904(a)(4)(D) and section 1904(bb).

¹⁷ PPACA section 4104(b), amending SSA section 1833(a)(1).

¹⁸ PPACA section 4103(a)(1)(C), adding SSA section 1861(s)(2)(FF).

¹⁹ PPACA section 1202(a)(1)(A)(iii), adding SSA section 1902(a)(13)(C).

²⁰ PPACA section 3022, adding SSA section 1899.

enter into a 3-year agreement with the government to provide care to at least 5,000 Medicare beneficiaries. It does not include individuals enrolled in Medicare managed care plans. An ACO must meet quality performance standards to be set by the Secretary. The ACO may agree to accept partial capitation or it may bill be paid under the existing fee-for-service system. If the ACO is able to reduce expenditures (Part A and Part B) by a yet-to-be-determined threshold, it may share in the savings up to a specific percentage, again yet to be determined. The concept is that the ACO will implement measures to better manage and coordinate care such that quality is improved and costs are reduced. This model is similar to the provider-sponsored organizations from the 1990s that generally are viewed as having very limited success.

- **National Payment Bundling Pilot:** This is a pilot project to begin Jan. 1, 2013, that will pay a provider entity a singled bundled payment for an “episode of care” surrounding a hospitalizations.²¹ The episode begins three days prior to hospitalization and runs until 30 days after discharge. Bundled services include physician services, acute care hospital services, and post-acute care, including skilled nursing facility, home health agency, LTCHs, or independent rehabilitation facilities. Participation in the program is voluntary in that an entity must apply to participate. The goal of this pilot is to incentivize providers to cooperate and coordinate care amongst themselves with the goal of improving outcomes and reducing costs. If the pilot is successful, it may be expanded in 2016.
- **Independence at Home Demonstration:** This demonstration project to begin by January 2012 focuses on the sickest and most expensive Medicare beneficiaries—those with two or more chronic conditions and two or more functional dependencies.²² The independence at home provider is a team of physicians, nurse practitioners, social workers, and others that provide home-based primary care with 24/7 availability. The first 5 percent of savings goes back to Medicare with the remainder being split 80 percent/20 percent between Medicare and the provider. CMS intends to enroll up to 10,000 beneficiaries in this program.
- **Physician Value-Based Payment Modifier:** The PPACA calls on the Secretary to establish a payment modifier for differential payment based on *quality of care compared to cost*.²³ Quality of care is to be evaluated based on quality measures which must include risk-adjusted *outcomes* measures. The quality and cost measures are to be developed for implementation by 2015 in a subset of a physician with application to all physicians by 2017. The Act leaves it up to the Secretary to determine the amount of the payment modifier which is, however, to be implemented in a budget neutral manner. This means reducing reimbursement to some physicians in order to increase payment to others. Implementing this payment modifier in the manner directed will be a heavy lift for

CMS. While there are many approved physician quality measures, they all focus on process—not outcomes. Moreover, none of them evaluate quality compared to cost. Further, the law provides no guidance on how the quality/cost comparison is to be made.

- **Patient-Centered Medical Home:** The PPACA contains a number of initiatives based on the patient centered Medical Home (PCMH). They include a Medicaid option for states to provide services to Medicaid recipients with chronic conditions²⁴, grants to establish interdisciplinary health teams to provide comprehensive and coordinated care in community based PCMHs²⁵, and a directive to the new Center for Medicare and Medicaid Innovation to promote PCMHs.²⁶ CMS’s Innovation Center has already announced the launch of a PCMH demonstration that would involve a partnership among Medicare, Medicaid, private insurers, and states and will make awards to up to six states. Also in development are PCMH demonstrations focused on federally qualified health centers and on the Medicare population.

Observations: All of these new models require more coordination among providers and increased reporting of quality measures. In addition, in at least some models, the primary care provider as gatekeeper re-emerges. Specialty practices may need to seek affiliations with larger primary care groups or large health systems if they are to maintain their role in the health care market place. In addition, as reform emphasizes primary care, specialties may need to develop data demonstrating the cost-effectiveness of specialty care and emphasize the specialists’ role as primary care providers for patients with certain diseases or chronic conditions.

7. Program Integrity/Compliance/Fraud and Abuse

- **Medicare Claims:** Must be submitted within one year of the date of service—a much shorter time frame than previously applied—subject to exceptions to be defined by the Secretary through regulations.²⁷
- **60-day Repayment of Overpayments:** Any Medicare or Medicaid overpayments must be reported and repaid within 60 days of when they are identified.²⁸ Failure to do so can be a False Claims Act violation and a basis for civil monetary penalties.
- **Notice to Patients of Alternative Imaging Providers:** Physicians offering MRI, CT, or PET scans must inform patients of alternative providers in the geographic area where the patient resides.²⁹
- **Documentation of Referrals:** Physicians are required to maintain for seven years and provide, upon request, documentation relating to written orders they make for DMEPOS, home health, clinical laboratory tests, imaging, and other diagnostic tests.³⁰

²⁴ PPACA section 2703(a), adding SSA section 1945.

²⁵ PPACA section 3502.

²⁶ PPACA section 3021(a), adding SSA section 1115A.

²⁷ PPACA section 6404(a), amending SSA sections 1814(a), 1842(b)(3), and 1835(a).

²⁸ PPACA section 6402(a), adding SSA section 1128J.

²⁹ PPACA section 6003(a), amending SSA section 1877(b)(2).

³⁰ PPACA section 6406(b)(3), adding SSA section 1861(a)(1)(W).

²¹ PPACA section 3023, adding SSA section 1866D.

²² PPACA section 3023, adding SSA section 1866E.

²³ PPACA section 3007(2), adding SSA section 1848(p).

- *Medicare/PECOS Enrollment:* Ordering/referring physicians must be enrolled in Medicare and suppliers of ordered/referred services must include the ordering/referring physicians NPI on the claim form.³¹ In an interim final rule to take effect July 6, 2010, CMS is requiring that all physicians who order/refer for covered Part B services revalidate their enrollment through the online PECOS system by July 6, 2010. Previously, CMS had announced that providers would have until January 3, 2011 to complete the PECOS revalidation process.
- *Requirement for Face-to-Face encounter:* Physicians (or non-physician practitioners) ordering DEMPOS or certifying home health must have a face-to-face encounter with the patient within six months preceding the order.³² Telehealth services may be permitted.

8. Independent Payment Advisory Board

The PPACA creates a new 15-member advisory board to recommend Medicare cost cutting and quality or care proposals to Congress. In years where projected Medicare increases are “unsustainable,” Congress must ei-

³¹ PPACA section 6405, amending SSA sections 1834(a)(11)(B), 1814(a)(2), and 1835(a)(2).

³² PPACA section 6407, amending SSA sections 1814(a)(2)(C), 1835(a)(2)(A), and 1834(a)(11)(B).

ther accept the IPAB’s recommendations or pass an alternative.³³ The IPAB cannot make recommendations that alter benefits, eligibility, beneficiary cost-sharing, or that ration care. There is no administrative or judicial review of the IPAB recommendations. The first advisory report to Congress is due Jan. 15, 2014. Many in the medical/health care community have expressed concerns about IPAB’s lack of accountability. There is also concern that it may exacerbate the payment differential between Medicare and private payers and could jeopardize patient access to care.

9. Physician as Small Employer

Beginning in 2010, employers with fewer than 25 FTE employees and with average wages of less than \$50,000 will be eligible for tax credits of up to 35 percent of premium.³⁴ Physician and family member employee income is not included in the calculation of average wages. The employer must pay at least 50 percent of the premiums of workers. The tax credits increase to 50 percent in January 2014. The credit must be claimed on the business’s income tax return. The details on qualifying are being developed by the IRS and more information is available at <http://www.irs.gov>.

³³ PPACA section 3403(a)(1), adding SSA section 1899A.

³⁴ PPACA section 1421, adding section 45R to the Internal Revenue Code (IRC).