Leadership Question #1

Should Your Organization Be Preparing For Greater Value-Based Payments?

Seven Value-Based Models Will Accelerate Value-Based Payments in 2021

By **LISA REMINGTON, PRESIDENT, THE REMINGTON REPORT**

Lessons learned by COVID-19 hit the healthcare industry hard for those organizations receiving the majority of their payments in fee-for-service.

Experts anticipate health systems to take on more aggressive approaches to value-based contracts and secure more reliable payments from health plans.

In 2019, 41% of Medicare payments, 30% of commercial payments, 53% of Medicare Advantage payments, and 23% of Medicaid payments were tied to alternative payment models (APMs) according to the Health Care Payment Learning & Action Network.

Insurers say about two-thirds of their patients are now seen by providers in value-based arrangements, and nearly half of them are seen by providers taking meaningful downside risks and deeply financially committed to delivering better care, more efficient care, more coordinated care, more preventive care, and better outcomes at lower costs.

ANTICIPATING THE FUTURE

The future direction is care across the continuum. Engaging in value-based delivery in primary care, specialty care, hospital, post-acute, home, and mental and behavioral health affords a deeper look at needs across the care continuum.

Industry experts predict wider use of value-based payments in Medicare and Medicaid as the Biden administration will seek to integrate advanced payment models into Medicaid (serves 76.2 million) in addition to their focus on 54 million non-disabled seniors in Medicare.

Last Year's Predictions made by **The Remington Report** were 100% Accurate

1.	2.	3.	4.	5.
Disruptors in the Post-Acute Space: Competitor or Partner?	Managing Higher Acuity Patients in the Home Will Redefine Home Care Services	Medicare Advantage Plans Contracting Gets Harder	Remaining Solo Gets Harder	Value-Based Contracting Coming Faster Than You May Think

SEVEN VALUE-BASED MODELS WILL ACCELERATE VALUE-BASED PAYMENTS IN 2021

Beginning in 2021, several value-based payment models will begin the shift from fee-for-service to value-based. Earmark this as the transformation of payment reform for care at home providers and how they will be paid in the future.

In this article, we explain the eight value-based models impacting care at home providers.

1.

Primary Care First Model

Well before COVID-19, CMS announced the Value-Based Transformation of Primary Care initiative. CMS's Primary Care Initiative includes five alternative primary care payment models designed to transform primary care to deliver better value for patients throughout the healthcare system.

Of the five alternative payment models, the two Primary Care First (PCF) payment models are risk-based/pay-for-performance payment options designed to test whether financial risk and performance-based payments that reward primary care practitioners and other clinicians for easily understood, actionable outcomes will reduce total Medicare expenditures, preserve or enhance quality of care, and improve patient health outcomes. Participation in the PCF payment models is a five-year commitment to commence on either January 1, 2021, or April 1, 2021, depending upon which PCF model is selected.

The PCF models offer two different payment – a General Track and a Seriously Ill Population (SIP) Track. The General Track is for primary care practices with advanced primary care capabilities that are prepared to accept increased financial risk. The SIP Track is for practices seeking to treat high need, high-risk patients who currently lack a primary care practitioner or care coordination that specifically opt to participate in the payment model option. Practices may participate in both tracks.

Additional Reference: Physicians Are Expanding Care into the Home. November/December 2020 – page 1

2.

Hospice Carve-In Tested Under Value-Based Insurance Design (VBID)

Fifty-three Medicare Advantage plans (MA) will offer increased access to palliative care and integrated hospice care through the Medicare Advantage Value-Based Insurance Design (VBID) model.

Under the Model beginning January 2021, nine MA organizations, through 53 plan benefit packages (PBPs) will participate in the Hospice Benefit Component of the VBID Model. These PBPs will test the Hospice Benefit Component in service areas that cover 206 counties.

By including the Medicare hospice benefit in the MA benefits package, CMS will test the impact on service delivery and quality of MA plans providing all original Parts A and B Medicare items and services required by statute.

Additionally, CMS is testing how the hospice benefit component can improve beneficiary care through greater care coordination, reduced fragmentation, and transparency in line with recommendations by the Office of Inspector General (OIG), the Medicare Payment Advisory Commission (MedPAC), and others.

PAYMENTS UNDER THE HOSPICE BENEFIT

- Paid on a per diem basis, based on enrollment, with the hospice assuming all financial and clinical responsibility for care related to the terminal condition.
- Daily payment rates are made according to a fee schedule that has four different levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC).
- As of 2016, there are two RHC base payment rates and Medicare makes additional RHC payments for services provided during the last seven days of life.
- Hospice payment rates are updated annually by the hospital market basket and other adjustment factors; hospices that fail to report quality data have the market basket % increase reduced by 2% points.

3.

State Medicaid Programs

Last September, CMS issued a new roadmap for States to accelerate the adoption of value-based care strategies across healthcare systems and align payer incentives across payers. The Centers for Medicare & Medicaid Services (CMS) believes that value-based payment (VBP) is a key driver of value-based care (VBC). Value is more likely to improve across the larger healthcare system when provider incentives are aligned across payers.

By advancing VBC in Medicaid, states have the opportunity to improve beneficiary health while reducing costs. Examples of payment models include advanced payment methodologies under fee-for-service, bundled payments, and total cost of care models.

While many states have made progress moving toward value-based payments, Medicaid made more fee-for-service payments to healthcare providers in 2018 compared to any other payer (66.1 percent versus the industry average of 39.1 percent).

Additionally, Medicaid had the least amount of payments through an alternative payment model that year (23.3 percent versus 30.1 percent for private payers, 53.6 percent for Medicare Advantage, and 40.9 percent for traditional Medicare). Providers should be expecting State Medicaid programs to accelerate value-based payments due to the increase in the number of people enrolling due to COVID-19.

For Additional Resources: State Medicaid Programs Are Expanding Value-Based Payments. November/December 2020 – page 6

"The future direction is care across the continuum. Engaging in value-based delivery in primary care, specialty care, hospital, post-acute, home, and mental and behavioral health affords a deeper look at needs across the care continuum."

4.

Medicaid Managed Care

As of July 2018, almost 54 million Medicaid enrollees received their care through risk-based Managed Care Organizations (MCOs) – or over two thirds (69%) of all Medicaid beneficiaries. Twenty-five MCO states covered more than 75% of Medicaid beneficiaries in MCOs. In FY 2018, state and federal spending on Medicaid services totaled nearly $593 billion. Payments made to MCOs accounted for about 45% of total Medicaid spending.

HOW MEDICAID MANAGED CARE IS ACCELERATING VALUE-BASED PAYMENTS

- Require managed care organizations (MCOs) to adopt a standardized VBP model.
- Require MCOs to make a specific percentage of provider payments through approved VBP arrangements.
- Require the MCOs to move toward the implementation of more sophisticated VBP approaches over the life of the contract.
- Require MCOs to actively participate in a multi-payer VBP alignment initiative.
- Require MCOs to launch VBP pilot projects subject to state approval.

ONE STATE'S RESPONSE

Massachusetts has enrolled 80% of its Medicaid managed care beneficiaries into its ACO program, in which providers take significant two-sided risk for cost, quality, and member experience. The program has three different ACO models. One model, the Partnership Plan ACO, is fully integrated between a health plan and delivery system and provides a full range of physical and behavioral health services. Massachusetts regulates the ACO like a health plan and requires the ACO to meet Medicaid network adequacy standards, which it may do by contracting with providers not part of an ACO (e.g., local specialists and facilities).

For Additional Resources: Medicaid Managed Care Are Linking Bonus Programs Tied to Performance. November/December 2020 – page 11

5.

Dual Eligibles

CMS's innovation center launched a risk-based model for dual-eligible allowing insurance plans to take on financial risk for patients enrolled in both Medicare and Medicaid.

CMS' innovation center (CMMI) is about to roll out a new model allowing insurance plans to take on financial risk for patients enrolled in both Medicare and Medicaid.

The pilot will allow managed care organizations that assume risk for a patient enrolled in Medicaid to also assume risk for that same patient in fee-for-service Medicare.

There are 12 million dual-eligible beneficiaries, according to CMS. Many of them have complex medical issues, including multiple chronic conditions.

Often, they also have socioeconomic risk factors that can lead to poor health outcomes.

Dually eligible individuals have accounted for 20 percent of Medicare enrollees and 34 percent of Medicare spending. The same individuals have accounted for 15 percent of Medicaid enrollees and 33 percent of Medicaid spending. Across both programs, that equates to over $300 billion in state and federal spending each year. Forty-one percent of dually eligible individuals have at least one mental health diagnosis, and about half use long-term services and supports (LTSS).

WHAT'S AHEAD?

Another model CMMI plans to roll out in the coming months is around geographic direct contracting. The trial would allow insurers, providers, and other healthcare organizations to assume financial risk for all Medicare lives, or a portion of Medicare lives, in a specific geographic region.

In exchange, they'd get much more flexibility in how to structure their program, including building preferred networks, potentially processing claims and other allowances while ensuring beneficiaries still have access to all providers available in Medicare.

For Additional Resources: New Care Models Allow Payers to Take on Risk for Dual Eligibles November/December 2020 – page 12

6.

Direct Contracting

Direct contracting creates the seismic change to level the playing field for small and large organizations, test risk-sharing payments, creates a playground to test payments that operated in silos (eg: MA program and Medicaid MCOs,) and creates greater financial alignment. The goal of Direct Contracting is to transform risk-sharing arrangements in Medicare fee-for-service.

HOW DIRECT CONTRACTING EXPANDS TEAM-BASED CARE

Under these models, a third-party firm contracts with private insurers to offer enhanced services to patients with high medical costs and needs. A multidisciplinary care team consisting of physicians, nurse practitioners, behavioral health specialists, social workers, and other providers offers a variety of in-home services including care evaluations, lab draws, IV medication administration, wound care, and minor procedures. This approach might be an option for ACOs participating in direct contracting to enhance team-based care services for the seriously ill.

DIRECT CONTRACTING (DC) MODEL OPTIONS

DC Model options consist of three new voluntary risk-sharing payment models, each spanning five years plus an initial year to align enough Medicare beneficiaries. Per CMS, the model options are as follows:

- **The Professional option** has the lower risk-sharing arrangement – 50% savings/losses and primary care capitation, a risk-adjusted per-member per-month (PMPM) payment for enhanced primary care services priced at 7% of total care cost of care.
- **The Global option** offers 100% risk-sharing of savings or losses, with two payment options: primary care capitation or total care capitation, a risk-adjusted monthly PMPM payment for all services provided by DC participants, and preferred providers with which the DC entity has an agreement.
- **The Geographic option** tests whether direct contracting entities can improve quality and lower costs for beneficiaries across an entire region. Providers in the region can enter into value-based care payment arrangements.

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DIRECT CONTRACTING ENTITIES

Under the model, healthcare providers which CMS calls "direct contracting entities," or DCEs will competitively bid to manage 100% of the Medicare Part A and Part B costs for a certain number of Medicare beneficiaries within a geographic region, starting at a minimum of 30,000 enrollees.

Under direct contracting, there will be three types of direct contracting entities:

- **Standard** will be comprised of organizations that generally have experience serving Medicare fee for service beneficiaries.
- **New Entrant direct contracting entities** will be comprised of organizations that have not traditionally provided services to a Medicare FFS population and that will primarily rely on voluntary alignment, at least in the first few performance years of the model.
- **High Needs Population Direct Contracting Entities** that serve Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries.

For Additional Resources: See related story in this issue: 2021 Regional Outcomes for Medicare Require Full Financial Risk – pages 16-17, and How The Direct Contracting Payment Model Creates Greater Financial Alignment. March/April 2020 – pages 29-31

7.

Rural Healthcare Transformation

The Centers for Medicare & Medicaid Services Innovation Center (CMMI) announced its new Community Health Access and Rural Transformation (CHART) Model focused on improving financial sustainability, removing regulatory burdens, and enhancing access to care for rural residents.

It directs the federal government to provide more than $8.7 million in grant funding for up to 29 providers to provide emergency care consults virtually to rural providers without specialists over the next four years.

The proposal would allow rural health clinics and federally qualified health centers to be allowed to furnish Medicare telehealth services and be reimbursed for virtual care at similar rates as comparable telehealth services under the Medicare Physician Fee Sched Rule. CMS released the 2021 physician fee schedule in early August adding nine new permanent telehealth codes.

The new value-based payment model for rural healthcare providers ties payment to value increases choice and lowers costs for patients, CMS said.

Providers interested in the CHART Model have two options for participation: the Community Transformation Track and the Accountable Care Organization (ACO) Transformation Track.

For Additional Resources: Expanded Access for Rural Communities and Transformation of Care November/December 2020 – page 14