AMA Advocacy Insights webinar series: What Congress needs to do now

Featured topic and speakers

As we approach the end of this year and head into the next, physicians are taking this message to Congress: Reforming Medicare payment and fixing prior authorization need to top the agenda. Without Congressional action, physician practices that have already been weathered by the pandemic will face an 8%+ pay cut next year. Not only that but prior authorization continues to delay patient care, cause patient harm and create practice hassles.

Watch this AMA Advocacy Insights webinar to hear about the AMA’s grassroots calls to action on these issues and what you can do.

Moderator

- Jack Resneck Jr., MD, president, AMA

Speakers

- Todd Askew, senior vice president, Advocacy, AMA
- Jason Marino, director, Congressional Affairs, AMA

Transcript

Dr. Resneck: Greetings, friends and colleagues, and thank you for joining us for today's Advocacy Insights webinar. I'm Jack Resneck, president of the American Medical Association and I'm really glad to be here today talking about two issues that urgently need congressional action—first, addressing
looming cuts to Medicare physician payments and, second, fixing the broken prior authorization process.

We're also going to discuss how you can help influence Congress on these issues. This has been a rough three years for physicians. You've put your lives on the line during the COVID-19 pandemic. You fought disinformation during your free time. You've dealt with growing burdens and obstacles like prior auth, struggled with pandemic-related fiscal uncertainties and now face sharply increased practice cost as you try to retain staff and work around supply chain issues during a period of unusually high inflation.

I can't think of a worse time for Medicare to threaten you with 8 and a half percent payment cuts. For 20 years, physicians have gone without an inflationary update in payment. This actually means Medicare physician payments dropped by 22%, adjusted for inflation, between 2001 and 2021, according to an AMA analysis of Medicare trustees data—22%—this while hospitals, nursing facilities and hospices, and others continue to get automatic inflation-based updates every year.

Apart from being tremendously unfair, it's also unsustainable, threatening patient access to care. There are a few sources for those 8.42% cuts and they include a 1.4% cut as part of budget neutrality to offset other payment policy improvements, an automatic 4% cut triggered by a congressional pay as you go, or PAYGO rules—those are the result of new federal spending that really has nothing to do with physicians—and a 3% reduction on top of all of that from letting prior COVID-related spending lapse just at a time when inflation continues to hit physician offices.

All of these cuts will kick in next year in 2023 unless waived by Congress. As I mentioned earlier, we face these cuts while other parts of the health care system get their automatic inflationary updates. Like all of you, I remember that we went through basically the same battle last year. So right now we must stop the 2023 physician payment cuts by advocating for passage of a bipartisan bill called the "Supporting Medicare Providers Act," H.R. 8800.

But in the longer term, this madness just has to stop, so we're laying the groundwork and building support for permanent Medicare reform. Physicians deserve financial stability and that includes automatic inflation-based annual updates that account for rising practice costs, and importantly, removal of budget neutrality rules.

The next item that needs action for Congress in the current administration is prior auth reform. If you've seen me speak just about anywhere, you've probably heard me talk about this issue, because it really, really frustrates me. I'm a dermatologist in my day job and I knew we hit a real low when I started having to fill out prior auths for generic topical cortisone creams invented in the 1960s.

It's pretty rare that I lose my temper but when it does happen and my staff hears me get really frustrated, it is almost always when I'm on the phone with a so-called peer-to-peer, arguing about some ridiculous denial or a suggestion that I give a patient an alternative that, frankly, would be
malpractice. Our data shows that the average physician across all specialties now does 41 prior auths per week—41.

This burden has really spiraled out of control and enough is enough. I'm happy to report there has been some good news on this front. At the state level, we're starting to see more and more bills passed to right size this prior auth mess. Most elected officials have now had their own experience with prior auth or witnessed it happen to a family member or friend, so they increasingly get it.

And at the Congressional level, the House of Representatives unanimously passed H.R. 3173, the Improving Seniors' Timely Access to Care Act, in September. That bill begins to address some of the prior auth problems in Medicare Advantage plans, which would reduce unnecessary delays in care, but we still need the Senate to act. There is a Senate companion bill, S. 3018, also titled the Improving Seniors' Timely Access to Care Act. And while it too enjoys broad bipartisan support, it has hit a snag, which we're going to discuss in a little bit.

So with us today are two advocacy experts from our AMA. And many of them already but I'll introduce them briefly. First, I'm delighted to introduce Todd Askew. Todd's AMA's senior vice president for advocacy. In this role, Todd leads the AMA's legislative, government affairs, political, health policy and private sector advocacy activities. Todd has extensive Washington experience and a track record of success on our advocacy initiatives. Welcome, Todd.

**Askew:** Thanks, Jack. Great to be here.

**Dr. Resneck:** Our second guest is Jason Marino, AMA's director of Congressional Affairs. Jason's a strong and passionate advocate for AMA policy. He's responsible for lobbying Congress on AMA federal advocacy priorities. Physicians and our patients are lucky to have Jason in our corner. Welcome, Jason.

**Marino:** Thanks, Dr. Resneck. Happy to be here.

**Dr. Resneck:** Thank you both for being here. So let's just jump right in. I'm going to pose some questions to the panel and then we'll move into a Q&A for questions from our audience. If you have questions, please feel free to contact us using the Q&A feature in Zoom. And we're also recording today's presentation and we'll send you a link to share with your colleagues.

All right, Todd, I'm going to start with you. Let's talk a little bit about Medicare and where we are at this moment. I hate to relive the trauma but can you remind us of how we got to this point where Medicare is on such an unsustainable path yet again?

**Askew:** Sure. We have been here before. You'll recall back in 2015, because of the previous payment system, known as the sustainable growth rate formula, we were facing cuts of over 20%, which is the culmination of a long series of what we're going through now, cliff financing and fixes that came one
after another, but no real effort at fundamental reform.

And in 2015, MACRO was enacted, which replaced the sustainable growth rate system with two real components—one, the MIPS program which was quality reporting. And the second—the option would be alternative payment models. So physicians could engage in new ways of delivering care to benefit patients and receive payment for those unique models.

And while those efforts were well-intended and probably a step in the right direction, it didn't really—the program has never really developed as was promised. One element of the macro bill was statutory freezes followed by very small updates, as opposed to a real inflationary update to keep up with the cost of delivering care. And that was largely for financial reasons. This was an extremely expensive bill. It was $140 billion or so.

So they felt that those freezes, while they understood they were not sustainable in the short term, were necessary to finance the—to pay for the bill or to pass the bill. And I don't think anybody thought they would not be coming back to revisit those. The MIPS component itself was really just kind of an amalgamation of some legacy quality reporting programs designed to help report quality data, encourage the use of EHRs, implement other clinical improvement activities within practices.

But the way it was implemented, the reporting requirements proved to be extremely burdensome for physician practices. Especially small practices were finding that it costs more to participate in the program than they ever hope to benefit from financially by participating. And so that has kind of held it back from being a really dynamic—dynamic as we, obviously, hoped it would have been.

And then also the alternative payment models—that was kind of the great promise. Nobody thought MIPS was the long-term solution. That was a bridge to get us into where physicians and physician practices could engage in health care and health care delivery in new ways. And physician practices and physician specialties were enthusiastic about it and have suggested all types of new models and new ways that they can from their experience deliver better care but very few of those models have been adopted through the process set up by HHS.

So while you may have practices that want to do this, there's nothing for them to do. There's no way for them to engage. So those two implementation issues with the MACRA program, combined with that lack of an inflationary update and the resulting requirement—and the requirements for budget neutrality adjustments, have really left us in a situation where we’re not talking about big reform like we need to be.

We're not talking about moving the program forward. We are falling back into this cadence where we've been before of every year having to get up to the end of the year and fight just to keep our heads above water. So it's very much the same situation we saw with the SGR. And as you said, we've been here before. And I think we know what we need to do to move forward.
Dr. Resneck: Yeah. It's unfortunate how much oxygen this just sucks out of the room every November, December and when we have all these other things we want to be working on. Thanks, Todd. Jason, last year physician practices, as we said, we're facing more than 10% in payment cuts. And those were stopped, thanks to sustained grassroots efforts from docs, from the AMA and our Medical Society colleagues really around the country.

I briefly mentioned the sources of these cuts in my opening comments but can you expand a little bit on why they're occurring or scheduled to occur and what we're up against in the long term?

Marino: Absolutely. I'll just say the stakes are high in that right now, we're in congressional recess. We have the elections next Tuesday. It'll take about a week or so to digest what happened in the election and then they come back. The staff come back the members all come back and they decide what we're going to do in a lame duck session before the new Congress begins in January—still got unfinished business between now and December.

And we are facing right now about, as you mentioned, 8.5% cuts. And just to unpack that, 4% of the Medicare across the board cut is from—it's called statutory PAYGO. It was an unrelated bill that passed Congress that triggered this across the board cut of 4%—nothing to do with physicians, as you mentioned, Dr. Resneck. And then you also have a new cut, a 4.5% cut. This is result of—they increase them by E&M services.

And when you increase a service, every year is physician fee schedule rule. And in the fee schedule rule, they increase the end services. And that check is what's called budget neutrality cuts. They increase it here. They have to pay for it by cutting every service across the board. And we had one a few years back. That was about 3.75.

And then we have a new one that was this year, because first it was E&M for office-space services that were increased, and then there was an increase for facility services for nursing homes, hospitals, home health. And that triggered a new 1.42% cut. And so you combine those, it's 4.5 about. And we're trying to say, stop that combined cut from happening this year. We've had success in the last two years stopping these cuts but we were told both times—especially last year—we hear you.

This was a one time—we did it a second time. That's it. We're done. We're not doing this every year. And we come back and said, well, we don't want to be here either. We don't want to be here at the end of the year stopping cuts. We want a permanent solution. But we have to be here, because we can't face these cuts. And they think that they were going to give us this one or two years, and we're coming back again and we're saying, well, look at the inflation rates—8.2% plus. We can't sustain these cuts.

So we have to get that done in the lame duck session. And we don't have the playing field to ourselves, so to speak. The hospitals—while they're increased with 3.8%, they need to say, well, inflation's 8.2%. We want some relief. And other providers are asking for relief. And there's other
issues outside of health care that cost money that are also—need to be addressed in the lame duck session of Congress. So the stakes are high for us to break through all of the other asks in—our asks are costly.

Dr. Resneck: Jason, in terms of getting through that mess and getting to yes, can you tell us a little bit about the legislation that's already out there and has been introduced to help provide some of the relief from the cuts?

Marino: Yeah. So I'll start first with some good news. The 4% statutory PAYGO cut that I mentioned—we are getting signs across the board that that's likely to be weighed, addressed. We are in a good spot on the 4% across the board cut. We've been pushing that. I feel like we're in a good spot.

But the 4.5%—this is the budget neutrality cuts—those we had Congressman, physician member, Dr. Bera a Democrat from California; a Republican physician, Dr. Bucshon from Indiana, that got together and introduced a bill, H.R. 8800.

It's called the—if I get exact name—Supporting Medicare Providers Act of 2022. And it has 72 co-sponsors. This bill would stop the 4.5% cut next year. It would prevent those cuts. And it has 72 co-sponsors. It was just recently introduced. We're going to try and drive that co-sponsorship number higher. We encourage you to call in, encourage your House members to sign on to that bill.

It's a signal to leadership on both sides, from Democrats and Republican leadership, that this is important priority—needs to be addressed. And we really need to drive those numbers up. And this bill is clean, and it fixes that. It's bipartisan.

Dr. Resneck: Speaking of signals, sometimes members of Congress create these dear colleague letters to sort of set the stage, and I know—I've seen one from Senator Stabenow and Barrasso to Senate leadership on this issue. What does that letter ask for? What does it say about congressional sentiment and where we stand?

Marino: This letter said, Dear colleague—that Senator Stabenow and Senator Barrasso, a physician member from Wyoming—got together and it basically said, physician practices can't sustain these cuts right now at this E&M, this 4.5% cut. It's too much and it's going to impede patient access. It's a letter to Senate leadership saying, we got to address this, essentially, in the lame duck.

And we need to address this—the whole MACRA, the whole Medicare payment system in a fiscally responsible way, permanently. It's not going to happen this year but that's got to be top of the list next Congress. We need to fix this. And I'm happy to say it closed out last night. We had 46 signers of that letter—bipartisan.

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It ranged the spectrum of ideology. That's a good showing for a Senate letter. It's hard to get senators on a letter, especially when they're all off campaigning. It was timed—the final rule—I mentioned there was a physician fee schedule that comes out every year. That came out earlier this week, and that locked in—that officially locks in the cuts. And the letter came right after that, and you're trying to create as big a splash as possible.

And it's gotten some good media coverage and it's on members' radar. We just spoke to the—some of the key Senate Finance Committee. They saw the letter. They thought it would help them. It puts it higher on the list. So those letters are very helpful.

**Dr. Resneck:** So Jason, just to sum things up for all of us who are going to be reaching out to Congress, so we got our short-term plan and our long-term plan. Can you just summarize briefly what the—what we're asking Congress to do really by year end?

**Marino:** So what you're asking year end—and I think this is really important that—as a physician reaching out to a member of Congress, that you put things in your own words and tell your story about what an 8.5% Medicare cut would mean to your practice. You've lived the last 21 years, which has only been a 10% increase and you've lost to inflation. You're living through an environment where next year, you're not going to get an update in your payments and so you cannot sustain a cut.

If you're not going to get an MEI or an update for inflation, then you shouldn't be getting cut. And you have to realize that we're not saying cut the other providers but they're also making the same pitch. And they're saying, we're hurting too. Well, we're hurting more. And if there's limited dollars, we should be a top priority. And I think you got to say you can't have one dime of cut. If you're not going to give us an increase, we can't have one dime.

And you have to say in your own words. And you have to say things like—I've heard other physicians in other meetings have mentioned how there was—when a physician was 65 years old, he just—he was trying to find a primary care physician. He couldn't. He couldn't even get his old colleagues to see him. And he's a physician, and he couldn't get his friends to see him. That's how bad it is in some parts. That was in California.

And they need to hear that that's the real world, or that you might retire. And you're one of the most esteemed professions. People respect the physicians. They save lives. You go into it to help people. And all the training involved—one person retires five years prematurely—they're 60 but retire at 55 or retire at 60 when they could have retired at 65—that's a big loss to a community. All that experience is gone.

And people get that but you have to say it in your own words and you have to stay focused. You can't talk about all the other issues that you might want to talk about. You really got to talk about not one dime of Medicare cut can happen this year. It's not like you can tell your suppliers, "Oh, I'm getting a 4.5% cut. Can you just cut my supplies 4.5?" You can't tell that to your staff.
You live in the real world, and you have real costs that are not being addressed by Medicare and you can't afford one dime of cut. And say it in your own words but it has to be forceful, because you have to break through.

Dr. Resneck: Those are really good points. It made me think that—we have recent survey data that one in five docs are contemplating quitting practice in the next two years, at a time when wait times for patients are really long and access is a huge issue. So the implication of another round of cuts would just be really devastating, so it is important to really bring that up when we talk to members of Congress.

Just a reminder to those of you who have joined us or joined us late, that you can use the Q&A function in the Zoom chat to let us know if you have questions—and we are going to have some time for questions and a little bit. In the meantime, Todd, I want to turn back to you so over the summer, AMA and—I think it was over 120 state associations and specialty societies put out a set of principles on Medicare payment reform.

And it's great to see the whole profession just so aligned in what we're asking for. So as we look to the next year and beyond, can you talk a little bit about what we're asking Congress to do for the medium and longer term?

Askew: Sure. The document you're referring to is titled "The Characteristics of a Rational Medicare Payment System"—not intended to be the complete answer but it was intended to be, from the perspective of organized medicine, what are the characteristics? What should we be looking for in asking for in a new system?

Financial stability is one, recognizing that we can do things to help financial stability and provide more efficient care. But that can't just all be on our backs. We need a system that works, more collaboration, rather than people desperately, a lot of times, having to consolidate with larger entities in order just to keep their doors open—encouraging innovation. These are the type of things that we need to be talking about.

And it's an important point that most all of organized medicine—over 120 organizations—got together and came up with these principles, and have shared them now with policymakers on Capitol Hill in the administration to bring them into that conversation, to begin to talk about, how do you put the meat on the bones of these principles and develop in partnership with policymakers a plan for moving us beyond not just the cuts—which Jason really, I think, put out the call to—that's where our focus needs to be over the remaining weeks of this year—but what is the longer term vision?

And that in some sense has already been taken up by policymakers. There is a request for information from a bipartisan group of members of Congress from the committees of jurisdiction that will have the say over this asking some of those very questions, asking organizations around the country to come to them and talk to them about, in more detail, what would a more rational Medicare payment system
look, answer some specific questions.

Those answers—I think a lot of different organizations, including the AMA, submitted extensive comments on that just in the last few days. The deadline was earlier this week to have those submitted. And so where do we go from there? I think, regardless, we're facing an election—we're not sure what's going to happen but I think the fact that we see bipartisan commitment and bipartisan recognition to the need to address this problem over the long term puts us in a good place for the wheels of Congress beginning to turn—not just on the emergency basis at the end of the year, but in development of longer term policies and activities.

So I do think we will see hearings early in the year looking at MACRA—what has worked, what, very importantly, has not worked and what a new system would look like a beginning of an exploration by Congress on what's next. That's not something that happens in a few weeks or a few months. It's something that we have been working on for over a year. It will take another year. It will take maybe two more years.

But this is where you have to start, with direct engagement by policymakers, direct interests, bringing them into the conversation, not telling them, this is exactly what we need, but to have that two-way conversation so that there is some ownership, some bipartisan support, and some level of understanding between policymakers and physicians about how we move forward. So we're looking forward to that conversation. It's already beginning, and I think it's going to be a place where every physician can get involved and be part of that conversation.

Dr. Resneck: I've been really impressed with the groundwork that you and your team are laying, and really the whole federation is doing on this front. How can individual docs contribute to this effort?

Askew: Well, part of it is those folks that are on the call today, stayed in touch, listening out for us, becoming involved in the AMA's position grassroots networks, listening out for information from your state medical associations from your specialties. There going to be plenty of opportunities to make our voices heard.

And the most important thing, though—it applies to what Jason talked about with the pending cuts this year but you've got to talk about the impact of this current Medicare physician payment system over the long-term ability for physicians to keep their practices open, for physicians continue to serve Medicare beneficiaries at the level they are serving them.

You got to make sure they understand what those challenges are—not where we as government affairs professionals are talking about theoretical and the big plans. They need to know what changes, what impact it's having on your practice back home, the challenges you face. They need to absolutely hear in exquisite detail how it's going to change health care in their own communities and how it's going to negatively impact the health care access for their own beneficiaries before they really begin to feel the imperative for change in a world where there are going to be a lot of competing demands for
limited federal resources and for limited time that the committee process in Congress has to take on a number of issues. We need to be at the front of that line, at the top of that list. You get there by having that ongoing dialogue with policymakers.

Dr. Resneck: Todd, I want to turn to prior auth for a few minutes. And it's—as you have seen, has really spiraled out of control. We talk to docs all the time who say, look, this has become my biggest area of friction and an obstacle to getting patients what they need. It's one of those things that really distracts and detracts from what drew us all to medicine in the first place, actually taking good care of patients.

Well, you've seen the data on this but you've also probably gotten an earful from frustrated docs and also patients who show up at the pharmacy and can't get their medications or can't get their procedures approved either. Tell us a little bit about the scope of the issue and how you view it as doing damage to the health care system.

Askew: Well, it is pervasive. It is in all basically areas of health insurance. We see it heavily in many Medicare Advantage programs. We see it in private and commercial insurers. I think the frustrations you expressed earlier in the conversation, the ones you just mentioned now, are those experienced by all physicians. Some of the recent studies—AMA keeps a very close tabs on this.

88% of physicians in our last survey reported that it directly has interfered with the continuity of care for their patients. 82% report they've seen patients abandon treatment because of the impossibility of going through this process. And I think one of the most critical numbers—34% of physicians in our survey have seen a serious adverse event directly attributable to delays associated with prior authorization.

And across the board, physicians report to us it's increasing that the number of PAs, the techniques, the types of things subject to prior authorization, it just grows year after year. You mentioned 41 prior authorizations per week. That is equivalent of two full-time staffers—or two full-time days for a staff member in a physician's office, all they're doing—40% of physicians have staff that all they do is work on prior authorization.

And that is not where we should be spending our resources. The resources of physician practices should be spent and directed towards patient care and improving quality, and the patient experience. And the fact that we just plow resources and time and effort into this process, which doesn't really show much benefit, is ridiculous. And so it is rightfully, I think, probably the number one thing we hear from physicians day to day that makes them frustrated with the practice of medicine that gets between them and their patients—and patients as well.

Patients have paid premium dollars for this care and now they have the organizations to which they pay their premium dollars actively working to deny them access to the care that they and their physician feel they need. So it's critical. If we're going to keep the health care system focused on the
Dr. Resneck: In my own office, we actually have multiple FTEs, equivalence work on this. But it can actually be a person or a couple of people, because it actually burns the staff out so badly that we have to rotate among them or else we’d have—we’d be losing staff because it's maddening for them too. Jason and I have been pleased to see some states actually take action. And I know AMA has collaborated with some state medical associations on this.

We've got gold carding in a couple of places. It's sort like TSA pre-check for prior auth, where if you're a doc who's practicing evidence-based medicine—as most of us are—and get most of your PAs approved, then you're excused from this whole process, which is really cool to see. At the federal level, there has been some movement, it looks like, with this Improving Seniors' Timely Access to Care legislation. What exactly would it do? I know that Congress actually has a role in regulating Medicare Advantage plans and that's the reason for the federal approach on this but what's our what's our position and what would it do?

Marino: Sure. As Todd mentioned, we've been dealing with prior authorization for quite some time now and it's getting worse. And in 2018, there was a consensus statement that emerged when the health plans, the AMA, hospitals, pharmacies all got together and said, "We can do prior authorization in Medicare Advantage better. It's not working. How do we improve it?"

How do we make better processes? How do we just make it work better? And everyone agreed, this is the way forward. And there was a big splash about that statement. And then that was later turned into legislation in 2018. And that's like two or three congresses ago. So it was introduced, and then we tried to push it, and just didn't get too much traction. The last Congress, it got a little more traction.

At the end of the year, there was a little movement and there was a draft and the plans got it, and it was all red. They hit too many changes they wanted and we didn't quite have momentum. So we started this Congress with the bill that you mentioned, the Improving Seniors’ Access to Timely Care legislation, and we did the old-school way, in that you get a bipartisan bill dropped and you just work it the entire Congress. And I'm happy to see ... And a lot of folks on this call help with that.

We went office to office, had congressional hearings that talked about some of the most egregious examples, mid-surgery prior authorizations, just all the worst case—and members got it. Why are we doing this? And we can do better. And here's the bill that can solve it. And everyone jumped on it. We—there's 435 House members. We have 326 members that sign on. You don't get numbers like that. That's very rare.

And we had the two House committees of jurisdiction passing unanimously. Usually, on a health care issue, you have the chair and the ranking Democrat, Republicans doing press releases. They both did press releases together. They did it with AMA on—in the press release, they were both cheering each
other, bipartisan. Everyone was happy. And then we were able to get this passed in the House in September by voice vote. That's a big deal—and so lot of momentum.

And we had HHS Inspector General report that came out, also amplified all the problems. So everyone recognized, we got to address this and we can do better. What the bill would do is have some transparency. First, show what is up for prior authorization? Why? What are the clinical guidelines? Are they updated? How long did it take to get it approved? Just tell the story, what's happening. And then why are we still using faxes and phones?

I just got a new printer in our office right here. It doesn't even have a fax capability anymore. That's dated. So why are—it's part of the problem. Why can't it be electronic? And so that can be done in real time, and it should be—everyone follows the same standard. You shouldn't have one for Aetna, one for Blue Cross, a new set of rules for the other Blue Cross.

It should be one and it should be simple. We can do this. And that's in there. And then there should be some standards for, if this is routinely a thing that's approved, usually always it should be 24 hours—if it's something that's not as usual, well, within seven days. It should be within reason, not two weeks, not one month dragged out.

And so that's all in the bill. We had a lot of momentum. There was a setback. Nothing gets through Congress easy. This is why it takes—sometimes it takes 10 years to get something through. It passed the House. We had momentum. We thought we were on a path to get it—you see in the Senate, which is really hard—everyone agrees in the Senate. And then we got the CBO score—Congressional Budget Office. They're a nonpartisan entity that is tasked with scoring all bills. How much will it cost over 10 years?

And they're the equivalent of the referee. And they came out and said, it's going to cost $16 billion over 10 years. And we were thinking it would be a no score or very small score, and not $16 billion over 10 years, at a time when that's a lot of money. And in CBO, when they come out with a score, it's kind of like—I coach my daughter's soccer team, and I have to sign every year a contract that says, I will never question the referee, because they have a shortage of referees and it's a bad look.

The referee makes a bad call, you just take it. You don't attack the referee. It is what it is. It's final. And it's like that with CBO. It's a bad call on their part. This is the worst part they are assuming that, if you're freed up—Dr. Resneck doesn't have 41 prior auths a week to deal with and spending two days of his staff time dealing with it, then he's going to be free to bill a bunch of new patients and spike up the cost of Medicare.

That's really what they said. They really think that it will increase utilization, because they'll be freed up to bill new patients and it's going to cost $16 billion. And even though we think that's faulty, we've sent information to them, other people have sent information, it's always one way. They don't talk to you really in real times.
And so it is what it is, but that means that the bill as drafted can't just pass. 16 billion is too much in this current fiscal environment. So where we are now is we have momentum, and you can never let up. You have to let up. There's an option, there's a rule at the Office of Management and Budget—that last step of a rule that administration puts out goes to OMB and then they can release it at their timeline.

And there's a chance that some of the electronic part of it that—get away from faxes—that may be in it, but they don't—it's not a public document. No one knows what's in it. We've had some key members of Congress call over to the administration and say, hey, here's our problem. We really could use some help with the rule. The problem is you don't know when they're released or how comprehensive it will be.

And the hope is that there could be a rule that's passed that will lower that score, but you don't know. And at the same time, you never know what can happen—the magic sometimes in the lame duck session, midnight, just before New Year's Eve—everyone wants to go home. Maybe they can cut a deal. And that's why we have the Senate Bill S. 318. And we need to keep the—we have 51. It's 51.

It's not public yet, because there are some people that committed to us, but we're going to when they come back in session, it's going to be 51. We want to get to 60—that's a magic number in the Senate—get it to 60, get it higher, and signal to the Senate leadership that this is really important. I know it's a problem at 16 billion. Let's just find a way, because the problem—prior auth is not going away.

Dr. Resneck: Right.

Marino: The patient access problem—that's not going away. And so we could—

Dr. Resneck: It's just totally maddening that the CBO score actually—it'll get held against us that patients who are not getting care because of prior auth will actually get care they need, and that that's a negative—totally frustrating. Todd, can you quickly address a couple of things? One, what—I had mentioned shopped progress in the States. And then also, CMS and HHS have some role here in regulating prior auth too. And so what's going on both of those fronts?

Askew: Right. So in the states, states have actually a bigger role in regulating insurance products, of course, than the federal government does. For the most part, in terms of commercial insurers. And so states have a lot of opportunity. I also think, in the states, you feel like you're closer to the problem. I think the legislators feel like they're closer to the problem. They're more engaged in insurance regulation activities and so there's just a great opportunity at the states to innovate and find new ways.

And we've seen some progress in states taking small step here, small step there. Other states can then emulate it and we try and share all those best practices and best thinking on this issue among states. And all the state medical associations are very attuned to opportunities here. And so we
support them in any way we can but that’s a real opportunity to advance—reform that prior authorization is at the state level as well.

And we can’t just pretend everything happens in Washington, because in this world, Washington’s ability to impact this may be even less than the ability of some states. Now, in terms of CMS, there probably is some opportunity there. Jason mentioned the rules that are out there that we’re waiting to see what they’ve done. They are not going to probably make this huge, massive change, although we are very much encouraging the administration to explore all options that they have through the regulatory process to enact some of these more important changes that Jason was discussing through the regulatory process.

And a lot of it is just an examination. They’re pushing CMS, pushing HHS to say, how is PA being used? Is it being implemented in a way that actually benefits the programs or is it being implement a way that burdens patients and physicians? What benefit does it actually bring and where are the opportunities?

You mentioned, I think, the generic topical cream that's been around for 50 years. Why are you doing PA there? And I guarantee you, I bet, once you sit on the phone for hour after hour, that they approve it almost every time. Why are we continuing to allow pre-authorization to occur on—for therapies that it's approved almost every time? It's just one more opportunity for a patient or physician just to abandon the attempt to get it covered.

And so those are the type of things they need to be looking at. And where can they apply their regulatory authority through the rulemaking process to make common sense improvements? PA is not going to go away. We're not just going to have a world where there is no review by payers of care being provided but there are so many cases where it just makes absolutely zero sense, unless it is primarily being done to encourage people to abandon care.

So we're encouraging the administration and we'll continue to encourage the administration to explore any opportunity, any pathway they have to make common sense improvements like that. And hope springs eternal but there are challenges to that approach and we will continue to hammer away.

**Dr. Resneck:** All right, I got a last question for both of you, and then I'm to bring up some audience and participant questions. We focus today on Medicare payment and prior auth. Is there anything else that could be moving related to health care during the lame duck?

**Askew:** Jason, do you want to—

**Marino:** I'll go first. One silver lining of COVID has been telehealth works. And we’ve had expansion of Medicare coverage for telehealth. And we even got past earlier this year. Once the public health emergency ends, then all of the expansion coverage goes away. And we got bill passed then—for five months after it expires. When the public health emergency ends, five more months of coverage, full
coverage of telehealth and then it goes away.

We got a bill passed in the House. Say, let's extend it for two full years, through 2024, just to give physicians more time, patients more certainty so you can plan and retool your practice accordingly, and give some time to make the case why it should be permanent. And the House passed the bill earlier this year, this summer—416 yes votes. That's pretty impressive.

And there's a chance to get that through at the end of the year. We're saying, let's just do that. That makes a lot of sense. And then I would say, on mental health, there's also—one of the most utilized codes for telehealth has been behavioral health care through telehealth. And just in general, mental health has become a big issue and it remains a big issue in this country.

And there's an issue, for instance, on workforce—behavioral health care workforce. And there's things you can do through grants and other ways to incentivize—even we're pushing for GME slots in that space that can help the pipeline issues. And then there's also the issue of things like the—it's called the MAAC, Mainstreaming Addiction treatment, where you can—the ... for buprenorphine decreased prescription access to those. It's very tightly limited—things like that.

Not all, unfortunately, I know is a source of frustration. That's not on the table. But things that I can mention here could be some smaller things that are meaningful that are on the table for the end of the year lame duck session, and then I'll—

**Askew:** And I would just mention one. I don't think we spend a lot of time on it. We maybe referenced it related to the Medicare payments—is the Value in Health Care Act. There is a pot of money—there was a pot of money, half a billion dollars to incentivize physicians to transition to alternative payment models. The problem was there were no alternative payment models. And that money expires.

2022 is the last year where you can participate and get access to those bonus funds there is a very strong bipartisan support for extending those the access to those grants to those funds. So as the federal government slowly begins to approve more opportunities for physicians to participate in alternative payment models, there will be that incentive pool there to help physicians with that transition. So I think we're hopeful that there's a pathway to see that done as well.

**Dr. Resneck:** Thanks. All right, so I want to try to get to as many audience questions as I can, so let's rapidly see how many we can get through. I'm going to start with one that asks, what is the best timing, given the election, for physicians to be reaching out to members of Congress and for our grassroots efforts as well?

**Askew:** Let me just add now, today, when you get off this call, reach out and then do it again next week. And on Monday when you're in the office, ask your staff to do it and ask—I mean, we have to be constantly in their ear. The phones need to be ringing. The email needs—box needs to be full, making an all-out push straight through. We got to be running full speed through the tape at the end of the
Marino: I’ll just give one example. My time when I worked in the Senate—you want to be the physician that is known in the office, the Senate office or House office. You want the Senator or House member thinking—because I dealt with this—so we met with Dr. Resneck six months ago. He asked about the Medicare thing. Where are we on that to the staff, member to the staff. Where are we on that?

And they want to have an answer because they know they’re going to speak to you again. You want them always thinking they’re going to speak to you again, have to see you again. Oh, God, look. Dr. Resneck. I met his fam—oh, my god—what are you doing to me? You want them feeling some pressure, and not a one and done, where they’re never going to see you again or have talked to you again. That’s why start now and keep talking, because we need a lot of help next Congress. So this is a good chance to build relationships for next Congress.

Dr. Resneck: Another question—AMA has been doing a tremendous amount of work across the board on health equity. And the question was how we’ve—whether we’ve spoken with legislators about the impact on health equity from all these impending cuts and sometimes who they can fall hardest upon.

Askew: No, I think that any time those who are marginalized, minoritized have less access to resources, less ability in many cases to fight for—to get the justice they need through the health care system, these burdens do fall less on them. A lot of folks can’t afford to pay out of pocket for this care that my insurer denied or what have you.

So each of these things, where it is a burden on your patients in terms of their financial ability or any other reason to engage in the health care system, is doubly so on those who have other disadvantages that have compounded their ability to—or compounded their opportunity to participate fully in our health care system. And so it is a magnifier, I think, of these problems, unfortunately.

Dr. Resneck: One question focused on budget neutrality, and its being really at the center of some of these problems. And that if we don’t get rid of that, there’s no fix. And they wanted to know what the prospects are for budget neutrality fix specifically.

Marino: I’ll jump in on that, we were just on a call for this with some of the Senate staff about this and that they asked, where these cuts keep coming from? And we tell them, look, the budget neutrality—if you make any change—every year, as a rule, if there is an adjustment to the payments and it hits more than $20 million—which was set 30 years ago, and no adjustment for inflation—it triggers this across the board cut.

And then the scope of things that can trigger are massive. And so I warn them. You’re going to deal with this every year. Unless you fix this, this is going to be—there’s always going to be something new. Who knows what next year’s rule’s going to bring, and the year after that? So let’s increase what
triggers it in the first place. Let's limit what allows it to be triggered.

And then a lot of the problem is that when the administration makes estimates. They overestimate its usage and then it's overcuts, but you can't reclaim it. Well, if you make an overestimation, we're cut. Let's reclaim it the next year or the year after that. There's things that make sense that can do that, but until they fix that, we're stuck here in this annual cuts in—You find out, where does this come from? And everyone always asks that. Where does it coming from? Every year there's a new thing.

**Askew:** Right. And Jason's absolutely correct. If the pot was growing, it wouldn't hurt as much when you have to make small rearrangements to rebalance things within the pool of funds. But when that pool of funds is static year after year after year, the impact of those changes is magnified. And to Jason's point, if they did a better job at estimating the utilization of some of these services—they assume that spending will go way up on a particular service and so that money gets moved, but when that spending doesn't happen, there's no way to bring that back in and redistribute it among the other services.

So exactly what Jason said—more opportunity to retrospectively look back and see, did they get that estimate right? But the key is really, you got to grow the size of the pot. You can't just keep rearranging things and hope that a cut is not going to fall on one particular service or one particular type of care.

**Dr. Resneck:** We got a couple of questions actually related to that fixed pie and how it's getting sliced. And one was how we got to a place where hospitals and MIPS have these automatic positive inflation-based updates and we don't. And the second one actually related to Medicare Advantage plans, in particular, and our thoughts on their failure to provide data about their costs—and that—it doesn't feed into the Medicare database or the CPT and RUC don't see those data, and it distorts things, and some of the extra funds that Medicare Advantage plans are getting. So any thoughts about—is AMA taking stands on either of these things?

**Marino:** I'll jump in first and I'll give Medicare Advantage to Todd. Just where are we today? Why are we here? A thought exercise—if you had a design payment system for hospitals, nursing homes, physicians right now, would you design it this way? I don't think so. Who would do this? Who would design this? It's a good question to ask people.

Why is it designed this way? And a lot of it is just things that happened years ago, decades ago, where one payment system got set up or tweaked, some "middle of the night deal" with some big massive bill in 1998. And then with us, our unique story is that we had the SGR, which was flawed and triggering all these cuts—and they used gimmicks to pay for them along all the years, 17 different little fixes and it grew the pot.

And just to get rid of that debt, we had to take a bill that got rid of all that debt but there's only so much you could do to get updates. Life's not fair. It's one of the examples I—it's not fair. It's not rationally
developed. And we're saying, this needs to be fixed.

This is unsustainable. This is not how you treat professions or preserve access to patients. This system's not working. I know it's complicated how we got here. That doesn't matter. It's all about what we do next going forward. This is not a sustainable payment system for physicians or their patients.

**Askew:** And on Medicare Advantage, I think we are starting to see—in fact, we are seeing explicitly the last couple of months—greater scrutiny, I think, in the way that those updates are calculated and in the—you've seen a lot of folks talking about the coding issues and the way the system's set up to allow additional diagnoses—whether or not that is being done faithfully as it was intended.

Marketing of Medicare Advantage plans is—I think, really come under scrutiny. I think there was actually a report released by the Senate Finance Committee today on marketing abuses. And so we're not prejudging actually what's there but I think there is a lot of scrutiny that is going to come to bear on that system, especially, I think, as you see policymakers looking more and more at the strain those increases are having on the trust fund and whether or not we are on a sustainable path in terms of the stability and the long-term projections for the trust fund, if that continues to be such a major element.

We're not prejudging any of it but I think it will definitely be coming under greater scrutiny in the coming year.

**Dr. Resneck:** OK, just a couple of last questions and we're going to wrap things up—although this one may not be a super quick answer. Todd, where does AMA stand on Medicare for all?

**Askew:** Medicare for all—AMA supports a plurality of health care choices and would like to make sure that folks are able to choose health care, access to health insurance that meets their needs. We don't think a one size fits all system is right. Look at us today. We are barely keeping Medicare—the physician ability to see patients under the current system is seriously threatened, and I'm not sure that—I don't think we feel like that's necessarily the model that we would want to adopt for every single patient.

We all know that right now, unfortunately, a lot of the shortfalls in payments for federal programs are made up by slightly higher payments from some commercial payers and that's just how the system has developed. But the AMA has fully supportive of access to coverage, quality coverage for everyone—but really feel like a plurality of choices and options is the more sustainable policy for our country.

**Dr. Resneck:** Thanks, Todd. And Jason, last question for you is a technical one. You had mentioned the CMS prior auth rule that's pending at OMB. How exactly does that help the issue with the CBO score on the prior auth bill?

**Marino:** No one’s seen it would be too precise in my answer but the idea is that it was an element of the bill that had some requirements for making things—making the claims—prior authorization process
electronic in different rules for the portals. The thinking is that, if you get that through regulation and it costs money, it goes against the scorecard, so to speak, of the administration and not the CBO scorecard.

So it's kind of budget games but it's how it works. And so you could take that part out and then you have that much left to deal with for the bill. And that's the hope, that would lower it somewhat. But no one has seen it. It's not a public document. Even the chairman of ... you can't see it.

So we don't know what we're facing. That's why we're saying, you guys figure this out. We know what the problem is. We have a bill that solves it. Let's find a way to get it done this year. We've been dealing with this since 2018. Everyone agrees we need to do this. Let's do it. Put it back on the members of Congress to address it.

Dr. Resneck: Thank you. And that pretty much finishes up our time. I want to thank all of our participants for joining us. A big thank you to Todd and to Jason for all the great info. It's your turn now, participants, so please go to physiciangrassrootsnetwork.org. That's physiciangrassrootsnetwork.org. Actually, no. It is not physicians. It is physiciangrassrootsnetwork.org—sorry about that—to help us press Congress to do what they need to do.

And of course, make your voice heard. Do not forget to vote on November 8, if you haven't already. We're going to continue to keep you abreast of other opportunities to engage around these topics and others that affect our physicians in this country and our ability to provide high-quality care to the patients of our country and advance the health of the nation. Thanks so much. Really appreciate your being here. Take care.

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