



Physicians & Non-physician Practitioners

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 2011, America's community hospitals employed approximately 226,000 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 2013 without legislative action. In December 2012, Congress passed the *American Taxpayer Relief Act (ATRA)*, which prevented a 26.5 percent cut to Medicare physician payments that was scheduled to take effect Jan. 1, and provided physicians with a zero percent update for the remainder of the year. The cost of this payment fix was \$25 billion. Unfortunately, this fix, along with other provisions, was funded in part by an \$11 billion documentation and coding reduction to hospital inpatient payments. **While averting a cut in payments to physicians was essential, it should not have been financed by reducing payments to hospitals. We will continue to work with Congress to find a permanent solution to the Medicare physician payment problem, while strongly opposing additional cuts that could be harmful to hospitals' ability to fulfill their mission of caring.**

Direct Supervision. In the calendar year (CY) 2009-2013 outpatient prospective payment system (PPS) rules, the Centers for Medicare & Medicaid Services (CMS) mandated new requirements for "direct supervision" of outpatient therapeutic services. Direct supervision requires that a physician or a non-physician practitioner (NPP) be immediately available to furnish assistance or direction throughout the performance of a procedure. Small, rural PPS hospitals and critical access hospitals (CAHs) have expressed concern that shortages of physician and NPPs in their communities make it difficult to comply with the direct supervision requirements. For CY 2013, as requested by the AHA, CMS again extended its policy not to enforce the direct supervision policy for therapeutic services provided in CAHs and rural hospitals with 100 or fewer beds. CMS expects this to be the final year of the enforcement moratorium and encourages hospitals to use the time to come into compliance with the supervision standard. CMS notes that the extension also will provide additional opportunities for stakeholders to bring their issues to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and for the panel to evaluate and provide recommendations on supervision of outpatient therapeutic services.

The HOP Panel is charged with assessing the appropriate supervision levels for individual hospital outpatient therapeutic services. As a result of the panel's input, CMS in 2012 reduced the level of supervision for 49 outpatient therapeutic services.

While the AHA appreciates CMS's efforts to make the requirements more flexible, we continue to be concerned that hospitals and CAHs will have difficulty implementing these requirements, and timely access to services will be reduced. **The AHA continues to work with CMS and Congress to make more fundamental changes to the outpatient PPS supervision policy. A workable solution would:**

- Adopt a default standard of “general supervision” for outpatient therapeutic services and then apply reasonable exceptions to identify specific procedures that should be subject to direct supervision;
- Ensure that for CAHs, the definition of “direct supervision” is consistent with the CAH conditions of participation that allow a physician or non-physician practitioner to present within 30 minutes of being called; and
- Prohibit enforcement of CMS's retroactive reinterpretation that the “direct supervision” requirements applied to services furnished since Jan. 1, 2001.

Physician Quality Reporting. The ACA extended the voluntary Physician Quality Reporting System (PQRS) program through 2014. The program provides an incentive payment to physicians, eligible professionals (EPs) and group practices that satisfactorily report data on certain quality measures under the physician fee schedule (PFS). In 2011, more than 280,000 EPs participated individually in the PQRS, and CMS paid more than \$261 million in incentive payments. For 2013, successful participants can earn an incentive payment of 0.5 percent of their total PFS charges. Beginning in 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 2015 penalty will be based on 2013 reporting. This 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 2013, EPs who are successful electronic prescribers may receive an incentive bonus of 0.5 percent. Those providers who do not participate will receive a 1.5 percent payment penalty.

In 2011, CMS paid 282,000 EPs more than \$285 million in eRx payments, and another 136,000 EPs were subject to the 2012 eRx payment penalty because they either did not meet the eRx reporting requirements in the first half of 2011, did not meet exclusion criteria for the adjustment, or did not otherwise qualify for an exemption. **Last year, at the AHA's urging, CMS adopted additional hardship exemption categories and extended the deadline for EPs to request an exemption. We will continue to urge CMS to base the 2013 payment penalty on a full year of CY 2013 data (rather than data from the first six months of CY 2013) to allow more EPs to satisfactorily meet the program requirements.**

Electronic Health Records. 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 2012, the second year of the program, only 106,000 eligible physicians and other professionals received incentive payments for achieving "meaningful use" of EHRs. Nevertheless, the Department of Health and Human Services is on track to raise the bar significantly in Stage 2 of meaningful use. **The AHA is concerned that the Stage 2 rules asks for too much, too soon, and we will carefully monitor the transition from Stage 1, with particular focus on clinical quality measures and EHR payment penalties that begin in fiscal year 2015.** (Refer to the AHA issue paper, "Health Information Technology," for more information.)

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. While the number of EPs who have adopted these programs has increased significantly over the past year, the total number of EPs participating remains low. Physicians and EPs have a number of competing demands related to their information technology systems, 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.**

In addition, the limited exception to the Stark law and anti-kickback law safe harbor that permit hospitals to assist physicians in developing EHRs will expire Dec. 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 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. In addition, in 2013, the AHA added a Committee on Clinical Leadership to its governance and policy groups to offer physicians a unique opportunity to participate in the AHA policy and advocacy development process. To learn more, visit www.ahaphysicianforum.org.

