Greetings! I wish to thank those of you that have shared your thoughts and concerns with me about organized medicine and the rapid change within our industry. I will address some of those comments and concerns in this report. I will also outline the most current activities of the Texas Delegation and the AMA of interest. The purpose is to encourage dialogue and activate members to self-advocate rather than to take on a sense of defeat.

Texas Delegation Highlights
Lou Goodman’s latest post on health spending has been published to Forbes. You can view it at: http://www.forbes.com/sites/physiciansfoundation/2014/08/01/does-more-health-spending-mean-better-health/

(8/1/2014, 1:19 PM) The unified voice of medicine calling for swift action to address veterans’ urgent health care needs resonated this week on Capitol Hill as Congress passed reform legislation.

The bipartisan framework agreed upon last week passed the U.S. House of Representatives Monday in a vote of 420-5, paving the way for veterans to seek medical care outside the U.S. Department of Veterans Affairs (VA) health care system if they aren’t receiving timely treatment. The U.S. Senate followed suit and passed the bill Thursday night. The AMA House of Delegates in June had adopted policy urging Congress to act quickly on improving access to care for veterans. Physicians already have been gearing up for the legislative reform by preparing registries of those who are willing to care for veterans.

Reforms outlined in the bill include:
• Veterans who cannot secure an appointment at a VA facility within established wait times or who live more than 40 miles from a VA facility will be able to seek care from physicians and hospitals outside the VA system using the new “Veterans Choice Card.”
• Additional VA facilities will be opened in 18 states and Puerto Rico, increasing access to facilities and specialists.
• Additional funds will be devoted to hiring more primary care physicians and specialists as well as other clinical professionals who are insufficiently staffed.
• The VA health system will be tasked with improving administrative functions throughout the system.

President Obama is expected to sign this bill into law immediately.

National
The AMA website has resources for those struggling and looking for a simple way to deal with the Sunshine Act. See the website. The AMA and 112 specialty and state medical societies told the Centers for Medicare & Medicaid Services (CMS) in a letter sent Wednesday. The groups asked the agency to postpone the release of physician financial data to March 31, six months after the current publication date of Sept. 30.

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A recent survey http://www.physicianspractice.com/login?referrer=http%3A//www.physicianspractice.com%2F2014-technology-survey-results (login required) by Physicians Practice found that physicians say EHR adoption, implementation and interoperability are their most pressing technology problem. While about 53 percent of the more than 1,400 physicians who responded to the survey said they did have a fully implemented EHR system in their practices, about 20 percent said they didn’t yet have one. The main reasons for not having an EHR system were related to cost or the lack of products available to meet their needs, according to the survey. Another 17 percent said they used an EHR system selected by their parent hospital or corporation. Roughly one-third of respondents said their EHR system has made practice work flow less efficient, while nearly one-half said the technology has made it more efficient.

The survey results echo findings from the AMA’s 2013 study, (http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf) conducted in partnership with the RAND Corporation, which found EHR systems to be a major contributor to physicians’ professional dissatisfaction. Nearly two-thirds said they have not seen a return on investment.

As part of its Professional Satisfaction and Practice Sustainability (http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/enhancing-professional-satisfaction-and-practice-sustainability.page) initiative, the AMA is developing a set of priorities and recommendations to improve the usability of EHR systems, identifying opportunities to achieve these improvements, and determining a research agenda to advance the evidence base for increasing usability. The AMA is taking physician issues and recommendations directly to the EHR vendors.

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Report from the AMA Alternate Delegate to the 
El Paso County Medical Society 
(Continued)

to EHR vendors to encourage them to make the necessary changes in their future product designs and is working with the Electronic Health Records Association on these efforts. Through research, data and analytics, the AMA is identifying effective care delivery and payment models that can improve the quality of patient care, reduce health care costs for the nation and increase professional satisfaction.

The AMA/RAND field research provides empirical evidence that informs and shapes AMA policies and services to help physicians thrive well into the future.

Fundamentals for a better health care system include:
- Development of best practices for care delivery that can improve health outcomes, increase operational productivity and reduce health care costs
- Adoption of payment policies that reflect the diversity of physician services and levels of clinical integration and risk
- Guidance for physicians to help them choose optimal payment and care delivery models that fit their practice

Court considers: Can doctors sue insurers for underpaid claims?
7/15/2014, 10:16 AM
At stake in a case before an appeals court is physicians’ right to bring a lawsuit against an insurer that fails to pay correctly for medically necessary services provided to a covered patient. Physicians are weighing in as the court considers whether a previous ruling that bars such action should stand.

In North Jersey Brain and Spine Center v. Aetna, a physician practice that received assignments of benefits from patients with employer-sponsored health plans sued the insurer for denying and underpaying medically necessary surgeries for three different patients. The claims were brought to court only after the practice exhausted internal appeals processes with the insurer.

The district court in which the case originally was heard ruled that physicians must have more than the standard assignment of benefits to give them grounds for a lawsuit. The decision goes against decades of previous court rulings, accepted practice and the intention of the Employee Retirement Income Security Act (ERISA). The case now is being heard by a U.S. court of appeals in Philadelphia.

“Physicians are willing to provide medical care without demanding … up-front payments because they are confident that, if necessary, they can pursue remedies under ERISA for improperly denied insurance benefits,” the Litigation Center of the AMA and State Medical Societies (http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/litigation-center.page) and the Medical Society of New Jersey said in a friend-of-the-court brief filed last week.

Insurers shell out $1.9 billion in refunds to patients 8/5/2014, 3:06 PM
Health insurance companies that spent too little on medical care last year had to refund more than $330 million to consumers by Aug. 1 in order to be compliant with a little-known provision in the Affordable Care Act (ACA). The total payout since 2011 comes to more than $1.9 billion, according a new report (http://www.cms.gov/CCHO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MI-R-Report_07-22-2014.pdf) from the U.S. Department of Health and Human Services (HHS).

The refunds stem from what is known as the medical loss ratio, or 80/20 rule, which calls for a minimum of 80 percent of insurance premiums to be spent on medical care or activities to improve health care quality. No more than 20 percent can be devoted to administrative costs and profit. In large group markets, the ratio is more stringent, at 85/15. The average refund was $80 per family. Through its advocacy efforts to the National Association of Insurance Commissioners, the AMA prevented the health insurance industry from undermining this important patient benefit from the health care law. When this rule was under development, insurers were advocating for provisions that would have allowed them to claim administrative expenses as medical losses, artificially inflate the medical loss ratio and calculate ratios generally at the national level. More recently, the AMA was instrumental in blocking revisions https://login.ama-assn.org/account/login (AMA login required) to the rule that would have provided considerable wiggle room for insurers to reduce their required refund payments and get away with not being fully compliant with the law each year.

CHARTER CHANGE - go to CMS website to provide your comments 
MEDICARE EVIDENCE DEVELOPMENT & COVERAGE ADVISORY COMMITTEE

Move to align GME accreditation paves way for “ideal” continuum 7/31/2014, 1:00 AM
The AMA will work with other relevant associations and accreditation bodies to develop strategies that will help reach the ideal medical education continuum. This includes identifying areas in which accreditation standards overlap between medical school and residency, and creating a standardized method of feedback from medical school to premedical institutions and from residency programs to medical schools about their graduates’ preparedness for entry (combined DO and MD).

Roxanne Tyroch, MD, FACP, AMA Alternate Delegate, El Paso County Medical Society Delegate.