The Future is Ahead of Schedule
***
Quality, Service & the Bottom Line

Jay Kaplan, MD, FACEP
President-elect,
American College of Emergency Physicians
Practicing Clinician and Director,
Patient Experience, CEP America
First Thoughts

- The biggest driver of health care reform is cost.
- What is most important to Americans – access, convenience, and cost.
- The least acute 20% of patients account for 4% of the cost, or the equivalent of 1/12 CT scans.
- Bundled payments are starting and emergency care will soon not be a “carve-out.”
Caveat #1: What Brought Us to this Dance . . .

Ain’t Going to Get Us to the Next One . . . .
Retail Clinics Abound

Minor illness exam

- Allergy symptoms (ages 2+)
- Bronchitis / cough
- Earache / ear infection
- Flu-like symptoms
- Mono
- Motion sickness prevention

$79-$99

- Pink eye & styes
- Sinus infection / congestion
- Sore throat / strep throat
- Upper respiratory infection
- Urinary tract / bladder infection (females 12+)

For lab tests, additional services and visit complexity may result in additional charges. Pricing subject to change. Age restrictions apply.
Direct to Consumer Mobile Video Visits

Now anyone with a camera-equipped smartphone, tablet, or computer can conduct a video visit with a physician for $49—assuming you live in a state that doesn’t prohibit it.

See a doctor 24/7 using LiveHealth Online.
It’s quick and easy to use with no appointment needed

Sign up now
You could win a $500 Amazon gift card

This flu season, don’t waste time waiting at urgent care. Using LiveHealth Online you can see a board-certified doctor in minutes on your smartphone, tablet or computer with a webcam. Telehealth visits using LiveHealth Online are now a covered benefit under your Anthem health plan. All you have to do is sign up to use it.

Here’s why you’ll love using LiveHealth Online:

It’s available 24/7. Doctors can provide medical advice, an assessment and send prescriptions to the pharmacy of your choice if needed. It’s a great option for care when your own doctor isn’t available and is here to help when you have the flu, a cold, sinus infection, pink eye and more.
Caveat #2 –
The Best Definition of Madness is

To keep doing things
the same way
and expect different
results . . .
Caveat #3
How Most of Us Approach Change
“Older guys want it to be the way it always was . . .
The younger guys want it to be the way they want it to be . . .”
Where Are We On the Journey?

Time

Performance

Can see the future but we are still doing well, so let’s hold on and stay the course . . .

Opportunity Won

Opportunity Lost
Simple Mathematics

X Divided by Y = Z
X = Health Care $
Y = Number of Patients
Z = $ per Patient for care

If X stays the same . . . And Y increases dramatically, Z per patient will decrease dramatically

Note: 10,000 Americans turn 65 every day, and will do so for the next 16 years
1.75% Medicare reimbursement withheld, only returned if >50th percentile
National Quality Strategy Priorities = CMS Measure Domains:
1. Clinical Effectiveness
2. Patient Safety
3. Patient Experience
4. Care Coordination
5. Population & Community Health
6. Efficiency

To avoid the PQRS penalty: 9 Quality Measures Across 3 NQS Domains, or 6 + PQRS-CAHPS
# Quality Tiering Under the VM

## Value Based Payment Modifier Amounts CY2017 – PY2015

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality 10(^{th}) percentile</th>
<th>Average Quality</th>
<th>High Quality 90(^{th}) percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+2.0x(^*)</td>
<td>+4.0x(^*)</td>
</tr>
<tr>
<td>10(^{th}) percentile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>+0.0%</td>
<td>+2.0x(^*)</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
<tr>
<td>90(^{th}) percentile</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
With the Repeal of the SGR $\rightarrow$ MIPS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Base</td>
<td>0.5%</td>
<td></td>
<td></td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.25%</td>
</tr>
<tr>
<td>EHR</td>
<td>+/-4% MIPS</td>
<td>+/-5% MIPS</td>
<td>+/-7% MIPS</td>
<td></td>
<td>+/-9% MIPS</td>
<td>Merit Based Incentive Payment System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS</td>
<td>+/-4% MIPS</td>
<td>+/-5% MIPS</td>
<td>+/-7% MIPS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If no reporting of metrics: -6%

In 2017, based upon your metrics this year, + or – 4% reimbursement depending on quality, cost, and meaningful use

In 2022, + or – 9%
An Analogy

Low sodium diet

High blood pressure

Risk of strokes
To Be Successful . . .

- We will need to show our VALUE to the outside.
- We become the Porch of the Medical Neighborhood and the Patient-Centered Medical Home for those who cannot find a medical home elsewhere.
- We control (through the decision to admit) up to 32% of the healthcare $ even though emergency care costs 2%.
- Demonstrate $ savings through evidence-based clinical guidelines, development of High Reliability/High Consistency Practice.
- Destroy the myth of “the most expensive place for care.”
Quality/Experience data will be transparent → will drive market share

Insurers will quality-tier physicians and will offer patients cost incentives → will drive market share

For patients seen, high quality → $$$
low quality → $
ACEP’s Qualified Clinical Data Registry is to be called CEDR – Clinical Emergency Data Registry

Will be required by CMS in order to provide quality metrics (claims-based reporting to sunset)

Pilot sites going on now (1st 1000 NPI’s free) – cost likely to be ~1/10 of captured revenue (huge ROI)

Opportunity to validate our own quality metrics, including patient satisfaction metrics, real-time patient clinical follow up outcomes . . .
The scope of CEDR is to accept patient data from practicing emergency physicians and clinicians on the care provided to emergency department patients. These data will inform the main goals of CEDR, which are to:

1. Provide a unified method for ACEP members to collect and submit Physician Quality Reporting System (PQRS) data, MOC, OCC, Ongoing Professional Practice Evaluation (OPPE), outcome data, and other related or applicable quality and patient safety data to meet quality improvement and regulatory requirements.

2. Promote the highest quality of emergency care for our patients.

3. Demonstrate the value of emergency care.

4. Facilitate appropriate emergency care research.
<table>
<thead>
<tr>
<th>Traditional PQRS registries</th>
<th>Qualified Clinical Data Registries (QCDRs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide quality data for Medicare patients only</td>
<td>Provides quality data on patients from all payers</td>
</tr>
<tr>
<td>Limited to PQRS measures</td>
<td>Includes PQRS measures plus up to 30 additional specialty specific measures</td>
</tr>
<tr>
<td>Requires new “cross-cutting” measures</td>
<td>Does not require “cross-cutting” measure</td>
</tr>
<tr>
<td>Requires groups of 100 or more to report “PQRS-CAHPS”</td>
<td>Does not require CAHPS reporting</td>
</tr>
<tr>
<td>Less control over quality measures reported</td>
<td>More meaningful measures to choose from</td>
</tr>
<tr>
<td>Quality measure data collected will be used to calculate the quality composite of the Value Modifier.</td>
<td>CMS will not include first-year QCDR measures in the VM quality composite until such time as CMS has historical data to calculate benchmarks for them. For the 2017 VM, in cases where groups are assessed under the “50% option” and all EPs report via QCDR in 2015, then CMS will classify the group’s quality composite score as “average”.</td>
</tr>
</tbody>
</table>
What Can We Do?

1 “Our Way” not 15 different “My Ways”

Answer “Do you really need that advanced imaging study, or do you need to admit that patient?”

Work with our hospital leaders to decrease cost.

Change our name and our scope.
Summary

- The Future is ahead of schedule
- Old paradigm (Care=Income) will be replaced with new paradigm (Outcome=Income)
- Emergency Medicine will need to re-brand itself. We are the true “Available-ists”. We are more than emergency doctors. We give people the health care they need when they need it.
- We are the hub of the medical enterprise, the center of the acute care continuum, the porch of the medical neighborhood, and the medical home for the medically homeless.
- We cannot afford to be “the most expensive place to receive care,” and neither can our patients have us remain that.
The ACA and Reforming Payments for Acute Unscheduled Care

Jesse M. Pines, MD, MBA, MSCE
Director, Office for Clinical Practice Innovation
Professor of Emergency Medicine and Health Policy
October 20, 2015
Thank you

- Funding provided by the Dr. Richard Merkin Foundation
- Research and support from the Brookings Institution Merkin Initiative on Payment Reform on Clinical Leadership
- Expert input and guidance from the American College of Emergency Physicians Performance and Quality Committee
Objectives

• Describe how the existing acute care system can build and sustain reforms that enhance value
Objectives

• Provide several recommendations to transition payment away from traditional FFS to alternative payment models
Acute unscheduled care

- “Acute care”
  - Care for the ill & injured
- Demands for acute care
  - Pain and anxiety, need for care during an acute illness, exacerbation of chronic disease, trauma or disaster event
Acute care system

• Multiple settings
  – EDs (hospital / FSED), urgent care centers, retail clinics, doctors’ offices, telemedicine
• Evolved over time to meet demands
• Much of the care is high quality
• Some care is fragmented
• Many acute care settings are high cost / overcrowded
Payment reform

• New focus on value
  – The ACA of 2010
  – Payment / delivery reforms
    • CMMI / Private market
  – Coordinate, low cost, and patient-centered
  – ACOs; PCMH; Focus on disease management
  – Little focus on acute care system
Payment reform issues

• Acute care
  – Demand
    • Exogenous / social determinants
  – Data availability
  – Critical role of system in public health emergencies
  – Patient Access and the Safety Net
  – Patient Safety
    • Reducing intensity -> Medical errors?
Alternative Payment Models

• Issues to consider
  – Disruptive, not destructive
  – How do we pay acute care providers if not through FFS?
  – What do we do about decreasing volumes
  – One-size-fits-all model may not work
  – Incentives need to be aligned across settings
  – How do acute care settings benefit from shared savings?
Moving towards value

• Demand management
  – Where should I go; High-cost users
• Standardizing care processes / transitions
• Sharing information across settings
• Accountability after acute care
  – Call-back programs; Paramedicine?
• Changing roles of acute care providers
Other interventions

• Expansion of acute care capacity?
• Better coordination at the regional level / telemedicine
  – U Mississippi ; Mayo
• Home visits
  – U Colorado
• Patient centered tools
• Need to engage acute care providers
Alternative Payment Models

• FFS + Pay for value-added services
  – Care coordination; Social work; Case management
  – Having high-value “structures” in place
    • PCMH -> Connected ED
Alternative Payment Models

• Bundled Payments for Episodic Conditions
  – URI; cellulitis
  – TIA; chest pain
  – Expansion of obs care
  – Currently being tested in Arkansas
Alternative Payment Models

• Capitation / global budgets
  – Example – Maryland
  – Kaiser
    • Demand management
    • Full information across settings
    • Full availability of follow-up

Pines JM, McClellan M. Case studies in emergency medicine: Integrating care for the acutely ill and injured Brookings Institution 2015
Recommendations

• Information sharing
  – Create a minimum data set to share across settings
  – In the long-term move to full interoperability
• Delivery / payment reform
  – Test new payment models
    • FFS + modifier
    • Connected ED
    • Episodes
    • Global budgeting; cross-subsidization
Recommendations

• Expand quality measures
• Develop patient-centered systems to manage care across the continuum
• Engage acute care providers
• Expand patient education
• Support around-the-clock access
Questions?