Aug. 5, 2022: National Advocacy Update

Big steps for bill to streamline prior authorization in Medicare Advantage

The House Ways and Means Committee has successfully marked up and passed via voice vote legislation that would streamline prior authorization processes in Medicare Advantage plans.

The major legislative milestone for “The Improving Seniors' Timely Access to Care Act of 2022” (H.R. 8487)—which has broad bipartisan support—came via a bipartisan agreement between Ways and Means Committee Chair Richard Neal, a Massachusetts Democrat, and the committee’s ranking member, Texas Republican Kevin Brady.

In a statement on the markup, AMA President Jack Resneck Jr., MD, said, “The American Medical Association (AMA) applauds the House Ways and Means Committee—and specifically Chairman Neal and Ranking Member Brady—for today’s successful markup of legislation to streamline and standardize onerous prior authorization processes that for too long have harmed patients and sapped physician hours. Bipartisan approval of the ‘Improving Seniors’ Timely Access to Care Act of 2022’ is an important step toward addressing this problem within Medicare Advantage plans.”

“For years, the American Medical Association has sounded the alarm about burdensome prior authorization processes and their negative impact on patient outcomes. Too often, prior authorization has resulted in delayed, denied, or abandoned care. In fact, according to AMA survey data (PDF), more than one-third (34%) of physicians reported that prior authorization led to a serious adverse event, such as hospitalization, disability, or even death, for a patient in their care. The AMA remains committed to fixing prior authorization, and made doing so a central tenet of our Recovery Plan for America’s Physicians.”

Specifically, the bill would:

- Require Medicare Advantage plans to implement electronic prior-authorization programs that adhere to newly developed federal standards, as well as establish real-time decision-making processes for items and services that are identified as “routinely approved.”

- Mandate that Medicare Advantage plans issue accelerated prior authorization decisions for all other services in Medicare Part C.
- Enhance transparency by requiring Medicare Advantage plans to report to the Centers for Medicare & Medicaid Services on the extent of their use of prior authorization and the rate of approvals and denials.

Read the full story by Kevin B. O'Reilly, AMA news editor, for more details. Additionally, patients, physicians and employers can learn more about reform efforts and share their personal experiences with prior authorization at FixPriorAuth.org.

Lawsuit could stop 150 million from getting free preventive care

Led by the AMA, leading medical organizations that represent physicians providing vital preventive health care services to millions of patients with private health plan coverage expressed concern that a federal court case could cause millions of Americans to lose access to preventive services. Kelley v. Becerra, a lawsuit before a federal district court judge in the Northern District of Texas, threatens the section of the Affordable Care Act (ACA) requiring insurers and group health plans to cover more than 100 preventive health services—with no cost to consumers. One of the ACA's most popular and widely recognized benefits, the provision resulted in an estimated 151.6 million people receiving free preventive care in 2020 alone.

"With an adverse ruling, patients would lose access to vital preventive health care services, such as screening for breast cancer, colorectal cancer, cervical cancer, obesity, heart disease, diabetes, preeclampsia, and hearing, as well as well child visits and access to immunizations critical to maintaining a healthy population," the organizations wrote. "Our patients cannot afford to lose this critical access to preventive health care services. Rolling back this access would reverse important progress and make it harder for physicians to diagnose and treat diseases and medical conditions that, if caught early, are significantly more manageable."

The joint statement sounding alarms about this threat to preventive services was signed by 61 organizations.

Read the full statement for more information.

Huge House win puts telehealth extension in Senate's hands

The House of Representatives voted overwhelmingly for a bipartisan bill that extends Medicare telehealth payment and regulatory flexibilities through the end of 2024. The House's 416–12 vote last week is a manifestation of the massive support among lawmakers, patients and physicians to build on the gains of telehealth seen during the COVID-19 pandemic and ensure it continues to be an accessible mode of care for the long haul.

According to a statement in response to the vote from AMA President Jack Resneck Jr., MD, "Increased Medicare-covered access to telehealth has been a lifeline to patients and physicians throughout the COVID-19 pandemic, and the American Medical Association (AMA) is pleased by today's bipartisan vote in the House. The COVID-19 public health emergency made plain that care via telehealth should be available to all Medicare patients, especially with their own physicians, regardless of where they live or how they access these services.

From continuity of care, broadened access to care, and removing geographic and originating-site restrictions, our hope is that the flexibilities afforded during the public health emergency will be made permanent. This legislation offers an important step in that direction by extending telehealth benefits to Dec. 31, 2024. We urge the Senate to act on this bipartisan bill, and for the Congress to build on this success."

For more information, read the full story from Kevin B. O'Reilly, AMA news editor.

Health care organizations press Congress to pass Conrad 30 legislation

The AMA, in conjunction with 60 national medical specialty, hospital and patient organizations, cosigned a July 29 letter urging the House (PDF) and Senate (PDF) Judiciary Committees to expeditiously pass H.R. 3541/S. 1810, the Conrad State 30 and Physician Access Reauthorization Act. The letter is an effort to turn the strong bipartisan support the bill has already generated in both chambers into legislative action. More specifically, the House and Senate bills have garnered 110 and 26 bipartisan cosponsors, respectively, and the legislation was a focal point during a Feb. 2022 hearing (PDF) in the House Judiciary Subcommittee on Immigration and Citizenship concerning the role of immigrant physicians in the American health care system.

Created in 1994, the Conrad State 30 program has brought thousands of foreign physicians that complete their residency in the U.S. to rural, inner city and other medically disadvantaged communities. Physicians who come to the U.S. on a J-1 visa to complete their residency are required to return to their country of origin for two years before they can apply for another visa or green card. Under the Conrad 30 program, each state is allocated 30 waivers that exempt J-1 physicians from the requirement to return to their country of origin in exchange for three years of service in an underserved

community. The program in its current structure plays an important role in helping to address the ongoing shortage of physicians, especially in rural or indigent areas.

Despite its past success, the Conrad 30 program needs expansion and improvement. In particular, H.R. 3541/S. 1810 seek to enact a number of targeted improvements including:

- Creating a process that would permit the federal government to allocate 45 total waivers to states
- Instituting new employment protections for Conrad 30 recipients, such as extending the amount of time between when the physician receives the waiver and when the work must begin
- Clarifying that expressing an intent to receive a Conrad 30 waiver at a future date does not prohibit physicians from obtaining a J-1 visa for GME
- Allowing spouses and children of Conrad 30 recipients to also be exempt from the two-year country of origin requirements
- Enabling physicians who complete five years of service in an underserved community or VA facility to receive expedited consideration for a green card

As stated in the July 29 letter, “The Conrad State 30 program provides an opportunity for IMG (international medical graduates) physicians who complete their residency in the United States to immediately provide necessary care in underserved locations. The bipartisan reforms included in this legislation are essential to helping combat the healthcare workforce shortage especially as we are entering a period with a rapidly increasing demand for physicians.”

Patient survey shows unresolved tension over health data privacy

The AMA and Savvy, a patient-owned cooperative, surveyed 1,000 patients across the U.S. on their perspectives toward the privacy of their medical information. By understanding the patient perspective on data privacy (PDF), industry and government can better act to help patients and their care team protect medical information and strengthen trust. The survey illustrates that patients are deeply concerned over the lack of security and confidentiality of personal health information.

Key findings include:

- More than 92% of people believe privacy is a right and their health data should not be available for purchase by corporations or other individuals.
- Patients are most comfortable with their physician or hospital having access to their data but least comfortable with social media sites, employers and big technology companies receiving

access to their data.
- 59% of patients worry about health data being used by companies to discriminate against them or their loved ones or to exclude them from opportunities to find housing, gain employment and receive benefits.

Patients trust that physicians are committed to protecting patient privacy—a crucial element for honest health discussions. Many digital health technologies, however, lack even basic privacy safeguards. More must be done by policymakers and developers to protect patients' health information. This concern is magnified with recent U.S. court rulings as the lack of data privacy could place patients and physicians in legal peril in states that restrict reproductive health services. Most apps and digital health tools are either unregulated or underregulated, requiring near and long-term policy initiatives and robust enforcement by federal and state regulators.

These survey findings (PDF) shed light on fundamental data privacy issues that can impact individuals nationwide. The AMA is calling on all policymakers—Congress and the administration—to take much-needed action to protect health information.

Physicians appreciate Appropriate Use Criteria delay, urge improvements

In a letter (PDF) to the Centers for Medicare & Medicaid Services (CMS), the AMA thanked the agency for delaying implementation of the penalty phase of the Appropriate Use Criteria (AUC) Program and continuing the Education and Operational Testing Period. The AMA appreciates the agency's recognition that physicians and their software vendors need more time before CMS begins enforcing the AUC Program, which requires consultation of AUC for advanced diagnostic imaging services by an ordering professional and claims-based reporting of the AUC information by the rendering professional.

The AMA also called on CMS to utilize this time to modify the AUC Program using its existing authority and to work with Congress for any additional authority needed to reduce burden, increase flexibility and maximize alignment with the Quality Payment Program (QPP). Specifically, the AMA recommended that CMS:

- Exempt from AUC qualifying alternative payment model participants and physicians who opt into the new Merit-based Incentive Payment System (MIPS) Value Pathways track.
- Apply the MIPS small practice exception to the AUC Program, as small practices are disadvantaged in programs that require substantial technological investments and staff time to comply.

- Evaluate alternatives to claims-based reporting of AUC information, including leveraging the data collected by third-party vendors like clinical decision support mechanisms and registries.
- Clarify that the medical emergency hardship exception applies to all care subject to the Emergency Medical Treatment and Labor Act. The AMA has heard concerns that the exception for suspected or confirmed medical emergencies is too narrow and subjective, and, as a result, is being interpreted to require emergency physicians to consult AUC.

CMS releases 2020 MIPS and APM participation and performance data

In the long-awaited 2020 Quality Payment Program (QPP) Experience report (PDF), CMS includes data about 2020 participation in the MIPS and alternative payment models (APMs), reporting options and performance categories, and final score and payment adjustments. As a result of AMA advocacy, CMS applied a MIPS automatic hardship exception policy in 2020 due to the impact of COVID-19, which held harmless physicians who did not submit data in two or more MIPS categories from a penalty and reweighted the Cost Performance Category to 0% of the final score. These flexibilities meant that 98% of MIPS-eligible clinicians avoided a penalty in 2020. Additional key findings include:

- 91% of MIPS-eligible clinicians received a positive payment adjustment in 2020 based on a performance threshold of 45 points.
- MIPS-eligible clinicians participating in APM Entities continued to earn the highest mean final score (96.24) in 2020, followed by groups (86.59), individuals (64.66) and virtual groups (38.89).
- The mean final score for MIPS-eligible clinicians participating as individuals rose from 52.44 in 2019 to 64.66 in 2020.
- The average final score for small practices remained largely the same at 69.56 in 2020 compared to 69.07 in 2019.
- The number of Qualifying Advanced Payment Model Participants (QPs) rose from 195,564 clinicians in 2019 to 235,225 in 2020.

Share your feedback regarding Provider Relief Fund reporting

The AMA has advocated for physician increased reporting time and an appeals process related to the Provider Relief Fund and has been instrumental in securing major revisions to the reporting process. Through AMA meetings and correspondence with the Health Resources and Services Administration (HRSA), the agency has created a late reporting process for Period 1 and Period 2, and in direct

response to AMA advocacy, it has recently instituted an appeals process to accommodate those providers who returned their funds before a late reporting period was implemented.

While there has been progress, work remains to be done on the Provider Relief Fund issues. The Government Accountability Office (GAO) is conducting a review of HRSA's oversight of the Provider Relief Fund. The AMA has been asked to provide testimonials and insights into important areas to help inform the report:

- Inaccuracy, overpayment or explanations of the PRF payment received—Did you understand how your payment was calculated? Was your payment different than what it should have been?
- The one-year timeframe to use provider relief funds—Was this enough time to use the funds as HRSA described?
- Did you have any issues or concerns with HRSA's reporting requirements, including administrative burden for completing the information by quarter? Was the calculation of COVID-related losses and expenses relatively easy to do?
- If anyone has received an audit from HRSA, we welcome the opportunity to hear from you.

Should you wish to provide your insight into any of the mentioned areas or have additional feedback related to the Provider Relief Fund, please contact Danielle Turnipseed at Danielle.Turnipseed@ama-assn.org or (404) 441-4635 by Wednesday, Aug. 17. The AMA thanks members in advance for their feedback.

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