New Physicians and Residents:
Alternative Payment Models - Practicing Family Medicine in a Managed Care Model

Nicole Bixler, DO, MBA, FACOFP
ACOFP FULL DISCLOSURE FOR CME ACTIVITIES

Please check where applicable and sign below. Provide additional pages as necessary.

Name of CME Activity: 2017 ACOFP Annual Convention & Scientific Seminars
Dates and Location of CME Activity: March 18 - 19, 2017, Gaylord Palms Resort and Convention Center, Kissimmee, FL, United

Name of Faculty/Moderator: Nicole H. Bixler, DO MBA FACOFP

DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

X A. Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services.

B. I have, or an immediate family member has, a financial relationship or interest with a proprietary entity producing health care goods or services. Please check the relationship(s) that applies.

- Research Grants
- Speakers' Bureaus
- Ownership
- Consultant for Fee
- Stock/Bond Holdings (excluding mutual funds)
- Employment
- Partnership
- Others, please list:

Please indicate the name(s) of the organization(s) with which you have a financial relationship or interest, and the specific clinical area(s) that correspond to the relationship(s). If more than four relationships, please list on separate piece of paper:

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<th>Organization With Which Relationship Exists</th>
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*If you checked "Speakers' Bureaus" in item B, please continue:
- Did you participate in company-provided speaker training related to your proposed topic? Yes: No:
- Did you travel to participate in this training? Yes: No:
- Did the company provide you with slides of the presentation in which you were trained as a speaker? Yes: No:
- Did the company pay the travel/lodging/other expenses? Yes: No:
- Did you receive an honorarium or consulting fee for participating in this training? Yes: No:
- Have you received any other type of compensation from the company? Please specify: Yes: No:
- When serving as faculty for ACOFP, will you use slides provided by a proprietary entity for your presentation and/or lecture handout materials? Yes: No:
- Will your topic involve information or data obtained from commercial speaker training? Yes: No:

DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS

X A. The content of my material(s)/presentation(s) in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

B. The content of my material(s)/presentation(s) in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated below:

I have read the ACOFP policy on full disclosure. If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether a conflict of interest may exist, and I may be asked to provide additional information. I understand that failure or refusal to disclose, false disclosure, or inability to resolve conflicts will require the ACOFP to identify a replacement.

Signature: ___________________________ Date: 1/19/2017
Nicole H. Bixler, DO MBA FACOFP

Please email this form to Joanne@acofp.org as soon as possible
Deadline: Friday, January 20, 2017
Alternative Payment Models – Practicing Family Medicine in a Managed Care Model

Nicole Heath Bixler, DO, MBA, FACOFP
New Physicians and Residents Lecture Series
ACOFP Convention – Kissimmee
March 17, 2017

A little about me...

- Graduate of Philadelphia COM – 2002 with a MBA degree obtained from St. Joseph’s University in Health Administration in 2000
- Osteopathic Family Practice residency at Frankford Health System in Philadelphia
- Worked in “traditional” FP office for 3 years
- Now practice in Medicare Managed Care Model for past 9 years
- ACOFP Board of Governors, Past President–FSACOFP, Immediate Past President –FOMA
- In practice with my husband and mother to 3 fabulous girls
What is important to me...

- Providing well rounded primary care that utilizes all the skills an osteopathic family physician possesses through training and the culture of our profession
- Being an advocate for our profession through awareness, leadership and education of future physicians
- Maintaining a balance of work and home life
- Providing for my family financially and serving as a role model to my girls

Why I am where I am...

- Learning early on what I loved most about being a family physician
  - time to talk to my patients
  - using entire skill set
  - being able to practice in multiple settings
  - having time to be involved in our profession
  - ability to use business education
Insurance Terms...Alphabet Soup

- A review of terms..
  - HMO
  - PPO
  - POS
  - HDHP with or without HSA
  - Medicare Advantage – Risk or Non-Risk
  - Alternative Payment Model
  - ACO
  - Direct Primary Care
  - MIPS, MACRA
  - ....where does it end?

HMO

- Health Maintenance Organization (HMO)
- Delivers health services through a network
- Least amount of freedom to choose health care providers
- Predictable out-of-pocket costs for patient
- Primary care doctor manages care and completes referrals to specialists when needed
- Per member per month payment to doctor regardless of amount of care provided and bill for services rendered
PPO

- Preferred Provider Organization (PPO)
- Moderate amount of freedom to choose health care providers -- more than with an HMO
- Generally higher out-of-pocket costs for patient than with an HMO (higher premiums and co-pays and over charges)
- Typically no referrals needed for specialists
- Ability for patient to manage own health
- Doctor collects co-pays and bills for services (fee for service)

POS

- Point-of-Service Plan (POS)
- Plan blends features of an HMO with a PPO
- More freedom to choose your health care providers than you would in an HMO, but a primary care doctor coordinates care and refers to specialists
- Cost is typically between HMO and PPO for patient
- Doctor charges co-pays and bills for services
HDHP with or without HSA

- High-Deductible Health Plan / Health Savings Account
- Patient pays less for insurance with a high-deductible health plan
- The plan may be an HMO, PPO, or POS
- Higher out-of-pocket costs than many types of plans, once maximum out-of-pocket amount is reached, the plan pays 100% of care
- A health savings account (HSA) helps pay for care (money put in HSA is not taxed)
- Doctor charges based on type of plan
- The “Obamacare” plans for the uninsured were HDHP

Medicare Advantage

- Type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits
- Medicare Advantage Plans include HMOs, PPOs, Private Fee-for-Service Plans, Special Needs Plans, and Medical Savings Account Plans
- Medicare services are covered through the plan and aren't paid for under original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage and other benefit services (vision, dental, wellness programs)
Medicare Terms

In general, Part A covers:

- Hospital care
- Skilled nursing facility care
- Nursing home care (except custodial care)
- Hospice
- Home health services
- Physician office visits

Medicare Terms

- Part B covers:
  - Clinical research
  - Ambulance services
  - Mental health
  - Durable medical equipment (DME)
  - Getting a second opinion before surgery
  - Limited outpatient prescription drugs
  - Preventive services: Health care to prevent illness (like the flu) or detect it at an early stage
Medicare Terms

- Part D – Drug coverage

- 2 ways to get Medicare prescription drug coverage
  - Adding a Medicare Prescription Drug Plan (Part D)
  - Medicare Advantage Plan (Part C) such as an HMO or PPO that offers Medicare prescription drug coverage

**with rising prescription costs – the most beneficial aspect of Medicare Advantage Plan**

Medicare Risk Adjustment

- Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries
- By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs
- Risk adjustment is used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee
- Risk scores measure individual beneficiaries’ relative risk and risk scores are used to adjust payments for each beneficiary’s expected expenditures
Direct Primary Care

- Patients may pay a combination of visit fees and/or fixed monthly fees which grant them access to a set of medical services from primary care physician
- Paired with either:
  - a high-deductible health plan, as DPC alone will not cover catastrophic health care such as most surgeries
  - A health savings plan, or health reimbursement account as the associated tax–benefits can generally be applied to DPC and other medical expenses
ACO – Accountable Care Organization

- Large healthcare organizations provide coordinated care for entire population groups, typically within a defined global budget.
- Physicians participating in these organizations may be financially rewarded for hitting quality of care benchmarks and for achieving cost savings.
- Primary care physicians coordinate patient care by managing a multidisciplinary team of clinicians – allocating resources and integrating medical specialists into treatment plans as appropriate.

Participation in Practice Models

*from 2016 Medscape Physician Compensation Report*

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<th>Participation in Payment Models Over 5 Years</th>
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<td>Not in ACO now but plan to be this year</td>
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<tr>
<td>Accountable care organization (ACO)</td>
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Alternative Payment Model

- Examples: ACO, Comprehensive Primary Care Plus (CPC+), Medicare Shared Savings Program (MSSP), Comprehensive End Stage Renal Disease (CEC), **DPC, Medicare Advantage**

- 3 requirements to meet:
  - Use of electronic health records
  - Payments based on set of quality measures comparable to MIPS
  - Entity needs to bear financial risk for monetary losses in excess of a nominal amount or be an expanded medical home model

CMS Report – 2017

- Over 359,000 clinicians participating in APMs
- More than 12.3 million Medicare and/or Medicaid beneficiaries served
- 572 ACOs across the Shared Savings Program, Next Generation ACO Model and CEC Model
- 131 ACOs in a risk-bearing track, including in the Shared Savings Program, Next Generation ACO Model and CEC Model
- 2,893 primary care practices participating in CPC+
CMS announced that 30% of Medicare payments to physicians had to be tied to quality/value by the end of 2016 (this is through MIPS or APM)

When physicians were asked, “Will your practice be able to meet this requirement?”

- Yes 31.5%
- No 18.2%
- Unsure 50.3%
My Practice Model

- 2000 Humana Medicare Advantage HMO patients (100% at risk)
- 300 Humana Commercial/ Non-Medicare Advantage HMO/PPO patients
- 6 full time physicians, 1 full time Nurse Practitioner
- Staff our offices (3 locations) from 8–5, Monday – Friday
- On call service 24/7
- Cover 3 hospitals and 2 SNF to see our patients only

GOALS of our Model

- To provide the best preventive care to our patients
- Limit unnecessary hospitalizations and ER visits
- Provide full extent of care to our ability in office before referral to specialists
- Manage pharmacy costs
- Use of network physicians with competitive contracted rates
- Manage referrals to specialists
Preventive Care

- Each patient visit reviews all medical conditions
- Routine immunizations provided in office
- All bloodwork done in office with routine labs done prior to each office visit
- Every patient scheduled an OV every 6 months at a minimum
- Appointments for mammograms, DEXA scans, colonoscopies all made for patients by our office

Limit Unnecessary Utilization

- On call 24/7 by our physicians only and continually make patients aware of availability
- High risk patient program – calls by Nurse Practitioner to patients on a weekly – monthly basis
- Chronic Disease Management programs – CHF, DM, COPD
- Open appointments daily for sick visits
- Home visits if necessary
- Manage patients in the hospital
In–Office Procedures – Full Extent of Care

- Dermatologic procedures – suturing, biopsies, cauterization, cryotherapy
- Gynecologic exams
- Joint injections/aspirations
- OMT
- Bloodwork, EKG, Immunizations, PFT
- Allergy Testing/Allergy Injections
- Diabetes Education
- IVF/IV ABX/Iron infusions/Reclast/Port flushes
- Wound Care

Manage Pharmacy Costs

- Awareness of formulary coverage
- Utilization of generic medications
- Monitoring of utilization monthly
- Use of samples if possible for high cost medications
- Comparison of pharmacies for cost
- Direct order for high cost meds – Lovenox, IV ABX, hormonal therapy
Use of Network

- Establish solid working relationships with in-network physicians
- Streamline routine specialist procedures – colonoscopies, stress tests
- Comparison of rates for hospitals and free standing facilities
- Utilization of case management for out of network admissions and specialty care
- Use of capitated providers for DME

Manage Referrals to Specialists

- All care outside of primary care office has to be authorized
- Make sure all preliminary work up has been completed
- Review necessity of follow ups
- Make sure requested codes are accurate for level of service expected
- Review if studies have been completed previously prior to new studies (check hospital records)
- Use outpatient/inpatient services appropriately
NOT the Goal of our Model

- Restriction of care
- Limitation of services

Normal Daily Schedule

- 8–9 patients scheduled (at least ½ hour with each patient)
- Routine review of labs, consults, reports
- Routine refill of prescriptions
- Address telephone calls for sick visits and concerns
- With current provider staffing – on hospital/call coverage one week out of every 6 weeks
Administrative Duties

- Contesting reports
- Pharmacy lists
- STARS/HEDIS measures
- Physician scheduling
- Network changes
- Hospital staff meetings
- Weekly provider meetings
- Oversight of Nurse Clinical Coordinator

Why it works...

- Patients have a high level of satisfaction with the amount of face time with providers in office and continuity of care in facilities
- Higher rates of compliance for routine testing when scheduled by our office
- Reduction of unnecessary specialist visits
- Significant costs are saved – most notably with prevention of unnecessary hospitalizations and ER visits
- Truly is the model that a PCMH and ACO are designed to achieve
Benefits to Physician

- Less daily patient volume
- More meaningful interaction with patients
- Greater use of skills
- Better understanding of healthcare system
- More autonomy in patient care decision making (no authorization from insurance company)
- Less paperwork
- Can be financially rewarding
2016 Physicians Foundation Survey

- What two factors do you find most satisfying about medical practice?

  Patient relationships: 73.8%
  Intellectual stimulation: 58.7%
  Interaction with colleagues: 19.7%
  Financial rewards: 16.1%
  Prestige of medicine: 10.2%

2016 Medscape Physician Compensation Report Survey

[Bar chart showing minutes personally spent with each patient by gender and time intervals]

- Minutes Personally Spent With Each Patient
  - Men
  - Women

[Bar chart showing time intervals with percentages for each gender]
2016 Physicians Foundation Survey

- 80% of physicians describe themselves as either overextended or at full capacity, up from 75% in 2012 and 76% in 2008. Only 19% say they have time to see more patients.

- 48% (up from 44%) of physicians plan to take steps that would reduce patient access to their services, such as cutting back on patients seen, retiring, working part-time, closing their practice to new patients, or seeking a non-clinical job

Direct Quote from Physicians Survey

- Because of the comparatively high degree of responsibility they hold, which often rises to the level of life or death, the potential repercussions of a physician having a “bad day” are arguably higher than the bad days experienced by the great majority of other types of professionals. It is clearly preferable from the patient care perspective that physicians be professionally satisfied and engaged

- It also is preferable from the patient access perspective. The primary public policy and healthcare concern attached to low physician morale is the prospect of physicians modifying their practice styles in ways that reduce patient access, or the prospect that physicians will abandon patient care roles or leave medicine altogether
Questions?

- My practice location:

Immediate Medcare & Family Doctor of Spring Hill
120 Medical Blvd., Suite 103
Spring Hill, FL  34609

352–666–6950
nickbixdo@gmail.com

References

- physiciansfoundation.org
- medscape.com
- merritthawkins.com
- cms.gov