

## Medicare Crystal Ball: A Five Year Look Ahead Reimbursement and Regulatory Structures

American Orthotic and Prosthetic Association  
January 2015

## Agenda

### Medicare 2015

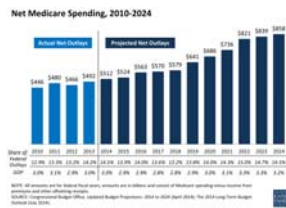
- Fee schedules
- "One size fits all"
- Audits, appeals, contingency-based contractors
- Limited barriers to entry
- Little care coordination or consumer information
- Physician-centric

### Medicare 2020

- Shared risk/shared losses, "packaged" payments
- Customized care
- Predictive analytics "real time" controls on reimbursement
- Accreditation, certification, CoPs
- Emphasis on care management and consumer tools
- Patient, allied health professional-centric

## Medicare Spending Today

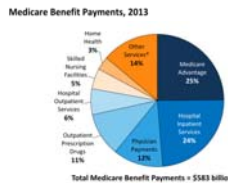
- In 2013, spending on all of Medicare accounted for 14% of the federal budget.
  - O&P just .3 of 1% of Medicare spending
- The cost of Medicare is a major contributor to federal spending – and costs projected to rise.
- Fee-for-service model is **volume-driven**.
- Program **evolving** to drive greater **value** over volume.



Actual	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
<b>Medicare Totals (billions of dollars)</b>												
Mandatory Outlays (a)	583	612	627	672	686	706	778	831	890	969	1,020	1,051
Discretionary Outlays	6	6	6	7	7	8	9	9	10	10	10	11
Gross Outlays	591	618	634	679	694	713	786	840	900	979	1,030	1,062
Total Offsetting Receipts (b)	-93	-99	-104	-109	-117	-126	-136	-145	-155	-166	-181	-191
Net Outlays (Total Outlays - Receipts)	498	518	530	570	577	587	650	695	745	813	850	869
Net Mandatory Outlays (Mandatory Outlays - Receipts)	492	512	524	563	570	579	641	686	736	801	839	858
<b>Components of Mandatory Outlays (Billions of dollars)</b>												
Part A	176	182	186	193	198	203	210	216	221	226	231	237
Part B	201	208	214	220	226	230	237	241	246	252	258	264
Part C	10	10	10	10	10	10	10	10	10	10	10	10
Part D	115	118	120	123	126	129	132	135	138	141	144	147
Budget Control Act Sequestration (offset of sequestration on spending for Medicare benefits) (c)	-	-11	-11	-12	-12	-13	-14	-15	-16	-17	-17	-17
Total Benefits	583	609	625	670	684	703	775	829	888	967	1,018	1,048
Mandatory Administration (d)	2	3	3	3	3	3	3	3	3	3	3	3
Total Mandatory Outlays	585	612	627	672	688	706	778	831	890	969	1,020	1,051
<b>Components of Benefits Payments (Billions of dollars)</b>												
Hospital Inpatient Care	139	143	148	154	157	164	171	179	187	195	203	210
Skilled Nursing Facilities	28	28	28	28	28	28	28	28	28	28	28	28
Physician Fee Schedule	71	73	75	77	78	79	80	81	82	83	84	85
Hospital Outpatient Services	37	41	43	46	47	49	51	53	55	57	59	61
Group Plans (includes Medicare Advantage)	145	156	164	167	172	178	212	230	248	262	288	281
Home Health Agencies	19	19	19	19	20	21	22	23	24	24	26	26
Part D (includes Prescription Drug)	25	26	26	26	26	26	26	26	26	26	26	26
Other Services (e)	70	73	76	78	80	80	80	81	82	83	84	85
Total Medicare Benefits Payments	583	609	625	670	684	703	775	829	888	967	1,018	1,048
<b>Net Mandatory Outlays (Billions of dollars)</b>												
Number of Capitation Payments (f)	12	12	12	13	12	11	12	12	12	12	12	11
Medicare Benefits, net of recoveries, adjusted to remove effect of long shifts (h)	566	590	605	627	650	702	749	800	857	918	979	1,047


## Medicare Payments Today

- Part A:** Hospital Insurance helps cover inpatient, hospice, skilled nursing facility services and certain home health care services.
- Part B:** Medical Insurance helps cover outpatient services, doctor services and other medical services.
- Part C:** Medicare Advantage (MA); private health plans administer parts A and B, usually in addition to other benefits, including Part D.
- Part D:** Prescription Drugs covers prescription drugs.



## The Way of the Future? Medicare's Evolving Models


- Value-based purchasing programs
- Alternative Payment Models
- Other approaches to shared risk
- Personalized medicine/customized care
- Quality and consumer information
- Admission or readmission avoidance
- Opportunities for allied health professionals
- Waste, fraud and abuse



## Value-Based Purchasing (VBP)

- Outcomes-driven incentive programs tied to consensus quality measures slowly adopted since 2004
- Systems tend to be more stick than carrot
- Recent addition of consumer “star ratings” creates additional layer of transparency
- Measure development essential
- Enhanced roles for CMS Chief Medical Officer, Center for Clinical Standards and Quality (CCSQ), Innovation Center

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## Alternative Payment Models (APMs)

- APMs could include arrangements such as bundling, gain sharing or global payments, among other approaches that link payments for multiple services patients receive during an episode of care
- Congress considering disease-specific APMs with incentive payments
  - Tie BIPA Section 427 to participation
- CMS Innovation Center testing new models of care that will focus on specific diseases, patient populations, and specialty practitioners in the outpatient setting to incentivize improved care, better health, and lower costs
  - Amputee health and/or rehabilitation medicine


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## Other Approaches to Shared Risk

- Accountable Care Organizations
  - Groups of providers take risk for FFS populations
  - Current law waivers allow for enhanced clinical coordination, care integration, consumer engagement
    - Tablets, phones, remote patient monitoring systems
  - Complicated benchmarking system, ~200 participants
- Bundled Payments
  - Bundled Payments for Care Improvement
    - ~6700 participants across 4 models
  - “Seamless Care” Initiative for ESRD
- Medicare Advantage
  - ~25% of beneficiaries and growing


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## Personalized Medicine/Customized Care

- Investments in personalized medicine and customized care for long term and chronic disease, including cancer, COPD, CHF, diabetes et al
  - Drug therapies tailored to individual's genetic profile
  - Care plans created in coordination with co-morbid conditions and community resources and the individual's life quality in mind
- Independence at Home Demonstration
  - Primary care practices provide home-based care to targeted chronically ill beneficiaries for 3 years
  - In-home visits tailored to patient's needs
  - Practices that meet quality measures while generating Medicare savings have an opportunity to receive incentive payments
- Complex Care Management (CCM)
  - Target with multiple or complex conditions, often combined with behavioral health problems or socioeconomic challenges. Use global payments, shared savings, or hybrid approach

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## Quality and Consumer Information

- Medicare's commitment to consumer information improvement evolving from online complex “compare” systems and science-based quality reviews to user friendly intuitive tools
  - Star programs tied to process, outcome measures and to CoPs
- CMS' star rating programs now or soon effective for drug and health plans, SNFs, HHAs, ESRD facilities and hospitals – the “Yelp” of healthcare – with more providers and suppliers likely included

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## Admission/Readmission Avoidance

- Community-based Care Transitions Program
  - Community-based organizations (CBOs) use care transition services to manage Medicare patients' transitions and improve quality of care
  - Early results do not show readmission reduction
- Hospital Readmissions Reduction Program
  - Specified payment penalties for readmissions tied to specific conditions
- Enhanced sensitivity to readmission risk across Medicare delivery system – CARE Tool


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## Opportunities for Allied Health Professionals

- Combination of shared risk incentives, new quality and accountability systems, increased regulatory burden and physician shortages, create opportunities for allied health professionals – including those in O&P
  - O&P engagement with adjacent providers
- Post Affordable Care Act Medicare environment demands resources from professionals other than physicians, regulatory system itself still has to catch up


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## Medicare Fraud and Abuse

<h3>Efforts Underway Now</h3> <ul style="list-style-type: none"> <li>▪ "Pay &amp; Chase"</li> <li>▪ MACs, RACs, ZPICs           <ul style="list-style-type: none"> <li>▪ Audits, backlogs</li> </ul> </li> <li>▪ HEAT Taskforce           <ul style="list-style-type: none"> <li>▪ DOJ/HHS</li> </ul> </li> <li>▪ National Fraud Prevention Partnership           <ul style="list-style-type: none"> <li>▪ Public-Private Partnership</li> </ul> </li> <li>▪ Provider Screening, Moratoria</li> <li>▪ Surety Bonds</li> </ul>	<h3>Potential Efforts in 2020</h3> <ul style="list-style-type: none"> <li>▪ Enhance Current Efforts</li> <li>▪ Predictive Modeling/ Predictive Analytics           <ul style="list-style-type: none"> <li>▪ Use algorithms and historical data to flag suspicious claims before payment</li> </ul> </li> <li>▪ Enhanced Provider Screening/Re-enrollment           <ul style="list-style-type: none"> <li>▪ Fingerprint background checks</li> </ul> </li> <li>▪ Data collection/pooling</li> </ul>
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## Other Predictions for Medicare 2020

- Continued rate and regulatory pressures for FFS providers (sequestration, productivity, other)
- Higher cost sharing for consumers
- More Medicare Advantage growth
- Continued declines in hospital-based services, increases in home and community based care
- Increasing reliance on risk arrangements, payment bundles, global payments and item/service packaging
  - May slow FFS spending growth (good for CMS)
  - May promote care coordination and relieve rate pressure/regulatory burden (good for patients and providers)
- Greater transparency into cost and quality of all items and services Medicare pays for

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## O&P Essentials for Medicare in 2020

- Be willing to take risk
- Refine O&P as a clinical specialty essential for outcomes-based payment system and alternative payment model success, *i.e.* cost containment
- Engage consumers, personalization/customization
- Align and affiliate with adjacent providers and services to create "seamless" care options in risk adjusted payment bundles
- Consider packaging O&P care with surgical, rehabilitative and other PAC services
- Demonstrate impact of O&P care with outcomes data, comparative effectiveness research ► life quality

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## Thank You

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