Medicare Payment Reforms: Transforming the Health Care Delivery System

October 28, 2009

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Overview of Presentation Topics

• The Problem – Can We Fix It?
• Medicare Payment Reform – Key to Fixing Our Broken System
• Innovative Payment Reforms Recommended by MedPAC
• Preparing for the Next-Generation Delivery System
• Implementation Challenges Under Existing Legal Framework
• What Role will the Hospital of the Future Play in this New System?
Our Episodic Care Model is Unsustainable

- Fragmented and Separate Provider Payment Silos (FFS)
- Aging Baby Boomers
- Increase Chronic Disease
- Obesity
- The Perfect Storm
But why are our health care costs higher than other countries?...

USA

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Failure of Consumerism to Rein in Costs

Consumer Oriented Solutions
• High-Deductible Health Plans
• Health Savings Accounts
• Information-Empowered Health Consumers

Provider-Oriented Solutions
• Payment Reductions
• Prospective Payment Systems
• Managed Care Capitation
MedPAC – Working Behind the Scenes – A Must Read –

“Report to the Congress: Reforming the Delivery System”

June 2008
The Principles Driving Payment Reform Policy

• Taking Aim at Laissez-Faire Treatment of Care (Variation) and Technology
• Cutting Specialty Care Prices
• Penalizing Lack of Coordination
• Rewarding Attempts to Better Coordinate Care
• Reallocating Reimbursement (Primary Care Based Delivery System)
• Reorganizing Delivery System to Change Utilization & Outcomes
Medicare Payment Reform Will Drive Needed Delivery Reform

• The largest purchaser of health care services is moving from a "passive bill-payer to an active purchaser of healthcare" [2009 Medicare Trustees Report]

• The payment reforms being considered are unprecedented in scope and complexity [MedPAC]

• New organizational structures and strategic provider alliances will be needed to manage the money and the product
Bundled Payment: What Are They And How Will They Shape Next-Generation Hospital-Physician Organizations

• Bundling of payments for Part A and Part B (single payment for physician + hospital)

• Covers all services during hospitalization and for a period after discharge

• Acute Care Episode (ACE) Program – 3 Year Pilot Project

• Organizational structures must implement and manage "bundled payments" (clinical integration)

• These are not the physician – hospital organizations of the 90s
Bundled (Part A+B) Hospital Payment Model

Payer provides single prospective payment intended to cover costs of entire patient hospitalization episode.
Hospital & Discharge Bundling: New Hospital and Post Acute Care (PAC) Affiliations Will Emerge

- Bundling of payments for acute care and post acute care (PAC) providers (i.e. SNFs, HHA, rehab facilities, long term hospitals)

- Single full bundled payment made to hospital

- No separate payments made to PAC providers

- New contractual arrangements and joint ventures needed to implement and manage these unique single bundled payments between and among hospitals and PAC providers

- What arrangements with physicians are needed to manage the transition across care continuums?
Fundamental Legal Paradigm Changes Needed

- Existing paradigm – supports fragmented delivery model
  - Physician self-referral statute (Stark)
  - Anti-kickback statute
  - Civil Monetary Penalty statute (CMP)
  - False Claims Act
  - Antitrust Issues
New Legal Paradigm Must Support Provider Integration Across Care Continuum

• New Stark exceptions (bundled performance payments)
• New safe harbors for shared savings programs
• New stand alone exceptions to CMP violations for bundled payment arrangements
• New "Integrated Providers" for Medicare enrollment purposes
• "Enterprise" liability
Accountable Care Organizations

Policy Background and Perspective
What are Accountable Care Organizations?

• Groups of providers that are jointly responsible for the quality and cost of health care services for a population of beneficiaries
  – Examples: combinations of one or more hospitals, physician groups including primary care physicians and possibly specialists, and other health care providers

• MedPAC has advocated for this model

• Objective is improved care coordination and reduced costs in FFS Medicare
Medicare Experience with ACOs

• Medicare Physician Group Practice Demo (PGP) similar to ACOs

• Physician groups rewarded for improving quality and cost efficiency of services

• CMS selected 10 physician groups on a competitive basis
  – Multi-specialty groups with clinical & management information systems
  – Ten groups represented 5,000 physicians and 224,000 Medicare beneficiaries.
Medicare Experience with ACOs – Results

• Groups that meet quality benchmarks and reduce total spending by more than 2% can share in the savings they generate for Medicare

• Results show promise
  – In the most recent year of demo, all groups showed quality improvements & achieved below average growth in costs.
  – Also, 4 were awarded incentive payments for reducing costs below the 2% threshold.

• ACOs would go beyond PGP model to include additional providers
ACOs in Senate Finance Mark (no legislative language)

• Groups of providers who “voluntarily meet … criteria”

• Eligible groups (providers and suppliers) must have established mechanism for joint decision making:
  – Group practices/networks of practices
  – Partnerships or joint-venture arrangements between hospitals & practitioners
  – Hospitals employing practitioners
  – Other groups as determined by Sec’y

• Practitioners defined as physicians, nurse practitioners, PAs, clinical nurse specialists, others as defined by Sec’y
  – Other practitioners or suppliers as defined by Secretary.
Eligibility for ACO Program

Criteria to qualify as an ACO:

1. Agree to become accountable for the overall care of their Medicare beneficiaries
2. Agree to a minimum three-year participation
3. Have formal legal structure to allow the organization to receive and distribute bonuses to participating providers
4. Include the primary care physicians for at least 5,000 beneficiaries
5. Provide CMS with info regarding physicians participating in the ACO
6. Have arrangements in place with a core group of specialists
7. Have in place a leadership and management structure, including for clinical and administrative systems
8. Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care
9. Demonstrate to Sec’y that it meets patient-focused criteria
ACO Pilot Program in HR 3200

• Creates an alternative payment model within fee-for-service Medicare to reward physician-led organizations that take responsibility for costs and quality of care

• ACOs can include groups of physicians organized around a common delivery system (including a hospital), an independent practice association, a group practice, or other common practice organizations

• Designation criteria and reporting requirements similar to Senate
ACO Pilot Program in HR 3200

• Bonus payment if expenditures are < target spending level or rate of growth plus meet quality targets

• Program starts 1/1/12; Contract may be for 3-5 years

• CMS may allow ACOs to continue operating so long as they are reducing costs while maintaining quality or improving quality while maintaining costs

• Physician Group Practice Demo participants can become ACOs
How Does an ACO Differ From a PHO?

• Both are provider networks to negotiate with payors

• ACO can be seen as the next generation of PHO
  
  – PHOs negotiated with payors to get favorable contract rates, shared financial risk
  
  – Pool of covered patients often a small percentage of overall patients in network system
In Contrast to a Traditional PHO, An ACO Has the Following:

- Extensive HIT and EMR system capable of tracking patient progress, analyzing and reporting patient safety and quality measurement data across multiple health care delivery settings

- Clinical integration with elements such as medical management program, protocols for managing high cost/complex cases, extensive clinical protocols, robust performance reporting and benchmarking, and corrective action
In Contrast to a Traditional PHO, An ACO Has the Following:

• A broader and more diverse patient population (initially Medicare), reflecting a more substantial percentage of the patients served within the network

• Fuller accountability to patient and quality outcomes through report cards, external reporting, benchmarking, internal review, corrective action, and reimbursement

• Performance based provider compensation, spending targets
In Contrast to a Traditional PHO, An ACO Has the Following:

• An organizational structure that more fully aligns physician and hospital incentives
  – Physician organizational options center on foundation/practice development, models allowing for both employed and independent physicians, joint accountability
  – Often creation of a new entity to allow for co-management of physician and hospital services to meet patient needs in inpatient and outpatient setting, address quality measurement
  – Must address legal issues, including those under state law
How is an ACO Structured?

- Important to recognize that there is wide variability, multiple options
- Can be hospital-led, physician organization-led, co-led
- Crucial decisions regarding physician organization structure, co-management structure
- Primary care group commitment is essential
- Be mindful of a structure that accommodates HIT; reimbursement methods; capital investment/risk assumption; and legal issues regarding entity form, regulatory approval, antitrust, corporate practice of medicine and permitted forms of compensation
# Who is the Accountable Party

<table>
<thead>
<tr>
<th>Model</th>
<th>Multispecialty Group Practice</th>
<th>Physician Hospital Organization</th>
<th>Hospital Medical Staff Organization</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Physician group practice operates as provider entity</td>
<td>Hospital and select physicians enter into voluntary provider entity</td>
<td>Hospital and entire medical staff assigned to single provider entity</td>
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<tr>
<td>Hospital Role in Reimbursement Allocation</td>
<td>None</td>
<td>Moderate</td>
<td>High</td>
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<tr>
<td>Potential Hospital Response</td>
<td>Acquire physician practices</td>
<td>Increase selectivity of PHO membership</td>
<td>Introduce total cost profiling</td>
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The Medical Home Model

Policy Background and Perspective
What is the Patient-Centered Medical Home?

- Developed by American Academy of Pediatrics
- Endorsed by American Academy of Family Physicians, American College of Physicians, American Osteopathic Association
- Basic principles:
  - Personal physician
  - Whole person orientation
  - Care coordination and integration
  - Quality improvement
  - Enhanced access
  - Adequate payment
MedPAC and CMS Policy Goals

- Improve health and control costs of “high-need” beneficiaries with multiple chronic diseases
- Recognition of “support infrastructure” needed for comprehensive care management
- Improve quality by following evidence-based measures
- Reduce costs through coordination of care and increased efficiency
The Medical Home is the Coordinating Spoke in the Wheel

- Hospital
- Pharmacy
- Outpatient Healthplex
- IDTF
- ASC
- Home Health
- Retail Clinic
- Home Health
- LTAC

Patient-Centered Medical Home
Medical Homes in Health Reform Bills

• Senate –

  CMS Innovation Center – ($10B/10 years)
  –  Medical Home Models
  –  Transitioning from fee-for-service payments towards comprehensive or salary-based payments

• House –

  Medical Home Pilot Program – ($1.6B/5 years)
  –  Independent patient-centered medical home
  –  Community-based medical home
Medical Home – Who Qualifies?

- Primary care and multi-specialty group practices
- Non-physician care managers
- Information systems to manage patient information and enable analysis
  - Quality measure reporting
  - Registry participation
Medical Home Model is Not 90’s Managed Care by Another Name

• Gatekeeper vs. care facilitator distinction
• Capitation vs. enhanced care coordination fees
• Cost control vs. quality focus
• Limited access vs. increased access
• This is Marcus Welby juiced up with technology
• The medical home will be a key player in the new bundled payment delivery system
The New Medical Home PCP Model

**Traditional PCP**
“Siloed Care Provider”
- Reactively treat patients’ primary complaints
- Employ nurses, mid-level providers as assistants
- Refer patients to specialists with minimal follow up
- Rely on paper-based charts

**Medical Home PCP**
“Integrated Care Coordinator”
- Proactively engage patients to ensure delivery or preventative care
- Manage interdisciplinary care delivery team
- Communicate with specialists to track referrals
- Integrate EMR into daily practice operations
The Reform Paradigm Shift

• Reallocation of resources ($) moving from specialists to primary care physicians

• Moving value based payments away from patch work acute episodic care to continuous coordination of chronic care

• Health IT will be the cutting edge medical technology

• Family-centered home visits (remotely)
What Role will Hospitals Play in the Next-Generation Delivery System – Some Food for Thought

1. Hospital’s role in payment allocation is uncertain (the “New Pay Masters”)

2. Will hospitals need to change their business models to compete in a market that increasingly devalues acute interventions – pursuing the new “hospital value” proposition

3. Does the hospital’s business portfolio need to shrink or expand (which lines?)

4. What kinds of capital investments need to be made to succeed in the new world order?
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