Trump Care: Overview of Healthcare Reform Plans

Dan Schwebach, MHA, CPPM
Vice President
Affordable Care Act
On Healthcare Today
Main Objectives

Expand Coverage
- Reforming Private / Small Group Insurance Market
- Expanding Medicaid Program

Improve Affordability
- Low income

Reduce healthcare spending through Delivery / Payment Models from Volume to Value
ACA Overview

73M Enrolled in Medicaid
• 32 States Participating in Expansion
• 14 M Enrolled Through the Expansion (18% total)

11 Million Insured Through Exchanges
80% Receiving Financial Subsidies

Creation of CMS Innovations Center
• ACO programs
• Bundled payment
ACA Overview

30M Uninsured after Implementation of ACA

6.4M Are Eligible for Medicaid

5.3M Are Eligible for Subsidies Through the Exchanges

2.6M Fall into Coverage Gap (States who did not Expand)

5.4M Not Eligible b/c Undocumented Immigrants

7.5M Can purchase in exchange but don’t

2016 Monthly Insurance Exchange Subsidies

# Enrollees Getting Credit = 9,389,609

Average Monthly Credit = $291

Total 2017 Cost = $32.7 Billion
Six in Ten Say When It Comes to Healthcare, Things In The U.S. Have Gotten Off on the Wrong Track

Public View of ACA

[Graph showing public sentiment on ACA from April 2010 to March 2017, with data points for favorable, unfavorable, and don’t know/refused opinions.]

Public Sentiment on Current Healthcare

View of ACA varies by Party Affiliation

- Republicans: 74% Favorable, 18% Unfavorable
- Independents: 50% Favorable, 39% Unfavorable
- Democrats: 19% Favorable, 73% Unfavorable
- Approves of Pres. Trump: 69% Favorable, 22% Unfavorable
- Disapproves of Pres. Trump: 71% Favorable, 22% Unfavorable

## Public Sentiment on Current Healthcare

### Top Consumer Priorities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower individual health care costs</td>
<td>67%</td>
</tr>
<tr>
<td>Lower the cost of prescription drugs</td>
<td>61%</td>
</tr>
<tr>
<td>Decrease federal government spending on health care</td>
<td>35%</td>
</tr>
<tr>
<td>Decrease federal government’s role in health care</td>
<td>35%</td>
</tr>
</tbody>
</table>

http://jamanetwork.com/data/Journals/JAMA/936178/jig170001fa.png
Americans are Divided on ACA Repeal and Replacement
THE AMERICAN HEALTH CARE ACT
ReadTheBill.gop

#RepealAndReplace
3 Tier Approach

1. RECONCILIATION (REPEAL)
2. ADMINISTRATIVE ACTIONS
3. ADDITIONAL LEGISLATION
Reconciliation allows committees to submit legislation changes to existing laws in order to bring spending, revenue or debt ceiling into conformity with the budget resolution.
AHCA Key Principles

**Primary Goal:**
Give people access to affordable healthcare and choices

**Key Principles:**

- De-Regulate insurance markets
- Provide consumers with more choices
- Provide universal access to care
- Lower cost of insurance through competition
## Individual Mandate

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Insurance coverage required</td>
<td>• Remove tax penalty for non-compliance</td>
</tr>
<tr>
<td>• Tax penalty for non-compliance</td>
<td>• Require continuous credible coverage</td>
</tr>
<tr>
<td>• Minimum level of essential coverage required</td>
<td>• Lapse in coverage 63+ consecutive days incur late enrollment penalty of 30% of premium</td>
</tr>
<tr>
<td>• Exemptions granted for affordability, religious or other objections</td>
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</tbody>
</table>
Insurance 101

Healthy → $ → Insurance Company → $$ → Claims → Providers

Sick
<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Insurance coverage required</td>
<td>• Remove tax penalty for non-compliance</td>
</tr>
<tr>
<td>• Tax penalty for non-compliance</td>
<td>• Require continuous credible coverage</td>
</tr>
<tr>
<td>• Minimum level of essential coverage required</td>
<td>• Lapse in coverage 63+ consecutive days incur late enrollment penalty of 30% of premium or enforce underwriting measures</td>
</tr>
<tr>
<td>• Exemptions granted for affordability, religious or other objections</td>
<td></td>
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</tbody>
</table>
## Insurance Exchanges

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Create state-based or federally managed insurance exchanges for individuals and small business health plan options.</td>
<td>• Maintain State exchanges, but allow tax credits for non-group policies to be used for plans outside the exchange.</td>
</tr>
<tr>
<td>• Subsidies for healthcare can only be applied to plans purchased in the exchange.</td>
<td></td>
</tr>
</tbody>
</table>
## High Risk Pools

- **Affordable Care Act (ACA)**
  - Eliminated high risk pools and created a single risk pool for plans on and off the exchange.
  - Migrate everyone to obtain coverage through the insurance exchanges.
  - Set prices based on Age, Geography, Family Composition and Tobacco use

- **American Health Care Act (AHCA)**
  - Keeps single risk pool rating requirement, but introduces an Invisible Risk Sharing Program.
Invisible High Risk Pools

- Provides $15B for Jan 2018 – 2026
- CMS would develop federal invisible risk sharing program and then States would take it over in 2020.
- Develop a list of high cost conditions (e.g. diabetes) that would qualify individuals for program participation.
- Acts as a form of Reinsurance
- Difference between this and traditional risk sharing pools is you don’t segregate consumers into a separate insurance program, where they face higher premiums, rather they have the same coverage and access as would be available to healthier enrollees.
# Individual Insurance Market Rules

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Require guaranteed issue for individual plans during open enrollment period.</td>
<td>• Also require guaranteed issue for all non-group health plans.</td>
</tr>
<tr>
<td>• Small group plans must guarantee issue of insurance year around.</td>
<td>• Price setting same as ACA, with exception of 5:1 ratio for age.</td>
</tr>
<tr>
<td>• Prohibit pre-existing condition exclusions</td>
<td>• Prohibit pre-existing condition exclusions except for short term non-renewable policies.</td>
</tr>
</tbody>
</table>
### Benefit Design

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Require to cover 10 categories of essential health</td>
<td>• Allow States to define categories of essential health Starting in 2020.</td>
</tr>
<tr>
<td>• Prohibits lifetime and annual dollar limits</td>
<td>• Ends Actuarial Value requirements 2019</td>
</tr>
<tr>
<td>• Limits annual cost sharing amounts</td>
<td>• All other elements of ACA stay same</td>
</tr>
<tr>
<td>• Free preventive services</td>
<td></td>
</tr>
<tr>
<td>• Exchange plans must be offered at set actuarial values.</td>
<td></td>
</tr>
</tbody>
</table>
## Insurance Premium Subsidies

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Subsidy to offset costs of your monthly insurance premium</td>
<td>• Tax to offset Premium costs</td>
</tr>
<tr>
<td>• Amount based on income level</td>
<td>• Amount based on age, not income</td>
</tr>
<tr>
<td>• Caps overall costs of the plan to % of your income</td>
<td>• Can purchase plans outside the exchange</td>
</tr>
<tr>
<td>• Must purchase plan through the exchange</td>
<td></td>
</tr>
</tbody>
</table>
## Cost Sharing Subsidies

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Subsidy to reduce deductibles, copays, co-insurance and out of pocket limits.</td>
<td>• Eliminated in 2020</td>
</tr>
<tr>
<td>• Required to purchase Silver Plan level in the exchange.</td>
<td></td>
</tr>
<tr>
<td>Affordable Care Act (ACA)</td>
<td>American Health Care Act (AHCA)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>• No Change to 2003 HSA Rules</td>
<td>Expand HSA rules</td>
</tr>
<tr>
<td></td>
<td>• Increase contribution limits</td>
</tr>
<tr>
<td></td>
<td>• Add $1,000 to catch up contribution limit if over age 55</td>
</tr>
<tr>
<td></td>
<td>• Allow over the counter drugs to be a qualified medical expense.</td>
</tr>
<tr>
<td></td>
<td>• Reduce tax penalty for non-qualified withdrawals from 20% to 10%</td>
</tr>
</tbody>
</table>
## Medicaid Expansion

**Affordable Care Act (ACA)**

- Expand Medicaid program eligibility to anyone over 138% FPL
- Finance expansion by providing Federal Enhanced Matched Funds for new enrollees.

**American Health Care Act (AHCA)**

- Eliminate ability to extend coverage to anyone over 133% FPL, but grandfather those who are already in the program.
- Revert Medicaid to Per Capita financing starting in 2020.
- Add state option to elect Medicaid block grant instead of per capita cap.
## Financing

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tax penalties from individual and employer mandate.</td>
<td>Repeal most all taxes effective Jan 2017</td>
</tr>
<tr>
<td>• Increased Medicare Payroll Tax</td>
<td></td>
</tr>
<tr>
<td>• New Taxes on Insurers</td>
<td></td>
</tr>
<tr>
<td>• Pharmaceutical taxes</td>
<td></td>
</tr>
<tr>
<td>• Increased tax on HSA distributions for non-qualified expenses</td>
<td></td>
</tr>
</tbody>
</table>
CBO Summary: Cost Impact

Cost Estimate 2017 – 2026 Period

Cut Taxes (Revenue) ($883 Billion)

Cost Savings (Expense) $ 1.2 Trillion

Net Savings / Expense $ 323B

CBO Summary: Coverage Impact

Coverage losses

Estimated Loss of Coverage (2018) 14 Million
Estimated Loss of Coverage (2026) 24 Million

Total Estimated Uninsured (2026) ACA 28M ACHA 52M

Impact on Premiums (Individual / Small Group Insurance Market)

Average Premiums Before 2020 ~15%

Average Premiums After 2020 ~ 20%

Premiums for younger adults would decrease

Premiums for older would increase

3 Tier Approach

1. RECONCILIATION (REPEAL)
2. ADMINISTRATIVE ACTIONS
3. ADDITIONAL LEGISLATION
Administrative Action

Tom Price, MD

New Secretary of Health and Human Services (HHS)

- Orthopedic Surgeon
- US Congressman from Georgia since 2005
- Long championed a plan of tax credits, expanded health savings accounts and market competition to replace ACA.
- Chairman of the House of Representatives’ Budget Committee and was a leader in the effort to dismantle the ACA.
Seema Verma

New CMS Administrator

• National Health Policy Consultant

• Redesigned Medicaid programs in several states.

• Architect the Healthy Indiana Plan (HIP), the nation’s first consumer directed Medicaid program in 2007.

• Helped many states implement 1115 Medicaid waivers.

• Participated on the Republican Governor’s Public Policy Committee on Medicaid reform and contributed to the development of the report “A New Medicaid: A Flexible, Innovation and Accountable Future.”
Characteristics of the Healthy Indiana Medicaid Program

- Charged enrollees up to $25 for non-emergency visits to the ED.
- Shifted patients away from poorly run state hospitals to managed care.
- Required enrollees to make monthly payments into a health savings account or lose benefits ($1 - $27 / month)
- Enrollees that receive preventative care and vaccines they would be eligible for discounts on next year premiums.
The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most

Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population. We wish to empower all states to advance the next wave of innovative solutions to Medicaid’s challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. States, as administrators of the program, are in the best position to assess the unique needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.
Theme

• Medicaid should be used to provide care to the most vulnerable population (not to non-disabled, working adults)

• Expansion puts burden on tax payers

• Federal intervention is not appropriate and States should be left to design their own programs.

• States should be held accountable for their outcomes (using budget neutrality and demonstration projects)

• Move to consumer directed and commercial insurance design
Planned Actions

• Fast Track State Waivers
• Authorize options to Move Medicaid to Private Insurance
• Market Stabilization Measures (Already Passed)
• Simplify State Plan Amendment Approval Process
Current State of Insurance Exchanges
Health Insurance Exchanges

Exchange Enrollment and Projections (millions)

- **CBO Projection as of March 2011**
- **Plan Selections**
- **Effectuated Enrollment**

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBO</td>
<td>9.0</td>
<td>8.0</td>
<td>11.7</td>
<td>14.0</td>
</tr>
<tr>
<td>Plan</td>
<td>6.3</td>
<td>9.3</td>
<td>10.4</td>
<td>13.8**</td>
</tr>
<tr>
<td>Effectuated</td>
<td>8.0</td>
<td>12.7</td>
<td>13.8**</td>
<td>11.4**</td>
</tr>
</tbody>
</table>

Additional factors causing instability of the Health Insurance Exchanges.

- Risk Adjustment programs ending and/or not accurately compensating issuers for the risk of the population.
- Consumers “gaming” system
- Uncertainty of New Administration Policy (Mandate and Subsidies)
### 2017 Insurance Exchange Premium Changes

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>$294</td>
<td>$360</td>
<td>23%</td>
</tr>
<tr>
<td>Arizona</td>
<td>$207</td>
<td>$507</td>
<td>145%</td>
</tr>
<tr>
<td>Indiana</td>
<td>$298</td>
<td>$286</td>
<td>-4%</td>
</tr>
</tbody>
</table>

#### Amount Before Tax Credit

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>$206</td>
<td>$206</td>
<td>0%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>$186</td>
<td>$207</td>
<td>11%</td>
</tr>
<tr>
<td>Alaska</td>
<td>$179</td>
<td>$178</td>
<td>-1%</td>
</tr>
</tbody>
</table>

#### Amount After Tax Credit

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>$88</td>
<td>$155</td>
<td>76%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$27</td>
<td>$159</td>
<td>481%</td>
</tr>
<tr>
<td>Ohio</td>
<td>$26</td>
<td>$22</td>
<td>-17%</td>
</tr>
</tbody>
</table>

### Source

Health Insurance Exchanges

Insurance Issuers Participation in Exchanges

<table>
<thead>
<tr>
<th>Year</th>
<th>3+ Issuers</th>
<th>2 Issuers</th>
<th>1 Issuer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>67%</td>
<td>29%</td>
<td>4%</td>
</tr>
<tr>
<td>2017</td>
<td>45%</td>
<td>19%</td>
<td>36%</td>
</tr>
</tbody>
</table>
The stability and competitiveness of the Exchanges, as well as that of the individual and small group markets in general, have recently been threatened by issuer exits and increasing rates in many geographic areas. Some issuers have had difficulty attracting and retaining the healthy consumers necessary to provide for a stable risk pool that will support stable rates. In particular, some issuers have cited special enrollment periods and grace periods as potential sources of adverse selection that have contributed to this problem. Concerns over the risk pool have led some issuers to cease offering coverage on the Exchanges in particular States and counties, and other issuers have increased their rates.

A stabilized individual and small group insurance market will depend on greater choice to draw consumers to the market and vibrant competition to ensure consumers have access to competitively priced, affordable, and quality coverage. Higher rates, particularly for consumers
CMS final rule to address Market Stabilization

- Guaranteed availability
- Open Enrollment
- Special enrollment periods
- Actuarial Value Flexibility
3 Tier Approach

1. RECONCILIATION (REPEAL)
2. ADMINISTRATIVE ACTIONS
3. ADDITIONAL LEGISLATION
Small Business Health Fairness Act of 2017

- Allow small businesses to join together to increase bargaining power in the health insurance market.
- Businesses from different states could join together
- Gives similar advantage to large employers by increasing size and economies of scale.
Highlighted Legislative Initiatives

1. Creating competition in the insurance market
2. Lowering drug costs
3. Medical legal reforms
Summary

• Government spending is too high
• Regulatory competition Vs. free market competition
• Comprehensive Vs. Elective benefits
• Universal coverage Vs. Universal access
• Subsidies Vs. Tax credits
• Centralization of government authority Vs. State control
Key Take Away

Insurance Market Shift back to Consumer-Oriented Care Delivery

• Will block granting Medicaid lead to a 2-tiered health care system and reduced access, or will it improve quality and reduce the increase in health care costs?

• If health savings accounts and tax credits replace the individual mandate, will individuals purchase health insurance?

• Will a pool of dollars to ensure coverage of those with preexisting medical conditions be sufficient, or will these individuals once again be “uninsurable.”

• Will de-regulating the markets / reducing government mandates improve market competition resulting in reduced costs?
The future of Value Based Healthcare Movement
Primary Objectives:

• Testing new delivery models and spreading successful ones,

• Testing alternative payment models to promote quality and value of care provided,

• Work with broad range of stakeholder to develop resources for system wide improvement.
CMMI Focus Areas

Payment Reforms

**Goal 1**
90% of all FFS payments are linked to Value

- Pay-4-Performance
- Hospital Value Based Purchasing
- Hospital Readmission Reduction Program
- Value Based Payment Modifier

**Goal 2**
50% of all Medicare is paid through Alternative Payment Models promoting Value

- Bundled Payments
- ACOs
- Comprehensive primary care initiative
Delivery Reforms

- Patient Centered Medical Homes (PCMH)
- Hospital Engagement Networks
- Pioneer ACOs
- Medicare Shared Savings Program ACOs
- Next Generation ACOs
Delivery Reforms Future of ACOs

Source: Leavitt Partners Center for Accountable Care Intelligence

Number of ACOs

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<tr>
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<tbody>
<tr>
<td></td>
<td>81</td>
<td>85</td>
<td>102</td>
<td>157</td>
<td>207</td>
<td>306</td>
<td>323</td>
<td>421</td>
<td>448</td>
<td>460</td>
<td>572</td>
<td>592</td>
<td>600</td>
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<tr>
<td></td>
<td>761</td>
<td>783</td>
<td>841</td>
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<tr>
<td>Number of Covered Lives</td>
<td>28.2 Million Lives</td>
<td></td>
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</table>
Medicare Shared Savings Program 2017
• 99 new participants joining
• 79 renewals
• 480 Total ACOs
• 9 million Medicare Beneficiaries

Risk Arrangements
• 438 have 1 sided risk (91%)
• 42 have 2 sided risk (9%)
ACOs

Progression of Payment arrangements

Population-Based Payments

| Pre-ACO | ACO |

<table>
<thead>
<tr>
<th>FFS</th>
<th>Care Management</th>
<th>P4P</th>
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<tbody>
<tr>
<td></td>
<td>Shared Savings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shared Savings/Losses</td>
<td></td>
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<tr>
<td></td>
<td>Partial Capitation</td>
<td></td>
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<tr>
<td></td>
<td>Full Capitation</td>
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</table>

Increasing Risk

Source: Leavitt Partners Center for Accountable Care Intelligence
CMS Bundled Payments Initiatives

Episode / Disease Specific - Based Payments

- Usual & Customary
- Fee Schedule
- Prospective Payments
- Bundled Payments

Source: Leavitt Partners Health Reform Presentation 4/11/2016
## Medicare Shared Savings Program

<table>
<thead>
<tr>
<th>Round</th>
<th>Start Date</th>
<th>Assigned Beneficiaries</th>
<th>Percent Savings/Loses</th>
<th>Net Savings/Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>April 2012</td>
<td>351,585</td>
<td>1.89%</td>
<td>$72,045,856</td>
</tr>
<tr>
<td>2</td>
<td>July 2012</td>
<td>1,704,341</td>
<td>0.13%</td>
<td>$21,966,968</td>
</tr>
<tr>
<td>3</td>
<td>January 2013</td>
<td>1,782,013</td>
<td>-0.60%</td>
<td>-$107,232,592</td>
</tr>
<tr>
<td>4</td>
<td>January 2014</td>
<td>1,783,929</td>
<td>-0.83%</td>
<td>-$148,839,104</td>
</tr>
<tr>
<td>5</td>
<td>January 2015</td>
<td>1,648,365</td>
<td>-0.34%</td>
<td>-$54,230,300</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7,270,233</td>
<td>-0.30%</td>
<td>-$216,289,172</td>
</tr>
</tbody>
</table>
Higher Quality Does not Generally Correlate to Savings

As asked by Chairman Hatch to give her view on “testing different Medicare payment approaches and how to assess them,” Verma said, “As we look at testing new ideas, we need to make sure we are not forcing, not mandating individuals to participate in an experiment or some type of a trial that there is not consent around.” She said the evaluation component needs to be set up “on the front end,” and the results need to be shared with stakeholders before it becomes formal policy. Verma said that in looking at some Accountable Care Organization (ACO) models, “we know that very few providers – even large health systems – have been comfortable taking on risk, so I think this is going to be a challenge for the smaller providers. Some of them may not want to do that.”

Verma also indicated she has concerns that fee-for-service arrangements reward “volume over quality of service. I support efforts to increase coordination of care and hold providers accountable for outcomes, but it’s another thing altogether to have them accepting risk.”
CMMI Focus Areas

MACRA
MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015
The goal of MACRA is to move physicians away from a Fee-for-Service payment model to a value-based model that pays based on quality and improved outcomes.

- Single largest regulation driving business models for providers
- Bi-partisan support
- Save money
- Improve quality
Providers accepting Medicare patients must adopt one of the following payment tracks:

- MIPS
- APM
Merit-based Incentive Payment System (MIIPS) Performance Criteria and Weighting

- Quality (60%)
- Cost (0%)
- Clinical Practice Improvement (15%)
- Advanced Care Information (25%)
Alternative Payment Models (approved for 2017)

Comprehensive ESRD Care (CEC) – Two-Sided Risk
Comprehensive Primary Care Plus (CPC+) 
Next Generation ACO Model
Shared Savings Program ACO Model – Track 2
Shared Savings Program ACO Model – Track 3
Oncology Care Model (OCM) – Two-Sided Risk
Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1)
Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
ACOs

Future of ACO Growth

Today

• Belief ACOs will bend the cost curve
• Willingness to experiment
• Opportunity to make money
• Preparation for future risk-bearing environment

Future

• Less focus on shifting broad financial risk, more focus on episodic risk.
• Results of ACO have been tepid
• Will commercial market continue to push the model if CMS makes it less of an emphasis

Source: Leavitt Partners Center for Accountable Care Intelligence
Thank You

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