The Future of Value-Based Care and Alternative Payment Models

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Speaker

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Cardinal Health

Transitioned from naviHealth, a Cardinal Health company

About naviHealth

• Experienced partner in post-discharge transitions
• Large convener in BPCI partnering with 50+ hospitals across the country
• Technology solutions that build upon a deep patient database
Agenda

• Policy Signals
  • ACA Repeal and Replace Efforts on Hold
  • Evolution of MACRA
  • Cancellation of Mandatory Models
  • Announcements and Stakeholder Input
• Implications for VBC and PAC
  • Next phase of voluntary bundled payments
  • PTAC continue to review new potential models – but really for the agency to decide
Policy Signals
ACA Repeal and Replace Efforts on Hold

- Senate Republicans could not get agreement on repeal and replace or a skinny repeal – most notably coming down to McCain’s vote at the end of July
  - The pressure continues for repeal, as polls show voters still expect Obamacare reform

- Graham-Cassidy Bill – no vote
  - Repeal expansion, cost-sharing subsidies, and tax credits, and replace with block grants
  - Repeal individual and employer mandates

- New bills would need 60 votes in the Senate

- Marketplace stabilization does not have enough bipartisan support

- Meanwhile, the CHIP deal would leave CHIP federal match stable for 2018-2019, but ratchet the match down to pre-Obamacare rates in 2021
MACRA Overview

• Created the Quality Payment Program, which replaces the prior physician quality reporting programs – Physician Quality Reporting System (PQRS), EHR meaningful use, and Value-Based Modifier (VBM)

• Replaced the Sustainable Growth Rate (SGR) with pre-established update %

Two pathways for physicians and practitioners to participate in the QPP

- Quality Payment Program
- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models
Potential Benefits of Participating in an Advanced APM

MACRA-related (some are dependent on whether patient or payment thresholds are met)

- Simplification of reporting or exclusion altogether from MIPS measurement
- Exclusion from possible MIPS payment reductions (for partial QPs and QPs)
- 5% lump sum incentive payment (for QPs)
- Larger payment rate increase beginning in 2026 (0.75% for QPs versus 0.25% for other eligible clinicians)

APM-specific – potential for shared savings or other payments from the APM

Important to balance these potential benefits with potential costs
Advanced Alternative Payment Models

Current Advanced APMs (as of 2017)
• Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model, LDO and non-LDO two-sided risk arrangement
• Comprehensive Primary Care Plus (CPC+) Model
• Medicare Shared Savings Program (MSSP), Tracks 2 and 3
• Next Generation Accountable Care Organization Model (NGACO)
• Oncology Care Model (OCM), two-sided risk arrangement only

Potential upcoming additions
• Comprehensive Care for Joint Replacement (CJR), CEHRT Track
• Medicare ACO Track 1+
• Medicare-Medicaid ACO Model
• Vermont Medicare ACO (VT All-Payer ACO Model)
• New voluntary bundled payment model (TBD)

CMS will publish and update the list of APMs that qualify as Advanced APMs as new APMs are included
Cancelling Mandatory Episode-based Payment Models

CMS created 3 new EPMs that required hospitals participation in select geographic areas

- Acute myocardial infarction (AMI)
- Coronary artery bypass graft (CABG)
- Surgical hip/femur fracture treatment excluding lower extremity joint replacement (SHFFT)

CMS proposed to cancel the 3 new models for AMI, CABG, and SHFFT, and significantly reduced the mandatory participation in CJR
CMS Shows Openness to New Ideas

One-off outcomes-based pricing
• Novartis will participate in an outcomes-based payment agreement with CMS
• Novartis would only be paid if patients respond to the treatment, Kymriah, within one month.

Request for Information (RFI) regarding CMMI’s future direction
• New leadership is seeking out support for new priorities and a new agenda
• RFIs are not binding on CMS – comments are due to CMS on November 20

CMMI is interested in testing models in the following eight focus areas

<table>
<thead>
<tr>
<th>Increased participation in Advanced Alternative Payment Models (APMs)</th>
<th>Medicare Advantage (MA) Innovation Models</th>
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<tbody>
<tr>
<td>Consumer-Directed Care &amp; Market-Based Innovation Models</td>
<td>State-Based and Local Innovation, including Medicaid-focused Models</td>
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<td>Physician Specialty Models</td>
<td>Mental and Behavioral Health Models</td>
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<td>Prescription Drug Models</td>
<td>Program Integrity</td>
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What does this mean for VBC?
The recently proposed cancellation and changes to mandatory bundles re-affirms the Administration’s support of voluntary models like BPCI, ACOs, and CPC+

Changing the scope of these models allows CMS to test and evaluate improvements in care processes that will improve quality, reduce costs and ease burden on hospitals.”
– Seema Verma, CMS Administrator

Voluntary participation in bundled payments will continue after CMS cancels mandatory initiatives, experts say

Providers await new voluntary models expected to soon be released.

Scraping new mandatory bundled payment models is also in line with the Trump administration’s larger efforts to reshape bundled payments, including the rumored new version of the Bundled Payment for Care Improvement, or BPCI 2.0.
Looking to expand footprint of APMs

- CMS plans to announce a new version of BPCI this year
- Evaluating new proposals through the PTAC
Future of Alternative Payment Models

Expectations

- Continued testing of alternative payment models (APMs), including bundled payments and ACOs
- A new voluntary bundled payment model announced in 2017, begin in 2018
  - BPCI Advanced (name tent.) structured like BPCI with some improvements
- CMS will use stakeholder feedback in the design of the model
- CMS has solicited feedback from BPCI participants

Explanations

- MSSP is a statutory program
  - Recent OIG report shows high savings
- Bundled payments work! BPCI is starting to show large spending reductions and care improvement
- BPCI has broad support from many providers who elected to participate
- MACRA encourages participation in APMs and development of new APMs
- Voluntary models don’t force providers to participate
- The concept of bundling and capitation have historically been supported by Republican leadership
The Case for Continued Bundled Payments

Providers are encouraged to make investments to deliver higher quality, more cost effective, and streamlined care across the continuum.

- Better Care
- Reduced Spending
- Bi-partisan Support

- 2% guaranteed savings to Medicare
- Bundled payments have historically and continue to been supported by Republican leadership

Patients, Medicare, the new administration, and Republican leadership all benefit from the continued movement towards bundled payment models.
What are bundled payments?

**Fee-for-Service Model:** all providers paid for individual services.

**Bundled Payment Model:** all providers share in target payment for an episode of care.
Bundled Payment Episode of Care

Bundled Payment Episode of Care (90-Day Risk Period)

Who will coordinate and/or manage across the risk period?
Role of Post-Acute Care in Alternative Payment Models

Why target PAC?

- Large & growing component of spend
- Significant variations in utilization
- Major contributor to readmissions

Driving to targeted use of PAC

Opportunity for savings

Anchor stay is locked in

Anchor
Readmits
SNF
IRF
HH
LTCH

Lower Joints
Additional Focus on Building PAC Efficiencies

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<tr>
<th>ACOs</th>
<th>MedPAC</th>
<th>IMPACT Act</th>
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<tr>
<td>• JAMA: Participation in ACOs resulted in a 9% reduction in PAC spending w/ no decrease in quality of care&lt;br&gt;• PAC will continue as a key focal point in VBC</td>
<td>• Advocating for unified payment system across all PAC providers, regardless of setting&lt;br&gt;• Would rely on patient condition or risk factors for payment amount</td>
<td>• Requires Standardized and Interoperable Patient Assessment Data&lt;br&gt;• Requires changes to discharge planning rules</td>
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## IMPACT Act: Measures Timeline

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<tr>
<th>Measure Domain</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
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<tbody>
<tr>
<td>Functional Status</td>
<td>1/1/2019</td>
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<td>Skin Integrity</td>
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<td>Medication Reconciliation</td>
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<td>Incidence of Major Falls</td>
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<td>Transfer of Health Information</td>
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<th>Resource Use &amp; Other Measures Domain</th>
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<th>LTCH</th>
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<td>Medicare Spending Per Beneficiary</td>
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<tr>
<td>Discharge to Community</td>
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<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
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<tr>
<td>Potentially Preventable Hospital Readmissions</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
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Source: CMS Medicare Learning Network
Expectations for New Bundled Payment Model

• Participation
  o Multiple provider types may participate
  o Voluntary
  o No rulemaking

• Episodes
  o More limited conditions/episodes that BPCI 1.0 – likely the ones that are “working”
  o Potentially test new approaches, such as outpatient bundles – especially in light of the proposal to shift TKA from the IPO list
  o Episode definition likely similar

• Payment methodology
  o Prospective target prices; different approach to trending

• Advanced APM qualification
• Provide a method for current participants to continue into 2.0
For providers potentially interested in participating, preparation should begin now.
Essential Clinical Elements for VBC Success

Providing care coordination

Assuring transitional care management for those at highest risk of readmission and/or with the highest needs

Identifying and mitigating unnecessary, unplanned readmissions

Ensuring safe, timely, efficient and effective care transitions to the least restrictive setting

Partnering with committed, active, and accountable post acute care providers

Creating an environment that positively impacts the patient’s experience

KEEPING the patient at the center

Designing SIMPLY

Focusing on the right patient in the right setting, receiving the right quantity/quality of care, for the right amount of time
Importance of PAC in Bundled Payment Initiatives

How to Prioritized PAC Efficiencies

1st PAC Setting
- Determine most appropriate level of post-acute care upon discharge from acute facility (i.e., home health, skilled nursing, home)

Appropriate Length of Stay in PAC
- Keep patients for the right length of time required to optimize patient’s recovery

Right Amount of Therapy
- Provide the right the amount and severity of therapy needed per episode of care

Preferred Provider Network
- Create a high-performance post-acute referral network that can meet quality, efficiency and cost standards
Questions and Follow Up

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