Healthcare Economics: The Changing Landscape of Physician Reimbursement

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• 61 year old male with chest pain is sent for evaluation to ER by PMD. Says CP like previous episodes, when patient was diagnosed with “reflux”. Has hx of HTN, CAD, and GERD. Never been cath’ed in past.

• ECG shows....
ECG
61 yo M with CP sent for eval by PMD. Pt says CP like previous episodes, when pt was diagnosed with “reflux”. Has hx of HTN, CAD, and GERD. Never been cath’ed in past.

• You **will** get paid ...$41.68 (“Level 2”)
• BUT you **should** get paid...$177.13* (“Level 5”)

5 x “Downcodes” (Level 5) per shift x 14 shifts/mn

= **Lost Charges $113,778 per year**

* Assumes other documentation supports 99285, E/M reimbursement only for CMS payment 2018.
If You Had Documented...

• 60 yo M with hx of HTN, CAD and GERD c/o left sided CP “pressure” x 1 hr. Sent in by PMD for eval. Started at rest, was 4/10, pt took own nitro with relief.

1. Location
2. Quality
3. Timing
4. Severity
5. Modifying factors

Now... “Level 5”
“The Rules Stink”

• Tedious
• Confusing
• Don’t Let Us Take Care of Patients
Move On
Objectives

• Describe the fee for service reimbursement system

• Describe the MIPS program and the impact on AMC’s.

• Evaluate the opportunities of the novel alternative payment model system.
1) Evaluate Pt
2) Procedure
3) Both

Document Encounter

Bill Sent Based on Charges from Practice’s Fee Schedule

Bill Processed by Insurance Carrier

Claim Paid
Better Care

Your partner in delivering coordinated care.

Read More

CMS Provides Health Coverage for 100 Million People...

Information for people with Medicare, Medicare open enrollment, and benefits.

Stay Connected with CMS
Resource-Based Relative Value Scale (RBRVS)

- 1985 Harvard study
- Published in 1988
- Took effect 1992
Resource-Based Relative Value Scale (RBRVS)

- George HW Bush signed into law
- Omnibus Budget Reconciliation Act of 1989
- Medicare payments
- Payments for services based on resource costs needed to provide the service
1) Evaluate Pt
2) Procedure
3) Both

Document Encounter

Translated into CPT Codes
CPT Codes

• Current Procedural Terminology

• Describe Healthcare Services Provided by Physicians or Other Clinical Providers (APRNs, PA, DPM, etc)

• Developed by AMA CPT Editorial Panel
  – Justify medical necessity (ICD-9 dx)

• 2 Types
  – Evaluation & Mgt Codes ("E & M Codes")
  – Procedure codes
Pick Your Code

Professional (You)
- CPT codes
- MD work
- Medicare B
- Charge based on confidential physician fee schedule
- CMS 1500 form

Facilities (Hospital)
- APC codes
- Non-physician labor, supplies, equipment (formerly HCPCS)
- Medicare A
- Fiscal Intermediary Outpt Prospective Payment System
- UB 92 form
Q. How Much is a Given CPT Code Worth ($)?

A. Depends on Resource-Based Relative Value Scale (RBRVS) “Inputs”
RBRVS Inputs:

Used to Determine “Resource Cost” of Each Service (CPT Code)

1. Physician Work (wRVU)
   - Cognitive
   - Procedural

2. Practice Expense
   - Supplies, Billing, Collections
   - Support Staff, Payroll

3. Professional Liability Insurance
RBRVS Equation

Work RVUs
Practice Expense RVUs
+ Liability Insurance RVUs
Total RVUs for a given CPT code

\[(RVU_{\text{Total}}) \times (\text{Geographic Adjust}) \times (\text{Conv Factor})\]

= Medicare Payment ($) per CPT Code
Example:
ER Patient in AZ with Abd Pain, Dx as Kidney Stone
(CPT Code 99284)

(Work RVUs) x (Work GPCI) +
(Practice Expense RVUs) x (PE GPCI) +
(Liability Insurance RVUs) x (PLI GPCI) = Total RVUs

(2.56)(1.000) + (0.62)(0.983) + (0.22)(0.913) = 3.37 Total RVUs

(Total RVUs) x (Conversion Factor) = Medicare Payment $

(3.37) x ($34.0376) = $114.70 in Phoenix, AZ
How Do Doctors Get Paid Today

1) Evaluate Pt
2) Procedure
3) Both

Bill Processed by Insurance Carrier

Document Encounter

Translated into CPT Codes (has assoc’t RVUs)

Bill Drop with Charges from Practice’s Fee Schedule

Bill Sent to Pt

Claim Paid

Modifications
Discounts

Claim Not Paid (Denied)

Appeal Process
How to Find “Hidden” $
How to Find “Hidden” $’s

1) Evaluate Pt
2) Procedure
3) Both

→ Document Encounter

→ Translated into CPT Codes (has assoc’t RVUs)

→ Bill Drop with Charges from Practice’s Fee Schedule

Bill Processed by Insurance Carrier

→ Bill Sent to Pt

→ Claim Paid

→ Modifications Discounts

→ Claim Not Paid (Denied)

→ Appeal Process
How To Increase Clinical Revenues?

• Increased volume
  – *See more patients*

• Capture more charges
  – *Improved documentation capture*
    • *Shorter bill drop time*
    • *Decrease write offs*
    • *Meet quality measure incentive targets*

• Decrease costs
  – *Remove “waste”*
“Fee for Service”
“But I heard that the way that we get paid is going to change…”

*Is that true...why?*
Actual andProjected Net Medicare Spending, 2010-2024

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<th>Year</th>
<th>Actual Net Outlays</th>
<th>Projected Net Outlays</th>
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<td>2010</td>
<td>$446</td>
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<td>2019</td>
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NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of Medicare spending minus income from premiums and other offsetting receipts.
SOURCE: Congressional Budget Office, Updated Budget Projections: 2015 to 2025 (March 2015); The 2015 Long-Term Budget Outlook (June 2015).
Healthcare Spending “Out of Control”
Growth in Total Health Expenditure Per Capita,
U.S. and Selected Countries, 1970-2008

Kaiser Family Foundation, 2014
Cost ≠ Quality; Variations by State

Relationship Between Quality of Care and Medicare Spending, by State, 2004

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality
Growing Medicare Roster

Number of people age 65 and over, by age group, selected years 1900–2006 and projected 2010–2050

Note: Data for 2010–2050 are projections of the population.
Reference population: These data refer to the resident population.
The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act

Patient Protection and Affordable Care Act (P.L. 111-148)

Health Care and Education Reconciliation Act (P.L. 111-152)
ACA “Value Based Purchasing” Programs

- VBM
- PQRS
- Episode payments
- Global payments
- ACO’s
- eRx
- Meaningful Use
- Gainsharing
Value Equation

Value as seen by customer = Product Quality
i.e. A Flawlessly made product

Price paid by customer
The Big RVU Variable...Quality Scores

- Increasingly our pay will be tied to federal “quality” scores and metrics
NEJM, 2013
April 2015,
Medicare Access & CHIP Reauthorization Act (MACRA)
Medicare Access & CHIP Reauthorization Act (MACRA)

- Passed April 2015
- Repeals SGR
- Reauthorize CHIP
- Established the “Quality Payment Program”
- Established Merit-based Incentive Payment System (MIPS)
- Establishes a path for Advanced APMs
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.

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.

Option 1:
Merit Based Incentive Payment System (MIPS)
Potential for positive or negative adjustments based on achievement on a composite quality score from 2020 - 2025.

Option 2:
Alternative Payment Model (APM) system
Potential for lump sum bonus equaling 5% of prior year’s payments from 2020 - 2025.

Jan 2020 to Dec 2025

Jan 2026 and Beyond

Merit Based Incentive Payment System (MIPS)
0.25% annual payment increase begins in 2026.

Alternative Payment Model (APM) system
0.75% annual payment increase begins in 2026.

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

Annual payment rates increases, vary by payment model.
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%
How Big Is The MIPS Adjustment

- Based on the MIPS **composite performance score**: positive, negative, or neutral adjustments
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.
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
APM vs MIPS
Q: What is an Alternative Payment Model?

A: An *Accountable* Payment Model
Payment Reform: Global Payments

Current Fee-for-Service Payment System

The Problem
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.

Current System:
- Hospital
- Specialist
- Primary Care
- Home Health

Patient-Centered Global Payment System

The Solution
Global payments made to a group of providers for all care. Providers are not rewarded for delivering more care, but for delivering the right care to meet patient’s needs.

New System:
- Primary Care
- Hospital
- Specialist
- Home Health

$
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<th>Year</th>
<th>Fee Schedule Updates</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>Meaningful Use of Certified EHR Technology</th>
<th>MIPS Payment Adjustment (+/-)</th>
<th>5% Incentive Payment</th>
<th>Excluded from MIPS</th>
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<td>2026 and later</td>
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<td>0.25 N-QAPMCF**</td>
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*Qualifying APM conversion factor
**Non-qualifying APM conversion factor
Most $$ Do Not Go to Physicians
All Physicians Could *Earn More* By Lowering *Other* Healthcare Costs

- **Total Healthcare Costs (Parts A, B, and D)**
  - Hospital & Post-Acute Care Costs (Part A)
  - Drug Costs (Part D)
- **Physician Payment (Part B)**
  - Specialist Payment
  - PCP Payment
  - Specialist Payment
  - PCP Payment

**SAVINGS**
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
APM Model #2

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.
APM Model #4

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.
APM Model #5

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.
Episode of Care

- MACRA requires the creation of "care episode groups"
- Episode = “case rate” payment model
Range of Value-based Arrangements: Risk Continuum

Source: Kaufman, Hall & Associates, Inc.
Episodes of Care

• First described in health policy circles, mid 2000’s

• Definition
  – Care defined over a period of time
  – Usually months to year

• Each episode design includes a definition of a Principal Accountable Provider (PAP)
Defining an Episode Payment for Acute Care

Source: http://www.chqpr.org
Episode Payments/ Single Case-Rate ... Novel?
NO...

- DRG for acute care non-provider payments
- Pregnancy care
- ESRD
- Transplant (90 day global)
- LTC
- Rehab
Sometimes I feel that I have the worst job in the world!
Attempts to Bend the Cost Curve: Accountable Care Organizations

Accountable Care Organizations
Accountable for What, to Whom, and How
Elliott S. Fisher, MD, MPH; Stephen M. Shortell, PhD, MPH, MBA

Interest in accountable care organizations (ACOs) has increased dramatically with the passage of the Affordable Care Act, which establishes ACOs as a new payment model under Medicare and fosters pilot programs to extend the model to private payers and Medicaid. Proponents hope that ACOs will allow physicians, hospitals, and other clinicians and health care organizations to work more effectively together to both improve quality and slow spending growth. Skeptics are concerned that ACOs will focus narrowly on their bottom line and either stunt on needed care or use the leverage they achieve through local integration to demand unreasonable prices from payers.

Whether ACOs achieve their ambitious promise remains far from certain. It is likely that the success of ACOs (and the many other payment-reform initiatives included in the Affordable Care Act) will depend in large part on whether the Centers for Medicare & Medicaid Services, private payers, physicians, and health system leaders can work together to establish a tightly linked performance measurement and evaluation framework that not only ensures accountability to patients and payers, but also supports rapid learning,
ACOs

Accountable Care Organizations

ACCOUNTABLE CARE ORGANIZATION (ACO)

PATIENT ACTIVATION

POST-ACUTE ALIGNMENT

PAYER PARTNERS

DISEASE MANAGEMENT PROGRAMS

PRIMARY CARE PHYSICIANS

POPULATION HEALTH ANALYTICS

HOSPITAL

SPECIALISTS
Who can Form ACO?

- Group practices
- Integrated delivery systems (e.g. Geisinger)
- Networks of individual practices (e.g. IPA)
- Partnerships or joint venture arrangements between hospitals and other providers (e.g. PHO)
- Hospitals employing other providers
- Regional Collaborations of health providers (NC Community Connections 646 Project)
## Next Generation ACOs

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<th>Shared Savings Opportunity</th>
<th>MSSP Track 1</th>
<th>Next Generation ACO Model</th>
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<tr>
<td></td>
<td>Maximum of 50% of savings generated compared to benchmark</td>
<td>Choose between 80% and 100% of savings generated compared to benchmark</td>
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<td>Savings attenuated by performance on quality metrics</td>
<td>Quality performance is included in benchmark</td>
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<th>Beneficiary Assignment</th>
<th>MSSP Track 1</th>
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<td>Retrospective—ACO clinicians only know who they are financially responsible for after the end of the year</td>
<td>Prospective—ACO clinicians know who they are financially responsible for at the beginning of the year</td>
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<td>Reduces ability of clinicians to focus care management activities on ACO beneficiaries</td>
<td>Enhances ability of ACO clinicians to focus care management activities on ACO beneficiaries</td>
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<th>Network Design</th>
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<td>Beneficiaries can receive care wherever Medicare is accepted</td>
<td>Beneficiaries can receive care wherever Medicare is accepted</td>
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<tr>
<td>Beneficiaries have no financial incentive to stay in-ACO network</td>
<td>CMS pays beneficiaries for staying in the ACO’s network for care</td>
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<th>Risk Adjustment</th>
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<td>CMS does not increase the financial target if the population’s risk status increases</td>
<td>CMS will increase the financial target by up to 3% if the population’s risk status increases</td>
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Total Public and Private ACOs To Date
Number of ACO Covered Lives

- 2011: 2.6 million
- 2012: 5.6 million
- 2013: 14.6 million
- 2014: 19.2 million
- 2015: 23.5 million
Number of ACOs by State
Number of Payers Participating in ACOs
The Opportunity

Which one are you?

1/2 Full?  1/2 Empty?
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
It is a challenge ...
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
- Think about Medicaid partnerships
Thank You
ACA “Value Based Purchasing” Programs