



## Physician Issues

### Background

The Affordable Care Act (ACA) provides strong incentives to increase collaboration between physicians and hospitals to deliver high-quality, efficient care. Success in value-based purchasing, reducing readmissions and managing costs within a bundle or per capita rate requires involving physicians as full partners in examining and redesigning care processes. In 2012, America's community hospitals employed approximately 233,000 physicians, including interns and residents, and that number is growing rapidly. Strong leadership teams and physician-hospital partnerships are needed to guide the complex changes already set in motion. As such, the AHA works on several physician issues that affect hospitals.

### AHA View

**Physician Payment.** The recently passed Protecting Access to Medicare Act of 2014 halts a projected 23.7 percent cut in Medicare physician payments by providing physicians and non-physician practitioners paid under the Medicare Physician Fee Schedule a 0.5 percent update through Dec. 31, 2014 and a 0 percent update from Jan. 1, 2015, through March 31, 2015. On April 1, 2015, physicians will once again face a significant decline in Medicare payments due to the flawed sustainable growth rate (SGR) formula.

While congressional leaders agreed on policies to permanently fix the SGR formula – outlined in the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015/S. 2000) – no agreement has been reached on how to pay for the legislation's significant cost. The legislation would permanently repeal the SGR and implement a performance-based payment system beginning in 2018. HR. 4015/S. 2000 would consolidate the current law Physician Quality Reporting System (PQRS), meaningful use program and physician value-based payment modifier (VBM) and eliminate the penalties associated with those programs. In addition, physicians would be incentivized to participate in alternative payment models, such as the Medicare Shared Savings Program.

**The AHA will continue to work with Congress to find a permanent solution to the Medicare physician payment problem, while strongly opposing hospital payment reductions to pay for the SGR fix.**

**Physician Quality Reporting and Pay-for-Performance.** Under the PQRS in current law, individual physicians and physician groups are required to report quality measures to earn an incentive payment or, beginning in 2015, avoid a payment penalty. Performance on these PQRS measures are then tied to payment through the VBM, with physicians eligible for an upward or downward payment adjustment of up to 1 percent in 2015 and up to 2 percent in 2016.

Hospitals have focused increasingly on physician quality reporting and pay-for-performance programs as integration efforts become more prevalent. In addition to direct employment, hospitals contract with physicians on a group or individual basis, such as emergency physicians or hospitalists. Physicians and hospitals are eager to build on integration efforts to better align quality improvement goals

and strategies, thereby improving care across the continuum. However, concerns exist that, to date, the reporting requirements, measures and scoring methodology for PQRS and VBM have been completely different than those used in analogous reporting and pay-for-performance programs for hospitals (e.g., the Inpatient Quality Reporting Program and the value-based purchasing program).

**To further encourage alignment of quality improvement goals and strategies between physicians and hospitals, the AHA will continue to urge the Centers for Medicare & Medicaid Services (CMS) to allow hospital-based physicians to use their hospitals' inpatient and outpatient quality reporting measures and data to meet PQRS and VBM requirements.** Using hospital-based measures would allow hospitals and affiliated physicians to be held accountable for performance on the same issues, thereby enhancing coordination and leading to improved quality and efficiency for patients.

**Electronic Health Records.** While the physician community is moving forward with adoption of electronic health records (EHRs), like hospitals, they have encountered a number of challenges due to complicated and confusing regulations. While the number of eligible professionals (EPs) who are participating in the EHR incentive program has increased over the past year, the total number of participating EPs remains low overall. Efforts to allow physicians to submit quality reports to PQRS, the Comprehensive Primary Care Initiative and EHR incentive programs present overlapping and often conflicting reporting requirements leading to compliance confusion for EPs. To date, efforts by CMS and the Office of the National Coordinator for Health Information Technology (ONC) have not enabled EHRs to generate feasible, reliable and valid quality data necessary for clinical quality reporting purposes; nor do EHR data provide accurate representations of physician performance. In addition, capturing electronic clinical quality measures (eCQM) data is significantly adding to clinicians' workload without perceived benefit to patient care. The current scale and pace required to adopt the meaningful use requirements that begin in 2014 for physicians ask for too much, too soon.

**In late February, the AHA, along with 47 other organizations, urged the secretary of Health and Human Services (HHS) to extend through 2015 the timelines for hospitals, physicians and other EPs to implement 2014 Edition Certified EHRs and add flexibility in meaningful use requirements. The AHA continues to urge CMS to remove the overlap and conflict in reporting requirements.** (Refer to the AHA issue paper, "Health Information Technology," for more information.)

Supporting Physician Adoption of EHRs. The AHA is pleased that, in response to our advocacy, HHS issued a final rule that extended through 2021 the limited exception to the Stark law and the anti-kickback law safe harbor that permits hospitals to assist physicians in developing EHRs. Those protections were set to expire on Dec. 31, 2013.

**Physician Leadership Forum.** An essential element to transforming America's health care is a strong collaborative relationship between physicians and hospitals. The AHA's Physician Leadership Forum (PLF) provides an avenue for physician-hospital collaboration to advance excellence in patient care. Through the PLF, the AHA works closely with the medical community to identify critical issues and solutions to improve the performance of physicians and hospitals, including value-based care delivery, adoption of physician competencies and development of new models of care delivery. The PLF shares learning and thought leadership through educational offerings, publications and other resources. In addition, the PLF partners with physician-based associations to improve physician development and leadership training. The AHA's Committee on Clinical Leadership offers a unique opportunity for a clinical perspective to be included in the AHA policy and advocacy development process. To learn more, visit [www.ahaphysicianforum.org](http://www.ahaphysicianforum.org).