How to Participate Today

*Click here* to expand or collapse the control panel.

*Click here* to type and send questions for us to address.
Today’s Presenters

**Craig Tolbert**  
Principal, DHG Healthcare  
• Works in the DHG Alternative Payment Model team with navigating new payment and delivery structures such as CMS’s Bundled Payments for Care Improvement demonstration and ACO initiatives  
• 22 years of experience in the healthcare industry  
• He provides strategic and analytic support to a broad array of clients including hospitals and post-acute providers in both current and future care delivery and payment reform environments

**Robert Kiskaddon, MD**  
Chief Medical Officer, DHG Healthcare  
• Helps to bridge the various gaps between clinical and non-clinical stakeholders and bringing common focus to the significant issues challenging medical practitioners and healthcare organizations  
• Brings over 20 years of clinical medical practice experience and over 30 years of combined healthcare administrative and medical staff leadership  
• He is a recognized expert in multidisciplinary collaboration, team building and communication

**Doral Davis-Jacobsen**  
Senior Manager, DHG Healthcare  
• Leads clients through next generation managed care contracting, operations assessment, revenue cycle assessments, physician-hospital integration, financial analysis and operations management  
• More than 20 years of healthcare experience in managerial consulting  
• Regularly assists ACOs/CINs, medical practices and hospital systems in navigating current payment reform environment and preparing for the future.
1. Healthcare Reform: How we got there
2. Alternative Payment Model Framework
3. Advanced APMs
4. Revenue Portfolio Design
5. Summary – APM Readiness
Healthcare Reform: How we got there
Institute of Medicine - 1999

TO ERR IS HUMAN:
BUILDING A SAFER HEALTH SYSTEM

Introduction

Health care in the United States is no as safe as it should be, and can be. At least 44,000 people, and perhaps as many as 98,000 people, die each year as a result of preventable errors in medical care. Even though the causes of these deaths are well understood, rigorous studies show that the problems can be avoided.

Medical errors can be described as the single most common cause of death in the United States. Among the leading causes of death, medical errors cause as many deaths as suicide, breast cancer, and prostate cancer combined.

To err is human. We all make mistakes, but the effects of these mistakes can be catastrophic. Medical errors can lead to permanent disability, lost productivity, and even death. In fact, medical errors are the third leading cause of death in the United States, after heart disease and cancer.

The Institute of Medicine (IOM) has been working to improve health care safety for many years. In 1999, the IOM released a report titled "To Err Is Human: Building a Safer Health System.

This report examined the causes of medical errors and proposed strategies to prevent them. The IOM recommended changes in the culture of health care, such as improving communication between patients and providers, and increasing the use of standardized care processes.

The report also highlighted the importance of patient safety and the need for more research into the causes of medical errors. The IOM called for increased funding for patient safety research and the development of new technologies to improve health care safety.

In conclusion, the IOM report "To Err Is Human: Building a Safer Health System" is a landmark document that has helped to raise awareness about the importance of patient safety in health care. The report's recommendations have been adopted by many organizations and have helped to drive improvements in health care safety across the country.
Quality Programs

Efforts of Joint Commission and Medical Societies

Hospital Inpatient Quality Reporting Program

Hospital Compare

Premier Hospital Quality Incentive Demonstration

Physician Quality Reporting System

Physician Group Practice Demonstration

Physician Value-Based Payment Modifier

Physician Compare

Hospital Value-Based Purchasing
Healthcare Reform is Expanding and Evolving

Value-Based Purchasing Through the Years

Penalty:
- FY 2013: 1%
- FY 2014: 1.25%
- FY 2015: 1.5%
- FY 2016: 1.75%
- FY 2017: 2%

- Clinical Care
- Patient Experience
- Safety - Outcomes
- Efficiency [MSPB]
- Mortality
Healthcare Reform – “Triple Aim”

- Production (Volume)
- Performance (Value)
- Population Health
- Lower per Capita Cost
- Improved Patient Care
Medicare Access & CHIP Reauthorization Act

- Replaces the Sustainable Growth Rate (SGR)
- Establishes the new Quality Payment Program
- Determines physician fee schedule increases
- Replaces existing programs:
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VM) program
  - Meaningful Use (MU)
  - ePrescribe
- Committee for Physician Focused Payment Model proposals

Proposed rule open for comment until June 27, 2016
In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

In 2018, at least 50% of U.S. health care payments are so linked.

These payment reforms are expected to demonstrate better outcomes and lower costs for patients.

Better Care, Smarter Spending, Healthier People
The Tipping Point at Altitude

1. Impact of Purchaser Pressure
2. When will our market tip?
3. How will you develop your Transformational Agility?

TIME

PROVIDER NET REVENUE

VALUE BASED PAYMENT

FEES FOR SERVICE
The Risk Capable Organization

Our clients share the common challenge of successfully navigating the unprecedented transition associated with the journey to higher quality at lower cost. The Risk Capable organization is proactively positioned to responsibly plan and confidently respond to the demands of that journey.
Alternative Payment Model Framework
The framework situates existing and potential APMs into a series of categories.

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
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<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td>APMs with Upside Gainsharing</td>
<td>Condition-Specific Population-Based Payment</td>
<td>Comprehensive Population-Based Payment</td>
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<td>Pay for Reporting</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
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<td>Rewards for Performance</td>
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<tr>
<td>Rewards and Penalties for Performance</td>
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</tbody>
</table>
Polling Question #1

1) What is the highest category of APM your organization is currently participating in?

A. Category 1
B. Category 2
C. Category 3
D. Category 4
E. N/A
Category 1

• Key Attributes
  – Professional and Facility services billed separately
  – Payment retrospective
  – Fee Schedules based on various methodologies & payer edit logic decreases reimbursements
  – Low Data Analytics Capabilities
  – No Integration necessary

• Fundamental Drivers
  – The more you do = the more you make
  – The more highly reimbursed the code = the better to bill
  – Quality not a consideration

Success Factors
  • Negotiate increases annually
  • Compare contracts using Medicare as a base
  • Ultimate leverage is market share
Category 2

• Key Attributes
  – FFS reimbursement architecture w/ added financial incentives tied to quality/efficiency metrics
  – Requires formalized process/investment by healthcare team to ensure quality metrics and cost efficiency measures are met
  – Minimal integration and data analytics capabilities necessary

• Fundamental Drivers
  – Financially incentivizes and rewards providers & healthcare team to target quality/efficiency metrics
  – Improves outcomes for given patient population
  – Potential for reduction in total medical expense

Success Factors
• Establish realistic goals & baseline quality/cost efficiency metrics being measured
• Understand the reporting/reconciliation process; what, when, who and how
• Recognize exposure for downside potential and/or withhold
• Requires investment in infrastructure that can improve quality of care
Category 3

• Key Attributes
  – FFS reimbursement architecture w/ added financial incentives and potential penalties tied to quality and efficiency
  – Performance measured compared to established ‘target’
  – Includes Bundle Payments (tied to procedures), Shared Savings/Risk
  – Requires higher degree of integration and collaboration across the care continuum and higher level of data analytics capabilities

• Fundamental Drivers
  – Improves outcomes for given patient population and minimizes ‘waste’
  – Encourages collaboration and establishes accountability between multiple providers – professional, ancillary and facility
  – Access to greater financial incentives and rewards providers for improving quality and lowering costs for a given population

Success Factors (all in Category 2 and...)
• Requires sustainable resources and more advanced infrastructure to achieve goals
• Must meet cost AND quality measures in order to access rewards
• Trust and collaboration between providers and payers critical
Category 4

• Key Attributes
  – Payment architecture reflects total cost of care for treating a primary (e.g., chronic) condition or managing an entire population
  – ‘Person Focused’ cover a wide range of services focused on preventive/maintenance
  – Requires the highest degree of integration and collaboration across the care continuum and highest level of data analytics capabilities

• Fundamental Drivers
  – Encourages providers to deliver well-coordinated, high quality person level care within a defined condition and/or population
  – Holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients

Success Factors (all in Category 2 & 3 and...)
• Necessitates virtual integration for some models or vertical integration for highly integrated models
• Requires most advance transformational thinking about delivery system reform
Polling Question #2

2) What is your organization’s biggest barrier to successful APM implementation?

a) Resources and data analytics
b) Vertical integration for population-based models
c) Collaboration across care continuum
d) Trust between providers and payers
e) N/A
Advanced APMs
Standards for Advanced APMs

Requires participants to bear a certain amount of financial risk:

- **Total Risk** – minimum 4% of APM spending target
- **Marginal Risk** – minimum 30% spending above APM target for which the Advanced APM Entity is responsible
- **Minimum Loss Rate** – maximum 4% of the amount by which spending can exceed the APM benchmark before the Advanced APM Entity has responsibility for losses

Base payments on quality measures comparable to those used in the MIPS quality performance category

Requires participants to use certified EHR technology

**2019 Advanced APM Menu:**
- Comprehensive Primary Care Plus (CPC+)
- MSSP Tracks 2 & 3
- Next Generation ACO
- Oncology Care Model Two-Sided Risk Arrangement (available 2018)
- Comprehensive ESRD Care Model
## Qualifying APM vs Partial Qualifying APM: Revenue Based or Patient Count

<table>
<thead>
<tr>
<th>Payment Amount</th>
<th>2019 to 2020</th>
<th>2021 to 2022</th>
<th>2023 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>QP % Payments</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
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<tr>
<td>Partial QP % Payments</td>
<td>20%</td>
<td>40%</td>
<td>50%</td>
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<tr>
<td>QP All Payer % Payments</td>
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<td>50%/*25%</td>
<td>75%/*25%</td>
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<tr>
<td>Partial QP All Payer % Payments</td>
<td>NA</td>
<td>40%/*20%</td>
<td>50%/*20%</td>
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</table>

* Medicare minimum

## Patient Amount

<table>
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<td>10%</td>
<td>25%</td>
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<tr>
<td>QP All Payer % Patients</td>
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<td>NA</td>
<td>25%/*10%</td>
<td>35%/*10%</td>
</tr>
</tbody>
</table>

Medicare Shared Savings Programs (MSSP tracks 2 & 3)

• Currently 433 MSSPs – 95% in track 1 and 5% in Tracks 2 & 3

• Shared Savings/Risk Model (two sided)

• Three Year Program

• Must have defined processes to:
  – Promote evidenced-based medicine
  – Promote patient engagement
  – Report quality and cost measures
  – Coordinate care
Oncology Care Model (OCM)

- New Model - each year over 1.6 million people are diagnosed with cancer, many are in Medicare
- Shared Savings/Risk Model
- Five Year Program begins in 2016
- Focus on episodes of care surrounding chemo administration patients
  - Covers Part A and B services and some Part D
  - Episode Length is 6 months
  - Multi Payer Program

http://innovation.cms.gov/initiatives/Oncology-Care/
Comprehensive ESRD Care Model (CEC)

- Currently 13 CECs participants - beneficiaries with ESRD 1.2% population, but total spend 6.3%
- Shared Savings/Risk Model
- Four Year Program next round 1/1/17
- ESRD Seamless Care Organizations (ESCOs)
  - Dialysis Centers
  - Nephrologists
  - Other Suppliers
  - Outcomes focused
  - 350 bene. ‘matched’ to the entity

https://innovation.cms.gov/initiatives/comprehensive-esrd-care/
Comprehensive Primary Care Plus (CPC+)

- New Model - builds upon Comprehensive Primary Care initiative (2012 - 7 Regions)
- P4P or Shared Savings/Risk Model
- Five Year Program starts 1/1/17
- Advanced Primary Care Medical Home Model
  - CPC + Region selection
    July 2016 (20 for CPC+)
  - Multi Payer
  - *Participants CAN include MSSP
  - HCC Risk Adjusted Payments

* Cap of 1,500 dual participants

https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
Next Generation ACO

- New Model - currently 18 Participants
- Advanced Shared Risk Model
- Three Year Program next round 1/1/17
  - Optional years 4 & 5
- Different from other MSSPs:
  - Applicants must demonstrate significant preparedness
  - Higher risk and rewards
  - Population Based Payments
  - More rigorous promotion of patient engagement
  - Enhanced collaboration with CMS
## APM Summary

<table>
<thead>
<tr>
<th>Payment Models</th>
<th>Provider Integration Necessary</th>
<th>Technology / Analytics Capabilities</th>
<th>Admin. Complexity</th>
<th>Care Management Capabilities</th>
<th>Provider Engagement Level</th>
<th>Advanced APM in QPP?</th>
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</thead>
<tbody>
<tr>
<td>Fee For Service</td>
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<td>MSSP Tracks 2 &amp; 3</td>
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<td>Global Payments</td>
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<td>High</td>
<td>High</td>
<td>High</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Polling Question #3

3) Is your organization prepared to participate in a 2019 Advanced APM?

a) Yes, highly prepared for multiple Advanced APMs
b) Maybe, early planning stage to prepare for Advanced APMs
c) No, we will not be participating in an Advanced APM
d) N/A
Revenue Portfolio Redesign
## What are you ready for?

### It Depends…

- Market?
- Providers?
- Gaps?
- Resources?
- Capital?
- Mission/Vision?
- Risk Tolerance?
- Culture?

<table>
<thead>
<tr>
<th>Risk Capability</th>
<th>Bundle Payments - BPCI, CJR</th>
<th>Shared Risk - Next Gen ACO</th>
<th>Your Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Integration</td>
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<tr>
<td>Technology/Analytics Capabilities</td>
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<td>Administrative Capabilities</td>
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<tr>
<td>Care Management Capabilities</td>
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<td>Medium</td>
</tr>
<tr>
<td>Provider Engagement</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>
Choosing the Best Path

OCM?      CEC Model?

Next Gen ACO?

Maximize MIPS?
P4P?

MSSP Track
1, 2 or 3?

Bundles?

Best Path for Us
Summary – APM Readiness

• More risk is coming: How will you choose to plan for it?
• The pace of improvement in quality metrics is critical
• You must plan at least 2 years ahead of the current year
• Accurate and complete Clinical Documentation has never been more important
• Planning and organizing across the continuum and across all payers are critical success factors
• Affiliations and partnerships, with payers and competitors must be re-evaluated and/or strengthened
Polling Question #4

4) What support does your organization need to prepare for APMs?

a) Targeted education for executive leadership

b) Current state assessment of APM opportunity

c) Enterprise wide financial analyses of APM implications

d) Playbook for implementation of APM strategy

e) All of the above
Audience Questions
Upcoming Webinars

IPPS Final Rule
June 16 at 12:00 PM EST

DESIGNING YOUR FUTURE STATE REVENUE PORTFOLIO WEBINAR SERIES

Session I:
Assessing Your Current State and Identifying Opportunities for Portfolio Design
June 22 at 1:00 PM EST

Session II:
A Strategic and Clinical Alignment--Leading Change
July 20 at 1:00 PM EST

Session III:
Designing the Optimal Revenue Portfolio Playbook and Implementation
August 10 at 1:00 PM EST
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