“Curiouser and Curiouser”

What Alice, Edward Bear, Dorothy and Dr. Seuss Can Tell Us about Health Care Reform
“Would you tell me, please, which way I ought to go from here?”

*That depends a good deal on where you want to get to,* said the Cat.

I don't much care where — said Alice.

*Then it doesn't matter which way you go,* said the Cat.

— so long as I get somewhere,* Alice added as an explanation.

“Oh, you're sure to do that,* said the Cat, "if you only walk long enough."
“Curiouser and Curiouser”—which way ought we go from here?

1. On health care costs?
2. On the ACA?
3. On GME?
4. On physician payment reform?
5. On EHRs and health care administration/paperwork?
“Curiouser and Curiouser:” unprecedented slowdown in health care spending

Implications: lower budget deficit, less public debt, more time before Medicare becomes insolvent, less political pressure for entitlement reforms. But can slowdown be sustained?
“Curiouser and Curiouser” – the Affordable Care Act

- By most objective measures, the ACA is providing coverage to millions who could not get it before.
- But it remains unpopular—although most don’t favor repeal.
The Affordable Care Act: By the Numbers

2014 enrollment:

- Most recent estimate is that 6.7 million enrolled in marketplace-based insurance and paid premium. Higher than CBO/JCT April 2014 projection that an average of 6 million would enroll in such coverage.
- Most like their coverage (Gallup):* 71% of ACA enrollees say their coverage is good or excellent, 19% said it was fair, only 9% said it was “poor.” 75% of new QHP enrollees satisfied with their cost of care compared to 61% in overall insured population nationwide.
- Medicaid/CHIP also experienced growth – enrollment has increased by 15% from February to August 2014.
- 1-3M people age 18-26 permitted to stay on parent’s health plan.

*Source: Good Reviews for Obamacare Coverage, Politico, 11/14/14
And the ACA is achieving its principal goal of reducing the number of uninsured Americans.
This map shows the % change in rate of uninsured by locality.

The darker the color, the greater the drop in the % uninsured.

By clicking on this interactive map, you can see actual numbers for your own county.

We know that about 10 million more people have insurance coverage this year as a result of the Affordable Care Act. But until now it has been difficult to say much about who was getting that coverage — where they live, their age, their income and other such details.
Nationally, Blacks and Hispanics had substantially larger gains in coverage.

Young adults had the biggest reduction in being uninsured of any age group.

More people gained coverage in Republican-leaning areas than in Democratic-leaning ones.

Critics of the Affordable Care Act have often warned that the program would be unfair to the young because it limits the ability of insurance companies to charge higher rates to older customers, who tend to be sicker. But young adults show the largest reductions in being uninsured of any age group. And that's not counting the approximately 3 million young adults who received coverage on their parents' policies before 2014.

Despite many Republican voters' disdain for the Affordable Care Act, parts of the country that lean the most heavily Republican (according to 2012 presidential election results) showed significantly more insurance gains than places where voters lean strongly Democratic. That partly reflects underlying rates of insurance. In liberal places, like Massachusetts and Hawaii, previous state policies had made insurance coverage much more widespread, leaving less room for improvement. But the correlation also reflects trends in wealth and poverty. Many of the poorest and most rural states in the country tend to favor Republican politicians. Of course, the fact that Republican areas showed disproportionate insurance gains does not mean that only Republicans signed up; there are many Democrats living in even the most strongly Republican regions of the country.
Whether a state chose to expand Medicaid is the single biggest factor in determining how many people gained health insurance coverage.

That state boundaries are so prominent in the map attests to the power of state policy in shaping health insurance conditions. The most important factor in predicting whether an American who had no insurance in 2013 signed up this year was whether the state that person lives in expanded its Medicaid program in 2014. (Just consider the contrast between Kentucky, which expanded Medicaid, and Tennessee, which did not.)
Eight States Undecided on Medicaid Expansion

Analysis

- The Supreme Court's ruling on the Affordable Care Act in NFIB vs. Sebelius allows states to opt out of the law’s Medicaid expansion, leaving this decision with state governors and legislatures.
- Governors of states participating in Medicaid expansion cited support for increased coverage for residents; governors of non-participating states cited high cost of expansion as reason for opting out; governors of undecided states are weighing costs of expansion before opting in or out.

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.
Figure 1

Income Eligibility Levels for Medicaid/CHIP and Marketplace Tax Credits in Virginia as of 2014

- Medicaid/CHIP
- Coverage Gap
- Tax Credits
- Unsubsidized Marketplace

Childless Adults

Parents

Children

0% FPL
51% FPL
100% FPL
205% FPL
400% FPL
($11,917 for a family of 4, $11,490 for an individual)
($23,550 for a family of 4, $11,490 for an individual)
($48,277 for a family of 4)
($94,200 for a family of 4, $45,960 for an individual)

Notes: Medicaid eligibility is based on current Medicaid eligibility rules converted to MAGI. Applies only to MAGI populations. Medicaid eligibility levels as a share of poverty vary slightly by family size; levels shown are for a family of four. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage. Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels.
What has been the ACA’s impact on premiums, availability of employer-sponsored HI?


- “Fewer employers said they are likely to drop health benefits within the next five years than was the case in Mercer’s most recent previous survey.”
- “(J)ust 1 percent of employers said they have decided to stop offering health coverage for 2015, one survey said.”

Family premiums increased at a modest rate [3 percent] and single premiums are not statistically different than those reported last year. On average, covered workers contribute the same percentage of the premium for single and family coverage as they did last year.” Source: 2014 Employer Health Benefits Survey, Kaiser Family Foundation, [http://kff.org/report-section/ehbs-2014-summary-of-findings](http://kff.org/report-section/ehbs-2014-summary-of-findings)
The ACA: 2015 enrollment

- Shorter Open Enrollment period for most people—ended 2/15/15 (with 2/22 extension for people who experienced technical glitches). Existing enrollees reenrolled and new enrollees enrolled for first time.
  - Charles Gaba: estimated 12.5M (11M paid) by end of extended enrollment, federal and state QHPs combined

- More competition: # of insurers offering indiv. plans has increased in 37 states (Indiana welcomed 6 new issuers!)
  - CA, OR will see net decrease in # of issuers offering QHPs
  - Average total number of QHP issuers per state in 2015 is 7.1, up from 5.7 in 2014. (KFF)
Change in Benchmark Silver Premiums, 2014 – 2015

Percent change in second-lowest silver plan, by county in 50 states and the District of Columbia

Source: Kaiser Family Foundation analysis of data from Healthcare.gov and insurer rate filings to state regulators. For more information see “Analysis of 2015 Premium Changes in the Affordable Care Act’s Health Insurance Marketplaces” Sept. 2014.
The ACA and the IRS

- 4/15: Penalties for not having a QHP go into effect for 2014 taxes, estimated 3-6 million will have to pay, 15-30M will qualify for exemptions: 1 percent of income above 10K, or $95 per adult, whichever is higher (taken out of refunds).

- HHS created a special “tax season” open enrollment period, 3/15-4/30, for people in federal exchange (e.g. VA) subject to 2014 penalties, allowing them to enroll in a QHP in time to avoid higher 2015 penalty.
  - 2% of household income over filing threshold of 10K, or $325 per adult, whichever is higher.
  - Some states with own exchanges are implementing a similar special tax season enrollment period

- Some who underestimated income may have to pay back excess premium subsidies.
What about narrow provider networks?

- NAIC in process of updating its 1996 network model act, on which many states base their network adequacy laws. Final vote expected next year.

- Draft model includes requirement that issuers submit access plans to state regulators, establishes new appeals process for consumers, and new continuity of care provisions. Also more stringent reporting requirements for provider directories to ensure accuracy.
Another challenge: few people understand the ACA

Alice, inquiring of the Mock Turtle:
“What is the use of repeating all that stuff, if you don't explain it as you go on? It's by far the most confusing thing I ever heard!”

Same might be said of the ACA:

Uninsured Largely Unaware Of Upcoming Open Enrollment, Marketplaces, and Financial Assistance

AMONG THE UNINSURED AGES 18-64: Percent of people who say they...

- ...do NOT know that open enrollment begins in November 89%
- ...know “only a little” or “nothing at all” about the health insurance marketplace 66%
- ...do NOT know that the health reform law provides financial help to low and moderate income Americans 53%

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted October 8-October 14, 2014)
And despite the ACA’s objective successes . . .

- It remains unpopular and subject to unrelenting political and judicial challenges.
What’s next for the Affordable Care?

The legislative environment

1. Although Republicans now have sizeable majorities in both chambers of Congress, they will not be able to repeal Obamacare.
   • They don’t have the 60 votes in Senate required to overcome a Democratic filibuster . . .
   • . . . and if they were somehow able to get a repeal bill to the president (reconciliation), they don’t have the two-thirds super-majority in both chambers needed to override a veto.
What’s next for the Affordable Care Act?  
**The legislative environment**

2. New 114th Congress will advance legislation to alter parts of Obamacare that are peripheral, but not essential, to getting people covered:

- Taxes on medical devices and insurance companies
- Repeal of the Independent Payment Advisory Board
- Employer-mandate work hours
- Health plan re-insurance/risk corridors program
- Will also try to use appropriations to limit discretionary dollars
- Some may get Democratic votes, and Obama may willing to accept modest changes--but Senate Dems would filibuster, and Obama would veto, changes in individual mandate, premium subsidies, Medicaid expansion, or funding restrictions that would cripple implementation.
What’s next for the Affordable Care Act: *The Supreme Court*

- Supreme court to rule this term on subsidies (*King case*); *brought by 4 Virginia residents*, who argue that statute refers to subsidies being available only in “exchanges established by the states.”
  - IRS ruled that Congress’ intent was for the subsidies to apply in exchanges run by the federal government.

- If subsidies are overruled, it would make premiums unaffordable in majority of states, and cause 8-9 million people to lose coverage.
  - *A ruling against the Supreme Court would scramble the politics, national and state; White, southern males mostly likely to lose coverage.*
    - FL, TX, NC, GA, PA, Virginia (385,000 as of 2/18), IL, MI are most at risk.

- ACP joined in an amicus urging SCOTUS to uphold the subsidies, citing potential harm to millions of patients.
“Curiouser and Curiouser”—GME financing and workforce

- Consensus that the current federal GME financing system is broken because it is not providing enough return on investment:

  “At a time when all federal programs are under close scrutiny and the return on the public’s investment in GME is poorly understood, the committee cannot support maintaining Medicare GME funding at the current level without establishing a path toward realignment of the program’s incentives and a plan for documentation of outcomes. The continuation and appropriate level of funding should be reassessed after the implementation of these reforms.”

Consensus that U.S. is facing a shortage of physicians, including primary care, is *unraveling*:

“Concerns that the nation faces a looming physician shortage, particularly in primary care specialties, are common. The committee did not find credible evidence to support such claims. Too many projections of physician shortages build on questionable provider–patient ratios, fail to consider the marked geographic differences in physician supply, and ignore recent evidence of the impacts of more effective organization, new technology, and deployment of health personnel other than physicians.”

“Curiouser and Curiouser”—GME financing and workforce

AAFP proposes to:

1. Limit payments for direct graduate medical education and indirect graduate medical education to training for first-certificate residency programs. [Eliminates federal GME funding for IM subspecialty training]
2. Establish primary care thresholds and maintenance-of-effort requirements for all sponsoring institutions and teaching hospitals.
3. Require all sponsoring institutions and teaching hospitals seeking new Medicare- and Medicaid-financed GME positions to meet primary care training thresholds as a condition of residency program expansion.
4. Align financial resources with population health care needs through a reduction in IME payments and allocation of those resources to support innovation in GME.
5. Fund the National Health Care Workforce Commission.
“Curiouser and Curiouser”—GME financing and workforce

- Yet for all of the attention being paid to GME reform, *the status quo has prevailed*
  - Congress hasn’t given hospitals, residency programs and specialties the billions more that they want, but neither has it cut funding
    - GME/IME has been on the budget chopping block for years, yet (so far) has escaped unscathed
    - IOM argues for “flat funding” with redistribution of money within a budget neutral pool
  - Most GME innovation is being done on a relatively small scale, pilot basis (e.g. teaching health centers)
  - But GME reform is coming—it’s just a matter of when
Believing in the impossible

"Alice laughed: "There's no use trying," she said; "one can't believe impossible things."
"I daresay you haven't had much practice," said the Queen. "When I was younger, I always did it for half an hour a day. Why, sometimes I've believed as many as six impossible things before breakfast."

It would be a mistake for us believe in the impossible:

- That GME will be immune from the push for accountability/value
- That Congress, at time of fiscal restraint, is just going to add hundreds of billions to GME and lift all specialties’ caps
- That Congress will just accept our word that there is a physician shortage
ACP’s approach to GME

- Expert advisory committee (being formed collaboratively with AAIM and Education Committee) will help HPPC update policies on:
  - Innovation Fund/Performance-based GME pool
  - Budget-neutral funding
  - Paying programs directly
  - Community-based teaching programs
  - All-payer GME
  - AAFP proposal to limit funding to first certificates
**Curiouser and Curiouser: Physician payment reform/SGR**

- Congress reached agreement on a bill to repeal and replace the SGR, but not on how to pay for it.
  - Instead, passed another “patch” that expires April 1, 2015, which would result in a 21% scheduled cut.

- Last year’s bipartisan-bicameral agreement expected to be re-introduced soon, with only modest changes (e.g. updating effective dates of implementation).
Last year’s bill would have:

- Repealed SGR.
- Provide positive and stable updates during a transition period to value-based payments.
- Consolidated current Medicare reporting programs into one Merit-based Incentive Program.
  - Higher score for physicians in certified PCMHs.
- Pathway for physicians to participate in Alternative Payment Models (5% FFS bonus payments) like ACOs, PCMH, bundled payments, supported by their own payment systems (e.g. shared savings, PCMH risk adjusted capitation+FFS)
Curiouser and Curiouser: Physician payment reform/SGR

- ACP will continue to urge Congress to act before the patch expires—but must be prepared to continue to advocate for action on full SGR repeal, based on last year’s bill, by the end of the year (should Congress enact another patch).

- While ACP continues to support the agreement made last year, changes are likely
  - But too many changes would upend the fragile consensus needed to get it enacted.
  - The bill could be tied to offsets, like repeal of the ACA’s individual insurance mandate, which the White House (and ACP) could not accept.
HHS: issued call for “historic” transition to value-based payments within 3 years

- Secretary Burwell, 1/16/2015, announced agency-wide initiative with goals of:

  “Tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.

  HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.”
ACP applauded “ambitious but achievable” goals, but identified 8 “critical steps” to achieve them

1. Repeal the Medicare SGR formula and create a clear pathway to a new merit-based incentive payment program and ACOs.
2. Harmonize and prioritize measures to reduce reporting burden.
3. Partner with professional medical membership societies to support and prioritize efforts to develop guidelines and measures relating to high value care, simplify reporting, and support physician practices.
4. Expand the programs funded by the Center of Medicare and Medicaid Innovation, including the Comprehensive Primary Care Initiative.
ACP applauded “ambitious but achievable” goals, but identified 8 “critical steps” to achieve them

5. Make improvements in FFS to facilitate the transition to value-based models, including improving on the new payment policy on chronic care management.

6. Improve the functionality of electronic health records including changes in MU.

7. Ensure that all measures are validated through the National Quality Forum.

8. Ensure that all of the programs and agency initiatives support the critical role that primary care physicians will play in ensuring that payments are aligned with value.
Physician reform: Medicare 10 percent primary care bonus program

- Since 1/1/2011, Medicare has paid internists, FPs, and geriatricians (as long as 60% of their billings were for primary care) a 10 percent bonus on all office visits and other designated services; expires 1/1/2016.
  - Winning GOP support is challenging because the program was created by Obamacare, and costs money.

- MedPAC: continue the program, pay bonuses on a per-beneficiary basis instead of number of services billed
  - Make it budget neutral: paid for by 1.4% re-allocation from all non-defined primary care codes (e.g. procedures, imaging, tests and E&M services provided in the ER and inpatient hospital setting) -- these services account for approximately 75% of fee schedule spending.
Medicaid pay parity

- This ACA-created program, which pays internists and other primary care physicians (and IM subspecialists) no less than Medicare rates for applicable services to Medicaid enrollees, expired on 1/1/15.
  - As a result, primary care physicians saw cuts of up to 60% in their Medicaid payments as of the first of the year.

- Why did pay parity not attract more GOP support?
  - Because it was created by Obamacare, which the GOP has pledged to repeal, it costs money, and is linked to the debate over Medicaid itself
  - While ACP continues to advocate for federal legislation, we have developed an updated action plan for state chapters to use to urge their own states to fund it (as 15 states plan to do)
Medicare begins paying for Chronic care management (1/1/15)

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<thead>
<tr>
<th>Program/policy</th>
<th>Description</th>
<th>Payment amount</th>
<th>For more information</th>
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<tr>
<td>Chronic Care Management Codes, CPT 99490</td>
<td>Non face-to-face work for patients with two or more chronic conditions, 20 minutes per 30 days, must meet other billing criteria</td>
<td>$42.90</td>
<td><a href="http://www.acponline.org/advocacy/where_we_stand/assets/summary_of_cy2015_proposed_rule_physician_fee_schedule.pdf">http://www.acponline.org/advocacy/where_we_stand/assets/summary_of_cy2015_proposed_rule_physician_fee_schedule.pdf</a> <a href="http://www.acponline.org/running_practice/physician_practice_timeline/">http://www.acponline.org/running_practice/physician_practice_timeline/</a></td>
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Also, penalties in 2017 if you do not successfully participate in PQRS, Meaningful Use, and Medicare Value Modifier in 2015. So look to ACP for help!
## ACP resources

### Physician and Practice Timeline

### PQRS Wizard—makes PQRS easier

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### Physician & Practice Timeline™

**Professional Requirements & Opportunities**

- **What's New?**
  - CCRB releases the FY 2015 Medicare Physician Fee Schedule Final Rule. The Centers for Medicare & Medicaid Services (CMS) issued its 2015 reimbursement policies affecting physicians starting January 1, 2015. A number of changes from the proposed rule were retained, including increasing coverage for chronic care management, changes to the open payments program, and changes to the Medicare Shared Savings Program and Value Based Modifier and Physician Feedback Program.
  - ACP's summary of the new issues included in the Final Rule.
  - ACP's summary of letters to CMS on the 2015 Medicare Physician Fee Schedule Final Rule.

**2014: Ongoing Items**

- Check the items below for guidance on what you should be working on, collecting and thinking about right now.

### What's New!

- **CPU** (Current Procedural Terminology) codes for Transitions Care.
  - Providers will use new codes for transitional care management services.
  - The codes allow for reimbursement of services provided in the home setting.

### Related Links
- [ACPs Medical Education](http://www.acponline.org/running_practice/physician_practice_timeline/)
- [ACPs Clinical Trials](http://www.acponline.org/running_practice/physician_practice_timeline/)
Why do we need to reform physician payments?

“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
“There really is another way”

- Risk-adjusted monthly per-patient payments (global primary care capitation).
- Bundled payments by diagnosis, episodes of care.
- “Hybrid” models that preserve some elements of FFS, plus risk-adjusted payments, shared savings (Comprehensive Primary Care Initiative).
- Direct (cash) payment? “Retainer” practices?
- Patient-Centered Medical Homes/PCMH Neighbors
“There really is another way”

- NYT: Blue Cross and Blue Shield plans reported that they collectively have invested $65 billion in new “value-based” models—including PCMHs—involving “215,000 physicians affecting more than 24 million members, including some in Medicare Advantage plans.”

  • “Horizon Blue Cross Blue Shield of New Jersey pays a primary care doctor roughly $5 per patient a month to manage a patient’s care. The doctor can earn an additional $11 a month per patient by meeting certain quality and efficiency goals. A practice with 1,000 patients could make an extra $60,000 to $192,000 a year.”

“There really is another way”

- KHN: “Beginning in 2011 CareFirst increased reimbursement [to] most of its primary care doctors in Maryland, the District and Virginia. . . Doctors who scored well have gotten raises of more than $40,000 on top of round-the-clock nursing assistance for their sickest and riskiest patients.” [http://www.kaiserhealthnews.org/Stories/2014/July/10/CareFirst-primary-care-costs-specialists-hospitals.aspx]

Care Management Payments to 500 Comprehensive Primary Care Initiative Practices

Figure 1. Total Care Management Payments to Practices, October 2012 – December 2013

* Practices reported payments from Non-Medicare Payers; CMS data was used to record Medicare payments. Incomplete reports of funding practices received from each payer were omitted from analysis, as were reports of extremely small or large quantities of care management funding per CPC attributed life.
Or in other words . . .

A Patient Centered Medical
“Curiouser and Curiouser”: health care administration and paperwork

- More and more administrative tasks and paperwork are being imposed on physicians, without any assessment of need, value or impact.
- Major contributor to dissatisfaction with practice, disincentive to enter or remain in primary care, and less time with patients.
“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.”

From “You Only Get Old Once” by Dr. Seuss
Physicians’ views of all these changes

Doctors
Getting
Squeezed, by
@HealthCare
Wen
ACP’s initiative to reduce administrative complexities

Patients Before Paperwork: Reinvigorating the Patient-Physician Relationship, By Challenging Unnecessary Practice Burdens

Goals:
1. Educate members, policymakers, public on what makes up administrative challenges and why they are not all equal
2. Identify which are the highest priorities and why
3. Implement most effective strategies to mitigate or eliminate top priority challenges and help members address those that can’t be eliminated
Putting patients before paperwork

Targeting the top three administrative burdens, according to ACP member focus groups and surveys:

1. Electronic health records
2. Quality reporting
3. Interactions with health plans
Dysfunctional EHRs=less time with patients

ACP study:

Mean Loss for attending physicians was 48 minutes per clinic day, 4 hours per five day clinic week


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). In a small survey, 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, 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 on medical record data with the EMR than without, and a similar proportion, 32.2%, that it was slower to read other clinicians’ notes.

Discussion | 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.

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—the use of scribes, standing orders, talking instead of e-mail—to re-capture 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.
As part of *Patients Before Paperwork*, ACP will explore opportunities for legislative relief

- GOP-led Congress may be more receptive to proposals to ease Medicare regulations that impose a burden on practices and require CMS to modify meaningful use for EHRs.
To recap, imagine that

“Alice” represents patients and the public, asking us which way health care ought to go,

And the Cheshire Cat is ACP and the Virginia chapter, pointing them in direction to which way health care ought to go
“Would you tell me, please, which way I ought to go from here?”

**Which way we ought to go:**

- To guaranteed coverage of evidence-based essential services for everyone, without regard to income, where they work, or health status

**Where we are today:**

- Despite the opposition, the ACA is taking us to a place where most Americans will have affordable coverage.
  - But court challenges, restrictive formularies, states refusing to expand Medicaid, congressional opposition remain barriers
“Would you tell me, please, which way I ought to go from here?"

<table>
<thead>
<tr>
<th>Which way we ought to go:</th>
<th>Where we are today:</th>
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<tr>
<td>To sustainable GME financing reforms to ensure accountability and transparency and allocate sufficient resources based on assessment of workforce needs</td>
<td>IOM report offers a thoughtful framework for reform, much (but not all) of which is in accord with ACP policies</td>
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<tr>
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<td>Congress is unlikely to make changes in short-term, but over longer-term, GME reform is inevitable and welcome</td>
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<td>Long-held consensus that there is a physician workforce shortage is under challenge</td>
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“Would you tell me, please, which way I ought to go from here?”

Which way we ought to go:

- To a payment and delivery system that recognizes and values the role of internal medicine specialists and others who provide primary and comprehensive care

Where we are today:

- Medicaid pay parity program expired on 1/1/15, and 10% Medicare primary care bonus program expires at end of 2015
- Despite bipartisan agreement on SGR repeal bill, legislation is stalled
- “There really is another way” : PCMHs/PCMH-N, ACOs, bundled payments, risk-adjusted capitation
“Would you tell me, please, which way I ought to go from here?”

Which way we ought to go:
- To a system that minimizes paperwork, regulatory and reporting requirements, and dysfunctional information systems that detract from patient care and the joy of practice

Where we are today:
- Poorly designed EHRs and federal MU regulations are adding hours to workload and contributing to physician-burnout
  - ACP is working with the industry on solutions and leading an effort to advocate for changes in federal standards and rules
- Too much paperwork and too many administrative processes!
  - ACP’s “Patients Before Paperwork” Initiative will propose solutions
“Would you tell me, please, which way I ought to go from here?”

- Through ACP advocacy, we can help lead the United States to
  - A health care system that covers everyone, costs less, recognizes the value of internists’ services, ensures stable and transparent GME financing aligned with workforce priorities, puts patients before paperwork, and uses information technology to improve, rather than detract, from patient care.
  - if only we are willing to walk long enough.