AMA Advocacy Update – April 2018

The AMA is pleased to provide the following advocacy update for the Southeastern Delegation to the AMA. We continue to make progress on key issues for physicians and patients, and truly value our collaborative partnership with the Southeastern Delegation in these efforts.

Health Care Provisions of the Bipartisan Budget Act

The Bipartisan Budget Act of 2018, signed into law on February 9 (P.L. 115-119), addressed a number of health policy issues of interest to physicians. With respect to physician payment issues, the new law includes a number of Medicare Access and CHIP Reauthorization Act (MACRA) refinements requested by the AMA:

- Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System (MIPS) payment adjustments and from the low-volume threshold determination.
- The Centers for Medicare and Medicaid Services (CMS) may reweight the MIPS cost performance category to not less than 10 percent for the third, fourth and fifth program years (rather than requiring a weight of 30 percent in the third year).
- CMS has more flexibility in setting the MIPS performance threshold for years three through five to ensure a gradual and incremental transition to the threshold being set at the mean or median performance level in the sixth year.
- The Physician Focused Payment Model Technical Advisory Committee may provide initial feedback regarding the extent to which alternative payment model proposals meet criteria and an explanation of the basis for the feedback.

In addition, the law:

- Extends the work geographic practice cost index (GPCI) floor for an additional two years;
- Eliminates a requirement that EHR meaningful use standards become more stringent over time;
- Permanently repeals the Independent Payment Advisory Board (IPAB);
- Extends authorization and funding for the Children's Health Insurance Program (CHIP) for 10 years;
- Funds community health centers, National Health Service Corps, and Teaching Health Center Graduate Medical Education programs for two more years; and
- Permanently repeals outpatient therapy caps.

Unfortunately, the law also reduces the Medicare physician fee schedule conversion factor update for 2019, from the 0.5 percent scheduled in MACRA to 0.25 percent. However, this is more favorable language than earlier House-passed language that would have extended the expiring "misvalued codes" provision for an additional year in 2019. The AMA estimated that the House misvalued codes provision would have reduced the 2019 update by 0.45 percent. In addition, rejection of the policy is an important outcome for future budget savings exercises in which the ill-conceived policy could have been further extended.

Consolidated Appropriations Act

The Consolidated Appropriations Act of 2018 (P.L. 115-141), signed into law on March 23, is the last spending bill Congress will pass for the current fiscal year; no more continuing resolutions will be required prior to September 30. This law built upon spending parameters established by the Bipartisan Budget Act and included funding for a number of health programs:

- Nearly $4 billion for prevention, treatment, and law enforcement efforts targeted at addressing the opioid epidemic;
- An 8.8 percent budget increase for the National Institutes of Health;
- Funding for the National Diabetes Prevention Program ($25.3 million), the Rural Residency Program ($15 million); mental health programs ($2.3 billion); and the Children's Hospital Graduate Medical Education Program ($315 million);
- Additional funding to support telehealth expansion in the Veterans Health Administration and for rural health under the Department of Health and Human Services; and
- $350 million and expanded eligibility for the Public Service Loan Forgiveness Program.

Unfortunately, Congress failed to reach agreement on individual insurance market stabilization measures, immigration reform, or reauthorization of the VA Choice Program.

Regulatory relief

Regulatory relief, particularly for smaller, independent practices, is a high priority for the AMA. Some of our most recent successes to reduce onerous administrative burdens on the federal level include:

- A $22 million reduction in Medicare Physician Quality Reporting System (PQRS) penalties;
- Reimbursement to physicians from Recovery Audit Contractors for pulling medical records;
- Improvements to the Merit-based Incentive Payment System (MIPS); and
- A beneficiary look-up tool for use by physicians as Social Security numbers are removed from beneficiaries' Medicare cards.

The AMA embraced the Trump Administration's emphasis on regulatory relief and convened a Federation workgroup to help identify government regulations that impose significant burdens on physicians. These efforts produced an extensive list of issues for which the AMA is seeking relief. In addition, we will soon be convening focus groups of physicians and practice managers to further refine and prioritize our regulatory relief agenda.

Prior authorization

Prior authorization (PA) is another issue that continues to be a major concern among physicians due to patient care delays and practice burdens. To establish a solid evidence base to support PA reform advocacy, the AMA conducted a survey of 1,000 practicing physicians in December 2017. The new survey results establish the significant impact that PA burdens can have on timely patient care. Among surveyed physicians, 64 percent reported waiting at least one day for PA decisions from health plans, while 30 percent reported waiting at least three business days.

Not surprisingly, 92 percent of physicians said that PA can delay access to necessary care. These delays may have serious implications for patients, as 78 percent of physicians reported that PA can lead to treatment abandonment, and 92 percent indicated that PA can have a negative impact on patient clinical outcomes. The survey results also capture the significant impact of PA on physicians. An overwhelming majority (84 percent) of physicians characterized PA-related burdens as high or extremely high. Moreover, PA hassles have been growing over time, with 86 percent of physicians reporting that PA burdens have increased over the past five years.

This data reinforces the need for strong reform efforts. The AMA has undertaken a major campaign to urge health plans to "right-size" PA programs. In January 2017, the AMA and a coalition of 16 other organizations (including North Carolina Medical Society) released a set of 21 Prior Authorization and Utilization Management Reform Principles. Over 100 additional provider and patient groups, including many members of the Southeastern Delegation, have signed on to the principles as formal supporters.

The principles have spurred conversations with health plans about the need for significant reform in PA programs. One result of these discussions was the January 2018 release of the Consensus Statement on Improving the Prior Authorization Process by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. This document reflects an agreement between provider and health plan organizations to pursue PA reform in several key areas, including reduction in the overall volume of PAs, improved transparency and communication, protection of continuity of care, and automation to increase process efficiency.

Physicians struggle with PA not only from private payers, but also with Medicare Advantage (MA) and Medicare Part D drug plans. The AMA is using the consensus statement as a springboard for our regulatory relief efforts with CMS. We are urging the agency to take a number of steps to reduce the practice burden and the delays in patient care, such as limiting PA requirements to "outlier" physicians, eliminating requirements for treatments that no longer warrant PA, and improving plan transparency and communication about PA requirements.

State legislative efforts also play a critical role in the AMA's campaign to improve PA processes, and the AMA is working with state and specialty societies to enact legislation. The AMA offers model legislation that continues to serve as the basis for many of the state bills and provides resources and support for these efforts. This year alone, more than 20 states are addressing utilization management reform in their legislatures.

The AMA also offers educational resources to help physicians and their staff reduce the manual burdens associated with PA and transition to automated processes. A new, three-part educational video series describes the current impact of the PA workload on physician practices, demonstrates the workflow improvements and other advantages of implementing pharmacy electronic PA transactions that integrate with electronic health record systems, and offers tips on how practices can start using this technology. Access these videos, along with additional resources and information about the AMA's advocacy efforts on PA reform, by visiting ama-assn.org/prior-auth.

Health care mergers

Several Southeastern Delegation states participated in an AMA-led coalition aimed at defeating the proposed mergers of Aetna-Humana and Anthem-Cigna. Our strong collective advocacy resulted in the blocking of these mergers in 2017, and a savings, for physicians, of $500 million annually from the Anthem-Cigna merger alone.

Coming on the heels of this successful effort, CVS and Aetna, as well as Cigna and Express Scripts, announced proposed mergers. These would be vertical mergers between non-competing companies, and the companies have claimed that the mergers will benefit patients. The AMA is currently analyzing the potential impact of both mergers and has urged Congress to closely scrutinize the CVS-Aetna merger.

The AMA submitted a statement to the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law in anticipation of a Feb. 27 hearing on competition in the pharmaceutical supply chain. The statement expresses the AMA's primary concern which is that the proposed mergers have the potential to decrease competition in three already poorly performing markets: pharmacy benefit manager services, local health insurance markets, and many local pharmacy markets. The AMA will continue to scrutinize merger activity closely moving forward.

Modifier 25 payment reduction policy withdrawal

At its 2017 Interim Meeting, the AMA House of Delegates established new policy to advocate against payment reductions for evaluation and management (E&M) codes appropriately reported with a Current Procedural Terminology (CPT) modifier 25. Considerable concerns regarding this issue have been raised by many state medical associations and national medical specialty societies, most recently in regard to health insurer Anthem's proposed policy to reduce payments by 50 percent for E&M services billed with CPT modifier 25 when reported with a minor surgical procedure code or a preventive/wellness exam beginning in the first quarter of 2018.

In November 2017, the AMA sent a letter to Anthem requesting that it immediately halt plans to implement its modifier 25 payment reduction policy. Following this letter and a meeting with AMA leadership in December, Anthem adjusted its proposed policy to reduce payments for E&M services reported with CPT modifier 25 by 25 percent instead of 50 percent, as originally planned. The AMA continued to voice strong objections to this unwarranted reduction in physician payment and presented additional supporting information showing that the recommendations of the AMA/Specialty Society Relative Value Scale Update Committee do not include duplicative physician work or practice expense for procedures typically billed with an E&M service on the same date. Many state medical associations and national medical specialty societies also continued strong advocacy efforts to urge Anthem to rescind this policy, which would impede the provision of unscheduled, medically necessary care.

Following a second meeting with the AMA in February 2018, Anthem Executive Vice President and Chief Clinical Officer Craig E. Samitt, MD, wrote to AMA Chair-elect Jack Resneck Jr., MD, and indicated that the company would not be proceeding with its modifier 25 payment

reduction. The AMA welcomed this news, as this policy would have had a significant nationwide impact on physician practices and the delivery of prompt patient care. The AMA also was pleased by Anthem's recognition of the need for a different type of collaborative dialogue and engagement between health plans and the physician community to improve health care quality, access, and affordability.

Additionally, Anthem has expressed commitment to continuing to work with the AMA, state medical associations, and national medical specialty societies to address physician concerns with other policies and guidelines. Concerns have been raised regarding Anthem's policies on the retrospective denial of payment for emergency room visits, restrictions on advanced imaging in hospital outpatient facilities, and the denial of payment for monitored anesthesia care or general anesthesia for cataract surgery. The AMA will continue to work with the Federation of Medicine to address these other problematic Anthem policies.

State activity

The AMA's Advocacy Resource Center (ARC) works to help shape and inform state laws, regulations and policies in support of patients and physicians. ARC staff work directly with state medical associations to enact laws and enhance the practice of medicine – and to defeat those laws that would create barriers to high-quality care. From 2017 to the present, the AMA has worked through the ARC with Southeastern Delegation states to either enact or defeat over 30 pieces of state legislation and regulation.

Top priority issues that exemplify this powerful collaboration (listed by state) include:

- **Alabama** (Medicaid, reversing the opioid epidemic)
- **Delaware** (Medicaid, prior authorization, end of life)
- **District of Columbia** (Medicaid, interstate medical licensure compact, sunscreen in schools, end of life, health insurance mergers, reversing the opioid epidemic)
- **Florida** (Medicaid, prior authorization, advance practice nursing independence, optometry and surgical authority, health insurance mergers, reversing the opioid epidemic)
- **Georgia** (prior authorization, balance billing, problematic insurer policies such as retrospective ER denials, Scope of Practice Partnership [SOPP] steering committee member, advance practice nursing independence, optometry and surgical authority, interstate medical licensure compact, sunscreen in schools, distracted driving, health insurance mergers, reversing the opioid epidemic)
- **Kentucky** (Medicaid, prior authorization, balance billing, problematic insurer policies such as retrospective ER denials, medical liability reform, sunscreen in schools, health insurance mergers)
- **Louisiana** (Medicaid, SOPP steering committee member, sunscreen in schools, reversing the opioid epidemic)
- **Maryland** (network adequacy, truth in advertising, interstate medical licensure compact, medical liability reform, sunscreen in schools, health insurance mergers, reversing the opioid epidemic)

- **Mississippi** (Medicaid, telemedicine, advance practice nursing independence, licensure of naturopaths, medical board licensing issues, business of medicine issues, reversing the opioid epidemic)
- **New Jersey** (balance billing, market stabilization efforts, telemedicine, truth in advertising, medical board licensing issues, tobacco, reversing the opioid epidemic)
- **North Carolina** (Medicaid, advance practice nursing independence)
- **South Carolina** (reversing the opioid epidemic)
- **Tennessee** (Medicaid, balance billing, network adequacy, fairness in contracting, advance practice nursing independence, reversing the opioid epidemic)
- **Virginia** (Medicaid, prior authorization, SOPP steering committee member, advance practice nursing independence, physician assistant issues, medical board licensing issues, sunscreen in schools, health insurance mergers, reversing the opioid epidemic)
- **West Virginia** (prior authorization, physician assistant issues, business of medicine issues, certificate of need, reversing the opioid epidemic)