



Washington
State **Medical**
Association | **WSMA**

Health Care Financing: ACC/ ACO's , beyond the hype hope

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Washington State Medical Association

Our vision

- Make Washington the best place to practice medicine and to receive care.

Our mission

- The WSMA delivers strong leadership and advocacy that is patient focused and physician driven, helping physicians deliver care patients can trust

Presentation Agenda

Health Care Financing: ACC/ACO: Beyond the hype

Where we've been:

- traditional health insurance
- fee-for-service payments

Where we are:

- Moving away from fee-for-service

Where we're going:

- Accountable Care Organizations
- Clinically Integrated Networks
- Value based payment
- Quality and performance metrics

Presentation Agenda

Health Care Financing: Evolution and Revolution

Where we've been:

- *traditional health insurance*
- *fee-for-service payments*

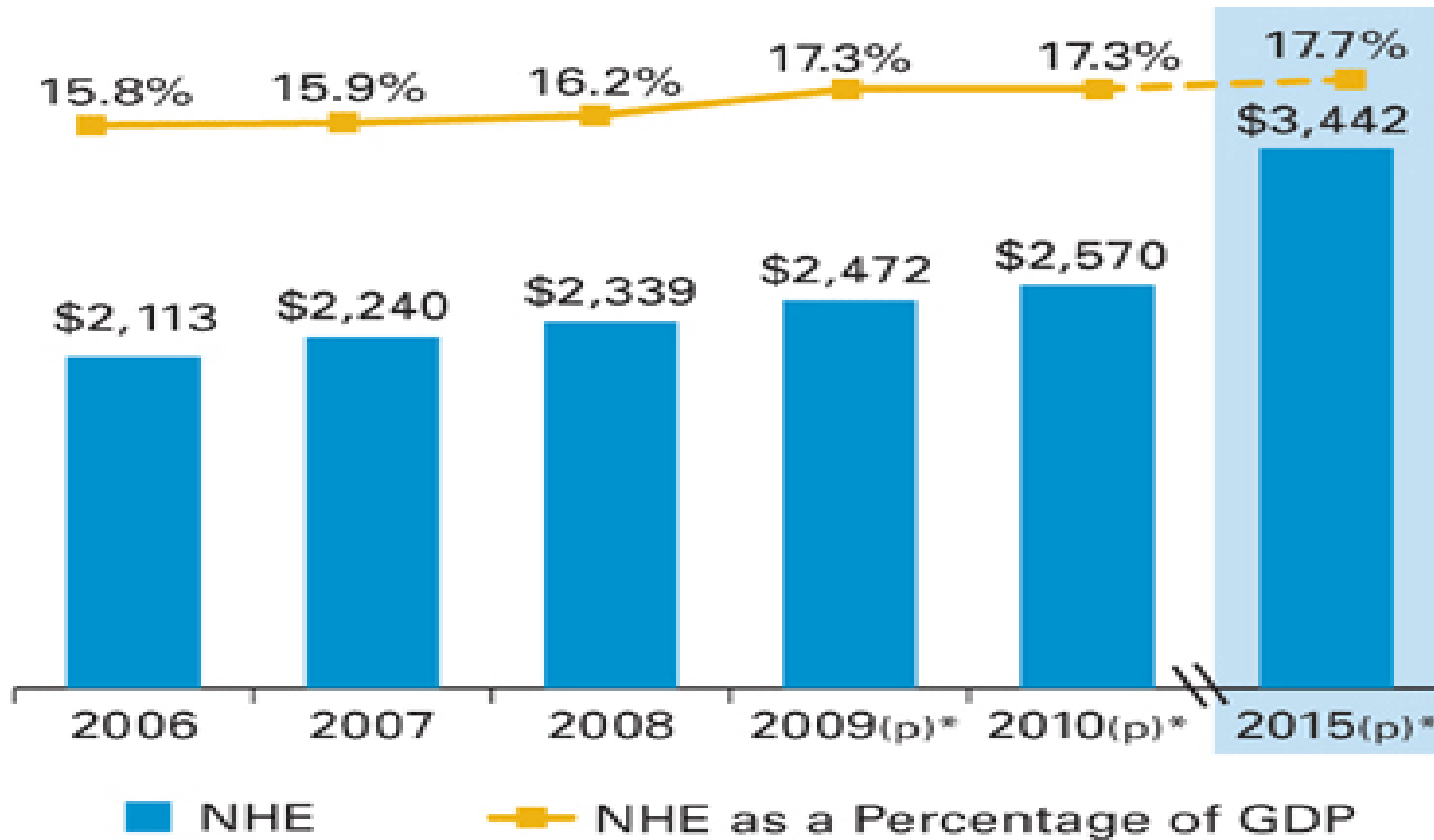
Where we are:

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Health Care Financing



US Health care spending in Billions of dollars

Source: Centers for Medicare and Medicaid Services (2010)
BCBSA: *Health Trends in America* (www.bcbsa.com)

Health Care Financing

Some Approaches We've Tried Along the Way...

- **Indemnity (Traditional Insurance or *Fee-for-Service*)**

Indemnity is a traditional insurance plan that pays (all or in part) for health care services provided to members.

Payment based on providers' bills, submitted *after the services are rendered*.

Program typically allows insured members to select any healthcare provider.

Health Care Financing

Some Approaches We've Tried Along the Way...

- **Preferred Provider Organization (PPO)**

A PPO is a Plan that allows members to choose any provider but offers higher levels of coverage if members receive services from health care providers in the plan's PPO network.

These in-network providers are contracted with the health plan to provide services at *negotiated* payment rates.

Members enrolled in PPO coverage can also receive coverage for services by healthcare providers who are not part of the PPO network, but typically at lower payment rates to the provider (and therefore higher out-of-pocket costs to patients).

Health Care Financing

Some Approaches We've Tried Along the Way...

- **Point of Service (POS) option**

Point-of-Service coverage is a healthcare option that allows members to choose medical services as needed and choose whether they go to a provider *within* the plan's network or seek medical care *outside* of the network.

- **Health Maintenance Organization (HMO)**

An HMO is a type of health benefits plan for which members are generally required to receive health care only from providers that are part of the HMO network. A primary care physician coordinates each member's health care. Services (except emergency care) performed by out-of-network providers are not covered except under specific circumstances, such as via a referral by the HMO.

Payment methodologies for Physician services

- *Per Service*: Fee-for-service (FFS): unbundled or bundled
- *Per Encounter* (or Per visit): bundled services (eg: “Global” maternity services)
- *Per “Episode of care”* of illness: Pay one amount for care of a specific condition (eg: URI), not separate “per visit” amounts.
- *Capitation payment*: **Per Member Per Month** (PMPM – *per capit*)
- *Per Month* (salaried)
- Various additional Financial Incentives for Physicians or Groups

Payment methodologies for Physician services

Resource Based Relative Value Scale (RBRVS)

Incorporates the components of providing a specific service:

- Physician Work
- Practice Overhead
- Professional Liability (medical malpractice) Insurance

Payment = service-specific weight x conversion factor

(and a geographic adjustment factor in Medicare's model)

- Weight (Relative Value Units - RVUs) balances several factors.
- Weight can correct historical imbalances.

Payment methodologies for Physician services

“Per Service” payment

- A separate payment for each service for the patient, based on UCR charges, discounted charges, or a fee schedule.
- Indemnity insurers and many PPO products, most major payers using RBRVS systems
- Pros: Payment for each service performed
- Cons: Incentive for doing more and maybe unnecessary services; billing/bundling rules complex and vary considerably by payer

Payment methodologies for Physician services

“Per Encounter” (or Per Visit) payment

- Fixed payment for all services at a given patient encounter (bundled care) based on CPT codes and fee schedules
- Most insurers, Medicare, Medicaid and most TPAs (for a limited set of codes)
- Pros: Promotes efficiency, discourages unbundling of small services for billing
- Cons: Assumes all necessary services will be performed; often not the case.

Payment methodologies for Physician services

“Per Episode of care” payment

- Fixed payment for defined course of routine treatments (e.g., maternity care)
- Virtually all payers for common types of conditions w/standard care processes
- Pros: No incentive for unneeded services
- Cons: Assumes all necessary services will be performed, but often not the case; complicated cases are often under-paid.

Payment methodologies for Physician services

Capitation payment: *Per Member Per Month* (PMPM)

- Fixed PMPM payment to provide a specific set of physician services (or all care)
- Medicaid, Medicare Advantage, a few commercial insurers (risk-adjusted global fee)
- Pros: Incentive to keep members healthy
- Cons: Incentive to not refer or hospitalize; can be complex to administer; data for effective care coordination is often lacking; you have risk but time lags mask financial difficulties.

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Challenges

- Health care costs rising.
- US employers seek to either get control of health care spending, or get out of funding health care as an employee benefit.
- Employers are increasingly considering:
 - ▶ Giving employees a “defined contribution” – a set dollar amount for employees to spend on purchasing health insurance,
 - ▶ Or offering insurance with very high deductibles; results in higher “out of pocket” costs borne by employees.
- Affordable Care Act (“Obamacare”) established requirements for employers and employees to have health insurance or face penalties.

Challenges

- Fee-For-Service: incentive to increase utilization
The more you do, the more money you make.
- Purchasers (premium payers) want to “Pay for Value, not Volume”.
Cost-effective care, not more care.
- Capitation (previous attempt to curb costs)
The less you do, the more money you keep.
that is, by discouraging the provision of care, usage of health care resources is curbed.

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ACOs – The CMS Definition

An Accountable Care Organization ... is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.”

Centers for Medicare & Medicaid Services

ACOs – Expected Core Competencies

1. Have complete and timely information on services and patients (EHR / registries)
2. Ability to manage a population - coordinate care across the full continuum of services
3. Engage patients (education/self-management)
4. Culture of teamwork within each practice

(continued)

Adapted from Harold Miller – “How to Create ACOs”

ACOs – Expected Core Competencies (*continued*)

5. Measure, report and improve quality

6. Assess/manage financial risk

7. Leadership commitment to “results”

8. Strong coordination with other providers

Build “bridges”

- ED & primary care physicians
- Discharges & long term care
- Discharges & physicians

Bundled payment methodology

- A single "bundled" payment would include payment for services delivered by two or more providers during a single episode of care, or over a specific period of time.
- For example, if a patient has cardiac bypass surgery, rather than making a payment to the hospital, a second payment to the surgeon and a third payment to the anesthesiologist, the payer would combine these payments, leaving the providers to divide the payment.
- Goal is to drive greater coordination of care among the various separate "providers". Seeks to achieve "alignment" or "integration".

Health Care Financing

Center for Studying Health System Change

Hospital-Physician Alignment

“Since 2007, in many communities, the trend of hospitals employing physicians has accelerated. Hospitals see physician employment and tighter alignment as a way to capture more specialty referrals and hospital admissions in a fee-for-service payment system.”

Source: Center for Studying Health System Change - www.hschange.org

Alignment Models

Alignment fall into three major classes of integration:

- *Limited Integration*
- *Moderate Integration*
- *Full Integration – Employment*

“Hybrids” – combining features of different models – are also possible.

Alignment Models

Limited Integration

- *Managed Care Networks* – loose alliances for contracting purposes.
- *Call coverage stipends* – pay for unassigned ED call.
- *Medical Directorships* – specific clinical oversight duties.
- *Gain sharing* – Economic benefits for hospitals and physicians; isolated and targeted initiatives.

Source: Max Reiboldt, The Coker Group

Alignment Models

Moderate Integration

- *Management Services Organizations (MSOs)* – Ties hospitals to physicians' business.
- *Service line management agreement* – Management of all specialty services within a hospital.
- *Equity Group Assimilation* – Ties entities via legal agreement; joint practice ownership.
- *Joint Ventures* – Unites parties under common enterprise.
- *Co-management of Clinical/Service Offerings* – Strong economic alignment; relatively minor return.

Source: Max Reiboldt, The Coker Group

Alignment Models

Full Integration - Employment

- *Physician employment* – Strongest alignment; minimizes economic risk for physicians.

Source: Max Reiboldt, The Coker Group

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“Quality” and “Value”

“Triple Aim”

The Triple Aim is a framework, developed by the Institute for Healthcare Improvement (IHI), that describes an approach to optimizing health system performance. Simultaneously pursue three dimensions:

- *Improving the **health** of populations;*
- *Improving the patient **experience** of care (including quality and satisfaction); and*
- *Reducing the per capita **cost** of health care.*

Source: Institute for Healthcare Improvement www.ihl.org

Clinical Quality Improvement Programs

- Physicians and Hospitals are increasingly being challenged to quantitatively demonstrate they provide *high quality* and *high value* care.
 - ▶ Nationally:
 - Dartmouth Atlas** – Efficiency & Effectiveness of care; Variations in care (www.dartmouthatlas.org)
 - ▶ Locally:
 - Washington Health Alliance**
 - *Community Checkup Report*
 - All Payer Claims Database (APCD)**
 - Price transparency

Clinical Quality Improvement Programs

Challenges:

- Metrics and mechanisms for measuring Quality and Value can be less than ideal for meaningful measurement:
 - ▶ Can be various different measurement standards and processes in use across the health care system;
 - ▶ Different focal areas for analysis and improvement.
- Costs imposed on practices and hospitals for participating in these processes:
 - ▶ Mix of rewards (eg: Shared Savings approach) and penalties (eg: payment reductions for failure to achieve targets).
 - Variation in *care patterns* drives up costs.
 - Variation in *administrative processes* also drives up costs.

Health Care Financing

Clinical Quality Improvement Programs

- Commercial health insurers are exploring Value Based initiatives, in response to demands by “purchasers” to lower their costs and premiums.
- Physician practices and health systems bear greater financial “risk”:
 - ▶ Achieve targets and have “shared savings” with the insurer.
 - ▶ Fail to meet targets – can lead to no financial rewards or even losses.
- Examples:
 - ▶ Massachusetts: *Alternative Quality Contract* by BCBS MA.
 - ▶ Washington: *Global Outcomes Contracting Model* from Premera Blue Cross.

Health Care Financing

Future: Transitioning from fee for service to risk based models

- As the payment model moves away from fee for service to risk based models providers will need to be able to transition to new payment models while still being able to function in a fee for service environment
- As *risk-based* model takes hold, then large outpatient networks will allow a system to shift patients away from higher-cost hospital based care, and capture revenues as shared savings or capitation surpluses (unspent capitation dollars).

Future: Payment methodologies

Harold Miller – *Center for Healthcare Quality & Payment Reform*;
leading expert on Accountable Care Organizations.

- Different payment models are not mutually exclusive. Rather, different models can function concurrently for different types of care delivery.
- Example:
Can use “fee-for-service” model in combination with “capitation” or with “per episode” model.

Miller, H. (2009, September). How to Create Accountable Care Organizations. *Center for Healthcare Quality & Payment Reform*. (www.chqpr.org)

2013 Physician Quality Reporting System (PQRS):

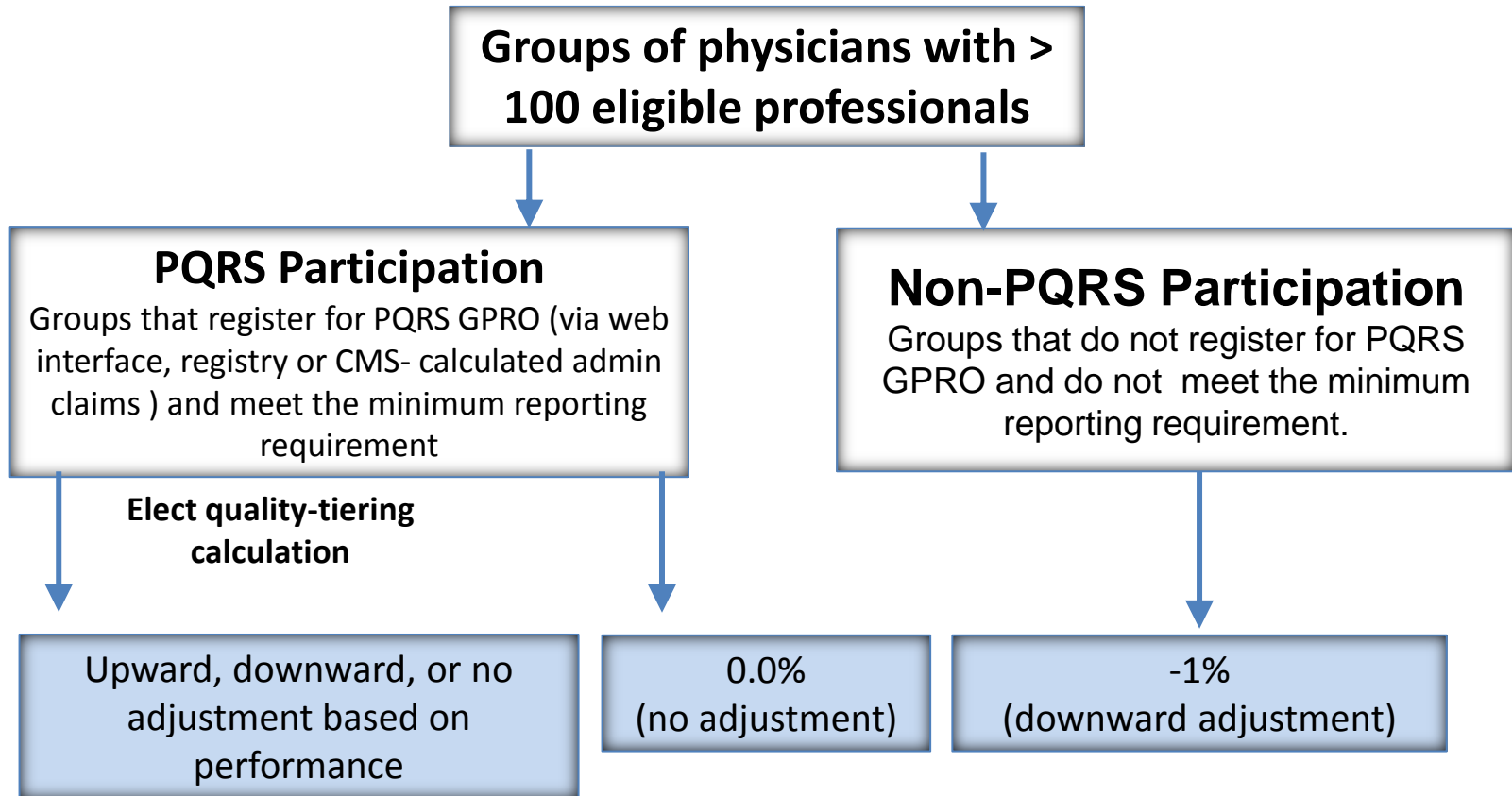
The Physician Quality Reporting System (PQRS) is a *voluntary* reporting program.

- The program provides an incentive payment to practices with eligible who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to **Medicare Part B Fee-for-Service (FFS) beneficiaries**
- Begin as a program that paid an incentive to submit data to CMS and progressed over time to a program that applied penalties if providers did not submit data.

Value-Based Modifier (VBM)

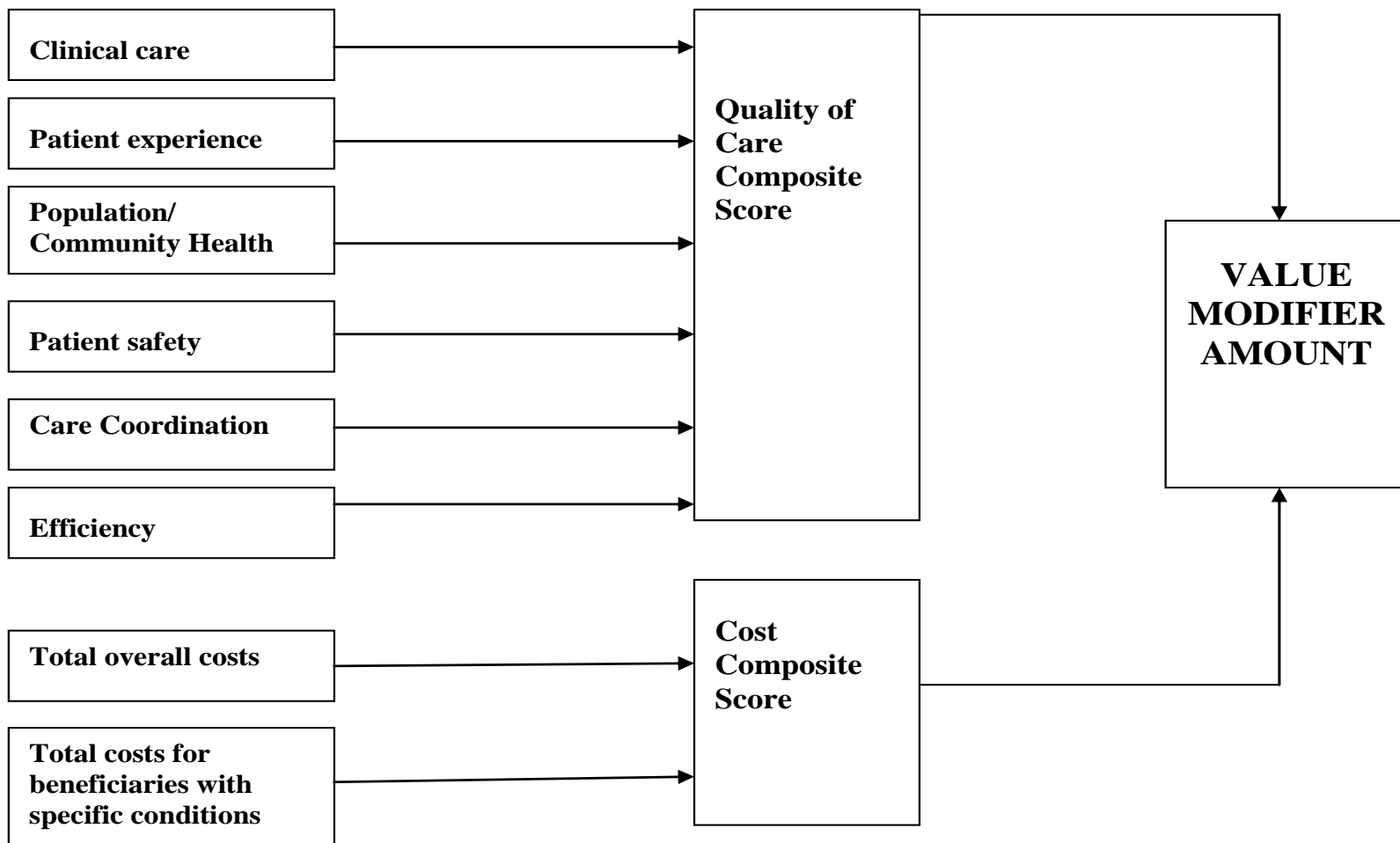
- VBM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule.
- Begin phase-in of VBM in 2015, phase-in complete by 2017.
- Implementation of the VBM is based on participation in Physician Quality Reporting System.
- For CY 2015, the VBM will apply to groups of physicians with 100 or more eligible professionals (EPs).

VBM implementation in 2015 is based on PQRS participation in 2013



Quality-Tiering Methodology

These “domains” combine each quality measure into a *quality composite* and each “cost measure” into a *cost composite*.



Quality-Tiering Approach for 2015

- Each group receives two composite scores (quality of care; cost of care), based on the group's **standardized performance** (e.g., how far away from the national mean).
- This approach identifies statistically significant outliers and assigns them to their respective cost and quality tiers.

	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

- * * Eligible for an additional +1.0x if :
- Reporting quality measures via the web based interface or registries
- AND**
- Average beneficiary risk score in the top 25% of all beneficiary risk scores

Health Care Financing

Washington State – Performance Measures

- An ongoing process to identify standard statewide measures.
- Goal is to promote voluntary alignment of measures among state and private payers.
 - *Performance Measurement Committee* provides leadership and direction;
 - Three *Technical Work Groups* identify and recommend measures: ***Prevention; Acute Care; Chronic Illness.***

Approach to Measure Set Development

- Start with points of alignment in existing measure sets.
- Consider the possible addition of measures based on:
 - greatest opportunities for improvement;
 - areas of focus of the State Health Innovation Plan; and
 - a library of available measures.

Health Care Financing

PREVENTION	ACUTE CARE	CHRONIC ILLNESS
Adult Screening(s)	Avoidance of Overuse	Asthma
Behavioral Health/Depression	Behavioral Health	Care Coordination
Childhood: early and adolescents	Cardiac	Depression
Immunizations	Cost and Utilization	Diabetes
Nutrition/ Physical Activity/ Obesity	Readmissions/Care Transitions	Drug and Alcohol Use
Obstetrics	Obstetrics	Functional Status
Oral Health	Patient Experience	Hypertension and Cardiovascular Disease
Safety/Accident Prevention	Patient Safety	Medications
Tobacco Cessation	Pediatric	
Utilization	Potentially Avoidable Care	
	Stroke	

SUMMARY

- Rising unsustainable costs of health care delivery will drive “innovation” – experiments in how to deliver “value” of high quality, low cost health care services.
- Move toward population health management.
- Increased demand for health care services with decreasing supply of physicians will drive “innovation” in redesigning care delivery and use of “teams”.
- A variety of different practice models exist, with trade-offs in each. For Physicians and Practices: Careful due diligence in assessing options is crucially important.

Thank you.

