Advocacy Update
Oct. 2, 2013

Federal government shut down
The Federal government’s non-essential services were shut down on Oct. 1 due to the inability of Congress to reach an agreement on funding for the new fiscal year. Negotiations will continue, with the chief sticking point being the House’s insistence that the implementation of the Affordable Care Act be delayed.

Most programs funded by mandatory spending will continue to operate, and those that involve the safety of human life and protection of property will largely be unaffected. In the short-term, the Medicare program will experience little disruption, and claims will be paid. States will continue to receive funding for Medicaid and the Children’s Health Insurance Program.

Among the activities that will not continue:

• FDA will be unable to support most of its food safety, nutrition, and cosmetics activities.
• With limited exceptions, NIH will not admit new patients or initiate new protocols, nor will it take any actions on grant applications or awards.
• The Centers for Disease Control and Prevention will be unable to support the annual seasonal influenza program.
• The Health Resources and Services Administration will be unable to make payments under the Children’s Hospital GME Program and Vaccine Injury Compensation Claims.

The AMA will continue to monitor the impact of the federal government shut down on health care programs and advise physicians of pending challenges as they arise.

Senate Republicans urge HHS to extend deadline for Meaningful Use Stage 2
On Sept. 24, Sen. John Thune (R-S.D.) and Sen. Lamar Alexander (R-Tenn.), along with 15 of their colleagues, sent a letter to Secretary of Health and Human Services (HHS) Kathleen Sebelius, urging her to grant a one-year extension to medical professionals working to meet Stage 2 requirements for the electronic health records (EHR) meaningful use program. The letter expresses concern that aggressive deadlines in Stage 2 may widen the digital divide for small and rural practices, and have other unintended consequences such as stifling innovation and increasing medical errors.

The AMA, along with the American Hospital Association (AHA), strongly supported this letter. The AMA supports successful implementation of EHRs, but is concerned about the overly aggressive deadlines and lack of flexibility in the meaningful use program. In July, the AMA and the AHA sent a similar joint letter urging Secretary Sebelius to make policy adjustments that would establish greater flexibility in meeting Stage 2 requirements.
Congress approves final version of compounding legislation

On Sept. 28, the House of Representatives passed by voice vote H.R. 3204, the “Drug Quality and Security Act.” This legislation establishes new FDA regulatory oversight for those who compound sterile drugs, while ensuring that traditional compounding practices continue. Additionally, it strengthens the prescription drug supply chain to protect Americans against counterfeit drugs. The legislation is a critical step to ensure compounding practices are safe and will prevent future public health crises, such as the meningitis outbreak of 2012.

The Senate is expected to take up the legislation soon.

The AMA worked with both the House and Senate to ensure physicians and patients can continue to receive safe compounded drugs, and that the new regulatory framework would not exacerbate drug shortages. Members of Congress have committed on the record that if H.R. 3204 results in unintended consequences that adversely impact medicine, Congress will act swiftly to rectify those issues.

MAC and RAC reviews on hold during transition to new observation care policy

In response to complaints and confusion expressed by hospitals, physicians and beneficiaries, the Centers for Medicare & Medicaid Services (CMS) announced this week that it will not delay the implementation of new criteria for distinguishing between observation care and short inpatient admissions. However, the agency has instructed Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) not to conduct patient status reviews of claims involving these claims for the next three months. The rule in question, which was included in the 2014 inpatient payment rule, stipulated that inpatient admissions would be presumed reasonable and necessary for Medicare beneficiaries who spend more than two midnights in a hospital, while shorter stays would be considered as outpatient/observation care unless physicians document that they expected beneficiaries to reach the two midnight benchmark. However, the agency also warned that its various contractors would be conducting reviews of any institutions suspected of gaming the new rules. The AMA and many other organizations had opposed adoption of the new rule on grounds that it would increase the physician documentation burden and did not offer adequate clarification and protection from retroactive payment denials and recoupments after a MAC or RAC audit. Many questions remain unanswered and the AMA will seek additional assurances that the policy does not increase administrative burdens or audit exposure for physicians.

Oct. 15: Last chance to avoid certain Medicare payment cuts

In the Affordable Care Act, Congress required CMS to apply a Value-Based Modifier (VBM) to all physicians’ Medicare payments by 2017 and to some physicians’ payment starting in 2015. In response, CMS intends to apply a 1 percent VBM penalty to the Medicare payments of physicians in groups of 100 or more that did not engage in GROUP participation in the Physician Quality Reporting System (PQRS) in 2013. This VBM penalty would be in addition to another 1.5 percent penalty that would apply to all physicians who did not participate in PQRS either as an individual or as part of a group. To avoid these penalties, physicians in groups of 100 or more should ensure that their GROUP is registered for one of the PQRS group participation options. Physicians who are not subject to VBM and are not yet participating in PQRS can still avoid the 2015 payment cut by registering for the CMS-calculated administrative claims reporting mechanism in 2013. The PQRS registration system, which will close on Oct. 15, can be accessed at https://portal.cms.gov. Use of the system requires an Individuals Authorized Access to the CMS
Computer Services (IACS) number, which can be acquired at https://applications.cms.hhs.gov. Additional information regarding registration and obtaining or modifying an IACS account is available at the Self Nomination/Registration web page.

**HIPAA privacy and security in a more digitalized world**

Physicians need to be aware of how best to protect their patient’s information in an increasingly digital environment. In addition to the AMA’s free HIPAA toolkit on privacy and security, which can be found on our website, the AMA wants to draw physician’s attention to tools created by HHS that may be helpful. They include 10 YouTube videos and information on how to protect mobile devices. Physicians should keep in mind that while encryption of electronic protected health information (ePHI) is not required, it is highly recommended and can shield a physician from significant penalties if there is a security breach of ePHI.

**2013 PQRS interim feedback data now available via CMS’ PQRS Dashboard**

CMS has released interim 2013 PQRS data via the CMS PQRS Dashboard. The Dashboard allows organizations and eligible professionals to log-in to a web-based tool and access their 2013 PQRS data on a quarterly basis in order to monitor the status of claims-based individual measures and measures group reporting. The Dashboard does not provide the final data analysis for full-year reporting, or indicate PQRS incentive eligibility. Data submitted for 2013 PQRS reporting via methods other than claims will be available for review in the fall of 2014 through the final PQRS feedback report. In order to access the Dashboard, individual physicians or group practices must have an IACS account. To assist with accessing the Dashboard and interpreting the interim data, CMS has developed a 2013 Interim Feedback Dashboard User Guide.

**AMA advocates on 2014 Medicare physician payment rule**

One month before the Nov. 1 legal deadline for the final 2014 Medicare physician payment rule, the AMA is continuing its aggressive advocacy to eliminate the Medicare proposal capping physician office payments at the hospital outpatient or ambulatory surgery center rates. AMA comments on the proposed rule urge other important revisions as well, including backing off changes to the PQRS. The proposal triples minimum reporting requirements from three measures to nine and bumps up the minimum number of measures reported in each group from four to six. The AMA also has serious concerns about the rush to implement the VBM. In 2013, application of the value modifier was limited to groups of 100 or more eligible professionals, but the 2014 proposal applies it to groups as small as 10 professionals while doubling the potential pay cut from one to 2 percent. A substantial number of physicians could then face a 2 percent PQRS penalty and an additional 2 percent penalty for the value modifier in 2016. On a more positive note, the AMA commends CMS for its decision to recognize complex chronic care management services beginning in 2015, building on the work of the CPT® Editorial Panel and Relative Value Scale Update Committee (RUC).

**AMA comments on proposed 2014 outpatient prospective payment system**

The AMA submitted comments to CMS on its proposed rule for the 2014 Hospital Outpatient Prospective Payment System (OPPS). We had a number of concerns with the proposed rule including:

- Transitioning the OPPS from a hybrid payment model, which includes a combination of individual payable services and packaged services, to a prospective model that more closely aligns with the original intent

- Replacing the Evaluation and Management coding structure for facilities, representing 5 families and 20 codes, with three Healthcare Common Procedure Coding System (HCPCS) G-codes and to align the Extended Assessment and Management Composite APC with the new G-codes
- Changing the nature and structure of Quality Improvement Organizations (QIO)
- Proposals to continue a number of Ambulatory Surgical Center (ASC) payment policies that will further widen the gap between hospital outpatient department and ASC payment rates.

Click here to view the AMA comments in their entirety.

View live Thursday: Health policy experts discuss reining in health care costs

Key thought leaders and decision-makers will be looking at the complex political, medical and business ramifications of implementing the Affordable Care Act during a National Journal forum Thursday. During a panel underwritten by the AMA, to take place from 1:25 to 2:30 p.m. Eastern time, participants will discuss the law’s far-reaching efforts to contain health care costs and improve quality. Reforms include changes to the way health care is paid and delivered and provisions for rewarding care quality rather than quantity. View a live webcast on the AMA website.

Meanwhile, Medicare’s failed payment formula prevents that part of the health care system from becoming an effective, 21st-century model of care. The AMA’s “Fix Medicare Now” campaign gives physicians and patients their own forum to tell lawmakers that now is the time to establish a new system that fosters high-quality care.

Encourage your members to watch the National Journal webcast starting at 1:25 p.m. Eastern time Thursday and send an email to their members of Congress through the AMA’s Fix Medicare Now campaign website.