

**APPROVED**  
MAR 23 2010



ACA – Essential Strategies and Emerging Payment Models  
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April 30, 2015



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ACA – Essential Strategies



- Legislation & Regulations
- What does this mean for me?
- Advanced Payment Models
- Essential Strategies
- Questions

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## Healthcare Reform and Transformation

### Legislation and Healthcare Change

- 1985 eClaims and eRemits Available – Limited Use
- 1996 – HIPAA Enacted (Kennedy-Kassebaum Act)
  - Standardization of Electronic Admin. and Financial Data
  - Unique Health Identifiers
  - Security and Privacy
- Today, 'Care/'Caid and Commercial nearly 100% Electronic
- 2008 – MIPPA – ePrescribing
  - 4% of Physicians used eRx in 2004
  - Today, 73% Physicians use eRx; 58% of ALL Prescriptions!
- 2009 – ARRA/HITECH – Certified EHR Technology ...




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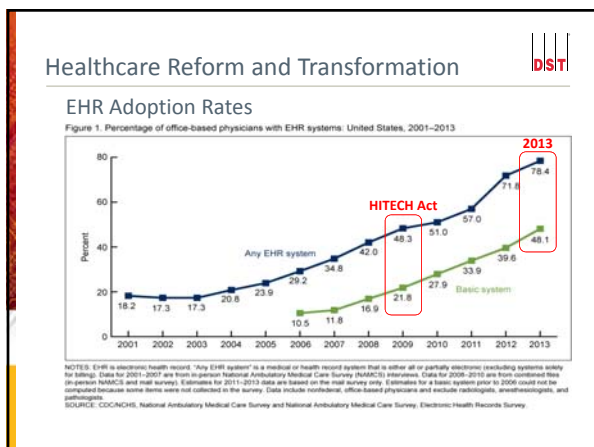
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## How'd We Get Here?!

- **1965** – Medicare / Medicaid established – Pres. Johnson
  - Life Expectancy – 70.2
  - U.S. Population age 65+ – 18.5M
  - Cost of Care as a % of GDP – **5.6%**
- **Today** – Medicare (52.3 M) and Medicaid/CHIP (69.98 M)
  - Life Expectancy – 78.7
  - U.S. Population age 65+ – 44.96M
  - Cost of Care as a % of GDP – **17.4%** (\$9,255/person)
    - New Medical Technologies and Services
    - Costly New Drugs and Increased Demand for Medical Care
    - 49.8% of patients have 1+ **Chronic Dz.** (25.5% have 2+)
    - Sector Prices and Administrative Costs
    - Lack of **Patient Accountability** (e.g. obesity, smoking, etc.)
    - Aging – **Baby Boomers** 60% projected growth in spending on entitlements ('Care, 'Caid, SS)
- **Projected** – **19.3%** of GDP by 2023




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## Healthcare Reform

**Affordable Quality Health Care**

Pay for Higher "Value"  
Value = f(Quality, Efficiency)

Pay-for-Reporting  
(MU CQMs, PQRS, HEDIS)

Voluntary Clinical Reporting (PDR)

Claims Data

- **ACA Paradigm Shift**
  - **Prevention, Wellness and Patient-Centeredness**
    - From episodic care to long-term prevention, chronic disease mgmt.
    - Must engage patient; cultural shift (ACO and PCMH Models)
  - **Redesign the way care is Compensated**
    - Discontinue blanket fee-for-service reimbursement
    - Purchase Value over Volume = Define value with data
    - 30% APM by 2016; 90% by 2018 – and – 85% FFS + quality by 2016
  - **Information Distribution**
    - Interoperability → Data wherever, whenever it is needed
    - Public Transparency

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## ACA Mega-Trends

- **Electronification** of Clinical Processes → PBMs, EHRs, Data Interoperability, "Big Data" Analytics
- Patient **Consumerism** → HDHP, CDHP
- **Population Health** Management
- **Value-Based Purchasing (VBP)** through **Alternative Payment Models (APMs)**
  - Value-Based Payment Modifier (VBPM)
  - ACOs, Health Homes and Care Mgmt. Fees
  - Pay-for-Performance and Shared-Savings
  - Global/Partial Capitation
  - Bundled Payments

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## Claims Submission = Data Reporting

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Must Do vs. Must Do 

Must Do → **Regulatory**

**The HIPAAMIPPATRHCAARRAPPACA Era!**

- **HIPAA** → ICD-10 Administrative Simplification; “5010 Rules;” **Oct. 1, 2014**
- **MIPPA/TRHCA** → Physician Quality Reporting System (PQRS) & CQMs; QRUR; Medicare PFS; **Annually**
- **ARRA/HITECH** → MU CEHRT Adoption; **Annually**
  - HIE, VDT → Health Information Exchange and View, Download, Transmit
  - TOC → Transitions of Care
  - CQMs → Clinical Quality Measure reporting
- **PPACA** → Mandatory Patient Centered and Affordable Care
  - CG-CAHPS → Patient-Centered Care; Patient Experience; **Annually**
  - HIX → Health Insurance Exchange; As Employer; As Provider; **Annually**
  - VBP → Value-Based Purchasing; Accountability; Industry wide; **Reform**

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Must Do vs. **Must Do**  

**Must Do** → This is **Your Health Care System!** 

- **21%** of the healthcare dollar goes to physicians
- PCPs generate **\$6.30** for every **\$1** billed
- **25 Million** onto **Medicaid** by **2016**
- **18 Million** more **Medicare** Beneficiaries by **2023** → 73% increase
- **84¢** of every dollar to treat **chronic disease**
- **66% over 65** and **75% over 80** → Multiple Chronic Dz.
- **5%** of patients spend **50%** of the healthcare dollars
- Need **Centralized** Patient Information
- Enhanced **Communication** → Provider-Provider; Provider-Patient
- Measurable **Performance Improvement**

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Call to Action 



**Tip 1: ICD-10 – Don't Delay**

- Protect Your Investment
- Continue Conversion Planning
  - Education and Train
  - **Clinical Documentation Improvement** Program
- Reassess Older Health IT Platforms
- Emphasize Long-term Success
  - Population health management
  - Strong structured data capture
  - Internal analytics impacting outcomes
- Visit CMS for Updates: [www.cms.gov/Medicare/Coding/ICD10/](http://www.cms.gov/Medicare/Coding/ICD10/)

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Call to Action 

- **Tip 2: Focus on a Sustainability Strategy**
  - Public/Private payer goals → Slow growth of healthcare costs
    - Reduce testing duplication
    - Decrease Hospital Inpatient Days and Re-admissions
    - Increase Patient Guideline Adherence through engagement/satisfaction
    - Support legislation to stabilize/repeal SGR and modify FFS models
    - Collaborate for nationwide data exchange and health IT standards




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Engaged Incentive Models 

**Tip 3: Meaningful Use 2 → Why?**

- **Care Coordination** and **Patient Engagement**
- Keys to Value-Based Purchasing Models
- Specific Measures: TOC, VDT, Pt. Secured Messaging
- **Benefit:** Efficiency, Quality, Revenue Enhancement

**Tip 4: Patient-Centered Care → Why?**

- Time to hear the **Patient's Point-of-View (POV)**
- Health Home is a model for PCPs
- NCQA Specialists → Pt-Centered Specialty Practice (PCSP)
- NCQA PCSP Compliments PCMH, especially care coordination
- Ask about NCQA PCMH Pre-Validation Auto Credits
- **Benefit:** Public/Private Differential Payment, Patient Satisfaction




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### Engaged Incentive Models

**Tip 5: Accountable Care Organization → Why?**

- Care is delivered by a “Community”
- Today, 740+ ACOs serving 25 Million Americans
- Physician Groups Dominant as Sponsor-Type
- CMS contracting annually; Next Generation ACO Announced
- Top 3 States: CA (58), FL (55), and TX (44)
- OR and UT – highest ACO penetration Medicaid lives
- Composition of ACO Care Continuum Widening
  - E.g., ACOs with Hospice increased to 42% (2013) from 19% (2012)
- **Benefit:** Provider Community Ecosystem, Revenue/Risk Control

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### Quality and Data Exchange

**Tip 6: Quality Measure Alignment Growing**

- National Quality Forum (NQF) endorsed Measures
- HIQRP / HOQRP / PQRS / MU Clinical Quality Measures Aligned
- Used to Define “Value” under ACA’s Value-Based Payment Modifier
- **Benefit:** Measurable Quality Improvement

**Tip 7: Interoperability and Data Exchange**

- **Foundational for Population Health**
  - MU2 Summary of Care Record Expanding in MU3
- Congress calling for Interoperability Results
- **Benefit:** Truly integrated care team for the patient




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### Market Evolution

**Tip 8: Align with emerging APMs**

- H.R. 2 → Medicare Access and CHIP Reauthorization Act
- Performance Data → You are being measured on quality and cost
  - Download your CMS Quality Resource Use Report (QRUR) → Medicare Value-Based Payment Modifier (VBPM)
  - Review your profile on CMS Compare and Commercial Payers’ Quality Tiering
- Identify issues with patient experience
- Data showing low quality, high cost = Impact reimbursement, cut from network (E.g., UHC)

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VBP 4-Dimensional Framework 

**NBCH** → 52 Coalitions; Over 4,000 Employers; 35 Million Employees/Dependents

1. **Standardized Performance Measurement** → Actionable data on cost, quality and care appropriateness
2. **Transparency and Public Reporting** → Inform decision-making
3. **Payment Innovation** → Links to expected or predictable outcomes
4. **Enlightened Consumerism** → Regarding providers and services across the care continuum



Source: NATIONAL BUSINESS COALITION ON HEALTH Value-Based Purchasing Guide

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Alternative Payment Models (APMs) 



- Value-Based Payment Modifier (VBPM)
- Accountable Care Organizations
- Capitation
- Bundled Payment / Episode Groupers
- Health Home a/k/a PCMH
- Shared-Savings
- Care Management Fees

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### Value-based Purchasing

- Medicare Improvements for Patients & Providers Act 2008 (MIPPA)
  - § 131 – CMS Physician Feedback reporting by 1.1.2009
  - Physician **Quality and Resource Use Report** (QRUR) began
- QRURs Reports** → **Value = f(Cost + Quality)**
  - MD performance on **28 Claims-based + PQRS** performance data
  - 2-year lag** → 2013 Medicare Physicians see 2011 data
  - Ultimately → CMS **Physician Compare** website
- Individual Eligible Professional (IEP) **PQRS Performance Report**
  - Each EP's performance as an individual and as a group

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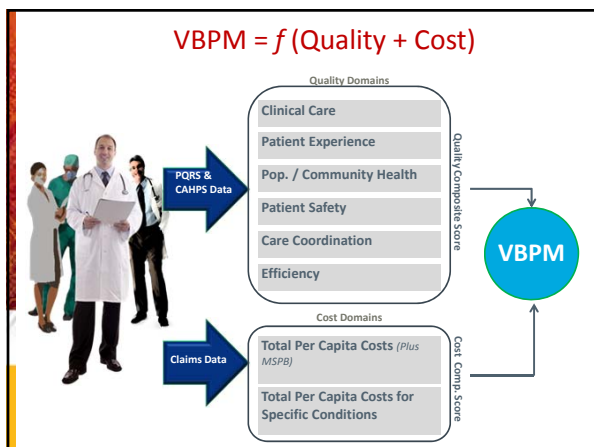
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### Calculating the Value Modifier

- Identify significant outliers against national mean

Quality / Cost	Low Cost	Average Cost	High Cost
High Quality	+2.0x*	+1.0x*	+0.0x
Medium Quality	+1.0x*	+0.0%	-0.5%
Low Quality	+0.0%	-0.5%	-1.0%

\* "x" refers to payment adjustment factor TBD; higher performance service high-risk patients (based on case mix scores) are eligible for an additional adjustment of +1.0x.

- Sept. 30, 2014** → All physicians receive QRUR for 2013
- More information: <http://www.cms.gov/> → "Physician Feedback"
- 2012 Sample at <http://go.cms.gov/1mSRD>

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### How can you use it?

- **How do you Measure Up?**
- Your **Quality** Composite Score
- Your **Cost** Composite Score
- Beneficiaries' Avg. **Risk Score**
- **Quality Tying** Performance
- **Payment Adjustment** based on Quality Tying

Low Cost	Quality	Average Quality	High Quality
-0.0%	+0.0%	+0.0%	+0.0%
-0.0%	-0.0%	-0.0%	-0.0%
-0.0%	-0.0%	-0.0%	-0.0%

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### The Non-PCPs

- Federal Policy largely focuses on **PCPs**
- **SCPs** Must Develop **Payment Innovation Strategy**
  - **Federal**
    - CMS uses NQF Measures → Which ones are relevant to you?
    - CG-CAHPS is universal for patient experience measurement
    - How do your costs compare to peers? CMS Inpatient/Outpatient Charge Data
    - Sample QRUR to explore common data-points used
  - **Commercial**
    - Use 80/20 Rule to ID Top Payers
    - Provider Relations → Alternative Payment Models? Quality Measures?
  - **Provider Communities** (E.g., ACOs, CCOs, RCOs, IPAs, etc.)

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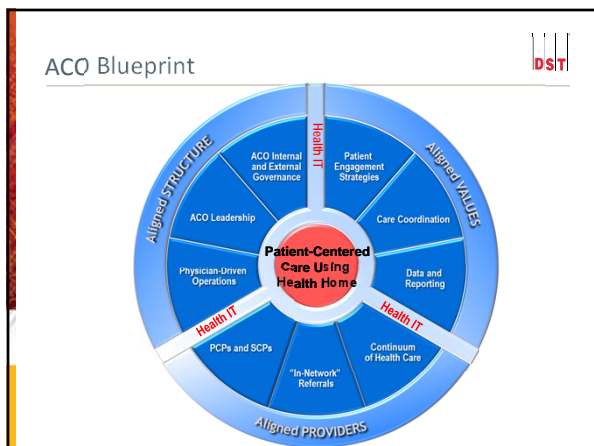
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### Health IT and ACO Physicians

Basic Needs	Extended Needs
<ul style="list-style-type: none"> <li>Utilization Trending and Reporting (E.g., Digital Dashboard)</li> <li>Evidence-Based Clinical Decision Support</li> <li>Population Health Tools</li> <li>Patient Survey / Questionnaire</li> <li>Tools</li> <li>HIE (Direct, minimum)</li> <li>Patient Education</li> <li>Patient Portal</li> <li>EHR-derived GPRO PQRS</li> <li>Lab, Radiology and Device Integration</li> </ul>	<ul style="list-style-type: none"> <li>Public Health related integration (E.g., State Labs, Immunizations Registry)</li> <li>Datacenter / Hosting Services</li> <li>PCMH Relevant Technology and "Toolkits" (Primary Care)</li> <li>Outsourced Billing Services</li> <li>Patient Communication Tools (E.g., Texting, Appt. Reminder Systems, Web-merge, etc.)</li> <li>Health Assessment and Risk Tracking</li> <li>HIE messaging for ED / Hospital</li> <li>Admission and other use cases</li> <li>Ad Hoc data aggregation</li> <li>Prospective payment systems</li> </ul>

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### Full Risk – Capitation / Provider Risk

ABC Health Plan Enrollees

Dr. PRIMARY	Dr. CARE
<ul style="list-style-type: none"> <li>1,000 Patients</li> <li>Median Age 27</li> <li>100 have Chronic Dz.</li> <li>\$10 PMPM</li> <li>1,000 Patients X \$10 PMPM = \$10,000 / Month</li> <li>20 Pts. Per Month X \$75 Avg. Coll. Per Visit = \$1,500 FFS Cost = GOOD</li> </ul>	<ul style="list-style-type: none"> <li>500 Patients</li> <li>Median Age 58</li> <li>50 have Chronic Dz.</li> <li>\$10 PMPM</li> <li>500 Patients X \$10 PMPM = \$5,000 / Month</li> <li>100 Pts. Per Month X \$125 Avg. Coll. Per Visit = \$12,500 FFS Cost = BAD</li> </ul>

**Adverse Selection**

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### Capitation Hybrids

#### Blended Capitation

- Cap mixed with other models (E.g., FFS or P4P)
- Rewards for performance in a "weak" area
- Can limit provider's financial risk
- Examples:
  - Capitation + Bonus for spending within Target Budgets
  - Capitation + FFS for preventive screening services
  - Capitation + Bonus for meeting quality / patient satisfaction goals

#### Global Capitation

- Shifts risk to a larger "network" (E.g., hospitals and physicians, ACO)
- Wide variance in dividing up capitation payments to individual members
- Example: Contact capitation for specialist care




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## Bundled Payments and Episode Groupers

**Bundled Payments**

- Fee covering defined clinical services; goal → payment simplification
- Includes hospital, physician and/or ancillary services
- CMS Bundled Payments for Care Improvement (BPCI)
- Care Coordination is key
- Example: Single payment for Hip replacement; Chronic Dz.

**Episode Groupers**

- Subset of Bundled Payments
- Covers all/portion of services provided by a physician
- Prometheus Payment → Relies on Clinical Practice Guidelines (CPGs)
- CPGs estimate resources needed (E.g., lab, equipment, rehab) for all provider settings (groups, hospitals, SNF, etc.)
- Example: CABG includes preop, surgery, inpatient + 90 days post-acute

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## ACA – Essential Strategies



- Legislation & Regulations
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## Health Care and Change



Pragmatist	Collaborator	Innovator
<ul style="list-style-type: none"> <li>• 60% Aim for Minimum</li> <li>• Only Core Processes for admin./compliance</li> <li>• Last Minute Adoption</li> <li>• Penalties Required</li> <li>• Aiming for Average = High Potential Risk</li> </ul>	<ul style="list-style-type: none"> <li>• 20-25% Aim for Opportunity</li> <li>• Improve Processes</li> <li>• Advanced Analytics, Process Improvement</li> <li>• Rewards Attained</li> <li>• Aiming for Improvement = Potential Value for Costs</li> </ul>	<ul style="list-style-type: none"> <li>• 15-20% Aim for Transformation</li> <li>• Complete Change Agent</li> <li>• Training, Outcomes Mgmt.</li> <li>• Rewards Attained</li> <li>• Aiming for Excellence = Competitive Advantage &amp; Strategic Positioning</li> </ul>

Source: Debitto, ICD-10 Funding Reg. Compliance into Strategic Advantage, 2009

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**Market Evolution** 

**Uptick in Health Communities/Ecosystems**

- Plurality of Care → “Degree of Involvement”
- Assess: Peers, Benchmarks, Patient Volume and Payer Transparency
- Shifting of Risk to defined Communities → E.g., ACOs
  - Education, ID patient volume, Patient Complexity Profiles
- Focus on MU Underpinnings:




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**Practice / Provider Positioning** 

**Community Care Coordination** → Use Health IT!

- EHR is foundational
- Standards-based Interoperability (E.g., Direct)
- Patient Engagement Tools (E.g., Portal)

**Evaluate Patient Populations**

- By Payer, By Disease, By Demographics
- Expansion strategy warranted?
- Strengthen community partnerships (Local practices and hospitals)
- Understand your evolving market → PCMH, ACOs, APMs
- Payer opportunities? (E.g., P4P, Bonusing, Incentives)

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**Practice / Provider Positioning** 


**Research Costs of Care**

- By Episode (E.g., Myocardial Infarction; Colonoscopy)
- By Disease (E.g., Diabetic Patients)
- By Demographics (E.g., Under 18, Over 65, Women)
- By Payer

Review Medicare **Cost Data**; inquire with private payers

**Understand how you measure up!**

- Knowledge is power → Trends for Opportunity
- Negotiating Contracts (E.g., Payers, ACO participation)




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Community Accountability 

- **Evaluate Community Relationships**
  - Peers, Associations, Payers, Employers, Health Systems
  - Current / Future Opportunities
- **Benchmark**
  - Outcomes and Costs
  - Patient Experience
- **Align with others** having strong measures
  - **Value =  $f(\text{Quality} + \text{Efficiency})$**
  - Data Matters!
- **Formulate interoperability strategy**



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Questions?

**Thank You!**

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