Advocacy Update
May 17, 2012

AMA Protects Physician Hospital Medical Staff

On Oct. 24, 2011, CMS published a proposed rule to revise the Medicare Conditions of Participation (CoPs) for hospitals that included a number of troubling provisions. AMA staff strongly advocated to CMS senior staff that the provisions therein would have the effect of severely diluting the authority of hospital medical staffs and could threaten hospital patient safety and health. On Dec. 22, 2011, the AMA and 81 state and national specialty societies submitted formal comments to CMS that voiced strong opposition to several of the proposals and recommended improvements to ensure the self-governance of the medical staff. On May 10, CMS published the final rule on CoPs.

As a direct result of AMA advocacy, the final rule makes the following improvements:

• The proposed concept of a single medical staff for a multi-hospital system has been removed.
• The proposed concept of the privileging of physicians without appointment to the medical staff has been removed.
• A hospital’s governing body must now include at least one medical staff member.
• The proposed concept of credentialing for medical staff membership in accordance with “hospital policies and procedures” has been removed; the final rule defers to state law and “medical staff bylaws, rules, and regulations.”
• The mandatory inclusion of non-physician practitioners on medical staffs strongly proposed by several other groups (e.g., American Nurses Association, AARP) was not adopted.

The final rule also retains several provisions from the proposed rule. A number of these, including the elimination of the current requirement that verbal orders be authenticated within 48 hours, were supported by the AMA. However, several AMA-opposed proposals were also finalized, namely, provisions that give multi-hospital systems the option to have a single governing body and permit (but not require) podiatrists to hold a leadership role on the medical staff. AMA staff has renewed our concerns regarding these provisions to CMS senior staff. AMA staff is still conducting an in-depth review of the rule and will continue to aggressively advocate on these issues.

AMA Supports Legislation to Address Drug Shortages

On May 10, the House Energy and Commerce Committee unanimously approved H.R. 5651, the “Food and Drug Administration Reform Act,” which would reauthorize expiring user fees that fund the Food and Drug Administration’s drug and medical device approval processes, also known as Prescription Drug User Fee Act (PDUFA), the Medical Device User Fee Act (MDUFA), respectively. The AMA supports provisions in the draft that would address the drug shortage crisis and incentivize the development of new antibiotics. The full House is expected to consider the legislation by the end of May. The Senate Health, Education, Labor and Pensions (HELP) Committee passed a similar piece of legislation on April 25. The full Senate is expected to begin considering the bill this week. The AMA remains engaged in negotiations regarding issues that directly impact the physician community as both bills move towards floor consideration.
Finance Committee Holds Roundtable On Medicare Physician Payment

On May 10, the Senate Finance Committee began its work on developing a new Medicare physician payment system by holding a roundtable entitled, “Medicare Physician Payments: Understanding the Past So We Can Envision the Future.” At this roundtable, the committee and panel examined the history of the sustainable growth rate (SGR) formula and its flaws. The panel was composed of four former CMS administrators: Gail Wilensky, Bruce Vladeck, Tom Scully and Mark McClellan, MD. During the panel, there was universal agreement that the SGR needs to be eliminated. Panelists and members of the committee discussed the merits of new models, including bundling and coordinated care models. At the conclusion of the roundtable, Finance Committee Chairman Max Baucus (D-MT) asked the panelists to provide the committee with short-term and long-term recommendations for addressing the SGR. Read the roundtable participants’ written statements.

This was the first in a series of Finance Committee roundtables on Medicare payment reform. Additional roundtables in the coming months will examine the perspectives of health plans and physicians.

House Passes Reconciliation Legislation

The House passed H.R. 5652, the “Sequester Replacement Reconciliation Act of 2012,” on May 10 by a vote of 218-199. This bill was a combination of the work of six House committees that were required by the FY 2013 Congressional Budget Resolution (H.Con.Res. 112) to produce legislation that would cut the federal deficit by a total of $261 billion over 10 years.

Of interest to physicians, the Judiciary Committee included in its portion of the bill the “Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act” (H.R. 5). The HEALTH Act, originally introduced by Rep. Phil Gingrey, MD (R-GA), contains a wide range of AMA-supported medical liability reforms, including a $250,000 cap on noneconomic damages. The Ways and Means Committee achieved its required $53 billion savings in part by enhancing provisions to recapture overpayments of health insurance subsidies, which were created under the Affordable Care Act (ACA), and by repealing block grants to states for social services. The Energy and Commerce Committee met its $96.8 billion target in part by including medical liability reform provisions (that differ slightly from the Judiciary Committee approved language). The Energy and Commerce Committee also achieved savings through several changes to the ACA including repealing the prevention and public health fund, defunding the “Consumer Operated and Oriented Plan” (CO-OP) program, repealing the Medicaid maintenance of effort requirement for states, and repealing the direct appropriation for state exchange grant authority.

It is unlikely that the reconciliation measure will advance beyond the House. The Senate is not expected to consider a reconciliation bill because it is not expected to approve a budget resolution.

AMA plus 100 State & Specialty Societies Comment on EHR MU Program

On May 7 the AMA together with 100 state and specialty societies submitted a comment letter to the CMS making several recommendations for how to improve the Electronic Health Record (EHR) Meaningful Use program in response to a proposed rule on Stage 2. Included among these recommendations the comments championed the need for a robust evaluation of Stage 1, avoiding high reporting measure thresholds, removing any measures that are outside a physician’s control, only requiring measures that are relevant to a physician’s practice, streamlining the number of requirements, including adequate exclusions, and reporting on six clinically relevant quality measures covering at least two domains. The comments also advocated for removing any “back-dating” of penalties and the overall need for greater synchronization among all Medicare reporting programs.
The AMA also submitted a comment letter the same day to the Office of the National Coordinator for Health IT (ONC) in response to a proposed rule on the standards vendors must meet for providing certified EHRs to physicians. The AMA continues to advocate strongly for a greater focus on EHR usability and patient safety issues.

**Medicare Physician Feedback Reports**

The nearly 24,000 individual physician feedback reports compiled by CMS for physicians in Iowa, Kansas, Missouri and Nebraska will remain available to physicians in the four states until June 6. The reports, officially called Quality and Resource Use Reports (QRURs) will be used in the development and application of the value-based modifier (VBM) required under the Affordable Care Act. CMS staff in charge of the project are actively seeking physician input on the utility and accuracy of the reports. In addition, the AMA, along with staff from several specialties and the medical societies in the four affected states, has formed a work group to provide CMS with recommendations on the reports and the future value-based modifier program. The work group is interested in hearing from physicians in the four states who have reviewed the reports and have comments on their design, methodology and contents. Practices in the four states should have received an e-mail notifying them of the availability of the reports in mid-March; reports can also be accessed by going directly to the website. Comments on the reports can be provided to Medicare officials in charge of designing the QRUR and VBM at CMS_Medicare_Photocare_Feedback_Program@mathematica-mpr.com and to members of the AMA-sponsored work group at sharon.mcilrath@ama-assn.org.

**CMS Proposes FY2013 Medicare Inpatient Payment System Proposed Rule**

On April 25, the Centers for Medicare & Medicaid Services (CMS) issued its proposed rule for rate updates and policy changes to the Medicare inpatient prospective payment system (IPPS) and long-term-care hospital prospective payment system (LTCH PPS) for federal fiscal year 2013.

For the past several years, CMS has proposed and adopted a number of Hospital Acquired Conditions (HACs) for which hospitals will not receive an increased payment unless they are properly coded as present on admission. For FY2013, the agency is proposing to add Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and iatrogenic Pneumothorax with Venous Catheterization as conditions subject to the HAC payment provision for FY 2013. CMS also proposes to add two codes, 999.32 (Bloodstream infection due to central catheter) and 999.33 (Local infection due to central venous catheter) to the existing Vascular Catheter-Associated Infection HAC Category. The AMA has been successful in urging CMS not to expand the HAC list for past program years, and will again advocate this year for not adding the aforementioned conditions to the non-payment list.

CMS also proposes to remove the reporting of HAC performance rates from Hospital Compare, along with the AHRO Patient Safety Indicators (PSIs). There were many problems with posting this information, due to data collection on all patients, and the AMA supports the removal of these performance rates from Hospital Compare.

The proposed rule also addresses policy changes regarding the establishment of hospital caps for both direct graduate medical education and IME payments, as well as the weighting of various performance elements for determining a hospital’s value based payment.

The proposed rule is available online and will be published in the May 11 Federal Register. Comments are due June 25 at 5 p.m.
HHS Releases First Annual Update to National Quality Strategy

On April 30, the Department of Health and Human Services (HHS) released the first annual update to its National Quality Strategy. The NQS is designed to be an evolving guide for the nation as the public and private sectors continue to move forward with efforts to measure and improve health and health care quality. The AMA submitted comments during the development of the HHS NQS. Accordingly, HHS will continue to work with stakeholders to create specific quantitative goals and measures for each of these priorities. The report details the implementation of strategies around the six priorities, and highlights key measures that were used to help promote progress around the goals. Read the full report.

Medicare Now Accepts Physician Enrollment Applications 60 Days in Advance

For years the AMA has been pushing CMS to expand the time frame physicians have to submit their enrollment application. Until recently physicians were only permitted to send their application to their Medicare contractor 30 days in advance of the “effective date” which is the later of: 1) the date a physician filed an application that is ultimately approved by Medicare; or 2) the date a physician began furnishing services at a new practice location. Under new guidelines CMS has extended this date to 60 days, with some exceptions. The change is effective May 14. Read a recent MLN Matters article outlining this change.

AMA, Federation staff tackle physician concerns with UnitedHealth Group

The AMA Practice Management Federation Staff Advisory Steering Committee (Committee) and Federation workgroups held their annual in-person meeting on May 3, 2012. The goal of this meeting is to: 1) discuss how to best address national payer trends; and 2) develop a plan of action to address practice management issues within the physician practice. The Committee and Federation workgroups also held their annual meeting with UnitedHealth Group (UHG) on May 4, 2012, to address current issues physician members have with UHG. Since these meetings began in 2007, 55 issues have been resolved and the groups have collaborated on 48 issues that have seen improvement. This year’s meetings were held at the AMA headquarters in Chicago and were attended by 25 Federation staff members representing 14 state medical associations, one county medical association and six national specialty societies, along with 18 representatives from UHG. Future efforts between the AMA, Committee, Federation workgroups and UHG will focus on developing action plans for collaborative ways to contain rising U.S. health care costs and to educate physicians on delivery system innovations.

New webinar on eliminating unfair discounts

Physicians are regularly solicited to participate in preferred provider networks (PPNs) via participating provider agreements. But how does a physician know if the agreement is beneficial for the practice? In today’s market of rental networks, it is imperative to understand which organizations physicians are contracting with and what the agreements should contain. View the webinar, “Eliminating unfair discounts” to learn how preferred provider networks work, what the difference is between a primary and secondary provider network and what should be contained in an agreement. This webinar also provides an update on the AMA’s related legislative activities.

Learn more with the AMA and the American Association of Preferred Provider Organization (AAPPO) toolkit, “Physician and other health care provider contracting toolkit.”
New Alabama law governs referrals for physical therapy services

The AMA collaborated with the Medical Association of the State of Alabama (MASA) to modify a bill that governs referral to physical therapists for physical therapy services. While the original version of the bill would have abolished the referral requirement for physical therapy and allowed physical therapists direct access to patients, the final bill signed by Alabama Governor Robert Bentley on April 30 provides a more nuanced approach to physical therapy services. The bill allows physical therapy to be practiced only upon the referral of a physician, a chiropractor, a physician assistant acting pursuant to a supervisory agreement, and a nurse practitioner in a collaborative practice agreement with a physician. In addition to collaborating with MASA, the AMA worked closely with several other national medical specialty associations, including the American Association of Orthopedic Surgeons and American Academy of Physical Medicine and Rehabilitation, to achieve this result. Learn more about the AMA’s scope of practice efforts.