



Healthcare Evolution in the World of Quality

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Outline of our conversation



History

2

The Cost Conundrum and Healthcare statistics in the US

3

ACA Quality of Care



Low Cost+ High Quality=Value



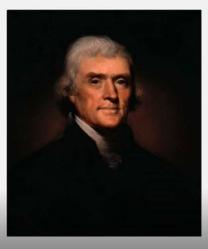
My view of healthcare, so far.

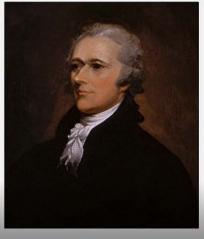




The Great American Ideological Divide

Thomas Jefferson States' rights Private sector Individual liberty





Alexander Hamilton Federalism Proactive government Collective power

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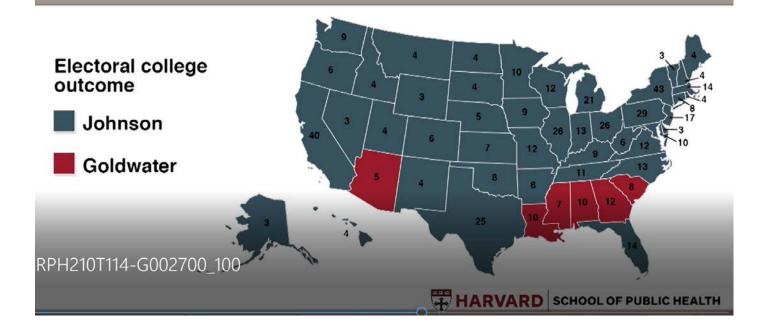
http://en.wikipedia.org/wiki/File:Thomas Jefferson by Rembrandt Peale, 1800.jpg http://en.wikipedia.org/wiki/File Alexander Hamilton portrait by John Trumbull 180





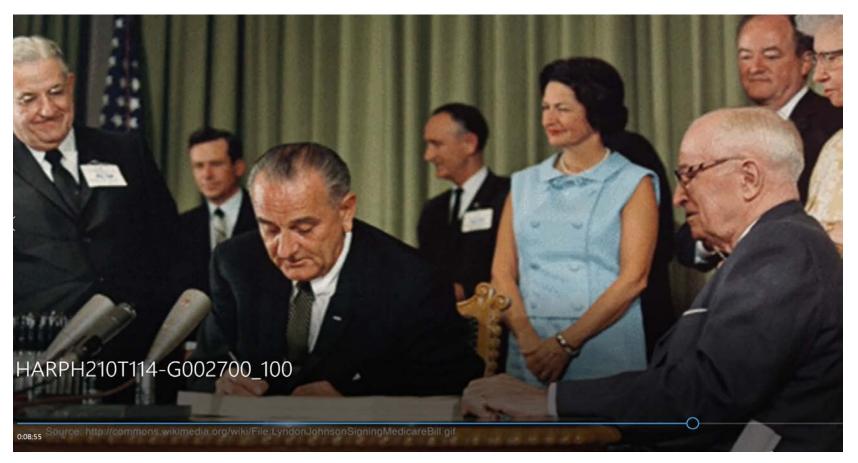


The Presidental Election of 1964



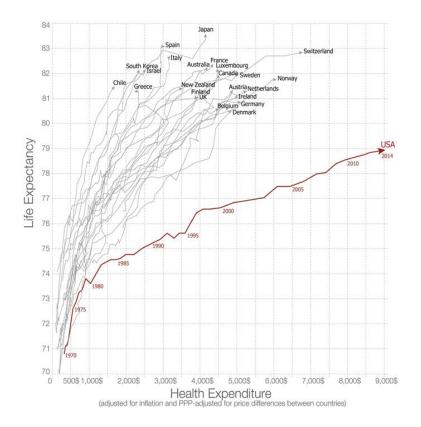




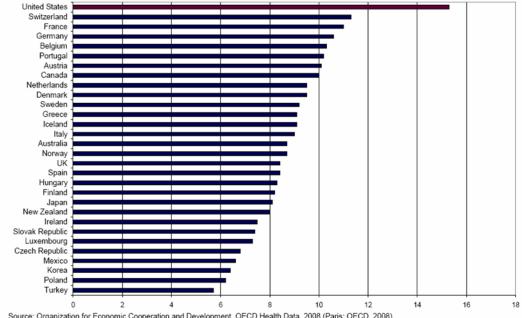








Healthcare Spending as % GDP



Source: Organization for Economic Cooperation and Development, OECD Health Data, 2008 (Paris: OECD, 2008).

Note: For countries not reporting 2006 data, data from previous years is substituted.





Coverage & Financing

ACA Title	Covered (#M)	\$ Spent (\$B)	\$ Raised / Saved (\$B)
1. Private Sector Coverage	16	\$509	\$80.6
2. Medicaid / CHIP	16	\$458.8	\$52.7
3. Medicare / Delivery Reform		\$54	\$449.9
4. Prevention / Public Health		\$18	\$0.8
5. Workforce		\$18.2	
6. M&M Fraud & Abuse		\$2.8	\$7
7. Biologic Similars			\$7
8. CLASS			\$70.2
9. Revenues			\$437.8
14-G0014001c100, etc.)		\$14.8	\$92.8
sional Budget Office estimates for	2010-2019	₩ на	RVARD SCHOOL OF

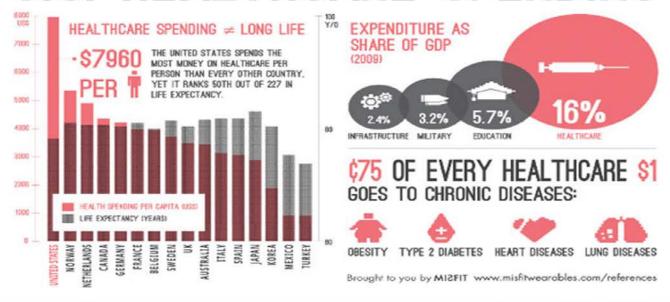


Patient Protection and Affordable Care Act viz. Obamacare/ PPACA(Patient Protection and Affordable Care Act)/ ACA-2010





U.S. HEALTHCARE SPENDING







Current State of Expenditures

National Health Expenditure- 17.8% of Gross Domestic Product (GDP) in 2015.(NHE)

Medicare spending grew 4.5% to \$646.2 billion in 2015, or 20 % NHE.

Medicaid spending grew 9.7% to \$545.1 billion in 2015, or 17 %NHE.

Private health insurance spending grew 7.2% to \$1,072.1 billion in 2015, or 33% NHE

Out of pocket spending grew 2.6% to \$338.1 billion in 2015, or 11 %NHE

Hospital expenditures grew 5.6% to \$1,036.1 billion in 2015, faster than the 4.6% growth in 2014.

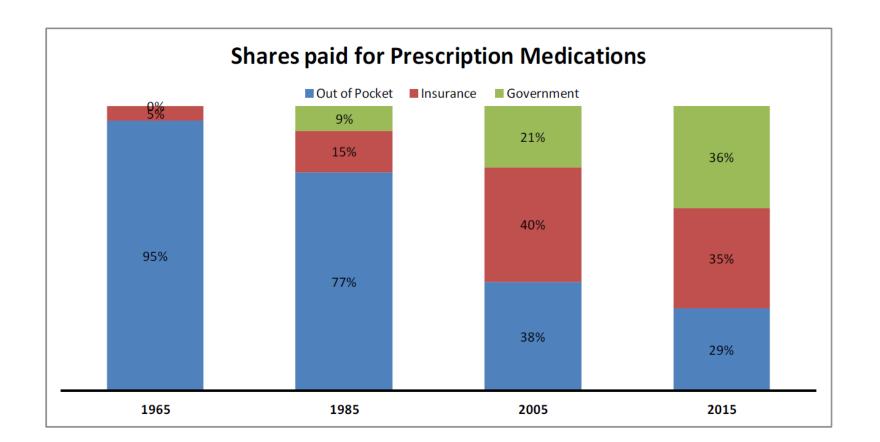
Physician and clinical services expenditures grew 6.3% to \$634.9 billion in 2015, a faster growth than the 4.8% in 2014.

Prescription drug spending increased 9.0% to \$324.6 billion in 2015, slower than the 12.4% growth in 2014.

The largest shares of total health spending were sponsored by the federal government (28.7 percent) and the households (27.7 percent).

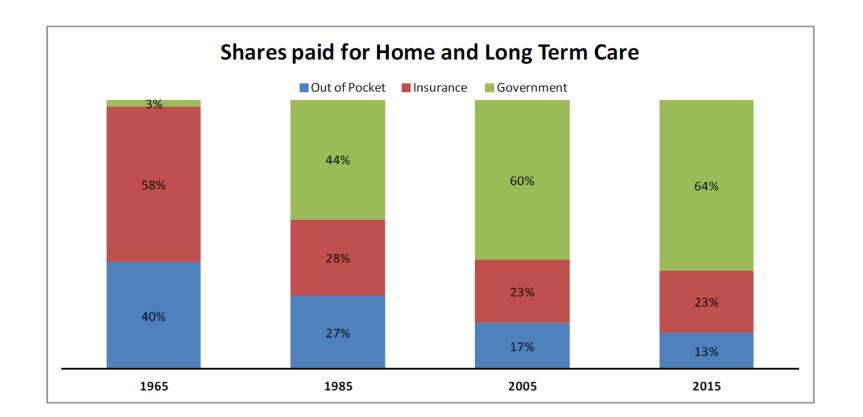






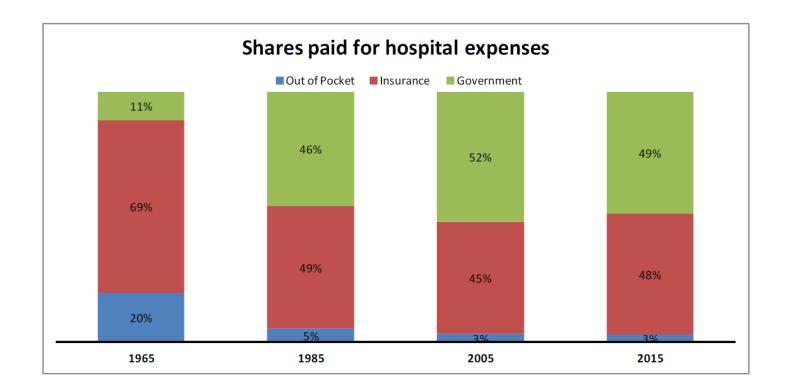






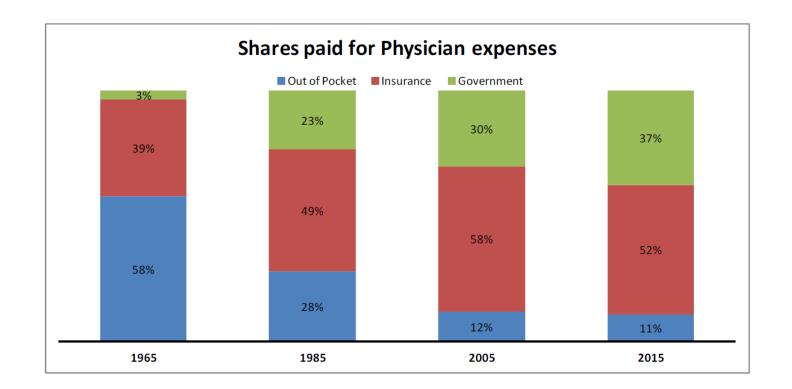
















Hospital Reimbursement by Payer Type 1990 2000 2010 42% 39% 35% 38% 39% 10% 10% 13% 16% 10% 2% 5% 6% 6% 3% 3% 2% Commercial Medicare Medicaid Other Uncompensated Care Non-patient

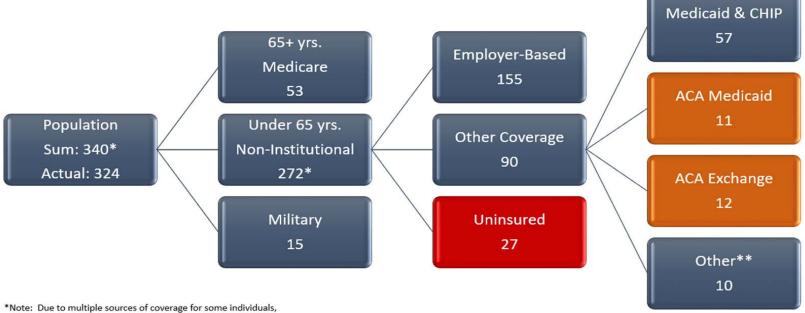
The shifting revenue mix from commercial to government payers means tighter hospital margins.



Source: American Hospital Association Annual Survey Data, 2013



Sources of Health Insurance Coverage in 2016 (Millions of Persons)



*Note: Due to multiple sources of coverage for some individuals, there is some double-counting in the components. The actual U.S. population in December 2016 was approximately 324m.

**Other: The 10m was reduced to tie to the total for "Other Coverage" of 90m. "Other" includes 23m persons (9m non-ACA)

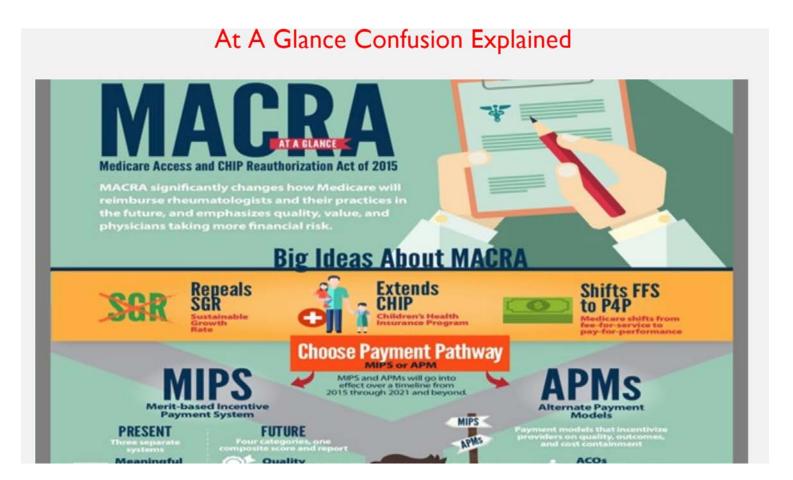
Source data:

CBO "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026" (March 2016) Census Bureau "Health Insurance Coverage in the United States: 2015 (September 2016)



marketplaces, 9m disabled in Medicare, 5m other).









Quality Payment Program: MIPS vs APMs

MIPS

- Adjusts payments up or down based on new reporting system
- Consolidates PQRS, MU, and value-based modifier

The MIPS Score will account for performance in 4 weighted performance categories:



Based on the MIPS composite score, clinicians will receive positive, negative, or neutral adjustments starting in 2019.



Those who score in the top 25% are eligible for an additional annual adjustment of up to 10%.

APM

Initial definitions from MACRA law for APMs include:

- CMS Innovation Center models that are not Health Care Innovation Award recipients
- MSSP-Medicare Shared Savings Program
- Medicare Health Care Quality Demonstration Program
- Demonstration program required by Federal Law

Most clinicians who participate in APMs will be subject to MIPS and will receive a favorable performance score under the MIPS Clinical Practice Improvement Activities category.

APM participants

Qualifying APM Participants

(QPs) are clinicians who participate in Advanced APMs and meet a volume threshold of Medicare payments or beneficiaries paid through the APM. QPs are not subject to MIPS and will receive 5% lump sum bonus payments for years 2019-2024.

Advanced Alternative Payment Models include:

- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program Tracks 2 & 3
- Next Gen Accountable Care Organization
- Oncology Care Model (2-sided risk)
- Comprehensive End-Stage Renal Disease Care (CEC) Model (Large Dialysis Organization arrangement)
- Potential expansion of Comprehensive Primary Care Initiative (CPCI) Patient-Centered Medical Home (PCMH)



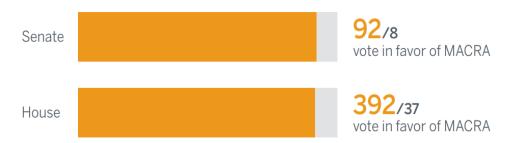




MACRA Is Here to Stay

Partisan battles continue to be fought over many aspects of health policy. But unlike the individual mandate and high-risk pools, MACRA legislation enjoys broad support from both sides of the aisle.

Congress Passed the Act with Overwhelming Bipartisan Support









MIPS Ups the Ante on Pay for Performance

Prior to MACRA, group performance standards under the Value-Based Payment Modifier were fairly forgiving. Average performance resulted in no payment adjustment. However, under MIPS, a single point above or below the mean or median composite score will result in a payment adjustment. By 2022, nine percent of clinicians' Medicare payment will be at risk.

Average Performance No Longer Enough

Group Performance Under VBPM 87% of groups that met reporting requirements held harmless in 2015



Group Performance Under MIPS











Population Health Is No Longer Optional

In the past, only providers participating in risk-based payment models faced meaningful incentives tied to cost and quality outcomes. In the new MIPS track, outcome metrics—many of which extend beyond discrete patient encounters—will increasingly factor in to clinicians' pay. While the advanced APM track may encourage more providers to join downside risk programs, MIPS makes population health a reality for everyone.

MIPS Tracking Quality and Cost Closely

MIPS Performance Category	Top Reporting Takeaways for 2017	
Quality (replaces PQRS, VBPM)	 ~300 measures to choose from 80% of measures tailored to specialists Eligible Clinicians only required to report 6 measures; in addition, all-cause readmissions will be calculated based on claims 	
Cost (expands VBPM cost metrics)	 Total percapita costs for all attributed beneficiaties and Medicare spending per beneficiary Adds 10 episode-based measures, rather than 41 While not factored in to overall MIPS performance in 2017, the weighting rises quickly to 10% in 2018, 30% in 2019 	







You Succeed or Fail as a Team

We anticipate most clinicians will report as a group under MIPS. Hence, scores for all providers in the group will be pulled down by low performers or pulled up by high performers, increasing the incentives for providers and other internal stakeholders to work as a team to achieve ongoing performance improvement.

Larger Practices Will Fare Better

Percentage of Eligible Clinicians¹ Projected to Recieve MIPS Penalties, Bonuses







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Practice Like Everyone Is Watching

The data reported under MIPS eventually will be available to the public on the Physician Compare website. With the rise of consumerism, you can expect patients to use these standardized quality metrics to choose their physicians. This level of transparency will also affect partnerships as hospitals seek out physicians with demonstrated success in MIPS.

The Future of Physician Compare

MIPS Score





Improvement Activities



Cost



Advancing Care Information

Potential Impacts of Transparency

Health System Scrutiny

Hospitals on the hook for group physician performance will **only partner with physicians demonstrating success in MIPS.**

Customer Shopping

Patients able to compare standardized quality metrics will **select highest performing physicians.**





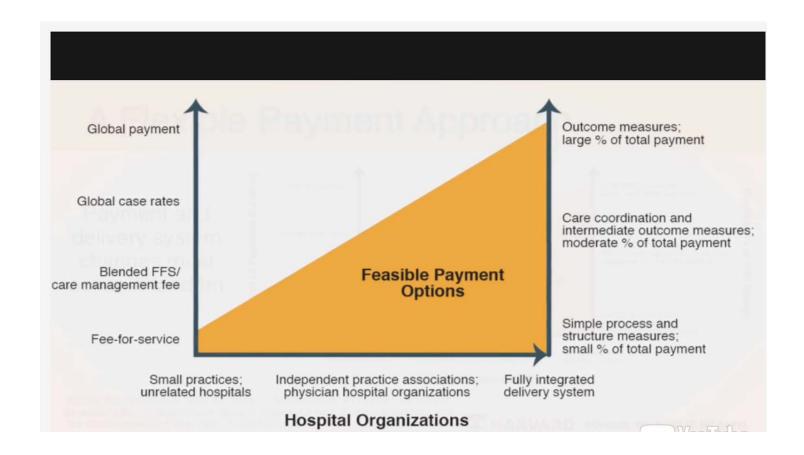
CMS Authorized Programs & Activities

Reducing & Preventing Health Care Associated Infections Reducing & Preventing Adverse Drug Events **Community Living Council Multiple Chronic Conditions** National Alzheimer's Project Act Partnership for Patients Million Hearts National Quality Strategy Data.gov Target surveys **Accountable Care Organizations Quality Assurance Performance** Community Based Transitions Care Improvement Program сммі & Survey & **Dual eligible coordination** Coverage of services Cert. Medicaid Care model demonstrations & projects Physician Feedback report 1115 Waivers **Quality Resource Utilization** Report **Hospital Readmissions** Payment **Reduction Program** Program Fraud & Abuse Enforcement Health Care Associated **Conditions Program** CMS ESRD OIP Value-Hospital VBP based National & Local decisions Coverage Physician value modifier Purchasing Mechanisms to support Plans for Skilled Nursing innovation (CED, parallel Facility and Home Health review, other) Agencies, Quality 8 Hospital Inpatient Quality Hospital Outpatient **Ambulatory Surgical** Quality Public In-patient psychiatric hospitals Improvement Centers Reporting Cancer hospitals Clinical OIOs **Nursing homes** Standards **ESRD Networks Home Health Agencies** Long-term Care Acute Hospitals Hospitals, Home Health In-patient rehabilitation facilities Agencies, Hospices, ESRD Hospices facilities





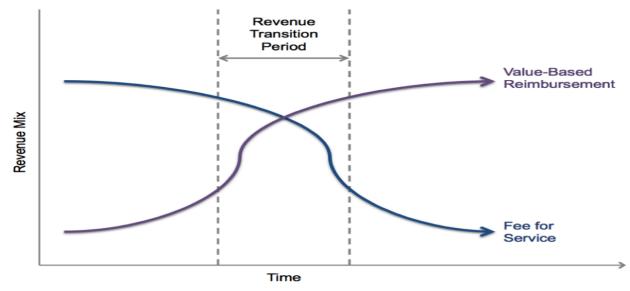
Ideal state







Transitioning from Fee-for-service to Value-based Reimbursements



Notice how's there's no specific unit of time to mark the transition from fee-for-service to value-based reimbursement. Nobody knows yet how long this process will take.



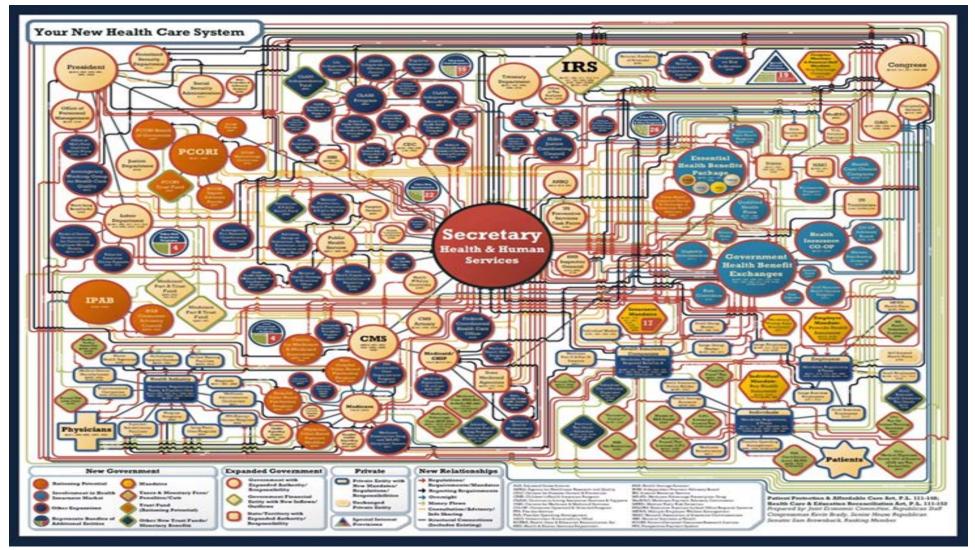


My lessons.. So far

- Understand the why, what will come
- Train, get new skills, never stop learning
- Emotional intelligence
- Situational awareness
- Embrace failures
- Have mentors, choose them carefully!
- Create an inner circle of confidants
- Allow yourself to be vulnerable
- Active listening
- Listen to opposing viewpoints
- People skills
- Never forget why you went into medicine
- Don't be harsh on yourself



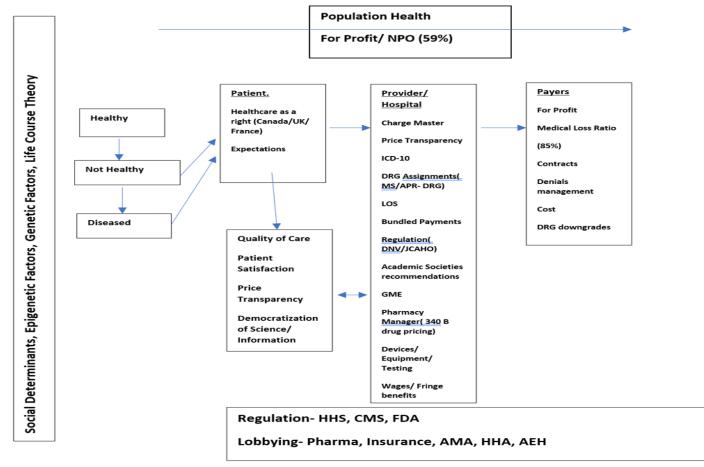








The complexities







If not us, who? If not now, when?
- Ronald Reagan



