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MEDICAL SOCIETY OF THE STATE OF NEW YORK
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To: *MSSNY Board of Trustees*
MSSNY Council

From: *Philip A. Schuh, CPA, MS*
Executive Vice President

Date: *June 15, 2017*

Subject: ***Meeting – Coalition of State Medical Societies***

During the course of the annual AMA meeting, a meeting of the Coalition of State Medical Societies was held on Sunday, June 11, 2017.

The Coalition is made up of representatives (Chief Executive Officer and Physician Leadership) from ten states: New York, Florida, California, Texas, North Carolina, South Carolina, Oklahoma, Nevada, Arizona and Louisiana.

The purpose of this meeting was to discuss and hopefully agree on a strategy for moving forward with legislative discussions on those issues that were most important to participating states and their physicians. Lou Goodman, the Exec from Texas distributed the attached, which formed the basis for the discussions.

It was agreed that both administrative relief should be sought through CMS utilizing the Coalition's ability to access Dr. Price, and through intensive lobbying efforts by Coalition members.

A discussion took place as to the various items listed on the attachment. It was agreed that each State would identify the top four (4) issues that they wanted to focus on and these would all be put together into a more streamlined document.

The Coalition will attempt to schedule a day's visit to the Hill, hopefully before the Fourth of July weekend and will utilize this revised document as the basis for the regulatory ask.

PAS/sr
Coalition Mtg. @ AMA

Health Care Reforms – Physician Perspective

As Congress works on repeal or revision of the Affordable Care Act, its primary goal should be to increase consumer access to medical care. This goal can be facilitated by reforms that:

- Allow patients a broad choice of physicians, plans, and coverage;
- Improve access to physicians;
- Continue or replace tax policies and subsidies that help low- and moderate-income patients afford health care services;
- Improve and stabilize the individual insurance market; and
- Allow each state to choose the best Medicaid options for its residents.

Congressional efforts to meet these complex goals likely will include some combination of subsidies and government programs. The impact of these efforts can be greatly enhanced by reforms that remove obstacles to efficient and effective services, or reduce the cost of providing medical care. Administrative costs in the U.S. private and public health care system consume an estimated $361 billion annually — 14 percent of all health care expenditures. Insurers and government health coverage require physicians' practices to adhere to many complex program rules and policies. The U.S. Department of Labor's Bureau of Labor Statistics reports that in 2011, physicians and health care providers employed more billing and posting clerks than any other industry. Increasing access to physician services can reduce the total cost of health care by encouraging the use of good, cost-effective outpatient care and thus decreasing the use of higher-cost emergency or inpatient services. Some legislative changes that can accomplish these goals include:

Changes That Will Reduce Cost and Improve Physician Office Operating Efficiency:

- **Allow physicians to decide whether EHR use is the best fit for their practice**. Federal requirements or incentives and penalties for electronic health record (EHR) use are based on the assumption that the potential value of EHRs is the same for all specialties and all settings of care. Although many physician practices have acquired EHR systems that do enhance the efficiency or effectiveness of their medical practices, many have found that the available systems do not fit their specialty or their practice setting. Because system design enhancements are now focused on satisfying government requirements rather than user needs, the federal intervention in this marketplace has actually slowed the expected product improvement cycle. EHRs designed to meet government objectives often add features like functional-use-measure checkboxes, which are duplicative processes unrelated to the necessary record of clinical care, decreasing usability and user satisfaction. If Congress wishes to regulate the performance of EHR products, standards should be imposed directly on software vendors, not levied indirectly through physician payments. An AMA-RAND study showed that EHRs are a primary source of decreasing practice efficiency and professional satisfaction. Physicians see the value and potential of EHRs, but product capabilities need development based on input from medicine and on physicians' clinical and

documentation needs. A 2016 study in the *Annals of Internal Medicine* found that physicians spend just 27 percent of their office time seeing patients, while they must devote 49 percent of that time with their EHRs and doing other paperwork. Although the original motive expressed for government incentives in this arena was the expectation that EHR use would eliminate errors, experience has proven that EHRs reduce some types of errors but create new risks for errors of different types. Furthermore, researchers at Harvard Medical School and Brigham Women's Hospital found no consistent difference in quality measures between physicians who reported "meaningful use" and those who did not. The net impact of an EHR on quality, on errors, and on cost and efficiency depends on the specific physician, his or her practice setting, specialty, and practice variables like available staff support. Rewards and penalties should be based on results, not on the use specific technologies. We should remove all federal requirements or penalties for EHRs and allow physicians to decide which tools and methods produce the best results in their specific circumstances.

- **Remove the prohibition on physician ownership of hospitals.** There is no justification for prohibiting physicians from owning and controlling hospitals while allowing hospital administrators to employ and control physicians. Physicians are professionally and ethically bound to serve the best interest of their patients. Hospital administrators are not. Patient interests are far better served by allowing physicians to exercise control over the facilities in which patient care is delivered. Texas physicians who practice in some of the existing, grandfathered, physician-owned hospitals report better working relationships in solving patient safety issues. Physicians who have ownership in hospitals or ambulatory surgical centers (ASCs) report enhanced practice efficiency, presumably because of improvements in scheduling, staffing, and communications. Seven of the top 10 hospitals receiving quality bonuses in the Hospital Value-Based Purchasing Program in 2015 were physician-owned hospitals, and an analysis by Avalon Health Economics concluded that physician-owned hospitals are saving Medicare $3.2 billion over 10 years. The prohibitions on hospital ownership should be removed immediately.

- **Ease HIPAA compliance requirements.** The Department of Health and Human Services estimates it will take 32.8 million hours for people in the U.S. interacting with health care to comply with HIPAA. More than 30 million hours will be devoted to the dissemination to patients and their acknowledgement of HIPAA notices of privacy practices for PHI. A wasteful time sink is the estimated 350,000 hours it will take 300,000 organizations to comply with "Documentation of Security Rule Policies and Procedures and Administrative Safeguards" for business associates of HIPAA-covered entities. Congress should eliminate the requirements for detailed tracking of disclosures for treatment and payment. Physicians have always protected patient privacy as part of their professional and ethical standards, and it should be possible to continue those protections without excessive paperwork requirements.

- **Remove the prohibition on physician joint ownership of clinical labs.** Although large physician groups are permitted to operate their own clinical laboratories, small practices are currently prohibited from investing in a shared laboratory. One shared lab among a group of

independent practices can be far more efficient than multiple small in-office labs, allowing small practices to offer a wider array of testing to patients in a convenient location. Physicians who refer to a lab where they have ownership interest always should disclose this relationship and offer patients the right to be tested elsewhere, but shared ownership should not be prohibited. Eliminating the restrictions on lab ownership can reduce cost due to economies of scale while also improving access and convenience for patients.

- **Remove Clinical Laboratory Improvement Act certification requirements for physicians who use waived tests or physician-performed microscopy**. Federal regulation requires all physicians who do specimen testing to purchase a federal CLIA permit, renew it every two years, and meet a wide range of personnel, documentation, and reporting standards, even when the tests performed in the physician's office use the same test kits that patients can purchase over the counter in grocery and drug stores (e.g. pregnancy test kits). Furthermore, in certain specialties, physician use of microscopes to examine specimens is an integral part of medical training and practice, subject to the licensing standards and liability risks faced by any practicing physician. In regulating the operations of physician offices, CLIA has always been a "solution" without a problem, as the problems of concern that had been reported had occurred in large reference labs.

- **Reduce Occupational Safety and Health Administration requirements on medical offices.** OSHA requires inefficient business practices such as:
    - Requiring on site written copies of detailed information on commonly used substances such as alcohol, disinfectants, anesthetics, and sterilants; or
    - Requiring annual plan updates and annual training for employees, even in the absence of changes to the practice operations or risks.

- **Enact federal liability reforms modeled after Texas' success.** Implementing caps on noneconomic damages and other measures have dramatically reduced the large burdens of defense efforts and costs that were previously wasted on unsubstantiated claims. Any federal reforms must contain language that does not preempt stronger state laws.

- **Reform the Recovery Audit Contractor program**. Medicare pays RACs like bounty hunters to find potential overpayments made to physicians. Nearly half of all RAC audit findings are overturned by an administrative law judge when a physician appeals. Prohibit RACs from recouping physician payments until appeals are final and impose penalties for inaccurate findings.

- **Create a *de minimus* amount exception from the duty to return overpayments under threat of False Claims Act prosecutions.**

Changes That Will Reduce Total Health Care Cost by Improving Patient Access to Physician Services:

- **Provide antitrust relief for physicians.** The ongoing trend towards health plan consolidation, exacerbated by the passage of the ACA, has led to extremely concentrated markets where one or a small number of health plans are dominant oligopsony purchasers. In this environment, individual physicians and small groups often face a contracting environment where the plans are unwilling to contract at all or are unwilling to negotiate terms or payment. Physicians who are locked out of networks or required to accept unprofitable or coercive terms often must close their practices, join large groups, relocate, or retire. The net effect is a loss of clinical autonomy and a reduction in patient care choices and access. Physicians should be allowed to negotiate collectively with payers who have dominant market power. Antitrust laws should be appropriately modified to facilitate fair physician negotiation with insurance plans.

- **Maintain or improve Medicare patients' access to outpatient physician services:**
  - Physician office operating costs are constantly increasing due to inflation and other factors, but Medicare physician fees are budgeted for no increase for five years. Failing to allow for increasing costs will gradually erode payment adequacy and force more physicians to limit their acceptance of Medicare patients. Hospitals and other facilities get annual updates based on the Medicare Economic Index, the federal estimate of increases in health care operating cost. Physician fees should be similarly updated annually.
  - Physician incentives and penalties should not be based on attributed average patient cost measures or other cost measures that are not within physician control. New cost measures based on untested episode measures should be thoroughly tested and analyzed before they are used in any incentive or penalty calculations. Testing should ensure that the new measures do not penalize physicians who serve patients who are disadvantaged or difficult to treat.
  - Medicare locality boundaries must be updated to reflect current economic conditions to correct underpayment to physicians in some rapidly-growing urban and suburban areas.
  - Quality measures that are adversely impacted by patients' inability or unwillingness to comply with physician recommendations should not be used in calculating incentives and penalties.

- **Adequately fund Medicaid to ensure patient access to services.**
  - Any change in funding methods should not penalize states that historically have been fiscally responsible in controlling spending.
  - Funding should be leveled up sufficiently to allow all Medicaid physician fees to be increased at least to parity with Medicare.

- **Allow Medicare patients an out-of-network option.** Currently, when Medicare beneficiaries chose physicians who have opted out of Medicare, they forfeit their applicable Medicare benefits because federal law prohibits payments for any part of those costs.

Medicare should implement policies that allow patients to choose out-of-network physicians without foregoing all relevant Medicare benefits.

- **Require government programs to pay for mandated services for patients who need special translation services due to a disability or limited English proficiency.** Current federal requirements constitute an unfunded mandate, imposing uncompensated costs on physicians that sometimes exceed any expected payment. Forcing physicians to bear the cost without compensation creates financial incentives to avoid treating patients that need these services. Any requirement that a covered entity provide a range of language assistance services should be accompanied by commensurate compensation. Alternatively, government mandated interpreter services could be covered with payments made directly to interpreters providing the service.

- **Expand the availability of HSAs for patients.** Remove the limits on contributions and spending imposed by the ACA and further expand eligibility to patients with any form of insurance coverage.

Evidence-Based Rulemaking:

- **No new rules or reporting requirements should be imposed on physician practices without reliable evidence that the expected benefits exceed the administrative costs.** These costs include both the expenses, time, and effort physicians must expend to comply with the regulation as well as the cost to taxpayers to administer, monitor, and enforce it. Existing rules and requirements should be reviewed periodically and eliminated if they are not cost effective. New and revised regulations should be evaluated by the Office of Management and Budget to evaluate both cost and benefit and returned to the authoring agency for revision when cost exceeds any likely benefit.