Aug. 21, 2020: National Advocacy Update

Five things to know about the temporary Stark Law waivers

On March 30 the Secretary of Health and Human Services (HHS) issued blanket waivers of the Physician Self-Referral Law, otherwise known as the Stark Law. The waivers were retroactive to March 1, apply nationwide and remain in effect for the duration of the public health emergency (PHE).

The AMA will be recommending that HHS maintain the Stark Law waiver flexibilities until the end of the calendar year during which the PHE ends. This will give physician practices sufficient time to make alternative arrangements if they are, for example, renting equipment or space below fair market value.

Read five things to know about the temporary Stark Law waivers here.

As a result of the COVID-19 pandemic, the AMA has, and will continue to, develop resources for physician practices regarding temporary changes to the Stark Law and Anti-Kickback Statute. As these changes continue to evolve, the AMA will evaluate and provide timely updates to our AMA members.

AMA calls on Congress to preserve medical staffing levels in the military

As Congress is currently working on finalizing the Fiscal Year 2021 National Defense Authorization Act (NDAA), the AMA, along with 15 other medical associations, sent a letter to the members of the House Armed Services Committee and the Senate Armed Services Committee expressing support for provisions included in the draft House and Senate bills that would consider the needs of the members and families of the Armed Forces by addressing issues related to preserving the military medical workforce and transformation of the Military Health System (MHS). The administration’s FY20 Department of Defense (DoD) budget proposed to eliminate approximately 15,000 military health care billets and there were reports that DoD was planning to cut up to 18,000 medical positions as part of the Defense Health Agency’s (DHA) strategy to modernize the MHS.

However, the final FY20 NDAA limited these proposals, limiting any reductions or realignment of military medical end strength until further analyses and review could be conducted regarding potential workforce realignment and the availability of health care services in the local area and plans for transitioning of health care services. The AMA is strongly encouraging the committee to include
language in the final conference report that would ensure any reductions or realignment of military medical end strength cannot take place for at least one year following enactment, and after that period is over, not until the previously described analyses and reviews are completed. Additionally, the AMA is asking that any plans for restructuring Military Treatment Facilities be put on hold until either a year has passed since their submission to Congress or the enactment of the FY21 NDAA. Both of these things can be accomplished by adopting House section 704 and 705 into the final FY21 NDAA conference report.

Proposal on asylum seekers would legitimize discrimination

The AMA is strongly urging the Trump administration to withdraw a proposed rule that would deny asylum seekers entry to the U.S. by linking their country of origin, or the nations they travelled through, to the likelihood they have a communicable disease. "The AMA is concerned that the proposed rule would legitimize discrimination against vulnerable asylum seekers, create a right to refuse to provide certain treatments or services, and arbitrarily discriminate against individuals based on border patrol agents' uninformed medical determinations or an individual's country of origin," AMA Executive Vice President and CEO James L. Madara, MD, wrote in a letter to U.S. Attorney General William Barr, acting Homeland Security Secretary Chad Wolf and Deputy Director of U.S. Immigration and Customs Enforcement Matthew Albence. The letter outlines humanitarian and public health arguments against the proposed rule on "Reasonable Grounds for Denying Asylum Based on Communicable Diseases." According to Dr. Madara, the measure would:

- Place asylum seekers in greater peril and provide the U.S. Department of Homeland Security (DHS) and border-patrol agents with unwarranted and heightened authority that will be detrimental to the nation's health security.
- Weaken the principle of making public health determinations based on evidence.
- Hamper the ability of international medical graduates (IMG) to enter, train and practice in the U.S.
- Endanger the lives and safety of torture survivors.

The AMA is deeply committed to ensuring the health and safety of all individuals regardless of immigration status. "The AMA believes that physicians have a professional responsibility to advocate for social and political changes that ameliorate suffering and contribute to the well-being of all humans," Dr. Madara's letter says. The proposed rule would allow DHS and U.S. Department of Justice to unduly raise the bar for asylum seekers and make it close to impossible for survivors to succeed in Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) withholding of
removal or asylum-seeking claims based on their country of origin, path of travel, or likelihood of coming into contact with a disease. Read the full story here.

Physician-led team-based care safeguarded by the advocacy of organized medicine

Thanks to the Federation's advocacy efforts, CMS did not finalize its proposal to amend the Inpatient Rehabilitation Facility (IRF) coverage requirements to allow non-physician health care professionals to perform certain duties that are currently required to be performed by a rehabilitation physician. In the IRF Prospective Payment System Final Rule for 2021, CMS instead allowed that a nurse practitioner, physician assistant or clinical nurse specialist may perform one of the three required face-to-face visits in lieu of the rehabilitation physician in the second and later weeks of a patient's IRF stay, when consistent with scope of practice requirements under applicable state law. CMS is maintaining the leadership responsibilities of the rehabilitation physician, including the requirements to establish and implement the overall plan of care and lead the weekly conferences of the interdisciplinary care team.

The AMA joined the American Academy of Physical Medicine and Rehabilitation in raising a unified voice with more than 120 state and specialty societies, patient groups and other stakeholders to oppose the proposal that would have had a detrimental impact on patient care and set a dangerous precedent for removing physician supervision requirements in other health care settings. CMS heeded stakeholders' caution that undermining access to physician-led, patient-centered, team-based care in the rehabilitation setting would jeopardize the care for the extremely vulnerable patients receiving care in the IRF setting.

COVID-19 relief fund applications reopened for previously excluded physicians

The U.S. Department of Health and Human Services (HHS) has reopened the application portal for physicians and practices that see Medicare or Medicaid patients and have not yet received the maximum amount of relief funds available to them. HHS is providing up to 2% of historic total revenue from patient care to account for lost revenues and increased expenses as a result of the COVID-19 pandemic. Physicians who received a prior payment based on Medicare fee-for-service revenue that totaled less than 2% of their annual revenue or who rejected and returned the funds have another opportunity to reapply for additional funds. The deadline to apply is Aug. 28.

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EHR Reporting Program feedback

The Office of the National Coordinator for Health Information Technology (ONC) and its contractor, the Urban Institute, are in the process of developing an Electronic Health Record (EHR) Reporting Program to compile physician and other clinician perspectives on the usability and interoperability of EHRs. The AMA has long championed the need for physicians to be empowered consumers of EHR technology. To support this, physicians must have access to publicly available, comparative information on EHRs. This should include EHR use, costs, patient safety, data security and privacy. The AMA responded to Urban’s recent request for feedback on draft reporting criteria to inform the purchasing and implementation decisions of EHR users. It its comments, the AMA requested that Urban and ONC provide more clarity on the purpose of collecting feedback, the need to capture additional EHR functionality such as support for medical apps and social determinants of health data, a strong focus on an EHR's ability to protect and secure patient data, additional transparency on EHR costs and vendor contracts and several recommendations to heighten patient safety concerns. The AMA expects additional rounds of feedback and comment before the EHR Reporting Program goes live.

CMS fields tests and seeks feedback about potential MIPS cost measures

The Centers for Medicare & Medicaid Services (CMS) and its contractor, Acumen, LLC, are conducting field testing from Aug. 17 through Sept. 18 for five episode-based cost measures before considering their potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS). Field testing is an opportunity for clinicians and other stakeholders to provide feedback on the draft measure specifications of the cost measures. Feedback shared on these draft specifications will be used to consider potential measure refinements following field testing. Clinicians and clinician groups meeting the minimum number of episodes outlined below will receive a Field Test Report with information about their cost performance. Reports will be made available for the following measures:

- Asthma/Chronic Obstructive Pulmonary Disease (COPD)
- Colon and Rectal Resection
- Diabetes
- Melanoma Resection
- Sepsis


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CMS announces relief from 2020 MIPS due to COVID-19

CMS announced that physicians will have the option to opt-out completely or partially from the 2020 MIPS program by completing a hardship exemption application and indicating it is due to the COVID-19 Public Health Emergency (PHE). Individual clinicians and group practices have until Dec. 31 to complete the hardship application. CMS plans on providing physicians with a couple of options on the hardship exemption application. A practice may submit a hardship application and indicate that they do not want to be scored on Cost and Quality and have their score calculated based on just Promoting Interoperability and Improvement Activities. Alternatively, practices may submit a hardship application and opt-out of all four performance categories and be held harmless from a 2022 payment adjustment. Submitting any MIPS data to CMS will override the hardship exception application and physicians will be scored on their submission.

The AMA is glad CMS heeded its recommendations to create flexible reporting options in 2020 with the option to reweight any or all the MIPS performance categories. The flexibilities should assist with allowing practices to focus their attention on caring for patients during the pandemic and reduce administrative burden. The AMA will continue to monitor the impact COVID-19 is having on practices and advocate to CMS for the appropriate relief and ensure CMS liberally grants hardship requests due to the COVID-19 PHE.

The CMS website is in the process of being updated with the 2020 policy and should reflect the announcement along with additional educational materials in a few weeks. The information currently posted on the website is regarding the 2019 MIPS COVID-19 policy. CMS has also indicated that additional information on MIPS COVID-19 policy will be included in upcoming rulemaking.

2019 MIPS Performance Final Score and Targeted Review Process open until Oct. 5

CMS has released and posted the 2019 Merit-based Incentive Payment System (MIPS) program performance feedback, including individual and groups MIPS final score and payment adjustment factor(s), on the Quality Payment Program website. Your final score will dictate the payment adjustment you will receive in 2021, with a positive, negative, or neutral payment adjustment being applied to the Medicare paid amount for covered professional services furnished by a MIPS-eligible clinician in 2021.

MIPS-eligible clinicians, groups and virtual groups (along with their designated support staff or authorized third-party intermediary), including alternative payment model (APM) participants, may request CMS to review the calculation of their 2020 MIPS payment adjustment factor(s) through a process called targeted review. If you believe an error has been made in your MIPS payment adjustment factor(s) calculation, you can request a targeted review until Oct. 5.

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Due to the COVID-19 pandemic, CMS instituted the MIPS automatic extreme and uncontrollable circumstances policy with 2019 data. Therefore, practices that did not submit 2019 data to CMS should receive a neutral payment adjustment. Practices also had the option to apply for a hardship application and request reweighting of MIPS performance categories to 0%. The AMA highly encourages practices to review their final scores and confirm for accuracy, especially if a practice chose not to submit data or submitted a hardship application.

Some examples of previous targeted review circumstances include, but are not limited to, the following:

- Errors or data quality issues for the measures and activities you submitted
- Eligibility and special status issues (e.g., you fall below the low-volume threshold and should not have received a payment adjustment)
- Being erroneously excluded from the APM participation list and not being scored under the APM Scoring Standard
- Performance categories were not automatically reweighted even though you qualify for automatic reweighting due to extreme and uncontrollable circumstances

You can access your MIPS final score and performance feedback and request a targeted review by going to the Quality Payment Program website and logging in using your HCQIS Access Roles and Profile System (HARP) credentials. Please refer to the QPP Access Guide for additional details. CMS may require documentation to support a targeted review request that is under evaluation. Please note that targeted review decisions are final and not eligible for further review. For more information about how to request a targeted review, please refer to the 2019 Targeted Review User Guide. For more information on payment adjustments please refer to the 2021 MIPS Payment Adjustment Fact Sheet. For questions contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, consider calling during non-peak hours—before 10:00 a.m. and after 2:00 p.m. Eastern time.

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