Hospitals and payment reform

Becky Hultberg, President/CEO
House Health & Social Services Committee
Feb. 16, 2016

Together
Shaping Our Future

ASHNHA
ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Alaska State Hospital and Nursing Home Association (ASHNHA)

OUR VISION

A unified Association providing effective statewide leadership to address health care delivery challenges affecting all Alaskans.

OUR MISSION

To be the premier provider advocate bringing unity to the health care community in addressing health care issues and to support our members' goal to improve Alaskan's health.

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Definitions: concepts

MANAGED CARE

A method of health care delivery that focuses on collaboration among and coordination of all services to avoid overlap, duplication and delays and to reduce costs. There is an emphasis on efficacy and timeliness of interventions. Payment is typically something other than fee-for-service

FEE-FOR-SERVICE

A payment model where services are unbundled and paid for separately. In health care, it gives an incentive to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.

Types of payment: risk continuum

Source: "Promising payment reform, risk-sharing with Accountable Care Organizations." The Commonwealth Fund, 2011

Definitions: types of payment

PAY FOR PERFORMANCE

Pay-for-performance programs offer financial incentives to physicians and other healthcare providers who meet defined performance targets which tend to focus on quality, efficiency, or related areas.

BUNDLED PAYMENT

Bundled payment, also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, package pricing, or packaged pricing, is defined as the reimbursement of health care providers (such as hospitals and physicians) "on the basis of expected costs for clinically-defined episodes of care." (e.g. a hip replacement)

Definitions: types of payment

CAPITATION

A payment arrangement that pays a provider or group of providers a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

GLOBAL BUDGET

Fixed-dollar payments for the care that patients may receive in a given time period, such as a month or year. Global payments place providers at financial risk for both the occurrence of medical conditions as well as the management of those conditions.

Definitions: types of organizations

ACO: An accountable care organization (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

CCO: A Coordinated Care Organization (CCO) is a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid).

MCO: A managed care organization (MCO) is a health care provider or a group or organization of medical service providers who offers managed care health plans. It is a health organization that contracts with insurers or self-insured employers and finances and delivers health care using a specific provider network and specific services and products.

ALSO: Independent Physician Associations, Patient-Centered Medical Homes, etc.

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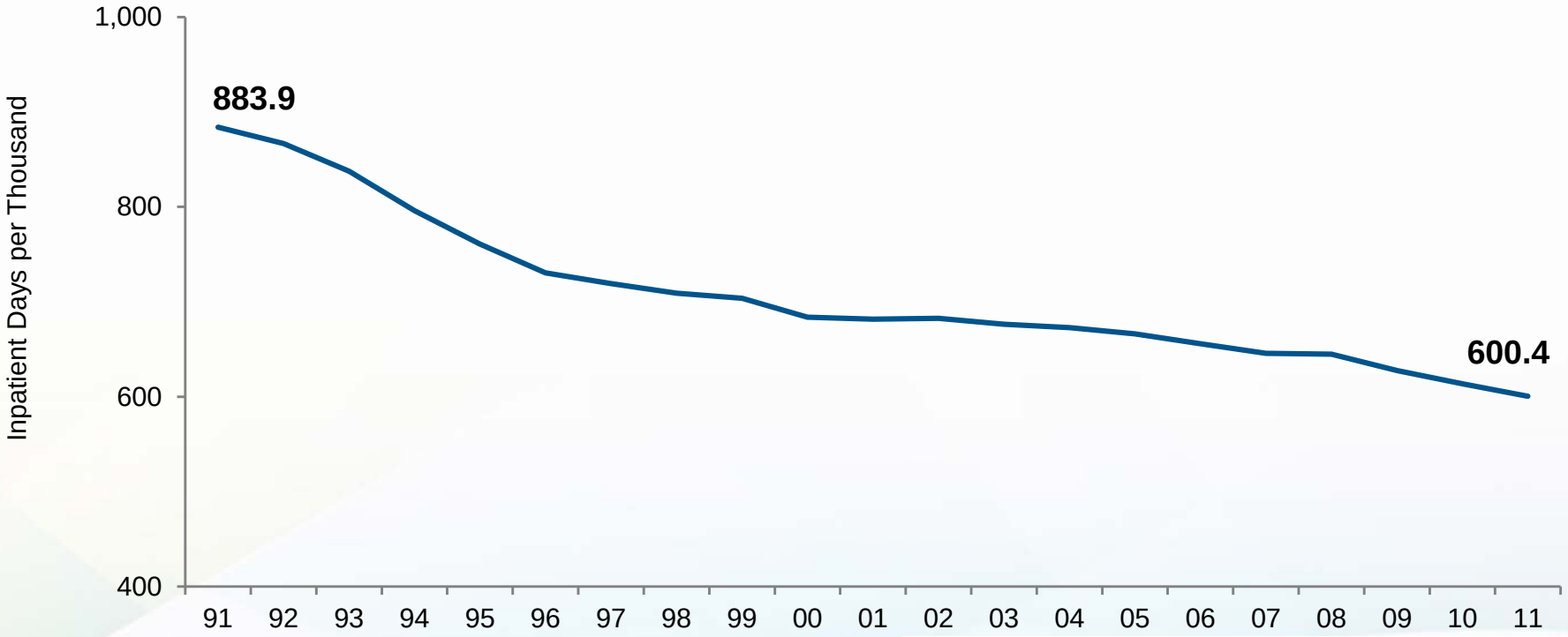
Volume to value

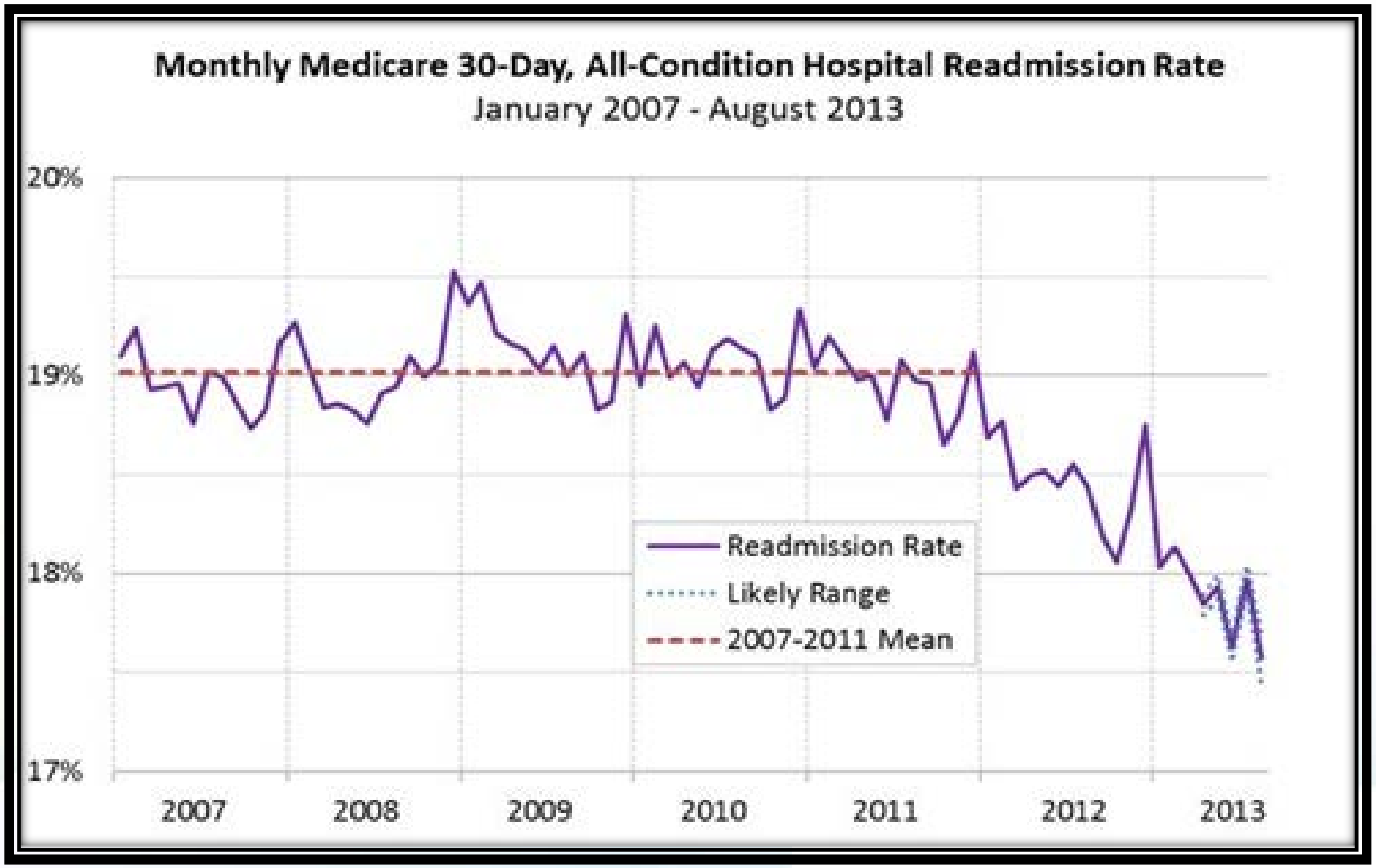
Hospital trends: lower inpatient use

Inpatient Days per 1,000 Persons, 1991 – 2011



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals. US Census Bureau: National and State Population Estimates, July 1, 2011.
Link: http://www.census.gov/popest/data/state/totals/2011/index.html.

Reduced readmission rates

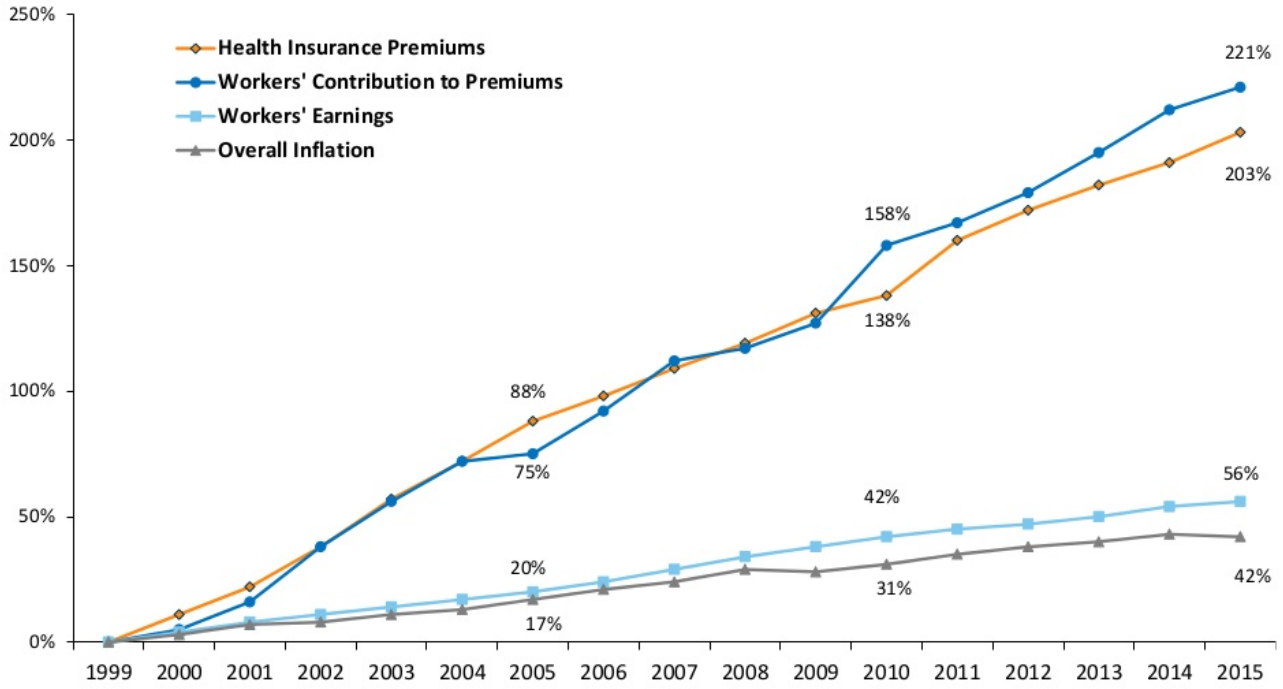


CMS: 2,610 PPS hospitals to receive penalties in 2015

Source: Centers for Medicare and Medicaid Services, Offices of Enterprise Management

Employer health insurance

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).

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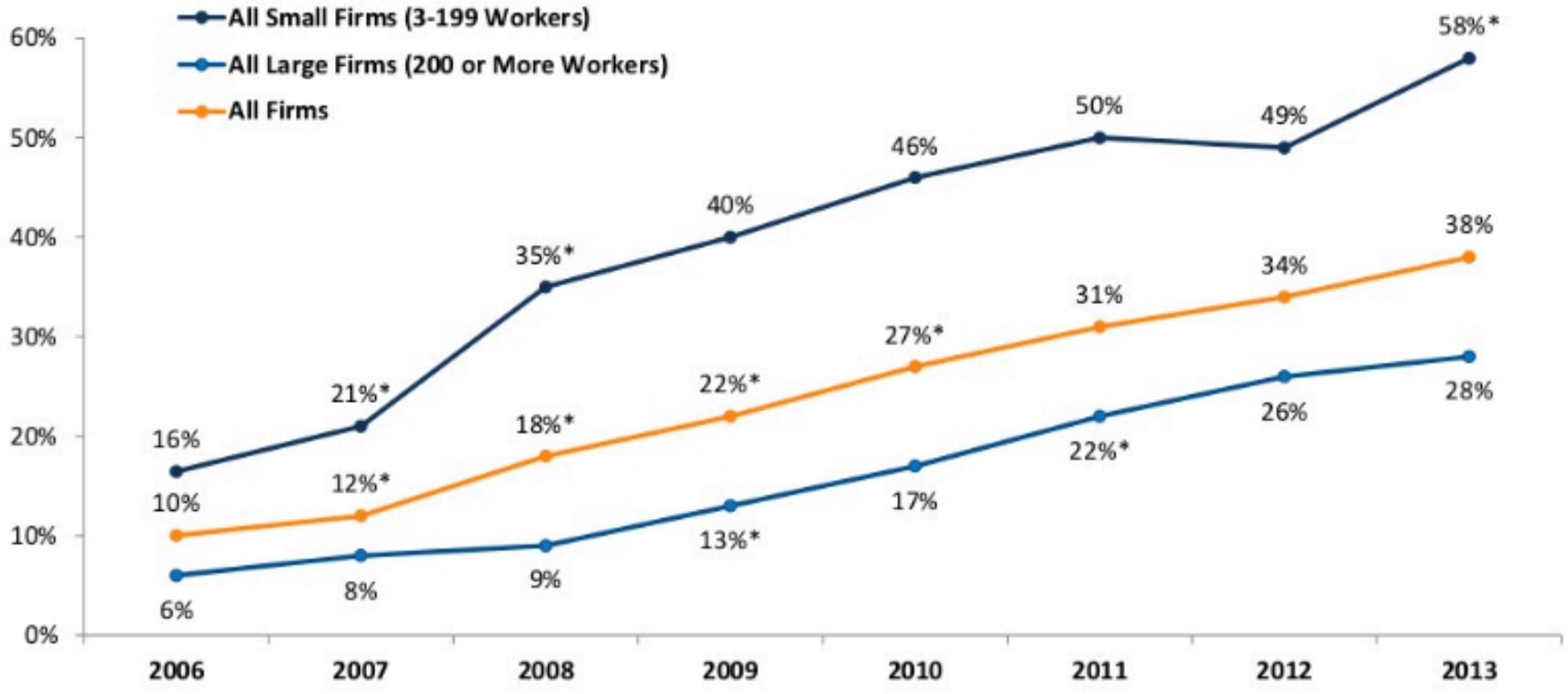
Growth in high deductible plans

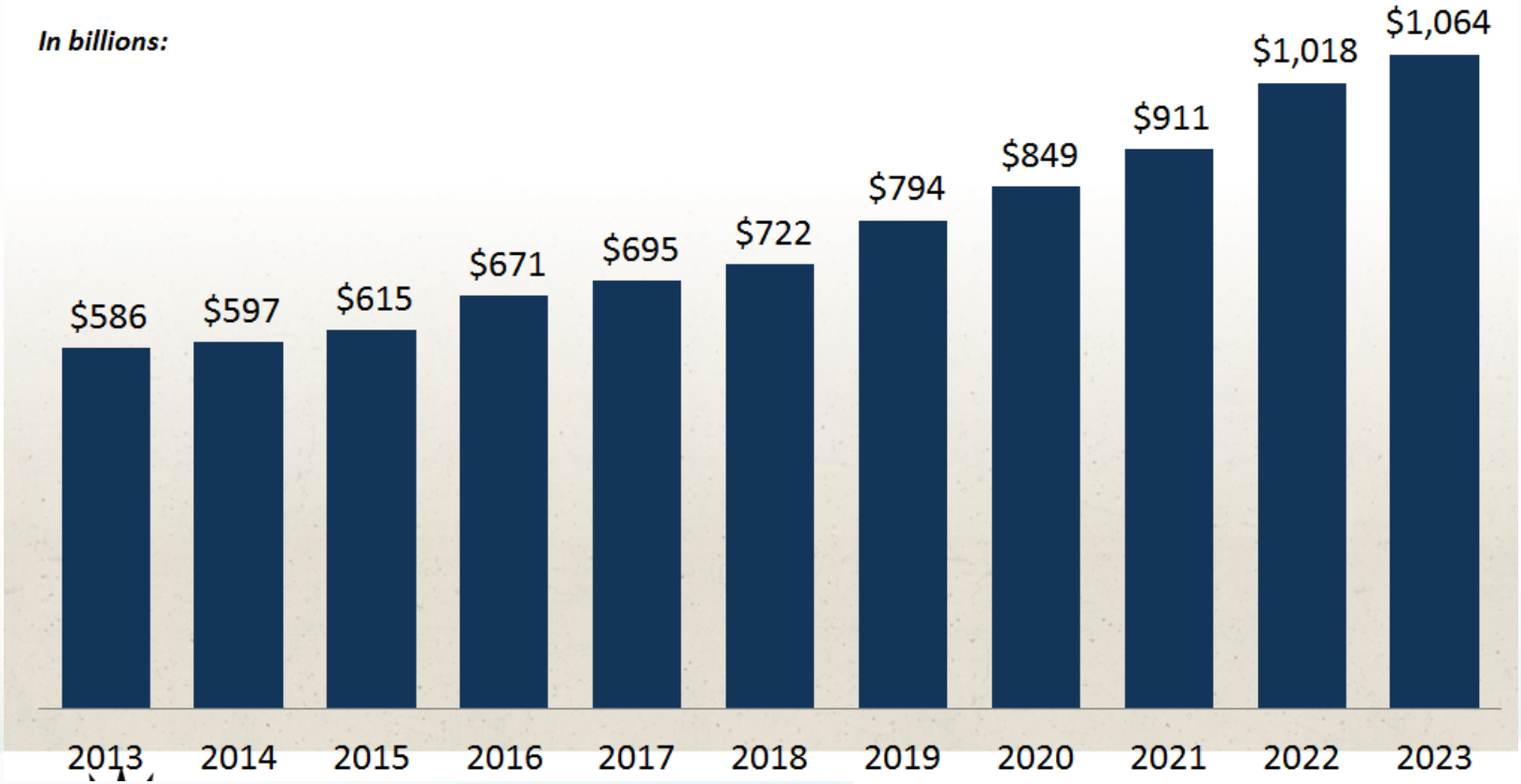


* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2013.

Projected Medicare Spending, 2013-2023



SOURCE: Congressional Budget Office (CBO) Medicare Baseline, May 2013.

Medicare payment policies

Enacted Cuts as a Percent of Total FFS Medicare Revenue 15 year summary value	-10.0%

Cuts Enacted (2010-2024): Legislative	
ACA Marketbasket Cuts	($266,013,300)
Sequestration	(93,961,800)
Medicare DSH Cuts	(79,844,200)
Quality	(6,743,300)
ATRA Coding	(9,932,500)
Bad Debt at 65%	(2,180,700)
Total Legislative Cuts	**($458,675,800)**

Cuts Enacted (2010-2024): Regulatory	
Coding Cuts	($127,744,400)
2-Midnight Offset	(4,769,600)
Total Regulatory Cuts	**($132,514,000)**
Total Cuts Enacted	**($591,189,800)**

Cuts Under Consideration (2015-2024)	
Rural Cuts	($228,923,000)
OPD Cuts	(46,733,800)
IME/DGME Cuts	(14,218,200)
Bad Debt Elimination	(10,567,500)
CMS Coding Cut	(9,821,600)
Post Acute Cuts	(9,500,700)
Total Cuts Under Consideration	**($319,764,800)**

These cuts will cost Alaska hospitals $591 million over 15 years.

Cuts under consideration could reduce revenue by an additional $320 million if enacted. (This does not include recent reductions proposed in the President's budget.)

15-Year Medicare Cut Analysis, DataGen, February 2015.

Medicare delivery system changes

News

FOR IMMEDIATE RELEASE
January 26, 2015

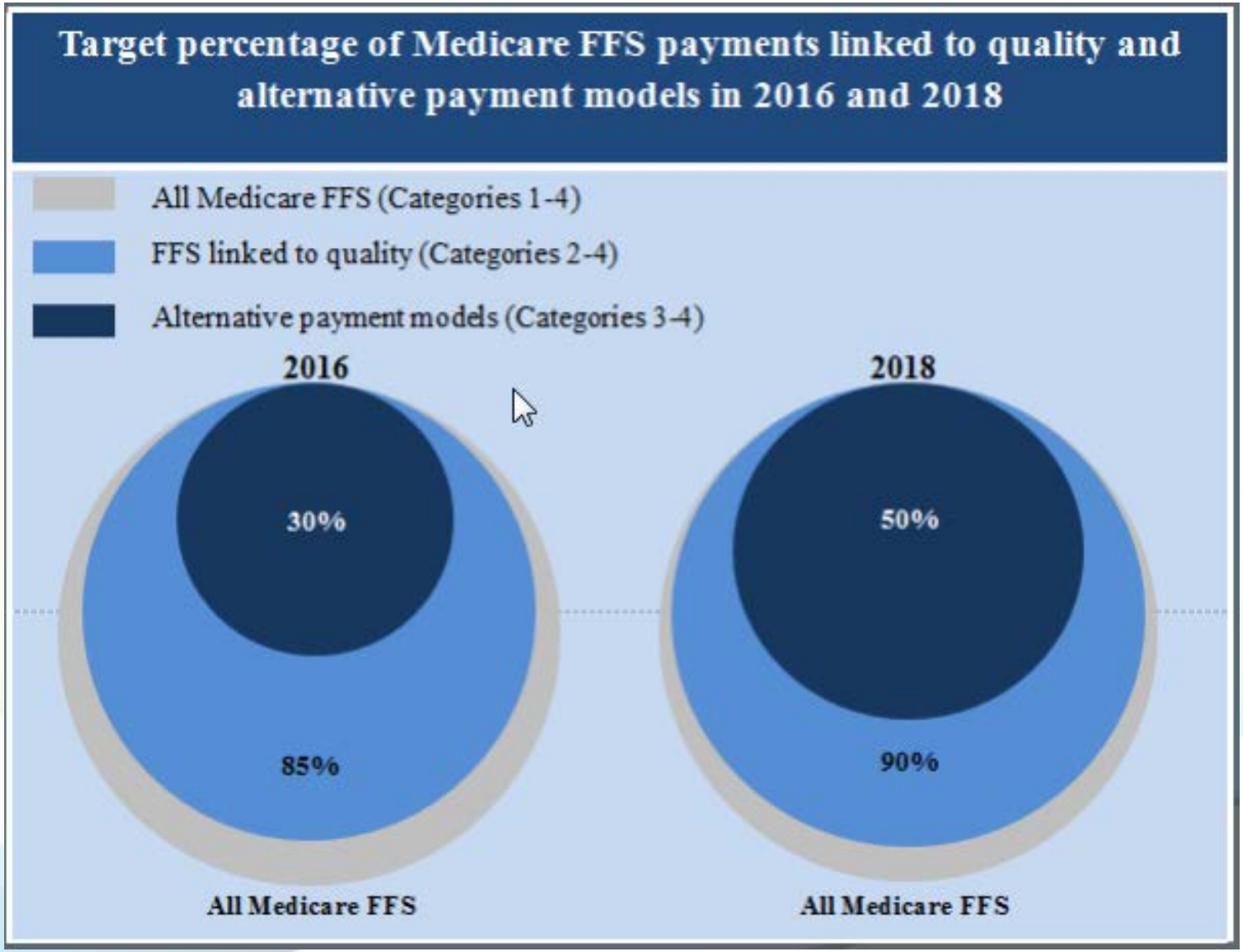
Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

Shrinking of Traditional Payment

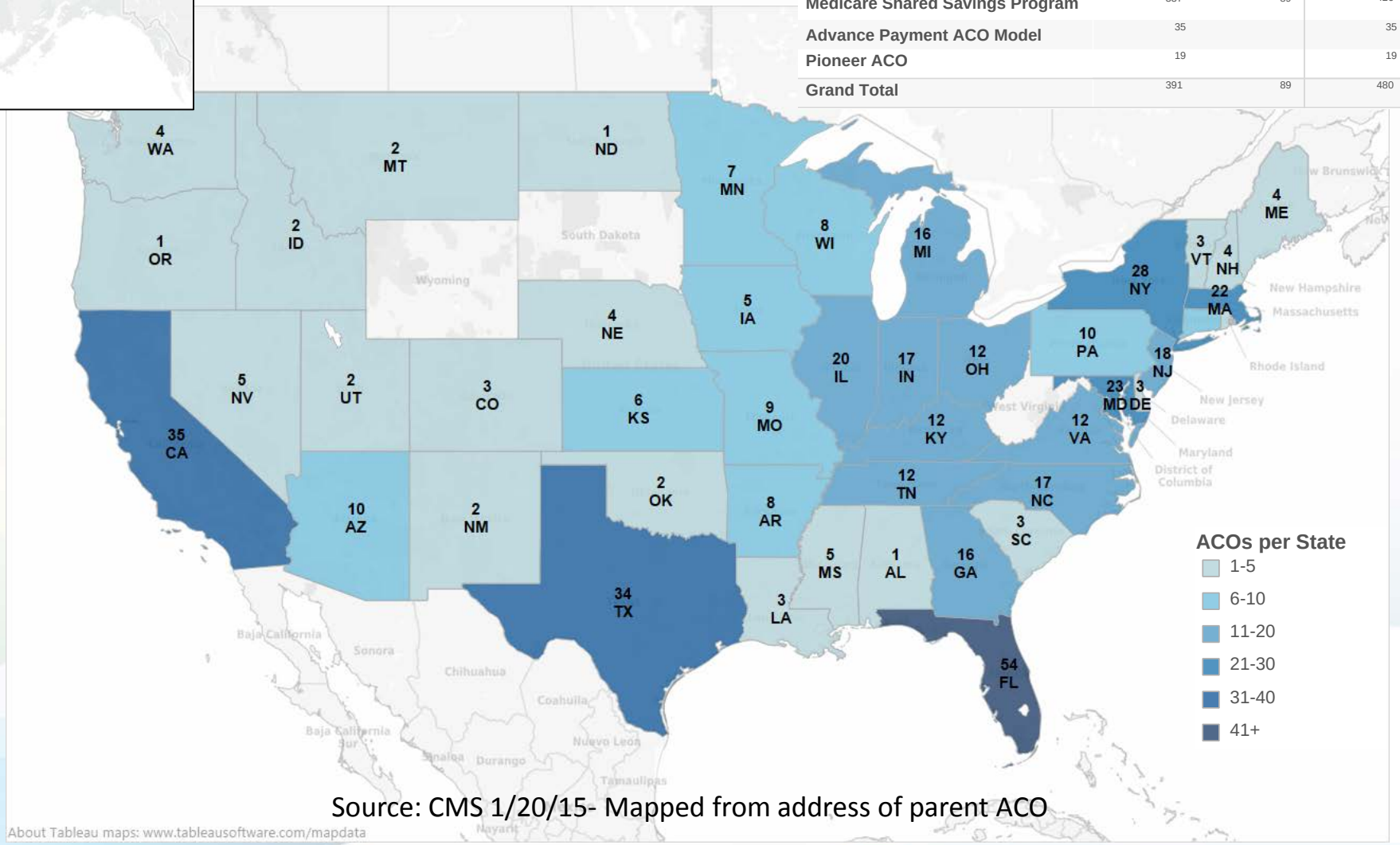


Move to Population-based Payment

	Payment Taxonomy Framework			
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

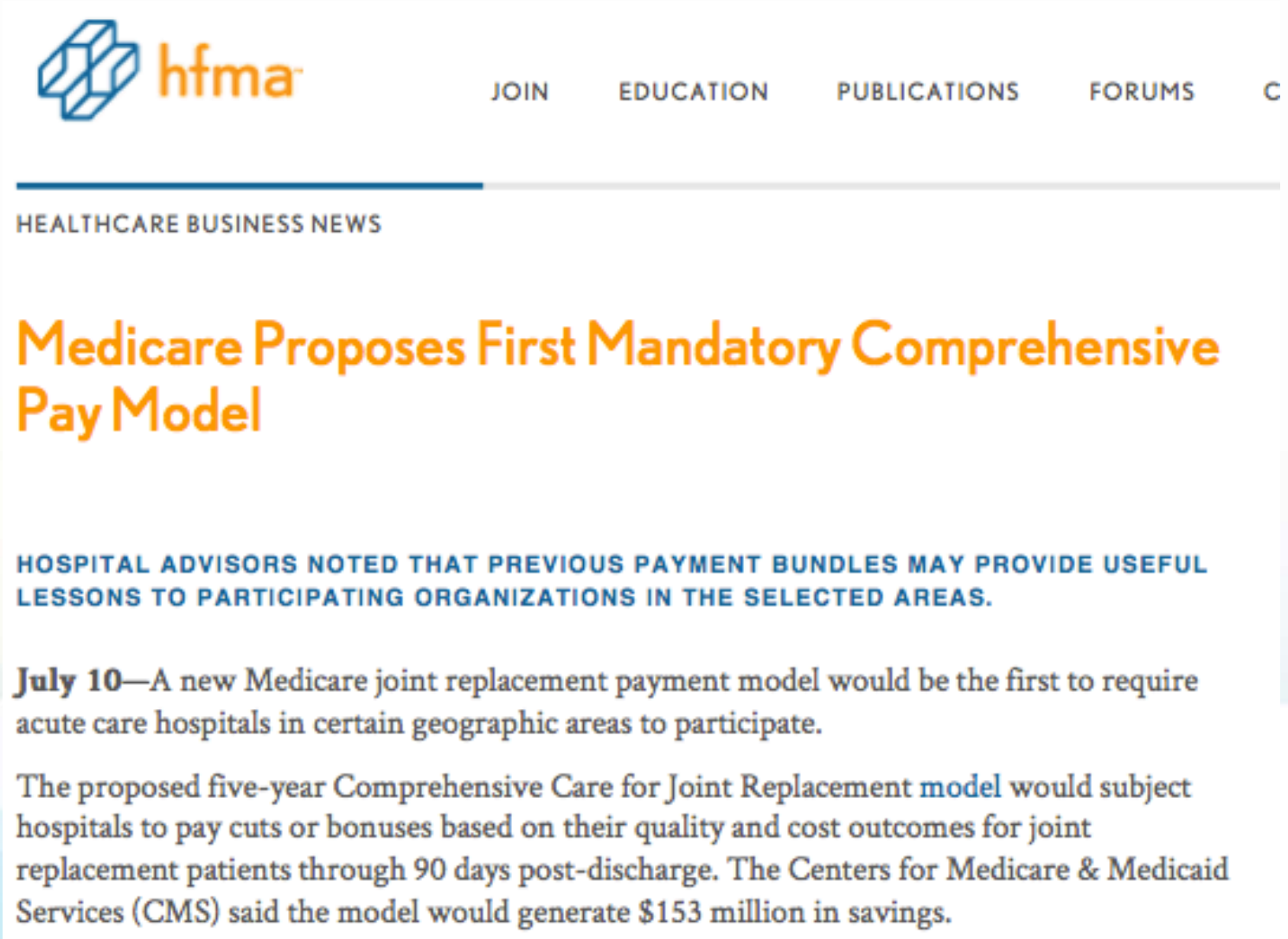
Accountable Care Organizations

Type	Existing	New 2015	Grand Total
Medicare Shared Savings Program	337	89	426
Advance Payment ACO Model	35		35
Pioneer ACO	19		19
Grand Total	391	89	480



Source: CMS 1/20/15- Mapped from address of parent ACO

Joint replacement comprehensive pay model



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HEALTHCARE BUSINESS NEWS

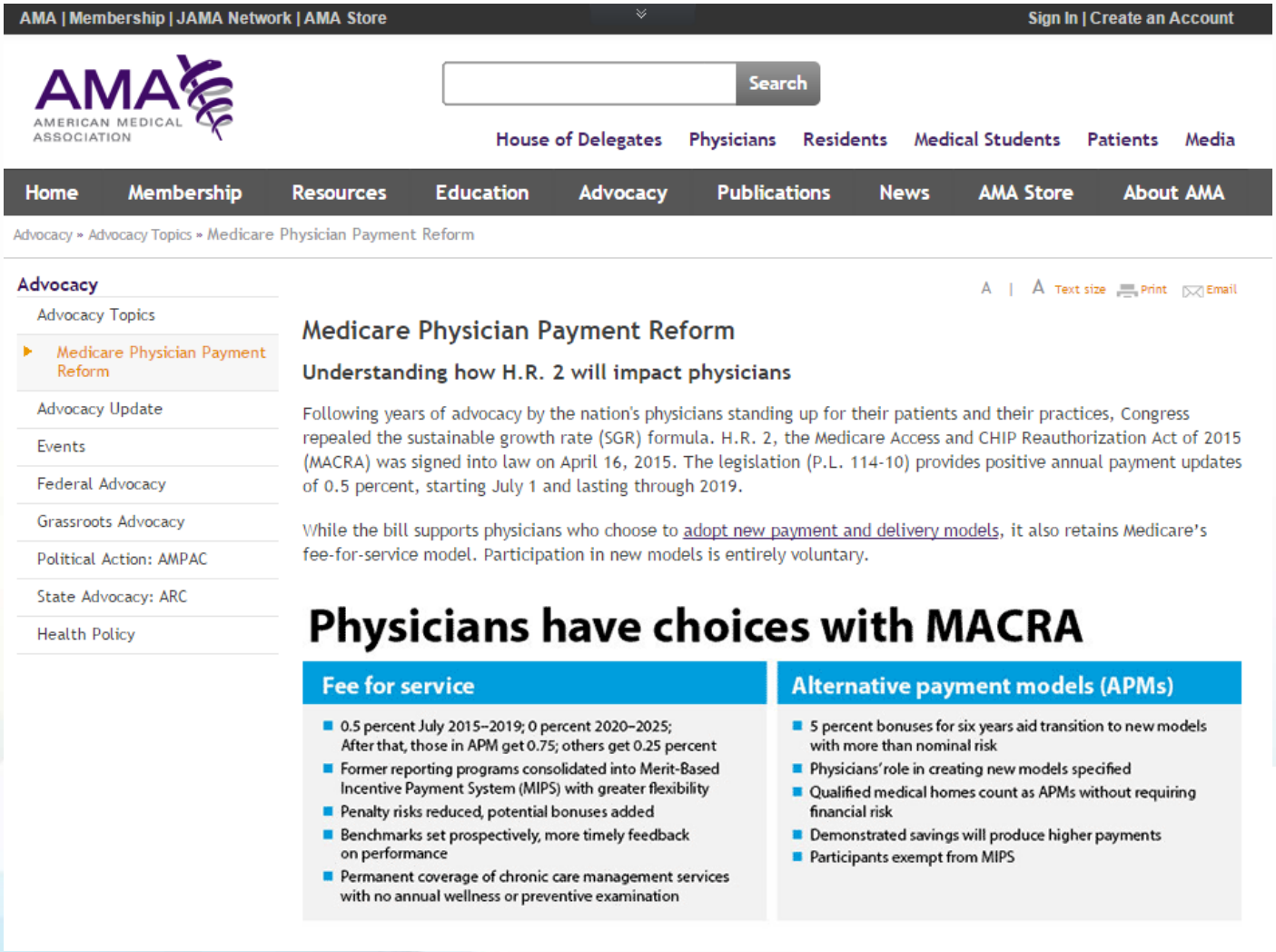
Medicare Proposes First Mandatory Comprehensive Pay Model

HOSPITAL ADVISORS NOTED THAT PREVIOUS PAYMENT BUNDLES MAY PROVIDE USEFUL LESSONS TO PARTICIPATING ORGANIZATIONS IN THE SELECTED AREAS.

July 10—A new Medicare joint replacement payment model would be the first to require acute care hospitals in certain geographic areas to participate.

The proposed five-year Comprehensive Care for Joint Replacement model would subject hospitals to pay cuts or bonuses based on their quality and cost outcomes for joint replacement patients through 90 days post-discharge. The Centers for Medicare & Medicaid Services (CMS) said the model would generate $153 million in savings.

SGR out, MACRA in



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Medicare Physician Payment Reform

Understanding how H.R. 2 will impact physicians

Following years of advocacy by the nation's physicians standing up for their patients and their practices, Congress repealed the sustainable growth rate (SGR) formula. H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015. The legislation (P.L. 114-10) provides positive annual payment updates of 0.5 percent, starting July 1 and lasting through 2019.

While the bill supports physicians who choose to adopt new payment and delivery models, it also retains Medicare's fee-for-service model. Participation in new models is entirely voluntary.

Physicians have choices with MACRA

Fee for service

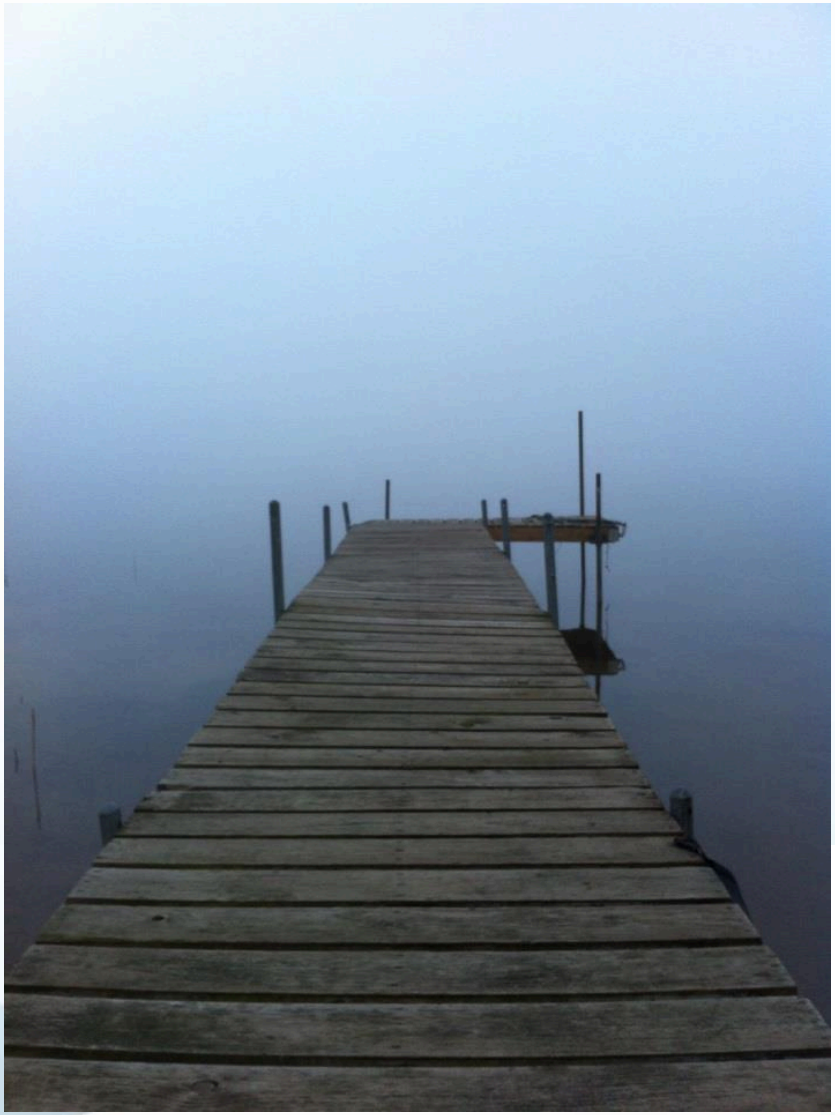
- 0.5 percent July 2015–2019; 0 percent 2020–2025; After that, those in APM get 0.75; others get 0.25 percent
- Former reporting programs consolidated into Merit-Based Incentive Payment System (MIPS) with greater flexibility
- Penalty risks reduced, potential bonuses added
- Benchmarks set prospectively, more timely feedback on performance
- Permanent coverage of chronic care management services with no annual wellness or preventive examination

Alternative payment models (APMs)

- 5 percent bonuses for six years aid transition to new models with more than nominal risk
- Physicians' role in creating new models specified
- Qualified medical homes count as APMs without requiring financial risk
- Demonstrated savings will produce higher payments
- Participants exempt from MIPS

Volume to value: implications for the market

Volume to value: implications for us



Thank you.
Questions?