Practice Landscape: California

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The current cardiovascular practice landscape has been changing with the onset of health care reform and the significant payment cuts included in the 2010 Medicare Physician Fee Schedule. Since January 2010, the American College of Cardiology (ACC) has been monitoring the practice landscape and has embarked on a cardiovascular practice survey. Additionally, in June 2010, ACC and MedAxiom (Neptune Beach, FL) staff met with 23 ACC members representing 7 practices (ranging from solo to large multispecialty groups) in Southern California to understand the impact of the Medicare Fee Schedule and to discuss measures physicians have taken to help their practices remain viable. These findings, as they pertain to the state of California, are discussed here.

In September 2010, the results of an ACC cardiovascular practice survey were presented to the Board of Governors. A total of 2413 practices in the United States and 194 in the state of California participated in this survey. In California, 845 cardiologists in varied practice settings participated: 38% in a cardiology group, 37% in solo practice, 8% in a multispecialty practice, 6% in an academic setting, 1% in an HMO setting, 3% in a government hospital, and 3% in a nongovernment (county) hospital. In California, 42% of physicians practiced in a suburban setting, 41% practiced in an urban setting, and 6% practiced in a rural setting.

The 2010 Medicare Physician Fee Schedule reduced payments for cardiovascular services by 30% to 45%, especially for diagnostic imaging such as nuclear perfusion studies and echocardiography. This has had a major impact on practice viability and practice structure. With regard to these Centers for Medicare & Medicaid Services (CMS) cuts, 45% of the practices indicated they will not be purchasing any new equipment, 41% reported reducing staff to save expenses, 34% reported reducing doctor salaries, 20% reported limiting services, and 12% stated they have limited the number of new Medicare patients accepted. Among the practices surveyed, 77 physicians were reduced, 62 mid-level practitioners were reduced, and 174 administrative support staff were reduced. Physician salaries were lowered by an average of 8.7%; this figure was reported as 8.5% nationally. In the meetings in Southern California, practices reported a decrease in accounts receivable (revenue) of 20% to 30%. This is consistent with the activity the ACC is seeing across the country. A majority of practices are being forced to reduce salaries at all staffing levels and, additionally, are reexamining their business models. Physicians in private practice continue to face an increasing number of challenges, including rising costs, declining reimbursement, increased administrative burdens, and

a growing number of patients experiencing financial hardship. These factors, along with the uncertainty of the new national health care reform legislation, threaten practice viability and patient access to quality care.

Physicians interviewed reported that the change in the practice environment is real, burdensome, and significant. Senior physicians reported that the practice of cardiology has changed drastically over the past 5 to 10 years. Various factors, including financial constraints, inappropriate referrals from primary care providers, strained hospital relationships, increased administrative hassles from private sector payers (preauthorization for tests and medication), and concerns regarding health care reform (including payment reform) have placed pressure on physicians and their practices. Practice survival is clearly an issue that is causing uncertainty among many cardiovascular professionals. As hospitals enter into exclusive arrangements with a limited number of physicians, there is more pressure on the remaining physicians in the community to maintain their referral sources. Most physicians expressed apprehension and distrust with regard to hospitals, which were thought to be adversarial. This apprehension has led to hasty decisions with regard to practice alignment. Other major issues include declining reimbursement and an increase in cumbersome documentation and reporting requirements. Physicians are concerned about how they will be able to function within a new payment model if they are not aligned with a hospital. Given concerns about future survivability, all practices had questions regarding appropriate practice legal structures and contracting and referral issues. Practices are exploring appropriate and available viability options open to them. It was also noted that there are limits on new physicians entering practices, despite growing patient demand. There is also placement difficulty for Fellows-in-Training, and reduced professional satisfaction as a result of these new stressors.

We are interested in hearing your thoughts on the practice of cardiology and what you identify as your challenges, frustrations, and rewards. Please contact us. ■

Centers for Medicare & Medicaid Services Meaningful Use Compliance

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In July 2010, the Centers for Medicare & Medicaid Services (CMS) released the Meaningful Use (MU) Stage 1 requirements for physicians to qualify for incentive payments for electronic medical records (EMR).[1] Starting in January 2011, physicians can qualify for incentive payments totaling up to $44,000 per doctor for Medicare and $63,750 for Medicaid, paid over 4 years. Doctors must be in compliance with 20 (out of a total of 25) objectives set forth by CMS, 15 core objectives, and another 5 "menu items" that may be chosen from a list of 10 "menu objectives." This allows a short 5-month window in which to reach MU compliance to qualify for the earliest incentive payments from the government. Physicians may qualify for the first year of incentive payments by meeting the published MU criteria for 90 consecutive days, beginning in January 2011, but no later than the fourth quarter of 2012.

Ours is an 8-physician cardiology group, and we have been using EMR for the past 4 years. Our first step was to review the MU requirements and compare them to our office EMR functions and capabilities. We then performed a current compliance status evaluation for our office, listing each criterion into 3 groups based on our current compliance status as 1) fully compliant, 2) partially compliant, or 3) not compliant. This allowed us to quickly identify the mandatory MU objectives on which we needed to improve, as well as the 5 menu items we could most easily target as compliant. This approach allowed us to focus our attention solely on the criteria upon which we needed to improve in order to meet compliance requirements.

After identifying criteria with which we were already in compliance, we targeted the objectives with which we were partially compliant. These were objectives that we determined could be achieved with changes in physician and staff workflow. The most difficult targets were those objectives with which we were currently not in compliance. Some of these were objectives that could not be achieved with our current EMR software and therefore required software updates. For objectives in this category, a cooperative effort is currently underway with our EMR vendor. Upgrades in the software currently being developed by our vendor are essential in order for physicians and practices to meet the criteria specified in the government's MU requirements documents.

Physicians in our group use EMR capabilities at varying levels of sophistication. Designing a single workflow for all of them, which does not put an extra burden on physicians but still allows them all to qualify for MU incentives simultaneously, is impractical. In addition, CMS permits physicians within a group to comply with MU requirements on an individual basis. Our plan is to initially achieve MU compliance with one physician while training the entire staff on new MU policies and procedures. This approach limits the potential overall negative workflow impact on the practice, and allows the "bugs" to be worked out by the more computer-literate doctors. This should create a smoother transition for the subsequent physicians who wish to qualify, and allows the incentive payment to serve as motivation for each individual doctor to meet the MU criteria. Clearly, the challenge to meet these criteria will vary by physician.

We believe that our approach, targeted to the criteria and tailored to the physician-user, will enable us to reach full MU compliance within our entire group. ■

Reference

1. Blumenthal D, Tavenner M. The "Meaningful Use" Regulation for Electronic Health Records. http://healthpolicyandreform.nejm.org/?p=3732. Accessed January 22, 2010.