Michigan Talking Points
2018 AMA National Advocacy Conference

TIER I ISSUES

BUDGET:

Early Friday (2/9) morning the President signed a FY2018 spending bill that delays another government shut-down until March 23rd. Several Medicare and other health related provisions received favorable action. More details are below.

Misvalued Codes

Previous versions of the Continuing Resolution contained harmful language extending the misvalued code offset. The original policy was mandated by the 2014 Protecting Access to Medicare Act (PAMA), which the AMA opposed. The legislated policy sets targets to reduce Medicare spending on so-called misvalued or overvalued codes, and then reduces payments in the Medicare fee schedule if the targets are not met. Had the current misvalued code process been extended for 2019, it would have resulted in the elimination of virtually all of the currently scheduled Medicare physician payment update.

The compromise was to reduce the physician fee update in lieu of extending the misvalued codes. As a result, the Physician Fee Schedule conversion factor for 2019 is reduced from 0.5 percent to 0.25 percent.

- Oppose any future consideration of continuing the misvalued code offset.

- Fails to recognize the eight years of work that had already been done on this issue and how there are no longer enough misvalued services left to review and revalue to meet the targets.

- Although we would have preferred not to have a reduction to the Physician Fee Schedule, there is recognition that were other provisions included that benefit physicians and their patients.

MACRA Fixes

The legislation included technical corrections to the Medicare Access and CHIP Reauthorization Act (MACRA) that were sought by the AMA and other physician organizations including. Under the agreement, Medicare Part B drug costs will be excluded from payment adjustments under MACRA's Merit-based Incentive Payment System (MIPS) and from low-volume threshold determinations. There will be greater flexibility in scoring and in the weight given to the Cost component of MIPS for an additional three years. The Centers for Medicare and Medicaid Services will also have more flexibility in setting overall performance thresholds for three more years. Finally, the Physician Focused Payment Model Technical Advisory Committee's authority has been clarified so that it can provide more helpful feedback on proposed alternative payment models.

- The physician community is supportive of these fixes.

- The cost provision was particularly important because there still is not consensus on how to fairly and accurately attribute costs. Physicians are concerned that they will be penalized for costs for which they have no ability to control.

- Providing CMS with additional flexibility is key to the successful evolvement of the Quality Payment Program.

Community Health Centers

- Funding for community health centers is reauthorized for two years at a level of $3.8 billion for FY 2018 and $4 billion for FY 2019.

Other Provisions of Interest to Physicians

- The Independent Payment Advisory Board was permanently repealed.

- The Children's Health Insurance Program (CHIP) was extended for an additional four years beyond the previous Continuing Resolution's six-year extension, with appropriations made through 2027.

- The work Geographic Practice Cost Index floor was extended for two additional years through January 1, 2020.

- The statutory requirement for electronic health record standards to become more stringent over time was eliminated. This eases the burden on physicians as they would no longer have to submit and receive a hardship exception from HHS.

- Two-year extensions were provided for the National Health Service Corps, Community Health Centers and the Teaching Health Centers Graduate Medical Education program.

    - Funding for the National Health Service Corps is extended at the FY 2015 – 2017 annual level of $310 million for two additional years.

    - Funding for Teaching Health Center Graduate Medical Education is extended for two years at an annual level of $126.5 million, more than doubling the current annual funding for this program.

- Medicare payment cap for therapy services. Permanently repeals the outpatient therapy caps beginning on Jan. 1, 2018

- Closes the Medicare Part D prescription drug "donut hole" sooner than under current law by increasing the discounted price manufacturers provide from 50 percent to 70 percent.

- Emergency Medicaid funding was provided for Puerto Rico and the U.S. Virgin Islands. Puerto Rico's Medicaid caps for 2018 – 2019 are increased by an additional $4.8 billion. The Virgin Islands' caps are increased over the same time period by $142.5 million. Also, 100 percent federal cost sharing for Medicaid is provided for both territories through September 30, 2019.

Although not included in this budget fix, there is agreement to include $6 billion in funding for the opioid crisis and mental health in the Omnibus before the March 23 deadline.

MEDICARE PHYSICIAN PAYMENT REFORM

Medicare and other insurers are making significant changes in physician payment systems by moving away from the traditional fee-for-service (FFS) model to either a modified FFS model or alternative payment models (i.e., ACOs, bundled payments, etc.) that focus more on outcomes than number of services provided. This transition requires an investment in infrastructure and time as physicians and others on the health care team develop core capabilities. While the repeal of the sustainable growth rate was much appreciated, it's replacement by MACRA's Quality Payment Program has caused some angst due to the regulations' complexities.

- Physicians support coordinated, high-value care and have always strived to deliver on that goal.
- Michigan has been a leader in Patient-Centered Medical Home and PCMH-Neighbor adoption, transformation, and physician-led quality improvement activities.
- Efforts to streamline existing legacy reporting programs are moving in the right direction.
- New policies intended to ease burdens for small practices are appreciated.
- Further changes are needed to support improvements in care rather than simply add new administrative burdens.
- Many are frustrated with the perceived complexity of the QPP and focus on checking off tasks versus "hands on" patient care.
- Congress and CMS should explore opportunities to reward and cultivate local efforts to improve care delivery and population health that are consistent with the QPPs overall mission.

MEDICAID EXPANSION

Like many other expansion states, Michigan Medicaid enrollment has surpassed expectations. As of February 5, 2018, Michigan's Medicaid expansion program, the Healthy Michigan Plan (HMP), had 673,275 beneficiaries enrolled.

The HMP was approved by the Michigan Legislature in September of 2013. Michigan's Section 1115 Demonstration Waiver was approved by HHS in December 2013 to mandatorily enroll adults with incomes up to 133 percent FPL into the existing managed care delivery system. The waiver was amended in 2015.

Under the initial waiver, beneficiaries with incomes above the FPL were expected to pay premium amounts up to two percent of income and pay co-payment amounts up to five percent of income. The Michigan waiver was notable because it was the first to require beneficiaries to contribute cost-sharing amounts to HSAs. However, premiums and co-payments can be reduced by the completion of a health risk assessment, which includes the selection of healthy behaviors and wellness activities by the beneficiary.

The managed care plans cover all benefits in the state's Alternative Benefit Plan. HHS approved an amended waiver in December 2 015. The amended waiver reflects state legislation passed in 2013 to require individuals enrolled in Healthy Michigan for 48 cumulative months to either enroll in a Qualified

Health Plan on the Marketplace using premium assistance or stay in Healthy Michigan with cost -sharing that could total seven percent of income. However, the seven percent cost -sharing will be reduced for beneficiaries that participate in wellness activities, which are mandatory. All beneficiaries, except the medically frail, with incomes above the poverty level must work with their physicians on certain wellness goals or enroll in a Qualified Health Plan. Thus, few, if any, beneficiaries will face cost-sharing amounts in excess of five percent of income.

- Protect the health and wellness gains made through the extension of Medicaid, especially to those who now have health care coverage for the first time.

- Support maintenance of federal funding for Medicaid expansion populations beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

- Retain the ACA's Medicaid expansion option.

MEDICAID FUNDING

Medicaid is a vital safety net program that helps ensure the most vulnerable patients are able to access needed health care services. Several of the talking points below are based on quotes from Doctor Madara:

- States must be able to react to economically driven changes in enrollment, as well as increased health care needs driven by external factors, including natural disasters, epidemics, or break-through treatments for serious medical conditions, such as hepatitis C.

- State flexibility in the Medicaid programs is critical so that states may pursue innovations that improve care for patients with low incomes in ways that best meet each state's unique needs

- Changes to the program, however, such as through per-capita caps or block grants, will likely limit the ability of states to respond to increased demand for certain services and force states to limit coverage and increase the number of uninsured.

- Changes to the financing of Medicaid must guarantee it maintains its indispensable role as a dependable safety net able to respond quickly to changing circumstances.

- Any new Medicaid proposals must also ensure that quality coverage remains available and affordable for Medicaid beneficiaries.

- When discussing Medicaid reform, it is imperative that states that chose to accept enhanced federal funding for Medicaid expansion not be disadvantaged for their efforts to improve and maintain the health of their citizens.

- Need to maintain the strength of safety net program's like Medicaid and the Children's Health Insurance Program (CHIP).

- Medicaid must be adequately funded and ensure physician payment rates are sufficient to ensure meaningful access to care.

PRIOR AUTHORIZATION

Prior authorization is often inefficient, lacks transparency and comes between patients and the care they need. This costs practices time and money. Also, it may have negative consequences for patient outcomes when treatment is delayed.

A December 2016 AMA survey measured the burden created by PA requests and the impact on timely patient care. Supported by this data, the AMA and 16 other health care and patient associations released a set of 21 principles in January 2017 to guide reform of PA and utilization-management requirements. The 21 principles were divided among five broad categories:

1. Clinical validity. UM criteria need to be based on up-to-date clinical criteria and never cost alone.
2. Continuity of care. PA requirements must not disrupt patients' care.
3. Transparency and fairness. All coverage restrictions need to be fully disclosed to the public in a searchable, electronic format, and denials must include detailed explanations.
4. Timely access and administrative efficiency. There must be a maximum response-time limit for UM decisions, and health plans must accept standardized electronic processing of PA requests.
5. Alternatives and exemptions. Health plans should offer alternative, less burdensome approaches to resource management than PA.

The AMA recently partnered with the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens.

- Physicians complete an average of 37 prior authorizations per week, spending the equivalent of two business days (16 hours), to receive approvals from health insurance companies and pharmacy benefit managers (PBMs). This equates to an annual burden of 853 hours (per the AMA's Web-based survey of 1,000 practicing physicians).

- Physicians lack insight on the criteria used to make coverage decisions, so they rarely know what services need prior authorization at the point-of-care and only find out later when a patient's access is denied.

- Ninety percent of physicians say prior authorization sometimes, often, or always delays access to care.

- Prior authorization is more than an administrative nightmare; it's a barrier to providing timely, patient-centered care.

- Research shows 40% of prescriptions requiring prior authorization are abandoned.

- Prior authorization programs and processes need to be 'right-sized.'

OPIOID TREATMENT

Opioid misuse, addiction, overdose and death have become an epidemic in America. In fact, over the past 15 years, the nation's opioid epidemic has claimed more than 250,000 lives, according to data from

the Centers for Disease Control and Prevention (CDC). In the last year alone, nearly 30,000 Americans died from opioid overdoses. Strategies to address this crisis must be mindful of the need to address trends related to deaths from prescription painkillers while protecting physicians' ability to care for patients with pain and/or addiction.

Adequate funding is needed to ensure Congress' passage of the Comprehensive Addiction and Recovery Act (CARA) succeeds in helping the thousands of Americans who are caught in the web of opioid addiction as well as allocating additional resources for treatment and prevention programs. CARA increases coverage for-and access to-comprehensive treatment for opioid use disorder, includes medication-assisted treatment; increases access to overdose prevention measures, such as naloxone; and expands Good Samaritan protections. It will be important to ensure that the agreement to include $6 billion in funding for the opioid crisis and mental health in the Omnibus before the March 23 deadline is honored.

- The root causes for the opioid epidemic are complex and multifactorial and require a multi-pronged approach that is inclusive of health professional, payer, law enforcement, judicial, and community action.

- It is imperative to shrink supply and demand for both prescription opioids and heroin/fentanyl analogues. Focusing only on prescription opioids without simultaneously addressing "heroin and fentanyl trafficking" will dramatically shrink probability of success.

- Policies must ensure that patients with chronic pain and/or addiction aren't abandoned and forced to self-medicate.

- Improve access to addiction treatment before abruptly restricting supply.

- Address diversion so that medication is used for its intended purpose.

- Bolster work force and infrastructure to ensure access to care for those who suffer from opioid tolerance and addiction to ensure access to legitimate pain management providers as well as SUD treatment and recovery.

- Full funding is needed for up-to-date, interoperable, at the point-of-care prescription drug monitoring programs that are integrated into a physician's workflow.

- Support for a national framework to support accessible community-level take-back locations to remove unneeded prescription drugs including controlled substances from the household.

- Voluntary physician education programs on safe prescribing practices that are tailored to meet a physician's practice/patient population needs.

- Enable enforcement actions to halt "pill mill" activities and rogue online pharmacies.

TEIR II ISSUES

ELECTRONIC HEALTH RECORDS

Medicine is early in its digital journey. Unfortunately, previous and current regulations on the use of electronic health record systems (EHRs) have fallen short and may have even delayed the transformation process. Physicians are concerned that they are spending more time on computers which results in less one-on-one time with patients, increased patient wait times, and often a monetary loss for little perceived value.

It has been reported that physicians will lose $43,000 on average over a five-year period complying with MU requirements. Additionally, one study found that ER doctors were spending 43% of their time on data entry and roughly 28% with patients.

Recent action by Congress to reduce EHR burdens, prevent EHR vendors from data blocking and require EHR vendors to be transparent about fees is well-intended and necessary. However, issues pertaining to vendor accountability, data blocking, lack of required certification, and lack of interoperability continue. Many physicians have been stuck with EHRs whose vendors have chosen not to upgrade to 2014 or 2105 Edition Certified Electronic Health Record Technology; thereby, making physicians ineligible for participating in Medicare's EHR quality initiatives unless they are willing to make a significant investment in another EHR product. When physicians try to switch vendors, many are being held "hostage" with exorbitant fees to obtain their data. And, the recent Allscripts ransomware attack is an example of the disregard vendors have for the obligations physicians have to their patients and to following laws such as HIPAA.

- Each weekday, physicians spent an average of 5.9 hours out of an 11.4-hour workday working in the EHR. That consisted of 4.5 hours during clinic times and 1.4 hours after work. Clerical and administrative tasks such as documentation, order entry, billing and coding and system security, accounted for 44 percent of the total EHR usage time. About one-third of the time was spent on medical care EHR tasks such as chart reviews and problem lists, while inbox management took up 24 percent of family physicians' time.

- "Work previously done by other team members has been shifted to the physician in the EHR," said Dr. Sinsky, who is the vice president of professional satisfaction at the AMA and practices at the Medical Associates Clinic and Health Plans in Dubuque, Iowa.

- "Tasks that may have earlier required a matter of seconds, now may each take one to two minutes. Add this up over the thousands of individual tasks each day and it wasn't surprising that I and other physicians began to wonder if we were spending more time caring for the computer than caring for the patient."

- Especially concerning, Dr. Sinsky said, is the 86 minutes family physicians spend doing administrative work after hours or at home, which she has dubbed "pajama time" with the EHR.

- The physicians surveyed for the AMA study expressed concern that current technology requires physicians to spend too much time on clerical work, putting up barriers to providing high-quality care. The AMA study also revealed that EHRs were costlier than anticipated and didn't provide the technology needed to interact with other systems, causing difficulties in transmitting patient information.

- Moving forward, it is critical that the physician voice is brought to innovators and entrepreneurs to ensure new digital health solutions facilitate effective care and relationships between patients and physicians.

- Overarching goals include enhancing patient-centered care, improving health outcomes and accelerating progress in health care.

Eight key insights physicians shared through the AmericanEHR survey:

- Many physicians feel their EHRs have had a negative impact on costs, efficiency and productivity. Close to one-half of respondents reported negative effects on total operating costs and said they had yet to overcome productivity challenges. Nearly three-quarters reported negative impacts on the ability of the EHR to decrease their workload.

- Even though more physicians are using EHRs, the overall satisfaction with these systems has declined. In a similar survey administered five years ago, the majority of respondents reported that they were satisfied with their EHR. Now, more than one-half say they are dissatisfied. According to the survey, only about one-third said they were satisfied or very satisfied with their system.

- Physicians' assessment of EHR ease of use is declining. In almost all cases where comparative data was available, fewer respondents reported that specific functionality was easy or very easy to use or that it had a positive effect on their practice.

- Physicians have to address the additional workload that EHRs impose. Some practices are employing scribes to address the increased data entry requirements—nearly one-quarter of respondents said they already employed scribes or were planning to do so.

- Documenting a progress note for encounters is becoming more difficult. The number of physicians reporting that it was easy or very easy to document a progress note decreased from 64 percent of respondents last year to 46 percent of respondents this year. Meanwhile, just over one-third of respondents said they found it difficult or very difficult to document a progress note, up from about one-quarter last year.

- The most significant positive impact of EHRs is on the time spent processing prescriptions and refills. Most respondents were positive or neutral on the amount of time it takes for their staff to process prescriptions and refills with the EHR. Less than one-third were negative about this aspect.

- Total practice operating costs stay the same or increase after EHR deployment. Slightly more than one-half of respondents said total practice operating costs increased, and 20 percent reported that total practice operating costs remained the same.

- The longer a respondent used their EHR system, the more likely they were to report it had a positive impact. In most cases, it appears to take at least three years for respondents to overcome initial challenges and experience any benefits their EHR system may offer. Still, more than one-half reported that they still had issues.

TIER III ISSUES

PREVENTING TYPE 2 DIABETES IN MICHIGAN

MSMS continues to be a key stakeholder in the work to create awareness around pre-diabetes. The Prevent Diabetes STAT: Michigan campaign began in May 2015. MSMS is in the second year of grant funding to continue work on this project. The funding comes from the National Association of Chronic Disease Directors (NACDD), through partnerships with the Centers for Disease Control (CDC) and the AMA, and is dedicated to continuing Michigan's important work on pre-diabetes.

- Identifying best practices around diagnosis and treatment of pre-diabetes - - specifically, how to screen, test and refer patients to a CDC recognized lifestyle change program.

- Working with physician organizations and their practices to follow their programs and document their processes.

- Sharing findings in a white paper for the NACDD and CDC to assist other organizations in rolling out the program to their members.

- Partnering with the Michigan Department of Health and Human Services on the State Diabetes Action Plan.

- Seeking to engage the payers in the state to expand coverage for the program.

- Supporting CMS's decision to include CDC's National Diabetes Prevention Program as a covered benefit for its Medicare beneficiaries in 2018.

- CDC's National Diabetes Prevention Program has been proven to reduce the risk of patients at risk for developing Type 2 Diabetes by over 50%.

- Statistics show that over 86 million people have prediabetes, and currently do not know about it, or do not have a plan to address it.

- The focus on prevention will ultimately lower the rate of patients developing Type 2 diabetes, which will decrease the burden on the health care system, and ultimately lower health care costs.

PHYSICIAN IMPACT ON THE ECONOMY

Physicians play "a vital role in the state and local economies by creating jobs, purchasing goods and services, and supporting state and community public programs through generated tax revenues," according to the AMA's latest physician economic impact study.

When clinical and administrative staffers work alongside physicians, they are often in positions that are stable, pay well and are immune to being shipped overseas. Overall, the research found physicians, nationally, are directly and indirectly responsible for a $2.3 trillion contribution to the nation's economy and the support for nearly 12.6 million jobs. But the greatest value of the report is that it details those contributions down to the state level, where many government decisions are made about the day-to-day practice of medicine, including Medicaid funding and medical liability reform. Key findings include:

- Physicians, at $2.3 trillion nationally, directly and indirectly produced value three times the $724.8 billion of the legal services industry, followed by nursing and community care facilities ($485.6 billion), higher education ($415.1 billion) and home health ($225.9 billion).

- Nationally, at 12.6 million jobs, physician-supported employment ran far ahead of its nearest comparator industry, nursing and community care facilities (4.4 million jobs), followed by legal services (4.1 million jobs), higher education (2.8 million jobs) and home health industries (2.6 million jobs).

- Overall, physicians supported $1 billion in wages and benefits.

- In Michigan, each doll in direct output applied to physician services supports $2.03 in economic activity.