ECG MANAGEMENT CONSULTANTS

Fourteenth National Value-Based Payment and Pay for Performance Summit Los Angeles, California

The Center for Medicare and Medicaid Innovation's New Mandatory Downside-Risk Payment Models

February 25, 2019

CONFIDENTIAL

About Us

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- We are particularly known for our expertise in value-based care strategy, hospital-physician relationships, business planning, and program development.
- We focus on creating customized, implementable solutions to meet our clients' specific challenges in both community-based and academic settings.
- We have more than 215 consultants nationwide.

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Agenda

I.	Introduction
II.	Medicare Shared Savings Program (MSSP) ACOs
III.	CJR
IV.	BPCI Advanced (BPCI-A)
V.	Oncology Care Model
VI.	Other Models
VII.	Planning, Implementation, and Management

I. Introduction

I.

The Value-Based Enterprise

Value and risk are focused on three key topics

Success will be measured by an organization's ability to achieve the "triple aim."

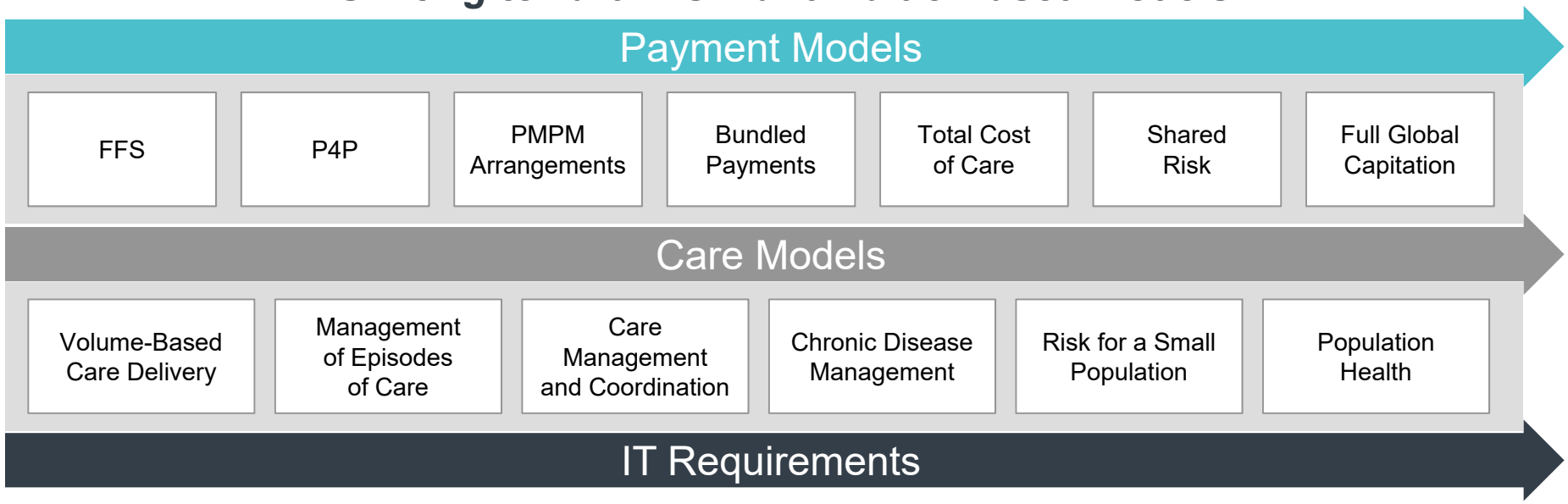
I.

Moving from FFS to Value

Payment Models and Care Models

Organizations will need to establish a strategy and roadmap to transition to value. This includes the development of a payer strategy, investments in care delivery, and a funds flow/payment model plan that paces with the organization's transformation.

Payment and Care Delivery Continuum
Shifting toward Risk- and Value-Based Models



I.

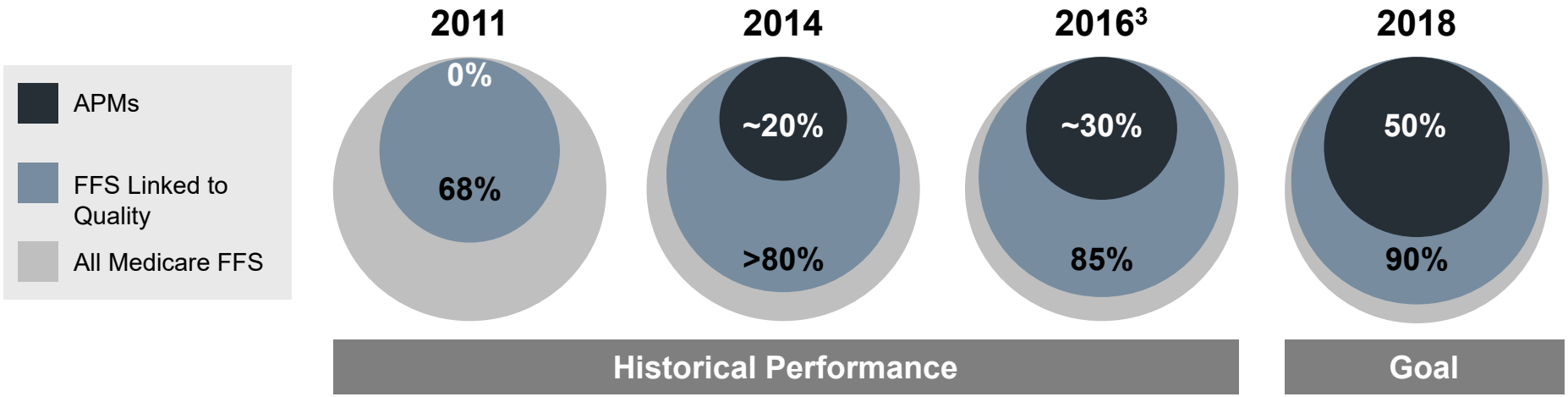
National Healthcare Trends

Transitioning to New Payment Models

At a national level, since the ACA, we are experiencing a transition to alternative payment models (APMs) and fee-for-service (FFS) payments linked to quality.

- The federal government and many states are establishing programs to distribute a material amount of payments through alternative models. MACRA is an example of the ongoing trend of evolving reimbursement incentives.
- The Health Care Transformation Task Force announced a goal in 2015 to shift 75% of its business to performance-based contracts.[1]

Medicare Payment Evolution[2]



1 *Modern Healthcare*, January 28, 2015.
2 Health Care Payment Learning and Action Network: https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/.
3 CMS reached the 30% APM target as of March 2016.

I.

Trending Towards Value

Not as Fast as Expected

While value-based incentives are continuing to grow in the market, the pacing has been slower than anticipated.

The Market: Every market is different (e.g., health plans, employers, providers, innovation) and as a result the pathway to risk-based models needs to be managed.

Do you want to be a market leader for risk-based arrangements?

FFS Continues: Hospitals and physician continue to be paid predominantly under a fee-for-service model.

Experimenting and Participating in Value-Based Incentives: Providers are continuing to evaluate opportunities for participation, but on a smaller, more manageable scale.

The Future: Risk based arrangements will continue to growth at a steady pace with CMS leading and commercial payers adopting selectively.

I.

New Payment and Service Delivery Models

The Center for Medicare and Medicaid Innovation, created under the ACA, has grouped 87 new payment and service delivery models into six categories.

Model Category	Total Models	Ongoing	No Longer Active	n/a	Announced and/or Under Development
Accountable Care	11	5	5	1	0
Episode-Based Payment Initiatives	13	7	4	2	0
Primary Care Transformation	9	4	5	0	0
Initiative Focused on Medicaid and CHIP Population	12	3	5	1	3
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	32	21	2	2	7
Initiatives to Speed the Adoption of Best Practices	10	7	3	0	0
Totals	**87**	**47**	**24**	**6**	**10**
Percentage of the Totals	**100%**	**54%**	**28%**	**7%**	**11%**

Not all of these models carry mandatory downside risk. Several of those that do are profiled in the subsequent slides.

I.

Where is CMS Going?

Continuing down the path of accountable payment models

Alex Azar - HHS Secretary

- CMS plans to test a mandatory model for cancer
  - Radiation oncology
- Relaunch two previously cancelled programs for cardiac care

Seema Verma - CMS Administrator

- "We need strategies and models that provide care at a lower price"[1]
- In some cases that's going to mean more mandatory models from CMMI
- Forthcoming models will be focused on ESRD, cancer care, chronic disease and other serious medical conditions

[1] CMS: Innovative new payment models are coming – and some will be mandatory, Susan Morse, Healthcare Finance News, September 20, 2018.

II. MSSP ACOs

II.

Medicare Shared Savings Program

Updates for 2019

In an effort called "Pathways to Success," CMS overhauled the MSSP in a final rule released in December of 2018.

Major Changes Include:[1,2]

- New tracks (BASIC and ENHANCED)
- Longer performance periods (five years versus three)
- Downside risk eventually becomes mandatory
- Changes to beneficiary assignment
  - Expanded definition of primary care services
  - More flexibility for patients to designate primary clinicians
  - Ability to choose prospective or retrospective assignment annually
- Benchmarking methodology changes
- Opportunity to provide beneficiary incentives

[1] See appendix A for a summary of the key differences between the MSSP proposed rule released in August 2018 and the final rule released in December 2018.
[2] See appendix B for additional details about key changes to the MSSP.

II.

Medicare Shared Savings Program

New Tracks: BASIC and ENHANCED

The biggest change under Pathways to Success is the consolidation of four MSSP tracks to two tracks with five-year performance periods and mandatory assumption of downside risk within at least three years.

Downside Risk Timeline for BASIC and ENHANCED Tracks under Standard "Glide Path"

MSSP ACO Track	Year One[1] Jul 2019 or Jan 2020– Dec 2020	Year Two Jan– Dec 2021	Year Three Jan– Dec 2022	Year Four Jan– Dec 2023	Year Five Jan– Dec 2024
BASIC Track	Upside-Only Model[2]		Two-Sided Model (Max Downside: 30% of Losses)		
ENHANCED Track	Two-Sided Model (Max Downside: 75% of Losses)				

BASIC Track

- ACOs entering the BASIC Track's standard "glide path" on July 1, 2019, would be allowed 2-1/2 years under a one-sided model.
- BASIC track ACOs can opt to advance more quickly through the five levels, taking on additional risk at an accelerated pace.

ENHANCED Track

- ENHANCED Track ACOs will have the largest opportunity (75%) to share in savings as well as the largest risk in sharing losses (40%–75%).
- This track is required for most existing ACOs with hospital participants that have experience with performance-based risk Medicare ACO initiatives.
- Care management and quality improvement capabilities are critical to mitigating the risk in this track.

[1] Note: For ACOs that begin in the BASIC or ENHANCED Track on July 1, 2019, the period from July to December 2019 will be considered their first performance year. Calendar year 2020 will be considered their second performance year, and so forth. But BASIC Track ACOs that begin the standard glide path on July 1, 2019 will not have to assume downside risk until January 1, 2022, as the timeline indicates. BASIC Track ACOs that begin the standard glide path on July 1, 2020 will also have to assume downside risk beginning January 1, 2022.

[2] Please note an exception to this timeline: New low-revenue ACOs will have the option to participate under one-sided risk for three years and in exchange will be required to move to the highest level of risk under the BASIC Track for the final two years of their five-year agreement period.

II.

Medicare Shared Savings Program

Message to Providers: Assessing the MSSP's Role in a Medicare Strategy

The changes to the MSSP give provider organizations an opportunity to re-evaluate how the program might (or might not) fit into their Medicare strategies.

CMS Is Increasing the Pressure

- The changes to the MSSP are expected to save CMS $2.9 billion over the next decade
- The majority of these savings to CMS would be generated by reductions in net ACO earnings, likely stemming from more ACOs paying shared losses back to CMS.

The MSSP May Still Make Sense

- The BASIC Track is still relatively low-risk compared to other value-based models (e.g., capitation).
- Reasons to consider MSSP participation include gaining experience managing risk, maintaining physician alignment, and earning the A-APM bonus under MACRA.

Consider Other Medicare Strategies

- With the A-APM bonus set to expire after 2022 and MIPS bonuses and penalties increasing, MACRA optimization could be more appealing than the MSSP for some provider organizations.
- Medicare Advantage plans can often offer more flexible value-based arrangements than the MSSP.

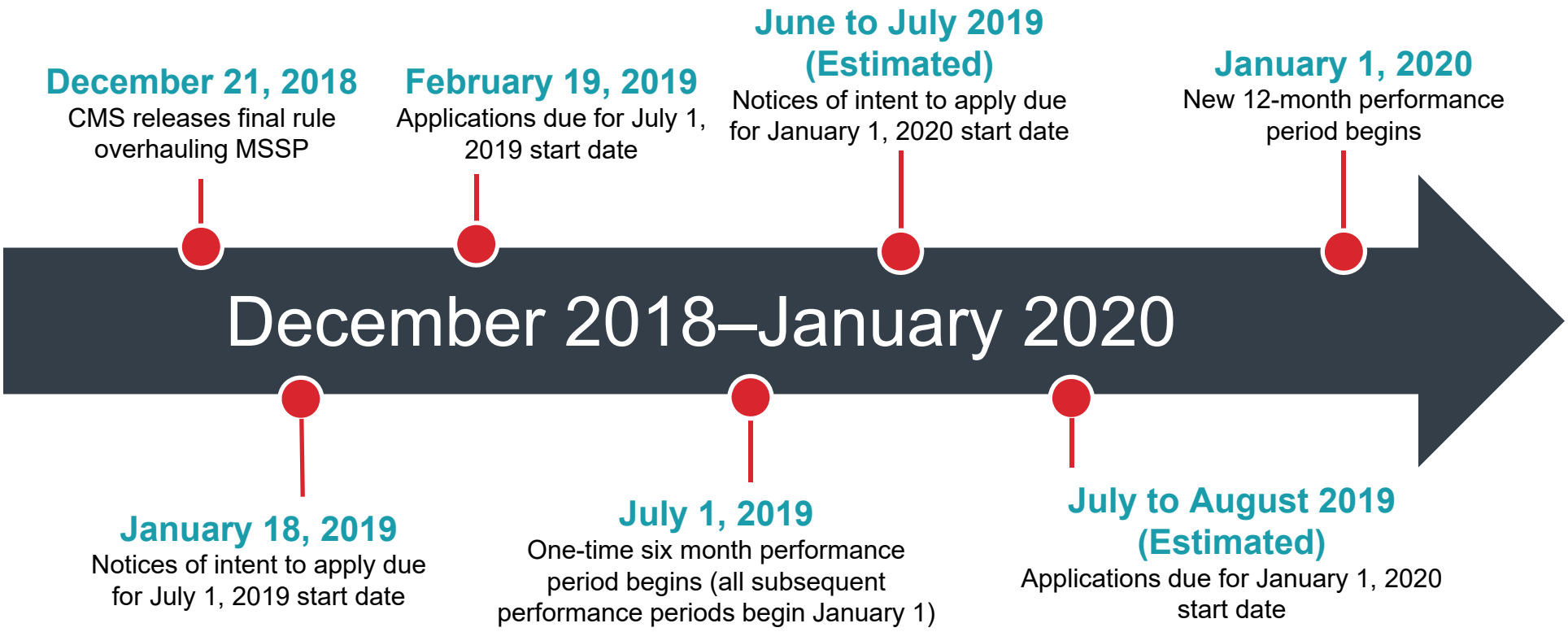
The best Medicare strategy for a provider organization will be situationally dependent.

II.

Medicare Shared Savings Program

Application Timeline for 2019 and 2020 Start Dates

ACOs interested in the July 1, 2019, start date should already be well into the application process. ACOs interested in the January 1, 2020, start date should begin compiling responses as soon as possible in anticipation of a summer 2019 deadline.



Sample applications for ACOs not currently participating in the MSSP are available on the CMS website.

II.

Key Differences between Proposed and Final Rules

The most notable difference between the proposed and final rules was the increase in the maximum savings rate for levels A through C of the BASIC Track.

Maximum Savings Rates

Track/Level	Proposed Rule	Final Rule
BASIC Track		
Level A	25%	40%
Level B	25%	40%
Level C	30%	50%
Level D	40%	50%
Level E	50%	50%
ENHANCED Track	75%	75%

II.

Key Differences between Proposed and Final Rules

Other Notable Updates

Low-Revenue ACO Threshold	The threshold for being designated a low-revenue ACO has increased from ACO participants accounting for 25% of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries to 35%.
New Low-Revenue ACOs	New low-revenue ACOs, inexperienced with performance-based risk Medicare ACO initiatives, can participate for up to 3 years (or 3.5 years for ACOs beginning on July 1, 2019) under a one-sided model of the BASIC Track's glide path before transitioning to Level E.
Track 1+ Participants	High-revenue ACOs that transitioned to Track 1+ within their current agreement period have the option to renew for one agreement period under Level E of the BASIC Track.
Regional Adjustment	The initial weight applied to the regional adjustment for ACOs with historical expenditures above their regional service area has been reduced to 15%, and the phase-in to the maximum weight for such ACOs has been lengthened.
Benchmark Risk Adjustment	Maintains the 3% risk score growth cap over the length of the agreement period but removes the negative 3% risk score growth cap on decreases.

II.

Additional Details about Key Changes to the MSSP

Shared Savings and Losses: BASIC and ENHANCED Tracks

	BASIC Track				ENHANCED Track
	Levels A & B (Upside Only)	Level C (Two-Sided Risk)	Level D (Two-Sided Risk)	Level E (Two-Sided Risk)	(Two-sided Risk)
Shared Savings (Once Minimum Savings Rate Is Met or Exceeded)	**First dollar savings at a rate up to 40%** based on quality performance; not to exceed 10% of updated benchmark	**First dollar savings at a rate of up to 50%** based on quality performance, not to exceed 10% of updated benchmark	**First dollar savings at a rate of up to 50%** based on quality performance, not to exceed 10% of updated benchmark	**First dollar savings at a rate of up to 50%** based on quality performance, not to exceed 10% of updated benchmark	**First dollar savings at a rate of up to 75%** based on quality performance, not to exceed 20% of updated benchmark
Shared Losses (Once Minimum Loss Rate is Met or Exceeded)	n/a	**First dollar losses at a rate of 30%**, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	**First dollar losses at a rate of 30%**, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	**First dollar losses at a rate of 30%**, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program, capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard	First dollar losses at a rate of 1 minus final sharing rate, with **minimum shared loss rate of 40% and maximum of 75%**, not to exceed 15% of updated benchmark
Advanced Alternative Payment Model?	No	No	No	Yes	Yes

See attachment A for additional details about the proposed new tracks and a comparison to the existing tracks.

II.

Additional Details about Key Changes to the MSSP

Beneficiary Assignment and Incentives

Primary Care Definition

The definition of primary care services used in beneficiary assignment is being expanded to include additional CPT codes.

Primary Clinician Designation

Beneficiaries may designate a physician, regardless of specialty, or nurse practitioner, physician assistant, or clinical nurse specialist as their "primary clinician" responsible for coordinating their overall care.

Assignment Options

- ACOs can elect prospective assignment or preliminary prospective assignment with retrospective reconciliation prior to the start of each agreement period and change that selection for each subsequent performance year.
- Beginning in 2019, if an ACO's beneficiary population falls below 5,000 during a performance year, the minimum savings and minimum loss rates can be adjusted to reward true cost savings that are not related to the loss in assigned beneficiaries.

Beneficiary Incentive Program

ACOs in certain two-sided models can provide an incentive payment of up to $20 to an assigned beneficiary for each qualifying primary care service that the beneficiary receives from certain ACO professionals or FQHC.

See appendix A for additional details about the beneficiary assignment refinements.

II.

Additional Details about Key Changes to the MSSP

Benchmarking Methodology Refinements

CMS has several new benchmarking methodology changes to ensure that ACOs do not unduly benefit from one aspect of the calculations while also ensuring that the program remains attractive to ACOs with complex patient populations.

- Using full CMS-Hierarchical Condition Category (HCC) risk adjustment for all assigned beneficiaries (with a 3% cap on aggregate risk score increases)
- Factoring regional expenditures into the benchmark for the first agreement period
- Reducing the maximum weight used for regional adjustments and applying a cap
- Blending national and regional growth rates in the trend factor

See appendix B for additional details about the benchmarking methodology refinements.

II.

Additional Details about Key Changes to the MSSP

Additional Features

Expanded Telehealth

Eligible physicians and practitioners in two-sided risk models could receive payment for telehealth services furnished to prospectively assigned beneficiaries, irrespective of the current geographic telehealth requirements (i.e., even if the call originates from the patient's home).

SNF 3-Day Rule Waiver

ACOs participating in a two-sided risk model will be eligible to participate in the SNF 3-Day Rule Waiver, regardless of their choice of prospective assignment or preliminary prospective with retrospective reconciliation.

EHR Technology

ACOs will no longer be required to meet the meaningful use EHR quality measure. Instead, ACOs will have to attest that a specified percentage of their eligible clinicians use certified EHR technology to be eligible for the program.

Repayment Mechanism

BASIC Track ACOs may have a lower repayment mechanism amount to reflect the potentially lower loss liability. Renewing ACOs will be able to maintain a single, existing repayment mechanism arrangement to support their ability to repay shared losses.

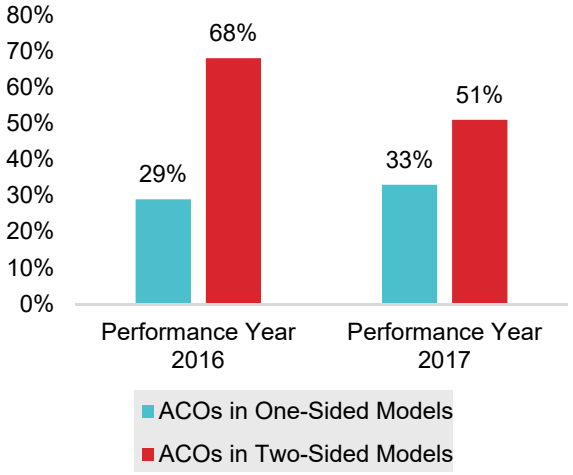
II.

MSSP ACO Success Factors

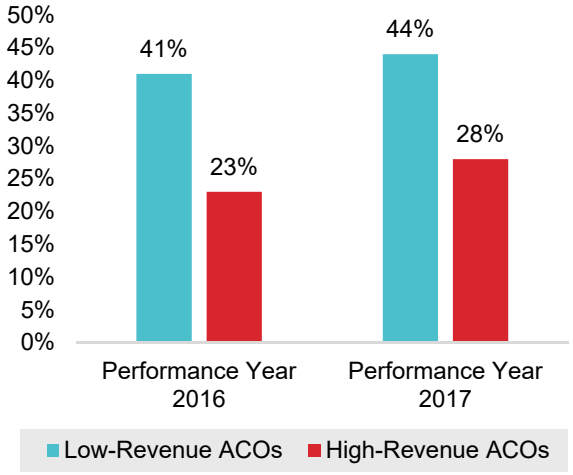
MSSP ACOs in two-sided models have outperformed those in one-sided models. Additionally, low-revenue ACOs have outperformed high-revenue ACOs (which often include hospitals), and ACOs have improved their performance over time.

Percentage of MSSP ACOs Earning Shared Savings

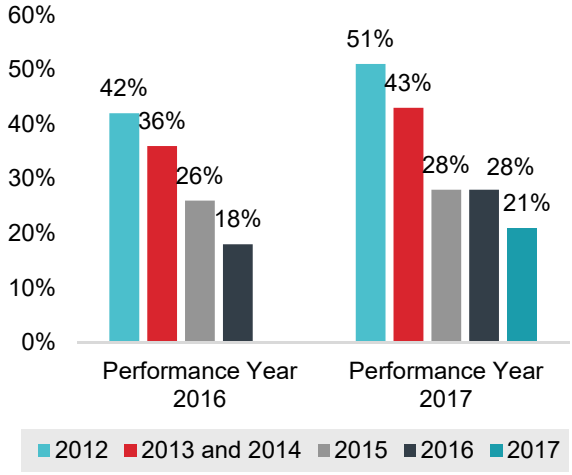
Risk Model (One-Sided versus Two-Sided)



Revenue Status (Low-Revenue versus High-Revenue)[1]



Initial Participation Year (2012 to 2017)



Source: Final Rule: "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017." Published December 31, 2018.

[1] A low-revenue ACO is one whose total Medicare Parts A and B FFS revenue of its ACO participants based on revenue for the most recent calendar year for which 12 months of data are available, is less than 35% of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries based on expenditures for the most recent calendar year for which 12 months of data are available. All other ACOs are high-revenue ACOs. Low-revenue ACOs tend not to have hospital participants, while high-revenue ACOs tend to have hospital participants.

These statistics were part of the rationale for CMS's overhaul of the MSSP, including the move to mandatory downside risk.

II.

2017 MSSP ACO Performance

As a whole, 2017 was a great performance year for MSSP ACOs in terms of both reducing costs and improving quality. Performance results, summarized below, demonstrate an improvement from 2016.

- 472 ACOs, serving 9 million beneficiaries, participated in the MSSP
- ACOs generated $314 million in net savings to Medicare
- 60% of ACOs saved money; 34% of ACOs earned shared savings
- ACOs achieved a mean quality score of 90.5% under the P4P measurement
- Older ACOs (began in 2012 or 2013) more likely to earn shared savings and save money overall for Medicare

II.

Next Generation ACO Model

Designed for experienced and successful ACOs, the Next Generation ACO Model built upon the initial version of the MSSP and introduced several features that were incorporated into the "Pathways to Success" overhaul.

Next Generation ACO Key Features

- Higher levels of risk and reward than the MSSP (shared savings and losses from 80% to 100%)
- Refined benchmarking methods that reward both attainment and improvement in cost containment
- Selection of payment mechanisms to enable a graduation from FFS payments to all-inclusive population-based payments (i.e., capitation)
- "Benefit enhancement"[1] tools for beneficiaries, such as:
  - Greater access to post-discharge home visits, telehealth services, and SNF services
  - Reward payments for receiving an annual wellness visit
  - Allowing beneficiaries to confirm their care relationships with ACO providers

Next Generation ACO Key Statistics

	Performance Year One (2016)	Performance Year Two (2017)
Participants	18	44
Average Patient Population	26,207	27,736
Average Total Cost of Care Benchmark	$286,062,590	$322,768,368
Percentage of Participants Earning Shared Savings	61%	73%
Average Savings Earned	$5,304,380	$7,180,526
Average Loss Incurred	-$2,910,726	-$4,783,054

[1] The "Pathways to Success" overhaul of the MSSP included similar features to these benefit enhancements.

III. CJR

III.

CJR Program Performance

Program Results

The CJR program is entering its fourth performance year in which hospitals will be subject to two-sided risk (20% upside/20% downside).

Program Year	Episodes Included	Risk (Percentage of Target Price)	Target Price Blending (Hospital/Regional)	Reconciliation Payment
PY 1	April 1, 2016, to December 31, 2016	One-sided n/a/+5%	66%/33%	$130,485
PY 2	January 1, 2017, to December 31, 2017	Two-sided -5%/+5%	66%/33%	$436,558
PY 3	January 1, 2018, to December 31, 2018	Two-sided -10%/+10%	33%/66%	$(140,590)[1]
PY 4	January 1, 2019, to December 31, 2019	Two-sided -20%/+20%	0%/100%	TBD
PY 5	January 1, 2020, to December 31, 2020	Two-sided -20%/+20%	0%/100%	TBD

[1] Reconciliation amount is represented in standardized dollars based on the CMS CJR monitoring report through Q3 2018.

Note: The South Atlantic region includes Delaware, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, and the District of Columbia.

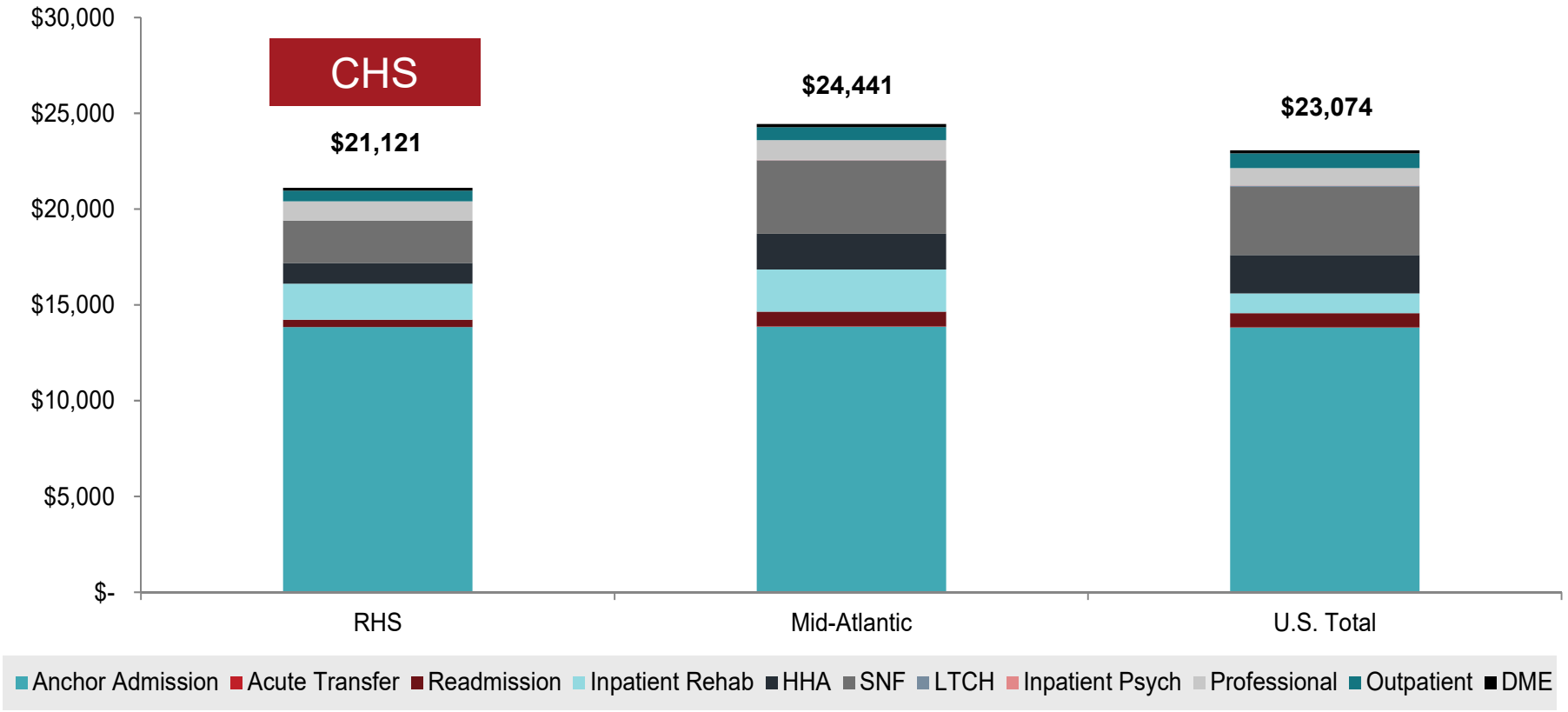
III.

CJR Analysis

Analysis Findings: Average Medicare Payment Excluding Hip Fractures

CHS is significantly better positioned than its regional market in terms of average costs for joint replacement episodes when excluding hip fractures.

Medicare Payment (Surgery and 90 Days Post–Acute Care) for Joint Replacement Episodes, Excluding Fractures (2012–2014)[1]



[1] DataGen Bundled Payments 360 v2.0 (2012–2014).

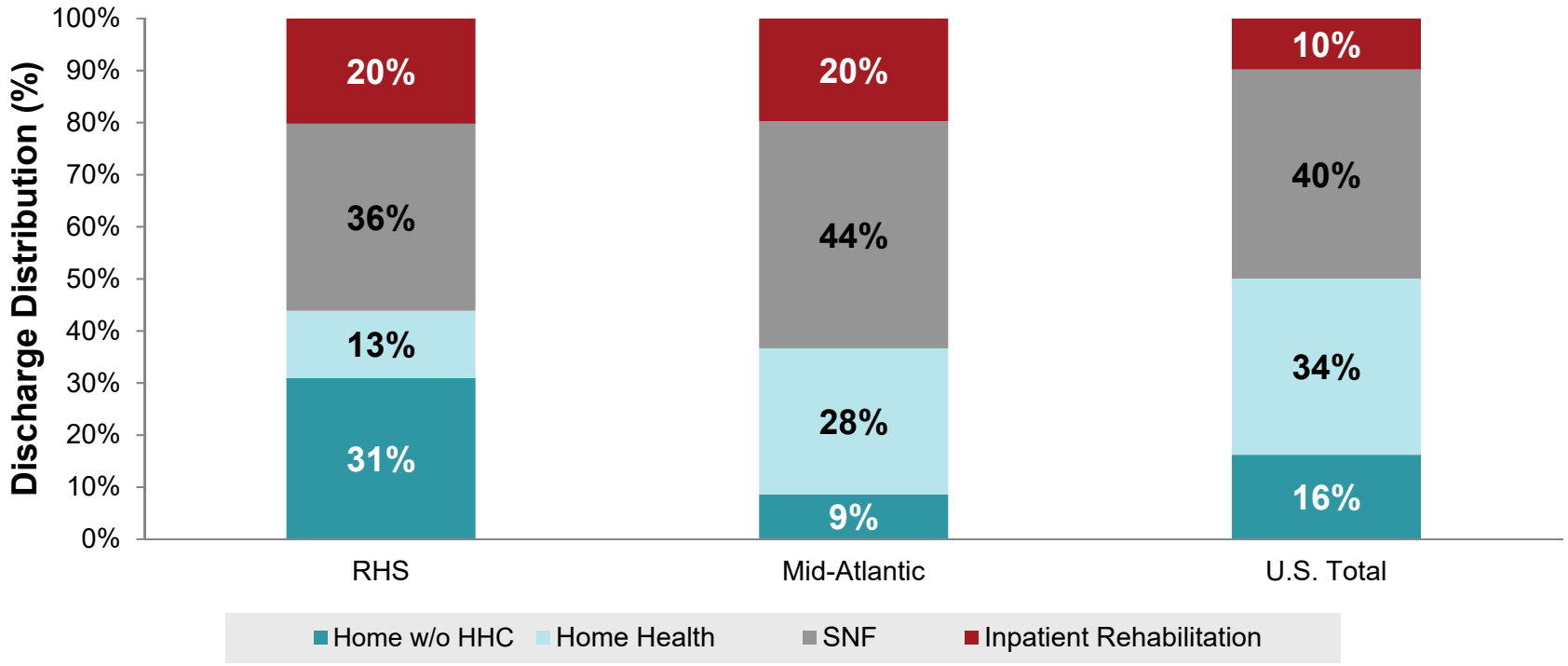
III.

CJR Post-Acute Care Discharges

Discharge Distribution

CHS has a much higher discharge-to-home rate with and without home care, compared to the region. The national target is 80% of patients discharged to home after joint replacement surgery.

Distribution of First Post–Acute Care Settings (2012–2014)[1]



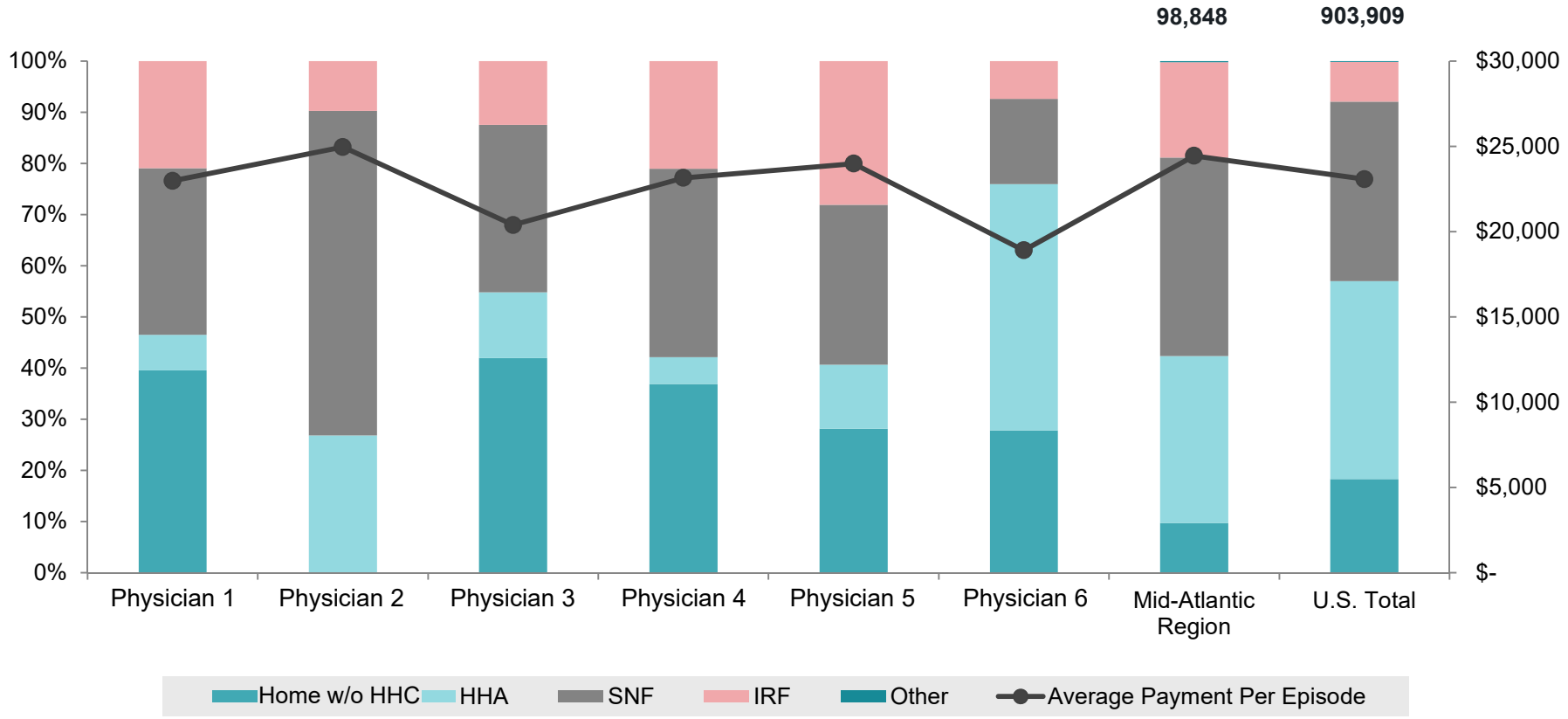
[1] DataGen Bundled Payments 360 v2.0 (2012–2014).

III.

CJR: Physician Data

Physician Discharge Distribution: Excluding Fractures

When hip fractures were excluded, orthopedic surgeons more frequently discharged to home and had lower average episode payments.[1]



[1] DataGen Bundled Payments 360 v2.0 (2012–2014).

III.

Provider Collaborator Arrangements

Financial Arrangements

CMS anticipates that hospitals will want to enter financial arrangements with providers and suppliers that contribute to the hospitals' episode spending or quality performance.

POTENTIAL CJR COLLABORATORS

- SNFs
- Home health agencies (HHAs)
- Long-term care hospitals
- Inpatient rehabilitation hospitals
- Physician group practices
- Physicians
- Nonphysician practitioners
- Outpatient therapy providers

SHARING ARRANGEMENT

CHS is assuming full financial risk (-5% to -20%) for the program, rather than shifting up to 50% of the risk to physicians, skilled nursing facilities, home healthcare agencies, etc.

PARTICIPATION AGREEMENT

Written agreement between a participating hospital and a CJR collaborator

Many of the requirements for gain sharing and alignment payments will be similar to those for Model 2 of BPCI.

III.

Example Physician Performance Metrics

Metrics have been identified in consideration of ongoing development efforts for the CJR initiatives. Accordingly, metrics and thresholds may evolve in years two through five of the program.

Measure	Description	Data Source	Target	Partial Credit Potential	Weighting
Citizenship					
Joint Class Redesign	Physician engagement in joint class redesign efforts[1]	Manual	50.0%	» 0.0% to 25.0% Attendance = 0% Credit » 26.0% to 50.0% Attendance = 50% » 51.0% to 100.0% Attendance = 100% Credit	25%
Outcomes					
Discharge to Home	Percentage LEJR discharges to home	Automatic	69.0%	» 0.0% to 25.0% = 0% Credit » 26.0% to 50.0% = 50% Credit » 51.0% to 70.0% = 75% Credit » 71.0% to 100.0% = 100% Credit	25%
Readmission Rate	All-cause readmission rate within 30 or 90 days of discharge date of index admission	Automatic	3.3%	» 3.6% or Greater = 0% Credit » 3.1% to 3.5% = 50% Credit » 0.0% to 3.0% = 100% Credit	25%
Complications Rate	Ratio of the number of predicted to the number of expected complications	Automatic	2.3%	» 2.6% or Greater = 0% Credit » 2.1% to 2.5% = 50% Credit » 0.0% to 2.0% = 100% Credit	25%

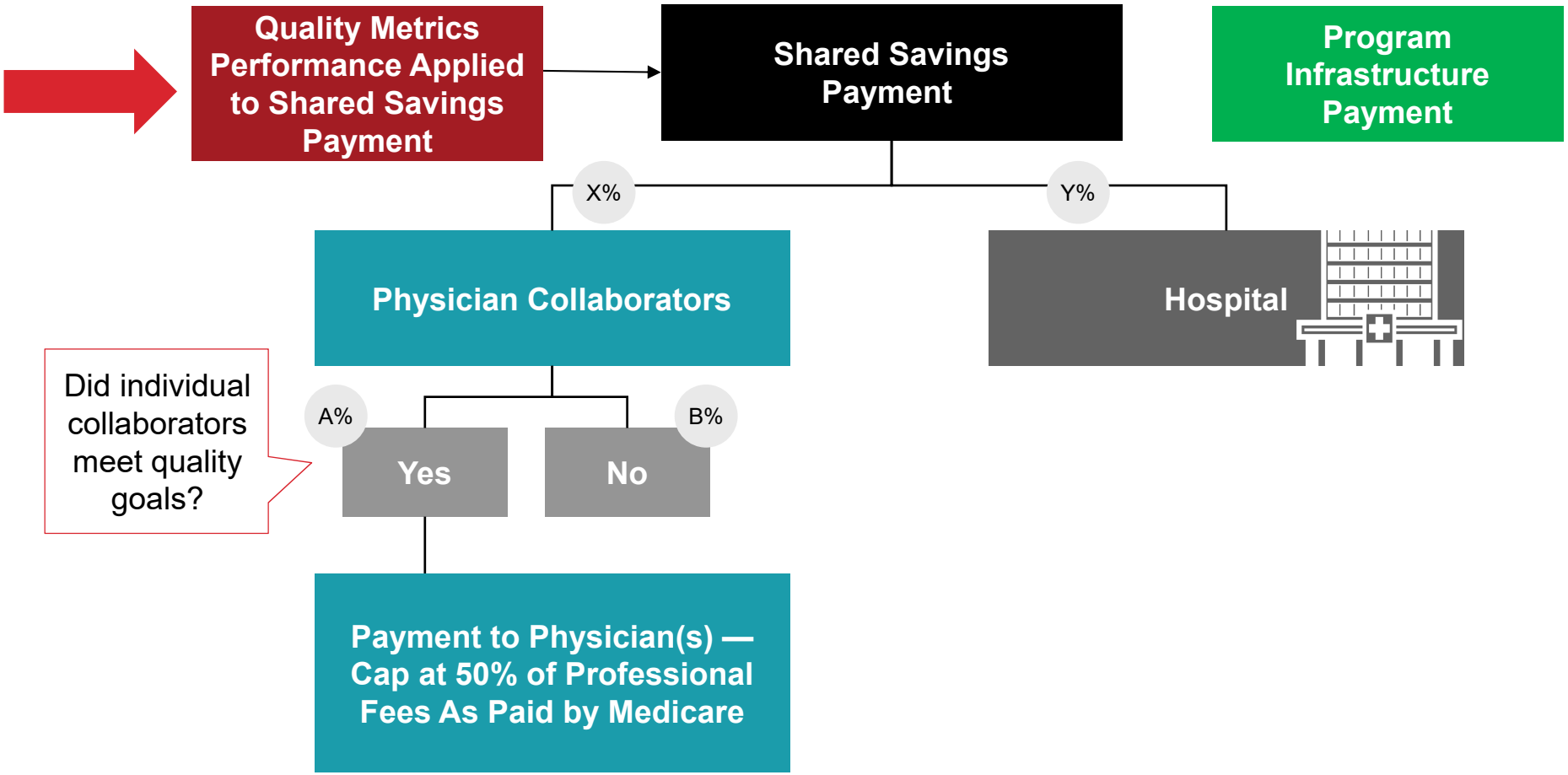
[1] Based on joint class redesign subcommittee meeting attendance.

III.

Provider Collaborator Arrangements

Physician Collaborator Agreements

Physicians receive shared savings payments only if the hospital and physician quality metrics are achieved. Splits and program costs need to be determined.



III.

CJR Program Update

Overview

Over the first two years of the CJR program, Hospital Z has performed exceptionally well, earning $886,201 in reconciliation from CMS. Annualized projections based on Q1–Q3 earnings estimate an additional $1,030,361 for PY 3.

	Dates	Number of Episodes	Target Spending	Actual Spending	Variance in Spending	Unadjusted Payment	Stop-Gain	Reconciliation
PY 1	4/1/16–12/31/16	221	$5,529,683	$4,837,289	-13%	$692,394	5%	$ 276,484
PY 2	1/1/17–12/31/17	471	$12,194,332	$10,507,982	-14%	$1,686,350	5%	609,717
PY 3 (Q1–Q3 2018)	1/1/18–9/30/18	313	$7,727,709	$6,277,111	-19%	$1,450,598	10%	772,771
							Total	**$1,658,972**

Note: For PY 4 and PY 5, the stop-gain amount increases to 20%. If Hospital Z maintains its current performance, it is on track to earn nearly $2 million in reconciliation payments each performance year.

Note: Data for PY 3 is based on the CMS CJR monitoring report for Q3 2018; however, reconciliation amounts are projected. Data and reconciliation for PY 1 and PY 2 are realized payment amounts (sourced from CMS CJR reconciliation reports).

RH has two more years of participation in the CJR program, which ends December 31, 2020.

IV. BPCI-A

IV.

BPCI-A Programmatic Details

Model Overview

Program Features

- BPCI-A is a **voluntary** bundled payment model with a **single risk track.**
- It includes **29 inpatient** episodes and **3 outpatient** episodes.[1]
- The program runs from **October 1, 2018,** through **December 31, 2023.**
- It qualifies as an **Advanced APM.**

Key Stakeholders

- **Convener participants** bring together multiple downstream entities and facilitate coordination; they bear and apportion financial risk.
- **Non-convener participants** bear financial risk only for themselves, not on behalf of multiple downstream entities.

Eligible Participants

- **Acute care hospitals** and **physician group practices** (PGPs) may take part as convener or non-convener participants.
- Other entities may take part as convener participants only.

Reconciliation and Payment

- A **single retrospective payment** includes a triggering inpatient stay or outpatient procedure and **90-day period** starting on the day of discharge.
- Total Medicare fee-for-service (FFS) payment for an episode is reconciled against target prices (TPs) on a **semiannual basis** and **adjusted by quality performance.**

Target Price

- A **3% discount** is applied to historical Medicare FFS expenditures for each episode.
- **Preliminary TPs** will be provided for each episode in **advance of the first performance period** of each model year.

Quality Measures

- For **all episodes**, an all-cause hospital readmissions and an advanced care plan measure are required.
- Five other quality measures are available for **select episodes.**

[1] Participants are not able to add or drop episodes until January 1, 2020.

Source: https://innovation.cms.gov/initiatives/bpci-advanced.

IV.

BPCI-A Program Update

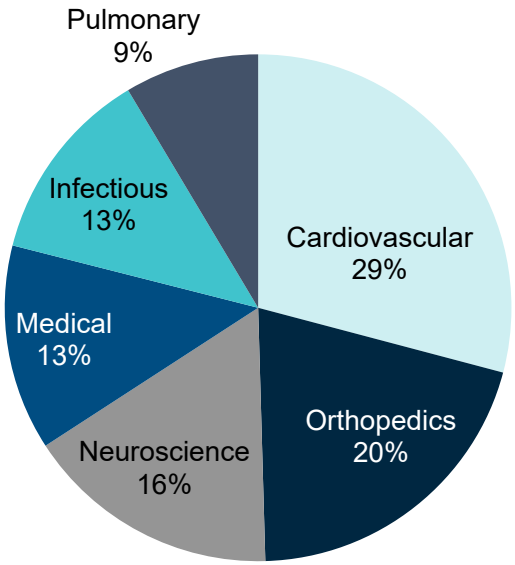
Program Participation

1,547 Participants

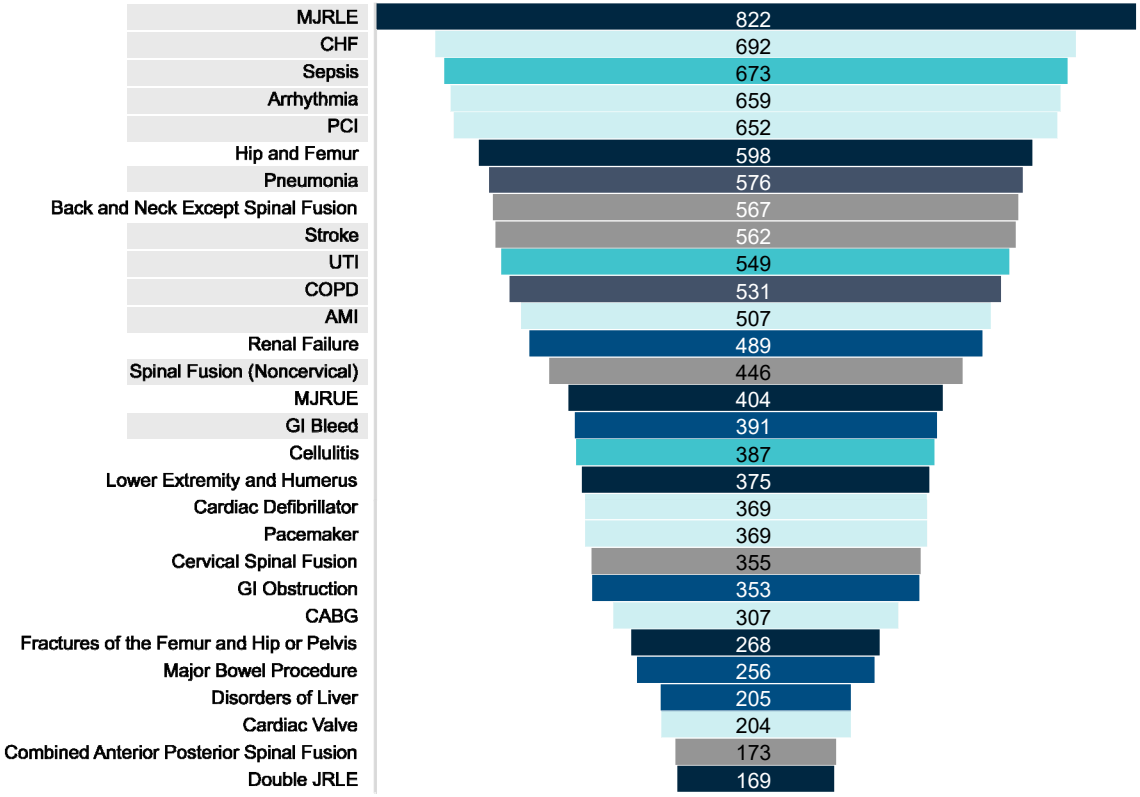
832 Acute Care Hospitals

715 Physician Group Practices

Participation by Service Line



Participation by Episode



Source: https://innovation.cms.gov/initiatives/bpci-advanced.

IV.

BPCI-A Program Update

Program Participation *(continued)*

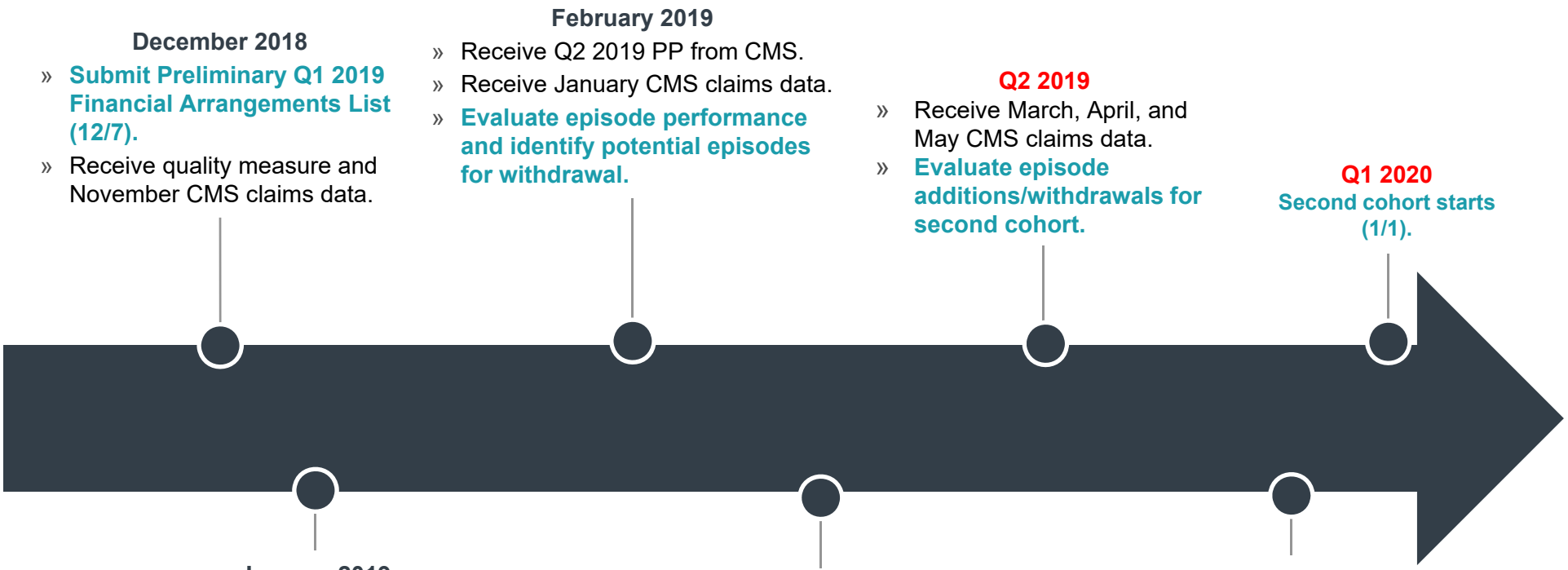
Early participants appear to have focused in particular on orthopedic procedures and several medical condition episodes, although there is notable variation between hospital and physician group participants.

- BPCI-A includes 261 regional health markets, representing 85% of all markets nationwide; 67% of participating markets have more than one participant.
- Of participants, 17% are enrolled in the program as individual EIs, while 83% are enrolled as conveners.
- The three largest conveners represent 19%, 8%, and 7% of program-wide episode participation.
- On average, participants enrolled in eight Clinical Episodes (CEs) each.
- Among hospitals, the most commonly chosen inpatient conditions included CHF (61%) and sepsis (58%); lower extremity joint replacement (LEJR) was the most frequently selected episode among physician groups (77%).

IV.

BPCI-A Program Update

Timeline

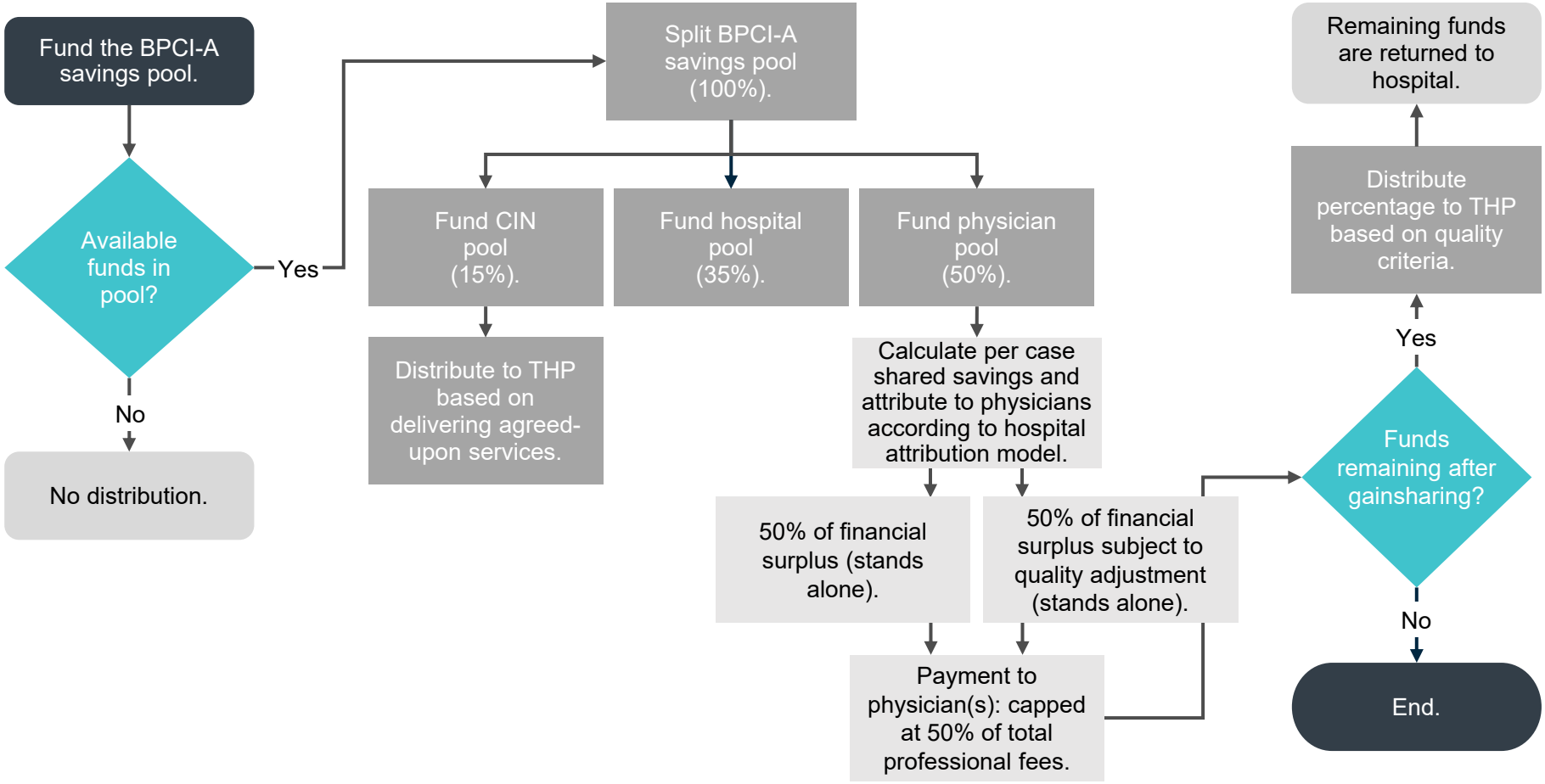


IV.

BPCI-A Gainsharing

Funds Flow CET

Savings generated under BPCI-A will be shared among eligible physicians and system A hospitals beginning January 1, 2019.



For attribution details, please refer to appendix A.

IV.

BPCI-A Attribution

Hospital-Specific Attribution Methodology

For the gainsharing arrangements, each Health System hospital developed a unique attribution methodology to best align with its physicians, care processes, and other needs.

Hospital	Model	Primary	Secondary A	Secondary B	Secondary C
A	Primary Physician Model	100%	--	--	--
B	Primary Physician Model with a Pool for all Secondary Physicians to Split Equally	60%	40% Split Equally (Unlimited Specialists)		
C	Multiple Physician Model with all Savings Split Equally (Limited to Three Specialties)	Split Equally (Limited to Three Specialties)			--
D: Sepsis and UTI	Primary Physician Model with a Pool for all Secondary Physicians to Split According to Specialty	70% (Hospitalist)	20% (Infectious Disease)	10% (Emergency Department [ED])	--
D: PCI Inpatient		80% (Cardiologist)	20% (Hospitalist)	--	--
D: PCI Outpatient		100% (Cardiologist)	--	--	--
E	Multiple Physician Model with All Savings Split Equally	Split Equally (Unlimited Specialists)			

IV.

Provider Engagement

Provider Engagement CET: Selected Quality Metrics

CMS requires physicians participating in gainsharing to be held to quality metrics. Specifically, 50% of the physician pool will be contingent upon quality performance. TH's selected quality metrics are outlined below.

Cardiac	Medicine	Neurology	Orthopedics
AMI » 30-day readmissions » Excess days in acute care **Cardiac Arrhythmia** » 30-day readmissions » Discharge summary within 24 hours **CHF** » 30-day readmissions » Medication adherence **PCI** » 30-day readmissions » Dual antiplatelet therapy	**COPD** » 30-day readmissions » Steroid treatment instituted upon admit **Pneumonia** » 30-day readmissions » Discharge summary within 24 hours **Sepsis** » 30-day readmissions » Mortality rate **UTI** » 30-day readmissions » Discharge summary within 24 hours **GI Bleed** » 30-day readmissions » Length of stay (LOS)	**Spinal Fusion** » 30-day readmissions » Smoking cessation education **Stroke** » 30-day readmissions » Stroke patient education	**LEJR** » 30-day readmissions » Discharge to home percentage

Note: 30-day readmissions and excess days in acute care are already tracked by CMS for programmatic metrics.

IV.

BPCI-A Implementation

CET Implementation

This health system planned and organized BPCI Advanced around Clinical Effectiveness Teams (CETs) and conducted gap assessments and begin implementation efforts to ensure strong performance under BPCI-A.

System-Wide CETs

- Post-acute care (PAC)
- Funds flow
- Quality, data, and IT

Service Line CETs

- Cardiac
- Medicine
- Neurology
- Orthopedic
- Bariatric surgery (does not apply to BPCI-A)

- ✓ Identified CET leaders
- ✓ Assembled members
- ✓ Provided BPCI-A program education
- ✓ Conducted gap assessments
- ✓ Obtained key data and information, as available (care process maps, order sets, etc.)
- ✓ Assessed “readiness”

CETs are now prepared to begin meeting regularly to address gaps in care delivery.

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IV.

BPCI-A Implementation

Gap Assessments

Over the past month, CETs have conducted gap assessments to identify their service line's strengths and weaknesses in terms of care delivery.

Standard Evaluation

Care Redesign/ Standardization	Care Coordination	Care Transitions	Readmissions	Oversight and Monitoring

Documentation of Resources

- Care Process Map
- Clinical Pathways
- Order Sets
- Risk Stratification Tools

Open Ended Questions

- Existing Forums for Care Redesign Initiatives
- Top Three Challenges/ Barriers to Success
- Additional Support Needed

A score of 100% means no clinical care redesign is needed, and 0% represents a need for total clinical care redesign.

IV.

IBPCI-A Gap Assessment

Gap Assessment: Cardiac CET

The health system performed a gap analysis to identify opportunities for improvement. Results targeted care process development and readmission reduction efforts.

	Score	Care Standard-ization	Care Coordination	Care Transitions	Read-missions	Oversight and Monitoring	Existing Forum	Focus
AMI								
A	68%	●	◔	◔	◑	◔	●	Formalize processes with all stakeholders.
E	80%	●	●	◔	●	◑	●	Dedicated case management resource
PCI								
D*	67%	●	◔	◔	◔	○	●	Timely documentation
E	80%	●	●	◔	●	◑	●	Dedicated case management resource
CHF								
A	25%	○	◔	◔	○	○	○	Initiate care redesign efforts.
POT*	50%	◔	◔	◔	◔	◔	●	Formalize processes with all stakeholders.
Cardiac Arrhythmia								
A	33%	○	◑	◑	○	○	○	Identify physician champion.

Notes: Red represents a score below 50%, yellow represents a score of 50% to 75%, and green represents a score of higher than 75%. Asterisk represents participation in BPCI Classic under naviHealth.

IV.

Funds Flow Model

Shared Savings
Model B: Individual Physician Performance, Total Net Cases

		Formula	
[1]	**Shared Savings Payment - 2018**	**A**	**$277,573**
	Programmatic Admin Fees	B	
	Net Shared Savings Pool	C	**$277,573**
	Physician Pool		
	% Share - Physician Pool	D	**50%**
	$ Share - Physician Pool	E = C × D	**$138,786**

CMS at Risk/Shared Savings Cap	Year 1 0.0%
	Year 2 5.0%
	Year 3 10.0%

Hospital Pool	
% Share - Hospital Pool	50%
$ Share - Hospital Pool	$138,786
Add: Unused Phys Payment	47,357
Total Hospital Payments	**$186,143**

Total Cases	220
Medicare Fee per Case	**$1,293**
Avg Payment per Elec Episode	**$18,050**
Avg Payment per Non Elec Episode	**$34,174**

			Total	Physician A	Physician B	Physician C	Physician D	Physician E	Physician F	Physician G	Physician H
[2]	Professional Fees Allowed Medicare Fee Sch	F	**$288,392**	$166,409	$16,516	$2,792	$69,716	$5,216	$10,406	$13,480	$3,857
	Shared Savings - Elective Procedures										
[3]	Estimated Target Price	G	**$22,662**	$22,579	$22,579	$22,579	$22,579	$39,159	$22,579	$22,579	
	Average Payment per Episode	H		$17,420	$20,814	$18,583	$18,269	$33,323	$17,122	$22,792	
	Episode Count	I		131	8	2	45	1	4	8	
[4]	Subtotal: Shared Savings-Elective	J = (G-H) × I	$917,930	$675,893	$14,119	$7,992	$193,963	$5,836	$21,829	$(1,702)	$ -
	Shared Savings - Non-Elective Procedures										
[3]	Estimated Target Price	K	**$43,402**	$41,646	$47,266		$43,988	$41,646	$41,646		$41,646
	Average Payment per Episode	L		$25,443	$45,870		$34,949	$33,614	$30,199		$29,308
	Episode Count	M		4	5	-	6	3	3	-	3
[4]	Subtotal: Shared Savings-Non-Elective	N = (K-L) × M	$221,473	$64,813	$6,976	$-	$54,230	$24,097	$34,341	$ -	$37,015
	Total Physician Shared Savings	O = J+N	$1,139,402	$740,706	$21,094	$7,992	$248,193	$29,933	$56,170	$(1,702)	$37,015
[5]	% of Quality Metrics Achieved	P		**75%**	**50%**	**88%**	**50%**	**100%**	**38%**	**63%**	**88%**
	Payment Cap	Q	**50%**								
[6]	Physician Payment Cap	R = Q × F	$144,196	$83,205	$8,258	$1,396	$34,858	$2,608	$5,203	$6,740	$1,928
	Physician Payment Cap adj Quality Metrics	S = P × R		$62,403	$4,129	$1,221	$17,429	$2,608	$1,951	$4,213	$1,687
	Shared Savings adj Quality Metrics	T = O × P		$555,530	$10,547	$6,993	$124,097	$29,933	$21,064	$(1,064)	$32,388
	Earned Physician Incentive lesser of T or Q	U = Min(S,T)		$62,403	$4,129	$1,221	$17,429	$2,608	$1,951	$(1,064)	$1,687
	Total Payments to Physicians	V = Sum(U)	$90,365								
[7]	Percentage Adjustment	W = (E÷V) - 1	0%								
	Adjusted Physician Payment PIP Pool adj	**X = U × (1+W)**	**$91,429**	**$62,403**	**$4,129**	**$1,221**	**$17,429**	**$2,608**	**$1,951**	**$ -**	**$1,687**
	Remaining Physician Payment	Y = E - X	**$47,357**								

IV.

Considerations

Hospital
February 11–14 Discussions

Strategic
- Has a physician champion been identified?
- Are physicians and other providers committed to evaluating current care processes and developing new workflows?

Operational

Based on the gap assessment and conversations with staff, determine how much work has been done in the following areas: care redesign and standardization, care coordinate, care transitions, readmissions, and oversight and monitoring.

Financial
- What is the volume and projected gain or loss based on the baseline period and current performance period?
- Have any interventions been put in place (especially during the post-acute period) that would change these projections?

System
Todays Discussion

Strategic
- Is physician engagement significant enough to effect change?
- Does the episode align with system priorities?

Operational
- Does the episode encourage building operational competencies across service lines and hospitals?
- Do opportunities exist to further drive collaboration and integration across hospitals?
- Can existing resources be used to initiate high-priority tactics or activities?

Financial

What is the overall financial risk/opportunity?

IV.

Community Hospital

Preliminary Financial Performance

October 2018 episode data is preliminary, and episodes may be incomplete. Therefore, the data should be evaluated with discretion. Due to claims processing lag, not all episode costs (particularly in institutional PAC settings) are reflected. The PY-1 opportunity is likely overstated.

Episodes Initiated October 2018 with Claims Processed as of December 28, 2018

Episode	Annualized Episodes	Preliminary TP	Average Cost per Episode	Average Variance	Average Variance Percentage	Average Anchor Cost	Average PAC Cost[1]	Average PAC Cost as % of Episode	Total Annual Dollars Earned/(Lost)	Total Annualized Risk[2] (+/-)
AMI	48	$26,032	$13,529	$12,503	48%	$5,758	$7,771	57%	$600,126	$249,907
PCI (IP)	84	$27,891	$31,759	$(3,868)	-14%	$20,492	$11,267	35%	$(324,875)	$468,572
PCI (OP)	168	$18,765	$16,925	$1,839	10%	$10,119	$6,806	40%	$309,036	$630,501
Sepsis	624	$30,156	$24,987	$5,169	17%	$11,540	$13,447	54%	$3,225,541	$3,763,451
Spinal fusion (noncervical)	12	$50,082	$31,271	$18,811	38%	$25,124	$6,147	20%	$225,736	$120,197
Stroke	228	$33,973	$24,482	$9,491	28%	$7,317	$17,165	70%	$2,163,974	$1,549,171

Source: CMS BPCI-A preliminary TPs (December 2018) and raw claims (October through December 2018), received from CMS on January 22, 2019.

Episodes Initiated 2014 through 2016

Episode	Average Episodes	Preliminary TP	Average Cost per Episode	Average Variance	Average Variance Percentage	Average Anchor Cost	Average PAC Cost[1]	Average PAC Cost as % of Episode	Total Annual Dollars Earned/(Lost)	Total Annualized Risk[2] (+/-)
AMI	75	$25,642	$27,232	$(1,591)	-6%	$7,602	$19,630	72%	$(119,325)	$384,630
PCI (IP)	116	$27,462	$28,484	$(1,022)	-4%	$15,304	$13,180	46%	$(118,552)	$637,118
PCI (OP)	94	$19,350	$17,903	$1,447	8%	$9,093	$8,810	49%	$136,018	$363,780
Sepsis	816	$29,589	$30,037	$(448)	-2%	$10,041	$19,996	67%	$(365,568)	$4,828,925
Spinal fusion (noncervical)	28	$49,139	$51,638	$(2,500)	-5%	$28,024	$23,614	46%	$(70,000)	$275,178
Stroke	209	$33,313	$35,109	$(1,796)	-5%	$7,175	$27,934	80%	$(375,364)	$1,392,483

Source: CMS BPCI-A preliminary TPs (2013 to 2016) and raw claims (2014 to 2016), received from CMS on July 9, 2018.
Note: Figures may not be exact due to rounding.
[1] PAC cost includes professional fees.
[2] TP multiplied by 20%, multiplied by annualized PY-1 episodes initiated in October 2018.

IV.

Community Hospital

Withdrawal Recommendations

Episode	Rationale	Preliminary Considerations				Annualized Opportunity		Total Annualized Risk[2] (+/-)
		Strategic	Operational	Financial	Score	Baseline 2014–2016	PY 1 October 2018	
AMI	» Leadership agrees to maintain cardiac episodes because Dr. AAA supports program participation. » Dr. AAA has provided leadership to the other hospitals participating in cardiac episodes.	3.8	3.3	1.9	**3.0**	$(119,294)	$600,126	$249,907
PCI (Inpatient)		4.0	3.6	1.5	**3.0**	$(118,593)	$(324,875)	$468,572
PCI (Outpatient)		4.0	3.6	2.7	**3.4**	$135,568	$309,036	$630,501
Sepsis	» There have been strong engagement with physicians and other providers. » Dr. BBB and CCC, recommend to maintain sepsis.	3.5	2.9	2.3	**2.9**	$(365,364)	$3,225,541	$3,763,451
Spinal Fusion (Non Cervical)	» Dr. DDD is supportive of maintaining participation. » Engagement has been strong especially with the development of a TH pain center.	3.5	3.0	2.2	**2.9**	$(70,824)	$225,736	$120,197
Stroke	The Stroke Clinical Redesign CET does not recommend participation given operational constraints they identified during an internal gap assessment.	3.0	3.4	3.2	**3.2**	$(376,044)	$2,163,974	$1,549,171

Score (1-4)	Preliminary Withdrawal Recommendation
Less than 1	Withdraw
Greater or equal to 1 less than 2	Strongly Consider Withdrawal Unless Compelling Reason Otherwise
Greater or equal to 2 less than 3	Reevaluate With a Focus on Financial Performance
3 or Greater	Maintain Participation

V. Oncology Care Model

V.

Oncology Care Model

Overview

This five-year CMS Medicare demonstration project is designed to improve care coordination, access, and appropriateness while lowering the total cost for Medicare beneficiaries receiving cancer treatment.

Program Aim

Promote whole practice transformation through the use of aligned financial incentives, including performance-based payments, to improve care coordination, appropriateness of care, and access for FFS Medicare beneficiaries undergoing chemotherapy.

Program Participation

187 practices and 14 payers are currently participating in OCM.

Current OCM Participating Practices

Source: CMS.

V.

Oncology Care Model

Episode Definition

Care episodes are six months in length and include all Medicare Part A and B services received by beneficiaries.

Episode Definition

- An episode is initiated when a beneficiary receives a qualifying chemotherapy drug (first Part B/D chemotherapy claim).
- Each episode lasts for six months.
- If a patient requires chemotherapy beyond those six months, they begin a new episode.
- Beneficiaries may initiate multiple episodes during the five-year model.

Included Services

- All Medicare Part A and B services received by Medicare FFS beneficiaries during the episode.
- Certain Part D expenditures: the Low-Income Cost-Sharing Subsidy (LICS) amount and 80% of the Gross Drug Cost above the Catastrophic (GDCA) threshold.

Source: CMS.

Although the OCM does not change *how* drugs are reimbursed, it incentivizes practices to select high-value options.

V.

Oncology Care Model

Payment Methodology

During OCM episodes, providers continue to bill for standard Medicare FFS payments. OCM incorporates two additional payment mechanisms: a Monthly Enhanced Oncology Services (MEOS) payment and retrospective Performance-Based Payment (PBP).

MEOS

- The MEOS payment provides OCM practices with financial resources to aid in effectively managing and coordinating care for Medicare FFS beneficiaries.
- The $160 per member per month (PMPM) payment can be billed for OCM FFS beneficiaries for each month of their six-month episodes.

PBP

- PBP encourages OCM practices to improve care for beneficiaries and lower the total cost of care during the six-month episodes.
- PBP is calculated retrospectively on a semiannual basis based on the practice's achievement on quality measures and reductions in Medicare expenditures below a target price.

Source: CMS.

V.

Oncology Care Model

Performance-Based Payment Methodology

(Target Price − Actual Price) × Performance Multiplier = PBP

1 Calculate Benchmark

CMS calculates benchmark episode expenditures for OCM practices.

- Based on historical data
- Risk-adjusted (including for geographic variation)
- Trended to applicable performance period
- Includes a novel therapies adjustment

2 Determine Target Price

Discount is applied to the benchmark to determine a target price for OCM-FFS episodes.

Example:

- Benchmark = $30,000
- Discount = 4%
- Target Price = $28,800

3 Compare Actual to Target

If actual OCM-FFS episode expenditures are below target, the practice could receive a PBP.

Example:

- Target Price = $28,800
- Actual = $25,000
- PBP = up to $3,800

Note: Actual expenditures include both FFS and MEOS payments.

4 Adjust Based on Performance

The PBP amount is adjusted based on the participant's achievement across five quality domains.

- Communications and care coordination
- Person- and caregiver-centered outcomes
- Clinical quality of care
- Patient safety
- Clinical data

Source: CMS.

Payments are calculated for the total cost for the episode of care (includes Part A, B, and D payments).

V.

Oncology Care Model

Lessons for Every Practice

While the OCM pilot includes only a small subset of US oncology practices, the pilot is generating important information regarding opportunities to reduce the cost of cancer care.

- Active case management is needed.
- Utilization of standardized pathways is critical.
- Without data and analytics, it is impossible to manage or improve performance.
- Narrow networks are essential to ensure pathway compliance and cost management.
- Look for areas of innovation to drive cost reduction all over the practice.
- Provider engagement is critical; without it, change will be nearly impossible.
- Coding and documentation (HCCs) are critical to getting credit for the complexity of your patient population.
- Infrastructure, infrastructure, infrastructure: people, processes, technology, and so forth are vital to generating and managing the information needed to manage change.
- Patient retention is important in a risk-based environment.

VI. Other Models

VI.

Vermont All-Payer ACO Model

Under the Vermont All-Payer ACO Model, significant payers throughout the state—Medicare, Medicaid, and commercial—incentivize value and quality under the same shared risk payment structure for the majority of providers.

Key Features for the Vermont All-Payer ACO Model

- Began in January 2017 and continues through December 2022
- Builds on the Maryland All-Payer Model
- Is largely based on the Next Generation ACO Model
- Encourages Vermont payers and providers to participate in ACO programs, so by 2022 70% of all insured residents, including 90% of Medicare beneficiaries, are attributed to an ACO
- Continues payer-specific benchmarks and financial settlement calculations for ACOs, but the ACO design (e.g., quality measures, risk arrangement, payment mechanisms, beneficiary alignment methodology) will be closely aligned across payers
- Limits the annualized per capita healthcare expenditure growth for all major payers in Vermont to 3.5%; limits Medicare per capita healthcare expenditure growth for Vermont Medicare beneficiaries to at least 0.1 to 0.2 percentage points below that of projected national Medicare growth
- Focuses on achieving health outcomes and quality of care targets in four areas prioritized by Vermont: substance use disorder, suicides, chronic conditions, and access to care

VI.

Pennsylvania Rural Health Model

A relatively new program, the Pennsylvania Rural Health Model is testing whether all-payer global budgets will enable rural hospitals to invest in quality and preventive care, as well as better tailor their services to their communities' needs.

Key Features for the Pennsylvania Rural Health Model

- Began in January 2017 and continues through December 2023
- Builds upon the Maryland All-Payer Model
- Provides participating rural hospitals with an all-payer global budget
  - A fixed amount set in advance for inpatient and outpatient hospital-based services and paid monthly by Medicare FFS and all other participating payers
  - Based primarily on a hospital's historical net revenue for inpatient and outpatient hospital-based services from all participating payers
- Requires participants to prepare a Rural Hospital Transformation Plan
  - Outlines how each hospital will invest in quality and preventive care, obtain support and continuous feedback from stakeholders, and tailor the services it provides to the needs its community
  - Must be approved by Pennsylvania and CMS

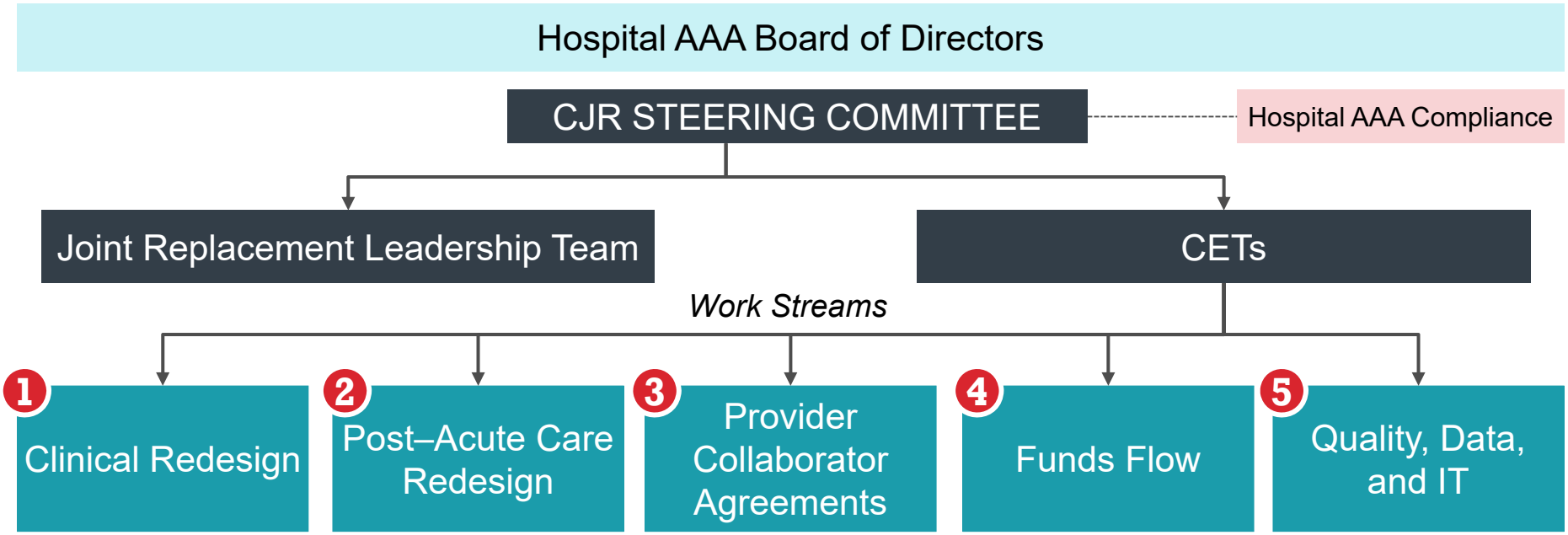
If the Pennsylvania Rural Health Model is successful, similar models may be introduced in other states.

VII. Planning, Implementation, and Management

VII.

Steering Committee and CETs

Governance is a key success factor in managing value-based performance. Organizations need to offer high level support and direction.

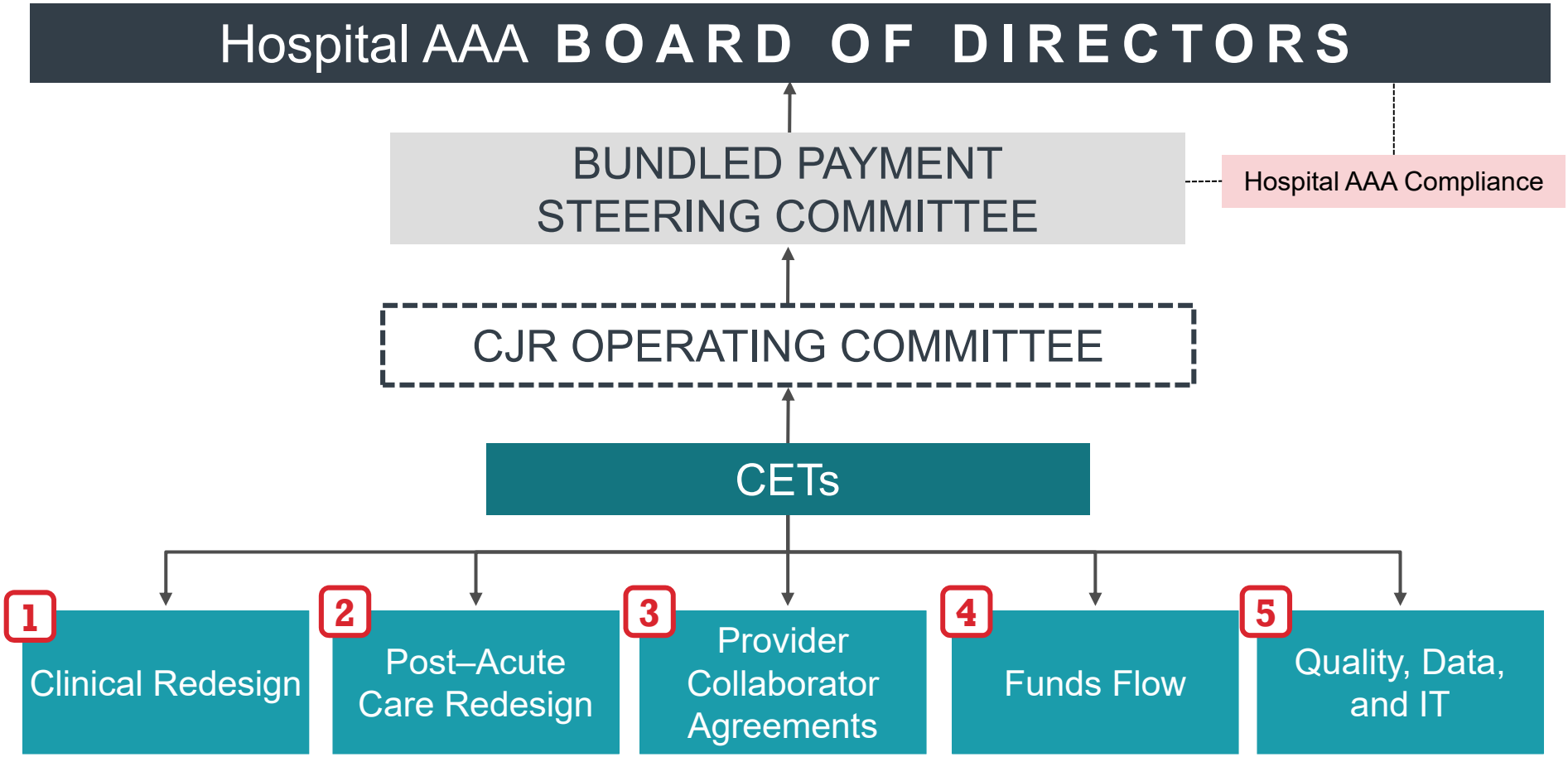


- Develop clinical protocols across preoperative and perioperative settings.
- Work across and within post–acute care (PAC) settings to align expectations with patients and physicians.
- Establish protocols.
- Negotiate directly with collaborators.
- Utilize parameters from the Funds Flow CET.
- Obtain collaborator agreements.
- Review and provide input regarding the funds flow model.
- Manage and execute the risk-sharing contract terms.
- Receive and analyze quarterly CMS reports.
- Design a CJR dashboard and tracker.

VII.

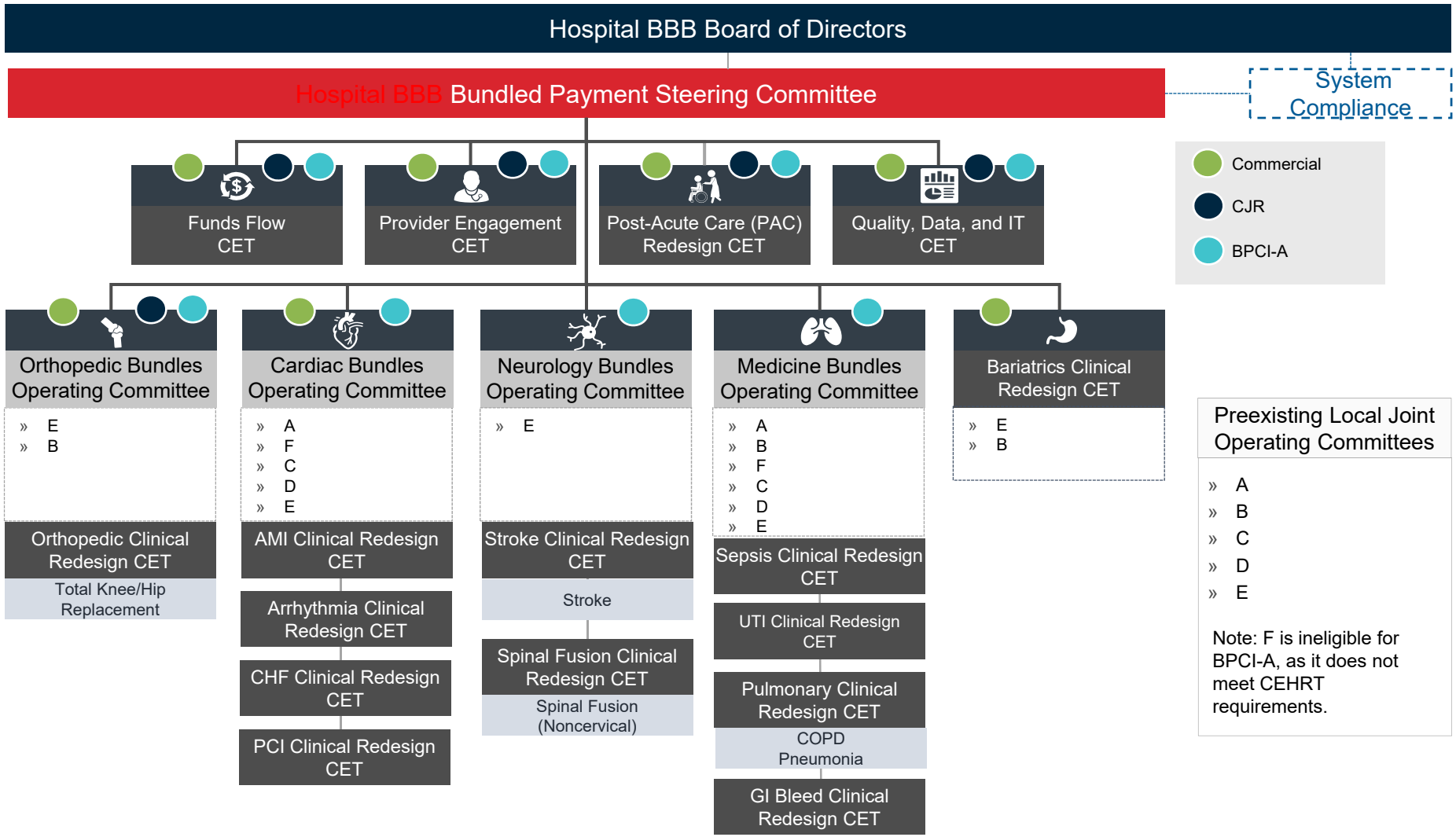
CJR Governance Structure

The CJR Operating Committee will maintain oversight and momentum for CJR implementation efforts beginning April 1. The Bundled Payment Steering Committee can expand its focus to additional bundled payment initiatives.



VII.

Governance Structure: Evolved

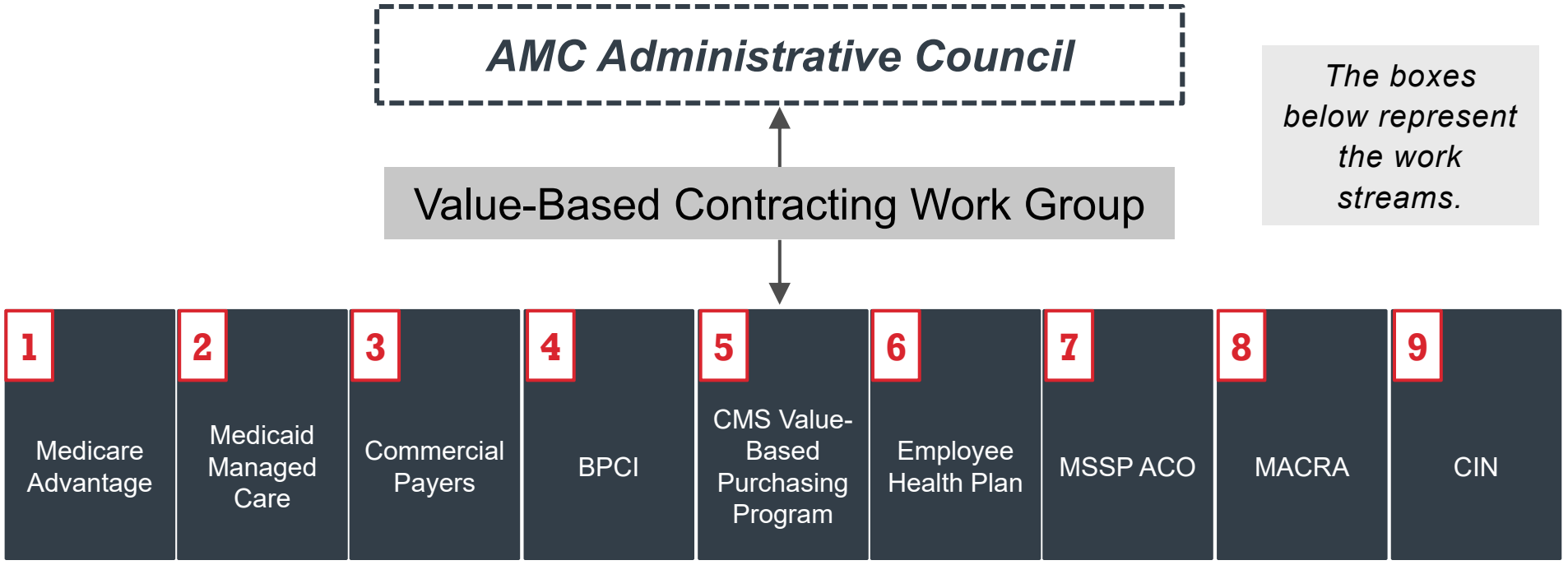


VII.

Governance Structure: New

AMC-Proposed Value-Based Contracting Work Group

AMC provided approval to establish a governance structure that will enable oversight, discussion, and strategic consideration of each value-based opportunity, as well as provide further clarity around topics and focus.



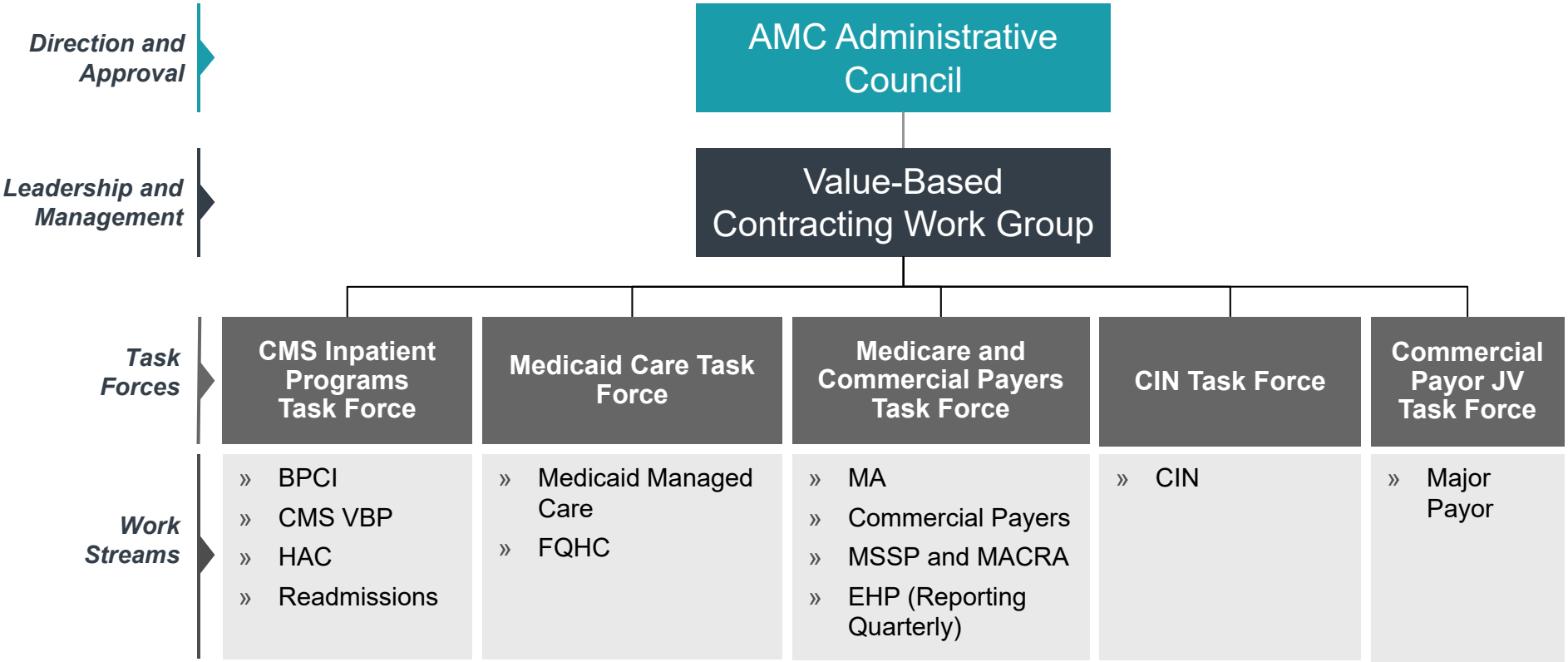
The boxes below represent the work streams.

VII.

Governance Structure: Evolved

Work Stream Changes

Per the September 10 Value-Based Contracting Work Group meeting, commercial payor joint venture and the CIN were added as Task Forces.



Questions & Discussion

Contact Us

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