Emergency Medicine and ACOs: Transitioning From the Fee For Service World to the Value Based World

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Chief Business Development Officer, CHESS

• Disclaimer: “I’m just a simple ER doc from the South.”

• Disclosures: AACEM is paying me thousands of dollars to give this presentation. Book tour to follow.
Agenda: EM and Value-Based Care

• What’s driving the move to value?
• What is Value-Based Care?
• Value-Based reimbursement strategies
• What are ACO’s? Clinically Integrated Networks?
• How does value-based care affect EM?
• Strategies for incorporation of EM in the move to value
THE BURNING PLATFORM

Healthcare costs are bankrupting America

We need to:
• increase quality
• lower cost
• increase patient satisfaction

Address decreasing physician income and satisfaction
Healthcare Cost: An Unsustainable Future

- Expected future trend (6.5% growth)
- Sustainable trend (affordability followed by 4.5% growth)

**Waste reduction**
A period of growth below GDP growth will be necessary to reach affordability (30% reduction in costs as a percent of GDP)

**Trend reduction**
After affordability is achieved, long-term growth must be at the same level of GDP growth to ensure sustainability

The funding gap is widening, creating a need for rapid transformation in the market

Sources: National Health Expenditure data, Bureau of Economic Analysis, Oliver Wyman analysis
Public Payer Reimbursement Reductions are coming

Medicare Payment Cuts Becoming the Norm

ACA’s Medicare Fee-for-Service Payment Cuts

Reductions to Annual Payment Rate Increases

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment Reduction</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>($4B)</td>
</tr>
<tr>
<td>2014</td>
<td>($14B)</td>
</tr>
<tr>
<td>2015</td>
<td>($21B)</td>
</tr>
<tr>
<td>2016</td>
<td>($25B)</td>
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<tr>
<td>2017</td>
<td>($32B)</td>
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<tr>
<td>2018</td>
<td>($42B)</td>
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<tr>
<td>2019</td>
<td>($53B)</td>
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<tr>
<td>2020</td>
<td>($64B)</td>
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<tr>
<td>2021</td>
<td>($75B)</td>
</tr>
<tr>
<td>2022</td>
<td>($86B)</td>
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$415B in total fee-for-service cuts, 2013-2022

$260B Hospital payment rate cuts, 2013-2022

$56B Reduced Medicare and Medicaid DSH payments, 2013-2022

$151B Reduced Medicare payments due to sequestration and 2013 budget bill


Includes hospital, skilled nursing facility, hospice, and home health services; excludes physician services. Disproportionate Share Hospital.
Transitioning from Carrots to Sticks: More work, less money

Financial Penalties for Nonparticipation Continue to Increase

Incentives
Available to participating providers

Penalties
Groups must meet size requirements to face VBPM penalties

CMS Physician Quality Incentives and Penalties

<table>
<thead>
<tr>
<th>Year</th>
<th>Incentives</th>
<th>Penalties</th>
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<tbody>
<tr>
<td>2012</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>(1.0%)</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td>(2.0%)</td>
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</tbody>
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PQRS, VBPM penalties in 2015-6 tied to reporting in 2013-4, respectively

Penalties for PQRS Non-Participation
- Levied by the PQRS program
- Levied by the VBPM program

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. HHS will intensify its work with states and private payers to support adoption of alternative payments models through their own aligned work, sometimes even exceeding the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

"Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today's announcement is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely," Secretary Burwell said. "We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement."

"Healthy and deliver care we can expect of a healthier" Douglas G. Hantley, M.D., executive vice president and chief medical officer of care, Kaiser Permanente, said. "We need to drive the system to deliver care a way our patients deserve and expect it, for their health and their health care dollars."

"The move to delivery of quality care is the only way to go," Dr. Richard Poulin of Hospital for Special Surgery in New York said. "This is a way to do it and make sure we are the best in the world at delivery of care and patient satisfaction. It's the right thing for patients and for our health care system."
Significant Shift Toward Self-Funding
Employers Bearing More Risk, Turning to Providers as Allies

Percentage of Self-Insured Employers

- Partially or Completely Self-Insured

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<tbody>
<tr>
<td>Self-Insured</td>
<td>49%</td>
<td>52%</td>
<td>55%</td>
<td>57%</td>
<td>60%</td>
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Employer Interest in Provider-Oriented Strategies

- Adopt new accountable payment models
  - In Place in 2013: 6%
  - Planned for 2014: 20%

- Contract directly with hospitals, physicians, ACOs
  - In Place in 2013: 7%
  - Planned for 2014: 13%

- Offer incentives for care coordination
  - In Place in 2013: 8%
  - Planned for 2014: 21%

- Offer performance-based payments
  - In Place in 2013: 12%
  - Planned for 2014: 29%

Many employers are also establishing narrow networks, high copays:
Contracting the number of providers to limit the cost of care. Effective but disruptive

A View from the Marketplace…

What are external parties looking for?

- Access
- Value = quality / cost (bundles, low cost)
- Partnership to reduce cost, improve wellness and engage workforce
- Excellence in care delivery and customer service
- Clinical innovations / programs for value
- Collaborative medical staff
- Population data – IT Infrastructure, PHS, etc.
- Assistance with World II contracting
- Trust

Meeting the triple aim of quality, cost reduction, and patient satisfaction means VALUE to the marketplace.
In October 2007 the Institute for Healthcare Improvement (IHI) launched the Triple Aim initiative, designed to help health care organizations improve the health of a population patients’ experience of care (including quality, access, and reliability) while lowering—or at least reducing the rate of increase in—the per capita cost of care.
What is Value-Based Care?

*In the value based delivery model, care is organized around the patient and meeting a defined set of patient needs over the full care cycle. The aim is improve health outcomes, and to do so with increased efficiency.*

5 Essential Elements for Transforming Into a Value Based Practice

1. Basing primary care on patients’ needs
2. Integrating delivery models by subgroup
3. Measuring value for each subgroup
4. Aligning payment with value, control the premium dollar
5. Integrating subgroup teams and specialty care
Segment and Focus the Effort Where it is needed

<table>
<thead>
<tr>
<th>% of Population</th>
<th>% of Cost</th>
<th>Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>29%</td>
<td>$54,444</td>
</tr>
<tr>
<td>7%</td>
<td>23%</td>
<td>$14,232</td>
</tr>
<tr>
<td>10%</td>
<td>19%</td>
<td>$7,728</td>
</tr>
<tr>
<td>30%</td>
<td>22%</td>
<td>$3,168</td>
</tr>
<tr>
<td>50%</td>
<td>7%</td>
<td>$660</td>
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</tbody>
</table>

Source: CareFirst Book of Business 2010, CareFirst Health Care Analytics
Fee-for-Service to Value-Based Care

The Old System
(FFS World)
- Fee for service model
- Patients “discharged”
- Disease Management focus
- Addressing Sickness
- Measuring Mortality/Harm

The New System
(Value World)
- Value based reimbursement model
- Patients “transitioned”
- Care Coordination and navigation
- Addressing Health
- Measuring Risk of Harm

Wake Forest Baptist Medical Center
TRANSFORMATION IN REVENUE

PROVIDER REVENUE WILL BE PRIMARILY DRIVEN BY PAY FOR VALUE IN THE NEXT DECADE ....

... ACCORDING TO LEADING INDUSTRY OBSERVERS

Revenue from Fee for Service (FFS) and from Pay for Value as % of total provider revenue

National Commission on Physician Payment Reform called for a phase out of the FFS model within 5 years

Partnership for the Future of Medicare (PFM) believes the FFS payment model should be phased out over the next 5-7 years

Harvard Business Review called for a shift from the volume and profitability of services provided to the patient outcomes achieved
What is Value-Based Reimbursement?

- Fee for Service Reimbursement:
  - Pay for procedures
  - Pay for visits
  - Pay for hospitalizations
  - Penalty for poor quality
  - Reduce utilization by perverse incentives

- Value Based Reimbursement:
  - Pay for population of patients
  - Share population savings (gain share) or keep all the savings (full risk)
  - Onus is on care givers to reduce costs
SOURCES OF REVENUE IN PAY-FOR-VALUE

- Risk
- Shared Savings - upside gainshare
- Management Fees, PMPM
- Quality, P4P
- Patient Satisfaction payments
- Fee for Service
VALUE BASED REIMBURSEMENT COMPENSATION TO PRIMARY CARE

Reimbursement by payment model based on a similar RVU productivity pattern by a PCP

Fee For Service | FFS + P4P | Gainshare | Risk
--- | --- | --- | ---
100% | 98% | 98% | 90%

2% | 7% | 25% |
Reimbursement by payment model based on a similar patient panel cared for by a health system.
Accountable Care Organizations (ACO’s) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Being deemed an ACO allows a safe harbor against Stark laws, allowing health systems and specialty groups to share quality initiatives, IT infrastructure, and contract together in order to improve the care of a population.
Definition of Population Health

Population health management is the coordination of care delivery across a population to improve care, improve outcomes and reduce costs. Population health should be thought of broadly and in common terms by a range of clinical and non-clinical stakeholders.

Population Health demands partnerships over geographic, health system, and specialty borders.
Clinical Integration: Partnership to provide population health to a region

Partnership on care models, quality measures, quality infrastructure, etc
Shared contracting allowed with NO LOSS OF BRAND to partners
Clinical Integration: Creating Partnerships through sharing of care models, Infrastructure and contracting Expertise

- **Care Model**
  - Transformation:
    - Care Redesign
    - Patient Engagement
    - Patient Safety
    - Physician Development & Education

- **Analytics:**
  - Effectiveness Analysis
  - Financial and Clinical Risk Management

- **Contracting:**
  - Value-Based Contracting
  - Business Development
Clinical Integration Drives High Value Care

Commitments to Delivering High Value Care

**Data Sharing**
- Sharing information across the CIN helps promote care coordination
- HIE shuttles data between physician, hospital IT systems

**Care Coordination**
- Health Navigators drive care coordination and can be embedded or centralized
- Mutually-defined standards of care
- Preferred network honored

**Discharge Planning**
- PCP notified of patient discharge, collaborates on discharge care plan
- Patient Care Advocates utilized to facilitate transitions of care (and capture enhanced revenue)

**Strategic Alignment**
- Partner hospital and physicians guide clinical integration projects
- Projects focus on strategically important areas of opportunity
Emergency Medicine in a Value-Based Reimbursement World

- Pressure to Reduce ED Utilization
- Pressure to Reduce Admissions
- Pressure to Reduce Test Utilization/Costs
- Hierarchical Categorical Condition Coding
- EM is not Driving the Train
## CHESS Care Models and Results

<table>
<thead>
<tr>
<th>Care Model</th>
<th>Target Population</th>
<th>Patients Enrolled</th>
<th>Clinical Impact</th>
<th>Estimated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXTENSIVIST MODEL</strong></td>
<td>Late Stage &amp; Poly Chronic (top 3-5% of spenders)</td>
<td>261</td>
<td>ED chg: -36%</td>
<td>$1.43 Million</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hosp Chg: -74%</td>
<td></td>
</tr>
<tr>
<td><strong>PERSONALIZED PRIMARY CARE</strong></td>
<td>Complex Conditions (and late stage &amp; poly chronic) healthy, at-risk, and Early stage chronic</td>
<td>PPCP A: 678</td>
<td>ED chg A: -42%</td>
<td>A: $.5 Million</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PPCP B 539</td>
<td>Hosp chg A: -53%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ED chg B: -54%</td>
<td>B: $2.2 Million</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hosp chg B: -54%</td>
<td></td>
</tr>
<tr>
<td><strong>CARE OUTREACH</strong></td>
<td>Focus on dual eligible patients and Medicaid</td>
<td>IMPACT model: 138</td>
<td>ED chg: -60%</td>
<td>$1 Million</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total: &gt;600</td>
<td>Hosp Chg: -64%</td>
<td></td>
</tr>
<tr>
<td><strong>CARDIOLOGY MODEL</strong></td>
<td>Sickest 20% of CHF patients</td>
<td>321</td>
<td>ED Chg: -41%</td>
<td>$1.8 Million</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hosp chg: -54%</td>
<td></td>
</tr>
<tr>
<td><strong>ONCOLOGY MODEL</strong></td>
<td>Oncology patients</td>
<td>Breast: 325</td>
<td>ED Chg: -84%</td>
<td>$1 Million</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung: 220</td>
<td>Hosp Chg: -27%</td>
<td></td>
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Where EM Can Make A Difference

• Safety Net (some things never change)
• Limit Admissions/Readmissions:
  • CDU Protocols/Short Stays
  • Coordination of Care
• EBM Test Utilization
• Better Contact with PCPs
  • Transitions of Care
• Hit our Quality/Pat Sat Targets
Playing the Value Based Game

• Participate in CIN Governance/Ops
• Lobby for Gainshare/Risk Based Reimbursement
• HCC Coding (get the reimbursement up)
• Track Outcomes (stories to tell the contracting administrators)
• Reduce Cost, Improve Outcomes
On a very windy day....

The pessimist complains about the wind.
The optimist expects it to change.
The leader adjusts the sails.

- John Maxwell