HEALTHCARE PAYMENT REFORM WARGAME

MEETING SUMMARY AND POLICY RECOMMENDATIONS

AUGUST, 2016

Booz | Allen | Hamilton

HEALTHCARE PAYMENT REFORM WARGAME: OVERVIEW

In April 2016, Booz Allen Hamilton (Booz Allen) sponsored a Healthcare Payment Reform Wargame (referred to here as "the Wargame," and also known as a strategic simulation). Twenty-seven executives participated in the game, which took them through a series of hypothetical scenarios. There were two objectives for the Wargame:

- Provide policymakers with advice about payment reform
- Test wargaming as a tool for evaluating policy options in healthcare

Participants brought to the Wargame a variety of perspectives on Medicare payment reform: providers participating in alternative payment models (APMs); providers not yet participating, health plans, policymakers, and researchers. Some participants have been proponents of Medicare payment reform, while others have been agnostic, awaiting more evidence. A smaller number of participants have been skeptics about Medicare's efforts at payment reform.

Participants were divided into three teams with nine members each. Each team represented a fictional market. Within their respective teams, participants were assigned roles to play (e.g., chief executive office [CEO] of an academic medical center [AMC] or of a vertically-integrated delivery system, regional vice president of a national health plan).

The markets varied in several ways: the level of Medicare per-beneficiary service use relative to the national average, the portion of Medicare payments flowing through APMs, the types of APMs in the market, Medicare Advantage (MA) enrollment, and market structure (e.g., the degree of vertical integration among providers and the number of AMCs). The three markets—Medianopolis, San Optimo, and Medicina—are summarized below; further description is provided in Appendix A.

Medianopolis

Individual players represent healthcare organizations doing business in the **market with average costs and extensive vertical integration of care delivery**

Medicina

Individual players represent healthcare organizations doing business in a **market with high costs and powerful "brand name" providers**

San Optimo

Individual players represent healthcare organizations doing business in a **market with low costs and limited vertical integration of care delivery**

Each team responded to three "moves," spanning a five-year period (2016-2021). Each move presented a fictional policy and economic environment and is described in detail in Appendix B:

- **Move 1** focused on how to encourage providers to leave fee-for-service (FFS) for APMs.
- **Move 2** focused on how to balance encouraging provider participation in APMs with the need to strengthen incentives for efficiency.
- **Move 3** focused on the implications of an aggressive move by a future Presidential Administration and U.S. Congress to eliminate FFS.

Within each move, there was an "inject" that required the teams to react to a modification of the scenario.

The structure of this wargame (e.g., the design of the markets, the moves, and the structure of teams) focused the discussion on some issues to the exclusion of others. For example, a wargame designed specifically to

simulate how payment reform affects rural areas, different patient populations, or quality of care may produce different, although not necessarily inconsistent, results.

ADVICE FOR POLICYMAKERS

One of the goals of the Wargame was to provide advice to policymakers. There was broad agreement among the teams—although not unanimity—on the many issues. The following advice resulted from the wargame discussions:

- **Stay the course.** Participants began the Wargame with varying levels of confidence in the effectiveness of Medicare payment reform. Those differences persisted during the game. However, there was broad agreement across the teams that the new Administration entering office in 2017 should continue to support payment reform. Providers and health plans, not to mention the Federal Government, have made substantial investments in payment and delivery reform. Continuity in policy will help assure that those investments are rewarded.
- **Hasten reform of FFS.** Enthusiasm for APMs should not obscure the importance of improving Medicare's FFS payment systems. FFS is likely to be an important part of Medicare for the foreseeable future, and it serves as the "chassis" for many of the new payment models. So long as FFS is sending inappropriate "signals" about what is valued (e.g., procedures and imaging being much more richly rewarded than cognitive services), efforts to improve value in care delivery will be handicapped.
- **Act more aggressively to support primary care.** Time and again over the course of the Wargame's three moves, the teams expressed concern about the state of primary care, highlighting it as a cornerstone for reform of health-care delivery. Teams were eager to see new methods of paying for primary care implemented throughout Medicare and incorporated into other APMs.
- **Include MA as an integral part of payment reform.** If enrollment in MA continues to grow, it may supersede Medicare APMs as a vehicle for encouraging delivery system reform in many markets. MA plans have the potential to tailor their efforts to local market circumstances and to be more flexible in designing new payment models to suit the varying circumstances of providers. MA plans are also often superior to Medicare in providing providers with data useful in managing care. Policymakers should consider MA and payment reform as complementary initiatives, not independent efforts, and consider explicit steps to increase their synergy (e.g., incorporating payment methods into MA star ratings).
- **Do more to encourage multi-payer reform.** Medicare payment reform is useful, but multi-payer reform is necessary to strengthen incentives for providers and to hasten the transition from maximizing revenue to producing value. Participants see value in continuing to attempt to establish performance measures to be used by all payers—public and private. Another step would be to reward MA plans for adopting APMs (e.g., by incorporating payment reform in star ratings). If done under the auspices of a state, multi-payer reform could also offset increased provider market power from consolidation.
- **Anticipate, and address, unintended consequences.** Even when APMs effectively encourage providers to reduce cost and improve quality, they may have unintended consequences. For example, the three teams agreed that APMs encourage mergers and other forms of consolidation among providers, which may pose particular problems for private purchasers who lack Medicare's leverage with providers. Fewer small practices and providers may also lead to declining physician and patient satisfaction. The teams also agreed that there could be an increase in "tiering" of care (i.e., different levels of access and service based on patient income) as Medicare ratcheted up pressure on providers and adopted premium support (which occurred in Move 3). Anticipating, and addressing, unintended consequences before they occur may be important for preserving any gains from Medicare payment reform.
- **Think, and act, strategically on how APMs fit with one another.** Policymakers have been focused on developing, testing, and promoting an ever-increasing number of new payment models. The proliferation of new models, which may accelerate due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), makes it vital to consider how APMs fit with one another (e.g.,

ACOs versus episode-based payment). Overlapping initiatives potentially raise the question of who gets credit for savings when those savings may be attributable to work done by two different groups (e.g., savings from reductions in readmissions). If policymakers wish to encourage population health, as exemplified by ACOs, then ACOs should be able to claim a significant share of the savings. If, on the other hand, policymakers wish to encourage episode-based payments—perhaps as a faster path to payment reform—then the organizers of episode-based payment initiatives should be able to claim a larger share of any savings. This issue will become increasingly acute, and policymakers' degrees of freedom may diminish, as constituencies form around new models.

- **Proceed with changing benchmarks, but be cautious on requiring risk.** The teams agreed that it is important to shift from ACO financial benchmarks based solely on provider-specific costs to benchmarks blending provider-specific and regional costs. Such a shift rewards provider efficiency, not just improvement. If done gradually, shifting benchmarks might be accomplished without driving out high-cost providers. However, requiring high-cost providers to begin assuming downside risk, while also making the transition in benchmarks, could markedly reduce participation by providers with high historical costs. The benchmarking change should take precedence, and ACOs should be given the option of continuing with an upside-only contract.
- **Consider market characteristics in making decisions about payment reform.** Fostering APMs may be more important in a market like that depicted by Medicina, which was stipulated to have high per-beneficiary service use, than in a market like San Optimo, which was stipulated to have low Medicare per-beneficiary service use. Decisions about the calculation of benchmarks, whether to require providers to bear risk, and how to combine ACOs (which are voluntary for providers) with episode-based bundling (mandatory) often involve trade-offs and uncertainty. Policymakers may wish to give precedence to what will work best in markets like that modeled by Medicina. Those markets are the most expensive for Medicare and, thus, are the highest priority from a fiscal perspective. However, markets like San Optimo and Medianopolis need not be given short shrift. For markets with those characteristics (lower-than-average service use, as modeled in San Optimo, or an advanced level of vertical integration, as in Medianopolis), Federal policymakers may wish to do more to facilitate and encourage waivers for state-level programs.
- Increase opportunities for beneficiary engagement with APMs. Providers can better coordinate and integrate care if patients embrace the idea that a collection of providers is responsible for their care, not a single provider. Achieving that understanding is difficult when beneficiaries are passively "attributed" to APMs based on where patients received care in the past. Many patients have limited, or no, knowledge of their "relationship" with the group of providers operating under an APM. Similarly, providers are handicapped when patients are attributed to them retrospectively. Introducing new payment methods without a stronger bond between providers and patients is problematic, especially if providers are required to assume financial risk.
- **Share savings with beneficiaries.** Medicare beneficiaries should share in the savings from APMs, especially if they use "in-network" providers (e.g., an ACO-tailored supplemental plan). The benefits of such an arrangement are two-fold:
  - Combining downside risk with patient free-choice-of-provider may expose providers to more risk than they can bear so creating a mechanism for encouraging beneficiaries to use "in-network" providers may be essential to making the combination feasible.
  - Assuring that beneficiaries share in savings could help avert the sort of beneficiary protest posited in Move 3.
- **Speed development of patient-focused quality measures.** Quality measures that address outcomes important to patients, and that are readily understood and used by patients, are essential. Such measures could help prevent a backlash against payment reform by beneficiary and patient organizations. Absent such measures, patients may be concerned that shifting from FFS to APMs encourages providers to deny needed services.

- **Protect safety-net providers.** Safety-net providers could be further imperiled by payment reform. Participating in new payment models requires investments in forging new relationships with other providers (perhaps, including new corporate structures), clinical programs, information systems, and staff with new skills. Safety-net providers may lack the means to make these investments, and they may be seen as less attractive partners for other providers seeking new relationships (e.g., because of their finances, payer mix, or location). Absent concerted action to address these challenges, safety-net providers could be increasingly vulnerable.
- **Invest in improving the Centers for Medicare & Medicaid's (CMS') operational capabilities.** Medicare payment reform could be compromised by CMS' limited operational capabilities. Problems with the timeliness of data, and the accuracy of data, were frequently cited. These problems will grow in importance if providers are required to bear financial risk, either through ACOs or mandatory bundling.
- **Include Part D drugs in APMs.** Given the importance of drugs in managing patients with serious medical problems and chronic illnesses, excluding Part D drugs from new payment models complicates efforts to improve value. Participants recognized that the exclusion of Part D drugs is attributable to the design of Part D (i.e., Part D is insured by a different party than Parts A and B). If it is not possible to incorporate Part D drugs into APMs, Medicare Advantage may be a more attractive path for reform.

MARKET REACTIONS: HOW TEAMS RESPONDED TO THE MOVES

Move 1

Set in 2016, Move 1 asked teams to identify policy tools that would increase provider participation in APMs in their market. At least two teams identified the following tools:

- Reform the FFS payment system that serves as the "chassis" for APMs (e.g., increase payment for primary care relative to specialty care; remove site-of-service payment differential; pay AMCs differently)
- Create incentives for beneficiaries to use providers participating in the APM (e.g., a tiered Medigap plan)
- Incorporate private health plans into payment reform initiatives (e.g., encourage them to participate by linking MA stars to how providers are paid)
- Continue to work toward standard performance measures for providers participating in APMs (aligning performance measures for private payers and Medicare)
- Integrate new models for delivering primary care into ACOs (e.g., CPC+), instead of carving them out
- Expand mandatory bundled payment for episodes

Teams were then asked whether they would advise the new Administration entering in 2017 to reaffirm Department of Health and Human Services (HHS) Secretary Sylvia Burwell's goals and policies or to change course. Two teams responded, but the third team did not have time to discuss this question. Each of the responding teams warned that frequent changes in course by policymakers are disruptive and wasteful. Continuing on the same general course is, therefore, preferable. Each team also urged HHS to integrate Medicare Advantage into the payment reform effort.

Move 2

Set in 2017, Move 2 asked teams whether CMS—having begun to transition from provider-specific ACO benchmarks to benchmarks also incorporating regional costs—should require MSSP ACOs to bear downside risk beginning with their third contract cycle.

The three teams approached this issue differently, reflecting the characteristics of their respective markets.

- **Medianopolis, the market that advanced furthest in combining different levels of care into integrated systems, urged CMS to accelerate its efforts to reward providers for their efficiency relative to their markets.** The teams acknowledged that shifting benchmarks to reward efficiency, not a provider's improvement relative to its own past performance, would apply significant pressure to high-cost providers. The Medianopolis team concluded, however, that most of those high-cost providers would remain in the ACO program because they also have the greatest opportunities to cut costs. **Even so, the team recommended CMS give Medicare Shared Savings Program (MSSP) providers the option of a third contract period with no downside financial risk.** The Medianopolis team also urged CMS to move quickly to give providers the option of selecting a model not based on the chassis of FFS payment (e.g., global capitation).
- San Optimo, a market with lower than average Medicare service-use per beneficiary and a less than average level of APM activity, emphasized the importance of multi-payer efforts to reduce costs and improve care. **The San Optimo team said that requiring MSSP ACOs to bear financial risk might stifle the already limited Medicare APM activity in its market, which would not advance the cause of multi-payer payment reform.** Multi-payer reform is urgent in San Optimo, because private purchasers do not necessarily have the same low costs as Medicare.
- Medicina, a market with high Medicare service use and powerful AMCs, focused on how to make APMs suitable and appealing for high-cost providers, while also rewarding low-cost providers for their

efficiency. The Medicina team concluded that a gradual convergence of benchmarks was the best approach, which could be accomplished by blending provider-specific and regional benchmarks or by permitting different rates of growth. **Requiring ACOs to bear risk would be inappropriate, in the team's view, unless combined with some mechanism to encourage beneficiaries to use in-network providers and limits on the maximum loss; otherwise, ACOs would be subject to risk over which they have too little control.** Without these conditions, requiring providers to bear risk may lead to marked decline in participation.

Each team was then asked whether its recommendations on benchmarking and risk would be different if mandatory episode bundling were implemented for 30% of Medicare inpatient expenses and if MA enrollment were significantly higher.

- **The teams agreed that expanding episode-based bundling presents an important strategic question: Does CMS wish to encourage providers to assume full responsibility for a defined population, as in ACOs? If so, ACOs should be given the option to claim a significant portion of the savings from bundled episode payments; otherwise, expanded bundling significantly diminishes potential ACO savings. The teams differed, however, on the priority to be given to ACOs.**
  - San Optimo, the market with the least vertical integration among providers, concluded that episode-based bundling and increased MA enrollment were more relevant for their community than ACOs.
  - Medicina, with much higher than average MA enrollment, agreed that further MA growth would likely reduce provider interest in ACOs.
  - Medianopolis, with its significant degree of vertical integration among providers, expressed support for the ACO model.

Move 3

Move 3, set in 2021, posits an aggressive move by a future Administration and the Congress to eliminate FFS as an option for providers. Policymakers seek to accomplish that goal by increasing the payment differential between FFS and APMs (first established by MACRA), expanding mandatory episode-based bundling to cover 50% of Medicare inpatient expenses, and converting Medicare to a "premium support" model under which beneficiaries have strong incentives to go to low-cost plans and providers.

- **The Medianopolis team concluded that policymakers would achieve their goal of accelerating payment and delivery reform, but not without risks.** On the positive side, the decisive move away from FFS would prompt the AMC to revamp its teaching curriculum to prepare future clinicians to practice with a focus on quality and value. Further, the market's highest-cost vertically-integrated system would conduct a top-to-bottom review of its operations to wring out wasteful spending. On the other hand, such aggressive policies would likely prompt still more consolidation among providers, testing the boundaries of antitrust. Pressure on the safety-net hospital would be intense, perhaps forcing it to find a partner among the vertically-integrated systems or to carve out a niche in providing low-cost care to lower-income Medicare beneficiaries and dually-eligible beneficiaries. Another risk is more "tiering" of care, with some providers and patients being consigned to tiers with fewer resources and amenities, as well as possibly lower quality.
- **San Optimo's team concluded that an aggressive move to end FFS would have a significant effect on its market, disrupting established patterns.** The San Optimo team would expect a wave of provider consolidation, even though its market has been characterized by less consolidation than the other markets. Given that San Optimo has relatively low Medicare service use per beneficiary, the market could become unattractive to national provider organizations as Medicare payments are squeezed (e.g., investor-owned hospital companies). Health plans would likely adopt narrower networks, both in Medicare Advantage and in the private sector, a substantial shift from where the market was in 2016. The AMC and safety-net hospital may be excluded from some networks, possibly compromising their

missions and viability. Private purchaser concerns about cost-shifting would increase still further absent some effort to establish a multi-payer effort at reform.

- **Medicina's team expects the increased financial pressure in Move 3 would compel some improvements in health-care organization and referral patterns, but not without some potential ill effects.** For example, secondary care may be shifted from AMCs to community hospitals, while community hospitals close tertiary-care programs. Tighter links may also be forged between hospitals and ambulatory-care providers to reduce inappropriate use of the ER. However, even more mergers and acquisitions would likely occur, with smaller physician groups finding it impossible to preserve their independence. Some physicians may opt to retire or leave the market, putting a premium on all clinicians practicing to the top of their license. The safety-net hospital, facing declining Medicare revenue, may be imperiled, especially if it is excluded from the AMC-sponsored networks. More tiering of care by income is likely.

The teams were then asked to respond to a hypothesized protest by beneficiary and patient organizations that claim "managed care is being forced upon them" under the guise of APMs. According to the protestors, providers decide whether to participate in an APM, while patients are "attributed" to APMs without their having any say in the matter. This is inappropriate, in the protestors' view, because APMs change the doctor/patient relationship in a fundamental way. Unlike FFS, APMs create incentives to withhold care. Compounding the problem, providers and the Federal Government get the bulk of any savings from APMs, not patients. The beneficiary and patient protest was joined by some physician specialty societies.

The teams were asked to respond to the protestors and whether Medicare beneficiaries should have the option of remaining in a Medicare plan offering a free-choice-of-provider and FFS payment, provided they are willing to pay an added premium if the FFS option costs more than other options in their region.

- **The three teams agreed that the beneficiary protest highlighted the importance of better quality measures and more transparency.** Better information—and more readily understood information—is critical if beneficiaries are to be persuaded that APMs encourage providers to improve care, not just withhold it. **San Optimo and Medicina favored offering a FFS option, although neither team expected it to be chosen by many beneficiaries, given the presumably high cost. The Medianopolis team opposed offering the FFS option as it was confident that beneficiaries could be persuaded that providers working under APMs are improving care, not withholding needed care.** Maintaining a FFS option, according to Medianopolis, would impede efforts to reorient care toward higher quality. Each of the teams supported giving beneficiaries the option to align with an ACO and share in any savings.

WARGAMING: A TOOL FOR POLICYMAKING

Policymakers are inundated with advice about Medicare issues. For the most part, that advice comes from a single affected party or an association that represents a relatively homogeneous group. Organizations like the Medicare Payment Advisory Commission (MedPAC) and the National Quality Form (NQF), which are designed to bring together diverse perspectives, are exceptions. MedPAC and NQF, however, have lengthy agendas and their policy advice may not be as timely or focused as policymakers may wish. Wargaming could help fill this void by eliciting input from a diverse group of participants in a focused and timely manner.

Booz Allen had three hypotheses about how wargaming might assist policymakers in executing Medicare payment reform, each of which was at least partially confirmed. Wargaming could help policymakers:

- Anticipate how payment reform might play out in markets with different characteristics.
- Think about potential interactions among policies as they unfold over a period of years.
- Anticipate unintended consequences of their decisions.

The market context did seem to influence the discussion and recommendations of the three teams, although (as discussed in Advice for Policymakers) there was also significant agreement among the teams. However, executing a market-based game is challenging. The market descriptions and the accompanying roles within the market must include sufficient detail to make them feel "real." In addition, role-playing is challenging, particularly if a participant is called upon to play a role dissimilar from his or her actual job.

Move 2 was designed to test interactions among policies (e.g., benchmarking and risk taking; ACOs and episode-based bundling and MA). Considering policies in combination did, in fact, influence the discussion, both within the teams and in the plenary sessions. (See Advice for Policymakers for examples.)

Finally, the discussion in each team, and across all three moves, was rife with examples of potential unintended consequences from APMs. The effect on safety-net providers, the tendency toward market consolidation, and the risk of "tiering" based on patient income are noteworthy examples.

Even if wargaming is deemed useful in helping policymakers anticipate how their actions might influence actors in the relevant space, there should be no illusion that a single wargame can capture all of the complexity and dynamism of the real world. The design of a wargame (e.g., markets, moves, team structure) will focus the discussion on some issues to the exclusion of others. Wargaming is, in that sense, no different than other forms of policy analysis; all analysis focuses and simplifies.

While this wargame did not identify issues about payment reform that had not been previously discussed in other forums, it demonstrated the interplay among various issues and policies. Existing forums (e.g., notice-and-comment rulemaking, legislative hearings, private and public meetings between policymakers and interested parties, journal articles) are effective in identifying issues. Wargaming could be a powerful tool to help policymakers assess the relative importance of issues and how to reconcile the competing perspectives of interested parties, all in a focused and timely manner.

APPENDIX A: MARKET SUMMARIES

	San Optimo	Medianapolis	Medicina
Medicare per beneficiary service use as % of national average	90%	100%	110%
% of Traditional Medicare's payments in HCLAN category 3 or 4	15%	50%	30%
Types of APMs present in market	MSSP Track 1 (1) BPCI Round 2 (1) Medical homes (few)	Pioneer (1) Next Gen (1) CJR site Medical homes (many within vertically-integrated systems)	Pioneer (1) Next Gen (1) Medical homes (many in vertically-integrated systems)
Medicare Advantage enrollment as % of beneficiaries in market	20%	30%	50%
Provider roles	+ AMC (MSSP) + Safety net + Vertically-integrated system, with multiple hospitals and clinics plus provider-sponsored plan + An independent community hospital (BPCI) + Medical society president	+ AMC + Safety net + Vertically-integrated systems (2) (Pioneer and NG) + Potential physician-led ACO	+ AMC with vertically-integrated system (Pioneer) + Safety net + Vertically-integrated system based on merger of large MD group and an AMC (NG) + An independent community hospital + Medical society president
Health plan roles	+ Local NFP (largest) + National FP seeking market share	+ Local NFP (largest) + National FP seeking market share	+ Local NFP (largest) + National FP seeking market share
Purchaser roles	State health dept. Purchaser coalition	State health dept. Purchaser coalition	State health dept. Purchaser coaltion

APPENDIX B: SUMMARY OF WARGAME MOVES

Move 1 (Present Day):

Scenario
Present Day

Background

- In April 2015, HHS Secretary Burwell announced goals for increasing use of value-based payments in Medicare:
  - 85% of all Medicare FFS payments will be tied to quality or value by 2016 and 90% of FFS payments will be tied to quality or value by 2019.
  - 30% of all Medicare payments will be tied to quality or value through APMs by the end of 2016 and 50% of all payments by the end of 2018.
- The Health Care Payment Learning and Action Network (HCPLAN) has established a framework to monitor progress toward achieving these goals, to serve as a taxonomy for payment reform, and to gauge overall progress in payment reform outside of Medicare.
- In March 2016, the Administration announced that CMS had already achieved the goal to have 30% of all Medicare payments tied to quality or value through APMs—ahead of the target date of December 2016.

Scenario

- HHS Secretary Burwell is meeting with healthcare leaders from a variety of markets across the country.
- Secretary Burwell wants to understand which policy tools will be most effective to encourage providers to volunteer for HCPLAN Categories 3 and 4.

MOVE 1

Discussion Questions

- What is your initial characterization of your market? What are your market's most important features/qualities?
- Develop a list of policy tools to address the Secretary's goals and why they might be effective
- Which of those policy tools would be most helpful for your market to encourage providers to leave traditional FFS in favor of an APM?
- Examples of policy tools include:
  - Payment differentials (e.g., pay more for a service provided in Category 3A than for the same service provided in Category 1 or 2)
  - Regulatory relief (e.g., grant greater flexibility to providers in Category 3B and Category 4 by easing or eliminating certain regulations)

Move 1, Inject (2017):

Scenario
2017

New Administration Floats ACA Repeal

- The new Administration has announced it will conduct a thorough review of payment reform, and has been having open discussions around whether the Affordable Care Act should be repealed.

Inject Questions

- From the perspective of your market, should the Administration reaffirm Burwell's goals or change course on payment reform? Why?

Move 2 (2017):

Scenario *2017*

- CMS is seeking the policy "sweet spot" that will encourage providers to participate in the ACO program but also strengthen the incentives for good performance. "Strengthening" incentives requires careful consideration of benchmarking and risk.
- After rapid initial growth following its inception in 2012, growth of the MSSP ACO program has slowed. Although new ACOs continue to sign up, some ACOs that joined the program in 2012 or 2013 have dropped out.
- ACOs seem to be improving quality, but cost savings have been limited. Some observers say the incentives for ACOs to reduce costs are too weak—especially in one-sided models (i.e., those where ACOs share in savings, but do not assume the risk of losing money).
- The likelihood that an MSSP ACO will earn shared savings continues to be directly related to the level of the ACO's financial benchmark (i.e., ACOs with high historical costs are more likely to earn shared savings than providers with lower historical costs).
- In late 2016, CMS revised the method for setting financial benchmarks for MSSP ACOs (finalizing a proposal made in January 2016):
  - For ACOs beginning their second contract period, the benchmark will be based in part on ACO-specific historical costs and in part on a comparison between the ACO's costs and average costs in its region.
  - The new benchmarking method is intended to increase rewards for ACO efficiency as opposed to the previous method of basing rewards on ACO improvement relative to its own past performance.
- This Benchmarking Matrix provides a framework for considering the implications of the new method:

	Service Area with low costs relative to nation	**Service Area with high costs relative to nation**
ACO with low costs relative to Service Area	Quadrant 1: Low-cost ACO in low-cost Service Area	Quadrant 2: Low-cost ACO in high-cost Service Area
ACO with high costs relative to Service Area	Quadrant 4: High-cost ACO in low-cost Service Area	Quadrant 3: High-cost ACO in high-cost Service Area

- The new method is expected to make the ACO model more attractive in Quadrants 1 and 2 of the Benchmarking Matrix, while making it less attractive to the high cost ACOs in Quadrants 3 and 4.
- CMS hopes to retain ACOs in Quadrants 3 and 4 by gradually making the shift to the new benchmarking method.

MOVE TWO Discussion Questions

- To improve your market's performance, is it more important to: (a) increase financial rewards to ACOs that already have low costs relative to your market (Q1, Q2) or (b) reward ACOs with high costs (Q3, Q4) for improving relative to their own past performance? What are the key tradeoffs your team members discussed?
- If CMS requires ACOs to bear financial risk, how would it effect the development of your market?
- What policy levers would be most effective in encouraging providers to participate in the ACO program, even if they are disadvantaged by policy decisions on benchmarking and risk?
- Bottom line: Should CMS require MSSP ACOs to bear financial risk in their third contract cycle?

Move 2, Inject 1 (2019):

Scenario
2019

- Two recent developments juxtapose mandatory and voluntary policy issues:
  - Comprehensive Joint Replacement (CJR) demonstration
    - Established mandatory episode-based bundles in 67 markets and has been implemented nationwide.
    - Covered episodes have been expanded so that one-third of Medicare inpatient costs would be paid through the new method.
  - Accelerated MA enrollment
    - Due to the aging baby boomers, over 40% of Medicare beneficiaries nationwide are now enrolled in MA plans.
    - Many are enrolled in plans with networks designed to steer patients to low-cost providers.

Inject Questions

- How do these developments in the health care policy environment (i.e., the expansion of CJR and the expansion of MA) change your market's advice to CMS about risk-bearing in ACOs?

Move 2, Inject 2 (2020)

Scenario
2020

- With CMS having adopted benchmarking and risk policies designed to maximize rewards for efficiency, and with episode bundling applied to one-third of Medicare inpatient expenses, many "essential community providers" (ECPs) (designated under ACA) are struggling financially
- Improving performance often requires investments in new organizational structures, clinical programs, skilled staff, and information systems. Some ECPs lack the financial resources to make the necessary investments let alone bear financial risk under the ACO and bundled payment programs

Inject Questions

- From your market's perspective, what are your recommendations to CMS on how to respond to this unintended effect on essential community providers?

Move 3 (2021):

Scenario
2021

- Secretary Burwell's goals for APMs have been achieved; the effect on quality and cost has been positive, but less than hoped.
- A weak U.S. economy and retiring baby boomers have combined to cause a rapid increase in the Federal budget deficit.
- With interest rates historically low, the Federal Reserve has little room to stimulate the economy.
- In response, the Administration and the Congress are proposing cuts in entitlement spending, specifically Medicare (to limit debt in the long run).
- The goal of the Medicare package is for Category 3 and 4 APMs to become the standard form of Medicare payment by 2030.
- The proposed Medicare cuts include:
  - The MACRA APM bonus is made permanent, increased to 10%, and expanded to apply to all providers (not just physicians).
  - To qualify for the APM bonus, participating providers must bear "significant financial risk" (as opposed to "more than nominal risk" under MACRA).
  - Episode-based bundled payment is expanded to inpatient episodes covering over half of Medicare spending.
  - Medicare Advantage is converted to "premium support," giving beneficiaries a strong incentive to leave Medicare when lower-cost private options are available.

MOVE 3 Discussion Questions

- How would the proposed Medicare changes impact your market?
- What are the benefits of the proposed changes to your market? What are the potential unintended consequences?

APPENDIX C: HEALTHCARE PAYMENT REFORM WARGAME PARTICIPANT LIST

Team	First Name	Last Name	Title	Organization
Medianopolis	Stuart	Altman	Sol C. Chaikin Professor of National Health Policy	The Heller School of Social Policy and Management, Brandeis University
Medianopolis	Robert A.	Berenson	Institute Fellow	Urban Institute
Medianopolis	Peter	Butler	President	Rush University Medical Center
Medianopolis	Kathleen	Fierros	Vice President (VP) of Provider Network Innovations	Geisinger Health Plan
Medianopolis	Robert A.	Greene	Executive Vice President, Chief Population Health Management Officer	Dartmouth-Hitchcock Medical Center
Medianopolis	Kim	Kauffman	VP of Value Based Care	Summit Medical Group
Medianopolis	Stephen	Nuckolls	CEO	Coastal Carolina Health Care, PA
Medianopolis	Caroline	Steinberg	Vice President of Health Trends Analysis	American Hospital Association
Medianopolis	John	Toussaint	CEO	ThedaCare Center for Healthcare Value
Medicina	Jordan	Asher	Chief Clinical Officer and Chief Innovation Officer	Mission Point Health Partners
Medicina	Karen	Fisher	Chief Public Policy Officer	Association of American Medical Colleges
Medicina	Jeff	Goldsmith	President	HealthFutures
Medicina	Lynn M.	Guillette	VP Finance, Payment Innovations	Dartmouth-Hitchcock Medical Center
Medicina	Barbara	McAneny	CEO	New Mexico Cancer Center
Medicina	Ralph W.	Muller	CEO	University of Pennsylvania Health System
Medicina	Jeanne	O'Brien	CEO	Value Care Alliance
Medicina	Greg	Poulsen	Senior Vice President (SVP) and Chief Strategy Officer	Intermountain Health Care
Medicina	Dana	Gelb Safran	Chief Performance Measurement & Improvement Officer, SVP Enterprise Analytics	Blue Cross Blue Shield of Massachusetts
San Optimo	David	Carmouche	President, Health Network	Ochsner Health System
San Optimo	Chip	Kahn III	President and CEO	Federation of American Hospitals
San Optimo	Peter	Lee	Executive Director	Covered California
San Optimo	Gene	Lindsey	Former CEO	Atrius (Retired)
San Optimo	Robert E.	Mechanic	Senior Fellow	Heller School of Social Policy and Management Brandeis University
San Optimo	Samuel	Nussbaum	Former Executive Vice President (EVP) for Clinical Health Policy and Chief Medical Officer	Anthem (Retired)
San Optimo	Frank	Opelka	EVP	Louisiana State University Health System
San Optimo	Rachel	Regan	Manager, Payment Initiatives	ThedaCare Center for Healthcare Value

San Optimo	Nick	Wolter	CEO	Billings Clinic