



## Life After Fee-for-Service, Part I: How Payment Reform Will Impact Physician Practices


Greater Kansas City Medical Managers Association  
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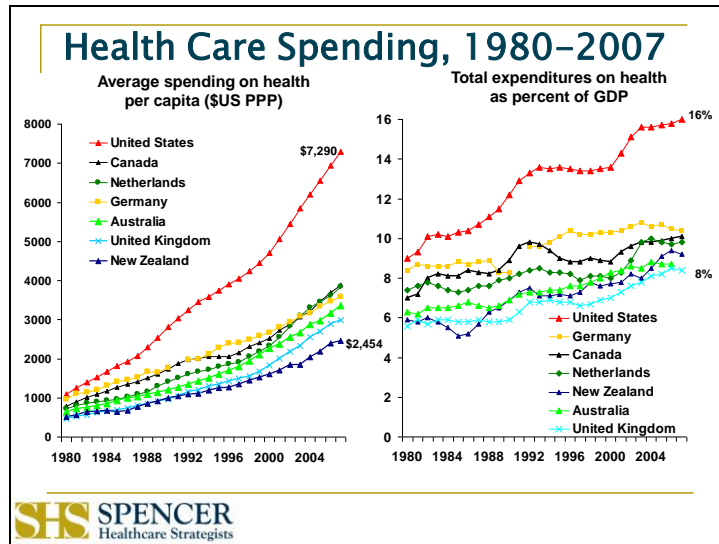
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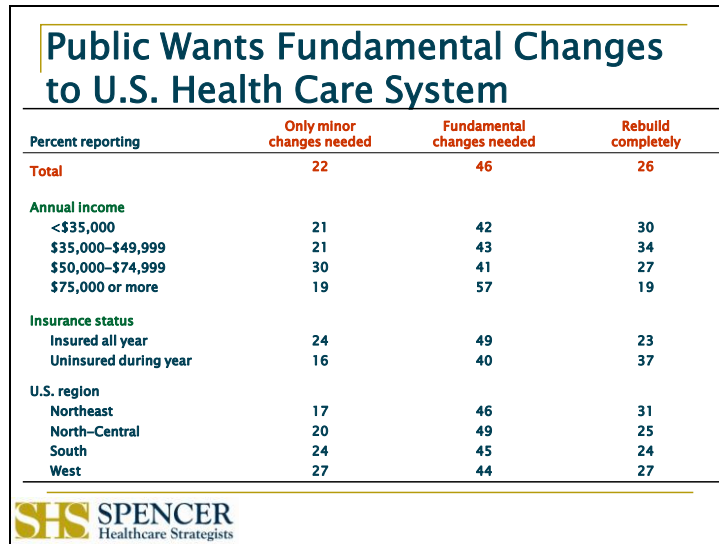
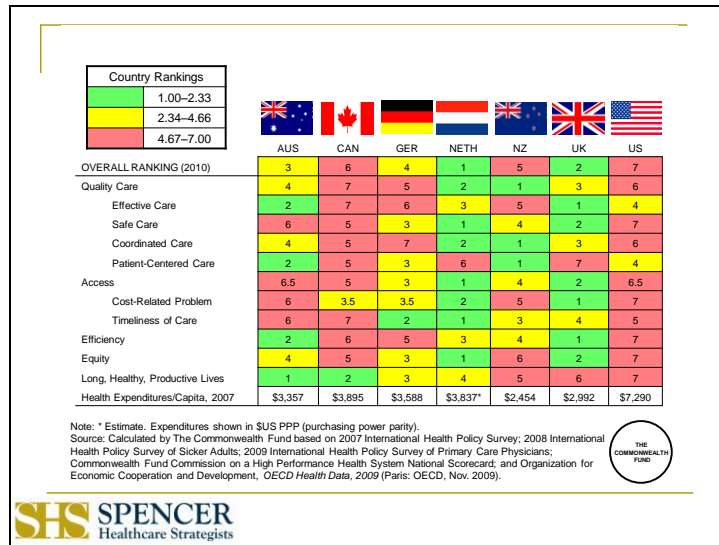
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## It's All About Money

- **Medicare annual spend**
  - 2010: \$525 billion
  - 2020: \$922 billion
- **Medicaid annual spend**
  - 2010: \$401 billion (\$271 billion federal/\$130 billion state)
  - 2020: \$908 billion (\$561 billion federal/\$347 billion state)
- **Total annual spend**
  - 2010: \$2.64 trillion; 17.6% of GDP; \$8,327 per capita
  - 2020: \$4.64 trillion; 19.8 % of GDP; \$13,708 per capita








- ## Possible Solutions
- Revamp current programs
    - Revise eligibility rules
    - Impose means testing
    - Change benefit structure
    - Slash provider payments
  - Replace with new programs
    - Premium support
    - Single payer system
  - Buy a better product
    - Create incentives for payment and delivery system reform
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## How We Got Into This Mess

- Perverse incentives created by fee-for-service reimbursement
  - Sick care v. health care
  - We don't know what works, so we do it all
- Over-regulation in a futile attempt to prevent overutilization and control costs
- Health care as piece work
- Data blind


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## Identifying Cost Drivers

- Increasing chronic disease rates
- Limited use of HIT/HIE
- Lack of standardization/undefined standards of care
- Defensive medicine
- Lack of care coordination
- Limited funding for preventive health services
- Shortage of primary care providers
- HACs and readmissions
- Costly drugs and devices
- High-dollar end of life care
- Non-compliant patients
- Regulatory burden


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## Key Transitions


- Paper records → *HIT/HIE*
- Defensive medicine → *Evidence-based medicine*
- Lack of data → *Transparency*
- Provider-centered → *Patient-centered*
- Provider silos → *Integrated provider networks*
- Blame someone else → *Accountability*

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## Reform in the 2000s

- Medicare
  - Quality reporting programs
  - Non-payment for HACs
  - Demonstration programs
- State Medicaid initiatives
- Private sector
  - LeapFrog Group, Bridges to Excellence
  - IHI's 5 Million Lives program
  - Patient-Centered Medical Home model
  - High performance networks: Geisinger, Mayo, Cleveland Clinic, etc.
  - PROMETHEUS payment

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## Reform in the 2010s

1. Link payment to quality
2. Promote clinical integration (Part II)
3. Focus on wellness and prevention (Part II)

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## Link Payment to Quality

- Hospital value-based purchasing
- Physician quality incentives
- Physician value-based purchasing

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## Hospital Value-Based Purchasing

- Penalties for high readmission rates
  - FY12–14 for AMI, heart failure, and pneumonia; expand list in FY15
  - Reduce overall inpatient payment by 1–3 percent
- Rewards and penalties based on quality measures and patient satisfaction scores
  - FY13, but based on current performance
- Penalties for HACs/Never Events
  - In FY15, top 25 percent in HACs will have payments reduced by 1 percent




## Physician Quality Incentives

- Physician Quality Reporting System
  - Submission of reports, not achievement of scores
  - Carrots followed by sticks
    - 0.5% bonus for 2012–2014
    - 1.5% *penalty* for 2015
    - 2.0% **penalty** for 2016 and thereafter
- Maintenance of Certification Program
  - Eligible if submit data through PQRS
  - Participate in CMS–approved MOC program + complete practice assessment
  - 0.5% bonus to MFPS payments thru 2014
  - [www.cms.gov/PQRS/](http://www.cms.gov/PQRS/)




## Physician Quality Incentives

- Meaningful Use Incentives/Penalties
  - Stage One objectives and clinical quality measures
  - 1% penalty in 2015 if not MU in 2014; 2% in 2016; 3% in 2017; 4% in 2018 or 2019
- eRx Incentive Program
  - 1.0% bonus in 2011 (unless receive EHR bonus)
  - 1.0% penalty in 2012 unless used eRx 10x by 06/30/11
  - 1.5% penalty in 2013 unless used eRx 25x by 12/31/11




## Physician Value-Based Purchasing

- Physician Feedback Program
  - Individual reports on resource use and quality of care as compared to peer group
  - KS and MO physicians to receive in early 2012
- Physician value-based payment modifier
  - Phased in between 2015 and 2017
  - 2013 performance determines 2015 modifier
  - Budget neutral
  - $wRVU \times \text{conversion factor} \times VBPM$ 
    - Positive number = paid more
    - Negative number = paid less



## What About the SGR?

- Mandated cut delayed until March 1
- Repeal has \$300/\$375 billion price tag
- Fast forward physician VBP?





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