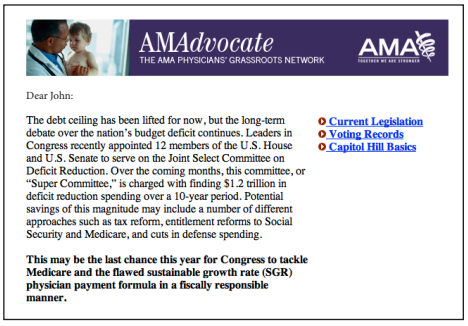
Advocacy Update

August 24, 2011

Call to action: Debt fight and the SGR

This week the AMA issued an alert to the Physicians' Grassroots Network regarding the opportunity to repeal the flawed sustainable growth rate (SGR) physician payment formula as part of the process that the recently formed Joint Select Committee on Deficit Reduction will be undertaking. The alert, which can be viewed in the AMA's online Legislative Action Center, drives activists to email their legislators and also encourages them to use the AMA's toll-free grassroots hotline to let their legislators know that eliminating the SGR now is the fiscally responsible way to fix this persistent problem and avoid increased costs in the future.

If no action is taken this year, the SGR will impose cuts of nearly 30 percent as of January 1, 2012. This would result in massive disruptions for patients needing access to care and more instability for physicians and their practices. With the deficit reduction committee providing one of the few opportunities for Congress to tackle SGR repeal before cuts automatically kick-in, the AMA will continue to engage grassroots activities in the coming months involving both physicians and patients in order to pressure their elected officials to act.


AMAdvocate
THE AMA PHYSICIANS' GRASSROOTS NETWORK

Dear John:

The debt ceiling has been lifted for now, but the long-term debate over the nation's budget deficit continues. Leaders in Congress recently appointed 12 members of the U.S. House and U.S. Senate to serve on the Joint Select Committee on Deficit Reduction. Over the coming months, this committee, or "Super Committee," is charged with finding $1.2 trillion in deficit reduction spending over a 10-year period. Potential savings of this magnitude may include a number of different approaches such as tax reform, entitlement reforms to Social Security and Medicare, and cuts in defense spending.

This may be the last chance this year for Congress to tackle Medicare and the flawed sustainable growth rate (SGR) physician payment formula in a fiscally responsible manner.

- Current Legislation
- Voting Records
- Capitol Hill Basics

Click here for a full-sized version.

AMA continues to press CMS on e-prescribing penalty

The AMA continues to hear concerns expressed by physicians, states and specialty societies that a significant number of physicians will be subjected to the e-prescribing penalty in January 2012. Consequently, the AMA's Executive Vice President, James Madara, MD, called Centers for Medicare & Medicaid Services (CMS) Administrator Donald Berwick, MD, to urge the agency to provide more flexibility so that a 1 percent penalty in 2012 does not affect as many physicians. During the call, Dr. Madara thanked Dr. Berwick for issuing a recent proposed rule creating additional penalty exemptions, but went on to alert the administrator to the concerns being expressed. He urged Dr. Berwick to consider additional steps, such as establishing a new reporting period in 2012 and refraining from applying the penalty until 2013. The AMA strongly believes that the agency plans to apply the penalty a year earlier than called for by Congress. Dr. Madara's call follows a July 25 sign-on comment letter to CMS, where the AMA was joined by 92 states and specialty societies in calling for greater program flexibility. The AMA will continue to follow-up with CMS to secure additional changes to the program.

AMA comments on CMS' new predictive modeling program for fraud efforts

On June 17, CMS announced a new, nationwide predictive modeling program to identify fraudulent claims on a prepayment basis. AMA staff met with CMS officials in July to learn more about the program, which is focused on identifying fraud using techniques similar to those used by credit card companies to identify unusual charges. The AMA sent a follow-up letter on August 8 to CMS expressing general support for the use of predictive modeling to identify fraud. However, the AMA requested that CMS ensure that the program is free of false positives or inaccurate results before denying payment based on

its findings. The AMA also strongly urged CMS not to rely on the program to identify improper payments unrelated to fraud, and cautioned CMS not to waive prompt payment in furtherance of the program. The AMA will remain vigilant as CMS implements the predictive modeling program to ensure that it is executed in as fair a manner as possible.

AMA supports two proposed coverage decisions

CMS sought comments on two separate proposed coverage decisions. In the first decision, CMS proposes to cover annual alcohol misuse screening, and for those patients who screen positive, Medicare would pay for up to four brief, face-to-face, behavioral counseling interventions annually. CMS proposes in the second decision to cover annual screening for depression for Medicare beneficiaries in primary care settings who have staff-assisted depression-care supports in place to assure accurate diagnosis. The AMA has urged CMS to provide Medicare coverage for these critical services and is pleased that CMS is taking these steps. The AMA sent a comment letter in support of the proposal on August 18.

AHRQ panel approves draft quality measures for Medicaid-eligible adults

On August 10, an advisory panel for the Agency for Healthcare Research and Quality (AHRQ) approved a draft set of 24 health quality measures for Medicaid-eligible adults. These measures focus on five general health quality areas: prevention and health promotion, management of acute conditions, management of chronic conditions, family experiences of care, and availability of services. The measures will ultimately be used by CMS to compare quality of care among state Medicaid programs. After CMS and other agencies within the Department of Health and Human Services review and approve the draft, a final core set of quality measures will be issued by January 1, 2012, as mandated by the Affordable Care Act (ACA).

State reporting of the quality measures to CMS will be voluntary. Under the timeline set forth in the ACA, CMS must develop a standardized reporting format for the core set of quality measures for Medicaid-eligible adults and "procedures to encourage voluntary reporting by the states" by January 1, 2013. Read additional information regarding the development of adult Medicaid quality measures by AHRQ.

Waiving cost-sharing for retroactive adjustments

Physicians are reminded that the HHS Inspector General has issued a statement that there is no need to bill Medigap and other secondary insurance plans for small copayment increases associated with the retroactive payment adjustments being made in 2011 to correct underpayments in 2010. Insurance plans have been receiving claims for as little as 27 cents. In these cases, medical practices are clearly spending more on billing and collection costs than they can recoup when the claims are paid. The notice is available on the Office of Inspector General website.