Value Based Care and Healthcare Reform

Dimensions in Cardiac Care
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Jacqueline Matthews, RN, MS
Senior Director, Quality Reporting & Reform
Quality and Patient Safety Institute
Cleveland Clinic
“The promise of our healthcare system is to provide all Americans with access to healthcare that is safe, effective and affordable. But our system as it is today is not delivering on that promise.”

CMS National Priorities - 2008
Current Healthcare System

- **Uncoordinated**: Fragmented delivery systems with highly variable quality
- **Unsupportive**: Costs rising at twice the inflation rate
- **Unsustainable**: of patients and physicians
Healthcare Spending as % GDP

- Proportion of spending attributable to Medicare/Medicaid is expected to rise from 4% of GDP in 2007 to 19% GDP in 2020.

- Healthcare spending will be the principle driving force behind rising federal spending in the decades to come.
U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

<table>
<thead>
<tr>
<th>Overall Health Care Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>U.S.</strong></td>
</tr>
<tr>
<td><strong>High</strong></td>
</tr>
<tr>
<td><strong>Low</strong></td>
</tr>
<tr>
<td>Switzerland</td>
</tr>
<tr>
<td>Sweden</td>
</tr>
<tr>
<td>Australia</td>
</tr>
<tr>
<td>Germany</td>
</tr>
<tr>
<td>The Netherlands</td>
</tr>
<tr>
<td>New Zealand</td>
</tr>
<tr>
<td>Norway</td>
</tr>
<tr>
<td>France</td>
</tr>
<tr>
<td>Canada</td>
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</table>

## International Study: Healthcare Quality

### Country Rankings

<table>
<thead>
<tr>
<th>Category</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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<tr>
<td>Overall Ranking (2013)</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>3</td>
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</tr>
<tr>
<td>Quality Care</td>
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<td>9</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>11</td>
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<tr>
<td>Effective Care</td>
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<td>7</td>
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<td>6</td>
<td>6</td>
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<td>Safe Care</td>
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<tr>
<td>Patient-Centered Care</td>
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<td>8</td>
<td>10</td>
<td>7</td>
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<td>Cost-Related Problem</td>
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<td>11</td>
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<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>11</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>8</td>
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<td>Healthy Lives</td>
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<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

### Health Expenditures (Capita, 2011**)

- AUS: $3,800
- CAN: $4,522
- FRA: $4,118
- GER: $4,495
- NETH: $5,099
- NZ: $3,182
- NOR: $5,669
- SWE: $3,925
- SWIZ: $5,643
- UK: $3,405
- US: $8,508

Notes: * includes ties, ** Expenditures shown in USD PPP (purchasing power parity); Australian $ data are from 2010.

Goal of Healthcare Reform

Transforming Medicare from a passive payer to an active purchaser of higher quality and more efficient health care
Future System

- Affordable
- Accessible – to care and to information
- Seamless and Coordinated
- High Quality – timely, equitable, safe
- Person and Family-Centered
- Supportive of Clinicians in serving their patients needs
Affordable Care Act

- Focus on the expanded access to affordable insurance coverage

- Key provisions to save $417.5 billion in 10 years

- Provisions also focus on initiatives to move CMS from a passive payer to an engaged payer.
Key Elements of Reform

• Expanding Coverage
• Delivery System and Payment Redesign
• Aligning Payment with Quality
• Workforce Development
• Wellness and Prevention
Affordable Care Act
Aligning Quality with Payment

Increase Access
- Marketplace for consumers to shop and purchase insurance
- Health plans guaranteed regardless of health status

Improve Affordability
- Exchanges promote price and quality transparency
- Coverage is subsidized for those who earn between 100% and 400% of federal poverty line

Improve Quality
- Plans must offer essential health benefit standards
- Exchange plans required to report on quality measures starting in 2016

Source: PwC Health Research Institute
National Strategy for Quality Improvement in Healthcare
TRIPLE AIM: KEY STRATEGIES
6 Priorities

- Safer Care
- Effective Care Coordination
- Person and Family Centered Care
- Prevention and Treatment of leading causes of mortality
- Supporting Better Health in Communities
- Making Care More Affordable
US Healthcare Transformation

- Delivery of Care Models designed around patients are integrated
- Alignment of incentives
- Transparency of quality and cost metrics
- Eliminating disparities
- Quality improvement
- Coordination of care
- Consistent national standards
Transforming & Implementing Payment Strategies

• CMS Pay for Performance
  - Readmission Reduction Program
  - HAC Reduction Program
  - Hospital Value Based Purchasing
  - Physician Value Modifier Program

• Payment Reform
  - Accountable Care Organizations
  - Bundled Payments
  - Medicare Shared Savings Programs
VALUE IN HEALTHCARE
What Does ‘Value’ Really Mean?

Achieving the best outcomes at the lowest cost.

Value = \frac{\text{Outcomes}}{\text{Cost}}
The Shift: Volume to Value

<table>
<thead>
<tr>
<th>Volume-Based</th>
<th>Value-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment</td>
<td>Fee-for-Service</td>
</tr>
<tr>
<td>Focus</td>
<td>Acute Episodes</td>
</tr>
<tr>
<td>Role of the Provider</td>
<td>Single Episodes</td>
</tr>
<tr>
<td>Information</td>
<td>Retrospective</td>
</tr>
</tbody>
</table>

Fundamentally new orientation & capabilities
Measuring Value

- Value
  - Total Cost of Care
    - Resource Use
    - Price
  - Quality
    - Patient Experience
    - Clinical Care
Measuring Value in Healthcare

Public Program

<table>
<thead>
<tr>
<th>Population Health</th>
<th>Measured Group(s)</th>
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</thead>
<tbody>
<tr>
<td>Accountable Care</td>
<td>Both</td>
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<tr>
<td>PQRS Value Modifier</td>
<td>Physicians</td>
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</table>

<table>
<thead>
<tr>
<th>Episodes of Care</th>
<th>Measured Group(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Cost of Episodes of care</td>
<td>Hospitals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discrete Hospitalizations</th>
<th>Measured Group(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Based Purchasing</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Hosp. Acquired Conditions</td>
<td>Hospitals</td>
</tr>
</tbody>
</table>
National Scorecard on Payment Reform

- Commercial health plans have dramatically shifted how they pay physicians and hospitals
  - 40% of payments now designed to encourage health care providers to deliver higher-quality and more affordable care
The Value Agenda

The strategic agenda for moving to a high-value health care delivery system has six components. They are interdependent and mutually reinforcing. Progress will be greatest if multiple components are advanced together.

1. ORGANIZE INTO INTEGRATED PRACTICE UNITS (IPUs)
2. MEASURE OUTCOMES AND COSTS FOR EVERY PATIENT
3. MOVE TO BUNDLED PAYMENTS FOR CARE CYCLES
4. INTEGRATE CARE DELIVERY ACROSS SEPARATE FACILITIES
5. EXPAND EXCELLENT SERVICES ACROSS GEOGRAPHY
CMS VALUE PROGRAMS
CMS Quality Reporting and Performance Programs

<table>
<thead>
<tr>
<th>Hospital Quality</th>
<th>Physician Quality</th>
<th>PAC &amp; Other Settings</th>
<th>Payment Model</th>
<th>Population Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicare &amp; Medicaid EHR Incentive Program</td>
<td>• Medicare &amp; Medicaid EHR Incentive Program</td>
<td>• Inpatient Rehab Facility</td>
<td>• Medicare Shared Saving Program</td>
<td>• Medicaid Adult Quality Reporting</td>
</tr>
<tr>
<td>• PPS-Exempt Cancer Hospitals</td>
<td>• Physician Quality Reporting System (PQRS)</td>
<td>• Nursing Home Compare Measures</td>
<td>• Hospital Value-based Purchasing</td>
<td>• CHIPRA Quality Reporting</td>
</tr>
<tr>
<td>• Inpt Psychiatric Facilities</td>
<td>• eRx Quality Reporting</td>
<td>• LTCH Quality Reporting</td>
<td>• Physician Value Modifier</td>
<td>• Health Insurance Exchange Quality Reporting</td>
</tr>
<tr>
<td>• Inpatient Quality Reporting</td>
<td></td>
<td>• ESRD QIP</td>
<td>• HAC payment Reduction Program</td>
<td>• Medicare Part C</td>
</tr>
<tr>
<td>• Outpatient Quality Reporting</td>
<td></td>
<td>• Hospice Quality Reporting</td>
<td>• Readmission Reduction Program</td>
<td>• Medicare Part D</td>
</tr>
<tr>
<td>• Ambulatory Surgical Centers Quality Reporting</td>
<td></td>
<td>• Home Health Quality Reporting</td>
<td>• Bundled Payment For Care Improvement</td>
<td></td>
</tr>
</tbody>
</table>
CMS Hospital Value Programs
Transforming Care

- Value Based Purchasing
- Readmission Reduction Program
- Hospital Acquired Conditions
CMS Hospital Value Programs
Current programs to support Triple Aim

- Inpatient Quality Reporting
- Hospital Compare
- Value Based Purchasing
- Readmission Reduction Program
- Hospital Acquired Conditions
Inpatient Quality Reporting 2003 to ?

- Pay for Reporting started in 2004
- Voluntary program
- Financial incentive to report quality metrics
- Provides quality data to consumers
- Footprint for Value Based Purchasing
IQR Growth

Measures Previously Finalized for IQR
FY 2005 – FY 2017

Starter Set FY06 FY07 FY08 FY09 FY10 FY11 FY12 FY13 FY14 FY15 FY16 FY17
10 10 21 27 30 44 45 55 57 59 59 57 62
Data Sources for Quality Programs

Provided by AAMC
# CMS Pay for Performance Programs

<table>
<thead>
<tr>
<th></th>
<th>Hospital Inpatient Value Based Purchasing</th>
<th>Hospital Readmission Reduction Program</th>
<th>Hospital Acquired Conditions Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incentive Structure</strong></td>
<td>Bonus or Penalty, depending on Performance</td>
<td>Penalty Only FY13- 1% FY14-2% FY15-3%</td>
<td>Penalty Only, 1% max FY15</td>
</tr>
<tr>
<td><strong>Payment Unit to be Modified</strong></td>
<td>Base Operating DRG Payment Amount</td>
<td>Base Operating DRG Payment Amount</td>
<td>Revenue after adjustment for Readmission and VBP</td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td>Budget Neutral, winners and losers</td>
<td>Above national average results in penalty, three year retrospective study</td>
<td>New program</td>
</tr>
</tbody>
</table>
# Affordable Care Act (ACA) Mandated Hospital Programs

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>VBP Program *</th>
<th>Readmission Reduction Program *</th>
<th>Hospital Acquired Conditions Program*</th>
<th>Overall, Potential Payment Reduction Risk by Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1%</td>
<td>1%</td>
<td>N/A</td>
<td>2%</td>
</tr>
<tr>
<td>2014</td>
<td>1.25%</td>
<td>2%</td>
<td>N/A</td>
<td>3.25%</td>
</tr>
<tr>
<td>2015</td>
<td>1.50%</td>
<td>3%</td>
<td>1%</td>
<td>5.50%</td>
</tr>
<tr>
<td>2016</td>
<td>1.75%</td>
<td>3%</td>
<td>1%</td>
<td>5.75%</td>
</tr>
<tr>
<td>2017</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
<td>6%</td>
</tr>
</tbody>
</table>

*Potential Reduction in Payment by Fiscal Year
Value Based Purchasing

• Winners and Losers
• Rewards for good performance
• Opportunity to be rewarded for high performance
• Withhold increases annually

1.0%  1.25%  1.5%  1.75%  2.0%

FY2013  FY2014  FY2015  FY2016  FY2017
# VBP Measures Across Time

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI-7a</td>
<td>Fibrinolytic therapy received within 30 minutes of hospital arrival</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>AMI-6a</td>
<td>Primary PCI received within 90 minutes of hospital arrival</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HF-1</td>
<td>Discharge instructions</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>IMM-2</td>
<td>Influenza immunization</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
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<tr>
<td>PN-30</td>
<td>Blood cultures performed in the ED prior to initial antibiotic received</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>PN-6</td>
<td>Initial antibiotic selection for CAP in immunocompetent patient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>SCIP-WI-1</td>
<td>Prophylactic antibiotic received within one hour prior to surgical incision</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>SCIP-WI-2</td>
<td>Prophylactic antibiotic selection for surgical patients</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>SCIP-WIII</td>
<td>Prophylactic antibiotics discontinued within 24 hours after surgery end</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>SCIP-MI-4</td>
<td>Cardiac surgery patients with controlled fiam postoperative serum glucose</td>
<td>X</td>
<td>X</td>
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<tr>
<td>SCIP-WIII</td>
<td>Urinary catheter removed on postoperative day 1 or postoperative day 2</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>SCIP-CDI-2</td>
<td>Surgery patients on prior 8-blocker receive 6-blocker during perioperative period</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>SCIP-VTE-1</td>
<td>Surgery patients with recommended venous thromboembolism prophylaxis ordered</td>
<td>X</td>
<td>X</td>
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<tr>
<td>SCIP-VTE-2</td>
<td>Patients receiving appropriate VTE prophylaxis 24 hours prior to and after surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Patient Experience</td>
<td></td>
<td></td>
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<td>HCAHPS</td>
<td>Patient satisfaction measures</td>
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<tr>
<td>Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MORT-15-AMI</td>
<td>Acute myocardial infarction 30-day mortality rate</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart failure 30-day mortality rate</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>MORT-30-PN</td>
<td>Pneumonia 30-day mortality rate</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>PSI-90</td>
<td>Complications/patient safety for selected indicators (composite)</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
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<tr>
<td>CAUTI</td>
<td>Catheter-Associated Urinary Tract Infection</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
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<tr>
<td>CLABSI</td>
<td>Central line associated blood stream infection</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SSI - Colon</td>
<td>Colon Surgical Site Infections</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
</tr>
<tr>
<td>SSI – Abdo Hyst</td>
<td>Abdominal Hysterectomy Surgical Site Infections</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSOPS.1</td>
<td>Medicare spending per beneficiary</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
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Domains: Moving to Efficiency and Outcomes

<table>
<thead>
<tr>
<th>Domain</th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process of Care</td>
<td>70%</td>
<td>45%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Patient Experience of Care</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>Outcomes of Care</td>
<td>-</td>
<td>25%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Efficiency</td>
<td>-</td>
<td>-</td>
<td>20%</td>
<td>25%</td>
</tr>
</tbody>
</table>

CMS is moving to Outcomes and Efficiency
Hospital Readmissions Reduction Program

- Penalty Program only for Excess readmissions
- Penalty applied to Operating Base DRG Payments
- Maximum penalty increases to 3% in FY 2015

1.0%  2.0%  3.0%
FY2013  FY2014  FY2015

- Current Metrics:
  - Heart Failure
  - Pneumonia
  - COPD
  - Heart Attack
  - Total Hip and Knee
Hospital Acquired Condition Reduction Program

- Regulated in the Healthcare Reform Act
- Starts in FY2015 (October 2014)
- Utilizing different metrics than HAC-POA program
  - Hospital Acquired Infections
  - Patient Safety Indicators
- Penalty program only for worse performing hospitals
HAC Program Domains

**Domain 1**
(AHRQ Measure)

**Weighted 35%**

*AHRQ PSI-90 Composite*
This measure consists of:
- PSI-3: pressure ulcer
- PSI-6: iatrogenic pneumothorax
- PSI-7: central venous catheter-related bloodstream infection rate.
- PSI-8: hip fracture rate
- PSI-12: postoperative PE/DVT rate
- PSI-13: sepsis rate
- PSI-14: wound dehiscence rate
- PSI-15: accidental puncture

**Domain 2**
(CDC Measures)

**Weighted 65%**

- 2015 (2 measures): CAUTI, CLABSI
- 2016 (1 additional measure): Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)
- 2017 (2 additional measures): MRSA, C Diff
HAC Domains and Measures

**Domain 1**

AHRQ Patient Safety Indicator (PSI)—90 Composite

**PSI-90 Composite:**
- PSI-3: Pressure Ulcer Rate
- PSI-6: Iatrogenic Pneumothorax Rate
- PSI-7: Central Venous Catheter-related blood stream infection Rate
- PSI-8: Hip Fracture Rate
- PSI-12: Postoperative PE/DVT Rate
- PSI-13: Sepsis Rate
- PSI-14: Wound Dehiscence Rate
- PSI-15: Accidental Puncture Rate

**Domain 2**

CDC Measures

2015:
- CAUTI
- CLABSI

2016 (1 Additional measure):
- Surgical Site Infection (Colon/Abd Hysterectomy)

2017 (2 Additional Measures):
- MRSA
- C DIFF
NEW CARE MODELS AND PAYMENT REFORM
• **Accountable Care Organizations** - offer a member-focused, doctor-driven approach to aligning financial incentives for health systems to effectively manage the health of populations.

• **Primary Care Medical Homes** - encourage PCPs to transform their practice to center around the patient – and reward PCPs who reduce cost and improve quality for attributed patient populations.
Value-Based Contracting Programs

• **Pay For Performance (P4P)** - these models offer physicians and hospitals a value-based “starter kit” by rewarding them for hitting incremental goals on a set of cost and quality metrics.

• **Bundled Payments** - these models pay a set amount for a given set of services oriented around an episode of care. Bundles encourage coordination across health providers and hospitals.
Getting to the Goal: Better Outcomes with Lower Costs

Range of Strategies for Improving Healthcare Cost and Quality

- Care Coordination / Partnerships
- Predictive Care Paths
- Quality & Efficiency Improvements
- Bundled Payments for Episodes
- Full Capitation
- Bundled Payments across the Continuum of Care

Degree of Complexity and Risk Sharing

Degree of Comprehensiveness

Alternate payment models require quality improvements

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Accountable Care Organizations

- An ACO promotes seamless coordinated carepaths
- The beneficiary and family at the center
- Remembers patients over time and place
- Attends carefully to care transitions
- Manages resources carefully and respectfully
- Proactively manages the beneficiary’s care
- Evaluates data to improve care and patient outcomes
- Innovates around better health, better care and lower growth in costs through improvement
- Invests in team-based care and workforce
Bundled Payments

• **Improve the care** for beneficiaries who are admitted to the hospital, both during and following the hospitalization

• **Reduce escalating costs** including costs born by beneficiaries

• **Eliminate waste** by improving the coordination and continuity of care across providers and settings

• Provide a first **step toward accountable care** and an effective tool for established ACOs

• Create flexible payment arrangements that support the **redesign of care** and increase alignment across providers and settings
COMMERCIAL PAYORS AND VALUE
Commercial Payment Transformation

Population Health/
Total Cost of Care
(TCC)
Quality + Shared Savings + Risk

Fee-for-service (FFS) / Pay for Performance (P4P)
Guaranteed + Earned
Total Cost of Care

• Align incentives towards prevention and improved outcomes
• Similar to CMS Shared Saving Program
  - Improve care while bringing down costs
  - Savings occur by avoiding unnecessary hospital admissions and procedures
Eligibility to share in savings and earn is based on meeting quality targets

- Today, metrics are mostly Primary Care driven and include both quality and efficiency
- Metrics differ by agreement
Quality Metric Guiding Principles

- Standardized, national measures
- Payer agnostic (including government)
- Measures that we can easily pull data on across the enterprise (decrease our reliance on data from the health plans)
- Current programs in place (or in development) to improve on the metrics
- Improves our performance, metrics we highly value

*Metrics vary significantly between commercial payers (primarily employer driven) and CMS*
Take Aways

• Healthcare Reform is not going away - Year 1 was a success!
• Increased buy-in transforming Payment Models by federal and private insurers
• Health Exchanges will continue to expand
• Organizations must understand the market place, beneficiaries needs, provide exceptional quality
Questions

Jacqueline Matthews
matthej1@ccf.org
Cleveland Clinic

Every life deserves world class care.