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Tomorrow's Doctors, Tomorrow's Cures®

Learn
Serve
Lead

Funding for Clinical Services in Academic Departments in the World of ACOs and Health Care Reform

2015 Association of Professors of Dermatology Annual Meeting

Atul Grover, M.D., Ph.D.
Chief Public Policy Officer

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agrover@aamc.org
@AtulGroverMD

Association of American Medical Colleges

Overview

- Health Care = Major US Economic Engine; Cost/Value = Major Concern.
- ACA, SGR Fix, Medicare Drive Reform – Changes in Payment Policy; Demos of Delivery and Financing Reforms.
- AAMC, AMCs = Learning, Leading - Reform Is Here to Stay.

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First, who we are…

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AAMC:
Med. Schools, Hospitals, Physicians

- Membership includes:
  - **144** U.S. medical schools (MD programs).
  - Nearly **400** major teaching hospitals & health systems.
    - ✓ **51** Department of Veterans Affairs medical centers.
  - **Nearly 90** academic and scientific societies, ***including the Association of Professors of Dermatology.***

- Over 300,000 "Voices:"
  - **141,000** faculty members.
    - ✓ Clinical and basic science (research) faculty.
    - ✓ Staff the physician practice groups and hospitals.
  - **83,000** medical students.
  - **115,000** residents.

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Academic Medicine's 3-Part Mission: Advances Health

Extraordinary clinical care:

- COTH hospitals comprise only 5% of all hospitals but account for:
  - 37% of charity care.
  - 23% of all hospital care.
    - ✓ 24% of all Medicaid in-patient days.
    - ✓ 20% of all Medicare in-patient days.
- 88,577 full-time docs work in medical school clinical departments.

Cutting edge research:

- Over half of NIH Extramural Research Awards go to an AAMC hospital or member medical school.

Comprehensive education and training:

- 74% of all residents train at an AAMC hospital.

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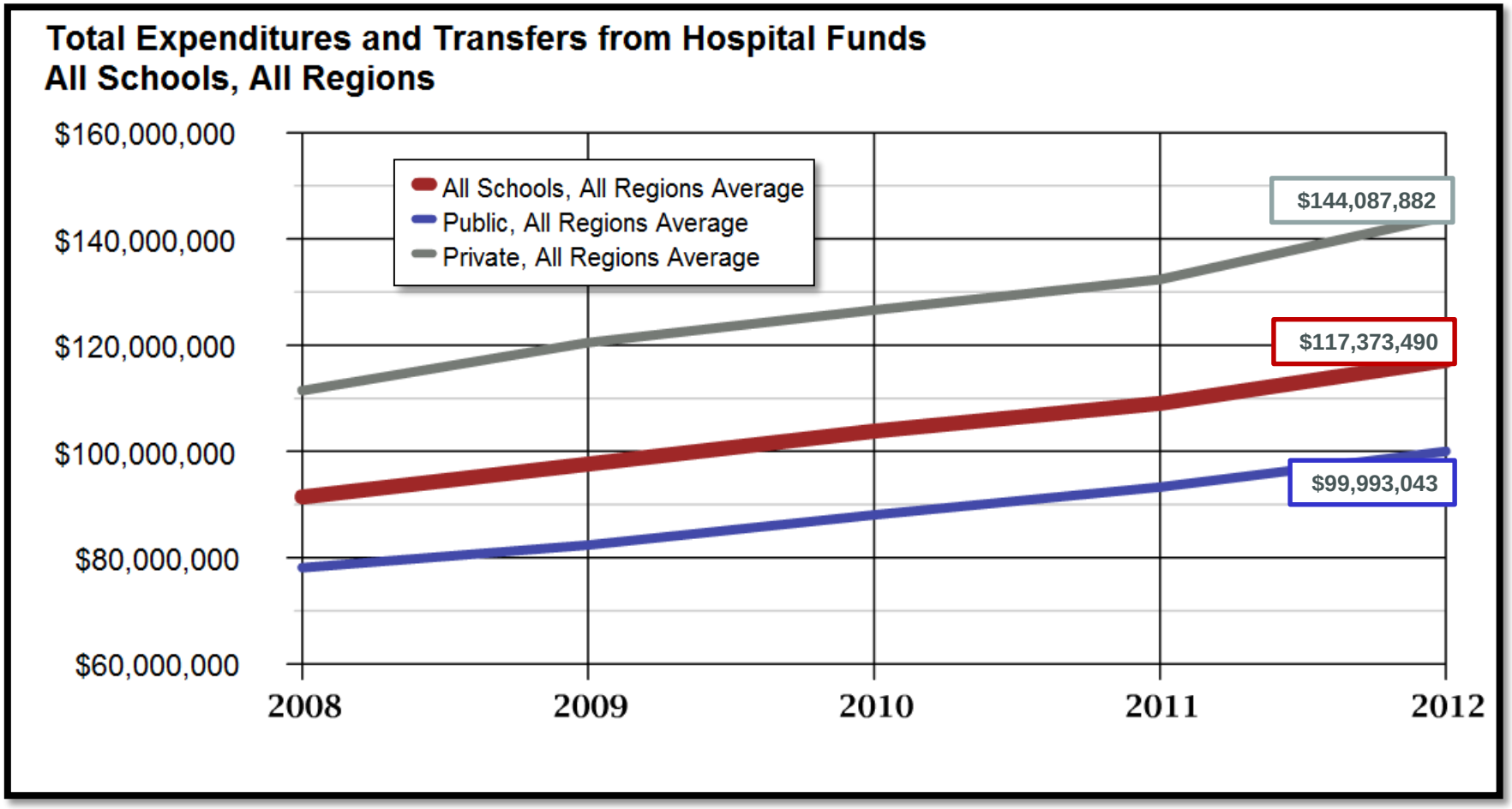
Background: Flow of Funds in Academic Medical Centers (AMCs)…



Expenditures and transfers are the same. These funds include payments for services provided to hospitals and clinics by medical school faculty and staff, payments to house staff, and strategic investments in the medical plan.

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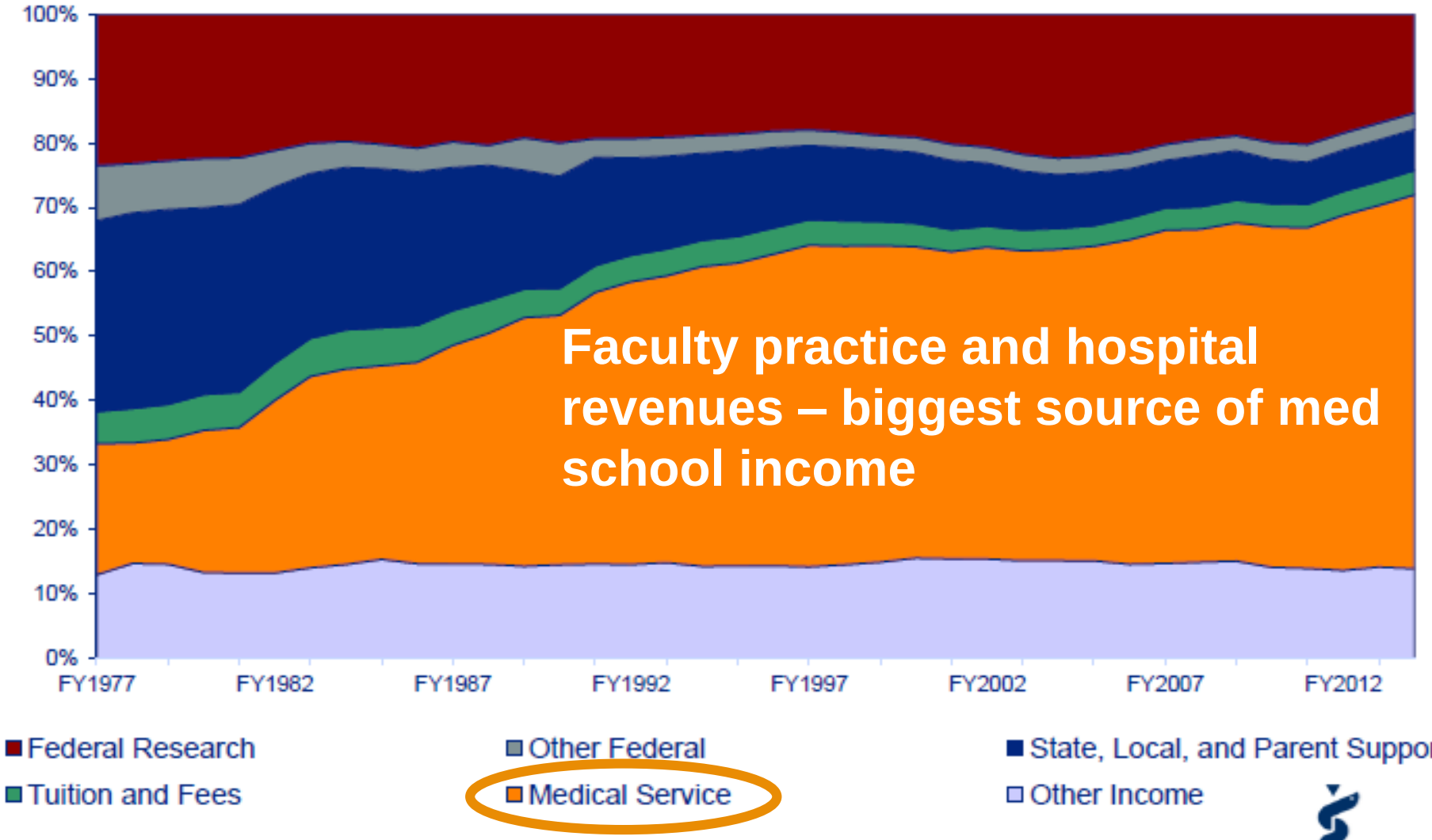
Medical School Revenue Sources

Figure 9: Revenue by Source as a Percentage of Total Revenue for Medical Schools with Full Accreditation, FY1977 through FY2014



Source: LCME I-A Annual Financial Questionnaire

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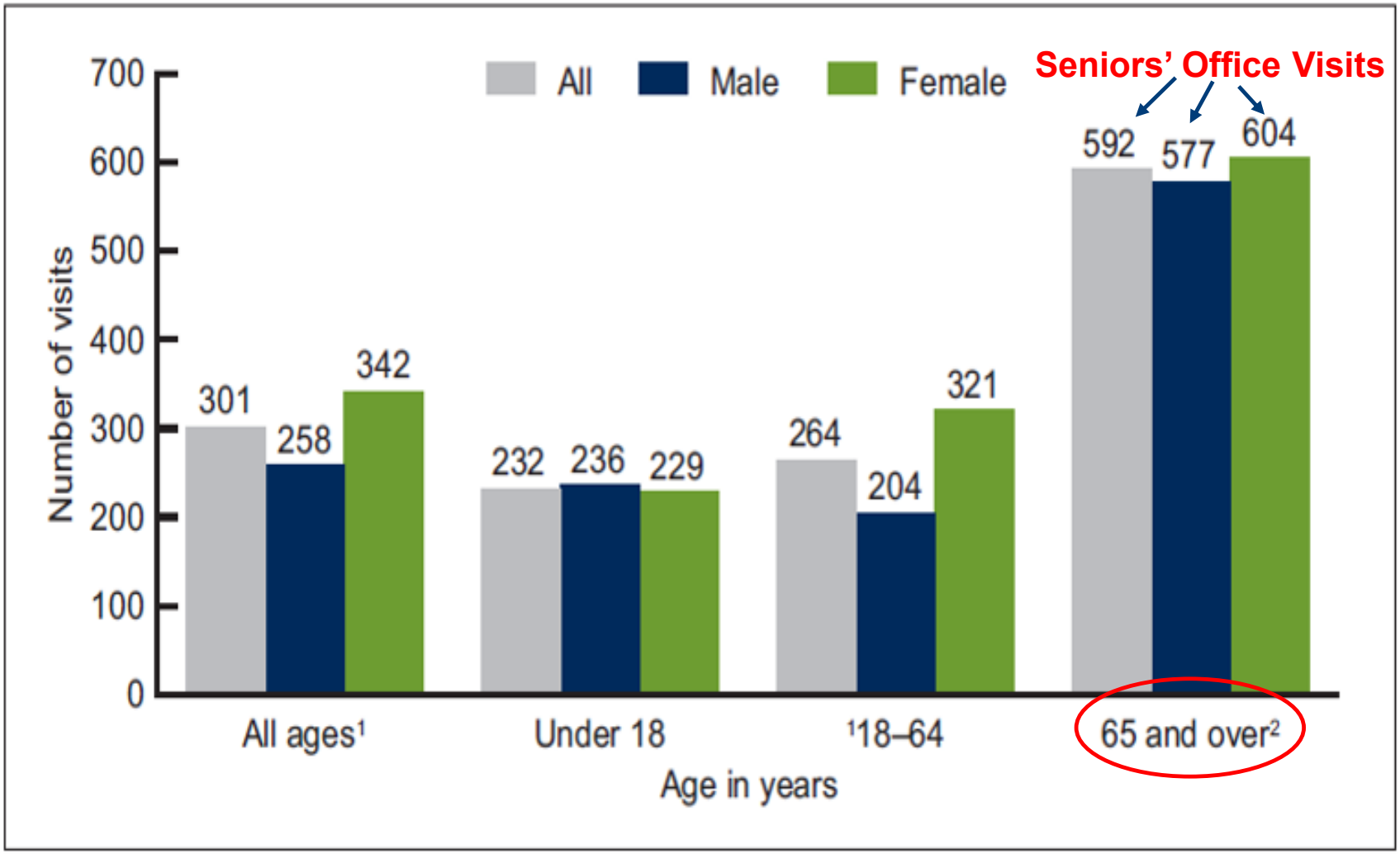
Physician Office Visits: Seniors Are Tops

Figure 1. Physician office visits per 100 persons, by sex and age: United States, 2012



Source: CDC/NCHS, National Ambulatory Medical Care Survey, 2012

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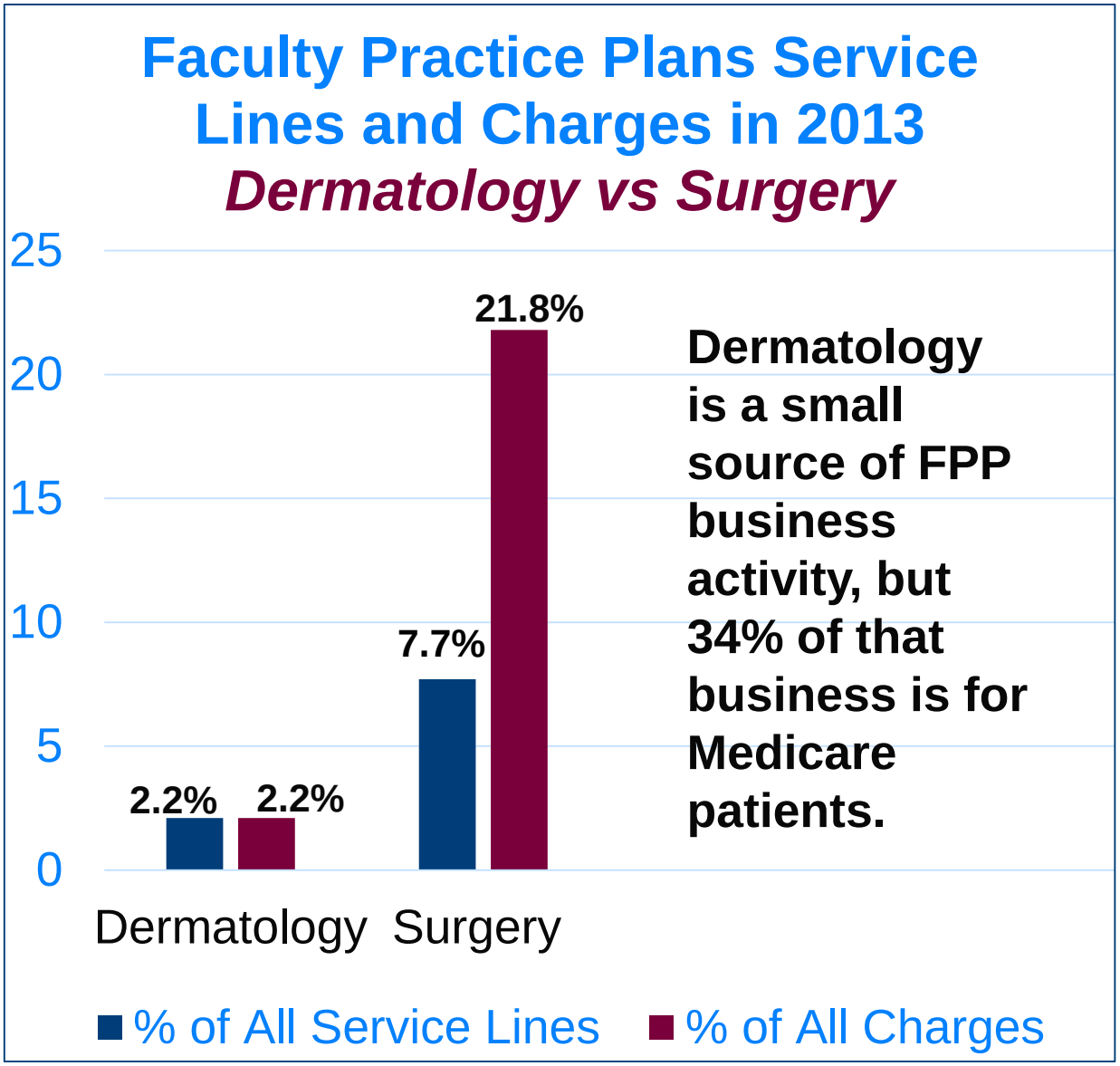
Dermatology's Role in Faculty Practice Plans



Source: Faculty Practice Plan Solutions Center data for 92 faculty practice plans in 2013 – analysis by AAMC.

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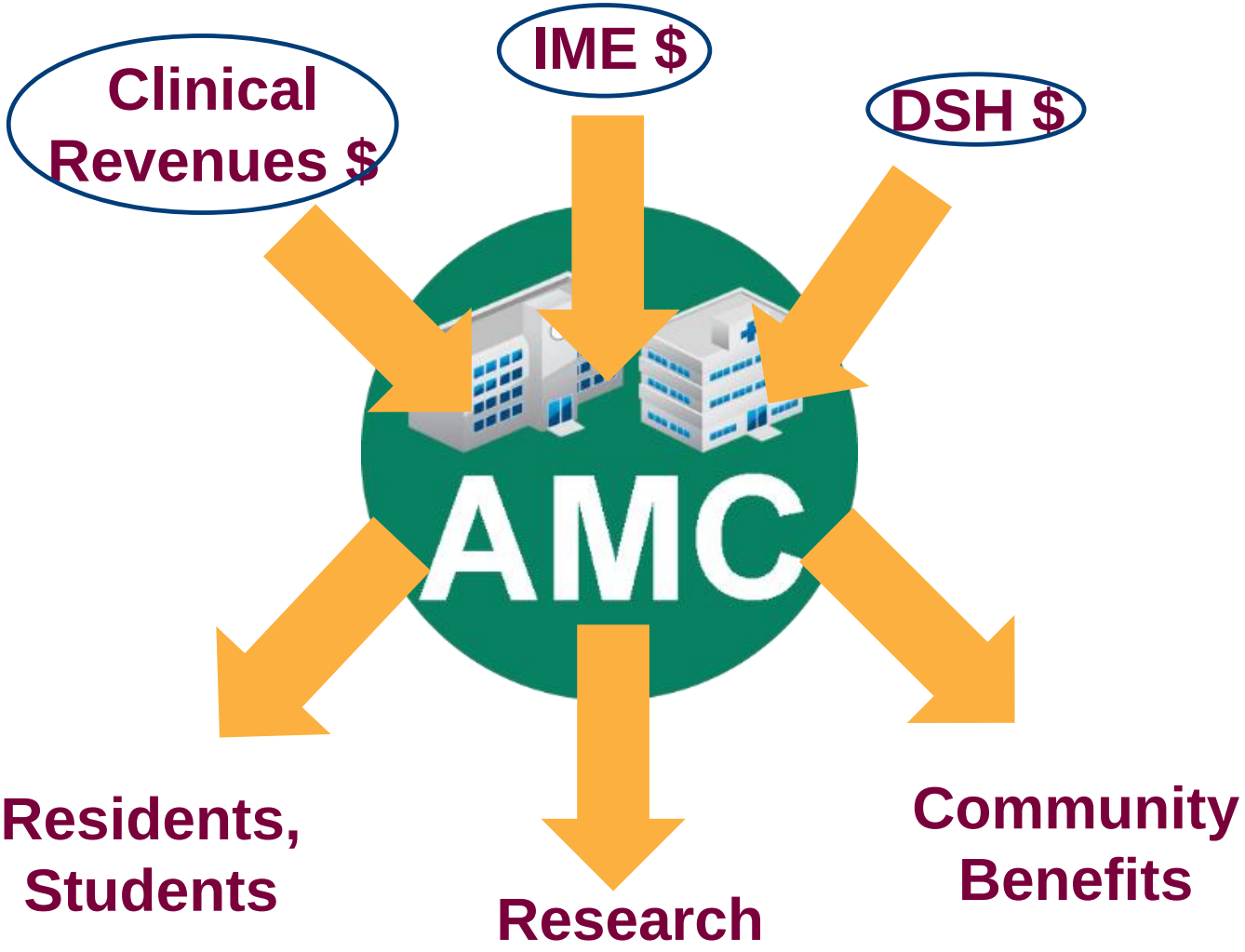
AMC Missions Rely on Multiple Revenue Streams; Revenue Cut ➡ Mission Cuts



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Context: All Funds Flow Constructs Are Different

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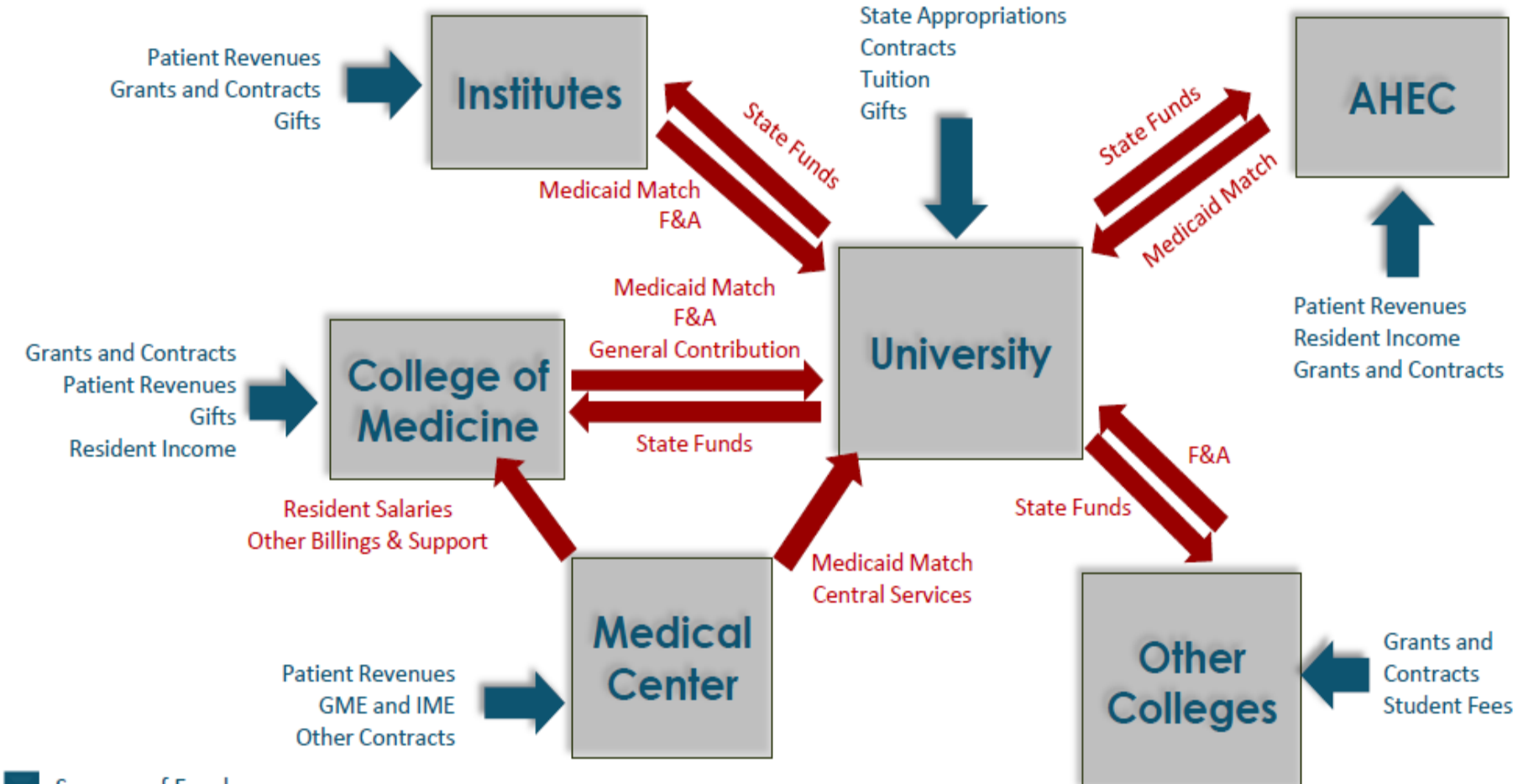
› The mission and vision of the entities, the level of fiduciary alignment, competitive and regulatory environment, and historical relationships all impact how funds flow models are structured



To State the Obvious:

Health Care Reform Is a Major Opportunity & Responsibility for AMCs.

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High Cost of US Care Compared to Others Motivates Health Care Reform

- "Health care costs = growing faster than other goods, services despite millions uninsured."
- "US healthcare costs growing faster than those of other countries."
- "Rising insurance premiums are a growing burden for employers and consumers."
  - And rising costs are a growing burden on government budgets as well as private economy.
- "Higher spending does not = better outcomes."

Source: J.E. Sackman, Numerof and Associates, The Essence of Accountable Care, January 24, 2013

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To State the Less Obvious:

Medicare Is Focus of ACA, Other Health Care Reforms.

Affordable Care Organizations (ACOs), Bundled Payments, more.

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ACA Drives Pop. Health Reform: ACOs

There = over 625 public/private ACOs nationwide.

CMS has 3 categories of ACO demos:

- Pioneer model = select group of 32 original participants; 23 today.
- Medicare Shared Savings (MSSP) model = > 400 programs participate.
- "Next Gen" = ACOs that bear up & down side of risk; former Pioneer, MSSP ACOs.

Goal: Link delivery, payment & outcomes on per capita basis:

- Reward better quality of care at lower cost for individuals plus improved population health.

Source: Molly Gamble et. al. 100 ACOs to know 2014, Becker's Hospital Review, August 13, 2014

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ACA Drives Episode Payment Models: Voluntary Bundled Payments - BPCI

Bundled Payments for Care Improvement (BPCI)

4 models promote care coordination:

- **Retrospective discounted payment** for inpatient stay only
- **Retrospective reconciliation of costs** to fee-for-service payments for inpatient + post discharge periods combined
- **Retrospective reconciliation of costs** to fee-for-service payments for post-inpatient discharge period only
- **Prospective payment** for acute care inpatient stay and readmissions for 30 days

Goal: Link delivery, payment & outcomes for a set of services for a specific condition or episode of care to reward better care at lower cost.

Source: Molly Gamble et. al. 100 ACOs to know 2014, Becker's Hospital Review, August 13, 2014

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ACA Drives Pay for Performance: Mandatory Bundled Payment - CCJR

Comprehensive Care for Joint Replacement (CCJR) is the first mandatory 5-year bundle:

- CMS proposed in July 2015.
- Retrospective model: Services continue to be paid FFS with retrospective reconciliation each year.
- To involve hospitals and providers in at least 75 MSAs.
- 90-day episode with all cause readmissions.
- Demo gives participants significant flexibility in care delivery, coordination to achieve goals.

Source: Jason Lee. Navigating the Uncertainty of the Comprehensive Joint Replacement Program. ECG Management Consultants. August 12, 2015.

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ACA Drives Pay for Performance: Hospital, Physician Payment Reforms

ACA authorized number of payment reforms for hospitals, physicians based on the premise:

- Poor quality + high earn reduced payment.

Hospital examples:

- Payments linked to VBP, HACs, readmission rates.

Physician examples:

- PQRS – Physician Quality Reporting System.
- MU – Meaningful use of technology.
- Value-modifier.

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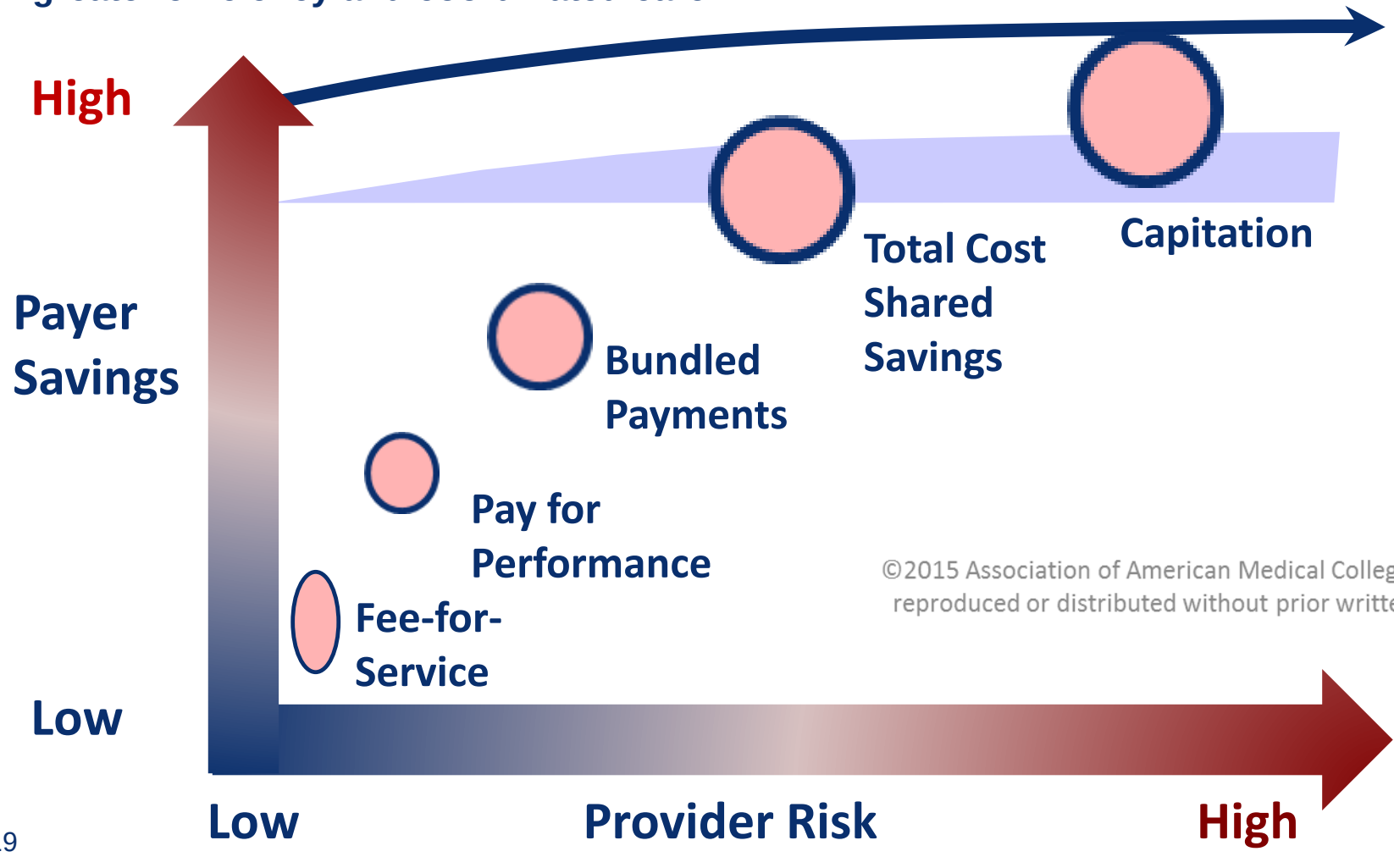
ACA Authorized Alternative Payment Models: How They Relate to Each Other

Each of the reform models is a different strategy in the progression from fee-for-service to global capitation. Ever greater risk should drive ever greater efficiency and coordinated care.



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What We've Learned Thus Far:

- ACA Reforms = Works in Progress.
- SGR Reforms to Come.
- Critical for AMCs, Physicians to Be Players, Leaders.

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What We've Learned Thus Far: ACOs

March 2015: 2-year evaluation of Pioneer ACOs.

- 32 ACOs in year 1; 23 still active start of year 3.

Mixed results: Achieved significant savings relative to market, but not all performed same.

- 10 had statistically significant savings both years.
- 10 had statistically significant savings for one year.
- 2 had significant losses in one year.
- 10 had no statistically significant savings or losses.

Savings = much stronger in year 1 than year 2.

- In year 2, 3 hospitals accounted for 70% of savings.

Source: L&M Policy Research LLC, Evaluation of CMMI Accountable Care Organization Initiatives, Wash., DC, March 10, 2015

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What We've Learned Thus Far: ACOs

March 2015 Pioneer ACO evaluation results cont'd.

Likely sources of savings = reductions in:

- Acute inpatient stays.
- Procedures, imaging, tests.

Patient satisfaction appears unrelated to savings.

Organizational features of different ACOs appear largely unrelated to savings.

Bottom line: Potential = real; conclusions not yet.

Source: L&M Policy Research LLC, Evaluation of CMMI Accountable Care Organization Initiatives, Wash., DC, March 10, 2015

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What We've Learned Thus Far: Bundled Payments

Bundled payment demos for nearly 30 years; most = narrowly focused - ESRD or OB care.

In 2010, AHA issued report that reviewed bundled payment experience to date and found:

- Potential to reduce costs, improve outcomes = real.
- Best opportunities for savings = 90-days post discharge.
- Provider readiness = varied.

In Medicare Bundled Payment program, up to 48 conditions may be paid as episode for up to 90-days.

- National summary results not yet published.

Ongoing research is helping to answer questions.

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What We've Learned Thus Far: Bundled Payments - Key Questions

- To which conditions should bundled payments be applied?
- What providers, services should be included?
- How can provider accountability be determined?
- What should be the timeframe of a bundled payment?
- What capabilities = needed for organizations to administer?
- How should payments be set?
- How should the bundled payment be risk-adjusted?
- What data are needed to support bundled payment?

Source: AHA. Bundled Payment: AHA Research and Synthesis Report. May 2010. AHA Committee on Research.

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What We've Learned Thus Far: Bundled Payments & AAMC Leadership

ACA authorized Bundled Payments for Care Improvement (BPCI) Initiative.

Nationally, program began 4th quarter of 2013.

- Hundreds of hospitals, physicians, post acute facilities volunteered.
- At risk for up to 48 medical, surgical conditions.

AAMC = facilitator/convener with 27 teaching hospitals.

- Bundling major joint replacement, CHF, COPD, stroke, etc.
- Half of hospitals are achieving quarterly savings; half are not.

National data not released yet.

Source: The Lewin Group, CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report. February 2015.

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What We've Learned Thus Far: Bundled Payments

CMS announced over 2,100 providers will be at risk as of July 2015:

- Additional episodes at risk in October 2015.
- Over 360 organizations & 1,700 individual providers will collaborate on multiple services per episode of care.
- Mostly in Models 2 and 3 with retrospective reconciliation and opportunity to benefit from savings.
- Eligible organizations = hospitals, skilled nursing facilities, group practices, home health agencies.

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Example of Other Medicare Reforms: HACs

Medicare payment penalties tied to hospital acquired conditions (HACs). New study found:

42% of "major teaching"* hospitals & 62% of "very major teaching"* hospitals were penalized – i.e., payment cut.

- Compared to only 22% of all hospitals
- 17% of all non-teaching hospitals.

Many of nation's most prestigious hospitals were penalized - often scored better on other public outcome measures.

Hospitals accredited by Joint Commission scored worse.

- They were more likely to be penalized than hospitals that are not accredited – 24% compared to 4%.

Source: Karl Y. Bilimoria, MD, MS et al Hospital Characteristics Associated With Penalties in the Centers for Medicare & Medicaid Services Hospital-Acquired Condition Reduction Program. *JAMA*. July 28, 2015.

***"Major teaching hospitals = hospitals with IRB ratio of 0.25 – 0.5; "very major teaching" = hospitals with IRB > 0.5.**

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SGR Fix Will Also Drive Drive Health Reform: New "MIPS" and "APMs"

In SGR fix, Congress replaced Medicare policy for updating Medicare physician payment with new program:

- "MIPS" – Merit-based Incentive Payment System
- "APMs" – Alternative Payment Models.
- Starts in 2019. By 2022, docs can earn incentives up to 9%.

Replaces 3 ACA established Medicare P4P programs:

- PQRS = physician quality reporting syst.
- MU = meaningful use of HER.
- VM = value-based modifier.

Physicians must participate in MIPS, unless they qualify for an APM or meet a low-volume threshold.

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SGR Fix Will Also Drive Health Reform: New "MIPS" and "APMs"

CMS to develop rules for MIPs, APMs over next year:

- Seeking public input now on what rules governing program should be.
- Expectation is final policy will be out next summer.
- Not possible to say what docs will qualify for APMs instead of MIPS.

It is likely that physician payments will not be predictable for many reasons, such as:

- RVU changes.
- Penalties and bonuses.

When MIPS is implemented, important to assess whether providers who see sicker, poorer patients = at greater risk.

- Reimbursement at risk up to 9% in 2019.

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SGR Fix Implementation Issues

What will MIPS framework look like?

- Performance period for MIPS will be before 2019 (possibly 2017?)
- Will there be a group option?
- How much variability will there be in benchmarks/incentives, etc.?
- How will the EHR Incentive program be integrated into MIPS?

New APM models:

- What does it mean to qualify as participating in an ACO or being a medical home?
- Will academic medical centers be able to meet physician thresholds?

New claims coding requirements:

- Will it improve attribution for claims-based measures?
- Will it be feasible to operationalize?

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A Top AAMC Concern: The Role of Risk Adjustment

AAMC's view:

- Financing and delivery reforms are important.
- AMCs = leaders in many of the CMS funded demos.
- AMCs = bear the same payment cuts & reforms that other hospitals bear, plus more.

CMS refusal to risk adjust, NQF failure to endorse risk adjustment = ongoing concern.

- Puts physicians, hospitals caring for poorest, sickest at risk of failure – e.g., HAC analysis by Northwestern faculty.
- Creates perverse incentives to avoid high-risk patients.

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What Does This Mean for:

- AAMC and AMCs?
- Physicians & Faculty Practice Plans?
- Dermatologists?

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What Does All of This Mean?
For AAMC and AMCs

How will ACOs, bundled payments address hospital payment adjustments:

- GME, outlier, DSH adjustments

Options for responding:

- Resist, follow, or take leadership responsibility.

AAMC and AMCs across the country are participating in reforms, learning, and leading.

- Understanding what doesn't work.
- Advocating for what does work.

Reform is here to stay. Important to learn and lead.

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What Does All of This Mean?
For Physicians and Physician Practices:

Imperative to engage with hospitals, post-acute providers to participate in demos, identify barriers, and figure out how to surmount them.

- Learn about reform initiatives, decide how to participate; decide whether to weigh in on development of MIPS/APMs.
- Identify participating partners. Be alert to opportunities to join current participants, prospective participants.
- Archived resources at: http://innovation.cms.gov/initiatives/Bundled-Payments/learningarea.html
- Also, archived resources at: http://invovation.cms.gov/Fiels/clides/NPVI-Overview2-4.pedf

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What Does All of This Mean? For Dermatologists

Multiple forces are at play:

- More patients than ever due to population growth & aging, rising incidence of skin cancers, more health conscious population, more insured. 42% of patients = 60+.
- Growing workforce shortages coupled with fewer solo practices, more group practices; more non-physicians; more team care.
- Dermatology has strong incentive to want to show value – only 4% of Medicare spending, 2% of faculty practice plan business, 1% of medicine. Dermatology practice mg't. industry fragmented; changing regs. stimulate move to practice consolidation.
- **Bottom Line: Medicare, dermatology's interests = aligned in wanting to s**how best quality for lowest price while improving population health.

Source: "Dermatology Market Overview. HarrisWilliams&Co. August 2013.

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What Does All of This Mean?
For Dermatologists

- Under terms of SGR fix, HHS will work with professional societies to set measures for use in:
  - MIPS
  - APMs
- CMS = Will release new measures next summer. Important to work with your professional groups.
  - Participate and set terms.
- Law also provides tech. aid for small practices (<16 members) to comply with MIPS, APMs.

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Recalibrating the Clinical Enterprise

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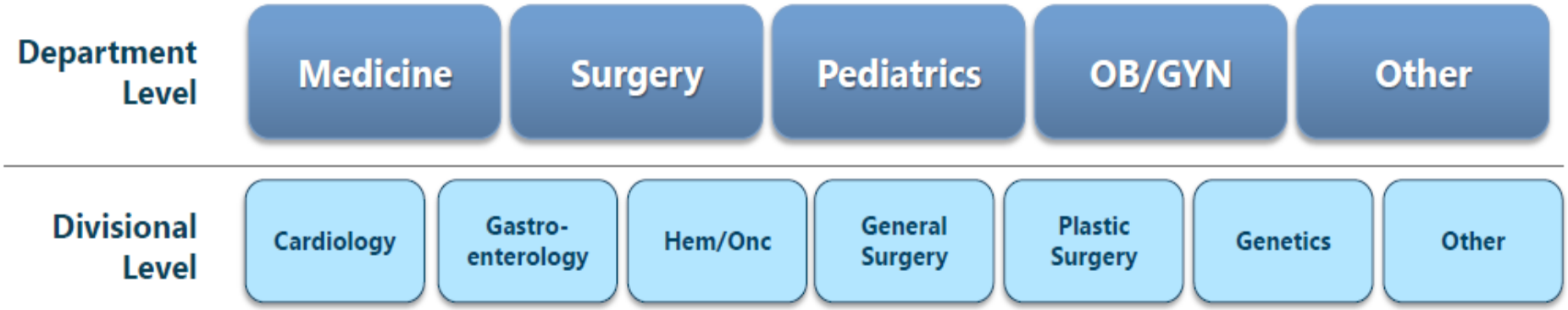
- Most AHCs are still organized under a traditional departmental structure. The departmental structure was put in place decades ago to support the education mission – it has less relevance when the driver of the structure is patient care



Benefits	→	**Physician grouping around relatively similar skill sets; aligned with requirements for graduate medical education**
Examples	→	Most common structure: OU, Yale, etc.

Linking Performance to Reward

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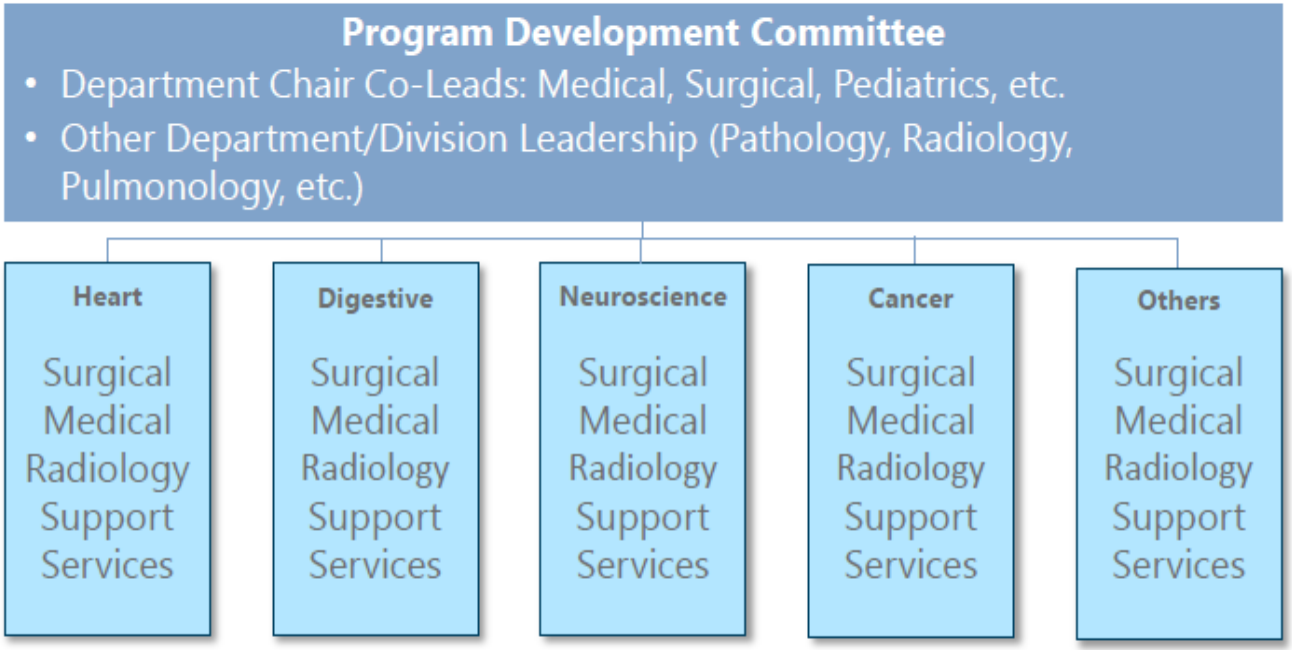
› Illustrative misalignment driven by existing compensation models
  – Many key stakeholders are measured based on their ability to manage within a budget, not their support of overall institutional goals

Entity	Role / Responsibility	Incentive-Driven Behavior	Misalignment?
College Dean	• Meet budget • Enhance school reputation • Support academic pursuits	• Fund departments • Grow reserves	• Underperforming departments often get the bulk of support, not those with highest upside
COM Chairs	• Meet budget • Support academic pursuits • Grow clinical programs • Attract excellent faculty • Train future leaders	• Grow departmental revenues/collections • Encourage faculty efforts in high RVU pursuits • Grow reserves	• Low RVU efforts (e.g., clinics) not emphasized • Limited incentives for service or quality • Multidisciplinary initiatives hard to coordinate
Faculty	• Generate wRVUs • Generate grant dollars • Meet teaching objectives	• Maximize activity that leads to high collections • Hoard block time to maximize revenue opportunity	• Spend less time on non- or low- RVU generating activities (clinic time, teaching, research) • Limited incentive to collaborate

Recalibrating the Clinical Enterprise



Multi-D Care Centers

- Dyad/Triad of co-clinical leaders
- Administrative Director
- Business intelligence support services to grow program (e.g., analytics, marketing)
- Leaders have responsibility to run and grow programs, assist with recruitment and no longer require Department-level approval for all decisions.

Benefits	→	**Supports a multi-disciplinary clinical approach; gives program leadership authority and accountability to make decisions**
Examples	→	**Many AMCs have developed "Centers of Excellence" in this structure**

In Conclusion:

- **Health Care = Major US Economic Engine; Cost/Value = Major Concern.**
- **ACA, SGR Fix, Medicare Drive Reform – Changes in Payment Policy, Demos of Delivery and Financing Reforms**
- **AAMC, AMCs = Learning, Leading - Reform Is Here to Stay.**

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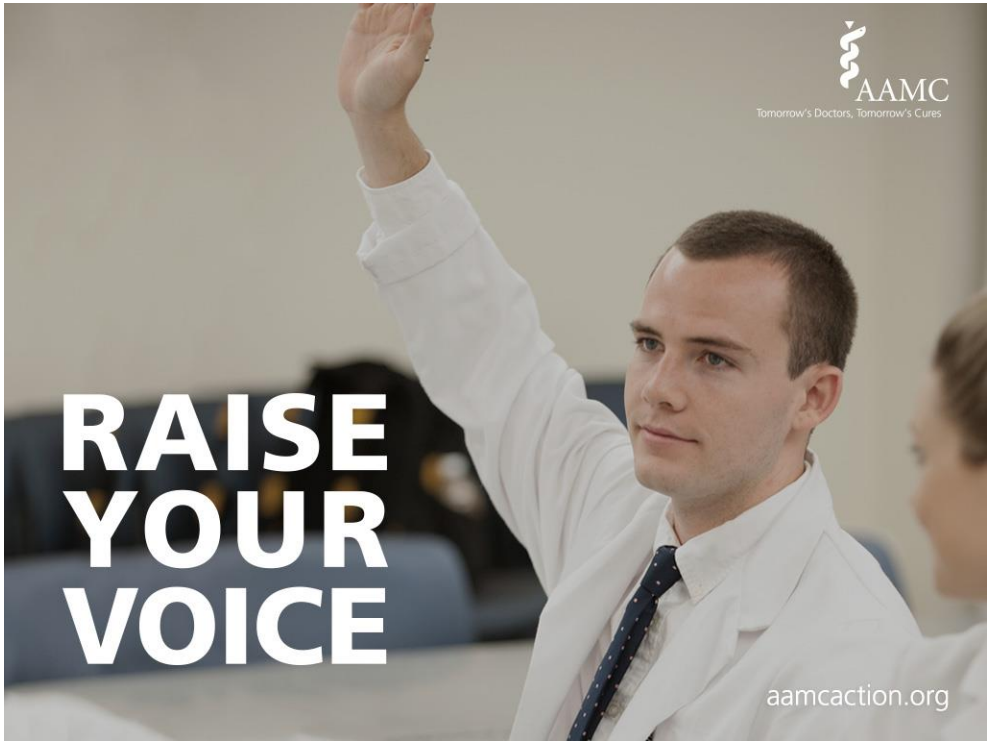
What You Can Do: Join AAMC Action
Power AAMC's Grassroots Advocacy



- Nearly 156,000 people are part of AAMC Action – over 10,000 new members in '15
- Over 29,000 responded to calls to action – 16+% of the community.
- Join the community at **www.aamcaction.org**
- Encourage friends, family, colleagues to do the same

www.aamcaction.org

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