Aligning Risk and Incentives

Value-based medicine has emerged.

BY RYAN GRAVER AND KIRK LIVINGSTON

Beginning January 1, 2015, physicians and practices that did not report Physician Quality Reporting System (PQRS) data by 2013 became subject to a 1.5% reduction (increasing to 2% in 2016) in their Medicare reimbursements.[1] Additionally, the year 2015 marks the beginning of the Value-Based Modifier program. Under this program, Medicare reimbursement to practices consisting of 100 or more providers that have not reported PQRS data by 2013 will face an additional 1% reduction in reimbursements. Groups that did begin reporting PQRS data will either receive a bonus or penalty, or see no change, based on their performance under the quality measures they reported. Incentive payments for "high-quality/low-cost" providers can be as high as 2%, whereas penalties can be up to 1% of a provider's payment, specified by the calendar year 2015 Medicare's Physician Fee Schedule.

In late January 2015, the Department of Health and Human Services announced ambitious goals for the health care industry, stating it wants 50% of Medicare payments based on how well patients are cared for by 2018, which was the first time in the history of the Medicare program such explicit goals have been set for alternative payment models.[2]

By 2016, the benchmark is to have 30% of all Medicare provider payments fall under an alternative model, which includes accountable care organizations (ACOs), patient-centered medical homes, or bundled payments.

In addition to the PQRS and Value-Based Modifier programs, 2015 is the first year in which groups will be scored on their Quality and Resource Use Report (QRUR) and Supplemental QRUR. The QRUR benchmarks providers on their cost per capita and specialty-specific quality measures. The Supplemental QRUR measures providers on costs per episode. Clearly, paying for value is not fodder for future speculation—providers are being affected today. In addition to facing a growing risk in reductions to their Medicare payments, providers are also dealing with more narrow networks. Commercial payers, such as United Healthcare,[3] are dropping providers from their Medicare Advantage program. Although payers cite quality measures as a justification, most observers believe that cost to the primary scorecard is being used to determine a provider's access to the new, more narrow network.

During this transition to value-based medicine, risk is being shifted from payer to provider (Figure 1). All of the payment reform programs discussed to this point are mandatory and certainly require both understanding and management from providers. Medicare has also developed voluntary payment program pilots that may give indications to what future payment models

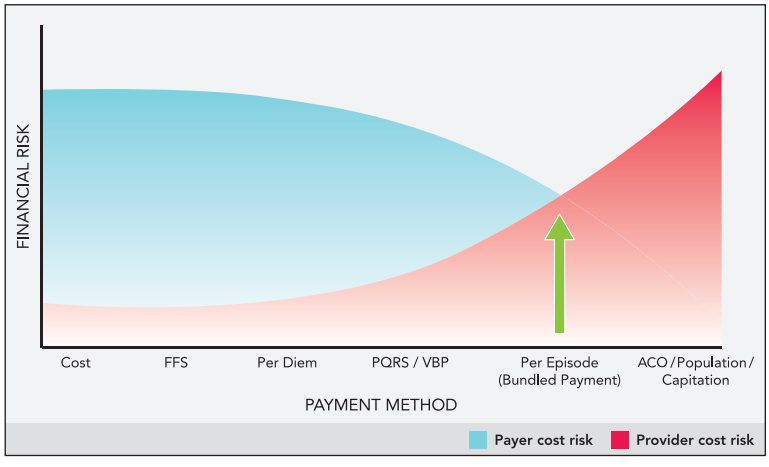

Figure 1. Medicare payment continuum for shift in risk to payers.

TABLE 1. SOURCES OF SAVINGS: FEE-FOR-SERVICE VERSUS BPC	
Fee-for-Service	**BPCI**
Increase efficiency in order to perform more procedures	Avoid readmissions
Reduce hospital length of stay	Reoperation or reduced revision risk
Heavy focus on supply chain to reduce implant pricing	Reduced utilization of skilled nursing facilities, long-term acute care hospitals, and inpatient rehabilitation facilities
Defensive/all diagnostic testing	Reduced/appropriate diagnostic testing only

will look like. Accountable care organizations and the Bundled Payment for Care Improvement (BPCI) are two opportunities for organizations to share the financial risk that is tied to clinical quality and financial performance. Accountable care organizations incentivize the performance of managing a patient population, whereas BPCI incentivizes the management of an episode of care. This article unpacks BPCI as an opportunity for interventionists to lead in developing a method of care delivery that achieves success in the new normal of health care.

"Like it or not, the shift to risk-shared, outcome-based medicine is here," said Jennifer Linville, Founder and CEO of MedAxiom. "And make no mistake: Medicare initiatives that start as voluntary typically become mandatory over time. I think it is important to see the current payment reforms as an opportunity for providers to lead the national health care system's transition to value-based."

ALIGNED INCENTIVES: BUNDLED PAYMENTS FOR CARE IMPROVEMENT

In the simplest terms, bundled payments provide a single reimbursement for all care consumed by a patient during a defined episode of care, whereas the fee-for-service model rewarded providers for the volume of care delivered. Shifting payments to cover an episode of care, including the postacute period, now requires providers and hospitals to manage the totality of patient care, which may include skilled nursing facilities, home health, and rehabilitation. Under the bundled payment programs, providers are incentivized to provide a higher quality of care (eg, avoiding readmission or urgent revascularization), which results in financial benefit. Shifting the focus to episodes of care will require providers to understand that they are now being rewarded when the patient consumes fewer resources. This will mean managing high-risk patients differently by establishing programs that extend beyond the cath lab and providing new levels of patient engagement to successfully deliver the highest quality of care at the lowest total consumption of health care dollars. Organizations that are the early adopters of BPCI will have the greatest opportunity to redefine how providers manage patient care and share in the associated savings.

BPCI moves payments from the fee-for-service model (Table 1), which currently covers roughly 75% of Medicare patients, to the model of payments per episode. With bundled payments, the Centers for Medicare & Medicaid Services receives 2% savings per bundle, and the participants receive the remainder of the savings. Those BPCI gains are currently distributed in a retrospective manner each quarter. If the BPCI program improves the quality-of-health outcomes and reduces costs based on the extensive data gathered, the Secretary of Health and Human Services will pass the Comprehensive Care Payment Innovation Act, making Medicare bundled payments permanent, which could take between 3 to 5 years.

In addition to payers, it seems physicians, hospitals, skilled nursing facilities, home health agencies, and even medical device companies have begun to align themselves with outcome-based contracts and pricing.[4] In 2014, several of the major medical device manufacturers began to offer risk-based contracts, wherein the price of a given device was directly tied to patient outcomes. Recognizing that providers and hospitals were bearing increased risk, these companies offered rebates if a patient required a revision or readmission after a procedure in which their technology was utilized.

FOUR MODELS OF CARE

The BPCI initiative is composed of four broadly defined models of care. These models provide incentives that link payments and providers to better outcomes during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. The four models provide measurement and alignment in different ways and require different considerations to be successful. It is important to note that although this program was initially designed for hospitals, it is now also available to physician groups.

The models of care are defined by the Centers for Medicare & Medicaid Services as follows:

TABLE 2. OPPORTUNITIES FOR THOSE UTILIZING CARDIOLOGY BUNDLES	
Leadership	Involved and committed leadership drives superior performance
Patient onboarding	Engaging patients and their family/caregivers early and setting expectations regarding postacute care
Skilled nursing facility relationships	Selecting a preferred network, reaching a consensus with skilled nursing facility leadership, and creating incentives to improve outcomes
Bundle assignment	Single and multispecialty practices must ensure that physicians are listed as either the attending or the operating physician on the hospital's UB-04 claim to Medicare
Patient care coordinators or navigators	Trained, sensitive health care workers who provide support, communication, and guidance throughout the care continuum
Aligned incentives and collaboration	Physicians, hospitals, and postacute providers participating in care throughout the episode

Model 1 includes episodes of care focused on the acute care inpatient hospitalization; a discount to Medicare inpatient reimbursement is applied, and hospitals are incentivized to reduce costs.

Models 2 and 3 involve a retrospective bundled payment arrangement in which actual patient expenditures are reconciled against a "target price" that has been established for each episode and includes the postacute period.

Model 4 is based on a prospective bundled payment arrangement in which a lump sum is paid to a provider for the entire episode of care.

Models 2 and 3 are the most commonly selected, perhaps because they represent the greatest opportunity for savings and include the postacute setting, which until now has had little or no scrutiny and reverse incentives. Historically, cardiologists have not participated in the coordinating of nor the economics of the postacute care setting. When programs implement a process whereby postacute programs become part of the care team, there is tremendous opportunity to make a significant impact.

For a physician group practice that will act as the "episode initiator" under model 2, an episode will be initiated every time a physician who is a member of the physician group practice treats an eligible Medicare beneficiary for an anchor Medicare Severity Diagnosis-Related Group included the BPCI program. This will occur if the physician is listed as either the operating or attending physician and will occur at any hospital, even one at which the physician has not previously practiced. When a hospital takes on the bundle, they are not affected by the attribution based on operating or attending status. "Many hospitals utilize hospitalists, and therefore the cardiologist is not named as the attending on many of the patients that they care for," said Ms. Linville. "If it is a cardiology or multispecialty practice that is participating in BPCI, this rule could decrease the number of patients attributed to them, which could be a big win for hospitalist programs. However, it is important to consider which provider has an ongoing relationship with the patient to best coordinate the care required. Clearly, a team-based approach is becoming essential."

BPCI PARTICIPATION

The BPCI program has two phases for models 2 through 4 in which participants use the first phase to prepare and the second phase to assume financial risk in the program. Initial program participants include hundreds of acute care hospitals, skilled nursing facilities, physician group practices, long-term acute care hospitals, and home health agencies.

Among those initial programs participating in BPCI, the top five bundles[5] (in terms of application) were predominantly related to cardiovascular health and, again, represent a significant opportunity for cardiologists to affect performance: major joint replacement of a lower extremity (78%); congestive heart failure (58%); coronary artery bypass graft (51%); chronic obstructive pulmonary disease, bronchitis, asthma (49%); and percutaneous coronary intervention (48%).

CONVENERS EMERGE TO ORGANIZE AND SHARE RISK

Along with awardees, conveners are another category of BPCI facilitator. Conveners help make these models

work for providers and organizations and are divided into two types: (1) awardee conveners who apply with partners and bear risk for bundled payment beneficiaries of their partners, and (2) facilitator conveners who apply with designated awardees or designated awardee conveners. Facilitator conveners do not bear risk.

Remedy Partners is the largest awardee convener company and is solely focused on bundled payments. Remedy Partners voluntarily assumes risk as it partners with a variety of organizations to work within the BPCI models and helps their partners establish programs. In addition, it helps its partners navigate systems and put infrastructure in place to process risk.

For Mr. Charlie Wiggins, Head of Field Operations for Remedy Partners, sharing the risk is a natural part of the ongoing opportunity. "The bundled care system wants providers to create efficiencies and to be rewarded for those efficiencies," said Mr. Wiggins. "As awardee conveners, we take risk right alongside our partners. And we take that risk with full knowledge from our very smart team of actuaries and data scientists. Sharing risk together—and looking at data together—makes us all more effective."

Not only is Remedy Partners assuming risk alongside partners, it is also embedded in its partner institutions, coordinating and educating with downstream patients and helping teams locate efficiencies.

OPPORTUNITY FOR INTERVENTIONAL CARDIOLOGY

Significant headwinds have challenged interventional procedure volumes and revenues for the last several years. Declining procedure volume, a shift to more procedures performed in the outpatient setting, declining reimbursement, the Recovery Audit Contractor program, and appropriate-use criteria have all affected the field of interventional cardiology. However, with coronary artery bypass grafting and percutaneous coronary intervention representing two of the top three bundles selected during the initial BPCI enrollment, cardiologists are faced with either passively accepting risk or proactively managing that risk in the new normal.

Under BPCI, both providers and hospitals can share the savings generated from the delivery of improved care. Again, this may be especially true in bundles that include postacute or downstream care. In this instance, interventional cardiologists and teams owning the entire episode of care can recommend solutions that are effective in terms of costs and outcomes. Examples include reducing readmissions, reducing the need for urgent revascularizations, reduction in stent thromboses, opting for skilled nursing facilities rather than inpatient care, using home health rather than a skilled nursing facility, and even reducing variation in the high costs of skilled nursing facilities.

"Bundled payment doesn't alleviate the need to be efficient in programs operations," said Ms. Linville. "Running your lab efficiently and managing the patient through the procedure, recovery, and discharge are all still required and will continue to be essential under any payment program. It's a two-sided coin."

There are unique opportunities for those working with cardiology bundles, according to Ms. Linville (Table 2). "As the role of interventional cardiologist transforms from acute care to postacute care, physicians can begin to expect certain things to happen," said Ms. Linville. "Cardiologists can expect more patient contact, and they can expect to participate in broader treatment plans, including postacute interventions, and less of a laser-like focus on procedures. The keys to success must include identifying and educating the patient, as well as patient care navigation."

Finally, Ms. Linville noted the importance of documenting comorbidities to remain clear on how health care resources are being used, "Documentation will continue to be the key driver of reimbursement and will heavily skew the perception of quality and cost."

The transition to risk-shared, outcome-based medicine is an opportunity to gather smart people who are close to the patient—people in the best position to recommend change. Bundled payments help us try those recommendations to learn what works. The result promises to be that patients, along with the entire system, recover more efficiently. ■

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