HEALTH SYSTEM REFORM

The American Medical Association has long advocated for health insurance coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice and universal access for patients. As the Senate considers health system reform legislation, these same core principles and priorities are guiding AMA advocacy efforts. Key elements of our health system reform objectives include the following:

• Individuals who are currently insured must not lose access to high-quality, affordable coverage.
• Key insurance market reforms must be maintained, including affordable coverage for pre-existing conditions, guaranteed issue and no annual or lifetime coverage limits.
• Medicaid, CHIP and other safety net programs must be adequately funded.

The AMA launched a website, patientsbeforepolitics.org, aimed at encouraging physicians and patients to advocate for affordable, meaningful coverage for all Americans. The interactive site provides the latest information on health system reform legislation moving through Congress, as well as the AMA’s efforts to shape the future of U.S. health care.

With a keen focus on a handful of targeted congressional districts that our team identified, the campaign has generated:

• More than 311,000 emails sent to members of Congress
• More than 560,000 social media engagements on Facebook and Twitter (defined as clicks, comments, likes and shares)

MEDICARE PHYSICIAN PAYMENT REFORM

The final rule issued last fall to implement the Medicare Access and CHIP Reauthorization Act’s (MACRA) Quality Payment Program (QPP) for physician services offered significant improvements over previous Medicare fee-for-service reporting requirements. Importantly, there also was an effort to ease the transition to the new QPP by requiring physicians to meet minimal reporting requirements in 2017 to avoid a 4 percent payment penalty in 2019. In addition, the service and revenue volume thresholds used to determine whether a physician is subject to MIPS reporting were raised. As a result, about 65 percent of all clinicians will be excluded from MIPS in 2017 because they are below this low-volume threshold, or because they are in a non-patient-facing specialty or participate in an advanced alternative payment model. This stands in stark contrast to original projections that well over half of physicians in small practices would be subject to the full 4 percent penalty. These improvements over a draft regulation issued earlier in the year followed advocacy efforts by the AMA and its Federation partners for a broad range of refinements.

Further regulations related to MACRA are expected to be finalized in the fall of 2017. The AMA continues to make recommendations to Medicare officials for additional improvements to the QPP, including: (1) further simplification of MIPS; (2) additional relief for small physician practices; (3) continued progress on expanding alternative payment models; (4) a performance threshold setting methodology that minimizes penalty risk; and (5) another transitional performance period for 2018.

REGULATORY RELIEF

Research conducted by the AMA on the sources of satisfaction and dissatisfaction for practicing physicians revealed that administrative tasks consume two hours of physician time for every hour spent in patient care. These administrative burdens, often imposed by government regulations, hamper productivity and are the leading cause of professional dissatisfaction. The AMA, in consultation with Federation groups, has developed a regulatory relief agenda that is being aggressively pursued. A few of the issues being addressed include:

• Improving usability of electronic health records, easing regulatory use requirements and eliminating data blocking
• Providing transparency of coverage determinations
• Reforming the Recovery Audit Contractor system and easing regulations that restrict innovative payment and delivery models
• Encouraging the interoperability of prescription drug monitoring program databases
• Ensuring that the Food and Drug Administration does not overregulate laboratory-developed tests or the appropriate practice of drug compounding in physician offices

HEALTH INSURER MERGERS

As a result of unrelenting and vigorous advocacy by the AMA and its 17-state medical association partners, two proposed mega-mergers between Anthem-Cigna and Aetna-Humana each were defeated. Anthem’s own expert stated that the Anthem-Cigna merger alone would have reduced provider payments by $2.4 billion. According to an analysis provided to the AMA, this $2.4 billion would have included physician payment cuts of at least $500 million per year.

These monumental victories are a result of medicine coming together—under AMA leadership—to block the mergers through a comprehensive advocacy campaign. But our work is not done. The AMA will continue its antitrust advocacy by opposing anti-competitive mergers at the state level through the passage of state legislation.
CYBERSECURITY

As cybersecurity threats increasingly expose physicians and their patients to risk, the AMA has taken several steps to increase awareness and understanding of sound cybersecurity practices:

- Developed resources to help physicians conduct a checkup of their systems, and to secure their networks and office computers
- Proposed a new improvement activity under the Merit-based Incentive Payment System (MIPS) to give credit to physicians who voluntarily adopt a cybersecurity framework
- Encouraged the HHS’ Office of Civil Rights to provide protections to physicians who voluntarily adopt cybersecurity frameworks
- Urged stakeholders to develop tools to help small practices implement best practices and adopt cybersecurity frameworks
- Raised concerns to the U.S. Food and Drug Administration about device cybersecurity and the need to maintain security of data sent to electronic health records
- Engaged with the administration to monitor and disseminate information to physicians about ransomware and the recent “WannaCry” cyberattack

REVERSING THE NATION’S OPIOID EPIDEMIC

Through the AMA Opioid Task Force, the AMA and the nation’s medical societies have urged all physicians to act—in their practices and in their communities—to help reverse the opioid epidemic. The increasing toll of opioid-related mortality and harm continues to show that much more work is needed, but there are continuing signs of progress in several areas within physicians’ control. Opioid prescribing has decreased nearly 17 percent nationwide since 2012, and prescription drug monitoring program use increased by more than 120 percent from 2014 to 2016.

The AMA continues to engage the administration, Congress and key stakeholders to advocate that this epidemic will require long-term focus on overdose prevention and comprehensive treatment for pain care and for substance use disorders.

DRUG-PRICING TRANSPARENCY

The AMA’s grassroots campaign and interactive website, TruthinRx.org, seeks to increase prescription drug-pricing transparency among pharmaceutical companies, pharmacy benefit managers and health plans. To date, more than 148,000 individuals have signed a petition in support of greater drug-pricing transparency.

In 2017 the AMA is initiating a social media action center as part of the “TruthinRx” campaign. Online activists will have the ability to send customized image cards to their lawmakers urging reforms that will inject greater transparency into the marketplace for prescription drugs.

The AMA also has a new model state bill that offers state medical societies the opportunity to take the lead in advocating greater transparency for patients and accountability from pharmaceutical companies, pharmacy benefit managers and health plans.

PRIOR AUTHORIZATION

A recent survey conducted by the AMA on the impact of prior authorization (PA) on physician practices showed that PA continues to be a manual, time-consuming process that siphons valuable resources away from patient care. Moreover, PA can delay treatment and impact optimal patient health outcomes.

The AMA has created the following resources as part of a national campaign to improve PA processes:

- **PA reform principles**: A coalition of 17 organizations—including the AMA, Federation members, provider associations and patient groups—created a set of 21 principles to ensure that patients have timely access to treatment and to reduce administrative costs. The coalition, now with the support of more than 100 additional organizations, is working to reduce the burden of prior authorization through the adoption of the principles by insurers, benefit managers, accrediting organization, and policymakers.
- **Academic research partnership**: The AMA is partnering with the University of Southern California Schaeffer Center for Health Policy and Economics on an academic research project to assess the growing impact of PA on physician practices and patients.
- **Electronic PA (ePA)**: The AMA ePA toolkit recommends steps that practices can take currently to help reduce the impact of PA on their practice, including taking advantage of ePA technologies.

This advocacy is making an impact across the country. Just in the last year, at least eight states have enacted laws that limit prior authorization or step therapy, and insurers are starting to change their practices.

PROVIDER NETWORKS AND MEANINGFUL COVERAGE

As health insurers continue to downsize their provider networks and shift more and more of the cost of care onto patients, the AMA is actively promoting health plan accountability for fair coverage and value for premiums paid. Having health insurance should mean having access to timely, quality, appropriate care.

As such, the AMA is:

- Urging state and federal action to strengthen network adequacy rules, with the goal of establishing meaningful and measurable access standards for primary and specialty care.
- Working with stakeholders to promote solutions to balance-billing problems that protect patients, hold insurers accountable for promised coverage and maintain incentives to contract.
- Advocating policies to stop benefit manager practices that shift drug costs onto consumers and undercut physicians’ ability to provide the best clinical care.
- Advocating for stronger transparency and accuracy requirements in provider directories, so patients have the information they need.