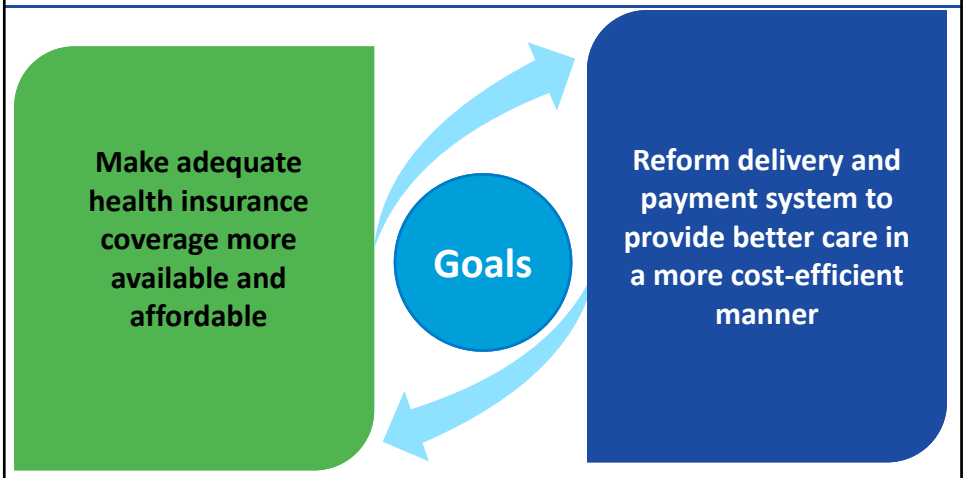
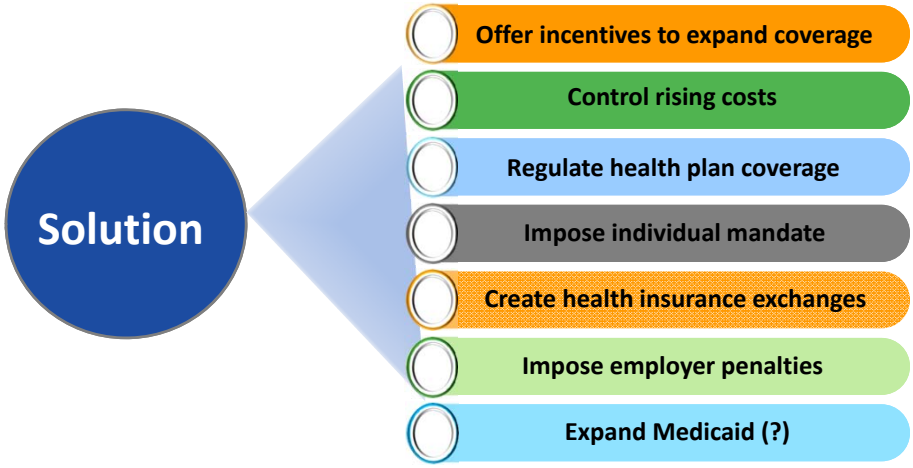
From Volume to Value:
New Payment Models to Incentivize Quality

Kansas Foundation for Medical Care
Quality Forum
June 6, 2013

ACA: Two Intertwined Goals



Available, Adequate, Affordable: The Seven-Part Solution



It's All About Money

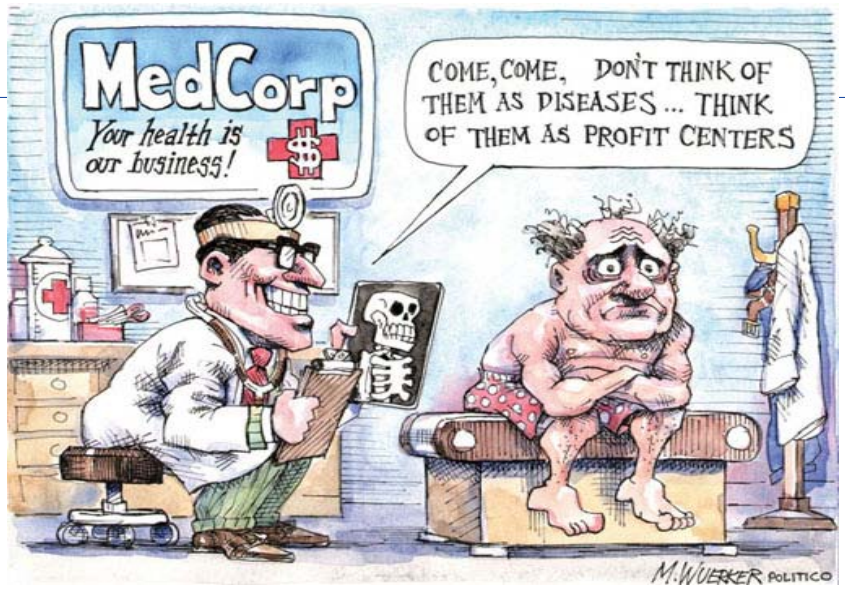
- **Medicare annual spend**
  - **2010**: $525B (15% federal spending)
  - **2020**: $922B
- **Medicaid annual spend**
  - **2010**: $401B ($271B federal/$130B state) (8% federal spending)
  - **2020**: $908B ($561B federal/$347B state)
- **Total annual spend**
  - **2010**: $2.64 trillion; 17.6% of GDP; $8,327 per capita
  - **2020**: $4.64 trillion; 19.8 % of GDP; $13,708 per capita

First Law of Improvement

Every system is perfectly designed to achieve exactly the results it gets

Volume-Based Reimbursement

- Reward providers for delivering more care
  - Not more health
  - Not high quality care
- Regulate providers to prevent overutilization and control costs



Evolution of Reimbursement

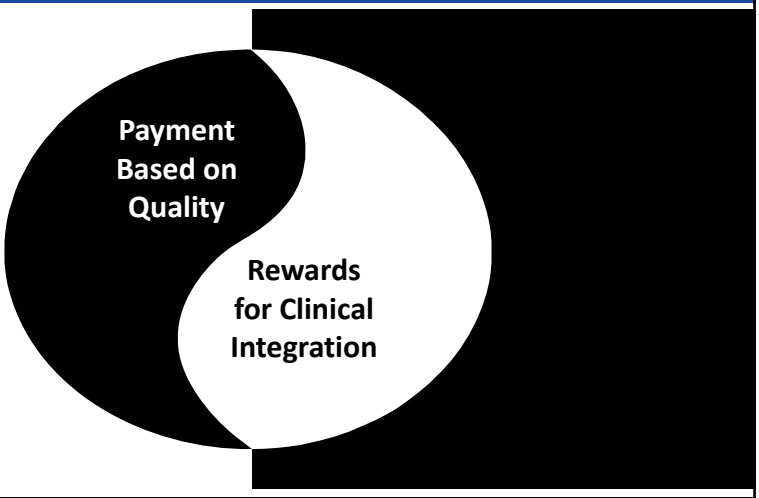
Fee for Service → Shared Savings → Bundled Payments → Partial Capitation → Global Payment

Reactive	Focused	Predictive
Visitor	Patient	Person
Symptomatic	Episode	Overall Health
Acute Needs	Most Common Conditions	Community Health Characteristics
Services and Supplies	Packaged Treatments	Manage Well-Being
Unit Based	Efficiency Based	Outcome Based
No Financial Risk	Partial Financial Risk	Full Financial Risk

Foundational Change

Today	Tomorrow
• Provide more services • Medical necessity as regulator • Cost is a function of charges	• Protocol drives what and when services are provided • Quality measures as regulators • Tracking and reducing costs is critical

Two Strategies



Payments Based on Quality
Four Tactics

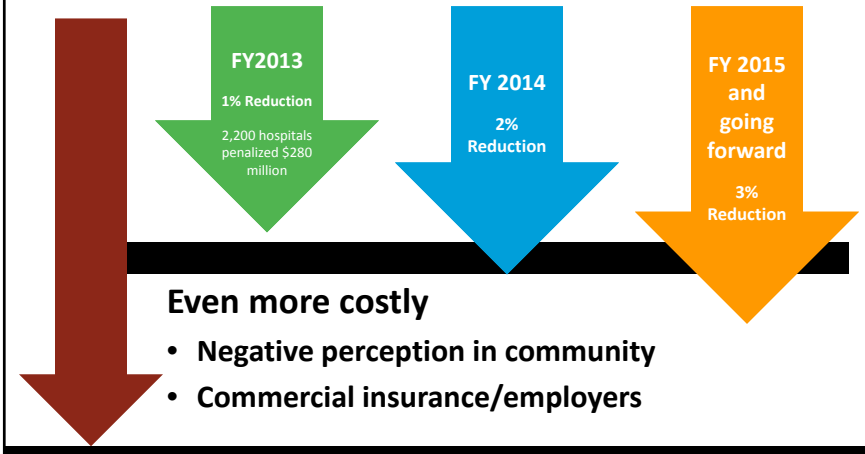
1. Hospital readmission reduction program
2. Hospital value-based purchasing
3. Physician quality incentives/penalties
4. Physician value-based purchasing

Hospital Readmission Reduction Program

- Penalty based on 3-year historical 30-day hospital readmission rates for AMI, heart failure, and pneumonia
  - Same or any other subsection (d) hospital
  - Reason for readmission irrelevant
  - List expands in 2015 to include hip/knee arthroplasty and COPD

Penalties

Penalty attaches to *all* DRG payments:



Even more costly

- **Negative perception in community**
- **Commercial insurance/employers**

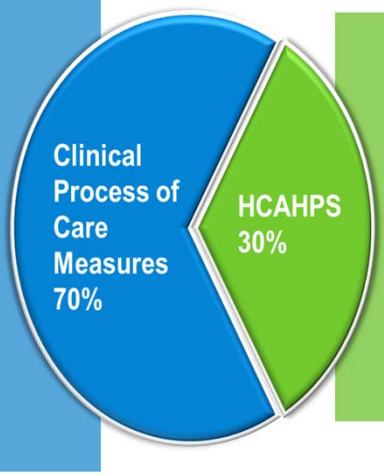
Hospital Value-Based Purchasing

- Medicare Modernization Act of 2003
  - Hospital IQR Program
    - Report on quality measures to avoid 2% cut in payment updates
    - 90% participation
- American Reinvestment and Recovery Act of 2009
  - Meaningful use incentive payments (quality reporting)
- Affordable Care Act of 2010
  - DRG modifier
  - HAC/never event penalty

DRG Modifier

- Adjustment to DRG payment based on clinical quality measures and patient satisfaction scores
  - Achievement and improvement
  - Budget neutral (winners and losers)
  - Percentage of DRG payments at risk (withhold and re-distribute)
    - 1.25% for FY2014

1. Fibronolytic therapy received within 30 minutes
2. Primary PCI received within 90 minutes
3. Discharge instructions for CHF
4. Blood cultures performed in Emergency Department for pneumonia
5. Initial antibiotic selection for Community Acquired Pneumonia
6. Prophylactic antibiotic received within one hour prior to incision
7. Surgery patients with appropriate selection of prophylactic antibiotics
8. Surgery patients with appropriate discontinuation of prophylactic antibiotics
9. Cardiac surgery patient with controlled post-operative serum glucose
10. Surgery patients with recommended venous thromboembolism prophylaxis ordered
11. Surgery patients who received appropriate venous thromboembolism prophylaxis before and after surgery
12. Appropriate beta blocker use in surgical patients



1. Communication with Nurses
2. Communication with Doctors
3. Hospital Staff Responsiveness
4. Pain Management
5. Communication about Medicine
6. Hospital Cleanliness & Quietness
7. Discharge Information
8. Overall Hospital Rating

Source: CMS Special Open Door Forum: VBP 2/10/2011

HAC/Never Event Penalty

- Begins in FY2015
- Top quartile will have payments reduced by 1 percent

Measures

- Proposed "never events"
  - Pressure ulcer rate
  - Volume of foreign object left in the body
  - Latrogenic pneumothorax rate
  - Postoperative physiologic and metabolic derangement rate
  - Postoperative pulmonary embolism or DVT rate
  - Accidental puncture and laceration rate
- Proposed HACs
  - Central line-associated blood stream infection
  - Catheter-associated UTI

Rock and a Hard Spot?

- JAMA: Surgical Complications and Hospital Finances
  - Analyzed data from 10-hospital system in southern US
  - Surgical complications = higher hospital contribution margins (except for Medicaid and self-pay)
  - Substantial adverse near-term financial consequences of reducing overall complication rate

Physician Quality Incentives

- Physician Quality Reporting System
  - Submission of reports, not achievement of scores
    - Range of reporting options
  - Carrots followed by sticks
    - 0.5% bonus in 2013 and 2014
    - 1.5% *penalty* in 2015 if ≠ report in 2013
    - 2.0% *penalty* in 2016 ≠ report in 2014 (and thereafter)
  - Meaningful use penalties
    - 1% penalty in 2015 if not MU in 2014; 2% in 2016; 3% in 2017; 4% in 2018 or 2019

Physician Value-Based Payment Modifier

- Phased in between 2015 and 2017
- 2013 performance determines 2015 modifier for providers in groups of 100+
- Budget neutral (winners and losers)
- wRVU x conversion factor x VBPM
  - Positive number = paid more
  - Negative number = paid less
- Far broader impact than Medicare payment

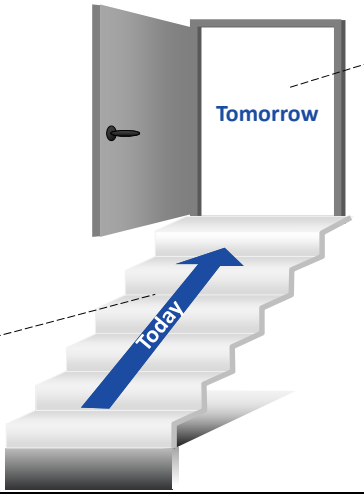
Physician Feedback Reports

- Individual reports on resource use and quality of care as compared to peer group based on Medicare data
- Used to calculate Medicare physician value-based payment modifier
- Schedule
  - By April 2013, reports to physicians in groups of 25+ in nine states based on 2011 data (CA, IL, WI, MN, MI, MO, IA, KS, NE)
  - By February 2014, reports to physicians in groups of 25+ nationwide based on 2012 data
  - All physicians by 2016

SGR Fix

- Formula used to calculate Medicare physician payment rates
- CBO estimates cost at $138 billion
- Proposal under serious discussion
  - Phase 1: Stable payment rates for specified period; medical specialties develop cost and efficiency measures
  - Phase 2: Payment adjustments based on quality
  - Phase 3: Payment adjustments based on efficiencies

Evolution of Relationships

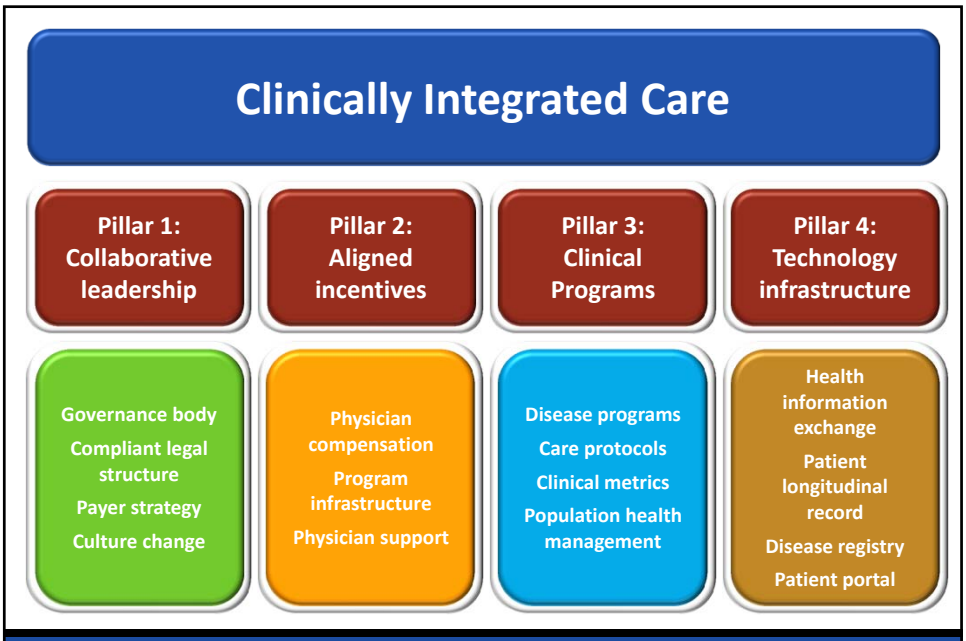


- Hospitals as police officers; physicians as cherry-picking competitors
- Exception-based practice
- Provider-entered care

- Care coordination and provider collaboration
- Evidence-based practice
- Patient-centered care

Clinical Integration

- Providers accountable to each other and to community to deliver high quality care in efficient manner
  - Collectively define and enforce standards of care
  - Coordinate patient care



Rewards for Clinical Integration Three Tactics

1. FFS Payment for Care Management
2. Accountable Care Organizations
3. Bundled Payments

FFS Payment for Care Management

- New Medicare payment for post-discharge transitional care management
- Key elements
  - Contact within 2 days of discharge
  - Face-to-face visit within 7 (or 14) days
  - Non-face-to-face care management services over 30-day period
- Chronic care management payments in CY2014?

Accountable Care Organizations

- Elliott Fisher's 2006 MedPAC presentation
  - Higher spending regions experience lower quality and satisfaction
  - Differences in spending = supply sensitive services
  - "No one is accountable for local capacity and political culture."
  - Create 5,000 extended hospital medical staffs accountable for care for defined population
    - Payment adjustments based on performance measurements

Accountable Care Economics

- Begin shifting risk from payer to provider
- ACO is risk management vehicle
- ACO risk = total FFS payments – benchmark
  - Held accountable for quality of care by performance standards
- HMO risk = provider cost – capitated payment

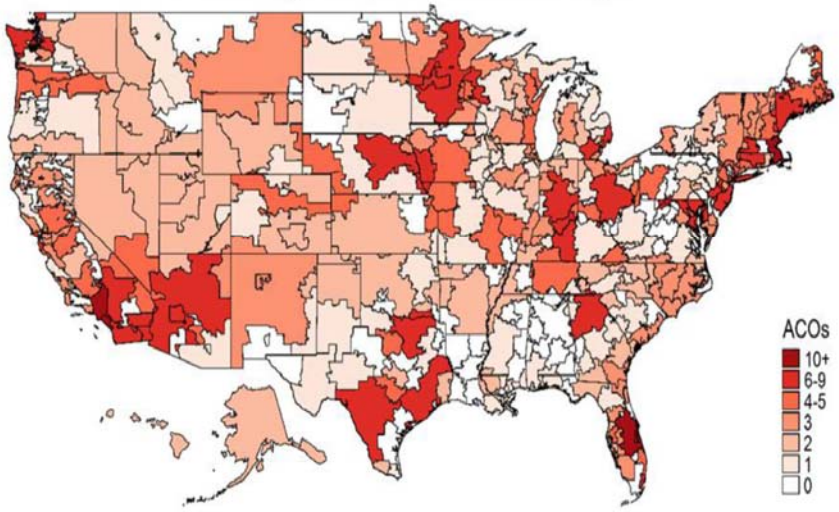
Calculating Shared Savings/Losses

- Each ACO participant continues to bill fee-for-service independently
- Eligibility for and level of shared savings based on performance score
- Calculate actual total cost of care for assigned patients against pre-determined benchmark
- Apply formula to determine share of savings (losses)

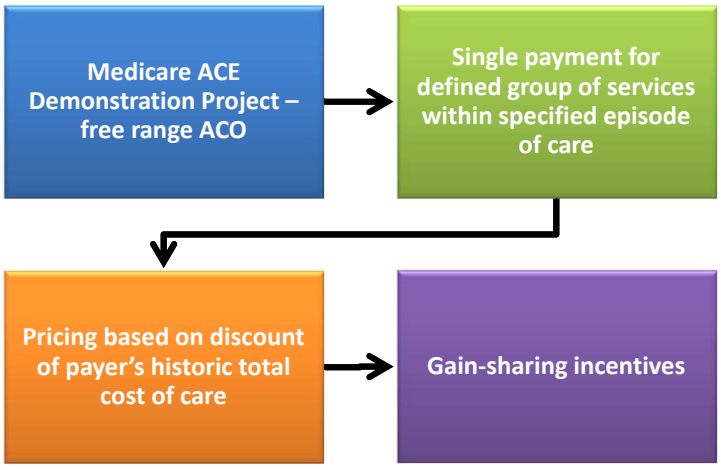
Medicare Shared Savings Program ACO Functions

- Establish and maintain quality assurance and improvement program
- Promote evidence-based medicine, patient engagement, care coordination, patient-centeredness
- Compile and report participants' quality measure scores
- Distribute shared savings and assess shared losses

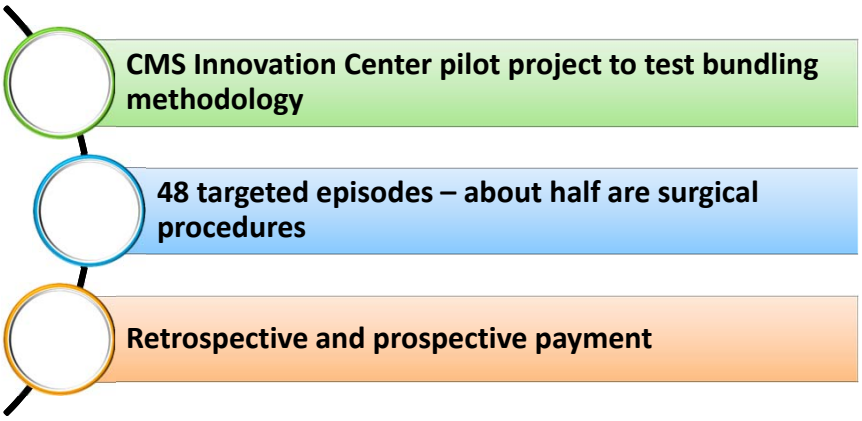
ACOs by Hospital Referral Region



Bundled Payments



Bundled Payments for Care Improvement Program



Commercial Payers

- Blue Cross Blue Shield of TN – ortho bundle
- Walmart bundled payments for spine and cardiac procedures
  - Exclusive to six "Centers of Excellence"
  - No-cost medical tourism for employees
- Cleveland Clinic's cardiac bundles with Boeing and Lowe's
- Carolina HealthCare cardiac bundles for private pay, local employers

8 Steps to Bundled Payments

- Define episodes of care
- Examine distribution of costs across services
- Identify sources of variation in care and costs
- Design pathways of care
- Assess performance of post-acute care providers
- Examine physician practice patterns to identify potential savings
- Assess levels/types of risk hospital is willing to assume
- Determine the bundle price

Thank You!

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