

May 18, 2019: National Advocacy Update

Federal Pain Task Force outlines road map for future policy

The AMA provided strong support for the final report and recommendations of the U.S. Department of Health and Human Services (HHS) Interagency Payment Management Best Practices Task Force, which were approved at its May 9-10 meeting. The recommendations call for reversing harmful policies such as arbitrary limits on prescribed pain medications and one-size-fits-all approaches, instead treating each patient as an individual.

The task force also seeks more support for multidisciplinary, multimodal pain care, better and more equitable health insurance coverage of non-opioid medications and non-pharmacologic treatments for pain, and recognizes an urgent need to address stigma faced by patients with pain and/or substance use disorders.

AMA President-elect Patrice Harris, MD, MA, participated in a roundtable discussion with task force members about dissemination and implementation of its recommendations. Dr. Harris emphasized the need to identify systematic and sustainable solutions to pain care and the epidemic of opioid-related overdose deaths, so that as a nation we can stop lurching from crisis to crisis and achieve a state of perpetual readiness.

The AMA will work to widely disseminate the final report once it is available.

AMA to Congress: Patients pay painful price for high drug costs

New, life-altering pharmaceutical discoveries are expected to be expensive. Dermatologist Jack Resneck Jr., MD, chair of the AMA Board of Trustees, understands that. In testimony to Congress, he highlighted the personal impact of prescription drug costs. These are prices that can rise dramatically even for drugs that have been on the market for years or even decades, such as etanercept or adalimumab (marketed as Enbrel and Humira, respectively).

“I currently have a patient unable to afford the Enbrel or Humira that would alleviate his psoriasis and painful psoriatic arthritis—the average wholesale prices for a year of these drugs, both out for more than 15 years—has quadrupled to around \$80,000 per year, and his PPO copay is 40% until he reaches his deductible,” Dr. Resneck said in his testimony. “So, he stopped his treatment.”

The U.S. spends nearly \$334 billion a year on prescription drugs, and that accounts for nearly 10% of the nation’s total health care bill. In addition to high dollar amounts, Dr. Resneck told members of Congress, the price patients must pay includes sleepless nights and living in pain because they cannot get the medications they need.

“Physicians see every day that costs are a major obstacle to our patients getting the right medication at the right time,” said Dr. Resneck during his testimony at a May 9 House Energy and Commerce Committee Health Subcommittee hearing on lowering prescription drug prices.

Prescription drug price increases can lead some patients to not be able to afford critical medicine, causing them to skip doses of their medications or split pills, or force them to abandon treatment altogether.

Read more here.

Trump Administration finalizes rule to mandate list prices in drug advertisements

On May 8, HHS finalized an earlier proposal that would require prescription drug manufacturers to disclose the prices of those drugs in some direct-to-consumer advertisements. The final rule requires manufacturers to disclose the wholesale acquisition cost, essentially the list price, of their drugs in all television advertisements. The requirement applies to drugs where the monthly cost of a typical treatment regimen is over \$35 and does not apply to print or internet advertisements.

The AMA strongly supports the new requirement (PDF), calling the move a meaningful step towards much-needed transparency in the prescription drug marketplace. The AMA continues to work with the administration and with Congress to ensure transparency throughout the drug supply chain and that policy changes result in meaningful impacts for patient out-of-pocket costs.

AMA supports bipartisan legislation to extend and expand Conrad 30 waiver program

The bipartisan Conrad State 30 and Physician Access Reauthorization Act, S. 948 (PDF), has been introduced in the Senate to reauthorize and improve a program that provides access to care in underserved communities. The AMA helped draft this legislation and voiced its support (PDF) in a letter to sponsors of the bill.

Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. Since 1994, the Conrad 30 waiver program has enabled more than 15,000 non-U.S. physicians to provide care in medically-underserved communities.

The Conrad State 30 and Physician Access Reauthorization Act would:

- Reauthorize the J-1 visa waiver program for an additional three years, protecting patient access to care in medically underserved area
- Make improvements to the program by requiring more transparency in employment contract terms
- Create additional waivers per states
- Protect spouses and children of physicians in the program

The legislation would also address the current physician green card backlog exacerbated by the statutory per-country cap for employment-based green cards. Physicians who practice in underserved areas for five years would be eligible to receive priority access within the green card system.

White House releases surprise billing principles

On May 8, the White House released principles and a fact sheet on developing solutions to “surprise billing,” which affects patients who receive unanticipated and sometimes large balance bills from out-of-network physicians in circumstances where they had no opportunity to choose who would be involved in their care.

The AMA supports the need for federal legislation to protect patients in these situations but has several concerns with some of the approaches that have been suggested, including some of the principles outlined by the White House. The AMA is working with specialty societies to raise awareness about insurers’ contributions to the problem as well as the challenges of proposals that would tie out-of-network billing to Medicare or contracted rates, bundling hospital and provider payments into a single bill, and other issues. The activity now moves to Capitol Hill, where it is anticipated that bipartisan legislation will be introduced in the next several weeks. The AMA will

continue to actively engage both the administration and Congress.

AMA, AHA issued comments to CMS on ABPM coverage expansion

In May 2018 the AMA and the American Heart Association (AHA) urged the Centers for Medicare & Medicaid Services (CMS) to expand the covered indications for ambulatory blood pressure monitoring (ABPM) coverage for Medicare beneficiaries to include the diagnosis of hypertension. As a result of this advocacy, CMS proposed a coverage expansion related to ABPM for confirming a diagnosis of hypertension. On May 9, 2019, the AMA and AHA jointly submitted comments on what CMS has proposed, which expands the covered indications for ABPM to include masked hypertension. The AMA and AHA encourage Medicare's ABPM coverage policy to be consistent with recent changes to the thresholds used for diagnosing hypertension.

Target: BP™ is a national collaboration between AHA and AMA to reduce the number of Americans who have heart attacks and strokes by urging physician practices, health systems and patients to prioritize blood pressure control.

The 2017 American Heart Association/American College of Cardiology Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults states that office based blood pressure measurements lack the precision and reproducibility needed to make an accurate diagnosis of hypertension, and thus, out-of-office blood pressure measurements are recommended to confirm a diagnosis of hypertension. This is consistent with the 2015 U.S. Preventive Services Task Force recommendation for obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

A final decision is expected July 2019.

MACRA, two years later: Nine ways to make it better

The Medicare Access and CHIP Reauthorization Act (MACRA) remains a work in progress, but there are several specific steps Congress can take with MACRA and its Quality Payment Program (QPP) that will help physicians succeed and advance patient care.

“The QPP is a complex program that remains challenging for CMS to implement and difficult for physicians to understand,” AMA President Barbara L. McAneny, MD, told the U.S. Senate Finance Committee at a May 8 hearing. “However, the AMA is confident that if Congress, CMS and the

medical community continue to work together to improve the program, we can ensure physicians have the opportunity to be successful and provide high value care to patients.” To improve MACRA programs, Dr. McAneny prescribed three priorities: continue support for small and rural practices, extend the bonus period for physicians investing in advanced alternative payment models (APM), and replace the scheduled payment freeze with annual updates. Dr. McAneny also outlined six suggested technical adjustments.

“We believe the goal of the program should be to help physicians succeed, not to cause physicians to fail, and we believe these technical changes, along with other changes, will allow CMS to increase the program requirements gradually and transition to a more meaningful program over time,” Dr. McAneny said.

She added that, despite all the changes that need to be made, the QPP remains an improvement over the sustainable growth rate (SGR) payment formula that it replaced.

Read more here.

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