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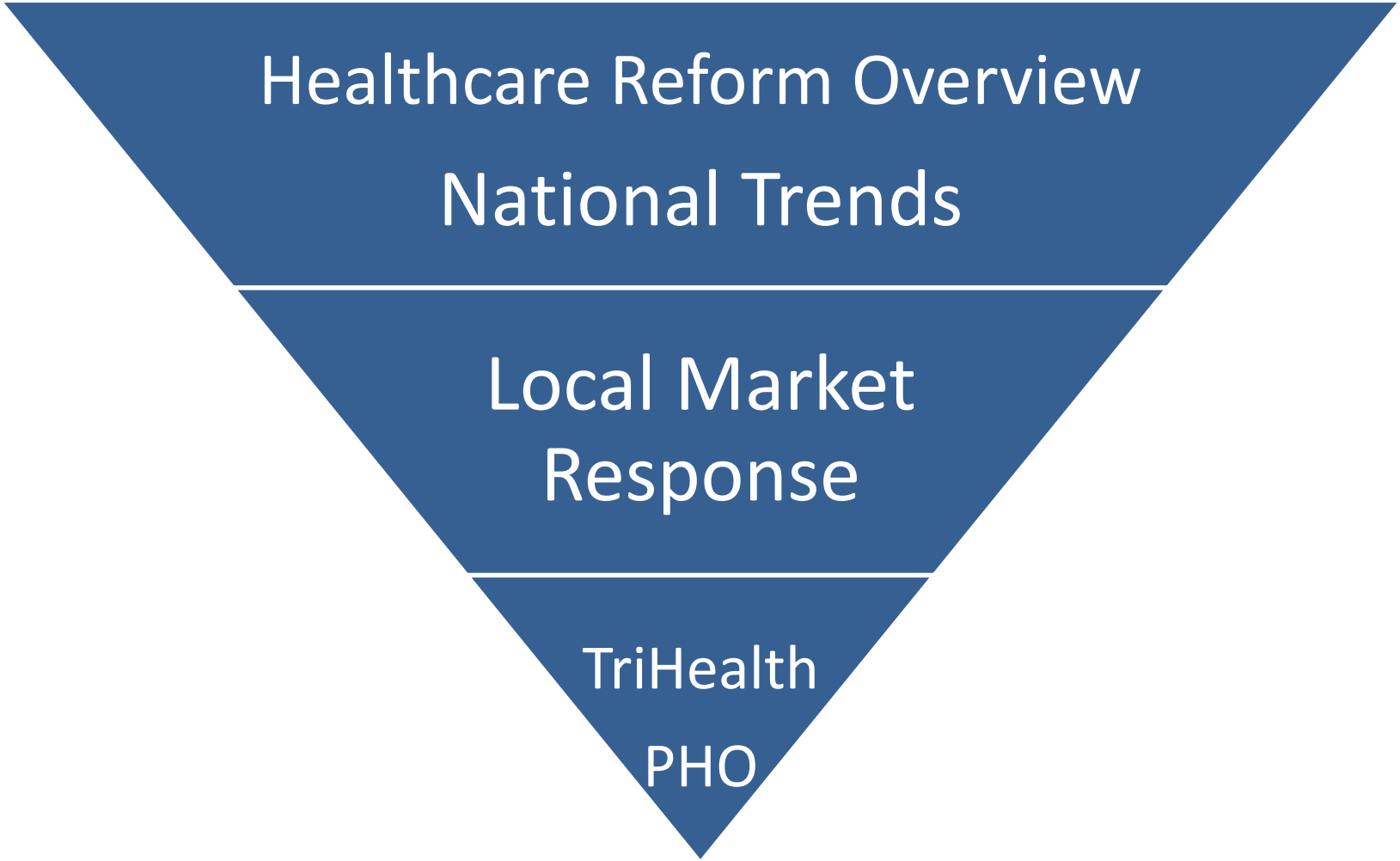
Healthcare Payment Reform:

Transition from Volume-Based to Value-Based Payments

October 6, 2014

Healthcare Payment Reform:
From Volume to Value-Based Payments



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Overview of healthcare reform in the United States

- **Nixon Administration**
  - The Health Maintenance Organization Act of 1973[1]
    - Alternative to fee-for-service
    - Put together a comprehensive range of medical or health services in a single organization
    - Laid groundwork for managed care
- **Reagan Administration:**
  - The Medicare Catastrophic Coverage Act of 1988[2] (*most repealed in 1989*[3])
    - Largest expansion of Medicare since enacted in 1965
    - Expanded Medicare coverage for outpatient drugs; Capped out-of-pocket expenses
    - Expanded skilled nursing facility and hospital payments
- **George W. Bush Administration**
  - The Medicare Drug Improvement and Modernization Act of 2003[4]
    - Changes to Medicare program e.g. implemented Medicare Advantage
- **Obama Administration**
  - 2010 Patient Protection and Affordable Care Act (PPACA)[5]
    - Center for Medicare and Medicaid Services Innovation Center – Innovative Payment Models

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Source:
1. Interprogram Studies Branch (1974). Notes and Brief Reports. http://www.ssa.gov/policy/docs/ssb/v37n3/v37n3p35.pdf
2. Christensen, S. & Kasten, R. (1988). https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/84xx/doc8430/88doc14.pdf
3. Rice, Desmond & Gabel (1990). http://content.healthaffairs.org/content/9/3/75.full.pdf
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5. Grossman, E. G. (2010). http://housedocs.house.gov/energycommerce/ppacacon.pdf
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Value-Based Payments

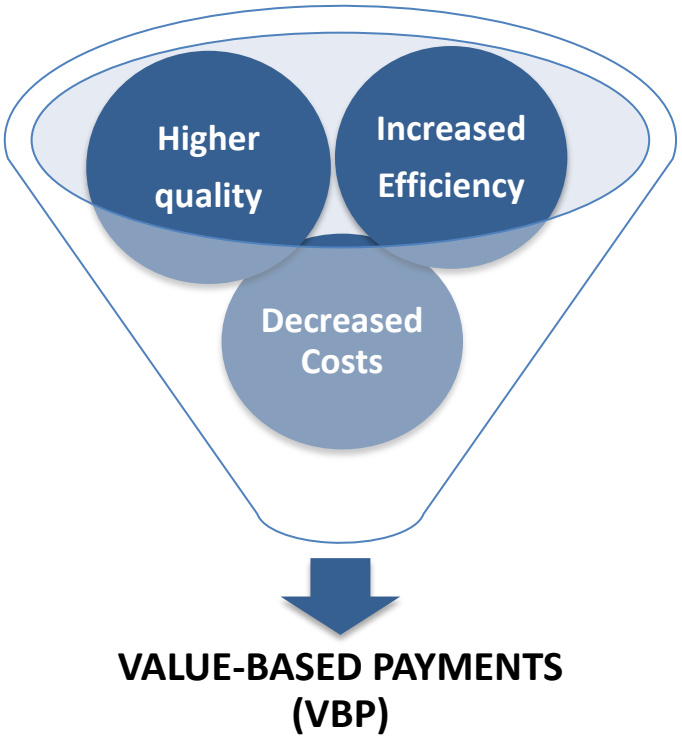
Value-Based Purchasing & Payments

- Value-Based Purchasing
  - Payment methodology that rewards **quality of care** through payment incentives and transparency. – Keckley, 2011[1].
  - Value: Function of **Quality, Efficiency, Safety, and Cost**

- Value-Based Payments (VBP)
  - Provider's total potential **payment is tied to their performance on cost-efficiency and quality performance measures**[2] e.g. risk sharing and global capitation[3].
  - Physicians get FFS **AND** could potentially earn a bonus or have payments withheld if quality and cost-efficiency targets are not met (FFS + Pay for Performance)

- Center for Medicare and Medicaid Services (CMS)[4]:
  - **Payment Incentives**: Medicare payments linked to value (quality and efficiency) of care provided
  - CMS sets the quality and efficiency measures
  - VBP expected to reduce Medicare spending by approximately $214 billion over the next 10 years

- On average, 40% of the hospital payer mix is Medicare



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Source:
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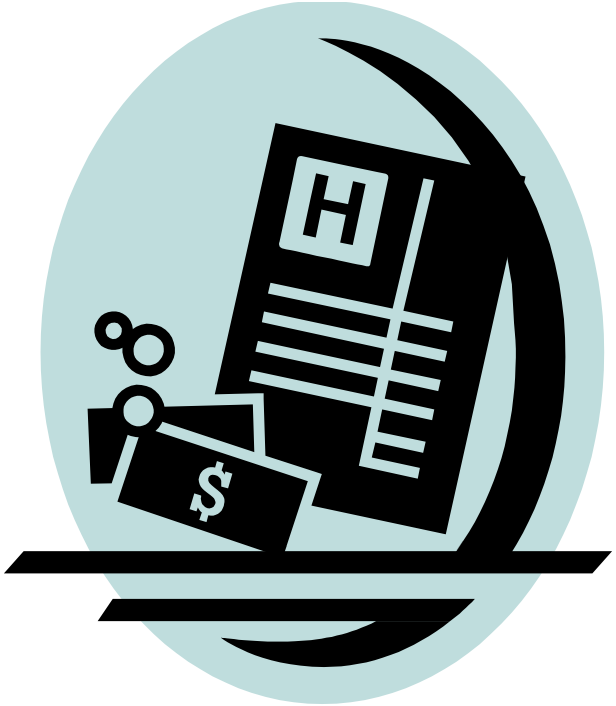
2 UnitedHealthcare. (2012) *Shifting from Fee-for-Service toValue-Based Contracting Model.* Retrieved from http://consultant.uhc.com/assets/vbc_overview_flier.pdf
3 Contractual arrangement where healthcare provider is paid a specified amount per patient to deliver services over a set period of time. Payment is determined on a per member/per month (PMPM) basis. http://www.hci3.org/content/capitation-models
4 Centers for Medicare & Medicaid Services (N.D.). *Roadmap for Implementing Value-driven Health Care in the Traditional Medicare Fee-for-Service Program.* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf

Incentives for Value-Based Payments

- Gain sharing incentives align hospitals and physicians to redesign care that achieves savings and **improves quality**
- Opportunity to **reduce costs**
- A highly effective way to **improve care** coordination and **efficiency** of care across settings
- Declining payment and thinning margins have created an urgent need for more effective approaches to cost and quality improvement



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Source:
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From Volume-Based to Value-Based Payments

	TODAY *Paid for Volume* An economic model driven by utilization and fee-for-service reimbursement	TOMORROW *Paid for Value* An economic model driven by size of defined population served and the cost of care to provide desired outcomes
Physician Role	Referral generator focused on specific care specialty	Manager of comprehensive patient health
Hospital Role	Profit centers	Cost centers
Patient Acquisition	Focus on broad referral network	Focus on defined population
Revenue Source	IP admissions, procedures & OP encounters	Aligned with size of population and clinical outcomes
Margin Driver	Geograpically distributed acute care platform	High-performing medical management

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IP: In Patient
OP: Out Patient
Source:
The Chartis Group (2011). *Transition Economics: Strategic Challenge and Opportunity.*

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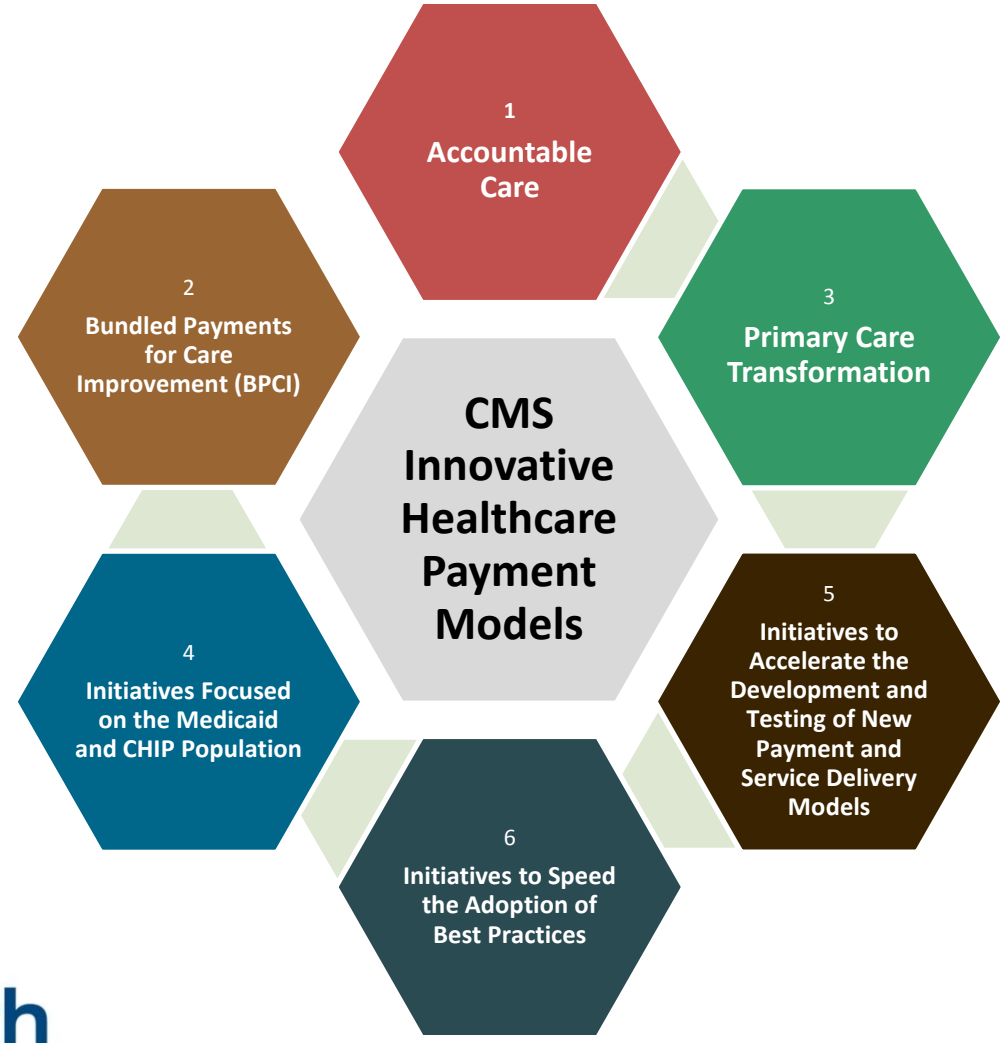
National Initiatives

Current CMS Innovative Payment Models



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Source:
Center for Medicare and Medicare Innovation Center (2014). *Innovation Models. http://innovation.cms.gov/initiatives/index.html#views=models*

CMS Innovative Payment Models

Accountable Care

Advance Payment ACO[1] Model

(35 ACOs participating in MSSP[2])

Sec. 3021 of the ACA[3]

- Physician-based & rural providers

- Upfront and monthly payments

Pioneer ACO Model

(23 Health care providers experienced in working together to coordinate care)

Sec. 3021 of the ACA

-providers experienced with care coordination

- Transition faster from MSSP to Population-based payment models

Bundled Payments for Care Improvement (BPCI)

Physician Hospital Collaboration Demonstration

Sec. 646 of the Medicare Modernization Act of 2003 & Sec. 3021 of the ACA

- Examine effects of incentive payments

-Track patients beyond hospital stays

Primary Care Transformation

Comprehensive Primary Care Initiative (CPCI)

Sec 3021 of the ACA

- Multi-payer initiative to strengthen primary care

- Bonus payments for PCPs[4] that better coordinate for patients

1 Accountable Care Organization
2 Medicare Shared Savings Program
3 Affordable Care Act
4 Primary Care Practices

Source:
Center for Medicare and Medicaid Innovation Center (2014). *Innovation Models.* *http://innovation.cms.gov/initiatives/index.html#views=models*

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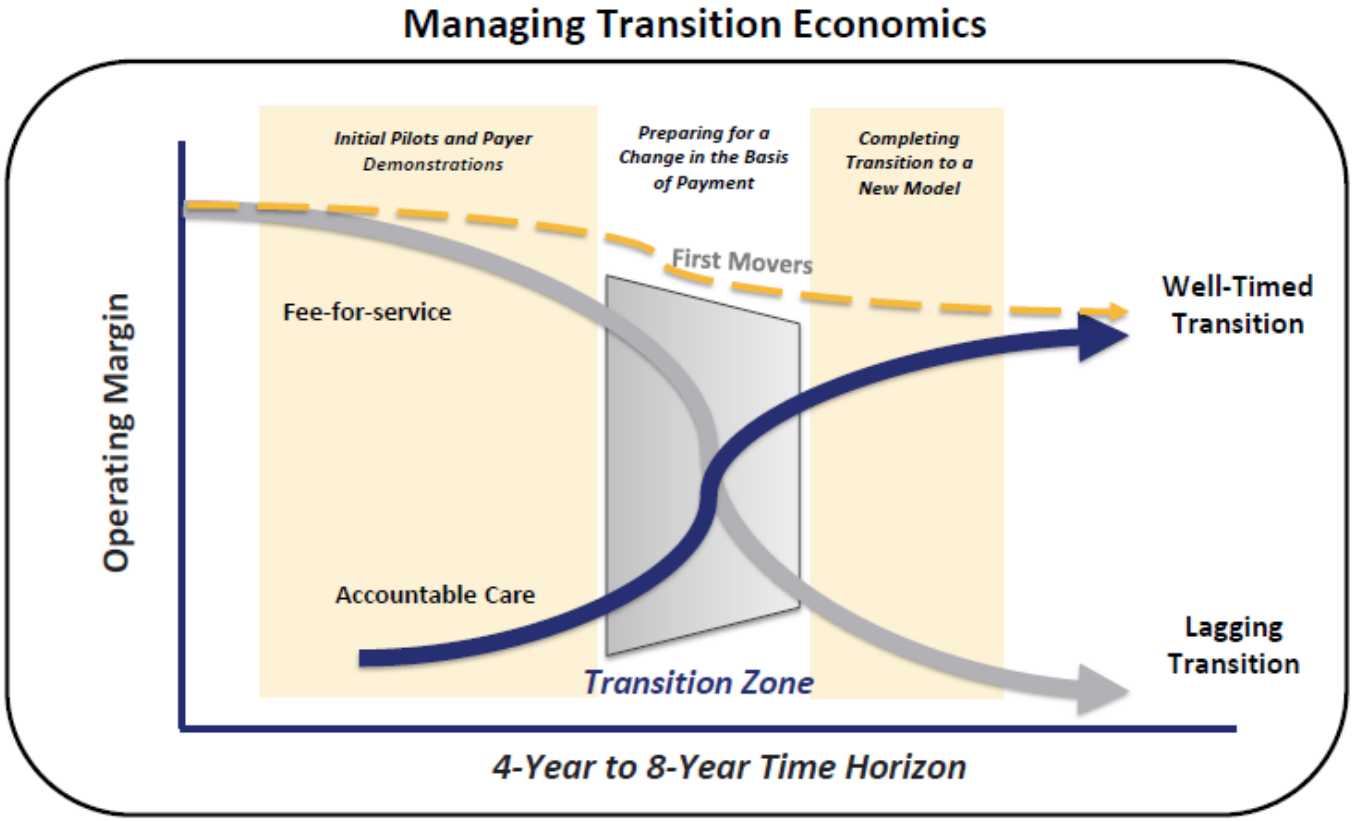
Local Market Response

Healthcare Payment Reform Continuum

While we understand this transition from fee-for-service to accountable care will take place, the details around timing and the impact on the operating margin are more unclear.



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Source:
The Chartis Group. *Managing Transition Economics.* www.chartis.com

Local Market Response to VBP

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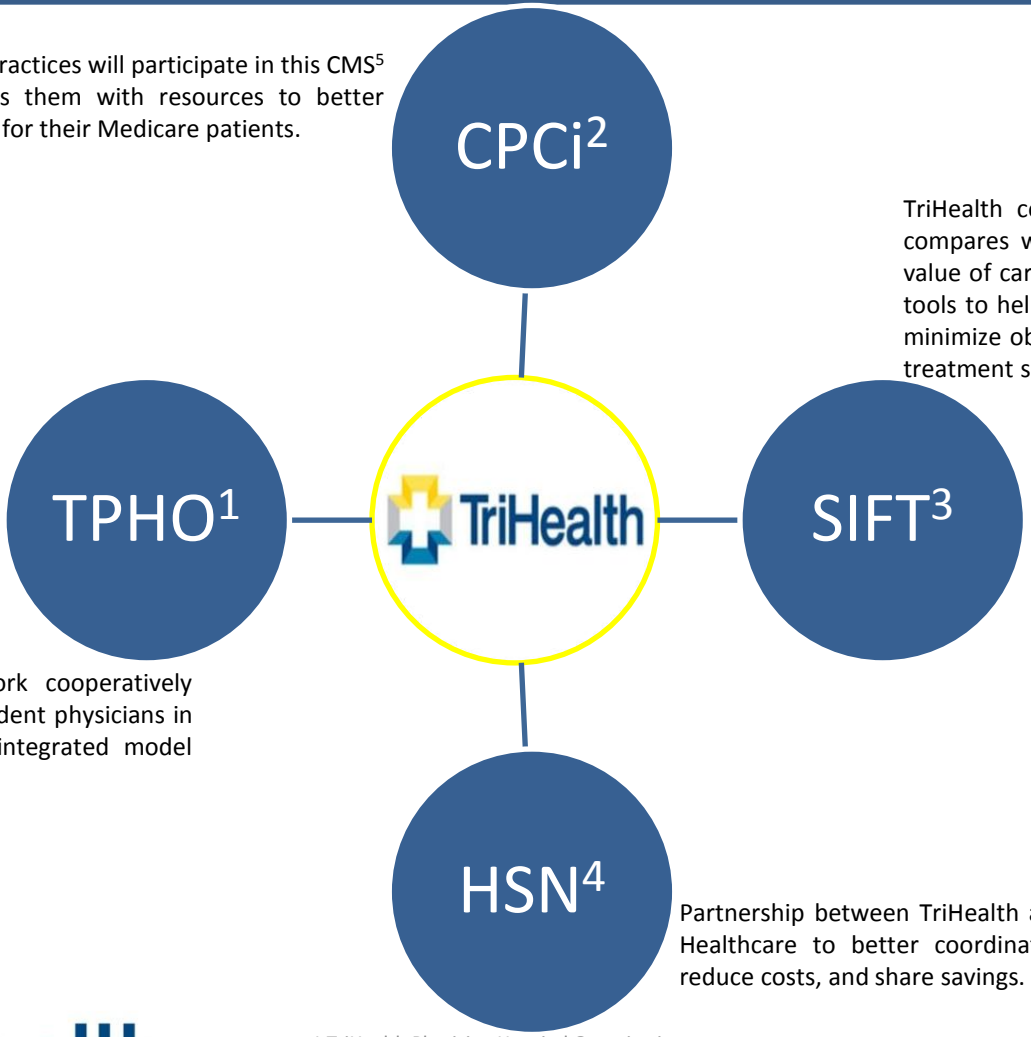
1 Accountable Care Organization
2 Medicare Shared Savings Program
3 Clinically Integrated Network
4 Physician Hospital Organization

TriHealth Initiatives

TriHealth primary care practices will participate in this CMS[5] initiative that provides them with resources to better coordinate primary care for their Medicare patients.



TriHealth continually monitors its rates for services and compares with local providers to ensure transparency and value of care for current and prospective patients. Deploys tools to help patients understand their financial liability and minimize obstacles to receiving preventative, diagnostic and treatment services within TriHealth.

TriHealth hospitals will work cooperatively with employed and independent physicians in a clinically and financially integrated model through joint contracting.

Partnership between TriHealth and St. Elizabeth Healthcare to better coordinate patient care, reduce costs, and share savings.

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1 TriHealth Physician Hospital Organization
2 Comprehensive Primary Care Initiative
3 Strategic Initiatives for Transparency
4 Healthcare Solutions Network
5 Center for Medicare and Medicaid Services

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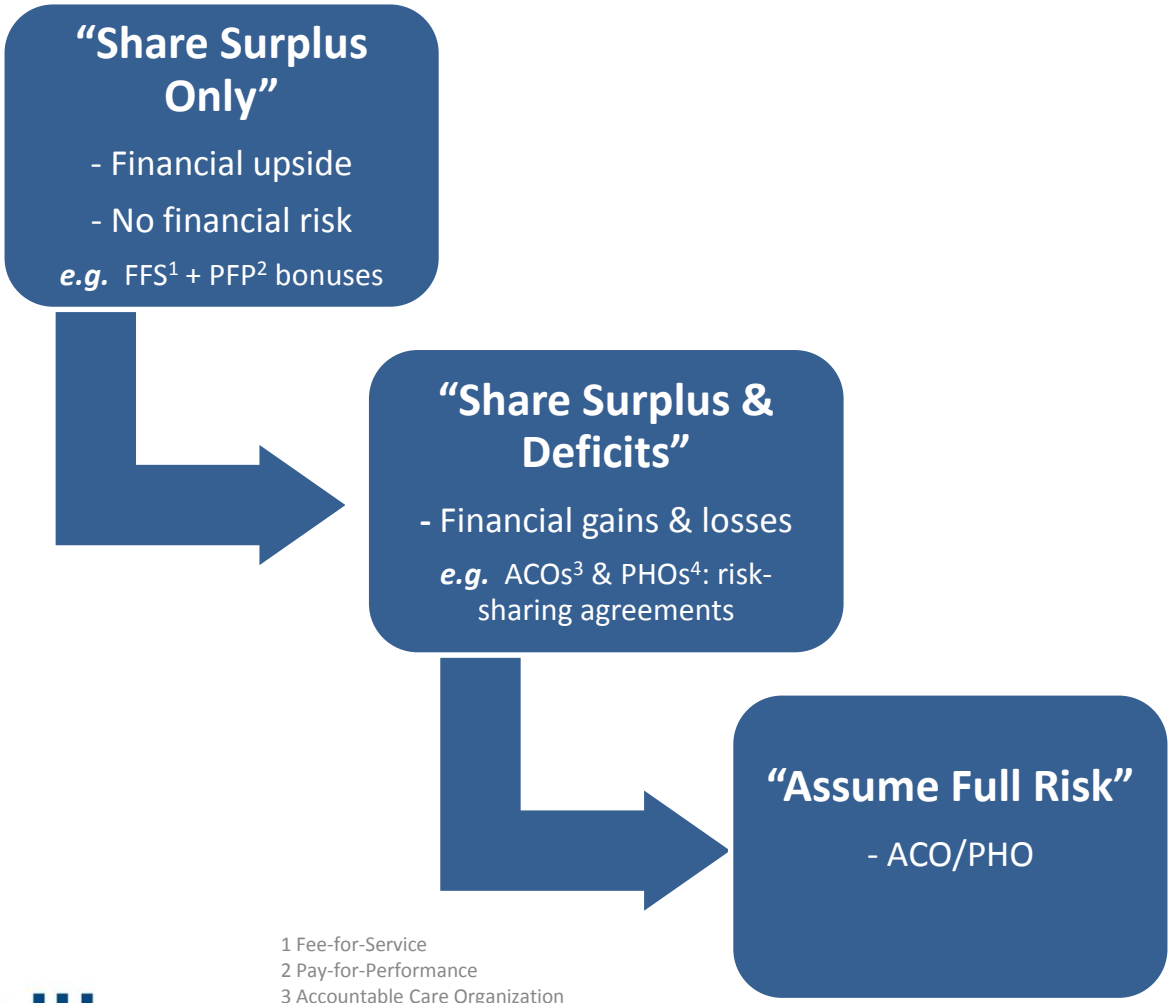
Financial Risk & Contracting

Payment Reform: Continuum of Financial Risk



1 Fee-for-Service
2 Pay-for-Performance
3 Accountable Care Organization
4 Physician Hospital Organization

Source:
Delbanco, S. (2014). The Payment Reform Landscape: Capitation with Quality. *Health Affaires.* http://healthaffairs.org/blog/2014/02/06/the-payment-reform-landscape-overview/
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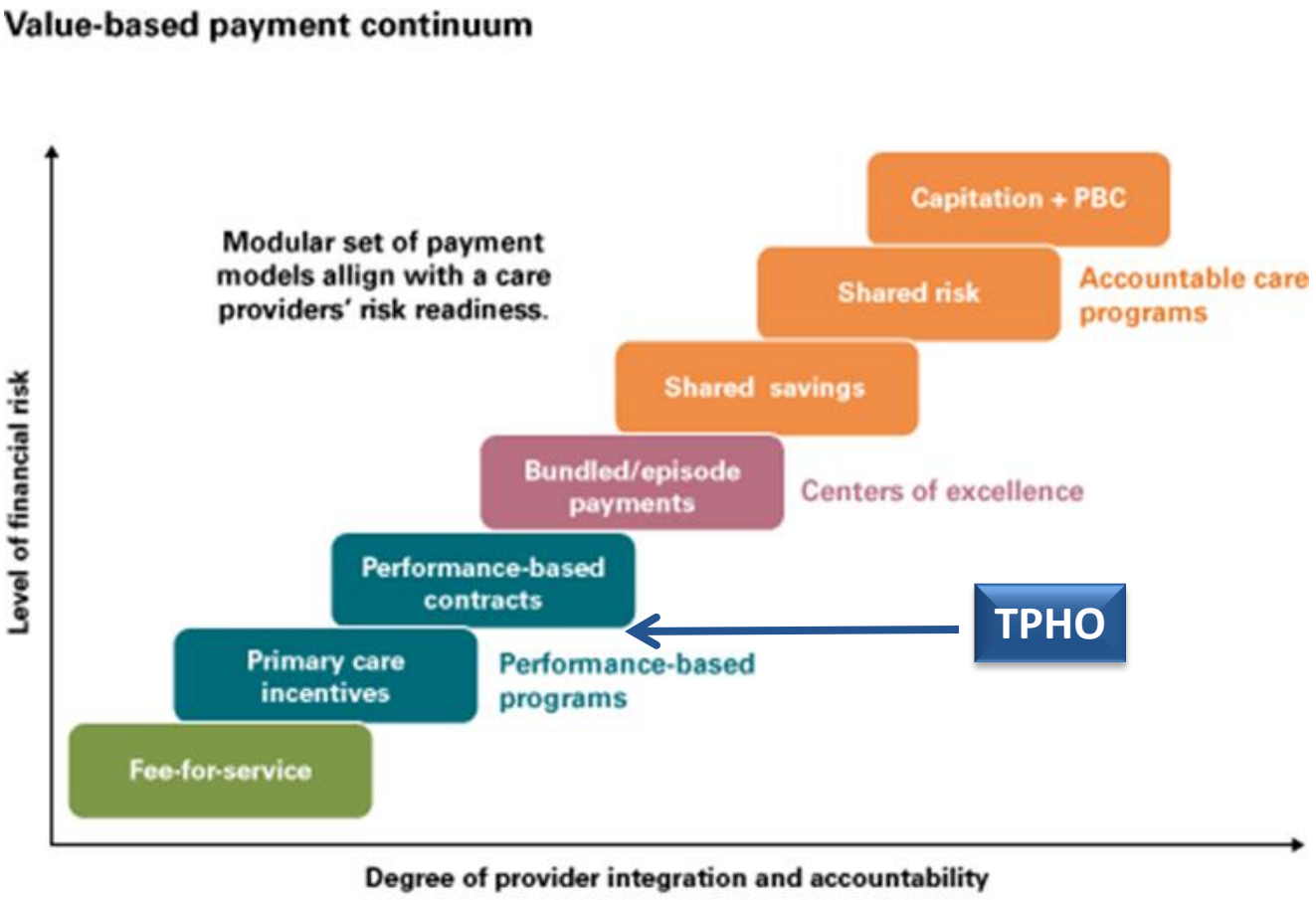
Payment Reform: Continuum of Financial Risk



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PBC: Performance-Based Contracts
TPHO: TriHealth Physician Hospital Organization
Source:
United Health Group (2012). http://www.kpmg.com/global/en/issuesandinsights/articlespublications/primary-care-paradox/pages/conclusions.aspx

FY 2015 Value-Based Penalties

Hospital Value-based Purchasing program

- Penalties & incentives based on performance on quality measures
- ***Withhold 1.5%*** of Medicare inpatient payments
- 4 Domains: Clinical Process of care, Patient Experience of Care, Outcomes of Care, & Efficiency
- Only PFP program that offers potential for bonus payments

Hospital Readmissions Reduction Program

- Penalizes hospitals that fail to provide quality care for recurring conditions
- ***3% reduction*** in Medicare inpatient payments for excess readmissions for the same condition
- Most significant for FY 2015 Payments

Hospital-Acquired Condition (HAC) Reduction Program

- ***1% penalty*** on Inpatient payments for patient conditions acquired at the hospital i.e. not present on admission (POA)
- Conditions include: blood stream infections, patient falls, bed sores, urinary tract infections, collapsed lungs, cuts that occur during or after surgery, and blood clots.

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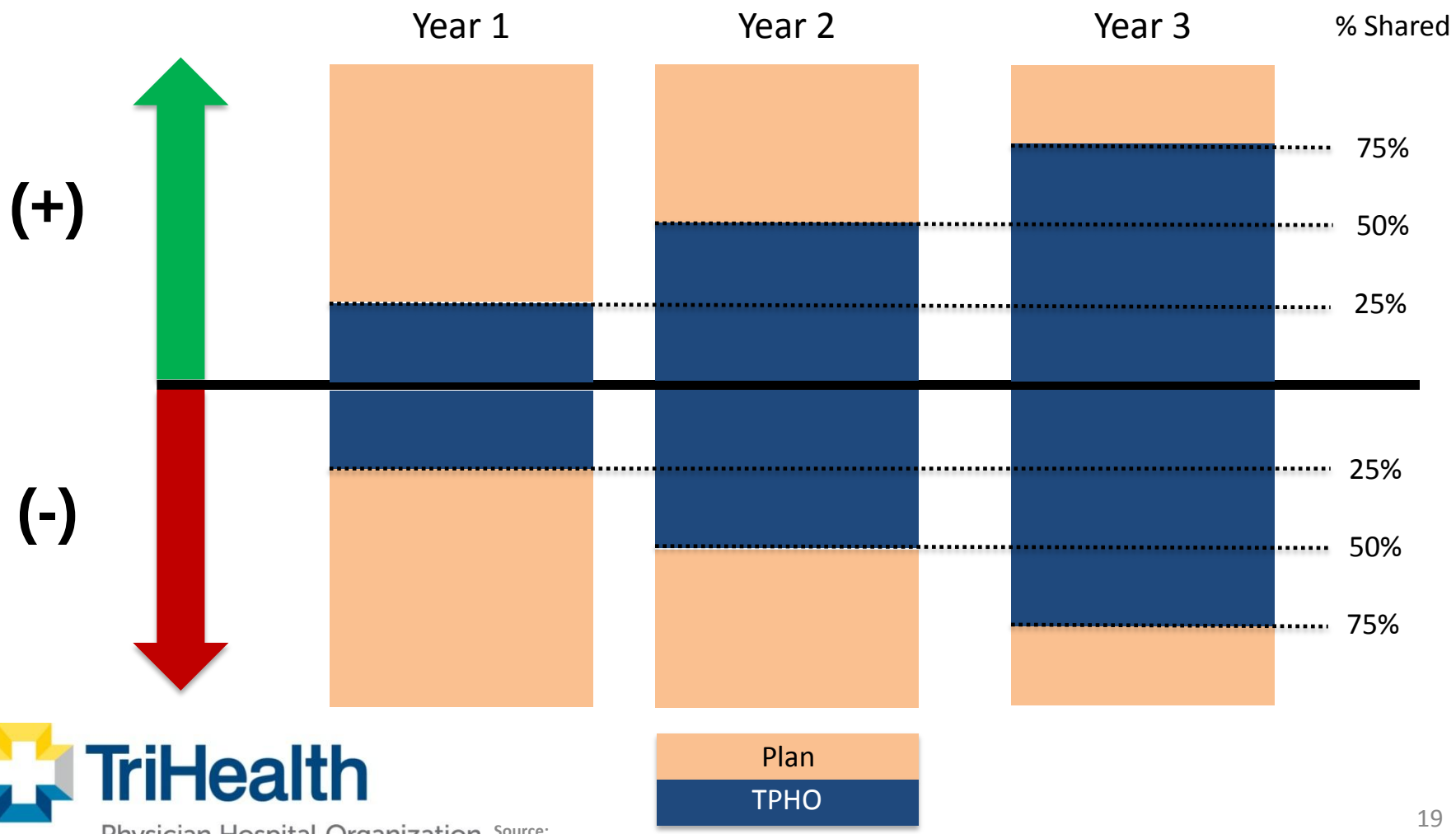
Risk-Based Contracts

Sample Risk - Sharing Terms

How we share surpluses and deficits with payors will change as we gain experience



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Source:
TriHealth Managed Care Organization

Payment Reform: Basic Risk Structure

		12-Month Performance
Attributed Members	3,000	
Total Members Months		36,000
Funding PMPM[1]	$594	
Target Spend (Funding PMPM*Total Member Months)		$21,384,000
Medical Expense (All claims, stop-loss premium, other)		$19,260,000
Surplus/(Deficit)		$2,124,000

Surplus/Deficit Share	25% →	$531,000
	50% →	$1,062,000
	75% →	$1,593,000

[1] Can be based on a **Percent of Premium** (typical for Medicare Advantage) or **Historical Spend** trended forward (typical for Commercial)

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Source: TriHealth Managed Care (2014).

TPHO Contracting Overview

- TPHO[1] will enter into contracts with health plans and offer members the opportunity to participate in those contracts
- TPHO members will have a choice to opt-into contracts; they are not required to participate in every contract
- Until TPHO is deemed to be "clinically integrated" it can only negotiate contracts that include risk sharing with health plans
- Once it is clinically integrated non-risk sharing contracts can be negotiated, such as
  - Fee-for-service
  - Pay for performance
- TPHO will pursue contracts with a variety of health plans
  - Managed Medicare, Commercial, Managed Medicaid
- The initial focus will be on managed Medicare contracts
  - The health plans are ready and anxious to share risk for this line of business
  - We have the opportunity to control expenses
  - We have the opportunity to increase our "budget" by improving coding and member **risk scores**

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Contracting Overview

- Initially risk contracts will not include negotiated payment rates for medical services; rather they will include the terms for how TPHO[1]'s financial and quality performance will be measured and how risk will be shared between TPHO and the health plan

- Throughout the contract year, providers will submit claims to the health plan and be paid based on their existing "direct" contract with the plan

- At the end of the contract year the plan and TPHO will conduct a settlement in accordance with the terms of the risk contract to determine if there is a surplus or a deficit

- After settling with the plan, TPHO will determine how the surplus/deficit is to be distributed among TPHO members

- TPHO will share with members the risk sharing terms and the rules for distribution of surpluses/deficits at the time they present to members the opportunity to opt into a contract.

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Strategic Positioning for Value-Based Payments

Organizations have the ability to shape their market and future by changing their perspective.

Market Position Dimensions	Traditional View: Retrospective	"New World View": Prospective
Market Trend	Change in discharge volumes	Change to value-based healthcare
Share	Percent of inpatient admissions	% of total cost of care & lives served
Performance	Operating income & change in inpatient share	Quality, Patient Experience, Cost
Geography	Origin of inpatient discharges	Geographic reach required to serve desired population(s)
Network Size	Number of owned hospitals and ambulatory locations	Number of network access points and breadth of network services across the continuum
Physician Alignment	Number of employed physicians	% of Network Providers (Hospitals & Physicians) clinically or financially integrated

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Source:
The Chartis Group (2011). *Shaping the Future: Market-Based Strategic positioning for value.*
http://chartis.com/files/pdfs/Strategic_Positioning_for_Value_June2014.pdf

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