CASE COORDINATION AND THE PATIENT CENTERED MEDICAL HOME

June in Washington has been a busy month. As we suspected, the Supreme Court took the easy path in its decision to uphold the Affordable Care Act at this time. It would have been a monumental task and very expensive to unravel all of the changes that have been implemented in the Medicare program as a result of the legislation. More focused challenges are sure to follow regarding Congress' power to regulate interstate commerce and its ability to address problems that are national in scope and that the states are unable to solve; however, the changes to the Medicare program imbedded in the law will remain with us. As one of my politically connected colleagues observed several weeks ago, "While the Act is bad constitutional law, it is good healthcare policy for a government facing a crushing financial burden." Despite the post decision posturing, bluster and declarations by Congressional leaders and campaign advisors, the private sector has been quietly and proactively moving ahead with an agenda that uses the Act and preceding legislation as a blueprint.

In a recent interview, Aetna CEO Mark Bertolini said the Supreme Court ruling on the law's constitutionality won't dramatically impact payers because they would have needed to implement many of the law's changes in order to be competitive in the marketplace. He also stated:

"The American healthcare system is in the midst of intense experimentation and change that cannot, and will not be stalled by the whims of the judicial system. The major forces behind the changes in our healthcare system—rising costs, an older, sicker population and technological innovation—show no signs of abating and do not depend on Federal legislation. They are fuelled by private sector demand, not policy preferences in Washington."

United Healthcare and Humana have also decided to follow many of the regulations included in the ACA including allowing young adults to remain on their parents' health plans, covering preventive services and promoting the development of patient centered medical homes. Humana has helped establish...
patient centered medical homes in several states. In a project in Cincinnati, Humana has experienced a 34 percent decrease in emergency room visits, 10 percent improvement in diabetic management, 15 percent improvement in blood pressure control and 22 percent decrease in patients with uncontrolled blood pressure. In Washington, D.C, CareFirst BlueCross BlueShield, the area’s largest insurer, has joined with the American College of Physicians to make the College’s Medical Home Builder available for free to 3,000 primary care providers who participate in CareFirst’s patient-centered medical home program.

The June MedPAC Report:

While intense interest has been focused on the release of the Supreme Court decision, MedPAC released its Report to the Congress: Medicare and the Health Care Delivery System on June 12. The report discusses issues related to Medicare’s benefit design, care coordination in fee-for-service Medicare, care coordination programs for dual-eligible beneficiaries, and risk adjustment in the Medicare Advantage Program. The report immediately triggered a hearing, on June 19, in the House Ways and Means Subcommittee on Health. In his testimony, MedPAC Chairman Glenn Hackbarth emphasized the issue of care coordination and promoted the advancement of the medical home policy.

MedPAC’s Care Coordination Policy:

MedPAC takes the position that gaps exist in care coordination because of the lack of a financial incentive to coordinate care:

Ideally, as more integrated payment and delivery systems evolve, the incentives for greater care coordination inherent in such systems will develop as well, leading to greater care coordination. However, in the interim, additional methods for encouraging care coordination may need to be pursued, including those that make explicit payments for related services to primary care clinicians— the linchpin of more coordinated care and eventual system redesign.

The Commission recognized that findings from recent Medicare demonstrations on care coordination and disease management models have not shown systematic improvements in beneficiary outcomes or reductions in Medicare spending. However, reviewing three recent demonstrations testing commercial disease management and practice based models of care coordination, they pointed out that the two programs that showed the most success targeted those with congestive heart failure, coronary artery disease, or chronic obstructive pulmonary disease.

The Commissioners continue to emphasize their position that a well-supported primary care system is the basis of any care coordination model. Along these lines, in an October 2011 letter to the Congress, the Commission recommended repealing the SGR formula and replacing it with specified updates that would no longer be based on an expenditure-control formula. They have subsequently repeated this recommendation in all their reports to Congress. The policy would include a 10-year freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years. This would be followed by a freeze in payment rates for the remainder of the 10-year window. This would result in a 20 percent higher reimbursement to a primary care physician for the same service provided by a specialist at the end of the 10 years.

The National Committee for Quality Assurance Proposal:

NCQA has been approached by specialty practices that want to be considered to be part of the patient centered medical home. Our representative societies have been asked by NCQA to comment on their proposal for a Specialty Practice Recognition program. NCQA is developing this program to encourage specialty providers to work toward communication and coordination with primary care providers. The goal of this program is to enhance collaboration and coordination between primary care and specialty care and to support patient access to specialty care. The program would include patient evaluation and recommended treatment, co-management of a subset of patients and temporary or permanent care management of specific patients. The draft standards are available for review on the NAMDRC website at: www.namdrc.org.
An overview of the financial impact of CMS regulations:

How will our practices be affected by the Medicare policies upheld by the Supreme Court? Medicare reimbursement will be headed down in the near term and in the intermediate term. It is a virtual certainty that the present fee for service system will be revised over the next three to five years. In the interim we will be facing a combination of incentive payments and penalties:

- eRx - electronic prescribing
- PQRS - physician's quality reporting system
- MOC - maintenance of certification program
- EMR - electronic medical record

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<th>Incentive Payment or Penalty</th>
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<td>With MOC</td>
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The incentive payment or payment adjustment amount will be calculated using estimated Medicare Part B PFS allowed charges for all covered professional services.

**PQRS:**

The 2006 Tax Relief and Health Care Act required the establishment of a physician quality reporting system including an incentive payment. The Affordable Care Act made a number of changes to the PQRS, including requiring a penalty beginning in 2015 for physicians who do not satisfactorily report data on quality measures in the applicable reporting period for the year. The ACA also required the establishment of an informal process whereby physicians may...
Electronic Prescribing:

Physicians may be exempt from the application of the payment adjustment if CMS determines that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship. This hardship exception is subject to annual renewal. For all inquiries regarding the eRx Incentive Program payment adjustment, including if a physician believes a payment adjustment was erroneously applied, contact the Help Desk Support. In March, CMS opened the Quality Reporting Communication Support Page to allow individual physicians the opportunity to request a significant hardship exemption for the 2013 eRx payment adjustment. The Communication Support Page can be accessed:

https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

To access your personal data in PQRI and eRx:

https://www.qualitynet.org/portal/server.pt/community/pqri_home/212

In order to access the system you must be registered with the CMS enterprise Identity Management and Authentication system (IACS).

The Future of Critical Care Medicine:

I would call your attention to an article recently been published jointly by the Society of Critical Care Medicine and the Society of Hospital Medicine:

In June of 2011, the executive leadership of the Society of Critical Care Medicine (SCCM) and the Society of Hospital Medicine (SHM) convened a daylong Summit to discuss intensive care unit (ICU) workforce issues as they affect intensivists and hospitalists……. Bringing qualified hospitalists into the critical care workforce through rigorous sanctioned and accredited 1-year training programs will open a new intensivist training pipeline and potentially offer more critically ill patients the benefit of providers who are unequivocally qualified to care for them.

Training a Hospitalist Workforce to Address the Intensivist Shortage in American Hospitals: A Position Paper From the Society of Hospital Medicine and the Society of Critical Care Medicine, Eric M. Siegal, MD, SFHM, Daniel D. Dressler, MD, MSc, SFHM, FACP, Jeffrey R. Dichter, MD, SFHM, FACP, Mary Jo Gorman, MD, MBA, MHM4, Pamela A. Lipsett, MD, MHPE, FACS, FCCM, Journal of Hospital Medicine Vol 7 | No 5 | May/June 2012.

For a copy of the paper go to the NAMDRC website at: www.namdrc.org.
PRODUCT AND TECHNOLOGY NEWS!

NAMDRC is providing this space to our benefactors and patrons who provide us with information about new products and innovations related to pulmonary medicine. NAMDRC reserves the right to edit this copy as appropriate.
A
BOUT
NAMDRC:
Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

NAMDRC MEMBERSHIP BENEFITS AT A GLANCE...

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

http://www.namdrc.org/coding.html

One of NAMDRC’s primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation’s health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC’s key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

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NAMDRC MEMBERSHIP APPLICATION

Two Easy Ways to become a NAMDRC member

1. Go to www.namdr.org and register for membership online.
2. Mail this application to:
   NAMDRC
   8618 Westwood Center Drive, Suite 210
   Vienna, VA 22182-2222

Please print clearly or type:

Name (Last) (First) (MI)

Degree

Address

City State Zip

Telephone Fax

E-mail

Facilities with which you are affiliated

☐ Respiratory Care Management
☐ Anesthesiology
☐ Sleep Disorders
☐ Pulmonary Rehabilitation
☐ Skilled Nursing Facility
☐ Hyperbaric Oxygen Therapy
☐ Critical Care
☐ Home Health Services
☐ Physiology Assessments

NAMDRC’s primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

Membership Dues Schedule
(Dues for the first year includes $75.00 Initiation Fee*)

Individual and Small Group Membership Dues $350.00
Can include groups of up to 6. Please include contact information for additional members.

Group Membership Dues
(For larger groups, please attach a list of names. If a group member wishes to receive mailings at an address other than that indicated above, please attach appropriate information.)

Groups of 7-10 $1,100.00
Groups of 11-20 $1,460.00
Groups of 21-30 $1,805.00

TOTAL PAYMENT DUE $_______

Payment
☐ Enclosed is a check payable to NAMDRC (US Dollars)
☐ Charge my credit card for total payment due
   ☐ VISA
   ☐ MasterCard

Credit Card Number ___________________________ Expiration Date _____________

Name as it appears on Credit Card

Billing Address (If different from registration)

E-mail ___________________________

Signature ___________________________

*The $75.00 Initiation Fee is waived if your membership application and an Annual Meeting Registration form are submitted at the same time.

In accordance with IRS Regulations, 95% of your 2012 Annual Dues are tax deductible. NAMDRC’s Federal Tax ID # is 74-2020988.

For More Information, Contact NAMDRC

Phone: 703-752-4359
Fax: 703-752-4360
E-mail: ExecOffice@namdr.org
Web Site: www.namdr.org

NAMDRC 36th Annual Meeting and Educational Conference
will be held March 21-23, 2013
U.S. Grant Hotel San Diego, CA

NATIONAL ASSOCIATION FOR MEDICAL DIRECTORS OF
RESPIRATORY CARE

PHYSICIAN ADVOCACY FOR EXCELLENCE IN THE DELIVERY OF
PULMONARY/Critical CARE AND SLEEP MEDICINE

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