Alternative Payment Models: Business and Physician Perspectives

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Agenda

• Medical Economics
• Value-Based Payment Framework
• The Rise of ACOs
• MACRA, MIPS, and APMS
• Messages from CMS
• New Revenue Opportunities
Medical Care Expense is 19.9% GDP in 2016

**EXHIBIT 2**

Growth in national health expenditures (NHE) and gross domestic product (GDP), and NHE as a share of GDP, 1989-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>7.7%</td>
</tr>
<tr>
<td>1990</td>
<td>11.4%</td>
</tr>
<tr>
<td>1991</td>
<td>11.3%</td>
</tr>
<tr>
<td>1992</td>
<td>11.1%</td>
</tr>
<tr>
<td>1993</td>
<td>10.2%</td>
</tr>
<tr>
<td>1994</td>
<td>8.6%</td>
</tr>
<tr>
<td>1995</td>
<td>7.3%</td>
</tr>
<tr>
<td>1996</td>
<td>5.9%</td>
</tr>
<tr>
<td>1997</td>
<td>3.8%</td>
</tr>
<tr>
<td>1998</td>
<td>3.0%</td>
</tr>
<tr>
<td>1999</td>
<td>2.7%</td>
</tr>
<tr>
<td>2000</td>
<td>2.0%</td>
</tr>
<tr>
<td>2001</td>
<td>1.8%</td>
</tr>
<tr>
<td>2002</td>
<td>2.4%</td>
</tr>
<tr>
<td>2003</td>
<td>2.2%</td>
</tr>
<tr>
<td>2004</td>
<td>1.7%</td>
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<tr>
<td>2005</td>
<td>1.4%</td>
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<tr>
<td>2006</td>
<td>1.0%</td>
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<tr>
<td>2007</td>
<td>1.0%</td>
</tr>
<tr>
<td>2008</td>
<td>1.2%</td>
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<tr>
<td>2009</td>
<td>1.4%</td>
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<tr>
<td>2010</td>
<td>1.6%</td>
</tr>
<tr>
<td>2011</td>
<td>1.5%</td>
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<tr>
<td>2012</td>
<td>1.4%</td>
</tr>
<tr>
<td>2013</td>
<td>1.2%</td>
</tr>
<tr>
<td>2014</td>
<td>1.0%</td>
</tr>
<tr>
<td>2015</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

**Sources** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; US Department of Commerce, Bureau of Economic Analysis; and National Bureau of Economic Research Inc.
Value-Based Payment Framework

Fee for Service
- Traditional FFS
- Infrastructure incentives
- Care Management

Adjusted Fee for Service
- Pay for Reporting
- Pay for Performance
- Pay/Penalty for Performance

APM with Fee for Service
- Cost of care shared savings
- Cost of care shared risk
- Bundled payments

Population based APM
- Condition specific
- Primary Care
- Comprehensive Care
Total Accountable Care Organizations

<table>
<thead>
<tr>
<th>Year</th>
<th>Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>64</td>
</tr>
<tr>
<td>2012</td>
<td>84</td>
</tr>
<tr>
<td>2013</td>
<td>336</td>
</tr>
<tr>
<td>2014</td>
<td>490</td>
</tr>
<tr>
<td>2015</td>
<td>744</td>
</tr>
<tr>
<td>2016</td>
<td>900</td>
</tr>
</tbody>
</table>
Payers Participating in Accountable Care

- 2011: 44
- 2012: 51
- 2013: 97
- 2014: 109
- 2015: 132
What are the Actions of CMS Telling Us

- Incentivize providers to join large groups
- Bend the cost curve
- Incentivize and measure ‘quality’
- Enhance provider transparency
- Incentivize providers to joint Quality Payment Programs (QPP)
- MACRA will impact all providers
Take Away Ideas

• ACOs are here to stay and are spreading to commercial payers
• Volume to value transition will continue
MACRA

Medicare Access and CHIP Reauthorization Act of 2015

Quality Payment Program

- Advanced Alternative Payment Model
- Merit-Based Incentive Payment System
MACRA Eligible Clinicians

Years 1 and 2

Physicians, (MD/DO, DPM, OD, DC, DMD/DDS) PA, APRN, CRNA

Years 3+

Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians/nutritional professionals

A physician or non-physician practitioner practicing in an RHC or FQHC still is subject to MACRA
Most providers will be subject to MIPS

MIPS

Non-Advanced APM

QP in Advanced APM
Who is exempt from MIPS?

• Newly enrolled providers
• Low volume provider (<100 beneficiaries or < $30k)
• 2018 participants in a qualified alternative payment model if they:
  > 25% of MC payments through an AAPM -or-
  > 20% of MC patients are attributed to AAPM
MIPS Payment Adjustment

- 2019: 4%
- 2020: 5%
- 2021: 7%
- 2022: 9%

- MAX NEGATIVE ADJUSTMENT
- PERFORMANCE THRESHOLD
- MAX POSITIVE ADJUSTMENT
MIPS payment adjustment after inflation and fee schedule adjustments
### Projected Impact of MIPS by Practice Size

**Table 64: MIPS Proposed Rule Estimated Impact**

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Percentage Eligible Clinicians with Negative Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>87%</td>
</tr>
<tr>
<td>2-9</td>
<td>69.9%</td>
</tr>
<tr>
<td>10-24</td>
<td>59.4%</td>
</tr>
<tr>
<td>25-99</td>
<td>44.9%</td>
</tr>
<tr>
<td>100 or more</td>
<td>18.3%</td>
</tr>
<tr>
<td>Over all</td>
<td>45.5%</td>
</tr>
</tbody>
</table>
ADVANCED APM

• More than nominal, bi-directional risk
• Quality reporting structure similar to MIPS or medical home model
• Certified EHR
• Provider must be ‘qualified’

5% BONUS IN 2019 UNTIL 2024
MIPS EXEMPT
APM Categories

• **Pay For Performance**: Fee for Service +/- adjustment based on benchmark variance
  - PQRS
  - Hospital Value-Based Purchasing Program
  - Hospital-Acquired Conduction Reduction Program

• **Shared Saving**: Fee for service plus % of savings
  - MSSP, Next Generation ACO

• **Episodic Payments**: Bundled payments

• **Global Budgets**: Comprehensive ESRD, Direct Primary Care
Advanced Alternative Payment Models

Definite

• Medicare Shared Savings Programs – Tract 1+, 2, and 3
• Next Generation
• Comprehensive ESRD
• Comprehensive Primary Care Plus
• Oncology Care

In Development

• Comprehensive Care for Joint Replacement
• Episodic Payment Model
• Cardiac Rehabilitation Incentive Payment Model
• Medicare Diabetes Prevention Program
• Voluntary Bundled Payment Program
• Vermont Medicare ACO Initiative
Qualifying Provider Percentage of Payment Threshold

- Medicare
- Commercial
Provider Impact

• Choose between strategy to maximize MIPS or join an Advanced APM and be a qualified provider

• Consider:
  The increasing qualified provider threshold
  The adoption of value-based payment in the commercial market
  The cost of Health Information Technology
  Need for practice redesign
  Timing the APM: Balance downside risk of Advanced APM against the 5% bonus window
• Focus on coordination among providers
• Technology and process will drive provider consolidation
  Mergers and large system
  Virtual groups
Factors to consider when choosing an APM

- Certified EHR
- Necessary partnerships for success
- Organizational structure
- Medicare volume
- Availability
- Prospective vs. retrospective assignment of beneficiaries
- Responsibility for total cost of care vs. specific episodes of care
2017 MIPS ‘Pick Your Pace’

• If clinician reports performance data by end of Q1 2018: Neutral or positive adjustment
• If clinician fails to report -4% adjustment
2017 Data Reporting Options

- Don’t participate: -4%
- Test – Submit something: 0%
- Partial Submission: 90-day data submission of two required measures
  Small +% possible
- Full year data submission of all required measures
  Possible moderated +%
Performance-to-Adjustment Cycle

- **Perform**
  - CY 2017
  - *Performance Measurement Period*
  - *You may elect 90 or 365 continuous performance period*

- **Submit**
  - March 31, 2018
  - *Deadline to report on required measures*

- **Feedback**
  - Q3 2018
  - *CMS gives feedback on performance*

- **Adjust**
  - CY 2019
  - *Positive or negative MPFS payment adjustments based on 2017 Final Score*
Take Away Ideas

• CMS is allowing providers to ease into pay for value
• Report something in 2017 – Pick your pace and avoid a 4% reduction
• The Medicare base fee schedule is frozen for several years and will not keep up with historic inflation
• CMS is encouraging the transition to alternative payment models, including commercial payer
• To be successful, providers must transition to risk contracts
Data Options

- **Quality Measure**
  - Replaces PQRS

- **Clinical Improvement Activity**

- **Advancing Care Information**
  - Replaces meaningful use
New Opportunities for Revenue

• MIPS, Alternative Payment Models
• Commercial ACO
• Medicaid ACO
• Medicare Well Visits
• Care Gap Closures
• Transitional Care Management (TCM)
• Chronic Care Management (CCM)
• Better Utilization of Services
Care Coordination Model

LOCAL CARE COORDINATION

MWV

CCM

TCM

UTILIZATION REDUCTION

CARE GAP CLOSURE
Modeling Assumptions

• **MY PRACTICE DATA**
  - An adoption rate of: **Year One** - 25%, **Year Two** - 35%, **Year Three** - 50%
  - Roll out # providers/year: **Year 1** - 48; **Year 2** - 100; **Year 3** - 148
  - 66% of Medicare patients qualify for chronic care management
  - 78 annual admissions, with 66% qualifying for transitional care
  - 20% Medicare patients have gap closures at $800/month
### Annual Revenue Projections

<table>
<thead>
<tr>
<th></th>
<th>YEAR ONE</th>
<th>YEAR TWO</th>
<th>YEAR THREE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MWV</strong></td>
<td>$787,644</td>
<td>$2,297,295</td>
<td>$4,660,227</td>
</tr>
<tr>
<td><strong>UTILIZATION REDUCTION DOLLARS</strong></td>
<td>$316,000</td>
<td>$474,000</td>
<td>$790,000</td>
</tr>
<tr>
<td><strong>UR = $15.7 REDUCTION ASSUMPTION</strong></td>
<td>2%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>CCM</strong></td>
<td>$1,831,358</td>
<td>$5,341,460</td>
<td>$11,445,985</td>
</tr>
<tr>
<td><strong>TCM</strong></td>
<td>$680,309</td>
<td>$703,042</td>
<td>$725,776</td>
</tr>
<tr>
<td><strong>CARE GAP CLOSURE</strong></td>
<td>$881,280</td>
<td>$2,570,400</td>
<td>$5,214,240</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>$4,496,491</td>
<td>$11,386,197</td>
<td>$22,836,227</td>
</tr>
</tbody>
</table>
### Impact of Volume to Value Transition

<table>
<thead>
<tr>
<th></th>
<th>YEAR #1 2% REDUCTION IN VOLUME</th>
<th>YEAR #2 3% REDUCTION IN VOLUME</th>
<th>YEAR #3 5% REDUCTION IN VOLUME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE LOST FROM VOLUME REDUCTION</strong></td>
<td>$1,495,810</td>
<td>$2,243,715</td>
<td>$3,739,525</td>
</tr>
<tr>
<td><strong>TOTAL REVENUE GAIN FROM VALUE</strong></td>
<td>$4,496,590</td>
<td>$11,386,197</td>
<td>$22,836,227</td>
</tr>
<tr>
<td><strong>TOTAL NET REVENUE GAIN</strong></td>
<td>$3,000,780</td>
<td>$9,142,482</td>
<td>$19,096,702</td>
</tr>
<tr>
<td><strong>ROI</strong></td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td><strong>MARKET SHARE GAIN</strong></td>
<td>GAIN</td>
<td>GAIN</td>
<td>GAIN</td>
</tr>
<tr>
<td><strong>QUALITY OF CARE IMPROVED</strong></td>
<td>IMPROVED</td>
<td>IMPROVED</td>
<td>IMPROVED</td>
</tr>
<tr>
<td><strong>POSITIONING FOR COMMERCIAL</strong></td>
<td>POSITIVE</td>
<td>POSITIVE</td>
<td>POSITIVE</td>
</tr>
</tbody>
</table>
Take Away Ideas

• To maintain or grow your revenue, you need to implement every new opportunity

• Results of a full care coordination program/ROI
  • The reduced revenue from lost volume is replaced 6:1 by value-driven revenue at a 5% reduction in volume
Questions