Support Physician Practices & Preserve Patients' Access to Treatments

The American Academy of Dermatology Association (AADA) thanks Congress for its hard work to pass legislation that supports physicians and their patients during the COVID-19 public health emergency (PHE). However, more work needs to be done to preserve the viability of the physician workforce and to ensure patients can access the medical care they need as physician practices continue to recover from the financial impact of the COVID-19 PHE.

The AADA represents ***nearly 16,500 dermatologists nationwide*** *who diagnose and treat* ***more than 3,000 diseases****, including skin cancer, psoriasis, immunologic diseases, and many genetic disorders. One in four Americans suffers from a skin disease and patients should have access to the full range of these specialists through private and public payers. Health care policy should support preserving the ability of dermatologists to own and operate their own practices and maintain competitiveness in a health system that is trending toward increased consolidation and impacting patients' access to quality and affordable care often with unintended consequences.*

Ensure Medicare Stability for Patients & Physicians

Issue Overview

Evaluation and Management Code Policy Implementation

The Medicare Access and CHIP Reauthorization Act of 2015 was enacted with the goal of improving the quality and value of care and patient outcomes with evidence-based policies that involve physician input without overly burdensome documentation and compliance activity. Essential to the success of these reforms is ensuring appropriate reimbursement for medical services and procedures under the current Medicare program.

Several years ago, the Centers for Medicare & Medicaid Services (CMS) proposed broad changes to the Medicare Physician Fee Schedule (MPFS) to reflect current clinical practice as it relates to evaluation and management (E/M) services that are provided in physician offices. Current law requires that such changes to the MPFS be enacted in a budget neutral manner that results in significant cuts to procedural and other services performed by specialists and other health care providers. To alleviate cuts in Calender Year 2021 (CY 21), last December Congress intervened to provide an additional 3.75% temporary funding increase to the MPFS conversion factor, the key component of the formula that determines Medicare reimbursement to physicians for providing services to beneficiaries in the Medicare program. While the AADA appreciates this relief, physicians are again facing significant Medicare payment reductions in reimbursement for their services in CY 22. CMS's proposed MPFS rule for CY 22 offsets the increase to E/M services with cuts to other sections of the fee schedule to maintain budget neutrality. The physician community is urging Congress to maintain the 3.75% increase to the conversion factor through at least calendar years 2022 and 2023 to ensure financial stability for physician practices that are still struggling through the effects of the pandemic.

Sequestration

The sequester was enacted as part of the Budget Control Act of 2011, which included automatic across-the-board cuts to Medicare payments that was intended to reduce federal spending over ten years. Since Congress has not achieved those savings through the regular budget process, the 2% cut to the Medicare program has become a regular occurrence for providers. Congress has acted three times since the start of the COVID-19 PHE to extend relief to health care providers by suspending the Medicare sequester through the end of 2021. Congress will now have to act a fourth time to extend the sequester moratorium.

Pay-As-You-Go

With passage of the American Rescue Plan Act of 2021, physicains face another 4% cut to Medicare payments on top of the 2% sequester and cuts to comply with budget neutrality with implementation of the E/M code policy changes. This 4% cut is due to the budget rules created by the Pay-As-You-Go Act of 2010, which requires that new legislation impacting tax and spending on entitlement programs not increase the budget deficit. In March, the House passed an initial version of H.R. 1868, which would have both extended the sequester moratorium and waived the PAYGO rules to avert both cuts; however, the Senate stripped the PAYGO section and amended H.R. 1868 to extend the sequester moratorium. Shortly thereafter, the House approved the amended bill, and President Biden signed H.R. 1868 into law on April 14. The physician community is urging Congress to act to waive the 4% PAYGO offset.

Legislative Ask

Take action to prevent Medicare physician payment cuts impacting patients' access to care, and mitigate the financial distress facing dermatology practices. Beginning January 1, 2022, dermatology practices are facing up to 10% or more overall in Medicare physician payment cuts.

Support legislation to:

- Maintain the 3.75% increase to the Medicare Physician Fee Schedule (MPFS) conversion factor through at least calendar years 2022 and 2023 to ensure financial stability for physician practices that are still struggling through the effects of the pandemic.
- Extend the Medicare sequester moratorium to avert the additional 2% reduction in Medicare payments.
- Waive the PAYGO requirements connected to the American Rescue Plan Act that would result in an added 4% cut to Medicare payments.

House Only: Oppose Medicare physician payment cuts and sign onto a letter being circulated by Reps. Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN) that asks House Leadership to prioritize aversion of these cuts.

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Preserve Patients Access to Treatments

Issue Overview

Step therapy or "fail first" strategies to medication and other treatment options can negatively impact patient outcomes and quality of life. Step therapy prevents physicians from prescribing drugs that will provide the best treatment results in the most expeditious manner. Requiring patients to try and fail treatments jeopardizes the health of patients who may have an adverse reaction, potentially resulting in dangerous consequences, after taking an inappropriate drug. These protocols require our patients to try one or more prescription drugs before coverage is provided for a drug selected by the patient's physician. The AADA understands the need to contain health care costs, but we are concerned that step therapy strategies often do not take into account:

- a patient's medical history,
- whether or not the patient has already tried a certain drug and failed,
- if a patient has a medical condition that would interfere with the efficacy of the drug,
- if a drug's side effects would interfere with the patient's ability to perform their job, or
- if the drug best for the patient is one with a different ingestion method or dosage form.

In general, patients must have access to alternative treatments if the first line option is not optimal or contraindicated. Switching therapy can promote a loss of effectiveness of the prescribed medication, especially if a patient resumes the original medication later.

Legislative Ask

Take action to ensure that physicians remain the clinical authority over a patient's care and lessen the burden on patients required to go through step therapy protocols instituted by insurance companies.

- Cosponsor and support passage of the **Safe Step Act (H.R. 2163/S. 464)**, which would ensure that step therapy protocols used by health plans will preserve the physician's right to make treatment decisions in the best interest of the patient.

The **Safe Step Act (H.R. 2163/S. 464)** would ensure that step therapy protocols used by health plans will preserve the physician's right to make treatment decisions in the best interest of the patient. Physicians know their patients' medical history, which enables them to identify potential contraindications and life-threatening adverse reactions. Retaining physicians' medical judgement in patients' treatment plans is a cost-effective way to prevent health care dollars from being used on medications that are not effective. It also prevents patients from a prolonged treatment that includes scheduling multiple visits to their physician and spending money on prescription medications that are not effective.

Specifically, the **Safe Step Act** would amend the Employer Retirement Income Security Act (ERISA) to require group health plans to provide an exception process for any medication step therapy protocol. The bill:

- **Establishes a clear exemption process.** The Safe Step Act requires insurers implement a clear and transparent process for a patient or physician to request an exception to step therapy protocol, including providing process forms and contact information on their website.
- **Outlines 5 exceptions to fail first protocols.** Requires group health plans grant an exemption if an application clearly demonstrates any of the following situations:
  - > **Patient has already tried and failed on the required drug.** A patient has already tried the medicine and failed before.
  - > **Delayed treatment will cause irreversible consequences.** The drug is reasonably expected to be ineffective, and a delay of effective treatment would lead to severe or irreversible consequences.
  - > **Required drug will cause harm to the patient.** The treatment is contraindicated or has caused/is likely to cause an adverse reaction.
  - > **Required drug will prevent a patient from working or fulfilling Activities of Daily Living (ADL).** The treatment has or will prevent a participant from fulfilling their occupational responsibilities at work or performing ADL, including basic personal everyday activities such as eating, toileting, grooming, dressing, bathing, and transferring (42 CFR 441.505).
  - > **Patient is stable on their current medication.** The patient is already stable on the prescription drug selected by his or her physician, and that drug has been covered by their previous insurance plan.
- **Requires a group health plan to respond to an exemption request within 72 hours in all circumstances, and 24 hours if the patient's life is at risk.**