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Developing Successful Alternative Payment Models

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Presenters

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- Bundled Payments for Care Improvement
- Oncology Care Model
- Other specialty physician models as yet unannounced / never implemented

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Formerly Division Director, Center for Medicare and Medicaid Innovation (2012 – 2014)

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Why would I want to participate in an Alternative Payment Model?

Potential Benefits of Participation in an APM

- MACRA – related (some are dependent on whether patient or payment thresholds are met)
  - Simplification of reporting or exclusion altogether from MIPS measurement
  - Exclusion from possible MIPS payment reductions (for partial QPs and QPs)
  - 5% lump sum incentive payment (for QPs)
  - Larger payment rate increase beginning in 2026 (0.75% for QPs versus 0.25% for other eligible clinicians)
- Potential for shared savings or other payments from the APM
- **Important to balance these potential benefits with potential costs**

Advanced Alternative Payment Models

Current Advanced APMs (as of June 2017)

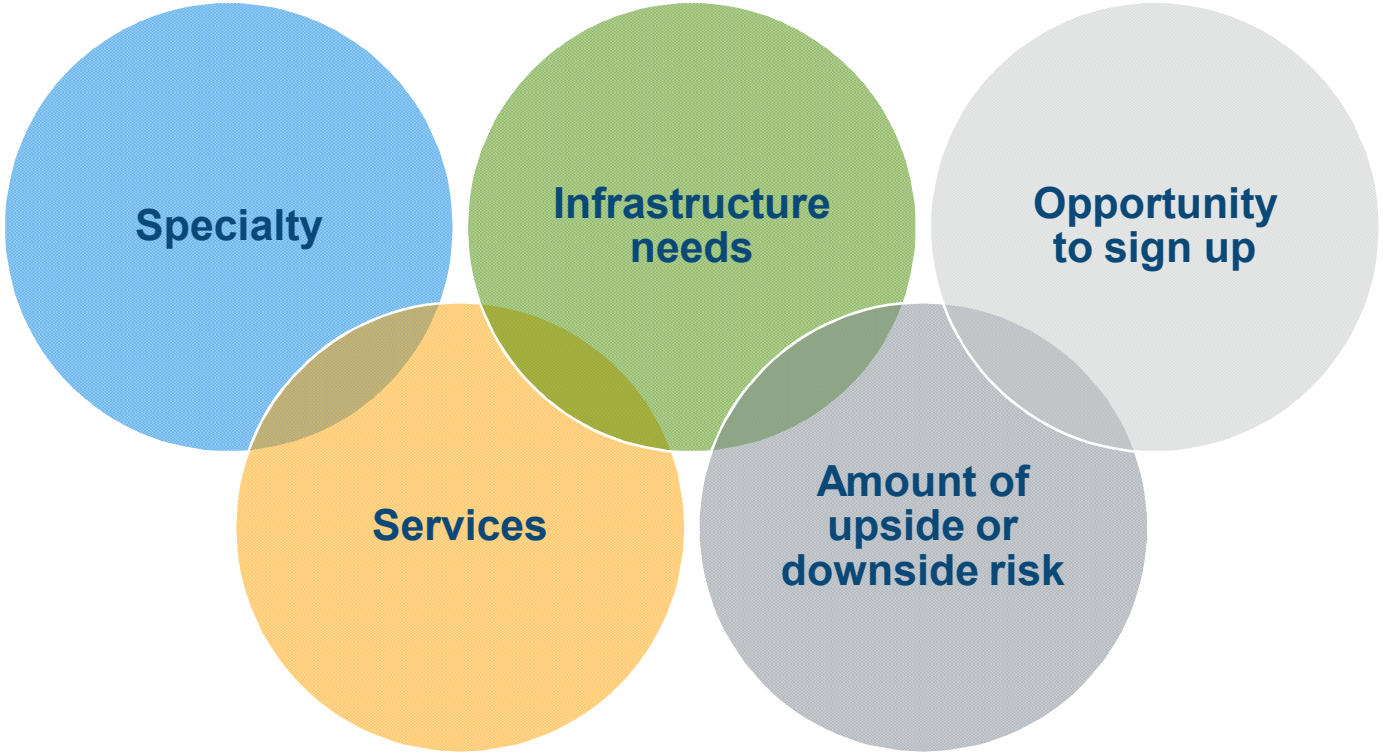
- Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model, LDO and non-LDO two-sided risk arrangement
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Shared Savings Program (MSSP), Tracks 2 and 3
- Next Generation Accountable Care Organization Model (NGACO)
- Oncology Care Model (OCM), two-sided risk arrangement only

Potential upcoming additions

- Episode Payment Models, CEHRT Track
- Comprehensive Care for Joint Replacement (CJR), CEHRT Track
- Medicare ACO Track 1+
- Medicare-Medicaid ACO Model
- Vermont Medicare ACO (VT All-Payer ACO Model)
- New voluntary bundled payment model (TBD)

CMS will publish and update the list of APMs that qualify as Advanced APMs as new APMs are included

Do the Current Models Work for You?



What if none of these APMs are relevant to my specialty, population, services, or product?

…Develop your own!

Submitting an Alternative Payment Model Proposal

- MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and make recommendations on potential APMs
- These can be developed and submitted by a wide variety of organizations, and may be implemented by CMS as nationally available models
- APMs can be designed to meet a wide variety of needs:
  - Patients
  - Payers
  - Providers
  - Life science companies

How do you develop a robust proposal?

Clinical Construct

- What aspects of robust clinical care do you find yourself challenged to accomplish in your current environment?
- What are the negative clinical impacts of the way you currently practice?

Financial Construct

- Is there any payment that you or your constituents receive that is wasteful or unnecessary?
- How can you change the financial constructs under which you operate to change behavior / incentives?

How many patients are affected?

Important Model Constructs

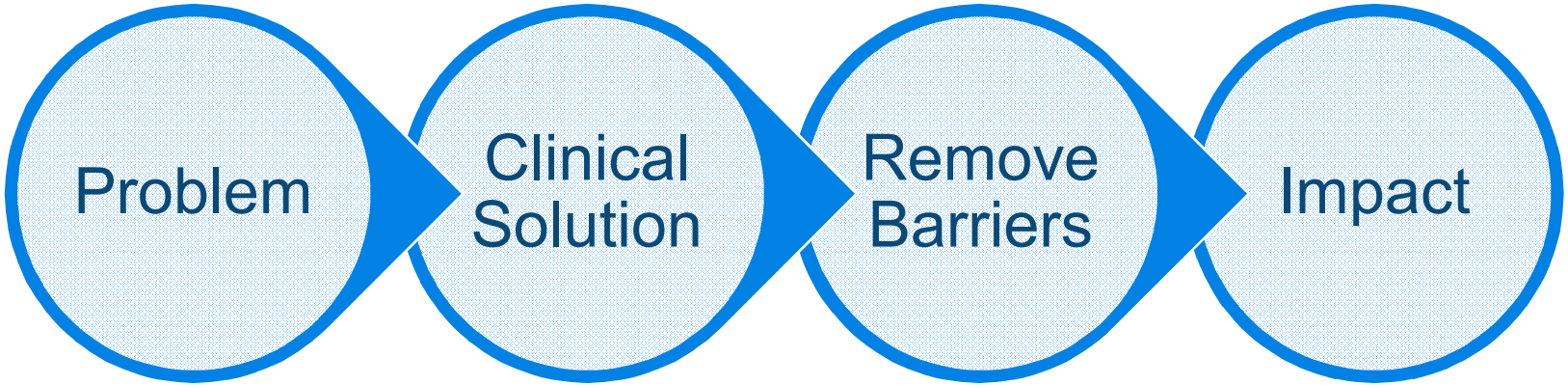
Care redesign constructs

- What providers and beneficiaries will be affected?
- Are waivers of CMS policies or fraud and abuse statutes necessary to implement the redesign?
- What claims processing challenges will be faced?
- How will quality be measured and monitored?

Incentivizing the redesign

- What is included in the APM?
- How will financial success be measured?
- What will the cost or savings be to CMS?
- Will other payers participate?

Defining the Clinical Construct



What is the Problem You are Solving?

Problem

Where is there need for improvement

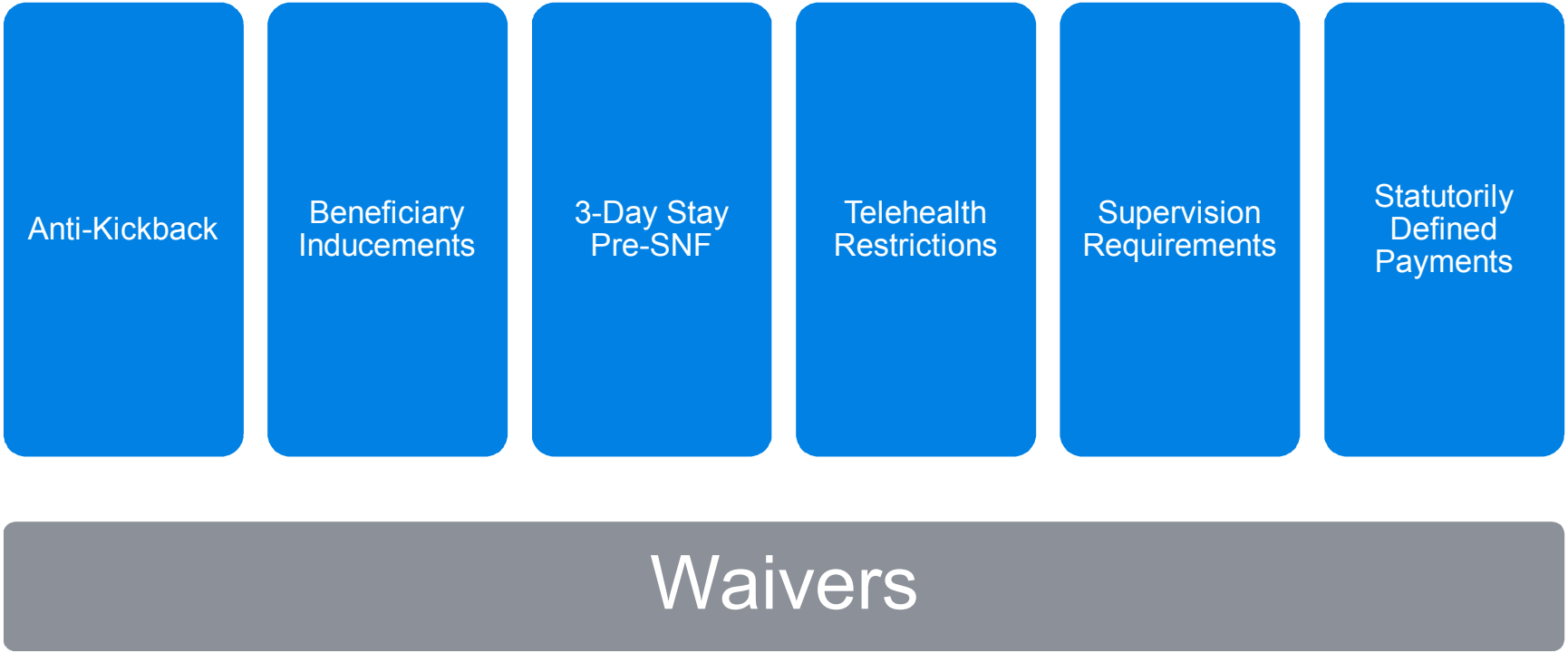
- What is the negative impact of suboptimal care
- Who are the affected patients
- How great is the problem (severity and volume)

Solution

Clinical changes needed to furnish better care

- Types of providers involved
- Types of providers that have the ability to control or fix the problem
- How challenging or simple is the change
- Who benefits and how

Which Legal Barriers Must be Removed?



Which Claims Systems Barriers Must be Removed?

- The current claims processing system for Medicare was not created with APMs in mind.
- The volume and variability of claims, as well as their interconnected nature make the systems difficult to adjust for a testing environment.

- Medicare-enrolled providers and suppliers are eligible payees
- Statutes dictate many aspects of payments and eligibility
- Regional MACs implement the Medicare claims systems
  - Even more disparate claims processing and data systems for Medicaid
- Automated prerequisites to payment must be adjusted during the test period
  - Updates and adjustments are made on a regular quarterly process

How Do You Measure the Impact?

Process Measures

- Often easier to evaluate
- Easily tied to care redesign in payment models
- May not represent patient outcomes

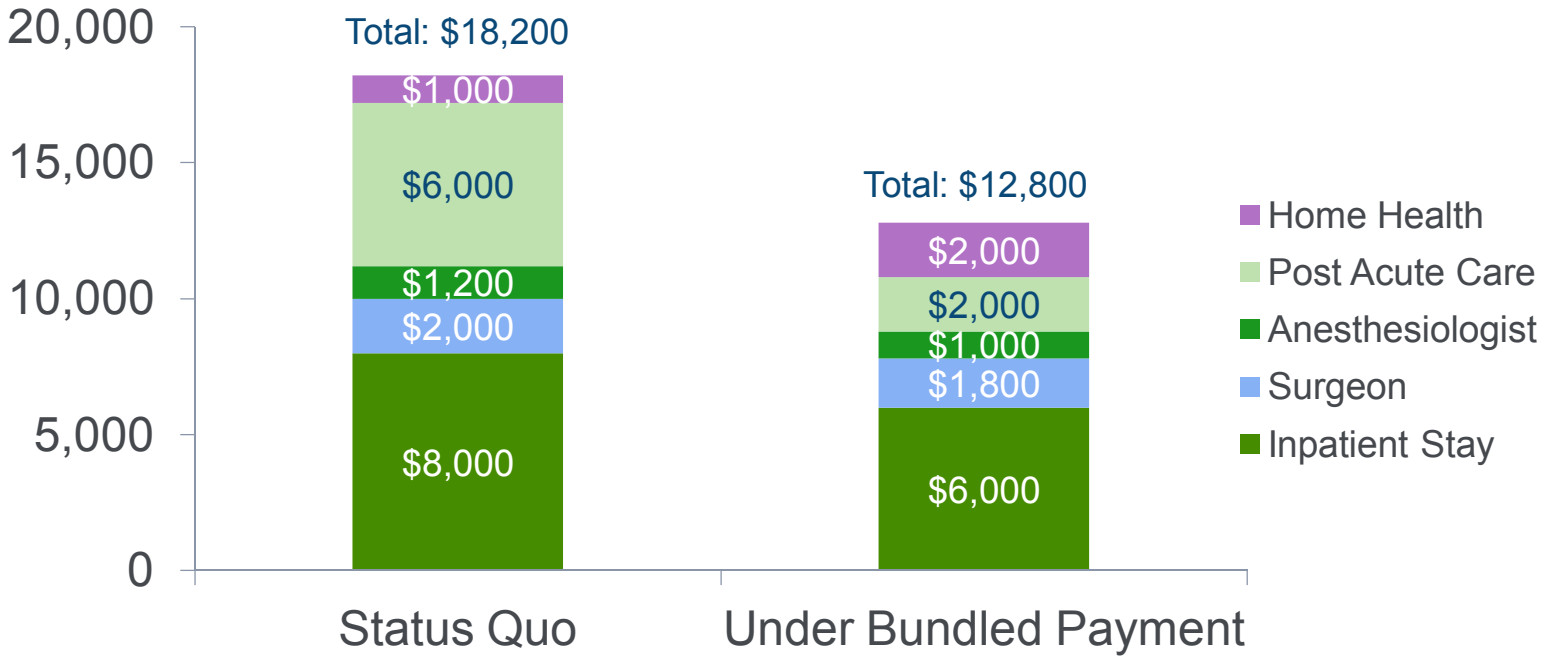
Outcome Measures

- More direct assessment of patient impact
- Difficult to risk adjust with low volumes
- Measures development lags behind models

Reporting Method

- Claims based measures
  - Less burdensome to providers
  - Payers have more control and insight
- Self-reporting
  - Broader information reporting

Episode Construction – What is Included Implicates Financial Opportunity



Example – Building a Bundled Payment Episode Definition

EXHIBIT - Inpatient Hip Arthroplasty - Cost Model
Rhode Island MSA - Utilization and Cost

Input:	
Inpatient Hip Arthroplasty	
# of patients	88
Average length of stay	3.0
Minimum Patient Age	16
Average Patient Age	54
Maximum Patient Age	64

Service utilization within the episode - across all patients		Average Utilization per Episode	Unit of Utilization*	Average Length of Stay (Days)	Average Allowed per Episode	% of episodes with any utilization	% of Total Episode Cost
Inpatient Facility	Medical	0.034	admits	0.15	$573	2.3%	1.6%
	Surgical	1.023	admits	2.85	$25,980	100.0%	73.7%
	Rehab	0.000	admits	0.00	$0	0.0%	0.0%
	Other	0.011	admits	0.05	$12	1.1%	0.0%
	Total	1.068	admits	3.05	$26,565		75.3%
Inpatient Professional	Total				$4,334	98.9%	12.3%
Outpatient Facility	Emergency Room	0.068	visits		$87	6.8%	0.2%
	Radiology - Other				$304	65.9%	0.9%
	Other Lab & Pathology				$189	72.7%	0.5%
	Drugs and Administration				$33	11.4%	0.1%
	Outpatient Surgery				$120	5.7%	0.3%
	Outpatient PT/OT/ST				$230	19.3%	0.7%
	Other				$125	44.3%	0.4%
	Total				$1,088		3.08%
Non-Inpatient Professional	Total				$2,075	98.9%	5.9%
Hospice	Total				$0	0.0%	0.0%
Home Health	Total				$1,201	84.1%	3.4%
Total Average Episode Costs					**$35,262**		**100.0%**

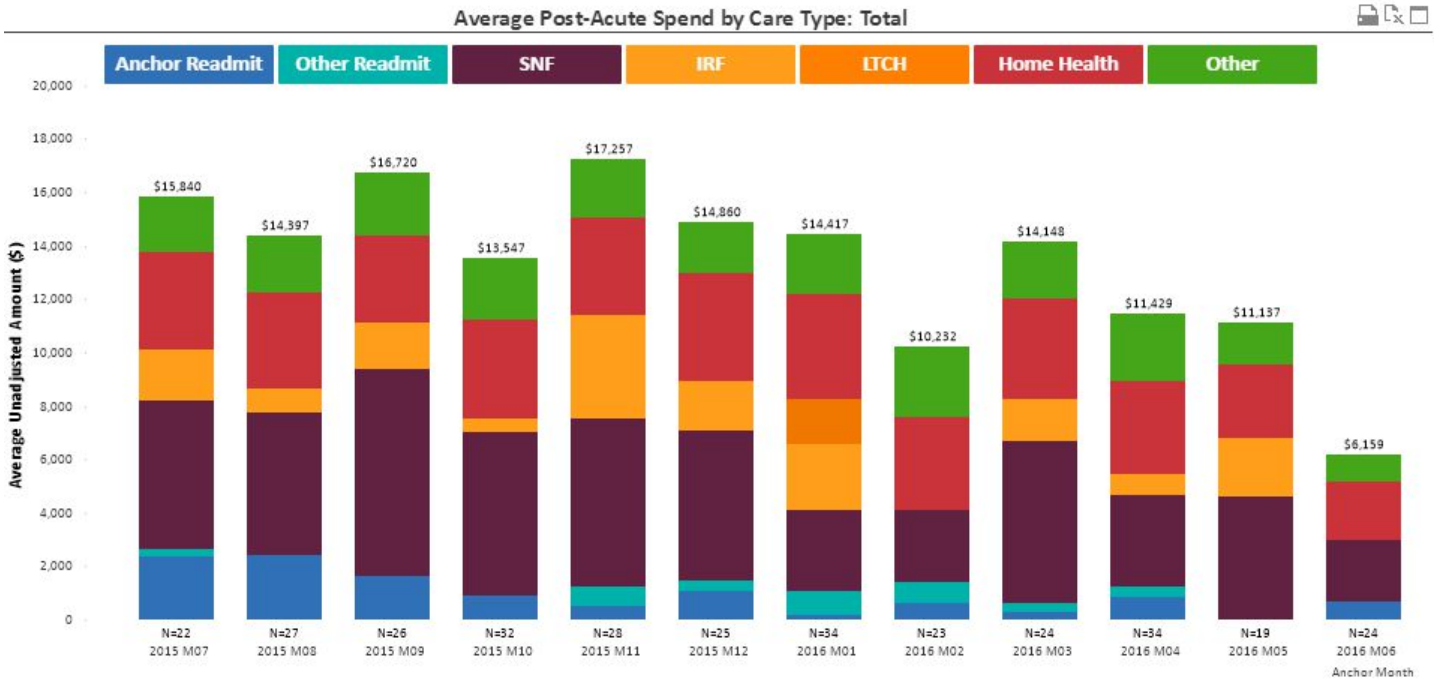
Source: 2012-2013 Truven MarketScan Database.

EXHIBIT - Inpatient Hip Arthroplasty - Cost Model - Member Drill Down
Rhode Island MSA - Utilization and Cost

Report Filters		
Patient Type:	Inpatient Hip Arthroplasty	
Member ID:	1088593301	
Total		**$25,750**

Service Date	Service Category	Allowed	HCPCS	HCPCS Description
8/3/2012	Outpatient Facility - Lab & Pathology	$234		
8/6/2012	Outpatient Facility - Other	$120		
8/6/2012	Outpatient Facility - Lab & Pathology	$89		
8/6/2012	Non-Inpatient Professional	$59	99213	Office/outpatient visit est
8/6/2012	Non-Inpatient Professional	$11	93010	Electrocardiogram report
8/14/2012	Inpatient Facility - Surgical	$18,734		
8/14/2012	Inpatient Professional	$2,306	27130	Total hip arthroplasty
8/14/2012	Inpatient Professional	$1,900	01214	Anesth, hip arthroplasty
8/14/2012	Outpatient Facility - Radiology	$11	73500	X-ray exam of hip
8/15/2012	Inpatient Professional	$300	01996	Hosp manage cont drug admin
8/17/2012	Non-Inpatient Professional	$82	E0143	Walker folding wheeled w/o s
8/23/2012	Non-Inpatient Professional	$34	73510	X-ray exam of hip
8/29/2012	Non-Inpatient Professional	$68	97001	Pt evaluation
9/5/2012	Non-Inpatient Professional	$101	99214	Office/outpatient visit est
9/5/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
9/7/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
9/11/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
9/13/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
9/18/2012	Non-Inpatient Professional	$68	G0283	Elec stim other than wound
9/25/2012	Non-Inpatient Professional	$68	97035	Ultrasound therapy
9/27/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
10/1/2012	Non-Inpatient Professional	$34	73510	X-ray exam of hip
10/1/2012	Non-Inpatient Professional	$30	72170	X-ray exam of pelvis
10/3/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
10/4/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
10/9/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
10/11/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises
10/15/2012	Non-Inpatient Professional	$68	97110	Therapeutic exercises

What Cost Categories Are Driving Spending?

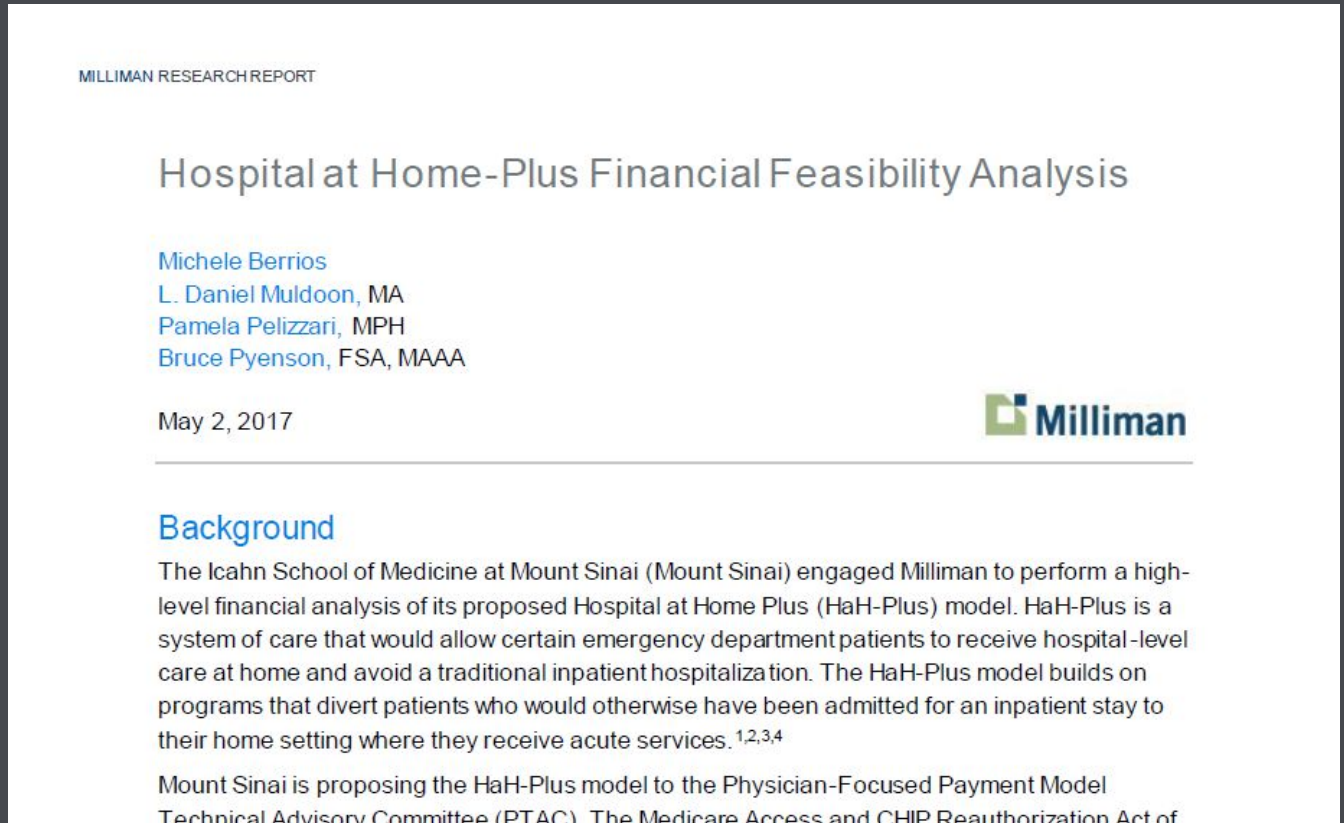


Benchmarking Methodology Considerations

- Comparison population
  - Contemporary or historical benchmark
  - Regional or national comparison, or individual historical utilization
- Updating methodology
- Adjustments to account for changes in care over time
- Outlier policies
- Incorporation of quality metrics

Financial Feasibility Analysis

How to demonstrate to CMS the potential savings associated with the model



MILLIMAN RESEARCH REPORT

Hospital at Home-Plus Financial Feasibility Analysis

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Milliman

Background

The Icahn School of Medicine at Mount Sinai (Mount Sinai) engaged Milliman to perform a high-level financial analysis of its proposed Hospital at Home Plus (HaH-Plus) model. HaH-Plus is a system of care that would allow certain emergency department patients to receive hospital-level care at home and avoid a traditional inpatient hospitalization. The HaH-Plus model builds on programs that divert patients who would otherwise have been admitted for an inpatient stay to their home setting where they receive acute services.[1,2,3,4]

Mount Sinai is proposing the HaH-Plus model to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The Medicare Access and CHIP Reauthorization Act of

Multi-Payer Model: Possible Benefits

- Can care redesign be leveraged to benefit patients covered by multiple payers?
- Benefits: Practice Level
  - Standardization of care across payers
  - Financial incentives for a broader range of patients
- Benefits: CMS
  - Encourage broader innovation in the healthcare system

Balancing the Possible Gains with Financial Liabilities

Opportunities

- APM payments (shared savings, reconciliation)
- 5% lump sum incentive payment
- Savings on quality reporting

Liabilities

- Cost of developing model
- Cost of implementing model (eg, care management staff, information technology)
- Possible APM losses
- Excess quality reporting cost

Questions?

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