

The Affordable Care Act and Physician Economics

What US practices should know about quality reporting, reimbursement changes, and more.

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At this time last year, there was still some question about the Affordable Care Act (ACA) and its implementation. The legality of the act was challenged by several states but was ultimately upheld by the Supreme Court. There was a threatened attempt to repeal the act, but the November 2012 elections did not change the political leadership and repeal, although still discussed, is unlikely to occur. This means that we, as physicians, need to understand the act and its implications for our practice of medicine.

This article provides an overview of the affected areas of medical practice and a basic time line for the changes. Most of the changes from the ACA will become effective in 2014, but there are several changes that have already occurred or are currently being implemented. In addition to the ACA, I review several other factors determining how physician services will be paid this year.

INCREASED TAXES

To increase revenue to pay for the benefits of the ACA, some tax increases went into effect in 2013. The Medicare payroll tax was increased 0.9% for individuals with an annual income > \$200,000 and for families with an annual income > \$250,000. In addition, the investment income tax was increased by 3.8%.

PHYSICIAN QUALITY REPORTING SYSTEM

The Physician Quality Reporting System (PQRS), previously the Physician Quality Reporting Initiative, is a program that allows providers to report specific quality measures related to patient care. This will be key in 2013, as practitioners will need to focus on this provision of the ACA starting immediately. Up to this point,

Year	Change
2011	Additional 1%
2012	Additional 0.5%
2013	Additional 0.5%
2014	Additional 0.5%
2015	Decrease of 1.5%
2016	Decrease of 2%

quality reporting measures were rewarded with incentive payments (an additional 1% in 2011 and an additional 0.5% in 2012–2014). Beginning in 2015, however, eligible professionals who do not report appropriate quality data measures will be penalized. The penalty in 2015 will be a payment decrease of 1.5% for Medicare services; in 2016, there will be a decrease of 2% (Table 1). The penalties in 2015 will be based on quality measures reported during 2013. Therefore, to avoid decreased payments in 2015, practitioners need to act immediately to be sure that they are enrolled in the PQRS and are collecting and reporting the appropriate measures for their practice.

The quality measures that are eligible for reporting may change from year to year, and providers are required to know about these changes. A provider does not need to sign up for the program, and there are several ways to report these measures. Also, providers are not required to report on every measure that might apply to their practice, but the reporting must be consistent with the requirements of the program.

The following are examples of quality measures that

could apply to an endovascular physician's practice: prevention of catheter-related bloodstream infections, electronic prescribing, use of electronic health records, documentation of current medications in the medical record, pain assessment and follow-up, exposure times reported for fluoroscopic procedures, documentation of specific methods for reporting carotid stenosis in imaging reports, use of aspirin or other antithrombotic medications in patients with ischemic vascular disease, screening and cessation intervention for tobacco use, chronic wound care measures, surveillance after endovascular abdominal aortic aneurysm repair, lipid control in patients with ischemic vascular disease, appropriate follow-up of biopsy results by the performing physician, and screening for hypertension with documented follow-up. There are certainly other measures that could apply, but these examples provide a sampling of possibilities.

As part of the "fiscal cliff" deal passed this year, Congress added provider participation in approved clinical data registries as another means of satisfying reporting requirements for PQRS. This alternative method of reporting quality measures is also a step toward developing a quality-monitoring system that will allow outcomes data to be collected, which are greatly needed for evidence-based medical practice and coverage determinations.

MISVALUED CODE PROVISION

All current Procedural Terminology (CPT) codes are being evaluated for potential "misvaluation." Almost every endovascular and interventional radiology/cardiology CPT code has been identified as being potentially misvalued, and during the past several years, these codes have gone through a process that has led to changing, bundling, and revaluation of this set of codes. This has almost uniformly led to reduced valuations for endovascular and other interventional services.

The process of revaluation of CPT codes has resulted in the redistribution of \$2.5 billion within the Medicare Physician Payment Schedule between 2009 and 2013.

MULTIPLE PROCEDURE PAYMENT REDUCTION

Multiple Procedure Payment Reduction (MPPR) is another means that CMS is using to try to correct for misvalued codes. CMS believes that there are efficiencies when multiple services are provided to the same patient on the same day. These reductions are used to help account for those efficiencies and limit the amount of overpayment for duplication of portions of the services (ie, overlap in pre- and postprocedure work when two services are provided, such as decreased time in preparing a patient for imaging of contiguous body parts rather

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than completing one study and having to start a new study on a different patient). In 2013, the MPPR has been expanded to include the technical component (TC) but not the professional component (PC) of diagnostic cardiovascular imaging. These changes result in a 25% decrease in the technical fee paid for each additional test performed on one patient in a single day. The highest-level service (based on payments listed in the Medicare Fee Schedule) will be paid at 100% of the listed fee, and additional tests will each be paid at 75% of the listed fee. The list of new procedures affected in 2013 includes most angiography, venography, vascular ultrasound/Doppler, and numerous cardiac imaging procedures.

When the MPPR was first implemented, it only applied to the TC portion and affected computed tomography, magnetic resonance (MR) imaging, and ultrasound imaging in certain coding families in which imaging was performed on contiguous body parts on the same session, same day, and same patient by the same physician. The TC reduction affects the technical payment for free-standing facilities by reducing the payment for additional services provided for the same patient on the same day. This results in a 25% to 50% decrease in payment for additional studies for the same patient in contiguous body parts. For instance, if a patient undergoes an MRI of the abdomen and an MRI of the pelvis, the MRI of the abdomen is paid at 100% of the technical fee, but the MRI of the pelvis is paid at a reduced technical fee.

The MPPR has subsequently been expanded several times and now includes the professional fee for certain procedures (the MPPR for the professional component was first implemented in 2011). It has also been expanded to include multiple services in both the same family of codes and across different families of codes. The PC of MPPR is newer and affects all professional interpretations of targeted studies by computed tomography, MR, and ultrasound involving contiguous body parts performed on the same day. This reduction was intended to extend to multiple physicians in the same practice beginning in 2012, but this aspect was

PERSPECTIVE:

Physician/Coding Expert

not implemented until January 1, 2013. At this time, a 25% PC MPPR will apply when one or more physicians with the same National Provider Identity (ie, in the same practice) interpret multiple procedures for the same patient in the same session on the same day.

EQUIPMENT UTILIZATION RATE

The equipment utilization rate (EUR) affects payment for the technical aspects of imaging procedures provided in a free-standing facility. This rate is part of the Practice Expense calculation. Beginning in 2011, the EUR was increased from 50% to 75% for expensive diagnostic imaging equipment (including CT, MRI, and MRA). In 2013, the EUR has been raised to 90% for some services, and further increases are under consideration. A higher EUR assumes that more procedures are performed on that unit of equipment during a workday, essentially amortizing costs over a larger number of procedures and decreasing the payment for each individual procedure/study.

INDEPENDENT PAYMENT ADVISORY BOARD

The Independent Payment Advisory Board was established in the ACA and aims to maintain Medicare spending below a specific cap by restricting payments to physicians and hospitals. This board will have the ability to decrease physician payments. It currently is defined as a 15-member panel of unelected federal employees appointed by the President and confirmed by the Senate. The minority of the board will be represented by health care providers, and the board is not required to be bipartisan. It will act when spending outpaces gross domestic product per capita plus 1%, a methodology similar to the Medicare Sustainable Growth Rate (SGR) that has been shown to be flawed. By January 15 of each year, beginning in 2014, the Independent Payment Advisory Board must propose a plan to Congress and the President for achieving Medicare savings targets in the following year.

OTHER FACTORS AFFECTING PHYSICIAN PAY

Focus on Primary Care

The ACA remains focused on reducing health care costs by enhancing preventive care. To do this, money will continue to be shifted to primary care medicine from specialty medicine—including endovascular medicine. This shift in focus is likely to affect specialist training (by not funding increased training spots for specialists), as well as physician payments.

The Fiscal Cliff and SGR

The Balanced Budget Act of 2011 appointed a “Super Committee” to determine budget cuts to reduce the

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nation’s debt and budget deficit. However, the committee was unable to come to any agreement, so the act defaulted to sequestration of \$2.1 trillion that would automatically begin budget cuts in 2013, extending over 10 years. These automatic budget cuts include \$400 billion in health care costs (\$123 billion for Medicare provider payments). A direct result of the sequestration was a 2% across-the-board cut for Medicare physician payment beginning January 1, 2013, but this cut was delayed for 2 months (until March 1) by congressional action taken at the last minute on New Year’s Eve.

As part of the fiscal cliff deal, a “doc fix” delayed a scheduled hefty 26.5% cut in all physician pay slated for January 1, 2013, until January 1, 2014, at a cost of \$30 billion. As of January 2013, the Medicare conversion factor was scheduled to dramatically decrease to \$25.0008 (from \$34.037 in 2012.) Congress averted this large change at the last moment as part of the fiscal cliff deal, and the conversion factor was set at \$34.023 for 2013. The conversion factor is the multiplier set by CMS each year that converts work RVUs into dollar amounts for payment. The conversion factor is legislatively based on SGR and is aimed at maintaining a stable overall Medicare spending level, but the methodology was found to be flawed. Congress has been unable to fix this flaw and for several years has avoided large physician pay cuts by decreasing payments for other parts of the Medicare budget. In 2013, that money was shifted mostly from hospital and imaging payments.

As Congress continues to look for ways to decrease spending, every government program is considered fair game. Additional cuts to health care spending are certain, including cuts that affect research funding. Patient benefits will likely remain safe (although some changes to these could happen, such as raising the minimum age for Medicare and increasing the copays and/or premiums for wealthy beneficiaries.) Additional provider cuts are almost certain to occur.

International Coding of Disease, Revision 10

The date for International Coding of Disease, Revision 10 (ICD-10) implementation has been moved from 2013 to October 1, 2014. Despite concerns about problems inherent to implementation of this coding system, it is unlikely that there will be further delays. These codes

MORE DETAILED INFORMATION

PQRS programhttp://bit.ly/PQRS_CMS**2013 procedures affected by the MPPR**<http://bit.ly/MPPR2013>**ICD-10 (CMS)**<http://bit.ly/ICD10CMS>**ICD-10 (AMA)**<http://bit.ly/ICD10AMA>

are used to report diagnoses and inpatient procedures. Practices need to plan how ICD-10 will be implemented, because the change will be mandatory, and the ICD-10 system is significantly different than the current ICD-9 reporting system. The ICD-10 system is much more detailed, and coders will need education to be able to accurately report. There will be some crosswalk suggestions to help convert to the new system from the old, but coders will not be able to fully rely on the crosswalks. In addition, the number of potential characters in the

codes themselves has increased; the codes will now be alphanumeric (rather than numeric only), and the number of available ICD-10 codes has increased, requiring software/system upgrades to be compliant.

CONCLUSION

The provisions of the ACA will continue to be gradually implemented and intend to improve the quality of health in the US while decreasing the money spent on health care. Some aspects of the ACA will cause further decreases in payments for endovascular and interventional services in 2013, adding to the decreases seen over the last several years. With knowledge of the mandated changes, physicians will be able to recognize opportunities for improvements in their practices and maximize the quality of care provided to patients while simultaneously limiting the loss of revenue. ■

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