Winning With The New Buyer –
Negotiations Skills Program

Value Vantage PARTNERS | Healthcare Value Pricing Marketing and Selling

ACA Payment Reform Initiatives

Initiative	What Is It?	Focus & Metric	Impact
Value-Based Purchasing Program	Pay-for-performance based on quality of care	Clincal Process Measures, Mortality, MSPB, Patient Satisfaction	FY 2016: 1.75% FY 2017: 2.00%
Readmissions Reduction Program	DRG payment reductions for “excess” readmissions	CHF, AMI, Pneumonia, COPD, TKH, THA FY 2017: CABG	FY 2016+: 3.00%
Hospital-Acquired Conditions	DRG payment reduction for bottom quartile performance on HACs	Procedure Specific	FY 2015+: 1.00%, bottom 25% of all providers
Accountable Care Organizations (ACO) & CPCI	New entities to align physician and hospital incentives	Population Cost/spend per beneficiary	Voluntary
Medicare Bundled Payment Pilot	Episode-based payments surrounding hospitalizations	Multiple (e.g.: AMI, CABG, HF, Stroke, etc.)	Voluntary
Physician Value Based Modifier/MACRA	CPT payment reduction or bonus based on quality of care	Process Measures, Quality Performance, PQRS reporting	Jan. 1, 2015+ Mandatory for some, 2018 for all

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Initiative	Summary
Value-Based Purchasing Program	Launched October 1, 2012 (FY 2013). VBP imposes cuts of 1.5% to all annual inpatient hospital Medicare 'base' payments, but provides earn-back opportunity as well as additional earn-up incentives (the only program to do so) of up to 1.5% of total Medicare inpatient payments in 2015. This cut (and potential incentive) increases to 2% by 2017. For FY 2016, hospitals are measured on 4 "dimensions": clinical care processes; patient satisfaction scores, measured via HCAHPS (pronounced "h-caps"); mortality scores and finally, medicare spend per beneficiary (MSPB). Hospitals are ranked and paid in proportion to their composite performance score (two components: improvement over prior years, and performance against benchmark/peers).
Readmissions Reduction Program	Launched October 1, 2012 (FY 2013), this program penalizes up to 3% of total Medicare inpatient revenue, for higher-than-average "all-cause" 30 day readmissions on select procedures (CV and non-CV). Current domains are: AMI, HF, Pneumonia, COPD, Total knee and total hip replacements.
Hospital-Acquired Conditions	This mandatory program , which launched FY 2015 (Oct 1, 2014) creates a list of 'never events' for which hospitals will not be paid. These include specific conditions that a patient acquires while an inpatient , like an infection or an injury, and which can be "reasonably prevented". We care about one procedural area: Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED). A hospital's rate of HACs will be compared to a national benchmark, and underperforming hospitals will risk an additional 1% risk to their total annual Medicare payments, functioning much like the VBP and excess readmissions programs.
Accountable Care Organizations (ACO) & CPCI	By definition, ACOs are any group of providers (hospitals, physician groups, etc.) who come together and agree to be held 'accountable' for the care of a given population. There are 2 primary types, "public" (Medicare's Pioneer or Shared Savings ACOs), and "private" (e.g., Aetna) – more are the 'private' type of ACO, which exist in greater number than Medicare ACOs. The goal of all ACO's is to 'bend the cost curve' down. ACO's share savings when their 'cost per beneficiary' is less than the national average and likewise, penalized, when their 'cost per beneficiary' is higher than the national average. While patient populations are the focus of ACOs, they are not 'legally' contracted parties to an ACO and are free to go where they want for care.
Medicare Bundled Payment Pilot	In this voluntary program, participants petition CMS to participate in one of 4'tracks' and negotiate a lump sum payment for a grouping of providers' payments (episode of care). Providers are then paid for their services under the original Medicare fee schedule, but at a negotiated discount. Then, the cost of the patient's care episode would be compared to the total 'bundled' payment, and those providers in the bundle would benefit from any savings realized. Many hospitals are using this program to reduce physician preference items.
Physician Value Based Modifier	CMS will apply a 'value modifier' to payments under the Medicare Physician Fee Schedule (MPFS), January 1, 2015. Both cost and quality data are included in calculating payments for physicians, to include mandatory PQRS quality reporting compliance. All physicians will be subject to the value modifier by 2017. This program will sunset in 2017 and will be replaced by the MACRA program in 2018. All physicians who participate in Fee-For-Service Medicare will be governed under this program (replaced SGR).