



Advocacy Update

November 2, 2011

Medicare payment

SGR Repeal strongly supported at bipartisan Congressional briefing

On Oct. 27, Representatives Allyson Schwartz (D-PA) and Phil Roe, MD (R-TN), held a briefing on the future of the Medicare physician payment system. The panel included three prominent health care experts: Mark McClellan, MD (Brookings Institution), Joseph Antos (American Enterprise Institute) and Stuart Guterman (Commonwealth Fund). They spoke in support of eliminating the Sustainable Growth Rate (SGR) formula and bringing more certainty, long-term stability and fiscal transparency to the Medicare payment system, both for physicians and seniors. Reps. Schwartz and Roe repeatedly called for the Joint Select Committee on Deficit Reduction to include a repeal of the SGR in its final legislative agreement.

Progress made to eliminate 3 percent Medicare payment withhold

Legislation (H.R. 674) to repeal the scheduled withholding of 3 percent of federal contractor payments, including Medicare payments to physicians, passed the House of Representatives on Oct. 27 by a vote of 405-16. The statute, originally passed in 2006 and since delayed, called for 3 percent of all federal, state and local government payments to those providing goods or services to be withheld until the following tax year in an effort to increase tax compliance. However, the original statute was overly broad and would have applied even to Medicare payments to physicians. Recently, the Internal Revenue Service released regulations that limited the burden on physicians by not applying the policy to current contracts, including Medicare provider agreements, or to payments of less than \$10,000. However, those changes still left physicians exposed if they were new Medicare providers or if they modified their participation status. Additionally, because many carriers aggregate payments, the \$10,000 threshold would have been exceeded in some cases. The bill moves on to the Senate where a similar proposal recently fell three votes short of the 60 needed for passage.

AMA Position: The AMA has been advocating strongly for eliminating the 3 percent withholding requirements and will continue to work with its partners in the Government Withholding Relief Coalition to urge Senate adoption of repeal legislation.

Know Your Options: Medicare Participation Guide updated for 2012

Facing a nearly 30 percent Medicare pay cut on Jan. 1, 2012, physicians may want to review their options for participation, nonparticipation or opting out of the Medicare program. The AMA's popular resource kit for physicians on the three available options has been updated and is available free of charge at www.ama-assn.org/go/medicareoptions. The kit includes a descriptive guide to the options, a calculator to help determine the impact of changing from participation to nonparticipation status, a sample affidavit and private contract,



sample letters to communicate status changes to patients and, new this year, a frequently asked questions resource. The Medicare options web page also contains an archived webinar in which former AMA President Cecil Wilson, MD, explained the participation options for 2011.

Delivery system reform and innovation

Register now for AMA webinar on final ACO rule

On Oct. 20, the Centers for Medicare & Medicaid Services (CMS) released its highly anticipated final blueprint for the Medicare accountable care organization (ACO) program. The AMA commented extensively on the proposed rule and CMS adopted many of its suggestions for encouraging physician-led ACOs in the final rule, including the establishment of a new \$170 million program to provide advance payments to physicians interested in forming a Medicare ACO. On Nov. 21 at 7:00 p.m. Eastern/4:00 p.m. Pacific Time, join AMA President-elect Jeremy Lazarus, MD, and national expert Harold Miller for a 60-minute webinar that will outline major provisions of the final rule, provide application information and timelines for the advanced payment and ACO programs, and answer physicians' questions about ACOs and other payment innovations. [Click here](#) to register for this program, which is free for AMA member and nonmember physicians and their staff.

ACO/Medicare shared savings program final rules are issued

In response to significant and sustained AMA advocacy, CMS released final rules for the Medicare ACO/ Shared Savings Program that are vastly improved over the proposed rule and are designed explicitly to ensure that physicians can lead in ACO formation and implementation. Key AMA wins include, but are not limited to:

- Adding an “upside only” option during the three-year contract period in which the ACO will not be liable to pay CMS if costs exceed projections
- Eliminating a proposed requirement to withhold shared savings payments to cover potential future cost increases
- Allowing ACOs to share in savings beginning with the first dollar of savings earned
- Enabling ACOs to keep more of the savings they generate
- Reducing the number of required quality measures by half, to 33 from the proposed 65
- Modifying the ACO patient assignment so that it is not completely retrospective--ACOs will receive a prospective list of “probable beneficiaries” that will be updated quarterly
- Including primary care services provided by specialist physicians in assigning patients to ACOs
- Eliminating the requirement that at least 50 percent of an ACO's primary care physicians must be “meaningful users” of EHRs by year two of the program
- Implementing a rolling application process, so prospective ACOs will have time to prepare without having to meet arbitrary deadlines that are too short

Advanced payment model created for physician-led ACOs

AMA advocacy secured a new \$170 million program to provide physicians with the upfront capital needed to invest in the infrastructure required to form an ACO. The program is targeted specifically at physician-led ACOs that do not include a hospital. The Center for Medicare and Medicaid Innovation's (CMMI's) new Advance Payment ACO Model will provide advance payments to address both the fixed and variable costs associated with forming an ACO. Qualifying entities are: 1) physician ACOs that do not include any inpatient facilities and that have less than \$50 million in total annual revenue, and 2) ACOs in rural areas that have less than \$80 million in total revenue. CMS will recoup the advance payments through the ACO's earned shared savings in year two.

Antitrust rules issued for Medicare ACOs

AMA advocacy led to the Federal Trade Commission (FTC) and Department of Justice (DOJ) issuing a Joint Statement on Antitrust Enforcement and ACOs that incorporates many AMA recommendations, including Rule of Reason analysis for those that want to jointly contract with private payers and a safety zone for ACOs that fall under a 30 percent market share threshold. The Final FTC-DOJ Statement also included two important changes that the AMA had urged: 1) eliminating mandatory antitrust review of ACOs above a 50 percent market share calculation, significantly reducing the burden and cost on potential ACOs; and 2) applying the statement to **all** ACO collaborations among otherwise independent providers. The draft statement applied only to new entities formed after March 23, 2010, which would have placed earlier collaborations under a separate antitrust review system

CMS solicits input on 2013 PQRS measure recommendations

On Oct. 7, the AMA-convened Physician Consortium for Performance Improvement (PCPI) submitted quality measure recommendations to CMS for the 2013 Medicare Physician Quality Reporting System (PQRS). The input was in response to the agency's call for individual measures and measures groups recommendations for its PQRS program. The AMA urged CMS to continue its efforts to include additional individual measures and measures groups, which will allow the agency to provide a more comprehensive measurement of quality of care across all patients and physician specialties. The letter also expressed support for a continuing focus to move toward measures reported via electronic health record (EHR) systems. To read more about CMS' processes for collecting quality measure suggestions for use in the PQRS, please visit the [CMS Measures Management System \(MMS\) Website](#).

Regulatory relief

AMA secures two-year delay of revalidation effort

CMS informed the AMA that the provider revalidation effort will be pushed back through 2015, and physicians will be among the last to be required to revalidate. Previously, CMS required that all physicians be revalidated pursuant to the new screening provisions in the Affordable Care Act (ACA) by March 23, 2013. CMS' decision to extend the revalidation effort by two years is a direct result of AMA advocacy. [The AMA sent a letter to CMS on Sept. 23](#) that disagreed with the agency's legal analysis of the ACA screening provisions. After careful consideration of the AMA's legal interpretation, CMA decided to extend the date by which all physicians must be revalidated and screened. CMS has also announced sweeping changes to the online PECOS system, such as e-signatures and the ability to upload documents electronically, which will improve the enrollment process for physicians.

AMA secures key guidelines regarding CMS' predictive modeling program

CMS recently launched a new prepayment review program for all Medicare claims that utilizes predictive modeling technology. On Aug. 8, 2011, the AMA sent a letter to CMS on the program to express concern regarding CMS' statutory authority to waive prompt payment for the program's activities and the capacity of the program to conduct complex claims review. In response to AMA advocacy, CMS has now published an article on the program that establishes the following guidelines: CMS will only waive prompt payment in exceptional and urgent circumstances; CMS will work with clinical experts across the country and of every specialty on claims review; and, CMS is not currently denying claims based solely on the program, and will develop and refine models that do not disrupt claims processing.

CMS article: <https://www.cms.gov/MLN Matters Articles/Downloads/SE1133.pdf>

AMA letter: <http://www.ama-assn.org/resources/doc/washington/predictive-modeling-letter-8aug2011.pdf>

RACs – Medicare program improved

The AMA continues to advocate for improvements to the Medicare Recovery Audit Contractor (RAC) program. CMS recently made several improvements to the program, including: a limit of 10 medical record requests in 45 days for offices of five or fewer physicians; a requirement that RACs complete complex coverage or coding reviews within 60 days or lose the contingency fee; an allowance of a discussion period wherein a request by a physician to speak with a Medical Director must be honored; and, a requirement that RAC websites list new audit issues by provider type.

Encourage your members to help Heal the Claims Process™ in November

November is here, and the AMA's "Heal that Claim"™ month is in full swing. The goal of the campaign is to help physician practices streamline their claims processing through the use of electronic health care transactions. An exciting feature of this year's campaign is the AMA's newest online community, the Paperless Practice Group. This community provides physician practices, health insurers and intermediaries with a forum for asking questions, offering tips and accessing resources about automating the practice and using electronic health care transactions. You and your members can join today at ama-assn.org/go/paperlessgroup.

You can also participate by pledging your medical society's support at ama-assn.org/go/htc or publishing ready-made campaign messages, which can be accessed at ama-assn.org/go/promotehtc, in your own communications. Encourage your members to take part in helping to Heal the Claims Process™. Contact Kate Seremek with the AMA's Practice Management Center at kate.seremek@ama-assn.org or (312) 464-5490 for more information.

AMA leads in the creation of Standards for Reporting Physician Data

To address the lack of uniformity and adequate detail contained in the physician profiling data reports that insurers give to physicians, the AMA has drafted Standards for Reporting Physician Data. These standards arose out of a meeting that the AMA convened in April with representatives from the major national insurers, accrediting organizations and employers to review a Standardized Physician Data Report, which would provide physicians with the data necessary to verify the accuracy of payer profiling reports and institute practice improvement opportunities. During the April meeting, the insurers expressed support for the concept but determined they could not support any single standard, as implementation would be time- and cost-prohibitive. The group felt that the best way to improve and

provide more uniformity to physician data reporting would be to create a set of guidelines rather than insist on a specific reporting format.

The AMA worked with the Federation of Medicine's Physician Profiling Workgroup to draft the standards, which provide guidelines for the reporting and transparency of individual physicians' quality and resource use data. The AMA has requested feedback on these standards from the organizations convened in April and a small representative subgroup, which includes representation from CMS, to develop a consensus version of the standards. Support for the standards will be solicited from the Federation, health insurers, the private and public health care community, and other interested parties.