Healthcare Reform Update Conference Call VI

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Healthcare Delivery System Reform Provisions in America's Healthy Future Act of 2009: A Comprehensive Set of Proposals with Significant Implications for Healthcare Providers

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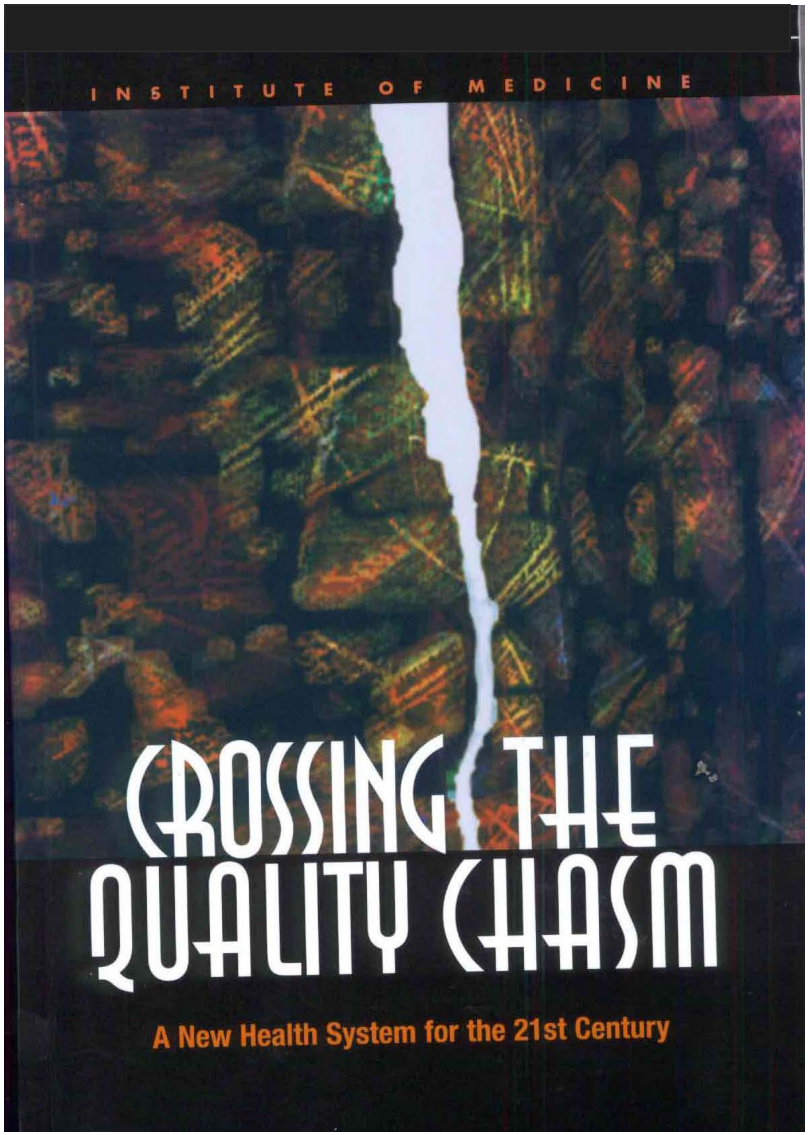
Crossing the Quality Chasm



"The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses and health care leaders are concerned that the care delivered is not, essentially, the care we should receive . . . . Quality problems are everywhere affecting many patients. Between the healthcare we have and the care we could have lies not just a gap, but a chasm."

— Institute of Medicine, 2001

The Six Aims of Crossing the Quality Chasm

Quality is defined by the Institute of Medicine as care that is:

- Safe
- Effective
- Efficient
- Patient-Centered
- Equitable
- Timely

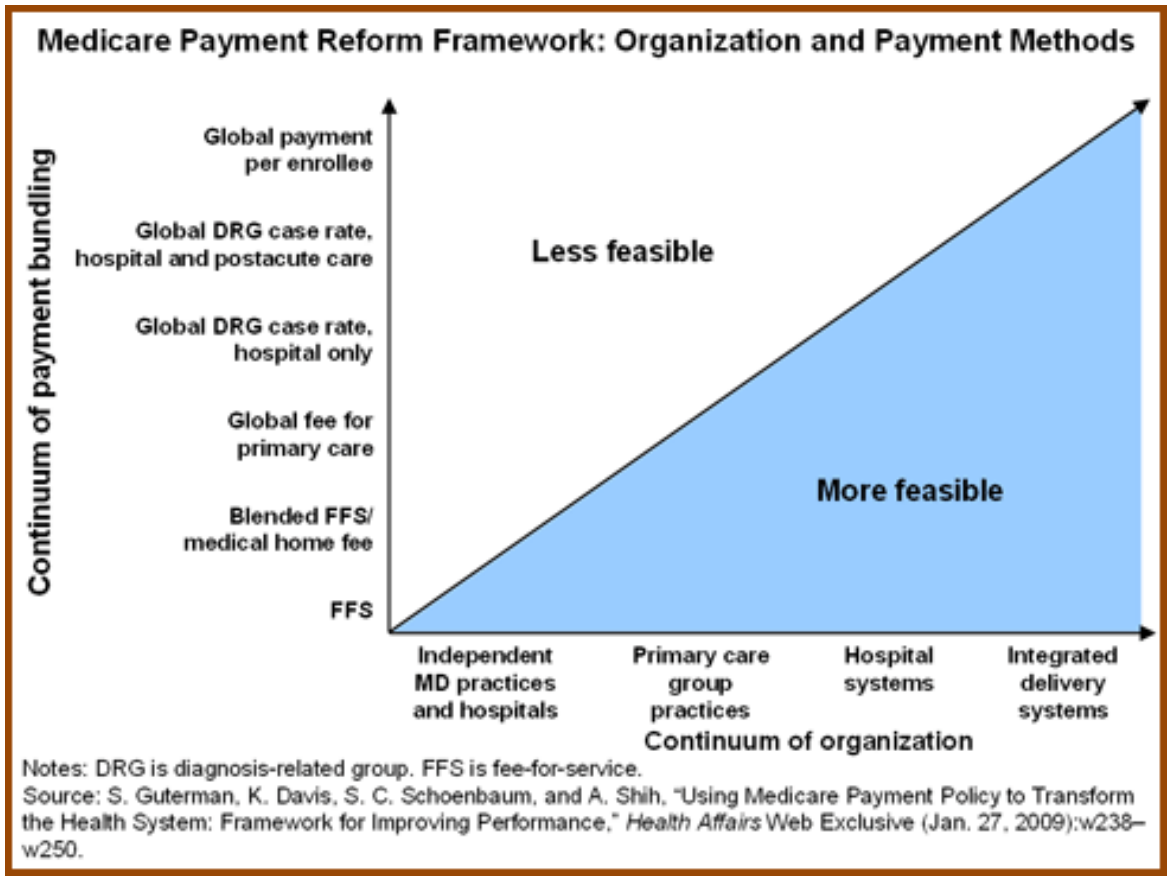
Achieving the Six Aims

- Evidence-based medicine identifies overuse, underuse and misuse
- Collaboration, cooperation, and care coordination among diverse providers is essential
- This necessarily includes transactions, arrangements, and payments that align incentives, enhance systemic approaches, and drive necessary size and scale
- Incentives to achieve the six aims, including financial incentives, are a necessary component and need to be allowed and encouraged

IOM Pay-for-Performance Recommendations for Medicare - 2006

- The Secretary of the Department of Health and Human Services (DHHS) should implement pay for performance in Medicare using a phased approach as a stimulus to foster comprehensive and system-wide improvements in the quality of healthcare
- Congress should create provider-specific pools from a reduction in the base Medicare payments for each class of providers (hospitals, skilled nursing facilities, Medicare Advantage plans, dialysis facilities, home health agencies, and physicians)
- Congress should give the Secretary of DHHS the authority to aggregate the pools for different care settings into one consolidated pool from which all providers would be rewarded when the development of new performance measures allows for shared accountability and more coordinated care across provider settings

Bundled Payments: From Volume to Value



"To change the way health care is organized and delivered, we need to change the way it is paid for — to move from fee-for-service payments to bundled payments."

– Gutterman, Davis, Schoenbaum and Shih, 2009

Current Efforts

- Gainsharing demonstrations
- Hospital quality data reporting
- Physician quality reporting system
- Development of quality measures
- Pay-for-performance demonstrations

Senate Finance Committee (Baucus) Bill Title III, Subtitle A: Transforming the Health Care Delivery System

- A hospital value-based purchasing program in Medicare that moves beyond pay-for-reporting on quality measures to paying for hospitals' actual performance on those measures
- Revisions to expand and extend quality reporting for physicians and other non-hospital providers
- A charge to the Secretary of DHHS to establish a national quality improvement strategy, which would, among other things, address improvements in patient safety, health outcomes, disparities, effectiveness, efficiency, and patient-centeredness
- Recognition of Accountable Care Organizations, which, beginning in 2012, would be allowed to qualify for incentive bonus payments; among other requirements, an ACO would have to have a formal legal structure to allow it to receive bonuses and distribute them to participating providers

Senate Finance Committee… *(cont.)*

- Formation at CMS of an Innovation Center that would be required to test and evaluate patient-centered delivery and payment models
- The establishment of a bundled payment pilot program involving multiple providers to cover costs across the continuum of care and entire episodes of care; if the pilot is successful, it would be made a permanent part of the Medicare program
- Beginning in 2013, reductions in Medicare payments to hospitals with preventable readmissions above a threshold based on appropriate evidence-based measures
- Extension of the current gainsharing demonstration

Hospital Value-Based Purchasing Program

- Implement payments to acute care IPPS hospitals that meet certain quality performance standards beginning in 2012
  - 2012 – Data collection only
  - 2013 – Hospitals that meet or exceed performance standards set by the Secretary would receive value-based incentive payments
- Funding would be generated through reducing Medicare IPPS payments to all hospitals, but aggregate reductions returned to hospitals same year
- Performance on each measure would be publicly reported
- Both attainment and improvement would be rewarded
- Performance score calculations and resulting incentive payments would be subject to an appeals process

Key Implications

- Quality performance would affect financial performance in a direct way
- Likely would accelerate similar pay-for-performance programs in the private sector
- The program would further highlight hospital board fiduciary responsibility as it relates to quality
- There would be a host of new legal issues that would arise in connection with performance standards, measurement, other uses of publicly available poor performance data, and the appeals process, among others

Pay-for-Reporting Expansion for Physicians, Rehab Facilities, LTACs, Hospices, Cancer Hospitals, HHAs, and SNFs

- More quality measures would be selected and adopted for the various care settings, and incentive payments would be extended and expanded (and reductions potentially put in place in future years) for physicians, HHAs, and SNFs
- Beginning in 2014, payment would be reduced by 5% if an aggregation of the physician's "resource use" is at or above 90% of national utilization
- The Secretary is required to put into place a budget-neutral payment modifier to FFS physician payment qualifier based on quality and cost measures, with payment consequences beginning in 2015
- Measurement of hospital-acquired conditions (HACs), reporting the results and in the future reducing payments to hospitals with high HAC rates

Key Implications

- Increased/improved reporting
- More compliance obligations
- Possible financial impacts, good and bad
- Much potential debate, and formal rulemaking, as to the right measures of quality and costs and methods of implementing payment modifiers

National Strategy to Improve Healthcare Quality

- Strategy would be comprehensive and far-reaching in developing priorities to improve overall population health; improve patient safety, health outcomes and patient-centeredness; reduce preventable hospital admissions and readmissions; reduce healthcare disparities; address gaps in quality and efficiency; improve payment policy to emphasize quality and efficiency; and enhance the use of data to improve quality, efficiency, transparency, and outcomes
- Secretary of DHHS is instructed to work with a broad array of stakeholders from the public and private sector; seek to align public and private payer approaches to quality; and convene an inter-agency working group among federal agencies

National Strategy… *(cont.)*

- The Secretary would update the national strategy not less than triennially, with the first report due December 31, 2010
- The Secretary would be required to identify gaps in measures and fill them
- $50 million provided each year for five years to fund strategy and measure development

Key Implications

- The structure for a regular, comprehensive public-private strategic planning process and dialogue with a focus on quality and population health is put in place
- Such a process is likely to trigger regular and repeated change and possible innovation
- Regular development and implementation of new measures would take place
- Additional legal issues, transactions, regulatory compliance, and other matters likely would result

Accountable Care Organizations (ACOs)

- ACOs eligible for bonuses beginning in 2012 are defined as group practices, networks of practices, joint ventures between hospitals and practitioners, hospitals employing practitioners, among others the Secretary determines appropriate
- Voluntary process to seek to meet criteria, obtain recognition as ACO, and qualify for an incentive bonus

Accountable Care Organizations (ACOs)

- Criteria:
  - Agree to become accountable for the overall care their Medicare fee-for-service beneficiaries
  - Agree to a minimum three-year participation
  - Have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers
  - Include the primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries
  - Have arrangements in place with a core group of specialist physicians

Accountable Care Organizations (ACOs)

- Criteria *(cont.)*:
  - Have in place a leadership and management structure, including with regard to clinical and administrative systems
  - Define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care
  - Demonstrate to the Secretary that it meets patient-centeredness criteria determined by the Secretary, such as use of patient and caregiver assessments or the use of individualized care plans
- A formula related to total per-beneficiary spending (for those Medicare beneficiaries assigned to an ACO) would be the basis for possible shared-savings payments to the ACO

Key Implications

- Organizational structuring and transactions related to forming qualifying ACOs or revising existing organizations, especially in light of current antitrust, Stark law, and anti-kickback requirements
- Application process for recognition as an ACO
- Development of similar private market arrangements between payers and providers
- Lots of new contracts
- New management jobs and Board positions, with concomitant responsibilities
- Compliance requirements for the ACOs with the new qualification and payment rules
- Penalties for non-compliance

CMS Innovation Center

- To be established by January 1, 2011
- Authorized to test, evaluate, and expand different payment structures and methodologies that would aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth
- Significant detail in what the Center is to test and what criteria to use, all reflecting current thinking about quality, cost efficiency, and evidence-based medicine
- $10 billion would be appropriated from the Part A and Part B Trust Funds to the Center over 10 years

Key Implications

- Possible widespread ultimate adoption of these kinds of models and approaches in the Medicare program
- An ongoing public-private dialogue on best practices
- Accelerated innovation and development in the private sector as a result of the federal effort
- Transactional, governance, regulatory, compliance, and other legal consequences, many unforeseen today, including new legislation to implement successful models

Bundled Payments

- The Secretary would be required to develop, test, and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013
- The Secretary would be required to determine which Medicare statutory provisions and related regulations would be appropriate to waive in order to conduct the pilot program (including waiving the anti-kickback and civil monetary penalty statute after consultation with the Inspector General)
- The Secretary is instructed to select eight conditions to be included in the pilot

Bundled Payments *(cont.)*

- Bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute care payments made over the hospitalization period per patient
- Payments could be made to a single provider or multiple providers, but acute hospital must be included
- If the Secretary finds that the pilot program results in significant improvements in quality and outcomes and reductions in cost, then the Secretary would be required to submit an implementation plan to Congress in FY2016 with recommendations regarding making the pilot a permanent part of the Medicare program in FY2018

Key Implications

- Potentially, this pilot could transform the Medicare payment system
- Significant new organizational structures and relationships among providers likely would result in response if payment changes are broadly adopted
- There would be many new implementing regulations and probably follow-up legislation
- Concomitant changes in private payment systems, some already beginning, would be likely

Reducing Avoidable Hospital Readmissions

- Starting in FY2013, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days and by 10% if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days
- Preventable readmissions would be defined as all readmissions that could have been reasonably prevented, as determined by the Secretary

Reducing Avoidable Hospital… *(cont.)*

- Hospitals with readmissions above the 75th percentile (based on 30-day rates) for selected conditions would be subject to readmissions payment policy related to the selected conditions
- Evidence-based measures, which may include condition-specific measures endorsed by NQF, would be used to calculate a national preventable readmissions benchmark by condition
- Additional funding also for evidence-based care transition services to high-risk patient

Key Implications

- Additional development, application, and debate of evidence-based measures
- Possible lowered reimbursement for some hospitals
- Additional reporting and compliance requirements

Extension of Gainsharing Demonstration

- Authority to conduct the gainsharing demonstration extended until September 30, 2011
- Date of the quality improvement and achieved savings report extended from December 1, 2008 to March 31, 2011

Key Implications

- Extension of shared-savings efforts
- Demonstration projects protected from CMP restrictions

Other Components in Subtitle A

- Home-based Chronic Care Management Program — for teams of healthcare professionals caring for patients with multiple chronic conditions in their homes
- Primary care/general surgery bonus for codes related to office visits, home visits, nursing facility visits, etc.
- Redistribute currently unused residency training slots to encourage increased training in primary care and general surgery, outpatient settings, and underserved areas
- Address health profession's workforce needs
- Promote residency training at community health centers and clinics

What Might Happen

- Political and press focus has been on access/insurance issues
- Widespread acceptance of value-oriented, care coordination concepts in the health policy community
- Not much amendment to Title III in markup
- House bills less detailed, but generally in accord
- If a health bill passes, these kinds of provisions, my guess, will be in there
- Additional legislation, regulations, and much delivery system activity to follow
- Stay tuned; this is a big deal being underreported