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AAHKS 2016 Spring Meeting - Washington Advocacy Update

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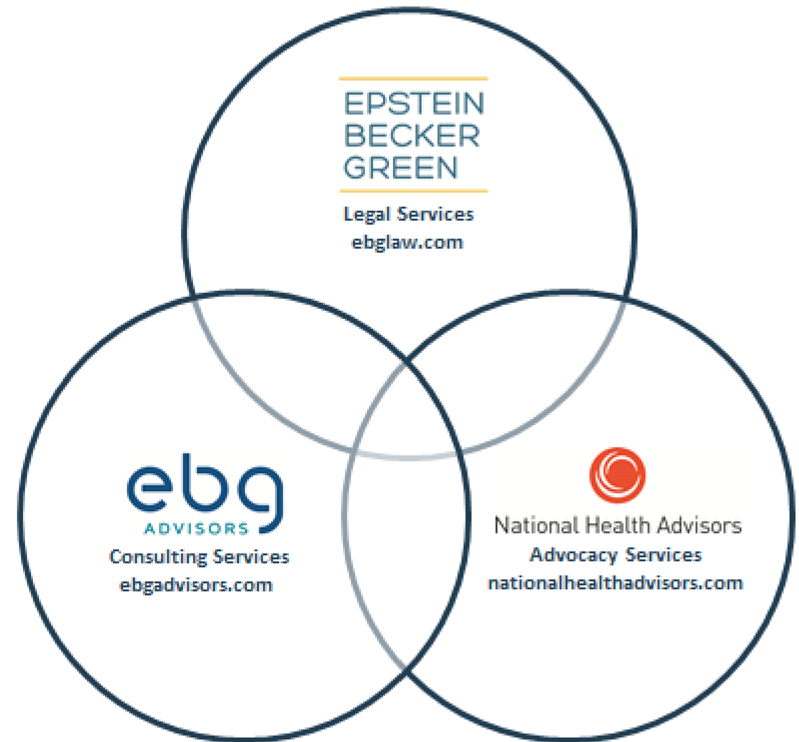

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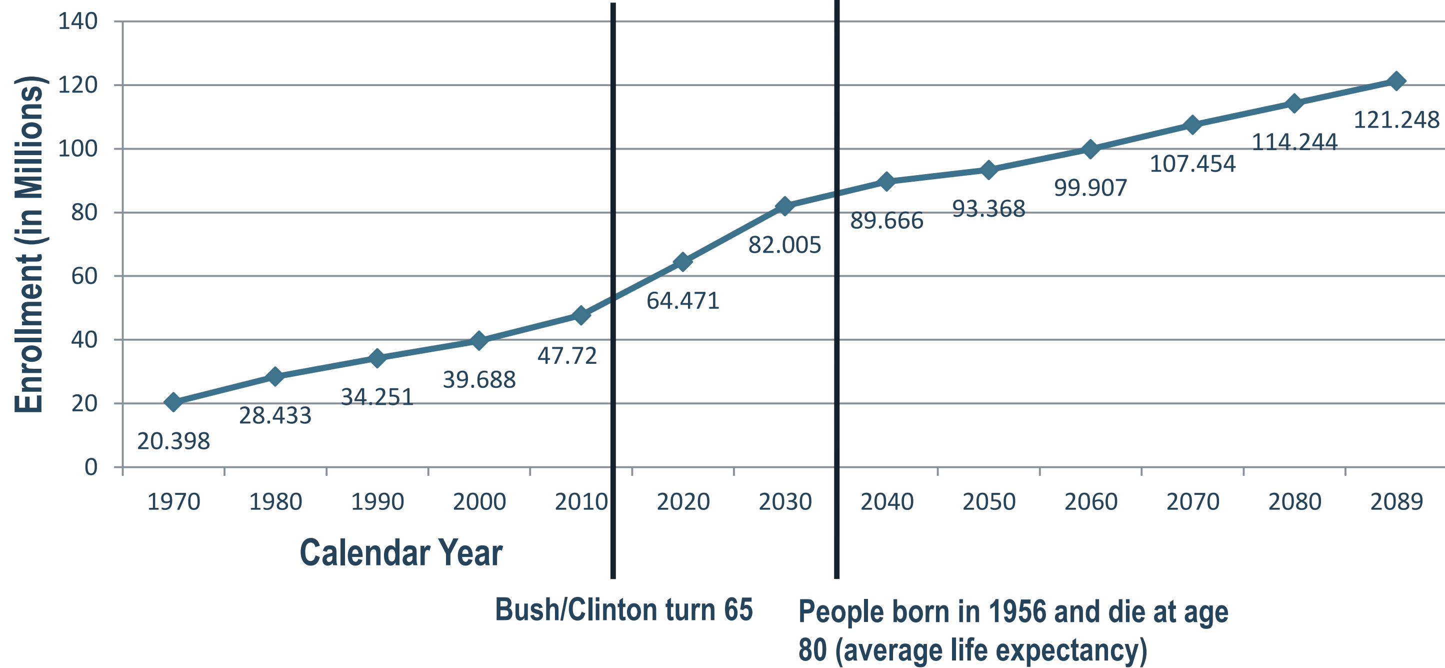
Medicare Demographic Trends

OVER 65 POPULATION – SOURCE OF COVERAGE



Key fact: Former President George W. Bush's birthday: July 6, 1946 & Former President Bill Clinton's birthday: August 19, 1946

Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.
Source: CMS Office of the Actuary. 2014

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Transition to APMs and VBP

HHS Goal for APMs and Value-Based Payments in Medicare

- In January 2015 HHS set internal goal to move towards rewarding value instead of volume, classifying payments into 4 categories:
  - 1) FFS with no link to quality
  - 2) FFS with link to quality
  - 3) APMs built on FFS architecture
  - 4) Population-based payment

- **Goal #1:** **30%** of Medicare payments tied to quality or value through APMs (categories 3-4) by the end of 2016, **50%** by the end of 2018
  - ***Update***: On March 3, 2016 CMS announced 30% goal had been reached

- **Goal #2:** **85%** of Medicare fee-for-service payments tied to quality or value (categories 2-4) by the end of 2016, **90%** by the end of 2018

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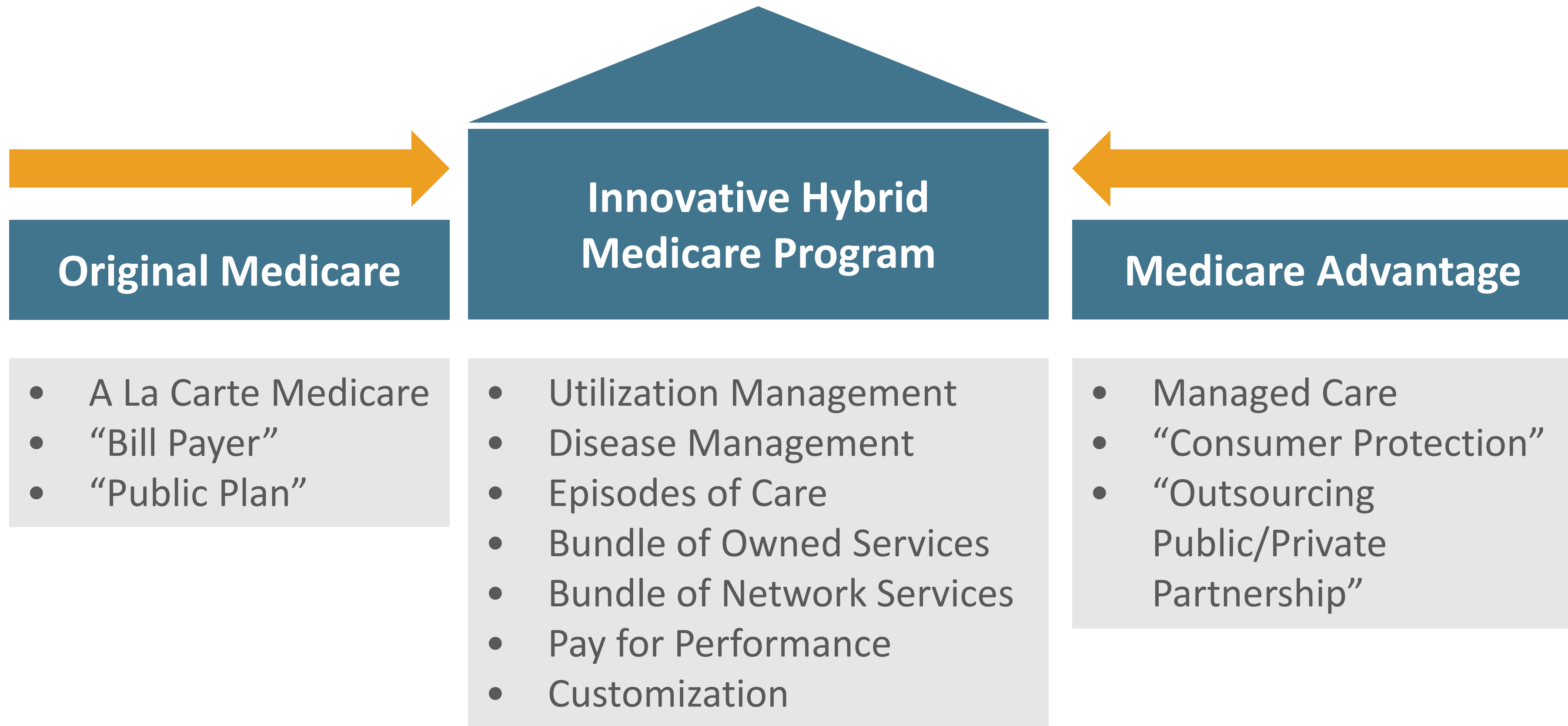
Transition to APMs and VBP

Innovative Hybrid Medicare Program Leads to Increased Integration and Collaboration



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Public and Private Payer Momentum

Current Preparation for Accelerated APM and VBP Transition

- **CMS Measures Development Plan (MDP)**
  - Formal government process to implement the new Medicare quality measures for physician Merit-based Incentive Payment System (MIPS) over the next 3 years. Consolidates PQRS, Value-Based Payment Modifier, and EHR Incentive Program
  - Informed by recommendations of the HCPLAN, Collaborative, and other private issue-specific groups
- **Health Care Payment Learning and Action Network (HCPLAN)**
  - Collaboration between CMS and America's Health Insurance Plans (AHIP) and others to develop consensus value-based payment models
- **Core Measures Collaborative**
  - Joint effort of CMS, AHIP, and others to develop consensus quality measures in key areas

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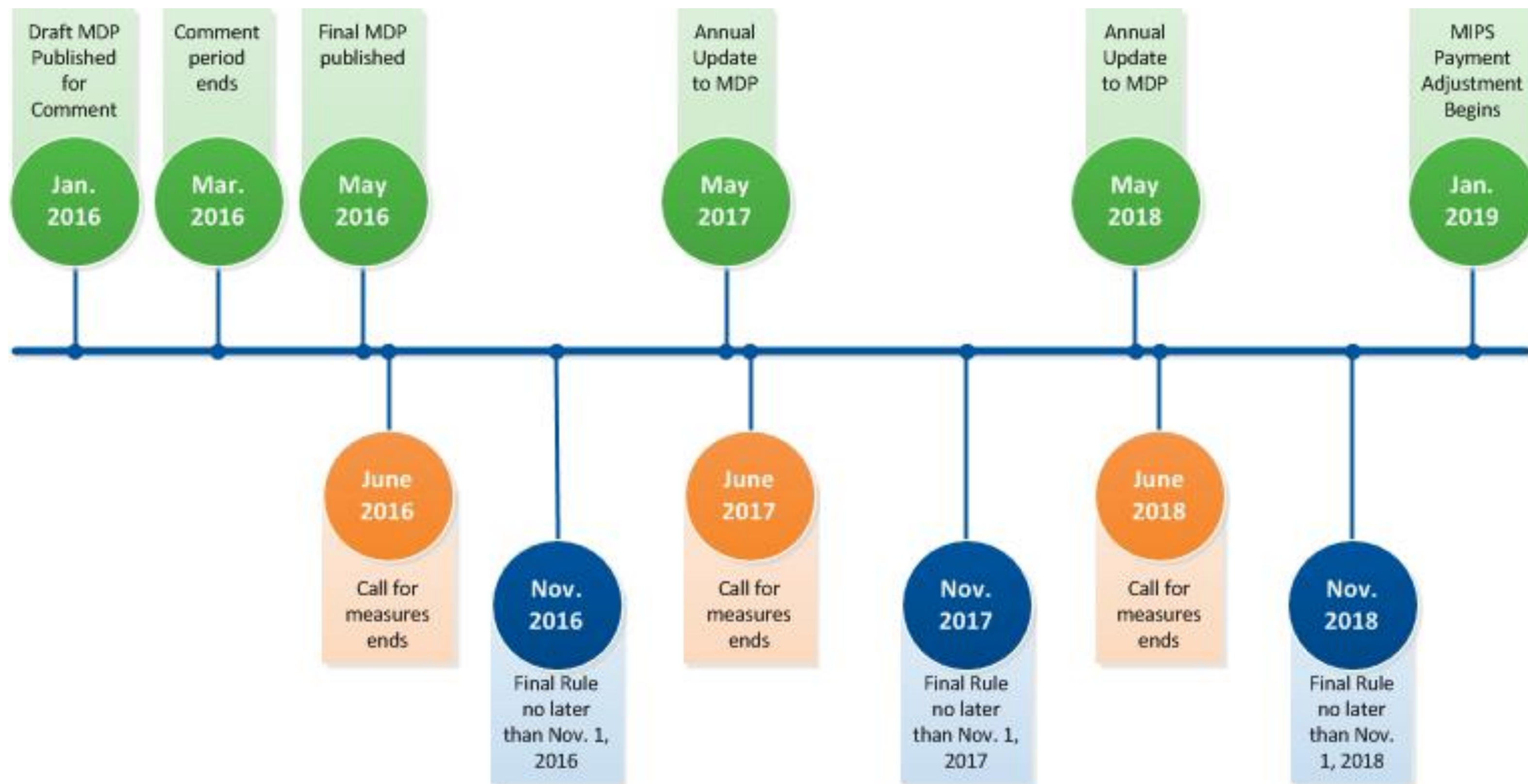
Key Dates In MDP

Productive Engagement Now For Impact Upon MIPS Implementation



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HCPLAN

Elective Joint Replacement – Proposed Episode

- HCPLAN membership also includes States, medical societies, health systems, and large employers
- CMS's collaboration with AHIP on the HCPLAN allows it to circumvent the Federal Advisory Committee Act
- HCPLAN recently released a proposed Elective Joint Replacement Episode
  - 30 days pre-procedure to 90 days post-procedure, with some quality measures including data up to 12 months post-discharge
  - Includes all services needed by patient related to TJR, including professional services and hospitalization
  - Patient Population: the broadest-possible pool of patients, using risk and severity adjustment to account for age and complexity
  - Physicians are the preferred accountable entity
  - **AAHKS Members Drs. Froimson and Bozic participated in drafting of White Paper**

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Transition to APMs and VBP

Top Medicare Hospital Utilization Costs, CY2013

DRG and Description	Total Discharges	Total Allowed Amount
470 – Major Joint Replacement or Reattachment of Lower Extremity w/o MCC	446,148	$6,600,563,136
871 – Septicemia or Severe Sepsis w/o MV 96+ Hours w/ MCC	398,004	$5,560,910,280
291 – Heart Failure & Shock w/ MCC	194,697	$2,114,205,303
193 – Simple Pneumonia & Pleurisy w/ MCC	145,391	$1,505,092,623
292 – Heart Failure & Shock w/ CC	198,483	$1,427,000,058

Source: CMS Provider Utilization and Payment Charge Data CY 2013

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Comprehensive Care for Joint Replacement (CJR)

CMS Targets Highest Expenditure Inpatient Procedure First

- Designed to test bundled payment and quality measurement for an episode of care associated with hip and knee replacements
  - CJR Model to begin on **April 1, 2016** in 67 geographic areas with a population of at least 50,000
  - Participation is mandatory
- Episode begins upon Medicare beneficiary's admission to a hospital that results in discharge paid under MS-DRG 469 or 470 and continues for 90 days post-discharge
  - Episode includes all related items and services paid under Medicare Part A and Part B
- Hospitals are the only episode initiator and are the accountable entity

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Comprehensive Care for Joint Replacement (CJR)

Congressional Developments

- On Mar. 24, 2016, U.S. Rep. Tom Price (R-GA; Chair of House Budget Committee) introduced H.R. 4848, the "Health Inpatient Procedures Act of 2016"
  - Co-sponsored by Rep. David Scott (D-GA)
- Bill ***suspends*** the CJR Model until January 1, 2018
  - "The implementation of [CJR Model] beginning April 1, 2016, provides physicians, hospitals, and post-acute providers with inadequate time to prepare for this abrupt shift in payment for these high-volume procedures and the changes in care delivery that they require."
- Passage in 2016 is possible but unlikely
  - Presently little prospect for passage of any health care legislation until 2017 with new President and new Congress
  - Best strategy for now is to work with CMS to improve the CJR Model

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Transition to APMs and VBP

Orthopaedic Surgeons are Not Alone in Being Targeted

- Oncologists represent the largest driver of Medicare Part B spending, with a large portion of the costs associated with administering drugs:

Provider Type	Average Allowed Amount Per Provider for Medical Services	Average Allowed Amount Per Provider for Drug Services
Hematology/ Oncology	$225,379	$583,237
Medical Oncology	$181,747	$473,926
Rheumatology	$156,839	$298,011
Hematology	$128,187	$265,011

Source: CMS Provider Utilization and Payment Charge Data CY 2013

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Transition to APMs and VBP

Part B Drugs Proposed Rule

- On March 8, 2016, CMS released a proposal to restructure payments for Medicare outpatient drugs, targeting the highest outpatient expenditures
- Drugs administered in outpatient setting are reimbursed the average sales price ("ASP") ***plus*** a 6% add-on
- CMS has proposed a 2 phase **mandatory** model it will pilot over 5 years:
  - **Phase I**: lower the add-on to 2.5% plus a flat fee amount of $16.80 per drug per day.
  - **Phase II:** pilot various reimbursement models that incorporate a variety of VBP tools, including reference pricing, outcomes-based pricing, indication-specific pricing, and elimination/discounting of the beneficiary cost share.
- Proposed rule is heavily criticized by providers, pharma and Congressional leaders (Sen. Hatch, Reps. Upton and Brady)

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AAHKS Input into Transition to APMs and VBP

Action to Date

- Comment letter to CMS on CJR; follow-up meeting with CMS leadership on AAHKS concerns
  - Planning AAHKS-AAOS follow-up with CMS after CJR is operational
- Meeting with and assisting Rep. Price to advocate for CJR reform
- Comment letter to CMS on MDP
- Comment letter to HCPLAN on the Proposed Elective Joint Replacement Episode
- Tracking next project of Core Measures Collaborative

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AAHKS' Washington Team

Broad Perspective and Experience

- **Lynn Shapiro Snyder**, JD – 35 years of federal health law experience
- **Philo Hall**, JD – Previously Counselor to Secretary of HHS, White House staff
- **Lesley Yeung**, JD – Previously CMS Office of Legislation
- **Brian Hall**, JD – Previously of American College of Cardiology, Senate staff
- **David McNitt** – 10 years experience as Congressional health care lobbyist
- **EBG Advisors** – Several dedicated former health plan medical directors; coding, coverage and reimbursement consultants to specialists

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