The Arkansas Family Physician

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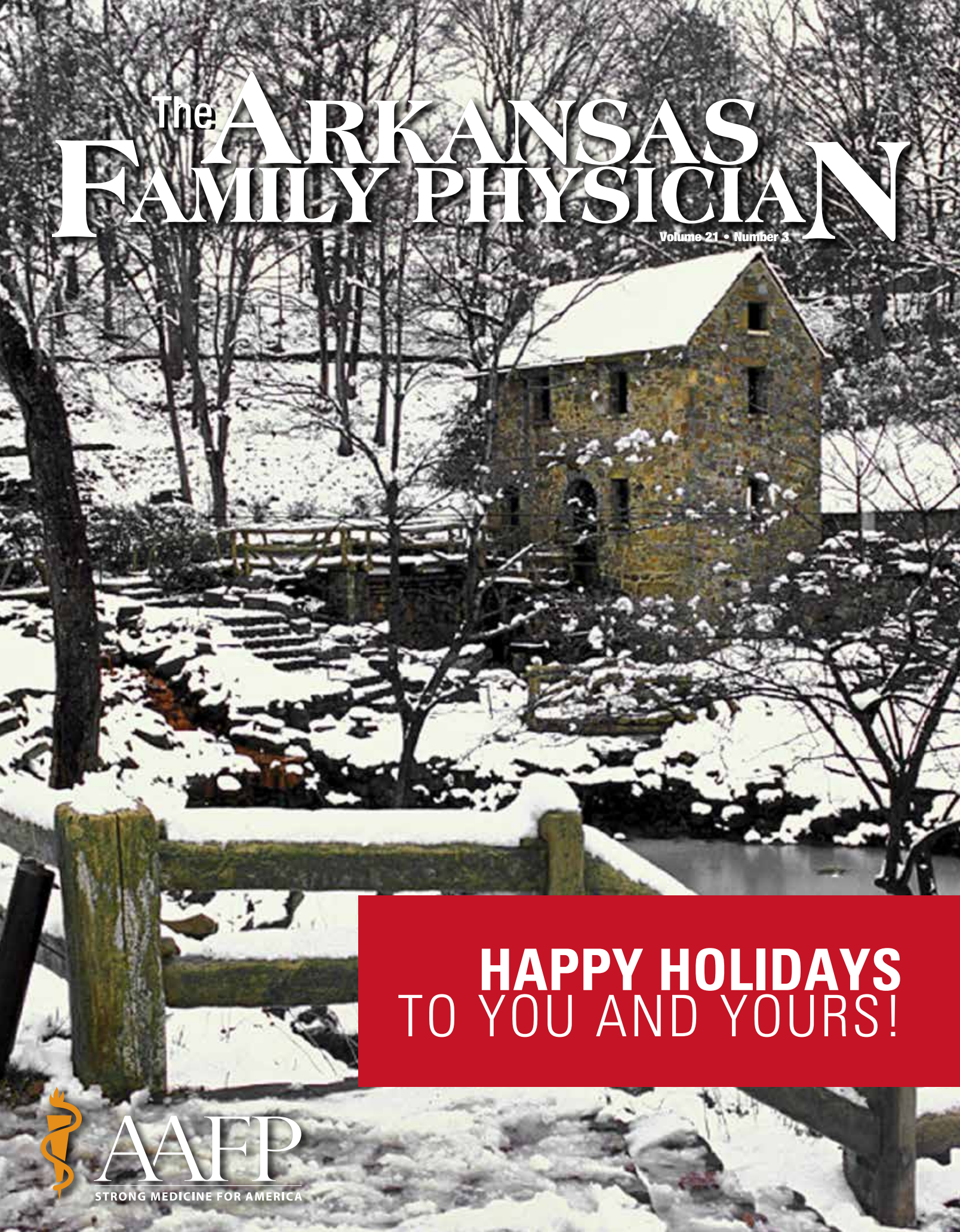

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Stay updated on our progress by visiting our website:
www.ConwayBH.com

The Arkansas Family Physician

The Arkansas Family Physician is the official magazine of the Arkansas Academy of Family Physicians

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EDITION 82

Dear Academy Member,

On behalf of our officers and directors , we thank each of you for your continued membership and support of your professional medical organization and would like to summarize our financial status for the period ending November 5 and our budget which will begin January, 2018 and some of the changes we have made.

We budgeted $359,213. for 2017 and should be very close to meeting this amount in income for this year. To remain at our present dues structure which has not increased in several years, the Board of Directors approved relinquishing part of our office space to the building's owner which will reduce our annual office rent by over $10,000. for the coming year. As always our two sources of income are: Membership Dues which we have collected $182,000. todate and the Annual Scientific Assembly which had a net profit of $50,465. Our 2018 budget was approved in the amount of $332,200. The reduction of expenses for health insurance, office equipment and primarily the office lease was the difference in the 2018 budget compared to the 2017 budget.

Priorities for our chapter in the coming year will be the recruitment of dropped members and retention of our Active members. We also have a lengthy list of board certified non members we will be contacting. Our membership totals 1408 with 880 of those as Active full dues paying members. A long range strategic planning session will be held in 2018 by the American Academy for our board to identify our plans for the coming years and to also identify leaders in the Arkansas AFP. Plans are also being made for a spring CME program . We will have more information to you very soon!

We hope you will mark your calendars for our 2018 Annual Scientific Assembly August 2-5 at the Embassy Suites in Little Rock. A Pre Assembly program will be held on August 1. We look forward to renovations of sleeping rooms and the courtyard at the Embassy which we understand will begin very soon. Any suggestions of speakers or topics for the Annual Meeting are requested – just send us an email and we will send it on out to our Program Committee for consideration!

And finally, we hope that you will contact our office if we can assist you in any way in locating courses, reporting hours, recruiting a Family Physician for your clinic or if you are looking for a practice to join!

Our very best to you in the coming year for a Happy Holiday Season and New Year!

Carla Coleman
Executive Vice President

On the cover:
The Old Mill,
North Little Rock, Arkansas

Patient Centered Medical Homes BEWARE: Not All Care Management Fees Are The Same

A Family Physician's Perspective
by: Lonnie Robinson, M.D., FAAFP,
Mountain Home

We are in an era of healthcare in which practices are struggling to meet the challenges of adapting to their new environment. New payment systems (Arkansas PCMH, CPCi, CPC+) have to some degree brought much-needed revenue to primary care practices whose services were previously undervalued, and this has been a welcomed change for those of us who are on the front-line of healthcare…who bring the most value and "bang-for-the-buck" of healthcare dollars spent. Many of these payment systems utilize "per member per month" (PMPM) care management fees, or CMFs, which are intended to pay primary care practices for additional high-value services like coordinating care, improving access, decreasing hospitalization and ER utilization, as well as others, which have all been demonstrated to improve quality, patient experience, as well as lowering the overall total cost of care.

Many of you know that I have been a vocal advocate for such changes, and have encouraged other primary care physicians in the state to embrace this change rather than resist it…especially since it is going to happen regardless of our level of enthusiasm! I truly believe that this is an opportunity for primary care to demonstrate its worth and its ability to change the existing wasteful and dysfunctional status quo of the U.S. healthcare system.

One of my concerns from the beginning has been that there might be a payer group out there who would attempt to reap the fruit of our labor (increased quality and lower costs) without investing to a concomitant degree as other payers involved in these programs. I knew that we, as providers, would need to be on guard against such attempts to "piggy-back" a "me-too" attempt at investment in primary care. Unfortunately, that fear has materialized, as described below.

My practice, like many of yours, has been involved since early in the process of practice transformation that began in Arkansas around 2012. At that time, we enrolled in the Arkansas Payment Improvement Initiative PCMH Program. Since then, we have made significant changes – costly changes – in our practice in order to meet the demands of value-based care. We hired care coordinators, invested in HIT resources to assist us in managing care and tracking quality measures, added providers in order to expand access, and ultimately achieved NCQA Level 3 PCMH Recognition, and have now successfully enrolled in CPC+.

As a result of these efforts, we were able to participate in Shared Savings with Arkansas Medicaid for both 2014 and 2015. Our hard work – as well as yours – saved the state a significant amount in healthcare expenditures. The investment by Medicaid (and other payers involved in the PCMH program) in our practices helped the entire system. This "Arkansas Experiment" has demonstrated clear results that are benefitting not only the practices, but the payers, the patients and the system as well. This is a clear demonstration of the ***Quadruple Aim*** (which I use rather than the Triple Aim)…***improved quality***, ***lower costs***, ***patient satisfaction***…AND ***provider satisfaction***.

To my main point and concern… as I stated previously, in the midst of all this change, I have been concerned that a "bargain hunter" would slip into the payer fold and offer cut-rate levels of payment for these high-value services. Earlier this year, I was reviewing a contract for participation in CPC+ with a certain private payer in the state. I was amazed at how low the CMFs were! They were half of the rate being offered by the other private payers and Medicaid. Surely, I thought, the requirements must be lower if the pay is lower… but as I reviewed the requirements for participation, I learned that the "ask" was exactly the same as the other payers! I became angry as I thought of the hoops we had jumped through in the last several years to get to the point we are now. I sent a message back to the person who had emailed our practice the electronic copy of the contract. I respectfully asked why they were so much lower than the other payers, but received no response. We reluctantly signed the contract for 2017, but I continued to fume over the issue.

A few months later, I had the opportunity to meet one of the medical directors for the payer in question at a Regional CPC+ meeting, and found this person to be very amicable and reasonable.

Unfortunately, I was unable to find an appropriate time and setting to ask this person the questions I had about the CMF in person at the meeting. Later, I sent this medical director an email, which I felt was respectfully but directly worded, asking about the low-level care management fees (CMF) being offered. I also included an evidenced-based article

continued on page 6

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continued from page 4

that indicates that the operation of a PCMH requires a level of at least $4 PMPM in order to maintain operations. (http://www.annfammed.org/content/13/5/429.full)

I shared with them my concern that their participation might be unsuccessful if providers viewed their offering as unfavorably as I had; my assertion being that providers in response might make their obligations to the payer under the CPC+ agreement a lower priority than the other payers that had put forth a more significant CMF.

I don't know what I was hoping for at that point. Perhaps I am more than a little naïve, but I would have been content with a response like this:

"Dr. Robinson, we understand your concerns and agree that our CMF is clearly not at the level of the other payers in the program. Unfortunately, we are not in a financial situation that would allow us to offer a CMF that is more on par with both the evidence and the market in Arkansas. We hope to be able to rectify this in the future."

However, this was not even close to what I received in return. My email was sent up the organizational chain to the CMO, who sent me a letter that essentially accused me of unethical behavior (discriminating against their beneficiaries based on the low CMF) as well as encouraging other practices to do the same. The CMO completely avoided addressing my concerns about the low CMF altogether.

I responded to the CMO by mail, and again (with what I felt was a respectful tone, despite receiving less than such from him) made the case for their CMF not meeting the level of evidence as well as the level of the current market. His response was,

"Your assertion that there are 'evidence based' Care Management Fees can be debated but will not be resolved to your satisfaction. If you are unhappy with the (payer name) CPC+ contract and no longer want to participate in the network, please contact the network services."

The following excerpt from my letter to the CMO summarizes my feelings well:

You made some assumptions about my character and intent based on the language in my email. This is both understandable and regrettable. ***In the same way, I make assumptions about payers based on their payment levels.*** *A CMF that meets the evidence base and that is competitive in the market makes a statement that the payer is serious about engaging practices to improve the overall health of their beneficiaries.* ***Anything less than that sends a message that you would like to receive the fruit of our labor without investing in the costs involved.***

I am quite certain that I do not understand the complexities and challenges that insurers are facing in the market today and how those forces impacted the decision to set the CMF at the current level. I am equally certain that I do, however, ***fully and completely understand the challenges facing my practice*** and others like it, and this is the basis for my concerns.

We will all have to decide if this level of CMF (as well as the accompanying arrogant attitude) from a payer are ones that we willing to accept or reject. As for me and my practice, we have made our decision. Ultimately, those practices which continue to accept this type of payer behavior will also be sentenced to a future in which primary care services…ONCE AGAIN…will become under-valued compared to the substantial benefit that we bring to the table.

Despite what the CMO in question has stated, there is an evidence-base for the minimum CMF or PMPM needed to maintain a PCMH and to provide high-quality, value-based primary care.

Despite what the CMO in question has stated, ***there is an evidence-base*** for the minimum CMF or PMPM needed to maintain a PCMH and to provide high-quality, value-based primary care (see previous reference). If a payer is offering less than this evidence base, ***WE*** will be providing our high value services at a loss, and furnishing such at our own expense for the benefit of the healthcare plan in question. The most worrisome issue to me is the precedence this will set for other payers, who may wonder in the future why they are paying a more-appropriate higher level CMF for these services if a competitor is getting the same services (and benefits) for less.

I'll let you decide whether or how your practice will come up with the additional funds required to "furnish" the PCMH services for such a payer, who is benefitting greatly from our services, but not reimbursing at an appropriate level. My advice is that you carefully consider your value-based contracts and not allow those who would seek a cheap/free ride to do so.

I will also continue to advocate for an appropriate level of compensation for these services at every opportunity, and I trust that our physician organizations will do the same. Our patients deserve the kind of care that PCMH brings to the table. Practices, likewise, deserve to be compensated appropriately for the hard work involved in delivering that care.

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Arkansans for Jobs and Justice Launches Campaign for Real Tort Reform in Arkansas

Group Committed to Passing Commonsense Reforms Protecting Arkansans, Jobs

Little Rock – A coalition representing a diverse group of Arkansans has joined together to support commonsense reforms that will help make Arkansas more competitive with surrounding states and protect everyday Arkansans. Paperwork was filed today for *Arkansans for Jobs and Justice* to advocate for the passage of SJR8. The committee will be anchored by the Arkansas State Chamber of Commerce with leadership from the Arkansas Medical Society, The Poultry Federation, Arkansas Health Care Association and Arkansas Trucking Association.

"It's time to once again level the playing field in Arkansas with commonsense reforms that strike a balance between protecting the rights of everyday Arkansans while creating an environment of economic growth and job creation in Arkansas," said Randy Zook, President of the Arkansas State Chamber of Commerce. "Unfortunately, the progress made on tort reform in 2003 has been stripped away, piece by piece, over the last 14 years by the Arkansas Supreme Court, making a constitutional amendment necessary. The passage of SJR8 by the voters of Arkansas will make Arkansas more competitive with surrounding states while still protecting the right to a jury trial and damages."

The legislative effort for the tort reform measure passed in 2003 was led by the Arkansas Medical Society. "We have learned from experience that without a constitutional amendment, Arkansas will not have real tort reform," said David Wroten, Executive Vice President of the Arkansas Medical Society. "Arkansas doctors know how important this commonsense amendment is to their patients and their families. The constant concern about frivolous lawsuits in Arkansas continues to be a significant factor in the decision of top physicians and specialists to continue to practice in or relocate to our state."

SJR8, sponsored by Senator Missy Irvin and Representative Bob Ballinger, along with 66 co-sponsors, is the proposed constitutional amendment that will appear on the November 2018 ballot for Arkansas voters. The popular name of the proposed amendment will be "An Amendment Concerning Civil Lawsuits and the Powers of the General Assembly and Supreme Court to Adopt Court Rules," and the ballot title will be:

A proposed amendment to the Arkansas Constitution providing that a contingency fee for an attorney in a civil lawsuit shall not exceed thirty-three and one-third percent (33 1/3 %) of the net recovery; defining "contingency fee" as an attorney's fee that is paid only if the claimant recovers money; providing that the General Assembly may amend the foregoing percentage by a two-thirds (2/3) vote of each house; limiting punitive damages awards for each claimant in lawsuits for personal injury, property damage, or wrongful death to the greater of (i) five hundred thousand dollars ($500,000), or (ii) three (3) times the amount of compensatory damages awarded; defining "punitive damages" as damages assessed to punish and deter wrongful conduct; providing that the General Assembly may not decrease the foregoing limitations on punitive damages but may increase the limitations by a two-thirds (2/3) vote of each house; providing that the limitations on punitive damages do not apply if the factfinder determines by clear and convincing evidence that the defendant intentionally pursued a course of conduct for the purpose of causing injury or damage to the claimant and that such intentional conduct harmed the claimant; limiting awards of non-economic damages in lawsuits for personal injury, property damage, or wrongful death to (i) five hundred thousand dollars ($500,000) for each claimant, or (ii) five hundred thousand dollars ($500,000) for all beneficiaries of an individual deceased person in the aggregate in a lawsuit for wrongful death; defining "non-economic damages" as damages that cannot be measured in money, including pain and suffering, mental and emotional distress, loss of life or companionship, or visible result of injury; providing that the General Assembly may not decrease the foregoing limitations on non-economic damages but may increase the limitations by a two-thirds (2/3) vote of each house; providing that the General Assembly shall adopt a procedure to adjust the dollar limitations on punitive damages and non-economic damages in future years to account for inflation or deflation; providing that the Supreme Court's power to prescribe rules of pleading, practice, and procedure for courts is subject to the provisions of this amendment; providing that the General Assembly, by a three-fifths vote of each house, may amend or repeal a rule prescribed by the Supreme Court and may adopt other rules of pleading, practice, or procedure on its own initiative; providing that rules of pleading, practice, and procedure in effect on January 1, 2019, shall continue in effect until amended, superseded, or repealed under the provisions of this amendment; providing that a rule of pleading, practice, or procedure enacted by the General 13 Assembly shall supersede a conflicting rule of pleading, practice, or procedure prescribed by the Supreme Court; providing that certain other rules promulgated by the Supreme Court may be annulled or amended by a three-fifths (3/5) vote of each house of the General Assembly instead of a two-thirds (2/3) vote as presently stated in the Arkansas Constitution; and providing that this amendment becomes effective on January 1, 2019.

About Arkansans for Jobs and Justice

Arkansans for Jobs and Justice is a broad coalition representing a diverse group of Arkansans that have joined together to advocate for the passage of SJR8 to provide commonsense legal reforms that will help make Arkansas more competitive with surrounding states and better protect everyday Arkansans.

(the Arkansas AFP Board of Directors approved providing funding for this effort and encourages individual members to also consider assisting with financial support)

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Part 5

The evolution of pharmacists

by: Sam Taggart, M.D.,
Family Physician and Author

Formal education for pharmacists in the United States began in 1821 with the creation of the Philadelphia College of Pharmacy. The mid-19th century saw a degree of professionalism begin to emerge in all of the health care professions. The American Medical Association was created in 1847 and the American Pharmaceutical Association in 1852. The Arkansas Medical Society was not created until the 1870s and the Arkansas Association of Pharmacists was founded in 1882. The men who created this organization were primarily physicians who had chosen to devote their time and efforts to pharmaceuticals. Prominent in the formation of this organization were representatives from several areas of the state including Little Rock, Fort Smith, Batesville, Hot Springs and Pine Bluff. Several of these men including Dr. John B. Bond (we discussed his emergence in a previous article), Dr. J.J. McAlmont, J.E. Gibson, E.J. Schaer played leading roles in the AAP over the next few years.

Led by Dr. John Bond, one of the first tasks of this new organization was to create a Model Pharmacy Bill and begin the process of registering pharmacists. Next on their list of priorities was to develop a formal training program of pharmacy education in the state. On all three issues, they ran into major obstacles that involved conflicts with the Arkansas Medical Society, grocers and patent medicine companies and established pharmacists out in the state who were opposed to any regulation on their activities.

It took a full twelve years before any real headway in pharmacy education was made. In 1894 ten students were admitted to a two-year course of study at the University of Arkansas in Fayetteville to provide a "certificate in pharmacy." Sadly, this program and a second program at the University folded by 1898 with no degrees granted.

The Federal Food and Drug Acts of 1906, revived interest in pharmacy education. This time a course of pharmacy was offered through the Physicians & Surgeons Medical College in Little Rock, a proprietary school started in competition with the Medical School associated with

the University of Arkansas. The new school of pharmacy was caught in the conflict between the two competing medical schools. When the two medical schools combined, the pharmacy school received very little attention and during WWI the University Trustees voted to disband the program.

At least two other pharmacy review courses were established in the Little Rock area after WWI: one at Camp Pike immediately after WWI and a second at Little Rock College, a private Catholic institution. Eventually, both programs were suspended. A third program in Jonesboro at Arkansas Baptist College was attempted but it too was discontinued after two years because of lack of interest.

During the 1930's and 1940s, the Depression and WWII got in the way of making any progress on pharmacy education and for almost two decades, Arkansas went without any pharmacy education. By the late 1940s, a study by the State Board of Pharmacy showed that only seven new pharmacist licenses had been issued between 1943 and 1946. The average age of pharmacists in the state was 62 years old and only 15% of the druggists in practice had pharmacy licenses. This same study projected that there would be a need of at least 500 new pharmacists over the next decade.

Returning veterans from WWII overcrowded the pharmacy schools in adjacent states dramatically reducing the number of positions available to Arkansans. Those who did go to school out of state tended to not come back to practice. The Arkansas Pharmacists Association began another campaign to establish a school for the state. Dr. Wiley Lin Hurie, the President of the College of the Ozarks in Clarksville, a Presbyterian-affiliated school, traveled to the annual convention of the Pharmacy Association and negotiated a deal to establish a pharmacy school at his institution. With the help of his local legislators and the pharmacy officials they lobbied the General Assembly for $50,000 to fund the first few years of the school. As opposed to earlier efforts the response to the school was excellent. By 1948, there were 271 students enrolled in the new school. The American Council on Pharmaceutical Education granted accreditation to the new program.

Almost as soon as the school was beginning to make strides the sky fell in. Within months of the signing of the state appropriation, a suit was filed in state court challenging the constitutionality of providing state funds to a religiously-affiliated school. It took until 1951 for the suit to make its way through the courts to the State Supreme Court. The court found that the legislature had erred, and the school could not receive the funds. The school announced that the class of 1951 would be the last graduating class.

A factor that helped save the fledgling new school survive was that Governor Sid McMath had chosen as one of the focuses of his first administration the upgrading of the University of Arkansas Medical School and the creation

of a University Medical Center that would serve the whole state.

The State Board of Pharmacy and the APA had been expecting the court's decision and had begun discussions with the University of Arkansas about taking over the program. Dean Lewis Webster Jones of the University of Arkansas agreed to assume responsibility for the school and assign the program to the medical sciences campus in Little Rock. Forty-six members of the Junior Class at College of the Ozarks became the senior class at the University of Arkansas Pharmacy School in 1952 with no loss of credit.

The temporary home of the pharmacy school was in a surplus state-owned facility at 16th and Lewis Street. The first two years of study were taken at the Fayetteville campus and the second two years in Little Rock. By 1956, McMath's dream of the new medical center was realized with the opening of the University of Arkansas Medical Center at 4301 West Markham. The pharmacy school occupied its permanent home at that time.

With their future assured, attention increasingly turned to curriculum. The American Association of Colleges of Pharmacy recommended that a course of training be equivalent to five years of college: two years of pre-pharmacy and three years of professional pharmacy training. These requirements were accepted by the Arkansas school.

During the second decade of the new school several new issues were raised including the problem of illegal drug consumption by the public of Arkansas. A new program was begun that assigned students to registered pharmacist preceptors in the community. This was designed to give the student a more realistic understanding of what they would face in "the real world."

Among other major steps forward, in 1974 the school helped to establish the State Poison Control and Drug Information Center in conjunction with the Arkansas Department of Health.

In the first thirty years of its existence the school granted degrees to 1253 graduates.

As an accepted member of the family at UAMS the School of Pharmacy has flourished.

Sam Taggart M.D.
Any questions or comments:
samtaggart@att.net

Arkansas Department of Health Influenza Report

A weekly influenza report is produced weekly by the Arkansas Department of Health on flu activity reported in Arkansas. These reports are only a fraction of flu and it is presumed there are many more people actually affected than the report shows.

For week 45 ending November 11, Arkansas reported "regional" activity to the Centers for Disease Control and Prevention for geographic spread of influenza and "minimal" or 1/10 for ILI intensity.

Since 10/1/17,over 1300 positive influenza tests have been reported to the ADH online database by health care providers. In Week 45, 39 counties reported influenza cases with the majority of reports coming from Benton, Pulaski, Saline, Lonoke, Desha, White, Faulkner, Boone, Jefferson, Craighead and Garland. Among flu antigen tests that can distinguish between Influenza A and B virus types, 78 percent were Influenza A and 22 percent were Influenza B. No influenza deaths have been reported in Arkansas.

You can report flu year round and view the weekly influenza report during the influenza season at: http://www.healthy.arkansas.gov/programs-services/topics/influenza. You can also access the reporting website directly at: https://FluReport.ADH.Arkansas.gov

Arkansas AFP's Foundation

The Arkansas Academy of Family Physicians Foundation was incorporated in 1990 as a not for profit corporation organized to establish and administer programs for educational and philanthropic purposes for the benefit of family medicine in Arkansas. It is exclusively charitable, educational, literary and scientific in purpose and is recognized by the Internal Revenue Service as a 501 © 3 organization thereby able to receive grants and tax deductible gifts and contributions. We support medical student activities through the AR AFP Foundation and encourage you to consider the Foundation for memorials to friends, coleagues or to support a medical student event.

PRACTICE OPPORTUNITY

If you are looking for a practice to join or if you have an opening in your clinic for a Family Physician, please contact us. We are happy to run an advertisement for you at no charge as part of our services to you as a member.

MARK YOU CALENDARS FOR THE ARKANSAS AFP'S 71ST ANNUAL SCIENTIFIC ASSEMBLY

The Arkansas Annual Scientific Assembly will be held August 2-4 at Embassy Suites Hotel in Little Rock. A Pre Assembly program will be held on Wednesday, August 1. If you have suggestions for topics or speakers for this program, please email us at arafp@sbcglobal.net as soon as possible!

IN MEMORY

Dr. Robert Wendell Ross of Fort Smith passed away recently. A 1968 graduate of UAMS, Dr Ross practiced in Van Buren for many years and was a Fellow of the AAFP. He was a member of the AAFP for 45 years and served on the Arkansas AFP Board of Directors for 5 years.

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- One in four Arkansas children has decayed teeth before the age of four.
- Over 50 percent of 5- to 9-year-old children have at least one cavity or filling, and that proportion increases to 78 percent among 17-year-olds.
- Professional care is necessary for maintaining oral health, yet 25 percent of poor children have not seen a dentist before entering kindergarten.
- Less than one in five Medicaid-covered children received a single dental visit in a recent yearlong study period.

Resources to Get Started- The Office of Oral Health (OOH) at the Arkansas Department of Health has initiated a program called *Paint A Smile for Arkansas* to encourage medical personnel to perform an oral health risk assessment, apply fluoride varnish, and refer children to a dental home. OOH has developed a toolkit containing:

- Dental Screening, risk assessment and fluoride application procedures
- Required one hour training course information
- Medicaid billing codes
- 50 free single use fluoride varnish applications

The OOH has Smile Ambassadors delivering Toolkits to pediatric and family practices across the state. If you have not received a visit, let OOH hear from you (501-661-2279).

For better oral health,

Donna Bailey, RDH

Donna Bailey, RDH
Chairman, Arkansas Oral Health Coalition

Reimbursement rates outlined above may not apply to all medical providers.

The Arkansas Oral Health Coalition, Inc. is recognized as a 501(c)(3) corporation by the IRS.

Office of Oral Health; 4815 W. Markham St, Slot 18; Little Rock, Arkansas 72205
501-661-2051; FAX 501-661-2240

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

ARKANSAS FACT SHEET

AAFP on Health Reform

The AAFP believes that policies should be adopted to ensure continued progress towards health care for all supported by a payment system that rewards value of care over volume of service. The health system should promote prevention and wellness, protect patients from financial barriers to needed services and build a primary care physician workforce that can meet the growing demand for care.

Arkansas Family Medicine

- There are 1,359 AAFP members in Arkansas[1].
- Arkansas has 7 family medicine residency programs.
- Arkansas has 92 medically underserved areas/populations.
- 10.5% of the residents in Arkansas live in a health professional shortage area.

Medicaid in Arkansas

- In 2015, 22% of people in Arkansas were covered by Medicaid/CHIP.
- Medicaid/CHIP enrollment increased by 374,300 between 2013 and 2016.
- Arkansas's uninsured rate decreased from 15% in 2013 to 9% in 2015.
- In Arkansas, 42% of Medicaid spending is for Medicare beneficiaries.[2]
- In Arkansas, 65% of people have a favorable view of Medicaid.[3]

Impact of the Graham-Cassidy-Heller-Johnson plan (amendment to HR 1628 being considered by the US Senate)

- The GCHJ plan would shift costs onto states.
  - By 2026, Arkansas will lose $6 billion, or 11%, in federal funding.
  - By 2036, Arkansas will lose $66 billion, or 41%, in federal funding.[4]
  - In a recent poll, 63% of Arkansas residents oppose cutting funding to Medicaid.[5]
- 439,000 people in the state of Arkansas would lose their health coverage by 2027.[6]
- The GCHJ plan would eliminate Medicaid expansion at the end of December 2019. In Arkansas, 310,800 Medicaid recipients were made newly eligible for Medicaid via Medicaid expansion.[7]
- In Arkansas, 556,000 non-elderly adults have a declinable preexisting condition. [8]
- The GHCJ would limit access to substance abuse treatment by cutting Medicaid. In Arkansas, 392 people died of overdose deaths in 2015.[9]

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[1] As of August 31, 2017
[2] *Medicaid State Fact Sheets.* (2017, January 26). Retrieved from http://kff.org/interactive/medicaid-state-fact-sheets/
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[4] Carpenter, Elizabeth, Chris Sloan. (2017, September 20). Graham-Cassidy-Heller-Johnson Bill Would Reduce Federal Funding to States by $215 Billion. Retrieved from http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta
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[6] Gee, Emily. (2017, September 20). *Coverage Losses by State Under the Graham-Cassidy Bill to Repeal the ACA.* Retrieved from https://www.americanprogress.org/issues/healthcare/news/2017/09/20/439277/coverage-losses-state-graham-cassidy-bill-repeal-aca/
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[8] Claxton, Gary, Cynthia Cox, Anthony Damico, Larry Levitt, and Karen Pollitz. (2016, December 12). *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA.* Retrieved from http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/
[9] *Drug Overdose Death Data*. (2016, December 16). Retrieved from https://www.cdc.gov/drugoverdose/data/statedeaths.html

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Arkansas Sees Improved Children's Immunizations - from 46th to 39th

State	MMR (≥1 dose)	DTaP (≥4 doses)	Hep B (birth dose)	HepA (≥2 doses)	Rotavirus	Combined vaccine series
US National 2016	91.1	83.4	71.1	60.6	74.1	70.7
Arkansas 2016	92.1	80.3	75.2	56.5	76.7	67.8
Arkansas 2015	90.2	76.4	80.6	54.2	68.2	66.6
Arkansas 2014	89.1	80	76.4	43.3	69.8	66
Arkansas 2013	88.3	74.3	79.7	35.8±	56	60.6
Arkansas 2012	92.3	79.8	81.7	40.1	56.3	66.4
Arkansas rank 2016	22	40	19	37	18	39
Arkansas rank 2015	41	50	6	40	41	46
Arkansas rank 2014	42	43	23	47	33	44

Have you met your CME Requirements for 2017??

Members due for re-election this year have until December 31, 2017 to earn your CME!

CME Requirements for Membership

ACTIVE and SUPPORTING (FP) MEMBERS must accrue at least 150 hours of approved continuing education within each three-year reporting period to retain membership. These credits must include at least 75 Prescribed credits and at least 25 group activity hours.

Reporting Your CME

The Academy offers several easy and convenient ways to report CME credit:

- Online at www.aafp.org/cme
- Complete quizzes for AAFP programs such as American Family Physician, Family Practice Management, Home Study Self Assessment, Video CME, and Proficiency Testing.
- Call a CME representative 1-800-274-2237 between the hours of 8:30 a.m. – 5:00 p.m. Central Time.
- Or call the Arkansas Chapter Office at 1-800-592-1093 or 501-223-2272 and we will be happy to assist you and report your hours for you!

The AAFP offers members over 200 credits of free online CME. For a complete listing, log-on to www.aafp.org/onlinecme.xml.

Questions About CME

If you have questions about your reelection or need a current copy of your CME record, please call Michelle at 1-501-223-2272 or 1-800-592-1093.

The 2018 Invoices for Membership Dues have now been mailed!

If you have not already done so, please renew your AAFP membership now.
You can pay in one of three ways:

- Return your invoice and payment in the envelope provided
- Call the AAFP and set up monthly installment payments, 1-800-274-2237
- Online at http://www.aafp.org/checkmydues

It's Easy to Pay Your 2018 Dues ONLINE

Thank you for maintaining your membership in the AAFP!

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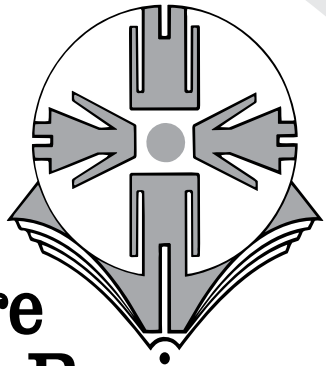

The Core Content Review of Family Medicine

Educating Family Physicians Since 1968

From AAFP NEWS NOW:

Panelists Discuss Telehealth Potential for Primary Care

November 13, 2017 03:13 pm Michael Laff Washington, D.C. – Telehealth has the potential to increase access and reduce costs, but physicians are still looking for the best ways to use the technology to improve patient care.

Family physician Wally Adamson, M.D., discusses the potential telehealth holds for delivering a better patient experience during a forum hosted by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care.

Panelists discussed promising uses of telehealth in areas such as mental health and group visits during a primary care forum(www.graham-center.org) on Capitol Hill that the Robert Graham Center for Policy Studies in Family Medicine and Primary Care hosted on Nov. 9.

Telehealth in the form of video consults is well-suited to value-based payment models, panelists said, because the technology is structured for patient interaction, CPT codes are available and the amount of physician time can be recorded easily. However, network connectivity among primary care physicians, hospitals and subspecialists has not caught up with the ambitions of telehealth users.

"Telehealth is easy for patients, but it's hard for doctors and health plans," said Wally Adamson, M.D., a family physician who is staff vice president of LiveHealth Online, a telehealth service. "There are a lot of local initiatives, but it hasn't been translated onto a broader scale."

Adamson said telehealth both expands access and offers a lower-cost alternative to patients with high deductibles. Some stakeholders initially were concerned that such increased access might manifest as a spike in virtual visits on weekends, but Adamson said most patients access telehealth during normal business hours, and he noted that the technology is especially helpful with chronic care management.

"There's no reason health care can't deliver a customer experience like Nordstrom's," he said. "Moving from episodic care to chronic care is where the power of telehealth is."

Adamson pointed out that telehealth also could help some physicians stay in practice longer, giving the example of a physician with multiple sclerosis who cannot visit patients in person but could still offer remote consults.

Mental health care is another area where wider adoption of telehealth could be beneficial, and the Parkview Research Center in Fort Wayne, Ind., has received a grant to study the delivery of mental health services through telehealth. Indiana has one the nation's highest rates of teen suicide, and Tammy Toscos, M.S., Ph.D., a research scientist at Parkview, said teenagers face limited access to health care services, as well as social stigma for seeking out mental health care.

A program funded through the grant allows students to use their phones to interact with mental health professionals without revealing their identity.

"We need it for mental health," patient rights advocate Regina Holliday said of this usage of telehealth. "I love all the gadgets, but this could completely change the life of a young person. That's what's important."

Holliday noted that telehealth is particularly beneficial in rural areas, where patients either do not have access to behavioral health or cannot access it without their neighbors knowing.

Family physician Michael Rodriguez, M.D., and patient rights advocate Regina Holliday discuss how telehealth can contribute to improved patient care.

Family physician Michael Rodriguez, M.D., said a telehealth platform he built years ago did not find much success among physicians or even among patients who were initially enthusiastic about it. But he believes that telehealth has more potential now because people have grown more comfortable using this type of technology, including for handling complex subjects.

"Now there aren't many people who go a week without participating in a teleconference," Rodriguez said.

He envisions telehealth expanding to group visits, but said the technology must first advance because most existing platforms only enable three people to participate at once.

To achieve the full potential of telehealth, however, payers must change the restrictive policies that discourage its use. For example, Medicare Advantage pays for telehealth only in rural or underserved areas and defines it strictly as two-way video technology.

"I can't get reimbursed unless it's a video (transmission)," Rodriguez said. "Removing that barrier would be huge."

MIPS RESOURCES

Family physicians must pick their pace by the end of 2017 to participate in the Merit-based Incentive Payment System (MIPS) to avoid a negative 4% payment adjustment. Chapters can ensure members have access to resources they need to take action by sharing the 2017 MIPS Playbook (free to AAFP members.)

It's important for members to know it's not too late to collect data. Submitting as little as one quality measure or one Improvement Activity can avoid the negative payment adjustment – just collect the data before the end of 2017.

For information go to: http://www.aafp.org/practice-management/payment/medicare-payment/cme-Macra.html

"You must Pick Your Pace in 2017. Are you prepared?

By the end of 2017, you must take action in the Merit-based Incentive Payment System (MIPS) to get paid under Medicare Part B. It's not too late to collect data—submitting as little as one quality measure or one Improvement Activity will allow you to avoid a negative 4% payment adjustment.

Don't delay. Let the AAFP guide you down the MIPS path of MACRA's QPP to help you take action, including the 2017 MIPS Playbook—AAFP's step-by-step guide to taking action in MIPS. Learn how to Pick Your Pace, select and report quality measures, and more.

It's time to Pick Your Pace in MIPS. Get started today."

CDC Launches Rx Awareness Campaign on Opioid Crisis

In 2015, 12.5 million people misused prescription opioids. Between 1999 and 2015, more than 183,000 Americans died from overdoses related to prescription opioids, and the battle to overcome this public health crisis continues.

Most recently, the CDC launched the Rx Awareness(www.cdc.gov) campaign, which features real-life testimonials of people affected by the opioid epidemic in the United States and communication tools family physicians can use to educate patients on this issue.

The campaign, which uses the tagline, "It only takes a little to lose a lot," will offer resources(www.cdc.gov) that include videos, radio spots and transcripts, social media images, internet banners, web graphics, signs and posters highlighting the importance of knowing the risks associated with prescription opioids to prevent misuse and overdose.

"This campaign is part of the CDC's continued support for states on the frontlines of the opioid overdose epidemic," said CDC Director Brenda Fitzgerald, M.D., in a news release(www.cdc.gov). "These heartbreaking stories of the devastation brought on by opioid abuse have the potential to open eyes -- and save lives."

STORY HIGHLIGHTS

- The CDC has launched the Rx Awareness campaign, which features real-life testimonials of people affected by the opioid epidemic in the United States and communication tools family physicians can use to educate patients on this issue.
- Campaign resources include videos, radio spots, social media ads, internet banners, web graphics and more highlighting the importance of knowing the risks associated with prescription opioids to prevent misuse and overdose.
- Rx Awareness campaign ads began running Sept. 25 for 14 weeks in Ohio, Kentucky, Massachusetts and New Mexico.

Real Stories From Those Affected

Maybe the most powerful resources the Rx Awareness campaign offers are the stories told by those who have been affected by opioid misuse and abuse. These currently include accounts from eight people who themselves have been addicted to opioids or who have lost family members to the powerful drugs.

For example, Judy Rummler speaks about her son Steve(www.youtube.com), who she described as a gifted musician who excelled in sports. After college, Steve became a financial adviser. He suffered a back injury as an adult that left him with severe, constant pain that physicians had trouble treating. Following related depression, Steve was prescribed antidepressants and subsequently opioids.

Initially, Steve was happy the opioid medication finally provided him pain relief, but he quickly became addicted. After three years, he was visiting multiple physicians to try to obtain new prescriptions.

Steve realized he was addicted and tried rehabilitation and treatment programs numerous times without success. Finally, after completing a 28-day addiction treatment program, Steve relapsed and died of an opioid overdose at age 43.

After his death, Judy found a message on a Post-it note that Steve had written about his experience with prescription opioids: "At first, they were a lifeline; now they are a noose around my neck."

Judy, along with her husband, William, subsequently founded the Steve Rummler Hope Network(steverummlerhopenetwork.org) to "heighten awareness of the disease of addiction as it relates to the physical and emotional burdens of chronic pain and to improve the associated care process."

Five-point Strategy to Combat Opioid Crisis

HHS and the CDC have committed to using evidence-based methods to communicate targeted messages about the opioid crisis and to prevent addiction and misuse, according to the news release. Rx Awareness is part of HHS' five-point strategy to fight the epidemic by

- improving access to prevention, treatment and recovery services, including the full range of medication-assisted treatments;
- targeting availability and distribution of overdose-reversing drugs;
- strengthening our understanding of the crisis through better public health data and reporting;
- providing support for cutting-edge research on pain and addiction; and
- advancing better practices for pain management.

Curbing the misuse of prescription opioids is also important because it's a strong risk factor for heroin use, which continues to climb in the United States. In fact, among new heroin users, about 75 percent reported having misused prescription opioids before using heroin, according to the CDC.

Campaign Rollout Details

Rx Awareness campaign ads began running Sept. 25 in Ohio, Kentucky, Massachusetts and New Mexico and will continue for 14 weeks. The effort is expected to later expand to additional states through funding from the CDC's Prescription Drug Overdose: Prevention for States(www.cdc.gov) and Data-Driven Prevention Initiative(www.cdc.gov) programs.

Overall, said the agency, the success of the Rx Awareness campaign depends on state and local agencies and organizations such as the AAFP to share its messages and resources with physicians, their patients and the general public.

From AAFP NEWS NOW:

If Payers Could Reduce Administrative Burden, 'That'd Be Great'

■ "You see, we are putting the cover sheets on all TPS reports before they go out. Did you see the memo about this?"

-- Bill Lumbergh to Peter Gibbons in "Office Space"

The quote above is from a scene in the classic movie *Office Space*, where the main character (Peter Gibbons) has a conversation with his boss (Bill Lumbergh) about his continued failure to comply with the company's new policy regarding "TPS reports." The comedy follows the day-to-day interactions of Peter and his co-workers and their growing frustration with the administrative burdens of their jobs. It is that mundane administrative complexity that drives Peter and his co-workers to a breaking point. If you have seen the movie, you know that they retaliate in the end.

If you exchanged the words "TPS reports" with "prior authorization form," "documentation guidelines" or "quality measures," you could easily have made this movie about modern-day family medicine practice. Like the characters in the movie, family physicians are feeling the strain of a complex regulatory system and work environment. During the past decade, the amount of administrative work associated with a medical practice has increased dramatically. Although much of the increased burden stems from electronic health records, there are other drivers of administrative burden -- most notably the mind-numbing and time-evaporating prior authorization process used by every health insurer.

I have written on the issue of administrative and regulatory burden and the AAFP's advocacy efforts related to the issue a couple of times in the past year. You can read those posts here. and here. Each time I broach this subject, the statistic that always drives my thinking is from a 2016 study in the *Annals of Internal Medicine*(annals.org) that found that during a typical day, primary care physicians spend 27 percent of their time on clinical activities and 49 percent on administrative activities. The authors concluded that for every hour primary care physicians spend in direct patient care, they spend two hours engaged in administrative functions.

To put this a different way, you spend twice as much time doing things for third parties as you do providing care to patients.

Although these statistics are not surprising, they are nonetheless maddening. There is little doubt that administrative and regulatory burden are hindering quality patient care and are the primary drivers of physician burnout. Earlier this year, the AAFP surveyed members about physician burnout, and the feedback was compelling. The issue is real, but the desire was to address the causes not the symptoms. You told us in no uncertain terms, "Don't focus on fixing me, focus on fixing the system." As I stated in my speech at AAFP FMX in September, "That message has been received, and that challenge has been accepted. The most important thing you do every day should not be your EHR, it should not be maintenance of certification, and it shouldn't be prior authorization. The most important thing you do every day should be being a compassionate listener and provider of care to the person sitting in the room with you."

Recognizing the importance of our work on this issue, the AAFP is devoting substantial resources to this effort. Our investment includes advocacy at the highest levels of government and with insurance companies. On Oct. 26, AAFP President Michael Munger, M.D., will be meeting with CMS Administrator Seema Verma to continue our work on identifying and implementing policies aimed at reducing the administrative burden on family physicians. This is our third meeting regarding this topic with CMS leadership this year.

We are strongly supportive of the administration's commitment to reducing the volume of complex regulations that contribute to the 2:1 time deficit I mentioned above. Throughout this process, the administration has been a focused and action-oriented partner and we look forward to continuing our efforts to engage with them on achieving meaningful administrative relief for family physicians.

Administrative burden is not solely a Medicare or Medicaid issue, so we also are pressing insurance companies to engage with us on identifying ways to reduce burden and improve efficiencies in the interactions between family physicians and insurers. On Oct. 4, the AAFP met with the CEO and senior staff of America's Health Insurance Plans (AHIP) to discuss how we can accomplish this goal.

The issue of physician well-being and burnout has garnered national attention during the past few years. In addition to our advocacy work to address the underlying drivers of physician burnout, the AAFP is focusing on assisting our members who are experiencing burnout. My colleague Clif Knight, M.D., AAFP Senior Vice President of Education, is widely recognized as a national expert on the issue and is leading the Academy's work in this area.

The AAFP has made physician well-being and wellness a priority. Last month, we launched the Physician Health First Initiative, which features extensive resources aimed at providing information and tools to assist you in caring for yourself and achieving personal and professional satisfaction. The "My Well-Being Resource" section features an exhaustive list of easily navigated, highly impactful resources, including access to the Maslach Burnout Inventory. If you have 10 minutes, take the inventory and evaluate where you are on the well-being continuum.

In addition, the AAFP will host its inaugural Family Physician Health and Well-Being Conference April 18-21, 2018, in Naples, Fla. This conference will allow you to learn from national experts on physician well-being. This is an excellent opportunity to join other family physicians and spend a few days focusing on individual wellness, while discovering solutions for improved professional satisfaction and better patient care within a broken system. Registration is open.

Drug Alerts & Adverse Event Reporting

Drug Alert

Xultophy 100/3.6

Xultophy 100/3.6 is a combination insulin indicated for adults with Type 2 Diabetes Mellitus. It is associated with an increased risk of acute pancreatitis and a potential risk of medullary thyroid carcinoma. Clinicians should refer to the **Xultophy 100/3.6 REMS**(51 KB PDF) when prescribing this medication (link).

Receive Drug Alerts

The AAFP has partnered with PDR Drug Alerts(www.pdr.net) to help you receive FDA-mandated and product-related patient safety alerts as soon as they are issued.

Features of PDR Drug Alerts include:

- Ability to appoint a family medicine team member to manage practice alerts
- Free for U.S.-based prescribers
- Traditional "dear doctor letter" (DDL) sent when online alert has not been reviewed within 72 hours (weekends not included)
- Email addresses kept secure and confidential
- Access to 12-month alert history master file
- No advertisements
- Information paid for by manufacturers required by the FDA to deliver safety alerts
- Exclusive specialty-specific service fulfilling FDA guidance for electronic delivery of drug warnings

Get PDR Drug Alerts

Receive urgent FDA-mandated and product-related patient-safety alerts from PDR Drug Alerts.

Adverse Event Reporting

Using RxEvent, U.S. physicians and other health care providers can easily and effectively report adverse drug events. This service is a collaboration of medical professional insurance carriers and governmental experts.

Features of RxEvent include:

- Easy-to-use, standardized report form with pre-populated information
- Minimal required questions
- Prompt acknowledgment sent upon submission of a report

RxEvent has been established for use by U.S. health care professionals for reporting adverse events on U.S.-distributed drugs only.

MACRA Streamlines Medicare

By Julia Kettlewell, MPH, BSN, RNP and Eldrina Easterly, BS

"If you always do what you've always done, you'll always get what you've always got." That famous quote appears to have been the mindset when the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) became law in 2016. The Centers for Medicare & Medicaid Services (CMS) wanted to change Medicare's results, so they changed the way we do things.

MACRA ended the Sustainable Growth Rate (SGR) formula. Physicians' billing regularly exceeded Medicare's expenditure targets, forcing Congress to pass a SGR "fix" each year to avert cuts in physicians' Medicare payments.

By amending the Social Security Act, MACRA created the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). MACRA also reformed Medicare payments to achieve the triple aim of improving quality and outcomes and controlling costs.

In response to MACRA, CMS created the Quality Payment Program (QPP). CMS calls QPP a "fresh start" and "paying for what works" to stabilize, strengthen and improve Medicare. QPP shifts Medicare payments from a fee-for-service, volume-based model to a pay-for-performance, value-based model.

QPP reforms Medicare Part B payments for more than 600,000 clinicians across the country and streamlines reporting, standardizes evidence-based measures and eliminates duplication. It promotes industry alignment through multipayer models and incentivizes cost-effective, quality care. QPP's goal is to bring patients increased access to care, better outcomes and enhanced coordination through patient-centered approaches to care.

Clinicians can choose to participate in QPP based on their practice size, patient population and specialty. QPP creates a single system by consolidating components of three legacy programs: the Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals or groups under the physician fee schedule.

Your choice: Advanced APMs or MIPS

QPP features two participation tracks. Providers may choose either the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (APMs). Clinicians who choose not to participate in either QPP track in 2017 will receive a 4 percent reduction in Medicare payments beginning in 2019.

For the 2017 **MIPS** performance period, Medicare Part B clinicians will participate in MIPS if they annually bill more than $30,000 and provide care to more than 100 Medicare patients. These clinicians include:

continued on page 28

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continued from page 26

- Physicians who are doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry and chiropractors
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Clinicians will not participate in MIPS if they are newly enrolled in Medicare, or fall below the low-volume threshold (100 or fewer Medicare Part B patients, or Medicare Part B allowed charges less than or equal to $30,000 a year), or they participate in Advanced APMs at a significant level.

Advanced APMs include accountable care organizations, bundled-payment models, patient-centered medical homes (PCMHs) and risk-bearing models. For the 2017 performance year, significant Advanced APM participation means involvement in the following models:

- Comprehensive End-stage Renal Disease Care Model
- Comprehensive Primary Care Plus (CPC+)
- Shared Savings Program Track 2
- Shared Savings Program Track 3

In Arkansas, TMF Health Quality Institute serves as both the QIN-QIO and the QPP-SURS contractor, with AFMC serving as an integral part of both contracts. AFMC is a subcontractor to TMF for both QIN-QIO and QPP-SURS assistance. AFMC can provide one-on-one technical assistance to MIPS-eligible clinicians, tailored to the needs of individual Arkansas practices, at no charge.

- Next Generation ACO Model
- Oncology Care Model

Participating in an Advanced APM as a qualifying participant provides three benefits: you do not participate in MIPS, you are eligible to receive a 5 percent lump-sum bonus and you will receive a higher Physician Fee Schedule update starting in 2026.

Clinicians have four performance categories in the **MIPS** track:

- **Quality** (replaces PQRS) includes measures such as health screenings, tobacco cessation and medication lists.
- **Cost** (replaces value-based modifier) is based on claims.
- **Improvement Activities**, a new category, includes activities such as care coordination, shared decision-making and safety checklists.
- **Advancing Care Information** (replaces Medicare's EHR Incentive program) includes e-prescribing, patient access to their health information, sending/accepting a summary of care and others.

MIPS provides clinicians an opportunity to choose activities or measures that are best for their practice. For the 2017 transition year, Quality is 60 percent, Improvement Activities are 15 percent and Advancing Care Information is 25 percent. Cost is not weighted in 2017. The total MIPS score translates into a neutral, positive or negative payment adjustment.

The performance period opened Jan. 1 and closes Dec. 31, 2017. Payment adjustments begin Jan. 1, 2019. MIPS does not apply to hospitals or facilities.

For the 2017 transition year, eligible clinicians can pick their participation pace. At a minimum, practices need to report some data at any point to avoid negative payment adjustment. Required reporting and payment options for each of the three "pick your pace" levels for 2017 are:

- Test – report at least one Quality or Improvement Activity measure, or report four or five Advancing Care Information measures (depending on CEHRT edition). This will result in neutral payment adjustment.
- Partial-year submission – report 90 days of data, and receive neutral or positive payment adjustment.
- Full-year submission – report a complete year of data and receive a moderate positive payment adjustment.

In 2019, the first year of payments, the maximum adjustment is plus or minus 4 percent, increasing annually to plus or minus 9 percent by 2022 and beyond.

Technical assistance available

MACRA is a complex program. CMS has established a network to provide direct, no-cost technical assistance to clinicians to enhance successful participation in QPP, particularly MIPS.

The support network serves all eligible clinicians, regardless of practice size or specialty. The Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) provide support for large groups of 16 or more clinicians. The QPP-Small, Underserved and Rural Support (SURS) contractors serve small, rural and underserved clinicians, especially those in medically underserved or health-professional shortage areas. The QPP-SURS contractors assist practices with 15 or fewer eligible clinicians with MIPS education, workflows, EHR technology optimization, program structure information, requirements and timelines.

In Arkansas, TMF Health Quality Institute serves as both the QIN-QIO and the QPP-SURS contractor, with AFMC serving as an integral part of both contracts. AFMC is a subcontractor to TMF for both QIN-QIO and QPP-SURS assistance. AFMC can provide one-on-one technical assistance to MIPS-eligible clinicians, tailored to the needs of individual Arkansas practices, at no charge.

Time is running out to participate in 2017.

For more information about MIPS/QPP, and how to access educational resources and technical support, visit https://tmfqin.org/qpp or https://qpp.cms.gov/, or contact TMF directly by emailing QPP-SURS@tmf.org, or phoning 1-844-317-7609.

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Let Us Focus on Patients, Not Paperwork

By: Michael Munger, M.D., President
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Family physicians are drowning in administrative burden, routinely wasting our valuable time on required tasks that add little or nothing to patient care. In the AAFP's most recent Member Satisfaction Survey, administrative burden was the No. 1 item that members asked the Academy to help them with.

We all feel the pain of the ever-growing layers of bureaucracy being piled upon us. As each year passes, more forms are demanded for the authorization of durable medical equipment, radiologic procedures and medications. Many times, prior authorizations are required even for generic medications, or worse yet, for an ongoing medication that already has proven beneficial in the long-term management of a chronic disease. Mandating that physicians jump through the hoops of filling out forms or requiring patients to repeat a step-therapy approach that has already failed disrupts patient care, is unsafe and flies in the face of common sense.

However, all that is just the tip of the proverbial iceberg. Decades-old documentation guidelines for evaluation and management codes, which reflect the majority of our day in family medicine, do not translate to current practice. When combined with death-by-a-thousand-clicks electronic health records technology, what is created represents not just"note bloat" but a needlessly complicated document that hinders meaningful patient care and overall comprehensive coordination. It is painful to try to read through a five-page tome to find exactly what condition or issue the patient presented with, and the resultant key findings and care plan. Just when I think there is nothing else I can see or experience after 31 years of practice that would make me shake my head with incredulity, I start another day of patient care, complete with yet more meaningless administrative tasks.

These impediments to patient care are not just frustrating, they are increasing our costs of doing business -- in both the physician time and the actual money required to complete these pointless tasks. A 2016 study published in *Health Affairs*(www.physiciansfoundation.org) found that primary care physicians were spending 3.9 hours every week reporting on quality measures for performance programs. The study further estimated that the average annual cost of compliance for these quality programs alone was $40,069 per physician. This is devastating for practices that already operate on the thinnest of margins.

A 2016 study published in *Annals of Internal Medicine*(annals.org) reported that during a typical day, primary care physicians spend 27 percent of their time on direct patient care but an amazing 49 percent on administrative activities. This discrepancy further serves only to cripple those in independent practice and is a leading reason physicians leave such settings to become employed. It is also a major driver of physician burnout.

On Oct. 26, I had the privilege of presenting comments at a CMS roundtable(280 KB PDF) on administrative burden chaired by CMS Administrator Seema Verma, M.P.H. The AAFP was one of only three organizations -- and the only physician organization -- invited to provide a presentation. I emphasized our pain and the true crisis that this represents to providing comprehensive, coordinated care to our patients. I offered three concrete steps to decrease the administrivia:

- Eliminate or significantly reduce the use of prior authorizations for durable medical equipment, diabetic supplies and generic medications.

- Eliminate the documentation guidelines for evaluation and management codes 99211-99215 and 99201-99205 for all primary care physicians.

- And finally, repeal the regulatory framework of the advancing care information component of the Quality Payment Program and simply require physicians to use a certified electronic health record.

I walked away from the meeting with hope. Verma announced a new CMS initiative, Patients Over Paperwork,(www.modernhealthcare.com) that the agency is beginning using a three-pronged approach. The plan is to increase outreach to physicians, other medical professionals and hospitals to better understand the scope of the administrative burden problem and obtain examples of how this needless complexity is affecting patient care. A goal has been set to decrease the time we spend doing administrative tasks. CMS also aims to harmonize and streamline the forms needed for processes such as prior authorizations.

We have a long road to travel before we can turn our full attention away from the unnecessary hassles that burden our practices and back to our patients. However, CMS has made a commitment to listen and attempt to decrease this burden. This appears to be an opportunity to continue our ongoing advocacy efforts and work with the agency to begin a process that could make a meaningful change for all of us.

Your AAFP has heard you, and I will continue to carry our voice forward at every opportunity.

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