The current system is changing from Fee-For-Service to payment for outcomes.

A Value-Based Purchasing system provides financial incentives for outcomes (Value)

Medicare Access and CHIP Reauthorization Act of 2015
  - MACRA legislation provides direct incentives to Physicians and Hospitals to move towards a system that pays for outcomes

In the past, there were real financial incentives to providers, when complications occur
Opportunities for EB Programs created by ACA

• Value-Based Purchasing
  – ACOs
  – Bundled Payment for Care Improvement (BPCI)
  – Comprehensive Joint Replacement (CJR)
• Medicare Advantage Reward-Incentive Programs
• Medical Loss Ratio Requirements

• Aligning your program to these initiatives will increase contracting opportunities
Purchasers

- Managed Care Organizations (MCOs)
  - Medicare Advantage
  - Medicare Special Needs Plans
  - Medicaid Managed Care
- Medicaid MLTSS Plans
- Bundled Payment Participating Organizations
- Accountable Care Organizations
- Duals Demonstration MCOs
Accountable Care Organizations

- Accountable Care Organizations
  - An association of hospitals, providers and insurers in which all parties assume accountability for the quality of patient care, and how money is spent as it pertains to a population.
  - ACOs are eligible for a percentage of the savings that they create – Shared Savings
    - Next Generation – Near Full Risk
    - Pioneer ACO – Up to 75%
    - MSSP ACOs – 50 – 60%
ACOs must improve quality and lower the total cost of care for the attributed population

- Falls: Screening and intervening for Fall Risk
- Medication Reconciliation
- Prevention: Influenza and Pneumococcal vaccination
- Weight screening and follow-up
- Diabetes: HbA1c control, B/P control, ASA compliance
- CVD: Medication compliance (ACE, Beta, Statin, ASA)
- All-Cause Readmissions
ACO Opportunity

- Ability of your EB-Program to assist the ACO in meeting their mandated quality metrics
- Requires data collection, reporting, and quality assurance
- ACO providers are graded on the documentation that is found in their E.H.R.
- Must have the ability to support transfer of pertinent information into physician/hospital E.H.R.
Why wouldn’t the ACO pay for my services?

• If the ACO reports a preference not to pay for services it may be tied to how they are compensated.

• Understanding their compensation model is key

• Often, their preference would be to assist the CBO in getting compensation from third-party payer (Medicare)
  – Become the preferred provider of preventive health programs for the entire ACO population
  – Your ability to bill Medicare directly or through partnership will facilitate the referral process
  – Same strategy may work for Medicare Advantage plans
• MCOs, ACOs, Health Systems, and Physicians that require improved outcomes will buy or build the infrastructure to improve outcomes

• Your value proposition must present an option where the value of the services and the COSTS provide a ROI that is much greater than the cost to build

• CMS ACO Information Website
  – http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-Your-State.html
Value-Based Purchasing Opportunities

• Disease self-management programs that can address the cost of care, reduce readmissions, and improve outcomes address key issues facing the healthcare system
  – Improve Physician Value-based purchasing
  – Reduce Readmissions Penalties
  – Improve Hospital Value-based purchasing
  – Health Systems and industry will create programs to address this problem if good options are not presented
• ROI must be clearly defined and measured
Bundled Payments for Care Improvement Initiative (BPCI)

• Bundled Payments for Care Improvement Initiative: One of the new payment and service delivery models created by the Innovation Center
• Innovation Center – The Center for Medicare & Medicaid Innovation. Division of CMS that supports the development and testing of innovative health care payment and service delivery models.

Bundled Payments for Care Improvement Initiative

- Initiative first awards were announced January 31, 2013
- Under this initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care
- Episode of Care
  - Key component of the initiative
  - All services rendered are bundled into one payment for an episode of care
  - Provides a financial incentive for the org. to keep costs down
Is there a BPCI Near You?

Source: Centers for Medicare & Medicaid Services
Medicare Basics

• Medicare (2015) consists of 4 parts
  – Part A
    • Inpatient hospital, SNF care, home health, hospice
  – Part B
    • Doctor services, office visits, screenings, therapies, preventive services, outpatient services, emergency care, ambulance care, medical supplies, & durable medical equipment
  – Part C
    • Medicare Advantage
      – Must cover all Part A and Part B benefits
  – Part D
    • Pharmacy benefits
Background

• Original Medicare, Part A & Part B
  – Pays for services under a Fee-For-Service delivery model
  – Separate payments are made for each individual providing services to a beneficiary
  – Since each provider bills separately for services, each provider focuses on how to secure their individual payment
  – Has the potential to cause fragmented care as there is no incentive for providers to work together to provide more efficient care
BPCI Financial Incentives

- Rewards providers for improvements in quality and efficiency of care
- Aligns incentives for coordinated care with the following provider types:
  - Hospitals, Post-Acute Care Providers, Physicians, and other Practitioners
  - Post-Acute Care Providers
  - Home Health Agencies
  - CBOs
BPCI Models

- Four Models – Each model links payments for multiple services serving beneficiaries
  - Model 1 – Retrospective Acute Care Hospital Stay Only
  - Model 2 – Retrospective Acute Care Hospital Stay Plus Post-Acute Care
  - Model 3 – Retrospective Post-Acute Care Only
  - Model 4 – Prospective Acute Care Hospital Stay Only
Eligible Beneficiaries

- Must be enrolled in Medicare Part A and Part B
- Must not have End Stage Renal Disease
- Must not be enrolled in any managed care plan for Medicare benefit coverage
- Beneficiary participates by selecting a participating provider for care
Model 2 - Retrospective

- Retrospective Acute Care Hospital Stay Plus Post-Acute Care
- Episode of Care: Inpatient stay plus related Post-Acute Care
  - 30 days
  - 60 days
  - 90 days
- Includes: All non-hospice Part A and Part B services
- Participants must select from 48 different clinical conditions
To SNF or Not to SNF?
Financially, we do not want to SNF
Target Price for 30 – 90 days
Limiting high cost, post acute care reduces the potential profits in a bundled payment scenario
If no SNF?
  – Coordinate support services in the home
  – Ensure coordinated post acute care and follow-up
  – Regular monitoring to advert complications
Model 3 - Retrospective

• Retrospective Post-Acute Care Only
  – Inpatient care is not included in the Model 3 bundled payment
• Episode of Care: Post-Acute Care Services with a participating skilled nursing facility
• Range of time: 30, 60, or 90 days
  – The longer the episode, the higher the payment
• Includes: All non-hospice Part A and Part B services
• Example: Rehab facility, long-term care hospitals, home health, and community support services
<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
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<tbody>
<tr>
<td>Acute Myocardial Infarction</td>
<td>Amputation</td>
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<tr>
<td>Atherosclerosis</td>
<td>Automatic implantable defibrillator</td>
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<tr>
<td>Back and neck except spinal fusion</td>
<td>Cardiac arrhythmia</td>
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<tr>
<td>Cardiac defibrillator</td>
<td>Cardiac Valve</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Cervical Spinal Fusion</td>
</tr>
<tr>
<td>Chest pain</td>
<td>COPD, bronchitis/asthma</td>
</tr>
<tr>
<td>Anterior/posterior spinal fusion</td>
<td>Non-Cervical spinal fusion</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Coronary artery bypass surgery</td>
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<tr>
<td>Diabetes</td>
<td>Esophagitis other digestive disorders</td>
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<tr>
<td>Joint replacement</td>
<td>Factures of femur and hip/pelvis</td>
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<td>GI Bleed</td>
<td>GI Obstruction</td>
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<tr>
<td>Hip and Femur procedures</td>
<td>Lower extremity procedure</td>
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<td>Major bowel</td>
<td>Major cardiovascular procedure</td>
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<tr>
<td>Major joint replacement of lower ex.</td>
<td>Major joint replacement of upper ex.</td>
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<tr>
<td>Medical non-infectious orthopedic</td>
<td>Medical peripheral vascular disorders</td>
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<tr>
<td>Nutritional and metabolic disorders</td>
<td>Other knee procedures</td>
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<tr>
<td>Other respiratory</td>
<td>Other vascular surgery</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>Pacemaker Device replacement</td>
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<tr>
<td>Percutaneous coronary intervention</td>
<td>Red blood cell disorders</td>
</tr>
<tr>
<td>Removal of orthopedic devices</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Revision of the hip or knee</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Simple pneumonia and resp. infections</td>
<td>Spinal fusion (non-Cervical)</td>
</tr>
<tr>
<td>Stroke</td>
<td>Syncope and collapse</td>
</tr>
<tr>
<td>Transient Ischemia</td>
<td>Urinary tract infection</td>
</tr>
</tbody>
</table>
BPCI Roles

- **BPPP** – Bundled Payment Physicians/Practitioners
- **BPPO** – Bundled Payment Provider Organization
- **Risk Bearing**
  - Awardee
  - Awardee Convener
- **Non Risk-Bearing**
  - Facilitator Convener
  - Can serve in an administrative or technical capacity
  - Supports awardees that are assuming financial responsibility
Comprehensive Care for Joint Replacement Model (CJR)

- Proposed rule published in the Federal Register on 7/14/2015
- Acute care hospitals in each of the 64 geographic areas will receive retrospective bundled payments for episodes of care
- All related care within 90 days of hospital discharge
- Episode initiator – Admission to the Acute Care Hospital
- DRG – Knee and Hip replacement surgery
Model Overview

• Bundled Payment for Lower Extremity Joint Replacement (LEJR) for designated hospitals
  – Start Date: April 1, 2016
• Final Rule established November 16, 2015
• Link to the Final Rule:
CCJR Risks

- Year 1 – No downside risk
- Year 2 – Participant hospitals will begin bearing financial risk
- Eligible beneficiaries who receive care at these hospitals will automatically be included in the model
- CMS proposed to test the model for five (5) years
- Retrospective reconciliation
  - If negative, CMS will require payment from the participant hospital for the difference
CBO Participation

- Know who is participating in Bundled Payment in your market
- Make yourself aware of the level of risk that they are incurring
- Propose an intervention that aligns with the financial and quality goals in support of the bundled payment
- Define your ROI and track your ability to deliver this ROI to the customer
Are Duals Included?

- Duals are included unless they are enrolled in a Medicare Advantage Plan or Special Needs Plan (SNP)
- A Dual that receives Managed Long-Term Services and Supports is also included
- A Dual on Medicaid Waiver for HCBS is included
- *Medicaid costs DO NOT attribute to the final aggregated costs. Therefore, a strategy of maximizing Medicaid spending to lower Medicare costs can have positive financial benefits (Gain)*
What are the characteristics of Duals?

- According to the CBO, in 2009, there were 9 million dual eligibles and they cost Federal and State governments more than $250 billion in healthcare benefits.
- Medicaid provides health care coverage to low-income people who meet requirements for income and assets.
- All Duals qualify for full Medicare benefits, but they differ on the Medicaid benefits they qualify for.
Duals and Chronic Disease

- Full duals are twice as likely as non-dual Medicare beneficiaries to have at least three chronic conditions.
- Duals are nearly three times as likely to have been diagnosed with a mental illness, including chronic depression.
  - Many more have undiagnosed or untreated chronic depression.
- In 2009, total average healthcare spending:
  - Nonduals - $8,300 per year
  - Full Duals - $33,400 per year
LTSS for Duals

- Less than 0.5% of partial duals are institutionalized
- 15% of full duals are institutionalized
- Partial duals often transition to a full dual after completing the spend down period after a SNF/nursing home admission.
- Full duals are five times as likely to use LTSS as non-duals
- Full duals are twice as likely to use LTSS as the non-dual ABD population
VD-HCBS?

- A Veteran that has Original Medicare and uses their Medicare benefit to obtain a LEJR in a target MSA is included.
- If the Veteran uses VD-HCBS or VA Choice post discharge does this cost get included in the final cost aggregation? **NO.** The VA pays for these services and they are not included in the Medicare final cost aggregate.
HCBS Waiver Services?

• Are beneficiaries receiving Medicaid HCBS Waiver Services included: Yes if they also have Medicare (Dual).

• *A Dual receiving Medicaid HCBS will NOT have their Medicaid costs included in the final Medicare cost aggregation after 90 days

• Maximizing HCBS to drive down Medicare costs can be a real strategy in a partnership.
OAA Services?

- Are OAA Services included in the final price aggregation for the beneficiary – NO
- The aggregation of all expenses includes all Medicare Part A and Part B services. Therefore, OAA expenses are not included.
Home Visit Waiver

- CMS waives the “incident to” direct supervision rule for physician services to support home visits
- A home visit performed by a licensed provider can occur and will be reimbursable under this waiver
  - Must occur during the 90 day episode
  - A HCPCS code as been established for this model
  - Maximum of 9 visits during the episode
  - For beneficiaries that do not meet home health skilled requirements
Tele-Health Waiver

- Geographic site requirement is waived for any Medicare approved tele-health service
- The originating site can include the following:
  - Beneficiary Home
  - Assisted Living facility
  - Other place of residence
Beneficiary Incentives

• Hospitals may provide in-kind patient engagement incentives to beneficiaries.
• Incentives are to be used to encourage positive behaviors
  – Examples:
    • Adherence to drug regimens,
    • Adherence to care plan,
    • Reduction in readmissions,
    • Management of chronic diseases that may affect the LEJR procedure
Suggested Collaborators

- Collaborators can participate in Gainsharing
  - Collaborators must be Medicare providers
  - Physicians, Home Health, SNF, DSMT providers, DME providers, etc.
- Hospital is free to pay directly for services to support the beneficiary as part of the in-kind beneficiary incentive
  - Two week home delivered meal service in the immediate post-acute period
  - Participation in an evidence-based group exercise program targeting knee movement
Gainsharing

- Participants have a waiver that allows for Gainsharing
- Hospitals can share in the gains and the losses with participating “Collaborators”
- Hospitals must execute an agreement for gainsharing
- Collaborator must be a Medicare provider
- Hospitals are free to pay directly for services to non-Medicare providers
Value-Based Payment Financial Incentive Participation

• Value-Based Payment programs under Medicare provide financial incentives for lowering Medicare spending and improving health outcomes
  – Medicaid Spending is not included
  – OAA or VA funded services are not included

• Waivers allow for Gainsharing with other providers

• Full participation in Gainsharing requires each participant to be a Medicare provider

• CBOs must have their own Medicare provider number or partner with a Medicare provider to fully participate in Value-Based Payment Models
Questions

• Questions can be submitted in this open forum or by e-mail:
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  Direct: (202) 344-5465