Clerk of the House of Representatives	Secretary of the Senate
Legislative Resource Center	Office of Public Records
B-106 Cannon Building	232 Hart Building
Washington, DC 20515	Washington, DC 20510

Secretary of the Senate
Received: Feb 04, 2008

LOBBYING REPORT

Lobbying Disclosure Act of 1995 (Section 5) - **All Filers Are Required To Complete This Page**

1. Registrant Name:

MARSHFIELD CLINIC

2. Address:
1000 NORTH OAK AVENUE, MARSHFIELD, WI 54449

3. Principal place of business (if different from line 2):

4. Contact Name: BRENT V. MILLER
Telephone: 2023275463
E-mail (optional): miller.brent@marshfieldclinic.org

Senate ID #: 57830-12
House ID #: 35355000

7. Client Name: ☒ Self

TYPE OF REPORT

8. Year 2007 Midyear (January 1 - June 30): ☐ **OR** Year End (July 1 - December 31): ☒

9. Check if this filing amends a previously filed version of this report: ☐

10. Check if this is a Termination Report: ☐ => Termination Date: 11. No Lobbying Activity: ☐

INCOME OR EXPENSES

Complete Either Line 12 **OR** Line 13

12. Lobbying Firms

INCOME relating to lobbying activities for this reporting period was:

Less than $10,000: ☐

$10,000 or more: ☐ => Income (nearest $20,000): _____

Provide a good faith estimate, rounded to the nearest $20,000, of all lobbying related income from the client (including all payments to the registrant by any other entity for lobbying activities on behalf of the client).

13. Organizations

EXPENSES relating to lobbying activities for this reporting period were:

Less than $10,000: ☐

$10,000 or more: ☒ => Expenses (nearest $20,000): 147,367.00

14. Reporting Method.
Check box to indicate expense accounting method. See instructions for description of options.

☒ **Method A.** Reporting amounts using LDA definitions only
☐ **Method B.** Reporting amounts under section 6033(b)(8) of the Internal Revenue Code
☐ **Method C.** Reporting amounts under section 162(e) of the Internal Revenue Code

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: BUD (one per page)

16. Specific lobbying issues:

the provision of Medicare and Medicaid services and benefits to patients, incentives to promote electronic health records for all Americans, comparative effectiveness research at the Agency for Health Research and Quality (AHRQ), and prescription drug benefits. Provisions in the President FY 2008 Budget and related appropriations legislation including public health programs in health and wellness and prevention; bioterrorism preparedness -- human, food, animal; human, animal and plant laboratory networks and response networks; Johnes research and eradication; Chronic Wasting Disease eradication and diagnosis; syndromic surveillance; National Institutes of Health research funding; research on childhood agricultural safety and health; waterborne disease research. Labor HHS Appropriations, HR 3043, Appropriations for Community Health Centers, Funds for the State High Risk Pool Grants, and Increased Funding for Tele-health Activities. Centers for Disease Control funding to prevent underage drinking. Funding for Dental programs in underserved areas. Provisions of the Presidents FY 2008 Budget and Budget Resolution (S Con Res 21) related Labor/HHS appropriations legislation (HR 3043) related to funding for the Centers for Medicare and Medicaid Services (CMS) for implementation of the Medicare program and Medicare Advantage Programs,

17. House(s) of Congress and Federal agencies contacted:
Centers For Medicare and Medicaid Services (CMS)
Congressional Budget Office (CBO)
Government Accountability Office (GAO)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
Health Resources & Services Administration (HRSA)
Medicare Payment Advisory Commission (MedPAC)
SENATE
White House Office

18. Name of each individual who acted as a lobbyist in this issue area:

Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: CPT (one per page)

16. Specific lobbying issues:

Among the major changes in the approved legislation would be moving the United States from a first to invent to a first inventor to file- a patent system that exists in other countries. Marshfield Clinic supports adopting a first inventor to file system, but not if the statutory framework creates an environment that is ripe for the misuse and misappropriation of inventions. Clinic support is contingent upon changes to the Patent Reform Act to include of two provisions: no narrowing of the current blanket grace period which encourages researchers to publish their discoveries and achievements; and an oath or sworn statement should be required for all applications. Violations of an oath or sworn statement could be subject to criminal penalties for false or fraudulent statements. The Patent Reform Act of 2007, (HR 1908) introduced by Rep. Howard Berman, (D-CA) contains a number of provisions designed to improve patent quality, deter abusive practices by patent holders, provide meaningful, low-cost alternatives to litigation for challenging patent validity and harmonize U.S. patent law with the patent law of most other countries.

17. House(s) of Congress and Federal agencies contacted:
HOUSE OF REPRESENTATIVES
SENATE

18. Name of each individual who acted as a lobbyist in this issue area:

Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: HCR (one per page)

16. Specific lobbying issues:

on the basis of genetic information or services to prohibit: (1) enrollment and premium discrimination based on information about a request for or receipt of genetic services; and (2) requiring genetic testing. The Genetic Information Nondiscrimination Act of 2007 (H.R. 493), introduced by Rep. Louise Slaughter (D-NY) amends the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to expand the prohibition against discrimination by group health plans and health insurance issuers in the group and individual markets

17. House(s) of Congress and Federal agencies contacted:
Agency for Health Care Policy & Research
Centers For Medicare and Medicaid Services (CMS)
Congressional Budget Office (CBO)
Government Accountability Office (GAO)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
Health Resources & Services Administration (HRSA)
Medicare Payment Advisory Commission (MedPAC)
SENATE
White House Office

18. Name of each individual who acted as a lobbyist in this issue area:

Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: MED (one per page)

16. Specific lobbying issues:

CMS views the competitive bidding design as a means to establish new lab fees based on costs. The current lab fee schedule is hopelessly outdated, and should be revised, but we urge caution regarding the structure and comprehensiveness of the demonstration. Competitive bidding will subordinate timeliness and specimen integrity in lab analysis to bulk quantity analysis at the expense of quality patient care. Lab fee schedule changes should be consistent with the emerging emphasis on quality and performance-based reimbursement. Oppose limits on the laboratory CPI update. Oppose limits on the laboratory CPI update. Lab Competitive Bidding -- The MMA 03 has required that HHS conduct a demonstration program on competitive bidding for clinical lab tests furnished without a face-to-face encounter between the Medicare beneficiary and the hospital personnel or physician performing the test.

17. House(s) of Congress and Federal agencies contacted:
Agency for Health Care Policy & Research
Centers For Medicare and Medicaid Services (CMS)
Congressional Budget Office (CBO)
Government Accountability Office (GAO)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
Health Resources & Services Administration (HRSA)
Medicare Payment Advisory Commission (MedPAC)
SENATE
White House Office

18. Name of each individual who acted as a lobbyist in this issue area:

Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: MMM (one per page)

16. Specific lobbying issues:

Subtitle D: Additional Demonstrations, Studies, and Other Provisions - (Sec. 649) Directs the Secretary to establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures Deficit Reduction Act (Section 5102) reduced reimbursements for multiple images on contiguous body parts in 2006; the DRA provision created in statute a basis for payment reductions on the imaging of contiguous body parts that CMS implemented through the rulemaking process in 2005; the DRA also requires that payment rates for imaging services delivered in physician offices do not exceed payment rates for identical imaging services delivered in hospital outpatient departments beginning in 2007. Clinic recommends that Congress repeal Section 5102, and direct MedPAC and CMS to conduct a comprehensive study of imaging and the geographic variation in services to determine where growth in the volume of imaging services is appropriate and develop workable solutions to control inappropriate imaging utilization. Medicare Provisions in the Tax Relief and Health Care Act of 2006 (HR 6111) Increases payments for physician services and implements a quality reporting system for physician services. Prevents physician payment cuts in 2007 by freezing payment rates for physician services. Provides a 1.5 percent bonus-incentive payment to physicians who report on quality measures in 2007. Establishes a $1.3 billion fund to promote physician payment stability and physician quality initiatives in 2008. Extends the Medicare Modernization Act (MMA) floor on the Medicare work geographic adjustment for physician services. Establishes a floor on the work component of the physician geographic adjustor in 2007 to raise payments in certain rural areas. CMS Physician Group Practice Demonstration On September 27, 2002 the Centers for Medicare and Medicaid Services published a notice in the Federal Register informing interested parties of an opportunity to submit proposals for participation in the Medicare Physician Group Practice Demonstration (PGP) project to test a hybrid payment methodology that combines Medicare fee-for-service payments with a bonus pool derived from savings achieved by improvements in patient care management. Marshfield Clinic submitted a proposal for this demonstration and was selected by CMS to participate in the demonstration program, effective April 1, 2005. Marshfield Clinic supported CMS determination to extend this program, beyond its initial 3-year term. Ambulatory Surgical Center Medicare Payment Modernization Act of 2007 H.R.1823 Ambulatory Surgical Center Medicare Payment Modernization Act of 2007 introduced by Rep. Wally Herger and Kendrick Meek - Amends title XVIII (Medicare) of the Social Security Act to revise the requirements and the formula for payments for services, including an implantable medical device, furnished to individuals in ambulatory surgical centers. Regulatory clarification of Medicare anti-markup issues, and postponement of the effective date of CMS final rule regarding the applicability of the anti markup provisions with respect to: (1) the technical component of a purchased diagnostic test and (2) any anatomic pathology diagnostic testing services furnished in space that is utilized by a physician group practice as a ''centralized building'' for purposes of complying with the physician self-referral rules and does not qualify as a ''same building''. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 - Public Law No: 108-173: Title II: Medicare Advantage -- (Sec. 211) Revises the payment system, requiring all plans to be paid at a rate at least as high as the rate for traditional Medicare fee-for-service plans. Makes change in budget neutrality for blended payments. Increases minimum percentage increase to national growth rate. Marshfield Clinic opposes reductions to Medicare Advantage payments in low payment states. Subtitle D: Additional Reforms - (Sec. 237) Provides that Federally Qualified Health Centers (FQHCs) will receive a wrap-around payment for the reasonable costs of care provided to Medicare managed care patients served at such centers. Raises reimbursements to FQHCs in order that when they are combined with MA payments and cost-sharing payments from beneficiaries they equal 100 percent of the reasonable costs of providing such services. Extends the safe harbor to include any remuneration between a FQHC (or entity controlled by an FQHC) and an MA organization. Title IV: Rural Provisions - Subtitle B: Provisions Relating to Part B Only - (Sec. 412) Directs the Secretary to increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00 for services furnished on or after January 1, 2004, and before January 1, 2007. Since this provision expires at the end of 2006 it must be extended or revised. See Tax Relief and Health Care Act provisions below (Sec. 413) Establishes a new five percent incentive payment program designed to reward both primary care and specialist care physicians for furnishing physicians' services on or after January 1, 2005, and before January 1, 2008 in physician scarcity areas. Directs the Secretary to pay the current law ten percent Health Professional Shortage Area (HPSA) incentive payment for services furnished in full county primary care geographic area HPSAs automatically rather than having the physician identify the health professional shortage area involved. Title VI: Provisions Relating to Part B - Subtitle A: Provisions Relating to Physicians' Services (Sec. 605) Requires the Secretary to review and consider alternative data sources than those currently used to establish the geographic index for the practice expense component under the Medicare physician fee schedule no later than January 1, 2005. Requires the Secretary to select two physician payment localities for such purposes, one to be a rural area and the other one will be a statewide locality that includes both urban and rural areas. Subtitle C: Other Provisions - (Sec. 626) Provides that in FY 2004, starting April 1, 2004, the ambulatory surgery center (ASC) update will be the Consumer Price Index for all urban consumers (U.S. city average) as estimated as of March 31, 2003, minus 3.0 percentage points. Provides that in FY 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the ASC update will be zero percent. Provides that subject to recommendations by the General Accounting Office, the Secretary will implement a revised payment system for payment of surgical services furnished in ASCs. Requires the new system to be implemented so that it is first effective on or after January 1, 2006, and not later than January 1, 2008. Requires the Comptroller General to conduct a study for a report to Congress that compares the relative costs of procedures furnished in ambulatory surgical centers to the relative costs of procedures furnished in hospital outpatient departments. (Sec. 628) Provides that there will be no updates to the clinical diagnostic laboratory test fee schedule for 2004 through 2008. Information Technology Under current law the capital and operating expenses of installing and maintaining an electronic medical record are assumed to be part of the overhead

expense of a medical practice. Since no more than 5 10% of the physician population has installed EMRs, CMS measurement of current physician practice expenses reflect minimal expense associated with IT. Congress should provide incentives for EMR adoption, and should establish standards to facilitate the sharing and exchange of data. S. 1693, the Wired for Health Care Quality Act introduced by Senator Ted Kennedy (D-MA) and Michael Enzi (R-WY) - Amends the Public Health Service Act to establish the Office of the National Coordinator of Health Information Technology to coordinate and oversee programs and activities to develop a nationwide interoperable health information technology infrastructure. Payment Fairness for Practice Costs The formulas by which Medicares payments are calculated are widely variable throughout Medicare localities, and are based upon outdated data assumptions regarding the cost and organization of medical practice. Alternatives: CMS should administratively revise its measurements of the costs of practice to assure the validity and fairness of payments; a payment floor could be established for practice expense; or the present variation (.705 1.501) in practice expense could be channeled into a narrower corridor of adjustment. Payment Equity Before MMA 03, Medicares payments were geographically adjusted based upon erroneous assumptions about the cost of hiring and retaining physicians. Congress established a floor payment mechanism for the physician work component of Medicare payment for 04 07 to assure that physicians in low payment localities were compensated for their work at least at the national average payment amount. This payment floor should be extended indefinitely or geographic adjustment of work should be eliminated entirely. The Rural Medicare Equity Act of 2007 (S 498), introduced by Senator Russ Feingold, Amends title XVIII (Medicare) of the Social Security Act (SSA) to eliminate the geographic physician work adjustment factor from the geographic indices used to adjust payments under the physician fee schedule. Rep. Braley introduced HR 2827, the Medicare Equity and Accessibility Act, along with Rep. Adrian Smith (R-Nebraska). This bill will increase the Medicare Part B reimbursement rates in Iowa and other rural states, by making permanent the 1.0 floor on the Geographic Practice Indexes for Work and Practice Expense. S 2499, the Medicare, Medicaid and SCHIP Extension act of 2007. Supported provisions that prevent the 10.1% cut in Medicare physician payment that was called for in the November 27, 2007 CMS final rule implementing the Medicare physician fee schedule. The bill replaces the 10.1% cut with a 0.5% increase but only through June 30, 2008. S 2499 also extended the 1.0 floor on the geographic adjustor for physician work initially included in the Medicare Modernization Act of 2003 -- also only through June 30. Sustainable Growth Rate Medicares SGR mechanism unfairly links physician payment updates to factors unrelated to patients needs and the cost of providing patient care. Reform proposals include reimbursement updated on a market basket basis, removal of prescription drugs from the calculation of Medicare Part B costs, and rebasing Part B to reflect current rather than cumulative costs. Pay-for Reporting and Performance Currently the prevailing methods of paying for health care in the US neither incent nor reward providing high quality care. The rising costs of care coupled with the increasing awareness of poor quality care have made clear the need for a transformation in the way health care is financed. In the fee-for-service system Medicare currently reimburses for units of service, in a manner that promotes service utilization without regard to quality. This has had the unanticipated, but now recognized effect of economically stimulating growth in the numbers of services provided by physicians. Medicare must implement quality based payments for physician services, and capture the data on performance measures utilizing available claims-based data recoverable through enhanced IT functions. In 2005, the Centers for Medicare and Medicaid Services (CMS) proposed the Physicians Voluntary Reporting Program (PVRP). In late 2006 CMS renamed PVRP the Physicians Quality Reporting Initiative. (PQRI) In the PQRI program CMS calls on physicians to report on evidence-based performance measures selected with input from the National Quality Forum, the Ambulatory Care Quality Alliance, and the National Committee for Quality Assurance, (NCQA). For reporting purposes physicians will utilize provisional G-Codes developed by CMS to indicate whether a patient received a service, did not receive the service, was not a eligible candidate to receive the service, or would not be considered a patient under the care of the physician at the time of the service. Marshfield Clinic has recommended that CMS allow medical groups to electronically report quality measures in an aggregated, periodic, statistically valid basis to PQRI; and re-focus the PQRI on high cost/high volume disease states. Marshfield Clinic supports a request for CMS authorization and funding for a multi-center demonstration project with access to vast data resources across multiple states. This proposed project will connect treatments with outcomes and develop quality metrics that reflect the realities of the care setting and the severity of the patients illness. Provisions of the Presidents FY2008 Budget and related appropriations legislation (S Con Res 21) related to implementation of the Medicare Advantage and Prescription Drug Programs, the provision of Medicare and Medicaid services and benefits to patients, incentives to promote electronic health records for all Americans, and prescription drug benefits.

17. House(s) of Congress and Federal agencies contacted:
Agency for Health Care Policy & Research
Centers For Medicare and Medicaid Services (CMS)
Congressional Budget Office (CBO)
Government Accountability Office (GAO)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
Health Resources & Services Administration (HRSA)
Medicare Payment Advisory Commission (MedPAC)
SENATE
White House Office

18. Name of each individual who acted as a lobbyist in this issue area:

Name: ELIAS, NATHAN
Covered Official Position (if applicable): N/A
Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: TAX (one per page)

16. Specific lobbying issues:

Congress is looking at several issues: how the standards for tax-exemption evolved; what criteria are used to assess if organizations meet the tax-exempt standard; whether tax-exempt organizations operate principally as businesses selling their services in a competitive market. According to the Joint Committee on Taxation, health-related organizations make up the largest percentage of Section 501(c)(3) non-profit organizations, accounting for almost 60 percent of total revenues of the 501(c)(3)s. Of the health-related organizations, hospitals constitute almost three-quarters of total revenues.

17. House(s) of Congress and Federal agencies contacted:
Agency for Health Care Policy & Research
Centers For Medicare and Medicaid Services (CMS)
Congressional Budget Office (CBO)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
Health Resources & Services Administration (HRSA)
Medicare Payment Advisory Commission (MedPAC)
SENATE
White House Office

18. Name of each individual who acted as a lobbyist in this issue area:

Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

Signature: ON FILE Date: Feb 04, 2008

Printed Name and Title: BRENT V. MILLER, DIRECTOR OF FEDERAL GOVERMENT REL -

Information Update Page:

Complete ONLY where registration information has changed.

LOBBYIST UPDATE

23. Name of each previously reported individual who is NO LONGER expected to act as a lobbyist for the client

ISSUE UPDATE

24. General lobbying issues previously reported that NO LONGER pertain

AFFILIATED ORGANIZATIONS

25. Add the following organization(s)

26. Name of each previously reported organization that is NO LONGER affiliated with the registrant or client

FOREIGN ENTITIES

27. Add the following foreign entities

28. Name of each previously reported foreign entity the NO LONGER owns, OR controls, OR is affiliated with the registrant, client or affiliated organization

Signature: ON FILE Date: Feb 04, 2008

Printed Name and Title: -