State of the Nation's Health Care 2013

A Two-pronged Strategy to Improve American Healthcare:
Make the Health System More Effective
AND
Remove Barriers to the Patient-Physician Relationship

Oral Remarks
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My name is Bob Doherty. I am Senior Vice President for Governmental Affairs and Public Policy in the Washington office of the American College of Physicians.

I am pleased to join with Dr. Bronson to share with you our evaluation of the state of the nation's health care in 2013, and our proposals to make it better.

As Dr. Bronson noted, there is much in the way of good news to report—especially the fact that in a little over ten months, nearly all Americans will begin to have access to affordable health insurance coverage. We are encouraged by the dramatic slowdown in health care cost increases—the last time health care cost increases were so low, Elvis Presley was making hit records!

Now is not the time to sit on our laurels, though. Resistance in many states to expanding Medicaid and setting up state-run exchanges—health insurance marketplaces—could leave millions of people without access to affordable coverage, especially for the poor. Even with the recent moderation in costs, we still spend much more than other countries and our outcomes are no better, and in many cases worse. We still have the challenge of providing care to an aging population requiring more health care services. Instead of declaring a premature victory on health care cost inflation and access, ACP believes we must redouble our efforts to achieve the "triple aim" of better individual health outcomes, better population health, and lower per capita costs.

There are other challenges that need to be overcome. With just a little over a week to go, Congress has made no apparent progress in reaching agreement on a plan to prevent devastating cuts in essential health programs. Cuts that will endanger the safety of our food and drugs,

curtail medical research, make us less prepared for pandemics and other potential disasters, lead to massive job losses, and reduce patient access to care.

These cuts must not stand. It simply is unacceptable that the political divisions in Washington have caused a recurring series of wholly unnecessary budget impasses that imperil the health and safety of the American people.

We are challenged by a growing shortage of primary care physicians, which will lead to higher costs and reduced access. We are challenged by a dysfunctional Medicare payment system that stifles innovation and creates enormous barriers to patient access.

We are challenged by the paralysis of our political system in coming to agreement on reasonable measures to prevent the 30,000 persons injured or killed by firearms each year. How many more need to die before we will act?

Physicians and their patients are challenged by the seemingly relentless intrusions on the patient-physician relationship.

None of us want our doctors to spend more time on paperwork than listening to us, yet we have a system that buries physicians in administrative tasks to the exclusion of patient care.

None of us want our physicians to be rushed from patient-to-patient, from task-to-task, but that often is the only kind of medicine that the system allows.

None of us want legislators telling our doctors what they can and can't advise us when it comes to our own health.

Yet this is the system we have, and this is the system we are trying to change.

ACP's two-pronged plan, released today, has specific recommendations to build upon the progress made in expanding coverage and lowering costs, and on reducing barriers to the patient-physician relationship. The entire 20-plus page plan is posted on our website along with one-to-two page summaries of our findings and recommendations.

In summary, this is what we recommend.

To build on the progress made in improving the health care system, we recommend the following:

> First, we call for a renewed commitment, at both the national and state levels, to effectively implement the coverage expansions and related policies under the Affordable Care Act, with particular attention to ensuring that the poorest and most vulnerable patients have access to affordable coverage. We call on states that are leaning against expanding Medicaid to reconsider. We call on physicians in those states to make the case that expanding Medicaid is ethically, morally, medically and economically the right thing to do. We call on the federal

government to use its waiver authority to allow states to innovate in delivering Medicaid-covered services more efficiently and effectively.

Second, Congress must reach agreement on a plan to replace across-the-board sequestration cuts and prevent future disruptions in funding. Our plan identifies fiscally- and socially-responsible alternatives to reduce unnecessary health care spending while preserving funding for essential health care programs.

Third, Congress must repeal Medicare's sustainable growth rate—SGR—formula and support the medical profession's commitment to transition to new payment models aligned with value to the patient. Our plan recommends specific steps to accomplish this.

Fourth, we must implement policies to recruit and retain primary care physicians. Our recommendations include protecting graduate medical training programs from cuts, but also, shifting residency positions and funding to general internal medicine and other primary care specialties. We call for all payers to contribute to funding GME as a public good. And we propose changes to reduce student debt and raise compensation to primary care physicians so that it is more in line with other specialties.

Fifth, we must as a nation come to agreement on approaches to reduce firearms-related injuries and deaths. We call for improvements in access to mental health services, research on the causes and prevention of violence, and reasonable controls over access to firearms that do not infringe on constitutionally protected rights including—including universal background checks and a ban on semi-automatic assault-type weapons.

These five proposals could make an enormous difference in making health care better and more affordable while reducing preventable deaths and injuries.

But by themselves, they will not give us the health care we need and want unless we put an end to the unrelenting assault on the patient-physician relationship—the hallmark of good medical care. To this end, ACP recommends the following:

> First, public and private policymakers and payers must ensure that any payment reforms have, as an explicit goal, allowing physicians to spend more time with their patients. New models of payment should be assessed against the standard of whether they create incentives or disincentives for physicians to spend appropriate clinical time with patients; those that do not should be rejected or modified. Existing relative value, coding and fee-for-service payments models, whether they are stand-alone or integrated into other payment frameworks, should be changed to create incentives for physicians to spend more appropriate clinical time with patients.
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> Second, payment and delivery reforms that hold physicians accountable for the outcomes of care (measurable performance on quality, cost, satisfaction and experience with care)

should concurrently eliminate the layers of review and second-guessing of the clinical decisions made by physicians. If individual physicians and their practices can show good results for their patients, payers should have no need to micro-manage the decision-making that leads to the results. And, a specific goal of payment reform must be to reduce the time that physicians must spend in administrative tasks that do not improve patient care; at a minimum, they should not add to the administrative burden.

Third, Medicare should harmonize (and to the extent possible, reduce) the measures used in its different reporting programs and work toward overall composite outcomes measures rather than a laundry-list of process measures. Measurement can be a good tool in helping to improve outcomes, but not if the measures themselves don't make sense, if they are in conflict with each other, or too difficult to report on.

Fourth, Medicare should provide a more clinically appropriate alternative to the mandate that physicians adopt a diagnostic coding system called ICD-10. The conversion to ICD-10 will impose enormous costs and administrative burdens on physicians, taking time away from patients. But more to the point, there are better, more appropriate terminology systems available to report clinical content.

Fifth, Medicare needs to reduce administrative barriers, create better incentives for ongoing quality improvements for all physicians, and broaden hardship exemptions—before imposing punitive payment cuts on physicians. If necessary, Congress and Medicare should consider delaying the penalties for not successfully participating in quality reporting programs, if it appears that the vast majority of physicians will be subject to penalties due to limitations in the programs themselves.

Sixth, the government, the medical profession, and standard-setting organizations should work with electronic health record vendors to improve the l capabilities of their systems, to improve the ability of those systems to report on quality measures and to ensure that those systems improve rather than adding to workflow inefficiency. Electronic health records have enormous potential to help physicians improve patient care but most are not easy to use and do not meet clinicians' and patients' needs.

Seventh, Medicare and private insurers should move toward standardizing claims administration requirements, pre-authorization, and other administrative simplification requirements even in advance of, and in addition to, the simplification rules included in the ACA.

Eighth, Congress should enact meaningful medical liability reforms including health courts, early disclosure of errors, and caps on non-economic damages. The current adversarial tort system interferes with the patient-physician relationship and inhibits physicians from responsibly ordering tests and procedures based primarily on clinical and cost-effectiveness in accord with practice guidelines.

> Last but not least, state and federal authorities should not enact mandates that interfere with physician free speech and the patient-physician relationship. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient, which may affect their health, the health of their families, and others who may be in contact with the patient.

ACP's plan includes more detail on how to carry out all of the above recommendations.

Now, some will say that what ACP is asking for is a tall order. Given the deep partisan divide in this country, how can we expect Congress, the administration, and state officials to come together to enact our plan to improve the health care system and reduce intrusions on the patient-physician relationship?

Yes, it is a tall order, but ACP's proposal aren't partisan, they are common sense changes that have broad support.

And what would it say about us if we ddidn't try? If we concede that it is not possible to build on the progress being made on expanding coverage and lowering costs? That is not possible to reform the physician payment system? That it is not possible to stop devastating cuts to programs that are essential to public health and safety? That it is not possible to reverse a shortage of primary care physicians that drives up costs and reduces access?

What would it say about us if we didn't try to prevent the tens of thousands of injuries and deaths from firearms?

What would it say about us if we didn't try to put a stop to the unrelenting assault on the patient-physician relationship? Do we really want to concede that it is simply impossible to change incentives and reduce administrative costs so that physicians can spend more time listening to their patients—rather than chasing paper?

No, now is not the time to concede that there is nothing that can be done to make our health care system work better for patients—and their physicians.

We may not get everything we want—who does?—but we have a chance now, this year, to make enormous progress on ensuring that all Americans have access to coverage at a cost that they and we as a country can afford, on reforming physician payments, on reversing the shortage of primary care physicians, on preventing injuries and deaths from firearms, and restoring the patient-physician relationship to what it needs to be—that is, to continue to build a health care system that puts the interests of patients before else.

Dr. Bronson and I will be pleased to answer your questions.