Advocacy Update

December 14, 2011

Federal legislation and regulations

House passes bill with payroll tax cut and two-year SGR patch

On Dec. 13, the House passed H.R. 3630, the "Middle Class Tax Relief and Job Creation Act of 2011," by a vote of 234 to 193. The bill would extend the payroll tax cut, reform and extend unemployment insurance, and provide a two-year SGR patch with 1 percent payment updates. This temporary SGR proposal would increase both the size of future cuts and the cost of repealing the SGR. The legislation also includes a controversial provision to fast-track a permit decision on the Keystone XL oil sands pipeline.

The Senate majority leadership has already announced that the proposed legislation is unacceptable in that body. In the alternative, the Senate could propose a physician payment proposal ranging from full SGR repeal to a one-year or even shorter-term patch. The debate over issues unrelated to the SGR could even lead to a legislative stalemate, effectively postponing action on Medicare issues into early next year. A clearer picture may emerge over the next several days.

AMA position: The AMA continues to urge members of the House and Senate to engage in a meaningful, bipartisan effort to repeal the SGR formula and protect access to care for our nation's seniors and military families. We continue to question why Congress continues to spend more money to preserve a fatally flawed policy opposed by Democrats and Republicans.

House passes legislation to ban the manufacture and sale of bath salts

On Dec. 8, the House passed H.R. 1254, The Synthetic Drug Control Act of 2011, by a vote of 317-98. This legislation would place two chemical substances, Mephedrone and Methylenedioxypyrovalerone (MDPV), on Schedule I of the Controlled Substances Act, effectively banning the manufacture and sale of a new synthetic drug marketed as "bath salts." The AMA House of Delegates voted to support a national ban on bath salts at the 2011 Annual Meeting in June. Bath salts currently are sold legally in convenience stores and smoke shops. Although usually packaged with a label that indicates they are not for human consumption, thousands of individuals have called poison centers for help after snorting, smoking, or injecting these powders as recreational drugs. Previously, the Senate Judiciary Committee passed similar legislation, S. 409, the "Combating Dangerous Synthetic Stimulants Act of 2011" on July 28. It is unclear when the Senate will consider H.R. 1254.

AMA position: The AMA has sent letters to Congress regarding both bills strongly supporting the passage of legislation to ban bath salts.

Bill introduced to provide liability protection to disaster volunteers

On Dec. 7, Rep. Cliff Stearns (R-Fla.) introduced H.R. 3586, the "Good Samaritan Health Professional Act of 2011." The legislation would provide liability protections to health professionals, including physicians, who volunteer to help victims of federally declared disasters. In the aftermath of Hurricanes Katrina and Rita, physicians and health professionals were turned away due to confusion and uncertainty of Good Samaritan laws. The legislation would ensure that health professionals who volunteer during federally declared disasters will have liability protections and will not face similar uncertainties.

AMA position: The AMA supports this legislation and will continue to work with Rep. Stearns to move the bill forward.

AMA encourages pilot testing of HIPAA electronic health care transactions

As a result of numerous AMA requests to the National Committee on Vital and Health Statistics (NCVHS) and the Centers for Medicare & Medicaid Services (CMS) for pilot testing of Health Insurance Portability and Accountability Act (HIPAA) electronic health care transactions prior to their adoption, CMS now appears to be committed to such tests. It just released a Sources Sought Notice seeking help to develop a means to pilot test the next version(s) of the HIPAA electronic transactions. Pilot testing of electronic health care transactions will also: provide advance notice to vendors on potential upgrade solutions to best leverage the new standards; and inform physician practices on what to expect from their vendor(s) for compliance and enhanced automation of the practice.

It is very rare to have standards developed and thrust upon any industry without pilot testing, as has been the historical case for health care revenue cycle standards. The AMA welcomes CMS's support of future pilot testing. Physician practices and other health care providers are encouraged to review the notice and consider submitting their interest to participate in the pilot testing to CMS, via the following link. The Sources Sought Notice can be found on www.fbo.gov. The solicitation number is: HHS-CMS-DBSC-SS-11-126.

Improvements proposed to NQF endorsement process

In a direct response to a letter initiated by the AMA and signed by 38 specialties, the National Quality Forum (NQF) is considering a redesign of its measure endorsement process. First, the NQF proposes to provide measure stewards with a determination of whether a "measure concept" satisfies the "importance to measure" endorsement criterion **prior to** its full development and testing. In addition, the NQF is proposing that once a measure concept has been approved, it would provide measure stewards greater flexibility to bring fully developed and tested measures back to the NQF at any point in time to complete the endorsement process. If the NQF Board of Directors sees merit in these proposals, the NQF will develop a detailed plan with input from measure stewards and NQF members, conduct a small pilot to assess this approach, and present the plan to the NQF Board for approval at its May 2012 meeting. The NQF estimates that implementation of these proposals would likely take a year to plan, test and implement smoothly. The AMA supports consideration of these proposals and believes a redesign of the NQF endorsement process could help address the need for timeliness and effectiveness of the endorsement process and assist in better alignment of the measure development and endorsement pathways.

AMA comments on use of a multi-payor claims data base for CER

On Nov. 22, the AMA submitted a comment letter to the Department of Health and Human Services (HHS) responding to an information request about the proposed multi-payor claims database (MPCD)

for comparative effectiveness research (CER). The AMA continues to have unaddressed questions as they pertain to the necessity and utility of the MPCD to undertake CER. The letter urges HHS to place the development of the MPCD on hold until a transparent and public process is developed to engage health care stakeholders, particularly physicians and organized medicine, in the development and governance of the MPCD.

The AMA will remain engaged with HHS as it moves forward on this critical activity.

Medicare

UnitedHealthcare makes changes to its Medicare Advantage audit practices

As a result of advocacy from the AMA and Federation—including the Medical Association of Georgia, California Medical Association and Texas Medical Association—UnitedHealthcare announced that it is making several changes to the way in which it conducts its Medicare Advantage audit programs. United has ended its relationship with MedAssurrant, the company that previously conducted United's payment integrity audits. This termination follows months of complaints from the AMA and Federation about the often confusing and onerous way MedAssurrant operated.

Additionally, United confirmed that it is making significant changes to its Risk Adjustment Data Validation (RADV) audit request letters that include clarifying the reason for the audit; identifying the line of business being audited; and providing consistent information on follow-up medical record reviews, audit requests, and post audit claim payment determinations. Finally, based on AMA and Federation guidance, United has updated its payment integrity audit recovery practices, which cover claims that it feels have been improperly coded. Currently, United asks physicians to refund the full amount paid on the original claim and then resubmit the claim using the new coding. Beginning in the first quarter of 2012, physicians will be able to merely resubmit the claim using the recommended coding and refund only the difference between the amount United originally paid and the amount that should have been paid using the new coding. Physicians who believe that they coded correctly on the initial claim will continue to have the option of appealing the claim.

CMS publishes Medicare data release final rule

On Dec. 7, CMS published its final rule regarding the "Availability of Medicare Data for Performance Measurement." The Affordable Care Act (ACA) authorizes the release of standardized extracts of Medicare claims data under parts A, B and D to be made available to "qualified entities" for evaluating the performance of providers and suppliers. This data may be provided to qualified entities beginning Jan. 1, 2012. As the ACA was drafted, the AMA secured a number of safeguards in these provisions, including requirements that enable physicians to review, appeal and correct errors in the reports prior to publication.

On Aug. 8, the AMA coordinated a comment letter with 81 physician organizations to CMS responding to the proposed rule. The AMA supports the use of physician data when it improves the quality of patient care, promotes the efficient use of resources in care delivery, preserves access to care, and provides accurate physician performance assessments. In the final rule, however, CMS eased some of the proposed requirements a qualified entity must meet to receive Medicare data. This may benefit highly qualified research efforts, but also poses greater risk of public release of poorly analyzed data. These factors increase the risk of multiple entities obtaining Medicare data in a single geographic area, and each of these entities could use different methodologies in analyzing the data, thereby resulting in a proliferation of physician performance reports that are conflicting, inaccurate, and not meaningful for patients and physicians. We do not yet know how serious this problem will be, since it will depend on implementation

of the program. We are also concerned that CMS maintained in the final rule that qualified entities must publically release performance reports, regardless of whether unresolved physician appeals are outstanding. The AMA will aggressively urge the administration to monitor the program and make modifications if qualified entities release misleading or confusing performance reports.

View the comment letter on the proposed rule, or view the complete final rule.

Innovation Challenge letters due Dec. 19

The Center for Medicare & Medicaid Innovation (CMMI) recently announced a new initiative, the Health Care Innovation Challenge, described in the Dec. 2 edition of HSR Insight. Awards will range from $1 million to $30 million per project and CMMI plans to award $1 billion total. The deadline for non-binding letters of intent is Monday, Dec. 19, 2011, with applications due Jan. 27, 2012. Letters of intent are very brief, with a maximum of 750 characters (not 750 words) provided for a brief summary of the proposal. Innovation Challenge funding will be provided for a wide range of local proposals that implement new payment and delivery models to improve medical care outcomes for Medicare, Medicaid and Children's Health Insurance Program beneficiaries. Proposals should be designed to address the following three CMMI objectives:

- Engage a broad set of innovation partners at the local level to identify and test new delivery and payment models that produce better care, improved health and reduced costs. These results should be reached through improvement efforts and impact identified target populations.
- Identify new models of workforce development and deployment as well as training and education that support these models. For example, a physician practice may propose to hire a nurse care manager to assist in care coordination activities.
- Support innovators who can deploy care improvement models through new ventures or expansion of existing efforts to new populations of patients within six months of the award. When possible, these ventures should be undertaken in conjunction with other public and private sector partners.

CMS posts educational products for 2012 PQRS and eRx programs

CMS has posted educational products for the 2012 Medicare Physician Quality Reporting System (PQRS) and electronic prescribing (eRx) programs. To access the 2012 PQRS System educational products, along with measure specifications, visit the *Spotlight* page. Further information on the 2012 PQRS may also be found on AMA's website, located at www.ama-assn.org/go/PQRS.

To access the 2012 eRx educational products, visit the *Spotlight* section on the eRx webpage to view the listing of educational products. Further information on the 2012 eRx Incentive Program may also be found on AMA's website located under the *incentive programs* page found at www.ama-assn.org/go/hit.

Additional AMA activities

AMA hosts specialty meeting with CER Institute leaders

On Dec. 2, the AMA hosted a specialty society meeting with two practicing physician members of the Patient Centered Research Outcomes Institute (PCORI) Board of Trustees, Drs. Arnold Epstein and Robert Zwolak, and PCORI's Executive Director, Dr. Joe Selby. Participants discussed recent PCORI activities, proposed national priorities, and identified opportunities for physician engagement in the

PCORI enterprise from priority setting, research and dissemination. The specialty societies provided a wide-range of substantive comments and recommendations on topics such as clinical registries, specific clinical research topics, and dissemination strategies where PCORI works directly with specialty societies. The AMA will continue to work closely with PCORI to ensure implementation of physician engagement and a clear role for specialties in the PCORI enterprise.

AMA resources

AMA workers' compensation webinar demonstrates need for education

After watching the AMA's new webinar, "How to automate your workers' compensation claims," health care revenue cycle management company ZirMed and some of its physician practice clients recognized the need for ZirMed to create a follow-up presentation about this important topic. ZirMed's clients demonstrated significant interest in learning more about workers' compensation electronic billing (eBilling); in just two days, ZirMed had 456 physician practices register for their workers' compensation webinar. The AMA's workers' compensation toolkit will be referenced during this webinar from ZirMed. This underscores the need for more education about workers' compensation automation.

New AMA resource on open access scheduling

In a continuing effort to improve patient satisfaction, the AMA has created an educational resource for physician practices considering changes to their scheduling process. The resource provides information on open access scheduling and the benefits and challenges associated with adopting this type of scheduling system. For many practices, open access scheduling has helped improve their patients' satisfaction while also growing their bottom line. Visit the AMA website to access this new resource.

New instructive webinar about the definitions and use of Modifier 25 to help avoid denials

In response to discussions between the AMA, the Federation and UnitedHealthcare regarding the top reasons for claim denials, the AMA Practice Management Center has recorded an instructive webinar, "Definitions and use of Modifier 25," to help physicians correctly and confidently record the performance of procedures and services amended with Modifier 25. AMA experts outline the proper and improper uses of Modifier 25 in this webinar.

New policy research perspective on employment of non-physician staff by self-employed physicians

The AMA has produced a new Policy Research Perspective (PRP) that examines the employment of clinical and administrative staff by self-employed physicians. The PRP finds that 88 percent of physicians who own or co-own their medical practice employ administrative staff, and 71 percent employ non-physician clinical staff. In fact, 42 percent of self-employed physicians own practices where administrative staff outnumber physicians by a margin of more than two to one. The report also looks at employment among physicians in different sized practices and in different specialties. View the report.

Two new Policy Research Perspectives on professional liability insurance

The AMA has produced two new Policy Research Perspectives (PRPs) on professional liability insurance (PLI) for physicians. The first PRP examines Physician Insurers Association of America (PIAA) data on indemnity and expense payments associated with PLI claims that closed between 2001 and 2010.

Indemnity payments were relatively stable, but average expense payments increased by 43 percent in real terms since 2005. The manner in which claims are disposed has not changed much over time. Nearly two-thirds are dropped, dismissed or withdrawn and fewer than 10 percent of claims were decided by trial verdict. Of these, the vast majority (93 percent) were decided in favor of the defendant. Finally, the share of claims with policy limits in excess of $1 million grew from 28 percent to 41 percent of closed claims over the past 10 years. The PRP can be accessed online by AMA members.

The second PRP summarizes data on PLI premiums from the Annual Rate Survey Issues of the *Medical Liability Monitor* (MLM). An overview of the 2004–2011 MLM premium data suggests that the medical liability climate for physicians is more favorable today than it was in 2004. More than half of premiums reported to MLM in 2011 were the same as in 2010. Premium increases were reported much less frequently and were smaller in size than at the start of the period. Although the overall climate for PLI is better than in 2004, it is not clear how long that will continue. Premium decreases have been shrinking in magnitude and there was a slight uptick in premium increases in the last two years—the first since 2004. And PLI premiums remain high in many states. The PRP can be accessed online by AMA members.

Sign up for AMPAC 2012 political education programs

On Feb.17–19, 2012 AMPAC (the AMA's Political Action Committee) will host the annual Candidate Workshop in Pentagon City, Va. The workshop is designed for AMA members and their spouses who are considering a run for public office, and includes training on campaign strategy and media advertising, as well as hands-on sessions in public speaking and fundraising.

AMPAC will conduct its annual Campaign School April 18–22, 2012, also in Pentagon City, for AMA members who wish to become involved in the political process as advocates and volunteers for medicine-friendly candidates. The school is organized around a simulated congressional campaign, where participants are put on campaign "staff" teams and attend daily lectures on campaign strategy, media advertising and political fundraising. Each team participates in nightly exercises such as creating a campaign strategy, taping a radio commercial and writing a political fundraising letter.

For both programs, all costs for AMA members, except transportation to the Washington, D.C., metro–area, are borne by AMPAC. For more information on these programs or an application, please see AMPAC's online registration form or contact Jim Wilson, Political Education Programs Manager, at jim.wilson@ama-assn.org.