Healthcare Financial Management Association

Winning the Shift from Volume to Value –
The Push towards Alternative Payment Models

January 26, 2017
Agenda

Introductions

Regulatory Update

Shift from Volume to Value

Bundled Payments

Operational Implications of VBC

Q & A
## The Road Ahead: Post-Election Policy Changes

The new administration will likely bring change to the ACA, but it is unlikely MACRA will be significantly impacted due to bipartisan support and other macro trends.

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>President Trump &amp; House Republican Policy Positions</th>
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<tbody>
<tr>
<td><strong>ACA</strong></td>
<td>• Repeal and replace some of the key provisions of the ACA while keeping basic protections intact (e.g., pre-existing conditions)</td>
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| **Exchanges** | • Repeal the ACA exchanges  
• Provide a tax credit in the form of a monthly payment to use toward purchasing insurance  
• Expand use of HSAs and other consumer-oriented options for coverage  
• Encourage expansion of private exchanges by allowing consumers to get tax credits  
• Allow the purchase of plans across state lines |
| **Cadillac Tax** | • Repeal the Cadillac tax and cap the tax break on employer-based premiums |
| **MACRA** | • President Trump has not indicated interest in unravelling payment reform or the focus on reducing cost and improving quality  
• MACRA was a bipartisan, bicameral agreement to address a long-standing problem from Congress and the medical profession  
• The increased emphasis on consumerism and affordability, including greater consumer responsibility for paying for health care, is likely to stay and perhaps even grow with President Trump  
• Repealing MACRA would essentially leave CMS without a way to pay clinicians for Medicare-related services |
| **Medicare** | • Move to a premium support model using an income-adjusted contribution toward a beneficiary’s choice of plan  
• Repeal the Medicare Advantage (MA) benchmark caps, coding payment adjustments, Independent Payment Advisory Board, and the US Centers for Medicare and Medicaid Services (CMS) Innovation Center  
• Combine Medicare Parts A and B in the premium support program  
• Create a Medicare Exchange allowing beneficiaries to shop for MA plans and traditional Medicare in one place |
| **Medicaid** | • Per-capita allotment (give states federal funds based on 4 categories: aged, blind/disabled, children, adults)  
• Block-grant funding |

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**Providers generally have “stayed the course” expecting activity around MACRA and shift towards value-based models to continue**
Drivers of VBC Contracting

The shift from volume to value is gaining traction, driven primarily by a few major forces

**Demand for Value**

Traditional payers, as well as engaged consumers, are demanding more—quality, evidence, and transparency—for fewer dollars.

**Status Quo Creates Financial Gap**

Health care reform mandates, rising costs, and declining reimbursements are pushing earnings down, while populations are shifting towards segments with lower reimbursements (e.g., Medicare, Medicaid).

**Government Pronouncements and Programs**

The federal government has made their mark on health care through regulations and guidelines, such as the ACA and MACRA.

**Need to Capture Market Share**

Payers (e.g., health plans, employers) are seeking value-based partnerships triggering the need to shift to VBC to maintain (defensive) and increase (offensive) market share in the face of increasing competition and new entrants.

**Expending Capabilities**

From genetic breakthroughs and nanotechnology to digital health and the cognitive cloud, technology is changing health care enabling new approaches to care.
MACRA: Disruptive by Design

MACRA is creating the impetus for a shift towards VBC that will require new investments and/or re-thinking of current strategies

<table>
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<th>What MACRA <em>Is</em></th>
<th>What MACRA <em>Is Not</em></th>
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| Offers significant financial incentives for clinicians to move from traditional fee for service systems into risk-bearing / coordinated care models | The first or only factor influencing a shift toward VBC, rather it is the tipping point amongst other initiatives focused on driving value:  
- Reference-based pricing  
- Benefit design changes / narrow network  
- Other innovation programs (e.g., MSSP) |
| Poised to drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare | Limited to professional fee schedules  
- As physician change referral patterns over next 2-3 years, it will have dampening impact on facility and other revenue streams  
- Given the downward pressure on revenue, fixed cost infrastructure will become a burden for many health systems  
- As utilization levels decrease, deliberate (and customized) strategies will be needed to balance volume and value models |
| Will illuminate performance of individual clinicians which will likely have brand and reputation implications | |
| Will create incentives for clinicians to re-evaluate decisions on services rendered, referrals, and networks that will impact hospital and physician utilization trends | |
How Value is Generated in VBC Payment

Organizations successfully bending the cost curve are pulling a combination of coordinated levers initially focused on shorter-term solutions.

- **Aligned Physician Network**: A clinically-integrated network is essential to knowing where members receive care and understanding the organization’s populations.

- **Payment Models**: Implementing mutually agreeable financial arrangements ensures all parties share in the upside and downside of the financial risks of managing the attributed population.

- **Medical Management**: Understanding your population’s health is crucial to managing your risk while ensuring patients receive coordinated care from the highest quality, lowest cost providers.

- **Patient Engagement**: Establishing communication channels and engaging patients wherever and whenever they need care is critical to empowering patients to be accountable for their own care.

Payment models are a critical element in the overall shift to VBC catalyzing the other levers and will be the focus of today’s discussion.
Payment Model Options and Characteristics

VBC payment arrangements come in many flavors. The right selection depends on the purpose and enabling capabilities.

**Support Better Performance**

**Pay for Better Performance**

**Pay for Higher Value**

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**Fee-for-Service (FFS)**
- Volume based model
- Low Risk

**Shared Savings (P4P, P4Q, and PCMH)**
- FFS until year-end reconciliation
- Incentives for achieving pre-defined cost and/or quality metrics
- No downside risk

**Bundled Payments**
- Arrangement with pre-determined reimbursement for clinically defined episodes
- Risk limited to specific episodes

**Shared Risk**
- FFS until year-end reconciliation with upside and downside risk within a pre-determined corridor
- Most flexible model
- Typically more upside potential than downside risk

Today's Focus

**Global Capitation**
- Full-risk arrangement with provider bearing the full impact of any upside or downside risk
- Provider receives PMPM for attributed lives
- Typically does not include insurance risk

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Increasing Level of Risk, Impact and Capabilities Required
Overview of Bundled Payment Programs

Bundled payments continue to expand in Medicare, resulting in an increase in activity in the Commercial sector as well as Medicaid

What is a Bundled Payment?

A single payment to providers or health care facilities for all services incurred in the same episode of care or to treat the same condition
- Both services incurred at the participating provider or other providers are included in the bundle
- Providers assume financial risks for the total cost of the services within the bundle

Illustrative example of bundled payment:

### Traditional Payment:

1. Pre-admission testing: $100
2. Inpatient admission: $8,000
3. Rehab visit: $400
4. Follow-up office visit: $200
5. Readmission: $5,000
6. Follow-up office visit: $200

Total: $13,900

Pre-determined Bundled Payment: $12,000

Provider lost $1,900 in this example (assuming same performance as in the traditional payment example)
Bundles in the Marketplace

Although innovation continues, bundled payments won’t completely overhaul FFS payments due to the difficult nature of bundling certain diagnoses or conditions.

- The CMS BPCI Program continues to expand
- The CMS Comprehensive Care of Joint Replacement (CCJR) program is anticipated to drive additional adoption of bundling across all lines of business
- MACRA is expected to drive participation in many types of risk-bearing arrangements including bundled payments
- The new administration has been critical of CMMI requiring certain bundling

Medicare

- Most bundled payment models that have been implemented are either
  - Narrow in scope
  - Implemented in highly integrated systems with a broad array of services, such as large hospitals or academic medical centers
- Cost reduction and quality improvement result from several factors (e.g., provider adherence to guidelines, elimination of waste and utilization reduction, physician-hospital alignment); it is unclear which has the greatest impact
- Providers’ readiness to participate in bundled payment programs varies

Commercial

Medicaid

- Arkansas was the first state to try bundled payments (funded through the CMS SIM Grant). Their program targets 14 episodes of care
- Several states are pursuing a similar model, including Vermont, Ohio, Tennessee and Kentucky
- Governors across the country have are exploring bundles as a way to cut costs while ensuring high quality care is provided to the residents of their states

[Map of states with bundled payments: AR, VT, OH, KY, TN]
Challenges to Bundled Payment Programs

As providers work to implement bundled payments, they have faced major challenges

1. Ensuring Sufficient Volume

**Issue:** Adequate case volume should exist to cover the investment in new capabilities (e.g., clinical redesign, automated payment systems)

**Consideration:**
- Providers should prioritize common conditions and procedures and limit exclusions

2. Lack of Timely Data

**Issue:** Many providers lack timely data needed for quickly identifying problems and improving their care systems

**Considerations:**
- Building timely reporting capabilities using providers’ own data is a good first step although
  - Only represents a portion of the patient costs
  - Will take time to be fully operational
- Third-party vendors and health plans can support analysis of historical data and development of best practices and care benchmarks

3. Patient Steerage

**Issue:** A closed system of care is a critical tool for delivering bundled care, but may be inconsistent with the Medicare requirements (and some commercial payers)

**Considerations:**
- Enhanced benefit designs when treated by a participating provider could increase enthusiasm for the program
- High quality care and a strong reputation may increase demand for certain physicians and/or health systems

4. Integrating Post-Acute Providers

**Issue:** Providers have challenges working with post-acute providers as partners to provider the full continuum of care efficiently

**Consideration:**
- Inviting high performing post-acute providers to join the bundle and providing financial incentives to do so has been linked to improved performance
Operational Implications of VBC Payment Models

In choosing a VBC payment model, providers must be internally aligned on key strategic elements of their capabilities

- Are physicians aware of the metrics they will be held to?
- Are emerging quality results being communicated back to physicians? How are they being reported?
- Do internal incentive arrangements correlate to financial outcomes rewarding individual quality performance?
- Will meeting quality targets act as a gateway to physicians’ receipt of any shared savings fund distributions?
- Are care coordinators actively involved in contract negotiations?
- Are care coordinators involved in picking reasonable quality metrics / setting attainable targets?
- Are care coordinators prepared to use emerging quality results to inform program management and ongoing initiatives?
- Can all necessary quality data be feasibly provided to payers?
- Are IT systems/analytics capable of independently tracking quality measures?
- Will other data sources be available to track quality, beyond claims data used in payer reports?

Given limited time and resources, prioritizing capabilities has been and continues to be a major focus of providers
Payment Model Relationships: Lessons Learned

Monitoring will help recognize successful payment models and enable continuous improvement across the network and spectrum of models.

- Build trust between parties
- Data driven
- Engage physicians
- Err on the side of simplicity
- Keep an eye to competitive premiums
- Make a multi-year commitment
- Mitigate risks
Questions