How Value-Based Reimbursement Will Impact Podiatrists

A new payment era is upon us.
Are you prepared?

BY JOLYNN TUMOLO

For podiatrists who treat Medicare patients, value-based reimbursement is about to get real. The Centers for Medicare & Medicaid Services is gearing up for next year's launch of its Merit-Based Incentive Payment System (MIPS), which will factor value, and not solely services performed, into the Medicare reimbursement a provider receives.

If that program is a success, other insurers will likely follow suit with pay-for-performance plans of their own. "If there are cost savings for the Medicare payers through doing value-based reimbursement, then you can bet private insurers are going to pick up on it as well," said James R. Christina, DPM, executive director and CEO of the American Podiatric Medical Association "Some are doing a type of value-based reimbursement already."

Dr. Christina

The days of fee-for-service as we've known it are seemingly numbered. How podiatrists fare in this changing reimbursement climate, experts say, will depend on how well they prepare for the coming storm.

"Of course, there is no alternative other than to face the changes ahead—not bury your head in the sand hoping it will not impact your practice—and work to be prepared," said Harry Goldsmith, DPM, CEO of Codingline, Cerritos, CA. "Forewarned is forearmed."

Dr. Goldsmith

Why Value-Based Reimbursement?

Unlike traditional fee-for-service programs that simply pay healthcare providers for the services they provide, pay-for-performance models provide financial incentives for delivering quality care at lower costs, Dr. Goldsmith explained. Value-based reimbursement, which typically rewards providers for meeting specific quality benchmarks and penalizes them when they do not, fits within the pay-for-performance framework.

At its essence, value-based reimbursement is a new take on an old tune: Payers are looking for ways to control costs. "Value-based reimbursement is just another way for them to figure out how they're

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going to pay for services," said Dr. Christina. "When you step back and look at the big picture, they continue to try to find different payment models because they don't have enough money to pay for all the services that need to be provided. So you continue to see they're trying to solve a problem without addressing the root cause—which is that they probably don't have enough funding in the right categories to pay for all the healthcare they're trying to pay for."

Dr. Goldsmith shared a similar perspective. "Payers have for decades tried to rein in the high costs of healthcare by introducing variations on the reimbursement model theme. We have gone from cash to indemnity plans to preferred provider organizations and HMOs to capitated arrangements to fee schedule caps on payment back to capitated arrangements to reimbursements based on reward and punishment," he said. "We know that quality healthcare delivery reduces overall healthcare costs. We also know that payers benefit by providing a lump sum (probably less than they estimate they would have otherwise had to pay) to organizations like accountable care organizations to provide, through their primary care and specialist networks, healthcare to a population. When you throw in 'risk' (financial) to those organizations for underperforming to the payers' expectation, you can imagine the interest and popularity in non-fee-for-service payment models … from the payers' standpoint."

MACRA Changes Medicare

Last spring's passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) marked a big step toward integrating value-based reimbursement into the Medicare system. The legislation ended the sustainable growth rate formula used for years to update Medicare payment rates and replaced it with a new structure aimed at rewarding healthcare providers for quality care. Under MACRA payment reforms, podiatrists and other providers can choose one of two types of reimbursement systems: the Merit-Based Incentive Payment System (MIPS) or an alternative payment model, such as an accountable care organization (ACO), patient-centered medical home or bundled payments.

"The point to keep in mind is that Medicare providers will need to choose reimbursement under a recognized alternative payment model or MIPS—and relatively soon," said Dr. Goldsmith. "This represents a dramatic change in how medicine is practiced, what defines quality, and how healthcare providers are reimbursed. And it's all happening just around the corner. "

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Option 1: MIPS

Set to begin in 2017, MIPS combines parts of the Physician Quality Reporting System, the Value-based Payment Modifier, and the Medicare Electronic Health Record incentive program into one program. Beginning in 2019 (but based on 2017 data), provider payment updates will be influenced by four metrics: quality, resource use, clinical practice improvement, and meaningful use of EHR.

"It's still going to be a fee-for-service type of payment model, but MIPS will determine whether you are paid at what the fee for services is or whether there is a plus or a minus adjustment made to what you are paid," Dr. Christina explained.

Providers participating in alternative payment models receive a 5% annual bonus payment and are exempt from MIPS participation.

"The penalties could grow as large as a 9% decrease in reimbursements by 2022," said Dr. Goldsmith. "A provider's success or failure will be determined by variables in his or her four-category composite score."

At press time, draft rules detailing the MIPS program had yet to be released. But as soon as they are, Dr. Christina said the APMA plans to sift through them and provide more specifics to members.

Option 2: Alternative Payment Models

A second option is participating via an alternative payment model. Providers participating in alternative payment models receive a 5% annual bonus payment and are exempt from MIPS participation.

"In terms of alternative payment models, podiatrists will need to be 'in' a group that is linked to an ACO, hospital, or even larger medical group in order to be considered for inclusion," said Dr. Goldsmith. "If a podiatrist in a community is not in, then that podiatrist is out and will need to look toward other reimbursement models such as MIPS or commercial equivalents."

Dr. Christina said more specifics on the alternative payment model route are expected, too, upon the forthcoming release of draft rules. "There are still some details to be worked out on the specifics of how they are going to run this," he said. "But besides MIPS and the ACO-type

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things, they have indicated there may be other alternative models based on if the provider shares in some of the risk. They haven't clearly defined that, but that's what is going to be coming."

What's Right for You?

As to which payment program is the best, the answer will vary by podiatrist and, in many cases, will be influenced by a slate of factors, such as a practice's location, patient population, and EHR set-up (or lack thereof).

The opportunity to join up with an ACO will likely depend on considerations as basic as whether or not any even exist in your region. While Dr. Christina is aware of a handful of podiatrists in Massachusetts who have affiliated with ACOs, Keith Borglum, a practice management consultant at Professional Management and Marketing in Santa Rosa, CA, worries that, in some areas, local-level medical politics could prove a barrier to podiatrists.

"A lot of orthopedists are not supportive of disciplines like podiatry and chiropractic, and they want to keep the surgeries for themselves," said Borglum, a member of the National Society of Certified Healthcare Business Consultants. "So they often have an interest in keeping podiatrists out of the ACO."

MIPS, meanwhile, factors EHR use in its formula for bonuses and penalties. For the fair number of independent podiatrists who opted out of the Meaningful Use program and stuck with paper-based records, participation in MIPS will require getting on board with EHR or facing payment penalties. Although that may sound scary, taking a step back and assessing what that really means for your practice may ease your mind.

"Say 20% of your practice is Medicare," reasoned Borglum. "You are facing by year 2020 or so maybe a 6-8% penalty on your Medicare. A 6% penalty on 20% of your practice is about a 1.2% penalty on your whole practice," said Borglum.

In other words, the dollars and cents of the issue may not justify the purchase of an EHR, the time it would take to set it up, and the reduced provider productivity linked with using it, he said—especially during the early years of MIPS and continued problems with interoperability among EHR systems.

In short, the bark of a penalty is far worse than its bite, Borglum said, referencing recent CMS data that showed 117,000 of 209,000 physicians hit with Meaningful Use penalties lost less than $1,000.

Other Insurers

As Medicare goes, so go other insurers, some say. But healthcare consultant David Zetter, founder of Zetter Healthcare, Mechanicsburg, PA, isn't one of them. For the foreseeable future, value-based care—in the form of MIPS, anyway —is solely a Medicare thing, he said. "Fee for service is not going away. It will never go away," said Zetter, also a National Society of Certified Healthcare Business Consultants member. "There are plenty of commercial payers out there that haven't even latched on to this program. Very few of them track quality measures yet, so how are they going to reimburse you for quality if they aren't even tracking that information?"

However, Dr. Christina sees the emergence of tiered health plans as evidence that private payers are beginning to factor value into payment. In a tiered plan, patients pay lower copays for choosing providers the insurer con-

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How to Protect Your Practice

Podiatrists concerned about the impact value-based reimbursement may have on their practice aren't powerless. Experts say there are several steps you can take to protect, and even bolster, your bottom line amid pay-for-performance uncertainty.

- ***Become an expert coder.*** "There is much more loss in income from inadequate or incorrect coding than from anything else. Most providers under-code because of fear of Medicare," said Keith Borglum, Professional Management and Marketing, Santa Rosa, CA. "By far, the best thing you could invest in is not cattle or oil wells but in an annual coding seminar. Learn it well enough to get on stage and teach it."
- ***Limit payer portions.*** To guard against reimbursement swings, no single payer, be it Medicare or a private insurer, should hold a majority share in a practice's reimbursement picture. "Don't let Medicare be more than one third. Don't let any plan be more than one third of your practice," said Borglum. "Even better, keep it down under one quarter."
- ***Pursue alternate profit streams.*** "You can get into other ancillary businesses to augment your podiatry," said Derrick Handwerk, Handwerk Multi Family Office, Lansdale, PA. Handwerk has physician clients who have begun offering Botox injections, for example, to supplement their reimbursement income and keep their practice independent. "Podiatrists can work as an expert witness for attorneys or sell orthotics or services that are lucrative and outside the Medicare system. Broaden your perspective and get creative."
- ***Consult an expert.*** You don't have to go it alone. Healthcare business consultants are geared to help providers evaluate the dollars-and-cents side of their practice and provide advice on how to proceed. The National Society of Certified Healthcare Business Consultants has a find-a-consultant feature on its website. •

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siders to offer the highest quality care at the lowest cost. "If you see Dr. X on the highest tier in terms of low cost and high quality, then your copay is $10. If you see Dr. White, who's on the mid-level tier, it might be a $20 copay. The lowest level is considered a higher cost provider, and you might have a $30 copay," explained Dr. Christina. "So there already are some value-type things going on in the private insurance world."

Early Stages

Value has been a buzzword ever since the passage of the Patient Protection and Affordable Care Act. Nevertheless, the reality is that value-based reimbursement is still very new to the payment scene, and payers are still trying to figure out how it will work best.

"U.S. healthcare is probably at the toddler stage of transition to value-based reimbursement," said Dr. Goldsmith. "There is an awful lot of growing left to do. While it sounds great that practices are to be incentivized to provide quality care and better outcomes, some of the thresholds set by payers are not evidenced as having actually achieved better outcomes at lower costs."

Personal CFO Derrick Handwerk, managing partner of Handwerk Multi Family Office, Lansdale, PA, uses a baseball analogy to describe the country's transition to this new payment framework. "You might say we are in the second inning. But an inning can go on for quite a long time, or an inning can be three batters up to three batters down," he said. "I think we are in the early innings of what's going on."

No one can predict whether value-based reimbursement will fly or fizzle. But with MIPS and alternative payment models on the agenda, podiatrists will best serve themselves by getting educated on their options. "Knowledge is everything. Understanding both systems of reimbursement, now, is key to planning on inclusion in alternative payment models or gearing a practice to meet and exceed MIPS thresholds. The bigger the practice group, the easier achieving the goals," said Dr. Goldsmith. **PM**

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A Closer Look at MIPS and APMs

Are you prepared for the new payment paradigms?

BY SEVERKO HRYWNAK, DPM, MD

Beginning in 2019, the new Merit-based Incentive Payment System (MIPS), which is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), will raise the focus on physician performance measurement to a new level.

As stated in a recent article from *Medical Economics* from March 22, 2016, "After seven years of requirements driving for high adoption rates for electronic health records (EHRs), the federal government is planning to put an end to its Meaningful Use program—at least as it exists today. The government instead will implement programs that focus less on how physicians use EHRs and more on their patients' health outcomes. Andy Slavitt, MBA, acting administrator of the Centers for Medicare & Medicaid Services (CMS), said recently the agency will fold Meaningful Use into a new system implemented under the Medicare and CHIP Reauthorization Act of 2015 (MACRA).

While MACRA also continues to require that physicians be measured on their meaningful use of certified EHR technology for purposes of determining their Medicare payments, it provides a significant opportunity to transition the Medicare EHR Incentive Program for physicians towards the reality of where we want to go next," Slavitt stated in a Jan. 19 blog posted along with Karen DeSalvo, acting assistant secretary for the Department of Health and Human Services.

According to CMS, MACRA "also makes it easier for more healthcare providers to successfully take part in our quality programs in one of two streamlined ways: Merit-based Incentive Payment System (MIPS) [and] Alternative Payment Models (APMs)."

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MIPS will replace the Physician Quality Reporting System (PQRS), and CMS will adjust Medicare payments to most physicians either up or down by as much as 9% depending on how well they score in four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records systems. Also, physicians who score extremely high will be eligible for a 27% payment bonus.

A recent quote from the AMA said, "Just remember one thing and one thing only, physicians will be getting a lot less income in the years to come."

The APMA Health Policy is working on this, and at the recent webinar held on March 23, 2016, "Highlights of Physician Payment Reform" provided an update. In summary, this update did very little to explain how much influence this profession will have on CMS and the insurance industry to protect our future incomes. But, what it did do was provide vital information on all the parameters regarding the new payment model that will replace the traditional fee-for-service that has been in force for many years with CMS.

The provisions of MACRA do the following: repeal the sustainable growth rate (SGR) formula and prevent a scheduled 21 percent cut in the Conversion Factor (CF); maintain the building blocks of the Physician Fee Schedule (PFS) with respect to Relative Value Units (RVUs) for physician services based on HCPCS codes, CF, and adjustments for budget neutrality. MACRA is a new consolidated pay-for-performance program, a Merit-Based Incentive Payment System (MIPS) including a new Alternative Payment Model (APM) to provide incentives; and it reverses CMS regulation for transitioning to 0-day global surgery payment.

This ultimately will change how we get paid for our professional services. The Conversion Factor (CF) is mapped out as follows: July through December 2015 the update was 0.5%, 2016 the annual update is 0.5%, 2017 through 2019 the annual update will be 0.5%, 2020 through 2025 there will not be any annual update, 2026 and beyond there will be two conversion factors: qualifying APM participants will have an annual update of 0.75% and all other healthcare providers will have an annual update of 0.25% in their respective Medicare fee schedules.

Beginning in 2019, CMS consolidates Electronic Health Record (EHR), Physician Quality Reimbursement System (PQRS), and the Value Based Modifier (VBM) into one large-pay-for-performance program with the following performance categories: Quality, Resource Use, Clinical Practice and Improvement Activities, and Meaningful Use of Electronic Health Records. The MIPS Eligibility Requirements in 2019 and 2020 will include eligible professionals (EPs), which includes all Medicare physicians, physician assistants, nurse practitioners, clinical nurse specialists, and registered nurse anesthetists. This may be expanded to include other healthcare professions.

There will be exclusions to MIPS: Qualifying APM Participant, Partial Qualifying APM Participant that does not report on all the MIPS measures, low volume providers, as determined by the Secretary (volume may be determined by number of Medicare patients), along with the number of services, or allowed charges billed. Based on a failure of the required performance categories listed above, the provider could see as high as a 9% reduction by 2022. In the future, physician groups will have a greater advantage in these performance categories versus the independent physician, and hence a physician must be considered part of a "group."

Starting in 2018, the MACRA law will have new claims reporting requirements to facilitate attribution for resource use measure. Claims will include information about: applicable care episode, patient condition, and the patient relationship code. Possible relationship codes could include: primary responsibility for a patient over an extended time period, lead physician or practitioner during an acute episode, supportive role during an acute episode which will include occasionally furnishing services, typically at the request of another provider, and furnishing items (DME) and services only when ordered by another provider.

MACRA will also have Alternative Payment Models (APM) which include: The Qualifying APM Participant, who will have significant participation in APM, eligibility for bonuses (2019-2024), higher physician fee schedule (PFS) updates starting in 2026, and no MIPS. Alternatively, The Partial Qualifying APM participant will have slightly lower thresholds for participation, no bonus,

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lower PFS annual update starting in 2026, and no MIPS. There are still many details regarding these actual qualifications regarding the APM and they will be revealed more clearly and/or modified as they become implemented and will be at the sole discretion of the HHS Secretary. However, starting in 2019 and through 2024, qualifying APM participants receive a lump sum 5% bonus payment (in addition to other APM payments).

In summary, the key MACRA Provisions Physician Payment Reforms are as follows: an annual 0.5% update to the Conversion Factor (CF), which applies for July through December 2015 and for 2016 through 2019. The CF is then frozen for the next six years (2020 through 2025). Physicians and others are eligible for incentive payments under a new Merit-Based Incentive Payment System (MIPS). Poor performers incur payment reductions. Health professionals participating in certain alternative payment models (APMs) are NOT subject to MIPS and could qualify for bonus payments. After 2025, there are two CFs and the updates are 0.75% for qualifying APM participants and 0.25% for others.

What is certain is that fee-for-service is being phased out and an incentive-based performance payment model has taken its place.

How podiatry will fit into this model is yet to be determined. But the fact remains that this will be an arduous task for any physician in independent practice. The number of requirements that it will take to get paid by Medicare and eventually other insurance companies may not be worth attempting in the long run. Regardless of the foot care services inherently needed by the public, podiatrists and other physicians who are in private practice may just consider MACRA to be financially burdensome and just opt out of Medicare completely.

This is an inevitable decision. But, as the current physician population is nearing retirement or just wants to leave the profession completely, it will slowly be replaced by employed physicians who will just accept the way things are and receive their contracted compensation and not worry about how they get paid. The fact is that over 62% of the physician population is employed currently and statistics show that that number will increase 20% over the next few years.

The rigors of the MACRA law will certainly change how physicians receive their revenue. But, was SGR the better of the two evils? Or was the SGR fix delayed for a sustained period of time so that the particulars of the new MACRA law and payment model could be formulated to replace it? The answers to these questions may never be known. However, what is certain is that fee-for-service is being phased out and an incentive-based performance payment model has taken its place.

How a podiatrist will make a living from here on out is still unknown. However, what is known is that physician extenders such as physician assistants, nurse practitioners, and other ancillary fully licensed providers are now providing foot care in most medical arenas. Now, the question remains on the table whether or not these providers, who are not podiatrists, will be able to fit the new model of quality care in a much more cost-effective manner. With that said, will there be a place for the podiatric physician, who does not have a full license, in these alternative payment models? Therefore, as with all things new, we will just have to wait and see. **PM**

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