Todd Askew on proposed rule for Medicare Physician Fee Schedule

AMA’s Moving Medicine video series amplifies physician voices and highlights developments and achievements throughout medicine.

Featured topic and speakers

In today’s episode of Moving Medicine, a discussion with Todd Askew, the AMA’s senior vice president of advocacy in Washington, D.C., about the recently released proposed rule for the 2022 Medicare Physician Fee Schedule, telehealth developments and advocacy efforts in the fight against the National Overdose Epidemic.

Speaker

- Todd Askew, senior vice president, advocacy, AMA

Transcript

Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today we’re joined by Todd Askew, the AMA’s senior vice president of advocacy in Washington, D.C., will give us an update on the AMA’s latest advocacy efforts. I'm Todd Unger, AMA’s chief experience officer in Chicago.

Todd, CMS has released the proposed rule for the 2022 Medicare Physician Fee Schedule. Can you tell us more about that and what it means for physicians?

Askew: Sure, Todd. This is an annual exercise. We go through a massive proposed rule, as it is every year, that sets out the parameters for the Medicare program for participation by physicians, payment rates and other policies for the coming calendar year.

This year’s proposal has weighed in at just over 1,700 pages, and so having just recently come out,
our staff is busy analyzing what CMS has put forth. One important thing to highlight, which is unfortunate but not unexpected, was that payment rates, or the conversion factor as most physicians will understand it, will be reduced for 2022 by about 3.75%.

Now this is, like I said, not unexpected, it’s roughly the reduction of the increase that was put in place last year to ameliorate the impact of some budget neutrality changes but it’s still going to sting and so we’re looking to work very hard on that.

Unger: So, why don’t you just talk a little bit more about AMA’s position on this and some of the advocacy efforts that are underway?

Askew: Absolutely. So, I mean, it's clear with physician practices still feeling the impact of the reduction of volume during much of the pandemic, that across the board 3.75% cut is going to hurt. It's not sustainable, especially given the fact that so many other payers will peg their rates to Medicare rates. It's also not the only cut that we're likely to see. There's some statutory things currently in law that could also further reduce payments.

You'll recall at the end of last year, we were able to delay for a year the annual sequester which reduces all payments by 2%. So that is scheduled to come back into place, as well as a 4% cut that reflects the impact of some of this spending the federal government undertook to address the pandemic. It adds up. It adds up quickly to almost 9% cuts, or over 9% cuts, potential for physician payments under the Medicare program. In addition to that, there's also the potential for downside on some of the quality reporting programs if those are not delayed.

So we take all this very seriously, as everybody should, and we are working with across the Federation of Medicine, with state medical associations and with national specialties to convince Congress to further delay or cancel some of these or all of these payment decreases that could impact physicians in the coming year.

Unger: Well, when you think about all of your efforts and this annual review, and a lot of not good news. When you step back and take a look at the big picture, how do we create a payment system that works for physicians and supports efforts to provide quality care?

Askew: Yeah, no, that's very important, Todd. We've seen over the years, over the last dozen years really, and really longer than that, the Medicare payment system become more and more complicated, beyond just the payment cuts that we seem always to be having to fight off. But the layering of regulation upon regulation of reporting requirements, programs that are siloed, they don't make a lot of sense, you can't relate many of the quality reporting requirements to how it actually might benefit patient care.

So, we and many of the other groups in organized medicine have called on Congress to take a step back. We're doing the same thing, to reimagine what the payment system should look like to better
serve patients, to be simpler, more understandable, less burdensome and more fair for physicians as well. So that starts, we've asked for oversight hearings. We've asked Congress to take a look at what has been heaped upon the Medicare payment system over the last decade or so and start to think about what we would do if we could begin again, if you will. If we could come up with a payment system as we would design it without the weight of everything else that's currently there.

Unger: Are there any other kind of models that you're looking at or can reference for that?

Askew: No, I think the main thing we're looking at is building backwards. What are the major problems with the current system? It basically in a lot of cases is reporting for reporting sake, it's data collection for the sake of having the data and not really being able to use that data to improve patient care and so it just creates burdens. So, we need to get rid of those burdens and focus the payment system on what it should be doing and that's helping physicians provide high quality care to their patients.

Unger: Well, in that realm, during the pandemic physicians were offered some flexibility with the use of telehealth, which was incredibly important when our patients couldn't be seen in the office and that was a lifeline really for patients. What was the most significant change that we saw in the telehealth space?

Askew: Well, during the pandemic patients needed care but much of the care could be done remotely, but it couldn't be done under Medicare rules. The Medicare telehealth benefit was a very, very narrow benefit, really only for patients in certain rural areas and under certain specific conditions. So during the public health emergency, most of those restrictions like the geographic and originating site restrictions have been lifted and it has really blossomed. Physicians who had previously never provided care through telehealth and patients who had never taken advantage of it were able to do so and it was very popular. It really met an important need during that time.

Unger: So to that end, the AMA is continuing efforts to extend those flexibilities around telehealth beyond the pandemic. Can you tell us more about what the advocacy team's work in this area looks like?

Askew: Right. So for example, just recently more than 400 prominent physician organizations, health care, technology groups, a whole group of stakeholders came together to urge Congress to continue to extend these benefits, this flexibility that's been provided during the public health emergency beyond this period, so that we can really build and have a meaningful benefit permanently in the Medicare program for physicians to be able to provide these services to their patients via these other modalities.

There have been some progress in the proposed rule for increasing the accessibility of mental health services, which has been a key benefit that's been delivered through telehealth but the biggest problem right now is the congressional budget office. Quite frankly, they see it as an additional thing
that beneficiaries will take advantage of in addition to, instead of in lieu of, in-person services.

We don't believe that's entirely the case. We don't believe you're going to have a massive spike in volume in addition to the in-person visits, we believe patients will continue to choose the in-person visits or the telehealth visit based on the need and the service that needs to be done. So it's about data collection, it's about making our case. We are well underway in doing that and working to convince, among others, the congressional budget office that this is not going to cause a huge increase in expenditures.

Unger: Well, in addition to the advances in telehealth and many other things we saw during the pandemic, one important trend was an increase in substance abuse. A few weeks ago, the CDC came out with a report that showed an unprecedented 29% increase in overdose deaths last year and that's 93,000 deaths. The AMA's been out there working to fight the national overdose epidemic for a number of years but can you tell us about some of the recent advocacy efforts?

Askew: Sure. This is kind of the story of the forgotten pandemic. Before COVID, this was at the very forefront of our public health efforts. It didn't just go away during this period, it actually has gotten worse and some of the progress that had been made, we've kind of taken a step back because we have seen these very large increases in overdose deaths.

We've recently provided some commentary on some plans from the ONDCP, the Office of National Drug Control Policy made a long series of recommendations. I would kind of bucket them into maybe three or four different buckets. One would be expanding access to evidence-based treatment for everybody to make sure that we can get treatment services and harm reduction services to patients.

Another is using the government's influence and control on all types of health insurance payers to get rid of arbitrary restrictions on access to some of these services that may otherwise apply for one reason or another. That includes access to opioid therapy for those patients who would benefit from opioid therapy.

As well as then disseminating best practices, continuing to make sure that we get the state of the art out to people so that they know the science and what treatment services are available. Then finally continuing to develop and support standardized data reporting systems and metrics, so that we have a clear and concise picture of the state of the opioid crisis that we have in this country.

But unfortunately, it's not just one side of the equation, there's two sides of the equation as well. Another area we've had to become engaged in recently, and actually we've not been disengaged from it, but it is moved up the ladder a little bit is the 2016 opioid prescribing guidelines from the Centers for Disease Control.

The guidelines were well-intentioned, giving physicians guidance on appropriate opioid therapies for pain patients but they've had kind of the negative implication of stigmatizing pain and making many
pain patients feel as if they're doing something wrong or they're drug seekers when they have legitimate needs and giving a lot of physicians pause about the appropriateness of certain therapies.

So these guidelines were taken, and rather than just be guidelines, I think you've had more than 35 states now basically write them into law. You've had pharmacies and health insurers take these guidelines and make them absolute non-flexible policies for their policy holders or their customers. So, you have patients who have real legitimate unmet need for pain control that are facing all these obstacles. This really runs in the face of solving the pandemic of opioid abuse because in the last decade we've seen a more than 40% decrease in opioid prescribing by physicians, while we have seen the rates of opioid deaths and overdoses continue to increase.

A lot of that is because the problem has shifted to illegal fentanyl, fentanyl analogs and other substances, so focusing solely on prescribing is missing the mark on what is really driving the opioid crisis we have in this country. So it's not an easy problem, it's a huge thing that we may have forgotten about. Not a lot of us but the public may have forgotten about during the current COVID pandemic but it is still there and it still needs all of our attention.

**Unger:** A lot of crises to contend with and that one continuing to get worse during the pandemic. Well, last question for you. There was some news recently from the Veterans Administration that proposed new standards that many feel could unintentionally lead to patient safety concerns and lower quality of care. Can you give us some background on what that is?

**Askew:** So, the Veterans Administration has decided to basically establish national standards of care for 48 different separate categories of health care professionals working within the Veterans Administration, the VA system. For example, they have one category for a physician, despite the fact that there's more than 40 specialties, more than 80 subspecialties employed by the Veterans Administration or the Veterans Health Administration.

It also treats different types of physicians separately in their own silos, as opposed to recognizing how care is really provided by teams of clinicians and other health care professionals, physicians, and nurses and advanced practice nurses, all working together to provide the best care possible for our veterans. So, it's a bit baffling really what's going on here. It's also confusing since there has really been very little transparency and very little stakeholder outreach or input into this process. It's been done very quietly and internally.

The biggest implication, I mean, obviously for patient safety but part of that is because you will be superseding state and federal laws that make it possible to discipline health care professionals who may provide substandard care. So current state licensing authorities, for example, would be powerless over some of these professionals using these new national standards for practice by the VA.

So we are deeply engaged, there's a lot of concerns throughout the Federation of Medicine. We have
been reaching out to the VA, we have had some interchange but I believe just today, a letter went to the VA calling for them to step back with a lot of support from medical specialties saying that they need to take another look at this and withdraw what they have put forward and start again.

**Unger:** Well, thanks so much, Todd. There never seems to be a shortage of critical things to work on in the advocacy world. We appreciate your perspective and look forward to having you back soon to talk again. Thanks again for being with us.

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