Volume to Value

The Great Transformation of American Medicine 2010-2020

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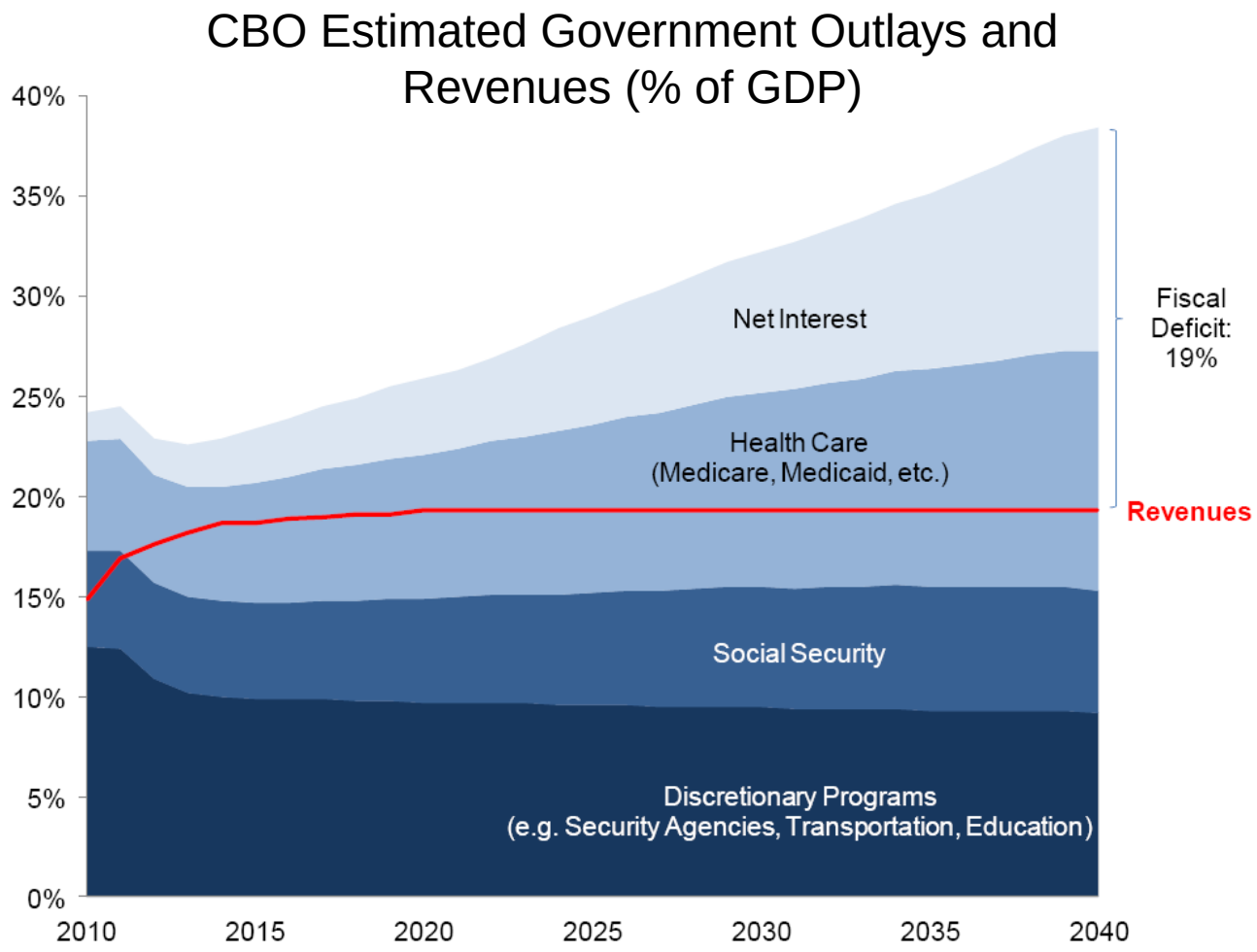
Fee for Service

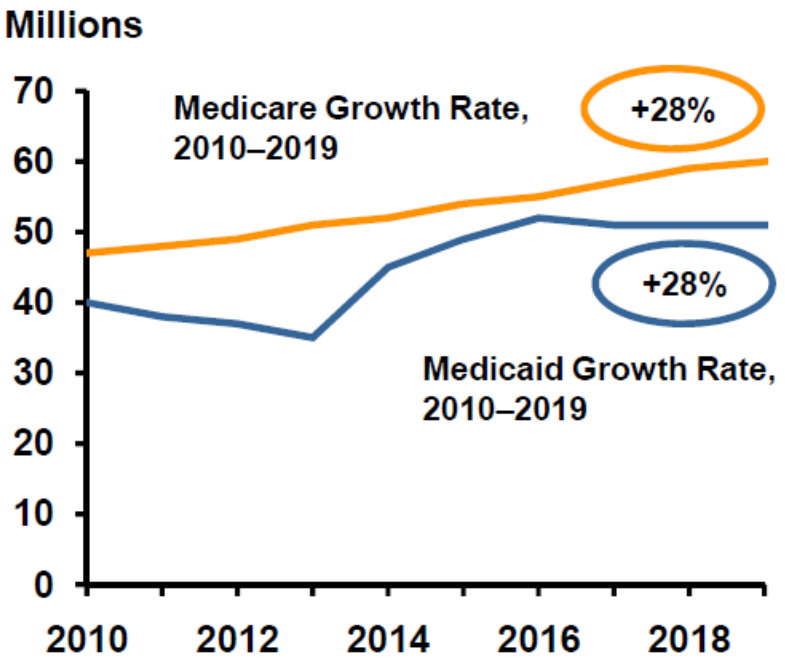
- You get paid for what you do
- The more you do, the more you make
- The problem
  - FFS promotes over-utilization (or so it is said)
  - FFS payment models are unsustainable

US per Capital Healthcare Spending



The Problem

- Baby boomers are getting older
- Patients are living longer
- Many more long term chronic disease survivors



Source: Sg2 & Charis Consulting | 2010

A Modern History of Healthcare Payment

- 1945: World War II ends
- 1945: The baby boom begins
- 1966: Medicare – Gov't funded health insurance age > 65
- 1945 – 2010: Major advances medicine and technology with patients living longer esp with chronic disease

  Note: 1945 – 2010 is 65 years
- 2010: Patient Protection and Affordable Care Act
  - Starts the transition from Volume to Value

Payment under Fee-for-Service

- Hospitals
  - In-patient DRGs (1983) – payment for hospital admission is capitated based on diagnosis
  - Out-patient APCs (2000) – payment for out-patient services: Ambulatory Payment Classification
  - To be successful:
    - Grow number of admissions esp. procedural
    - Manage efficiently

Payment Under Fee-for-Service

- Physician
  - wRVU x Conversion Factor
  - Conversion Factor set by SGR formula
  - SGR formula unsustainable – called for continued cuts to conversion factor – tied spending growth to growth in the economy (Great Recession)
  - To control physician spending pre-ACA, Medicare made cuts to wRVU (physician fee schedule) – esp card imaging
  - As CV reimbursement decreased, cardiology hospital integration increased

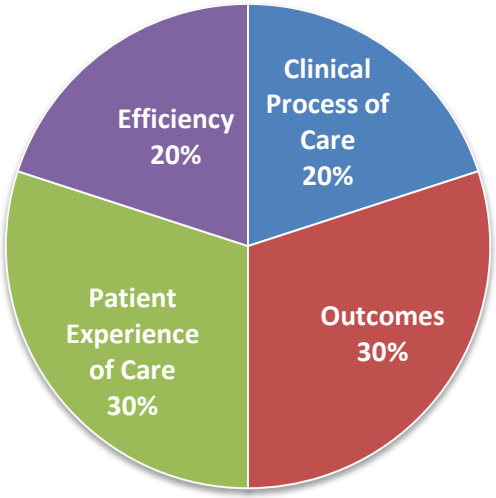
Fee for Value

- Hospitals
  - Value Based Purchasing
  - Readmission Penalties
  - Hospital Acquired Conditions
  - Meaningful Use

CMS Value Based Purchasing

Payment Period FY 2014

Payment Period FY 2015



Payment Period FY 2016

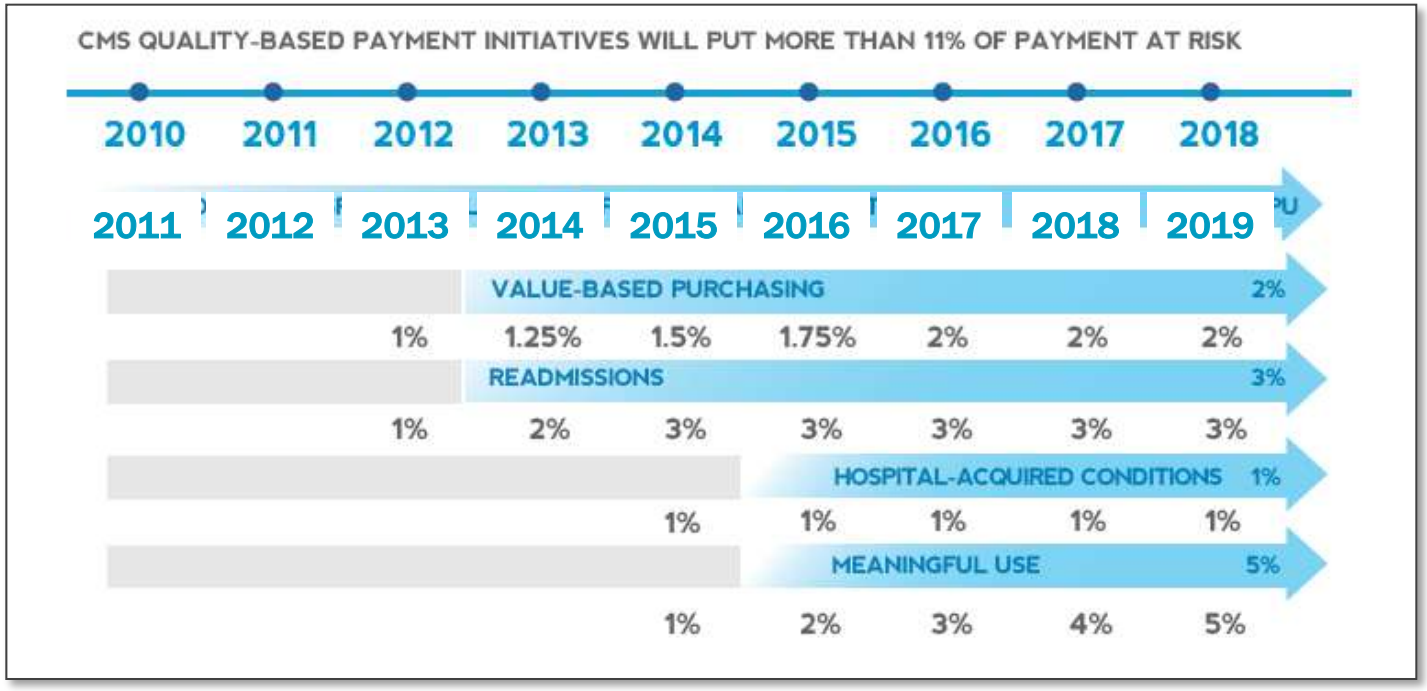
CMS is rapidly changing the weighting of each Value Based Purchasing Domain as well as the content within each domain making systematic and proactive performance improvement more difficult.

Fee for Value

- Hospitals
  - Value Based Purchasing
  - Readmission Penalties
  - Hospital Acquired Conditions
  - Meaningful Use

Hospital Incentives and Penalties

CMS at risk dollars for Quality are 3.25% of Total Medicare Reimbursement in the current Fiscal Year, and will escalate to 11% over the next 3 years.



Note: The above is the CMS Fiscal Year Payout Period.
The Performance Period is generally the Calendar Year Two Years Prior.

Fee for Value

- Physicians
  - PQRS: Physician Quality Reporting Initiative
    - Multiple Measures tied to Quality Bonus
  - Value Based Purchasing
    - For 2015 applies to groups of > 100 providers
    - Very complicated
      - Elect to participate: can receive +, -, or 0.0% modifier
      - Elect not to participate and accept a – 1.0% modifier

Fee for Value

- Health Care Systems
  - Shared Savings
    - Medicare Shared Savings Program (MSSP)
    - aka Medicare ACO's

Accountable Care Organizations

- Clinically integrated network of physicians, physician groups and hospitals
- Cost and quality targets
- Incentives (from cost savings) distributed back to ACO
- Modified capitation

Accountable Care Organizations

- Example: NewCo ACO Network is formed by a hospital and its employed physicians
  - All patients who receive their primary care through NewCo ACO are tracked by CMS
  - CMS projects what it should have cost to provide medical services for the ACO patient population
  - CMS calculates the actual cost of providing care for the ACO beneficiaries
  - If the ACO generates savings, (ie spends less than projected), the CMS gives a proportion of the savings (based on quality metrics) back to the ACO.

Accountable Care Organizations

- Characteristics
  - Strong primary care base (Medical home)
  - Shared IT systems
  - Common treatment protocols
- Size – minimum 5,000 patients
- Issues
  - Law limits physician to signing with only one ACO
  - Assignment of beneficiaries – retrospective

Issues with Shared Saving Models

- For a health system – success means less revenue
  - The only way to make up this lost revenue is through market share growth
  - For well performing systems, it is not easy to achieve the saving targets
    - ie historical good performers are dis-advantaged
  - The is a finite limit to how much savings can be achieved
  - Putting in place a population health infrastructure requires a substantial investment that can offset any achieved shared savings

Fee for Value

- Health Care Systems
  - Bundling
  - CMS Innovation Center
  - BPCI: Bundled Payment for Care Improvement Models

Bundled Payments

- Multiple kinds of Bundling
  - Hospital + Physician (Medicare A + B)
    - Example – CMS will pay one package price for a CABG. How this is divided up will be determined by the hospital and providers
  - Episodes of care
    - Example – CMS will pay one price to the physician for all services related to a pacemaker implantation (pre-procedure, procedure, hospitalization, post-procedure, and follow-up)
  - Acute + Post Acute Services
- Main principle of bundling: One + One < Two

Fee for Value

- Health Care Systems
  - Medicare Advantage
    - Managed Medicare – through Insurance Company
      - eg Anthem, Cigna, United
    - Health care system for MA patients paid using **capitation**
      - Per member Per month (PMPM)
      - Capitation determined by HCC score
    - Usually a narrow(er) network

The Future of Physician Reimbursement

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Repeals SGR
  - Annual 0.5% payment increase 2015 to 2018
- Furthers transition to quality based payments Jan 1, 2019
  - 2 Models (physicians choose)
    - MIPS (Merit-based Incentive Payment)
    - APMs (Alternative Payment Models)

New Payment Models beginning 2019

- MIPS (Merit-based Incentive Payment System)
  - Payment based on clinical quality, resource use, meaningful use and clinical practice improvement activities
    - Uses pre-existing quality reporting programs (PQRS, MU, VM)
    - Additional rules to be defined – esp around performance improvement (?MOC)
    - Could result in bonuses/penalties of up to 4% in 2019 and increasing to 9% in 2022

New Payment Models beginning 2019

- APM – Alternative Payment Models
  - 5% payment bonus if 25% Medicare revenue through an APM (eg MSSP) in 2018
    - ? What other programs count as an APM
    - In order to continue to receive the 5% bonus, will need 50% Medicare revenue through an APM in 2021 and beyond

Cardiology Group Comp Models

- Significant evolution in progress
- Shift from pure FFS to some value based comp
- Multiple different models
  - RVU-based + non-clinical
  - Straight salary + quality bonus
  - Straight salary based on predefined metrics

Productivity + Non-clinical Component

- Majority still based on wRVU or TVUs
  - 75-90%
- Non-clinical Component – up to 25%
  - Quality
  - Patient Satisfaction
  - Citizenship
  - Leadership/management
  - Service line development

Straight Salary + Bonus Opportunity

- Base salary (often even split based on sub-specialty)
- Up to 15-25% dependent on individual and group targets
  - Overall group RVU target
  - Overall sub-specialty RVU target
  - Patient satisfaction (individual and group)
  - Program development
  - Scholarly Activity

Summary

- Historically, the payment and compensation models were based on volume (the more you do, the more you make)
- We are in the midst of a shift from volume to value at the system, practice and individual levels
- At some point in the near future, value based compensation > volume based compensation
  - Primary care sooner than specialty and surgical care