How Healthcare Reform Will Impact Your Physician Group

By Michel Marcoux

Following a year of sustained negotiations and wrangling, President Obama signed the Patient Protection and Affordable Care Act (PPACA) and modifying legislation, the Health Care and Education Reconciliation Act (jointly, with PPACA, the Act), in March 2010.

The Act sets the stage for dramatic Medicare and Medicaid payment revisions, for the establishment and development of new health care delivery models, for new disclosure, reporting and repayment requirements, and for the significant expansion, auditing and enforcement of fraud and abuse laws during the next decade. This article identifies and addresses selected payment and program integrity provisions affecting providers – specifically physicians and physician groups – participating in the Medicare and Medicaid programs.

Primary Care Physicians

The Act provides a 10% Medicare incentive bonus during 2011-2016 for primary care physicians in family practice, internal medicine, and geriatrics for office, nursing facility, and home visit services, if such services comprise at least 60% of a physician's Medicare charges. A 10% incentive bonus is also available during 2011-2016 for general practice surgeons who perform major procedures in a health professional shortage area.

Medicaid payment rates to family medicine physicians, general internists, and pediatricians for evaluation and management services and immunizations will be required to be not less than 100% of Medicare payment rates for the same services during 2013 and 2014.

Independent Payment Advisory Board

The Act establishes a new 15-member Independent Payment Advisory Board (IPAB). The IPAB will be required to develop proposals to reduce per-capita Medicare spending if spending increases exceed inflation-related thresholds. The first determination will be made in April 2013 and the first spending reduction proposals (if required) will be due in January 2014.

IPAB proposals to reduce payments to Medicare providers and suppliers must be implemented by the Secretary of Health and Human Services (HHS) unless Congress passes an alternative set of payment reductions that meet the savings targets set forth in the IPAB's proposals. The IPAB proposals may not ration care, raise Part B premiums, or change benefits, eligibility, or cost sharing. Hospitals and hospices will be exempt from IPAB spending reduction through 2019.

Medicare Physician Reimbursement

Incentive payments will be extended for voluntary physician participation in the Physician Quality Reporting Initiative (PQRI – 1.0% in 2011 and 0.5% in 2012-2014). Beginning in 2011, an additional 0.5% incentive payment will be available to physicians who submit data through a qualified Maintenance of Certification Program operated by a specialty body of the American Board of Medical Specialists. In 2015, physician payments will be reduced by 1.5% for failure to participate in PQRI. This penalty will increase to 2.0% in 2016 and subsequent years.

The HHS Secretary is also directed to implement a budget-neutral payment methodology for adjusting physician payments based on the quality and cost of care they deliver. The new system will be phased in over two years, starting in 2015.

Payment for Imaging Services

The 2010 Medicare Physician Fee Schedule proposed to decrease reimbursement for advanced diagnostic imaging services by increasing the assumed utilization rates for the equipment. The Act requires that these assumptions be set at 65% in 2010 and at 75% in 2011 and subsequent years.

Stark Law – In Office Ancillary Services

The in-office ancillary services exception under the Stark Law has been changed to require a referring physician to inform patients in writing, at the time of a referral, that the patients may obtain specified imaging services (MRI, CT, and PET), or other designated health services

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Medevac Crews Save Lives in Afghanistan, *continued from page 17*

collisions when they fly in black-out conditions.

"Sometimes, you can be doing everything right, and you still can't prevent a near accident," he said. "It's an eye opener. There's a lot of chance involved, and you do everything you can to prevent your portion of it."

He thinks about some of the injuries he's witnessed—patients who are victims of IEDs or gunfire and realizes he's compartmentalized part of his brain to cope with being in a war zone.

"I think you desensitize yourself," Duncan said. "If I were back in Alabama and came on a wreck scene and saw someone mangled as bad as we see here, it would bother me more. You separate yourself somehow."

While Duncan copes with whatever situation he comes upon, for some pilots and medics, varying circumstances evoke different responses.

"In getting ready for this mission, we had an honest conversation with the medics and crew chiefs," Wilson said. "Different people react differently to different things. We asked, 'What's your thing?' Is it kids? Is it burns? As best we can, we know each other well, and if someone has an issue, we try to pick a different crew to fly that mission."

According to Wilson, the challenges his team faces are different than the conditions he flew in evacing injured troops in Iraq. The fast Blackhawk helicopters, which had been able to accommodate two sets of three patient litters stacked in the cargo area, now can only carry two stretchers. The machines have two engines and ample power, but have been modified for the high-altitudes, and the pilots, who had learned to fly at heights barely above sea level, now have to learn how differently their machines handle in the thin air.

"Flying at these altitudes is different," Wilson said. "There's a steep learning curve. This is challenging and beautiful terrain."

At 40, Wilson wonders, at times, how long he'll continue to deploy. "I'm almost 40 years old and some days, I can't believe I'm still wearing my name on my shirt," he said. "Then, it's dawn, and I'm flying through the mountains, and I think, 'I can't believe they're paying me to do this job."

While some pilots have the luxury of choosing not to fly in adverse conditions, the medevac teams fly regardless.

"We have to do it," Wilson said. "That's the difference. If you're dropping off supplies or troops, the leader considers the risks of the mission and might wait for the sun to come up or wait for the storm to break. We can't postpone a mission. I have to decide if it's worth risking my guys' lives to save one guy, or do we let him die instead of risking eight lives? That's what's in my head—the payoff versus the risk. And we go. We don't do crazy stuff, but we do give it a damn good try. It's important for those guys out there to know when they go outside the wire, we're going to be there for them."

"We fly in heavy dust or light snow. It whites out when you get close to the ground, and you have to know what's under the snow, because you're in a 20,000-pound helicopter, and it's going to sink through that—on rocks or on tree stumps.

Captain Jeff Morgan, a physician's assistant, flies with the medevac missions at times and works with the Third battalion's combat unit, as well. He handles a constantly changing schedule and works in the close confines of the back of a Blackhawk, providing medical care.

"When we get an urgent call, we're out of here quick," he said. "We may have just the basic information, and we have to get somebody on a litter and figure it out. Then you may have a 30-minute ride back here to BAF. You give them the best care possible to keep them alive."

He says it's the whole team who should take credit when a patient survives. The medics are working in the back with small blue lights to keep them invisible from the ground. They're often crouched down, working over patients as the pilots try to maximize the Blackhawk's power to get the patient to the hospital as quickly as possible.

"There are so many people behind the scenes," he said. "Everybody here takes pride in doing their job.

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as designated by the HHS Secretary, from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual directly supervised by the physician or by another physician in the group practice.

The provision requires the referring physician to provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides. Although the law specifies that this provision is effective for any service provided after January 1, 2010, physicians obviously could not have complied with the provision until the law was passed and signed by the President.

Fraud and Abuse

Finally, the Act will increase funding for the detection and prosecution of fraud, waste, and abuse in the Medicare and Medicaid programs. Beginning in 2011, the Act appropriates $250 million for increased government fraud and abuse enforcement efforts over a six-year period. It also directs the HHS Secretary to impose enhanced screening and oversight measures of Medicare enrollment and to require all Medicare providers to implement compliance programs that incorporate core elements to be developed by HHS. Adoption of compliance programs was previously optional.

Michel Marcoux is an associate in Balch & Bingham, LLP's Health Care Law Practice Group.

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of that program, created by the Balanced Budget Act of 1997. Their cost-based reimbursements from Medicare improve their financial performance and reduce hospital closures. Marker said his local 24-bed, critical-access hospital is a recruiting tool, and that communities working to recruit physicians should nurture the partnership that physicians and the hospital enjoy. "That's a nice thing to have in my backyard," he said.

Said Longenecker, "Right now, rural hospitals are quite strapped financially, and the economy has just made things worse. Just in Ohio, several hospitals have declared bankruptcy, and many rural hospitals have closed in the last decade. If it weren't for the critical-access hospital program, a lot more would have gone under."

The Pay Debate

Does it really all come down to salary – that specialists in urban areas make more than family practitioners in a rural setting? Sure it does, but both Marker and Longenecker have something to say about that.

Marker said the idea is to bring potential rural physicians into the fold and focus on the positive. "One of our hurdles in family medicine is that we tend to be treated badly by our specialty colleagues. If you're treated badly all the time, you tend to grumble. I don't want to show that to students," he said.

So why don't generalists make more? "Our country does not value that anymore. That's my in-a-nutshell answer," Marker said. "We started valuing doing things to people higher than listening to and touching people and working them through the problems of their life. It's just not sexy enough. … Our country has had this happen to it."

Here's Longeneckers's take on the issue: "I personally think that family physicians are paid enough, maybe not quite as much as some people think we should be paid, but certainly much more than any of our neighbors in our rural communities. I'm well paid. … My take on it is that the specialists are making too much. Our culture is such that we say we value one thing, but we pay for something else."