ADVOCACY UPDATE

June 30, 2011

Federation advocates for SGR reform in debt limit negotiations

The AMA and 112 state and medical specialty societies sent a **letter** on June 27th to the president, vice president and congressional leaders urging reform of Medicare's sustainable growth rate (SGR) formula as part of any deficit reduction plan. In the letter, the physician organizations told policymakers that the cost of physician payment reform has grown over the years as Congress enacted frequent short-term fixes. As recently as 2005, the ten-year cost of permanent reform would have been $48 billion, but today it is estimated to be nearly $300 billion. If action is not taken now, the cost will continue to escalate to $500 billion in only a few short years. Meanwhile, the SGR is set to cut Medicare physician payments by nearly 30 percent on Jan. 1, threatening access to care for Medicare patients.

The AMA and other physician organizations have called for a three-pronged approach to reforming the physician payment system that include: repealing the failed SGR formula; implementing a five-year period of stable Medicare physician payments; and developing new health care payment and delivery models that could form the basis for a new Medicare physician payment system.

Across-the-board spending cuts could harm vulnerable patient populations

The AMA joined consumer and health care provider groups in releasing a **study** last week that highlights the impact that across-the-board spending cuts in federal programs could have on some of the nation's most vulnerable people, including the elderly, children and low-income families. Other organizations involved in commissioning the study, which was conducted by The Lewin Group, include the American College of Cardiology, the American Hospital Association, AARP, and LeadingAge.

As Congress considers ways to cut the nation's spending, many proposals under review call for across-the-board spending cuts based on arbitrary caps or targets. The study focused on one such proposal, the Commitment to American Prosperity (CAP) Act. This bill would limit federal spending to about 20.8 percent of the nation's gross domestic product and automatically cut across all federal programs in any year in which spending is projected to exceed the cap.

The Lewin Group **analysis** found that the CAP Act would cut $4.2 trillion from federal spending between 2013 and 2021. This would greatly impact programs such as Social

Security, Medicare and Medicaid that serve a growing aging population and those who have been adversely impacted by the economic downturn. Specifically, cuts for major programs during this period would be $1.3 trillion in Social Security, $859 billion under Medicare and $575 billion in federal Medicaid payments to states.

AMA supports the Health Savings Account and Flexible Spending Account bills

On June 14, the AMA announced its support for the "Family and Retirement Health Investment Act of 2011," which was introduced by Senate Finance Committee Ranking Member Orrin Hatch (R-UT) as S. 1098, and by Rep. Erik Paulsen (R-MN) as H.R. 2010. The legislation would streamline and enhance current law governing health savings accounts (HSAs) and health flexible spending accounts (FSAs). Of note, the bill would repeal Section 9003 of the Patient Protection and Affordable Care Act (ACA), which prohibits the use of tax-free accounts such as HSAs and FSAs for over-the-counter medicines without a prescription. The bill would also make several important changes to simplify HSAs and FSAs and provide greater flexibility in using such accounts, including: allowing a husband and wife to make catch-up contributions to the same HSA; allowing individuals to roll over up to $500 of unspent funds from their FSAs; clarifying that the use of prescription drugs as preventive care will not be subject to an HSA-eligible plan deductible; reauthorizing the use of Medicaid health opportunity accounts; allowing for the purchase of low-premium health insurance and long-term care insurance with HSA dollars; and promoting wellness by expanding the definition of qualified medical expenses to encourage more exercise and improved nutrition. In the House, the bill has been referred to the Ways and Means Committee, the Energy and Commerce Committee, and the Judiciary Committee. In the Senate, it has been referred to the Finance Committee.

CMS publishes proposed rule on Medicare data release

The Centers for Medicare and Medicaid Services (CMS) published its proposed rule on June 8 regarding the "Availability of Medicare Data for Performance Measurement." The ACA authorizes the release of standardized extracts of claims data under Medicare parts A, B, and D to "qualified entities" for evaluating the performance of providers and suppliers. These data may be provided to qualified entities beginning Jan. 1, 2012. While the ACA was being drafted, the AMA secured several safeguards in these provisions, including requirements that enable physicians to review, appeal and correct errors in the reports prior to publication.

The proposed regulation defines a "qualified entity" as a public or private entity that is qualified to use claims data to evaluate the performance of service providers and suppliers on measures of quality, efficiency, effectiveness, and resource use. To evaluate an organization's qualifications, CMS will examine three areas: organizational and governance capabilities; ability to add claims data from other sources; and data privacy and security. The regulation also requires entities applying for data access to describe their risk adjustment and physician attribution methods, as well as data specifications. In addition, they must outline processes for physician to review, appeal, and correct errors.

AMA staff participated in a Sept. 20, 2010, CMS Listening Session that solicited input from relevant stakeholders on implementation of the Medicare data release program. The AMA also submitted a formal **statement** (**http://www.ama-assn.org/resources/doc/washington/medicare-data-performance-measurement-**

statement-27sept2010.pdf) to the agency. AMA is currently reviewing the proposed regulation and will work with the Federation to solicit input and develop comments, which are due to CMS by August 8.

HHS provides additional funds for its patient safety initiative

On June 22, the US Department of Health and Human Services (HHS) announced that up to $500 million in *Partnership for Patients* funding will be available to help hospitals and provider organizations reduce healthcare acquired conditions and hospital readmissions. This funding will be awarded by the **CMS Innovation Center**.

The *Partnership for Patients* is a public-private partnership focused on two goals over a three-year period: (1) reducing harm in hospital settings by 40 percent; and (2) reducing hospital readmissions by 20 percent. To achieve these goals, the *Partnership* is seeking to contract with large healthcare systems, associations, state organizations, or other interested parties to support hospitals in redesigning care processes to reduce harm.

In addition to providing funds to "Hospital Engagement Contractors," CMS will also work with other contractors to develop and share ideas and practices that improve patient safety. Solicitations for proposals are available on the Federal Business Opportunities website at **www.FBO.gov** (solicitation number **APP111513**).

When the ***Partnership for Patients*** was announced in April, the Administration committed up to $1 billion in funding to help achieve its two goals. The first $500 million was announced at the launch event, and is available through the **Community-based Care Transitions Program,** which focuses on funding efforts to promote safe transitions between settings of care. The AMA continues to develop tools and promote efforts to improve patient safety, and was an early supporter of the *Partnership for Patients*. To read more about our efforts, please visit **www.ama-assn.org/go/patientsafety**.

CMS announces use of predictive modeling technology to prevent Medicare fraud

HHS and the Department of Justice (DOJ) recently held a Regional Fraud Summit in Philadelphia, PA to obtain feedback from local physicians, health care providers, and law enforcement on efforts to combat fraud in Medicare and Medicaid. At the Summit, attended by HHS Secretary Kathleen Sebelius, Attorney General Eric Holder, CMS Administrator Don Berwick, MD, and over 300 stakeholders, the Administration emphasized its commitment to eliminating health care fraud and highlighted its collaboration with private insurers to detect fraud. At a provider breakout session, physicians voiced concerns about the number of audits they are subjected to and the complexity and burden of complying with multiple audits. CMS said it is conducting an "audit of audits" to examine and address this burden, including a review of the Recovery Audit Contractor (RAC) program. The agency also stated it is working on a plan to address physician identify theft. The AMA has been urging CMS to address both these issues.

Also at the Summit, CMS announced that beginning July 1, it will use new predictive modeling technology to help target and identify potentially fraudulent Medicare claims before they are paid. According to CMS, the new technology will allow Medicare parts A and B claims data to be analyzed in real time to spot suspect claims. Risk scoring

technology that applies predictive models will also be used, combined with other data, such as information on stolen provider or beneficiary identification. The AMA is working with CMS to ensure that: (1) physicians are educated about CMS's use of this new technology; (2) its application does not impact the timeliness of physician payments to physicians; and (3) physicians who have their claims flagged by this technology through honest mistakes are informed and have the ability to correct and/or appeal any determinations.

Liability reform continues to advance at the state level

This is turning out to be very productive year on the medical liability reform (MLR) front in several states. In Oklahoma, the state enacted a $350,000 cap in personal injury actions (**H.B. 2128**). Tennessee enacted a $750,000 cap on non-economic damages for all civil actions (**H.B. 2008**). Florida's governor also just signed a significant bill: H.B. 479 which will reform the state's expert witness requirements, make private and public payer determinations inadmissible and close a judicially-created loophole that exposes school team physicians to potential liability. These bills, along with the other positive MLR bills that have advanced around the country, represent the hard work of the state medical associations in collaboration with the AMA and the national medical specialty societies to improve the liability climates in these states.

The good news continued on liability reform in West Virginia, where the state's highest court affirmed West Virginia's cap on non-economic damages in **MacDonald v. City Hospital**. The AMA Litigation Center worked closely with the West Virginia State Medical Association to defend the state's cap, and this is a major victory for the Federation.

Visit the AMA Advocacy Resource Center's **legislative tracking website** to view all of the MLR legislation tracked by AMA staff in 2011.

New Truth in Advertising laws in Connecticut, Oregon and Tennessee

New Truth in Advertising (TIA) laws were recently enacted in Connecticut, Oregon and Tennessee—that makes four medical association TIA victories in 2011 after Utah's TIA bill enactment earlier this year. Based on AMA model TIA legislation, Tennessee's new law requires: (1) all appropriate licensed health care professionals to clearly communicate the type of license they hold by posting a sign at the entrance to their office that contains the name and recognized abbreviation indicating their professional degree; (2) health care professionals providing direct patient care services in unlicensed settings to either wear a photo identification that includes the licensee's photograph, name and type of license, or provide a document to a new patient with this same information (which cannot include professional abbreviations); and (3) practitioners who provide information online to disclose their full name and type of license on the website. Connecticut's new law, which was part of a two-year effort, requires all health care professionals who provide direct patient care to wear a photo identification badge that includes the name of the institution and professional and the type of license, certificate or employment title the professional has within the institution. Oregon's new law, for which AMA provided legislative analysis to the Oregon Medical Association, amends current law and requires all "doctoral" trained health care professionals to list the type of health care profession in which the doctoral degree was earned. This applies for all written and printed materials, including advertisements, billboards, signs or professional notices. Access the new laws:

Connecticut Substitute House Bill No. 5045, Oregon House Bill 2395, Tennessee Public Chapter No. 75 and **Utah Senate Bill 124**.

2011 AMA National Health Insurer Report Card finds increasing inaccuracy in claims payment

The AMA unveiled its fourth annual National Health Insurer Report Card during an educational session at the AMA's Annual Meeting on June 20. As the cornerstone of the AMA's "Heal the Claims Process"™ campaign, the report card encourages a more efficient claims payment system by providing an annual check-up for the nation's largest health insurers and benchmarking the systems they use to manage, process and pay claims. This year's findings show that commercial health insurers have an average claims-processing error rate of 19.3 percent, an increase of 2 percent compared to last year. The increase in overall inaccuracy represents an extra 3.6 million in erroneous claims payments, and added an estimated $1.5 billion in unnecessary administrative costs to the health system. A 20 percent error rate among health insurers represents an intolerable level of inefficiency that wastes an estimated $17 billion annually," said AMA Board Member Barbara L. McAneny, M.D. Visit **www.ama-assn.org/go/reportcard** to access the report card's findings, including denial and accuracy rates and claims processing timeliness. You can also watch an **archived webinar** that details the findings and learn more about the **"Heal the Claims Process"™ campaign**.

UnitedHealth Group becomes first insurer to join AMA's "Heal the Claims Process"™ campaign

The AMA's "Heal the Claims Process" campaign engages all participants in the claims process in an industry-wide effort to eliminate administrative waste. The campaign highlights the need for compliance with the 5010 version of the HIPAA electronic standard transactions and provides empowering resources to help physician practices realize savings of time and money with the electronic transactions. UnitedHealth Group has become the first health insurer to officially participate in this campaign. As one of the nation's largest health insurers, UnitedHealth Group's commitment to electronic efficiencies has the potential to make real strides in eliminating waste from the claims process. Visit **www.ama-assn.org/go/healthatclaim** to add your organization's name to the list of individuals and organizations that have pledged their support for the campaign.