



**ASTS Webinar - March 22, 2017**

**Medicare Access and CHIP  
Reauthorization Act  
(MACRA)**

**&**

**Transplant:**

**How We Got Here, What You Need To  
Know For 2017, And What Lies Ahead**

# Agenda

- What is MACRA and what should you do about it?  
MIPS and APMs - The why, what and how  
David J. Reich, MD, FACS
- What is the potential impact of MACRA?  
What does it mean – Implications for transplant  
Alan I. Reed, MD, MBA
- Q&A, Panel Discussion  
Jill Sage, MPH  
Alan I. Reed, MD, MBA  
David J. Reich, MD, FACS

# Faculty

- Jill Sage, MPH  
Quality Affairs Manager,  
American College of Surgeons Division of Advocacy and Health Policy  
Washington, DC
- Alan Reed, MD, MBA, FACS  
ASTS Task Force on MACRA, Value Based Practice and Pay Reform  
Professor and Chief, Transplant and HPB Surgery  
Director, UI Organ Transplant Center  
Adjunct Professor of Accounting, Henry B. Tippie College of Business  
University of Iowa Hospitals and Clinics  
Iowa City, IA
- David J. Reich, MD, FACS  
Chair, ASTS Task Force on MACRA, Value Based Practice and Pay Reform  
Professor and Chief,  
Division of Multiorgan Transplantation and Hepatobiliary Surgery  
Vice Chair, Department of Surgery  
Drexel University College of Medicine, Hahnemann University Hospital  
Philadelphia, PA

# Disclosures

No relevant financial relationships  
or other conflicts of interest:

David J. Reich, MD, FACS

Alan I. Reed, MD, MBA

Jill Sage, MPH

# Part 1

## What Is MACRA And What Should You Do About It?

David J. Reich, MD, FACS

Chair, ASTS Task Force on MACRA, Value Based Practice and Pay Reform

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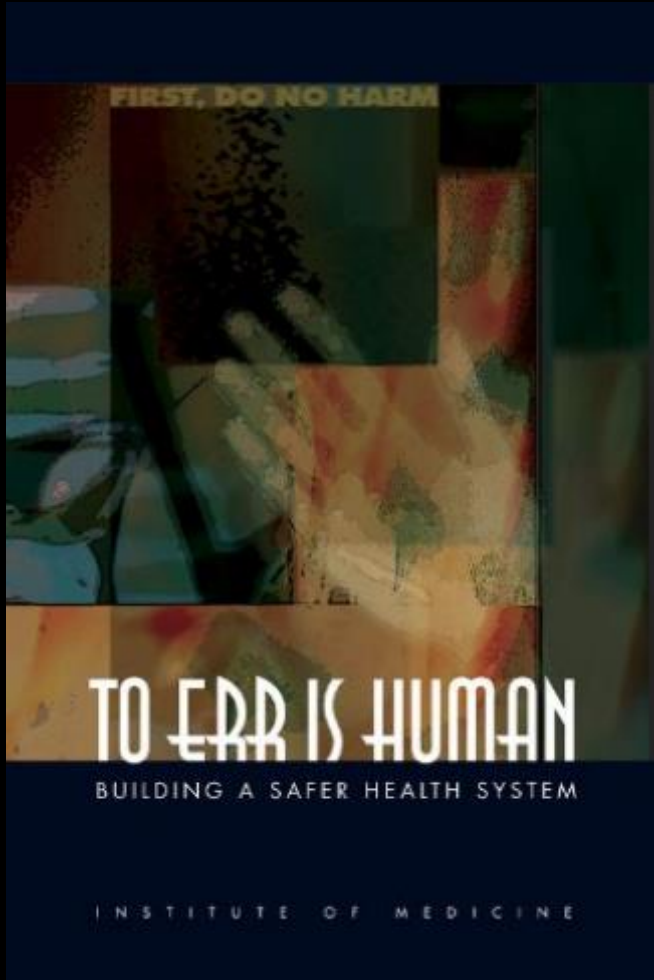


# Part 1: Goals

- Why was reform needed?
  - What does MACRA intend to do?
- What is MACRA
  - MIPS and APMs - The why, what and how  
(broad strokes and some specifics)
- What should you do regarding MACRA?
  - What is ASTS doing?

# Why?

## 1) Healthcare Quality Gaps



- 1999 IOM report
- 98,000 avoidable hospital deaths/yr
- Most errors are system-based
- Costs \$17-\$29 billion
- Subsequent IOM reports:
  - Gov't mandate
  - EMR, Performance measurement, P4V

# Why?

## 2) Healthcare Expense










- USA is deficit spending
  - Entitlement reform
- Healthcare spending (2015):
  - 18% of GDP
  - \$3.2 trillion
  - Medicare = 15% Federal budget



# Why?

## 3) Other Nations Spend Less & Rank Higher

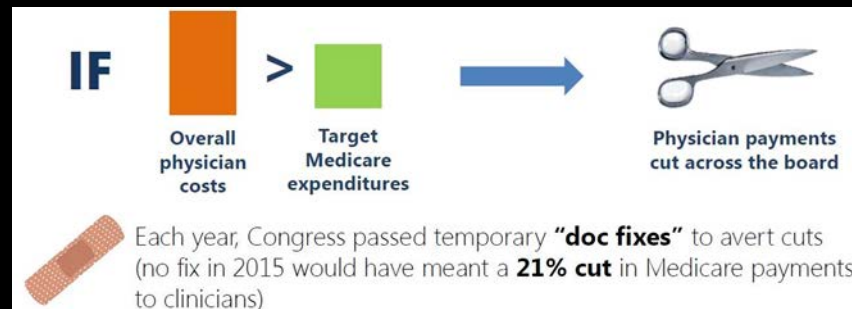
# Bloomberg Business

Rank 2014	Country	↓	Efficiency score	Life expectancy	Health-care cost as percentage of GDP	Health-care cost per capita
1	<b>Singapore</b> 		78.6	82.1	4.5%	\$2,426
2	<b>Hong Kong SAR</b>		77.5	83.5	5.3	1,944
3	<b>Italy</b> 		76.3	82.9	9.0	3,032
4	<b>Japan</b> 		68.1	83.1	10.2	4,752
5	<b>South Korea</b> 		67.4	81.4	7.0	1,703
6	<b>Australia</b> 		65.9	82.1	9.1	6,140
7	<b>Israel</b> 		65.4	81.7	7.0	2,289
42	<b>Belarus</b> 		37.3	72.1	5.0	339
43	<b>Dominican Rep...</b> 		35.0	73.2	5.4	310
44	<b>United States</b> 		34.3	78.7	17.2	8,895
45	<b>Bulgaria</b> 		33.7	74.3	7.3	516

# Why?

## 4) SGR Formula = Broken

- SGR established through Balanced Budget Act of 1997
- Statutory formula to determine Medicare updates for MD pay
- Intended to assure annual increase in spending < GDP growth
  - Compared actual spending to target spending
  - Proposed a conversion factor for the following year
- Spending outpaced SGR targets each year since 2002
  - Aging population, technology
- Impending mandated pay cuts led to 17 Congressional patches
- Problematic: threatened patient access, destabilizing for MDs



# MACRA

M: Medicare

A: Access (and)

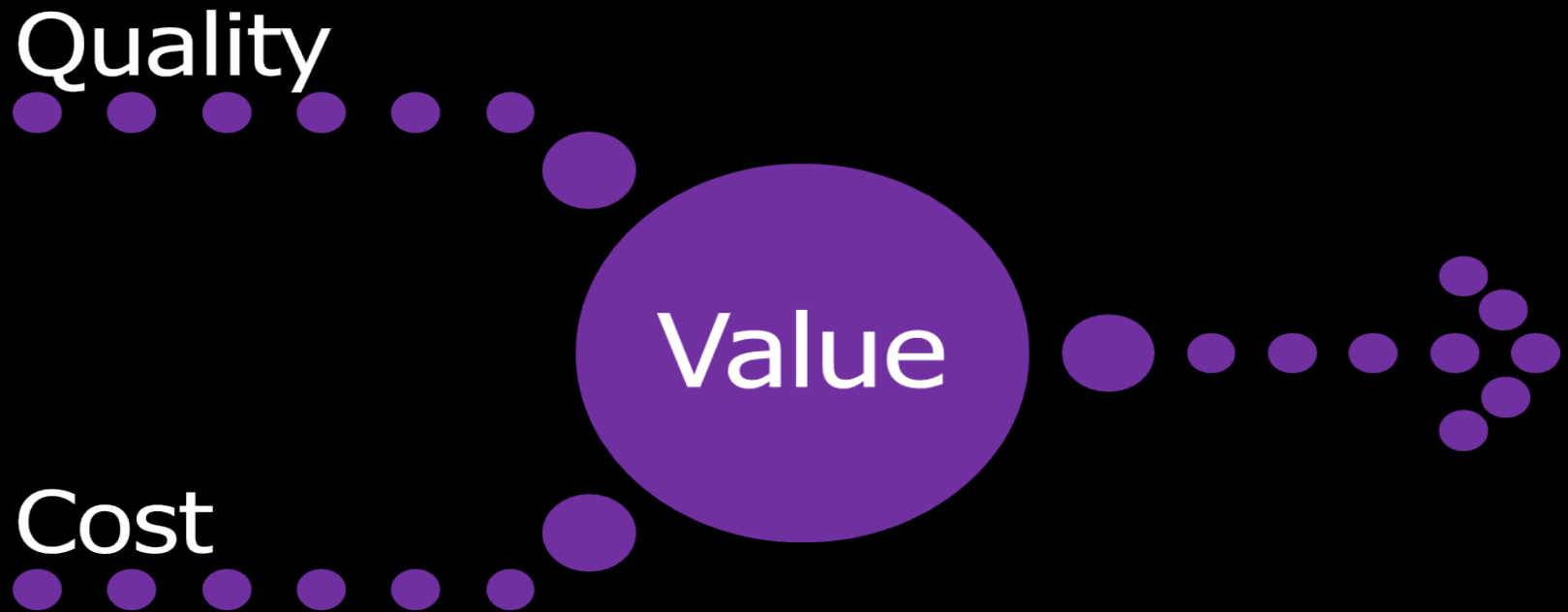
C: CHIP (Children's Health Insurance Plan)

R: Reauthorization

A: Act

- Passed by Congress in 2015; signed into law 4/16/2015
- Replaces the Sustainable Growth Rate (SGR) calculation for CMS physician payment updates
- Post-SGR Reform

# MACRA: Holds MDs Accountable for Value



- Volume moves to value
- Measure quality & price (moves from claims to EMR / registries)
- Publish on quality and price
- Pay for value (decline of fee-for-service)

# National Quality Aims

```
graph TD; A[National Quality Aims] --> B[Better Care]; A --> C[Reduced Cost]; A --> D[Healthier Population];
```

## Better Care

- Safer
- Patient Centered

## Reduced Cost

- Patients
- Employers
- Government

## Healthier Population

- Behaviors
- Environment

- Crafters: Kathleen Sebelius, Carolyn Clancy, Donald Berwick
- Bipartisan support
- Promoted by: HC orgs like Kaiser, employer groups like Leapfrog, research foundations like RAND, QI groups...

# FFS Era is Ending!



- Volume driven
- Fragmented care
- Risk on payor

- Episode based
- Manage condition
- Prevention
- Manage population

- Value driven
- Coordinated/integrated care
- Shared risk

# Private Payers also Push P4V

**Bloomberg**

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## UnitedHealth Overhauls Doctor Payments By Tying them to Quality of Care

By Sarah Frier and Drew Armstrong - Feb 9, 2012 4:06 PM ET

 **ADD TO QUEUE**

[UnitedHealth Group Inc. \(UNH\)](#), the largest U.S. health insurer by sales, will pay doctors based on the quality of their care in a cost-cutting effort that also benefits the company's consulting business.

UnitedHealth expects to save twice as much as it would spend on incentive payments for doctors because patients will be healthier, according to company documents forwarded by spokeswoman Cheryl Randolph. The program may cover as much as 70 percent of the insurer's commercial members by 2015, from less than 2 percent now,

the company said.

The nationwide expansion of the program follows similar efforts by the U.S. government and rival insurers to trim medical costs by shifting away from paying based on the amount of services provided. Optum, UnitedHealth's services business, will be able to sell software, data and consulting to providers making the changes, Sam Ho, chief clinical officer of the insurer's UnitedHealthcare unit, said in an interview.

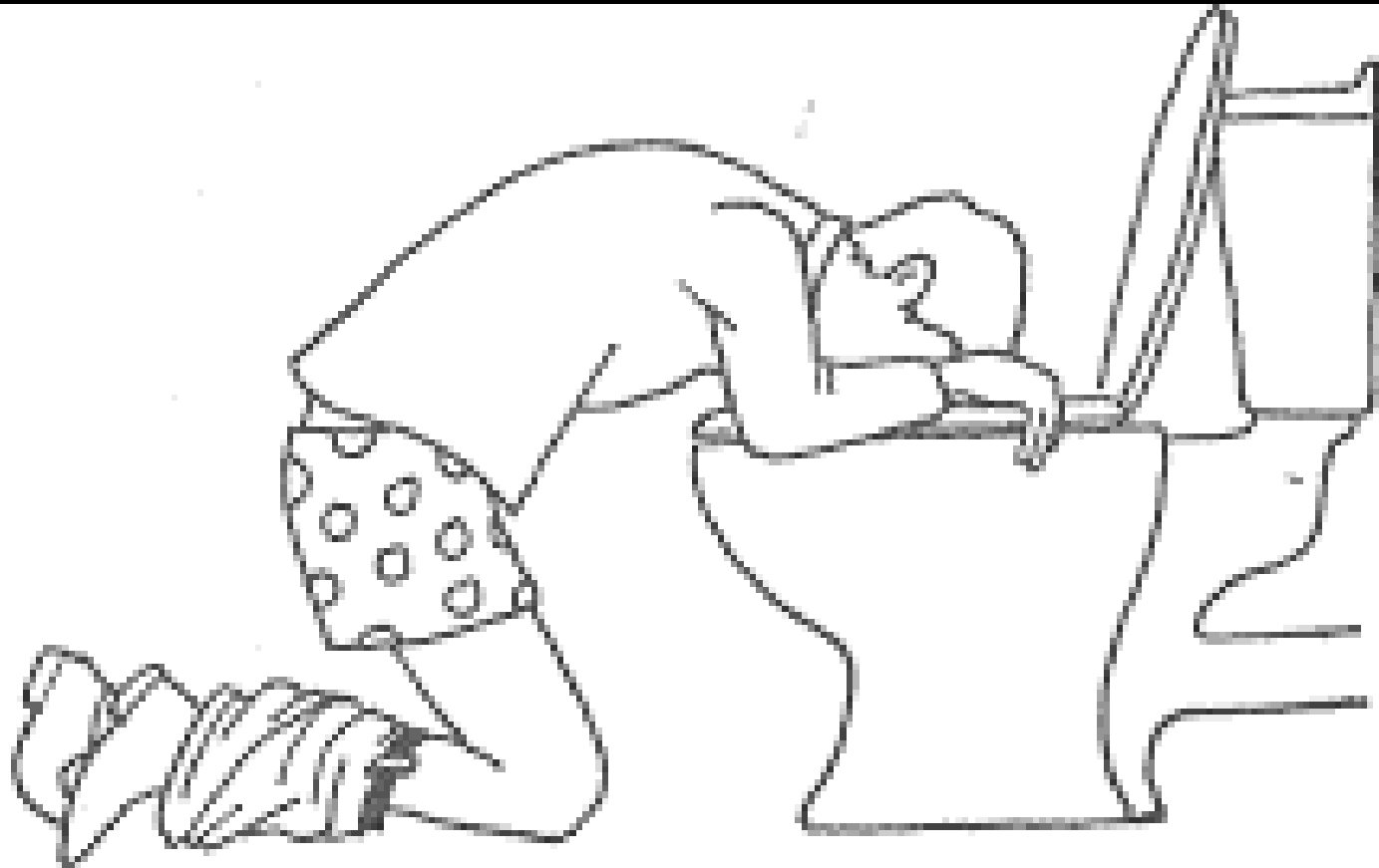


# INTRODUCING THE QUALITY PAYMENT PROGRAM

- In October 2016, DHHS/CMS issued Final Rule to implement key provisions of MACRA

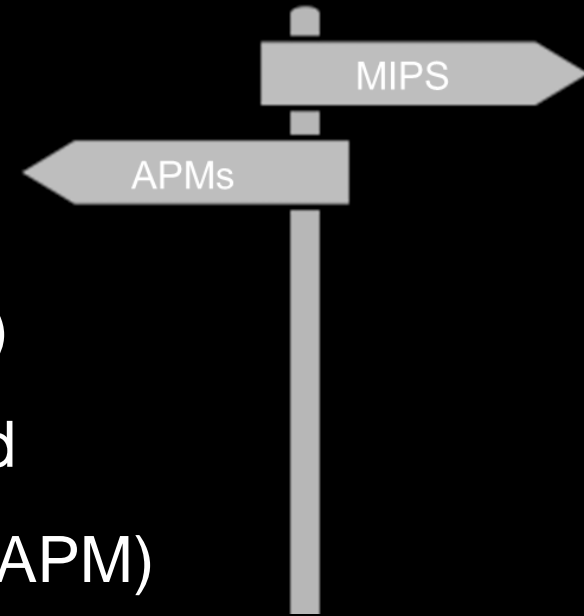


**Brace Yourselves!**



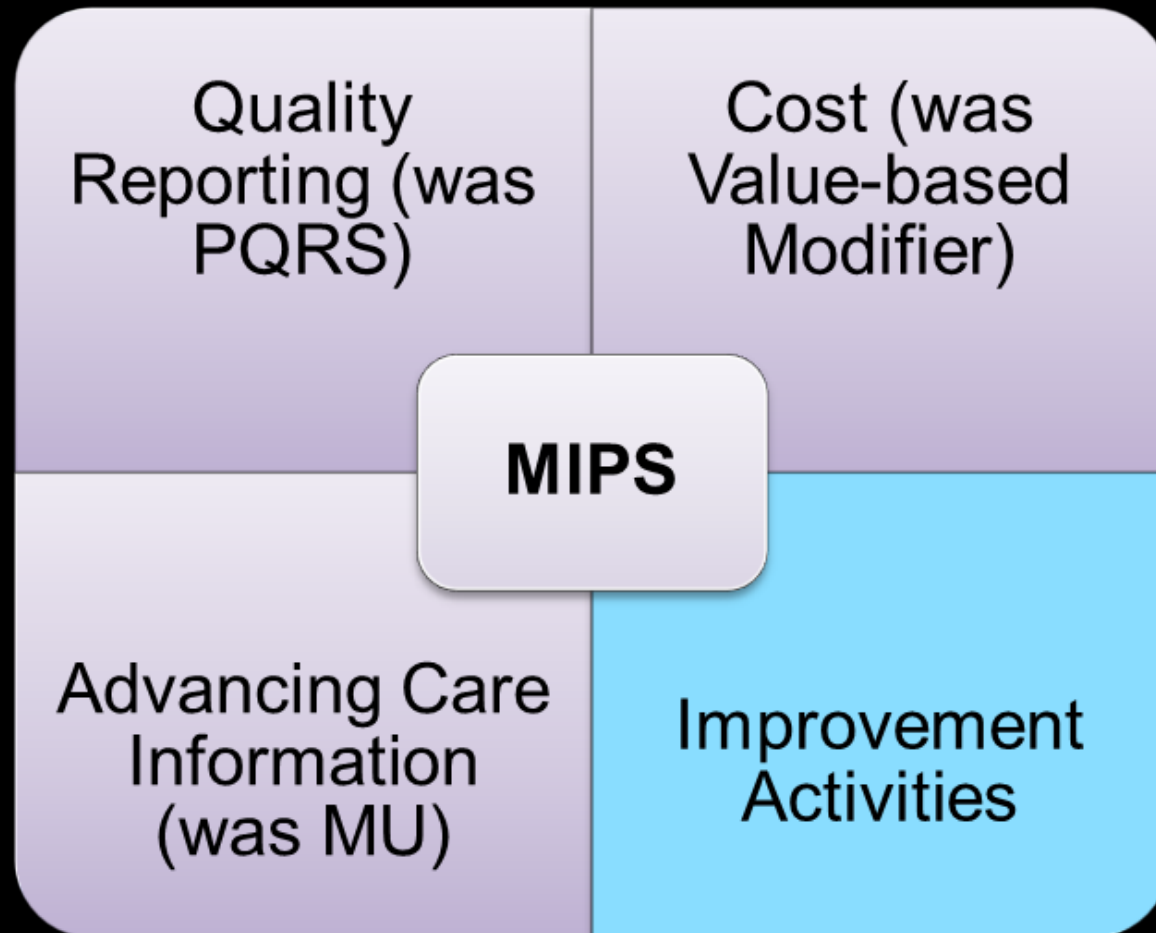
# What's in MACRA?

- Full and permanent repeal of SGR
- Annual positive updates
  - 0.5% per year for 5 years (2015-2019)
- Penalties for existing programs eliminated
- Differential payment methodology (MIPS/APM)
  - Most clinicians will do MIPS (individual or group TIN)
- Performance measurement starts 2017 – pay adjusted 2019
- 0% update 2020-2025, 0.25% / 0.75% updates starting 2026
- Prohibits CMS from implementing 0 day-global payments
- Two years additional funding for CHIP



# MIPS: Merit-Based Incentive Payment System

Consolidates FFS & 4 pay-for-performance programs



# How Does MIPS Work?

- Single Composite Performance Score (CPS: 0-100)
  - Quality (60% in 2017; eventually 30%)
  - Advancing care information (EHR) (25%)
  - Clinical Practice Improvement Activities (15%)
  - Resource Use (0%); eventually 30%)
- Score compared to threshold based on prior period
  - ABOVE threshold: Positive Adjustment
  - BELOW threshold: Negative Adjustment
  - Bonus/Penalty on a % basis; not all-or-none
- Max bonus/penalty varies by year:

2019 +/- 4%	2020 +/- 5%
2021 +/- 7%	2022 +/- 9%
2023 +/- 9%	2024 +/- 9%

# MIPS: Quality

- Selection of 6 measures (reporting threshold 50% in 2017)
- GPRO: surgeons can fly under radar in 2017
- Individual reporting: paucity of transplant relevant measures
  - % patients >65 who have an advance care plan / surrogate
  - documented current medications on date of encounter
  - BMI during previous 6 mo (and follow-up plan if BMI high)
  - Surgical patients with cephalosporin prophylaxis  
(no longer PQRS: abx within hr and abx dc within 24 hr)
  - Surgical patients with VTE prophylaxis
  - Others?
- Some measures are topped out (abx, VTE): less than 100% compliance = no points! Why bother???
- Need to develop transplant relevant measures...

# MIPS: Advancing Care Information

## THE BASE SCORE

CMS proposes six objectives and their measures that would require reporting:



**Protect Patient Health  
Information**  
(yes required)



**Electronic  
Prescribing**  
(numerator/denominator)



**Patient Electronic  
Access**  
(numerator/denominator)



**Coordination of Care Through  
Patient Engagement**  
(numerator/denominator)



**Health Information  
Exchange**  
(numerator/denominator)

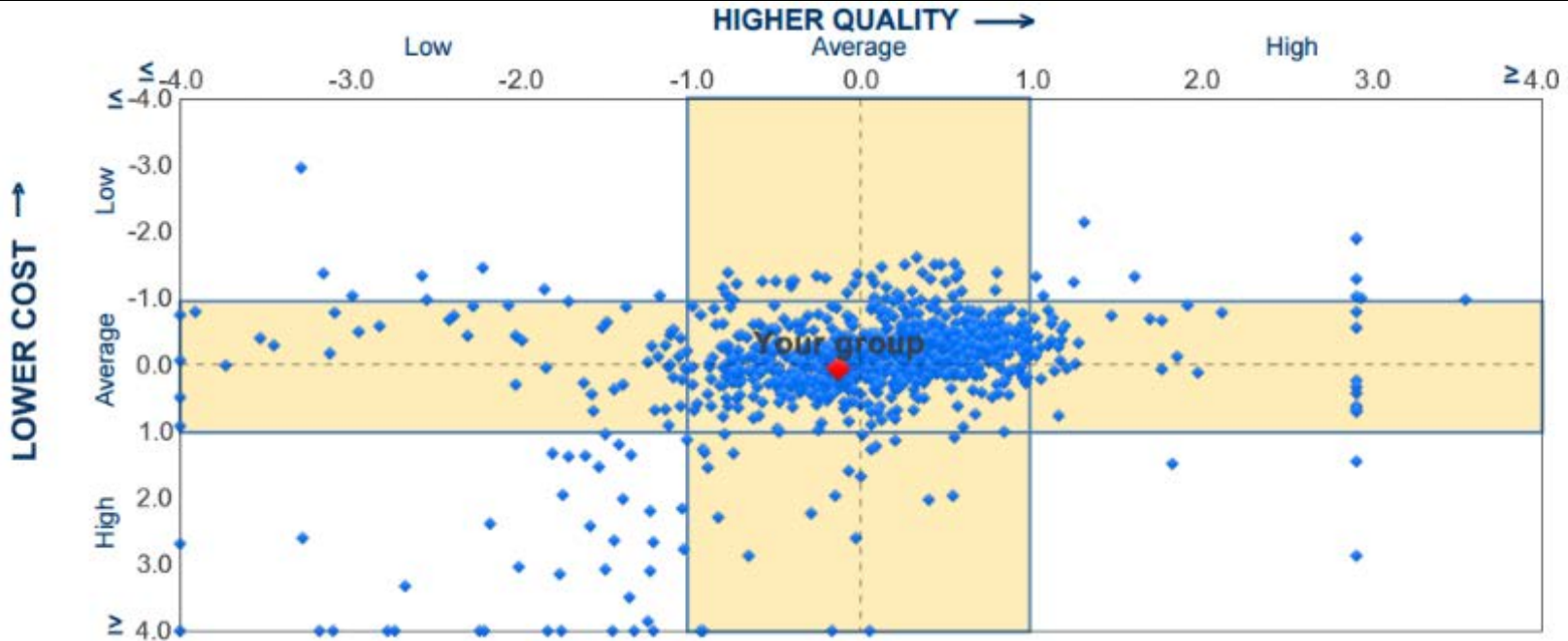


**Public Health and Clinical Data  
Registry Reporting**  
(yes required)

Your organization should report this for you automatically – check...

# MIPS: Resource Use

- Doesn't count in 2017
- Based on claims – no reporting; but check reports
- 3 elements: \$ per beneficiary, total \$, \$ for episodes/conditions
- Supposed risk adjustment
- Exemption for APM participation (CPIA & EMR will count more)



# MIPS: Clinical Practice Improvement Activities

- Increased access, Population health management, Care coordination, Beneficiary engagement
- Examples: evening hours, QCDR, results communication, self-management, PRO, safety checklists, QI...
- Minimum one activity
- APM participation counts!
- Attestation in March 2018
- ABO verification Checklist
- Evaluation consent Engagement
- QAPI  
QI
- Waitlist  
Population management?
- Others...



## Pick Your Pace: 2017 transitional performance reporting options

### MIPS Testing

- Report some data at any point in CY 2017 to demonstrate capability
  - 1 quality measure, or 1 improvement activity, or 4/ 5 required ACI measures
- No minimum reporting period
- No negative adjustment in 2019

### Partial MIPS reporting

- Submit partial MIPS data for at least 90 consecutive days
  - 1+ quality measure, or 1+ improvement activities, or 4/ 5 required ACI measures
- No negative adjustment in 2019
- Potential for some positive adjustment ( < 4%) in 2019

### Full MIPS reporting

- Meet all reporting requirements for at least 90 consecutive days
- No negative adjustment in 2019
- Maximum opportunity for positive 2019 adjustment (  $\leq$  4%)
- Exceptional performers eligible for additional positive adjustment (up to 10%)

### Advanced APM participation

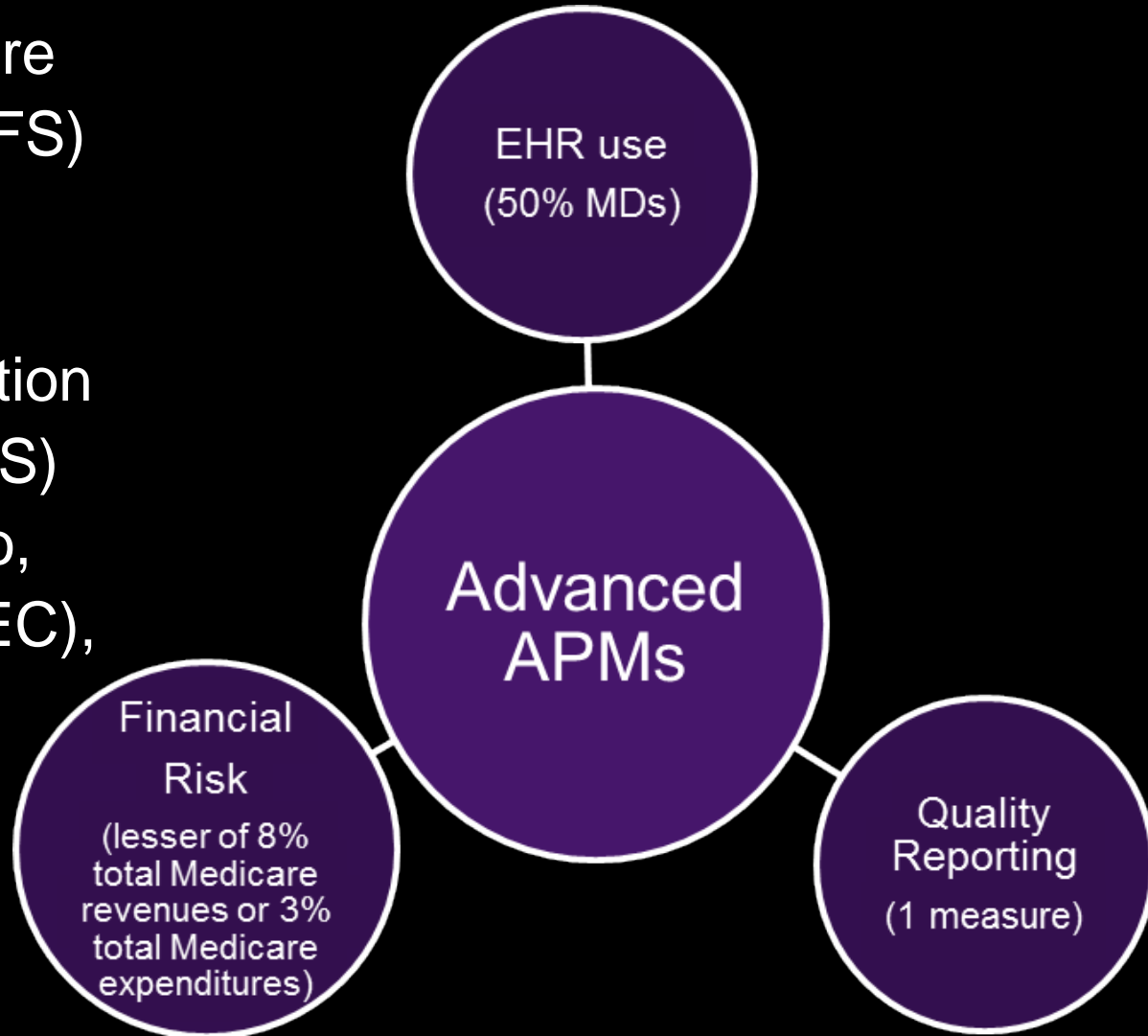
- No MIPS reporting requirements (APMs have their own reporting requirements)
- Eligible for 5% advanced APM participation incentive in 2019

The only physicians who will experience negative payment adjustments (-4%) in 2019 are those who report no data in 2017

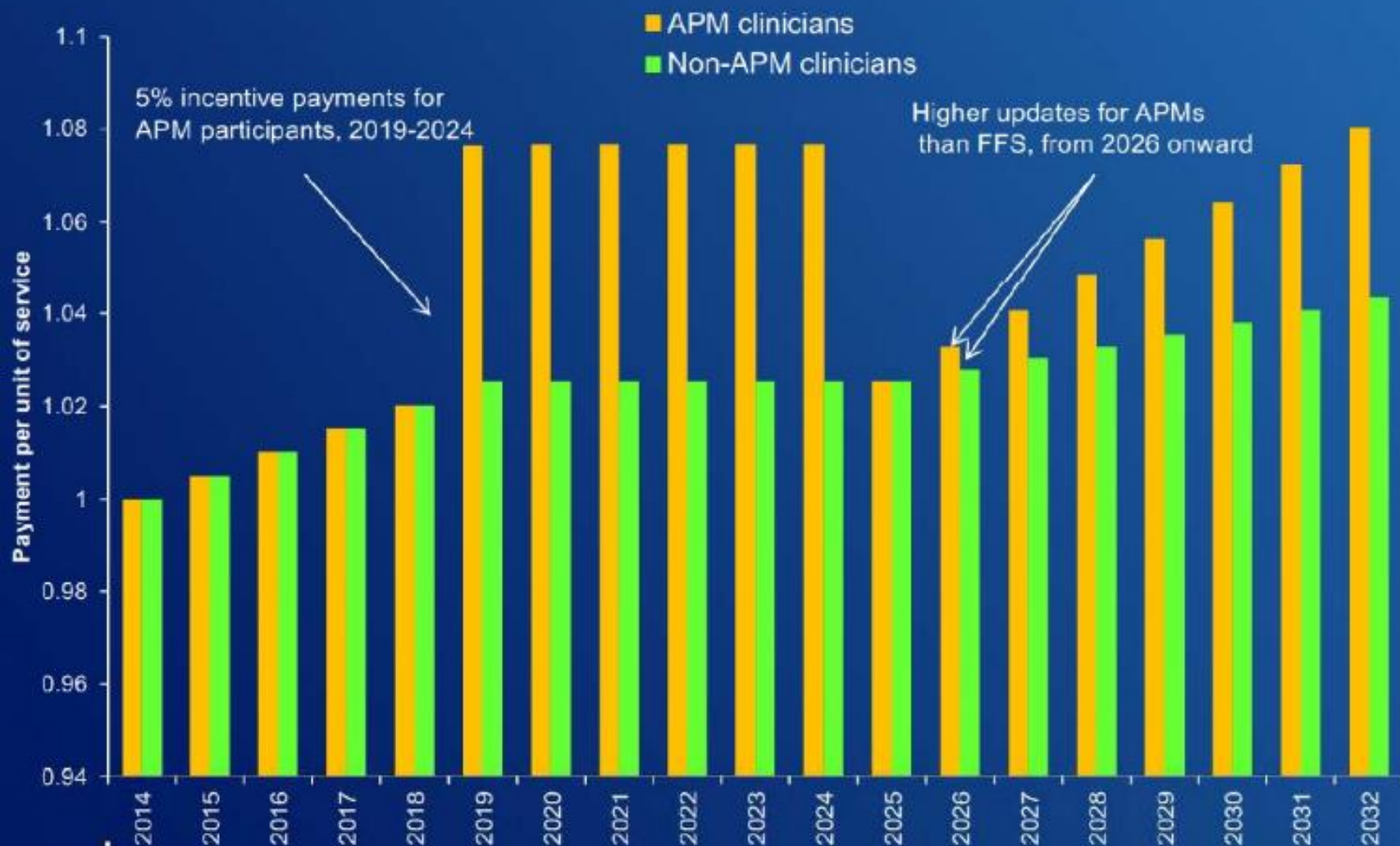


# APMs: Alternative Payment Models

- Bundled payments
  - For episode of care (KTX; modified FFS)
  - For condition (ESRD; not FFS)
  - For larger population (like ACO; not FFS)
- Must qualify as demo, CMMI model (like CEC), or some ACOs
- Must be ADVANCED APM to be fully excluded from MIPS

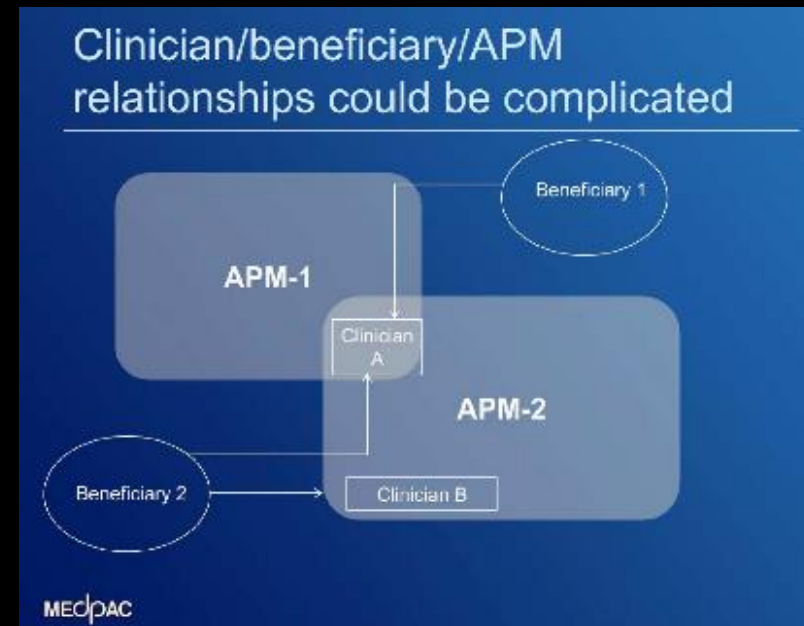


# Two payment update paths



# APMs: Issues

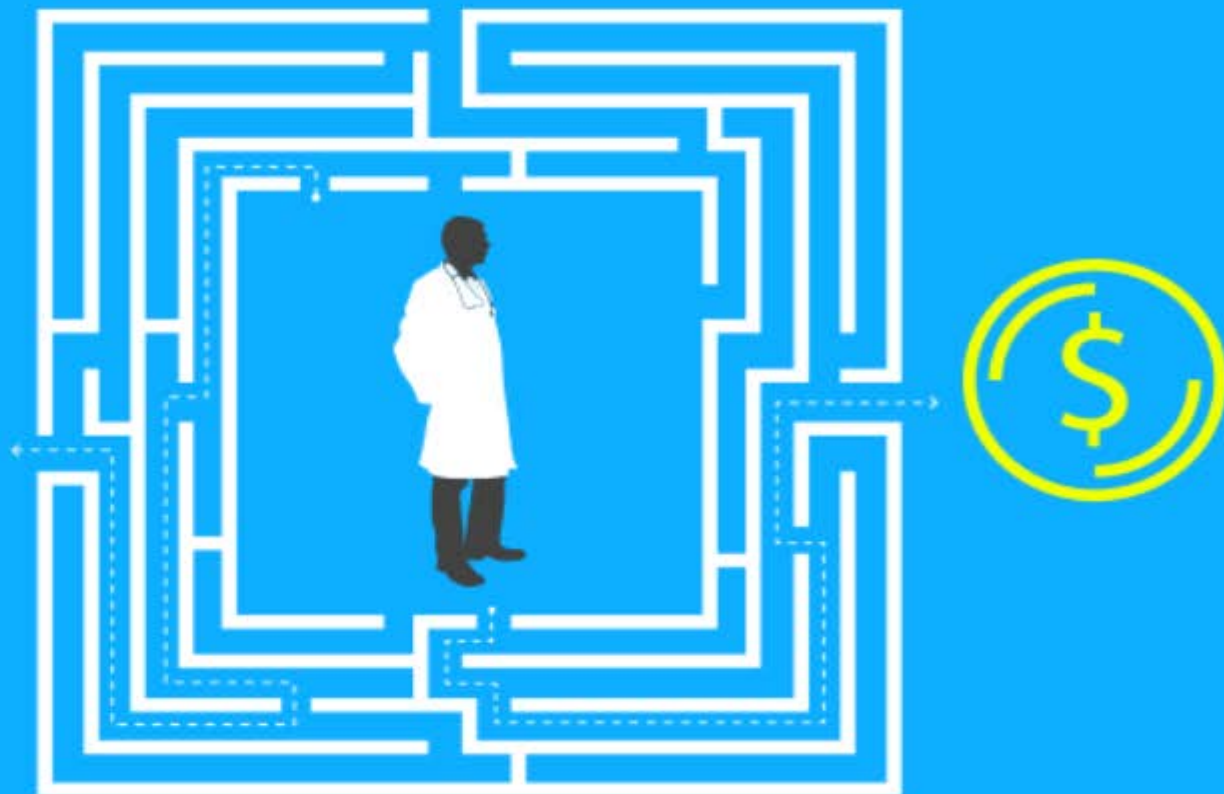
- Will more APMs become eligible
  - Physician-Focused Payment Technical Advisory Committee
  - Private insurers? Medicaid?
- Financial risk
- MD participation threshold:
  - 2019 payment threshold @ 25% (increases to 75%) or
  - 2019 patient threshold @ 20% (increases to 50%)
- How will clinicians & beneficiaries be attributed to APMs? →
- Surgeons vs others (carve outs)
- Threat to OACC?
- CEC (ESRD) as barrier to referrals



GET READY FOR  
**MACRA**  

---

**2017**



# Public Reporting - Physician Compare

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# Medicare.gov

The Official U.S. Government Site for Medicare



## Physician Compare

About Physician Compare

### About the Data

» About the Data

Physician Quality Reporting  
System (PQRS)

Electronic Prescribing (eRx)  
Incentive Program

EHR Incentive Program

Resources

Help

## About the Data

Physician Compare gives you information to help you make informed healthcare decisions.

On Physician Compare, you can find out which Physicians, Other Healthcare Professionals, and Group Practices take part in Centers for Medicare and Medicaid Services (CMS) quality programs.

At this time, you can find an indicator on the Profile Page showing participation in:

- ◆ [Physician Quality Reporting System \(PQRS\), including the Group Practice Reporting Option \(GPRO\);](#)
- ◆ [Electronic Prescribing \(eRx\) Incentive Program;](#) and
- ◆ [Electronic Health Record \(EHR\) Incentive Program.](#)

In the future, CMS will add information on participation in other quality programs to Physician Compare.

Beginning in 2014, Physician Compare will also include quality of care ratings for Group Practices. Ratings for individuals will be added in the future.



# What Should You Do About MACRA?

- MACRA likely here to stay; impact pay and reputation
- This year you'll be part of MIPS
  - Avoid penalty (up to 4%) by reporting one item one time
  - Try for a bonus?
- Following years focus on measures, CPIA, EMR, cost
  - Learn who is the MACRA czar for your practice/institution and how MACRA is being tackled (GPRO or individual reporting?)
  - Virtual groups could help
- Ultimately APMs will dominate
  - MIPS APM may be good to get feet wet
  - ASTS/ACS/Brandeis/Harvard AAPM project
- ASTS webinars and written materials

# ASTS MACRA Task Force

- Diane Mossholder
- Kim Gifford, MBA
- Diane Millman, JD
- David J. Reich, MD
- Kareem M. Abu-Elmagd, MD, PhD
- Kenneth A. Andreoni, MD
- David A. Axelrod, MD, MBA
- Sherilyn A. Gordon Burroughs, MD\*
- James J. Pomposelli, MD, PhD
- Alan I. Reed, MD, MBA
- Christopher Sonnenday, MD, MHS

\*deceased





*"You get to drink from the firehose!"*

# ASTS MACRA Task Force Activities

- Study regulatory requirements
- React
  - Transplant focused (i.e. SRTR, measures)
  - Interact with legislators and regulators
  - RFIs: MACRA, Physician Fee Schedule, CEC initiative
  - Economies of scale: ACS, AMA, SRTR, UNOS
  - Reasonable priorities
- Query members (% in GPRO?)

# Member Education re MACRA

- Keynote talks on MACRA at ASTS/Kellogg LDP (2015, 2016)
- MACRA talks during BP / Legislative Seminar (2016, 2017)
- Webinars on MACRA (March 2017)
- Disseminate reading materials and tools (Chimera, etc)
- Academic Universe

# Patient Reported Outcomes (PRO)



# ACS/Harvard/Brandeis APM Grant

- ACS exploring subspecialty bundles for payment
- Submitted APM to PTAC for CMS approval
- Brandeis & Harvard Schools of Policy (episode grouper software)
- Fiscal benchmarks and bonus/penalty adjustments ("at-risk" episodes).
- ASTS would propose start/stop points [global period], inclusions/exclusions, exceptions/carve outs, complications, risk adjustment, relevant providers for shared savings, attribution
- Performance metrics (quality, safety, experience)

# ACS/Harvard/Brandeis APM Grant (2)

- Benefits:
  - >50% of CMS payments will fall under APMs
  - We don't have bandwidth to do alone
  - CMS can pursue independently of us (ortho BCI)
  - Be at table as transplant bundles are developed
  - Build program that incorporates donor and recipient risks into the payment structure?
  - Build for MIPS APM
- Concerns:
  - Financial risk
- Plan: Stay engaged, be careful

# Part 2

## Alan I. Reed, MD, MBA

- Professor and Chief, Division of Transplant and HPB Surgery,  
University of Iowa Carver College of Medicine
- Director, Organ Transplant Center,  
University of Iowa Health Care
- Cornell University - Medical School
- New York Hospital / Cornell - General Surgery Residency
- U. of Wisconsin / Madison – Transplant Surgery Fellowship
- University of Iowa Tippie College of Management - MBA

What does it mean?



# **PART 2**

# **Medicare's Quality Payment Program**

## **Potential Impact on Solid Organ Transplantation**

ASTS Webinar  
22 March 2017

Alan Reed MD, MBA, FACS | Director, UI Organ Transplant Center

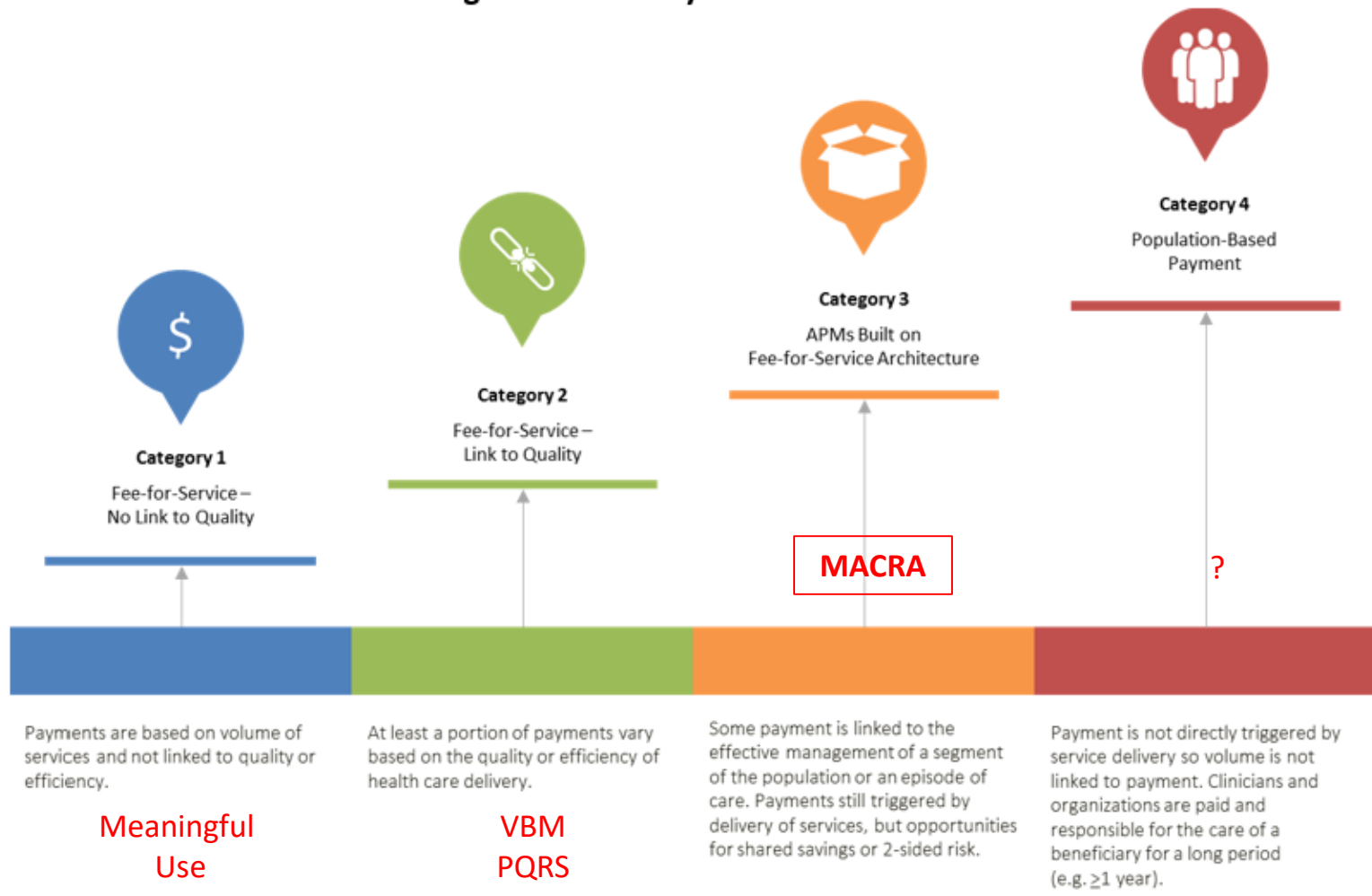


# POTENTIAL IMPACT ON AMCs & SOT?



# Quality Payment Program Overview

Figure 1: CMS Payment Framework

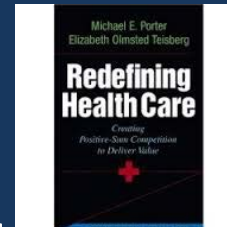


# From the Final Rule...Six Strategic Objectives

- Improve outcomes & engage patients through patient centered policy
- Enhance clinician experience through program flexibility
- Promote alternative payment models
- Support needs of diverse (read: small) MD practices through customized tools
- Improve data/info sharing
- Create operational excellence

# Michael Porter's Strategic Agenda for Successful VBP Healthcare Delivery

- Organize into integrated practice units around specific medical conditions
- Establish universal measurement(s) of outcome & cost (value = outcome/cost)
- Move to bundled pricing for care cycles
- Integrate care delivery across facilities along the arc of patient management
- Create enabling IT platforms



<https://www.youtube.com/watch?v=DRkhppxZzL0>

# Wait! What? In The Future???

- Organize into integrated practice units around specific medical conditions
- ✓ Multi-specialty, disease based transplant centers
- Establish universal measurement(s) of outcome & cost (value = outcome/cost)
- ✓ Risk adjusted, outcomes based measure (SRTR) & paid a DRG
- Move to bundled pricing for care cycles
- ✓ Been there, done that; phases of care (pre, listing, tx, post)
- Integrate care delivery across facilities & along the arc of patient management
- ✓ Responsible for long term follow-up and outcomes
- Create enabling IT platforms
- ✓ OTTR, EPIC-Phoenix, UNET, auto-uploads, tele-health platforms

**Sound vaguely familiar.....?**

# QPP: Transplant Specific Issues

- Medicare is major transplant payer
- Organ acquisition cost center (MDCR) is the last bastion of fee-for-service
- Transplantation is the ultimate team sport; MIPS looks at individuals
  - But there is a GPRO option
  - How will things be attributed in the two options?
    - MIPS very complex and not “transplant friendly”
  - Basic Payment rates still based on PFS; Methodology for RVU same
  - QPP MIPS adjusts these payments *ex post*
- Most of us don’t qualify as AAPM now, what about the future?
  - Must consider the risk piece
  - AAPM (QPP)
  - Bundled Payments Care Improvement (BPCI): CMS Demonstration Initiative for TJR, CABG, others?

# AAPM\* For Kidney Transplant Episode?

## What to Think About?

- Appropriate time frame?
- What is the appropriate amount of (cost of) risk to bear for?
  - Acute rejection
  - Hi KDPI
  - PHS hi-risk treatment/follow-up
  - Desensitization
  - Infection
- What are the other APMs?
  - Tx Nephrology Post 30 day care
- What are the appropriate quality metrics?
- How do you allocate?
  - Risk
  - Cost
  - Shared Savings (??? HaHa)

## Who's Included?

- Primary Provider
  - Primary Care Physician
  - Referring Nephrologist
- Principal Provider
  - Transplant Surgeon
- Episodic Provider
  - Transplant Nephrologist
- Supporting Provider
  - Anesthesiologist
- Ancillary Provider
  - Radiologist
  - Pathologist
  - Tissue Typing

\* As strictly defined in MACRA

# Current Barriers for SOT

- Quality Domain in MIPS
  - The SRTR is not recognized as a QCDR (yet!)!
    - Important for CPIA
  - Quality metrics
    - QPP is focused largely on process measures, with minimal investment in outcomes, but we are already invested in outcomes
    - How can we leverage our robust (CMS mandated!) FQAPI program to count entirely for the Quality domain?
    - Will TransQIP play a role? Individual vs team attribution?
- We are (in the big picture) a small volume-high cost product; where will we fit in a population health (AAPM) chassis?
  - Long arc of care
  - High cost of care
  - Assumption of high cost of risk in this model

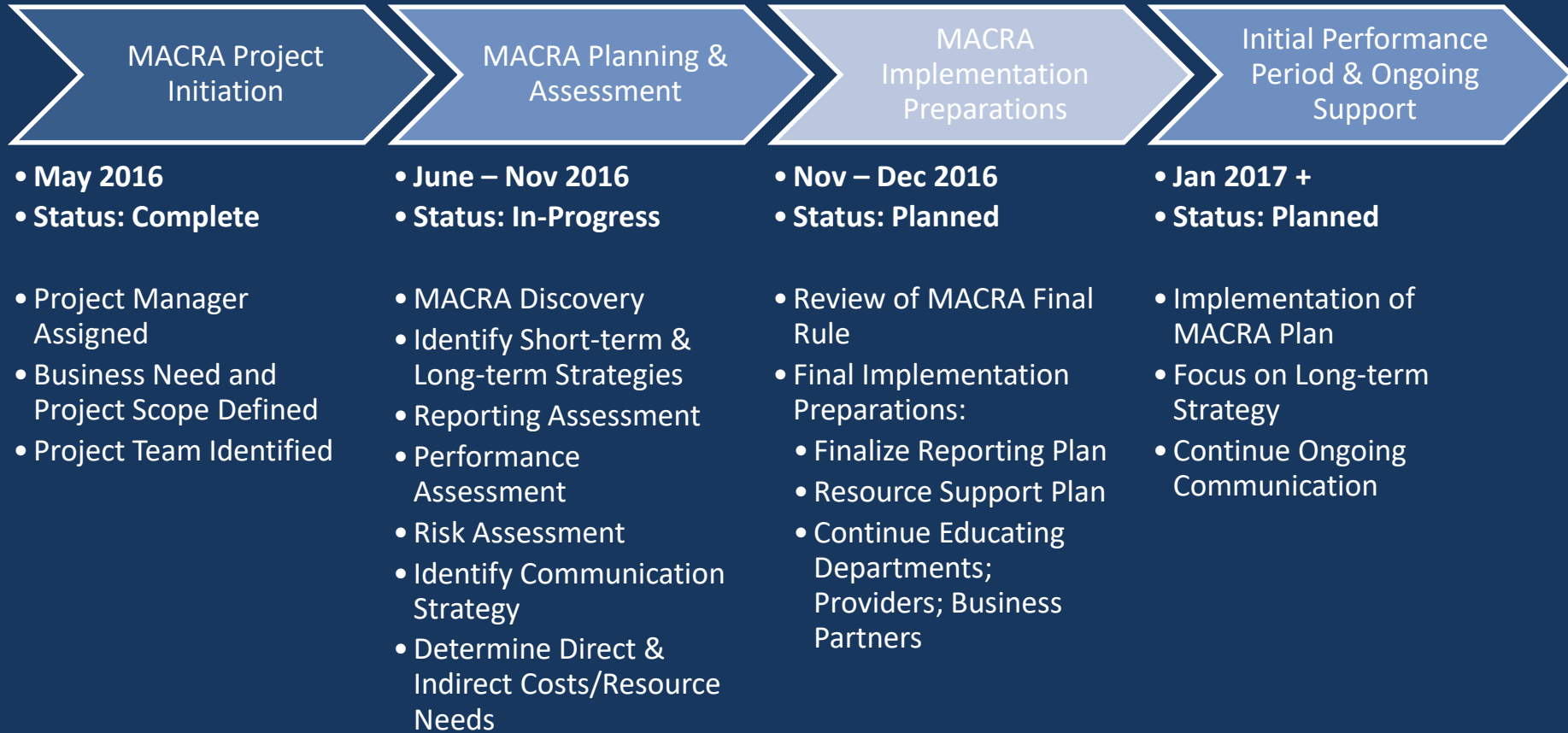


# What Went On At Your Institution?

- I assume your practice plan had a QPP task force?
  - I assume the practice plan, institution and/or ACO prepared for QPP?
- Did they assess their EHR reporting capabilities?
  - What measures are easily and currently captured; what needs to be built?
- ROI: How are they assessing the risk/impact of resources required to comply (cost) vs \$ at stake (risk) in any given time period?
  - Other reporting types do not go away (MU!)
- I assume they have engaged the MD workforce:
  - Provider education and communication strategy?
  - Short & long term implementation plans

**Transplantation has been a leader in this effort. As leaders at your institutions, you can still play a role in developing the QPP response**

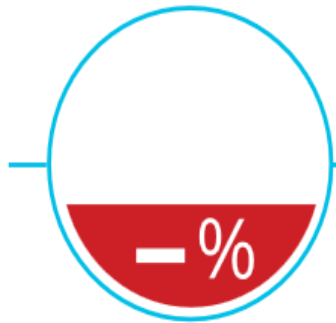
# University of Iowa Physicians MACRA Project Plan



# Pick Your Pace for 2017

## Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.



**Don't Participate**

### **Not participating in the Quality Payment Program:**

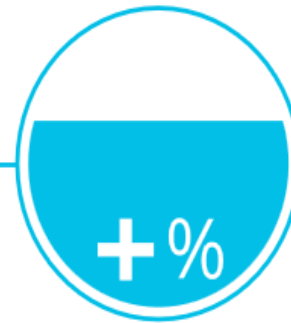
If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.



**Submit Something**

### **Test:**

If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.



**Submit a Partial Year**

### **Partial:**

If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.



**Submit a Full Year**

### **Full:**

If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

# Some Good News For AMCs in ACOs

MIPS APM Summary				
Measurement Status	Quality	<b>Resource Use</b> <u>Exempt</u> from reporting through MIPS Report through ACO interface	CPIA	ACI
Measurement Selection	<ul style="list-style-type: none"> <li><u>GPRO Reporting via ACO</u></li> </ul>		<ul style="list-style-type: none"> <li>TBD</li> <li><a href="#">MACRA CPIA Measurements</a></li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Current MU Measures?</a></li> </ul>
Total Possible Points	<ul style="list-style-type: none"> <li>For groups reporting via CMS Web Interface, the total possible points for the quality performance category would be 200 points</li> <li>(17 measures x 10 points + 3 population-based measures x 10 points = 200)</li> </ul>		<ul style="list-style-type: none"> <li>60 total points needed</li> <li>MIPS APM = 30 points</li> <li><b><u>Need only 30 points</u></b></li> <li>✓ High Measures = 20</li> <li>✓ Medium Measures = 10</li> </ul>	<ul style="list-style-type: none"> <li>100 total points possible</li> <li>Base = 50 points</li> <li>Performance = 80</li> <li>Question – Do we meet this category with our current MU measure set?</li> </ul>
Weight 2017	<ul style="list-style-type: none"> <li>50%</li> </ul>		<ul style="list-style-type: none"> <li>20%</li> </ul>	<ul style="list-style-type: none"> <li>30%</li> </ul>
Submission Method	<ul style="list-style-type: none"> <li>CMS Web Interface</li> </ul>		<b>Options:</b> <ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified registry</li> <li>✓ EHR</li> <li>✓ CMS Web Interface</li> <li>✓ Administrative Claims</li> </ul>	<ul style="list-style-type: none"> <li>CMS Web Interface?</li> </ul>

# Bad News For the Little Guy

- MIPS favors hospitals with EHR and IT resources
- Newly minted and low volume providers will be exempt (30-35%)
  - $\leq 30,000$  allowable part B
  - $\leq 100$  MDCR patients
- Will hit small physician groups, rural groups hardest

# What Are Your Choices?

1. Do Not Accept MDCR: Really not a viable option for OTC
2. Status Quo: Do nothing means work harder or accept lower Part B reimbursement
3. MIPS: Resource Intensive; add resources?
4. MIPS-APM: ACO level reporting takes the sting out of some requirements, but still requires some individual action and ACO chapter partner collaboration!
5. AAPM: Likely not a viable option for most AHS for several years unless BPCI becomes viable

These are my [thoughts].  
If you don't like them, I have others!



Paraphrased from Groucho Marx

# What Does The Future Look Like For Providers?

- Cost containment takes center stage
  - Cost problem is not the sole fault of providers, but it is/will be largely our problem to solve
  - The burden to reduce costs will fall to PROVIDERS
- Medicare (Private Insurers and other large purchasers of health care services such as employers) want providers to bear risk for outcome, costs and safety
  - Do providers have the right skill sets?
- Health systems are developing their own insurance products (and acquiring the skill sets)
  - Population health care in integrated products
  - Providing the data and infrastructure to go from volume to value



# What Concerns Me About QPP & SOT

- MIPS will be a penurious a Pain in the A\*\* and it is here, but it is the space most of us will play in for the short-term
  - There is an easy button (MIPS-APM)
- In this experiment of social anthropology among specialty driven APMs, SOT is at the top of the food chain
  - We have been “doing this” for more than 20 years

- **BUT, THAT IS NOT A PLUS, BECAUSE**

- Transplantation is already a commodity

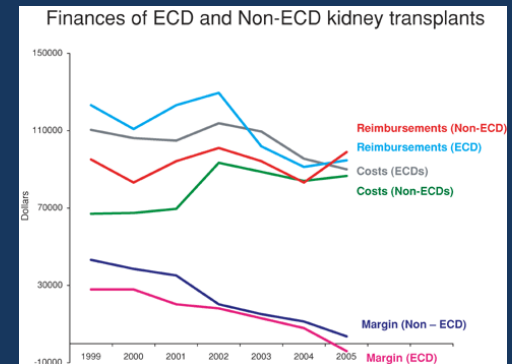
- We are Price Sensitive
    - We do not compete with each other on a differentiated strategy
    - Easy for purchasers of service to shop for lowest cost
    - Imperfect market conditions

- What value is there left to extract for us from APMs? For more risk?

- Example of Pioneer ACOs, Dartmouth

- Will we get credit or get penalized for being ahead of the curve

- Financially
    - Advanced quality initiatives?

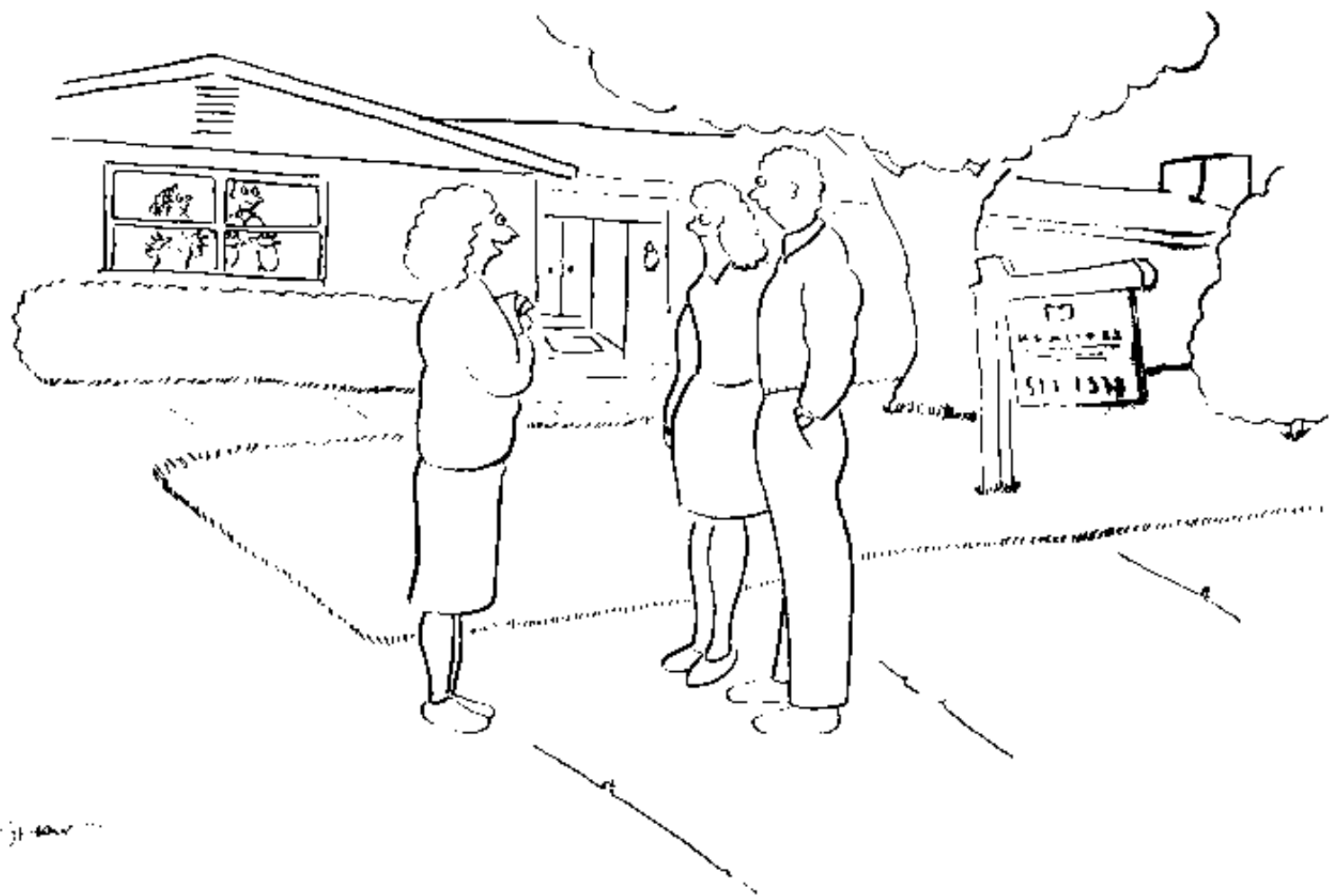


Englesbe et al. AJT 2008; 8: 586-592

# What Concerns Me About QPP & SOT

- CMS FQAPI program (already part of daily life)
  - Why should we go back to focusing on process measures?
  - Will participation in the SRTR count as a QCDR? As a CPIA activity?
- How can we control for the unpredictability in the arc/length of the patient's illness if we move from episodes of care to “organ failure centers” or population health models (price of risk)?
  - “bundled payments allow providers to manage risk and begin to engage in population health....to create a more sustainable and relevant healthcare operating model” CMS
  - Bear more than “nominal financial risk”
- Who will bear the brunt of this in the end?





*"They're willing to throw in their kidneys."*

## Part 3

- Q & A, Panel Discussion

Jill Sage, MPH

Alan I. Reed, MD, MBA

David J. Reich, MD, FACS