

The Impact of Healthcare Reform

Chapter FastFACTS

- 1.** The Patient Protection and Affordable Care Act extends Medicare quality-reporting incentive payments for physicians.
- 2.** Physicians in small independent practices may pursue other business options, such as becoming part of larger physician groups or employees of larger organizations, to cope with the results of reform.
- 3.** Reform requires health insurers to standardize and simplify claims processing procedures, authorization requirements, electronic funds transfers, and more.
- 4.** You can expect to see more younger people who will be newly insured under their parents' plans or through Medicaid expansion.
- 5.** The American Association of Medical Colleges estimates that there will be 39,600 fewer primary care physicians in 2015.

You don't have to read all of the more than 2,000 pages of the Patient Protection and Affordable Care Act (PPACA) to know that the new law means changes for your practice over the next few years. But add in other forces—such as advancing technology and new views on physician-patient communication—and you have a period of perhaps the most profound change your practice has ever experienced. There's a strong sense that healthcare reform may have the most significant impact. But

In patients with type 2 diabetes, the TITRATE® study demonstrates

Once-daily Levemir® gets the majority of patients to goal safely¹

64% of patients achieved A1C goal <7% with once-daily Levemir®*

The Levemir® TITRATE trial shows how a majority of patients with type 2 diabetes taking a basal insulin, some with A1C levels as high as 9%, achieved the ADA-recommended target of A1C <7%.^{1,2} Patients experienced a mean A1C decrease of -1.2%* and achieved goal safely with low rates of hypoglycemia, nearly all of which were minor or symptoms only.^{1†}

*70 to 90 mg/dL group.



Model is for illustrative purposes only.

To see how Levemir® can help your patients achieve their goals, and to learn more about TITRATE, visit TITRATEstudy.com.

[†]Minor hypoglycemia rates were 0.42 (70-90 mg/dL) and 0.26 (80-110 mg/dL) per patient-month. A single major hypoglycemic event was reported in the 70 to 90 mg/dL group; no major hypoglycemic events in the 80 to 110 mg/dL group.¹

Results from a 20-week, randomized, controlled, multicenter, open-label, parallel-group, treat-to-target trial using the PREDICTIVE® 303 self-titration algorithm in insulin-naïve patients with type 2 diabetes, A1C ≥7% and <9% on OAD therapy randomized to Levemir® and OAD (1:1) to 2 different FPG titration targets (70-90 mg/dL, [n=121] or 80-110 mg/dL, [n=122]).¹

PREDICTIVE = Predictable Results and Experience in Diabetes through Intensification and Control to Target: an International Variability Evaluation.

Indications and usage

Levemir® is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

Important safety information

Levemir® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

Levemir® should not be diluted or mixed with any other insulin preparations.

Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir®. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Levemir® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetes treatment may require adjustment.

Needles and Levemir® FlexPen® must not be shared.

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir® from other intermediate or long-acting insulin preparations. The dose of Levemir® may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation. Less common but more serious are severe cases of generalized allergy, including anaphylactic reaction, which may be life threatening.

Please see brief summary of Prescribing Information on adjacent page.

References: 1. Blonde L, Meriläinen M, Karve V, Raskin P, for the TITRATE™ Study Group. Patient-directed titration for achieving glycemic goals using a once-daily basal insulin analogue: an assessment of two different fasting plasma glucose targets—the TITRATE™ study. *Diabetes Obes Metab*. 2009;11(6):629-631. 2. American Diabetes Association. Standards of medical care in diabetes—2010. *Diabetes Care*. 2010;33(suppl 1):S11-S61.



Levemir®

insulin detemir (rDNA origin) injection



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Levemir® (insulin detemir [rDNA origin] injection)

Rx ONLY

BRIEF SUMMARY. Please see package insert for full prescribing information.

INDICATIONS AND USAGE: LEVEMIR® is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long acting) insulin for the control of hyperglycemia.

CONTRAINDICATIONS: LEVEMIR® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

WARNINGS: Hypoglycemia is the most common adverse effect of insulin therapy, including LEVEMIR®. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations. Glucose monitoring is recommended for all patients with diabetes. LEVEMIR® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Concomitant oral antidiabetic treatment may need to be adjusted. Needles and LEVEMIR® FlexPen® must not be shared.

PRECAUTIONS: General: Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal. LEVEMIR® is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration. **LEVEMIR® should not be diluted or mixed with any other insulin preparations** (see PRECAUTIONS, Mixing of Insulins). Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins. As with all insulin preparations, the time course of LEVEMIR® action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity. Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

Hypoglycemia: As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR®. Hypoglycemia is the most common adverse effect of insulins. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions). Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients' awareness of hypoglycemia. The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from other intermediate or long-acting insulin preparations to once- or twice-daily LEVEMIR®, dosages can be prescribed on a unit-to-unit basis; however, as with all insulin preparations, dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia. **Renal Impairment:** As with other insulins, the requirements for LEVEMIR® may need to be adjusted in patients with renal impairment. **Hepatic Impairment:** As with other insulins, the requirements for LEVEMIR® may need to be adjusted in patients with hepatic impairment. **Injection Site and Allergic Reactions:** As with any insulin therapy, lipodystrophy may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR®. In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique. **Systemic allergy:** Generalized allergy to insulin, which is less common but potentially more serious, may cause rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

Intercurrent Conditions: Insulin requirements may be altered during intercurrent conditions such as illness, emotional disturbances, or other stresses. **Information for Patients:** LEVEMIR® must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR® therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, life-style management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, timing of dosage, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as intercurrent conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the LEVEMIR® "Patient Information" circular for additional information. As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hypoglycemia or hyperglycemia. Patients with diabetes should be advised to inform their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy). **Laboratory Tests:** As with all insulin therapy, the therapeutic response to LEVEMIR® should be monitored by periodic blood glucose tests. Periodic measurement of HbA_{1c} is recommended for the monitoring of long-term glycemic control. **Drug Interactions:** A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring. The following are examples of substances that may reduce the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives). The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, fibrates, fluoxetine, MAO inhibitors, propoxyphene, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics. Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent. The results of *in-vitro* and *in-vivo* protein binding studies demonstrate that there is no clinically relevant interaction between insulin detemir and fatty acids or other protein bound drugs. **Mixing of Insulins:** If LEVEMIR® is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR® with insulin aspart, a rapid acting insulin analog, resulted in about 40% reduction in AUC_(0-2h) and C_{max} for insulin aspart compared to separate injections when the ratio of insulin aspart to LEVEMIR® was less than 50%. **LEVEMIR® should NOT be mixed or diluted with any other insulin preparations. Carcinogenicity, Mutagenicity,**

Impairment of Fertility: Standard 2-year carcinogenicity studies in animals have not been performed. Insulin detemir tested negative for genotoxic potential in the *in-vitro* reverse mutation study in bacteria, human peripheral blood lymphocyte chromosome aberration test, and the *in-vivo* mouse micronucleus test. **Pregnancy: Teratogenic Effects: Pregnancy Category C:** In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 nmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 nmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 nmol/kg/day (approximately 135 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. Drug-dose related increases in the incidence of fetuses with gall bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 nmol/kg/day. The rat and rabbit embryofetal development studies that included concurrent human insulin control groups indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity. **Nursing mothers:** It is unknown whether LEVEMIR® is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR® is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both. **Pediatric use:** In a controlled clinical study, HbA_{1c} concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR® and patients treated with NPH human insulin. **Geriatric use:** Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR®, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be considered to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

ADVERSE REACTIONS: Adverse events commonly associated with human insulin therapy include the following: **Body as Whole:** allergic reactions (see PRECAUTIONS, Allergy). **Skin and Appendages:** lipodystrophy, pruritus, rash. **Mild injection site reactions** occurred more frequently with LEVEMIR® than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy). **Other: Hypoglycemia:** (see WARNINGS and PRECAUTIONS). In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR® was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4). **Weight gain:** In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR® was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in the effects of LEVEMIR® and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

Table 4: Safety Information on Clinical Studies*

Treatment	# of subjects	Weight (kg)		Hypoglycemia (events/subject/month)		
		Baseline	End of treatment	Major**	Minor***	
Type 1						
Study A	LEVEMIR®	N=276	75.0	75.1	0.045	2.184
	NPH	N=133	75.7	76.4	0.035	3.063
Study C	LEVEMIR®	N=492	76.5	76.3	0.029	2.397
	NPH	N=257	76.1	76.5	0.027	2.564
Study D Pediatric	LEVEMIR®	N=232	N/A	N/A	0.076	2.677
	NPH	N=115	N/A	N/A	0.083	3.203
Type 2						
Study E	LEVEMIR®	N=237	82.7	83.7	0.001	0.306
	NPH	N=239	82.4	85.2	0.006	0.595
Study F	LEVEMIR®	N=195	81.8	82.3	0.003	0.193
	NPH	N=200	79.6	80.9	0.006	0.235

*See CLINICAL STUDIES section for description of individual studies
** Major = requires assistance of another individual because of neurologic impairment
*** Minor = plasma glucose <56 mg/dl, subject able to deal with the episode him/herself

OVERDOSAGE: Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid recurrence of hypoglycemia.

More detailed information is available upon request.

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Levemir®
insulin detemir (rDNA origin) injection

what specifically does reform mean for your practice? According to Susan Wilder, MD, a family practitioner in Scottsdale, Ariz., and medical director of Concierge Choice Physicians (CCP), “That question is like asking, ‘If we have a hurricane heading towards the city, what is the city going to look like in five years?’



“Very importantly, underlying this whole concept of a national quality strategy is that down the road we’ll be looking at report cards on the quality of care provided by individual clinicians, hospitals, and others.”

Bob Doherty

Senior Vice President
Governmental Affairs and Public Policy
American College of Physicians

It’s a massive attempt at revising things in the system that are poor quality and not responsive to technological development. It’s going to be a mixed bag.” Almost everything may be in play, from your office operations to the type of patient you will be seeing; you may even question whether your practice will need to join forces with a larger practice in order to stay afloat.

Those decisions will likely be affected by other changes happening at the same time, like coding. “With the transition from ICD-9 to ICD-10, along with the conversion of the requirements for submitting payments, an awful lot is happening. It all pretty much falls into place about 2015,” says Jeff Bauer, PhD, health futurist, medical economist, and author of *Paradox and Imperatives in Health Care: How Efficiency, Effectiveness, and E-Transformation Can Conquer Waste and Optimize Quality*.

This issue of *Doctor’s Digest* will explore the healthcare reform changes that are likely to have the greatest impact on your practice and will provide practical insights to help you make decisions during these turbulent times that will position you for success in 2015.

The Incentives

Under reform, some payments to physicians will rise as will

the pressure to provide healthcare to an increasing number of patients. Despite some initial details—mostly involving electronic health records (EHRs) (see Chapter 4 for more on technology)—at this point it's unclear how the reform process and its ultimate impact will play out, says Judy Capko, founder of Capko & Company, a medical practice management and market research company, and author of *Secrets of the Best-Run Practices*. For example, payment for prevention-related benefits may be under consideration for the first time. Nonetheless, Ms. Capko says there's one sure thing: Physicians need to be prepared to make changes in their practices that correlate with changes in payment. “[Physicians] with consistent and better outcomes will be rewarded financially in their effort to improve quality of care, which inevitably results in better patient compliance, early detection of complex conditions, and, inevitably, fewer hospitalizations and lower cost,” she says.

The PPACA will extend Medicare quality-reporting incentive payments. According to the American Medical Association (AMA), incentive payments of 1% in 2011 and 0.5% from 2012 to 2014 will continue for voluntary participation in Medicare's Physician Quality Reporting Initiative (PQRI). Physicians who participate in a qualified Maintenance of Certification Program can earn an additional 0.5% incentive payment. But there's a downside: Physicians who do not participate in the PQRI program in 2015 will be penalized 1.5%; that rate rises to 2% in later years. In addition, the EHR incentive program requires that physicians meet “meaningful use” rules—which require reporting on quality measures—in order to qualify for incentive payments, according to the American College of Physicians (ACP).

For year-by-year details on how healthcare reform will affect your practice, go to ACP's “An Internist's Practical Guide to Understanding Health Care Reform” at http://www.acponline.org/advocacy/where_we_stand/access/int_prac_guide.pdf.

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“Very importantly, underlying this whole concept of a national quality strategy is that down the road we’ll be looking at report cards on the quality of care provided by individual clinicians, hospitals, and others,” says Bob Doherty, ACP’s senior vice president of governmental affairs and public policy. “The goal is to have those report cards developed based on valid measures through a very rigorous process with public input.”



“By 2015, I won’t be at all surprised if only 40% of all doctors still work for themselves. That would be roughly 70,000 more physicians becoming employees. I think the trend is pretty inescapable.”

Jeff Bauer, PhD
Health Futurist, Medical Economist
Author, *Paradox and Imperatives in Health Care*

Meeting these quality goals will be easier with EHRs, says Charles Cutler, MD, FACP, chair of ACP’s Board of Governors and a practicing internist in Norristown, Pa. “Once [EHRs are] in place..., it will be so much easier to use the computer to provide better care, particularly in the areas of prevention, vaccines, blood tests, and [others],” he says

This positive impact on healthcare consumers is worth what may at times be difficult transitions for primary care physicians, Dr. Cutler says. He calls expanding health coverage to 96% of Americans an “incredible” step forward: “People with health insurance will be healthier, will be treated better, and will not have to wait in emergency rooms for hours when they are sick. They are going to get better quicker,” explains Dr. Cutler. In fact, he says, this end result will also lead to greater physician satisfaction. “I think doctors will be so much more satisfied with their care, [knowing] that they are doing the right thing at the right interval,” he says.

Your Changing Practice

Experts believe that heavier patient loads, increased costs of

technology, new security requirements for protection of data, and new confidentiality requirements could prompt physicians in small independent practices to seek other business options, such as becoming employees of larger healthcare organizations or local hospitals. While currently data suggest that half of all physicians are in private practice and the other half employed, that split will change over the next five years, Dr. Bauer says: “By 2015, I won’t be at all surprised if only 40% of all doctors still work for themselves. That would be roughly 70,000 more physicians becoming employees,” he says. “I think the trend is pretty inescapable.”

Private primary care doctors who want to stay that way will need to consider other options. “You will still have an appreciable number of physicians who are going to say, ‘By 2015, there’s no way I am going to work for a hospital or health system or an insurance company or a large employer,’” Dr. Bauer says. These physicians may need to consider working in larger groups. “Economies of scale are the only way you can still practice medicine,” Dr. Bauer adds. “If you want to be a private doctor by 2015, it is going to be so complex, you would never have time to see patients if you did it yourself.” (For other options see “Alternative Care Models.”)

Joining forces with larger groups may be done physically or virtually via state-of-the-art technology. “Bundle fees pay doctors an amount for overall care of patients, not for every individual procedure that they do. So in order [for doctors to be profitable] they need to work together more closely,” says Joseph W. Stubbs, MD, MACP, an internist in Albany, Ga., and ACP’s immediate past president. “I see healthcare as a consolidating situation. . . . I think the only way we’re going to be able to [provide more primary care] is to increasingly use a team-based model of care where a lot of the . . . internists or family care doctors oversee those [patients] who are continuing to have problems.” That team effort means better coordination with specialists and hospitals. “It will be somewhat gradual but at an accelerated pace for the next five years,” he says.

Mr. Doherty says being involved in a team-based model will have a bottom-line impact: You’ll now be paid for the work involved in coordinating care instead of being paid only for the

Alternative Care Models

Some physicians are considering new models of care delivery to better manage their financial and administrative burdens. Industry estimates vary considerably from a low of about 750 to a high of 5,000 physicians who are already offering an alternative way to pay for and receive care. However, it's important to note that alternative models still represent a very small percentage of practices. Still, many analysts believe the number of alternative practice models will grow in the coming years. Those models include the following:

- **Hybrid**—Physicians are encouraged to see patients who are paying for a concierge physician as well as those with Medicare and private insurance. Patients pay a fee for services that are not covered by traditional insurance. Physicians typically care for 50 to 150 patients under the hybrid program.
- **Concierge**—Physicians close their practices to all but the select few willing to pay a yearly fee. Most full-model concierge practices care for about 200 to 600 patients.
- **Direct Pay/Cash Only**—Physicians accept little or no insurance, and most do not accept Medicare. This is primarily a cash-only model. The AAFP estimates that there are 1,000 family physicians offering cash-only practices.
- **Administrative Service Fee**—Patients pay a periodic administrative

face-to-face visit. “This could create enormous opportunities for practices to find new ways of getting revenue and also getting better outcomes for their patients,” he says.

Those who stay in private practice will have to contend with “an incredible influx of regulations, more compliance issues, and many nitpicking little things,” possibly having to add more people in the back office to ensure compliance, Dr. Bauer says. That includes the new billing code. The current five-figure code will start a transition to a more complex seven- to nine-digit code next year. Patients will also have a new set of complexities regarding co-pays and deductibles.

The reform legislation has been intended to ease some of the complexity for physicians, Mr. Doherty says: A whole section requires the health insurer to standardize and simplify its claims-processing procedures, authorization requirements, electronic

fee in exchange for physician access. Most patients continue to have some insurance coverage.

Pricing for alternative care models varies. Full concierge programs can cost patients from \$1,000 to \$15,000 a year, with most costing \$1,500 to \$2,000, according to CCP. Direct pay programs charge \$50 to \$75 for short visits and \$300 or more for extended visits. Hybrid programs average \$1,500 to \$1,800 per year.

The average practice offering a hybrid model reports revenue increases of 15 to 20%; individual physicians within the practice see revenue increased by 10 to 40%, depending on the number of patients in the program. Under full-model concierge programs, physicians can see income decline (if they are unable to attract and retain patients) or increase significantly; however, workloads are dramatically reduced.

“The direct practice model is growing rapidly because a lot of people are saying let’s skip the middle man,” Dr. Wilder says. “More and more patients are going to a higher-deductible health plan or a health savings account where they are responsible for their first dollar. It’s ‘win-win’.”

The key, Dr. Martin says, is to prepare for the increased number of patients that are going to be seeing internists, family physicians, and pediatricians. While a daunting task, he says it’s not one to fear but rather to prepare for. “Understand it’s coming. We’ve been warned about it, so we just have to act accordingly,” he says.

funds transfers, enrollment-eligibility verification, and more. “There will be written rules requiring insurance companies to standardize and simplify those processes; and if they don’t, they will be fined,” he says.

Coping With the Patient Surge

As a result of healthcare reform, primary care physicians can expect to see more Medicaid patients, some of whom may not have had access to preventive primary care in the past. Medicaid regulations in each of the states will expand the number of people who can be in the Medicaid system by a predicted 15.9 million by 2019, according to The Kaiser Commission on Medicaid and the Uninsured. Beginning last April, states have the option to cover parents and childless adults who earn no more than 133% of the federally defined poverty level and receive current

federal matching contributions, says Roland Goertz, MD, president of the American Academy of Family Physicians (AAFP). Individual states also may choose to phase in eligibility for this group based on income. “By January 1, 2014, state Medicaid programs must cover this population in its entirety with a higher federal contribution, but states will have the option to provide new coverage for individuals who have income that exceeds 133% of the federal poverty level,” he says. See “Timeline for Change in Medicaid” for more details.

However, the new Medicaid patient mix will differ from what you may currently see in your practice. According to the Kaiser Family Foundation Focus on Health Reform analysis of the Accountable Care Act, Medicaid would be expanded to all peo-

Timeline for Change in Medicaid

Are you ready for the upcoming changes in Medicaid? Here's how they will roll out, according to Dr. Goertz:

2010: States have had the option to expand Medicaid eligibility to childless adults beginning April 1, 2010, but will receive their regular federal medical assistance percentages (FMAP) until 2014. Those states that have already expanded eligibility to adults with incomes up to 100% of the federal poverty level will receive a phased-in increase in the FMAP for non-pregnant, childless adults so that by 2019 they will receive the same federal financing as other states (i.e., 93% in 2019 and 90% in 2020 and beyond).

2013-2014: Medicaid payments for fee-for-service and managed care for primary care services that are provided by family physicians, general internal medicine physicians, or pediatricians will increase to 100% of the Medicare payment rates for 2013 and 2014.

2014-2016: States will receive 100% federal funding to pay for people who were not previously eligible for this benefit package or who were eligible for a capped program but were not enrolled. On January 1, 2014, states will receive 100% federal financing for the increased payment rates.

2017: States will receive 95% federal financing.

2018: States will receive 94% federal financing.

2019: States will receive 93% federal financing.

2020 and beyond: States will receive 90% federal financing.



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ple under age 65—including children, pregnant women, parents, and adults without dependent children—with incomes up to 133% of the federal poverty level, based on modified adjusted gross income, Dr. Goertz says. “Under both current law and the Accountable Care Act, undocumented immigrants are not eligible for Medicaid,” he notes. All newly eligible adults will be guaranteed a specific benefit package that provides at least the essential health benefits.

Physicians can expect to see more younger people who will be newly insured under parents’ plans—the new law allows for people up to age 26 to remain on their parents’ insurance plans—or through Medicaid expansion. This will be in addition to the annual preventive care services that Medicare will pay for Medicare beneficiaries, so doctors are likely to see more elderly patients for regular preventive services as well. “There will hopefully also be a significant increase, one that is desperately needed, in patients seeking preventive and primary care services that they postponed or forfeited due to lack of insurance or money prior to the changes,” Dr. Goertz says.

Beginning next January, Medicare will pay for an annual risk assessment—the opportunity for another source of revenue—in addition to the regular physical. “This is not a hands-on physical exam. This is more of a ... counseling session, where the physician can sit down with the patient on an annual basis and

develop a personalized risk assessment and prevention program,” Mr. Doherty explains.

That revenue stream will help. Although by 2014 Medicaid reimbursement rates will equal those that Medicare pays, Dr.



“The [physician] shortages stress the need for Congress to expand the number of residency training positions funded by Medicare to ensure there will be an adequate supply of doctors in the healthcare system.”

Atul Grover, MD, PhD

Chief Advocacy Officer

Association of American Medical Colleges

Goertz says practices will have to decide how to cope with the anticipated increase in patients covered by Medicaid. Mr. Doherty recommends first looking at your current mix of patients—Medicare and Medicaid as well as those who are privately insured. Then look at the payment rates under Medicare and Medicaid and the payment rates that will be applicable to the currently uninsured patients who won’t end up with Medicaid but will get coverage through private health plans offered through state-based health exchanges. “See what the payment rates for those programs are, and make a determination about what mix of patients makes sense for [your] practice,” he says.

One unknown factor is whether the payment rates for private health insurance plans offered through the state health exchanges, which come into effect in 2014, will be better or worse than the traditional rates on private insurance that now exist in the states. “We really don’t know yet,” Mr. Doherty says.

Susan Murphy, MBA, PhD, author of *Building and Rewarding Your Team: A How-to Guide for Medical Practice*, suggests considering whether it would be appropriate and feasible for your practice to pursue other revenue streams such as offering executive physicals, pre-operation physicals, support groups, group medical appointments, therapeutic massage, ultrasound, nutrition consultations, and concierge medicine.

A 'Right-sized' Workforce

By 2015, physician shortages will be 50% greater than previously expected, according to the Association of American Medical Colleges (AAMC). Previous projections showed a baseline shortage of 39,600 physicians in 2015, but the AAMC now anticipates that the number is closer to 63,000 as many more patients will be seeking care by then.

The lack of primary care physicians will become dire by 2014, Dr. Stubbs predicts, as many more patients will be seeking care by then. That's when the more-than-30-million Americans who will have health insurance will be looking for primary care doctors, and baby boomers will have greater healthcare needs. With a growing, aging population, and one-third of physicians expected to retire in the next decade, timely access to high-quality healthcare will be difficult for some Americans, says Atul Grover, MD, PhD, the AAMC's chief advocacy officer.

While the reform bill offers higher incentives and scholarships for students to enter primary care, it will take time for enrollments to grow. "Over the next decade, you can't just turn a switch and get those students to become primary care doctors," Dr. Stubbs says. A national workforce group mandated by the reform bill will monitor physician numbers.

Some point with caution to Massachusetts, which in 2006 offered state-sponsored healthcare insurance to lower-income residents who were not eligible for Medicare. The plan didn't live up to many of the expectations. Patients had to wait months to get an appointment with a primary care physician, and the situation put stress on emergency rooms and clinics. To avoid that scenario on a national level, the primary care workforce must be "right sized" to provide access to the newly insured, says Paul Martin, DO, who practices in Dayton, Ohio. "In providing essen-

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tially all of the citizens of Massachusetts with healthcare coverage, the state miscalculated the number of primary care providers available to provide quality healthcare to the newly insured patients in the state. Thus, this shortage created a situation where the newly insured had no or poor access to primary care physicians due to workforce mismatches,” he says. This chaos led patients to the more expensive and over-extended emergency rooms, he adds.

Congress needs to act to help find the “right-sized” workforce that can handle the anticipated influx of patients into the system, Dr. Grover says. In addition to an estimated 39,600 fewer primary care physicians in 2015, the AAMC estimates that there will be a deficit of at least 33,100 non-primary care physicians in specialties such as cardiology, oncology, and emergency medicine. “The shortages stress the need for Congress to expand the number of residency training positions funded by Medicare to ensure there will be an adequate supply of doctors in the health-care system,” Dr. Grover says.

Another solution is to give more patient responsibilities to physician extenders—nurse practitioners, mid-level assistants, and physician assistants. “We’ll see a bigger role for nurse practitioners and PAs because we’re not going to have enough primary care physicians in the next ten years,” Dr. Stubbs says.

The Technology Connection

Even if you haven’t thought about the impact of reform on your practice, you probably know that 2015 is the deadline for the new EHR incentives for Medicare. With the government’s offer to reward doctors who practice meaningful use of EHRs with financial incentives, primary care physicians who have been on the fence about switching to EHRs—or at least fully exploring their facets—have no excuse now not to hop on board. “Medicine currently is probably the only sector of the economy that hasn’t moved to a computer system like Macy’s. We have to move into the electronic era,” Dr. Martin says.

Your computer investments, whether they include a Web-based EHR or a stand-alone system, will result in improved workflow and productivity, and a new type of relationship with patients. Add even more pressure and expectations involving

social media, smartphones, and other technological advancements that may not even be on our radar yet, and experts say that by 2015 your office communications will likely function very differently from today.

John R. Thomas, president and CEO of MedSynergies, a physician management company based in Irving, Tex., is in the business of readying his physician clients for the future. He cautions primary care physicians not to take a wait-and-see approach and instead recommends having all electronic medical systems in place by January 2013. "If physician groups do not have their strategy down and their tactics and contingency plans in place for [an EHR system] and what they're going to out-source and where they're going to get those functions, they are in real trouble," he says. (See "Tips for Revenue Forecasting.")

Tips for Revenue Forecasting

Now is this time for your practice to evaluate various revenue systems and to perform a series of varying scenarios to cope with the possible results of healthcare reform, Mr. Thomas of MedSynergies says. When forecasting revenues, use the following tips to plan for a variety of healthcare reform what-ifs:

1. Base revenues upon 2009 Medicare less 10%.
2. Assume patient payments are greater than 30% of your payer mix.
3. Verify coverage on each patient visit.
4. If 20% of your business results from out-of-network patients, 20% of your current referral base is not on par with your commercial plans.
5. Assume that your practice's patient base will undergo a 25% turnover each year.
6. Assume an investment of \$25,000 per physician for a technology platform investment as well as \$5,000 per physician for annual maintenance cost with a re-investment every three to five years. The investment for small practices may be higher per physician.
7. Take three hours each week away from your office, phone, and e-mail to construct a strategic grid for your healthcare system that sketches out the probable impact of the various financial, operational, and organizational changes that lie ahead.

Finding Solutions

Outsourcing nonessential basic services is one way to relieve the increasing pressures on your time. Start with the tedious annual tasks that may remain unchanged and undigitized in 2015, for example, back-to-school shots from a pediatrician. “Look at what you really have to do. Where can you get alternative providers that give you better capital utilization, better technology utilization, versus people-skill utilization?” Mr. Thomas asks.



“If you don’t feel that you have the fiscal ability to get the technology, you will have to work with larger groups ... to get the health information technology necessary. I think if you do that, you can thrive.”

Joseph W. Stubbs, MD, MACP
Internist
Albany, Ga.
Immediate Past President
American College of Physicians

Physicians can feel discouraged by the amount of paperwork that is required in simply getting paid. “Apart from the cost effectiveness, there’s a psychological cost of having to deal with all of this. [Physicians] say, ‘Why did I go to medical school? I don’t need to learn all of this stuff,’” Dr. Bauer says. Additional options, he says, include hiring a practice management expert and accessing resources and meetings offered by the Medical Group Management Association.

Adopting electronic records can sweeten the deal for outsourcing. As you are expected to have more and more of your records online, you could pay a monthly fee to outsource your electronic records to somebody who also handles the security, confidentiality, coding, and billing requirements. An outsourcing arrangement may also include a deal with the banks. “Several different models are being developed right now, but electronic billing mechanisms are likely to prevail in the long run. For example, I expect to see more payments through credit

cards linked to health savings accounts. The uncertainty and complexity of future payment mechanisms and the hassles of trying to stay on top of all the changes are key reasons why so many physicians are opting for employment,” Dr. Bauer says.

Another advantage of outsourcing is that you don’t have to make a huge down payment up front. There are different outsourcing models, but in general the industry is moving towards a per-patient-per-year fee or a per-patient contact fee. It’s hard to compare the costs, Dr. Bauer says, but he estimates that monthly costs range from a few hundred to a few thousand dollars a month depending on system capabilities. “I recommend that physicians first decide exactly what capabilities they want from their system...and then shop for the best deal for the system needs they have specified,” says Dr. Bauer.

In addition, Dr. Stubbs foresees organizations similar to visiting nurse organizations available to provide case managers as part of an evolving view of mobile health. These managers could contract with physician offices to provide an extension of a doctor’s orders to follow patients closely on an outpatient basis.

Your Best Options

To find out your best options, stay on top of healthcare reform developments and continue to evaluate strategies that appear to work best for you. “You will not need to suddenly look for employment. The Titanic is not sinking,” Dr. Stubbs says. In fact, there is a growing need for primary care physicians. It’s just a matter of finding the right practice vehicle. “If you don’t feel that you have the fiscal ability to get the technology, you will have to work with larger groups ... to get the health information technology necessary. I think if you do that, you can thrive,” he says.

For many physicians, the prospect of providing more patients with excellent care and being able to manage their own health is exciting. “I see opportunity,” Dr. Stubbs says.



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