MassMedic
Healthcare and Payment Reform: Impact on Value Demonstration
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David Martin, Senior Director,
Health Policy
## Provider Macroeconomics

| General economic decline leading to procedure volume decline and shift from inpatient to outpatient procedures |
| Aging demographic leading to increased Medicare patients and associated decline in case revenue |
| Evolving physician reimbursement formula to fairly compensate for high practice and malpractice costs, risk |
| Future of health reform nearly settled |
Current Inpatient Hospital Payment Methodology

Medicare Severity Diagnosis-Related Grouping (MS-DRG):
Prospective, capitated, acuity-adjusted payment methodology

Patient characteristics = MS-DRG weight
- Diagnoses
- Procedures
- Age
- Complications

Operating Base Payment Rate

Adjustment Factors

Physicians bill and may be paid separately for their professional services associated with many procedures they perform

But what comes next?

http://www.medpac.gov/payment_basics.cfm
Prospective payment system
Pay-for-performance
Hospital-physician bundling
Episodic bundling
Shared-savings model/ACO
Capitation

Integrated, Episodic Data

Episodic costs
Total costs

Acute-care costs

Prospective payment system
Pay-for-performance
Hospital-physician bundling
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Capitation

Episode definition?
What’s included?
How much does it cost?
Where to save costs and improve care?

Post-discharge utilization rehab, etc.
Hospital readmissions/reoperations
Outcomes and quality tracking
Two Reforms May Impact Device Makers

Accountable Care Organizations (ACO)

- Providers (physician groups/networks/Joint Ventures) organize to provide care
- Voluntary for providers and patients
- ACOs “Accountable” for quality and coordination of care for Medicare members – including community-based care – and reducing cost to Medicare
- Savings from reduced costs will be shared with ACO – Creates incentives for ACOs to manage care and benefit from the savings
- Must promote EBM, report on quality, costs
- High organizational commitment and risk: Quality reports may constrain savings

Value-Based Purchasing (VBP)

- Performance-based provider arrangements such as:
  - Pay for Performance (P4P)
  - Hospital readmissions penalties
  - Penalties for healthcare-acquired conditions
- Designed to align healthcare payments with clinical best practices and quality thresholds
- Basis for ACO quality standards as well as independent provision
- Hospitals, office-based physician practices impacted currently
- Payment adjustments to DRG base rates

Accountable Care and Value-Based Purchasing Proposed Rules: [www.cms.hhs.gov](http://www.cms.hhs.gov)
ACO’s: **Value versus Volume** Based Purchasing & Care

**Status quo**

- **Manage care in physician silos** Physicians singularly focused on their specialty
- **Physician defined treatment** Significant discretion (and limited data) to treat patients
- **Compensated for activity** Bill (and behave) on a fee-for-service basis
- **Capture activity** Focus on maximizing utilization & price realization per case
- **Deliver efficient processes** Standardize processes to drive efficient throughput
- **Compete for more of the pie** Negotiations and alliances with most counter-parties, especially payors, are focused on price

**Full Accountable Care Organization**

- **Integrate care across the network**, both specialties, and care continuum
- **Protocol defined treatment** Defined protocol for many acute & chronic issues
- **Compensated for outcomes** Increasing pressure to ensure value for dollars
- **Manage risk** Focus on predicting & minimizing utilization and cost per case
- **Deliver effective data analysis** Manage populations, customize care to reduce utilization
- **Collaborate to grow the pie** Alliances and negotiations are focused on collaborating to reduce system costs & aligning incentives

Learn to collaborate to create value in this process
### Opportunities

- Contract pricing
- Quality products
- Service; service improvements
- Evidence development
- Decision support
- Business-to-business Distribution

### Threats

- Hospital/System Mergers
- Standardization of Inventory
- Margin Pressures: Cost controls to generate provider savings
- Capital spend focused on information technology (IT) systems and decision support infrastructure instead of new product purchases
VBP Structure/Incentives

Inpatient Quality Reporting (IQR) – 45 reported measures
- Example: Blood Cultures Before Antibiotics (Y/N)
- “Post-Operative Respiratory Failure” reported on in FY12; payment penalties in FY14

Physician Quality Reporting (PQRI) – 190 reported measures

ACO Quality Reporting – 65 measures scored on sliding scale of attainment

Quality Bonuses
Reimbursement At-Risk, particularly in ACO models
## VBP Opportunities/Threats

### Opportunities
- VBP concepts not “new” – long evolution, and hospital customers are used to reporting
- Inclusion of “Post-Operative Respiratory Failure” as a measure raises awareness of an issue (e.g. post-operative pulmonary complications)
- Inclusion of ventilator-associated pneumonia as a HAC has elevated customer focus

### Threats
- Increased value/quality requirements will increase provider demand for evidence of improved outcomes
- Immediate hospital impact is expense and resource constraints associated with IT buildup to collect and report data – resource constraints may impact providers purchases, prices, timelines, etc.
4 Key Takeaways:

1. Device makers must reposition themselves for *value versus volume* reform.
2. Device makers should consider whether their product line(s) lends itself to participate in “gain/risk sharing.”
3. Understand ACO leadership and decision making and how that will impact product decisions and/or distribution channels.
4. Entrepreneurial medicine will evolve . . . device makers must evolve with it.