



Healthcare Roundtable Series

Medicare's Transition to Value-Based Payment Models

Written by Jeffrey Herschler
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Entitled ***Medicare's Transition to Value Based Care***, the fifth and final installment of the 2015 Healthcare Roundtable series was held at Office Edge in Ft. Lauderdale on November 17.

The discussion was led by Brian Foster, MBA. The panelists were Rich Lucibella, MHS, MBA, Rick Yarosh, MBA, PA-C, Lee Lasris, JD, Jeffrey Kaplan and Ariel Rodriguez, MD. Jeffrey Kramer, CPA delivered opening remarks while Kimberly Valentin delivered the closing.

The event sponsors were CareCloud and Goldstein Schechter Koch.

Jeff Kramer Opening Remarks Presentation Outline

I have been focusing my accounting practice in the healthcare industry for my entire career so for many years I have been working with healthcare clients and have seen a lot of changes throughout the years.

The transition to Value-Based payment models is not a new concept. We have been seeing this idea presented in one form or another for many years now.

Back in the late 80's health insurers began to complain that the fee for service system was being exploited and began exploring capitation models and eventually full risk capitation. This was popular for a while and then lost some steam.

These changes have been considered necessary since the US health system is considered expensive.

According to an October 8, 2015 report by the Commonwealth Fund, a private foundation supporting independent research on health care issues, the United States health care system is the most expensive in the world, and underperforms relative to other countries on most dimensions of performance.

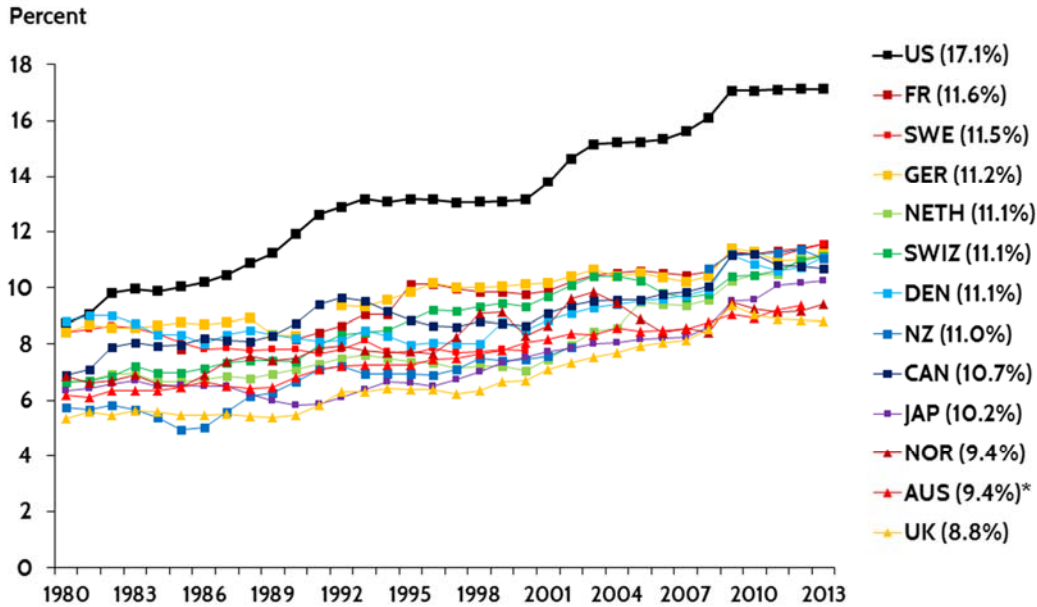
According to the study, the U.S. ranks behind most countries on many measures of health outcomes, quality, and efficiency. U.S. physicians face particular difficulties receiving timely information, coordinating care, and dealing with administrative hassles. Other countries have led in the adoption of modern health information systems, but U.S. physicians and hospitals are catching up as they respond to significant financial incentives to adopt and make meaningful use of health information technology systems.

The United States is the highest spender on health care.

The U.S. spent 17.1 percent of its gross domestic product (GDP) on health care in 2013. This was almost 50 percent more than the next-highest spender (France, 11.6% of GDP) and almost double what was spent in the U.K. (8.8%).

U.S. spending per person was equivalent to \$9,086 (not adjusted for inflation) with the next highest Switzerland \$6,325 and Norway \$6,170.

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

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Exhibit 2. Health Care Spending, 2013

	Total health care spending per capita ^e	Real average annual growth rate per capita		Current health care spending per capita, by source of financing ^{e,f}		
		2003–2009	2009–2013	Public	Private	
					Out-of-pocket	Other
Australia	\$4,115 ^a	2.70%	2.42% ^c	\$2,614 ^a	\$771 ^a	\$480 ^a
Canada	\$4,569	3.15%	0.22%	\$3,074	\$623	\$654
Denmark	\$4,847	3.32%	-0.17%	\$3,841	\$625	\$88
France	\$4,361	1.72%	1.35%	\$3,247	\$277	\$600
Germany	\$4,920	2.01%	1.95%	\$3,677	\$649	\$492
Japan	\$3,713	3.08%	3.83%	\$2,965 ^a	\$503 ^a	\$124 ^a
Netherlands	\$5,131 ^d	4.75% ^d	1.73% ^d	\$4,495	\$270	\$366
New Zealand	\$3,855	6.11% ^b	0.82%	\$2,656	\$420	\$251
Norway	\$6,170	1.59%	1.40%	\$4,981	\$855	\$26
Sweden	\$5,153	1.82% ^d	6.95% ^d	\$4,126	\$726	\$53
Switzerland	\$6,325 ^d	1.42% ^d	2.54% ^d	\$4,178	\$1,630	\$454
United Kingdom	\$3,364	4.00%	-0.88%	\$2,802	\$321	\$240
United States ^e	\$9,086	2.47%	1.50%	\$4,197	\$1,074	\$3,442
OECD median	\$3,661	3.10%	1.24%	\$2,598	\$625	\$181

^a 2012. ^b 2002–2009. ^c 2009–2012.

^d Current spending only; excludes spending on capital formation of health care providers.

^e Adjusted for differences in the cost of living.

^f Numbers may not sum to total health care spending per capita due to excluding capital formation of health care providers, and some uncategorized spending.

Source: OECD Health Data 2015.

Despite its high spending on health care, the U.S. has poor population health.

On several measures of population health, Americans had worse outcomes than their international peers. The U.S. had the lowest life expectancy at birth of the countries studied, at 78.8 years in 2013, compared with the median of 81.2 years. Additionally, the U.S. had the highest infant mortality rate among the countries studied, at 6.1 deaths per 1,000 live births in 2011; the rate in the median country was 3.5 deaths.

The prevalence of chronic diseases also appeared to be higher in the U.S. The 2014 Commonwealth Fund International Health Policy Survey found that 68 percent of U.S. adults age 65 or older had at least two chronic conditions. In other countries, this figure ranged from 33 percent (U.K.) to 56 percent (Canada).

Change the Trend

As a way of reducing healthcare spending, the U.S. has been exploring Value-Based payment models and CMS has been helping to pave the way. The U.S. Department of Health and Human Services recently announced a Timeline for Accelerated the Transition to Value-Based Payments in Medicare Program.

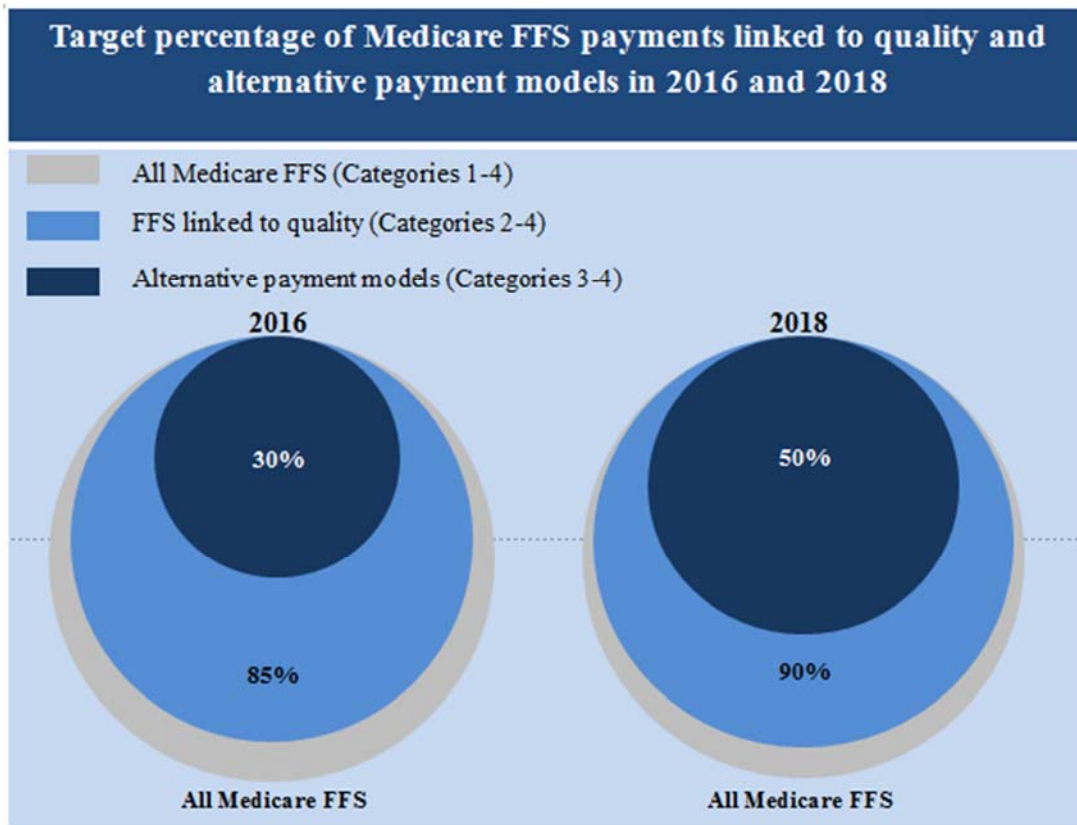
On January 26, 2015, the U.S. Department of Health and Human Services ("HHS") announced the launch of the *Better Care. Smarter Spending. Healthier People: Why it Matters* initiative. According to HHS, this is the first time the agency has identified specific goals and a timeline for transitioning the Medicare program away from the historic fee-for-service model and toward a system that ties Medicare reimbursements to alternative payment models and value-based payments.

Three years ago, Medicare had limited payments in alternative payment models, but at the end of 2014 these value-based payments represented approximately 20 percent of Medicare fee-for-service payments to providers. HHS is working with private payers, including health plans in the Health Insurance Marketplace and Medicare Advantage plans, as well as state Medicaid programs to move in the same direction toward alternative payment models and value-based payment to providers and to meet or exceed the goals outlined above wherever possible.

In its announcement, HHS stated two distinct goals. First, HHS plans to tie 30 percent of fee-for-service Medicare payments to quality or value through alternative payment models by the end of 2016 and 50 percent of Medicare payments by the end of 2018. HHS suggested that this would be accomplished through payment models such as accountable care organizations (ACOs) and bundled payment arrangements.

Second, HHS intends to tie 85 percent of all traditional, fee-for-service, Medicare payments to quality or value by 2016 and 90 percent of Medicare payments to these goals by 2018. HHS stated that it would accomplish this goal through programs such as Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

In support of this initiative, and a movement away from volume based reimbursements, HHS stated that the Medicare program has realized a total savings of \$417 million through existing ACO programs. HHS also noted that approximately 20 percent of Medicare payments today are being made through alternative payment models – up from almost no such payments in 2011.



How We Get There

All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success: providers must make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care. Making operational changes will be attractive only if the new alternative payment models and payment reforms are broadly adopted by a critical mass of payers. When providers encounter new payment strategies for one payer, but not others, the incentives to fundamentally change are weak. In fact, a provider that alters its system to prevent admissions and succeed in an alternative payment environment may lose revenue from payers that continue fee-for-service payments.

In the consumer world, value is a familiar concept. Consumers tend to equate good value with products of the highest quality for the lowest price. When applied to health care, however, value is more complex, as the consumer — from patients and providers to payers and purchasers, and the product — patient outcomes, can vary widely.

According to the Institute of Medicine (IOM), an organization that has studied the issue closely, value is in the eye of the beholder, representing different things to different stakeholders:

- For health care providers, value hinges on making decisions based on appropriateness of care.
- For payers, it means using evidence-based interventions and paying based on outcomes.
- For employers, value is keeping workers and their families healthy and more productive at lower costs.
- For patients, value is having a high-quality relationship with care providers, meeting personal health goals and being assured that out-of-pocket payments are targeted to these goals.

Concerns:

- How will bundled payments will be split among providers?
- Who absorbs the cost in a bundled payment arrangement when unanticipated situations result in the need for additional resources to be added to the mix? For example, who covers the added costs if an intensivist or infectious disease doctor needs to be called in after a procedure is performed due to an accident or infection and the cost is not covered under the bundled arrangement.
- How will disputes between the hospitals and other providers be resolved? Some years ago, I was involved as an expert witness in one such dispute where the hospital controlled the money and did not pay the physician in some cases and short changed the physician in other cases.
- How will physicians not having the resources of hospitals and managed care plans be able to analyze cost data and actuarial data necessary to negotiate and operate under these value based agreements?
- How will physicians be able to afford the technology and resources necessary to operate in the Value Based world?
- Will these new models make it impossible for sole proprietor and small groups to compete?
- How will stakeholders know if the shared savings figures provided are accurate? Do they need to rely solely on Medicare or other payors or will the data details be made available for review?

Let's Get Started

With that I turn things over to Brian Foster who will be moderating today's discussion.