Global Center for Health Innovation
CLEVELAND, THE MEDICAL CAPITAL

Alternative Payment Models Impacting Care Delivery Across the Care Continuum

Contributing Tenant Partners

Cleveland Clinic

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AT A GLANCE

The recent announcement by HHS and CMS accelerates the movement away from FFS and provides greater clarity on the urgent pace of change that demands providers accept new institutional and market risk to perform against new reimbursement expectations. The continued emphasis on value-based reimbursement by the nation's largest payer requires providers to evaluate the future of care delivery models. It also requires considering long-term investment needs in infrastructure, reporting capabilities, education, and transformational leadership to meet the new expectations of patient-centered, high-quality, affordable care. Absent an urgent and proactive response to properly align clinical, operating and financial performance with these emerging mandates, providers will continue to face declining revenue attributed to the populations they serve.

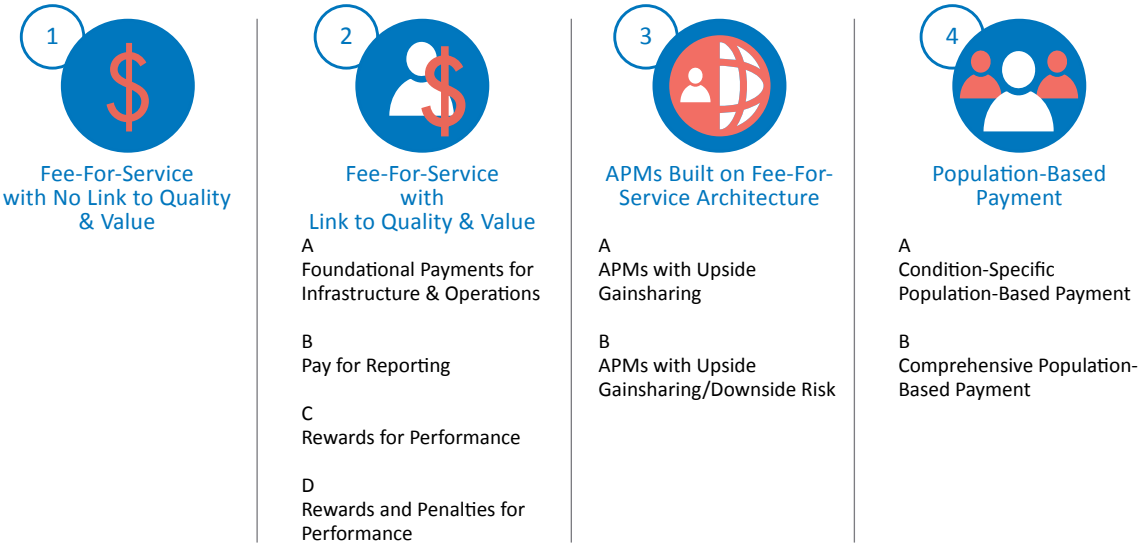
Public and private reform is underway, shifting traditional Fee-For-Service (FFS) revenue streams to value-based payments that reward outcomes, compliance with processes and benchmarks for quality. The recent announcement by Health and Human Services (HHS) in January 2015 rapidly accelerated the FFS payment system to value-based reimbursement through three meaningful steps aimed at more aggressively shifting Medicare, and potentially other payers, substantially away from traditional FFS by 2018:

- Ensure 30 percent of traditional Medicare FFS payments are tied to alternative models, such as Accountable Care Organizations or bundled payments, by the end of 2016; and 50 percent of these payments by 2018.
- Ensure 85 percent of traditional Medicare FFS payments will be tied to quality or value by 2016 and 90 percent by 2018 through programs such as Value Based Purchasing and the Readmission Reduction Program.
- Launch a Health Care Learning and Action Network that will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs.

The recent launch of the Health Care Learning and Action Network in May 2015 continued to focus on these goals through the established framework of Alternative Payment Models that can be used to track progress and guide provider decisions. The current implementation of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) further complicates the decisions that providers have to make by 2019 when Medicare requires physicians to enter the Merit Incentives Payment track (MIPS) track unless they qualify for the Alternative Payment Model (APM) track. MIPS consolidates three existing programs – Meaningful Use (MU), the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBPM) – and adjusts annual physician compensation based on individual physician with four categories focused on quality, resource use, meaningful use of EHR technology, and clinical practice improvement activities.

The recent MACRA announcement and work by the HCPLAN further complicates the growing demands on providers to accept new risk to meet increasing reimbursement expectations. In this dynamic market environment, providers are challenged to consider a series of delivery models along the continuum to manage patients and perform against increasing performance metrics. To discuss this in greater detail, the HCPLAN's APM Framework will be used to explore several delivery models that providers are considering.

APM Framework (At-A-Glance)[1]



[1] Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. "Alternative Payment Model (APM) Framework Final White Paper." Health Care Payment Learning and Action Network. 12 Jan. 2016.

The APM Framework organizes payment models into four categories and eight subcategories. The graduated framework requires an increased level of provider accountability for both quality and total cost of care, with a greater focus on population health management as a provider moves through the framework from left to right.

The continued emphasis on value-based reimbursement by the nation's largest payer requires providers to evaluate the future of care delivery models. It also requires considering long-term investment needs in infrastructure, reporting capabilities, education, and transformational leadership to meet the new expectations of patient-centered, high-quality, affordable care. The pathway for most health systems and physicians to begin meeting this objective is through integrated care delivery models that can leverage the necessary resources, including human and technology, to be cost effective in the implementation efforts. Clinically Integrated Networks (CIN) are common models adopted by a network of providers working together, using proven protocols and measures, to coordinate patient care, improve quality, decrease cost, and demonstrate value to the market. Once the CIN is confident it can demonstrate a compelling value proposition, the network will approach payers and employers to contract with the network based on shared incentives aligned with defined quality and economic goals. CINs play a critical strategic role in adopting new care delivery models and executing against payment reform. In the near future, it will be an important component to establish MACRA readiness that will enable the APM vs. MIPS transition starting in 2019.

Alternative Payment Model (APM) Framework Examples

As the mandatory elements of reform progress, it is important to recognize that some providers are already dealing with and learning to manage the ongoing transformation that ties payment to clinical outcomes. What was called pay-for-performance under the previous administration has transformed into value-based purchasing, readmission penalties, and other performance-based, risk-sharing payment models. These mandatory programs, such as value based purchasing, are represented in Category 2 of the APM Framework.

All markets are different and are driving various new delivery models. Unique market characteristics, including the profile of existing healthcare providers, competition, physician supply and access, and payer dynamics will play a significant role in determining how fast or slow a market will transition toward value-based delivery models. The following examples are the more commonly pursued APMs that work to align care in a community and provide better care for the patients, while accepting risk and managing new forms of reimbursement.

Patient Centered Medical Homes (PCMH) – Category 3

Healthcare delivery, especially in the outpatient setting, often is coordinated by primary care providers and, therefore, is a source for quality improvements and cost reductions. There are six standards that serve as building blocks for a PCMH: Patient-Centered Access, Team-Based Care, Population Health Management, Care Management and Support, Care Coordination and Care Transitions, and Performance Measurement and Quality Improvement. These standards help shift a primary care physician's approach to healthcare from reactive to proactive. Previously, physicians and hospitals would care for patients when they walked into the clinic or the hospital. The focus for healthcare organizations is to now keep patients out of the hospital by taking preventative measures to proactively manage the care, as opposed to waiting until an issue has developed.

The recently passed Medicare Access and CHIP Reauthorization Act (MACRA) presents two options for practices starting in 2019. Specifically called out, Patient-Centered Medical Homes that achieve certain distinction receive specific advantages compared to other programs, such as no requirement for participation in programs that have downside financial risk. Without the downside risk requirement, practices will be able to earn the 5 percent lump sum bonuses, as well as become eligible for the higher physician fee schedule increases. There are other requirements an Alternative Payment Model must meet, such as having an increasing percentage of payments linked to value through Medicare.

Bundled Payments – Category 3

Bundled payment arrangements are a type of risk-contracting. Also known as an episode-based payment, a bundled payment is defined as the reimbursement two or more providers receive on the basis of the expected costs for a clinically-defined episode of care. If the cost of services is less than the bundled payment, participating physicians and providers retain the difference as a gain. However, if the costs exceed the bundled payment, physicians and other providers are not compensated for the difference and can owe the difference to the insurer. Bundled payments are on an accelerated path as hospitals, health systems and other providers, including the post-acute market, are asked to redefine patient care and financial responsibilities across the patient care experience.

Two major bundled payment initiatives, Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR), 'formerly CCJR', are real world examples of CMS' commitment to implementing alternative payment methods – whether on a voluntary or mandatory basis. The BPCI program is voluntary and currently has two cohorts live with more than 1500 providers live with more than 14.000 episodes (groupings of DRGs). For BPCI, a hospital, medical group, skilled nursing facility, inpatient rehabilitation hospital, long term care hospital or a home health agency can be the risk taker. In fact, the most dominant provider in the BPCI program is the skilled nursing facility, followed by hospitals and then medical groups. The CJR program that started in April 2016, is mandatory for 67 Metropolitan Statistical Areas for a single bundle for lower joint replacements. CJR requires the hospital to be the at-risk provider.

Accountable Care Organizations (ACO) – Category 3

As organizations consider adopting voluntary Alternate Payment Models currently available by CMS, it is important that they explore all the options. One of the more popular and highly publicized ways CMS has facilitated the transition to value is through the development of voluntary alternative payment models known as Accountable Care Organizations (ACO), which provide "coordinated, high-quality care and better value to Medicare beneficiaries". To make this model available to providers of all shapes and sizes, CMS developed a "portfolio" of ACO models:

- Medicare Shared Savings Program (Shared Savings Program)
- Pioneer ACO Model
- ACO Investment Model (AIM)
- Next Generation ACO Model
- Comprehensive End Stage Renal Disease (ESRD) Care Model
- Medicare Health Care Quality Demonstration
- Private, For Profit Demo Project for the Program of All-Inclusive Care for the Elderly (PACE)
- Rural Community Hospital Demonstration

With a variety of program offerings available to providers, organizations interested in establishing Medicare ACOs should assess a number of key market and organizational elements as they consider joining a defined ACO program or initiating their own. As each individual market and organization will differ regarding the pace of change necessary to be successful in the "new-normal" of value-based care, addressing these elements as early as possible helps position organizations appropriately for future success. The Medicare Shared Savings Program (MSSP) will reward ACOs that lower their growth in healthcare costs while meeting performance standards on quality of care and putting patients first. CMS continues to refine the MSSP program in response to feedback from the participants. There are currently 434 active MSSPs.

University Hospitals
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Accountable Care Organizations (ACO) Model

Dr. William Steiner, Interim President and Medical Director, University Hospitals (UH) ACO has stated, "There is no question about it. Better information and better coordination leads to reduced costs. When treatment is fragmented, and not coordinated, the treatment is done in episodic fashion rather than looking at the long-term big picture."

Focusing healthcare on populations that need it the most requires analyzing socio-economic patient population data, which was not a traditional skill of hospitals until the advent of population health. UH had an advantage as an early adopter of the Accountable Care Organization (ACO) model. The UH ACOs are networks of physicians, hospitals and providers that agree to share responsibility, information and costs for patient populations. The aim is to create a tight-knit combination of patient data and expertise that helps prescribe the exact care required at specific points along the patient journey. Established in 2010, the UH ACO began covering just UH employees and has since grown to cover more than 300,000 patients in the region, including Medicare and Medicaid beneficiaries, the self-insured, and those covered by commercial insurers. With a healthcare footprint across 14 counties, UH partnered with a large number of providers across northeast Ohio, creating a deep pool of detailed intelligence on the diverse needs of the region.

"Within the ACO, we have an ability to really assess population needs," said Elizabeth Hammack, associate general counsel and advisor to the UH ACO. The data collected by an ACO can tell UH everything from what neighborhoods need better transportation to providers, to which neighborhoods have the greatest need for nutrition services or legal advocacy.

Analyzing that data enables the "upstream" approach to care, a focus on preventative and wellness care rather than reactive treatment. This approach helps reduce healthcare costs by preventing acute conditions before they occur. In addition, by using alternative payment models to enable high quality doctors to share information regarding personal costs savings, doctors are incented to treat and test only when necessary, instead of maximizing procedure fees. Dr. Steiner explained the mission of an ACO is as basic as providing good healthcare to patients and their families: "What the ACO can do, and is doing, is raising the quality and the level of care for everybody."

Bundled Payments

In July 2015, UH established participation in Medicare's Bundled Payments for Care Improvement Initiative (BPCI) for Total Joint Replacements with three system hospitals, UH Case Medical Center, UH Elyria Medical Center and UH Parma Medical Center. The BPCI Initiative is intended to coordinate payment for patient services into a single "bundle" based on patient episode of care. The three UH hospitals are responsible for managing the patient's journey to a target price for all care associated with total joint replacements, beginning with the procedure through a 90-day period post-procedure. The episode of care includes inpatient stay at UH and all related services during the episode. This is an important initiative as it reinforces UH's commitment to value-based care and builds on its experience with innovative payment models that will continue to play a larger role in overall reimbursement.

Cleveland Clinic

Bundled Payments

Beginning in 2007, Cleveland Clinic reorganized into clinical institutes centered on organ systems to better complement the group practice model. These institutes foster an environment that maximizes coordination, improves patient access to multiple specialties, enables experts to act as a dynamic team, and results in optimal treatment for patients and potential cost savings for employers.

Cleveland Clinic is extending its group practice model to ensure care is coordinated for patients beyond its providers and facilities. This extended care model is comprised of care paths, care coordination and connected care (post-acute care management), based on the following three pillars:

1) **Care Path Utilization** – Following evidence-based, best practice guidelines to ensure consistent, high quality care is delivered to every patient during every episode of care they experience.

2) **Care Coordination** – Leveraging a single point of contact for patients and their family members before the patient enters the acute hospitalization, during the actual surgical intervention, and following the patient after discharge across multiple sites of care.

3) **Connected Care** – Focusing in on care transitions reduces the fragmentation of care delivery and enables delivering the right care for the patient in the appropriate setting.

This model enabled Cleveland Clinic to offer innovative value-based contracts to employers, government and commercial payers. Cleveland Clinic currently has value-based agreements with multiple commercial and government payers. These agreements span Categories 2, 3 and 4 of the HCPLAN APM framework. The adoption of alternative payment models enables the Cleveland Clinic and its contracted payers the ability to ensure financial stability as they continue to improve care.

In 2013, the Department of Orthopaedic Surgery in the Orthopaedic and Rheumatologic Institute at the Cleveland Clinic developed standard clinical care paths for Total Joint Replacements. Cleveland Clinic applied a Complete Care approach for the program that included the use of Care Paths, Connected Care and Orthopaedic Specialty Care Coordinators. At the same time, Cleveland Clinic Euclid Hospital entered into a bundled payment contract with Medicare for Lower Total Joint Replacement. The contract is a 3-year contract that concludes on September 31, 2016. The bundle payment terms guarantees CMS a 3 percent discount over its historical spend for Lower Total Joint Replacements surgery and 30 days post discharge. This care delivery payment model also is being offered to commercial health plans and self-funded employers.

Between October 1, 2013 and September 30, 2014, Euclid Hospital showed progressive improvement over the performance quarters:

- Average length of stay in the hospital reduced by nearly half a day from 3.4 to between 2.67 - 3.01 days
- The CAUTI rate reduced to zero from 5.2 (N/1000)
- The readmission rate decreased from 5 percent to between 1.6 - 2.7 percent
- Discharge to home or home with home healthcare rate increased from 39 percent to 68 – 75 percent

The HCAHPS overall rating percentage increased from 74 percent to 78 – 88 percent, as noted in the table below. This quality of care improvement resulted in total financial value creation of $522,389 (9.8 percent) across 271 episodes of care. The total financial value creation was distributed between CMS and Cleveland Clinic at $159,571 and $362,818, respectively.

Care Redesigns Illustrate an Improvement of Quality and Outcomes

Metric	Baseline	BPCI Live in Phase II			
	Q1 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014
Medicare A/B Patients*,†	72*	65†	61†	66†	79†
Cauti rate*	5.2	0	0	0	0
ALOS*	3.40	2.90	2.67	2.87	3.01
Readmission*	5%	2%	1.6%	2.7%	2.0%
Discharge Disposition Home / HHC*	39%	71%	75%	70%	68%
Discharge Disposition SNF*	56%	28%	25%	30%	31%
HCAHPS - Overall Rating*	73%	88%	78%	84%	85%

SOURCE: † 2014Q3 CMS Reconciliation Report 2058-002 | *Cleveland Clinic
Notes: Internal quality reporting data at Euclid Hospital for Total Joint Replacement of Lower Extremity patients in BPCI program

With the success of the bundled payment pilot, Cleveland Clinic expanded the program to an additional eight hospitals in 2015. The expansion hospitals are experiencing similar gains in quality, outcome and patient experience.

The Cleveland Clinic believes that care redesign under alternative payment models (i.e., accountable care, total cost of care, capitation, and provider sponsored health plans and bundled payments) will continue to positively impact its healthcare system by improving the quality of patient care, encouraging care coordination across delivery venues, and ultimately resulting in a reduction of total healthcare spend.

Perspective and Considerations for Providers

DHG Healthcare firmly believes a healthcare organization's success is predicated on achieving "risk capability;" i.e., placing the organization in a position to responsibly and confidently accept risk contracts. This means modifying the current healthcare delivery business model to perform against the new reimbursement expectations. Healthcare providers will need to consider the long-term risk capability needs and invest in multiple alternative payment models to coordinate patient-centered care across the care continuum.

Provider Considerations

HOSPITALS / HEALTH SYSTEMS

It is important for organizations to develop a deep understanding of their current market and the rate of adoption of these models. All organizations considering ACO participation should evaluate their ability to appropriately manage the clinical and financial requirements of providing value-based care for a given population when considering new models designed around population health and value-based reimbursements. It is vital that organizations possess the ability to identify their potential gaps and, in the process, address the following questions:

- What is our risk tolerance and transformational agility?
- When should we "act" and transition to a new delivery model?
- Do we understand the implications of current regulations on these decisions?
- Should we partner with organizations in close geographic proximity or in other markets?
- Will we have enough attributed lives in our market to do this alone?
- Can we develop the infrastructure to support the care coordination and business intelligence necessary to be successful?
- What key components may be outsourced to a selected partner?
- Where does our organization currently rank based on performance from a Medicare cost and quality perspective?

PHYSICIANS

While independent physician consolidation continues to occur nationally, defining the right model for independent physicians (especially primary care physicians) is extremely important in considering the new value-based models in development. Understanding the value proposition, or lack thereof, of pursuing a new model and building necessary relationships will be essential for success. Each physician currently contemplating these models should consider the following questions:

- How are the independent primary care physicians in my market currently aligned?
- Are there any Independent Practice Associations (IPA) that might consider participation in an ACO and how might that impact the hospital?
- How will referral patterns shift as a result of this partnership?
- How do current regulations affect future reimbursement and does that impact the choices?
- Can alignment vehicles be utilized to further solidify relationships with key groups?

Conclusion

The announcement by HHS and CMS accelerates the movement away from FFS and provides greater clarity on the urgent pace of change that demands providers accept new institutional and market risk to perform against new reimbursement expectations. Absent an urgent and proactive response to properly align clinical, operating and financial performance with these emerging mandates, providers will continue to face declining revenue attributed to the populations they serve.

This transformational transition requires enhanced collaboration around education, knowledge sharing and innovation with competing and partnering organizations. The Cleveland Clinic, DHG Healthcare, University Hospitals and other leading healthcare organizations come together at the Global Center for Health Innovation to develop solutions to some of the most critical and complex challenges facing providers, payers and healthcare consumers today.

Contributing Tenant Partners

- **The Cleveland Clinic** – Cleveland Clinic, is a nonprofit, multi-specialty academic medical center that integrates clinical and hospital care with research and education employing more than 3,000 full-time salaried physicians and researchers and 11,000 nurses, representing 120 medical specialties and subspecialties.
  More at: www.clevelandclinic.org

- **DHG Healthcare** – DHG Healthcare is a top 10 private healthcare consulting firm ranked by Modern Healthcare and serves the industry with approximately 300 dedicated healthcare industry professionals across consulting, assurance and tax.
  More at: www.dhgllp.com/healthcare

- **University Hospitals** – University Hospitals (UH) founded in May 1866, serves the needs of patients through an integrated network of 18 hospitals, more than 40 outpatient health centers and primary care physician offices in 15 counties throughout Northeast Ohio. UH is home to some of the most prestigious clinical and research programs in the nation, including cancer, pediatrics, women's health, orthopedics, neuroscience, cardiology and cardiovascular surgery, digestive health, transplantation and genetics.
  More at: www.UHhospitals.org