Mini Summit V: Case Studies in Successful Integrated Value-based Care: ACOs, Bundles - How Do I Choose?- A Case Study

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Disclaimer: This presentation is offered for discussion purposes only and shall not constitute legal advice.

Roadmap

- Overview of Current Environment
- Bundled Payments and ACOs
- How do you Choose?
- Case Study


Overview of Current Environment
Bundled Payments and ACOs
How do you Choose?
Case Study

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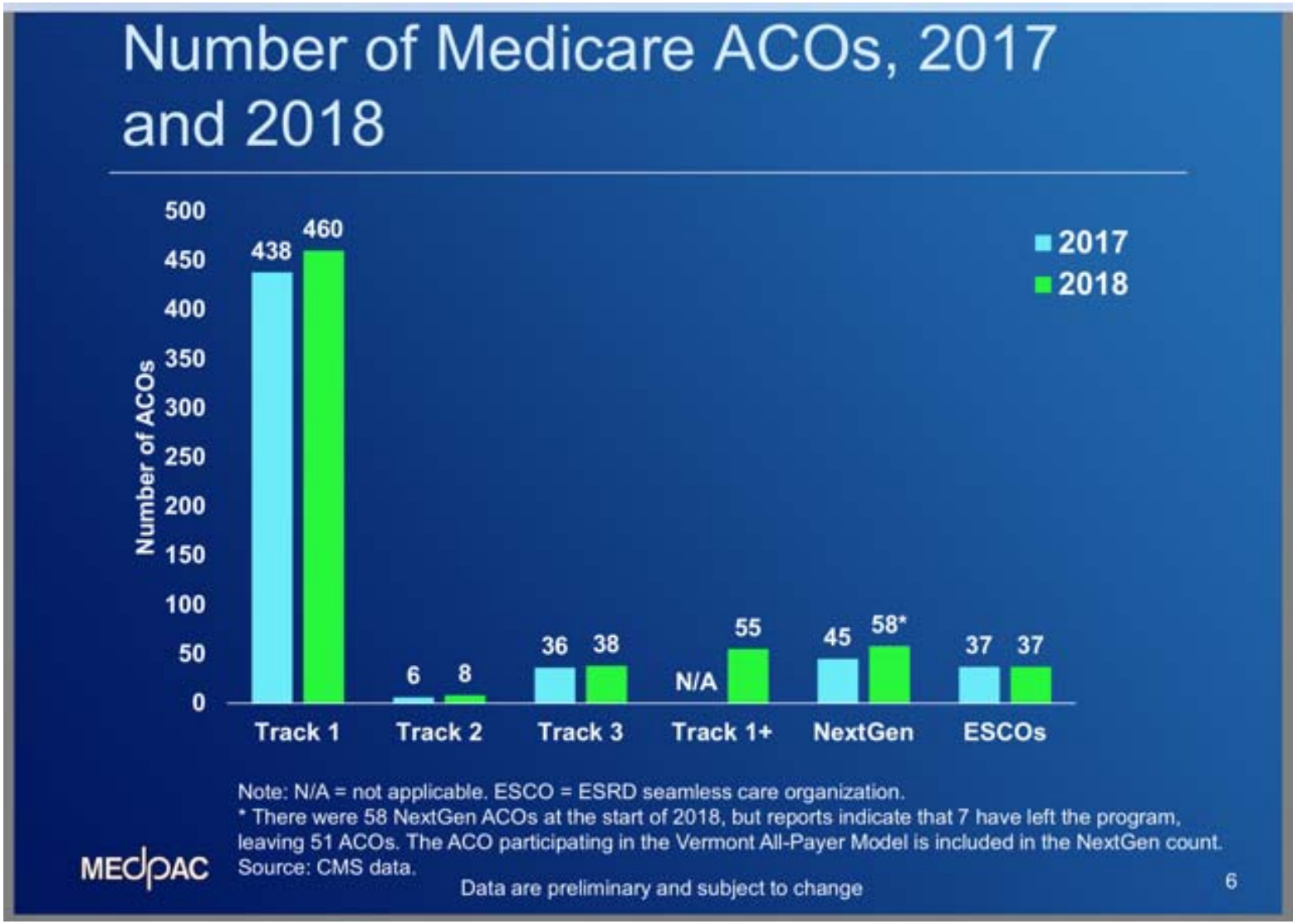


Source: MedPac Long-term issues confronting Medicare Accountable Care Organizations (ACOs) (April 6, 2018)

Risk Models and Savings

- CMS data show that, relative to CMS benchmarks, one-sided ACOs generate small losses and two-sided ACOs generate small savings
- In January, HHS Secretary Alex Azar stated that value-based healthcare "needs to accelerate dramatically" in the U.S., calling for a range of changes to the healthcare system that he said would provide more tools to give consumers more control over their care. “This is no time to be timid — today’s healthcare system is simply not delivering outcomes commensurate with its cost."

Source: MedPac Long-term issues confronting Medicare Accountable Care Organizations (ACOs) (April 6, 2018); https://www.washingtonexaminer.com/hhs-alex-azar-urges-bolder-action-on-value-based-healthcare/article/2650690

Quality Payment Program

Two Tracks to Choose From:

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

Estimated number of clinicians subject to and exempt from MIPS, 2017 and 2018 reporting years

	2017	2018
Total number of Part B – billing clinicians	1,380,000	1,548,000
Exempt: Low volume	384,000 *(Less than $30,000 in Medicare payments per year or fewer than 100 patients)*	540,000 *(Less than $90,000 in Medicare payments per year or fewer than 200 patients)*
Exempt: A-APM-qualifying participants	70,000 to 120,000	185,000 to 250,000
Exempt: Other reasons	285,000	315,000
Required to participate in MIPS	600,000 to 640,000	445,000 to 510,000

Bipartisan Budget Act of 2018 Changes

- Expanded Prospective Attribution: ACOs in Track 1 and 2 can now choose prospective attribution; effective for agreements entered into or renewed on or after January 1, 2020
  - Budget Act Language: "(A) CHOICE OF PROSPECTIVE ASSIGNMENT.—For each agreement period (effective for agreements entered into or renewed on or after January 1, 2020), in the case where an ACO established under the program is in a Track that provides for the retrospective assignment of Medicare fee-for-service beneficiaries to the ACO, the Secretary shall permit the ACO to choose to have Medicare fee-for-service beneficiaries assigned prospectively, rather than retrospectively, to the ACO for an agreement period.

Source: https://www.congress.gov/bill/115th-congress/house-bill/1892/text; http://www.medpac.gov/docs/default-source/default-document-library/aco_april-2018.pdf?sfvrsn=0


Overview of Current Environment
ACO's and Bundled Payments
How do you Choose?
Case Study

Shared Savings Program ACO Participation Options

The Shared Savings Program offers different participation options (tracks) that allow ACOs to assume various levels of risk.

Track	Financial Risk Arrangement	Description
1	One-sided	Track 1 ACOs do not assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.
Medicare ACO Track 1+ Model*	Two-sided	Medicare ACO Track 1+ Model (Track 1+ Model) ACOs assume limited downside risk (less than Track 2 or Track 3).
2	Two-sided	Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.
3	Two-sided	Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk, but may share in the greatest portion of savings if successful.

*The Track 1+ Model is a time-limited CMS Innovation Center model. An ACO must concurrently participate in Track 1 of the Shared Savings Program in order to be eligible to participate in the Track 1+ Model.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html

Advanced-Alternative Payment Models: A-APMs and ACOs

- Participation in A-APMs helps qualify clinicians for 5% incentive bonus on physician fee schedule revenue
- Goals of ACOs:
  - Improve provider accountability
  - Increase quality of care and patient experience
  - Lower costs
- If successful ACOs are rewarded with shared savings

Available Payment Models for Performance Year 2018

Advanced APMs

- **Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)**
- Comprehensive ESRD Care (CEC)-Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- **Medicare Accountable Care Organization (ACO) Track 1+ Model**
- **Next Generation ACO Model**
- **Shared Savings Program-Track 2**
- **Shared Savings Program- Track 3**
- Oncology Care Model (OCM)-Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)

Stark, Anti-Kickback, and Beneficiary Inducement CMP Waived

CMS/OIG issued five (5) waivers for MSSP:

1. ACO Pre-Participation Waiver
2. ACO Participation Waiver
3. Shared Savings Distribution Waiver
4. Compliance with the Stark Law Waiver
5. Patient Incentive Waiver

CMS/OIG issued four (4) waivers for Next Gen:

1. Next Generation ACO Participation Waiver
2. Shared Savings Distribution Waiver
3. Compliance with the Stark Law Waiver
4. Waiver for Patient Engagement Incentives

Fraud and Abuse Waivers Issued by HHS to Enable APMs:

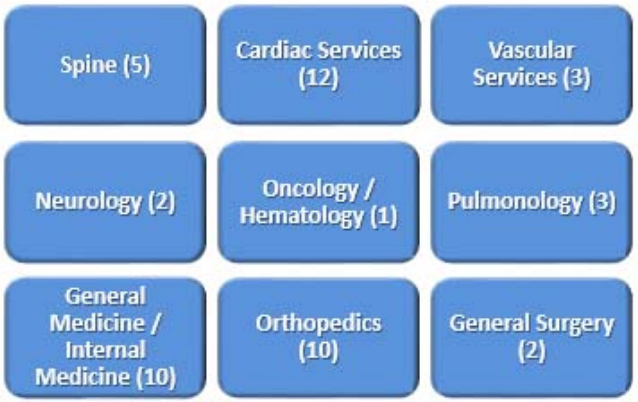
1.Dec. 8, 2011, Pioneer ACO Model
2.Sept. 13, 2012, Bundled Payment for Care Improvement (BPCI) Model 1
3.July 26, 2013, BPCI Model 2
4.July 26, 2013, BPCI Model 3
5.July 26, 2013, BPCI Model 4
6.Jan. 20, 2015, Health Care Innovation Awards (HCIA) Round Two
7.July 15, 2015, Comprehensive ESRD Care (CEC) Model
8.Oct. 29, 2015, Medicare Shared Savings Program
9.Nov. 16, 2015, Comprehensive Care for Joint Replacement (CJR) Model
10.Dec. 9, 2015, Next Generation ACO Model
11.June 2, 2016, Part D Enhanced Medication Therapy Management (MTM) Model
12.July 1, 2016, Oncology Care Model (OCM)
13.Dec. 29, 2016, Amended Next Gen ACO Model Waivers
14.Apr. 27, 2017, Maryland All-Payer Model Care Redesign Program
15.Dec. 5, 2017, New CJR Model Waivers
16.Mar. 1, 2018, Medicare Diabetes Prevention Program (MDPP) Expanded Model
17.BPCI Advanced ??

Source: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Fraud-and-Abuse-Waivers.html

BPCI

There are 48 Episodes to Choose From

- CMS created 48 Episodes, each with up to 15 individual MS-DRG codes
- The Episodes can be categorized into 9 Service Lines; illustrative purposes only
- Model 2, 3, or 4 applicants may select 1-48 Episodes for testing

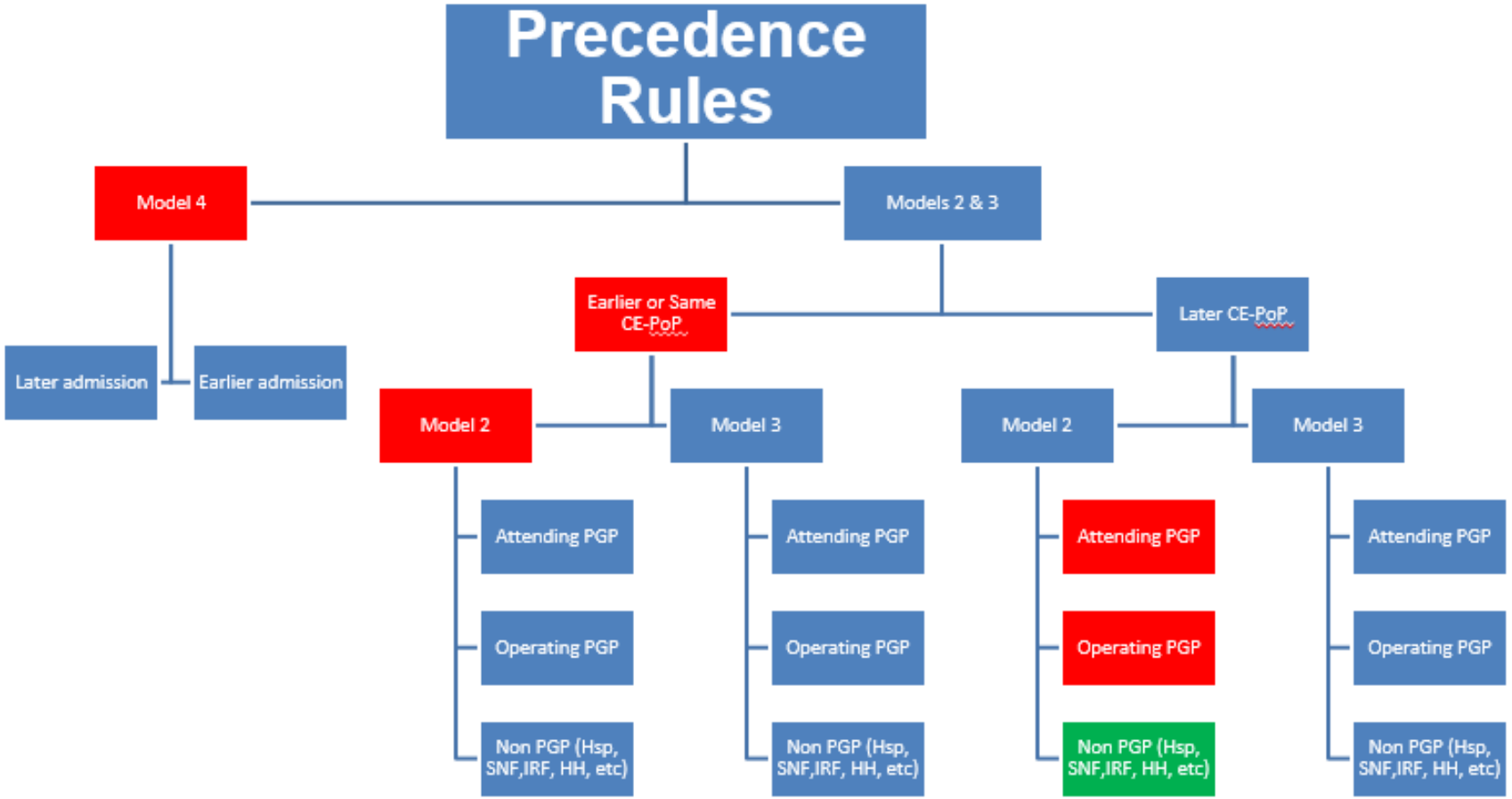


Example

Category: Vascular Services

- **Episode: Major cardiovascular procedure**
  - **MS-DRGs 237 & 238**
- **Episode: Medical peripheral vascular disorders**
  - **MS-DRGs 299, 300, & 301**
- **Episode: Other vascular surgery**
  - **MS-DRGs 252, 253, & 254**

BPCI: Precedence Hierarchy



BPCI: Participating in Both Bundled Payments and ACO

- Overlap policies favor bundled payment programs over ACOs
- Bundled payment participant is responsible for any financial gains or losses during the episode of care
- Potential savings or losses are not included in the ACO's year-end financial reconciliation

Source: https://www.naacos.com/naacos-position-statement-on-episode-payments-and-acos; https://revcycleintelligence.com/news/aco-bundled-payments-alignment-key-to-success-for-both-models

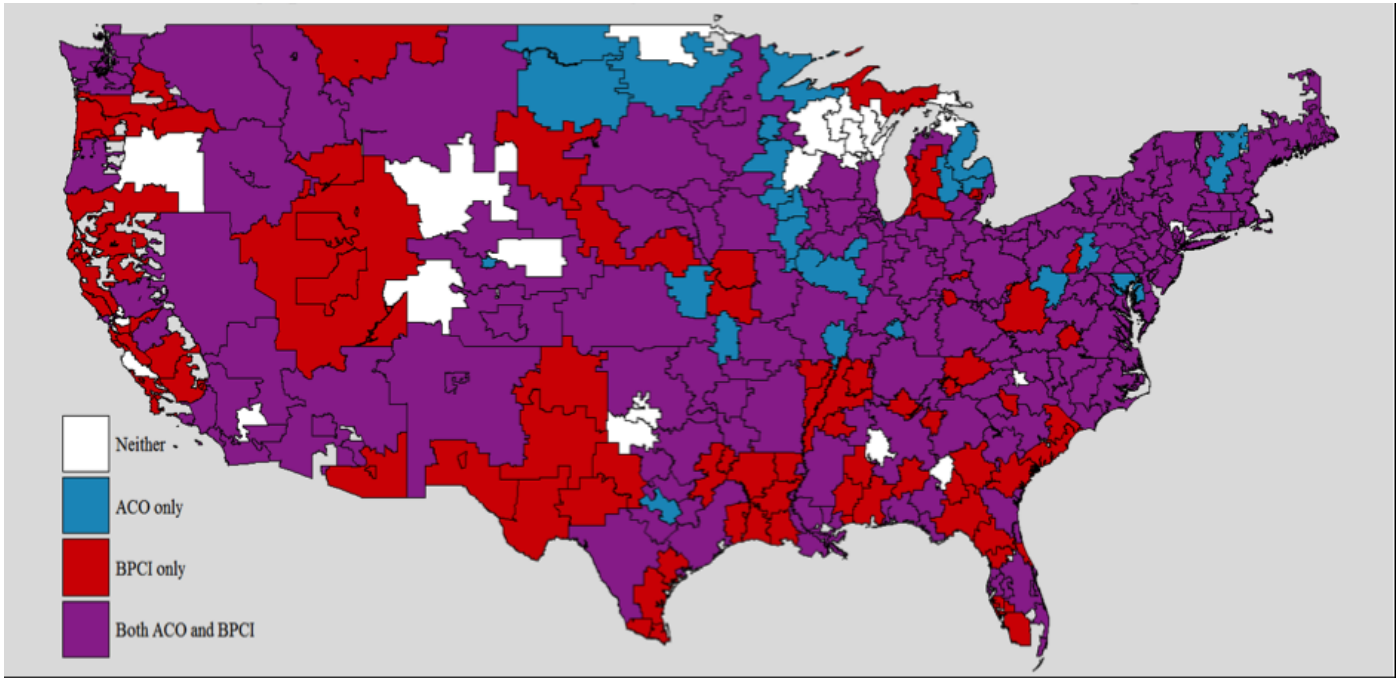
BPCI: Participating in Both Bundled Payments and ACO

- When CMS calculates an ACO's shared savings, the spending for ACO patients with an episode of care provided by a bundled payment participant is set to that bundler's target price, regardless of actual spending
- Target prices based on higher cost baselines arbitrarily raises an ACO's performance cost and removes their saving opportunity
- Undermines ACOs' opportunity for savings through care redesign since any savings would automatically go to the bundler

Source: https://www.naacos.com/naacos-position-statement-on-episode-payments-and-acos

BPCI Interaction with MSSP

Geographic Distribution Of Markets By Presence Of MSSP ACO and BPCI Hospitals in 2015



Source: https://www.healthaffairs.org/do/10.1377/hblog20180409.159181/full/

BPCI Interaction with MSSP

- When patients attributed to an MSSP ACO trigger an episode at an unrelated BPCI provider, the BPCI provider's target price is functionally counted in the MSSP ACO's cost performance
- When BPCI providers are also MSSP participants, BPCI episode claims for MSSP-attributed beneficiaries are tied back to the MSSP ACO via the process described above
- When BPCI providers participate in MSSP ACOs that achieve shared savings, BPCI episode savings could contribute to those MSSP savings.
- Medicare recoups the portion of the episode discount paid out as shared savings (a portion of the savings that would have gone to the BPCI provider)
- BPCI providers may see a smaller financial upside based on MSSP ACO performance

Source: https://www.healthaffairs.org/do/10.1377/hblog20180409.159181/full/

BPCI Regulatory Concerns

Legal Issue	Status
Stark Law	No blanket waivers for bundled payments; provider may request a waiver in their application
Federal Anti-kickback Statute	No blanket waivers for bundled payments; provider may request a waiver in their application
Federal Civil Monetary Penalties	Gainsharing arrangements must be disclosed as part of application process
State laws	May apply - must check with each state individually

Bundled Payments

What Matters for BPCI

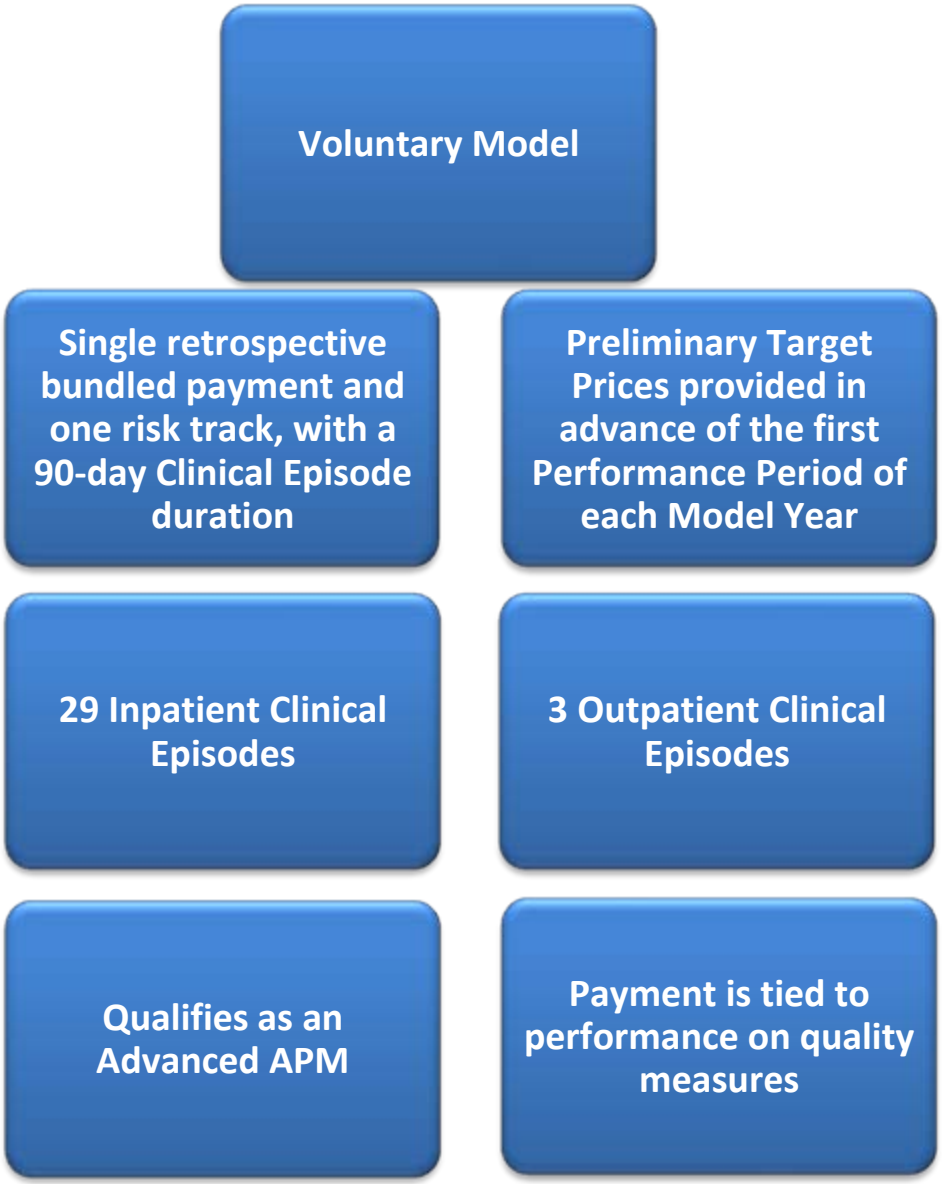
- Discharge Destination
- Readmissions
- ED Visits
- “Bad Stuff” that happens within 90 days of discharge
- Inconsistent Care Delivery

Outside of Required BPCI Scope

- Acute Care Length of Stay
- Staffing Ratios

BPCI Advanced

BPCI-Advanced Characteristics



Source:
https://innovation.cms.gov/initiatives/bundled-payments/

Clinical Episode Length

IP Clinical Episode:
Anchor Stay

+ 90 days beginning the day of discharge

OP Clinical Episode:
Anchor Procedure
+ 90 days beginning on the day of completion of the outpatient procedure

Source: https://innovation.cms.gov/Files/slides/bpciadvanced-wc-modeloverview-slides.pdf

Path to Advanced APM Qualified Physician (5% Incentive Payment)

Step 1
- Sign NPRA Sharing Agreement (by August 2018)

Step 2
- Exceed **EITHER** Payment Amount **OR** Patient Count Threshold

Step 3
- Surpass % Threshold Requirement by 3/31, 6/30, or 8/31 CMS Snapshot

5% Bonus
- Become Advanced APM Qualified Physician

MAR 31
JUN 30
AUG 31

5%

5% lump sum incentive

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/QPP-Participation-Criteria-Webinar-Slides.pdf

How to become a “Qualifying Advanced APM Participant”

The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

- - Green circle targets must be met with Medicare payer arrangements only
- - Blue circle targets may be met with non-Medicare payer arrangements such as private payers

Source: CMS

Methods for Calculating Threshold Score

Payment Amount Method

$$\frac{\text{\$\$\$ for Part B professional services to attributed beneficiaries}}{\text{\$\$\$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score \%}$$

Patient Count Method

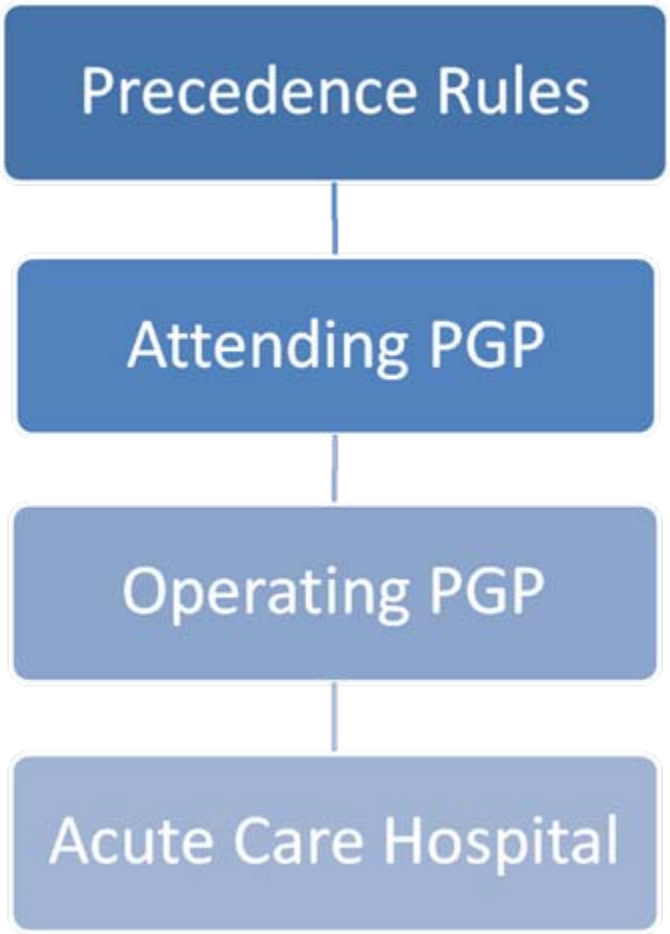
$$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} = \text{Threshold Score \%}$$

Attributed (beneficiaries for whose cost and quality of care the APM Entity is responsible)
Attribution-eligible (all beneficiaries who could potentially be attributed)

Source: CMS

BPCI Advanced: Precedence Hierarchy for Attribution of a Clinical Episode among different Episode Initiators

BPCI Advanced Simplified Precedence Rules



Source: https://innovation.cms.gov/Files/slides/bpciadvanced-wc-modeloverview-slides.pdf

BPCI Advanced Interaction with MSSP

- Beneficiaries aligned to ACOs in Track 1, 1+ and 2 will trigger Clinical Episodes in BPCI Advanced
- CMS will recoup a portion of the BPCI Advanced discount amount for any Medicare fee-for-service beneficiary who:
  - was aligned with an MSSP ACO in Track 1, 1+, or 2 that achieved shared savings, and
  - began a BPCI Advanced Clinical Episode that was attributed to a BPCI Advanced Episode Initiator that participated with the ACO to which the beneficiary was also aligned

Source: https://innovation.cms.gov/Files/x/bpci-advanced-faqs3.pdf

Participating in both BPCI Advanced and other CMS Innovation Models

- BPCI Advanced Participants also participating in CJR cannot participate in BPCI Advanced for the Clinical Episodes included in CJR
- Current Participants in OCM will be allowed to participate BPCI Advanced and will run concurrently with OCM
  - One model will not take precedence over the other
  - CMS will adjust OCM performance-based payments for BPCI Advanced NPRA payments based on the proportion of the BPCI Advanced Clinical Episode that overlaps with the OCM episode

Source: CMS

BPCI Advanced Bundled Payments Excluded for Prospective Attribution Models

- Clinical Episodes in BPCI Advanced will be excluded for Medicare Beneficiaries aligned to:
  - Next Generation ACOs
  - ACOs participating in Vermont Medicare ACO Initiative
  - Track 3 Medicare Shared Savings Programs ACOs
  - Comprehensive End Stage Renal Disease Care Seamless Care Organizations with downside risk
- Pulls the bundle out
- Reduces the total spend available

Source: CMS

Participating in BPCI Advanced: Providers and Beneficiaries

- Entities in Next Gen ACO model, MSSP Track 3, and CEC model are still able to apply for BPCI Advanced
  - BPCI Advanced does not exclude them based on participation in these other models
- Beneficiaries that are prospectively aligned to the Next Gen ACO Model, MSSP Track 3, and the CEC model are not able to trigger BPCI Advanced Clinical Episodes
  - If the Medicare provider serves other beneficiaries that are not prospectively aligned to the excluded models, they would be able to potentially trigger a BPCI Advanced Clinical Episode
- Providers can be in both models, but beneficiaries cannot

Source: https://innovation.cms.gov/Files/x/bpci-advanced-faqs3.pdf

Precedence Rules Applied to Various Episode Payment Models

- Clinical Episodes triggered under the CJR Model will take precedence over Clinical Episodes in BPCI Advanced

Source: CMS; https://www.edifecs.com/e/applying-comprehensive-care-for-joint-replacement-ccjr-model/edifecs-healthcare-blog-applying-comprehensive-care-for-joint-replacement-ccjr-model/


Overview of Current Environment
Bundled Payments and ACOs
How do you Choose?
Case Study

Considerations in Decision-Making

- Downside Risk
- Current Performance
- Capacity and Utilization Levels
- Primary Care/Specialty Physician Breakdown
- Patient Population
- Beneficiary Overlap with ACOs

Hospitals and ACOs

- Potential Conflict between Incentives
  - Hospitals want to maintain/increase admissions
  - ACOs want to restrain spending
- Reducing post-acute care—not inpatient admissions—is the primary source of ACO savings
  - Much less variation in inpatient use relative to PAC use
  - ACO growth does not appear to have contributed to decline in hospital admissions

Source: http://www.medpac.gov/docs/default-source/default-document-library/aco_april-2018.pdf?sfvrsn=0

Asymmetric Models

- Some models are “tilted” toward ACOs
  - Share of savings greater than share of losses
  - Cap on savings higher than cap on losses
- Potential to increase availability of two-sided ACOs
- Could cost the Medicare Program
- Track 1+ is asymmetric and has attracted many ACOs in its first year
- Could monitor progress of Track 1+ to inform policy on “tilting” toward ACOs

Source: http://www.medpac.gov/docs/default-source/default-document-library/aco_april-2018.pdf?sfvrsn=0

Specialist Participation in Two-Sided ACOs

- Some concerned about specialists in ACOs
  - Attribution focused on primary care
  - Specialists might increase costs
- Specialists are participating
- If more efficient, specialists:
  - Could help control spending
  - Could get more referrals
  - Could share in savings
- Some models are specialty focused, e.g. ESCOs

Source: http://www.medpac.gov/docs/default-source/default-document-library/aco_april-2018.pdf?sfvrsn=0

ACOs as a Transition Step to Medicare Advantage Plans?

- Concern: Eventually ACOs will want to be MA plans because that is the most efficient model
- MA plans require beneficiary enrollment and have higher administrative costs
- MedPac found in some markets ACOs were the low-cost model
  - Lower administrative cost
  - If ACO dominant, may get benefits of limited without “lock-in”

Source: http://www.medpac.gov/docs/default-source/default-document-library/aco_april-2018.pdf?sfvrsn=0


Overview of Current Environment
Bundled Payments and ACOs
How do you Choose?
Case Study

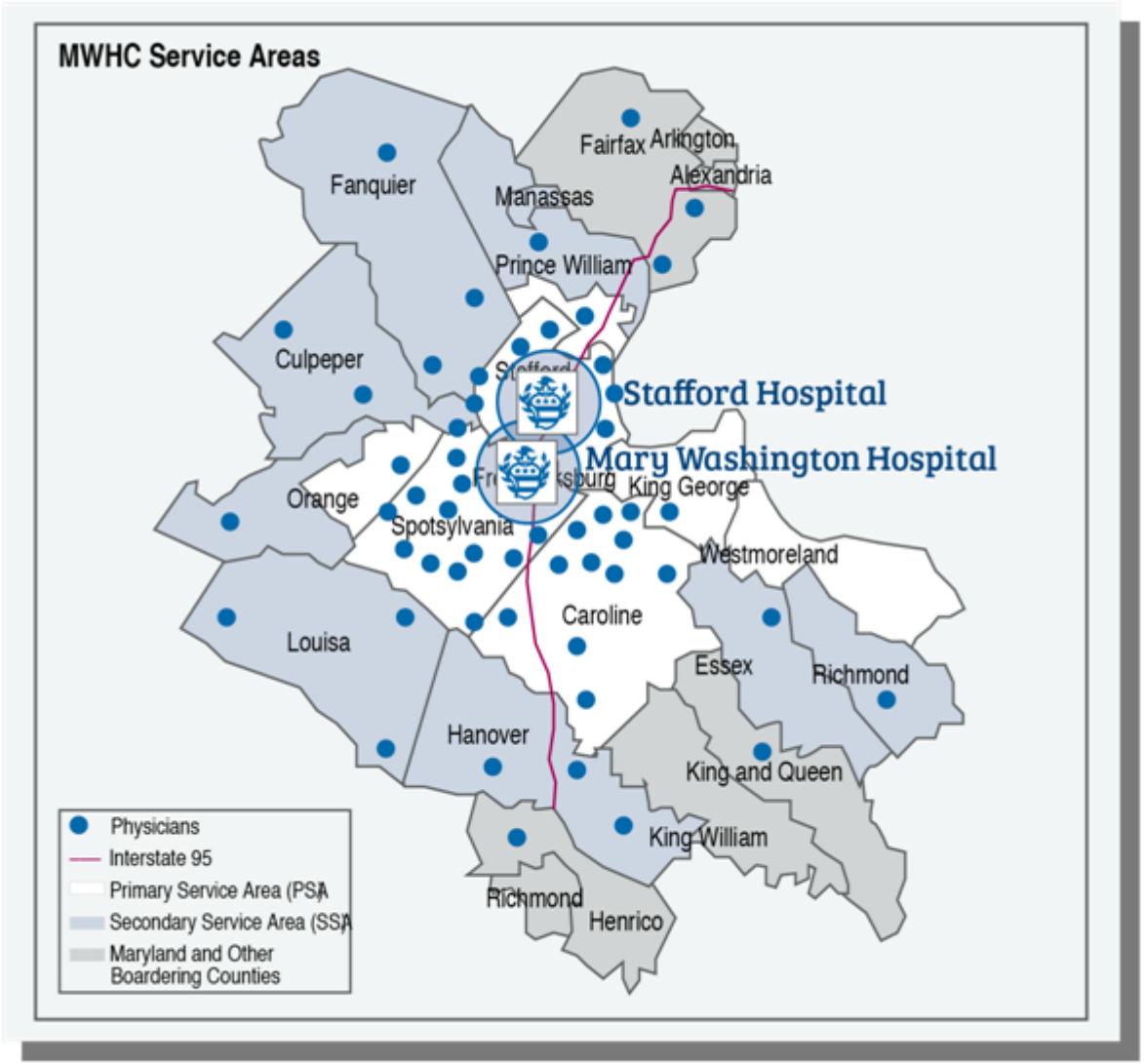
The Hospitals

- The region's tertiary care provider
- 451 beds
  - Cardiac Surgery
  - TAVR
  - Electrophysiology
  - Neurosurgery
  - Thoracic Surgery
  - Stereotactic Radiosurgery
  - Level II Trauma Center
  - Level III NICU
- 14 Operating Rooms
- 3 Cardiac Catheterization Laboratories
- 3 Interventional Radiology Laboratories
- *daVinci* Surgical System

- 100 beds
  - Cardiac and Interventional Radiology Lab
  - Level II Nursery
  - Radiation Oncology
- 4 Operating rooms

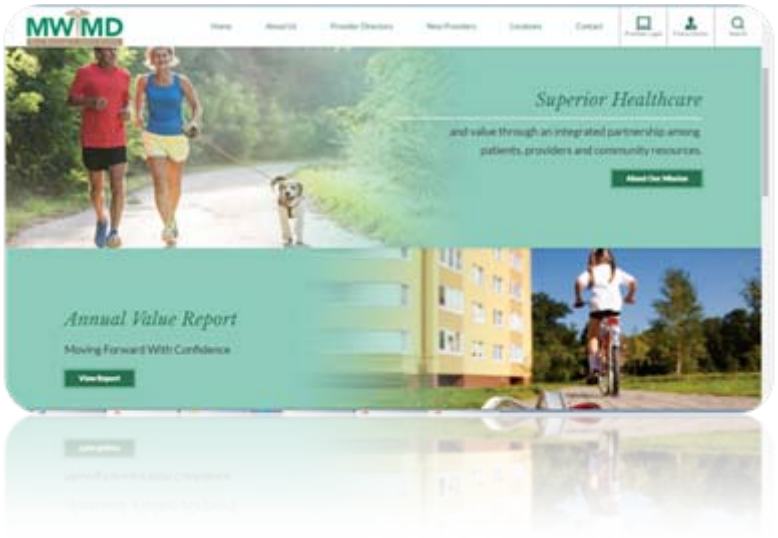
MWHC Service Areas

Mary Washington Healthcare Serves the Region



Mary Washington Health Alliance

- 400 Physicians
- 100 PCPs across 43 Practices
- 300 Specialists across 73 Practices
- Multiple EMR's (22+)
- http://MWHealthAlliance.com



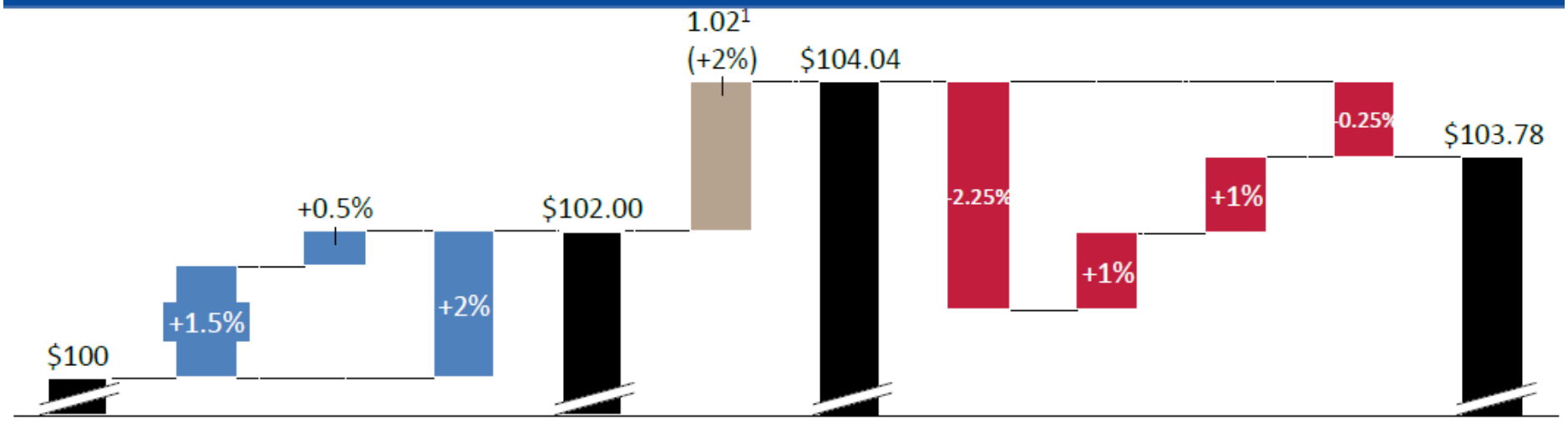
- Diverse Participation:
- Participants, Facilities, Affiliate Agreements:
- 350 Independent Practitioners (85% of total)
- 50 Employed by MWHC (15% of the total)
- Facilities
- Urgent Care/Primary Care

MWMD
Mary Washington Health Alliance

Total LIVES IN MWMD

Value Based Partner	Covered LIVES
MWHC	4,500
NGACO	15,000
BPCI	4,000 (episodes)
Commercial Contracts	56,500
Medicare Advantage	2,000
Million Heart Program	10,500
TOTAL:	**>80,000 + Lives**

Building from baseline to benchmark (graph)



Baseline expenditure: Run alignment in baseline year (2014) to determine ACO's historic expenditures

National projected trend: Projected trend from baseline year to performance year

Regional price adjustment: Change in regional price factors (e.g., AWI / GPCIs) relative to the nation

Total trend adjustment

Baseline, trended

Risk adjustment: Ratio of performance year to baseline year average risk score

Baseline, trended and risk adjusted

Base discount (always 2.25%)

Quality bonus (always +1% in PY1)

Efficiency adjustment (regional and national components, range of -1.5% to +1.5%)

Overall Quality and Efficiency Adjustment

Benchmark

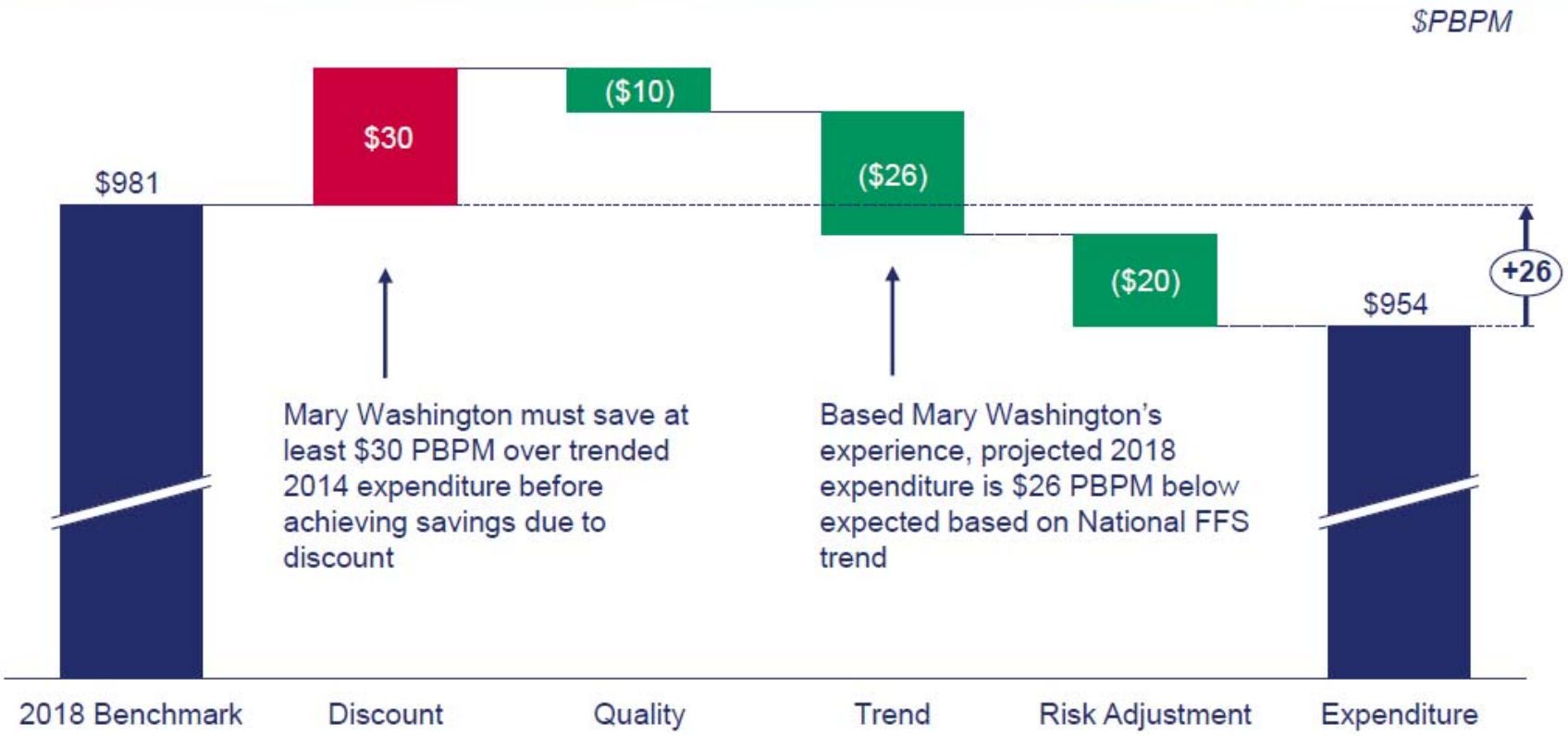
Trend – set prospectively (i.e. does not change during/after course of performance year)[2]

Risk adjustment – not set prospectively (i.e. ratio not final until final risk scores known, after performance year)[3]

Quality and Efficiency Adjusted Discount – efficiency adjustments set prospectively, quality adjustments set mid-year[4]

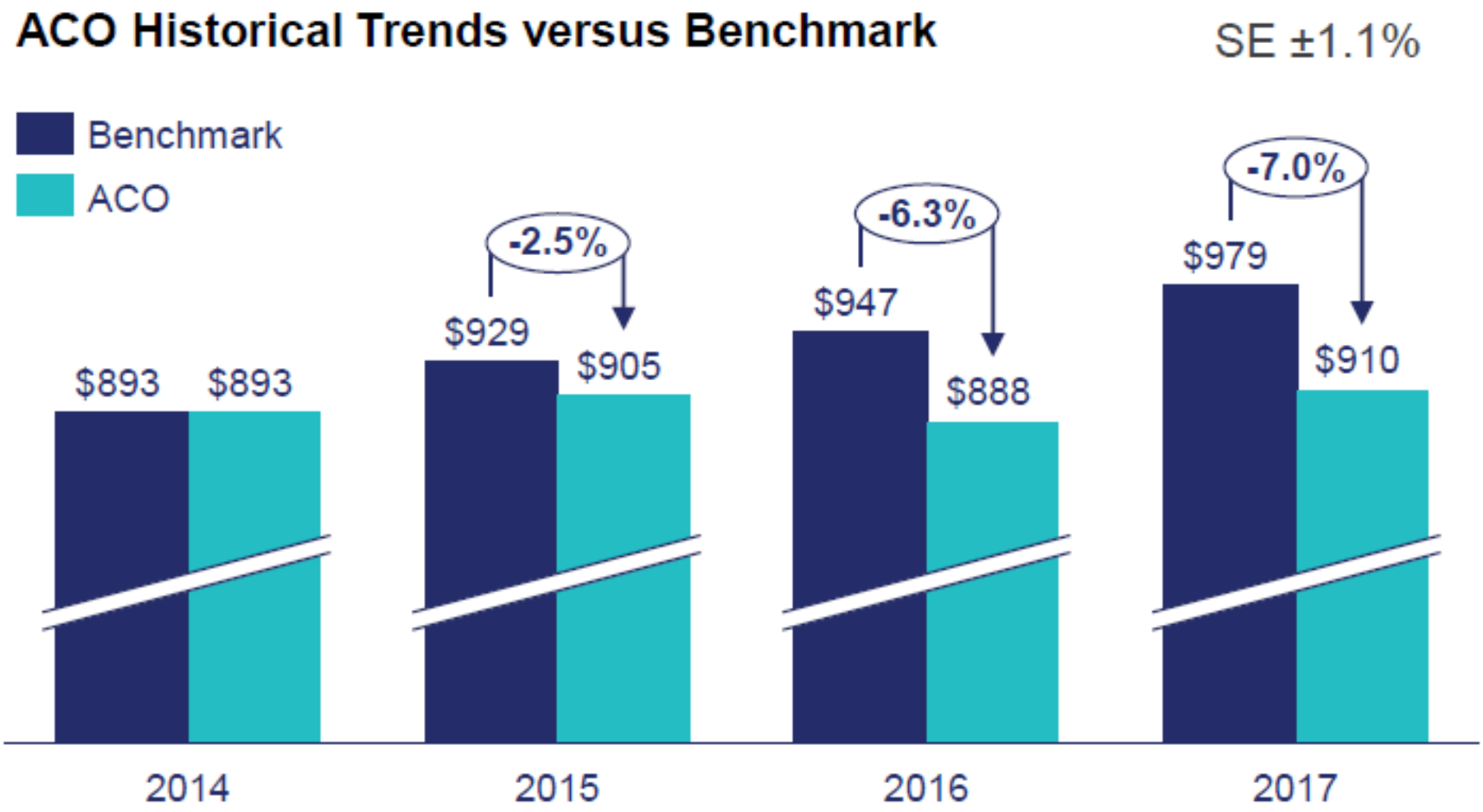
MWMD NGACO 2018 Projection

Components of Baseline Projected Settlement



- Baseline expected gross savings/(loss) is **$26.11 PBPM**, resulting in **$25.59 PBPM** in shared savings (after 2% sequestration)
- Mary Washington can earn 1% ($10 PBPM) through reporting on all quality measures and 2.0% ($20 PBPM) through risk adjustment, assuming MW risk scores grow at the same pace as the national reference population

Trend Performance vs. Benchmark



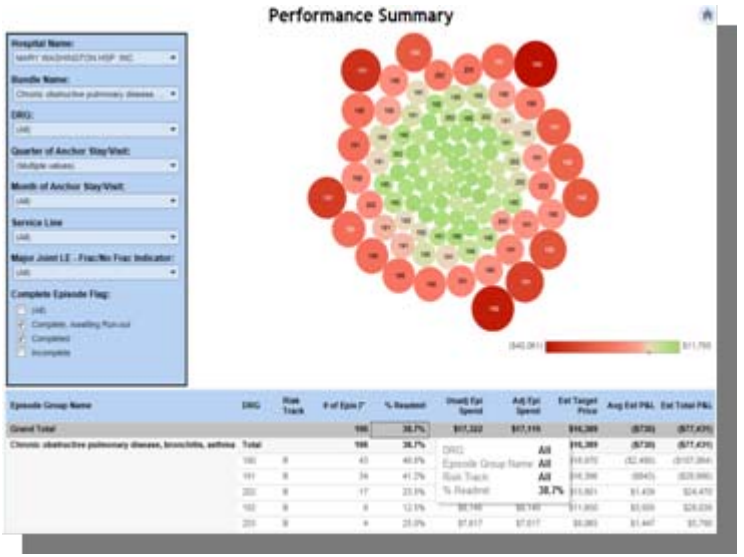
BPCI Phase 2

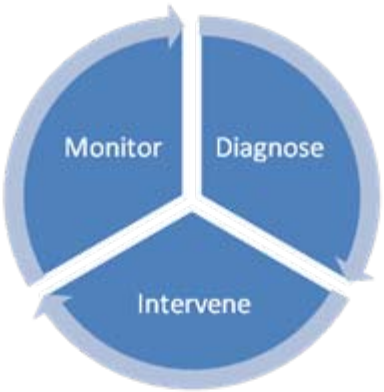
- Convener for MWH and SH
- Precedent set on 48 Episodes
- Robust Data Sets
- June 2015 thru Oct 2018
- >$12m Q3 2015 thru Q3 2017.

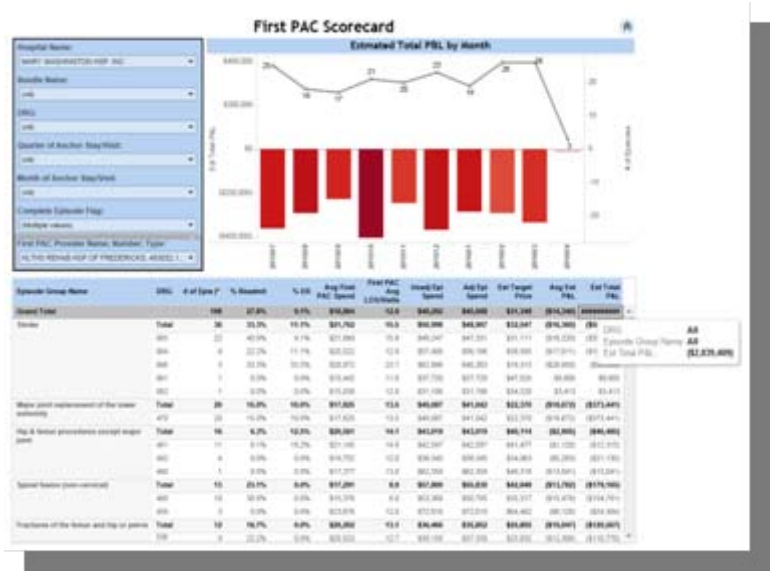
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

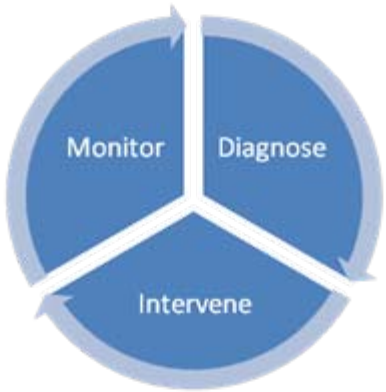
Bundled Payments for Care Improvement
BPCI

Hindsight-Insight-Foresight









Lessons Learned-Next Steps

- Communication x 3
- Build trust around guiding principles
- Strong physician and executive leadership
- The right structure – don’t be afraid to adjust
- Read the regulatory environment
- Measure and Share it!

- Learning, Timing and Flexibility
- NGACO, PSHP and BPCI-A

Discussion