National Trends in Medicare Alternative Payment Models

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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**

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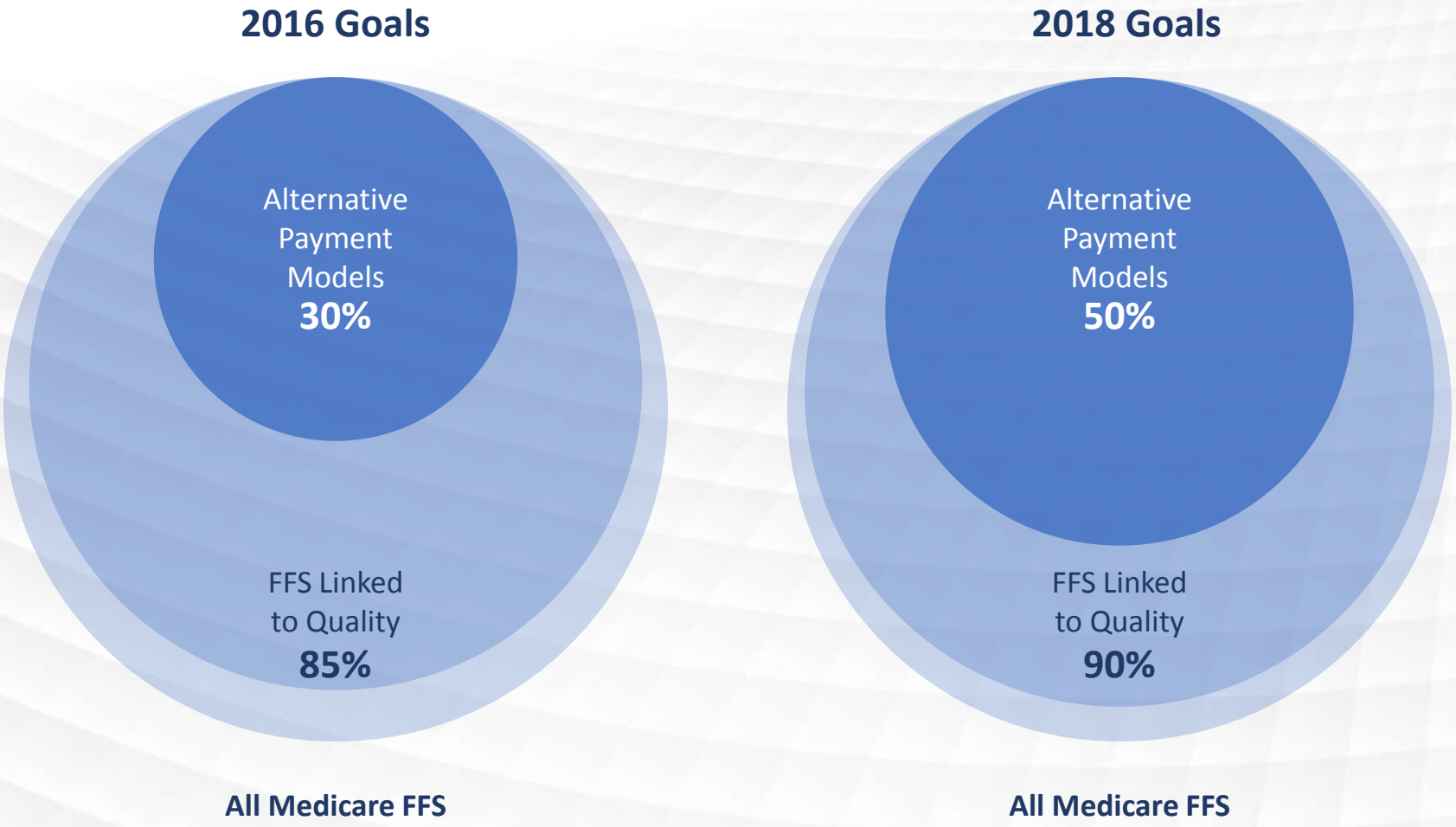
CMS Targets to Shift Payments



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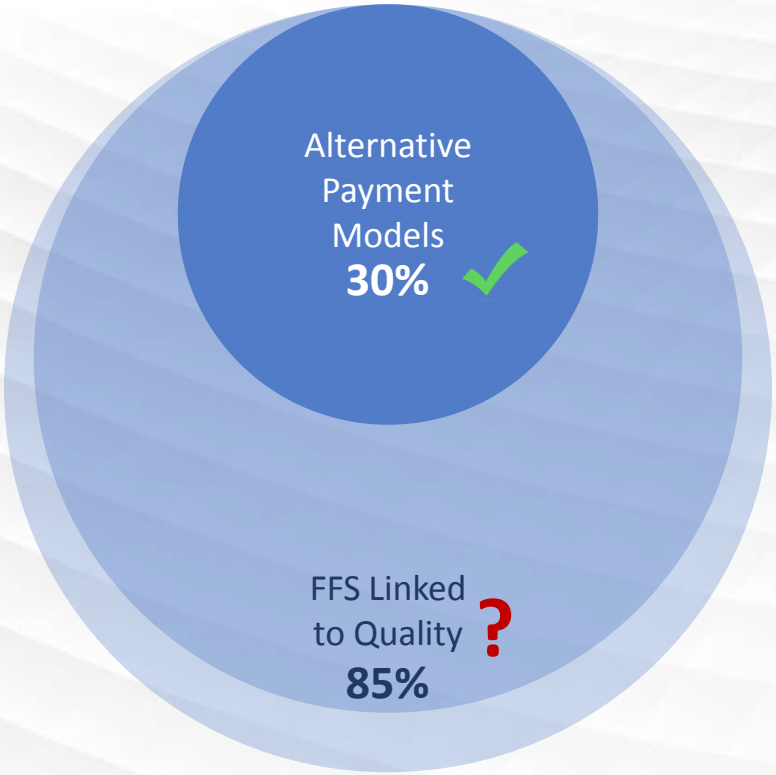
CMS Hits First Goal Early

2016 Goals



- 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

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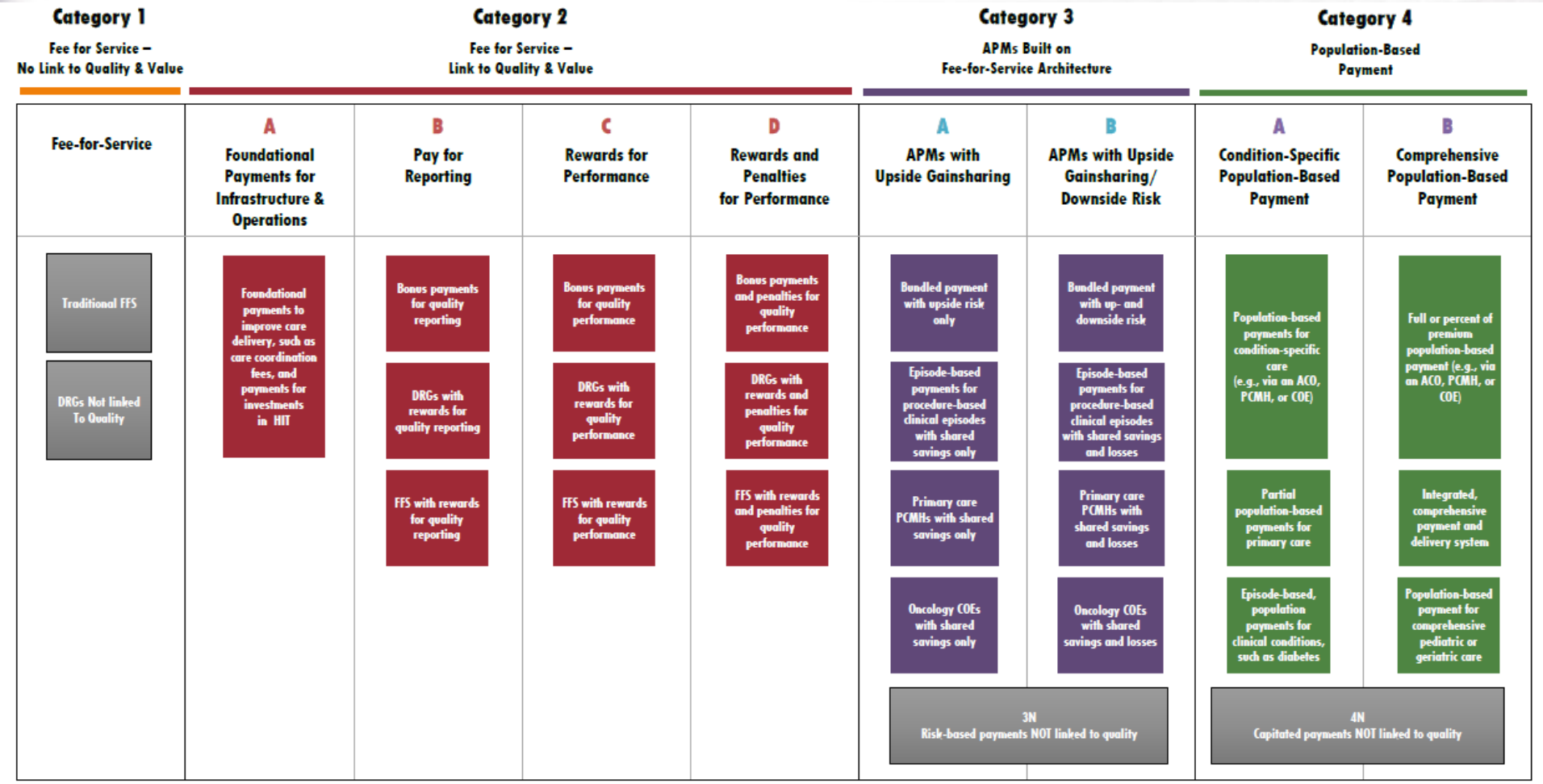
APM Framework



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

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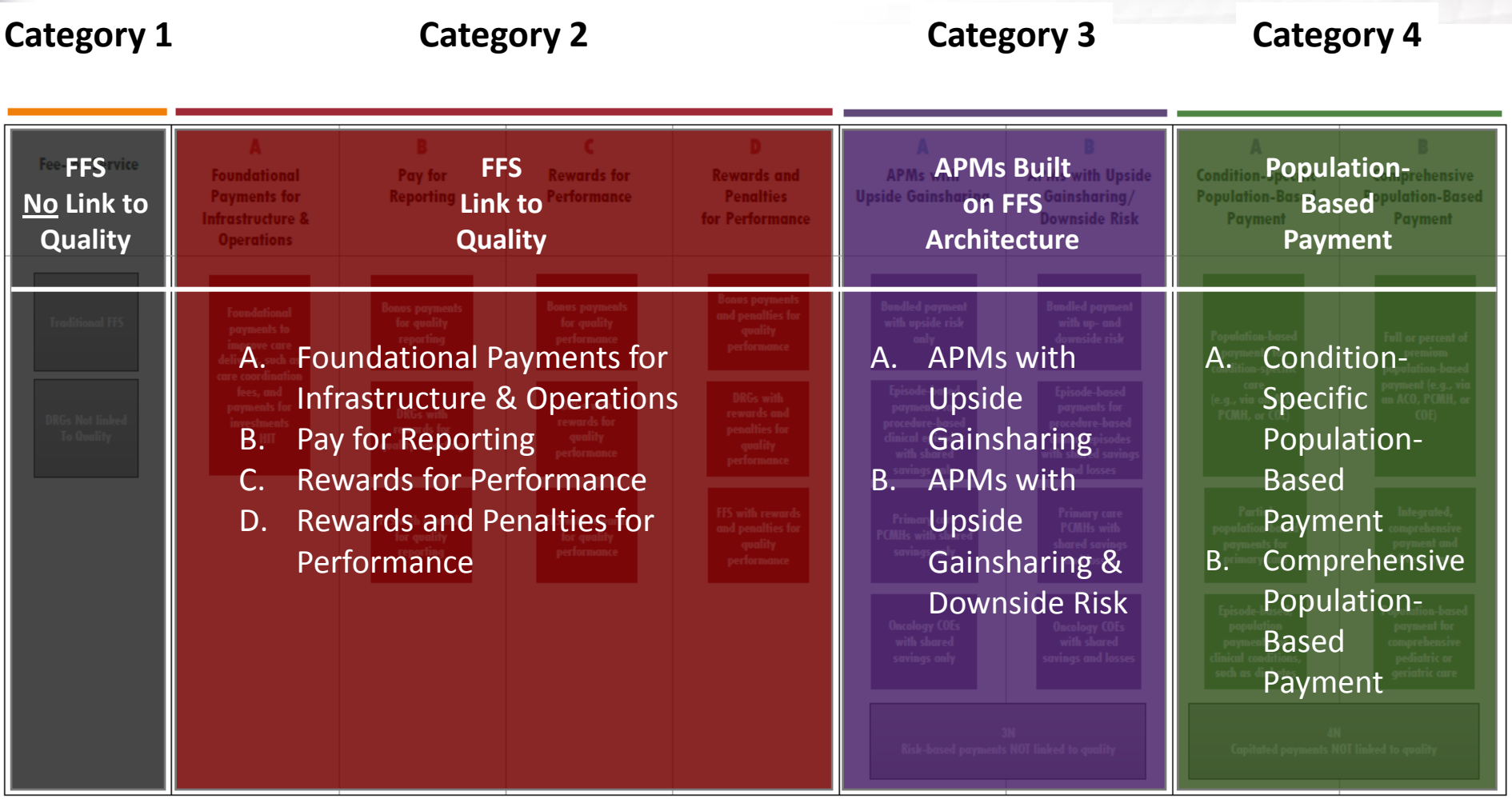
APM Framework



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

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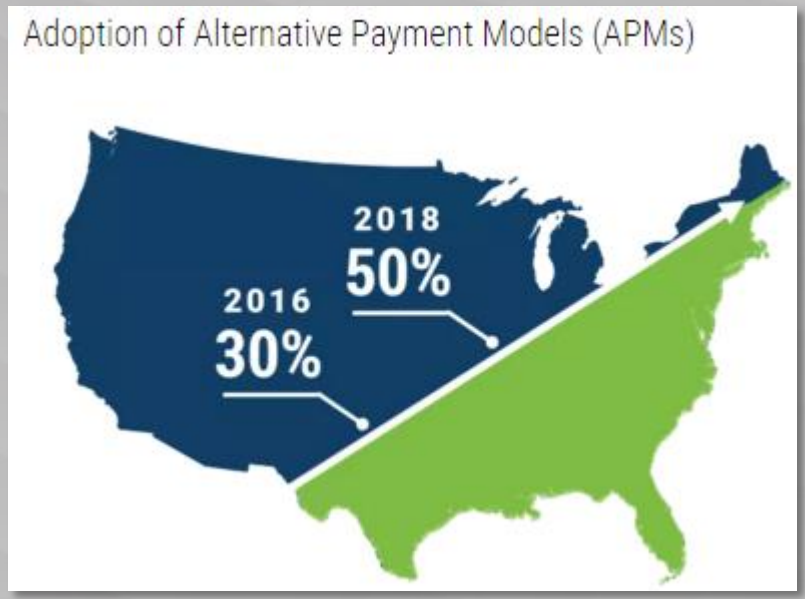
HCP LAN
Health Care Payment Learning & Action Network

- 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.



2016
30%
In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs

2018
50%
In 2018, at least 50% of U.S. health care payments are so linked.

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

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Alternative Payment Models

Accountable Care Organizations

- Groups of providers who voluntarily agree to be held finically 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**

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Alternative Payment Models - Financial

Accountable Care Organizations

- ***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

Bundled Payments

- Provider fully responsible for savings/losses per episode
- Total bonus/loss potential capped at some percentage of ***total spending*** to account for high-cost outliers within episode category
- Providers have some variable options:
  - ***Clinical conditions***
  - ***Episode length***

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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

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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*

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Alternative Payment Models

Program	Demonstration?	Voluntary
MSSP ACO		✓
Pioneer ACO	✓	✓
Next Generation ACO	✓	✓
BPCI	✓	✓
CJR	✓	

- 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)

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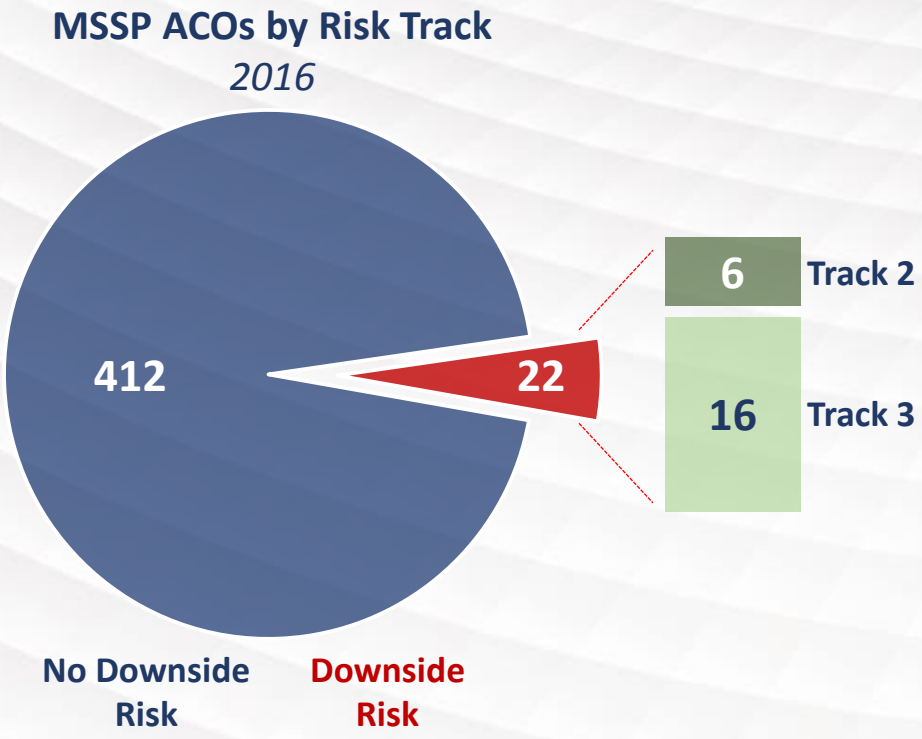
Medicare Shared Savings Program ACOs

MSSP ACO Program Statistics

434 # of MSSP ACOs



Top 10 ACO Markets	# ACOs	% Benes
Boston	37	20%
New York	59	14%
Philadelphia	59	15%
Atlanta	109	11%
Chicago	82	16%
Dallas	54	11%
Kansas City	30	18%
Denver	12	9%
San Francisco	45	7%
Seattle	7	7%

Sources: CMS Data Library, accessed at http://data.cms.gov; Leavitt Partners, *Medicare ACOs Announced: What Happened and Why It Matters,* January 20, 2016.

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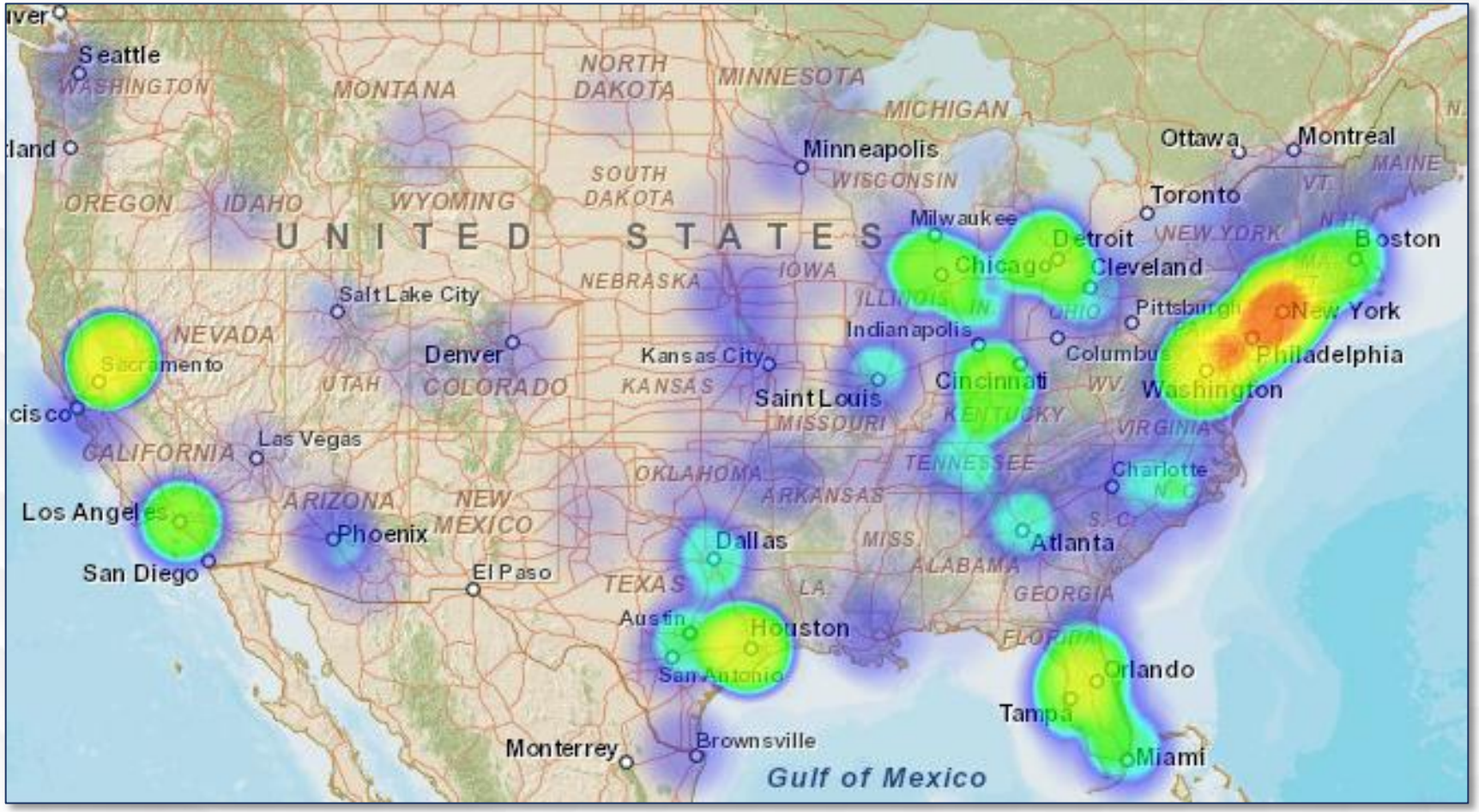
MSSP ACO Program Statistics

Heat Map of MSSP ACO Activity

January, 2016



Source: CMS Data Library, accessed at http://data.cms.gov.

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MSSP ACO Results

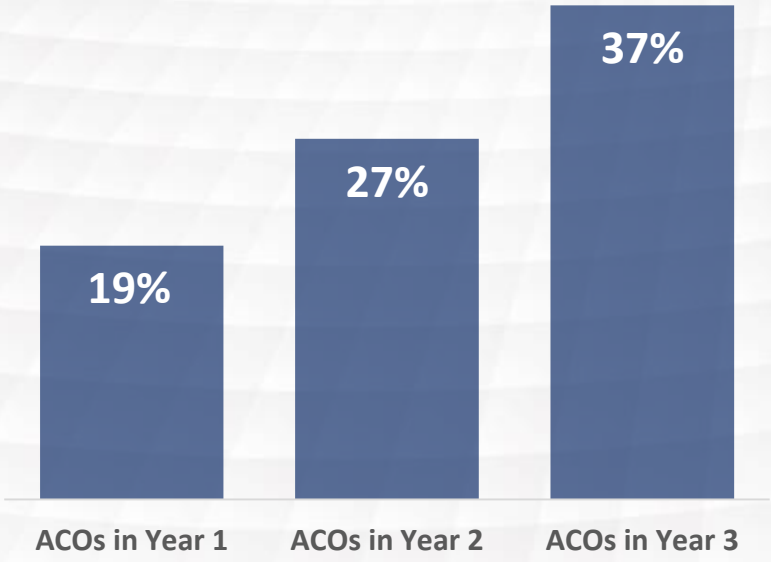
MSSP Performance Year 3 Results (2014)

$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 tend to perform better financially the longer they are in the program

Source: CMS Data Library, accessed at http://data.cms.gov.

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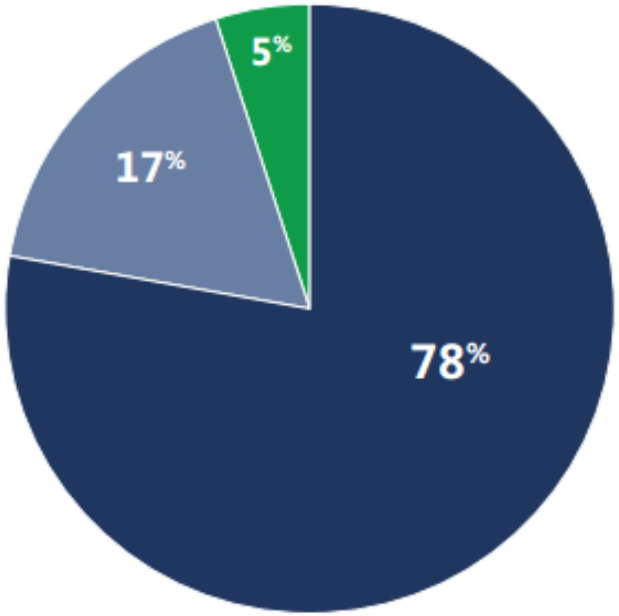
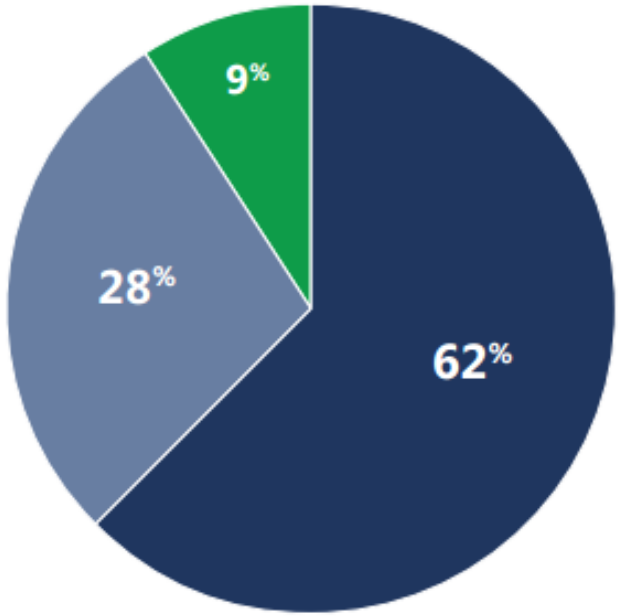
MSSP Attrition & Financial Performance

Contract Status of ACOs with Positive Financial Results



Contract Status of ACOs with No Positive Financial Results



Renewed | Didn't Renew | No Longer in MSSP

Source: Tu, T., Caughey, W., Leavitt Partners, *MSSP ACOs: Financial Savings and the Appetite for More.* Research Brief, February 2016.

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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*

Source: Center for Medicare and Medicaid Innovation: http://innovation.cms.gov.

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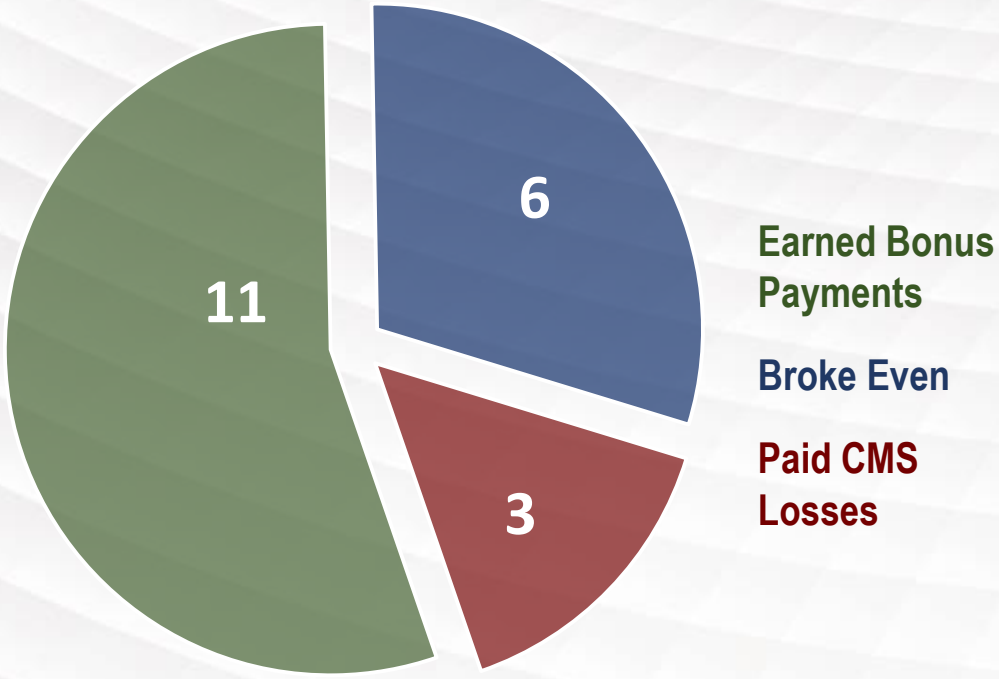
Pioneer ACO Results

Pioneer ACO Financial Performance, Year 3 (2014)
n = 20



$120 M

Pioneer ACO total savings to Medicare in 2014

$9 M

Total payments made to CMS by 3 Pioneers who had losses

87.1 %

Average quality composite score among Pioneer ACOs

Source: Center for Medicare and Medicaid Innovation: http://innovation.cms.gov.

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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

Source: Center for Medicare and Medicaid Innovation: http://innovation.cms.gov.

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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
- **Manage down SNF LOS** → *Increased overall costs due to higher front-end costs*
- Shift SNF to home health
- **Shift hospital ED to SNF** → *Increased acuity of SNF patients require increased resources*
- Shift to outpatient

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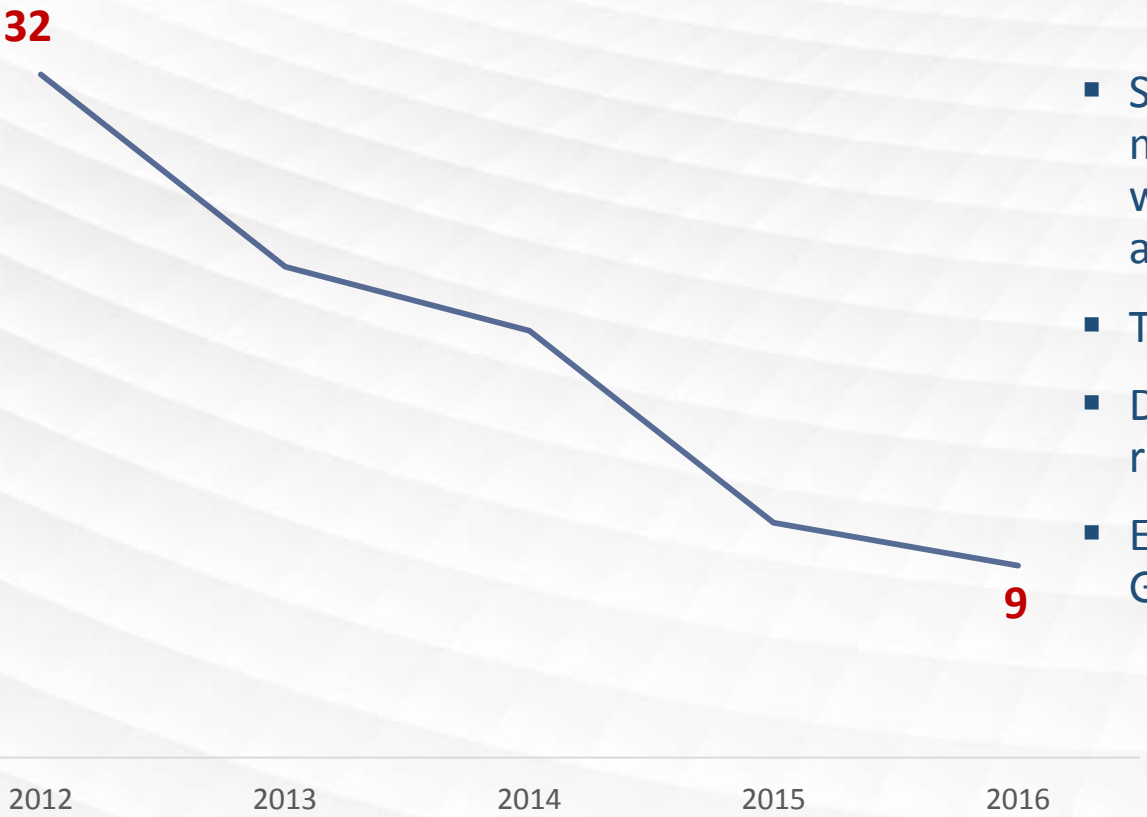
Pioneer ACO Program Attrition

Number of Pioneer ACOs



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.

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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

Source: Center for Medicare and Medicaid Innovation: http://innovation.cms.gov.

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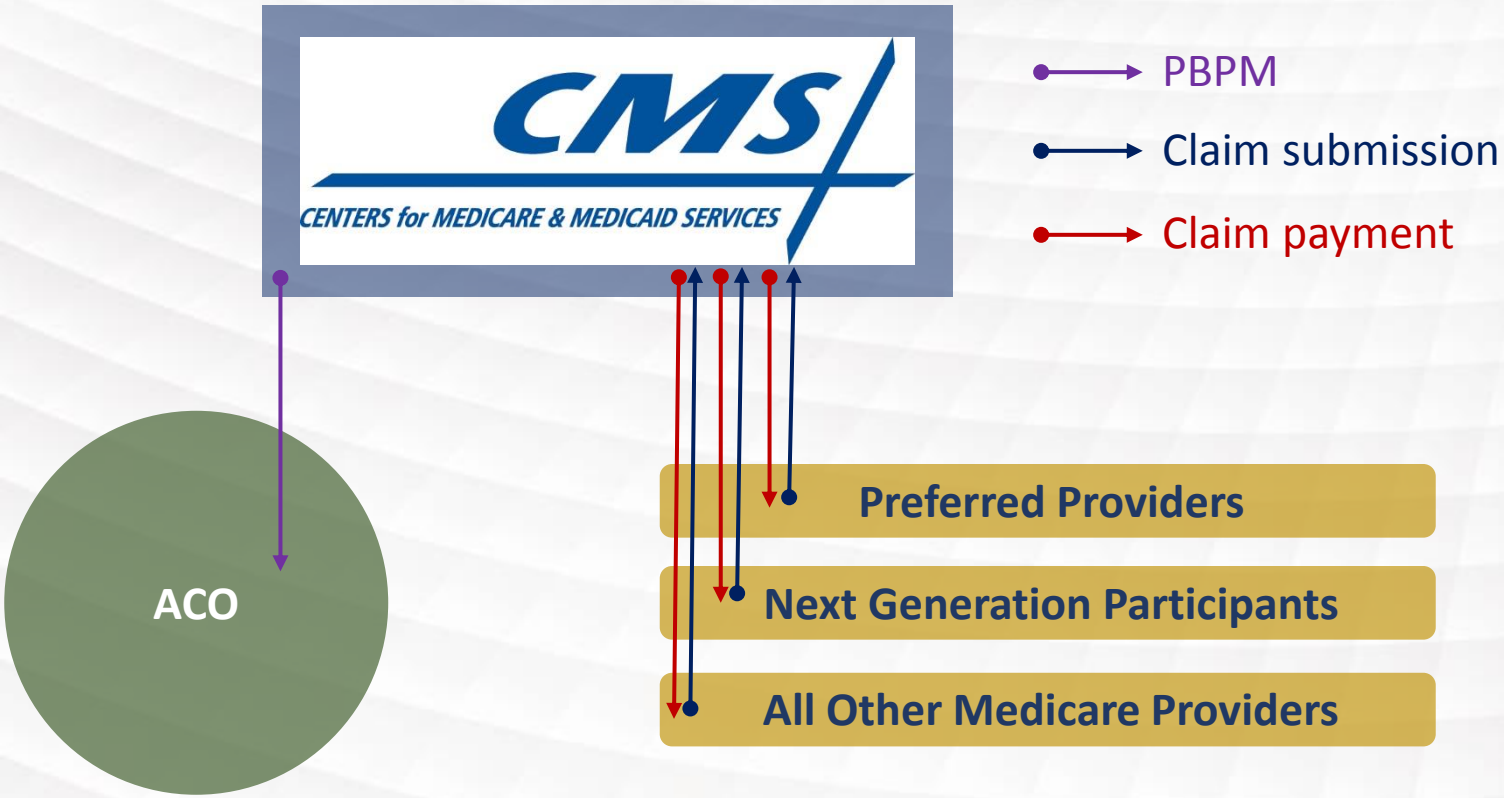
Flexible Payment Arrangements

Mechanism 1: Normal FFS Payment + Monthly Infrastructure Payment



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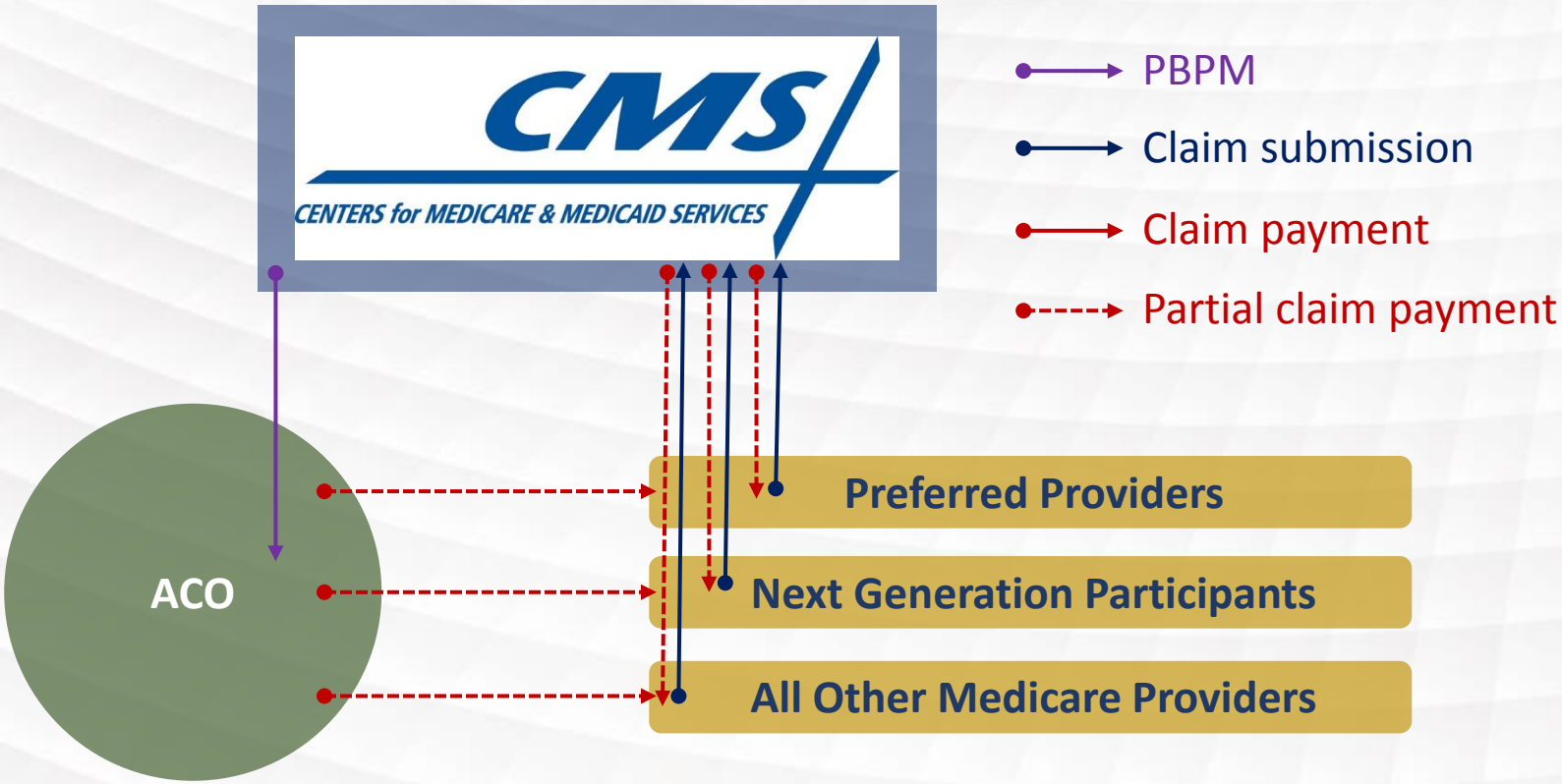
Flexible Payment Arrangements

Mechanism 2: Population-Based Payments (PBP)



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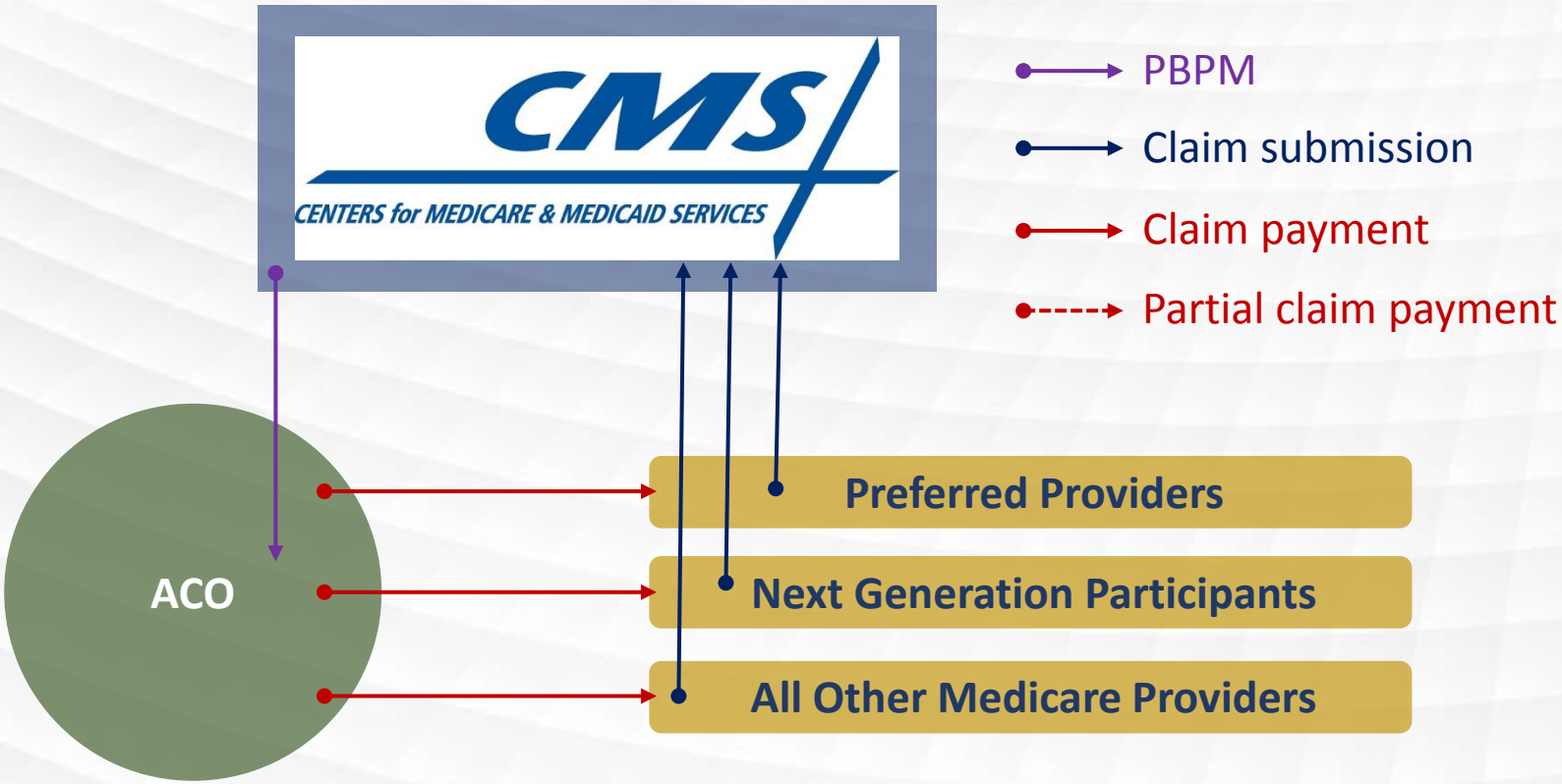
Flexible Payment Arrangements

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



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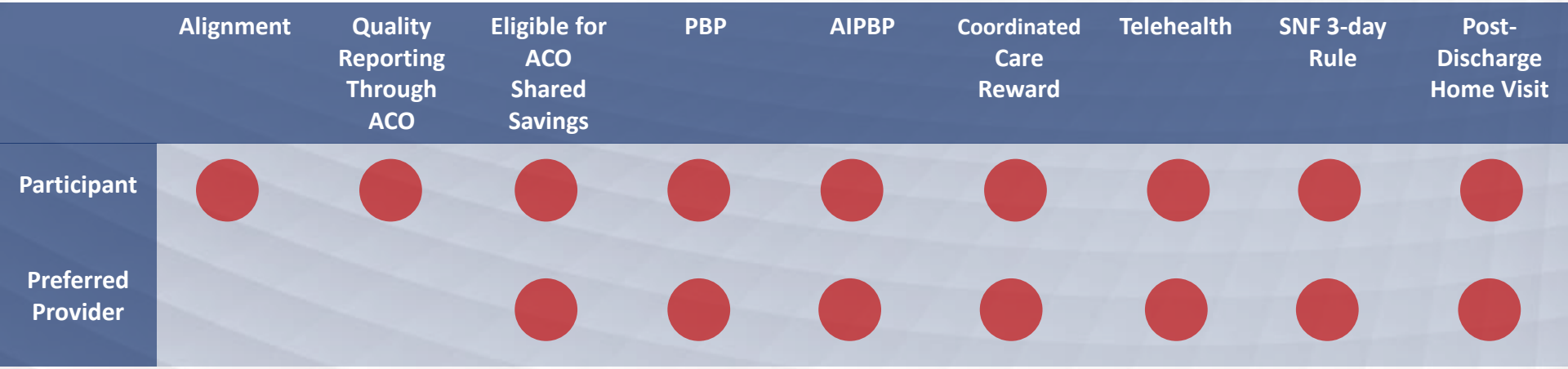
Flexible Payment Arrangements

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



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

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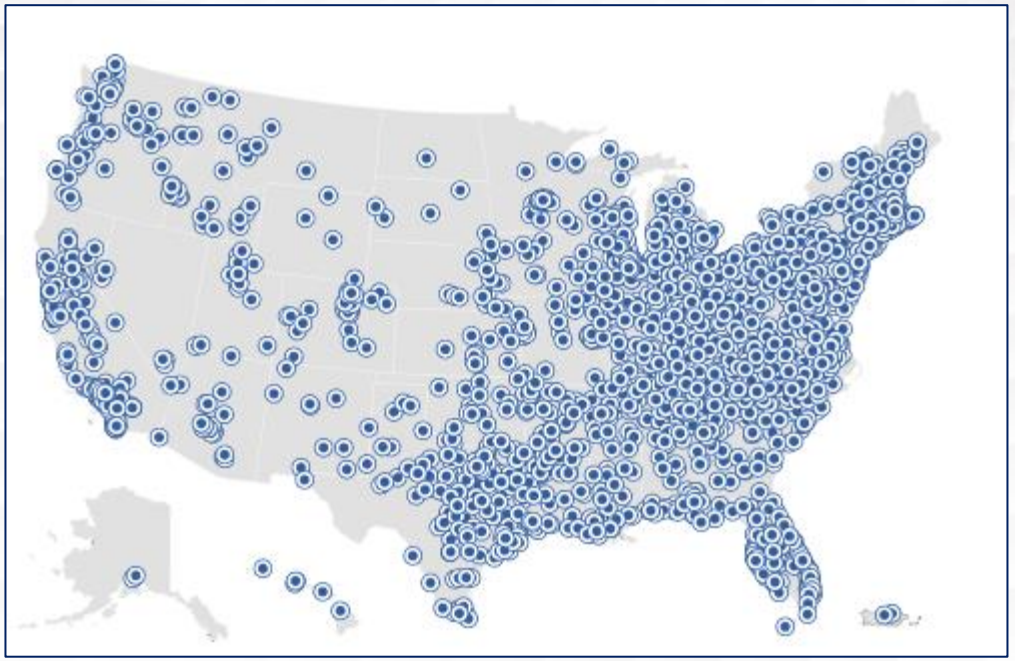
Bundled Payment for Care Improvement (BPCI) Initiative

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

BPCI Participants



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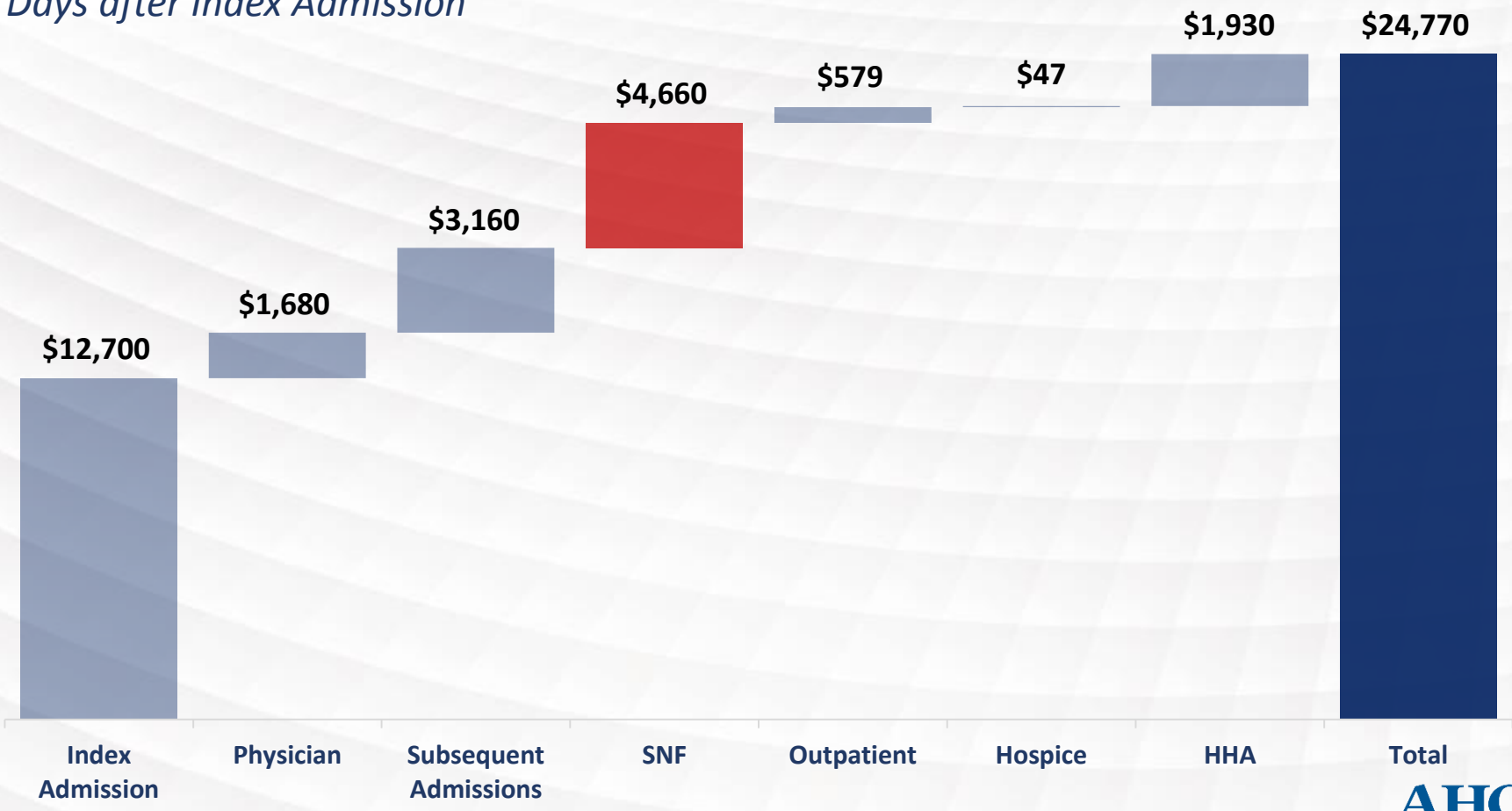
Targeting Opportunities for Savings

Episode Costs for Major Joint Replacement of the Lower Extremity (2013)

90 Days after Index Admission



Source: Analysis of CMS Claims Data, 2013.

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BPCI Results – Year 1

Model 2

66%

Percent of BPCI patients discharged to institutional PAC* *before* program start

47%

Percent of BPCI patients discharged to institutional PAC* *after* program start

Model 3

$12,082

Average SNF payment 90 days post-discharge for non-BPCI patients

$7,465

Average SNF payment 90 days post-discharge for BPCI patients

* SNF, IRF, LTCH

Source: *BPCI Evaluation Report, Year 1*. The Lewin Group, February 2015.

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Provider Experience in BPCI

Opportunities

- Fortify relationships with care partners
- Care redesign / collaboration on protocols and pathways
- Shared savings
- 3-Day waiver (Model 2)
- Early adopter / seat at the table

Challenges

- Access to data when not an episode initiator
- Low volume / inability to adequately scale risk
- Identifying patients in the bundle
- Hospital dictation of rules (Model 2)
- SNF avoidance and utilization management

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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)

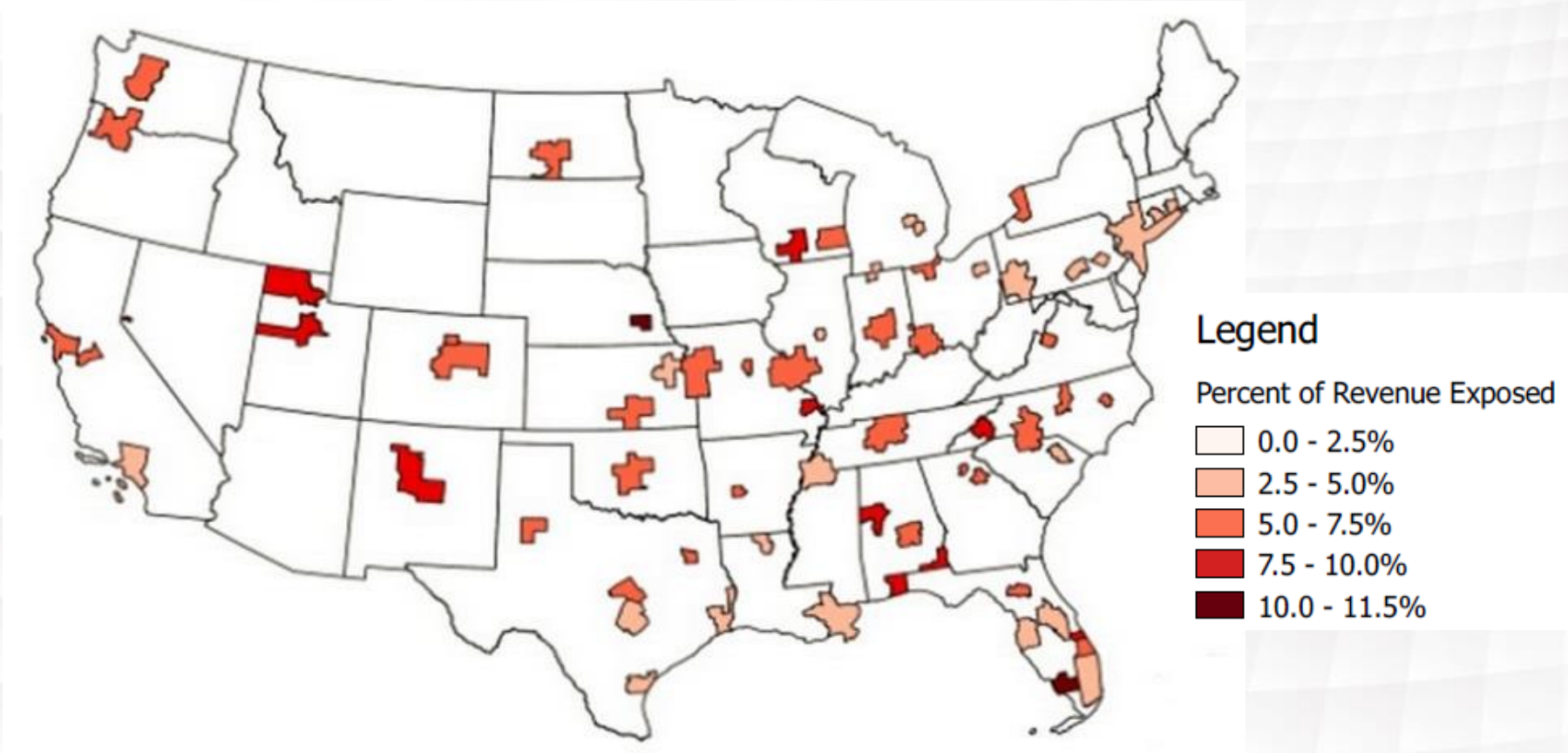
Comprehensive Joint Replacement (CJR) Initiative

- 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)



Source: AHCA internal analysis.

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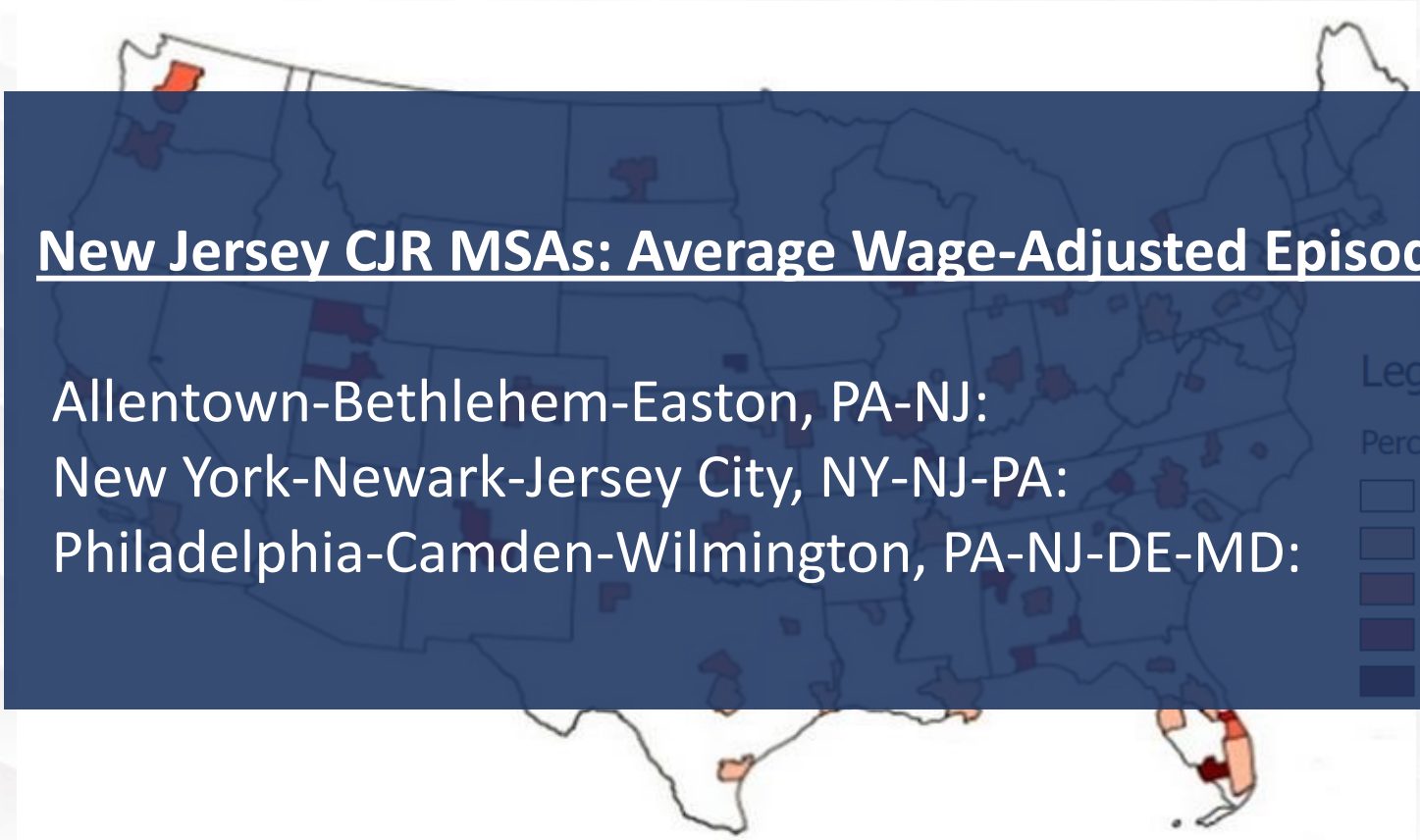
CJR Program Overview

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.

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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

Percentile	THA/TKA Complications	HCAHPS Survey	PRO Data (Reporting Only)
≥90th	10	8	2
≥80th and <90th	9.25	7.4	"
≥70th and <80th	8.5	6.8	"
≥60th and <70th	7.75	6.2	"
≥50th and <60th	7	5.6	"
≥40th and <50th	6.25	5	"
≥30th and <40th	5.5	4.4	"
<30th	0	0	"

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CJR Composite Quality Score

Quality Composite Score Range	Quality Category	Eligible for Reconciliation Payment	Effective Discount % for Reconciliation Payment	Effective Discount % for Repayment Amount
>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%

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CJR 3-Day Stay Waiver

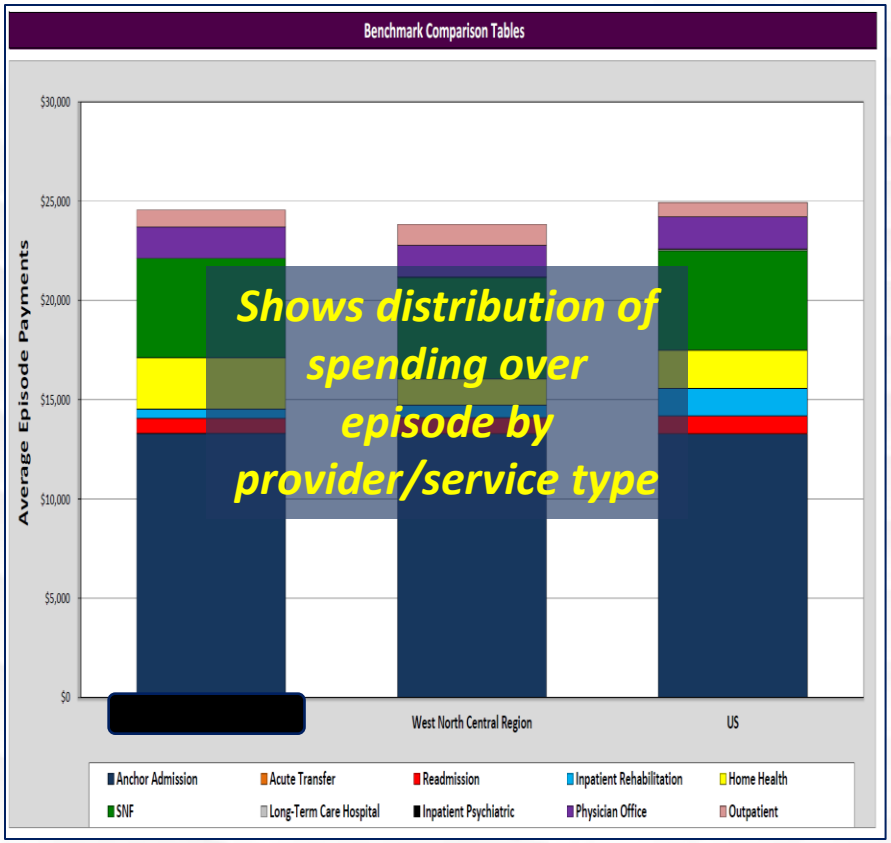
- Blanket waiver –providers will not have to "apply" to access the waiver
- SNFs may access the waiver if they have been rated **3 stars or higher** for at least **7 of the preceding 12 months**
- CMS will publish a "master list" of eligible SNFs updated at some time interval (e.g., quarterly)
- CMS 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

Report Sample



Reports will be available in 3-5 weeks

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

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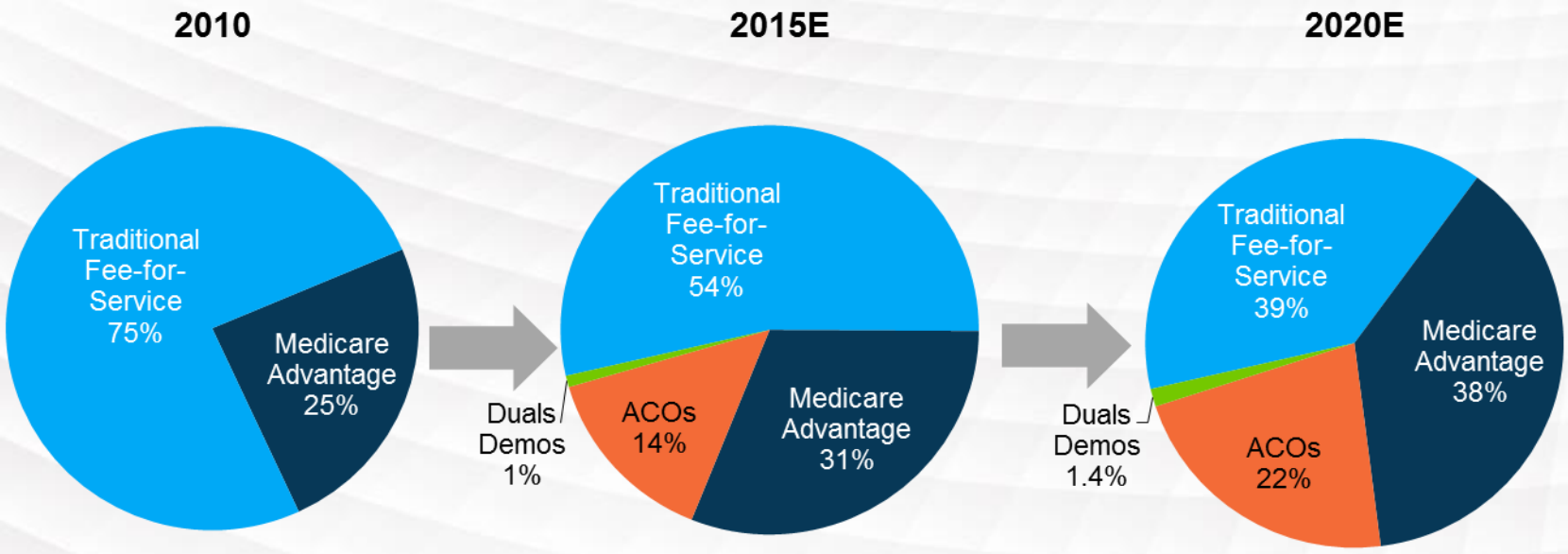
Outlook for the Industry

Erosion of Fee-for-Service

Projection of SNF Medicare Payer Mix

2010-2020



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.

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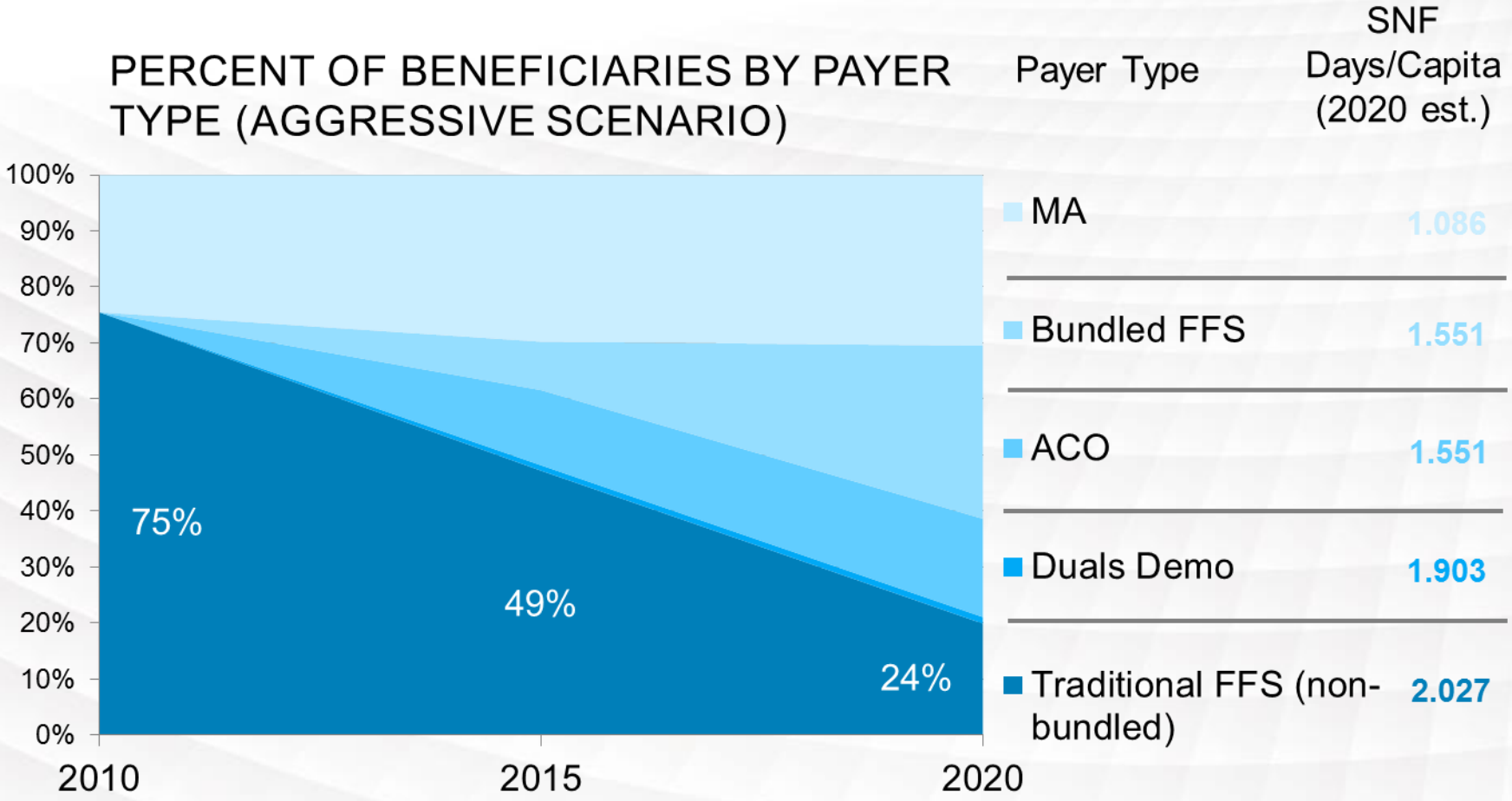
Big Shift in Payer Mix



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

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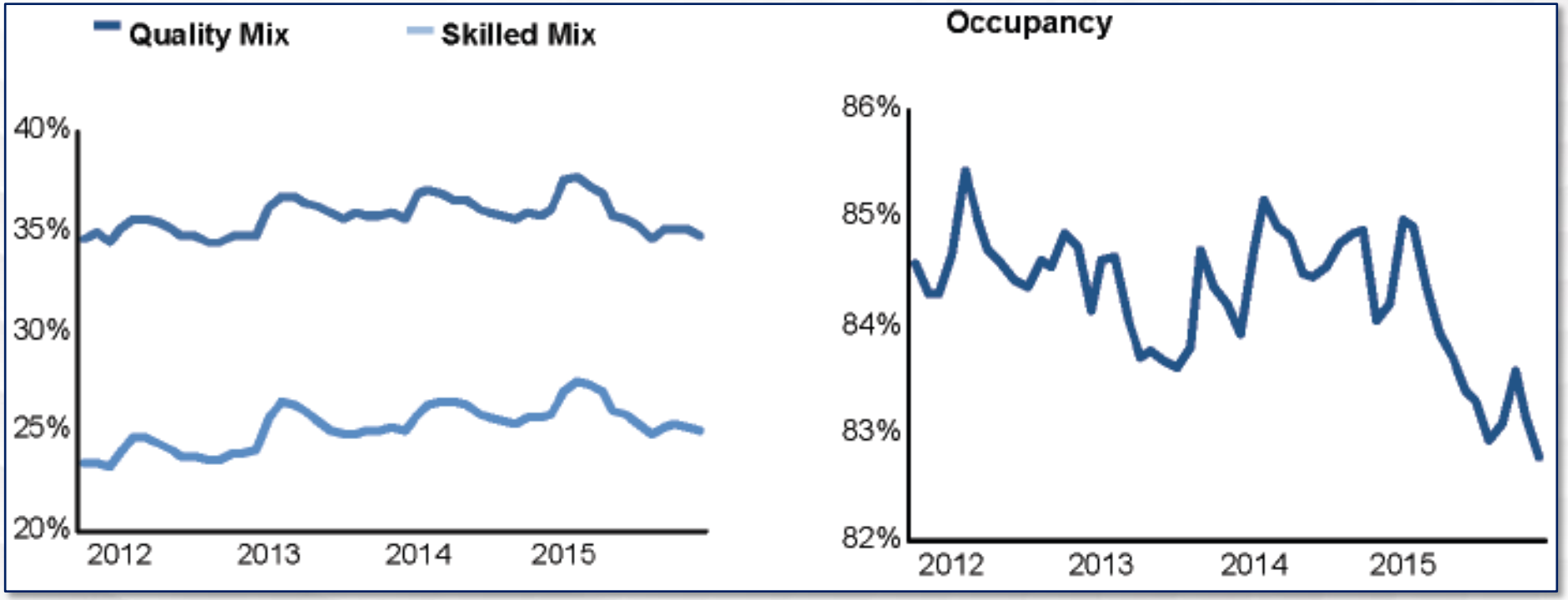
SNF Occupancy Down in Recent Years



Source: National Investment Center for Seniors Housing & Care (NIC).

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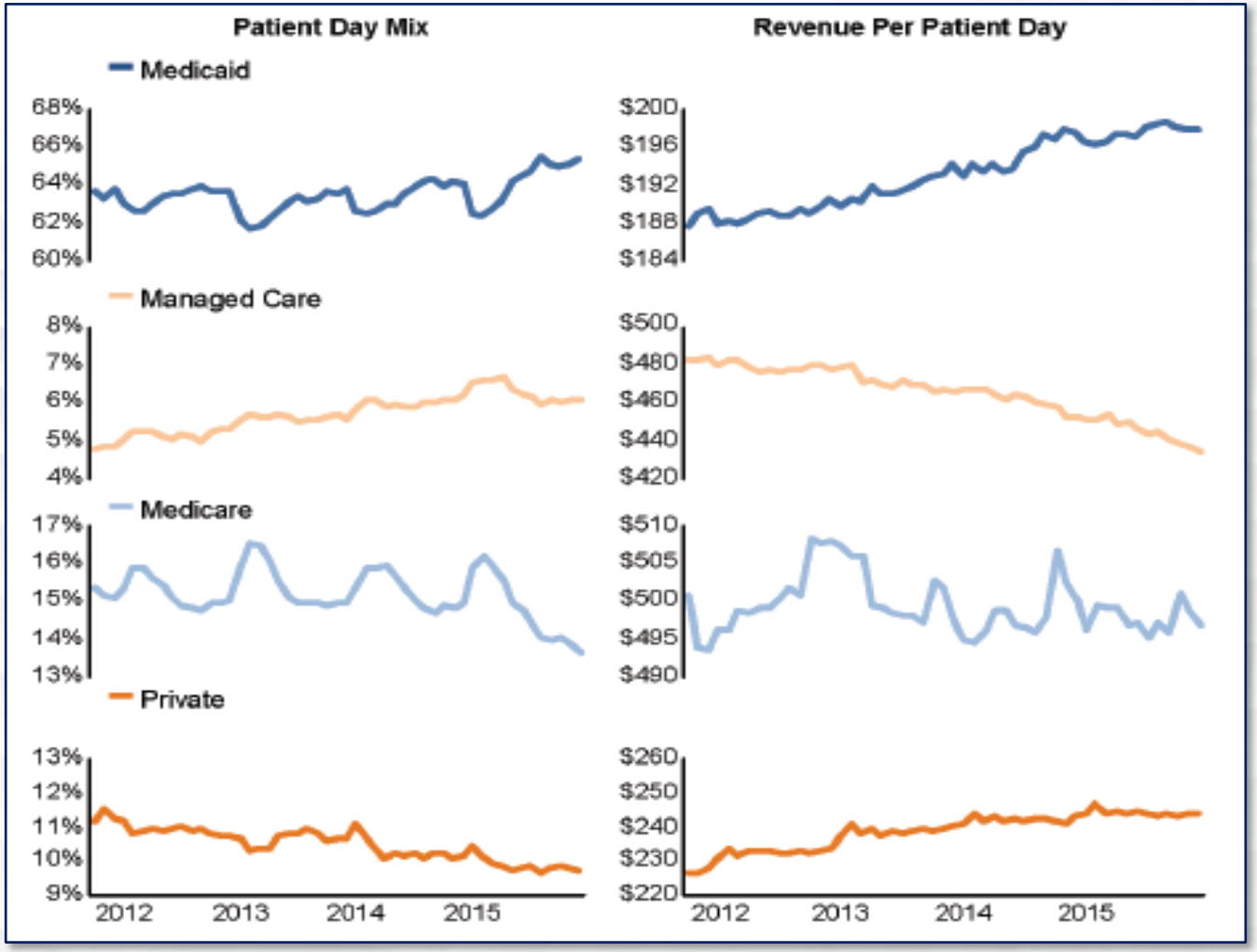
Downward Rate Pressures Continues to Increase



Source: National Investment Center for Seniors Housing & Care (NIC).

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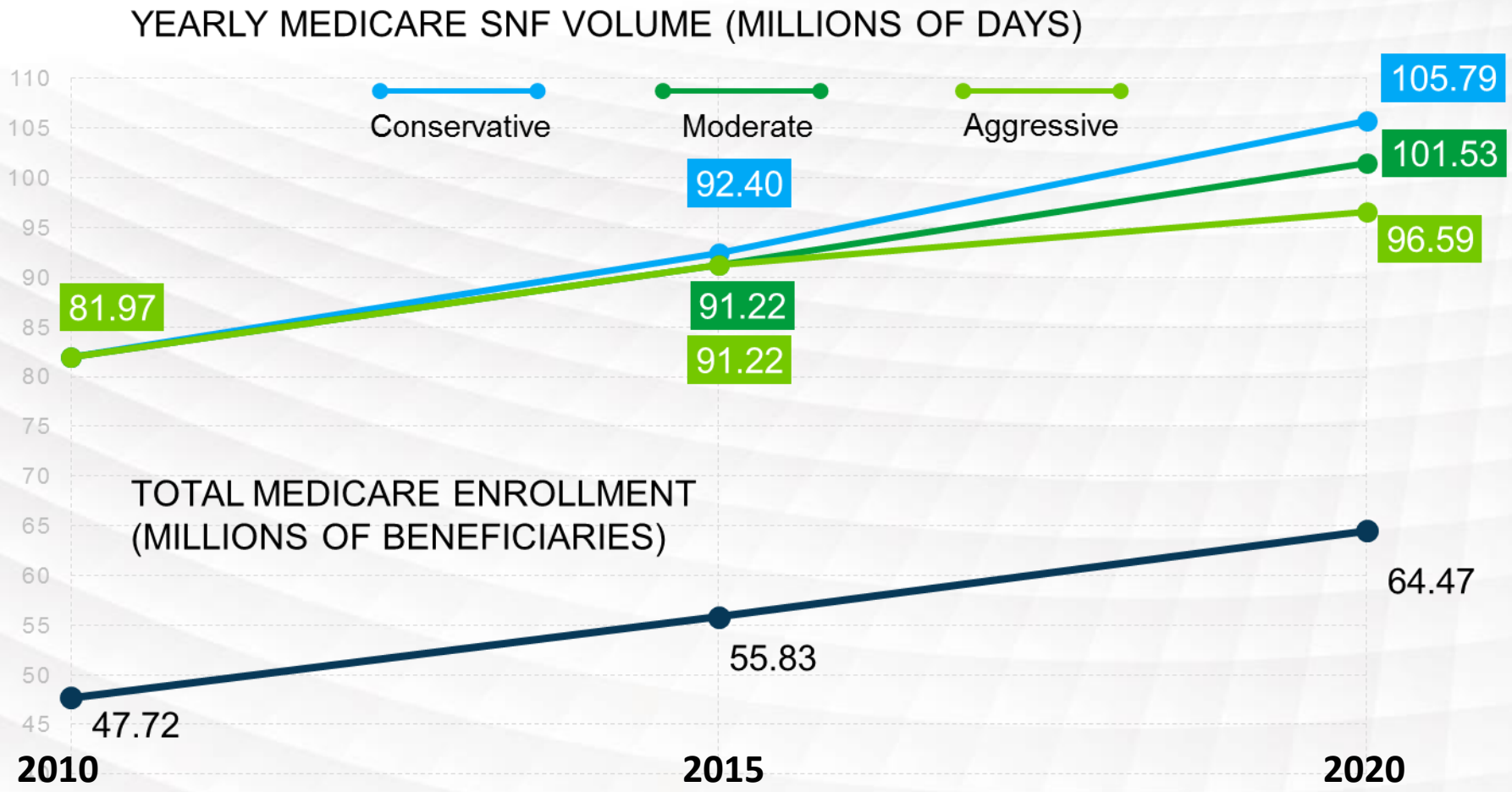
Despite Current Environment, Outlook is Positive



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