The ABC’s of the ACA

“How the Affordable Care Act Improves Your Practice”

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Past Chair ACP Board of Regents
Macro
Micro
The ACA as of October 25, 2014

- The ACA has worked to improve access—it will succeed if the withering opposition and unrelenting legal challenges ever soften.
- From the outset, the ACA recognized that primary care is undervalued, and established programs to create incentives for primary care.
- But many of the incentives are at risk of going away.
During the 1912 presidential election, Teddy Roosevelt campaigned for national health insurance. He lost the election to Woodrow Wilson who captured > 80% electoral votes.

Almost 100 years later, the Patient Protection and Affordable Care Act was signed into law.

March 23, 2010
What does the Affordable Care Act do?

- Ended most discriminatory insurance practices
- Established coverage for nearly all legal residents
- Provided for programs to address primary care shortage and begin to bend the cost curve
What does the ACA do about coverage?

- No pre-existing condition exclusions
  - Children (2010)
  - Adults: Temporary high risk pool (2010), then all plans must cover (2014)
- No rescissions (2011)
- Up to age 26 covered by parents’ plan (2010)
- Preventive services with no-cost sharing (2010 for new plans, 2014 for all Hl)
What does the ACA do about coverage?

- Medicare Part D doughnut hole: $250 rebate (2010), 50% discount on brand name drugs (2011), to be completely phased out by 2020
- Individual and small business tax credits applied to purchase of HI through state exchanges (2014)
- Qualified health plans must offer basic benefits packages: bronze, silver, gold, platinum, plus low cost-plan for under age 30 (2014)
What does the ACA do about coverage?

- Large employers must pay a penalty if their employees obtain coverage through an exchange (2014) → 2015
- Individuals required to buy coverage or pay penalty (2014)
- Medicaid expanded to 133% of FPL with 100% of cost initially paid for by federal government (2014), phases down to 90%.
What does it the ACA do about coverage?

If fully implemented by all 50 states, then 32 million previously uninsured Americans would have coverage.

• Half by HI offered through exchanges, half by Medicaid
• Although most Americans will continue to obtain coverage through employer-sponsored HI
What does the ACA do about Cost?

- Center on Medicare and Medicaid Innovation (ongoing)
  - ACOs
  - Bundling
  - Other voluntary pilots to align incentives with value
  - Must include models to reform primary care payments
- Pay-for-performance (ongoing)
- Review of Mis-valued services (ongoing)
What does the ACA do about Cost?

- Insurers must spend at least 85% of premium dollar on direct patient care or pay a rebate (80% for smaller plans), 2011
- Insurers will be required to streamline and reduce paperwork on patients and physicians, including enrollment, electronic funds transfers, and authorization requirements, or pay a fine (rules were rolled out in 2011)
What does the ACA do about Cost?

- Patient-Centered Outcomes Research Institute (ongoing CER)
- Prevention and Public Health Trust Fund ($15 Billion/10 yrs)
- National Quality Strategy (subsidiary of AHRQ & CMS)
- IPAB (2013)
- Employers may offer 50% premium discount for employees who achieve personal health goals (2014).
January 2014

- Premium tax credits and cost-sharing subsidies available.
- Beginning of Medicaid expansion.
- Most people required to have health insurance.
- The bulk of the remaining insurance regulations went into effect, including essential health benefit package, guaranteed issue, premium regulations, etc.
How Did the Marketplaces Do?

• Over 8 million individuals selected a health plan through a Health Insurance Marketplace.
• 28% of potential Marketplace eligible individuals enrolled in a plan. Highest: VT - 85% of eligible enrolled. Lowest: IA – 11% of eligible enrolled.
• Choice of plans varied by state. Half of states had 4 or more insurers competing in the marketplace and a dozen states had 10 or more insurers offering plans.
• 57% of Marketplace individual market enrollees were uninsured prior to enrollment in current coverage.
Percentage of Adults 18 to 64 Years of Age without Health Insurance, January 2012 through June 2014


http://www.nejm.org/doi/full/10.1056/NEJMsr1406753#results#t=references
Most adults with Obamacare say they're better off

"Would you say you are better off now or worse off now than you were before you had this new plan, or there has been no effect?"

- Better off
- No effect
- Worse off

Source: The Commonwealth Fund
How is Physician Access?

Most enrollees can get an appointment within 2 weeks

"How long did you have to wait to get your first appointment to see this primary care doctor [or specialist]?

- Primary care doctor
- Specialist

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<th></th>
<th>Within one week</th>
<th>8 to 14 days</th>
<th>15 to 30 days</th>
<th>More than 30 days</th>
<th>Have not been able to make an appointment</th>
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<td>20</td>
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<td>5</td>
</tr>
<tr>
<td>Specialist</td>
<td>30</td>
<td>30</td>
<td>20</td>
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Source: The Commonwealth Fund
Yet despite the ACA’s objective successes . . .

- Increased enrollment, reasonable access, guaranteed benefits, shrinking donut hole, guaranteed coverage, etc.

- the ACA remains unpopular and subject to unrelenting political and judicial challenges.
  - Many voters still believe in myths like “death panels”

- .... How much of the public discontent is due to believing in the impossible?
Believing in the impossible

Voters want:

- Coverage for people with pre-existing exclusions
- With no higher premiums, taxes, or cost-sharing for anyone
- With no one being forced to change insurers or doctors
- With no increase in the deficit
- And with no mandates on individuals or businesses!
I HATE OBAMACARE! HEALTH-CARE REFORM SHOULD BE REPEALED!!

WHICH PART? THE ONE THAT ENSURES CHILDREN AREN'T DENIED CARE DUE TO A PRE-EXISTING CONDITION?

NO, I LIKE THAT.

THE PART THAT ALLOWS KIDS TO BE COVERED BY THEIR PARENTS' PLAN UNTIL THEY'RE 26?

NO, THAT'S GOOD.

THE PART THAT STOPS INSURANCE PROVIDERS FROM DROPPING PEOPLE WHEN THEY GET SERIOUSLY SICK?

IT'S THE OTHER PART I CAN'T STAND.

NO, THAT'S GREAT.

WHICH ONE?
Opinion Of ACA Holds Steady, Tilting Negative

As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

_SOURCE: Kaiser Family Foundation Health Tracking Polls_
Outstanding Issues

• **Will provider networks offer substantial choice to patients?**
  o New rules for fed marketplace plans – CMS will closely scrutinize provider networks especially for primary care, behavioral/mental health, hospital, and cancer treatment access.

• **Will medically necessary drugs be available?**
  o *Concerns that some plans are creating formularies that discriminate against certain patients, i.e., people w/ HIV/AIDS*

• **Will provider directories be accurate?**
  o California investigating 2 insurers due to provider directory inaccuracies; patients enrolled thinking their physician was in-network, only to find that wasn’t the case.

• **Will insurer/provider communication be improved?**
  o MGMA survey (April 2014) – *60% of respondents* indicated that for patients with ACA Exchange coverage it is somewhat or more difficult to verify patient eligibility, obtain cost-sharing or network information, obtain information about the plan’s provider network in order to facilitate referrals.
ACA benefits
ACA benefits

1. More financially viable practices
2. Medicare payment bonus...10%
3. Medicaid payments raised to Medicare
4. Transitional Care Management payments
5. Chronic Care Management payments
6. Simplification of required reporting to CMS
7. Administrative Simplification
Benefit #1...increasing financial viability

- More patients than ever before have HI
- Less uncompensated care
- Preventive services covered
- Vaccines covered.
Benefit #2...10% Medicare Bonus

- Beginning with services rendered on or after 01-01-11 through 12-31-15, Section 5501(a) of the Affordable Care Act authorizes an incentive payment of **10 percent** of Medicare's program payments to be paid to qualifying primary care physicians who furnish specified primary care services.

- Medicare specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine
Benefit #2...10% Medicare Bonus

- A physician is eligible: If 60% of charges from historical claims data exceeds charges from the following.
  - 99201 through 99215 (office and other outpatient visits).
  - • 99304 through 99340 (nursing facility, domiciliary, rest home, or custodial care).
  - • 99341 through 99350 (home services).
**Benefit #2...10% Medicare Bonus**

- An average annual increase in Medicare revenue of an estimated $5,000 per internist over the course of 5 years (from 2011 to 2015).

- Based on the *most recent CMS report*, nearly half of all the bonus payments in 2012 went to internists—the most of any specialty—with a total pay-out of $327,923,480 or an average of nearly $5,000 per internist.

- ACP is advocating to extend this program beyond 2015.
Benefit #3...Medicaid “pay parity”

- Starting on January 1, 2013 and continuing through 2014, Medicaid payments to internists for their evaluation and management services and vaccine administration are no less than the comparable Medicare rates.

- Physicians in the three eligible specialties must self-attest that they are:
  - Board certified in IM, FP, PED or
  - [if not board certified], that 60% of their billable codes are for the designated primary care and vaccine services

- As advocated for by ACP, this increase applies to both general internists as well as internal medicine subspecialists—and includes services that are not currently paid for under Medicare, such as the consultation services codes

- ACP is advocating to extend this program beyond 2014.
Benefit #3...Medicaid “pay parity”

- The service codes specified for reimbursement at the applicable 2013 or 2014 Medicare rate are E&M codes 99201 through 99499 to the extent that those codes are covered by the approved Medicaid state plan or included in a managed care contract.
  - New Patient/Initial Comprehensive Preventive Medicine—codes 99381 - 99387;
  - Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 - 99397;
  - Counseling Risk Factor Reduction and Behavior Change Intervention—codes 99401 - 99404, 99408, 99409, 99411, 99412, 99420 and 99429;
  - E&M/Non Face-to-Face physician service—codes 99441 - 99444
Benefit #3...Medicaid “pay parity”

- The current program, which expires on 1/1/15, was created by the ACA a non-starter for Republicans,
- We have incomplete data to show the program is boosting access:
  - In April 2014, ACP conducted a survey of a representative sample of its members: 46 percent of the respondents indicated they had enrolled in the Medicaid Pay Parity program and would accept fewer Medicaid patients in 2015 (40 percent) or drop out of Medicaid entirely in 2015 (6 percent) if the were allowed to expire
- The cost has to be paid for (offset) by cutting someone else
- NPs, some other physician specialties want to be included
Medicaid pay parity: the opportunity

- Senators Patty Murray (D-WA) and Sherrod Brown (D-OH) introduced a to:
  - Prevent an across-the-board Medicaid primary care cut on January 1, 2015 by extending the current-law Medicaid Pay Parity program through 2016 to IM, FP, PEDs (and IM and pediatric subspecialties)
  - Add ob-gyn physicians as an eligible specialty if 60% if their billing are for designated primary care and vaccine codes (maternity care not included)
  - Include NPs as authorized by state law—they would be paid for designated primary care at 100% of the Medicare payment rate that is applicable to NPs (which is 85% of the physician rate)
Benefit #4...Transitional Care Management

Medicare is now paying you and your staff for work outside of a face-to-face visit involved with transitioning a patient from the hospital to the community setting—as much as $231 for each time you bill for this service under new codes that became effective on January 1, 2013.
Benefit #4...Transitional Care Management

- These codes include:
- 99495 transitional care management services with face-to-face visit within 14 days of discharge: 2.11 work RVUs, with 40 minutes physician time. Average payment is $164.
- 99496 transitional care management services with face-to-face visit within 7 days of discharge: 3.05 work RVUs, with 50 minutes physician time. Average payment is $231.
Benefit #4...Chronic Care Management

- Medicare will soon be paying you and your staff for work outside of a face-to-face visit involved with chronic care management—starting on January 1, 2015, the Centers for Medicare and Medicaid Services (CMS) will begin making a separate payment via a G-code for non-face-to-face chronic care management services for Medicare beneficiaries who have multiple (two or more), significant chronic conditions.
Benefit #5...Chronic Care Management

1. 20 minutes of time over 30 days, with billing occurring on the 30\textsuperscript{th} day

2. Practice must provide 24/7 access to address a patient’s acute chronic care needs (including clinician access to the EHR).

3. Practice must develop a comprehensive, patient-centered care plan written in consultation with the patient and with other key practitioners who are treating the patient.

4. CCM services must be performed with the use of EHR or other health IT information exchange platform.
   
   At the very least the EHR must meet the standard of data capture of demographics, problem lists, medications, and other elements required to create and electronic summary record.
Benefit #5...Chronic Care Management

- CMS proposes work RVUs for CCM code GXXX1 of 0.61 - down from the 1.0 work RVU recommended by the RUC.
- Therefore, the estimated payment for code GXXX1 is $41.92 – is this enough???
Benefit #6...Administrative Simplification (Required Reporting to CMS)

- CMS is implementing significantly greater alignment of program requirements across their quality initiatives, particularly for the Value-Based Payment Modifier (VBPM) and PQRS.

- This includes a single website that will be established, whereby group practices can make multiple elections for both PQRS and VBPM, as well as other CMS programs. Additionally, the CY2016 VBPM will use all of the PQRS measures available to be reported under the various PQRS reporting mechanisms in CY2014, including quality measures reported by individual eligible professionals in a group through “quality clinical data registries” (QCDRs), to calculate a group of physicians’ VBPM in CY2016.
Benefit #7...Payment Simplification (Claims submission)

1. New national standards, as required by the Affordable Care Act (ACA), are now in place for insurance companies that will simplify claims payments, allowing internists to spend more time with patients and less time on paperwork.

2. This is due to significant improvement in the way electronic fund transfers are made for health insurance claims—across both public and private payers—and is something ACP has been advocating over a number of years.

3. Starting in 2014, and in some cases this started even sooner, physician practices and other healthcare entities will receive claim payments electronically, and then be able to automatically match (re-associate) explanations regarding any adjustments to these payments by the health plans with the correct claim. More information on these standards can be found at the Committee on Operating Rules for Exchange Information (CORE) website.
What has the ACA done for your practice?

- Enrollment and coverage
- Access
- Attention/payment on prevention
- Reimbursement Medicare & Medicaid
- New codes CCM & TCM
- Administrative simplification
By many measures, The Affordable Care Act has improved your practice!

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Past Chair ACP Board of Regents, 2014