Advocacy for Patients, Advocacy for Physicians

ACP’s Agenda to Improve and Reform American Health Care

District of Columbia Chapter, ACP
November 17, 2018
Disclosure

I have no actual or potential conflict of interest in relation to this program/presentation.
What’s it all about?

The American College of Physicians works for you – providing internists with education, clinical support, practice resources, and advocacy for policy changes that will make a difference in your daily work, your professional development, and your patients’ health.
We work to improve your daily lives, and the health of your patients, by

- Advocating for improvements within the existing policy, regulatory and legislative frameworks, and the overall health care system, while recognizing that they are imperfect and have unintended consequences.

- While challenging the status quo by proposing bold new policies to fundamentally reform our health care system—through our New Vision for American Health Care Initiative.
Making a difference in your daily work, and the health of your patients

- Through our *Patients Before Paperwork* Initiative, ACP is leading an effort within American medicine to reduce the paperwork burden on physicians and patients.
  - By *pushing back* on payers, government, and others to justify *why* they are proposing a task, what it’s intended to accomplish, assess what its *likely impact* will be, and then—either get rid of it or make it less burdensome, if the negative impact is greater than any good it might accomplish.
ACP’s Patients Before Paperwork Initiative (started in 2015 – and going strong still...)

ACP Patients Before Paperwork Initiative

What is Patients before Paperwork?
ACP’s Patients Before Paperwork initiative’s goal is to reinvigorate the patient-physician relationship by reducing administrative complexities and eliminating unessential tasks that detract from patient care and contribute to physician burnout.

Policy Development
ACP policies provide a cohesive framework for identifying and evaluating administrative tasks, and offer detailed recommendations to analyze administrative tasks to determine whether they need to be challenged, revised, or eliminated entirely.

Tools You Can Use
Resources and tools help physicians put ACP’s policies into practice. They include resources that assess practice efficiencies and resources on physician well-being and professional satisfaction.

Collaborating with Stakeholders
ACP engages with key regulatory agencies and stakeholders to help streamline regulations imposed by insurers, federal regulators and other external entities to reduce administrative burdens for physicians.

Advocating for Internists
ACP has long identified reducing administrative complexities or burdens as a priority. ACP works to advocate for changes in our health care system that simplify excessive administrative burdens that put a strain on physicians and patient care.

For more information, visit, www.acponline.org/pb4p

https://www.acponline.org/advocacy/where-we-stand/patients-before-paperwork
Patients Before Paperwork Initiative

ACP Position Paper, "Putting Patients First by Reducing Administrative Tasks in Health Care," outlining cohesive framework for identifying/evaluating administrative tasks as well as detailed policy recommendations to reduce excessive administrative tasks across the health care system.
Figure 1: Framework for Analyzing Administrative Tasks

- Sources
  - External
  - Internal

- Intents
  - Products & Services
  - Quality & Safety
  - Cost & Fraud Reduction
  - Financial Security
  - Lack of Clear Intent

- Impacts
  - Cost & Time - Billing/Insurance Related
  - Cost & Time - Measurement & Reporting
  - EHR/Health IT
  - Appropriate & Timely Patient Care
  - Physician Satisfaction & Burnout

- Solutions
  - Assessment of Tasks by Stakeholders
  - Transparent Alignment & Streamlining of Tasks
  - Collaborate to Improve Quality Measures
  - Innovative Use of Health IT
  - Eliminate or Replace Duplicative Tasks
  - Research Impacts & Best Practices

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

Legend: Each circle indicates a characteristic of an administrative task

- Administrative tasks in these categories are worthwhile
- Administrative tasks in these categories require careful consideration of alternatives
- Administrative tasks in these categories should be eliminated

- Task questions physician judgment
- Task promotes timely and appropriate care
- Task improves quality of care
- Task has negative financial effect
Reducing Administrative Tasks Action Plan: ACP developed a post-publication work plan to operationalize the framework and recommendations outlined in the policy paper.

Further Policy Development (Published Oct 2, 2017): *Promoting Transparency and Alignment in Medicare Advantage* – ACP policy recommendations to promote transparency and align MA policies to decrease administrative burdens associated with participating in MA.

Comments to Regulatory and Legislative Groups:
- **Feedback** to Ways and Means Subcommittee on Health regarding Medicare Red Tape Relief Project
- **Statement** before the Ways and Means Subcommittee on Health Medicare Red Tape Relief Project Roundtable
- **Recommendations** to CMS on their “Patients over Paperwork” Initiative on: Re-conceptualizing and Re-scoring ACI; Streamlining and/or Eliminating Prior Authorization Requirements; Simplifying E/M Documentation Guidelines
- **Letter** to CMS regarding the Proposed Policy Changes and Updates for Medicare Advantage and the Prescription Drug Benefit Program for Contract Year 2019.
Reducing Administrative Tasks
Action Plan cont.

Ongoing Outreach to External Sources of Administrative Tasks Identified in the Paper:

- Initial round of outreach letters sent to: CMS, ONC, AHIP, BCBSA, EHRA, MDMA, MedPAC
- Meetings held with stakeholders to discuss policy and establish next steps for future collaboration

Administrative Tasks and Best Practices Data Collection Tool

PowerPoint Presentations and Talking Points: For chapter presentations and other educational opportunities to educate members and provide guidance on how to communicate ACP’s policy recommendations and framework for reducing administrative burdens

Resources Under Development:

- **Individual Advocacy Letters**: Letter templates for individual members to contact the External Stakeholders.
Patients Before Paperwork

▪ Held recent meetings with high-level administration officials include: CMS Administrator Seema Verma, and Deputy Administrator/Director of CMMI, Adam Boehler.

▪ Listening session held at IM 2018 with Dr. Tom Mason (ONC).

▪ Group of 6 coalition—ACP, ACOG, AAP, AAFP, AOA, APA--released principles on reducing administrative burdens, major topic of June 18 fly-in.
Enjoyed meeting with @ACPInternists today to discuss how we can work together on promoting interoperability and reducing the burden of documentation associated with E&M visits, in order to ensure the highest quality of care for patients.

Thanks in particular to Dr. Tom Mason for listening to @ACPInternists members at our annual meeting in May on #PatientsOverPaperwork #PatientsBeforePaperwork. We look forward to providing comments on the #QPP and #PFS proposed rules!

Hear from CNC's Dr. Don Rucker (@donrucker) and Dr. Tom Mason about @CMSgov's #PatientsOverPaperwork initiative.
October 30, 2017, Remarks by CMS Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit:

*Doctors are frustrated because they got into medicine to help their patients. But, paperwork has distracted them from caring for their patients, who often have waited weeks, if not months, for the brief opportunity to see them.*

*We have all felt this squeeze in the doctor’s office…we have all seen our doctors looking at a computer screen instead of us. I hear it from patients across the country. This must change. The primary focus of a patient visit must be the patient.*

*Just last week, CMS announced our new initiative “Patients Over Paperwork” to address regulatory burden. This is an effort to go through all of our regulations to reduce burden. Because when burdensome regulations no longer advance the goal of patients first, we must improve or eliminate them.*

*Our door is open to your ideas and we invite a two-way discussion about how we can accomplish our shared mission of delivering the best possible care at the lowest cost.*
ACP advocacy to improve your daily lives, and health of your patients: *CMS’ proposed payment overhaul*

- On September 10, ACP submitted comments on CMS’s proposals to radically restructure payment and documentation for Evaluation and Management Services, and improve Medicare’s Quality Payment Program.

- Our goal was to offer a better approach that would ease documentation, *while halting implementation of changes that would devalue complex cognitive care.*
Four things you should know about CMS’s original proposed rules:

1. It would be less burdensome for physicians to participate in the Quality Payment Program, removing the separate components within the Promoting Interoperability (formally Advancing Care Information) Category score to create a streamlined scoring methodology; increasing the ways in which physicians and other clinicians can qualify for the low-volume threshold; and removing a number of quality measures deemed by the agency to be of low-value.
Four things you should know about CMS’s original proposals:

2. Medicare would pay for additional physician services that are not part of a face-to-face office visit, including new codes and RVUs for “virtual check-ins,” remote consults of patient videos and photos, and inter-professional online consultations.

3. Documentation requirements associated with evaluation and management (E/M) services would be reduced, allowing medical decision-making to be the basis for documentation; requiring physicians to only document changed information for established patients, allowing them to sign-off on basic information documented by practice staff, and allowing documentation by total time as an option.
Four things you should know about CMS’s original proposals:

4. There would be single blended payment for most office visits (levels 2-5), *regardless of their complexity*, with additional add-on payments to primary care physicians and non-procedural subspecialists.
Primary care add-on

- New primary care add-on code: GPC1X is intended to reflect visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services. CMS expects that this will be billed for all primary care visits.
  - Additional $5.40 per office visits levels 2-5.
Specialty add-on

- New specialty code: GCG0X is intended to reflect visit complexity inherent to evaluation and management associated with:
  - Endocrinology,
  - Rheumatology,
  - Hematology/oncology,
  - Urology,
  - Neurology,
  - Obstetrics/gynecology,
  - Allergy/immunology,
  - Otolaryngology,
  - Cardiology, or
  - Interventional pain management-centered care.

- CMS: results in additional $14 payment for levels 2-5 new and established office visits
Prolonged Services

- **CMS proposal**: CMS is proposing to create a new HCPCS code GPRO1 for prolonged evaluation and management or psychotherapy service(s) in the office or other outpatient setting requiring direct patient contact beyond the usual service time of the primary procedure or office visit (30 minutes). The Agency is proposing a work RVU of 1.17, which is half the work RVU of CPT code 99354, or $67.
ACP Encouraged by Changes in Medicare Payment Policies in 2019

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) released the final rules on 2019 Physician Payments and the Quality Payment Program (QPP).

**CMS Responsive to ACP Recommendations**

**ACP is encouraged** that CMS was responsive to many of the concerns ACP raised during the comment period. Highlights include:

**Physician Fee Schedule Updates**

👍 **Reduced documentation requirements for physicians starting in 2019** – CMS is eliminating redundancies and only requiring physicians to document changed information since the last visit for established patients.

👍 **While CMS is moving forward with evaluation and management (E/M) coding payment reforms, they have made revisions to their original proposal and delayed implementation until 2021.**

👍 **CMS modified its proposal of a flat rate for office/outpatient E&M level 2 through 5 visits and will continue to pay a higher rate for the most complex patient care, or level 5 visits.** (Effective 2021)

👎 **ACP has concerns and will continue to advocate for paying level 4 visits, the second most complex visits, at a higher rate** – and will work with CMS on alternate approaches that recognize the value of complex, cognitive care.
Add-on codes for level 2-4 visits in primary care and certain specialties will be allowed, as well as extended visits – to account for the value of cognitive work in treating more complex patients. This change equalizes primary care payments to specialty payments. (Effective 2021)

ACP is pleased that CMS finalized the new prolonged services codes but would like them implemented in 2019.

New payment codes in 2019 for non-face-to-face visits – including virtual check-ins, e-consultations, and remote evaluation of patient images and videos.

CMS has cancelled the Multiple Procedure Payment Reduction (MPPR) proposal.
Quality Payment Program Updates

A Merit-based Incentive Payment System (MIPS) opt-in option will be added by CMS for practices previously excluded under the low-volume threshold, expanding participation without increasing burden.

CMS continues to identify and remove low-priority, low-value quality measures – they will work with stakeholders to focus on measures that offer the most promise for improving patient care while minimizing reporting burdens.

Implementation of 2015 Certified Electronic Health Record Technology (CEHRT) for the 2019 reporting period will be required. While ACP agrees that using updated standards can help improve interoperability, we are disappointed that CMS did not call out the need to provide physicians flexibility as they implement these upgrades over the course of 2019. Rushing implementation of these upgrades to meet a reporting deadline can have serious patient safety risks and is a major expense and burden, particularly to small practices.

CMS will continue the consistent risk threshold for advanced Alternative Payment Models (APMs) — this will provide consistency and predictability for advanced APM model developers and will help APMs continue to grow.

CMS finalized changes to the Cost Category – including adding several new episode-based measures, despite concerns over low reliability ratings, while simultaneously increasing the weight of the Cost Category from 10 to 15 percent, despite objections from ACP and other stakeholders.
Hospital Outpatient Perspective Payment System (HOPPS) Rule

CMS finalized site-neutral payments for clinic visits – equalizing payments across facility types has been a longstanding goal of ACP, so this is a big win for members. This issue and ACP's position is examined further in a recent ACP Advocate article.

ACP recognizes that these are promising steps and is encouraged that CMS expressed interest in working with ACP and other physician organizations on these issues, in particular, the E/M changes. ACP will continue to advocate for its members to improve the Medicare payment system and press regulators for changes that make a difference in your daily work and your patient's health.

Learn more here: ACP Regulatory Update
ACP advocacy to make a difference in the daily work of internists, and the health of patients

- Firearms injury and violence prevention (new policy paper) and hate crimes
- Public policy response to the opioids epidemic
- Immigration policies: separation of children from parents, long-term detention, refugees
- Medicaid work requirements; high cost of prescription drugs (new policy paper)
ACP advocacy to make a difference in the daily work of internists, and the health of patients

- Women’s health
- Social determinants of health
- Health care for LGBTQ persons—including addressing the administration’s plans to reverse protections for transgender persons
- Climate change and public health
- Public charge proposed rule
- Preserving coverage gains and consumer protections
Bipartisan progress on other ACP’s priorities

Five of the 12 annual appropriations bills have been passed by Congress and signed into law by President Trump, as well as a continuing resolution that would fund the remaining seven appropriations bills through December 7th, 2018.

- This is the first time in over 20 years that the Labor-HHS-Ed appropriations bill became law before the October 1st beginning of the federal fiscal year.
More $ for ACP’s priorities

- Community Health Centers
- NHSC*
- Title VII primary care grants (PCTE)**
- AHRQ ***
- CDC

* Dedicated to opioids misuse treatment
** Continuation of increased funding from FY 2018
*** Proposed for elimination by President Trump
**Bipartisan progress on ACP’s priorities**

Congress enacted, and the President signed into law, a comprehensive bipartisan bill to address the opioids epidemic. As we recommended, it:

- Expands alternatives to opioid treatment,
- Lifts barriers to medication-assisted treatment (MAT) using buprenorphine and naloxone,
- Improves the interoperability of state-run prescription drug monitoring programs,
- Authorizes grants to provide additional education and training for clinicians to improve treatment for individuals with opioid and substance use disorders.
- Requires HHS develop a standard, secure, electronic prior authorization system, no later than 1/1/21, for drugs under Medicare Part D.
We continue to have concerns about other policies that will harm patient care.

- Immigration policies—long-term detention, separation of children from parents.
- Employer exemptions to contraception coverage.
- Public charge rule.
- Sale of “short-term” plans that don’t cover necessary care.
- Inaction on climate change.
Scrolling down the list of my primary care patients, I wondered who might be affected. A pregnant woman from Cameroon. An elderly woman with brittle bones from the Dominican Republic. A man with cancer from Ecuador. The Trump administration’s proposal to deny green card status to people who use services like food assistance and Medicaid threaten several of my patients with a harrowing choice: their health, or their immigration status.
Estimated impact of the “public charge” proposed rule on Medicaid/CHIP enrollment

Figure 3
Declines in Medicaid/CHIP Enrollment among Individuals in a Household with a Noncitizen Under Different Disenrollment Scenarios

In Millions:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Disenrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>If 15% Disenroll</td>
<td>-2.1</td>
</tr>
<tr>
<td>If 25% Disenroll</td>
<td>-3.5</td>
</tr>
<tr>
<td>If 35% Disenroll</td>
<td>-4.9</td>
</tr>
</tbody>
</table>

Medicaid/CHIP Enrollees in Households with a Noncitizen: 14.1 million

Source: Kaiser Family Foundation Analysis of 2014 Survey of Income and Program Participation data.
Short-term policies:

- are often medically underwritten — applicants with health conditions can be turned down or charged higher premiums, without limit, based on health status, gender, age, and other factors;
- exclude coverage for pre-existing conditions
- do not have to cover essential health benefits like maternity care, prescription drugs, mental health care, preventive care, and other essential benefits, and may limit coverage in other ways
- can impose lifetime and annual limits — for example, many policies cap covered benefits at $2 million or less
- are not subject to cost sharing limits — some short term policies, may require cost sharing in excess of $20,000 per person per policy period, compared to the ACA-required annual cap on cost sharing of $7,350 in 2018; and
- are not subject to other ACA market requirements — such as rate review or minimum medical loss ratios; for example, while ACA-compliant non-group policies are required to pay out at least 80% of premium revenue for claims and related expenses, the average loss ratio for individual market short-term medical policies in 2016 was 67%; while for the top two insurers, who together sold 80% of all short-term policies in this market, the average loss ratio was 50%.

Limiting global warming to 1.5°C would require rapid, far-reaching and unprecedented changes in all aspects of society, the IPCC said in a new assessment. With clear benefits to people and natural ecosystems, limiting global warming to 1.5°C compared to 2°C could go hand in hand with ensuring a more sustainable and equitable society, the Intergovernmental Panel on Climate Change (IPCC) said on Monday.

"With more than 6,000 scientific references cited and the dedicated contribution of thousands of expert and government reviewers worldwide, this important report testifies to the breadth and policy relevance of the IPCC," said Hoesung Lee, Chair of the IPCC.

Ninety-one authors and review editors from 40 countries prepared the IPCC report in response to an invitation from the United Nations Framework Convention on Climate Change (UNFCCC) when it adopted the Paris Agreement in 2015.

https://www.ipcc.ch/news_and_events/pr_181008_P48_spm.shtml
What will the midterm elections mean for ACP priorities?

- The ACA will not be repealed or replaced.
  - Congress will need to act to preserve the ACA’s protections for preexisting conditions if the courts rule against them.
  - Congress and the administration may be able to agree on improvements in the ACA, especially to make it more affordable for people who make too much to get premium subsidies.

- More states will expand Medicaid.

- Congress and the administration may be able to reach agreement on policies to reduce Rx prices.

- More states may enact policies supported by ACP to reduce firearms-related violence.

- Continued opportunity to advance bipartisan policies to reduce administrative burdens, improve Medicare’s Quality Payment Program especially for smaller independent practices, address opioids
Where we are today, is not where we want to be.

- By necessity, much of ACP public policy and advocacy is to seek improvements within established legislative, regulatory and policy frameworks.
- While we challenge policies that are not serving patients or physicians, we also advocate for their interests within the current imperfect frameworks.
- Public policy, by its nature, will always achieve imperfect results.
  - For example: while both MACRA and the ACA are imperfect, they were an improvement of what existed before, and as long as they remain as established frameworks, we need to work to make them better.
- Our system makes it very difficult to achieve huge and sudden shifts in policy.
  - It took 18 years before Congress replaced the SGR with MACRA.
- Yet advocacy within the current policy framework does not mean that we can’t strive for something better.
As part of the BoR-approved strategic theme, innovation:

“[ACP will] develop a new vision for the future of health care policy, including recommendations for how to achieve universal coverage with improved access to care; reduce per capita health care costs and the rate of growth in spending; reduce market consolidation and ensure competition and choice (of insurers, providers, and services); reform how physicians are compensated to truly achieve better value for patients and to recognize the value of care provided by internists; and reduce the complexity in our health care system.
How will we do this?

✓ Conduct an evidence-based review of what is working, and what’s not working well, with American health care.

✓ Bring these analyses to the principal policy committees (HPPC and MPQC) for discussion and direction.

✓ Develop evidence-based policy options for HPPC and MPQC consideration. Get direction on which to pursue in more detail. Will look at both transitional and transformative policies.

✓ Obtain input from other committees and councils, including experts on technical committees, and individual members, on proposed policies.
How will we do this?

✓ HPPC and MPQC approve draft policy options and supporting analyses; circulate for comments from regents, governors, and councils through our usual process.

✓ Bring revised policies, with all comments tabulated, back to HPPC and MPQC for final approval.
  • Some “building block” position papers on specific issues may be approved and published at interim steps throughout this process.
  • Final policies and analyses will be put together into an overarching New Vision for American Health Care paper (or papers) for HPPC and MPQC consideration/approval, and then Board of Regents approval.
  • Expected timeline: 12-18 months.
Every clinical, technical and public policy committee will be involved. RFIs will be sent out to the technical and policy committees.
“Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try.”

Atul Gawande
A health care system that costs too much, leaves too many people behind, is too complex, and devalues care provided by internists.

What We Have Today

ACP’s New Vision for Health Care will propose solutions that make our system better for you and your patients.

What would you write on the clean slate?