Washington Update

NERVES Annual Meeting

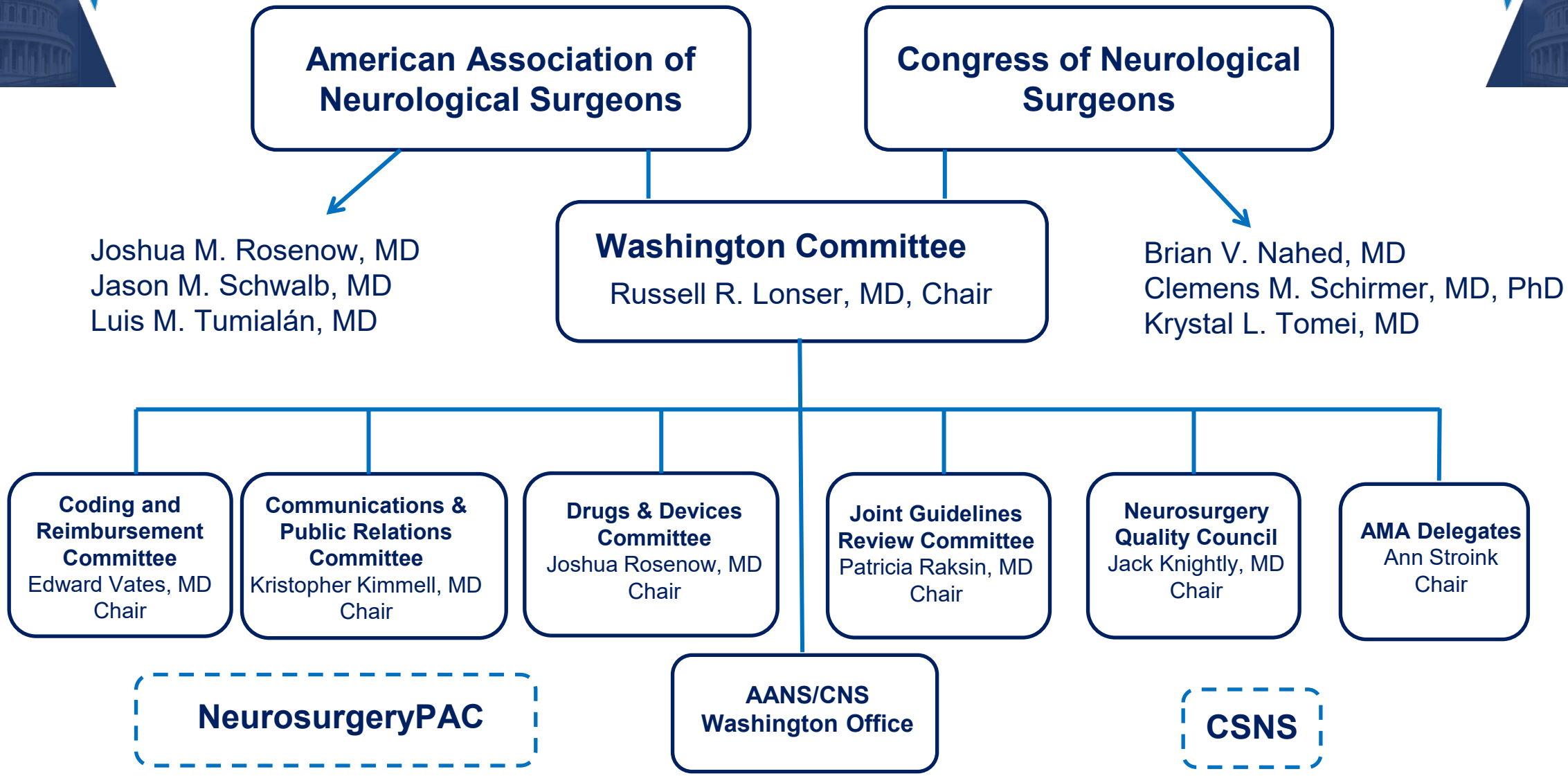
April 20, 2023

Katie O. Orrico, Esq., SVP, Health Policy & Advocacy

AANS/CNS Washington Office

AANS/CNS Washington
Committee for
Neurological Surgery

Washington Committee Members



Washington Committee Liaisons

TEAM NEUROSURGERY

- AANS/CNS Joint Sections
- American Board of Neurological Surgery
- Council of State Neurosurgical Societies
- NeuroPoint Alliance
- NeurosurgeryPAC
- Neurosurgery Practice Managers (NERVES)
- Society of Neurological Surgeons
- Young Neurosurgeons

The ONLY Place ALL of Neurosurgery Comes Together at the Same Table

Washington Committee Mission

Quality neurosurgical care is essential to the health and well-being of society. As the voice of neurosurgery before legislative, regulatory and other health care stakeholders, the AANS/CNS Washington Committee exists to advocate for our specialty and patients.

American Association of Neurological Surgeons

AANS/CNS Washington Committee for Neurological Surgery

Congress of Neurological Surgeons

AANS/CNS 2023 Advocacy Agenda

- ✓ Reduce Prior Authorization Hassles
- ✓ Champion Fair Reimbursement
- ✓ Expand GME Support
- ✓ Medical Liability Reform
- ✓ Boost Biomedical Research Funding
- ✓ Alleviate the Burdens of EHRs
- ✓ Improve Competition in Health Care

American Association of Neurological Surgeons
Congress of Neurological Surgeons

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS
CONGRESS OF NEUROLOGICAL SURGEONS

Congress of Neurological Surgeons

2023 Legislative & Regulatory Agenda

☑ PROTECT PATIENTS' TIMELY ACCESS TO CARE

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for medical treatments or tests before rendering care to their patients. The process for obtaining this approval is lengthy, typically requiring physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies — time better spent taking care of patients. Patients experience significant barriers to medically necessary care due to prior authorization requirements for items and services that are eventually routinely approved. Additionally, Medicare's Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging — which affects virtually every medical specialty — requires physicians to consult AUC before ordering advanced imaging services, such as MRIs and CT scans. Like prior authorization, the AUC program is costly and administratively burdensome, which may delay patient access to vital diagnostic tests.

To ensure timely access to care, policymakers must regulate the use of prior authorization by Medicare Advantage and other health plans. Such regulations should, among other things, increase transparency, streamline the prior authorization process and minimize the use of prior authorization for routinely approved services. Furthermore, Congress should pass legislation to repeal Medicare's Appropriate Use Criteria Program.

☑ CHAMPION FAIR REIMBURSEMENT

Over the past 20 years, Medicare physician payments have fallen 22%. The combination of these cuts, along with high inflation and workforce shortages, will have negative consequences as seniors face difficulty accessing care from the physician of their choice. In addition, Medicaid payments are typically 30% below Medicare and well below commercial rates, raising significant health equity concerns. Moreover, new regulations implementing the No Surprises Act (NSA) have unfairly empowered health plans to drive down provider reimbursement. Finally, the COVID-19 pandemic demonstrated the need to expand telehealth options.

To ensure access to vital neurosurgical services, policymakers must take steps to improve the Medicare physician payment system by providing an inflationary payment update, revisiting budget-neutrality requirements, maintaining the 10- and 90-day global surgery payment package — including preventing the Centers for Medicare & Medicaid Services (CMS) from using arbitrary, flawed or incomplete data to value global surgery codes — and improving Medicare's value-based care programs, particularly by leveraging the use of physician-led clinical registries. Steps should also be taken to close the gap between Medicaid and other insurer payments to reduce access to care disparities. Federal regulators must also follow the clear language of the NSA and implement a fair process for resolving provider and health plan payment disputes. Finally, Congress should permanently expand telehealth, including increased payments for telehealth visits, removing geographic restrictions for telehealth services and allowing flexibility on telehealth modalities, such as audio-only.

☑ FIX THE BROKEN MEDICAL LIABILITY SYSTEM

Our nation's medical liability system is broken — it costs too much, takes too long to resolve claims and does not serve the needs of patients or physicians — and the fear of lawsuits forces physicians to practice defensive medicine, which is estimated to cost between $46 billion to $300 billion annually.

Congress can fix the system to reduce health care costs, preserve patient access to medical care and end medical lawsuit abuse by adopting common sense, proven, comprehensive medical liability reform legislation. Federal legislation modeled after the laws in California or Texas — which includes reasonable limits on non-economic damages — represents the "gold standard." Other solutions should be adopted, including liability protections for physicians who volunteer their services and follow practice guidelines established by their specialties. Finally, the Federal Tort Claims Act should apply to services mandated by the Emergency Medical Treatment and Labor Act.

☑ ALLEVIATE THE BURDENS OF ELECTRONIC HEALTH RECORDS

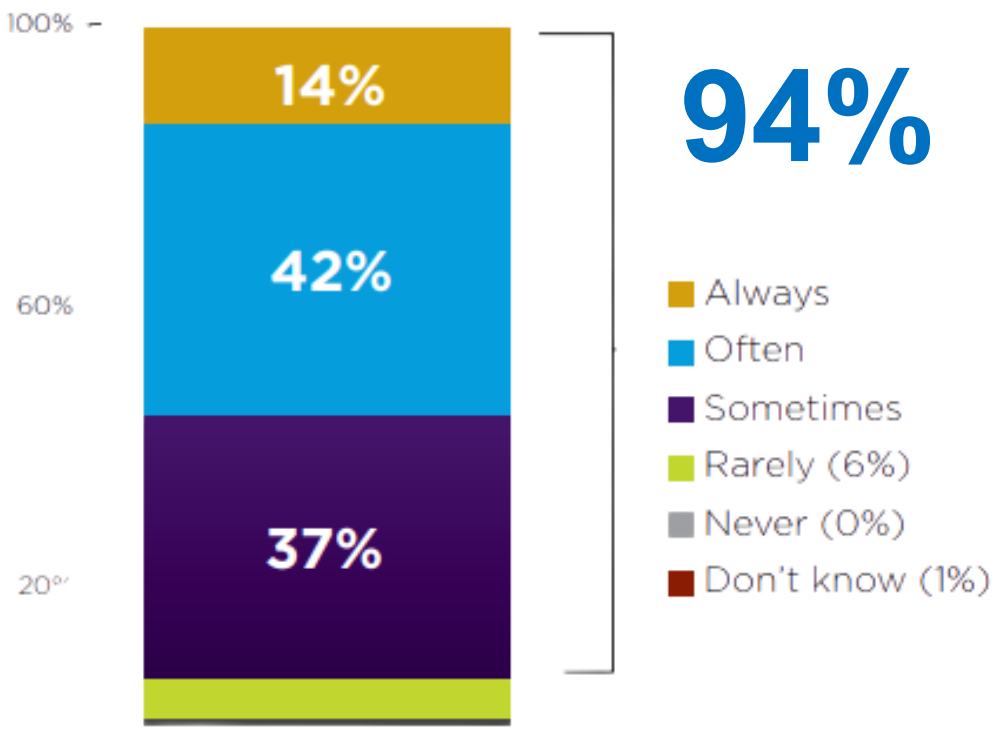
Physician burnout is at an all-time high, with nearly 63% of physicians reporting signs of burnout, impacting physicians and patients alike. A leading cause of burnout is the electronic health record (EHR) and the estimated *one billion* clicks per day, contributing to toxic stress in physicians. The economic impacts of burnout are also significant, costing the U.S. some $4.6 billion every year. Lack of interoperability, poor EHR usability that does not match clinical workflows, time-consuming data entry, interference with face-to-face patient care, and pages and pages of useless template-based patient notes are but a few of the frustrations physicians have with electronic health records.

Policymakers must take all necessary action to correct the current state of EHR technology, achieve interoperability, prevent data blocking, improve functionality, and hold EHR vendors accountable for delivering user-friendly systems that serve physicians and their patients.

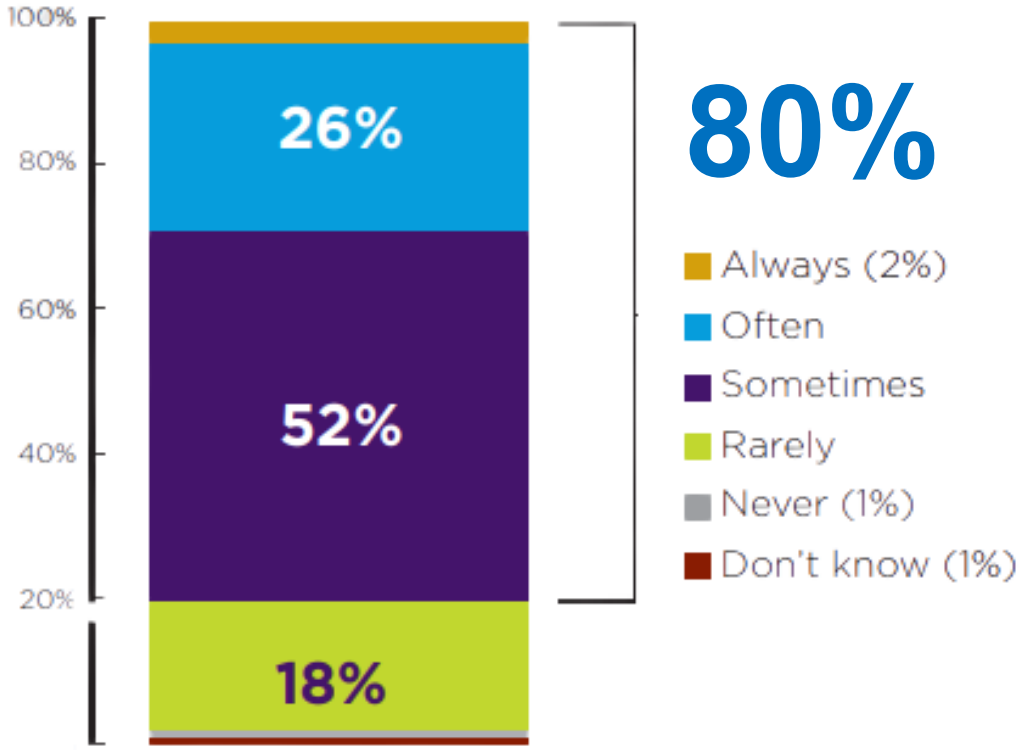
Prior Authorization Reform

Facts: Patient Impact

Care Delays



Abandoned Treatment

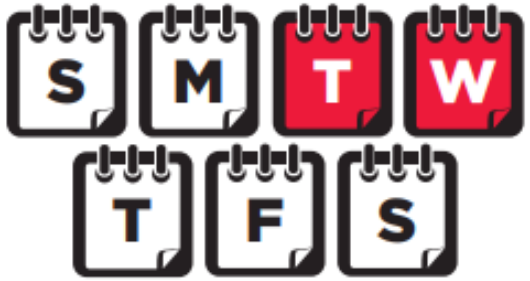


Facts: Physician Impact

45

PAs per physician, per week

Physicians spend **almost two business days** each week completing PAs



35%

have staff who work exclusively on PA

88%

describe burden with PA as high or extremely high

Facts: Health Plans are Rolling in the $$$

Forbes

UnitedHealth Group Reports $4.7 Billion Profit As Optum And Health Plans Maintain Momentum

Jan 13, 2023, 08:58am EST

Forbes

Cigna Profits Top $1 Billion With One Million New Health Plan Members Forecast For 2023

Feb 3, 2023, 07:56am EST

Forbes

Elevance Health Profits Hit $1.6 Billion As Medical And Drug Plans Grow

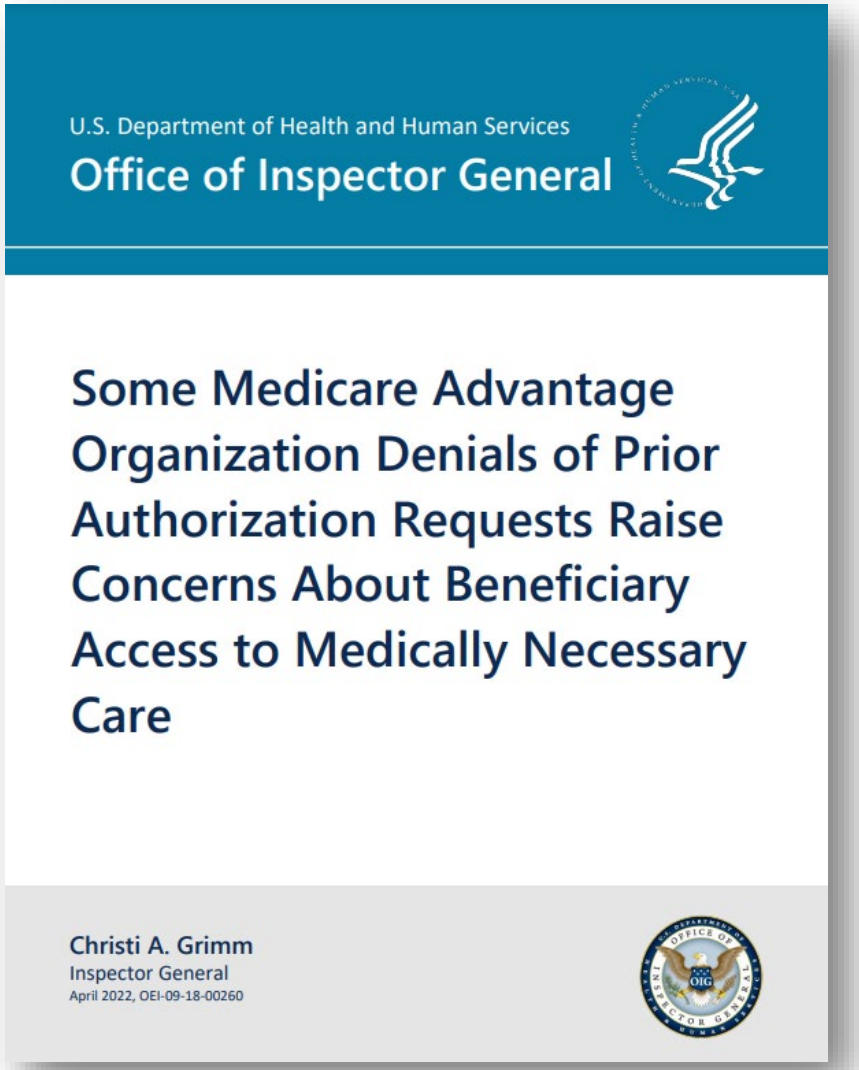
Oct 19, 2022, 07:04am EDT

Forbes

Humana Eclipses $1 Billion Profit On Medicare Growth And Lower Costs

Nov 2, 2022, 07:39am EDT

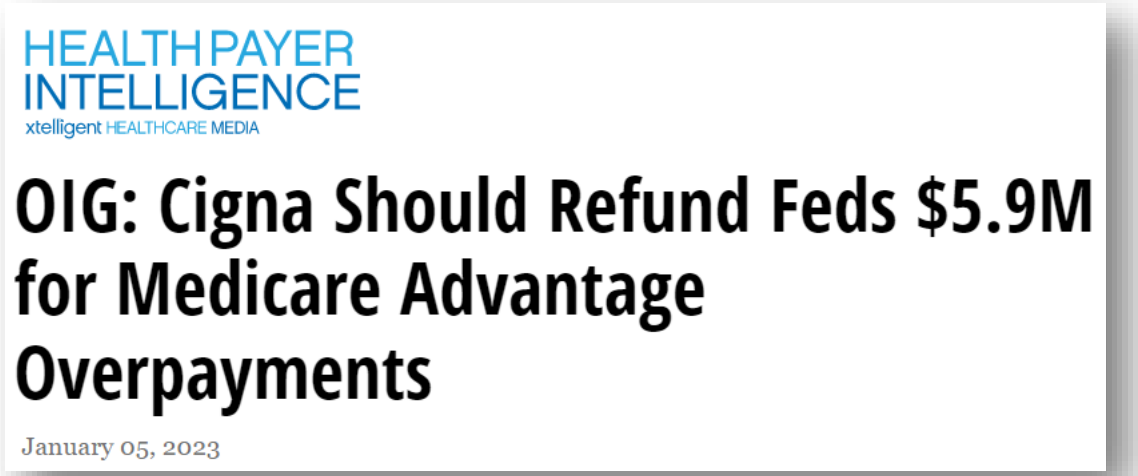
Facts: Mounting Evidence Against the Plans


U.S. Department of Health and Human Services

Office of Inspector General

Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care

Christi A. Grimm
Inspector General
April 2022, OEI-09-18-00260


HEALTH PAYER INTELLIGENCE
xtelligent HEALTHCARE MEDIA

OIG: Cigna Should Refund Feds $5.9M for Medicare Advantage Overpayments

January 05, 2023


HEALTHCARE FINANCE

OCT 05, 2022 | MORE ON COMPLIANCE & LEGAL

Judge orders Anthem to face lawsuit over alleged Medicare overpayments

The court estimates the alleged overpayments far exceeded $100 million over a span from 2014 to 2018.

Facts: Mounting Evidence Against the Plans

PROPUBLICA

Investigative Journalism in the Public Interest

Health Care

How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them

by Patrick Rucker, Maya Miller and David Armstrong

March 25, 5 a.m. EDT

- Internal documents & former company execs reveal how Cigna doctors reject patients' claims w/out opening their files!

> *We literally click and submit. It takes all of 10 seconds to do 50 at a time.*
>
> *Former Cigna physician reviewer*

Legislative Outcome for 2022

✓**House of Reps. Passed Improving Seniors' Timely Access to Care Act** (H.R. 3173/S. 3018).

- ***But…*** $16 billion price tag stalled progress (since revised to $10b)

- **Bill would:**
  - Create an **electronic prior auth** program + **real-time** decisions for **routinely approved** services
  - Ensure prior auth denials are **reviewed by qualified** medical **personnel**
  - Require prior auth criteria to adhere **to evidence-based medical guidelines**
  - Mandate plans report **rate of approvals/denials**

Last Congress: 380 combined co-sponsors

HHS Secretary, Xavier Becerra and CMS Administrator, Chiquita Brooks-LaSure

Regulations: MA Prior Auth Reform

** NEW ** Final Regs Effective Jan. 2024:

- PA only used to confirm diagnose and/or ensure service is medically necessary;
- PA valid through entire course of treatment and for 90-day transition if patient changes plan;
- Medicare Advantage plans must honor national/ local Medicare coverage policies;
- MA plans may establish other coverage policy criteria ***but…*****must** be based on widely used treatment guidelines or clinical literature;
- MA plan may not deny coverage (i.e., payment) of a pre-authorized service. Emergency services may not be retroactively denied; and
- MA plans must establish Utilization Management Committee to ensure compliance.

Regulations: e-Prior Auth

HHS Secretary, Xavier Becerra and CMS Administrator, Chiquita Brooks-LaSure

** Proposed ** Regs on 12/6/22:

- Applies to ACA plans, Medicare Advantage, Medicaid managed care, CHIP;
- Requires electronic prior auth;
- Prior auth decisions must be made w/in 72 hours for urgent requests and 7 days for others;
- Coverage determinations reviewed by relevant professionals;
- Supports efforts to waive/modify PA requirements based on provider performance; and
- Health plans must publicly report use of prior authorization, including information on delays and denials.

Next Steps: Pathway to Reform

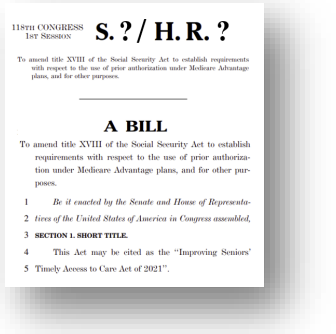
√ Finalize MA PA Rule

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Finalize e-PA Rule (by fall?)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amend PA legislation to reflect CMS final rules



118TH CONGRESS
1ST SESSION

S. ? / H. R. ?

To amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans, and for other purposes.

A BILL

To amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Seniors' Timely Access to Care Act of 2021".

New CBO cost estimate (goal to get to zero)

Congressional Budget Office

Pass PA bill & send to Pres. Biden to sign into law!

Footnote: Private Sector Initiatives

United Healthcare's 3/29/23 Announcement:

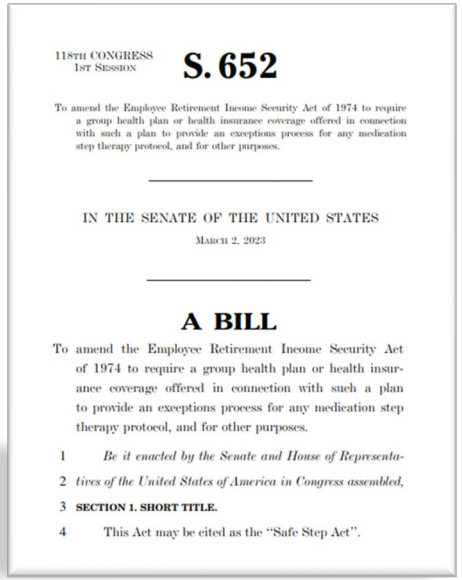
- Eliminating nearly 20% of current prior authorizations (starting in Q3)
- Applies to Commercial, Medicare Advantage and Medicaid plans
- New national "Gold Card" program in 2024 → prior auth eliminated for all eligible physicians

United Healthcare

Legislation: Step Therapy Reform

Safe Step Act (S. S.652/H.R. 2630)

- ERISA plans must exempt certain medication requests from step-therapy (aka fail first). Exemption granted if:
  1. Another treatment has been ineffective;
  2. Treatment will continue to be ineffective & delaying use of preferred medication would lead to irreversible consequences;
  3. Treatment is likely to cause an adverse;
  4. Treatment is expected to prevent the individual from performing daily activities; and
  5. Individual is stable using the preferred medication



118TH CONGRESS
1ST SESSION

S. 652

To amend the Employee Retirement Income Security Act of 1974 to require a group health plan or health insurance coverage offered in connection with such a plan to provide an exceptions process for any medication step therapy protocol, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 2, 2023

A BILL

To amend the Employee Retirement Income Security Act of 1974 to require a group health plan or health insurance coverage offered in connection with such a plan to provide an exceptions process for any medication step therapy protocol, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Safe Step Act".

Last Congress: 235 combined co-sponsors

Fair Reimbursement

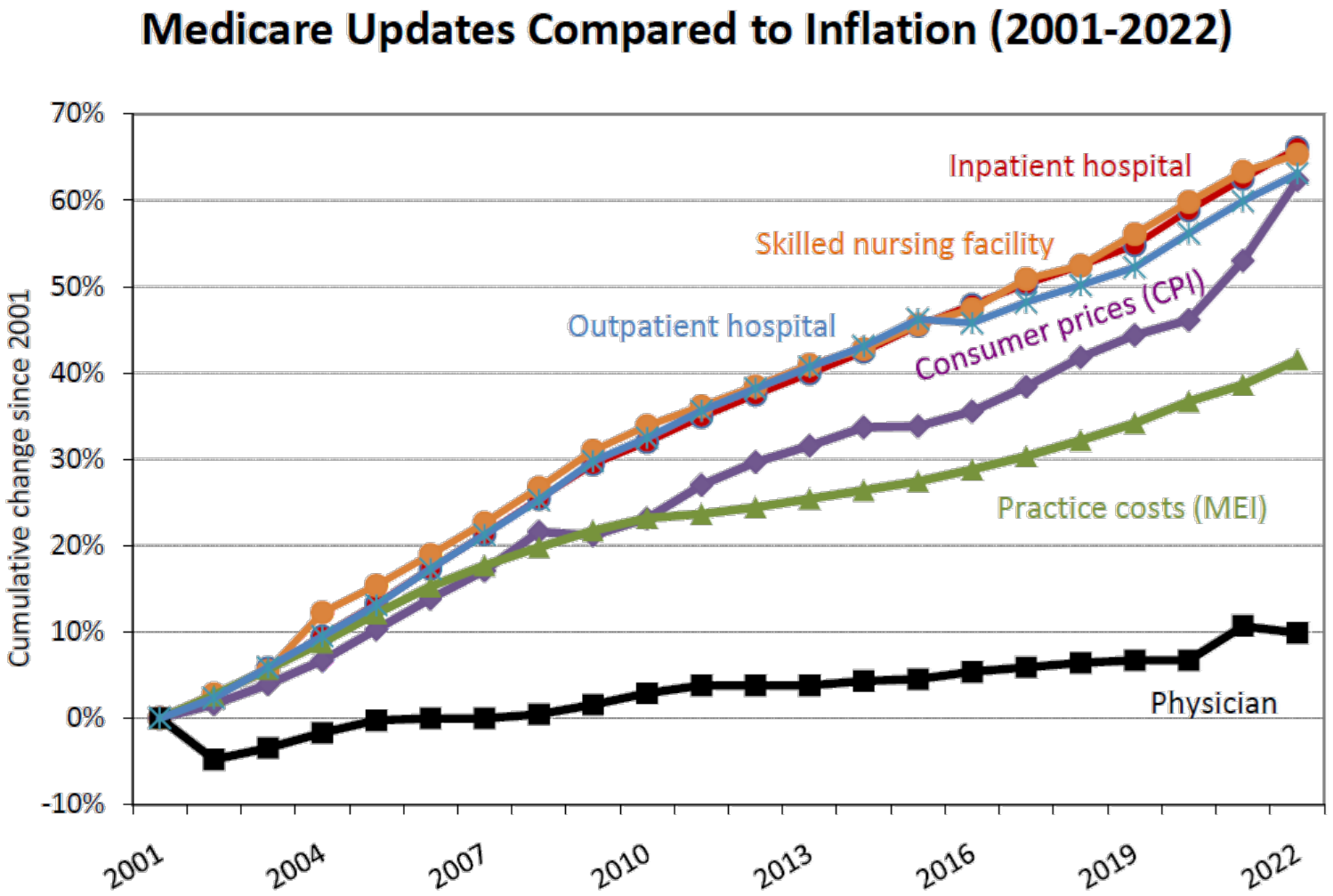
Legislative Outcome for 2022

✓Consolidated Appropriations Act, 2023:

- Total *expected* cut in 2023: **-8.5%**
- Total relief provided: **+7.75% over 2 years**
  - + 2.5% added to conversion fact in 2023; 1.25% in 2024
  - + Delayed 4% "PAYGO" cut for 2 years

AANS/CNS Advocacy for the past 3 years has prevented Medicare payment cuts to neurosurgery **totaling $181 million**

One Key Problem: Physician Payments vs. Other Providers/Inflation



Hospitals = 66.1%↑

CPI = 62.3%↑

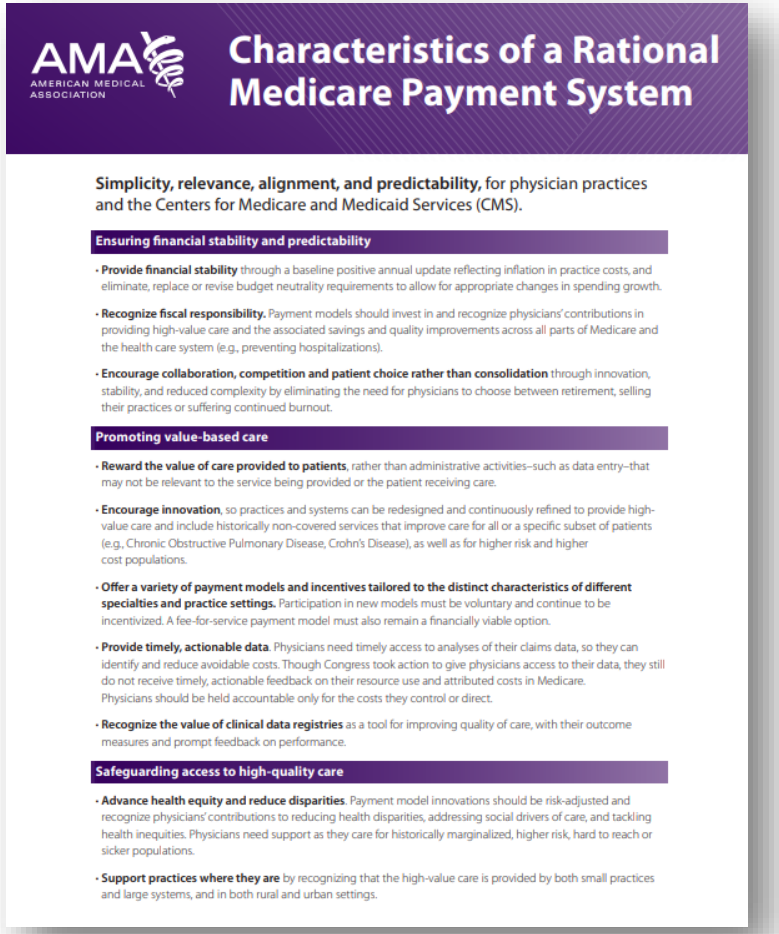
Practice Costs = 41.5%↑

Physicians = 9.9%↑

Adjusted for inflation, payments to physicians have **declined by 26%**

Legislation: Medicine's Principles

- Positive annual updates based on Medicare inflation
- Modifications to Medicare's budget-neutrality rule
- Improvements to Medicare's Quality Payment Program:
  - More specialty APM's
  - Leverage clinical registries



AMA AMERICAN MEDICAL ASSOCIATION

Characteristics of a Rational Medicare Payment System

Simplicity, relevance, alignment, and predictability, for physician practices and the Centers for Medicare and Medicaid Services (CMS).

Ensuring financial stability and predictability

- **Provide financial stability** through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace or revise budget neutrality requirements to allow for appropriate changes in spending growth.
- **Recognize fiscal responsibility.** Payment models should invest in and recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations).
- **Encourage collaboration, competition and patient choice rather than consolidation** through innovation, stability, and reduced complexity by eliminating the need for physicians to choose between retirement, selling their practices or suffering continued burnout.

Promoting value-based care

- **Reward the value of care provided to patients**, rather than administrative activities--such as data entry--that may not be relevant to the service being provided or the patient receiving care.
- **Encourage innovation**, so practices and systems can be redesigned and continuously refined to provide high-value care and include historically non-covered services that improve care for all or a specific subset of patients (e.g., Chronic Obstructive Pulmonary Disease, Crohn's Disease), as well as for higher risk and higher cost populations.
- **Offer a variety of payment models and incentives tailored to the distinct characteristics of different specialties and practice settings.** Participation in new models must be voluntary and continue to be incentivized. A fee-for-service payment model must also remain a financially viable option.
- **Provide timely, actionable data**. Physicians need timely access to analyses of their claims data, so they can identify and reduce avoidable costs. Though Congress took action to give physicians access to their data, they still do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. Physicians should be held accountable only for the costs they control or direct.
- **Recognize the value of clinical data registries** as a tool for improving quality of care, with their outcome measures and prompt feedback on performance.

Safeguarding access to high-quality care

- **Advance health equity and reduce disparities**. Payment model innovations should be risk-adjusted and recognize physicians' contributions to reducing health disparities, addressing social drivers of care, and tackling health inequities. Physicians need support as they care for historically marginalized, higher risk, hard to reach or sicker populations.
- **Support practices where they are** by recognizing that the high-value care is provided by both small practices and large systems, and in both rural and urban settings.

Roadmap to Reforming the Medicare Physician Payment System

√ Introduction of Medicare Inflation Update Bill

Introduction of Budget-Neutrality Reform Bill

Introduction of MIPS Modifications Bill

Congress passes the bills (or some version of them)

Legislation: Strengthening Medicare for Patients and Providers Act (H.R. 2474)

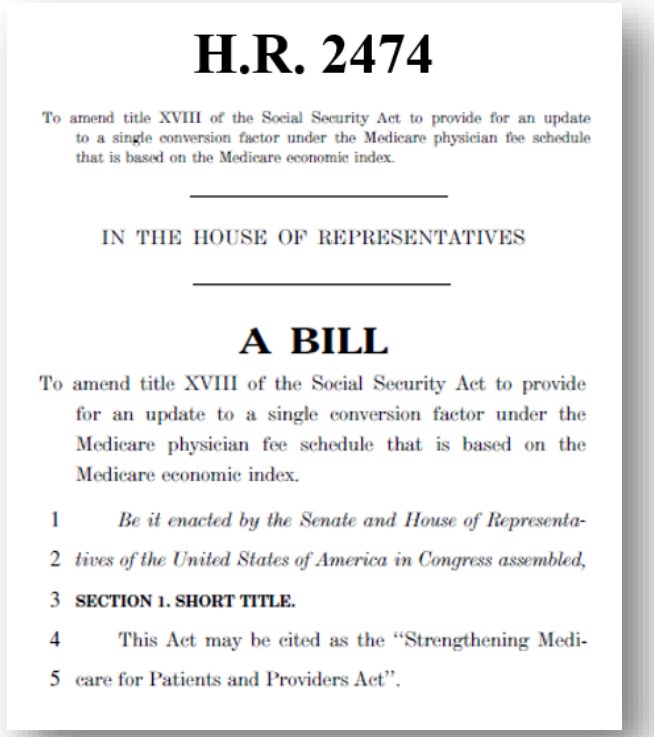
- Introduced on 4/3/23
- Provides annual physician payment update based on the Medicare Economic Index

Raul Ruiz, MD
(D-CA)

Larry Bucshon, MD
(R-IN)

Ami Bera, MD
(D-CA)

Mariannette Miller-Meeks, MD
(R-Iowa)



H.R. 2474

To amend title XVIII of the Social Security Act to provide for an update to a single conversion factor under the Medicare physician fee schedule that is based on the Medicare economic index.

IN THE HOUSE OF REPRESENTATIVES

A BILL

To amend title XVIII of the Social Security Act to provide for an update to a single conversion factor under the Medicare physician fee schedule that is based on the Medicare economic index.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Strengthening Medicare for Patients and Providers Act".

Legislation: Under Development

- **Budget Neutrality Reform**
  - Increase B/N cap to $100m (up from current $20m)
  - Establish lookback period to recoup $ from utilization over-estimates
  - Exempt certain services from B/N
- **MIPS Reform**:
  - Eliminate “tournament” system and +/- 9% bonus/penalties → instead, .25% of annual payment update at risk
  - Remove MIPS silos
  - Automatic credit for certain MIPS categories if participating in clinical data registry

Judicial: No Surprises Act Lawsuit

- No Surprises Act (which bans surprise medical bills) rules established a *de facto* federal payment benchmark for out-of-network care
  - Health plans have weaponized the rules to **drive down in-network payments → 15-30% (and more)**

- AANS and CNS filed *amicus brief* supporting lawsuit filed to overturn Biden Administration rules
  - Case filed in Texas (Texas Medical Association v. U.S. Dept. of HHS)
  - Court ruled ***in favor*** of TMA on 2/6/23
  - Government appealed on 4/6/23

Telemedicine/ Telehealth

Legislative Outcome for 2022

- ✓**Consolidated Appropriations Act, 2023:**
  - Extends through Dec. 2024 key COVID-19 telehealth waivers:
    - Removes geographic restrictions for telehealth services
    - Flexibility on originating sites
    - Telephone/audio-only

Improve EHR Interoperability

Regulations: EHR Interoperability

HHS Secretary, Xavier Becerra and
ONC Director, Steven Posnack

** Proposed ** ONC Regs on 4/13/23

- Updates to the ONC Health IT Certification Program with new & updated standards, implementation specifications, and certification criteria.
- Advances interoperability, improves transparency, and supports the access, exchange, and use of EHR info
- Improvements for e-Prior Auth and real-time decision for prescriptions

Non-Compete Clauses

FEDERAL TRADE COMMISSION

PROTECTING AMERICA'S CONSUMERS

Proposed Prohibition on Non-competes

Federal Trade Commission proposed ban on employer non-compete clauses:

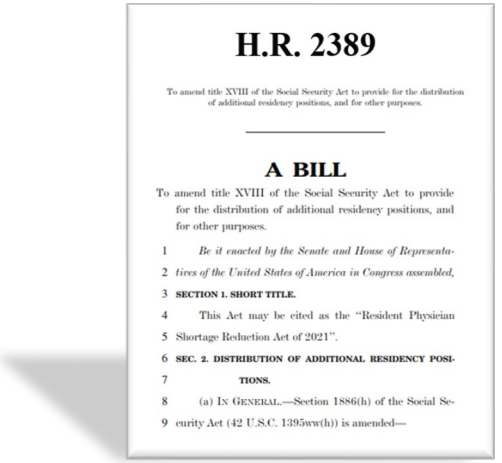
- Employer defined as individual, partnership, corporation, association or other legal entity
- Ban applies retroactively and affects current contracts w/non-compete clauses
- Ban applies to employees, partners and independent contractors
- **Exception: Partners *if*** an owner, member, or partner holding at least a 25% ownership interest in a business entity

GME Funding & Loan Debt Relief

Legislative Outcome for 2022

- ✓**Consolidated Appropriations Act, 2023:**
  - Funding for 200 additional Medicare-supported GME slots
  - $385 million for Children's Hospitals GME

Legislation: Resident Physician Shortage Reduction Act (H.R. 2389)



H.R. 2389

To amend title XVIII of the Social Security Act to provide for the distribution of additional residency positions, and for other purposes.

A BILL

To amend title XVIII of the Social Security Act to provide for the distribution of additional residency positions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Resident Physician Shortage Reduction Act of 2021".

SEC. 2. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

- 14,000 new Medicare-supported residency training slots → 2,000 each year for 7 years
- Priority distribution:
  - Hospitals in rural areas
  - Hospitals training over their current GME caps
  - Hospitals that serve areas designated as health professional shortage areas.
  - Hospitals in states with new medical schools or new branch campuses.

Last Congress: 239 combined co-sponsors

Rep. Terri Sewell
(D-AL)

Rep. Brian Fitzpatrick
(R-PA)

Student Loan Debt

- Resident Education Deferred Interest (REDI) Act (S. 704/ H.R. 4122)
  - Defers medical student loan interest during residency

Rep.. **Brian Babin**
(R-Texas)

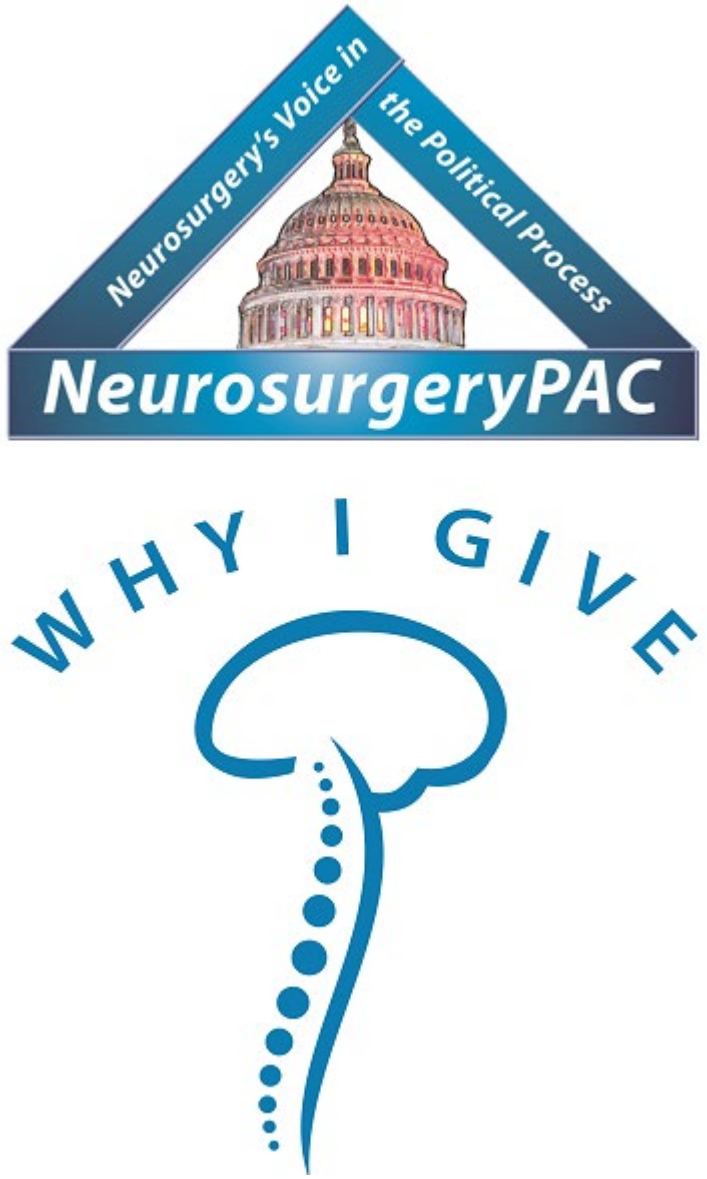
Rep.. **Chrissy Houlahan**
(D-Pa.)

Sen. **Jackie Rosen**
(D-Nev.)

Sen. John Boozman
(R-AR)

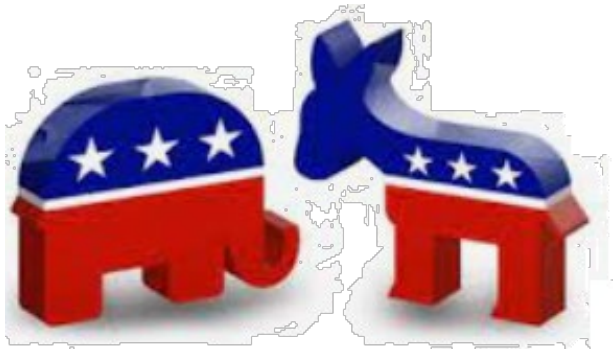
Last Congress: 32 combined co-sponsors

Political Action



Please Encourage Your Neurosurgeons to Support NeurosurgeryPAC!

- Provides ***mechanism to support*** candidates who share our views on legislation that affects neurosurgery.
- Contributions give us ***access*** to lawmakers to advocate on YOUR behalf
- NeurosurgeryPAC is ***BIPARTISAN***



Contribute Here!

Information and Advocacy Action

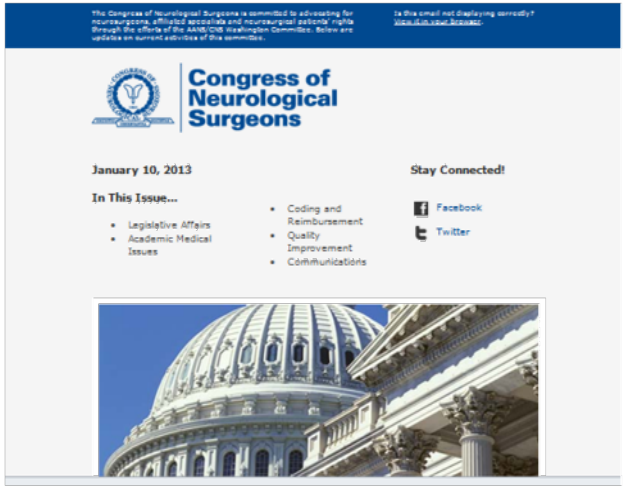
Spreading the Word: Communications & Public Relations

@Neurosurgery

Neurosurgery Blog
More Than Just Brain Surgery

UPDATE

neurosurgery



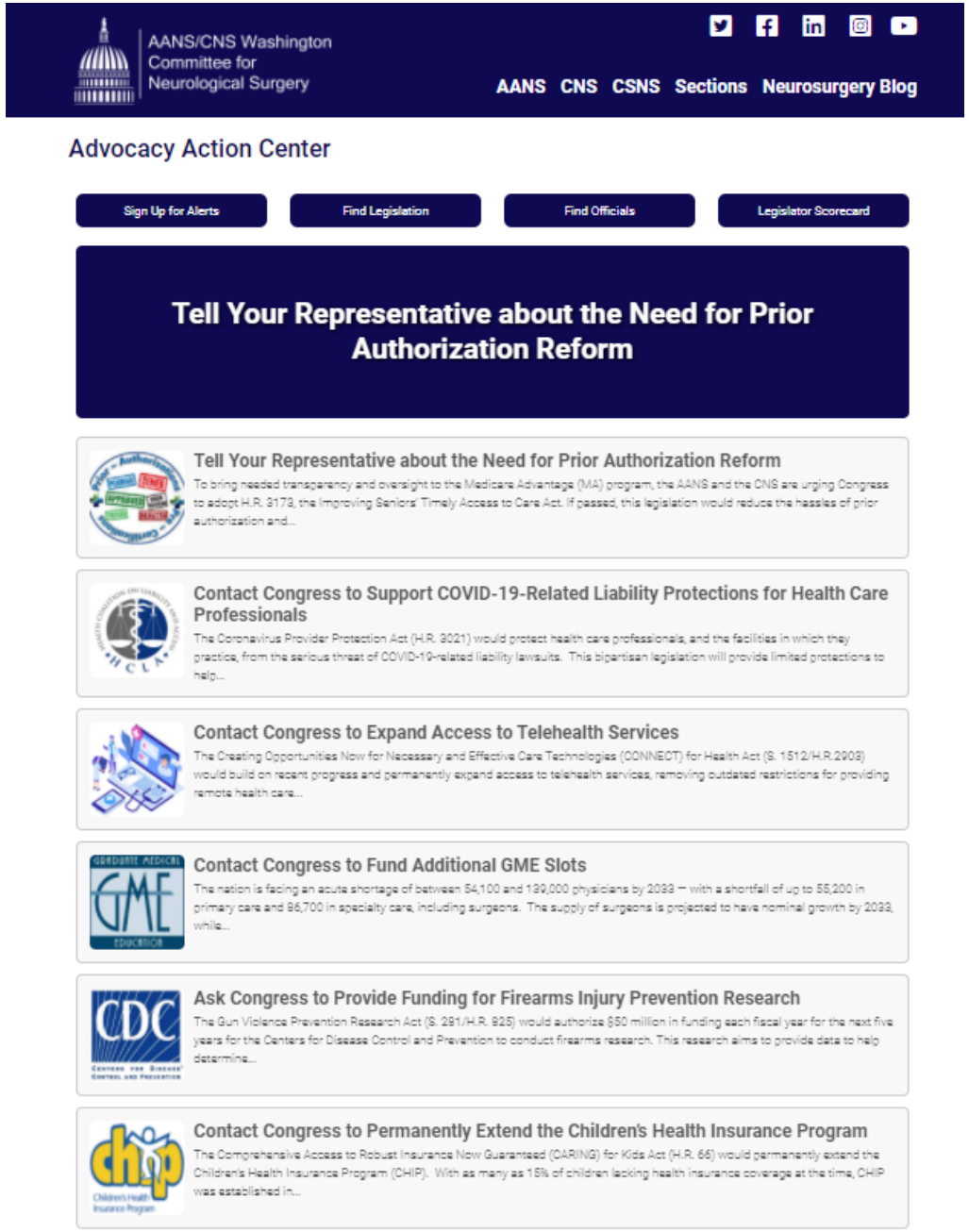
AANS NEUROSURGEON
Online. Anytime.
By and for neurosurgeons.

congressquarterly
WINTER 2013

Washington Committee Web Hub

www.neurosurgery.org

- Links to AANS & CNS Advocacy Web Pages
- Links to CSNS and Jt. Sections
- Includes most recent @neurosurgery Tweets
- Includes most recent Neurosurgery Blog posts



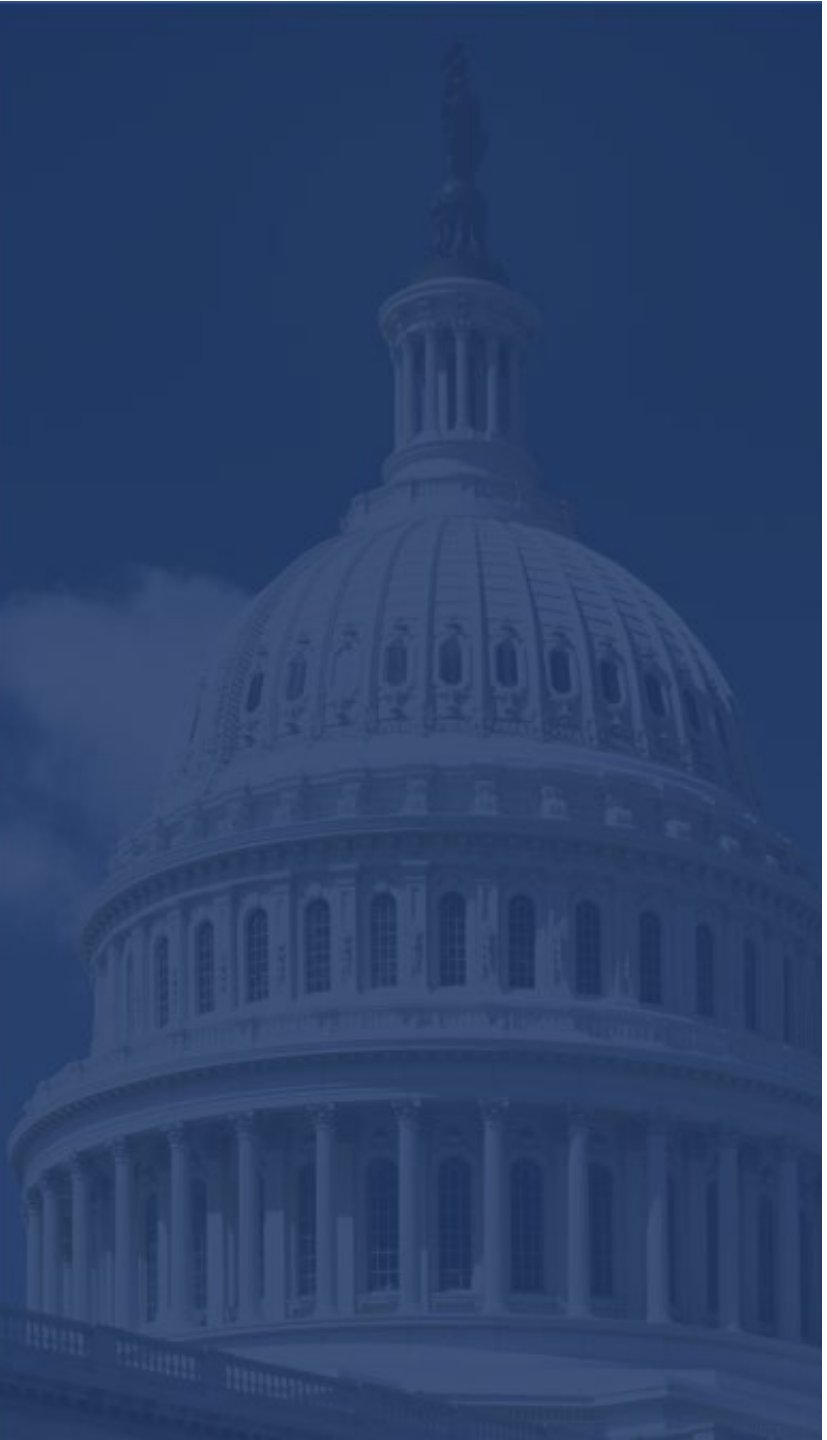
Advocacy Action Center

- ✓Send letters to Congress
- ✓Track legislation
- ✓Legislative Scorecard
- ✓Find Officials

Take Action!

neurosurgery.org/voter-voice/

Questions?



More Information:

Katie O. Orrico, Esq.
SVP, Health Policy & Advocacy
AANS/CNS Washington Office
Phone: 202-446-2024
Email: korrico@neurosurgery.org