June 4, 2021: National Advocacy Update

Utilizing data mapping to tackle maternal mortality

In the ongoing effort to improve maternal health the AMA sent a letter to members of the Senate (PDF) expressing support for S.198 and H.R.1218, “Data Mapping to Save Moms’ Lives Act.”

This legislation would instruct the Federal Communications Commission (FCC) to consult with the U.S. Centers for Disease Control and Prevention (CDC) to determine ways to incorporate data on maternal health outcomes for at least one year postpartum into broadband health mapping tools in an effort to reduce maternal mortality and morbidity in the U.S.

Telehealth services can be especially helpful for new mothers, who are adapting to the demanding schedules of caring for an infant. Commuting to a doctor’s office for a visit may require finding child care for older children or require commuting long distances for those in rural or other underserved areas. As a result of these and other challenges, 20-40% of women have difficulties attending these critical postpartum visits between three and eight weeks after delivery. As such, the AMA supports ensuring new mothers have access to and coverage of telehealth services and broadband and internet-connected devices, so that the barriers to accessing postpartum care and addressing health disparities are reduced.

Congress introduces Conrad State 30 legislation

The effort to expand, improve and provide a longer-term extension of the Conrad 30 program received a major boost following the introduction of H.R.3541/S.1810, the Conrad State 30 and Physician Access Reauthorization Act, on May 25. Absent congressional activity, the Conrad 30 program expires on Oct. 1, however, it is anticipated that lawmakers will include at least a one year extension of this crucial policy in forthcoming legislation to fund the federal government in Fiscal Year 2022. In the House, Representatives Brad Schneider (D-IL), Don Bacon (R-NE), Antonio Delgado (D-NY) and David McKinley (R-WV) jointly introduced this bill that has already generated nearly 40 bipartisan cosponsors. Senator Amy Klobuchar (D-MN) is, once again, spearheading the bipartisan Senate bill along with Senators Susan Collins (R-ME), Jacky Rosen (D-NV), Joni Ernst (R-IA), Angus
King (I-ME), John Thune (R-SD), Shelley Moore Capito (R-WV) and Jeff Merkley (D-OR).

Created in 1994 and named after former Senator Kent Conrad (D-ND), the Conrad 30 program has brought more than 15,000 physicians, who complete their residency in the United States, to rural, inner city and other medically underserved communities. Every state in the nation has utilized the Conrad 30 program following its inception. Currently, physicians from other countries working in the United States on J-1 visas are required to return to their country of origin upon conclusion of their residency for two years before they can apply for another visa or a green card. Under the Conrad 30 program, each individual state is granted 30 waivers to allocate to physicians permitting them to forgo the requirement to return to their country of origin so long as they are willing to work in a medically underserved community for three years.

In addition to reauthorizing the program for an additional three years, the Conrad State 30 and Physician Access Reauthorization Act outlines a process to gradually increase the total number of waivers per state, mandates additional transparency in employment contract terms, permits greater immigration flexibilities for spouses and children of participating physicians and requires an annual report from the U.S. Citizenship and Immigration Services to the Department of Health and Human Services on the annual utilization of the waivers in hopes of better informing rural states how to make full use of the program. In an effort to ease the current per-country backlog, the legislation also authorizes physicians who practice in underserved areas or Veterans Affairs facilities for five years to receive priority access within the green card system. The AMA was joined by the Federation of American Hospitals, American Hospital Association, National Rural Health Association and Association of American Medical Colleges, as proud supporters of this bipartisan legislation.

**Joint letter urges changes to Medicare alternative payment models**

The AMA has worked closely with specialty and state medical societies for a number of years to foster development and implementation of patient-centered alternative payment models (APM) designed by physicians. To advance this goal, the AMA and 44 national medical specialty societies recently sent a letter to Liz Fowler, PhD, JD (PDF), deputy administrator and director of the Center for Medicare and Medicaid Innovation (CMMI), seeking greater transparency in CMMI’s APM development process and for CMMI to allow for greater physician engagement in the design and implementation of APMs.

The letter notes that utilizing models designed by practicing physicians will enable CMMI to accelerate value-based payment and care delivery for patients with Medicare and Medicaid, and that currently most physicians do not have the opportunity to participate in an APM designed for the kinds
of patients they treat or the level of risk they are equipped to take on. Examples are also provided of several patient-centered APM proposals that have been recommended for Medicare adoption by a federal advisory committee but to date have not been tested by CMMI.

**AMA submits comments on surprise billing implementation**

On May 21, the AMA submitted initial comments (PDF) to the Centers for Medicare and Medicaid Services (CMS) to help guide the agency’s implementation of the No Surprises Act (NSA), which seeks to limit surprise billing of patients for services by out-of-network providers in settings where use of out-of-network providers was not a patient choice, such as when urgent or emergent care is needed. The legislation outlined very aggressive timelines for implementation of the NSA, which has led the AMA and other physician and stakeholder organizations to begin submitting comments in advance of any rulemaking.

The first statutory deadline requires finalization of rulemaking by July 1 on the methodology for determining the “qualifying payment amount,” which is the amount on which patient cost-sharing will be based and will be a central factor used in any arbitration between physicians and payors going forward. Additional rulemaking deadlines follow in the fall. AMA’s initial comments centered on consideration for calculation of the qualifying payment amount. The AMA will continue to submit additional written comments on NSA implementation to regulators over the coming months.

**Medicare Coverage of Innovative Technologies rule delayed until December 2021**

CMS announced (PDF) that it will again delay implementation of the Medicare Coverage of Innovative Technologies (MCIT) rule until Dec. 15. The MCIT rule, which was initially finalized at the end of the Trump administration, seeks to provide four years of immediate Medicare coverage to medical devices receiving breakthrough designations from the Food and Drug Administration (FDA) and subsequently approved or cleared for marketing. CMS has noted ongoing operational questions and concerns regarding the potential for a lack of evidence of clinical utility in Medicare and Medicaid populations of these devices as reasons for the continued delay in implementation.
The AMA has submitted comments on the proposed coverage pathway, generally less burdensome pathways to coverage for innovative, high-quality technologies, but raising similar concerns regarding lack of evidence and lack of incentives to continue to develop the evidence base for these new products. The AMA has also noted the significant operational questions yet to be answered and has asked for clarity on those issues prior to implementation.

More articles in this issue

June 4, 2021: State Advocacy Update