What Sleep Physicians Need to Know About The ACA and Population Health

Presented by Carol Ash, D.O. FASM
How many of these do you know?

- AASM
- FAASM
- OSA
- HST
- NPSG
- CPT
- ICD-10
- PPACA
- Exchanges
- NQF
- PPH
- ROI
- ACHE
- ACPE
• Two aims

1. Expand availability of healthcare coverage
   • In 2009 there were 50.7 million people in US without health insurance
   • This was 16.7% of the population (1 in 6)

2. Change the cost curve of healthcare in USA
ACA to change the # of uninsured

- 32 million will get health insurance.
- Why not all? It excludes illegal immigrants and allows people to opt out.
- Uninsured will decrease to 6%
- 16 million will be insured through Medicaid
- 2012 Supreme Court Ruling allows states to opt out of Medicaid expansion
- It is unclear how these numbers will be affected by those states opting out of Medicaid expansion
- Expect 10% increase in number seeking care
Health Insurance Mandate

- Individual Mandate: Health insurance is mandated. Penalty $695 ($2085 for families) or 2.5% income above filing minimum (whichever is larger)
- Employer mandate: 50 or more employees penalty $2000 per employee penalty (over 30 employees) if fail to offer health insurance
4 systems

• U.S. doesn’t have one health-care system, but three: Medicaid, Medicare, and private insurance.

• A fourth, ACA exchanges was launched 2014
Expansion through exchanges

• Way in which health insurance policies will be offered to all comers.

• Initially anticipated healthcare exchange in each state. Most now run by federal gov or in partnership.

• It will offer very substantial premium support depending on income up to 400% of Federal Poverty level

• Small business are encouraged to offer insurance through the exchanges by means of a premium credit
Increased patient volume

- Expected there will be an incentive to sign up for these exchanges and we need to be prepared to handle a larger volume of patients.

- What are states saying about the ACA Medicaid expansion? Who is participating?

Advisory board Company
Exchange Rules

• Why is it not clear? What are the rules? Coverage, reimbursement? Minimum level of insurance and premiums.
• States were to create rules.
• 20012 Supreme Court validated ACA.
• We are still sorting it out
Small Employer Credits

• Small employers (including physicians offices) have been getting credits for providing health insurance to employees under the ACA

• These credit will continue after 2014 for small employees using health exchanges
Purpose of ACA #2

- Change the cost curve of healthcare in the USA
- USA is the outlier in healthcare expenditure and life expectancy.
- 50% US GDP to be spent on Healthcare in 50 years (2062). ACA decreases it to 30%.
- 60% of physicians think the ACA will negatively impact their ability to make decisions and affect their relationships with patients.
Healthcare Spending per capita vs. Average Life Expectancy Among OECD Countries

![Graph showing the relationship between healthcare spending per capita and average life expectancy among OECD countries. Key countries marked include Japan, S. Korea, Mexico, Hungary, UK, and USA. The trend line indicates a positive correlation.](image)
<table>
<thead>
<tr>
<th>Country</th>
<th>Breast Women</th>
<th>Colorectal Men</th>
<th>Colorectal Women</th>
<th>Prostate</th>
<th>Average</th>
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<td>United States</td>
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• U.S. doesn’t have one health-care system, but three: Medicaid, Medicare, and private insurance.
• A fourth, ACA exchanges was launched 2014.
• Makes assessment difficult.
• Still not sustainable, and not acceptable.
We are all responsible

- Transforming our healthcare system to be safe, equitable, and of the highest value will take time and the work of many, but the potential rewards are great.
- The National Quality Forum (NQF) is a nonprofit, nonpartisan, public service organization committed to this transformation.
The U.S. healthcare system is one of the most innovative and talented systems in the world. Yet it is fragmented and uncoordinated. Our system delivers compassionate care and healing, but also generates preventable harm and costs without better patient outcomes.
• NQF reviews, endorses, and recommends use of standardized healthcare performance measures.

• Performance measures, also called quality measures, are essential tools used to evaluate how well healthcare services are being delivered.
• Working with members and the public, NQF is defining our national healthcare improvement 'to-do' list, and encourages action and collaboration to accomplish quality improvement goals.
Healthcare costs: 18 percent of GDP and Rising
Strongest evidence that the Council of Economic Advisors (CEA) used to suggest there was a need for healthcare reform?

Inefficiencies in the current system are evidenced by large variations in spending across the states with no evidence of corresponding variations in either medical needs or outcomes.

Sources of inefficiencies in the US healthcare suggest 30% of costs could be saved.

http://www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform
Independent Payment Advisory Board

- 15 person Board
- Task is to control Medicare spending by making payment and practice decisions
- By reducing Medicare cost we can transfer savings and pay for exchanges
- Cannot propose anything that rations care, increases revenue, changes benefits/eligibility/beneficiary cost sharing
- Hospital and hospices exempted till 2019
• Health & Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) may experiment with new payment and delivery systems
• The results of these experiments may be imposed on health care providers
• Identify research priorities and conduct research to compare clinical effectiveness of medical treatments

• Findings cannot lead to mandates, guidelines or recommendations for payment/coverage treatment, or used to deny coverage

• Healthcare industry in general concerned that findings might find decrease reimbursement
Physician Compare website

- The physician compare website was set up by CMS
- Disseminates provider quality measures reported through PQRI
- Effective in 2015. Physicians not participating will get a 1.5% reduction in Medicare payments.
- Initial bar is low (3%). Full sleep history and exam, test for AHI, if moderate treat with CPAP, follow patient compliance
Changes in Primary Care

- Already a shortage
- The increased in insured population will exacerbate the shortage
- One outcome may be that routine care will be provided by physician extenders with PCP being responsible for oversight and complex patients.
Enhanced primary care

• Increased reimbursement rates for PCP
• Patient Centered Medical Homes (PCMH)
• Accountable Care Organizations (ACO)
• Medicaid PCP reimbursement to be at Medicare levels.
• This will decrease reimbursement for specialists
• Focus on decreasing utilization with quality care defined by outcome
Healthcare Looks ahead

• Redesign primary care through patient engagement and a team approach
• Close gaps in care transitions with outpatient care managers
• Build an effective population health management system through data mining, risk stratification, and disease registries
• Promote best practices and sustainable systems of care
Patient Centered Medical Home

- The PC-MH is an approach to providing comprehensive primary care.

- A healthcare setting that facilitates partnerships between individual patients, their personal physicians and when appropriate the patients family
ACA created the Medicare Shared Savings Program (MSSP) which allows ACO contracts to be established with Medicare

ACO payment models allow sharing and savings (and financial risk) with the ACO

ACO Coordinates across Part A and B

Forces us to provide quality care for least dollar
What can you do?

• Improve quality
  – PAP adherence is not good. We do not know how many people really use it.
  – Create Patient Centered Sleep Homes that focus on comprehensive evaluation, treatment and follow-up, including provision of DME for sleep apnea, and a focus on PAP adherence
  – This will require a Safe Harbor from Medicare for Sleep Medicine physician/centers dispensing DME
Decrease Overall costs

- Using PSG for every patient followed by a CPAP initiation is expensive
- Use the evidence-based standards of practice as a guide to create Out of Center Sleep Testing (OCST)/Home Sleep Testing (HST) models focus on appropriate utilization
- State Sleep Societies to coordinate with local payers/state exchanges
- The AASM to coordinate with Medicare and national payers/federal exchanges
• 20% of the population is enrolled in Medicaid

• This may increase to 25% as a result of the Medicaid expansion

• Need to figure out a way to break even on the Medicaid fee schedule

• Medicaid will help cover overhead and disposable income will come from other insurers
Change is already here

- HST 45% of all sleep tests in the near future
- 2013, Sleep Health Centers in Boston abruptly closed and went out of business when HST became widespread
- July 2013, CMS decreased DME provider payments for CPAP by 47%, causing consolidation in the industry.
- It seems safe to expect more dislocation and financial pain in the sleep community
We need a better plan

He who every morning plans the transaction of the day and follows out that plan, carries a thread that will guide him through the maze of the most busy life. But where no plan is laid, where the disposal of time is surrendered merely to the chance of incidence, chaos will soon reign.

Victor Hugo (1802-1885)
Sleep Clinician Goals

• Need to relook at process and redesign to reduce cost
• Increase number of patients utilizing your system as their care provider
• Integration across system – decrease fragmentation to ensure quality and decrease cost
• We must own this
  – Any plan we create must ensure the sleep service line advances these goals.
John Kotter Change Model

- Our Iceberg is melting
- Establish a sense of urgency. Create compelling reason why change is needed.
- Create the guiding coalition. Select the team to lead change.
- Develop a vision and a strategy.
- Communicate the change vision.
- Devise and implement a communication strategy to consistently convey the vision.
We often focus on sleep specialists as the referral source. The red indicates referrals we can control.
• Focus on health outcomes of groups of individuals, patterns of health determinants, and policies and interventions that link the two

• Groups patients into Low, Rising, High Risk

• Is an Opportunity for Sleep Clinicians
Sleep is in the future of PH

• Empowering the individual to learn how to best take care of himself or herself to promote health and wellness will be necessary to curtail the cost.

• The key ingredients include management of stress and anxiety, nutrition, physical activity, **improved sleep**, and lifestyle choices.
• Dennis Hwang, MD, FCCP, medical director of the Sleep Medicine Department at the Kaiser Permanente Fontana Medical Center

• “Sleep docs need to get message to primary docs and go direct to consumer.”

• Saw 1000% increase in referrals in 4 years.
Trends to be watching

- Customer driven healthcare environment
- ACA bundled payments
- Population health - Low, Rising, High risk
- IT methods allow population health and patient monitoring
- National Quality Forum – repository of all quality measures for reimbursement
  - Designated Planetree Patient Centered Hospital
  - Providers - responsible for healing environment
  - Physician empathy QA measures are coming
- Dean Ornish certificate/reimbursement – healthcare dollars now allocated to patient care under this program
- Integrative Medicine, Board Certification – principles of practice aligned with patient centered care and prevention
- Change in types of patients entering hospitals for Sleep related diagnostics and treatments.
Conclusion

• More of the population will have healthcare coverage
• The cost curve will be bent
• More than 50% of physicians as of 2012 are employed
• Trend will accelerate, demise small group private practice, with most physicians working for large groups or hospitals
• You need to be part of the solution