The Current Health Care Landscape

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Presentation Outline

- Current State of Health Care
- Drivers of Change
- Payment Models Forcing Change
- The Future Health Care Organization
- After the November Elections
- Summary and Take Home Messages
Current State of Health Care

- Fragmented Care
- Lacks Coordination
- Expensive
- Lacks Transparency
Drivers of Greater Integration

- Changes in Reimbursement
- Ageing of Population
- Need for Efficiency
- Economic Climate
- Value-Based Payment
More Drivers...

- Patient/Customer Expectations
- Regulatory and Payment Complexity
- Workforce Expectations
- Demand for HIT/Capital
Payment Models Forcing Change

- ACOs and Shared Savings
- Bundled Payments
- Comprehensive Primary Care Initiative
- FQHC
Payment Models Forcing Change

- Health Care Innovation Challenge
- Innovation Advisors Program
- Partnership for Patients
- State Engagement Models
- State Insurance Exchanges
Future Health Care Organization will be:

High-Performing Health Systems
Everyone is Defining It

- Physician Self Referral Regulations


More Attempts to Define It

- IOM “Crossing the Quality Chasm: A New Health System for the 21st Century” (July 2011)
- Draft legislative language for In Office Ancillary (February 2011)
More Definitions...

- Criteria Established by the AMA Committee on Integrated Physician Practice Section (Summer 2012)

- AMGA Work Group Definition of High-Performing Health Systems (Summer 2012)
What is a High-Performing Health System?

- A multi-specialty medical group or other organized system of care that is integrated or has partnerships with other care sites to provide patients with better services and care. HPHS successfully manage the per capita cost of health care, improve the overall patient experience, and improve the health of their respective populations.
What do you have to do to be deemed a HPHS?

- Efficient provision of services
- Be an organized system of care
- Conduct quality measurement and improvement
- Care coordination activities
- Use of IT and evidence-based medicine
- Accountability
- Compensation practices that promote these objectives
Must I own a hospital to qualify?

- No, but you need to have partnerships, such as:
  - Acute care hospitals
  - Long-term acute care hospitals
  - Inpatient rehabilitation facilities
  - Skilled nursing facilities
  - Home health agencies
  - Ambulatory surgery centers
  - Hospices
Is a Registry required?

- No, the definition uses the phrase “such as” when referring to registries and other forms of patient outreach.
What compensation structures qualify?

- Structures MAY include:
  - Incentives affiliated with patient experience, and
  - Quality metrics that:
    - Measure level of chronic disease
    - Prevention compliance within a managed population
Why create a definition?

- Proposed legislation in past has had definitions that most AMGA members cannot meet
- If we don’t write one, someone else will
- We can use definition to promote improved health and better patient experience
- We can use the definition when responding to proposed regulations
What if my group doesn’t meet this definition?

- Not all AMGA members currently meet this definition, so AMGA will provide educational programs and other tools to assist members to attain this definition as soon as possible.
2012: Election

- Low Congressional Approval Rating
  - Most unpopular Congress ever
- November 6 Election
  - 33 Senate seats are up
    - 23 Democrat seats
    - 10 Republican seats
  - All 435 House Seats Are Up
After the 2012 Elections

• Health Care Reform and the Supreme Court Decision
• Lame Duck Session (Starts on November 7 and ends on Inauguration Day)
  • Expiring Tax Rates and Estate Taxes ($4 Trillion Tax Increase)
  • Budget Sequestration
  • Increase the Debt Ceiling
  • And, of Course the SGR
The 10-Month SGR Fix

- SGR is a flawed system
- Legislation averted a 27.4 percent cut
- Provided for a 10-month extension of current physician payment rates (i.e., a zero percent update, or “freeze”) until December 31, 2012
- Required a GAO and HHS report concerning long-term replacement to the current Medicare physician payment system
Repealing SGR Has High Budgetary Costs

- Cost of repealing the SGR continues to rise
  - $48 billion in 2005
  - About $316 billion today*
  - Delay of repeal will result in increased costs (i.e., SGR cut plus the cost of temporary patches)

Even Greater Cuts in the Future

- The cuts have a cumulative effect and they also impact Medicare Advantage
  - 2012 – 27.4 percent
  - 2013 – 32 percent
  - 2014 – 36 percent
  - 2015 – 39 percent
MedPAC SGR Reform Recommendations

- Congress should repeal the SGR and replace it with 10-year statutory fee schedule updates
- Freeze in current payment levels for primary care
- For all other services, annual payment reductions of 5.9 percent for three years followed by a freeze
- The Commission offered a list of proposals for the Congress to consider if it decides to offset the cost of repealing the SGR system
SGR Predictions

- An extension will occur
  - Timing
  - Possible bifurcation of the package
- Duration Possibilities
  - Month-to-month fixes
  - Longer-term fix
- Offsets
Offsets...

- *Are Few and Far Between*
  - Overseas Contingency Operations (commonly referred to as “OCO”)
  - Super Committee recommendations
  - Rivlin/Domenici and Simpson/Bowles proposals
What AMGA is doing...

- SGR
- Medicare Overpayments
- Medicare Advantage
- Advanced Diagnostic Imaging
- ACO Implementation
Thank You

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