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Implementing a Value Based Colonoscopy Contract in Gastroenterology

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Disclosures

- None

Who We Are… and Growing

- Independent seven physicians GI group
- Own two-room ASC
- Open Access Colonoscopy
  - No preop visits
- Virtual Colonoscopy and CT scan on site
- Employed anesthesiologists and pathologists
- Pathology lab
- Infusion Center

Healthcare Delivery Environment

- Three competing hospital systems
- Two competing ACO’s
- Splintering of physician referral base between different hospital systems

Vision of Digestive HealthCare Center

- We believe that staying independent as GI specialists best serves the interests of our patients

Quality Goals

- Better care by measuring and being rewarded for patient satisfaction
- Better quality by
  - Monitoring and reporting quality data
  - Making quality data transparent to patients and payers
- .

Costs Goals

- Lower costs by following evidence based guidelines
  - Appropriate screening timeframe
  - Appropriate follow up intervals
  - Managing and Controlling potentially avoidable costs during the episode time frame

Why Colonoscopy

- Time frame around the colonoscopy procedure easy to define
- Very common procedure for colorectal cancer screening and polyp removal
- Diagnostic and therapeutic i.e. can diagnose disease and take out polyps at the same time

Colonoscopy

- How performed affects quality
  - Greater than 95% completed procedures (cecal intubation rate)
- Lower costs by following evidence based guidelines
  - Appropriate screening timeframe
  - Appropriate follow up intervals
  - Managing and Controlling potentially avoidable costs during the episode time frame

Colonoscopy

- Rare complications of bleeding and perforations
  - Usually with polyp removal
  - Minimized by appropriate training and board certification in gastroenterology

Colonoscopy

- Quality increased by monitoring and reporting the number of premalignant polyps found
  - Adenoma detection rate
  - 25% women/30% men
  - The higher the Adenoma Detection Rate the better quality is the procedure
    - Ask your favorite gastroenterologist what their adenoma detection rate is
      - Mine is 36%

Colonoscopy

- Where performed affects costs
  - Inpatient hospital most expensive
  - Outpatient hospital expensive
  - Ambulatory Surgery Center less expensive

Evidence Based Quality Measures

- Adenoma detection rate
- Cecal intubation rate
- Patient satisfaction added to our contract
  - Shared savings only if high patient satisfaction as measured by the payer

Barriers in Fee for Service

- Some experts believe this incentives overutilization
  - Hospitals
    - Aligning physician practices raises costs for patients
  - PCP
  - Specialists
  - Affects essentially all providers

Barriers in FFS

- No direct financial recognition for providing and documenting quality
- No transparency in patient satisfaction, quality and outcomes

Barriers in FFS

- No financial support for value based initiatives
  - Monitoring quality and patient satisfaction and reporting to databanks costs money
  - Significant time investment by physicians in developing and implementing these contracts not recognized in FFS.
    - Needs to be supported in Bundled contract negotiations above and beyond shared savings

Barriers in FFS

- It actually costs money to lower costs!

Value Based Contracts

- First Retrospective Episode of Care Contract for Colonoscopy with Horizon Blue Cross and Blue Shield of N.J.
  - 3 years
- Prospective bundled contract for Colonoscopy with regional TPA
  - 4 years

Retrospective Colonoscopy Contract with BC/BS NJ

- Budget is established based on own practice costs
- FFS Payments are used as baseline going forward
- Quarterly financial reconciliation and sharing of savings
- Quarterly clinical analysis
  - Potentially avoidable complications and services

Prospective Colonoscopy Contract with TPA

- One price for
  - Initial consultation and follow up for 30 days
  - Colonoscopy
  - ASC
  - Anesthesia
  - Pathology
  - Guarantee to redo procedure at our cost if unable to complete due to bad colon preparation
  - Virtual Colonoscopy for failed optical colonoscopy

Quality Measures

- Quality measures reported to certified clinical registry (GiQualC)
  - Shared with patients on our website
  - Shared with payers

Achieving Savings

- Provide service in most cost efficient location
  - ASC
  - Move hospital outpatient procedures to ASC
- Standardize care to decrease variation
  - Across all contracts

Achieving Savings

- Attention to minimizing potentially avoidable complications
  - Clinical/Therapeutic complications
  - Bad preparations
  - ER visits
  - Pharmaceuticals
- Leads to coordination of care among all providers

Achieving Savings

- Clinical and financial alignment leads to increased coordination of care, including with risk-bearing PCP, PCMH and ACO's
- It's a work in progress.
- New lessons learned every quarter

Results of BC/BS NJ EOC (3 years)

- 97% patient satisfaction rate
- BC/BS Episode partners across N.J. trending better in terms of quality and cost
- Digestive HealthCare Center has achieved shared savings every quarter since the start of the program

Results Prospective Bundle

- Payment is appropriate for the services we provide
- Major infrastructure investment at the payer to administer these contracts in different practice environments

Results Prospective Bundle

- Difficult to expand to other practices
  - Many gastroenterologists do not employ anesthesiologist and pathologist and thus cannot negotiate for them
- Some GI's do not have full ownership of the ASC to be able to negotiate the costs into the bundle
  - Need relief from anti-kickback regulations in order for providers to cooperate in developing these new programs
  - Requires a "general contractor" to organize and pay for the downstream services
    - Who gets the payment
    - How do you disburse it downstream

Opportunities

- Chronic disease management in gastroenterology
  - Inflammatory Bowel Disease
    - SonarMD-Larry Kosinsky M.D.
  - Chronic Liver Disease
  - Gastro esophageal Reflux Disease

Opportunities

- We are getting better at communicating, collaborating and coordinating care
- Starting to understand how to create success in value-based contracts for our patients

Impact of Projects

- Cultivated new working relationship with payers
- Financial incentives are working to change behavior
  - Payer
  - Physicians
  - Hospital Systems
    - Need physician leaders, particularly specialists to implement these value based programs

Impact of Projects

- These contracts align the financial interests of the patients and all the participating providers

Impact of Projects

- Appropriate care and utilization
- Better Care given the Quality Metrics
- Better Service as Patient Satisfaction one of the Metrics for Shared Savings

Potential Impacts

- PCP,PCMH,ACO providers financially rewarded in their own cost containment programs when coordinating care with specialists in EOC’s and Bundled Contracts

Potential Impacts

- ACO’s and Hospital Systems have potential to increase their in network referrals when these programs are included in their delivery model
    - Physician referral patterns can be best redirected to in network providers if the physicians feel that these programs are in the best interests of the patients

Current Challenges

- Access to actionable information to coordinate care in real time
- Interoperability of practice management systems and Electronic Medical Records
- Current practice management systems are not designed to administer value based contracts
- Finding Payers who are willing to start a program

Current Challenges

- Educating Patients to Seek Care in EOC Practices
- Educating Referring Physicians, ACO's and hospital systems
- ACO's primary care focused
  - Including specialty programs challenging
- Starting a program even if all the pieces are not in place.

Lessons Learned

- Implementation costs may be reduced by negotiating an upfront “management fee” which can be credited from shared savings, thus not increasing cost of program
- Small practices need support to be able to compete with integrated systems.

Lessons Learned

- Outlier protection clause limits against catastrophic cases.
- Include only costs that participating physicians can actually control.

Lessons Learned

- Retrospective model with FFS and Shared Savings
  - Opportunity to collaborate in low risk environment
  - No downside risk initially
  - Easier to implement thus a good way to start on the road to Value Based Care

Lessons Learned

- Prospective Model
  - Difficult to implement unless all services are controlled by GI practice

Advice Based on Experience

- Payers need to identify these practices as “preferred providers”
- Payers need to educate their providers on these programs.
- Participating specialists need to reach out to other providers, particularly other specialists, to collaborate on implementing programs
- Strong message that there is clinical and financial alignment

What Can the Payers Do

- Develop a Medical Neighborhood of philosophically and economically aligned physicians and other providers
- Educate and financially incentives patients for using these programs
- Share quality and cost data with customers
- Support the medical practices in these programs by any means that increases patient volume

What Not To Do

- Don’t stand on the sidelines, start a value based program
- Don’t underestimate the clinical and financial rewards of working with specialty physicians

What Not To Do

- Don’t assume that working with Hospital Systems and ACO’s is the only way to go
  - Work with physicians first, we are closer to the patient
- Don’t forget about the “Power of the Pen” that physicians control. Include physicians particularly specialty physicians in the design and implementation of these contracts.

Acting on the Opportunity

- Meaningful payment models for care delivery by SPECIALISTS is possible
- Specialty physicians are willing and able to help redesign care
- Financial alignment of specialty physicians can lead to lower cost and better quality for PATIENTS

THANK YOU