Value-Based Payments – MACRA & Bundled Payments for Urology Groups

Presented by: Alec Koo, M.D., Chad Beste & Dana Jacoby

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Dr. Alec Koo has been practicing medicine for over 28 years. He received his B.S. and M.D. from UCLA. He completed his residency in Surgery/Urology at UCLA in 1992. Dr. Koo is a Diplomat of the American Board of Urology, Fellow of American College of Surgeons, a Regents Scholar of UCLA School of Medicine, and a member of UCLA’s Honors Colleges. He is a current member of AUA, CMA, LACMA, SLS, and AACU.

Dr. Koo is well known for his expertise in group management as well as value-based care and health economics outcomes. He is respected for his knowledge in areas including data integration and analytics in medicine, medical group dynamics, and provider/pharmaceutical relationships.

Dr. Koo has been the architect and the Managing Partner of Skyline Urology in Southern California since its inception in 2008. Under his leadership, Skyline Urology has grown to be the largest urology group in western United States. He also serves on the Board of Directors of the Large Urology Group Practice Association (LUGPA). Additionally, Dr. Koo participates in other projects to advance the practice of specialty medicine including defining episode-of-care and bundled payment in various disease states.
Chad J. Beste is a Partner within the consulting division of PBC Advisors, LLC, a provider of management consulting and accounting services to healthcare professionals and related healthcare concerns. Chad has been with PBC for 16 years, all of which have been in his current role. Chad is an astute veteran of the healthcare industry and brings over 30 years of experience to PBC.

Chad and his team provide a wide range of management consulting services to the healthcare community. Several examples include the merger and ongoing management of multiple previously practices into larger organizations such as Orthopaedics, Urology, Obstetrics/gynecology, Gastroenterology, Dermatology, primary care and multi specialty organizations. Also, Chad has been instrumental in assisting client organizations prepare and succeed in value-based models including bundled payments, PCMH related models and ACO development. In addition, Chad has advised numerous hospitals on the development and implementation of their physician and alignment strategies.

Chad graduated with a Bachelor in Arts degree in Business Administration, Economics, and Psychology from Westminster College. Chad is a Certified Employee Benefits Specialist and a member of MGMA. He is a frequent speaker on healthcare-related issues and has also served on several organizations’ Board of Directors.
Dana Jacoby is the President/CEO of DJI Consulting. DJI Consulting conducts project management, client leadership forums, and market research for industry, community-based medical groups, hospitals and health systems, and associations in the United States, Canada, Europe, and Asia.

Ms. Jacoby consults with physicians, with a specific focus in urology and oncology, in the areas of strategic planning, alternative payment models, financial management, operational efficiencies, service line development, and process improvement.

Prior to launching DJI Consulting, Ms. Jacoby was involved in change management, operations, equipment sales, and/or product positioning at 30 of the 35 major medical markets across the United States. Additionally, she was responsible for business planning with management, medical staff, and physicians at 17 top-tier hospitals, as ranked by U.S. News and World Report.

Ms. Jacoby graduated from Louisiana State University, holds a Master of Management from Tulane University, and a Master of Health Systems from the University of Medicine and Dentistry. She is a Wharton Fellow Inductee from Wharton University. She serves as a Board Member and Business Advisor for multiple civic and healthcare corporations across the country.
Understanding MACRA
MACRA
(Medicare Access & CHIP Reauthorization ACT)

- Passed to replace SGR
- Proposed rules released April 27, 2016
- Final rule published October 14
- Applies to Part B

- Combines existent and new reporting systems into
- QPP (Quality Payment Program) with 2 tracks
  - MIPS (Merit-based Incentive Payment System)
  - APM (Alternative Payment Models)
MIPS is a Competition

- MIPS is designed by law to be budget-neutral.
  - There will be losers and there will be winners.
- We will not know the benchmarks for the MIPS components before Q3 2017.
  - We must aim for the highest possible score (i.e., 100%)
MIPS

- Combines scores from 4 components
- To give a total Composite Performance Score (CPS)
- All MIPS physicians “graded on a curve”

- Based on score providers will see anywhere from -4 to +4% adjustment to their Medicare reimbursement in year 1, to +/- 9% in year 4.
- With a potential 3X multiplier for exceptional performances (+27%!!!!!)
To Allow Graduated Transition, Three Options Will Be Available In 2017:

**OPTION 1**
Report “some” data within the performance categories to avoid a negative payment adjustment.

**OPTION 2**
Submit data for only part of the year to potentially qualify for a “small” positive payment adjustment.

**OPTION 3**
Submit data for the full calendar year to potentially qualify for “modest” positive payment adjustment.
MIPS Component - Quality

- Replace PQRS
- 60% of CPS in year one (2017)

- 6 measures plus one cross-cutting measure
- Groups of 25 providers or more would only need to report on the first 248 patients
- Whereas smaller groups will need to report 80-90% of all Medicare patients
MIPS Component - ACI

Advancing Care Information

- Replaces MU
- 25% of CPS in year one
- One option IS MU 3
- Alternate option a bit easier
- Some EMRs not capable of reporting in 2017
  - Yours?
- Some of the measures
  - Security Risk Analysis
  - HIE patient record exchange
MIPS Component - CPIA

Clinical Practice Improvement Activities

- 15% of total CPS in year 1
- Select from 90+ activities
- Participation in a MIPS APM gives half of maximum score
- Examples of “high points” activities:
  - Expanded practice access (evening hours etc.)
  - Equity in care (timely Medicaid or Medi/Medi visits)
  - Use of a Qualified Clinical Data Registry (QCDR)
MIPS Component - Resource Use

Cost

- Replaces cost component of value modifier (VM)
- Not measured in year 1 increasing to 30% in year 3

- Based on Medicare Claims data
  - So no reporting necessary/possible
- Uses 40 episode-specific measures
- Proposed episode-based Urology measures
  - Radical Prostatectomy
  - TURP
- Commercial Insurers likely to join in on this program
- There is a great deal of strategy/planning recommended
Resource Use - Why It’s So Important

- CMS/Payors no longer want to pay FFS – they want to base payments on VALUE
- One definition of Value = Costs/Quality
- Quality is hard to define
- Costs are easy for the payors to calculate BUT – we as providers never see/understand costs other than our own.

- Increasingly, payors will utilize “Episodes of Care” and other total cost measures (while de-emphasising costs per unit of care)
- Regardless of weighting – Costs are the #1 issue
## Resource Use
### Comparison to Value Modifier Program

<table>
<thead>
<tr>
<th>Value Modifier</th>
<th>Resource Use</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total per capita costs for Attributed beneficiaries</td>
<td>Same</td>
<td>Silly measure for specialty practices due to patient attribution rules</td>
</tr>
<tr>
<td>Medicare spending per beneficiary</td>
<td>Same</td>
<td>Hospitalized patients only. Has some relevance</td>
</tr>
<tr>
<td>Per capita costs for the 4 condition specific groups (e.g. COPD, heart failure, diabetes and coronary heart disease)</td>
<td>Eliminates</td>
<td>Positive - illustrates CMS will make improvements over time</td>
</tr>
<tr>
<td>N / A</td>
<td>Proposed Episodes-based measures</td>
<td>In effect, a bundle - Very important</td>
</tr>
</tbody>
</table>
### Example Per Capita Costs

**For Attributed Medicare Beneficiaries**

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Cost Measure</th>
<th>Your TIN’s Eligible Cases or Episodes</th>
<th>Your TIN’s Per Capita or Per Episodes Costs</th>
<th>Benchmark</th>
<th>Reference Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Costs for all Attributed Beneficiaries</td>
<td>Per Capita Costs for all Attributed Beneficiaries</td>
<td>1,300</td>
<td>$8,000</td>
<td>$12,214</td>
<td>$8,120 – $16,308</td>
</tr>
<tr>
<td></td>
<td>Medicare Spending per Beneficiary</td>
<td>500</td>
<td>$19,500</td>
<td>$20,298</td>
<td>$19,056 – $21,541</td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td>Diabetes</td>
<td>100</td>
<td>$10,000</td>
<td>$18,084</td>
<td>$11,747 – $24,420</td>
</tr>
<tr>
<td></td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>30</td>
<td>$19,800</td>
<td>$29,382</td>
<td>$18,845 – $39,920</td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Disease (CAD)</td>
<td>225</td>
<td>$13,300</td>
<td>$21,592</td>
<td>$14,007 – $29,178</td>
</tr>
<tr>
<td></td>
<td>Heart Failure</td>
<td>75</td>
<td>$19,200</td>
<td>$33,411</td>
<td>$21,749 – $45,074</td>
</tr>
</tbody>
</table>

- **Per Capita costs**
- “Attributed” beneficiary is where your practice has provided the “preponderance” of primary care services - there is NOT actionable information and suspect CMS will eliminate over time (and the commercial payors will ignore anyways)
## Medicare Spending Per Beneficiary
Mean Per Episode Costs among TINs with this Measure by Service Category

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Amount by which your TIN’s Costs Were Higher/(Lower) than the Benchmark:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Per Episode Costs</td>
<td>$330</td>
</tr>
<tr>
<td>Evaluation &amp; Management Services*</td>
<td>$30</td>
</tr>
<tr>
<td>Major Procedures And Anesthesia</td>
<td>$70</td>
</tr>
<tr>
<td>Ambulatory/Minor Procedures</td>
<td>$280</td>
</tr>
<tr>
<td>Outpatient Physical, Occupational Or Speech And Language Pathology Therapy</td>
<td>($15)</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>($60)</td>
</tr>
<tr>
<td>Hospital Inpatient Services</td>
<td>$2,218</td>
</tr>
<tr>
<td>Emergency Services Not Included In Hospital Admission</td>
<td>($60)</td>
</tr>
<tr>
<td>Post-acute Services</td>
<td>($1,700)</td>
</tr>
<tr>
<td>Hospice</td>
<td>($100)</td>
</tr>
<tr>
<td>All Other Services**</td>
<td>($400)</td>
</tr>
</tbody>
</table>

- Medicare spending per beneficiary - based on admissions
- While not directly actionable, this is comparative data
## Potential Value Opportunities

<table>
<thead>
<tr>
<th>Description</th>
<th>Example</th>
<th>Level of Control</th>
<th>Strategy</th>
<th>Profit Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled payment program where Provider/System &quot;owns&quot; 100% of services under the Bundle</td>
<td>GI practice with &quot;owned&quot; Endoscopy Center</td>
<td>Maximum</td>
<td>Lower prices will translate into increased market share</td>
<td>Nominal - only via increased market share</td>
</tr>
<tr>
<td>Bundled payment program for Joint replacement</td>
<td>Orthopaedic practice under CMS BPCI program</td>
<td>Moderate</td>
<td>Lower post-acute expenses</td>
<td>Significant</td>
</tr>
<tr>
<td>Specialty-based &quot;Patient Centered Medical Home&quot;</td>
<td>Crohn's Disease Management Program</td>
<td>Moderate</td>
<td>Focused care managers for sickest patients &amp; lower cost sites of care</td>
<td>Moderate</td>
</tr>
<tr>
<td>Episodes of Care programs</td>
<td>CMS QRUR reports - e.g. &quot;Resource&quot; via new MIPS program</td>
<td>Modest</td>
<td>Use lower cost sites of care including ASCs, free-standing facilities, etc.</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
More on Bundled Payments and/or Episodes of Care

- Access to complete cost information is critical
- Volumes matter
- General framework for defining the Bundle
  - Pre-procedure
  - Procedure
  - Post-procedure
- Inclusions / Exclusions are critical
  - Identified/managed by ICD-10
  - This needs to be tightly controlled

- Reinsurance / Risk mitigation
  - Have found that reinsurance products are too expensive
  - Defining the Bundle is the 1st step
  - Outliers - Risk Corridors – One to Two standard deviations up/down from the mean seem most appropriate
Bundled Payments
Required Capabilities

- Data and analytics - cost and utilization
- Collaboration with physicians and other providers
  - Contracting
  - Defining roles/expectations
- Redesign care delivery with the end in mind;
  - Enhanced coordination of care
  - Patient engagement
- Infrastructure & management
- Reporting results
- Incentives
  - Effective communications
    - Internally
    - External providers
Bundled Payments
Generalized Approaches

- Medicare bundles - Generally, it’s about managing utilization and transitions of care
- Commercial bundles - Generally, it’s about saving on unit prices (facility fees)
- Case Rates (and/or packaged pricing) - a form of bundled payment
  - Saving on Unit prices because group can negotiate a lower costs (e.g. hospitals and/or other facility fees, anesthesiology, other professional services);
  - Savings on Unit prices because group can transition to lower cost settings (e.g. transitioning care that used to be performed in hospitals to ASCs)
- Accept lower overall reimbursements in return for hopefully more volume.
- Reference-based pricing
Bundled Payment
Joint replacement case study

- Received CMS data - cost variation is all in the post-acute world (SNFs, Inpatient Rehab & home health
- Invested in technology to facilitate coordination of care across care settings;
- Focused on rehab - 80% of costs
- Hired nurse care navigators - staffing model 1 nurse/900 patients

- Invested over $500,000 in costs before any results were known (reconciled data from CMS - 9 months after the end of a quarter
- Board was supportive but this was expensive to build
- Results have been positive
Joint Replacement Bundle
Utilization summary & cost savings

Percentage of Change From Baseline to BPCI Program

- Hospital Readmits: -19%
- SNF ALOS: -21%
- Inpatient Rehab % Initiated: -50%
- Home Health % Initiated: 20%
- SNF % Initiated: -3%

Overall Saving: $1,646/patient

- Reducing expenses outside of your practice is significantly more profitable
- Illustrates that WHERE patients receive care significantly impacts Costs of care (and not the quality)
Specialty-based PCMH Example Crohns Disease

- **GI physician overview:**
  - More than 50% of their income is related to Endoscopy procedures;
  - To the payors, Crohns Disease/other IBD diseases represents more than 50% of the total spend on GI related conditions

- **Claims data indicated**
  - Overall costs are increasing by > 13% per annum;
  - Primary drivers of costs are related to hospitalization and infusion costs

- **Program summary**
  - “Ping” patients monthly using technology and simple validated questions on disease state (“Patient engagement tools”)
  - Depending on answers a range of congrats to scheduling visits
  - Implemented clinical decision support tools into practice EMR
  - Move as many services to the office as possible (e.g. Infusions and lab services)
Costs of Care - Location Matters

- Reviewed data on multiple specialties related to sites of care for procedures;
- Urology physicians utilize hospitals for outpatient services far more than other specialties
  - One practice --> 80% of procedures are performed at outpatient hospitals and not ASCs;
  - CMS pays hospitals about 50% more for the same procedures as ASCs;
  - Commercial payors pay hospitals about 100% more for the same procedures
- Lab/Imaging services - Hospitals can be paid 2x - 4x more than your offices/Quest/free-standing facilities etc...
Implications for LUGPA Members

• LUGPA members are well positioned for success;
  • Significant ancillary/related services exist in most practices;
  • Need to continue to move services to your practices where you can provide high quality/lower costs of care – Access to/investing in ASCs are now important to your future;

• Smaller practices need to join you or the hospital – not a bright future;

• Use LUGPA as the launching pad for the development of select Episodes of Care – either “bundles” or Urology specific PCMH services
  • Work with CMS to qualify such programs as an Advanced APM
  • Engage commercial carriers as well –
  • Local plans are easier than national plans to develop new programs

• Most important takeaways from today
  • Public policy – physicians are accountable for BOTH the costs and quality of care;
  • WHERE you provide care is directly correlated to the total costs of care
APM

• CMS encourages physician participation in APMs
• Limited but expanding choices
• “Advanced” APM offered in year 1, as applicable to GU
  • ACO MSSP Track 2 or 3
  • Next generation ACO
  • Medical Home Specialty Recognition
  • OCM double-sided risk
• If group were in an APM and also qualify by volume
  • Has 20% of Medicare patients through APM
  • Or 25% of Medicare payments through APM
  • Then qualifies as an “Advanced APM”
  • Receives 5% lump sum bonus and need not report MIPS
MIPS APM

- Physicians who participate in APM but do not qualify for Advanced APM

- Have advantages within MIPS
  - CPIA: MIPS APM counts as 50% of total score
  - Cost: Not evaluated in the resource-use category
  - Quality: If in ACO, then quality reporting is done by ACO
    - So how good is the quality reporting of your ACO?
Oncology Care Model (OCM)

Episode of Care Model

• Aim to reduce cost over a 6 months episode
  • Episodes starts with administration of any “chemo”
    • Includes BCG, LHRH-A, casodex
  • Pays $160 pmpm for care coordination
    • CMS subsidizes care coordination structure!
  • Utilize fund to create infrastructure
    • Improve quality of care
    • Reduce cost
      • Improved end-of-life care
      • Reduce ER visits, ICU admissions
Why is OCM important?

- One of very few models where care is SPECIALTY-CENTRIC
  - Most APMs are primary care - centric
  - Care coordination conducted by specialists
  - ONLY CMMI/CMS model where urology is at the table
    - To demonstrate urologists can be the quarterback of patient management
  - Manage care to
    - Improve quality
    - Reduce Cost
    - Create Value
Too Late for OCM?  
Try CCM!

- Other case where CMS pays for care coordination
  - CCM (chronic care management)
  - For patients with 2 or more chronic conditions
    - Includes BPH, cancer, HTN, DM, etc.

- Fee monthly for NON face-to-face service, 20 min
  - CPT 99490. $42.60 adjusted for region
  - Only one provider can bill for given month
  - Can be provided by physician’s staff (include CMA)
  - Use of certified HER
  - 24/7 access
CCM Implementation Items

- Patient identification
  - BPH and cancer are two of the chronic disease diagnoses that qualify

- Patient consent
  - Establishes provider’s ability to bill

- Create electronic Comprehensive Care Plan
  - Must be able to e-transmit care plan to other care providers in a HIPPA-compliant fashion (not fax).

- Physician/covering have 24/7 access to Care Plan

- Patient has 24/7 access to provider/care management

- Clinical staff document 20 minutes of time spent rendering care
What is Value, really?

• Value (in plain terms):
  • Paying a fair price for a good product

• What’s a good product:
  • Predictable and good outcome

• Concept of Integrated Practice Unit (IPU)
  • Michael Porter, who introduced “value” in healthcare, championed IPU
  • What’s an IPU
    • Virginia Mason Spine Clinic
Paradigm of Care: Examples for Care of Back Pain

“Traditional” Care
- Fragmented
- Delayed
- Inefficient

IPU Care
- Integrated
- Expedited
- Efficient
IPU in Urology

Kidney Stone Treatment Center

- A comparison of current fragmented care (case)
- vs an integrated efficient care center (proposed case)
- Clinic, CT, Ultrasound, ASC in an integrated unit
- Rapid diagnosis, treatment, and return to work
- Reduced ER/ICU admission risk/cost
- Reduced Productivity Loss
- Significant savings to self-insured employers
- Set-up for case-rate pricing
- Yes. It can be called a “bundle”
IPU in Urology

- Robotic Surgery Center of Excellence
- Case Rate (Bundle pricing)
- Quality Metrics
  - LOS
  - Average Blood Loss
- Hospital partner or owned-ASC
- Risk corridor
Physician Compensation:
Streamlined Pathway-driven Care

- The worst type of value-based payment is **CAPITATION**
  - Fixed payment based on pmpm
    - Set amount each month, regardless of amount of services provided
  - Loss of FFS incentive
    - Creates perverse incentive to reduce/deny care

- How to compensate physician to maintain physician satisfaction and ensure quality of care?
  - Pathways to ensure quality of care
  - FFS to maintain physician incentive
How to Thrive in Capitation

- **70%** of care (traditionally rendered by MD) rendered by
  - Physicians-designed system
  - Pathway-driven
  - Leverage software and lower level care providers
  - At 50% of total revenue

- **30%** of care
  - By MDs
  - Paid FFS
  - Surgeries, and higher-complexity decision making
  - 50% of revenue goes to physician compensation FFS
Capitation Pathway Example

- Hematuria
  - Screening criteria (risk stratification)
    - Screen out UTIs
    - Screen out insignificant micro-hematuria
      - e.g. “real” micro exam showing > ? Rbc/hpf
    - Treat UTIs with pathway/APPs
  
- Identify “real” high-risk hematuria
  - Elevate level of care
    - Expedite MD visit
    - Pre-test with CT/U and scheduled for cysto
    - MD compensated FFS for cysto/surgery
What is your practice’s MACRA preparedness?

1. Will likely qualify as Advanced APM
2. Well prepared and ready to do
3. Fairly well along in evaluating preparedness
4. Starting to evaluate practice’s preparedness
5. Has not started. Hoping implementation will be delayed.
What is your understanding of Advanced APM?

1. Not sure what an APM is
2. Know APM, but not sure what makes it “advanced”
3. Know it. Understand it
4. Am part of one
What type of tools and resources does your practice need to get ready for MACRA?

① Physician training
② Staff training
③ Software purchase/upgrade
④ IT support
⑤ Set up care coordination
Audience Response

How will MACRA change your group?

① Not at all
② I’m concerned about the independence of our group
③ We are actively seeking to merge into/with a larger entity
④ We will have tougher payer negotiation coming up
⑤ Partners in my group are not on the same page with respect to necessary changes
If merging into a larger entity is an option your group is considering, is it:

1. A multi-specialty group
2. A larger urology group
3. A hospital system
4. Purchase by a MSO
What is your practice’s current awareness of CCM?

1. Have heard of it
2. No plan of using it
3. Looking into implementation
4. Started implementation
5. Well into implementation
Audience Response

Does your practice have plans of changing physician compensation plan to better meet needs of value-based payment?

① No
② Yes
③ Having discussions within group
Thank you