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Six Key Takeaways for Providers on Value-Based Medicare Payment: BPCI-Advanced

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Introduction

The recently announced Bundled Payment for Care Improvement – Advanced (BPCI-A) program is the first alternative payment program proposed by the Trump Administration. The time for participants to apply for the first round of the BPCI-A has passed, but providers may still be able to participate in the initial round of BPCI-A by reaching out to the convener or non-convener participants who are accepted into BPCI-A. In addition, there will an opportunity to apply for a second round, expected to be in 2020. But, even if providers do not elect to be involved in BPCI-A, there are many reasons to understand the program and to consider how to succeed in such a model.

Value-based payment methodologies are gaining momentum and will likely increase across all provider niches. This change is partly a function of the need for cost savings driven by the lower profit margins generally on inpatient care compared to outpatient care as well as by government led payment models rewarding quality and efficiency. As an example, passage of the Medicare Access and CHIP Reauthorization Act (MACRA), provides that physicians can be paid higher compensation under Medicare if they participate in Advanced Alternative Payment Models (AAPM) in which they take some downside risk. BPCI-A qualifies as an AAPM and additional programs that qualify may be added. Recent comments by Department of Health and Human Services Secretary Alex Azar suggest that he believes the results of tested voluntary payment models have been underwhelming and he may be ready to propose bolder payment programs to reform Medicare payments, including more mandatory programs.

Commercial payers, including health insurers and self-funded employers are also increasingly utilizing alternative payment programs that have designs similar to the CMS models. Payer/provider mergers and acquisitions as well as the Berkshire Hathaway, J.P. Morgan and Amazon health-care alliance, at least in part reflect the desire and need to control costs in a value-based world. Government programs, like BPCI-A, often serve as examples that payers and others will utilize and refine as they develop their own programs. Moreover, bundled payment programs have been viewed as a superior and sustainable payment model that align the incentives of providers around care delivery for clinical episodes. *See* R. Kaplan and M. Porter, *The Case* for *Bundled Payments in Health Care*, (Harvard Business Review (July – August 2016 issue).

For all these reasons, it is important for providers and other participants in health care to understand bundled payment programs and BPCI-A in particular. Some key points providers should understand about BPCI-A include:

1. Obtain Data

As BPCI-A is a voluntary Medicare program focused on a limited set of episodes of care, not all providers will want to make the investment of time and resources to assess if BPCI-A is worthwhile. Some may feel they will be challenged to achieve savings after the Centers for Medicare and Medicaid Services (CMS) retains its three percent (3%) discount on historic fee-for-service charges in setting the target price for the selected clinical episodes. Others, including post-acute providers, may feel that gainsharing will not be pushed to down-

stream providers to reward them for the steps they take to reduce episode costs. In fact the empirical results from the original BPCI program indicated that there was limited use of any gainsharing with providers and, when used, gainsharing was largely utilized to reward physicians and physician group practices (PGPs). Gainsharing rarely involved other downstream providers. Bundled payments are not new and many of the initial barriers to adoption such as necessary infrastructure investment, personnel, and compliance functions need to be addressed in advance of knowing if a bundle arrangement and the provider team involved will achieve savings. Notwithstanding that, getting the data on provider costs from CMS for specific episodes and, if involved from a third party convener, benchmarking that data on readmissions, length of stay, locus of care and other care plan metrics with other providers, will only help to clarify the strengths, weaknesses, and strategy of providers receiving that data. In that sense, BPCI-A represents a very valuable, low-cost option to engage in as a market check for inclusion in a provider's strategic plan. A decision whether to proceed ultimately with BPCI-A may be made at a later time, after data are received and analyzed. If a provider elects to proceed ultimately, it should be prepared to take downside risk for the selected episodes.

2. It's Not Necessary to Be Masters of the Universe

BPCI-A allows the participant to ultimately select limited episodes of care to be included in the model. The Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO), in contrast, includes all Medicare episodes. As such, focusing on the data for only those selected clinical episodes will permit providers to be more strategic in the direction in which they seek to invest and expand both clinically and geographically. While laudable, a goal of being best-in-class across a broad swath of clinical diagnoses may not be achievable for all providers. In some cases, focusing on a select episode cohort allows an acute focus and can drive greater quality and greater savings. Having access to data empowers those choices.

3. Data to Assist With Plan of Care Redesign

Regardless of any ultimate decision to accept a bundle or episode payment arrangement with CMS, having access to key data including a) readmission rates; b) locus of discharge (e.g. Skilled Nursing Facilities (SNF) versus home health); and c) ER visit percentages by physician, will ultimately empower hospitals to:

- Improve care coordination protocols
- Invest in technology
- Provide educational opportunities for identified physicians
- Develop possible strategies on acquisitions of providers or joint ventures.

This access allows hospitals to help ensure cost-effective post-discharge care. Without the data, hospitals are flying blind.

4. Engaging Post-Acute Providers

Under BPCI-A only acute care hospitals (ACHs) and PGPs can be episode initiators. There is no bundled payment available for just post-acute episodes as was the case with Model 3 of the original BPCI program. As such, post-acute providers must partner with PGPs and ACHs as ''Sharing Partners'' to participate in any Net Payment Reconciliation Amount, as gainsharing is called. Although it's likely that home health will continue to be an attractive lower cost venue for direct discharge from an ACH where clinically appropriate (thus generating savings by avoiding a more expensive SNF or IRF stay), providers with home health and/or SNF continuum capability (via either common ownership or contractual affiliation) will be well positioned to partner in BPCI-A with upstream providers. Whether this takes the shape of downstream gainsharing will depend on the market including the ability of a downstream provider to help deliver quality outcomes and hence savings across a broad reach of clinical episodes and markets. What is certain is that post-acute providers that do not engage and embrace value-based payment in some fashion will be left behind over the long run as episode payment and other value-based methods increase in both public and commercial payment plans.

5. Waivers and Gainsharing

Evaluations of the original BPCI models showed that participants made little utilization of the available program waivers (e.g., 3-day hospital stay for SNF coverage, expansion of telemedicine, and ''incident to'' services for home health visits), nor was there much utilization of gain-share models beyond the PGP. It's likely that many of these initial BPCI participants were in learning mode and sought to avoid the complexity of broader convener groups that would need access to the waivers to succeed. With BPCI-A continuing these waivers, it appears the next generation of ''advanced'' bundles should make better use of the waivers which will presumably broaden the range of providers and relationships to permit greater creativity in care redesign. Undoubtedly, this is CMS's desired objective.

6. Financial Markets and Investors Look for Advance Strategic Planning

Many investors, public and private, bond rating firms, and underwriters are increasingly sampling the percentage of a provider's revenues that are risk-based both to assess that exposure and to determine if the provider has made plans for how value-based methods of payment could enhance or harm the bottom line and whether they can succeed in that environment. Investors generally welcome prudent and strategically sound alternative payment methodologies as part of the revenue mix and strategy plan. Alternatively, they view the absence of such planning as a red flag where vision and adaptability reward nimble operators.

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