Oct. 8, 2021: National Advocacy Update

Surprise billing regulation favors insurers

On Sept. 30, the Biden administration issued an interim final rule (IFR) (PDF) with comment period to further implement the No Surprises Act (NSA), signed into law as part of the Consolidated Appropriations Act of 2021.

Among other provisions, the IFR implements the Independent Dispute Resolution (IDR) process that can be used to settle out-of-network payment disputes between payers and providers in surprise billing situations. In an effort to reduce the frequency with which the IDR process will be used, the IFR significantly undermines the fairness with which the process will be implemented by requiring IDR entities to make their decisions based on the “qualifying payment amount (QPA)” unless the provider can prove otherwise. Although the QPA is meant to represent the median in-network rate, the method used to calculate it as outlined in the first IFR will often result in much lower amounts.

As a result of these two rules combined, physicians will face an uphill battle to receive fair payment for their out-of-network services. But perhaps even more concerning is the impact these rules will have on the ability of physicians to enter into meaningful negotiations with health plans that have little incentive now to offer fair contracted rates.

The AMA issued a press release calling the IFR “an undeserved gift to the insurance industry that will reduce health care options for patients.” The release states, “The interim final regulation issued to implement the No Surprises Act ignores congressional intent and flies in the face of the Biden administration’s stated concerns about consolidation in the health care marketplace. It disregards the insurance industry’s role in creating the problem of surprise billing at the expense of independent physician practices whose ability to negotiate provider network contracts continues to erode,” said AMA President Gerald A. Harmon, MD.

Other physician organizations and hospital associations issued similar statements. The AMA is in the process of developing a summary of the IFR and is drafting comments that will continue to urge the Biden administration to delay implementation and allow full evaluation of policies in the IFR that have negative long-term implications for patients and the health care system.
Biden administration reverses title X family planning “gag rule”

On Oct. 4, the Biden administration issued a final rule that reverses the Trump-era “gag rule” that prevented family planning grantees under Title X from referring patients for abortion. Title X of the Public Health Services Act is a federal grant program for family planning, which finances community clinics and other facilities, such as those operated by Planned Parenthood, to provide these services. The Trump administration had finalized the rule governing Title X projects in 2019, which the AMA strongly opposed, that kept Title X grantees from counseling or referring patients for abortion services and required that Title X projects and abortion-related activities be physically and financially separated.

The Biden administration proposed its rule earlier this year to reverse these provisions, arguing that the previous administration’s rule had cut the number of Title X grantees by a quarter and could have led to up to 181,477 unintended pregnancies. The AMA’s comments (PDF) supporting the Biden administration’s proposed rule noted that the rule needed to be changed because it interfered with the patient-physician relationship by preventing physicians in Title X-funded programs from counseling pregnant patients about their full range of health care options, including abortion, and referring such patients for abortion services.

In addition, AMA noted that this conflicted with physicians’ ethical and legal responsibilities to their patients. The 2019 rule was challenged by the AMA, medical specialty and state medical societies and more than 20 states in different lawsuits in federal court and advanced to the U.S. Supreme Court; in May, the High Court dismissed the challenges in light of the Biden administration’s plans to reverse the 2019 rule. The final Title X rule will go into effect on Nov. 8.

CMS reconsidering financial risk requirements in alternative payment models

In a recent presentation to the National Association of Accountable Care Organizations (NAACO), the Centers for Medicare & Medicaid Services’ (CMS) Principal Deputy Administrator Jonathan Blum said that the agency is reconsidering its previous goal of increasing the number of Medicare patients attributed to alternative payment models (APM) that require organizations to assume financial risk for the total cost of care. This reversal of the drive to steeper downside financial risk in APMs would be a significant improvement in CMS’ approach to APMs, and one that the physician community has long
sought.

For a number of years, the AMA has recommended that APMs be designed to hold physicians accountable only for factors over which they have influence or control instead of the total cost of care. For example, physicians cannot control drug prices but they may be able to choose which medications to prescribe based on evidence-based clinical pathways. In a recent comment letter (PDF), the AMA also expressed concern about steep proposed discounts in the new radiation oncology APM. Blum noted that APMs with steep financial risk requirements tend to favor organizations that are better capitalized and can afford risk. The AMA believes that this is one reason that most physician practices have not been able to participate in CMS APMs. The AMA agrees with Blum’s comments to NAACOs that, instead of having more patients in total cost of care models, the goal should be “better care, better experience, better life and better overall care system.”

CMS re-opens 2020 MIPS performance period reweighting requests

CMS informed the AMA that it recognizes the COVID-19 pandemic continues to impact all clinicians across the U.S. and that not everyone may have had the time to submit an Extreme and Uncontrollable Circumstances (EUC) Exception Application for the Merit-based Incentive Payment System (MIPS) Performance year 2020 before the March 31, 2021, deadline. As a result, CMS is allowing clinicians, groups, virtual groups and APM entities to request MIPS performance category reweighting for Program Year (PY) 2020 under the EUC policy now through Nov. 29 at 8 p.m., Eastern. The AMA urges physicians to take advantage of the extended flexibility for the 2020 MIPS program to avoid a 2022 payment adjustment.

CMS has specifically highlighted to the AMA that many individual and small practices may have incorrectly filed a EUC application as a group. CMS was able to identify this error because only small practices and physicians reporting as an individual can submit quality measures through Part B claims. Many small practices reported quality through the claims reporting option but did not report group-level data for other performance categories. As a result, these small practices may wish to re-request performance category reweighting on behalf of the entire group, which the AMA greatly encourages. As part of the AMA’s ongoing communication with CMS, the AMA is advocating for CMS to directly contact each physician impacted by the mistake, as well as inquiring about the feasibility of providing a list of names of the affected physicians to better ensure small practices do not inadvertently receive a 2022 MIPS penalty.

As a reminder, if you did not submit any 2020 MIPS data, CMS applied its automatic EUC policy to all individual MIPS eligible clinicians for Program Year 2020. Under this policy, CMS reweighted to 0%

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any performance category for which data was not submitted, and these performance categories do not contribute to the clinician’s individual final score. However, the automatic EUC policy only applies to those clinicians who were eligible to participate in MIPS as individuals; it does not apply to clinicians who were only eligible to participate as a group or APM entity or who elected to participate as a virtual group.

Given the COVID-19 pandemic continues to impact the country, the AMA is also urging CMS to extend the automatic EUC policy to the 2021 MIPS performance period/2023 payment adjustment. The AMA believes physicians should be provided maximum flexibility with avoiding a MIPS penalty as physicians continue to be on the frontline with treating patients with COVID-19 and the multiple challenges with providing care during the public health emergency.

When using the Targeted Review form to submit a EUC reweighting request for PY 2020, you’ll need to:

- Select the performance categories for which you’re requesting reweighting.
- Select “Extreme and uncontrollable circumstances” in the issue selection.
- State explicitly in the Description that you’re submitting a EUC application due to the continuing COVID-19 Public Health Emergency (PHE). (In addition, we encourage you to reiterate the performance categories for which you are requesting reweighting: quality, improvement activities, and/or Promoting Interoperability.)


Contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov, Monday–Friday 8 a.m.- 8 p.m. Eastern. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. Eastern.

**CMS recalculates 2020 MIPS performance period/2022 payment adjustments scores, extends targeted review deadline until Nov. 29**

Recently, CMS released performance feedback for clinicians included in the MIPS program for the 2020 performance year (PY). Upon release of the 2020 MIPS scores, CMS discovered that it inadvertently excluded two items from scores and had to re-calculate ALL scores:

1. Complex Patient Bonus Correction for Medicare Shared Savings Program ACOs: Specifically,
CMS determined that the complex patient bonus was not added to the final scores of Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs). This issue affected every Shared Savings Program ACO with MIPS-eligible clinicians. In the updated performance feedback, Shared Savings Program ACOs will see up to 10 complex patient bonus points reflected in the performance feedback and added to the final scores, if applicable. (There are approximately 20 ACOs that did not qualify for any complex patient bonus points.) As a reminder, the final score cannot exceed 100 points.

2. Patient-Reported Outcome Measure Correction: CMS determined that its system did not recognize patient-reported outcome measures as outcome measures. CMS corrected its scoring logic, which resulted in two potential changes to quality performance category scoring for approximately 30,000 MIPS-eligible clinicians:

1. Patient-reported outcome measures submitted in addition to another outcome measure became eligible for two high-priority bonus points. (As a reminder, these bonus points are capped at 10% of the quality denominator.)

2. Patient-reported outcome measures became eligible to fulfill the requirement to report an outcome measure.

The majority of affected clinicians will see a modest increase in their quality performance category score and MIPS final score as a result of this correction. However, approximately 4,400 clinicians will see a decrease in their quality performance category score and MIPS final score. This occurred when a lower-scoring patient-reported outcome measure replaced a higher-scoring high priority measure in their top six measures, fulfilling the requirement to report an outcome measure. (A high-priority measure is only selected for the top six measures in the absence of an available outcome measure.)

As a result of the recalculations, MIPS-eligible clinicians with a final score between 85 and 100 points receive an additional adjustment for exceptional performance. This adjustment is not subject to budget neutrality but is scaled to ensure the appropriate distribution of available funds. When CMS corrected final scores for alignment with the existing policies, more clinicians moved into the exceptional performance pool, causing a slight decrease in the exceptional performance adjustment.

Furthermore, to offer additional time for clinicians, groups, virtual groups and APM entities and their participants to access and review their performance feedback, CMS is extending the targeted review deadline to Nov. 29, at 8:00 p.m. Eastern. You can submit a targeted review by signing in to the Quality Payment Program website.
GAO releases report examining the MIPS program from performance years 2017-2019

As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress included a provision for the Government Accountability Office (GAO) to examine the MIPS program (PDF) and GAO’s analysis of CMS’ data found that MIPS final scores were generally high and at least 93% of providers earned a small positive adjustment in 2017 through 2019, with the largest payment adjustment in any year being 1.88%. In addition, about 72% to 84% of providers earned an exceptional performance bonus, depending on the year.

GAO also interviewed several stakeholders, including the AMA, as part of its research and most of the organizations interviewed highlighted and questioned whether the program helps to meaningfully improve quality of care or patient health outcomes. In reaction and response to GAO’s report, CMS stated that it believes the MIPS Value Pathways (MVP) that are proposed to begin in 2023 will help address some of the challenges with the MIPS program. While the AMA is supportive of the MVP concept—focusing on cohesive sets of measures that span a medical condition or episode of care—there is concern that CMS’ proposed approach just contorts traditional MIPS into MVPs and lacks sufficient change to the program.

The AMA continues to advocate to CMS the need for the MVP framework to be flexible enough to allow specialty societies to co-develop with CMS a pathway that is like an APM in that it centers on quality improvement, efficient resource use, patient-reported outcomes and satisfaction and enhanced technology to care for patients with specific medical conditions. The new report from the GAO may lend additional support for the changes needed in the current MVP framework.

AMA urges Biden administration to address the family glitch

The AMA urged the Biden administration to take action to fix the Affordable Care Act’s (ACA) “family glitch” in a Sept. 29 letter (PDF) to CMS Administrator Brooks-LaSure. Under the family glitch, families of workers facing unaffordable premiums for coverage offered through their employers remain ineligible for premium and cost-sharing subsidies to purchase ACA marketplace coverage. As a result, families affected by the family glitch are left to either pay a significant percentage of their income for family coverage or go uninsured. The AMA asked CMS to use its authority to address this issue and will continue to update members on any progress.

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Medicare coverage needed for self-measured blood pressure monitoring devices

The AMA and the American Heart Association recently teamed up to make a formal request to CMS (PDF) for a national coverage determination for validated self-measured blood pressure (SMBP) monitoring devices for patients with Medicare. The letter described national survey data finding that, while the percentage of adults with controlled blood pressure increased from 31.8% in 1999-2000 to 48.5% in 2007-2008, it fell to 43.7% in 2017-2018. In addition, the percentage of non-Hispanic Black adults with controlled blood pressure is lower than for non-Hispanic White adults. The letter described multiple evidence-based guidelines recommending the use of out-of-office BP measurements to confirm a diagnosis of hypertension as well as strong and compelling evidence indicating that SMBP monitoring provides benefit to managing hypertension.

Based on this strong evidence, Medicare has been paying for two CPT codes, 99473 and 99474, since 2020 for the physician services associated with training patients in effective SMBP monitoring and integrating their SMBP readings into their clinical care. It is impossible to do SMBP monitoring without a validated SMBP device, though, so a positive national coverage determination would address an important barrier to successful implementation of SMBP. Studies have also shown that health insurers providing SMBP devices to patients are associated with a positive return on investment.

The joint letter provided detailed information for CMS to consider in specifying the details of a national coverage determination for validated SMBP devices, including the benefit category, description of which items should be covered and the specific indications and limitations of coverage.

More articles in this issue

- Oct. 8, 2021: Advocacy Update spotlight on health insurance competition study
- Oct. 8, 2021: State Advocacy Update
- Oct. 8, 2021: Advocacy Update other news