Doctors, Dollars, and Health Reform: Physician Reimbursement from Fee-for-Service to MIPS

Psychology (and Physician Reimbursement) 101

You get the behaviors you reward

It's a rather interesting phenomenon. Every time I press this lever, that post-graduate student breathes a sigh of relief.
Will It Work in Healthcare?

That is the $3 trillion question

What is “Health Reform”?

Health Reform

Reimbursement Reform

Behavior Modification

MERRITT HAWKINS
an allied health care company
So Let’s Follow the Money From
• The Way We Were
• to Where We Are Now
• to Where We Are Going

Part I:
The Way We Were (circa 1900)

Hospitals provided five things:

1) A bed
2) Comfort
3) Milk
4) Meat and
5) Mashed potatoes

These were not “the good ol’ days”
The Past: A Nice Place to Visit, But…

- **No antibiotics** – surgical and venereal disease often fatal
- **Few vaccinations** – chicken pox, rubella, diphtheria, and mumps were killers, polio a parent’s nightmare, and cancer was a death sentence
- **Infant mortality** – United States approached rates now seen in the Third World
- **Amputations** – could not risk infection from broken bones
- **Diabetes** – insulin not synthesized until 1923
- **Tuberculosis** – both George Orwell and “Scarlet O’Hara” died of it
- **Blood transfusions** – Dr. Charles Drew died because unable to receive a transfusion

The “Gateways to Death”

Hospitals were charitable institutions for those who could not afford home-care. It’s where patients went to die.

But the Price was Right

- Average daily cost of keeping a patient in St. John’s Hospital/NYC (1880)?
  80 cents
- Total annual budget of St. John’s Hospital (1880)?
  $4,869


Was There a Doctor in the House?

Yes, but they couldn’t do much for you, either.

However, the price was right:

Annual salary of St. John’s Hospital house physician (1880)? $300

Hospitals: The Big Change…
Charging for Care

• It costs money to maintain antiseptic conditions, add new technology
• Hospital costs rise from 7.6% of family medical bills in 1918 to 13% in 1929
• Talk of health insurance begins


Physicians: The Big Change…
The Flexner Report

• From 162 medical schools in 1906 to 85 in 1919
• Less competition, better training, more technology, more groups (Mayo, Cleveland) lead to higher costs
Sound Familiar?

- National health insurance part of the Progressive party platform…in 1912
- “The inability of the people to pay the cost of modern scientific medicine” was the first item on the AMA’s annual convention…in 1927

In 1929, Talk of Health Insurance, But the Consumer Still Paid

$3.6 billion total medical expenditures:

- $2.9 billion paid by consumers
- $485 million paid by public sources
- $217 million paid by philanthropy

Health Care Payments: The Big Change…
From Consumer to Employer

- 1920s – Dallas teachers arrange for Baylor Hospital to provide 21 days of hospitalization for an annual payment of $6
- 1930s and 1940s – Enter the Blues
- WWII – Wages fixed, but not health benefits
- Kaiser Steel morphs to Kaiser Permanente
- 1943 – Congress says insurance premiums provided by employers not taxable as wages

The Employed Have Options, But What About the Elderly and the Indigent?

**Medicare and Medicaid (1965)**

Life expectancy for men: 66
For women: 72
Part A: Hospitals
Part B: Physicians
The Good News: We Got You Covered

- In 1939, just 6% of the population have private health insurance for hospitalization
- By 1941 – 12.4%
- By 1945 – 23% (59% covered by Blue Cross/Blue Shield)
- By 1970 – 86%
- Today – 89%

The Bad News: Pay as You Go – Our Original Sin

- BCBS establishes a pay-as-you-go model
- Unlike home insurance where you get a lump sum for a disaster and the insurance company pays you
- Medical insurances pay the provider for each service, not the person paying for the policy
- All services paid, even routine, easily affordable services
- No deductibles, no co-pays
- The golden age of “fee-for-service”
Getting the Behaviors You Reward

- **Total health care spending (1929):** $3.6 billion, or 4% of GDP
- **Total health care spending (2014):** $3 trillion (83,000% increase), or 17% of GDP
- Fee-for-service just one factor, but it gets the blame

Ever Since Medicare We Have Been Retrofitting Reimbursement

- **1966:** *Current Procedural Technology* (CPT) codes and *International Classification of Disease* (ICD)
- **1983:** *Prospective Payment System* – Flat hospital payments for 467 “diagnosis related groups” (Critical Access Children’s, and long-term facilities excepted)
- Preauthorization, clinical pathways, and managed care
- **1997:** *The Balanced Budget Act/Sustainable Growth Rate* formula
- **2005:** *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS)
The Biggest Retrofit Yet – The ACA: From Volume to Value

Key Alternative Payment Models
• Accountable Care Organizations (ACOs)
• Bundled Payments
• Pay-for-Performance
• Patient Centered Medical Home
• Hospital Readmission Reduction Program (HRRP)
• Pay for Prevention

Quality Reporting Mechanisms
• Physician Quality Reporting System (PQRS) and Group GPRO
• Hospital Inpatient Quality Reporting (IR) Program
• Unlike the 1990s, this time we have the data
CMS Draws a Line in the Sand

By 2018, 50% of Medicare payments to flow through value-based entities

Where Are We Now?

How much are physicians compensated, and more importantly, how are they compensated?

Does value or volume still rule?
Merritt Hawkins 2016 Review of Physician and Advanced Practitioner Recruiting Incentives

- Industry benchmark for 23 years
- 3,342 recruiting assignments
- Types of settings into which physicians are recruited
- Starting salaries, not total compensation
- Customary and competitive incentives

Types of Facilities Recruiting Physicians

Multiple Service Sites...

- Academic Centers
- Hospitals and health systems
- Large group practices
- ACOs
- Free standing emergency departments
- Urgent care centers
- Retail clinics (NP/PA's Walgreens)
- Employers
- Insurance Companies

...All Seeking Physicians
## Physician Salaries

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>$135,000</td>
<td>$225,000</td>
<td>$340,000</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$195,000</td>
<td>$250,000</td>
<td>$370,000</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>$195,000</td>
<td>$237,000</td>
<td>$320,000</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>$180,000</td>
<td>$249,000</td>
<td>$390,000</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>$92,000</td>
<td>$117,000</td>
<td>$197,000</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>$210,000</td>
<td>$321,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Neurology</td>
<td>$220,000</td>
<td>$285,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>$350,000</td>
<td>$521,000</td>
<td>$800,000</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$195,000</td>
<td>$221,000</td>
<td>$275,000</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$165,000</td>
<td>$224,000</td>
<td>$308,000</td>
</tr>
</tbody>
</table>

Source: Merritt Hawkins 2016 Review of Physician and Advanced Practitioner Recruiting Incentives

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## Physician Employment

90% of Merritt Hawkins searches featured employment with hospital, medical group, FQHC, academic facility, etc.

Less than 10% featured independent practice
One Effect Of Employment: Turnover

Annual Physician Move Rates
- Family Medicine: 13.5%
- Emergency Medicine: 13.3%
- Internists: 12.0%
- Pediatricians: 9.2%

Source: Physicians on the Move, SK&A, August 2015

Does not include “Switching Flags”

What Types of Contracts?

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>23%</td>
</tr>
<tr>
<td>Salary with Production Bonus</td>
<td>75%</td>
</tr>
<tr>
<td>Income Guarantee</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Merritt Hawkins 2016 Review of Physician Recruiting Incentives
If Salary with Production Bonus, On What is the Bonus Based?

<table>
<thead>
<tr>
<th>Metric</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVUs</td>
<td>58%</td>
</tr>
<tr>
<td>Net Collections</td>
<td>22%</td>
</tr>
<tr>
<td>Gross Billings</td>
<td>2%</td>
</tr>
<tr>
<td>Patient Encounters</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Quality/Value</strong></td>
<td><strong>32% (&lt;7% in 2011)</strong></td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Merritt Hawkins 2016 Review of Physician Recruiting Incentives

Value-Based Metrics

The “perpetual motion machine” of physician compensation

We must reward “quality” & “value”...

But how?
Value-Based Metrics

Bonuses (fixed or as a % of base) for:
- Achieving minimum average of patients per day
- Exceeding average patient satisfaction scores
- Correctly documenting charts
- Appropriate coding and billing
- Citizenship (peer review, community relations)
- Accuracy of charting/EMR input

Value-Based Metrics

Bonuses (fixed or as a % of base) for:
- Participation in annual quality improvement project
- Clinical process effectiveness
- Patient safety
- Population/ Public Health
- Efficient use of resources
The Production Bonus

29% of the bonus is based on value

Source: Merritt Hawkins 2016 Review of Physician Recruiting Incentives

A Real World Hypothetical

Family Physician
Base salary: $225,000
Bonus achieved: $50,000
29% of bonus based on value: $14,500
Income tied to value as % of total compensation: 6.5%

Enough to change behavior?
Value Metrics Are Up Again

<table>
<thead>
<tr>
<th>Productivity Bonuses Featuring Value Metrics</th>
</tr>
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<tbody>
<tr>
<td>2010/11</td>
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<tr>
<td>2011/12</td>
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<tr>
<td>2013/14</td>
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<tr>
<td>2014/15</td>
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<tr>
<td>2015/16</td>
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</tbody>
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What is the “Goldilocks Zone”?

The right formula for balancing volume and value
Why Does Volume Still Rule?

- Consider the average annual revenue family physicians generate for their affiliated hospitals: $1,493,518*

- 89.1% of commercial health plan payments to providers are still based on traditional fee-for-service and are not tied to improving quality or efficiency**, but, by 2020, 75% of commercial plans will be value-based***

*Source: Merritt Hawkins' 2016 Survey of Physician Inpatient/Outpatient Revenue
**Source: Catalyst for Payment Reform, March 2013
***Source: U.S. Department of Health and Human Services, January 2015

Ready or Not, Behavior Has to Change

Where we are going: The Medicare Access and CHIP Reauthorization Act (MACRA)
Goodbye to SGR (and Good Riddance)

- MACRA repeals the SGR formula – Medicare payments no longer tied to GDP
- Medicare payments will increase by 0.5% each year from July 2015 through December 2018

What happens in January 2019?

MACRA Gives Physician Who Wish to Bill for Medicare Services Two Choices

Walk the Plank (MIPS)

or

30 Lashes (APMs)
The Merit-Based Incentive Payment System (MIPS)

- Combines PQRS, VBM, and meaningful use into one program
- Physicians continue to get a volume-based payment based on the Physician Fee Schedule
- Physicians who see more patients or rack up more RVUs can earn more
- Physicians also will get a quality/value-based score from 0 to 100

On What is the Score Based?

- Quality of Care (30%)
- Use of healthcare resources (30%)
- Activities undertaken to improve clinical practice (15%)
- Meaningful Use (25%)
One Mean to Rule Them All

- Medicare will derive a mean score based on all physicians who participate in MIPS
- Clinicians scoring above the mean will get bonuses
- Physicians scoring below the mean will get penalized (paying for the said bonuses)
- Physicians at the threshold will get no adjustment
- Scores will be publicly available through “physician compare”

Carrots and Sticks

MIPS scores will impact physician Medicare payments:

In 2019, +/- 4%.
In 2020, +/- 7%.
In 2021, +/- 9%.

In order to remain budget neutral, CMS will offer bonuses up to three times the initial bonus — in 2021, high performing physicians could receive three times the 9% bonus for a 27% bonus.
Don’t Care for MIPS? Try an Alternative Payment Model (APM)

Participation in an ACO, primary care medical home, or bundled payment model will qualify as an APM under MACRA:

- Physicians take on financial risk through lump payments
- If they provide care for less than the capped amount, and hit quality goals, they share in the savings
- 5% Medicare bonus each year from 2019 to 2024 on top of all other Medicare payments
- In 2026, physicians qualify for a 0.75% increase in payments each year

As a result of the difficulty in qualifying as an advanced APM, almost all groups will begin 2017 in MIPS

Value-Based Models in Action

Bon Secours Health System in Marriottsville, Maryland has introduced a shared savings model for their physicians called the Primary Care Quality Incentive Program (PCQIP). The model incentivizes physicians to work within ACOs. Physicians must first meet their budgeted target volumes, then they become eligible to receive a quality bonus. PCQIP bonus requirements include citizenship, meaningful use, and quality measures (metrics similar to MIPS). Physicians can earn a partial bonus for meeting only one or two of the requirements. Bon Secours are above the threshold for all performance measures required to be eligible for shared savings in their model.
Value-Based Models in Action

**Meriter Hospital** in Madison, Wisconsin has contracted with the CMS BPCI initiative. According to HealthLeaders, “Meriter’s bundled payment programs have resulted in a 12% reduction in patient length of stay, a 23% decrease in discharges to skilled nursing facilities, and a 68% drop in hospital readmissions.”

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**Intermountain Healthcare** in Utah and Idaho has implemented their value-based payment model **Shared Accountability** with great success. In an interview with HealthLeaders, senior vice president and chief strategy officer, Greg Poulson, said that one-third of Intermountain’s healthcare services are tied to value-based payments. Intermountain relies on its Geographic Committees to assess their performance and make necessary adjustments for improving their system.
Healthcare Spending Today: Where Will it Go?

The Nation’s Health Dollar ($2.9 Trillion), Calendar Year 2013: Where It Went

- Hospital Care: 32%
- Physicians and Clinics: 20%
- Dental Services and Other Professionals: 7%
- Prescription Drugs: 9%
- Other: 14%
- Public Health Services: 3%
- Other Medical Products: 3%
- Government Public Health Activities: 3%
- Nursing Care Facilities and Continuing Care Retirement Communities: 5%
- Home Health Care: 3%
- Other Health, Residential, and Personal Care: 5%
- Investment: 6%
- Government Administration and the Net Cost of Health Insurance: 7%

Source: CMS Office of the Actuary

Will Controlling Physician Behaviors Really Have an Impact?

Physicians and clinics: 20% of total healthcare spending

Public health services: 3% of total healthcare spending
The United States is an Anomaly

How Will Doctors Respond?

- Throw in the towel on independent practice
- Join an ACO/system
- Turnover
- Retire
- Locum tenens
- Concierge/Direct Pay *(Back to the Future)*
- Deal with it
For a complete review of reimbursement see:

A Raised Hand – Blog by Kurt Mosley

Follow on Twitter: @Kurt_Mosley
If you have any questions, please contact Kurt Mosley at:
Kurt.Mosley@amnhealthcare.com

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