Enabling Value and Quality: Reflections on Practical and Legal Considerations for Healthcare Transformation
Overview

- Value and Quality – Practical Reflections
  - Transforming Healthcare Services
  - Volume to Value (Quality/Experience/Cost)
- Collaboration and Accountability
- Quality Models through Risk Sharing
- Case Study (Episodic Payment Programs)
  - Overview
  - Legal Considerations
  - Practical Implementation
- Discussion and Questions
Transforming Healthcare

- Practically speaking and from the view of regulators: **Healthcare reform = Payment reform**
- Vision, direction, and pace play important roles in transforming the healthcare landscape
- Healthcare reform is predicated on differentiating the high-performers from the “pack”
- Adaptation is survival
In Challenging Times - Commitment

*Healthcare changes and the need to adapt provides a moment in time to listen to our better angels, to serve our noble purpose*

8/14/16 4 PM UPDATE: Ochsner—Baton Rouge Provides Family Hotline for Transferred Patients
Adopting the Triple Aim

Better Care
Better care for patients through coordinated, higher quality care during and after a hip or knee replacement surgery

Healthier Populations
Healthier populations by encouraging coordination of care across hospitals, physicians, and other health care providers

Reduced Costs
Smarter spending of health care dollars by shifting accountability to hospitals for total episode spending, not just inpatient costs
Moving to Value-Based Care

From
- Fragmented care
- Volume-based payments
- Only treating individuals
- Payer-driven managed care

To
- Coordinated/Integrated care
- Value-based payments
- Caring for a population
- Provider-driven accountable care
Health Care Transformation
Patient-Centered Care

**Quantity**
Fee-for-Service

**Quality**
Pay-for-Service

Where we've been

Where we're headed
Managing the Gap

• Move to collaboration across the care continuum
  • Identifying gaps in care
  • Addressing population needs
  • Establishing data analytics for success

• Overcoming current FFS-based environment
• Identifying opportunities for value-based reimbursement
Aligning Quality Care and Incentives

- Overcome **gravity**
- Change behavior through **meaningful incentives**
  - Financial (Better reward)
  - Outcomes (Better care)
- Understand risk readiness (success breeds success)
- **Manage** change – organizationally, personally, structurally
- Communicate to all stakeholders, often and build transparency as core **value**
Managing the Transformation

Value-based payment continuum

- Fee-for-service
- Performance incentives
- Performance-based contracts
- Bundled/episode payments
- Shared savings
- Shared risk
- Capitation + PBC
- Accountable care programs

Degree of provider integration and accountability
Strategy and Planning

- Consider timing for change
- Identify partnerships that are needed
- Understand and prepare organizationally for acceptance of risk
  - Required risk (e.g., readmission penalties, mandatory episodic payment)
  - Voluntary risk (e.g., pay for performance, employer/commercial partnerships, capitation programs)

If Incentives are changing 180° . . . Strategy and Behavior must change as well
Quality Achievement and Risk Sharing
What’s the value in value-based payment?

Value-based payment may be evaluated in multiple ways:

- Success on individual contracts
- Gaining market share
- Driving improvement in operational efficiency and outcomes
- Patient experience
- Organization learning and growth
Medicare offers several types of ACO programs:

- Medicare Shared Savings Program—a program that helps a Medicare fee-for-service program providers become an ACO. Apply Now.
- Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program.
- Pioneer ACO Model—a program designed for early adopters of coordinated care. No longer accepting applications.
- Next Gen ACOs – upgrading MSSP model and movement to MA-style capitation
Principles for Next Gen ACOs

- Protect Medicare FFS beneficiaries’ freedom of choice
- Create a financial model with long-term sustainability
- Use a prospectively-set benchmark that:
  - Rewards quality
  - Rewards both attainment of and improvement in efficiency
  - Ultimately transitions away from updating benchmarks based on ACO’s recent expenditures
- Offer benefit enhancements that directly improve the patient experience and support coordinated care
- Allow beneficiaries a choice to remain aligned to the ACO
  - Mitigates fluctuations in aligned beneficiary populations – Respects beneficiary preferences
  - Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms
Bundled Payment is a payment method whereby the “Bundled” approach combines the payment for physician, hospital, and other provider services into a single bundles payment of a predetermined amount for all services furnished to a Medicare beneficiary during an episode of care.

- CMS Bundled Payment Care Initiative
Bundled Payment for Care Initiative

<table>
<thead>
<tr>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective Acute Care Hospital Stay plus Post-Acute Care</td>
<td>Retrospective Post-Acute Care Only</td>
<td>Prospective Acute Care Hospital Stay Only</td>
</tr>
<tr>
<td>Episode</td>
<td>Selected MS-DRGs + post-acute period (30/60/90)</td>
<td>Post-acute only for selected MS-DRGs</td>
</tr>
<tr>
<td>Services included in the bundle</td>
<td>Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>Part A and B services during the post-acute period and readmissions</td>
</tr>
<tr>
<td>Payment Adjustments</td>
<td>Retrospective</td>
<td>Retrospective</td>
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Consists of 48 BPCI Clinical Condition Categories representing 179 DRGs
**Mandatory Bundles**

- **Comprehensive Care for Joint Replacement (CJR)**
  - Mandatory in 67 metropolitan statistical area
  - 90-day bundle for lower extremity joint replacement
  - 5-year performance period
  - Target price is a blend of hospital and regional data that changes over time
  - CMS allows gainsharing of upside and downside risk

- **Proposed Cardiac Bundles**
  - Currently proposed rule
  - Metropolitan statistical areas have not been defined
  - Expands CJR DRGS (initially involved LEJR procedures but now includes femur fractures as well)
  - Modeled generally on CJR provisions
# Mapping the Future – Episodic Payment

<table>
<thead>
<tr>
<th>Payment of Bundle</th>
<th>Acute Care Hospital Stay Only</th>
<th>Acute Care Hospital Stay plus Post-Acute Care</th>
<th>Post-Acute Care Only</th>
<th>Chronic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Retrospective”</td>
<td>Model #1</td>
<td>Model #2</td>
<td>Model #3</td>
<td>Model #7</td>
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<tr>
<td>(Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)</td>
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<tr>
<td>“Prospective”</td>
<td>Model #4</td>
<td>Model #5</td>
<td>Model #6</td>
<td>Model #8</td>
</tr>
<tr>
<td>(Single prospective payment for an episode in lieu of traditional FFS payment)</td>
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</tbody>
</table>

= Current

= Future
Commercial Bundles

- Lowe's
- Walmart
- Boeing
- Pepsi
- Kohl's
- United Healthcare
Legal and Practical Considerations
Quality Performance and Episodic Payments
The BPCI program is intended to permit the alignment of incentives for providers across a continuum of acute and post-acute care services.

The BPCI agreements and waivers allow for two sources of funding for gainsharing payments:

- Net Positive Reconciliation Payments (NPRA)
- Internal Cost Savings from hospital participants (hospitals do not need to be the awardee)

The complexity of gainsharing requirements is included in the Awardee Agreement and the Notice of Waivers from the Secretary of Health and Human Services.
Waivers for Gainsharing under BPCI Model 2

- The Notice of Waivers covers various financial arrangements that may otherwise implicate the following health care regulatory laws:
  - The Physician Self-Referral Law (42 USC § 1395nn)
  - The Federal anti-kickback statute (42 USC § 1320a-7b(b))
  - The Gainsharing Civil Monetary Penalty Law (42 USC § 1320a-7a(b)(1) and (2)), and
  - The Beneficiary Inducements Civil Monetary Penalty Law (42 USC 1320a-7a(a)(5))

- The scope of the waivers includes the following elements of the BPCI program:
  - contributions of internal cost savings to a BPCI savings pool for BPCI participants
  - incentive payments from the compensation pool to BPCI gainsharers
  - gainsharing payments from group practices to group practice practitioners, and
  - patient engagement incentives.

- Each type of gainsharing funding or payment imposes requirements to qualify for the waivers.
✓ Gainsharers must be required to comply with the BPCI Awardee Agreement and are participating on a voluntary basis in the Gainsharing Arrangement (no penalties for non-participation)
✓ Incentive payments are made only to the following parties: Awardees, EIPs, BPCI Entities, and Gainsharers
✓ EIPs and Gainsharers must meet Medicare enrollment requirements (TIN and NPI)
✓ The BPCI savings pool should be managed in a manner that meets the following criteria:
  ✓ Managed in accordance with GAAP (generally accepted accounting principles)
  ✓ Is only funded through NPRA or internal cost savings
  ✓ Internal cost savings, if applicable, must be actual savings and not savings based on “paper”
  ✓ Is administered by the Awardee and cannot be comingled in the Awardee’s operating funds or other accounts
✓ The arrangement includes a method for recouping funds (through either a withhold of future payments or repayment of NPRA) in the event the positive NPRA was miscalculated by CMS (or affected by MSSP savings)
✓ The incentive payments cannot be based in any manner on the volume or value of past or anticipated future referrals or other business generated
✓ Incentive payments are to be conditioned on the quality performance requirements in the Implementation Protocol (i.e., failure to meet those objectives would make gainsharers ineligible to receive incentive payments)
✓ Incentive payments cannot be designed to reduce or limit medical necessary services to beneficiaries and medical judgment of practitioners is to be protected
✓ The incentive payment to an individual physician or nonphysician practitioner cannot exceed the cap in the BPCI Agreement (which is 50% of the Medicare FFS payment to the practitioner)
✓ The recipients for any incentive payment are listed on the Gainsharing List, Attachment F, to the BPCI Agreement and approved by the CMS; no retroactive incentive payments are permitted for periods during which such gainsharers are not on the list or approved by the CMS
Post-Acute Performance (DRG+90)

It’s not just what happens here ...
Performance for Episodes
Quality follows the patient ...

1. Episode Performance Analytics
   - Quantitative understanding of baseline episode performance and components?
   - Insights on the greatest opportunities to improve episode cost efficiency?

2. PAC Network
   - Highest performing PAC providers identified? What criteria was used?
   - Providers under an Aligned/Performance contract?
   - Readmission Mitigation Programs?
   - Ongoing performance management structures?

3. Care Transition Effectiveness
   - Culture, processes and standards to support “right time, right place”?
   - Protocols followed for bundles/ACO cohorts?
   - PAC Network Connectivity and Information Exchange?

4. Care Model Design
   - Care models/evidence-based practices spanning acute through post-acute for current at risk episodes (ACO/Bundles)?
   - PACs following protocols toward reduced variation and performance monitored?

5. Optimization of Owned Post-Acute Assets
   - Optimized revenue capture?
   - Outmigration mitigation programs?
   - Superior Performance (the carrot vs. the stick)?
   - Home Health
   - SNF
   - IP Rehab
Patient Episodes - CHF

Opportunity to reduce episode spend in CHF is lowering readmission rates and reducing SNF LOS.

Biggest opportunity to reduce CHF episode spend is reducing readmissions – Every readmission doubles the cost of an episode.
Most significant opportunities to reduce cost variation:
1) maximize discharges to home
2) reduce SNF LOS
Variability in Cost Efficiency

- Same DRGs but significant variation.
  Business practices drive variation more than clinical need.

Avg. Episode Payment to SNF Providers from Hospital X
Highest Volume DRGs and Highest Total Volume SNF Providers

DRGs listed in order of greatest to least total volume; SNFs listed in order of greatest to least total volume

Each bar represents a top SNF referral destination; large variation in performance
1. Invest in Case Management Education  
   - New Role, New Day, New Script

2. Establish “Performance-Based” PAC Networks versus only amicable relationships

3. Provide incentives for PAC providers to change behaviors/business models

4. Ensure Care Models are Clinically-Driven and reduce variation in delivery

5. Readmission Mitigation Programs – “be the patient”

Questions?