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Overview of Value Based Payment Efforts Under Medicare

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Medicare Value-Based Payment Initiatives

OVERVIEW

- Bundled Payments
- Hospital-Specific
- Post Acute
- Primary Care/Outpatient
- Accountable Care

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Medicare Value-Based Payment Initiatives

BUNDLED PAYMENTS

- Bundled Payments for Care Improvements Initiative
  - Incentivizes providers to take **accountability for both cost and quality** of care
  - Four Models – can choose 48 clinical condition episodes to test (on models 2-4)
    - 1: Acute care hospital stay only – discounted payment rate with incentives
    - 2: Retrospective acute care hospital stay plus post-acute care
    - 3: Retrospective post-acute care only
    - 4: Prospective acute care hospital stay only
- Comprehensive Care for Joint Replacement
  - Effective 4/1/2016
  - Mandatory bundled payments for lower extremity joint replacement procedures in 67 select markets
  - Retrospective bundled payment model holds hospitals accountable for quality and cost of episodes of care extending 90 days post-discharge, including all related Part A and Part B services

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Medicare Value-Based Payment Initiatives

HOSPITAL-SPECIFIC INITIATIVES

- Hospital Readmission reduction
  - Payment reduction based on a hospital's excess readmissions as compared to that of hospitals nationally over a 3-year performance period
- Hospital Value-Based Purchasing
  - Funds are withheld from participating hospitals' base operating diagnosis-related group (DRG) payments and redistributed based on "Total Performance Scores"
- Hospital-Acquired Conditions Reduction
  - Based on conditions identified by HHS as high cost/volume which result in higher payment as a secondary diagnosis and could reasonably have been prevented through use of evidence-based guidelines
  - Where condition not present on admission, hospital paid as if secondary diagnosis not present

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POST-ACUTE INITIATIVES

- Skilled Nursing Facility Value-Based Purchasing Program (under development)
  - Required under Protecting Access to Medicare Act of 2014 (PAMA)
  - Must include an all-cause, all-condition hospital readmission measure, to be replaced as soon as practicable by an all-condition risk-adjusted potentially preventable hospital readmission measure
  - To provide increased/decreased payments based on measurements
- Home Health Value-Based Purchasing Demonstration
  - Provides a reduction or increase of up to 8-percent based on the HHA's performance on quality measures and improvement relative to its peers
  - Mandatory for all HHAs in the selected states

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Medicare Value-Based Payment Initiatives

PRIMARY CARE/OUTPATIENT INITATIVES

- Physician Value-Based Payment Modifier
  - Required under ACA, to be applied to physician payments by 1/1/2017
  - Provides for differential payment under the physician fee schedule based on the quality of care compared to the cost of care furnished to FFS beneficiaries during a performance period
  - In 2019 and beyond, the value-based payment modifier will be replaced by the merit-based incentive payment system (MIPS)
    - MIPS combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier, and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on:
      - Quality
      - Resource use
      - Clinical practice improvement
      - Meaningful use of certified EHR technology

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Medicare Value-Based Payment Initiatives

PRIMARY CARE/OUTPATIENT INITATIVES

- Oncology Care Model – for 6-month Episode of Chemotherapy/Related Services
  - Will use aligned financial incentives to improve care coordination, appropriateness of care, and access and decrease use of unnecessary services
  - To use per-beneficiary-per-month payment for the duration of the episode and a potential performance-based payment based on performance on quality measures
- Comprehensive Primary Care (CPC) initiative
  - Offers population and non-visit based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five “Comprehensive” primary care functions
- Comprehensive Primary Care Plus (to begin 1/2017)
  - National advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation
  - will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization

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Medicare Value-Based Payment Initiatives

PRIMARY CARE/OUTPATIENT INITATIVES

- The Independence at Home Demonstration
  - Participating practices will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations
  - Practices that meet quality measures and generate savings will have an opportunity to receive incentive
- Comprehensive ESRD Care Model
  - Dialysis clinics, nephrologists and other providers join together to create an ESRD Seamless Care Organization (ESCO) to coordinate care for matched beneficiaries
  - ESCOs are accountable for clinical quality outcomes and financial outcomes, measured by Parts A/B spending, including dialysis services
  - Participants receive savings/bear losses, with larger organizations able to bear higher levels of risk as compared to smaller entities

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Medicare Value-Based Payment Initiatives

ACCOUNTABLE CARE INITIATIVES

- Medicare Shared Savings Program (MSSP)
  - Two risk models – one allowing for sharing of savings only, the second allowing for sharing of both savings and losses, calculated by comparing expenditures to a CMS-established benchmark
- The Pioneer ACO Model
  - Similar to MSSP though allows for higher levels of payment and risk for the first two years
  - Those achieving savings during the first two years may move to a full risk
- ACO Investment Model (not yet operational)
  - Will test the use of pre-paid shared savings to encourage ACOs in rural and underserved areas and encourage current MSSP ACOs to transition to arrangements with greater financial risk

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Medicare Value-Based Payment Initiatives

ACCOUNTABLE CARE INITIATIVES

- Next Generation ACO Model (not yet operational)
  - Participants will bear higher risk and be eligible for higher reward than those under other current Medicare ACO initiatives
  - Will also allow a participant to accept a graduated level of risk from FFS reimbursements to capitation
  - May also offer "benefit enhancement" tools to help ACOs retain beneficiaries, including: (1) increased access to home visits, tele-health services, and skilled nursing facility services; and (2) opportunities to receive rewards for receiving care from the ACO and certain affiliated providers

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Questions?

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Upcoming Webinars

Value Based Payments Crash Course Series

- **Alignment and Simplification of Quality Measures Across Markets**
  May 10, 2016 at 2:00 – 2:15 p.m. ET
  Richard H. Hughes IV
- **Physician Payment Reforms: The Future of MIPS and APMs**
  May 17, 2016 at 2:00 – 2:15 p.m. ET
  Lesley R. Yeung
- **Value-Based Payments in Managed Care: The Legal Landscape**
  May 24, 2016 at 2:00 – 2:15 p.m. ET
  Jackie Selby
- **VBP and Managed Care Contracting**
  May 31, 2016 at 2:00 – 2:15 p.m. ET
  Basil H. Kim

To register, please visit: http://www.ebglaw.com/events/

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