Keynote "Volume to Value: Orchestrating provider payment models and care plans"

By Ronald Kuerbitz

Ronald started his presentation with sharing a small anecdote about Frank Maddux and his upcoming visit to Washington DC for a meeting with Andy Slavitt, administrator for the Centers for Medicare and Medicaid (CMS). During this visit, Ronald and Frank were faced with the question, why dialysis, despite the bipartisan agreement on improving value around quality, patient experience, and costs, had made so little progress on value in the past years.

In his keynote speech, Ronald took the opportunity to elaborate on this question further and to highlight at which stage the provision of care for patients with kidney disease in his opinion currently is and where he thinks it will be heading to in the future. One of the major backdrops is the expansion of costs has led to changing from a Fee For Service (FFS) system to a more quality valued system. CMS has taken the lead in this change and is gaining traction by changing a very large landscape in a short period of time. So far there are around twelve hundred accountable health care organizations that have taken on value based systems. CMS is driving this change via healthcare payments and developing learning action networks, so called HLAN, to help the community understand how they can engage in organizing value-based care.

So far, there are four categories of payment models. First, the traditional Fee For Services (FFS) model. Second, a type of quality based FFS, which has some elements of quality attached to it as well as some risks for providers. The third category are bundles, which can either be episode-based, e.g. the bundled payments for care improvement (BPCI) where hospitals or physician groups can take risks for admission up to 90 days after care, or condition based, e.g. dialysis bundles for end-stage renal disease (ESRD), which can build in responsibilities for pharmaceutical management alongside the treatment. The fourth category of payment models is population management, for example as capitation for regional or condition-based populations.

HHS has set out the objective to have 30% of all payments in category 3 or 4 by the end of this year (2016). However, they did even better and had this objective already accomplished by the end of last year (2015). By the end of 2016 CMS targets to have 85% of CMS reimbursements in advanced quality payments of FFS with the goal to move 50% to bundles or population based payments soon.

Fresenius Medical Care North America (FMCNA) is committed to moving towards value based payment. They want to take full responsibility of payment for their dialysis clinic. FMCNA is the largest provider of full capitation for renal patients under managed care. However, the challenge of going "all in" doesn't get close to all FMCNA's patients. FMCNA will need multiple payment methodologies to partner with Medicare Advantage plans, ACOs and other providers where there is an overlap of the population and to organize the delivery of care through incorporating transactions on payments. In order to ensure their population gets to CMS objective of value-based payments, it is important to develop relationships where you can organize the way care is delivered and to create sub-systems that work within regional health systems. This remains a challenge.

When Ron and Frank met with Andy Slavitt, they pointed out that there was already tremendous success driving down costs and improving quality of care even within FFS systems. This success was due to the nature of the workforce within FMCNA. There is no problem to engaging the staff and the mission of FMCNA. However, according to Ronald, the problem in healthcare is more within leadership. Simply put, you get the outcome your

system is designed to produce. Therefore, the problem is less about engaging the workforce but more about designing a system that delivers the outcome that is desired.

In recent years, cardiac mortality has been reduced by 45%, all causes by 25% and 90 day hospitalization by 20%. At the same time, patient experience and access to care have been improved. Initially, incidence rates have been high single digits but they have been stable at 3-4% for the past 5-6 years. According to Ronald, the US has reached a point where they can provide convenient and affordable access to renal care when and where needed.

The challenge FMCNA is facing now is to build upon these achievements and to develop a new and better organized system that strives to improve outcomes. Bending the life time cost curve will require a new payment methodology to align all actors (providers, labs, pharma etc.) and for FMCNA to better manage care and educate patients to understand end of life decisions. So far, there is no payment system that supports renal end stage disease care. Today, 50% of the patients start dialysis unprepared as they crash into emergency departments despite seeing nephrologists. 40% of the patients die in the first 120 days. A key factor influencing patients initially on dialysis is the high level of anxiety and depression. Most of them face a life changing event which influences not only their biological health but also their entire social system. Although not designed in bad intention, current organization of care fails to invest resources to help patients navigate through this change in life.

Ron pointed out that FMCNA has a 38% readmission rate and that 10% of the population consumes 50% of the hospitalization costs. In his opinion, a FFS system that is based on hoping that people do the right thing will never achieve any meaningful outcomes. 76% of patients are in the hospital at last 8 weeks of their life. Over half are admitted to ICUs. 45% of patients die in the hospital. Very few patients would like that but the current system is not designed to deliver a better outcome or a better end of life experience.

In order to change this situation, FMCNA is running some CMS experiments on condition-based capitation. This has achieved a 5-10% cost reduction which reduced mortality by 25%. This was accomplished via a very simple case management strategy and very simple interventions. FMCNA saw that changing physician practice can reduce incident catheter rates as well as mortality by 10-20% within the initial dialysis period. Evidence shows that keeping the patient alive throughput the first 120 days can extend their life expectancy by 2 years. This shows, that it is not only about constant care but that a lot can already be achieved within the first 120-days care episode. FMCNA has still not piloted a lot on end of life care.

One of the fundamental questions that Ronald and FMCNA are facing now is how to institutionalize this into a system? How can FMCNA bring these advantages to all patients? In Ronald's opinion, this is where payment comes into play. Medicare is working on multiple models which can allow for flexibility to redesign the system to address its fundamental needs. For example, FMCNA can run an insurance plan just for dialysis and ESRD to improve care, outcomes and experiences. Only 25% of the population could get into this program where FMCNA can organize the entire care process. This is not bad, but there is lots of room for improvement. What is needed is a new model that is organized to deliver better integrated care and that works with all relevant people who can manage kidney disease end of life care.

Ronald is confident and optimistic that there are 1200 ACO's for 20% of the Medicare population as this presents an opportunity for dialogue and coordination with FMCNA in order to redesign systems for improving care and to prevent complications. It is important

for each actor in the system to know their responsibilities, whom to talk to and whom to work with. This sounds simple but is in reality rather challenging to get in place. But CMS developing concepts of bundles for vascular procedures gives FMCNA a model to engage with ACO's and to reduce high cost events. The Kaiser model is the gold standard but unfortunately, can't be replicated that easily. The second best solution, in Ronald's view is therefore for FMCNA to re-organize the key components of care. But the industry can't achieve the CMS goal unless new payment models are developed to promote better care. He concluded that against this background it would be a shame if FMCNA cannot find some way to remove cost on a population that consumes 5% of total US healthcare costs.