Value-Based Care: Opportunities for Gastroenterology

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Challenges facing health care

- “Value based purchasing” places pressures on hospitals and physicians to eliminate redundancy, inappropriate, unnecessary and costly care.
- Payers and purchasers push providers toward bundled services that define quality and efficiency.
- Instead of “how much did you do”, value-based care moves us to “how well did the patient do”.
- Physicians and administrators must break down silos to redesign care delivery or suffer the consequences of a failed system.
- There is no “Plan B”.
What will value-based care require?

- Reimbursement linked to measurement of
  - quality
  - efficient service delivery
  - safety
  - cost reduction thru improvement
- Public reporting and sharing of data
- Leverage evidence-based clinical decision support to turn data and information into knowledge
- Coordinate care across settings to effectively manage chronic diseases and populations
  - Providers held accountable through rewards and consequences conditional on achieving performance
- Empower and engage consumers
Value-based care –
Potential opportunities in GI

- Inflammatory bowel disease
- Viral hepatitis
- Malnutrition
- GERD / Barrett’s
- Obesity
- Colorectal cancer screening/surveillance/prevention
- GI motility disorders
New payment models

- Centers of excellence / service line approach
  - Demonstrate the impact on clinical and financial outcomes
  - Incorporate revenue-cycle and population health analyses when feasible
  - “Right care in the right setting by the right provider in the right amount at the right time”
  - With 1-2 day admits becoming observation stays, changing case-mix severity impacts overall profitability
  - Requires collaboration, not win-lose
Evaluation / recognition criteria

- **Patient outcomes**
  - Patient response rates to intervention
  - Complication rates
  - Readmission rates
  - Patient safety
  - Mortality rates

- **Treatment expertise**
  - Physician credentials
  - Dedicated team focused on providing the particular area of specialty care
  - Length of time a provider / facility has performed a procedure

- **Procedure volume**
Evaluation / recognition criteria

Structure
- Availability of services 24/7
- Collect data, track and coordinate care
- Whole patient assessment (e.g. address preventive / population health measures)

Process
- Use of evidence-based care
- Systematic follow-up of patient results after procedures
- Measure and improvement performance
- Public reporting (e.g. Bridges to Excellence)
Preparing for change

- Multiple stakeholders are part of the process
  - Hospital
  - Healthcare professionals (physician, midlevel, pharmacist, etc.)
  - Ancillary providers (lab, imaging, dietician, case manager, social work, behavioral health, home health, SNF, DME, specialty pharmacy, etc.)
  - Purchaser / payer
  - Patient and caregivers
Medical staff issues

- Value based purchasing, quality issues, and readmissions will impact hospital revenues
- Medical staff will need to develop new competency standards
- Value based purchasing erases economic credentialing by emphasizing quality / value
- Performance standards defined in membership requirements and contracts
- Economic survival is at stake
The CMS Value-Based Modifier

- Budget-neutral adjustment to physician payment
- Varies payments for physicians based on quality of care relative to costs
- Each group receives two composite scores
  - quality of care (benchmark based on previous CY)
  - cost of care (benchmark based on current CY)
- Composite scores based on the group’s standardized performance (e.g. how far away from the national mean)
- Impacts more physicians over time
  - 2015: groups of 100 or more eligible professionals
  - 2016: groups of 10 or more eligible professionals
  - 2017: everyone
Quality Tiering Methodology

Clinical care
Patient experience
Population/Community Health
Patient safety
Care Coordination
Efficiency

Quality of Care Composite Score

Value Modifier Amount

Cost Composite Score

Total overall costs
Total costs for beneficiaries with specific conditions
How will CMS Calculate the Value Modifier?

- Groups of physicians with ≥10 eligible professionals
  - PQRS Reporters (using GPRO web-interface, registries, EHR, or the individual 70% option)
    - Upward, neutral, or downward adjustment based on quality tiering
  - Non PQRS Reporters (not participating in PQRS reporting)
    - Upward or no adjustment based on quality tiering
    - -2.0% (downward adjustment)

Groups of physicians with 100+ EP
Value-Based Payment Modifier

<table>
<thead>
<tr>
<th>Quality/cost</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
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</thead>
<tbody>
<tr>
<td>High quality</td>
<td>+2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Medium quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Low quality</td>
<td>+0.0%</td>
<td>-1.0%</td>
<td>-2.0%</td>
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* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.
Key elements when modeling value-based contracts

- Patient attribution
- Global target
- Trend / inflation
- Gain / loss sharing
- Cash flow
- Payment rates
- Quality measures + performance standards
- Defining medical management responsibilities
Market assessment

- What is your market position? What % of your referrals are owned / controlled?
  - Hospitals
  - Physician groups
  - Payers
  - ACO / shared-savings
  - What could happen to hospital employed physicians if provider-based payment goes away? Impact on your practice?

- What is the payor mix in your local market?
  - Government (Medicare, Medicaid, Tricare)
  - Commercial, self-funded employers, unions
  - Marketplace (exchanges)
  - What would be the impact on your practice if employers and unions move their patients to the marketplace?
Practice assessment

- Assess current level of performance on quality, efficiency, patient experience
- How are you currently being ranked / measured (Castlight, Healthcare Blue Book, CMS Physician Compare, Payer, etc.)
- Identify areas of needed improvement and implement
- Determine your strategic direction, identify key success factors
Creating value

- Improve performance
  - Identify opportunities to improve preventive services (e.g. BMI, immunization status, tobacco use, depression screen, etc.)
  - Improve patient experience and safety
  - Effective patient management through adoption of clinical best practices and clinical decision-making tools
  - Care coordination, service / capacity management
  - Integrate care with other providers, align financial incentives
  - Tracking outcomes
  - Reporting on evaluation criteria
  - *Initiate, participate, anticipate*
Threats or opportunities?

- CRC screening driven by lab tests
- Frequent fliers, readmissions and malnutrition
- Metabolic syndrome / obesity
- Pharmaceuticals IV->IM->PO
- Episode of care risk for chronic conditions
Questions?

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