ALIGNING FOR SHARED ACCOUNTABILITY

LAN SUMMIT
Health Care Payment Learning & Action Network

Specialty Care And APMs
Welcome

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Panelists

Paul Casale
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Specialty Care and APMs

Paul N. Casale, MD, MPH, FACC
Professor of Clinical Medicine
Weill Cornell Medicine
Adjunct Professor, Columbia University
Executive Director, NewYork Quality Care
The ACO of NewYork-Presbyterian • Columbia • Weill Cornell
Overview of NewYork Quality Care

NewYork Quality Care: ~38,000 attributed beneficiaries

- Columbia Doctors
- Weill Cornell Medicine
- NewYork-Presbyterian Ambulatory Care Network
- NewYork-Presbyterian Medical Group Westchester

~75% of beneficiaries attributed to PCPs or APPs
~25% of beneficiaries attributed to Specialists
**NYQC Performance – 2015 to 2018**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Savings</th>
<th>Minimum Savings</th>
<th>Quality Performance</th>
<th>Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015*</td>
<td>$2,857,805</td>
<td>$8,804,069</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>2016*</td>
<td>$1,719,794</td>
<td>$8,961,357</td>
<td>94%</td>
<td>No</td>
</tr>
<tr>
<td>2017*</td>
<td>$17,841,991</td>
<td>$11,490,917</td>
<td>81%</td>
<td>Yes</td>
</tr>
<tr>
<td>2018*</td>
<td>$23,446,828</td>
<td>$11,654,564</td>
<td>89%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

For 2017 performance year, NYQC earned shared savings of $7,130,145.
For 2018, NYQC earned shared savings of $10,189,748.

*Numbers from CMS final performance data*
Value-Based Payment Programs

- MSSP ACO Track 1
- Oncology Care Model (OCM)
- Comprehensive Care for Joint Replacement (CJR)
- Comprehensive ESRD Care Model (CEC) at The Rogosin Institute
- Delivery System Reform Incentive Payment (DSRIP)
- Commercial Payers
NewYork Quality Care

- Care Management
- NYQC Analytics team
- Telehealth
- Remote Patient Monitoring
- Community Tele-paramedicine
- Regional Health Information Exchange
Bundled Payment for Care Improvement

- Penn Medicine Lancaster General Health
  - Lower extremity joint replacement
  - Spine
  - CABG
  - PCI
  - Pacemaker
  - Cardiac Defibrillator
Why We Participated in BPCI

- Engage specialists in APMs
- Understand cost of care
  - Physician & Finance collaboration
- Redesign across the care continuum
  - Supply costs/length of stay
  - ED utilization/readmissions
  - Post-acute care
  - Access/patient portal
- Improve the quality of care and the patient experience
BPCI Advanced Clinical Episodes
(Application for Year 3 start)

Inpatient Episodes (33):
- Acute myocardial infarction
- Congestive heart failure
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft surgery
- Transcatheter Aortic Valve Replacement (TAVR)
- COPD, bronchitis, asthma
- Simple pneumonia and respiratory infections
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis
- Major bowel procedure
- Bariatric Surgery
- Inflammatory Bowel Disease
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Back & neck except spinal fusion
- Spinal fusion (non-cervical)
- Cervical spinal fusion
- Combined anterior posterior spinal fusion
- Renal failure
- Sepsis
- Cellulitis
- Urinary tract infection
- Stroke
- Seizures

Outpatient episodes (4):
- Percutaneous coronary intervention
- Cardiac defibrillator
- Back & Neck except Spinal Fusion
- Total Knee Arthroplasty
Condition-Based Bundled Payments Drive Care Redesign to Produce Greater Value for Patients: A Case Study

Kevin J. Bozic, MD, MBA
Professor and Chair, Department of Surgery and Perioperative Care
Dell Medical School at the University of Texas at Austin
Senior Institute Associate, Harvard Business School
Burden of Osteoarthritis

30+ Million US Adults have Osteoarthritis

www.cdc.gov/arthritis

The High Cost of Arthritis in the US

$304 Billion in 2013

$140 Billion in Medical Costs

That's $2,117 in extra medical costs per adult with arthritis

$164 Billion in Lost Wages

That's $4,040 less pay than an adult without arthritis
Growth in TJA Procedure Rates and Costs


Focus of Alternative Payment Models

Acute Care Episode (ACE) Demonstration

Bundled Payments for Care Improvement

Figure 3. Top five clinical episode bundles selected by Model 2 BPCI participants

- At least one orthopedic surgery bundle
- Major joint replacement of the lower extremity
- Congestive heart failure
- Chronic obstructive pulmonary disorder
- Pneumonia

Focus of Alternative Payment Models (cont.)

Acute Care Episode (ACE) Demonstration

Bundled Payments for Care Improvement

Comprehensive Care for Joint Replacement (CJR) Model

BPCI Advanced

Bundle Payment Program
Increasing Quality · Reducing Cost
Cost of Joint Replacement Using Bundled Payment Models

Amol S. Navathe, MD, PhD; Andrea B. Troxel, ScD; Joshua M. Liao, MD; Nan Nan, MS; Jingsan Zhu, MS; Wenjun Zhong, PhD; Ezekiel J. Emanuel, MD, PhD

Figure 1. Episode Spending for Major Joint Replacements of Lower Extremities With and Without Major Complications or Comorbidities Over ACE and BPCI

Figure 2. Quality of Care for Major Joint Replacements of Lower Extremities With and Without Major Complications or Comorbidities as Measured by ER Visits, Readmissions, and PLOS Over ACE and BPCI
Payment Model Drives Delivery System Reform

EXHIBIT 4
Transition In Both The Payment And The Delivery Systems

<table>
<thead>
<tr>
<th>Delivery system</th>
<th>Payment system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-driven coordinated care</td>
<td>Episode-of-care or comprehensive care payment</td>
</tr>
<tr>
<td>Interim/virtual coordination arrangements</td>
<td>Virtual episode-of-care and comprehensive care payment</td>
</tr>
<tr>
<td>Volume-driven fragmented care</td>
<td>Fee-for-service</td>
</tr>
</tbody>
</table>

**Transition**
- Co-evolution of organization and payment
- Failure due to lack of organizational capacity to manage value-driven payment

**Today**

**Ideal**

**SOURCE:** Author’s analysis.
TJR Bundles Drive Care Coordination Across Acute, Post-Acute Settings
What’s Missing from Procedure-Based Bundles?

Dartmouth Atlas Knee Replacement Rates

Total Knee Replacement per 1,000 Medicare Beneficiaries by Hospital Reform Region (2001-07)

- 9.8 to 13.8 (64)
- 8.7 to < 9.8 (60)
- 7.9 to < 8.7 (63)
- 7.1 to < 7.9 (60)
- 2.9 to < 7.1 (59)
- Not populated
Payment Model Drives Delivery System Reform

TJR Bundles

Arthritis Bundles
Changing the Delivery Model

Existing Model
Organize by Specialty and Discrete Service

- Imaging Centers
- PT/OT
- Chiropractor
- Pain Mgmt
- Orthopaedic Surgeons
- Primary Care Provider
- Hospitals
- Behavioral Health
Measuring Outcomes That Matter to Patients

PATIENT REPORTED Outcomes (PROs)
Report of a Patient’s Health Status that comes directly from the patient

- Physical Functioning
- Health Related Quality of Life
- General Health
- Mental Health
- Bodily Pain
- Energy-fatigue
- Social Functioning

Role limitations due to physical and emotional problems
Using Pros to Inform Appropriateness Of Surgery

[Diagram showing the relationship between preoperative KOOS and SF12v2 MCS scores, with percentage thresholds and counts indicated for each category.]
Personalized Shared Decision Making

How will total knee replacement surgery affect your overall quality of life?

68% of patients like you improve after surgery
Alternative Payment Models for Hip and Knee OA

Start of hip or knee OA care

Hip or Knee OA Care Management

Care pathway focused on improvement of patient outcomes

First E&M visit with a specialist for hip or knee OA trigger the non-surgical case rate

Up to 12 months episode of care for non-surgical care

Last E&M visit with a specialist for hip or knee OA before surgery trigger a SEPARATE surgical case rate

Up to 4 months episode of care for surgical care

Surgical case rate

Pre-operative care, surgery, post-acute care

Condition case rate

Evaluation and Management, Exam Room Procedures, Diagnostic Ancillaries, Support Services¹, Treatment Ancillaries, Patient Education²

1. Support Services include DME, immunization/vaccine, etc. (only will be given if it is necessary),
2. Patient education includes service & materials fees, patient’s history, registration, education, etc.
Summary

• Musculoskeletal disease is prevalent, costly
• Management of MSK conditions is characterized by variation in treatment approach, outcome, cost
• SIGNIFICANT opportunity to drive value through care redesign, payment reform
• Procedure-based bundles will only get us so far
• Real opportunity lies in redesigning care across the continuum, changing payment incentives through condition-based bundles
Thank You!!

@KevinBozic, @DellMedSchool, @UTHealthAustin
American Academy of Hospice and Palliative Medicine

Patient and Caregiver Support for Serious Illness (PACSSI)

Phil Rodgers, MD FAAHPM
Professor of Family Medicine and Internal Medicine
University of Michigan Medical School
Chair, AAHPM Alternative Payment Model Task Force

2019 LAN Summit
October 24, Washington DC
**Patient and Caregiver Support for Serious Illness (PACSSI)**

- Focused on seriously ill patients with likelihood of unmet symptom, care coordination and support needs who are either not eligible or not ready for hospice care
- Provides new payment for interdisciplinary Palliative Care Teams (PCTs) to deliver high-value services across settings
- PCTs receive per-enrolled beneficiary per month (PMPM) payments which are adjusted for performance on quality and spending
AAHPM APM Development Timeline

- **June 2016** – AAHPM Board approves formation of APM Task Force
- **November 2016 - February 2017** – Task force engagement, data gathering, workgroup input, academy member input
- **March - August 2017** – Seek and incorporate feedback from members and multiple stakeholders, including CMMI
- **August 15, 2017** – Submit AAHPM-endorsed APM proposal to PTAC
- **March 26, 2018** – Present PACSSI to PTAC, which recommends limited-scale testing with high priority
- **April 2018 - present** – engagement with CMMI and key stakeholders on model development
- **April 23, 2019** – CMS announces Primary Care First Payment Model with ‘Seriously Ill Population’ (SIP) option based in part on PACSSI
Key Model Design Elements

- Eligibility
- Services
- Quality
- Payment
Key Model Design Elements (cont.)

- **Eligibility and Services**
  - Which patients need what types of serious illness services?
  - How are patients identified, for both care delivery and control matching?

- **Quality Measures**
  - What structure, process and outcome measures of serious illness care are both viable and valuable?
  - What measures are we willing to be accountable for?

- **Payment Methodology**
  - What payment is sustainable? What ‘risk’ is acceptable?
  - How are spending benchmarks for serious ill patients created?
Lessons Learned

- **Eligibility and Services**
  - Data limitations (claims vs clinical/administrative data)
  - Diversity of provider types and teams

- **Quality Measures**
  - Serious illness quality measurement still in development
  - Patient-reported outcomes challenging for seriously ill patients

- **Payment Methodology**
  - Payment needs to support diverse service delivery models and communities (in both scale and geography)
  - Needs to improve on existing FFS mechanisms
Exit Survey

We want to know what you think!

Let us know your thoughts at the end of each session! The Guidebook app provides quick, simple evaluations for your feedback.

Session Evaluation Survey (or scan QR code)

LAN Summit Overall Survey
Contact Us
We want to hear from you!

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