Value-Based Reimbursements are Here: Are you Ready?

White Paper

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INTRODUCTION

Many healthcare executives remain reluctant to prepare adequately for value-based payment models. The prevalent attitude continues to be that somehow "this too shall pass." Thus, expending the time and resources to re-tool the care delivery enterprise so that it functions as well in a fee-for-value reimbursement environment as it has in a fee-for-service reimbursement environment doesn't seem to be worth the effort.

Furthermore, many healthcare organizational leaders believe that there will be plenty of time to make the changes necessary to move from volume to value, once there is more evidence that this transition is happening.

This paper will outline several payment changes that are occurring in the current marketplace. These changes are not conceptual or anticipated; rather, they are happening today to many providers in many markets.

Also, this paper will outline what healthcare executives need to be doing to manage through these payment changes and remain successful in a more value-based care delivery model.

CONTEMPORARY CHANGES TO THE REIMBURSEMENT MODEL

The Centers for Medicare and Medicaid Services (CMS) is leading the charge to shifts in the way providers are being paid to care for Medicare and Medicaid beneficiaries. In January 2015, Sylvia Burwell, the Secretary for Health and Human Services (HHS), made it clear that Medicare would be moving toward more alternative payment models (APMs) and that many of these would be value-based. In April 2015, the Medicare & Chip Reauthorization Act or MACRA was passed, and with it came a new value-based reimbursement model for paying physicians called the Merit Incentive Payment System (MIPS).

As usual, the commercial payers have followed CMS's lead to value-based reimbursement models, and the top three commercial payers (Anthem BCBS, Aetna, United) have committed significant dollars to move in this direction.

Some of the payment models that are being rolled out include:

1. **The CMS Value-Based Purchasing Program**. This program penalizes hospitals for certain quality outcomes, such as having an excessive number of patients readmitted within 30 days of discharge, or having an excessive number of hospital-acquired complications (HACs), such as infections, falls, pressure sores, or blood clots.
2. **The CMS Bundled Payment Pilot Program.** Now this program, which was initially voluntary, will become mandatory for 67 community hospitals that perform total joint

surgery.

3. **The Merit Incentive Payment System (MIPS).** As noted above, this program was launched as part of the MACRA legislation, also known as the SGR "Doc Fix" bill that was passed by Congress in April 2015. MIPS allows physicians who care for Medicare patients to receive up to a 26 percent bonus or a nine percent penalty depending on their quality of care as measured by a roll-up of CMS quality payment programs. Examples are the Physician Quality Reporting System (PQRS), the meaningful use attestation program (MU), and the Value Payment Modifier (VPM).
4. **Chronic Care Management (CCM).** CMS now allows physicians to receive approximately $44 per-member-per-month for managing patients with two or more chronic diseases.
5. **Annual Wellness Visits.** CMS will also pay providers for performing an annual wellness visit on Medicare beneficiaries.
6. **Transitional Care Management.** Moving from an acute to a post-acute level of care has been found to be one of the points along the care continuum where many patients experience sub-optimal care delivery. CMS is trying to rectify this problem by offering physicians a reimbursement for improving the management of patients through this stage.
7. **End-of-Life Counseling.** Labeled as "death panels" and removed from the original Affordable Care Act (ACA), payments for these services have been reintroduced by Medicare and physicians now can receive payments for talking to patients about advanced directives, hospice care, or other appropriate end-of-life care topics.
8. **Telemedicine Care Delivery.** CMS has realized that effective care can occur through non-face-to-face encounters, and providers now can be paid for delivering care telephonically or via video hookups.
9. **Diabetic Preventive Care.** A pilot program between CMS and the YMCA has been shown to be so effective that the pilot program is under expansion. This initiative is a landmark move in that it represents the first time that CMS has demonstrated a willingness to pay for not only the care of chronic diseases but the prevention of them.

As previously mentioned, reimbursements for almost all of the above services are now being offered by both commercial and government payers. Further, the above payments do not require providers to join or be a part of accountable care organizations (ACOs) or clinically integrated networks (CINs). In fact, the only way that physicians will be able to opt out of MIPS will be to join up with an organization, such as an ACO, that participates in alternative payment models (APMs).

PREPARING FOR CHANGE

Just filing for reimbursement from Medicare or a commercial payer for rendering one of the above services won't be sufficient to function successfully under one of these models. Providers

will have to re-tool the clinical care delivery system to operate effectively in this reformed payment environment. Key changes that they will need to undertake include:

1. **Care Process Design.** Providers will need to understand their current care processes and procedures better and to design new processes that meet the criteria set for some of the above-listed activities. As an example, establishing a chronic care management program will require providers to put into place the staff, technology, and other components of the chronic care management processes.
2. **Cost Accounting.** Many of the new payment models will require providers to have a better understanding of their costs. Sophisticated cost accounting methodologies, such as time-driven, activity-based cost accounting will be necessary to account for costs. More accurate cost accounting will then allow providers to identify non-value-added costs that they can eliminate without sacrificing quality and patient safety. Finally, specific knowledge of costs will allow providers to negotiate improved pricing with payers and preserve margins in a rapidly changing healthcare economy.
3. **Measuring Outcomes.** Many of the quality metrics now widely used within the healthcare industry are process measures as opposed to true outcome measures. Going forward the goal should be for true outcomes measurements (complication rates, readmission rates, physiologic parameters, e.g., Hemoglobin A1C levels in diabetes, and others) will be necessary to demonstrate value, i.e., quality divided by cost. Process measures are not the goal: better outcomes are, and more and more payers will require the measurement of true outcomes before rendering value-based payments.
4. **Practicing Data-Driven Process Improvement.** Providers must learn how to use data, e.g., true outcomes for quality and costs, to drive continuous process improvement and remain competitive in the healthcare marketplace. Standing still and resting on your laurels as being the biggest, the oldest, the most famous, or the most well-endowed physician practice or hospital will no longer suffice in a market where consumers (individuals and employers) are looking increasingly for higher value.

CONCLUSIONS

While it is true that the healthcare industry is still in a great state of flux, and no one knows how things will play out over the next several years, it is becoming clear that a move to value-based reimbursements is eminent and, in many cases, is already here.

Providers who wish to remain competitive in the industry must realize that maintaining a predominantly fee-for-service model won't be possible and that, regardless of political change, consumers are now demanding more value for their dollar from the healthcare system.

Therefore, critical elements of the delivery system must be re-tooled. Those who embrace this hard work will receive rewards for creating these adaptations and creating change that will drive higher value and enable them to maintain a competitive position in the marketplace.

Finally, special note should be taken by smaller or rural healthcare providers who may think they are exempt from the higher value conundrum. Rural healthcare providers, in fact, are more vulnerable to acquisition or dissolution than larger hospitals or healthcare systems if they don't re-engineer their care delivery model. Rural providers operate on smaller margins, and many have worked for years on a cost-based reimbursement system that is not a viable model for the future where the lowering of costs is one of the overarching imperatives.

In summary, all providers regardless of size should pay attention to the changes that are going on all around them and seek to develop the skills, capabilities, and innovations that will allow them to provide higher value to the healthcare consumer.