



## How the passage of federal health system reform legislation impacts your practice

On March 23, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) into law. A number of key provisions in the new law may have an immediate impact on your practice and your patients, while others have a much longer time frame before they will take effect.

### Medicare payment changes

Although Congress will address the flawed sustainable growth rate formula in separate legislation later this year, H.R. 3590 includes a number of payment improvements for physicians that, combined, will result in immediate and significant Medicare payment increases for many physicians.

- **10 percent incentive payments for primary care physicians.** All physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges will be eligible for a 10 percent bonus payment for these services from 2011–16.
- **10 percent incentive payments for general surgeons performing major surgery in health professional shortage areas.** All general surgeons who perform major procedures (with a 10- or 90-day global service period) in a health professional shortage area will be eligible for a 10 percent bonus payment for these services from 2011–16.
- **5 percent incentive payment for mental health services.** For 2010, Medicare will increase payment for psychotherapy services by 5 percent.
- **Geographic payment differentials.** The national average “floor” on Medicare’s geographic payment adjustment (commonly known as the GPCI) for physician work expired at the end of 2009. The law re-establishes that floor in 2010. In 2010 and 2011, Medicare will also reduce the GPCI adjustment for physician practice expenses in rural and low-cost areas. And, beginning in 2011, the practice expense GPCI adjustment will be brought up to the national average for “frontier” states (Montana, North Dakota, South Dakota, Utah and Wyoming). Physicians in 56 localities in 42 states, Puerto Rico and the Virgin Islands will benefit from these geographic payment adjustments.
- **Medicare quality reporting incentive payments extended.** Incentive payments of 1 percent in 2011 and 0.5 percent from 2012–2014 will continue for voluntary participation in Medicare’s Physician Quality Reporting Initiative (PQRI). An additional 0.5 percent incentive payment will be made to physicians who participate in a qualified Maintenance of Certification Program (quality practice-based learning programs through specialty boards). Following the practice now in place for hospitals, beginning in 2015 physician payments will be reduced if they do not successfully participate in the PQRI program. In 2015, the penalty will be 1.5 percent; in subsequent years it will be 2.0 percent.

### **Medicaid payment changes**

Separate legislation, the Health Care Education Affordability Reconciliation Act (H.R. 4872), still pending at press time, would raise Medicaid payments to family medicine physicians, general internists and pediatricians for evaluation and management services and immunizations to at least Medicare rates in 2013 and 2014. The legislation also provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

### **Administrative simplification**

Beginning in 2010, national rules will be developed and implemented between 2013 and 2016 to standardize and streamline health insurance claims processing requirements. Physicians should benefit from the changes because it will be easier to track claims and, in many cases, should improve physician revenue cycles and lower overhead costs.

### **Employer requirement to offer coverage**

Employers with more than 50 employees with at least one full-time employee who receives a premium tax credit are required to offer health insurance coverage to their employees or be assessed a range in fees, effective in 2014. Employers with 50 employees or less, who represent the vast majority of physician practices are exempt from this requirement. A range of small business tax credits for employers contributing at least 50 percent of the costs of coverage for their employees will also be established, with credits phasing out as firm size and average employee wages increase.

### **Medical liability protection and grants**

The Secretary of Health and Human Services (HHS) is authorized to award five-year demonstration grants to states to develop, implement and evaluate alternative medical liability reform initiatives, such as health courts and early offer programs, beginning in 2011. Medical liability protections under the Federal Tort Claims Act will be extended to officers, governing board members, employees and contractors of free clinics.

### **Preventive and screening benefit expansions**

Beginning in 2010, Medicaid will be required to cover tobacco cessation services for pregnant women. In 2011, cost-sharing for proven preventive services will be eliminated in Medicare and Medicaid. Medicare payments for certain preventive services will be increased to 100 percent of payment schedule rates (that is, co-payments will be eliminated), and incentives will be available to encourage Medicare and Medicaid beneficiaries to complete behavior modification programs.

In the private sector, beginning in 2010, health plans will be required to provide a minimum level of coverage without cost-sharing for preventive services such as immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women.

### **Medicare prescription drug coverage**

Medicare patients whose prescription expenses reach the so-called Medicare Part D coverage “doughnut hole” (\$2,700 to \$6,150) in 2010 will receive a \$250 rebate. During the next 10 years, the beneficiary co-insurance rate for this coverage gap will be narrowed in phases from the current 100 percent to 25 percent in 2020.