The U.S. Supreme Court Decision & Patient Protection and Affordable Care Act: What It Means for Clinical Gastroenterology

BACKGROUND

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (HR 3590) into law (now known as the "ACA").

After much deliberation and negotiations throughout 2009, the final version of comprehensive health reform largely reflected the version drafted and passed in the Senate on December 24, 2009, by a vote of 60-39. On March 21, 2010, the House of Representatives passed HR 3590 by a vote of 219-212, but only after receiving assurances from the Senate leadership that the Senate would vote on a "package of House of Representatives fixes," structured as a budget reconciliation bill, to amend HR 3590. By crafting the legislation in such a way, it allowed the Senate to quickly pass the modified bill with a simple majority vote, instead of the traditional 60 votes necessary to overcome a filibuster. The legislation was signed into law on March 23, 2010.

On March 30, 2010, the President also signed into law the Health Care and Education Reconciliation Act of 2010 (HR 4872 or "Reconciliation Act"), which made certain technical modifications to ACA.

It is important to note that the neither HR 3590 nor HR 4872 included the standard "severability" clause in the legislation, which allows the Court to "severe" certain sections of a law but also keep other provisions intact. This omission opened the door for opponents to challenge constitutionality of the entire law. The U.S. Supreme Court agreed to hear the challenge to the ACA that involved 26 states, with Florida as the lead state. In January 2011, the Federal District Court in Florida found the individual mandate unconstitutional. The 11th Circuit Appellate Court in Atlanta upheld this ruling in August 2011 but also held that the law should remain intact (including a provision to expand the Medicaid program).

In March 2012, the U.S. Supreme Court held 3 days of oral arguments on whether certain provisions in ACA are constitutional, and if not, whether the rest of the law can remain intact. The 3 days of argument covered:

Monday, March 26: Whether the Anti-Injunction Act precluded the Court from hearing challenges to the constitutionality of the individual mandate until 2015.

Tuesday, March 27: Whether the "individual mandate" provision is constitutional.

Wednesday, March 28: Whether the mandate is "severable" from the remainder of the ACA if found unconstitutional, as well as whether the ACA's expansion of Medicaid is lawful.

SUPREME COURT DECISION

On Thursday, June 28, the Supreme Court upheld the entire law save certain limitations to the Medicaid expansion provision of the ACA. In a 5-4 ruling, Chief Justice John Roberts joined Justices Elena Kagen, Ruth Bader Ginsburg, Stephen Breyer, and Sonia Sotomayor holding Congress was acting within its power of the U.S. Constitution in requiring Americans to purchase health insurance or face a penalty. However, the Court *did not uphold the law under the Commerce Clause, but instead, chose to uphold the law under the "taxing clause" of the Constitution*, which allows Congress to lay and collect taxes.

The Court also ruled that Congress cannot withhold current federal Medicaid dollars if states fail to comply with the expansion of Medicaid eligibility requirements.

According to Chief Justice Roberts:

> "The Affordable Care Act is constitutional in part and unconstitutional in part. The individual mandate cannot be upheld as an exercise of Congress's power under the Commerce Clause. That Clause authorizes Congress to regulate interstate commerce, not to order individuals to engage in it. In this case, however, it is reasonable to construe what Congress has done as increasing taxes on those who have a certain amount of income, but choose to go without health insurance. Such legislation is within Congress's power to tax."

> "The Framers created a Federal Government of limited powers, and assigned to this Court the duty of enforcing those limits. The Court does so today. But the Court does not express any opinion on the wisdom of the Affordable Care Act. Under the Constitution, that judgment is reserved to the people."

Justices Anthony Kennedy, Antonin Scalia, Samuel Alito and Clarence Thomas joined the dissent: "The Act before us here exceeds federal power both in mandating the purchase of health insurance and in denying nonconsenting states all Medicaid funding. These parts of the Act are central to its design and operation, and all the Act's other provisions would not have been enacted without them. In our view it must follow that the entire statute is inoperative."

SUPREME COURT DECISION AND IMPACT TO CLINICAL GASTROENTEROLOGY

So what does the recent Supreme Court decision mean for practicing physicians and gastroenterologists in particular?

When the ACA was passed in March 2010, the ACG Past President Philip O. Katz, M.D wrote an article in the Red Section of *the American Journal of Gastroenterology* highlighting important provisions impacting clinical gastroenterology. ACG membership may also click here to read this article: http://www.nature.com/ajg/journal/v105/n7/pdf/ajg2010238a.pdf

Please find below an update on some of these provisions contained in the ACA impacting the GI clinician.

LOOKING BACK… THEN FORWARD
The tables below provide an update on certain provisions contained in the ACA impacting ACG members.

KEY PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS MODIFIED BY THE SUPREME COURT

PROVIDER REIMBURSEMENT & REPORTING:

ISSUE	ACA LANGUAGE	UPDATE
Sustainable Growth Rate (SGR) and Medicare Physician Pay Reform	There was no provision in the ACA to reform Medicare reimbursement and the SGR formula.	Absent a legislative fix or full SGR repeal this year, Medicare providers face a 30% reimbursement cut in 2013. Medicare providers also face a 2% annual cut over 10 years pursuant to "sequestration."
"Physician Compare" Website	A "physician compare" website. Requires Secretary of HHS to develop a website with information on providers enrolled in the Medicare program and others participating in the PQRI program. Website will provide public comparable information on quality measures, patient experience, and assessment of patient outcomes.	CMS developed the following website: http://www.medicare.gov/find-a-doctor/provider-search.aspx ACG has provided comment to CMS in multiple letters regarding ways to improve this website, including participation in a nationally recognized quality improvement registry such as GIQuIC. Please visit the ACG website to learn more: http://gi.org/national-affairs/latest-news-and-recent-actions/
Impact from Supreme Court Decision?		Will move forward

PQRS	Physician Quality Reporting System. This was formerly known as the Physician Quality Reporting Initiative (PQRI). The ACA made the program permanent and changed the name to the Physician Quality Reporting System (PQRS).	Incentive payments for successful reporting PQRS measures are 0.5% (2012-2014). Beginning in 2015, physicians who do not successfully reports PQRS measures will have their Medicare Part B payments reduced by 1.5%. This is based on calendar year 2013 reporting data. The reimbursement cut is 2% for 2016 and beyond.
Impact from Supreme Court Decision?		Will move forward
"Misvalued" Codes	Misvalued Codes Under the Physician Fee Schedule. Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates. Strengthens the Secretary's authority to cut reimbursement fees schedule rates that are found to be "overvalued" or "inaccurate."	In November 2011, CMS finalized its proposal that AMA RUC determine whether provider evaluation and management (E & M) codes are undervalued. The AMA RUC must review and provide a recommendation for at least one half of these E & M codes by July 2012 and the remaining E & M codes by July 2013. Even more alarming to GI is the second category of codes CMS proposes the RUC to review: high expenditure procedural codes. CMS chose a list of codes that have not been reviewed since CY 2006 and also have 2010 allowable charges greater than $10 million. CMS requested the AMA RUC to review at least one half of the codes (35) contained on this list of 70 procedural codes by July 2012 so that CMS can make proposals to the 2013 Medicare PFS final rule. Among the codes on this list impacting gastroenterology: 45378 (Diagnostic Colonoscopy) and 43235 (Upper GI Endoscopy, diagnosis). Apart from this provision, the GI societies conducted RUC surveys for other endoscopy codes in the summer 2011.
Impact from Supreme Court Decision?		Will move forward

Physician Feedback Program & Value-Based Payment Modifier	Physician Feedback Program. Expands Medicare's physician resource use feedback program to provide for individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs. Value-Based Payment Modifier Under the Physician Fee Schedule. Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. Requires CMS to implement a "value-based payment modifier" for certain physicians by 2015, as determined by CMS, and all physicians by 2017.	In 2012 CMS began issuing tailored quality and resource use report (QRURs) based on PQRS performance measures as well as resource use and other Medicare cost information to certain successful PQRS providers in four states: Iowa, Kansas, Missouri, and Nebraska. This was for informational purposes only but will be used to further implement the "value-based payment modifier." The ACA requires CMS to implement a "value-based payment modifier" for certain physicians by 2015, as determined by CMS. This will be expanded to all physicians by 2017. CMS proposes to use CY 2013 as the reporting year to implement the 2015 payment adjustment and will provide more details on this payment modifier in future rulemaking.
Impact from Supreme Court Decision?		Will move forward

Physician "Sunshine" Provisions	Transparency Reports and Reporting of Physician Ownership or Investment Interests. Requires drug and device manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. Directs any applicable manufacturer or group purchasing organization to submit to the Secretary of HHS information relating to any ownership or investment interest held by a physician in the applicable manufacturer or group purchasing organization. Noncompliance *by the manufacturer or group purchasing organization* will result in civil money penalties of not less than $1,000 and not more than $10,000 for each violation. Reported information to the Secretary will be made available to the public.	In December 2011, CMS published the proposed "physician sunshine payment" rule. CMS has yet to release the final regulation. In February 2012 ACG submitted comment to this proposed regulation regarding drug and device manufacturers' payments to physicians and teaching hospitals. Among ACG's concerns with the rule as written is whether a company is required to trace, identify, and report grants for sponsoring continuing education courses that ultimately help to pay speakers' honoraria or travel expenses. ACG believes this was not the intent of the statute and is very concerned that public reporting of these payments creates an inferred financial relationship between GI clinicians and industry. Once an inferred relationship is out in the public domain, it is nearly impossible to remove this public perception. ACG requests the CMS to specifically exclude from reporting requirements grants that sponsor continuing medical education courses and other educational events. Please click here to access the ACG comment letter: http://d2j7fjepcxuj0a.cloudfront.net/wp-content/uploads/2012/02/SunshinePaymentRuleComments021712.pdf
Impact from Supreme Court Decision?		Will move forward

Independent Payment Advisory Board	Independent Payment Advisory Board (IPAB). Creates a 15-member Independent Payment Advisory Board (IPAB) tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress will be allowed to consider an alternative provision on a fast-track basis. The Board is prohibited from making proposals that "ration care," raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. This leaves Medicare provider reimbursement as the only major option left to reduce Medicare costs.	IPAB will begin making proposals to Congress and the President in 2014, and annually thereafter for those years when growth exceeds target growth. In March 2012, the House of Representatives passed legislation that abolished the IPAB. House Republicans merged the repeal of IPAB with a bill restricting medical malpractice lawsuits. Democrats objected to the $250,000 cap on noneconomic damages as well as the infringement of states' rights as medical malpractice. House Republicans have long advocated for the medical malpractice reform and decided to merge the issues into one bill as repealing the IPAB is estimated to increase federal spending by $3 billion over ten years. However, the Congressional Budget Office (CBO) concludes that reforming medical malpractice lawsuits reduce federal health care expenditures. Thus, the CBO cost-estimate of this combined bill saves the Federal Government $45.5 billion over ten years due to a reduction in estimated spending in the Medicaid, Medicare, and federal employee health insurance programs. The bill was largely symbolic as the Senate is not expected to take up this legislation. President Obama also issued a veto threat in the unlikely scenario of the Senate Democratic Leadership bringing the legislation to the floor and then the full Senate passing the bill.
Impact from Supreme Court Decision?		Will move forward

Payment Bundling	National Pilot Program on Payment Bundling. Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. Requires CMS to establish a shared savings program or "accountable care organizations" (ACOs) program by January 1, 2012.	Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending. After publication of the ACO proposed rule in April 2011 that met with widespread criticism by health care providers, CMS released a final rule in October 2011 which included major changes from the proposed rule in a an attempt to create additional incentives for participation, decrease the risks of participation, and address concerns expressed by physicians and hospitals. As of June 2012, there are an estimated 27 ACO models in place, and according to CMS, another 150 applications are under review. There are also 32 "pioneer" ACOs that were established apart separate from this program. Final rules were also released by the HHS Office of Inspector General (OIG) re waivers to the federal fraud and abuse laws for ACOs, the Federal Trade Commission (FTC) re treatment of ACOs under the antitrust laws, and the Internal Revenue Service (IRS) which clarifies some of its earlier guidance on participation by charitable organizations in ACOs.
Impact from Supreme Court Decision?		Will move forward
Medical Malpractice Reform	State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation. Authorizes states to conduct demonstration programs to evaluate alternatives to current medical tort litigation. Grants may be awarded for no more than 5 years. Alternatives to tort litigation should allow for resolution of disputes and promote a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved by organizations that engage in efforts to improve patient safety and the quality of health care. Authorized $50 million for the 5-year beginning with FY 2011.	Congress never appropriated the $50 million authorized by the ACA. Congress also rejected the $250 million President Obama requested for FY 2012 for the Department of Justice to explore alternatives to traditional medical malpractice suits. In March 2012, the House of Representatives passed legislation that abolished the Independent Payment Advisory Board (IPAB). House Republicans merged the repeal of IPAB with a bill restricting medical malpractice lawsuits. Democrats objected to the $250,000 cap on noneconomic damages as well as the infringement of states' rights as medical malpractice. House Republicans have long advocated for the medical malpractice reform and decided to merge the issues into one bill as repealing the IPAB is estimated to increase federal spending by $3 billion over ten years. However, the Congressional Budget Office (CBO) concludes that reforming medical malpractice lawsuits reduce federal health care expenditures. Thus, the CBO estimate of this combined bill saves the federal government $45.5 billion over ten years due to a reduction in estimated spending in the Medicaid, Medicare, and federal employee health insurance programs. The bill is largely symbolic as the Senate is not expected to take up this legislation. President Obama also issued a veto threat in the unlikely scenario of the Senate Democratic Leadership bringing the legislation to the floor and then the full Senate passing the bill.
Impact from Supreme Court Decision?		Will move forward

** Note: The Medicare and Medicaid Electronic Health Record Incentive Program or "meaningful use" program was not part of the ACA. Rather, the program was included in the 2009 American Recovery and Reinvestment Act or commonly known as the "stimulus law." This program also cuts Medicare Part B reimbursement beginning in 2015 for those providers failing to demonstrate being a "meaningful user" of HHS-certified health IT. Please click here to learn more: http://gi.org/national-affairs/legislative-affairs/acg-this-week-national-affairs-news/this-week-may-11-2012/

ADDITIONAL FACILITY-RELATED PROVISIONS:

ISSUE	ACA LANGUAGE	UPDATE
Ambulatory Surgical Centers (ASCs) & Value-Based Purchasing Plan	Plans for a Value-Based Purchasing Program. Requires the Secretary of HHS to develop a plan to reimburse ASCs based on the quality and efficiency of care delivered in ASCs.	In April 2011, CMS released its "ASC Value-Based Purchasing" Report to Congress, outlining the steps the Agency could take when implementing an ASC value-based purchasing program.
Impact from Supreme Court Decision?		Will move forward
Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals.	Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals. The ACA limited expansion of physician-owned hospitals beyond what the hospital was licensed for on March 23, 2010 (the day ACA was signed into law) and also required CMS to propose exceptions to this prohibition on hospital expansion.	CMS released regulations in 2011 on this exception process, outlining the requirements an "applicable hospital" or "high Medicaid facility" must meet to seek an exception. Beginning 2012, CMS proposed to allow community input on expansion requests and provides other clarifying guidance for hospitals seeking an exception under the "applicable hospital" or "high Medicaid facility" application process. There is also ongoing litigation over these limitation imposed on physician-owned hospitals, *Physician Hospitals of America v. Sebelius*.
Impact from Supreme Court Decision?		Will move forward

** The Medicare Improvements & Extensions Act-Tax Relief & Health Care Act of 2006 (MIEA-TRHCA) authorized the forthcoming ASC quality reporting program. The 2012 ASC and hospital outpatient facility final rule established a quality reporting program for ASCs beginning in October 2012 and adopts five quality measures that will used for the 2014 payment determination. Please click here to help prepare your ASC for October 2012: http://gi.org/practice-management/medicare/medicare-asc-quality-reporting-toolkit/

PATIENT PROVISIONS:

ISSUE	ACA LANGUAGE	UPDATE
Individual Mandate	Requires individuals to purchase health care insurance. Requires most Americans to either obtain health insurance by January 1, 2014, or face a monetary penalty on CY 2014 income tax returns.	Effective January 1, 2014.
Impact from Supreme Court Decision?		Upheld
Colorectal Cancer Screening & Medicare	Removal of Barriers to Preventive Services in Medicare. Waives cost sharing in all settings (co-payment and deductible) for certain preventive and screening services. Such services are those recommended (rated A or B) by the U.S. Preventive Services Task Force, for any indication or population. Removal of Barriers to Preventive Services in Medicare. Provides that the waiver of the deductible (cost sharing amount before insurance applies) for colorectal cancer screening shall apply regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	Effective January 1, 2011. ACA waived both the Medicare beneficiary deductible and the coinsurance for colon cancer screenings. However, if a physician detects a polyp and removes it during a screening colonoscopy, the procedure is coded as a diagnostic or therapeutic procedure. Medicare beneficiary cost-sharing still applies for any screening that turns into a therapeutic procedure. This means that a beneficiary may go into the procedure expecting to have neither a deductible nor coinsurance, but if a polyp is found, would have to pay the office co-pay and coinsurance (usually 20% Medicare coinsurance). Two bill currently introduced in Congress would eliminate this unintended consequence in Medicare: "The SCREEN Act" (HR 3198) introduced by Rep. Richard Neal and the "Removing Barriers to Colorectal Cancer Screening Act" (HR 4120) introduced by Rep. Charles Dent. The SCREEN Act also increases reimbursement to physicians demonstrating that they are participating in a nationally recognized quality improvement registry and provides Medicare coverage for a pre-screening office visit (currently Medicare only covers an office visit prior to diagnostic colonoscopy).
Impact from Supreme Court Decision?		Will move forward

Preventive Health Services & Private Insurance	Coverage for preventive care without cost sharing. Requires individuals and group health insurance plans to cover and not impose cost-sharing on preventive services recommended with A or B rating by the U.S. Preventive Services Task Force, including colorectal cancer screening.	Newly established plans: Implemented six months after the bill is signed into law. (plans established after March 2010) All other plans: Effective 2014 for all plans participating in the state-based health insurance exchanges. (the vast majority of private health plans) The SCREEN Act (HR 3198) also waives patient cost-sharing for colorectal cancer screenings turning into diagnostic or therapeutic procedures in Medicare *as well as* the private insurance market.
Impact from Supreme Court Decision?		Will move forward
Expansion of Medicaid	Require states to expand Medicaid program eligibility requirements. Requires that in order for states to continue receiving federal Medicaid funds, states would now need to allow uninsured low-income citizens (those with incomes up to 133 percent of the federal poverty level) to participate in Medicaid.	Effective January 1, 2014.
Impact from Supreme Court Decision?		Upheld in part.

Improved Access to Preventive Services in Medicaid	Access to Preventive Services for Eligible Adults in Medicaid. Expands the current Medicaid State option to provide other diagnostic, screening, preventive and rehabilitation services to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.	Effective January 1, 2013.
Impact from Supreme Court Decision?		Will move forward
Private Insurance Lifetime Limits	No lifetime Limits. Restricts and prohibits individual plans from establishing lifetime or annual coverage limits.	Effective 6 months after bill was signed into law.
Impact from Supreme Court Decision?		Will move forward
Private Insurance Annual Limits	Regulated, restricted annual limits on benefits.	Restricted annual limits effective 6 months after bill was signed into law; then bans annual limits beginning in 2014.
Impact from Supreme Court Decision?		Will move forward
Pre-Existing Conditions	Prohibition of Pre-Existing Conditions and Health Status Exclusions. Prohibits private insurers from imposing insurance exclusion based on a pre-existing condition or health status.	Effective 6 months after bill was signed into law for children. Effective 2014 for all persons.
Impact from Supreme Court Decision?		Will move forward