TMA'S HealthREFORMSchool

Survive and Thrive in the New Health Care Landscape

Imporant news for physicians in a large practice

14 Things Physicians Practicing in a Large Practice Need to Know

Although the Affordable Care Act (ACA) to reform the nation's health care system was enacted in March 2010, the legal and political wrangling will go on for years. Texas physicians cannot allow the new law to get in the way of what medicine is all about — caring for patients.

ACA is immense in size and scope, and many provisions are not yet fully understood. That is why the Texas Medical Association is continuing its massive education campaign to help Texas physicians and their practices survive and thrive in this environment. Here are 14 things about the new health law that every physician practicing in a large practice needs to know.

1. More Patients Covered

An estimated 4.5 million Texans will gain health coverage through the new law, which may impact your practice. Some coverage increases began in 2010, while others don't occur until 2014. Here are the ways coverage will expand in Texas:

High-risk pool. In July 2010, a national high-risk pool began providing coverage for previously uninsured individuals with preexisting conditions. These federal high-risk pools will be phased out in 2014 as health care exchanges become available.

Consumer protections/Insurance reform. Consumer protections went into effect September 2010 for newly written policies and upon renewal of existing policies in the individual and group markets. Some of the provisions below apply to all health insurance products, including self-funded or ERISA plans, while others do not:

- Allow parents to keep their children up to age 26 on individual or group family policies;
- Eliminate lifetime dollar spending limits;
- Prohibit use of rescission for patients who get sick (except in cases of fraud);
- Restrict waiting periods to 90 days or less; and
- Prohibit exclusions based on preexisting conditions for children enrolled in group plans (for adults, the provision becomes effective in 2014 for group health plans).

Preventive health care services. Physicians may want to prepare for more patients who now have new insurance coverage for preventive services. The law requires new individual and group health plans or nongrandfathered renewed health plans to cover in-network preventive health services without any copayment or deductible, including immunizations, preventive care for women and children, and other preventive services rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF). This provision went into effect September 2010.

In January, the Centers for Medicare & Medicaid Services (CMS) removed cost sharing for some preventive services and provides for an annual personalized preventive care plan for Medicare patients.

Health care exchanges. Beginning in 2014, more than 3 million Texans will qualify for health care coverage under the new health care exchange. ACA creates state-based health insurance exchanges for individuals and some small businesses. Patients with incomes up to 400 percent of poverty, or $88,000 for a family of four by 2009 standards, will be eligible to receive federal tax subsidies to purchase certain qualified coverage in the exchange.

Medicaid expansion. The new law expands Medicaid in 2014. Children and adults, including childless adults, under the age of 65 and earning up to 133 percent of poverty will be eligible for Medicaid. The income limits will be about $14,404 for an individual and $29,326 for a family of four.

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Texas Medical Association
Physicians Caring for Texans

Important Effective Dates

March 2010	Increased scrutiny of medical profession
July 2010	High-risk pool
Sept. 2010	Consumer protections
	Insurance reforms
	Preventive services
	Government development of self-referral disclosure protocols
Dec. 2010	RAC contracts
	New physician-owned hospitals cannot participate in Medicare
Jan. 2011	Business tax reporting
	Physician Compare website
Jan. 2011-15	Increased Medicare payments for primary care physicians
June 30, 2011	Action needed to avoid e-prescribing penalties in 2012
Jan. 2012	E-prescribing penalties
Jan. 2013	Physician performance measures on website and employer penalties
Jan. 2013-14	Increased Medicaid payments for primary care services
March 2013	Required education of employees on coverage options
	Manufacturers' disclosure requirements
Jan. 2014	Health insurance exchange
	Medicaid expansion
	Individual mandates to purchase insurance
	Employer penalties relating to health coverage
Jan. 2015	PQRS penalties
Dec. 2015	IPAB

As a result, around 1.5 million more Texans will become newly eligible for health care coverage. As under current law, undocumented immigrants will not be covered by Medicaid except in an emergency.

2. Increased Medicaid Payments for Primary Care

In 2013 and 2014, Medicaid payments for primary care services will increase to Medicare parity for primary care services provided by family physicians, general internists, and pediatricians. Primary care services are defined as evaluation and management services and vaccine administration. The federal government will pay states the full costs of paying the higher fees.

3. Increased Medicare Payments for Primary Care

Primary care physicians (those specializing in family medicine, internal medicine, and pediatrics) who treat Medicare patients may receive a 10-percent bonus payment. To qualify, physicians' Medicare charges for office, home health, and nursing facility visits must make up at least 60 percent of their overall Medicare charges. This bonus is in addition to existing bonuses for physicians practicing in shortage areas. The bonus begins in 2011 and lasts through 2015.

4. Penalty for Not Participating in Medicare PQRS

The Physician Quality Reporting System (PQRS), a voluntary Medicare reporting initiative, will continue. Currently, physicians participating in PQRS receive a 2-percent bonus for reporting their quality measures. Beginning in 2015, physicians will be penalized 1.5 percent if they don't participate. The penalty increases to 2 percent in 2016.

5. E-Prescribing Bonuses/Penalties

E-prescribing Medicare bonuses will continue through 2012 (1-percent, Medicare Part B) but be reduced in 2013. However, eligible physicians who do not report successful e-prescribing on their claims and have not received an exemption will be penalized 1 percent. **To avoid the 1-percent penalty in 2012, by June 30 THIS YEAR, physicians must e-prescribe successfully and report via claims using the G-code 8553 on at least 10 Medicare encounters.** Physicians who report 25 claims using the G-code by Dec. 31 this year will be eligible for the 1-percent 2012 incentive and avoid the 1.5-percent penalty in 2013.

6. Independent Payment Advisory Board

The law creates a 15-member Independent Payment Advisory Board (IPAB) that has the authority to control Medicare spending. It is responsible for reducing the per-capita rated growth in Medicare spending. Recommendations must reduce Medicare spending starting in 2015 but may not include provisions that would ration health care, raise revenues, increase beneficiary premiums, increase cost sharing, or reduce payment rates for services prior to Dec. 31, 2018. IPAB recommendations on what Medicare should pay physicians would automatically become law unless Congress passes another proposal to reach the same budgetary savings.

7. Recovery Audit Contractors

The new law expands the Recovery Audit Contractor (RAC) program to Medicaid and Medicare parts C and D. Texas will be required to contract with at least one RAC by the end of the year. The sole purpose of the RACs is to identify underpayments and overpayments and to recoup any overpayments.

8. Disclosure of Self-Referral Violations

The new law requires the U.S. Department of Health and Human Services to develop and post on CMS' website self-referral disclosure protocols. The protocols must include the procedures for self-disclosures, the effect of self-disclosure on corporate integrity agreements, and information regarding possible reductions in penalties for self-disclosure of Stark Law violations.

9. Physician-Owned Hospitals

The new law significantly limits a physician's ability to own a hospital and receive payment for any services provided. The law modified the Stark Law, which prohibits physician self-referrals for certain services.

Physician-owned hospitals that had a provider agreement before Dec. 31, 2010, may not participate in Medicare. Ambulatory surgical centers that have converted to a hospital after March 23, 2010, also are not eligible for an exception that will allow payment in Medicare.

Physician-owned hospitals exempt from the ban include those that had a provider agreement in effect on Dec. 31, 2010. These hospitals cannot have increased the

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number of licensed operating rooms, procedure rooms, or beds after March 23, 2010. Also, they must meet requirements that prevent conflicts of interest, prevent increased physician investment, and ensure emergency medical treatment and transfer. These hospitals may expand the number of operating rooms, procedure rooms, or beds only by applying to the government for an exception.

10. Required Coverage Option Education for Employees

Starting in March 2013, large employers must educate new and current employees in writing about the exchange program. They must explain what services the exchange offers and how to contact it for help. Employers who cover less than 60 percent of their employees' health plan benefits also must inform their employees they may be eligible for a premium tax credit and a cost-sharing reduction if they buy health insurance through the exchange.

11. Disclosure Requirements

Various pieces of the health system reform law address the interaction between physicians and manufacturers. For instance, in 2013, any manufacturer that pays (or otherwise transfers value to) a physician must report annually to the federal government the name, address, specialty, and National Provider Identifier of the physician; the amount of the payment; and the dates on which payments were made. The manufacturers must separately designate any payment made in connection with clinical research.

The law permits a delay of disclosures for payments to physicians under a product research or development agreement for services furnished in connection with research on a potential new medical technology. When finally reported, the information will include the date of the Food and Drug Administration approval or clearance of the covered drug, device, biological, or medical supply as well as the payment itself.

If a physician or a physician's family has an ownership interest in a manufacturer, that manufacturer must disclose that information to the federal government unless the investment is through a mutual fund or publicly traded security. The government will publish those disclosures on a website.

12. Increased Scrutiny of the Medical Profession

Health system reform increases many burdensome regulatory efforts on top of the already existing scheme of fraud and abuse laws. For instance, the federal government is expanding its national database of physician "adverse actions." The National Practitioner Data Bank and the Health Care Integrity Data Bank are being merged, and the types of activities that must be reported are expanded. Under the new law, "any adverse action" taken against a physician by a state or fraud enforcement agency must be reported and listed. This is an expansion of the current standard. Health plans and hospitals already are required to report adverse actions of certain types. Physicians should take time to review their operations and compliance programs to ensure they are in compliance with the new laws.

13. Physician Compare Website

The health system reform law creates a Physician Compare website that will contain information on physicians enrolled in Medicare. On Jan. 1 of this year, CMS launched the Physician Compare website at www.medicare.gov/find-a-doctor/provider-search.aspx. The website has little comparative information but rather has basic information regarding a physician's specialty and enrollment status. The website is difficult to use and contains some inaccurate information. The government continues its attempt to improve it.

By 2013, the website must contain physician performance information for the public that compares clinical quality and patient experience measures to the extent that the government develops "scientifically sound" measures. Some form of patient survey likely also will obtain feedback on specific physicians for comparison purposes.

Measures to be considered include those developed under the Physician Quality Reporting System, along with measures that will assess patient health outcomes, patients' functional status, and risk-adjusted resource use.

Physicians will have an opportunity to review and correct performance ratings prior to their publication. The law does not spell out exactly what the review process will look like, nor whether physicians will be entitled to a formal review as Texas law requires of such systems.

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14. Business Tax Implications

Business Tax Reporting

Starting in 2012, employers must disclose the value of all tax-excluded health benefits on employees' W-2 forms. The law originally required all businesses to report annually all payments for purchased goods, property, or services in excess of $600 on an IRS Form 1099. In April, 2011 Congress repealed this requirement.

Employer Penalty

In 2013, employers with more than 50 full-time employees must report information about the health plan they offer, including the plan's premium, employer contribution, and enrollment of employees and dependents in the offered plans. Employers are subject to penalties if:

- They do not offer a health plan with "minimum essential coverage." The penalty is up to $2,000 per full-time-equivalent employee.
- They offer coverage but the coverage is "unaffordable" for some employees. The penalty is up to $3,000 per employee who uses tax credits to purchase a plan in the exchange.

Tax Penalty for Uninsured

Beginning in 2014, individuals who do not maintain qualifying health insurance coverage are subject to tax penalties:

- 2014 — the greater of $95 or 1 percent of income,
- 2015 — the greater of $325 or 2 percent of income, and
- 2016 — the greater of $625 or 2.5 percent of income.

After 2016, penalties increase annually depending on inflation.

Cadillac Plan Tax

Beginning in 2018, high-cost plans above $10,200 for individuals or $27,500 for families are subject to a 40-percent tax. The plan costs include employer and employee premiums as well as contributions to health savings or reimbursement accounts. It does not include the cost of separate vision or dental plans. Taxability thresholds increase by inflation plus 1 percent for 2019 and are based on inflation after that.

Questions? Turn to TMA for Answers

TMA has a wealth of information posted on our website. We also have webinars, online tools, publications, and live seminars to help you learn more about the new health law. The best part is you can earn continuing medical education credits at the same time. Our resources include:

1. "Health Reform and "Accountable" Care" live seminar (3 hours CME)
2. "Avoiding RAC Audits" recorded webinar (1 hour CME)
3. "Physician Ethics and Enforcement of Commercial and Government Program Fraud Laws" online course (2 hours CME)
4. Health System Reform Timeline for Provisions Effective in 2011 (texmed.org/hrs)
5. "Evaluating Your Medicare Options" recorded webinar (1 hour CME)
6. *Switch: How to Change Things When Change Is Hard* publication and home study (4.5 hours CME)

Call the TMA Knowledge Center at (800) 880-7955 for more information, or go to texmed.org/hsr for a complete list of resources available for you and your staff.

Please note: The new law is very complex and will be influenced considerably by the many regulations that must be adopted under its provisions. Further, the law may be amended over time. This document is intended as a summary only. To read the act in its entirety, go to www.texmed.org/hsr (June 2010).

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans