THE FUTURE OF PAYMENT IN POST-ACUTE & LONG-TERM CARE

A summary of "The Future of Payment in Post-Acute and Long-Term Care" presentation by Amy Bassano, Deputy Director of the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare & Medicaid Services (CMS), during the Advancing Excellence in Long-Term Care Collaborative's (AELTCC's) 9/23/19 meeting. Discern Health hosted the meeting at our Washington, DC office.

Moderator: Theresa Schmidt, Discern Health

Panelists

- David Gifford, American Healthcare Association
- Victoria Walker, Evangelical Lutheran Good Samaritan Society
- Donna Doneski, National Association for the Support of Long-Term Care
- Brianna Palowitch, American Society of Consultant Pharmacists

Presentation

- Introduction
  - Twenty-six million Medicare beneficiaries are touched by 40+ value-based care models.
  - More than 967,000 health care providers participating.
  - Value considerations for model development and testing — priority is given to proposed models that emphasize quality, cost, and beneficiary choice.
  - CMMI is looking at the difference between episodic and longitudinal health.
  - How much risk is any entity taking on with a particular model? How do we get participants to take on higher levels of risk?
    - Providers would need experience in risk-based models before moving on to models with more risk.
    - Providers need health information technology (IT) support.
    - How do you measure success?
      - Total cost of care, quality.
    - How do you measure quality without adding additional reporting burden on providers?
      - It is important to give providers flexibility. The more risk you take on, the more flexibility you should have.
    - There is broad waiver authority in CMMI models. There are ways to deliver health care that the Medicare payment systems were not designed to support when they were put in place years ago (e.g., telehealth).
    - Sometimes waivers do not go as far as people would like.
- Multipayer alignment in value-based payment (VBP) models is a focus as well.
  - CMMI has relatively limited oversight of Medicaid payment models.
  - Wants to bring Medicaid into existing CMMI payment models as a parallel track.
- Bundled Payments for Care Improvement (BPCI)
  - BPCI evolved into BPCI Advanced.
  - Now focuses on fewer clinical episodes.
  - Moving to outpatient services as well.

    - Did not continue model 3 (post-acute services). This left a gap that CMMI is looking to fill with a different post-acute services payment model.
- Comprehensive Care for Joint Replacement (CJR) model: First mandatory model
    - Mandatory models are modified through formal rulemaking.
    - Gives an opportunity to get formal feedback, but less flexibility.
- Home Health VBP model
    - Mirrors other VBP models for post-acute care.
    - Seen good results to date.
    - Thinking about what comes next — Is this model still state of the art? Is there more we want to be doing?
- Medicare Choices Model
    - Model for patients who are eligible for hospice under Medicare.
    - Enhanced palliative care.
    - Seen some interesting results and experiences.
    - Took a while to get patients into this model. Education was important.
    - What do we do with seriously ill patients?
- Accountable Health Communities
    - Addresses social determinants of health.
    - It is a screening and partnering model.
    - CMMI has to determine what its authority allows it to do in terms of direct provision of interventions that address social determinants.
    - In this model, the physician office is used as a screening tool to connect people with services in their communities.
    - Medicare Advantage recently changed its rules on social determinants of health and uptake has been modest. CMMI is looking at what can be done under current law.
- Primary Care First
    - Builds on Comprehensive Primary Care (CPC) and CPC+ models.
    - Providers get paid for total primary care payments + performance-based adjustments.
    - Gives primary care physicians more flexibility and allows them to focus less on billing.
- Direct Contracting
    - New forms of capitated population-based payments (PBPs).
    - Proposed Global and Geographic PBP models (100% savings/loss) — Got a robust response to this proposed model.

Panel Q & A / Discussion

- How are CMMI models thinking about fostering partnerships where everyone shares in upside/downside risk?
    - There has been a physician and hospital focus.
    - How do you get post-acute-care providers engaged more upstream? In the hospital directing where the patient goes?
    - A concern is trying not to further consolidate or increase costs.

    - How do you get the provider engaged with the model in the post-acute setting? And what do we expect them to do?
- How does CMMI interface with Medicaid? CMS is hands-off in letting states design their managed care models.
    - Have invested in state innovation models, results have been mixed.
    - States mean well, but their resources are limited and they're being pulled in different directions.
    - How can CMMI provide states more opportunity, but give them more guidance and specific parameters so they do not have to reinvent the wheel every time?
    - Looking at models in rural health, maternal health, opioids.
- The health care delivery system is intensely complex. There are lots of changes coming from new CMMI models, and it is a lot to keep straight. Every state is doing things differently. What is a provider to do amid all of this? Everything involves an investment on the provider side, but some providers, especially in rural areas, don't have the necessary resources. How is CMMI looking to reduce the complexity?
    - On value-based programs, CMMI is trying to align with the Medicaid programs and other payers in an effort to make things similar, if they cannot be exactly the same, so that both programs are "driving in the same direction."
    - CMMI is trying to reduce burdens and give providers more flexibility.
    - There is a tension between "we would love to have this information" and "what does that mean for the participant who would have to report this information?"
    - Lot of discussion of voluntary vs. mandatory models.
    - Feedback is useful; CMMI cannot solve problems it doesn't know about.
- How does CMMI look at structure, process, and outcomes?
    - CMMI can be very outcomes-focused.
    - The rest of the federal government may not be comfortable yet with giving up some control over the process of providing care.
    - No one wants to be a barrier. There is just a fear of things going wrong and patients potentially being harmed.
- Mental health (chronically mentally ill patients)
    - CMMI wants to do something in this space, but does not really know where to begin.
    - There are a lot of supply/workforce issues outside the scope of CMMI.
    - Dementia is an area where CMMI feels like it can do something.
    - CMMI has very limited Medicaid waiver authority.
- CMS is changing skilled nursing facility (SNF) and home health programs soon. A lot of long-term-care organizations do not have the necessary health IT.
- There is a lot of penalty management instead of incentive management.
- The Office of the National Coordinator for Health Information Technology and CMS have done a great job working together, and it has been an impactful partnership.
- Health IT infrastructure is going to be necessary to achieve efficiencies.
    - Want to use CMMI models to push health IT forward (carrots and sticks).
- On social determinants of health (SDOH), we work with patients to increase medication adherence. Patient understanding and socioeconomics are reasons people are Medicaid non-adherent.
    - Trying to get patients engaged in their own care is important.

    - CMMI wants to give providers flexibility to address SDOH, especially if providers are responsible for total cost of care.
    - Legal authority of what programs are allowed to pay for is constricting.
- Pharmacist integration into primary care and nursing homes
    - Pharmacists are trying to get into primary care settings. The physician community is welcoming of this.
    - Pharmacists work in nursing homes with admissions medication reconciliation.
    - Pharmacists are also involved in cost of care. The "cheapest" drug is not always the least expensive in terms of total cost of care.
    - Patients on experimental medications (e.g., clinical trials) cannot receive that medication in a nursing home, so those patients cannot be admitted to a nursing home.
        - This is due to a Medicare rule that nursing homes have to pay for all medications for patients.
- Geriatricians deal with high-cost, high-risk patients. There is no incentive for providers to have in-depth conversations with patients about their goals, but these conversations could save Medicare a lot of money.
- Reorganize the emphasis of these programs on the patient instead of the provider.
    - Medicare often reinforces this emphasis on the provider.
    - Statutory constructs that have been around for decades are difficult to change.
    - Focusing on the desired outcomes is important.
    - Patient experiences and goals are extremely variable.
- There has been an increase in SNF plans. How does CMMI work with SNF plans?
    - We work with them, but not enough.
    - It would be helpful for CMMI to know if there is a collective set of issues that come from this group that CMMI should be focusing on.