

From Volume to Value – and the Physician Value-Based Modifier

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Agenda

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1. Health Care Landscape
2. "Value" is Coming
3. Value-Based Modifier



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Affordable Care Act

- Major ACA titles
 - Insurance coverage and reform
 - Public programs / public health
 - Quality and efficiency
 - Workforce
 - Transparency
 - CLASS
- Different perspective – major *themes*
 - **Value**
 - **Collaboration**



Value Equation

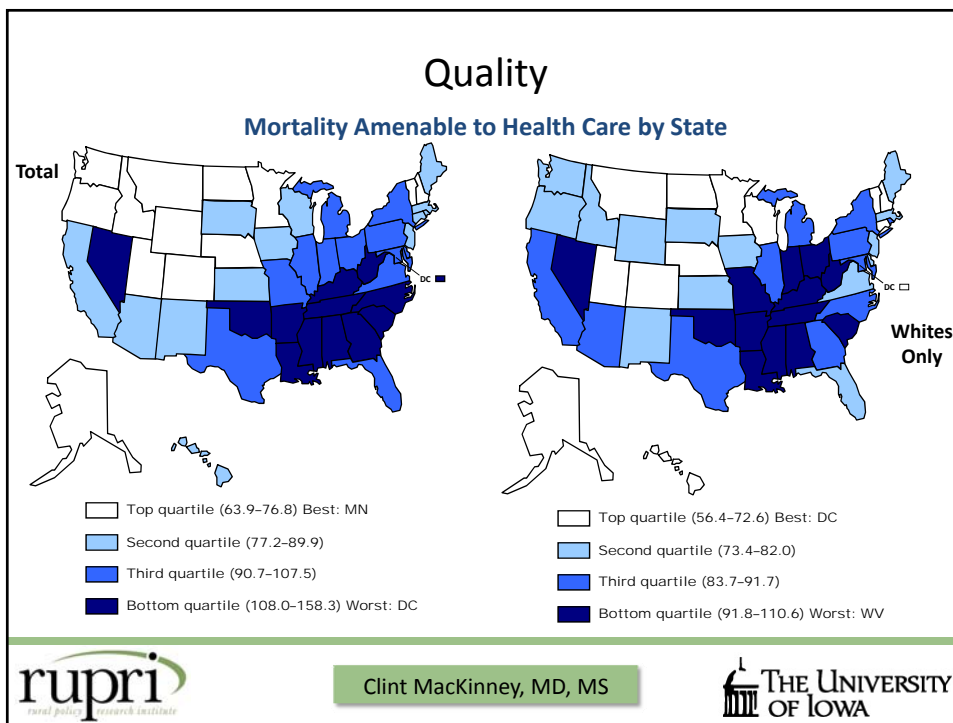
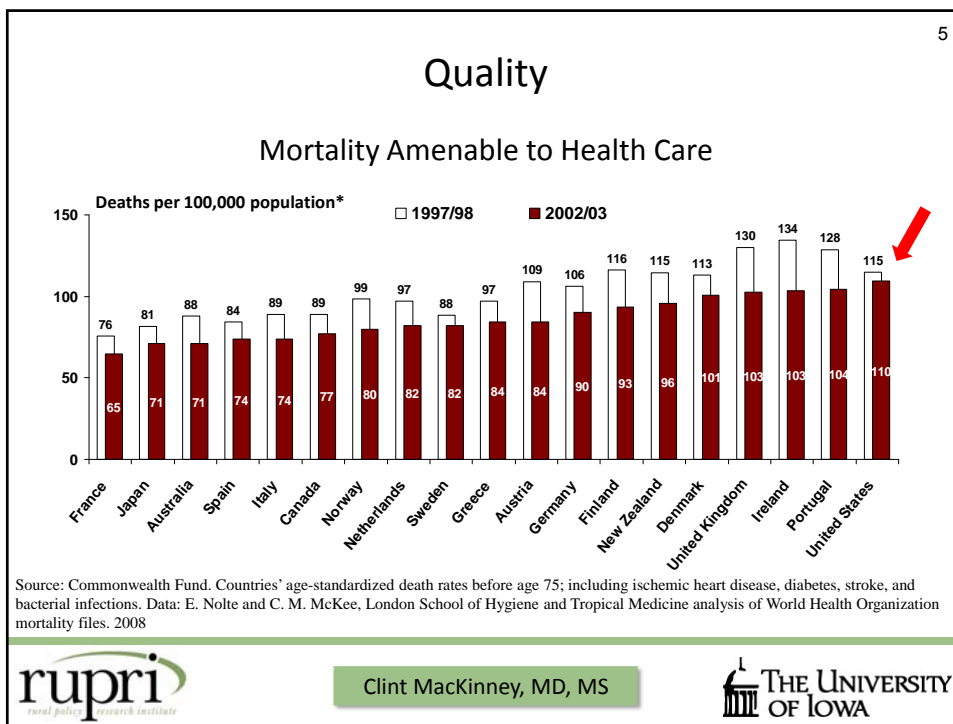
$$\text{Value} = \frac{\text{Quality} + \text{Service}}{\text{Cost}}$$

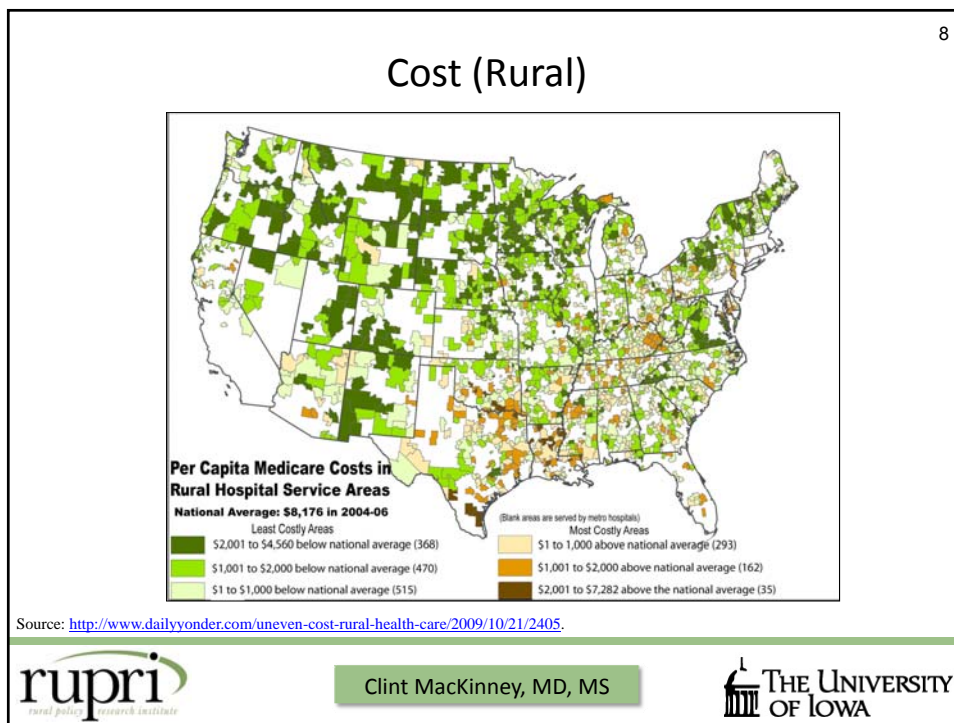
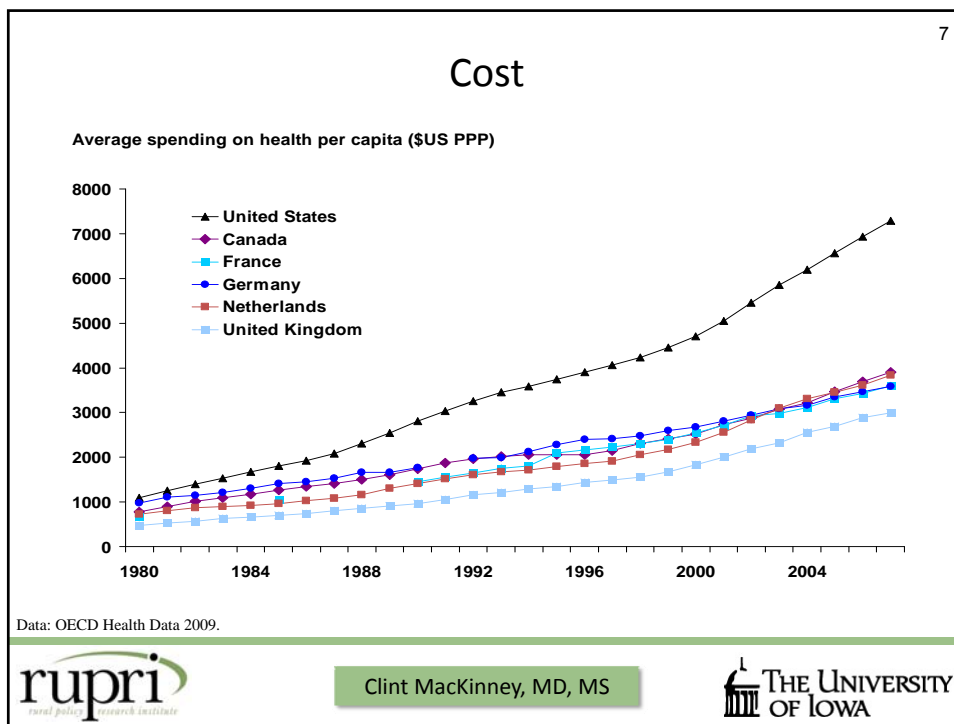
IOM Six Aims

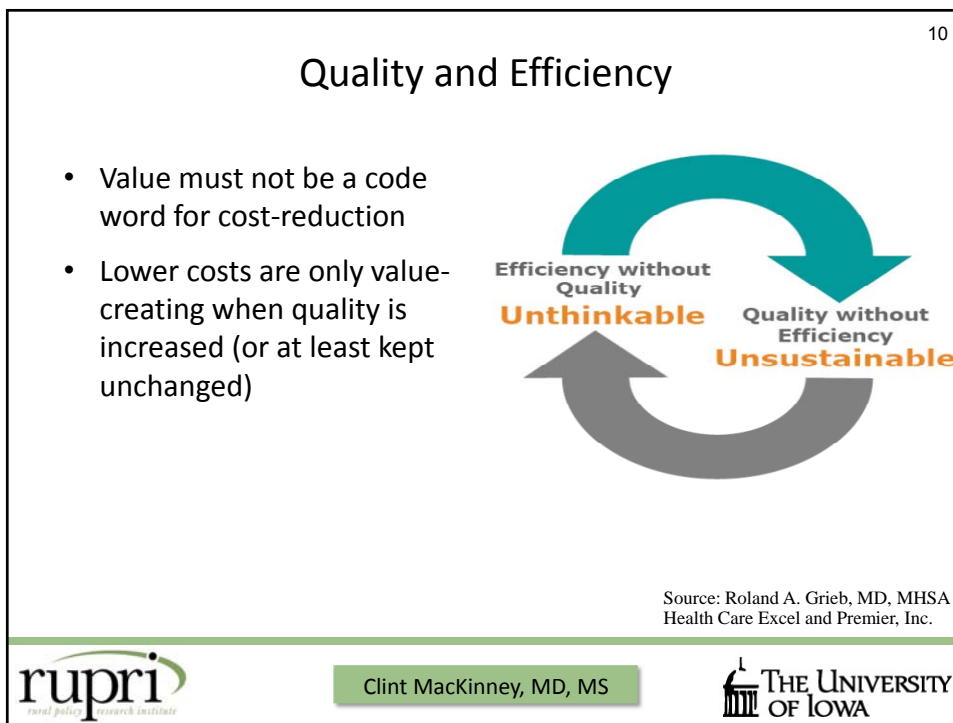
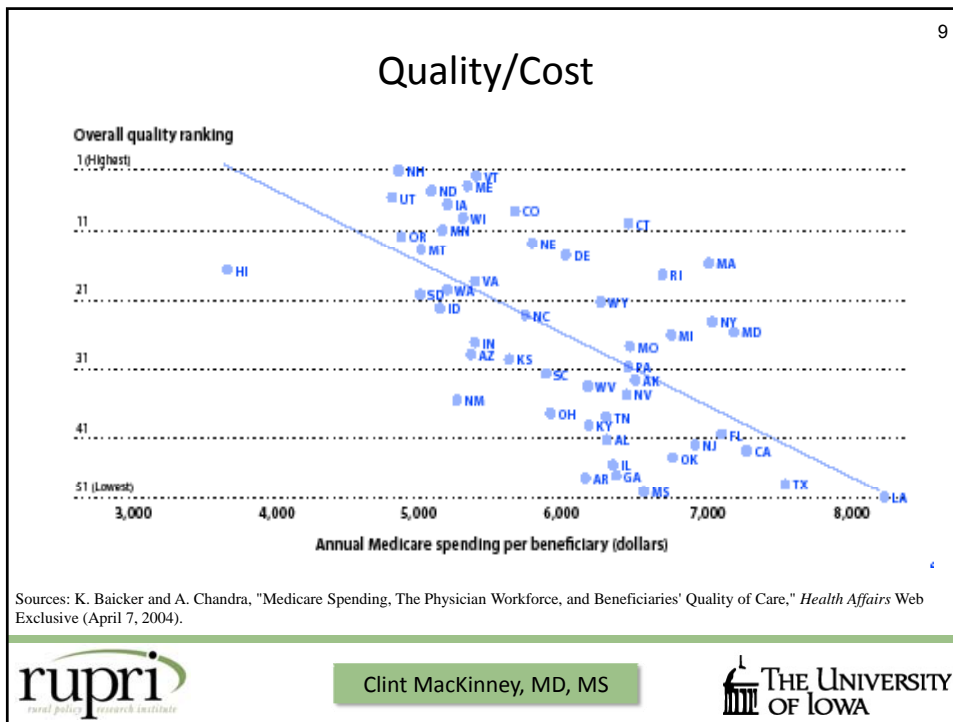
- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

CMS Triple Aim

- Better care
- Better health
- Reduced cost







Unacceptable Health Care Value

- **Quality** suboptimal
 - Deficient when compared internationally
 - Wide geographic variation – where you live matters
- **Cost** unsustainable
 - Annual growth of 9.6%
 - Highest cost in the world
- **Waste** inexcusable
 - Easily enough money to provide care for the uninsured
 - Immeasurable harm
- **But we don't agree about what to do!**



Solutions to the Value Conundrum



*You can always count on
Americans to do the right thing –
after they've tried everything else.*

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police
- **P4P and VBP?**

P4P “Pipeline”

- Voluntary performance data reporting
- Mandatory reporting
- Publicly available data
- Payment for reporting
- Payment based on actual performance
- Payment withholds with potential for “claw back”



Does It All Come Down to Money?

If all the metrics that define an organization's success are related to dollars, then let's get the dollars behind the quality agenda.

— Margaret E. O'Kane
President, NCQA



CMS Value-Based Purchasing

VISION FOR AMERICA

Patient-centered, high quality care delivered efficiently.



GOALS FOR VBP

- Financial Viability
- Payment Incentives
- Joint Accountability
- Effectiveness
- Ensuring Access
- Safety and Transparency
- Smooth Transitions
- Electronic Health Records

Reality – It Depends on Where You Stand

Old Guard

- Volumes drive revenue and market share
- But is volume what we really want to buy?
- Physician's role



Public Policy Young Turks

- Value-based purchasing
- ACOs
- Bundled payments
- Episodes of care
- Physician quality reporting
- Medical homes
- Care coordination demo
- Physician value modifier

Physician Feedback Program

- ACA Section 3007, but begins with Section 3003 – the Physician Feedback Program
 - Also included in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
- 2009: 310 physicians
- 2010: 1,600 physicians
 - Large groups in 12 metro areas in 2010 – also includes PAs/NPs
- 2011: 10,000 – 20,000 physicians
 - IA, KS, MO, NE
- Feedback reports are the foundation for value-based modifier (the P4P pipeline!)



Patient Attribution

- Who should be accountable for patient quality and cost?
 - Individuals or teams?
 - What services should count?
 - How much cost should a provider be accountable for?
- RAND study
 - How patients are attributed to a physician makes a difference in cost and other outcomes!



Patient Attribution for Cost and Quality Assessment

Cost

- Beneficiary is attributed to a single medical professional if he/she billed for the greatest number office, ED, inpatient, or consult E&M visits.
 - As long as the professional billed for at least 20% of the beneficiary's E&M costs (30% for group practice).

Quality

- The greatest number of E&M visits (as in cost) as long as medical professional billed at least two eligible E&M visits.
 - Quality metrics only attributable to primary care and certain medical specialists associated with a particular metric.

Cost Measures

- Total Part A and Part B costs
- Includes Medicare payment, co-pays and deductibles, and third party payments
- Cost risk-adjusted for age, sex, co-morbidities, ESRD, Medicaid, and percent of year in Medicare program
- Also compares hospital and ED admissions



Quality Measures

- 12 claims-based measures (subset of HEDIS) – not necessarily the same as PQRS
- 28 measures proposed for 2011
- Quality compared to peers within metro region and across all areas
- At least 11 cases need for quality determination



Cost Measures – Risk-adjustment

- Using the CMS Hierarchical Condition Category (HCC)
 - Thus cost for riskier patients is adjusted down and cost for healthier patients is adjust up
 - Cost standardized for geography
 - Per capita costs by type of service (e.g., inpatient and outpt/ED)
 - Per capita cost for 5 chronic conditions – may overlap
 - At least 30 cases needed for per capita cost determination



Peer Groups for Comparisons

- Medical professionals of same specialty in same metro area
- Medical professionals of same specialty across all 12 metro areas
- Rural comparison group?



Physician Value-Based Modifier

- Value-modifier
 - Budget neutral; **winner and losers**
- We do not yet know how the modifier will be implemented.
 - Will there be a differential rural impact?
- Could we learn from PPS value-based purchasing program (VBP)?
 - Withhold and claw back
 - Thus far, only quality and patient satisfaction (HCAHPS) measures
 - Efficiency measures not developed



Next Steps

- 2012
 - Publish final value modifier quality and resource use measures.
- 2013
 - Develop system to convert measures to a value-based modifier.
 - Scale up feedback to include all applicable physicians serving Medicare beneficiaries.



Next Steps

- 2014
 - Complete value modifier through rule-making.
- 2015
 - Apply value modifier to fee schedule for specific physicians and medical groups.
- 2017
 - Apply value modifier to fees schedule for all applicable physicians.



Cautions

- What is the rural provider comparison group?
- Will rural providers have the systems to proactively improve quality?
- How will rural physicians identify low cost hospital and specialist providers?
- Does financial risk promote change, yet not unfairly jeopardize rural practices?



Recommendations

1. Assess fairness of rural provider feedback comparison groups
2. Assess differential impact of the value-based modifier on rural and urban
3. Request that HHS implement a comprehensive communication strategy to disseminate value-based program opportunities
4. Request that HHS make available technical assistance (QIO, Flex, AHRQ, etc.) that fosters cultural change
5. Request that ORHP design and implement programs with health care value improvement as an explicit goal

