SPECIAL REPORT:

Committees approve SGR repeal legislation; Short-term bridge to stop pending SGR cut advances in Congress

On Dec. 12, the House Committee on Ways and Means and the Senate Committee on Finance approved their bipartisan, bicameral proposal to repeal Medicare’s sustainable growth rate (SGR) formula and reform the physician payment system. The Ways and Means Committee approved the legislation by a vote of 39-0 and the Finance Committee approved it by voice vote.

The Ways and Means bill was revised to include three years of 0.5 percent updates from 2014–2017. The Finance bill does not include automatic annual positive payment updates. Other changes to both bills were adopted prior to the markups that are consistent with recommendations made by the AMA and others. These include reducing the maximum potential cuts to physicians under the proposed Value-Based Performance Program (VBP) in the early years, so they are less severe than penalties that may be imposed under in current law. The VBP program also includes potential bonus incentive payments. The committees reduced the targets for identifying and reducing payments for misvalued services, and they eliminated the 10 percent penalty for not providing requested valuation information. Separately, on Dec. 6, the Congressional Budget Office revised its 10-year score for repealing the SGR, reducing it from $139.1 billion to $116.5 billion.

The AMA sent letters to the Finance Committee and the Ways and Means Committee urging members to vote “yes” on these proposals during the committee markups. The AMA will continue to urge the committees to provide positive updates and make other improvements to the SGR repeal proposals as they move forward in the legislative process.

Separately, Congress reached an agreement on the budget this week which was encapsulated in the “Bipartisan Budget Act of 2013.” This bill, which establishes aggregate spending levels for fiscal years 2014 and 2015, also contains provisions to replace the 24 percent Medicare physician payment cut that is scheduled to take effect on Jan. 1 with a 0.5 percent update for three months. This payment bridge is intended to allow the Congress time to complete its work early in 2014 on legislation to repeal the SGR. The House passed the budget agreement on Dec. 12 by a vote of 332-94, and the Senate is expected to consider this legislation during the week of Dec. 16.

CMS extends Stage 2 Meaningful Use an additional year

Due to AMA advocacy, the Centers for Medicare and Medicaid Services (CMS) announced that it is extending Stage 2 of the Meaningful Use (MU) program—which starts Jan. 1, 2014. Originally, CMS planned for Stage 2 to end after 2015, but now it will last an additional year, through the end of 2016. The Stage 2 extension follows the AMA’s recommendation that physicians need adequate time to participate in Stage 2 before being thrust into Stage 3.

The AMA recognizes that extending Stage 2 is helpful, but addresses only one chief physician concern with the MU program. We are fully committed to obtaining more flexibility for physicians to meet all stages of MU, so that they will not miss out on the program’s incentives and face financial penalties.
The AMA has met repeatedly with high administration officials seeking these changes. We also continue to push for changes to make certified electronic health records work better for physicians, given evidence that these systems currently interfere with workflow and productivity.

**Last chance to avoid 2015 PQRS payment penalty!**

Eligible professionals (EP) who do not participate in Medicare’s 2013 Physician Quality Reporting System (PQRS) program will receive a 1.5 percent penalty on Medicare charges in 2015. To avoid the penalty, EPs in 2013 must report:

- One valid measure via claims, participating register, or through a qualified Electronic Health Record (EHR), OR
- One valid measure in a measures group via claims or participating registry.

EPs who successfully participate in PQRS in 2013 will automatically avoid the 2015 PQRS payment adjustment.

**CMS to conduct an Open Door Forum conference call on Medicare’s 2014 physician quality reporting programs**

On Dec. 17, from 1:30–3 p.m. ET, CMS will hold a conference call to review program updates for the PQRS and the following:

- How an EP or group practice can meet the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment;
- Criteria for satisfactory participation under the new qualified clinical data registry option; and
- Program updates for EHR Incentive Program and Physician Compare.

To register, go to: [http://www.eventsvc.com/blhtecnologies](http://www.eventsvc.com/blhtecnologies)

**CMS releases quality strategy**

CMS recently released its [Quality Strategy](#) and is accepting comments until Jan. 10, 2014. The CMS Quality Strategy is built on the foundation of the CMS Strategy and the HHS National Quality Strategy (NQS). The document identifies quality-focused objectives that CMS can drive or enable to further these goals. Quality interventions are inherently interrelated, thus many goals include concepts that could be articulated under more than one goal. In addressing comments, CMS is particularly interested in the following questions:

- What are the top three quality topics that you think CMS should focus on?
- Do you see your organization reflected in this strategy? If so, how will your organization help execute the CMS quality strategy?
- Please select the goal most applicable to your organization and provide your thoughts on how your organization can contribute to CMS’ effort to achieve this goal.

Please send your feedback and responses to [Quality_Strategy@cms.hhs.gov](mailto:Quality_Strategy@cms.hhs.gov).
New AMA model bills available on state implementation of the ACA

There are several issues that physicians and patients may face as the health insurance exchanges, created under the Affordable Care Act (ACA), are implemented in their state. AMA Board of Trustees Chair-Elect, Barbara L. McAneny, MD, recently provided testimony about the new exchanges to members of the National Conference of Insurance Legislators at the group’s winter meeting, calling on state lawmakers to implement solutions to improve access to health care in their states. In addition the AMA has created six new model bills to help states address some of these key issues, including narrow and tiered networks, the ACA 90-day “grace period,” and transparency in contracting practices. A full toolkit on these issues will be available in January, but if you would like copies of these model bills in advance, email Emily.Carroll@ama-assn.org or Daniel.Blaney-Koen@ama-assn.org. Learn more about implementation of state-based exchanges and take advantage of the opportunity to discuss with colleagues at the State Legislative Strategy Conference Jan. 9–11, 2014, in Tucson, AZ.

AMA urges comprehensive approach as prescription drug abuse soars

Prescription drug abuse and diversion have become an epidemic in the United States, highlighted in recent reports from the Trust for America’s Health and the National Safety Council. The AMA has been advocating for a comprehensive approach to address the issue, while also preserving the ability of physicians to provide pain management for patients in need. Steven J. Stack, MD, immediate past chairman of the AMA Board of Trustees, provided testimony to a House subcommittee in November as it considered the “National All Schedules Prescription Electronic Reporting Reauthorization Act of 2013” (NASPER). Since it was enacted in 2005, NASPER has been an essential tool in combating prescription drug abuse and diversion. Also in November the AMA presented a statement on “proposed best practices to address opioid abuse, misuse and diversion” to the National Conference of Insurance Legislators (NCOIL). Incorporating many of the AMA’s recommendations, NCOIL adopted a set of best practices to curb opioid abuse, which “honed on prescription drug monitoring programs (PDMPs), physician prescribing practices, education and outreach, and treatment and prevention.” State legislators from many states voted to adopt these best practices and will be able to use these best practices as a framework for creating and enriching their own requirements. Visit www.ama-assn.org/go/stopdrugabuse for additional information on the AMA’s ongoing commitment and advocacy efforts on this issue.

Colorado Clean Claims Task Force releases last set of payment rules for public comment: Comment period ends Jan. 6, 2014

The Colorado Clean Claims Task Force (CCCTF), co-chaired by Colorado Medical Society staff, focuses on the development of a standardized set of claim edits and payment rules, in order to develop a uniform set of processes to be used by all payers contracting with providers in Colorado. TheAMA is also participating in the Task Force.

The final set of payment rules has been released for public comment, available to all interested parties, including the Federation. A letter was sent to all Colorado specialty societies alerting them of this release. Based on Current Procedural Terminology (CPT®), national medical specialty guidelines and the Centers for Medicare and Medicaid Services (CMS), these payment rules are: Bundled, Procedure to Modifier Validation, Rebundled, Multiple E/Ms on the Same Day and the Effect of CPT & HCPCS Modifiers on Edits. The rules and comment form are posted at hb101332taskforce.org on the CCCTF website. The deadline for offering comments on these rules is Jan. 6, 2014. The AMA will continue to keep you informed of the activities of the CCCTF. Visit the CCCTF’s website for more information.
New AMA Policy Research Perspectives on professional liability insurance

The AMA has produced two new Policy Research Perspectives (PRP) on the market for medical Professional Liability Insurance (PLI). The first PRP presents information on PLI premiums from the Annual Rate Survey Issues of the Medical Liability Monitor (MLM), including the latest from October 2013. An overview of the 2004-2013 MLM premium data suggests that the medical liability climate for physicians is more favorable than it was in 2004. First, almost 58 percent of the premiums reported to the MLM in 2013 were the same as in the previous year. In contrast, over 80 percent of premiums rose in 2004. Second, recent increases in premiums have occurred less often and are smaller in size than increases at the beginning of the study period. While the overall liability picture in 2013 is more positive for physicians than it was in 2004, the prospects for the near future are uncertain.

Using data from PIAA's 2013 Closed Claims Comparative, the second PRP provides an overview on indemnity payments and expenses associated with PLI claims that closed between 2003 and 2012. It also describes the disposition of claims and how policy limits have changed over time. Between 2003 and 2012, average indemnity payments were relatively stable, particularly since 2006. As in previous years, most claims that closed in 2012 were dropped, dismissed or withdrawn (65 percent). Just over 22 percent of claims were settled, and 8.1 percent were decided by trial verdict. Of these, the vast majority (89.9 percent) were won by the defendant. Expenses have been relatively stable since 2009, but this was preceded by a period of sharp growth between 2005 and 2009, when average expenses increased by 62.8 percent. Over the 2003-2012 period, expenses increased by 81 percent. Growth in expenses has outpaced increases in indemnity payments. In fact, between 1985 and 2011, total expenses rose by 2½ times as much as total indemnity payments. Consequently, the share of total costs incurred on expenses increased from 19 percent to 37 percent over that period.

Both PRPs are available to AMA members.