Winds of Change: Emerging Issues in Payment Models

SDSMA, May 29, 2015

David Basel, MD
Medical Director of Clinical Quality
Objectives

At the end of this continuing medical education activity, participants should be able to:

– Identify the financial, market and consumer forces that impact payment systems.
– Differentiate between the available new payment models.
– Assess the specific programs available and shift their thinking of the models available.
– Formulate a plan for switching models.
– Examine the population of patient centered medical homes, care coordination and transitions.
Introduction

Legacy Payment Systems
- Financial Forces
- Market Forces
- Consumer Forces

Paradigm Shift
- New Model(s)
- “Managing the Flip”
- Specific Programs

Population Health / Population Management
- Patient Centered Medical Homes
- Care Coordination, Transitions, Management
Legacy Payment System

• Hospital = Diagnosis Related Group (DRG)
  – Yale, 1970’s
  – CMS implementation, 1983
  – Subtle Incentives / Disincentives

• Clinic = Fee For Service (FFS) / CPT E/M
  – Subtle Incentives / Disincentives

• CAH’s
Costs by Age Categories

U.S. is spending much more for older ages

Copyright 2012 Kaufman, Hall & Associates, Inc. All rights reserved.
Medicare Beneficiaries and The Number of Workers Per Beneficiary

Source: Commonwealth
The Cost of Health Care

How much is waste?

- Unnecessary Services: $210 Billion
- Fraud: $75 Billion
- Excessive Administrative Costs: $190 Billion
- Inefficiently Delivered Services: $130 Billion
- Prices That Are Too High: $105 Billion
- Missed Prevention Opportunities: $55 Billion

Source: Data from workshop presentations and discussions summarized in *The Healthcare Imperative*
“Government Reimbursement Is An Experimental Science”

~ Dan Zismer
Alternate Models

• Pure Capitation
  – HMO’s in the 90’s
  – Subtle Incentives / Disincentives

• Pay for Performance
  – Wellmark Collaboration on Quality
  – Physician Quality Reporting Initiative/System (PQRS)
PQRS

• 0.5% incentive 2012-2014 Date of Service
• 2% penalty 2014 onwards DOS
• 9 measures across 3 domains
• Clinic Quality Domains (6)
  – Care coordination, patient safety, patient and family engagement, clinical process/effectiveness, population/public health, efficient use of healthcare resources
• Claims, Registry, EHR options.
• Individual vs Group Reporting Option.
• Public perception: patient satisfaction/safety
  – Publically reported on Physiciancompare.gov
Alternate Models – Risk Blends

• Episode of Care Bundles
  – Time/Dx limited capitation
  – Ex: Total Knee, t-7 to t+30d.

• Accountable Care Organizations
  – A **clinically integrated network** of physicians, hospitals, and others providers committed to using and advancing the latest thinking in clinical care, quality and efficiency.
ACO Model

Total cost of care for defined population

$MM

- SAVINGS FOR EMPLOYER/PAYOR

Projected cost based on medical inflation trends

Actual costs based on ACO and Medical Home collaboration

Performance Incentives for Physicians & Hospitals

Alternate Models – Risk Blends

CMS Quality-Based Payment Reform Initiatives

- Inpatient Quality Reporting Requirement (IQR, formerly RHQDAPU) 2% of APU
  - 2010: -0.10%
  - 2011: -0.30%
  - 2012: -0.20%
  - 2013: -0.20%
  - 2014: -0.75%

- Value-Based Purchasing (VBP)
  - 2010: -1.00%
  - 2011: -1.25%
  - 2012: -1.50%
  - 2013: -1.75%
  - 2014: -2.00%

- Readmissions
  - 2010: -1.00%
  - 2011: -2.00%
  - 2012: -3.00%
  - 2013: -3.00%
  - 2014: -3.00%

- Physician Quality Reporting System (PQRS)
  - 2010: -1.50%
  - 2011: -1.50%
  - 2012: -2.00%
  - 2013: -2.00%

- Hospital Acquired Conditions (HAC)
  - 2010: -1.00%
  - 2011: -1.00%
  - 2012: -1.00%

- Meaningful Use
  - 2010: -1.00%

Annual % at Risk
- 2010: -2.10%
- 2011: -5.05%
- 2012: -7.20%
- 2013: -7.95%
- 2014: -9.75%

* Federal fiscal year begins October 1st
Value-Based Payment Modifier

• Numerator is based on PQRS performance
• Additional +/-2% 2014; +/-4% 2015 DOS
• Moved from Pay for Measurement to Pay for Performance (Value)
• Both Quality and Cost components
• Starting 2015, 10% differential in Part B PFS between top and bottom performing clinics.
To account for differences in patient risk and reduce the influence of very high-cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 16.1 percent.

Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

**YOUR QUALITY TIERING PERFORMANCE: HIGH QUALITY, AVERAGE COST**

**YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING**

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +1.0x%.
2012 % of Clinic Quality Revenue that is a Penalty

- Penalty: 9%
- Incentive: 91%

2015 % of Clinic Quality Revenue that is a Penalty

- Penalty: 47%
- Incentive: 53%
“It’s not value or volume, it’s value and volume”
~ John Morrissey
Primary Care Returns Across the Transition to Accountable Payment

Realizing Returns Today
- Improved performance on key quality and cost initiatives
- Increased practice access, patient visit volume
- Stabilized PCP practice retention

Preparing for Tomorrow
- Infrastructure base for care coordination, management, patient engagement
- Patients treated at lowest-cost site, by lowest-level provider possible
- Expanded panel size

Source: Health Care Advisory Board interviews and analysis.
Shift from Volume to Quality

JAN 2015 HHS Releases Medicare Goals
• Alternative Value/Quality Based-Payments such as ACO’s and Bundled Payments (vs traditional FFS)
  • 30% of total by end of 2016
  • 50% of total by end of 2018
• Payments Partially at risk for Value/Quality such as Value-Based Purchasing and Readmission Reductions Program
  • 85% of total by end of 2016
  • 90% of total by end of 2018

## Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Category 2:</th>
<th>Category 3:</th>
<th>Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service—No Link to Quality</td>
<td>Fee for Service—Link to Quality</td>
<td>Alternative Payment Models Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

### Description
- **Category 1:** Payments are based on volume of services and not linked to quality or efficiency.
- **Category 2:** At least a portion of payments vary based on the quality or efficiency of health care delivery.
- **Category 3:** Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.
- **Category 4:** Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr).

### Medicare FFS
- Limited in Medicare fee-for-service
- Majority of Medicare payments now are linked to quality
- Hospital value-based purchasing
- Physician Value-Based Modifier
- Readmissions/Hospital Acquired Condition Reduction Program
- Accountable care organizations
- Medical homes
- Bundled payments
- Comprehensive primary care initiative
- Comprehensive ESRD
- Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model
- Eligible Pioneer accountable care organizations in years 3-5

---

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016:
- 30% for All Medicare FFS
- 85% for FFS linked to quality

2018:
- 50% for All Medicare FFS
- 90% for FFS linked to quality

Shift from Volume to Quality

JAN 2015 HHS Releases Medicare Goals

• Health Care Payment Learning and Action Network
• Work with states, Medicaid, private payers, employers, consumers.
• Sole purpose to make alternative payment mechanisms scalable and ubiquitous outside of CMS as well.

2015 SGR Fix: MACRA

Medicare Access and CHIP Reauthorization Act
  • 0.5% yearly PFS increases
  • 2019 5% PFS bump if 25% Value Based Contracts
  • Merit-Based Incentive Payment Program (MIPS)
    • +/-5% 2019, +/- 9% 2022
    • Combines MU, PQRS, VBPM
  • 30% Qual, 30% Cost, 25% MU, 15% Practice Improvement Activities (All TBD)
Consumerism: Top Ten Preferred Primary Care Clinic Attributes

- I can walk in without an appointment, and I’m guaranteed to be seen within 30 minutes
- If I need lab tests or x-rays, I can get them done at the clinic
- The provider is in-network for my insurer
- The visit will be low cost to me
- The clinic is open 24 hours a day, 7 days a week
- I can get an appointment for later today
- The provider explains possible causes of my illness and helps me plan ways to stay healthy in the future
- Each time I visit the clinic, the same provider will treat me
- If I need a prescription, I can get it filled at the clinic instead of going to another location
- The clinic is located near my home
Managing the Flip
(How Do I Get There From Here)

• New Competencies
  – Better IT and EMR systems
    • Hardwiring EBM processes
    • Enhanced Analytics
  – Team Based Approach to Care
  – Enhanced Access
  – Care Coordination across locations and time
  – Patient Engagement & Self-management
  – Aligned Incentives
All Roads Lead to the Medical Home
Benefits of Medical Home Investment Under Different Payment Scenarios

Fee-for-Service
Medical home models operating under fee-for-service reimbursement have achieved a return on investment through increased visit volumes, testing revenues, and provider/patient experience benefits.

Increases Testing Revenues

Compared to the Pre-Home Year
- 45% increase in diabetes visits
- 37% increase in microscopic test visits
- Care improvements netted an extra $76,879 in revenue

Reduces Provider Burnout
At 12 months, emotional exhaustion was less frequent at the PCMH site with 10% reporting high burnout compared with 30% of controls.

Improves Patient Access
25-day reduction in appointment wait time

- 26 days
- 1 day

Pay-for-Performance
Patient-centered medical homes can attain additional gains under pay-for-performance through improvements in quality, generic drug prescribing, and lower readmission rates.

Improves Quality Outcomes
For Diabetes Patients:
- 6.7% improvement in blood pressure control
- 10.3% improvement in cholesterol control
- 64.3% improvement in optimal diabetes care

Promotes Generic Drug Prescribing
Generic Prescribing Rate Changes
- 38% in 2004
- 74% in 2013

Fewer Readmissions
- 25% fewer hospital readmissions in New Jersey
- 50% lower hospital readmissions in San Francisco

Shared Savings/Capitated Contracts
Benefits of the medical home model continue to accrue under shared savings and capitation, which present an opportunity to share in the gains from appropriate utilization and lower costs.

Reduces Emergency Department Visits
- 26% fewer emergency department visits in New Jersey
- 29% fewer ED visits in San Francisco

Inflacts Inpatient Admissions
- 17% fewer inpatient admissions in Michigan
- 21% fewer inpatient hospital stays in New Jersey
- 37% fewer inpatient stays for coronary care in Michigan

Lowers Costs
- $17,25, $37 in cost savings through medication use program
- $3.4M in cost savings through medication use program


Learn More
www.averamedicalgroup.com
Coordinated Care Model
Primary Responsibilities Navigating and Activating Patients Across the Continuum

<table>
<thead>
<tr>
<th>Navigation</th>
<th>Activation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinates Across Sites</td>
<td>Provides Education</td>
</tr>
<tr>
<td>• Facilitates access to services</td>
<td>• Coaches patients on disease management goals, monitors progress, offers encouragement</td>
</tr>
<tr>
<td>• Develops care plan with physician, embedded in PCP practices</td>
<td>• Supports symptom management</td>
</tr>
<tr>
<td>Manages Referrals</td>
<td>Supports Patient Self-Management</td>
</tr>
<tr>
<td>• To disease management</td>
<td>• Encourages adherence to care plan, improvement through patient-centric goal setting</td>
</tr>
<tr>
<td>• To specialists</td>
<td>• Fosters patient and caregiver activation, offers education</td>
</tr>
<tr>
<td>• To medication management support</td>
<td></td>
</tr>
<tr>
<td>• To psychosocial support</td>
<td></td>
</tr>
<tr>
<td>Tracks Patient Activity</td>
<td>Encourages Frequent Communication</td>
</tr>
<tr>
<td>• IT system alerts care manager to inpatient, ED utilization</td>
<td>• Promotes open communication through consistent monitoring, feedback, and follow up</td>
</tr>
<tr>
<td>• EMR “icon” alerts system physicians when patient is assigned to a care manager</td>
<td>• Forges one-on-one relationship with patient to promote two-way communication</td>
</tr>
</tbody>
</table>
## Joint Principles for the Patient-Centered Medical Home

<table>
<thead>
<tr>
<th>Principles</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Physician</td>
<td>Each patient has ongoing relationship with personal physician trained to provide continuous, comprehensive care</td>
</tr>
<tr>
<td>Physician-Directed Medical Practice</td>
<td>Personal physician leads team of individuals who take responsibility for ongoing care of patients</td>
</tr>
<tr>
<td>Whole-Person Orientation</td>
<td>Personal physician responsible for addressing all patient’s health care needs, appropriately arranging care with other qualified professionals; includes care for all stages of life—acute care, chronic care, preventive services, end-of-life care</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>Care is coordinated, integrated across health care system, patient’s community</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>Evidence-based medicine, clinical decision support tools guide decision making; patients actively participate in decision making; information technology is utilized appropriately; patients, families, staff participate in quality improvement activities</td>
</tr>
<tr>
<td>Enhanced Access to Care</td>
<td>Enhanced access to care available through systems such as open scheduling, expanded hours</td>
</tr>
<tr>
<td>Payment</td>
<td>Payment appropriately recognizes added value provided to patients in patient-centered medical home through combination of PMPM payment, fee-for-service visits, pay-for-performance incentives, gainsharing on cost savings</td>
</tr>
</tbody>
</table>
## Not the same as patient centered Medical Home

<table>
<thead>
<tr>
<th>Category</th>
<th>Health Homes</th>
<th>Medical Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Populations Served</strong></td>
<td>Individuals with specified chronic conditions; Medicaid population</td>
<td>All populations served</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td>Includes a designated provider with a support team of health professionals and social services. Both primary care and behavioral health homes.</td>
<td>Are typically defined as physician-led primary care practices, but also mid-level practitioners</td>
</tr>
<tr>
<td><strong>Payers</strong></td>
<td>Currently are a Medicaid-only construct</td>
<td>In existence for multiple payers: Medicaid, commercial insurance, etc.</td>
</tr>
<tr>
<td><strong>Care Focus</strong></td>
<td>Strong focus on integrating behavioral health (including substance abuse treatment), social support, and other services (including nutrition, home health, coordinating activities, etc.)</td>
<td>Focused on the delivery of traditional medical care: referral and lab tracking, guideline adherence, electronic prescribing, provider-patient communication, etc.</td>
</tr>
<tr>
<td><strong>Technology</strong></td>
<td>Use of IT for coordination across continuum of care, including in-home solutions such as remote monitoring in patient homes</td>
<td>Use of IT for traditional care delivery</td>
</tr>
</tbody>
</table>

What must a Health Home do?

- Provide quality driven, cost effective, culturally appropriate person/family-centered services.
- Coordinate/provide access to high quality, evidence based services, preventive/health promotion services, mental health/substance abuse services, comprehensive care management/coordination/transitional care across settings, disease management, individual/family supports, Long Term Care supports and services.
- Develop a person-centered care plan that coordinates/integrates clinical/non-clinical health care needs/services.
- Link services with health information technology, communicate across team(s), individual and family caregivers, and provide feedback to practices, and
- Establish a continuous quality improvement plan.
A Patient’s Story

Age: 44
Gender: Female
Diagnosis: Diabetes, Hypertension, Anxiety, Hyperlipidemia and Hypothyroidism
Date of Enrollment into Coordinated Care: February 2014

Summary: Patient was noncompliant with medical treatment due to financial concerns and anxiety. Avera Coordinated Care team was able to obtain pharmaceutical assistance to help pay for medications and provided counseling by MSW for underlying anxiety. patient states, “I have hope now” and continues with regular PCP follow-up.
A Patient’s Story
Medical Homes - Payment

• SD Medicaid Health Homes
• Other States Medicaids
• Medicare January 2015 (preliminary)
Conclusion

• We are in the middle of a shift from traditional FFS to more risk-based and value-based payment systems
• Managing this transition will require a new, expanded set of competencies from our health care system
Questions??