Making Sense of Value-Based Healthcare and How Medtech Companies Should Respond

CMS has an objective to shift 50% of all reimbursement services from fee-for-service to alternative, value-based methods by 2018. And bundled payment models, according to Dr. Dan Mazanec, will be the principal driver of this transformative initiative.

But this stuff is confusing, right? Comprehensive Care for Joint Replacement. Medicare Access and CHIP Reauthorization Act. MIPS vs. APM. The list goes on and on. How do you begin to understand it all? And if you're a leader within your medtech or biotech organization, how should you begin to prepare your company for the future?

To help answer some of these questions, I invited the aforementioned Dan Mazanec to join Medsider Radio. He's currently the Chief Medical Officer for Dorsata. Prior to joining Dorsata in 2016, Dr. Mazanec was the Associate Director of the Center for Spine Health at the Cleveland Clinic. Board certified in internal medicine and rheumatology, Dan led the development and implementation of the Spine CarePath across the entire Cleveland Clinic Health System.

Here are some of the topics we cover:

- How did the original concept of bundled payment models start? And what was the original intent?
- An overview of the Comprehensive Care for Joint Replacement (CCJR) program and the potential ramifications for medical device companies.
- The shifting financial risk in healthcare and why care coordination will be so important.
- What the Medicare Access and CHIP Reauthorization Act (MACRA) means for healthcare, and more specifically, the 2 paths to reimbursement for physicians (MIPS vs. APMs).
- In regards to bundled payments and reimbursement, the top 2-3 things that medtech companies need to consider right now.

SCOTT: Dan, welcome to the Medsider program. I appreciate you coming on.

DAN: My pleasure.

SCOTT: Dan, welcome to Medsider Radio. I appreciate you joining us. Let's start with the fact that CMS has an objective to shift 50% of all reimbursement services from fee for service to

alternative value-based methods by 2018. I know you wrote recently in one of your pieces that bundled payment models will be the principal driver of this disruptive or transformative initiative.

Can you provide a highlight or an overview of the original concept for bundled payment models? How did this start, and maybe what was the original intent?

DAN: I think you have to go all the way back to the early ’80s, at which point the CMS reimbursement to hospitals and physicians was entirely cost-based. There was no cost control. If you went to a hospital for an appendectomy, the hospital essentially passed all the charges – the lab test, the nursing care, the room, etc. – directly to Medicare and got paid. CMS saw a tremendous increase over a period of just a few years. The Medicare costs to reimburse for that type of care had increased more than 50%. In fact, I think it was approaching 80%.

So in 1983, Medicare introduced the so-called Diagnosis Related Group, or DRG concept, which said we’re not going to pay the hospital for individual costs. Instead, we’re going to pay by diagnosis. So they came up with about 500 different diagnoses. For example, for an appendectomy, the hospital would receive a fixed amount of money, which obviously caps the exposure of Medicare or CMS. It effectively forced hospitals to bundle all the charges associated with that procedure.

That is where the original concept of bundling comes from. Medicare essentially made hospitals bundle all their charges for a set fee. Clearly, the original intent of the program was to reduce costs. Not too much later, in all fairness to Medicare, they added the phrase “preserved cost” and “preserved quality,” and now as bundling has evolved, I would say they’re not only controlling costs, but they’re actually improving quality in this so-called value-based system.

Outside of DRGs, another good example is the Surgical Global Package. Sometime in the ’90s, Medicare started paying surgical fees in a global package. In this scenario, the surgeon would get a set amount of money for all the care associated with the procedure, beginning with the first day in the hospital or the first pre-op day, through the surgery, and anywhere from 10 to 90 days afterwards. That model is still out there today. So irrespective of how many visits a person had to make to the surgeon, even if the surgeon had to take the person back to the operating room, there was a single set fee, or so-called global fee, for that set of services.

So that’s another example of bundling. Those were two early examples of this concept of associating all the costs of a so-called episode of care into a single figure, and essentially

shifting some of the risk away from the Medicare system and shifting it to the individual providers or the hospital, in the case of DRGs.

SCOTT: Before we get into some of the newer bundling models, like the comprehensive care for joint replacement, CMS has changed bundling quite a bit over the past few years. Can you quickly highlight that for us?

DAN: There are really two trends, I would say, that CMS has focused on in the last several years. And really, these trends were accelerated with the Affordable Care Act in 2013. But the two trends are really focused on folding physicians' costs into the hospital. As I said, DRGs reflected hospital costs, but they did not include professional fees for the physicians caring for the patient in the hospital. In the new bundling models, physicians' fees tend to now be incorporated in the same bundle with all the other hospital-related costs.

The other major trend is the definition of an episode of care, which for DRG purposes was related to a single period in the hospital. Now, the episode of care really extends through the hospitalization into the post-acute phase of care, going up to 90 days after discharge. So for someone hospitalized, for example, for a total knee replacement, that episode of care begins with the admission into the hospital and extends after discharge into rehabilitation and any post-acute care all the way up to 90 days.

So now, the bundle really involves the whole continuum of care. It involves both the doctors as well as the hospital or healthcare organization.

And then the other aspect of bundling is that it has now been applied to outpatient care. DRG is related to the inpatient experience. Now, outpatient care, in a variety of models, is being bundled as well. Again, the objectives are the same as with DRGs. Control or reduce costs, and incentivize quality, and drive more integration of care. That relates to quality as well. It really forces healthcare organizations and providers at multiple levels to coordinate care within these bundles.

SCOTT: A couple of those points that you just mentioned are part of the Comprehensive Care for Joint Replacement program, or CCJR. Correct?

DAN: That's correct. There are some differences, but basically that program is for patients who are going to have either knee or total hip replacement surgery. This program is just being introduced, and the rules were just rolled out this year. This program involves 800 hospitals, and unlike some of the other bundling projects, the Comprehensive Care for Joint Replacement

program is mandatory for all 800 hospitals specific to hip and knee replacement, which are big ticket items. There's 400,000 hip and knee replacements a year. Hospitalization alone is probably upwards of seven, eight billion dollars, and there's a lot of variability in cost.

What CMS has said is for all the care for your joint replacement - from the day of admission through 90 days post discharge - all of that care is bundled together, and a targeted price is set based on historical data. The totaling of the costs is done after the fact, but if the hospital or the organization comes in under target, they get some money back. On the other hand, if their cost of providing the care throughout the whole continuum exceeds the target, then there will be a penalty, and the hospital or organization will have to give money back.

So it's really bundling multiple providers, physicians across a whole continuum of care, and the goal is to reduce costs, and it will certainly drive better coordination of care. It certainly should, if the organization expects to be successful.

SCOTT: That's why this concept of reducing readmissions for hospitals is so important, because that's such an expensive event. If a patient is going to be readmitted into the hospital and it's part of that 90-day window, as you mentioned, it can be very expensive for the hospital and they're going to miss their economic targets. Is that right?

DAN: That's absolutely right. The healthcare organization has to make sure that complications are avoided. For joint replacement procedures, a major complication is DVT, a blood clot in the leg. It's very common after knee replacements, and less so after hip replacements. Managing people in the acute hospital to ensure you minimize those risks, getting them out of the hospital quicker, avoiding re-hospitalization, unnecessary care, etc. These are all very important things to consider.

The post-acute space is one that's been somewhat overlooked in these bundling packages until recently, and it's an important one because that's where 40% or 50% of the costs of that total episode of care resides. And that's the portion of the continuum where there has been, I think it's fair to say, somewhat uncoordinated care. But this really will force better care in that post-acute space, whether it's home care or in a rehab facility. It's the place where the hospitals also have to focus if they're going to be successful economically in this new reimbursement model.

SCOTT: Just to confirm, you said 50% of the cost is going to be in that post-acute care phase, correct?

DAN: Depending on the nature of the procedure. For example, to contrast hip and knee, with hip replacement surgery, very little rehab is needed. Most people have a hip replacement and kind of rehab themselves at home. They may need some home care, but that's a lot cheaper than having to go to a rehab facility for a week or two, which is more common after knee replacements.

So I would say that that post-acute space is more costly after a knee replacement than a hip, but it's upwards of at least 40% of the entire episode of care.

SCOTT: In terms of economics and the financial risk, there's an entire shift that's happening because of some of these changes, right? That financial risk is shifting now to a different party.

DAN: Right. So one of the issues is that for a healthcare organization, or let's say a hospital, they traditionally have had less control over what happens after discharge. Again, going back to joint replacement, some hospitals, depending on the surgeon, have had pretty free rein in terms of choosing the hardware, so to speak, the prosthesis for the hip or knee. You may have six orthopedic surgeons choose six different brands of hardware at considerable variance in cost. So one of the things hospitals are not doing is negotiating harder on getting the surgeons to agree on using Brand A rather than Brand A, B, C, and D, in order to save money. So there are ways to control costs that hospitals are beginning to exercise.

But the idea of managing that post-acute space, where you may have physical therapists who don't work at the hospital, who are in private practice. You may have a rehab facility that's not necessarily within your system. It's a little harder to control and coordinate the care in the post-acute space. And that's where the information highway, as I like to call it, the Electronic Medical Record, serves as the backbone. Because these so-called handoffs from the hospital to the care facility, or to the home caregivers or to the physical therapist, transferring information and keeping communication open between the surgeon and the therapist after discharge is critical to success in this new reimbursement world.

SCOTT: I can definitely see the importance that health IT would play in solving for some of these care coordination challenges, especially post-procedure. Let's talk about that more specifically. Are there a couple of things that come to mind when we focus on that point of health IT being able to help facilitate or overcome some of these challenges that hospitals and other healthcare providers will encounter through some of these bundling and program changes?

DAN: We'll talk maybe more about some other aspects later, but I think in terms of these models, the information highway is what's going to be the glue that will really hold together

these various components of the episode of care. You have to have all the providers in the loop so that you can track and record data, events, provide practice medical decision support within the hospital, etc.

I mentioned the example of blood clots earlier. There's good evidence-based medicine that needs to be built into a smart EMR that helps clinicians make the right decisions in the hospital to keep those complications down and reduce the length of stay. The length of stay is a critical cost driver.

And then the EMR has to be able to guide the post-acute care, the home care nurses or the rehab directors or providers, in maintaining continuity of care and avoiding errors in those handoffs. The repository of information, whether it's the drugs the patient is on or what the other comorbidities are, whether it's diabetes or hypertension, need to be managed to avoid visits to the ER or re-hospitalization in a worst case scenario. All of these things are really glued together by the EMR.

For example, one of the things that attracted me to Dorsata is that we're kind of a unique information technology company in terms of building very user-friendly interfaces that sit on top of EMRs in order to allow for better clinician engagement. Because one of the things that we certainly have seen in the post-acute space is that some of the documentation requirements are unwieldy and the decision support isn't there. So the EMR has to have a user-friendly interface to engage clinicians to collaborate, to cooperate, and really ensure the best possible outcome.

I think the other thing that I would say is that there's a likelihood of there being a significant role for telemedicine in the post-acute space. There was just a study looking at telemedicine from the standpoint of behavioral health and people discharged after a heart attack. This study showed tremendous benefit in terms of reduced re-hospitalizations, reduced ER visits, and an almost million-dollar savings in cost as a result of those reductions. This was ased solely on a telemedicine intervention in patients who had just been discharged.

So I think telemedicine will be used to help manage the post-acute space increasingly to provide better care, but also to save money. That's going to be critical, obviously, in the new healthcare world.

SCOTT: Dan, before we move on to a couple of these other programs that fit under this bundling umbrella, anything else to add that you think is worthy of mentioning with respect to CCJR, the Comprehensive Care for Joint Replacement program?

DAN: Again, I think the thing is it's mandatory. It's being rolled out across the country. I think there's 67 different geographic areas. It's going to be interesting. It's certainly going to drive better coordination of care between not only hospitals and surgeons, but through the whole post-acute space. I think this, certainly for surgical care, is really where reimbursement and CMS is going. And it's going to be the way this whole concept of value-based care is going to be pursued.

SCOTT: Let's move on to a couple other programs. One is MACRA, the Medicare Access and CHIP Reauthorization Act. Can you cover that, and maybe start out with the two paths to reimbursement for physicians under this new program?

DAN: MACRA is the law that was passed in late 2015, or maybe January of 2016. It really replaces the SRG initiative. Every year, there was a panic in December/January, and Congress had to pass a patch law to fix it. So this is the new law, 900 pages, that really rewrites the reimbursement rules for physicians in American healthcare.

It's really based on three drivers. One is that reimbursement is going to be based on value, not volume – again, it's moving away from the fee-per-service approach to a value-based model. It has a strong emphasis on IT, and the focus shifts from process to performance in regards to IT. And then again, much as the CCJR bundling concept, it really fosters movement towards integrative practice.

MACRA also identifies two paths to reimbursement. There's two ways doctors will be paid, and you'll be in one of these two groups. One is the MIPS, or Merit-Based Incentive Payment System. This program is going to affect about 800,000 doctors. It's estimated 85% to 90% will be under the MIPS model.

The other model, which exists now, is the Advanced Alternative Payment Model, APM. For example, CCJR is an example of this. I think it's fair to say these are pilots, where CMS is saying, "We're going to reorganize care in a patient-centered medical home where there are multiple specialists, physicians, social workers, behavioral specialists, nurses, nurse practitioners, etc. who will provide care to a population of patients." Again, coordinated care, you might say, with the same goals of reduction in cost and improvement in quality.

Since most physicians are not in these pilots, they will be dealing with the MIPS program, which, again, is incentive-based. Essentially, the physicians will be scored in four categories that will determine their reimbursement. One category is related to quality metrics, which is 50% of

the score. An interesting note about MACRA, which is certainly good from the physician's perspective, is that one of the goals is to give physicians some input in the selection of these quality metrics. One of the major complaints of physicians is that there's just so many quality metrics they have to report on, and they differ from payer to payer. So there's an effort to standardize those and reduce the number.

25% of the score is based on what's called Advancing Care Information, or ACI. This is a big change. This program, ACI, replaces Meaningful Use, which has been a program that CMS has had for the last several years to essentially incentivize the adoption of electronic health records in physician practices. And it has succeeded. 80-90% of physician practices now have electronic records. But the program itself was widely discouraged and disliked by physicians. Sometimes Meaningful Use has been called Meaningless Abuse, largely because it focuses so much on process. It really wasn't focused on what clinicians might consider the important outcomes of quality.

And then 15% is on clinical practice. Lastly, improvement activities and costs are 10% of the score.

The big change with MIPS is that it's budget-neutral. It rolls out in 2017, and by 2019, the data will be in and the reimbursement will be adjusted upward or downward by as much as 4%. I think by 2020, it's 7%, which in a Medicare payer environment is a huge amount of money. So there will be winners and losers since the program has to be budget-neutral. Efficient, high quality practices that can provide coordinated care will presumably succeed in this program.

SCOTT: With some of those changes, like the Advancing Care Information Act, as well as the two different reimbursement pathways for physicians, how will that, in your opinion, affect solo or smaller physician practices?

DAN: When this was published a month or so ago, the immediate reaction was a lot of outcry about smaller or solo practices. In the law itself, there is a table from CMS projecting that 87% of solo practices face negative adjustments in reimbursement, totaling up to $300 million. In the document, they're actually predicting that the losers, so to speak, will be the small groups and solo practices.

There's a risk that some physicians will say, "I'm taking early retirement" or "I'm not going to see Medicare patients", or maybe "I'm going to do a concierge practice". This obviously has implications for healthcare delivery, since many solo and smaller groups are in rural areas or underserved areas, and there's a real threat that the access to care could be compromised.

What this program requires and what they need to do is to develop the capability to collect this information. Essentially, it means building and acquiring the technology to meet all the reporting requirements. That's the objection of the smaller practices, that it's expensive and difficult. And there's some truth to that, but if they're going to succeed economically, they need to be able to do that.

That's another area, actually, where I think a company like Dorsata can help with the clinician-smart technology that we're building.

SCOTT: For those interested in learning more about Dorsata, I would presume that you could just direct them to Dorsata.com?

DAN: Correct. Absolutely.

SCOTT: The way I would explain Dorsata – and feel free to step in – is that your technology sort of sits on top of a traditional EMR in order to allow for better clinician engagement. I'm sure everyone that's reading this interview has encountered a healthcare provider that complains about their EMR. I personally have never come across a healthcare provider that's actually enjoyed working with their EMR. That's one of the reasons I think you guys are onto something with Dorsata.

DAN: The Electronic Medical Records, these dinosaur products, are a significant factor in physician burnout. It's very hard to find physicians who are happy working with the medical records. So with Dorsata, we're trying to build a technology that really thinks the way the clinician thinks. You'll have happier and more productive physicians, happier patients, etc.

SCOTT: Sounds very cool, Dan.

So to summarize, I know you're a physician yourself, Dan. You're a healthcare provider. But let's pretend like we're sitting down for dinner, and I'm someone in medtech, maybe a senior level executive at a medtech company, and I want your opinion on what I should do. Are there a couple things that I should consider moving forward in light of some of these major changes, whether it's the CCJR or the MACRA program? Can you give me maybe two or three insights to summarize our conversation?

DAN: I think the first thing is, whether you're a provider or whether you're involved in a healthcare organization, or if you're a manufacturer of healthcare technology or healthcare

hardware, you need to be aware that the bundling of services along the entire continuum of care is really the direction that CMS is taking to reshape care along the lines of value, meaning quality over cost.

From the healthcare organization standpoint, having robust, clinician-friendly, and smart healthcare IT is the glue throughout this process. I think it's critical. I would look at health IT in this whole thing as the backbone of the bundle, really, that ties it together. I think that's really my primary message.

SCOTT: Let's finish off with some rapid fire questions. What's your favorite non-fiction business book?

DAN: I would have to say – and it's not a new book, but it's really relevant to our time. It's Redefining Healthcare by Michael Porter. Michael Porter is a Harvard professor and economist, whose book really embodies the elements of the whole evolution in healthcare redesign. Many of his concepts have been adopted in the Affordable Care Act, have been adopted by CMS, and it's really a very important book from the standpoint of the business of healthcare.

SCOTT: Second question, is there a business leader that you're following right now, or one that is inspiring to you?

DAN: As you know, I was at the Cleveland Clinic for more than 30 years, and I would say that the business leader that I would reference is actually Toby Cosgrove, who was and is the CEO at the Cleveland Clinic. He's a heart surgeon who became CEO maybe 10 years ago. Really an amazingly insightful and innovative CEO. Visionary. I think from a health IT standpoint, he was several years ahead of the game.

Toby, just to give you a brief example, several years ago recognized that access to care was a big problem. Not that that's a new idea, but his answer was somewhat disruptive. At the Cleveland Clinic, this huge organization where people sometimes were waiting two, three months for an appointment, he basically said, literally almost overnight, "We're going to offer same-day appointments. If you call the Cleveland Clinic before noon, you get seen that day." He said "This is the way it's going to be, and make it happen."

I can tell you from my perspective, a lot of people said, "What? That's impossible. We can't do that. How are we going to do this?" But the bottom line is I think the last time I heard, there were more than a million same-day appointments scheduled since he instituted this a couple years ago. He's just a very out-of-the-box, savvy, innovative CEO.

SCOTT: That's great. I think most people are probably familiar with him in name only, but that anecdote that you just shared is pretty cool. It gives us a better feel for his style in terms of running the Cleveland Clinic.

Last question for you, Dan, is when you think about your career in healthcare, if you had the opportunity to use a time machine and rewind the clock, is there a piece of advice that you'd tell your 30 or 40-year-old self?

DAN: When I reflect on a question like that, I think about my own career. I started out as a board-certified internist, a rheumatologist practicing arthritis care, probably about when I was 30 or 32, and then an opportunity came along. I was asked to become involved in nonsurgical spine care. That led to becoming the Director of the Center for Spine Health at the Cleveland Clinic until I left. I did that for 15, 20 years.

And then in the last five or six years at the clinic, I was basically asked – because to some degree, nobody else wanted to do it – to become involved in building care paths, which is kind of what we're talking about. Building a clinical pathway and then enabling it in the EMR. So I got into the health IT area that way.

What I would say, the advice I'd give reflecting on all that, I'd say you just have to be open to change and opportunity. Be flexible. Because I would have never guessed 30 plus years ago that I'd be working for a health IT startup as I am now. It was really a matter of being flexible, willing to take on challenges and not be locked in a box. I think that's probably the best advice I would give myself.

SCOTT: That's good stuff. I can't thank you enough, Dan, for coming on the program.