CMS gives physicians more time to review draft cost measures

In response to advocacy (PDF) from the AMA and eight national medical specialty organizations whose members will be most impacted by the measures, the Centers for Medicare & Medicaid Services (CMS) is extending the field-testing period for reviewing and providing feedback about five draft cost measures by 30 days.

Now, physicians have until March 25 to provide feedback on the draft measures. The five draft measures are emergency medicine, heart failure, low back pain, major depressive disorder and psychoses-related conditions. Because physician feedback is critical to ensuring these measures are appropriate and the field-testing period overlapped with the COVID-19 Omicron surge, the AMA urged CMS to extend the previous deadline by at least 30 days.

The AMA has submitted comments to CMS regarding the five draft cost measures and will consider re-submitting its comments based on additional feedback that it receives during this extended field-testing window. The AMA urged CMS to exclude Part D prescription drug costs in Medicare cost measures and to test and publicly release information that the impact of COVID-19 has had on the cost of care as captured by these measures and all the MIPS cost measures. In 2020, CMS reweighted the Cost Performance Category to 0% of the final MIPS performance score and found that episodes with COVID-19 diagnoses generally had higher observed and risk-adjusted costs, indicating COVID-19 impacted service utilization and was not sufficiently accounted for through risk adjustment.

The AMA also urged CMS to release detailed, aggregate level reports about the reliability, validity and actionability of the tested measures and reiterated the AMA’s concerns with the psychoses and related conditions measure, which holds inpatient psychiatrists accountable for costs outside of their control after a patient is discharged.

AMA urges Congress to extend current Medicare sequester moratorium

On Feb. 28, the AMA cosigned a letter (PDF) to House and Senate leadership along with more than
45 stakeholders representing national medical specialty societies, hospitals and skilled nursing facilities urging Congress to retain Medicare Sequester cut relief for health care providers for the duration of the COVID-19 public health emergency (PHE).

This relief has been critical in helping physicians weather the challenges of the COVID-19 virus and its variants and to maintain patient access to care. While we are beginning to turn the tide against the virus, COVID-19 infections and hospitalization rates remain high. As a result, the Biden administration extended the PHE until the end of March citing over 900,000 fatalities linked to the disease.

The administration has also indicated that it will likely extend the PHE an additional 90 days beyond the current expiration date in April 2022. For this reason, the AMA and stakeholders are asking Congress to revisit and extend the relief it provided in The Protecting Medicare and American Farmers from Sequester Cuts Act which authorized a 3-month delay of the full 2% Medicare sequester payment reductions (Jan. 1, 2022—March 31, 2022), followed by a 3-month, 1% reduction in Medicare sequester payment reductions (April 1, 2022—June 30, 2022). While physicians and other providers remain grateful for this relief, resuming the Medicare sequester cuts before the end of the PHE would compromise providers' caregiving abilities at a time when the pandemic is ongoing and the threat of new, potentially more dangerous or contagious variants continues to loom.

The AMA will continue to work with the provider community and urge Congress to stave off the resumption of these Medicare Sequester cuts.

**ONC issues new information blocking FAQ in response to AMA advocacy around patient harm**

After sustained advocacy by the AMA calling for regulatory guidance for clinicians, the Office of the National Coordinator for Health Information Technology (ONC) has issued a new Frequently Asked Question (FAQ) on the Preventing Harm Exception included in ONC’s information blocking regulations. The Preventing Harm Exception permits clinicians to deny a request for electronic health information (EHI) under certain circumstances that could lead to harm. The precise way it applies depends on (1) who is requesting access to a patient’s EHI; (2) who is referenced in the EHI; and (3) what type of harm may occur.

ONC’s new FAQ provides a chart explaining that when a patient’s personal representative requests access to a patient’s EHI (for example, a parent asking for access to their minor child’s record), an Actor (as defined by the information blocking regulations) may consider whether the patient or another person may suffer “substantial harm,” which is defined to include “physical, emotional or psychological harm.” In response to AMA advocacy (PDF), ONC’s new guidance allows physicians to consider emotional and psychological harm, in addition to physical harm, when evaluating the release of EHI.
of medical records to a patient’s personal representative. This contrasts with when a patient requests their own records, in which case an Actor may only consider physical harm.

Still, the AMA is aware that individuals may experience psychological and emotional harm even when accessing their own medical information. For example, a patient may have tests done while unconscious in an ER and awake to surprising results pushed to them through a health app or patient portal before their physician has an opportunity to discuss the results with them. The AMA has been and will continue to work with ONC to develop exceptions for patients who may wish to speak to their doctors before receiving alerts about potentially serious or life-threatening illness.

Changes made to Medicare's Direct Contracting model

On Feb. 24, the CMS Innovation Center announced significant changes to its Global and Professional Direct Contracting model. Serious questions had been raised about the model by a number of members of Congress who wanted it to be immediately terminated. The Innovation Center did not terminate the model but did adopt a number of changes to the model's design that will take effect in 2023. The model will then become one of the Medicare accountable care organization (ACO) models and its name will change to the ACO Realizing Equity, Access and Community Health (REACH) model.

Some of the key changes are that the REACH model will have a major focus on promoting health equity and addressing health disparities for underserved communities and, instead of 25%, the governing bodies for REACH ACOs will need to have participating providers hold at least 75% of governing board voting rights. Another important change in the AMA’s view is that CMS will now assess annually whether the model is leading to Medicare patients being inappropriately shifted into or out of Medicare Advantage. More information about the transition from Direct Contracting to the new ACO REACH model is available on the CMS website.

EHR cyber vulnerabilities outlined in new brief

The U.S. Department of Health and Human Services' (HHS) cyber agency published an updated threat brief (PDF) outlining common threats to electronic health records (EHR), including phishing attacks, malware and cloud threats. While EHRs are important components in managing patients’ electronic medical records, EHRs are valuable targets for cyber attackers because of the protected health information they contain.

Cyber threats can originate from criminals seeking to sell medical records on the dark web or black market. Cybercriminals may also lock down EHRs using ransomware and demand a ransom payment
before access is restored to your EHR. Attacks may also originate from threat actors looking to disrupt the U.S. health care system.

This brief helps EHR users understand vulnerabilities in their health information technology (health IT) environment and provides guidance in identifying and preventing attacks—which is key to protecting EHRs and vital patient data. The AMA has created several additional cybersecurity resources targeted for small and solo medical practices to help physicians strengthen their health IT environment.

**CMS implementation of 1,000 new Medicare-funded physician residency slots raises concerns**

Though AMA applauds CMS for additional 1,000 new Medicare-funded physician residency slots, the AMA is concerned that most of the suggestions offered in its June 28, 2021, comment letter were not addressed. As such, on Feb. 25, 2022, the AMA sent a letter offering comments (PDF) to CMS on the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS). Specifically, the comments focused on Graduate Medical Education (GME) and other related provisions and Organ Acquisition Payment Policies contained in the final rule.

Relating to GME the AMA:

- Urged CMS to revise the application deadline to Oct. 1 to align with the residency recruitment cycle
- Urged CMS to allow hospitals to apply for up to 15 residency slots
- Opposed the use of Health Professional Shortage Area (HPSA) scores to determine priority for awards of residency slots
- Opposed the proposed requirement that the hospital or provider-based department be physically located in an HPSA in order to meet the criteria to be awarded slots

Additionally, the AMA applauds CMS for not finalizing proposed changes to longstanding Medicare organ acquisition payment policies that had the potential to significantly reduce the deceased donor organs available for transplantation, reduce access to transplantation and increase the number of patients who die while waiting for a transplant.

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