# VBP: Great Promise but… Policy Rx Needs Adjustment
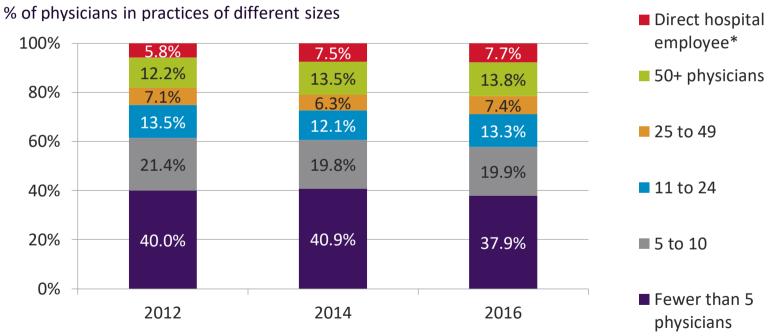
- Vision:
  - Patients/Payers: Better care, lower spending trends
  - Physicians/other providers: Better rewards for delivery redesign

- Current reality:
  - Fragmented delivery system
  - Quality measure tensions
  - Black box perceptions
  - Data gaps/lags
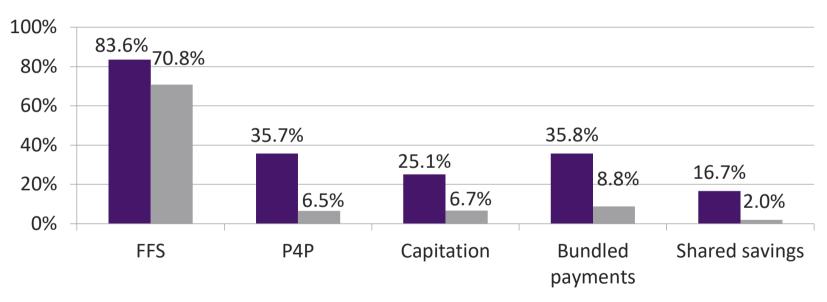  - Capital barriers
  - Limited APM options



WHAT IF I TOLD YOU THAT IF YOU SEND MIXED MESSAGES

YOU WILL GET MIXED RESULTS?

memegenerator.net

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# In 2016, about 58% of physicians worked in practices with 10 or fewer physicians

% of physicians in practices of different sizes



Legend:
- Direct hospital employee*
- 50+ physicians
- 25 to 49
- 11 to 24
- 5 to 10
- Fewer than 5 physicians

| | 2012 | 2014 | 2016 |
|---|---|---|---|
| Direct hospital employee* | 5.8% | 7.5% | 7.7% |
| 50+ physicians | 12.2% | 13.5% | 13.8% |
| 25 to 49 | 7.1% | 6.3% | 7.4% |
| 11 to 24 | 13.5% | 12.1% | 13.3% |
| 5 to 10 | 21.4% | 19.8% | 19.9% |
| Fewer than 5 physicians | 40.0% | 40.9% | 37.9% |

*Practice size information is not collected from hospital employees

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# FFS is still the dominant payment method used by insurers to pay practices



Legend:
- ■ % of physicians in practices that receive positive revenue from that method
- ■ Average share of practice revenue from that method

Bar chart values:
- FFS: 83.6%, 70.8%
- P4P: 35.7%, 6.5%
- Capitation: 25.1%, 6.7%
- Bundled payments: 35.8%, 8.8%
- Shared savings: 16.7%, 2.0%

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# Allocation of Physician Time



## Annals of Internal Medicine

## ORIGINAL RESEARCH

### Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties

Christine Sinsky, MD; Lacey Colligan, MD; Ling Li, PhD; Mirela Prgomet, PhD; Sam Reynolds, MBA; Lindsey Goeders, MBA; Johanna Westbrook, PhD; Michael Tutty, PhD; and George Blike, MD

**Background:** Little is known about how physician time is allocated in ambulatory care.

**Objective:** To describe how physician time is spent in ambulatory practice.

**Design:** Quantitative direct observational time and motion study (during office hours) and self-reported diary (after hours).

**Setting:** U.S. ambulatory care in 4 specialties in 4 states (Illinois, New Hampshire, Virginia, and Washington).

**Participants:** 57 U.S. physicians in family medicine, internal medicine, cardiology, and orthopedics who were observed for 430 hours, 21 of whom also completed after-hours diaries.

**Measurements:** Proportions of time spent on 4 activities (direct clinical face time, electronic health record [EHR] and desk work, administrative tasks, and other tasks) and self-reported after-hours work.

**Results:** During the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work. While in the examination room with patients, physicians spent 52.9% of the time on direct clinical face time and 37.0% on EHR and desk work. The 21 physicians who completed after-hours diaries reported 1 to 2 hours of after-hours work each night, devoted mostly to EHR tasks.

**Limitations:** Data were gathered in self-selected, high-performing practices and may not be generalizable to other settings. The descriptive study design did not support formal statistical comparisons by physician and practice characteristics.

**Conclusion:** For every hour physicians provide direct clinical face time to patients, nearly 2 additional hours is spent on EHR and desk work within the clinic day. Outside office hours, physicians spend another 1 to 2 hours of personal time each night doing additional computer and other clerical work.

**Primary Funding Source:** American Medical Association.

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.

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# AMA/Rand "Effects of Health Care Payment Models on Physician Practice in the United States"

- 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



**Effects of Health Care Payment Models on Physician Practice in the United States**

Mark W. Friedberg, Peggy G. Chen, Chapin White, Olivia Jung, Laura Raaen,
Samuel Hirshman, Emily Hoch, Clare Stevens, Paul B. Ginsburg, Lawrence P. Casalino,
Michael Tutty, Carol Vargo, Lisa Lipinski

# Prior Law vs. MACRA/QPP Framework

| Prior Law | 2019 adjustments |
|---|---|
| PQRS | -2% |
| MU | -5% |
| VBM | -4% or more* |
| Total penalty risk | -11% or more* |
| Bonus potential (VBM only) | Unknown (budget neutral)* |

*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 factors | 2019 scoring |
|---|---|
| Quality measurement | 60% of score |
| Advancing Care Info. | 25% of score |
| Resource use | 0% of score |
| Improvement Activities | 15% of score |
| Total penalty risk | Max of -4% |
| Bonus potential | Max of 4%, plus potential 10% for high performers |

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# 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

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# 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

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# Examples of physician-focused APM pilots

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

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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

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# 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

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