PRIMARY CARE SURVIVAL GUIDE
HEALTHCARE REFORM
MEDICAL TECHNOLOGY

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UNPRECEDENTED CHANGES IN HEALTH CARE ARE UNDERWAY AND THE PRIMARY CARE PHYSICIAN IS IMPACTED THE MOST
CHANGES IN HEALTHCARE

PAYMENT METHODS ARE CHANGING

EXPECTATIONS ARE RISING

TECHNOLOGY IS NO LONGER OPTIONAL

PROFITABILITY IS AN INCREASING CONCERN
WITHOUT DIRECTION AND CLEAR SET OF OBJECTIVES AND GOALS, IT IS SIMPLY IMPOSSIBLE FOR ANY PROVIDER TO NAVIGATE, LET ALONE SURVIVE, CHANGES IN HEALTH CARE.
WHAT PRIMARY CARE PHYSICIANS EARN (MEDIAN INCOME 2014)

INTERNAL MEDICINE PHYSICIANS:  
$188,000

FAMILY/GENERAL PHYSICIANS:  
$188,000

CARDIOLOGY:  
$363,000
## Earnings by Community

<table>
<thead>
<tr>
<th>Community</th>
<th>Earnings</th>
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<tbody>
<tr>
<td>Inner City</td>
<td>$232,000</td>
</tr>
<tr>
<td>Urban</td>
<td>$236,000</td>
</tr>
<tr>
<td>Suburban</td>
<td>$248,000</td>
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<tr>
<td>Rural</td>
<td>$232,000</td>
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MALPRACTICE COSTS

INTERNAL MEDICINE PHYSICIAN:
  $12,300

FAMILY/GENERAL PHYSICIAN:
  $11,100

CARDIOLOGY:
  $18,700
JAN 1, 2014: ALL PUBLIC AND PRIVATE HEALTHCARE PRODUCERS AND OTHER ELIGIBLE PROFESSIONALS HAVE ADOPTED AND DEMONSTRATED “MEANINGFUL USE” OF ELECTRONIC MEDICAL RECORDS (EMR) TO MAINTAIN THEIR EXISTING MEDICAL AND MEDICARE REIMBURSEMENT LEVELS.
ELECTRONIC HEALTH RECORD (EHR)

MORE COMPREHENSIVE PATIENT HISTORY THAN EMR

MEANINGFUL USE TO ACHIEVE:

- IMPROVE QUALITY, SAFETY, EFFICIENCY
- REDUCE HEALTH DISPARITIES
- ENGAGE PATIENT AND FAMILY
- IMPROVE CARE COORDINATION AND POPULATION AND PUBLIC HEALTH
## EHR AND EMR DIFFERENCES

<table>
<thead>
<tr>
<th>EHR</th>
<th>EMR</th>
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<tbody>
<tr>
<td>A DIGITAL VERSION OF A CHART</td>
<td>A DIGITAL RECORD OF HEALTH INFORMATION</td>
</tr>
<tr>
<td>STREAMLINED SHARING OF UPDATED REAL TIME INFORMATION</td>
<td>NOT DESIGNED TO BE SHARED OUTSIDE THE INDIVIDUAL PRACTICE</td>
</tr>
<tr>
<td>ALLOWS A PATIENT’S MEDICAL INFORMATION TO MOVE WITH THEM</td>
<td>PATIENT RECORD DOES NOT EASILY TRAVEL OUTSIDE THE PRACTICE</td>
</tr>
<tr>
<td>ACCESS TO TOOLS THAT PROVIDERS CAN USE FOR DECISION MAKING</td>
<td>MAINLY USED BY PROVIDERS FOR DIAGNOSIS AND TREATMENT</td>
</tr>
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</table>
MEANINGFUL USE RULE

PART OF A LARGER FEDERAL PROGRAM THAT GIVES INCENTIVES TO DOCTORS AND HOSPITALS TO MAKE MOST OF MEDICAL HEALTH RECORDS

HELPS DOCTORS’ OFFICES AND HOSPITALS BECOME MORE EFFICIENT AND PROVIDE HIGHER QUALITY PATIENT CARE TO QUALIFY FOR MEDICAID AND MEDICARE INCENTIVES
MEANINGFUL USE RULE

ALLOWS CREDENTIALED MEDICAL ASSISTANTS TO ENTER PHYSICIAN'S ORDERS INTO THE COMPUTERIZED ORDER ENTRY SYSTEM FOR MEDICATION, LABORATORY, AND RADIOLOGY SERVICES

DOCTORS WILL BE ABLE TO SPEND MORE TIME WITH THEIR PATIENTS

CREDENTIALED MEDICAL ASSISTANTS CAN SAVE
NO MEANINGFUL USE BY 2015

1% DEDUCTION IN MEDICARE REIMBURSEMENT

RISE ANNUALLY THEREAFTER:

- 2% BY 2016
- 4% BY 2018
- UP TO 95% DEPENDING ON FUTURE ADJUSTMENTS
UNCERTAINTY AHEAD FOR MEANINGFUL USE RULE AND PHYSICIANS

AFTER 7 YEARS OF EHRs, THE FEDERAL GOVERNMENT IS PLANNING TO PUT AN END TO THE MEANINGFUL USE PROGRAM
INCENTIVES

$44,000 MEDICARE INCENTIVES BEGINNING 2011

STAGE 1: 2011-2012
STAGE 2: END OF 2014
STAGE 3: TO BE DEFINED
THE AFFORDABLE CARE ACT HAS OPENED THE DOOR FOR MORE TECHNOLOGY.

THIS INCLUDES EHR, BUT ALSO DIGITAL DIAGNOSTICS AND OTHER WAYS TO GATHER INFORMATION IN THE EXAM SPACE.
NAVIGATING 2016’S REIMBURSEMENT CHALLENGES

I. THE SHIFT TO VALUE-BASED CARE

II. PAYER CONSOLIDATION

III. HIGH-DEDUCTIBLE INSURANCE POLICIES

IV. EXPANSION OF TELEHEALTH
I. THE SHIFT TO VALUE-BASED CARE

A. MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

B. ALTERNATIVE PAYMENT MODEL (APM)

BOTH WILL TAKE EFFECT ON JANUARY 1, 2019

PHYSICIANS SHOULD INCORPORATE THE NEWER BILLING CODES, SUCH AS TRANSITIONAL CARE MANAGEMENT, CHRONIC CARE MANAGEMENT, AND ADVANCE CARE PLANNING INTO THEIR PRACTICE IN 2016
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- UNDER THIS PROGRAM, TRADITIONAL FEE-FOR-SERVICE PAYMENTS WILL BE ADJUSTED EITHER WITH BONUSES OR PENALTIES, DEPENDING ON A PHYSICIAN’S SCORE ON A NEW REPORTING PROGRAM

- WILL REPLACE AND COMBINE ASPECTS OF THE PHYSICIAN QUALITY REPORTING SYSTEM (PQRS), MEANINGFUL USE, AND VALUE-BASED MODIFIER
A. MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- Physician will receive a score from 0 to 100 based on the four areas:
  - Clinical Quality
  - Meaningful Use
  - Resource Use
  - Practice Improvement

Details of each will need to be worked out during the rulemaking process.
A. MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- Scoring weights in these areas may be adjusted to account for a physician’s ability to successfully report on each area.

- Credit for improvement will be given on a yearly basis.

- Physicians with the best MIPS scores can potentially earn “exceptional performance” bonuses.
B. ALTERNATIVE PAYMENT MODEL (APM)

- Physicians who choose an APM will receive a 5% annual bonus to fee-for-service payments if they can prove they receive substantial revenue through an APM.

- Substantial revenue defined in two ways:
  - By 2019-2020, 25% of Medicare payments must be attributable to the APM increasing to 50% in 2021.
  - Starting in 2021, 50% of combined payments from Medicare and other payers must be attributable to the APM.
B. ALTERNATIVE PAYMENT MODEL (APM)

- APM WILL HAVE THEIR OWN PAYMENT RULES, DEPENDING ON THE PARTICULARS OF THE PAYMENT ARRANGEMENTS OF THE ORGANIZATION

- OPTIONS FOR APM INCLUDE USE OF SHARED SAVINGS/FINANCIAL RISK ARRANGEMENTS
  - ACCOUNTABLE CARE ORGANIZATIONS
  - USE OF BUNDLED PAYMENTS

- PATIENT-CENTERED MEDICAL HOMES (PCMH) CAN QUALIFY IF THE PCMH IMPROVES QUALITY WITHOUT LOWERING COSTS, OR
II. MAJOR PAYER CONSOLIDATIONS

AETNA’S PROPOSED ACQUISITION OF HUMANA FOR $37 BILLION
ANTHEM’S $54 BILLION BID FOR CIGNA

- ANTI-COMPETITIVE
- FEWER CHOICES
- BOTTOMLINE: BAD FOR PHYSICIANS
II. MAJOR PAYER CONSOLIDATIONS

ANALOGY OF THE THIRD-GRADE BULLY:

ON THE PLAYGROUND, THEY DON’T PICK ON THE BIGGEST, TOUGHEST CHILD; THEY PICK ON THE WEAKEST.

HERE, THE WEAKEST REPRESENTS THE SMALL INDIVIDUAL PRACTICES
II. MAJOR PAYER CONSOLIDATIONS

SOLUTION: PHYSICIANS SHOULD JOIN FORCES

- INDEPENDENT PRACTICE ASSOCIATION
- ACCOUNTABLE CARE ORGANIZATION
- RURAL AREA PHYSICIANS NEED TO PARTNER WITH ONES IN THE METROPOLITAN HEALTHCARE SYSTEM
- PHYSICIANS TAKE A LOOK AT THEIR PATIENT BASE:
  - IF NOT ENOUGH PATIENTS IN A CERTAIN PLAN, LEAVE IT RATHER THAN TAKE A BAD CONTRACT
III. HIGH DEDUCTIBLES AND COPAYS

As a result of the Affordable Care Act, more Americans have healthcare insurance today but the drawback is that many also now have high annual deductibles.

- $5,000 a year is not uncommon.
III. HIGH DEDUCTIBLES AND COPAYS

IF SOMETHING CATASTROPHIC HAPPENS, IT IS GREAT TO HAVE COVERAGE

PATIENTS END UP PAYING CASH FOR MOST OF THEIR HEALTHCARE (THEY MAY START BRINGING CHICKENS AND EGGS FROM THEIR FARM TO PAY FOR THEIR BILL)
IV.  TELEMEDICINE

Patients seeking care for routine problems may be cherry-picked out of your practice because it is more convenient for them to call somebody on a video conference and talk about their problem.

Service and strong physician-patient relationships are going to be more important than ever before.
MACRA—MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

“DOC-FIX” BILL

WILL REPEAL THE MEDICARE SUSTAINABLE GROWTH RATE (SGR)

IMPROVE MEDICARE PAYMENTS TO PHYSICIANS SO THEY WILL CONTINUE TO ACCEPT MEDICARE PAYMENTS AND WILL FUND THE CHIP

ENCOURAGES CHRONIC CARE MANAGEMENT

REDUCES ADMINISTRATIVE BURDENS FOR PHYSICIANS

PREVENTED A 21% PAYMENT CUT FOR SERVICES PROVIDED TO MEDICARE PATIENTS
CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

PROGRAM THAT PROVIDES HEALTH INSURANCE TO CHILDREN OF LOW- AND MODERATE-INCOME FAMILIES WITH INCOMES TOO HIGH TO QUALIFY FOR MEDICAID ESTABLISHED IN 1997 AND COVERS 8 MILLION CHILDREN NATIONALLY
QUALITY PROGRAMS COVERED UNDER MACRA

I. PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

II. VALUE-BASED MODIFIER PROGRAM

III. MEANINGFUL USE

IV. NEW CRITICAL PRACTICE IMPROVEMENT ACTIVITIES
FOUR BASIC STEPS TO TAKE AND PREPARE

I. BE READY TO BE PAID BASED ON YOUR PERFORMANCE

II. CONSIDER PCMH (PATIENT-CENTERED MEDICAL HOME) CERTIFICATION

III. DON’T JUST TOLERATE TECHNOLOGY, EMBRACE IT

IV. EXPLORE OTHER REVENUE OPPORTUNITIES
1. Prepare to Be Paid Based on Performance

Private and public patients are driving a shift from fee-for-service to value-based care through pay-for-performance models.
ACCOUNTABLE CARE ORGANIZATION (ACO)

HEALTH CARE PROVIDERS HELD ACCOUNTABLE

SAVINGS FROM HIGHER QUALITY

BOTH LOWER COSTS AND PROVIDE OVERALL
IMPROVEMENT IN CARE WITHIN THEIR PATIENT
POPULATION
II. PURSUE PCMH CERTIFICATION

A MODEL OR PHILOSOPHY OF PRIMARY CARE THAT IS PATIENT-CENTERED, COMPREHENSIVE, TEAM-BASED, COORDINATED, ACCESSIBLE AND FOCUSED ON QUALITY AND SAFETY
II. PURSUE PCMH CERTIFICATION

PATIENT CENTERED MEDICAL HOME CERTIFICATION HAS BECOME THE STANDARD BY WHICH PRIMARY CARE PROVIDERS DEMONSTRATE THEIR WILLINGNESS AND ABILITY TO CONFORM TO THE NEW METHODS OF MANAGING THEIR PATIENT POPULATION
III. EMBRACE TECHNOLOGY

Technology is required to qualify for more incentives in the new payment models

Example: Electronic Health Records
ADDITIONAL TECHNOLOGY

PRACTICE MANAGEMENT

REFERRAL MANAGEMENT

PAYMENT FACILITATION

AUTOMATED MESSAGING

PATIENT PORTALS
IV. ADDITIONAL REVENUE OPPORTUNITIES

WEIGHT LOSS

COSMETICS
TOP 12 SECONDARY INCOMES FOR PHYSICIANS

1. CONSULTING
   29%

2. OTHER MEDICAL WORK
   19%

3. CLINICAL WORK
   13%

   NON-MEDICAL WORK
   13%

1. EXPERT WITNESS
   12%
TOP 12 SECONDARY INCOMES FOR PHYSICIANS

7. HOSPICE
   7%

8. URGENT CARE
   5%

9. LOCUM TENENS
   4%
   PRECEPTOR
   4%
CONGRESS CLOSES SOME SOCIAL SECURITY LOOPHOLES
NEW CONGRESSIONAL LEGISLATION

PASSED IN NOVEMBER 2015, ELIMINATING SMALL NUMBER OF CLAIMING BENEFITS THAT RESULT IN HIGHER BENEFITS

INDIVIDUALS AGES 70 OR ABOVE AS OF 2016 WILL NOT BE IMPACTED

THOSE AGED 66 OR ABOVE SHOULD RE-EVALUATE THEIR CURRENT SOCIAL SECURITY BENEFITS BEFORE APRIL 30, 2016
FILING A RESTRICTED APPLICATION: OLD LEGISLATION

INDIVIDUALS REACHING FULL RETIREMENT AGE WERE GIVEN AN OPTION TO APPLY FOR ONE BENEFIT AND RETAIN THE ABILITY TO SWITCH TO ANOTHER AT A LATER DATE

EXAMPLE: IT WAS POSSIBLE TO CLAIM ONLY A BENEFIT BASED ON ONE SPOUSE’S EARNINGS AND LATER CLAIM A RETIREMENT BENEFIT BASED ON THEIR EARNINGS
FILING A RESTRICTED APPLICATION: NEW LEGISLATION

INDIVIDUALS CANNOT RESTRICT THEIR APPLICATION, AND MUST TAKE THE HIGHEST AVAILABLE BENEFIT APPLIES TO THOSE YOUNGER THAN AGE 62 BY THE END OF 2015

THOSE 62 AND OVER AT THE END OF 2015 ARE “GRANDFATHERED” AND CAN STILL APPLY THE OLD RULES WHEN THEY REACH FULL RETIREMENT AGE