

2011 FALL IDN SUMMIT RESEARCH REPORT

In an Era of Change, the Healthcare
Payment System Focuses on Value

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Introduction

The landscape for healthcare reimbursement is undergoing seismic shifts, and uncertainty is likely to prevail for years as the aftershocks from national healthcare reform, changes in the private insurance marketplace and a continuing economic downturn take their toll. Although it is nearly impossible to predict what the new terrain will look like, it appears certain that healthcare providers are going to have to build a more solid foundation for lower-cost, higher-quality care.

For the supply chain, payment changes will lead to tighter controls on high-cost purchases, greater reliance on clinical evidence in decision-making, better use of materials management information systems and standardization of supplies across clinical departments, wherever possible.

Underlying the shifts in payment is the fault line known as national healthcare costs. The U.S. spent \$2.6 trillion on healthcare in 2010, or more than 17% of the gross domestic product (GDP), according to a recent report by the Centers for Medicare and Medicaid Services (CMS). While recent health spending inflation has slowed, the expansion of coverage from reform and other factors will drive growth to 5.8% per year for the period 2010 through 2020, reaching a peak of 8.3% in 2014, easily outpacing the expected average annual rise in GDP. Unless action is taken, the healthcare share of the economy is projected to be 19.8% by 2020.

For families, the rising cost of care, coupled with greater cost sharing by employers and a doubling of insurance premiums in the past decade, have taken a staggering toll. For a family of four with a PPO plan, the 2011 Milliman Medical Index finds that the average cost for care hit \$19,393 this year.

For providers, the future outlook on government reimbursement is grim. According to the most recent report, Medicare cost \$523 billion in 2010, overrunning revenue by \$37 billion. Despite provisions of the Affordable Care Act (ACA) that call for reduced fee-for-service provider payments and lower payments to Medicare Advantage plans, CMS predicts average annual Medicare spending growth to be 6.3% from 2013 to 2020, largely as a result of the retirement of the massive baby boom generation.

By 2020, government healthcare spending is projected to reach a total of \$2.3 trillion and be 49% of total national healthcare spending, up from 47% in 2014. It is expected that the federal government will pay almost two-thirds of this amount. Clearly, given the scale of our national debt, this is an unsustainable course.

With \$155 billion in Medicare provider payment reductions over 10 years already law as a result of a deal struck to pass the ACA, recent legislation to reduce the federal debt could have severe implications. President Obama and Congress in August agreed on a plan to raise the nation's debt ceiling while trimming about \$2.1 trillion in spending over a decade. While Medicare and Medicaid are exempt from the first round of \$917 billion in discretionary spending reductions, by Nov. 23 a bipartisan panel of 12 lawmakers from both houses of Congress must report recommendations to trim at least \$1.2 trillion more in spending over 10 years. The panel can make recommendations for cuts in any part of the budget, including Medicare and Medicaid. If the committee members don't reach consensus, or if Congress does not approve a package they offer by Dec. 23, a series of automatic spending cuts would kick in by 2013. Growing pressures mean access to healthcare services under Medicaid may be restricted, despite its role in expanding health coverage to 32 million more people under the ACA.

Medicaid spending (federal and state combined) grew 7.2% in 2010 to \$401 billion. In 2014, the cost of the program is projected to increase by 20.3%. That year, anyone under 65 in families with incomes at or below 133% of the federal poverty level can gain Medicaid coverage. It does not come as a surprise that many in Congress are looking to Medicaid as a prime source of deficit reduction.

Carrots and Sticks

Mindful of this growing need to address healthcare spending, the ACA establishes a number of new programs to encourage providers to work together to improve care quality and cost-efficiency.

One of the most prominent is the Hospital Inpatient Value Based Purchasing Program (VBP). Under this new payment scheme, a portion of virtually every hospital's Medicare reimbursement is at risk, beginning with 1% in fiscal year 2013 and growing to 2% in fiscal year 2017.

The regulations create a formula that will convert scores on measures of clinical quality and patient satisfaction into a single VBP score. A hospital with VBP scores at the median will be entitled to 50% of its Medicare withhold and a hospital at the 100th percentile will be entitled to all of the withhold.

Value-based purchasing has other aspects. A new measure of quality set to take effect in 2014 that will account for 20% of the VBP score will assess Medicare spending per beneficiary. A hospital whose Medicare charges are higher than national averages could see all of its reimbursement reduced.

Beginning in 2013, CMS will rank hospitals according to performance on a 30-day readmission rate for heart attack, heart failure and pneumonia. Hospitals with excess readmissions will be subject to a 1% reduction in Medicare reimbursement. In 2015, the scope of diagnoses and conditions will expand to include chronic obstructive pulmonary disease, coronary artery bypass graft surgery, percutaneous coronary intervention and other vascular conditions. Also in 2015, the penalty for excess readmission will have increased to 3% of Medicare reimbursement.

In 2015, CMS will begin ranking hospitals on their risk-adjusted rates for certain hospital-acquired conditions. Hospitals in the top quartile will be subject to a 1% payment penalty under Medicare.

Another cost-focused program resulting from reform is the Medicare Shared Savings Program. Under proposed regulations from CMS, accountable care organizations (ACOs) – alliances of primary care providers and others – would each coordinate care for at least 5,000 Medicare beneficiaries and have mechanisms for shared governance and shared savings.

Eligible Medicare providers include group practices, networks of individual medical practices, partnerships or joint ventures between hospitals and physicians, and hospitals employing physicians.

CMS would require ACOs to report metrics on their clinical processes and outcomes, patient experience, utilization and costs – all of which will be calculated to create a per-member cost for treatment in a given time frame. This figure would be compared to benchmarks the government would establish based on rolling averages of per-beneficiary costs for the ACO, plus an adjustment to account for national expenditure growth. Based on those numbers, ACOs would either share in any savings achieved in caring for beneficiaries or risk losses.

Healthcare trade groups have complained that the 429-page rule is overly regulatory, that there are too many clinical measures (65) to report on, that retrospective assignment of beneficiaries would mean ACOs would not be able to track who is in the program and that the cost of participation would be too high.

Despite the pushback against the rule, a *USA Today* and Fidelity Investments survey in late July of executives at 1,852 hospitals found that one-third of respondents' organizations were "extremely likely" to become part of an ACO.

Finally, the "meaningful use" of electronic health records (EHRs) is interwoven into all major efforts to reform the U.S. healthcare system. The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, the ACA, the Inpatient Prospective Payment System rule for fiscal 2012 and the National Quality Forum's current electronic quality measures effort all emphasize the central role that EHRs will play in the delivery of cost-effective, high-quality care to patients.

The HITECH Act contains a number of general and technical definitions addressing aspects of meaningful use, but in layman's terms it is about using certified EHR technology to improve the quality, safety and efficiency of healthcare. As with most aspects of healthcare reform, there are financial ramifications of the law. By meeting the yardsticks established in the program, a hospital can earn well in excess of \$2 million over five years, either through Medicare or Medicaid, depending on its volume under those programs. Ultimately, subsidies for hospitals in all 50 states could wind up totaling \$27.4 billion. There are also penalties for failure to comply. Beginning in 2015, hospitals that fail to achieve benchmarks for use of certified EHRs stand to lose 1% of Medicare payments. That will increase by a full percentage point each year and could reach a maximum of 5% of base diagnosis-related group (DRG) payments.

Actions by the States

Meanwhile, states are continuing to try a number of strategies to slow the growth of Medicaid spending, including changes to benefits and program design.

In fiscal year 2012, 24 states are planning to cut at least \$4.7 billion from their Medicaid programs, according to separate analyses by the Center on Budget and Policy Priorities and Families USA.

Eighteen states are cutting provider payments, while 16 states are freezing them. In California, a bill enacted last spring cut Medicaid reimbursement rates by 10% effective June 1, 2011.

Several states hope to restrict eligibility under enhanced Medicaid plans that offer services beyond the basic mandate. Arizona is leading that charge. It suspended new enrollments for adults without children as part of a \$500 million savings package.

In addition to cutting provider reimbursement rates, plans call for expanding previous efforts to change program design. Gubernatorial budget proposals for 2012 revealed several common strategies for reducing Medicaid costs:

- Limit spending on prescription drugs: 27 states
- Limiting benefits: 25 states
- Instituting new or higher copayments: 21 states
- Changing care-delivery systems: 20 states
- Expanding managed care: 19 states

States are also focusing on Medicaid recipients with chronic conditions through the use of medical homes as a means to coordinate care. Wisconsin, for example, is looking at giving fixed "bundled payments" to providers to oversee all aspects of care for people with chronic diseases.

Private Payers

No area of payment is unaffected by the rise in healthcare costs and by changes in regulation. The private health insurance market is going to look quite different in the coming years, with implications for healthcare providers.

Although coming under court challenge, the ACA requires every U.S. citizen and legal resident to have healthcare coverage or pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income.

The law expands the private health insurance marketplace by creating new “exchanges” where individuals and small employers will be able to shop for insurance coverage. They must be set up by Jan. 1, 2014. That year, an estimated 13.9 million previously uninsured people will obtain private coverage, which would affect providers in terms of fewer people seeking uncompensated care.

Some states, including California, Colorado, Oregon, Maryland, Washington and West Virginia, have adopted legislation to set up the exchanges. Others are either still discussing such proposals or have measures awaiting a governor’s signature. Meanwhile, efforts have either died or been rejected in at least a dozen states, including Arizona, Florida and Louisiana, as lawmakers and governors object to the ACA and seek to have it overturned in court.

The ACA also makes a number of changes to insurance practices that will affect uncompensated care. Beginning in 2014 it prohibits individual and group healthcare plans from placing lifetime limits on the dollar value of coverage and prohibits insurers from rescinding coverage except in cases of fraud. It will also end the practice of denying coverage based on pre-existing conditions.

The federal reform law is similar in concept to a 2006 Massachusetts law. There, initial goals were to cover some 650,000 uninsured residents and improve the level of benefits provided in the marketplace. To accomplish those goals, Massachusetts established a number of features similar to those in the federal law, such as subsidies offered to individuals with incomes of up to 300% of the poverty level, an individual mandate to buy insurance, a minimum level of benefits and a health insurance exchange for consumers and small businesses.

While Massachusetts now has the lowest uninsured rate (2%) in the nation, critics have pointed out that the reforms have done little to curb costs; the state outpaces the national average on healthcare spending.

In 2010, the state’s Division of Health Care Finance and Policy delivered its analysis of Massachusetts’ healthcare spending. It recommended that health insurers create products that steer members to high-quality, lower-cost providers. One plan, Network Health, responded by excluding high-cost hospitals from its provider networks.

That concept of “tiering,” in which healthcare insurers place higher-cost hospitals in plans with higher premiums and cost sharing, is a tactic that has been tried elsewhere as insurers try to rein in cost growth. WellPoint, Inc.’s Anthem subsidiary in Missouri, for example, offers a network option that excludes the high-profile 13-hospital BJC HealthCare system.

There is a host of other insurer tactics designed to have members take better care of themselves and ensure that patients only get necessary tests and treatment. Those include:

- Pre-authorizations for routine services such as lab work and imaging.
- Wellness and prevention programs to encourage healthier lifestyles and reduce chronic illnesses.
- Using “nurse navigators” to ensure that patients do not have duplicate tests, see the right specialists and follow through on medications.

Another tactic is to work with providers to reduce readmissions. Independence Blue Cross in Philadelphia is providing \$5 million to a patient-safety initiative involving more than 70 hospitals that hopes to reduce re-hospitalizations by 10% by early 2012. The programs cover about 25 conditions with high risk of readmissions. One key practice: following up with discharged patients who leave the hospital with new prescriptions to ensure they fill them. That is especially important when antibiotics are needed to combat a surgical site infection that was under control when the patient left the hospital.

Many health insurance plans have adopted radiology benefit management programs to promote the appropriate use of diagnostic imaging services, according to America’s Health Insurance Plans, a trade group. The tactic is in response to the phenomenal growth in imaging services since the late 1990s and the need to minimize the risks associated with unnecessary imaging, the group says.

Methods used by radiology benefit management programs for new imaging technologies include pre-authorization and use of evidence-based medicine to change physician ordering patterns. Some health insurance plans use in-house resources to carry out programs while others have turned to radiology benefit management firms. In 2006, a survey of benefit managers of large U.S. corporations found that 40% of companies surveyed had some form of radiology management in place and another 20% said they would have one in place within the next two years.

Plans report that radiology benefit management programs cut utilization rates from 20% to greater than 100%.

Paying for Performance

A number of healthcare plans have embarked on more ambitious programs to use payment to encourage cost-efficient care. The most famous of these efforts is in California, which has a rich history of insurer-provider collaboration. In fact, healthcare plans played a key role in the development of many of the state's provider organizations, mainly through the use of standardized, capitated payment that reduced providers' administrative burden, allowing them to focus on quality.

A study by the Integrated Healthcare Association, which runs a pay-for-performance initiative in the state, found that California has 285 physician organizations with many of the characteristics of ACOs, serving 16 million people.

Capitation has been vital to encouraging coordinated care by California's providers, as it has forced financial discipline and allowed for investment in the infrastructure necessary to manage care across the continuum. "Fee-for-service (FFS) payments do not offer the same incentive for providers, and it is unclear whether FFS with shared savings – one of the reimbursement strategies that will be used by Medicare in its ACO pilot – will be enough to incentivize providers to transition from volume to value, or to invest in the infrastructure needed for ACOs to provide effective care management," according to the association.

A core component of ACO development is the ability to measure and report on performance. The California Pay for Performance Program is the largest non-governmental value-based purchasing program in the nation, and the longest running example of data aggregation and standardized reporting across multiple health plans. Seven healthcare plans participate in incentive payments and public reporting (Aetna, Anthem Blue Cross, Blue Shield of California, Cigna, Health Net, United Healthcare, and Western Health Advantage), and an eighth – Kaiser Permanente – participates for public reporting purposes only. The program covers 221 medical groups, representing approximately 35,000 physicians who provide care to over 10 million commercial HMO enrollees.

The goal of the program is to incentivize performance improvements in clinical quality, efficiency and patient experience through a common measure set, a public report card and incentive payments. These payments, made by health insurance plans to physician groups, totaled \$52 million in 2009.

The program utilizes 23 clinical care measures, nine patient experience measures, 11 information technology measures, eight measures of clinical integration, 11 measures for coordination of diabetes care and six for efficiency of resource use.

A study in the journal *Health Affairs* published in October 2009 found that the impact of the \$264 million spent on the California pay-for-performance program between 2003 and 2007 was modest because even this large sum amounted to less than 2% of the physician organization's annual revenues. Performance on the clinical quality metrics improved by an average of 3% annually, while performance as measured by patient satisfaction surveys stagnated; adoption of information technology increased annually by 7%. A survey of physician and plan leaders reported that the majority felt the program had motivated improvements in the data systems and measurement capabilities but that no "breakthrough" quality improvements had been achieved.

"Whatever the achievements of the California P4P program in its first years, the quality focus was at risk of being sidelined by the continuing rise in healthcare costs and concomitant decline in health insurance coverage," the study found. "Premiums grew by an average rate of 10.9% for the commercial HMO during these years, and enrollment dropped by 7.7%, despite strong population growth in the state. Facing intense pressure from purchasers, the health plans tired of quality-only P4P and demanded that efficiency be included as a dimension of performance alongside quality."

A Quality Contract

Another major effort by an insurer to use the payment system to spur quality is called the Alternative Quality Contract. Launched in January 2009 by Blue Cross and Blue Shield of Massachusetts, the contract includes a modified global payment. The model differs from past capitation arrangements because it explicitly connects payments to achieving quality goals and defines the rate of increase for each contract group's budget over a five-year period.

Alternative Quality Contract groups agree to accept a global budget to cover all healthcare services delivered to Blue Cross HMO and point-of-service patients, whether or not the care is provided by that provider group's physicians and hospitals. Blue Cross negotiates a base-year budget with each participating provider group. The starting point for the negotiation is the past year's medical spending for participating Blue Cross patients of the groups' primary-care physicians.

Blue Cross does not seek to reduce a group's initial budget below its current spending levels. Rather, it focuses on controlling future growth rates. This helps ensure that there are adequate resources to provide the level of care delivered in the past and that no group will be forced to reduce quality as a result of initial budget reductions.

Prior versions of capitation were criticized for creating financial incentives for medical groups to withhold necessary care in order to save money. Blue Cross has attempted to address this criticism by creating quality incentive payments of up to 10% of the total per-member, per-month payments. The incentive payments are determined based on quality measures drawn from nationally accepted sets of measures.

As of the end of 2009, eight provider groups had joined the Alternative Quality Contract; four more have since joined. The groups are diverse in terms of size, geography, organizational form, and prior experience with risk contracting. The Alternative Quality Contract groups include one independent multispecialty group practice, several independent practice associations that contract on behalf of multiple smaller physician groups, and several physician-hospital organizations.

All groups participating in the Alternative Quality Contract earned significant quality bonuses in the first year.

Bundled Payment

Private payers have been increasingly interested in aligning incentives and optimizing the delivery of care throughout an illness. Episodic payment, also known as “bundled” reimbursement, involves a group of providers agreeing to work together for one fee to ensure that care is coordinated and that the total cost of an episode is within the budget. Under this model, providers share risk of the costs of any unplanned readmissions or complications, creating an economic incentive to prevent those costly events. To ensure quality, patient experience and outcomes are monitored.

CaroMont Health, a regional, not-for-profit healthcare system based in Gastonia, N.C., has partnered with physician practices and Blue Cross and Blue Shield of North Carolina on a bundled payment program for knee replacements. The program covers the 30-day pre-surgical period, the surgery and most follow-up care within 180 days of discharge.

Additionally, the initiative includes a number of features that promote care coordination. “Specific quality and patient satisfaction measures are built in to the plan because we wanted the patient’s needs to guide our program,” said Betty Herbert, CaroMont Health’s director of managed care.

CaroMont Health President and CEO Valinda Rutledge said that this initial program is likely to lead to other improvement opportunities. “Our collaboration with Blue Cross and Blue Shield of North Carolina for the knee replacement bundle is paving the way for us to redesign the delivery of care for other diseases and procedures,” she said.

Conclusion

As this overview of a payment system in transition indicates, the old ways of doing business in healthcare are rapidly becoming obsolete. A new era is being ushered in as healthcare costs have reached a tipping point. Payment for volume of services delivered by physicians based on their preferred method of practice is no longer sustainable.

Hospitals, physicians and clinicians will all have to work together on patient care, ensuring that only needed tests and treatment are employed. High-cost imaging devices, surgical supplies, pharmaceuticals and other materials will have to meet the test of cost-efficiency as well as clinical effectiveness.

Ultimately, the payment system will have to stabilize at a place where providers have a predictable means of fair reimbursement based on the value of care they give to every patient they see.