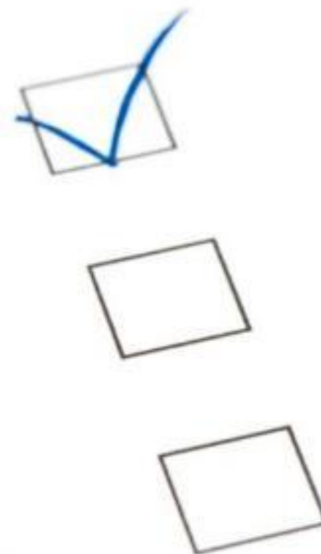
Healthcare Financial Management Association

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

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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

Policy Area	President Trump & House Republican Policy Positions
ACA	• Repeal and replace some of the key provisions of the ACA while keeping basic protections intact (e.g., pre-existing conditions)
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

Providers generally have "stayed the course" expecting activity around MACRA and shift towards value-based models to continue

Source: Deloitte Health Care Current Special Election Issue (11/11/2016)

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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

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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

What MACRA *Is*

Offers significant financial incentives for clinicians to move from traditional fee for service systems into risk-bearing / coordinated care models

Poised to drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare

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

What MACRA *Is Not*

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)

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

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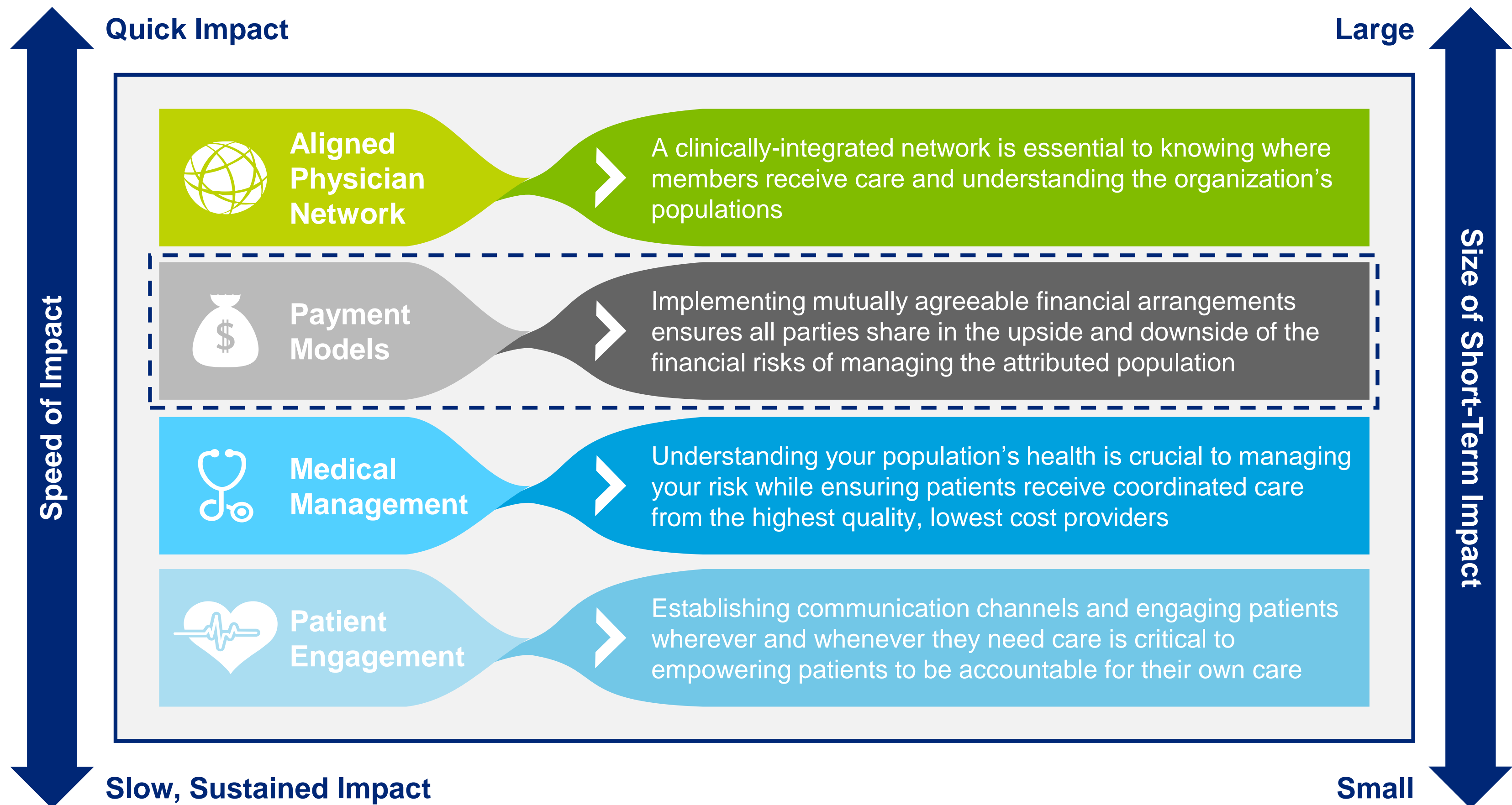
How Value is Generated in VBC Payment

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



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

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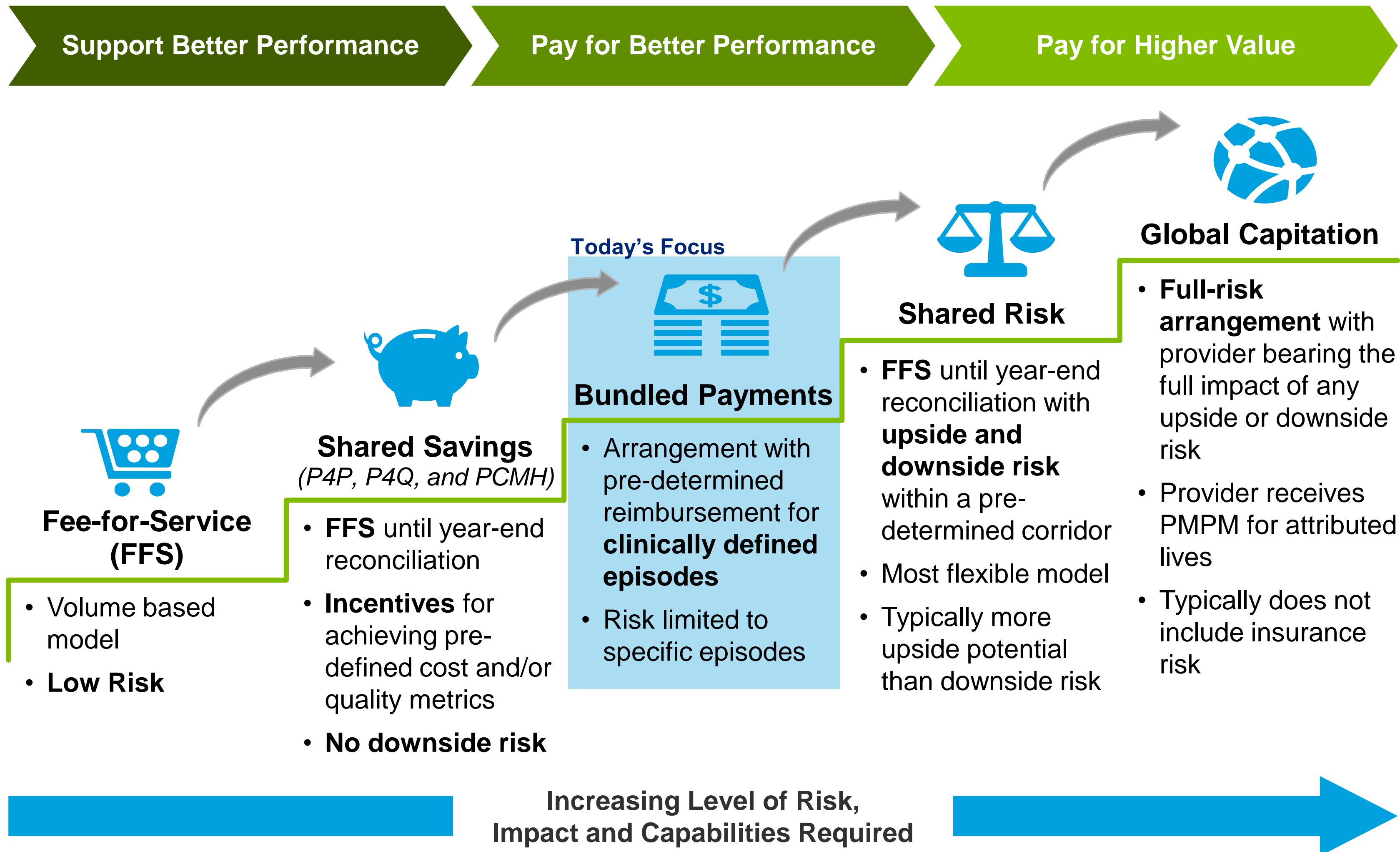
Payment Model Options and Characteristics

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



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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

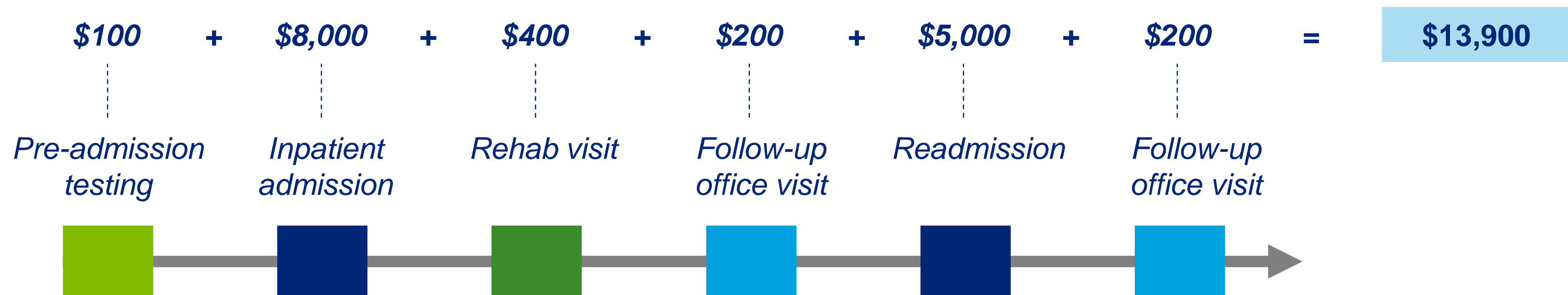
What is a Bundled Payment?

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:



Pre-determined Bundled Payment: $12,000

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

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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

Medicare

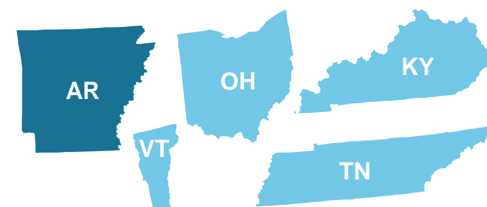
- The CMS BPCI Program continues to expand
- The CMS Comprehensive Care of Joint Replacement (CCJR) program is anticipated to drive additional adoption of bundling across all lines of business
- MACRA is expected to drive participation in many types of risk-bearing arrangements including bundled payments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

Commercial

- 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

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



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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

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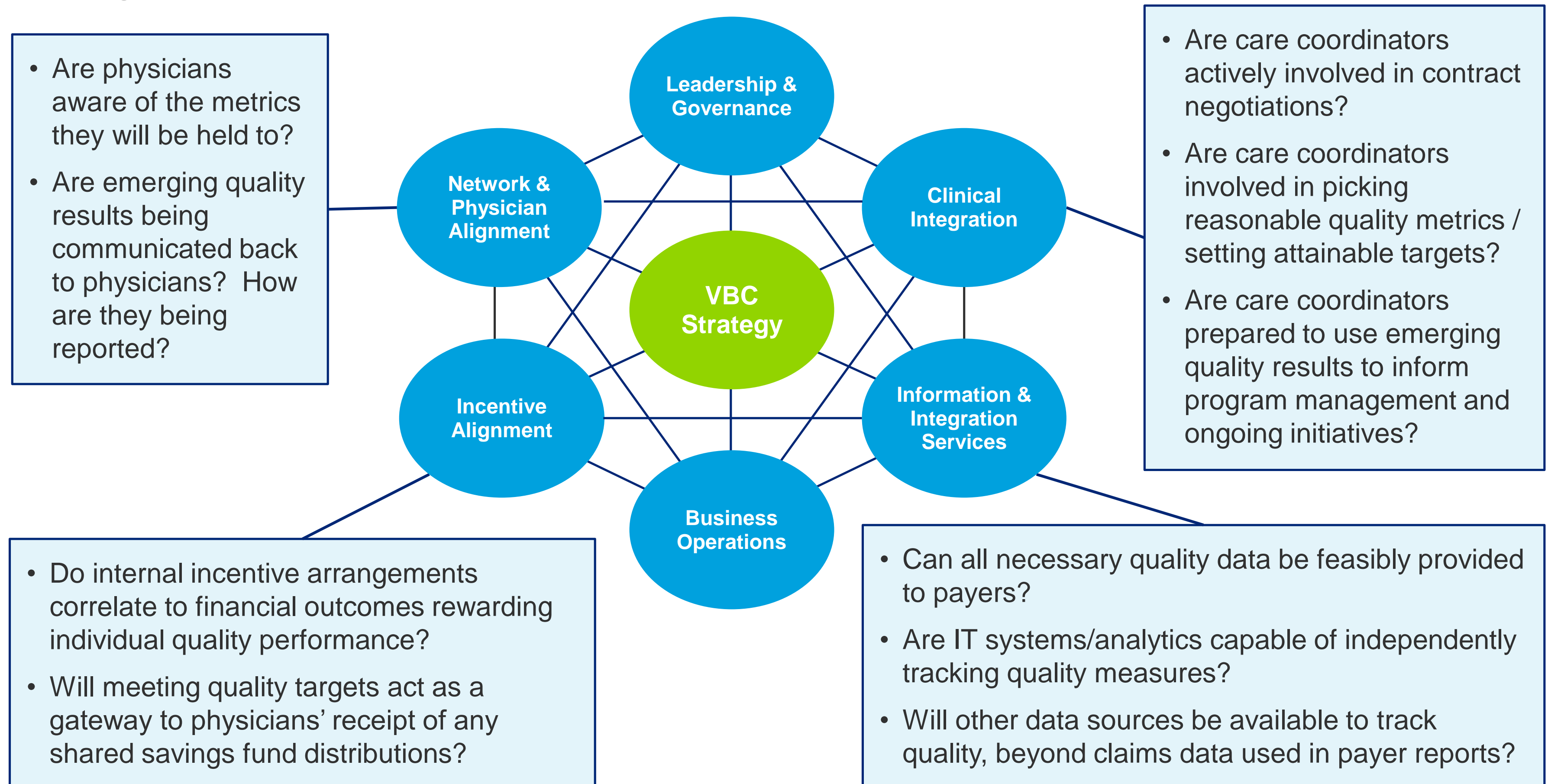
Operational Implications of VBC Payment Models

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



Given limited time and resources, prioritizing capabilities has been and continues to be a major focus of providers

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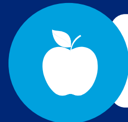
Payment Model Relationships: Lessons Learned

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

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Questions