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

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Agenda

Medicare 2015

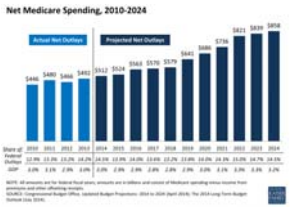
- Fee schedules
- "One size fits all"
- Audits, appeals, contingency-based contractors
- Limited barriers to entry
- Little care coordination or consumer information
- Physician-centric

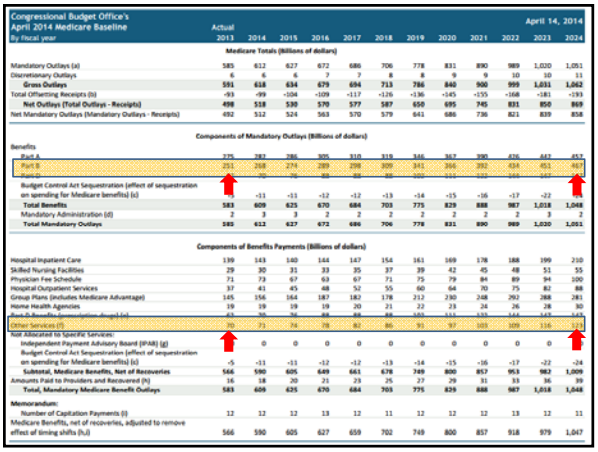
Medicare 2020

- 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

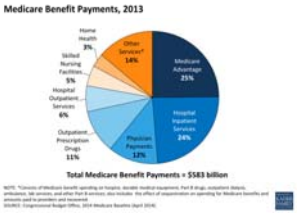
- In 2013, spending on all of Medicare accounted for 14% of the federal budget.
  - O&P just .3 of 1% of Medicare spending
- The cost of Medicare is a major contributor to federal spending – and costs projected to rise.
- Fee-for-service model is **volume-driven**.
- Program **evolving** to drive greater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





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

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

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

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

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

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

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

Medicare Fraud and Abuse

Efforts Underway Now

- "Pay & Chase"
- MACs, RACs, ZPICs
  - Audits, backlogs
- HEAT Taskforce
  - DOJ/HHS
- National Fraud Prevention Partnership
  - Public-Private Partnership
- Provider Screening, Moratoria
- Surety Bonds

Potential Efforts in 2020

- Enhance Current Efforts
- Predictive Modeling/ Predictive Analytics
  - Use algorithms and historical data to flag suspicious claims before payment
- Enhanced Provider Screening/Re-enrollment
  - Fingerprint background checks
- Data collection/pooling

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

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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