O&P Leadership Conference:
CMS’ Goal of Converting 50% of Medicare Payments to Value-Based vs. Fee-for-Service

Hospital Challenges in an Alternative Payment Model Environment

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Many Forces Are at Work as CMS Transitions from Prospective Payment to Alternative Payment Models (APMs), Including...

- Additional Challenges under Prospective Payment
  - Sequestration
  - Productivity adjustment
  - Medicare and Medicaid disproportionate share hospital (DSH) payment reductions
  - Meaningful use
  - Recovery Audit Contractor (RAC) and Medicare Administrative Contractor (MAC) audits
  - Observation days
  - MS-DRG coding adjustments

- Transition from Volume to Value
  - Hospital VBP program
    - Clinical Process of Care
    - Outcome
    - Patient Experience
    - Medicare Spending Per Beneficiary (MSPB)
  - Hospital Acquired Conditions (HACs)
  - Hospital Readmissions Reduction Program
  - Medicare Access and CHIP Authorization Act (MACRA)
  - APMs
    - ACOs
    - Bundling
      - BPCI Initiative
      - CCJR Model (proposed)
  - All-payer

Note: VBP is value-based purchasing. MACRA is Medicare Access and CHIP Reauthorization Act of 2015. ACOs is Accountable Care Organizations. BPCI is Bundled Payments for Care Improvement. CCJR is Comprehensive Care for Joint Replacement.
CMS Has Set Explicit Goals to Shift Medicare Payment Away from the Traditional FFS

- 50% of Medicare payment will be tied to APMs by 2018
- CMS actions indicate this is not “empty rhetoric”, as evidenced by its recently proposed mandatory Comprehensive Care for Joint Replacement (CJR) model

### Target Percentages for Medicare FFS Payments Linked to Quality and Alternative Payment Models in 2016 and 2018

- **Category 1**: FFS with no link of payment to quality
- **Category 2**: FFS with a link of payment to quality
- **Category 3**: APMs built on FFS architecture
- **Category 4**: Population-based payment

Source: U.S. Department of Health and Human Services
The Number and Complexity of CMS Pilot Programs has Created APM Overlaps and has Potential to Transform Stakeholder Alignments

- Given program overlaps, hospitals and physicians are often placed in opposition (e.g., physician-managed bundles take precedence over hospital-based bundles)
- CMS is offering Medicare providers greater incentives for alignment
- The interaction between APMs may create unintended consequences

Note:
BPCI is Bundled Payments for Care Improvement.
CJR is Comprehensive Care for Joint Replacement.
LEJR is Lower Extremity Joint Replacement.
MSPB is Medicare Spending Per Beneficiary.
MACRA is Medicare Access and CHIP Authorization Act.
VBP is Value Based Purchasing
AMP is Alternative Payment Models

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The Number of Candidates Participating in Bundled Payment Is Expanding\(^1\)

• About 2,041 providers moved to BPCI Round 2 as of July 1, 2015\(^2\)
  • Approximately two thirds of the participants in Rounds 1 and 2 dropped out before the risk-bearing period

• Top 10 convening organizations accounted for approximately 77% of BPCI market share\(^2\)

• The recently proposed CCJR bundles will be hospital managed – hospitals will take no less than 50% of the financial risk

Sources:
BPCI Models 2-4: Year 1 Evaluation – Not Much Is Known

• Recent implementation and limited participation of providers under BPCI have restricted evaluators in their ability to measure the impact of the program, but there does appear to be movement toward home health agencies (HHAs) and away from skilled nursing facilities (SNFs)

• There is uncertainty regarding which bundled payment designs are most effective

• Evaluation of BPCI Models 2-4 suggests that differences do exist between hospitals that selected to participate in BPCI and those that did not
  • Those hospitals that did not participate in BPCI tend to be small or rural providers, have fewer financial resources, serve low-income populations, and/or have a low case volume
  • Under the proposed mandatory CCJR, “reluctant” providers will be forced into the program


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As Evidenced by CJR, Mandatory Bundling Could Be A Next Step for Medicare and Medicaid Payment

CMS finalized the CJR model to start April 2016 to implement bundled Medicare payment to acute care hospitals furnishing Lower Extremity Joint Replacement (LEJCR) services. The model’s major features include:

- Mandatory in 67 randomly selected Metropolitan Statistical Areas (MSAs), targeting more high-cost regions, capturing close to 800 acute care hospitals
- 5-year program for 2016-2020, starting April 1, 2016
- No preparatory phase, but no financial risk payment in Year 1
- Hospitals bear financial risk, but can share some upside and downside risk with participant providers
- Gains are dependent on quality measures and voluntary data submission
- Reconciliation is conditioned upon:
  * meeting the target price
  * submitting quality data, and
  * satisfying both (2) quality measures

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Guidelines for How CMS Sets Expenditure Benchmark for ACOs or Target Price for Bundling

• In general, CMS pays regular FFS amounts upfront, after which shared savings (for ACOs) or gain-sharing (for bundling) are reconciled based on providers’ performance against:
  • the benchmark/target price,
  • quality data reporting, and
  • quality requirements

• The process follows a 3-step approach as below

  Set Expenditure Benchmark or Target Price
  • Set benchmark or target price based on historical Medicare spending data
  • Apply certain adjustments or discounts

  Upfront FFS Payments
  • Medicare pays all Part A and Part B using current FFS payment systems

  Payment Reconciliation/Risk
  • Adjust shared savings or gains/loss sharing based on providers’ performance against a number of set requirements
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Legislative Efforts on O&P Exemption from Post Acute Care Bundling

- AOPA discussions with key members of congress
  - Suggested legislative language exempting O&P from Medicare post acute care bundling legislation
  - Two suggestions for legislative language
    1. Exempt all O&P services
    2. Exempt all O&P services except OTS orthoses included in competitive bidding specifically under the narrow “minimal self adjustment” definition
The American Orthotics and Prosthetics Association (AOPA) submits the following suggested language and accompanying rationale for purposes of consideration during discussion of post-acute care payment bundling for Medicare services.

Rationale: Prosthetics and orthotics (artificial limbs and orthopedic braces) are very different from durable medical equipment (DME) inasmuch as it is not the distribution of commodities; rather orthotic and prosthetic care involves an ongoing series of clinical services provided by licensed and/or certified professionals which results through the use of devices, in the ability to regain or maintain ambulation and full function. Under the present Medicare structure, beneficiaries with limbo-loss or limb-impairment are permitted to choose the licensed and/or certified health care professional with whom they establish a patient care relationship. Importantly, as limb-loss is a permanent condition, this relationship is generally established for patient’s entire life. The patient has the right to choose a provider with whom they are comfortable and who best addresses their mobility needs. This clearly is a relationship that needs to be based on more than just a lowest-bid contractual relationship.

As we indicated in our meeting, there is a history which argues strongly in favor of the broadest exemption of prosthetics and orthotics from post-acute care bundling to protect the prerogatives and quality of care interests of these patients. Past experience with hospital DRGs and with SNFs illustrated that patterns developed whereby providers responded to comparable bundling by delaying and denying O&P patient care until the patient was discharged when it was clear that Medicare Part B assumed the cost of O&P treatment. Patient quality of care declined with these inappropriate delays in access to O&P care, often irreversibly compromising independent living and relegating the patient to nursing home care. It is imperative to avoid this damage to these mobility-compromised patients, which is a compelling reason why the best resolution is to completely exempt prosthetics and orthotics from the P&O bundle.

In addition, Congress and CMS have determined that competitive bidding is an ill-suited means of providing complex O&P care to Medicare patients. Similarly, bundled payments are poorly suited for the delivery of custom O&P care because the devices and related clinical services are of a unique nature that is not appropriately captured by a system that relies on a comparison between what may seem to be similar or substitute items and services. To include O&P in bundling would be a radical change to the Medicare system, and catastrophic for these limb-impaired individuals. Adoption of post-acute care bundling were to interrupt existing patient care relationships or deny Medicare beneficiaries the right to choose their prosthetist/orthotist.

Fortunately, Congress has previously addressed this issue in an appropriate manner when in 2003 Congress exempted all prosthetics and custom orthotics from Medicare competitive bidding. Congress limited competitive bidding to only “off-the-shelf” orthotics, which Congress further defined as devices which could be used by the patient with “minimal self-adjustment” and which do not require any expertise in trimming, molding, assembling, or customizing to fit to the individual. The number of “off-the-shelf” orthotic devices is limited both in number and in potential savings from bidding and/or bundling.

We believe the bundling bill you propose would best serve beneficiaries by simply exempting O&P care from the bundled payment and preserving the licensed and/or certified prosthetist/orthotist relationship in the same way you are protecting the patient/beneficiary’s right to select his/her physician, physical occupational therapist. That would be the safest route to protect these lido-loss/limb-impairment Medicare beneficiaries. If the Committee chooses not to afford beneficiaries
similar protections in their choice of the health professional committed to their lifetime mobility care, then we have offered an alternative in language, albeit much less desirable, which would address these patients vis-à-vis post-acute care bundling in parallel to and consistently with the policy Congress already adopted as to competitive bidding authority.

A. Proposed and Preferred Statutory Language:

“(B) EXCEPTIONS.—Such term does not include—

“(i) physicians’ services;
“(ii) hospice care;
“(iii) outpatient hospital services;
“(iv) ambulance services;
“(v) outpatient physical therapy services; and
“(vi) ‘prosthetics and orthotics’ as defined by Section 1861(s)(9)

B. Alternative, less preferable because it is more intrusive to patients, to follow the pathway Congress set in competitive bidding:

“(B) EXCEPTIONS.—Such term does not include—

“(i) physicians’ services;
“(ii) hospice care;
“(iii) outpatient hospital services;
“(iv) ambulance services;
“(v) outpatient physical therapy services; and
“(vi) prosthetic and orthotic devices and services, with the exception of those off-the-shelf orthotic devices if:

(a) CMS has included such devices in an actively operating competitive bidding program under section 1861(s)(9);
(b) A list of such off-the-shelf orthotic devices has been published pursuant to final notice and comment rulemaking under 5 U.S.C. § 500 et seq.; and
(c) In developing the list of such devices, the Secretary uses a strict definition and criteria of off-the-shelf devices established in Section 1847(a)(2), consistent with section 1834(h).”

*(Section 1847(a)(2) defines OTS orthotics as those orthotics described in section 1861(s)(9) of the Social Security Act for which payment would otherwise be made under section 1834(h) of the Act, which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.*)
Legislative Efforts on O&P Exemption from Post Acute Care Bundling

• H.R.2502-Comprehensive Care Payment Innovation Act of 2015
  – Introduced by Rep. Diane Black (R-TN)
  – Includes exemption of all O&P services from post acute care bundling except OTS orthoses included in competitive bidding defined as requiring “minimal self adjustment by the patient and not by any other person”
  – Restricts OTS orthoses to those that can be adjusted by the patient and not by any other person
Legislative Efforts on O&P Exemption from Post Acute Care Bundling

• H.R. 1458-Bundling and Coordinating Post-Acute Care Act of 2015
  – Introduced by Rep. David McKinley (R-WV)
  – Includes exemption of all O&P services from post acute care bundling
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  – Published in the November 16, 2015 Federal Register
  – Establishes a mandatory Medicare payment policy demonstration that will apply for hospital inpatient, outpatient, post-acute, and physician services rendered in connection with certain Total Hip Arthroplasty, Total Knee Arthroplasty, and select other lower extremity surgeries for the duration of the inpatient stay \textbf{and 90 days following hospital discharge}. 
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  – Demonstration policy will apply to hospitals in 67 Metropolitan Statistical Areas (MSAs), beginning on April 1, 2016 and lasting through December 31, 2020
  – Hospitals, physicians, and post acute care providers will continue to bill and be reimbursed through Medicare fee for service provisions for the duration of the demonstration
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  - Total Medicare Part A and Part B spending for services provided during the 90 day post discharge window would be reconciled against hospital-specific target expenditure amounts that are derived from a blend of hospital-specific and regional historical Medicare Part A and Part B payments for CJR episodes.
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  – For year 2 through 5, after reconciling actual spending with the target prices, hospitals (and any providers with which the hospital has entered into a joint risk-sharing contractual arrangement for the CJR model) would be required to repay the excess costs above the target price up to certain “Stop-Loss Limits” that would vary by year
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  – Hospitals and their risk-sharing contractual partners that achieve actual episode spending below the target price (and meet quality performance thresholds on required quality measures) would be eligible to earn a reconciliation payment for the difference between the target price and actual episode spending, up to the “Stop-Gain Limit”
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  – If all providers get to bill Medicare at standard pricing, the only way hospitals can meet cost reduction targets to earn bonus payments is to **reduce** the number of services Medicare beneficiaries receive from all providers in the first 90 days post-discharge
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  – The final rule establishes a 5% Stop-Loss Limit and Stop-Gain Limit for year 2, a 10% Stop-Loss Limit and Stop-Gain Limit for year 3, and a 20% Stop-Loss Limit and Stop-Gain Limit for years 4 through 5
Regulatory Impact on Post Acute Care Bundling

• Comprehensive Care for Joint Replacement Final Rule
  – The final rule provided for a waiver of the Skilled Nursing Facility (SNF) 3-day stay coverage requirement beginning in year 2 for SNFs rated 3 stars or higher on the SNF quality measurement system
VALUE-BASED REIMBURSEMENT
COMMERCIAL PAYER PERSPECTIVE

AOPA Leadership Conference
Rebecca Hasting
Hanger, Inc
January 9, 2016
HEALTH CARE ENVIRONMENT FOR COMMERCIAL PAYERS

2016 challenges – self-funded plans looking to cut fees, exchange businesses not yet self-sustaining

Increasing Medicare Advantage and Managed Medicaid plans – both with potentially lower margins than employer-based business

Driving scale – industry consolidation (fixed cost over a bigger enrollment base)

Automation and outsourcing

Continued commitment to increase in value-based schemes (although more nimble and market based than CMS)
VALUE-BASED PAYER ACTIVITY

Payers are committed to value transition for hospital and physician contracts
  - Estimates range from 30-80% over the next 3-5 years

Partnering and acquiring value-based delivery systems – significant ACO activity

Multiple models with goals being specific to market, driving specific behaviors (e.g., cost reduction, patient safety, care coordination, removing waste)

Engaging patients
  - “Skin in the game” with increasing deductibles and max out of pocket
  - Information sharing
  - Price transparency

*Hanger*
PAYER PERSPECTIVE ON VALUE-BASED REIMBURSEMENT FOR ANCILLARY PROVIDERS*

Value-based concepts will be translated and applied to ancillary services and value will be defined locally; must be measurable and meaningful.

Price pressure will continue; volume of services will be scrutinized in FFS setting.

Value will not be a stand-alone concept; it will be measured as a contribution to the whole (e.g. population health, patient safety, cost savings, established measures such as HEDIS, STARS).

No specific, grand plan today; in fact, 2-3 years may be a more realistic timetable.

Today—medical spend above $500-800 million/year in a specialty area is getting attention.

* Based on payer interviews
VALUE-BASED ENVIRONMENT FOR O&P

Today’s definition
VALUE = Reduced cost (reimbursement)
Slow or no adoption of more costly technology
Increasing prior-authorization requirements
Payers don’t have models for risk and aren’t administratively ready

Small number of payers contemplating some “innovation”
Potential introduction of measurable performance standards/guarantees with risk and upside

Lower community rate of reimbursement with “opportunities” to earn back

Outcomes – still no direct tie to reimbursement in our space
HOW O&P CAN GET READY

Examine and improve cost structure for more efficiency
  How can quality be maintained while delivering at less cost?
  How can cost be spread across a larger patient base?

Data to examine and to share
  What data driven improvements in care can be made?
  Are you working with an electronic medical record?

Demonstrable care pathways and outcomes
  Will accepted clinical practice and outcomes be required to get paid in the future?

Define and promote to payers what is acceptable
  Do methods like payment bundling or capitation have any relevance to O&P?
  How can O&P contribute to the larger measures in population health?