Alabama Gastroenterological Society
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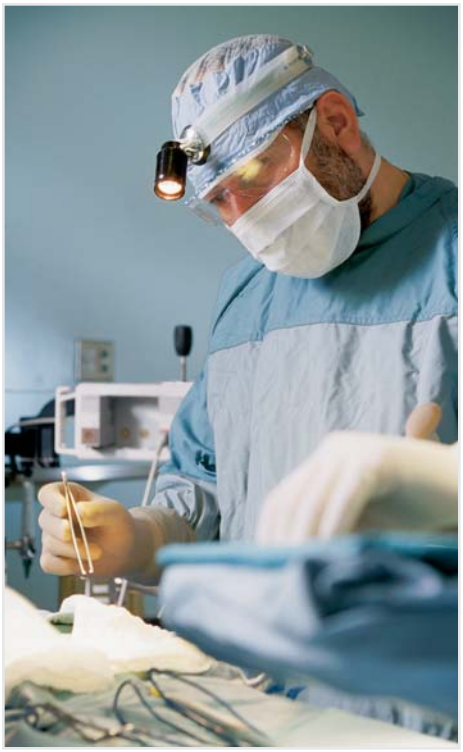

Budget proposal eliminates coinsurance when screening colonoscopy turns therapeutic

American College of Gastroenterology

On Tuesday, February 9, President Obama released his ***blueprint federal budget*** for fiscal year (FY) 2017. Each year, the President sends a recommended federal budget for congressional consideration. GOP lawmakers quickly criticized the budget plan, announcing last week that they will skip the budget committees' usual hearings over the President's budget.

The budget includes two important provisions impacting ACG members and our patients:

• **Eliminate Beneficiary Coinsurance for Screening Colonoscopies with Polyp Removal.** Medicare beneficiaries are not subject to the Part B deductible or coinsurance for most recommended preventive and screening services, including screening colonoscopies. However, if a screening colonoscopy results in removal of a polyp, ablation, or other procedure, beneficiaries are subject to 20 percent coinsurance, which presents a financial challenge for beneficiaries to receive care. This budget proposal eliminates beneficiary coinsurance when the screening results in removal of a polyp or other procedure, thereby removing a significant barrier that beneficiaries face in receiving necessary preventive care. [Estimated cost to Federal Government: $2.4 billion over 10 years]

• **Hepatitis C Treatment in People Living with HIV.** According to the budget proposal, people living with HIV are disproportionally affected by viral hepatitis and are at an increased risk for serious, life-threatening complications. The Administration estimates that one quarter of all people living with HIV are co-infected with hepatitis C, and the rate is even higher (80 percent) amongst people living with HIV who inject drugs. Given the changes in the health care environment and advances in hepatitis C Treatment, the FY 2017 Budget includes $9 million to expand screening and treatment of hepatitis C in people living with HIV

Since Republicans have already decided this budget proposal is "dead on arrival," ACG continues to urge Congress to pass the SCREEN Act. The SCREEN Act (S. 1079, HR 2035) removes all financial barriers for Medicare beneficiaries throughout the screening continuum, so that cost-sharing would not apply, whether the colonoscopy was a preventive test or as the result of a positive finding from another screening modality.

Please urge your congressman to Pass the SCREEN Act!
Visit the ***ACG website*** for draft messages you can edit and send to your senator and representative.

What's Inside

Renew your membership with AGS!

As we begin another year, I sincerely thank you for your support of the Alabama Gastroenterological Society. AGS is the only state organization advocating on the behalf of Alabama's gastrointestinal specialists and you play a vital role in our success.

In 2015 we faced numerous challenges from Blue Cross Blue and Shield of Alabama regarding profound rate cuts and changes in anesthesia reimbursement and requirements tying types of anesthesia used to our reimbursement. There were also proposed policy changes by BCBS on the use and payment for Remicade and other ancillaries. We also advocated through our Tri-societies and DHPA for gastroenterologists and our patients when the Centers for Medicare and Medicaid Services proposed cuts to payments for colonoscopies.

I encourage you take a moment to renew your membership with AGS. We will be having further meetings with BCBS this year and will reach out to you as these occur. We encourage you to speak to your reps frequently, and to keep abreast of what is occurring locally and nationally with our GI organizations. We welcome your comments, suggestions, and any news that you think requires action. We are only as strong as our members, and we ask your support for an organization dedicated to protecting the profession you have already given so much to, and allow us to continue striving to protect our profession and our patients.

Lastly, please mark your calendar for our 2016 Conference, June 25-26 at the Hilton Sandestin. Last year's conference provided nine hours of continuing medical education and valuable information for your practices. Now's the time to make plans to attend. Reserve a room online at ***www.hiltonsandestinbeach.com*** with Group Code AGE or call (800) 267-9500. For information or visit ***www.alagastro.org***.

Sincerely,

Robert Shaffer, MD | President

AGS partners with Medical Association, other stakeholders to combat prescription drug abuse

Prescription drug abuse initiative aims to save lives

To combat the growing problem of prescription drug abuse, AGS has partnered with the Medical Association of the State of Alabama and a coalition of medical, business, health insurance and law enforcement organizations in the launch of a new initiative – **Smart & Safe** – aimed at providing education on and encouraging the safe prescription, use, storage and disposal of medication.

Recent studies indicate most first-time abusers get their drugs from a family member or friend, and Alabama is no different. Raising awareness about proper medication use is essential to preventing accidental overdose and death. According to Acting State Health Officer Dr. Tom Miller, prescription drug abuse is a significant threat to Alabama's public health.

"The number of deaths due to drug overdose, including prescription drugs, has resulted in the deaths of 762 Alabama residents between 2010 and 2014," Dr. Miller said. "In 2014 alone, there were 221 deaths due to drug overdoses. We wholeheartedly support the Smart and Safe campaign and the effort to tackle prescription drug abuse by promoting responsible and safe prescription use and the proper disposal of medications."

Roughly a quarter of Americans has been touched by this epidemic. Unfortunately, these estimates continue to increase every year.

"According to a recent study, Alabama has the 26th highest drug overdose mortality rate in the United States, and the number of drug overdose deaths in Alabama has tripled since 1999, a majority from prescription drugs. ... Blue Cross is proud to support the Medical Association to help ensure its success," said Dr. Darrel Weaver, medical director for Blue Cross and Blue Shield of Alabama.

While drug abuse directly affects families and individuals, its indirect effects on Alabama communities and the businesses therein are substantial according to Denson Henry, vice president of Henry Brick Co., in Selma, and co-chair of the Business Council of Alabama's Health Committee.

Download posters and find more information about Smart & Safe on AGS' website.

"Abuse of legal and illegal drugs is expensive to business, industry and employees due to higher insurance claims, lost productivity, injuries both on and off the job…not to mention the human cost. Encouraging and supporting treatment and prevention can help the employee, co-workers, management and families," Henry said.

Smart & Safe will build upon the success already realized through passage of a 2013 legislative package (Prescription Drug Monitoring Program) aimed at reducing prescription drug abuse.

Learn more at ***www.SmartAndSafeAL.org***.

Wrap up: Key recommendations from AGA's 2015 Guidelines

www.gastro.org

Clinical practice guidelines are critical to reducing physician variation and providing high-quality patient care. In 2015, the American Gastroenterological Association (AGA) issued six clinical practice guidelines, all published in AGA's official journal, *Gastroenterology*, offering current, evidence-based point-of-care recommendations to guide physicians at the bedside.

Review the following compilation of new AGA guidelines released in 2015. To view all of AGA's clinical practice guidelines, as well as accompanying clinical decision support tools and patient guideline summaries, visit ***http://www.gastro.org/guidelines***.

1. Medical Management of Microscopic Colitis (November 2015)

In patients with symptomatic microscopic colitis, AGA recommends first-line treatment with budesonide for induction and, when appropriate, maintenance therapy. (This guideline is currently an Article in Press and is subject to minor edits. Login required for Gastroenterology subscribers.) ***http://www.gastrojournal.org/article/S0016-5085(15)01625-X/pdf***

2. Management of Acute Diverticulitis (October 2015)

This guideline suggests that antibiotics be used selectively, rather than routinely, in patients with acute diverticulitis. It also recommends a fiber-rich diet or fiber supplementation, and identifies future areas of research. ***http://www.gastrojournal.org/article/S0016-5085(15)01432-8/pdf***

3. Role of Upper GI Biopsy to Evaluate Dyspepsia in the Adult Patient in the Absence of Visible Mucosal Lesions (August 2015)

AGA recommends against obtaining endoscopic biopsy of a normal-appearing esophagus in an immunocompromised patient with dyspepsia, providing evidence that this alone would have no added value. ***http://www.gastrojournal.org/article/S0016-5085(15)01065-3/pdf***

4. Diagnosis and Management of Lynch Syndrome (July 2015)

All colorectal cancer patients should undergo tumor testing to see if they carry Lynch syndrome, according to this AGA guideline. AGA also recommends performing a surveillance colonoscopy every one-to-two years in patients with Lynch syndrome, versus less frequent intervals. ***http://www.gastrojournal.org/article/S0016-5085(15)01031-8/pdf***

5. Diagnosis and Management of Asymptomatic Neoplastic Pancreatic Cysts (April 2015)

This guideline changes clinical practice by recommending a two-year screening interval for asymptomatic pancreatic cysts of any size and stopping surveillance after five years if there is no change. This guideline also limits surgery to those who will receive the most benefit. ***http://www.gastrojournal.org/article/S0016-5085(15)00100-6/pdf***

6. Prevention and Treatment of Hepatitis B Virus Reactivation During Immunosuppressive Drug Therapy (January 2015)

Preventing HBV reactivation in patients on long-term immunosuppressive therapy involves screening those at risk, identifying patients for risk based on HBV serologic status and the type of immunosuppression, and consideration of prophylaxis with anti-hepatitis B therapeutics; all three steps are detailed in this guideline. ***http://www.gastrojournal.org/article/S0016-5085(14)01331-6/pdf***

Federal Health Care Issues: 2015 Year in review

Source: Medical Association of the State of Alabama
www.alabamamedicine.org

Medicare Physician Payment System

2015 saw a big victory for physicians in the long overdue repeal of the Medicare sustainable growth rate (SGR) formula, which each forced physicians and the seniors under their care to wonder if Congress would have the courage to act to protect Medicare beneficiaries access to care. The Medical Association and 13 allied Alabama medical specialties, in response to a CMS request for comment on a number of questions related to its Congressional directive to fill in the details of long-term SGR, sent a strongly-worded letter to CMS outlining opposition to one of the main tenets of CMS's questionnaire, whether physician Medicare payments should be conditioned on acceptance of Medicaid or health insurance exchange plans which would move us closer to a single-payer system.

"… instead of finding innovative ways to expand access to care by rewarding physicians, CMS now proposes to dictate individual physicians' patient sets. This is a direct attack on practice autonomy and will put the nation's health care system much closer to single-payer, a move we believe would ruin Alabama's and America's health care system," the letter reads.

ICD-10 mandate

Despite the Medical Association's efforts and those of Congressman Gary Palmer (AL-06) to delay ICD-10, the new coding system went live on October 1 as scheduled. Leading up to implementation, the Medical Association had petitioned the Alabama Delegation for support for Rep. Palmer's bill and shepherded a resolution through the Alabama Legislature sponsored by physician-Senators Tim Melson and Larry Stutts urging Congressional delay of ICD- 10.

"CMS is putting the computer between the doctor and the patient with ICD-10," Sen. Larry Stutts, MD, (R-Tuscumbia), co-sponsor of the resolution, said.

CMS is "… forcing this unfunded mandate on the health care community, and it couldn't come at a worse time," SJR 79 sponsor Sen. Tim Melson, MD (R-Florence), said.

Despite disagreeing with CMS about the unfunded ICD-10 mandate on physicians, the Association's Board of Censors felt it imperative to provide as much information as possible to its members about complying with the mandate so they would not be caught flat-footed if delay efforts were unsuccessful, including webinars, meetings and advice from experts in the field of medical practice management and health IT during 2015.

Electronic Health Records (EHR) and Meaningful Use

Meeting CMS's requirements for meaningful use (MU) continues to become more and more difficult for physicians. Perhaps the greatest sign this year being the fact that CMS's final rule for MU Stage 2 compliance required 90 consecutive days of adherence in 2015 despite the fact that the rule was issued when less than 90 days left in the year. The Medical Association led a coalition of 38 Alabama specialty and county medical societies in asking our Congressional Delegation to support a bill – H.R. 3940 – by fellow-physician and Congressman Tom Price (R-GA) to allow CMS to grant a blanket hardship exception for physicians from its impossible Stage 2 MU final rule.

"While current federal statute allows physicians to apply to CMS for a temporary MU hardship exemption, given the lateness of the strict Stage 2 final rule, hundreds of thousands nationwide will be petitioning CMS for a waiver which can only statutorily be granted on an individual basis. This will be time-consuming for the agency and may lead to administrative backlogs internally that end up docking payments to medical practices for services rendered to Medicare patients," the letter reads.

Before adjourning for the Christmas break, Congress took language from H.R. 3940 and added it to another broader bill, approving it. This means CMS now has the authority to process requests for hardship exemptions to physicians through a more streamlined blanket-exemption process, alleviating burdensome administrative issues for both providers and the agency.

Federal Fraud and Abuse Programs

Medicare's effort to stop dishonest activities may be well-intended but its focus on physicians as the main source of fraud and abuse is off target. Medicare's recovery audit contractors show a very poor return to the government for the dollars spent chasing fraud and abuse, as more than 60 percent of their determinations are overturned when appealed and CMS has at present a multi-year backlog of appeals to sort through. In the Omnibus Appropriations Bill for 2016 is language directing HHS to improve consistency, transparency and processing of appeals and to use funds recovered through audits to better educate physicians and others on how they may reduce errors likely to trigger audits. As well, the omnibus bill language directs CMS to increase monitoring of the recovery audit process, its contingency-fee-operating contractors and provide reports to Congress.

Scope of Practice

The U.S. Department of Veterans Affairs continued efforts in 2015 to update its nursing handbook and organizations representing nurse anesthetists and other advanced practice nurses tried to use the updating process as a way expand their scope of practice within the VA system. Nurse anesthetists in particular unsuccessfully lobbied the VA to abandon team-based anesthesia and authorize a nurse-only model of anesthesia care. The Medical Association worked with the Alabama State Society of Anesthesiologists during 2015 on this issue to ensure the Alabama Congressional Delegation understood our shared principle that the safety of our veterans is and should remain the highest priority through preserving the physician-led team care model. (**Provide feedback to the VA on the importance of preserving the physician-led health care team by visiting *www.SafeVACare.org*.**)

National Medical Licensure

Telehealth companies lobbied Congress in 2015 (albeit unsuccessfully) to enable nationalized medical licensure and to do away with state-based licensure, whether for Medicare services alone or for all services.

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2015 Year in review, cont.

The Medical Association was outspoken on this issue in 2015 and successfully shepherded legislation through the Alabama Legislature allowing Alabama to become the seventh state to join the Interstate Medical Licensure Compact, a streamlined licensure process for physicians from participating states who are board-certified and who have never been disciplined by a medical or health board. Eligible physicians with a license in a participating state can apply for an expedited license in another Compact-participating state. This approach ensures quality standards do not suffer and plaintiff trial lawyers aren't able to expand their ability to sue doctors in federal law.

ACA's Independent Payment Advisory Board (IPAB)

The IPAB is a 15-member presidentially appointed board with the power to make unilateral decisions regarding Medicare. It is a bureaucrat's dream, with broad and dangerous authority to make decisions regarding Medicare that without formal Congressional disapproval, are entirely binding. To date, not one member of the IPAB has yet been appointed and the 2016 omnibus bill cuts funding from the program.

Release of Physician Payment Data

The federal government's track record on release of physician payment data is abysmal. CMS continues to provide no context for interpreting the data it releases, preventing patients from being able to make informed decisions about choice of physician. Instead, CMS released raw data in 2015 that was likely misinterpreted by the public and was certainly misinterpreted by the media. The Medical Association was vocal on this issue during 2015 on the need for significantly more context from CMS when releasing any physician data and for more thorough review of information before it is published as many physicians were tagged with inaccurate payment data.

Expanding Veterans' Access to Care

Despite passage of legislation in 2014 expanding access to non-VA physicians for some veterans, much more needs to be done in order to ensure our veterans can receive the care they deserve. A new VA facility was opened in Montgomery in late 2015. As well, additional funds were made available through the omnibus appropriations bill and set aside for improving the VA EHR system. Any expansion of access should have quality as its top concern.

Repeal of ACA's Non-Discrimination Clause

Section 2706 of the ACA provides that insurance plans cannot discriminate in payments for services provided by non-physicians when those same services are covered if provided by physicians and if the service provided is within the scope of practice of the non-physician. Significant differences can exist between the quality of a service provided by a physician and the same service provided by a non-physician. No action was taken on this during 2015, but the Medical Association and other state and specialty societies continue to push for repeal.

Physician Compare Website

CMS continues to add limited data sets of physician groups participating in a number of Medicare quality initiatives to the Physician Compare website. The agency has admitted to flaws in the operations of this program and this is especially concerning given that CMS uses these scores to alter Medicare payment rates under its value-based reimbursement models and physicians could face penalties in 2016 if they do not report their results to CMS.

Net Neutrality

The FCC this year moved to essentially keep the Internet neutral by barring Internet Service Providers from creating tiered systems where users could pay more for faster Internet speed and some users opting for slower speeds could be barred from sending or receiving data. The one area where the FCC said ISPs could charge more for was certain health care service data including remote heart monitoring. Though it has not launched a formal investigation, the FCC sent letters late this year to three internet service provider/data companies seeking more information about new services they are offering that could circumvent net-neutrality rules.

Breast Cancer Screening

Via the Omnibus Spending Bill, recommendations issued by the U.S. Preventive Services Task Force on breast cancer screening, mammography and prevention were blocked for two years.

Medical Device Tax

Via the Omnibus Spending Bill, a two-year moratorium on the medical device tax was imposed.

"Cadillac tax"

Via the 2016 tax package that at press time had not been, but is expected to be approved by Congress, a two-year delay of the so-called "Cadillac tax" on benefit-rich health insurance plans (for 2018 and 2019) as well as a one-year delay of the health insurance tax (for 2017) will be imposed.

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*Send article submissions and comments to Charlotte Morris at **cmorris@alamedical.org** two weeks in advance. Scope is printed bimonthly. Comments and letters to the editor are welcome.*