

April 29, 2022: National Advocacy Update

Becerra sees need to end Medicare physician pay “cliffs”

In a positive sign in the long-term project of overhauling the Medicare physician payment system to make it more sustainable for doctors and the nation, Health and Human Services (HHS) Secretary Xavier Becerra said he is “definitely interested” in examining the feasibility of such reform.

The AMA was “deeply appreciative” of Becerra’s comments “about the need to address the instability and the continual threat of payment cuts in the Medicare physician payment schedule,” says a letter to the HHS secretary (PDF) from James L. Madara, MD, the AMA’s executive vice president and CEO.

“We know from our discussions on the Hill that hearing from the secretary of Health and Human Services about the potential for physicians to leave the practice of medicine due to insecurity in Medicare payments making their practice unsustainable has added tremendous credibility to this concern,” Dr. Madara wrote.

“Physician payment rates have been further eroded by the manner in which rates are adjusted to meet budget neutrality requirements, as well as Medicare sequestration,” Dr. Madara wrote to Becerra. “As you noted in your remarks, the COVID-19 pandemic also has placed enormous stress on medical practices, with an AMA analysis of Medicare claims for physician services identifying a 14% reduction in 2020 due to COVID-19.”

The AMA is working with national specialty and state medical associations “to determine the best path forward to get the Medicare physician payment system on a more sustainable track,” Dr. Madara’s letter adds. “We have also been working to increase awareness of the problems in the current system among members of Congress to build interest and support for the needed reforms.”

Read the full article by Kevin B. O’Reilly, AMA news editor, for more details. Additionally, visit the AMA website for updated charts on the unsustainable path of the current Medicare payment system.

Modernizing enforcement of antitrust laws regarding mergers

Responding to a Department of Justice (DOJ) and Federal Trade Commission (FTC) joint request for information on merger enforcement policy, the AMA last week asked the agencies to develop policy that protects against mergers that create or augment health insurer buyer power in physician markets.

As explained in AMA's letter (PDF), health insurer markets are mostly highly concentrated. Thus, most health insurers have market power in both the markets where they sell health insurance and where they purchase physician services, so-called "monopsony power." Health insurers have sought to justify mergers on the grounds that even greater size will enable them to negotiate even lower provider charges, savings that the health insurers have said will be passed along to consumers. However, this claimed consumer benefit has been belied by past experience. It shows that insurers pocket their negotiated savings with providers and that consumers are left with higher prices, reflecting insurer market power enhanced by the merger. Meanwhile, physicians are required to negotiate contracts under noncompetitive conditions.

The AMA's letter asks that the Agencies review health insurer mergers not just for their competitive effects in consumer markets for health insurance but also for their so-called "monopsony" or buyer effects in the markets where health insurers buy physician services. Thus far, antitrust enforcement to protect physicians from health insurer mergers raising monopsony concerns has been largely (and incorrectly) absent. The AMA's letter says it is time for the Agencies to strengthen merger enforcement by bringing monopsony challenges to health insurer mergers. As grounds for encouragement, AMA points to DOJ's success, with the amicus support of AMA, challenging the Anthem/Cigna merger in 2017, partly based on buyer power/monopsony concerns. Also, there has recently emerged substantial antitrust scholarship calling for antitrust enforcement to protect labor markets. This new scholarship provides a powerful foundation for federal antitrust enforcement protecting physicians from health insurers' acquiring monopsony power in mergers.

AMA welcomes National Drug Control Strategy's focus on harm reduction

The Biden administration's National Drug Control Strategy (PDF) provides a "sober, clear-eyed report" on the nation's drug overdose and death epidemic, said AMA Board Chair Bobby Mukkamala, MD, who also serves as chair of the AMA Substance Use and Pain Care Task Force. The report, which was released last week, emphasizes seven priorities:

1. Expanding access to evidence-based treatment, particularly medication for opioid use disorder
2. Advancing racial equity in our approach to drug policy
3. Enhancing evidence-based harm reduction efforts
4. Supporting evidence-based prevention efforts to reduce youth substance use

5. Reducing the supply of illicit substances
6. Advancing recovery-ready workplaces and expanding the addiction workforce
7. Expanding access to recovery support services

In a statement, Dr. Mukkamala praised the report and urged the administration to continue to take action to help remove barriers to medications for opioid use disorder as well as harm reduction services, including naloxone, syringe services programs and drug-checking supplies.

“The AMA urges all health insurers and state legislatures to take steps to make this strategy a reality,” said Dr. Mukkamala. “The AMA is a willing partner. This epidemic has gone on too long and claimed too many lives. We need to make sure evidence-based overdose prevention and treatment is available for everyone.”

CMS releases FY2023 IPPS proposed rule

On April 18, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2023 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) proposed rule proposing updates to Medicare fee-for-service payment rates and policies for acute care inpatient hospitals and long-term care hospitals.

In the rule, CMS proposes to increase payment rates by 3.2% for hospitals paid under the IPPS. In addition, CMS is proposing several policies intended to advance health equity, 10 new measures to the inpatient quality reporting (IQR) program and updates to Medicare’s Promoting Interoperability Program. The proposed rule also includes several requests for information on various policy topics including maternal health, climate change and health equity, and payment adjustments for N95 respirators.

AMA staff are currently reviewing the proposed rule in its entirety and will submit comments to CMS. For more information, read the full proposed rule, a CMS fact sheet highlighting key provisions and a fact sheet specific to the maternal health and health equity measures included in the proposed rule.

Physician resource available on CMS EFT/VCC guidance

In March, CMS released guidance on physician payment via electronic funds transfer (EFT) and virtual credit cards (VCC), as well as business associate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification requirements. AMA has developed a resource document (PDF) for physicians explaining policies detailed by CMS in this guidance.

Specifically, the resource covers physician payment via VCCs, physician use of health plan business associates, physician acceptance of EFT “value-add” services and liability for business associate HIPAA compliance. Key takeaways include:

- Health plans may not force physicians to use VCCs.
- Physicians can choose whether to work with a specific health plan business associate for certain services.
- Health plans may not force physicians to accept EFT “value-add” services (or, by extension, associated fees).

The policies communicated by CMS in these guidance documents are positive for physicians and well-aligned with AMA’s advocacy on EFT and virtual credit cards.

AMA supports NSA patient protections; urges fair IDR process in letter to administration

In an April 22 letter (PDF) to the Departments of Health and Human Services, Treasury and Labor, the AMA expressed its strong support for the patient protections offered by the No Surprises Act (NSA), which seeks to end surprise billing. In recent weeks, physician issues with the independent dispute resolution (IDR) process and its rebuttable presumption in favor of the insurer-derived qualified payment amount (QPA) have been mischaracterized, leading the AMA to once again express its support for the NSA and the end of surprise billing.

The AMA’s letter to the various Departments implementing the NSA states that the AMA “continues to support the goal of the NSA—to protect patients from the financial burdens of surprise medical bills—and we continue to work closely with physicians and the state and national specialty medical societies to ensure these important patient protections are in place” but also that an imbalanced IDR process could undermine the ability of physician practices to negotiate fair network contracts. The AMA will continue to work closely with HHS, Treasury and Labor to implement the NSA in the way that best protects patients while ensuring fairness for physicians.

Due to AMA advocacy, 2021 MIPS cost measures will not count toward final score

In response to the AMA’s concerns about COVID-19’s impact on cost measures, CMS will automatically reweight the 2021 Merit-based Incentive Payment System (MIPS) Cost Performance Category to 0% for all eligible clinicians and groups. In other words, cost measures will not be factored

into 2021 final MIPS scores that will impact Medicare physician payments in 2023. Physicians do not need to take any action.

The AMA has raised concerns about the unfairness of measuring physicians on cost measures that use a national average benchmark when COVID-19 surges are impacting geographic areas and specialties differently. This is the second year that CMS has agreed with the AMA's position and not counted cost measures towards MIPS final scores. Specifically, CMS found that most 2021 cost measures have higher observed and risk-adjusted costs at the episode level, indicating that risk adjustment at the episode level does not entirely account for differences in resource use, particularly for broader measures or measures that are clinically proximate to respiratory disease and COVID-19. CMS also found a small number of cost measures where scores may be adversely affected by the volume of episodes with a COVID-19 diagnosis.

If no other MIPS categories are reweighted due to an Extreme and Uncontrollable Circumstances or other exceptions, MIPS Quality and Promoting Interoperability Performance Category weights will increase as a result of the Cost Performance Category weight decreasing from 20% to 0. Specifically, quality measures will account for 55% of MIPS final scores, up from 40%, and Promoting Interoperability will increase from 25% to 30% of final scores.

The AMA appreciates that CMS will provide patient-level feedback reports on the 2021 cost measures for clinicians and groups who met the case minimums. Note that CMS will not include measure-level scoring information on cost measures as the agency cannot reliably calculate scores due to COVID-19.

AMA submits additional comment on OSHA Healthcare ETS

On April 22, the AMA submitted additional comments (PDF) in response to the Occupational Health and Safety Administration's (OSHA) solicitation for additional comment on their Occupational Exposure to COVID-19 in Healthcare Settings Emergency Temporary Standard (ETS). The comment period was reopened as part of the OSHA process for finalizing a standard for health care settings. In the comments, AMA strongly urged OSHA to not make the standard permanent, to exempt non-hospital care settings or to otherwise exempt care settings in compliance with current Centers for Disease Control and Prevention (CDC) guidance on preventing COVID-19 transmission for health care workers.

Comments focused primarily on continued burdens to smaller practices and care settings of complying with multiple infection control guidelines and suggested that CDC guidelines were best positioned to be up to date with the rapidly changing threat of COVID-19.

AMA had previously submitted similar comments (PDF) on the initial OSHA Healthcare ETS. OSHA held a public hearing on potential finalization of the ETS on April 27.

AMA presses HRSA for heightened outreach and more time for late Period 1 reporting to retain Provider Relief Funds

The AMA met with the Health Resources and Services Administration (HRSA) leaders to strongly reiterate the need for more time for late reporting of Period 1 Provider Relief Funds (PRF) by those recipients who did not report through the HRSA PRF Reporting Portal by the Nov. 30, 2021, deadline. The AMA was astonished to learn the number of providers who missed the deadline was closer to 16,000, a 60% increase over the originally published number. Reporting is required by physicians who received \$10,000 or more in Provider Relief Funds. Those who fail to report are subject to recoupment of the funds.

The AMA offered to work with HRSA on outreach to the remaining physicians beyond the two emails and one U.S. postal letter that have been sent. While HRSA cited privacy concerns that limit their ability to share the list of physicians with the AMA, our organization has continued to emphasize the steps to comply with the reporting deadline. The AMA sent a follow-up letter (PDF) to HRSA addressing concerns subsequent to the meeting.

The AMA vigorously debunked the notion that physicians who did not report do not need the Provider Relief Funds and were waiting to have the funds recouped. The AMA reiterated that the funds are needed, especially by the rural and small practices that have used the funds to address staffing shortages, high-priced medical equipment, and to compensate for reduced patient encounters. The AMA also asked HRSA for data on how many late reporting forms were received. As the data becomes available, the AMA will continue to ask for greater flexibility to allow physicians to become compliant with the reporting requirements and will restate its offer to assist with outreach to physicians.

Increased funding for Hospitals Promoting Breastfeeding program

It was recently announced that the Fiscal Year 2022 budget includes \$9.75M for the CDC Hospitals Promoting Breastfeeding program, an increase of \$250K from the previous year. Last year, the AMA signed on to a letter (PDF) urging for this increased investment into the Promoting Breastfeeding program, as the AMA believes that good nutrition and healthy weight gain begins with breastfeeding.

This investment will help build and strengthen programs and initiatives throughout the nation to:

- Improve maternity care practices
- Increase access to lactation support
- Ensure continuity of breastfeeding care
- Increase support for lactating employees
- Address disparities in breastfeeding rates

The AMA is thankful for this increased budget and looks forward to the promotion of optimal breastfeeding practices and increasing breastfeeding rates throughout the U.S.

AMA provides input to FTC on PBM practices

In an April 26 letter, the AMA provided comments to the FTC on a variety of topics related to the impact of pharmacy benefit managers (PBM) on prescription drug access and affordability. The letter was in response to a request for information (RFI) issued by the FTC as part of their recent dive into PBM practices and their impact on drug pricing and patient access.

In response to the broad RFI, AMA commented in support of increasing PBM transparency and provided significant comment on PBMs' use of utilization management policies to the detriment of patient care. Additionally, the AMA urged careful monitoring and possible intervention in both horizontal and vertical consolidation in this space, citing the potential for significant anti-competitive impacts in these cases.

More articles in this issue

- April 29, 2022: Advocacy Update spotlight on major wins for scope of practice
- April 29, 2022: State Advocacy Update
- April 29, 2022: Advocacy Update other news