



Nov. 11, 2022: National Advocacy Update



Bipartisan House letter coincides with launch of APM coalition

With the 117th Congress quickly coming to a close, the AMA, in conjunction with other key stakeholders, is ramping up the pressure on federal lawmakers to prevent the expiration of existing policies that promote value-based care.

While value-based care takes many forms, including advanced payment models (APMs), it is primarily focused on reimbursing physicians for savings generated from improved patient outcomes rather than simply the volume of services performed on an individual.

In terms of congressional action, Representatives Peter Welch (D-VT), Suzan DelBene (D-WA), Earl Blumenauer (D-OR), Darin LaHood (R-IL), Brad Wenstrup (R-OH) and Michael Burgess, MD (R-TX), wrote a letter (PDF) to House leadership urging passage of Section 4 of H.R. 4587, the Value in Health Care Act, before the end of the year. A total of 44 bipartisan members of Congress ultimately cosigned the Nov. 2 letter in support of continuing the 5% APM incentive payments and granting the secretary of the Department of Health and Human Services (HHS) the authority to more gradually increase the Qualifying APM Participant (QP APM) threshold. The QP APM threshold is the amount of revenue an APM must generate to even be eligible for the incentive payments. Absent congressional intervention, the 5% APM incentive payments expire and the QP APM threshold jumps from 50% to a virtually impossible to reach 75% on Jan. 1, 2023. AMA diligently advocated for members of Congress to cosign this letter and appreciates Reps. Welch, DelBene, Blumenauer, LaHood, Wenstrup and Burgess for their bipartisan leadership in support of expeditious legislative action on H.R. 4587.

The bipartisan letter from the House of Representatives coincided with the Nov. 1 launch of the Alliance for Value-based Patient Care. The AMA, along with the American Medical Group Association, America's Physician Groups, the Health Care Transformation Task Force, the National Association of ACOs, and Premier, Inc., are the six founding members of this coalition committed to passing Section 4 of H.R. 4587. In the short-term, this newly formed coalition will be primarily focused on passing legislation to continue the 5% APM incentive payments and preventing the QP APM threshold from jumping from 50% to 75%. The broader goal of the Alliance, however, is to educate congressional lawmakers about the importance of value-based care, in general, and enacting additional policies to help APMs become more accessible for physicians.



The AMA is hopeful that the combination of strong, bipartisan congressional champions working in collaboration with key value-based care stakeholders will ultimately lead to the inclusion of Section 4 of H.R. 4587 within a larger health care package enacted before the end of 2022.

AMA leads the fight against scope expansion in Congress

The AMA led a Federation letter (PDF) signed by more than 90 national physician specialty organizations and state medical associations strongly opposing H.R. 8812, the “Improving Care and Access to Nurses Act,” or the “I CAN Act.”

H.R. 8812 effectively removes physicians from important decisions in care for Medicare patients by authorizing nonphysician providers to order and supervise cardiac and pulmonary rehabilitation, establish home infusion services, refer patients for medical nutrition therapy, certify and recertify a patient’s terminal illness for hospice eligibility, perform all mandatory examinations in skilled nursing facilities and order diabetic shoes. In fact, the American Nurses Association President was quite open about what the bill does stating, “The ICAN Act means that APRNs, including nurse practitioners, nurse anesthetists, nurse-midwives, and clinical nurse specialists will be able to care for their patients at the fullest extent of their abilities while experiencing fewer disruptions and less interference.”

Of note, the lack of clarity surrounding the impact and intent of section 401 of the bill, Revising the Local Coverage Determination Process Under the Medicare Program, is troubling and could lead to unintended consequences. Regardless of how its vague language is interpreted, the assessment of civil monetary penalties up to \$10,000 for each violation of section 401 will undermine efforts by HHS and Medicare Administrative Contractors, working in concert with medical experts, to develop local coverage determinations that provide the highest quality of care for patients.

The I CAN Act is a top priority for non-physician providers. This strong Federation letter will help lay the foundation for the expected scope battles ahead in the next Congress.

Henry Ford Health updates credentialing application to “current”

Henry Ford Health recently updated its credentialing application for physicians and other health care professionals to only ask about “current” impairment rather than past diagnosis—a change that the AMA, Dr. Lorna Breen Heroes’ Foundation and other key stakeholders believe is essential to help support physician health and wellness.



The former question asked, “Have you been diagnosed with and/or received treatment for a physical, mental, chemical dependency or emotional condition which could impair your ability to practice medicine?” and the updated question now asks, “Are you diagnosed with or receiving treatment for any condition (physical, mental, emotional or substance dependence related) that currently impairs your ability to practice medicine?”

“The use of ‘could’ could mean all sorts of things, and it is not an indicator of whether that physician can safely and competently provide medical care,” said Lisa MacLean, MD, Chief Clinical Wellness Officer of the Henry Ford Medical Group. “The key is whether there is a ‘current’ impairment that currently affects the physician’s ability to practice medicine.”

In making the change, Dr. MacLean said that she hoped staff members and new applicants understand that her health system strongly supports physicians’ efforts to seek care for mental wellness, career fatigue, substance use disorders and any other medical condition needing care.

“We understand that the previous question might have caused some to answer ‘no,’ or to not seek any care because of the stigma and concern that a truthful answer could lead to not being hired,” said Dr. MacLean. “Now, we want to promote this change system-wide with the additional message that receiving care helps protect one’s career while at the same time, could also be saving lives.”

“It’s not just semantics,” said Corey Feist, JD, co-founder and president of the Dr. Lorna Breen Heroes’ Foundation. “Physicians and other health care professionals need to know that their institutions not only support their journey to seek care for wellness, but that the system’s policies and procedures—and applications—also support that journey. That’s why our foundation has published a toolkit (PDF) for hospitals and licensing boards to use to audit, change and communicate changes. The concern by the health workforce about the career impact of obtaining formal mental health care is a significant barrier to them accessing much needed care and has been identified as one of the key drivers of suicide by the health care workforce.”

“Physicians are among the most resilient, but when we need care for wellness or burnout, we need to know our health systems support us,” said AMA President Jack Resneck, Jr., MD. “We commend Henry Ford Health’s leaders for working closely with its physicians, and for taking action to make an important change that balances support for physicians’ health and wellness with protecting patient safety. The AMA is ready to work with all health systems to take similar actions.”

The AMA and the Dr. Lorna Breen Heroes’ Foundation provided technical assistance to Henry Ford Health and strongly support the change. The AMA continues to advocate (PDF) for the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications. Reducing physician burnout and supporting physician wellness is one of the key pillars of the AMA Recovery Plan for America’s Physicians.



Health systems who have already changed their credentialing applications to focus only on current impairment rather than past diagnosis are encouraged to share that information with the AMA.

AMA recommends health equity, physician wellbeing changes to CMS

The AMA made extensive recommendations in response to a sweeping Centers for Medicare & Medicaid Services (CMS) Request for Information on health equity and physician well-being. To improve access, the AMA recommended that CMS improve maternal health, close gaps across the country and leverage factors that are demonstrated to be strongly linked to equitable workforce distribution and health outcomes in rural areas.

To improve physician well-being, the AMA recommended that CMS use its existing authority to require holistic prior authorization reforms of federally regulated health plans, including Medicare Advantage Organizations, such as:

- Programs that exempt physicians with high approval rates
- Regular review of prior authorization lists to identify services that represent consistently approved or potentially detrimental prior authorizations, and adjustment to either “real-time” responses or elimination of prior authorization for these services
- Improved transparency of prior authorization requirements

Because physicians, especially women, are leaving the workforce due to professional stressors, personal stressors and burnout that have been exacerbated during the pandemic, the AMA urged CMS to add an institutional focus on physician well-being as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians. In addition, the AMA urged CMS to allow standing laboratory orders to be active for at least 15 months to reduce regulatory requirements that contribute to physician burnout.

Regarding opportunities to improve health equity, the AMA urged CMS to:

- Work with Congress to cover language services, including directly paying interpreters for such services to ensure that proper and effective care can be provided
- Improve care and health care coverage for individuals with disabilities
- Play a key role in accelerating behavioral health integration into care settings
- Reduce unmet needs for mental health services and substance use disorder treatment
- Refine several health equity quality measures



In addition, the AMA urged CMS to further encourage, evaluate and disseminate information about and scale up additional innovations in payment models that support:

- Addressing social determinants of health
- Leveraging reimbursement to support transition of health care institutions, particularly with in-house labs, away from race-based laboratory tests
- Using administrative data to assess and influence desegregation of care

Finally, the AMA outlined key steps that CMS should take to advance equity in the emerging telehealth landscape.

CDC issues new opioid prescribing guideline to “update and replace” 2016 version

In response to considerable medical society and patient advocacy—and recognition of the widespread misapplication and harms resulting from its 2016 opioid prescribing guideline—the U.S. Centers for Disease Control and Prevention (CDC) on Nov. 4 issued the “CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022,” which “updates and replaces the CDC Guideline for Prescribing Opioids for Chronic Pain released in 2016.” In the update, the CDC removed the 2016 numeric thresholds for dose and quantity of opioid prescriptions from its recommendations, saying that “the recommendations are not intended to be implemented as absolute limits for policy or practice across populations by organizations, health care systems, or government entities.”

In a news release, the CDC also makes clear that the new “publication updates and replaces the CDC Guideline for Prescribing Opioids for Chronic Pain released in 2016.” In its revision, CDC said multiple times that the updated guideline “is meant to be a flexible clinical tool and should not be used as a rigid standard of care or one-size-fits-all policy or law.”

The AMA urges all stakeholders to follow the CDC and replace all current policies based on the old guideline to align with the 2022 guideline recommendations. Failure to do so will result in continued misapplication and harm to patients with pain and physicians who treat patients with pain. Several federal agencies, more than 35 states and nearly all payers, pharmacy benefit managers and pharmacy chains currently have policies based on the 2016 guideline.

The CDC will hold a Zoom call on Nov. 17 from 2–3:00 p.m. Eastern, to discuss the updated 2022 guideline. Additional details, including access information for the call, are available on the CDC website.

CDC follows AMA recommendations for individualized patient care decisions



Earlier this year, the CDC issued a proposed revision to its 2016 opioid prescribing guideline. The AMA submitted extensive comments (PDF) expressing support for CDC emphasizing that its “voluntary guideline” should not be used as the basis for any law or policy from a health insurer, pharmacy or other entity.

In the published 2022 guideline, the CDC accepted nearly all the thematic and specific recommendations the AMA provided. The AMA strongly supports CDC’s emphasis on shared decision-making and the importance of not using the guideline as justification for discontinuing patient care or stigmatizing patients with pain. The 2022 guideline adopted AMA’s recommendation to emphasize individualized patient-care decisions and encourage clinical decisions to be made on a risk-benefit analysis.

The narrative underlying the recommendations, however, is much more complicated. The CDC makes clear that the guideline should not be used as inflexible law or policy, although CDC does not explain how it will help rectify the widespread misapplication of the 2016 guideline that has hurt many patients with pain and caused many physicians to no longer treat patients with chronic pain. There also is extensive use of new numeric thresholds in the 2022 guideline narrative, and the new guideline has greatly increased in length and clinical complexity. AMA is also concerned with CDC’s use of three categories of pain—acute, subacute, chronic—to differentiate different clinical considerations. It is unclear whether this will help inform clinical care or further confuse the pain care landscape.

The 2022 guideline also contains a strong preference for non-opioid and non-pharmacological therapies but does not meaningfully explain how or why payers would increase access to these therapies—many of which are expensive, and access is dependent on social determinants of health such as transportation, childcare and employment flexibility. While physicians have decreased opioid prescribing by nearly 50% over the past decade, payers have not meaningfully increased access to non-opioid pain care options. The AMA also supports the CDC’s acknowledgment of health inequities based on race and gender and continues to work to end such disparities. These areas are generally confined to the guideline narrative, but they are areas that deserve increased attention as CDC promotes the 2022 guideline.

In its discussion of special populations, such as pregnant people and people with substance use disorders, CDC makes clear that such special populations deserve pain care, including opioid therapy or medications to treat opioid use disorder, and that additional care and coordination with specialists may be needed. Removing the stigma faced by pregnant people with substance use disorders and people with opioid use disorder are embedded within the work of the AMA Substance Use and Pain Care Task Force, which continues to urge compassionate, comprehensive care for all patients with pain.



2022 update to the AMA's Competition in Health Insurance: A Comprehensive Study of U.S. Markets

The AMA is pleased to announce publication of its 2022 update to Competition in Health Insurance: A Comprehensive Study of U.S. Markets (PDF). This study reports the two largest health insurers' market shares and market concentration (HHI) levels in 383 metropolitan statistical areas (MSAs), the 50 states and the District of Columbia. For the first time, the update also presents this information for Medicare Advantage (MA) markets. Starting with the key findings in commercial markets, the study finds that the average HHI increased by 181 points to 3504 between 2014 and 2021, while the share of markets that are highly concentrated rose from 71% to 75%. Fifty-eight percent of markets experienced an increase in the HHI. Among those markets, the average increase was 540 points. The study also finds that a Blue Cross Blue Shield insurer had the largest market share in 81% (311) of MSAs.

Turning to MA, despite a decrease in concentration over time, on average MA markets remain highly concentrated. In 2021, the average MSA-level market had an HHI of 3331—down from 3923 in 2017, while the proportion of markets that were highly concentrated fell from 87% in 2017 to 79% in 2021. Finally, in both commercial and MA markets, UnitedHealth Group was the largest health insurer at the national level.

More articles in this issue

- Nov. 11, 2022: Advocacy Update spotlight on Medicare payment
- Nov. 11, 2022: State Advocacy Update