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COVERYS[®]



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MEDICAL LIABILITY INSURANCE • BUSINESS ANALYTICS • RISK MANAGEMENT • EDUCATION

TABLE OF CONTENTS

| | |
|---|----|
| COVID-19..... | 02 |
| Executive Summary | 03 |
| Introduction..... | 04 |
| How We Got Here..... | 05 |
| Shared Risk: Not a New Idea | 06 |
| Not Your 90s Capitation | 06 |
| The Evolution of Value-Based Care Models | 07 |
| A Shifting Business Model | 09 |
| The Looming Insolvency Cliff..... | 10 |
| Not Changing Is Not an Option | 11 |
| Outrunning the Bear | 12 |
| Managing ‘Episodes of Care’: The Imperatives of Data Analytics & Communication..... | 13 |
| Asking the Right Questions | 14 |
| Data Analytics & Benchmarking Performance..... | 15 |
| Right-Sizing and Reimbursement: What Providers Are Saying | 16 |
| Are APMs Good for Patients? Yes | 18 |
| Taming Risk, Taking Advantage of Opportunities | 19 |
| Managing Episodes of Care – Paramount to Success | 19 |
| Care Path Coordination | 20 |
| Care Transitions..... | 20 |
| Emerging Insurance Innovations for the Value-Based World..... | 21 |
| Juggling Numerous Medicare Programs: Adopt an Enterprise VBC Strategy | 22 |
| Insurers Developing Downside Risk Protection Products..... | 22 |
| Don’t Get Left Behind | 23 |
| Conclusion | 24 |

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COVID-19

The pervasive and emergent nature of the COVID-19 pandemic has profoundly impacted the healthcare sector. In the short term, it will cause the shift in value-based care (VBC) to slow down somewhat, at least through the first half of 2020. For providers on the front lines of the crisis, the focus will obviously be on helping as many infected patients recover as quickly as possible and getting their overwhelmed facilities through the pandemic. Non-front-line care providers will likely see volume and revenue significantly reduced as elective procedures and routine visits are canceled until the crisis subsides. As a result, CMS is offering some downside forgiveness in VBC programs for the duration of the pandemic, as providers shift their attention to more urgent patient care and business operations.

In remarks delivered during a May 21, 2020 webinar, CMS suggested that the public health emergency was likely to result in an increased commitment to value-based care.

As Brad Smith, the Director of the Center for Medicare & Medicaid Innovation, said in late-May 2020,
"I think we're only going to double down on our commitment to value-based care based on what we've seen in the public health emergency."¹

As we move past the crisis, hopefully in the second half of 2020, COVID-19 is expected to accelerate the shift to VBC as budgets face new and sizable constraints at all levels. The federal government has allocated over \$3 trillion to support the economy during the crisis, and many states have also invested in major relief efforts. This spending will exacerbate existing deficits and increase pressure to reduce healthcare costs into the future. The commercial healthcare market will also be impacted as the crisis has thrown the economy into its first recession since the Affordable Care Act was passed in 2010. In a shrinking economy, employers and consumers will become much more aggressive in finding new ways to better manage their healthcare spending and accelerate the movement toward value.

¹America's Physician Group's Webinar, Deep Dive on the Future of APM's, May 21, 2020.

Executive Summary

The U.S. federal deficit is at an all-time high, and healthcare spending makes up the biggest and fastest growing share of it. To get healthcare costs under control and “bend the cost curve,” the Centers for Medicare & Medicaid Services (CMS) is moving from a volume-based reimbursement model to one based on value, which shifts healthcare risk from their books onto provider organizations.

Currently, less than 20% of Medicare spending is value-based, but by 2025, CMS wants to have close to 100% tied to VBC contracts. That means \$1 trillion of healthcare risk will be shifting from the government to hospitals, health systems, and physician practices across the country.

To make this happen, the Center for Medicare & Medicaid Innovation (CMMI) has developed over a dozen new voluntary and mandatory value-based payment models. These new programs follow two basic models: accountable care organizations (ACOs) and bundled payments. In an ACO, patients are usually assigned a primary care physician who, in collaboration with the ACO, is responsible for managing all the care and costs for that patient.

The bundled payment model focuses on patients who have an acute condition or who require a procedure and are actively receiving care from a specialist. In these programs, specialists are given a set budget to care for patients with a specific healthcare need such as a cardiac procedure or joint replacement. Providers participating in bundled payment contracts are generally specialists, such as cardiologists, orthopedic surgeons, oncologists, or nephrologists; or large health systems who partner with such specialists.

While these programs come with real financial risk, participating providers who deliver care efficiently and well against quality outcome measures can significantly increase their revenue through performance-related bonus payments. Another benefit is the increased autonomy that specialists have in providing care and running their businesses. At Coverys and Archway, we have seen many providers more than double per patient revenue in their organizations while improving outcomes and saving money for Medicare.

The shift from volume to value is still in the early stages, but it is already having a dramatic effect on how care is delivered and paid for, as well as on who assumes the risk. Over the next five years, every provider organization in the country will face new choices and challenges on how best to manage and finance this shift.

In order to be successful, providers need to have a deep understanding of the value-based programs they are pursuing, their opportunities for revenue growth, and the risk of loss. Together, Coverys and Archway Health are working to create innovative strategies to address these challenges, and we are eager to work with the broker community to bring their solutions to market.

Introduction

The American healthcare industry is undergoing major payment reform brought on by the dramatic rise in healthcare costs and clinically unwarranted variation in the quality of patient care. CMS, as well as employers and commercial health plans, are driving this shift from the fee-for-service (FFS) reimbursement model, which rewards quantity over quality, to value-based care payment models, which encourage providers to deliver the best care at the most reasonable cost, thus improving the overall value of care.

To achieve this goal, the U.S. healthcare system must substantially change its payment structure to incentivize quality health outcomes, and value over volume. This realignment requires a fundamental change in how healthcare is organized, delivered, and paid for.

Embracing this change is not a choice. CMS aims to have 100% of Medicare providers in two-sided risk arrangements by 2025. CMS wants half of Medicaid and commercial contracts to be in value-based reimbursement models by 2025.

The central challenge for providers is figuring out how to successfully transition from FFS to shared risk and population-based payment models. Many are not sure what their downside exposure is or if they can afford it. Some are unsure how to even calculate that or if they can survive in value-based contracts. This report focuses on what providers need to know to navigate this sea change.

How We Got Here

The passage of Affordable Care Act (ACA) in 2010 crystallized value-based care as we know it today. Among its many provisions, the ACA mandated that hospital Medicare reimbursement be tied to quality through a number of vehicles including the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, the Hospital-Acquired Condition Reduction Program, and substantial quality reporting requirements.

The ACA also added a section to the Social Security Act requiring the establishment of a permanent Shared Savings Program and established the CMMI to test innovative payment models, including ACOs and bundled payments. In addition, successful models tested under CMMI can be expanded without having to obtain approval from Congress.

The ACA also gave the secretary of Health and Human Services (HHS) authority to waive certain fraud and abuse laws including the Stark Law, the federal Anti-Kickback Statute, and gainsharing civil monetary penalties (CMPs), to give providers in alternative payment models (APMs) the flexibility necessary to innovate. The parallel adoption of certified electronic health record technology (CEHRT), mandated by the stimulus bill passed the year before the ACA, helped drive value-based care. The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) mandated all clinician reimbursement be tied to quality through the two tracks of the Quality Payment Program (QPP): the Merit-based Incentive Payment System (MIPS) and APMs. Additional acts of Congress and ongoing regulatory activity further support value-based care through provisions for site neutrality, price transparency, telehealth, and drug pricing.

The adoption of the MACRA resulted in a dramatic acceleration of this effort by CMS. MACRA repealed the sustainable growth rate (SGR) formula used to update the Medicare Physician Fee Schedule (MPFS) and determine physician reimbursement. The SGR was replaced by a "value-based" payment system that incorporates quality measurement into payments intended to create an equitable payment system for physicians.

By law, MACRA required CMS to establish value-based healthcare business models that link an ever-increasing portion of physician payments to service-value rather than service-volume. These incentive-based business models, collectively referred to as the QPP, provide two participation tracks for eligible clinicians—MIPS and APMs—both of which involve levels of financial rewards and risks.

In November 2016, CMS published the final rule on the MIPS and Advanced APMs under MACRA. The final rule established the criteria for determining which APMs are considered Advanced APMs under MACRA and thus offer participants an opportunity for a bonus payment.

Shared Risk: Not a New Idea

The concept of two-sided risk is not a new one and started taking hold not long after the inception of the Medicare program in 1965. In a message to Congress in 1971, President Richard Nixon decried the federal government's "growing investment in health care" and championed a novel approach to national healthcare reform that relied on market forces to bring discipline to the healthcare system.

| | 2009 | 2010 | 2015 | 2019 |
|--|---|--|--|--|
| Legislative Developments Catalyzing Shift to Value-Based Care | American Recovery and Reinvestment Act (Stimulus bill) – mandated meaningful use of CEHRT | Affordable Care Act – mandated a little bit of performance-based downside risk for hospitals | MACRA – forced all physician reimbursement into mandatory upside/downside risk | Stark and Anti-Kick-back reform to support value-based care arrangement |
| Current Regulatory Activity | | | | Presidential executive order "Improving Price and Quality Transparency in American Healthcare to Put Patients First" |

Cost containment and risk-sharing efforts have been evolving ever since, beginning in 1972 with amendments to the Medicare act that introduced Medicare Health Maintenance Organization (HMO) enrollment and contracting. The Tax Equity and Fiscal Responsibility Act (TEFRA), a risk contracting program authorized in 1982, followed that. More recently, the Balanced Budget Act of 1997—considered at the time to be the most significant changes in private plan contracting in Medicare history—introduced revisions to the types of private plans eligible for Medicare contracts, what contracting standards would be applied, who could enroll, and payment rules.

Not Your 90s Capitation

Skeptics might wonder how the latest iteration of value-based care is any different from the capitation efforts of the past. The passage of the American Recovery and Reinvestment Act of 2009 mandated the adoption of certified electronic health record technology (CEHRT). Providers in the 90s weren't using electronic medical records (EMRs), which are critical to participation in Advanced APMs (A-APMs). The ACA has also opened doors to data sharing and gainsharing, which now makes it possible for providers to access significant amounts of data and share in financial gains. In addition to that, quality measurement was not as much a part of the conversation in the 1990s. Now there are hundreds of quality measures used in programs, including patient-reported outcomes. Lastly, risk adjustment and pricing is far more sophisticated than it has ever been, driven in part by coding and documentation capabilities made possible with ICD-10 codes and widespread adoption of CEHRT.

The Evolution of Value-Based Care Models

The ACO was the first value-based care model introduced after the passage of the ACA in 2010 and served as the catalyst for value-based care. While Medicare ACOs are most prevalent, many commercial ACOs target coordinated care for their privately insured members as well. Currently there are over 40 different APMs that tie payment to quality performance instead of total billable services. Other models include:

- Bundled Payments for Care Improvement Model (BCPI).
- Comprehensive Primary Care Plus Model (CPC+).
- Home Health Value-Based Purchasing Model (HHVBP).
- Integrated Care for Kids Model (InCK).
- Oncology Care Model (OCM) (two-sided risk arrangement).

In a bundled payment model, a single provider is responsible for managing all aspects of care during an episode of care. Episodes are typically 90 days in length, tied to specific clinical conditions, and have most costs included.

CMS has been experimenting with bundled payments for some time and, in 2013, launched the Bundled Payments for Care Improvement (BPCI) initiative, which includes four separate models of care. In 2016, CMS launched the Comprehensive Care for Joint Replacement Model (CJR), and the Oncology Care Model (OCM). The CJR uses a bundled payment approach for hip and knee replacements. Initially slated to run through the end of 2020, CMS recently proposed extending CJR through the end of 2023. It plans to update the program to include hip and knee replacements in the hospital outpatient setting and is revising target pricing methodology.

In 2018, CMS rolled out BPCI Advanced (BPCI-A), a new voluntary bundled payment model that covers 35 clinical episodes and continues through the end of 2023. Currently, around 1,500 providers are participating in this model.

The program is very popular with providers for reasons that include new incentives for improved quality of care, opportunities to earn significantly more revenue than under fee-for-service payment models, and more autonomy over how providers care for patients and run their business. BPCI-A bundle-based target pricing includes all costs incurred by the patient during the episode of care—for example, a target price of \$25,000 to cover all Medicare costs for 90 days.

It's in the reconciliation period of BPCI-A that providers find out how they have performed over the episode. Providers not meeting the target price must pay CMS back. Providers delivering cost-effective care that yields good outcomes can receive bonus payments. In other words, if the total cost of the entire episode is lower than the target price of the episode, the provider retains the difference.

Results: Archway's practice partners have tripled their revenue

Bundle: Lower Extremity Joint Replacement (DRG 470)

| Archway Practice | A | B | C |
|---------------------------|-----------|----------|-------------|
| # of Surgeons in Practice | 1 | 12 | 35 |
| Annual Volume | 211 | 252 | 1,783 |
| Bundled Price | \$23,161 | \$25,348 | \$25,768 |
| Savings per Case | \$2,491 | \$3,841 | \$2,050 |
| New Practice Revenue | \$525,658 | \$80,884 | \$3,654,487 |
| New Revenue per Surgeon | \$525,658 | \$80,657 | \$104,414 |

Existing specialty bundled payment programs include orthopedics—spine, bone, and joint—cardiology, medical oncology, pulmonology, neurology, and gastroenterology. Other existing value-based care programs including Medicare Shared Savings, Next Generation ACO, Comprehensive Primary Care Plus (CPC+), and Comprehensive ESRD Care (CEC) target primary care and nephrology specialties as well.

These specialties will continue to be central to Medicare's value-based care efforts as CMMI rolls out second-generation programs. Those programs include:

- Primary Care First Models (PCF) – the successor to CPC+.
- Direct Contracting Models (DC) – the successor to Next Gen ACO.
- Kidney Care Choices – the successor to Comprehensive ESRD.
- Oncology Care First Model (OCF) – the successor to the Oncology Care Model.
- BPCI Advanced Model – expected to continue for several more years.

The proposed Radiation Oncology Model (RO), a future mandatory model, will bring radiation oncology into the fold.

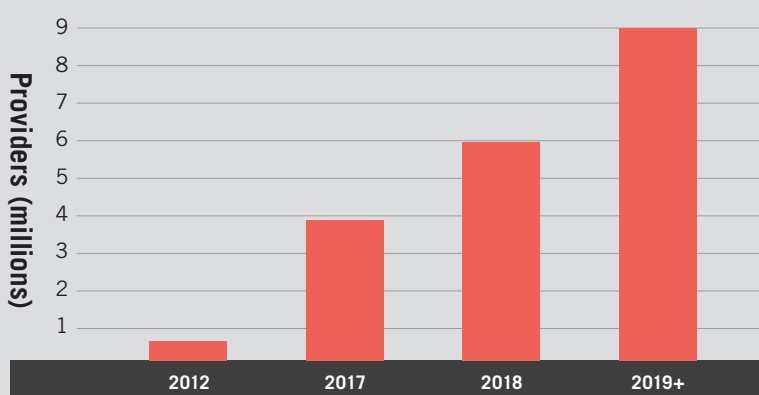
A Shifting Business Model

In 2018, Medicare covered 59.9 million people—51.2 million people aged 65 plus and 8.8 million people with disabilities. VBC currently accounts for 10–15% of Medicare beneficiaries, but voluntary adoption by providers of population-based models with significant downside risk is steadily increasing. In 2012, when CMMI introduced the first population-based risk program, there were fewer than 1 million. The number hit 4 million in 2017, the first performance period under MACRA, and in 2018, hit 6 million. The growth continued in 2019 and is projected to reach more than 9 million by the end of 2020.

**Medicare:
2018 Coverage**



Growth In Number of Providers



As a business model, fee for service has always been unusual because it doesn't connect cost and price. Physicians who treat patients are even further removed—and in many cases shielded entirely—from cost and price conversations. New payment models are trying to fix that. The leadership of CMS takes a more entrepreneurial view and sees room for business practices in healthcare that would help curb costs. Some of the payment models—where CMS is prospectively paying money up front with a budget—are forcing providers—sometimes for the first time—to think about what healthcare costs and examine how they are delivering care. They are forced to look at their budget and be as efficient and high value as possible.

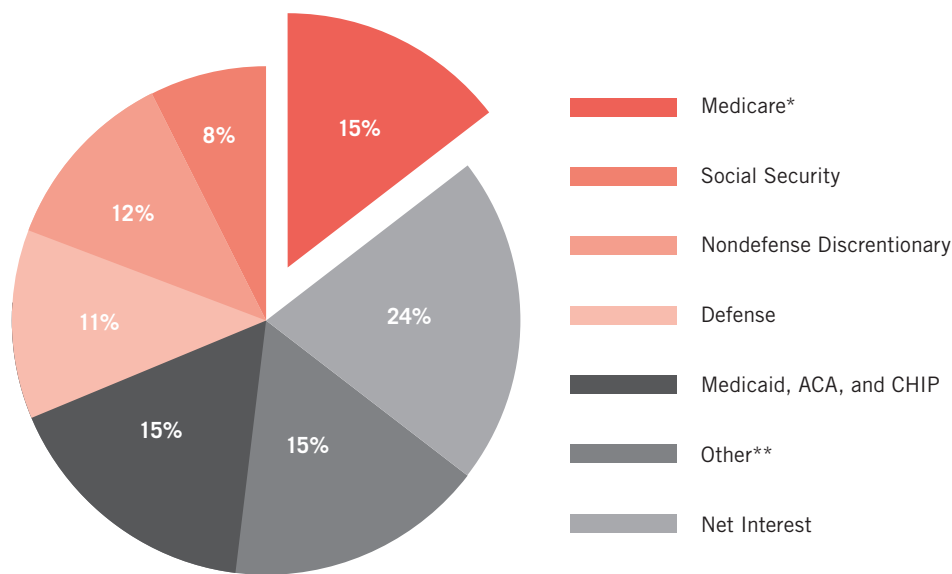
Medicare has far and away the highest number of attributed lives in the U.S. healthcare ecosystem and is easily the largest payer in the country. As a result, CMS is a very influential purchaser of services and is leading a lot of the innovation occurring within the system. Commercial payers, though not replicating everything CMS is doing, are taking note and implementing these innovations where it makes sense. Of the 2,454 providers making up the current risk market in Medicare programs, 714, or 29%, are commercial ACOs.

The Looming Insolvency Cliff

However inconvenient the push to value-based care may be, one reality is unavoidable: FFS as a payment model is actuarially unsustainable. Since 1960, U.S. national health expenditure (NHE) growth rates have typically outpaced economic growth rates. From 2008–2015, expenditures from the Hospital Insurance (HI) Trust Fund exceeded income each year, and in 2018, HI expenditures exceeded income by \$1.6 billion.²

The shifting demographics of healthcare in the U.S. explain this surge in expenditures. In this century, America has become home to an aging population. This year, an estimated 17% of the U.S. population³ will be 65 or older. That's 50 million adults with an escalated reliance on healthcare. By 2030, the last of the baby boomers⁴—76.4 million people or 20% of Americans—will have moved into the ranks of the older population, with the eldest of this group—8.7 million people—aged 85 and older.

Medicare as a Share of the Federal Budget, 2018



Total Federal Outlays, 2018: \$4.1 trillion
Net Federal Medicare Outlays, 2018: \$605 billion

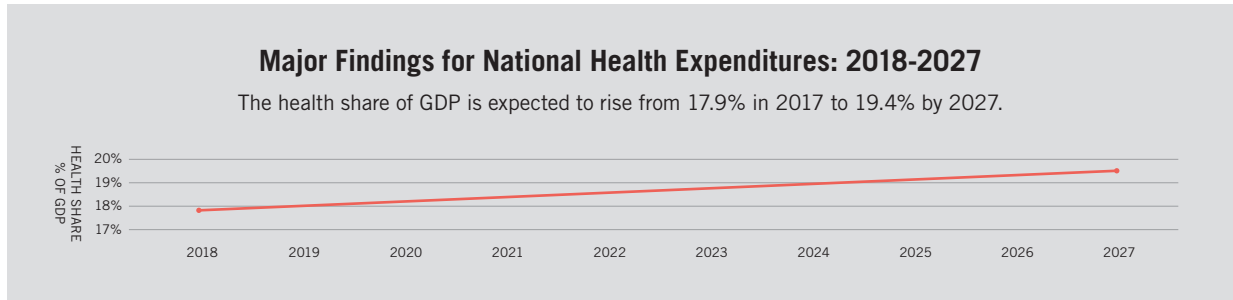
Note: All amounts are for federal fiscal year 2018. *Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts. **Includes spending on other mandatory outlays minus income from offsetting receipts. ACA is Affordable Care Act. CHIP is Children's Health Insurance Program. Source: KFF analysis of federal spending from Congressional Budget Office, The Budget and Economic Outlook, 2019 to 2029 (May 2019).

²2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

³Population Reference Bureau, Fact Sheet: Aging in the United States, July 15, 2019.

⁴The Next Four Decades: The Older Population in the United States, Current Population Reports, P25-1138, May 2010.

According to the 2019 Medicare Trustees Report, the HI Trust Fund will be able to pay full benefits only until 2026. In 2018, CMS projected⁵ health spending would grow 0.8 of a percentage point faster than gross domestic product (GDP) per year between 2018 and 2027, pushing the percentage of GDP tied to healthcare from 17.9% in 2017 to 19.4% by 2027.



Not Changing Is Not an Option

In the face of this reality, the switch from volume-based to value-based care is inevitable. With the passage in December 2018 of the final rule for the Medicare Shared Savings Program (MSSP), CMS increased pressure to push all ACOs into meaningful downside risk contracts. On the plus side, the legislation comes with provisions that help to lower a provider's technical risk. They include:

- An updated regional benchmark adjustment that improves methodology and limits the regional fee-for-service adjustment to plus or minus 5% of the national assignable per capita expenditures by enrollment type.
- Risk adjustment that more accurately reflects morbidity changes and limits the effects from coding practices.
- Setting a benchmark trend as a blend of national and regional trends.
- Extending the duration of the agreement period from three to five years.

VBC is also better-suited for initiating investments and sustaining population health management innovations such as information technology, clinical decision support tools, patient engagement and care coordination functions, and opportunities to increase access to care, such as payments for telehealth, home visits, group visits, and additional office hours. Innovative approaches to healthcare delivery stand to benefit patients and society alike, with patients coming to expect a more coordinated, more accessible, and more effective healthcare system, and a nation benefiting from reductions in national healthcare expenditures, thanks to a healthier, more productive population.

⁵National Health Expenditure Projections, 2018-2027, Forecast Summary, Centers for Medicare & Medicaid Services.

Outrunning the Bear

The well-worn adage of worrying less about outrunning the bear than focusing on staying ahead of the guy next to you applies nicely to the peril of putting off entering into downside risk contracts. Those moving into VBC contracts are running ahead and driving down spending trends. Providers lagging behind are in a decidedly more vulnerable position.

That's because CMS is increasingly using regional trends to set target prices in risk arrangements including CJR, BPCI-A, OCM, MSSP, and the new geographic Direct Contracting model.

Growing provider participation in two-sided risk programs is expected to drive down regional spending over time, and providers who sit on the sidelines of value-based care initiatives will fall further behind.

When risk models are mandated and pricing is set by peers who have already taken steps to provide more efficient care, providers who have not will be at an even greater disadvantage. In other words, the success that others have in risk models today will dictate pricing in mandatory programs tomorrow.

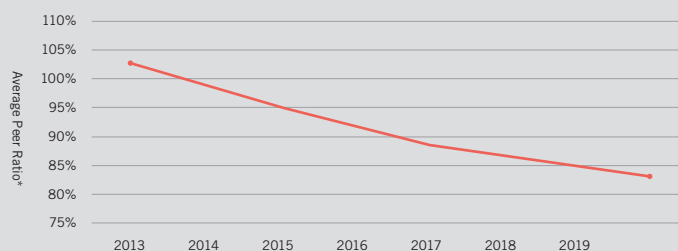
One example already playing out in the market is major joint replacement of the lower extremity (MJRLE). Through BPCI Classic, which had robust and successful participation by many orthopedic practices, the spending curve for MJRLE has been aggressively trending downward. This trend is playing out in other episodes of care as well, including percutaneous coronary intervention and hip fracture surgery.

Improvement Impact of ACO and Bundled Payment Programs

2018 ACO Results

- Over \$900 million in program savings
- 27% increase in quality measure performance
- ACOs with multi-year experience saved 2X than ACOs in their first contract period

90 Day Bundled Payment Results: Major Joint Replacement



*The relative cost to the national average of providers in various peer groups.

Managing ‘Episodes of Care’: The Imperatives of Data Analytics & Communication

The value-based care paradigm has arrived in earnest and continues to gain momentum.

Understandably, providers are often at a loss about where to even start this process. Under the new model of care, they are not only responsible for their own performance, they are also responsible for the performance of their downstream partners who are critical contributors to the entire ‘episode of care.’ This responsibility encompasses clinical and financial outcomes. Sending an orthopedic patient to any rehabilitation facility, for example, is no longer an option. Under a VBC contract, providers need to evaluate which of the available rehab facilities has the best patient outcomes, or, if the facility is still working on an FFS basis, whether the extra night they are keeping patients is warranted.

These considerations can make the transition to value-based care feel daunting and leave providers with myriad questions ranging from how to calculate the financial impact of the change, to whether the practice will be able to provide care under the benchmarks or target price for each clinical episode. If they do take the plunge, providers might wonder how they will then use the changes in care management or in technology to ensure they are being consistent. That might involve making hard decisions about internal policies, such as who in the practice is doing knee surgeries, or disrupting long-standing referral relationships, if warranted by outcome data.

How providers respond to these conversations ranges from apprehensive to all-in. Regardless of how ready they feel, the transition is coming and not slowing down.

Asking the Right Questions

In our view, successfully transitioning to the value-based payment model starts with asking the right questions. These questions break down into two general categories: organizational and data.

On the organizational front, providers need to determine the specific needs of their patient population. They also need to ask themselves if they have the appropriate resources in place to support their program. Other key questions include:

- Is there stakeholder buy-in on actionable levers for success?
- Does the steering committee review progress against set performance metrics?
- Is there a process in place to identify patients in the program?
- Are risk assessment tools used to develop patient-specific care plans?
- Are decision support tools and/or clinical pathways used, and, if so, do they impact care?
- Is a preferred provider network in place?
- Are care redesign efforts improving patient care?

Data Analytics & Benchmarking Performance

When it comes to data, start by comparing what's driving cost and performance variation within the organization and compare that to what's driving cost and variation among peers. Then, ask these questions:

- When compared against regional and peer benchmarks, does the organization's performance create opportunities?
- How has the organization's cost trended over time?
- Do recent performance trends create opportunities when compared against baseline performance?
- What are the probabilities of success within each bundle/risk track?
- How does improving performance vs. benchmark change the probability of success?
- What impact does the risk adjustment methodology have on the organization's target prices?
- Which bundles/risk adjustment methodology should be used to calculate target prices?
- Which bundles/risk track should be used to create the highest-value/lowest-risk program?
- Are there specific improvement drivers? If so, what?
- How do program target prices compare among providers in the organization's market?
- For physical group practices treating patients at multiple hospitals: How do costs at different hospitals compare? What are the respective opportunities for savings reduction?

Right-Sizing and Reimbursement: What Providers Are Saying

Kyle Matthews, CEO, Phoenix Heart PLLC

Kyle Matthews, Chief Executive Officer of Phoenix Heart PLLC, a cardiology group with six offices in greater Phoenix, Arizona, reported that getting the practice to buy into a BCPI Advanced contract was a hard sell, but that doing so not only saves money, it saves lives.

In closely tracking one patient's journey through the entire 90-day episode of care, Phoenix Heart staff discovered that the patient, who had recently undergone a percutaneous coronary intervention (PCI), was no longer in contact. They took action immediately and found that the patient had been dispatched by another physician to a rehab facility for a non-cardiac-related issue. They learned the patient was not receiving medication prescribed after their discharge, leading to a potentially life-threatening situation.

Phoenix Heart physicians immediately arranged for the patient to be put back on the medication and set up an appointment at a Phoenix Heart office the next day. The patient was "very sick" when they arrived, said Matthews. Because the patient's case was part of a bundled payment program which requires constant and clear communication between all of the providers involved, Phoenix Heart was able to make a timely intervention that helped the patient recover.

"We really credit the bundle for putting the patient back on the right track, especially getting them on the medication they should have been on in the first place, and potentially saving their life," Matthews said.

Right-Sizing and Reimbursement: What Providers Are Saying

Stephen Murphy, MD, Orthopedic Surgeon, Boston, MA

Dr. Stephen Murphy, a Boston-based orthopedic surgeon, reported consistently achieving quarterly savings of 15% since deciding to participate in BCPI, even with CMS price drops.

“It’s very dramatic how much more efficient you can make these episodes for patients,” he said.

Jordan Simon, MD, Orthopedic Surgeon, NY

Dr. Jordan Simon, an orthopedic surgeon affiliated with Northeast Orthopedics & Sports Medicine, a group serving Rockland, Westchester, and Orange counties in New York, found that their cost was significantly higher for the region due to utilization of acute rehabilitation services for their Medicare patients. An analysis of historical data helped Simon discover an opportunity for savings through better management of patient care after discharge.

“We looked at this and realized it could be very profitable and that it could also help us bring together our merged entity,” Simon said. **“We shared best practices and worked on a common goal of being successful with BCPI. We have been extremely effective. The gainshare has been tremendous.”**

Are APMs Good for Patients? Yes

A common misconception of alternative payment models is that they incentivize providers to withhold care to save on costs. On the contrary, well-designed value-based care programs align high-quality care with lower cost.

As an example, being discharged from a skilled nursing facility (SNF) too soon after a hip or femur fracture surgery can lead to costly readmissions, while staying in an SNF longer than clinically necessary exposes patients to unnecessary risks including infection.

Provider organizations that use risk assessments to create patient-specific care plans, manage care to the patient-specific goals of the care plan, and transition patients home as quickly and safely as possible provide higher-quality care at a lower overall cost.

The average 90-day spending for an SNF stay after a hip or femur fracture surgery is over \$17,000, which is more costly than the surgery itself.

After a pacemaker procedure, common reasons for readmissions and ER visits include heart failure, chest pain, arrhythmia, sepsis, and acute myocardial infarction (AMI). A provider organization that is able to reduce readmissions and ER visits through enhanced care management services will have delivered high-quality care—as evidenced by keeping their patients healthy and out of the hospital—at a lower overall cost. Average total spending on readmission and ER visits per pacemaker episode ranges from \$3,000 to \$4,000.

| | |
|-----------------------------------|---|
| Average Total Spending | \$17,000+ • For a 90-Day SNF Stay (Example: After Hip or Femur Fracture Surgery) |
| | \$3,000-\$4,000 • Readmission and ER Visits (Per Pacemaker Episode) |

Another way well-designed programs align high-quality care with financial incentives is by adjusting bonus payments according to provider performance in quality metrics, such as 30-day complication rates following a total joint replacement or 30-day mortality rates following a coronary artery bypass graft (CABG) procedure and proper use of antibiotics.

Taming Risk, Taking Advantage of Opportunities

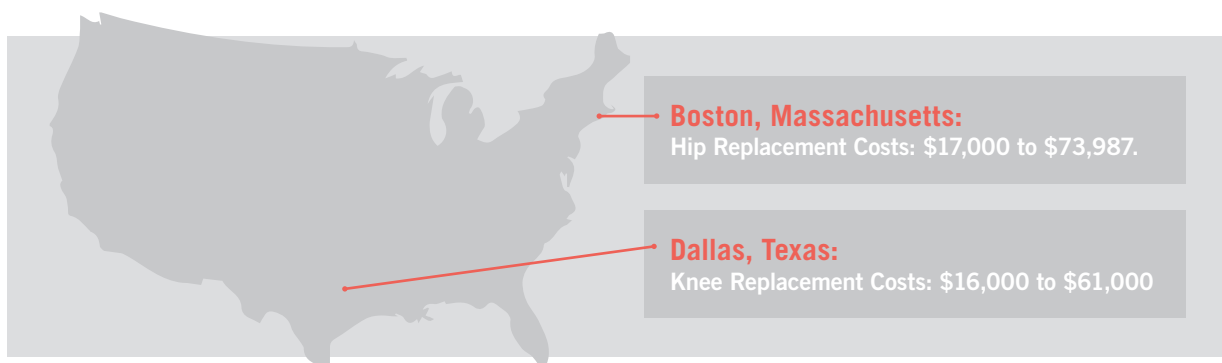
An intimidating aspect of APMs is the way they consolidate risk to providers on three fronts. There's the technical risk providers face if the programs are not designed perfectly. There's the insurance risk already inherent to healthcare shaped by the unknowable variation in the volume and severity of illness. Thirdly, there's the performance risk associated with providers' favorable or unfavorable performance.

Through a disciplined and methodical approach, providers can mitigate each of these risks. For example, to reduce technical risk, providers can increase focus on managing each phase of a patient's episode of care and improving inter-provider communications. Evaluating the impact of quality measures on reconciliation payments, closely monitoring risk adjustments, and gain/risk sharing are other methods to reduce technical risk. Methods to manage insurance risk include analysis of various VBC downside risk protection products, contingent capital, and risk pooling. An experienced insurance consultant can provide assistance in evaluating options.

Managing Episodes of Care – Paramount to Success

How providers manage episodes of care is key to mitigating all three areas of risk. According to the Centers for Disease Control and Prevention (CDC), total hip and total knee replacements are among the most commonly performed surgical procedures, with over 1 million performed each year. Despite the huge volume of these surgeries, outcomes and costs vary greatly among providers, across geographic areas, and among homogeneous populations.

In Dallas, Texas, a knee replacement can cost anywhere from \$16,000 to \$61,000, depending on the hospital. In Boston, Massachusetts, a hip replacement can cost anywhere between \$17,000 and \$73,987. A study of 64 markets in the U.S. by Blue Cross Blue Shield found that costs can vary up to 313%.⁶



⁶A Study of Cost Variations for Knee and Hip Replacement Surgery in the U.S., Blue Cross/Blue Shield: The Health of America Reports, Jan. 21, 2015.

Factors affecting variation include duplication of exams, imaging, and other diagnostics due to lack of communication between the surgical practice and the hospital. Site of service is another reason, such as performing the procedure in an inpatient hospital setting when a less costly outpatient setting would be deemed safe and appropriate for a given patient. Other variations include length of stay at various care sites, poor post-inpatient hospital discharge planning, and cost of equipment/implants. Cost and quality are impacted by these variations.

Fortunately, there are strategies providers can use to maximize their success across episodes of care. These common-sense measures fall generally into two phases of the care continuum: before and during the performance period. Healthcare conveners and risk management professionals can provide education and consultative support in these areas.

Care Path Coordination

How providers apply these strategies will differ by specialty and procedure, however, the concept of care redesign and care pathways runs through all of them. Care redesign takes inspiration from well-established management theories, some of which have been around since the 1950s, including critical path method, Lean Six Sigma, business process redesign, and others. Care pathways goals include improving efficiency, promoting coherence, increasing quality, and supporting caregiver and patient autonomy by predicting the tasks and resources needed before, during, and after specific healthcare events, such as surgery.

Adoption of care pathways through care redesign has proven to yield substantial savings, in part, by reducing errors, avoiding duplication, and limiting unnecessary resource utilization. Patient-centric care, increases in care coordination, and the expanded use of clinical decision support (CDS) tools are among the core components of VBC.

Care Transitions

Transitions of care occur when patients are at their most vulnerable, so heightened attention in this phase of care is a key opportunity to reduce costs and inefficiencies.

Providers can also promote high-quality care and lower costs in the value-based care environment by incorporating care transition assessments into existing quality assurance measures. These assessments provide an opportunity to examine care transitions at each level of care as the patient transitions throughout the system. They include recommendations on how to minimize facility-specific risks.

Emerging Insurance Innovations for the Value-Based World

The moment of reckoning with value-based reimbursement models occurs during the reconciliation periods. That's when providers find out how they've managed patient care and service needs over the episode. Providers who meet target price are able to keep any revenue above that. If they do not meet the target price, they must pay CMS back.

The good news is that Medicare offers providers a lot of flexibility when it comes to participating in risk models. In the BPCI Advanced program, for example, there are 31 inpatient bundles and four outpatient bundles providers can choose from that range from orthopedic procedures to acute exacerbations of chronic cardiovascular and pulmonary diseases.

Under the Medicare Shared Savings Program (MSSP) overhaul, Pathways to Success, there are six different tracks ACOs can participate in, reflecting varying levels of risk. In MSSP, ACOs also have a range of choices for their minimum savings rate/minimum loss rate and different patient attribution options. Choosing the optimal program requires preliminary analysis of the providers' utilization data.

Juggling Numerous Medicare Programs: Adopt an Enterprise VBC Strategy

New Medicare models including Direct Contracting, Kidney Care Choices, and Oncology Care First offer a wide range in risk levels to choose from. As Medicare continues to roll out numerous value-based care programs and as other payers follow suit, healthcare organizations will be increasingly challenged with managing an array of programs that vary between services under risk and patient population.

The total risk of these collective programs can be substantial. It is essential for organizations to have an enterprise approach in place to track and manage total financial exposure. This is particularly critical as VBC programs evolve. Innovative, enterprise-level value-based risk insurance represents a valuable option for organizations seeking protection against catastrophic losses.

Insurers Developing Downside Risk Protection Products

Current risk for the value-based contract market is estimated at \$226 billion, and there is limited availability of risk protection products. A small number of insurers are introducing products that offer providers protection against this downside risk. This coverage is designed to provide downside protection for all types of value-based care risk programs involving population-based ACO models and episodes of care in defined performance periods. This coverage can be applied to hospitals and healthcare systems, primary care groups, specialty physician groups, conveners, and any provider that enters into a risk-based contract with downside exposure.

One product gaining momentum in the two-sided risk environment is Stop-Loss coverage.

Stop-Loss protection allows providers to take advantage of financially beneficial programs in value-based care by protecting against the downside risk associated with these programs. Stop-Loss insurance provides protection in the aggregate. With VBC-related risk insurance, providers can insure their bottom line and protect their organization.

Don't Get Left Behind

As organizations approach this transition, the impact of value-based reimbursement on the healthcare market should not be ignored. Those who wait will almost certainly find themselves at a competitive disadvantage to those who embrace the model.

The goal of CMS is to have 100% of providers participating in upside and downside value-based care contracts by 2025.

Currently, the participation rate is less than 20%. That means over the next five years, there will be a massive shift in risk from the government onto provider organizations and other players in the private market.

Goal Statement: Accelerate the percentage of US healthcare payments tied to quality and value in each market segment through the adoption of shared accountability alternative payment models.

| | Medicaid | Commercial | Medicare Advantage | Traditional Medicare |
|------|----------|------------|--------------------|----------------------|
| 2020 | 15% | 15% | 30% | 30% |
| 2022 | 25% | 25% | 50% | 50% |
| 2025 | 50% | 50% | 100% | 100% |

Increasing the value of healthcare services has tended to transcend political partisanship. VBC—a concept built on the goal of delivering higher-quality care at a lower cost—has had broad bipartisan support since its inception. MACRA, as an example, which mandates performance-based reimbursement for physicians, was passed in 2015 with overwhelming support in both the House and Senate.

With the HI Trust Fund projected to reach insolvency in 2026, two-sided risk payment models are likely here to stay.

Conclusion

The flight from volume to value is accelerating, and it represents a major opportunity for providers to grow their businesses. It is also the beginning of a massive shift in risk from payers to providers. To be prepared, providers need to fully understand what programs are available to them, whether they're positioned to win or lose, how their performance compares to that of their peers, what opportunities they have to earn new revenue, and their level of risk to financial loss.

In order to answer these questions, forward-leaning provider organizations are bringing together key stakeholders from their risk management, clinical quality, contracting, and medical management teams to assess the risk contracts they currently have, as well as other programs they may be interested in pursuing. Once that initial step is taken, it can be very helpful to bring an insurance broker into the process who can help define the risk that is being considered and structure downside protection products that match with the risk tolerance of the organization. Once that step is taken, we encourage you to have your broker reach out to Coverys —we're here to help.

⁷ Remarks on Value-Based Transformation to the Federation of American Hospitals, March 5, 2018.

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