HFMA Region 9 Webinar
Are You on the Right Path to Value?

March 21, 2016

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Vice President
The Affordable Care Act’s Path to Payment Reform and Corresponding Impact on the Health Care Industry (1 of 2)

- The original law focused on:
  - Premium subsidies and new taxes
  - Expansion of coverage, and
  - Reduction in overall healthcare spend in the Traditional Medicare and Medicare Advantage programs.

There was limited consideration in the overall corresponding effect on utilization and intensity of services, among other fundamental economic impacts – leaving the door open for “market-driven” payment reform.
Federal and state agencies and commercial payers have used the momentum behind the law to begin driving to various forms of:

- Value-based contracting
- Accountable care, and
- Population health management initiatives

Key examples of these trends include:

- **In 2016, CMS is extending value-based alternative payment models** to its fee-for-service program in addition to expanding the MSSP and Pioneer ACO (Next Generation) programs.

- **Medicare Advantage and many managed Medicaid plans are selectively partnering with high performing and risk-ready providers** to ensure that patient engagement, accurate documentation, and gaps-in-care quality targets and ratings are met or risk becoming unprofitable.

- **Commercial payers are leveraging “accountable care” as a new generation of tools** to re-encourage a fifteen year relaxation of price and performance competition between providers by linking commercial accountable care initiatives to narrow network benefit designs that manage unit costs, drive deeper discounts, and reduce hospital admissions.
Some “Juicy” Quotes that Signal Public-and Private-Sector Support for Payment Reform......

“HHS has set a goal of tying 90% of all traditional Medicare payments to quality or value by 2018”

- Sylvia M. Burwell, Secretary, HHS 1/26/15

“There is considerable bipartisan support for moving away from fee for service toward alternative payment models that reward value, improve outcomes, and reduce costs”

- Janet Marchibroda, Bipartisan Policy Center

“Today’s announcement by Secretary Burwell is a major step forward in achieving [the goal of] advancing a patient-centered health system”

- Karen Ignani, President & CEO, America’s Health Insurance Plans, 1/26/15

“In 2017, 100% of Medicare physicians will be in outcomes-based payment arrangements”

- Patrick Conway, Chief Medical Officer, CMS, 4/10/14
.....And the Resulting Pace to Operationalize Value-Based Payments has Accelerated Significantly

“Looking forward, we project that 20% to 25% of our medical costs will run through some form of value-based network contract in 2014 and are committed to increasing that participation percentage to 45% by 2017.”

“Thirty-seven Blue Plans have more than 350 value-based programs in market or in development, with more than 215,000 participating providers providing care to nearly 24 million members.”

“Cigna has been at the forefront of the accountable care organization movement since 2008 and now has 114 Cigna Collaborative Care arrangements with large physician groups that span 28 states, reach more than 1.2 million commercial customers and encompass more than 48,000 doctors.”

“...increase value-based payments to doctors and hospitals by 20% this year to north of $43 billion...ended the year at about $36 billion of spend in value-based arrangements and we’re looking to drive that north of $43 billion in 2015.”

“We hope to have 75 percent of primary care physicians in our networks participating in this population health model by 2016.”

“HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.”

125%
350 VB Pmt. Programs
114 Coll. Care Programs
20%
75% of PCPs in Pop. Health
67%
Thru MACRA
Some Quick Grounding on MACRA.....and MIPS

MACRA = The Medicare Access and CHIP Reauthorization Act of 2015

It Did Three Key Things:
1. Repealed the Sustainable Growth Rate Formula (aka Doc Fix).
2. Authorized Medicare to change how it rewards clinicians: value over volume; and
3. Created the Merit-Based Incentive Payments Systems (MIPS), which aggregated 3 separate payment programs:
   - Physician Quality Reporting Program (PQRS)
   - Value-Based Payment Modifier
   - Medicare EHR Incentive Program

And provided bonus payments for participation in eligible alternative payment models (APMs)

Alternative payment models: Some payment is linked to the effective management of a population or an episode of care
FFS Linked to Quality: At least A portion of payments vary based on quality or efficiency
All Medicare FFS

Source: CMS
A Closer Look At Alternative Payment Models

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td>Accountable Care Organizations</td>
<td>Medicare Shared Savings Program ACO*</td>
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<td>Pioneer ACO*</td>
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<td>Comprehensive ESRD Care Model</td>
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<td>Next Generation ACO</td>
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<td>Bundled Payments</td>
<td>Bundled Payment for Care Improvement*</td>
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<td>Comprehensive Care for Joint Replacement</td>
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<td>Oncology Care</td>
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<td>Advanced Primary Care</td>
<td>Comprehensive Primary Care*</td>
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<td>Multi-payer Advanced Primary Care Practice*</td>
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<td>Other Models</td>
<td>Maryland All-Payer Hospital Payments*</td>
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<td>ESRD Prospective Payment System*</td>
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* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011  Source: CMS
## And where Payers are Potentially Headed with Them

<table>
<thead>
<tr>
<th>Value-Based Payments</th>
<th>Shared Savings/ACO</th>
<th>Shared Risk</th>
<th>Full Risk</th>
<th>Global Risk</th>
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<tbody>
<tr>
<td>• FFS contracts-paid based on codes billed</td>
<td>• Group level agreement.</td>
<td>• Group at risk for professional services.</td>
<td>• Group at risk for Professional Services.</td>
<td>• Group/Risk Bearing Entity (RBE) capitated globally (Professional and Hospital)</td>
</tr>
<tr>
<td>• Payer measures, reports, and pays based on achieving selected metrics</td>
<td>• PPO Patients attributed vs. assigned.</td>
<td>• DOFR*** sets risk for Group, Hospital, Payer</td>
<td>• Hospital at risk for all facility and hospital based services</td>
<td>• RBE is at 100% financial risk for all medical services with few exceptions (e.g. OOA, transplant, mental health)</td>
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<td></td>
<td>• FFS rates + incentives.</td>
<td>• Group and Hospital partner(s) or Plan share % of the surplus (and possibly deficit).</td>
<td>• Plan retains premium dollars and assumes risk for out-of-area emergencies, etc.</td>
<td>• Claims and UM delegated to RBE for all risk services</td>
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<tr>
<td></td>
<td>• Good step toward managing a budget</td>
<td>• Claims and UM delegated to Group</td>
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### Table:

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<th>CMS*</th>
<th>Commercial</th>
<th>Direct Employer</th>
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<td>Discounted FFS</td>
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<td>Episodic Payment Bundles</td>
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*Includes MA

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**Legend:**
- 2016
- 2020

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**No Member Attribution**
- Member Attributed
- Member Assigned
- Member Assigned
- Member Assigned
- Member Assigned

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**Text:**

• **FFS contracts**—paid based on codes billed.
• **Payer measures, reports, and pays** based on achieving selected metrics.
• **Group level agreement.**
• **PPO Patients attributed vs. assigned.**
• **FFS rates + incentives.**
• **Good step toward managing a budget.**
• **Group at risk for professional services.**
• **DOFR*** sets risk for Group, Hospital, Payer.
• **Group and Hospital partner(s) or Plan share % of the surplus (and possibly deficit).**
• **Claims and UM delegated to Group.**
• **Group at risk for Professional Services.**
• **Hospital at risk for all facility and hospital based services.**
• **Plan retains premium dollars and assumes risk for out-of-area emergencies, etc.**
• **Group/Risk Bearing Entity (RBE) capitated globally (Professional and Hospital).**
• **RBE is at 100% financial risk for all medical services with few exceptions (e.g. OOA, transplant, mental health).**
• **Claims and UM delegated to RBE for all risk services.**
Critical Considerations when Tracking to Value

- Appropriate reward for value and risk
- Cost coverage for infrastructure & investments
- The entire continuum of care must be addressed
- Care process redesign

* Source with Coker Analysis: The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement, Bobbi Brown & Jared Crapo, 2014
Plotting Population Health Capability to Payment Models

Sustaining

*Delivering patient-centered approach and demonstrating adaptability to changing needs, expectations and market dynamics*

Developing

*Educating stakeholders on capabilities required for care management, network adequacy, financial position and information technology*

Lower

*Upside $ potential tied to specific activities*

Level of Financial Risk/Reward

Higher

*Full $ Premium for Medical and Administrative Costs*

**Population Health Capability Maturity**

- **Value-based payments & quality bonuses**
- **Direct Employer Contracting**
- **Commercial or Medicare ACO (1-Sided Risk)**
- **Commercial or Medicare ACO (2-Sided Risk)**
- **Pioneer ACO**
- **Commercial Shared Risk Arrangements**
- **Bundled Payments**
- **Full Risk Arrangements**
- **Next Generation ACO**
- **Licensed Medicare Advantage Plan**
- **Triple Aim Heaven**
What Are Payers Seeking in Provider Partners?

<table>
<thead>
<tr>
<th>NATIONAL</th>
<th>TIERED</th>
<th>LOCAL</th>
<th>FOCUSED</th>
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<tbody>
<tr>
<td>Growth Orientation</td>
<td>Transformative Efficiency</td>
<td>Tight Physician Integration</td>
<td>Care Redesign &amp; Activation of the Consumer</td>
</tr>
<tr>
<td>• Large. National. Seamless.</td>
<td>• Quality and cost efficiency designation</td>
<td>• A local, limited network of doctors and hospitals</td>
<td>• Locally customizable capabilities to meet unique market needs</td>
</tr>
<tr>
<td>• Access to away from home care</td>
<td>• 21 specialties representing 85% of total medical spend</td>
<td>• Drives value through quality, cost-effective providers</td>
<td>• Delivery system collaboration to help increase quality and cost-efficiency</td>
</tr>
<tr>
<td>• ~840,000 care providers</td>
<td>• 35-40% of xxx doctors receive designation</td>
<td>• 19 markets in 2016</td>
<td>• Dedicated level of customer support and advocacy throughout care</td>
</tr>
<tr>
<td>• ~15,000 facilities</td>
<td>• In 32 states (72 markets)</td>
<td>• Flexible options:</td>
<td>• Advanced tools/resources give customers the insight, guidance and confidence to choose the coverage that fits them best</td>
</tr>
<tr>
<td>• Flexible copay, coinsurance and deductible options</td>
<td>• Included in online directories to make finding doctors and facilities simple and clear</td>
<td>– Away from home care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Copay, coinsurance and deductible</td>
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Source: HFMA; Coker Analysis
What Are Providers Seeking in Payer Partners?

Traditional Value Chain
- Product Innovation
- Sales/Distribution Management
- Member Servicing/Outreach
- Medical Economics/Underwriting/Pricing
- Claims Management
- Care Management
- Provider Management

New Business Model
- Service Advisor
- Financial Manager
- Transaction Processor
- Health Services Navigator/Optimizer

Seamless Integration of Individualized Data and Predictive Analytics
What Does a Sustainable Population Health Management Program Look Like?

A connected system of value-based care that centralizes the patient while

• Taking appropriate levels of risk for the population that it serves and the associated plan designs

• Leveraging data and expertise to drive continuous quality improvement

• Improving margins and rewarding high performing providers for their contributions to providing the right care at the right time, and in the right setting
The First Step To Take: Assess the Vagaries of Your Market

Engaged Employers and Consumers
Taking more responsibility for health and wellness — “my employees, my health, my money, my way”

Providers Reorganizing and Redesigning Care Delivery
Assuming more performance accountability as fee-for-value payment models continue to emerge

Better experience
Improved outcomes
Reduced costs

Assess Payer and Product Market Dynamics
Determine Service Area Demographics and Local Population Health Profile
Risk Continuum/Market Product Alignment, and Delegation Readiness
Direct Employer Relationship and Payer Partnership Opportunities

Streamlining operational processes in order to support new business models
Integrated clinical and claims business intelligence with zero latency
Then Ask and Address the Following Key Questions and Considerations

<table>
<thead>
<tr>
<th>Assess</th>
<th>Design</th>
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<tbody>
<tr>
<td>• What impact will Service Area &amp; Local Population Demographics have?</td>
<td>• What is the consumer engagement strategy?</td>
</tr>
<tr>
<td>• What are the Optimal Product/Delivery Models that will support the transformation?</td>
<td>• Which providers will constitute the core of the program? How will they be contracted and what incentives will be deployed?</td>
</tr>
<tr>
<td>• What is the path to performance accountability?</td>
<td>• Which payer(s) will be optimal partners for PH initiatives? Is there willingness to modify/customize plan designs around PH program?</td>
</tr>
<tr>
<td>• How deep will the organization want to go with performance risk &amp; reward?</td>
<td>• What is the funding/risk model?</td>
</tr>
<tr>
<td>• Which partnerships need to be cultivated w/ local Employers, Payers, and other Providers?</td>
<td>• Will the value/risk-based infrastructure be bought or built? Is dedicated leadership required?</td>
</tr>
<tr>
<td>• What is the ROI-based Impact associated with the transition?</td>
<td>• What is the transition timeline?</td>
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<tr>
<td></td>
<td>• Which quality measures can be standardized for all payers?</td>
</tr>
<tr>
<td></td>
<td>• Are there progressive employers that want to engage?</td>
</tr>
</tbody>
</table>

*Provider Network & Contracting*

*Care Delivery & Management*

*Product Placement & Consumer Engagement*

*Population Health & Care Process Improvement*

*Service Operations & Capability Delivery*
Thank You

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