Shifting Reimbursement Paradigms

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Course Objectives

• Discuss major shifts to health care payments
• Examine alternatives to fee-for-service reimbursement

US Population Growth

Aging Population

• 51 million Medicare beneficiaries (2013)
• 75 million baby boomers (1946 to 1964)
  • In 2010, 13% of US population will be ≥65 y/o
  • In 2030, 20% of US population will be ≥65 y/o
• Longer life expectancy
• 32 million may be gaining health insurance

Sources: US Census Data, CMS enrollments

U.S. Healthcare Costs as a Percentage of GDP

Source: Centers for Medicare and Medicaid Services
### Demand: The Short Story
- The baby boom means more people will need eye care
- Eye disease will increase
  - AMD
  - Cataract
  - Glaucoma
- ObamaCare increases number of insured
  - ≥30 million
- New technology creates more eye care
  - Lucentis, Avastin, Eylea, Jetrea
  - OCT
  - Ophthalmic lasers

### Physician Supply Projections
- Growth and aging of US population will cause a surge in demand for physician services
- Requirements for physicians will increase 21% – 22% from 2005 to 2020
- Requirements for ophthalmologists will increase 28% from 2005 to 2020

Source: DHHS Physician Supply and Demand Projections to 2020
http://bhpr.hrsa.gov/healthworkforce/reports/physiciansupplydemand/

### Physician Shortage
- Approximately 6,500 more doctors retire each year than enter medical school
- Physicians are becoming older, decreasing their hours, and moving away from direct patient care
- Medical students prefer specialties with better lifestyle
- Younger physicians work fewer hours, see fewer patients
- More female physicians who work 18% fewer hours
- More temporary physicians

Source: www.nasrecruitment.com/MicroSites/Healthcare/Articles/featureH5b.html

### Characteristics of New Residents
- Half of new residents are women
- More are sub-specializing; fewer generalists
- Fewer pediatric and neuro specialists
- Lifestyle is an important consideration
  - Less time devoted to patient care

### Physician Assistant
- Potential capabilities
  - Assistant surgeon (e.g., oculoplastics)
  - Minor procedures (e.g., intravitreal injections)
  - Intravenous injections (e.g., IVFA)
  - Chronic disease management (e.g., diabetes)
  - Pre-op history and physical
  - Orthoptist
  - Weekend call, triage
- Generally not regarded as a competitive threat

### Ophthalmologist Trends

<table>
<thead>
<tr>
<th>Year</th>
<th>Ophthalmologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>18000</td>
</tr>
<tr>
<td>2000</td>
<td>21000</td>
</tr>
<tr>
<td>2005</td>
<td>24000</td>
</tr>
<tr>
<td>2010</td>
<td>26000</td>
</tr>
<tr>
<td>2015</td>
<td>28000</td>
</tr>
<tr>
<td>2020</td>
<td>30000</td>
</tr>
<tr>
<td>2025</td>
<td>32000</td>
</tr>
</tbody>
</table>

Sources: DHHS Physician Supply and Demand Projections to 2020
**Optometrists Trends**

![Graph showing optometrists trends from 1995 to 2035.](image)

**Manpower Shortage**

<table>
<thead>
<tr>
<th>Source</th>
<th>2014</th>
<th>2024</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Population (M)</td>
<td>319</td>
<td>342</td>
<td>23</td>
<td>7%</td>
</tr>
<tr>
<td>≥65 y/o (M)</td>
<td>45</td>
<td>65</td>
<td>20</td>
<td>44%</td>
</tr>
<tr>
<td>Ophthalmologist FTE</td>
<td>14,457</td>
<td>14,457</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>People per MD</td>
<td>22,081</td>
<td>23,656</td>
<td>1,575</td>
<td>7%</td>
</tr>
<tr>
<td>Elders per MD</td>
<td>3,091</td>
<td>4,495</td>
<td>1,404</td>
<td>45%</td>
</tr>
<tr>
<td>Optometrist FTE</td>
<td>30,810</td>
<td>33,180</td>
<td>2,370</td>
<td>8%</td>
</tr>
<tr>
<td>People per OD</td>
<td>10,361</td>
<td>10,307</td>
<td>54</td>
<td>0%</td>
</tr>
<tr>
<td>Elders per OD</td>
<td>1,451</td>
<td>1,958</td>
<td>507</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Sources:** White, AJ., Workforce Projections for Optometry, Abt Study, 2000

**Eye Care Spending Model**

<table>
<thead>
<tr>
<th>Source</th>
<th>2014</th>
<th>2024</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>US GDP (Trillion)</td>
<td>$15.8</td>
<td>$20.2</td>
<td>$4.4</td>
<td>28%</td>
</tr>
<tr>
<td>Health Care</td>
<td>17.9%</td>
<td>14.9%</td>
<td>-3.0%</td>
<td>-17%</td>
</tr>
<tr>
<td>Eye Care (2%)</td>
<td>$56.6</td>
<td>$60.3</td>
<td>$3.7</td>
<td>7%</td>
</tr>
<tr>
<td>Doctors (Billion)</td>
<td>$11.9</td>
<td>$13.3</td>
<td>$1.4</td>
<td>12%</td>
</tr>
<tr>
<td>Facilities (Billion)</td>
<td>$17.5</td>
<td>$19.3</td>
<td>$1.8</td>
<td>10%</td>
</tr>
<tr>
<td>Other (Billion)</td>
<td>$27.1</td>
<td>$27.7</td>
<td>$0.6</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Eye Care Encounters Model**

<table>
<thead>
<tr>
<th>Source</th>
<th>2014</th>
<th>2024</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥65 yrs</td>
<td>20</td>
<td>35</td>
<td>15</td>
<td>75%</td>
</tr>
<tr>
<td>18-64 (M)</td>
<td>69</td>
<td>86</td>
<td>17</td>
<td>25%</td>
</tr>
<tr>
<td>≤18</td>
<td>27</td>
<td>28</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>≥65 yrs</td>
<td>$150</td>
<td>$124</td>
<td>$(26)</td>
<td>-17%</td>
</tr>
<tr>
<td>18-64 Pro Fee</td>
<td>$91</td>
<td>$79</td>
<td>$(12)</td>
<td>-13%</td>
</tr>
<tr>
<td>≤18</td>
<td>$91</td>
<td>$79</td>
<td>$(12)</td>
<td>-13%</td>
</tr>
</tbody>
</table>

**Ophthalmologist’s Production ($000s)**

<table>
<thead>
<tr>
<th>Visits/day</th>
<th>30</th>
<th>35</th>
<th>45</th>
<th>55</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>$333</td>
<td>$390</td>
<td>$500</td>
<td>$610</td>
</tr>
<tr>
<td>Tests</td>
<td>$100</td>
<td>$120</td>
<td>$150</td>
<td>$190</td>
</tr>
<tr>
<td>Surgery</td>
<td>$150</td>
<td>$180</td>
<td>$230</td>
<td>$285</td>
</tr>
<tr>
<td>Total</td>
<td>$583</td>
<td>$690</td>
<td>$880</td>
<td>$1,085</td>
</tr>
</tbody>
</table>

**Key Factors of Eye Care Model**

- Continued US economic slow growth (2.5%)
- Health care contained (18% shrinks to 15% of GDP)
- Slower growth in health care spending (1% per year)
- FFS payments down 13-17%
- Growing demand (27% more encounters)
  - ≥65 y/o 75% increase in volume
  - 18-64 y/o 24%
  - ≤18 4%
- More insured lives also fuels demand
- Medicare/Medicaid expand 33%

**Sources:** Utilization projection, 50% Medicare, 15% NP, 6 wks off, 80% of 2013 MPFS
### Key Factors (continued)

- MD supply stagnates; OD supply expands
- PA and NP add very little to manpower
- More part time doctors (22% of total)
- Modest productivity increase (10%)
- Provider compensation increases slightly (8%)
  - Increasing efficiency and patient triage produce greater provider compensation

### Changes To Payment Methodology

- Bundling of services
- Payment for episodes of care
- Capitation
  - Full capitation
  - Contact capitation
- Value based purchasing
  - Lower cost and equal or better outcomes = value

### Consider Reading

- *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*
  - T. R. Reid
  - New York Times bestseller

### Restaurant Chain as an Example?

- *The New Yorker Magazine*
  - 8/13/12 – Big Med
- Author – Atul Gawande, MD
- Considers restaurant chain’s success in 3 areas
  1. Quality control
  2. Cost control
  3. Innovation
- Can health care learn from the model?

### Physicians Foundation Survey

- 60% of physicians would retire today if given opportunity
- 52% have already or plan to limit Medicare patients
- 25% closed practice to Medicaid patients
- Discontent
  - Pressures related to potential lawsuits
  - Medicare / Medicaid regulations
  - Reimbursement reductions
  - Uncertain future of health care

Payment Reform

• Recommendations by the National Commission on Physician Payment Reform
  • Eliminate over time stand-alone, fee-for-service
  • Shift to system based on quality and value
  • Repeal the SGR
  • Eliminate higher payments for facility-based services that could be performed in lower-cost settings

Source: Modern Healthcare 3/4/13

Payment Reform

• Recommendations by the Medicare Payment Advisory Commission
  • Reduce payments in HOPDs to equal rates for same service performed in doctor’s office

Source: Modern Healthcare 3/4/13

Alternative Models

• Shared Savings Programs
  • Value-Based Payment Modifier
  • Accountable Care Organizations
  • Capitation
  • Bundled Payments

Sources: AMA Practice Management Center

Shared Savings

• Two categories
  • Upside risk – cost of care is lower than budgeted costs, provider receives a percentage of the savings
  • Upside and downside risk – in addition to receiving a percentage of savings the provider also could be responsible for a percentage of shortfall if the cost of care is higher than budgeted costs

Sources: AMA Practice Management Center

Shared Savings

• Realize how payer calculates the quality and cost benchmarks against which you are judged
• Understand how payer intends to set your cost budget from year to year

Sources: AMA Practice Management Center

Value Based Modifier

• Mandated by Congress under the Affordable Care Act
• Aligned with PQRS
• Applies to practices with 100 or more providers in 2013
• Affects reimbursement in 2015
• Applicable to all practices in 2017
• ASCRS and Alliance of Specialty Medicine concerned about the impact on specialty practices

Sources: Part B News; amednews.com; ASCRS 12/14/12
Value Based Modifier

Successful PQRS reporting
• No reduction in reimbursements
  or
• Opportunity for bonus using quality-tiering approach

Unsuccessful PQRS reporting
• 1% reduction in reimbursements
  and
• Potential additional penalties from other programs

Sources: Part B News; amednews.com; ASCRS 1/2014

Quality Resource Use Reports

• QRUR is confidential feedback report for those billing fee-for-service
  • Clinical quality measures derived from claims
  • Individual physician performance on quality measures
  • Overall costs for patients whose care a physician directed, contributed to or influenced
  • Per capita costs for patients with diabetes, coronary artery disease, chronic obstructive pulmonary disease and heart failure
• Groups with > 25 eligible professionals may obtain report for 2012

Sources: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2012-QRUR.html

Accountable Care Organizations

• Network of doctors and hospitals
• Share responsibility for providing care
• Minimum of 5,000 Medicare beneficiaries for at least 3 years
• 360 ACOs have been established, serving over 5.3 million Americans with Medicare as of December 2013
• HHS estimates ACOs could save Medicare up to $940 million in the first four years.

Sources: Kaiser Health News; Arnold & Porter Advisory 11/12; http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html

Fee-for-service payment model remains
• Savings incentives by offering bonuses for reducing costs
• Physicians and hospitals required to meet specific quality benchmarks
• Potential financial liability / penalty if ACO does not meet performance and savings benchmarks
• Patients will have option of seeing physicians outside of the network

Sources: Kaiser Health News; Arnold & Porter Advisory 11/12

Capitation

• Payment per person rather than payment per service
• Per member per month (PMPM) type of plan
• “Carve out” options
• Government revisiting capitation as a means to control the growth of health care costs
• Many arrangements unpopular in 1990s
• Today’s IT capabilities could improve capitated payment systems

Sources: AMA Practice Management Center

Capitation Considerations

• Implement accrual accounting and tracking liabilities paid for from capitation revenue
• Trust actuarial accuracy of the PMPM payment based on scope of services
• Track patient demographic and determine if actuarial projection is risk adjusted accordingly
• Monitor capitated payments for timeliness and accuracy
• Consider stop-loss insurance and possible carve-outs

Sources: AMA Practice Management Center
**Bundled Payments**

- AKA “fee for episode of care”
- Described as a system in between FFS and capitation
- One “fee” covers all services delivered during a single episode of care or over a specific period of time
- Risk-contracting type of arrangement

**Issues with Bundled Payments**

- Which entity receives the payment?
- How is the episode of care defined?
- Duration of the bundle
- What percentage is distributed to each entity?
- How is the risk adjustment applied?

**Strategic Planning**

- Gather information about opportunities in your locale
- Do cost accounting for all items and services you provide
- Gather outcomes and quality measurements
- Develop business and practice operation acumen that exceeds what you need to know in a fee-for-service environment
- Engage the right people to assist (e.g., actuaries, attorneys, consultants)

**Next Steps**

- Strengthen bargaining position – size helps
- Improve market visibility; increase market share
- Diversify to reduce risk; integrate ASC, optical, other
- Assess and improve customer service levels
- Increase capital; grow balance sheet
- Recruit human resources – increase talent pool
- Strengthen management team
- Reduce overhead expenses proportionately
- Revise physicians’ compensation plan
- Revise shareholders’ agreements

**More help...**

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(800) 399-6565
or
www.CorcoranCCG.com