EVOLVING LANDSCAPE OF PHYSICIAN PAYMENT

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Medicare Access & Children’s Insurance Plan

MACRA

- Passed July 2015
- Eliminates SGR
- Establishes a path for APMs
- Consolidates reporting programs (MIPS)
MIPS Score
Four categories, one composite score and report

Quality + Resource Use + Clinical Practice Improvement Activities + Meaningful Use of Certified EHR Technology = MIPS Composite Performance Score

50 10 15 25
### Clinical Practice Improvement Activities

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Beneficiary Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Same day appointments for urgent needs</td>
<td>• Monitoring health conditions &amp; providing timely intervention • Participation in a qualified clinical data registry</td>
<td>• Timely communication of test results • Timely exchange of clinical information with patients AND providers • Use of remote monitoring • Use of telehealth</td>
<td>• Establishing care plans for complex patients • Beneficiary self-management assessment &amp; training • Employing shared decision making</td>
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<tr>
<td>• After hours clinician advice</td>
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MIPS Incentive Payment Formula

- Measurement starts 2017, payments based on those measures begins 2019
- EPs receive positive adjustment if score is above the performance threshold, negative adjustment factor if score is below threshold
  - 2019 4%
  - 2020 5%
  - 2021 7%
  - 2022 & onward 9%
- “Scaling” (up/down) for budget neutrality
Figure: Post-SGR Medicare Payments Under MACRA

Current Fee for Service
Starting in 2019, physicians will be required to transition to one of two systems that will determine future payment updates.

Present to 2019

Option 1

January 2020 to December 2025

Merit-Based Incentive Payment System
Potential for positive or negative adjustments based on achievement on a composite quality score from 2020-2025

Option 2

Alternative Payment Model System
Potential for lump sum bonus equaling 5% of previous year’s payments from 2020-2025

January 2026 and Beyond

Merit-Based Incentive Payment System
0.25% annual payment increase begins in 2026

Alternative Payment Model System
0.75% annual payment increase begins in 2026

2014 “doc-fix” rates will apply through June 2015. Beginning in July 2015, those rates will increase by 0.5%. Rates are then further increased by 0.5% annually through 2019.

Payment rates are flat, with potential for performance and additional incentives.

Annual payment rates increase, vary by payment model.

MACRA indicates Medicare Access and CHIP Reauthorization Act of 2015; SGR, sustainable growth rate.
Adapted with permission from the Association of Community Cancer Centers. https://accc-cancer.org/assets/images/advocacy-Post-SGR-Medicare-Payments-1200x1553.png.
APM vs MIPS

- Manage Risk
- APM
- 2018
- Providers' Choice
- MIPS
- Manage Penalties
MACRA Defined APMs

- A CMMI model under section 1115A
- Begins in 2019
- Requirements:
  - Use certified EHR technology
  - Quality measures “comparable to” measures used in MIPS
  - Not “nominal” financial risk unless is a medical home expanded under section 115A(c) of the SSA
- Successful reporting, excludes from MIPS
- Annual lump sum payment (5%)

Source: “RFI on Physician Payment Reform” CMS-3321-NC External FAQ
### Fee Schedule Updates

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### MIPS

- **Quality**
  - Clinical Practice Improvement Activities: 4%, 5%, 7%, 9%
- **Resource Use**
- **Meaningful Use of Certified EHR Technology**
- **PQRS, Value Modifier, EHR Incentives**

### Certain APMs

- **Qualifying APM Participant**
  - Medicare Payment Threshold Excluded from MIPS
- **5% Incentive Payment**
- **Excluded from MIPS**

*Qualifying APM conversion factor
**Non-qualifying APM conversion factor
APM Participation Revenue Thresholds

Revenue thresholds based on Medicare Payments to EP

- 2019 & 2020 - 25% of Part B payments
- 2021/2022 - 50% of Part B payments
- 2023 onward - 75% of Part B payments

Beginning in 2021… A Second Option

- Thresholds can be for combined payments from Medicare and other payers.
Partial Qualifying APM Participants

- A partial qualifying APM participant does not meet the thresholds established but meets slightly reduced thresholds.
- Partial qualifying APM participants do not receive the 5% APM incentive payment.
- They can participate in MIPS but are held harmless if they do not participate in MIPs.
- For partial QPs, the Medicare-only payment thresholds are
  - 20 percent (instead of 25 percent) for 2019 and 2020
  - 40 percent (instead of 50 percent) for 2021 and 2022
  - 50 percent (instead of 75 percent) for 2023 onward
How will MACRA affect me?

Am I in an APM?
- Yes
- No

Am I in an eligible APM?
- Yes
  - Do I have enough payments or patients through my eligible APM?
    - Yes
      - Qualifying APM Participant
        - 5% lump sum bonus payment 2019-2024
        - Higher fee schedule updates 2026+
        - APM-specific rewards
    - No
      - Subject to MIPS

- No
  - Is this my first year in Medicare OR am I below the low-volume threshold?
    - Yes
      - Not subject to MIPS
    - No
      - Subject to MIPS
ALTERNATIVE PAYMENT MODELS: A NEW SPECIES OR JUST A PIG WITH LIPSTICK?
## CMS APMs Announced to Date

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<td>FFS + Shared Savings on Attributed Total Spending</td>
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Current ACO Penetration

Accountable Care Organizations by Hospital Referral Region; Source: Leavitt Partners Center for Accountable Care Intelligence
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“Shared Savings” Payment Reform Pilots being Implemented Across the Country
Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)

Comprehensive Primary Care Plus (CPC+)

Medicare Shared Savings Program – Track 2

Medicare Shared Savings Program – Track 3

Next Generation ACO Model

Oncology Care Model Two-Sided Risk Arrangement (available in 2018)
CMS Trying to Make Each Provider Accountable for Total $ Spend

- ACOs: Spending on All Services the ACO's Patients Receive
- Comprehensive Primary Care Initiative: Spending on All Services the PCP's Patients Receive
- Oncology Care Model: Spending on All Services the Oncologists' Patients Receive During Chemo Treatment
- Comprehensive Care for Joint Replacement: Spending on All Chronic Disease Care and Care Related to Joint Surgery After Discharge

Payments to ACOs
Payments to PCPs
Payments to Oncologists
Payments to Hospitals
Most $$ Do Not Go to Physicians
All Physicians Could *Earn More* By Lowering *Other* Healthcare Costs
DEVELOPING MODELS
APM Model #1

Payment for a High-Value Service.

- A physician practice would be paid for delivering one or more desirable services that are not currently billable, and the physician would take accountability for controlling the use of other, avoidable services for their patients.

- Acute Care Coordination/Care Transition
- Telehealth
- Anticoag Management
Condition-Based Payment for Physician Services

- A physician practice would have the flexibility to use the diagnostic or treatment options that address a patient’s condition most efficiently and effectively without concern that using lower-cost options would harm the operating margins of the physician’s practice.

- Stroke/TIA
- PE/DVT
Multi-Physician Bundled Payment

- Two or more physician practices that are providing complementary diagnostic or treatment services to a patient would have the flexibility to redesign those services in ways that would enable high-quality care to be delivered as efficiently as possible.
Physician-Facility Procedure Bundle

- A physician who delivers a procedure at a hospital or other facility would have the flexibility to choose the most appropriate facility for the treatment and to work with the facility to deliver the procedure in the most efficient and high-quality way.
Warrantied Payment for Physician Services

- A physician would have the flexibility and accountability to deliver care with as few complications as possible.
Episode Payment for a Procedure

A physician who is delivering a particular procedure could work collaboratively with the other providers delivering services related to the procedure (e.g., the procedure is performed, other physicians who are involved in the procedure, physicians and facilities who are involved in the patient’s recovery or in treating complications of the procedure, etc.) to improve outcomes and control the total spending associated with the procedure.
APM Model #7

Condition-Based Payment

- A physician practice would have the flexibility to use the diagnosis or treatment options that address a particular health condition (or combination of conditions) most efficiently and effectively and to work collaboratively with other providers that deliver services for the patient’s condition in order to improve outcomes and control the total spending associated with care for the condition.
## Health Care Payment Learning and Action Network

**http://www.hcp-lan.org; 10/2015**

### Category 1: Fee-for-Service – No Link to Quality
- **Traditional FFS**
- DRGs for limited fee-for-service

### Category 2: Fee-for-Service – Link to Quality
- **A** Payments for Infrastructure & Operations
  - Bundles payments for reporting or quality performance
- **B** Pay for Reporting and Research for Performance
  - DRGs with rewards for reporting or quality performance
- **C** Rewards for Performance
  - DRGs with rewards and penalties for quality performance
- **D** Rewards and Penalties for Performance
  - FFS with rewards and penalties for quality performance

### Category 3: APMSs Built on Fee-for-Service Architecture
- **A** APMS with Upside Risk
  - Bundled (e.g., episode-based) payment with upside risk only
- **B** APMS with Upside/Risk
  - ACOs with upside risk only

### Category 4: Population-Based Payment
- **A** Limited Population-Based Payments
  - Risk-based payments not linked to quality
- **B** Comprehensive Population-Based Payments
  - Global budget based on population served linked to quality

**SN**: Capitalized payments not linked to quality
Examples

- FFS+
  - *Anthem “Quality Cancer Care” Program*
- FFS+ PMPM+ Shared savings
  - *CMS Comprehensive Primary Care (CPC) Initiatives*
- Population Based Payment
  - Maryland Global Budget
Burning Platform for EM
Acute Care ... The Facts

- Acute care is common
  - > 1/3rd of all pt encounters
    (Health Affairs, 2010)

- EDs admitted over 80% of unscheduled hospital admissions
  - 65% ↑ from 2000 to 2009 (Med Care, 2013)

- Large portion of U.S. health spending is attributed to acute care
  - EM services account for 6% of Medicare Part B spending, $2.3 billion dollars/yr (NEJM, 2015)
Emergency Physician Decisions are Expensive

- Avg cost of inpt admission is 10x ED visit\(^1\)

- In 2010, total costs for all hospital stays was $375.9B
  - Avg cost per stay = $9,700

- Total Medicare spend was nearly 50%
  - Avg cost per stay $11,600\(^2\)

The Opportunity

Which one are you?

1/2 FULL?  1/2 EMPTY?
Reduce Acute Care Costs

- Decrease avoidable emergency care costs
  - Decrease inappropriate utilization
  - Improve diagnostic accuracy
  - Decrease unnecessary variability
- Reduce avoidable hospitalizations
- Prevent prolonged stay (ICU)
- Reduce avoidable ED visits

Choosing Wisely
In August 2015, the American College of Emergency Physicians convened a Task Force on APMs to explore potential models that could give Emergency Physicians the resources and flexibility they need to improve the quality of patient care, to reduce overall healthcare spending for Medicare and other payers, and to improve the financial viability of the physicians’ practices.
Possible APMs for EM

1. ED Disposition Planning Payments
2. Condition Based Payments
3. Case Rates for ED Services
4. Population Management of Ambulatory Acute Care
APM#1 ED Disposition Planning Payments

- Additional resources (e.g., PMPM, new CPT codes)
- ID ED patients who could be safely discharged without hospitalization

+ Cost to system $, Cost savings to system $$$
  - Requires new CPT codes
  - May not qualify as APM
B2C Collaboration

- Community organizations, primary care clinics, mental health clinics and UCH
- Intensive care coordination services from multidisciplinary team for 60d
  - Health coach - promote healthy behavior lifestyle changes
  - PCP - promote preventive care and visits to the clinic
  - Care coordinator - connects clients with community resources
  - Community organizer – health advocacy training to promote better delivery of health care services
  - Behavioral health assessment & interventions/referrals
- Recruited in ED by a community health worker
ED & Inpt Utilization Decreased 50%
System Cost Decreased > 50%

Total site cost $1.2M Total saved $13.5 M

Total Reduction: $2,201,285 (38%)
Per Person Savings: $22,930
Bundled payment for episode (starts with admit from ED) for all ED, inpt +/- post acute care

- Initially seems less complicated
- Is actually very difficult, usually requires dx vs complaint
- Most conditions do not meet population “threshold” for CMS APM
Example: “Stroke”

- Thrombolytic stroke (“big”)
- Thrombolytic stoke (“small”)
- TIA
- Hemorrhagic stroke

- Accountable provider for episode(??)
APM#3 Case Rates for ED Services

- A single bundled payment (imaging, lab, E&M, etc) for emergency provider and hospital for each patient evaluated/treated in ED

  + Both EP and hospital benefit if services delivered more efficiently
  + Total ED spend decreases
  - Requires EP and hospital to develop mechanism for the bundled payment sharing
  - Requires risk adjustment by patient
UCH CDU Chest Pain (Coronary) Pathway

Are any of the following present?
- Classic angina or >20 min CP concerning for ACS
- Known history of CAD (PCI, MI, CABG) with worsening symptoms (unstable angina)
- New ECG changes consistent with ischemia; OR initial ECG concerning for ischemia without prior for comparison
- Elevated POCT troponin ≥0.5 in patient without renal disease
- Unstable vital signs
- Anhythmia or significant valvular disease contributing to presentation

YES → Admit to Cardiology

NO → Admit to ED CDU AND Calculate TIMI Score

TIMI 0 (2.1% risk)
- Age <50
- Patient with:
- >1 Cardiac Risk Factor

TIMI 1-2 (5-8% risk)
- Age 50-64
- >1 Cardiac Risk Factor
- Evaluation criteria for cardiac CTA present
  - GFR <60 ml/min/1.73 m²
  - [calculator: www.mdcalc.com, use MORD GFR]
  - Inability to lower HR to ≤60

TIMI >2 (≥13% risk)
- Obtain ECG and POCT troponin 6hr after initial P2Y12 therapy

TIMI Risk Score
- (1 point for each positive)
  - Age ≥65
  - >3 Cardiac Risk Factors
  - Coronary Artery Disease (≥50% stenosis)
  - Aspirin in past 7 days
  - Severe angina (≥2 episodes in 24 hours)
  - ST changes ≥0.5 mm
  - Positive cardiac marker

[Predicts 14 day risk of: All-cause mortality, new or recurrent MI, or severe recurrent ischemia requiring urgent revascularization (http://www.timi.org/)]
Single bundled payment for each individual in pre-defined population group to EP; higher payments for sicker pts

- biggest opportunity to dec costs
- Assumes stable population utilizing acute care
- Most risky
- Requires system redesign
Ideal State

- Easy
- Fair
- One size fits all (provider, patient, facility) but customizable
- Improves health of patients
- Applies to most patients
- Considers severity of condition
- Minimizes administrate costs
- Minimizes provider risk

- Incentives aligned w/ partners
- Provides fair payment for services
- System does not collapse in transition
The Market is Changing

- 24% of physicians practices part of a medical home
- 29% of physician practices part of an ACO
- 59% of physician practices received revenue from at least 1 APM
OPPORTUNITIES FOR DISRUPTIVE INNOVATORS
Rethinking Our Strategy

- Leveraging competitive advantage with accountability

- Fixed cost of ED is cheaper than outpatient cost
  - “Public utility payment” for stand by service
Rethinking Our Strategy

- Finding the “Accountable” partner to share risk
  - Community Provider
    - Specialist or non specialist
  - Payer
  - Health system
  - Patient?
  - Medical home
  - Medical neighborhood
  - Perioperative Surgical Home
  - ED = Medical home for the homeless?
Final thoughts....

- Payers will drive the market
- Cost reduction + will be the primary strategy (capitation+)
- Uninsured and high deductible will be left out
- Dominant long-term model will not be specialty specific (may be bridging strategy)
- There is an early move opportunity
- We should think about Medicaid partnerships
THANK YOU

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