ACP Health Policy Update: Patients Before Paperwork
ACP’s Agenda to Improve and Reform American Health Care

ACP Massachusetts Chapter
November 17, 2018

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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...)

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
“Putting Patients First”
Solutions

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 Tasks Action Plan

**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

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 #QFP and #FFS proposed rules!

Hear from ONC’s Dr. Don Rucker (@donrucker) and Dr. Tom Mason about @CMSGov’s #PatientsOverPaperwork initiative. twitter.com/SeemaCMS/status...
Call it Patients Before Paperwork (ACP), or Patients Over Paperwork (CMS), the goal is the same!

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.
How can you help us?

Administrative Tasks and Best Practices Data Collection Tool:

- ACP members enter either an administrative task or best practice with the option to return and add multiple entries – these entries will be added to the Administrative Tasks and Best Practices Library (hosted on ACP Online)

- Resource for physicians to communicate administrative pain points with staff and share and review best practices to address these issues

- It will also serve as a tool for staff to advocate and provide specific examples to the external sources of these tasks.

https://www.acponline.org/reduceburdens
ACP advocacy to improve your daily lives, and patients’ health: CMS’ proposed payment overhaul

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

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.

Note - #3 (documentation reduction) and #4 (single, blended payment) are tied together in the proposal.
New proposed payments, *without* add-ons

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<th>CPT Code</th>
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<th>CY 2019 Proposed Non-Facility Payment Rate</th>
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<th>CY 2019 Proposed Non-Facility Payment Rate</th>
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<tr>
<td>99205</td>
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Original Proposed 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.
Original Proposed 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
Original Proposed New 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’s recommendations to CMS:

1. **ACP strongly believes that cognitive care of more complex patients must be appropriately recognized with higher allowed payment rates than less complex care patients.** CMS’s current proposal to pay a single flat fee for E/M levels 2-5, even when combined with proposed primary care and specialist add-on codes and payment for prolonged services, undervalues cognitive care for the more complex patients, creating incentives for clinicians to spend less time with patients, to substitute more complex and time-consuming visits with lower level ones of shorter duration, schedule more shorter and lower-level visits, and potentially, avoid taking care of older, frailer, sicker and more complex patients. It could also create a disincentive for physicians to practice in specialties, like geriatrics and palliative care, that involve care of more complex patients. Accordingly, the proposal to pay a single flat fee for E/M levels 2-5 must not be implemented.
ACP’s recommendations to CMS:

2. ACP appreciates and supports the overall direction of CMS’s proposals to reduce the burden of documentation for E/M services, yet strongly disagrees that such improvements should be contingent on acceptance of CMS’s proposal to pay a single flat fee for E/M levels 2-5. While we understand CMS’s concerns that changes in E/M documentation requirements, without changes in the underlying payment structure for E/M services, could create program integrity challenges, we believe that CMS should consider testing of alternatives that would allow it to move forward on simplifying documentation, ensure program integrity, and preserve the overarching principle that more complex and time-consuming E/M services must be paid appropriately more than lower level and less time-intensive services.
## ACP’s recommendations to CMS:

| 3. | **ACP urges CMS not to establish a regulatory deadline (e.g. January 1, 2019 or January 1, 2020) for finalizing and implementing its flat E/M fee proposals or possible alternatives that change how E/M services would be paid, and instead, to take the time to “get it right.”** Sufficient time must be allowed to engage the physician community to develop and pilot-test alternatives that preserve the principle that more complex and time-consuming E/M services must be paid appropriately more than lower level and less time-intensive services, while allowing CMS to move forward on simplifying E/M documentation while ensuring program integrity. The stakes for patients, clinicians, and the Medicare program are too great for CMS to rush changes. |

For more information, read [ACP comment letter to CMS](https://www.acponline.org/), **September 10, 2018**
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.
### E&M Payment Amounts

<table>
<thead>
<tr>
<th>Complexity Level under CPT</th>
<th>Current (2018) Payment Amount</th>
<th>Revised Payment Amount***</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Visit Code Alone*</td>
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<tr>
<td>New Patient</td>
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<tr>
<td>Level 2</td>
<td>$76</td>
<td>$130</td>
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<td>Level 3</td>
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<td>Level 4</td>
<td>$167</td>
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<td></td>
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<td>(at 38 minutes)</td>
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<tr>
<td>Level 5</td>
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<td>$344</td>
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<tr>
<td></td>
<td></td>
<td>(at 90 minutes)</td>
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<tr>
<td>Established Patient</td>
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</tr>
<tr>
<td>Level 2</td>
<td>$45</td>
<td>$90</td>
</tr>
<tr>
<td>Level 3</td>
<td>$74</td>
<td>$103</td>
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<tr>
<td></td>
<td></td>
<td>(at 34 minutes)</td>
</tr>
<tr>
<td>Level 4</td>
<td>$109</td>
<td>$157</td>
</tr>
<tr>
<td>Level 5</td>
<td>$148</td>
<td>$281</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(at 70 minutes)</td>
</tr>
</tbody>
</table>

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.

Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.

**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.
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.
**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.
Better is possible.

“Arriving at meaningful solutions is an inevitably slow and difficult process. Nonetheless, what I saw was: 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 willingness to try:
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.
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.

A Clean Slate

What would you write on a clean slate?
Questions?

- ACP is on Facebook and Twitter (@ACPOnline)

- Also, please follow both Bob Doherty (@BobDohertyACP) and Shari Erickson (@SEricksonACP) on Twitter for the latest!