The Transition to Value-Based Reimbursement: Past, Present, & President Trump

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Chris Emper, JD, MBA, is the founder and President of Emper Healthcare Advisors, a government affairs and healthcare consulting firm in Washington, D.C. that specializes in helping healthcare providers and technology companies successfully navigate complex regulations and new value-based reimbursement models. Prior to forming Emper Healthcare Advisors in 2016, Chris was Vice President of Government Affairs at NextGen Healthcare and Chair of the Electronic Health Record Association (EHRA) Public Policy committee.

An expert in The Patient Protection and Affordable Care Act (ACA or Obamacare) and The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Chris is a frequent speaker at industry conferences and has written or appeared in articles in publications such as Politico, Health Data Management, Accountable Care News, and Medical Economics. Chris also currently serves as Chair of the HIMSS Government Relations Roundtable, a leading coalition of health IT government affairs professionals.

Prior to joining NextGen Healthcare in 2013, Chris served as a Domestic Policy Advisor for former Massachusetts Governor Mitt Romney’s 2012 Presidential Campaign, where he advised the campaign on policy issues including healthcare, technology, and innovation. He holds a law degree and an MBA from Villanova University and a BA from Boston College.
Agenda

• Value-Based Reimbursement
  • Past
  • Present
  • President Trump

• Questions
The Transition to Value-Based Reimbursement
From Volume to Value...

**Fee-for-Service (FFS)**
- Payment is triggered by service delivery with no link to quality or efficiency

**Fee-for-Value (FFV)**
- Payment is not triggered by service delivery; payment will be population or condition based, tied to quality
Obama Administration’s Roadmap for Payment Reform

Fee-for-Service (FFS)
- Payment is triggered by service delivery with no link to quality or efficiency

Fee-for-Service linked to Value
- Payment is triggered by service delivery but 5-10% of payment depends on quality or cost

Alternative Value-Based Payment Models
- Payment is still triggered by service delivery, but varies based on managing a population or an episode of care

Fee-for-Value (FFV)
- Payment is not triggered by service delivery; payment will be population or condition based, tied to quality

In January 2015, the Department of Health and Human Services announced goals for value-based payments and APMs in Medicare...
Framework finalized in January 2016

Public & private sector payer & provider collaboration

HCP LAN workgroups have published subsequent white papers on specific APMs

In January 2016, a broad coalition of public & private sector stakeholders announced this framework would extend beyond Medicare to commercial payers...
### Linking Medicare FFS Payments to Value

1. **EHR Adoption (MU)**
2. **Quality Reporting (PQRS)**
3. **Quality Performance (VBM)**

These programs use the carrot/stick or incentive/penalty approach...

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Payment Year</th>
<th>MU Penalty</th>
<th>PQRS Penalty</th>
<th>VBM Penalty</th>
<th>Total Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
<td>1-2%*</td>
<td>1.5%</td>
<td>1%**</td>
<td>3.5-4.5%</td>
</tr>
<tr>
<td>2014</td>
<td>2016</td>
<td>2%</td>
<td>2%</td>
<td>2%**</td>
<td>6%</td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
<td>3%</td>
<td>2%</td>
<td>4%**</td>
<td>9%</td>
</tr>
<tr>
<td>2016</td>
<td>2018</td>
<td>4%</td>
<td>2%</td>
<td>4%**</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Notes and exceptions**

*The 2015 MU penalty will be 2% for EPs who were subject to 2014 e-Rx payment adjustment. Also, EPs who demonstrate MU for the first time in 2014 will avoid both the 2015 and 2016 MU penalties; **The 2015 VBM penalty will only apply to physicians in group practices of 100 or more; the 2016 VBM penalty will only apply to physicians in group practices of 10 or more; the 2017 VBM penalty will apply to ALL physicians but the penalty for physicians in practices with less than 10 physicians will be 2%.

- **Similar programs for Medicare Part A have linked hospital payments to value**

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# CMS’ Portfolio of Alternative Payment Models

## Center for Medicare & Medicaid Innovation (CMMI) : Identify, Test, Evaluate, Scale...

### Accountable Care Organizations (ACOs)
- Pioneer ACO Model
- Next Generation ACO Model
- Medicare Shared Savings Program
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

### Primary Care Transformation
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice Demo
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration
- Medicare Care Choices Model

### Episode Based Payment Initiatives
- Bundled Payment for Care Improvement Models 1-4
- Oncology Care Model
- Comprehensive Care for Joint Replacement Model

### Initiatives Focused on Medicaid
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative
- Medicaid Innovation Accelerator Program

### Dual Eligible (Medicaid-Medicare Enrollees)
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

## Goals for Shifting Medicare Payments into APMs

- **2015**: 20%
- **2016**: 30%
- **2018**: 50%

## CMS Finalizes Mandatory Hip and Knee Bundling Program

- November, 2015
Then came 95, 962, 2171 pages of MACRA...

**MACRA = The Medicare Access & CHIP Reauthorization Act of 2015**

- Became law in 2015 with the bipartisan support of over 90% of lawmakers in both political parties
- Supported by every major healthcare industry stakeholder, interest, and advocacy group
- Repealed the unsustainable SGR payment formula that since 1997 had dictated annual Medicare FFS payment rates for physicians and replaced it with MIPS & APM value-based payment tracks
MACRA’s Quality Payment Program: MIPS & APM Tracks

- **Fee-for-Service (FFS)**
  - Payment is triggered by service delivery with no link to quality or efficiency

- **Fee-for-Service linked to Value**
  - Payment is triggered by service delivery but 5-10% of payment depends on quality or cost

- **Alternative Value-Based Payment Models**
  - Payment is still triggered by service delivery, but varies based on managing a population or an episode of care

- **Fee-for-Value (FFV)**
  - Payment is not triggered by service delivery; payment will be population or condition based, tied to quality
Merit Based Incentive Payment System (MIPS)

• Sunsets MU, PQRS, and VBM penalties after 2018
  • 2018 payment will be based on program performance in 2016

• Consolidates programs into MIPS to assess physicians in four categories:
  • Quality (60%)*
  • Cost (0%)*
  • Advancing care information/MU (25%)**
  • Improvement activities (15%)**

• Scores of 0-100 will be assigned and compared against a benchmark:
  • Scores below the benchmark will receive a negative adjustment
  • Scores above the benchmark will receive a positive adjustment
  • Adjustments will be budget neutral so the “losers” will pay the “winners”

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Payment Year</th>
<th>Maximum Negative Adjustment</th>
<th>Maximum Positive Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2019</td>
<td>-4%</td>
<td>+12%</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
<td>-5%</td>
<td>+15%</td>
</tr>
<tr>
<td>2019</td>
<td>2021</td>
<td>-7%</td>
<td>+21%</td>
</tr>
<tr>
<td>2020 +</td>
<td>2022 +</td>
<td>-9%</td>
<td>+27%</td>
</tr>
</tbody>
</table>

*Quality and cost will each be 30% by 2019
**Can be decreased to 15% if more than 75% of physicians meet MU

*Additional +10% adjustments are possible with $500 million annual pool of incentive money
MACRA’s Alternative Payment Model Incentives

Earning MACRA APM Incentives is a Two-Step Process:
1. APM must meet definition of “advanced” and
2. Participants must “qualify” by meeting revenue or patient threshold

Financial Rewards:
- Exclusion from MIPS adjustments
- 5% lump sum bonus for the 2019-2024 payment periods
- Higher annual fee schedule updates in 2026: 0.75% vs 0.25%
- Any APM specific performance rewards (shared savings, etc.)
MACRA’s Overall Impact:

CMS Proposed Rule Estimated Impact of 2017 MIPS

<table>
<thead>
<tr>
<th>All clinicians</th>
<th>Negative Adjustment</th>
<th>Positive Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46%</td>
<td>54%</td>
</tr>
</tbody>
</table>

"The passage of MACRA is responsible for an additional 37 million ACO-covered lives." -Leavitt Partners

MACRA’s Projected Impact on ACO Growth

"MIPS winners vs losers & APM growth!"
Medicaid Managed Care Reforms

• More than 70% of Medicaid is provided through managed care
  • Only 8 percent of Medicaid was in 1992
  • Medicaid managed care regulations were last updated in 2003

• This regulation supports states’ efforts to encourage delivery system reform initiatives within managed care programs
  • Would require a quality strategy for a state’s entire Medicaid program

• Establishes a Medicaid managed care quality rating system that would include performance information on all plans
  • Intended to align with the existing rating systems in Medicare Advantage and the Exchange Marketplace

• May 2016 final rule follows June 2015 proposed rule & extended CMS review
Commercial Payer Activity

Aetna Buys Humana in $37 Billion Deal In Latest Health Care Merger

20 health systems, insurers agree to make 75% of contracts value-based

Anthem to Buy Cigna Amid Wave of Insurance Mergers
The Transition to Value-Based Reimbursement

PRESENT
The Transition to Value-Based Reimbursement

PRESIDENT TRUMP
Remember when in 2009 & 2010?

- President Obama takes office with Democratic House & 59 Senate votes
- Senator Arlen Specter (R, PA) switches parties to give Democrats 60 Senate votes
- Senator Ted Kennedy (D, MA) passes away
- Senates passes healthcare bill on Christmas Eve 2009 with exactly 60 votes
- Scott Brown (R, MA) wins special election to give Republicans 41 Senate votes
- House passes Senate bill and uses budget reconciliation to pass final PPACA bill
- U.S. Supreme Court upholds legality of individual mandate as a tax, but strikes down Medicaid expansion as unconstitutional
- Healthcare.gov insurance marketplace gets off to a disastrous start but rebounds
The American Health Care Act
(aka House GOP bill to repeal & replace Obamacare)

• Introduced in U.S. House of Representatives Monday, March 6
• Highly controversial and political legislation
• Most industry trade associations and interest groups have publicly opposed the bill
• Supported by President Trump and House & Senate GOP leadership
• House leadership wants to vote on the bill ASAP, but is getting strong pushback from both the left and right wings of the party
• Budget reconciliation only requires 51 Senate votes but also limits the bill to include only budgetary provisions so full repeal is not possible through reconciliation

Please note: Information subject to change; current as of 3/15/17.

Summary of Major Provisions

✓ Repeals most ACA taxes and individual & employer mandates/penalties
✓ Retains popular ACA provisions such as pre-existing conditions, adult children, and no lifetime limit regulations
✓ Creates a refundable tax credit for premiums for those not eligible for employer or gov’t sponsored insurance
✓ Creates a $100 billion “Patient and State Stability Fund” for high-risk individuals and state reforms
✓ Would eliminate ACA’s Medicaid expansion in 2020 and transition program to a per-capita state block grant

Summary of 10-Year CBO Score

✓ In 2018, 14 million fewer individuals would be insured and by 2026 that number would grow to 24 million
✓ Premiums in individual market would be higher in 2018 and 2019 and then lower starting in 2020 (10% lower in 2026)
✓ Reduces deficit by $337 billion ($1.2 trillion spending reduction and $0.9 trillion tax revenue reduction)
There are three phases of this plan…One is the bill that was introduced last evening in the House of Representatives…Second are all the regulatory modifications and changes that can be put into place…And then there’s other legislation that will need to be addressed that can't be done through the reconciliation process.”

“The goal of all of this is patient-centered health care, where patients and families and doctors are making medical decisions and not the federal government.”

—HHS Secretary Tom Price, March 7

1. Reconciliation legislation (*The American Health Care Act*)

2. Administrative action

3. Other legislation
Let’s now take a step back to consider the proper context…
“The plan I’m announcing tonight would meet three basic goals:

• It will provide more security and stability to those who have health insurance.

• It will provide insurance to those who don’t.

• And it will slow the growth of health care costs for our families, our businesses, and our government.

It’s a plan that asks everyone to take responsibility for meeting this challenge – not just government and insurance companies, but employers and individuals.”

- President Obama, September 9, 2009

Americans Again Cite Cost and Access as Top Health Issues

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President Trump’s Healthcare Agenda: Repeal & Replace Obamacare

Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal

“It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended (the "Act").

- President Trump, January 20, 2017

“This isn’t a return to the pre-Obamacare status quo. And it isn’t just an attempt to replace Obamacare and leave it at that. This is a new approach. It’s a step-by-step plan to give every American access to quality, affordable health care.”

- House GOP Healthcare Reform Plan, June 2016

Americans Again Cite Cost and Access as Top Health Issues

| HITECH | ? | ? |
| ObamaCare | 2017 | 2018 |
| MACRA | | 2019 |
| Cures | | 2020 |

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Goal # 1- Expand Access to Care

**ObamaCare vs TrumpCare**

- **U.S. HEALTH INSURANCE COVERAGE**
  - Employer: 50%
  - Medicare: 14%
  - Medicaid: 20%
  - Individual: 7%
  - Uninsured: 9%

- **Major differences exist between the two plans in this area**
Bipartisan reforms started under Obama are likely to continue under Trump...

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

- Supported by over 90% of lawmakers in 2015
- Repealed Medicare’s SGR formula, avoiding a 21% cut in 2015 Medicare reimbursements
- Merit Based Incentive Payment System (MIPS)
  - Quality, Cost, Advancing Care Information, Improvement Activities
- Alternative Payment Models (APMs)
  - ACOs
  - Episode based payment models
  - Medical homes

- Fewer regulations could slow the pace of this transition, but...

HHS Secretary Dr. Tom Price

- Repeal and replace Obamacare
- Reduce regulatory burden
…FFS reimbursement rates were flat before MACRA…

*Code Relative Value Unit (RVU) x Geographic Adjustment x Conversion Factor = Code $ Reimbursement*
…MACRA continues this trend for the next decade…

*Code Relative Value Unit (RVU) x Geographic Adjustment x Conversion Factor = Code $ Reimbursement*
MACRA’s *Real* Impact = Declining FFS Reimbursement Rates

*Code Relative Value Unit (RVU) x Geographic Adjustment x Conversion Factor = Code $ Reimbursement

✓ **Repealing MACRA = ~20% FFS Rate Cut!**
Evolution of Value-Based Reimbursement under ObamaCare

Fewer Dollars, More Risk...

Financial Risk for Cost & Quality

Regulatory Flexibility

Shared Savings

Shared Savings & Losses

Partial Capitation

Full Capitation
Evolution of Value-Based Reimbursement under TrumpCare

"Fewer Dollars, More Risk..."

Financial Risk for Cost & Quality vs. Regulatory Flexibility

Full Capitation
Transparency & insurance market reforms will enable more consumer choice

- CMS is creating a star rating system (1-5) for Medicare physicians
- MIPS scores of 0-100 will be published on the Physician Compare website
Summary

• The transition to value-based reimbursement will continue under President Trump

• “Value-adjusted FFS” with *real* declining reimbursement rates is the new baseline

• ACOs, medical homes, and bundled payments will remain “optional” but will increasingly look more attractive in comparison to value-adjusted FFS

• Expanding consumer choice through insurance market reforms will incentivize patients to act as consumers for quality and cost efficient care

• President Trump’s healthcare policy agenda will not be limited by the initial reconciliation legislation, so stay tuned!
Questions?

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Thank You!

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