The Managed Care Paradigm Shift in the Post Reform Environment

FICPA Health Care Industry Conference
Breakout Session 20

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Today’s Agenda

- Where We Were, Where We are Going, And Why We Are Going There
- The New Realities
- Redefining The Delivery of Care – Making It Accountable
- Some “411” on Medical Homes
- Provider Realignment
- Clinical Integration – An End In and Of Itself; Not a Means to Another End
- Quality
- Payment Models of the Future?
- A Few Closing Comments
The New Realities

(REALITY CHECK AHEAD)

The Coming Storm
(Photo By Jonathan Knight)
The Current System is Not Sustainable

- Consider the economic backdrop:
  - $2 trillion, $400 billion dollars – This is amount spent on health care in the US alone – not taking into account Canada, Western Europe, Asia or anywhere else.
  - That represents more than 17% of our national GDP, with increases averaging about 7% per year.
  - By 2016, and before taking into account the costs of health care reform, healthcare spending was projected to surge to $4.1 trillion.

Effect of Health Care Reform on Hospital Economics

- Medicare and Medicaid payment cuts
- More insured lives (reduced bad debt and uncompensated care)
- Under new payment schemes, poor quality and inefficiency will have economic consequences
- “Expanding the DRG” – making hospitals the centerpiece of new payment and delivery models that go beyond the acute care hospital stay
Effect of Health Care Reform on Physician Economics

- Medicare cuts (especially for specialists)
- Health reform emphasis on reducing premiums, leading to reduced payments to providers
- Shift of $ from specialists to primary care
- Higher practice costs
  - Health Information Technology ("HIT")
  - Quality data reporting
  - Increased regulation
- Shifting payment from FFS to bundled payments and shared savings payments involving broader swath of the care continuum, i.e., more financial (performance) risk for providers

In the End It is All About Medicare
The Facts and Nothing But the Facts

- In the year 2000, Medicare provided coverage to 43.3 million seniors
- The first baby boomers reach the age of Medicare eligibility in 2011 (2008 eligibility for Social Security)
- By 2030, the year the last baby boomers reach Medicare eligibility, the number of people covered by Medicare will balloon to 78 million. A change from 43 to 78
- Need to become profitable at Medicare reimbursement levels due to changing demographics
- Shrinking ability to cost shift

Patient Protection and Affordable Care Act

- Section 3001 – Hospital Value-Based Purchasing Program
- Section 3022- Medicare Shared Savings Program
- Section 3023 – National Pilot Program on Payment Bundling
- Section 3025 – Hospital Readmissions Reduction Program
- Section 3008 – Payment Adjustment for Conditions Acquired in Hospitals
Where Is The Market Going …

- Patient-centered care
- Slowing the rate of cost growth
- What will be rewarded
  - Quality
  - Outcomes
  - Safety
  - Efficiencies

. . . How Does the Market Intend to Get Where It Now Thinks It Should Be

- Coordination/Integration
  - of health care services across treatment settings
- Reduction
  - in the cost of health care services
  - of preventable hospitalizations
  - of emergency room visits
  - of hospital readmissions
- Improvement
  - in quality and health outcomes
  - in patient and family-caregiver satisfaction
  - in the efficiency of care
Redefining The Care Models

Hospital Physician Alignment

- Hospitals need to enlist physician support to meet quality targets and earn the pay for performance incentive payments
- Physicians need to enlist hospitals to help with systems to drive quality across the continuum of care
- CMS adoption of goals of quality and efficiencies
Re-Setting the Bar and Innovating the Offering
The Olympic Gold Medal Winners in High Jump Analogy*

*Source: Richard Pascale

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Rethink the Organization of Care

Accountable Care Organizations

- Acute Care Episode with PAC Bundling
- Post Acute Care Episode Bundling

Primary Care Physicians
Specialty Care Physicians
Outpatient Hospice Care and ACOs
Ambulatory Care
Long-term Acute Care
Ambulatory Care
Subacute Nursing Facility Care
Home Health Care

Medical Home

Source: American Hospital Association
The Triple Aim Journey (Institute for Healthcare Improvement):

- Organizing Care To:
  - Improve the health of the population
  - Enhance the patient experience of care (including quality, access, and reliability); and
  - Reduce, or at least control, the per capita cost of care.

Source: http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

The Triple Aim Journey (Institute for Healthcare Improvement):

- Initial set of components of a system that would fulfill the Triple Aim:
  - Focus on individuals and families
  - Redesign of primary care services and structures
  - Population health management
  - Cost control platform
  - System integration and execution
The Triple Aim Journey (Institute for Healthcare Improvement):

- The Triple Aim concept includes roles for “macro” and “micro” integrators
  - The macro-integrator is not necessarily a new structure or organization, but rather an entity that can pull together the resources to support a defined population
    - Ensures the system is optimized for the sake of the defined population
    - Works with and helps to improve the front-line systems that support individuals.
  - The micro-integrator is the person or team that makes sure that the best and most appropriate care is provided to individuals
    - A primary care team or “medical home” could fulfill this role as well, and there are likely to be other workable approaches to micro-integration.

Patient Centered Criteria

- Ongoing patient experience evaluation
- Patient involvement with governance
- Evaluating population needs and diversity
- Identifying high risk individuals
  - Use of individualized care plans
  - Use of community resources
Patient Centered Criteria

- Coordination of care
  - Use of EHRs and exchange of e-information between sites of care
- Communicating clinical knowledge
  - Use of shared decision making
- Beneficiary access to medical records
  - Written standards that describe related policies and procedures
- Internal Process to measure clinical service by physicians
  - As part of the quality assurance program requirements

Overarching Goals Of Realignment

- Better healthcare
  Improve individual patient experiences of care along the IOM 6 domains of quality: Safety, Effectiveness, Patient-centeredness, Timeliness, Efficiency, and Equity
- Better health
  Encourage better health for entire populations by addressing underlying causes of poor health, such as physical inactivity, behavioral risk factors, lack of preventive care and poor nutrition
- Reduced costs
  Lower the total cost of care resulting in reduced monthly expenditures for Private Pay, Medicare, Medicaid or CHIP beneficiaries improving care
Overarching Goals (cont.)

- To put the beneficiary and family at the center of all its activities.
- To ensure coordination of care for beneficiaries regardless of its time or place.
- To attend carefully to care transitions.
- To manage resources carefully and respectfully, make investments where necessary, and move resources to meet beneficiaries’ needs.
- To continually reduce its dependence on inpatient care.
- To be proactive by reaching out to patients with reminders and advice that can help them stay healthy and let them know when it is time for a checkup or a test.
- To collect, evaluate, and use data on healthcare processes and outcomes sufficiently to measure what it achieves for beneficiaries and communities over time and use such data to improve care delivery and patient outcomes.
- To be innovative in the service of the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures.
- To invest in the development and pride of its own workforce, including clinicians.

The Accountable Care Organization

How to Create Accountable Care Organizations
Harold B. Miller
In Search of An Accountable Care Organization

- http://www.youtube.com/watch?v=IF8bK7AJyL0

... In Search of Accountable Care

Clinical Efficiency

Operational Efficiency
Designing An Accountable Health Organization

- Locally focused on quality and cost across the continuum of care
- Inter- and multi-disciplinary care coordination
- Built on collaboration and shared responsibility/accountability
- Reliant upon transparency for the consumer and ability to capture and report data
- Limited not on a single group of providers (medical home) or episode of care (bundled payments)
- Migration from volume/intensity of care to efficiency and quality

The Medical Home

www.mwe.com
Medical Home

- Unlike an ACO, the Medical Home is not responsible or accountable for the total cost of care or population level quality of outcomes
- The Medical Home is not a gatekeeper. It functions as a:
  - Coordinator
  - Trusted Advisor
  - Without imposing financial penalties on either patient or provider

Concierge Medicine for the Masses – The Medical Home

- A personal physician, directly accountable to the patient for the full range of care, rather than being a gatekeeper, leverages the resources of the medical home to coordinate and facilitate the care of patients . . . advocating for and providing guidance to patients and their families as they negotiate the health care system
- Goals and Objectives
  - the right care, at the right time, in the most appropriate setting
  - minimize overtreatment or under-treatment and efficiently allocate resources while improving the overall quality of care
  - guided by evidence-based medicine
  - enhanced access to care
Hospital-Physician Alignment Before Health Care Reform

- Characterized by:
  - Shared interest in increasing **volume** of profitable acute inpatient interventions
  - Shared interest in increasing **volume** of profitable ambulatory/outpatient services paid on a fee-for-service ("FFS") basis, e.g., ambulatory surgery, leading to
    - Competition
    - Joint ventures
  - Limited incentives for collaboration in reducing costs and improving quality

Hospital-Physician Alignment After Health Care Reform

- Increasingly focused on:
  - Acquiring or otherwise integrating physician practices
  - Benefiting from, commercial and governmental payor value-based purchasing initiatives
  - Creating Accountable Care Organizations ("ACOs") and other coordinated care organizational initiatives designed to benefit from new payment models
We Haven't Been There, We Haven't Done That

- Insurance Risk (based on the numbers and types of diseases that occur in a population)
  - Panel of patients
  - Scrum for Share of Revenue
  - Charge Based
  - Managed Care Leverage
  - Pay for quantity (covered lives)
  - Episode of care focused
  - Split control and governance
  - Do more
  - Intervention
  - Clinical Integration to achieve antitrust compliance

- Performance Risk (based on what is done to mitigate diseases, a function of the numbers and types of treatments that are applied)
  - Population of patients
  - Rational Allocation of Revenue
  - Value Based
  - Care Coordination
  - Pay for quality
  - Patient-centric focused
  - Physician leadership
  - Do less
  - Prevention
  - Clinical Integration to achieve efficiencies and quality improvement

Integration Is More Than Collaboration

- Benchmarking and benchmarks
- Monitoring, Reporting, Counseling
- Performance Improvement Tools
- Technology Infrastructure (e.g. EHR)
- Accountability of Participants and Sanctions (Financial and Non-Financial)
- Performance Based Compensation
  - Quality Attainment
  - Quality Improvement
**Clinical Integration**

Source: Healthcare Informatics and FTC

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**Pro-competitive efficiencies**

- “Raise the Quality Bar and “Bend the Cost Curve”
  - Deliver services efficiently
  - Reduce practice variances
  - Enhance provider knowledge base
  - Realize benefits of clinical data exchange
A Rose By Any Other Name

- Old School Inquiry: Is joint pricing reasonably necessary to accomplish the clinical integration goals? How does joint contracting with payors contribute to accomplishing the program’s clinical goals?
- New School Inquiry: Is there a sufficient high degree of interdependence and cooperation among the providers to “raise the quality bar” and “bend the cost curve.”

Achieving Clinical Integration

- What specific activities will (and should) be undertaken?
  - How does this differ from what each provider already does individually?
  - What ends are these collective activities designed to achieve?
- How do the providers expect to actually to accomplish these goals?
  - What infrastructure and investment is needed?
  - What specific mechanisms will be put in place to make the program work?
  - What specific measures will there be to determine whether the program is in fact working?
Achieving Clinical Integration

What basis is there to think that the individual providers will actually attempt to accomplish these goals?

- How are incentives being changed and realigned?
- What specific mechanisms will be used to change and re-align each individual provider’s incentives?

What results can reasonably be expected from undertaking these goals?

- Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?
- To what extent is the potential for success related to the system’s size and range of services?

It is going to be all about “Quality”
Today’s ABCs – The Concepts

- **CPG/Clinical Practice Guidelines**
  - “Systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances” (Field & Lohr 1990)
  - Can be generated
    - through a professional consensus process
    - more directly on hard, empirical evidence

- **EBM/Evidence Based Medicine**
  - “The judicious use of the best current evidence in making decisions about the care of the individual patient integrating clinical expertise with the best available research evidence and patient values”

Today’s ABCs – The Sources

- **NQF – National Quality Forum**
  - A nonprofit organization operating under a three-part mission to improve the quality of health care by:
    - Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
    - Endorsing national consensus standards for measuring and publicly reporting on performance; and
    - Promoting the attainment of national goals through education and outreach programs.
Today’s ABCs – The Sources

- AHRQ – Agency for Healthcare Research and Quality
  - Part of the U.S. Department of Health and Human Services, AHRQ is dedicated to improving the quality, safety, efficiency, and effectiveness of health care for all Americans
  - http://www.ahrq.gov

- NGC - The National Guideline Clearinghouse
  - Publicly available database of evidence-based clinical practice guidelines and related documents. It provides Internet users with free online access to guidelines

Additional Sources for Benchmarks

- The Specifications Manual for National Hospital Quality Measures, published by the Joint Commission
  - Collaborative effort of CMS and The Joint Commission; uniform set of national hospital quality measures

- The American Medical Association/Physician Consortium for Performance Improvement (PCPI)
  - Focused on quality of care and patient safety; development, testing, and maintenance of evidence-based clinical performance measures and measurement resources for physicians
Essential Program Components

- Opportunities for improvement in the overall quality, efficiency, and effectiveness of the care provided to patients
- Transparency, quality controls and safeguards against influencing physician decisions regarding the referral of patients
- No adverse effects on, or diminution in, the quality of patient care services
- Quality targets selected for, and compensation designed to reward, improving patient care
- Public scrutiny
- Physician accountability

Do’s and Don’ts of Adopting Quality Bonus Criteria

- Be prepared to explain (and have documented) how the selected/proposed criteria will be utilized as part of an overall continuous quality improvement program
- All criteria should be screened initially to ensure that they are, and documented as being, "patient-centric" as opposed to "physician/hospital centric"
- Criteria should address a documented and known "gap" or "deviation" in care/performance, which will have a positive effect on outcomes/quality
### Process Measures v. Outcomes

**Focus of Measures**
- Patient safety
- Clinical Effectiveness
- Utilization
- Cost management
- Patient satisfaction

**Structural Measures**
- Investment in and use of EHR
- Investment in and use of CPOE

**Process Issues**
- Uniform system of reporting
- Uniform measurement
- Audit of data

### Gating Questions

- How was the reliability of the performance metric determined in terms of patient-centric improvement in the quality of care?
- What is the documented justification for adopting the selected quality measure including addressing why the payor is interested in this metric; what patient-centric beneficial outcomes is intended to be achieved by adopting and using this metric?
- How is the payor going to measure, record and document actual performance against the metric?
- What steps were taken to identify, as if necessary address, unintended consequences of the metric that could have an adverse effect on the care provided, and accessible to, patients?
The Law of Unintended Consequences

- **Stinting**
  - Limiting patients' use of quality-improving but more costly devices, tests or treatments.

- **Quicker-sicker discharge**
  - Discharging patients earlier than clinically indicated either to home or to post acute care settings

- **Cherry-picking**
  - Treating only healthier patients

- **Steering**
  - Avoiding sicker patients

Limited Regulatory Guidance

- **OIG Advisory Opinion 08-16** (relating to a hospital's proposed performance-based compensation sharing arrangement)

- **Proposed rule 42 CFR 411.357** (the Stark exception for Incentive Payment and Shared Savings Programs)
When Should You Be Shown the Money?

- Superior care coordination
- Improved access to care
- Improved outcomes
- Patient communication and education
- Patient satisfaction
- Preventive care and chronic condition management

The Jury Is Still Out

- Need for empirical evidence regarding specific behavior changes
- Need for empirical evidence on whether changes have lead to any improvements
- Right Focus: Quality metrics not utilization metrics
- Is it an illusion – are perceived improvements driven by better data rather than quality improvement
- Teaching to the Test Syndrome
  - Gaming of Data
  - Redlining (i.e. refusing to treat complex patients/cases)
  - Ignoring other aspects of the QI continuum
- Is a shift from achievement of benchmarks (attainment) to incremental performance and outcome improvement required
Payment Models of the Future

Frank and Ernest

“Pay for Quality” Model

- Payor
- MDs
- Hospital
- Medical Staff Entity

P4P Contract

Per Capita Distributions

Up to 50% of P4P Dollars

OH WOW! PARADIGM SHIFT!
“Pay for Quality” Model

- Physicians create a legal entity to be owned by all physicians who have been on the active medical staff in relevant departments for at least one year ("PO")
- Each physician makes an equal capital contribution to provide for the PO’s working capital
- The physician-investors commit to practice in compliance with certain protocols calculated to assist hospital in meeting quality performance metrics

“Pay for Quality” Model

- The PO contracts with the hospital; agrees to:
  - Cause its physicians to make the changes in clinical behavior calculated to assist hospital in achieving quality metrics
  - Provide management services related to the quality initiative
- Hospital payment to the PO is based on percentage of pay for performance dollars earned by the hospital (up to 50%) and then distributed to the physicians on an equal or per capita basis
Bundled Payment/Episode of Care

- PPACA mandates a pilot program
- Single payment for all professional and facility component services rendered during an episode of care involving a hospitalization
- Episode of care includes:
  - 3 days prior to hospitalization
  - during length of inpatient stay
  - 30 days post discharge
- The Secretary of HHS must select up to 10 clinical conditions
- No requirements to date as to how the bundled payment is to be redistributed to the care providers

ProvenCare Process

- Identify eligible patients
- Document appropriateness
- Enroll and activate the patient and family
- Deliver evidence-based care
- Geisinger is paid a global fee
- One fee for the entire identified period of time
- Global fee includes 50% share of historical readmission rate (guaranteed payer savings, Geisinger upside based on complication and readmission reduction and efficient care
ProvenCare - Health Policy Considerations

- Access to health insurance is key
  - Should include regional plans (provide flexibility and innovation)
- Formation of Integrated Systems should be facilitated
  - Bundled payments
  - Episode of care payments
  - Treatment based – not insurance risk
  - Accountable care organizations
  - “Cost saving” shared with providers
- Healthcare Information Technology
  - Computers and Electronic Health Records are necessary, not sufficient
  - Redesign of care required
  - Ongoing upgrades needed
- Comparative effectiveness research
- Training of next generation

Geisinger: ProvenCare FAQ

- Why travel to Geisinger for a ProvenCare™ procedure?
  - Patients who undergo a ProvenCare surgery or procedure/process of care at Geisinger receive the best available information and techniques every time. We follow and document each of the benchmarks of care during each procedure. Experts tell us that these benchmarks are consistently performed and documented in only about half the time at other hospitals.

- How does ProvenCare help avoid errors?
  - Based on leading edge medical data, we’ve documented the best practices for our ProvenCare procedures and now require our doctors to follow these guidelines. In addition, a system of checks and balances holds various members of the surgical team responsible for elements of the patient’s care. These checks are built into the patient’s Electronic Health Record and ensure that the steps are documented and cross-referenced.
  - Clearly, avoiding errors is a never-ending struggle. But having a reliable system in place to help each member of the surgical team do all the right things the right way at the right time is critical in minimizing errors. Obviously it isn’t possible to get a complication/readmission rate to zero, but that’s what we strive for.

Source: http://www.geisinger.org/provencare/faq.htm

www.mwe.com
What’s the deal with the “warranty?”

- ProvenCare has a key financial piece that the media has labeled “surgery with a warranty.” While no surgical procedure comes with a guarantee, the ProvenCare program is about more than continually providing the highest level of service. If a patient experiences an avoidable complication within 90 days of the procedure, we’ll cover the entire cost of any follow-up care provided by a Geisinger clinician or if it’s provided at a Geisinger facility.

- Right now, this financial element applies only to members of Geisinger Health Plan, which insures 206,000 people within 40+ counties in Pennsylvania. We would like to expand this part of ProvenCare to other insurance groups.

- The most important part of ProvenCare is the absolute commitment to providing the best possible care every time. Unless there is a substantial medical reason not to, all of our elective CABG patients receive the 40 best practice steps. In fact, our doctors don’t even know the patient’s insurance carrier when they operate.

Source: http://www.geisinger.org/provencare/faq.html

Are you the first healthcare provider to use this system?

- Geisinger’s heart surgery team was the first to participate in an inpatient acute (short-term) care program that uses the Electronic Health Record and pay for performance principles to improve care and reduce costs. While the ingredients have been around for a while, we’ve combined them in a novel way.

How many ProvenCare programs have been developed?

- The following ProvenCare programs are now underway: coronary artery bypass graft (CABG), hip replacement, cataract surgery, PCI/angioplasty, perinatal care, bariatrics, low back pain, and erythropoietin management.

Source: http://www.geisinger.org/provencare/faq.html
ProvenCare - All or None Measures

- Measure percentage of patient who receive all related services (not individual measure alone)
- Most all or none measures will not reach 100%
- Some goals not appropriate for all patients, some goals not achievable for all patients

ProvenCare CABG Financial Results

- Average total LOS fell 0.5 days (6.2 vs. 5.7)
- 30-day readmission rate fell 44%
A Few Closing Thoughts

If You Don’t Study History, You Are Doomed to Repeat History
Disruptive innovation (a/k/a Thinking Outside of the Box)

- A term coined by Harvard Business School Professor Clayton Christensen, describes a technology, process, or business model that enables more consumers in the market to afford and/or have the ability to use a product or service. The change caused by such an innovation is so big that it eventually replaces, or disrupts, the established approach to providing that product or service.

- In the health and health care arena, services historically have been designed and delivered with providers' needs in mind. They also tend to be procedure-oriented, treating patients more as passive recipients than engaged participants in the care process. Recasting patients as consumers puts them in an active role and challenges the system to meet consumers' interests in managing their health and health care in ways that are more affordable, accessible, simple, and convenient.

- Consider how shifts or changes in the marketplace can help consumers manage their health and health care—how they want to, where they want to, when they want to. What such innovations produce ought to make sense to consumers and respond to what they value.

Source: Robert Wood Johnson Foundation

The Last Word .................

- If you don’t like change, you are going to like irrelevance even less
  – Tom Peters

- Shift Happens
  – Jim Feldman
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