ACP American College of Physicians℠
INTERNAL MEDICINE | *Doctors for Adults*

Top 10 Things ACP Advocacy and Policy Development Did in 2013 to Improve Your Practice Environment & Enable You to Provide High Quality Care

Because of ACP advocacy and policy development efforts, working with other allied organizations:

1. **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.
    a. These codes include:
        i. 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.
        ii. 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.
    b. In order to succeed in this new environment of payment for team-based care, dynamic clinical care teams and nimble, adaptable partnerships that encourage collaboration and smooth transitions of responsibility that are focused on patient needs will be required. Therefore, ACP has drafted a set of key "Principles Supporting Dynamic Clinical Care Teams" that will help physicians prepare for the rapidly evolving delivery and payment system environment—one that is moving toward payment for value rather than volume of services.

2. **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. Chronic care management services are defined to include the development, revision, and implementation of a plan of care; communication with the patient, caregivers, and other treating health professionals; and medication management—and will be paid to a physician or other eligible practitioner from a qualified practice that furnishes these services over 30-day periods. The specific payment amount for this G-code (GXXX1) and the detailed standards that will be required for a practice to qualify to provide these services will be determined over the course of the coming year.

3. **The annual Sustainable Growth Rate (SGR) cut that would have gone into effect on January 1, 2014 has been averted for 90 days and a comprehensive Medicare payment reform bill that would permanently repeal the SGR has been reported out of the major congressional committees of jurisdiction.**
    a. Shortly before New Year's Day, President Obama signed the Bipartisan Budget Act, which includes the Pathway for SGR Reform Act, providing a three-month SGR "bridge"—which expires on March 31, 2014. Therefore, the steep cut that would have taken place on January 1, 2014, due to the SGR has been averted. This SGR "bridge" increased Medicare payments by 0.5 percent across-the-board on January 1, 2014, with the conversion factor being $35.8228.
    b. In December 2013, the Senate Finance Committee and Ways and Means Committee reported out nearly identical bills that would achieve many of ACP's top priorities for physician payment reform. Specifically, the College is pleased that the bill:
        i. Repeals the SGR and all future scheduled cuts from it.
        ii. Provides multiple pathways for physicians to earn positive updates for participating in quality improvement, clinical practice improvement, meaningful use of electronic

health records, and for effective management of resources, in a new single Value-Based Payment (VBP) program that will replace the current three separate Medicare reporting programs (Medicare Physician Quality Reporting System-PQRS, Meaningful Use, and Medicare Value Modifier programs). We are pleased that the existing penalties for those programs that would be imposed starting in 2016 will be eliminated. We are also pleased that the bill references a variety of different programs and activities that would qualify for VBP incentives. We also are encouraged that the bill would require a GAO study of harmonizing measures used by Medicare and private payers, which could greatly reduce administrative burdens on physicians.

iii. Creates strong incentives for Patient-Centered Medical Homes (PCMHs) and PCMH Specialty Practices, which would receive the highest performance score for the clinical practice improvement activities. PCMHs would also be eligible to bill and be reimbursed for complex chronic care management. PCMHs could also earn bonus payments as an Alternative Payment Model (APM). These provisions recognize that the PCMH model has been shown to improve quality and lower costs in the many programs where it has been offered to patients throughout the country.

iv. Provides funding for smaller practices to help them successfully participate in the VBP program or APMs. We are especially pleased that the bill substantially increases funding for smaller practices, and makes smaller practices that are not in rural or health professional shortage areas eligible for the funding.

v. Provides funding for measure development, doubling the amount of funding that currently is available.

4. CMS and private health insurance plans are making progress toward administrative simplification in two key areas:

a. 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.

In order to find out more about the PQRS and VBPM programs, you can access **ACP's Physician & Practice Timeline℠**. The Timeline provides a helpful at-a-glance summary of upcoming important dates related to a variety of regulatory, payment, educational, and delivery system changes and requirements—including VBPM, PQRS, Meaningful Use, ICD-10, the Sunshine Act, the transitional care management codes, and Maintenance of Certification (MOC).

b. 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. 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. 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 (reassociate) 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.

5. **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**. This change, also mandated by the ACA, was designed to make it more feasible for eligible physicians to take care of Medicaid patients, both in states that are expanding the program to everyone up to 138 percent of the Federal Poverty Level (as also authorized by the ACA) as well as in states that have not yet agreed to the expansion. Although many states have been slow to roll this out, it is a very substantial increase in Medicaid payments in most states and, in most cases, will be retroactive to the beginning of 2013. And, 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.

   The average index of Medicaid/Medicare payment throughout the country is 66 percent; therefore, this change has or will result in substantial increases in payments to most physicians providing primary care services to Medicaid patients—and, as noted above, is not limited by specialty designation.

   a. To qualify for these higher payments in both the fee-for-service and managed care settings, physicians must meet ONE of the following requirements (via self-attestation):
      i. Have a specialty designation of family medicine, general internal medicine, or pediatric medicine or be board certified as a subspecialty within those specialties OR
      ii. If not board certified, then at least 60 percent of the codes billed by the physician for all of CY 2012 must be for the specified E&M codes and vaccine administration codes.
   b. 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. This includes codes within the specified range not currently covered by Medicare (e.g. E&M Non Face-to-Face codes, Consultation Services codes). ACP is particularly pleased with and had advocated for the inclusion of services that are not currently paid for under Medicare, such as the consultation codes.

   We also have more information on the Medicaid "Pay Parity" provision of the ACA, including ACP's analysis and frequently asked questions (FAQs).

6. **In addition to the Medicaid payment increases outlined above, Medicare will continue to pay a 10 percent bonus to primary care internists, and other primary care physicians, for your office visits and other evaluation and management codes**—an average annual increase in Medicare revenue of an estimated $5,000 per internist over the course of 5 years (from 2011 to 2015).

   ACP was a driving force behind Congress' creation of this program, also mandated and funded by the ACA, including persuading CMS to greatly expand the number of internists who will qualify for the bonus. 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. These payment increases are a direct result of ACP advocacy. ACP is advocating to extend this program beyond 2015.

7. **More and more individuals are getting access to health insurance coverage either via the state health insurance marketplaces or the expansion of Medicaid.** While the roll out of the ACA has

not been as smooth as many would have liked, the health insurance marketplaces have launched and patients who need coverage will be able to enroll until March 31, 2014. To help you help your patients determine health insurance choices, as well as to answer questions that you might have, ACP has put together a series of documents to address questions about the changes in healthcare coverage brought about by the new marketplaces. These resources include:

a. Prepare for January 1, 2014 - Affordable Care Act Issues Physicians Need to Know. This document provides practical information to physicians and their patients regarding provider network adequacy issues, the health insurance appeals process, information about cost sharing, and how physicians can help their patients acquire non-covered drugs.
b. 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.
c. ACP's Frequently Asked Questions about Patient Enrollment in Health Insurance Marketplaces
d. ACP's Questions & Answers About Physician Concerns on the ACA
e. An Internist's Practical Guide to Understanding Health System Reform
f. Crowley and Tape. "Health Policy Basics: Health Insurance Marketplaces." Annals of Internal Medicine. 2013;159(11):784-786.
g. Crowley and Golden. "Health Policy Basics: Medicaid Expansion." Annals of Internal Medicine. Published online 24 December 2013.

8. **Programs that you and your patients depend on to ensure: (1) access to public health services, (2) the undertaking of critical medical research, and (3) an adequate physician workforce were protected.** The Bipartisan Budget Act of 2013 (BBA) was signed into law on December 26, 2013. The BBA provides much-needed respite from sequestration (across-the-board budget cuts), restoring about $23 billion or almost two-thirds of the scheduled sequestration cuts for nondefense discretionary programs in FY2014.

   Additionally, a separate and related omnibus appropriations bill, enacted in January 2014, ensures the following:

   - $29.9 billion in funding for NIH, which while $714 million less than the FY2013 enacted level, is still $1 billion more than the post-sequester level;
   - $2.55 billion in funding for the FDA, which is $96 million more than the FY2013 enacted level and $226 million more than the post-sequester level;
   - $371 million for AHRQ, which is $2 million more than the FY2013 level and $6 million more than the post-sequester level;
   - $6.3 billion for HRSA, which while $130 million less than the FY2013 enacted level, is $200 million more than the post-sequester level; and
   - $6.9 billion for CDC, which is about $1.2 billion more than the FY2013 level and $1.4 billion more than the post-sequester level.

   ACP was among the most vocal national physician membership organizations in advocating that Congress replace the sequestration cuts with a more responsible approach that ensures adequate funding for essential health programs.

9. **Five hundred primary care practices in seven regions are receiving substantial increases in Medicare revenue—plus financial and other support services from other payers in their communities—for providing patient-centered, coordinated care.** ACP has been actively engaged

in advising on this project from its inception. CMS is paying the participating primary care practices a risk-adjusted care management fee, initially set at an average of $20 per beneficiary per month, to support enhanced, coordinated services on behalf of Medicare fee-for-service beneficiaries and, when proven to be successful, the Secretary of Health and Human Services has the authority to roll out this payment approach throughout all of fee-for-service Medicare.

This program, called the 4-year Comprehensive Primary Care (CPC) Initiative, was kicked off by the CMS Innovation Center with the intent of fostering collaboration between public and private health care payers to strengthen primary care in the U.S. The CPC initiative extends and builds upon the PCMH concept to include payment reform to support practice transformation. The initiative includes 500 primary care practices, representing 2,144 clinicians, that serve an estimated 313,000 Medicare beneficiaries. ACP played a critical role in helping the Innovation Center design the program and in encouraging internal medicine practices to enroll in it.

Additionally, in the SGR legislation described earlier, this is the only project without a requirement for physicians to share risk for financial losses that would be automatically considered an Alternative Payment Model (APM)—all other APMs must have this "two-sided risk" component. Therefore, if the legislation passes, the current participating practices—plus any new practices added once it is proven successful—could become eligible to receive a 5 percent payment bonus in 2017 through 2022, followed by a 2 percent bonus in subsequent years.

10. **ACP members, other physicians, patients, policymakers, and key stakeholders can depend on the College to address controversial and complex issues of importance to internists, including:**
    a. Protecting the physician-patient relationship and calling for broader reforms in the area of firearms violence. In 2013, ACP updated and reaffirmed our firearm injury prevention policy and will be issuing a more in-depth report on preventing firearm violence in 2014.
    b. Providing critical guidance to prescribers and policymakers regarding measures to effectively address the problem of prescription drug abuse.
    c. Influencing implementation of the ACA, providing comments and regularly communicating with administration officials on a wide range of issues raised by the law, including: network adequacy standards, grace periods for qualified health plans, essential health benefits, formularies, cost sharing, and health insurance marketplace structure.