



# ADVOCACY UPDATE

July 28, 2010

## **HHS releases regulations on Medicare / Medicaid EHR incentive programs**

Last week, the Centers for Medicare and Medicaid Services (CMS) released the final regulation on the Medicare and Medicaid Electronic Health Record (EHR) incentive program often referred to as the "meaningful use" regulation. This final rule pertains to Stage 1, which covers the first two years of adoption and meaningful use of certified EHR technology. Stages 2 and 3 will be defined in future rulemaking.

The Office of the National Coordinator (ONC) published a separate final rule on required standards for certified EHRs. While the Administration did make some positive changes, the American Medical Association (AMA) believes that it will be challenging for many physicians to participate successfully in the program. This will be especially true for those physicians in solo or small group practices who have not previously used an EHR. The AMA will work to educate physicians about how they can participate in the program. For more information please visit our website at: <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/health-information-technology/hit-resources-activities.shtml>.

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## **FDA sends new plan for opioids to advisory committees**

Last year, in response to the Food and Drug Administration's (FDA) plan to require industry development of a risk evaluation and mitigation strategy (REMS) for long-acting and extended-release opioids, the AMA recommended that the FDA solicit input from the public and its advisory committees on the plan before moving forward. At a joint meeting of the Anesthetic and Life Support Drugs and the Drug Safety and Risk Management Advisory Committees on July 22-23, the FDA provided an opportunity for the public and advisory committee review that the AMA had sought. In a comment letter to the FDA available at [www.ama-assn.org/go/regrelief](http://www.ama-assn.org/go/regrelief) the AMA commended the agency for the new proposal's thoughtful and deliberative approach, which is more likely to avoid unintended consequences for patients with chronic pain or terminal illness than the FDA's initial plan. A major improvement is that, although companies are to provide additional training in pain management and substance use disorders, the new FDA proposal does not require physicians to complete training in order to continue prescribing long-acting and extended release Schedule II opioids. The AMA also supports the FDA proposal requiring sponsors to provide FDA-approved education sheets for prescribers to use in their interactions with patients to promote safe use of opioids, and we agree with the agency that no other mandatory elements are necessary.

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## **CMS addresses physician concerns about glaucoma eye drop refills**

Six years after the Medicare Part D drug benefit regulation was published, the AMA Part D Workgroup continues to work with senior officials at CMS to solve implementation issues that arise. Most recently, the AMA and the American Academy of Ophthalmology identified and then worked with Jeffrey Kelman, MD, Chief Medical Officer for the drug benefit, to fix an important problem with eye drop refills for glaucoma patients. Unlike tablets or capsules, eyedrop dosing is imprecise and patients may run out before the normal refill period due to inadvertent wastage that occurs when drops miss the eye or they use more than intended. Some Part D plans had early refill edits in place that were preventing glaucoma patients from obtaining covered refills in a timely manner. In a memo to all Part D plans, CMS has provided guidance consistent with recommendations provided by the AAO and its glaucoma specialists that refills are to be permitted at 70% of the predicted days of use. For example, if the prescribed medication is expected to last for 30 days, refills will be permitted at day 21. Plans are also directed to ensure that the refill allowances are the same regardless of purchase through retail or mail-order sources, and to permit physicians to authorize earlier refills than 70% days of use for particular beneficiaries who continue to have difficulty with inadvertent wastage. The CMS memo to plans is available at [www.ama-assn.org/go/regrelief](http://www.ama-assn.org/go/regrelief).

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## **AMA testifies before federal committee on need for National Health Plan Identifier**

The AMA testified recently before the National Committee on Vital and Health Statistics (NCVHS), an advisory body to the U.S. Department on Health and Human Services (HHS). While the National Health Plan ID was enacted as part of the Health Insurance Portability and Accountability Act (HIPAA), no rules were ever published creating a national system for these numbers. The Affordable Care Act (ACA) calls for HHS to draft an interim final rule and make effective a unique health plan identifier by no later than October 1, 2012. The AMA presented a vision for how this could be achieved by reducing ambiguities arising from: 1) the proliferation of administrative intermediaries; 2) multiple provider contracts; 3) numerous benefit plan designs; 4) ERISA preemption; and 5) the widespread lack of transparency. The AMA also presented feedback to the Committee on fixing problems associated with electronic health care transactions to make the process more efficient for physicians.

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## **CMS announces imaging demo**

To test the ability of decision support systems (DSS) to improve quality of care and reduce inappropriate use of advanced imaging services, Medicare officials are soliciting proposals from “convener” groups that would bring together networks of physicians to participate in a demonstration project. The two-year demonstration, which is to start on January 1, 2011, will focus on 11 MRI, CT and nuclear medicine procedures.

As mandated under the Medicare Improvement for Patients and Providers Act of 2008, demo participants will use decision support systems that are based on appropriateness guidelines developed by medical specialties and that do not will require prior authorization. CMS is looking for up to six convener groups representing a total of 2,500 to 3,500 physicians from 500 to 650 physician practices that vary in size, specialty mix, type (academic and private practice) and location.

Potential conveners could include, but are not limited to, medical specialties, independent practice associations, health plans, radiology benefits managers, IT vendors or combinations of these groups. Participating physicians will be paid for using the DSS when they order covered imaging procedures and will receive immediate feedback on relevant appropriateness guidelines as well as periodic data comparing them to their peers. The demo then will assess the effect of feedback on physicians' ordering behavior.

The procedures involved in the demonstration are: Spect MPI, MRI of the lumbar spine, knee and shoulder, and CT of the lumbar spine, brain, sinus, thorax, abdomen, and pelvis. Bids are due by September 21, 2010. Additional information, including how to apply, can be found at

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS122207>  
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### **AMA advocates out-of-network benefit transparency to NCOIL**

The AMA's state Advocacy Resource Center (ARC) attended the National Conference of Insurance Legislators (NCOIL) meeting in Boston July 8–10. On July 10, the Health, Long Term Care, and Health Retirement Committee discussed a proposal that would promote facility, health insurer, and physician and other health care provider disclosure of out-of-network costs. The AMA urged committee members to require health insurers to provide consumers with accurate and up-to-date benefit information. While NCOIL's initial goal for this model bill was to prohibit balance billing, the AMA successfully urged NCOIL to focus on transparency instead of banning balance billing. The committee will discuss the issue again at its November 2010 meeting. ARC staff also attended several other sessions at the NCOIL meeting that focused on state implementation of the ACA. States will play an integral role in ACA implementation, particularly with such issues as medical loss ratio requirements, rate review processes and health insurance exchanges. The AMA will work closely with the state medical associations, the national medical specialty societies and other Federation partners as ACA state implementation moves forward.

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### **AMA and state medical associations warn health insurers about profiling inaccuracies**

The RAND Corporation recently issued a series of studies looking at the state of the art of physician cost-of-care profiling and concluded that "current methods of physician cost profiling are not ready for prime time." Based on these studies, the AMA and 47 state medical associations sent e-mails and letters to the leading U.S. health insurers (copying health policy think tanks, Fortune 100 companies, health care business coalitions, and other people and organizations that are prominent in the health care community), asking them to work with us to reevaluate the use of any programs that involve profiling physicians based on their alleged cost of care. The letter noted that while the AMA supports efforts to improve health care quality and efficiency, it cannot support current physician profiling programs that use, or provide to the public, incorrect physician ratings and misleading information. These letters and the results of the RAND studies have been widely published by the trade press as well as major newspapers throughout the country.