



## Physician Issues

### Background

*The Patient Protection and Affordable Care Act (ACA)* requires increased collaboration between hospitals and physicians to deliver high-quality, efficient care. In 2009, America's hospitals employed approximately 200,000 physicians, including interns and residents, and that number is expected to increase. Strong leadership teams and hospital-physician partnerships are needed to guide the complex changes coming as a result of health reform. As such, the AHA has identified several areas that directly affect physicians who work in hospitals.

### AHA View

**Physician Payment.** The Medicare physician payment formula is severely flawed and would have resulted in significant payment cuts to physicians in 2010 without legislative action. Congress intervened numerous times to prevent scheduled payment reductions and provided physicians with a 2.2 percent update from June 1 through December 31, 2010. Physicians were scheduled to receive a 25 percent cut in their Medicare payments as of January 1, 2011, but Congress passed the *Medicare and Medicaid Extenders Act of 2010* (MMEA), which delayed implementation of this cut and extended physician payments at 2010 levels for one year, through 2011. **The AHA supports a replacement of the flawed physician payment formula; the fix should be done in a manner that does not result in reduced payments to other providers. In the interim, legislation should be enacted to prevent the cuts to physicians scheduled to begin January 1, 2012.**

**Physician Supervision.** For the past three years, the Centers for Medicare & Medicaid Services (CMS) has modified its policies related to the "direct supervision" of outpatient therapeutic services. These policy modifications have magnified physician shortage problems, especially in rural areas. For 2011, at the AHA's urging, CMS adopted several positive changes to the regulations. Specifically, the agency:

- Revised the definition of "direct supervision" to require that the supervising physician be "immediately available to furnish assistance" rather than be physically present on the same campus or in the provider-based department;
- Created a two-tiered supervision approach for certain services so that direct supervision is required only for the "initiation" of the service followed by general supervision;
- Made a commitment to establish a process for independent review of alternate supervision levels in 2012 rulemaking; and
- Delayed enforcement of the direct supervision policy through calendar year (CY) 2011 for critical access hospitals and small and rural hospitals with fewer than 100 beds.

While we are pleased with this increased flexibility, the AHA remains concerned that the regulations are vague and confusing. We continue to disagree with CMS' repeated assertion that it has required direct supervision of outpatient therapeutic services since 2001. The AHA continues to work with CMS and Congress to make additional fundamental changes to the supervision policy. Specifically, **we will urge the agency to adopt a default standard of "general supervision" for outpatient therapeutic services**, indicating that these procedures should be performed under the physician's overall direction and control, but the physician's presence should not be required during the performance of the procedure. In addition, we will urge CMS to develop a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision levels. Refer to the AHA issue paper "Medicare" for more information.

**EHR Incentive Program.** In 2009, Congress passed the *American Recovery and Reinvestment Act* (ARRA), which included \$19.2 billion in funds to increase the use of electronic health records (EHRs) by physicians and hospitals. While the physician community is moving forward with adoption of EHRs, like hospitals, they have encountered a number of challenges due to complicated and confusing regulations. For example, CMS has required that each individual physician personally register for the meaningful use incentives and attest to meeting the program's requirements. **The AHA will work to ensure that hospitals, with permission, can help their physicians sign up for the program and attest to meeting its requirements.**

The limited exception to the Stark law and anti-kickback law safe harbor that permit hospitals to assist physicians in developing EHRs will expire December 31, 2013. **The AHA will urge policymakers to extend these regulatory provisions beyond the current expiration date. In addition, the regulation should include greater flexibility, such as allowing hospitals to share hardware or completely subsidize connectivity and software.**

**Physician Quality Reporting.** In 2007, Congress enacted a voluntary Physician Quality Reporting System (PQRS) program that provides an incentive payment to physicians, eligible professionals (EP) and group practices who satisfactorily report data on certain quality measures under the physician fee schedule (PFS). This program, previously referred to as the physician quality reporting initiative (PQRI), has undergone several legislative changes. Most recently, the ACA extended the voluntary quality reporting program through 2014 and established a mandatory quality reporting program in 2015. For 2011, successful participants can earn an incentive payment of 1 percent of their total PFS charges. **The AHA is committed to partnering with physicians, eligible professionals and others to ensure that hospital and physician quality measures are harmonized and support high-quality, efficient care across the continuum of care.**

**eRx Incentive Program.** Congress in 2009 adopted the Electronic Prescribing (eRx) Incentive Program for physicians and other EPs to promote the adoption and use of electronic prescribing. The eRx incentive program is separate from, and in addition to, the PQRS. Qualifying EPs may receive an incentive payment of 1 percent of their total PFS charges in 2011, with penalties for nonparticipation beginning in 2012. CMS will not allow EPs to receive incentive payments from both the eRx and Medicare EHR programs.

The PQRS, eRx and EHR incentive programs present overlapping and often conflicting reporting requirements for EPs who may be eligible for incentive payments or subject to penalties. **The AHA will encourage CMS to address the inconsistencies in its incentive programs and remove the overlap in reporting requirements to minimize the administrative burden on physicians and better encourage their reporting of quality measures and use of health information technology.**

**Extension of Key Legislative Provisions.** The MMEA not only prevented a scheduled payment cut for physicians, it also extended a number of important provisions affecting physicians. The law extended through CY 2011 the existing 1.0 floor on the physician work index; the ability of independent laboratories to receive direct payments for the technical component for certain pathology services; and the 5 percent increase in payments for certain Medicare mental health services. **The AHA will urge Congress to continue to extend these key provisions through CY 2012 and beyond.**