VBP: Great Promise but… Policy Rx Needs Adjustment

• Vision:
  • Patients/Payers: Better care, lower spending trends
  • Physicians/other providers: Better rewards for delivery redesign

• Current reality:
  • Fragmented delivery system
  • Quality measure tensions
  • Black box perceptions
  • Data gaps/lags
  • Capital barriers
  • Limited APM options
In 2016, about 58% of physicians worked in practices with 10 or fewer physicians

*Practice size information is not collected from hospital employees*
FFS is still the dominant payment method used by insurers to pay practices

- **FFS**: 83.6% of physicians in practices that receive positive revenue from FFS, with an average share of 70.8% of practice revenue from FFS payments.
- **P4P**: 35.7% of physicians in practices that receive positive revenue from P4P, with an average share of 6.5% of practice revenue from P4P payments.
- **Capitation**: 25.1% of physicians in practices that receive positive revenue from Capitation, with an average share of 6.7% of practice revenue from Capitation payments.
- **Bundled payments**: 35.8% of physicians in practices that receive positive revenue from Bundled payments, with an average share of 8.8% of practice revenue from Bundled payments.
- **Shared savings**: 16.7% of physicians in practices that receive positive revenue from Shared savings, with an average share of 2.0% of practice revenue from Shared savings.
The researchers found that during the office day, physicians spent 27 percent of their total time on direct clinical face time with patients and more than 49 percent of their time on EHRs and desk work. After hours, physicians spent another 1 to 2 hours each night on clerical work, mostly related to EHRs.
Physicians receiving bonuses couldn’t explain what they did to achieve rewards.

To succeed in alternative payment models, physician practices need data and resources for data management and analysis.

Harmonizing key components of alternative payment models, especially performance measures, would help physician practices respond constructively.
## Prior Law vs. MACRA/QPP Framework

### Prior Law vs. 2019 Adjustments

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 Adjustments</th>
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<tbody>
<tr>
<td>PQRS</td>
<td>-2%</td>
</tr>
<tr>
<td>MU</td>
<td>-5%</td>
</tr>
<tr>
<td>VBM</td>
<td>-4% or more*</td>
</tr>
<tr>
<td>Total penalty risk</td>
<td>-11% or more*</td>
</tr>
<tr>
<td>Bonus potential (VBM</td>
<td>Unknown (budget</td>
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<tr>
<td>only)</td>
<td>neutral)*</td>
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### MIPS Factors vs. 2019 Scoring

<table>
<thead>
<tr>
<th>MIPS Factors</th>
<th>2019 Scoring</th>
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<tbody>
<tr>
<td>Quality measurement</td>
<td>60% of score</td>
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<tr>
<td>Advancing Care Info.</td>
<td>25% of score</td>
</tr>
<tr>
<td>Resource use</td>
<td>0% of score</td>
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<tr>
<td>Improvement Activities</td>
<td>15% of score</td>
</tr>
<tr>
<td>Total penalty risk</td>
<td>Max of -4%</td>
</tr>
<tr>
<td>Bonus potential</td>
<td>Max of 4%, plus potential 10% for high performers</td>
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*VBM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years; there were no ceilings or floors on penalties and bonuses, only a budget neutrality requirement.
MIPS vs. P4P

**Improvements**

- Better alignment of measures
  - Less duplication, double-jeopardy
- Pass-fail approach largely eliminated
- Penalties less severe
- “Pick Your Pace” transition
  - Helpful for those not participating in past P4P
- MIPS APMs can be accommodated
  - Support transition to new delivery models

**Challenges**

- Still complex, burdensome
- Practice diversity remains
- 2-year time lag remains
- Feedback timeliness and usefulness TBD
- How will improvement be rewarded?
- EHR interoperability and data blocking problems remain
- Will MIPS APMs lead to meaningful delivery systems reforms?
- CMS operational issues
MACRA APM observations

- APM physicians generally “satisfied”
  - High quality care, support for non face-to-face services, better use of staff
  - Too few models currently available for primary care specialists
    - Likelihood of approval for new models unclear
    - All or nothing approach? Future for condition-based models?
- More opportunities for reduced regulatory burdens (e.g., prior authorization exemption)
- Risk criteria, attribution methods, risk adjustment need refinements
- Are MIPS APM advantages sufficient?
- Some specialties/services may never neatly fit into an APM
Examples of physician-focused APM pilots

<table>
<thead>
<tr>
<th>Project, MD leader, Payer</th>
<th>Care Improvement Opportunity</th>
<th>Barriers in Current Payment System</th>
<th>Results from Payment Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent Emergency visits, Jennifer Wiler, MD, Univ. of Colorado, CMS Innovation Award</td>
<td>Many patients with 3+ ED visits per year: are uninsured; have behavioral health problems; do not have a PCP</td>
<td>No pay for pt education and care coordination in ED • No pay for home visits post-ED • No coverage for non-medical needs such as transportation</td>
<td>• 41% fewer ED visits • 49% fewer admissions • 80% now have PCP • 50% lower total spending</td>
</tr>
<tr>
<td>Crohn’s disease, Lawrence Kosinski, MD, Illinois Gastroenterology Group and SonarMD, Illinois BCBS</td>
<td>Payer spends $11,000/yr for each Crohn’s patient • &gt;50% of $ for hospitals, mostly for complications • &lt;33% patients seen by MD w/i 30 days before admit</td>
<td>No payment to support: o Nurse care managers o Clinical decision support tools o Proactive outreach to high-risk patients</td>
<td>Hospitalization rate cut &gt;50% • Health plan spending cut 10% • Improved patient satisfaction due to fewer complications, lower out-of-pocket costs</td>
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<tr>
<td>Total joint replacement, Stephen Zabinski, MD Shore Medical Center, Horizon BCBS of NJ</td>
<td>Reduce risk factors for complications preoperatively • Obtain lower implant prices • Use lower-cost settings for surgery &amp; rehab</td>
<td>No support for pre- or post-op care coordination &amp; risk reduction, ie, BMI, smoking, diabetes control, deconditioning • Lack of data on facility costs to support better decision making</td>
<td>Avg LOS reduced 1.5 days for knees, 1.3 days for hips • Avg device cost cut 33% • Discharge to home: 34% 78% • Readmit rate: 3.2% 2.7%</td>
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Key Takeaways March APM Workshop

• APMs can support:
  • more accurate diagnosis of patients with complex symptoms
  • services not separately payable under FFS

• Great interest in risk-stratified bundled payments linked to diagnosis & treatment plan
Revised VBP Policy Rx

- Recognize/reflect practice realities
- Fewer, consistent, transparent and more timely incentives
- Enhance technical assistance and data distribution
- Substantial reduction in administrative burden/costs
- Expand APM options, rethink risk requirements