

21st Century Health Care Politics and the Challenges They Pose for Pediatric Academic Medicine


2015 NASPGHAN Annual Meeting

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

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agrover@aamc.org
[@AtulGroverMD](https://twitter.com/AtulGroverMD)

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Overview:



- Health Care Is a Huge Part of the Economy; Budget Politics Drive Reform.
- Health Care Reform Is Focused on Elderly, Medicare; Not Kids.
- But It Can Have Big Impact on Kids and Their Providers.


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First, who we are...

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**AAMC:
Medical 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.

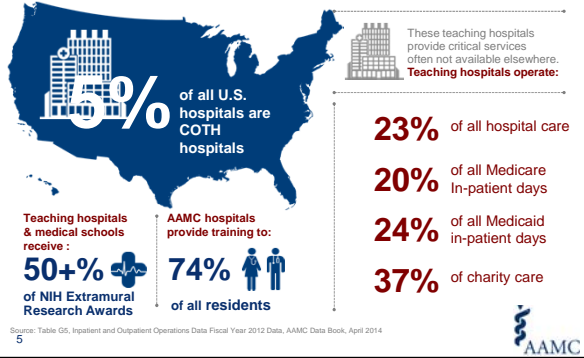
- **Over 300,000 "Voices:"**
 - **141,000** faculty members.
 - ✓ Clinical and basic science (research) faculty.
 - ✓ Staff the physician practice groups and hospitals.
 - **83,000** medical students.
 - **115,000** residents.

4

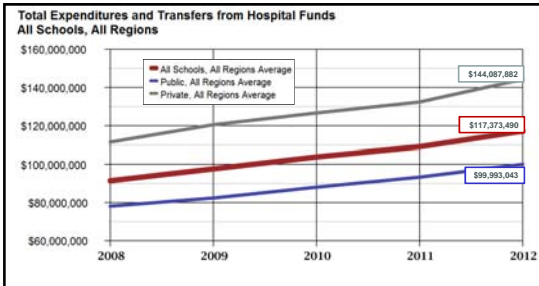
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**Academic Medicine: Disproportionate
Provider of Patient Care, Research, Training**



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

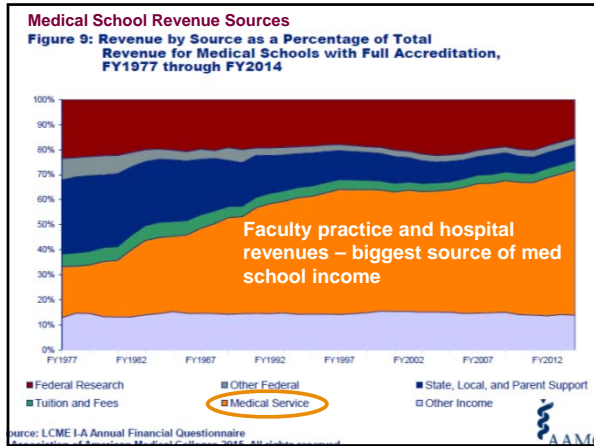


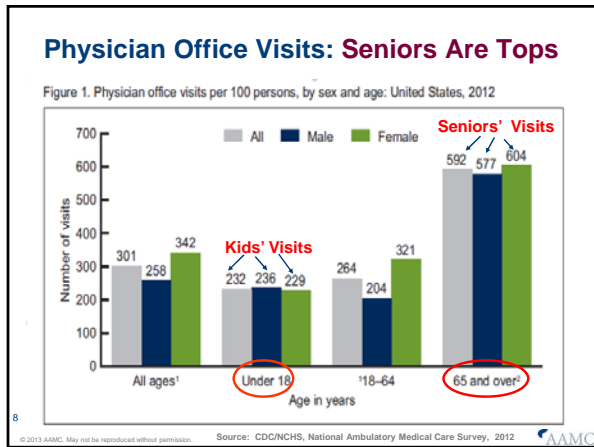
Expenditures and transfers are the same. These funds include payments for services provided to hospitals and clinics by medical school faculty and staff, payments to house staff, and strategic investments in the medical plan.

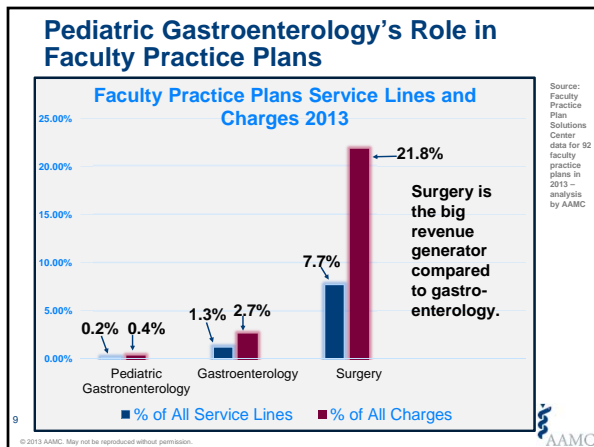
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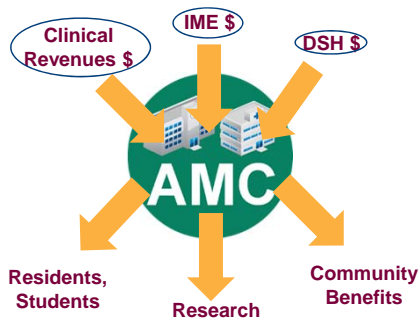








AMC Missions Rely on Multiple Revenue Streams; Revenue Cut → Mission Cuts



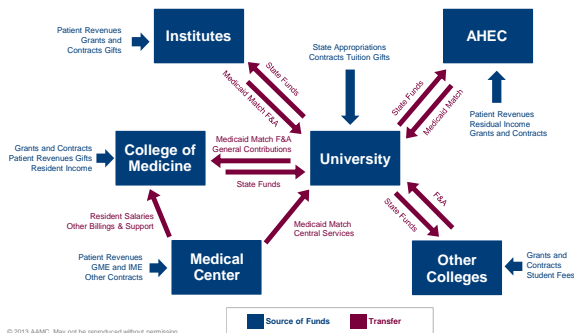
10

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Context: All Funds Flow Constructs Are Different

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



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Health Care: Huge Part of National Economy

It accounts for 17+% of the US economy.

- It's one of the nation's biggest industries, biggest employers, and fastest growing.

It's a major annual expenditure for most people.

- It's the leading cause of personal bankruptcy.

It's close to the largest federal government expenditure.

- It's first or second largest for state governments.

As a result, health care = focus of budget politics.

Source: National Health Expenditures Survey 2013
<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

12

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Pediatric Health Care: Just a Small Part of US Health Care Economy

In 2010, children accounted for:

- 13% of total personal health care spending
- Almost 0% of Medicare spending
- 14.6% of private insurance spending
- 23% of Medicaid spending, 1/2 of Medicaid recipients

Children are not the focus of budget politics or health reform but caught up in it as bystanders

Source: National Health Expenditures Survey 2013
<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

13

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ACA, Other Health Reforms:

Focused Mostly on Medicare, Elderly

- ACOs
- Bundled Payments
- P4P,
- SGR Fix

14

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ACA Drives Pop. Health Reform: ACOs

There = over 625 public or 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 to reward:

- **Better quality of care at lower cost for individuals plus improved population health.**

15

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

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.

16

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 Payments - 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.

17

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 (P4P): Hospital, Physician Payment Reforms

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

- Poor quality + high earn reduced payment.

Hospital examples:

- Payments linked to VBP, HACs, readmission rates.

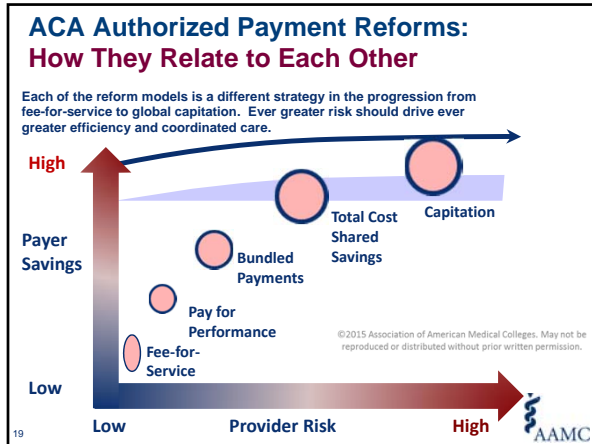
Physician examples:

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

18

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What We've Learned Thus Far:



- ACA Reforms = Works in Progress.
- SGR Reforms Still 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 the 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.

21

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 in.

22 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 - 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?

23 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 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.

24 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.

25

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What We've Learned from Other Medicare Reforms: E.g. – Payments Tied to 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.
- Only 17% of all non-teaching hospitals.

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

Hospitals accredited by Joint Commission scored worse.

- More likely to be penalized than unaccredited hospitals 24% vs. 4%.

Source: Karl Y. Bilimoria, MD, MS 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.

26

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

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?
- 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?

27

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A Top AAMC Concern in All Health Reform: 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.
- Creates perverse incentives to avoid high-risk patients.

28

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To State What Is Obvious to You But Not to Others:

These Health Reforms Are Not
Focused on Kids.

But Kids Are Not Little Adults.

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Health Care Reform as Defined by ACA Has Many Benefits for Children

- **Expands coverage for kids, including kids with chronic and catastrophic conditions.**
 - No pre-existing conditions, no life-time maximums.
- Subsidizes state expansions of Medicaid - biggest payer of kids' health care.
- Reauthorized CHIP with guaranteed funding; has been extended until 2017.
- Establishes funding for pediatric quality measurement, authorizes pediatric demo.
 - **However, no money for demo.**

30

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But Health Care Reform Is Also Different for Children & Their Providers

Unlike adults, before ACA, most kids already insured, thanks to Medicaid expansions, CHIP.

- 2009: 8.6% of kids = uninsured; 18.2% non-elderly adults.
- 2013: 7.1% of kids = uninsured; 20.3% non-elderly adults.

40 - 50% of kids = now covered by Medicaid/CHIP depending on how you count them.

- Medicaid pays for 60% of all kids' ER visits; 56% of kids inpatient care.

Together, 50 state Medicaid programs = single biggest payer of health care, particularly for kids with special needs.

31

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But Health Care Reform Is Also Different for Children & Their Providers

Health reform of delivery and payment for kids = driven less by ACA and more by other factors

- **Unintended consequences of ACA, Medicare** reforms applied to kids, regardless of whether they fit.
- **Medicaid reforms** undertaken at the state level, including reforms focused on kids.
- **Private sector pediatric provider reform** initiatives.

32

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Examples of Unintended ACA Reform Issues for Children

- The "**Family Glitch**" makes it harder for families with children to qualify for subsidies for coverage.
- The focus of exchanges on **narrow networks** can exclude pediatric subspecialists, hospitals.
- Interpretations of "**essential benefits**" do not always address unique benefits for children with special needs.
- Congress didn't renew Medicare **floor for Medicaid payment for kids' primary care, which expired.**
 - **Medicaid = often very poor payer** of kids' care.
- **Private insurers, Medicaid** programs often **follow Medicare's lead** in adopting payment models.

33

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Examples of Unintended ACA Reform Issues for Children

ACOs could set per capita rates, outcomes measures based on adult care.

- Long history of payers using Medicare payments rates, only gradually adjusting for kids. E.g., DRGs.

Risk of reforms not adjusted for socio-economic status of patients – kids' providers vulnerable.

- 22% of children live in families below poverty level.

Evaluations of ACA, Medicare reforms not conclusive, too soon.

- But pose risks for patients of academic medicine, kids.

34

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Examples of Federal Health Reform for Kids: Primarily CHIP, CMMI Funded

ACA Title II, Subtitle I, § 2706 Pediatric ACO Demonstration Project, Authorized but no \$.

CHIPRA Sec. 401(b) Pediatric Quality Measures

- Authorized development, updating of core pediatric measures for voluntary state reporting, other purposes.
- CMS' 2015 Recommended Pediatric Core Measures = part of the agency's Clinical Quality Measures = released 12/20/14.
- CHIPRA also created Pediatric EHR Project, centers of excellence to produce pediatric measures, other initiatives.

ACA created CMMI - big bucks. Some awards for pediatric initiatives on care management.

35

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Example of Private Sector Pediatric Reform

"Children's Hospitals' Solutions for Patient Safety National Children's Network" - partly CMMI funded

- 80+ children's hospitals collaborate to improve quality of care

Results as of 2014:

- 81% reduction in falls
- 25% reduction in CA-UTI
- 7% reduction in readmissions

2015-16 goals:

- 40% reduction in HACs
- 10% reduction in readmissions
- 25% reduction in serious safety events (SSEs)

36

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Medicaid Has Long Been the Big Focus for Delivery, Financing Reform for Kids

Children = half of all Medicaid recipients.

Over 20 years, states have been more aggressive in adopting managed care than Medicare has.

- Most states – 37 – outsource all or part of Medicaid programs to managed care companies.
- 71% of all kids in Medicaid enrolled in managed care – 20+ million kids, including kids with special needs.
- 30% of all seniors in Medicare enrolled in managed care – about 15+ million seniors.

37

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Medicaid Has Long Been the Big Focus for Delivery, Financing Reform for Kids

Examples of state Medicaid reform initiatives according to National Governors Association:

- Medical/health homes
- Quality-based payment incentives
- Bundled payments for episodes of care
- ACOs

National Governors Association, 2013

Effect of Provider Payment Reforms on Maternal and Child Health Services

http://www.nga.org/files/live/sites/NGA/files/pdf/2013/1305_Effect_of_Provider_Payment_Reforms_Paper.pdf

38

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What We've Learned from Medicaid Reforms

"Early experience suggests that **payment reform policies** designed for the general patient population or adults with chronic illnesses **may need to be tailored to fully address maternal and child health...priorities**, particularly to ensure appropriate care for vulnerable populations such as children with special health care needs..."

National Governors Association, 2013

Effect of Provider Payment Reforms on Maternal and Child Health Services

39

http://www.nga.org/files/live/sites/NGA/files/pdf/2013/1305_Effect_of_Provider_Payment_Reforms_Paper.pdf

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What We've Learned from Medicaid Reforms

"It is hard to generalize with any certainty about the impact of Medicaid managed care on costs, access or quality. The uncertainty is due in large part to the extraordinary variation in Medicaid managed care initiatives..."

Michael Sparer, Mailman School of Public Health, Columbia University
 Medicaid Managed Care: Costs, quality, and access to care
 The Robert Wood Johnson Foundation September 2012

<http://www.rwjf.org/content/dam/farm/reports/reports/2012rwjf201106>

40

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What = Health Reform Issues for Medical Faculty of AMCs?

Health care reform poses challenges for AMCs that put pressure on faculty practice plans:

- ACA cuts in Medicare, DSH payments to hospitals.
- GME financing reforms that could significantly reduce Medicare GME support to teaching hospitals.
- Medicare patient care payment reforms could significantly affect teaching hospitals – HACs, readmissions.
- CMS does not risk adjust any of these reforms, which disadvantages academic centers.
- MIPS and APMs = big change in Medicare payment.

Advocacy critical; AAMC and AMCs learning, leading.

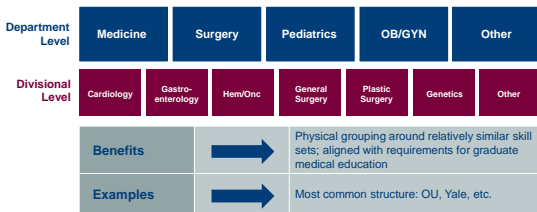
41

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Recalibrating the Clinical Enterprise

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



Source: Kurt Salmon, September 12, 2014

42

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Linking Performance to Reward

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	<ul style="list-style-type: none"> Meet budget Enhance school reputation Support academic pursuits 	<ul style="list-style-type: none"> Fund departments Grow-reserves 	<ul style="list-style-type: none"> Underperforming departments often get the bulk of support, not those with highest upside
COM Chairs	<ul style="list-style-type: none"> Meet budget Support academic pursuits Grow clinical programs Attract excellent faculty Train future leaders 	<ul style="list-style-type: none"> Grow departmental revenues/collections Encourage faculty efforts in high RVU pursuits Grow reserves 	<ul style="list-style-type: none"> Low RVU efforts (e.g., clinics) not emphasized Limited incentives for service quality Multidisciplinary initiatives hard to coordinate
Faculty	<ul style="list-style-type: none"> Generate wRVUs Generate grant dollars Meet teaching objectives 	<ul style="list-style-type: none"> Maximize activity that leads to high collections Hoard block time to maximize revenue opportunity 	<ul style="list-style-type: none"> Spend less time on non-or low RVU generating activities (clinic time, teaching, research) Limited incentive to collaborate

Source: Kurt Salmon, September 12, 2014



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Recalibrating the Clinical Enterprise

Program Development Committee

- Department Chair Co-Leads: Medical, Surgical, Pediatrics, etc.
- Other Department/Division Leadership (Pathology, Radiology, Pulmonology, etc.)



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

Bottom-line for Pediatric Gastroenterology in Practice and in Academia

ACA has rewards for children and their families in coverage, benefits.

But it poses many challenges for academic medicine overall, including pediatrics.

- Financial pressures on AMCs trickle down to press on need for faculty to generate income.
 - Can take time, resources away from research, training.
- Narrow networks, inappropriate outcomes measures, no risk adjustment can press down on physician payment.

45



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In Conclusion



- Health Care Reform Helps Kids.
- But Poses Challenges, Too, Because Most Reforms = Focused on Seniors.
- Pediatric Leadership Is Critical – ACA, Medicare, Medicaid, private sector.

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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

47
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