



AMA 2011 Regulatory Wins

ACO/Medicare Shared Savings Program Final Rules

In response to significant and sustained AMA advocacy, CMS released final rules for the Medicare Accountable Care Organization (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: addition of 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; elimination of the proposed requirement to withhold shared savings payments to cover potential future cost increases; ACOs will be allowed to share in savings beginning with the first dollar of savings earned; ACOs will be able to keep more of the savings they generate; the number of required quality measures has been cut in half to 33 from the proposed 65 and measures are better aligned with other Medicare quality reporting programs; patient assignment to ACOs will not be completely retrospective in that ACOs will get a prospective list of “probable beneficiaries” that will be updated quarterly; patients who receive all of their primary care services from specialist physicians will be assigned to ACOs based on these specialist services; elimination of the requirement that at least 50 percent of an ACO’s primary care physicians must be “meaningful users” of EHRs by year 2 of the program; physicians who have multiple taxpayer identification numbers will be able to participate in multiple ACOs; ACOs will be protected from “outlier” spending exceeding the 99th percentile of average beneficiary spending; ACOs will be required to have physician medical directors and ACO governing bodies must be 75% controlled by ACO providers; rural health centers will be able to form and participate in ACOs; and 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 for Physician-Led ACOs

AMA advocacy secured a new \$170 million program to provide physicians with the upfront capital necessary to invest in the infrastructure required to form an ACO. As the AMA had urged, the new program is targeted specifically to physician-led ACOs that do not include a hospital. The Center for Medicare and Medicaid Innovation’s (CMMI) new Advance Payment ACO Model will provide upfront 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 an ACO’s earned shared savings in year two.

Antitrust Rules for Medicare ACOs

AMA advocacy led to the FTC and DOJ issuing a Joint Statement on Antitrust Enforcement and ACOs that incorporates many AMA recommendations, including Rule of Reason analysis for Medicare ACOs that want to jointly contract with private payers and a safety zone for ACOs that fall under a thirty percent market share threshold. The Final FTC-DOJ Statement also included two important changes that the AMA had urged: 1) elimination of mandatory antitrust review of potential ACOs resulting in significant removal of burden and cost on potential ACOs, and 2) the statement applies to ALL collaborations among otherwise independent providers seeking to be a Medicare ACO. The draft statement applied only to “newly formed” entities, defined as formed after March 23, 2010. This would have placed all collaborations that existed prior to March 23, 2010 under a separate antitrust review system for purposes of the Medicare ACO program. Newly formed entities may still seek a 90 day expedited, voluntary review.

Administrative Simplification

AMA has been actively providing critical input on administrative simplification solutions to the Department of Health and Human Services (HHS). Our efforts have resulted in HHS’ adopting uniform operating rules for eligibility and claims’ status electronic transactions.

Audit of Audits

At the urging of AMA, the Center for Medicare and Medicaid Services (CMS) has undertaken a first ever internal “audit of audits” to review and potentially reduce the number of duplicative and burdensome program integrity audits physicians are currently subject to.

Enrollment Program Significantly Improved

In direct response to AMA advocacy, CMS has made a number of improvements to the enrollment program. CMS decided that the revalidation effort will be pushed back through 2015 and physicians will be among the last to be required to revalidate. CMS has also announced sweeping changes to the online PECOS system, such as e-signatures and the ability to upload documents electronically, that will improve the enrollment process for physicians. CMS has also implemented new procedures for MACs to follow-up with physicians to assist with revalidation requests. The AMA also secured an indefinite postponement of the requirement that calls for all referring/ordering physicians to be in PECOS. CMS will not move forward with this policy until almost all physicians are in the PECOS system. Lastly, CMS made two Medicare questions optional on the enrollment form - the acceptance of new Medicare patients as well as Advanced Diagnostic Imaging (ADI) certification.

E-prescribing Penalty –Flexibility Created

After significant advocacy from the AMA, CMS took the rare step of opening up the regulatory process to greatly expand the number and breadth of hardship exemptions in order to help more physicians avoid the e-prescribing penalty. We also secured additional time for physicians to apply for the hardship exemption. CMS also implemented some of AMA's recommendations regarding outreach, including sending letters to and calling physicians the agency anticipated would be subjected to the penalty. When at the 11th hour physicians were encountering technical difficulties filing for hardship exemptions, AMA immediately secured a week's extensions for physicians to file.

HIPAA Version 5010 - 90 Day Enforcement Grace Period

Due to AMA advocacy, CMS agreed to delay enforcement actions against physicians and other HIPAA covered entities until March 31, 2012, to allow physicians and others more time to comply with the required HIPAA Version 5010 electronic transactions standard.

Home Health Reg Enhanced

Due to AMA advocacy, CMS revised the home health face-to-face encounter requirement to significantly extend the period of time in which the encounter can occur. The AMA also secured a three month delay in implementation of the face-to-face home health requirements to allow for more time to educate physicians on the new policy.

Identity Theft Protection

Due to continued AMA advocacy, CMS has just announced a new streamlined process for investigating and restoring the financial integrity of physicians who are victims of identity theft in the Medicare program. CMS has created and publicized an ombudsman for each contractor to assist physicians who have been victims of identity theft. If needed, CMS will work with other agencies to resolve the physician's outstanding financial liabilities, like erroneous taxes.

Innovation Center Flexibility

In response to AMA advocacy on the need for payment innovations to provide flexibility, upfront payments and a range of models, the CMS Innovation Center launched two new initiatives focusing on bundled payments and comprehensive primary care. Applicants for these new initiatives will have the flexibility to determine the type of payment and delivery models that will work best for them and which types of patients and health conditions they wish to focus on. These initiatives are consistent with AMA recommendations to offer multiple paths to payment reform, rather than a single, one-size-fits-all approach.

Lab Signature Requirement Retracted

AMA secured a retraction of burdensome CMS policy requiring a physician signature on laboratory test requisitions.

Meaningful Use Stage 2 – Implementation Flexibility

Due to AMA advocacy, Secretary Sebelius of Health and Human Services recently announced that the Department will postpone the implementation of Stage 2 of the electronic health records (EHRs)

meaningful use program until 2014. Greater flexibility in the implementation of this program will allow for better evaluation of Stage 1 and ultimately adoption of EHRs.

Meaningful Use – Usability Criteria Considered

Physicians have expressed significant reservations about purchasing a certified EHR for the Medicare incentive program without any knowledge whether it will meet their particular practice needs. As a result of AMA's efforts, ONC is now considering whether to include "usability" among the criteria EHR vendors must meet in order to receive certification.

Medicare to Cover Screening for Depression and Alcohol Misuse

The AMA had urged and CMS has recently announced that Medicare will now cover screening for depression and screening and behavioral counseling by primary care physicians for alcohol misuse. The new policy goes beyond treatment for alcohol dependence and will include patients who misuse alcohol but do not meet the criteria for alcohol dependence. In addition, annual screening for depression will now be covered for Medicare patients in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Medicare Economic Index Technical Panel Created

For years, the AMA has been advocating the need for a comprehensive review and revision of the Medicare Economic Index (MEI) so that it will reflect the realities of Medicare practice in the 21st century. CMS has finally announced it is accepting nominations for the MEI Technical Advisory Panel. The Panel is to complete its work no later than September 28, 2012.

Multiple Procedures Cuts

In response to comments from the AMA, the RUC and many specialties, CMS scaled back its proposal from 50 to 25 percent to apply a reduction to the professional component of all but the highest valued code when more than one procedure on a list of 119 CT, MRI, MRA and ultrasound performed on the same patient on the same day.

NPIs Redacted

CMS recently published a list of providers who have been contacted to revalidate their Medicare enrollment. In response to AMA advocacy, CMS has now revised the list to redact provider National Provider Identifier numbers (NPIs)—to display only the last four digits—in an effort to guard against provider identity theft.

NQF Measures Reconsidered

In a direct response to a letter initiated by the AMA and signed by 38 specialties, the National Quality Forum (NQF) is considering a redesign of its measure endorsement process.

Predictive Modeling Program –Guidelines Established

As a direct result of AMA advocacy, CMS has established the following guidelines for the predictive modeling program: 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.

Pre-payment Demonstrations

On December 29th, after the AMA objected to the hasty implementation of CMS' Recovery Auditor pre-payment audit and wheelchair pre-payment audit demonstration projects, CMS indefinitely postponed the demonstrations, which were scheduled to begin on January 1, 2012.

Physician Compare Website

Pursuant to the Affordable Care Act (ACA), CMS launched the Physician Compare Website with information based on the CMS Provider Directory. AMA recognized that there were significant problems with the Website. With input solicited from the states and specialties, we secured significant improvements in the data. For example, as a result of the AMA's advocacy contractors are now refreshing the data on a timely basis.

Physician Representation in Fraud Summits

In an effort to ensure that the physician perspective is heard, AMA secured participation of physicians and state medical societies in the regional fraud and abuse summits hosted by the Obama Administration.

PQRS Improvements

The AMA has been working aggressively to address significant issues with the Physician Quality Reporting System (PQRS). Improvements to the PQRS include: increased frequency of educational calls; creation of an implementation guide; lower thresholds to ease reporting; and posting of quarterly feedback reports by measure on its Website to assist AMA and physician specialties in identifying quality data reporting errors associated with specific measures. In 2012, CMS plans to provide interim feedback reports to individual providers reporting via claims.

RACs – Medicare Program Improvements

The AMA continues to advocate for improvements to the Medicare RAC program. CMS recently made several improvements to the Medicare RAC 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.

RACs – Medicaid Program Improvements

Due to considerable AMA advocacy, including extensive comments from the AMA that were co-signed by eighty state and specialty societies, CMS delayed the implementation of and improved the Medicaid Recovery Audit Contractor (RAC) program. In the recently released Medicaid RAC final rule, CMS adopted many of our specific recommendations, including: 1) a 3-year maximum claims look back period; 2) RACs are required to employ a full-time physician Medical Director; 3) States must set limits on the number and frequency of medical record requests; 4) RACs must hire certified coders; 5) RACs must provide outreach and notify providers of audit policies and protocols; 6) RACs must accept submission of electronic medical records by fax or CD/DVD; 7) RACs cannot audit claims that have already been audited or are currently being audited by another entity; 8) RACs must return the contingency fee if an overpayment determination is reversed at any level of appeal; 9) States must adequately incentivize the identification of underpayments; and, 10) States must coordinate the efforts of the RACs with other auditing entities.

Retroactive Pay Increases Implemented

ACA passed a series of Medicare physician pay increases (i.e. GPCI work and practice expense) that became effective January 1 of 2010. But CMS could not incorporate the changes into its system until about June 2010 and the agency was not moving forward on reimbursing physicians for the January-June period. In response to AMA advocacy, CMS did pay physicians the increases that were due.

Screening requirements – Physicians Put in Lowest Tier

The ACA included increased screening requirements for providers and suppliers enrolling in Medicare. In response to AMA advocacy, CMS agreed to place physicians in the lowest risk tier category which requires the fewest screening requirements among all providers who enroll. CMS also revised their initial proposal to place physician victims of identity theft in the high risk tier. Other improvements to the proposal due to AMA advocacy included: CMS' omission of "geographic circumstances" as a factor, generally suspensions can not exceed 18 months, and CMS' decision not to place physicians who have had their billing privileges denied in the high risk category.

Secret Shopper Survey Abandoned

Due to advocacy from the AMA, CMS abandoned the offensive secret shopper survey.