The Case For Value
ACA to MACRA to MIPS
2016-2019

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What Keeps Us Up at Night?

- The Medicare population will increase by 86 million people over the next 10 years. ACA expanded Medicaid by 38%. This has major regulatory and financial implications starting now.
- Disruptive innovation is all around us. Are we “disrupting” ourselves?
- Large self insured employers are our market. They may move to defined contribution insurance for their employees. Then what?
- We don’t know the capacity of our system to change. Doctors are burned out.

Are we competitive and relevant for our patients, payers, employers, government, and our staff?

Mayo Clinic Payer Relations Workgroup discussion 8/2013
What is Driving the Change in Healthcare?

• Common Belief: The Affordable Care Act and new Accountable Care Organizations.
• Reality: The Affordable Care Act primarily changed insurance models and eligibility for Medicare and Medicaid and set up a public marketplace for subsidized insurance known as an “exchange.”

Who are these 2 people and Why are they central to the issue?

Variable Quality/High Cost= LOW VALUE
US Government Spending 2015

BILLIONS OF DOLLARS

$ Billions

Congressional Budget Office 2016
Overall Health System Performance

Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

Best Performance 2015
Rochester, MN
Dubuque, IA
Honolulu, HI
What do we mean by value

$\text{Value} = Q + S + S / \text{Cost Over Time}$

- Value Based Payment models reward good outcomes that meet performance targets for cost
  - They transfer some risk to providers or offer shared savings if the performance goal is met
  - Most plans assign responsibility for a “population” of patients to a provider or payer group
Value is not new

"We must bear in mind the difference between thoroughness and efficiency. Thoroughness gathers all the facts, but efficiency distinguishes the two-cent pieces of non-essential data from the twenty-dollar gold pieces of fundamental fact.”  -- William J. Mayo
“In 2006 physician groups will work with CMS to reach agreement on a starter set of evidence based quality measures.”
The Essentials Of The Move To Value

- Understand the inconvenient truth of your current reality
- Understand the structure of the problem
- Discover the gaps in your position and performance relative to succeeding in your reality
- Honor your mission and values
- Adapt and move forward
Proposed Medicare Payment Model Change 2015-2018

Quality based payment programs
- Hospital Value-Based Purchasing
- Hospital Readmissions Reduction
- Hospital-Acquired Condition Reduction
- End-Stage Renal Disease (ESRD)
- Quality Incentive
- Value-Based Modifier

Alternative payment programs
- Pioneer Accountable Care Organization
- Medicare Shared Savings Program
- Bundled Payments for Care Improvement
- Comprehensive Primary Care Initiative
- Patient Centered Medical Homes

- Comprehensive End Stage Renal Disease
- Oncology Care Model
- Medicare/Medicaid Financial Alignment

Source: PwC Health Research Institute analysis, Centers for Medicare & Medicaid Services

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The New World for Medicare/Medicaid

- The Affordable Care Act is in place
- Medicare SGR repealed and replaced by MIPS “pay for value” for > 80% of Medicare patients and 50% alternate payment models by 2019
- Medicare performance metrics based on billing, patient care process quality, and patient experience. Performance penalties increasingly relevant
- Private MA insures > 35% of Medicare patients
# Medicare Bonus and Penalties

**SRP to MIPS 2016-2020**

<table>
<thead>
<tr>
<th>Bonus and Penalties</th>
<th>2016</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2022</th>
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<tbody>
<tr>
<td>Meaningful Use</td>
<td>-2%</td>
<td>-4% to +4%</td>
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<td>PQRS *</td>
<td>-2%</td>
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<td>Value Modifier **</td>
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<td>-4% to +4%</td>
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<tr>
<td>MIPs***</td>
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<td>-4% to +4%</td>
<td>-5% to +5%</td>
<td>-9% to +9%</td>
<td></td>
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<tr>
<td>Alternate Payment Model 2019-2024</td>
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<td>5% based on prior year CMS expenditure</td>
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• Physician Quality Reporting System- CMS quality and safety measures
** Value Based Modifier Measures- CMS resource use and efficiency measures
*** Medicare Incentive Payment System- Planned consolidation of meaningful use, PQRS, and VBM measures . (Exceptional performance bonus of +10% proposed)

MN Medicine November 2015
Bundling Demonstrations CJR Mandate

FOR IMMEDIATE RELEASE
July 9, 2015

CMS proposes major initiative for hip and knee replacements
Model supports quality and care improvements for patient’s transition from surgery to recovery
Hip and knee replacements are some of the most common surgeries that Medicare beneficiaries receive. The quality and cost of care...still vary greatly among providers.
New Commercial Insurance Models

- Preferred Provider Network and Centers of Excellence Models (narrow networks)
- Traditional Plans with increasing deductible
- High Deductible Health Plans
- Gain share and risk transition underway
- Reference Based Pricing
The Reality of High Deductible Health Plans

• When asked what they would do if they had a $1,500 medical bill, 43% of those with high-deductible plans said they would have to borrow money or go into credit-card debt to cover a $1,500 medical bill. Fifteen percent said they would not be able to pay such a bill.

Kaiser Family Foundation 2015
Total Payment Per Procedure Before And After Implementation Of Reference-Based Benefits In California,

James C. Robinson et al. Health Aff 2015;34:415-422
Analysis – National Trends & Projections

**Adult Inpatient Forecast**

US Market, 2012–2022

- **5 Year**:
  - 2012: 25
  - 2017: 25 (−1%)
  - 2022: 25 (−4%)

- **10 Year**:
  - 2012: 25
  - 2017: 25 (−1%)
  - 2022: 25 (−4%)

**Adult Outpatient Forecast**

US Market, 2012–2022

- **5 Year**:
  - 2012: 3.0
  - 2017: 3.3 (+7%)
  - 2022: 3.5 (+15%)

- **10 Year**:
  - 2012: 3.0
  - 2017: 3.3 (+7%)
  - 2022: 3.5 (+15%)

Note: Forecast excludes 0–17 age group, psychiatry and obstetrics service lines and the not assigned category.

Sources: Impact of Change® v12.0; NIS; PharMetrics; CMS; Sg2 Analysis, 2012.
Our New Reality

Physician Visits Peaked in 2005

Source: IMS Health, National Disease and Therapeutic Index, 2012

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Where are we now?

- We will see more patients and reimbursement for their care will decrease
  - outpatient care is moving to a retail market
  - in-patient census of patients with chronic co-morbid disease will likely increase

- We will be accountable for the value of our care and our outcomes.
- We will be at risk for cost, quality, and outcomes of care
- We must integrate our system to accept bundled payments for selected procedures with more to come
The Statements of Mayo Clinic

• Primary Value
  – The needs of the patient come first.

• Mission
  – To inspire hope and contribute to health and well being by providing the best
care to every patient through integrated clinical practice, education, and
research.

• Vision
  – Mayo Clinic will provide an unparalleled experience as the most trusted
partner for health care.

• Core Business
  – Create, connect and apply integrated knowledge to deliver the best health
care, health guidance and health information.

• Value Proposition/Differentiation Statement
  – Mayo Clinic combines knowledge, integrity, and teamwork into a uniquely
effective, integrated model of care
The Core Business

Essential strategic requirement

TRUSTED AND AFFORDABLE

Core Business

KNOWLEDGE DELIVERY

INTEGRATION

Essential organizational requirement
Significant Transformation of Clinical and Financial Models

FEE-FOR-SERVICE MODEL

Primary Care

Specialty Care

Acute Inpatient Care

VALUE/ EPISODE MODEL

Preventive Health

Primary Care

Specialty Care

Acute Inpatient Care

Adapted from SSB 2014
MAYO CLINIC HEALTH SYSTEM

- Organizations: 12
- Communities: 71
- Physicians: 800
- Allied health staff: 13,000

Map showing locations in Minnesota, Wisconsin, and Iowa with communities and links to Mayo Clinic Health System services.

www.mayohealthsystem.org

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Fundamental Specialty Care Roles

**Destination Center**
(Tertiary / Quaternary Care)

- Tertiary/Quaternary Care to all Regions
- Academic support to regional care delivery
- Knowledge Resource and specialty care support

**Regional Hub**
(Secondary Care)

- Secondary (Tertiary) Care to Region
- Regional Leadership Structure complements the system (NOT different businesses)
- Administrative Center for region
Risk Market Profile by Market - 2015

- Early
- Intermediate
- Advanced

*Note: Markets are defined as hospital referral regions. Scores across the US include 301 markets with available data. Sources: Sg2 Market Evolution Tool, Sg2 Analysis, 2014.*

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Moving to Risk 2018

2018:
Progressive markets will span the West Coast and Northeast. Markets in the Rocky Mountain region will continue on their path toward value-based care.

Note: Markets are defined as hospital referral regions. Areas across the US include 281 markets with available data.
The New Model of Pay for Value

- Traditional
  - Health Plan or Self Insured Employer
- New model
  - Active employer engagement in care delivery or care choices if still offering insurance vs. fixed contribution
  - Consumer responsible for a majority of usual costs
  - Accountable provider group that patient sees for care must justify their performance to the consumer and the employer or government payer
    - Bundling with set single payment for episode, transfers risk and care mgmt. to providers centered on the hospital.
The Path to Payment Reform

1. Optimize Performance
   - Patient Access
   - Medical Necessity
   - Reimbursement
   - Clinical Care
   - Coding and Documentation

2. Prepare for Value-Based Care
   - Care Delivery Model

3. Invest in Managing Risk
   - Population Health Management
   - Financial and Clinical Analytics

Adapted from Optum 2016
Practice Management Analytics: The Basics

- Give providers timely knowledge about the health and needs of their patients
- Integrate clinical and claims data across the continuum
- Predict patients at-risk and reduce preventable cost
- Improve performance via comparative clinical benchmarks
- Justify pay for performance reimbursement
Cost Distribution of Value

10,000 Adult Cardiac Surgery Patients 2011-2014
(Mayo Clinic data)

Median 1.00
75th PERCENTILE 1.36
90th PERCENTILE 2.11
Outliers

Appropriate to bundle payment

Proportion of patients

Normalized cost per case

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The new metrics for financial success

**Today**
- Expense per admission
- Revenue per admission
- Rates x volume = revenue
- Profitability by payer
- Revenues by payer
- Market share by # of visits and admissions

**2019**
- Expense per episode of care
- Revenue per beneficiary in Med Home
- Episode cost / fixed payment = revenue
- Revenues from FFS vs. fixed payment
- Market share gain requires high value care model (quality and cost structure)

Adapted from: Moody’s Investors Service 5/10/2011
What is the relationship between provider capability and the fundamental requirements for success?

- A network of providers
  - Physical or virtual
  - Governance model
- Alignment of purpose
- Coordinated care delivery
- Practice analytics
- Financial alignment

Teamwork
Group Process
Interdisciplinary Training
Emotional Intelligence
Communications

Health Services Research
“New age” statistics
Population Health
Self learning
Why Aren’t We Moving Faster?

Structural Barriers?

Inertia and Daily Management challenges

Past Experience with Contracts and Payment

Mission and Culture

Provider angst

Payment Transformation

Care Transformation

Lose on Risk Payments from payer

Lose on FFS Payments from payer

A NARROW CORRIDOR FOR SUCCESS