CENTRE FOR HEALTH SERVICES AND POLICY RESEARCH ANNUAL HEALTH POLICY CONFERENCE

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- MEDTRONIC
WHAT'S TRIGGERING THE SHIFT TOWARD VBHC?
GLOBAL HEALTHCARE SUSTAINABILITY

2. Source: ICHOM analysis, Martin Makary, How Health Care’s Successes Became Distractions, Health Affairs August 2014

$7.2 TRILLION

Healthcare costs are increasing dramatically

There’s wide variation in care and delivery of meaningful outcomes

The need for care is only growing

Incremental “solutions” have had limited impact

- Consumer-driven healthcare
- Evidence-based medicine
- Prior authorization for expensive services

- 2x variation in 30-day mortality rate from heart attack in U.S.
- 18x variation in reoperation rates from radical prostatectomies in the Netherlands
- 20x variation in mortality after colon cancer surgery in Sweden
NEW PAYMENT MODELS SEEK TO TRANSITION PAYMENT LANDSCAPE TO VALUE-BASED CARE

Payment and delivery models seek to shift risk back to providers in an effort to drive alignment, improve quality of care, and decrease healthcare spending. Many of these models attempt to move away from FFS to paying for “value over volume.” That said, some models continue to pay for services on a FFS basis in addition to value-based payments.
MEDTRONIC’S FOCUS: INNOVATION IN A VBHC WORLD

Understand **economic value** of innovation

Broaden innovation horizon to ensure **value is realized**

Collaborate and generate new business models
LEADERSHIP VIEWS AT US DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIRECTLY INFLUENCE NATURE AND PACE OF CHANGE TO VALUE

“We know that we need to move [to a system where physicians and hospitals are paid] for the outcomes and value they deliver…We believe value is best determined by markets and consumers, not arbitrary rules and central planners.”

January 2015

August 2017

August 2018

CMS Proposes Cancellation of Medicare Cardiac/Hip Fracture Episode Payment Models, Scale-Back of Mandatory CJR Participation

Source: https://www.hhs.gov/about/leadership/secretary/speeches/2018 - speeches/remarks-on-state-healthcare-innovation.html
Bundled payments set a payment amount for a period or episode of care.

Bundled episodes are tied to a procedure or treatment for a particular condition.

The bundled payment is the target to achieve for providers, which shifts risk from the payer to the provider thereby creating incentives for efficiencies.

Participants are financially incentivized to reduce duplication, prevent avoidable utilization, and provide more cost effective care.

Bundles can align incentives across many providers when they share the incentives.

PAYMENT MODEEXAMPLES

Bundled Payments for Care Improvement (BPCI); BPCI Advanced; Comprehensive Care for Joint Replacement (CJR)

![Chart showing spending during bundle, bundled payment amount, and historical spending](chart.png)
## COMPARISON OF CMS BUNDELED PAYMENT PROGRAMS

<table>
<thead>
<tr>
<th>Participation Type</th>
<th>BPCI</th>
<th>BPCI Advanced</th>
<th>Comprehensive Care for Joint Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Dates</td>
<td>2013 – 2018</td>
<td>2018 – 2023</td>
<td>Mandatory for 34 MSAs; voluntary 33 MSA</td>
</tr>
<tr>
<td>Participants (Risk-Bearing Entities)</td>
<td>Hospitals, PGPs, PAC, Conveners</td>
<td>Hospitals, PGPs, Conveners</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Gainsharing and Risk sharing</td>
<td>Gainsharing permitted with provider organizations; silent on risk-sharing</td>
<td>Gainsharing, risk sharing allowed with NPRA Sharing Partners</td>
<td>Gainsharing, risk sharing allowed with CJR collaborator in accordance with written sharing arrangement</td>
</tr>
<tr>
<td>Episode Initiators (episode owners)</td>
<td>Hospitals, PGPs, LTAC, IRF, SNF, HH</td>
<td>Hospitals, PGPs</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Risk Exposure</td>
<td>Participant choice from among three risk tracks (different levels of risk and gain potential)</td>
<td>Downside risk begins on day 1; One-time, risk-free retroactive withdrawal allowed on March 1, 2019</td>
<td>No downside risk performance year 1; 2% in performance years 2 and 3; 3% in performance years 4 and 5</td>
</tr>
<tr>
<td>Program start date</td>
<td>Rolling between Oct 2013 and Oct 2015*</td>
<td>October 2018 for first applicants; possible second enrollment period around January 2020</td>
<td>April 1, 2016</td>
</tr>
<tr>
<td>Bundle Length</td>
<td>Inpatient hospital plus 30, 60, 90-days (participant choice)</td>
<td>Inpatient hospital/outpatient procedure plus 90 days post discharge/completion of the procedure</td>
<td>Inpatient hospital stay plus 90 days post discharge</td>
</tr>
<tr>
<td>Bundle Episodes</td>
<td>48 clinical conditions options (participant choice)</td>
<td>29 inpatient episodes and 3 outpatient episodes (participant choice)</td>
<td>2 inpatient lower extremity joint replacement episodes (MS – DRGs 469, 470)</td>
</tr>
<tr>
<td>Episode Exclusions</td>
<td>Episode-specific exclusions for Part B services</td>
<td>Part B costs will be excluded only if incurred during an inpatient readmission that is excluded based on its MS-DRG.</td>
<td>NTAP &amp; Pass-Through services; Hemophilia clotting factors; Inpatient admissions or surgical services for oncology, trauma, severe injury, or chronic disease unrelated to EPM episode</td>
</tr>
</tbody>
</table>

*First round participants were able to begin the program starting October 2013; the program has been closed to new episode initiators since July 2015 and to additional episodes since October 2015.

HH: Home Health Agency; ICS = Internal Cost Savings; IRF: Inpatient Rehabilitation Facility; LTAC: Long-term acute care hospital; NPRA = Net Payment Reconciliation Amount; PAC = Post Acute Care; PGP = Physician Group Practice; SHFFT= Surgical Hip/Femur Fracture Treatment; SNF=Skilled Nursing Facility
EVALUATION REPORTS FROM OF KEY INNOVATION CENTER PILOTS SHOW MIXED RESULTS

FINDINGS

**BUNDLED PAYMENT FOR CARE IMPROVEMENT (BPCI)**
Year 5 Evaluation Report (fourth quarter 2013 - fourth quarter 2016)

- FFS payment decreased across clinical episodes, largely due to decreases in PAC LOS and intensity
- However, net Medicare spending went up because reconciliation payments to participants were greater than decline in FFS payments
- Shift to less intense PAC did not impact readmission rates, emergency department visits, or mortality
- Overall, quality of care was maintained

**COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CJR)**
Year 1 Evaluation Report (April 1, 2016 - December 31, 2016)

- Average total payments for LEJR episodes decreased by $910 (3.3%) from CJR baseline payments due to reductions in institutional PAC
- Shifts in PAC utilization did not impact readmission rates, emergency department visits, or mortality

TAKEAWAYS

- **Impacting care delivery** (beyond shifts in PAC intensity and utilization) is proving difficult under models - growing sense that incremental changes to incentives are not enough to drive higher system performance and reduce cost growth
- More **dramatic policy changes** will be necessary moving forward to counter de minimis results
- Early models have helped CMMI **identify key levers to increase program savings** (greater downside risk among participants, implement mandatory models)
BPCI ADVANCED OVERVIEW
EARLY PARTICIPATION IS STRONG DESPITE INCREASED RISK-SHARING

MODEL OVERVIEW

- October 1, 2018 to December 31, 2023
- All Participants Subject to Downside Risk
- 29 Inpatient & 3 Outpatient Episodes
- 90-Day Retrospective Episodes
- Target Price = 3% Discount Off Benchmark Price
- One-Time Retroactive Withdrawal on March 1, 2019
- Second Application Period Begins January 1, 2020

MODEL PARTICIPATION

- Participants include 1,299 entities, making BPCI-A the second largest CMMI APM
  - 832 Acute Care Hospitals
  - 715 Physician Group Practices
- Participants span 49 states plus DC and Puerto Rico
BPCI ADVANCED PARTICIPATION ANALYSIS

MOST PARTICIPANTS ARE SELECTING FEWER EPISODES

- Only 44 providers have elected to participate in all 32 episodes
- PGPs more likely to take on the risk associated with selecting all episodes
- Most popular episodes are LEJR, CHF, and sepsis
- Least popular episodes are OP PCI, OP ICD, OP back & neck procedures, and disorders of liver, which are newly introduced episodes

Whether participation in BPCI Advanced remains high depends on the number of entities undertaking Retroactive Withdrawal, which allows participants to remove downstream episode initiators and/or clinical episodes by March 1, 2019 without penalty.
MEDTECH AND THE MOVE TO BUNDLED PAYMENT
OPPORTUNITY TO PARTNER

- Medtech has a long history of collaboration with physicians to improve patient outcomes, which will be required in value-based healthcare.

- Appropriate application of medical technology in the healthcare system can help drive inflection points in value creation – iterative innovation will be required to ensure continual improvement in outcomes and reduction in costs rather than one-time savings.

THE CASE FOR BUNDLED PAYMENT FOR ISOLATED CABG
HOW CAN MEDTRONIC HELP PROVIDERS SUCCEED IN A CABG BUNDLE?

<table>
<thead>
<tr>
<th>Pre- and Peri-Procedure</th>
<th>Post-Discharge</th>
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<tbody>
<tr>
<td>Technologies</td>
<td>Services</td>
</tr>
<tr>
<td>INVOS™ Cerebral Oximetry System</td>
<td>Rethinking Blood Conservation Initiative</td>
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<tr>
<td>HMS Plus Hemostasis Management System</td>
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<tr>
<td>Minimal invasive ECP circuit</td>
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<tr>
<td>Medtronic Care Management Services</td>
<td></td>
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<tr>
<td>- Telemonitoring platform, disease management protocols, and TeleNurses</td>
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</tbody>
</table>

Value Delivered
- Reduce unnecessary blood use
- Lower rate of costly complications, such as stroke, renal failure, and prolonged mechanical ventilation

Post-Discharge
- Reduce unplanned readmissions
- Manage patients in lower cost, post-acute care settings or at home

Offer technologies and services across the CABG care continuum.
Willing to share financial accountability for the performance of our products and services.
ADMINISTRATION REMAINS COMMITTED TO VALUE-BASED PAYMENT MODELS

- Despite mixed results with early models, the Administration remains firmly committed to value-based payment models.
- Early pilots have helped CMMI understand the levers that can be changed in models to increase program savings (i.e., risk-sharing, target price methodology).

HEALTH CARE PAYMENT LEARNING & ACTION NETWORK REPORT
(October 2018)

- About 34 percent of health care payments in 2017 were tied to alternative payment models, up from 29 percent in 2016.
- “The report’s findings reinforce our understanding that there is sustained, positive momentum in the effort to shift health care payments from traditional fee-for-service into value-based payments...further progress on payment reform will be important to ensure health care dollars flow through models that have more risk.”

-- Mark McClellan, co-chair of the LAN Guiding Committee and director of the Robert J. Margolis Center for Health Policy.
LESSONS LEARNED/OBSERVATIONS

Payment Policy Considerations

- VBHC and pay for value interest and momentum continue but lack forcing factors; FFS is still predominant
- Running both systems at the same time may be increasing costs for all stakeholders
- Results from new models are seen as middling, with a growing sense that incremental changes to incentives aren’t enough to drive higher system performance and reduce cost growth
- Vast majority of models have had upside risk only. Highest percentage of spend under APMs found in Medicare Advantage and FFS, then Commercial and then Medicaid.
- Some limited evidence that over time and with experience new incentives do have an effect - more dramatic policy changes may be coming given Sec. Azar’s stated goals on value and reform. Administration emphasizing commitment to predictability, simplicity, accountability and multi payer alignment with goal of all Medicare payments in APMs by 2025 – LAN APM Roadmap to help support payers and providers during this transition
- Most promising APM practices identified from the field include meeting providers where they are (different models for large and small practices), engaged leadership and provider champions, multi-payer alignment, multidisciplinary care management teams, engaged patients
- Advanced BPCI gives some new momentum to episodes
  - Immediate provider and payer interest still focused on Joints (CJR, experience, more straightforward, learn by doing)
  - APMs do exist in other areas, but providers don’t always elect to participate
  - Tension between simple CMS mandatory payment mechanisms (scalable) and individualized, fragmented, highly nuanced arrangements to support specific partnerships (difficult to scale)
- Legal reforms needed for new multi-stakeholder business models have some traction
KEY TAKEAWAYS

EXPERIMENTATION IS NECESSARY FOR THE EVOLUTION OF HEALTHCARE, BUT FULL TRANSFORMATION REQUIRES A PUSH TOWARD GREATER RISK.

PROGRESS HAS BEEN SLOW, BUT HAS GIVEN INSIGHT INTO NECESSARY CHANGES TO SPEED TRANSITION.

VBHC IS A LONG-TERM JOURNEY THAT REQUIRES INNOVATIVE PARTNERSHIPS.