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Value-Based Reimbursement: Preparing Your Hospital for the Paradigm Shift

Jim Tufts, Leadership Solutions Team Lead

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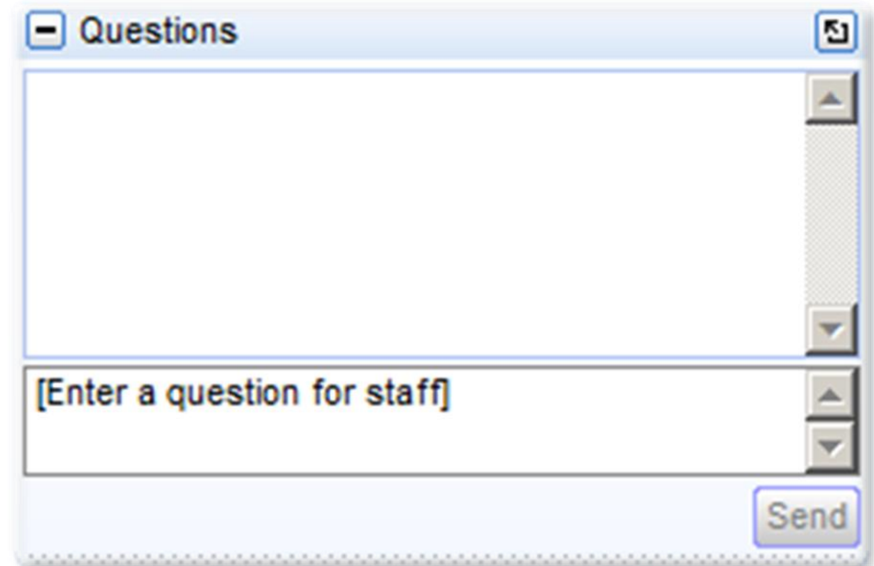
Welcome to "A Silver Lining: Improving Provider Productivity With Technology"

- All Attendees Are In Listen Only Mode
- Please Participate!
  - Enter your questions into the questions box and we'll talk through those at the end
- If you're having audio difficulties, please reach out to gotowebinar at 877-582-7011



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Agenda

- Defining Value-Based Reimbursement
- VBR Timeline
- VBR Options
- Preparation for VBR
- Next Steps
- Q & A

MACRA, MIPS & APMs

- Medicare Access & CHIP Reauthorization Act (MACRA)
  - Ends the Sustainable Growth Rate (SGR) formula for Medicare payments
  - Creates new framework for rewarding providers for better care (not just more care)
  - Combines existing quality reporting programs into one new system
- Merit-Based Incentive Payment Systems (MIPS)
  - Combines parts of the PQRS, Value Modifier and the EHR incentive program
  - Based on quality, resource use, clinical practice improvement and meaningful use of certified EHR technology
- Alternative Payment Models (APMs)
  - Value-Based Reimbursement models

Value-Based Care…

“Value is defined as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes. Improving value requires either improving one or more outcomes without raising costs or lowering costs without compromising outcomes, or both.”

Michael Porter and Thomas Lee - Harvard Business Review (2013)

Value-Based Reimbursements

- Shift from volume to value
  - Payment for how much you do
  - Payment for how well you do
- Tied to quality & outcomes
  - Linking Medicaid, Medicare, and other payor payments to value
- Healthcare providers will need to accept some risk going forward…
- Time to rethink care delivery

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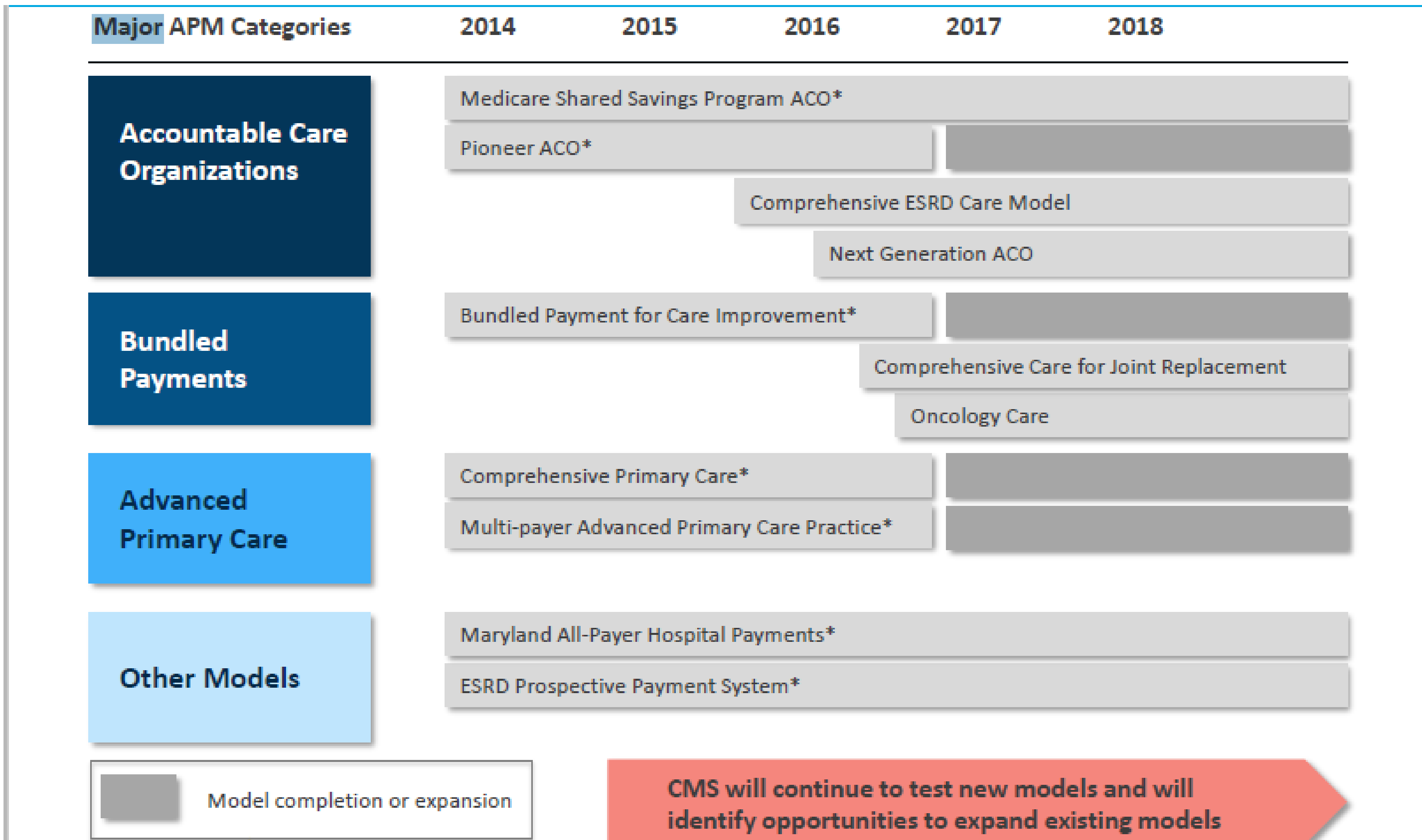
VBR Timeline



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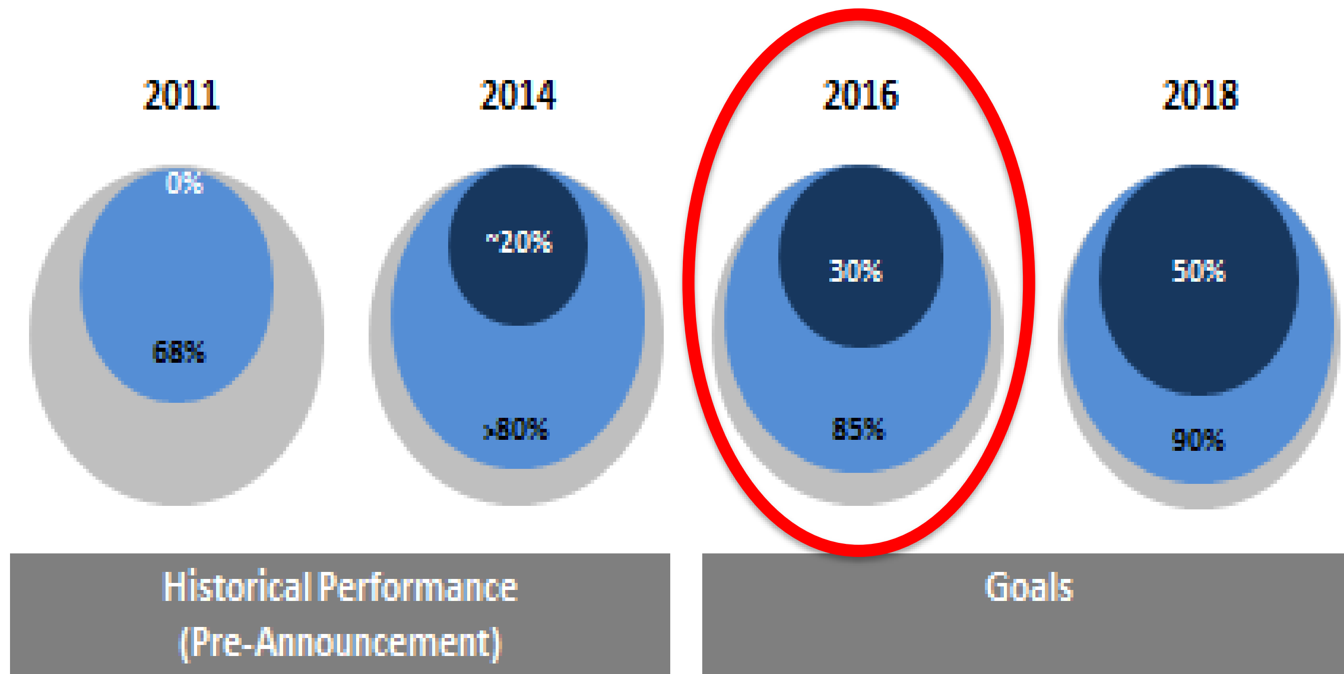
INCENTIVES: Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

The Office of the National Coordinator for Health Information Technology

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

VBR Programs

- Value-Based Purchasing
- Bundled Payment (Episode of Care)
- Patient Centered Medical Home (PCMH)
- Shared Savings
- Shared Risk
- Capitation (Full Risk)

Value-Based Purchasing

- CMS initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to people with Medicare
  - How well they perform on each measure, or
  - How much they improve their performance on each measure vs. their baseline
- Approved set of measures & dimensions, grouped into quality domains:

Fiscal Year	Applicable Domains
2013	Clinical Process of Care Domain Patient Experience of Care Domain
2014	Clinical Process of Care Domain Patient Experience of Care Domain Outcome Domain
2015	Clinical Process of Care Domain Patient Experience of Care Domain Outcome Domain Efficiency Domain

Value-Based Purchasing

- CMS assesses each hospital's total performance by comparing its Achievement and Improvement scores for each applicable measure
  - Uses a threshold (50th percentile) and benchmark (mean of the top decile) to determine how many points are awarded for the Achievement and Improvement scores
  - Compares the Achievement and Improvement scores and only uses whichever is greater
- Calculates a hospital's Total Performance Score
- Funded by withholding % of DRG payments:

Fiscal Year	Applicable Percentage
2013	1.0%
2014	1.25%
2015	1.50%
2016	1.75%
2017 and subsequent years	2.0%

Bundled Payments (Episode of Care)

- Single negotiated payment for a specified condition or procedure for all services provided, regardless of care setting
- Benefit realized if they can deliver services with reduced costs (better efficiency, reduce waste/duplication, etc.)
- Risk - costs are higher than bundled payment
- Must coordinate care across the delivery system, agree to payment split structure
- CMS piloting program on limited basis – expectation they will roll out to broader base with additional covered episodes

Patient Centered Medical Home (PCMH)

- Establish a team responsible for coordinating all medical care revolving around individual patient needs
  - Physician led team that manages care holistically
  - Focused on preventative care to keep patients well to avoid acute care episodes
  - Uses evidence-based guidelines of care, driven by quality measures
  - Engages patient, encouraging them to interact with their care team
  - Utilizes IT to support & coordinate care (electronic record, registries, etc.)
- Typically receive a per-member-per-month (PMPM) payment (in addition to standard FFS payments) to cover the cost of care coordination
- Seeks to lower overall costs

Shared Savings Programs

- Establish a baseline cost per covered life
- Submit claims as they do today
- Periodically review costs (typically on an annual basis) and determine cost per life
  - If cost is lower, potential bonus is earned (usually split cost savings with payer)
  - Dependent on meeting minimum quality standards, savings targets, use of CEHRT, etc.
- Medicare Accountable Care Organizations (ACO) use a shared savings-type program
- Many early ACOs used a limited risk SSP, but seeing shift to a more balanced risk arrangement in latest iterations of the program
- Limited success so far – difficulties & shortcomings exist

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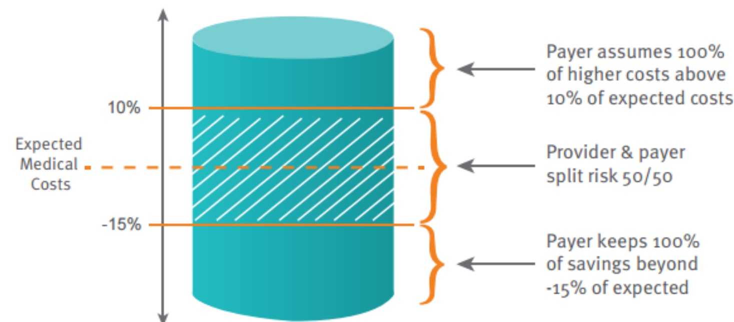
Shared Risk Programs

- Similar to Shared Savings, providers share in the savings of reduced cost per patient, but
- Includes sharing the excess cost of care
  - Based on an agreed upon target, if costs are higher, provider must cover a portion of the overrun (based on the agreed upon split, such as 50/50)
- Because more risk is assumed by the provider, the financial reward is typically higher (larger share of savings, etc.)
- Plans sometimes allow carve-outs for some patients or conditions
- Some include “risk corridor” arrangements to limit risk



Capitation (Full Risk)

- Providers receive a set payment from payers per patient for specified medical services
- Usually a monthly per-patient amount
- Determined by analysis of historical costs and adjusted by acuity of the patient population
- Two basic models:
  - Global Capitation - a provider organization, or group of organizations (primary care, hospital, specialist care and ancillary services), receive a single fixed payment for medical services.
  - Partial Capitation - only covers a defined set of healthcare services provided to the patient.
- Providers rewarded for providing care at a cost below the rate (keep all the savings), but bear the cost of care above the rate (assume full risk of the excess costs)

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VBR Options

- Variety of programs with varying levels of risk/reward
- Healthcare providers may participate in multiple programs
- Programs usually require meeting some threshold of quality measures and use of CEHRT
- CMS driving force in promotion of value-based programs, other payers are joining the push
- As more reimbursement for healthcare services shift to value-based, providers need to be ready to participate in these programs
- How can you be better prepared?

Preparation for VBR

- Dig into the data
  - Determine the real cost of providing care
  - Get specific – *"devil is in the details"*
  - Understand your patient population (80/20 rule)
  - Develop metrics to monitor progress (lead/lag measures)
  - Analytics & dashboards
  - Mine information out of the EHR/EMR (don't depend on claims data)

Preparation for VBR

- Redesign your care delivery model
  - Disruptive – can't do things like we've always have
  - Collaboration among the care team
  - Relationship building
  - Think Lean – eliminate waste (reducing cost) while building value
  - Include the patient in the process
  - Don't forget Change Management
  - Identify change champions & support their efforts
  - Seek professional help

Preparation for VBR

- Get everyone rowing in the same direction
  - Include all stakeholders
  - Align compensation / incentives properly
  - Identify changes and alert those impacted
  - Be nimble and proactive
  - Promote the future state and reinforce commitment
  - Solicit ideas and celebrate creativity

Preparation for VBR

- Think holistically
- Use the proper tools
- Be prepared to invest
- Promote and foster patient engagement
- Train and prepare staff (don’t forget customer service)
- Focus on the Patient

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Next Steps

- Learn more about the value-based programs
- Determine which one(s) would be most appropriate
- Begin preparations now

Thanks!

Questions?

Thanks!

Email
jtufts@icetechnologies.com

Subject Line: VALUE

For a copy of today's presentation.

Jim Tufts | 641.628.0226 | jtufts@icetechnologies.com

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