The Future of Healthcare Delivery; Are we ready?

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Objectives

1. Discuss 5 of the projected transformational changes in health care and the impact of these on patients and providers.
   - A. Payment reform
   - B. New delivery models
   - C. Technology/telehealth
   - D. Prevention and wellness*
   - E. Consumer engagement*

2. Identify resources to help you meet the challenges ahead
Value-Based Healthcare

- Medicare to shift incentives for payment from volume to value/quality and to alternative payment models
  - 2016: 30% of FFS payments based on value and provided through alternative payment models
  - 2018: 50% of FFS payments based on value and provided under alternative models that base payments on quality of care

Health Care Transformation Task Force:

Private payers to shift 75% of operations to contracts designed to improve quality and lower costs by 2020

http://www.hcttf.org/
### Major Changes to Quality Reporting Programs Under Medicare

<table>
<thead>
<tr>
<th>Health Care Setting</th>
<th>Reporting Level</th>
<th>Program Details/ Data</th>
<th>Payment Incentive/ Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care Hospitals (LTCH)</td>
<td>Facility</td>
<td>• IMPACT Act: standardized data set and quality measures for all PAC settings</td>
<td>Likely to evolve to P4P over time with IMPACT implementation</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Facilities (IRF)</strong></td>
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<td>Skilled Nursing Facilities (SNF)</td>
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<td>Home Health</td>
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<tr>
<td><strong>Outpatient</strong></td>
<td>Individual or Group</td>
<td>MIPS (merit-based incentive program) *Replaces PQRS</td>
<td>P4P</td>
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</tbody>
</table>

P4P= Pay for Performance
Improving Medicare Post-Acute Care Transformation (Impact ACT)

• Require standardized patient assessment data reporting at times of admission and discharge by October 1, 2018, for SNFs, IRFs, and LTCHs and by January 1, 2019, for HHAs.

• Require new quality measures beginning 10/1/2016-1/1/2019, including functional status, skin integrity, medication reconciliation, incidence of major falls, and patient preference regarding treatment and discharge.
Improving Medicare Post-Acute Care Transformation (Impact ACT)

- Require resource use measures by October 1, 2016, including spending per beneficiary, discharge to community, and hospitalization rates of potentially preventable readmissions.

- Require MedPAC and HHS to study alternative PAC payment models.
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Bipartisan legislation passed in 2015 to replace sustainable growth rate formula to pay clinicians.

- Quality payment program that has two paths:
  - Merit based incentive payment system (MIPS)
  - Advanced alternative payment models (APMs)
Merit Based Incentive Payment System

- MIPS will replace PQRS, value modifiers and the EHR incentive system.

- MIPS has 4 components:
  1. Cost; 10% of total score based on claims data so no additional reporting required.
  2. Quality; 50% based on 6 chosen quality measures (replaces 9 from PQRS).
3. Clinical Practice Improvement Activities; 15% of total score and clinicians can select from 90 goals to improve practice (i.e. beneficiary engagement).

4. Advancing Care Information; 25% of total score based on clinician choices regarding how they use EHR with emphasis on interoperability and information exchange.
<table>
<thead>
<tr>
<th>Current Year (Reporting Year)</th>
<th>Year Penalty/Payment Applied</th>
<th>PQRS Penalty</th>
<th>Incentive/ Penalty</th>
<th>MIPS Incentive/ Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>2017</td>
<td>-2.0%</td>
<td></td>
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</tr>
<tr>
<td>2016</td>
<td>2018</td>
<td>-2.0%</td>
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<tr>
<td>2017</td>
<td>2019</td>
<td>4.0 to -4.0%</td>
<td>Includes specified non physician eligible providers (PA, NP, CRNAs)</td>
<td>3.0 to -4.0%</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
<td></td>
<td></td>
<td>3.0 to -5.0%</td>
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<tr>
<td>2019</td>
<td>2021</td>
<td></td>
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<td>3.0 to -7.0%</td>
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<td></td>
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<td>CMS may add remaining practitioners**</td>
<td></td>
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<tr>
<td>2020</td>
<td>2022</td>
<td></td>
<td></td>
<td>3.0 to -9.0%</td>
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MIPS Must be Budget Neutral
Advanced alternative payment models (APMs)

- Clinicians who participate to a “sufficient” extent in APMs would be exempt from MIPS adjustments and would quality for 5% incentive payment.

- Advanced APMs are the CMS Innovation Center models, Shared Savings Program tracks, or statutorily-required demonstrations where clinicians accept both risk and reward for providing coordinated, high quality, and efficient care.
Proposed APM Models

Current models include

- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program—Track 2
- Medicare Shared Savings Program—Track 3
- Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)
Acute Care Hospital Reimbursement

• Medicare Inpatient Prospective Payment System
  • Medicare Severity-Diagnostic Related Group (MS-DRG)
  • Adjustments made for the following quality indicators;
    • value based purchasing program (VBP)- (patient experience, outcomes, efficiencies)
    • hospital readmissions reductions
    • hospital acquired conditions reductions (HAC)
  • EHR
Payment Reform: Bundled Payments
CMMI/CMS – Comprehensive Care for Joint Replacement (CCJR) Bundled Payment Model
Proposed Comprehensive Care for Joint Replacement Payment Model

- Proposed CCJR Model focused on elective primary hip and knee replacement patients
- Model includes inpatient stay and post discharge care 90 days after discharge
- Pilot begins January 1, 2016 and lasts for 5 years
CCJR Quality Measures

- **Required:**
  - Hospital-level 30-day following elective primary THA and/or TKA
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS Survey)

- **Optional:**
  - Patient reported outcome measures
    - Patient-Reported Outcomes Measurement Information System (PROMIS Global)
    - Veterans RAND 12 item health survey
    - Knee injury/Osteoarthritis Outcome Score (KOOS)
    - Hip disability/Osteoarthritis Outcome Score (HOOS)
Financial Arrangements

- CMS sets Medicare episode prices for each participant hospital that includes payment for all related services received.

- All providers and suppliers would be paid under the usual payment system rules and procedures throughout the year.

- At year end actual spending for the episode would be compared to the proposed episode price.

- Depending on the hospital’s quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.
Impact of Payment Reform

- Impact on patients?

- Impact on providers? No change in size of the payment pie
“THE PESSIMIST COMPLAINS ABOUT THE WIND; THE OPTIMIST EXPECTS IT TO CHANGE; THE REALIST ADJUSTS THE SAILS.”

WILLIAM A. WARD
Alternative Delivery Models
Accountable Care Organizations

The ACO, in its most basic form, is a collaboration among primary care clinicians, a hospital, specialists and other health professionals who accept joint responsibility for the quality and cost of care provided to a population of patients. If the ACO meets certain quality and savings targets, its members receive a financial bonus.
Triple Aim of ACOs

• Better care for individuals with respect to safety, patient-centeredness, timeliness, efficiency and equity

• Better health for populations through preventive services and education

• Slower growth in costs through improvements in care and elimination of waste in the healthcare system
Accountable Care Organizations

Number of ACOs
- Non-CMS ACOs
- Medicare ACOs

Number of non-Medicare patients served by Medicare ACOs
- Jan 2013: 15MM
- July 2013: 25MM
- Jan 2014: 33MM

http://www.oliverwyman.com/insights/publications/2014/apr/aco-update--accountable-care-organizations-now-
Patient Centered Medical Homes

The “medical home” provides patients with a central primary care practice or provider who coordinates the patients’ care across settings and providers. This might be promoted through a capitated payment or other financial incentive to providers to encourage preventive care and chronic care management, as well as reduce reliance on specialist and emergency care.
Patient Centered Medical Homes

NCQA PCMH Growth 2008-2015

www.ncqa.org
Health Related Technology
Dr. Watson Sample

1. **Computerized diagnosis and treatment:**

- IBM developing the supercomputer known as Watson to help physicians make better diagnoses and recommend treatments. Doctors at Memorial Sloan-Kettering Cancer Center in New York are expected to begin testing Dr. Watson later this year.

- Medical consultations online and by phone, potentially saving a trip to the ER (Sherpaa). The medical advice is provided by some of the city’s top medical specialists. Employers are signing up for the service.
2. Helping healthcare providers communicate with patients:

a. Science Applications International Corporation (SAIC) has developed Omnifluent Health, a translation program for doctors and others in the medical field. Instant verbal translation of health related information.

b. Mobile apps for compliance and monitoring

c. Mobile and computer applications for scheduling, accessing medical records

d. Telemedicine
Telehealth: Predicted Growth

• Analysts predict that the U.S. telehealth market will grow to $1.9 billion in 2018 from $240 million today, an annual growth rate of 56 percent.

• Driving forces: Enhancing patient access and convenience while producing quality outcomes and potentially reducing costs.
Telehealth: Opportunities

**HRSA Grants:**

**Telehealth Network** grants fund projects that demonstrate the use of telehealth to improve healthcare for the medically underserved in urban, rural, and frontier communities.

**Telehealth Resource Center** grants provide support for the establishment and development of TRCs. These centers assist in the implementation of cost-effective telehealth programs to serve rural and medically underserved areas and populations.
3. Linking healthcare providers with other healthcare providers

- Doximity, a social network allowing doctors to collaborate on difficult cases.
- Telemedicine
5. Helping patients stay healthy:

- Activity/exercise monitors/apps
- Sleep monitors/apps
- Calorie counters/menu tracker apps
- Physician initiated mobile reminders for everything from taking meds to applying sunscreen
7. Technologies to assist with diagnosis
   • Digestible sensors
   • Mobile ultrasounds
   • Mobile cardiac monitors

8. Other
   • 3D printed biological materials
   • Microchip modeling of clinical trials
   • Electronic Underwear Preventing Bed Sores
   • Lightbulbs that Disinfect and Kill Bacteria
   • Prosthetics controlled by the mind/brain
Prevention and Wellness

- National Prevention Strategy developed by National Prevention Council formed by Affordable Care Act

- 4 primary strategies
  - Building Healthy and Safe Community Environments (work, home etc)
  - Expanding Quality Preventive Services
  - Empowering People to Make Healthy Choices
  - Eliminating Health Disparities
7 Priorities

- Tobacco free living
- Preventing drug abuse and excessive alcohol use
- Healthy eating
- Active living
- Injury and violence-free living
- Reproductive and sexual health
- Mental and emotional wellbeing
Mandatory Insurance Coverage for Prevention Services

https://www.healthcare.gov/coverage/preventive-care-benefits/
Consumer Engagement and Transparency

Inform Me

Support my eCommunity

Engage Me

Partner with Me

Empower Me
Consumer Engagement and Transparency

• Medicare Physician Compare Website
  https://www.medicare.gov/physiciancompare/search.html

• e-patients: Health consumers sometimes referred to as “internet patients” who participate fully in their medical care.
Either you’re an agent of change, or you’re destined to become a victim of change. You simply can’t survive over the long term if you insist on standing still.

- Norm Brodsky, Entrepreneur
Questions/Discussion