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# The Leadership Forum

*a publication from the Association of Chiefs and Leaders in General Internal Medicine (ACLGIM)*

## Editor's Corner

Carlos Estrada, MD, MS. Birmingham VA Medical Center and The University of Alabama at Birmigham. cestrada@uab.edu

In the March issue of the Leadership Forum, Mark Linzer introduced the Policy Briefs from the ACLGIM Winter Summit, 2010. In this issue, the Forum presents summaries of presentations and discussions on health reform, advocacy, and how academic medical centers should assume a leadership role. More to come.

The pieces were made possible with generous support from the Commonwealth Fund, with review by Anne-Marie J. Audet, MD, MSc, SM (Vice President, Health System Quality and Efficiency at The Commonwealth Fund (AMA@cmwf.org) and with editorial support by Sara Poplau and Mark Linzer at Hennepin County Medical Center.



## Physician Payment Reform: Medicare's Sustainable Growth Rate (SGR).

Mark D. Schwartz, MD. New York University School of Medicine, VA New York Harbor Healthcare System, New York, NY. mark.schwartz3@va.gov

What principles should drive physician payment policy? In 1997, the Sustainable Growth Rate (SGR) provision refined the formula by which Medicare determines the annual change in physician fees. The SGR links annual fee updates to the growth of the economy. The Center for Medicare and Medicaid Services (CMS) determines physician reimbursement by multiplying the number of Relative Value Units (RVUs) for each service by a Conversion Factor. The Conversion Factor ($36.87 in December 2010) is driven by the SGR and spending rates relative to previous targets. If physician spending exceeds the target, fees are cut.

Each year since 2002, the SGR has required cuts in physicians' fees, and each year Congress has postponed the cuts. The law now calls for a ~30% cut on 2012 and budget rules require the Congressional Budget Office (CBO) to assume the current law continues in perpetuity. CBO estimates the cost of an SGR freeze at about $1 billion/month, and the cost of repealing the SGR at about $300 billion over 10 years.

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There are many problems with the SGR. For one, it has not worked—physician services are growing at double the rate allowed by the SGR. The SGR cannot distinguish appropriate from inappropriate growth, and some specialties (e.g. procedural and imaging) contribute more to growth than others.

Congress could revise the SGR by modifying the target formula, adding other non-physicians, and determining unique SGR targets for various services or geographic areas. The alternative is to repeal the SGR and rely instead on incentives to constrain expenditure growth (e.g. pay for performance or accountable care organization). However, Congress is unlikely to relinquish even a flawed mechanism for constraining growth since increasing spending by $300 billion is politically untenable.

If Congress continues to avert SGR cuts, physicians will likely face cuts by the Independent Payment Advisory Board (IPAB) established in the

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### *Physician Payment Reform*

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Affordable Care Act (ACA). Starting in 2014, IPAB will propose cuts in Medicare spending if spending exceeds a target growth rate.

The dramatic SGR cut (>30%) scheduled for 2012 provides Congress with ongoing leverage to keep physicians at the table for implementation of reform. Having enacted *painless* cost control by promoting primary care, prevention, and health information technology, the Administration must now implement *painful* practice and payment changes including bundling, pay for performance programs, capitation, patient centered medical homes, and accountable care organizations. If these reforms do not bend the cost curve, *very painful* remedies will be necessary—including price control via SGR and IPAB cuts.

Republicans are likely to try using some of the more vulnerable provisions in the ACA to pay for the cost of SGR patches. One might anticipate trade-offs for the prevention fund, comparative effectiveness research funding, and federal subsidies for insurance exchanges.

SGIM and general internists will play a central role in the success of practice and payment reforms by participating in the design and testing of ACOs and patient-centered medical home care models. The jury is out on whether these changes will reduce cut cost growth while improving quality. Only time, and active ACLGIM participation, will tell.

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## Health Reform and the Missions of Academic Medicine.

Atul Grover, MD, Chief Advocacy Officer, American Association of Medical Colleges (AAMC). Washington, DC. agrover@aamc.org

Over the next 10 years, the number of insured Americans will increase by 32 million. As part of the Accountable Care Act (ACA), leaders in academic medicine have been challenged to develop policies and programs to 1) bend the cost curve, 2) increase quality, 3) enhance patient safety, and 4) better educate future physicians. Academic medical centers have been asked to provide price transparency, decrease readmissions, promote value based purchasing and decrease hospital-acquired conditions. The "ask" due to health reform is not inconsequential.

Under the ACA, Medicare will incentivize efficient, higher quality care.

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A process will start in 2012 to define measures of quality and cost (i.e. value), and culminate in 2017 with published data and suggested reimbursement adjustments. The Center for Medicare and Medicaid Innovation (CMMI) will oversee projects to develop new care models to reduce costs and maintain quality. However, there are challenges in risk adjustment procedures for patients cared for by academic physicians.

One method of payment allotment will be through Health Innovation Zones (HIZs). HIZs consist of teaching hospitals, provider groups and clinical care units that comprise an integrated delivery system. This health care system will provide comprehensive health care to patients while initiating unique teaching programs. HIZs would attempt to integrate such entities as FQHCs, LTACs, Nursing homes, teaching hospitals, medical schools, health information technology (HIT) units, and insurance plans. HIZs can provide real time course corrections and adjustable reimbursement mechanisms (e.g. up-front payments to prevent hospital readmissions). The accountability model promotes new paradigms: collaborative rather than hierarchical, teamwork rather than autonomous, patient centered more than expert centered, and mutually accountable rather than individualistic.

Academic medical centers and medical schools will be challenged to produce more primary care clinicians

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while reimbursement mechanisms will shift to accountability.

Leaders in academic general internal medicine will need to assume key leadership roles to:

- Modify the learning environment so learners better understand quality, value and patient centered care
- Improve the practice of primary care in the community
- Work with administrative leaders to design novel systems of care. There may be challenges around ACOs for urban communities. Many patients have neither a fixed address nor phone, and would be difficult to reach for coordination of care. There's also a higher rate of dual diagnoses, where substance abuse and mental illness complicate things. On the care system side, because patients have more choices of doctors and hospitals, the responsible provider and ACO may not know when patients have had episodes of care somewhere else. It will take a lot of education or some restrictions on choice to have them stay within an ACO.

**Academic medical centers and medical schools will be challenged to produce more primary care clinicians while reimbursement mechanisms will shift to accountability.**

## How one integrated delivery system is preparing to be an Accountable Care Organization (ACO).

Timothy G. Ferris, MD, MPH, Massachusetts General Hospital, Boston MA. tferris@partners.org

Mass General Hospital, a part of Boston's large integrated delivery system (IDS) - Partners - is considering becoming an Accountable Care Organization (ACO). The importance of being in a network has to do with a complex relationship between the financial implications of reducing costs through decreased utilization, and the structure of incentives under an ACO agreement. The most compelling case for cost savings lies in reduced hospitalizations for frail elderly, some of who are hospitalized up to 8 times a year. To determine if we could reduce these hospitalizations, we undertook a Medicare demonstration project.

**…we reduced overall Medicare costs 4% by reducing hospitalizations for the highest risk patients by 20%.[1]**

Our project was straightforward: we were paid $120 every month for 2500 of our sickest Medicare patients. We used Medicare payments to hire 12 care managers, social workers and a pharmacist. We assigned staff to our primary care practices, enrolled nearly 90% of the patients, and began managing their care. Care managers became the primary medical contact for their patients. Results were impressive: we reduced overall Medicare costs 4% by reducing hospitalizations for the highest risk patients by 20%.[1]

What happens to hospital finances if the bulk of savings come from reductions in hospitalizations, specialty services, and imaging—services that contribute most to an AMC's fiscal stability? *The answer depends on the nature of the shared savings arrangement*. In general, ACOs must deliver 2% savings to recoup shared savings. Achieving a positive contribution margin with this type of arrangement may be very difficult, as the high fixed costs of academic medical centers limit cost-cutting options.

But what if we reduced utilization AND improved efficiency? Could you make care more efficient with a waiver for the rule prohibiting patient transfers to nursing facilities within 72 hours of admission? What if these facilities no longer needed to admit patients based on lengths of stay? What if your home health agency could be paid for visits to non-home bound Medicare beneficiaries at high risk for re-admission? What if your primary care doctors were paid for managing complex patients by phone with a care manager? To succeed under an ACO contract, you need engaged partners, an integrated delivery system and *a change in the regulatory process*.

**Internists who currently practice outside of an organized system of care will need to affiliate with a group if they participate in an ACO.**

General internists are positioned to be leaders in the coming changes. We are the point of first contact for ambulatory patients and leaders of medical teams for hospitalized patients. General internists also understand the trajectory of patients through their illness episodes and see the barrie rs to high quality, efficient care. Internists who currently practice outside of an organized system of care will need to affiliate with a group if they participate in an ACO. For internists to be effective, we will need to embrace the goals of higher quality at lower cost, and lead the process of care changes necessary for our institutions to succeed.

*1. Evaluation of Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration. Available at: http://www.massgeneral.org/News/assets/pdf/FullFTIreport.pdf*

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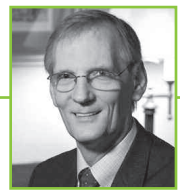
2501 M Street, NW, Suite 575
Washington, DC 20037



# Preparing for Changes in the Healthcare Market—One Academic Medical Center (AMC) Perspective.

Richard P. Lofgren, MD. Vice President for Healthcare Operations, UK Healthcare. Professor of Medicine, University of Kentucky. lofgren@email.uky.edu.



As the Affordable Care Act (ACA) is implemented, leaders of academic medical centers (AMCs) need to understand how it will, or should, alter their strategic plans. Currently, most AMCs depend on a small fraction of complex, expensive patients to make their margins. To provide highly specialized care, AMCs have made enormous technological investments creating expensive infrastructures that need financial support. It is essential these costly facilities and clinical services have patients to generate large revenues. The cornerstone of strategic plans at most AMCs is to attract these complex cases. In addition many AMCs have difficulty competing with community facilities, with less costly infrastructure, more effective throughput, and more personal "high touch" care for patients with common conditions. However, as AMCs expand to capture additional complex cases, they attract more common cases. Many AMCs are now acquiring lower cost community hospitals and actively transferring low cost patients there, making room for more (profitable) complex patients at their higher cost facility.

**Currently, most AMCs depend on a small fraction of complex, expensive patients to make their margins.**

The ACA encourages experimentation with delivery and payment systems like Accountable Care Organizations (ACOs), and also calls for expansion of health insurance coverage for uninsured citizens. Hurdles that may interrupt the implementation of this expansion include: a tax increase, legal challenges for mandatory coverage, emerging crisis in funding Social Security, and a presidential election. The contrary forces regarding demand for services and the ongoing political uncertainty creates a dilemma for AMC leaders.

Successful ACOs will require large physician networks to manage populations, which would be expensive and likely divert resources from the AMCs core business of complex care. Another shortcoming is few ACOs will capture sufficient patient populations to support advanced specialty services. For institutions with a large existing primary care base, becoming an ACO probably makes sense. For the remaining AMCs, it is debatable.

Many AMCs will therefore need to continue to pursue their pre-legislation strategies. AMCs have expensive, capital-intense facilities and services, and need to continue to attract a relatively large number of very complex patients to support these investments. However, there continues to be pressure to bend the cost curve by reducing prices while improving quality, safety, and service. Market demand for greater efficiency can be achieved by eliminating waste, redundancies and unnecessary care. This can best be accomplished by greater integration and coordination. Funding models for AMCs are emerging that encourage efficient, multidisciplinary, advanced specialty service lines in the care of complex cases.

**Market demand for greater efficiency can be achieved by eliminating waste, redundancies and unnecessary care.**

In response to forces affecting AMCs, UK Healthcare is developing advanced specialty services, shifting less complicated cases to lower cost facilities, and strengthening relationships with regional community partners while improving clinical infrastructure, quality and efficiency. We are actively addressing internal issues including: clinical integration, increasing quality and safety, improving access and throughput, and lowering costs by enhancing efficiencies.

We are preparing for changes in payment models such as bundling reimbursement into a single payment to be divided by the participants (i.e. hospitals, physicians, home health), gain sharing with hospitals as the result of improved efficiency, and possibly risk sharing (a new variant of capitation).