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# Value Based Healthcare: The Missing Formula for Quality Patient Care

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Value Based Healthcare: The Missing Formula for Quality Patient Care

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OCTOBER 30, 2018

APRIL TAPSCOTT

Murray State University

**FIELD OF STUDY  
PROJECT APPROVAL**

I hereby recommend that the project prepared under my supervision by

\_\_April Tapscott,

entitled \_\_Value Based Healthcare: The Missing Formula for Quality Patient Care, be

accepted in partial fulfillment of the requirements for the degree of

Bachelor of Integrated Sciences: Human Resource Management.

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BIS 437 Senior Project Faculty Adviser Signature

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BIS 437 Instructor Signature

## Abstract

Value Based Care is driving the need to balance value with cost. Health care organizations must address the value component as part of the patient care experience. Reimbursements to physicians and healthcare organizations are the focus on delivering value care to the patient while keeping costs down for the insurance company and overhead for the organizations. Health care providers face challenges on how to connect ethics, patient safety, and decision making to quality of care for each individual patient. Insurance companies are looking at the volume of people, how many episodes of care for each condition, how many providers for each separate condition, and finding the lowest cost for highest quality of care the patient can experience. Creating, testing and implementing new policies and procedures is what the leading insurance companies are currently doing to make Value Based Care a reality in the United States Healthcare System. This paper will focus on the integration of value, cost, and customer satisfaction with patient care delivery.

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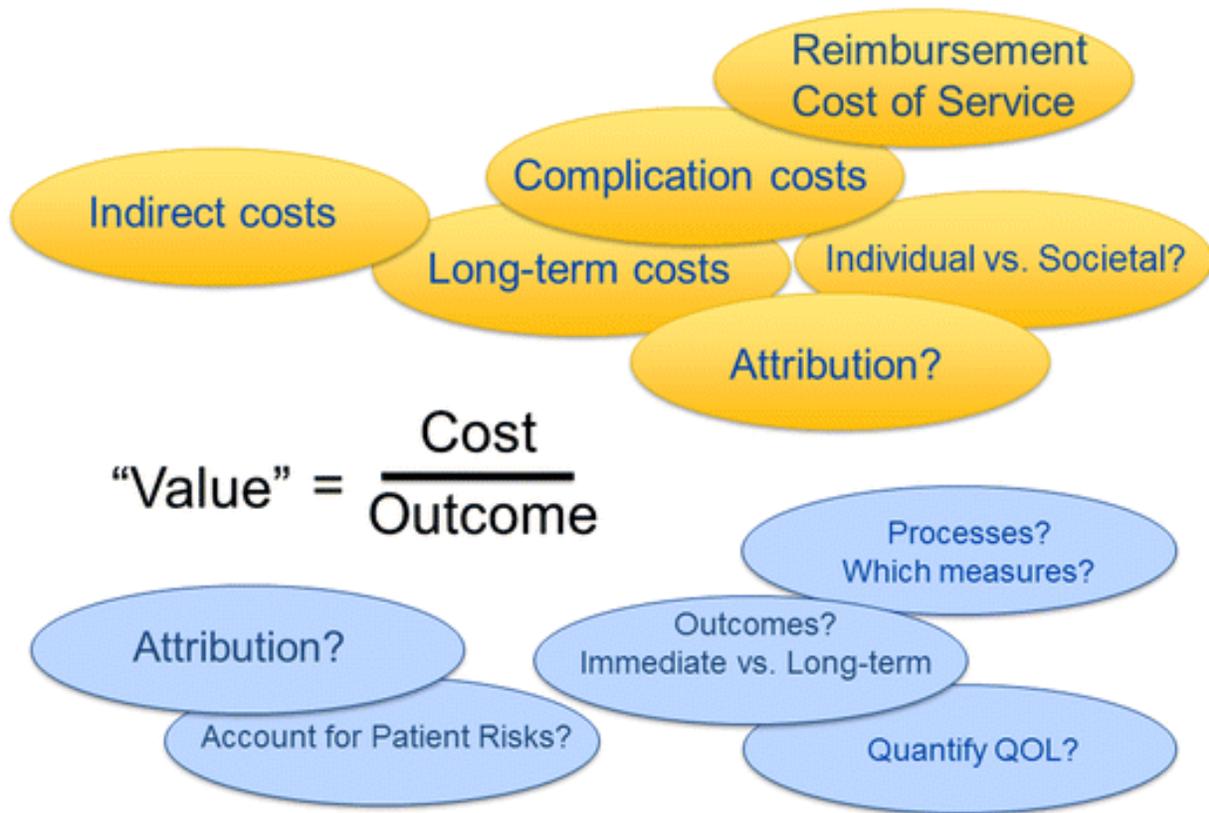
## Introduction

Value Based Healthcare Delivery System is a newer model being slowly adopted in the United States in all healthcare facilities. One of the biggest insurance companies, Centers for Medicare and Medicaid Services (CMS) is the driving force behind health care change. The well-established model of a fee for service visit will transition to a newer fee for value model in an attempt to better align reimbursement to the medical services rendered. Value Based Healthcare Model focuses on caring for patients in a successful treatment plan. Whether it is bundling services, increasing communication between patients and healthcare team, educating the patient so they are more compliant during treatment plan or the healthcare team is in constant communication for what is best to achieve the preventative based care approach.

### Fee for Service vs Value Based Care

According to the website Healthinsurance.org, the definition of fee for service is “it is a system of health insurance payment in which a doctor or other healthcare provider is paid a fee for each particular service rendered. Essentially rewarding the medical provider(s) for volume of services provided regardless of outcome or success of treating the patient.” (Healthinsurance, 2018)

The illustration below shows a representation of what value based care is defined as. Value is equal to quality over cost, or high quality of patient care over decreased costs. Showing there are multiple components that make this term value based healthcare complex in every area. There is not just one explanation or one approach that can be made to incorporate this into the United States Healthcare System. Ray and Kusumoto, authors of the article “The Transition to Value Based Care” state that “over the last 50 years, the United States healthcare system has increased its spending by 800% while the gross domestic product has increased by 170% in this same period.” (Ray, J.C., & Kusumoto, I.J., 2016) Making it difficult to define one certain item as the cause to drive down the cost and improve patient quality.



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(Ray, J.C., & Kusumoto, I.J., 2016)

The overall complete health outcome would no longer focus on the broken down parts of a treatment plan that lead to uncompliant patients and staff that ultimately leaves the patient in a chronic pattern of doctors’ visits, unnecessary hospital or emergency room visits with more diagnostic tests. Therefore, the healthcare team focuses on quality and patient engagement with education value based care instead of quantity of patients being seen daily. When a healthcare organization changes its goals to deliver a value based treatment, its success will be the bottom line in numbers and patients’ health improving. Shifting from the number of patients being seen daily to the value it delivers to each patient a shift will take place. The shift will have an upward increase showing amount of value delivered will directly correspond with the more money the organizations receive to decrease overall costs.

The delivery model currently is set up (fee for service) that each provider who sees or treats the patient is paid regardless of outcome of patient's health. It was a good approach when healthcare was first set up. Patients saw usually one or two doctors if there was a specific problem and treatment was rendered successful. Initially when health care was enacted a treatment successfully rendered meant the patient was compliant in the treatment plan, it was handled in a reasonable amount of time and costs were down due to not having so many providers treating at the same time. Providers were then rewarded with reimbursement checks from the insurance company. Over time the healthcare system has grown in types of specialists, types of technology used to treatment illnesses, price gouging, insurance fraud and patients not getting better from illnesses that are turning into chronic or lifelong diseases. Therefore, the healthcare system is being used and abused by patients, providers, and organization. A call to action for change was presented to help decrease the overall cost of healthcare to all parties.

The value based healthcare model is based solely on physicians and healthcare organizations effort to improve a patients' wellbeing. The new model will place reimbursement rates to the organization on an improved outcome of the patient. In that event, if the patient improves in health or the physician eliminates a chronic disease the patient satisfaction of their experience in the treatment plan score increases. This model is not based on how much money an organization or doctor can receive each time they see or treat a patient, it is forcing them to treat in the best way possible with the lowest costs possible. (Porter, 2015)

Basic definitions that are involved with Value Based Care principles are found on many different website, articles and insurance companies defining it to their own standards. A Medicare Advocacy website defines quality of care as

“the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. What this really means is that each individual consumer should receive the best possible health care available every time services are needed. Health care providers should provide care that meets the needs of each individual patient, including the use of appropriate advances in medical technology. Health care should also be non-discriminatory, providing the same quality of service regardless of race, ethnicity, age, sex or health status. (CMA, 2018)

The article “What is Value Based Healthcare” states value is “derived from measuring health outcomes against the cost of delivering the outcomes. (NEJM Catalyst, 2017) On the website SearchHealthIT, authors Margaret Rouse and Tayla Holman state “definition of value based healthcare, also known as value-based care, is a payment model that rewards healthcare providers for providing care to patients. Under this approach, providers seek to achieve the triple aim of providing care for patients and better health for populations at a lower cost.” (Rouse, M. & Holman, T. , 2018) In the article “The Strategy That Will Fix Healthcare” authors Michael Porter and Thomas Lee explain how the true costs of

“health care providers come under increasing pressure to lower costs and report outcomes, the existing systems are wholly inadequate. Existing costing systems are fine for overall department budgeting, but they provide only crude and misleading estimates of actual costs of service for individual patients and conditions. To determine value, providers must measure costs at the medical condition level, tracking the expenses involved in treating the condition over the full cycle of care. This requires understanding the resources used in a patients care including personal, equipment, and facilities; the

capacity costs of supplying each resource; and the support costs associated with care, such as IT and administration. Then the cost of caring for a condition can be compared with the outcomes achieved.” (Porter, M., & Lee, T., 2013)

Comparing Patient centered care and value based care, authors Eric Tseng and Lisa Hicks, state “patient centered care addresses multiple dimensions of patient care including patient preference, emotional support, physical comfort, information, and family and friends, and access to care.” (Tseng, E.K., & Hicks, L.K., 2016)

### ***Medicare and Medicaid Services***

There is no model that is sufficient in scale, size, volume, or experience existing for the United States healthcare industry. James Robert Cimasi states in his book on page 16, “Medicare is the largest single purchaser of healthcare and what they do other insurance companies tend to follow. CMS is the single largest purchaser of healthcare and has the biggest base of beneficiaries.” (Cimasi, 2013) It provides the means to achieving price reform to be used for future reimbursement models. In 2010, Obama Administration implemented the Affordable Care Act and put Medicare and Medicaid at the forefront of reform by putting them in charge to test new payment systems. Author Rick Mayes, explains in the Journal of Health Service Research and Policy stating

“Among others, these new systems will include: bundled payments for episodes of care, global or capitated payments, and blended versions of these and other salaried approaches. Under these new models, payments will go not to individual providers, but to larger specialty group practices (e.g., Marshfield Clinic), integrated delivery systems (e.g., Group Health Cooperative of Puget Sound), and virtual physician organizations

(e.g., Community Care of North Carolina).<sup>19</sup> Medicare does not need extensive payment reform that affects all of its 46 million plus beneficiaries in order to slow the rate of expenditure growth and drive delivery system improvements. Just 20% of the programme's beneficiaries—those with five or more chronic conditions—account for two-thirds of the programme's expenditures, while 5% of Medicare beneficiaries account for almost 45% of programme spending.<sup>20</sup> Annually, this small minority of very ill Medicare beneficiaries sees nearly 15 separate physicians, makes 40 office visits, and fills 50 prescriptions.” (Mayes, 2011)

There are many definitions and summaries of Value Based Healthcare out there. In summary it is to provide an incentive to healthcare providers to treat the patient as a whole, to provide better care plans, improve the patients' overall health at a lower cost. Providers are encouraged to keep patients healthy or a population as a whole healthy which in turn lowers overall costs. Medicare and Medicaid label value based healthcare as value based programs. According to the website for the Centers for Medicare and Medicaid Services (CMS) it explains “value based programs have a three-part aim which are identified as:

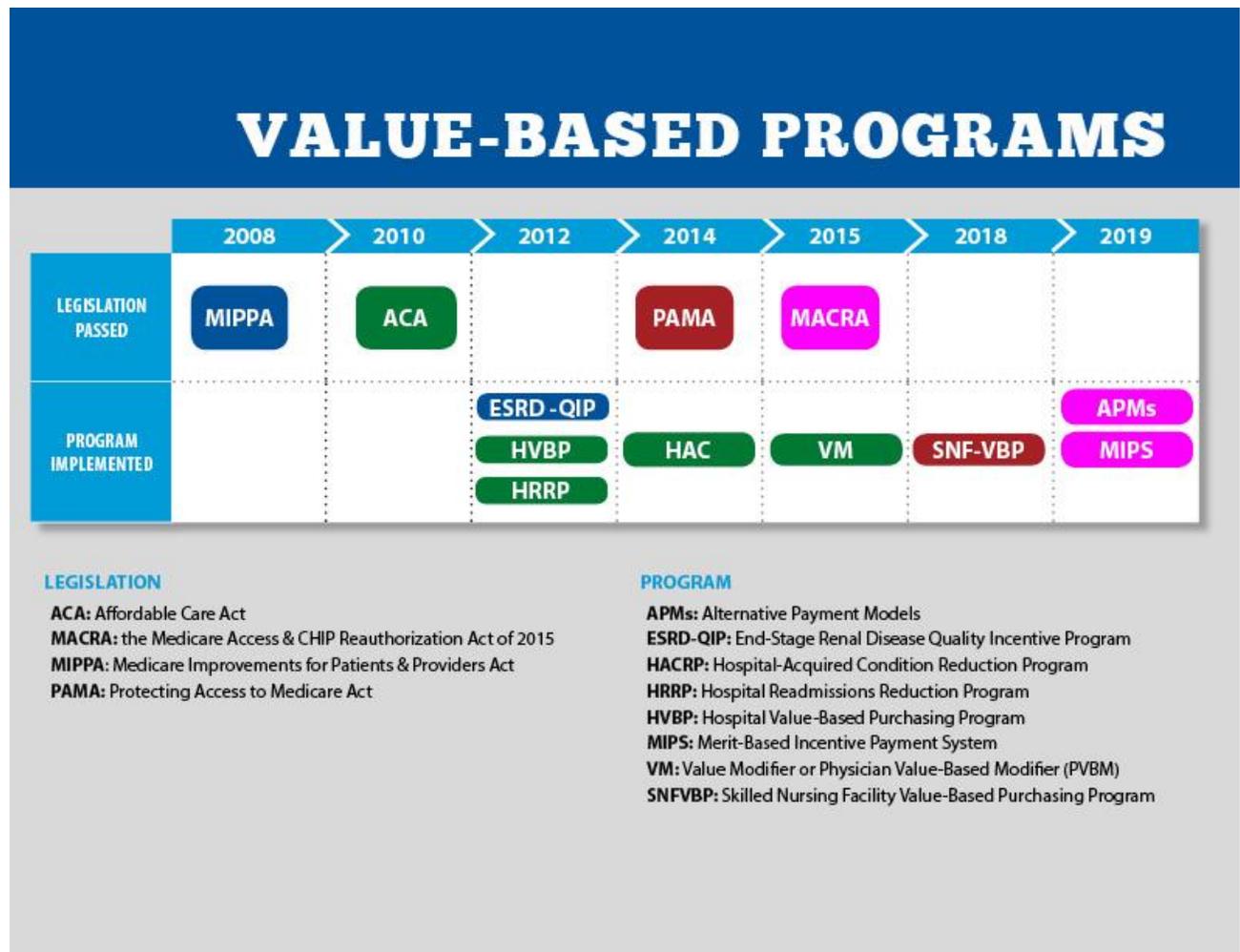
- 1) Better care for individuals
- 2) Better health for populations
- 3) Lower cost” (Centers for Medicare and Medicaid, 2018)

CMS also lists “five original value based programs on their website as the following:

- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital Value-Based Purchasing (HVBP) Program
- Hospital Readmission Reduction (HRR) Program

- Value Modifier (VM) Program (also called the Physician Value-Based Modifier or PVBM)
- Hospital Acquired Conditions (HAC) Reduction Program
- Skilled Nursing Facility Value-Based Program (SNFVBP)
- Home Health Value Based Program (HHVBP)” (U.S. Centers for Medicare and Medicaid Services, 2018)

Implementing Value Based Healthcare into hospitals and doctors’ offices will take time. Legislation, laws, bills, policies all have to be updated, created or passed in order for it to go into practice in our healthcare facilities. CMS has been the leader in creating new policies, implementing them and getting bills passed in Congress. The chart below explains the efforts CMS has made this far in moving towards a value based healthcare system. Starting in 2008 MIDDAs were passed but not implemented yet. In 2010, ACA was passed, and the programs implemented in ACA were over the years 2012 to present. In 2014, PAMA was passed and 2015 MACRA was passed but legislation can take years to implement them into a working program for organizations to use properly.



CMS used the Acts in place currently to create new programs to deliver home care models to different areas of healthcare. Starting out in small sectors of care, to do trial runs of programs, collect data and improve upon the programs before introducing it into the mainstream of healthcare institutions.

Shifting from a Fee for Service to a Value Based Service from a strategic approach in healthcare could work with some thought and planning. The healthcare team coming up with a plan to re-organize care around each patient’s condition. Such as a patient with diabetes; you would begin to look at how to bundle services, including primary care physician with specialist, medications, testing equipment, laboratory services plus any outpatient services or surgery

required. You begin to look for ways to bundle services into a one fee package that has distinct patient segments for care.

There are multiple payment models Medicare has used to test pilot programs in transitioning into value based care. Stated in the article, “The Transition to Value-Based Care” it is explained the many different types of payment models that are offered such as:

“Under MACRA there are two different payment models offered:

Merit Based Incentive Payment System: (MIPS): a fee for service model with addition of a value based modifier dependent on quality parameters.

Alternative Payment Models (APM): alternative payment model which continues the trend initiated by the ACA for further exploration of different methods for paying for care other than fee for service.

The other payment models that served as the pilot programs are:

Accountable Care Organization: a network of healthcare providers and hospitals are paid on the bases of the health for a defined population.

Bundled payments: multiple providers and a hospital are given a single payment for an episode of care.

Pay for Performance: providers are reimbursed for meeting predefined quality metrics.

Patient centered medical homes: incorporates multiple models but all emphasize integrated and coordinated care through a primary physician.

Other payment models that have resulted from the restructuring of healthcare to value based care are:

Pay for Coordination: this goes one step beyond fee for service, it coordinates the care with physician, specialist and other members of the patients care team.

Pay for Performance: also known as Value based purchasing. This is based on a payment correlated too achievable defined and measured goals. That are related to the patients' experiences, outcome, and resources used for care. (Ray, J.C., & Kusumoto, I.J., 2016)

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) passed legislation making changes to the way reimbursement was given to physicians from the government. The biggest change would be reimbursement would no longer be based on quantity. In the article, "How Value Based Medicare Payments Exacerbates Healthcare Disparities", the author Rubin explains "Medicare would assess the quality, value and results of care physicians provided to their beneficiaries and reward top performers while penalizing the worst." (Rubin, 2018) An issue not being accounted for is measuring the differences in patient's socioeconomic status or individuals' health status in each city. There isn't enough data or quality measures to sort out in patient populations, socioeconomic status and high/low risk patients. One main issue under MACRA is the physician treating poor or sickly patients are scoring lower on star ratings due to the correct pay for performance system therefor they never hit bonuses. In 2020, a new program will be implemented to fix this issue called MIPS (Merit Based Incentive Payment System). MIPS will look at each patient eligible for Medicaid and adjust payments this way. (Rubin, 2018)

Healthcare costs play a different role in the government or political arena compared to an individual's healthcare costs. Politics mostly argue about who or what should be covered or how much money is allotted to the condition or about the Affordable Care Act. Addressing the cost

of medicine and pharmaceuticals is one thing Capitol Hill is in agreement on, but how it is to get done is the debate.

### *Medicare and Pharmacy*

Pharmacies in the United States are all learning new ways to educate their customers. New rules and regulations are stating the pharmacists are the leaders in getting patients to comply with treatment plans. (i.e., taking their medications on time each month for successful treatment of illness). CMS is using local pharmacists to implement “medication optimization” to potentially save billions of dollars in lowering healthcare costs and improving quality of patients’ lives. Pharmacists are now looking in their computer database, for patients that have not only a controlled pain drug but also taking a medication for a chronic disease.

An example I came across involves a pharmacist calling the patient to inform them of the new regulations that are being rolled out regarding medications, patient compliance, physician, and pharmacy rules and regulations now.

Pharmacist: “I see you have been filling your pain medication every thirty days but chose to pick up your blood pressure medication every 40 to 45 days.”

Patient: “I take my pain medication every day, but I miss some of my doses of my blood pressure medication because I do not like the way it makes me feel.”

Pharmacist: “I can understand that; you need to speak to your doctor about how the blood pressure medication makes you feel. It is important for your health to take the medication as prescribed so you do not have additional health issue. You don’t want to end up in the hospital for an unnecessary visit, do you? But I am now required by law to inform you that if you do not

start to pick up your blood pressure medication every thirty days along with your pain medication, Medicare can stop the payment on both of the medicines because you are non-compliant with the treatment plan. They can also go a step further and penalize your doctor, which will cause you to have to change doctors and you might be asked to change pharmacies also. We all are penalized if you do not pick up both medications as prescribed.”

Pharmacist now educates the patient about staying in compliance with treatment plan, doctors’ orders, explaining the importance of taking their medicines exactly the way it is prescribed and if she chooses not to comply then she cannot only lose her prescription coverage for the drug but also might have to find a new doctor and pharmacy for not being in compliance with treatment.

Although empowering a patient is more favorable in a treatment plan, sometimes telling the truth has more impact. Patients are aware they need to take their medicine, or they could go back to hospital, be admitted for their disease, or go back to the doctor’s office. Another type of professional such as a pharmacist states "look you will lose far more than just a day at the healthcare facility, you could lose your doctor and pharmacy," can be the exact reason why they will start to be in compliance with treatment plans.

Questioning at the doctors’ visits is a must, this is a first line in patient education, finding out if the patient is sharing medications or if they can financially afford the prescribed medication. In the table below, a list of common, easy to answer questions can be asked at doctors’ appointments or when a patient calls to ask for a refill on their medication without a doctor’s appointment.

**TABLE 2. Questions a Clinician Can Ask to Assess a Patient's Medication Adherence**

---

I know it must be difficult to take all your medications regularly. How often do you miss taking them?<sup>3</sup>

Of the medications prescribed to you, which ones are you taking?

Of the medications you listed, which ones are you taking?

Have you had to stop any of your medications for any reason?

How often do you not take medication X? (address each medication individually)

When was the last time you took medication X? (address each medication individually)

Have you noticed any adverse effects from your medications?

---

(Brown, M.T., & Bussell J.K., 2011)

This assessment of a Medicare beneficiary is pivotal when the average Medicare beneficiary can see two separate primary care doctors and multiple specialists for their health. Coordinating and having an open communication channel between several physicians is a must especially when a patient only retains approximately 50% of information while being seen. Implementing care teams for each patient would help physicians, pharmacists, specialists, and patients have a common goal, a place where questions would be answered simply, and a treatment plan that holds the patient accountable. In the article, "Value Based Care and Patient Centered Care: Divergent or Complementary?" lists six elements to high quality healthcare being "safety, efficacy, patient centeredness, timeliness, efficiency and equity." (Tseng, E.K., & Hicks, L.K., 2016)

A patients' healthcare team should originate out of the Primary Care Physicians office (PCPs). A person from this office connects the PCP, specialists, pharmacy, diagnostic, patient, and technology then coordinates the treatment plan. Whether it is preventive, chronic or acute diagnosis all the information for care is delivered on time. The success of treatment for each patient is by identifying that each patient is different, some are high or low risk, poor or good health, proactive or non-compliant. The first step for the team member is to identify which the patient is and form an individual plan. Then the healthcare team will then lead each patient through the feelings of overwhelming or stuck by educating them. Through the education, they can begin to feel they can do something about their own health (be proactive) to gaining confidence and start to act in such a way of being their own advocate in their treatment plan.

Medicare is currently leading the way in this area of pharmaceuticals by flagging Medicare patients in the database. The database that is used is called Medicare Advantage Prescription Drug Plan. Flagging them under the criteria of how many prescriptions are they currently taking, are they picking up all of them every 30 days (being in compliance), and correlating that with physician visits for improvement in the disease. For example, if a patient is taking a pain medication with blood pressure medication and is only picking up the pain medication every 30 days and not the blood pressure medication every 30 days. The patient is flagged in the pharmacy database, the pharmacist is to call the patient and educate them about the medication, why it is important for them to take it as the doctor prescribed. To encourage patient to call doctor if there is an issue so it can be corrected such as financially unable to pay or unwanted side effects. If the patient is still non-compliant then it is explained that Medicare will decrease their payment not only of cost out of pocket for patient, but it affects the star rating of the pharmacy, and the doctor's office since the quality of care has not improved, the patient is

not compliant with treatment plan. On I-Medicare website, it states the number one reason why people do not take their medication is education about why it is important for them to do so. CMS now believes it becomes the pharmacists, and their staffs' responsibility to educate the patient, explaining with the new value care based system being launched if they do not wish to take their medication the pharmacy has the right to not fill the medications anymore. (Gutherie, 2014)

In 2014, the Pennsylvania Project a large scale project was formed with pharmacists evaluating how the overall impact could or could not have for patient adherence for the five most common medication classes most prevalent within Medicare and Medicaid patients take. Medicare believes that pharmacists not only dispense the medication but also provide professional counseling and can be the most influential in getting all patients to comply with taking medications on time each month. Heart disease and diabetes are the major driver of increasing costs in healthcare, mortality, and quality of life for the patient. According to claims filed with Medicare these patients have the lowest medication compliance and are deemed non-compliant in treatment. This not only affects the quality of life of the patient, but the star ratings of the pharmacy and ultimately the physician and hospital as well. Noncompliance is increased office visits, hospital admissions, emergency room visits, or surgery due to disease damaging the individuals body. In this study, the pharmacists stepping in and communicating openly with patients about their medication and following a treatment as prescribed. This study showed an overall improvement in medication adherence; thus, decreasing overall healthcare spending, decreasing costs and increasing revenues. (Pringle, 2014)

Another example of pharmacies and Medicare rules is if a new patient comes to the pharmacy with a pain killer prescription it has to be combined with another drug for Medicare to

pay the pharmacy. Physicians and Pharmacies know this rule, if the patient just had surgery or has transitioned to a pain management clinic they would be an exception to this rule, just a pain killer can be prescribed. For a new patient that comes in and only has a pain killer the pharmacist is allowed to explain, regular patients that come in often get first option to purchase due to a percentage law that can be filled. A doctor or pharmacist cannot have more than 30-35% of prescriptions ordered in a given month for just pain killers, or they get penalized. As a result, some new customers are turned away from the pharmacy, or the pharmacist can ask do you have prescriptions elsewhere? We can transfer them here to this pharmacy and fill them all at once. Medicare has a database with wholesale houses that send out the medications to pharmacies. The controlled drugs have to be under 30% of volume each month. For example, a patient had surgery and a doctor prescribed pain medication for up to 14 days sometimes 21 days but after that they have to go to a pain management clinic. But the problem remains if no other prescriptions are filled other than pain medications on a consistent basis each month, pharmacies can turn patients away due to this 30% rule.

Authors, Stefanacci and Guerin (2013), describe in their article “Why Medication Adherence Matters to Patients, Payers, Providers,” medication non-adherence falls into four different categories that CMS looks at before assigning a penalty listed below as:

“These four categories are: primary, secondary, unintentional and intentional. Primary nonadherence is when a patient does not fill an initial prescription; secondary nonadherence is when a patient does not refill a prescription on time. Unintentional nonadherence occurs when a patient simply forgets to take medication or is careless in some way as to miss a scheduled dose; intentional nonadherence is a decision to not take the medication and may be the most important aspect of nonadherence that must be

addresses, with some estimates showing that up to 80 percent of nonadherences may be intentional. Two trends in nonadherence that have been identified relate to the specific forms of intentional nonadherence. One trend involves the primary care physician. This happens when a specialist recommends a medication and the patient later argues with the PCP that the dose is too high or is unneeded. If the primary care physician reduces the dose, the patient becomes non adherent and, as a result, is undertreated. The second trend in intentional nonadherence is called Web-induced nonadherence. This happens when the patient investigates a prescribed medication on the Web and becomes inappropriately concerned about side effects or other aspects of the drug and does not take the medication as ordered.” (Stefanacci, R.G., & Guerin, S., 2013)

Nonadherence usually happens when the patient’s expectation of the medicine exceeds the benefit they received, or it is costlier than they thought it would be. CMS is now moving toward requiring drug companies list the cost of their medication on television commercials to help make a fair pricing market to cut down on the outrageous prices for medication and patients know what to expect. Another reason for a nonadherence is fearful of adverse side effects. Often patients weigh the cost of the medication to their perceived benefit of taking the medication without all the facts or information about the medication prescribed. To turn around the patients’ adherence providers or pharmacists must cater to the patients concerns, benefits, and cost of medication. During a survey it was uncovered the elderly population are the ones that are most concerned about cost of prescriptions because they can usually be on four to five different types. They stretch out their medications by skipping doses during the month to make it last longer. But those doing this may not get the full benefit of the drug therapy; thus, declining their overall health in the long run. CMS believes pharmacists are at the front line in

spotting this sporadic behavior with refill pickup and asking patients what is going on and urging them to talk to their doctor about other options if this current one is too costly for them.

Therefore, decreasing overall cost to everyone in the long run in unnecessary visits or hospital charges.

### ***Prevention in Value Based Care***

Disease prevention is the best idea for cutting costs, delivering health to the patient and the medical system. In the Medical Dictionary, listed on the website the definition for disease prevention is “activities designed to protect patients or other members of the public from actual or potential health threats and their harmful consequences. 2 Any manoeuvre intended to minimize the incidence or effects of disease.” (Mosby's Medical Dictionary , 2018) Even with disease prevention, there are still unknown factors physicians do not have enough information about to prevent such as Alzheimer’s Disease. The next step for lawmakers is to look at cutting costs, giving the costs to the American people and bundling healthcare costs in the organizations billing systems. With Medicare and Medicaid leading the way in cutting costs due to value based care, pharmaceuticals are being looked at now, as a new model with cutting those costs or capping them more in the future. (Cutler, 2017) Giving high deductibles to families strains not only family’s pockets but creates a doctor’s office as a bill collector. Which in turn has shown patients giving the doctor a lower rating on questionnaires from Medicare. In the article, “A Center for Medicare and Medicaid Service Lens Toward Value Based Preventive Care and Population Health,” the author states it is “projected that 90% of all fee for service care would be based on value and quality the patient received from organization. By 2018, she declared, at least 90% of all Medicare fee for service payments should be based on quality or value.” (Burd, 2016)

Burd (2016) continued to state in the same article “most Centers for Medicare & Medicaid Service payments will no longer be based on the volume of services delivered but will instead be based on models of delivery that promote meaningful outcomes in care and health.” (Burd, 2016) It would shift from volume of services surrendered for each patient, but payment would be based on delivery of a meaningful outcome for each patient. In 2010, Medicare shifted when the Affordable Care Act was passed to a value based service. This shift is leading the way to look at prevention treatment, providing quality care and educating patients on their health to make them part of the solution.

### ***Laws and Policies in place hurting VBC***

Value Based Care (VBC) is hitting roadblocks with laws and policies currently in place to protect patients, physicians, and facilities. The Stark Law sets very strict limits on who physicians can refer to for tests and other facilities to send patients to. The definition of the Stark Law according to the website starklaw.org states “the Stark Law is three separate provisions, it governs a physician self-referral for Medicare and Medicaid patients.” (Starklaw.org, 2013)

The Stark Law is also known as the *The Ethics in Patients Referral Act* meaning payments made to Medicare for either inpatient or outpatient services to organizations the physician, or their families have a financial tie to they cannot refer to the organization for financial compensation. Whether is it directly or indirectly done. A violation results in civil penalties, a return of all monies that came in form of payments from Medicare.

In the article, “Legal Impediments to Implementing Value Based Purchasing in Healthcare,” explains,

“the Anti-Kickback Statute is a Federal law that states that any person who knowingly and willingly solicit, receive, offer or pay any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or any kind, to any person, in return for or to induce such a person either to refer patients for Medicare or Medicaid reimbursable services, or to arrange, recommend or order any item or service reimbursed by Medicare or Medicaid. The statute is one of broad application and courts have held that a violation may be found if even one purpose of an arrangement is to induce referrals.

US Department of Health and Human Services (HHS) Office of Inspector General (OIG) has developed safe harbors to protect certain arrangements that the OIG has determined present a low risk of fraud and abuse. Unlike the Stark Law, an arrangement that does not qualify for an Anti-Kickback safe harbor is not per se illegal, but rather would be evaluated based on “facts and circumstances” analysis that takes into account various attributes of the payment arrangement to determine whether payments were made with the intent to induce referrals and, therefore, are impermissible. Violations of this statute can result in imprisonment or substantial fines. Further the Government can exclude a physician, hospital or other provider from participating indefinitely in the Medicare and Medicaid programs.” (Clairborne, 2009)

Clairborne et al. (2009) also mentions the definition of “Civil Monetary Penalties Statute (CMP Statute) prohibits any hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit items of services to Medicare or Medicaid beneficiaries under the physicians’ care. To violate the CMP statute, a payment need not be tied to an actual diminution in care-mere knowledge that the payment may influence the physician to

reduce or limit items or services is sufficient to trigger liability under the CMP statute. The OIG interprets the CMP Statute broadly to prohibit “any physician incentive plan that conditions hospital payments to physicians or physician’s groups on savings attributable to reduction in hospital costs for treatments. The OIG reads the plain language of the CMP Statute to prohibit tying physician compensation to reductions or limitations in items or services provided to patients.” (Clairborne, 2009)

Clairborne et al. (2009) also mentions “HIPAA, The Health Insurance Portability and Accountability Act of 1996 was enacted in part to protect the privacy and security of individually identifiable health information. Privacy regulations promulgated under HIPAA (collectively the “HIPAA Privacy Rule”) prevent a covered entity from using or disclosing protected health information (PHI), except as permitted or required by regulations. Covered entities include health plans, healthcare clearinghouses, and certain healthcare providers. HIPAA’s security regulations (the HIPAA “Security Rule”) require covered entities to ensure confidentiality, integrity, availability of all electronic PHI the covered entity creates, receives, maintains or transmits. HIPAA also provides that a covered entity may not disclose PHI to a “business associate” or allow a business associate to create or receive PHI on its behalf unless the covered entity executes a satisfactory agreement with the business associate concerning the privacy and security of PHI. Violations of the HIPAA Privacy and Security Rules can result in substantial fines and criminal penalties.” (Clairborne, 2009)

Clairborne et al. (2009) defines the “Federal Income Tax Law as a nonprofit organizations may seek federal tax-exempt status under section 501© of the Internal Revenue Code of 1986, as amended (the Code). Section 501c (3) of the Code exempts such organizations from taxes and makes them eligible to receive tax-deductible contributions so long as they are organized and operated exclusively for, among other things, religious, charitable, scientific, or educational purposes. Section 501c(3) organizations are prohibited from providing any private inurement of their assets to, or conferring an excessive personal or private benefit from their activities on, any person having a personal and private interest in the activities of an organization. In the case of a nonprofit hospital, an “insider” could include a physician-leader, or a physician in a position to admit many patients to the hospital. A corporation’s tax-exempt status may be revoked if any such private inurement or excessive benefit is found. Because loss of tax-exempt status is a serious penalty, the Internal Revenue Service has also introduced a category of lesser, though still substantial, “intermediate sanctions,” which are penalty taxes that may be imposed upon both the corporation’s management, and the individuals who received the excessive benefit.” (Clairborne, 2009)

Clairbone et al. (2009) also defines the Antitrust Law as “the federal antitrust laws, which include, but are not limited to, the Sherman Act, the Clayton Act, and the Federal Trade Commission Act, are designed to benefit consumers by promoting competition, encouraging product innovation, and increasing consumer choice. They are aimed at preventing both improper “unilateral” conduct (where an organization acts on its own) and “collusive” activities (where two entities agree to act in concert) that interfere with the normal economic operation of supply and demand factors that would occur in a free market. Examples of improper unilateral conduct include abuse of market power and exclusionary conduct that harms a competitor or

potential competitor. Examples of prohibited joint or collusive behavior include price-fixing among competitors and group boycotts (agreements among competitors to refuse to deal with another member of the industry or not to buy or sell to a particular company). Courts have held certain practices such as price fixing are so restrictive of competition and so lacking in justification that they are per se illegal. Other practices potentially implicating the antitrust laws (but not constituting per se violations) are analyzed under the more permissive “rule of reason” standard, which weights an activity’s likely procompetitive benefits against the likelihood of competitive harm. The United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) are the federal agencies with authority to bring enforcement actions to stop or prevent anticompetitive behavior. They can also prosecute individuals and corporations under certain antitrust laws and impose substantial fines. Most states also have their own antitrust laws that are enforced by state attorneys general. Private plaintiffs harmed by anticompetitive behavior may bring civil actions under certain antitrust laws.” (Clairborne, 2009)

Starklaw.org also mentions the definition of “physician self-referral as the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement. Critics of the practice allege an inherent conflict of interest, given the physician’s position to benefit from the referral. They suggest that such arrangements may encourage over-utilization of services, in turn driving up health care costs. In addition, they believe that it would create a captive referral system, which limits competition by other providers.” (Starklaw.org, 2013)

With the Stark Law, is it difficult for providers to provide VBC while trying to control costs of the treatment and staying within the guidelines of the law. Congress has recognized the

Stark Law does create a barrier to value based healthcare models granting exceptions to hospitals but not individual physicians. Therefore, more freedom given to hospitals to not have penalties imposed upon them for patient treatment but individual doctors in private independent practices. Bigger healthcare facilities and hospitals can develop and implement alternative payment models or grouping of services into one price easier. The Stark Law prohibits independent practices from sharing in services like the bundled payment models due to sharing services or other facilities that has the potential of a monopolized hospital system put into place. Individual practicing physicians, or private practices are not yet factored into the overall picture of value based healthcare policies, they do not have the regulations that bigger hospitals have, therefore that is one driving reason why private practices are partnering with hospitals.

According to Congressman Larry Bucshons website," a bill has been submitted called Medicare Care Coordination Improvement Act (MCCIA) that would reduce legal barriers for physicians to enter into agreements with other healthcare providers to better coordinate patient care and more efficiently use Medicare dollars. MCCIA would give the Centers for Medicare & Medicaid Services (CMS) the regulatory authority to modernize the Stark Law by creating certain exceptions for alternative payment models and removing barriers to the development and operation of such arrangements." (Bucshon, 2018)

This act if passed will help remove the barriers that are now in place for individual physician practices to help level out the playing field with large healthcare organizations. The system in place currently is outdated and physicians cannot promote quality, value based healthcare due to the possibility of providing incentives to physicians, pharmacies or specialized care.

Lawsuits are in the courts regarding hospitals exaggerating costs and lying about patient specifics such as wait times to improve their scores to receive higher reimbursement from

Medicare. One example of a hospital that has gained attention in the media is a Northern California Hospital chain called Sutter Health. With over 5,000 practicing physicians in its 24 hospitals, 35 surgery centers and 32 urgent cares it has become a powerhouse buying up private medical practices to gain an upper hand in monopolizing the northern California market. To summarize the charges brought before Sutter Health they include:

- a 20-30% higher inpatient pricing than Southern California. Illegal practice in attempting to monopolize the health market in Northern California and increase overcharges to their customers.
  - Negotiating an all or nothing contract with insurance agencies that will require them to exclude competitors.
  - Mandatory exclusion of sharing price information with patients before they receive treatment, to do treatment with hidden fees or costs and not informing the patient, but obtaining a signature they will pay the bill.
  - If a facility is not owned by Sutter and a physician refers a patient outside of their contracted facility, Sutter Health prevents insurance companies from awarding bonuses to the physicians for that action.
  - Setting their own, extremely high rates for out of network services done on patients.
  - Sutter Health is also charged with destroying 192 boxes of documents related to this case.
- (Brennan, 2018)

With the complexity of providers having to report under certain types of requirements that go with not only government but also with private payers, physicians and hospitals are trying to figure out how to be paid more. The Lawrence Memorial Case, one of many showing up in the court system, is uncovering how whistle blowers are uncovering the mistakes and missteps of

hospital staff attempting to comply with all these regulations. Falsifying patient records such as patient arrival times in the Emergency Room to match the recommended time allotment for chest pain when doing an EKG. The charges brought against this hospital shows administration changing the times patients checked in to match closer to the time the tests were run when chest pain was reported. This lawsuit is also showing how this hospital was overcharging Medicare, exaggerating numbers to reflect them delivering quality care to patients to push their star rating up for increase reimbursement kickbacks from Medicare. Higher scores submitted to Medicare means higher incentive payments back to the hospital under the current federal laws in place. (McLean, 2015)

During the fiscal year of 2014, the Federal Government recovered almost \$2.3 Billion in false claims they had uncovered in the healthcare industry. These claims mainly were uncovered in Medicare, Medicaid and Tricare (military healthcare division (Justice, 2014)). CMS states patient healthcare providers and insurers are open to fraudulent practices due to outdated identification verification and record keeping practices. The authors, Probst and Cogent (2018) explain “even with new or updated electronic health records and incentive programs in place, the healthcare system as a whole is still vulnerable.” (Probst, M., & Cogent, G., 2018) Having better record keeping and being transparent would give better care to the patients and organizations. Currently, most healthcare providers manually verify patients IDs at registrations by asking for a photo or government issued ID. If fingerprints or face recognition software were incorporated at check in, a patients' identity couldn't be stolen or fraudulent claims be field. Authors, Probst and Cogent (2018) also mention “doctors could also use their thumbprints as a useful fraud prevention tool. Rather than tracking treatment with familiar paper-and-barcodes system, doctors could use their own thumbprints to digitally sign instructions, prescriptions and patient

records, helping increase transparency of treatments and the associated costs between patients, provider and insurer.” (Probst, M., & Cogent, G., 2018)

Private practices can begin to terminate certain patients that fall under the categories of non-compliant, difficult to deal with, low income or sicker patients. Physicians could start to intentionally hand pick which patients to see. They can beat the system by screening the higher education or economic brackets to boost their organizations scores. (Rubin, 2018)

Lawsuits for physician practices are prevalent in risk adjustment coding. One lawsuit from Freedom Health and Optimum Healthcare are ordered to pay \$32.5 Million dollars back to Medicare Advantage. This being a whistle blower lawsuit in nature of circumstances an insider turned in Freedom Health and Optimum Healthcare for risk gaming. “Risk gaming occurs when payers inflate patient risk scores and subsequently request higher payments from the government. A patients’ risk score is determined by their diagnosis and treatment requirements, which in the case of gaming is either inflated, unsubstantiated or false.” (Migneault, Two payers liable for \$32.5M in Medicare Advantage fraud suit, 2017) According to the lawsuit 80% of payment codes that were submitted were unnecessary office visits that increased the risk scores. The gaming of the Medicare Advantage has Congress now calling for more audits and being aggressive in collecting the monies in fraudulent claims.

One other high profile case is against United Health for alleged Medicare Advantage fraud. The accusations in this case are long term, altering multiple diagnosis codes. Thus, resulting in higher amounts paid to United Health from Medicare. “Medicare Advantage payments are determined by the risk score of individual enrollees. Patients are divided into two categories: high risk patients with higher health costs, and lower risk patients with less patients with higher health costs. To cover the high-risk patients, Medicare Advantage plans charge more

for coverage.” (Migneault, 2017) With an increasing aging population, Medicare Advantage is expected to grow significantly. Opening the door for more fraudulent billing with health care organizations. United Healthcare is currently being sued for the \$1 Billion dollars in payments received fraudulently.

### ***Star ratings with Medicare and Medicaid Beneficiaries***

The star ratings are a “report card” on the medical facility issued by Medicare based on certain criteria based performance. These star ratings have become an interest for the population as a whole looking at who has the best rating but not understanding how the facility came up with a certain score. Beneficiaries state they look at ratings to see whom has the highest and goes there with confidence to the physician or facility. According to ehealthmedicare.com the “Star Rating was set up to help beneficiaries and their families to compare their plans performance in three areas which are: Medicare Advantage plan, Medicare Cost plan and the Medicare Prescription Drug Plan. It is a number scale of 1-5, with 5 being excellent service, 4 above average, 3 is average, 2 below average and 1 is poor performance.” (ehealthmedicare, 2018) There are 5 main categories in the Medicare Advantage plan and Medicare Cost plan these five categories are the following:

Staying healthy: patients/medical facilities are surveyed to find out if the members had access to preventive services such as flu vaccines, pneumonia vaccines, physical exams and other preventative screenings to keep them healthy.

Chronic conditions management: healthcare facilities are rated for the care coordination offered and how frequently the beneficiaries came in to be seen for long-term health conditions,

compliant with treatment plan. Looks at how often members had certain tests or treatments for their chronic conditions.

Member experience: patients are surveyed for overall satisfaction with the health provider, staff, and treatment plan. If they were seen in a timely manner, called back within a reasonable time, value was placed on the experience rather than feeling unvalued as a patient.

Member complaints: if a member reaches out with a complaint or lists a complaint on the survey, it is investigated for validity. If a member leaves the plan, or could not obtain needed services is rated on the Star Rating System.

Customer service: rating system is also based on the quality of the appointment, front desk assisting, (including TTY and interpreter services), new enrollments, processing appeals and authorizations in a timely manner.

The Star Rating System for Medicare Prescription Drug Plans follows a slightly close format but mainly focuses on member experience, complaints, customer service, drug compliance and drug pricing accuracy. The plan rating system focuses on patient compliance with taking their medications consistently, the pharmacies pricing and patients safety when taking medication. The Star Rating System compares safety in drugs and patients experience, you will score lower if a safer drug could have been prescribed with less severe side effects.

All information is collected by patients doing member surveys, healthcare facilities physicians and staff, Medicare monitoring, and information submitted by the plan. Other ways can be information submitted by drug plan and reviews of the billing submitted to Medicare.

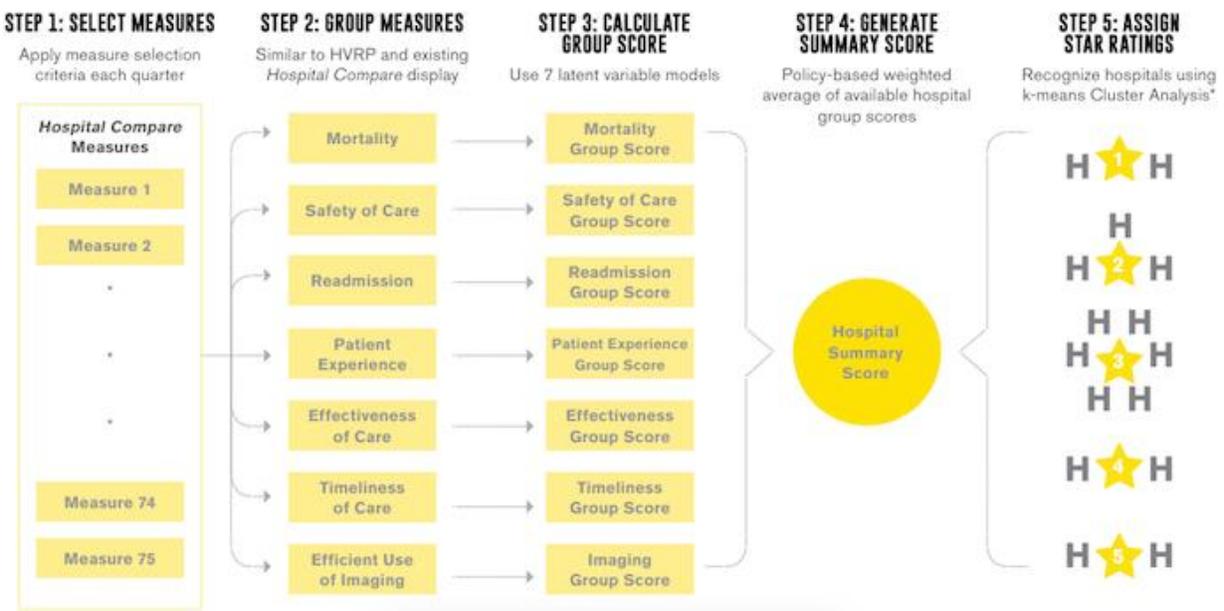
***Patients Education about Star Ratings Matter***

The role of the patient will change once value based healthcare is put into practice. Medicare's goal is to make the patient responsible for their own health, being compliant with the treatment plan laid out by the physician and if they get worse it is the patients fault for not adhering to the plan. If the patient is held responsible for not getting themselves better, the consequences we see now with the pharmacy is the patient is labeled not adhering to treatment plan. The patient is flagged in the system, medications they once had paid for will no longer be paid for, the doctors rating will lower, so the patient risks not returning to the physician and not having prescriptions filled at the pharmacy they are currently at. The pharmacy star rating will also go down because the patient is not picking up the medication on time every month. If the patient is admitted or readmitted it affects the star rating of the hospital, lowering it. The role of the patient isn't just about them filing out surveys when they are upset with the doctor, or they had a great experience. The surveys will be outweighed by patient compliance in the healthcare data base system, and that is really where the doctor's reimbursement checks will come from. Scientific hard proof is what will yield the star rating, not a survey that has a patient upset at time of filing out the form. Medicare goes back and double checks the times the patient checked in to when they were seen, any complaints listed on the survey. Medicare also goes back to date of service of any patient to see diagnosis codes, medication database, documentation in the chart and any test results before the star rating is given out. Once the star rating is given, the goal is to have it updated yearly but right now it is every two years.

A healthcare organization should look into having a team solely looking and working toward high star ratings, coming up with plans to raise it and keep it at a five-star rating as best it

can yearly. This would lower costs, bring in a maximum amount of reimbursement and deliver the best in value based care the organization can give the community and patients. Why do we have a five-star rating practice put into place? It was originally for Medicare beneficiaries to look at organizations and pick the ones with the highest scores for value based care. When Obamacare came into effect, it made it mandatory that hospitals would receive a star rating system to keep hospitals accountable and transparent. To help them see where they needed to improve and give patients a chance to voice concerns. Below is a graph, showing the methodology of the five-star rating of hospitals.

### FIVE-STEP OVERALL STAR RATINGS METHODOLOGY



(Silverman, 2016) In this diagram, it looks as though the Emergency Department is the main door to the hospital according to the broad groups in steps 2 and 3. Seeing they had a 3-star rating, the Emergency Department was approached to see what they could improve upon in delivering value based care. The diagram shows times that weigh the heaviest are patient arrival time, being seen, to discharging the patient would be what needs to be focused upon first for

improvements. The focus on these would be cost effective, and ultimately would raise the star rating for the organization as the whole.

Each domain is not weighted the same, in this example the chart below states how the Emergency Department is being rated. Four of the domains are measured at 22% and the other three are only at 4%. Once each hospital is given its score, it is then put into a collective or grouped so they can all be compared side by side for patients to see and compare. (Silverman, 2016)

## STAR RATINGS WEIGHTING BY MEASURE GROUP

MEASURE GROUP	STAR RATINGS WEIGHT
Mortality (N=7)	22%
Safety of Care (N=8)	22%
Readmission (N=8)	22%
Patient Experience (N=11)	22%
Effectiveness of Care (N=16)	4%
Timeliness of Care (N=7)	4%
Efficient Use of Medical Imaging (N=5)	4%

What does this mean for hospitals? Hospitals can use a higher star rating to negotiate insurance contracts, showing them, they have high quality of care. Patients if they pay attention

to star ratings might be more comfortable coming to a higher rated quality medical center. Eventually individual physicians will have star ratings within the Medicare/Medicaid System.

*Suggestions on how medical facilities can be successful in implementing VBC reform*

Real change is going to be needed in communicating with patients and their families in a one on one atmosphere. Valuing patients means being available to speak with them, answer questions when they call or reach out, seeing them in an appropriate time frame and being honest about a treatment plan that involves educating the patient. Moving a patient from being told what is good for them to take to having them do the research and finding out what is best for them is the most successful route in keeping a patient compliant. Healthcare centers can learn from other successful companies that have excellent customer service care and build their own models for patient care centers. They can use terms such as “Patient Relationship Management” or “Chief Experience Officer” to portray their dedication to the patient and their family, to develop trust and create a leadership role within the organization to show they are a leader in a value based delivery system. The article called, “Patient Relationship Management: What the US Healthcare System Can Learn from Other Industries” by authors Poku, Behkami and Bates (2107), states “a Chief Experience Officer as an emerging leadership role critical to the transformation of the value driven system.” According to Poku et al. (2017) they listed what qualities this person should have, including the following

- Identify key areas needing improvement
- Helping manage patient’s paths throughout the healthcare organization
- Addressing barriers with deleterious impact on patient’s health, and their experience with the healthcare organization

- They will need a staff and backing of the organization to implement change
- Understanding and enhancing the patient/family experience
- Developing a dedicated PRM system (including both change management and measurement components). (Poku, 2017)

If the old saying is true, where Medicare goes other insurance companies will follow, changes are occurring in both private and public sectors of insurance. Healthcare organizations are in the middle of daily changes with new rules, policies, and laws changing to accommodate a successful value based healthcare system. Having a specialty group that is dedicated to customer service like other non-healthcare companies out there such as Disney, Zappos, or Starbucks they can learn valuable principles in patient relationship management. To strategically plan a model based on patient outcomes questions such as how can we give them the best care possible, how can we deliver the best outcome possible, what types of teams can we put together that are specific to patient's needs, community needs and wants. What are the best ways to go about delivering and addressing their needs and wants? Keeping in mind answering the overall question what is in it for me and for them. With the issue of trying to come up with one plan fits all, break it down into questions so each state, city, town, community can create their own answers to these questions or concerns. Having one simple question of how can we develop and deliver the best possible outcome to the patients' health and care while lowering costs gives each organization freedom to come up with a plan and implement it the best way for their community.

Dealing with complaints can be a different department within the organization. (Poku, 2017) Social media complaints, missed appointments, not feeling valued or billing can all be handled by a department set for a customer based service. Developing and implementing new IT programs that allow patients to pay bills, payment plans, complete pre-visit forms, so they do not

have to wait as long in the waiting rooms, obtain lab results ahead of time, text message courtesy reminders, with the ability to cancel or reschedule right then. Reliable health education on the patient's condition and a patient ability to request a call back from the nurse via text or online portal. Changing the dynamics between a doctor, staff and patient will no longer be prescribing medicines because the patient thinks they need it. The over prescribing abuse will be lowered, patients receiving medication unnecessarily will result in better health overall.

Medicare listened to physicians and patients and recently made some much needed corrections in the Value Based Care program. In August 2018, CMS announced new changes and upgrades to old models to help ease physician based practices, geographic models that were not applicable to hospitals and many other issues. The first issue CMS handled was the MyHealthEData and Interoperability making patient accessibility to prices and a fluid exchange of information between the hospital and patient. By granting patients access to prices, this gives them the flexibility and information to decide on their own care. Thus the hospital cuts back on paperwork, and time needed to answer all of these value based care questions. This "rule" makes it required for hospitals to now put prices up on the internet when patients are looking at procedures. On the website, MyHealthEData states the following three policy changes listed below as:

1. Make the program more flexible and less burdensome
2. Emphasize measures that require the exchange of health information between providers and patients
3. Incentivize providers to make it easier for patients to obtain their medical records electronically. (Medicare, Trump Administration announces MyHealthEData initiative at HIMSS18, 2018)

President Trump's new MyHealthEData also has a program that gives Medicare beneficiaries their medical information through a program called Medicare's Blue Button 2.0. This will provide beneficiaries their claim data on a universal secure platform. This is designed to help patients know their information, share it with the doctors and improve overall clinical decision making on behalf of the patients' care. It covers Medicare Part A, B and D, to fill prescriptions, make appointments and give access to their physicians on current medication and refilling dates. To track patient compliancy or non-compliant. With the use of Blue Button 2.0, it is hopefully other insurance agencies will begin to incorporate this model into their own structure for their patients.

“Certified electronic health record technology is used not only for patients access to records but for Medicare to keep track of payment incentives and avoid unnecessary reductions to Medicare payments. On the CMS website, it states “in 2019 there will be an update to this program, with the application programming interfaces (APIs) that will improve the flow of information between providers and patients. This will enable a patient, and their care team to communicate easier, reduce duplication and encourage the patient to comply with treatment plan.” (Centers for Medicare and Medicaid, 2018)

The CMS website also states, under this plan there is a

“CMS Meaningful Measures initiative that is centered around patient safety, quality of care, transparency and ensuring that the measure sets providers are asked to report make the most sense. In the IPPS/LTCH PPS final rule, CMS is removing unnecessary, redundant and process-driven measures from several pay-for-reporting and pay-for-performance quality programs. The final rule eliminates a number of measures acute care hospitals are currently required to report across the four hospital pay-for-reporting and

value-based purchasing quality programs. It also “de-duplicates” certain measures that are in multiple programs, keeping them in the program where they can best incentivize improvement and maintaining transparency through public reporting. In all, these changes will remove a total of 18 measures from the programs and de-duplicate another 25 measures while still ensuring meaningful measures of hospital quality and patient safety. In addition to the changes to the changes that apply to acute care hospitals, the final rule eliminates three measures in the LTCH Quality Reporting Program. Lastly, CMS is making a variety of other changes to reduce the hours’ providers spend on paperwork. This new flexibility will allow hospitals to spend more time providing care to their patients, thereby improving the quality of care their patients receive. Overall, changes in the hospital quality and value measures across the four programs will eliminate more than 2 million burden hours for hospitals impacted by the IPPS/LLCH PPS rule, saving them about \$75 million annually after these changes are implemented.” (Centers for Medicare and Medicaid, 2018)

Listed on the CMS.org website it lists the following three objectives “in promoting better value in its overhaul of its Electronic Health Record (EHR) Incentive Programs.” Its objective is to “save time and costs” by doing the following three items: (Medicare, 2018)

1. Streamlining Meaningful Use and QPP

- This includes streamlining the Medicare and Medicaid HER Incentive Programs for eligible hospitals and critical access hospitals (Commonly referred to as the Meaningful Use programs), and the Quality Payment Program (QPP) for clinicians (part of MACRA) to increase the programs’ focus on interoperability and to reduce the time and cost required to comply with them.

## 2. Prioritizing Quality Measures That Lead to Interoperability

- CMS intends to prioritize the use of quality measures and improvement activities in value-based care and quality programs that lead to interoperability.

## 3. Preventing Information Blocking

- CMS is also taking steps against information blocking (a practice in which providers prevent patients from getting their data) as required by law by requiring hospitals and clinicians under some CMS programs to show they have not engaged in data blocking activities. (Medicare, 2018)

Patients over paperwork reduces the administrative “burden on providers by easing documentation requirements and more flexibility” with patients in Skilled Nursing Facility (SNF). (Centers for Medicare and Medicaid, 2018) These new rules and regulations will be under the Patient Driven Payment Model (PDPM) that is tied to skilled nursing facility payments. Each patient will be reviewed based on their illness, chronic or short lived condition, whether improvement is being made for their condition for reimbursement rate to be determined. Its objective is to treat the patient as a whole patient, rather than the mentality of how many services can be provided for each individual patient. This creates a substantial amount of paperwork over time, many hours spent interpreting the paperwork and inputting it into the computer system. In the article, “CMS Finalizes Changes to Empower Patients and Reduce Administrative Burden” it explains “under this new SNF model for reimbursement, patients will have more flexibility in choosing a skilled nursing facility that offers services they need specifically.” (Centers for Medicare and Medicaid, 2018)

### ***Bundling Payment Models***

Fee for Service has been blamed as a major contributor, if not cause of driving up costs in the United States Healthcare System. Fee for Service rewards physicians and healthcare organizations by encouraging volume of visits, tests, procedures, medications, and lab work by rewarding them with reimbursement checks without being held accountable for the success of treatment. Each provider does what he/she wants to, driving up costs with tests and procedures while not talking to other caretakers for each patient. If each patient was responsible for their outcome or cost of their care, the number of tests ran, or quality of care would be different, the cooperation of each patient would be better and they would want to obtain because it is less coming out of their own pocket, lawmakers, and insurance policy makers feel.

According to the website American Hospital Association, “under the Affordable Care Act (ACA), the Department of Health and Human Services (HHS) started a five-year program beginning in 2013 that bundles certain health conditions.” (Association, 2013) The program includes ten conditions that deal with acute, surgical and medical conditions to see how well bundling of payments would work, what needs to be improved upon and what did not work at all. In 2011, Centers for Medicare and Medicaid and Centers for Medicare and Medicaid Innovation (CMMI) also launched their bundling program from their beneficiaries. Their program is called Bundled Payments for Care Improvement (BPCI) and it’s divided up into four defined models listed below. American Hospital Association explains it on their website as

- Model 1 includes only inpatient hospitalization services for all Medicare severity diagnosis related groups (MS-DRGs). Medicare will pay participants traditional fee for service payment rates, less a negotiated discount. In return, participants may enter into gainsharing arrangements with physicians.

- Model 2 includes the inpatient hospitalization, physician and post-discharge services. Medicare will pay participants their “expected” Medicare payments, less a negotiated discount.
- Model 3 includes only post-discharge services. Payments will be made as in Model 2.
- Model 4 includes the inpatient hospitalization, physician and related readmission services. Medicare will pay participants a prospectively determined amount.

(Association, 2013)

Many facilities and private insurance companies have applied to work in the BPCI. Paving the way for future ways to dive into their own data, to figure out the best way to bundle their own packages, the risk and reduce costs while staying compliant within Medicare and Medicaid guidelines.

The newest bundled payment program that went into effect October 1, 2018 is called the “Bundled Payments for Care Improvement Advanced (BPCI)” (CMS, 2018) and the trial period ends December 31, 2023. During this trial period voluntary organizations can fill out the appropriate paperwork to enter into a partnership with CMS, download a risk form and agree to terms listed. “Providers will be eligible for bonuses under MACRA based on their performance scores to the new model.” (Castellucci, 2018) This newer model operates under the total cost of care concept, instead, of individualized billing of services. Castellucci (2018), also explains in the article she wrote, “payments would be based on a 90-day episode of care; the participants would have to select one of the 32 clinical episodes that apply to the model.” (Castellucci, 2018) The author Castelluccis’ model overview applies to these following aspects:

- Voluntary Model

- A single retrospective bundled payment and one risk track, with a 90- clinical episode duration
- Qualifies as an advanced APM
- Payment is tied to performance on quality measures
- Preliminary target prices provided in advanced of the first performance period of each model year
- Castellucci also mentions these 29 Inpatient Clinical Episodes are listed below:
  1. Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis \*  
\*(New episode added to BPCI Advanced)
  2. Acute myocardial infarction
  3. Back & neck except spinal fusion
  4. Cardiac arrhythmia
  5. Cardiac defibrillator
  6. Cardiac valve
  7. Cellulitis
  8. Cervical spinal fusion
  9. COPD, bronchitis, asthma
  10. Combined anterior posterior spinal fusion
  11. Congestive heart failure
  12. Coronary artery bypass graft
  13. Double joint replacement of the lower extremity
  14. Fractures of the femur and hip or pelvis
  15. Gastrointestinal hemorrhage

16. Gastrointestinal obstruction
17. Hip & femur procedures except major joint
18. Lower extremity/humerus procedure except hip, foot, femur
19. Major bowel procedure
20. Major joint replacement of the lower extremity
21. Major joint replacement of the upper extremity
22. Pacemaker
23. Percutaneous coronary intervention
24. Renal failure
25. Sepsis
26. Simple pneumonia and respiratory infections
27. Spinal fusion (non-cervical)
28. Stroke
29. Urinary tract infection

- Castellucci explains about what the 3 Outpatient Clinical Episodes are listed below:

1. Percutaneous Coronary Intervention (PCI)
2. Cardiac Defibrillator
3. Back & Neck except Spinal Fusion (Castellucci, 2018)

On CMS.gov website, it explains “CMS has seven quality measurements that it lists on its website for the BPCI Advanced model. Only two of them providers will be required to meet every time and those are Advanced Care Plan and the All-Cause Hospital Readmission Measure. The other five quality measures do not have to each be met every

time; they only apply to certain clinical episodes.” (Medicare, BPCI Advanced, 2018)

The CMS.gov website mentions these seven quality measures are:

1. All-cause Hospital Readmission Measure (NQF #1789)
2. Advanced Care Plan (NQF #0326)
3. Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
4. Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
5. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
6. Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
7. AHRQ Patient Safety Indicators (PSI 90) (Medicare, BPCI Advanced, 2018)

### ***Home Health Star Ratings***

A star rating for Home Health is beneath the Center for Medicare and Medicaid umbrella. This star rating is a summary on how well the home health agency performs on eight separate care measures. Based on the process and outcome of care measures that help a beneficiary has their all of their needs met.

Listed on the Medicare.gov website it states “the process of care measures is determined by how often the agency gave the care recommended for the patients’ illness. Based on the agency

initiating care in a timely manner and drug education on all medications they are currently taking.” (Medicare, 2018) To determine the outcome measures the agency is rated based on how often they successfully met the criteria with each patient in a successful way. (Medicare, 2018)

The stars are calculated by patient assessments and Medicare care claims that are then updated quarterly. Taken from Medicare.gov website its lists “the process of care measures or how often the agency assess the patient is done in the following eight steps listed below:

1. Initiates patient care in a timely manner
2. Provided patient/caregiver drug education on all medications. (Medicare, Home Health compare, 2018)

The Medicare.gov website, also explains the outcome of care measures have these certain steps to follow for their rating system:

3. Got better at walking or moving around
4. Got better at getting in and out of bed
5. Got better at bathing themselves
6. Was able to engage in activity with less pain
7. Experienced less shortness of breath
8. Required acute care hospitalization (Medicare, Home Health compare, 2018)

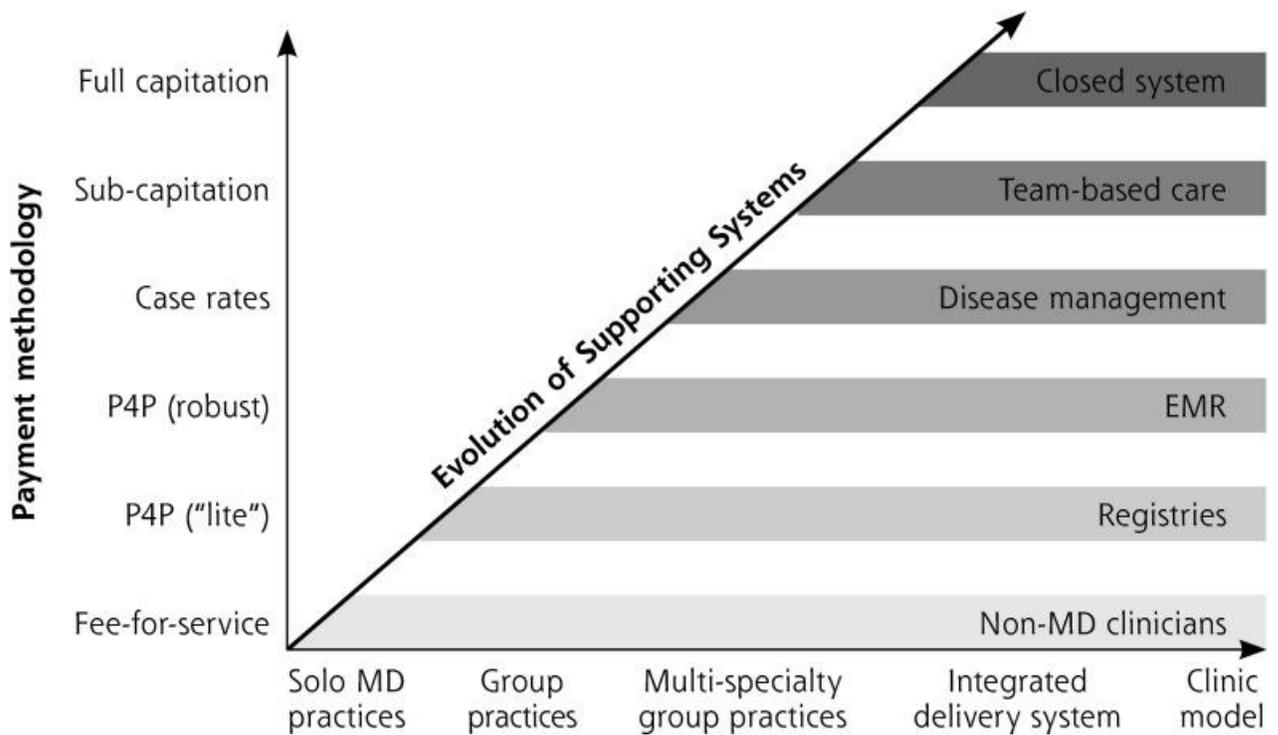
On the Homehealthcahps.org website it explains “the Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS) hands out a survey with multiple questions grouped into four sections under care of patients, quality of communication between patients and providers, special care issues were addressed, and an overall rating of care given.”

(Homehealthcahps.org, 2018)

*Challenges for private practices in transition to value based care*

Small private physician practices are under pressure to consolidate to a larger hospital practice. The patients testing cannot be duplicated as easily if the patient is in one database, being seen in one organization. For the small private physician, being a part of a larger organization there will be lower overhead costs. There will be a single electronic medical record system making the patients' medical records easier to access with fewer mistakes. Physicians can save on the overhead expenses when joining a bigger medical organization that already has the electronic medical records established, management/leadership teams and team based care already staffed with personnel.

Recent evidence showing that small private owned practices are thriving despite what is presented as downfalls for not joining a hospital organization. Private practices are showing a greater level of being responsive to patient's needs, higher quality of care due to it being personalized, fewer hospital admissions and patient feeling the doctor is acting in their best interests, not for the hospital.



(Mostashari, 2016)

According to the graph above, this shows how small family practices can prosper in a value-based care setting. The author, Mostashari (2016) explains “having federal policies that support competition and patients choosing include the following four bullet points:

1. Primary care practice rates should be set to parity with those paid to organized systems, reducing the financial incentives for independent primary care practices to join hospital systems.<sup>12</sup> This incentive structure ignores the unique benefits small practices bring to the health care system and underestimates the power of their relationships with patients; and is counterproductive for patients and payers alike.
2. The federal government and payers should avoid undue regulatory burdens on providers and offer administrative relief for small practices. Limiting the number of process

measures reported and following the lead of CMS in permitting quality intermediaries to conduct the reporting of quality measures could alleviate burdens.

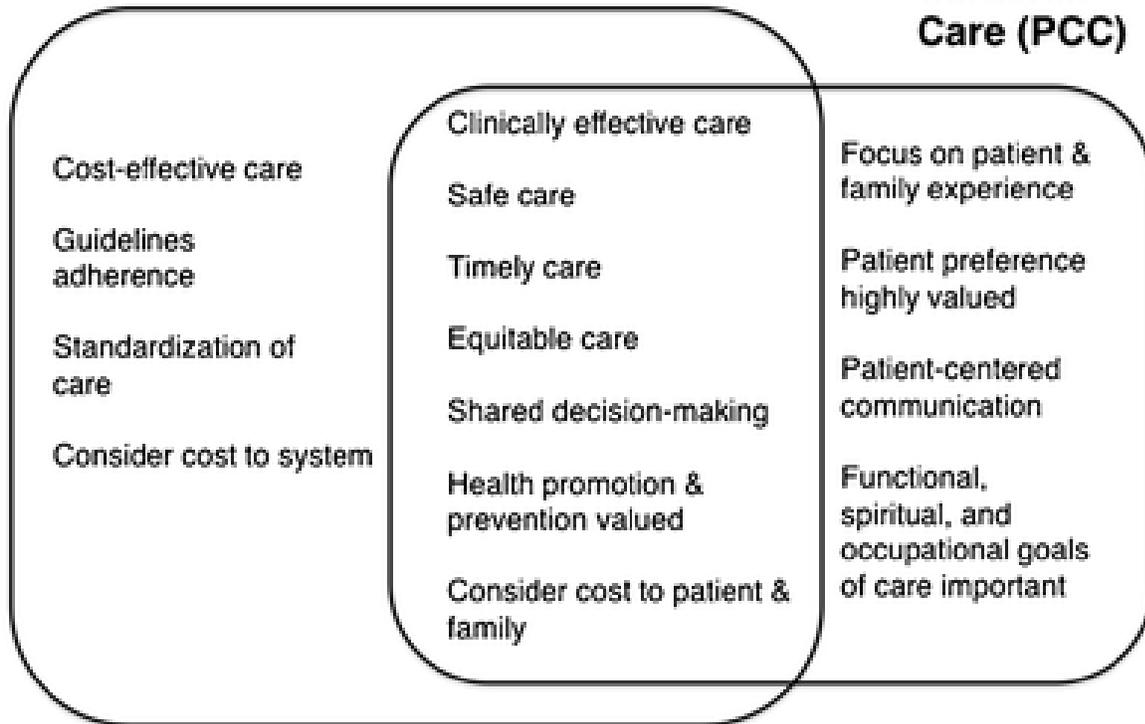
3. The Federal Trade Commission should investigate complaints regarding limiting hospital admitting privileges, restricting care by hospital employees, and vendors and health systems using their market power to force independent physicians away from true market choice. The Department of Justice must continue to emphasize investigating cases of fraud, such as parties “overpaying” physicians (ie, those hiring at a loss) in order to obtain referrals.<sup>13</sup>
4. CMS should discourage “ACO squatting” by requiring hospital-owned ACOs with capital reserves to switch to 2-sided risk models after an initial 3-year contract period, while allowing flexibility for physician-led ACOs.” (Mostashari, 2016)

Patient centered care (PCC) takes individual patient’s needs, values and expects them to be responsive in all clinical decisions. PCC does not come from a service orientation, authors Tseng and Hicks (2016) points out “it is integrated with the patient and their family. It works from eight aspects of care which are: “communication and information needs, emotional support, physical comfort, continuity and transition, care coordination, involvement of family and friends and access to care.” (Tseng, E.K., & Hicks, L.K., 2016) Its positional statement is to make sure patients are well informed, so they have the opportunity to make their own minds up to preferences and concerns regarding their treatment.

PCC and VBC are two different types of models but centered around patient needs. Both are driven by quality and cost effectiveness as shown in the below illustration.

**Value-Based Care (VBC)**

**Patient-Centered Care (PCC)**



Care coordination, patient centered care and transitions are not at the forefront to be measured. Instead patient satisfaction, joint decision making, and communication are a few of the trends doctors are now focusing on. Driven largely by how a physician will be reimbursed for treatment of each patient. The physician who practices PCC and actively invites or encourages the patient to be involved in his/her own care may be viewed as giving lower quality of care if patient decides what treatment they feel is best for themselves and their physician is not listening to their wishes. A popular example is a cancer patient that does not want to do chemotherapy and, instead, feels doing it a holistic way or dying would be better, and the physician encourages chemo and radiation therapy only. Doctors are increasingly aware of if they do not agree with what the patient wants as a treatment it could cause lower scores, thus, increasing costs of

unnecessary treatments, tests, or hospital admissions to keep the patients happy. Open communication is important between a physician and patient when the patient goes against what the doctor has ordered. Leaving the patient feeling supported and giving them time to process all possible outcomes often brings the patient back to the physician or medical team to discuss options again and make the best one. (Frenkel, 2013)

### ***Primary Care Practices***

Urgent care centers are increasing in numbers across the United States, seeing them in retail pharmacies, supercenter grocery stores, schools and stand-alone chains are starting to take up what primary care offices were originally set up to see patients for, illness. Telemedicine companies are now offering urgent care services over secure platforms to see patients and treat them in the convenience of their homes, without taking a trip to the doctor's office or hospital. The patients view of the traditional primary care doctor office not adequately meeting their needs and expectations. Not enough same day office visits available for sick patients, leaves primary care physicians main role now as follow-up visits and routine well visit physicals. Future of healthcare is leaning towards giving patients a place for sick care, and a place for well care. A place to go or a space on the virtual platform to be seen is where patient care is heading.

Primary Care Physicians (PCP) roles in the beginning were set up not only on a fee for service basis but to control costs. In the article "The Coming Primary Care Revolution." Authors Elner and Phillips (2017) describe the original model consisted of PCP offices to do the following:

- Being first contact of care for new health needs. This would reduce unnecessary hospital visits or admissions. Reduce specialist visits, improve rates of immunizations, encourage yearly physicals (well visits) and some counseling.
- For long term care it would include chronic disease management and the use of preventive services, reduce emergency department visits and lower hospitalizations. To improve the quality of care and decrease costs. (Value based service)
- Comprehensive care would reduce overall costs, provide screening and counseling in a preventive way.
- Coordination of care if it was needed outside of PCP scope of practice, would help to reduce costs and improve the specialty of referral process through insurance companies. (Elner, A.L., & Phillips, R.S., 2017)

Within in PCP office, nurse practitioners, physician assistants, patient navigators and case workers can often step in and stop unnecessary hospital visits or urgent care visits. Giving the PCP offices a pivotal role in value based care and first in line with giving quality care to each patient. To clarify the role of primary care offices the same authors, Elner and Phillips, describe primary care offices need to assert themselves into a new position, a leadership role they must do the following:

“Primary care must assert itself as the only viable solution to the interrelated problems of rising costs, renewed biomedical technological innovation in the direction of more personalization, public demand for convenience, and widespread waste. The essential functions of primary care will be just as relevant to the future of healthcare as they have been up to now. Thus, the task at hand is to optimize for these functions, in addition to technical excellence in the

prevention, diagnosis, and treatment of disease. Doing so in a way that enables financially sustainable care at the massive scale needed to adequately serve all U.S. citizens will require an unsentimental reexamination of how the competencies, actions, information, and power in primary care and the rest of healthcare are distributed among people and technology.” (Elner, A.L., & Phillips, R.S., 2017)

The relationships primary care provide will serve as the model in giving quality care. Within the primary care office patients will first go there, their team will form from this office visit for their care and treatment plan, follow up will be consistent and costs will be lowered overall. Instead of following the past compartmentalized care such as separating each type of doctors visit, mental health, and/or socioeconomic status under old models. Primary care can lead the way in combining it into one package or bundle. Integrating it for the patients, making it a team approach and the patient be more involved in their own care and the outcome of their health.

President Trumps, MyHealthEData initiative, listed on the Medicare website states “the patients team will need to coordinate and cooperate with one another for a value based system to ultimately work for everyone involved. The CMS is committed to putting policies and procedures in place and guidelines recommending for smaller physicians to make it work.” (Medicare, Trump Administration announces MyHealthEData initiative at HIMSS18, 2018) The website then goes on to state, the two biggest points the CMS recommends are the following:

“Requiring providers to update their systems to ensure data sharing. As part of the effort to ensure that data follows the patient, CMS finalized for some of its programs the requirement for health care providers to use 2015 Edition certified HER technology (CEHRT) beginning in 2019 which is capable of giving data to patients in a usable and

secure electronic format. The updated 2015 Edition CEHRT includes technical requirements focused on interoperability and the ability of patients and their care teams to share healthcare data more effectively through API'-application programming interfaces. APIs are software that allow other software to connect to one another and are the primary way that data is shared electronically CMS continues to collaborate with the ONC to improve the clinician experience with EHRs. Ensuring patients receive their data upon discharge. In an effort to ensure that healthcare data follows the patient, CMS intends to specify what types of information-ideally in electronic format-must be shared by hospitals with a patient's receiving facility or post-acute care provider." (Medicare, Trump Administration announces MyHealthEData initiative at HIMSS18, 2018)

#### ***Four cornerstones to a more balanced Value Based Care model***

The need for a large interoperable Healthcare Information Technology (HIT) to reduce medical reporting errors, increase administration and transcribing accuracy in the healthcare delivery system. In the article, "Legal Impediments to Implementing Value Based Purchasing in Healthcare", it defines "HIT is a technology used to collect, store, retrieve and transfer clinical administrative and financial health information electronically defined by the Government Accountability Office (GAO)." (Clairborne, 2009) This system shares electronic health information in a safe, secure and consistent way through a database. Can be in different software application, networks, and technology systems. To do this a universal clinical vocabulary needs to be adopted. Clairborne et al. (2009) states "in 2009, American Recovery and Reinvestment Act included the Health Information Technology for Economic and Clinical Health Act to fund and implement HIT into the architecture of a nationwide exchange of health information. The

same authors then give examples of these being implemented as: “electronic prescribing (e-prescribing), Electronic Health Record Systems (EHR), Electronic Care Management tools, Electronic Quality Registries and technology tools essential to creating a patient centered coordinated “medical home” model of care.” (Clairborne, 2009)

Clairborne et al. (2009) also mention “the second cornerstone of the value driven healthcare change is measuring and publishing information about healthcare quality. Federal agencies are directed by the Executive Order to develop a quality of metrics based on services supplied by healthcare providers to Medicare and Medicaid beneficiaries. This is made available publicly through the Health and Human Services (HHS) on the Hospital Compare website. This is where beneficiaries can look up reports based on quality in the sections of payment, reporting, and quality improvement by the HHS operating divisions and their agencies. Private insurers and nonprofit organizations have also used this model for their beneficiaries and the public.” (Clairborne, 2009)

Clairborne et al. (2009) explains “the third cornerstone of value based care is measuring and publishing information about price. Federal agencies are required by the Executive Order to make information about pricing of services available to the Medicare beneficiaries. The beneficiaries can find this pricing on the CMS Hospital Compare website. To deliver high value care, many private insurers are doing this same thing, giving their consumers the same provider cost efficiency information.” (Clairborne, 2009)

Clairborne et al. (2009) defines “the fourth and last cornerstone of value based care covers the use of incentives to promote high quality and cost effective care. This is where the new Pay for Performance (P4P) models of reimbursement for value based care come into effect. These tie payments for services a patient receives and measures the achievement of outcome. This is at

the core of many public and private value based programs reform efforts. In 2009, the P4P plan for Medicare hospital services are to start being paid under the Inpatient Prospective Payment Services (IPPS). Many private insurers are now implementing the P4P models into their reimbursement models.” (Clairborne, 2009)

CMS believes that motivational interviewing might be another way to improve quality care with patients. With each service having their own strength in the delivery of the ultimate goal of quality care, patient adherence and decreasing costs. When the outcome is improved for all involved, over time it saves money for everyone involved as well. Patients being non-compliant in treatment and with medications it can cost billions of dollars in lost profits and on the quality of life for the patient. Authors Stefanacci and Guerin (2013), define strategies to assist patients in their article called “Why Medication Adherence Matters to Patient, Payers, Providers” by explaining the roles of everyone involved.

**“Health care teams.** Although physicians play a key role in improving medication adherence by their patients, the problem is often too complex for the physician alone, necessitating support through the creation of care teams incorporating nurses, care managers, pharmacists and other clinicians either inside or outside the physician’s practice. These teams increase the number of touchpoints for patients, offering repeated checks as they move through the health care system.

**Patient engagement and education.** Counseling by primary care providers and pharmacists to help patients understand their disease and the important role of their medication in improving their condition is critical to motivating patients.

**Payment reform.** Realigning payment incentives away from rewarding volume and toward rewarding good outcomes would encourage providers to strive for improved outcomes by way of improved adherence, as would performance-based or global-service payments. Payment reform would encourage providers to invest in resources such as counseling services that would improve outcomes by increasing medication adherence.

**Health information technologies.** Secure, reliable, and robust information flowing via technologies such as electronic health records, e-prescribing, and clinical decision support systems would ensure that complete and accurate medication data are shared among all the key players, including patients, prescribing physicians, and pharmacists. For instance, a patient medication profile in a health IT system would give providers a full sense of a patient's current medications and, if linked to a pharmacy system, would indicate whether a patient filled or refilled a given medication. These systems can also include medication reminder and dispensing systems.” (Stefanacci, R.G., & Guerin, S., 2013)

### ***Conclusion***

The Value Based Healthcare System is a complex model that doesn't have a definite answer as to how it will work for everyone involved. The Centers of Medicare and Medicaid are the leaders in developing and testing multiple trials for healthcare organizations, patients, physicians, facilities, and future private insurance companies to use successfully. The reimbursement models currently in place have uncovered many changes that will need to be made in laws, technology, HIPPA and patient access to increase communication between healthcare teams and patients. CMS enacting the star rating has had revisions and continues to revise to make the

hospital, pharmacy, and home health care ratings more universal across the board. Patients will now be encouraged to be more hands on in their own care, complying to treatment but also encouraged to be educated in their treatment plan. With a healthcare team assigned to each patient, quality over quantity of visits will increase, thus, decreasing overall costs associated with treatment in patient care.

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