CREATING A PHYSICIAN-LED HEALTHCARE FUTURE
Designing Alternative Payment Models for Better Care, Lower Spending, and Financially Viable Physician Practices

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org
Three Doors to the Future Under MACRA

MACRA

DOOR #1

DOOR #2

DOOR #3
Door #1: MIPS (Pay for Performance)

MIPS = PAY FOR PERFORMANCE

SGR Repeal
The Problem That P4P Was Supposed to Solve

PROBLEM

Physicians are paid the same amount under fee-for-service regardless of the quality of care they deliver.
Most P4P “Solutions” Have Been Worse Than the Problem

PROBLEM

Physicians are paid the same amount under fee-for-service regardless of the quality of care they deliver

BAD “P4P”

Requiring physicians to deliver high-quality care regardless of whether they are paid adequately to do so

Penalizing physicians for quality problems they did not cause and cannot control

Penalizing physicians when patients don’t receive services they don’t need or want
Do Physicians Need “Incentives” to Deliver Higher Value Care?

- FFS
- P4P Based on Quality and Cost Measures
- Bonus
- Penalty
The Problem Isn’t “Incentives” But Barriers in FFS Payment

- A small bonus may not be enough to pay for delivering a high-value service or for the added costs of improving quality.
- A small bonus may not be enough to offset the costs of collecting and reporting the quality data.
- A small penalty may be less than the loss of fee-for-service revenue from healthier patients or lower utilization.

Bonus
Penalty

P4P Based on Quality and Cost Measures

FFS

Unpaid Services
Door #1: Accountability Without Resources or Flexibility

MACRA

MIPS = PAY FOR PERFORMANCE

- **Accountability for:**
  - Quality Measures
  - “Meaningful Use”
  - “Practice Improvement”
  - Total Spending on Patients

- **No Change in the Services Physicians are Paid For or the Adequacy of Payment**
Door #2: Alternative Payment Models

MACRA → ALTERNATIVE PAYMENT MODELS (APMs)

MIPS = PAY FOR PERFORMANCE
MACRA Encourages Use of APMs Instead of MIPS

• Physicians who participate in approved Alternative Payment Models (APMs) at more than a minimum level:
  – are exempt from MIPS
  – receive a 5% lump sum bonus
  – receive a higher annual update (increase) in their FFS revenues
  – receive the benefits of participating in the APM
The Need for “Alternative Payment Models”

PROBLEM

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost
The Need for “Alternative Payment Models”

PROBLEM

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost

BARRIER #1
No payment or inadequate payment for many high-value services, e.g.,
- Responding to patient phone calls that can avoid office or ER visits
- Calls among physicians to determine a diagnosis or coordinate care delivery
- Hiring nurses to help chronic disease patient avoid exacerbations
- Providing palliative care, not just hospice

BARRIER #2
Loss of revenue when patients stay healthy and don’t need procedures
Most Medicare APMs Are “Shared Savings” Programs

**PROBLEM**

Barriers in fee-for-service prevent physicians from delivering higher-quality care at lower total cost

**“ALTERNATIVE” PAYMENT MODELS**

“Shared Savings”
- If the physician or health system can reduce spending below expected levels, the provider receives a share of the payer’s savings
Is Shared Savings Better Than MIPS?
Is Shared Savings Better Than MIPS?

MIPS/P4P

• Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
Is Shared Savings Better Than MIPS?

MIPS/P4P

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• Provide a bonus if
  – quality is higher than average and
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**SHARED SAVINGS**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
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- (“Track 2”) Impose a penalty if:
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Is Shared Savings Better Than MIPS?

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**SHARED SAVINGS IS JUST A DIFFERENT FORM OF P4P**
Problems With “Shared Savings”

• Already efficient providers receive little or no additional revenue and may be forced out of business
• Physicians who have been practicing inefficiently or inappropriately are paid more than conservative physicians
• Physicians could be rewarded for denying needed care as well as by reducing overuse
• Physicians are placed at risk for costs they cannot control and random variation in spending
• Shared savings bonuses are temporary and when there are no more savings to be generated, physicians are underpaid
Medicare ACOs Aren’t Succeeding Due to Flaws in Shared Savings

2013 Results for Medicare Shared Savings ACOs

• 46% of ACOs (102/220) increased Medicare spending
• Only one-fourth (52/220) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved

2014 Results for Medicare Shared Savings ACOs

• 45% of ACOs (152/333) increased Medicare spending
• Only one-fourth (86/333) received shared savings payments
• After making shared savings payments, Medicare spent more than it saved
Private Shared Savings ACOs Are Also Floundering

Many private-payer ACOs fail to yield lower costs, better quality

By Bob Herman | October 15, 2015

CHICAGO—Medicare’s investment in accountable care organizations has inspired hospitals and doctors to create their own versions of ACOs with private insurers. But as with Medicare, not all private ACOs are achieving lower costs and higher quality.

Providers and insurers need to do a better job of reaching patients and employers, according to physician executives at four large health insurance companies. They gave their take on the private ACO movement at an event held by America’s Health Insurance Plans, the industry’s trade group.

Their experiences reflect that ACOs are still a new structure, and building a new payment and care model as complex as an ACO is not easy to roll out.

“Our alternative payment models are succeeding at a much lower rate than they should be,” said Dr. Stephen Ondra, chief medical officer at Health Care Service Corp., the Blue Cross and Blue Shield insurer for five states. “In the ACO, the consumer engagement is very, very low.”
Why?? No Change in the Way Physicians Are Paid

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

PATIENTS
- Heart Disease
- Inflammatory Bowel Disease
- Back Pain
- Pregnancy

ACO

Primary Care
Cardiology
Gastro-enterology
Neurosurgery
OB/GYN

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Most ACOs Spend a Lot on IT and Nurse Care Managers

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

ACO
  Expensive IT Systems
  Nurse Care Managers

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Possible Future “Shared Savings” Doesn’t Support Better Care Today

MEDICARE, MEDICAID HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment??

ACO

Expensive IT Systems

Nurse Care Managers

Share of Shared Savings Payment??

PATIENTS

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Inflammatory Bowel Disease
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Cardiology
Gastro-enterology
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Most ACOs Today Aren’t Truly Redesigning Care

MEDICARE, MEDICAID
HEALTH PLAN

Fee-for-Service Payment

Shared Savings Payment??

ACO

Expensive IT Systems
Nurse Care Managers

Share of Shared Savings Payment??

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The Problem With ACO Payment
Is It Doesn’t Solve Barriers in FFS

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The Obvious Solution: Improve Physician Payment

**MIPS/P4P**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
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**APM**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Change the way physicians are paid to address FFS barriers
  - Provide a bonus if:
    - spending is lower than expected and
    - quality has improved
  - (“Track 2”) Impose a penalty if:
    - spending is higher than expected
Instead, Everyone Thinks the Answer is “More Risk”

**MIPS/P4P**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Provide a bonus if:
  - quality is higher than average and
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- Impose a penalty if:
  - quality is lower than average and
  - spending is higher than average

**MORE PROVIDER RISK**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
- Provide a bonus if:
  - spending is lower than expected and
  - quality has improved
- (“Track 2”) Impose a penalty if:
  - spending is higher than expected
Or Only Pay Physicians Differently If They Accept Significant Risk

**MIPS/P4P**
- Continue to pay only for what is billable under the Physician Fee Schedule at standard payment rates
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  - quality is higher than average and
  - spending is lower than average
- Impose a penalty if:
  - quality is lower than average and
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**EVEN MORE RISK**
- Add additional payments beyond what is billable under the Physician Fee Schedule
- Provide a bonus if:
  - spending is lower than expected and
  - quality has improved
- (“Track 2”) Impose a LARGE financial penalty if:
  - spending is higher than expected
Requirements for Financial Risk in APMs

What MACRA Says

- The APM Entity must
  - “bear financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount;” or
  - be a medical home expanded by the Innovation Center
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What Proposed Regs Say
• The APM Entity is required to repay Medicare when spending on patients exceeds expected amounts, up to:
  – 4% of total Medicare spending (except for PCP practices with <50 clinicians)
Only 16% of Medicare Spending Goes to *Physicians*

![Bar chart showing Medicare Part A, Part B, and Part D Spending in Billions, 2012. The chart indicates that Prescription Drugs (Part D) account for the largest share, followed by Other Services, Home Health Agencies, Skilled Nursing Facilities, Hospital Outpatient Services, Hospital Inpatient Care, and Physicians, which constitute 16%.](chart.png)
4% of Medicare Spending = Huge Risk for Average Physician

Physicians: 16%

25% of Physician Revenues

4% of Total Medicare Spending

Gastroenterologists Receive a Smaller Share of Total Spending..
...So Accountability for Total Spending Is Even Greater Risk

Average Medicare Spending Per Patient, 2011
Patients with 20-35% of E&M from Gastroenterologists

- 4% of Total Medicare Spending
- 41% of Gastroenterologist Revenues
A Better Way to Define “More Than Nominal Financial Risk”

**What MACRA Says**

- The APM Entity must
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**What ProposedRegs Say**

- The APM Entity is required to repay Medicare when spending on patients exceeds expected amounts, up to:
  - 4% of total Medicare spending (except for PCP practices with <50 clinicians)
  - 5% of the entity’s total revenue…
More Reasonable Risk Standard Should Be Used for All Practices

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• The APM Entity must
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What Proposed Regs Say

• The APM Entity is required to repay Medicare when spending on patients exceeds expected amounts, up to:
  – 4% of total Medicare spending (except for PCP practices with <50 clinicians)
  – 5% of the entity’s total revenue, if the entity is a primary care practice with 50 or fewer clinicians (2.5% of revenue in 2017, 3% in 2018, 4% in 2019)
Are Bundled Payments Better Than ACOs?
Bundles Today: Too Few, Too Small, or Too Big

• Too Few:
  – Focused mostly on hip and knee replacement surgery

• Too Small:
  – No reward for avoiding unnecessary procedures
  – No reward for moving procedures to lower-cost, non-hospital settings
  – No real flexibility to change care – it’s just P4P on top of standard FFS

• Too Big:
  – Single payment amount for patients with very different needs
  – No protection against cherry-picking patients
  – Individual providers placed at risk for costs they can’t control
CMS “Comprehensive Care for Joint Replacement”

EPISODE PAYMENT FOR SURGERIES

PATIENT

Hospital Costs for Surgery | Readmits | Post-Acute Care (IRF, SNF, HH)
Principal Goal of CMS Proposal Is Reducing Post-Acute Care Cost

EPISODE PAYMENT FOR SURGERIES

- Hospital Costs for Surgery
- Readmits
- Post-Acute Care (IRF, SNF, HH)
- Hospital Costs for Surgery
- Readmits
- Post-Acute Care
- SAVINGS
Proposed Structure Encourages Lower Spending, Not Better Care

- No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- No flexibility to deliver different types of post-acute care or to be paid differently – no change in current payment systems
Hospitals at Risk for Total Cost With Everyone Still Paid the Same

EPISODE PAYMENT FOR SURGERIES

- No risk adjustment – target spending amount is the same for high-risk, poor functional status patients as low-risk patients
- No flexibility to deliver different types of post-acute care or to be paid differently – no change in current payment systems
- Hospital is at risk for higher post-acute care spending
Over Time, CMS Keeps More of the Savings, If There Are Any

**EPISODE PAYMENT FOR SURGERIES**

- **PATIENT**
  - Hospital Costs for Surgery
  - Readmits
  - Post-Acute Care (IRF, SNF, HH)

- **CMS**
  - SAVINGS

- **Hospital**
  - Physicians and Post-Acute Care

- **No risk adjustment** – target spending amount is the same for high-risk, poor functional status patients as low-risk patients

- **No flexibility to deliver different types of post-acute care or to be paid differently** – no change in current payment systems

- **Hospital is at risk for higher post-acute care spending**

- **Target spending is reduced every year to match lower FFS spending**
If There Are Fewer Surgeries, CMS Keeps ALL of the Savings

EPISODE PAYMENT FOR SURGERIES

- Hospital Costs for Surgery
- Readmits
- Post-Acute Care (IRF, SNF, HH)

SAVINGS

CMS

Hospital

Physicians and Post-Acute Care

Non-Surg. Treatment

SAVINGS
Notice of proposed rulemaking for bundled payment models for high-quality, coordinated cardiac and hip fracture care

Date
2016-07-25

Title
Notice of proposed rulemaking for bundled payment models for high-quality, coordinated cardiac and hip fracture care

Contact
press@cms.hhs.gov

Notice of Proposed Rulemaking for Bundled Payment Models for High-Quality, Coordinated Cardiac and Hip Fracture Care

On July 25, 2016, the Department of Health & Human Services (HHS) proposed new models that continue the Administration’s progress to shift Medicare payments from quantity to quality by creating strong incentives for hospitals to deliver better care at a lower cost. These models would reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions, and speed recovery.

Today’s proposal contains three new significant policies:

• New bundled payment models for cardiac care and an extension of the existing bundled payment model for hip replacements to other hip surgeries;
• A new model to increase cardiac rehabilitation utilization; and
• A proposed pathway for physicians with significant participation in bundled payment models to qualify for payment incentives under the proposed Quality Payment Program.
What’s Behind Door #3?

MACRA

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

ALTERNATIVE PAYMENT MODELS (APMs)

DOOR #3
Door #1 and Door #2 are *Payer-Designed* Payment Systems

HOW PAYMENT REFORMS ARE DESIGNED TODAY

- Medicare and Health Plans Define Payment Systems
- Physicians Have To Change Care to Align With Payment Systems
- Patients and Physicians May Not Come Out Ahead
Physicians Need to Design Payments to Support Good Care

HOW PAYMENT REFORMS ARE DESIGNED TODAY

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- Patients and Physicians May Not Come Out Ahead

THE RIGHT WAY TO DESIGN PAYMENT REFORMS

- Physicians Redesign Care and Identify Payment Barriers
- Payers Change Payment to Support Redesigned Care
- Patients Get Better Care and Physicians Stay Financially Viable
The Third Door Under MACRA

MACRA

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)
- Physician-Focused Payment Models
MACRA Requires Development of *Physician-Focused* APMs

- Physician-Focused Payment Model Technical Advisory Committee (PTAC) created by Congress to solicit and review proposals from physician groups, medical specialty societies, and others for “physician-focused payment models” and to make recommendations to CMS as to which models to implement.

- Under MACRA, CMS must respond to PTAC recommendations, but is not required to implement them. (However, there will considerable pressure on CMS, from Congress and others, to implement the recommendations.)
What Happens When *Physicians* Redesign Patient Care and Receive Adequate Payments to Support It?
Better Care at Lower Cost for Total Joint Replacement

PHYSICIAN LEADER: Stephen J. Zabinski, MD
Director, Division of Orthopaedic Surgery, Shore Medical Ctr
Better Care at Lower Cost for Total Joint Replacement

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OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• Reduce surgical complications by reducing patient risk factors prior to surgery
• Obtain lower prices for implants from vendors
• Match implants to patient needs
• Return patients home as quickly as possible
• Use lower cost settings for surgery and rehabilitation
## OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

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## BARRIERS IN THE CURRENT PAYMENT SYSTEM

- No payment for pre-operative patient risk reduction programs
- No payment for care coordination throughout surgical episode
- Separate payments to hospital and physician
- No data on costs of facilities

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# Better Care at Lower Cost for Total Joint Replacement

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## RESULTS WITH ADEQUATE PAYMENT FOR BETTER CARE

- Average length of stay  
  TKR: 3.3 → 1.8 days  
  THR: 2.9 → 1.6 days
- Average device cost  
  $6,301 → $4,242
- Discharges to home  
  34% → 78%
- Readmission rate  
  3.2% → 2.7%
- Total Episode Spending  
  TKR: $25,365 → $19,597  
  THR: $26,580 → $20,636

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Better Care at Lower Cost for Crohn’s Disease

PHYSICIAN LEADER: Lawrence R. Kosinski, MD
Managing Partner, Illinois Gastroenterology Group
Better Care at Lower Cost for Crohn’s Disease

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Managing Partner, Illinois Gastroenterology Group

OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

• Health plan spends $11,000/year/patient on patients with Crohn’s
• >50% of expenses are for hospital care, most due to complications
• <33% of patients seen by physician in 30 days prior to hospitalization
• 10% of expenses for biologics, many administered in hospitals
• 3.5% of spending goes to gastroenterologists
## OPPORTUNITIES TO IMPROVE CARE AND LOWER COSTS

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## BARRIERS IN THE CURRENT PAYMENT SYSTEM

- No payment to support “medical home” services in gastroenterology practice:
  - No payment for nurse care manager
  - No payment for clinical decision support tools to ensure evidence-based care
  - No payment for proactive telephone contact with patients

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**PHYSICIAN LEADER:** Lawrence R. Kosinski, MD
Managing Partner, Illinois Gastroenterology Group
## Better Care at Lower Cost for Crohn’s Disease

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  ➢ No payment for nurse care manager  
  ➢ No payment for clinical decision support tools to ensure evidence-based care  
  ➢ No payment for proactive telephone contact with patients | • Hospitalization rate cut by more than 50%  
• Total spending reduced by 10% even with higher payments to the physician practice  
• Improved patient satisfaction due to fewer complications and lower out-of-pocket costs |
| • >50% of expenses are for hospital care, most due to complications | | |
| • <33% of patients seen by physician in 30 days prior to hospitalization | | |
| • 10% of expenses for biologics, many administered in hospitals | | |
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How Do You Define a *Physician-Focused* Alternative Payment Model?
Step 1: Identify Opportunities to Reduce Related Spending

Fee-for-Service Payment (FFS)

Total Spending Relevant to the Physician’s Services

$ Avoidable Spending

Payments to Other Providers for Related Services

FFS Payments to Physician Practice

OPPORTUNITIES TO REDUCE SPENDING THAT PHYSICIANS CAN CONTROL
- Reduce Avoidable Hospital Admissions
- Reduce Unnecessary Tests and Treatments
- Use Lower-Cost Tests and Treatments
- Deliver Services More Efficiently
- Use Lower-Cost Sites of Service
- Reduce Preventable Complications
- Prevent Serious Conditions From Occurring
Step 2: Identify Barriers in Current Payments That Need to Be Fixed

Fee-for-Service Payment (FFS)

Avoidable Spending

Payments to Other Providers for Related Services

FFS Payments to Physician Practice

Unpaid Services

OPPORTUNITIES TO REDUCE SPENDING THAT PHYSICIANS CAN CONTROL

- Reduce Avoidable Hospital Admissions
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- Use Lower-Cost Tests and Treatments
- Deliver Services More Efficiently
- Use Lower-Cost Sites of Service
- Reduce Preventable Complications
- Prevent Serious Conditions From Occurring

BARRIERS IN CURRENT FFS SYSTEM

- No Payment for Many High-Value Services
- Insufficient Revenue to Cover Costs When Using Fewer or Lower-Cost Services
Step 3: Design an APM That Removes the Payment Barriers

Fee-for-Service Payment (FFS)

- Payments to Other Providers for Related Services
- FFS Payments to Physician Practice
- Unpaid Services

Avoidable Spending

Physician-Focused Alternative Payment Model

Flexible, Adequate Payment for Physician’s Services

Physician Practice Revenue

Total Spending Relevant to the Physician’s Services

$
Step 4: Include Provisions to Assure Control of Cost & Quality

Fee-for-Service Payment (FFS)

- Avoidable Spending
  - Payments to Other Providers for Related Services
  - FFS Payments to Physician Practice

Physician-Focused Alternative Payment Model

- Savings
  - Payments to Other Providers for Related Services

Flexible, Adequate Payment for Physician’s Services

Unpaid Services

Accountability for Controlling Avoidable Spending
The CMS Models Are NOT the Only Way to Define APMs

CMS APM Models

- Primary Care Medical Home
- Episode Payment to Hospital
- Upside-Only Shared Savings
- “Two-Sided Risk” Shared Savings
- Full-Risk Capitation
There are More & Better Ways to Create *Physician-Focused APMs*

APM #1: Payment for a High-Value Service
APM #2: Condition-Based Payment for a Physician’s Services
APM #3: Multi-Physician Bundled Payment
APM #4: Physician-Facility Procedure Bundle
APM #5: Warrantied Payment for Physician Services
APM #6: Episode Payment for a Procedure
APM #7: Condition-Based Payment
There are More & Better Ways to Create *Physician-Focused* APMs

APM #1: Payment for a High-Value Service
APM #2: Condition-Based Payment for a Physician’s Services
APM #3: Multi-Physician Bundled Payment
APM #4: Physician-Facility Procedure Bundle
APM #5: Warranted Payment for Physician Services
APM #6: Episode Payment for a Procedure
APM #7: Condition-Based Payment

Multiple Types of APMs Needed Because Physicians Deliver Different Types of Care to Different Patients
Proceduralists Can Reduce Complications & Improve Efficiency

- **Hospital**

- **High Spending on Complications & Post-Acute Care**

- **Low Complication & PAC Spending**
Procedural Episode Payments Support Higher Quality/Lower Cost

- Proceduralist
- Hospital

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending
What if You Can Avoid the Procedure Altogether?

Procedural
Episode
Payment

Proceduralist
Hospital

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Medical Management
Specialists Managing a *Condition* Can Avoid Unnecessary *Procedures*
Condition-Based Payment Supports Use of Highest-Value Treatment

Condition-Based Payment

Procedural Episode Payment

Proceduralist

Hospital

Medical Management

Condition Specialist

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Proceduralist

$
Are We Making the Payment for the Correct Condition??

Condition-Based Payment

Wrong Condition

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Procedural Payment

Proceduralist

Hospital

Medical Management

Correct Condition

Correct Treatment
Diagnostic Error is a Fundamental Quality Issue Underlying All Others
The Diagnostician Ensures the **Right Condition** is Being Treated
“Condition-Based” Payment Also Needed to Support Good Diagnosis

Condition-Based Payment (Symptoms)

Condition-Based Payment (Diagnosis)

Procedural Episode Payment

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Proceduralist

Hospital

Medical Management

Correct Condition

Correct Treatment

Diagnositician

Condition Specialist
Gastroenterologists Play All These Roles & Need Appropriate APMs

- Procedural Episode Payment
- High Spending on Complications & Post-Acute Care
- Low Complication & PAC Spending
Gastroenterologists Play All These Roles & Need Appropriate APMs

- **Condition-Based Payment (Diagnosis)**
  - Gastroenterologist
  - Hospital
  - Medical Management
- **Procedural Episode Payment**
  - Gastroenterologist
  - Hospital
- **High Spending on Complications & Post-Acute Care**
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- **Low Complication & PAC Spending**
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Gastroenterologists Play All These Roles & Need Appropriate APMs

- **Condition-Based Payment (Symptoms)**
- **Condition-Based Payment (Diagnosis)**
- **Procedural Episode Payment**

High Spending on Complications & Post-Acute Care

Low Complication & PAC Spending

Correct Condition

Correct Treatment

Gastroenterologist

Medical Management

Hospital

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How Would You Design APMs for Gastroenterology?
Identify the Types of Patient Needs That Physicians Address

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#### Inflammatory Bowel Disease

#### Other Conditions & Procedures

### Opportunities to Improve Care and Reduce Cost

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- Improve adenoma detection rate
- Avoid complications in colonoscopy
- Focus on highest-risk patients

### Barriers in Current Payment System

- All providers paid separately
- No payment for outreach to high-risk patients
- Higher payment for repeat & unnecessary procedures

### Solutions via Alternative Payment Models

- Bundled payment for colonoscopy
- Warrantied payment for colonoscopy
- Population-based payment for cancer screening
Opportunities, Barriers, and Solutions Will Differ by Condition

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                                 | • Avoid complications |
|                                  | • Bundled/warrantied payment for acute conditions  
                                 | • Condition-based payment for chronic conditions |
| Inflammatory Bowel Disease       | • Reduce ED visits & hospitalizations  
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Not Every Condition Needs an Alternative Payment Model

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Operationalizing APMs
## Five Key Elements of an APM

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<td><strong>Physician Who Is Accountable for Cost &amp; Quality?</strong></td>
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### Implementation of These Elements in the Physician Fee Schedule

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Physicians Find Out What They’ll Be Paid After Care is Delivered

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Example #1 of Problems w/ APMs
Built on (Current) FFS Structure

Patient-Centered Medical Home (PCMH) programs (e.g., CMS Comprehensive Primary Care Initiative and private health plan programs) pay PCPs a monthly payment per patient (PMPM) in addition to E&M payments for face-to-face visits

- Good: PMPM gives PCP flexibility to deliver a wide range of services beyond what is possible through E&M visits; PMPM provides resources to manage patient care without the need for face-to-face visits
- Bad: PMPM is only paid for patients “attributed” to the PCP, and the attribution formula is based on the number of E&M visits the physician had with the patient, so if the physician doesn’t bring the patient in for office visits, they could lose the payment needed to support the non-office-visit-based care
- What’s Missing: A way for the physician to indicate that they are managing the patient’s care for one or more conditions during the month
Example #2 of Problems w/ APMs
Built on (Current) FFS Structure

CMS and private health plans are using “episode groupers” to determine which services are related to a patient’s condition or treatment and they are using episode attribution rules to determine which physician is responsible for the episode

- **Good:** Most physicians can only influence the services patients receive for the conditions they are treating, not the total cost of care for all of the patient’s health problems
- **Bad:** Episode groupers “guess” at which services are inter-related based on their proximity in time and based on the presence or absence of diagnosis codes, and the groupers make a lot of mistakes
- **Bad:** Attribution rules assign episodes to physicians based on who had the most expensive services or who saw the patient the most, not based on who was actually in charge, and the attribution formula can make mistakes
- **What’s Missing:** A way for a physician to indicate that they are managing the patient’s care during an episode and a way to determine the clinical rationale for a service and whether it’s related to previous services
Example #3 of Problems w/ APMs Built on (Current) FFS Structure

CMS uses the Hierarchical Condition Category (HCC) system to risk adjust payments to physicians under various APMs

- **Good:** Risk adjustment is needed to ensure that physicians receive higher payments for patients who have more health problems that require more services and increase the likelihood of poor outcomes.
- **Bad:** HCCs were designed to predict total spending by Medicare Advantage plans (and do not do that very well), they were not designed to predict patient needs for services related to specific health problems.
- **Bad:** HCCs are based on ICD diagnosis codes, and even ICD-10 codes do not capture many important differences in disease severity or other patient characteristics that can significantly affect service needs and outcomes.
- **Bad:** HCCs weight diagnoses codes the same way for all patients, even though different diagnoses have different impacts on the types of care delivered by different physicians.
- **What’s Missing:** A way for the physician to indicate that a patient has the specific characteristics that affect their need for the services delivered by that physician and/or their risk of complications and poor outcomes.
A Better Way to Define APMs: An *Expanded FFS Architecture*

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<tbody>
<tr>
<td>Submission of claim with CPT and ICD codes</td>
<td>Submission of claim with bundled service or condition mgt code</td>
<td>Trigger formula based on retrospective pattern of CPT and ICD codes</td>
<td></td>
</tr>
</tbody>
</table>

| Services Included In Single Payment | CPT code defines services included; coding rules avoid double billing | Bundled service code defines services included and excluded & time period involved | Claims retrospectively “grouped” into bundle using formula based on CPT and ICD codes |

| Amount of Payment for Service | Defined in advance by standard RVU weight and annual conversion factor | Defined in advance based on expected cost of delivering services in bundle | Determined after services delivered by comparison to FFS billings by non-bundled providers + discount |

| Adjustment for Differences in Patient Needs | More billable services delivered to higher-need pts | Multiple levels defined based on patient characteristics | Adjusted using risk score based on (some) prior ICD codes |

| Physician Accountable for Cost & Quality | Physician who bills using the CPT code | | Physician is “attributed” responsibility after care is delivered using CPTs |
## A Better Way to Define APMs: An Expanded FFS Architecture

<table>
<thead>
<tr>
<th></th>
<th>Current RBRVS</th>
<th>Physician-Focused APMs</th>
<th>Payer-Administered APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trigger for Payment of Service</strong></td>
<td>Submission of claim with CPT and ICD codes</td>
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<td><strong>Services Included In Single Payment</strong></td>
<td>CPT code defines services included; coding rules avoid double billing</td>
<td>Bundled service code defines services included and excluded &amp; time period involved</td>
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</tr>
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<td><strong>Amount of Payment for Service</strong></td>
<td>Defined in advance by standard RVU weight and annual conversion factor</td>
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</tr>
<tr>
<td><strong>Physician Accountable for Cost &amp; Quality</strong></td>
<td>Physician who bills using the CPT code</td>
<td>Physician who bills as the manager of the bundle of services</td>
<td>Physician is “attributed” responsibility after care is delivered using CPTs</td>
</tr>
</tbody>
</table>
MACRA Requires Development of Three New Types of Codes

• Care Episode Groups (and associated codes)
• Patient Condition Groups (and associated codes)
• Patient Relationship Categories (and associated codes)
DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS

The Secretary shall establish care episode groups and patient condition groups, which account for a target of an estimated 1/2 of expenditures under parts A and B (with such target increasing over time as appropriate); and assign codes to such groups.

CARE EPISODE GROUPS.—In establishing care episode groups, the Secretary shall take into account the patient’s clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and other factors determined appropriate by the Secretary.

PATIENT CONDITION GROUPS.—In establishing patient condition groups, the Secretary shall take into account the patient’s clinical history at the time of a medical visit, such as the patient’s combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and other factors determined appropriate by the Secretary.
Patient Relationship Categories
Under MACRA

DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES

The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.

Patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.
## Timetable for CMS Adoption and Use of New Codes Under MACRA

<table>
<thead>
<tr>
<th>Estimated Date</th>
<th>Care Episode Groups and Codes</th>
<th>Patient Condition Groups and Codes</th>
<th>Patient Relationship Categories &amp; Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16, 2016</td>
<td>Draft list of care episode codes</td>
<td>Draft list of patient condition codes</td>
<td>Draft patient relationship categories and codes</td>
</tr>
<tr>
<td>November 25, 2016</td>
<td>Operational list of care episode codes</td>
<td>Operational list of patient condition codes</td>
<td>Operational list of patient relationship categories and codes</td>
</tr>
<tr>
<td>April 20, 2017</td>
<td></td>
<td></td>
<td>Include patient relationship category codes on claim forms</td>
</tr>
<tr>
<td>December 20, 2017</td>
<td></td>
<td></td>
<td>Include patient condition codes on claim forms</td>
</tr>
<tr>
<td>January 1, 2018</td>
<td>Include care episode codes on claim forms</td>
<td>Include patient condition codes on claim forms</td>
<td>Include patient relationship category codes on claim forms</td>
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</tbody>
</table>
What Happens to ACOs with Physician-Focused APMs?
Each Patient Should Have a Good Primary Care Practice…

PATIENTS

<table>
<thead>
<tr>
<th>Heart Disease</th>
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<tbody>
<tr>
<td>Inflammatory Bowel Disease</td>
</tr>
<tr>
<td>Back Pain</td>
</tr>
</tbody>
</table>

Primary Care Practice
…With Payment That Enables Delivery of Good Primary Care…

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

| Heart Disease | Inflammatory Bowel Disease | Back Pain |

Payment That Supports Good Primary Care

Primary Care Practice
...And PCPs Take Accountability for Costs They Can Control/Influence

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

Heart Disease
Inflammatory Bowel Disease
Back Pain

Payment That Supports Good Primary Care

Primary Care Practice

Accountability for:
• Avoidable ER Visits
• Avoidable Hospitalizations
• Unnecessary Tests
• Unnecessary Referrals
• Adequate Preventive Care
Give PCPs a Medical Neighborhood to Consult With on Difficult Cases

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Inflammatory Bowel Disease
- Back Pain

Primary Care Practice

Cardiology, Gastroenterology, Physiatry

Payment That Supports Good Primary Care
Pay the Medical Neighbors to Support the PCPs

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Inflammatory Bowel Disease
- Back Pain

Primary Care Practice
- Payment That Supports Good Primary Care

Cardiology, Gastroenterology, Physical Therapy
- Payment That Supports Diagnostic & Care Management Help From Specialists
Ask the Medical Neighbors to Be Accountable for Costs They Control

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS

Heart Disease
Inflammatory Bowel Disease
Back Pain

Primary Care Practice
Cardiology, Gastroenterology, Physiatry

Accountability for:
• Appropriate Use of Testing and Interventions
• Improving Chronic Disease Management

Payment That Supports Diagnostic & Care Management Help From Specialists
Payment That Supports Good Primary Care
Have Good Specialists Ready to Manage Serious Conditions…

MEDICARE, MEDICAID
HEALTH PLAN

PATIENTS
- Heart Disease
- Inflammatory Bowel Disease
- Back Pain

Primary Care Practice

Cardiology Group
Neurosurg. Group
GI Group

Cardiology, Gastroenterology, Physiatry

Payment That Supports Good Primary Care
Payment That Supports Diagnostic & Care Management Help From Specialists
Pay Them To Deliver Quality Care at the Most Affordable Cost

MEDICARE, MEDICAID HEALTH PLAN

PATIENTS
- Heart Disease
- Inflammatory Bowel Disease
- Back Pain

Primary Care Practice
- Payment That Supports Good Primary Care

Cardiology Group
- Payment That Supports Good Management of Heart Disease

Neurosurg. Group
- Payment That Supports Good Care for Back Pain

GI Group
- Payment That Supports Good Care for Inflammatory Bowel Disease

Cardiology, Gastroenterology, Physiatry
- Payment That Supports Diagnostic & Care Management Help From Specialists
Ask Specialists to Be Accountable for Costs They Can Control

MEDICARE, MEDICAID HEALTH

Accountability for:
• Using Appropriate Procedures
• Avoiding Complications of Procedures

PATIENTS
Heart Disease
Inflammatory Bowel Disease
Back Pain

Payment That Supports Good Primary Care

Payment That Supports Good Management of Heart Disease

Payment That Supports Good Care for Back Pain

Payment That Supports Good Care for Inflammatory Bowel Disease

Payment That Supports Diagnostic & Care Management Help From Specialists

Primary Care Practice

Cardiology, Gastroenterology, Physiatry

Cardiology Group

Neurosurg. Group

GI Group

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That’s an “ACO,” But Built from the Bottom Up, Not the Top Down

MEDICARE, MEDICAID HEALTH PLAN

Alternative Payment Models

PATIENTS
- Heart Disease
- Inflammatory Bowel Disease
- Back Pain

Primary Care Practice

Cardiology Group
Cardio Group
GI Group
Neurosurg. Group

Payment That Supports Good Primary Care
Payment That Supports Good Management of Heart Disease
Payment That Supports Good Care for Back Pain
Payment That Supports Good Care for Inflammatory Bowel Disease

Cardiology, Gastroenterology, Physiatry

Payment That Supports Diagnostic & Care Management Help From Specialists

“ACO”
A True ACO Can Take a Global Payment And Make It Work

MEDICARE, MEDICAID
HEALTH PLAN, EMPLOYER

Risk-Adjusted Global Payment

PATIENTS
Heart Disease
Inflammatory Bowel Disease
Back Pain

ACO

Primary Care Practice
Cardiology, Gastroenterology, Physiatry
Cardiology Group
Neurosurgeon Group
GI Group

Payment That Supports Good Primary Care
Payment That Supports Good Management of Heart Disease
Payment That Supports Good Care for Back Pain
Payment That Supports Good Care for Inflammatory Bowel Disease
Payment That Supports Diagnostic & Care Management Help From Specialists
Physician-Focused APMs Can Create Win-Win-Win Solutions

MACRA

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

ALTERNATIVE PAYMENT MODELS (APMs)

PHYSICIAN-FOCUSED PAYMENT MODELS
Three Paths to the Future: Which Will Gastroenterologists Choose?

- **#1** MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
- **#2** ALTERNATIVE PAYMENT MODELS (APMs)
- **#3** PHYSICIAN-FOCUSED PAYMENT MODELS

MACRA

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If You Don’t Like Doors 1 & 2, What Should You Do?
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3. Tell ASGE/AGA leadership that developing gastroenterology-specific Alternative Payment Models should be a top priority and that you want to help
Learn More About Win-Win-Win Payment and Delivery Reform

www.PaymentReform.org
For More Information:

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