Healthcare Reform & Evolving Payment Mechanisms

Maine Chapter Annual Meeting

September 15, 2016

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Director, Healthcare Finance Policy, Operational Initiatives HFMA
The Uninsured Rate is Decreasing

Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage? Among adults aged 18 and older

% Uninsured

Q1 2008  Q1 2009  Q1 2010  Q1 2011  Q1 2012  Q1 2013  Q1 2014  Q1 2015  Q1 2016

14.6%  

11.0%  

SOURCE: GALLUP-HEALTHWAYS WELL-BEING INDEX
Varying by Demographic

While this survey done by Gallup reflects an 11.0% rate, HHS released a report with an uninsured rate of 8.6% on September 7th.
Exchange Plans Premiums Continue to Increase

Figure 1
Lowest-Cost Silver Premium Percent Change from Previous Year
Lowest-cost silver plan change, in a major city in 16 states and the District of Columbia, where 2017 data are available.

<table>
<thead>
<tr>
<th>City</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providence, Rhode Island</td>
<td>-14%</td>
<td>6%</td>
</tr>
<tr>
<td>Indianapolis, Indiana</td>
<td>-10%</td>
<td>3%</td>
</tr>
<tr>
<td>Los Angeles, California</td>
<td>-1%</td>
<td>5%</td>
</tr>
<tr>
<td>Burlington, Vermont</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Seattle, Washington</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Albuquerque, New Mexico</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Portland, Maine</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Average of 17 Cities</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Las Vegas, Nevada</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Baltimore, Maryland</td>
<td>2%</td>
<td>8%</td>
</tr>
<tr>
<td>Detroit, Michigan</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Richmond, Virginia</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Hartford, Connecticut</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Denver, Colorado</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>New York City, New York</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>29%</td>
<td>31%</td>
</tr>
<tr>
<td>Portland, Oregon</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>Nashville, Tennessee</td>
<td>26%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation analysis of 2017 insurer rate filings to state regulators.
Notes: Rates are not yet final and subject to review by the state. Premium changes are representative of the rating area that contains the major city.
Employer Plan Premiums Also Increasing
Insured Still Challenged to Pay Bills

Figure 8
Problems Paying Medical Bills Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014

- **Any problem paying medical bills**: 36% (Uninsured), 17% (Newly Insured), 18% (Previously Insured)
- **Problem with medical bills led to using up savings**: 21% (Uninsured), 10% (Newly Insured), 9% (Previously Insured)
- **Problem with medical bills led to difficulty paying for basic necessities**: 18% (Uninsured), 8% (Newly Insured), 8% (Previously Insured)
- **Problem with medical bills led to borrowing money**: 15% (Uninsured), 6% (Newly Insured), 6% (Previously Insured)
- **Problem with medical bills led to being sent to collection**: 24% (Uninsured), 10% (Newly Insured), 10% (Previously Insured)

**NOTE**: Includes adults ages 19-64. “Previously Insured” includes people who were insured as of interview date and have been insured since before January 2014. “Newly Insured” include people who were insured as of interview date and gained coverage since January 2014. “Uninsured” includes people who lacked coverage as of the interview date.

* Significantly different from Newly Insured at the p<0.05 level.

**SOURCE**: 2014 Kaiser Survey of Low-Income Americans and the ACA.
Many Challenged with Understanding Cost

Very or Somewhat Confident in Understanding of the Term: “Deductible”

84% 60%

Nongroup: Nonelderly adults currently purchasing individual coverage and not eligible to buy health insurance through an employer or other group. Source: Urban Institute Health Policy Center - Health Reform Monitoring Survey, 2013
Driving Change in the Patient Financial Experience

**Historical Model**

- Gather basic info before & at the time of service.
- Billing process is post-service. Amount due is based on data gathered after service, calculated retrospectively.
- Patients told of financial obligations after insurance is billed & paid.

**The Near Future**

- Gather detailed info before & at time of service. Estimate out-of-pocket costs.
- Bill at or right after service. Many patients know in advance what they owe & agree on terms.
- Insurance bill verifies what patient already expects.
Convenient Competition

- Retail healthcare gaining momentum
  - Walgreens, CVS and Walmart providing non-urgent care for affordable rates
  - As High Deductible Health Plans (HDHP) increase across the country, these retail clinics are less costly than a visit to an urgent care or primary care physician
  - Full payment is handled at time of service

- Private companies opening increasing number of Urgent Care centers
  - Similar to retail clinics, these are more convenient than scheduling an appointment
CMS Continues to Push Providers into APMs

- Medicare Shared Savings & Pioneer ACO
  - At-risk portion of Medicare payments with quality metrics impacting financial outcome
- Bundled Payment Models
  - Governmental and commercial models combining different aspects of care episode
- Pay for Performance (MACRA/MIPS)
  - Physician and professional payment system using comparative data to incentivize quality and financial performance
Other Current Issues

• Mergers and Acquisitions continue across the country in provider and health plan segments

• Cost of new IT systems adding to expense base of many health systems and physician practices, as well as changing workflow in various operational areas

• Not-for-profit status of some providers could be challenged

• Presidential election will likely create another round of change to ACA in the next 12-24 months
Items to Consider

• Healthcare reform has impacted uninsured rates as well as **out-of-pocket costs** for consumers

• **Education and communication** are critical for both providers and patients

• The **payment models will evolve and vary** depending on payer, providers and type of service

• Managing the efficient **delivery, cost, and quality of care** will be key to success as **additional risk shifts** to providers
Challenges Ahead

• **Aligning goals** amongst providers delivering services

• Measuring **current cost** of delivering services

• Delivering care at a **lower cost**

• Changes in **risk pool** of patients receiving bundled services

• Accuracy and timeliness of **performance data**
Volume to Value

Does **Not** Mean Volume is **Bad**
Overview

Trend Drivers

FFS to Outcomes Based Payment
ACO and Bundled Payment Contracts
CMS Alternative Payment Models
Medicare and CHIP Reauthorization Act (MACRA)
Federal Deficit Impacting FFS Payment Growth

Long-Term Federal Fiscal Imbalances Are Driven by Healthcare and Retirement Programs...

...the CBO Projects Input Prices Will Grow Faster than Medicare Payments

Illustrative Hospital Medicare Margin Impact:
CBO Projections of Growth in Medicare Pymt and Input Prices

Sources:
1) 2014 Margin: MedPAC; Assessing Payment Adequacy and Updating Payments: Hospital Inpatient and Outpatient Services; December 10, 2015
2) Growth in Medicare Revenue and Input Prices: The Congressional Budget Office Economic Outlook: 2016 – 2026, pg 67
3) HFMA Analysis
Health Costs Eating into Wages

Health Insurance Costs Have Grown at an Unsustainable Rate, Depressing Employee Wages

A Growing Number of Americans Cannot Afford Health Care

Percentage of US Population By Federal Poverty Level
Family of Four

1. 100% FPL
   - Income: $24,250
   - Liquid Assets: $700

2. 200% FPL
   - Income: $48,500
   - Liquid Assets: $1,500

3. 300% FPL
   - Income: $72,750
   - Liquid Assets: $3,426

4. 400% + FPL
   - Income: $97,000
   - Liquid Assets: $18,343

Sources:
2) http://familiesusa.org/product/federal-poverty-guidelines
3) http://kff.org/other/state-indicator/distribution-by-fpl/
Variation Exists Across and within Markets By Purchaser

Medicare Spending Variation Is Mostly Driven by Utilization Differences...

Commercial Spending Variation Is Mostly Driven by Pricing Differences

Medicare spending per capita

Private insurance spending per capita

Implications

• Governmental health expenditures are crowding out investments in other areas valued by society.

• Fee for service in the public sector is unsustainable.

• Even insured “Middle Class” families would struggle financially if they had a significant medical event.

• As a result, purchasers are looking to reduce both unnecessary utilization and payment rates.
Overview

Trend Drivers

FFS to Outcomes Based Payment

ACO and Bundled Payment Contracts

CMS Alternative Payment Models

Medicare and CHIP Reauthorization Act (MACRA)
CMS’s Glide-Path to Outcomes Payment

CMS’s Long-Term Goal Is to Shift Providers to Prospective Population Based Payments
### Shifting Risk

*Payment System Reforms Will Require Providers to Bear Greater Population-Based Financial Risk*

<table>
<thead>
<tr>
<th>Degree of Population Risk Transferred to Provider by Payment System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong></td>
</tr>
<tr>
<td>Fee for Service</td>
</tr>
<tr>
<td>Paid for each unit of service w/o constraint on spending</td>
</tr>
<tr>
<td>Pay for Coordination</td>
</tr>
<tr>
<td>Additional per capita payment based on ability to manage care</td>
</tr>
<tr>
<td>Pay for Performance</td>
</tr>
<tr>
<td>Payments tied to objective measures of performance</td>
</tr>
<tr>
<td>Episodic Payments</td>
</tr>
<tr>
<td>Payment based on delivery of services within a given timeframe</td>
</tr>
<tr>
<td>Shared Savings</td>
</tr>
<tr>
<td>Shared savings from better care coordination and disease management</td>
</tr>
<tr>
<td><strong>High</strong></td>
</tr>
<tr>
<td>Capitation</td>
</tr>
<tr>
<td>Providers share savings from better care coordination and disease management</td>
</tr>
</tbody>
</table>

hfma
healthcare financial management association
Slow Transition to Risk Based Payments

*Nationally, Only 20% of Commercial Payments Are Outcomes Based*

% of Commercial Health Plan Revenue by Payment Mechanism

CMS Is Attempting to Align Quality Measures Across Payers

In Response to Negative Feedback from Providers...

...CMS Has Defined Core Measure Sets with Groups Representing Health Plans and Providers

How Consistently Are Value Metrics Defined Across Carriers in Your Market?

Specialties That Have Core Measures Sets

- ACO, PCMH, PCPs
- Cardiology
- Gastroenterology
- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics

Sources:
1) HFMA Value Project Research
Volume Still Matters

Under Outcomes Based Payment, A Large Number of “Covered Lives” Allows for Decreased Performance Variability and Provides A Sufficient Population to Support Existing Delivery System Assets

Note: This graphic indicates that entities with greater than 250,000 covered lives achieve lower variability in operating margin performance, with average performance consistently of 1-3 percent.

Implications

- Outcomes Risk Is Being Pushed to Delivery Systems, though It’s Occurring Slowly
- Many of the Models for Transferring Risk to Delivery Systems Are Experimental
- CMS Recognizes the Need to Align Efforts with the Private Sector but Hasn’t Done so on a Broad Scale Yet
- Volume (Lives under Management) Will Still Drive Profitability
Overview

Trend Drivers
FFS to Outcomes Based Payment
**ACO and Episodic (Bundled) Payments**
CMS Alternative Payment Models
Medicare and CHIP Reauthorization Act (MACRA)
What is an ACO?

From a Structural Perspective ACOs Can Include A Variety of Provider Types

Examples of Different Combination of ACO Components
Episodic(Bundled) Payments Overview

• Single payment for all services provided during the defined episode of care
  • Typically less than the sum of the individual services

• Creates a package for patient and payer simplifying billing and cost for these parties

• Incent reduction in provider cost by shifting risk
  • Should result in lower patient cost as well

• Increase collaboration across hospitals, physicians, and post-acute providers

• Improve patient outcomes and experience
Illustration of Bundled Concept

Sample Inpatient Stay

1: Current Payment Methodology:

- MS-DRG Pmt
- Physician Fee Schedule (PFS)
- Home Health PPS Episode
- Readmission: MS-DRG Pmt

- 3 Days Admit Discharge + 7 days + 14 days + 19 days + 30 days

30 Day Episode of Care

2: Bundled Payment System:

- MAC
- NORIDIAN

MS-DRG + PFS+ Avg. PAC Cost - “Efficiencies” - Readmissions

Medicare Provider

Negotiated Pmts
Current Models And Mechanics

• **Reconciliation Model**
  - Billing practices remain the same
  - Total savings or overages are determined after ‘performance period’
  - If savings target achieved, payer sends payment to provider(s)
  - If target not achieved, provider(s) send payment to payer
    - Example: Comprehensive Joint Replacement (CJR) model

• **Global Payment Model**
  - Consolidated claim/bill submitted
  - Single episodic payment received by primary provider or ACO and then distributed amongst all providers for that episode
    - Would require agreement with other providers in advance of care being provided
    - System mechanics would need to be revised
  - Example: Medicare Acute Care Episode (ACE) model
Current Models

• **Per Member Per Month (PMPM) Model**
  • Similar to Periodic Interim Payment structure (PIP)
  • If performance targets achieved, payer sends payment to ACO, if not, ACO owes payer
  • May or may not follow financial structure of Global Payment model in that the ACO
  will adjudicate claims/bills from care providers
  • Example: Medicare Oncology Care Model (OCM)

• **Direct Employer and Commercial Payer Models**
  • Employers are beginning to work directly with providers in an effort to deliver
    affordable, high quality care to their employees
  • Commercial payers utilizing various models depending on region, providers and
    patient population
Collaboration

• All providers involved in episode of care must work together to increase coordination and efficiency

• Relationships and agreements will need to be established for compliant and efficient operational and financial structures

• Need for infrastructure investments to support operational model
Direct Contracting with Centers of Excellence

Sources:
1) http://thehealthcareblog.com/blog/2012/10/18/walmart-moves-health-care-forward-again/
2) http://my.clevelandclinic.org/about-cleveland-clinic/newsroom/releases-videos-newsletters/lowes_expands_heart_healthcare_benefits
Implications

• ACOs taking on risk require significant infrastructure and collaboration to be successful

• At this point, the Episodic payments still rely on the FFS platform with a settlement post performance period

• Many different programs ongoing with more to come

• Health systems using similar episodic methods with employers to increase volume and brand awareness
Overview

Trend Drivers

FFS to Outcomes Based Payment

ACO and Episodic (Bundled) Payments

CMS Alternative Payment Models

Medicare and CHIP Reauthorization Act (MACRA)
Several Models Already in Place

Large Population Programs

• Pioneer(Next Gen) ACO
• Medicare Shared Savings Program (MSSP)
• Medicare And CHIP Reauthorization Act (MACRA)

Specific Population Programs

• Bundled Payment for Care Improvement (BPCI)
• Comprehensive Care for Joint Replacement (CJR)
• Oncology Care Model (OCM)
• Episode Payment Model for AMI, CABG and SHFFT* (EPMs)

*SHFFT = surgical hip/femur fracture treatment
Sharing More Appealing Than Downside Risk

Figure 2
Accountable Care Organization (ACO) Models

- Medicare Shared Savings Program (MSSP)
- Pioneer ACOs
- Advance Payments ACOs

NOTE: One MSSP in Puerto Rico not pictured.
SOURCE: Map data downloaded January 19, 2016 from CMS: https://innovation.cms.gov/initiatives/map/index.html. Participant counts in this dataset are updated periodically. See Table 4 for official counts in most recently-available CMS documents and webpages.
### Medicare ACO Models

<table>
<thead>
<tr>
<th>Issue</th>
<th>MSSP Track 1</th>
<th>MSSP Track 2</th>
<th>MSSP Track 3</th>
<th>Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min # Beneficiaries</strong></td>
<td>5,000</td>
<td>5,000</td>
<td>5,000</td>
<td>10,000*</td>
</tr>
<tr>
<td><strong>Attributed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assignment</strong></td>
<td>Preliminary Prospective w/ Reconciliation</td>
<td>Preliminary Prospective w/ Reconciliation</td>
<td>Prospective Assignment w/ Beneficiary Attestation Allowed</td>
<td>Prospective Assignment w/ Beneficiary Attestation Allowed</td>
</tr>
<tr>
<td><strong>Risk Adjustment</strong></td>
<td>Newly Assigned Adjusted by CMS-HCC; Continuously Assigned by Demographics Unless HCC Decreases</td>
<td>Newly Assigned Adjusted by CMS-HCC; Continuously Assigned by Demographics Unless HCC Decreases</td>
<td>Newly Assigned Adjusted by CMS-HCC; Continuously Assigned by Demographics Unless HCC Decrease</td>
<td>HCC Model Allowed to Increase up to 3% Year Over Year</td>
</tr>
<tr>
<td><strong>Waivers</strong></td>
<td>None</td>
<td>None</td>
<td>SNF 3 Day Rule (2017) Telehealth (2017)</td>
<td>SNF 3 Day Rule Telehealth Homebound Primary Care Co-Pay</td>
</tr>
</tbody>
</table>

## Medicare ACO Models

<table>
<thead>
<tr>
<th>Issue</th>
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<th>MSSP Track 2</th>
<th>MSSP Track 3</th>
<th>Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings Sharing Rate</td>
<td>Up to 50% Once MSR Exceeded</td>
<td>Up to 60%</td>
<td>Up to 75%</td>
<td>A: Up to 85% B: Up to 100%</td>
</tr>
<tr>
<td>Loss Sharing Rate</td>
<td>N/A</td>
<td>1st $ Once MLR Is Met or Exceeded; May Not be Less Than 40% or Exceed 60%</td>
<td>1st $ Once MLR Is Met or Exceeded; May Not be Less than 45% or Exceed 75%</td>
<td>1st $ for Spending above the Benchmark</td>
</tr>
<tr>
<td>Performance Payment Limit</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>MSR/MLR</td>
<td>2 – 3.9% Based on Attributed Lives</td>
<td>Choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in 0.5% increments between 0.5% - 2.0%; symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1)</td>
<td>Choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in 0.5% increments between 0.5% - 2.0%; symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1)</td>
<td>No MLR/MSR. CMS Applies a Discount to the Benchmark.</td>
</tr>
</tbody>
</table>
# Medicare ACO Models

<table>
<thead>
<tr>
<th>Issue</th>
<th>MSSP Track 1</th>
<th>MSSP Track 2</th>
<th>MSSP Track 3</th>
<th>Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Benchmark</td>
<td>Based on 3 years of historical costs, using risk-adjusted average per capita spending for Parts A and B Medicare FFS beneficiaries who would have been assigned to the ACO.</td>
<td>Based on 3 years of historical costs, using risk-adjusted average per capita spending for Parts A and B Medicare FFS beneficiaries who would have been assigned to the ACO.</td>
<td>Based on 3 years of historical costs, using risk-adjusted average per capita spending for Parts A and B Medicare FFS beneficiaries who would have been assigned to the ACO.</td>
<td>Uses a hybrid approach to incorporate historical and regional costs. Initially, the prospective benchmark is established through the following steps: (1) determine the historic baseline expenditures; (2) apply regional projected trend; (3) risk adjust using HCC model; (4) apply the discount,</td>
</tr>
<tr>
<td>Subsequent Benchmark</td>
<td>Same approach with as 1st period but uses equally weights historical benchmark years (33% each year) and accounts for savings generated by the ACO in its prior agreement period.</td>
<td>Same approach with as 1st period but uses equally weights historical benchmark years (33% each year) and accounts for savings generated by the ACO in its prior agreement period.</td>
<td>Same approach with as 1st period but uses equally weights historical benchmark years (33% each year) and accounts for savings generated by the ACO in its prior agreement period.</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**Note:**
- MSSP Track 1, MSSP Track 2, and MSSP Track 3 refer to the different tracks of the Medicare Advantage Model, each with its own benchmark approach.
- Next Gen ACO refers to the next generation of ACO models, which may incorporate different methodologies and approaches.
- Initial Benchmark details the initial establishment of the benchmark, while Subsequent Benchmark details the subsequent calculations and adjustments.
- The hybrid approach for Next Gen ACO involves combining historical and regional costs with risk adjustment and discount application.
MSSP’s Evolving Benchmarks

Responding to Feedback CMS Has Finalized Changes to the MSSP Benchmark Calculation

Finalized MSSP Benchmarking Methodology for ACOs Beginning After 2014

<table>
<thead>
<tr>
<th>Agreement Period</th>
<th>Trend Factors</th>
<th>Blend of Regional vs. National Benchmark Data</th>
<th>Adj. for Prior Savings</th>
<th>Adjusted for Changes in ACO Participant List</th>
<th>Adjustment for Health Status and Demographic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>National</td>
<td>100% National</td>
<td>No</td>
<td>Uses benchmark year assignment based on the ACO’s certified Participant List for the performance year.</td>
<td>New bene’s adj. using HCC model; continuously assigned adj. using demographics</td>
</tr>
<tr>
<td>2nd</td>
<td>Regional</td>
<td>35% Regional/* 65% National</td>
<td>No</td>
<td>Same as above; regional adjustment re-determined using ACO Participant List for the performance year.</td>
<td>Same as above</td>
</tr>
<tr>
<td>3rd</td>
<td>Regional</td>
<td>70% Regional/** 30% National</td>
<td>No</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
<tr>
<td>4th</td>
<td>Regional</td>
<td>70% Regional/ 30% National</td>
<td>No</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
</tbody>
</table>

*If an ACO is determined to have higher spending compared to region blend is 25% regional/75 national
**If an ACO is determined to have higher spending compared to region blend is 50% regional/50 national
Medicare ACOs Not Producing Significant Savings

In 2014 Approximately 50% of ACOs Generated Savings with Only 25% Receiving Shared Savings

CMS MSSP Performance Year 2 Results - 2014

<table>
<thead>
<tr>
<th>ACO Performance</th>
<th># of Beneficiaries (1,000s)</th>
<th># of ACOs</th>
<th>Total Spending ($,millions)</th>
<th>Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Benchmark</td>
<td>Minus Actual</td>
</tr>
<tr>
<td>Negative</td>
<td>152</td>
<td>2,619</td>
<td>25,078</td>
<td>(683)</td>
</tr>
<tr>
<td>Positive (w/in Corridor)</td>
<td>89</td>
<td>1,323</td>
<td>13,231</td>
<td>168</td>
</tr>
<tr>
<td>Shared Savings (Quality Issues)</td>
<td>6</td>
<td>34</td>
<td>386</td>
<td>29</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>86</td>
<td>1,354</td>
<td>14,190</td>
<td>777</td>
</tr>
<tr>
<td>Total</td>
<td>333</td>
<td>5,330</td>
<td>52,885</td>
<td>291</td>
</tr>
</tbody>
</table>

http://healthaffairs.org/blog/wp-content/uploads/4482230_Introcaso_table_revised.jpg
Mixed Results for ACOs Continue in 2015

• Over 400 Medicare ACOs generated more than $466 million in total program savings in 2015 with 125 qualifying to share savings.

• The results show that more ACOs are sharing savings in 2015 compared to 2014 and that ACOs with more experience in the Pioneer ACO Model and the Medicare Shared Savings Program tend to perform better over time.

• While the cohort of Pioneer ACOs decreased between PY3 (2014) and PY4, they still generated total model savings of over $37 million.
  • Of the eight Pioneer ACOs that generated savings, six generated savings outside a minimum savings rate and earned shared savings.
  • Of the four Pioneer ACOs that generated losses, one generated losses outside a minimum loss rate and owed shared losses.

• The mean quality score among Pioneer ACOs increased to 92.26 percent in PY4 from 87.2 percent in PY3. The mean quality score has increased in every year of the model, with a total increase of over 21 percentage points since the first year.

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html
Initial Episodic Programs Still Ramping Up

• **ACE Demonstration**: A three-year experiment by the CMS, the Acute Care Episode (ACE) Demonstration, that included 28 cardiac and nine orthopedic procedures led to savings of $319 per patient.

• **BPCI**: For most BPCI models, results are preliminary and unspecified due to minimal timeframes of analysis and small sample sizes. In one model, early comparison group analysis showed lower cost growth during the hospitalization phase, but not during the post-acute phase.

  • In another model, post-acute spending was lower. Preliminary results from other models showed either no statistical difference in overall spending, or results are unavailable.

  • Early analysis found no notable differences in quality between BPCI and non-BPCI participants across all four BPCI models.

  • Three of the four models increased in provider participation since the start of the BPCI program.
Noticeable Impact on Care Delivery

BPCI Model 2 Early Results Suggest Participants Are Changing Care Pathways

% of PAC Users Discharged to Institutional PAC
Model 2 Surgical Orthopedic Excluding Spine Episodes

Est. ∆ in Part A Pmt Per Case
Model 2 Surgical Orthopedic Excluding Spine Episodes

Source:
Lewin Group, CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report
Attribution Rules Are Complex

“Precedence” Rules Govern Who an Episode Is Attributed to If Multiple BPCI Participants Are Involved in an Episode

Precedence Rules

Model 4
- Later admission
- Earlier admission

Models 2 & 3
- Earlier or Same CE-PoP
- Later CE-PoP

Model 2
- Attending PGP
- Operating PGP
- Non PGP (Hsp, SNF, IRF, HH, etc)

Model 3
- Attending PGP
- Operating PGP
- Non PGP (Hsp, SNF, IRF, HH, etc)

Source: Bundled Payments BPCI Program; Melinda Hancock, Partner DHG Healthcare; HFMA BPCI-CJR Council Web-Discussion; December 2014
Multiple Models with Different Criteria

The Voluntary BPCI Program Offers Four Different Models, Two of Which Involve Retrospective Payments

- **Model 1**: All MS-DRGs 1% Discount
  - Prospective

- **Model 2**: Acute Care Episode with PAC Bundling
  - Part A & B Discount: 30 and 60 Day Episodes – 3%, 90 Days – 2%
  - Retrospective

- **Model 3**: Post Acute Care (PAC) Episode Bundling
  - Part A & B Discount: 3% Regardless of Length
  - Retrospective

- **Model 4**: Prospective Acute Bundling
  - Part A & B Discount: “ACE DRGs” -3.25%; All Others – 3%
  - Prospective
Some Moving From Voluntary to Mandatory

CJR Mandates a 90-Day Episodic Payment for Lower-Joint Replacement for 25% of IPPS Hospitals

Comprehensive Care for Joint Replacement

Consumer Fact Sheet

Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. In 2013, there were more than 400,000 inpatient primary procedures costing more than $7 billion for hospitalization alone.

While some incentives exist for hospitals to avoid post-surgery complications that can result in pain, readmissions to the hospital, or protracted rehabilitative care, the quality and cost of care for these hip and knee replacement surgeries still varies greatly. For instance, the rate of complications like infections or implant failures after surgery can be more than three times higher at some facilities than others, which can lead to hospital readmissions and prolonged recoveries. And the average Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,500 to $33,000 across geographic areas.

HFMA Executive Summary: http://www.hfma.org/Content.aspx?id=45125
More Mandatory Bundles Expected

Like CJR, CMMI’s Next Mandatory Bundles Will Meet Three Criteria

- High Cost/Volume
- Relatively Defined Care Path
- High Outcome Variability

Likely candidates include:
- Cardiology*
- Gastroenterology
- More Orthopedics

*CABG & AMI part of Cardiac EPM
Identify the Savings Opportunity

Given the Index Admission Spending Is Fixed, Most Savings Will Come from the Post-Discharge Period

Source: Maximizing Success in a Bundled Payment Environment, Melinda Hancock, Partner – Healthcare, DHG; Presentation at HFMA’s 2015 Annual National Institute
Recently Announced Bundles

**Overview of EPM for AMI, CABG and SHFFT***

- CMS will set targets each year on historical regional and hospital-specific data for inpatient stay and care provided 90 days post-discharge.

- Beat the target and meet quality metrics to keep savings. Miss target and pay Medicare at end of the year.

- The calculation will shift from relying mostly on hospital-specific data in the first two years of the program to only regional data in the final two years.

- Risk will be phased in with hospitals held harmless for first 15 months, capped at 5% for remainder of second year, 10% in year three and 20% in years four and five.

- The upside is capped at 5% for first two years and follows same schedule as downside in years three through five.

*SHFFT = surgical hip/femur fracture treatment*
Private Sector Bundling Efforts

Half of Commercial Bundled Payment Efforts Are Employer Driven and Focus on Centers of Excellence for Select Conditions

Common Commercial Bundles
- Joint Replacement
- Cardiovascular
- Spinal Surgery
- Cancer

Source: https://www.ebmcdn.net/~advisoryboard/infographics/Commercial-Bundled-Payment-Adoption-Tracker-10/story.html
Implications

- Many different programs following a variety of financial and quality models
- Most programs producing savings, though many participants are not sharing in savings.
- Identify at risk (clinically and socioeconomically) patients and proactively manage
  - Improve low cost cost/high convenience touch points
  - Engage and activate patients/families in their own care
  - Partner with community groups to Provide Social Support
  - Initiate tracking of episodic costs for those populations likely to be bundled
- Understand the cost/quality impact of referral decisions
  - Be selective about partners (non-employed MDs and Post-Acute providers)
- CMS will continue to roll out new programs where they see opportunity for quality and cost improvement.
Overview

Trend Drivers
FFS to Outcomes Based Payment
ACO and Episodic (Bundled) Payments
CMS Alternative Payment Models

Medicare and CHIP Reauthorization Act (MACRA)
Overview of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

Passed Last Spring, MACRA Makes Three Significant Changes to Medicare Physician Payments

• Ends the Sustainable Growth Rate (SGR) formula

• Establishes Merit-Based Incentive Payment System (MIPS)

• Establishes incentives for Alternative Payment Models (APMs).

• Applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and groups of these professionals.
## Merit Based Incentive Program

While CMS Will Continue Using Existing Measures, It Is Also Developing New Ones

<table>
<thead>
<tr>
<th>Summary of MIPS Performance Categories</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong>: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong>: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities</strong>: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost</strong>: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>
Physicians with exceptional performance can earn an additional bonus up to 10%
Advanced Alternative Payment Model Incentives

MACRA Encourages Physicians to Participate in Advanced Alternative Payment Models

- **2016 -- 2019**: +0.5%
- **2020 -- 2025**: 0%
- **2026 & Beyond**: +0.25% for MIPS Path
  - 5% Per Year Lump Sum APM Bonus
  - +0.75% for APM Path
Advanced Alternative Payment Models (AAPMs)

To Qualify as an AAPM Participant, the Model and Physician Must Meet the Following Criteria:

| Alternative Payment Model                  | • A CMS Innovation Center Model  
|                                          | • Medicare Shared Savings Program ACO  
|                                          | • CMS Demonstration Project  
|                                          | • Demonstration required under law  
| Eligible Alternative Payment Entity       | • A payment model that requires participants to use certified EHR technology  
|                                          | • Provides for payment based on quality measures comparable to those in MIPS  
|                                          | • Bares more than nominal financial risk for monetary losses under the APM or is a medical home expanded under CMS Innovation Center authority.  
| Qualifying APM Participant:               | A specified percent of the physician’s payments or patient volume must be attributable to services furnished under an Alternative Payment Model.  

For an APM to Qualify as “Advanced” It Must Meet the Following Risk Requirements

**AAPM Risk Requirements**

- Bear total risk of 4% of expected expenditures
- Bear marginal risk of at least 30%
- Be subject to a minimum loss ratio (MLR) of no more than 4%

**Examples of AAPM Financial Structures That Meet and Do Not Meet Requirements**

<table>
<thead>
<tr>
<th>Example</th>
<th>Benchmark</th>
<th>Actual</th>
<th>Marginal Risk Sharing Rate</th>
<th>Stop Loss</th>
<th>Amount Owed</th>
<th>Is Financial Risk Criterion Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1</td>
<td>$1,000,000</td>
<td>$1,100,000</td>
<td>50%</td>
<td>15%</td>
<td>$50,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Example 2</td>
<td>$1,000,000</td>
<td>$1,100,000</td>
<td>60%</td>
<td>10%</td>
<td>$60,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Example 3</td>
<td>$1,000,000</td>
<td>$1,100,000</td>
<td>40%</td>
<td>3%</td>
<td>$30,000</td>
<td>No</td>
</tr>
<tr>
<td>Example 4</td>
<td>$1,000,000</td>
<td>$1,100,000</td>
<td>100%</td>
<td>5%</td>
<td>$50,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Example 5</td>
<td>$1,000,000</td>
<td>$1,100,000</td>
<td>25%</td>
<td>10%</td>
<td>$25,000</td>
<td>No</td>
</tr>
</tbody>
</table>
Limited AAPM Options

Based on CMS’s Proposed Rule, Few Currently Available Models Qualify as AAPMs

Alternative Payment Models that Meet CMS’s Proposed Risk Criteria

- Comprehensive Primary Care Plus*
- MSSP Tracks 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care
- Oncology Care Model**

*Practices of Less than 50 Providers Under the Corporate Umbrella
**Two-sided Risk Only
APM Volume Requirements

For a Practice to Qualify as Participating in an APM, It Must Meet Specific Volume Requirements

Percentage of Payments that Must be Attributable to an Eligible APM Entity

- **2019 & 2020 Medicare**: 25% Volume in an APM, 75% Volume in an FFS
- **2021 & 2022 Medicare or All-Payers**: 50% Volume in an APM, 50% Volume in an FFS
- **2023 & Beyond Medicare or All-Payers**: 75% Volume in an APM, 25% Volume in an FFS
Implications

- Model and understand the Risk/Reward Trade-Off of participating in an AAPM.

- Analyze CMS Quality and Resource Use Reports to understand practices’ performance.
  - If participating in MIPs, select metrics to submit based on relative performance.

- If pursuing the AAPM Bonus Payment, align AAPM contracts with provider-owned plan to CMS requirements.
  - Understand volume of patients attributed to your qualifying AAPMs and monitor other APMs/providers that could sap volume.
Questions?

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