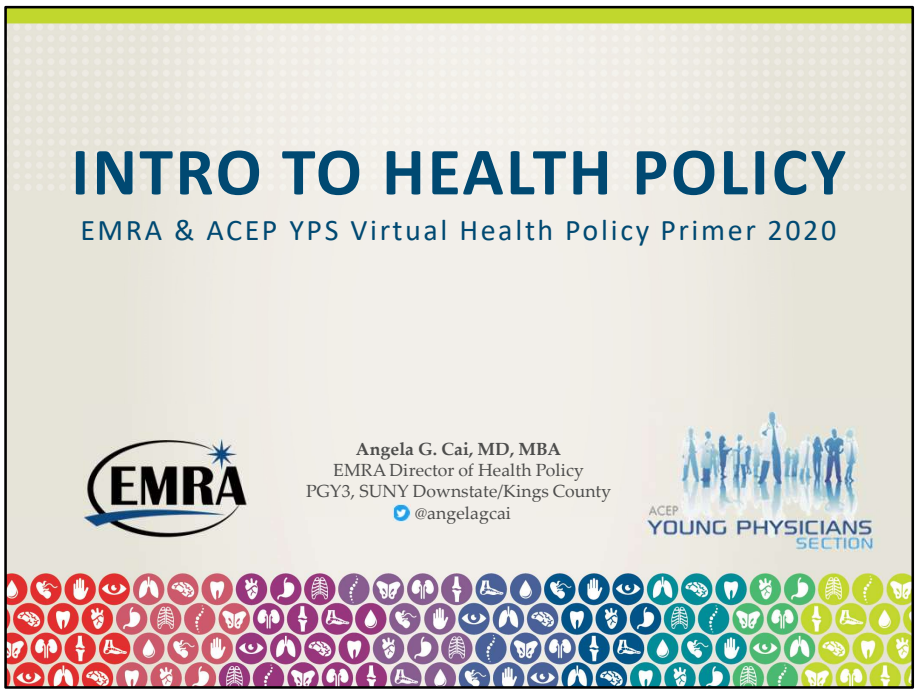
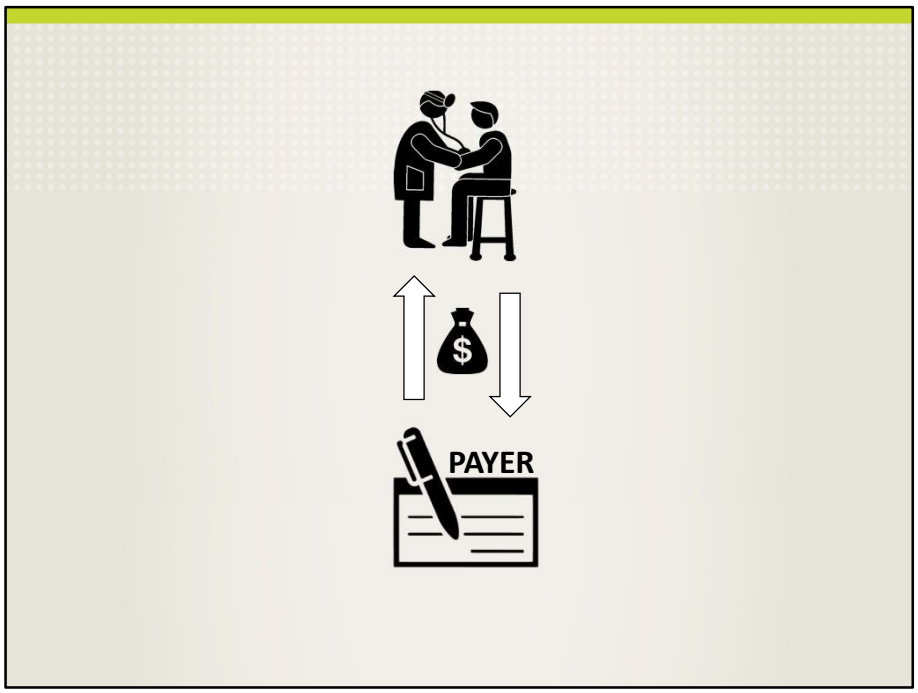



Please feel free to learn and share for educational purposes with appropriate credits, for example: Cai, AG. Intro to Health Policy. Slide presentation at: ACEP Leadership and Advocacy Conference; April, 2020; Washington, DC.


NOW
HOW
WHAT'S NEXT?
EMRA
Medical Students | Residents | Fellows | Alumni
16,000 Strong!

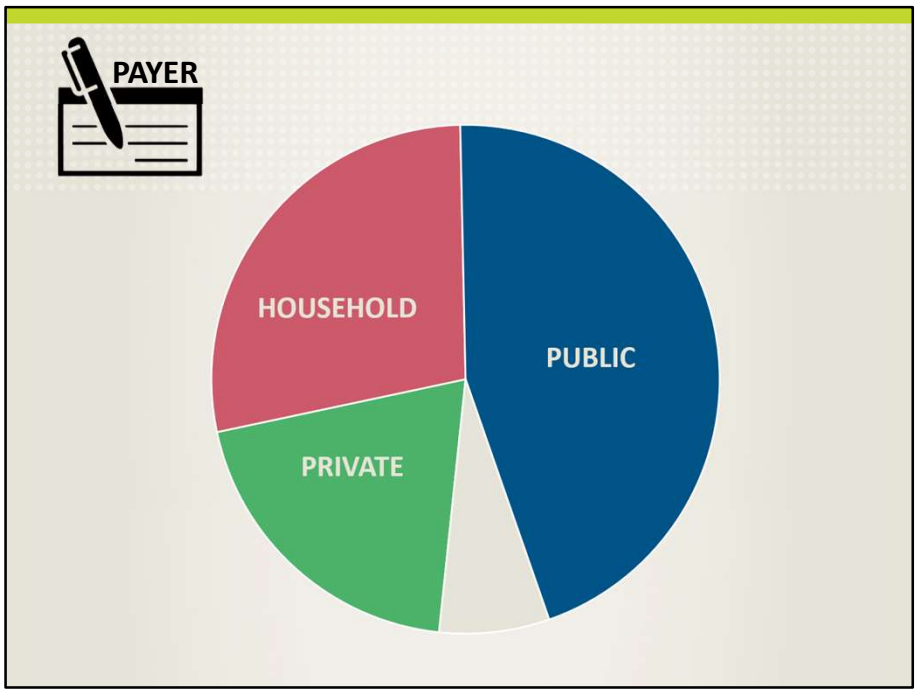

NOW
HOW
WHAT'S NEXT?
EMRA
Medical Students | Residents | Fellows | Alumni
16,000 Strong!




Normally when you pay for a service like a meal at a restaurant, you pay the person or company immediately. In health care we have an unusual situation. Payment goes through 3 rd party payers, that is insurance, for about 90% of people. This adds multiple layers of complexity to our system – multiple insurance companies with thousands of different plans, government vs private payers, etc.

Transition: Where is the money coming from?
---

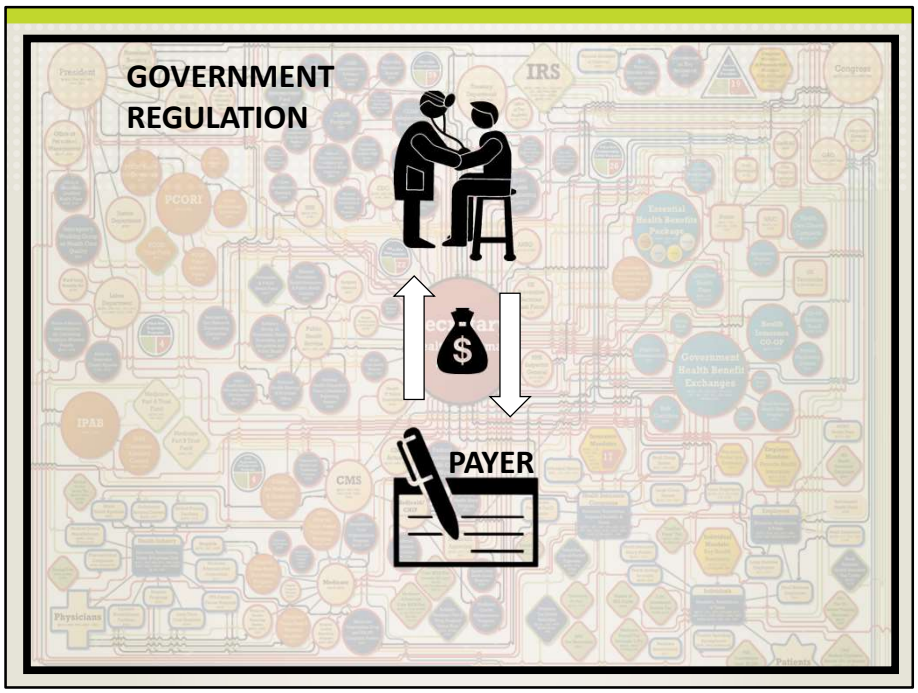
(https://www.census.gov/library/publications/2018/demo/p60-264.html)
https://commons.wikimedia.org/
svgsilh.com



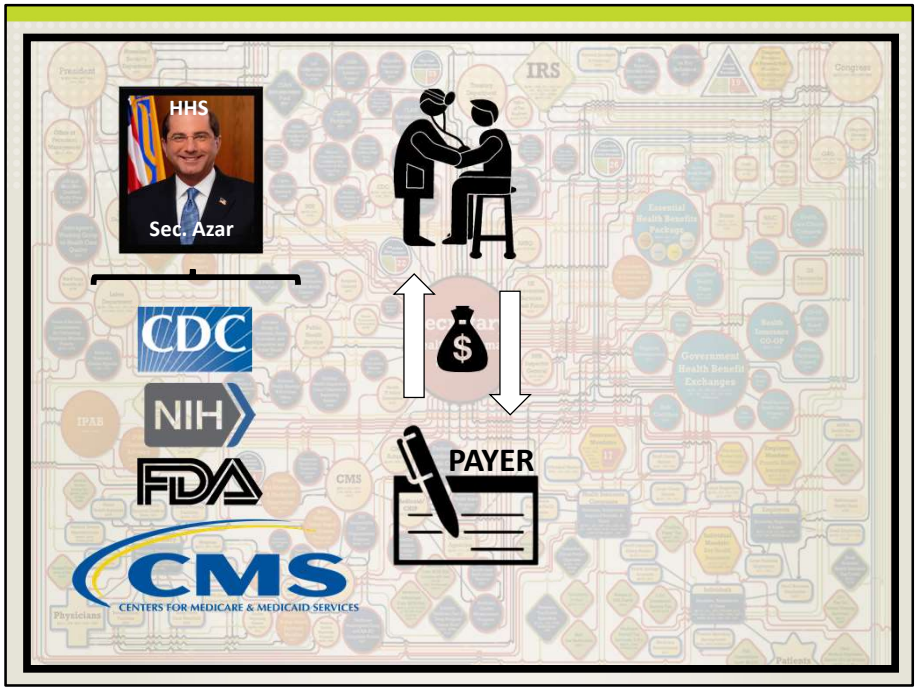

20% private = business
28% household (OOP (10.5% total NHE) purchase of policies, employee premiums, payroll taxes)
Most notably 45% is public – meaning the local/state (17%), and federal (28%) government money
(other 7%: other private i.e. philanthropy)

--

CMS National Health Expenditure Accounts
https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-u-s-similar-public-spending-private-sector-spending-triple-comparable-countries
https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html
https://www.ama-assn.org/system/files/2019-04/prp-annual-spending-2017.pdf



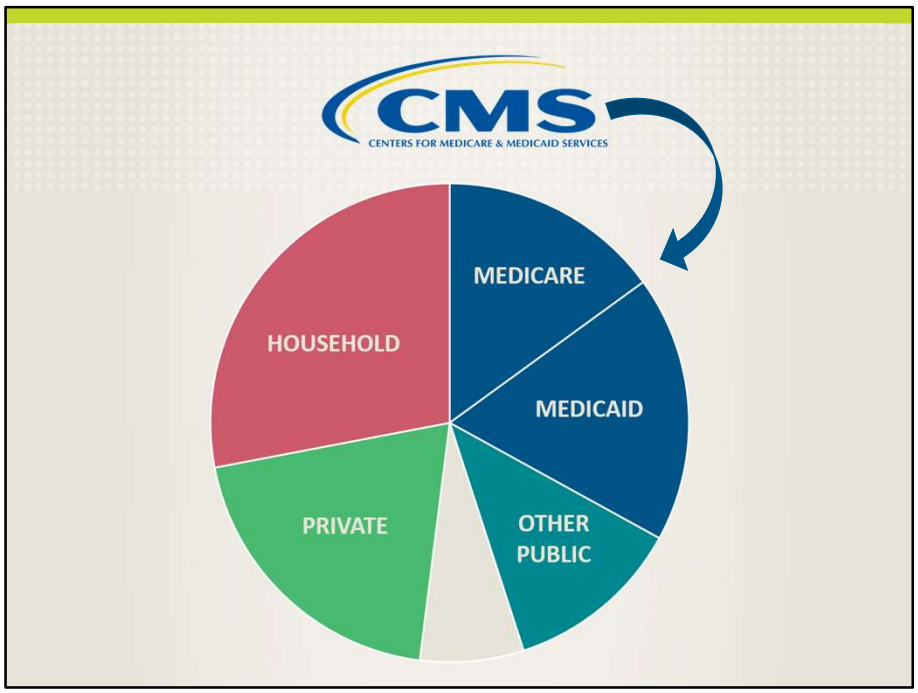

Everything that happens in this system is regulated through the government




The major governmental influencers live under the Department of Health and Human Services, HHS, led by Secretary Azar.
Notable agencies under HHS include
CDC, the public health arm
FDA, regulator of food, drugs, vaccines, medical devices, radiation emitting products (CT, XR)
NIH, federal funder of biomedical research
And finally & most prominently CMS, and specifically Medicare, is probably the singular most important health care influencer

Transition: Let's talk a little bit about why and how CMS is so influential.

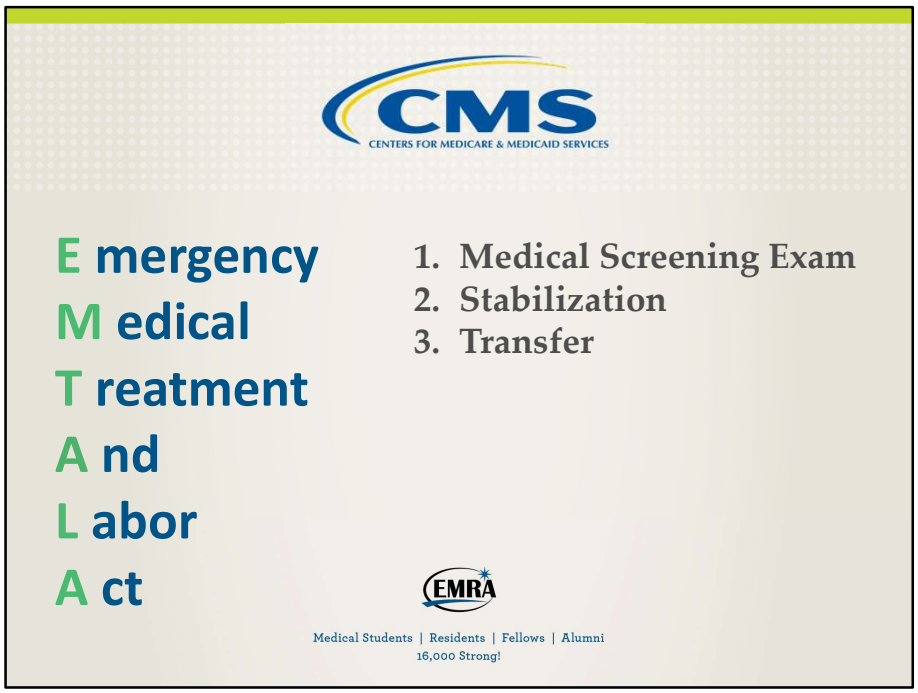
---
https://commons.wikimedia.org/
https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html




If we breakdown the payers, Medicare, the elderly insurance administered by CMS is the single largest payer of health care dollars.
While we do not have a single payer health system or a government sponsored insurer for the general public, Medicare is the main influencer because they command a lot of dollars that effectively all providers rely on. Medicare tends to set the reference point for payment rates.
They also influence provider behavior by withholding payments or setting penalties for lack of adherence to quality metrics, data reporting, or EMTALA violations.

Transition: Let's zoom in on EMTALA violations.

---
https://commons.wikimedia.org/
https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html



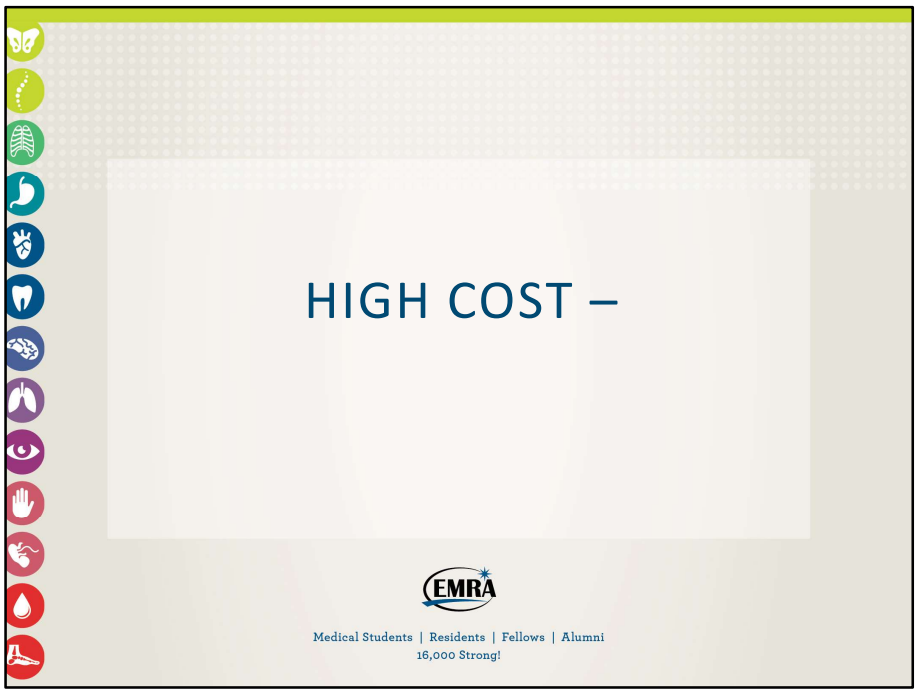

EMTALA is an anti-dumping law. It was passed in 1986 in response to private hospitals turning away unstable patients who could not pay. It states that every patient presenting to an ED must have a medical screening exam to determine the presence of an emergency condition, if there is an emergency to stabilize or transfer for higher level of care as medically necessary.
(The receiving hospital with the higher level of care must accept the patient)
EMTALA is the legal underpinning of our mandate to see all patients in the ER regardless of ability to pay. It is regulated by CMS. Penalties for EMTALA violations include fines or even termination of payment from Medicare.

Transition: This leads us to our first theme of our system

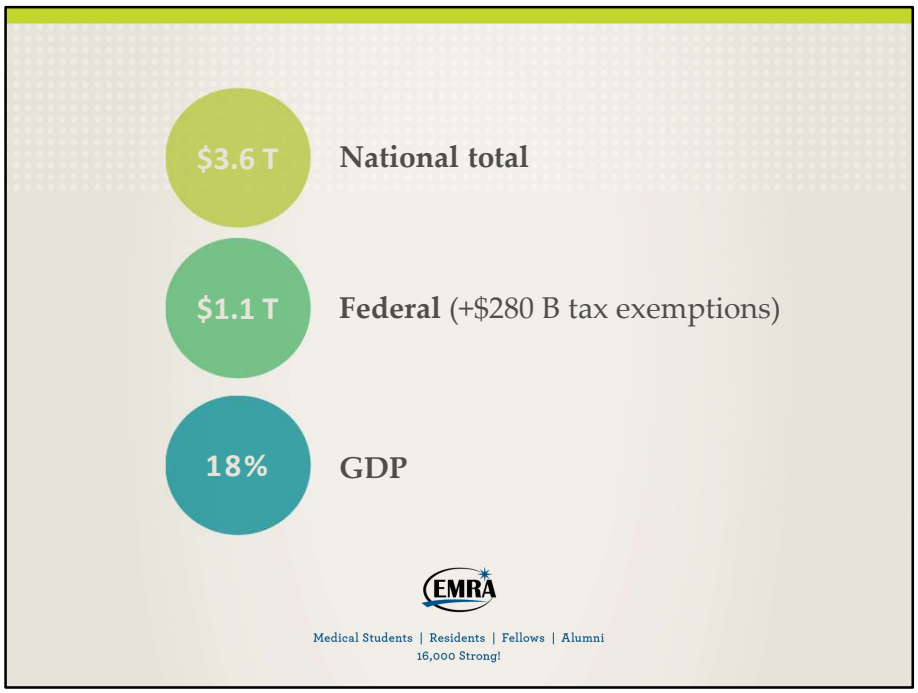
---
https://www.emra.org/books/advocacy-handbook/chapter-3-the-impact-of-emtala/


Through its spending and regulatory power, with CMS being the single greatest influencer of the system.

Transition: The next theme probably comes as no surprise to anyone.



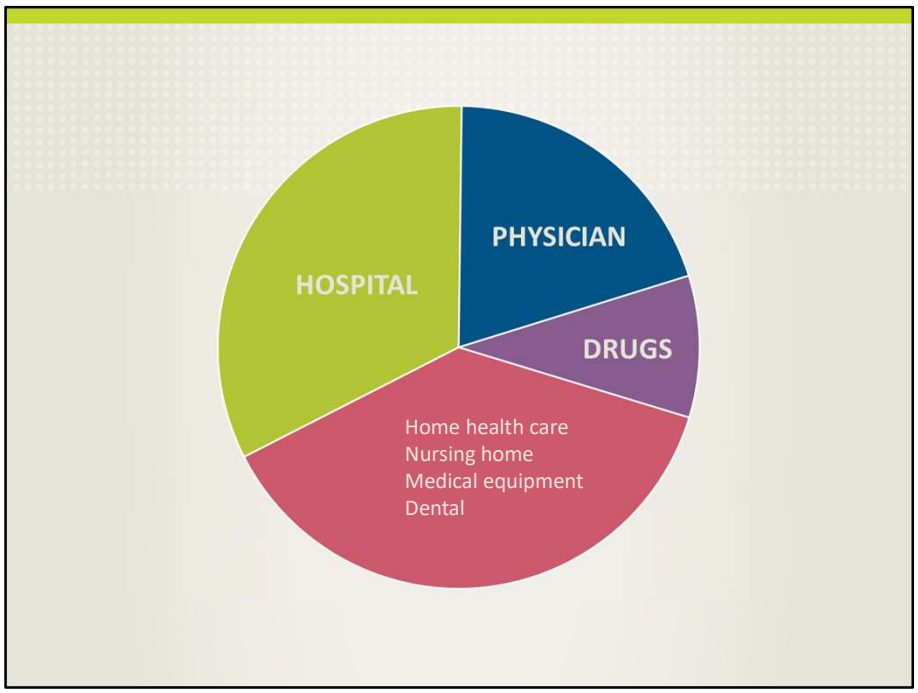

The second theme of the system should come as no surprise.




This spending is quantified in….
Why do we care how much we're spending on health care if it's for a good cause? Because government & the economic spending is limited and growth in health care means less money for other things – social security, defense, education, transport, SNAP food assistance

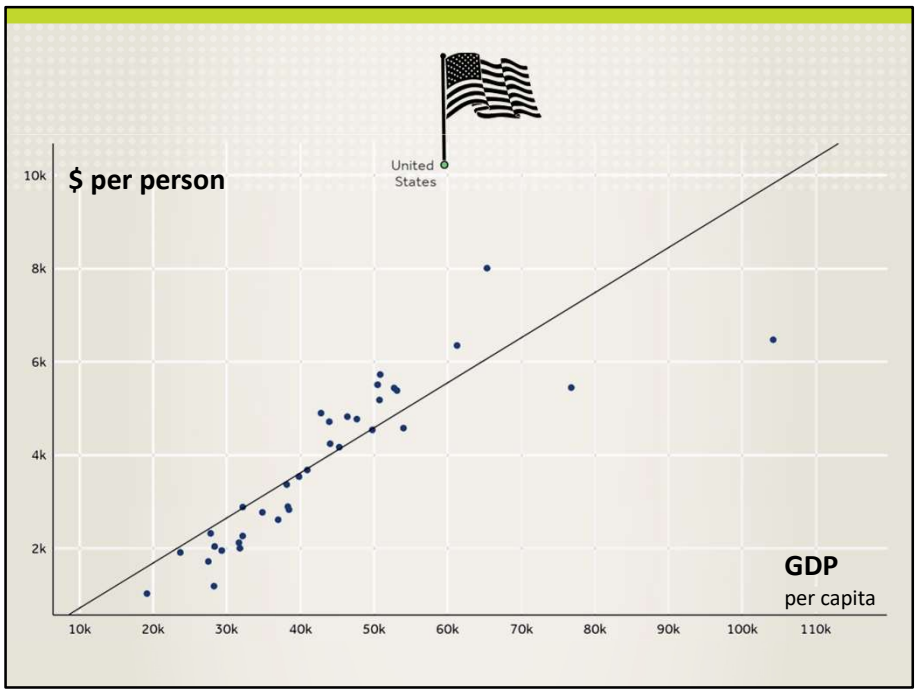
Transition: What services are these dollars paying for?
--
Mcare $591B
Mcaid $375B
SS $939B
Defense $590 B
Everything else (Transport, education, veterans benefits, housing, unemployment, SNAP [food assistance]) $1.4 trillion

CBO 2017 Budget https://www.cbo.gov/publication/53624
https://www.crfb.org/papers/american-health-care-health-spending-and-federal-budget
https://www.taxpolicycenter.org/briefing-book/how-much-does-federal-government-spend-health-care




Hospital 33%
Physician 20%
Rx 9%
The rest is smaller pieces of pie e.g. home health care, nursing home, medical equipment, dental

Transition: Not only is health care occupying a significant portion of our budget, in the US we seem to be spending more than other countries.
---
Other personal 15%: other professional services, eyeglasses and appliances, and other health services
Dental (4%), home health (3%), nursing (5%)
https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-hospital-and-physician-services-represent-half-of-total-health-spending
https://www.ama-assn.org/about/research/trends-health-care-spending
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191492/




The OECD (Organization for Economic Cooperation and Development) comprises a group of well developed, democratic, market economies that gives us a group to compare ourselves to.
We deviate from the curve of spending proportional to size of economy

Transition: What are we getting for our money? How are our health outcomes? Is our spending cost effective?

---

https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends

| | $$ | Life Expectancy | Infant Mortality | Maternal Mortality | Premature Death |
|---|---|---|---|---|---|
| 1 | United States | Japan | Slovenia | Finland | Iceland |
| 2 | Switzerland | Switzerland | Finland | Iceland | South Korea |
| 3 | Luxembourg | Spain | Japan | Greece | Switzerland |
| 4 | Norway | Italy | Iceland | Poland | Japan |
| 5 | Germany | Iceland | Norway | Sweden | Australia |
| 6 | Ireland | Australia | Sweden | Czech Republic | Sweden |
| 7 | Sweden | Norway | Czech Republic | Italy | Italy |
| 8 | Netherlands | Luxembourg | Estonia | Austria | Israel |
| 9 | Austria | France | Spain | Japan | Norway |
| 10 | Denmark | Sweden | South Korea | Norway | Luxembourg |
| 11 | Belgium | South Korea | Luxembourg | Spain | Canada |
| 12 | Australia | Israel | Italy | Israel | Spain |
| 13 | Canada | New Zealand | Portugal | Switzerland | Finland |
| 14 | France | Canada | Israel | Australia | Ireland |
| 15 | Japan | Netherlands | Austria | Germany | New Zealand |
| 16 | Iceland | Finland | Australia | Denmark | France |
| 17 | United Kingdom | Ireland | Netherlands | Slovakia | Netherlands |
| 18 | Finland | Austria | Belgium | Netherlands | United Kingdom |
| 19 | New Zealand | Portugal | Germany | Belgium | Austria |
| 20 | Italy | Greece | Ireland | Canada | Portugal |
| 21 | Spain | Belgium | Denmark | Ireland | Chile |
| 22 | Slovenia | United Kingdom | France | France | Denmark |
| 23 | Israel | Slovenia | Switzerland | Slovenia | Belgium |
| 24 | Portugal | Denmark | United Kingdom | Estonia | Germany |
| 25 | South Korea | Germany | Greece | United Kingdom | Greece |
| 26 | Czech Republic | Chile | Poland | Luxembourg | Slovenia |
| 27 | Greece | United States | Latvia | Portugal | United States |
| 28 | Slovakia | Czech Republic | Hungary | South Korea | Mexico |
| 29 | Hungary | Turkey | Canada | New Zealand | Czech Republic |
| 30 | Estonia | Estonia | New Zealand | United States | Turkey |
| 31 | Chile | Poland | Slovakia | Turkey | Estonia |
| 32 | Poland | Slovakia | United States | Hungary | Slovakia |
| 33 | Latvia | Hungary | Chile | Latvia | Poland |
| 34 | Turkey | Mexico | Turkey | Chile | Hungary |
| 35 | Mexico | Latvia | Mexico | Mexico | Latvia |

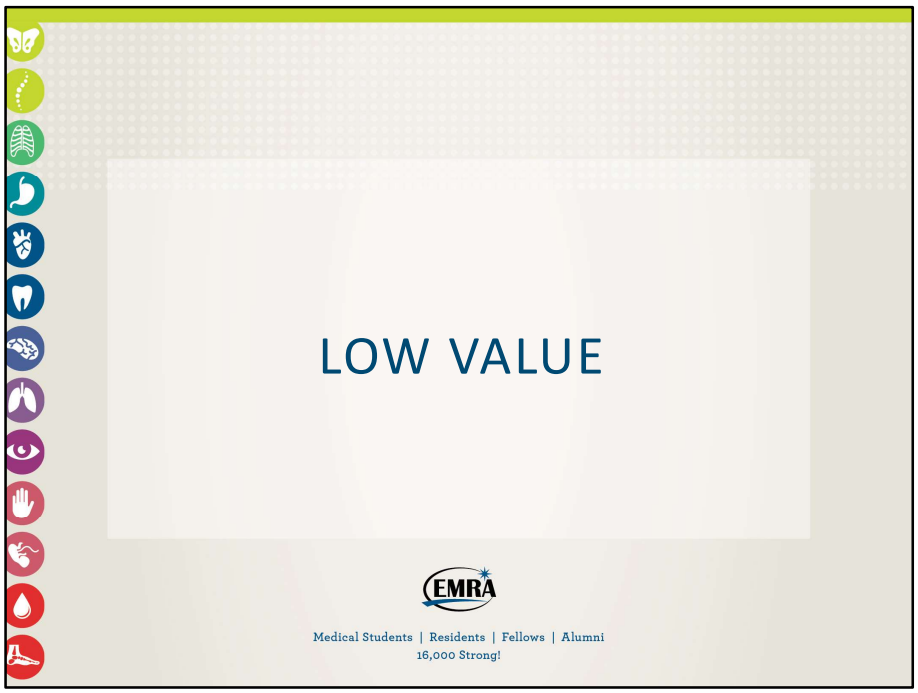
Here is the US at the top of spending among 35 OECD countries.
For all of our spending, we don't seem to be getting good outcomes for our patients. On multiple basic quality indicators we routinely rank at the bottom.
Life expectancy, etc
We have some of the most advanced care and technology but for the average person, we are failing to deliver quality care.

Transition: This cost-quality conundrum is the second theme of US health care

---
OECD
Bloomberg

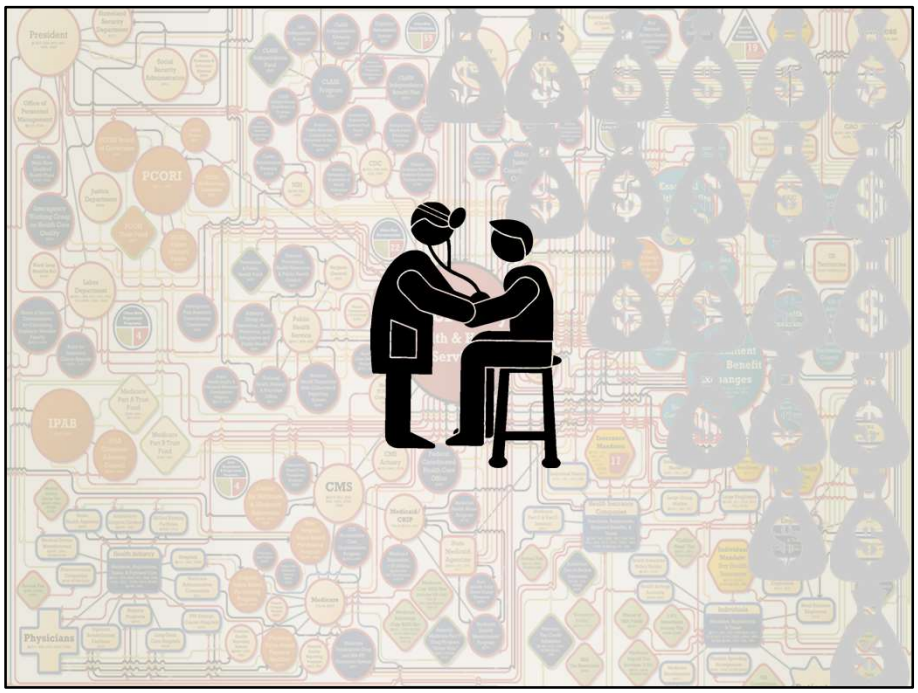

HIGH COST –
LOW QUALITY
on average
EMRA
Medical Students | Residents | Fellows | Alumni
16,000 Strong!


Another way to frame this cost-quality problem is in terms of value.




In other words, in the US we deliver low value health care.

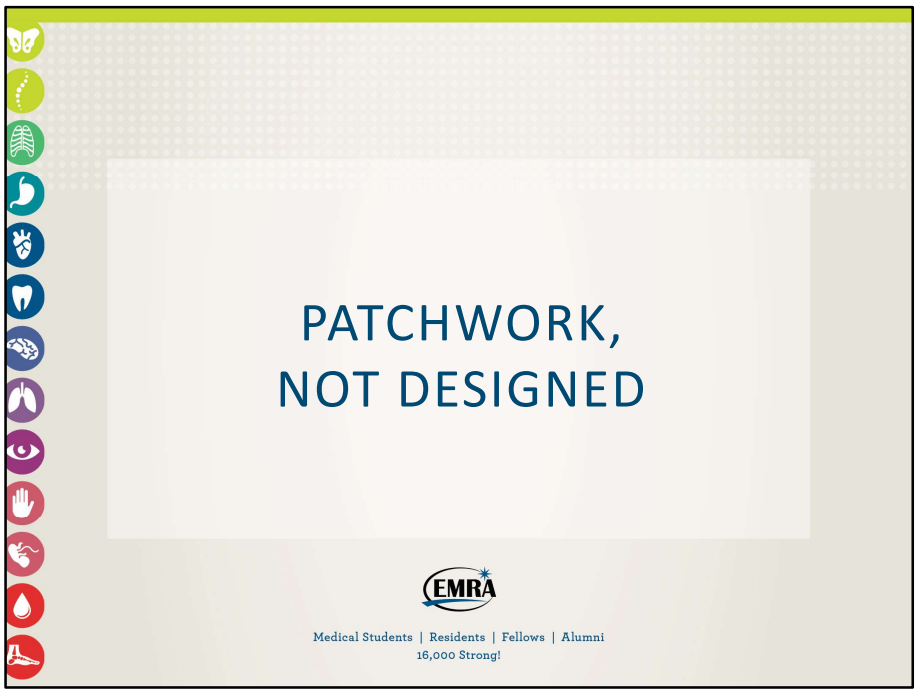
The concept of value in US health care is a very timely theme. When you hear things like "value-based care," it's an attempt to target this value problem and demanding that the system we are paying for is delivering value to patients – specifically that it delivering better health outcomes for a good price.



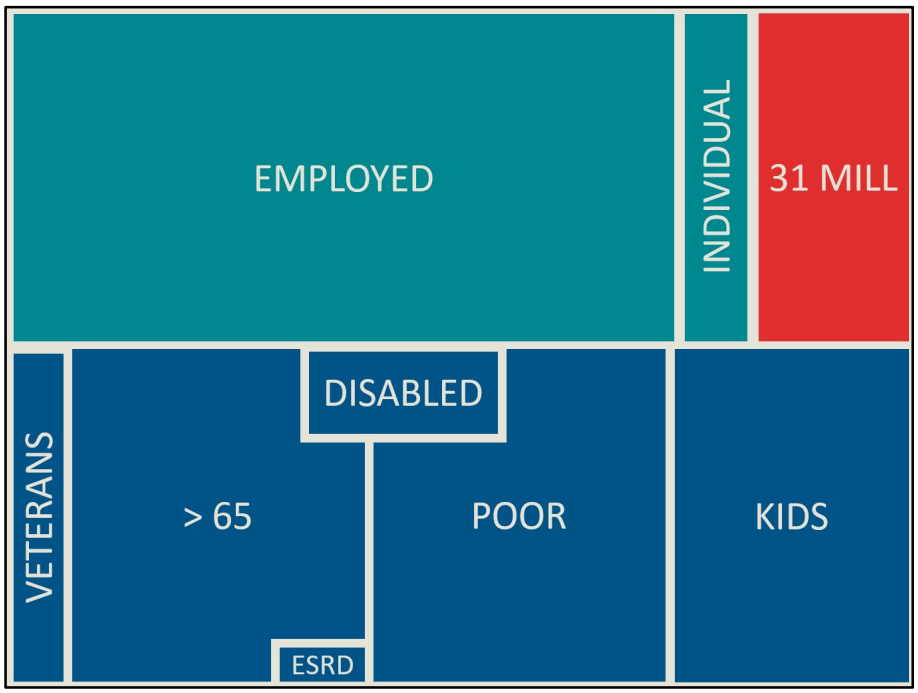

This massive, expensive, & complicated system is the background in which we practice the doctor-patient relationship.

Transition: Let’s go back in time to try to understand how we got here.


How was our health care system, specifically health coverage built?




The constant theme is that our system was built out of a patchwork of fixes. It was not designed.
This is the root of a lot of inefficiencies we are all familiar with in our personal or professional interactions with the system.
Why can't hospital records talk to each other? Why don't I know how much a service costs? Why are there thousands of different insurance plans?




Health coverage in this country was built in stages with different populations of people gaining coverage.
Veterans have had some form of government sponsored coverage and care delivery since the civil war.
The largest group of people is those covered by insurance purchased by their jobs. There are a few who buy their own insurance through what's known as the individual market.
Overtime, the government tried to fill in coverage gaps for sympathetic populations.
Elderly over 65 are covered by Medicare.
Poor and children are covered by Medicaid.

Advocates have used existing government programs like Medicare and Medicaid to cover specific populations like dialysis patients and persons with disabilities.

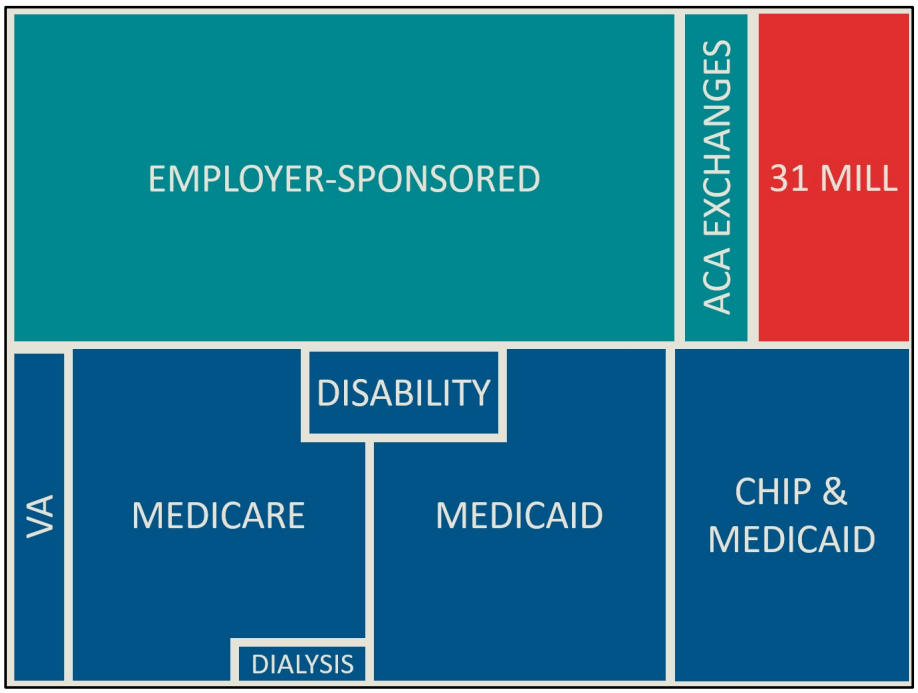
Not everyone in one of these groups is covered, and many people have coverage from multiple sources. There are still millions of people without coverage – which in this country almost equates to no access to care. These are the 27 million who remained uninsured.
The vast majority of these people are the working poor.

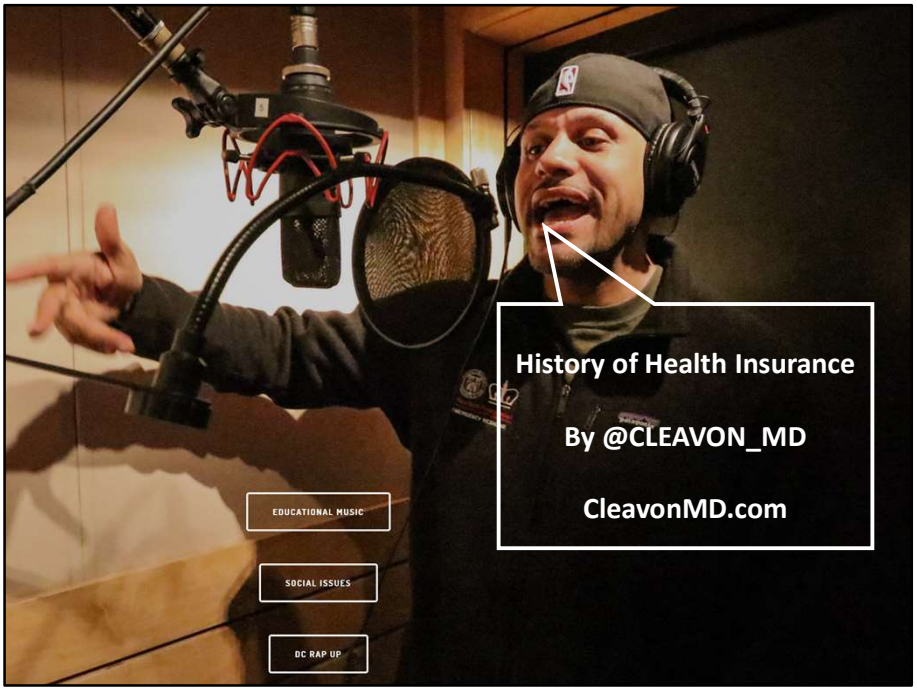
Transition: to tell you the story of this patchwork, we have a special message from Cleavon MD, PGY3 at NYP Queens and health policy rapper.

---

VA 9M
Medicaid 75 M (2017)
Medicaid children 36 M (2014)
Medicaid Vets 875K (40% Medicaid only)
Disabled (11M, 2014)
CHIP 8.1 M (2014)
Medicare elderly & disabled 60 M
Disabled under 65 receiving SS disability 9.1 M (since 1973, 2016)
ESRD 395 K (2017, $ 11B)
Employer sponsored 153 M (2017)
Uninsured 27 M (2016)
Mostly (77%) nonelderly adults (86%) from low-income families with 1+ full-time worker
Young invincibles 20 M uninsured pre ACA 12 M post-ACA 2015 (dependent coverage 2.3 M , Medicaid expansion 3.8 M, marketplace 3.5M)
Individual: 10 M pre-ACA 15 M (2016)

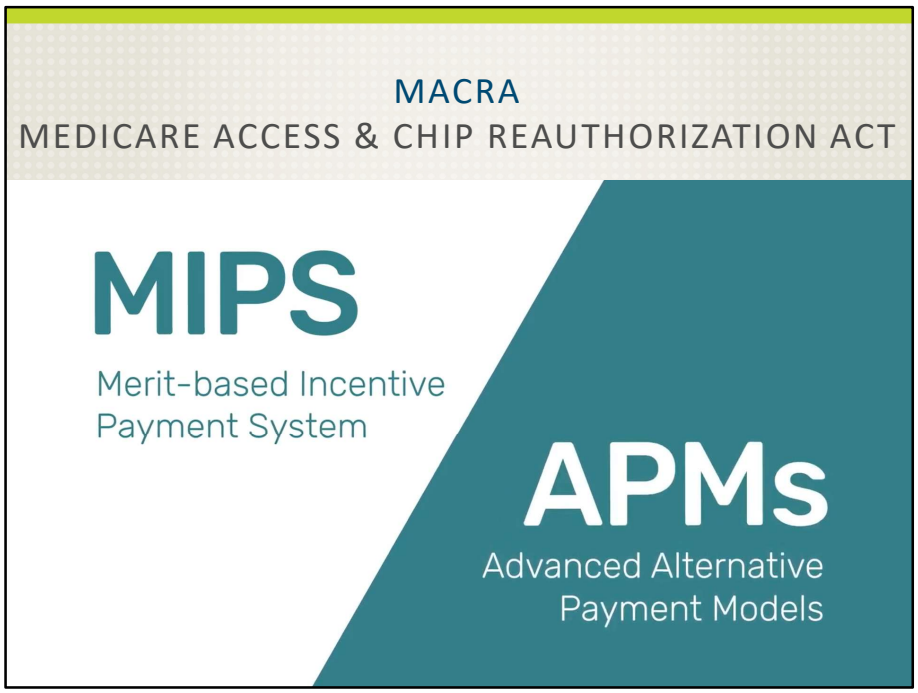
https://www.va.gov/health/
https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/
https://www.kff.org/health-reform/issue-brief/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future/
https://www.kff.org/infographic/medicaids-role-in-covering-veterans/
https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?dataView=0&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/
March 2019 Report to the Congress: Medicare Payment Policy Ch 6 Outpatient Dialysis
https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/#item-start
https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/
https://younginvincibles.org/whats-happened-millennials-since-aca-unprecedented-coverage-improved-access-benefits/
KFF Data Notes: Changes in Enrollment in the Individual Health Insurance market
https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/

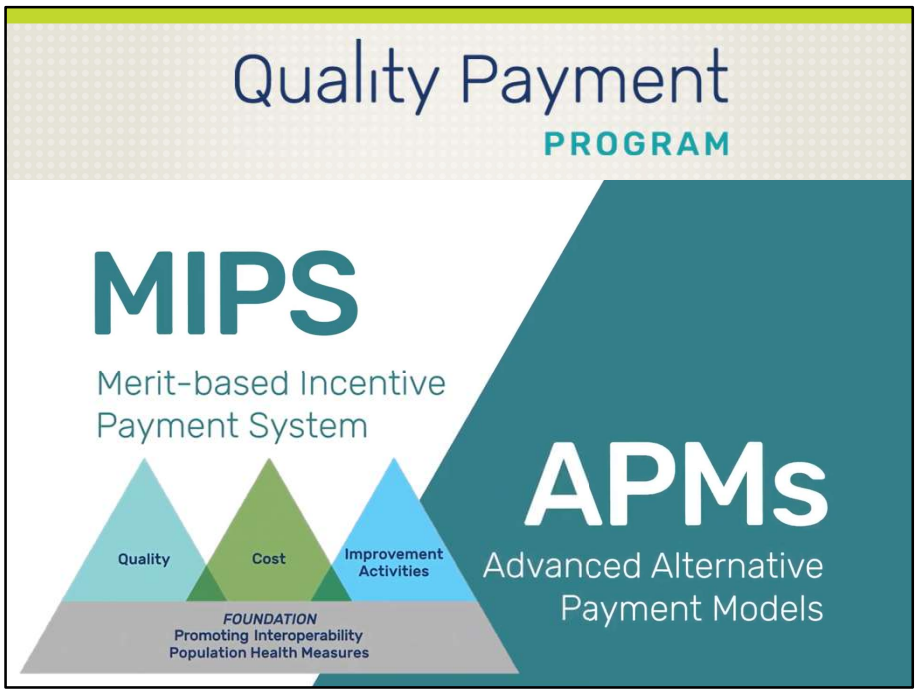

EMPLOYER-SPONSORED
ACA EXCHANGES
31 MILL
VA
MEDICARE
DISABILITY
MEDICAID
CHIP &
MEDICAID
DIALYSIS



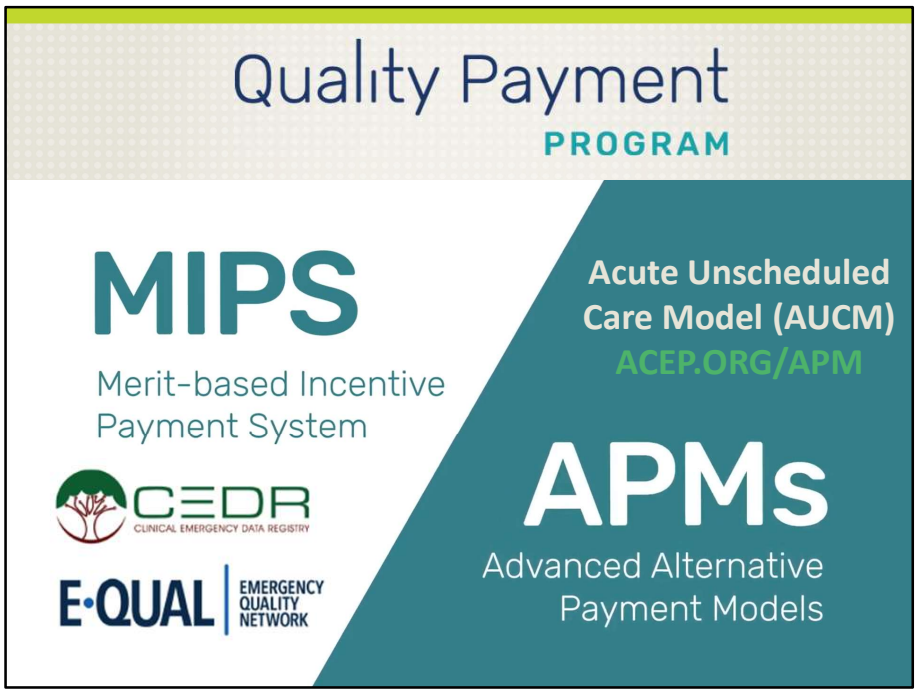

https://www.youtube.com/watch?v=3oIGNCvuz-0&ab_channel=CleavonM.D.


NOW
HOW
WHAT'S NEXT?
EMRA
Medical Students | Residents | Fellows | Alumni
16,000 Strong!

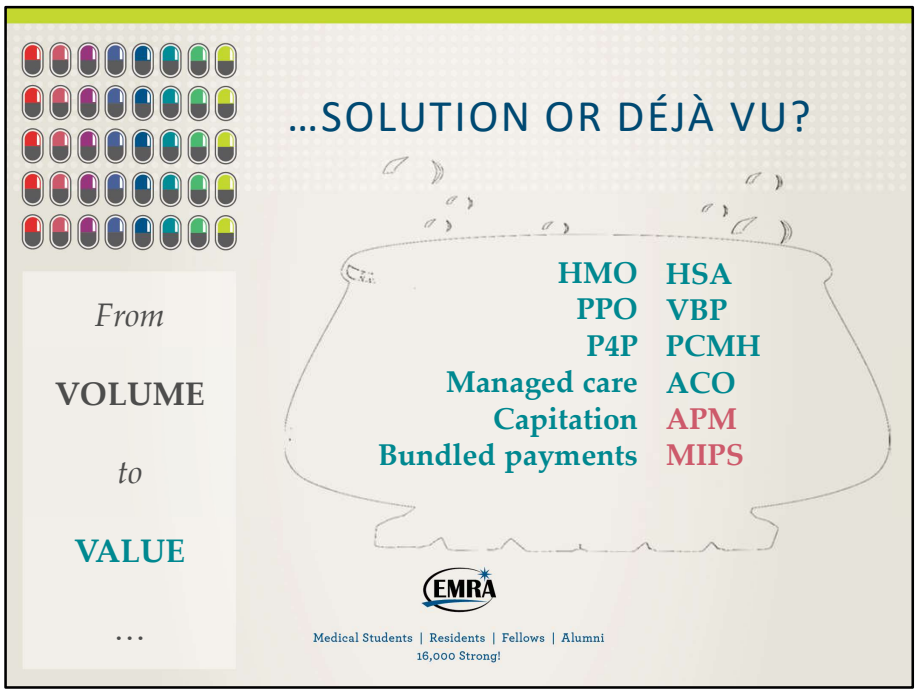

MACRA
MEDICARE ACCESS & CHIP REAUTHORIZATION ACT
MIPS
Merit-based Incentive Payment System
APMs
Advanced Alternative Payment Models




2 tracks: MIPS or APMs Most EM will use MIPS The four performance categories for MIPS are: Quality (60%): ACEP CEDR, e.g. CT head use in trauma Practice Improvement (15%) e.g. use PDMP opioid website Advancing Care Information (rebrand of Meaningful Use 25%) – not for EM Resource Use or Cost (10%): doesn't apply to EM yet




The American College of Emergency Physicians (ACEP) have created some tools to help EM docs work in either of these programs.

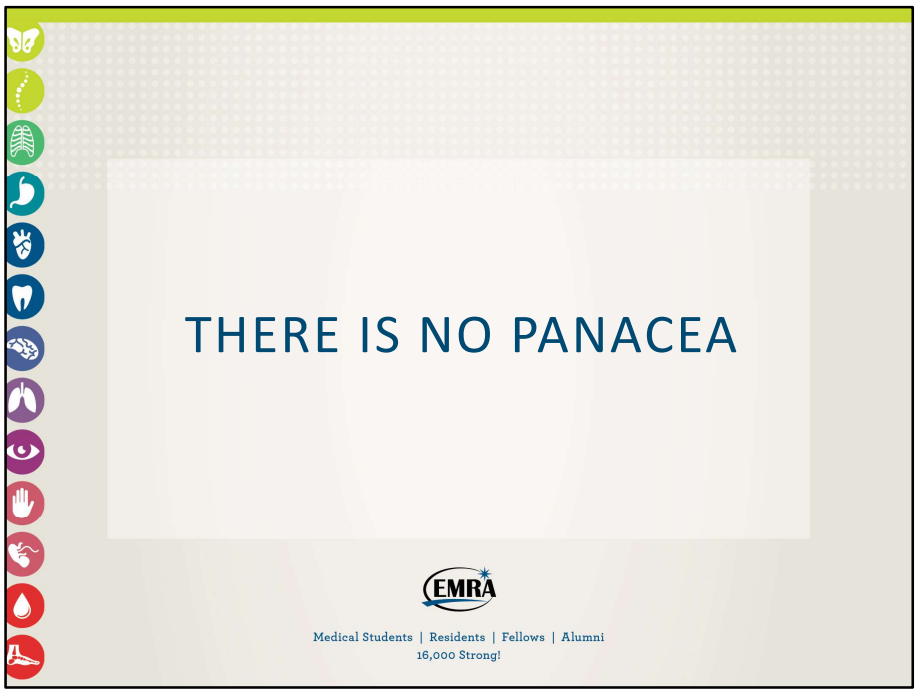



"The American health care system long presented an intriguing paradox: perennially in crisis, but impervious to comprehensive reform. Throughout the 20th century reformers repeatedly failed to enact proposals for universal coverage. Efforts to control medical care spending did not fare any better. As a result, the United States has the most expensive health care system in the world and is the only rich democracy with a large uninsured population." (Oberlander syllabus)

Trying to get more from less in a setting where spending is health care income income. So who is going to lose money?

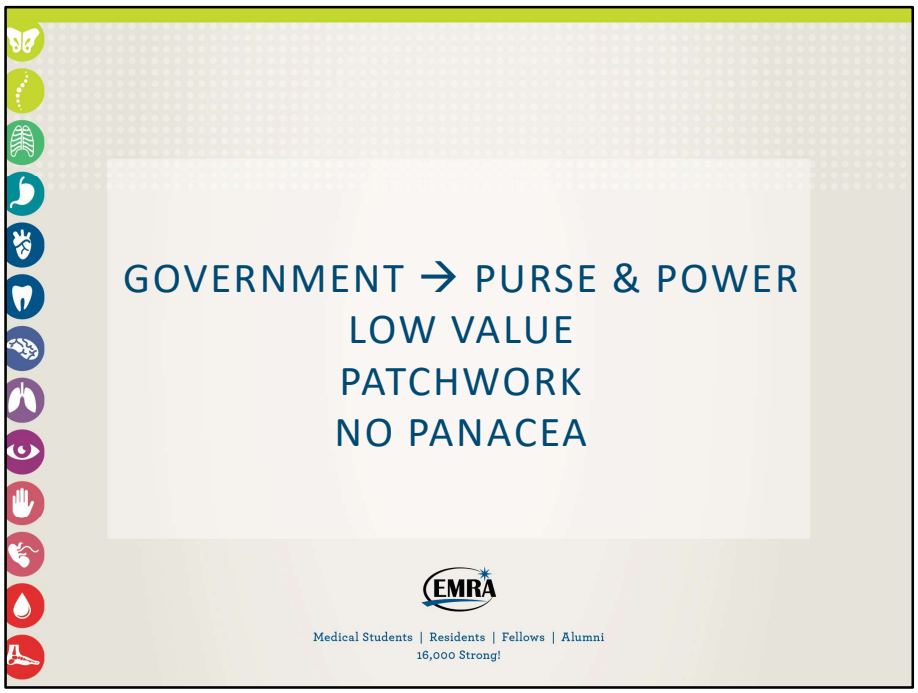
--

From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy
Theodore Marmor, PhD1 and Jonathan Oberlander, PhD
The American health care system long presented an intriguing paradox: perennially in crisis, but impervious to comprehensive reform. Throughout the 20th century reformers repeatedly failed to enact proposals for universal coverage. Efforts to control medical care spending did not fare any better. As a result, the United States has the most expensive health care system in the world and is the only rich democracy with a large uninsured population. (Oberlander syllabus)



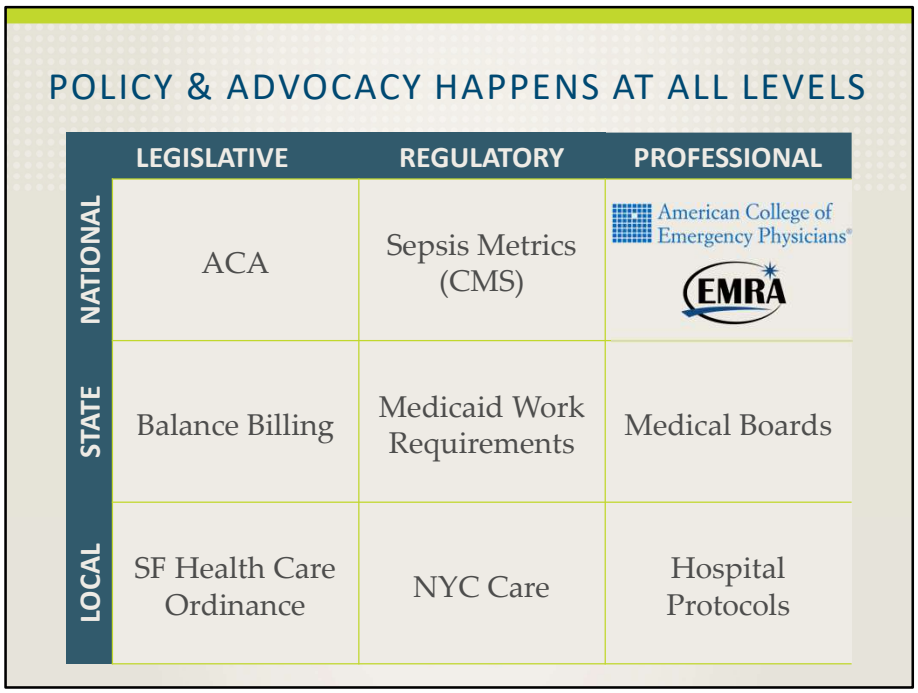

Learn from the past.
Don't expect a singular legislation or a shift in payment models to fix a system that was built over decades and problems that have persisted in spite of repeated attempts at overhaul.
Health policy is a constantly shifting which makes it and endlessly frustrating yet fascinating space to be in.

Transition: Let's review our system themes




Transition: Moving forward, how and where can you get plugged in?


NOW
HOW
WHAT'S NEXT?
EMRA
Medical Students | Residents | Fellows | Alumni
16,000 Strong!




The first thing to realize about advocacy is that it happens at multiple levels and in fact some of the most impactful things we can do are not on this scale that we have been talking about e.g. sweeping legislation a la Medicare, ACA. What happens in your institution, city, or state matters just as much.

There are 3 major categories of advocacy.
First is legislative or the passing of laws.
LOCAL: SF who passed a city ordinance requiring employers to pay a fee for their workers' insurance coverage.
STATE: balance billing AKA surprise billing laws vary by state, currently no federal legislation
FEDERAL: ACA – passing AND funding

Next is regulatory which make changes not through laws but within existing governmental agencies and budgets
LOCAL: NYC care is the city's attempt to insure all the uninsured by expanding insurance coverage through the public hospital system
STATE: Remember Medicaid is a joint federal & state program. States are now allowed to attach work requirements for people to qualify for Medicaid
REGULATORY: as we discussed before CMS is a huge player here. You've probably all seen the impact that CMS' tracking of adherence to sepsis bundle has impacted the flow of

triage, documentation, & orders in your ED.

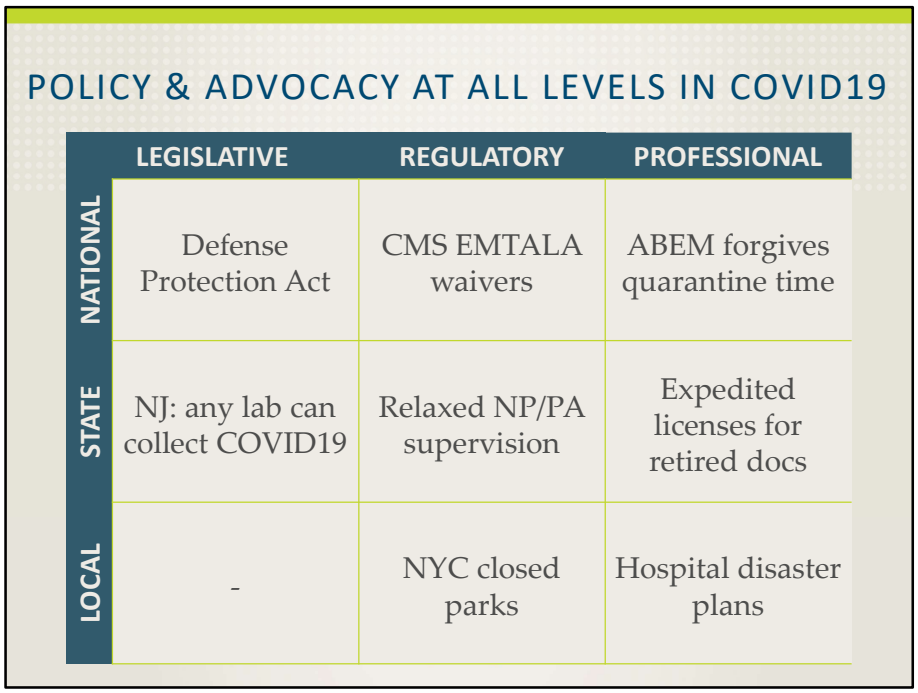
Professional refers to the ways we as doctors self-regulate or advocate as a group
INSITUTION: we create hospital & departmental protocols
STATE: we obtain licenses to practice from state medical boards
FEDERAL: we organize together at the national level through ACEP & our political action committee, NEMPAC

These categories don't include other influential forces like executive orders, the judicial system (Medicaid expansion, torts)

Transition: This sounds complicated. Didn't we go to medical school to take care of patients? Since you all are here, you are probably already sold on the idea of advocacy. I want to give you one more way to frame your motivation to advocate.

--

https://www.reuters.com/article/us-health-sodas-tax/sugary-drink-tax-tied-to-drop-in-soda-consumption-idUSKCN1QI5J9
http://newsroom.acep.org/2015-01-09-freestanding-emergency-departments
http://www.ncsl.org/research/health/out-of-state-health-insurance-purchases.aspx
http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx
https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/
https://www.nytimes.com/2007/09/14/us/14health.html

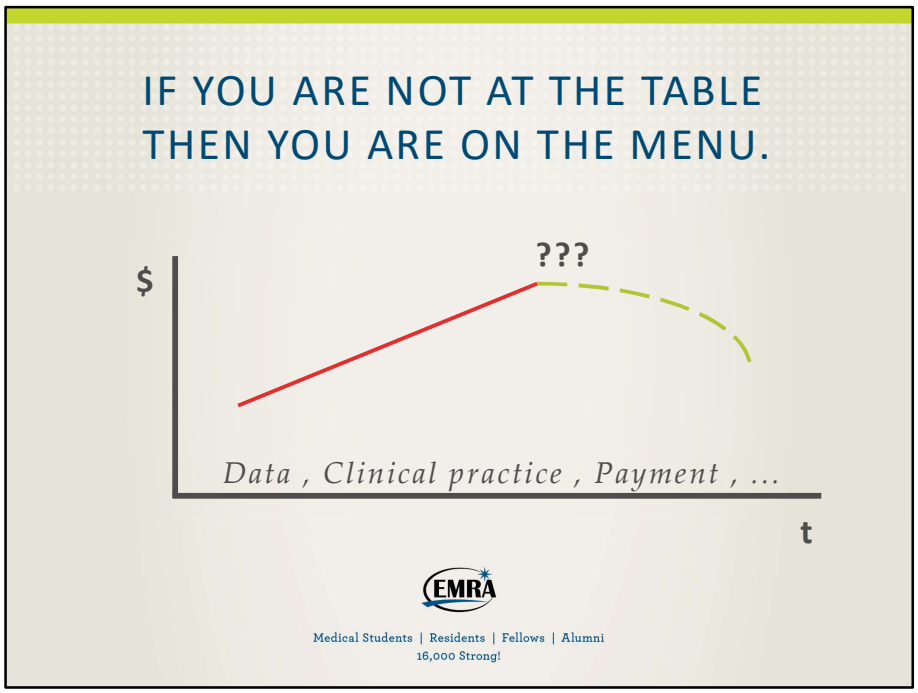



4/7: At least thirty-five states, the District of Columbia, Guam and Puerto Rico have introduced legislation to support state action related to COVID-19. Several resolutions adjourn legislative sessions or adopt temporary rules to allow governing bodies to meet or vote electronically. Many bills appropriate funds or focus on health topics such as insurance coverage, medical costs or telehealth services. Others involve paid leave, unemployment benefits, guidance for schools, or workforce protections for those in quarantine or isolation. Some bills address price gouging or eligibility for public services, temporarily prohibit evictions and ensure utility services, or extend certain legal deadlines. Thirty-two states, the District of Columbia and Puerto Rico have enacted or adopted legislation.

--

https://www.theatlantic.com/ideas/archive/2020/04/how-actually-use-dpa-fight-covid-19/609469/
https://www.ncsl.org/research/health/state-action-on-coronavirus-covid-19.aspx#Table
https://www.fsmb.org/siteassets/advocacy/pdf/states-expediting-licensure-for-inactive-

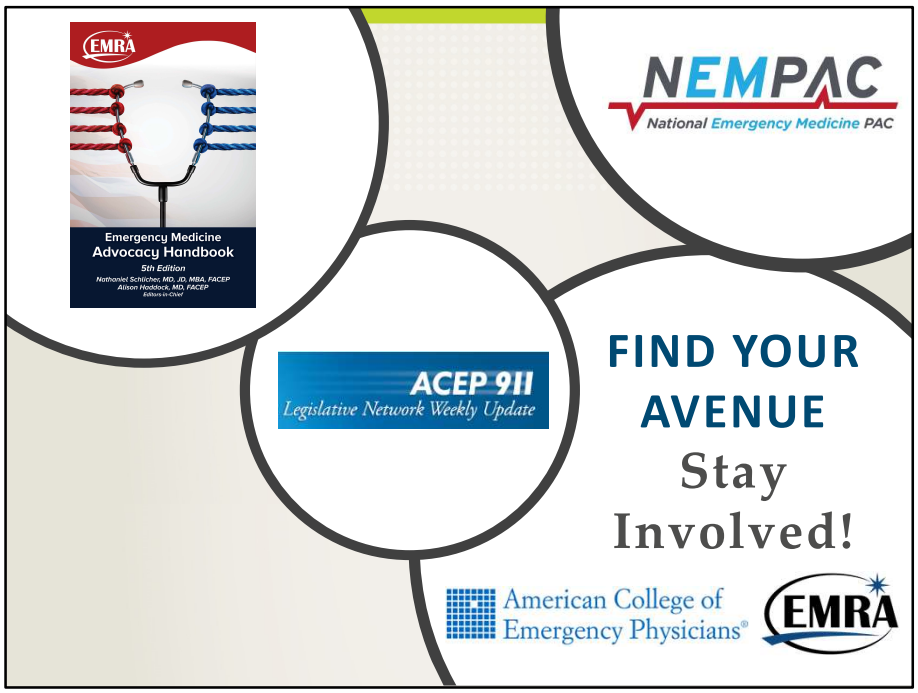
retired-licensees-in-response-to-covid19.pdf
https://www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements
https://www.abem.org/public/docs/default-source/default-document-library/letter-to-abem-certified-physicians-and-em-residents
https://www1.nyc.gov/office-of-the-mayor/news/214-20/mayor-de-blasio-create-hospital-billie-jean-king-tennis-center-relieve-need-elmhurst




With increasing pressure to solve the cost-quality conundrum – literally greater than ever in history – there are even more people trying to dictate what patient care looks like and how to pay for it. How are we going to bend the cost curve?

What you can do for your patient's doesn't just depend on what the doctor thinks anymore.
We need to be at the table where those decisions are made about what data we are going to collect, how medical decisions are regulated, and who is getting paid for what.

Transition: Let's close with specific thing you can do today.




1. Make a contribution to NEMPAC, our bipartisan EM PAC. To have a seat at the table in Congress, we need to spend money in unison to make a statement.
   Contribute at the give-a-shift level for your training, starting at $120 for residents, to fund the EM voice and receive VIP perks
2. Stay up to date by signing up for ACEP 911, a weekly newsletter and notification network for things in your district that require your immediate action, such as calling a legislator
3. Sign up for committees at EMRA or ACEP.
4. Keep learning. A great place to start is EMRA's EM advocacy handbook.