National Trends in Medicare Alternative Payment Models

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AHCA
Discussion

- Review of **CMS priorities and goals** related to shifting Medicare spending from FFS to value-based models
- Compare and contrast **alternative payment models**
- Discuss current status and future direction of **ACO programs**
  - Medicare Shared Savings Program (MSSP) ACOs
  - Pioneer ACOs
  - Next Generation ACOs
- Discuss current status and future direction of **bundling programs**
  - Bundled Payments for Care Improvement (BPCI) Initiative
  - Comprehensive Care for Joint Replacement (CJR) Model
- Wrap up with a discussion of **the outlook for the industry** and **Q&A**
CMS Targets to Shift Payments

2016 Goals

- Alternative Payment Models: 30%
- FFS Linked to Quality: 85%

All Medicare FFS

2018 Goals

- Alternative Payment Models: 50%
- FFS Linked to Quality: 90%

All Medicare FFS
CMS Hits First Goal Early

CMS announced that as of January 1, 2016, the Office of the Actuary estimates that more than 30% of Medicare FFS payments are linked to an alternative payment model.

APMs include:

- MSSP ACO
- Pioneer ACO
- Next Generation ACO
- BPCI
- Comprehensive Primary Care Model
- Medicare Advanced Primary Care Program
- Comprehensive ESRD Care Model and ESRD PPS
- Maryland All-Payer Model
- Medicare Care Choices Model
## APM Framework

### Category 1: Fee for Service – No Link to Quality & Value
- **A:** Foundational Payments for Infrastructure & Operations
  - Traditional FFS
  - DRGs Not Linked to Quality

### Category 2: Fee for Service – Link to Quality & Value
- **A:** Foundational Payments for Infrastructure & Operations
  - Bonuses payments for quality reporting
- **B:** Pay for Reporting
  - DRGs with rewards for quality performance
- **C:** Rewards for Performance
  - DRGs with rewards for quality performance
- **D:** Rewards and Penalties for Performance
  - FFS with rewards for quality performance

### Category 3: APMs Built on Fee-for-Service Architecture
- **A:** APMs with Upside Gainsharing
  - Bundled payment with upside risk only
- **B:** APMs with Upside Gainsharing/Downside Risk
  - Episode-based payments for procedure-based clinical episodes with shared savings only

### Category 4: Population-Based Payment
- **A:** Condition-Specific Population-Based Payment
  - Population-based payments for condition-specific care (e.g., chronic care)
- **B:** Comprehensive Population-Based Payment
  - Full or partial payment based on comprehensive care

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Source: APM Framework White Paper, Health Care Payment Learning and Action Network
# APM Framework

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FFS No Link to Quality</strong></td>
<td><strong>FFS Link to Quality</strong></td>
<td><strong>APMs Built on FFS Architecture</strong></td>
<td><strong>Population-Based Payment</strong></td>
</tr>
<tr>
<td>A. Foundational Payments for Infrastructure &amp; Operations</td>
<td>B. Pay for Reporting</td>
<td>A. APMs with Upside Gainsharing</td>
<td>A. Condition-Specific Population-Based Payment</td>
</tr>
<tr>
<td>B. Pay for Reporting</td>
<td>C. Rewards for Performance</td>
<td>B. APMs with Upside Gainsharing &amp; Downside Risk</td>
<td>B. Comprehensive Population-Based Payment</td>
</tr>
<tr>
<td>C. Rewards for Performance</td>
<td>D. Rewards and Penalties for Performance</td>
<td>D. Risk-based payments NOT linked to quality</td>
<td>D. Capitated payments NOT linked to quality</td>
</tr>
</tbody>
</table>

Source: APM Framework White Paper, Health Care Payment Learning and Action Network
• Joint partnership between the Department of HHS and private, public, and non-profit sectors
• Transform the health care system to one that emphasizes value over volume.

Source: APM Framework White Paper, Health Care Payment Learning and Action Network
Alternative Payment Models

**Accountable Care Organizations**
- Groups of providers who voluntarily agree to be held financially accountable for the total Medicare spending on a **defined population** of patients **for one year**

**Bundled Payments**
- Groups of providers who voluntarily agree to be held financially accountable for the total Medicare spending on a **single patient** over a **single episode of care**
Alternative Payment Models - Financial

- **Shared savings** approach where any savings or losses are split with CMS
- Savings/loss potential **capped** at some percentage of spending
- ACOs may choose from 1 of 3 “tracks” which determine the level of financial risk:
  - **Track 1**: one-sided risk model
  - **Track 2**: low two-sided risk model
  - **Track 3**: high two-sided risk model

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<table>
<thead>
<tr>
<th>Accountable Care Organizations</th>
<th>Bundled Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider fully responsible for savings/losses per episode</td>
<td>Provider fully responsible for savings/losses per episode</td>
</tr>
<tr>
<td>Total bonus/loss potential capped at some percentage of <strong>total spending</strong> to account for high-cost outliers within episode category</td>
<td>Total bonus/loss potential capped at some percentage of <strong>total spending</strong> to account for high-cost outliers within episode category</td>
</tr>
<tr>
<td>Providers have some variable options:</td>
<td>Providers have some variable options:</td>
</tr>
<tr>
<td>- <strong>Clinical conditions</strong></td>
<td>- <strong>Clinical conditions</strong></td>
</tr>
<tr>
<td>- <strong>Episode length</strong></td>
<td>- <strong>Episode length</strong></td>
</tr>
</tbody>
</table>
Alternative Payment Models - Quality

**Accountable Care Organizations**

- Defined quality program where ACOs must meet specific performance thresholds on 33 quality measures falling into 4 domains:
  - Patient/caregiver experience (8)
  - Care coordination/patient safety (10)
  - At-risk population (7)
  - Preventive care (8)

**Bundled Payments**

- Quality requirements and programs vary by bundled payment model
## Alternative Payment Models

### Accountable Care Organizations
- Medicare Shared Savings Program (MSSP) ACOs
- Pioneer ACOs
- Next Generation ACOs

### Bundled Payments
- Bundled Payment for Care Improvement (BPCI) Initiative
- Comprehensive Care for Joint Replacement (CJR) Initiative
## Alternative Payment Models

<table>
<thead>
<tr>
<th>Program</th>
<th>Demonstration?</th>
<th>Voluntary</th>
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</thead>
<tbody>
<tr>
<td>MSSP ACO</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pioneer ACO</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Next Generation ACO</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>BPCI</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CJR</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

- Demonstrations implemented by CMMI
- Demonstrations are not required to undergo rulemaking
- Demonstrations are typically voluntary, though more mandatory programs likely
- CJR the first example of CMS requiring providers to be reimbursed under an episodic methodology
- More mandatory programs likely (e.g., cardiac episode)
Medicare Shared Savings Program ACOs
MSSP ACO Program Statistics

434 # of MSSP ACOs

MSSP ACOs by Risk Track 2016

<table>
<thead>
<tr>
<th>Track 2</th>
<th>Track 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>16</td>
</tr>
</tbody>
</table>

412 No Downside Risk

22 Downside Risk

Top 10 ACO Markets

<table>
<thead>
<tr>
<th>Markets</th>
<th># ACOs</th>
<th>% Benes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>37</td>
<td>20%</td>
</tr>
<tr>
<td>New York</td>
<td>59</td>
<td>14%</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>59</td>
<td>15%</td>
</tr>
<tr>
<td>Atlanta</td>
<td>109</td>
<td>11%</td>
</tr>
<tr>
<td>Chicago</td>
<td>82</td>
<td>16%</td>
</tr>
<tr>
<td>Dallas</td>
<td>54</td>
<td>11%</td>
</tr>
<tr>
<td>Kansas City</td>
<td>30</td>
<td>18%</td>
</tr>
<tr>
<td>Denver</td>
<td>12</td>
<td>9%</td>
</tr>
<tr>
<td>San Francisco</td>
<td>45</td>
<td>7%</td>
</tr>
<tr>
<td>Seattle</td>
<td>7</td>
<td>7%</td>
</tr>
</tbody>
</table>

MSSP ACO Program Statistics

Heat Map of MSSP ACO Activity
January, 2016

MSSP ACO Results

MSSP Performance Year 3 Results (2014)

- **$465 M** Total savings to Medicare Trust Fund
- 0 Number of ACOs Who Owed CMS Losses
- 82% Percent of quality measures on which ACOs improved

% of MSSP ACOs Achieving Savings by Performance Year*

- ACOs in Year 1: 19%
- ACOs in Year 2: 27%
- ACOs in Year 3: 37%

*ACOs tend to perform better financially the longer they are in the program*

MSSP Attrition & Financial Performance

Contract Status of ACOs with Positive Financial Results

- Renewed: 78%
- Didn’t Renew: 17%
- No Longer in MSSP: 5%

Contract Status of ACOs with No Positive Financial Results

- Renewed: 62%
- Didn’t Renew: 28%
- No Longer in MSSP: 9%

Pioneer ACO Model
Pioneer ACO Model

Pioneer ACO Program Distinctions

- Ongoing CMMI demonstration currently in 5th (final) year
- Higher levels of shared savings/risk possible than in MSSP
- May experiment with alternative payment arrangements, such as reduced fee arrangements with SNFs
- May access certain payment waivers, such as telehealth and SNF 3-day requirement waivers

Where Pioneer ACOs Are

As of January 2016, 9 of the original 32 Pioneer ACOs remain in the program

Pioneer ACO Results

Pioneer ACO Financial Performance, Year 3 (2014)

- 11 Earned Bonus Payments
- 6 Broke Even
- 3 Paid CMS Losses

$n = 20$

$120 \text{ M}$
- Pioneer ACO total savings to Medicare in 2014

$9 \text{ M}$
- Total payments made to CMS by 3 Pioneers who had losses

87.1%
- Average quality composite score among Pioneer ACOs

Pioneer ACO Impacts on SNF

40%
Reduction in Pioneer ACO utilization of SNF services in the first performance year

17%
Reduction in Pioneer ACO utilization of SNF services in the second performance year

$0.46
Pioneer ACO increase in per capita Medicare spending on Home Health, second year

Key ACO Strategies

- Aggressive management of narrow preferred PAC provider networks
- Buying or starting PAC lines of business, primarily home health
- Manage down SNF LOS
- Shift SNF to home health
- Shift hospital ED to SNF
- Shift to outpatient

Pioneer ACO Impacts on SNF

Key ACO Strategies

- Aggressive management of narrow preferred PAC provider networks
  Risk to be included, may lose significant referral volume
- Buying or starting PAC lines of business, primarily home health
  Increased overall costs due to higher front-end costs
- Manage down SNF LOS
  Increased acuity of SNF patients require increased resources
- Shift SNF to home health
- Shift hospital ED to SNF
- Shift to outpatient
Pioneer ACO Program Attrition

Number of Pioneer ACOs

2012: 32
2013: 9
2014: 9
2015: 9
2016: 9

Reasons for Drop-Out

- Start-up and maintenance costs were higher than anticipated
- Took financial loss
- Dropped into lower-risk ACO model (MSSP)
- Entered Next Generation ACO model

Source: Center for Medicare and Medicaid Innovation: http://innovation.cms.gov
Next Generation ACO Model
Next Generation ACO Model

- Center for Medicare & Medicaid Innovation (CMMI) announced the new demonstration model last year
- Model builds upon the Pioneer ACO model and will be used to test even more program changes to determine what might be applied to the broader MSSP ACO population
- Provides even more payment program waivers and other benefit enhancements that apply to skilled nursing providers
- Creates new categories of aligned providers to ACOs, each with different opportunities – implications for SNF providers
Next Generation ACO Model

Next Gen ACO Program Distinctions

- Newest CMMI ACO demonstration model
- 22 NGACOs announced for January 2016 start date
- Built upon Pioneer model
- Many program enhancements:
  - Greater level of risk/reward potential
  - Beneficiary engagement tools
  - Stable and predictable benchmarks
  - Program waivers (SNF 3-day)
  - Flexible payment arrangements

Where Next Gen ACOs Are

Flexible Payment Arrangements

Mechanism 1: Normal FFS Payment + Monthly Infrastructure Payment

- **Preferred Providers**
- **Next Generation Participants**
- **All Other Medicare Providers**

- PBPM
- Claim submission
- Claim payment
Flexible Payment Arrangements

Mechanism 2: Population-Based Payments (PBP)

- Preferred Providers
- Next Generation Participants
- All Other Medicare Providers

PBPM
Claim submission
Claim payment
Partial claim payment
Flexible Payment Arrangements

Mechanism 3: All-Inclusive Population-Based Payments (AIPBP)

- ACO
- Preferred Providers
- Next Generation Participants
- All Other Medicare Providers
- PBPM
- Claim submission
- Claim payment
- Partial claim payment
Flexible Payment Arrangements

Mechanisms 2 & 3

- AIPBP provider must sign a “Fee Reduction Agreement,” which is an agreement between the provider and CMS stating that CMS will withhold claim payments and instead pay a predetermined amount to the ACO in monthly payments.

- AIPBP Provider and ACO negotiate agreement establishing program and payment terms:
  - Methodology of payment (e.g., per diem vs. episodic)
  - Rate/amount of payment (*negotiated rates*)
  - Consensus on clinical protocols and pathways
  - Expectations/criteria around quality performance to “earn back” withhold
## Provider Categories & Implications

<table>
<thead>
<tr>
<th>Participant</th>
<th>Quality Reporting Through ACO</th>
<th>Eligible for ACO Shared Savings</th>
<th>PBP</th>
<th>AIPBP</th>
<th>Coordinated Care Reward</th>
<th>Telehealth</th>
<th>SNF 3-day Rule</th>
<th>Post-Discharge Home Visit</th>
</tr>
</thead>
</table>

### Implications for Skilled Nursing Providers

- NGACO Model offers more options for SNF engagement
- Increasing use of SNF 3-day stay waiver
- Trend toward population-based payment and provider-to-provider rate negotiations
Bundled Payment for Care Improvement (BPCI) Initiative
Bundled Payments for Care Improvement (BPCI) Initiative

- Three-year demonstration program administered by CMMI, currently in Year 2
- Tests 4 models of acute and post-acute care bundled payment
  - Model 1: Acute care only
  - Model 2: Acute + post-acute
  - Model 3: Post-acute only
  - Model 4: Acute care only (prospective payment)
- 48 defined clinical episodes available for testing
- Officially ended Phase 1 “trial” period in October 2015 – all BPCI providers are now in risk-bearing Phase 2
Targeting Opportunities for Savings

Episode Costs for Major Joint Replacement of the Lower Extremity (2013)
90 Days after Index Admission

Source: Analysis of CMS Claims Data, 2013.
**BPCI Results – Year 1**

<table>
<thead>
<tr>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>66%</td>
<td>$12,082</td>
</tr>
<tr>
<td>Percent of BPCI patients discharged to institutional PAC* before program start</td>
<td>Average SNF payment 90 days post-discharge for non-BPCI patients</td>
</tr>
<tr>
<td>47%</td>
<td>$7,465</td>
</tr>
<tr>
<td>Percent of BPCI patients discharged to institutional PAC* after program start</td>
<td>Average SNF payment 90 days post-discharge for BPCI patients</td>
</tr>
</tbody>
</table>

* SNF, IRF, LTCH

## Provider Experience in BPCI

<table>
<thead>
<tr>
<th><strong>Opportunities</strong></th>
<th><strong>Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fortify relationships with care partners</td>
<td>Access to data when not an episode initiator</td>
</tr>
<tr>
<td>Care redesign / collaboration on protocols and pathways</td>
<td>Low volume / inability to adequately scale risk</td>
</tr>
<tr>
<td>Shared savings</td>
<td>Identifying patients in the bundle</td>
</tr>
<tr>
<td>3-Day waiver (Model 2)</td>
<td>Hospital dictation of rules (Model 2)</td>
</tr>
<tr>
<td>Early adopter / seat at the table</td>
<td>SNF avoidance and utilization management</td>
</tr>
</tbody>
</table>
BPCI Initiative – What’s Next?

- Evaluation Report #2 expected in Q1 2016
  - First significant, conclusive results
- BPCI is a closed demonstration – very likely there will be no future opportunity to engage
- Secretary may expand any BPCI model nationally if evaluation shows a reduction in the cost growth rate and an improvement in quality
- Future of bundling will look more like CJR than BPCI
Comprehensive Care for Joint Replacement (CJR) Initiative
Comprehensive Joint Replacement (CJR) Initiative

- Five-year, mandatory bundled payment program for providers who operate in one of 67 MSAs
- Runs April 1, 2016 – December 31, 2020
- 90-day episode spending targets for lower-extremity joint replacement (LEJR) procedures, primarily total hips and knees
  - MS-DRG 469
  - MS-DRG 470
- The hospital is the at-risk entity under CJR; no downside risk until Year 2
- Hospitals may share up to 50% of financial risk with CJR “collaborators,” which include SNFs
- Program waivers and alternative financing options begin in Year 2 (January 1, 2017)
Comprehensive Joint Replacement (CJR) Initiative

- Target prices based on 3-year historical spending of the hospital at first, transitioning to regional trend by year 4

- Built-in limits to savings and loss potential

- BPCI takes precedence

- Rule encourages hospitals to gain-share with “collaborators,” including SNFs

- CCJR waives:
  - SNF 3-day rule starting in Year 2 for SNFs with 3 or more stars on Nursing Home Compare (Five-Star)
  - Limits on physician home visits
  - Geographic site requirement and originating site requirement for telehealth reimbursement
CJR Program Overview

SNF Medicare Revenue Exposure to CJR
*(based on analysis of 2013 claims data)*

Legend

Percent of Revenue Exposed
- 0.0 - 2.5%
- 2.5 - 5.0%
- 5.0 - 7.5%
- 7.5 - 10.0%
- 10.0 - 11.5%

Source: AHCA internal analysis.
CJR Program Overview

SNF Medicare Revenue Exposure to CJR
*(based on analysis of 2013 claims data)*

New Jersey CJR MSAs: Average Wage-Adjusted Episode Payments

Allentown-Bethlehem-Easton, PA-NJ: $29,568
New York-Newark-Jersey City, NY-NJ-PA: $31,076
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD: $27,395

Source: AHCA internal analysis.
No Room for Conveners

- CJR Final Rule specifies that hospitals must maintain at least 50% of their total financial risk in the program.
- Rule encourages hospitals to gain-share with partner “collaborators,” which must be providers, including SNFs, and cannot be third-party administrative entities/conveners.
- Hospitals may still partner with third-party entities in other ways (e.g., decision support tools, network management functions, etc.)
## CJR Composite Quality Score

<table>
<thead>
<tr>
<th>Percentile</th>
<th>THA/TKA Complications</th>
<th>HCAHPS Survey</th>
<th>PRO Data (Reporting Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;=90th</td>
<td>10</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>&gt;=80th and &lt;90th</td>
<td>9.25</td>
<td>7.4</td>
<td>“</td>
</tr>
<tr>
<td>&gt;=70th and &lt;80th</td>
<td>8.5</td>
<td>6.8</td>
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<tr>
<td>&gt;=60th and &lt;70th</td>
<td>7.75</td>
<td>6.2</td>
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<td>&gt;=50th and &lt;60th</td>
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<td>“</td>
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<td>&gt;=30th and &lt;40th</td>
<td>5.5</td>
<td>4.4</td>
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<tr>
<td>&lt;30th</td>
<td>0</td>
<td>0</td>
<td>“</td>
</tr>
</tbody>
</table>
## CJR Composite Quality Score

<table>
<thead>
<tr>
<th>Quality Composite Score Range</th>
<th>Quality Category</th>
<th>Eligible for Reconciliation Payment</th>
<th>Effective Discount % for Reconciliation Payment</th>
<th>Effective Discount % for Repayment Amount</th>
</tr>
</thead>
</table>
| >13.2                         | Excellent        | Yes                                 | 1.5%                                          | PY1: N/A*  
PY2-3: 0.5%  
PY4-5: 1.5% |
| ≥6 and <13.2                  | Good             | Yes                                 | 2%                                            | PY1: N/A  
PY2-3: 1%  
PY4-5: 2% |
| ≥4 and <6                     | Acceptable       | Yes                                 | 3%                                            | PY1: N/A  
PY2-3: 2%  
PY4-5: 3% |
| <4                            | Below Acceptable | No                                  | 3%                                            | PY1: N/A  
PY2-3: 2%  
PY4-5: 3% |
CJR 3-Day Stay Waiver

- Blanket waiver – providers will not have to “apply” to access the waiver
- SNFs may access the waiver if they have been rated 3 stars or higher for at least 7 of the preceding 12 months
- CMS will publish a “master list” of eligible SNFs updated at some time interval (e.g., quarterly)
- CMS will issue sub-regulatory guidance to providers with more specific information about how to use the waiver
- Represents broadest effort yet to test a waiver of the 3-day stay requirement
Broader Implications of CJR

- Sets precedent as first mandatory bundled payment program

- CMS preference for “hospital-controlled” bundled payments
  - CMS language in final rule: “‘We may consider, through future rulemaking, other episode of care models in which PGPs or PAC providers are financially responsible for the costs of care’”

- May expect to see another mandatory bundled payment program modeled after CJR, perhaps focused on cardiac episodes
AHCA CJR Data Resource

Reports Will Include

- By MSA:
  - Hospital volume
  - Average episode spend by provider/service type
  - Volumes to different PAC settings
  - Readmission rates
  - SNF average LOS

- By Hospital:
  - Volumes
  - PAC referral patterns
  - Readmission rates

Reports will be available in 3-5 weeks
Outlook for the Industry
Erosion of Fee-for-Service

Fee for service continues to dwindle away, replaced by managed care, ACOs, bundled payments and other reform demonstration programs.

Source: Analysis by Avalere Health, LLC, for the American Health Care Association.
Big Shift in Payer Mix

PERCENT OF BENEFICIARIES BY PAYER TYPE (AGGRESSIVE SCENARIO)

Payer Type | SNF Days/Capita (2020 est.)
--- | ---
MA | 1.056
Bundled FFS | 1.551
ACO | 1.551
Duals Demo | 1.903
Traditional FFS (non-bundled) | 2.027

Source: Analysis by Avalere Health, LLC, for the American Health Care Association.
SNF Occupancy Down in Recent Years

Source: National Investment Center for Seniors Housing & Care (NIC).
Downward Rate Pressures Continues to Increase

Source: National Investment Center for Seniors Housing & Care (NIC).
Despite Current Environment, Outlook is Positive

YEARLY MEDICARE SNF VOLUME (MILLIONS OF DAYS)

Conservative
- 2010: 81.97
- 2015: 91.22
- 2020: 96.59

Moderate
- 2010: 92.40
- 2015: 91.22
- 2020: 101.53

Aggressive
- 2010: 105.79
- 2015: 91.22
- 2020: 105.79

TOTAL MEDICARE ENROLLMENT (MILLIONS OF BENEFICIARIES)

- 2010: 47.72
- 2015: 55.83
- 2020: 64.47

Source: Analysis by Avalere Health, LLC, for the American Health Care Association.