New Models of Payment and Delivery

Devdutta Sangvai, MD, MBA
September 6, 2015

DukeMedicine

Disclosure

- No conflicts of interest or items to disclose

Current Practice

- Physicians have, for the most part, not been active in understanding how broader economic forces impact the deliver of care
- Conventional economic attention has been paid to rates, fees, and reimbursement and sometimes policy
- In large measure, physicians have been able to absorb negative economic changes by modifying practice (e.g. increasing volume when rates decrease)

Best Practice

- Understanding and participating in the dialogue related to the economic forces of healthcare can allow for a more efficient healthcare system
- Physicians should understand new models of payment as these models are starting to frame discussions around reimbursement
- Modifying practice through volume alone is likely not sustainable and physicians need to consider value as a metric of their performance

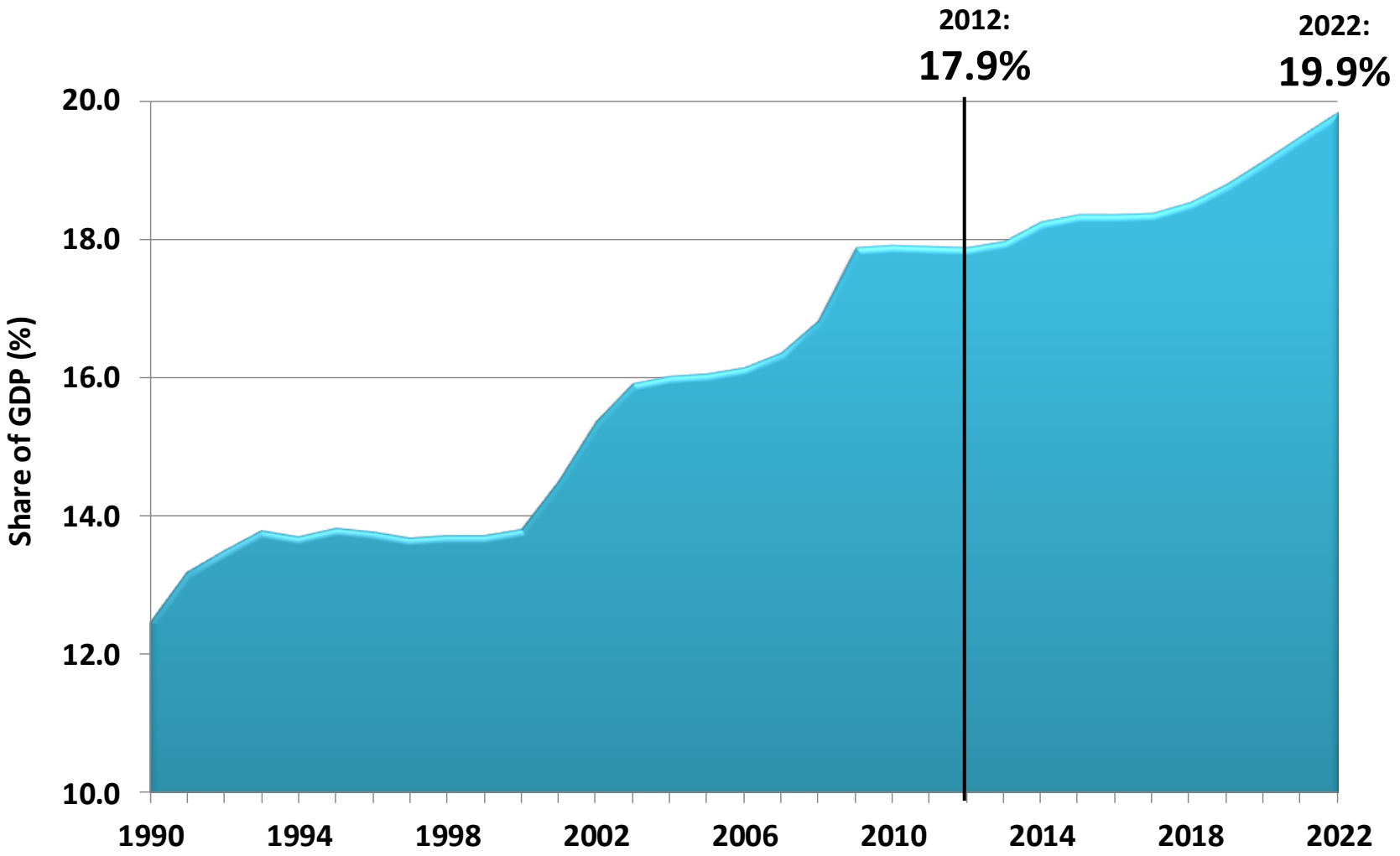
Learning Objectives

- Review the macroeconomic healthcare environment compelling development of new models of care
- Describe newer models of payment for healthcare services
  - Uncover challenges and opportunities to the underlying, conventional business model
- Review Accountable Care Organizations as a new model of payment and delivery

Learning Objectives

- Review the macroeconomic healthcare environment compelling development of new models of care
- Describe newer models of payment for healthcare services
  - Uncover challenges and opportunities to the underlying, conventional business model
- Review Accountable Care Organizations as a new model of payment and delivery

U.S. Healthcare Spending, as % of GDP

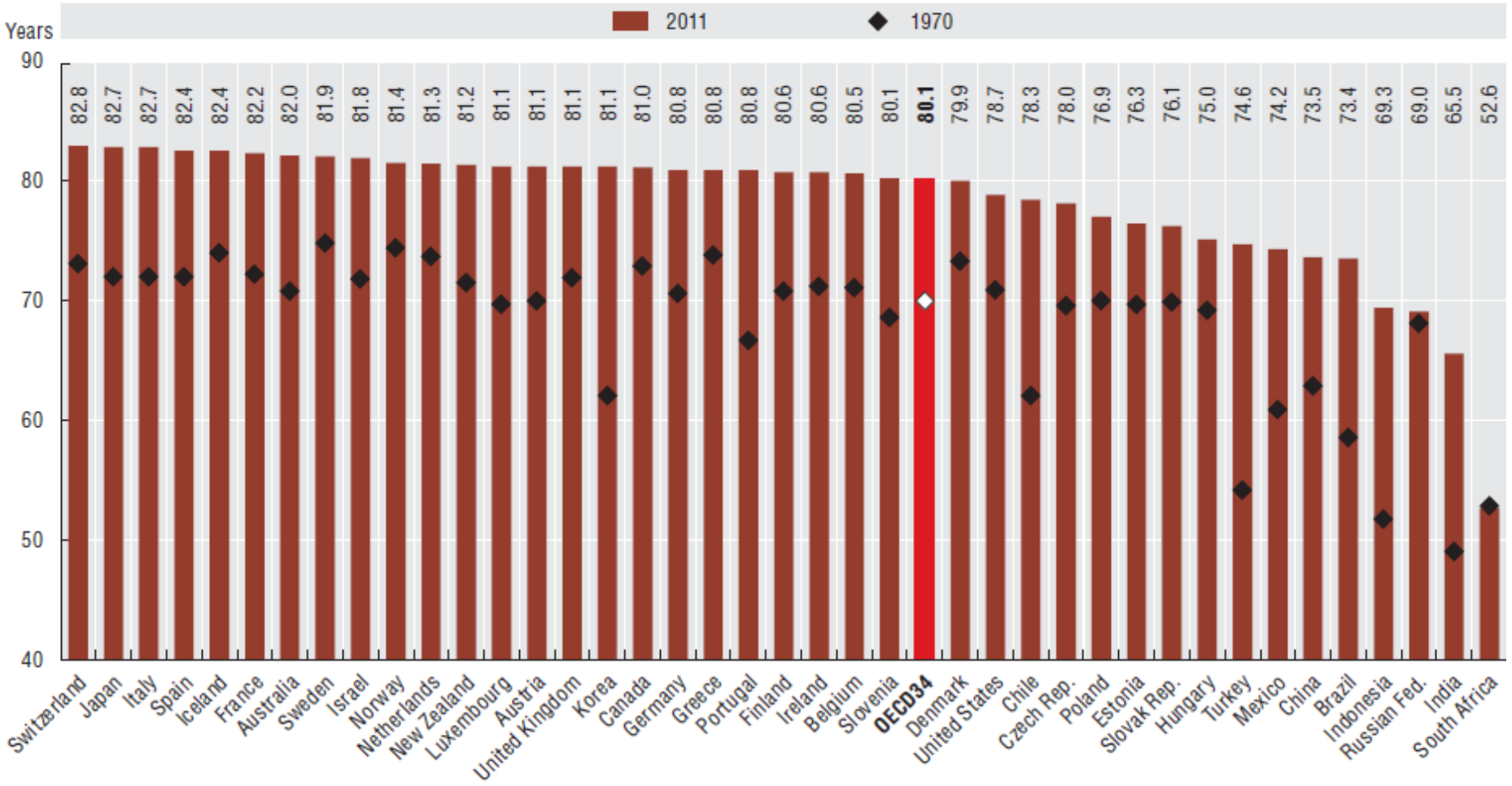


Source: Cuckler G et al., "National Health Expenditure Projections, 2012–22: Slow Growth until Coverage Expands and Economy Improves" *Health Affairs* 32, no. 10 (2013).

What's wrong with 18%?

- "Don't we have the best healthcare system in the world?"
- "If we need to spend money, why not on healthcare?"
- But, we are not getting a good return on our healthcare dollar
- And our healthcare spending is not making us healthier

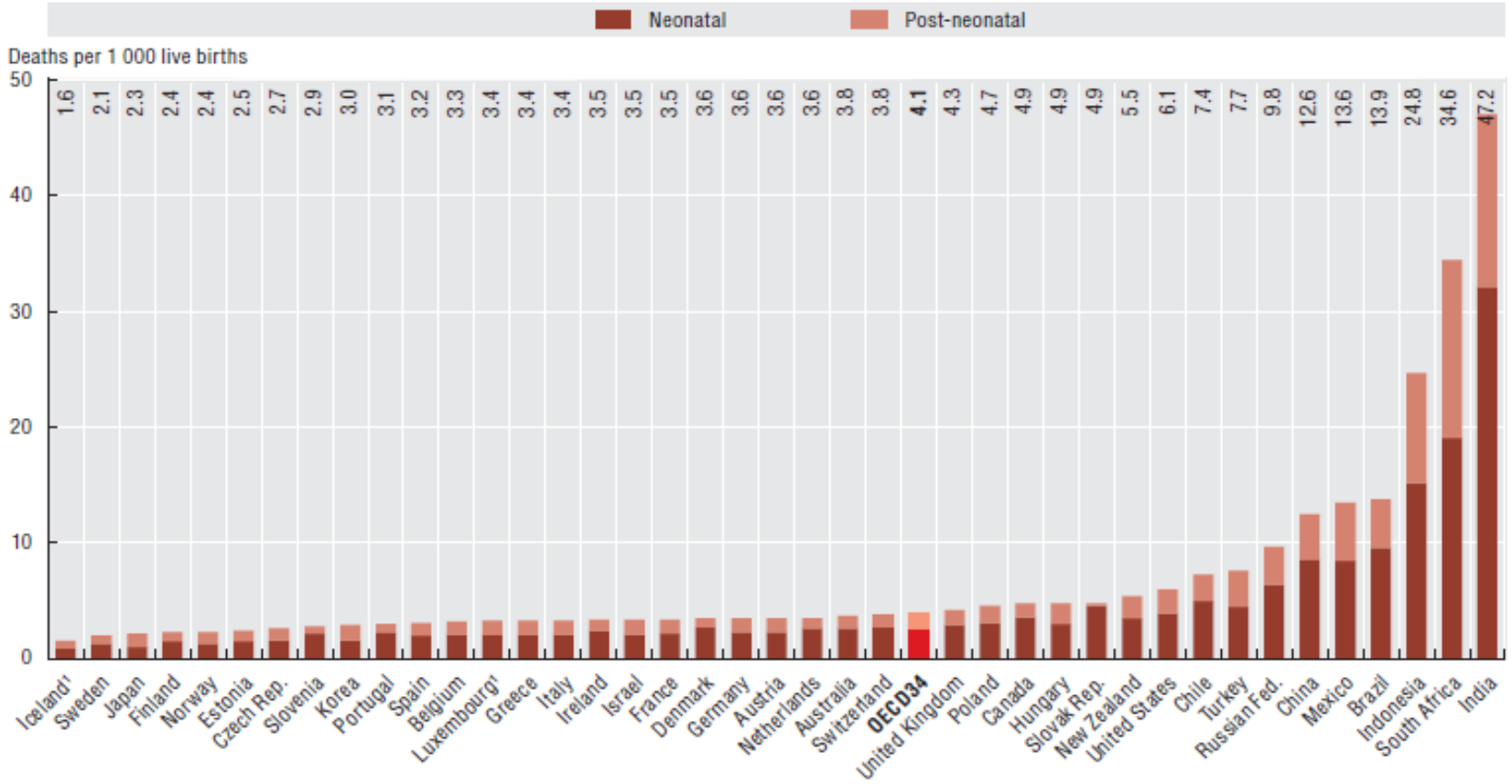
Average Life Expectancy, 1970 & 2011



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; World Bank for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888932916000

Infant Mortality Rates

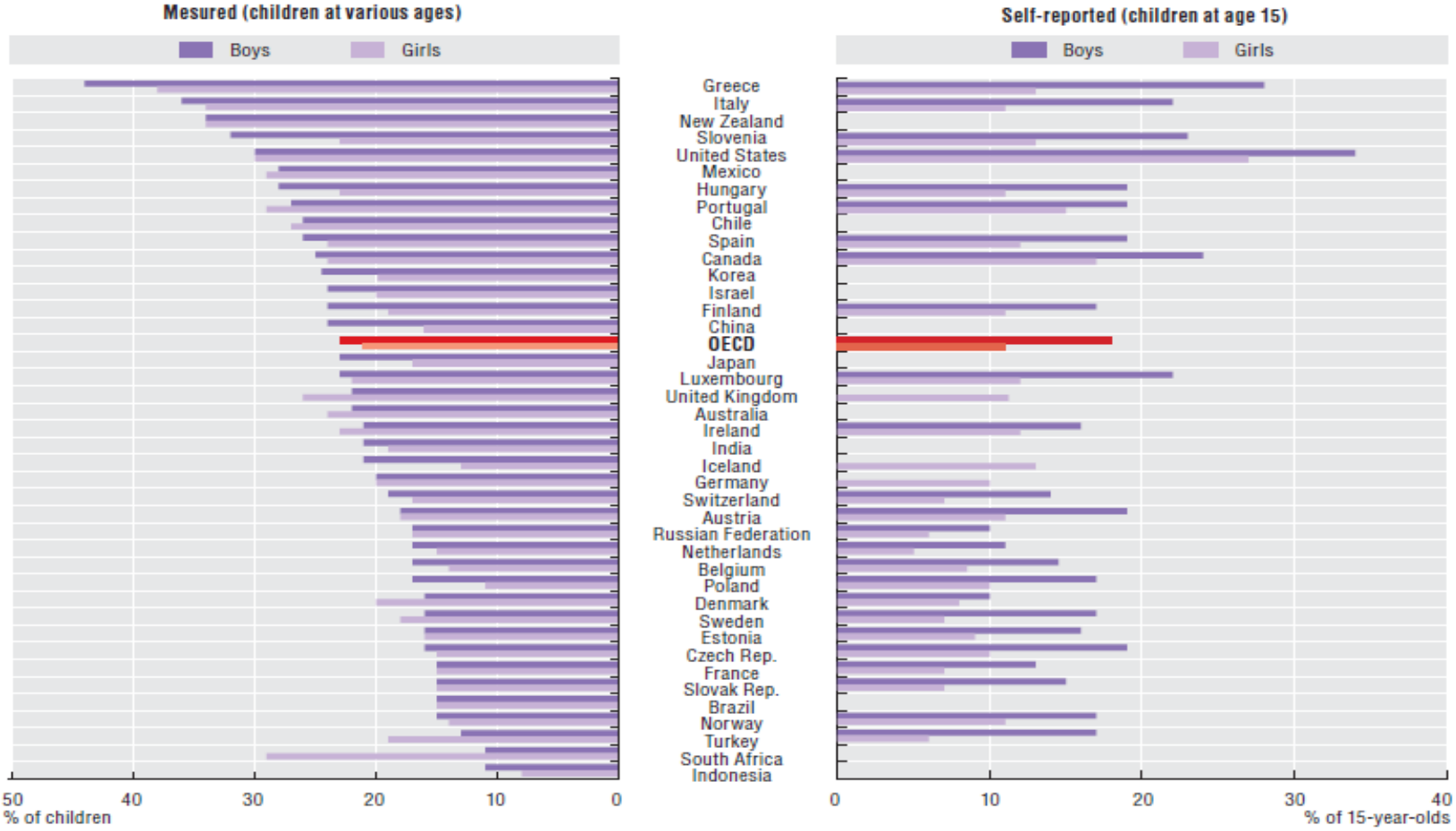


1. Three-year average (2009-11).

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; World Bank for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888932916249

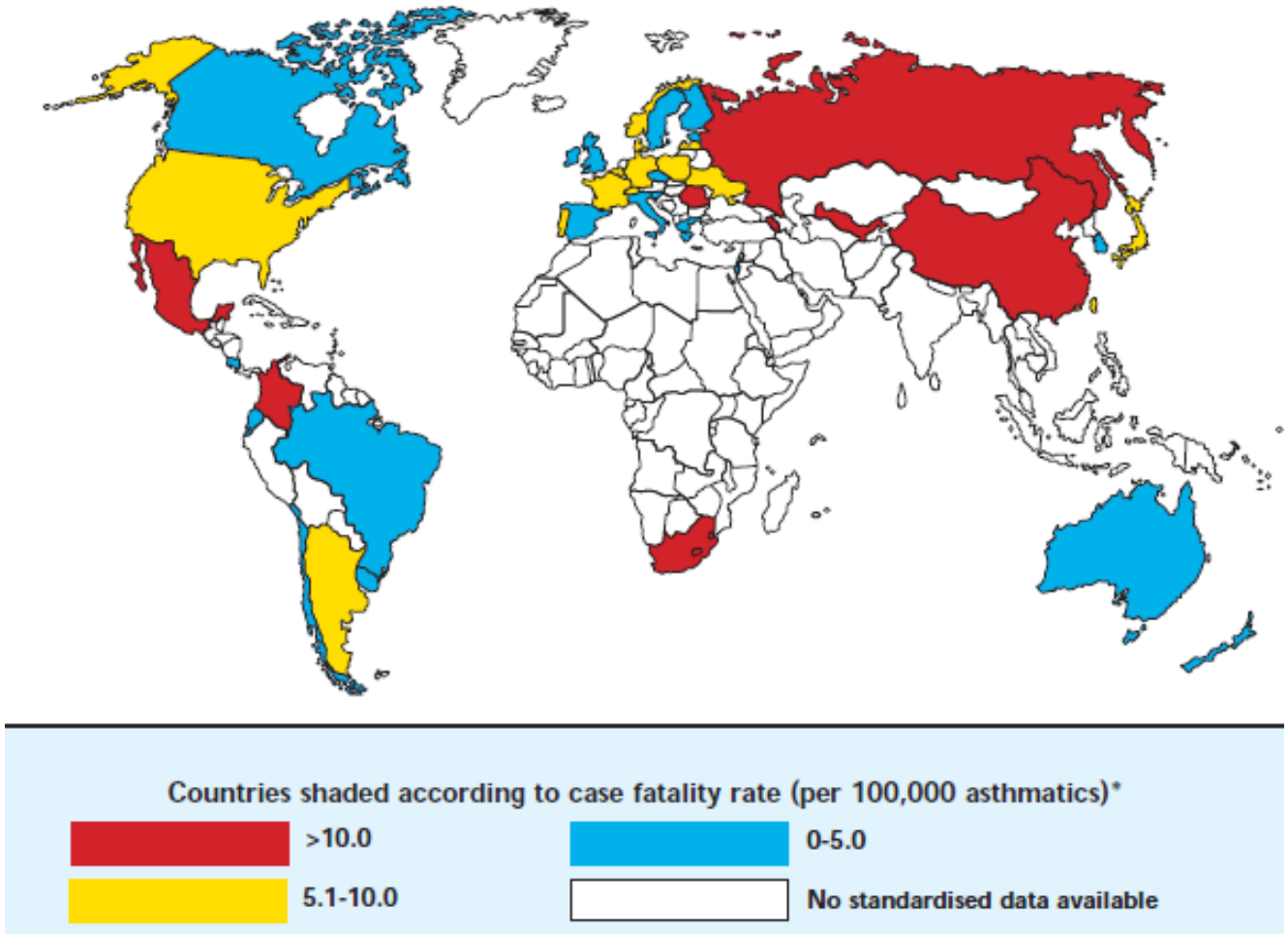
Childhood Obesity Rates



Note: Measured data for United Kingdom refer to England.
Source: International Association for the Study of Obesity, 2013; Bös et al. (2004) for Luxembourg; and KNHANES for Korea (measured data). Currie et al. (2012) (self-reported data).

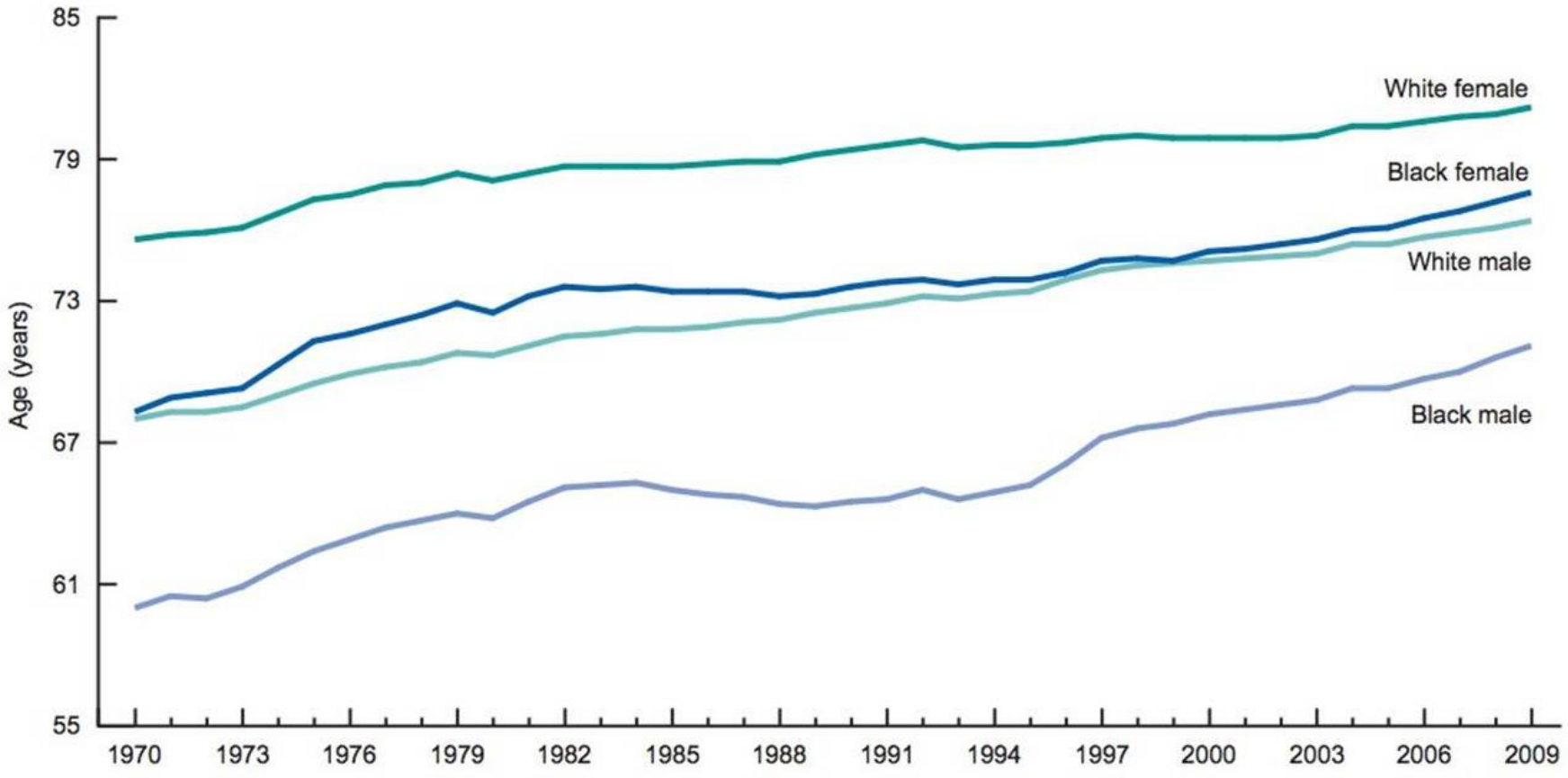
StatLink http://dx.doi.org/10.1787/888932916477

Asthma Deaths per 100,000 Asthmatics



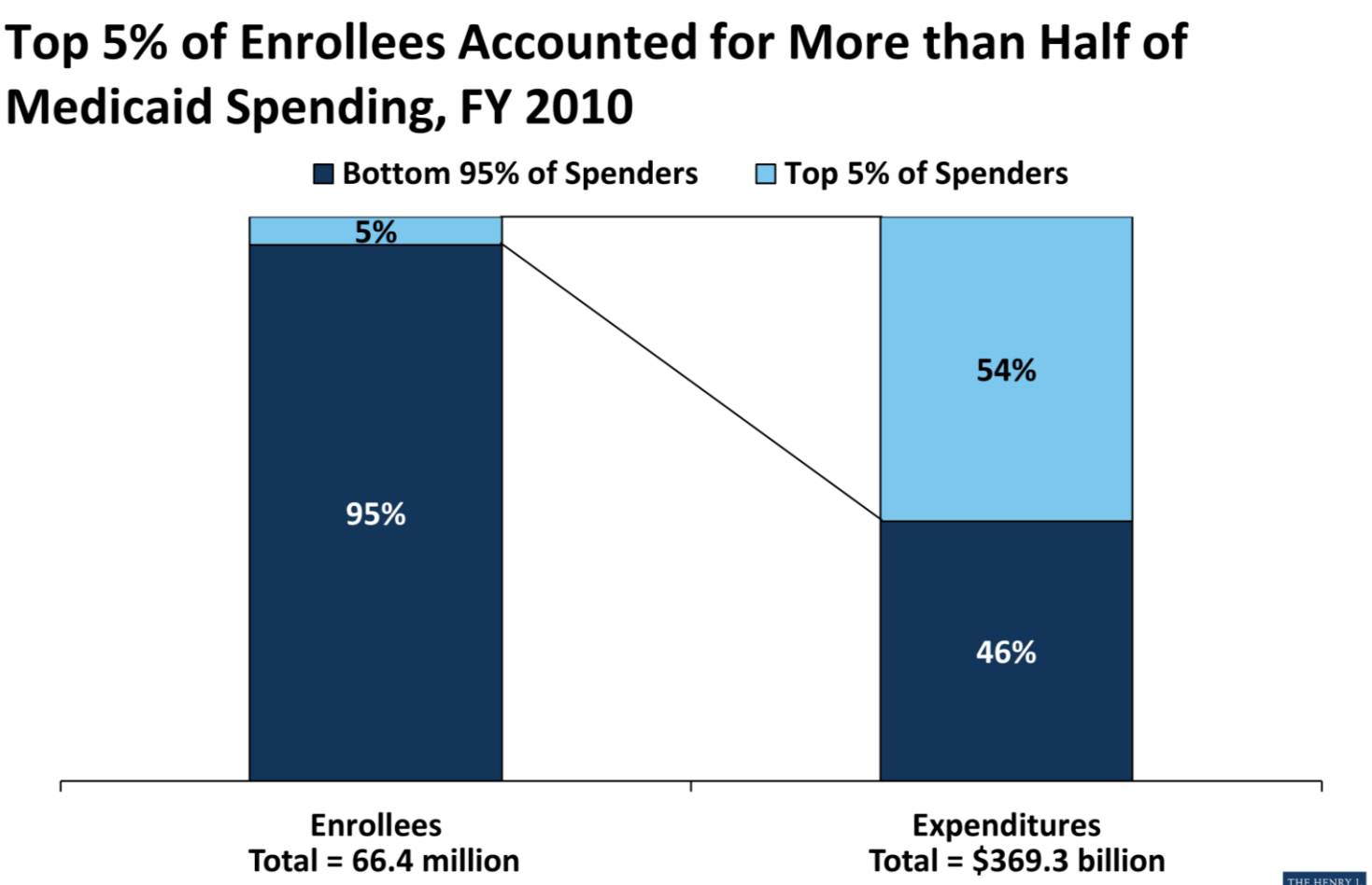
Source: Global Initiative for Asthma, Global Asthma Burden Report

U.S. Longevity, by Race and Gender



SOURCE: CDC/NCHS, National Vital Statistics System.

Disproportionate Spending



SOURCE: KCMU/Urban Institute estimates based on data from FY 2010 MSIS and CMS-64.
MSIS FY 2009 data were used for CO, ID, MO, NC, and WV, but adjusted to 2010 CMS-64.

THE HENRY J. KAISER FAMILY FOUNDATION

Variations in Spending

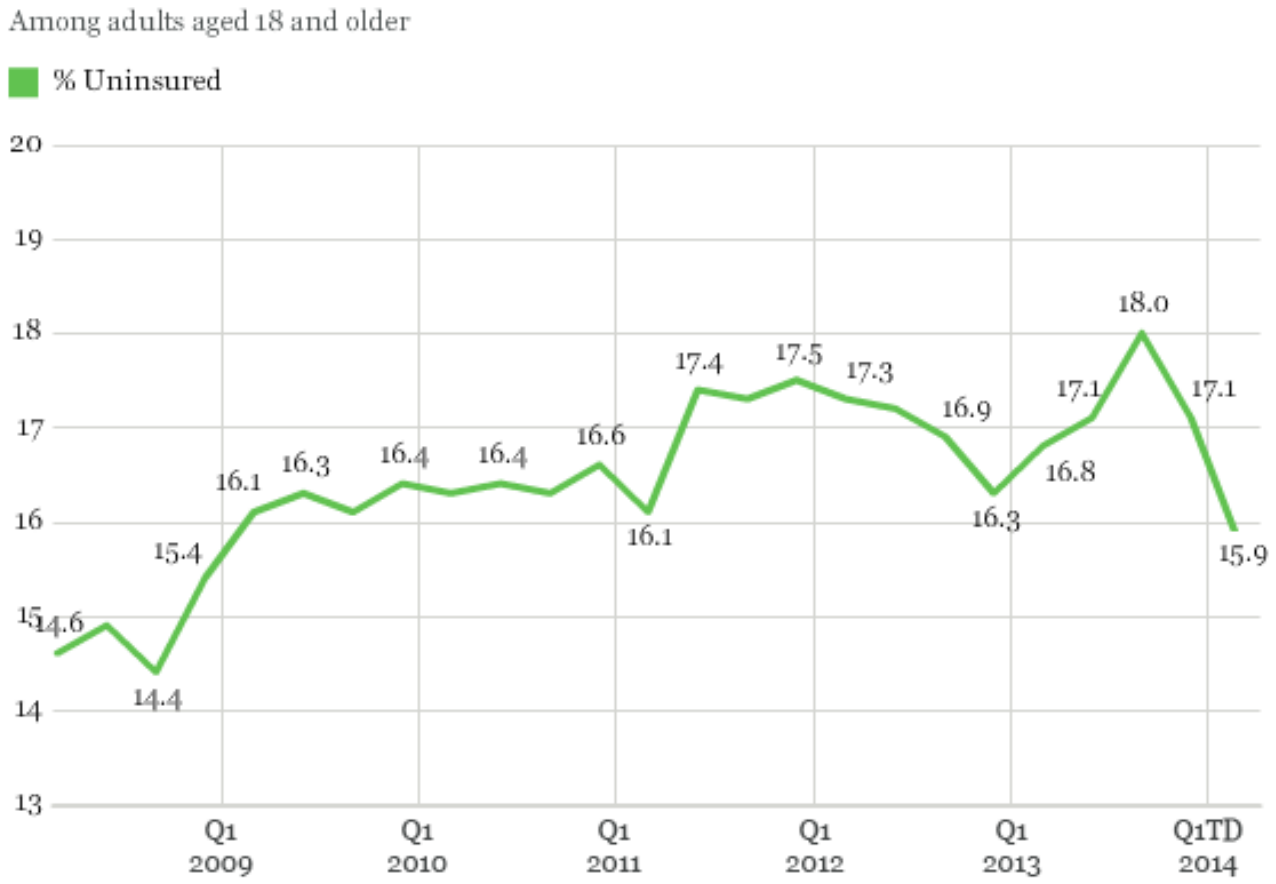
Five Hospital Referral Regions (HRRs) with the Highest and Lowest Actual Per Capita Medicare Spending in 2012

Highest per capita HRR	2012 actual per capita spending
Miami, Fla.	$15,357
Bronx, N.Y.	$14,699
Manhattan, N.Y.	$13,699
Los Angeles, Calif.	$13,319
Chicago, Ill.	$13,059

Lowest per capita HRR	2012 actual per capita spending
Honolulu, Hawaii	$6,790
Dubuque, Iowa	$6,716
Bend, Ore.	$6,667
Missoula, Mont.	$6,633
Grand Junction, Colo.	$6,569

SOURCE CMS.gov, "Geographic Variation Public Use Files," updated December 2013.

Percentage of Uninsured in U.S.



Quarter 1 2008-February 2014
Gallup-Healthways Well-Being Index

GALLUP

A Broken System Delivering Suboptimal Value

- U.S. lagging behind other countries in healthcare outcomes, despite greater spending
- Patients with zero or limited coverage foregoing or delaying seeking necessary care
- Care providers facing crushing paperwork, uncertain payment, and rising costs
  - Now too many points and clicks!
  - Insurance bureaucracy adding more paperwork to practices, reducing time spent with patients
- We need a new way to deliver and be accountable for the care we provide.

Learning Objectives

- Review the macroeconomic healthcare environment compelling development of new models of care
- Describe newer models of payment for healthcare services
  - Uncover challenges and opportunities to the underlying, conventional business model
- Review Accountable Care Organizations as a new model of payment and delivery

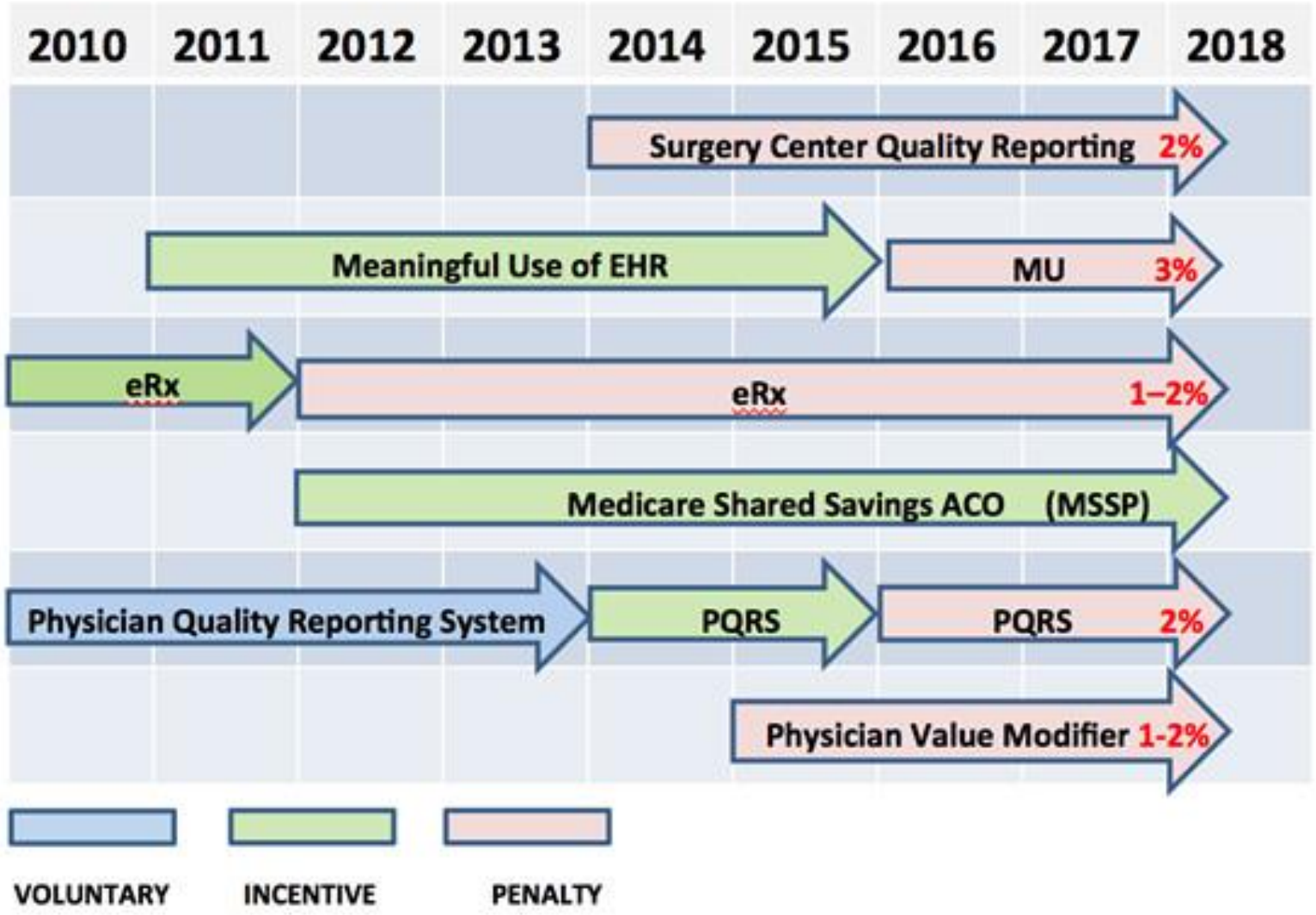
Themes in New Models

- Guided by increasing value and quality
  - Decrease waste, inefficiency
  - Improve clinical outcomes
  - **Value = f(price, quality, appropriateness)**
- Incentives and Pay for Performance (P4P)
- Penalties for non/poor performance
- Predictability, removing uncertainty
- Minimizing opportunity for arbitrage

Value

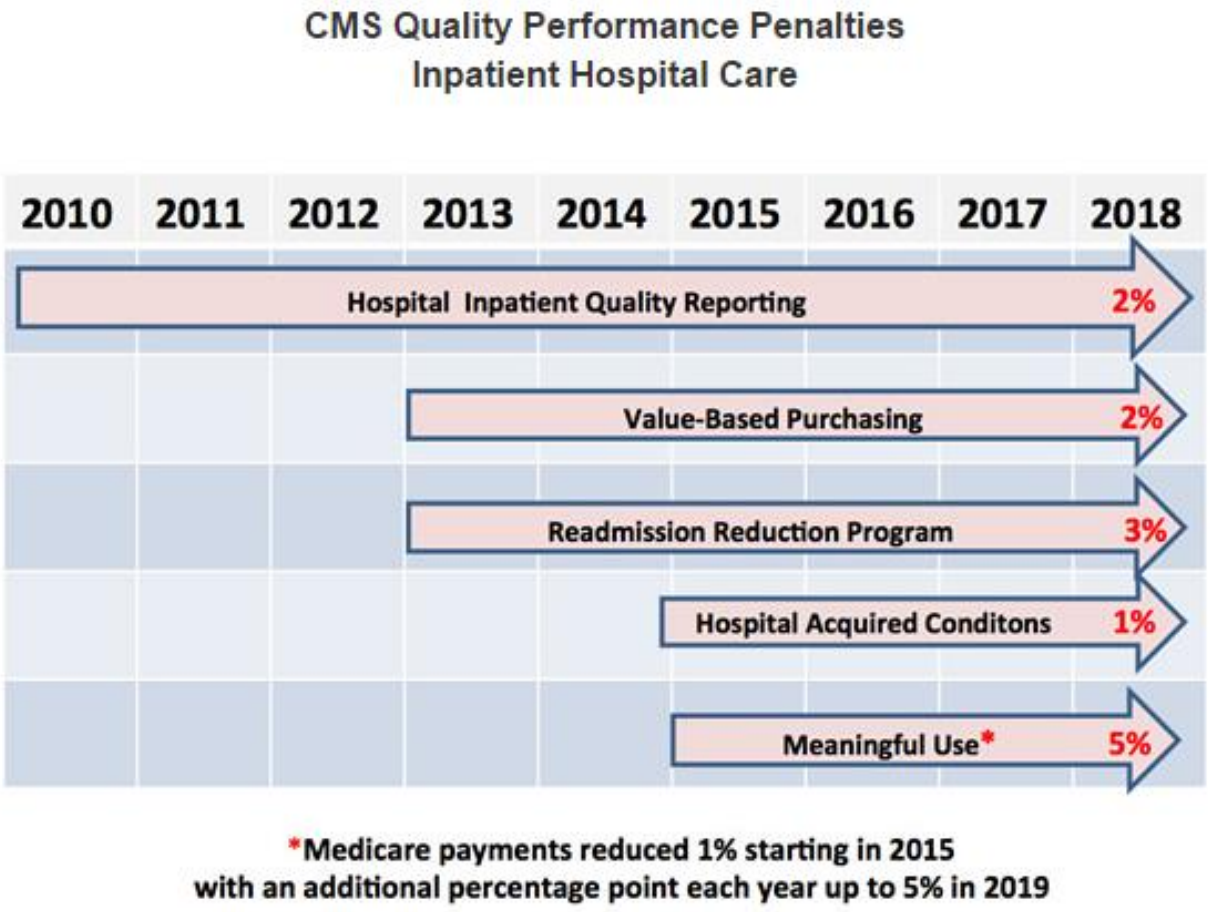
- Is Golden Corral a good value?
- Why? Why not?

Incentives and Penalties



Source: CMS

Incentives and Penalties



Source: CMS

Case: Initial Presentation

- 56 year old female from DC with a history of DM
- Considering retirement as botanist and moving to Arizona to focus on farming
- Very active, runner, quit smoking 7 years ago
- Presents to her PCP of one year with a CC of R knee pain for 2 weeks
- Chose this PCP because of “Patient Centered Medical Home Status” (PCMH)

Case: Initial Presentation

- PCP diagnosed her with osteoarthritis (OA)
- Used his EHR to document patient's visit
- Recommends rest and medication
- Sends prescription for NSAID to pharmacy via electronic prescribing (eRx)
- Reviews DM status, and notes her blood pressure is 118/78 or under control

Case: Orthopedic Consult

- 2 weeks later, patient reports no improvement after following directions
- PCP refers her to orthopedic surgeon, who she sees 2 weeks later
- Surgeon agrees with diagnosis, is worried about ligament stability as well
- Orders x-ray and MRI of knee
- Imaging confirms OA, R>>L; ligaments normal
- Offers elective knee replacement
- Patient declines in favor of conservative mgmt

Case: Orthopedic Consult

- 12 weeks later sees orthopedic surgeon again
- Interim functional status has deteriorated markedly
- Surgery is now not considered elective
- Patient agrees to have surgery

Case: Surgery and Hospitalization

- Arrives to the surgery 2 weeks later for 3 days stay
- Has R knee replacement surgery
- On POD #2 complains of SOB
- Workup confirms PE and patient is transferred to the ICU
- Patient was not anticoagulated
- After 12 days in the hospital is discharged to SNF

Case: Recovery and New PCP

- 4 weeks later, after regaining strength and mobility, she is discharged to home
- Feels frustrated by the care she received and feels like she needs more attention from her medical team
- Transfers primary care to a boutique practice closer to her home

Case: Return to Former PCP

- 18 months later is medically doing well
- DM under control, having on-and-off abdominal pain
- Peanut business has not been successful and is burdened by the complexities of agribusiness
- Has to liquidate assets and is now living with limited resources; qualifies for Medicaid
- Has to abandon boutique practice, and seeks to return to her former PCP
- PCP is no longer taking traditional Medicaid patients, but agrees to see her

Initial Visit to PCP

- Claim requires a level of documentation
- Payments are typically prenegotiated
- Patient co-pay can include deductible, coinsurance, and other patient-level responsibility
- Where are the incentives? Dis-incentives?

Assumption with FFS

- Premiums paid by both employee (member) and employer
- Larger employers often offer some choice
  - Insurance does not equal access
- Where are the incentives? Dis-incentives?

- Does “insurance” = “access”

Visit to PCP with PCMH

- Patient Centered Medical Home status achieved through robust accreditation process
- PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family
- Blue Cross Blue Shield of North Carolina PCMH Blue Quality Physician Program; "double digit" premiums for eligible providers

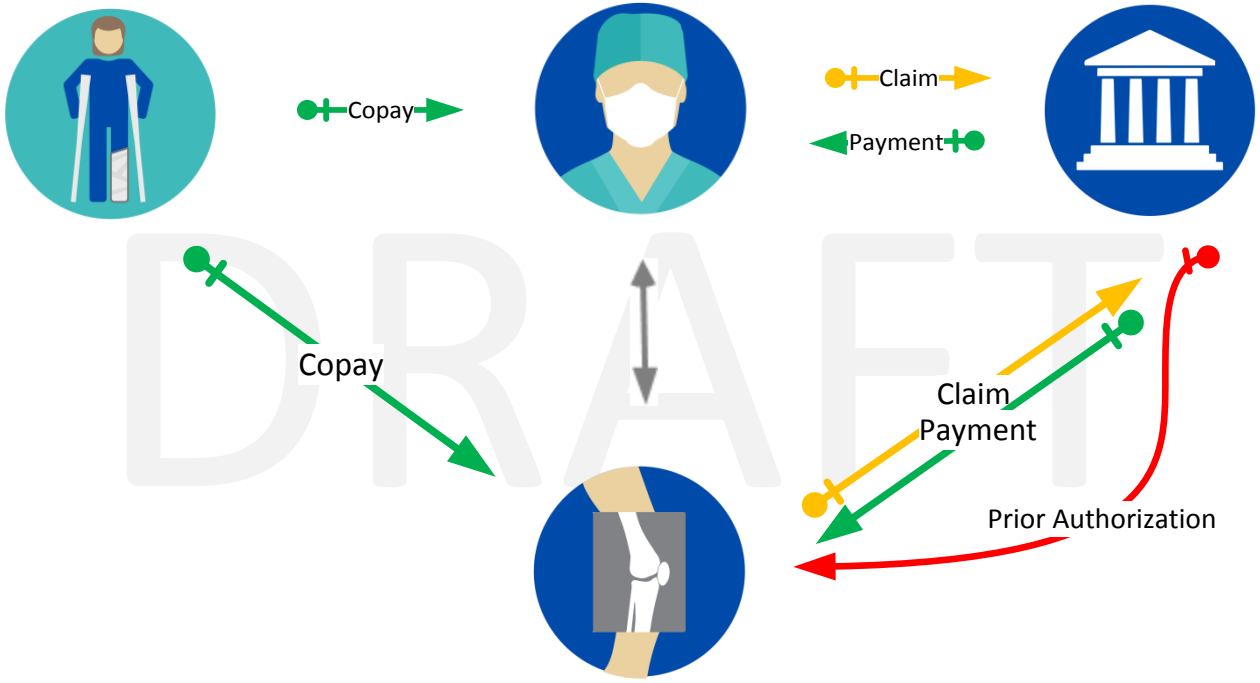
Meaningful Use

- Established in 2009 American Recovery and Reinvestment Act
- Medicare EHR Incentive Program
- Provides incentive payments to eligible professionals that demonstrate meaningful use of certified EHR technology
- Up to $44,000 over 5 years
- Medicaid program also
- After 2015 payment is adjusted for not complying

Electronic Prescribing (eRx)

- Established in 2008 Medicare Improvements for Patients and Providers Act (MIPPA)
- Provides an incentive payment for eligible professionals for using eRx
  - Variety of ways to demonstrate compliance
- Up to a 2% premium
- Variety of ways to demonstrate activity

Visit to Orthopedist



- Where are the incentives? Dis-incentives?
- Where is the opportunity to drive value?

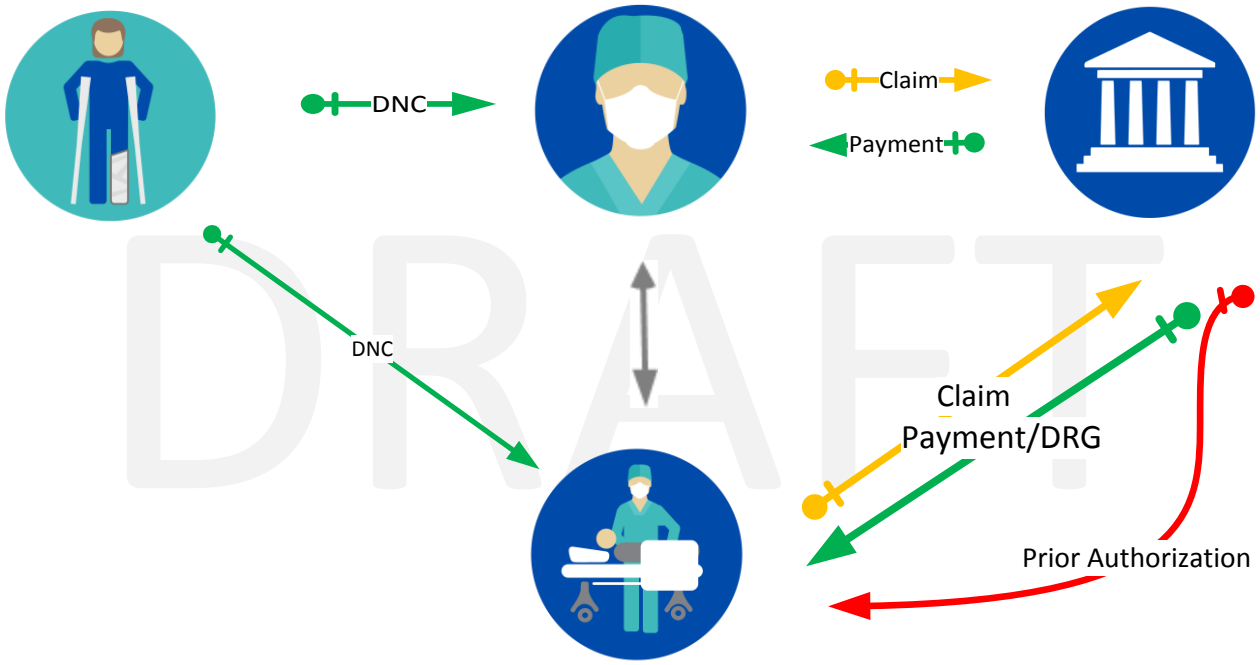
Consumerism and Transparency

- http://www.bcbsnc.com/content/providersearch/treatments/index.htm#/?distance=25&treatment=MRI%20knee&location=27713
- Castlight and others

Prior Authorization

- Not a new model of payment per se but important to remember as a process whenever working with third-party payors
- Considered by some to be a form of “penalty”
  - Bad debt risk

Surgery



- Where are the incentives? Dis-incentives?
- Where is the opportunity to drive value?

Transfer to ICU

- Where are the incentives? Dis-incentives?
- Where is the opportunity to drive value?

Errors That Should Never Occur

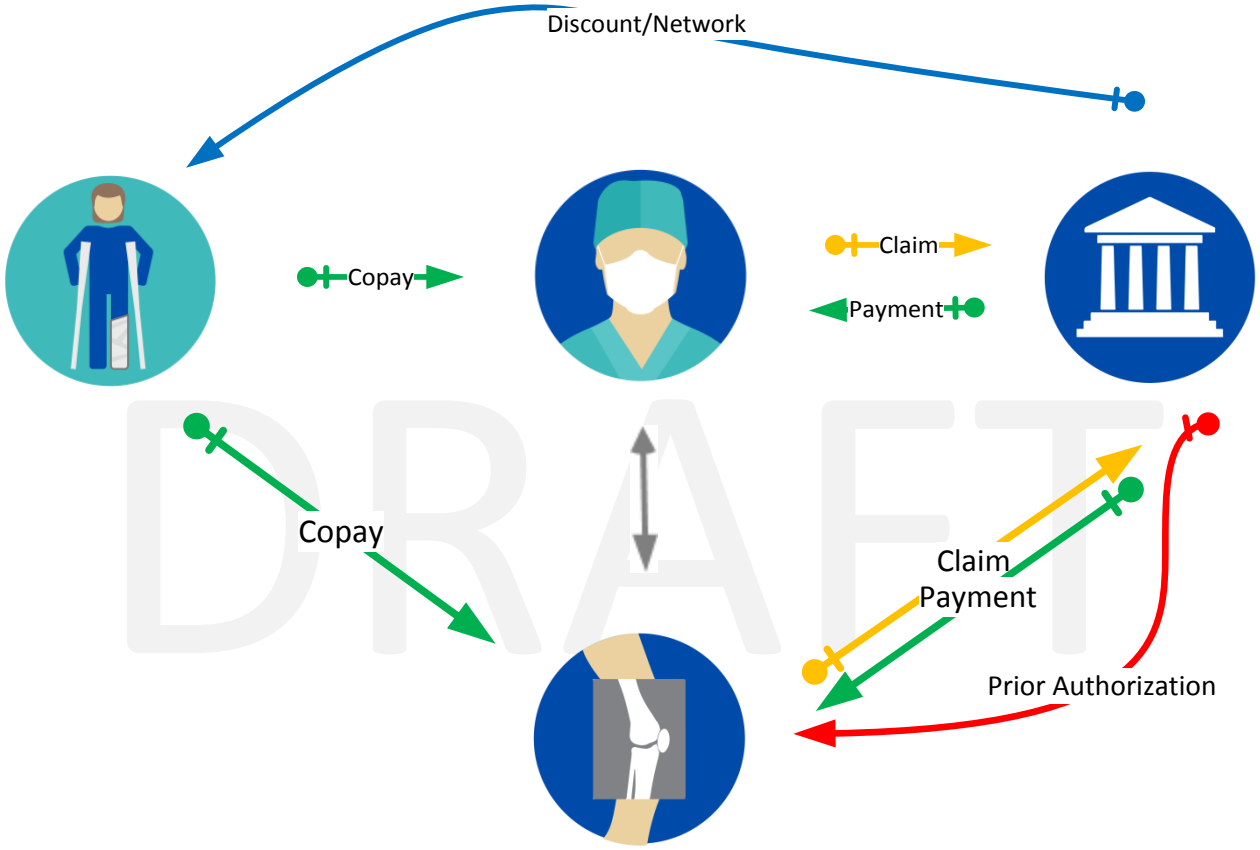
- Compiled by National Quality Forum in 2001
- Occurrences considered inexcusable outcomes in a health care setting
  - Involve death and serious disability
- Similar to Medicare not reimbursing serious preventable events
  - Surgical site infections
  - Certain manifestations of poor sugar levels
  - Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures

NQF
National Quality Forum

Boutique Practice

- Subscription practice that increases access
  - Retainer fee (+/- insurance)
  - Improved telephone access, e-mail, limited panel
- Very popular in late 1990's and early 2000's
- Dependent on disposable income

Discounts, Networks, Tiering



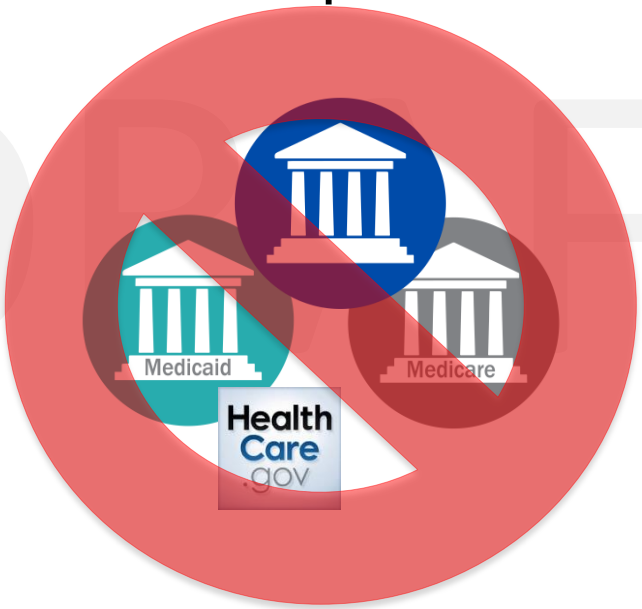
- Where are the incentives? Dis-incentives?
- Where is the opportunity to drive value?

Return to former PCP

- Care managed practice offers PMPM fee to help with managing patients
- Variations include recent CCM fees by Medicare

Discontinuing Payers

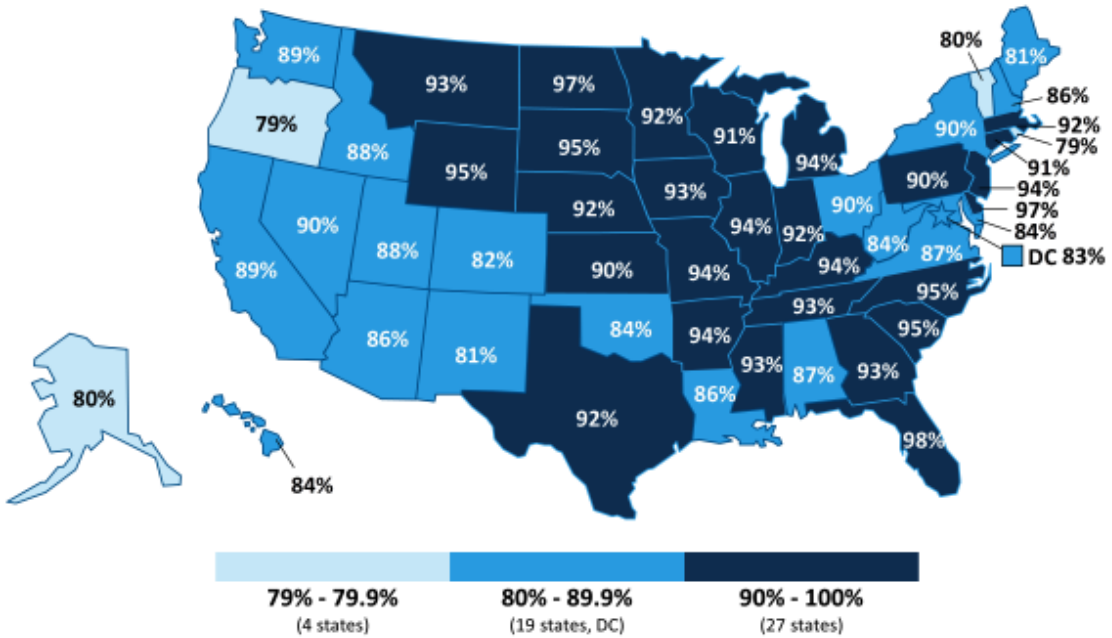
- Growing trend among some as costs of care are greater than reimbursement
- What are implications for patients? Providers?



Medicare Participation Rates

Exhibit 7

Across all states, most physicians accept new Medicare patients



NOTES: Pediatricians are excluded from this analysis. Physicians were not asked to distinguish between patients in traditional Medicare and Medicare Advantage plans.
SOURCE: National Ambulatory Medical Care Survey – National Electronic Health Records Survey, 2012.

THE HENRY J. KAISER FAMILY FOUNDATION

Exhibit 7. Across all states, most physicians accept new Medicare patients

Source: http://kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/

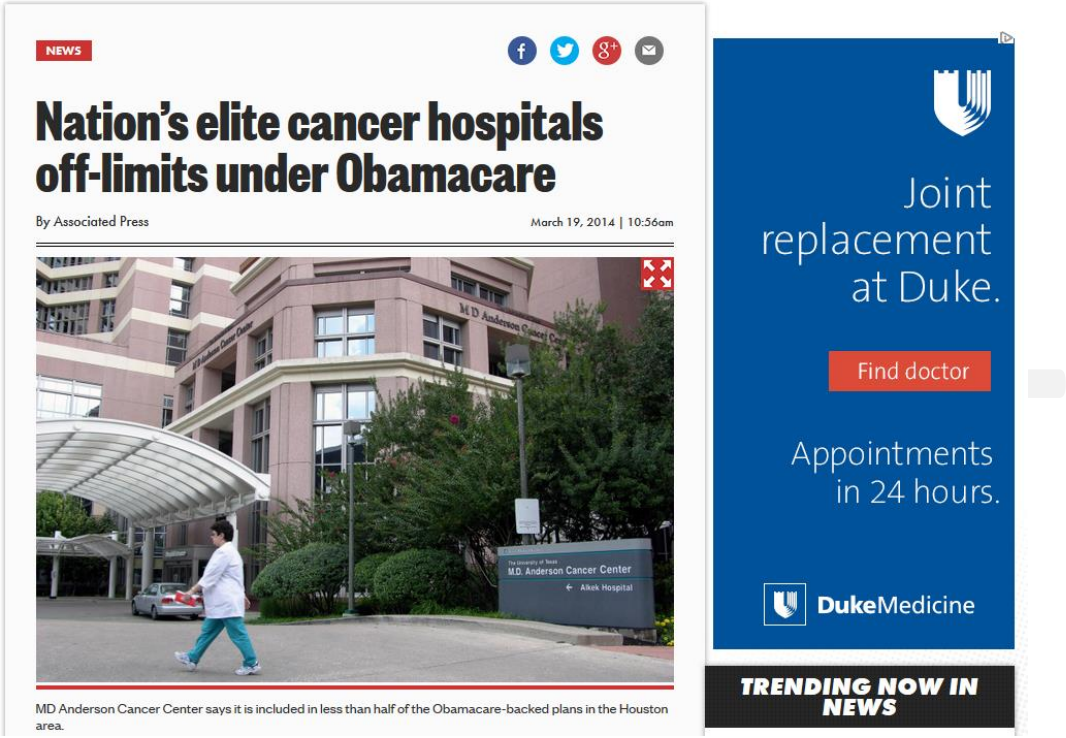
Medicaid Participation Rates

Acceptance Of New Medicaid Patients Among US Office-Based Physicians, By Practice Type And Specialty Category, 2011–12

Physician practice type and specialty category	Percent of physicians	95% CI	Percent of physicians not accepting new Medicaid patients	95% CI
All	100.0	—	29.9	(28.2–31.6)
PRACTICE TYPE				
Community health centers[a]	3.6	(3.1–4.3)	5.8	(2.5–9.1)
Other practice types[a]	96.4	(95.7–96.9)	30.9[b]	(29.2–32.6)
SPECIALTY CATEGORY				
Primary care	41.7	(39.8–43.5)	33.2	(30.7–35.7)
General/family medicine	18.5	(17.2–20.0)	33.6	(28.5–38.6)
Internal medicine	12.1	(10.9–13.4)	43.6[c]	(36.6–50.6)
Pediatrics	11.0	(9.9–12.2)	20.5[c]	(14.4–26.7)
Other specialties	58.4	(56.5–60.2)	27.5[c]	(25.3–29.7)
General surgery	3.9	(3.2–4.7)	21.7	(9.6–33.8)
Obstetrics/gynecology	7.5	(6.5–8.5)	22.2	(15.1–29.4)
Orthopedic surgery	4.9	(4.0–5.9)	40.0	(29.1–59.9)
Cardiovascular diseases	4.0	(3.3–5.0)	9.2[d]	(1.6–16.8)
Dermatology	2.3	(1.8–2.9)	44.5[d]	(29.1–59.9)
Urology	2.0	(1.5–2.6)	15.1	(3.2–27.0)
Psychiatry	5.7	(4.7–6.8)	56.2[d]	(45.5–66.9)
Neurology	2.4	(1.8–3.2)	21.5	(6.5–36.5)
Ophthalmology	4.4	(3.6–5.3)	18.1[d]	(7.8–28.5)
Otolaryngology	2.0	(1.5–2.7)	25.6	(0.9–41.3)
Other	19.5	(18.0–21.1)	23.6	(18.7–28.6)

Source: Sandra L Decker *Health Affairs*, 32, no.7 (2013):1183-1187 A Baseline To Measure Future Acceptance Rates Two-Thirds Of Primary Care Physicians Accepted New Medicaid Patients In 2011-12:

Commercial Products



NEWS

Nation's elite cancer hospitals off-limits under Obamacare

By Associated Press

March 19, 2014 | 10:56am

MD Anderson Cancer Center says it is included in less than half of the Obamacare-backed plans in the Houston area.

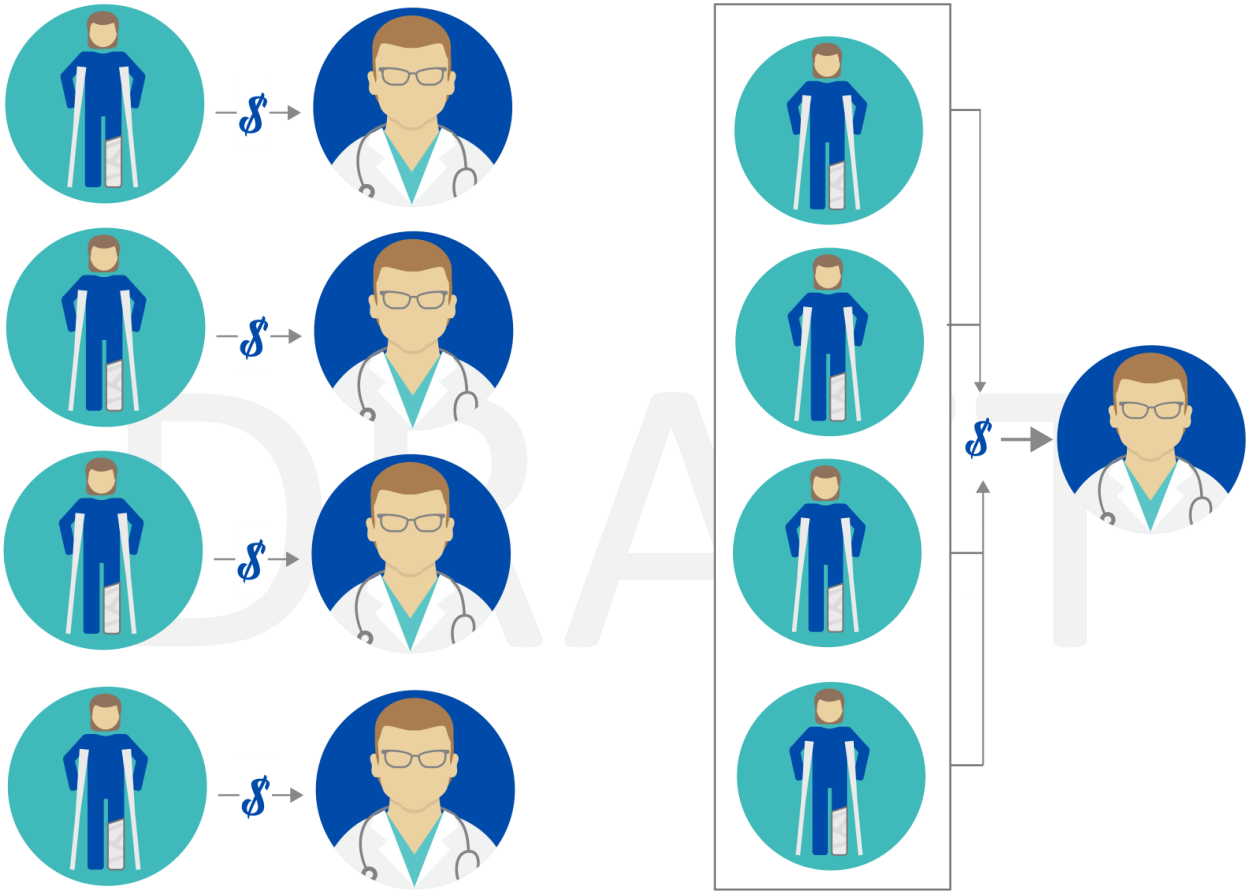
- 19% of nationally recognized cancer centers take all exchange products in state

Source: http://nypost.com/2014/03/19/nations-elite-cancer-hospitals-off-limits-under-obamacare/

Bundled Payment

- Payment based on episode of care
- Middle ground between FFS and capitation
- Minimizes some of the challenges with DRG
- Seen by some as a way to get healthcare providers to work/fight internally

FFS vs Capitation



- When might one model be preferred to another?
- By whom?

Learning Objectives

- Review the macroeconomic healthcare environment compelling development of new models of care
- Describe newer models of payment for healthcare services
  - Uncover challenges and opportunities to the underlying, conventional business model
- Review Accountable Care Organizations as a new model of payment and delivery

Healthcare Delivery is in Transition

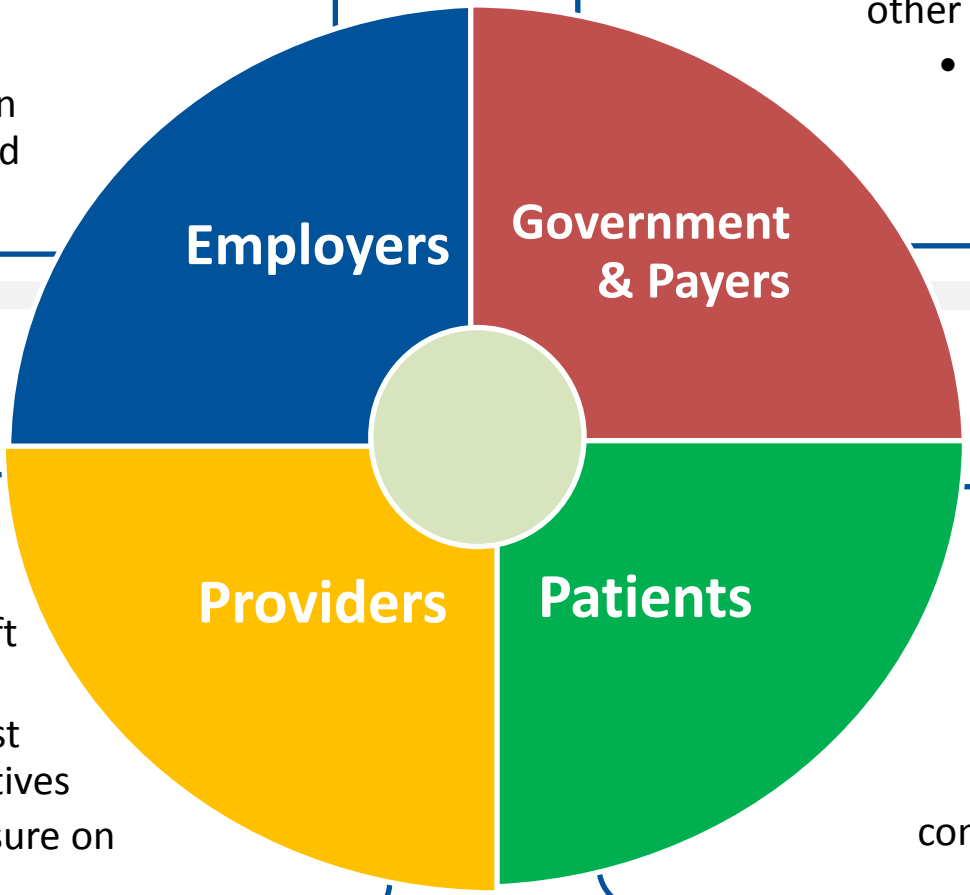
Today		Future
Pay for volume	→	Pay for value
Fragmented care	→	Patient- and family-centered care
Limited population focus	→	Population health management
Inconsistent medical records	→	Comprehensive EHR
Specialty care focus	→	Primary care / prevention focus

In this evolving landscape, providers are **developing the infrastructure and systems** to meet these changes and **continue to deliver high-quality care**

Financial Responsibility is Also Shifting

- Not absorbing cost increases
- Exchanges may accelerate decline in employer-sponsored insurance

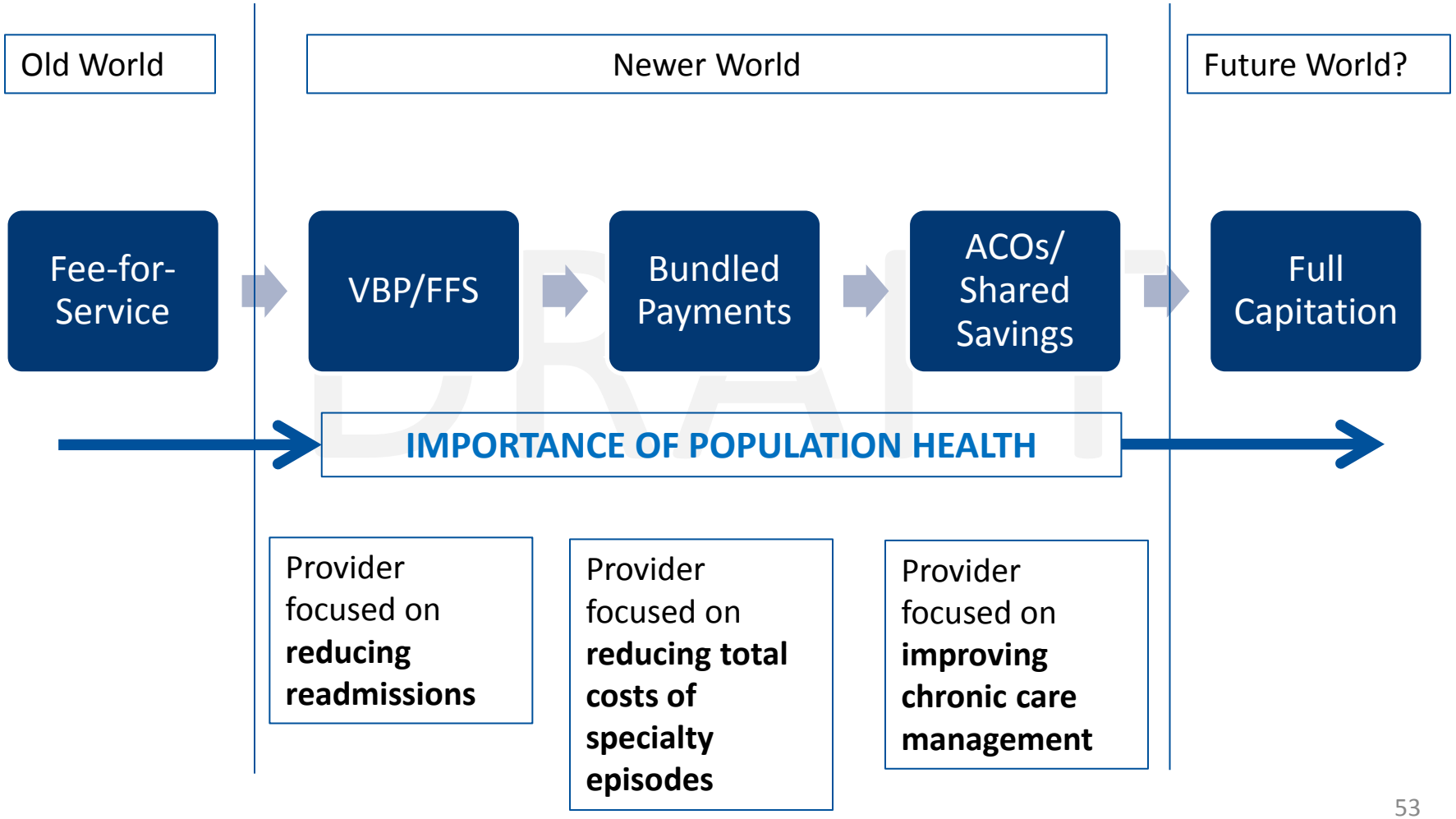
- Overall reimbursement, other support decreasing
- Commercial payers competing on cost



- Nowhere to shift costs
- Undertaking cost reduction initiatives
- Increasing pressure on vendors

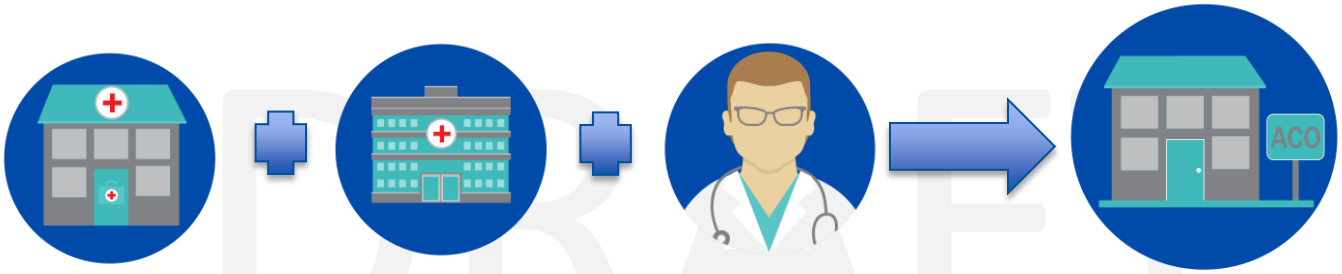
- Costs shifting to consumers (HDHPs, tiering)
- Costs shifting from consumers to purchasers (exchanges)

U.S. Model of Risk-Shifting Initiatives



ACO Defined

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to a group of patients.



- The goal of coordinated care is to ensure that patients, or ***a population***, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Population Health

- "…the health outcomes of a group of individuals including the distribution of such outcomes within the group." (Kindig and Stoddart, 2003)
- "…the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services." (Dunn Hayes, 1999)
- "…better health by encouraging healthier lifestyles in the entire population, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventive care." (CMMI)

Primary Objectives of ACOs

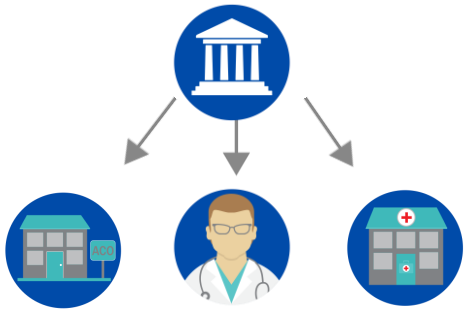
- Coordinate care across and among primary care physicians, specialists, and other providers
- Promote evidence-based medicine, cost efficiency and patient engagement
- Improve clinical quality and health outcomes by establishing methods and processes to optimize utilization and drive value
- Develop and maintain a infrastructure for tracking clinical quality goals and related physician performance
- Capture incentives available for care management and shared savings

1

Attribution

Payer assigns patient to the providers in the ACO

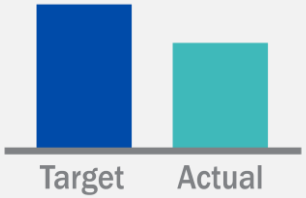
2



Claims and Bills

Current mechanics of payments remain in place with FFS rates

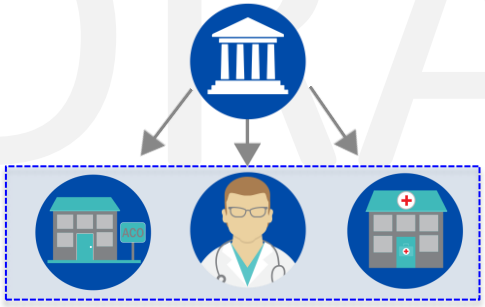
3



Reconciliation

Cost of care of patients in ACO are compared to benchmark (usually known in advance)

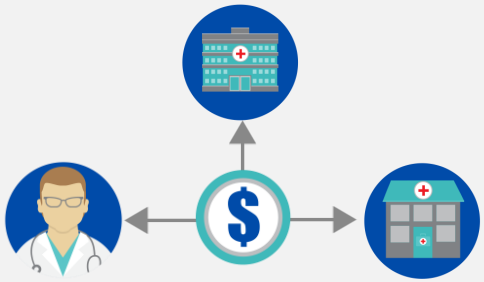
4



When Actual>Target

Upside or downside of reconciliation is made known to the ACO.

5



Shared Savings Distribution

ACO shares bonus with participating providers

How Do ACOs Generate Savings?

	Focus	Outcome
Admissions and Readmissions	Transition management, better access to PCP and primary care	Decreased admissions, readmissions, decreased LOS
Post-acute Care	Coordinating with post-acute care settings	Optimal utilization, minimizing return admissions
Emergency Dept.	Optimal use of the emergency department	Reduction in avoidable ED visits, emphasis on urgent care
Utilization/ Medications	PCP assignment, medication management	Smarter use of available resources and referrals

Potential Impacts of ACOs on Physicians

- Increase in preventive services (e.g., breast cancer screening, flu shots)
  - Impacts quality rating
- Increase in primary care use
- Availability of care management and care managers to support patients who are high risk or high utilizers
  - Pursuit of alternative treatments that get patients right care, in right setting, at right time
- Improve ability to exchange information, including best practices

Summary

- A combination of incentives and penalties are being used to solve
  - Aiming to solve central dogma of value-based care
  - **Value = f(price, quality, appropriateness)**
- Not all efforts apply to all payers and physicians at all times
- The focus on value and quality will continue
- Well informed physicians and systems can achieve reasonable gain by doing the right thing at the right time with a reasonable time horizon