# AES 2012
# Practice Management Course
December 4, 2012

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## Outline

- What actually happens if we hit the so-called "fiscal cliff"
- Health Care Financing, 2013, What are the facts?
- 2013 Medicare Conversion Factor and SGR
- 2013 CPT Code Changes

## What is affected by the so-called "fiscal cliff"

- Across-the-board spending cuts (also known as "sequestration") under the Budget Control Act of 2011 ($109 billion per year) affecting both defense spending and domestic programs including Medicare
- Expiration of the Bush 2001 and 2003 tax cuts (this includes individual rates, capital gains, dividends, child tax credit expansion, marriage penalty reduction, and the estate tax)
- Alternative Minimum Tax patch ends
- Expiration of the 2 percent payroll tax cut

## Challenges in 2013

- CMS is required by law to cut the Conversion Factor on January 1, 2013 to maintain budget neutrality.
- Conversion Factor cut in 2013 is scheduled to be 26.5% to $25.0008 unless Congress changes the law as it has done annually since 2002.
- The Bush tax cuts will sunset on December 31, 2012 and Sequestration rules of automatic across the board cuts in Federal spending will start on January 1, 2013 unless Congress changes the law.
- The current 2% rollback in payroll taxes will expire on December 31, 2012
- The Supreme Court upheld the legality of the Patient Protection and Affordable Care Act (PPACA), the proper title for the new health care reform law know called Obamacare, but gave the states the right to opt out of Medicaid expansion
- Academic medical centers face increasing cuts in Federal and State support for patient care and training programs
- ICD-10 now slated to begin on October 1, 2014
- Proposed rules on stage III Meaningful Use have now been released
- Unprecidented wave of consolidation of health care has started with 80 mergers and acquisitions so far in 2011 and continuing this year

## The Medicare Fee Schedule

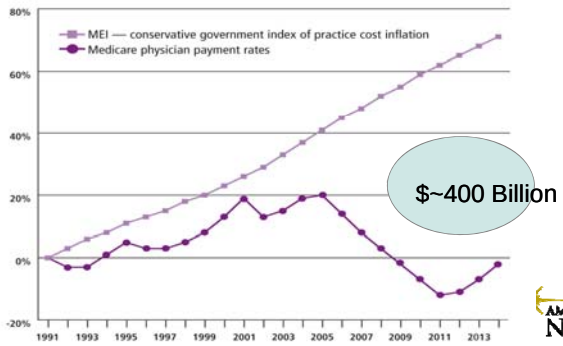
- In 2009, the Neurology Member Census showed 37% of Neurology patients are 65 and older and are thus on Medicare
- Medicare Fee Schedule is an open process
  - Private payers use a closed process but base payments on Medicare
- Codes are defined by the AMA CPT Editorial Panel
- Codes are given a relative work value (RVU) by the AMA RBRVS Update Committee (RUC) as a recommendation to CMS
- CMS reviews RUC values and assigns RVU (~90% unchanged from RUC)
- CMS publishes annual Conversion Factor (CF)
- Medicare payment formula is RVU x CF = Payment
- Annual Medicare payment determined by Sustainable Growth Rate

## Sustainable Growth Rate (SGR)

- Law passed in 1997, requires Medicare payments to follow a formula linked to the cost of medical care, MEI
- Medicare Economic Index (MEI) is a conservative government estimate of the rate of inflation of medical care
- Annual overrides have prevented decreased payments to physicians since 2002, but the law has not been changed so the deficit keeps building
- In 2011, temporary override prevented a 21% drop
- In 2012, temporary overide with CF of $34.0376 prevented a 27.4% drop
- 2013 CF is $25.0008 to comply with SGR.
- Proposed 2013 override would have a Conversion Factor of $34.0066 down slightly
- President Obama supports repeal of the SGR

# SGR Annual Override

- On January 1, 2013, the Medicare Conversion Factor is scheduled to drop 26.5% unless Congress intervenes.
  - Congress has intervened annually since 2001 but all this has done is increase the amount to be repaid

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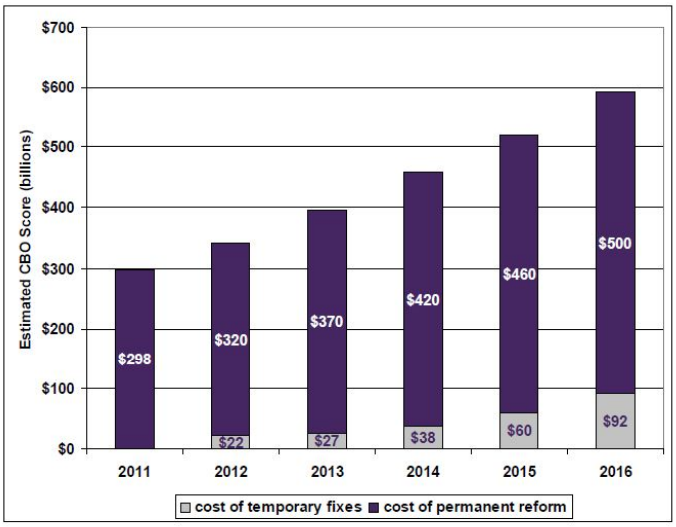
## SGR reform: Delay means higher cost




Source: American Medical Association, Economic and Health Policy Research, June 2011, based on "Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies," Congressional Budget Office, June 14, 2011, and AMA Economic and Health Policy Research estimates.

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## What You Should Do Now

- Call this AMA phone number: 800-833-6354
  - Give your zip code and speak to staff for your 2 senators and representative
    - Call to ask for a permanent fix of the SGR formula before 1/1/13.
- Or Go to this AMA website and fill in your information
  - Your senators and representative will receive the email

http://capwiz.com/ama/issues/alert/?alertid=53132696

## All Physicians are not Paid the Same, I

- New since 2011: some physicians are paid more by specialty
- Primary Care Incentive Payments (PCIP) now in place, 2011-2015
- Primary care physicians will be paid a 10% bonus for non-hospital E&M visits.
- The payments will be paid quarterly to primary care physicians.
- Does not apply to neurologists despite the attempts of the AAN to include neurologists.
- For 2013, CMS estimates that family physicians will see a 7% increase in pay and other primary care physicians will see a 3-4% increase in pay

## 2007-8 Physician Practice Information Survey redistributes practice expenses

- Average physician spends 2200 hours per year on patient care over 50 weeks
- Total direct and indirect office expenses are
  - $116.96/hr for average doctor
  - $127.21 for average neurologist
  - Overall, there is a 3% increase in practice expense for neurologists
- Four year roll out of new practice expense payments 2010-2013
- Equipment is assumed to be used 50% of the time in a 48 hour work week except for CT/MRI which is assumed to be used 90% of time
- Increases in practice expense limited by budget neutrality resulting in decrease in the conversion factor and decreased payments for professional services

## All Physicians are not Paid the Same, II

- Your type of practice and the site of service determines how you will be paid
- In private offices, payments are global
- In medical centers, payments to physicians are for professional fees only
  - Technical payments by HOPPS as APCs to medical center
  - Same applies to patients seen in emergency rooms who are not admitted
- For inpatients, payments to physicians are for professional fees only
  - Technical payments are bundled IPPS as DRGs paid to hospital

# CPT Medicare Payment Relative to Site of Services

- Inpatient care:
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid by DRG to hospital using IPPS
- Outpatient care: Provider-based billing
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid to medical center using HOPPS
- Outpatient care: private office
  - Professional fee bundled with technical payment, so-called global billing using CMS MFS largely following RUC recommended values

# 2007-8 Physician Practice Information Survey redistributes practice expenses

| | | Indirect Expenses | | | Direct Expenses | | |
|---|---|---|---|---|---|---|---|
| **Specialty** | **Total Practice expense/hour** | **Office expense** | **Clerical Payroll** | **Other Expense** | **Medical supplies** | **Medical Equipment** | **Clinical Payroll, can't bill independently** |
| **Average all MD/DOs** | $116.96 | $46.38 | $28.03 | $11.95 | $7.47 | $4.77 | $18.36 |
| **Neurology** | $127.21 | $64.68 | $35.95 | $9.76 | $3.10 | $2.74 | $10.98 |
| **Highest (Repro Endocrinology)** | $350.65 | | | | | | |
| **Lowest (Psychiatry)** | $32.10 | | | | | | |

## How to Improve Your Net Revenue, I

- Control costs
- Control costs
- Control costs
  - Rent, supplies, staff each need to be scrutinized

## How to Improve Your Net Revenue, II

- Check to make sure that your staff is not stealing from you
  - If it involves money, someone will try and take it from you
  - Set up checks & balances for for all processes involving money
    - Always have two people handling money
- Nearly 83% of 688 practice managers were affiliated at some point with medical offices where employee theft occurred (MGMA Survey 11/5/2010)
- Nearly 45% of practice managers reported cash stolen before or after it was recorded on the books.
- Profile of embezzler: first one in, last to leave, never takes a vacation, stops by on weekends, very friendly and helpful

## 2013 Practice Expense (PE) Changes

- Fourth year of 4 year transition on PE methodology
  - CMS is using results of 2009 AMA Physician Practice Information Survey
    - www.ama-assn.org/go/ppisurvey
    - Neurology $73 PE/hr, $127.21Total PE/hr; Overall increase 3%
    - Neurosurgery $81 PE/hr, $132.52 Total PE/hr; Overall increase 2%
  - Assume that imaging equipment such as CT and MRI is used 90% of the time instead of current 50% (plus multiple procedure payment reduction to Professional fee)
  - Other equipment remains at 50% usage for now
  - Work defined as 150,000 minutes/year (48 hour work week)

## 2013 MFS for Neurology Services*

*Assuming conversion factor of $34.006

- 95812, EEG 41-60 minutes
  - Total RVU: 13.32; +24%
  - PE: 12.17 RVU; +26%, $397.20, +23.45%
  - Professional: 1.64 RVU, +3%; $55.77, +3.05%
  - Physician Work (wRVU): 1.08, No change
- 95813, EEG > 1 hour
  - Total RVU: 15.31, +23%
  - PE: 13.47 RVU, +26%; $431.20, +22.47%
  - Professional: 2.63 RVU, +4%; $89.44, +3.45%
  - Physician Work (wRVU): 1.73, No change

## 2013 MFS for Neurology Services*

*Assuming Conversion Factor of $34.0066

- 95816, Awake EEG
  - Total RVU: 12.22, +23%
  - PE: 11.06 RVU, +27% $359.11, +23.32%
  - Professional: 1.66 RVU, +4%; $56.45, +3.66%
  - Physician Work (wRVU): 1.08, No change
- 95819, Awake and Asleep EEG
  - Total RVU: 14.04, +25%
  - Practice Expense: 12.89 RVU, +28% $421.34, +28.28%
  - Professional: 1.65 RVU, +4%; $56.11, +3.68%
  - Physician Work (wRVU): 1.08, No change

## 2013 MFS for Neurology Services*

*Assuming Conversion Factor of $34.0066

- 95822, Sleep EEG
  - Total RVU: 12.55, +22%
  - PE: 11.40 RVU, +25%; $370.67, +25.75%
  - Professional: 1.65 RVU, +4%; $56.11, +3.68%
  - Physician Work (wRVU): 1.08, No change
- 95824, EEG for Brain Death
  - Practice Expense: none (IPPS only)
  - Professional: 1.15 RVU, +4%; $39.11; +3.51%
  - Physician Work (wRVU): 0.74, No change

## 2013 MFS for Neurology Services*

*Assuming Conversion Factor of $34.0066

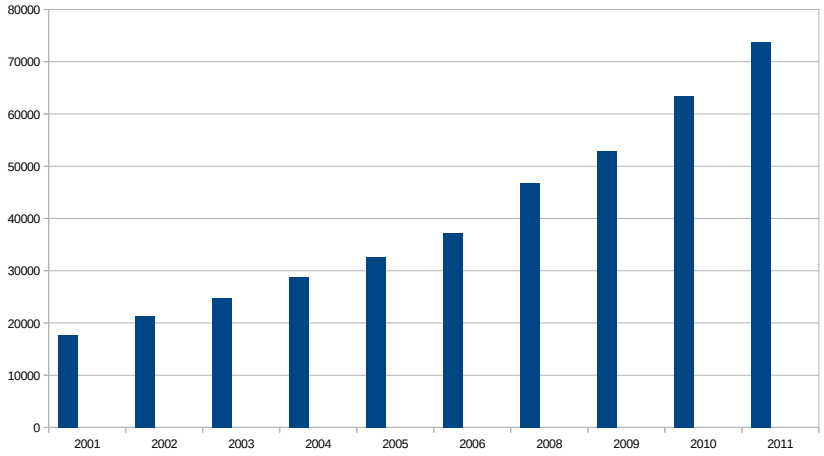
- 95827, Overnight EEG
  - Total RVU: 23.88, +21%
  - PE: 22.67 RVU, +22%; $755.97, +22.57%
  - Professional: 1.65 RVU, +3%; $56.11, +3.03%
  - Physician Work (wRVU): 1.08, No change
- 95829, Surgery Electrocorticogram
  - Total RVU: 57.96, +18%
  - PE: 51.55 RVU, +21%; $1652.72, +21.21%
  - Professional: 9.36 RVU, +3%; $318.30, +3.10%
  - Physician Work (wRVU): 6.20, No change

## 2013 MFS for Neurology Services*

*Assuming Conversion Factor of $34.0066

- 95950, Ambulatory Cassette EEG, unattended
  - Total RVU: 10.28, +17%
  - PE: 8.67 RVU, +21%; $271.03, +21.94%
  - Professional: 2.31 RVU, +4%; $78.56; +3.49%
  - Physician Work (wRVU): 1.51, No change
- 95951, 24 Hour Video EEG
  - Practice Expense: *Carrier-defined technical expense
  - Professional: 9.40 RVU, +4%; $319.66, +3.43%
  - Physician Work (wRVU): 5.99, No change
  - Hospital coders: use 89.19 for inpatient coding

# 2001-2011 Claims for 95951, RUC database




# 2013 MFS for Neurology Services*

## *Assuming Conversion Factor of $34.0066

- 95953, 24 hour automated computerized digital EEG, <u>unattended</u>
  - Total RVU: 13.03, +3%
  - Practice Expense: 9.77 RVU, +4%; $282.93, +3.39%
  - Professional: 4.71 TVU, +3%; $160.17, 2.74%
  - Physician Work (wRVU): 3.08, no change
- 95956, 24 Hour <u>attended</u> EEG without video (assuming 1 tech: 2 patients)
  - Total RVU: 51.17, +48%
  - Practice Expense: 47.24 RVU, +54%; $1553.08; +55.04%
  - Professional: 5.50 RVU, +6%; $187.04; +5.47%
  - Physician Work (wRVU): 3.61, no change

## 2013 MFS for Neurology Services*

*Assuming a Conversion Factor of $34.0066

- 95954, EEG with administration of drugs
  - Total RVU: 14.03, +18%
  - Practice Expense: 11.43 RVU, +23%; $356.05, +23.65%
  - Professional: 3.56 RVU, +3%; $121.06, +2.80%
  - Physician Work (wRVU): 2.45, no change
- 95955, EEG during surgery
  - Total RVU: 7.02, +23%
  - Practice Expense: 5.96 RVU, +28%; $186.02, +29.81%
  - Professional: 1.55 RVU, +4%; $52.71, +3.93%
  - Physician Work (wRVU): 1.01, no change

## 2013 MFS for Neurology Services*

*Assuming Conversion Factor = $34.0066

- 95957, EEG Digital Analysis
  - Total RVU: 13.69, +21%
  - Practice Expense: 11.60 RVU, +25%; $362.51, +26.34%
  - Professional: 3.03 RVU, +3%; $103.04, +3.32%
  - Physician Work (wRVU): 1.98, no change
- 95958, EEG monitoring, functional mapping (Wada Test)
  - Total RVU: 17.24, +18%
  - Practice Expense: 12.74 RVU, +27%; $367.95, +30.56%
  - Professional: 6.42 RVU, +2%; $218.32, +2.30
  - Physician Work (wRVU): 4.24, no change

## 2013 MFS for Neurology Services*

*Assuming a conversion factor of $34.0066

- 95961, Electrode stimulation, brain, first hour
  - Total RVU: 8.44 RVU, +6%
  - Practice Expense: 5.32 RVU, +10%; $132.97, +10.98%
  - Professional: 6.42 RVU, +2%; $154.05, +1.93%
  - Physician Work (wRVU): 2.97, no change
- 95962, Electrode stimulation, brain, each additional hour
  - Total RVU: 7.31 RVU, +5%
  - Practice Expense: 3.95 RVU, +10%; $82.64, +10.86%
  - Professional: 4,88 RVU, +3%; $165.95, +2.64%
  - Physician Work (wRVU): 3.21, no change

## 2013 MFS for Neurology Services*

*Assuming a Conversion Factor of $34.0066

- Technical Expenses not defined, only APCs assigned for MEG codes
- 95965, MEG, spontaneous
  - Professional: 15.55 RVU, +3%
  - Physician Work (wRVU): 7.99, no change
- 95966, MEG, evoked, single
  - Professional: 5.77 RVU, -5%
  - Physician Work 9sRVU): 3.99, no change
- 95967, MEG, evoked, each additional
  - Professional: 5.07 RVU, -4%
  - Physician Work (wRVU): 3.49, no change

# 2012 MFS for Neurology Services*

*RVUs, excluding the conversion factor

- 95970, Analyze neurostimulator, no programming
  - Total RVU: 2.11, +13%
  - Practice Expense: 1.49 RVU, +8%
  - Physician Work (wRVU): 0.45, no change
- 95974, Cranial neurostimulation, complex analysis and programming, first hour (3 or more parameters)
  - Total RVU: 6.04, +8%
  - Practice Expense: 2.78 RVU, +18%
  - Physician Work (wRVU): 3.00, no change
  - Use -52 modifier if less than 30 minutes
- 95975 Cranial neurostimulation, complex, each additional 30 minutes
  - Total RVU: 3.23 RVU, +7%

# MEG Practice Expense Payment Rate

- The Affordable Care Act (ACA) requires that CMS establish the equipment utilization rate for CT, MR and PET at 75 percent. CMS had previously set the equipment utilization rate for this equipment at 90 percent, phasing in reduced payments over four years. This may result in changes to payment rates for CT and MR services.
- May affect MEG technical pricing since MEG grouped in imaging APCs
- 2013, 25% cut in Professional Component of the Multiple Procedure Payment Reduction, PC MPPR, to radiology may affect MEG payments
  - This reduces the professional and technical fees by 25% for every subsequent image on the same day when anyone in the group performs the study.

## CPT Medicare Payment Relative to Site of Services

- Inpatient care:
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid by DRG to hospital using IPPS
- Outpatient care: Facility-based billing
  - Professional fee paid to physician using -26 modifier
  - Technical fee paid to medical center using HOPPS
- Outpatient care: private office
  - Professional fee bundled with technical payment, so-called global billing using CMS MFS largely following RUC recommended values

## Mapping of Seizure codes to DRGs

- Terminology is important:
  - Epilepsy, 345.00-345.91, maps to DRGs 100, Seizure without MCC, and 101, Seizure with MCC.
  - Seizure(s), 780.39, maps to DRG 100 and 101.
  - Recurrent seizures, seizure disorder, 345.8x maps to DRG 100 and 101
  - Pseudoseizure, Conversion disorder, psychogenic conversion disorder, 300.11 (even with a secondary code of 780.39), maps to DRG 880, Acute Adjustment Reaction

# 2013 Hospital Outpatient Prospective Payment System (HOPPS)

- Published 11/01/2011

http://interactive.snm.org/docs/HOPPS%20CY%202013%20Final%20Rule2.pdf

- Payment for the technical portion of CPT codes done on Medicare Outpatients
- Some outpatient procedures with HOPPS values have no payment assigned in MFS for doctors billing global
  - 95951 24 hour video EEG is “carrier priced”
  - 95965-95967 MEG is “carrier priced”
- Payment for technical portion of Medicare inpatients is bundled into a single DRG payment
- Payment for technical fees in outpatients in private offices is in the Medicare Physician Fee Schedule
    - Billing “global” in private offices

# 2013 HOPPS APC 0213

- APC 0213 Level 1 Sleep, EEG, and CV studies
  - 95812 EEG 41-60 min
  - 95812 EEG > 1 hour
  - 95816 EEG awake and drowsy
  - 95819 EEG awake and asleep
  - 96822 EEG sleep and/or coma
  - 95827 EEG all night recording
  - 95958 EEG monitoring/function test
- 2012 APC rate is $170.12
- 2013 APC rate will be $172.61, +1.4%

## 2013 HOPPS APC 0209

- APC 0209 Level II sleep, EEG, & CV
  - 95950 ambulatory cassette EEG
  - 95951 24 hour video EEG
  - 95953 ambulatory digital EEG
  - 95956 24 hour EEG without video
  - MSLP and polysomnograms
- 2012 APC Rate is $795.16
- 2013 APC Rate will be $806.13, +1.3%

## 2013 HOPPS APC 218

- APC 218 Level II Nerve and Muscle Tests
  - 95970 Neurostimulation, analysis with no programming
  - 95954 EEG monitoring with drug administration
- 2012 payment is $84.19
- 2013 payment will be $79.83, -5.18%

## 2013 HOPPS APC 216

- APC 216 Level III Nerve and Muscle Tests
  - 95961 Cortical Stimulation, 1st hour
  - 95962 Cortical Stimulation, each additional hour
- 2012 payment is $185.46
- 2011 payment will be $184.02, -0.78%

## 2013 HOPPS APC 0692

- APC 0692 Level III Electronic Analysis of Devices
  - 95971 Analyze neurostim, simple
  - 95972 Analyze neurostim, complex
  - 95973 Analyze neurostim, complex
  - 95974 Cranial neurostim, complex
  - 95974 Cranial neurostim, complex
  - 95978 Analyze neurostim brain, 1st hour
  - 95979 Analyze neurostim brain, each 1 hour
  - 95982 Low gain neurostim subseq w/ reprogram
- 2012 payment is $111.63
- 2013 payment will be $111.47, -0.14%

# 2013 MEG HOPPs

- Technical payments for MEG studies in hospital-based outpatient care facilities
  - Does not apply to free standing MEG sites
    - Carrier priced
  - Does not apply to MEG studies done on inpatients
    - Technical fees bundled to DRG

# 2013 HOPPS APC 0066

- APC 0067 Level III Stereotactic Radiosurgery, MRgFUS, and MEG
  - 95965 MEG, spontaneous
  - 2012 payment is $2,520.30
- APC 0066, Level II Stereotactic Radiosurgery, MrgFUS, and MEG
  - 2013 payment will be $2,520.30, a decrease of -6.57%.
- The big decrease in this code happened in 2012 when the APC was changed from 0067 to 0066 resulting in a drop in payment of about $800.

# 2013 HOPPs APC 0065

- Level I Stereotactic radiosurgery, MrgGUS, and MEG
  - 95966 MEG Evoked Response
  - 95967 Additional MEG Evoked Response
- 2012 payment is $902.53
- 2013 payment will be $978.25, +8.39%

# Medicare and Federal Spending Facts

- Medicare taxes are designed to cover Medicare Part A expenses (largely hospital coverage)
  - Medicare Part B & D expenses (physician and drugs) subsidized from general taxes
  - In 2009, Medicare spent $11,743 per beneficiary (WSJ 4/6/11)
  - Typical 56 yr old couple making $43,100 per year each will pay about $140,000 in Medicare taxes from age 22 to 65 and receive $427,000 in Medicare coverage from 65 until death. D Leonhardt NYT 4/6/11
- Current Federal spending is ~25% of GDP and current Federal tax revenue is ~15% of GDP L. Seidman WSJ 4/6/11

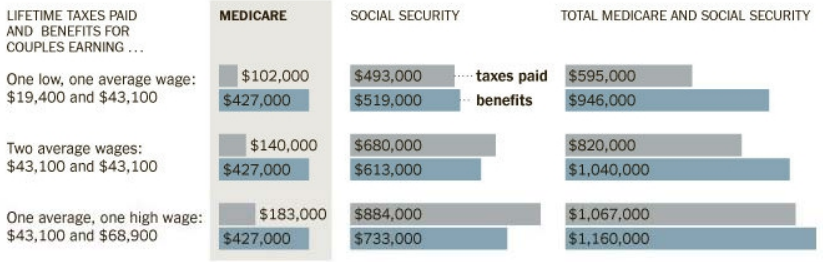
# Medicare and Social Security Taxes vs. Benefits for Typical

The New York Times

April 6, 2011

## Reaping More in Benefits Than Paying in Taxes

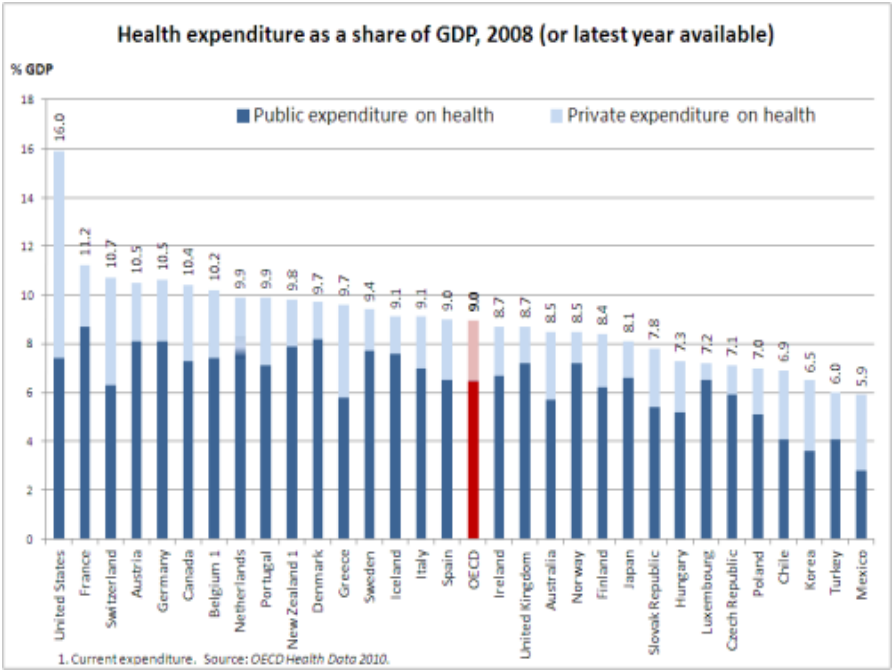
When today's 56-year-olds retire in 2020, many will receive more Medicare benefits than they paid in taxes for the program. But the amounts those workers receive and pay for Social Security are similar.

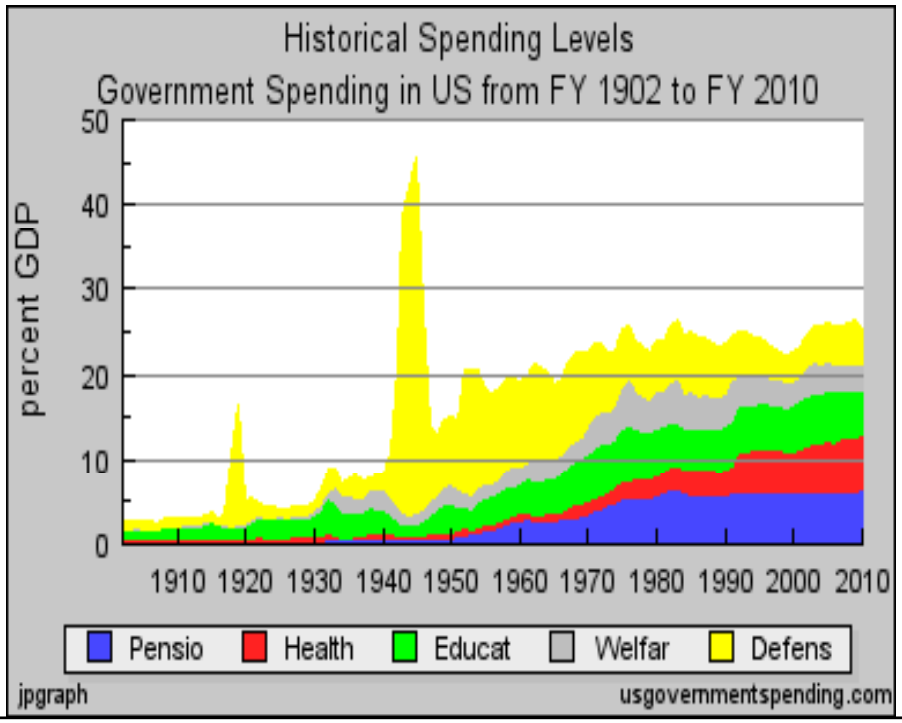


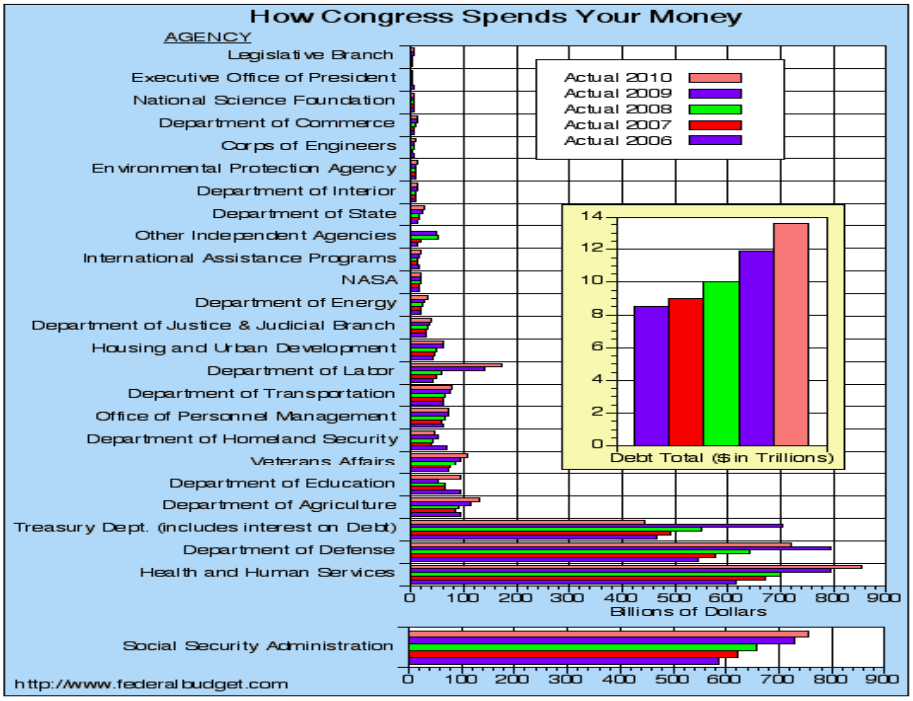

Note: Calcuations are for 56-year-olds who will retire at age 65 in 2020 and have worked every year, starting at age 22. Amounts are in 2010 dollars, adjusted to present value at age 65 using a 2 percent real interest rate.

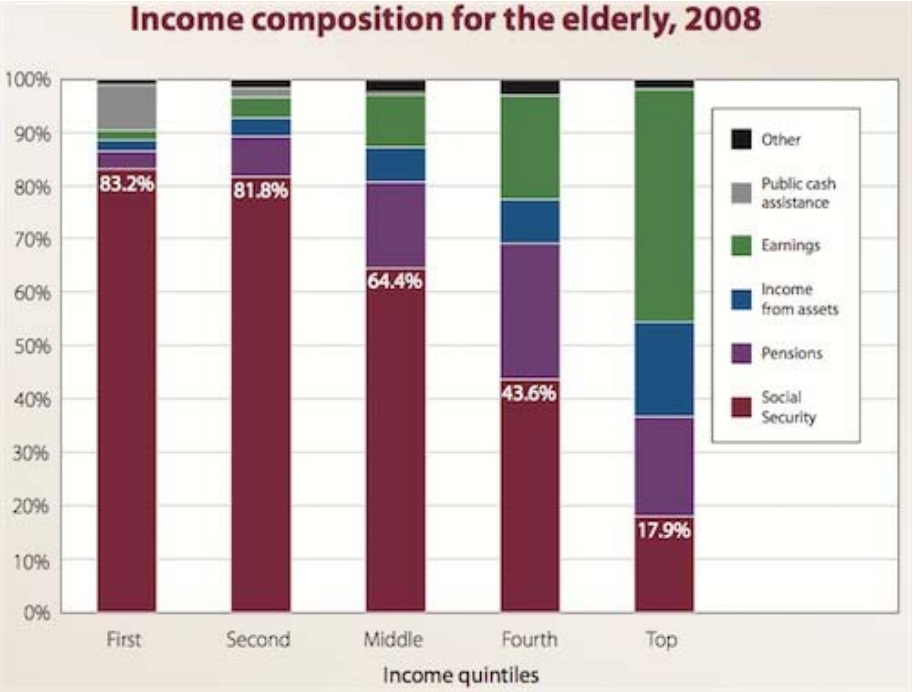
Source: Eugene Steuerle and Stephanie Rennane and based on their earlier work with Adam Carasso

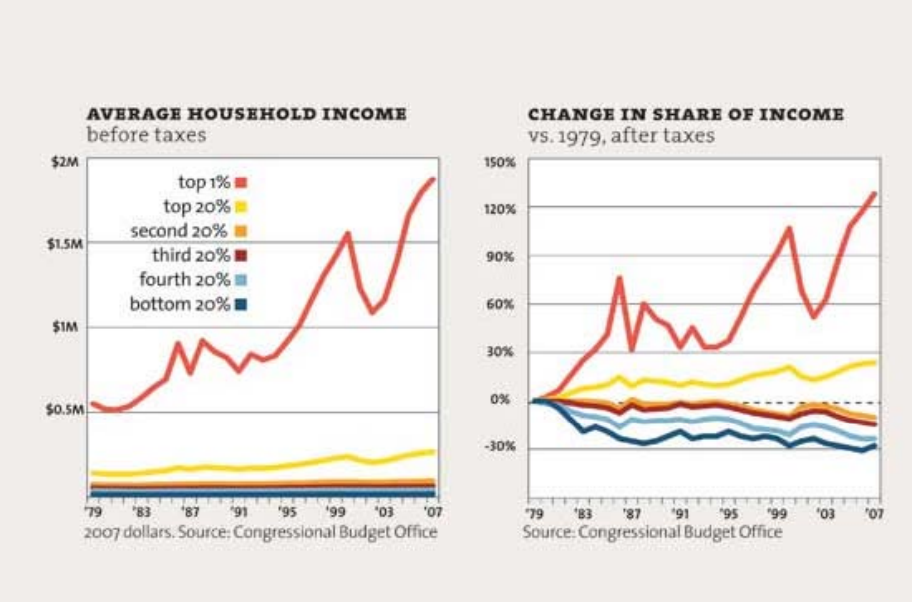
The New York Times

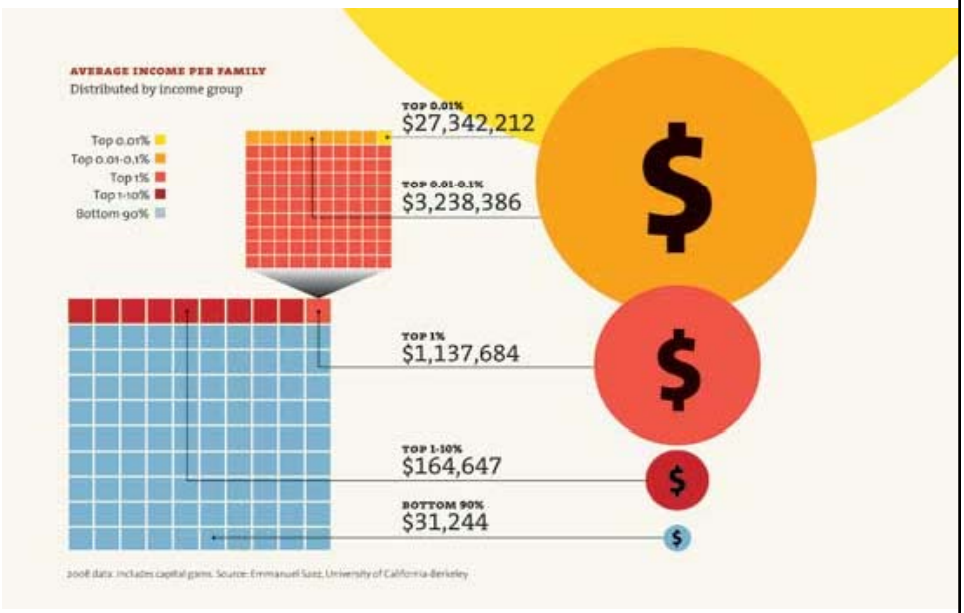



Historical Spending Levels
Government Spending in US from FY 1902 to FY 2010
percent GDP
50
40
30
20
10
0
1910 1920 1930 1940 1950 1960 1970 1980 1990 2000 2010
Pensio
Health
Educat
Welfar
Defens
jpgraph
usgovernmentspending.com


How Congress Spends Your Money
AGENCY
Legislative Branch
Executive Office of President
National Science Foundation
Department of Commerce
Corps of Engineers
Environmental Protection Agency
Department of Interior
Department of State
Other Independent Agencies
International Assistance Programs
NASA
Department of Energy
Department of Justice & Judicial Branch
Housing and Urban Development
Department of Labor
Department of Transportation
Office of Personnel Management
Department of Homeland Security
Veterans Affairs
Department of Education
Department of Agriculture
Treasury Dept. (includes interest on Debt)
Department of Defense
Health and Human Services
Social Security Administration
Actual 2010
Actual 2009
Actual 2008
Actual 2007
Actual 2006
Debt Total ($in Trillions)
0 100 200 300 400 500 600 700 800 900
Billions of Dollars
http://www.federalbudget.com


Income composition for the elderly, 2008
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83.2%
81.8%
64.4%
43.6%
17.9%
Other
Public cash assistance
Earnings
Income from assets
Pensions
Social Security
First
Second
Middle
Fourth
Top
Income quintiles


AVERAGE HOUSEHOLD INCOME
before taxes
$2M
$1.5M
$1M
$0.5M
top 1%
top 20%
second 20%
third 20%
fourth 20%
bottom 20%
'79
'83
'87
'91
'95
'99
'03
'07
2007 dollars. Source: Congressional Budget Office
CHANGE IN SHARE OF INCOME
vs. 1979, after taxes
150%
120%
90%
60%
30%
0%
-30%
'79
'83
'87
'91
'95
'99
'03
'07
Source: Congressional Budget Office




# The Affordable Care Act, 2012

- A hospital Value-Based Purchasing program
  - Requires public reporting of quality measures
  - Pays hospitals extra for achieving quality targets
- Begins Accountable Care Organizations
- Requires new standardized electronic exchange of health care information
- Requires ongoing and new Federal health programs to collect information on disparities
- Creates a new voluntary long-term care insurance program, CLASS
- Requires pharmaceutical and medical device companies to publicly disclose all payments to physicians

# The Affordable Care Act, 2013

- New funding is provided to Medicaid plans to expand preventative care services at little or no cost
- Authority to bundle payments to hospitals and providers under a pilot program will expand
- Medicaid payments to primary care providers will be increased to at least 100% of Medicare rates
  - Medical specialists are included but neurologists are not because they have a separate board
- Additional funding to CHIP programs for children not eligible for Medicaid will be provided.

# The Affordable Care Act, 2014, I

- The act prohibits discrimination due to pre-existing conditions or gender
- Eliminates higher rates in the individual insurance market based upon gender or health status
- Eliminates annual limits on health care coverage
- Insures coverage for individuals participating in clinical trials
- Provides tax credits to individuals between 100 and 400% of the poverty line and gives reduced co-payments and deductibles,
- Establishes Health Insurance Exchanges if an employer does not offer insurance
- Requires Members of Congress to get their insurance through Exchanges

# The Affordable Care Act, 2014, II

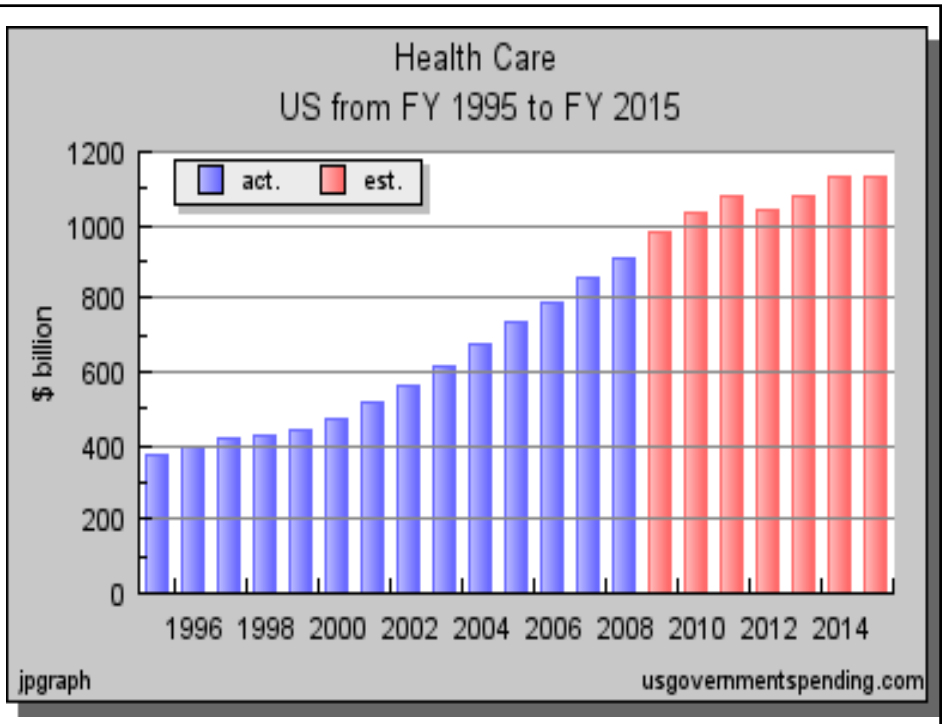
- Increases the small business tax credit for up to 50% of employer's contribution
- Provides Medicaid to anyone who earns up to 133% of the poverty level
  - Provides 100% reimbursement to the states for the extra costs
  - Supreme Court ruled that states can choose to opt out of this provision
- Gives employees the funds that their employer would have spent to allow them to join a new Health Insurance Exchange
  - States have until end of year to submit plans or Federal Government will run the exchange
- Begins the individual mandate to purchase insurance

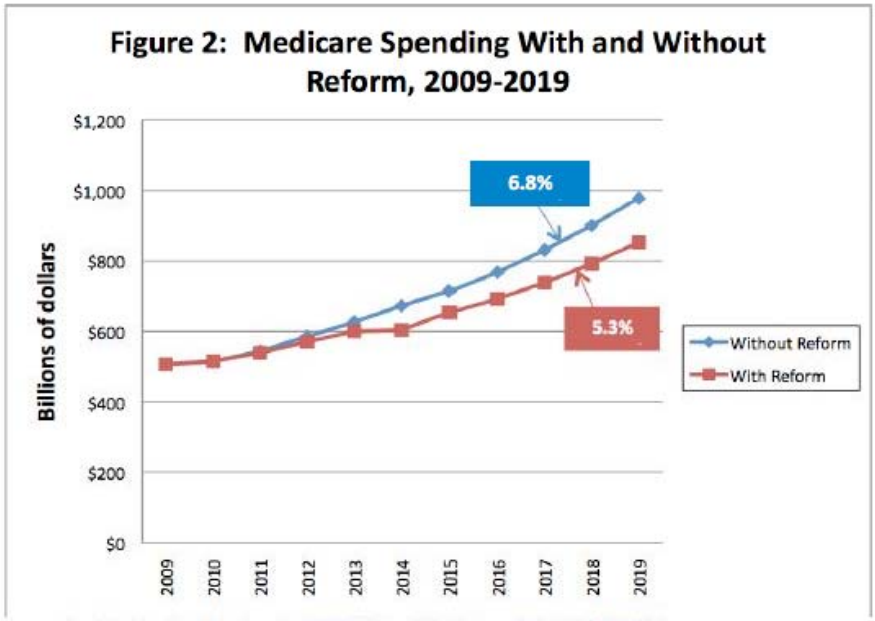
# The Affordable Care Act, 2015

- Physician payment will be tied to quality measures not volume
- IPAB, 15 member independent panel, appointed by President, confirmed by Senate begins to enforce upper limit on Medicare spending growth, set to be a fixed growth rate
- In 2018, IPAB, will enforce permanent maximum Medicare growth at per capita GDP growth plus 1%
  - It cannot change cost-sharing for covered Medicare services
  - It can cut Medicare payments for providers
- This will reward highly efficient providers and penalize less efficient ones

# Financial Impact of the ACA

- Congressional Budget Office estimated that the ACA:
  - Would reduce the deficit by $143 billion over the first decade
  - Would reduce the deficit by $1.2 trillion over the second decade.
- The graph on the next slide is taken from a web site sympathetic to the tea party movement and shows the "bending of the health care curve" cited by supporters of the ACA.






Source: Analysis based on data from the CMS Office of the Actuary's April 22, 2010 Memo

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# Professionalism

This has been a business talk, but do not forget why you became a physician in the first place

You are expected to give back to the community by donating your talent, your time, and your money to support worthy causes

These include: your hospital, nonprofit disease organizations such as the Epilepsy Foundation, the American Academy of Neurology, etc.