Access to coverage

The American Medical Association remains committed to reducing the number of uninsured people in our nation and to increasing access to affordable and meaningful health care coverage for patients. **In 2018 the AMA successfully sought reauthorization of the Children’s Health Insurance Program, which Congress funded for 10 years.** The AMA is also opposing any efforts to rollback health care coverage gains.

Opioid epidemic

The opioid epidemic continues to have a devastating effect on our nation; however, there are signs of progress in physicians' actions included in a report issued by the AMA Opioid Task Force. Between 2013 and 2017, the number of opioid prescriptions decreased by more than 55 million—or 22.2 percent. Use of prescription drug monitoring programs (PDMPs) is growing—**more than 300.4 million queries were made in 2017.** Naloxone prescriptions **more than doubled in 2017, from approximately 3,500 to 8,000 per week.** More than **549,000 physicians and other health care professionals** completed continuing medical education training and accessed other Federation education resources in 2017. Finally, the number of physicians certified to provide buprenorphine in-office continues to rise—**more than 50,000 physicians** are now certified—a **42.2 percent increase** in the past 12 months.

Mergers

After helping to block the Anthem/Cigna and Aetna/Humana mergers in 2017 (the failure of the Anthem/Cigna merger alone saved $500 million annually in physician payments), the **AMA is calling for rigorous and transparent reviews of the proposed CVS/Aetna and Cigna/Express Scripts mergers by state and federal officials.** There has been a federal hearing on the proposed merger between CVS and Aetna at which the AMA submitted testimony. The AMA also submitted comments to the California Department of Managed Health Care after its hearing on the CVS/Aetna merger.
Regulatory relief

In direct response to AMA advocacy, there have been several improvements on the regulatory relief front. In 2018 Congress eliminated the requirement that the federal electronic health record (EHR) program become more stringent over time. The Centers for Medicare & Medicaid Services (CMS) has taken several positive steps to reduce burdens for physicians in the “Inpatient Prospective Payment System” proposed rule. For example, CMS proposed to reduce redundant quality measures in various hospital reporting programs. The agency also proposed to overhaul the Meaningful Use program (renamed Promoting Interoperability) by drastically reducing the number of measures (from 16 to 6), moving away from a pass/fail scoring system, and focusing on patient access and interoperability. Also in response to AMA advocacy efforts, CMS now requires recovery audit contractors (RACs) to reimburse physicians for the costs associated with pulling medical records for audits. Another positive development is that teaching physicians may now use medical student documentation of components of E/M services as long as the physician verifies the student’s documentation. Finally, the VA agreed to only exempt employed physicians from multistate licensure requirements when delivering telehealth services rather than a wider array of services.

Physician payment

Congress acted on a long-standing AMA priority and eliminated the Independent Payment Advisory Board (IPAB). The AMA also convinced lawmakers to block a detrimental mis-valued code provision contained in a key spending bill. The AMA continues to focus on helping physicians with the transition to the Quality Payment Program (QPP). Due to AMA advocacy, Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System (MIPS) payment adjustments and from the low-volume threshold determination. CMS has been given wide latitude to reduce the weight of the cost category in MIPS under the OPP, and the Physician-focused Payment Model Technical Advisory Committee (PTAC) can provide helpful feedback to proposal submitters. The AMA continues to advocate with the CMS Innovation Center and PTAC for adoption of alternative payment models. PTAC has now advanced 10 models to the HHS secretary for testing and the CMS Innovation Center is moving forward with plans for a new model using direct provider contracting.

Insurer practices

When Anthem announced a change in its “Modifier 25” policy that could cost physician practices an estimated $100 million annually, the AMA convinced Anthem to reverse course. The AMA is also pushing back on the indiscriminate use of prior authorization (PA) and other utilization management programs by insurers. The AMA is advocating directly to insurers calling for changes in their PA practices and conducting research to show the negative impact PA can have on patients. We’ve already seen positive results from these AMA advocacy efforts, including the adoption of a set of consensus principles by industry stakeholders to “right size” the PA process and reduce this burden on physicians. The AMA is also pursuing a concurrent state legislative strategy to reduce the impact of payers’ utilization management programs on patients and physicians and has shared in legislative victories with the state medical associations in New Mexico, Indiana, Missouri, West Virginia and others.