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Public Policy Committee Meeting Overview

On September 29th and 30th, SHM's Public Policy Committee (PPC) travelled to Washington D.C. for our annual strategic planning meeting. In addition to discussing SHMs policy goals and strategies for achieving them, members of the PPC attended meetings on Capitol Hill. Throughout the course of a packed day, the PPC and SHM staff attended **fifty two** meetings. We also had the opportunity to personally meet with a number of legislators, including Senator Chuck Grassley, Representative Scott DesJarlais, Representative Greg Walden, Representative Andy Harris, Representative Joe Courtney, and Representative Jack Bergman.

In addition to meeting with many legislators, many of our meetings were with key committees and the legislative offices of Congressmen who sit on key committees. We met with Republican and Democratic committee staffers on the Senate HELP Committee and House Energy and Commerce Committee (both of which oversee Medicare), as well as Democratic staffers on the House Judiciary Subcommittee on Immigration and Citizenship and Senate Judiciary Committee (both of which oversee immigration). These committee meetings are very important because committee members review, mark up, and are most knowledgeable about legislation within their jurisdiction. Committee membership is assigned by leaders of each party, and

committee members help shape the agenda of both the House and the Senate. By meeting with committee staffers, we are advocating directly to staffers and legislators who help determine what legislation related to healthcare and immigration should be advanced for a vote.

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The Issues

The issues we discussed on the Hill this year include immigration reform measures aimed at bolstering the physician workforce and improving the treatment of immigrant physicians who are already providing care to our nation's patients. We also advocated to expand access to Medication Assisted Treatment (MAT) for opioid use disorder (OUD), and to reform Medicare's current policy on observation status. While these issues seem unrelated, immigrant hospitalist physicians provide crucial, high quality medical care, often in underserved areas, rural regions, and critical access hospitals. These same physicians are forced to navigate outdated observation policies and provide care in regions hardest hit by the opioid crisis. In order to care for patients with a myriad of illnesses, including opioid addiction, we need to ensure our skilled and employment-based immigration system is functioning, fair, and incentivizes high quality medical professionals to emigrate to the United States.

Included below are the bills for which we advocated, as well as key information about each bill:

The Mainstreaming Addiction Treatment Act (S. 2074/ H.R. 2482).

- Buprenorphine, a partial opioid medication, is a highly effective form of addiction treatment, and unlike methadone, it does not

need to be administered in tightly monitored conditions. Despite its low risks for abuse, buprenorphine is classified as a Schedule III controlled substance. As a result, only providers with a special license, known as an "X-waiver," can prescribe this lifesaving medication for opioid use disorder treatment.

- This legislation will eliminate the x-waiver prescribing requirement. Eliminating the x-waiver will increase access to treatment both at discharge from hospitals and in the community. Additionally, it will help reduce stigma because patients will be able to get treatment from a provider they know and trust.

The Fairness for High-Skilled Immigrants Act (S. 386 and H.R. 1044).

- Many highly trained hospitalists come to the United States on an employment-based visa. They are vital to the functioning of hospitals and healthcare systems across the country and care for patients in many underserved and rural locations.

- This bill would level the playing field for those holding H-1B visas by removing per-country caps on attaining a green card/permanent residency and alleviate the decades-long backlogs that many hospitalists and their families currently face.

The Conrad State 30 and Physician Access Reauthorization Act (S. 948/ H.R. 2895).

- Individuals who enter the United States on a J-1 visa, which is reserved for work- and study-based exchange programs, are required to return to their home country for two years before they can apply for an H1-B visa or a green card. However, the Conrad State 30 Program, created in 1995, allows participants to remain in the United States if they work in an underserved area for a minimum of three years. Since the establishment of this program, over 15,000 high quality physicians have remained in the U.S. to care for patients in underserved areas.

- This reauthorization bill includes additional program improvements, such as:
    - Granting states an additional five waivers, should the state meet certain requirements
    - Creating three additional waivers per state for academic medical centers
    - Streamlining the green card application process for participating physicians
    - Increasing employment protections for participating physicians

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Why We Advocate

While advocacy work can be a slow-moving process and it is more often a marathon than a sprint, it is extremely rewarding when a representative decides to support legislation as a result of meeting with an SHM member. Take, for example, this response we received from an office we visited this October:

"It was truly a pleasure meeting with you, and I know [the representative] greatly enjoyed the conversation as well.

I also have good news to share! [The representative] has agreed to be a cosponsor of HR 2895, the Conrad State 30 and Physician Access Reauthorization Act, for which we discussed during our meeting.

Much thanks again for your advocacy, and we look forward to working together moving forward!"

Taking the time to travel to D.C. to meet with elected officials makes a concrete difference in the legislative process-and our Hill visits do have an impact.

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UPDATE: Fairness for High-Skilled Immigrants Act

On July 10, the House of Representatives passed The Fairness for High-Skilled Immigrants Act by a margin of 365 to 65, with 2 members abstaining. However, this bill has languished in the Senate and has been blocked from a vote several times. Senators who have blocked the vote on this bill cite concerns that this bill will increase green card wait times for immigrant nurses, many of whom emigrate

from places like the Philippines. Under the current law, many foreign trained nurses are approved for green cards almost immediately, whereas this bill would increase their relative wait time. Other concerns raised in the Senate are that this legislation would prioritize some professions or immigrant communities over others.

Senator Dick Durbin (D-IL), who is currently holding this bill from Senate passage, has argued that this legislation is a flawed solution to a deeper problem. He has introduced legislation that would increase the overall number of green cards available as a way to decrease wait times. SHM's Public Policy Committee has visited Senator Durbin's office in support of the Fairness for High Skilled Immigrants Act. While he has not yet signaled support for this bill, we believe continued advocacy efforts will help advance this legislation.

If you would like to send a message in support of this bill, click here.

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Physician Fee Schedule 2020 Final Rule

Changes to the Definition of Hospital-Based in the MIPS

Hospital-based providers are meant to be exempt from requirements in the Promoting Interoperability category of the Merit-Based Incentive Payment System (MIPS). This exemption was granted because the majority of hospital-based providers utilize their hospitals' Certified Electronic Health Record Technology (CEHRT) and are participating in the hospital version of the Promoting Interoperability Program (formerly EHR Incentive Program). This policy also prevents unnecessary duplication and excessive administrative burden caused by requirements to procure and maintain separate EHRs for practices that work primarily in the hospital setting.

Within the MIPS, eligible clinicians are able to report as individuals or as a group. The majority of hospitalists who participate in the MIPS report as a group, although many hospitalist groups were surprised to find themselves responsible for the Promoting Interoperability category, for which they expected to be exempt. That is because CMS defined a group as hospital-based only if 100% of the individual clinicians (defined as MIPS eligible NPIs) met the criteria for a hospital-based clinician. In effect, this meant that if a single provider

in a group did not meet CMS' criteria as a hospital-based clinician, the entire reporting group was not exempt from the Promoting Interoperability category. This created an acute problem in hospital medicine practices due to the widespread use of locum tenens, moonlighting providers, and the increasing prevalence of hospitalists within a group following patients into post-acute and post-discharge settings.

SHM was made aware of this issue in October 2018 when several large hospitalist groups were unexpectedly affected by the definition of a hospital-based reporting group. We led the charge to collaborate with several other specialty societies in a letter to CMS. We also raised this issue to CMS via comment letters and listening session feedback and discussed with legislators on the Hill. We recommended that CMS amend the definition of a hospital-based group to align with the definitions of non-patient facing and facility-based groups. In effect, that policy would define a group as hospital-based if 75% or more providers in the group are deemed hospital-based. We recommended this change be made applicable to the 2020 Payment Year.

CMS corrected this issue within the 2020 Physician Fee Schedule Final Rule, which was released on November 1st. CMS finalized a change that defines hospital-based groups and virtual groups as those with more than 75% of individual NPIs classified as hospital-based MIPS eligible clinicians. This change will ensure that hospital-based reporting groups are excluded from the Promoting Interoperability category.

We are excited and appreciative that CMS has taken our feedback to implement this change so quickly. By changing the definition of a hospital-based reporting group, CMS has ensured hospital-based groups will not be penalized by Promoting Interoperability in the MIPS for circumstances out of their control, beginning with the payment year 2020.

For more information for hospitalists about the Quality Payment Program and the MIPS, visit www.macraforhm.org.

Changes to Physician Supervision of PAs and Medical Documentation Requirements

CMS finalized two changes to supervision and documentation requirements that should help streamline hospitalist practice and

recognize the critical role of all members of the hospital medicine team.

In order to reduce unnecessary administrative burden and repetitive documentation, CMS changed documentation requirements related to physician supervision of Physician Assistant (PA) services. In the absence of state laws, physician supervision requirements would be evidenced by documentation in the medical record. However, PAs must adhere to the documentation and supervision requirements of their state laws, should any exist. This final rule aligns PA requirements with previously existing Medicare regulations for nurse practitioners (NP) and clinical nurse specialists (CNS). PAs are integral members of the hospital medicine team and having consistent supervision requirements streamlines the management of team-based care in the hospital.

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