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Tomorrow's Doctors, Tomorrow's Cures

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Washington Update
Spring APPD Meeting
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Ivy Baer
AAMC
ibaer@aamc.org; 202-828-0499

Association of
American Medical Colleges

What's Happening?

- On the Hill:
  - The challenge of the pay-fors
  - Sequester: stay or go?
  - Everyone loves NIH, but will there be enough funding?
- Legislative trends similar to regulatory trends
  - APMS are popping up all over
  - Payment based on quality continues to spread
- A regulatory tsunami is coming this year!
- FTC Workshop: is the transformation of our healthcare system pro-competitive?

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Discretionary Spending Caps

($ in billions)	FY 2013	FY 2014 w/ seq.	FY 2014 revised[1]	FY 2015 revised[1]	FY 2016
Defense	$518	$498	$520	$521	$523
Nondefense	$468	$469	$492	$492	$493
Total	$986	$967	$1,012	$1,014	$1,016

[1] Caps for FYs 2014-15 adjusted by Bipartisan Budget Act of 2013.

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FY 2015 NIH Budget
[Labor-H appropriation]

FY 2012	$30.6 billion
FY 2013 post sequester	$28.9 billion
FY 2014 enacted	$29.9 billion
FY 2015 President's request	$30.1 billion

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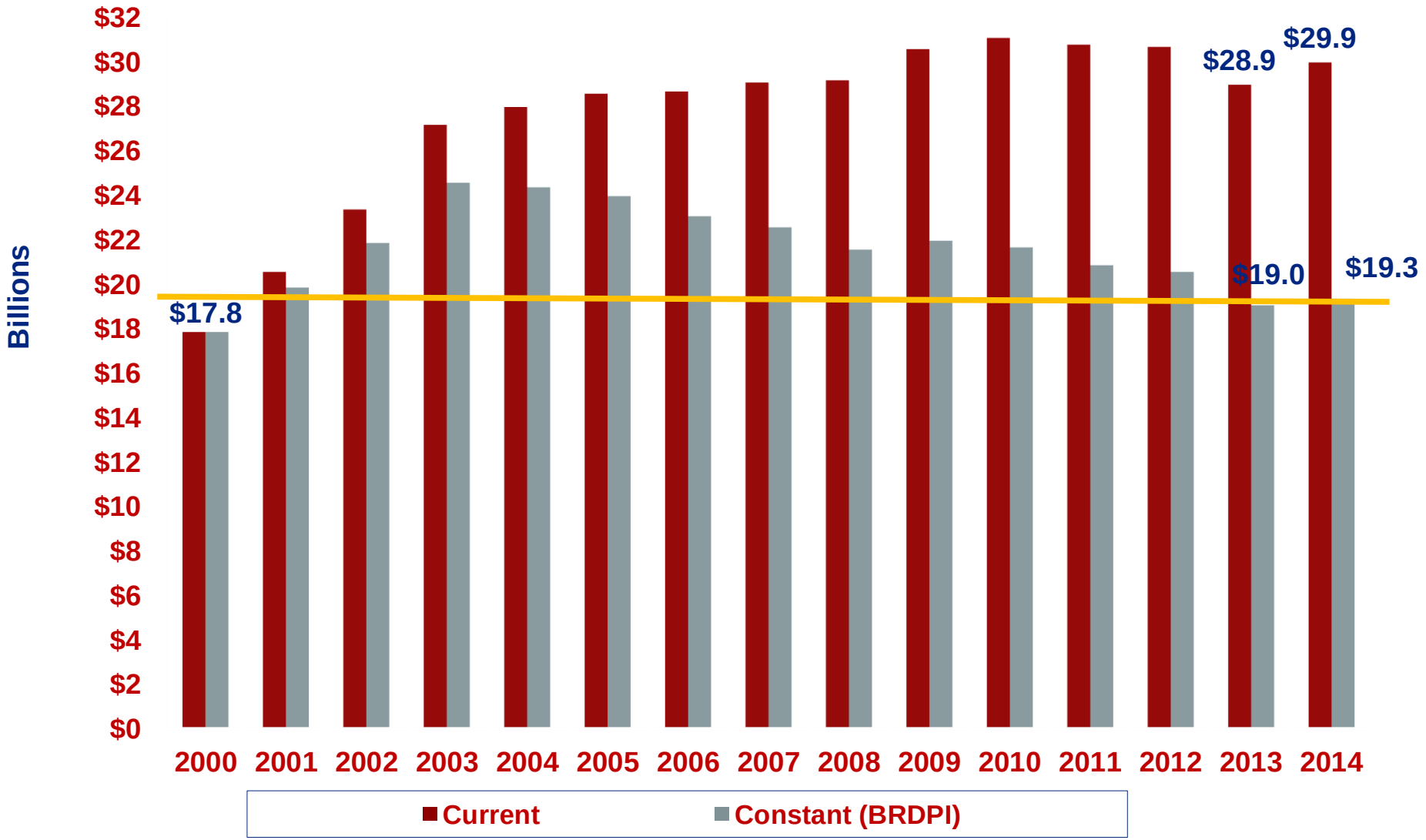
NIH Funding – FYs 2000-2014



Labor-HHS Budget Authority only

Sources: NIH Budget Office; House and Senate Appropriations Committees

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President's 2015 Budget

NIH: $30.36B

- +0.7% over 2014; +2.11% over 2013 (post-sequester)
- AAMC pushing for $32B

IME: $14.6 cut over 10 years; $14.6B in health workforce (focus on ambulatory and preventive care)

Extension of Medicaid physician payment floor for primary care services through 12/31/15

Assumes repeal of SGR at cost of $110b/10years but no offsets identified

- Several years of payment stability then incentives for new models of care

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Medicare put on the brink, yet again

FORTUNE

By Claire Zillman, reporter March 20, 2014: 5:00 AM ET

Next week, Congress will be racing against the clock to put a band-aid on an automatic measure that will significantly cut what doctors receive for treating Medicare patients.

So, what did Congress do?

- SGR patch through 3/31/15
- 0.5% update through 12/31/14; 0% update 1/1/15-3/31/15
- Extends Medicare GPCI thru 3/31/15
- ICD-10 delay to 10/1/15
- 2 midnights: no RAC reviews through 3/31/15
- Delays DSH reductions by 1 year but additional reductions through 2024

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And how was it paid for?

- Sequester extension
  - 4% sequester 1/1/24-6/30/24 and then 0% sequester 7/1/24-12/21/24
- $2.3B from Bipartisan Budget Act of 2013

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Take-Aways from SGR Replacement Bill (S. 2110)

A future where updates will rely on physician participation in alternative payment systems

- 1/1/18: merit-based incentive payment system (MIPS) in 4 performance categories: quality, resource use, clinical practice improvement, EHR meaningful use
  - Funded by reduced fee schedule amounts; rewards/penalties NTE fee schedule percentage for that year.

Biggest challenge: pay-fors

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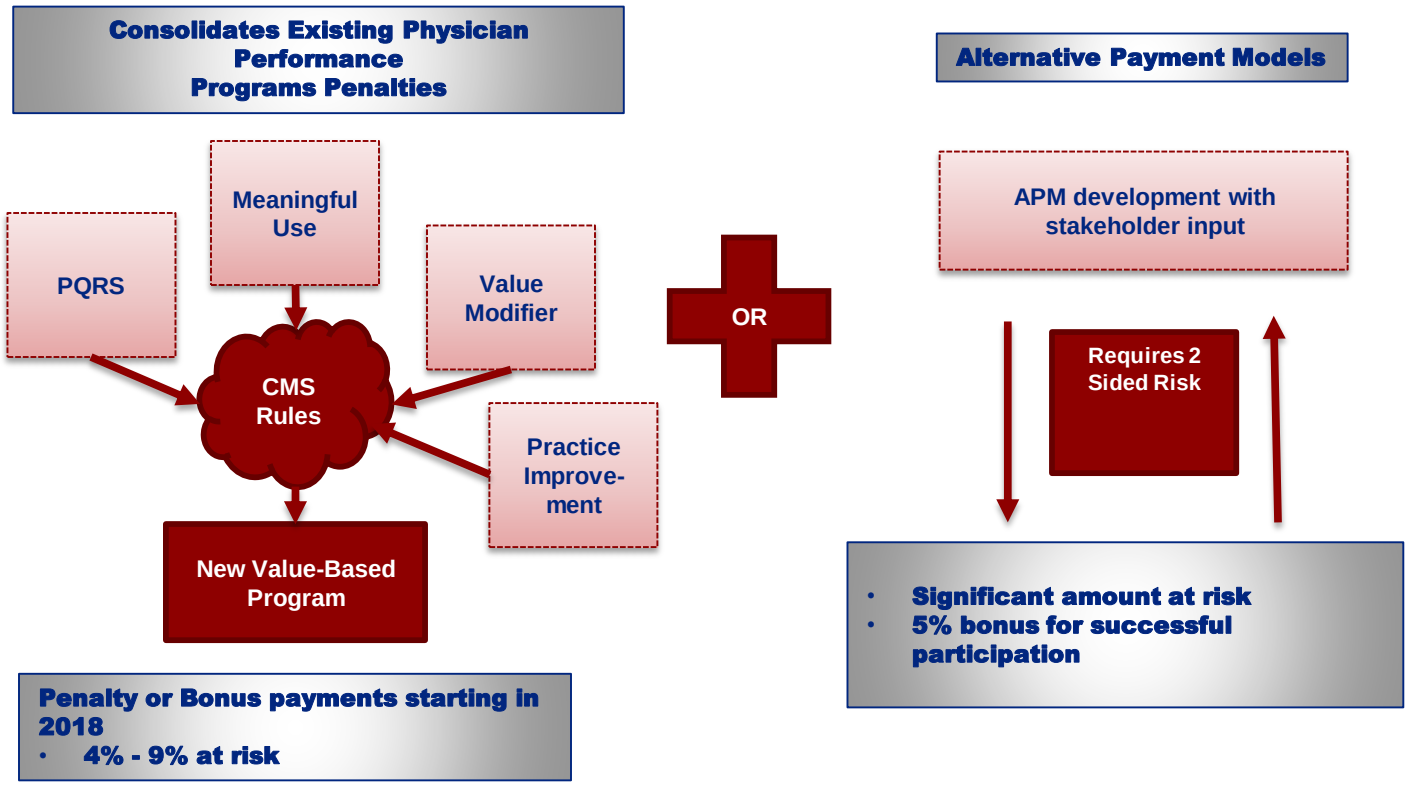
Alternative to SGR

- **Update: 0.5% for first 5 years; 0.0% for next 5 years PLUS**



SGR Repeal: Clinical Practice Improvement

Expanded access (eg, same day appointments)

Population management (participation in a qualified clinical data registry)

Care coordination (use of remote monitoring or telehealth)

Beneficiary engagement (shared decision-making)

Patient safety and practice management (surgical check-lists)

APM participation

Need not perform in each category to get highest score

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SGR Repeal: Qualifying APM Thresholds

2018-19: at least 25% of Medicare payments

2020-21: at least 50% of Medicare payments or at least 50% of total payments (with at least 25% Medicare payments)

2022 and beyond: at least 75% of total payments (at least 25% Medicare payments)

- Don’t count DoD/VA payments or Medicaid payments in state in which no medical home or Medicaid APM is available
- Non-Medicare payment arrangements must involve quality measure comparable to Medicare and use CEHRT; EP must bear more than nominal financial risk

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SGR Repeal: Payments under APMs

2018-23: EPs who are qualifying APM participants would ge lump sum 5% bonus (based on services furnished in preceding year) in addition to payments made under APMs

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SGR Repeal: Core Measure Sets

Measure from PQRS, VM and EHR meaningful use

- These will sunset as separate payment adjustments after 2017
- Quality clinical data registry reporting under PQRS available for group reporting, not just individual reporting

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Amount at Risk Increases Over Time

Potential Incentives	2014	2015	2016	2017	2018	2019
PQRS	0.5% (1.0% w/ MOC)					
Mcare/Mcaid EHR Incentive	Varies	Varies	Varies	Mcaid Only	Mcaid Only	Mcaid Only
Value-Modifier (Max incentive) [a]		+1.0(x)	+2.0(x)	TBD	TBD	TBD

Potential Reductions	2014	2015	2016	2017	2018	2019
eRx Incentive	-2%					
Medicare EHR Incentive		-1.0%[c]	-2.0%	-3.0%	-4.0%[b]	-5.0%[b]
PQRS		-1.5%	-2.0%	-2.0%	-2.0%	-2.0%
Value-modifier (Max reduction)[a]		-1.0%	-2.0%	TBD[d]	TBD[d]	TBD[d]
Total Possible Reduction[c,d]	**-2%**	**-4.5%**	**-6%**	**-7%+**	**-8%+**	**-9%+**

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SES Adjustment for Hospital Quality Measures

Establishing Beneficiary Equity in the Hospital Readmissions Program Act (Rep. Renacci, R-OH)

- Would require adjustment for hospital's percentage of dually-eligible patients in Hospital Readmission Reduction Program

NQF considering changing its long-standing policy that automatically excludes SES from the risk adjustment of all quality measures

- To identify and reduce health disparities stratify by relevant sociodemographic factors

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Regulations: Now, Later, Probable

Premium support (interim final comment period now)

The usual: IPPS, OPPS, PFS

The not-so-usual:

- MSSP ACO proposed rule
- HIPAA Accounting for Disclosures final rule
- 340B proposed rule (June)
- Proposed rules on exchanges and other ACA provisions
- Meaningful Use Stage 3 proposed rule (end of 2014)
- More RFIs from CMMI?

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3 RFIs from CMMI:

Pioneer ACOs

Specialty Practitioner Payment Models

- Procedural Episode-Based
- Complex and Chronic Disease Management Episode-Based

Transforming Clinical Practices

- Helping smaller physician practices

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FTC: Examining Health Care Competition

Professional regulation of health care providers

- Scope of practice issues; any safety or other benefits to consumers?

Innovations in Health Care Delivery

- New models; retail clinics; telemedicine

Advancements in Health Care Technology

- EHRs, health data exchanges, technology platforms for payers and providers

Measuring and Assessing Quality of Health Care

- Affect, if any, that quality information has on competition and informs health care choices

Price Transparency of Health Care Services

- Does it dampen competition? Relationship between price transparency and quality information?

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FTC Workshop: Worth Noting

Some interesting comments

- If people want access to certain institutions, maybe they're better in ways we can't measure (Mark McClellan)
- Is teaching or DSH or higher quality an explanation for different prices? Need more sophistication than Steven Brill. (Bob Berenson)
- Organizations with real market power should lead the way in putting together price and quality information (FTC staff)

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Final Word from FTC

- It’s not about price alone; need to have quality information too

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AAMC's Guiding Principles for Public Reporting of Provider Performance

Purpose

- Explicitly state target audience and intended purpose of report
- Data, measures and data display should fit stated purpose

Transparency

- All information necessary to understand the data is available
- Sufficient details to allow for independent replication of results

Validity

- Methodology, data collection, scoring and benchmarks are accurate reflection of the characteristic being measured

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