Congressional Agenda
Environmental Scan

Concerns

• Repeal and replace “fever” continues
• Year end spending packages often contain “surprise” provisions
• Rising tide of deficit spending
• 2% Medicare sequester cut in provider payments likely to be extended

Opportunities

• Substantial reduction in regulatory burdens (MACRA, quality measures, EHRs)
• Democratic leaders use leverage on bills to fund govt. operations to advance other priorities (DACA, CSRs?)
Congressional To Do List

- Continue funding of govt. operations (December 8 deadline)
- CHIP, CHC, NHSC, Teaching Health Centers reauthorizations
- Medicare extenders (vehicle for MACRA adjustments)
- Cost Sharing Reduction (CSRs) funding linked to ACA modifications
- Tax cut package
- Deferred Action on Early Childhood Arrivals (DACA)
- Additional disaster relief funding
CHIP Reauthorization

Another missed deadline

Bipartisan policy framework brokered in Senate in September

House battle over budget offsets

• Expect final passage before year end
ACA: Repair or Undermine?

Alexander-Murray proposal stalled despite 60 yes votes in the Senate

• GOP leaders seeking greater flexibility on state waivers
• Hatch-Brady proposal to end/defer individual & employer mandate unacceptable to Ds

Series of moves by Administration to undermine ACA:

• Limited duration policies
• Greater state flexibility on essential benefits and medical loss ratios
• Shorten enrollment period; 40% cut in Navigator funding; 90% cut in enrollee outreach $ 
• Stopped CSR payments 2 weeks before open enrollment 
• Ongoing media effort to highlight negative physician and provider experience
## Tax Reform Legislation

<table>
<thead>
<tr>
<th>Point</th>
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<tr>
<td>Historically, AMA has not staked out positions on broad tax policy issues</td>
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<tr>
<td>• Narrow focus on issues that impact physician practices (accounting rules)</td>
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<td>Current proposal will experience many deaths &amp; resurrections</td>
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<td>Many moving parts and interactions</td>
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<td>Student loan deductions: Weigh net impact considering increase in standard deduction</td>
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<tr>
<td>End medical expense deduction: Patient groups taking this on</td>
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MACRA / QPP
Final MACRA Rule for 2018 Reporting Period

• MIPS performance threshold moves from 3 to 15 points
• Low volume threshold exemption increased to $90,000/200 patients
• Quality weight lowered to 50%, cost weight 10%
• Ok to use 2014 Certified Electronic Health Record Technology (CEHRT)
• Reduced reporting burden and bonus points for small practices
• Establishes virtual group option
• Complex patient bonus
2017 Relief for Physicians Impacted by Natural Disasters

• Automatic exemption without submitting hardship exception application for physicians affected by Harvey, Irma and Maria and California fires

• Physicians can opt to participate in MIPS if they perceive benefit in doing so
QPP Eligibility

• Eligible clinicians include:
  • Physicians
  • Physician Assistants
  • NPs, CRNAs, Clinical Nurse Specialists

• Exempt clinicians include:
  • Those in first year billing Medicare
  • Participants in qualifying advanced APMs
  • Those meeting a low-volume threshold

• CMS will increase LVT from $30,000 or 100 patients to $90,000 or 200 patients
  • Also considering an opt-in provision beginning in 2019

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<tr>
<td>All Medicare clinicians billing Part B</td>
<td>1,380,209</td>
<td>1,548,022</td>
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<tr>
<td>MIPS ineligible types</td>
<td>-199,308</td>
<td>-233,289</td>
</tr>
<tr>
<td>Newly enrolled</td>
<td>-85,268</td>
<td>-81,954</td>
</tr>
<tr>
<td>Low volume</td>
<td>-383,514</td>
<td>-540,347</td>
</tr>
<tr>
<td>Qualifying APM participants</td>
<td>-70K-120K</td>
<td>-70,732</td>
</tr>
<tr>
<td>Eligible clinicians who can report under MIPS</td>
<td>43-47%</td>
<td>621,700</td>
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2018 MIPS Components and Proposed Scoring Weights

MIPS aims:

- Align 3 current independent programs
- Add 4\textsuperscript{th} component to promote improvement and innovation
- Provide more flexibility and choice of measures
- Retain a fee-for-service payment option
### Accommodations for Small Practices

#### In effect for 2017
- Pick your pace transition
- Low-volume threshold $30K/100 patients
- Reduced IA reporting
- $100 million in grants for technical assistance via QIOs and regional health improvement collaboratives

#### Proposed for 2018
- Low-volume threshold raised to $90K/200 patients
- Reduced IA reporting continued
- Reduced quality reporting
- Technical assistance grants continued
- Virtual groups created
- ACI hardship exemption for small practices
- Bonus points added to final score for small practices

CMS estimates 81.2% of EPs in practices of 1-15 will experience positive or neutral adjustments in 2020.
Improvement Scoring for Quality and Cost

- MACRA calls for rewarding improvement as well as overall score
  - Second year of QPP provides first opportunity

- For Quality: proposal would base improvement scoring on rate of improvement in your total Quality score
  - Greater improvement results in more points; lower performance in transition year could produce highest improvement score
  - Up to 10 points available

- For Cost: proposal would base score on statistically significant changes at the measure level
  - Weight cost at 10% in 2018; comments sought on methodology only

- In neither category could improvement score raise total over 100%
Virtual Groups

• Must include at least 2 solo and small group (<10) clinicians
• All practices in virtual groups must be eligible for MIPS
• Requirements
  • Formal written agreement between each virtual group member
    • CMS has created a model agreement
  • Must elect by December 1 prior to performance year
    • For 2018, have until Dec. 31 to elect
  • May only participate in one virtual group during a performance period
Potential Advantages of Virtual Groups

- Share burden of MIPS reporting
  - Combine credit for MIPS categories like Improvement Activities
  - Eligible for small practice requirements & special scoring rules if virtual group is 15 or fewer eligible clinicians
- Combine patient counts in quality reporting and cost calibration for more reliable sample sizes
- Maintaining independence
- Take advantage of group reporting options
- CMS will provide technical assistance
- Challenges:
  - IT infrastructure lacking
  - Different EHR systems
  - Workflow and staff training changes
CMS Criteria for Advanced APMs

- 50% of participants must use certified EHR technology
- Must report and at least partially base clinician payments on quality measures comparable to MIPS
- Bear “more than nominal risk” for monetary losses
  - Defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures
    - 2018 proposal would extend standard for 2 more years
  - Primary Care Medical Home models with < 50 clinicians have different standards (2.5%-5% total Medicare revenues increased over time)
    - 2018 proposed rule would allow Round 1 CPC+ practices to exceed 50 clinicians
    - 2018 risk reduced to 2% of total Medicare revenues; delays increase to 5% by one year
New CMMI Request for Information

- Sept. 20 CMS Administrator announced new direction for CMMI
- Issued Request for Information highlighting CMS interest in specialty models, limited scale testing, PTAC models, behavioral health
Physician-Focused Payment Model Proposals

• 11-member Physician-Focused Payment Model Technical Advisory Committee created to review stakeholder APM proposals, make recommendations to HHS

• 19 proposals submitted to PTAC, of which 6 reviewed at 4/17 & 9/17 meetings, with 3 recommended for limited scale testing and one for implementation:
  1. Project Sonar
  2. The ACS-Brandeis Advanced APM
  3. Hospital at Home Plus
  4. Oncology Bundled Payment Program Using CNA-Guided Care

• 16 additional Letters of Intent submitted with future proposals expected
AMA Legislative Proposals

• Extend transitional period from 2 to 5 years
  • Maintain cost component weight at 10% or less
  • Permit established performance thresholds instead of median or mean

• Clarify that Physician-Focused Payment Model Advisory Committee may offer technical assistance to applicants (e.g., data)

• Clarify that Part B drug payments not subject to performance adjustments

• Clarify that small practices are defined as 15 or fewer MIPS eligible clinicians
MEDPAC Proposal

- Repeal MIPS & establish new “Voluntary” Value Program (VVP)
- 2% withhold from each physician
  - Earn back by electing to be measured with a voluntary group and be eligible for a value payment
  - Join an APM and get withhold back
  - Not make any election and lose the withhold
- VVP would use broad population based outcome, patient experience & cost measures to evaluate physicians
- Congressional buy-in?
Regulatory Relief
Regulatory Relief Dashboard

2017 regulatory relief dashboard

REGULATORY WINS
Wins in Quality Payment Program (QPP) proposed rule
- Makes 2018 another transitional year
  - As a result, 90 percent of physicians in practices of 1-15 eligible clinicians and 96 percent of physicians in all practice sizes are estimated to receive a neutral or positive payment adjustment in 2020
- Triples low-volume threshold exemption to $90,000 or 200 Medicare beneficiaries
  - According to CMS estimates, this change increases the number of MIPS-exempted clinicians by more than 50 percent from an estimated 383,514 in 2017 to 585,560 in 2018
- Initiates virtual groups
- Proposes favorable scoring and reduced requirements for small practices
- Postpones mandate for physicians to upgrade to 2015 edition certified EHRs
  - Saved physicians from needing to choose among only 3 percent of all available health IT products for their next EHR upgrade
- Does not increase requirements for number of quality measures or data completeness
  - Physicians only have to report on six quality measures (as opposed to nine under PQRS), of which one must be an outcome measure, on 50 percent of applicable patients. CMS originally proposed to gradually increase the reporting threshold and require reporting on a cross-cutting measure, which would have significantly increased the quality reporting burden.
- Keeps reporting on CAHPS as optional
  - Under PQRS, if a practice was reporting as a group they were required to report on CAHPS, which was a costly requirement and excluded certain specialties from

Other regulatory wins
- CMS retroactively modifies 2016 PQRS, MU, and VBM policies to align with MIPS; changes will reduce penalties for physicians in 2018
  - CMS estimates that 23,625 eligible clinicians will avoid a total of $22 million in 2018 PQRS penalties as a result of the change to PQRS requirements
- Congress requires CMS to replace beneficiaries’ social security number on Medicare cards; CMS agrees to create look up tool for physicians and an education campaign
- CMS delays implementation of Appropriate Use Criteria
- MACs begin to use targeted modeling for audits
- CMS affirms physicians’ right to refuse virtual credit card payments and receive basic standard-electronic funds transfer without fees imposed by health plans or their vendors
- ONC promotes STEPS Forward modules with the Federal Health IT Playbook
- Focused the Administration’s attention on the unique cybersecurity needs of small practices* Policy included in Proposed Physician Fee Schedule Rule

Other EHR wins
- Vendors must communicate to physicians the fees associated with EHR functions
- Law passed preventing vendors from data blocking
- Law passed requiring reduction of EHR burdens
- EHRs must now include enhanced interoperability technology and support for apps
  - With the new EHR upgrades, physicians will have access
Medicare Regulatory Wins

• CMS retroactively modifies 2016 PQRS, MU & VBM policies that will result in reduced penalties in 2018
  • 23,625 eligible clinicians will avoid $22M in penalties

• ONC promotes STEPS Forward modules with Federal Health IT Playbook

• EHR upgrades will offer access to new apps to improve usability

• As a result of new complaint process, over 100 EHR products labeled noncompliant with federal certification requirements

• Delayed implementation of Appropriate Use Criteria

• MACs begin to use targeted modeling for audits
New Medicare Card: Advocacy and Education

• CMS will begin issuing new Medicare cards—with new identifiers—to existing Medicare beneficiaries beginning April 2018

• Practices must be prepared to use the new Medicare identifier by April 2018 to ensure a successful transition

• As a result of AMA advocacy, CMS will offer a secure look-up tool for providers to obtain the new patient identifier

• A two-page educational handout about the New Medicare Card is included in the I-17 nonofficial business bag

• A new AMA webpage outlines steps practices should take to prepare for the New Medicare Card
Advocacy Win on Electronic Payment Guidance

- CMS issued FAQs in September 2017 that offer key protections for practices on health plan electronic payments
  - Practices can refuse virtual credit card payments (e.g., fees of up to 5%)
  - Practices have the right to request and receive payment by standard electronic funds transfer (EFT)
  - Health plans and vendors may not require practices to enroll in “value-added” EFT programs, which charge fees of up to 2.5%
- This win represents a multi-year AMA advocacy effort to ensure that physicians are not “paying to get paid”
Prior Authorization Advocacy and Education

• A workgroup representing the AMA, AHA, APhA, MGMA, AHIP, and BCBSA is working toward completion of a consensus statement on actions to reform prior authorization programs consistent with the AMA/Federation *Prior Authorization and Utilization Management Reform Principles*

• Other activities supporting the AMA’s prior authorization advocacy include:
  
  • Addition of prior authorization content to the Physician Grassroots Network and Patient Action Network
  
  • Re-fielding the physician prior authorization survey in December 2017 to assess any changes in current practice burdens
  
  • Creation of a 3-part educational video series on electronic prior authorization
-AMA model bill is basis for most state proposals:
  - response times
  - clinical criteria
  - retrospective denials
  - notice of changes
  - availability of data
  - ePA

-Not all laws (purples) are comprehensive reforms, so much work still to be done

-OH, DE, AR, VA, have recently enacted some of the strongest laws in the country based on the AMA model
Ending the Opioid Epidemic
High Stakes for Medicine

• Policymakers, media and public identify two villains:
  • Drug companies
  • Physicians

• Mounting pressure to limit # of pills & mandatory education
  • Objections viewed as impeding progress

• Resources haven’t matched the rhetoric – election year bill likely

• Press, policymakers & payers to expand access to treatment & coverage for alternative pain therapies
Opioid-Related Mortality, PDMP use, Opioid Prescribing

- Natural and Semisynthetic Opioids (e.g. oxycodone, hydrocodone)
- Synthetic Opioids, other than Methadone (e.g. fentanyl, tramadol)
- Heroin

Total Opioid Overdose Deaths

- PDMP queries by health care professionals
- Total Opioid Rx (millions)

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State, National and Federal Issues and Advocacy

• Engaging FDA Commissioner, US Attorney General and other federal officials to promote access to non-opioid pain relief and treatment for opioid use disorder

• Assisting medical societies with the 100s of new state laws and policies

• Urging nation’s payers (and attorneys general) to help remove prior authorization for MAT

• Ongoing advocacy to improve DEA regulations for e-prescribing of controlled substances and advance alternative payment models for addiction treatment
Final Recommendations from President’s Commission

• Alignment with AMA advocacy
  • Unequivocal support for increasing access to medication assisted treatment (MAT) and removing prior authorization and other administrative barriers
  • Removing all pain-related patient satisfaction survey questions
  • Increasing access to naloxone and identifying co-prescribing best practices
  • Support prescription drug monitoring program (PDMP)—electronic health record integration and remove DEA barriers to electronic prescribing of controlled substances

• Areas for further analysis and vigilance
  • Single national standard for opioid prescribing for all physicians
  • Tying DEA registration to unknown CME requirement
  • Unclear consequences for patient privacy with PDMPs and opening up 42 CFR Part 2