2011 ISSUES

- State
- Federal

TEXAS LEGISLATURE

- Meets every two years for five months (140 days)
  - Creates a state budget
  - Passes legislation
- Bicameral
  - Senate
  - House of Representatives
- Governor may call special sessions to consider specific issues

SENATE

- 31 members
- Lieutenant governor presides
  - Appoints committee members
  - Sets bills for floor debate
- Two thirds of senators (21) signatures on bill necessary; lieutenant governor may (but is not required to) then recognize the bill floor debate

HOUSE OF REPRESENTATIVES

- 150 members
- Elect speaker on first day
- Speaker presides and appoints committee members
- This year, speaker’s race was contentious
- Republicans now hold a supermajority in the House
2009: 81st Texas Legislature
- Preserved Texas’ 2003 medical liability reforms
- Limited creeping expansion of scopes of practice of various allied health professionals
- Fought the creeping encroachment of the corporate practice of medicine doctrine
- Increased graduate medical education and cancer research funding

2011: 82nd Texas Legislature
- The Texas Legislature began its 82nd session this week, on January 11, 2011
- Focuses:
  - Redistricting
  - Significant budget shortfall
- All other issues will be considered in light of these issues

2011: State of Mind
- Reduced state tax revenues and uncertain revenue projections
- Many new legislators, both Democrat and Republican, consider their voters reject the status quo

2011: Issues
- Redistricting
- Health care
- Sunset legislation
- Immigration
- Budget shortfall possibly over $25 BILLION

Budget
- $25 BILLION—potential shortfall
- Over ¼ of all discretionary revenue
- Changes will be difficult and unpopular
- Many Republicans, including Governor Perry, have pledged not to raise taxes

Budget
- Revenue may arise from tax break rollbacks, increased current fees, new fees, and possibly, legalized casino gambling
- Budget cuts may include previously exempted areas, such as public education
- Expect deep budget cuts in, and elimination of, some state agencies
**REDISTRICTING**
- Texas must, after each census, approve a redistricting bill; required to do so now
- Draws boundaries for seats in the Senate, House of Representatives, and State Board of Education
- Any bill must be precleared by the U.S. Department of Justice, as with other southern states, to ensure adequate minority voter representation

**IMMIGRATION**
- Prior immigration bills have been unsuccessful; in 2009, a voter identification bill brought the House to a standstill
- Expect contentious bills regarding voter identification, citizenship status checks for work authorization on state projects by contractors
- Possibly an Arizona type bill requiring law enforcement to check citizenship status

**SUNSET REVIEW**
- Occurs about every 12 years
- State agencies are reviewed
- Includes self-review, review by sunset staff, and public hearings
- Sunset Advisory Committee then recommends legislation regarding the agencies, including ending some

**OVERALL**
- This session, expect only bills with no or a negligible cost to progress

**PHYSICIAN-CENTRIC ISSUES**
**2011: HEALTH CARE ISSUES**
- What are some of the big health care issues?
  - Texas remains the uninsured capital of the US
  - Texans: older, poorer, more obese, less educated
  - Increased health care demand and increased spending

**2011: TEXAS HEALTH CARE**
- About 1/3 of discretionary spending is health care related
- The federal health care law’s mandates may limit the Texas legislature’s ability to limit health care spending by cutting services
- Hospital and other advocates will lobby for increased spending in focused health care areas

**CORPORATE PRACTICE OF MEDICINE**
- An extremely important issue
  - Physicians’ clinical autonomy and physicians’ primary responsibility to the patient are the underpinnings of the doctrine prohibiting the corporate practice of medicine
  - Texas licenses only physicians to practice medicine and provide medical services
- Corporate entities are not licensed by the state to practice medicine
  - The prohibition is intended to ensure that physicians can provide independent medical judgment
  - Patients’ health comes first, not the corporate bottom line

**EVOLVED: EXCEPTIONS EXIST**
- A medical school may employ physicians
  - Physician group practice
  - Nonprofit health care corporation (so-called 501[a] corporation
  - Federally qualified health center (FQHC)
  - Some local hospital districts
- With the exceptions, physicians remain responsible
  - E.g., 501[a] hospital must have a physician board of directors governing the institution and with direct responsibility for medical quality and other medical issues
**Removing the Doctrine**

- Direct employment of physicians by hospitals and other layperson-owned corporations not overseen by the Texas Medical Board
- Threatens independent physicians decision making
- Potentially divisive to the medical community

**Examples**

- Favoring employed physicians at the expense of independent physicians
- Using access to a hospital to keep independent physicians out
- Hiring physicians who will benefit the hospital at the expense of appropriate patient care
- Put charity care burden on independent physicians

**2009 Legislature**

- More than 20 bills were filed to allow small rural hospitals to directly employ physicians
- Arguments: slow economy, difficult to recruit physicians to these areas, hospitals can provide benefits, such as health insurance and retirement
- One bill moved forward; the TMA worked to try to include strong protections for physician autonomy under a Texas Medical Board-supervised process

**2009 Legislature**

- At the end of the session, the bill had an amendment added that dramatically increased physician exposure to liability
- This is the situation most feared: responsibility with potential liability, but without autonomy to freely determine patient care
- Bill passed! But was vetoed

**2011: Focus**

- Continue to oppose efforts by hospitals and other layperson-owned corporations to employ physicians
- Improve Texas Medical Board oversight of existing exceptions to the Corporate Practice of Medicine doctrine
- Empower the Texas Medical Board to establish more mechanisms protecting physicians’ responsibility to make clinical decisions in the patients’ best interest

**2011: Focus**

- As arguments against the doctrine typically are based on meeting needs in underserved areas, disincentives to physicians practicing in underserved areas, such as payment formulas and lawsuit concerns, should be addressed and corrected
- Encourage physicians to practice in underserved areas via existing tools hospitals already have, rather than compromising physician judgment or eliminating the private practice of medicine
**Health Care Reform**
- Federal law with significant state consequences

**March 23, 2010**
- President Obama signed the Patient Protection and Affordable Care Act (PPACA)
- It expands Medicaid in 2014 to cover uninsured persons up to 133% of the federal poverty level
- Federal law requires states to maintain Medicaid coverage at the same levels as pre-bill

**PPACA**
- Requires states to establish insurance exchanges
- Health insurance can be obtained
- Federal subsidies to afford coverage
- State plan must be approved by January 1, 2013, or federal government with design and operate a plan

**PPFCA**
- Texas legislature, after this session, will not meet again until January, 2013
- If this session’s legislature does not implement a plan, the legislature may default to the federal government the authorization to design and operate the exchange

**PPACA**
- PPACA passed without a single Republican vote
- After it was signed, Texas Attorney General Greg Abbott, along with 19 other state attorneys, filed lawsuits against the federal government, to overturn PPACA
- Most likely will move quickly to SCOTUS

**PPACA**
- Expect the Texas legislature to respond to PPACA; and legislation has been filed to prohibit individual mandates to purchase health insurance
- Even though Medicaid expansion will not occur until 2014, PPACA currently restricts Medicaid cuts
- Expect budget cuts to federally unprotected health care areas, such as mental health services
**CHILDREN**
- Childhood poverty: Texas leads the country
- Currently about 2.8 million children enrolled in CHIP and Medicaid
- At tension with the budget crisis, pressure is on to expand coverage and funding

**MEDICAID**
- With the economic recession, annually Medicaid enrollment increases about 11%
- Budget cuts most likely will take the form of lower rates paid to doctors who accept Medicaid
- Problematic; physicians already see Medicaid patients as a revenue loss
- May see even fewer physicians accept Medicaid patients

**ELIMINATE MEDICAID IN TEXAS?**
- A proposed solution
- Possible $60 billion savings between 2013 and 2019 if end CHIP and Medicaid
- But lose about $24 billion in federal Medicaid funding, about 60% of biennial cost
- Texans would still pay Medicaid taxes
- Possibly millions of poor Texans uninsured

**MEDICAID: WHAT TO EXPECT**
- Continued expansion of Medicaid enrollment; PPACA may increase Texas Medicaid population by 45%
- Deep cuts in federally unprotected health services such as mental health services
- Legislative opposition to PPACA registered by proposed constitutional amendment prohibiting individual mandates

**TEXAS MEDICAL BOARD**
- Has made great progress this last decade in streamlining license processing time and improving enforcement
- 2009: Two TMA-supported bills passed; one directs TMA to eliminate complaints dismissed or held in the physician’s favor after 5 years, and one establishes the Texas Physician Health Program, providing assistance to impaired physicians
- However, 2009 showed a strong movement to weaken the TMB’s authority
- 2011: Need to support adequate TMB funding and to continue to improve licensure and enforcement efficiency
- Fear that budget crisis may precipitate limited TMB funding
Texas is a large, growing state

Texas has a physician shortage in almost all specialties

2003 liability reform has ushered in an unprecedented influx of physicians

Nonetheless, has only barely kept up with growth

This year, for the first time, there are more medical school graduates in Texas than there are residencies to fill

How to fund? Probably not state revenues

Possibly from communities, with increased numbers of community-based programs

This would probably be most effective with primary care specialties

Risky to entrust Texans’ health to physicians from other states or countries

In recent years, the legislature has increased state funding for medical schools and residencies

Important; physicians are likely to practice within 100 miles of their training programs

Continuing scope of practice issues

Procedural, diagnosing, and prescribing privileges involving, among others, chiropractors and advance practice nurses

Physicians should promote the idea that all work as a team, but the physician is the team leader, supervising and delegating to others

Corporate practice of medicine

Laboratory tech certification by the state

Medical examiner tissue for use in research

Public Health:

Obesity

Mental health

Smoking

Quality: payors want better quality and do not want to pay for physicians’ or hospitals’ mistakes

Expect very high deductible for patient going out of coverage system
**MEDICAL EXAMINER TISSUE**
- Senate bill No. 133 (C.S.S.B. 133) filed by Senator Jeff Wentworth (Bexar county)
- Drs. Laucirica and Hunter have been working actively on this, with the assistance of Dr. Luis Sanchez, the Harris County Chief Medical Examiner

**FEDERAL**
- Backdrop of uncertainty about the institution of health care reform

**ACCOUNTABLE CARE ORGANIZATIONS**
- “HMO on steroids with a heart”
- Driven by a need to reduce cost
- Capitated bundle of payments
- Patient satisfaction-centric and outcome-centric

**ACO—CMS DEFINITION**
- “An organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to [the ACO].”
- Mandated by the PPACA
- Medicare shared savings program for ACOs will begin no later than January 2012

**ACO**
- Can be formed by hospitals, by hospitals with physicians, physician groups, and hospital-employed physicians
- How they work will depend on who sponsors them, their visions, and their guiding principles
- The AMA has set up guiding principles
Many misconceptions already exist in private form. Public form is coming via national health care, and it may be found unconstitutional or not funded in Texas.

Leadership is yet to be determined. Hospitals? Physicians?

Problems with physician ownership:
- Requirement for significant clinical, administrative, and financial collaboration by physicians; lack of revenue to invest in ACO
- Difficulty in allocating shared payments among the physicians
- Required investment in information technology to document accountability
- Need for increased professional management to achieve goals so as to quality for bonus payments in the shared savings program

Physician control:
- Declining hospital census, declining revenue, little outpatient clinic growth

Hospital control:
- Hospitals will increase revenues
- Physicians income and professional status will decline
- Both difficult to regain once lost

Problems with ACOs:
- Compel providers to constrain costs across the population of an entire community; probably impossible with current fee-for-service payment structure
- Hospitals are likely to dominate ACOs because (1) most avoidable Medicare costs are hospital related, and (2) hospitals are in many places the only health care entity capable of forming a viable ACO

“Many hospital executives view it as essential that hospitals become ‘prime contractors’ in the ACO model. Further, the executives believe that unless they ‘align physicians’ incentives’ with those of the hospital, they will not be able to create and manage successful accountable care organizations. However, for many hospital administrators, alignment is a code word for ‘physicians work for me and will do what I say.’”

Hospital-physician collaboration has traditionally been marked by distrust.

With the rise of hospitalists, physicians are becoming bifurcated into two groups—those that never or rarely use a hospital, and those who practice almost entirely within a hospital.

Weak physician financial incentives to change.

No patient involvement or participation.

What is the pathologists' role?

That remains to be determined; CAP and ASCP are active.

CAP joining Brookings-Dartmouth Accountable Care Organization Learning Network.

ASCP has written to CMS arguing that pathologists should be central and participate in gain-sharing arrangements.

TMA has an ad hoc committee on ACOs with three work groups:

- Statutory/regulatory
- Implementation/payment methods
- Education/communication by the TMA

Needs significant physician oversight.

Success will be defined by the level of physician control.

In the late 1980s, non-radiologist physicians invested in free-standing imaging centers and ordered more tests, many for a purely financial motive.

In 1991, federal anti-self-referral legislation, known as Stark II law, ended self-referral to imaging centers for which physicians or their immediate family members had a financial interest.

One exception is for in-office ancillary testing.

Allows self-referral.

Originally intended to provide patient convenience for simple clinical laboratory tests.

Core premise: the services are intended to support patient care while the patient is physically present in the physician's office.

Time has passed.

Testing equipment is smaller and less expensive.

Increased numbers of lab tests are being performed in physicians' offices.

Lab testing may be a minor issue overall; in-office radiologic studies have increased dramatically.
Currently, 1 in 6 physicians own or lease advanced (not x-ray) imaging equipment.

From 2000 to 2005, spending on MRI, CT, and PET scans increased 5 times the rate of medical inflation.

More than half of these services are not provided on the same day as the patients’ original appointments.

Orthopedists and neurologists began the trend in the early 2000s; now all specialties are involved.

Unlike x-rays, other imaging studies have not been shown to shorten the duration of illness, even while increasing the total cost of care per patient visit.

Expanding area of self-referral.

PPACA cuts technical fees and amount paid for imaging of contiguous body parts, and requires public disclosure of facility ownership.

Ironically, recent cuts for imaging payment has prompted many cardiologists to sell practices to hospitals; however, hospitals get paid more for imaging that physician practices.

CAP and ASCP are working with other groups to close IOAS loopholes.

Radiologists
Physical therapists
Radiation oncologists
The American Clinical Laboratory Association.

CAP is working with a Georgetown health economist, Jean Mitchell, Ph.D.
Mitchell is completing a study on clinician overutilization.
CAP is also working with the GAO (General Accountability Office), a non-partisan Congressional investigative office.

Several members of Congress requested the GAO investigate potential overutilization of services in the Medicare system.

Both the Mitchell study and GAO report are due in spring, 2011.
CAP is working on draft legislation addressing the issue and is searching for Members of Congress willing to introduce the bill.
○ CAP, ASCP, and others are working in Washington, D.C. to educate legislators about this

○ One more recent loophole is anatomic pathology

○ Why?

○ A federal rule designed to limit situations where physicians bill for services that they do not actually perform

○ Until recently, with a few exceptions, physicians could not purchase the professional component for work that was triggered by that physician’s own referral

○ Physician purchasing the technical component was not allowed to mark it up when billing Medicare

○ This limited physicians’ ability to share in revenues generated by their own anatomic pathology referrals

○ Recently, under the MMA, CMS enacted a new exception to the Prohibition on Reassignment

○ Purportedly done in order to make it easier for ER staffing companies to bill for independent contractor physicians

○ CMS now permits an entity, including a person, group, or facility, to be paid for any physician service as long as there is a “contractual arrangement with that entity, regardless of where the service is furnished”

○ In conjunction with IOAS exception, this rule has permitted the proliferation of new and abusive arrangements

○ Physician groups are now performing and billing for services such as physical therapy, therapeutic radiology, and anatomic pathology

○ The loosening of the Prohibition on Reassignment, along with the IOAS exception, has allowed physicians who are large referrors for pathology services, such as gastroenterologists, urologists, and dermatologists, to share in the revenues earned from their own referrals, even though the referring physician does not supervise or oversee the anatomic pathology work
**PROHIBITION ON REASSIGNMENT**

- Dramatically changes payment for physician services in ways Congress did not intend by the MMA

- Arrangements should not be used to camouflage inappropriate fee-splitting relationships or payments for referrals

- Has given rise to condo labs

**CONDO LABS: TWO TYPES**

- Pod labs

- Referring physician billing arrangements

**POD LABS**

- Joint venture or “turnkey” arrangements between pathologists and other physicians

- Pathologist performs anatomic pathology services and “supervises” a lab space

- Clinic hires histotechnologist

- Clinic bills for both technical and professional components, and pays pathologist a discounted fee and a “management” fee

**REFERRING PHYSICIAN BILLING ARRANGEMENTS**

- Lab merely offers anatomic pathology services to a referring physician, performs the anatomic pathology service in the lab, and bills the referring physician at a discount

- The referring physician then marks up the laboratory bill and bills Medicare

**WHY IS THIS BAD?**

- Incentive for referring physicians to order more tests, often for financial reasons

- As each separate biopsy is billable, there is an incentive to biopsy more sites in order to increase the payment a referring physician can receive

- These arrangements are prohibited for clinical laboratory services

- Inconsistent with 20 years of federal policy

**WHY IS THIS BAD?**

- Many arrangements raise issues with the OIG’s Special Alert on Contractual Joint Ventures, issued April 2003

- OIG has significant concerns about these arrangements’ lawfulness under both anti-kickback and anti-self-referral statutes

- Along with threat of loss of corporate practice of medicine doctrine, undermines pathologists’ professionalism
SGR
- Sustainable Growth Rate cuts

SGR
- December 9, 2011
- Congress passed a one-year fix to the SGR formula for Medicare physician payments
- Averted a 25% cut set to occur on January 1, 2011
- Cuts averted until December 31, 2011
- A temporary, one year “fix”
- CAP, ASCP, and others are collaborating with the AMA and other medical societies to replace and reform the SGR payment system

TC “GRANDFATHER” PROVISION
- Technical Component “Grandfather” Provision

GRANDFATHERING TC
- Traditionally, independent laboratory pathologists billed for both the professional component and the technical component of anatomic pathology services
- 1999: Federal government stopped paying hospitals for the technical component, arguing it was being paid as part of the DRG payment

GRANDFATHERING TC
- As such, independent laboratory pathologists could only have billed for the professional component
- But grandfather arrangements were put in place, which expire every few years, and have to be extended
- The extensions have been successful; however, they are not a permanent solution

GRANDFATHERING TC
- CAP, ASCP, and others will work to reintroduce legislation permanently extending the technical component “grandfather” provision
- Has been extended until December 31, 2011
- Want permanent extension; need new 112th Congress sponsors; House sponsor John Tanner (D-TN) retired, and Senate sponsor Blanch Lincoln (D-Ark) lost
GRANDFATHERING TC

- If TC grandfathering is not made permanent, and if another temporary extension is not passed, what is the independent laboratory pathologists’ responsibility?

- Independent laboratory pathologists will have to negotiate with hospitals for TC payment

- Most of these hospitals are small and financially struggling

- May not be able to negotiate for TC payment

- May negotiate but find that payments are delayed, possibly quite delayed or never paid

- Cannot simply provide it for free or at a discount; OIG would consider that as an illegal inducement for referrals

TORT REFORM

- The House of Representatives may attempt to reform medical malpractice law via federal law

- Regarding tort reform, expect stiff opposition in the Senate

- Anything that might make it past the Senate is likely to be vetoed

REPEAL OF HEALTH CARE REFORM

- Health care reform may not be repealed or replaced

- Republican majority in the House of Representatives will attempt to defund the health care reform bill

- Without funding, several key bill provisions will be jeopardized

SUMMARY

- The predominant state issues affect all physicians, not just pathologists, including Medicare payment issues and threats to the corporate practice of medicine doctrine

- The primary federal issues directly involving pathologists concern in-office testing and pod labs

- Direct threat to pathologists’ professionalism

- Expect some health care reform defunding