Much Ado About… Just About Everything (that is important to doctors and patients):

ACP Advocacy from A (Access) to Z (Zika)

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Much ado about . . . Just about everything (important to doctors and patients)

- ACP has a broad and deep advocacy agenda, from *Access* to *Zika*.
- All in support of 6 overarching themes.
Overarching advocacy themes:

1. Improve access to care.
2. Make healthcare affordable.
3. Improve population and public health.
4. Improve health care delivery to achieve greater value.
5. Ensure there are enough well-trained internists in the numbers needed.
6. Make internal medicine practice more satisfying.
Much ado about . . . Improving access to care

- Affordable Care Act (Obamacare)
- Behavioral and Mental Health
- Disparities: racial, ethnic, LGBT
- Medicaid expansion/waivers
- Telemedicine
- Veterans Administration
Largely because of the ACA, uninsured rate has dropped to lowest ever.
Yet there are growing concerns about ACA marketplace stability

- Rising premiums and some large insurers exiting have raised concerns about the continued viability of the ACA’s state marketplaces.
- But after subsidies, most eligible Americans will still have access to an affordable plan in 2017 enrollment period.
Jonathan Gold, a spokesman for the U.S. Department of Health and Human Services, said Minnesotans would still have affordable options for coverage next year. “Headline rate changes do not reflect what these consumers actually pay because tax credits reduce the cost of coverage below the sticker price,” Gold said in a statement.
This year, premium requests by carriers have been higher on average than last year. Part of the reason for the increase is the phase-out of the law’s reinsurance program, which reimbursed carriers for high claims costs. The program has lowered premiums by as much as 14 percent, and without it carriers are raising their premiums to compensate. But even if final premiums in many plans are higher, most people who will enroll in marketplace plans this year will not pay much more than they did in 2015. This is because more than 80 percent of marketplace enrollees receive tax credits to help pay their premiums, which means most of the increase will be absorbed by the credits. Marketplace customers are also highly price-sensitive and will likely shop for the best deal. Last year, people who received tax credits through the federal marketplace experienced an average premium increase of only 4 percent.

This price competition is brand new to the individual insurance market, and is likely contributing to the large insurers’ exits. The ACA’s market reforms, and the design of premium tax credits fundamentally changed the competitive dynamic. While insurers used to compete by avoiding risk, they now must lure consumers with competitive pricing and high-value products. As in all competitive markets, there will be winners and losers. An analysis by the Urban Institute suggests that some of the large insurers staging high-profile departures were not the most price-competitive in some markets: Blue Cross Blue Shield Plans, Medicaid managed care plans, health provider-sponsored plans like Kaiser Permanente, and smaller regional plans have been more so.
Trump's Proposals
Here's how many people would lose insurance coverage if Obamacare were repealed and each of Trump's health policies were put in place.

- Insurance across state lines:
- Medicaid block grants:
- Tax-deductible premiums:

Additional Uninsured People (Millions)

Source: Rand Corp./Commonwealth Fund

Clinton's Plans

Here's how many people would gain health insurance coverage under Hillary Clinton's plans to build on the Affordable Care Act.

- **Public Option**: 1 million
- **Bigger ACA subsidies, fix "family glitch"**: 4 million
- **Tax credit for high health-care costs**: 10 million

Source: RAND Corp./Commonwealth Fund

Improving Access to Behavioral Health

Mental Health Care Health Professional Shortage Areas, as of Sept. 8, 2016

SOURCE: Kaiser Family Foundation’s State Health Facts.

KFF.org
Improving Access to Behavioral Health

- On July 6, the House of Representatives passed the Helping Families in Mental Health Crisis Act of 2016.
- Includes several key programs supported by ACP, including grants to integrate behavioral health into primary care, as called for by recent ACP position paper.
- The Senate HELP committee reported out its Mental Health Reform Act of 2016, but no Senate vote has been scheduled on the bill.
Much ado about . . . making health care affordable

- High-deductible plans
- Prescription drug pricing
- Health insurer mergers/consolidation
- High-value care
- Site-neutral payments
“The one that really blew my mind was the nasal spray,” said Robin Levi, Hannah and Abby’s mother, referring to her $80 co-payment for Rhinocort Aqua, a prescription drug that was selling for more than $250 a month in Oakland pharmacies last year but costs under $7 in Europe, where it is available over the counter.

The Centers for Disease Control and Prevention puts the annual cost of asthma in the United States at more than $56 billion, including millions of potentially avoidable hospital visits and more than 3,300 deaths, many involving patients who skimped on medicines or did without.
DRUG PRICES ARE RISING AT AN UNSUSTAINABLE AND SEEMINGLY IRRATIONAL RATE.

Diabetes Drugs with Significant Percent Price Changes Over Five Years

<table>
<thead>
<tr>
<th>Drug</th>
<th>Percent Change</th>
<th>Price Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levemir®</td>
<td>167%</td>
<td>$1,110</td>
</tr>
<tr>
<td>Lantus®</td>
<td>189%</td>
<td>$1,269</td>
</tr>
<tr>
<td>NovoRapid®</td>
<td>189%</td>
<td>$1,249</td>
</tr>
<tr>
<td>Humalog®</td>
<td>127%</td>
<td>$1,210</td>
</tr>
<tr>
<td>Januvia®</td>
<td>93%</td>
<td>$1,102</td>
</tr>
</tbody>
</table>

High costs affect both brand-name and generic drugs and span therapeutic areas. This graphic focuses on brand-name diabetes drugs, with no generic options yet available for insulin in the U.S.

THERE'S ENORMOUS PRESSURE ON...

Consumers and their families, who may be faced with the difficult decision of choosing between paying for diabetes medications and other necessities.

Employers, who may be forced to make cuts to their overall benefits package in order to fund rising drug costs.

Health care providers, who treat an increase in uncontrolled diabetes and disease-related complications due in part to non-adherence to costly medications.

Health plans and other payers, who are required to ensure the right people get the right drugs, yet whose budgets cannot finance the high cost of drugs.

Federal government, which is bearing an ever-growing share of the costs of these drugs, placing increasing pressure on the federal budget.

SOURCES >>

Medicare Part D Spending for the EpiPen Has Grown 1151% Since 2007

IN $ MILLIONS

<table>
<thead>
<tr>
<th>Year</th>
<th>EpiPen Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>7.0</td>
</tr>
<tr>
<td>2008</td>
<td>8.7</td>
</tr>
<tr>
<td>2009</td>
<td>10.8</td>
</tr>
<tr>
<td>2010</td>
<td>13.7</td>
</tr>
<tr>
<td>2011</td>
<td>20.3</td>
</tr>
<tr>
<td>2012</td>
<td>41.4</td>
</tr>
<tr>
<td>2013</td>
<td>63.3</td>
</tr>
<tr>
<td>2014</td>
<td>87.9</td>
</tr>
</tbody>
</table>

KFF.org
"This one shows great promise...
It keeps the patient alive until their money runs out."
Majority of the Public Favors Most Actions to Keep Drug Costs Down

Please tell me whether you would favor or oppose the following actions to help keep prescription drug costs down...

- Requiring drug companies to release information to the public on how they set their drug prices: 86% favor, 13% oppose
- Allowing the federal government to negotiate with drug companies to get a lower price on medications for people on Medicare: 82% favor, 17% oppose
- Limiting the amount drug companies can charge for high-cost drugs for illnesses like hepatitis or cancer: 78% favor, 20% oppose
- Allowing Americans to buy prescription drugs imported from Canada: 71% favor, 25% oppose
- Creating an independent group that oversees the pricing of prescription drugs: 66% favor, 29% oppose
- Eliminating prescription drug advertisements: 47% favor, 49% oppose
- Encouraging people to buy lower-cost drugs by requiring them to pay a higher share if they choose a similar, higher cost drug: 42% favor, 49% oppose

NOTE: Question was asked of separate half sample.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted September 14-20, 2016)
ACP has developed its own policies; endorsed recommendations from Campaign for Sustainable Rx Pricing

For more information about the CSRxp and its proposals, see http://www.csrxp.org/
Much ado about . . . improving population and public health

- Climate change
- Ebola
- Firearms violence
- Opioids epidemic
- Vaccines
- Zika virus
July was ‘absolutely’ Earth’s hottest month ever recorded

Overview - An introductory document, “How to Use the Climate Change Action Plan,” that provides background on the project, links to general resources, and describes the components of the Action Plan toolkit.

PowerPoint presentation - This can be used for chapter presentations, grand rounds, and other educational opportunities. It explains climate change, how it affects health, regional impacts, mitigation and adaptation, and how the health care sector can become more environmentally sustainable.

Talking Points - These brief talking points provide guidance on how to talk about how climate change impacts health and the co-benefits of taking action.

Patient FACTS - This easy-to-understand patient education resource explains how climate change can affect health and gives examples of what patients can do to reduce their impact on the environment.

Greening the Health Care Sector - The health care sector uses a massive amount of energy and is responsible for millions of tons of waste a year. These documents provide guidance on how physicians, their colleagues and staff can take action to curb climate change and make their practices more environmentally sustainable.

Why Green Your Health Care Facility?

Greening the Physician Office

Energy Management

Built Environment

Waste

Transportation

Healthy Food

Document Collection - A single PDF file with the Overview, Talking Points, Patient FACTS, and Greening the Health Care Sector documents.

https://www.acponline.org/advocacy/advocacy-in-action/climate-change-toolkit
On July 22, President Obama signed the Comprehensive Addiction and Recovery Act (CARA):

- Review, update best practices for pain management.
- Grants to educate physicians, and patients on risks associated with the misuse of opioids.
- Improve state-based Prescription Drug Monitoring Program (PDMP)
- Increase availability of opioid overdose reversal drugs.
- Alternatives to incarceration.
- Increase use of “partial fills”

9/28 “stop gap” spending law provides “down payment” on CARA funding
Zika virus

- ACP repeatedly urged Congress to authorize and appropriate sufficient funds to address Zika virus; successfully led effort at June AMA to get the AMA to take action.

- For months, Congress couldn’t agree on a Zika funding bill because of disagreement over Planned Parenthood.

- On 9/28, Congress approved a stop-gap spending bill with $1.1 billion for prevention, treatment, and vaccine development; no restrictions on Planned Parenthood--233 days after administration first requested funding.

- In the meantime: from 1/1/15 through 9/21/16, there were 20,870 Zika cases in the U.S. and its territories; many associated with travel.

Much ado about . . . improving healthcare delivery to achieve greater value

- ACOs and other Alternative Payment Models
- Bundled payments
- Comparative Effectiveness Research
- Chronic care services
- **MACRA**
- Medicare fee schedule payments
- Medical Homes
- Quality measurement
- Value-based benefit design
What’s MACRA? Law intended to align physician payment with value

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a law enacted by Congress with large bipartisan majorities; signed into law on April 16, 2015. Replaced failed Medicare SGR formula with:

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

How Much Can MIPS Adjust Payments?

- Based on their score, physicians and other eligible practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- It’s designed so that the maximum positive updates for physicians who score above the required performance threshold are paid for by reductions in payments to those who fall below it. If most physicians do well, the potential positive updates will be much lower than the maximums below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Maximum Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>9%</td>
</tr>
<tr>
<td>2020</td>
<td>7%</td>
</tr>
<tr>
<td>2021</td>
<td>5%</td>
</tr>
<tr>
<td>2022  onward</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Adjustment to provider’s base rate of Medicare Part B payment**

But Congress set aside extra $ so that the highest performers (scoring in top 25%) could earn up to 10% in additional annual bonus payments, 2019-24.

APMs are **new approaches to paying** for medical care through Medicare that incentivize quality and value.

As defined by MACRA, 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

PROPOSED RULE

Advanced APM Incentive Payment

QPs will:

Be excluded from MIPS

Receive a 5% lump sum bonus

Bonus applies in payment years 2019-2024; then QPs receive higher fee schedule updates starting in 2026

✓ The “APM Incentive Payment” will be based on the estimated aggregate payments for professional services furnished the year prior to the payment year.
✓ E.g., the 2019 APM Incentive Payment will be based on 2018 services.

Proposed Rule
Advanced APMs

Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- **Shared Savings Program** (Tracks 2 and 3)
- **Next Generation ACO Model**
- **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- **Comprehensive Primary Care Plus (CPC+)**
- **Oncology Care Model (OCM)** (two-sided risk track available in 2018)

How physicians may feel about MACRA (and other “value-based” payment programs)

“Let me be that I am and do not seek to alter me.”

From Shakespeare’s *Much Ado about Nothing*
MACRA won’t go away. But we can make it better:

• Simplify and reduce burden of reporting of quality measures.
• Simplify scoring.
• Revamp “Meaningful Use” HIT reporting to ensure clinical relevance.
• Help all practices but especially smaller ones.
• Create more opportunities for physician-led APMs, including PCMHs in all states.
Much ado about ... ensuring there are enough well-trained internists in the numbers needed

- GME refinancing and reform (joint paper with AAIM)
- Primary care workforce (Title VI, NHSC)
- Team-based care (Dynamic Clinical Care Teams paper)
  - Continued debate over roles of APRNs, Physician Assistants, Clinical Pharmacists, other non-physician clinicians.
  - ACP opposed VA proposed rule to override state laws to grant full independent practice to APRNs.
Much ado about . . . making internal medicine practice more satisfying

- Surveys show that internists (and other physicians) are experiencing growing dissatisfaction with practice and even burn-out.
- Due in large part to excessive documentation requirements, red tape, and hours entering data into EHRs that don’t meet your, or your patients, needs.
Table 4. Physician Time Distribution During Office Hours, by Task Category

<table>
<thead>
<tr>
<th>Task Category, by Activity During Office Hours</th>
<th>Tasks, n</th>
<th>Mean Time to Complete Task, s</th>
<th>Tasks per Hour, n</th>
<th>Time Spent (95% CI), %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct clinical face time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With patient</td>
<td>4483</td>
<td>93</td>
<td>10</td>
<td>33.1 (31.9-34.5)</td>
</tr>
<tr>
<td>With staff and others (patient not present)</td>
<td>2121</td>
<td>45</td>
<td>5</td>
<td>6.1 (5.7-6.5)</td>
</tr>
<tr>
<td><strong>EHR and desk work</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation and review</td>
<td>8623</td>
<td>69</td>
<td>20</td>
<td>49.2 (47.8-50.6)</td>
</tr>
<tr>
<td>Test result</td>
<td>1661</td>
<td>59</td>
<td>4</td>
<td>38.5 (37.3-39.8)</td>
</tr>
<tr>
<td>Medication order</td>
<td>622</td>
<td>59</td>
<td>1</td>
<td>6.3 (5.8-6.8)</td>
</tr>
<tr>
<td>Other order</td>
<td>610</td>
<td>52</td>
<td>1</td>
<td>2.4 (2.2-2.5)</td>
</tr>
<tr>
<td><strong>Administrative tasks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>191</td>
<td>49</td>
<td>&lt;1</td>
<td>1.1 (0.9-1.3)</td>
</tr>
<tr>
<td>Scheduling</td>
<td>125</td>
<td>59</td>
<td>&lt;1</td>
<td>0.6 (0.5-0.7)</td>
</tr>
<tr>
<td><strong>Other tasks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed to observation</td>
<td>163</td>
<td>524</td>
<td>&lt;1</td>
<td>19.9 (18.2-21.6)</td>
</tr>
<tr>
<td>Other (aggregated)</td>
<td>969</td>
<td>183</td>
<td>2</td>
<td>5.5 (4.5-6.5)</td>
</tr>
<tr>
<td>Transit</td>
<td>2546</td>
<td>15</td>
<td>7</td>
<td>5.2 (4.3-6.0)</td>
</tr>
<tr>
<td>Personal</td>
<td>902</td>
<td>109</td>
<td>2</td>
<td>2.9 (2.8-3.0)</td>
</tr>
</tbody>
</table>

EHR = electronic health record.

* Total sums to 103.3% because the Work Observation Method by Activity Timing platform allows recording of 2 tasks done in parallel. Multitasking results in overlapping time records, which are additive. Thus, the total task time is >100% of the total time observed.

Wow! Your cholesterol has me really worried!

Gack!

Uh... you might want to actually look at the patient...
THE MODERN MEDICAL TEAM

[Cartoon depicting healthcare professionals in a hospital setting, labeled as CASE MANAGER, UTILIZATION REVIEWER, BILLING SUPERVISOR, INSURANCE, DISCHARGE PLANNER, DOCTOR, and NURSE.]
Doctor Getting Squeezed, by @HealthCareWen
Doesn’t this describe the mood of many internists?

“Why, what's the matter, 
That you have such a February face, 
So full of frost, of storm and cloudiness?”

From Shakespeare’s *Much Ado about Nothing*
Through ACP’s advocacy to make internal medicine practice more satisfying, we hope to

Turn internists’ “February” faces, “so full of frost, storm and cloudiness”, from this

To “June” faces, like this:
Our advocacy to make practice more satisfying is focused on:

- Clinical documentation
- EHRs: functionality, usefulness, clinical relevance
- Patients Before Paperwork
  - Captures all of ACP’s activities to reduce administrative burdens
  - Look for major new policy paper toward end of year/early 2017
- Quality measures: relevance, burden of reporting
ACP advocacy, from A to Z

- Together, our policies support the following overarching themes:
  1. Improve access to care.
  2. Make healthcare affordable.
  3. Improve population and public health.
  4. Improve health care delivery to achieve greater value.
  5. Ensure there are enough well-trained internists in the numbers needed.
  6. Make internal medicine practice more satisfying.
So that we can chart a way to a better healthcare system, for you and your patients!

“It is not in the stars to hold our destiny but in ourselves.”

Shakespeare, from Julius Caesar