Value Based Purchasing
Objectives

- Identify the momentum behind healthcare reform & its efforts on Emergency Medicine
- Discuss the basic tools and tenants in value-based emergency care
- Discuss the effects of value-based purchasing on EM reimbursement & practice
- Discuss best practice involved in transitions of care in the Emergency Department

Overview

- Economics
- Value and Payments
- Market Forces
- Emergency Medicine and the Future
## Value

- Value = Quality / Cost
- Quality = Safety, Outcomes and Experience

## Value of Emergency Medicine

- Time Sensitive Diagnosis
- Acute Undifferentiated Care/ All Ages
- Rapid High Quality Diagnostic Center
- Transitions of Care
Value of Emergency Medicine

- Reduce Unnecessary Testing
- Decreasing Patient Cycle Time
- Increase Observation Services
- Reduce Avoidable Admissions
- Reduce Avoidable Re-admissions

Value of Emergency Medicine

- Patient Experience
- Market Share
- Interface with ACO/Bundled Payments
- Regionalization of Emergency Care Services
Value of Emergency Medicine

- **EM Profile**
- 4% of Physicians in the US practice EM
- 10-12% of all outpatient visits/ particularly higher acuity
- 28% of all acute care visits
- 1/2 of all acute care Medicaid and CHIP
- 2/3 of all uninsured visits
- 1/2 of all hospital admissions
- 1/3 of all National Healthcare spending

Value Based Purchasing

**Value of EM**

**2% Campaign**
### US Gross Healthcare Spending

![Graph showing healthcare spending](chart.png)

### Federal Spending 2012-2013

<table>
<thead>
<tr>
<th></th>
<th>2011 ($ trillion nom)</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending</td>
<td>3.6</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Federal Deficit</td>
<td>1.3</td>
<td>1.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Other Borrowing</td>
<td>-0.1</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Gross Federal Debt</td>
<td>14.8</td>
<td>16.4</td>
<td>17.5</td>
</tr>
</tbody>
</table>

![Pie chart showing federal spending categories](pie_chart.png)
2010 Healthcare Spending as a Percent of GDP

Average Annual Premiums for Single and Family Coverage 1999-2012

* Estimate is statistically different from estimate for the previous year shown (p<.05).
Percent of Median Family Income Required to Purchase Family Health Insurance

Source: Len Nolte’s (Director, Health Policy Reform, New America Foundation) calculations, using KFF and AHRQ premium data, CPS income data, plus projections from Carpenter and Axeen, The Cost of Doing Nothing, 2008.

Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2012

Figure 6: Average Prices per Service for Inpatient Admissions: 2011

- Deliveries & Newborns: $7,908
- Medical: $13,023
- MHSA: $7,837
- SNF: $4,734
- Surgery: $29,658

Note: All data weighted to reflect the national, younger than 65 ESI population. MHSA: Mental Health and Substance Abuse. SNF: Skilled Nursing Facility.

---

Average Prices per Service for Outpatient Visits and Other: 2011

- Ancillary Services: $177
- Emergency Room: $1,381
- LabPathology: $57
- Observation: $1,803
- Other Outpatient Services: $253
- Outpatient Surgery: $3,673
- Radiology Services: $471

Note: All data weighted to reflect the national, younger than 65 ESI population.
Economics 101

Concentration of Health Care Spending in the U.S. Population, 2009

Note: Dollar amounts in parentheses are the annual expenses per person in each percenttile. Percentiles are the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies. Health insurance premiums are not included.


Economics 101

Distribution of Average Spending Per Person, 2009

<table>
<thead>
<tr>
<th>Age (in years)</th>
<th>Average Spending Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>$2,468</td>
</tr>
<tr>
<td>5-17</td>
<td>1,095</td>
</tr>
<tr>
<td>18-24</td>
<td>1,834</td>
</tr>
<tr>
<td>25-44</td>
<td>2,739</td>
</tr>
<tr>
<td>45-64</td>
<td>5,511</td>
</tr>
<tr>
<td>65 or Older</td>
<td>9,744</td>
</tr>
</tbody>
</table>

Sex

<table>
<thead>
<tr>
<th></th>
<th>Average Spending Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>$3,559</td>
</tr>
<tr>
<td>Female</td>
<td>4,635</td>
</tr>
</tbody>
</table>

Note: Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies. Health insurance premiums are not included.

Economics 101

Value Based Purchasing

- Strategy for Healthcare financing
- Attempts to hold providers accountable for both quality and cost
- Rewards the “best performers”.
- Shifts from volume based payments to payments related to outcomes.
Value Based Purchasing

- Premise – Change financial incentives and you will get different performance.
- Population Health says – effective, efficient and proper utilization costs less and is of higher quality.
- Fee for Service – more expensive and poorly aligned.
- Global payments drive effectiveness

Value Based Purchasing

- Pay for Performance programs
- PQRS
- VBP
- Bundled payments
- Episodes of care
- ACO’s
Value Based Purchasing

- Examples:
  - Pay for performance programs that reward improvements in quality metrics.
  - Bundled payments that reduce avoidable complications.
  - Global trend rates that tie payments to quality score cards and actual target cost trends.
  - Common goals is to slow the total cost of care.

Value Based Purchasing

- ACA mandate starting 2015.
- Different pay based on cost and quality.
- Applies to all MD payments for group greater than 100 or more based on 2013 claims.
- Goal is to encourage shared responsibility, shared savings and ACO’s.
PQRI now Physician Quality reporting System (PQRS)

- Requires 50% on 3 measures
- Transitioning to penalty phase
  - 2012-2014 0.5 % Bonus
  - 2015 penalty phase -1.5%
- PQRS Update with publication of Physician Final Rule
- ED Measures continue: ASA for AMI, EKG for Chest Pain and Syncope, Some Pneumonia measures
- Retirement Issues:
  - Pneumonia O2 saturation (#57) and mental status (#58)
  - Pregnancy test for female abdominal patients (#253)
  - Otis externa pain assessment (#92)

www.acep.org/quality/pqrs

PQRS – Now available: 2011 PQRS Reporting Experience

- Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System through the Claims Individual Measures Reporting Option (2011)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Eligible Professionals</th>
<th>Eligible Professionals who participated</th>
<th>Percent of Eligible Professionals who Participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>50,984</td>
<td>33,976</td>
<td>66.6%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>42,936</td>
<td>23,070</td>
<td>53.7%</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>44,104</td>
<td>17,130</td>
<td>38.8%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>96,445</td>
<td>17,110</td>
<td>17.7%</td>
</tr>
<tr>
<td>Radiologist</td>
<td>37,474</td>
<td>17,012</td>
<td>45.4%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>94,732</td>
<td>16,944</td>
<td>17.9%</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>46,784</td>
<td>11,093</td>
<td>23.7%</td>
</tr>
<tr>
<td>Optometry</td>
<td>32,404</td>
<td>8,811</td>
<td>27.2%</td>
</tr>
<tr>
<td>Other Eligible Professional</td>
<td>43,735</td>
<td>8,307</td>
<td>19.0%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>56,593</td>
<td>8,115</td>
<td>14.3%</td>
</tr>
</tbody>
</table>
PQRS

Table 13: Measures Reported by the Largest Numbers of Eligible Professionals Under the Physician Quality Reporting System (2011)

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Description</th>
<th>Participated</th>
<th>Percent of Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)</td>
<td>70,961</td>
<td>9.1%</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>43,775</td>
<td>6.2%</td>
</tr>
<tr>
<td>59</td>
<td>12-lead Electrocardiogram (EKG) Performed for Non-Cardiac Chest Pain</td>
<td>42,918</td>
<td>59.2%</td>
</tr>
<tr>
<td>57</td>
<td>Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation</td>
<td>41,747</td>
<td>56.6%</td>
</tr>
<tr>
<td>30</td>
<td>Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics</td>
<td>40,033</td>
<td>49.6%</td>
</tr>
<tr>
<td>224</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>38,357</td>
<td>54.4%</td>
</tr>
<tr>
<td>50</td>
<td>Community-Acquired Pneumonia (CAP): Assessment of Mental Status</td>
<td>37,279</td>
<td>11.2%</td>
</tr>
<tr>
<td>1</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus</td>
<td>37,279</td>
<td>11.2%</td>
</tr>
<tr>
<td>26</td>
<td>Community-Acquired Pneumonia (CAP): Vital Signs</td>
<td>37,279</td>
<td>11.2%</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus</td>
<td>36,001</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

*Note: Some measures are not currently available for reporting.*

PQRS – Getting your PQRS Reports

- **Group (TIN#) level through IACS**
  - Individuals Authorized Access to the CMS Computer Services
  - TIN representative must create an IACS account
  - Required to Log on to the Portal via QualityNet
  - CMS help desk resources: Phone: (866) 484-8049

- **Provider level no IACS Required**
  - Established in 2011
  - Can view 2008-2011 reports – helpful user manual
  - [http://www.qualitynet.org/portal/server.pt/community/communications_support_system/234](http://www.qualitynet.org/portal/server.pt/community/communications_support_system/234)
### PQRS – CMS Value Based Payment Modifier Overview

- "The modifier will adjust your payments based on the quality and cost of care physicians deliver starting 2013."

### 2013 CMS Final RULE
- Initial focus on groups > 100 providers
- Satisfactorily report in 2013 no 2015 VBP penalty
  - Held harmless and your VBP will be 0.0%
- Fail to report PQRS your VBP will be as much as -1.0% plus an additional -1.5% as a PQRS program specific penalty for a total of -2.5%
- Option to elect “quality tiering calculation” with ~1% at risk ... not recommended

---

### PQRS – Interaction between 2013 PQRS and 2015 VBP

<table>
<thead>
<tr>
<th>Tiering</th>
<th>No Tiering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elect quality tiering: Up/down adjustment based on quality/cost composite score.</td>
<td>0.0% VBP No Penalties in 2015</td>
</tr>
<tr>
<td>Failure to report at least 1 GPRO measure or to elect Administrative Claims Reporting for the 2013 PQRS reporting period.</td>
<td>1.0% VBP Penalty in 2015 -1.5% PQRS Penalty in 2015 -2.5% Total Penalties in 2015</td>
</tr>
</tbody>
</table>

**Groups of physicians with >100 eligible professionals nominate in 2013 7.15-10.15**

Self nominate to elect Administrative Claims Reporting within PQLS GPRO and report at least one measure by Oct 15, 2013
PQRS – Table. Calculation of the Value Modifier Using the Quality - Tiering

<table>
<thead>
<tr>
<th>Quality/ cost</th>
<th>Low cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Medium Quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

---

PQRS/ VBM

Table 3. VBM Measures Used to Calculate Care Coordination Domain for Quality Composite

<table>
<thead>
<tr>
<th>Domain of Care</th>
<th>Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Prevention Quality Indicators (PQIs) Composite</td>
<td></td>
</tr>
</tbody>
</table>
  - Pneumonia: # of admissions per 100,000 population  
  - UTI: # of discharges for UTI per 100,000 population  
  - Dehydration: # of admissions for dehydration per 100,000 population |
| 2. Chronic Prevention Quality Indicators (PQIs) Composite:  
  - Diabetes Complications:  
    - Uncontrolled diabetes: # of discharges per 100,000 population  
    - Short-term diabetes complications: # discharges per 100,000 population  
    - Long-term diabetes complications: # of discharges for per 100,000 population  
    - Lower extremity amputations for diabetes: # per 100,000 population  
  - COPD: # of admissions for COPD per 100,000 population  
  - Heart Failure: % population with admissions for CHF |
| 3. All Cause Readmissions: rate of provider visits within 30 days of discharge per 1,000 discharges for eligible beneficiaries assigned |

To calculate the cost composite score, CMS will evaluate the five measures listed in Table 3 below.

Table 3. VBM Measures Used to Calculate Cost Composite

<table>
<thead>
<tr>
<th>Domain</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Overall Costs per Beneficiary</td>
<td></td>
</tr>
</tbody>
</table>
  - Total Costs per Beneficiary for Chronic Conditions Composite:  
    - Total Costs per Beneficiary with COPD  
    - Total Costs per Beneficiary with CHF  
    - Total Costs per Beneficiary with CAD  
    - Total Costs per Beneficiary with Diabetes |
| 2. Total Costs per Beneficiary for Chronic Conditions Composite:  
  - Total Costs per Beneficiary with COPD  
  - Total Costs per Beneficiary with CHF  
  - Total Costs per Beneficiary with CAD  
  - Total Costs per Beneficiary with Diabetes |
PQRS – Who will be impacted by the VBP Modifier?

- D/W CMS re: roll out for ED Physicians
  - CMS is Starting at the group level
  - If the group has > 100 providers in the PECOS (Provider Enrollment Chain & Ownership System)
    - MDs, PAs, NPs
    - Not residents, locums, or students
- Aggressive roll out 2015-2017
  - Starting with larger groups
  - Seems to stratify to >100, 25-99, < 25
  - 2017 all providers

Interaction between PQRS & Value-Based Modifier

- To avoid -1.5% payment adjustment in 2015, based on CY 2013 claims must successfully report PQRS
- To avoid all penalties, groups ≥ 100 eligible professionals must report at the group level
- If the group reports at the individual level instead, they will all be subject to the value modifier of -1.0%
- Total Failure to Report PQRS = -2.5% (2015 payment adjustment, based on CY 2013 claims)
- Total Failure to Report PQRS = -3.0% (2016 payment adjustment, based on CY 2014 claims)
**PQRS Impact (CMS)**

**Total Potential Impact of PQRS Participation**

For 2013 there are Four PQRS Programs:

<table>
<thead>
<tr>
<th>Program</th>
<th>2013 Reports</th>
<th>2014 Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Traditional PQRS Incentive</td>
<td>+0.5% payment in 2014</td>
<td>+0.5% payment in 2015</td>
</tr>
<tr>
<td>2. PQRS MOC Incentive</td>
<td>+0.5% payment in 2014</td>
<td>+0.5% payment in 2015</td>
</tr>
<tr>
<td><strong>Total Potential PQRS Incentives</strong></td>
<td><strong>+1.0% in 2014</strong></td>
<td><strong>+1.0% in 2015</strong></td>
</tr>
<tr>
<td>3. PQRS Penalties for failure to report</td>
<td>-1.5% in 2015</td>
<td>-2.0% in 2016</td>
</tr>
<tr>
<td>4. VBM* for failure to Report PQRS*</td>
<td>-1.0% in 2015</td>
<td>-1.0% in 2016</td>
</tr>
<tr>
<td><strong>Total Potential PQRS Penalties</strong></td>
<td><strong>-2.5% in 2015</strong></td>
<td><strong>-3.0% in 2016</strong></td>
</tr>
</tbody>
</table>
CMS Readmission Measures 2013

- Hospital Readmission Reduction Program
  - HRRP
- “Program is designed to reduce CMS payments to hospitals with higher than expected risk-adjusted readmission rates.”
- Began 10.1.2012
- Reductions of 1% increasing to 3% in 2015
  - Acute Myocardial Infarction
  - Heart Failure
  - Pneumonia

CMS Inpatient Proposed Rule (4/26/2013)

- Adds knee and hip implants and COPD admissions to the readmissions reduction program starting in 2015

- Pays for the 2013 physician “SGR fix” with $11B in hospital cuts over 4 years
CMS Inpatient Measures

- HCAPS
- Inpatient Quality Measures
- Hospital Acquired Conditions/Complications
- MAC/ RAC Audits

HACs and Codes

<table>
<thead>
<tr>
<th>HAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Object Retained After Surgery</td>
</tr>
<tr>
<td>Air Embolism</td>
</tr>
<tr>
<td>Blood Incompatibility</td>
</tr>
<tr>
<td>Pressure Ulcer Stages III &amp; IV</td>
</tr>
<tr>
<td>Falls and Trauma:</td>
</tr>
<tr>
<td>• Fracture</td>
</tr>
<tr>
<td>• Dislocation</td>
</tr>
<tr>
<td>• Intracranial Injury</td>
</tr>
<tr>
<td>• Burn</td>
</tr>
<tr>
<td>• Other Injuries</td>
</tr>
<tr>
<td>Catheter – Associated Urinary Tract Infection (UTI)</td>
</tr>
<tr>
<td>Vascular Catheter – Associated Infection</td>
</tr>
<tr>
<td>Manifestation of Poor Glycemic Control:</td>
</tr>
<tr>
<td>• Diabetic Ketoacidosis</td>
</tr>
<tr>
<td>• Nonketotic Hyperosmolar Coma</td>
</tr>
<tr>
<td>• Hypoglycemic Coma</td>
</tr>
<tr>
<td>• Secondary Diabetes with Ketoacidosis</td>
</tr>
<tr>
<td>• Secondary Diabetes with Hyperosmolarity</td>
</tr>
</tbody>
</table>

Surgical Site Infection, Mediastinitis, following Coronary Artery Bypass Graft (CABG)
### Accountable Care Organizations

- Provider-led organizations with a strong primary care base that take accountability for the full spectrum of healthcare services for a defined population
- Financial incentives tied to:
  - Total cost of care
  - Quality and patient satisfaction
CMS ACO Programs
(260 Participating Organizations)

- Physician Group Practice Transitions Program
  - Six organizations (started Jan 2011)
- Pioneer ACO Program
  - 32 organizations (started Jan 2012)
- Medicare Shared Savings Program
  - 27 organizations began in April 2012
  - 89 organizations began in July 2012
  - 106 organizations announced in Jan 2013

ACO’s

- Provider led (physicians, hospitals, insurers, pharmacy companies, etc.) organizations forming a network to coordinate care
- Quality
- Cost
- Patient experience
ACO’s

- Reduce national deficit with Medicare as a prime target
- Goal to get paid more for keeping patients healthy and out of the hospital
- ACO patients are not required to stay in the network.
- Reduce ED visits, admissions, readmissions, specialty consultations and testing.

ACO’s

- Medicare contracts with 260 ACO’s (about 4 million patients)
- Private insurance covering another 14-23 million people
- 10-15% of Americans are in ACO’s
ACO’s

- Challenges:
  - Financial
  - Networks
  - Patient Choice

- Solutions:
  - IT
  - Outreach and service
  - Pricing
  - Med PAC ("Medicare Select ACO Supplement Plan" aka Medigap)

ACO’s

- New products
- New Ideas
- New Partners
- New Payor/Provider relationships
ACO’s

<table>
<thead>
<tr>
<th>Providers</th>
<th>Payors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>Insurance Companies</td>
</tr>
<tr>
<td>Health Systems</td>
<td>Integrated Delivery Systems</td>
</tr>
<tr>
<td>Large MSG’s</td>
<td>New Entities</td>
</tr>
<tr>
<td>IPA’s</td>
<td></td>
</tr>
<tr>
<td>ACO’s</td>
<td></td>
</tr>
</tbody>
</table>

Bundled Payments

- Competition for employer’s direct business
- Cardiac/ Orthopedics
- Medicare has a much wider variety of diagnoses for bundled payments
Implications for Emergency Medicine

- Reduction of avoidable ED visits is a goal for every one of the 260 ACOs and private insurance products in the US today
- Contrary to what you may hear, this is based on sound economics
- Every smart ACO should try to partner with EDs to coordinate care and create alternatives to admissions/readmissions
- Bundled payment conundrum

Strategic Opportunity

- We already know how to deliver acute unscheduled care quickly and at a low marginal cost
- Why are we content to do this in an environment that has:
  - Long waiting times due to hospital boarding; and
  - High fixed hospital costs that drive a non-competitive business model?
Creating Value and Sustainability

- Evaluation of our Role
- Understanding how to improve and advance
- Recognition of market and disruptive innovations
- Emergency Medicine Importance regardless of model

Innovation and Creativity

- Free standing EDs
- Urgency Centers
- Urgent Care Centers
- Internet and Social Media Platforms
- Retail Clinics
- FQHC
- PCMH
Planning, Implementation and Execution

- Streamlined Strategic Plan
- EMF, EMAF
- Collaboration
- Quality Metric Development
- Focus on the changing environment

ACEP’s Mission Statement

The American College of Emergency Physicians promotes the highest quality emergency care and is the leading advocate for emergency physicians, their patients, and the public.
New Strategic Plan

- Goal 1: Reform and Improve the Delivery System for Emergency Care
- Goal 2: Enhance Member Value and Member Engagement

Quality Metrics/Registry

- EM Derived Value Metrics
- ACEP Members Expertise
- Budget/Resources
- Fair and Equitable Process
Immediate Action Items

- H.R.36/ S.961 Liability Reform
- H.R. 1179/ S.569 Observation/ 3 Day Stay Rule
- Value of Emergency Medicine
- GME Funding

EMRA
EMF
NEMPAC
EMAF
Who will be impacted?

- Every dollar of waste in healthcare is somebody’s dollar of revenue

- Hospitals stand to lose the most from reductions in TCOC
  - Admissions for chronic diseases
  - Readmissions
  - ED visits