Washington Update

AHA Physician Leadership Forum
January 26, 2012
What did Congress do?

Extensions until February 29

- Payroll tax cut
- Unemployment compensation benefits
- Medicare physician payment (prevents 27.4 percent cut)
- Medicare extenders

[Cartoon image: Kicking the "can" down the road]
Congressional schedule

January

<table>
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<td>2</td>
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<td>(New Year's Day observed)</td>
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<td></td>
<td>Martin Luther King Jr. Day</td>
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<tr>
<td>House convenes</td>
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<td>House Republican retreat</td>
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<td>23</td>
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<tr>
<td>Senate convenes</td>
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February

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<tr>
<td>Presidents Day</td>
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<td>Ash Wednesday</td>
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<td></td>
<td></td>
<td>House in session, Senate calendar uncertain</td>
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Both chambers: In session

One chamber in session:

- House only
- Senate only
House and Senate Pass Two-Month Physician Fix

*No cuts to hospitals included*

Friday, December 23, 2011

The House and Senate today gave final approval to a two-month extension of the Social Security (SS) payroll tax holiday and emergency unemployment insurance (UI) benefits, along with a two-month extension of the current Medicare physician payment rates, thereby preventing a 27.4% cut to Medicare physician payments that was scheduled to take effect Jan. 1. The bill also includes extensions of the so-called health care “extenders” due to expire this year for an additional two months. The president is expected to sign the bill into law shortly.

Congress ultimately rejected a number of payment reduction options to hospitals to fund the legislation, including those passed by the House last week in H.R. 3630. This was in large part due to the grassroots efforts of hospital leaders throughout the country. Reports from Capitol Hill indicated that legislators were hearing from their hospital constituents, and that those contacts made the difference.

This development means that, while we avoided new payment reductions in the short term, we will be back debating these same issues early next year. The extensions will expire Feb. 29, so there will once again be pressure to identify offsets to finance the SS tax holiday, emergency UI benefits, and physician payment fix. Consequently, we will need to remain vigilant against unwarranted cuts in payments for hospital services as we begin the new year and the Second Session of the 112th Congress convenes.
Our challenge...the offsets

• Medicare bad-debt
• Medicare hospital outpatient (E&M codes) services
• Providing CMS with authority to make additional across-the-board cuts (retrospective coding offsets for FY 2010-2011)
• Extending cap (and exceptions process) on Medicare therapy services to HOPDs
• Relaxing restrictions on physician-owned hospitals
Key Hospital Provisions
(one year estimate)

- Section 508 area wage index reclassifications [$200 million]*
- Treatment of technical component of physician pathology services [$100 million]
- Payment adjustment for low-volume hospitals [$150 million]
- Reasonable cost reimbursement for laboratory services in small rural hospitals [Less than $50 million]
- Increase payments for ambulance services [$100 million]
- Hospital outpatient department hold-harmless payments [$200 million]**
- Medicare dependent hospital program [Less than $50 million]***

* Expires September 30, 2011
** Expires December 31, 2011
*** Expires September 30, 2012
Our strategy

Our Advocacy Message

- Support passage of Medicare extenders and physician fee fix

- *But, cannot support cutting payment for hospital services as method to finance...”Enough is Enough!”*

- Other alternatives exist for offsets...including OCO

- Also oppose relaxing restrictions on physician-owned hospitals
<table>
<thead>
<tr>
<th>House Republicans</th>
<th>Brady (TX)</th>
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<td></td>
<td>Camp (MI)</td>
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<td>Ellmers (NC)</td>
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<td>Hayworth (NY)</td>
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<td>Price (GA)</td>
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<td>Reed (NY)</td>
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<td></td>
<td>Upton (MI)</td>
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<td>Walden (OR)</td>
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<td>House Democrats</td>
<td>Becerra (CA)</td>
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<td>Levin (MI)</td>
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<td>Schwartz (PA)</td>
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<td>Van Hollen (MD)</td>
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<td>Waxman (CA)</td>
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<td>Senate Republicans</td>
<td>Barrasso (WY)</td>
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<td>Crapo (ID)</td>
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<td>Kyl (AZ)</td>
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<td>Senate Democrats</td>
<td>Baucus (D)</td>
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<td>Cardin (MD)</td>
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<td>Casey (PA)</td>
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Our strategy

• Advocacy ALERT
• Leveraging the jobs argument
  – New study
  – Media strategy

• Legislative strategy
  – Conferees
  – Leadership
  – Doctor’s caucus
  – House Republicans expressing concern
  – Elections
Hospital constituencies

- Medicare extenders and rural issues
- Medicare bad-debt reductions (high impact)
- Medicare GME (targeted)
- Medicare hospital outpatient (E&M) payment reductions (high impact)
- Extending cap on Medicare therapy services to HOPDs (high impact)
- Medicare post-acute care payment (targeted)
- Relaxing restrictions on physician-owned hospitals (targeted)
- Medicaid provider taxes (targeted)
Other controversial issues

• Other offsets
  – Overseas contingency operations
  – Millionaires tax

• Health care for health care
  – Length of physician “fix”

• Unemployment compensation reforms

• Riders
  – Keystone Pipeline
As the Deadline for Action Draws Near...

Plan to Come to Washington to Remind Your Legislators: “Don’t Cut Payments for Hospital Care”

Wednesday, February 15, 2012

The Burke Theater at the Naval Heritage Center
701 Pennsylvania Avenue NW
(between 7th and 9th Streets NW at the Navy Memorial)
Washington, DC

Join your colleagues as we again take to Capitol Hill to urge our legislators to extend key hospital provisions and reject cuts to Medicare payments for hospital services as part of any final agreement to extend the Social Security tax holiday, unemployment insurance benefits, and physician fix.

See the AHA Action Center at www.aha.org for our latest Advocacy Action Alert.

Schedule

9:00 a.m. – Continental Breakfast
9:30 a.m. – Briefing on Key Issues

Hill visits to follow

*Please coordinate your Hill appointments with your state hospital association.*

Click here to RSVP or go to http://www.surveymonkey.com/s/PNB973W

If you have any questions, please contact Michael McGue at m.mcgue@aha.org or 312-422-3319, or Debra Thomas at d.thomas@aha.org or 312-422-3327.

Hotel rooms available at the JW Marriott, Washington, DC for $259 (877.212.5752)
Mention the AHA (American Hospital Association) Advocacy Day.
IN THE
Supreme Court of the United States

FLORIDA, et al.,

Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

BRIEF FOR THE AMERICAN HOSPITAL
ASSOCIATION ET AL. AS AMICI CURIAE IN
SUPPORT OF NEITHER PARTY ON SEVERABILITY

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CATHERINE E. STETSON*
DOMINIC F. PERELLA
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(202) 637-5491
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Counsel for Amici Curiae
*Counsel of Record

(additional amicus representatives listed on inside cover)
Our position

• Individual (responsibility) mandated is constitutional
• Medicaid expansions are constitutional
• Severability should be decided by the Supreme Court
• If coverage expansions are thrown out...then budget reductions (update factor, DSH and readmissions) also must go
Regulatory Update:
Implications for Physicians
AHA Physician Leadership Forum
January 26, 2012
Today’s Agenda

• Changes Beginning January 1
• Physician Bonus/Penalty Programs
• Hospital Payment Reforms
• Innovation Center Opportunities
I. Policy Changes Jan 1, 2012

Medicare PFS Final Rule:

- Multiple Procedure Payment Reduction (MPPR)
- Three-day Payment Window
- Geographic Adjustment
- Annual Wellness Visit - Health Risk Assessment
- Telehealth Services

SGR and Extenders (Feb 29)
• 25% MPPR to the professional component of advanced imaging services (CT, MRI, ultrasound) provided by same practitioner to same patient in the same session

• CMS proposed a 50% MPPR

• The 50% MPPR to the TC continues
MPPR for Imaging Services (cont.)

- MPPR will not apply when MD interprets images in separate sessions (Use “-59 modifier”)
- Policy is budget neutral - redistributes ~$50 million
- Reduces payments to the specialties of radiology and interventional radiology

CMS will explore further expansion of MPPR policy for CY 2013
Bundling/3-Day Payment Window

- Outpatient diagnostic and non-diagnostic services
- Performed in a physician office or clinic wholly owned or operated by a hospital
- Within 3-days of a hospital admission
- Services paid at lower the lower facility (rather than non-facility) rate

Begins July 1, 2012 (delayed from Jan 1)
Bundling/3-Day Payment Window

• Does not apply:
  – When admitting hospital and physician clinic are owned by a third entity
  – When the admitting hospital is not the sole owner or operator of the physician clinic
  – To physician nondiagnostic services unrelated to the hospital admission
  – To FQHCs and RHCs
Geographic Adjustment

• Based on revised and rebased 2006 MEI

• Other policy changes for 2012
  – Revise the occupations and use BLS Occupational Employment Statistics to calculate the PE employee wage index
  – Use rent data from the 2006-2008 American Community Survey (not HUD rental data)

• IOM study
Annual Wellness Visit

• ACA provision effective Jan 1, 2011

• Mandates inclusion of a Health Risk Assessment (HRA)...

• CMS finalizes a set of minimum topics the HRA must include.

• Payment through same Level II PCPCS codes, but payment rate increased
Telehealth Services

- Smoking/tobacco cessation counseling added to list of approved Medicare telehealth services

- Loosened criteria for adding new codes to the list
  - No longer comparability standard
  - Now clinical benefit standard
II. Physician Incentive Programs

- Electronic Prescribing (eRx)

- Medicare and Medicaid Electronic Health Record (EHRs)

- Quality reporting (PQRS / VBM)
Electronic Prescribing

• For 2012: **1.0% bonus** if report on one eRx measure for at least 25 unique e-prescribing events (2013 = 0.5% bonus)

• Penalties for non-participation
  – **2012 = 1.0%**, 2013 = 1.5%, 2014 = 2.0%

• **To avoid 2012 penalty**, must have reported on 10 e-prescribing events by June 30, 2011 or filed for a significant hardship exemption
Electronic Prescribing

Significant Hardship Exemptions (2013/2014)

• In a rural area with limited high-speed Internet access;

• Limited available pharmacies for e-prescribing;

• Unable to e-prescribe due to local, state or federal law; or

• Prescribe fewer than 100 prescriptions during a six-month payment adjustment reporting period.

In 2012, exempt if adopted a certified EHRs (and applied for the exemption) last fall
AHA continues to believe that penalties should be based on a full year of data

<table>
<thead>
<tr>
<th>eRx Program Year</th>
<th>Reporting Period</th>
<th>Reporting Period</th>
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<tbody>
<tr>
<td></td>
<td><strong>For the Payment Bonus</strong></td>
<td><strong>For the Payment Penalty</strong></td>
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</table>
eRx – Status Update

- Currently only 15% of EPs (about 100,800) are participating in the program

- CMS estimates bonus payments of $74 million in 2012 (and $37 million in 2013)

- CMS estimates payment penalty will be $111 million in 2013 and $148 million in 2014 (no estimate for 2012 was provided)
Physician Quality Reporting

Voluntary PQRS

– Bonus payment:
  • 2012, 2013 and 2014 = 0.5%
  • CMS estimates bonuses of $60 million in 2012

– Penalty:
  • 2015 = negative 1.5%
  • 2016 = negative 2.0%

New for CY 2012

– Changed definition of group practice to 25 or more EPs (thus eliminating GPROs with 2-24 EPs)
– Adopts 32 new measures (via claims/registry), 29 new core measure sets, and 8 new measure groups
– Makes all 44 EHR quality measures available for reporting in PQRS
Public Reporting

- Beginning 2013, ACA requires public reporting of physician performance
- CMS will start by reporting on performance of group practices not individual EPs
- Data will be on Physician Compare

Maintenance of Certification

- 0.5% bonus (2011-2014) for participation in a qualified MOC program
**Value-Based Payment Modifier**

- **Budget neutral**
- Reporting period is CY2013 (baseline)
  - Individual EPs – 44 quality measures
  - GPROs – 31 quality measures
  - 5 efficiency measures
    - Total Medicare Part A & B spending, and
    - Total Medicare Part A & B spending for beneficiaries with COPD, heart failure, CAD and diabetes.

- **Implementation in 2015** for specific physicians (TBD) and groups of physicians
- Phased up to all physicians by 2017
Update On EHR Incentive Programs

- Medicare and Medicaid EHR incentive program registrations:
  - 3,077 Hospitals
  - About 173,000 Physicians/EPs

- A growing number, but still small share, have been paid for meeting meaningful use requirements
  - 604 Hospitals
  - 15,859 Physicians

- 41 states have opened Medicaid programs

Data from CMS, as of end-December 2011
Trends in Year-to-Date Payments, in millions, May through December 2011

Payments to eligible professionals and hospitals under the Medicare and Medicaid EHR incentive programs

Data from CMS, as of end-December 2011.
Most, but not all, states have now established Medicaid EHR incentive programs.

Red = Made Payments (33);
Blue = Accepting Registrations (8)
Data from CMS as of December 2011
### Physician Payment

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<td><strong>Payment Update</strong></td>
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<tr>
<td>(SGR)</td>
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<td>-27.4%</td>
<td>March 1</td>
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<tr>
<td><strong>eRx</strong></td>
<td>+ 1.0%</td>
<td>+ 1.0% or -1.0%</td>
<td>+0.5% or -1.5%</td>
<td>- 2.0%</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td><strong>EHR</strong></td>
<td>+ $18K</td>
<td>+$12-18K</td>
<td>+$8-15K</td>
<td>+$4-12K</td>
<td>+$2-8K or -1.0%</td>
<td>$2-4K or -2.0%</td>
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<tr>
<td><strong>PQRS</strong></td>
<td>1.0% or 1.5% (MOC)</td>
<td>0.5% or 1.0% (MOC)</td>
<td>0.5% or 1.0% (MOC)</td>
<td>0.5% or 1.0% (MOC)</td>
<td>-1.5% non reporting</td>
<td>-2.0% non reporting</td>
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### III. Hospital Payment Reforms

#### Mandatory Programs

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<tr>
<th>Inpatient PPS</th>
<th>Fiscal Year 2013</th>
<th>Fiscal Year 2014</th>
<th>Fiscal Year 2015</th>
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<tr>
<td>Hospital Value-Based Purchasing</td>
<td>MB – 1.0 Potential for Earn Back</td>
<td>MB – 1.25 Potential for Earn Back</td>
<td>MB – 1.5 Potential for Earn Back</td>
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<tr>
<td>Readmissions</td>
<td>MB – Hosp-specific amount capped at 1.0</td>
<td>MB – Hosp-specific amount capped at 2.0</td>
<td>MB – Hosp-specific amount capped at 3.0</td>
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<td>Hospital Acquired Conditions</td>
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<td>MB – 1.0 For Bottom Quartile Hospitals</td>
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## Final vs. Proposed ACO Program

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<th>Measure</th>
<th>Final ACO Program</th>
<th>Proposed ACO Program</th>
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<tr>
<td>Beneficiary attribution</td>
<td>Prospective</td>
<td>Retrospective</td>
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<tr>
<td>Start date</td>
<td>April 1 or July 1, 2012</td>
<td>Jan 1 or July 1 2012</td>
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<td>Anti-trust</td>
<td>No pre-approval</td>
<td>Pre-approval</td>
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<tr>
<td>Annual risk-adjustment</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Quality measures</td>
<td>33 Reported</td>
<td>65 Reported</td>
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<tr>
<td>Meaningful use</td>
<td>None</td>
<td>50% of primary care</td>
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<tr>
<td>Marketing guidelines</td>
<td>File and use</td>
<td>Pre-approval</td>
</tr>
<tr>
<td>Governance</td>
<td>75% of board must be providers</td>
<td>75% of board must be providers</td>
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</table>
## Final vs. Proposed ACO Program

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<tr>
<th>Measure</th>
<th>Final ACO Program</th>
<th>Proposed ACO Program</th>
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<tbody>
<tr>
<td>First dollar savings</td>
<td>Track 1 and 2</td>
<td>Track 2 only</td>
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<tr>
<td>Down-side risk</td>
<td>Track 2 only</td>
<td>Track 1 and 2</td>
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<tr>
<td>Withhold</td>
<td>None</td>
<td>25%</td>
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<tr>
<td>Sharing Rate</td>
<td>50/50 (1) and 60/40 (2)</td>
<td>50/50 (1) and 60/40 (2)</td>
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<tr>
<td>Benchmark adjustments</td>
<td>Removes IME, DSH (no wage or VBP)</td>
<td>None</td>
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<td>Savings threshold</td>
<td>3.9 – 2.0%</td>
<td>3.9 – 2.0%</td>
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The Bottom Line.... Final rule

<table>
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<tr>
<th>Total Savings</th>
<th>CMS Share of Savings</th>
<th>ACO Share of Savings</th>
<th>Total Savings</th>
<th>CMS Share of Savings</th>
<th>ACO Share of Savings</th>
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<tr>
<td></td>
<td>90%</td>
<td>10%</td>
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<td>60%</td>
<td>40%</td>
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IV. Innovation Center (CMMI)

Accountable Care Organizations

- **Pioneer ACO Model**
  - 32 organizations chosen
  - Move more rapidly to a population-based payment model
  - Began Jan 1, 2012

- **Advanced Payment Model**
  - Provide up-front funds to develop ACOs
  - Physician models – those with no inpatient facilities AND less than $50 million in revenue
  - Advanced payment recouped by shared savings ACO earns
CMMI Bundled Payment Initiative

Model 1
- Initiating Event: Hospital Stay
- 30-day Post Discharge: No services
- Review Period: 30-day Review Period

Model 2
- Initiating Event: Hospital Stay
- 30-day Post Discharge: All services (30-89 days) or (90 + days)
- Review Period: 30-day Review Period

Model 3
- Initiating Event: Post Acute Service
- 30-day Post Discharge: All services (including readmissions)
- Review Period: 30-day Review Period

Model 4
- Initiating Event: Hospital Stay
- 30-day Post Discharge: Related 30-day Readmissions Only
- Review Period: 30-day Review Period

Applications for Models 2-4 now due on April 30, 2012
Comprehensive Primary Care Initiative

- Link private payers with Medicare to invest in primary care
- Monthly care management fee to the PC practices for their FFS Medicare beneficiaries
- In years 2-4, potential for shared savings

Health Innovation Challenge

- $1 billion in awards to test programs that improve quality and decrease costs

The Innovation Advisors

- 73 to date. Second round open in Spring 2012
Innovation Center (CMMI)

Partnership for Patients

• Goal: Decrease HACs by 40% and readmissions by 20% in 3 years
• AHA one of 26 “hospital engagement networks”
• Potential to save up to $10 billion in Medicare savings
Regulatory Update: Implications for Physicians
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