Regulatory Burden and Aging
Baby Boomers – Patient Throughput Incongruity

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Baby Boomer Demographic

• Born during the post-World War II baby boom
• Birth dates between 1946 and 1964

Population Age Structure: 1950 to 2020

Percentage Increase of the Elderly and Oldest Old Populations: 1995 to 2020

Source: U.S. Bureau of the Census
AHA 2030 Boomer Projections

- Over 65 population will double
- 60% of population will be managing more than 1 chronic condition
- More than 1 in 3 will be considered obese
- 25% will have diabetes
- Nearly 50% will have arthritis

Source: American Hospital Association

Life Expectancy 1900 - 2050

Demand: The Short Story

- The baby boom means more people will need care
- Eye disease will increase
  - AMD
  - Cataract
  - Glaucoma
- ACA increases number of insured
  - ≥30 million
- New technology creates more eye care
  - Lucentis, Avastin, Eylea, Jetrea
  - OCT
  - Ophthalmic lasers

New Health Care Payment Models

- Category 1 – fee for service with no link of payment to quality
- Category 2 – fee-for-service with a link of payment to quality
- Category 3 – alternative payment models built on fee-for-service architecture
- Category 4 – population-based payment


CMS Quality Programs

- Physician’s Quality Reporting System (PQRS)
- Value-based Payment Modifier (VM)
- Health Information Technology (HIT) Incentives
- Merit-Based Incentive Payment (MIPS)
Regulatory Burden and Its Effect on Access to Care

- Prior to January 1, 2015, all public and private healthcare providers had to have adopted and demonstrated “meaningful use” (meaningless use) of electronic health records (EHR) in order to maintain their existing Medicare reimbursement levels.

What EHR is supposed to do:
- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

EHR: The Hope

- Access to timely, accurate, detailed patient information
- Point-of-care clinical decision support
- Patient-centric care delivery methods
- Data analysis opportunities
  - Individual patient
  - Population studies

MU Attestations dropped in 2014

- Attestations dropped 12% from 2013
- Less than 1/3 attested to Stage 2 in 2014
- 62% of providers remain at Stage 1
- Reasons for decreased participation in 2014
  1. Cost to upgrade to a 2014 certified product
  2. Vendor issues with installation of upgrade
  3. Patient portal issues

Sources: Modern Healthcare Today 8/12/15

AMA Survey

- 34% satisfied or very satisfied with their EHR systems, compared with 61% asked five years ago
- 42% of respondents described their EHR system’s ability to improve efficiency as difficult or very difficult
- 43% of respondents still addressing productivity challenges
- 54% of respondents said EHR system increased total operating costs
- 72% of respondents described their EHR system’s ability to decrease workload as difficult or very difficult

Source: https://www.advisory.com/_apps/dailybriefingprint?i=D44C75B8-2472-4F8F-B7CA-F689A592A33C – Published August 2015

Survey Variables

- Size of practice
  - Physicians in large-groups having better EHR experiences
  - Large practices have more staff to support EHR adoption and maximization
  - Smaller practices bought inexpensive and / or free EHRs with little or no support.
- Server vs. Cloud-based
  - Improvements in web-based EHRs have “reversed overall satisfaction . . .”
- Time
  - 3 years of use or less – 25% satisfied
  - 5 years or more – 50% satisfied


EHR Adoption Sequelae

According to data published in Medical Economics, physicians implementing EHR experience
- a decrease in patient volume.
- an increase in total work hours

**Efficiency – Scribes**

- Detail-oriented, willing to learn, good work ethic
- Assertive enough to keep the physician on task and ask questions when they don't understand something
- Consider existing staff
- Assess computer skills (i.e., typing)


**EMR and Scribes**

- Objective 3 – Computerized Provider Order Entry (CPOE): Use CPOE for medication, laboratory and radiology orders
- Certified ophthalmic scribes that perform duties similar to a medical assistant, certified ophthalmic assistants and certified ophthalmic technicians are now permitted to enter medication, radiology, and laboratory test orders for purposes of meaningful use. Physicians using certified ophthalmic scribes should maintain in their records a document illustrating that the duties the certified scribe performs are similar to the duties of a certified medical assistant.

Source: AAO

**EMR and Scribes**

- COA, COT, COMT, CO, CMA are certified and credentialed medical assistants
- ACMSS certified scribe (CMSS), OSC® Ophthalmic Scribe Certification (JCAHPO)
- AAMA credentialed scribe for assessment-based recognition in order entry

Source: AAO

**PQRS**

- PPACA made PQRS mandatory by 2015
- Punitive if not participating in 2015
  - 1.5% reduction in Medicare reimbursement in 2015
  - 2.0% reduction in Medicare reimbursement in 2016 and beyond
- On 9/11/15, CMS notified eligible professionals who would be penalized in 2016 for failure to be successful PQRS reporters in 2014

Source: Patient Protection & Affordable Care Act (PPACA)

**2013 PQRS Results**

- Participation increased from 15% to 51% between 2007 and 2013
- Success rates were highest with those submitting through a registry (99%) or EHR (95%)
- 28% of ophthalmologists were penalized in 2015 either due to nonparticipation or failure to successfully submit PQRS data
- Claim errors made with incorrect procedure codes for the measure
- Registry errors for incorrect performance rates
- EHR errors for invalid HIC numbers

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html)

**Value-based Payment Modifier**

- Provides for differential payment to a physician or group under the MPFS based upon the quality of care furnished compared to cost during a performance period.
- Program in effect for groups of >10 in 2016; based on 2014 performance
- Program in effect for all providers in 2017; based on 2015 performance
- Based on participation in PQRS program
- Applied at the Tax Identification Number (TIN) level

Source: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html)
2014 VBM Results

- Applied to groups of 10 or more eligible professionals
- Results affect 2016 reimbursements
- 97.8% - 8,208 groups have had no change in Medicare reimbursement in 2016
- 0.7% - 59 groups have a downward adjustment of either 1% or 2%
- 1.5% - 128 groups have an upward adjustment of either 15.92% or 31.84%

Merit-Based Incentive Payment System (MIPS)

- Combines and builds on 3 existing incentive programs
  - PQRS, VBM, MU
- Adds a new category – Clinical Practice Improvement Activities
- Score of 0-100 given based on performance in each of the 4 categories
- Composite score compared with performance threshold to determine bonus vs. penalty

Source: Arnold and Porter Advisory – Saying Farewell to the Sustainable Growth Rate: Are Physicians Better Off Now? 4/15/15; Medscape.com

Helpful Hints – PQRS / VBPM

- Consider a registry or EHR reporting
- Report for all eligible professionals
- Start early with a plan for all providers
- Use measure groups if possible
- Review Quality Resource Use Report

Merit-Based Incentive Payment System (MIPS)

Government Warnings

Our government warns us of
- increasing patient volumes as Baby Boomers age.
As a result
- physicians will have to see more and more patients and;
- they will have to increase patient throughput to do that.
BUT
- Government regulations and mandates work in opposition to practice efficiency.
- Physicians need to see more patients, but can’t because Bureaucracy slows them down.

Government Warnings (cont.)

AND
As a reward for seeing more patients in the face of regulatory burdens (i.e. working longer days), physicians get to do this while reimbursements decline and/or new payment models.

What happened in 2013?
- Standard cataract surgery reimbursement reduced by 13%
- Complex cataract surgery reduced by 21%
- Technical components of 2nd and subsequent diagnostic tests performed on the same day reduced by 20%
- Government mandated 2% sequestration cuts on all Medicare reimbursements (including MU)

Medicare Access and CHIP Reauthorization Act of 2015

- Repealed flawed Sustainable Growth Rate (SGR)
- Provides 5 years of 0.5% positive updates to Medicare physician reimbursement

Source: ASCRS 4/14/15
Sequestration

- Sequestration ordered as of March 1, 2013
- Reduces Medicare payments 2%
- Bipartisan Budget Act of 2015, H.R. 1314, extends sequestration 2 more years through 2025

Source: ASCRS Washington Watch Weekly 3/8/13; 10/30/15

2016 Relative Value Unit Changes

- Amniotic membrane placement (65778) 4%
- Probing NLD (68810) -19%
- Trabeculectomy (66170 & 66172) -19%
- Trabeculoplasty (65855) -19%
- Complex RD repair (67113)* -19%
- RD repair (67108)* -19%
- Destruction retinopathy, cryo (67227) -53%
- Treatment of retinopathy PRP (67228) -66%

* Additional reductions in 2017 subject to phase in rules
Percentage change from 2015

Phase-in of Significant RVU Reductions

“. . . for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs shall be phased in over a 2-year period.

. . . 19 percent of the reduction in value in the first year, and the remainder of the reduction in the second year”

Source: CMS-1631-FC

Phase-in of Significant RVU Reductions

“We also excluded from the phase-in as new and revised codes those codes with changes to the global period, since the code in the current year would not describe the same units of service as the code in the update year.”

Source: CMS-1631-FC

What’s Happening with GME?

GME (sic Graduate Medical Education) is at a crossroads:
- Residency program directors are under pressure to do more with less.
- Beginning in 2014, budget cuts called for government $ reductions for GME.

Most GME dollars are from CMS
- Approximately 2/3rds (about $6.5 billion) is an indirect medical expense (IME) adjustment
- Goes to teaching hospitals for training associated patient care costs
- FY 2013 budget reduced IME by $9.7 billion over 10 years (beginning 2014) and;
- The number of residency slots was frozen at 1996 levels by the Balanced Budget Act of 1997.

Source: The Squeeze Is On: Residency Programs Face New Pressures, Jean Shaw, Contributing Writer (http://www.aao.org/eyenet/article/squeeze-is-on-residency-programs-face-new-pressure)

Characteristics of New Residents

- More are sub-specializing; fewer generalists
- Fewer pediatric and neuro specialists
- Lifestyle is an important consideration
- Less time devoted to patient care

Source: The Squeeze Is On: Residency Programs Face New Pressures, Jean Shaw, Contributing Writer (http://www.aao.org/eyenet/article/squeeze-is-on-residency-programs-face-new-pressure)
Changes To Payment Methodology

- Bundling of services
- Payment for episodes of care
- Capitation
  - Full capitation
  - Contact capitation
- Value based
  - Lower cost and equal or better outcomes = value

Bottom Line

- Physicians need to see more patients
- Government mandates make that difficult
- Physicians are coping with decreasing reimbursements and anticipated new payment models.
- Cutbacks resulting in less residency programs and/or less students in the ones that survive

What do we do?

Strategic Planning

- Gather information about opportunities in your locale
- Do cost accounting for all items and services you provide
- Gather outcomes and quality measurements
- Develop business and practice operation acumen that exceeds what you need to know
- Engage the right people to assist (e.g., actuaries, attorneys, consultants)

Sources: AMA Practice Management Center

Next Steps

- Strengthen bargaining position – size helps
- Improve market visibility; increase market share
- Diversify to reduce risk; integrate new lines of business
- Assess and improve customer service levels
- Increase capital; grow balance sheet
- Recruit human resources – increase talent pool
- Strengthen management team
- Reduce overhead expenses proportionately
- Revise physicians’ compensation plan
- Revise shareholders’ agreements

Practice Efficiency Tips

**Bottleneck Elimination**

- Minimize walking (clinic staff and patients)
  - Move patients to physicians and technicians
  - Create centrally located dilating room
  - Assign individual technician exam rooms
  - Create side-by-side physician exam rooms
- Perform General Supervision diagnostic tests on non-clinic days
- Create 6 foot clinic hallways (new building or renovating)
- Utilize scribes
- Duplicate equipment (e.g. lensometer in each tech room)

Income Replacement Strategies

- Optical shops
- Hearing services
- Patient reactivation programs
- Pharmaceutical sales (e.g. vitamins)
- Ancillary tests and procedures
- Tear osmolarity testing
- Cosmetic services and procedures
- Allergy testing