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Top 5 Issues for Physicians to Follow in 2012

What's next?! By now, you've heard that another bipartisan committee has failed to accomplish its primary objective. The "Super Committee" was created as a compromise between Republicans and Democrats to raise the U.S. debt ceiling in August 2011. Comprised of a half dozen each Republicans and Democrats (three each from the House and Senate), the Super Committee was charged with identifying $1.5 trillion in additional deficit reductions by November 23, 2011—the day before Thanksgiving. Barring that, automatic spending cuts of $1.2 trillion would be triggered to take effect in 2013. Of the $1.2 trillion, $600 billion would come from defense cuts and the other $600 billion would come from cutting Medicare and other spending.

With Congress in turmoil and politicians gearing up for the upcoming election year, there are a number of high priority issues for physicians to watch that will impact their practice, patients and other healthcare providers. But, as I see it, these are the top five issues facing a physician this coming year:

1. In last month's St. Louis Medical News article, "Emergency: Will Congress Act in Time to Halt Medicare Reimbursement Cuts?," I noted that the 27.4 percent reduction in the Medicare Physician Fee Schedule (MPFS) would go into effect Jan. 1, 2012 unless Congress enacted a change to the regulations. With the failure of the Super Committee—both parties point fingers for the failure—the opportunities for Congress to reach agreement on anything appears to be further and further distant.

2. Meanwhile, the most far-reaching and impactful item has to be the Supreme Court's review of the constitutionality of the Patient Protection and Affordable Care Act (PPACA), initially scheduled for March 2012. In question is not just the constitutionality of the individual insurance mandate, but the following four issues:

a. Is the PPACA valid without the individual insurance mandate? PPACA requires individuals to purchase healthcare insurance or be covered by a government or similar program by 2014 or face financial penalties.

b. Are parts of the law severable and if so, does it make the PPACA invalid? PPACA was passed without a severability clause that would, in essence, allow portions of the law to be severed and still keep the remainder of the law in place.

c. Is the Supreme Court legally empowered to rule on the mandate before it takes effect in 2014 or must it wait until after implementation? The individual mandate is written into the IRS tax code and has been interpreted as a tax. The Anti-Injunction Act prohibits federal courts from hearing cases against federal taxes until they have been implemented.

d. Is the expansion of the Medicaid program as required in the PPACA constitutional? Individual state Medicaid funding is provided in part from the applicable state. States typically have different programs and eligibility requirements. The PPACA requires that each state expand its eligibility and fund an increasing portion of these costs to its enrollees.

3. One of the prime tenants of the PPACA is the access to and transparency of information. The Federal Physician Payment Sunshine Act (part of the PPACA) requires manufacturers of drugs, medical devices and other medical supplies that are covered by Medicare, Medicaid or other government funded healthcare programs, to report to the government any payments or transfers of value to physicians and/or academic or teaching hospitals and medical centers starting Jan. 1, 2012. The reporting requirement includes consulting fees, any compensation, gifts, entertainment, charitable contributions, and others that could be defined at a later time. Even though the intent was to help limit influence of those manufacturers on the physicians or hospital practice patterns, one concern is how the information will be interpreted by the various parties. The information submitted to the Department of Health and Human Services will over time be made available to the public, which would include consumers, the media, prosecutors and other government agencies.

4. Clarification on the privacy and security of protected health information, including the rules defining Stage 2 of Meaningful Use, are anticipated to be released in 2012. Under Stage 1, Medicare offers incentive payments for eligible providers to implement specific electronic health records (EHR) requirements. Eligible doctors and hospitals that began participating in the program in 2011 would've had to have met new standards that would be clarified in 2012 and implemented in 2013. If a physician starts participation in the program in 2012, they would not have to be compliant with the new standards until 2014, while still being eligible for the same incentive payment. Many providers had postponed entering the program in 2011 for fear of the short turnaround time from the publication of the final rules to the actual implementation date. Health and Human Services (HHS) Secretary Kathleen Sebelius announced that HHS intends to allow all doctors and hospitals who adopted the EHR program in 2011 to comply with the new standards by 2014. Therefore, the earlier a physician practice can implement an appropriate EHR, the sooner it will be eligible for incentive payments with what should be an appropriate amount of time for implementation of Stage 2.

5. The clarification and voluntary implementation of the Bundled Payments for Care Improvement (BPCI) initiative, as identified in the Affordable Care Act and launched by the Center for Medicare and Medicaid Innovation, could have a direct impact on reimbursement, revenue streams and patient/provider relationships. It's critical that physicians understand what impact that it will have on their practice if their affiliated hospital is, or plans to, participate in any of these programs. Generally, there are four bundled payment options in which a provider could participate:

a. Acute care inpatient stay. This is a gain-share model under which physicians may be able to participate in cost savings.

b. Inpatient stay and post acute care services. Physician services are paid on a fee-for-service basis, but aggregate savings over an identified target price can be shared among all participants.

c. Post-acute services. Similar to option 2, physician services are paid on a fee-for-service basis, with aggregate savings over an identified target price able to be shared among all participants.

d. Hospitals paid prospectively for an acute care inpatient stay. However, physicians are paid out of the bundled payment.

With so many changes already taking place and so many others in process, you should be asking how you protect yourself and stay current on issues that impact your practice. Two practical solutions are to stay close to your relevant professional associations. Those associations should be able to provide you information and direction in response to changing regulations. And secondly, surround yourself with the appropriate professionals that cannot only keep you current on changing regulations, but provide realistic and implementable value-based solutions.

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