Value Based Purchasing and Your Profession

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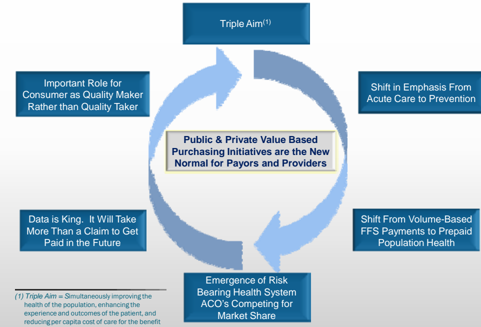
Today's HealthCare Ecosystem

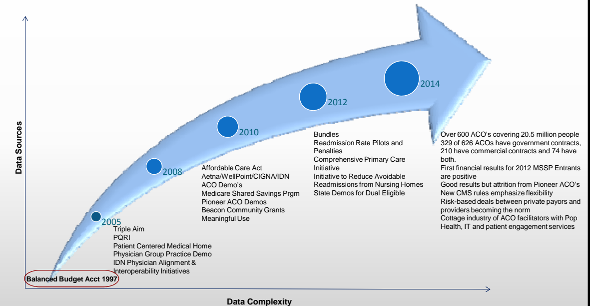


(1) *Triple Aim = S*imultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities.

VBP: How Does It Work?

- **Value Based Purchasing** is a broad set of performance-based payment strategies that link financial incentives to improve provider performance on a set of defined measures by both public and private payors. There are four broad types of VBP models:
- **Pay-for-performance are** payment arrangements designed to change provider behavior to achieve a set of objectives specified by the payer in which providers are rewarded (bonuses) or penalized (reductions in payments) based on meeting pre-established targets or benchmarks for measures of quality and/or efficiency.
- **Readmission Rate Penalties** will penalize as much as 3% of Medicare revenue (2,610 hospitals totaling $428M) in 2014 for excessive readmissions within one month. Elective Hip and Knee replacements were added in 2014.
- **Accountable care organizations are** health care organizations comprising doctors, hospitals, and other health care providers, that voluntarily come together to coordinate care and agree to be held accountable for the overall costs and quality of care for an assigned population of patients. Providers in the ACO agree to take financial risk and are eligible for a share of the savings achieved through improved care delivery provided they achieve quality and spending targets negotiated between the ACO and the payor.
- **Bundled payments** is a method in which payments to health care providers are based on the expected costs for a clinically defined episode or bundle of related health care services involving both financial and quality performance accountability for the episode of care. Episodes can be defined in different ways, cover varying periods of time (e.g., one year for a chronic condition, the period of the hospital stay and 30 days post-discharge), and include single or multiple health care providers of different types (e.g., hospital only, hospital and ambulatory provider).

Accelerating Growth in VBP Initiatives



Risk Sharing: Results from the MSSP & Pioneer ACO's

Medicare Shared Savings

- The first organizations in the MSSP were launched in two waves in April and July 2012, and CMS added additional ACOs to the program in January and December 2013.
  - As of May 2014, the organizations in the **MSSP covered 5.3 million of the total 20.5 million lives covered by all ACOs**, according to Leavitt Partners analysis.
- In September 2014, CMS released the quality and financial results of the MSSP ACOs with 2012 start dates for the first performance year. Overall, the results not seem promising, with only about **26 percent of the organizations decreasing spending enough to receive bonus payments.**
- **The 53 ACOs that received bonuses earned more than $300 million** as their share of program savings.
  - Houston-based Memorial Hermann ACO and Palm Springs (Fla.) ACO earned the largest bonuses, receiving $28.34 million and $19.34 million respectfully.
- ACOs participating in the program improving on **30 of 33 quality measures**.

Pioneer ACO

- In September 2014, CMS announced that the Pioneer Program was able to yield total **program savings of $96 million (2012-2013) and resulted in ACOs sharing in savings of $68 million**.
- CMS also reported that the Pioneers were able to improve mean quality scores by 19 percent and **increased performance on 28 of 33** measures between performance year one and performance year two.
- The program has experienced some attrition because of the higher levels of risk and program design from 31 at the outset to 19 after two years.

Commercial ACO's

- Since 2011, the number of commercial ACOs has steadily grown, and as of May 2014, 12.4 million lives were covered by an ACO with a commercial contract.
- Commercial ACOs are very similar to their Medicare cousins, but the commercial insurers generally set their own quality metrics. Risk and length of ACO contracts vary from payer to payer.
- Commercial payors with the largest share of accountable care contracts are the following, according to Leavitt Partners: Cigna (19 percent), Aetna (9.1 percent), United (4 percent), Blue Shield of California (3.7 percent) and the Oregon Health Plan (3.7 percent).
- Of commercial accountable care contracts, self-insured employers make up 2.8 percent.
- In 2012, Cigna announced its goal to form 100 collaborative accountable care initiatives, its version of ACOs. By 2014, it surpassed this mark with 105 collaborative care arrangements in 27 states, covering more than 1.1 million commercial customers.
- United Healthcare intends to continue to contract with ACOs, and estimates $50 billion of its reimbursements to providers will be attributable to accountable care by 2017, double the $20 billion of its reimbursements that are currently attributable to the model of care.
- Anthem Blue Cross Vivity Plan launched in 2014 is an HMO that pools risk and reward for a network of 6,000 docs and 14 hospitals including Cedars-Sinai Health System, Good Samaritan Hospital and UCLA Health, all in Los Angeles; Huntington Memorial Hospital, Pasadena; MemorialCare Health System, Fountain Valley; PIH Health, Whittier; and Torrance (Calif.) Memorial Medical Center.

Is VBP Vulnerable to Changes in ObamaCare?

- While certain aspects of ObamaCare are vulnerable, specifically how the program is funded, few in Congress will vote against controlling health care costs.
- We can trace VBP purchasing back to the Balanced Budget Act of 1997 that emphasized the need to use Medicare and Medicaid resources more efficiently.
- The concept of VBP have expanded to reduce health plan, hospital and provider reimbursements through Republican and Democratic administrations and has strong bipartisan support.
- New CMS rules for ACO spell flexibility going forward:
  - Participation agreement renewals;
  - The beneficiary assignment algorithm;
  - Data sharing;
  - Financial benchmarks;
  - The risk-based model;
  - Minimum savings and loss rates for Track 2;
  - MSSP eligibility requirements.

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Some Lessons Learned in MSSP Years 1 & 2

- **Early movers have the advantage:** The successful ACOs are "playing a long ball," They believe all risk will eventually be shifted to local providers and that their ACO strategy centered on integration to improve outcomes is central to their long-term solvency.
- **Assessing risk is key:** It requires a significant capital investment for an organization to create an effective population health infrastructure. Just because physicians sign up to participate in an ACO does not mean it will be successful, particularly when they lack the infrastructure to manage populations, as well as high risk patients.
- **Managing physician expectations is a challenge:** Many physicians are accustomed to individual production-based income, and it's difficult for them to transition into an ACO's team-based compensation arrangements based on continuity of care across the health system.
- ***Could the same be said of AOPA members?***

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What About the Consumer in VBP

- Health Care Consumers to date have been "Quality Takers" rather than "Quality Makers"
- A recent Watson Wyatt survey found that the VBP strategy being adopted at the fastest rate among employers with 1,000 or more employees is "Consumerism"
- Although it is estimated that only 12% of consumers currently look at quality as a factor in choosing a provider or health plan and have historically used high price as a proxy for high quality
- This is changing steadily albeit slowly as consumers become increasingly involved in cost sharing through high deductible plans.
- A recent study by the Institute for Policy Research and Innovation found that when cost and quality information were provided side by side in an easy to interpret format, consumers were more likely to make value-based choices.
- We see an enormous investment today by health plans and entrepreneurial companies in new mechanisms to ensure that such data follows the consumer, e.g.,
  - Aetna's Member Payment Indicator covering over 550 common services;
  - Change Healthcare's mobile consumer engagement strategy using text and email to alert people on how they can save money on routine medical services and prescription drugs.

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Key Trends in Orthotics and Prosthetics

- There will be a 3.9 percent compound annual growth rate through 2018 in the orthopedics and prosthetics industry.
- The orthopedic industry has been under pressure since the economic downturn and struggling to achieve growth amid tough market conditions.
- Increased obesity and aging population, as well as unstable financial conditions in the established markets, have forced medical device manufacturers to become more responsive to macro- and micro-economic factors.
- There is an expected rise in musculoskeletal disorders as a result of the more active and demanding customer base.
- Principal growth drivers are the uptake of new products and technologies in developed markets, high growth in extremity and biologic products and rapid uptake of standard and market-specific products in emerging regions.
- *RAC Audits are here to stay and have huge institutional tail winds.*
- *Reimbursement discussions with CMS will remain much like trench warfare in WWI.*

Source: Becker's Hospital Review, October 20, 2014

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So How Does VBP Affect My Business Strategy

- The cornerstone of Blue Ocean Strategy is 'Value Innovation,' the simultaneous pursuit of differentiation and low cost, creating value for both the buyer, the company, and its employees, thereby opening up new and uncontested market space.
- The aim of value innovation is not to compete, but to make the competition irrelevant by changing the playing field of strategy.
- To achieve this change, the business must raise and create value for the market, while simultaneously reducing or eliminating features or services that are less valued by the current or future market.
- Red Oceans represent all the industries in existence today – the known market space. In the red oceans, industry boundaries are defined and accepted, and the competitive rules of the game are known.
  - Here companies try to outperform their rivals to grab a greater share of product or service demand. As the market space gets crowded, prospects for profits and growth are reduced as products become commodities and cutthroat competition turns the ocean bloody.
- Blue Oceans, in contrast, denote industries not in existence today – the market space that is not yet explored, untainted by competition.
  - Here demand is created rather than fought over. Here there is ample opportunity for growth that is both profitable and rapid. In blue oceans, competition is irrelevant because the rules of the game are waiting to be set.

Reference: Blue Ocean Strategy by Kim and Maugborne, Harvard Business Review Press, 2005

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Setting Course for the Blue Ocean

- While the AOPA member's % of a hospital risk pool may be very small, it is not so small that a business cannot project a compelling value proposition to a risk-bearing ACO.
- Your competitor, apart from your fellow AOPA member, may be the risk bearing health system's desire to vertically integrate your services to control the quality, consistency and cost of services.
- **First movers** will enjoy a significant advantage as hospitals attempt to lock in long term agreements with ancillary providers.
- These arrangements will typically be a **volume for rate play**.
- They will also require participation in a **model of care (MOC)** developed by the risk bearing health system -- written protocols laying out workflows, timelines and expected results.
- The financial impact of your services will be judged in two ways: (a) contractual impact on the **risk pool** and (b) the downstream impact on the **drivers of systemic costs**, i.e., hospital admissions and institutional care.

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Does the Data Support O&P Services in VBP?

- Among **lower extremity prostheses** patients, patients who received lower extremity prostheses had comparable Medicare episode payments (including the cost of the prosthetic) and better outcomes than patients who did not receive prostheses. The receipt of physical therapy is associated with **fewer acute care hospitalizations and emergency room admissions**, and less facility-based care, offsetting the cost of the prosthetic.
- Patients who received **lower extremity orthoses** had better outcomes over 18 months, defined as **fewer acute care hospitalizations and emergency room admissions** and reduced costs to Medicare (episode payments approximately 10 percent lower than the comparison group, including the cost of the orthosis). Additionally, these patients were able to sustain significantly more rehabilitation, **and were able to remain in their homes as opposed to needing placement in facility-based settings**.
- Patients who received **spinal orthoses** had comparable Medicare payments over 18 months to those who did not receive the orthosis, and **had higher reliance on ambulatory and home-based care (as opposed to facility-based care)**. This could suggest that the use of spinal orthoses allows patients to be less bedbound and "age in place" in their homes. ***While these patients tend to have more falls and fractures***, which may be due to their increased ambulation and independence, these falls did not result in a higher number of emergency room admissions compared to comparison group patients.
- Each AOPA member seeking VBP business, should have a cheat sheet with information like this, and AOPA should take this on.

Source: Retrospective Cohort Study of the Economic Value of Orthotic and Prosthetic Services Among Medicare Beneficiaries, Prepared for AOPA by Dobson DaVanzo & Associates, LLC, 2013

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The Cost of Falls and Fractures

- One of the leading causes of hospital readmissions in the elderly. Ground level falls are highly predictive of a pattern of future readmissions to hospitals that has risen sharply over the last decade.
- $36 Billion in direct medical costs was spent treating the elderly for the effects of falls.
- Falls and fractures are the leading cause of injury-related death in the elderly; death rates have risen sharply over the last decade.
- About 2.5 million seniors are treated for non-fatal fall injuries in the emergency room annually of which 1/3 are hospitalized. Medicare reimburses about 80% of these services.
- Hip fractures caused by falls are highly correlated to the "cliff effect" that accelerates decline in the elderly. Upwards of 25% of seniors with hip fractures spend a year in a nursing home (largely reimbursed by Medicaid).
- This problem will only get worse as Boomers, in particular, those with the burden of lifestyle related chronic illness, age-in.
- **Your business should have a well honed argument for the relationship between mobility and the rate of avoidable cost like those associated with hospital admissions.**

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Making VBP Work for the O&P Profession

- Each member and the industry have a role to play.
- On a tactical level, each member needs to be able to make the cost and quality argument around independence, utilization of the least restrictive level of care and avoidable admissions.
- At the industry level, AOPA has demonstrated added value by developing some data that can be very useful in establishing VBP relationships.
- Going forward, AOPA should:
  - Make studying the relationship between quality and cost in your professional a mission, in particular, how its insight on falls and fractures can lead to clinical process improvement;
  - Reduce this information to useable form by members;
  - Tackle falls and fractures as a strategic marketing cause to associate the profession in a positive light with their prevention.
- In so doing to start a meaningful conversation with:
  - The current consumer of O & P products and services.
  - A future consumer of your products and services, who is looking for answers, and who now makes decisions for the current consumer of your products and services.
  - Public policymakers.
  - Health plan and ACO executives.

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