Health reform 2.0: What can you expect from the next generation of health reform?

ACP Virginia Chapter

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Disclosure of Financial Relationships

Robert Doherty

Has no relationships with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.
The next generation of health reform

- Health Reform 1.0 (Affordable Care Act) was mainly about expanding coverage and regulating the insurance market, with modest initiatives to address cost and value.

- Health Reform 2.0 is all about:
  - Coverage and Under-insurance
  - Restraining prices, getting more value
  - Achieving real E-health connectivity and functionality
  - Simplifying healthcare
Health reform 2.0: Coverage

- Because of the ACA, between October 2013 and September 12, 2015:
  - 4.0 million Latino adults gained coverage (an 11.5 percent drop in uninsured rate)
  - 2.6 million African American adults gained coverage (a 10.3 percent drop)
  - 7.4 million White adults gained coverage (a 6 percent drop)
- In total, 17.6 million people gained coverage (exchange plans and Medicaid) as the ACA provisions took effect.
- At start of 2016 enrollment period, 10.5 million remained eligible for marketplace coverage.

Uninsured rate is the lowest ever!
Who’s eligible for health coverage?

About 32.3 million non-elderly Americans are currently uninsured.

Sixty percent of them could get coverage through subsidized or unsubsidized plans in the health-insurance marketplaces of the Affordable Care Act or through Medicaid and the Children’s Health Insurance Program.

Source: Kaiser Family Foundation
At close of 2016 open enrollment period:

- 12.7 million had signed up through [www.healthcare.gov](http://www.healthcare.gov) or state exchanges
  - 4 million were new enrollees
  - Total of 1 million more than at close of 2015 enrollment
  - Normal attrition (e.g. people getting a job with coverage, becoming Medicare-eligible) will likely reduce # covered to 10+ million at year end
- Doesn’t include another 71 million enrolled in Medicaid (as of November, 2015), a gain of 14 million since October, 2013*

Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/2016. LA’s Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as “adoption under discussion.”


Expansion states covered more, had lower Medicaid spending growth than non-expansion states

FY 2015 enrollment and total spending growth in expansion states far exceeded non-expansion states; state spending growth was lower.

NOTE: Data show the year over year change in enrollment FY 2014 to FY 2015. Expansion States for FY 2015 include 29 states. Total Medicaid spending includes federal, state and local spending. SOURCE: KCMJ survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.
Will coverage gains be sustained, expanded or reversed?

- If a Democrat is elected President, the parts of the law that are most critical to coverage will be maintained (individual mandate, premium subsidies, marketplaces, non-discrimination, modified community rating, benefit mandates, and Medicaid expansion)—especially if Dems retake the Senate
  - Potential modifications include repeal of “Cadillac” and medical device taxes
  - Senator Sanders’ “single payer” plan would face enormous political obstacles (especially since GOP likely will keep control of the House)
ACP policy on single-payer vs. multiple payers

ACP . . recommends that the federal and state governments consider adopting one or the other of the following pathways to achieving universal coverage:

1. Single-payer financing models . . can achieve universal access to health care without barriers based on ability to pay. *Single-payer systems generally have the advantage of being more equitable, with lower administrative costs . . lower per capita health care expenditures*, high levels of consumer and patient satisfaction, and high performance on measures of quality and access. They *may require a higher tax burden* . . Such systems typically *rely on global budgets and price negotiation* to help restrain health care expenditures, *which may result in shortages of services and delays in obtaining elective procedures and limit individuals’ freedom* to make their own health care choices.

2. Pluralistic systems *can assure universal access, while allowing individuals the freedom to purchase private supplemental coverage*, but are more likely to result in inequities in coverage and higher administrative costs . Pluralistic financing models must provide 1) a legal guarantee that all individuals have access to coverage and 2) sufficient government subsidies and funded coverage for those who cannot afford to purchase coverage through the private sector. [Emphasis added in italics]
   - Affordable Care Act is an example of a pluralistic approach that moves towards universal coverage.
Will the ACA’s coverage gains be sustained, expanded or reversed?

If a Republican is elected President, substantial changes in the ACA are possible but full repeal is unlikely, especially if Democrats re-take the Senate. What’s the (likely) GOP alternative?

- HSAs, and tax credits to buy coverage of choice; no individual, employer or benefit mandates
- Allow insurance to be sold across state lines
- Medicaid block grants
- Bar pre-existing condition exclusions or higher rates for those who maintain continuous coverage, state-based risk pools for others

Result would make coverage more affordable for some, with fewer benefits, but add millions to the uninsured (CBO, other analyses)

What about 10+ million ACA plan enrollees who would lose coverage? And 14 million who gained coverage through Medicaid expansion?
Could the ACA itself become the basis for a bipartisan compromise?

“As former leaders in Congress, we have a message for both sides in this debate: It’s time to give the states a chance.

This doesn’t mean that conservatives and Republicans have to give up the fight to reduce the regulations and taxes in the law. It also doesn’t mean that progressives and Democrats have to stop defending protections for the underinsured and uninsured.

Instead, it’s time to look to a provision of the Affordable Care Act — Section 1332 — that can achieve what both sides earnestly wish for: providing more Americans with access to more affordable, flexible, patient-centered health care.”

--Former Speaker of the House Newt Gingrich (R)
--Former Majority Leader Tom Daschle (D)
Since 2011, ACP has endorsed Section 1332 waivers as a potential bipartisan way forward

- Beginning in 2017, states can seek *State Innovation Waivers*.
- Allows states to opt-out of many of the ACA’s requirements. Including individual and employer mandates, as long as they can offer coverage that:
  - At least as comprehensive as the ACA’s essential benefits
  - At least as affordable
  - Insures comparable numbers
  - Doesn’t cost the federal government more
- States could use federal dollars that otherwise would subsidize coverage through the exchanges (could be expanded by Congress to include Medicaid and other funding streams).
- Would conceivably allow states to test everything from market-based reforms to a public option plan.
Even with more insured people, healthcare remains too expensive for many.

- Rise in high deductible, high cost-sharing health plans have led to millions of Americans becoming underinsured.
## Exhibit 5. Deductibles Have Become a Growing Factor in Underinsurance Rates

<table>
<thead>
<tr>
<th>Indicators of underinsurance among adults ages 19–64 who were insured all year</th>
<th>2003</th>
<th>2005</th>
<th>2010</th>
<th>2012</th>
<th>2014</th>
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<tbody>
<tr>
<td>Out-of-pocket costs were 10% or more of income or 5% or more of income if low-income[^1]</td>
<td>14 million</td>
<td>14 million</td>
<td>25 million</td>
<td>23 million</td>
<td>24 million</td>
</tr>
<tr>
<td>Deductible equals 5% or more of income</td>
<td>4 million</td>
<td>4 million</td>
<td>8 million</td>
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<td>14 million</td>
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<tr>
<td>Net increase in millions underinsured because of high deductible</td>
<td>2 million</td>
<td>2 million</td>
<td>5 million</td>
<td>6 million</td>
<td>7 million</td>
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</table>

[^1]: Low income refers to those with incomes below 200 percent of the federal poverty level.
[^2]: Underinsured defined as insured all year but experienced one of the following: out-of-pocket expenses equaled 10% or more of income; out-of-pocket expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income. Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, and 2014).
Health reform 2.0: Restraining prices, getting more value

- MACRA is just the opening act of efforts to align payment and delivery systems with value: outcomes, effectiveness, efficiency.
- Pressure to get more value from the dollar spent will likely increase over the next 5-10 years, especially if a new President and Congress pursue entitlement reforms.
The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

- **Merit-Based Incentive Payment System (MIPS)**
- **Alternative Payment Models (APMs)**
Starting in 2019*, physicians will choose from or land in one of two paths: MIPS or APMs?

* This decision will actually need to be made sooner than 2019. The initial performance period for MIPS in MACRA is 2017.
Two pathways: MIPS versus APMs (2019)

**MIPS**

- MIPS adjusts traditional fee-for-service payments upward or downward based on new reporting program, integrating PQRS, Meaningful Use, and Value-Based Modifier
- **Measurement categories (composite score of 0-100):**
  - Clinical quality (30%)
  - Meaningful use (25%)
  - Resource Use (30%)
  - Practice improvement (15%)

**APMs**

- Supported by their own payment rules, plus
- 5% annual bonus FFS payments for physicians who get substantial revenue from alternative payment models that
  - Involve upside and downside financial risk, e.g. ACOs or bundled payments
  - OR
  - PCMHs, if ↑ quality with ↓ or ↔ cost; ↓ cost with ↑ or ↔ quality (e.g., CPCI)
MIPS changes how Medicare links performance to payment

There are currently multiple individual quality and value programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

MACRA streamlines those programs into MIPS:

Merit-Based Incentive Payment System (MIPS)

What MIPS means for Medicare’s PQRS, Value-based Payment Modifier Program, and Meaningful Use …

PQRS, VBM, and MU no longer exist as stand-alone programs starting in 2019.

In fact ... 2016 is the FINAL reporting period for all of these programs as stand alones!

However, the infrastructure for these programs is expected to be used for MIPS beginning in 2017.

This is an opportunity to improve them all!
How will Physicians and Clinicians be Scored Under MIPS?

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:

- **Quality**: 30%
- **Resource Use**: 30%
- **Clinical practice improvement activities**: 15%
- **Meaningful use of certified EHR technology**: 15%

**MIPS Composite Performance Score**

NEW Clinical Practice Improvement Activities

The subcategories shall include at least the following:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an APM
Clinical Practice Improvement Activities—PCMH and PCMH Specialty Practices

- “Certified” PCMH and PCMH specialty practices receive highest potential score
- Key questions (to be answered via rulemaking):
  - What will be the role of existing PCMH and PCMH specialty practice accreditation and recognition programs?
  - Will CMS consider PCMH programs that are led by other payers, states, etc.?
How Much Can MIPS Adjust Payments?

- Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are budget neutral. A scaling factor may be applied to upward adjustments to make total upward and downward adjustments equal.

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral).

MAXIMUM Adjustments

4%  5%  7%  9%

2019  2020  2021  2022 onward

Merit-Based Incentive Payment System (MIPS)

Alternative Payment Models (APMs)

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

According to MACRA law, 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

- MACRA does not change how any particular APM rewards value.
- APM participants who are not “Qualified Participants” will receive favorable scoring under MIPS.
- Only some of these APMs will be eligible APMs.
- Over time, more APM options will become available.

Two basic “screens” for APMs

- Eligible APM:
  - The **most advanced** APMs that meet the following criteria according to the MACRA law:
    - **Base payment on quality** measures comparable to those in MIPS
    - Require use of certified EHR technology
    - Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

- Qualifying APM participants (i.e., qualifying participants or QPs):
  - Physicians and other clinicians who have a certain % of their patients or payments through an **eligible** APM
How does MACRA Provide Additional Rewards for Participation in APMs?

Most physicians and clinicians who participate in APMs will be subject to MIPS and will receive favorable scoring under the MIPS clinical practice improvement activities performance category.

Those who participate in the most advanced APMs may be determined to be qualifying APM participants (“QPs”). As a result, QPs:

1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019-2024
3. Receive a higher fee schedule update for 2026 and onward

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

Encourage new **APM options** for Medicare physicians and other clinicians.

<table>
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<tr>
<th>Submission of model proposals</th>
<th>Technical Advisory Committee (11 appointed care delivery experts)</th>
<th>Secretary comments on CMS website, CMS considers testing proposed model</th>
</tr>
</thead>
</table>

Review proposals, submit recommendations to HHS Secretary

How Will MACRA affect me?

Am I in an APM?

YES

Am I in an eligible APM?

YES

Do I have enough payments or patients through my eligible APM?

YES

Qualifying APM Participant

• 5% lump sum bonus payment 2019-024
• Higher fee schedule updates 2026+
• APM-specific rewards
• Excluded from MIPS

NO

Is this my first year in Medicare or am I below the low-volume threshold?

YES

Not subject to MIPS

• Subject to MIPS
• Favorable MIPS scoring
• APM-specific rewards

NO

Subject to MIPS

Bottom line: There are opportunities for financial incentives for participating in an APM even if you don’t become a QP

PCMH as an Alternative Payment Model in MACRA

Strict definition initially:

- PCMH as expanded under the CMS Innovation Center can be an eligible APM **without taking on financial risk**
  - i.e., the Comprehensive Primary Care (CPC) Initiative

  but ...

- There are lots of other PCMH programs across the country
  - Initially, they will fall under MIPS (but will score well there!)
  - However, over time this is expected to change
In other words, when it comes to doing well under MACRA . . .

A Patient Centered Medical
MIPS or APM? ACP plans to help members choose the right path

1. **Advocacy** so that whatever path you choose, it gets you to a destination of higher quality, more cost-effective care, without unnecessary obstacles, barriers, potholes, and detours along the way!

2. **Education & Resources** to help you succeed (e.g. Practice Advisor, Genesis Registry, PQRS Wizard, Timeline)

3. **Decision tool (?)** to guide you on which path to take, MIPS or APMs
Current and Evolving Products

- ACP online Running a Practice ([www.acponline.org/running_practice/](http://www.acponline.org/running_practice/))
- ACP Practice Advisor® ([www.practiceadvisor.org/](http://www.practiceadvisor.org/)) will be growing through ACP’s CMS Innovation Center Support & Alignment Network (SAN) grant
- Genesis Registry (for PQRS, MU, etc.)—QCDR ([www.medconcert.com/content/medconcert/Genesis/](http://www.medconcert.com/content/medconcert/Genesis/))
ACP’s CMMI Support & Alignment Network (SAN) Grant—New Opportunities

- Transforming Clinical Practice Initiative (TCPI) - Announced by the U.S. Department of Health and Human Services 9/29/2015
  - Practice Transformation Networks (PTN) 29
  - Support & Alignment Network (SAN) 10
    –ACP is one of these!!!

Objectives of ACP’s SAN Grant:

- Broad dissemination and provision of evidence-based practice transformation tools and information
- Development and dissemination of Transforming Clinical Practice Initiative (TCPI)-aligned modules on the ACP Practice Advisor®
- Evaluation of practice transformation tools and impact

Want to Join a Practice Transformation Network (PTN)?

Benefits:

• Developing core competencies in practice transformation AT NO COST
• Improved health outcomes and better coordination of care for patients
• Closer alignment with new federal policies and incentives
• Free CME credit and MOC points

You are likely eligible to participate if your practice uses a 2014 certified EHR and is NOT currently participating in one of the following:

• Medicare Shared Savings Program
• Pioneer ACO Program
• Comprehensive Primary Care Initiative
• Multi-Payer Advanced Primary Care Program

Contact the ACP at SAN@acponline.org and we will connect you with a network in your region.
Getting more *value* also means . . .

- Paying internists commensurate with your value in managing care of patients with multiple chronic diseases.
  - TCM, CCM, and Advance Care Planning codes are a good first step but more is needed!
- Senate Finance Committee: Bipartisan Chronic Care Working Group, co-chaired by Senators Johnny Isakson (R-GA) and Mark Warner (D-VA), sought ACP’s input in preparing a draft options paper
  - Most of ACP’s recommendations have been incorporated!
SFC’s Chronic Care Options Paper:
ACP’s recommendations include:

- Establish reimbursement and coverage of additional codes for chronic care management (CCM) services for patients who require more complex medical decision-making.
- Move chronic care management services to the preventive services category to eliminate any beneficiary cost-sharing.
- Better integrate care for behavioral health conditions into the primary care setting.
SFC’s Chronic Care Options Paper:
ACP’s recommendations include:

- Fill gaps in quality measures focusing on needs and outcomes, patient engagement, care coordination, population and prevention.
- Give more flexibility to ACOs to design packages of services for chronic care patients and remove co-payments for high value services.
- Eliminate geographic restrictions on use of telemedicine for strokes.
- Expand the Comprehensive Primary Care Initiative (PCMH pilot) to all eligible practices nationwide.
Health reform 2.0: Restraining prices

- Despite recent slowdown, (prices for physician services actually declined in 2015!), prices for healthcare services in U.S. are far higher than in other countries.
- Some sectors—especially pharmaceuticals—stand out.
- Insurer and provider mergers may further drive up prices—and spending.

“The historically low 1.1% growth in health care prices in 2015 was heavily influenced by physician prices, which actually fell by 1%; and more generally by economy-wide inflation, which, at 1.0% in 2015 (as measured by the gross domestic product deflator), barely exceeds the 0.8% rate seen in 2009, the last year of the recession.”

Unsustainable drug prices

Drugs With Big Price Hikes

Some brand medicines for heart problems, skin conditions, high blood pressure, parasite infections, and kidney issues have had enormous price spikes recently on a percentage basis.

- Percent price increase, December 2014 to January 2016

- Daraprim 25 mg
- Novacort
- Aicortin A
- Aloquin
- Lithostat 250 mg
- Zestril 5 mg
- Glumetza 1000 mg
- Isuprel 1 ml
- Tenormin 50 mg

Source: DRX, a unit of Connecture Inc.
Note: Price changes calculated from late December 2014 through January 15, 2016.
Most Say Costs Are Unreasonable And Prices Higher Than In Other Countries

In general, do you think the cost of prescription drugs is reasonable or unreasonable?

- Reasonable: 24%
- Unreasonable: 72%
- Don't know/Refused: 4%

In general, do you think people in this country pay higher or lower prices than people in Canada, Mexico, and Western Europe pay for the same prescription drug, or do you think they pay about the same amount?

- Pay higher prices: 74%
- Pay about the same amount: 12%
- Pay lower prices: 6%
- Dk/Ref.: 7%

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted August 6-11, 2015)
Monthly and Median Costs of Cancer Drugs at the Time of FDA Approval
1965 - 2014

100-fold price increase

Source: Peter B. Bach, MD, Memorial Sloan-Kettering Cancer Center
ACP advocacy on Rx drug pricing:

- Member of the Campaign for Sustainable Rx Pricing, [http://www.csrxp.org/](http://www.csrxp.org/) and new AMA Task Force
- New position paper coming soon!
Insurer and provider mergers

The Big Three?
Major proposed deals would leave three giants atop the U.S. health-insurance industry.

- **Aetna**
  - Projected 2015 Revenue: $115 Billion
  - Chief Executive Officer: Mark T. Bertolini
  - Combined membership: 33.5 Million
  - Headquarters: Hartford, Conn.
  - Strengths: Biggest player in Medicare Advantage

- **Anthem**
  - Projected 2015 Revenue: $117 Billion
  - Chief Executive Officer: Joseph Swedish
  - Combined membership: 53.2 Million
  - Headquarters: Indianapolis
  - Strengths: Biggest overall membership

- **UnitedHealth Group**
  - Projected 2015 Revenue: $154 Billion
  - Chief Executive Officer: Stephen Hemsley
  - Combined membership: 45.8 Million
  - Headquarters: Minnetonka, Minn.
  - Strengths: Largest annual revenue, fueled by growing Optum health-services arm

*As of March 31, 2015. †Assuming Anthem maintains CEO and headquarters.

Source: the companies

THE WALL STREET JOURNAL.
Insurer and provider mergers

- David Balto, former policy director at the FTC: 58 largest insurers and the largest hospital networks will go into joint agreements on pricing, all others will be subject to their will (which could be particularly damaging to providers outside of the 60 largest hospital networks and to consumers).

- A study of rates in state exchanges in 2014 and 2015
  - Showed that, on average, the largest insurance company in each state increased their rates by 75% more than the smaller insurers in the same state and the changes in these rates did not reflect higher medical cost per premium dollar.

Health reform 2.0: Achieving real e-health connectivity and functionality

- Make EHRs truly functional and useful for the clinician and the patient.
- Improve Meaningful Use 2, pause MU 3 implementation
- Achieve true interoperability.
- Enable reporting of measures through EHRs.
- Ensure that the purpose of clinical documentation is to help physicians deliver better care.
- Use telemedicine to improve access in a way that supports the patient-physician relationship.
MU Stage 2 Modifications – finally final, but not ideal in terms of timing ...

Key ACP asks...

90-Day Reporting Period for 2015

DONE!

But, it came late* and we now need to work on this change for 2016 (when full year reporting is required).

Stage 2 Objective for Patient Electronic Access, measure #2 – change threshold from 5% to “equal or greater than 1”

DONE!

This change applies to 2015 and 2016! Need to work on fixing it for 2017.

Stage 2 Objective for Secure Electronic Messaging – the threshold changed from % of patients to be a yes/no response

DONE!

Fixed for 2015, but changes to at least 1 patient in 2016 & 5% in 2017. Not ideal.

* However, there is now a hardship exemption for 2015!
New Hardship Exemption for MU 2015 Reporting…

- As a result of Patient Access and Medicare Protection Act (PAMPA), enacted December 28, 2015 – CMS issued a streamlined MU hardship exception application and guidance for EPs on how to apply.

- The deadline for applying for a hardship exception for the 2015 MU reporting period and 2017 payment adjustments is March 15, 2016.

ACP’s Stage 3 Comments ... it needs to be a bold new world!

- We believe that CMS has a golden opportunity for a MU “do-over”
  - MU should aim to fill in key gaps and/or strive to incent optimization of value from health IT (based on specialty and setting of care).
  - **MU measures should not be burdensome**, and should be built into existing or emerging workflows, such that as care is provided, process or activity measurements can be auto-generated.
    - No measure thresholds!!!!
    - We can learn from all the data submitted.
- In fact, MU must permit and even encourage flexibility and innovation!
- CMS and ONC must collaborate with physicians to determine the key tasks that physicians and staff will need to perform better to improve care—and help facilitate health IT education.

CMS is Listening…

In 2016, MU as it has existed-- with MACRA-- will now be effectively over and replaced with something better #JPM16

— Andy Slavitt (@ASlavitt) January 12, 2016


And ACP is not stopping with that...

• Comments on the EHR Certification and Reporting of Electronic Clinical Quality Measures

www.acponline.org/acp_policy/letters/acp_comments_cms_certification_frequency_rfi_2016.pdf
Health reform 2.0: *Simplifying health care*

- Making EHRs work for you and your patients!
- Simplify health insurance interactions: pre-authorization, claims review and denials, coding, and documentation.
- Reduce, simplify, harmonize and improve measures.
- Link value-based payment to easing of intrusive review/approval requirements.
- Share work and leadership within *dynamic* clinical care teams.
<table>
<thead>
<tr>
<th></th>
<th>Hours per week</th>
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<tr>
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<td>PCP vs. medical specialist</td>
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<td><strong>Lawyer/accountant</strong></td>
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<tr>
<td>Primary care</td>
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<tr>
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<td>3.0</td>
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<tr>
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<td>0.7</td>
<td>1.8</td>
<td>5.3</td>
<td>2.1</td>
<td>0.29</td>
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</table>

1–2 vs 3–9 vs 1–2 vs
### EXHIBIT 3
Mean Dollar Value of Hours Spent Per Physician Per Year For All Types Of Interactions, By Practice Specialty And Size, 2006

<table>
<thead>
<tr>
<th></th>
<th>1–2 MDs</th>
<th>3–9 MDs</th>
<th>10+ MDs</th>
<th>Weighted mean</th>
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<tbody>
<tr>
<td><strong>Total per practice</strong></td>
<td></td>
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</tr>
<tr>
<td>Primary care</td>
<td>$72,675</td>
<td>$63,611</td>
<td>$57,480</td>
<td>$64,859</td>
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<td>70,788</td>
<td>87,566</td>
<td>78,553</td>
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<tr>
<td>Surgical specialty</td>
<td>61,187</td>
<td>76,429</td>
<td>59,866</td>
<td>66,954</td>
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<tr>
<td><strong>Physician time</strong></td>
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<td></td>
</tr>
<tr>
<td>PCPs</td>
<td>16,864</td>
<td>12,858</td>
<td>11,118</td>
<td>13,691</td>
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<tr>
<td>Medical specialists</td>
<td>23,083</td>
<td>20,850</td>
<td>18,014</td>
<td>20,497</td>
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<tr>
<td>Surgical specialists</td>
<td>15,197</td>
<td>18,091</td>
<td>16,814</td>
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<tr>
<td><strong>Nursing staff time</strong></td>
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<tr>
<td>Primary care</td>
<td>16,079</td>
<td>25,142</td>
<td>25,518</td>
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<td>29,000</td>
<td>24,731</td>
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<td>20,426</td>
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<tr>
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</tr>
<tr>
<td>Primary care</td>
<td>31,666</td>
<td>21,833</td>
<td>17,918</td>
<td>23,980</td>
</tr>
<tr>
<td>Medical specialist</td>
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<td>32,411</td>
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<tr>
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<td>29,118</td>
<td>19,180</td>
<td>26,650</td>
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<tr>
<td><strong>Senior administrative time</strong></td>
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</tr>
<tr>
<td>Primary care</td>
<td>6,299</td>
<td>3,474</td>
<td>991</td>
<td>3,697</td>
</tr>
<tr>
<td>Medical specialist</td>
<td>5,939</td>
<td>3,705</td>
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<tr>
<td><strong>Lawyer/accountant time</strong></td>
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<tr>
<td>Primary care</td>
<td>1,767</td>
<td>304</td>
<td>1,835</td>
<td>1,237</td>
</tr>
<tr>
<td>Medical specialist</td>
<td>892</td>
<td>1,800</td>
<td>14,515</td>
<td>6,192</td>
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<tr>
<td>Surgical specialist</td>
<td>219</td>
<td>531</td>
<td>1,582</td>
<td>618</td>
</tr>
<tr>
<td><strong>All practices</strong></td>
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<td></td>
</tr>
<tr>
<td>MD</td>
<td>17,817  (1,024)</td>
<td>15,670 (1,380)</td>
<td>13,798 (1,593)</td>
<td>15,767 (769)</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>14,897 (745)</td>
<td>25,225 (2,121)</td>
<td>24,314 (3,402)</td>
<td>21,795 (1,279)</td>
</tr>
<tr>
<td>Clerical staff</td>
<td>30,014 (1,639)</td>
<td>25,632 (2,004)</td>
<td>18,636 (2,461)</td>
<td>25,040 (1,168)</td>
</tr>
<tr>
<td>Senior administrative</td>
<td>5,829 (694)</td>
<td>3,269 (405)</td>
<td>1,235 (196)</td>
<td>3,522 (287)</td>
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<tr>
<td>Lawyer/accountant</td>
<td>1,249 (694)</td>
<td>626 (194)</td>
<td>4,455 (3,851)</td>
<td>2,149 (999)</td>
</tr>
<tr>
<td><strong>Total per practice cost</strong></td>
<td>69,805 (2,954)</td>
<td>71,422 (4,860)</td>
<td>62,438 (7,262)</td>
<td>68,274 (2,394)</td>
</tr>
</tbody>
</table>

We need dynamic teams to share workload and expertise, but not like *this*!
Patients Before Paperwork

An ACP Initiative to reinvigorate the patient-physician relationship by challenging unnecessary practice burdens.

ACP has long identified reducing administrative complexities or burdens as a priority. Actions taken to achieve this goal have included developing and maintaining related policy, participating in various efforts to work to alleviate specific regulatory and insurance requirements, and eliminating other unessential tasks that detract from patient care and contribute to physician "burn-out." However, we are now working to develop an evidence-based, comprehensive approach to better address the top priority administrative complexities that are faced by ACP members.

ACP Strategies for This Initiative

- Identify and prioritize which complexities are of the top concern for ACP members and their patients.
- Educate ACP members, other physicians, consumer advocates, and policy makers on what makes up administrative complexities, including the intent of the requirement and how the complexity impacts patients and physicians.
- Implement the most effective advocacy, stakeholder engagement, and practice support approaches to help mitigate or eliminate the top priority complexities and to help ACP members (and other physicians) address those complexities that cannot be eliminated.
- Achieve results that reduce physician burn-out, help restore the joy of practice, and reinvigorate the patient-physician relationship.

Top Priorities for ACP Members

- Electronic Health Record Usability
- Quality Reporting
- Dealing with Insurance Companies

What ACP Is Doing

Policy Development and Education


learn more at: https://www.acponline.org/advocacy/where_we_stand/patients_before_paperwork/
So, what can **you** do to be part of Health Reform 2.0?

- **Become informed** about the issues—including what the candidates propose.
  - ACP’s election guide
    - [https://www.acponline.org/advocacy/where_we_stand/election_2016/](https://www.acponline.org/advocacy/where_we_stand/election_2016/)
  - Follow me on twitter @BobdohertyACP and read my blog, [http://advocacyblog.acponline.org/](http://advocacyblog.acponline.org/)

- **Prepare** your practice for MACRA success, using ACP resources.


- **Spread the word** about ACP advocacy to members and non-members alike.
In sum, help us, help you, as ACP seeks to influence Health Reform 2.0 so it results in:

- Continued gains in getting people covered
- In health plans that are affordable
- In a health care system that produces greater value
- With payment and delivery system reforms that recognize the unique value provided by internal medicine specialists
- With more transparent and sustainable prices for services, including medications
ACP advocacy on Health reform 2.0 (continued)

- In competitive insurance markets that do not allow payers to dictate prices, contracts and clinical decision-making
- With functional, useful, and interoperable health care technologies, including EHRs and telemedicine, that support rather than undermine the patient-physician relationship
- In a *simplified* system that puts your Patients before Paperwork!
“The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise with the occasion. As our case is new, so we must think anew and act anew.”

Abraham Lincoln, Annual Message to Congress, December 1, 1862