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
Utah Chapter
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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
Health Care Reform=Disruptive Innovation

“Innovation and disruption are similar in that they are both makers and builders. Disruption takes a left turn by literally uprooting and changing how we think, behave, do business, learn and go about our day-to-day. Harvard Business School professor and disruption guru Clayton Christensen says that a disruption displaces an existing market, industry, or technology and produces something new and more efficient and worthwhile. It is at once destructive and creative.”


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?

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Payment and Delivery System Reforms

- The Medicare SGR and the Future of FFS
- Value-based payments
- Alternative Models
Light at the end of the SGR tunnel?

- CBO has lowered the “score” for SGR repeal: $138 billion over 10 years

- May 10 letter from Senate Finance Committee sought input from ACP, ACR, and others “as we develop a more viable alternative to the SGR that will provide stability for physician reimbursement and lay the . . . foundation for a performance-based system.”

- House Energy and Commerce committee unanimously reported a bipartisan bill to eliminate SGR and reform physician payments

House bill is mostly consistent with approach recommended by ACP and others

<table>
<thead>
<tr>
<th>ACP’s Recommendations</th>
<th>House Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeal SGR</td>
<td>YES</td>
</tr>
<tr>
<td>Positive baseline updates for five years for all services. Higher updates for E/M codes not limited by specialty.</td>
<td>YES, 0.5% annual FFS updates for five years. But does not include higher updates for E/M codes.</td>
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<tr>
<td>Process and timetable to transition to new payment/delivery models</td>
<td>YES</td>
</tr>
<tr>
<td>Transitional value-based FFS updates above “baseline” updates with graduated payment structure</td>
<td>YES</td>
</tr>
<tr>
<td>Positive incentives for Care Coordination and Patient-Centered Medical Homes</td>
<td>YES</td>
</tr>
<tr>
<td>Improve accuracy of RVUs</td>
<td>Yes, but takes savings out of the physician pay pool</td>
</tr>
</tbody>
</table>
Quality update program (2019)

- Physicians *self-select* a clinical “cohort” for their specialty and type of practice
- Creates process for CMS to approve “weighted” measures for each cohort
- Measures would address care coordination, patient safety, prevention, patient experience
- Measures would be harmonized to extent possible
- Physician scored on a 1-100 scale depending on how well they do each year on the measures for their cohort

### Quality Incentive Program FFS Updates, starting in 2019

<table>
<thead>
<tr>
<th>Physician’s Annual Quality Score</th>
<th>Total Annual FFS Update (0.5% plus/minus quality adjustment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>67-100</td>
<td>PLUS 1.5%</td>
</tr>
<tr>
<td>34-100</td>
<td>PLUS 0.5%</td>
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<tr>
<td>1-33</td>
<td>MINUS 0.5%</td>
</tr>
<tr>
<td>Physician does not successfully report any quality data</td>
<td>MINUS 5.0%</td>
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</table>
Alternative Payment Models

- CMS will hire a contractor to consider/evaluate APM proposals from physicians and others
- APMs must show that they can improve quality without increasing costs, or lower costs without decreasing quality
- Two-types of APMs will be selected:
  - those for which strong data already exist on their effectiveness (e.g. PCMHs)
  - those that have a high potential but less data on effectiveness

Alternative Payment Models

- Initial APMs selected within one year of enactment
- APMs would *not* participate in the FFS quality update program (but would considered to have met the reporting requirements—and applicable update for their FFS payments?)
- APMs would be paid by Medicare under the payment rules applicable to them
Authorizes payment for coordination of complex chronic illnesses, starting in 2015

- Physicians in practices that have achieved independent certification as a PCMH, or as a PCMH specialty practice (PCMH-neighbor), would be eligible to bill and be paid for new chronic care codes

- Tracks closely with CMS proposal rule to begin paying for such codes in 2015

CMS proposes to pay for chronic care management, defined as:

Complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;

- GXXX1, initial services; one or more hours; initial 90 days
- GXXX2, subsequent services; one or more hours; subsequent 90 days
To qualify, CMS proposes that practices must:

- Have a Certified, practice-integrated EHR that meets meaningful use; members of the team must have access to the patient’s full electronic medical record, even when the office itself is closed.
- Employ at least one APN or PA for care of patients who require complex chronic care management.
- Demonstrate use of written protocols.
- Provide 24/7 access.
- Provide continuity of care with a designated practitioner or member of the care team.

ACP is asking CMS to make changes in its CCM proposal:

- Create pathway for practices that are not certified PCMHs.
- Eliminate overly prescriptive hiring mandates.
- Align more closely with new CPT codes for CCM.
ACP recommendations to improve House bill include:

- Higher baseline FFS updates for undervalued E/M services and monitor impact of 0.5% annual updates on access
- Further harmonize measures including counting MOC toward qualifying
- Create way for practices that are not PCMH-certified to demonstrate they can meet comparable criteria for chronic care codes
- Redistribute savings from overvalued RVUs to E/M codes

Hearing Statement of Senator Max Baucus (D-Mont.)
On Improving the Flawed Medicare Payment System
As prepared for delivery

Benjamin Franklin once said, “You may delay, but time will not, and lost time is never found again.”

Those words ring true today as we work to repeal the sustainable growth rate, or SGR. This is the formula used to pay doctors who treat Medicare patients. It is antiquated, inefficient and flawed.

Over the past decade, the SGR has called for Medicare payment cuts to physicians that are unsound. Next year, physicians face a 25 percent cut under the formula. This deep cut would mean many seniors could lose access to their doctors. I refuse to let that happen.

In each of the last 10 years, Congress has prevented these cuts to physicians by passing a patch, but we never addressed the root cause of the problem — the SGR itself.

It is time to repeal this broken formula, and we need to do it this year.
“I want to highlight the letter from the American College of Physicians. They gave us concrete examples, down to how Medicare could incentivize physicians to use guidelines that help them decide when to order tests and perform procedures. This would encourage doctors to provide the care seniors need, and avoid unnecessary care that might cause harm. I’m not saying we will accept all of their suggestions, but their comments help us see different angles of potential policies.”

Senator Max Baucus, June 10, 2013

ACP proposals to SFC

- Fund and certify shared decision support tools, focused on the top twenty most expensive and/or most frequently performed procedures, particularly those that are considered preference-sensitive or are elective

- Authorize payment to physicians who use such tools
  - Create E/M code modifier for physicians who use High Value Care clinical guidelines in shared decision-making with patients
ACP proposals to SFC

- Provide physicians with accurate data on the quality and total cost of care provided by other clinicians and hospitals within their geographic communities to enable them to make informed referral decisions

- Monitor utilization of high cost/high frequency testing in practices where physicians own their own testing facilities, provide education feedback and encourage more extensive use of specialty-developed appropriateness criteria, targeted at practices that are outliers

What happens next?

- SFC bill expected to be released within days (followed by “mark up?” and Senate vote)?

- House Ways and Means committee may modify Energy and Commerce bill, and then the two House bills would have to be reconciled and passed by the House

- And then House and Senate will have to reconcile their bills, followed by a vote on an identical bill

- All with fewer than 35 legislative days left in 2013! (If not completed this year, a short-term patch into 2014 is likely, allowing Congress more time to complete action on the bills)
Swim or sink? Are you ready to:

- Be accountable for outcomes, quality and cost?
- Accept more financial risk?
- Acquire best practices and information systems?

Swim or sink? Are you ready to collaborate with others?

- *No one can do it alone*: physicians will need to collaborate with other physicians and health care professionals in their own communities
- *No one can do it alone*: policymakers, physician membership organizations, other stakeholders will need to advocate for pay stability, incentives, innovation and flexibility
- No one can do it alone: team-based care will replace “silos” of practice
How ACP is helping internists swim . . .

- Advocacy for better models (PCMH, PCMH-N, ACOs, other)
- Advocacy for better pay—FFS and in new models
- Resources to help you make changes in your practice (e.g. Practice Planner, PQRS Wizard)
- New principles on team-based care
Team-based care: definitions

ACP adopts the Institute of Medicine (IOM) definition of primary care: “The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

Team-based care: definitions

Primary care encompasses various activities and responsibilities. It is simplistic to view primary care as a single type of care that is uniformly best provided by a particular health care professional. The diverse activities that are often considered under the rubric of primary care often extend into what may be better considered “secondary” or even “tertiary” care.
Team-based Care and **Professionalism**

Professionalism requires that all clinicians—physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals—consistently act in the best interests of patients, whether providing care directly or as part of a multidisciplinary team.

**Principles: matching the patient to most qualified team member**

Assignment of specific clinical and coordination responsibilities for a patient’s care within a clinical care team should be based on what is in that patient’s best interest, matching the patient with the member or members of the team most qualified and available at that time . . .
Principles: leadership and responsibility within teams

ACP reaffirms the importance of patients having access to a personal physician who is trained in the care of the “whole person” and has leadership responsibilities for a team of health professionals, consistent with the Joint Principles of the Patient-Centered Medical Home.

Although physicians have extensive education, skills, and training that make them uniquely qualified to exercise advanced clinical responsibilities, well functioning teams will assign responsibilities to ... other health care professionals for specific dimensions of care commensurate with their training and skills.

Principles: workforce

A cooperative approach including physicians, APRNs, other registered nurses, PAs, clinical pharmacists, and other health care professionals in collaborative team models will be needed to address physician shortages.
Principles: **competency and liability**

The creation and sustainability of highly functioning care teams require essential competencies and skills in their members.

The team member who has taken on primary responsibility for the patient must accept an appropriate level of liability associated with such responsibility.

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Principles: **licensure and regulation**

- The purpose of licensure must be to ensure public health and safety. It should
  - Ensure a level of consistency (minimum standards) in the credentialing of clinicians
  - Recognize that the skills, training, clinical experience, and demonstrated competencies of physicians, nurses, physician assistants, and other health professionals are not equal and not interchangeable.
**Principles: licensure and regulation**

State legislatures should conduct an evidence-based review of their licensure laws. The review should consider how current or proposed changes in licensure law align with the documented training, skills, and competencies of each team member within his or her own disciplines and across disciplines and how they hinder or support the development of high-functioning teams.

State regulation of each clinician’s respective role within a team must be approached cautiously, recognizing that teams should have the flexibility to organize themselves consistent with the principles of professionalism described previously.

**Principles: reimbursement**

Reimbursement systems should:

- encourage and appropriately incentivize the organization of clinical care teams, including but not limited to patient-centered medical homes and patient-centered medical home neighbor practices

- account for differences in the risk and complexity of the patient population being treated, including adequate risk adjustment
Principles: organization and measurement

Optimal formulation, functioning, and coordination in team-based care to achieve the best outcomes for patients should be evidence-based.

Efforts should be made to address the deficiency in the availability of validated measures with strong theoretical underpinnings for team-based health care.

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 maximum 1.5% Medicare FFS updates (under House SGR bill)
- But physicians will need our help!

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?
Obamacare implementation will:

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

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

- Will be confusing and not go smoothly on day one, but this is nothing new, same was true for Medicare Part D and original Medicare

New York Times, April 23, 1966

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.

http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/17/when-medicare-launched-nobody-had-any-idea-whether-it-would
The next six months

- October 1: open enrollment period begins for people to sign up for coverage through state marketplaces
- January 1, 2014: coverage and tax credit subsidies go into effect
- January 1, 2014: persons up to 138% of FPL can enroll in Medicaid (in participating states)

The next six months

- January 1, 2014, new consumer protections go into effect for all insured persons (no annual limits, no pre-existing condition exclusions, essential benefits)
- March 30, final day to buy coverage through the marketplaces, avoiding tax penalty for being without coverage
- [One year delay] January 1, 2015: penalties imposed on large employers that do not offer qualified coverage
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

\[ P_i = \text{premium quoted to individual} \]

\[ X_i = \text{Xi-expected outlays for covered health benefits for that individual} \]

\[ L_i = \text{a ‘loading factor’ added to cover the cost of marketing and administration, as well as a target profit margin} \]

**Premium “shock and joy”**

“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.”

What about the Obamacare “delays”?  

- None of the delays announced so far will have a major impact on coverage. *But these delays would have a big impact:*  
  - If the federal exchanges and state exchanges and information hubs are not ready to enroll people beginning 10/1/13  
  - If navigators and call centers are not ready to assist consumers  
  - If Treasury department isn’t ready to administer the subsidies  
    - (Administration insists all of the above will be ready, but . . . ?)  
  - If physicians and other health care stakeholders aren’t ready to help patients (consumers) understand new coverage options  
  - If many states continue to delay Medicaid expansion.

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**States Split on Participation in Medicaid Expansion**

- Working to Implement (24+DC)  
- Not Working to Implement (21)  
- Debate ongoing (5)

Analysis

- The Supreme Court’s ruling on the Affordable Care Act allows states to opt out of the law’s Medicaid expansion, leaving this decision with state governors and legislatures  
- Governors of states participating in Medicaid expansion cited support for increased coverage for residents as reason for opting in; governors of non-participating states cited high cost of expansion as reason for opting out; governors of undecided states weighing costs of expansion before opting in or out.

Obamacare implementation is facing *unprecedented* political headwinds

- State opposition to expanding Medicaid, setting up exchanges and helping people enroll
  - In most extreme cases, state opposition is bordering on *nullification*
- Organized political effort to discourage people from signing up
- Effort to defund the law, tied to resolution to fund the government and/or debt ceiling

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**Views of ACA Largely Unchanged This Year**

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?

![Graph showing views of ACA over time](chart.png)

*SOURCE: Kaiser Family Foundation Health Tracking Polls*
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 Obamacare fails, nothing good will replace it
Most Trusted on ACA: Doctors and Nurses, Federal and State Agencies, Pharmacists

Percent who say they would trust information about the health care law from each of the following: 44% said their doctor or nurse, 34% said federal agencies, 33% said state agencies, 50% said their local pharmacist, 21% said an employer, 22% said their local church or place of worship, 20% said non-profit or community organization, 18% said friends and family, 15% said a health insurance company, 8% said the news media, and 3% said social networking sites.

Percent who say they have heard something about the law from each of the following in the past 30 days: 22% heard from their doctor or nurse, 14% from federal agencies, 13% from state agencies, 9% from their local pharmacist, 9% from an employer, 6% from their local church or place of worship, 6% from non-profit or community organization, 4% from friends and family, 3% from a health insurance company, 1% from the news media, and 1% from social networking sites.

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 varied. For full question wording see toplines:

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted August 13-19, 2013)
How New Yorkers Can Access Affordable, Comprehensive Health Insurance

Patients trust their doctors. Polls show that when the public is asked which profession rates highest on honesty and ethical standards, physicians appear towards the top of the list. So when patients have questions about health insurance, they’re likely to ask their physician for advice on picking the plan that best suits their needs.

As a recognized source of consumer information, the American College of Physicians has agreed to provide unbiased and understandable resources to its physician members in ways you can help your patients obtain coverage through the affordable care act (aca). This guide provides specific information for New York residents and patients on the resources that are available to them.

The aca will make health insurance more affordable by providing health insurance tax credits and cost sharing to the uninsured, underinsured, and small businesses. Creating health insurance marketplaces to make shopping for health insurance easier; and implementing insurance reforms to make the market more accessible, predictable, and fair. In many states, the Medicaid program will be expanded to serve more people and health insurers in all states will no longer be able to deny insurance to those with pre-existing conditions.

According to the institute of Medicine, being uninsured poses a hazard to one’s health. Adults without health insurance are less likely to receive clinical preventive services that can reduce the likelihood of developing serious illness. Those with chronic disease are more likely than the insured to forego necessary therapies. Uninsured adults are also more likely to die from serious acute conditions than those with insurance. Lack of health insurance also takes a financial toll, as a high of all expenses are uninsured by the costs of medical care.

ACP Policies and Recommendations

This library is a collection of ACP clinical guidelines, ethical guidelines, policy statements, and copies of testimony and letters to government and non-government officials.

Search the Library

The ACP Advocate Blog

- How Physicians can counter __________ Wednesday, September 11, 2013
- Signs what Congress has already __________ Friday, August 17, 2013
- How exactly does Obamacare __________ Friday, August 16, 2013

The ACP Advocate Newsletter

- Health care and the immigration debate: ACP and Other __________ July 19, 2013
- ACP First: Other New Way to Refund __________ March 28, 2013

Do You Need Health Coverage? Resources are available to help Georgians find and enroll in health insurance.

Starting in 2014, most individuals will have to pay a fine if they don’t have health insurance. If you need health insurance you will be able to purchase it through the state’s health insurance marketplace and may be eligible for financial assistance to help with premiums and out-of-pocket costs. Even if you are young and healthy it is important that you get health insurance. Health insurance gives you the peace of mind of knowing that you will be covered and be more able to afford your medical expenses if you have an accident or get sick.

Depending on your income, family size, and a few other factors, you may qualify for health coverage tax credits.

This brief will provide information and useful links to resources that can help you obtain coverage that is right for you and your family.

Resources for Patients

Find help online: Enrollment in Georgia’s health insurance marketplace begins October 1st. More information can be found here: https://www.healthcare.gov/send-to-the-marketplace-in-my-state

Speak with someone over the phone: Georgia’s health insurance marketplace has a call center staffed by health insurance experts to provide help and information. The call center number is 1-855-258-2556, 24 hours a day, 7 days a week. (TDD: 1-855-884-4320)

Get help in person: Georgia has certified health insurance navigators who are trained to help you understand and choose among the health insurance plans available to you. Below are the names of the organizations for your state. More information will be available on http://www.georgiahealth.org:

- Structured Employment Economic Development Corporation
- University of Georgia

Community health centers will also be providing outreach and enrollment help: http://www.hhs.gov/about/programs-services/community-health-center-network/

Find the community health center nearest you http://findmyhealthcenter.hhs.gov/
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

Appropriations and debt ceiling

- Appropriations for federal government will run out at midnight, 9/30
- Followed by debate over increasing the debt ceiling
- Threat to tie Obamacare funding to CR complicates matters (but won’t succeed)
- No substantive negotiations or discussions are taking place to resolve differences!
Debt and Spending: Key Dates in 2013

Congressional recess
White House officials expect to meet with Republican senators to move closer on a fiscal deal

Key and expected dates
Congress back in session with nine days to resolve debt deficit, budget disagreements, and debt ceiling


Appropriations and debt ceiling

- How the battle over appropriations and the debt ceiling will determine the resources available for workforce programs, NIH, other discretionary programs

- In the less likely case that a deal is reached that includes entitlement savings, GME/IME cuts could be on the table
Another Dylan insight

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

*Subterranean Homesick Blues, 1965*

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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 uninsured</th>
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<td>2000</td>
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<td>27,000</td>
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<td>Total</td>
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A Final Dylan Insight

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

To Ramona, 1964