Franciscan ALLIANCE
Accountable Care Organization

# Value-Based Healthcare & Payment Models

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# Medicare's Push Towards Quality and Value

## Medicare Fee-for-Service

### GOAL 1:

**30%**

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

### GOAL 2:

**85%**

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

**STAKEHOLDERS:**

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

# Medicare Access and CHIP Reauthorization Act (MACRA) &The Merit-Based Incentive Payment System

The Merit-Based Incentive Payment System (MIPS) Path offers potential bonuses or penalties depending on how eligible professionals perform in four categories:

1. Quality - drawn from existing Medicare Part B Physician Quality Reporting System (PQRS)

2. Resource use - drawn from existing Medicare Part B value-based payment modifier program

3. Meaningful use of certified electronic health records technology

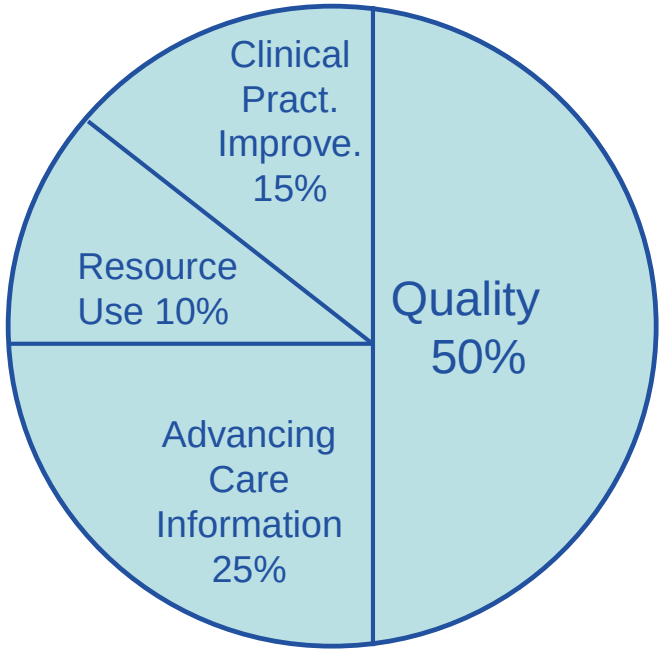
4. Clinical practice improvement activities

Eligible professionals will receive a composite score across the categories, which determines whether they receive a bonus or a penalty, with the bonus or penalty amount increasing

# MIPS Regular Scoring

- Regular scoring - MIPS Composite Performance Score (CPS) derived from performance in 4 categories

- Performance determines positive, negative, or neutral adjustment




| Performance Year | Payment Year | Merit-Based Incentive Payment System (MIPS) and MIPS APMS* |
|---|---|---|
| 2017 | 2019 | +/- 4% |
| 2018 | 2020 | +/- 5% |
| 2019 | 2021 | +/- 7% |
| 2020 | 2022 | +/- 9% (and beyond) |

* Bonus for exceptional performers and potential 3x scaling factor

# Value-Based Care

- Nearly all value-based care models focus on the same principles emphasized by Medicare in the proposed MACRA rule:
  - Quality of care/outcomes
  - Use of electronic data to increase efficiency of care
  - Activities focused on clinical improvement
  - Controlling costs of care

- Franciscan currently participates in several value-based healthcare models, most predominantly in Accountable Care Organizations

- Currently, Franciscan Alliance holds over 8 ACO agreements in Central Indiana with various payers, including Medicare, Medicare Advantage, and Commercial payers

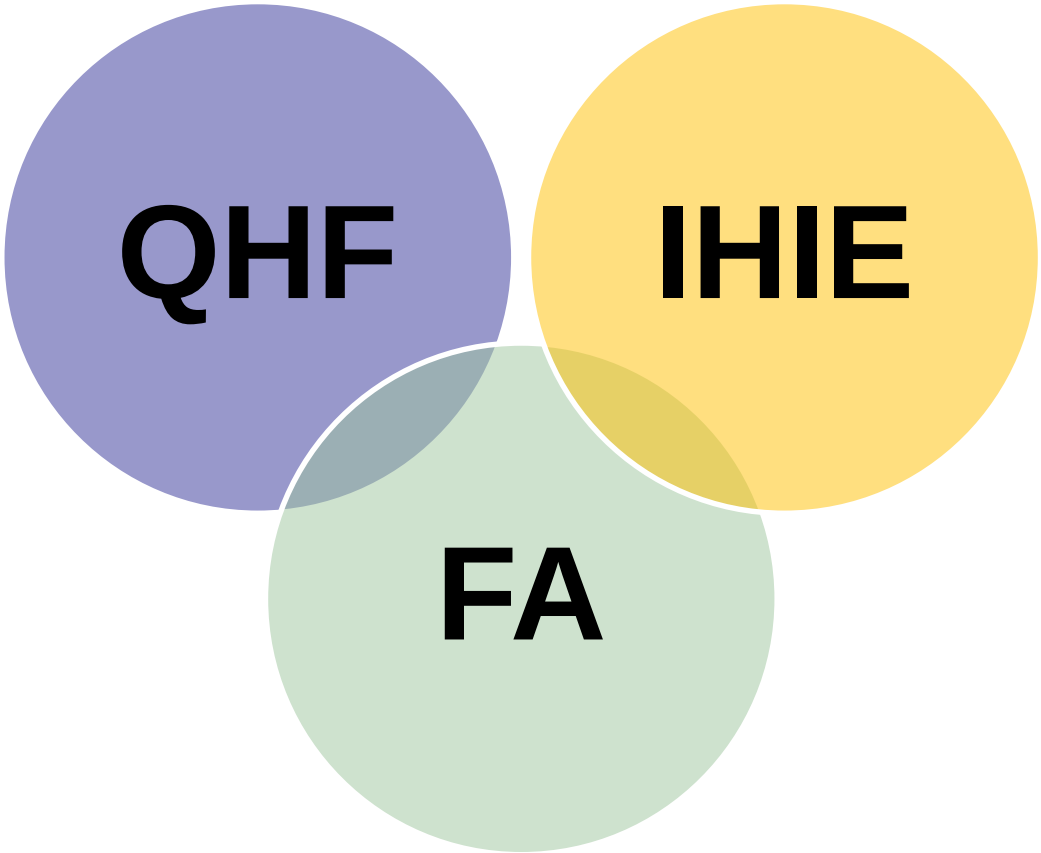
# Accountable Care Organizations (ACOs)

- ACOs have the three-pronged goal of: better population health; increased quality of care; and lower costs of care

- ACOs focus on coordination of care for patients across the entire care continuum, including care management

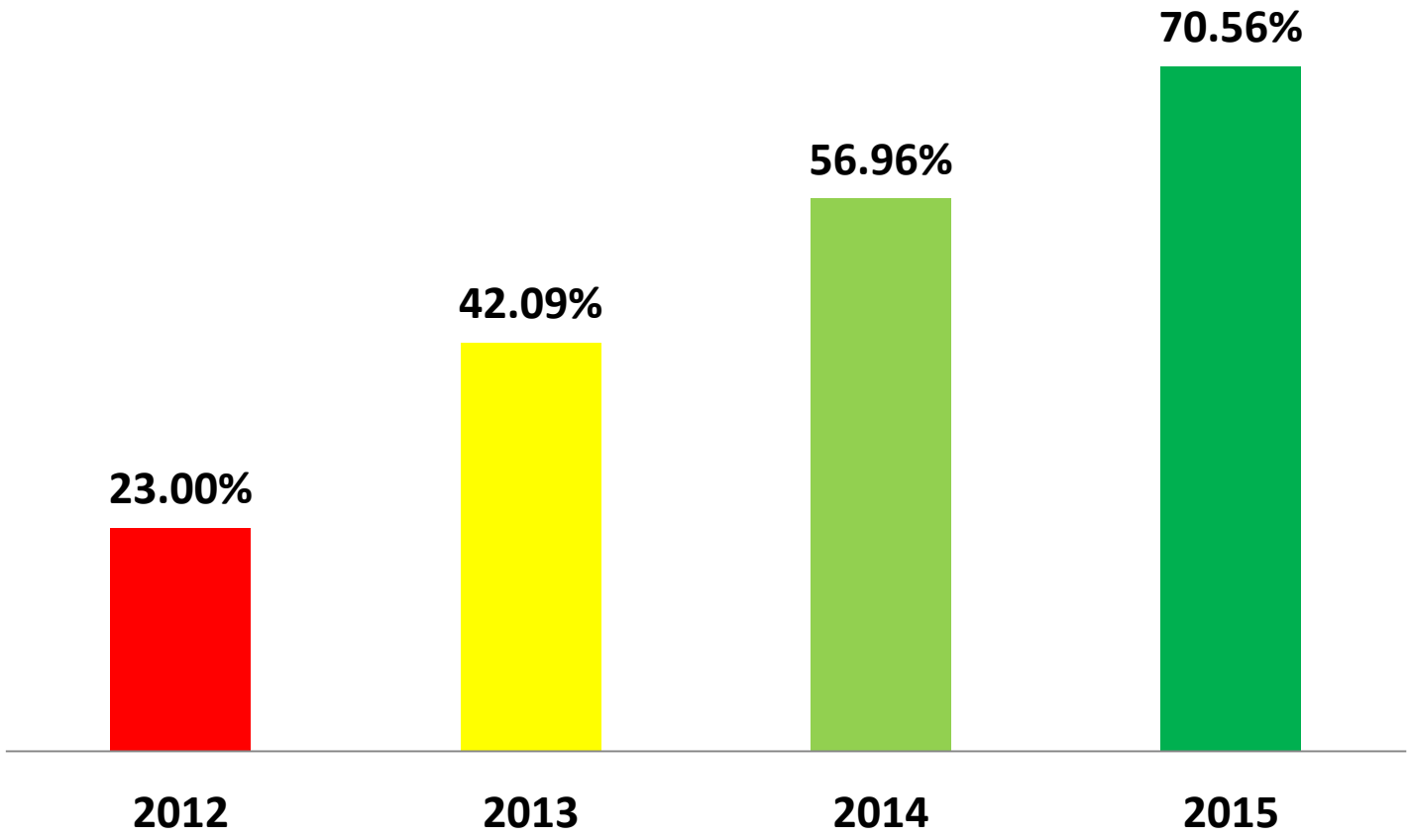
- Unlike historical healthcare models, ACOs:
  - Require extensive collaboration among healthcare providers (yes, even competitors!) and payers. This collaboration includes sharing of claims and clinical data
  - Receive ‘shared savings’ payments based on controlling cost AND quality; no dollars are earned if quality is lacking
  - Are accountable for patients regardless of where they seek healthcare services

# Franciscan Results can Really be Traced Back Here



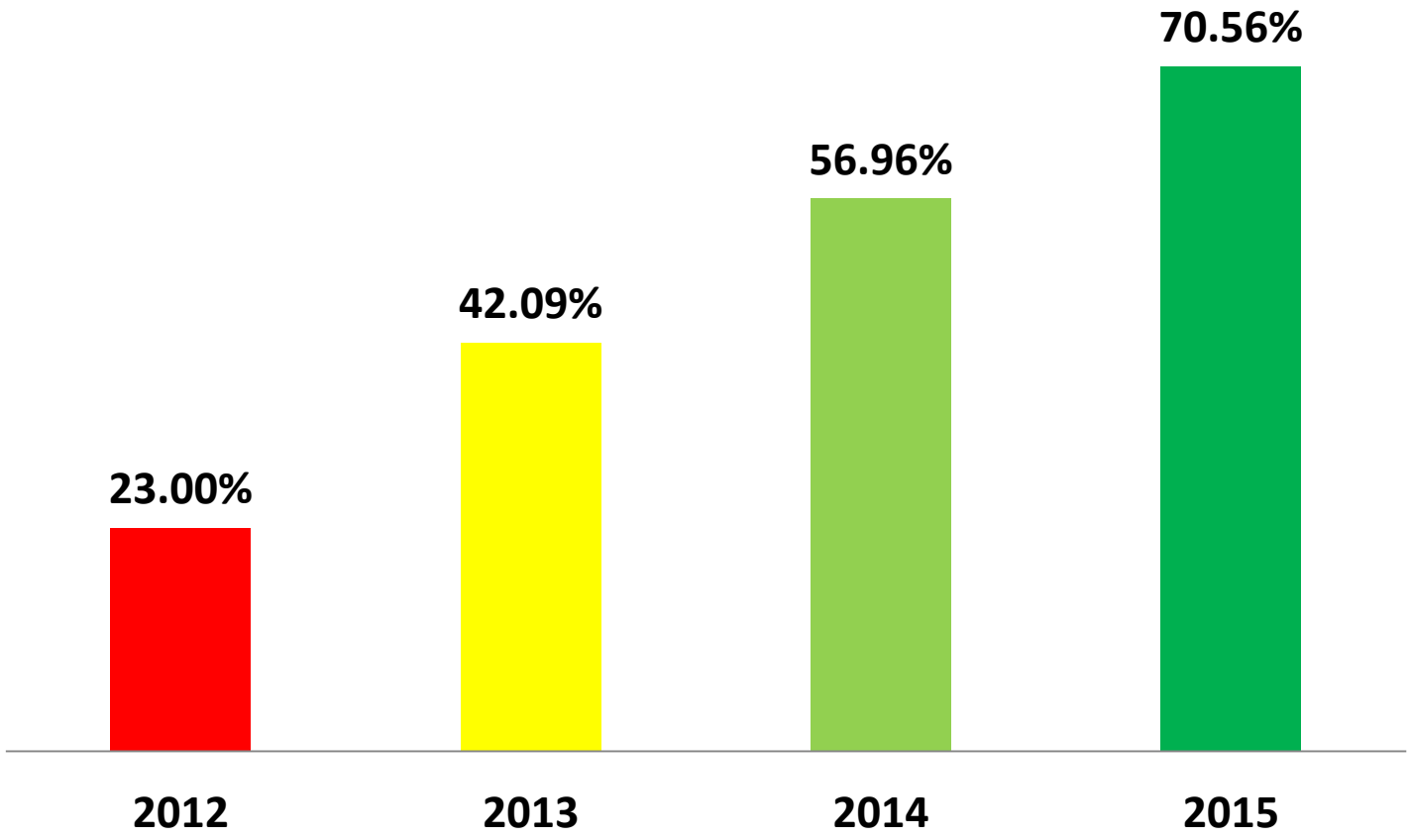
# Franciscan Quality Results: Depression Screening

## FA Medicare ACO Data 2012-2015



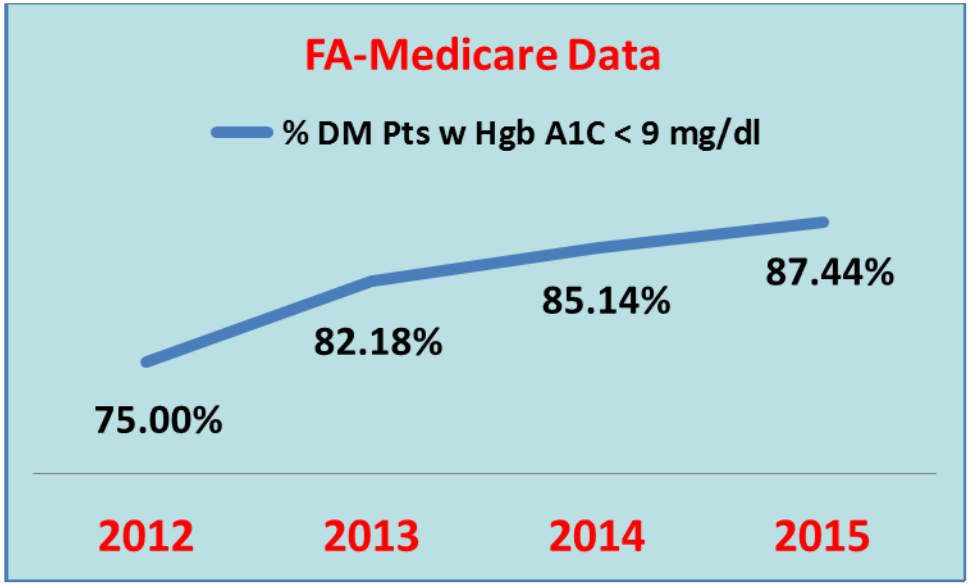
# Franciscan Quality Results: Fall Risk Screening

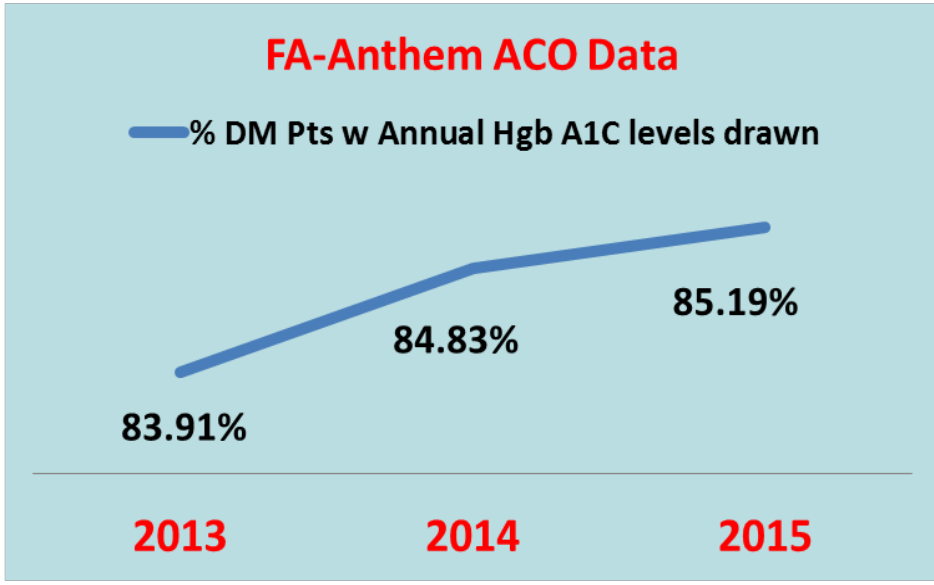
## FA Medicare ACO Data 2012-2015



# Franciscan Quality Results: Diabetes

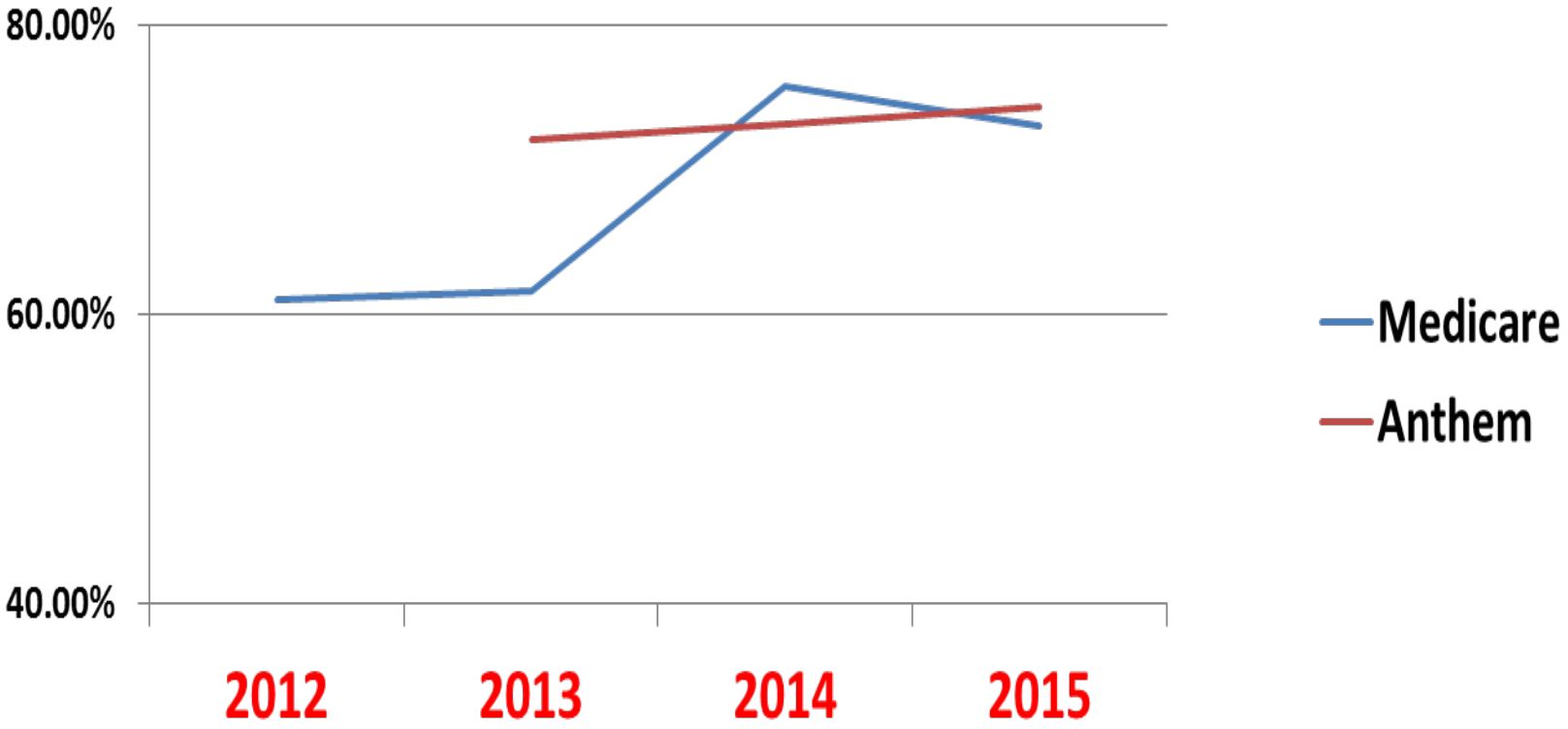
## FA Medicare ACO and FA Anthem ACO Data 2012-2015



# Franciscan Quality Results: Mammograms

## FA Medicare ACO and FA Anthem ACO Data 2012-2015



# Challenges

- Provider engagement
- Patient engagement
- Out-of-network

# Model Limitations & Benefits

Limitations

- Quality reporting/integration (provider-payer)
- Time lag between start of performance year and results (18 months!)
- Large shifts in population health takes time
- Patient responsibility lacking
- Shifts responsibility entirely to ACO (provider)

Benefits

- Better quality scores/patient outcomes
- Increased access for patients
- Slowing rate of cost increase

# Thank you!