For the Times They Are A’ Changin’
How ACP Is Helping Internists to Start Swimmin’
(so You Don’t Sink Like a Stone)

And other Health Care Insights from America’s Greatest Contemporary Songwriter

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American College of Physicians
Delaware Chapter, ACP
February 22, 2014
If your time to you,
Is worth savin'
Then you better start swimmin'
Or you'll sink like a stone
The times they are a-changin’

The Times They Are A-Changin’ 1963
Swim or sink?

Will physicians, medical schools, and hospitals be able to successfully participate in new payment/delivery models?
Swim or sink? *Will the ACA . . .*

- Deliver on its promise of providing affordable care to nearly all Americans?
  - Will the marketplaces work as expected?
  - Will premiums be affordable or cost too much?
  - Will the states expand Medicaid?
  - Will there be enough doctors?

- Or will political opposition, complexity, and misunderstanding cause it to fail?

- And will physicians help it “swim” . . . or sink?
Payment and Delivery System Reforms

- The Medicare SGR and the Future of FFS
- Value-based payments
- Alternative Models
Medicare payment reform

- Agreement reached on a bipartisan, bicameral bill to repeal the SGR, reform payments

- Budget cost of SGR repeal is less than half of previous estimates

- Congress must still find the will—and the budget offsets—to pass the bill, and get it to President Obama, before 24% cut on April 1
Bicameral physician payment bill: Out with the old, in with the new

**Old:**
- Updates determined by SGR (-24% on 4/1/14)
  - Likely continued scheduled cuts, no matter what you do
  - $120 billion cut in physician payments over 10 years
- Separate PQRS, Meaningful Use, and Value Index programs
  - With penalties:
    - PQRS -2.0% in 2017 and beyond
    - MU -3.0% in 2017, -4% in 2018, -5% in 2019

**New**
- Baseline updates set by law
  - +0.5% for 2014 through 2018
  - $128 billion added back to physician payments
- Starting in 2018: New Merit-based Incentive Payment System (MIPS; replaces existing PQRS, MU and Value Index)
  - All 2017 penalties canceled
  - Can earn more or less than baseline updates
Bicameral physician payment bill: Out with the old, in with the new

- Old:
  - Same conversion factor for all physicians, plus/minus penalties
  - Limited incentives for PCMHs and other Alternative Payment Models (APMs)

- New
  - Physicians determine your own conversion factor, based on MIPS score or APMs
    - Certified PCMHs and PCMH specialty practices will get highest possible scores for clinical practice improvement under MIPS (15% of total) and can bill for chronic care management starting in 2015; Advanced PCMHs can qualify as an APM and get 5% annual bonuses for six years without taking direct financial risk
<table>
<thead>
<tr>
<th>Year</th>
<th>Merit-based Incentive Payments (FFS)</th>
<th>APMs (only for physicians in APMs)</th>
<th>Above or Below Baseline Update of:</th>
<th>SGR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-17</td>
<td>N/A—2017 PQRS, MU penalties cancelled</td>
<td>N/A</td>
<td>0.5%</td>
<td>-24% cut on 4/1/14; even with another patch, rates expected to be frozen or reduced</td>
</tr>
<tr>
<td>2018</td>
<td>-4% to +4%</td>
<td>5.0%</td>
<td>0.5%</td>
<td>Frozen or reduced</td>
</tr>
<tr>
<td>2019</td>
<td>-5% to +5%</td>
<td>5.0%</td>
<td>0.0%</td>
<td>Frozen or reduced</td>
</tr>
<tr>
<td>2020</td>
<td>-7% to +7%</td>
<td>5.0%</td>
<td>0.0%</td>
<td>Frozen or reduced</td>
</tr>
<tr>
<td>2021 and beyond</td>
<td>-9% to +9%</td>
<td>5.0% thru 2023</td>
<td>0% thru 2023, then 1% for APMs, 0.5% for all others</td>
<td>Frozen or reduced</td>
</tr>
</tbody>
</table>
APMs

- APMs will be supported by their own payment rules, in addition to the 5% annual APM-only incentive payments in 2018-23. For example:
  
  - Comprehensive Primary Care Initiative (PCMHs): 500 practices in 7 markets are now getting $20 per Medicare patient per month (risk adjusted) plus FFS, with opportunity for shared savings
  
  - ACOs: opportunity to share in savings; the greater the upfront risk, the greater the potential savings
Other features:

- APMs must accept financial risk, except for PCMHs
  - PCMHs approved as an APM have to show that they have the elements needed to improve quality without increasing cost, or reduce costs without decreasing quality

- Expert panel reviews and recommends approval of other APMs including those proposed by specialties
Other features:

- $500 million set aside each year for top 25% of MIPS performers
- $40 million per year in technical assistance to small practices
- $75 million for measure development (over 5 years)
- Process to improve accuracy of RVUs
Is the new bill better than current law?

- Of course it is!
  - Positive (albeit small) baseline updates for 5 years, versus 24% cut on 4/1/2014 (and likely more SGR cuts afterwards)
    - Even if Congress were to override SGR cut, it would be at best a freeze
  - The SGR results in scheduled pay cuts *no matter what you do*, versus giving you the *opportunity to earn higher updates* for quality improvement or being in a PCMH or other APM
  - Adds $128 billion to physician pay versus $120 billion in cuts
  - Cancels 2018 PQRS and MU penalties, adding the $ back to physician payments; harmonizes measures and reporting
Is the new bill everything we want?

- Of course it’s not!
  - We would have preferred higher baseline updates but the budget cost made this impossible
    - Can lobby for higher updates later if access problems occur, but we first have to get out of the $120 billion “hole” created by SGR
  - We need to make sure that the “correct” measures are used with greater harmonization, with the least possible reporting “hassles”
  - We need to advocate for APMs that work for all sizes of practice
REPEAL SGR

11 YEARS 16 Patches $154 Billion *Wasted*

It is time for Congress to act. It is time for Congress to pass the “SGR Repeal and Medicare Provider Payment Modernization Act of 2014” (H.R. 4015/S. 2000)

Twitter: #SGR_11_16_154
Another Dylan insight

“How does it feel, how does it feel, to be without a [medical] home, like a complete unknown, like a Rolling Stone.”

*Like a Rolling Stone, 1965*
Prediction: rapid growth in # of PCMH practices

- Gateway to reimbursement for chronic care management codes
- Gateway to being paid better than the flat baseline updates
ACP Practice Advisor

- Agreement with NCQA to incorporate PCMH 2014 recognition criteria
- Evaluating option to directly submit data from Practice Advisor to NCQA for recognition
- PCMH specialty practice modules launched 12/2013
  - Also built with NCQA permission to use specific criteria
- New: Access to free modules (Mar 2014)
- New: MOC Part IV options
The ACA (Obamacare) and the Future of American Medicine

- What can you expect over the next six to twelve months?
- When it is finally fully implemented over the next decade?
ACA implementation:

- Is highly disruptive to insurance markets, employers and “providers” (as it was supposed to be)

- Political resistance and headlines on “chaos, confusion, and problems” make it especially challenging (critics are “rooting for failure”)

- Is confusing and did not go smoothly on day one, but this is nothing new, same was true for Medicare Part D and original Medicare
The federal government launched “Project Medicare Alert,” a program that hired 5,000 workers to enroll seniors in Medicare. The “$2 million crash effort,” as described by The Post, was meant to “inform isolated elderly Americans of the availability of Medicare benefits.” Workers, hired for a 20-week stint, were paid $1.25 per hour.
<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2013</td>
<td>Open enrollment period began to buy coverage from marketplaces</td>
</tr>
<tr>
<td>January 1, 2014</td>
<td>Marketplace coverage and tax credits went into effect</td>
</tr>
<tr>
<td>January 1, 2014</td>
<td>Medicaid plans enroll persons with incomes up to 138% of FPL (participating states only)</td>
</tr>
<tr>
<td>January 1, 2014</td>
<td>Consumer protections implemented for all insurance plans (no lifetime limits, no pre-existing condition exclusions)</td>
</tr>
</tbody>
</table>
## ACA Milestones

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31, 2014</td>
<td>Open enrollment period closes, except for persons who have life changes that make them eligible to buy coverage later. Persons without qualified coverage in 2014 subject to tax penalty equal to $95 or one percent of taxable income, <em>whichever is greater</em></td>
</tr>
<tr>
<td>January 1, 2015</td>
<td>Employers with 100 or more FTEs must provide coverage that meets federal requirements or pay a penalty (delayed by one year from initial 1/1/14 deadline)</td>
</tr>
<tr>
<td>January 1, 2016</td>
<td>Employers with 50-99 FTEs must provide coverage that meets federal requirements or pay a penalty (delayed by two years from initial 1/1/14 deadline)</td>
</tr>
</tbody>
</table>
Premiums, cost-sharing in the marketplaces

- Average of 53 qualified health plan choices in states where HHS will fully or partially run the Marketplace

- Premiums before tax credits will be more than 16 percent lower than projected. Premiums tend to be lower in states where there is more competition and transparency

- After taking tax credits into account, fifty-six percent of uninsured Americans may qualify for health coverage in the Marketplace for less than $100 per person per month, including Medicaid and CHIP in states expanding Medicaid

http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/jb_marketplace_premiums.cfm
### Qualified health plans: cost-sharing levels

<table>
<thead>
<tr>
<th>Plan</th>
<th>% of actuarial cost of required benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60-69%</td>
</tr>
<tr>
<td>Silver</td>
<td>70-79%</td>
</tr>
<tr>
<td>Gold</td>
<td>80-89%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90-100%</td>
</tr>
<tr>
<td>Catastrophic plan for under age 30</td>
<td>$6350 deductible</td>
</tr>
</tbody>
</table>

All plans cover same essential benefits. No cost-sharing for USPSTF screening tests. Maximum out-of-pocket expenses for all plans: $6350 for individuals, $12,700 for family of four. Individuals and families with incomes between 100 percent of the federal poverty line ($23,550 for a family of four) and 250 percent ($58,875 for a family of four) are eligible for cost-sharing reductions (or CSRs) if they are eligible for a premium tax credit and purchase a silver plan through the health insurance marketplace in their state. People with lower incomes receive the most assistance.
What about so-called “premium shock?”

- Some will pay more (healthy and younger) but many will pay less (older, less healthy)

- Even those who pay more can’t be turned down and will be getting better coverage (lower cost-sharing, better benefits) than usual plans in small and individual insurance market

- Affects very small percentage of the population in small group and individual market
Premium “shock and joy”

Traditionally, the premium in the nongroup market can be expressed as

\[ \text{Pi-premium quoted to individual} \]

\[ \text{Xi-expected outlays for covered health benefits for that Individual} \]

\( L \) is a ‘loading factor’ added to cover the cost of marketing and administration, as well as a target profit margin

**Family Health Insurance Premium Obligations Vary by Age, Income**

<table>
<thead>
<tr>
<th>Family Income as % of Poverty Level</th>
<th>Policyholder Age</th>
<th>Percentage of Premium Paid by Family of Four vs. Covered by Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>20%</td>
<td>Medicaid</td>
</tr>
<tr>
<td>150%</td>
<td>30%</td>
<td>Medicaid</td>
</tr>
<tr>
<td>200%</td>
<td>40%</td>
<td>Medicaid</td>
</tr>
<tr>
<td>250%</td>
<td>50%</td>
<td>Medicaid</td>
</tr>
<tr>
<td>300%</td>
<td>60%</td>
<td>Medicaid</td>
</tr>
<tr>
<td>350%</td>
<td>70%</td>
<td>Medicaid</td>
</tr>
<tr>
<td>400%</td>
<td>80%</td>
<td>Medicaid</td>
</tr>
<tr>
<td>450%</td>
<td>90%</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>

**Analysis**
- A family of four is eligible for Medicaid at 133%, the same percentage below the poverty level as an individual.
- A family of four buying coverage in new state-based health insurance exchanges will be eligible for federal subsidies if their joint income is below 400% of the poverty level; above 400%, families pay full cost.

*For families of four purchasing coverage in the exchange, not through an employer; numbers reflect standard plan for coverage.

Source: The Henry J. Kaiser Family Foundation.
“Less frequently noted in commentaries about the law — certainly among its critics — is that the law is likely to bring what I call ‘premium joy’ to individuals and families with health problems. Many such people simply could not afford the high, medically underwritten premiums they were quoted in the traditional nongroup market. This joy will be shared by high-risk applicants who were refused coverage by the insurer, along with people now in high-risk pools.”

## Where Delaware stands (as of 2/1/14)

<table>
<thead>
<tr>
<th># of Individuals Eligible for a Market Plan</th>
<th>Estimated Number Eligible to Enroll with Financial Assistance</th>
<th>Number who have selected a Market Plan</th>
<th>Determined by the Marketplace to be Eligible for Medicaid/CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>12,063</td>
<td>6930</td>
<td>4927</td>
<td>6484</td>
</tr>
</tbody>
</table>

## Individual Rates With Tax Credits Applied*

**Advanced Payment Tax Credits Applied – Individual Age 30**

The table below shows examples of advanced premium tax credits applied to the 2nd lowest Silver plan rate for an individual age 30. See Glossary for definitions of terms used in table.

### Estimated Premium Rates with APTC Applied for an Individual Non-Smoker Age 30

<table>
<thead>
<tr>
<th>Percent of FPL</th>
<th>Annual Income ($)</th>
<th>Premium Limit (%)</th>
<th>Maximum Annual Premium ($)</th>
<th>Monthly Subsidy ($)</th>
<th>2nd Lowest Silver Plan Rate ($)</th>
<th>Adjusted Monthly Premium ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>138%</td>
<td>15,856.20</td>
<td>3.29%</td>
<td>521.67</td>
<td>213.37</td>
<td>256.84</td>
<td>43.47</td>
</tr>
<tr>
<td>150%</td>
<td>17,235.00</td>
<td>4.00%</td>
<td>689.40</td>
<td>199.39</td>
<td>256.84</td>
<td>57.45</td>
</tr>
<tr>
<td>200%</td>
<td>22,980.00</td>
<td>6.30%</td>
<td>1,447.74</td>
<td>136.20</td>
<td>256.84</td>
<td>120.65</td>
</tr>
<tr>
<td>250%</td>
<td>28,725.00</td>
<td>8.05%</td>
<td>2,312.36</td>
<td>64.14</td>
<td>256.84</td>
<td>192.70</td>
</tr>
<tr>
<td>300%</td>
<td>34,470.00</td>
<td>9.50%</td>
<td>3,274.65</td>
<td>0.00</td>
<td>256.84</td>
<td>256.84</td>
</tr>
<tr>
<td>400%</td>
<td>45,960.00</td>
<td>9.50%</td>
<td>4,366.20</td>
<td>0.00</td>
<td>256.84</td>
<td>256.84</td>
</tr>
</tbody>
</table>

*http://www.delawareinsurance.gov/health-reform/DE-QHP_Ind_and_SHOP_PlanYear2014Overview.pdf*
The number of Delawareans signing up for health insurance under the Affordable Care Act climbed again last month. At the same time, state officials are scaling back expectations for first year enrollment.

5,062 people enrolled in a plan through January 31st, a nearly 60 percent increase over the previous month’s numbers. Health Secretary Rita Landgraf announced the new figures at Thursday’s Health Care Commission meeting in Dover.

The Department of Health and Social Services is also embracing a September internal memo from the Centers for Medicare and Medicaid Services estimating Delaware’s first-year enrollment at 8,000.

That’s substantially lower than DHSS’ original target of signing up 35,000 of the state’s estimated 92,000 uninsured. Landgraf downplayed the dramatically lowered expectations, saying outreach is also important.

“I’m trying not to focus necessarily on a number for a number’s sake,” said Landgraf. “What I am hopeful is that everyone is learning about gaining access to health insurance either through the marketplace or through our expansion in the Medicaid program.”

The new numbers show the state continues to have difficulty enrolling people in areas critical to the law’s success. Nearly 56 percent of those who’ve signed up are between the ages of 45 and 64. Just over 20 percent of enrollees are between 18 and 34, an age group that’s typically healthy and critical for diluting the risk pool.

First State enrollment also continues to vary widely from county to county.
Winners and Losers from Obamacare

3% "Potential Losers": (Will have to buy a higher-quality health plan with no annual cap)

3% No real consequence (Have to buy new plans, but similar to existing policies.)

14% Clear winners: Currently uninsured who gain access to an affordable policy

80% Unaffected (Largely people who keep their current employer plan)

Source: Estimates from Jon Gruber, reported by Ryan Lizza: http://www.newyorker.com/online/blogs/newsdesk/2013/10/obamacares-three-per-cent.html
Obamacare implementation is facing unprecedented political headwinds

- Organized political effort to discourage people from signing up

- Failed effort to defund the law, tied to resolution to fund the government and/or debt ceiling

- State opposition to expanding Medicaid, setting up exchanges and helping people enroll
  - In most extreme cases, state opposition is bordering on nullification
Physicians *should* want Obamacare to swim, not sink

- Will provide coverage to tens of millions of uninsured and better consumer protections for everyone else

- State resistance to Medicaid expansion will result in 2 out of 3 poor and near-poor going without coverage

- Coverage associated with better outcomes and fewer preventable deaths

- If the ACA fails, *nothing good will replace it*
### Most Trusted on ACA: Doctors and Nurses, Federal and State Agencies, Pharmacists

<table>
<thead>
<tr>
<th>Source</th>
<th>Percent who say they would trust information about the health care law from each of the following ‘a lot’</th>
<th>Percent who say they have heard something about the law from each of the following in the past 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your doctor or nurse</td>
<td>44%</td>
<td>22%</td>
</tr>
<tr>
<td>Federal agencies</td>
<td>34%</td>
<td>16%</td>
</tr>
<tr>
<td>State agencies</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>Your local pharmacist</td>
<td>30%</td>
<td>NA</td>
</tr>
<tr>
<td>An employer</td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>Your local church or place of worship</td>
<td>21%</td>
<td>NA</td>
</tr>
<tr>
<td>Non-profit or community organization</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>Friends and family</td>
<td>18%</td>
<td>49%</td>
</tr>
<tr>
<td>A health insurance company</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>The news media*</td>
<td>8%</td>
<td>81%</td>
</tr>
<tr>
<td>Social networking sites</td>
<td>3%</td>
<td>23%</td>
</tr>
</tbody>
</table>

NA = Item not asked for this question.

*The news media includes cable TV news, national or local TV news, radio news or talk radio, online news sources, and newspapers/magazines.

NOTE: Wording for some items abbreviated; item wording between questions varies. For full question wording see topline:

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted August 13-19, 2013)
ACA: Resource for Members, Chapters

Help Your Patients Enroll in Health Insurance Marketplaces

One of the principal ways that the Affordable Care Act (ACA) will expand coverage to millions of uninsured persons is through state-by-state health insurance marketplaces. These marketplaces will help eligible patients buy individual health insurance plans that they can afford. They will provide a web-based platform that will enable patients to effectively comparison shop and select the best plan for them and their families. Eligible persons will also be able to get tax subsidies to help them afford the plans offered by the marketplaces.

Health insurance marketplaces are launching this fall and patients who need coverage will be able to begin using them in October. To help you help your patients determine health insurance choices, as well as to answer questions that you might have, the American College of Physicians has put together a series of documents to address questions about the changes in healthcare coverage brought about by the new marketplaces.

The following documents include general information on resources that are available to you and your patients, and answers to frequently asked questions about insurance enrollment. In addition, ACP has also assembled state-specific resources to tell you more about what is happening in your area and help you provide your patients with accurate contact information.

ACP's State-by-State Guides to Helping Patients Enroll
Find information about how the insurance marketplace will operate in your state and a resource guide you can give to your patients to help them find the appropriate people to answer their questions about health insurance.

Questions and Answers about Health Insurance Marketplaces and the Affordable Care Act

- ACP's Frequently Asked Questions about Patient Enrollment in Health Insurance Marketplaces
- ACP's Questions & Answers About Physician Concerns on the ACA

An Internist's Practical Guide to Understanding Health System Reform

This Guide is intended to serve as a practical resource for Internists on health system reform legislation, the Patient Protection and Affordable Care Act (ACA), enacted in March 2010. The Guide is organized by the year in which a policy issue is to be implemented, making it easy apparent which new policies may be impacting physicians/patients immediately. Simply click on the policy provision of interest, in any given year, to find a summary of that provision of law, in an easy “frequently asked questions” format. Additional resources and information on each topic are also included in each summary.

*Updated January 2013.

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  - Temporary High-Risk Pool
  - Pre-existing Conditions Exclusions Banned for Children
  - Restricting Annual or Lifetime Dollar Limits on Coverage
  - Prohibiting Coverage Rescissions
  - Justifying Premium Increases
  - Covering Core Preventive Services
  - Option for Early Medicaid Coverage Expansion

- Rebates through Medicare’s Prescription Drug Program
- National Health Care Workforce Commission
- Teaching Health Centers
- Loan and Scholarship Programs under Title VII

Also available:
- Members can contact staff with issues and questions directly via e-mail.
- Additional FAQs for our members to help as the exchanges and Medicaid expansion rolls out (e.g., on the premium grace period, network adequacy, etc.)
- Identification of additional policy development needs related to the ACA rollout (e.g., Medicaid public-private partnerships)
ACP Advocacy

➢ State of the Nation’s Health Care Report, released 2/11/14

➢ Documented gains in coverage

➢ Proposed improvements
Our recommendations include:

- Improve current network adequacy standards by taking into additional criteria—such as wait time, travel distance, patient-to-physician ratios

- Provide more transparency by giving physicians and their patients advance notice of network changes and opportunity to appeal.
Our recommendations include:

- Require transparency in the criteria used by QHPs to determine who will be allowed into networks.
- Require that network selection consider multiple criteria, not just cost, related to professional competency, quality of care, and the appropriate utilization of resources.
Our recommendations include:

- Require QHPs to provide up-to-date network directories in “real-time” when a potential enrollee is choosing a plan.

- Create a special enrollment period to allow patients to choose another QHP if an outdated provider directory has incorrectly listed an enrollee’s preferred physician as being part of the network.
Our recommendations include:

- Establish standards for QHPs to inform physicians that they are included in the network.

- Create an appeals process to authorize in-network cost-sharing if a medically necessary service is not available within the network but is available from an out-of-network physician willing to accept terms of the service.
Our recommendations include:

- QHPs with restrictive formularies should allow patients to have access to Rx in dispute during an entire exception review process, and if an exception is granted, continue to provide coverage for the exception drug during subsequent plan years. Require expedited internal appeals for urgent care situations.
Our recommendations include:

- Regulators should closely monitor formularies and other benefit design features to ensure that coverage does not exclude vulnerable patients, such as those with patients with complex chronic conditions undergoing therapy, including patients with cancer, transplants, mental health treatment, HIV/AIDS, and hepatitis C.
Our recommendations include:

- QHPs should be required to provide real-time notification of when a patient enters the 90-day grace period for non-payment of premiums.
  
  • Notification should provide information on what month of the grace period the enrollee is in.
  
  • Failure to notify a physician of grace period entry would initiate a binding eligibility determination.
26 states + DC are expanding

25 states not expanding

There's more work to be done!
Another Dylan insight

There must be some way out of here said the joker to the thief,

There's too much confusion, I can't get no relief.

*All Along the Watchtower, 1967*
“Too much confusion”

- E-Rx, PQRS, Meaningful use, rewards and penalties
- ICD-10
- Transitional Care Management Codes
- And many more!
Physician & Practice Timeline

<table>
<thead>
<tr>
<th>Program</th>
<th>Start Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create IACS Account</td>
<td>OCT 1</td>
<td>Make sure your practice has an &quot;Individuals to CMS Computer Services (IACS)&quot; account. If you do not have an IACS account you will not be able to self-nominate for the Value-Based Payment Program (VBP).</td>
</tr>
<tr>
<td>ICD-10 Suggested Start Date</td>
<td>OCT 1</td>
<td>Begin external testing of transactions and claims with all your business partners. Contact vendors to confirm that changes/upgrades have been completed. Begin training of high-level, non-coding team members.</td>
</tr>
<tr>
<td>Reporting Deadline</td>
<td>OCT 3</td>
<td>Last day for Eligible Professionals to begin 90-day reporting period for 2013 - October 3 through December 31.</td>
</tr>
<tr>
<td>PQRS Deadline</td>
<td>OCT 15</td>
<td>October 15, 2013 is the last day for physicians to register for 2013 PQRS reporting and avoid the 2015 penalty.</td>
</tr>
<tr>
<td>Second Self-Nomination/Registration Period</td>
<td>OCT 15</td>
<td>The second self-nomination/registration period for the Value-Based Payment Program (VBP) is from July 15, 2013 to October 15, 2013.</td>
</tr>
</tbody>
</table>
More from Bob Dylan

You don’t need a weatherman to know which way the wind blows

*Subterranean Homesick Blues*, 1965
Which way is the wind blowing?

- Away from pure FFS to new models that put physicians (potentially) in more control in patient-centered systems of care, but with more risk and accountability.

- From a health system that leaves tens of millions without coverage to one that insures “nearly” everyone (even if it takes longer than originally planned) with better protections for all.
Another Dylan insight

How many times must a man look up
Before he can see the sky?

Yes, ’n’ how many ears must one man have
Before he can hear people cry?

Yes, ’n’ how many deaths will it take till he knows
That too many people have died?

‘The answer, my friend, is blowin’ in the wind
The answer is blowin’ in the wind

_Blowin’ in the Wind, 1963_
Why is it important to get Obamacare successfully implemented? Because too many people have died.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of deaths due to uninsurance</th>
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<tbody>
<tr>
<td>2000</td>
<td>20,000</td>
</tr>
<tr>
<td>2001</td>
<td>21,000</td>
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<tr>
<td>2006</td>
<td>27,000</td>
</tr>
<tr>
<td>Total</td>
<td>165,000</td>
</tr>
</tbody>
</table>
A Final Dylan Insight

Everything passes
Everything changes
Just do what you think you should do

To Ramona, 1964