The Impact of Health Care Reform on Pathology Practice and Payment:
From Volume to Value

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The Impact of Health Care Reform on Pathology Practice and Payment:
From Volume to Value

Objectives -
• Briefly review pathology practice and payment
• Describe the recent history of healthcare delivery and payment reform
• Detail the impact of these reforms on pathology practice and payment
• Give examples of value-based pathology practice
• Propose a potential pathology-related project for the OCPI
Pathology practice . . . in 3 minutes

Anatomic pathology
  • Surgical pathology – General, subspecialties
  • Cytopathology
  • Autopsy pathology

Clinical pathology
  • Clinical chemistry, hematology, transfusion medicine, microbiology, immunology, etc.

Special areas
  • Molecular/genomic pathology
  • Forensic pathology
Pathology payment . . . in 3 minutes

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Pathology payment . . . in 3 minutes

Anatomic pathology
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Pathology payment . . . in 3 minutes

Anatomic pathology
- Surgical pathology – General, subspecialties FFS
- Cytopathology FFS
- Autopsy pathology Part A

Clinical pathology
- Clinical chemistry, hematology, transfusion medicine, microbiology, immunology, etc. Part A

Special areas
- Molecular/genomic pathology
- Forensic pathology
Pathology payment . . . in 3 minutes

Anatomic pathology
- Surgical pathology – General, subspecialties  FFS
- Cytopathology  FFS
- Autopsy pathology  Part A

Clinical pathology
- Clinical chemistry, hematology, transfusion medicine, microbiology, immunology, etc.  Part A

Special areas
- Molecular/genomic pathology
- Forensic pathology  Government
Pathology payment . . . in 3 minutes

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Special areas
  • Molecular/genomic pathology  ??
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Pathology payment . . . in 3 minutes

Anatomic pathology
• Surgical pathology – General, subspecialties 80%
• Cytopathology 10%
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• Clinical chemistry, hematology, transfusion medicine, microbiology, immunology, etc. 10%?

Special areas
• Molecular/genomic pathology ??
• Forensic pathology
Pathology payment . . . in 3 minutes

In the FFS world . . . live or die by

CPT 88305

CPT 88342
Pathology payment . . . in 3 minutes

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The dream . . .
the challenge
. . . the challenge
. . . the challenge
... the challenge
the challenge
... the challenge
So what’s wrong with the traditional health care system?

- No built-in system for coordination of care
- No real incentive to give high-quality care
- Little connection between care of individual patients and the health of the population
- No effective way to control costs → volume rewarded over value
Projected Future Spending on Health Care in the US If Nothing Changes (% of GDP)

Source: Congressional Budget Office
Modern health care reform: The “triple aim”

• Better quality care for individuals
• Improved health for the population
• Lower cost

Value = \frac{\text{Quality/Outcome}}{\text{Cost}}

The goal: Value-based health care → value rewarded over volume
Value-based health care . . . so far

• Accountable care organizations
• Patient-centered medical homes
• Bundled payment/episodes of care arrangements
• Pay-for-performance (P4P)
• Meaningful use of HIT
• ________________________??
HHS targets for value-based payments

• By 2016
  - 85% of provider payments $\rightarrow$ value-based
  - 30% of payments $\rightarrow$ “alternative” models

• By 2018
  - 90% of provider payments $\rightarrow$ value-based
  - 50% of payments $\rightarrow$ “alternative” models
Accountable care organizations: What are they?

• Health care organizations that accept accountability for the . . .
  - Quality of care
  - Health of the population served
  - Per capita cost of care for a designated population

• Formed by combination of providers and/or hospitals
Accountable care organizations: What are they?

- Health care organizations that accept accountability for the . . .
  - Quality of care
  - Health of the population served
  - Per capita cost of care for a designated population
- Formed by combination of providers and/or hospitals
  → group practice, network of individual provider practices, joint venture/partnership of hospital(s) and providers, hospital-employed providers, etc.
Accountable care organizations: What are they not?

HMOs by another name?

<table>
<thead>
<tr>
<th></th>
<th>HMO</th>
<th>ACO</th>
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<tbody>
<tr>
<td>1. Better <strong>quality</strong> care for individuals*</td>
<td>??</td>
<td>+</td>
</tr>
<tr>
<td>2. Improved <strong>health</strong> for the population*</td>
<td>?</td>
<td>+</td>
</tr>
<tr>
<td>3. Lower <strong>cost</strong></td>
<td>+</td>
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</tbody>
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*HIT can now facilitate all three
Accountable care organizations

Total Number of ACOs – 1/15
Medicare vs. Non-Medicare

Accountable care organizations

Total Covered Lives in ACOs – 4/14
Accountable care organizations

% Covered Lives in ACOs by Hospital Region – 4/14
Accountable care organizations: Different models

- CMS Medicare Shared Savings Program (MSSP) ACOs
- CMS CMMI Pioneer ACOs
- Medicaid ACOs
- Private sector ACOs
Accountable care organizations: Different models as of 1/15

- CMS Medicare Shared Savings Program (MSSP) ACOs...................... 427
- CMS CMMI Pioneer ACOs....... 23
- Medicaid ACOs...................... 7 states
- Private sector ACOs.............. 250+

Total 710+
Accountable care organizations: Common elements

- **Coordination of care** key to success
  - Chronic disease management, transitions of care (i.e. handoffs), population health management, etc.
- Use of EHR and informatics to improve care, manage utilization, and monitor performance
- **Payment:**
  - Based on meeting quality measures
  - Shared FFS savings → capitation, bundled payments, etc.
Accountable care organizations: Different models

**CMS Medicare Shared Savings Program ACO**

- Accountable for the . . .
  - Quality of care – 33 quality measures
  - Cost of providing care (compared to past)
- Costs and savings based on fee-for-service
- ACO can share in FFS savings and/or be at risk for added costs
Accountable care organizations: Different models

- CMS Medicare Shared Savings Program (MSSP) ACOs
- CMS CMMI Pioneer ACOs
- Medicaid ACOs
- Private sector ACOs
Patient-centered medical home

• Care delivery model based on “partnership” between individual patients and their provider (usually primary care, may be specialty care)
• Team-based care coordinated across the continuum of care
• Focused on quality and safety
• Currently, >8,000 accredited PCMHs
PCMHs and ACOs

(James Crawford, 2014)
Bundled payment/episodes of care arrangements

- Single “fixed dollar” global payment to hospital, provider organization, and/or individual providers for single “episode of care”
- Similar to Medicare DRGs for hospitals, but . . . providers may now be included in bundle
- Distribution of payment is determined internally
Pay-for-performance (P4P), etc.

- Started in 2000 with Benefits Improvement and Protection Act
- Reinforced with
  - 2009 HITECH Act
  - 2010 Affordable Care Act
- Applies to hospitals and providers
- Started as voluntary bonus payments for good performance
Pay-for-performance (P4P), etc.

- Started in 2000 with Benefits Improvement and Protection Act
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  - 2009 HITECH Act
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- Applies to hospitals and providers
- Started as voluntary bonus payments for good performance . . . in 2015 → involuntary payment penalties for non-compliance or poor performance
Pay-for-performance (P4P)

- Physician Quality Reporting System (PQRS)
- Value-Based Modifier (VBM) for providers
- Value-Based Purchasing (VBP) for hospitals

etc.

- Meaningful Use of HIT
Value-based health care – 2015

Currently voluntary . . . but for how long?

• Accountable care organizations
• Patient-centered medical homes
• Bundled payment/episodes of care arrangements

Involuntary → penalties starting in 2015
• Pay-for-performance (P4P)
• Meaningful use of HIT
HHS targets for value-based payments

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Value-based health care: Challenges for pathologists

• Payment increasingly moving from FFS to capitated/bundled payment → requires internal sharing of payment among providers, hospital, etc.

• Voluntary models becoming more common

• Involuntary P4P requirements and penalties increasing

• Quality and performance measures difficult to meet; most don’t apply to pathologists
Value-based health care: Meeting the challenges → Value-based pathology

As bundled/capitated payment increases, pathologists need to . . .

1. Establish value-added roles in support of ACOs, PCMHs, bundled payment arrangements, etc.

2. Gain internal recognition for these roles

3. Get paid fairly for these roles
Pathology payment . . . in 3 minutes

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Value-based health care: Meeting the challenges → **Value-based pathology**

Value-added roles for pathologists . . . some examples:

- Lab utilization management – CP and AP
- Consultation – Pre-order and post-result
- Assist in chronic disease/population health management
- Ensure actionable lab/pathology result format in EHR
- Use HIT/informatics for practice analytics, care improvement
- Management of tissue biorepository
Value-based health care: Meeting the challenges → **Value-based pathology**

Value-added roles for pathologists . . . some examples:

- Lab utilization management – CP and AP
  
  CP – Develop lab test order sets, testing algorithms, test formularies; emphasis on molecular and other high-cost tests → “the right test at the right time”
  
  AP – Manage ancillary testing in surgical pathology, hematopathology
Value-based health care: Meeting the challenges → **Value-based pathology**

Value-added roles for pathologists . . . some examples:

- Lab utilization management – CP and AP
- Consultation – Pre-order and post-result
  - With clinicians
  - With patients
Value-based health care: Meeting the challenges → Value-based pathology

Value-added roles for pathologists . . . some examples:

- Lab utilization management – CP and AP
- Consultation – Pre-order and post-result
- Assist in chronic disease/population health management
  - Use HIT for scheduled testing alerts, testing compliance/test result tracking, intervention alerts
  - Develop and apply clinical decision support tools
Value-based health care: Meeting the challenges → Value-based pathology

Value-added roles for pathologists . . . some examples:

• Lab utilization management – CP and AP
• Consultation – Pre-order and post-result
• Assist in chronic disease/population health management
• Ensure actionable lab/pathology result format in EHR
  → Provides clinical decision support to clinicians
Value-based health care: Meeting the challenges → **Value-based pathology**

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Value-based pathology

Payment of pathologists

- Employee → $ incentives
- Member → share in capitation/bundles
- Vendor/subcontractor → low FFS?

→ Involvement in ACO/organizational leadership

Be at the table . . . or on the menu.
“As soon as possible, Medicare should extend competitive bidding to medical devices, laboratory tests, radiographic diagnostic services, and all other commodities.”

– The Center for American Progress, et al
NEJM, August 1, 2012
Value = \frac{Quality/Outcome}{Cost}
OCPI pathology project?

Pathology “cost per diagnosis” of cancer

• CMMI interested in utilization management
• CMMI interested in cancer care (e.g. new CMMI Oncology Care Model)
• CAP, ASCO, ASH, etc. developing cancer diagnostic guidelines
  → study drivers of pathology cost in cancer diagnosis
  → develop a CMMI pilot: Episodes of care?
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