American Hospital Association

Physician Issues

Background

The Patient Protection and Affordable Care Act (ACA) provides strong incentives to increase collaboration between hospitals and physicians to deliver high-quality, efficient care. Success in value-based purchasing, reducing readmissions and managing costs within a bundle or per capita rate requires making physicians full partners in examining and redesigning care processes. In 2010, America's community hospitals employed approximately 212,000 physicians, including interns and residents, and that number is growing rapidly. 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 physician issues that affect hospitals.

AHA View

Physician Payment. The Medicare physician payment formula is severely flawed and would have resulted in significant payment cuts to physicians in 2012 without legislative action. In February, Congress passed the *Middle Class Tax Relief and Job Creation Act of 2012,* which prevented a 27.4 percent cut to Medicare physician payments that was scheduled to take effect March 1, and provided physicians with a zero percent update for the remainder of the year. **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, 2013.**

Direct Supervision. For the past four years, the Centers for Medicare & Medicaid Services (CMS) has modified its policies related to the "direct supervision" of outpatient therapeutic services, threatening to magnify physician shortage problems. For 2012, at the AHA's urging, CMS adopted several positive changes to the regulations. Specifically, the agency:

- Allowed non-physician practitioners authorized to furnish direct supervision to also provide general or personal supervision for certain services;
- Established a process for independent review of alternate supervision levels using the Advisory Panel on Hospital Outpatient Payments; and
- Delayed enforcement of the direct supervision policy through calendar year (CY) 2012 for critical access hospitals (CAHs) and small and rural hospitals with fewer than 100 beds.

While we are pleased with this increased flexibility, the AHA remains concerned that hospitals and CAHs will have difficulty implementing these requirements. We continue to disagree with CMS's 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 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 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*, 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. At the end of 2011, the first year of the program, only 4 percent of physicians received incentive payments for achieving "meaningful use" of EHRs. In March, CMS published a proposed rule defining Stage 2 of meaningful use. **The AHA is concerned that the proposed Stage 2 rule asks for too much, and we will urge the development of final rules that represent a true incremental change from Stage 1, resolve problems with the clinical quality measures, and implement fairly the EHR payment penalties that begin in fiscal year 2015.** (Refer to the AHA issue paper "Health Information Technology" for more information.)

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. The ACA extended the voluntary Physician Quality Reporting System (PQRS) program through 2014, which provides an incentive payment to physicians, eligible professionals (EPs) and group practices who satisfactorily report data on certain quality measures under the physician fee schedule (PFS). For 2012, successful participants can earn an incentive payment of 0.5 percent of their total PFS charges. Beginning 2015, the ACA implements a mandatory physician quality reporting program, where EPs will be penalized 1.5 percent of their payments if they fail to successfully report quality measures. The penalty increases to 2.0 percent in 2016 and beyond. CMS estimates that approximately 20 percent of EPs are successfully reporting quality data. **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. For 2012, EPs who are successful electronic prescribers may receive an incentive bonus of 1.0 percent. Those providers who do not participate will receive a 1.0 percent payment penalty. CMS estimates that only 15 percent of all EPs are participating in the eRx program. In order to allow more providers to meet the program's requirements and thus be exempt from the payment penalty, **the AHA will urge CMS to base the 2013 payment penalty on a full year of CY 2012 data (rather than data from the first six months of CY 2012).**

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 number of EPs that have adopted these programs remains low. Physicians and EPs have a number of competing demands related to their information technology systems, including adoption of certified EHRs, new rules for electronic claims submission and other administrative transactions (5010), movement to a new coding system for payment (ICD-10), and the introduction of other health reform initiatives. **The AHA will encourage CMS to adopt reasonable implementation timeframes and remove the overlap in reporting requirements to minimize the administrative burden on physicians and encourage their reporting of quality measures and use of health information technology.**

Physician Leadership Forum. An essential element to transform America's health care is a strong collaborative relationship between hospitals and physicians. To foster that collaboration, the AHA launched the Physician Leadership Forum (PLF) in 2011 as a new way for physicians and hospitals to advance excellence in patient care. Through the PLF, the AHA works closely with the medical community to identify best practices to deliver value-based care and disseminate them through educational offerings and resources. The PLF also offers physicians a unique opportunity to participate in the AHA policy and advocacy development process. To learn more, visit www.ahaphysicianforum.org