The Road Ahead 3.0: Changing Payments, Changing Practice

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The first article during my tenure as editor of the "Practice Management: The Road Ahead" section of Clinical Gastroenterology and Hepatology *published in July 2012 (*Clin Gastroenterol Hepatol *2012;10:692–696) and outlined anticipated changes in health care delivery, due in large part to mandates or trends contained in the Patient Protection and Affordable Care Act. A second article was published in 2013 (Health care reform 3.0: the road gets bumpy.* Clin Gastroenterol Hepatol *2013;11:1527–1528). In this month's Road Ahead column, Dr Spencer Dorn, faculty at University of North Carolina, adds a third update with an article focused on alternative payment models. These new reimbursement models are becoming common and will be part of all of our practice strategies in the years to come. No matter what occurs in the 2016 election, the movement from volume- to value-based payment will continue relentlessly, and practices that do not understand how to respond will struggle. We hope these articles will kick-start conversations in your practice.*

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Fee-for-service (FFS) reimbursement has been criticized for encouraging quantity over quality, favoring procedures over cognitive services, and fragmenting care.[1] The landmark Patient Protection and Affordable Care Act (ACA) and more recent Medicare Access and Children's Health Insurance Program Reauthorization Act modify Medicare's FFS and encourage alternative payment models (APMs) that better reward value rather than volume.

Prior articles in this series have identified the specific trends driving gastroenterology practice strategies and business decisions,[2] including an increasing need to demonstrate value, an emphasis on improved population health, an increasing number of practices becoming employees of large integrated delivery networks, reduced FFS reimbursements that are more closely linked to performance metrics, and increasing demands for risk-based contracts.[3] In this article I dive more deeply into these last 2 trends (declining FFS and the rise of APMs) and consider strategies gastroenterology practices can take in response.

Changes in Fee-for-Service

The ACA directed the Secretary of Health and Human Services to establish a formal process to review potentially misvalued procedure codes. Compared with the pre-ACA fee schedule, the final 2016 Medicare Physician Fee Schedule includes cuts to professional fees for upper endoscopy, endoscopic retrograde cholangiopancreatography, endoscopic ultrasound, and colonoscopy. At the same time, over the past decade facility fees paid for procedures performed in hospital outpatient departments have increased. Those to ambulatory surgery centers have gradually increased, although they still remain far below pre-2008 levels. Thus, the full economic impact of fee revaluation on an individual gastroenterology practice depends on whether it collects associated facility and ancillary fees.[4]

In addition, in the 2016 Fee Schedule Centers for Medicare and Medicaid Services (CMS) described its intention to remove the value of moderate sedation from all gastrointestinal (GI) procedures. This is to prevent paying twice for sedation in procedures that involve anesthesiology professionals (ie, one payment to the endoscopist as part of the overall procedure fee and a separate payment to the anesthesia professional for sedation they provide and bill for separately). The AMA/Specialty Society Relative Value Scale Update Committee, based on survey data from the GI specialty societies and other specialties that perform their own moderate sedation, has submitted recommendations to

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Abbreviations used in this paper: **ACA, Patient Protection and Affordable Care Act; ACO, accountable care organization; APM, alternative payment models; CMS, Centers for Medicare and Medicaid Services; FFS, fee-for-service; GI, gastrointestinal; PQRS, Physician Quality Reporting System.**

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the value of a new set of moderate sedation Current Procedural Terminology codes to CMS. The agency is expected to provide the specifics on how it will remove moderate sedation from the GI procedure codes in the 2017 Medicare Physician Fee Schedule Proposed Rule. The more that moderate sedation is valued the less that endoscopic procedures will be valued. Consequently, gastroenterologists who rely on anesthesiology professionals to sedate their patients will generate less revenue per procedure, unless they rearrange contracts with anesthesia providers. Gastroenterologists who perform moderate sedation will not be impacted, because the sum of the value of the new moderate sedation code plus the underlying endoscopic procedure code will equal the original value of the procedure.

Beyond revaluing services, CMS outlined its rather ambitious goal "to have 85% of all Medicare fee-for-service (FFS) payments tied to quality or value by 2016, and 90% by 2018."[5] Currently this includes the Physician Quality Reporting System (PQRS), which requires gastroenterologists report performance on either 3 or more individual PQRS measures or 1 PQRS measures group (collection of related individual measures) or face 2% Medicare payment penalty. It also includes the value-based payment modifier, through which by 2017 all practices with better-than-average quality (linked to PQRS measures) and lower costs will receive bonus payments, whereas those with worse-than-average performance (or who choose not to report) will be penalized.

The Medicare Access and Children's Health Insurance Program Reauthorization Act changes all of this. Starting in 2019, the meaningful use incentive program, PQRS, and value-based payment modifier will be consolidated into the Merit-Based Incentive Payment System. Physicians who elect to remain on a FFS tract will receive a 0–100 composite performance score based on quality (30%), resource use (30%), meaningful use (25%), and clinical practice improvement activities (15%). At the start of a performance period a composite threshold necessary to achieve incentive payments and avoid penalties will be determined. Throughout the performance period physicians will receive timely feedback on their performance. At year's end, those below the threshold will face penalties proportionate to their performance (as much as 4% in 2019 and going up to 9% in 2022), those at threshold will not receive a payment adjustment, and those above threshold will receive bonuses proportionate to their performance (although overall payments will be capped at $500 million).

Alternative Payment Models

CMS' ultimate goal is to move beyond FFS and have "30% of Medicare payments tied to quality or value through APMs by the end of 2016 and 50% of payments by the end of 2018."[5] The Medicare Access and Children's Health Insurance Program Reauthorization Act supports this ambitious goal: starting in 2019, providers who "sufficiently" participate in APM will receive 5% across-the-board bonuses. The 3 main APMs are bundled payments, accountable care organizations (ACOs), and patient centered medical homes.

A bundled payment is a single fixed price paid to cover services for a specific episode of care. Depending on how an episode is defined, the bundle may encompass all professional fees, facility fees, and medical device and supply costs for a given service, including postacute care and any complications. If costs are reduced beyond the already discounted price of the bundle and quality metrics are achieved then participants share the savings. Conversely, if costs exceed the bundled payment amount then participants lose money. Unlike FFS, bundling incentivizes participants to coordinate care, reduce complications and unnecessary services, and cut purchasing costs.

To date, CMS has launched 3 bundling programs. The Acute Care Episode Demonstration Project provided hospitals and clinicians a bundled payment to cover orthopedic and cardiovascular procedure-related episodes of care. This program reduced Medicare costs, primarily because the bundle payment was lower than what the sum of individual payments would have been. Providers were able to cope mainly by reducing their surgical implant costs. Second, more than 6000 providers are currently participating in Medicare's Bundled Payments for Care Improvement Program. The results of this program have not yet been released. Third, CMS recently announced the Comprehensive Care for Joint Replacement Program under which hospitals and physicians in 67 metropolitan areas will be *required* to participate. Mandatory participation signals CMS' strong motivation to shift away from FFS. Beyond Medicare, many commercial insurers offer bundled payment programs, primarily for cardiovascular and orthopedic conditions.[6] Although promising, it is technically challenging to define what is in a bundle, and to adequately risk-adjust and mitigate random variation in spending for certain episodes of care. Providers are also challenged to find ways to divide payment among participants, coordinate all care, and accept financial risk.[7,8] The American Gastroenterological Association recently published a