Feb. 22, 2018: National Advocacy Update

Energy and Commerce Committee advances Good Samaritan legislation

On Feb. 14, the House Energy and Commerce Committee unanimously voted to advance H.R. 1876, the Good Samaritan Health Professionals Act of 2018. The AMA strongly supports this bipartisan legislation. The bill, introduced by Reps. Marsha Blackburn (R-TN), Dutch Ruppersberger (D-MD), Ami Bera, MD (D-CA), Phil Roe, MD (R-TN), Larry Bucshon, MD (R-IN), and David Scott (D-GA), would limit the civil liability of volunteer health professionals who provide their services to disaster victims during a federally declared disaster.

The current patchwork of federal and state laws to encourage medical volunteerism during emergencies is inconsistent and often unclear, especially when applied to large-scale disasters that may cross state lines. This has resulted in qualified health care volunteers being turned away during disasters, such as 9/11 and Hurricane Katrina, due to liability concerns, hampering efforts to provide needed care to disaster victims. H.R. 1867 would ensure volunteer health care providers receive clear federal Good Samaritan protection when surges from private citizens are needed.

It is not yet known when the full House of Representatives will consider the measure. Senators Bill Cassidy (R-LA), Angus King (I-ME), and Joe Manchin (D-WV) have introduced the Senate companion bill, S. 781.

Senate Finance Committee seeks stakeholder input on opioid abuse

The AMA sent a letter (PDF) to Senate Finance Committee Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) on Feb. 16, in response to their Feb. 2 letter requesting recommendations in the Committee's jurisdiction to address the opioid epidemic. While there is more work to be done, the letter highlighted that the medical profession's collective efforts are having an impact, with opioid prescriptions in the United States decreasing by 43 million—a nearly 17 percent decrease nationally—from 2013 to 2016. Federal payment and delivery system reforms provide opportunities to better support clinicians' efforts.

The AMA's recommendations to the Committee include:

- Creating a seventh protected class of drugs under Medicare Part D for medication-assisted treatment;
- Improving coverage and eliminating payment barriers for Medicare Advantage and Part D Plans;
- Allowing Medicare to coverage methadone;
- Ensuring that quality measurement does not lead to inappropriately treating pain;
- Supporting alternative payment models for opioid therapy;
- Increasing inpatient treatment capacity under Medicaid and waiving or repealing Medicaid's 15-bed IMD limit;
- Encouraging electronic prescribing of controlled substances (EPCS); and
- Supporting and expanding innovative Medicaid waivers to improve treatment.

New electronic clinical quality measure on potential opioid overuse cause for concern

The Centers for Medicare and Medicaid Services (CMS) contracted with Mathematica Policy Research to develop a new electronic clinical quality measure (eCQM) on potential opioid overuse. The agency recently sought comments on the measure, which focuses on the percentage of patients aged 18 years or older who receive opioid therapy for 90 days or longer, and who are prescribed a 90 milligram or greater morphine milligram equivalent (MME) daily dose.

In its comments to CMS (PDF), the AMA highlighted that quality measures pertaining to opioid use should focus on how well patient pain is controlled, whether functional improvement goals are met, and what therapies are being used to manage pain. When pain can be well controlled and function improved without high doses of opioids over a long period of time, there is a good indication of high-quality patient care. However, focusing on reducing opioid doses alone, such as opioid prescriptions that exceed 90 or more MME per day, is not an appropriate goal. Daily dose amounts may serve an indicator of whether a patient is at risk of overdose and should be co-prescribed naloxone, but do not

signal that a physician provides poor quality care.

In addition, the letter highlighted that calculated MMEs may vary between tools for certain opioids, depending on the algorithm used. These calculations also fail to account for individual patient characteristics and the great potential for patients not receiving necessary care. Furthermore, the AMA highlighted its concern about the feasibility of directly calculating the measure from the electronic health record (EHR) because the measure relies on a function that is not consistently supported by EHR vendors. The AMA will monitor progress on the measure and continue to advocate for changes based on its disagreement over the fundamental premise of the measure.

RACs now required to reimburse physicians for the cost of pulling medical records

In a policy reversal, the Centers for Medicare and Medicaid Services (CMS) directed the Recovery Audit Contractors (RAC) to reimburse physicians for the cost of printing and mailing medical record documentation. CMS indicated that it is working on a change to the Program Integrity Manual (PIM) language to reflect this new policy.

This is how one RAC contractor explained the change in a question and answer on its website: "Per CMS and the PIM guidelines, institutional providers will receive 0.12 cents per page + 1st class postage and non-PPS providers receive 0.15 cents per page + 1st class postage. An additional $2 is added for esMD submissions in lieu of postage. The maximum payment to a provider per medical record shall not exceed $25. Performant."

The AMA has long sought this policy change and continues to advocate that other CMS contractors reimburse physicians for the cost of pulling medical records.

New proposed RAC review topics posted to CMS website

The Centers for Medicare and Medicaid Services (CMS) has posted nine proposed Recovery Audit Contractor (RAC) Review Topics to its website. This was the result of a recommendation made by the AMA and medical specialty societies to provide feedback on possible RAC review. Medical societies and physicians now get to provide input before CMS approves a topic as appropriate for the RACs to audit.

Below are the titles of the nine proposed RAC review topics:

- Lab Services Rendered During an Inpatient Stay
- Cataract Removal – Excessive Units by Physician (Partial Denial)
- Cataract Removal – Excessive Units by Physician (Full Denial)
- Ancillary Services Billed without an Approved Surgical Procedure
- CSW (Clinical Social Workers) during Inpatient Stay
- Technical Component of Lab/Pathology for Outpatient Hospitals
- Labs Subject to Part B Consolidated Billing by Clinical Lab – End Stage Renal Disease (ESRD)
- Observation Evaluation & Management (E&M) Services Billed Same Day as Inpatient Admission
- Ventilators Subject to ACA Requirements Prior to January 1, 2016

The proposed topics were posted to the CMS website at the following URL on Feb. 14 and will be available for comment for 30 days. After 30 days, CMS will evaluate whether to allow the RACs to proceed with the audits. If CMS approves the topics, the RAC(s) will post them to their respective RAC websites for an additional 14 days, prior to beginning the reviews.

AMA suggests areas of study to improve CMS's readmission reduction program

The AMA recently sent a letter to CMS (PDF) recommending further study of the Hospital Readmission Reduction Program (HRRP) in order to improve the program. The letter was sent in response to an article recently published in the *JAMA Cardiology* in which the authors described an association between implementation of the Centers for Medicare and Medicaid Services (CMS) HRRP and an increase in mortality for fee-for service Medicare beneficiaries discharged after a heart failure admission.

To better understand the significance of the authors' findings within the larger body of literature on readmissions, and out of concern that a government-sponsored program might be leading to negative unintended consequences, the AMA performed a literature search to evaluate whether the article's conclusions could be replicated. Because the published literature uses inconsistent data sources and varying versions of the CMS readmission measures, the results of the AMA's literature search to confirm the study's findings were inconclusive. However, the results did raise additional questions that the AMA urged CMS to review and study. The AMA will continue to monitor the HRRP and advocate for changes in the program so the healthcare system, including physicians and providers, have better tools for discriminating between necessary or unnecessary admissions.

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