AMA

Todd Askew on AMA’s latest advocacy efforts to support physicians

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Featured topic and speakers

In today’s episode of Moving Medicine, AMA Chief Experience Officer Todd Unger talks with AMA Senior Vice President of Advocacy in Washington, D.C., about the AMA’s latest advocacy efforts. Topics include surprise billing, prior authorization, Medicare physician payment reform and telehealth.

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Speaker

- Todd Askew, senior vice president, advocacy, AMA

Transcript

Unger: Hello, this is the American Medical Association's Moving Medicine video and podcast. Today I'm joined by Todd Askew, AMA's senior vice president of advocacy in Washington, D.C. He's going to give us an update on advocacy issues that are very critical to physicians right now. I'm Todd Unger, AMA's chief experience officer in Chicago. Todd, thanks so much for joining us. We're going to talk about kind of four big issues that your team is working on right now. Let's start with this issue of surprise billing, which, there's been a lot of news out. Why don't you just update folks on kind of where

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we're at right now?

Askew: Thanks, Todd. Thanks for having me. You'll remember that the surprise billing law passed just over a year ago and there were some important protections there to protect patients from unexpected bills. For example, when they go to an emergency room and there's not a sufficient number of in-network providers at that facility. So, in those cases where the patient didn't really have the option to select an in-network physician, the patient's cost-sharing was to be limited to the amount that they would've paid a network and then the plan and the physician kind of work out the difference.

But in those cases where they couldn't work out a difference, the law set up an independent arbitration provision, so that there was a process to determine what the final payment amount was. So, as written by Congress, the arbiter was supposed to consider what was known as the qualified payment amount, which is essentially what they pay others. Then also, other factors that either party could submit. It could be special circumstances surrounding the case. It could be previously contracted amounts. So, things like that, that could potentially help the physician argue for a more favorable payment rate.

However, when the government issued their final rules this past fall, they instructed the arbiter to consider that insurance plan amount as the proper amount, unless these other factors met a fairly high bar. That was really in contradiction to what the statute said, that the arbiter was supposed to look at all these factors. So, as a result of that interpretation by the government, a number of lawsuits have been filed, one by Texas and one by the AMA and the AAJ, as well as others.

Unger: So, we're all in agreement that the patient shouldn't be in the middle of this, but what are the implications Todd, for that change, what are those?

Askew: So, essentially, the plan, the arbitrator would look at the plan payment amount and what the plan decided was the appropriate amount by what they have contracted with other providers that are in-network. Typically, those in-network rates are somewhat lower. So, by weighting that unfairly, it meant that providers, physicians included, would be at a disadvantage in that arbitration process and likely end up being paid lesser amount. The most important thing to remember here though, is the patient is totally removed from the process. The physician arguing for a more fair payment from the plan does not impact it any way, the amount the patient would be obligated to pay. They are protected, and everyone agrees on that.

Unger: So, you mentioned a number of different lawsuits. Let's start with the one where's got some recent news and that's the one from Texas.

Askew: Absolutely.

Unger: What's the background there?

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Askew: Yeah. No. So, Texas filed a suit, back towards the end of the year in the Eastern District of Texas, making the arguments that several other suits, including the one that AMA has filed with the American Hospital Association, basically arguing that the government, in interpreting the regulations, in writing the regulations, interpreting the statute unfairly, essentially put their thumb on the scale to favor the health plans and not give equal weight to the other items that the providers or physicians could submit, as was required by the law. Last week, Texas won and they not only won on the fact that the government had read the statute improperly and weighted things improperly, they also won on a claim they brought that the government unfairly did not give all of us the opportunity to comment and kind of rushed the regulation through without going through the normal process.

Askew: So, it's a pretty big deal. It was a very strong ruling and the judge was very clear that the statute says that these things are to be considered equally and not favor given to one side or the other.

Unger: So, how does that impact us? What's the next step there? Is that the end of it, so to speak or—

Askew: It would be great if that's the end of it, because the ruling is exactly what I think is not only correct, but what is fair. The government does have 60 days to appeal and they're going to be under a lot of pressure from the payers to appeal. There are also all these other lawsuits that have to be resolved as well. So, this could continue to work its way through the court but if the indication and the ruling from Texas is any indication of the direction and the way the courts will look at this, I think it's very favorable and we're very hopeful that at the end of this process, that we will see the interpretation of the statute as applied fairly, like was intended, when we supported the legislation.

Unger: Thanks for your continued work on that and a shout out to our friends in Texas Medical Association for their continued work as well. On the burden front, our burden reduction front, something your team spent a lot of time looking at, one of the key elements there is this issue around prior authorization. Any news happening on that front?

Askew: Well, unfortunately, I wish there was but there's not a lot in terms of improvements that we've been working on, and that quite frankly, the industry has been promising to streamline and make this more or efficient for a number of years but there hasn't been a lot of movement. AMA survey, that has just come out with our annual survey, that pretty much documents the status quo, and even in some cases, a little bit worse. Insures tout to employers that these programs, these utilization management programs, including prior authorization, can result in cost savings. They even say to the public that we are stopping providers from providing all this care that you shouldn't be getting.

Which is, I think any physician who has had to sit on the phone for hours trying to get a simple drug approved or a simple procedure approved, would disagree with that. But the new survey from the AMA, the kind of the updated survey from the AMA, shows, as we know, that these issues have pretty

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severe consequences for patients. The most startling finding in my mind was that 34% of physicians reported that a prior authorization had led to a serious adverse event with one of their patients. So, the need to continue to work to streamline, right-size, these prior authorization requirements is really critical in order to protect our patients from those adverse consequences.

Unger: So, I know one of this is one of your top priorities for 2022. Anything specific you want to talk about in terms of what the AMA is working on?

Askew: No, absolutely. There's a couple of things out there that are very promising. There's a great deal of bipartisan congressional support for the legislation. I believe it's the Senior's Timely Access to Care Act, which would bring a lot of important prior authorization reforms to the Medicare Advantage Program, and really demonstrate that the industry can live with these reforms and still be able to care for patients in a reasonable way. Another, the trend that we're seeing, which is a positive one, is the concept of a gold card. Texas, again, our friends in Texas that passed a bill in the state that looks very promising and there are similar efforts at the federal level to say that if a physician or other provider routinely receives prior authorization for a particular service or a particular type of care, that they would not need to continue to jump through that hoop every time they need a patient approved. So, it's a way of streamlining, clearly, unnecessary authorizations and we're hopeful that different reforms like Gold Card and some other efforts to streamline utilization management programs can right-size some of these programs.

Unger: Well, let's move on to a third topic, a very, very hot topic, which is Medicare payment reform. Some of you out there may not know. a big move, with the support and help of the AMA at the end of last year was to avert what could have been devastating cuts in payments for physicians. Todd, obviously, what you've talked about before is this issue is not over and it's not something that can be just handled by kicking the can down the road, so to speak, every year. What's in store for the coming year?

Askew: Well you're right, Todd. We constantly seem to be fighting to stop the next cut. It's always a cut hanging over our heads that must be stopped because of the way the payment system is set up. It's not sustainable. We cannot continue to just make the entire effort of the physician community stopping the next cut. It's creating huge financial instability in the Medicare physician payment program for a lot of reasons. One, physicians never know in the next year what the payment rates are going to be. There's also statutory payment cuts that we're facing. There are lack of inflationary updates. We have budget neutrality, which means when we're able to get an increase in one service, then all other services must be a decrease to compensate for it.

Also, the significant administrative costs the physicians face in complying with some of the quality programs like the MIPS Program, over $12,000 a year per physician. So these type of pressures on a Medicare physician payment system, which has not provided updates to physicians adequate to meet their cost in many years. In fact, over the last two decades, physician payments under Medicare are

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up 11% and over 3% of that came just last year, in an effort to provide some relief from the negative pressures that COVID had placed on the health care system. Meantime, costs providing a physician practice over that period are up almost 40%.

Unger: Wow.

Askew: These gaps just continue to grow. Most other Medicare providers have in their payment system something that keeps them up with the inflation, related to the medical economic index, that as inflation grows, their payments grow automatically, in order that they don't fall behind. Physicians don't have that, unfortunately. As a result, the real inflation adjusted value of physician payments in Medicare is down about 20% over the last two decades. With all the other pressures on physician practices, that is clearly not sustainable and has to be addressed. We really, really are coming to a breaking point.

Unger: Those are some really significant numbers. When you think about kind of the go forward here, what does reform look like?

Askew: Well, I think there's multiple components to it. Obviously, one component is reliable, predictable updates, is to make sure that physicians know that they're not going to be subject to arbitrary cuts in their reimbursement year after year after year. So, stability is number one. Predictability, also some tied to inflation. We can't just continue to watch costs grow out of control and not keep up with those, with being able to meet those costs. There are productivity increases that can happen but they're not going to be enough to keep up with inflation. So, predictability, some sort of link to cost growth is important. A second component is right sizing all of these administrative requirements that we find under Medicare, particularly with the MIPS program, and making sure that the reporting burden does not outweigh the benefit, either to the practice or importantly to the patient for participating in these programs.

Right now, a great number of practices, they would be better off, financially, not participating because the potential penalties are less than the cost participating, and that doesn't make any sense. It doesn't make any sense financially for the practice and it doesn't make any sense for the implementation or working of a real quality program that focuses on increasing and maintaining quality care for Medicare beneficiaries.

Unger: Well, number four is quite a big topic, that's, we've been talking a lot about over the course of the pandemic and that is telemedicine. Where does the work stand with there? What needs to happen from here? This is not going away, right?

Askew: No, it's well, we hope it's not going away. We've talked about this. I think pretty much every time we've spoken, Todd, in that telemedicine has been, this one thing during this entire experience of the last two years, that has been a positive, has advanced our ... advanced the Medicare program in

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terms of being a better program for seniors and the value of telemedicine, prior to the waivers that were put in place during the public health emergency, telemedicine was really only available to a very small number of beneficiaries located mostly in rural areas. Even then, only through certain designated originating sites. They couldn't do it from their home. They couldn't do it if they weren't in certain shortage areas. So, that was waived during the pandemic and it is proven extremely valuable. The bad thing is though, when the public health emergency ends, those waivers end and Congress is the one that has to step up and make the changes in the statute, in order to continue the program. Otherwise, all this value we've seen created for this new benefit for Medicare beneficiaries will go away.

Unger: Anything in particular on the agenda that we're doing to challenge or to address the challenge there?

Askew: Yeah, no. So, there's a couple of bills. There's broad ... This is important. There's broad bipartisan support in Congress for this. This is proven extremely popular. There's a couple of bills. The Telehealth Modernization Act of 2021 and the Connect for Health Act is another. Both of those bills would essentially get rid of the need to have the waiver. They would make this part of the Medicare program, get rid of the geographic and originating site restrictions, which is critical. The barrier is the cost. Just the way the Congressional Budget Office, which determines how much we have to pay for these things looks at, it is that this is not a new benefit. This is, I mean, not a ... they say it's a new set of services on top of all the other services that Medicare's paying for. They don't see it as we do, as substituting for many of the in-person care services that a beneficiary might receive.

So, they just add on the cost of each of these, each of these services, which makes it really, really expensive, which is why Congress has not been able to address it so far. What we are facing right now, is continued short-term extensions, efforts by Congress to say, "Okay, we will, if the public health emergency expires, we will extend this by one year, or six months or whatever they can afford in any particular bill. So, for a while, we're stuck in that pattern. Again, broad support of continuing this but it is going to take a big effort and probably an expensive effort, at the end of the day, in order to make this a permanent part of the Medicare program.

But we are also working to identify more and more data and prove, make our case to the congressional budget office, that they are looking at this incorrectly, that this does substitute. It's a more efficient way of providing care. In a lot of cases, it prevents a lot of care, a lot of unnecessary visits from occurring. So, they should not see it as a big, as a huge coster.

Unger: So, surprise billing, prior auth, Medicare payment reform and telehealth, four big time topics for 2022. It sounds like we have a lot of work to do this year.

Askew: There's plenty more where that came from but those are really critical ones. We are getting a lot of support from members, both members of the AMA but also Members of Congress wanting to

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address these issues.

Unger: Todd, thanks so much for being with us here today. That's it for today's Moving Medicine video and podcast. Make sure to hit 'Subscribe' on our YouTube channel so you don't miss any more of these terrific episodes or check out all our videos and podcasts at ama-assn.org/podcasts. Thanks for joining us. Please take care.

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