Bundling in Context of the Spectrum of Value-Based Payment

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CURRENT PRICING SYSTEM
Irrationality of Current Health Care Pricing System

• Highly variable prices charged by providers and paid by commercial insurers within and across markets

• Little transparency or ability for patients to compare total charges for procedure (e.g. hip replacement) or treatment of acute or chronic condition (e.g. breast cancer treatment; diabetes)

• Higher payment for more specialized services and procedures without respect to benefit or value to patients

• Medicare has leverage to obtain lower payment rates generally; commercial insurer charges also lower when Medicare payments are tighter
Figure 1 -- Large N.J. Insurer's Payments for Colonoscopies

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>$178</td>
<td>$431</td>
</tr>
<tr>
<td>Hospital</td>
<td>$716</td>
<td>$3,717</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>$443</td>
<td>$1,396</td>
</tr>
</tbody>
</table>

SOURCE: N.J. Commission on Rationalizing Health Care Resources, Ch. 6.
Figure 2 -- ACTUAL PAYMENTS MADE BY ONE CALIFORNIA INSURER TO VARIOUS HOSPITALS, 2007 (WAGE AdjustED)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Appendectomy (DRG 167)</th>
<th>CABG (DRG 107)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$1,800</td>
<td>$33,000</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$2,900</td>
<td>$54,600</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$4,700</td>
<td>$64,500</td>
</tr>
<tr>
<td>Hospital D</td>
<td>$9,500</td>
<td>$72,300</td>
</tr>
<tr>
<td>Hospital E</td>
<td>$13,700</td>
<td>$99,800</td>
</tr>
</tbody>
</table>

SOURCE: N.J. Commission on Rationalizing Health Care Resources, Ch. 6.

## Payment Variation Among Oregon Hospitals

<table>
<thead>
<tr>
<th>Service</th>
<th>State Average</th>
<th>Oregon State</th>
<th>Portland Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Average Low</td>
<td>Average High</td>
</tr>
<tr>
<td>Balloon angioplasty (no heart attack)</td>
<td>$26,161</td>
<td>$18,553</td>
<td>$53,810</td>
</tr>
<tr>
<td>Coronary artery bypass (without angioplasty)</td>
<td>$63,985</td>
<td>$33,302</td>
<td>$64,427</td>
</tr>
<tr>
<td>Uncomplicated childbirth</td>
<td>$6,424</td>
<td>$2,969</td>
<td>$8,765</td>
</tr>
<tr>
<td>Laparoscopic gallbladder removal</td>
<td>$16,834</td>
<td>$10,540</td>
<td>$28,816</td>
</tr>
<tr>
<td>Knee replacement surgery</td>
<td>$28,682</td>
<td>$18,472</td>
<td>$45,547</td>
</tr>
</tbody>
</table>

Massachusetts: Private Payment Variation for Professional Services and Hospital Care

Private $ Variation, Professional Services

Private $ Variation Across Hospitals

Total Cost Comparisons: Bypass Surgery

2012 Total Hospital and Physician Cost: Bypass Surgery

NEW PAYMENT METHODS
Rationale Guiding New Payment Methods

• Reward lower cost of total care for a patient, procedure, condition, or episode by creating incentives to:
  – Emphasize prevention and primary care, prompt intervention before exacerbation occurs; team approach to care
  – Ensure 24/7 access and reduce emergency room use
  – Use generic prescribing or lower cost treatment alternatives
  – Reduce hospitalization and readmissions, improve transitions in care, avoid complications
  – Develop post-acute plan of care and contract with lower cost, higher quality post-acute care providers
  – Better manage chronic conditions
  – Avoid waste, duplication, and use of low-value services
  – Better integrate care across care continuum

• Reward higher quality

• Public information on quality and total charges; promote competition among providers by facilitating patient and payer comparison of total charges and quality
Payment Innovation to Support Care Coordination and Integration

• Tools: Primary care, payment reform, health information technology, data on comparative performance, technical assistance

• Innovative Payment Methods:
  – Patient-Centered Medical Homes
  – Accountable Care Organizations
  – Value-Based Purchasing
  – Bundled Payment for Care Improvement
Payment and Delivery System Reforms Support a High Performance Health System

Payment and Delivery System Integration

Payment Integration

Global Payment

FFS and DRGs

Small MD practice; unrelated hospitals

Integrated delivery system

Value-Based Purchasing

Comprehensive Primary Care Initiative

CMMI Acute Episode Bundled Payment Pilots

Medicare Shared Savings Plan

Pioneer ACOs

## Overview of CMS Primary Care Payment Innovations

<table>
<thead>
<tr>
<th>Demonstration</th>
<th>Multi-Payer Advanced Primary Care Practice Demonstration</th>
<th>Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration</th>
<th>Comprehensive Primary Care Initiative (CPCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Scope</td>
<td>ME VT, RI, NY, PA, NC, MI, MN</td>
<td>500+ clinic sites In 44 States</td>
<td>7 “Markets”: Statewide: AR, CO, NJ, OR; Mid-Hudson/Capital (NY); Cincinnati-Dayton (OH); and Greater Tulsa (OK)</td>
</tr>
<tr>
<td>Participants</td>
<td>Up to 1,200 practices (MD &amp; NP) participating in state health care reform initiatives promoting APCP</td>
<td>FQHCs (and “look-alikes”) serving relatively large numbers of Medicare beneficiaries</td>
<td>45 payers (commercial, states, unions) 500 primary care practices 2,144 providers serving an estimated 313,000 Medicare beneficiaries</td>
</tr>
<tr>
<td>Practice Qualifications</td>
<td>Dependent on state program</td>
<td>&gt; 200 Medicare beneficiaries per site</td>
<td>High performing practices</td>
</tr>
<tr>
<td>Targeted Beneficiaries</td>
<td>Dependent on state program</td>
<td>Medicare beneficiaries</td>
<td>Medicare beneficiaries</td>
</tr>
<tr>
<td>Payment</td>
<td>Care management fee. Established by state multi-payer reform initiative</td>
<td>Medicare all-inclusive rate plus $6.00 PMPM care management fee</td>
<td>Avg $20 PMPM (risk-adjusted) Years 1-2 Avg. $15 Years 3-4 Opportunity for shared savings starting Yr. 2</td>
</tr>
</tbody>
</table>
Accountable Care Organizations

• Local entity, comprised of a group of providers that are accountable for the cost and quality of services delivered to a defined population of patients

• 260 ACOs now enroll over 4 million Medicare beneficiaries; CMS estimates up to 270 ACOs with up to 5 million beneficiaries will participate between 2012 – 2015

• Payments for quality reporting and meeting quality standards
  – 33 measures with 4 domains: patient/caregiver experience (7); care coordination/patient safety (6); preventive health (8); at-risk populations (12)
  – ACO must achieve threshold on 70% of measures within each domain

• ACO programs offered
  – Pioneer ACO Program
    • Designed for more advanced ACOs willing and able to assume full or partial risk for meeting target spending level
  
  – Medicare Shared Savings Program (MSSP)
    • Began April 1, 2012 with 27 organizations; additional 193 started as of January 10, 2013 [https://www.cms.gov/sharedsavingsprogram/](https://www.cms.gov/sharedsavingsprogram/)
    • Eligible for savings if Medicare outlays below target
  
  – Advance Payment ACO Model
    • Designed for physician-based and rural providers to receive upfront and monthly payments, which they can use to make important investments in care coordination infrastructure

Shared Savings Offers a Wide Range of Approaches

<table>
<thead>
<tr>
<th>One-Sided</th>
<th>Two-Sided</th>
<th>Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Continue operating under current insurance contracts/coverage models (e.g., FFS)</td>
<td>- Payments can still be tied to current payment system, although ACO could receive revenue from payers and distribute funds to members</td>
<td>- ACO receives prospective fixed payment</td>
</tr>
<tr>
<td>- No risk for losses if spending exceeds targets</td>
<td>- At risk for losses if spending exceeds targets</td>
<td>- If successful at meeting budget and performance targets, greater financial benefits</td>
</tr>
<tr>
<td>- Most incremental approach with least barriers for entry</td>
<td>- Increased incentive for providers to decrease costs</td>
<td>- If ACO exceeds budget, more risk means greater financial downside</td>
</tr>
<tr>
<td>- Attractive to new entities, risk-adverse providers, or entities with limited organizational capacity, range of covered services, or experience working with other providers</td>
<td>- Attractive to providers with some infrastructure or care coordination capability and demonstrated track record</td>
<td>- Only appropriate for providers with robust infrastructure, demonstrated track record in finances and quality and providing relatively full range of services</td>
</tr>
<tr>
<td>- MSSP - Can participate in one-sided model, sharing up to 50% of savings for 1st 3 years.</td>
<td>- MSSP - Offers a 2-sided track, sharing up to 60% savings. Must participate in 2-sided model after 3rd year</td>
<td>- Ultimate goal for most ACOs</td>
</tr>
<tr>
<td>- Pioneer: Offers a 1-sided option for one year</td>
<td>- Pioneer - Offers greater potential (up to 75%) for shared savings earnings</td>
<td>- Pioneer - in 3rd year, high-performing ACOs have option for partial capitation for Part B services or full capitation, including Part A and Part B</td>
</tr>
</tbody>
</table>
CMS Hospital Value-Based Purchasing Program (VBP)

- Rewards hospitals that meet a set standard of clinical quality measures and penalizes those that do not
- Levies fines on hospitals that have too many patient readmissions because of complications within 30 days of discharge
- Participants began to receive incentive payments on October 1, 2012
- More than 3,400 acute-care and 400 long-term care hospitals across the country are eligible to participate, with >99% participating
  - For the FY 2013 Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain, which is comprised of 12 clinical process of care measures, and the patient experience of care domain, which is comprised of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure
  - Hospitals participating in the program will have their base operating DRG payments for each patient discharge across all hospitals reduced by a small percentage each year in order to fund incentive payments
  - CMS estimates that roughly half of participating hospitals will receive a net increase in payments, while the rest will receive a net decrease in payments. CMS estimates that no participating hospital will receive more than a net 1-percent decrease in payments in FY 2013.

BUNDLED PAYMENT FOR CARE IMPROVEMENT
CMS Bundled Payment for Care Improvement (BPCI) Initiative

- 3-year program started January 31, 2013
- >500 organizations participating
- Test 4 different models of care, allowing physicians, hospitals, and post-acute care to participate

Key Components of BPCI

• Minimum discounts of 2-3%
• Detailed bundled payment design, including list of DRGs, inclusion and exclusion criteria, episode trigger and window, and risk adjustment mechanism
• Detailed action plan to redesign care to maximize coordination, patient-centeredness, efficiency, and improved quality
• Detailed physician gain sharing model (up to 50% of professional fees), including criteria for participating, methodology and frequency of sharing gains, and safeguards and quality control mechanisms to ensure that medically necessary care is not reduced
The 4 Models

• Model 1: Hospitalization with gain-sharing for physicians
• Model 2: Inpatient hospital (including readmissions), physician services, post-acute-care, and other related services
• Model 3: Post-hospitalization services
• Model 4: Inpatient hospital and physician services including readmissions, but not post-acute-care services
# Types of Services by Model

<table>
<thead>
<tr>
<th>Type of Services Included in Bundle</th>
<th>Model 1: Acute Hospital Stay Only</th>
<th>Model 2: Acute Hospital Stay + Post-Acute Care</th>
<th>Model 3: Post-Acute Care Only</th>
<th>Model 4: Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Related post-acute care services</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-acute care services</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Related readmissions</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other services defined in bundle (Part A &amp; Part B)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Type of Episodes Covered

- 48 clinical condition episodes by DRG groupings
  - Coronary artery bypass surgery (CABG) – DRG 231-236
  - Acute myocardial infarction – DRG 280-282
  - Stroke – DRG 61-66
  - Chest pain – DRG 313
  - Urinary tract infections – DRG 689, 690
  - Chronic obstructive pulmonary disease (COPD) – DRG 190-203
  - Diabetes – DRG 637-639
  - Revision of the hip or knee – DRG 466-468
  - Amputation – DRG 239-241, 255-257, 474-476, 616-618
  - Simple pneumonia and respiratory infections – DRG 177-195
  - Nutritional and metabolic disorders – DRG 640-641
# Bundled Payment Model Designs

<table>
<thead>
<tr>
<th>Model 1: Acute Hospital Stay Only</th>
<th>Model 2: Acute Hospital Stay + Post-Acute Care</th>
<th>Model 3: Post-Acute Care Only</th>
<th>Model 4: Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs, hospital plus post-acute period</td>
<td>Selected DRGs, post-acute period only</td>
<td>Selected DRGs, hospital plus post-acute period and readmissions</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Part A services paid as part of the DRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
<tr>
<td></td>
<td>based on preset target price</td>
<td>based on preset target price</td>
<td></td>
</tr>
<tr>
<td><strong>Number of initiatives</strong></td>
<td>32</td>
<td>193</td>
<td>166</td>
</tr>
</tbody>
</table>

INNOVATIVE PAYMENT MODELS DRIVING DELIVERY SYSTEM REFORM

From Michael C. Zucker, Chief Development Officer of Baptist Health System
Gain Share Example

DRG 470 – Major Joint Replacement or Reattachment of Lower Extremity w/o MCC

**Standard Payment Approach**
- Surgeon = $1,200 (80%) + $300 (20% co-pay) = $1,500
- Hospital = $10,400
- Patient = $0

**Bundled Payment Approach**
- Surgeon = $1,500 + up to $375 (25%) from lower cost
- Hospital = $10,400 – ($600 to CMS) + (rest of cost savings after MD share)
- Patient = $300 (up to 50% of CMS savings)

Cost Savings under ACE  
June 2009-May 2012

Volume

4,750 Medicare Patients

Hospital Savings

$9,500,000

Shared Savings to Patients

$1,341,198

Gain Share to Physicians

$1,109,415

Walmart “Centers of Excellence” Program

- Provide employees with quality health care with no out-of-pocket cost for heart, spine, and transplant surgeries at six hospital and health systems in the U.S.
- Use exclusive and unique bundled pricing arrangements for these types of procedures.
- Projected to save employees $5,000 to $12,000.
- “Triple win” for hospitals and employers - improve quality, improve value, and eliminate out-of-pocket costs for employees.
- Program started January 2013.

Walmart “Centers of Excellence” Procedures

• Cardiac surgeries including open-heart surgery, CABG, heart valve replacement/repair, closures of heart defects, thoracic and aortic aneurysm repair
  – Cleveland Clinic in Cleveland, Ohio
  – Geisinger Medical Center in Danville, Pa.
  – Scott & White Memorial Hospital in Temple, Texas
  – Virginia Mason Medical Center in Seattle

• Spinal procedures including cervical and lumbar spinal fusion, total disk arthroplasty, spine surgery revisions
  – Mercy Hospital Springfield in Springfield, Mo.
  – Scott & White Memorial Hospital in Temple, Texas
  – Virginia Mason Medical Center in Seattle

• Transplant surgeries
  – Mayo Clinic sites in Arizona, Florida, and Minnesota
Other Private Sector Collaborations

• Cleveland Clinic has similar programs for cardiac surgeries with
  – Lowe’s Corporation
  – Kohl’s
  – Rich Products
  – Alliance Oil

• Johns Hopkins Hospital and PepsiCo for cardiac and joint replacement surgeries
  – Rates tend to be set at the national average for a certain procedure

• Programs tend to have higher than expected participation from employees

MEDICARE ESSENTIAL: REINFORCING PAYMENT REFORM WITH BENEFICIARY INCENTIVES
Medicare Essential: A New Option to Enhance Value

1. Single plan with comprehensive benefits, one premium, and lower administrative costs (replaces Part A, Part B, Part D, and supplemental coverage); default option beginning in 2014; Medicare Advantage and traditional Medicare continue; Medi-Gap minimum $250 deductible

2. Comprehensive benefits with reduced and rationalized cost-sharing; single deductible ($250) for hospital, physician, and other A/B services; $20/$40/$50 copayment for primary care, specialty care, ED use; limit on patient costs ($3400)

3. Single Rx formulary and pharmaceutical benefits manager negotiating drug prices; lower cost-sharing for generic and essential medications

4. Provider payment reform – blended/bundled/global provider payment options with value based-purchasing, shared savings

5. Reduced beneficiary cost-sharing for selecting high-value patient-centered medical homes and health systems.
# Medicare Essential Incentive Benefit Design

<table>
<thead>
<tr>
<th>Medicare Essential Core Benefits</th>
<th>Medicare Essential Incentives: Lower Cost-Sharing for High-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>Deductible does not apply to primary care if registered with primary care practice or a patient-centered medical home (PCMH). Deductible does not apply if referred to specialist by PCMH or high-cost care team.</td>
</tr>
<tr>
<td>Hospital/physician: Unified $250 deductible ($500 family). Does not apply to preventive care (including prescription drugs).</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance Co-payment</strong></td>
<td>Co-insurance lowered to 5 percent for lab, diagnostic if PCMH, high-cost care team, or accountable care organization (ACO) network. No cost-sharing for care management. Health home networks covered for dually-eligible where available.</td>
</tr>
<tr>
<td>$20 primary care visit.</td>
<td>$10 co-pay for primary care if PCMH practice</td>
</tr>
<tr>
<td>$40 specialist visit.</td>
<td></td>
</tr>
<tr>
<td>10% lab/diagnostic outpatient.</td>
<td></td>
</tr>
<tr>
<td>10% other Part B services currently subject to 20% cost-sharing (outpatient surgery, durable medical equipment, etc.).</td>
<td></td>
</tr>
<tr>
<td>$50 emergency department visit unless urgent, accident.</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td>Use reference pricing – pay up to level of equivalent drugs (lowest cost two drugs) – patients pay the difference unless doctor specifies reference drug not appropriate for patient. Nominal co-payment for generic. No deductible.</td>
</tr>
<tr>
<td>25 % cost sharing for non-preferred brand. (Out of pocket limit includes Rx)</td>
<td></td>
</tr>
<tr>
<td><strong>Home health</strong></td>
<td>If in ACO network or high-cost care teams, expanded benefit as needed to avoid hospitalization.</td>
</tr>
<tr>
<td><strong>Skilled nursing</strong></td>
<td></td>
</tr>
<tr>
<td>Home health: no cost-sharing (same as current).</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing: $80/day for days 21-100.</td>
<td></td>
</tr>
<tr>
<td><strong>Ceiling on Out of Pocket (OOP) Costs</strong></td>
<td>$2,000 OOP limit if low-income.</td>
</tr>
<tr>
<td>$3,400 annual.</td>
<td>$2,000 if high-cost care team or certified ACO network.</td>
</tr>
<tr>
<td><strong>Other provisions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Low-Income: Up to 150% poverty</strong></td>
<td>Medicaid eligible: Current provisions for Medicaid supplement; Medicaid pays additional Medicare Essential premium. Other under 150%: Out of pocket limit of $2,000 per year.</td>
</tr>
<tr>
<td><strong>Medigap</strong></td>
<td>Starting in 2014, Medigap does not cover the $250 deductible and all plans must include at least $20 co-payment per physician and emergency room visit (similar to current Medigap Plan N).</td>
</tr>
<tr>
<td><strong>Medicare Advantage</strong></td>
<td>Limit out-of-pocket maximum to no more than $3,400 (lower limits permitted). No cost-sharing for home health if part of care plan (to avoid risk selection).</td>
</tr>
</tbody>
</table>
Estimated Total Monthly Out-of-Pocket Costs for a Typical Medicare Beneficiary with Medicare Essential (Using Standard Providers and Using High-Value Providers), Compared with Traditional Medicare with Medigap and Part D, 2014

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Costs for Medicare Covered Services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--Medical Care (Parts A and B)</td>
<td>$0</td>
<td>$80</td>
<td>$80</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>--Prescription Drug (Part D)</td>
<td>$48</td>
<td>$36</td>
<td>-$12</td>
<td>$8</td>
<td>-$40</td>
</tr>
<tr>
<td>Premiums:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--Part B</td>
<td>$127</td>
<td>$127</td>
<td>$0</td>
<td>$127</td>
<td>$0</td>
</tr>
<tr>
<td>--Part D</td>
<td>$35</td>
<td>$0</td>
<td>-$35</td>
<td>$0</td>
<td>-$35</td>
</tr>
<tr>
<td>--Medigap Plan F</td>
<td>$217</td>
<td>$0</td>
<td>-$217</td>
<td>$0</td>
<td>-$217</td>
</tr>
<tr>
<td>--Medicare Essential</td>
<td>$0</td>
<td>$111</td>
<td>$111</td>
<td>$79</td>
<td>$79</td>
</tr>
<tr>
<td><strong>Monthly Cost: Premiums plus Out-of-Pocket</strong></td>
<td><strong>$427</strong></td>
<td><strong>$354</strong></td>
<td><strong>-$73</strong></td>
<td><strong>$254</strong></td>
<td><strong>-$173</strong></td>
</tr>
</tbody>
</table>

Notes: Estimates reflect full implementation of Medicare Essential in 2014. Source: Estimates provided by Actuarial Research Corporation based on ARC Medicare micro-model.
### Changes In Health Expenditures with Medicare Essential Compared To Projected Spending, By Payer Source, $ Billions

<table>
<thead>
<tr>
<th></th>
<th>2014-2018</th>
<th>2014-2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Expenditures</td>
<td>-$12.9</td>
<td>-$179.9</td>
</tr>
<tr>
<td>Federal Government</td>
<td>32.6</td>
<td>0.0</td>
</tr>
<tr>
<td>State and Local Government</td>
<td>-8.1</td>
<td>-27.0</td>
</tr>
<tr>
<td>Private Employers</td>
<td>-27.1</td>
<td>-89.9</td>
</tr>
<tr>
<td>Households/Beneficiaries</td>
<td>-10.3</td>
<td>-63.1</td>
</tr>
</tbody>
</table>

Notes: Projected spending under current law assumes replacement of sustainable growth rate formula with freeze of Medicare physician fees throughout the ten-year period. Assumes increased participation in Medicare Essential over time compared to traditional Medicare, with 90% of those in Medicare core program selecting the option by the end of the decade. Share of Medicare Advantage enrollment is assumed unchanged.

Source: Estimates provided to authors by Actuarial Research Corporation based on ARC Medicare micro-model.
Benefits of Medicare Essential

- Potential to simplify and lower costs for beneficiaries
- Lower administrative costs and complexity
- Better financial protection for beneficiaries
- Creates incentives for beneficiaries to choose lower-cost, higher quality care
  - Supports spread of care system innovation
- Potential to reduce retiree-benefit costs for employers
- New choice to compete on level playing field with Medicare Advantage plans
- Inefficient Medigap plans likely to decline overtime
Incentives for Better Care

• Provides incentives for wise choice of care, choice of less expensive diagnostic and treatment options with comparable or better outcomes
  – No cost-sharing for preventive services; rationalized cost-sharing of $20 per visit for primary care, $40 for specialty care and $50 for emergency department care; encourages use of lower-cost primary care
  – Eliminates deductibles for beneficiaries choosing high-performing patient-centered medical homes and accountable care organizations
  – Reduces cost-sharing for obtaining specialty care within ACO networks and through health systems accepting bundled payment
• Promotes coordinating care, improving medical adherence, and reducing hospitalization and emergency department cost by having all services in a single plan
• Incentives for shared decision-making, information for patients
Incentives for Providers

• Incentives for providers to participate in innovative payment methods, meet high standards of performance, be accountable for better care, better outcomes, lower cost
  • Blended payment for patient-centered medical homes (FFS, care management fee per beneficiary, performance bonuses)
  • Bundled payment for health systems (bundled case rate for selected conditions and procedures including inpatient hospital, inpatient physician, post-acute care for 30 days for selected conditions and procedures)
  • Global payment for ACOs (full or partial risk or shared savings)
• Bonuses for high performance, shared savings
• Contribute to lower-cost care, better care and outcomes for patients; eliminate incentives for overuse by providers
THE PROMISE AND THE CHALLENGES OF BUNDLED PAYMENT
The Promise and the Challenges

• Promise:
  – Simplicity, transparency in costs, transparency in benefits
  – Potential for promoting competition, lower prices
  – Better rewards for efficiency and quality

• Challenges:
  – Assumption of risks
  – Implementation
  – Administrative claims systems
  – Evaluation
  – Spread
Thank You!

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