

Dec. 28, 2017: National Advocacy Update

Tax Cuts and Jobs Act enacted; repeals the ACA individual mandate

Last week, both the House and Senate passed H.R. 1, the Tax Cuts and Jobs Act. The bill passed on partisan votes of 51–48 in the Senate and 224–201 in the House. President Donald Trump signed the bill into law on Dec. 22. The bill overhauls the individual, corporate and international components of the existing federal tax code. It includes recommendations highlighted in an AMA letter (PDF) sent to the conferees.

Specifically, the final bill includes language that would maintain the tax deductibility of high medical expenses, and also lower the percentage of a person's adjusted gross income that qualified medical expenses must exceed—from 10 percent to 7.5 percent for 2017 and 2018—in order to claim the deduction. In addition, the final bill adopted the AMA's recommendation to maintain the deduction for student-loan interest and the exemption from taxation for qualified tuition reductions. Despite the urging of the AMA and many other health care stakeholders, the final bill included language that effectively repeals the individual responsibility provisions of the Affordable Care Act by zeroing out the tax penalty for individuals who fail to maintain health care insurance coverage.

Congress passes temporary funding bill

As lawmakers raced for the exits at the conclusion of the first session of the 115th Congress last week, many important health care-related issues remained on the to-do list. Prior to adjourning, Congress passed yet another temporary funding bill to keep the government operating, this time until Jan. 19. Also included in that legislation were provisions for a three-month extension of the Children's Health Insurance Program (CHIP) as well as short-term funding for Community Health Centers, the National Health Service Corps and Teaching Health Centers GME, offset in part by a \$750 million reduction to the Prevention and Public Health Fund.

The bill also provided a six-month extension for the VA Choice program and waived requirements under the law that would have required annual Medicare cuts of 4 percent over the next ten years to partially offset the deficits produced by the recently passed tax cut legislation.

When Congress returns in January, they will have roughly two weeks to tackle a mountain of expired programs and policies—including dozens of health care items—if they are going to be included in final legislation funding the government for the fiscal year that began in October 2017. In addition to providing needed stability by reauthorizing CHIP and the other public health programs which were temporarily extended in last week's bill, Congress hopes to extend multiple expiring Medicare provisions, consider legislation providing stability for insurance markets in the wake of the effective repeal of the individual mandate, and advance legislation improving chronic care.

The AMA and other physician organizations are also urging the inclusion of provisions to improve the implementation of the Merit-based Incentive Payment System component of the Quality Payment Program, as well as make other technical improvements to the Medicare Access and CHIP Reauthorization Act. Additionally, the clock is ticking and the pressure is growing for Congress to act to resolve the status of immigrants whose protections under the Deferred Action for Childhood Arrivals program will expire in March.

Prior to leaving, Congress also passed legislation providing for \$81 billion in supplemental spending for areas impacted by recent hurricanes and wildfires. This spending did not, however, include desperately needed support for Puerto Rico's health care system, though it did increase funding for the Medicaid program on that island and in the U.S. Virgin Islands.

Anthem reduces proposed cut for services reported with modifier 25; AMA pursuing further changes

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 Anthem's new policy, planned for implementation in the first quarter of 2018, 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.

In late November, the AMA sent a letter to Anthem requesting that the company immediately halt plans to implement its modifier 25 payment-reduction policy. At a subsequent meeting with senior Anthem leadership, the AMA provided information clarifying how the recommendations of the

AMA/Specialty Society Relative Value Scale Update Committee (RUC) do not include duplicative physician work or practice expense for procedures typically billed with an E&M service on the same date. The AMA also provided Anthem with further supportive data on those procedures for which practice expense already has been reviewed by the RUC and, using Medicare payment data, shared many procedure codes for which implementation of the proposed policy would result in steep physician payment cuts after accounting for direct expenses.

Anthem recently informed the AMA that it still plans to reduce payments for E&M services billed with CPT modifier 25, but that payments will be reduced by 25 percent instead of 50 percent, as originally planned. Additionally, the policy will be effective March 1, 2018, in all states where physicians have been notified of the policy change (California, Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, New Hampshire, Nevada, New York, Ohio, and Wisconsin), which represents an implementation delay for some states. The policy will also be effective upon network contract renewal in Georgia and Virginia.

While this adjustment is an improvement on Anthem's original planned policy, the AMA still strongly opposes this unjustified reduction of physician payment. The AMA will pursue a follow-up meeting with Anthem in early 2018 to present additional evidence to challenge the revised policy and work with state medical associations and national medical specialty societies to secure further changes from Anthem on this issue. The AMA will also continue to collaborate with the Federation of Medicine to address other recent problematic policy changes implemented by Anthem, including those related to hospital outpatient imaging and retrospective review of payment for emergency services.

HHS Office of Civil Rights issues new guidance on information sharing

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) has issued new guidance in response to the opioid crisis aimed at ensuring that patients and family members receive necessary information in the event of an emergency, such as an opioid overdose or mental health crisis. It created two new Health Insurance Portability and Accountability Act (HIPAA) webpages focused on information related to mental and behavioral health, one for professionals and another for consumers.

The webpages contain guidance on sharing information related to mental health and substance-use disorder treatment with a patient's family, friends and others involved in the patient's care or payment for care. These materials include fact sheets, an infographic, decision charts, materials specifically tailored to the parents of children who have a mental health condition, and illustrative scenarios that address sharing information when an individual experiences an opioid overdose.

Survey highlights increased need for cybersecurity

A recent first-of-its-kind physician survey, sponsored by the AMA, has signaled a call to action for the health care sector to increase cybersecurity support for medical practices. The findings, which examined the experiences of roughly 1,300 physicians, underscore the recognition that it is not "if" but "when" a cyberattack will occur. More than four in five U.S. physicians (83 percent) have experienced some form of a cybersecurity attack. These findings help bolster the AMA's advocacy efforts to ensure physicians have the right resources, tools, and support to protect their patients' health and data.

The AMA is advancing the message that cybersecurity is not just a technical issue but also a patient safety issue. The AMA will work with health IT developers, health systems, and the federal government to better empower physicians to be advocates for their patients and promote a shared responsibility to secure electronic information. Information on the survey and additional resources are available on the AMA's website.

Physician-focused payment models recommended to HHS

The federal Physician Focused Payment Model Technical Advisory Committee (PTAC) met in December to review seven proposed models and recommended two of them to Department of Health and Human Services (HHS). Both of the recommended models had been supported by the AMA.

The first is a proposal from the Renal Physicians Association for a model to improve the transition of patients from chronic kidney disease to end stage renal disease and dialysis. This transition period is often marked by high rates of hospital admissions, complications, and mortality. The model will help improve patient treatment planning and care coordination during the crucial first six months of dialysis. The second recommended model was developed by the American Academy of Family Physicians and would greatly expand Medicare patients' access to primary care medical homes. During the debate on the PTAC recommendation, one PTAC member said that the lack of a nationwide medical home model after so many years of pilot projects should be viewed as a national

embarrassment.

Despite APM participation, fee for service still dominates

Based on the AMA's Physician Practice Benchmark Survey, a new Policy Research Perspective (PDF) examines participation in medical homes, accountable care organizations, and alternative payment models. The PRP highlights the continued importance of FFS in physician practices.

Although 59.1 percent of physicians were in practices that received payment from at least one APM in 2016, FFS remained the dominant source of practice revenue with an average of 70.8 percent of practice revenue coming from this method, similar to what was observed in 2012 and 2014. The PRP also found that 25.7 percent of physicians were in a practice that belonged to a medical home, and participation rates for ACOs ranged from 20.9 percent for Medicaid ACOs to around 32 percent for Medicare and commercial ACOs. About 25 percent of physicians did not know if their practice belonged to a medical home or Medicare ACO. Rates of uncertainty were higher, around 31 percent, for Medicaid and commercial ACOs.

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Staying on track for 2017 MIPS reporting: Pick your pace

At this point in the year, physicians should verify that they that they are on the right path for their goals for the Medicare Merit-based Incentive Payment System (MIPS). If not, they should take advantage of the "one patient, one measure" reporting option to avoid a 4 percent payment penalty in 2019.

In deciding which pick-your-pace participation track to choose, physicians should consider whether their focus will be earning a bonus or avoiding a penalty. They also need to determine which measures are the most feasible to report, and evaluate their capacity for submitting 90 or more days of data.

For physicians who have not collected quality or Advancing Care Information measures or completed improvement activities, or are confused by the MIPS process, the minimum reporting option may be the best course of action to take. The AMA "One Patient, One Measure, No Penalty" tutorial offers a step-by-step guide to complete the minimum-reporting process and help physicians avoid a 4 percent Medicare payment penalty for 2019.

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