



Reimbursement Analysis (1/2)

Case Studies



Engagement Type

Transaction Diligence

Transaction Diligence

Situation

A private equity sponsor evaluating an investment in a large single-state multispecialty physician practice and management services organization sought to understand the government program and commercial reimbursement outlook for the practice.

A lender evaluating providing debt financing to a multi-state operator of skilled nursing facilities sought to understand the key federal and state reimbursement catalysts and policy trends impacting the target company.

- Conducted Medicare fee-for-service reimbursement analysis at a code-specific and payment reform level
- Analyzed Medicare Advantage penetration rate and premium analysis at a national and county level
- Provided an outlook for Accountable Care Organization (“ACO”) migration to risk sharing models
- Assessed commercial health plan reimbursement at an E&M code-specific level

- Performed a Medicare SNF analysis including overview and assessments of Medicare coverage, reimbursement methodology, reimbursement outlook, SNF value-based purchasing and bundled payment initiatives, and Dual Eligible/Coordinated Care Demonstration programs
- Analyzed Medicaid and Medicaid Managed Care reimbursement for the company in select key states, including insights from Medicaid Managed Care Plans on trends in utilization management, network management and reimbursement for SNF services

Description of Marwood's Work and Analysis

Medicare Payment Scenario Analysis

Scenario	Revenue	Cost	Net
Scenario 1: Base Case	\$100M	\$60M	\$40M
Scenario 2: High Penetration	\$100M	\$65M	\$35M
Scenario 3: Low Penetration	\$100M	\$55M	\$45M

MA Enrollment in the State Will Likely See Steady Enrollment Growth, As There is Not Currently High Penetration

Year	MA Enrollment	Medicare Advantage
2015	15%	85%
2016	18%	82%
2017	22%	78%
2018	25%	75%
2019	28%	72%
2020	32%	68%

ACA Expanded The Physician Quality Reporting System As A First Step To Physician Pay For Performance

ACA expanded the Physician Quality Reporting System (PQRS), which includes dermatologists, by establishing a penalty as a first step in developing a physician pay-for-performance program.

- The PQRS is a precursor to pay for performance.
- CMS provides incentive payments to eligible professionals (EPs) who voluntarily report data through the PQRS on quality measures for services furnished to Medicare beneficiaries.
- The Medicare Incentives for Physicians and Providers Act of 2009 extended the PQRS through December 31, 2013, and extended the PQRS through 12/31/2014 to 12/31/2015, respectively.
- ACA extended this program through 2014 and added a penalty starting in 2015 for eligible professionals who do not report the required data.
- Eligible professionals who successfully reported on quality measures for the January 1, 2014 to December 31, 2015 reporting period will be subject to a 1% reduction in their fee schedule payments in 2016.
- The same penalty will apply to subsequent reporting periods.
- CMS estimated that PQRS will cost approximately \$1.5 billion over the next five years, but only \$1 billion over the following five years, as savings begin to accrue from the reporting adjustments.
- The PQRS will end following the 2016 calendar year, as the newly passed permanent doc fix includes the Merit-based Incentive Payment System (MIPS), which combines 3 quality incentive payment programs, including PQRS, into a single quality incentive payment program.

CMS Will Continue To Support The ACO Program; The Long Term Goal Is To Move Providers To Two-Sided Models

Marwood believes that CMS will continue to significantly invest in ACO program over the next five years as motivated by continued efforts to “align”, “integrate” elements to improve performance, over time, the goal is to move more ACOs to models with two-sided risk.

- Expansion of alternative payment models, primarily ACOs and bundled payments, is a top priority for CMS.
- In January 2013 announcement, CMS released “Strategic Roadmap” with a goal of having 50 percent of total net patient payment arranged by the end of 2018, and having 50 percent of patients in two-sided models by the end of 2017.
- Over the past few years, as the ACO program has continued to roll out, CMS has made notable adjustments to incentives to encourage participation and success. Looking at this continued:
- Changes include allowing ACOs to receive “top 1” in the same shared savings percentage, adjustments to the shared savings calculation, and changes to the attribution rules for ACOs.
- Expansion of these models is likely to remain a priority for CMS and the ACO program is not an area of disengagement (i.e., creating barriers while improving quality).
- Programs have generally moved to risk sharing arrangements of the ACO program.
- Over time, CMS will likely continue to “encourage” ACOs to two-sided risk models, although it is unlikely ACOs will be forced to do so in the short term.
- For example, ending the alternative Payment Model from Track 2 and 1 MSP ACO will encourage ACOs to move under these models rather than 1.
- The “top bonus incentive for APMs will be a substantial incentive to move physicians to two-sided risk models.
- CMS has proposed an ACO Track 1+ model that will be available in 2014 and will combine and advance APMs to the top of the ACO program.

The Outlook For Part A SNF Reimbursement Is Slightly Positive In The Near Term, Potential Pressure For Medium Term

Year	SNF Reimbursement	Outlook
2015	\$100M	Stable
2016	\$105M	Slightly Positive
2017	\$110M	Stable
2018	\$115M	Potential Pressure
2019	\$120M	Potential Pressure
2020	\$125M	Potential Pressure

Dual-Eligible Plans Receive Medicare And Medicaid Capitation Payments For Service Delivery

Under the demonstration program, in states utilizing a capitated payment model, duals plans receive Medicare and Medicaid capitation payments, which are then used by the plans, as the single public payer, to reimburse providers for the delivery of services.

- Medicare Related Capitation Payment:
 - For Medicare Part A, CMS develops a portfolio of incentive codes for Medicare A and B services for each demonstration county – an assessment of each CMS model is based on the demonstration plan.
 - Monthly fee amount, which is derived each year from the competitive Part D bidding process.
 - Each state utilizes a state-specific, aggregate savings assessment to the Medicare A component.
 - The Medicare A/B capitated component are risk-adjusted according to the risk profile of each universe, based on the CMS HC and RHC risk adjustment models, respectively.
- Medicaid-Related Capitation Payment:
 - States develop their own Medicaid capitation payment methodology, but generally premium is calculated using a base rate that is modified by risk-conversion, risk-adjustment, and other factors.
- Under the capitated model, the duals plans are responsible for reimbursing service providers – there are no set fee schedules that plans must use, as plans negotiate rates with providers.

SNF Utilization Management Will Continue To Grow As A High Priority In Both State 1 And State 2

State	Utilization Management	High Priority
State 1	High	Yes
State 2	High	Yes

Marwood Completed A Referral Source Analysis Within Three Key Markets

Provider Type	MSA 1	MSA 2	MSA 3
Rehab	1	2	9
Long Term Acute	1	2	5
Hospital	5	14	6
Home Health	17	12	10
TOTAL	24	30	30



Reimbursement Analysis (2/2)

Case Studies



Engagement Type

Reimbursement Strategy

Transaction Diligence

Situation

A clinical-stage company specializing in the development of an endovascular medical device sought Marwood's assistance in developing a strategy to achieve the best CMS approval, coverage and reimbursement outcomes for its medical device.

A leading private equity-backed physical therapy treatment provider was evaluating an add-on acquisition with operations in three key states and needed to understand the reimbursement outlook for Medicaid, workers' compensation and commercial health plan payors.

- Provided an overview of the process by which CMS would grant coverage, coding and reimbursement determinations
- Crafted a positioning strategy for the client to utilize in approaching CMS about the benefits and value of its therapy based on Marwood's regulatory and reimbursement expertise

- Provided an outlook of Medicaid, workers' compensation, auto insurance and commercial health plan payor environments in key states
- Conducted surveys and discussions with commercial health plans and Medicaid Managed Care plans to assess trends in coverage, utilization, network access, reimbursement methodology and reimbursement trends for outpatient physical therapy services

Description of Marwood's Work and Analysis

If No Existing Codes Adequately Describe A New Device, The Manufacturer Can Apply For A New HCPCS Code

Manufacturers can submit applications for a HCPCS code throughout the year, but determinations are only made once per year.

- To be considered for inclusion for the upcoming year, manufacturers must submit their applications as early as a year before a deadline date (i.e., to be considered for inclusion for 2018, applicants could submit requests as early as January 2018 until the January 2017 deadline)
- HCPCS codes are publicly meeting every 180 days to receive stakeholder input
- Medical devices are generally assigned "C" codes

Manufacturers should begin the application process once they have received FDA approval (or are near approval) and can provide the proper paperwork with the application. If a HCPCS code is not yet granted or the request has been denied, the manufacturer can use the most appropriate existing code or use a miscellaneous code.

If a HCPCS code is granted by CMS, the next step for manufacturers is securing payment. To seek a payment designation, manufacturers can apply for pass-through status (Q) new technology APC

The manufacturer can apply for either a pass-through (Q) a new tech APC, or both.

- As the applicant, the manufacturer should take the lead in pricing and get professional organizations' input/sponsorship.
- The process of acquiring pass-through status or new tech APC is done on a quarterly basis, compared to first arrival process for HCPCS.
- Determinations of payment status often occur approximately after two quarters (~6 months).
- If pass-through or new tech APC is granted, CMS gives the manufacturer 3-5 years to gather data on the product's utilization at the medical community before making a reimbursement decision of how to proceed with payment of the product.
- If the device is being widely used by the manufacturers, the device likely to be added to the relevant bundle and bundle will be updated to reflect the use of the new device.
- If the device is being used, but the device likely to be added to the relevant bundle, but the bundle will only be updated to reflect the device's temporary utilization.
- If the device utilization is great but the device is not used by the manufacturer or stakeholders that convince CMS that the device is added to the relevant bundle with an exact request to the value of the bundle, this is an unachievable outcome.

Pass Through	New Tech APC
A single payment system	A bundled payment system
Typically by requirement methodology	Typical for assessment methodology
Stakeholders manufacture at the rate	Manufacturers set about the average for comparable procedures in the same space
CMS considers costs to manufacturer and passed overhead	CMS considers costs to provider and passed overhead

Not all are viable options, but the manufacturer will need to discuss what category the product CMS does not do this. However! Believe that a pass-through will be the best option for the company.

The flowchart details the process from FDA approval to CMS reimbursement determination, including steps for CPT code submission, HCPCS code submission, and final reimbursement status.

The flowchart details the CMS reimbursement process, including application submission, review by the CPT Executive Committee, and final reimbursement determination.

State By State Health Plan View Comparison

State	Commercial Health Plan View	Medicaid Health Plan View
State 1	Health networks will continue to add services with new APCs and codes.	Health networks will continue to add services with new APCs and codes.
State 2	Health networks will continue to add services with new APCs and codes.	Health networks will continue to add services with new APCs and codes.
State 3	Health networks will continue to add services with new APCs and codes.	Health networks will continue to add services with new APCs and codes.

