Value-Based Purchasing/Value-Based Payment for Physicians and Hospitals

Patrick J. Torcson, MD, MMM, FACP, SFHM
ptorcson@stph.org

(No Disclosures)
Value-Based Purchasing/
Value-Based Payment

- The CMS/Medicare Agenda for Healthcare Payment Reform
- Alternative Payment Models
  - Pay for Performance
  - Shared Savings
  - Bundled Payments
  - Capitation
- Future Trends
- Summary/Conclusions
Case Presentation

CC: Left arm and left leg weakness

HPI: 83-y.o. female, nursing home resident. Hospitalized 3 weeks prior with pneumonia and new onset a fib. Discharged on abs, diltiazem and warfarin. Anticoagulation discontinued 1 week pta because of hematuria. On day of admission woke up with arm and leg weakness and was sent to ED via ambulance.
Case Presentation (cont.)

**PMH**
1. CAD: remote CABG, PCI TNTC
2. ICM: EF 35% by echo 3 wks ago
3. Hypertension
4. DM Type II
5. Hyperlipoproteinemia
6. Gen OA, TKRs and THRs

**SH**
Former smoker. Widow. Lives in NH X 5 yrs

**Meds**
diltiazem, clopidogrel, atorvastatin, lisinopril, sitagliptan, metformin, furosemide, albuterol, hydrocodone, carvedilol

**ROS**
Non ambulatory, urinary catheter placed in NH, residual cough and wheezing
Case Presentation (cont.)

PE  Gen – Heavyset, chronically ill
VS – BP: 108/68  P: 110  R: 16  T: 97.6
Lungs – Decreased air exchange
Heart – Irregularly irregular tachycardia
Ext – 1+ edema, chronic venous stasis
Neuro – A and O x3, left arm and leg hemiparesis
Diagnostic Studies:

- ECG: A fib with RVR
- CBC: WBC 12.9, Hb 11.8
- BMP: Glucose 215
- BNP: 675
- Troponin: 1.6
- UA: RBC’s TNTC; WBCs > 200 hpf
- CXR: Right base infiltrate, chronic changes
- CT Head: Microvascular ischemia, no acute hemorrhage
Problem List:

1. Stroke
2. A. Fib
3. UTI
4. Hematuria
5. Non STEMI
6. Heart Failure
7. Resolving Pneumonia
8. Hypertension
9. Diabetes Mellitus
10. Stable CAD
11. Ischemic Cardiomyopathy
12. HLP
13. Generalized OA
A New Era for Healthcare Payment

The Past – Fee for Service
- Payment for *quantity* of services

The Future – Value-Based Payment
- Payment for *quality* of care and accountability for cost of care
1965 Medicare Program
CMS Influence:

- **Mission:** “CMS is a constructive force and trustworthy partner for the continual improvement of health and healthcare for all Americans.”
- **Largest payer for healthcare in US:**
  - 45 million beneficiaries
- **Sets national agenda for healthcare payment and policy.**
CMS Challenge: Unsustainable Cost

Net Medicare Spending, 2010-2024

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</thead>
<tbody>
<tr>
<td>Federal Outlays</td>
<td>12.9%</td>
<td>13.3%</td>
<td>13.2%</td>
<td>14.2%</td>
<td>14.5%</td>
<td>13.9%</td>
<td>14.0%</td>
<td>13.6%</td>
<td>13.2%</td>
<td>13.8%</td>
<td>14.0%</td>
<td>14.3%</td>
<td>15.0%</td>
<td>14.7%</td>
<td>14.5%</td>
</tr>
<tr>
<td>GDP</td>
<td>3.0%</td>
<td>3.1%</td>
<td>2.9%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>2.8%</td>
<td>2.9%</td>
<td>3.0%</td>
<td>3.1%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>3.2%</td>
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</tbody>
</table>

NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of Medicare spending minus income from premiums and other offsetting receipts.
CMS Challenge: Untrustworthy Quality

Sources: modified from C. Buck, GE; Dr. Sam Nussbaum, Wellpoint
States with higher spending per Medicare beneficiary tended to rank lower on 22 quality of care indicators. This inverse relationship might reflect medical practice patterns that favor intensive, costly care rather than the effective care measured by these indicators.

Relationship between quality and Medicare spending, as expressed by overall quality ranking, 2000–2001

Overall quality ranking

1 (Highest)

11

21

31

41

51 (Lowest)

Annual Medicare spending per beneficiary (dollars)

Source: Medicare administrative claims data and Medicare Quality Improvement Organization program data, as analyzed by Baicker and Chandra (2004). The solid line shows that for every $1,000 increase in Medicare spending per beneficiary, a state’s quality ranking dropped by 10 positions. Adapted and republished with permission of Health Affairs from Baicker and Chandra, “Medicare spending, the physician workforce, and beneficiaries’ quality of care” (Web Exclusive), 2004. Permission conveyed through the Copyright Clearance Center, Inc.

Leatherman and McCarthy, Quality of Health Care for Medicare Beneficiaries: A Chartbook, 2005. The Commonwealth Fund
The Value Equation:

\[
\text{Value} = \frac{\text{Quality}}{\text{Cost}}
\]
“Even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systemically improve the quality of care, and may even prevent such actions.”

IOM, Crossing the Quality Chasm, p 193.
Fee for Service Reimbursement

- Rewards volume/quantity of services – not value/quality.
- Lower revenues for performing fewer tests and procedures.
- Financial risk with payer.
- No incentives to coordinate care.
- No reimbursement for phone calls, email, tele-medicine, etc.
Payment System Changing from Volume (Curve 1) to Value (Curve 2)

Curve #1: FEE-FOR-SERVICE

Curve #2: VALUE-BASED (ALTERNATIVE) PAYMENT MODELS

Natural Trajectory
How to Pick a Health Plan on the Exchange

Step 1: Decide on the diseases you and your family are going to have in the coming year.

Step 2: Find the best doctors and hospitals for those diseases.

Step 3: Identify which plans offer those doctors and hospitals.

Step 4: Select the cheapest plan.

Step 5: If there are no affordable plans with all the doctors and hospitals you want, go back to step 1 and pick some new diseases.
Monday, August 28, 2006

Part IV

The President

Executive Order 13410—Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs
Notice of August 24, 2006—Intention To Enter Into a Free Trade Agreement With Colombia
Executive Order 13410:

Directs Federal Agencies to:

1. Encourage adoption of health information technology standards for interoperability
2. Increase transparency in healthcare quality measurements
3. Increase transparency in healthcare pricing information
4. Promote quality and efficiency of care, which may include *pay for performance*
CMS Quality Agenda:

Transform Medicare from a *passive payer* to an *active purchaser* of higher quality, more efficient health care

Value-Based Purchasing
(payment based on quality)

Tools and initiatives for promoting better *quality*, while avoiding unnecessary *costs*

**Triple Aim:** Better Care, Better Health, Lower Cost
Triple Aim

Better health

Better care

Lower cost
The ABC’s of Medicare

**Part A** covers inpatient hospital stays, skilled nursing facilities, hospice care and home health care.

**Part B** covers doctors' services, outpatient care, medical supplies and preventive services.

**Part C** is the Medicare Advantage Plans

**Part D** covers pharmacy benefits
Alternative Payment Models

• Pay for Performance
  o Incentive on top of fee-for-service

• Shared Savings
  o Sharing of difference in actual versus targeted spending on a population

• Bundled Payments
  o One payment for episode or diagnosis

• Capitation
  o Payment per person
# Medicare P4P Programs

## Hospital (Part A)
1. **Hospital Value-Based Purchasing Program**
2. **Readmissions Reduction Program**
3. **Hospital Acquired Conditions Reduction Program**

## Physician (Part B)
1. **Physician Quality Reporting System**
2. **Physician Value Based Modifier**
HVBP Program FY 2018 Measures

Patient Experience of Care Dimensions
1. Nurse Communication
2. Doctor Communication
3. Staff Responsiveness
4. Pain Management
5. Medication Communication
6. Cleanliness & Quietness
7. DC Info
8. Overall Rating
9. *3 Item Care Transition

Domain Weights
- Patient Experience of Care 25%
- Clinical Care 25%
- Efficiency 25%
- Safety 25%

Clinical Care Measures
- Outcome Measures
  1. AMI 30-Day Mortality
  2. HF 30-Day Mortality
  3. PN 30-Day Mortality

Safety Measures
1. AHRQ PSI-90 Composite
2. CLABSI
3. CAUTI
4. Surgical Site Infection: Colon & Hysterectomy
5. C. diff
6. MRSA
7. Elective Delivery < 39 Weeks

Efficiency Measure
1. MSPB-1 Spending per Beneficiary
HVBP Performance Model Overview

- Hospitals submit data during **Baseline** and **Performance** periods
- Each measure has a **Threshold** and **Benchmark**
- CMS determines performance score of 0 to 10 points based on **Improvement** or **Achievement** for each measure
- **Total Performance Score** - weighted combination of domain scores:
  - 25% based on Clinical Care
  - 25% based on Experience of Care
  - 25% based on Efficiency
  - 25% based on Safety
HVBP Incentive Payments

- Not all hospitals earn the full VBP incentive payment
- Budget neutral - funded by reduction to base operating DRG payments
- Withhold applies to all DRGs, not just clinical areas measured
- Incentive payments as discharge add on
## HVBP Base Operating DRG Reduction

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>HVBP Medicare Revenue Withhold</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1%</td>
</tr>
<tr>
<td>2014</td>
<td>1.25%</td>
</tr>
<tr>
<td>2015</td>
<td>1.5%</td>
</tr>
<tr>
<td>2016</td>
<td>1.75%</td>
</tr>
<tr>
<td>2017</td>
<td>2%</td>
</tr>
</tbody>
</table>
Public Reporting on hospitalcompare.gov
Medicare P4P Programs

HOSPITAL (PART A)

1. HOSPITAL VALUE-BASED PURCHASING PROGRAM
2. READMISSIONS REDUCTION PROGRAM
3. HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM

PHYSICIAN (PART B)

1. PHYSICIAN QUALITY REPORTING SYSTEM
2. PHYSICIAN VALUE BASED MODIFIER
“Rates of unplanned readmission show whether a hospital is doing its best to prevent complications, provide clear discharge instructions to patients, and help patients make a smooth transition to their home or another setting such as a nursing home.”
Readmission Reduction Program

- Based on 30-day readmission rates for MI, HF, pneumonia, COPD and total hip/knee replacements
- "Any other conditions the Secretary chooses" will be added
- If readmit rate > Medicare expected, hospital payment adjusted:
  - 2013: 1% reduction in base DRG payments
  - 2014: 2% reduction in base DRG payments
  - 2015 and beyond: 3% reduction in base DRG payments
- Structure such that up to 50% hospitals will always have penalty
Excess Readmission Ratio = Risk Adjusted Actual Readmissions / Risk Adjusted Expected Readmissions

**Numerator: Adjusted Actual Readmissions**

**Step 1:**
Calculate each patient’s predicted probability of readmission = \( \frac{1}{1 + e^{Z_a}} \)

\[ Z_a = \text{hospital-specific effect} + X\beta \]

*intercept + risk-adjustment coefficients*

**Step 2:**
To get the numerator result, add all patients’ predicted probabilities of readmission

**Denominator: Expected Readmissions**

**Step 1:**
Calculate each patient’s expected probability of readmission = \( \frac{1}{1 + e^{Z_e}} \)

\[ Z_e = X\beta \]

*intercept + risk-adjustment coefficients*

**Step 2:**
To get the denominator result, add all patients’ expected probabilities of readmission
Public Reporting of Readmissions

Rate of readmission after discharge from hospital (hospital-wide)

Why is this important?
Hide Graph

Lower Percentages Are Better

ST TAMMANY PARISH HOSPITAL

Number of included patients: 2271

U.S. National Rate of all cause hospital-wide readmission = 16.0%
Medicare P4P Programs

HOSPITAL (PART A)
1. HOSPITAL VALUE-BASED PURCHASING PROGRAM
2. READMISSIONS REDUCTION PROGRAM
3. HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM

PHYSICIAN (PART B)
1. PHYSICIAN QUALITY REPORTING SYSTEM
2. PHYSICIAN VALUE BASED MODIFIER
The Hospital Acquired Condition Problem

- HAC’s: 17 to 29 Billion of Medicare spending annually
- HAC’s selected by CMS:
  - High cost, high volume or both
  - Trigger higher payment as a secondary diagnoses (CC or MCC)
  - “Reasonably preventable” through the application of evidence-based guidelines
Hospital Acquired Condition Reduction Program

- Began October 1, FY2015
- Applies to one quarter of hospitals with lowest performance
- Payment adjustment: 1% reduction of inpatient hospital payments
- HAC Reduction Program in addition to HAC non-payment
- HAC Reduction Program adjustments applied after HVBP and Readmission penalties
HAC Domains and Measures

Domain 1
(AHRQ Measure)

Weighted 35%

AHRQ PSI-90 Composite
This measure consists of:
- PSI-3: pressure Ulcer
- PSI-6: iatrogenic pneumothorax
- PSI-7: central venous catheter-related bloodstream infection rate.
- PSI-8: hip fracture rate
- PSI-12: postoperative PE/DVT rate
- PSI-13: sepsis rate
- PSI-14: wound dehiscence rate
- PSI-15: accidental puncture

Domain 2
(CDC Measures)

Weighted 65%

2015 (2 measures):
- CAUTI
- CLABSI

2016 (1 additional measure):
- Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)

2017 (2 additional measures):
- MRSA
- C Diff

ACP
American College of Physicians™
Leading Internal Medicine, Improving Lives
# Medicare P4P Programs

<table>
<thead>
<tr>
<th><strong>HOSPITAL (PART A)</strong></th>
<th><strong>PHYSICIAN (PART B)</strong></th>
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</thead>
<tbody>
<tr>
<td>1. <strong>HOSPITAL VALUE-BASED PURCHASING PROGRAM</strong></td>
<td>1. <strong>PHYSICIAN QUALITY REPORTING SYSTEM</strong></td>
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<tr>
<td>2. <strong>READMISSIONS REDUCTION PROGRAM</strong></td>
<td>2. <strong>PHYSICIAN VALUE BASED MODIFIER</strong></td>
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<tr>
<td>3. <strong>HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM</strong></td>
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</table>
The Value Equation:

\[
\text{Value} = \frac{\text{Quality}}{\text{Cost}}
\]
Value of Physician Services

Lower Quality/Lower Cost

Higher Quality/Lower Cost

Lower Quality/Higher Cost

Higher Quality/Higher Cost

Your Quality/Cost Ranking

COST

QUALITY
Physician Performance is All Over the Map

Low Quality
High Cost
Low Cost
High Quality
High Cost
Low Cost
Low Quality
(Worst)
(Best)

MD Quality Index
(outcomes or % adherence to EBM)

50th %ile

MD Longitudinal Cost Index
(total cost per case mix-adjusted treatment episode or chronic illness yr)

© 2006 A. Milstein MD

Adapted from Regence Blue Shield
Physician Branding

- High Quality, Low Cost
- High Quality, High Cost
- Low Quality, Low Cost
- Low Quality, High Cost
Physician Quality Reporting System

- Formerly PQRI
- Voluntary Program (at first)
- Pay for Reporting (at first)
- Statutory Authority:
  - 2006 Tax Relief and Health Care Act
PQRS Reporting: Choose 9 Measures*

Reporting Options:
1. Medicare Part B Claims
2. CMS Qualified PQRS Registry
3. Electronic Health Record Reporting
4. Group Practice Reporting Options (GPRO)
5. Qualified Clinical Data Registry
6. ACO Participation

*Less than 9 measures subject to Measure-Applicability Validation (MAV)
## IM – Top 5 PQRS Performance Measures

<table>
<thead>
<tr>
<th>PQRS Measure Number</th>
<th>Measure Description</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Diabetes Mellitus: HbA1c Poor Control</td>
</tr>
<tr>
<td>111.</td>
<td>Preventive Care and Screening: Pneumococcal Vaccine</td>
</tr>
<tr>
<td>128.</td>
<td>BMI Screening and Follow Up</td>
</tr>
<tr>
<td>130.</td>
<td>Documentation of Current Medications in the Chart</td>
</tr>
<tr>
<td>226.</td>
<td>Tobacco Use: Screening and Cessation Intervention</td>
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</tbody>
</table>
# PQRS Participation in 2013

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Eligible Professionals</th>
<th>Eligible Professionals who Participated</th>
<th>Percent of Eligible Professionals who Participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Individual Measures</td>
<td>--</td>
<td>--</td>
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</tr>
<tr>
<td>Emergency Medicine</td>
<td>50,051</td>
<td>34,292</td>
<td>68.5%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>40,527</td>
<td>26,914</td>
<td>66.4%</td>
</tr>
<tr>
<td>Physical/Occupational Therapy</td>
<td>49,006</td>
<td>24,308</td>
<td>49.6%</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>46,266</td>
<td>23,484</td>
<td>50.8%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>78,441</td>
<td>22,631</td>
<td>28.9%</td>
</tr>
<tr>
<td><strong>Internal Medicine</strong></td>
<td><strong>76,041</strong></td>
<td><strong>21,695</strong></td>
<td><strong>28.5%</strong></td>
</tr>
<tr>
<td>Radiology</td>
<td>31,213</td>
<td>19,980</td>
<td>64.0%</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>50,626</td>
<td>15,383</td>
<td>30.4%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>62,216</td>
<td>13,100</td>
<td>21.1%</td>
</tr>
<tr>
<td>Optometry</td>
<td>33,698</td>
<td>12,646</td>
<td>37.5%</td>
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<tr>
<td>Claims Measures Groups</td>
<td>--</td>
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<td>--</td>
</tr>
<tr>
<td>Family Practice</td>
<td>78,441</td>
<td>1,474</td>
<td>1.9%</td>
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<tr>
<td><strong>Internal Medicine</strong></td>
<td><strong>76,041</strong></td>
<td><strong>1,429</strong></td>
<td><strong>1.9%</strong></td>
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<tr>
<td>Cardiology</td>
<td>18,851</td>
<td>764</td>
<td>4.1%</td>
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<tr>
<td>Orthopaedic Surgery</td>
<td>18,384</td>
<td>602</td>
<td>3.3%</td>
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<tr>
<td>Nurse Practitioner</td>
<td>62,216</td>
<td>512</td>
<td>0.8%</td>
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<tr>
<td>Physical/Occupational Therapy</td>
<td>49,006</td>
<td>387</td>
<td>0.8%</td>
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</table>
PQRS Incentive Payment

Percentage of Total Allowable Medicare Charges:

- 2010 - 2% Bonus
- 2011 - 1% Bonus
- 2012 - 0.5% Bonus
- 2013 - 0.5% Bonus
- 2014 - 0.5% Bonus
- 2015 - negative 1.5% payment adjustment (non-participating physicians will receive only 98.5% of their Total Allowable Medicare Charges for the year)
- 2016 - negative 2% payment adjustment
Public Reporting on physiciancompare.gov

<table>
<thead>
<tr>
<th>General Information</th>
<th>Locations</th>
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<tbody>
<tr>
<td>Quality Programs:</td>
<td></td>
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<tr>
<td>✓ Physician Quality Reporting System (PQRS) <img src="https://www.medicare.gov/physiciancompare/qualprogs.png" alt="i" /></td>
<td></td>
</tr>
<tr>
<td>View information about Medicare quality reporting programs</td>
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</table>

**PATRICK J TORCSON, MD**
Primary Specialty: Internal Medicine

<table>
<thead>
<tr>
<th>Add to My Favorites</th>
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<tbody>
<tr>
<td>Is this you?</td>
</tr>
<tr>
<td>Update your information here</td>
</tr>
</tbody>
</table>

**Gender:** Male

**Education:**
Graduated: 1987
School: LOUISIANA STATE UNIVERSITY SCHOOL OF MEDICINE IN NEW ORLEANS

**Residency:**
Alton Ochsner Med Fdn, Internal Medicine, 1987-1990 ![i](https://www.medicare.gov/physiciancompare/residency.png)

**Group Affiliations:**
ST. TAMMANY PARISH HOSPITAL

**Hospital Affiliations:**
OCHSNER MEDICAL CENTER
ST TAMMANY PARISH HOSPITAL
LAKEVIEW REGIONAL MEDICAL CENTER
RIVERSIDE MEDICAL CENTER

**Medicare Assignment:**
Accepts Medicare Assignment ![i](https://www.medicare.gov/physiciancompare/medicare.png)

**Board Certification:**
Internal Medicine
1. Physician payment based on quality of care and cost of care.

2. Budget Neutral: payment increased for some but decreased for others - aggregate Medicare spending for physician services does not change.

3. VM applies to:
   - Groups of 2 to 9 and Solo Practitioners
   - Groups with 10 to 99 Physicians
   - Groups with 100 or more Physicians

4. Group assignment based on Tax ID Number (TIN)
# 2013 Medicare Fee-for-Service Quality and Resource Use Report

**St. Tammany Parish Hospital**

Last Four Digits of Your Taxpayer Identification Number (TIN): 8620

## About This Report from Medicare

<table>
<thead>
<tr>
<th><strong>What</strong></th>
<th>This Quality and Resource Use Report shows how you performed in 2013 on the quality and cost measures used to calculate value-based performance. Because you will not be subject to the value-based payment modifier in 2015, the report is for informational purposes only and will not affect your Medicare Physician Fee Schedule reimbursements in 2015. This report also includes performance information on new measures that will be used in the value-based payment modifier for 2016.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who</strong></td>
<td>The Centers for Medicare &amp; Medicaid Services (CMS) is phasing in a value-based payment modifier under the Medicare Physician Fee Schedule in 2015 and 2016.</td>
</tr>
<tr>
<td></td>
<td>o In 2015, physician groups of 100 or more eligible professionals that submit claims to Medicare under a single Taxpayer Identification Number (TIN) will be subject to the payment modifier, based on their performance in calendar year 2013.</td>
</tr>
<tr>
<td></td>
<td>o In both 2015 and 2016, the value-based payment modifier will not apply to those physician groups and solo practitioners participating in the Medicare Shared Savings Program (MSSP), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative.</td>
</tr>
<tr>
<td></td>
<td>o Medicare records indicate that the value-based payment modifier will not apply to you in 2015 because either no physicians or fewer than 100 eligible professionals billed to your TIN in 2013.</td>
</tr>
<tr>
<td><strong>How</strong></td>
<td>In 2015, the value-based payment modifier for physicians in groups of 100 or more eligible professionals will be based on participation in the Physician Quality Reporting System (PQRS) in 2013.</td>
</tr>
</tbody>
</table>
VM Quality Measures

- PQRS Measures
- Acute Prevention Quality Indicator Composite
  - Bacterial Pneumonia
  - Urinary Tract Infections
  - Dehydration
- Chronic Prevention Quality Indicator Composite
  - COPD
  - Heart Failure
  - Diabetes
- All-Cause Hospital Readmission Measure
VM: Cost Measures

- Total Per Capita Cost Measure
- Per Capita Cost Measure for Chronic Conditions
  - Diabetes
  - Heart failure
  - CAD
  - COPD
- Medicare Spending Per Beneficiary Measure
<table>
<thead>
<tr>
<th>Value-based Payment Modifier</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mandatory Quality-Tiering for PQRS reporters</strong>-</td>
<td></td>
</tr>
<tr>
<td><strong>Groups with 2-9 EPs and solo practitioners:</strong> Upward or neutral VM adjustment only based on quality-tiering (+0.0% to +2.0x of MPFS)</td>
<td></td>
</tr>
<tr>
<td><strong>Groups with 10+ EPs:</strong> Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)</td>
<td></td>
</tr>
<tr>
<td>Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-PQRS reporters</strong>-</td>
<td></td>
</tr>
<tr>
<td><strong>Groups with 2-9 EPs and solo practitioners:</strong> automatic -2.0% of MPFS downward adjustment</td>
<td></td>
</tr>
<tr>
<td><strong>Groups with 10+ EPs:</strong> Automatic -4.0% of MPFS downward adjustment</td>
<td></td>
</tr>
</tbody>
</table>
Medicare Shared Savings Program

- “Accountable Care Organizations”
- 424 in US; 7.8 million Medicare beneficiaries
- Tracks performance measures and cost of care for min of 5,000 Medicare beneficiaries
- If 2.9% savings or greater, share 50/50
- *Results since 2012:
  - ACO’s generate savings in excess of CMS actuarial calculations
  - ACO’s outperformed Medicare FFS on performance measures

The Medicare Shared Savings Program (Shared Savings Program) facilitates coordination among providers to improve the quality of care for Medicare beneficiaries. This map shows the locations of Accountable Care Organizations (ACOs) participating in the program across various states, including Oklahoma, Arkansas, Tennessee, Mississippi, Alabama, Louisiana, Texas, and Florida.
ACO Public Reporting Information

Aggregate Amount of Shared Savings/Losses

- Performance Year 1: Total Shared Savings $28,338,705.
- Performance Year 2: TBD
- Performance Year 3: TBD

How Shared Savings Are Distributed

- Reinvest in infrastructure: 6%
- Distribution to ACO Participants: 94%
- Facility Fund Surplus
  - Physicians 25%
  - Hospital 75%
- Professional Fund Surplus
  - Physicians 100%

NOTE: Percentages are included by way of example only. The distribution may vary from organization to organization.

ACO Participants

Abbas Jafri MD PA
Affiliates Of Family Medicine
Medicare’s New Bundled Payment Program
Begins April 1, 2016 - Ready or Not
## Comprehensive Care for Joint Replacement (CJR)

<table>
<thead>
<tr>
<th><strong>Participants</strong></th>
<th>Mandatory for Hospitals in 67 MSA’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode Definition</strong></td>
<td>DRGs 469 and 470 for LE Joint Replacements</td>
</tr>
<tr>
<td><strong>Episode Duration</strong></td>
<td>Hospitalization Plus 90 Days After DC</td>
</tr>
<tr>
<td><strong>Payments Included in Bundle</strong></td>
<td>All Part A and Part B Payments for Clinically Related Services</td>
</tr>
</tbody>
</table>
| **Financial Performance Risk** | Year 1: 0% Downside, 5% Upside  
Year 2: 5% Upside and Downside  
Year 3: 10% Upside and Downside  
Years 4 and 5: 20% Upside and Downside |
| **Payment Mechanism** | Retrospective |
| **Quality Measures** | 1) Complications; 2) Patient Experience; 3) Patient Self-Reported Outcomes |
Capitation

- Payment per person rather than for service (per member per month - pmpm)
- Medicare Part C plans are primary opportunity
- Requires sophisticated business and operational acumen:
  - Necessary to know cost of providing services
  - Actuarial projections for utilization
  - Accrual accounting and IBNR
- Assumption of significant risk ("stop-loss insurance")
Payment Models and Risk
Problem List:

1. Stroke
2. A Fib
3. UTI
4. Hematuria
5. Non STEMI
6. Heart Failure
7. Resolving Pneumonia
8. Hypertension
9. Diabetes Mellitus
10. Stable CAD
11. Ischemic Cardiomyopathy
12. HLP
13. Generalized OA
### Coding Summary

**Print Date:** 1/8/2014  2:12:54PM  
**Billing Number:** 937654321  
**MRN:**  
**Sex:** Female  
**Race:**  
**Total Charges:**  
**Financial Class:** M  Medicare  
**Disch Date/Time:** 01/07/2014 0000  
**Payor 1:** M01 MEDICARE INPATIENT  
**Payor 2:**  
**Payor 3:**  
**Discharge Status:** AHR Home - Routine or Residential Care

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>MDC</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>064</td>
<td>INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC</td>
<td>001</td>
<td>1.7417</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seq</th>
<th>POA</th>
<th>CC</th>
<th>Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Y</td>
<td>*</td>
<td>434.91</td>
<td>Unspecified cerebral artery occlusion with cerebral infarction</td>
</tr>
<tr>
<td>2</td>
<td>Y</td>
<td>%</td>
<td>486</td>
<td>Pneumonia, organism unspecified</td>
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<tr>
<td>3</td>
<td>Y</td>
<td>#</td>
<td>599.0</td>
<td>Urinary tract infection, site not specified</td>
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<tr>
<td>4</td>
<td>Y</td>
<td></td>
<td>427.31</td>
<td>Atrial fibrillation</td>
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<tr>
<td>5</td>
<td>Y</td>
<td></td>
<td>599.70</td>
<td>Hematuria, unspecified</td>
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<tr>
<td>6</td>
<td>Y</td>
<td></td>
<td>401.9</td>
<td>Essential hypertension, unspecified benign or malignant</td>
</tr>
<tr>
<td>7</td>
<td>Y</td>
<td></td>
<td>250.00</td>
<td>Diabetes mellitus without complication, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>8</td>
<td>Y</td>
<td></td>
<td>414.01</td>
<td>Coronary atherosclerosis of native coronary vessel</td>
</tr>
<tr>
<td>9</td>
<td>Y</td>
<td></td>
<td>414.8</td>
<td>Specified form of chronic ischemic heart disease</td>
</tr>
<tr>
<td>10</td>
<td>Y</td>
<td></td>
<td>272.4</td>
<td>Unspecified hyperlipidemia</td>
</tr>
<tr>
<td>11</td>
<td>Y</td>
<td></td>
<td>715.00</td>
<td>Generalized osteoarthrosis, site unspecified</td>
</tr>
</tbody>
</table>
Hospital P4P Bottom Line:

DRG 064: 1.7417 X $5,906 = $10,286.48

P4P Incentive:
- HVBP Program: 2% = $205.73
- Readmissions Reduction: 3% = $308.59
- HAC Reduction Program: 1% = $102.86

Total P4P Incentive = $617.84

Net Hospital Reimbursement = $9,668.64
*Hospital P4P Bottom Line:

Medicare Part A Revenue: $50,000,000

P4P Incentive:

- HVBP (MI, HF, HCAHPS): 2% = $1,000,000
- Readmissions Reduction: 3% = $1,500,000
- HAC Reduction Program: 1% = $500,000

Total P4P Incentive at Risk: $3,000,000

*250 bed community hospital
Physician P4P Bottom Line:

Total Reimbursement 5-day LOS: $518.14

P4P Incentive:
- PQRS: 2% = $10.37
- VM: 4% = $20.73

Total P4P Incentive = $31.10

Net Physician Reimbursement = $487.04
Physician P4P Bottom Line:

Medicare Part B Revenue $101,063.20

P4P Incentive:
  PQRS: 2% = $2,021.26
  VM: 4% = $2,021.26

Total P4P Incentive at Risk: $6,063.78
# Case Presentation in Context

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Reward</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician</td>
<td>Hospital</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>****</td>
<td>****</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>***</td>
<td>**</td>
</tr>
<tr>
<td>Bundled payments</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Capitation</td>
<td>***</td>
<td>***</td>
</tr>
</tbody>
</table>
Calling the shot.
“New targets have been set for value-based payment: 85% of Medicare fee-for-service payments should be tied to quality or value by 2016 (90% by 2018); 30% of Medicare payments should be tied to quality or value through alternative payment models by 2016 (50% by 2018).”
Future of FFS in Medicare

NOW

FFS

2016

Alternative Payment Models “Built on FFS Architecture” & Population-Based Payment 30%
Fee for Service – “Link to Quality” 55%
FFS - No Link to Quality 15%

2018

Alternative Payment Models “Built on FFS Architecture” & Population-Based Payment 50%
Fee for Service – “Link to Quality” 40%
FFS - No Link to Quality 10%
BREAKING: President Obama Signs SGR Repeal Legislation, Shifting Medicare Physician Payment Incentives

On Apr. 16, President Obama signed into law a bill that ushers in a new era in value-based MD payment

On Thursday afternoon, April 16, President Barack Obama signed the Medicare Access and CHIP Reauthorization Act of 2015, or “MACRA,” a bill passed by the House of Representatives on March 26 and by the Senate on April 14 that now permanently repeals the long-maligned Sustainable Growth Rate (SGR) formula for Medicare physician payment.

As the Washington Post reported, in signing the bill into law, the President praised the bipartisan nature of the legislation, cobbled together in the House by Speaker John Boehner (R-Oh.) and Democratic Leader Nancy Pelosi (D-Calif.) for negotiating the terms of the legislation. He further said that “It also improves it [physician reimbursement] because it starts encouraging payments based on quality, not the number of tests that are provided or the number of procedures that are applied but whether or not they are possible.”
Repeals SGR - gives 0.5% per year Part B payment update X 5 yrs

Beginning 2019 - 2 options:

- **Option 1**: 5% additional lump sum payment for participating in APM
- **Option 2**: Merit-Based Incentive Payment System (MIPS)
  - Combines PQRS, VBPM, MU
  - 4 to 9% of payment at risk in 4 domains:
    1. Quality
    2. Resource Use
    3. EHR’s
    4. Clinical Practice Improvement
Summary/Conclusions

- Healthcare payment system is changing
- CMS driving payment reform - commercial insurance plans following
- Transition taking off more quickly than anticipated:
  - Hospitals > Physicians
- Physicians/Hospitals will take a more active role in managing risk
Summary/Conclusions

- Demands new skills and competencies:
  - Understanding quality data and attribution models
  - Implementing PI methods
  - Population health management
  - Advocacy and public policy

- Physician engagement and leadership will be key to success
“Ultimately, however, what a physician does or does not do depends on the Hippocratic Oath, ethics, and morals.”
Value-Based Purchasing/
Value-Based Payment
for
Physicians and Hospitals

Comments/Questions?