

Health Care Reform: Predicting the Future of Provider Revenue Streams



Obama's Campaign Platform for Health Care

“Every American has the right to affordable, comprehensive and portable health insurance. America can and must do better when it comes to health care.”

Obama's 8 Principles of Health Reform

- Reduce long-term growth of costs
- Protect Families' Financial Health
- Invest in Prevention and Wellness
- Guarantee Choice
- Improve Patient Safety and Quality of Care
- Assure Affordable, Quality Coverage for All
- Portability of Coverage
- End Barriers to Coverage for Pre-Existing Conditions



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What Do We Know For Sure?

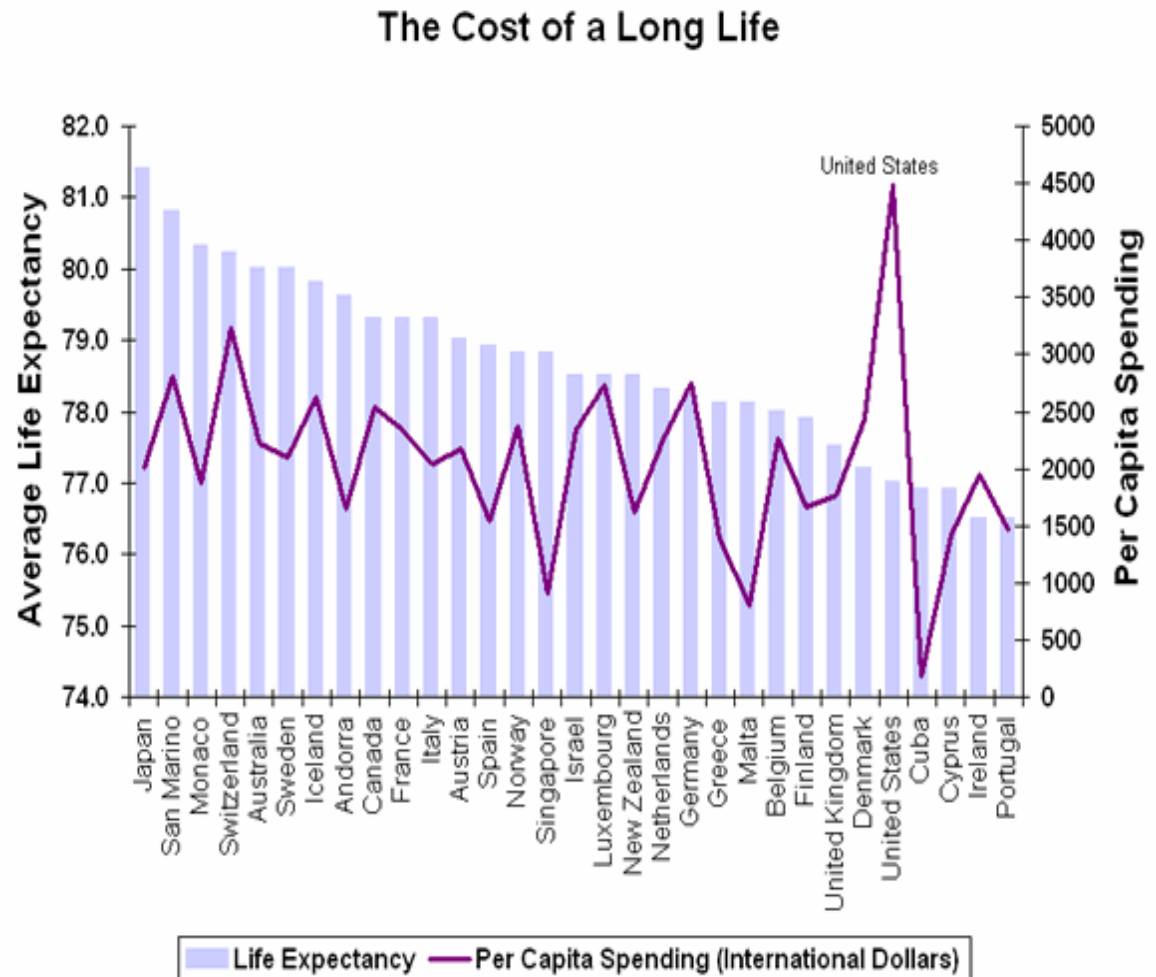
- Nothing.....
- At a broad view, many similarities between the two bills
- President and Congress appeared very confident the plans as laid out, will accomplish the 8 key principles established by President Obama
- America*, however, is not so sure:
 - Majority believe current legislation will increase costs and decrease quality
 - 58% are opposed to reform legislation, with 50% strongly oppose
 - 78% expect it will add to the deficit and lead to tax increases
 - 61% of voters want Congress to drop the health care plan

* Rasmussen Reports: Health Care Reform Final Tracking Poll, Friday January 22, 2010 www.rasmussenreports.com



What Do We Know For Sure?

- Reform is a must!
 - Cost is too high
 - Quality is too low
- The United States spends more than any other country on health care, but historically ***has not*** received a return on its investment when compared to other countries.



* Sources: UC Atlas of Global Inequality: Health Care Spending <http://ucatlas.ucsc.edu/spend.php>

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And Then.....

The Massachusetts election put
a (temporary) halt to it all.....



Massachusetts Senate Elections – The Game Changer

What we think might happen next:

– **Relative uncertainty about the specifics....**

- ◇ Universal Coverage
- ◇ Health insurance market reforms
- ◇ Anti-trust regulations
- ◇ Prevention services & public health

– **Relative certainty that the cost curve will get bent – could be by regulation or legislation**

- ◇ Payment reform through across the board reimbursement cuts
- ◇ Voluntary participation in selected demonstrations
- ◇ Expanded demonstration projects and focus on performance incentives
- ◇ Increase and expansion of fraud & abuse recoveries
- ◇ Continued changes & reductions in Medicaid monies for SNF
- ◇ Increased focus on community based services as a lower cost service
- ◇ Increase in family care and appropriate supports
- ◇ Greater variances state to state



Regardless of the Political Landscape.....

- True reform is necessary, and payment reform will play a critical role in any reform initiative.
- The majority of health care opinion leaders view payment reforms that focus on improving value and increasing productivity are most effective in controlling spending.

Exhibit ES-1. Projected Savings and Effectiveness of System Reform Provisions in House and Senate Reform Bills
2010–2019 (in billions)

	CBO Estimate of Budget Savings, House of Representatives Bill 11/07/09	CBO Estimate of Budget Savings, Senate Bill 12/24/09	Percent Opinion Leaders Favor, or View as Effective	Projected System Cost Containment Effectiveness
Establish a health insurance exchange with market rules; repeal antitrust exemption			92% ^a	++
Public health insurance plan option	-\$5	—	76% ^a	++
Institute payment innovation to reward physicians and hospitals for value not volume	-\$2	-\$8	97% ^b	+++
Require annual provider productivity improvements	-\$177	-\$151		+++
Independent commission	—	-\$28	75% ^d	++
Negotiate pharmaceutical prices	-\$75	—	81% ^d	++
Increase payment for primary care services	-\$6	\$6	61% ^b	+
Cover preventive services and invest in community and employer prevention and wellness programs	\$48	\$17		+
Institute value-based benefit design linked to comparative effectiveness research			86% ^d	+
Level the playing field between Medicare Advantage plans and traditional Medicare coverage	-\$170	-\$136	77% ^b	+
Tax on premiums in excess of threshold	—	-\$149	58% ^c	+

Authors' views of long-term effectiveness in controlling total health system spending: Very effective = +++, Effective = ++, Somewhat effective = +. Health Care Opinion Leaders Surveys: ^a Dec. 2008; ^b April 2009; ^c June 2009; ^d Oct. 2009.
Source: Commonwealth Fund estimates; Congressional Budget Office, Letter to the Honorable John D. Dingell, Nov. 20, 2009; Letter to the Honorable Harry Reid, Dec. 19, 2009.

THE COMMONWEALTH FUND



What Can We Expect?

We believe reform will and must continue, and there will be 5 emerging themes that will prevail:

1. Operational efficiency will be critical
2. Collaboration among **all providers** will be required for survival
3. Significant investments in technology will be necessary
4. Increased quality expectations, reporting and monitoring
5. Elevated regulatory risk



From The LarsonAllen Crystal Ball.....

1. Health care reform will create changes throughout health care provider continuum including reductions and changes in reimbursement methodologies, increased focus on quality, greater personal accountability and more substitution between levels of care....
2. The recovery from the economic downturn has begun, but will require eight to ten years for return to “the good old days” producing a new normal...
3. Operational excellence will be critical to creating sustainable growth & value.....
4. Relationships across the health care spectrum are being reordered and will define success....



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What we believe we know....

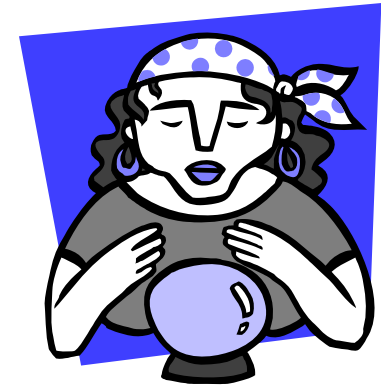
1. Health care reform change will start with doctors, hospitals and insurance companies. *Reimbursement reform will cut across all sites of services.*
2. Long term payment reform will focus on new ways to create greater value. Short term payment reform will be designed to reduce costs and indicators of perceived poor quality.
3. Many of the current care delivery model changes have not achieved their initial goals.
4. In aging services, Home & community based services as a substitute and lower cost alternative are a priority, but limiting the “woodwork effect” and supporting greater family/informal care are also critical.



What we believe we know.....

5. The “new operating environment” will require significant organizational change which will take multiple years to implement:
 - Health information exchange
 - Predictive measures
 - Contracting strategies
 - Relationships with physician and “C-suite” leadership
 - Best practice implementation
 - Culture changes supported by facility change
 - Other

6. Common wisdoms will change:
 - Medicare is profitable
 - Saving way to financial profitability is not possible
 - SNF beds are in oversupply
 - Referrals grow business



Key Provisions Impacting Reimbursement

- There are key provisions in both the House & Senate reform bills that we believe will survive (in some form).
- The majority of these provisions are projected to decrease reimbursement (i.e. **“reduce costs”**), and are as follows:
 - Productivity Adjustment
 - Adjustment to DSH Payments
 - Preventable Hospital/Hospital Acquired
 - Medicare Advantage Reforms
 - Primary Care Incentives
 - Revision to Address Geographic Inequities
 - **Bundled Payments**
 - **Accountable Care Organizations**
 - **Medical Home**
 - **Value Based Purchasing**
- The above items are not controversial, and do not require sweeping reform to be enacted.



Analyzing Spending & Cuts

While certain elements of the legislation are controversial, others are not and can be easily implemented.

		(Dollars in Billions)	
		House Bill *	Senate Bill *
		H.R. 3962	H.R. 3590
Controversial Elements	Projected Spending Increases		
	Expansion of Medicaid/CHIP/Etc.	\$ 425.0	\$ 395.0
	Exchange Subsidies	602.0	436.0
	Small Employer Tax Credits	25.0	40.0
	Total Gross Projected Increase	\$ 1,052	\$ 871
Not Controversial	Projected Current Spending Reductions		
	Impact of Productivity Adj. Into Market Basket Updates & Othr Mrkt Bskt Reductions	\$ (173.3)	(147.0)
	Reduction in DSH Payments	(10.3)	(42.9)
	Home Health Reductions (Market Basket 2010 payment update & productivity)	(54.7)	(39.4)
	Preventable Hospital/Hospital Acquired	(9.3)	(8.6)
	Medicare Advantage Reforms	(170.0)	(118.1)
	Prescription Drug Coverage	(42.30)	(38.4)
	Impact of ACO's/CMS Innovation Center & Eliminate Medicare Improvement Fund	(2.60)	(22.3)
	Net Impact of Other Provisions	8.4	(66.3)
		Net Changes in Direct Spending	\$ (454.1)



Analyzing Spending & Cuts *(cont'd)*

While certain elements of the legislation are controversial, others are not and can be easily implemented.

*Controversial
or at a
minimum
will require
additional
negotiation*

(Dollars in Billions)

	House Bill * H.R. 3962	Senate Bill * H.R. 3590
Projected New Revenue Sources		
Add'l Income Tax on High Earners	\$ (460.0)	-
Penalty Payments Uninsured/Employers	(168.0)	(43.0)
Excise Tax on High Premium Plans	-	(149.0)
Other Effects on Tax Revenues & Outlays	6.00	(64.0)
Estimated Additional Tax Revenues	(114.0)	(264.0)
Net Revenue Provisions	\$ (736.0)	\$ (520.0)
Estimated Net Impact on Deficit	\$ (138.1)	\$ (132.0)
Add: H.R. 3961 Medicare Physician Payment Reform Act of 2009 (Restructure SGR) **	\$ 209.6	\$ -
Total Estimated Net Impact	\$ 71.5	\$ (132.0)

* Source: Congressional Budget Office reports to:
Honorable John D. Dingell, U.S. House of Representatives November 20, 2009
Honorable Harry Reid, Majority Leader United States Senate December 19, 2009

** Source: Congressional Budget Office Cost Estimate dated November 4, 2009



Potential Payment Reform Elements

Key Concepts:

- Care Coordination/Case Mgmt/Disease Mgmt
- Medical Home & Care Transitions
- Patient centered care
- Patient engagement
- Physician practice profiling
- Performance incentives
- Comparative Effectiveness
- Accountable organizations
- Increased informal caregiving

Payment Tools

- Electronic information exchange
- Software to support care delivery
- E-communication tools
- Patient grouper software – diagnoses, severity & episode
- Performance metrics
- Best practice guidelines
- Compliance monitoring
MS-DRGs/APR-DRGs/CPT Coding, etc.

Expected Outcomes:

- Improved effectiveness
- Reduced growth in expenses
- Appropriate utilization
- Better patient experience

Program Examples & Demos:

- Physician Group Practice Model
- Acute Care Episode Demo
- Prometheus Demonstrations
- Hospital Quality Incentive Program
- Medicare Care Management Performance
- Medicare Hospital Gainsharing Demonstration
- Physician Hospital Collaboration Demonstration
- Nursing Home Value Based Purchasing Demo
- Multipayer Advanced Primary Care Initiative
- Physician Episodic Benchmark Report Initiative
- Medical Home Demonstration
- Post-acute Care Bundled Payment Research
- Geisinger ProvenCare Plan

Payment Models

- Fee for Service
- Capitation
- Global Payment – Full or Partial
- Performance Incentives
- Value Based Payments
- Bundled Payments for Episodes of Care
- Pay for Reporting
- Blended Systems

Payment Reform Elements – Bundled Payments

House Bill

- Goals:
 - Improve coordination, quality, efficiency and reduce need for readmission to hospital
- Proposed Models:
 - Bundling Post-Acute Services
 - Conversion of Acute Care Episode (ACE) Demonstration to Pilot Program & Expand to Post-Acute Services

Senate Bill

- Goals:
 - Improve coordination, quality & efficiency of health care services provided to beneficiaries around a hospitalization.
- Proposed Models:
 - Bundles payments for services as a result of hospitalization for 1 or more of 8 conditions selected by the Secretary



Current Understanding – Episodes of Care

EXHIBIT 1

Median Number Of Physicians Involved In Medicare Beneficiaries' Episodes Of Care Related To Nine Clinical Conditions, 2005

Condition	Primary care	Specialist
Acute myocardial infarction	2	6
Bacterial pneumonia	1	3
Breast cancer	0	3
Cerebrovascular disease	1	3
Chronic obstructive pulmonary disease	1	2
Congestive heart failure	1	1
Diabetes	1	0
Hip fracture	1	5
Low back pain	0	1

SOURCE: Authors' analysis of Medicare claims data.

The complexity of preparing for and managing Episodes of Care and Bundled Payments should not be underestimated.

Source: *Episode-Based Performance Measurement & Payment: Making it A Reality*; Hussey, Peter, et. Al., Health Affairs, Sept/Oct 2009, pgs 1406- 1417



Current Understanding – Episodes of Care

There are 524 identified episodes of care for Medicare:

- 20 conditions account for 58% of all episodes of care
 - ◇ Fracture & dislocation of lower extremity and bacterial lung infections are the only two that are acute. Remaining 18 are chronic conditions, i.e., diabetes, AMI, CHF, etc.
- 10 of these conditions represent the fastest growing costs of care and represented 29% of Medicare spending in 2005
- The growth and spending on episodes varies significantly by geographic areas of the country
- Episodes of care information is the basis for the Physician Quality Improvement Report that is being distributed confidentially to physicians
 - ◇ Data base of information has multiple years
 - ◇ Extensive analysis has been conducted



Episodes of Care – Key Diagnostic Groups

The 20 highest spending level episodes, 2005

Rank	Episode	Share of total spending	Incidence rate*
1	Ischemic heart disease	14.0%	20
2	CHF	4.3	8.0
3	Hypertension	4.0	44.0
4	Cerebral vascular accident	3.6	8.0
5	COPD	3.4	7.0
6	Diabetes	3.2	18.0
7	Joint degeneration - knee and lower leg	3.1	7.0
8	Joint degeneration - back	3.0	12.0
9	Chronic renal failure	2.8	4.0
10	Closed fracture or dislocation - thigh, hip & pelvis	2.3	1.0

*per 1000 beneficiaries with episodes

Source: "Greatest total Medicare spending and fast growing episodes"; Podulka, J.; MedPac; September 18, 2009 meeting presentation accessed via the web October 8, 2009



Episodes of Care – Key Diagnostic Groups

The 20 highest spending level episodes, 2005 (continued)

Rank	Episode	Share of total spending	Incidence rate*
11	Cataract	2.3%	24.0
12	Bacterial lung infections	2.1	3.0
13	Malignant neoplasm of pulmonary system	1.6	1.0
14	Malignant neoplasm of prostate	1.4	3.0
15	Malignant neoplasm of breast	1.4	3.0
16	Psychotic & schizophrenic disorders	1.3	2.0
17	Malignant neoplasm of skin, major	1.2	8.0
18	Joint degeneration - thigh, hip and pelvis	1.2	2.0
19	Other metabolic disorders	1.2	6.0
20	Atherosclerosis	1.1	3.0

*per 1000 beneficiaries with episodes

Source: "Greatest total Medicare spending and fast growing episodes"; Podulka, J.; MedPac; September 18, 2009 meeting presentation accessed via the web October 8, 2009



Episodes of Care – Key Diagnostic Groups

The 20 fastest* growing episodes to 2005

Rank	Episode	Ave. annual growth	Share of total 2005 spending
1	Joint degeneration - neck	19.0%	0.8
2	Other metabolic disorders	18.0	1.2
3	Lymphoma	16.0	0.6
4	Joint degeneration - back	16.0	3.0
5	Joint degeneration - knee and lower leg	14.0	3.1
6	Chronic renal failure	14.0	2.8
7	COPD	12.0	3.4
8	Malignant neoplasm of breast	11.0	1.4
9	Adult rheumatoid arthritis	11.0	0.1
10	Malignant neoplasm of large intestine	11.0	0.6

*among episodes that accounted for $\geq 0.5\%$ of total Medicare spending on episodes

Source: "Greatest total Medicare spending and fast growing episodes"; Podulka, J.; MedPac; September 18, 2009 meeting presentation accessed via the web October 8, 2009



Episodes of Care – Key Diagnostic Groups

The 20 fastest* growing episodes to 2005 (continued)

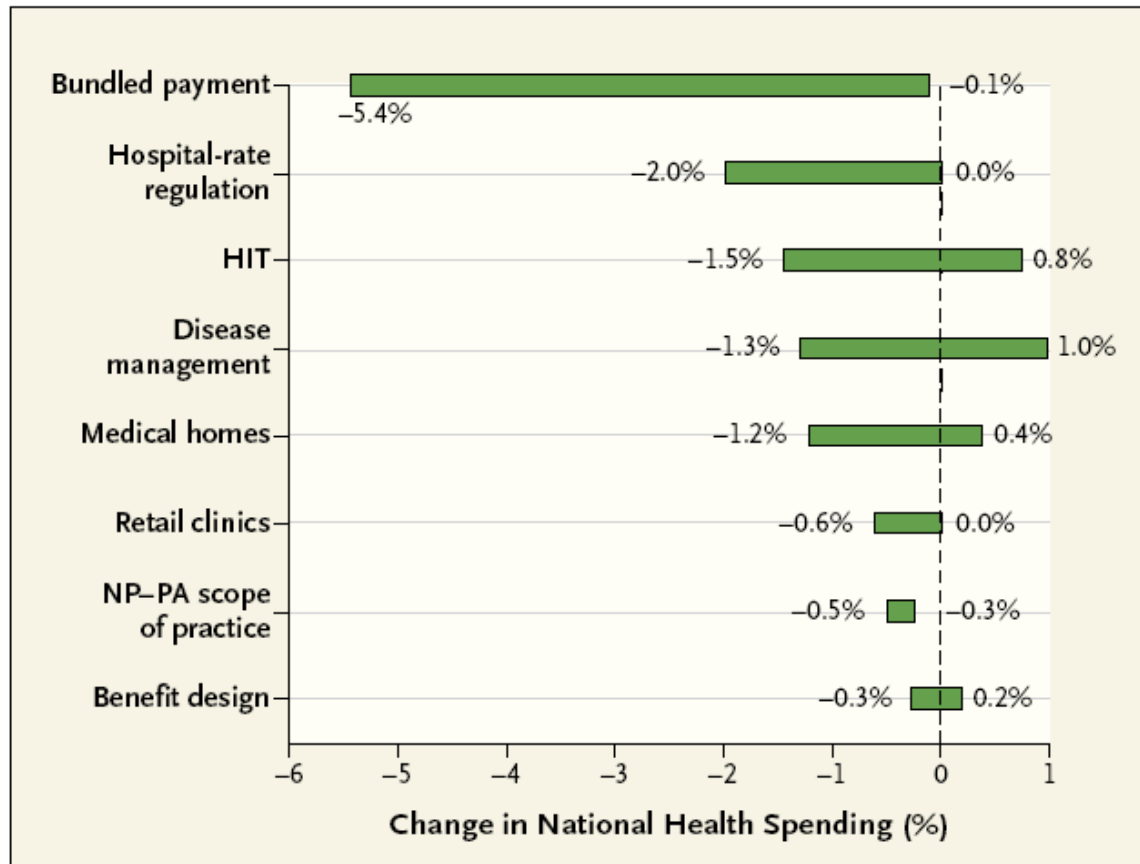
Rank	Episode	Ave. annual growth	Share of total 2005 spending
11	Atrial fibrillation and flutter	10.0%	0.8
12	Malignant neoplasm of skin, major	10.0	0.8
13	Atherosclerosis	10.0	1.1
14	Hypertension	10.0	4.0
15	Spinal trauma	10.0	0.6
16	Chronic skin ulcers	10.0	0.6
17	Joint degeneration - think, hip and pelvis	9.0	1.2
18	Non-malignant neoplasm of prostate	8.0	0.5
19	Leukemia	8.0	0.5
20	Infection of lower genitourinary system...	7.0	0.9

*among episodes that accounted for $\geq 0.5\%$ of total Medicare spending on episodes

Source: "Greatest total Medicare spending and fast growing episodes"; Podulka, J.; MedPac; September 18, 2009 meeting presentation accessed via the web October 8, 2009



Why Bundled Payment Method is Key



*“....under optimistic scenarios and with broad use of the Prometheus model of bundled payment for six chronic conditions and four acute conditions...health care spending could be reduced by 5.4%.....”**

*“....many of the options being considered are likely to improve the value of our health care system, only some have the potential to reduce spending.”**

Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform.

* Source: Perspectives: *Controlling US Health Care Spending – Separating Promising from Unpromising Approaches*, Hussey, Peter, Ph.D., et. al., NEJM, 11/09; accessed via the web 12/09.



Key Strategic Issues - Proposed Bundled Payment Pilots

HHS Secretary to further define many of the implementation details for implementing the bundling payments pilots such as:

- Who can receive bundled payments?
- Which services should be included (e.g. should inpatient payment)?
- What duration of service does the bundled payment cover?
- Which inpatient providers should be included, (i.e., Critical Access Hospitals)?
- Define the relationships between providers, such as terms of contracts, application of gain sharing, anti-referrals, anti-kickbacks, etc.
- What are the expected payment offsets for efficiencies achieved through bundling?
- What are the payment rates, (i.e., national, regional, etc.)?
- What consumer protections are needed to assure quality care and access from their provider of choice?
- What standard assessment tool should be used? (building off the CARES tool)
- What is the estimated extent to which transitions of care would be improved?
- What are the proposed quality measures?
- Should current program rules apply? If not, which ones should be waived? (e.g. post-acute transfer payment rules, the SNF three-day acute care rule, the 65% rehab rule)



Strategic Questions: Bundled Payments

- What are our organization's current costs of care per episode (focus on current 8 MS/DRGs)?
- How do we track costs throughout our system? How would we do this if we worked with other providers?
- Are we an integrated system with all of the components of the health care system? Or do we need to develop relationships with other providers in order to participate?
- Do we have an Electronic Health Record? Can we share it with other provider groups?
- Do we want to be the administrator of the bundled payment or subcontract with another provider/organization/system to provide certain services?
- Who are our natural partners?
- How do we track quality currently? How do we rank on quality benchmarks currently compared to our peers? Where do we need to improve on quality and efficiency?
- What type of legal structure must be in place to receive a bundled payment? Do we have it? Should we pursue it?



Payment Reform Elements – Accountable Care Organizations (ACOs)

House

- Goals:
 - Test different payment incentive models including models designed to reduce growth of expenditures and improve health outcomes.
 - Encourage investment in infrastructure, redesign care processes for quality and efficiently and reward providers.
- Eligible Providers:
 - Physicians and other health care providers that enter into agreements with physicians.

Senate

- Goals:
 - Promote accountability for a patient population and coordinates items and services, encourages investment in infrastructure and redesigns care processes for high quality and efficient service delivery.
 - Share savings with eligible ACOs.
- Eligible Providers:
 - Professionals in group practices; networks of individual practices; partnerships & joint ventures between hospitals & ACO professionals; hospitals employing ACO professionals; other groups of providers of services approved by the Secretary.



Accountable Care Organizations: Background

Medicare has been testing the ACO concept via demonstrations and pilot projects

- **Medicare Physician Group Practice Demo**: paid pay-for-performance incentives to physician groups to coordinate overall care for Medicare patients.
 - 5,000 physicians and 224,000 Medicare FFS patients participated
 - Promising outcomes: improved care coordination, careful attention to hospital discharge processes, expanded role for non-physician providers, IT investments.
 - Incentive compensation was material
 - 10 Physician practices participating:
 - Billings Clinic, Billings, MT; Dartmouth-Hitchcock Clinic, Bedford, NH; The Everett Clinic, Everett, WA; Forsyth Medical Group, Winston-Salem, NC; Geisinger Clinic, Danville, PA; Marshfield Clinic, Marshfield, WI; Middelsex Health System, Middletown, CT; Park Nicollet Health Services, St. Louis Park, MN; St. John's Health System, Springfield, MO; & University of Michigan Family Group Practice, Ann Arbor, MI.



Preparation for an ACO

1. How will providers or hospitals determine who to include in the ACO?
 - How will enrollment of specialists be included?
 - How will integrated health systems include non-employed physicians?
 - Will there be an open platform or will it be based on some criteria?
2. What kinds of technology will be required to develop an ACO across organizational participants?
 - How will technology support care coordination, individualized care plans?
 - How will technology support monitoring best practice compliance?
 - How will we develop systems to monitor billing by multiple providers?
3. How will best practices be identified and implemented? How will compliance be monitored?
4. How will enrollment be done and beneficiaries targeted to assure a balanced beneficiary profile?
5. How will risks and rewards be structured?



Strategic Questions

- Which providers can form an ACO? – physicians, LTC, hospitals, specialists
- Which providers would lead an ACO vs. subcontract?
 - What does this mean for hiring, staffing in the near term?
 - How will subcontractor care delivery behavior change in an ACO?
 - What skills or staff does an ACO owner need to be successful? (e.g., risk management, financial, etc.)
- If provider isn't the ACO owner...
 - How can an organization position itself to be included as a subcontractor?
 - How does a subcontracting provider get paid? How much can they expect?
 - What leverage do they have in contracting with the ACO?
- What is the organizational structure of an ACO and how will control be shared?
- What is the appropriate size – revenue, number of physicians --for an actuarially sound ACO?
- What must providers do in Phase I of ACOs/bundled payments? Phase II? Phase III? Etc.



Payment Reform Elements – Medical Home Model

House

- Goals:
 - Evaluate feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services to beneficiaries and high need beneficiaries.
 - Test payment incentive & service delivery model utilizing physicians & nurse practitioner directed home-based primary care teams designed to reduce cost & improve outcomes.
- Models:
 - Independent Patient-Centered Medical Home Model
 - Community-Based Medical Home Model
 - Home-based and monitored care for chronically ill beneficiaries

Senate

- Goals:
 - Test payment incentive & service delivery utilizing physicians & nurse practitioner directed home-based primary care teams designed to reduce cost & improve outcomes.
- Models:
 - Home-based and monitored care for chronically ill beneficiaries.



Initial Findings from Medical Home Pilots

1. Medical Homes were woefully under funded and required more time and energy than initially anticipated
2. Physicians do not have the resiliency or training for long term change efforts – changing to a Medical Home requires “whole-practice reimagination and redesign.”
3. Technology was not readily available to support care coordination, individualized care planning, etc. &/or it did not readily integrate with EMR technology
4. Implementing best practices was difficult and the results were less than anticipated
5. Transformation to a Medical Home requires personal transformation of physicians which is hard, difficult work
6. Medical homes are driven by local characteristics and one-size does not fit all

Source: *Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*; Nutting, MD, Paul, et. Al., *Annals of Family Medicine*, June 9, 2009; accessed via the web 6/25/09.



Value Based Performance Payment

Value Based Performance Payment is a generic term for payments that:
“improve beneficiary health outcomes and experience of care by using payment incentives & transparency to encourage higher quality, more efficient professional services.”

Key Objectives:

1. Encourage use of evidence based medicine
2. Reduce fragmentation, duplication & inappropriate use of services
3. Encourage effective management of chronic disease
4. Accelerate the adoption of health information exchange
5. Empower & engage consumers

Key Assumptions:

1. Performance based payments will drive change
2. Different practice arrangements will be accommodated
3. Multidisciplinary team members will be recognized
4. Accountability will be across multiple levels and sites of services
5. Plan will be budget neutral
6. Focus will be to change FFS and there will be a short term and long term strategy

Source: *Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physicians and Other Professionals, Issue Paper, Public Listening Session, December 9, 2008; CMS*



Payment Reform Elements – Value Based Purchasing

House

- Goals:
 - Conduct a study on geographic variation and growth in volume and intensity of services per capita, and issue a report that outlines how the Medicare payment system should be modified to incentivize high-value care.
- Specific Considerations:
 - Adoption of a “value index” on a composite of appropriate measures of quality & cost that would adjust provider payments on a regional or provider-level basis.
- Timing:
 - Report due to Congress by April 15, 2011, with final implementation plan due within 240 days thereafter

Senate

- Goals:
 - Establish a hospital value-based purchasing program under which valued-based incentives are med to hospitals for meeting established performance standards.
- Specifics Considerations:
 - For FFY 2013 following measures will be selected:
 - ◇ Acute Myocardial Infarction (AMI)
 - ◇ Heart Failure
 - ◇ Pneumonia
 - ◇ Health-associated infections
- Timing:
 - Payments for discharges on or after October 1, 2012.



Payment Reform Elements – Value Based Purchasing

Senate – Additional Provisions

- **Physician Services**
 - Extends Physician Quality Reporting Initiative (PQRI) through 2014
 - Establishes up to a 2% penalty for non-participation beginning in 2014
 - Requires a plan to incorporate quality reporting with EHR meaningful use regulations.
 - Directs Secretary to develop “value-based modifier” that will adjust physician payments based on quality & cost of care.
- **Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals & Hospices**
 - Requires Secretary to implement quality measure reporting system by FY 2014
 - Providers who do not successfully participate would be subject to reductions in market basket updates.
- **Skilled Nursing Facilities**
 - Secretary required to file a plan with Congress by FY 2012 on how providers can be moved to a value-based purchasing payment system.



Moving to Value Based Purchasing

- CMS has outlined key areas where they would focus their efforts for the next 3 to 5 years to restructure the payment system*:
 - ESRD Services
 - ◇ Begins 4 year transition to bundled payments beginning in 2011.
 - ◇ Passed as part of MIPAA.
 - Hospital VBP Plan
 - ◇ CMS has submitted plan to Congress laying out steps to move hospitals to a pay-for-performance system.
 - Physician VBP Plan Development
 - ◇ CMS has completed key steps in this process, and would focus on completing plan to be submitted to Congress.
 - Post-Acut Care Payment Reform Demonstration
 - ◇ Authorized by Section 5008 of DRA
 - Promote Better Alignment of Financial Incentives Among Providers
 - ◇ Goal of promoting better alignment of financial incentives among providers.
 - ◇ Would take regulations revision to allow for ACO development

Source: * Centers for Medicare & Medicaid Services: "Roadmap to Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program



Preparing for Change....

Key Strategies for Health Care Providers:

1. Creating an understanding of existing patient care delivery patterns
2. Developing robust predictive measurement systems for utilization, quality and costs
3. Developing organizational capabilities for electronic health exchange and communications
4. Identifying and implementing best practices and strategies by diagnoses
5. Determining processes and demonstrating patient-centered care and patient engagement approaches
6. Developing relationships at the “C-Suite” Level



Conclusions

1. The promise of change will eventually happen, but timing is uncertain.
2. There is substantial work to be done to assure preparation for many of the proposed reforms.
3. The expectation is that changes will be gradually implemented.
4. Costs of care will be reduced and the impact will occur across all venues of care, but particularly hard hit will be hospitals.
5. New relationships with physicians and post-acute providers will be required.
6. Others.....



Thank You

Thank you for joining our webinar.

Be sure to watch for our weekly blog on health care and payment reform at:

<http://www.larsonallen.com/blog.aspx?category=Health+care&blogid=537>

Additional questions can be submitted by email to:

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