AMA to Seek Medicare Payment Option

BY SUSAN BIRK

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION'S HOUSE OF DELEGATES

CHICAGO — Frustration and concern about the lack of a permanent replacement for the Medicare Sustainable Growth Rate formula held center stage as the American Medical Association's legislative body met here.

Delegates passed a resolution calling for the AMA to "immediately formulate legislation for an additional payment option in Medicare fee-for-service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule."

Such a fee-for-service option would allow physicians to balance-bill—they could bill patients for the difference between the Medicare fee schedule and their regular fee schedules.

In addition to helping physicians keep pace with inflation, the option would "give patients control of their Medicare benefit" by allowing them to use the 80% of the fee schedule that they receive from the government plan with physicians outside of "the very strict confines of a participating Medicare physician provider," Dr. David O. Barbe, a member of the AMA board of trustees, said in an interview.

According to the resolution, the AMA must present the legislative language to its members by Sept. 30.

Introduced as an amendment from the floor during voting, the resolution provided teeth and proactive fervor to another proposed resolution from the AMA's legislative reference committee calling for the organization to study alternative payment options. The resolution that was passed eliminates this step.

Patients "want the conversation about health care to come from their doctors," Dr. Marcy Zwelling-Aamot, president of the American Academy of Private Physicians, said in support of the substitute resolution, which passed by a large margin. "I don't want Congress writing the bill about how I'm going to take care of my patients. We should write the bill. We don't need a study, we need action," she added.

At a "Write Coat Rally" prior to the start of the house proceedings, delegates expressed opposition to the current Medicare payment system.

"Physicians want to care for seniors, but multiple short-term delays have created instability for physician practices nationwide, and this cut is basically the last straw," Dr. J. James Rohack, then president of the AMA, said during a press conference at the meeting.

He cited a recent AMA survey of 9,000 physicians indicating that one in five physicians overall and nearly one in three primary care physicians currently restrict the number of Medicare patients they see because they feel Medicare payment rates are too low or that the likelihood of additional cuts makes Medicare an unreliable payer.

At the rally, delegates wrote on white lab coats about the urgent need for a workable alternative to the Sustainable Growth Rate (SGR) formula. The lab coats were delivered to Congress after the meeting.

Support for the resolution during the voting session was strong but not unanimous.

AMA Past President Richard F. Corlin said that a bill from the AMA asking that physicians be allowed to contract for a fee that differs from Medicare payment and that does not forfeit benefits "is completely unachievable and will cause us to not be taken seriously by other people who would like to be our allies."

He recommended focusing instead on changing the 2-year drop-out rule that prohibits physicians who opt out of Medicare from submitting claims to Medicare for any of their patients for 2 years.

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"Let me abide by the Medicare limits for the patient who can't afford any more, and let me go my own way and bill what I want for the patient who can," he argued.

Other delegates felt the resolution was too narrowly focused on physicians' financial interests and could ultimately do physicians more harm than good.

"We cannot keep going and asking for more and more money based on what we want to get without cutting the costs down," said Dr. Lynn Parry, a Denver neurologist who received applause for her comments. "None of this discussion has talked about our responsibilities; it's just talked about what we want. It's going to make us look stupid, it's going to make us look greedy, it's going to come back and haunt us."

According to Dr. Jeff Terry of the Alabama delegation, "We're not asking for more. … We're asking for continued access for our patients to care. This is not greedy to say the least."

Dr. Jeffrey W. Cozzens of the American Association of Neurological Surgeons added, "By having legislation that we wrote, we'll show the world that we have solutions to this problem."

Dr. Barbe added, "If [the federal government is] not able to provide access for patients by providing appropriate reimbursement to physicians ... then take off the [price] caps. Pay whatever you can pay ... and then let the market take care of the rest. Let the patient and the doctor decide what that service is worth."

Although the SGR and physician pay dominated action at the House of Delegates meeting, other topics were deliberated. Among them:

► **Skin cancer awareness.** Delegates voted for the AMA to work with public health agencies and specialty societies, such as the American Academy of Dermatology, to promote skin cancer screening and education about sun-protective behavior among people of color. Five-year survival rates for melanoma are significantly lower among African Americans than whites (58.8% vs. 84.8%), and melanoma incidence among Hispanics now approaches that of whites, according to a statement from the AMA. Noting that African Americans and Hispanics are much less likely to practice sun-protective behaviors, AMA board of trustees member Peter W. Carmel said, "All patients regardless of race or ethnicity should use the same sun-protection measures including sunscreen of at least SPF 15, avoid the sun during peak hours, and [get] regular exams."

► **Support for new antibiotics.** Delegates adopted policy to educate the public, physicians, the Obama administration, and Congress regarding the looming problem of antimicrobial resistance and the shortage of new antibiotic drugs in the development pipeline. Specifically, the policy endorses the "10 20" initiative sponsored by the Infectious Diseases Society of America, which urges global action by political, scientific, medical, industry, and policy leaders to drive the development of at least 10 effective new antibiotics by 2020.

► **Smoke-free housing.** Delegates passed a resolution to encourage federal, state, and local housing authorities to adopt policies prohibiting smoking in multi-unit housing. The word "public" was removed from language recommended by the public health reference committee to broaden support for efforts to include private multi-unit housing as well. Mention was made on the floor of evidence pointing to the health hazards of third-hand smoke, the residue that remains on walls, carpeting, and other surfaces for extended periods.

► **E-cigarette regulation.** Delegates voted in favor of a report from the AMA Council on Science and Public Health recommending that e-cigarettes be classified as drug delivery devices and be subject to regulation by the Food and Drug Administration with standards for identity, strength, purity, packaging, and labeling, and with instructions and contraindications for use. The new policy also asks state legislatures to prohibit the sale of non–FDA approved e-cigarettes and recommends that the devices be covered by smoke-free laws but be classified separately from tobacco products.

► **Education about the Gulf oil spill.** Delegates approved policy advocating that the AMA work to educate health professionals and the public on the potential health risks of oil spills and to encourage research on the Gulf oil spill's impact on air and water quality. ■

AMA: Claims Process Now 80% Accurate

BY SUSAN BIRK

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CHICAGO — Twenty percent of health insurance claims are processed inaccurately, according to the American Medical Association's third annual National Health Insurer Report Card, which rates the nation's largest commercial insurers on timeliness and accuracy of claims processing.

Eliminating discrepancies in expected payment amounts would save doctors and insurers $15.5 billion annually, according to the report, which is based on a random sample of 2 million claims for 3.5 million services filed electronically February-March 2010 by 200 practices in 43 states. Each year, claims processing costs as much as $210 billion and takes up 10%-14% of physicians' gross revenue and the equivalent for each physician of 5 work weeks, Dr. Nancy H. Nielsen, then immediate past president of the AMA, said in an educational session. "Physicians are drowning in this."

To remedy the problem, the AMA urges the creation of a single, transparent insurance industry standard "so that everybody knows in a seamless way how those claims are to be submitted and processed," Dr. Nielsen said, adding that such a standard would reduce errors and free physicians to focus more on patients and less on administrative red tape.

The report card "has actually turned out to be not just a 'gotcha' against the insurers, but an actual 'win win' between national payers and the AMA" because the insurers appear to be using the feedback to improve, Dr. Nielsen said.

Insurers made some gains, including accuracy in the reporting of contract fees to physicians. They correctly reported contract fees 78%-94% of the time in 2010 versus 62%-87% of the time in 2008.

They also increased the transparency and accessibility of their fee schedules, according to Mark Rieger, chief executive officer of National Healthcare Exchange Services Inc. of Sacramento, which conducted the research.

Physicians' electronic access to complete fee schedules plays a major role in processing accuracy, he said. "Where the payer makes the fee schedule available we have higher match rates."

Coventry Health Care had the highest overall accuracy (88%), while Anthem Blue Cross Blue Shield had the lowest (74%). Other insurers addressed by the report were Aetna, CIGNA, Health Care Services Corporation, Humana, and UnitedHealth Group.

Mr. Rieger said that every 1% increase in the match rate for claims would generate a conservatively estimated $777.6 million for physicians and payers. A 100% match rate would yield an annual savings of $15.5 billion. ■