SGR and Medicare Physician Reimbursement

A View From the Delivery System Perspective

Nicholas Wolter MD
Billings Clinic
Who We Are

Multispecialty Group Practice at the Core

- Community governed, physician led, patient centric
- Merger/Integration of a MSGP and Community Hospital in 1993 → NFP
- Organized clinical care
- One patient record (& bill)
- Multiple clinical providers, but one team
- An obsessive dedication to quality and service

- 3600+ Employees
  - Group practice w/250 Physicians, 75 NPs and PAs, 10 clinic locations
  - 272 (230) bed level II trauma & tertiary referral hospital
  - Manage/support 10 CAHs
  - 3rd largest employer in Montana
- Board of Directors: Community-based w/ MDs included
- “Internal Board”: Leadership Council
  - Physicians and Administrators
Who We Are

An outstanding medical foundation built upon the following cornerstones:

• A multi-specialty physician group practice in which a “community of physicians” work together in a collegial manner is at the core of this model.

• The partnering of physicians, excellent business managers, professional staff, and volunteers create a team whose synergies drive our success.

• Not-for-profit, community-owned and governed.

• Mission-driven decision-making dedicated to a higher purpose in the community and the region.

• An obsessive dedication to quality and service.
Billings Clinic
Physician Group Practice

Decision Making Processes/Places

• Departments and Chairs
• Department Chair Meetings
• Divisions- Primary Care, Surgery, Region
• All Physician Meetings
• Hospital Clinical Units
• Physician Compensation Committee
• Leadership Council
• Administration (SET- Senior Executive Team)
• Physician Chief Executive Officer
• Board of Directors
• CMO Hospital, CMO Clinic, Chief Quality/Safety Officer
Vision

• 2005  Best in Nation Safety, Quality, Service
• 2010  Best in Nation Safety, Quality, Service, Value
Early Adoption and Innovation

- CMS Physician Group Practice Demonstration and Transition Demo
- Magnet Designation
- Complexity Theory Initiatives
- Medicare Shared Savings Pilot
- Bundling: Hip & Knee
Early Adoption and Innovation

• Leadership Billings Clinic
• Physician Leadership HayGroup Project
• BCBS Medical Home Project
• NCQA ACO Designation
• Operational Excellence (Lean Six Sigma)
• Cerner Partnership
Early Adoption and Innovation

- Mayo Clinic Care Network
- New West Health Services (Medicare Advantage)
- Research and Center for Translational Research
- Board Quality and Safety Committee
- Internal Medicine Residency
Quality and Patient Safety Recognition

HealthGrades Distinguished Hospital Award for Clinical Excellence

Solucient 100 Top Hospitals in America Modern Healthcare and Truven Health Analytics
2004, 2013

Magnet™ Designation by the American Nurses Credentialing Center

HealthGrades Distinguished Hospital Award for Patient Safety

National Cancer Institute Community Cancer Centers Program
2008 – 2014

“A” Rating for Hospital Safety by The Leapfrog Group
2011, 2012

Accredited as an Accountable Care Organization by The National Committee for Quality Assurance
2012

Rated #1 in Nation for Patient Safety by Consumer Reports ®
2012

US News and World Report Best Regional Hospitals - #1 in Montana for Diabetes and Endocrinology, Gynecology, Nephrology and Pulmonology
2012-2013
PGP Demo: Financial Outcomes

Savings:

Year 1: $9.5M, 2 org → $7.3M
Year 2: $17M, 4 orgs → $13.8M
Year 3: $32.3M, 5 orgs → $32.3M
Year 4: $37.8M, 5 orgs → $31.7M
Year 5: $36.2M, 4 orgs → $29.4M

5 yr. Savings Total = $133M* $115M shared with 6 orgs
1 org captured >50% total
5th year savings payment reflects 1.8% of net patient expend

For most, savings < ↓ revenues/business costs of implement.

Risk adjustment was significant factor in performance

Data feedback problematic; reconciliation @ 18 months

True patient engagement hampered by retro attribution

Overall evaluation of success?

10 separate comparison groups and no national benchmark

*Only amounts >2% threshold are recognized, actual net $218M
PGP Demo: Clinical Outcomes

Clinical interventions applied to all patients, payer-neutral
Increased focus on population management and chronic disease
Increased outpatient utilization, decreased inpatient utilization.
Examples from PGP organizations:

40% reduction of HF hospitalizations ($4M+ revenue) for 15% pop
20% reduction in 1 day psych hospitalizations
Planned visits, improved PCP access to reduce emergency visits
Chronic condition management for anticoagulation, HF, lipids, diabetes, & 24/7 nurse triage
Risk stratification with case management for complex patients
Improved coordination for transitions in care

Significant spending on EMR optimization & quality reporting/documentation
All 10 orgs with significant quality achievement (year 5, 7@100%)
Billings Clinic ACO has approximately 12,000 beneficiaries
Must achieve about 2.8% in savings before any sharing

Exhibit 3. Minimum Savings Rates and Confidence Interval by Number of Assigned Beneficiaries for ACOs Participating in the One Sided-Model

<table>
<thead>
<tr>
<th>Number of Beneficiaries</th>
<th>MSR (low end of assigned beneficiaries)</th>
<th>MSR (high end of assigned beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000–5,999</td>
<td>3.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td>6,000–6,999</td>
<td>3.6%</td>
<td>3.4%</td>
</tr>
<tr>
<td>7,000–7,999</td>
<td>3.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>8,000–8,999</td>
<td>3.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>9,000–9,999</td>
<td>3.1%</td>
<td>3.0%</td>
</tr>
<tr>
<td>10,000–14,999</td>
<td>3.0%</td>
<td>X</td>
</tr>
<tr>
<td>15,000–19,999</td>
<td>2.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>20,000–49,999</td>
<td>2.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>50,000–59,999</td>
<td>2.2%</td>
<td>2.0%</td>
</tr>
<tr>
<td>60,000 +</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

MSR = minimum savings rate.
Source: Centers for Medicare and Medicaid Services, Medicare Shared Savings Program Final Rule, CMS–1345–F.
MSSP: Billings Clinic View

• Attribution improved- still retrospective, 60% stayer rate

• Threshold a problem for smaller populations (BC 12,000+ bens, 2.7% threshold)

• Quality/safety measures reasonable- reporting vs achieving benchmark issue

• Risk adjustment fixed for 3 years

• Beneficiary notification

• HCAHPS, CCAHPS
## Operational Excellence Savings

<table>
<thead>
<tr>
<th>Year</th>
<th>Dollar Total</th>
<th>% Operating Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$2,670,987</td>
<td>0.6%</td>
</tr>
<tr>
<td>2010</td>
<td>$3,821,665</td>
<td>0.9%</td>
</tr>
<tr>
<td>2011</td>
<td>$5,244,335</td>
<td>1.1%</td>
</tr>
<tr>
<td>2012</td>
<td>$9,945,136</td>
<td>2.1%</td>
</tr>
<tr>
<td>2013</td>
<td>$8,559,062</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
# Billings Clinic

## Annual Overall Charge Increase

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 2014</strong></td>
<td><strong>0%</strong></td>
</tr>
<tr>
<td><strong>FY 2013</strong></td>
<td><strong>1%</strong></td>
</tr>
<tr>
<td><strong>FY 2012</strong></td>
<td><strong>1%</strong></td>
</tr>
<tr>
<td><strong>FY 2011</strong></td>
<td><strong>4%</strong></td>
</tr>
</tbody>
</table>
Reference for Graph

• Data is from the expenditure reports provided to all MSSP ACO participants each quarter
• Expenditures do not include DSH or IME payments
• There is data from 220 MSSP ACO’s that started in 2013 represented on the graph
SGR

- Ineffective policy
- Has plagued providers and policymakers alike
- $170 billion fix
## PFS Update 5 year History

<table>
<thead>
<tr>
<th>Year</th>
<th>SGR scheduled Pmt Cut</th>
<th>Effective increase per CMS</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>-5.5%</td>
<td>1.1%</td>
<td>Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) – Extended through FY 2009. The update to the conversion factor was 1.1 percent</td>
</tr>
<tr>
<td>2010</td>
<td>-21.3%</td>
<td>1.3%</td>
<td>Patient Protection and Affordable Care Act of 2010 (ACA) – Extended through FY 2010. In June 2010, Congress passed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMB), which prevented physician payment reductions until December 1, 2010. PACMB legislation not only blocked a 21.3% reduction in physician payment rates then mandated by the SGR, but it also provided a 2.2% increase. Next Congress passed the Physician Payment and Therapy Relief Act of 2010, which contained a one-month extension, freezing payment rates through December 31, 2010. The additional 2.2 percent was continued during December by the one-month extension.</td>
</tr>
<tr>
<td>2011</td>
<td>-25.0%</td>
<td>0.9%</td>
<td>The Medicare and Medicaid Extenders Act of 2010 was passed in December and maintained PPTRA’s physician payment rates, avoiding a scheduled 25% payment cut.</td>
</tr>
<tr>
<td>2012</td>
<td>-27.4%</td>
<td>0.0%</td>
<td>Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) Section 301 of the TPTCCA specified a zero percent update to the PFS claims from January 1, 2012 through February 29, 2012. February 22, 2012, the MCTRJCA was signed into law. Section 3003 extended the zero percent PFS update to the remainder of CY 2012.</td>
</tr>
<tr>
<td>2013</td>
<td>-26.5%</td>
<td>0.0%</td>
<td>Reflects the zero percent update for calendar year 2013 adopted by section 601(a) of the American Taxpayer Relief Act of 2012.</td>
</tr>
</tbody>
</table>
## PFS Update History

### Table 6. Actual Past Medicare Economic Index Increases and Physician Updates for 1992-2013, and Estimated Values for 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Medicare Economic Index Increase</th>
<th>Physician Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td>3.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>1993</td>
<td>2.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td>1994</td>
<td>2.3%</td>
<td>7.0%</td>
</tr>
<tr>
<td>1995</td>
<td>2.1%</td>
<td>7.5%</td>
</tr>
<tr>
<td>1996</td>
<td>0.0%</td>
<td>0.8%</td>
</tr>
<tr>
<td>1997</td>
<td>2.0%</td>
<td>0.6%</td>
</tr>
<tr>
<td>1998</td>
<td>2.2%</td>
<td>2.3%</td>
</tr>
<tr>
<td>1999</td>
<td>2.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>2000</td>
<td>2.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>2001</td>
<td>2.1%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2002</td>
<td>2.6%</td>
<td>-4.8%</td>
</tr>
<tr>
<td>2003</td>
<td>3.0%</td>
<td>1.4%</td>
</tr>
<tr>
<td>2004</td>
<td>2.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td>2005</td>
<td>3.1%</td>
<td>1.5%</td>
</tr>
<tr>
<td>2006</td>
<td>2.8%</td>
<td>0.2%</td>
</tr>
<tr>
<td>2007</td>
<td>2.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2008</td>
<td>1.8%</td>
<td>0.5%</td>
</tr>
<tr>
<td>2009</td>
<td>1.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>2010</td>
<td>1.2%</td>
<td>1.3%</td>
</tr>
<tr>
<td>2011</td>
<td>0.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>2012</td>
<td>0.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2013</td>
<td>0.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2014</td>
<td>0.7%</td>
<td>-24.4%</td>
</tr>
</tbody>
</table>

#### Average Annual

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Medicare Economic Index Increase</th>
<th>Physician Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992-2014</td>
<td>2.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>1998-2014</td>
<td>1.9%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>1992-2013</td>
<td>2.1%</td>
<td>1.7%</td>
</tr>
<tr>
<td>1998-2013</td>
<td>2.0%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

#### Cumulative

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Medicare Economic Index Increase</th>
<th>Physician Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992-2014</td>
<td>59.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td>1992-2013</td>
<td>57.9%</td>
<td>44.9%</td>
</tr>
</tbody>
</table>

*Notes: For 2003, 2004, 2010, and 2011, the update shown is a weighted average annual update. For 2006, the Deficit Reduction Act froze the physician fee schedule conversion factor. The conversion factor freeze, together with refinements to the relative value units, resulted in an update of 0.2 percent for 2006.*

Potential Offsets to Pay for SGR Reform

• E&M cut – $11 billion
• Post-acute care cuts -- $50 billion
• Beneficiary cost-sharing changes -- $55 billion
• Drug rebates and related policies $100+ billion
<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>Average Compensation per Work RVU</th>
<th>Medicare Payment per Work RVU</th>
<th>Billings Clinic difference per Medicare Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEUROSURGERY/NEUROLOGY</td>
<td>$ 85.61</td>
<td>$ 34.02</td>
<td>$ 51.59</td>
</tr>
<tr>
<td>PSYCHIATRY</td>
<td>$ 80.35</td>
<td>$ 34.02</td>
<td>$ 46.33</td>
</tr>
<tr>
<td>INTERNAL MEDICINE</td>
<td>$ 68.48</td>
<td>$ 34.02</td>
<td>$ 34.46</td>
</tr>
<tr>
<td>ONCOLOGY</td>
<td>$ 77.25</td>
<td>$ 34.02</td>
<td>$ 43.23</td>
</tr>
<tr>
<td>DIABETES/ENDOCRINOLOGY</td>
<td>$ 86.59</td>
<td>$ 34.02</td>
<td>$ 52.57</td>
</tr>
<tr>
<td>FAMILY PRACTICE</td>
<td>$ 65.93</td>
<td>$ 34.02</td>
<td>$ 31.91</td>
</tr>
<tr>
<td>CARDIOLOGY/CV SURGERY</td>
<td>$ 63.55</td>
<td>$ 34.02</td>
<td>$ 29.53</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>$ 68.92</td>
<td>$ 34.02</td>
<td>$ 34.90</td>
</tr>
<tr>
<td>SURGERY</td>
<td>$ 60.72</td>
<td>$ 34.02</td>
<td>$ 26.70</td>
</tr>
</tbody>
</table>
### Fiscal Year 2012

**Losses for RVU Based Departments**

<table>
<thead>
<tr>
<th>Department</th>
<th>Operating Profit (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>($986,072)</td>
</tr>
<tr>
<td>Psychiatric (BHC)</td>
<td>($2,506,317)</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>($1,487,923)</td>
</tr>
<tr>
<td>Oncology</td>
<td></td>
</tr>
<tr>
<td>Infusion Center</td>
<td>($2,583,029)</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>$1,349,059</td>
</tr>
<tr>
<td></td>
<td>$597,699</td>
</tr>
<tr>
<td>Family Practice</td>
<td>($1,714,024)</td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Cath Lab</td>
<td>($1,554,855)</td>
</tr>
<tr>
<td></td>
<td>$18,410,779</td>
</tr>
<tr>
<td>Cardiovascular Surgery</td>
<td>($920,661)</td>
</tr>
<tr>
<td>Orthopedics</td>
<td></td>
</tr>
<tr>
<td>Surgery Center</td>
<td>($661,260)</td>
</tr>
<tr>
<td></td>
<td>$3,297,701</td>
</tr>
<tr>
<td>General Surgery</td>
<td>($57,456)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>(1,830,139)</td>
</tr>
</tbody>
</table>
### Fiscal Year 2012

#### Service Line Profits (Loss)

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Profit (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>($13,458,229)</td>
</tr>
<tr>
<td>Specialty Medicine</td>
<td>($1,986,150)</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>$7,704,895</td>
</tr>
<tr>
<td>Medical/Surgical Inpatient Units</td>
<td>($12,860,425)</td>
</tr>
<tr>
<td>Critical Care Services</td>
<td>$2,752,170</td>
</tr>
<tr>
<td>Women’s &amp; Children</td>
<td>($2,835,154)</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>($6,664,916)</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>$27,253,612</td>
</tr>
<tr>
<td>Cardiac Services</td>
<td>$15,860,437</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$5,531,500</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>($4,843,359)</td>
</tr>
</tbody>
</table>
Why PCMH within ACO?

- Emphasizes prevention
- Encourages cognition/relationship over technology
- Less variation in utilization
- Allows for most efficient delivery methods: allied professionals, phone, e-mail, web-enabled
- Proven concept in other modern nations, staff-model HMOs
- Access closest to patients
- Promotes shared decision making
- Leverage point for post-hospital care
Medical Home and ACO

- Care Navigator
- NPs & PAs
- Medical Assistants
- Pharmacists
- 5% High Risk Patients Special Clinics
- PCMH 25-35% Patients
- Chronic Disease Management
  - CHF, DM, HTN
- (A Different “Site” of Outpatient Care in Many Ways)
Integrated Health Care Coalition

- Scott and White Healthcare
- Henry Ford Health System
- Munson Health System
- Billings Clinic
- Cleveland Clinic
- University of Michigan Health System
- Trinity Mother Frances (Texas)
- Indiana University Health
- Geisinger
- Essentia Health
- Gunderson Lutheran
IHCC E&M REFORM CRITERIA

• EHR w data platform allowing shared information between hospital and outpatient and clinic facilities and which is used in clinical decision making

• Use and application of data analytic tools including patient registries to improve patient care, including focusing on high cost/high volume conditions seen in ambulatory settings in order to more effectively address annual per capita costs
IHCC E&M REFORM CRITERIA

• Use of decision making tools to involve patients in shared decision making
• Provider access to care coordination support and activities in outpatient and clinic facilities
• Open access to outpatient primary care services for medicare beneficiaries within 48 hours across all ambulatory sites
IHCC E&M REFORM CRITERIA

• Consistent application of charity care and financial assistance across all sites
• Evidence that governing board, hospital leadership, and physicians are participating in integrated quality and safety improvement activities with measurable and transparent results
Medicare Payment Policy

- Many moving parts
- Conflicting messages at times
Medicare MD Payment Changes

• Primary care incentive program (2011-2015)
• Sequestration
• GPCI floors: practice expense and physician work
• Multiple procedure payment cuts for imaging services
Medicare MD Payment Changes

• Bundling of cardiology codes (ex stents)
• e prescribing incentives
• e prescribing penalties
External Forces Influencing the Current Payment Environment

Source: AHA, January 10, 2011 Report of the Task Force on Variation in Health Care Spending
Physician Self-Referral

• When physicians refer patients to facilities in which they have ownership (“self-referral”), the physicians receive payment for their professional services and share in the profits of the facilities they own.

• Potential for conflict of interest resulted in passage of the “Stark Law” in 1989.
Increasing Physician Ownership

• Prior to 2002 there were fewer than 50 physician-owned specialty hospitals, yet today there are perhaps as many as 235 nationwide.

• A 2008 national survey found that one in six physicians owned or leased advanced imaging equipment, and nearly one in seven owned or leased three or more types of medical equipment.
Physician Self-Referral: Volume

• Numerous studies have found that the volume of services provided is higher in areas with physician-owned specialty hospitals than in areas without specialty hospitals.
Self-Referral: Volume

• The growth in the volume of advanced imaging services is also positively associated with physician ownership.
• Baker (2010) found that once physicians began billing for the technical component of MRI services, they ordered more scans for their patients than they had before they owned or leased the equipment.
• Numerous older studies highlight the relationship between ownership of imaging equipment and increased utilization.
Hospital Volume Strategies

- Cardiac Services
- Imaging
- Orthopedics
- Other Surgical Specialties: Urology, ENT, General Surgery,
- Laboratory
Negative Margins

- Hospital Outpatient Care
- Primary Care: IM and Family Practice
- Geriatrics
- End of Life Care
- Long Term Care
## Comparison of Shared Savings Models

<table>
<thead>
<tr>
<th></th>
<th>PGP</th>
<th>TD</th>
<th>ACO</th>
<th>Pioneer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attribution</strong></td>
<td>retrospective All Specialty</td>
<td>retrospective Primary Care</td>
<td>retrospective Primary Care</td>
<td>retrospective Primary Care</td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td>Prior Year (2004)</td>
<td>3-year wt. Averaging</td>
<td>3-year wt. Averaging</td>
<td>3-year wt. Averaging</td>
</tr>
<tr>
<td><strong>Term (before rebasing)</strong></td>
<td>3--&gt;5 years</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Comparison</strong></td>
<td>Local Rate of growth</td>
<td>National Absolute amount</td>
<td>National Absolute amount</td>
<td>National 50% amount + 50% rate growth</td>
</tr>
<tr>
<td><strong>Threshold (MSR)</strong></td>
<td>2%</td>
<td>1.47%-4.65%</td>
<td>2-3.9% or 2%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td>80% above MSR</td>
<td>50% first dollar</td>
<td>50% above MSR or 60% first dollar</td>
<td>50% first dollar</td>
</tr>
<tr>
<td><strong>Quality Gate</strong></td>
<td>50%</td>
<td>80%, 90%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Quality Measures</strong></td>
<td>32</td>
<td>45</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td><strong>Loss Risk</strong></td>
<td>No</td>
<td>No</td>
<td>No (1 sided)</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Risk Adjustment</strong></td>
<td>retrospective updated yearly</td>
<td>prospective adjusted yearly</td>
<td>prospective fixed for term</td>
<td>prospective fixed for term</td>
</tr>
</tbody>
</table>
## Bundled Payment Initiative

**Major joint replacement or reattachment of lower extremity w/o MCC**

<table>
<thead>
<tr>
<th></th>
<th>Billings Clinic</th>
<th>Compare Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count of Anchor Admissions:</td>
<td>187</td>
<td>1,878</td>
</tr>
<tr>
<td>0-90 days post discharge spend:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Post Acute Care - Part A and B</td>
<td>$5,665</td>
<td>$5,073</td>
</tr>
<tr>
<td>Readmissions</td>
<td>$156</td>
<td>$408</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>$4,419</td>
<td>$2,328</td>
</tr>
<tr>
<td>Home Health</td>
<td>$737</td>
<td>$990</td>
</tr>
<tr>
<td>All Other</td>
<td>$353</td>
<td>$1347</td>
</tr>
</tbody>
</table>
Strengths/Opportunities

Readmissions: Billings Clinic’s cost for readmissions are well below the compare group and national benchmarks for high performing facilities.

Skilled Nursing Facility: Billings Clinic cost for post acute skilled nursing facilities is well above compare group and national benchmarks for high performing facilities.

Opportunity is to shift post acute discharge to home health or outpatient rehabilitation when clinically indicated. Both settings provide cost savings for Medicare.
Physician Quality Reporting System  
(Formerly known as Physician Quality Reporting Incentive [PQRI])  
Incentive to Penalty

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.5% of</td>
<td>2% of</td>
<td>2% of</td>
<td>2% of</td>
</tr>
<tr>
<td></td>
<td>Medicare B</td>
<td>Medicare B</td>
<td>Medicare B</td>
<td>Medicare B</td>
</tr>
<tr>
<td></td>
<td>PFS</td>
<td>PFS</td>
<td>PFS</td>
<td>PFS</td>
</tr>
<tr>
<td>2012</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1% of</td>
<td>.5% of</td>
<td>.5% of</td>
<td>Penalty to be</td>
</tr>
<tr>
<td></td>
<td>Medicare B</td>
<td>Medicare B</td>
<td>Medicare B</td>
<td>enacted for</td>
</tr>
<tr>
<td></td>
<td>PFS</td>
<td>PFS</td>
<td>PFS</td>
<td>non-reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1.5-2%)</td>
</tr>
</tbody>
</table>
# VBP in Context: Mandatory Delivery System Reforms for Hospitals

## VBP
- Begins October 1, 2012 (FFY 2013)
- Redistributes inpatient payments
- Budget neutral

## Readmissions
- Begins October 1, 2012 (FFY 2013)
- Cuts Medicare inpatient payments
- $7 billion cut /10 years nationwide

## HACs
- Begins October 1, 2014 (FFY 2015)
- Cuts Medicare inpatient payments
- $1.4 billion cut / 10 years nationwide.

## EHR Meaningful Use (ARRA)
- Incentives for qualifying hospitals now
- Cuts Medicare inpatient payments in FFY 2015 for hospitals that do not meet “meaningful use” standard
Implications of Mandatory Delivery System Reforms

• Hospitals will be competing against each other
• Play or pay

<table>
<thead>
<tr>
<th>VBP</th>
<th>Readmissions/HACs</th>
<th>EHR Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Best performers win</td>
<td>• No winners, only losers</td>
<td>• Carrot and stick</td>
</tr>
<tr>
<td>• Others break even or lose</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Medicare DRG $$$ at Risk for Quality Performance

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value Based Purchasing</strong></td>
<td>1% of All DRGs</td>
<td>1.25% of All DRGs</td>
<td>1.5% of All DRGs</td>
<td>1.75% of All DRGs</td>
<td>2.0% of All DRGs</td>
</tr>
<tr>
<td><strong>Hospital Acquired Conditions</strong></td>
<td>1% of All DRGs</td>
<td>1% of All DRGs</td>
<td>1% of All DRGs</td>
<td>1% of All DRGs</td>
<td>1% of All DRGs</td>
</tr>
<tr>
<td><strong>Re-admissions</strong></td>
<td>1% of All DRGs</td>
<td>2% of All DRGs</td>
<td>3% of All DRGs</td>
<td>3% of All DRGs</td>
<td>3% of All DRGs</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>2% of All DRGs</td>
<td>3.25% of All DRGs</td>
<td>5.5% of All DRGs</td>
<td>5.75% of All DRGs</td>
<td>6% of All DRGs</td>
</tr>
</tbody>
</table>
U.S. Health Care

Urgent need to:
• Slow cost growth
• Reduce cost curve growth
• Improve quality and safety
• Provide universal access
Total U.S. Spending

- 1999 1 Trillion
- 2010 2.6 Trillion 16% of GDP
- 2013 18% of GDP
- 2006-2016 will grow 6.9% per year
- 2016 4 Trillion 20% GDP
National Health Expenditures

• Grew 4.3% in 2012
• 3.9% per year 2009-2011
• 4 consecutive years record low growth for the first time in 50 years
• ? Recession and/or health system delivery changes
IOM September 2012

• $750 billion waste in healthcare per year
• Unnecessary services $210 b
• Inefficient care delivery $130 b
• Excess admin cost $190 b
• Inflated prices $105 b
• Prevention failures $55 b
• Fraud $75 b
The current model leads to waste and overuse

1. Unexplained variation in the intensity of med/surg services.
   - **Potential annual savings:** $600 billion

2. Misuse of drugs and treatments resulting in preventable adverse effects.
   - **Potential annual savings:** $52.2 billion

3. Overuse of non-urgent ED care.
   - **Potential annual savings:** $21.4 billion

4. Underuse of appropriate medications, such as generic hypertensives, asthma controllers
   - **Potential annual savings:** $5.5 billion

5. Overuse of antibiotics for respiratory infections
   - **Potential annual savings:** $1.1 billion

Source: NQF report Waste Not Want Not, July 2009

Transforming Healthcare Together™
Delivery System Fragmentation

• Culture of Autonomy
• Entrepreneurship
• Technology Advances
• Payment Policy: FFS, Physician Equity Models
• Law and Regulation
• Hospital Capability and Co-Dependency
• Professionalism and Ethics
Why clinical integration?

- Coordinate care across silos and over time
- Deliver evidence-based medicine at 100% levels
- Develop system approaches to the safest and most reliable care
- Manage cost of care optimally
- Provide access to all in a timely manner
IOM Crossing the Quality Chasm

Re-engineering the delivery system to meet six challenges

• Evidence based care processes
• Effective use of information technology
• Knowledge and skills management
• Development of effective teams
• Coordination of care across patient conditions, services, and settings over time
• Use of performance and outcome measurement for continuous quality improvement and accountability

National Academy of Sciences, 2001
IOM’s Description of Key Delivery System Characteristics

“Can be seen as a virtual blueprint for expansion of the multispecialty group model.”

Frances J. Crosson, M.D.
The Delivery System Matters
Health Affairs
November/December 2005
**Figure 4. Direction for payment and delivery system reform**

**Current FFS payment systems**
- Physician
- Inpatient & outpatient - hospital
- LTCH
- IRF
- Psych
- SNF
- Home health
- DME
- Lab
- Hospice
- Dialysis Services

**Recommended tools**
- Comparative effectiveness
- Reporting resource use
- Pay for Performance
- Individual services “bundled” within a payment system
- Readmissions
- Gain sharing
- Creating pressure for efficiency through updates
- Price accuracy (e.g. primary care adjustment)
- Disclosure of financial relationships

**Potential system changes**
Pay across settings and across time

For example:
- Medical home
- Payments “bundled” across existing payment systems
- Accountable care organization (e.g. PGP demo)
Commonwealth Fund Commission

Accountable, Coordinated Care

“To end the current fragmentation, waste, and complexity, physicians and other care providers should be rewarded, through financial and non-financial incentives, to band together into traditional or virtual organizations that can provide the support they need to practice 21st century health care.”

November 2007
Importance of the Delivery System

- IOM
- MedPAC
- Commonwealth Fund
- Mayo Clinic Health Policy Center
- AHA
- AMGA and CAPP
- HFMA
- HC4HR
Exhibit 13. Illustrative Health Reform Goals and Tracking Performance

1. Secure and Stable Coverage for All
   - Percent of population insured
   - Percent of population with premiums and out-of-pocket expenses within affordability standard

2. Slowing Growth of Total Health Spending and Federal Health Outlays
   - Annual growth rate in total health system expenditures
   - Annual growth rate in Medicare expenditures
   - Impact on federal budget: new spending, net savings, new revenues

3. Health Outcomes and Quality
   - Percent of population receiving key preventive services or screenings
   - Percent of population with chronic conditions controlled
   - Percent reduction in gap between benchmark and actual levels of quality and safety

4. Payment and Delivery System Reform
   - Percent of population enrolled in medical homes
   - Percent of physicians practicing in accountable care organizations
   - Percent of provider revenues based on value

Commonwealth Fund
High-Performing Health System

Organized System of Care
- Continuum of care provided for populations
- Integrated or has partnerships
- Physicians as principal leaders of medical care
- Shared responsibility for non-clinical activities
- Accountable for care transitions

Efficient Provision of Services
- Manage per capita cost of care
- Improve patient care experience
- Improve health of populations

Quality Measurement & Improvement Activities
- Preventive care & chronic disease management
- Patient outreach programs
- Continuous learning & benchmarking
- Research to validate clinical processes & outcomes
- External & transparent internal reporting
- Patient experience surveys

Care Coordination
- Team-based approach with team members working at the top of their field
- Single plan of care across settings & providers
- Shared decision making

Compensation Practices
- Incentivize improved health & outcomes of populations
- Affiliate with patient experience or quality metrics

Use of IT & Evidence-based Medicine
- Meaningfully use IT, scientific evidence, & comparative analytics
- Aid in clinical decision making
- Improve patient safety
- Aid in the prescribing of Rx

Accountability
- Shared financial & regulatory responsibility & accountability for efficient provision of services
The past 50 years have been marked by advances in the science of medicine. The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered.
Interrelated Determinants of Healthcare Quality

• Aims: better experience of care (STEEEP), better health for the population, lower total per capita costs
• Design of care processes that affect the patient: clinical Microsystems
• The health care organization that houses the Microsystems: care of patients across silos and over time
• The environment: policy, payment, regulatory, legal, education

Payment Policy Observations

• Payment for value critically important
• Current models are early, complex, ripe with issues: data/information accuracy and timely feedback, severity adjustment, thresholds, beneficiary engagement
• Underlying FFS system in urgent need of improvement and recalibration
• Intense focus on unit price reduction within separate silos is often counterproductive
Payment Policy Observations

• Payments incenting delivery system organization and performance and care of patients across silos and over time critically important

• Payment policy addressing inappropriate waste and volume variation is the next frontier and urgently needed
Thank You

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- 406.238.2609