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HEALTH CARE REFORM VIGNETTE

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SUMMARY: The voluminous bill known as the PPACA of 2010 enabled substantial changes to our health care delivery system, some of which remain to be enacted for several years to come. While the overarching goal is to align incentives and improve quality and access, implementing PPACA initiatives in a highly complex environment is fraught with economic and political implications. The purpose of this and future AJNR Health Care Vignettes is to provide relevant updated information as it becomes available.

ABBREVIATIONS: CMS = Centers for Medicare and Medicaid Services; EHR = electronic health record; GDP = gross domestic product; HITECH = Health Information Technology for Economic and Clinical Health; MRA = MR angiography; PET = positron-emission tomography; PPACA = Patient Protection and Affordable Care Act

What Is the PPACA? How Does It Address the US Health Care Crisis?

On March 23, 2010, sweeping health care legislation, in the form of the PPACA,[1] was signed into law by President Barack Obama. There are many highly interdependent challenges in the current US health care system, including rising cost, variable access and quality, fragmented delivery, geographic workforce misalignments, and barriers to translation of innovation. The PPACA focuses most heavily on cost containment and, to a lesser extent, on matters of access and delivery integration.

Indeed, bending the health care cost curve has become a national priority; US health care spending has reached a high of 17.6% of the US GDP.[2]

One of the most significant features of the new health care legislation is the universal requirement for health insurance, beginning in January 2014. (The Institute of Medicine estimates approximately 18 000 deaths per year are related to a lack of health insurance.)[3,4] Accountable Care Organizations would establish integrated networks of care delivery eligible for incentives if they achieve a threshold savings per Medicare beneficiary.

Effective in June 2010, insurance may not be denied on the basis of pre-existing health conditions for children. While this provision is not fully implemented for adults until 2014, a temporary insurance program provides financial assistance to those who have been uninsured for several months and have a pre-existing condition (PPACA, section 1101).[5,6] Over 16% of the population is uninsured, and more than an additional 20% is underinsured. (Of note, academic health centers, which constitute only 6% of all hospitals, care for 40% of the hospital-based uninsured in this country).[7]

What Features of PPACA Will Affect Me and Other Neuroradiology Colleagues Most?

There are several provisions that impact our field, and there is little question that the rapid growth of advanced imaging (CT, MR imaging, PET) has made radiology overall a target for cost cutting. Such provisions include the following:

Equipment Utilization Rate (Sec. 3135). Effective January 1, 2011, the equipment utilization rate assumption used to calculate the technical component payment under Medicare increased from 50% to 75%. This applies to imaging equipment costing more than $1 million.

Multiple Procedure Payment Reduction (Sec. 3135). Effective July 1, 2010, this provision applies a 25%–50% reduction for imaging procedures of consecutive body parts performed in a single session. More than 200 codes are subject to this multiple imaging payment reduction, including MR imaging and MRA (head/brain/neck), MR imaging and MRA (spine), and spine CT.

Medicare Imaging Demonstration (Sec. 3504). The PPACA contains approximately 5 pilot and 30 demonstration projects administered through the CMS. Recently awarded to several "conveners," the 2-year Medicare Imaging Demonstration will permit collection of data on the appropriateness of physician use of advanced diagnostic imaging services using decision-support systems. Eleven procedures with high use and growth have been targeted for inclusion in the demonstration, including brain MR imaging and CT, sinus CT, and lumbar spine MR imaging and CT.

Physician Quality Reporting Initiative (Sec. 10327). A provision in PPACA extends the Physician Quality Reporting System incentive payments through 2014 (1% bonus in 2010, 0.5% bonus 2011–2014). Providers who meet requirements of Maintenance of Certification could receive an additional 0.5% beginning in January 2011. Beginning in 2015, there will be a penalty (1.5% in 2015, 2% in 2016) for providers who do not report eligible measures (eg, percentage of CT or MR imaging reports final within 24 hours of admission to hospital, exposure time for procedures using fluoroscopy). Effective January 2011, eligible physicians who report over a 12-month period may receive an additional 0.5% incentive payment when American Board of Radiology MOC Program Incentive requirements have also been met.[8]

Misvalued Codes Under the Physician Fee Schedule (Sec. 3134). This provision authorizes the periodic review and adjustment of physician services that are potentially misvalued. Because those services with the highest growth rates and those that incorporate new technologies are likely to be assessed as

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potentially inaccurate by using the outlined criteria, imaging is a prime model for this avenue of review.

Where Does Electronic Health Record Meaningful Use Fit In? Is It Part of the PPACA?

The HITECH Act[9] was not officially part of PPACA, though the health care reform law refers heavily to an EHR. HITECH had initial provisions within the American Recovery and Reinvestment Act of 2009, and recently CMS has developed the detailed incentive plans that provide the backbone for EHR meaningful use.

The Act provides a $2 million base payment and incentives beginning in May 2011 to reward the implementation of EHRs that incorporate computerized physician order entry, interoperability/integration of systems, and demographic detail and provides a platform for practice quality improvement.[10]

What Does All This Mean for Academic Radiology Departments?

The Healthcare Innovation Zone Program Act (H.R. 3134) provision challenges academic health centers to develop demonstration projects of health care delivery that enhance access, quality, and outcomes in select populations. This provision permits academic health systems to test new care models.[11]

During the past several decades, we have increasingly turned to the clinical margin as the primary way of funding research and education in US academic medical centers. With further cuts to clinical revenue streams, particularly in radiology, one wonders how our discovery and training engines will be sustained. As Barack Obama said in his January 25, 2011, State of the Union Address, "Innovation doesn't just change our lives; it is how we make our living."

What Is Not Addressed in the Law?

Despite the infamous physical bulk of the law, there remain questions and unaddressed issues. These include the lack of a permanent fix to the flawed sustainable growth rate formula and the persistence of outdated caps on graduate medical education funding that supports residents and Accreditation Council for Graduate Medical Education fellows. PPACA also contains only an anemic anti-self-referral provision (effective January 1, 2011), which requires physicians with ownership interest in CT, MR imaging, and/or PET scanners to disclose such to patients at the time of referral and to provide alternate available sites within a 25-mile radius. Unfortunately, there is no requirement that the patient provide signed verification of receiving or comprehending this information. (A recent article by Sunshine and Bhargavan[12] analyzed 2006–2007 Medicare data to evaluate the contention that physician-owned/leased equipment enhances patient convenience and earlier diagnosis and treatment. They reported that self-referral provided same-day imaging in only 15% of CT and MR imaging examinations.)

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