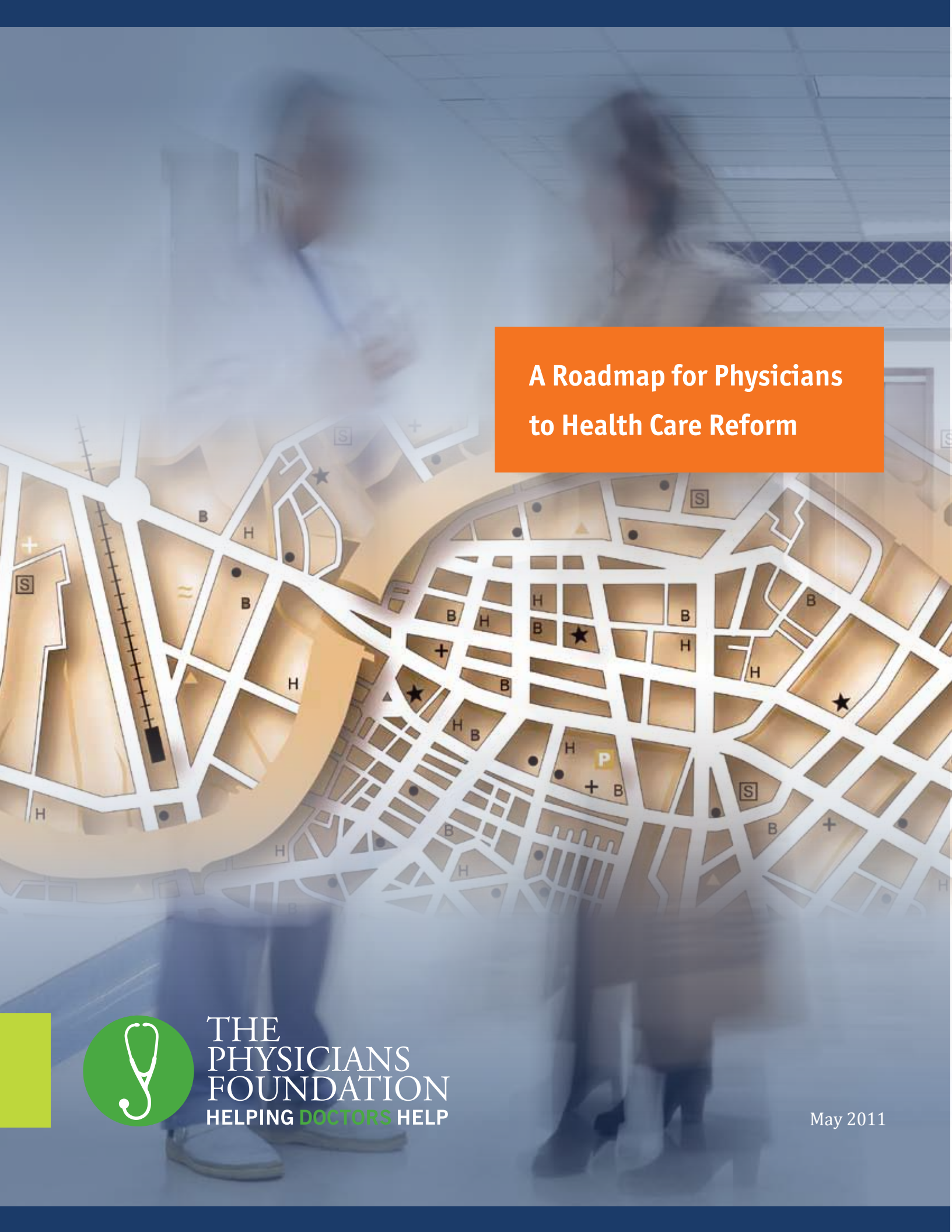

# A Roadmap for Physicians to Health Care Reform

THE PHYSICIANS FOUNDATION
HELPING DOCTORS HELP

May 2011

# *A Roadmap for Physicians to Health Care Reform*

A Report Examining the Impact of Health Care Reform on Physicians

**Prepared by:**

Bostrom

and

Old Creekside Consulting

**Prepared on Behalf of**

THE PHYSICIANS FOUNDATION

Physicians Committed to a Better Health Care System for All Americans

**About the Physicians Foundation**

The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and to improve the quality of healthcare for all Americans. It pursues its mission through a variety of activities including grant-making, research and policy impact studies. Since 2005, The Foundation has awarded numerous multi-year grants totaling more than $28 million. In addition, The Foundation focuses on the following core areas: health system reform, health information technology, physician leadership, workforce needs and pilot projects. As the health system in America continues to evolve, The Physicians Foundation is steadfast in its determination to foster the physician/patient relationship and assist physicians in sustaining their medical practices during this evolution.

**LEAD AUTHORS**

The authors want to thank Lou Goodman, PhD; President, Walker Ray, MD, Vice President; and Tim Norbeck, Chief Executive Officer of the Physicians Foundation who provided support throughout this project. More information about the Physicians Foundation can be found at www.physiciansfoundation.org.

### *Kathy Means, Lead Author*

Ms. Means is a nationally recognized expert on Medicare, Medicaid and health care reform, and manages Old Creekside Consulting, an independent health care consultancy located in Fredericksburg, VA. For more information on Old Creekside Consulting you may contact Kathy Means at meanskathleen@msn.com.

### *Ken Monroe, Author/Editor*

Ken Monroe is a recognized expert in the management of not-for-profit associations including the American Medical Association where he was COO for ten years. He now serves as the Chairman and CEO of Bostrom, a leading association management and professional services company providing comprehensive management, consulting and outsourcing services to professional societies, trade associations and charitable organizations. For more information about Bostrom visit www.bostrom.com.

## Foreword

The Physicians Foundation (PF) surveys, completed in 2008 and 2010 by Merritt Hawkins, revealed a deep sense of physician frustration, stress and anxiety. Navigating an increasingly hostile practice environment was causing widespread dissatisfaction and low morale. In the wake of burgeoning insurance red tape and government regulatory measures—plus the constant threat of a liability action—physicians were having serious problems in sustaining their medical practices.

And then along came The Affordable Care Act (ACA), passed by Congress on March 23, 2010. With its myriad of provisions affecting physician practices, not to mention its length and sheer comprehensiveness, physician angst only multiplied. Many physicians throughout the country openly expressed their disillusionment and concerns with the legislation. In taking over the U.S. House of Representatives in the mid-term elections, many newly elected Republicans campaigned against the ACA. Suddenly the future of this health reform legislation was somewhat in doubt, as legal and court challenges were mounted from a number of states. The ACA became a moving target while physician practices were struggling to cope with the new requirements. There was now a question over how the practice terrain might be impacted or possibly changed by the political posturing of both parties with regard to the legislation.

With this physician turmoil, and in light of the unstable political landscape, the Physicians Foundation wanted to provide something of value to America's physicians—and in a very readable format. Therefore, the PF contracted with Ken Monroe of Bostrom, a well-respected national association management and professional services company, and Kathy Means of Old Creekside Consulting, an independent consultancy on health care legislation and regulations, to produce a white paper examining the provisions of the ACA and how they will impact physician practices. We wanted it to be a non-partisan Roadmap for Physicians to answer questions and help physicians to better navigate through all of the practice uncertainties ahead.

It is hoped that this Roadmap may help to alleviate some physician concerns, anxieties and fears, and to better enable them to move forward as they strive to make their practices more sustainable.

For the Research Committee of the PF
Walker Ray, MD

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# Executive Summary

**INTRODUCTION** What is the truth about health care in America? Is it the vision of the current trillion dollar medical-industrial complex that grows unchecked in cost and complexity? Or is it the private space that occurs between a physician and patient as the patient seeks medical counsel and care? These are two real points on a wide continuum. The seemingly unbridgeable gulf between them illustrates the challenge of health care reform. The central challenge is how to balance evidence-based and effective health care with appropriate cost management starting at the entry point, which is where physicians counsel, diagnose and prescribe care for individual patients.

Last year, the U.S. Congress enacted a package of health care laws of unprecedented scope and complexity known as the Patient Protection and Affordable Care Act (more commonly, the ACA). The Congressional framers of the ACA had the deepest of ambitions to reshape the American health care system.

The Congress sought to:

1. Significantly expand health insurance coverage,
2. Establish a new federal framework for the offering of private health insurance plans and employer-based coverage,
3. Reshape Medicaid and create wider availability of public subsidies to lower income individuals and families for access to health insurance,
4. Reshape the financing and operational relationships between states and the federal government on these matters, and
5. Lower the cost trajectory of the Medicare program while strengthening quality programs and adoption of health information technology (HIT).

The Congress also created a requirement for individuals to carry insurance in the future or to pay a federal penalty for doing so (aka "the individual mandate"). Across all the sources of

health insurance, private and public (including Medicare), new initiatives were created to drive the adoption of value-based purchasing concepts. There are numerous provisions intended to foster the use of health technology in quality standards and performance measurement, in electronic medical records and in electronic prescribing. Other provisions are intended to improve access to care in rural areas, and to promote improvements in prevention, comparative effectiveness research (CER), and the healthcare workforce.

In seeking remedial control over the quality variations and growing costs of the health care system, the government is pursuing systemic interventions that penetrate quite directly into essential elements of medical practice. These elements include bolstering the comparative effectiveness research evidence available to guide care decisions, the adherence to medical steps and actions of demonstrated value, the tools used to manage a practice (e.g., electronic medical records), and external validation to payers of compliance with requirements for payment purposes.

*A Roadmap for Physicians to Health Care Reform* (aka, Roadmap), commissioned by the Physicians Foundation, focuses on interventions under the ACA that reach most directly into that private practice space held by a physician providing care to a patient. It offers a guide to physicians of the major legislative changes that will impact most directly upon his or her practice of medicine. We appreciate that America is a hugely diverse country. That diversity is equally true of the style, location and scope of physicians' practices. Many physicians support the broad aspirations for expanded access to coverage and improved quality sought through the ACA. Others, reflecting the nearly perfect divide in opinion polls across all Americans, are dismayed by the scope and implications of many actual policies enacted under the ACA.

*The central question now for all physicians; have the right things for health care been done in the right way? And if not, what must be fixed, and how should it be fixed?*

The task we set ourselves at the Physicians Foundation was threefold. The first goal was to provide physicians with a perspective on the issues, societal and economic, influencing federal legislators and policymakers and leading to reforms (Part I). The second goal was to provide insight into the 112th Congress, seated in January 2011 after stunning changes brought about by the 2010 elections, and their possible "reform of reform"(Part II). The third was to focus on the ACA provisions that we believe are 1) of genuine import to the actual daily practice of medicine, 2) likely to endure in their general thrust, even if modified somewhat, and 3) possible targets for advocacy action (Part III).

*We conclude that the ACA provisions that focus on physicians: 1) to drive core shifts in quality and performance measurement and reporting; 2) to drive adoption of health information technology in medical care and business practices, and, 3) to drive greater risk assumption by physicians for the economic aspects of care, will largely survive any re-making of the ACA.*

## Content of the Roadmap Report and Resources

First, a word on the Roadmap report itself. Make no mistake—this is complex stuff. It is not always a short or easy read, but we think it will reward your attention. You can focus on those areas that are most meaningful to your practice circumstance. Material occurs throughout that is useful for those of you or your representatives who are engaged in advocacy regarding federal or state government policies. If that is not your focus, we suggest you concentrate on Part III, which summarizes changes in payment, quality reporting, shared savings programs and other matters that reach most clearly into daily medical practice. Perspectives on government actions appear throughout, with suggestions in this Executive Summary about possible areas in which to focus attention and advocacy efforts.

Second, detailed as it is, the Roadmap report is not exhaustive. No single report on the ACA can be due both to the sheer magnitude of the law, and because the law simply provides a framework that is leading to a barrage of ongoing interpretive regulations and policies. We have exercised editorial judgment about

which topics to focus on at this time. We focus more on:

- the Medicare program,
- shared savings programs, especially as embodied in Accountable Care Organizations,
- quality reporting, and comparative effectiveness research,
- the Independent Payment Advisory Board,
- select workforce and rural initiatives, and
- select aspects of changes in the private health insurance market, including health insurance exchanges.

Major and important changes are also occurring in the Medicaid program and to employer-based programs, but while we highlight the direction of these changes they are not the focus of this report. We invite you to tell us whether these or other topics would be a useful focus for the Physicians Foundation in the future.

Finally, the Roadmap report is accompanied by access to a "curated" set of the resources reviewed and relied upon to create the report. These are extensive, drawn from public and reputable private sources, and are made available to you electronically on the Physicians Foundation Health Reform website. We invite you to consider the Roadmap report as useful in its own right, but also as a platform by which to access a broader, more detailed, and cross-cutting set of resources on topics you choose to investigate further. From time to time, the Physicians Foundation will refresh these resources. The Roadmap report and the accompanying resources can be accessed electronically on the Physicians Foundation website at http://www.physiciansfoundation.org.

We turn now to discussion of the perspectives that emerged from this project about the potential impact of the ACA on the practice of medicine. What are the common objectives uniting disparate provisions? While many things in the ACA have their roots in pre-ACA initiatives, now their reach is extended and they have the force of law. What do the ACA provisions we examined, which continue to grow through regulatory and sub-regulatory policies, suggest about pressures for changes in physician practice? And, what most in the direct sphere of medical practice needs to be most closely examined, and possibly re-shaped or repealed?

## Perspectives for Physicians

In brief, the ACA reflects actions that many policymakers have argued for years are necessary to change the trajectory of the American health care system. The health care system has been viewed as ailing and dysfunctional, and unable to self-correct. That is, cost growth in health care has consistently exceeded growth in the overall economy, as measured by the gross domestic product (GDP), consuming a steadily growing share of the nation's resources. Some researchers have documented wide variations in the provision and cost of medical services across the U.S.

Many complex factors contribute to cost and quality issues in our healthcare system. But, for federal policymakers, overseeing an annual budget of over $1 trillion in annual Medicare and Medicaid spending alone, physicians have been the most elusive target for technology, cost and quality reform efforts. This is due in part to their unique professional roles, diversity in specialization, and decentralization and autonomy of practice. Physicians are central to medical care, regardless of whether their clinical services are provided in private offices, ambulatory surgery centers, clinics, hospitals, long-term care facilities, or other settings. There is ample evidence that the best medical care in the world can be found in the U.S., but it is not universal. The challenge from policymakers' perspectives has been how to harness the expertise of physicians and incent them to participate fully in collaborative practice efforts to raise quality standards, while constraining costs.

Many of the ACA provisions (described in Part III) impose significant compliance burdens on physicians, in terms of capital costs, staffing and personal time not directly engaged in patient care. More positively, new tools are being provided to physicians to access information about which interventions lead to the best outcomes. New tools are provided

to increase the efficiency of medical practice with respect to medical records creation and maintenance, to meet data and reporting requirements, and to allow physicians to participate in programs like shared savings, that may grant physicians greater control over their future practice models. But, all of these changes come with risks and challenges for doctors. In order to better understand these risks, we next focus on the broad shifts these changes represent.

## ISSUE 1

### *Physicians will assume greater responsibility for the health of populations, not individuals.*

In our view, the ACA provisions directed to physicians have a central thrust, from which many of the primary risks and opportunities flow. *First and foremost, the ACA embodies a drive toward creating incentives for physicians to assume responsibility for the care and general health of "populations" or groups of individuals, rather than simply managing the care of individual patients.* For many physicians in the U.S., this represents a more profound shift in the practice of medicine than may be immediately realized. ACA provisions are heavily oriented toward increased collaboration among physicians and allied health professionals, extensive adoption of quality standards, performance measurement relative to adherence to such standards, reporting of performance in a manner accessible to payers and ultimately to patients, and assumption of a share of the risks of costs of care for groups of individuals. Shared savings programs, including the Accountable Care Organization (ACO) model require commitments around the care of groups of patients. Note that the ACO model initially would require a minimum of 5,000 enrollees for approval.

*There are growing pressures under many of the ACA provisions, taken collectively, to align with hospitals, clinics, and other entities, in order to care for patients across settings, working collaboratively with other providers.* The primary care physician is incented to be a linchpin girding the "medical home" approach ranging from wellness and preventive to acute care, depending on what an individual patient needs. The policy goals are to reduce fragmentation in care, improve quality and contain costs through broader sharing of medical and financial responsibilities.

## ISSUE 2

### *Significant numbers of physicians may feel compelled to relinquish private practice autonomy in favor of networks and group formations.*

The growing requirements for widespread adoption of health information technology (HIT) impose significant time, technological and capital cost burdens on physicians. The myriad applications for electronic medical records, e-prescribing, and adherence to dozens of quality measures, plus the input, maintenance and reporting of these data require sophisticated HIT tools and commitment. As these burdens grow, many physicians may feel compelled to align with networks and groups, or even to sell their practice to a medical group, insurer or hospital, if only to share the costs of these requirements and to secure necessary HIT and payment support. By example, over time, current financial **incentives** under Medicare to adopt quality reporting requirements end, and physicians will be actively **penalized** under the Medicare payment system if they fail to adopt these changes in their practices.

*ACO and other shared savings models carry a significant set of legal, economic and medical care requirements – an entire superstructure, in fact.* These require alignment with other professionals for legal, contractual, financial planning, and even actuarial support (due to health plan elements such as risk-adjustment and capitation elements that are integral to success). Many physicians practicing solo or in small groups, or in less urban areas, may find limited opportunities to take full advantage of such programs. Regardless of practice model, or professional objectives, all shared savings models carry genuine financial risk

for participants and must be fully evaluated before participation. A broader question for the medical profession is how to prevent fragmentation of the profession into the "haves and have-nots" based on geographic location and practice model.

## ISSUE 3

### *Physicians increasingly are losing the "private" in private practice.*

In the growing technological environment of medicine, the ability to collect data on individual physician performance is growing by leaps and bounds. It is intrinsic to the shared savings models. But it is proceeding independently of collaborative practice models. The Medicare program is a major driver in this regard, focusing on adoption of electronic medical records, e-prescribing, and especially in the Physician Quality Reporting System and the developing Physician Compare program. Over time, the latter program is developing a major database of quality performance data on physicians, and is required under the ACA to evolve from a private feedback program to a planned, publicly available set of information on each Medicare participating physician in the U.S.

*Physician Compare appears to resemble a "Doctor GPS", meaning that the program could ultimately reveal who you are, where you are and what you do, arrayed on a public website accessible to the general public.* This is a program that could have significant implications for practicing physicians over time. *To our knowledge, no other profession in the U.S., with the full power of the U.S. government behind it, is subject in this way to having their professional lives scrutinized, measured and publicly reported upon.* While it is true that hospitals, nursing homes and other institutional providers are also subject to profiling under their respective Compare sites, we consider public profiling of individual professionals to be vastly different from public profiling of institutions, and of greater concern.

## ISSUE 4

### *Physicians could become a major nexus for risk-bearing arrangements, thereby assuming significant shared financial risks and quasi-insurance roles.*

As noted earlier, the ACA is fueling a drive toward growing professional collaboration in performance-based, shared savings practice arrangements and programs. These can occur under a variety of models. Some could permit contractually binding linkage of large numbers of solo practitioners and members of group practices. Others could occur under affiliations with or outright ownership by hospitals or insurers encompassing a geographic area.

**HOSPITALS.** In this environment of rapid-paced change, *it is critical that doctors be fully apprised of the environmental pressures (fiscal and quality) that insurers and hospitals are under and evaluate what it means for any potential contractual relationship*. For instance, hospitals are also subject to quality reporting and performance measurement, as well as public profiling. There is a growing array of payment penalties attributable to the measurement and incidence of avoidable medical errors, hospital-acquired conditions, and inappropriate readmission rates. This is in addition to deep payment reductions under the ACA for hospital services, and in special payments for graduate medical education and disproportionate share payments for high shares of low-income patients. These changes will influence hospitals' efforts to gain greater control over admitting and treating physicians in ways that doctors should evaluate carefully as part of any practice acquisition or shared savings agreement.

**INSURERS.** Separately, deep changes are underway for insurers, as well. First, insurers' abilities to engage in favorable enrollment selection practices are curtailed. Minimum benefit requirements have been enacted at the federal level imposing new benefit costs. Although there are significant new federal standards affecting the commercial insurance market, states still bear the primary responsibility for the oversight and regulation of

health plans doing business in their states, except where the ACA makes provision for federal default regulation where states choose not to act, i.e., formation of a health insurance exchange.

A significant new standard, known as the medical loss ratio standard, compels insurers to return at least 80%-85% (depending on insurer size) of the value of the benefit package to enrollees in covered services. Under elaborate claims cost and other accounting calculations, if a plan's "pay-out" falls short, pro-rata premium refunds must be made to enrollees. Collectively, these pressures are also invitations to insurers to re-evaluate their position in the changed environment. Like many hospitals, insurers are acting to change their relationships with physicians, including practice purchases or entering into new kinds of contractual relationships that can include significant risk-bearing by the physician. *All major institutional players in health care, government, insurers and hospital systems, are coming to grips with the centrality of physicians in their fiscal and quality of care futures and are determined to gain a greater measure of control.*

**PHYSICIANS AND RISK ASSUMPTION.** Physicians assumption of financial risk associated with the cost of total care provided to a group of patients, for services the physician may, or more likely may not, provide directly, brings us full circle to the first issue of physicians assuming responsibility for enrolled populations, rather their care of individual patients. At its core, this is an insurance, or quasi-insurance function.

The ACO model, as proposed, has several elements that closely resemble rules observed by Medicare Advantage plans. Central to such a role is the concept of risk-adjustment. Risk-adjustment tools are used in Medicare Advantage, in the Medicare Part D drug benefit plans, in commercial insurance and in many State Medicaid programs.

Risk-adjustment involves statistical and modeling tools to normalize health care costs to reflect the health status of a given population. This is important to any shared savings arrangement, because it is central to estimating whether the group (or ACO) has achieved savings or incurred losses relative to a benchmark. Under the ACO model, the benchmark is a risk-adjusted estimate of what patients with the same risk characteristics would have cost the government under its standard payment system. There are significant design decisions and implications for risk-adjustment models, which can vary widely. These are powerful and complex tools that materially affect savings and loss calculations that physicians can certainly understand and learn to work with. However, as stated earlier, physicians must understand what impact these and other key elements of a shared savings arrangement or model will have on professional relationships, and financial and other contractual or legal risks.

We close with some suggestions for areas in the ACA that physicians and their professional representatives might focus on. Some are federally-oriented, others are state-oriented. Regardless, we suggest that physicians work very closely within their local medical societies to develop the focus of and strategies for advocacy.

## Target Areas for Evaluation and Advocacy

Almost immediately upon enactment, the sheer scale of the new roles for government (state and federal), and the estimated costs of the legislation, came under fire on political, fiscal and legal grounds. This has led to court challenges in multiple states over the individual mandate, the refusal of about 23 states to assume responsibility for the creation of new health insurance exchanges (a form of consumer-oriented marketplace) in their states, and in the 2010 elections, ascendancy of Republicans (bolstered by Tea Party candidates) to the Majority in the U.S. House of Representatives. The debates continue in the federal fiscal year budget agreements and negotiations, shifting now from the fiscal year 2011 budget agreement to the fiscal year 2012 agreement (with an intervening debt ceiling debate).

We can expect the ACA to be remade over time by the Congress and this or future Administrations; the only real questions are in which areas and to what degree? For instance, Part II of the Roadmap report discusses areas such as directed spending for some programs and the CLASS Act that, among other areas,

are targeted by House Republicans for repeal or change. *President Obama has recently proposed to tighten the cost-savings standard that triggers savings actions by the Independent Payment Advisory Board (IPAB), and to give the IPAB strengthened enforcement powers.* Some Members of both parties in Congress seek to abolish the IPAB, viewing its existence as an abdication of Congressional responsibility and prerogatives. We include the IPAB in the following suggested areas for deeper evaluation and potential advocacy for change.

**Target Areas:**

**1 ➤ *Harmonization of federal and State quality and related clinical measures used for physician quality reporting, performance measurement, profiling and payments.***

There are numerous clinical and patient care-related measures developed by different entities and applicable in multiple settings, and under multiple programs including Medicare and Medicaid. In some instances, the same conceptual standards have different names in different program areas and potential applications under Medicare and Medicaid, although they seem to have similar objectives in mind. We believe this is a critical area in which to invest research effort and medical expertise to advocate for uniform definitions and applications of measures, and to seek modifications in the statute and regulations, as appropriate. *Clarity and consensus regarding the descriptions, data sources, and appropriate uses of an array of clinical, quality and performance measures is especially important now as such measures gain in numbers and applications, and find their way into payment systems and provider profiling.*

In other words, there needs to be something like a "Medical Measurement Matrix" that has clearly articulated governing principles shaping which measures are acceptable for use for which purposes. Examples include hospital-acquired conditions, health care acquired conditions, measures utilized under the Medicare physician quality reporting system and similar measures that government is actively adapting to government programs and purposes without a clear underlying set of governing principles.

**2 ➤ Modification or repeal of the Independent Payment Advisory Board.**

The IPAB is discussed at length in Part III of the Roadmap report. As discussed in the IPAB section, there are serious issues with the existing provisions relating to: 1) the scope of the IPAB's authority, 2) the standards and measures specified in the law, 3) the reporting and action timeline, 4) the relationship of the IPAB with the Congress, Congressional organizations such as the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC), and the Administration, and 5) the complete lack of clarity as to the IPAB's powers relative to the existing Medicare sustainable growth rate system, or to effect reductions in physician payments under the Medicare program. *The President's proposal to strengthen the IPAB, despite crucial and identifiable flaws, makes this a must for physician evaluation and advocacy efforts.*

**3 ➤ Potential legislative action regarding Accountable Care Organizations and related shared savings models.**

We suggest that physicians evaluate carefully the standards and requirements that the government has proposed for the ACO model, and any other shared savings models that emerge from the Innovation Center of the Centers for Medicare and Medicaid Services. This requires review of both the ACA legislation, and the manner in which the government proposes to implement the law in proposed rules, and in the design of demonstrations. For physicians, a central issue is whether the rules are tilted too strongly toward the insurance model, either denying physicians genuine opportunities to contribute to innovation, or requiring them to bear excessive costs and professional risks for participation.

**4 ➤ Assessment of the growing aggregate burden of compliance for physicians due to an array of ACA provisions.**

We noted that there are numerous new or intensified requirements for physicians relating to HIT adoption, quality measures, data reporting, etc. Participation in shared savings models brings opportunities, but also additional burdens. Some proposed

rules and sub-regulatory guidance coming out of the government, most notably CMS, impose discrete new requirements. We suggest this may be an important area for evaluation to quantify the sources and costs of these collective requirements. These are, in effect, unfunded mandates, although the government would argue in many areas that their adoption is voluntary. Evaluation of these burdens could suggest pathways to legislative and/or regulatory advocacy to moderate or keep such requirements within appropriate, professionally acceptable boundaries.

**5 ➤ Review of Physician Compare.**

We suggest a close review of the evolving Physician Compare program, both the legislative authority and the regulatory implementation and future plans of CMS. CMS has initiated the Physician Compare website with limited data. The real shift toward public reporting of performance data occurs in 2013 and beyond. CMS has published a solicitation for comments on measures to be used and on processes to provide physicians with an opportunity to review their data before it is made public. The Physician Compare program is too important to "just let happen" without clear professional understanding and engagement, and advocacy for legislative change, if needed.

In closing, these are just a few suggestions based on concerns raised by this focused review of the ACA as it affects physicians. We also recommend that physicians work together within their state medical societies to closely monitor major changes in Medicaid, and the adoption of health insurance exchanges whether by the State, or by default to the federal government. These areas are both subject to considerable state legislative and regulatory discretion. Therefore, they will vary by State and require local scrutiny and advocacy.

The Physicians Foundation's mission is educational. It has been our privilege to develop the Roadmap report and offer it to physicians nationwide for assistance in understanding and engaging in all the changes that are occurring in the U.S. health care system. Health care reform is proceeding rapidly on many, many fronts and could be redirected by further Congressional action this year. For too many purposes of this report, we were obliged to set a cut-off date for publication purposes of April 22, 2011. We remind you to visit our website for additional and updated resources (http://www.physiciansfoundation.org). We hope you will share this report with your colleagues and, as always, share with us your thoughts about other ways or topics by which we can aid the practicing physician. ■


# Introduction


The United States is in the early stages of a vast reworking of the entire health care system, due largely to enactment on March 23, 2010 of the Patient Protection and Accountable Care Act (the ACA). This legislation, exceeding 2,000 pages in length, is the most sweeping health system reform law enacted in the United States since the advent of the Medicare and Medicaid programs in the mid-1960s. Arguably, the scope of this government intervention in health care is even broader than was caused by the introduction of those programs.

The purpose of this report is to examine the key fiscal, political and regulatory dynamics of reforms as they are unfolding, and to aid physicians in gauging the implications for their medical practice. The report will broadly inform physicians of the most important aspects of current reform efforts, and provide a closer survey of those that affect physicians most directly. In effect, we hope you will find it useful in the following ways:

**1** ➤ As a primer on why the ACA was enacted and what is driving Congressional reconsideration of the new law,

**2** ➤ As a study guide and springboard to learning what you need to know more about in order to improve your professional and practice experience,

**3** ➤ As a source of a "curated" library of documents that will help you now, as well as numerous links to a carefully selected array of governmental and private sector websites and resources that will continue to provide useful information in the future (the Physicians Foundation Health Reform website),

**4** ➤ As a catalyst for considering how best to work individually, and collectively, with your colleagues and professional societies to improve patient care and at the same time, the professional experience of physicians, and

**5** ➤ As a basis for participating in the implementation of the ACA, addressing issues and seeking opportunities, while working to potentially reshape the law where changes are needed.

The report is the initial link to a planned "website" on health system reform matters established by the Physician Foundation as a public service to the medical profession. The focus is on providing resources of particular value to physicians, as well as selected resources of broader applicability.

Throughout, we've kept the following key questions in mind, understanding that judgments arrived at now are necessarily speculative and subject to the actual lessons of time.

## Why the ACA?

The scope of the ACA is breathtaking upon close examination. It is the culmination, from an activist government perspective, of trends and policy concerns unfolding in the U. S. health care system since the enactment of the Medicare and Medicaid programs in the mid-1960s. These roughly relate to:

**COVERAGE** — Concern over fragmented sources of health insurance (HI) coverage for Americans, e.g. employment-based, individual private market, Medicare, Medicaid or, especially, no coverage from any source,

**PRIVATE HEALTH INSURANCE** — Dissatisfaction with and inequities arising from the myriad rules across states over regulation of private

## Key Questions for Doctors

Which aspects of health system reform might be most meaningful over time due to their impact on the practice of medicine, physician practice models, relationships with patients, record-keeping and reporting burdens, and payment for professional services?

What are other important considerations, such as differential impacts by practice model, or geographic location?

Are there elements of HSR that particularly affect practice in rural areas?

Are there implications for the future physician workforce—given the extensive changes, who will likely enter medical practice in the future?

What areas should physicians target for particular vigilance or action on the legislative, regulatory or policy front?

health insurance companies and benefit offerings, with differential practices over minimum benefit packages and benefit mandates, premium levels, lifetime maximum benefits and denials or revocation of coverage,

**HEALTH CARE COSTS** — Concern over the steep trajectory of health care costs in both the private and public sectors, with special attention paid to growing Medicare and Medicaid costs, in part due to the shared burdens for taxpayers and enrollees,

Physicians bring essential perspectives on how the health care system can and should support optimal patient care.

**HEALTH CARE QUALITY AND WORKFORCE** — Dissatisfaction with well-documented and unsupportable variations in the quantity and quality of medical care provided to patients relative to outcomes, and attributed to a variety of factors which policymakers seek to address, as well as workforce shortages,

**FINANCIAL CROSS-SUBSIDIES AND INCENTIVES** — Issues of explicit and implicit cross-subsidies in health care (some of which are contained in the federal tax code) that introduce distortions in incentives for individuals, providers, employers and insurers,

**TECHNOLOGICAL INNOVATION** — Issues over where and how best to employ technology to introduce efficiencies and support electronic health records, electronic prescribing, data collection for health services research, provider performance profiling, and reduction of medical errors,

**FRAUD AND ABUSE** — Issues over effective prevention, detection and prosecution of fraud and abuse in health care services, and finally,

**UNIFIED PAYER SYSTEMS AND APPROACHES** — A desire to create a framework for more unified and effective federal and state government management of public health care programs, partnering with private health insurer approaches, to address coverage expansion, cost containment and quality improvements in health care.

The political and policy crosscurrents across all of the above areas came to a head in the enactment of the ACA in March 2010. Selected modifications occurred in short order, later in March 2010, and again in December 2010. As of this writing, no further legislation changing the ACA has been enacted, although an initial repeal effort has been attempted, unsuccessfully, as of this writing. The ACA provisions, as amended, are remarkably extensive, and we can expect far-reaching impacts upon all of the areas described above, many of which are of direct relevance to physicians.

## Focus on Physician Perspectives

Patients are the beating heart of the American health care system. And, physicians alone are fully licensed in the United States to diagnose and treat the complete array of complex ills human beings are subject to. This fact in no way diminishes the major contributions to patient care that other health care professionals offer to patients in many home and facility-based settings. Indeed, nurse practitioners, physician assistants, therapists, and many other allied health professionals of varying degrees of education and training provide essential and invaluable services to patients in the continuum of medical care.

Administrators and other employees of major facilities in which health care is provided, such as hospitals, ambulatory surgery centers, skilled nursing facilities, home health agencies, rehabilitation facilities, nursing homes and hospice care facilities bring an array of skills and talents (administrative, organizational, financial, legal and technological) necessary to support quality care in the settings best suited to patients' needs. These contributions need to be structured to ensure that physicians can provide their medical services in environments

that fully support their professional obligations and patients' diagnostic, treatment and care requirements.

Physicians are at the heart of the medical care provided to patients and as such, play an essential role in and are deeply affected by ongoing health system reform efforts in the United States. Physicians have both legitimate professional and business concerns, combined with a central concern for the care and wellbeing of the patients they serve. Physicians bring essential perspectives on how the health care system can and should support optimal patient care.

To help inform these efforts, this report is organized into three broad areas, as follows.

**The Roadmap in 3 parts:**

1. **Economic and budget framework**
2. **The 2010 elections and the "reform of reform"**
3. **ACA matters for doctors and targets for action**

➤ **Part I** provides an overview of the economic and budgetary context of health system reform. This includes the federal deficit, the economic concerns driving the debates over health care in the U.S. Congress, a brief overview of the provisions and fiscal scoring of the ACA, and what the fiscal debate might mean for repeal or modifications to the ACA. Part I also includes material on federal budget processes, sufficient to aid in understanding the timing and significance of what is occurring this year in the political arena. It provides data on key-cost drivers in health care that are important to keep in mind for both fiscal and health policy reasons.

Part I also discusses briefly the Congressional Budget Office (CBO), which plays a pivotal role in legislation due to its role in "scoring" or estimating the effects of proposed legislation, including actions to repeal or further modify the ACA. In addition, it highlights the role of the federal Office of Management and Budget (OMB), which is in the Executive Office of the President, and the role of the Office of the Chief Actuary (OACT), located in the Centers for Medicare and Medicaid (CMS), which is part of the Department of Health and Human Services (DHHS).

➤ **Part II** summarizes the election results in 2010, the resulting changes in leadership in the U.S. Congress, and tees-up the political debates underway now as they affect further "the reform of reform." This section also provides an overview of the tools the 112th Congress has to work with to carry out their political, budgetary and policy efforts.

➤ **Part III** takes a deeper look at the distribution of responsibilities, regulatory tools, creation of new entities and selected regulatory implementation of the ACA, to date. Despite the lively political environment, and the potential legislative efforts underway in the U.S. Congress, the Administration's implementation of the ACA is proceeding full-bore. Multiple federal and state agencies, private insurers, employers, and providers throughout the U.S. are mobilized to implement the law, as enacted.

No matter what actions the Congress or federal courts take to amend the ACA, the most direct provisions affecting physicians will endure in some form.

Even if major provisions under the ACA 1) fall due to litigation (e.g. the individual mandate), 2) are amended by Congress through new legislation, or 3) are curtailed due to funding limits, we anticipate that the majority of *provider-centric provisions* of most direct import to physicians and the ongoing practice of medicine will endure somewhat intact. These are often referred to as delivery system reforms, as distinguished from the broader societal objectives of the ACA related to access, coverage, subsidies for lower-income individuals, and enhanced revenues from higher-income individuals, employers and health insurers. Part III examines the main delivery system aspects and focuses on the related federal regulatory agenda items and actions most applicable to physicians and their practice environment.

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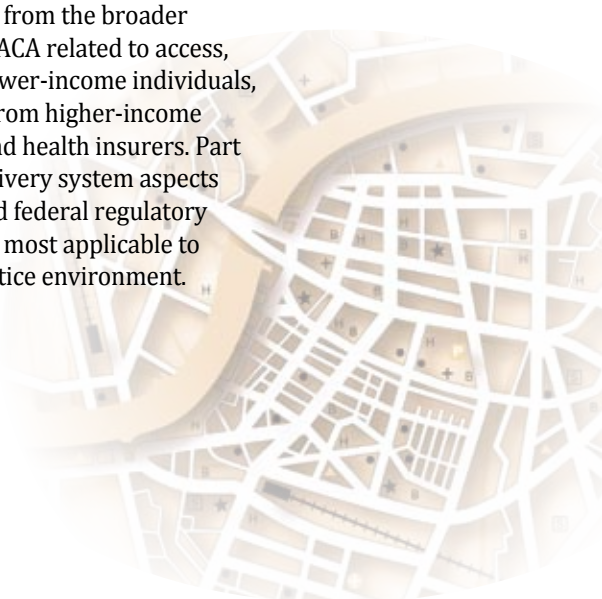

# PART I: Overview of the ACA

## Economic and Budgetary Perspectives

**Introduction** — Over the past 3½ years, the U.S. and the global economy have suffered widespread downturns in prosperity and employment. In the U.S., the so-called "Great Recession," as measured by the federal government, began in December 2007 and ended in June 2009. Despite the official end of the recession, the U.S. economy continues to be plagued by high unemployment, a sagging housing market, and anemic growth in the Gross Domestic Product.

Beginning under the Bush Administration and advanced under the Obama Administration, billions of dollars in bank-bailout and federal stimulus funds were expended in efforts to stabilize the financial services, automobile, and housing industries. These efforts combined with other global and U.S. factors to raise U.S. federal deficits to historical levels. In CBO's recently re-estimated baseline released in January, the federal deficit is estimated at about $1.5 trillion for 2011.

Despite the fiscally grim picture, and the daunting potential costs of health system reform, the Obama Administration and the Democratic Congressional leadership in the 111th Congress (2009–2010) acted to deliver on their long-sought, societal objective of universal access to health insurance in the U.S. The Democratic Party of the President held the Majority in both the House and Senate in the 111th Congress. The clean sweep of party control ultimately provided the political muscle necessary to proceed successfully.

The catalyst was a drive to honor election commitments made by Presidential candidate Barack Obama in the 2008 election to extend health insurance coverage to nearly all U.S. citizens. That objective joined with pent-up demand among many policy-makers for health care cost containment and numerous delivery system reforms. These goals coalesced into an enormously complex piece of legislation.

After several months of extensive legislative effort and rancorous debate, the ACA was enacted into law in March 2010. There was virtually no corner of the U.S. health care system left unaffected. As will emerge later in this report, the forms taken and scale of the changes in the ACA provided unifying issues for Republican candidates to run on in seeking office in the 2010 Congressional elections, leading to their regaining the Majority in the U.S. House of Representatives, and strengthening their presence in the U.S. Senate.

### Highlights of the Patient Protection and Accountable Care Act

The goal of the highlights section is to enable a basic appreciation of the aspects of the American health care system touched by provisions of the ACA, understanding that many areas of ACA action are unprecedented and extensive in scope and detail. A very detailed set of factual, non-partisan summaries is available to the reader whom requires greater detail through linkage to the Physicians Foundation Health Reform website.

**A Little History—What the Congress Did *Not* Do:** By way of introduction to the ACA, it's helpful to first review what the Congress did *not* do in the ACA, despite historic interest in these approaches by primarily Democratic Members of Congress. In general, the 111th Congress rejected a federalized, uniform national health insurance approach similar to models followed in several Western European countries. Second, the Congress also rejected a "pure" so-called "employer pay-or-play" system that in past models required all employers to provide a federal minimum benefit package to all full-time employees or, alternatively, to pay to enroll them in a single, federally administered health insurance program. However, the ACA does have significant employer "pay-or-play" features.

Under some past models of these approaches, the federally administered Medicare program, and the state-administered Medicaid program would both have been folded into a single, national health insurance system. Employers would have been required to offer comparable coverage or pay to enroll their workers into the public insurance system. The late Senator Ted Kennedy of Massachusetts was long an active Congressional advocate for such a model. Instead, under the ACA, the Congress chose to keep the basic legal framework for the Medicare and Medicaid programs intact, with changes. They added the concept of an individual requirement to carry health insurance (individual "mandate"). The final ACA borrowed other ideas for novel new legal approaches from many other models, including certain elements of the employer pay-or-play concepts that have been debated over nearly a 35-year period.

The ACA, as amended, is a tightly interlocking web of new law intended to achieve three broad objectives: (1) expand coverage to nearly all legal residents in the U.S., (2) reduce health insurance costs under private and public programs for individuals, employers and government, and (3) ensure quality in patient care and good value for spending on health services.

These are laudable objectives—what's at issue is how and whether they are likely to be realized under the new law. Among other issues, there is widespread controversy over the extent to which the federal government, or even States, must pursue the above objectives through extensive statutory and regulatory interventions. To understand the bases for the controversy, let's first look at the key areas of legislative action. For detailed summaries of the law and timelines, by major areas, please refer to the Physicians Foundation Health Reform website.

## The ACA, in brief:

**1 ➤ INDIVIDUAL COVERAGE REQUIREMENT:** Imposes a mandate on most U.S. residents to obtain health insurance, creating tax penalties on individuals for failure to do so.

**2 ➤ PRIVATE HEALTH PLAN AND EMPLOYER BENEFIT RULES:** Restructures the private health insurance market via a novel federal regulatory frame-work, sets new federal standards regulating the amount of health plans' revenues that must be paid out on benefits, de facto limiting profit margins, and sets an excise tax on plans found to have high premiums. Creates employer rules regarding workers' health benefit offerings, limits on worker access to subsidies, and tax penalties under certain scenarios, many adapted from employer "pay-or-play" ideas.

**3 ➤ LONG-TERM CARE INSURANCE PROGRAM:** Creates a national, federally administered and voluntary insurance program for purchasing *community living assisted services and supports* known as the CLASS program.

**4 ➤ NATIONAL MINIMUM BENEFITS:** Sets comprehensive standards regarding health insurance coverage under a federal definition of "minimum essential coverage."

**5 ➤ HEALTH INSURANCE EXCHANGES:** Establishes by 2014 a system of health insurance exchanges (HIEs) through which many individuals will be able to access insurance and receive subsidies for the cost of coverage depending upon levels of income, while granting States access to generous planning grants.

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**6** ➤ **HIGH-RISK POOLS:** Establishes temporary high-risk pools for hard-to-insure adults with pre-existing conditions that are federally sponsored, but if States so choose, can be administered by them (about 23 States have declined to do so forcing federal action to operate them directly).

**7** ➤ **MEDICAID EXPANSION:** Expands the Medicaid program while providing time-adjusted, enhanced federal matching dollars for States.

**8** ➤ **MEDICARE CHANGES:** Amends Medicare in numerous ways to reduce spending growth for many provider services and for Medicare Advantage plans, while increasing coverage for prescription drugs under the Part D benefit.

**9** ➤ **SYSTEMIC HEALTH DELIVERY SYSTEM:** Creates an array of programs addressing payment reform models such as payment bundling and shared savings, including Accountable Care Organizations; comparative effectiveness research; work-force issues; fraud and abuse issues; quality improvement, provider performance measurement and data reporting; health information technology; public reporting; and, enhanced alignment of public and private payers' systems and approaches for quality and cost containment.

**10** ➤ **NEW ENTITIES:** Creates numerous (approximately 46) new entities in the Executive Branch such as an Independent Payment Advisory Board (and related Consumer Advisory Council) for Medicare spending, and a Center for Medicare and Medicaid Payment Innovation within the Centers for Medicare and Medicaid Services (CMS), among others.

**11** ➤ **COMPLEX FINANCING UNDERPINNING:** Creates complex financing sources and interactions, including controversial new taxes (e.g., 2.3% federal sales tax on medical devices, employer tax penalties, insurer taxes) and expansions of existing taxes beyond their original scope (e.g., application of a revised Medicare HI payroll tax to non-payroll items such as capital gains and real estate transactions). The high cost of new provisions, such as expansions of Medicaid and new subsidies for private health insurance, are offset by deep spending reductions elsewhere, such as in Medicare, plus tax increases and penalties.

**Multiple Modifications to the ACA in First Year:** The ACA had barely passed the Congress, when it was modified by enactment on March 30, 2010 of the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152, hereinafter referred to as the Reconciliation Act). Finally, the ACA was modified again under the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309), signed into law on December 15, 2010. *For purposes of this report, unless otherwise noted, all references to the ACA refer to the law in its totality, as amended, incorporating all amendments as of December 15, 2010*. For an immediate snapshot, following is a timeline of selected key milestones that have occurred in 2010, or are in effect this year. Detailed Congressional Research Service summaries and timelines, by broad areas, e.g. Medicare, Medicaid and CHIP, private health insurance, employers, etc., that are in the public domain are provided in the Physicians Foundation Health Reform website. We suggest they be consulted for authoritative details in your area of interest.

## ACA: Selected Timeline Highlights for 2010 and 2011

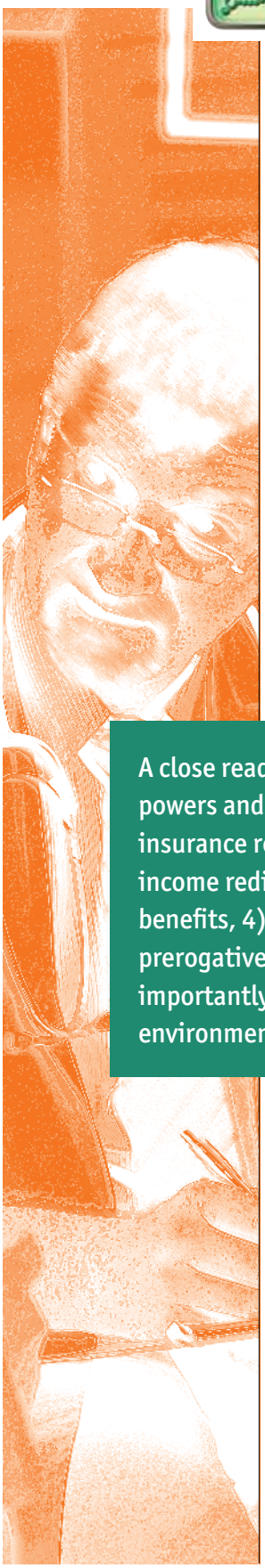
### 2010

- Temporary reinsurance program for employers who provide insurance to retirees over age 55 who are not yet eligible for Medicare – ends in 2014
- High-risk pools to cover adults with pre-existing conditions – ends in 2014
- Parents may keep children on their insurance plan until the child reaches age 26
- Lifetime caps on insurance benefits are prohibited
- Medicare enrollees in Part D who have drug expenses of at least $2700 (reaching the so-called "donut hole" gap in coverage) receive $250 in assistance
- Insurers are required to cover children regardless of pre-existing conditions
- DHHS Secretary allowed to modify Medicare preventive benefits
- A Community Health Centers and National Health Service Corps Fund is created intended to expand funding to community health centers by $11 billion over five years beginning in 2010
- Extends physician quality reporting system beyond 2010, penalizes eligible providers that do not participate beginning 2015, expands Medicare physician feedback program, and provides reports to physicians that compares their resource use to patterns of other physicians
- Created an Interagency Working Group to coordinate and streamline federal quality activities
- Established a Medicaid global payments demonstration to fund large, safety-net hospitals in five states to alter payment
- Extended the Medicare hospital gainsharing demonstration project through September 30, 2011.
- Provided for modification of market basket updates to provider payments under Medicare to account for productivity improvements in a variety of provider settings
- For advanced diagnostic imaging services, changed the assumed utilization rate for advanced diagnostic imaging services for purposes of calculating the practice expense portion of Medicare physician payment (to reduce payments)
- Numerous additional provisions affecting physicians such as enhanced Medicare and Medicaid program integrity provisions, disclosure requirements for in-office ancillary services, misvalued codes under the RB-RVS, home health and durable medical equipment certification requirements, and extension of gain-sharing projects, among others
- Provides for tax relief for health professionals with state loan repayments by excluding from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008. Establishes a National Health Care Work Force Commission to review health care workforce needs.
- Establishes framework for creation of a private, not-for-profit Patient-Centered Outcomes Research Institute, governed by a private Board, to set a national research agenda and conduct comparative clinical effectiveness research. Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and would contain patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.

### 2011

- At federal expense, states expand Medicaid eligibility to *all* individuals with incomes below 133 percent of the federal poverty level
- Payments increased to primary care physicians with a 10 percent Medicare payment bonus for primary care services for five years beginning in 2011. General surgeons providing care in a designated Health Professional Shortage Area (HPSA) also would be eligible for a 10 percent bonus on payments for major procedures. Provide an additional 0.5 percent Medicare bonus payment to all physicians who successfully report quality measures to CMS under a qualified Maintenance of Certification program.
- Numerous provisions to increase support for primary care training under Graduate Medical Education policies, and expansion of primary care and nurse training programs
- Workers can either opt out or begin contributing premiums to the CLASS Act insurance program. After a five-year vesting period, the program will begin to provide benefits. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program unless they choose to opt-out.
- Medicare Advantage plans begin to experience a 3-year phase-out of the current payment system, with many plans expecting significant reductions in payments
- Small businesses offering health insurance to their workers (under 25 employees with average wage less than $50,000) become eligible for a tax credit, beginning with 2010 taxes
- Medicare payroll taxes increase from 1.45% to 2.35% for single earners over $200,000 and for married filing jointly earning over $250,000
- Implementation of Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services
- Community-based care transition programs begin
- MedPAC mandated Congressional study on adequacy of payments for providers serving in rural areas, and selected payment protections for frontier state providers
- New assessments begin on the pharmaceutical industry according to a formula based on a company's relative aggregate revenue from branded drugs
- Medicare beneficiaries in Part D receive discounts off of the price of branded and generic drugs

*As noted earlier, the above items are a mere snapshot of what is unfolding. The year 2014 is intended to be the first full year of all major ACA requirements and implementation, including availability of Health Insurance Exchanges to all eligible individuals in the U.S. Please refer to timeline summaries on the website for more detailed information on 2010 and 2011, and on later years.*



## COMMENTARY >> Initial ACA Passage

The ACA taps into earlier enacted, as well as failed initiatives, but also charts new territory. Certain prior government initiatives are strengthened by the ACA (e.g. quality measures development and reporting, and comparative effectiveness research). The ACA is also triggering broad shifts in federal and state roles, especially around the regulation of private health insurance (previously reserved primarily to the States under the McCarran-Ferguson Act of 1945), and deepening already extensive interventions in provider roles and responsibilities. Broad paradigm shifts in the U.S. healthcare system are underway that even repeal of significant modifications to the ACA may not completely undo – the genie is truly out of the bottle.

To a certain extent, as can happen with any major legislative effort, especially with one political party dominating the process with little or no bi-partisan participation or support, a "piling-on" of ideas can occur, unchecked by opposing views. Arguably, this may characterize what occurred during passage of the ACA—not a single Republican voted for it on passage in the House or Senate. In fact, it cleared the Senate by only a 1-vote margin, and in the House vote, 34 Democrats voted against it. The partisan process brought forward deep ideological disputes in the U.S. Congress over the proper role of government and the degree of federal intervention in healthcare. In fact, even among the Democrats who crafted the law, there were significant differences between the House and Senate versions of health care reform, and novel Parliamentary maneuvers that had to be resolved in order to enact the final law.

Presently, the centerpiece of coverage expansion under the ACA, the individual mandate, is being challenged in multiple federal court jurisdictions as being impermissible under the U.S. Constitution—these cases are likely to consolidate for Supreme Court review. There also is growing controversy over the scale of the estimated costs of the ACA relative to the federal deficit, and deep skepticism over whether the main objective of nearly universal access to health insurance coverage is likely to be met. Under CBO's original scoring of the ACA in March 2010, CBO estimated that while millions would gain coverage, primarily due to Medicaid expansions and private health insurance subsidies, approximately 23 million could still be uninsured by the end of the 10-year scoring window in 2019.

A close read of the ACA reveals significant new federal powers and policies relating to 1) private health insurance regulation, 2) expansion of taxation and income redistribution, 3) the structure of employer health benefits, 4) the partial abrogation of state government prerogatives, 5) expansion of public health programs, and importantly, 6) deeper incursions into the medical care environment and payments for patient care.

Many of the objections to the ACA are ideological, reflecting widely disparate views on the proper role of government and the degree of government intervention in health care markets. A close read of the ACA reveals significant new federal powers and policies relating to 1) private health insurance regulation, 2) expansion of taxation and income redistribution, 3) the structure of employer health benefits, 4) the partial abrogation of state government prerogatives, 5) expansion of public health programs, and importantly, 6) deeper incursions into the medical care environment and payments for patient care.

In the upcoming sections, we will highlight select differences of opinion, some ideological, some practical and some economic and budget oriented, which are shaping efforts to modify or repeal the ACA.

## Federal Budgetary Context

### *ACA Reassessment and Potential Modification*

**State of the Federal Budget:** A reinvigorated drive to bring federal deficits under control, balanced with a desire to not imperil the recovery of a fragile economy, are central to the ACA debates underway in the 112th Congress. Leaders in both parties rely heavily upon the work of the Congressional Budget Office, which is a non-partisan federal agency that reports directly (and solely) to the U.S. Congress. CBO is chartered to advise Members of Congress of the ongoing economic and budget outlook of the United States, and to provide cost estimates and budget impact of any legislation effectuating changes in federal law and programs.

According to CBO's March 2011 report on options to reduce the federal deficit, "since 2007, financial turmoil and a severe drop in economic activity, combined with various policies implemented in response to those conditions, have sharply reduced federal revenues and increased spending. Those changes added to the imbalance between revenues and spending that had existed before the recession, causing annual budget deficits to surge. *As a result, debt held by the public grew to more than $9 trillion by the end of fiscal year 2010—equaling 62 percent of GDP, the highest percentage since shortly after World War II* (emphasis supplied.)"

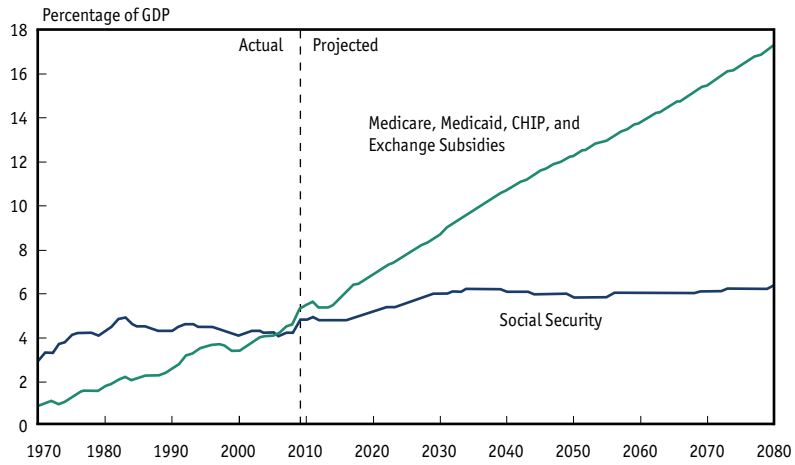
**COMMENTARY** Why are the deficit and spending numbers so important to the ACA debate? *In short, the federal budget is where the U.S. Congress lives.* The spending trajectories shown above are viewed by many as unsustainable and damaging to the country's future economic wellbeing. Managing the Federal power of taxation (revenue raising), and setting spending levels for the nation's defense and other high public purposes, is the Congress's central role. This role is carried out within a framework of ever-changing federal law, coupled with budget authorizations and appropriations for mandatory and discretionary spending. Oversight of government programs is also an essential role, and helps inform the budget and legislative process.

Republican campaigns in the 2010 elections, emphasizing reduction of the federal deficit and controlling government's size and spending, are widely credited with their heavy wins in the Congressional races. *Current efforts to repeal or modify the ACA are spurred by the election results and are rooted in the budget process.* Therefore, it is worth spending a few minutes on that process as the underpinning to legislative changes. Physicians and their representatives interested in reshaping the ACA require this information to plan where, how and on what basis to target their advocacy efforts in the U.S. Congress. Successful advocacy requires knowledge of key Committees of jurisdiction, the identity and roles of various Members, the active priorities of Members, and the budget and legislative process, with all its intricacies of politics, policies, and timing.

**Administration's Budget Submission:** The President's annual budget submission to the Congress lays out the President's priorities on taxation and spending, which also reflect the Administration's legislative priorities. It is a blueprint for the Administration's initial negotiating position entering into the Congressional budget process.

Current efforts to repeal or modify the ACA are spurred by the election results and are rooted in the budget process.

FEDERAL SPENDING FOR MEDICARE AND MEDICAID AND FOR SOCIAL SECURITY




SOURCE: CBO. *LONG-TERM BUDGET OUTLOOK.* 2010

Successful advocacy requires knowledge of key Committees of jurisdiction, the identity and roles of various Members, the active priorities of Members, and the budget and legislative process, with all its intricacies of politics, policies, and timing.

Each month that passes without successful legislative or budgetary actions to redirect or reduce ACA implementation, provides time for the Administration to obligate (commit) existing funding resources and to create legal and political structures that are ever more difficult to disentangle.

Each year, from summer into late fall, the Executive Branch assembles the President's budget priorities for the following federal fiscal year. This includes requests for legislative and spending changes in existing, or for new, programs. The Office of Management and Budget, or OMB, which is part of the Executive Office of the President, leads this effort across all the Cabinet Departments and Agencies. This process results in a final Administration Budget submission being forwarded to the Congress early in the following calendar year. At the time of public release of the President's Budget, senior OMB and other Executive Branch officials fan out across the Congress to brief Congressional leaders and selected staff with responsibilities for budget and legislation. From this point forward, senior Administration officials are on a tight leash, politically speaking, in their dealings with the Congress. It is customary for the White House to designate a relatively tight circle of individuals to whom negotiating power will be delegated as the Congressional session proceeds.

From a Congressional perspective, where there are deep political differences, such as between House Republican leaders in the 112th Congress and the Obama Administration, it is not unusual for the President's budget to be declared "dead on arrival" by Congressional opponents. This is what the Republicans have declared in 2011 regarding the President's priorities regarding the ACA, taxes, and other areas.

➤ **Congressional Budget Process:** Separately, House and Senate leaders work to arrive at their own budget resolution and accompanying legislative packages. This occurs through a detailed process operating among the respective Chambers' Budget, Appropriations and Authorizing Committees (the latter write legislation for government programs crafted to meet the either revenue-raising or saving targets developed by the Budget Committees, as well as policy goals).

This process can be a source of great political conflict, both within the Congressional Chambers and between the Congress and the President. In the pitched battle period leading into the 2012 Presidential elections, and with Republicans leading the House and Democrats leading the Senate, any budget and legislative agreements will be especially hard-fought and will likely only address the narrowest strip of common ground. Multi-lateral negotiations among Congressional leaders and the White House will likely substitute for "regular order" Committee and Floor procedures as the Congress struggles to pass budget agreements for the waning months in FY 2011, while also initiating action on the FY 2012 budget to be passed by this Fall. *It is in the context of these budget efforts that the House Republicans are advancing their priorities regarding ACA repeal or modification, including partial de-funding of selected areas in the ACA.*

➤ **Fiscal Challenge:** As of this writing (cut-off date of April 22, 2011), the fiscal challenge is to arrive at an overall federal budget agreement that can pass the House and Senate and be agreed to by the President for the fiscal year ending on September 30, 2012. The Congress should have enacted the FY2011 budget prior to October 1, 2010, but failed to do so. Through April 7, 2011, the federal government remained open solely due to 6 consecutive, short-term concurrent budget resolutions (CRs). These CRs and final FY 2011 agreement later in April, simply deferred the real work that must be done on the FY 2012 budget prior to October 1 of this year. They also effectively defer real work on modification of the ACA.

**COMMENTARY** At this point, the toughest fights will likely be reserved for the FY 2012 budget, which would grant the Republicans a little more time to fashion a full strategic plan and set of tactics in their efforts to modify the ACA, among other programs. Each month that passes without successful legislative or budgetary actions to redirect or reduce ACA implementation, provides time for the Administration to obligate (commit) existing funding resources and to create legal and political structures that are ever more difficult to disentangle. This is occurring over the

vigorous objections of Congressional critics who must harness their objections to sustainable budget and legislative actions to alter the path the Administration is on. In a political and budgetary sense, in this environment, the reform of reform has become a "contact sport."

In summary, it is the Congress that holds the ultimate responsibility for setting spending priorities, working with the President to secure the President's signature, or alternatively, working within the Congress to secure the veto-proof number of votes necessary to enact law and over-ride a Presidential veto. The Republican efforts to repeal or modify the ACA, or failing that, to "de-fund" major sections of the law, reflect their different priorities in favor of smaller government and reduced government spending. Both parties actively court public opinion and are on a drive to optimize their positions entering into the 2012 elections.

Now, we'll turn for a closer look at the scoring details and specific budget implications of the ACA, and examine why it is in the political crosshairs.

## Fiscal Scoring of the Patient Protection and Accountable Care Act, as Amended

**Legislative Scoring "101":** CBO's legislative "scores," which include detailed explanations of legislative proposals and related budgetary effects, play a crucial role in legislative decision-making. Budgetary impact can be decisive in determining whether a piece of legislation will gain the votes necessary to achieve enactment. As a result, CBO's estimates, data, modeling approaches and conclusions come under continual scrutiny and on occasion, intense criticism and pressure.

The ACA scoring is a case study in the cobbling together of dozens of complex policies in a manner that achieves a desired budgetary result (deficit reduction), although many provisions created significant new federal costs in the future. When Members create new spending in existing programs or by adding new programs, they seek to also enact offsetting reductions or "cuts" in existing programs or by eliminating programs. In this high deficit environment, the goal is usually to find a combination of policies that, on balance, does not add to total federal spending (increase the deficit).

Separately, CBO works closely with the Joint Committee on Taxation (JCT), a shared House of Representatives and Senate Committee that does related work focusing on federal revenues, and quantifying the estimated impact of any legislation on federal taxes and other revenues. Coming from different charters, CBO and JCT play very important roles in assisting and advising Members on budgetary matters in the legislative process. Finally, scoring estimates are calculated over a specified period, or so-called budget window.

**ACA Scores:** CBO and JCT issued combined estimates of the direct cost and revenue effects of the PPACA, as amended by the Reconciliation Act, on March 20, 2010. These are complex and lengthy estimates. To make that information more readily accessible, CBO has compiled many of those documents in one volume, entitled Selected CBO Publications Related to Health Care Legislation, 2009-2010,

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CBO's projections assume that the Independent Payment Advisory Board established by PPACA will be effective in reducing costs.

available on the website. Based on those materials, following is a synopsis of the key scores. To paraphrase a Congressional Research Service abstract:

"CBO estimates that the provisions *{in the ACA}* that affect the Medicare, Medicaid, State Children's Health Insurance Program (CHIP) and other federal programs, will *reduce* direct spending by $511 billion over the FY2010-FY2019 period. Medicare (absent interaction effects) accounts for approximately $390 billion of the reduction. Total Medicare reductions in direct spending over the 10-year period are estimated to be about $460 billion. The Medicare spending reductions are offset by certain Medicare spending increases totaling about $70 billion. As noted by CBO, the provisions that are expected to result in the largest savings include the following:

- Permanent reductions in the annual updates to Medicare's fee-for-service payment rates (other than physicians' services) will account for an estimated budget savings of $196.3 billion over 10 years,
- Tying maximum payment rates in the Medicare Advantage program closer to spending in fee-for-service Medicare (or below that level) will account for an estimated $135 billion in savings (before interactions) over 10 years,
- Reducing Medicare payments to hospitals that serve a large number of low-income patients, known as disproportionate share (DSH) hospitals, is expected to decrease expenditures by about $22 billion,
- Modifying the high-income adjustment for Part B premiums is projected to save $25 billion over 10 years
- Creating an Independent Payment Advisory Board to make changes in Medicare payment rates is expected to save approximately $16 billion over 10 years,
- Additionally, a new Hospital Insurance tax on taxable wages over $200,000 per year for single filers ($250,000 for joint filers) is expected to raise $87 billion from FY2013 through FY2019, and a new tax on investment income is projected to raise an additional $123 billion over 10 years.

Finally, CBO estimates that Medicare spending under health care reform legislation will increase more slowly over the next 20 years compared to the past 20 years—a 6% average annual rate compared to the prior 8%. CBO notes, however, that the estimates are subject to uncertainty. For example, the savings rate assumed that the sustainable growth rate (SGR) mechanism that constrains Medicare physician payment rates would go back into effect in 2010; at the time the estimate was made, physicians were facing an approximate 23% cut in payments. This cut was later deferred for 2012.

CBO's projections assume that the Independent Payment Advisory Board established by PPACA will be effective in reducing costs. CBO was not able to determine whether the reduction in the growth rate would be achieved through greater efficiencies in the delivery of health care or if the payment reductions would lead to lower quality of care" (Source: CRS. *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*. November 3, 2010.)

## COMMENTARY >> ACA Scores

The principal scoring of the ACA was done by CBO at time of original enactment, including the closely following modifications of the Reconciliation Act. The scoring period or "budget window" covered the years 2010 – 2019. However, the majority of major, new spending under the ACA does not occur until 2014 and beyond. This means that *CBO's scores for the ACA have captured only 6 years of new spending, not 10 full years, greatly understating the full potential costs of the ACA*. Deficit reduction hawks in the Congress identify the delay in start dates of new spending as a key reason that the long-term cost of new ACA spending is concealed by the "net" scores.

It is important to note that behind these broad numbers are literally hundreds of technical assumptions. As noted above, CBO scored off of a baseline that included a crucial assumption relevant to physician spending obligations. The ACA score anticipated that a 23-percent reduction in Medicare fee-for-service (FFS) payments to providers, saving $196 billion, would occur effective January 2011. This assumption (not borne out by subsequent action in the Extender's Act to delay the effect of the sustainable growth rate formula or SGR through December 31, 2011), artificially lowered the ACA baseline and magnified the savings attributable to the ACA, understating the projected spending that is actually being incurred under the Medicare program over the scoring period.

More recently, the independent Chief Actuary at HHS, Rick Foster, testified in front of the House Energy and Commerce Committee about the overall costs of the ACA. Mr. Foster emphasized the fact that only 6 years of costs, in major spending areas, were scored in the ACA, understating the Act's true longer-term costs. He also noted that there are multi-year transition effects in major areas of implementation of new law due to administrative implementation and other causes. For instance, not everyone who is eligible to be enrolled in an existing health plan option in the first full year of implementation will, in fact, be enrolled, further delaying the full costs of the law beyond specified implementation dates. Following is a helpful table summarizing the OACT (Office of the Actuary) numbers.

In closing, note that OACT plays a major role in estimating spending under all CMS programs and in preparation of estimates and analyses relating to Trust Fund(s) solvency in the Annual Report of the Board of Trustees for the Medicare HI and SMI programs. OACT will also play an important role in the future functioning of the new Independent Payment Advisory Board.

### ESTIMATED FEDERAL COSTS OR SAVINGS UNDER SELECTED PROVISIONS OF THE AFFORDABLE CARE ACT
[Costs (+) or savings (-) in billions]

| | Fiscal Year | | | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Provisions | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2010-19 |
| Total* | $9.2 | -$0.7 | -$12.6 | -$22.3 | $16.8 | $57.9 | $63.1 | $54.2 | $47.2 | $38.5 | $251.3 |
| Coverage† | 3.3 | 4.6 | 4.9 | 5.2 | 82.9 | 119.2 | 138.2 | 146.6 | 157.6 | 165.8 | 828.2 |
| Medicare | 1.2 | -4.7 | -14.9 | -26.3 | -68.8 | -60.3 | -75.2 | -92.1 | -108.2 | -125.7 | -575.1 |
| Medicaid/ CHIP | -0.9 | -0.9 | 0.8 | 4.5 | 8.6 | 5.1 | 4.6 | 3.4 | 1.3 | 1.7 | 28.3 |
| Cost trend‡ | — | — | — | — | -0.0 | -0.1 | -0.2 | -0.4 | -0.6 | -0.9 | -2.3 |
| CLASS program | — | -2.8 | -4.5 | -5.6 | -5.9 | -6.0 | -4.3 | -3.4 | -2.8 | -2.4 | -37.8 |
| Immediate reforms | 5.6 | 3.2 | 1.2 | — | — | — | — | — | — | — | 10.0 |

* Excludes Title IX revenue provisions except for sections 9008 and 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes expansion of Medicaid eligibility and additional funding for CHIP.

‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates (which are reflected in the Medicare line) and the section 9001 excise tax on high-cost employer plans.

Source: OACT, CMS. *Testimony of Rick Foster before the House Energy and Commerce Committee.* January 2011.

Of the $420 billion in new revenues raised under the ACA, about $391 billion of that amount comes from health-related provisions.

**Key Revenue Sources:** Spending decreases generally receive the most public attention. However, it is important to review the significant amounts of revenue to be raised under the ACA from health-related provisions, with uncertain potential for unintended consequences or negative economic effects. Of the $420 billion in new revenues raised under the ACA, about $391 billion of that amount comes from health-related provisions. These are summarized below in a table prepared by the Joint Committee on Taxation (JCT).

TABLE I. HEALTH-RELATED REVENUE PROVISIONS IN PPACA AS AMENDED

| | *Effective Date, Taxable Years Beginning* | *Increase in Revenues (FY2010-FY2019)* | *Share of Health-Related Revenues* |
|---|---|---|---|
| Provisions Affecting Employers | — | $146.9 billion | 37.5% |
| Excise Taxes and Fees | — | $141.8 billion | 36.2% |
| 40% Excise Tax on High-Cost Plans | 2018 | $32.0 billion | 8.2% |
| Impose Annual Fee on Health Insurance Providers | 2014 | $60.1 billion | 15.3% |
| Annual Fee on Manufacturers and Importers of Branded Drugs | 2011 | $27.0 billion | 6.9% |
| Annual Fee/Excise Tax on Manufacturers and Importers of Certain Medical Devices | 2013 | $20.0 billion | 5.1% |
| 10% Excise Tax on Indoor Tanning Services | July 1, 2010 | $2.7 billion | 0.5% |
| Limitation on Employer Deductions | | $5.1 billion | 1.3% |
| Eliminate Deductions for Expenses Allocable to Medicare Part D subsidy | 2013 | $4.5 billion | 1.5% |
| Limit Deduction for Compensation to $500,000 for Executives of Health Insurance Companies | 2013 | $0.6 billion | 0.0%[a] |
| Provisions Affecting Individuals | — | $244.8 billion | 62.4% |
| Medicare Tax | — | $210.2 billion | 53.6% |
| Medicare Payroll Tax | 2013 | $86.8 billion | 22.1% |
| Medicare Contribution on Unearned Income | 2013 | $123.4 billion | 31.5% |
| Modifications to Tax-Advantaged Accounts and Itemized Deductions | | $34.6 billion | 8.8% |
| Limit Health Flexible Spending Accounts (FSAs) to $2,500 | 2013 | $13.0 billion | 3.3% |
| Raise Penalty for Non-Qualified Health Savings Account (HSA) Withdrawals from 10% to 20% | 2011 | $1.4 billion | 0.0%[a] |
| Change the Definition of Medical Expenses for FSAs and HSAs | 2011 | $5.0 billion | 1.3% |
| Raise 7.5% Floor for Itemized Medical Expenses to 10% for Those Under Age 65 | 2013 | $15.2 billion | 3.9% |
| Total Revenues Relating to Health Care | — | $391.7 billion | 100% |

Source: Joint Committee on Taxation, March 20, 2010. JCX-17-10.
Notes: Totals may not add to 100% due to rounding.
a. Less than 0.02%

## COMMENTARY >> ACA Revenue Sources

Each of the sources of revenue tends to create a political constituency for its repeal or modification. In some instances, Members of Congress face stiffer lobbying pressures from sources of so-called "pay-fors" in bills than occur for the actual provisions whose costs are being offset by the revenue source(s). Finally, as with all significant shifts in public financing, whether money is being distributed to or removed from selected targets, important shifts in incentives or behavior can occur in the healthcare system. While many may be positive, it is equally possible there can be negative unintended results over time. Opposition to revenue raisers and other impacts will likely force the Congress to revisit programs and financing repeatedly in later years as the need arises to address emerging problems. In fact, continuing issues under the Medicare physician payment system and its sustainable growth rate mechanism are a good example of such an on-going legislative and policy problem that, so far, has defied permanent solution.

**Opposition to revenue raisers and other impacts will likely force the Congress to revisit programs and financing repeatedly in later years.**

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With this backdrop, we will now turn to Part II and focus on the 2010 election and the 112th Congress.

# PART II: The 112th Congress and the Dynamics Affecting Healthcare System Change

## AFTERMATH: The 2010 Elections and the U.S. Congress

With the advantage of hindsight, January 2010 was a harbinger of things to come. A towering figure of liberal progressivism, former Massachusetts Senator Ted Kennedy, passed away in August 2009, leaving vacant a seat he had occupied as a Democrat for nearly 47 years. In an upset victory in a special election, that seat was won by Scott Brown, a Republican running with the support of the fledgling Tea Party movement. That success helped propel the Tea Party movement into prominence and energized potential Republican candidates across the country into challenging even relatively "safe" Democratic incumbents for U.S. Senate and House of Representatives seats.

**Tea Party Movement:** The Tea Party, an activist, conservative-leaning grassroots movement gathered political attention and clout as the November elections approached. Not cohesive enough to be a political party or platform in the traditional sense, nonetheless, their activists spread a strong message of fiscal conservatism advocating reductions in federal spending, achievement of a balanced budget, and reductions in federal debt. This movement was a clear response to the recessionary economy, concern over federal stimulus and bank bailout spending (initiated under President Bush, but continued and expanded under President Obama), and healthcare reform spending.

By election day, November 2, the country had racked-up reportedly the most expensive mid-term election in U.S. history. At stake for Republicans was the power of potentially regaining the Majority in the House and Senate and taking greater control of federal spending and legislation. At stake for the Democrats was the loss of the Majority they had just regained four years earlier. With President Obama's election in 2008, their Congressional leadership control had allowed them to act on a long-cherished Democratic Party objective, healthcare reform. For both parties, what was at stake was the relative strength of their positions leading into the 2012 Presidential election, where it is assumed President Barack Obama will seek a second term.

**Election 2010 Verdict:** Post-election, the verdict came in. According to exit polls conducted by the National Election Pool, a consortium of television stations and The Associated Press, the polling suggested the eventual outcome. Nine out of ten leaving the polling booths said they were worried about the economy, and four out of ten said their personal family situation had worsened in the past two years.

The Republicans, plus a number of self-described Tea Party candidates, whom had campaigns targeted to such fears, claimed 63 seats in the House and 6 in the Senate. This led to a Majority victory in the House at a ratio of 242 seats for the Republicans and 193 seats for the Democrats. It is worth noting that prior to the election, the Democrats had held a 41-seat cushion in the house under a ratio of 258 to 177 seats. Achieving the Majority in the House requires capturing 218 seats.

The verdict on the Senate side was a loss of 6 Democratic seats, allowing the Democrats to retain a weakened Majority under a ratio of 53 seats to the Republicans' 47 seats. Overall, 40 of the successful Congressional candidates were supported by the Tea Party, making them a force to be dealt with. Finally, in the Gubernatorial races, the Democrats lost 6 states, leading to a ratio of 20 Democratic governors, 29 Republican governors and 1 Independent governor (Lincoln Chafee, RI). Twelve states did not have gubernatorial races in this election.

## The 112th Congress

The 112th Congress was sworn in January 2012. Even prior to being sworn in, the Republican victors in the House showed considerable muscle in influencing the shape of the Medicare and Medicaid Tax Extenders Act of 2010, enacted on December 15. However, it is clear that there were and continue to be tensions in the House Republican caucus between the more senior Republican leaders and the highly activist new Members entering the House with Tea Party ideals and backing. To a certain extent, as noted in the New York Times on November 3rd, the Tea Party members have no clear mandate, have an uneasy and challenging relationship with Republican Party leaders, and are not showing much inclination for the compromises inherent in legislating. One Tea Party operative was even quoted as saying that "the Republicans are on probation."

With this backdrop, leadership elections occurred, Committee rosters and Chairmanships were awarded, and multiple legislative efforts are underway, including difficult negotiations with the Administration and Senate Democrats over multiple FY 2010 budget resolutions, pending the even tougher confrontation looming over FY 2012, described earlier in this report. This includes an early failed attempt at outright legislative repeal of the ACA. It was acknowledged by House leaders that repeal was doomed to failure (at least now) due to lack of Democratic support in the Senate and Administration opposition, but the vote had been promised during the campaign and had to be taken. So what are the tools and tactics Republicans can employ in their efforts to, if not fully repeal, at least modify or "de-fund" major aspects of the ACA? And what are some of the countercurrents to such efforts? These are discussed in the next section. But first, following is the current roster of House and Senate leaders courtesy of the Center for Responsible Politics. That is followed by a profile of the characteristics of the new Congress, courtesy of The Congressional Quarterly.

### 112TH CONGRESS HOUSE LEADERSHIP

| REPUBLICANS | DEMOCRATS |
|---|---|
| SPEAKER<br>John Boehner (Ohio) | MINORITY LEADER<br>Nancy Pelosi (Calif.) |
| MAJORITY LEADER<br>Eric Cantor (R-Va) | ASSISTANT MINORITY LEADER<br>James E. Clyburn (D-SC) |
| MAJORITY WHIP<br>Kevin McCarthy (R-Calif) | MINORITY WHIP<br>Steny H. Hoyer (D-Md) |
| CONFERENCE CHAIR<br>Jeb Hensarling (R-Texas) | CAUCUS CHAIR<br>John B. Larson (D-Conn) |
| POLICY CHAIR<br>Tom Price (R-Ga) | CO-STEERING CHAIR<br>Rosa DeLauro (Conn.) |
| NRCC CHAIR*<br>Pete Sessions (Texas) | CO-STEERING CHAIR<br>George Miller (D-Calif) |
| | DCCC CHAIR*<br>Steve Israel (N.Y.) |

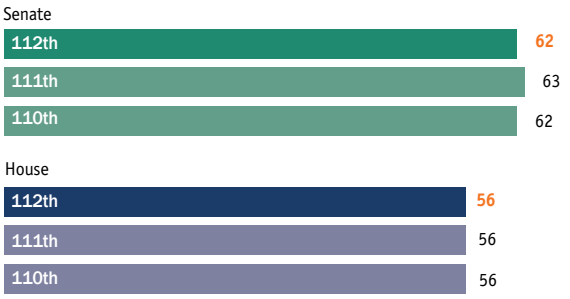
### 112TH CONGRESS SENATE LEADERSHIP

| DEMOCRATS | REPUBLICANS |
|---|---|
| MAJORITY LEADER<br>Harry Reid (Nev.) | MINORITY LEADER<br>Mitch McConnell (Ky.) |
| MAJORITY WHIP<br>Dick Durbin (Ill.) | MINORITY WHIP<br>Jon Kyl (Ariz.) |
| CONFERENCE SECRETARY<br>Patty Murray (Wash.) | CONFERENCE CHAIR<br>Lamar Alexander (Tenn.) |
| POLICY CHAIR<br>Charles Schumer (N.Y.) | POLICY CHAIR<br>John Ensign (Nev.) |
| DSCC CHAIR*<br>Patty Murray (Wash.) | NRSC CHAIR*<br>John Cornyn (Texas) |

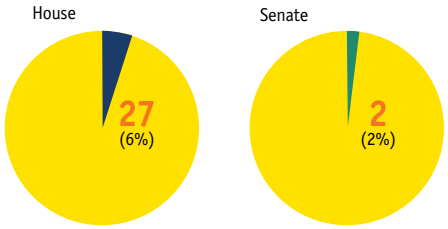
* These are the chief fundraising positions supporting members of their own party in each house of Congress.
DSCC = Democratic Senatorial Campaign Committee
NRSC = National Republican Senatorial Committee
DCCC = Democratic Congressional Campaign Committee
NRCC = National Republican Congressional committee

## CHARACTERISTICS OF THE MEMBERS OF THE 112TH CONGRESS

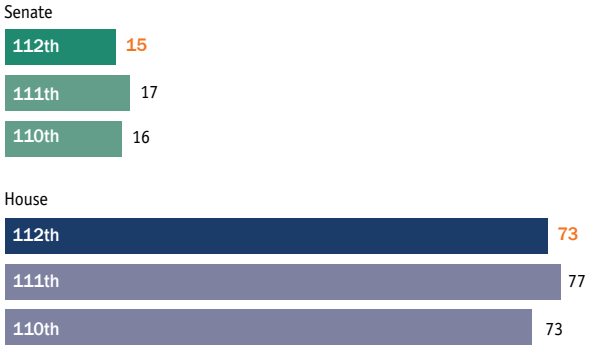
### AVERAGE AGE




### UNDER THE AGE OF 40




### WOMEN IN CONGRESS

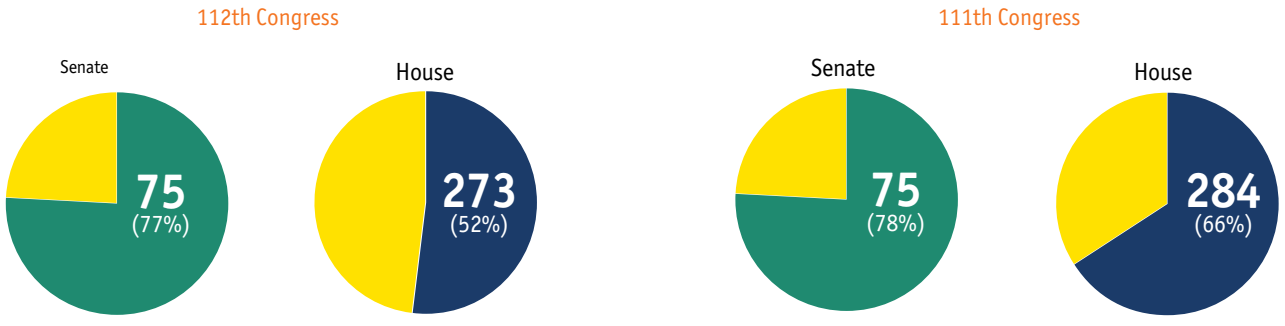



### OCCUPATIONS

| SENATE | 110th | 111th | 112th |
|---|---|---|---|
| Law | 58 | 54 | 52 |
| Public service/politics | 31 | 32 | 36 |
| Business | 27 | 26 | 28 |
| Education | 14 | 16 | 13 |
| Real estate | 3 | 6 | 7 |
| Journalism | 7 | 5 | 6 |
| Agriculture | 6 | 5 | 5 |
| Medicine/doctor | 3 | 3 | 5 |
| Labor/blue collar | 3 | 2 | 3 |
| Artistic/creative | 2 | 2 | 3 |
| Actor/entertainment | 0 | 1 | 3 |
| Military | 2 | 1 | 1 |
| Homemaker/domestic | 0 | 1 | 1 |
| Miscellaneous | 0 | 1 | 1 |
| Professional sports | 1 | 1 | 0 |

| HOUSE | 110th | 111th | 112th |
|---|---|---|---|
| Business | 162 | 175 | 181 |
| Public service/politics | 171 | 182 | 172 |
| Law | 158 | 152 | 148 |
| Education | 86 | 78 | 68 |
| Real estate | 35 | 35 | 40 |
| Agriculture | 23 | 26 | 24 |
| Medicine/doctor | 13 | 16 | 19 |
| Homemaker | 6 | 12 | 13 |
| Labor/blue collar | 12 | 13 | 13 |
| Secretarial/clerical | 9 | 11 | 10 |
| Health care | 8 | 10 | 9 |
| Journalism | 7 | 7 | 9 |
| Law enforcement | 9 | 10 | 8 |
| Military | 4 | 6 | 8 |
| Engineering | 3 | 6 | 5 |
| Professional sports | 1 | 1 | 4 |
| Science | 5 | 6 | 4 |
| Technical/skilled labor | 2 | 4 | 4 |
| Clergy | 3 | 1 | 3 |
| Actor/entertainment | 3 | 3 | 2 |
| Aeronautics | 1 | 0 | 2 |
| Miscellaneous | 2 | 1 | 1 |
| Artistic/creative | 1 | 0 | 0 |

### WITH ADVANCED DEGREES




Source: Congressional Quarterly. *Guide to the 112th Congress*. November 2010

## Congressional Tools, Tactics and Prospects; The Accountable Care Act on Life Support?

**Congressional Tools:** In brief, the Congress can legislate changes in existing federal programs, act to modify discretionary spending and appropriations, and effect alterations in implementation through oversight and investigations, leading to either new legislation or modifications in Executive Branch policies and actions as federal agencies carry out legislative intent. A uniquely detailed and complex law, the ACA has far-reaching social ramifications, directly affecting millions of individuals in the "around the kitchen table" sense as they grapple with health care coverage and cost concerns as families. Due to its scope and reach, ACA implementation has mobilized numerous federal government agencies, state governments, employers, health insurers and the entire health care community across the U.S. to address its requirements, costs and opportunities. For all these reasons, it is a particularly large target for opponents, but also a particularly large ship to turn around.

**Committee Hearings, Oversight and Investigations:** Members of Congress carry out numerous activities. These include legislation, representation, constituent service and political activities. We will focus on their legislative activities, which also include oversight, budget and funding aspects. This is background useful for advocacy purposes. Readers not involved in advocacy may choose to proceed to the next section on ACA funding.

According to the Congressional Research Service, at the beginning of the 112th Congress, there were 20 standing committees in the House with 103 subcommittees, and one select committee. The Senate has 16 standing committees with 74 subcommittees, as well as four select or special committees. In addition, there are four joint committees. There are three main types of committees: standing, select or special, and joint. Standing committees (for example, the House Committee on Ways and Means, or the Senate Committee on Finance) are permanent panels identified as such in chamber rules. Because they have legislative jurisdiction, standing committees consider bills and issues and recommend measures for consideration by their respective chambers. They also have oversight responsibility to monitor agencies, programs, and activities within

their jurisdictions, and in some cases in areas that cut across committee jurisdictions. Most standing committees recommend funding levels—authorizations—for government operations and for new and existing programs. A few have other functions. For example, the Appropriations Committees recommend legislation to provide budget authority for federal agencies and programs. The Budget Committees establish aggregate levels for total spending and send "instructions" to the other standing committees on their obligation to report legislation, as appropriate, that will achieve a stipulated share of the aggregate budget result sought by the Budget Committee, working with leadership.

The standing committees all have authority to conduct hearings and carry out other oversight activities concerning programs within their jurisdiction. Also, the Appropriation Committees in the House and Senate exercise oversight over fiscal issues. With respect to the ACA, to date, the House leadership has initiated a series of hearings into the ACA law, implementation and spending which are being carried

The ACA has far-reaching social ramifications, directly affecting millions of individuals in the "around the kitchen table" sense as they grapple with health care coverage and cost concerns as families.

out across the respective jurisdictions of multiple Committees (primarily Budget, Appropriations, Ways and Means, and Energy and Commerce). While certain Senate Committees (primarily Health, Education, Labor and Pensions (HELP) and the Senate Finance Committee) are also conducting hearings on the ACA, they are fewer and less adversarial under Democratic leadership. The ultimate purpose of oversight is to form a basis for Members to evaluate the direction of programs and the actions of the bureaucracy, with a view to effecting necessary changes in legislation and spending.

As the House Republicans delve more deeply into the ACA, the challenges they face grow. Noting how formidable a task it may be to successfully enact significant legislative changes at this time, there is a concerted effort to review options for "de-funding" the law instead. This is in keeping with their stated policy objectives and reduced federal spending goals. However, the following information reveals important details about funding methods and priorities tucked within the ACA that present challenges for the de-funding effort.

In effect, the statutory structure of the ACA presents a serious "follow-the-money" challenge for legislators to disentangle and act upon.

➤ **Internal ACA Funding Structures:** ACA structural and funding-linked issues have surfaced that are deeply relevant both to ACA implementation and to the repeal/modification/de-funding constituency in the Congress. Recall that the ACA is a deeply complex and lengthy set of legal provisions exceeding 2,000 pages in length. It is now evident that a number of decisions were made using binding statutory language to secure and direct, and in some areas "front-load," financing for key initiatives. In other words, novel provisions were enacted that reduce the ability of the Congress to review and modify spending priorities under their typical controls over discretionary spending and appropriations. In other words, it is not a straightforward process to exercise the usual discretionary tools over spending to modify or even deny funding to programs that are authorized under the ACA. This is so complex a problem that Members asked the Congressional Research Service to comb through the entire law to identify any and all such funding commitments in the law. In effect, the law is crafted in such a way as to complicate normal budget prerogatives that Members expect to be able to exercise over virtually any major federal program. Those tools will be covered in a following section.

According to the Congressional Research Service, "In some instances, PPACA, as amended, mandates appropriations or requires the Secretary of Health and Human Services (HHS) to transfer from the Medicare Part A and Part B trust funds billions of dollars to support new or existing grant programs and other activities. Among other provisions, PPACA appropriates funding for health workforce and maternal and child health programs, and establishes three multi-billion dollar funds. The first fund will provide a total of $11 billion over five years in supplementary funding for community health centers and the National Health Service Corps. (A separate appropriation provides $1.5 billion for health center construction and renovation.) The second fund will support comparative effectiveness research through FY2019 with a mixture of appropriations and fund transfers. The third fund, which is funded in perpetuity, is to support prevention, wellness, and other public health-related programs and activities authorized under the Public Health Service Act (PHSA)." (Source: CRS Report. *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act*., R41301.)

The Congressional Research Service has literally combed through the ACA and identified funding directives so extensive that it took them pages to summarize even in simplified chart form. This is beyond the scope of this report, but we would recommend your attention to the descriptive tables prepared by the Congressional Research Service and linked to this report. In effect, the statutory structure of the ACA presents a serious "follow-the-money" challenge for legislators to disentangle and act upon.

## COMMENTARY >> ACA De-Funding Challenges

The dilemma for any Member of Congress interested in repealing, modifying or de-funding the ACA is as follows. Repeal requires passage in the Senate, as well as the House, and the President's signature. Neither will happen under current conditions. It is conceivable that a narrow strip of common ground could be found to address issues that Congressional leaders and the Administration agree should be done within a negotiated budget agreement or by normal legislative means. One example of common ground was the agreement after the 2010 election to prevent the Medicare physician payment reduction from taking effect on January 1, 2011. Such common ground is not yet within sight regarding the ACA.

Separately, there are mechanisms and precedents by which Members historically have placed limitations on appropriations. Such limitations raise a unique set of involved Parliamentary rules (and rulings) on the House and Senate floor as to the permissible structure and substance of such limitations as legislation is being debated and voted upon. It is possible within this framework to enact 1) a total ban on spending for specific areas, 2) limitations to not exceed a certain level or percentage of otherwise authorized spending, or 3) language to prevent a specific regulation from being carried out. Such efforts can bring into play complicated rules regarding whether an action constitutes non-permissible "legislating on appropriations", and can raise fatal points of order on the House and/or Senate floor. In highly select circumstances, where there are sufficient votes, virtually any precedent or rule can be set aside to achieve an agreed-upon legislative objective. Ultimately, all strategies lead to the same place, i.e., neither the House nor Senate can act unilaterally to disrupt a law or the financing; the Chambers must act in concert on common ground, with .

In conclusion, it is possible that some changes could be agreed upon between the Congress and the President affecting the design and cost of the ACA. It is too soon to predict what those changes, if any, might be. In less partisan times, it is typical for federal agencies to work with the Congress to identify areas of law that need modification based on ongoing program experience and implementation. Once short-term FY 2011 debt ceiling and budget issues are addressed, the largest looming issue for Congressional leaders and the Administration is finding common ground on an overall budget agreement for FY 2012. It is unclear whether such ground can be found prior to the 2012 Presidential election, or whether the Congress will lurch through a series of confrontational short-term measures. Assuming that the ACA provisions and implementation proceed largely unimpeded in the near term (FY 2011), we now turn to Part III of the report to take a close look at select areas of most interest to physicians.

# PART III: Select Health System Reform Elements of Special Import to Physicians

In Part III, Section 1, we begin with a brief overview of how areas of responsibility under the ACA have been distributed across Cabinet Departments and other entities. This does not address the responsibilities required of many private sector entities, other than physicians, except tangentially, due to the focused scope of this report. This is followed by an overview of "new entities" created by the ACA. Finally, we will provide information on the main methods by which the government carries out its responsibilities in implementing any new piece of legislation.

Section 2 follows with topical summaries of selected delivery system and other reform provisions that we consider of special interest to physicians. Note that the Executive Summary provides commentary on broad implications for medical practice emerging from these reforms and concludes with suggested areas for attention and potential action for physicians as the Congress, federal and state governments, and the private sector act to implement and modify the ACA.

**Section 1**: ACA government responsibilities, implementation procedures, and new entities.
**Section 2**: Summaries of selected ACA areas of reform: A Study Guide

## SECTION 1

## Overview of Government Responsibilities, Implementation Procedures and New Entities Under the ACA

**Delivery System Reform Themes:** As we focus on health delivery system reform, rather than on all the broader aspects of the ACA, two key themes evolve. The first major theme is creation of a medical care and payer environment that fosters "value-based" provision and purchasing of health care services. Physicians' medical practices are at the heart of this effort, but it also includes hospital and other facility-based providers, and other caregivers, including those assisting in care coordination across medical settings. *Value-based purchasing of health care services, to policy-makers, marries quality care with cost management and cost reduction.*

The second major theme is achieving universal access to high-quality care, as closely as is possible in a country as large and diverse as the United States. As stated by HHS in its March 2011 Report to Congress on A National Strategy for Health Care Quality, "… our goal is to ensure that all patients receive the right care, at the right time, in the right setting, every time." The unspoken subtext is "at the right price."

The tension in the ACA is between the attempt to:

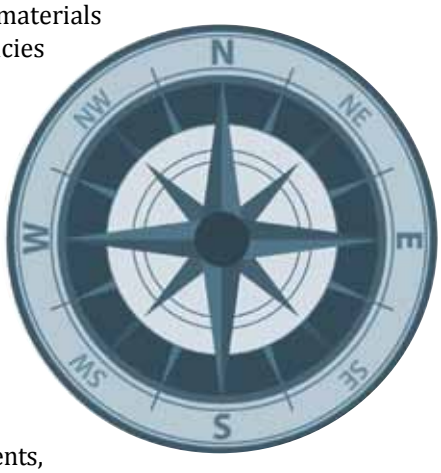
- design successful coverage expansions through public and private sector requirements,
- promote delivery system changes to achieve higher quality (workforce improvements, wellness, prevention, and evidence-based services that promote optimal outcomes for patients),
- all while bending the cost curve down (reducing unnecessary and inappropriate medical services, improving efficiencies and rewarding cost-effective care).

Before discussing individual areas, it is helpful to first understand selected entities and tools by which the Executive Branch is implementing the law.

**Distribution of Responsibilities:** Overall, the Department of Health and Human Services bears the brunt of new and expanded responsibilities under the ACA. These include new responsibilities for coverage expansions to be achieved under private health insurance, such as health insurance exchanges and high-risk pools via the new Center for Consumer Information and Insurance Oversight (CCIIO), located in CMS, plus a host of new provisions under Medicaid and Medicare. There are expanded roles for the Agency for Healthcare Quality and Research (AHRQ) and the Food and Drug Administration (FDA), among others. There are expanded healthcare fraud and abuse provisions that will be administered primarily by the HHS Office of the Inspector General, working with the Justice Department. There is a new role for the Administration on Aging (AOA), which has not traditionally managed direct benefit programs—the AOA has been charged with the responsibility for administering the CLASS Act, the voluntary, community support services insurance program.

The Department of Labor also has new responsibilities, primarily relating to numerous new provisions affecting employer and employee health benefit plans. These are being handled primarily within the Employee Benefit Security Administration (EBSA). There is a new Medicaid and CHIP Advisory Commission known as MACPAC. In addition, existing entities such as the Government Accountability Office (GAO), the Medicare Payment Advisory Commission (MedPAC), and the Institute of Medicine are charged with carrying out a variety of studies in areas within their charters. Separately, the Department of Treasury, including the Internal Revenue Service, is responsible for addressing a variety of ACA-initiated tax provisions and policies that will require interpretation and enforcement.

**ACA Implementation Mechanisms and Procedures:** Federal agencies have numerous tools by which to develop policies, invite public participation and implement policies. The major focus is the promulgation of regulations, which have the force of law. Regulations are often supplemented by sub-regulatory materials, such as program manuals, advisory bulletins, website announcements, educational materials, and memoranda. To date, over 20 regulations with ACA provisions in them have been published, along with reams of sub-regulatory materials across all the Departments and agencies implementing ACA provisions.




In the statutory language of the ACA, the Congress took a variety of approaches to providing direction on implementation. In various areas, the ACA specified that regulations are required, specified the form of regulation required or permitted (e.g., negotiated rulemaking), set effective dates for rules or other required actions, and/or remained silent on such requirements, leaving discretion to the Secretary. In a post-ACA report (supplied on the Physicians Foundation Health Reform website), the Congressional Research Service observed that the ACA:

> "…is a recent and particularly noteworthy example of congressional delegation of rulemaking authority to federal agencies. PPACA contains numerous provisions stating that federal agencies "shall promulgate regulations," or "shall, by regulation" take certain actions to

implement the legislation. During the past 65 years, Congress and various Presidents have developed an elaborate set of procedures and requirements to guide the federal rulemaking process, including the Administrative Procedure Act (APA, 5 U.S.C. §551 et seq.), the Regulatory Flexibility Act, the Paperwork Reduction Act, the Unfunded Mandates Reform Act, and Executive Order 12866. For example, Section 553 of the APA generally requires that agencies publish a notice of proposed rulemaking in the Federal Register, allow "interested persons" an opportunity to comment on the proposed rule, and then publish the final rule, which generally cannot take effect for at least 30 days. In addition to these crosscutting rulemaking requirements, certain statutes require that particular procedures be followed in the development of rules under those statutes. Other provisions in PPACA permit, but do not require, federal agencies to issue certain regulations. The amount of discretion provided to the agencies appears to vary with the wording of each provision, as do the implications of that discretion." (Source: CRS Report - *Regulations Pursuant to the Patient Protection and Affordable Care Act*. April 17, 2010.)

**Key implementation process points.**

**FAST FACTS**

- There are three types of federal rulemaking—formal, informal (also called "notice and comment,") and negotiated. Informal rulemaking will be the type most commonly used in implementing the health reform law.
- Federal regulations fill in details left vague in a law, either because lawmakers wanted a federal agency to make these decisions or because lawmakers couldn't reach agreement about an aspect of the legislation.
- Federal regulations carry the full force of law.
- The federal government and state governments have roles and responsibilities spelled out in the Patient Protection and Affordable Care Act.
- Among the roles states may choose to accept is setting up a pre-existing condition insurance plan and/or a health insurance purchasing exchange. A state can leave these tasks to the federal government. In 23 states, the federal government (rather than the states) is operating the pre-existing condition insurance plan.
- New minimum eligibility standards for Medicaid will require changes to the Medicaid program in most states.

SOURCE: ALLIANCE FOR HEALTH REFORM. *IMPLEMENTING HEALTH REFORM: FEDERAL RULES AND STATE ROLES*. OCTOBER 2010.

**State Issues:**
The ACA provisions are structured to distribute to and through States billions of dollars in administrative and benefit financing to participate in coverage expansions affecting Medicaid and the Children's Health Insurance Program (CHIP), as well as to carry out other functions such as establishment of temporary high-risk pools and the Health Insurance Exchanges. The extensive new responsibilities envisioned for States, especially paired with inflexibilities in the federal framework, are controversial in many States. This has led some States to legally challenge aspects of the ACA in federal court, and/or to decline to carry out selected discretionary tasks, e.g. high-risk pools or Medicaid expansions, unless the State is granted authority to deeply restructure the program. (Keep in mind that *under Constitutional separation of powers, no State is actually required to have a Medicaid program, but all have chosen to establish one*.)

These issues are outside the scope of this report, but we describe selected private insurance provisions briefly at the end of the Key Topics section below. These are areas to be aware of and watch over time. These disputes both challenge the constitutional and other legal bases for certain ACA provisions (e.g., interpretation of the applicability of the Constitution's Commerce Clause as a basis for the individual requirement to carry health insurance), as well as the "social contract" regarding federal and state roles. Where States decline to carry out certain functions, as a general rule, the law provides for the federal government to intervene and administer the legal requirements. Therefore, in some parts of the country, it is the federal government that is implementing some provisions that the law had intended States would voluntarily administer. The most immediate example is that 23 States have declined to establish temporary high-risk pools, necessitating direct federal administration in those jurisdictions.

For rules and issuances affecting physicians most directly, the primary website is **www.cms.gov**, which is maintained by the Centers for Medicare and Medicaid Services, within the Department of Health and Human Services. This website is a primary reference on Medicare, Medicaid, CHIP and private health insurance oversight, and also has links to other organizations within DHHS and in other Departments in federal government carrying out ACA requirements. Other useful links are provided on the Physicians Foundation Health Reform website.

➤ **New Entities:** The ACA provides for a number of new *entities*, although not nearly as many (159 or thereabouts) as were claimed initially in the "blogosphere" in 2010. Entities are distinct from the many trust funds, spending directives, grant programs, demonstration authorities and other new, and occasionally novel, matters initiated in the law.

A Congressionally commissioned review of the law uncovered approximately 46 references to entities, defined as Commissions, Boards and advisory councils of various stripes (Principal source: CRS Report. *New Entities Created Pursuant to the Patient Protection and Accountable Care Act*. July 8, 2010.) Of the 46, three relate to CMS and are significant to medical practice (discussed below), and others of varying significance relate to other areas. Of these, two relate to elder issues, seven relate to establishing or transferring the location of Offices of Women's Health, two relate to the CLASS Act, three to prevention matters, one to Minority Health, one to Health Information Technology (HIT), and several are vaguely defined, and/or discretionary, advisory councils (ten of which are not named in the law, but which are referred to in different program areas). Following is a selected list of notable entities.

**CENTER FOR MEDICARE AND MEDICAID INNOVATION** (CMI)—S. 3021(a)— for the purpose of testing innovative payment and service delivery models to reduce expenditures under Title XVIII and Title XIX. There are 18 models that could be included and specified factors for consideration. Models must be evaluated and annual reports to Congress must begin in 2012.

**INDEPENDENT MEDICARE PAYMENT ADVISORY BOARD** (IPAB)—S. 3403(a)—for the purpose of making annual recommendations to the Secretary and to MedPAC on reducing projected Medicare per capita spending if it will exceed a target rate of growth. The IPAB works relative to a framework of spending baselines and projections provided by the Chief Actuary of CMS. The Secretary is required to implement the IPAB proposals unless Congress intervenes legislatively. The first year proposals must be submitted is 2014. There is a law reference to a **"consumer advisory council"** to the IPAB for the purpose of representing the interests of consumers and particular communities that is to meet twice annually.

Note that there are significant policy and technical issues associated with the IMAB charter, and it is subject to intense lobbying in favor of repeal by provider groups. However, as noted above in ACA scoring discussions, CBO assumed significant savings ($16B) in the IPAB provision for an initially short budget window of 6 years. It is likely that if repeal were scored this year or next, the *cost of repeal* will have grown considerably if only because more years of IPAB action would be included in any updated, 10-year budget window, raising the price tag in a Congress that is now keen to reduce the deficit.

**NATIONAL HEALTH CARE WORKFORCE COMMISSION**—S. 510(a)—This is a 15 member entity with health care labor market expertise to review workforce issues, such as supply and demand, career pathways, etc., and is charged with advising the Administration and Congress on workforce priorities at least annually. Note that there is also a **National Center for Workforce Analysis** (S. 5103(a)) and a **Personal Care Attendants Workforce Advisory Panel** (S. 8002(c)). The former is poorly specified, but would develop information regarding the workforce and develop measures, as well as evaluate programs. The latter is within HHS for the purpose of advising the Secretary of workforce issues relating to personal care attendant workers.

**BOARD OF TRUSTEES OF THE CLASS INDEPENDENCE FUND, AND THE CLASS INDEPENDENCE ADVISORY COUNCIL**—S. 8002(a)—The Board oversees the actuarial soundness and operation of the CLASS Independence Fund, with annual reporting to Congress responsibilities. The Council advises the Secretary of HHS on the policies, premiums, benefits and administration of the CLASS program. Note that the CLASS Act, due to its 5 year window of collecting premium revenues before benefits begin, was a significant scoring advantage in the overall ACA, reducing the apparent cost in the 10-year budget window.

**INTERAGENCY WORKING GROUP ON HEALTH CARE POLICY**—S. 3012(a)—Without specifying creation date, this is composed of representatives from major agencies (22+, including the CMS, the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the Agency for Healthcare Research and Quality (AHRQ)). It is chaired by the Secretary of HHS and is intended to promote greater collaboration, avoidance of duplication and alignment of public and private initiatives.

**HHS COORDINATING COMMITTEE ON WOMEN'S HEALTH**—S. 3509(a)—This is within HHS and is chaired by the Deputy Assistant Secretary for Women's Health and is to be composed of senior representatives from throughout HHS. Note that actions to move location of or to establish new offices relating to women's health were taken in numerous sections. Note that the office created within **FDA** (S. 3509(g)) must examine women's participation in clinical trials and analysis by sex in testing of drugs, biological products, and devices. Separately, there is established in S. 3509(e)), an **Office of Women's Health and Gender-Based Research**. This office is placed within AHRQ and is to help establish goals within AHRQ for women's health, to assist in external consultation, and to identify projects that should be supported.

**OFFICES OF MINORITY HEALTH**—S. 10334(b)—Although drafted differently, this section is similar in purpose to the multiple provisions relating to women's health offices. This section requires six new Offices of Minority Health to be located in different HHS agencies, without specifying duties or composition, other than that Directors must be experienced in minority health services research and health disparities elimination.

**PREVENTIVE SERVICES TASK FORCE**—S. 4003(a)—This is to be convened by AHRQ, with no specificity on dates or composition. It is intended to review evidence on preventive services and contribute updates to the Guide to Clinical Preventive Services. Note that there are multiple and potentially overlapping entities described in the ACA with prevention responsibilities. These include the **National Prevention, Health Promotion and Public Health Council** (S. 4001(a)), and the **Advisory Group on Prevention, Health Promotion and Integrative and Public Health** (S. 4001(f)). The former is chaired by the Surgeon General and cuts across Cabinet Departments such as HHS, Labor, Education, Agriculture, Homeland Security and several agencies**.** The latter is within HHS and reports to the Surgeon General. Both support national prevention, chronic disease, and health strategies with differing reporting requirements.

**PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE**—S. 6301(a)—This is required to be non-profit corporation that is "neither an Agency nor establishment of the United States government." Having said that, the Comptroller General appoints nineteen members to the Institute's Board of Governors, plus the Directors of AHRQ and NIH, or their designees. Membership composition is specified to achieve a cross-section of representation. The purpose is to carry out an agenda on how to improve evidence on the prevention, diagnosis, and treatment of health conditions, including authority to conduct research, award contracts and disseminate findings.

In closing, for those key entities that seek or are required to draw members from outside of government, physicians and their representatives are advised to consider how best to actively secure appropriate representation of physicians and their interests on those Boards and advisory committees. It is important to also investigate the staff assigned or delegated to such bodies, and to try to ensure that genuine medical expertise is represented among professional staff, as well.

SECTION 2

## Key Health Care Delivery and Payment Provisions in the ACA

# A Study Guide


➤ **Overview.** As noted in the opening of this report, the healthcare delivery and payment system elements of the ACA are likely the most resistant to repeal. This is because they reflect long-growing consensus among policy-makers of the need to act in tangible ways to 1) improve quality and efficiency, 2) achieve value-based purchasing, and 3) to bend the cost curve downwards. However, despite some common ground, the ACA inevitably will be modified over time, including some of the delivery system reforms. The key is to bring individually and collectively, physicians' professional training and practice experience to bear in each of the areas identified below to shape responses and changes, as needed.

➤ **Supplemental Resources**. To date, there are about 40 major areas of direct interest to physicians, not including specific Medicaid and private insurance elements that are likely of general interest. An exhaustive review of each of these areas is beyond the scope of this report. However, to maximize assistance to physicians, the following sections will provide information on several key areas with links to further resources for those who need to pursue topics in greater depth. The following technical information draws primarily from a review of statutory language, edited abstracts derived from multiple Congressional Research Service documents prepared for Congressional Committees, and review of Administration implementation materials posted on multiple government websites. Additional reputable private sources, including those of several physician organizations, were also consulted. All source documents are identified in the Bibliography and made available on the Physicians Foundation Health Reform website.

➤ **Key Changes for Physicians—Introduction to Topical Summaries:** The ACA made numerous changes to the Medicare program that will affect physicians and how they practice, both immediately and over time. Some of the provisions will have clear and direct consequences; for instance, they've already begun to alter physician reimbursement. Other changes may influence how physicians practice medicine in the future by changing the incentives in the organization and delivery of care.

➤ **Immediate Modifications**. The most *immediate modifications* included extensions of several existing demonstration programs and payment policies, plus modifications to the Medicare fee schedule. These include: 1) payment and care model demonstrations, 2) the extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule, 3) the payment for the technical component of certain physician pathology services, and 4) the extension of the mental health add-on to the physician fee schedule. In addition, changes were made to the equipment utilization factor assumption used to determine payment for advanced imaging services, in order to reduce payment levels for such services. The ACA created new demonstration authority for payment of certain complex diagnostic laboratory tests, and modifies Medicare payment for certain bone density tests.

The ACA gives the Secretary (through CMS) additional flexibility to be able to review and adjust potentially misvalued codes under the physician fee schedule, establishes floors for some Medicare payments for providers who practice in states that meet the definition of a

Notably, the Physician Compare website, in its infancy now, aims to eventually include publicly available information on physician performance.

"Frontier State." There is a new bonus payment for evaluation and management, and certain general surgery, services for five years beginning January 1, 2011, with the intent to expand support for and improved access to primary care and general surgery services.

➤ **More Systemic Modifications**. Other provisions are more deeply systemic and will significantly influence physician practice into the future. This includes extension of the Medicare Physician Quality and Reporting Initiative (PQRI) incentive payments through 2014, and which implements an incentive (penalty) for providers who do not report quality measures beginning in 2015. The PQRI provides for an additional bonus to physicians who meet the requirements of a continuous assessment program (the Maintenance of Certification Program, MOCP) as well as a penalty for those who do not meet the standards in the future. [Please note that CMS has recently renamed this program as the Physician Quality Reporting "System", rather than "Initiative."]

The ACA requires new types of reports and data analyses under the Physician Feedback Program established under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275). This includes the development of an episode grouper that combines separate, but clinically related, items and services into an episode of care payment for an individual, as appropriate, and the provision of reports to physicians that compare patterns of resource use of each physician to the patterns of other peer physicians. Information on Medicare physicians will be reported publicly on a new Physician Compare website already established by CMS. *Notably, the Physician Compare website, in its infancy now, aims to eventually include publicly available information on physician performance.*

Finally, there are key provisions that pursue deeper objectives to fundamentally alter how physicians organize, practice, and deliver care in the future. Some of these provisions create new structures and entities, like the CMS Center for Medicare and Medicaid Innovation, the Independent Payment Advisory Board, and the Patient-Centered Outcomes Research Institute (PCORI). Other provisions lay a foundation for alternatives to traditional fee-for-service payment, such as the National Pilot Program on Payment Bundling, the shared savings program (including the much-discussed accountable care organization, or ACO, model), and the value-based payment modifier under the physician fee schedule.

The PCORI focus on comparative effectiveness research results dissemination, when combined with incentives under alternative payment models, could generate changes in practice organization and financing, care delivery approaches and patient outcomes. The CMS Medicare and Medicaid Innovation Center is granted the authority and flexibility to adopt new payment alternatives, so long as certain criteria are met—for instance, maintaining quality while reducing expenditures, or improving quality without increasing expenditures.

➤ **Key Topics and Detailed Summaries**. Following are more detailed summaries on the above issues. These sections are followed by a brief discussion of other areas within the ACA that physicians should be aware of, for example, workforce initiatives and selected health plan rules that could influence provider contracting in the future. Associated resources are linked via the Physicians Foundation Health Reform website

(Principal sources: The statute, plus multiple Congressional Research Service reports, cited in the Bibliography, on Medicare provisions, Medicaid and CHIP provisions, the CLASS program, and private health insurance provisions in the ACA, all of which provide further detail for interested readers.)

## KEY TOPICS

Key topics appear in the order, and as numbered, below:

1. CMS Center for Medicare and Medicaid Innovation
2. Independent Payment Advisory Board
3. Patient-Centered Outcomes Research Institute, Comparative Effectiveness, Quality Reporting, Feedback Programs and Physician Compare
4. Value-based Purchasing (Hospitals)
5. Payment Pilots and Reform Initiatives
   - Accountable Care Organizations
   - Medical Home
   - Bundled Payments and Global Capitation
   - Value-Based Modifier on the Physician Fee Schedule
   - Gainsharing Demonstrations
6. Physician Fee Schedule Adjustments; Market Basket Update and Productivity Adjustment; Geographic Adjustment; Other Payment Adjustments
7. Workforce Initiatives
8. Rural Initiatives
9. Health Plans and Medical Loss Ratios
10. Health Insurance Exchanges

### Key Topic Summaries

### 1 CMS Center for Medicare and Medicaid Innovation

The Secretary of HHS has broad authority to develop and engage in experiments and demonstrations to test new approaches to paying providers, deliver health care services, or provide benefits to beneficiaries participating in federal health care programs. All demonstrations are required to be budget neutral and be approved by the Office of Management and Budget (OMB) prior to implementation.

This provision requires the Secretary, no later than January 1, 2011, to establish a Center for Medicare and Medicaid Innovation (CMI) within CMS. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting these models, the Secretary is also required to give preference to models that improve the coordination, quality, and efficiency of health care services. In carrying out these functions, the Secretary is required to consult with relevant federal agencies and experts in medicine and health care management.

**PHASE I—MODEL SELECTION.** The Secretary is required to select models that address a defined population with poor clinical outcomes or avoidable expenditures. The provision provides the Secretary with the authority to limit testing to certain geographic areas and select demonstration models that address a variety of themes, including medical homes, coordinated care, alternative payment mechanisms, HIT, medication management, patient education, integrated care for dual-eligibles, care for cancer patients, post-acute care, chronic care management, telehealth, and collaboration among mixed provider types.

The Secretary will not have to require, as a condition for testing, that the model be budget neutral initially with respect to expenditures. When selecting models, the Secretary is authorized to consider additional factors such as whether the model includes a process for managing patient care plans, places the applicable individual at the center of the care team, utilizes technology, and demonstrates effective linkage with other private and public sector payers, among other elements.

**EVALUATION.** The Secretary is required to conduct an evaluation of each model tested and make the evaluations publicly available in

**The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished to individuals under such titles.**

a timely fashion. Evaluations are required to include an analysis of (1) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centered criteria as determined by the Secretary, and (2) the changes in spending. The Secretary may require States and other entities participating in the demonstrations to collect and report information necessary to evaluate these models.

**TERMINATION AUTHORITY.** The provision requires the Secretary to terminate or modify demonstrations that do not meet one of three conditions: (1) improve quality without increasing spending; (2) reduce spending without reducing quality; or (3) improve quality and reduce spending.

**PHASE II—DEMONSTRATION MODIFICATIONS.** Taking into account the results of an evaluation, the Secretary has the authority to expand the duration and scope of a demonstration, including nationwide, if the Secretary determines that an expansion would: (1) reduce spending without reducing quality or improve quality without increasing spending; (2) the CMS Office of the Actuary certifies that an expansion would reduce (or not increase) net program spending under applicable titles; and (3) not deny or limit coverage.

**WAIVER AUTHORITY.** The provision grants the Secretary the authority to waive requirements of Titles XI, Titles XVIII, and sections 1902(a)(1), 1902(a)(13), and 1902(m)(2)(A)(iii) as necessary to conduct these demonstrations. The provision also exempts the testing, evaluation, and expansion of demonstrations from Chapter 35 of title 44, the Paperwork Reduction Act (PRA), which requires federal agencies to receive OMB approval for each collection of information request.

**FUNDING.** The provision appropriates $5 million for the design, implementation, and evaluation of models for FY2010; $10 billion for the activities under this section for the years 2011 through 2019; and $10 billion for the activities initiated under this section for each subsequent 10-year fiscal period beginning with 2020. Amounts are available until expended. The provision requires that no less than $25 million be allocated to design, implement, and evaluate the specific models identified in this provision.

**OVERSIGHT.** Beginning in 2012, the Secretary is required to submit to Congress, at least once every other year, a report on the activities performed by the CMI. Reports are required to include a description of the demonstrations, the number of participants, the amount of payments made on behalf of these participants, models chosen for expansion, and evaluation results. Reports are also required to include recommendations for legislative action to facilitate the development and expansion of such models nationwide.

The CBO score was $0.7 billion for FY2010-FY2014 and minus $1.3 billion for FY2010-FY2019.

## 2 Independent Payment Advisory Board

**OVERVIEW.** This provision establishes an Independent Payment Advisory Board (IPAB) to develop and submit detailed proposals to Congress and the President to reduce Medicare spending. The Board is to consist of 15 members with expertise in health care financing, delivery, and organization. All members are to be appointed by the President and confirmed by the Senate. There are ex-officio members of the IPAB, namely, the Secretary of HHS, and the Administrators of CMS and HRSA. The Chief Actuary of CMS plays a very significant technical role in supplying the cost estimates that the IPAB relies upon in triggering action.

The IPAB proposals are to primarily focus on payments to certain providers, although in later years, the IPAB is authorized to address broader-scope health care cost matters beyond the Medicare program. *It is unclear whether or to what degree the IPAB, which is appointed, not elected, is authorized to adjust physician payments (see commentary at the end of this section).* The law directs the Board to recommend savings for Medicare if the per capita growth in Medicare spending exceeds defined benchmark growth rates. The initial target is based on an inflation

It is unclear whether or to what degree the IPAB, which is appointed, not elected, is authorized to adjust physician payments (see commentary at the end of this section).

measure; in 2020 and beyond, the target shifts to per capita growth in the economy (GDP, or gross domestic product, plus one percent.) Importantly, the targets are not caps on Medicare spending; rather, the IPAB is intended to reduce Medicare spending by the amount of excess over the target rate of growth, subject to a limit. The spending correction is limited by a specific percentage ceiling on the magnitude of the correction. This is known as the "applicable percent." That limit in 2015 is 0.5%; in 2016, 1.0%; in 2017, 1.25%; and, in 2018 and beyond, 1.5%.

The Board is prohibited from developing proposals related to Medicare benefits, eligibility, or financing. Recommendations made by the Board automatically go into effect unless Congress enacts specific legislation within specified timeframes and procedures, to prevent their implementation. The first year the Board's proposals can take effect is 2015. Following is a detailed description of the structure, scope and requirements relating to IPAB actions, Congressional review and a built-in opportunity for the Congress to terminate the Board. These are, in part, abstracted from the previously referenced Congressional Research Service Report on Medicare Provisions in the PPACA, made available in full on the Physicians Foundation website. For a thoughtful preliminary discussion of longer-term IPAB issues, we refer you to a Kaiser Family Foundation report entitled *The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending.* April 2011—also made available in the resource documents for this report.

**THE IPAB BOARD.** The Board is to be composed of 15 members, appointed by the President with the advice and consent of the Senate. Members of the Board will serve six-year, staggered terms. Members may not serve more than 2 full consecutive terms. The Senate Majority Leader, the Speaker of the House, the Senate Minority Leader, and the House Minority Leader each present three recommendations for appointees to the President. The President, with the advice and consent of the Senate, is required to appoint a Chair for the Board. The Board elects the Vice Chairman. Members can be removed by the President for neglect of duty or for malfeasance in office. In addition to the 15 members of the Board, the Secretary of Health and Human Services (HHS), the Administrator of the Center for Medicare and Medicaid Services (CMS), and the Administrator of the Health Resources and Services Administration (HRSA) will serve as ex-officio, non-voting members of the Board.

**QUALIFICATIONS.** Qualifications for membership are similar to the qualifications required for members of the Medicare Payment Advisory Board (MedPAC). Individuals involved in the delivery or management of health care services cannot constitute a majority of the Board. In addition to these qualifications, the President is required to establish a system for publicly disclosing any financial or other conflicts of interests relating to members. Individuals that engage in any other business, vocation, or employment cannot serve as appointed members of the Board.

Members are considered officers in the executive branch for purposes of applying Title I of the Ethics in Government Act of 1978. After serving on the Board, former members will be barred from lobbying the Board and other relevant executive branch departments and agencies and relevant congressional committees for one year.

The Chair will be responsible for exercising all of the Board's executive and administrative functions, including those related to the appointment and supervision of employees and the use of funds. All requests for discretionary appropriations to fund the Board's activities must be approved by a majority vote.

**REQUIREMENTS FOR PROPOSAL SUBMISSION.** The provision requires that the Board submit proposals to the President for years in which the projected rate of growth in Medicare spending per beneficiary exceeds a target growth rate. Determinations of the projected and target growth rates are to be made by the CMS Office of the Actuary (OACT) beginning in 2013. The Board is required to submit its first proposal to the President by January 15, 2014, for implementation in 2015. If the Board fails to submit a proposal to the President

The Board is to be composed of 15 members, appointed by the President with the advice and consent of the Senate. Members of the Board will serve six-year, staggered terms. Members may not serve more than 2 full consecutive terms.

by January 15, the Secretary will be required to submit a contingent proposal to Congress meeting the same requirements by January 25.

For years 2014 through 2017, the Board will be required to submit proposals for years in which the projected rate of growth in Medicare spending per beneficiary exceeds the average of the projected percentage increase in the Consumer Price Index for All Urban Consumers (CPI) and the Consumer Price Index for Medical Care (CPI-M). Beginning in 2018, proposals will only be required for years in which the projected rate of growth in Medicare spending exceeds the Gross Domestic Product (GDP) plus 1.0%. Recommendations proposed by the Board are required to reduce Medicare spending by the lesser of 0.5 percentage points in 2015, 1.0 percentage points in 2016, 1.25 percentage points in 2017, 1.5 percentage points in 2018, and the amount by which the rate of growth in Medicare spending exceeds the target growth rate. Proposals cannot increase Medicare spending over a 10-year period.

In the above-referenced Kaiser Foundation Report, they provided a helpful timeline chart that is displayed below. It depicts the 3-year process cycle created by the operational and reporting requirements in the law. In effect, using their terminology, the IPAB process in brief is:

- a *determination year* regarding the Actuary's spending calculations relative to the applicable target (by April 30), followed by *draft* IPAB recommendations (by September 1), followed by
- a *proposal year* in which the IPAB submits its *final* recommendations (by January 15), followed by
- an *implementation* year, which can be either October 1 of the proposal year (for federal fiscal period policies), or January 1 of the next year (for calendar year policies).

**Note:** The latter part of the determination year and early-mid part of the proposal year create the timeframe in which the Secretary of HHS and MedPAC carry out certain specified tasks, and the proposal year encompasses Congressional fast-track review procedures described in detail below.

**SCOPE OF PROPOSALS.** The provision lays out a number of specific fiscal and policy criteria that the Board will be required to meet in making its recommendations. When developing and submitting proposals, the Board is required, to the extent feasible, to (1) prioritize recommendations that would extend Medicare solvency and target reductions to sources of excess cost growth; (2) include only those recommendations that improve the health care delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement and protect beneficiary access to care, including in rural and frontier areas; (3) consider the effects of changes in provider and supplier payments on beneficiaries; consider the effects of proposals on any provider who

IPAB SCHEDULE AND DEADLINES BASED ON THREE-YEAR CYCLE: DETERMINATION YEAR; PROPOSAL YEAR; IMPLEMENTATION YEAR

| | 1st "Determination Year" CY 2013 - *Quarters:* | | | | 1st "Proposal Year" CY 2014 - *Quarters:* | | | | 1st "Implementation Year" CY 2015 - *Quarters:* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| CMS Actuary projection, determination | | 4/30 | | | | | | | | | | |
| IPAB draft to MedPac and HHS Secretary | | | 9/1 | | | | | | | | | |
| IPAB proposal to President and Congress | | | | | 1/15 | | | | | | | |
| Default - HHS Secretary proposal if IPAB doesn't act | | | | | 1/25 | | | | | | | |
| HHS Secretary and MedPac reports on IPAB proposal | | | | | 3/1 | | | | | | | |
| Deadline for Congressional Committees | | | | | | 4/1 | | | | | | |
| Secretary Implements Recommendations | | | | | | | 8/15 | | | | | |
| Recommendations for CY payment rates effective | | | | | | | | 10/1 — 9/31 | | | | |
| Recommendations for FY payment rates effective | | | | | | | | | 1/1 — 12/31 | | | |

has, or is projected to have, negative profit margins or payment updates; (4) consider the unique needs of individuals dually eligible for Medicare and Medicaid, and (5) include recommendations for administrative funding to carry out its recommendations.

**RECOMMENDATIONS AND LIMITATIONS.** As appropriate, each proposal is required to include recommendations that would reduce spending in Medicare Parts C and D. Reductions could be obtained by reducing Medicare payments for administrative expenses to MA and PDP plans, denying or removing high bids for drug coverage from the calculation of the monthly bid amount for Part D plans, and reducing performance bonuses for MA plans. Recommendations may not target the base beneficiary premium percentage or the full premium subsidy for Part D plans. The Board is prohibited from making recommendations that would ration care, raise revenues, increase beneficiary premiums, increase beneficiary cost-sharing, restrict benefits, or modify eligibility. Additionally, proposals submitted before December 2018 for implementation in 2020, cannot include recommendations that would reduce payments to providers and suppliers scheduled to receive a reduction in their payment updates in excess of a reduction due to productivity.

**PRESIDENTIAL REVIEW.** At the beginning of the year following the determination by the Secretary, the Advisory Board is to submit its recommendations to the President who is to, in turn, immediately submit them to Congress. (Note that this is typically the kind of authority that can be delegated by the President to an office within the Executive Office of the President, such as the Office of Management and Budget.) The provision dictates certain information that must accompany the Advisory Board's submission, including a requirement for legislative language implementing the recommendations.

**CONGRESSIONAL REVIEW AND FAST TRACK PROCEDURES.** These provisions create a very tight, rapid procedural window within which the Congress can act to change or overturn a pending IPAB action affecting Medicare spending. *The following details are complex, but are important for those who either wish to advocate for changes in this area, or influence Congressional deliberations if the law proceeds as currently written.* Other readers can move to the next sections.

Section 3403 directs the Secretary to automatically implement the Board's recommendations unless Congress, by August 15 of the year in which the recommendations

are submitted, enacts legislation superseding the Board's proposal. The provision establishes special "fast track" parliamentary procedures governing congressional consideration of legislation implementing the Board's recommendations. These fast track procedures differ from the normal parliamentary mechanisms used by the chambers to consider most legislation and are designed to ensure that Congress, should it choose to do so, can act quickly on the proposal put forth by the Advisory Board.

The fast track procedures established by the provision mandate the introduction of the Board's legislative proposal by the House and Senate majority leaders "by request" on the day it is submitted to Congress. When introduced, such legislation is to be referred to the Senate Committee on Finance and to the House Committees on Energy and Commerce and Ways and Means. These committees may mark up the measure, and must report

it to their respective chambers not later than April 1 or be discharged of its further consideration. The expedited procedure waives the provisions of Senate Rule XV, which would ordinarily bar the Finance Committee from reporting a committee amendment containing significant matter not in its jurisdiction so long as the amendment in question "is relevant" to a proposal in the Advisory Board bill.

***Note:*** *The provision also restricts the House or Senate from considering any amendment (including committee amendment), bill, or conference report that would repeal or change the Board's recommendations unless those changes meet the same fiscal and policy criteria (described above) that the Board was required to meet in developing its recommendations.* The ACA provides for this restriction to apply not only to House and Senate consideration of the Board legislation submitted by the President, but to all other legislation Congress considers as well. This restriction may be waived solely by a vote of three-fifths of the Members.

No expedited procedures are established for initial House floor consideration of the Board's legislation. In the Senate, a motion to proceed to consider the legislation is privileged and not debatable. Amendments offered to the legislation on the Senate floor must be germane and may not reduce the savings in Medicare per capita growth below established targets. Debate in the Senate on each amendment to the bill is limited and overall Senate consideration of the legislation may not exceed 30 hours, after which a final vote will be taken on it. In the event that there is a need to resolve bicameral differences on the legislation, debate on any conference report or amendment exchange is limited to no more than 10 hours, after which a final vote will occur. Should the measure be vetoed, Senate debate on a veto message is limited to one hour.

**TREATMENT OF LEGISLATION TO DISCONTINUE PAYMENT ADVISORY BOARD.** The provision establishes an additional set of fast track parliamentary procedures governing House and Senate consideration of a joint resolution to discontinue the Independent Payment Advisory Board and the "automatic" process of implementation described above. These procedures ensure that the House and Senate may act promptly on such a measure by limiting debate and amendment at the committee and floor level. *The procedures also establish a supermajority voting requirement of three-fifths of Members duly chosen and sworn for passage of such a joint resolution in each chamber.*

**IMPLEMENTATION BY THE SECRETARY.** The Secretary is required to implement the Board's recommendations by August 15 of the year in which the proposal was submitted. Any recommendation that would change a provider's payment rate will apply on the first day of the first fiscal year, calendar year, or rate year (which varies depending on provider type) after August 15th. Beginning in 2019, the Secretary will be prohibited from implementing the Board's recommendations if two conditions are met: (1) the Board was required to submit a proposal to Congress in the preceding year, and (2) the CMS Chief Actuary determined that the rate of growth in per capita national health expenditures (NHE) exceeded the rate of growth in per capita Medicare spending. These restrictions are not to affect requirements pertaining to the Board's submission of proposals to Congress or the rules related to congressional consideration of these proposals.

**ADDITIONAL REVIEW PROCEDURES.** The Board must submit a draft copy of each proposal it develops to the Medicare Payment Advisory Commission (MedPAC) and to the Secretary of HHS for review.

**ADVISORY FUNCTIONS.** Beginning in 2014, for any year the Board is not required to submit a proposal to the President and Congress, the Board will be required to submit to Congress advisory reports on matters related to the Medicare program. Prior to 2020, these reports may include recommendations

to improve payment systems for those providers and suppliers exempted from the Board's recommendations. Beginning in 2015, the provision also requires that the Board submit to Congress and the President advisory recommendations to slow the rate of growth in national health expenditures (NHE). These recommendations cannot target expenditures in federal health care programs. The Board will be required to coordinate these recommendations, which must be made available to the public, with those contained in other Board proposals and advisory reports.

**Note:** *IPAB recommendations, which are required at least every two years, can be implemented administratively by the Secretary or legislatively by the Congress. These advisory reports will not be subject to the rules for congressional consideration.*

**FUNDING.** The provision appropriates $15 million to the Board to carry out its functions beginning in year 2012. This amount will increase by the rate of inflation for each year thereafter. Sixty percent of the appropriation will come from the Part A Medicare Trust Fund and 40% from the Part B Trust Fund.

**OVERSIGHT.** The provision establishes a **consumer advisory council** to advise the Board on the impact of payment policies on consumers. The Council is to be composed of 10 consumer representatives appointed by the Comptroller General of the United States, each from among the 10 regions established by the Secretary. The provision also requires the GAO to conduct a study on changes in payment policies, methodologies, rates, and coverage policies under Medicare resulting from the Board's proposals. Specifically, the study is to provide an assessment of the effect of the Board's proposals on Medicare beneficiary's access to providers, affordability of premiums and cost-sharing, the potential impact of changes on other government or private sector purchasers of care, and the quality of care provided. The report is due by July 1, 2015. The GAO is to conduct additional studies as appropriate.

The CBO score was $0.0 billion for FY2010-FY2014 and -$15.5 billion for FY2015-FY2019.

**COMMENTARY** **The impetus for the IPAB was concern from many quarters about the ability of the Congress, in a deeply complex program and political environment, to effectively contain the growing costs of the Medicare program. In enacting the IPAB, the Congress chose to grant to an independent entity exceptional powers over the aggregate spending trajectory in the Medicare program.** While there was support for such an approach, there is also growing opposition to it. There are also serious technical and administrative issues surfacing as analysts dissect the potential operations of the future IPAB.

It is important to note that certain classes of providers are exempt from mandatory IPAB recommendations due to recognition that they are already subject under the ACA to payment reductions below the level of the automatic annual productivity adjustments called for under the Act. These include inpatient and outpatient hospital services, inpatient rehabilitation and psychiatric facilities, long-term care hospitals, and hospices until 2020. Clinical laboratories are exempt until 2016.

As noted in the Kaiser Foundation paper, the sustainable growth rate (SGR) formula creates a complicated and ambiguous set of issues regarding the IPAB's purposes and any recommendations as they relate to physician payments. The law specifies that the CMS Chief Actuary is to assume a zero-percent increase in the physician services baseline for IPAB spending projection purposes, not the reductions that the SGR is known to require, but which the Congress repeatedly overrides, at a scoreable legislative cost. This means that *for IPAB purposes*, physician spending is set on a no-growth or freeze trajectory. This does not necessarily mean that legislative action to fix or repeal the SGR would not score (legislative baselines are different and current cost estimates for repeal are about $300 billion), but it raises serious technical and policy matters for potential advocacy. This and related issues are raised for further discussion in the conclusion of the report.

There are a number of other questions raised, technical, administrative, and political. These include, but are not limited to:

The impetus for the IPAB was concern from many quarters about the ability of the Congress, in a deeply complex program and political environment, to effectively contain the growing costs of the Medicare program. In enacting the IPAB, the Congress chose to grant to an independent entity exceptional powers over the aggregate spending trajectory in the Medicare program.

- the two-pronged inflation determination,
- the rolling average base blending actual and projected spending data,
- questions around the scope of IPAB authority,
- judicial review,
- indirect impacts upon beneficiaries of recommendations and actions,
- premature timing of a mandated GAO oversight report, and
- the mechanics and politics of working relationships between the IPAB, HHS, MedPAC and other entities involved in this process, including the significant role granted to the Office of the Actuary in CMS.

All of these questions and more bear scrutiny and may be targets for advocacy and modification. Finally, it is important to note that in President Obama's release on April 13 of budget proposals to reduce the deficit, the President advocated strengthening the role of the IPAB and tightening the target formulas in a way to permit the IPAB to deepen potential reductions in Medicare spending relative to current law. In addition, it was also proposed to grant IPAB additional enforcement mechanisms such as automatic sequestration of funds "as a backstop for IPAB, the Secretary of HHS, and the Congress. It should be noted that questions are already being raised as to whether the IPAB represents an abdication of Congressional and Administration responsibilities and authorities. Proposals to increase IPAB's powers will stimulate that debate and are expected to heighten opposition to the IPAB in provider communities.

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## 3 Patient-Centered Outcomes Research and Physician Quality Reporting

### *3. A. Comparative Effectiveness Research (CER)*

**WHAT IS CER?** Research about which clinical strategies work best, under what circumstances and for whom, is commonly referred to as comparative effectiveness research (CER). As summarized by the Congressional Research Service, the Institute of Medicine (IOM) defines this type of research as the "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, monitor a clinical condition and improve delivery of care" with the aim of tailoring decisions to the needs of individual patients. CBO has referred to CER as "a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients." MedPAC has referred to "comparative-effectiveness" as "analysis [that] compares the clinical effectiveness of a service (drugs, devices, diagnostic and surgical procedures, diagnostic tests, and medical services) with its alternatives." The phrase "patient-centered outcomes research" has also been used as an alternate term.

**LEGISLATIVE HISTORY.** Comparative effectiveness research has been addressed multiple times in recent years under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) and the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). Section 1013 of the MMA authorizes the Agency for Healthcare Research and Quality (AHRQ) to conduct and support research on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. The section also prohibits the CMS from using the data to withhold coverage of a prescription drug. The ARRA provided $1.1 billion in funds to support the development and dissemination of CER. ARRA also asked the Institute of Medicine to recommend national priorities for the research to be addressed by ARRA funds. This section of the ACA modifies Title XI of the Social Security Act to add a Part D, Comparative Clinical Effectiveness Research, after sections on General Provisions, Peer Review, and Administrative Simplification.

**THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI).** As touched on briefly above under new entities, the provision authorizes the establishment of a private, nonprofit, tax-exempt corporation, which is to be neither an agency nor establishment of the United States government called the "Patient-Centered

Outcomes Research Institute" or PCORI. This institute is to enhance the capacity to conduct *comparative clinical effectiveness research* (CCER). The purpose of the Institute would be to "assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient sub-populations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items."

**PCORI DUTIES.** The duties of the Institute are to (1) identify research priorities and establish a research agenda, (2) carry out the research project agenda, (3) collect relevant data from CMS and other sources, (4) appoint expert advisory panels, (5) support patient and consumer representatives, (6) establish a methodology committee, (7) provide for a peer-review process for primary research, (8) release research findings, (9) adopt the national priorities, the research project agenda, the methodological standards developed and updated by the methodology committee, and any peer review process provided under point (7), and (10) submit an annual report to Congress and the President. The Institute is to give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health in the awarding of contracts to conduct the research, if the organizations are so authorized in their governing statutes.

**BOARD OF GOVERNORS.** The provision establishes a Board of Governors for the Institute, which would be responsible for carrying out the duties of the Institute. The Institute's Board is to consist of the Directors of AHRQ and the NIH (or their designee) as well as 17 members appointed by the Comptroller General of the United States representing patients and health care consumers, physicians and providers, private payers, pharmaceutical, device, and diagnostic manufacturers or developers, representatives of quality improvement or independent health service researchers, and representatives of the federal government or the states.

**LIMITATIONS ON CCER.** The provision includes a number of limitations on the use of CCER.

**NON-MANDATE FOR PUBLIC AND PRIVATE PAYERS.** A rule of construction specifies that *the Institute is not to be permitted to mandate coverage, reimbursement or other policies for any public or private payer* nor to prevent the Secretary from covering the routine costs of clinical care received by Medicare, Medicaid, or CHIP beneficiaries in the case where the individual is participating in a clinical trial where the costs would be covered by the program.

**MEDICARE COVERAGE.** In addition, the Secretary could only use evidence and findings from CCER to make a Medicare coverage determination if the process is iterative and transparent and includes public comment and considers the effect on subpopulations. CCER is not to be construed as (1) superseding or modifying the coverage of items or services under Medicare that the Secretary determines are reasonable and necessary, nor (2) authorizing the Secretary to deny coverage of items or services under Medicare solely on the basis of comparative clinical effectiveness research.

**NON-DISCRIMINATION.** The Secretary is prohibited from using CCER evidence and findings in determining Medicare coverage, reimbursement, or incentive programs in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, non-disabled, or not terminally ill, nor in a manner that would preclude or have the intent to discourage individuals from choosing health care treatments based on how the individual values the tradeoff between extending the length of life and the risk of disability.

**STATISTICAL MEASURES.** The Institute will also not be allowed to develop or employ a dollars-per-quality adjusted life year or similar measure that discounts value of life because of disability as a threshold to establish what type of care is cost effective or recommended, nor would the Secretary utilize such an adjusted life year (or such a similar measure) as a threshold

A rule of construction specifies that the Institute is not to be permitted to mandate coverage, reimbursement or other policies for any public or private payer nor to prevent the Secretary from covering the routine costs of clinical care received by Medicare, Medicaid, or CHIP beneficiaries in the case where the individual is participating in a clinical trial where the costs would be covered by the program.

to determine coverage, reimbursement, or incentive programs under Medicare.

**PCOR TRUST FUND.** The provision creates a new trust fund, the Patient-Centered Outcomes Research Trust Fund (the PCORTF) in the U.S. Treasury to fund the Institute and its activities. *Sizable monies will be directed to this fund from the general fund of the Treasury as well as the Medicare Trust Funds and from fees imposed on health insurance and self-insured plans.* In years 2010, 2011, and 2012, $10 million, $50 million, and $150 million will be appropriated from Treasury to the fund.

Beginning in 2013, the PCORTF will also be financed from fees on health insurance and self-insured health plans. For FY2013, the Secretary will transfer amounts from the Medicare Federal Hospital Insurance and the Federal Supplemental Medical Trust Funds to the PCORTF in proportion to total Medicare expenditures that come from each Fund for a given year. In FY2013, the amount is to be equivalent to $1 multiplied by the average number of individuals entitled to benefits under Part A or enrolled under Part B of Medicare during the year. (In FY2014 through FY2019, the amounts are to be equivalent to $2, adjusted for increases in health care spending FY2014, multiplied by the average number of such individuals for the given year.) For fiscal years 2014 through 2019, the provision requires a transfer of $150 million from the Treasury as well as the net revenues from a fee of $1 in FY2013 and $2 (adjusted for health care spending increases) in FY2014 through FY2019, on each health insurance policy in the United States multiplied by the number of lives covered under that policy. Insurance policies that primarily provide non-health benefits will be exempt. This fee will sunset after FY2019 (plan years ending after September 30, 2019).

The CBO score was $0.1 billion for FY2010-FY2014 and -$0.3 billion for FY2010-FY2019.

Due to its large and unusual funding structure, the PCORTF is coming under congressional scrutiny.

### *3. B. Physician Quality Reporting System*

The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) required the initial establishment of a physician quality reporting system that would include an incentive payment to eligible professionals. Eligible physicians are those who satisfactorily report data on quality measures, based on a percentage of the allowed Medicare charges for all such covered professional services. CMS named this program the Physician Quality Reporting Initiative (PQRI).

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5% of total allowable charges under the physician fee schedule in 2007 and 2008 to 2% in 2009 and 2010. The ACA extends PQRI incentive payments through 2014 and implements an incentive (penalty) for providers who do not report quality measures beginning in 2015. Eligible professionals who successfully report in 2010 are to receive a 1% bonus in 2011; those who successfully report in 2011, 2012, and 2013 will receive a 0.5% bonus in 2012, 2013, and 2014, respectively.

**MAINTENANCE OF CERTIFICATION PROGRAM.** An additional 0.5% incentive payment will be available in years 2011 through 2014 for eligible professionals who also meet the requirements of a Maintenance of Certification Program (MOCP), defined as a continuous assessment program that "advances quality and lifelong learning and self-assessment of board certified specialty physicians" by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. MOCPs will require the physician to (1) maintain a valid, unrestricted medical license in the United States, (2) participate in educational and self assessment programs that require an assessment of what was learned, (3) demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty, and (4) successfully complete the MOCP practice assessment. These eligible professionals will be required to participate in and successfully complete a qualified MOCP practice assessment more

frequently than is required to qualify for or maintain board certification status. The MOCP is to submit information to the Secretary on behalf of the eligible professional that the professional has successfully met the program criteria and on the survey of patient experience with care, if requested.

**MOCP FAILURE PENALTIES.** The Secretary is to incorporate participation and successful completion in a MCOP into the composite of measure of quality of care furnished pursuant to the physician fee schedule payment modifier. Subsequently, eligible professionals who failed to participate successfully in the program would face a 1.5% payment penalty in 2015, and a 2% payment penalty in 2016 and in subsequent years. The incentive payments and adjustments in payment will be based on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percentage of the fee schedule amount. *The provision also requires CMS to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records as created in the American Recovery and Reinvestment Act of 2009.*

CBO estimated that the provision would cost $600 million over FY2010-FY2014 and $300 million over FY2010-2019; savings will accrue beginning in 2016 and in subsequent years.

### *3. C. The Physician Feedback Program.*

**PERCEIVED VALUE OF FEEDBACK DATA.** MedPAC, GAO and others have recently recommended providing information to physicians on their resource use. MedPAC asserts that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate. MedPAC notes that in certain instances, the private sector's use of feedback has led to a small downward trend in resource use. The GAO noted that certain public and private health care purchasers routinely evaluate physicians in their networks using measures of efficiency and other factors and that the purchasers it studied linked their evaluation results to a range of incentives to encourage efficiency.

**PHYSICIAN FEEDBACK PROGRAM ORIGINS.** MIPPA established a physician feedback program with the intent to improve efficiency and to control costs. Under the Physician Feedback Program (PFP), the Secretary will use Medicare claims data to provide confidential reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. The resources to be considered in this program may be measured on an episode basis, on a per capita basis, or on both an episode and a per capita basis. The GAO will conduct a study of the Physician Feedback Program, including the implementation of the Program, and is to submit a report to Congress by March 1, 2011, containing the results of the study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

**PFP DATA AND ANALYSES.** The ACA provision requires new types of reports and data analysis under the Physician Feedback Program. Not later than January 1, 2012, the Secretary is to develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate. Beginning with 2012, the Secretary will also be required to provide reports to physicians that compare patterns of resource use of the individual physician to such patterns of other physicians. In preparing these reports, the Secretary is to establish methodologies as appropriate to (i) attribute episodes of care, in whole or in part, to physicians, (ii) identify appropriate physicians for purposes of comparison, and (iii) aggregate episodes of care attributed to a physician into a composite measure per individual. In preparing these reports, the Secretary is required to make appropriate adjustments, including adjustments (i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals, and (ii) to eliminate the effect of geographic adjustments in payment rates. CBO estimates that this provision will have no effect on spending over the 5-year or 10-year budget window.

MedPAC asserts that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate.

### *3. D. Physician Compare Website—Public Reporting of Performance Information*

SSA §1848(m)(5)(G) requires the Secretary to post on the CMS Internet website a list of eligible professionals who satisfactorily submitted data on quality measures as part of the Physician Quality Reporting Initiative (PQRI). In addition, Sec. 131(d) of the Medicare Improvements for Patients and Providers Act of 2008 requires the Secretary of HHS to develop a plan to transition to a value-based purchasing program for payment under the Medicare program for covered professional services. Not later than May 1, 2010, the Secretary is required to submit a report to Congress containing the plan and recommendations for legislative and administrative action.

The Secretary is required, not later than January 1, 2011, to develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program. The Secretary has announced the preliminary version of the site. In addition, the Secretary is required, not later than January 1, 2013, to implement a plan for making publicly available information on physician performance through Physician Compare.

**The Secretary is required, not later than January 1, 2013, to implement a plan for making publicly available information on physician performance through Physician Compare.**

**DATA, PROCESS, AND SYSTEMS REQUIREMENTS.** The section requires the Secretary to, in developing and implementing this plan, include (1) processes to assure that data made public is statistically valid and reliable; (2) processes by which providers whose performance is being publicly reported to have an opportunity to review individual results prior to publication; (3) processes to assure that the implementation of the plan provide a robust and accurate portrayal of a physician's performance; (4) data that reflects the care provided to all patients seen by physicians to the extent such information would provide a more accurate portrayal of physician performance; (5) processes to ensure appropriate attribution of care; (6) processes to ensure timely statistical performance feedback is provided to physicians; and (7) implementation of computer and data systems by CMS that support valid, reliable and accurate public reporting activities authorized under this section.

**LINK TO VALUE-BASED PURCHASING FOR PHYSICIAN SERVICES IN THE FUTURE.** The section also requires the Secretary, in developing the plan under this section, to consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under Sec. 131 of MIPPA. The Secretary is required to submit to Congress a report on the Physician Compare Internet website, including information on the plans to collect and publish data on physician quality and efficiency. Finally, the Secretary will be allowed to establish a demonstration program to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians.

The CBO score was $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.

## 4 Value-Based Purchasing for Hospitals

It is important for physicians to be aware of the fact that hospitals are also engaged in value-based purchasing programs under Medicare, and will be subject to a variety of requirements that change in out-years beyond what is described below. Additional information is available in the Congressional Research Service Medicare provisions summaries available on the Physicians Foundation Health Reform website. Details on the value-based payment modifier for physician payments are described in section 5.C. below.

Briefly, since FY2005, acute care hospitals that submit required quality data have received higher payments than those hospitals that do not submit such information under Medicare's "Reporting Hospital Quality Data for Annual Payment Update" program (RHQDAPU). This is often referred to as the hospital pay-for-reporting program or P4P program. There are 46 quality measures collected in the P4P program that impact upon the FY2011 payment update. Individual hospital performance on specific quality measures and on certain conditions is available on Hospital Compare on the CMS website. In November 2007, CMS released a mandated report on the implementation of a Medicare hospital value-based purchasing

(VBP) program, which recommends expanding the P4P program in order to financially reward hospitals differentially for performance. Public reporting of performance would be a key component as well.

Under the ACA, starting for discharges on October 1, 2012, hospitals will receive value-based incentive payments (VBPs) from Medicare. The first year of the VBP program will be a data collection/performance year. Beginning in FY2013, hospital payments will be adjusted based on performance under the VBP program. Certain hospitals will be excluded in a fiscal year: those that are subject to payment reductions associated with reporting required quality data in that fiscal year; those that have been cited for deficiencies that pose immediate jeopardy to their patients; and, those for which there are not sufficient number of measures or cases that apply to the hospital for a performance period. Acute-care hospitals in Maryland paid under their state specific Medicare system will be exempt if an annual report documents that a similar state program achieves at least comparable patient outcomes and cost savings.

The CBO score was $0.0 billion for FY2010-FY2014 and is $0.0 billion for FY2010-FY2019.

## 5 Payment Pilots and Innovations

### *5. A. Medicare Shared Savings Program and Accountable Care Organizations*

In April 2005, CMS initiated the Physician Group Practice (PGP) demonstration, which offers 10 large practices the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service beneficiaries. Accountable care organizations (ACOs) will go beyond the PGP model, which is based on physician groups, to include additional providers. On March 31, 2011, HHS/CMS issued a proposed rule on ACOs. Companion documents and provisions addressing anti-trust, taxation and program integrity concerns were released simultaneously by the Department of Justice, the Department of the Treasury, and the Office of the Inspector General in HHS, respectively. Highlights of those provisions and information on the public comment period follow the legislative description. Commentary on issues and implications of ACOs appear in the conclusion to the report.

#### 5. A. 1. ACO GENERAL LEGISLATIVE PROVISIONS.

The ACA allows groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as ACOs and be eligible to share in defined cost savings they achieve for the Medicare program. Beginning no later than January 1, 2012, this shared savings program will enable eligible ACOs to qualify for an annual incentive bonus if they achieve a threshold savings amount, established by the Secretary, for total per beneficiary spending under Medicare Parts A and B for those beneficiaries assigned to the ACO.

**ACO Defined**. An eligible ACO is defined as a group of providers and suppliers who have an established mechanism for joint decision-making, and are required to participate in the shared savings program for a minimum of three years, among other requirements. An ACO includes practitioners (physicians, regardless of specialty; nurse practitioners; physician assistants; and clinical nurse specialists) in group practice arrangements; networks of practices; and partnerships or joint-venture arrangements between hospitals and practitioners, among others.

**Eligibility for Shared Savings Payments.** In each year of the three-year agreement period, an ACO will be eligible for a shared savings payment only if the estimated average per capita Medicare

ACOs are defined as a *legal entity* under applicable State laws; are Medicare certified providers and suppliers; have a shared governance system that exercises decision-making control; and, will work together to manage care in coordination for a population of not less than 5,000 Medicare beneficiaries.

expenditures for Parts A and B services, adjusted for beneficiary characteristics, is at least the specified percentage below the applicable benchmark. This appropriate percentage is to account for the normal variation in expenditures based on the number of beneficiaries assigned to the ACO. The ACO's benchmark for each agreement period is to be based on the most recent available three years of per beneficiary Part A and B spending for its assigned beneficiaries. This benchmark will be adjusted for beneficiary characteristics and updated by the projected absolute growth in national per capital expenditures for Part A and B fee-for-service Medicare services, as estimated by the Secretary. The benchmark will be reset at the start of each agreement period. Subject to attaining quality performance standards, an ACO will receive a percentage of the difference between the estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and the ACO's benchmark. The remainder of the difference will be retained by the program. The Secretary is to establish limits on the total amount of shared savings that may be paid to an ACO.

**Possible Payment Models**. The Secretary may use a partial capitation model or other payment models. Under the partial capitation model, a qualifying ACO would be at financial risk for some, but not all, of the Part A and B items and services. The Secretary may limit participation in this model in highly integrated systems capable of bearing risk. Also, spending under this model cannot result in greater spending than would otherwise be expended if the model were not implemented. To earn the incentive payment, the organization is to submit data pertaining to quality and fulfill certain quality requirements related to clinical processes and outcomes, patient and caregiver experience of care, and utilization measures. The Secretary has the authority to adjust the savings thresholds to account for the varying sizes of participating ACOs.

**ACO Termination Authority.** If the Secretary determines that an ACO has taken steps to avoid at-risk patients in order to reduce the likelihood of increasing costs, the Secretary is authorized to impose an appropriate sanction, including terminating agreements with participating ACOs. The CBO score is -$0.5 billion for FY2010-FY2014 and-$4.9 billion for FY2010-FY2019.

#### 5. A. 2. ACO NOTICE OF PROPOSED RULEMAKING.

On March 31, 2011, CMS released the proposed rule for accountable care organizations. The public comment period closes on June 6. The proposed rule, in excess of 400 pages, is highly complex, and of intense interest to physicians and many hospitals. An exhaustive description of this rule is outside the scope of this report. Readers are urged to review the proposed rule and detailed summary materials made available on the Physicians Foundation website, as well as consult with local medical societies and other expert sources. Following is a distillation of key features.

**Summary**. ACOs are defined as a *legal entity* under applicable State laws; are Medicare certified providers and suppliers; have a shared governance system that exercises decision-making control; and, will work together to manage care in coordination for a population of not less than 5,000 Medicare beneficiaries. ACOs can be viewed as a complex, risk-bearing, quasi-insurance plan model that provides physicians an opportunity to exercise greater control over collaborative patient care, but which also carries significant legal, financial and practice organization investment and risks.

**ACO organizational requirements**. CMS proposes to require ACOs to be a legally formed corporation, partnership, limited liability corporation or foundation, capable of fiduciary responsibilities, ensuring compliance of participants with ACO requirements, and performance of all data collection, recordkeeping, reporting and other required functions. There are detailed governance requirements, and providers within the ACO must have 75-percent control of the governing body. There are detailed specifications regarding leadership and management structures, clinical integration commitment, quality assurance processes and information technology infrastructure.

**Eligible participants**. Formation of an ACO is voluntary and eligible participants

| Design Element | One-Sided Model (performance years 1 and 2) | Two-Sided Model |
|---|---|---|
| Maximum Sharing Rate | 52.5% (50% quality sharing rate plus up to a 2.5-percentage-point FQHC/RHC participation bonus) | 65% (60% quality sharing rate plus up to a 5-percentage-point FQHC/RHC participation bonus) |
| Quality Sharing Rate | Up to 50% based on quality performance levels | Up to 60% based on quality performance levels |
| FQHC/RHC Participation Incentives | Up to 2.5 percentage points based on proportions of assigned beneficiaries visiting a participating FQHC or RHC | Up to 5 percentage points based on proportions of assigned beneficiaries visiting a participating FQHC or RHC |
| Minimum Savings Rate | From 2% to 3.9% based on the size of the assigned population | Flat 2%, regardless of size |
| Minimum Loss Rate | Not Applicable | Flat 2%, regardless of size |
| Maximum Sharing Cap | Payment capped at 7.5% of ACO's benchmark | Payment capped at 10% of ACO's benchmark. The cap will be phased in over 3 years with 5% and 7.5% used in the first two years, respectively. |
| Shared Savings | Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2% threshold; up to 52.5% of net savings up to cap | Savings shared on a first-dollar basis once MSR is exceeded; up to 65% of gross savings up to cap |
| Shared Losses | Not Applicable | First-dollar shared losses once the minimum loss rate is exceeded, up to cap. Actual amount of shared losses would be based on final sharing rate that reflects ACO quality performance and any additional incentives for including FQHCs and/or RHCs using the following methodology (1 minus final sharing rate). |

Source: Centers for Medicare and Medicaid Services, Notice for Proposed Rule-Making, March 31, 2011, p. 292.

include: networks of individual practices, group practices, joint ventures between hospitals and professionals, and hospitals employing professionals. Other categories of providers, such as rural health clinics and federally qualified health centers, can participate by partnering with eligible providers.

**Patient-centered model**. There are significant guidelines addressing promotion of evidence-based medicine, patient engagement, data reporting, care coordination, and organization around the concept of patient-centered care models.

**Three-year agreements**. Under the ACA statute, ACOs must commit to three-year agreements. There are numerous details around the initial round of agreements, process requirements for ACO changes during the agreement period, and a proposed requirement that an ACO be responsible for complying with all regulatory changes that occur during the period, except for beneficiary assignment, eligibility requirements concerning ACO governance, and calculation of the savings rate.

**Beneficiary assignment**. There are proposed rules for beneficiary assignment relying upon assignment to primary care providers only, and explicitly excluding specialists for assignment purposes. It is proposed that all ACO marketing materials require prior CMS approval.

**Program integrity**. There are program integrity and legal compliance plan requirements.

**Savings model**. There are two shared savings models offered. Following is a CMS chart that compares the key features. Related to the shared savings program, there are detailed prescriptions (and technical issues) around CMS's development and application of the expenditure baseline against which an ACO's expenditure experience is benchmarked. These relate to data sources and averages, national vs. locality adjustments, treatment of other Medicare payments such as indirect medical education or disproportionate share hospital payments, among others. There is also a required ACO minimum savings rate (MSR), meaning that ACOs must first exceed that threshold before qualifying for shared savings. There is also a minimum loss ratio (MLR) requiring ACOs to share in losses if their costs exceed the benchmark by more than the MLR amount. There are special rules for small ACOs (less than 10,000 beneficiaries.) There are caps on shared savings and losses, and details around timing and processes for evaluating and distributing shared savings.

**Quality performance**. Shared savings are only possible where an ACO meets both cost reduction and quality performance targets. This is a dual-pronged test of cost management and quality achievement. The latter requires meeting standards on 65 performance measures in 5 domains (patient/caregiver experience, care coordination, patient safety, preventative health, and at-risk population/ frail elderly health). The last is the most heavily featured with 31 of the 65 measures. Failure to

It should be noted that accountable care organizations and a variety of demonstrations around patient-centered care all incorporate medical home concepts, which is becoming a familiar, mainstream conceptual framework for patient care.

meet the quality performance levels, failure to report a measure or provision of inaccurate information can lead to termination of an ACO. CMS provides a variety of data sources. CMS proposes that shared savings payments in the first year will be only for meeting quality reporting standards. CMS proposes a scoring measurement system encompassing scores by domain, a weighted average of domain scores, and measure-specific benchmarks, the latter of which will be provided by CMS in advance.

**Termination**. There are not less than 13 categories of issues for which an ACO can be terminated. CMS also proposes to require that an ACO, including all its providers, suppliers and other contracted entities, grant the right to have all data, books, records relevant to ACO participation and operation, available to be opened and subject to inspection and audit to ensure compliance with ACO requirements and entitlement to claimed shared savings. Note that there are also separate anti-trust, tax, and anti-fraud and abuse provisions requiring review and understanding, violation of which can lead to termination and possible legal risks.

**COMMENTARY** The ACO model embodies the thrust of the ACA as the overall law most directly begins to change the world of physician practice. Consequently, discussion of the broader import of this model is contained in the executive summary to this report where major directional changes and implications of the law for physicians is discussed.

To immediate point in this section, physicians must consider that the ACO model has elements that very strongly resemble the role of Medicare Advantage plans. As has been noted by others, the ACO resembles a capitated or managed care model, but based on fee-for-service payments. However, it has risks that managed care plans are permitted to control, but which an ACO may not be able to. Unlike a managed care plan, most notable is that beneficiaries participating in an ACO do not relinquish their right to seek care outside of the ACO. Yet, those expenditures are claimed against the ACO for purposes of calculating eligibility for shared savings.

In addition, an ACO is essentially entering the insurance world in its assumption of considerable financial risk for adverse selection and the limitations of CMS risk-adjustment models and data sources that plague the Medicare health insurance environment. As with insurers, an ACO should be well-capitalized to bear both operational infrastructure costs, and to be able to repay any shared loss obligations.

Finally, from a practice standpoint, the ACO model raises issues regarding professional collaboration and internal distribution of savings and risk across primary care physicians and specialists, and the relationship between hospitals and physicians. It also compels more of a "partnership" relationship with the Medicare program than does independent private practice—an element to consider carefully. Within the federal framework, a number of arrangements are possible. This is a complex model, and one in which physicians should enter only after considering expert information on all key legal, financial and practice implications.

### *5. B. Medical Home and Advanced Primary Care Models.*

**OVERVIEW.** The concept of a medical home for patient-centered care has been under development for a number of years. The basic concept has been to develop a team approach with the patient at the center, utilizing an array of concepts and tools to promote optimal care, efficiently delivered. The Tax Relief and Health Care Act of 2006 (Sec. 204), authorized HHS to investigate and evaluate models to "… redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations."

Under that authority, CMS initiated development of demonstrations in multiple sites and across urban, rural, and underserved areas. Central to the medical home model is a "personal physician" responsible for ongoing support, oversight, and guidance in implementing a plan of care. These approaches provided insight into medical home design issues, the capacity of practices

to coordinate care, the role of HIT in facilitating care and record-keeping, staffing and other resource needs, the patient's responsibilities and other important issues. The latter included payment model design, fee structures, cost measurement and shared savings concepts.

**PATIENT-CENTERED PRIMARY CARE COLLABORATIVE.** There are a wide array of physician organizations and practices participating in these and related programs. One of particular note is the Patient-Centered Primary Care Collaborative, which has published a variety of resources for physicians interested in these models (www.pcpcc.net).

**MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION.** On April 12, 2011, CMS published updated information on its program to extend these concepts under their Multi-Payer Advanced Primary Care Practice Demonstration.

CMS's stated purposes for the so-called MAPCP demonstration are "to evaluate whether the advanced primary care practice, when supported by Medicare, Medicaid, and private health plans, will (1) reduce unjustified variation in utilization and expenditures; (2) improve the safety, effectiveness, timeliness, and efficiency of health care; (3) increase the ability of beneficiaries to participate in decisions concerning their care; (4) increase the availability and delivery of care that is consistent with evidence-based guidelines in historically underserved areas; and (5) reduce unjustified variation in utilization and expenditures under the Medicare program."

CMS indicates that all major payers in the state or proposed region (Medicare, Medicaid, as well as a significant representation of the large private insurers/managed care organizations) will be participating. Eight states were selected (see CMS chart with contact information). Medical practices, in order to participate, will be required to meet medical home specifications established by their State's program. More information is available on www.cms.gov, or by contacting the representative in the participating state.

Note that on April 14, 2011, CMS released the following announcement:

| State | Name | Title | Phone |
|---|---|---|---|
| Maine | Alexander Dragatsi | Program Coordinator, Maine Quality Forum, Dirigo Health Agency | (202) 287-9965 |
| Michigan | Carol Callaghan | Director, Division of Chronic Disease & Injury Control, State of MI Department of Community Health | (517) 335-8368 |
| Minnesota | Ross Owen | Health Services & Medical Management, MN Department of Human Services | (651) 431-4228 |
| New York | Foster Gesten, MD | Medical Director, NY Department of Health | (518) 486-6865 |
| North Carolina | Chris Collins | Director, Community Care, Office of Rural Health/Community Care | (919) 855-4788 |
| Pennsylvania | Ann Torregrossa | Director, Governor's Office of Healthcare Reform | (717) 772-9065 |
| Rhode Island | Tricia Leddy | Senior Policy Advisor, Office of the Director, RI Department of Health | (401) 222-1013 |
| Vermont | Craig Jones, MD | Director, Vermont Blueprint for Health | (802) 879-5988 |

"CMS is currently testing the patient-centered medical home model in the Multi-payer Advanced Primary Care Practice Demonstration and the Federally Qualified Health Centers Advanced Primary Care Practice Demonstration. CMS also plans to test the patient-centered medical home model under the Innovation Center created by Section 3021 of the Patient Protection and Affordable Care Act, which provides CMS with an opportunity to test a variety of models and expand their implementation nationwide if they reduce spending without reducing quality or improve quality without increasing spending, and if the CMS Chief Actuary certifies that their expansion would be budget neutral, and if the Secretary determines that such an expansion would not result in denying or limiting coverage or the provision of benefits. Therefore, CMS plans not to pursue implementation of the Medicare Medical Home Demonstration specified in section 204 of the Tax Relief and Health Care Act of 2006 as modified by section 133(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008."

In closing, it should be noted that accountable care organizations and a variety of demonstrations around patient-centered care all incorporate medical home concepts, which is becoming a familiar, mainstream conceptual framework for patient care.

**MEDICAID MEDICAL HOME (SEC 2703.)** Effective Jan 1, 2011, States have an option of enrolling

Medicaid beneficiaries with chronic conditions into a health home. Such health homes would be composed of a team of state-designated health professionals and are to provide a comprehensive set of medical services, including care coordination. States taking up this option will receive enhanced federal matching payments of 90% for 2 years. There is provided funding for planning grants, not to exceed $25 million.

### *5. C. National Pilot Program on Payment Bundling.* (Sec. 3023 as modified by Sec. 10308.)

As Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services. The Medicare Payment Advisory Commission (MedPAC), among others, has suggested that Medicare test new incentives and payment models to encourage providers to better coordinate across patients' episodes of care and to evaluate the full spectrum of care a patient may receive during these episodes. Under this provision, no later than January 1, 2013, the Secretary is required to establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program. This program is to be designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care around a hospitalization. An episode of care is the full period that a patient stays in a hospital plus the first 30 days following discharge. The Secretary will be able to expand the duration and scope of the pilot after January 1, 2016, if the Secretary, with certification from the Chief Actuary determines it is cost-effective.

### *5. D. Value-Based Payment Modifier Under the Physician Fee Schedule*

**VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE. (SEC. 3007).** Under this provision, the Secretary of HHS is required to establish and apply a separate, budget-neutral payment modifier to the Medicare physician fee schedule. The separate payment modifier is to be based on the relative *quality and cost* of the care provided by physicians or physician groups. Quality of care is to be evaluated on a composite of risk-adjusted measures of quality established by the Secretary, such as measures that reflect health outcomes. Costs, defined as expenditures per individual, are to be evaluated based on a composite of appropriate measures of costs established by the Secretary that eliminate the effect of geographic adjustments in payment rates and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals) and other factors determined appropriate by the Secretary.

**IMPLEMENTATION DATES AND REQUIREMENTS.** By January 1, 2012, the Secretary is required to publish the specific measures of quality and cost, the specific dates for implementation of the payment adjustment, and the proposed prospective performance period. The Secretary is to begin implementing the value-based payment adjustment in the 2013 rulemaking process. During the performance period, which begins in 2014, the Secretary is to provide information to physicians about the value of care they provide, as reflected by the measures of relative quality and cost. The Secretary will be required to apply the payment modifier for items and services furnished beginning on January 1, 2015, for specific physicians and groups of physicians the Secretary determines appropriate, and not later than January 1, 2017, for all physicians and groups of physicians.

**SPECIAL REQUIREMENTS FOR RURAL OR UNDERSERVED AREAS, AND SPECIAL CIRCUMSTANCES.** The Secretary is to apply the payment modifier in a manner that promotes systems-based care and takes into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

CBO estimated that this provision would have no effect on spending over the 5-year or 10-year budget window.

The value-based payment modifier on the physician fee schedule raises important design, data and impact issues.

### *5. E. Extension of Gainsharing Demonstrations*

**EXTENSION OF GAINSHARING DEMONSTRATION (SEC. 3027).** Certain gainsharing demonstrations to evaluate arrangements between hospitals and physicians have been authorized. CMS is currently operating two projects, each consisting of one hospital in New York and West Virginia. Although authorized to begin on January 1, 2007, the project began on October 1, 2008, and was scheduled to end on December 31, 2009. The Secretary was required to submit mandated reports by certain due dates. The project was appropriated $6 million in FY2006 to be available for expenditure through FY2010. Under this provision of PPACA, the authority to conduct the gainsharing demonstration project in operation as of October 1, 2008 will be extended until September 30, 2011. The due date of the required interim report is extended from December 1, 2008, to March 31, 2011, with the final report due on March 31, 2013. An additional $1.6 million is to be appropriated in FY2010; all appropriations are available through FY2014 or until expended.

The CBO score was $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.

## 6 Physician Fee Schedule Adjustments

### *6. A. Physician Work Index and Geographic Practice Cost Indices.*

The Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices—known as Geographic Practice Cost Indices (GPCIs)—that reflect how each area compares to the national average in a "market basket" of goods. A value of 1.00 represents an average across all areas. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December, 2009. The other geographic indices (for practice expense and medical malpractice) were not modified by these acts.

**PAYMENT ADJUSTMENTS.** This provision provides a short extension of the floor and introduces a new methodology to determine the practice expense GPCI. First, the provision extends the 1.00 floor for the geographic index for physician work for an additional year through December 31, 2010. Second, the provision directs the Secretary to adjust the practice expense GPCI for 2010 and 2011 to reflect 1/2 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e., a blend of 1/2 local and 1/2 national), instead of the full difference under current law. Relief applies only to areas with a practice expense GPCI less than 1.0. The provision holds harmless any areas negatively impacted by the adjustment.

**PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT EVALUATION.** The provision directs the Secretary to analyze current methods of establishing practice expense geographic adjustments under the physician fee schedule (aka, the PE GPCI) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different Medicare payment localities. Based on the analysis and evaluation, the Secretary is to make appropriate adjustments to the PE GPCI to ensure accurate geographic adjustments across payment areas, no later than January 1, 2012. Adjustments made in 2012 are to be made without regard to the adjustments made in 2010 and 2011. If the Secretary has not completed the required analysis and evaluation and made appropriate adjustments in the Medicare Physician Fee Schedule rule for 2012 (or subsequent year), the 2011 payment rule would remain in effect.

CBO estimated that this provision will cost a total of $2.2 billion over the next three years with no further impact over the remaining years of the 10-year budget window.

### 6. B. *Extension of Payment for Technical Component of Certain Physician Pathology Services (Sec. 3104).*

In 1999, the Health Care Financing Administration, (now the Centers for Medicare and Medicaid Services or CMS), proposed terminating an exception to a payment rule that had permitted laboratories to receive direct payment from Medicare when providing technical pathology services that had been outsourced by certain hospitals. This exception has been extended through legislation at various times.

Most recently, the Medicare Modernization Act of 2003 (MMA, P.L. 108-173) extended the provision until January 1, 2010. This proposal extends the provision until January 1, 2011. CBO estimates that this provision will cost $100 million in 2010, with negligible or zero costs in future years.

### 6. C. *Misvalued Codes Under the Physician Fee Schedule (Sec. 3134).*

**OVERVIEW.** The Medicare physician fee schedule is based on assigning relative weights to each of the more than 7,000 physician service codes used to bill Medicare. The relative value for a service compares the relative work involved in performing one service with the work involved in providing other physicians' services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS). CMS is responsible for maintaining and updating the fee schedule, including the modification and refinement of the methodology for estimating relative value units (RVUs). CMS relies on advice and recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in its assessments.

In general, as currently implemented, increases in RVUs for a service or number of services lowers the resultant fees for other physician services because of the budget neutrality condition. One consequence has been that the payments for evaluation and management codes, whose RVUs typically are not increased over time, have fallen relative to other codes whose RVUs have increased, and as a consequence of new technologies that have been introduced into coverage with relatively high RVUs. CMS is required to review the RVUs no less than every five years.

**LEGISLATIVE REQUIREMENTS.** Under this provision, the Secretary is required to periodically identify physician services that are potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. To identify potentially misvalued services, the Secretary is required to examine:

- codes (and families of codes as appropriate) with the fastest growth,
- codes that have experienced substantial changes in practice expenses,
- codes for new technologies or services,
- codes that are frequently billed in conjunction with furnishing a single service,
- codes with low relative values, particularly those that are often billed multiple times for a single treatment,
- codes that have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'), and
- other codes the Secretary determines to be appropriate for review.

The Secretary is to review and make appropriate adjustments to the work relative value units under the fee schedule.

The provision also repeals Section 4505(d) of the Balanced Budget Act of 1997, which established requirements for developing new resource-based practice expense relative value units, as well as Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)), which established the Practicing Physicians Advisory Council, a group of physicians who meet quarterly to discuss proposed changes

in regulations and carrier manual instructions related to physician services.

CBO estimated that this provision will have no impact on spending over the 5-year or 10-year budget window.

### *6. D. Modification of Equipment Utilization Factor for Advanced Imaging Services (Sec. 3135 as modified by Sec. 1107 of the Reconciliation Act).*

**OVERVIEW.** Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. For example, imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component). Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components.

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services assumed that imaging machines are operated 25 hours per week, or 50% of the time that practices are open for business. Setting the equipment use factor at a lower rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90%, rather than the 50% previously assumed, MedPAC has urged CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services. CMS adopted a 90% use rate assumption in its 2010 final rule for Medicare physician payment.

**LEGISLATIVE PROVISIONS.** The ACA provisions change the utilization rate assumption for calculating the payment for advanced imaging equipment from 50%, as assumed in prior years, to 75% for 2011 and in subsequent years. This overrides the CMS 2010 final rule that applied a 90% use rate assumption.

According to MedPAC and the Government Accountability Office (GAO), there are opportunities to improve the efficiency of the Medicare fee schedule. In 2005, MedPAC recommended reducing certain fees to account for efficiencies and savings from the technical preparation and supplies achieved when multiple imaging services are furnished sequentially on contiguous body parts during the same visit. Starting January 1, 2006, physicians receive the full technical component fee for the highest paid imaging service in a visit, but technical component fees for additional imaging services are reduced by 25%. The provision increases the technical component payment reduction for sequential imaging services on contiguous body parts during the same visit from 25% to 50%.

**ACTUARIAL REVIEW OF IMPACT.** By January 1, 2013, the CMS Chief Actuary is to conduct and make publicly available an analysis of whether the cumulative expenditure reductions attributable to these adjustments are projected to exceed $3 billion for the period 2010 through 2019.

The CBO score was -$0.9 billion for FY2010-FY2014 and -$2.3 billion for FY2010-FY2019.

### *6. E. Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services (Sec. 6003).*

This section amends section 1877 of the Social Security Act, which prohibits physician referrals, for certain services that may be paid for by Medicare, to entities with which the physician has a financial relationship. Specifically, section 6003 amends one of the exceptions to this prohibition, the in-office ancillary services exception. The provision adds a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services as determined by the Secretary, the referring physician must inform the individual in writing at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice. The

individual must be provided with a written list of suppliers who furnish these services in the area in which the individual resides.

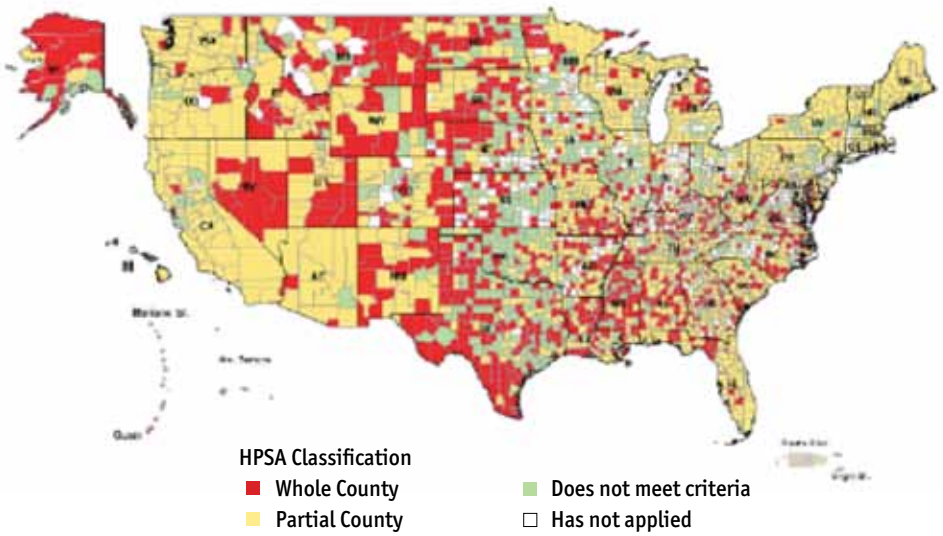
The CBO score was $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.

## 7 Workforce Initiatives

**OVERVIEW.** The following section highlights select workforce initiatives. For a comprehensive summary, we refer you to a brief, but thorough, summary prepared by the American Association of Medical Colleges (AAMC) and listed as a resource document available on their website and on the Physicians Foundation Health Reform website. AAMC has a lengthy track record of analyzing and publishing data on physician supply issues in the U.S. In their 2009 report on the physician workforce, they note that over 24% of the practicing physicians in the U.S. are over the age of 55, and project significant longer-term shortages in physician supply by the year 2020 relative to our growing population.

**UNDERSERVED AREAS.** Medicare generally uses the RB-RVS fee schedule to reimburse physicians for the services they provide. In certain circumstances, physicians receive an additional payment to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas. For instance, Section 1833(m) of the Social Security Act provides bonus payments for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Services Administration (HRSA) as primary medical care health professional shortage areas (HPSAs) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act. The bonus payment equals 10% of what would otherwise be paid under the fee schedule. Note the following depiction by HRSA of the population residing in underserved areas (Source: American Association of Medical Colleges. *Workforce Chartbook*.)

30 MILLION PEOPLE LIVE IN FEDERALLY DESIGNATED SHORTAGE AREAS




**NEW BONUSES FOR EVALUATION AND MANAGEMENT, AND GENERAL SURGERY CODES.** The provision establishes a new 10% bonus on select evaluation & management (E&M) and general surgery codes under the Medicare fee schedule for five years, beginning January 1, 2011. The primary care service codes to which this bonus applies will be office visits, nursing facility visits, and home visits. The bonus will be available to primary care practitioners who (1) are physicians who have a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine, or are nurse practitioners, clinical nurse specialists, or physician assistants, and (2) furnish 60% of their services in the select codes. Practitioners providing major surgical procedures in health professional shortage areas will also be eligible for a bonus under this provision. Over the same five year period beginning January 1, 2011, general surgeons providing care in a HPSA will be eligible

for a 10% bonus on major surgical procedure codes, defined as surgical procedures for which a 10-day or 90-day global period is used for payment under the Medicare fee schedule.

**RELATIONSHIP TO RELATIVE VALUE UNITS.** The review and adjustment of RVUs (under Section 1848(c)(2)(B)) will be adjusted for these incentives; only half (50%) of the cost of the bonuses are to be taken into consideration in the budget neutrality calculation in 2011 and in subsequent years, with an across-the-board reduction to all codes (through a modification of the conversion factor) accounting for the adjustment, except for physicians who primarily provide services in health professionals shortage areas.

The CBO score was $2.5 billion for FY2010-FY2014 and is $3.5 billion for FY2010-FY2019.

**PUBLIC HEALTH, WORKFORCE AND QUALITY PROVISIONS.** There is an extensive array of provisions (over 100) enacted under the ACA relating to these referenced matters. An exhaustive review is outside the scope of this report, but we highly commend your attention to the Congressional Research Service's Report on Public Health, Workforce, Quality and Related Provisions in the PPACA, published on August 2, 2010. This report is made available on the Physicians Foundation Health Reform website. It addresses maters such as:

- Physician, nursing, dentist, geriatric and public health workforce matters,
- Medicare and Medicaid quality and HIT provisions,
- Public health programs addressing drugs, vaccinations, maternal and child health, and elder justice,
- FDA requirements for medical products, biomedical research, biosimilars, and nutrition labeling,
- Emergency services and systems, and pain care management, and
- Medical malpractice liability and reform, among other topics.

**COMMENTARY.** In addition, note that there are numerous individual workforce provisions scattered throughout the ACA. These touch on matters such as educational grants, the National Health Service Corps, teaching health centers, primary care residency grant programs, the geriatric workforce, rural physician training, development of nursing and allied health professionals, pediatric and mental health programs, and more. In closing, please note that the Prevention and Public Health Fund has come under Congressional scrutiny in the House of Representatives due to its financing provisions and levels, and may be modified. As of this writing, the House of Representatives seeks to repeal that fund; the Administration has signaled it would veto such a bill. While outright repeal is unlikely, in the context of larger federal budget negotiations, it is possible that funding levels could be reduced or that provision otherwise altered.

## 8 Selected Rural Provisions

### *8. A. Improvements to the Demonstration Project on Community Health Integration (Sec. 3126).*

**MODELS IN CERTAIN RURAL COUNTIES.** A demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties has been authorized. Those eligible to participate in the demonstration project are limited to certain entities in States with at least 65% of its counties in the State with 6 or fewer residents per square mile. Based on these criteria, the Secretary is instructed to select up to 4 states to participate in the demonstration program, and within those states, up to 6 counties. For a county to be eligible to participate, it must have 6 or fewer residents per square mile and contain a critical access hospital (CAH) that furnished one or more of specified services (home health, hospice, or rural health clinic) and had a daily inpatient census of 5 or less as of date of enactment; skilled nursing facility services must be available in the eligible county. The three-year demonstration project is to be done in a budget neutral manner.

This section of the ACA eliminates the former limit of 6 eligible counties that may participate in the demonstration project within the qualifying states. Rural health clinic

**The Prevention and Public Health Fund has come under Congressional scrutiny in the House of Representatives due to its financing provisions and levels, and may be modified.**

services will no longer be one of specified CAH services. Rural health clinic services are removed from the definition of other essential services and replaced with physician services.

The CBO score was $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.

### *8. B. MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas (Sec. 3127).*

Under this provision, MedPAC is required to review payment adequacy for rural health care providers and suppliers serving the Medicare program and provide a report to Congress by January 1, 2011. MedPAC is to analyze rural payment adjustments, beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and suppliers, and quality of care in rural areas, and submit a report to Congress by January 1, 2011.

The CBO score was $0.0 billion for FY2010-FY2014 and $0.0 billion for FY2010-FY2019.

### *8. C. Miscellaneous Rural Provisions (see section citations below).*

Small rural hospitals and sole-community hospitals may receive improved payments for their hospital outpatient department services (Sec. 3121).

Medicare reasonable cost payments to rural hospitals are extended for certain clinical laboratory diagnostic tests in certain rural areas (Sec. 3122, as modified by section 109 of the Extender's Act).

Multiple demonstration provisions expanding the Rural Community Hospital Demonstration Program permitting reasonable cost reimbursement for selected hospitals with less than 50 beds in low population density areas (Sec. 3123, as modified by Sec. 10313).

The Medicare-Dependent Hospital program is extended, permitting higher payments for qualified hospitals (Sec. 3124).

Inpatient payment increases, within limits, are permitted for certain isolated, low-volume hospitals (Sec. 3125, as modified by Sec. 10314).

Under the community health integration demonstration project, and under strict low-population qualification criteria, a demonstration to develop and test new models of delivering care has been authorized (Sec. 3126).

MedPAC is required to review and report specifically on payment adequacy for rural health providers and suppliers, and beneficiaries' access to services (Sec. 3127).

Certain protections are extended for physician and hospital services in frontier states (where 50% of the counties have less than six people per square mile). For physicians, a floor of one on the practice expense index will be established for services on or after January 1, 2011. For hospitals, for discharges on or after October 1, 2010, the area wage index will be no less than one (Sec. 10324).

## 9 Private Health Plans and Medical Loss Ratios

**OVERVIEW.** The ACA will have a major impact upon the offering of health insurance in the U.S. due primarily to a broad new federal framework affecting minimum benefit requirements, premium subsidies and restrictions, tax treatment and conditions for the offering and marketing of plans. There are differing provisions relating to private plans, employer-based plans, and other models. In addition, States have major new changes and options to address under the Medicaid program, as well as the potential administration of American Health Benefit Exchanges, low-income subsidies and related matters. These changes are each a topic for extensive review in their own right. For purposes of this report, we chose to focus on a few areas to simply make physicians aware of selected key changes.

The principal feature that we believe could most impact upon insurers' long-term behavior in the marketplace with respect to cost control and provider contracts is the so-called medical loss ratio standard, which effectively sets limits on health plans profitability. This is discussed following a brief summary of changes to set the stage.

**MAJOR PRIVATE HEALTH INSURANCE CHANGES.** The new federal standards applicable to private health insurance coverage enter into

The principal feature that we believe could most impact upon insurers' long-term behavior in the marketplace with respect to cost control and provider contracts is the so-called medical loss ratio standard, which effectively sets limits on health plans profitability.

force primarily after full implementation in 2014. As noted in Part I of this report, certain changes went into effect in 2010 and 2011. These included:

- Restriction of annual benefit maximums and elimination of lifetime coverage maximums,
- Coverage of dependents to age 26,
- Required coverage of specific preventive benefits, and
- Elimination of pre-existing medical condition exclusions for children under age 19.

The broader standards will affect private health insurance in the individual, small group, and large group markets, depending on the standard. The new federal framework imposes new requirements on states related to the allocation of insurance risk, modifies the current state-based regulatory system applicable to private plans, and requires coverage for specified categories of benefits.

As noted earlier, there are numerous provisions affecting employer-sponsored plans. Note that employers are not required to offer their employees health insurance coverage. However, if they do so, there are substantive new rules governing such plans.

Separately, under section 1331 of the PPACA, as enacted, States are permitted to offer a Basic Health Program (BHP) for individuals and families whose incomes are low (generally, below 200% of the federal poverty level), but not low enough for Medicaid eligibility. There are unique federal financing incentives offered to States for the BHP, but there are complicated financial risk and care dynamic issues for States to consider in evaluating whether it is better to offer a state-sponsored BHP, or allow such individuals to access insurance through the exchanges, with a slightly different set of subsidies made available to them.

With respect to health plans overall, the ACA defines "qualified health plans" (QHPs), which are subject to a specified list of requirements related to marketing, choice of providers, plan networks, essential benefits, and other features. The Secretary will specify the "essential health benefits" included in the "essential health benefits package" that QHPs will be required to cover (effective beginning in 2014). Essential health benefits will include at least the following general categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services, and chronic disease management; and
- pediatric services, including oral and vision care.

Plans offered under the essential health benefits package requirements will provide four levels of coverage referred to as bronze, silver, gold, or platinum level of coverage (described below). Bronze is the least comprehensive and platinum the most comprehensive plan. They differ according to the level of benefits and the cost of their plans. Bronze pays 60% of coverage costs; silver, 70%; gold, 80%; and platinum, 90%.

Beginning in 2014, the ACA generally requires QHPs to provide coverage of at least one of these levels. This applies regardless of whether or not the QHP is offered through an exchange. Excluding dental-only plans, health insurance issuers must offer a silver plan and a gold plan in the exchange. Each coverage level is to be based on a specified share of the full actuarial value of the defined essential health benefits. A health insurance issuer that offers coverage in any of these four levels will be required to offer the same level of coverage in a plan specifically designed for individuals under age 21. Finally, a QHP issuer must comply with regulations applicable to exchanges.

**MEDICAL LOSS RATIOS.** Effective for plan years beginning on or after six months after enactment, issuers in the group and individual mar-

There are numerous provisions affecting employer-sponsored plans. Note that employers are not required to offer their employees health insurance coverage. However, if they do so, there are substantive new rules governing such plans.

kets (including grandfathered health plans) are required to submit to the Secretary of HHS a report describing their medical loss ratios. In simplified form, this is a rule that requires a certain amount of total premium revenue to be paid out to policyholders in the form of benefits. The rule is expressed as the ratio of incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) relative to earned premium revenues.

After all the required calculations are performed, the amount spent on clinical and quality services must equal at least 80% for the individual and small group market, or 85% for the large group market. In effect, the plans must derive their profits from within the permissible margin of 20% or 15%, respectively, which also include other administrative and overhead expenses. For many plans, this could represent a significant decline in aggregate profitability. For instance, some plans previously experienced medical loss ratios of 60%, or thereabouts, meaning they were paying out only 60% of their premium revenues in benefits to policy-holders, and claiming higher profit margins.

As of January 1, 2011, health plans must provide an annual rebate to each enrollee on a pro rata basis if the medical loss ratio is less than 85% in the large group market and 80% for the small group and individual markets. States are permitted to increase the percentages, but the Secretary may adjust the state percentage for the individual market if it is determined that the application of 80% would destabilize the market. The rebate amount will be equal to the product of the amount by which the percentage exceeds the ratio (both described above) and the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees) and after accounting for risk adjustment, risk corridors and reinsurance. The National Association of Insurance Commissioners, working to assist the Department of Health and Human Services in their rulemaking obligations on this provision, played a unique role under the ACA in helping to develop the technical details.

**COMMENTARY** Physicians need to be aware that new health plan medical loss ratio standards could impact upon plan network design and contracting efforts. Plans may be incented to reduce their overhead costs or otherwise respond in ways difficult to predict in order to retain maximum profitability. Insurers will be looking at ways to manage their claims more efficiently and attempting to lower certain operational costs. There may be increased pressure, already high, on adoption of electronic health record systems, and shifts in medical management processes and programs. Some plans may seek deeper provider discounts.

The medical loss ratio rule is coupled with the higher benefit costs associated with the already effective provisions described in the opening paragraph, as well as new ACA compliance costs. In addition, insurers face new rules governing what constitutes "unreasonable increases in premiums." The authority for judging and approving rate increases resides with the states, but plans may find scrutiny of premium increases somewhat tougher in the future under ACA language and rulemaking interpretations. Physicians are advised to work with their state medical societies to stay abreast of the specific plan environment unfolding within their states as ACA implementation proceeds, or of changes in the ACA, if modified by the Congress.

## 10 Health Insurance Exchanges.

The ACA authorizes and supports states' creation by 2014 of "American Health Benefit Exchanges." Exchanges are not insurers, but a regulated marketplace that will provide qualified individuals and small businesses with access to insurers' QHPs via standardized methods of marketing, plan offerings and

benefit comparisons, etc. Exchanges are intended to facilitate benefit plan and premium comparisons for consumers, among other objectives. They can be mandatory (all covered policy offerings must be offered through the exchange), or they can be voluntary (insurance carriers would have a choice over whether they offered policies within or outside of the exchange). There are risk-pool and selection issues attendant upon this decision. In addition, federal and state risk-adjustment tools will be a part of the tools employed in some of the decisions and processes that are coming into play under these provisions.

Exchanges are required to be government or nonprofit entities that have additional responsibilities as well, such as certifying plans and identifying individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits. The Secretary of HHS has already released grant awards permitted under the ACA to many states to create exchanges, with such sums appropriated as necessary. The grants can be renewed to states making progress in establishing an exchange, implementing the private health insurance market reforms, and meeting other benchmarks established by the Secretary. If the Secretary determines before 2013 that a state will not have an exchange operational by 2014, or is declining or will not be able to implement the standards, the Secretary is required (directly or through an agreement with a non-profit entity) to establish and operate an exchange in the state and to implement the standards.

**COMMENTARY** Initially, exchanges would apply to the individual and small group markets, with large groups potentially permitted to enter in later years. There are many complex administrative issues for States with respect to the decision to offer or govern an exchange, and many matters and choices available concerning the internal operations of any exchange, once launched. There are also implications for Medicaid interactions and operations. In most, if not all, states, this area requires new authorizing legislation in the State and changes within state government. Within the federal framework, there is room for significant differences in insurance regulation and exchange operation across states. There is also authorization under the ACA for States to collaborate across state lines by establishing regional exchanges.

As of this writing, 23 states have declined to develop or operate exchanges, necessitating federal steps to insure exchanges will operate in those states. This is a complex area of intergovernmental relations that bears watching over time, and whose success, or lack thereof, could materially affect the broader success of the ACA's coverage objectives. Note that many of the states that have declined to participate thus far are among those that are challenging the constitutionality of the individual mandate.

**COMMENTARY** As noted above in the general private plan section, the private health insurance market will undergo considerable upheaval over the next several years. The degree and direction of changes will vary across states. Physicians should work closely with their local medical societies and other professional representatives to stay abreast of the changed health plan environment in their state and continually gauge the impact upon physician practice issues.

Further, as discussed under ACOs, there is a growing "quasi-insurance" element to physician practice to the extent any physician participates in ACOs, medical home or related models that involve risk-sharing and/or shared savings elements. Some of the issues associated with population-based care costs, risk-adjusted payments and benchmark measures that were previously confined primarily to insurers, are now entering into the business aspects of conducting a medical practice. This is discussed more fully in the executive summary to this report.

In closing, it has been our privilege to bring this information to physicians' attention. We invite you to review additional resources on our website at http://www.physiciansfoundation.org. ■

**Physicians should work closely with their local medical societies and other professional representatives to stay abreast of the changed health plan environment in their state and continually gauge the impact upon physician practice issues.**

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