For the Times They Are A’ Changin’

*Will Physicians Start Swimmin’or Sink Like a Stone?*

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

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Huge thanks to Bob Doherty

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The Times They Are A Changin’
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*

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**Swim or sink?**

Will physicians be able to successfully participate in new payment/delivery models?
Swim or sink?

Physicians will:

- Be accountable for outcomes, quality and cost
- Accept more financial risk
- Need to acquire best practices and information systems

Swim or sink?

- *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:* team-based care will replace “silos” of practice
- *No one can do it alone:* policymakers, physician membership organizations, other stakeholders will need to advocate for pay stability, incentives, innovation and flexibility
ACP ADVOCACY ON PAYMENT AND DELIVERY SYSTEM REFORMS

Advocacy

SPOTLIGHT

ACP Advises Congress on Fixing Medicare Payments

The Chair of ACP’s Board of Regents testified before the House Ways and Means Subcommittee on Health on Tuesday, May 7 about repealing the flawed Medicare sustainable growth rate (SGR) formula. ACP recommended a phased approach that rewards quality and effectiveness.
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 “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’s health subcommittee reported a bipartisan bill on July 23 to eliminate SGR and reform physician payments

House bill is mostly consistent with ACP’s approach

<table>
<thead>
<tr>
<th>ACP’s Recommendations</th>
<th>House Bill</th>
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<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, but does not include higher updates for E/M codes.</td>
</tr>
<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>
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Stable, positive FFS updates for 5 years

<table>
<thead>
<tr>
<th>Percent</th>
<th>2019 and after</th>
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<tbody>
<tr>
<td>0.5%</td>
<td>Range of POSITIVE 1.5% to MINUS 5% depending on quality update</td>
</tr>
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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>
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</thead>
<tbody>
<tr>
<td>67-100</td>
<td>PLUS 1.5%</td>
</tr>
<tr>
<td>34-100</td>
<td>PLUS 0.5%</td>
</tr>
<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>
</tr>
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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

Directs CMS to improve RVUs

- Agency directed to achieve 1% in savings by reducing “misvalued” RVUs
- Savings would not be redistributed to other physician services
- CMS would collect data from physician practices who voluntarily agree to provide data on their volume of services, appointment scheduling (with compensation from CMS)
- Supplements the RUC, doesn’t replace it
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 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.
- Require all measures to go through NQF.
- 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.
“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 frequent, high priority performed procedures, particularly those that are considered preference-sensitive or are elective.

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

ACP proposals to SFC

- Eliminate provider-based billing—where a service is charged at a higher rate when delivered in an outpatient, hospital-system owned practice—when the care being provided is not dependent on the hospital facility and its associated technologies.
  - Create alternative funding sources for safety net institutions that depend on facility payments.
ACP proposals to SFC

- Authorize HHS to conduct a pilot-test of benchmarking tools to enable physicians to compare their utilization patterns with their peers and make voluntary improvements

- Direct HHS to explore ways to 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

ACP proposals to SFC

- Continue to support and fund research on comparative effectiveness through the Patient-Centered Outcomes Research Institute

- 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 such practices that are outliers compared to peers that do not have an ownership interest
ACP’s proposals to SFC

- Ensure RVU accuracy: improve RUC process, provide for external validation, set numerical goal to reduce over-valued RVUs to be redistributed to undervalued E/M codes
- Reimburse for End of Life/Advanced Care planning
- Pay for chronic disease care coordination (including work outside face-to-face encounters)

ACP ADVOCACY ON OBAMACARE
Swim or sink?

- Many interests are working to ensure that the ACA “sinks” by actively working against it, and highlighting failures.
- Will ACP members help make the law succeed—that is, to swim—or watch it sink?

ACP advocacy on Obamacare:

- Strongly supports the goals and key coverage programs in Obamacare (ACA)
- Committed to helping implementation succeed for patients at federal and state levels
- Continue to influence Obamacare implementation by submitting comments on all major rules
- We plan to update our state chapter advocacy campaign to support Medicaid expansion (being updated)
All 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 will replace it

Obamacare implementation will:

- Be disruptive (but that isn’t necessarily bad)

- 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 program
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
**ACP: PROVIDING PRACTICAL TOOLS AND HELP**

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**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!

ACP: reducing the confusion and getting some relief

- Physician and Practice Planner Timeline
- Resources on implementation of ObamaCare
Physician & Practice Timeline

Professional Requirements & Opportunities

Following is a helpful at-a-glance summary of upcoming important dates related to a variety of regulatory, payment, educational, and delivery system changes and requirements. Check back frequently for updated information.

Click the colored badges for more information about specific programs.

http://www.acponline.org/running_practice/physician_practice_timeline/
But are we doing enough to help them swim?

- **2012 Member Survey:** only 47% of members are participating in Medicare Physician Quality Reporting System

- **By 2019,** if House bill becomes law, they must all be reporting quality to Medicare, or face annual 5% cut—unless they are in a PCMH or other APM

- **Although thousands of members are in certified PCMHs,** most are not . . .
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*

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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
- But our members will need help!
How can we help them make the necessary changes over next 5 years?

- Leverage existing practice support resources (e.g. Practice Advisor, PQRS Wizard)?
- Develop new or better practice support resources? (registries?)
- Link them to external resources?
- All of the above?
- Other?

Resources on Obamacare

- **ACP has updated** *The Internist’s Practical Guide to Health System Reform*
- We are reaching out to Enroll America, AARP, others to serve as a distribution hub for ACP members on all aspects of Obamacare implementation (practical, not political)
- We will be developing our own resources for members on health exchanges, other issues
- We need to *push info* on the ACA to members, and urge them to help their patients enroll (all-member email)
Other resources

- Social media
- Redesigned advocacy website and policy library
- At a glance summaries of policy papers

Other ACP priority issues

- GME/Workforce
- Federal budget: sequestration, debt ceiling, FY 2014 appropriations
- Immigration Reform
- Firearms Safety
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

- Blowing 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>
</tr>
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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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<td>2002</td>
<td>23,000</td>
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<td>2004</td>
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<td>2005</td>
<td>25,000</td>
</tr>
<tr>
<td>2006</td>
<td>27,000</td>
</tr>
<tr>
<td>Total</td>
<td>165,000</td>
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Dorn, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality, Urban Institute, 2008
A Final Dylan Insight

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

To Ramona, 1964
Premium “shock and joy”

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

\[ P = \text{premium quoted to individual} \times \left( 1 + \text{loading factor} \right) \times \text{expected outlays for covered health benefits for that individual} \]

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


<table>
<thead>
<tr>
<th>Policyholder Age</th>
<th>Percentage of Premium Paid by Family of Four</th>
<th>Percentage of Premium Covered by Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>450%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>400%</td>
<td>97%</td>
<td>37%</td>
</tr>
<tr>
<td>350%</td>
<td>95%</td>
<td>32%</td>
</tr>
<tr>
<td>300%</td>
<td>85%</td>
<td>32%</td>
</tr>
<tr>
<td>250%</td>
<td>73%</td>
<td>38%</td>
</tr>
<tr>
<td>200%</td>
<td>61%</td>
<td>40%</td>
</tr>
<tr>
<td>150%</td>
<td>49%</td>
<td>42%</td>
</tr>
<tr>
<td>100%</td>
<td>37%</td>
<td>48%</td>
</tr>
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Source: The Henry J. Kaiser Family Foundation.

**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.
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 to date will have a major bearing on coverage expansions or consumer protections that go into effect on 1/1/14

- Even though the delays could smooth implementation and be viewed as a good faith effort by the administration to respond to concerns, critics are seizing on them to argue for repeal
What about the Obamacare “delays”?  

- One year delay in requirement that large employers pay a fine if they do not provide coverage will have negligible impact on % who will qualify for coverage in 2014  
  - But allows employers and government more time to agree on reporting requirements and implications for workforce, current health benefit programs

- Delay in implementing income-verification, employer-coverage to determine tax credit subsidies will not likely have significant effect on who will qualify in 2014 for health insurance subsidies

What about the Obamacare “delays”?  

- Delays that could really affect coverage in 2014:
  - If the federal exchanges and state exchanges and information hubs are not open for business on October 1 and ready to enroll people on 1/1/14
  - Navigators and call centers are not ready to assist consumers
  - Treasury department isn’t ready to administer the subsidies  
    - (Administration insists all of the above will be ready, but . . . ?)
  - States refuse or delay a decision to expand Medicaid
  - Physicians and other health care stakeholders aren’t ready to help patients (consumers) understand new coverage options