2015 IN REVIEW, LEGISLATIVE WATCH FOR 2016: VALUE-BASED THEME PREVAILS

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The growth of value-based initiatives in 2015 was unprecedented. As we enter 2016, we will see the continuation of established programs in addition to new developments resulting from proposed legislation. We can expect value-based initiatives to progress faster than ever. Here are key value-based initiatives and legislation from 2015 to be monitoring in the upcoming year:

Accountable Care Organization (ACO) Models Evolve And Expand

Four years have passed since the launch of the Centers for Medicare and Medicaid Services (CMS) Pioneer and Medicare Shared Savings Program (MSSP) ACOs. Throughout these four years, we have seen tremendous growth in the number of MSSP ACOs and, conversely, a number of providers exit the Pioneer program. In January 2016, 100 new ACOs were accepted into the MSSP, growing the number of MSSP ACOs to 434 nationwide. Changes to the MSSP offer participating ACOs opportunities to take on greater financial risk along with greater savings opportunities. In addition, the first round of Next Generation ACOs launched in March 2015. The second round of applications is due this spring, which offers round two participants the option of pursuing a true capitated payment risk arrangement.

Bundled Payment Gains Momentum: No Longer Just A Voluntary Pilot

CMS opened up a second round of voluntary participation to providers in the Bundled Payment for Care Improvement (BPCI) initiative. Overall interest in the pilot was overwhelming, to say the least, with Model 3 proving the most popular and most pursued by applicants. BPCI attracted the interest of nearly 7,000 providers, with approximately 1,600 providers moving forward with formal contracts. Of the six provider groups participating in BPCI—acute care hospitals, skilled nursing facilities (SNFs), physician group practices, home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals—SNFs are the most represented, accounting for 46 percent of all providers. A mandatory bundling proposal, the Comprehensive Care for Joint Replacement (CJR) model, was both introduced and passed in 2015. CJR will officially commence in April 2016, with hospitals in 67 identified metropolitan statistical areas. Effective in January 2017, hospitals will assume a 90-day risk for lower extremity joint replacement DRGs 469 and 470.

Comprehensive Payment Reforms At State Level

Since the first Delivery System Reform and Incentive Payment (DSRIP) program was implemented in 2010 by California, five additional states have launched their own DSRIP programs. Because DRSIP links performance to payment within each state's Medicaid program, tremendous opportunities exist to better manage chronic conditions and reduce unnecessary care within the population of highest utilizers. While Texas will end its demonstration in 2016, several other states are entering the peak of their demonstration periods. New York, in particular, will be a state to keep an eye on. At the core of New York's DSRIP program are Performing Provider Systems (PPSs), which are partnerships of regional care and community-based providers. PPSs are responsible for implementing their projects and contracting with key organizations with the goal of improving health outcomes and transitioning payments away from fee-for-service towards risk-based.

Demonstration To Integrate Care For The Dual Eligible: Results To Be Determined

To date, there are 12 states with signed memoranda of understanding (MOUs) participating in this CMS demonstration. Two states have MOUs pending and a number of states withdrew their applications. From a macro perspective, the initiative has been disappointing; several states have struggled with program delays, reimbursement challenges to awarded managed care organizations (MCOs), high opt-out rates, and subpar enrollment numbers. Despite these challenges, the demonstration has continued and states have made adjustments as necessary. In addition, the state of New York reached an agreement with CMS to create an additional dual-eligible demonstration: Fully Integrated Dual Advantage-Intellectual and Developmental Disabilities (FIDA-IDD) to commence this upcoming year. Results of the demonstration are largely undetermined at this point but we anticipate garnering some concrete preliminary findings in 2016.

Expansion Of PACE Model

In 2015, the Program of All-inclusive Care for the Elderly (PACE) achieved record numbers: 116 PACE programs operating throughout 32 states and serving 35,000 participants. Additionally, the PACE Innovation Act was signed into law in November 2015. Specific to the Act, CMS is allowing the development of pilot projects, expanding the model to include a younger population as well as older adults in the community who are at-risk but do not meet the nursing home level of care certification. Additionally, CMS has lifted the not-for-profit status requirement, allowing for-profit providers to develop PACE programs as well.

IMPACT Act On The Move

While the IMPACT Act was passed back in 2014, providers have yet to experience any major implementation. However, this will shift in 2016 and upcoming years as providers start to experience major changes that are driving the IMPACT Act. One key requirement is resource use reporting, which includes total estimated Medicare spending per beneficiary (MSPB), discharge to community, and measures to reflect all-condition, risk-adjusted potentially avoidable hospital readmissions. Skilled nursing facilities, long-term care hospitals, and inpatient rehabilitation facilities will begin reporting for all three of these domains on October 1, 2016; home health agencies will follow shortly after, with reporting for these three domains beginning January 1, 2017. The IMPACT Act is designed to standardize data used in post-acute care settings, with the ultimate goal of streamlining payment systems and comparing patient outcomes across PAC settings.

Medicare Spending Per Beneficiary (MSPB): From Acute To Post-Acute

In fiscal year 2015 an efficiency domain, which encompasses the MSPB measure three days prior through 30 days post-acute stay, was added to the Hospital Value-based Purchasing (VBP) program—comprising 20 percent of a hospital's total performance score. In fiscal year 2016, the weighted score for MSPB increased to 25 percent. While MSPB currently impacts only the acute care world, the proposed Medicare Post-Acute Care Value-based Purchasing Act would expand to also hold post-acute care providers responsible for MSPB. The Act is currently in its comment period.

Proposed Revisions To Discharge Planning Requirements

Under the proposed rule which was released December 2015, hospitals would be required to develop a discharge plan within 24 hours of admission and complete a discharge plan before the patient is discharged. The proposed rule, which entails other requirements, seeks to increase patient participation and the patient experience by emphasizing patient goals and preferences. Long-term care hospitals, IRFs, and HHAs are included, and discharge planning requirements set forth within the IMPACT Act would also be implemented within the proposed rule.

Value-Based Purchasing And Readmissions Programs Enter New Provider Settings

Acute care hospitals entered year three of the Hospital Readmissions Reduction and Hospital Value-based Purchasing (VBP) programs. Hospitals experienced the largest penalties to date, as well as the largest opportunities to receive VBP bonuses. Post-acute specific initiatives include finalized rules for the Home Health Value-based Purchasing (HHVBP) model as well as finalized rules to SNF payment, including SNF 30-day all-cause, all-condition readmission measures in anticipation of the SNF

Value-based Purchasing program. HHVBP is being implemented in nine states that are representative of each region throughout the country: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. The recently approved Medicare Advantage Value-based Insurance Design (VBID) model brings innovation to the health plan sector. The VBID model will be tested in seven states (Arizona, Indiana, Iowa, Massachusetts, Pennsylvania, Tennessee, and Oregon) with a January 2017 start date.