



Value-Based Payments: Coming Soon To a Payer Near You

By Susanne Madden, MBA
President & CEO
The Verden Group
May 2010

Agenda

- The origin of, and driving forces behind, VBP models
- What to expect from CMS and When
- Non-CMS Payers' Models
- Risks and opportunities
- Prepare for change

The Concept of Value-Based Payments

- Origin: The University of Michigan Center for Value-Based Insurance Design
 - Established in 2005 to develop, evaluate, and promote value-based insurance initiatives in order to ensure efficient expenditure of health care dollars and maximize benefits of care.
- Driving Force: “Obama-Care”
 - Tasked Congress with eight principles for “Transforming and Modernizing America's Health Care System” which ultimately led to the signing of the Patient Protection and Affordable Care Act (March 23, 2010)

The Origins of Value-Based Concepts

UM Center for Value-Based Insurance Design

- Value-based insurance design programs focus on removing barriers for screenings, tests, and treatments that are proven to be effective.
- The VBID Center provided the conceptual foundation and empirical research to allow health plans nationwide to remove barriers for high-value preventive, diagnostic, and therapeutic medical services.

"What value-based insurance design does is invest in those medical services that produce the most health and maximize benefits of care." – Mark Fendrick, co-director, VBID

Making Value-Based Designs A Reality

Obama-Care: The Agenda (8 Principles)

1. Protect Families' Financial Health.
2. Make Health Coverage Affordable.
3. Aim for Universality.
4. Provide Portability of Coverage.
5. Guarantee Choice.
6. Invest in Prevention and Wellness.
7. Improve Patient Safety and Quality Care.
8. Maintain Long-Term Fiscal Sustainability.

Making Value-Based Designs A Reality

The Patient Protection & Affordable Care Act: PPACA

The law includes a large number of health-related provisions to take effect over the next four years, including:

- Expanding Medicaid eligibility
- Subsidizing insurance premiums
- Providing incentives for businesses to provide health care benefits
- Prohibiting denial of coverage/claims based on pre-existing conditions
- Establishing health insurance exchanges
- Support for medical research

Value-Based Models: What to Expect from CMS

2010 Forces: CMS' Current Programs

CMS currently offers value-based payment programs, some of which will be extended and some expanded in 2010.

- Expansion of Physician Quality Reporting Initiative (PQRI)
Key changes to the 2010 PQRI:
 - Introduction of an electronic health record (EHR)-based reporting mechanism; addition of 30 new individual quality measures; addition of six new PQRI measures groups; addition of a six-month reporting period for claims-based reporting of individual measures; and addition of a Group Practice Reporting Option (GPRO).
 - Payments made to physicians that meet targets, in addition to FFS
 - By 2015 physician payments will be reduced 1.5% for those who do not participate, 2% by 2016

2010 Forces: CMS' Current Programs

CMS currently offers value-based payment programs, some of which will be extended and some expanded in 2010.

- Extension of Gain-sharing Demonstration
 - The existing project has been extended for through 2012. Established to test and evaluate methodologies and arrangements between hospitals and physicians governing the use of inpatient hospital resources and physician work to improve the quality and efficiency of care.
 - Hospital provides payments to physicians that represent a share of savings attributable to collaborative efforts between the hospital and the physician.
- Mental Health Services
 - Medicare will increase payment for psychotherapy services by 5 percent.

2010 Forces: CMS' Current Programs

HHS required to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices.

- Developing community Health Team support for PCMHs
 - Teams developed to provide support to primary care including OBGYN practices
 - Teams collaborate with patient-centered medical homes to coordinate prevention and chronic disease management services
 - Assist in development and implementation of care plans that integrate preventive and health promotion services
 - Payments made to teams through capitated arrangements

2011 Forces: CMS Center for Innovation

The passage of PPACA establishes several CMS demonstration programs to test and evaluate new Medicare health care delivery and payment models. Models to be tested include:

- Promoting broad payment and practice reforms in primary care
 - Patient-centered medical home models
 - Medical homes for women's unique health care needs
 - Bonus payments made for outcomes in addition to FFS
- Using geriatric assessments and comprehensive care plans
 - To coordinate care for patients with multiple chronic conditions who are unable to perform daily living activities or who have cognitive impairments

2011 Forces: CMS Center for Innovation

Models to test (continued):

- Supporting care coordination for chronically ill individuals
 - High-risk for hospitalization
 - Delivery through a health information technology-enabled provider network
- Establishing community-based health teams to support small-practice medical homes
 - As support and assistance for primary care providers in chronic care management
 - Patient self-management activities
- Assisting individuals in making informed health care decisions
 - Through compensating physicians and other providers for using patient decision-support tools

2011 Forces: CMS Center for Innovation

Payment incentives: 2011-2016

- 10 percent incentive payments for primary care physicians.
 - All physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for office, nursing facility and home visits comprise at least 60 percent of their total Medicare charges will be eligible for a 10 percent bonus payment
- 10 percent incentive payments for general surgeons.
 - All general surgeons who perform major procedures (with a 10- or 90-day global service period) in a health professional shortage area will be eligible for a 10 percent bonus payment for these services

2012 Forces: CMS Shared Savings

Development of Accountable Care Organizations (ACOs)

Qualification in the program requires at least 5,000 assigned Medicare beneficiaries and

- a formal legal structure to allow for distribution of payments to members of the ACO for any shared savings;
 - a leadership and management structure that includes clinical and administrative systems;
 - promotion of evidence-based medicine through defined protocols and processes
 - ability to report on quality and cost measures
- FFS payments + shared savings
- Organizations share among their provider participants a portion of any savings achieved in excess of a threshold benchmark
- (Participation in the demonstration must be for at least 3 years)*

2012 Forces: CMS 'At Home' Care

Establishment of an independent at-home demonstration program.

- Designed to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple chronic conditions.
 - Health teams required
 - Patient satisfaction will be a measurement
 - Expected that medical homes will deliver these services
- Payment based on shared savings and achieving high-quality outcomes

2013 Forces: CMS Payment Bundling

Medicare pilot program for **integrated care** required by 2013

- Episodes of care involving hospitalization to improve the coordination, quality and efficiency of health care services.
Targeting:
 - physician services delivered inside and outside an acute care setting;
 - other acute care inpatient services;
 - outpatient hospital services, including emergency department services;
 - post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals
- **Payment model to be determined, likely to be bundled payments or bids for episodes of care**
- **Payment will be made to the participating organization (e.g. hospital system)**

2010-2013: CMS At-A-Glance

Primary Care 10%; Surgical Specialties Shortage Areas 10%

- PQRI
- Gain-Sharing
- Mental Health 5%
- Health Team Support for PCMH

- PCMH incentives
- Community-based Health Programs & Care Coordination
- Outreach to Educate Patients

- Advent of ACOs
- At Home initiative

- Roll-out of Integrated Care Delivery

2010

2011

2012

2013

Value-Based Models: What to Expect from Non-CMS Payers

Non-CMS Payer VBP Models

The Payers' view of VBP concepts is centered around delivering payment to providers for producing quality outcomes, delivered in a safe environment, resulting in a satisfied patient at a reasonable cost over time.

- Commercial Payer VBP models include
 - Shared Savings/Gain Sharing
 - Narrow Networks
 - Bundled Episodes of Care
 - Patient-Centered Medical Home
 - Accountable Care
 - Prometheus Payment System

Non-CMS Payer VBP Models

- Shared Savings/Gain Sharing
 - Currently exists as Pay-For-Performance (P4P)
 - Contracts designed where a portion of the savings is returned to the practice or organization
 - Hospitals (or Physician Organizations) share savings with physicians who implement certain cost-saving measures
 - Larger practices receive P4P payments directly
 - P4P Programs gaining momentum in 2010, could roll out across networks
 - Bonuses typically between 1%-6% of FFS payments
 - Expect to see move to NP4PP (no-pay-for-poor-performance) as quality of care improves within networks

Non-CMS Payer VBP Models

- Narrow Networks
 - Also known as 'tiered' networks
 - Penalizes patients for selecting 'high cost' physicians and hospitals by imposing higher out-of-pocket costs for co-pays and co-insurance
 - Performance measurement programs based on claims data
 - Payment rates may be set according to tiering; less pay for those who don't make the grade
 - Potential for Payers to drop poor-performing providers from their networks

Non-CMS Payer VBP Models

- Bundled Episodes of Care
 - One payment split by the hospital and physicians for acute-care procedures
 - Poorly designed bundles could encourage cherry-picking healthy patients or denying needed care
 - Both Payers and States helping to drive this change
 - UnitedHealth piloting bundled payments for oncologists
 - Minnesota passed a health-reform law that will create “baskets of care” for several conditions, including asthma and diabetes
- Lack of robust cost data could be problematic for defining appropriate payments

Non-CMS Payer VBP Models

- Patient Centered Medical Home
 - Requires significant coordination of patient care and disease management
 - Core element is paying an additional fee per patient by type of diagnosis (e.g. diabetes management)
 - Requires significant practice investment in accreditation, resources, developing protocols, and technology for data capture and reporting
 - Hybrid payment system of FFS + PMPM + P4P

Payments will need to be adjusted based on the types of conditions, severity of conditions, and other characteristics of the patients being cared for to offset potential for 'cherry-picking' patients

Non-CMS Payer VBP Models

- Prometheus Payment
 - Uses claims data to establish patterns, payments, and compliance
 - Ability to analyze Potentially Avoidable Complications (PACs)
 - Establishes the exact payment amount - using Evidence-informed Case Rates (ECRs) - rather than recommending it, and bases full payment on whether all processes used in establishing the payment amount are performed

www.prometheuspayers.org

Example: Hybrid Payment Model

IBC Invests in Quality Incentive Payment System (QIPS)

- Investing \$47 million in 2010 to supplement primary care physicians' compensation.
- Changes in IBC's reimbursement are designed to help attract and retain high performing primary care physicians.
- Modifying its reimbursement for costlier, episodic, specialty care services, which it believes can often be avoided with regular, effective preventive care.
- From July 1, 2010, base reimbursement will increase 10%; P4P incentives provided to highest performing providers; additional financial incentives available for coordinating outpatient care.

Example: Episode-of-Care Model

UnitedHealthcare Pilot program (Oncology)

- Adherence to NCCN Clinical Practice guidelines for chemotherapy administration (started 2008)
- Episode-of-care payment pilot with 6 practices and 19 clinical conditions (started Aug. 2009)
 - Covers all aspects of need based on disease stage and patient status.
 - Choice of pathways for each practice from which to select.
 - Upfront lump sum payment for following pathways. Drug costs separately reimbursed.

Examples: Payers' Member Programs

Several insurers offer their members information on costs, clinical quality and physician efficiency:

- Blue Cross and Blue Shield Plans
 - Blue Health Intelligence (BHI) shares health information with employers, consumers and providers.
- Humana
 - Has a 'Compare' tool online that shows comparison information for how often doctors adhered to specific treatment standards.
- Aetna
 - Provides clinical quality and efficiency information to members
- UnitedHealthcare
 - Report card that rates quality of care and affordability
- CIGNA
 - Has average cost data by facility for select procedures and service

Risks and Opportunities

Contracting Initiatives

- Payers pushing for full risk contracts
 - Provider organizations need to negotiate 'modified risk' contracts instead
- Use of modified risk contracting options
 - Budget-Based (using withholds and P4P incentives)
 - Corridors of Risk (Provider risk with minimum FFS guarantees)
 - Risk with Exclusions (Full risk less negotiated carve-outs)
 - Discounted FFS with P4P
 - Capitation or FFS with hospital shared risk/incentives

Preventive vs. Specialty Care

- Focus on incentivizing preventive care and disease management
 - Expect Payers to distribute payments differently
- Modified / Increased Fees for Counseling, Monitoring, Disease Management
 - Adjustments in payment for:
 - performance on outcomes and patient satisfaction
 - patient utilization of major acute care services
- Patient-Centered Medical Home
 - Care management fees to physicians serving as a patient's medical home
 - Qualification limited to select specialties

EBM and CER

- Payers already adopting Evidence-Based Medicine guidelines for treating specific diseases
 - Organizations not utilizing EBM guidelines and standard protocols of care can expect reduces payments
- Medicare investing heavily in Comparative Effectiveness Research
 - Federal government investing \$1.1 billion for CER
 - Expect resulting findings to drive guidelines that will become a cornerstone for modeling payment methodologies

Changing Landscape

- Move to consolidated entities
 - Solo and small practices may not have the resources or technology to restructure operations to respond to new payment system incentives (heavy use of IT and resources)
 - More practices merging and / or joining physician associations (IPAs, PHOs, etc)
 - Providers in non-integrated systems do not have mechanisms for accepting and allocating a bundled payment among multiple providers
 - Increase in physician employment at hospitals, fewer small private practices

Legal Risks

- Legal implications
 - Information sharing and clinical “best practices” dictated by parties outside of the provider’s office will create a new era of malpractice liability
 - Payment incentives that are tied to adherence to protocols may create additional liability for providers
 - Civil Monetary Penalty Law and Anti-Kickback Statute could limit opportunity for creative hospital/physician collaboration and revenue sharing

Provider-Patient Relations

- Relationship Risk
 - Many plans are developing (or have already launched) web-based, interactive information systems which allow their members to rate their providers and view quality and efficiency information
 - Improvement in patient relationships possible through greater transparency or a deterioration of the “professionalism” of medicine

Prepare for Change

What To Do To Prepare

- Assess the capabilities of your current information systems abilities to track and report the information that will be required to meet new contract terms
 - Can you develop patient registries by disease grouping?
 - Are you ready to e-prescribe?
 - Can you extract data from your patient records to demonstrate performance?
 - Will you need to invest to fill gaps?

What To Do To Prepare

- Assess the capabilities of your staff and resources to deliver care under new models
 - Do you have a method for creating and implementing protocols?
 - Can care be effectively coordinated by your team?
 - What communication processes are currently in place with your patients? Do you have follow up procedures in place?
 - Will your current resources be able to adjust their skills to meet new opportunities?

What To Do To Prepare

- Assess whether the quality programs being offered by your largest plans are likely to create revenue opportunities commensurate with the effort required
 - Evaluate which offerings can benefit you today
 - Start preparations for mandatory changes coming tomorrow
- New contracting initiatives will require physician behavior modification
 - Determine how willing your physicians are to embrace change and begin planning for it now

Providers' Unique VBP Implementation

Example: Shared Savings/Gain Sharing

400+ bed hospital in Chicago currently receiving P4P payments from Payers decides to create an incentive for buy in by developing its own P4P model with physicians.

- Benefits: (1) provide greater incentive to engage physician collaboration to improve quality outcomes at the hospital; (2) potentially capture additional reimbursement dollars from the commercial payer's P4P program; and (3) prepare for the future landscape of health care reimbursement.
- Challenges: (1) Obtaining OIG approval to head off any issues with the Civil Monetary Penalty Law and Anti-Kickback Statute; (2) Strategic planning and structuring to develop a sustainable value proposition for both the hospital and physicians; (3) physician participation.

Q & A

Contact Information

Susanne Madden, President & CEO

The Verden Group, Inc
99 Main St, Suite 302-303
Nyack, NY 10960
877-884-7770 ext 7

madden@theverdengroup.com
www.TheVerdenGroup.com

Business, Legal and Clinical Consulting Services