"*The future ain't what it used to be*"

Health care policy in the era of President Trump

ACP Missouri Chapter

September 16, 2017

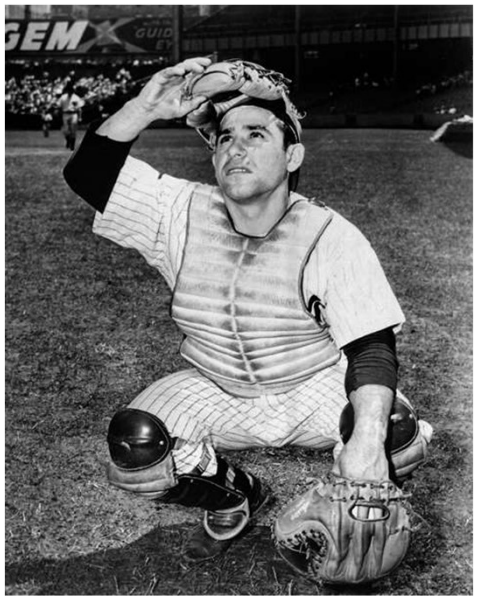
American College of Physicians
Leading Internal Medicine, Improving Lives

The one, and only, thing that is certain about health care . . .

"The future ain't what it used to be."

The late, great
Yogi Berra

New York Yankee Catcher
St. Louis, Missouri native



The new political realities:

1. President Trump and his administration are highly *disruptive,* upsetting long-held assumptions on the direction of U.S. health care policy.
2. GOP-control of Congress means that they *on paper* have the votes to carry out much of this disruptive agenda—but only *if they stay* united; Democrats have *limited ability* to influence action in Senate.
3. Trump presidency has unleashed a passionate grass roots progressive backlash, resulting in most Democrats favoring confrontation over cooperation.

"The future ain't what it used to be."

- Before the election, most of us who advocate for doctors and patients anticipated a future of advocating for continued expansion of coverage, building and improving on the ACA.
- Since the election, we have had to devote much of our efforts to stopping the GOP effort to rollback coverage by repealing and replacing the ACA.

For 7 years, this has been how the GOP has viewed the "Obamacare." ***Now they can actually do something about it.***

But it's not just ACA repeal. This administration and Congress are charting a very different course on:

- Federal funding priorities
- Scientific research and public health
- Immigration
- Regulations
- And much, much more . . .
  - While this has necessitated that ACP play *defense* on many issues, we concluded that the best approach is to *advocate our own forward-looking agenda for better health care.*

ACP's Rx for a Forward-Looking Agenda to Improve American Health Care

1. Expand coverage and access.
2. Bring greater value for the dollars spent.
3. Reduce the crushing administrative burden on physicians and patients.
4. Leverage technology to improve patient care.
5. Support a well-trained physician workforce.
6. Reduce barriers to chronic care management.
7. Support scientific research and policies to improve public health.

https://www.acponline.org/acp_policy/policies/forward_looking_policy_agenda_2017.pdf

ACP's Rx for better health care

1. Expand coverage and access.
   - Improve, don't repeal, the ACA.
   - Stabilize markets, commit to cost-sharing reduction payments.
   - Create Medicare buy-in option for aged 55-64.

ACA repeal and your patients

- Where do things stand on ACA repeal?
- What would be the impact on your patients? and your practice?

The rise and fall of ACA repeal

- **March 7**: the House version of ACA repeal, the American Health Care Act (AHCA), introduced in the House.
- **March 24**: House Speaker Ryan withdraws the AHCA because of lack of support.
- **May 4**: modified AHCA narrowly passes House, 217-213, with amendment that allows states to waive essential benefits and modified community-rating requirements.

The rise and fall of ACA repeal

- **June 22**: draft of Senate version, the Better Care Reconciliation Act (BCRA), released.
  - Incorporated many of the elements of the AHCA: Medicaid caps/block grants, end of higher federal match for expansion, repeal of individual and employer mandates; state waivers of essential benefits and community rating, $ for high risk pools and market stabilization, repeal of most ACA taxes; tax credit subsidies that would increase premiums and deductibles for older, sicker and poorer patients.

The rise and fall of ACA repeal

<u>July 17</u>: Majority Leader Mitch McConnell decides not to go forward with vote on BCRA, after 4 Senate Rs declared opposition. Issues statement that the current effort to immediately repeal and replace the ACA through BCRA "will not be successful."

Headlines declare the bill is dead.


THE WALL STREET JOURNAL.

What's News

GOP Stares Down Loss on Health

Insurers Brace for New Uncertainty

Discovery, Scripps In Talks On Tie-Up

Goldman's Trading Slide Surprises

Foreigners Pump Up Home Prices in U.S.

AMERICA'S FARMERS TURN TO BANK OF JOHN DEERE

INSIDE

NEW PUSH OPENS THE TAP FOR SHOPPERS

HIGH-END GUTTERS, AT AUCTION

The Open Takes Place in Britain—but Don't Call It the British Open

The rise and fall of ACA repeal

July 18: Majority Leader McConnell announces he would push ahead with vote in "coming days" to partially repeal the ACA with a 2-year delay before the repealed provisions would sunset. Based **on 2015 repeal bill vetoed by President Obama.**

July 25-27: Motion to Proceed passes the Senate, 51-50 with Vice President Pence casing the tie-breaker. Senators Murkowski (R-AK) and Susan Collins (R-ME) are only Republicans to vote no. Senator John McCain (R-AZ) votes yes while decrying the process. Hours later, a revised version of BCRA fails on procedural vote, 43-57. Senate votes down repeal with 2-year delay, 45-55. Consideration moves to "skinny repeal"—repeal of individual and employer mandates and medical device tax.

The rise and fall of ACA repeal

July 28: At 1:30 a.m., the Senate voted by 49-51 to reject the "skinny repeal" amendment offered by Senator McConnell, with Senator McCain joining Murkowski and Collins in voting no. Leader McConnell says "it's time to move on."

Senate leaders react after John McCain, Republican of Arizona, who returned to the Senate this week after receiving a diagnosis of brain cancer, cast the decisive vote to defeat his party's "skinny repeal" of Obamacare. By THE ASSOCIATED PRESS. .

Embed

How did ACP help lead the effort to stop ACA repeal?

- Grass roots:
  - 36 action alerts to our grassroots network across the country, which includes targeted alerts to key House members and senators.
  - A “write to Congress” letter-writing campaign for all of our 50 chapter governors during the March Board of Governors meeting.
  - 7 separate full-scale action campaigns for our 50 chapters that also involved targeted campaigns for 8-10 states with Republican senators who have expressed concerns about the AHCA/BCRA.
  - ACP’s 2017 Leadership Day in May brought 400 members from across the country representing 47 states and DC; a major component of our advocacy for this event was messaging in opposition to the AHCA.
  - Messaging in opposition to the AHCA was printed on mock prescriptions for use by ACP advocates with their lawmakers during Leadership Day.

How did ACP help lead the effort to stop ACA repeal?

- Coalitions:
  - Inspired a partnership among 6 allied physician organizations working together in opposition to the AHCA/BCRA (ACP, AAFP, AOA, ACOG, AAP, APA)
  - The six allied groups above have conducted 5 separate fly-ins (2-2-17, 3-7-17, 5-11-17, 6-28-17, 7-12-17) involving the leadership of those six front-line physician organizations, the most recent one was July 12. Meetings were held with targeted reps/senators. 100 letters were hand delivered on June 28 to all Senate offices, signed by the group of six, containing state-specific data on the harmful impact of BCRA in each state.
  - In conjunction with these leadership fly-ins, a twitter hashtag was adopted and is still utilized for twitter campaigns: #docs4coverage. An additional hashtag has been adopted for our twitter campaigns, #stopthebill
  - Separate and parallel women's health coalition—ACP, ACOG, Planned Parenthood, others—organized to oppose defunding PP and repeal of essential benefits.
  - Regularly share information and strategy with consumer groups, especially National Partnership for Women and Families and Center for American Progress.

Group of 6: ACP, AAFP, AOA, ACOG, AAP, APA

- Five "Group of 6" Fly-ins with the U.S. Senate

- And letters, grass roots, news releases, social media to oppose repeal and replace!


ARKANSAS

How did ACP help lead the effort to stop ACA repeal?

- Letters/Media:
  - 15 ACP National letters to Congress; 14 coalition letters to Congress
  - 3 TV appearances (one with Bob Doherty; two with Nitin Damle) on MSNBC “the Last Word” and with Kate Snow
  - Satellite Media Tour with Bob Doherty and Nitin Damle (January 9th), reached more than 16.2 million people with 549 airings of the content.
  - Dr. Damle testified at a “hearing” on the AHCA organized by House Democrats, Facebook live video).
  - Press briefing at ACP's Annual Meeting (Doherty/Damle) (Facebook live video)
  - A press event in conjunction with the Group of 6 leadership fly-in in February and again on June 28.
  - A press event in opposition to BCRA, sponsored by senators Stabenow and Hassan featuring the group of six on June 28. The president of AAP spoke on behalf of the group.
  - A July 12 lunch featuring the G6 leaders and a reporter from the Washington Post to discuss Hill visits and events for that day’s fly-in.
  - The G6 featured by MSNBC’s Katy Tur in a July 12 segment on the Hill. AAFP’s leader spoke for group.
  - 9 articles in “The Advocate” in opposition to the AHCA/ACA repeal efforts
  - 28 ACP and/or joint releases/statements on the AHCA or repeal efforts
  - 5 Blog posts by me on the AHCA/repeal; Consistent social media postings on Facebook, Twitter

Yet this may not be the end for ACA repeal.

- Like a Zombie attack, no matter how many times its left for dead, it keeps coming back, and back, and back.

What would be the impact on your patients if ACA repeal succeeds?

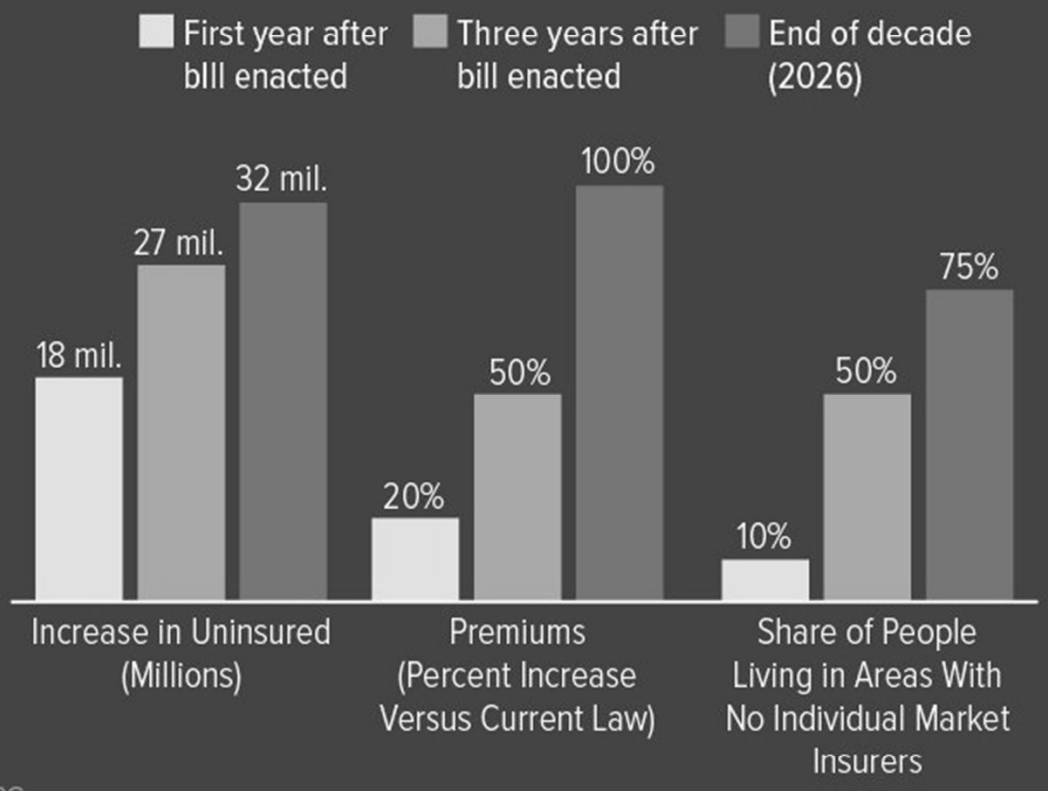
Tens of millions more uninsured

Higher deductibles and premiums for poor and sick

Loss of coverage of essential benefits

Denial of coverage for preexisting conditions

ACA REPEAL WITH NO REPLACEMENT WOULD LEAD TO 32 MILLION LOSING COVERAGE AND INDIVIDUAL MARKET COLLAPSE



Source: Congressional Budget Office, January 2017

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

Per Capita Caps and Block Grants Shift Medicaid to a Fixed Funding Structure

- Today, federal funding of Medicaid is open-ended-the federal government contributes a fixed share of each state's actual spending
- Medicaid reform proposals limit federal spending to a target

Per Capita Cap

Fixed federal funding per beneficiary

Block Grant

Fixed federal funding for a group of beneficiaries

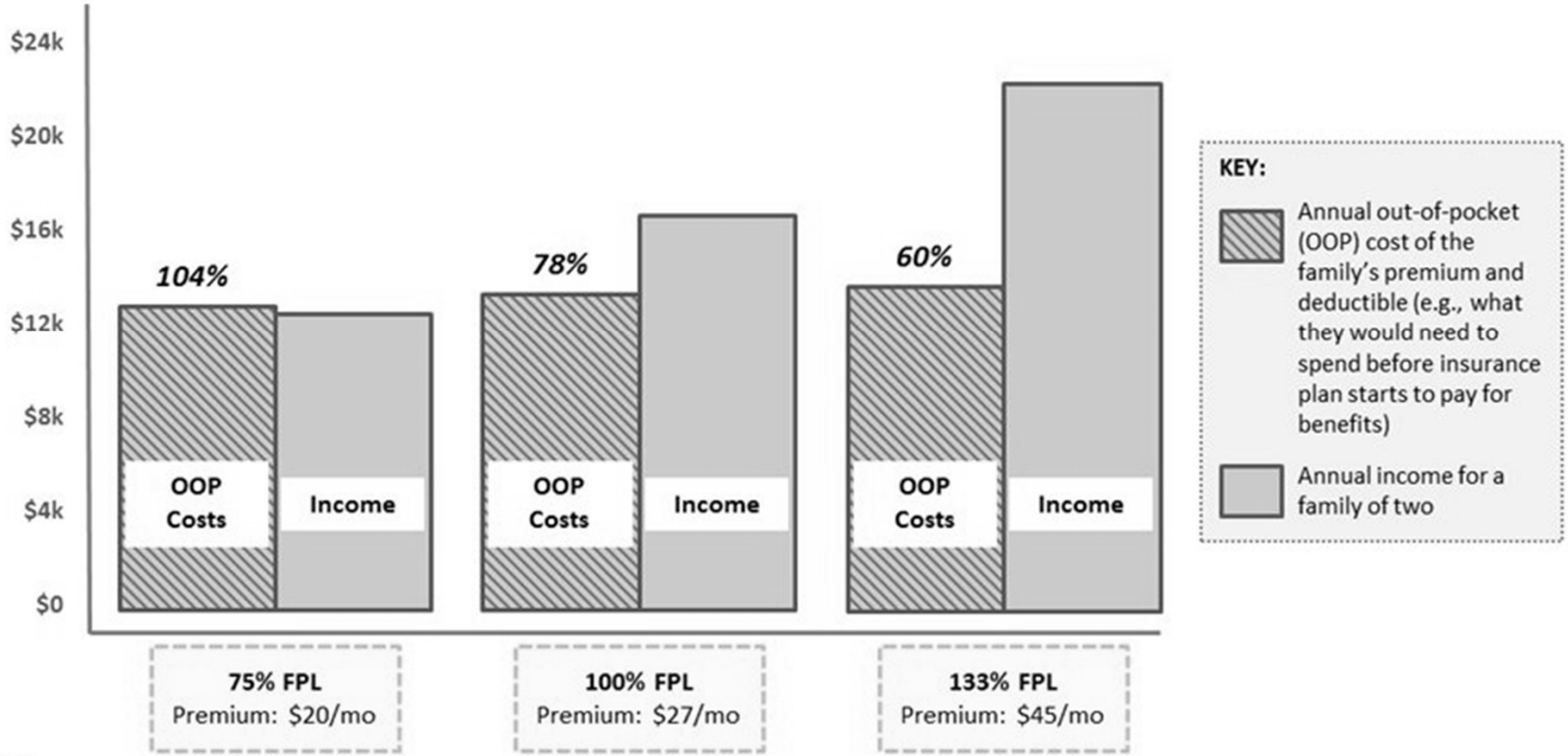
Core Components of the Federal Funding Formula

Avalere®

Source: Avalere presentation to National Governors Association

Cost of Marketplace Coverage under BCRA for People Losing Medicaid

Even with tax credits, the cost of care for adults losing Medicaid would consume from 60% to 104% of their total annual incomes.



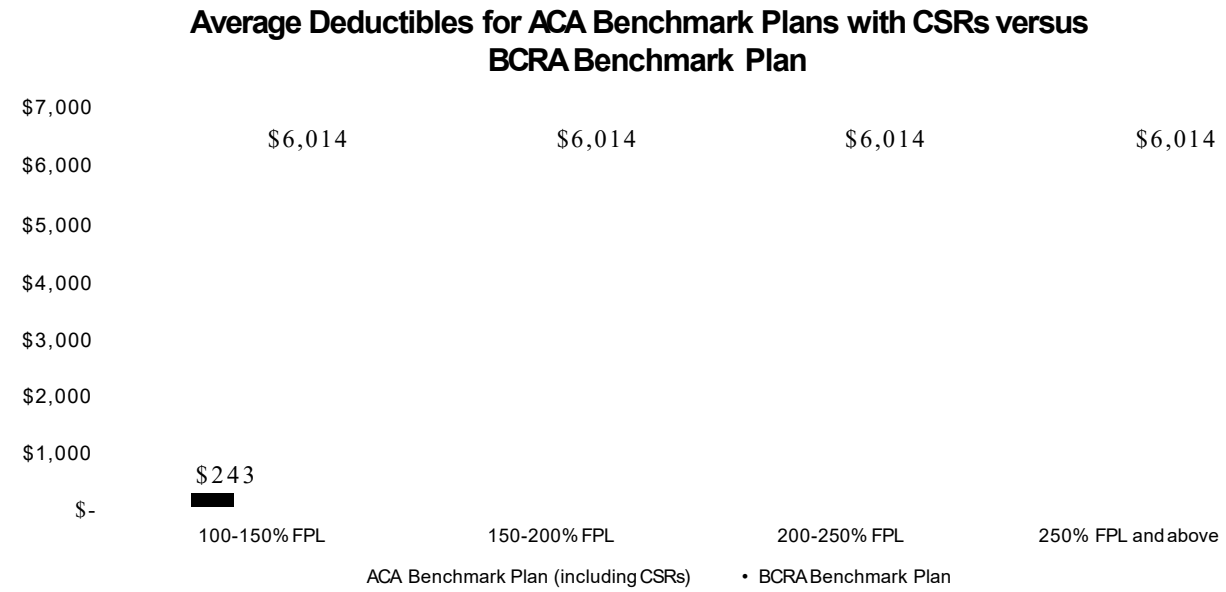
NOTES:

(a) Premiums are the net premiums paid for the BCRA benchmark plan (58% AV), after tax credits are applied.

(b) Deductibles are based on the 2017 national average for a bronze plan ($12,393 for a family). Bronze plans have a 60% AV.

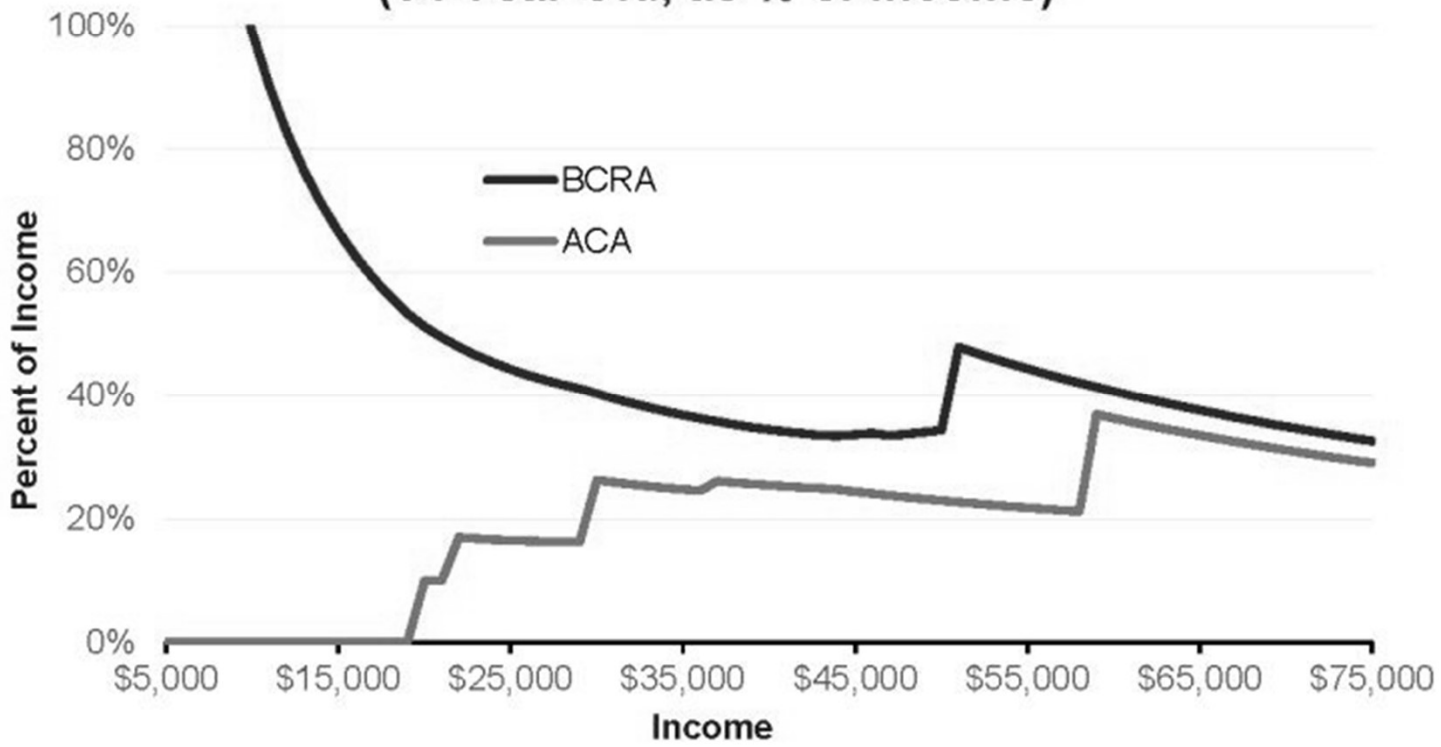
Sources: Manatt analysis of (1) ASPE, Department of Health and Human Services, 2017 Federal Poverty Guidelines. https://aspe.hhs.gov/poverty-guidelines, and (2) HealthPocket, 2017 Premiums and Out-of-Pocket Costs, Oct. 26, 2017. https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles#.WV64K4QrKUI

Low-Income Individuals May Face Increased Deductibles with Repeal of CSRs and Change to Lower Benchmark Plan



Source: Avalere presentation to National Governors Association

Average Annual Cost of Health Care in Individual Market (64 Year Old, as % of Income)



Source: CBO, CMS OACT, authors' calculations; Note: Graph assumes a Medicaid expansion state

USC Schaeffer BROOKINGS

CBO estimate of the ACA deductible for someone making $26,500 in 2026: $800

Under the BCRA: $13,000, a 1525% increase!!!

Who loses if insurers can again waiver coverage or charge more for preexisting conditions? *Your* patients.

DECLINABLE MEDICAL CONDITIONS

Before the ACA, individual market insurers in all but five states maintained lists of so-called declinable medical conditions. People with a current or past diagnosis of one or more listed conditions were automatically denied. Insurer lists varied somewhat from company to company, though with substantial overlap. Some of the commonly listed conditions are shown in Table 2.

Table 2: Examples of Declinable Conditions In the Medically Underwritten Individual Market, Before the Affordable Care Act

Condition	Condition
AIDS/HIV	Lupus
Alcohol abuse/ Drug abuse with recent treatment	Mental disorders (severe, e.g. bipolar, eating disorder)
Alzheimer's/dementia	Multiple sclerosis
Arthritis (rheumatoid), fibromyalgia, other inflammatory joint disease	Muscular dystrophy
Cancer within some period of time (e.g. 10 years, often other than basal skin cancer)	Obesity, severe
Cerebral palsy	Organ transplant
Congestive heart failure	Paraplegia
Coronary artery/heart disease, bypass surgery	Paralysis
Crohn's disease/ ulcerative colitis	Parkinson's disease
Chronic obstructive pulmonary disease (COPD)/emphysema	Pending surgery or hospitalization
Diabetes mellitus	Pneumocystic pneumonia
Epilepsy	Pregnancy or expectant parent
Hemophilia	Sleep apnea
Hepatitis (Hep C)	Stroke
Kidney disease, renal failure	Transsexualism

SOURCE: Kaiser Family Foundation review of field underwriting guidelines from Aetna (GA, PA, and TX), Anthem BCBS (IN, KY, and OH), Assurant, CIGNA, Coventry, Dean Health, Golden Rule, Health Care Services Corporation (BCBS in IL, TX) HealthNet, Humana, United HealthCare, Wisconsin Physician Service. Conditions in this table appeared on declinable conditions list in half or more of guides reviewed. NOTE: Many additional, less-common disorders also appearing on most of the declinable conditions lists were omitted from this table.

Even if the legislative effort to repeal the ACA fails, the administration could sabotage implementation

- Discontinuing cost-sharing reduction payments to plans.
- Failing to encourage or actively discourage enrollment.
  - HHS has re-directed funds meant for enrollment through www.healthcare.gov website to anti-ACA talking points.
  - Did not renew contracts with groups helping people sign up.
- Not enforcing individual insurance mandate.
- Easing essential benefit requirements, conscience exemptions.
- Not supporting legislative and regulatory actions to stabilize markets.

So what's the *practical* impact on your practice and your patients if the ACA is repealed?

- Reduced Medicaid payments.
- Fewer patients on Medicaid, many of whom would be enrolled instead in high deductible plans.
- Higher out-of-pocket costs for older, sicker and poorer patients.
- Loss of coverage/higher premiums for patients with preexisting conditions.
- Many benefits that are now defined as essential would be subject to co-payments and deductibles, or not covered at all.
- Result will be that tens of millions more people will go without any health insurance coverage and those who have it, will pay more for less coverage.
- More uncompensated care.
- Loss of lives.

Table 1. Summary of Studies on Relationship Between Insurance Coverage and All-Cause Mortality*

Study, Year (Reference)	Participants	Information on Baseline Health	Estimated Mortality Effect of Coverage vs. Uninsured	Comments
RCTs				
Oregon Health Insurance Experiment, 2013, 2011, 2012 (10, 16, 17)	74 922 nondisabled adults on waiting list for Medicaid	Retrospective survey of a subsample; no baseline blood pressure or other measurements	OR, 0.84 (NS)	Study was underpowered because of crossovers between insured and uninsured groups, low mortality rate, short follow-up. Coverage was associated with nonsignificantly lower (0.81 mm Hg) average diastolic blood pressure
Quasi-experimental studies, population-based				
Sommers et al, 2012, 2017 (29, 30)	Nonelderly adults in states expanding Medicaid (Arizona, New York, Maine) and comparison states	None at individual level; compared trends in death rates in expansion with those in neighboring states	RR of death expansion/nonexpansion states, 0.939 ($P = 0.001$)	Study examined Medicaid expansions that preceded the ACA's expansions
Sommers et al, 2014 (31)	Nonelderly adults in Massachusetts and comparison counties	None at individual level; compared trends in death rates in Massachusetts with those in matched control counties	RR for death in Massachusetts counties/matched counties, 0.971 ($P = 0.003$)	The 2006 reform expanded Medicaid and implemented subsidized coverage for low-income persons
Hanratty, 1996 (51)	Newborns in Canadian provinces expanding coverage at different times	None at individual level; compared infant mortality trends pre- vs. postreform	RR for death, 0.95 or 0.96 ($P < 0.05$ for both)	Estimates varied slightly depending on how time trends were modeled
Quasi-experimental studies, clinic cohorts				
Lurie et al, 1984, 1986 (40, 41)	186 clinic patients terminated from Medicaid vs. 109 who remained eligible	Clinic-based data	OR at 1 y, 0.23 (NS)	Large effect probably reflects very high baseline risk. Among terminated patients with hypertension, average diastolic blood pressure increased 10 mm Hg at 6 mo vs. decrease of 5 mm Hg among controls ($P = 0.003$)
Fihn and Wicher, 1988 (42)	157 patients terminated from outpatient VA care vs. 74 controls	Clinic-based data	OR not calculable from published data; per authors, "at least 6% of terminated patients died"	Marked deterioration in blood pressure control among terminated patients
Quasi-experimental studies using longitudinal data from the Health and Retirement Study (26, 32–37)	Several cohorts followed for varying time periods from age ≥51 y	Repeated questionnaires linked to Medicare records and National Death Index; no examination or laboratory data	Conflicting results; some found lower deaths among insured, and others were null	Studies compared mortality before age 65 y and relative changes in death rates after acquisition of Medicare eligibility. Different analytic strategies yielded different conclusions
Population-based cohort follow-up studies				
Sorlie et al, 1994 (23)	CPS respondents 1982–1985	None other than being employed	HR for employed white women, 0.83 (NS); HR for employed white men, 0.77 ($P = 0.05$)	No data on smoking, health status or other non-demographic predictors of mortality at baseline
Franks et al, 1993 (27)	NHANES respondents 1971–1975	Surveys, physical examinations, and lab test results	HR, 0.8 ($P = 0.05$)	Controls for baseline health status included physician-assessed morbidity
Kronick, 2009 (24)	NHIS respondents 1986–2000	Questionnaires only	HR, 0.91 ($P < 0.05$; without control for self-rated health) and 0.97 (NS; including self-rated health)	Control for self-rated health may bias findings because this variable is probably confounded by coverage
Wilper et al, 2009 (28)	NHANES respondents 1988–1994	Surveys and physician-rated health after a physical examination	HR, 0.71 ($P < 0.05$)	Controls for baseline health status included physician-assessed health status

ACA = Affordable Care Act; CPS = Current Population Survey; HR = hazard ratio; NHANES = National Health and Nutrition Examination Study; NHIS = National Health Interview Survey; NS = nonsignificant; OR = odds ratio; RR = relative risk; VA = Department of Veterans Affairs.
* For studies not reporting ORs, HRs, or RRs, the authors computed them from data in the original report.

In 2002, an Institute of Medicine review concluded that lack of insurance increases mortality, but several relevant studies have appeared since that time. This article summarizes current evidence concerning the relationship of insurance and mortality. The evidence strengthens confidence in the Institute of Medicine's conclusion that health insurance saves lives: The odds of dying among the insured relative to the uninsured is 0.71 to 0.97.

Woolhandler S, Himmelstein DU. The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?. Ann Intern Med. [Epub ahead of print 27 June 2017] doi: 10.7326/M17-1403

ACP's Rx for better health care.

2. Bring greater value for the dollars spent.
   - Lower prescription drug prices.
   - Apply evidence to clinical decision-making, cost-sharing and coverage.
   - Enact reforms to our medical liability system.
   - Promote transparency across health care.
   - Improve Medicare's new Quality Payment Program.

Quality Payment Program In a Nutshell

Law *intended* to align physician payment with *value*

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**

Or now the…

Quality Payment Program

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

This new MIPS "report card" will replace current Medicare reporting programs

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program **(PQRS)**
- Value-Based Payment Modifier (quality and cost of care)
- "Meaningful use" of EHRs

MACRA streamlines those programs into **MIPS**:

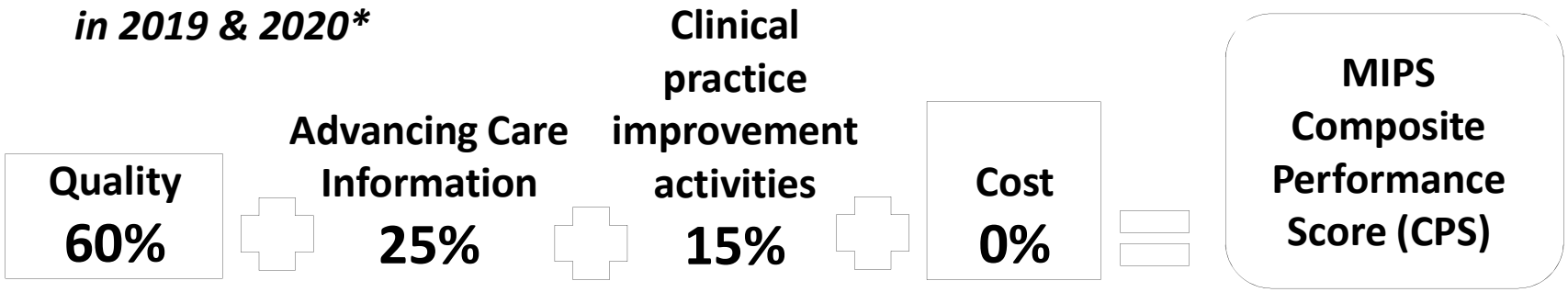
Merit-Based Incentive Payment System **(MIPS)**

Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

How Will Clinicians Be Scored Under MIPS?

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:

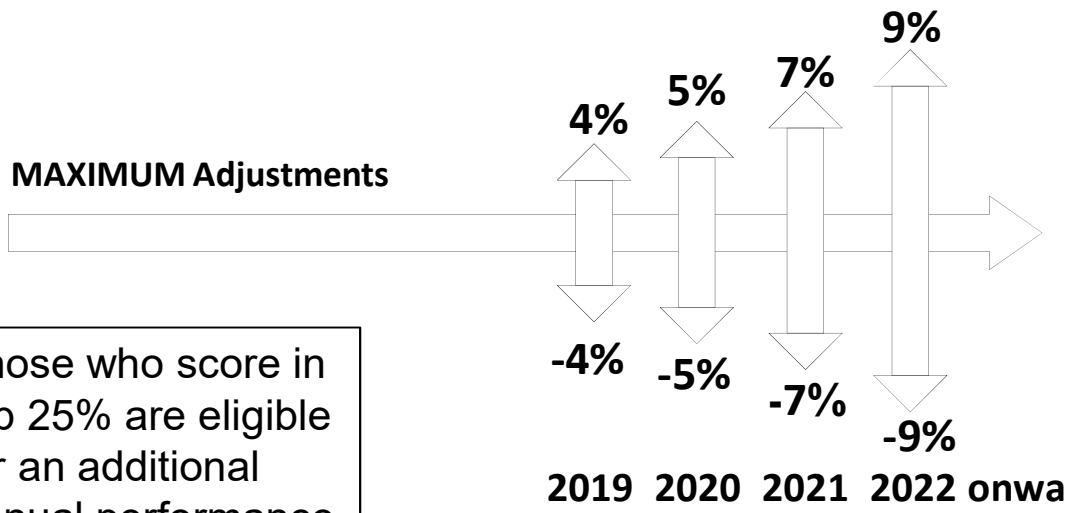
Year 2 payment adjustments in 2019 & 2020*



* Based on reporting data for 2017 and proposed for 2018

How Much Can MIPS Adjust Payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**.



Adjustment to provider's base rate of Medicare Part B payment

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral)

Merit-Based Incentive Payment System **(MIPS)**

New for 2018:

- Complex patient and small practices bonuses
- Virtual reporting option
  - Tax identification number (TIN) with 10 or fewer clinicians can join; at least 2 TINs join to form a group; assessed across all performance categories as a group practice
- Cost
  - Based on statistically significant changes at measure level; will not affect final score for 2018 performance since cost category has 0% weight
- Quality (proposed)
  - Based on rate of improvement
  - More points awarded for those not performing well previously
  - Up to 10 percentage points available for category

Advanced Alternative Payment Models (APMs)

Initial definitions from MACRA law, APMs include:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by Federal Law

As defined by MACRA, advanced APMs **must meet the following criteria**:

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

Proposed ⇨ FINAL Rule (and beyond)
Advanced APMs

Proposed in 2017	New for 2017	New for 2018
Shared Savings Program (Tracks 2 and 3)		Track One Plus (details recently released)
Next Generation ACO Model		Adding new participants (applications in 2017)
Comprehensive ESRD Care (CEC) (large dialysis organization)	CEC for non-LDOs with 2-sided risk	
Comprehensive Primary Care Plus (CPC+)		Adding more payers & practices (applications in 2017)
Oncology Care Model (OCM) announced to start in 2018	OCM – 2-sided risk (now starting in 2017)	
	Comprehensive Care for Joint Replacement Payment Models (originally planned for 2018)	
	Vermont Medicare ACO Initiative	
		Advancing Care Coordination through Episode Payment Models Track 1
		Cardiac Rehabilitation (CR) Incentive Payment Model

Source: https://qpp.cms.gov/learn/apms

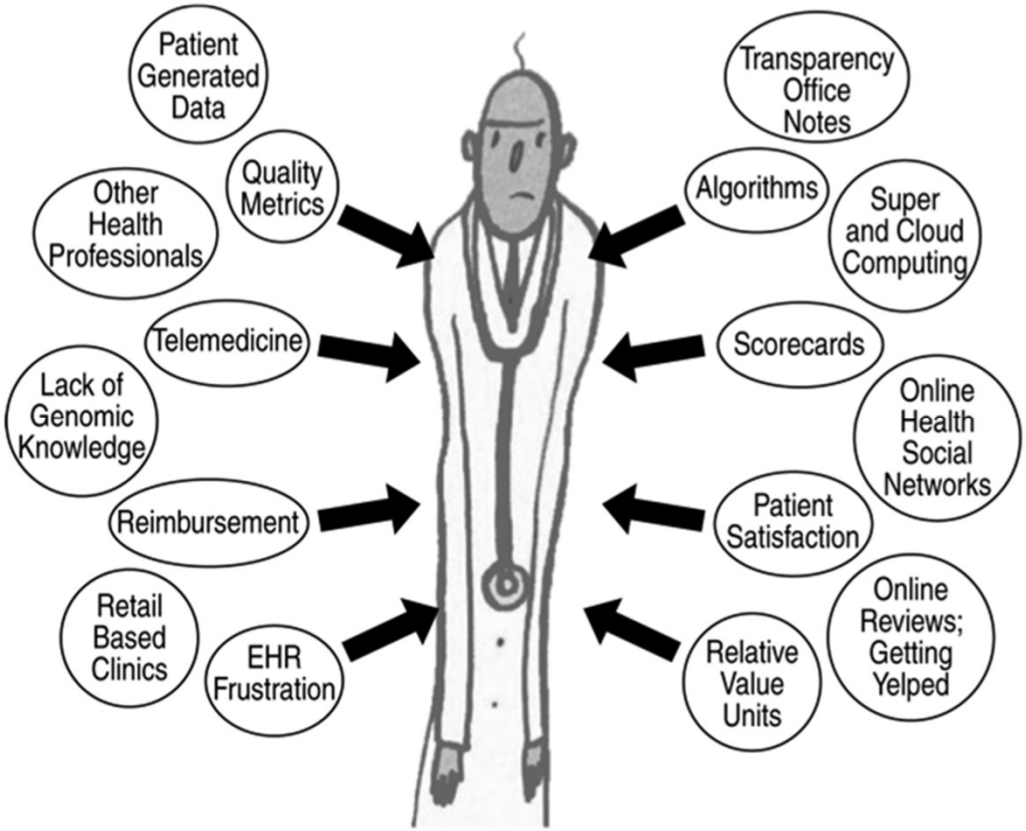
What does this *practically* mean for your practice?

- Since most of you will be in MIPS, participate and "pick your pace" to avoid reductions (or earn positive updates).
- Learn about the weights, scoring, measures and activities required under MIPS—commit to doing *something*.
- Use ACP resources https://www.acponline.org/practice-resources/business-resources/payment/medicare/macra including our new *Quality Payment Advisor* https://www.qualitypaymentadvisor.org/

ACP's Rx for better health care

3. Reduce the crushing administrative burden on physicians and patients.
   - Unnecessary regulation (and other administrative tasks) takes time away from patients, creates barriers to care, results in unnecessary spending, and contributes to professional burn-out.
   - The Trump administration and GOP-led Congress have expressed a greater willingness to ease unnecessary federal regulations.
   - In ACP's view, the most effective approach will be to create an entirely new framework to assess regulations: *intent, impact, and alternatives*.

Isn't this how *you* feel?



And its not just physicians who are dissatisfied. A *patient's* perspective:

"When at last we are sure you've been properly pilled,

then a few paper forms must be properly filled,

so that you and your heirs may be properly billed."

Dissatisfaction with EHRs is a major contributor to burn-out

- Takes away time from patients, diverts physicians' attention to looking at a screen instead of the patient.
- Does not produce clinically useful information in a user-friendly way.

ACP study:

Mean Loss for attending physicians was

48 minutes per clinic day,

4 hours per five day clinic week

JAMA Internal Medicine, September 8, 2014, http://archinte.jamanetwork.com/article.aspx?articleid=1901114

Letters

RESEARCH LETTER

Use of Internist's Free Time by Ambulatory Care Electronic Medical Record Systems

Physicians complain about the time costs and other effects of electronic medical records (EMRs).[1-3] In a small survey,[4] family practice physicians reported an EMR-associated loss of 48 minutes of free time per clinic day ($P < .05$). We collaborated with the American College of Physicians (ACP) to revise the instrument from this study and surveyed the ACP's national sample of internists to determine the extent of this problem.

Methods | The ACP invites 1% of its members, including internal medicine attending physicians and trainees (resident and fellows), into its research panel,[5] narrows the candidates by random sampling to ensure balance, and then adds nonmember internists. On December 12, 2012, the ACP mailed a 19-question survey to its panelists (900 ACP member and 102 nonmember internists at that time) who provided ambulatory care, and left it in the field for 10 days. The survey (Q11-Q12) focused on free time to get a sense of the EMR's overall effect

medical record data with the EMR than without, and a similar proportion, 32.2%, that it was slower to read other clinicians' notes.

The mean time loss for attending physicians was −48 minutes per clinic day ($P < .001$), or 4 hours per 5-day clinic week. The mean loss for trainees was −18 minutes per day, less than that of attending physicians ($P < .001$). For the 59.4% of all respondents who did lose time, the mean loss was −78 minutes per clinic day, or 6.5 hours per 5-day clinic week.

Discussion | The loss of free time that our respondents reported was large and pervasive and could decrease access or increase costs of care. Policy makers should consider these time costs in future EMR mandates. Ambulatory practices may benefit from approaches used by high-performing practices[6]—the use of scribes, standing orders, talking instead of e-mail—to recapture time lost on EMR. We can only speculate as to whether better computer skills, shorter (half-day) clinic assignments with proportionately less exposure to EMR time costs, or other factors account for the trainees' smaller per-day time loss.

Why are EHRs so bad? Because they are designed to document billing, not improve patient care.

"The primary purpose of clinical documentation should be to support patient care and improve clinical outcomes through enhanced communication."

ACP 2015 position paper, Clinical Documentation in the 21st Century, developed by our Medical Informatics Committee

Part of the EHR solution: *simplify documentation requirements*

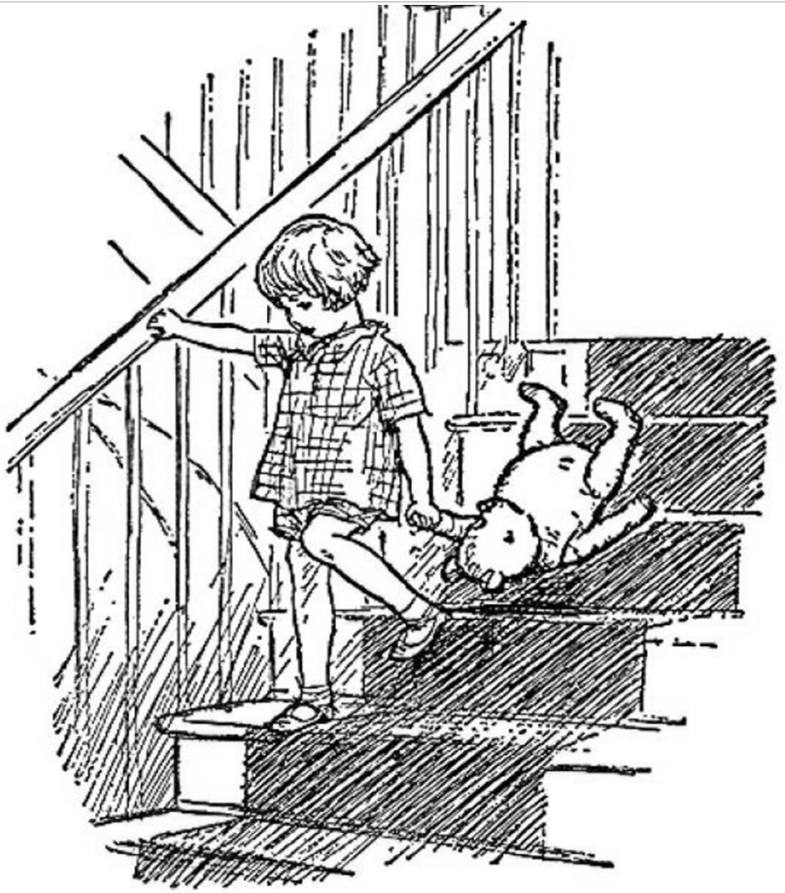
Reworking Evaluation & Management (E/M) Documentation Guidelines:

- Based on Clinical Documentation in the 21st Century the College has held numerous meetings with the deputy administrators at CMS and other agencies within HHS regarding reducing the administrative burden of the E/M documentation guidelines.
  - On June 28, 2017 ACP attended a meeting with Secretary Price where the College outlined a proposal to move forward with reform of E/M documentation guidelines.
  - This has led to Solicitation of Public Comment on the reform of the E/M documentation guidelines through the 2018 Medicare Physician Fee Schedule NPRM.
  - ACP will provide detailed comments and recommendations for simplification and alignment of E/M documentation through the rulemaking process

Link to paper: http://annals.org/aim/article/2089368/clinical-documentation-21st-century-executive-summary-policy-position-paper-from

Easing regulatory burdens on physicians requires that we consider *another way* of looking at them

"Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it."



A.A. Milne, 1920
illustration by E. M. Shepard

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POSITION PAPERS | 28 MARCH 2017

Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians FREE

Shari M. Erickson, MPH; Brooke Rockwern, MPH; Michelle Koltov, MPH; Robert McLean, MD; for the Medical Practice and Quality Committee of the American College of Physicians (*)

Article, Author, and Disclosure Information

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Abstract

This American College of Physicians (ACP) position paper, initiated and written by ACP's Medical Practice and Quality Committee and approved by the Board of Regents on 21 January 2017, reports policy recommendations to address the issue of administrative tasks to mitigate or eliminate their adverse effects on physicians, their patients, and the health care system as a whole. The paper outlines a cohesive framework for analyzing administrative tasks through several lenses to better understand any given task that a clinician and his or her staff may be required to perform. In addition, a scoping literature review and environmental scan were done to assess the effects on physician time, practice and system cost, and patient care due to the increase in administrative tasks. The findings from the scoping review, in addition to the framework, provide the backbone of detailed policy recommendations from the ACP to external stakeholders (such as payers, governmental oversight organizations, and vendors) regarding how any given administrative requirement, regulation, or program should be assessed, then potentially revised or removed entirely.

The American College of Physicians (ACP) has long identified reducing administrative tasks as an important objective, maintaining significant policy and participating in many efforts with this goal in mind, including developing the "Patients Before Paperwork" initiative in 2015. The growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. health care system, individual physician practices, and the patients themselves. Excessive administrative tasks also divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. In

http://annals.org/aim/article/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper

Figure 1: Framework for Analyzing Administrative Tasks

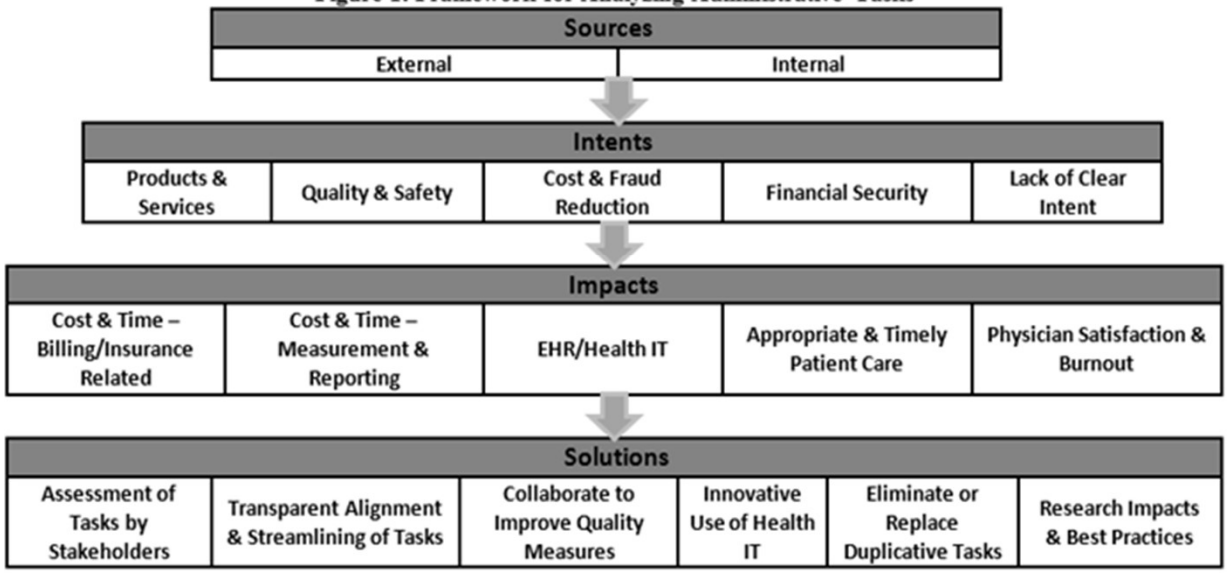
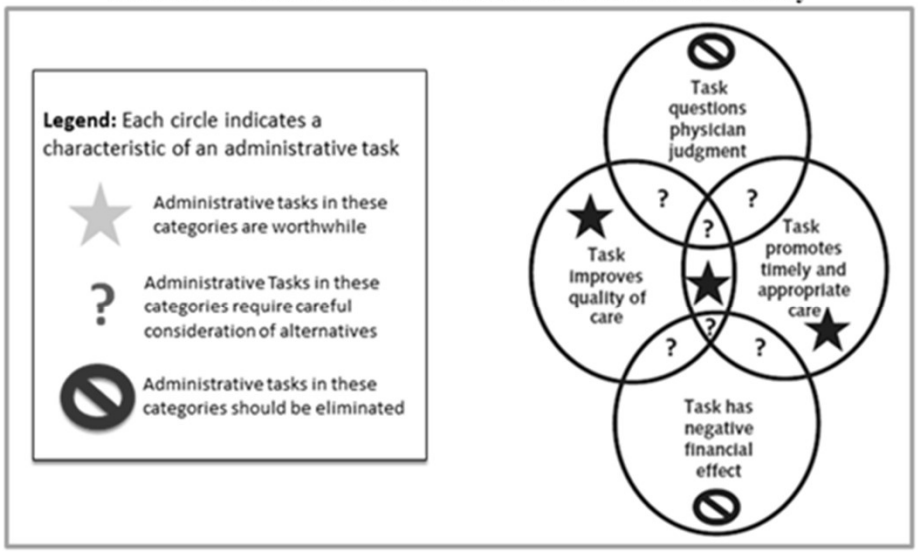


Figure 2: Taxonomy for Categorizing Administrative Tasks as Worthwhile and Should Remain in Place, or Tasks that are Burdensome and Should Be Revised or Eliminated Entirely



ACP's Patients Before Paperwork Initiative

ACP Policy Recommendations to Reduce Administrative Tasks:

1. Stakeholders who develop or implement administrative tasks should provide financial, time, and quality of care impact statements for public review and comment.
2. Tasks that cannot be eliminated must be regularly reviewed, revised, aligned and/or streamlined, with the goal of reducing burden.
3. Stakeholders should collaborate to aim for performance measures that minimize unnecessary burden, maximize patient- and family-centeredness, and integrate measurement of and reporting on performance with quality improvement and care delivery.
4. Stakeholders should collaborate in making better use of existing health IT, as well as develop more innovative approaches.
5. As the US health care system evolves to focus on value, stakeholders should review and consider streamlining or eliminating duplicative administrative tasks.
6. Rigorous research is needed on the impact of administrative tasks on our health care system.
7. Research on and dissemination of evidence-based best practices to help physicians reduce administrative burden within their practices and organizations.

Reducing administrative burdens: what have we accomplished?

- **First round of outreach letters sent to external sources of administrative tasks identified in the paper:** CMS, ONC, AHIP, BCBSA, EHRA, MDMA
- **Meetings held with stakeholders to discuss policy and establish next steps for future collaboration:**
  - **May 2, 2017: ONC and CMS Office of Clinician Engagement:**
    - **NEXT STEPS:**
      - CMS will look to ACP for help recruiting physicians to join short-term workgroups and evaluate potential solutions to an administrative burden issue, working the solution through several scenarios and use cases to see if it will achieve its intended outcomes.
      - ONC requesting direct feedback and/or data so that ONC can take an analytical approach to administrative burdens and make data driven decisions on what to tackle and how to do it.

Reducing administrative burdens: what have we accomplished?

- **May 12, 2017: Electronic Health Record Association**
  - **NEXT STEPS:**
    - EHRA is hosting a Usability Summit in Washington, DC and proposed using this meeting as a starting point to further understand how to incorporate end user needs.
    - ACP to reach out directly to EHR vendors to help address their issues with engaging physicians in their end-user testing initiatives.

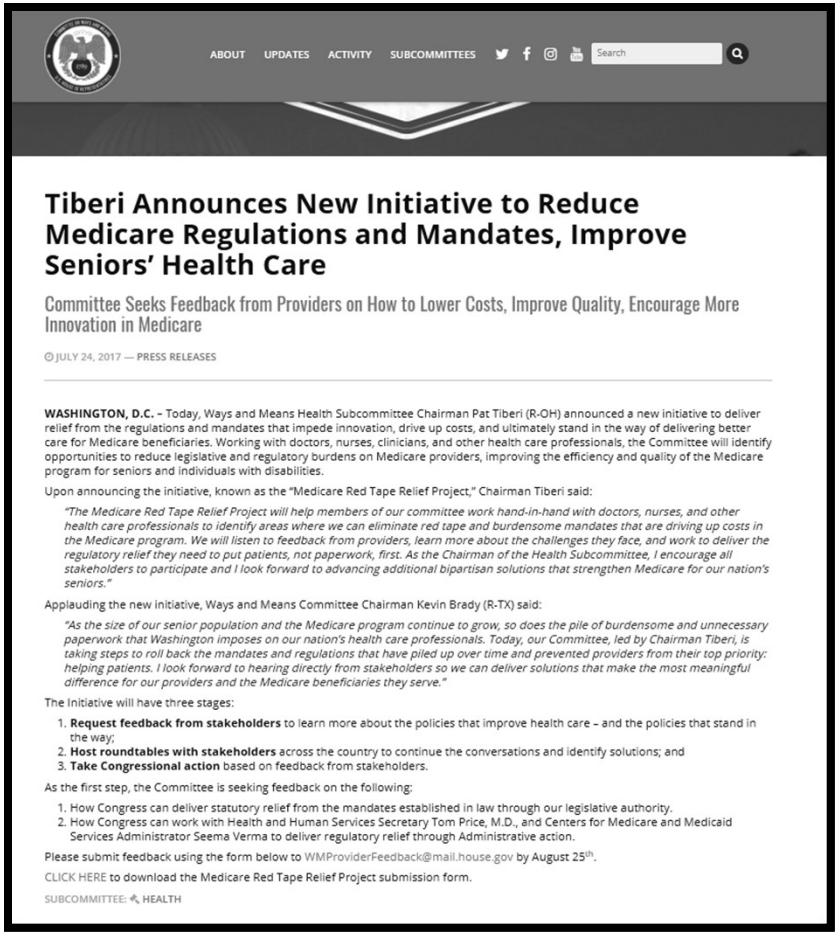
Reducing administrative burdens: what have we accomplished?

- **June 1, 2017: AHIP and BCBSA**
  - **NEXT STEPS:**
    - Opportunity to partner with ACP on education around accuracy and timeliness of provider directories.
    - ACP to work with AHIP on the direct to consumer advertising issues
    - Further collaboration in quality metrics and reporting
    - Aligning PCMH certification across payers
    - Aligning QPP incentives with private payer incentives
    - Aligning public private payers on attribution
    - BCBSA working with ACP on education with physicians around prior authorization – how to get at the variation across different locations in the country

Reducing administrative burdens: what we have accomplished?

- **June 5, 2017: MedPAC**
  - **NEXT STEPS**:
    - MedPAC was interested in the idea of developing a pilot project that removes specific administrative tasks for participating physicians
    - ACP to follow up with MedPAC on their thoughts about quality measurement – specifically what ACP is doing in the Quality Improvement space and how there are way to lessen burdensome quality reporting without moving entirely to population/claims-based measures

We have the attention of Congress!



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Tiberi Announces New Initiative to Reduce Medicare Regulations and Mandates, Improve Seniors' Health Care

Committee Seeks Feedback from Providers on How to Lower Costs, Improve Quality, Encourage More Innovation in Medicare

JULY 24, 2017 — PRESS RELEASES

WASHINGTON, D.C. – Today, Ways and Means Health Subcommittee Chairman Pat Tiberi (R-OH) announced a new initiative to deliver relief from the regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries. Working with doctors, nurses, clinicians, and other health care professionals, the Committee will identify opportunities to reduce legislative and regulatory burdens on Medicare providers, improving the efficiency and quality of the Medicare program for seniors and individuals with disabilities.

Upon announcing the initiative, known as the "Medicare Red Tape Relief Project," Chairman Tiberi said:

"The Medicare Red Tape Relief Project will help members of our committee work hand-in-hand with doctors, nurses, and other health care professionals to identify areas where we can eliminate red tape and burdensome mandates that are driving up costs in the Medicare program. We will listen to feedback from providers, learn more about the challenges they face, and work to deliver the regulatory relief they need to put patients, not paperwork, first. As the Chairman of the Health Subcommittee, I encourage all stakeholders to participate and I look forward to advancing additional bipartisan solutions that strengthen Medicare for our nation's seniors."

Applauding the new initiative, Ways and Means Committee Chairman Kevin Brady (R-TX) said:

"As the size of our senior population and the Medicare program continue to grow, so does the pile of burdensome and unnecessary paperwork that Washington imposes on our nation's health care professionals. Today, our Committee, led by Chairman Tiberi, is taking steps to roll back the mandates and regulations that have piled up over time and prevented providers from their top priority: helping patients. I look forward to hearing directly from stakeholders so we can deliver solutions that make the most meaningful difference for our providers and the Medicare beneficiaries they serve."

The Initiative will have three stages:

1. **Request feedback from stakeholders** to learn more about the policies that improve health care – and the policies that stand in the way;
2. **Host roundtables with stakeholders** across the country to continue the conversations and identify solutions; and
3. **Take Congressional action** based on feedback from stakeholders.

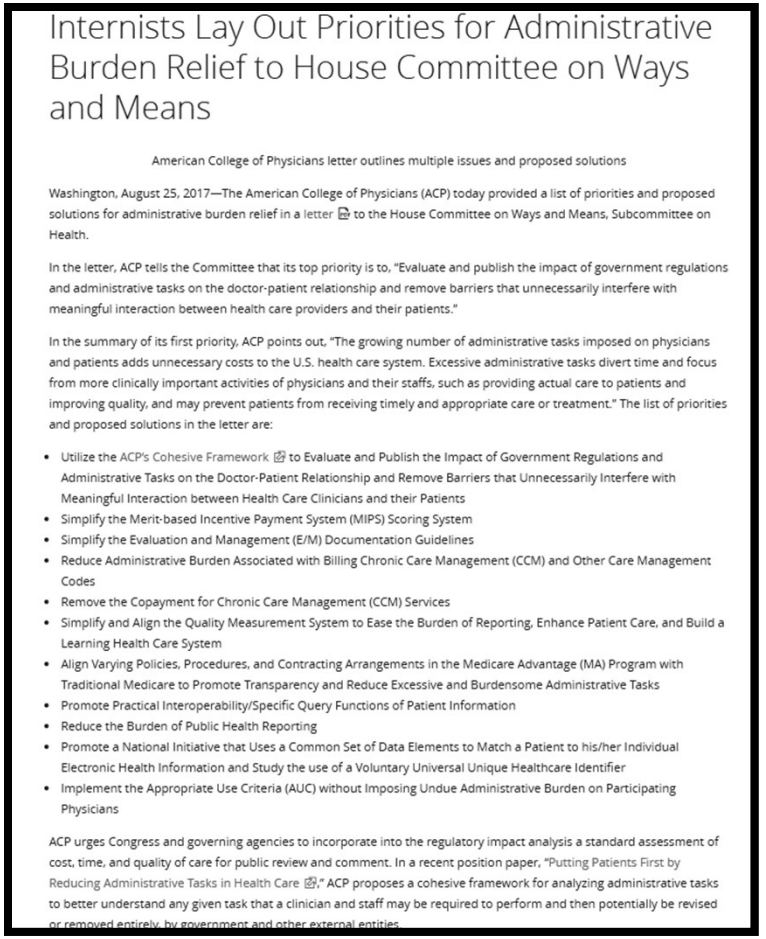
As the first step, the Committee is seeking feedback on the following:

1. How Congress can deliver statutory relief from the mandates established in law through our legislative authority.
2. How Congress can work with Health and Human Services Secretary Tom Price, M.D., and Centers for Medicare and Medicaid Services Administrator Seema Verma to deliver regulatory relief through Administrative action.

Please submit feedback using the form below to WMProviderFeedback@mail.house.gov by August 25th.

CLICK HERE to download the Medicare Red Tape Relief Project submission form.

SUBCOMMITTEE: HEALTH



Internists Lay Out Priorities for Administrative Burden Relief to House Committee on Ways and Means

American College of Physicians letter outlines multiple issues and proposed solutions

Washington, August 25, 2017—The American College of Physicians (ACP) today provided a list of priorities and proposed solutions for administrative burden relief in a letter to the House Committee on Ways and Means, Subcommittee on Health.

In the letter, ACP tells the Committee that its top priority is to, "Evaluate and publish the impact of government regulations and administrative tasks on the doctor-patient relationship and remove barriers that unnecessarily interfere with meaningful interaction between health care providers and their patients."

In the summary of its first priority, ACP points out, "The growing number of administrative tasks imposed on physicians and patients adds unnecessary costs to the U.S. health care system. Excessive administrative tasks divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment." The list of priorities and proposed solutions in the letter are:

- Utilize the ACP's Cohesive Framework to Evaluate and Publish the Impact of Government Regulations and Administrative Tasks on the Doctor-Patient Relationship and Remove Barriers that Unnecessarily Interfere with Meaningful Interaction between Health Care Clinicians and their Patients
- Simplify the Merit-based Incentive Payment System (MIPS) Scoring System
- Simplify the Evaluation and Management (E/M) Documentation Guidelines
- Reduce Administrative Burden Associated with Billing Chronic Care Management (CCM) and Other Care Management Codes
- Remove the Copayment for Chronic Care Management (CCM) Services
- Simplify and Align the Quality Measurement System to Ease the Burden of Reporting, Enhance Patient Care, and Build a Learning Health Care System
- Align Varying Policies, Procedures, and Contracting Arrangements in the Medicare Advantage (MA) Program with Traditional Medicare to Promote Transparency and Reduce Excessive and Burdensome Administrative Tasks
- Promote Practical Interoperability/Specific Query Functions of Patient Information
- Reduce the Burden of Public Health Reporting
- Promote a National Initiative that Uses a Common Set of Data Elements to Match a Patient to his/her Individual Electronic Health Information and Study the use of a Voluntary Universal Unique Healthcare Identifier
- Implement the Appropriate Use Criteria (AUC) without Imposing Undue Administrative Burden on Participating Physicians

ACP urges Congress and governing agencies to incorporate into the regulatory impact analysis a standard assessment of cost, time, and quality of care for public review and comment. In a recent position paper, "Putting Patients First by Reducing Administrative Tasks in Health Care," ACP proposes a cohesive framework for analyzing administrative tasks to better understand any given task that a clinician and staff may be required to perform and then potentially be revised or removed entirely by government and other external entities.

What does this *practically* mean for your practices?

- The number 1 thing that can be done to improve physician satisfaction with practice is to ease unnecessary regulations and tasks. The new administration and Congress offers us an opportunity to make our case.
- Patients will also benefit as their physicians are able to spend more time with them with less distraction.
- Making EHRs more clinically relevant and useful requires that we examine and simplify the embedded federally-mandated documentation requirements.
- We also need an entirely new way of looking at administrative tasks, to assess their intent, impact and possible alternatives.

ACP's Rx for better health care.

4. Leverage technology to improve patient care.
   - Reduce barriers to telemedicine/enact Connect Act.
   - Improve functionality of EHRs.
5. Support a well-trained physician workforce with skills and numbers needed.
   - Develop a national workforce policy.
   - Maintain funding for Title VII primary care training.
   - Expand GME slots on prioritized basis.
   - Enact legislation to establish all-payer GME funding.
   - Address impact on workforce of travel ban.

President Trump's EO on immigration

- Why did ACP speak out against the EOs?
  - At least two internal medicine residents who are ACP members were impacted by the first EO.
  - Discrimination based on religion violates ACP's longstanding policies on non-discrimination based on gender, race, ethnicity, religion and other factors.
  - On June 26, The Supreme Court lifted the suspensions that federal judges had put on the EO in March, but only partially: People from the affected countries who have "a credible claim of a bona fide relationship with a person or entity in the United States" would still be allowed to enter the country. The Court agreed to review the case in the fall.
  - ACP, joined by 21 health professional education and practice organizations, filed a June 12 amicus brief with the U.S. Supreme Court opposing the government's applications for a stay of the lower courts' injunctions against the executive order barring entry of individuals from Iran, Libya, Somalia, Sudan, Syria, and Yemen.

ACP's prescription for better health care.

6. Reduce barriers to chronic care management.

- The College effectively advocated for significant administrative burden reduction for CCM codes.
- ACP also worked with the CMS and the CPT Editorial Panel to develop separate payment for a variety of codes to reimburse physicians for non-face-to-face work under Medicare FFS.
- ACP supports that bipartisan Chronic Care Act, approved by the Senate Finance Committee.

ACP's prescription for better health care.

7. Support medical and health services research and public health.
   - Ensure sufficient funding for NIH, AHRQ, CDC.
   - Maintain commitment to preventing and mitigating adverse health impact of climate change.
   - Support research and enact policies to reduce firearms-related violence.
   - Support policies to address opioid epidemic.

Support for research and public health.

- **Climate Change:**
  - **Climate Change and Health: A Position Paper of the American College of Physicians, May 3, 2016**. http://annals.org/aim/article/2513976/climate-change-health-position-paper-american-college-physicians
  - Also developed a climate change action toolkit https://www.acponline.org/advocacy/advocacy-in-action/climate-change-toolkit to educate our members about effect of climate change on health and how physicians can act to address climate change in their practices and facilities.
  - Released statements denouncing action to remove United States from Paris Agreement and Executive Order to reverse federal government progress on addressing climate change.
  - ACP will be releasing an updated climate change action toolkit to further enable our members to advocate for actions to tackle climate change.

Support for research and public health.

- **Opioids:**
  - **Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper, May 16, 2017. http://annals.org/aim/article/2613555/health-public-policy-facilitate-effective-prevention-treatment-substance-use-disorders**
    - Paper affirms substance use disorder a chronic, treatable disease and calls for policies to expand treatment access.
  - College has been active in educating members about safe pain management, working with CDC on chronic pain guidelines, and providing practice resources on substance use disorders.
  - Supported 21st Century Cures and Comprehensive Addiction and Recovery Act; advocating for funding.
  - Strongly fighting for Medicaid – a key source of SUD treatment.

Another top ACP priority: *embracing diversity, opposing discrimination in ALL forms*

- **Position Statement on Recognizing Hate Crimes as a Public Health Issue, Approved by the Board of Regents, July, 2017.**
  https://www.acponline.org/acp_policy/policies/hate_crimes_public_health_issue_2017.pdf
- **Immigration Position Statement, Approved by the Board of Regents, January 30, 2017.**
  https://www.acponline.org/acp_policy/policies/immigration_position_statement_2017.pdf
- **Position Statement on Gender Pay Gap Within the Field of Medicine, Approved by the ACP Board of Regents, November, 2016**.
  https://www.acponline.org/acp_policy/policies/gender_pay_gap_position_statement_2016.pdf
- **Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians, July 21, 2015.**
  http://annals.org/aim/article/2292051/lesbian-gay-bisexual-transgender-health-disparities-executive-summary-policy-position?resultClick=3

Another top ACP priority: *embracing diversity, opposing discrimination in ALL forms*

- **National Immigration Policy and Access to Health Care, Position Paper of the American College of Physicians, 2011.**
  https://www.acponline.org/acp_policy/policies/natl_immigration_policy_access_healthcare_2011.pdf
- **Racial and Ethnic Disparities in Health Care, Position Paper of the American College of Physicians, Updated 2010.**
  https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf
- **Coming soon! Policy papers on women in medicine, women's health, and social determinants of health care.**

What's next for ACP advocacy?

- Urge continuation of cost-sharing reduction payments to ACA marketplace plans.
  - 9/27/17: Insurers sign 2018 contracts.
- Offer ideas for bipartisan ways to stabilize and improve markets.
- Enact CHIP reauthorization (expires October 1, 2017)
- Federal budget (potential shutdown looming if no agreement reached by midnight 10/1) and debt ceiling vote (which could be linked to spending cuts if not "clean" or U.S. government default, if it fails).

What's next for ACP advocacy?

- Continuing to promote our forward-looking agenda to:
  - Improve Medicare's QPP
  - Reduce administrative tasks
  - Improve performance measures
  - Introduce greater transparency
  - Oppose discrimination
  - Lower Rx costs
  - Address social determinants
  - Expand women's access to health care
    - And so much more!

Summary

- ACP advocacy is more important than ever.
- The College is advocating on behalf of a forward-looking agenda, addressing 7 key elements of a effective health care: access, value, technology, workforce, research and public health, chronic care, and administrative tasks.
- We are making substantial progress, particularly on improving Medicare's QPP and easing administrative tasks.
- But first, we have to continue to do everything to stop ACA repeal and close gaps in coverage!

Final words of wisdom from Yogi:

"You've got be careful if you don't know where you are going, 'cause you might not get there."