Alternative Payment Models

Driving Healthcare Innovation

May 2, 2018

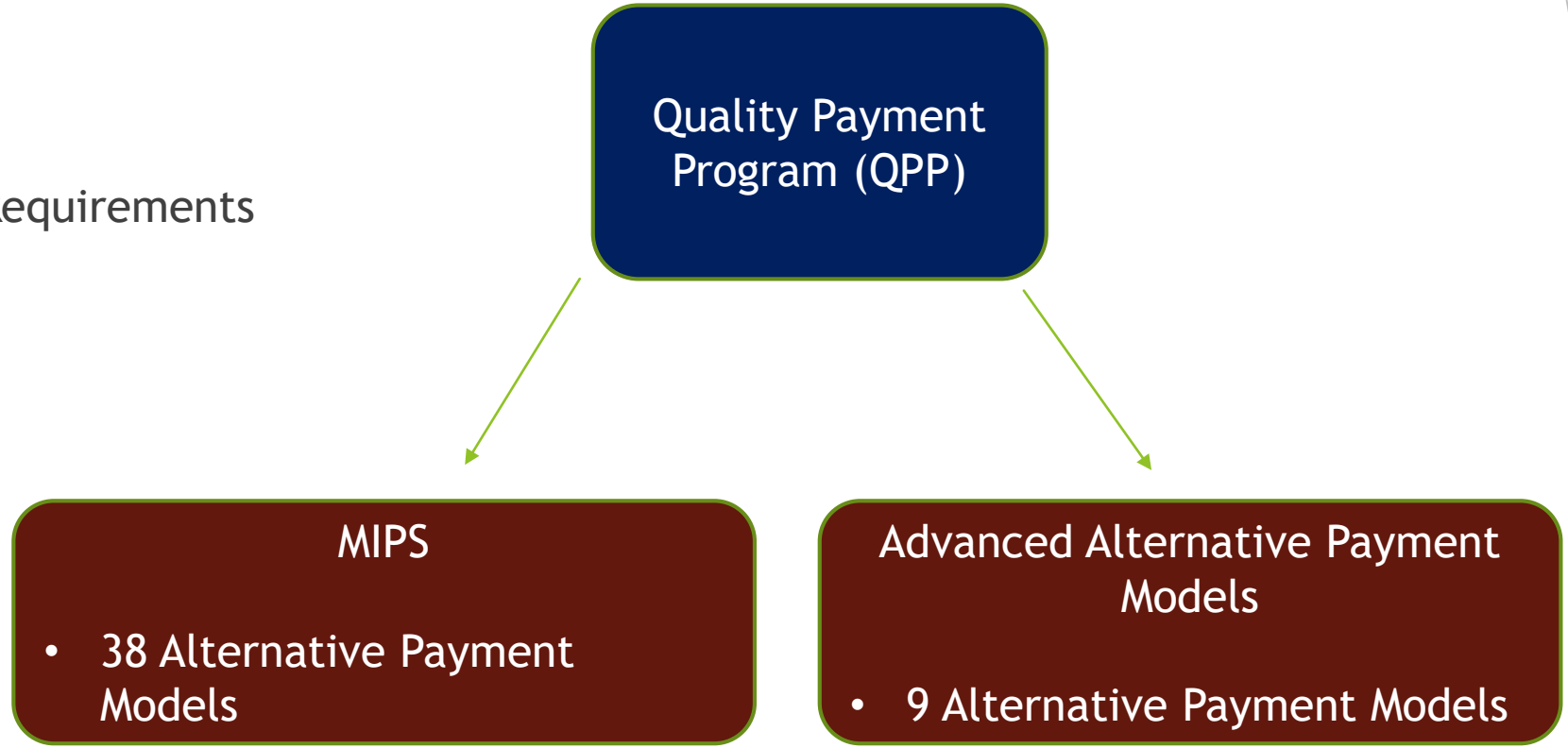
Presenter: Dale Henion

Why I Chose This Topic

- All sessions were about improving health care
  - Aggregating data in better ways: Blockchain, RISE registry, RWD/RWE, Computational Approaches to Patient Stratification
  - Improved delivery models: Telehealth (NC Telepsychaitry Program)
  - Two talks addressed the relation between EHRs, patient engagement, and improved health outcomes
- All efforts work towards improving quality & lowering cost
  - Alternative payment models (APMs) provide the business support to innovate
- I've heard terms like "bundled payments" but everything I see in my daily career reflects the fee for service model
- How and where are alternative payment models being used?
- This presentation will provide an overview of alternative payment models and conclude with a brief discussion of their impact and future outlook.

Background

- CMS Requirements



- Organizations can participate in 4 APMs under MIPS or 1 Advanced APM

MIPS

- Merit Based Incentive Payment System
- Providers must participate in 4 Alternative Payment Models per year
- Penalty for not participating is decreased CMS reimbursement
- Reward for meeting quality and financial benchmarks is increased CMS reimbursement
- 2019 is the first year for positive/negative incentive payout based on 2017 performance
- Most providers at UNC participate in the MIPS as of 2017

Characteristics of MIPS Programs

- Use EHR technologies
- Measure quality and meet specified benchmarks
- Shift a portion of the financial risk to the clinician

Advanced APMs

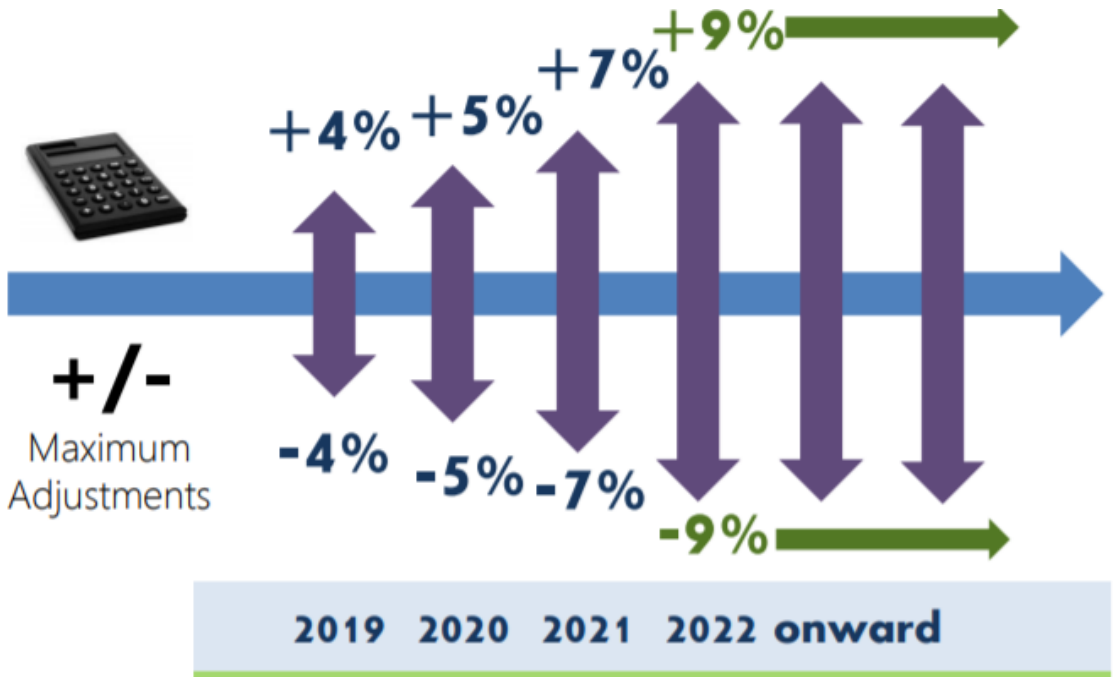
MIPS Program

+

Increased Financial Risk to Provider

= Advanced APM

CMS Incentives for APMs



https://www.cms.gov

- For 2018 Performance, organizations earn 5% incentive payment if 25% of Medicare part B payments were received through an advanced APM OR 20% of Medicare patients were seen through an “advanced APM”

Definitions used in APMs

- Shared Savings: when providers are able to achieve outcomes with costs that are under benchmark, the providers and insurance providers split that savings
- Shared Risk:
  - 1 sided risk: Providers receive portion of shared savings (incentives) if they meet quality measures and do not exceed specified cost, but do not get penalized if they exceed specified cost
  - 2 sided risk: Providers receive shared savings for exceeding benchmarks under budget AND take on a portion of the financial losses if they exceed specified cost

Advanced Alternative Payment Models (APMs)

- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)
- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk

Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)

- Reimbursement is based on patient condition (coded by DRG) rather than specific services rendered
- 48 different types of conditions (acute MI, amputation, joint replacement, bowel procedure, etc.)
- 1100 Participants including facilities for acute care, skilled nursing, rehab, long term care, physician practices

Bundle Payment Programs Conditions Treated

- Joint Replacement (hip and knee)
- AMI (acute myocardial infarction)
- Cardiac valve
- Chronic Obstructive Pulmonary Disorder (COPD)
- Coronary Artery Bypass Graft (CABG)
- Gastrointestinal Hemorrhage
- Hip and Femur Procedures
- Percutaneous Coronary Intervention
- Renal Failure
- Sepsis
- Simple Pneumonia and respiratory infections
- Spinal Fusion
- Stroke

Bundled Payment Care Initiatives (BPCI) Results

- Ledwin Group released its annual evaluation for CMS of bundled payment initiatives (released 10/2017)
  - Quality of care remained unchanged despite less reimbursement
  - 4.5% less reimbursement than control group (non BPCI participants)
  - Built in incentives for better care coordination across services did not result in any systematic improvements
  - Participating providers were larger sized institutions and chose to participate in episodes of care in which they historically received higher reimbursements
  - Frequent delays identifying qualifying patients for bundled payment service due to multiple diagnosing conditions and MS-DRGs that determine the bundled payment. This delay may hamper some of the benefits of the programs

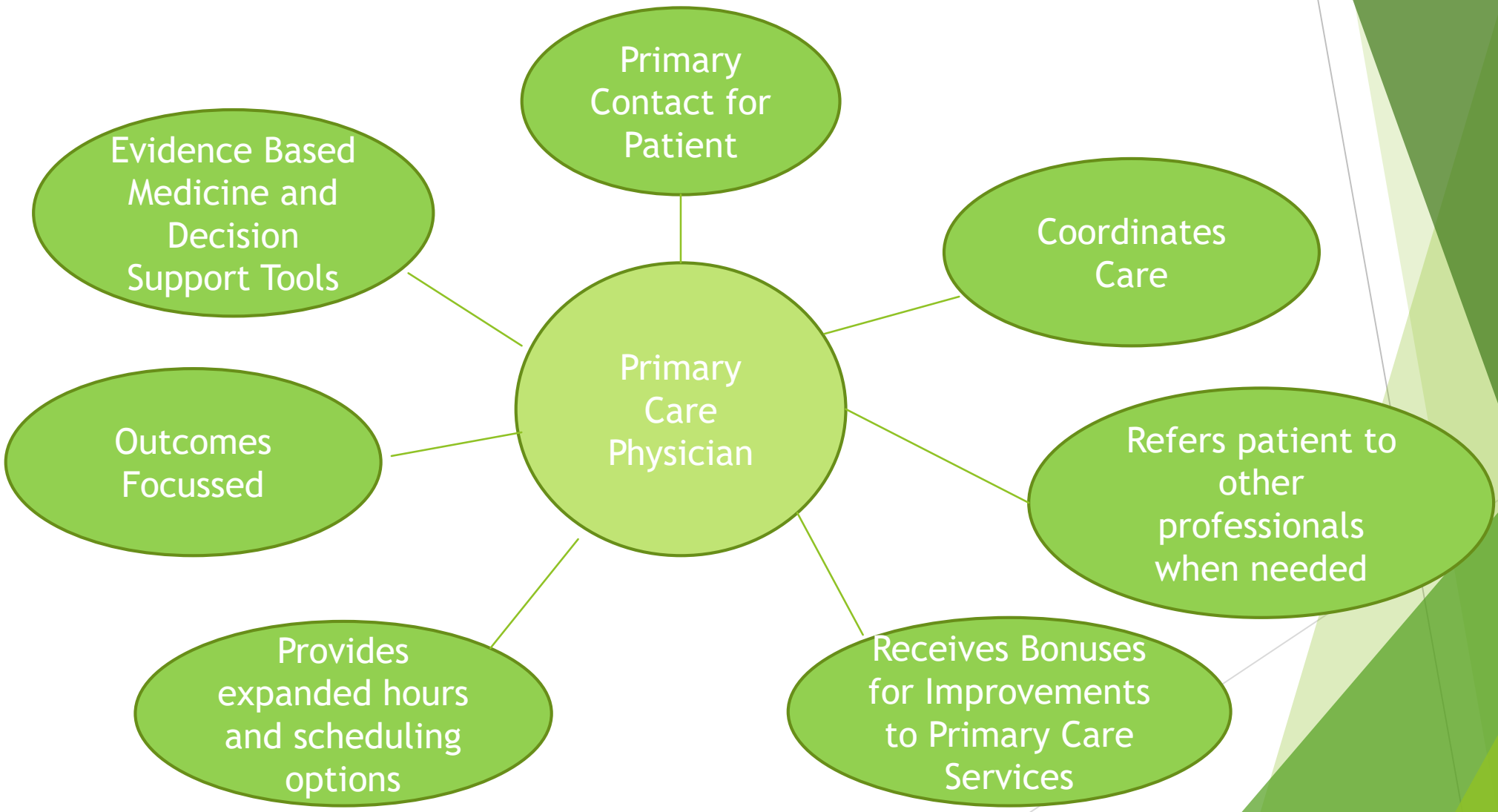
Comprehensive ESRD Care (CEC) - Two-Sided Risk

- Takes elements of ACO Models, Medicare Shared Savings Program, and Accountable Care Organizations
- ESRD spending accounts for about 7.1% of Medicare costs (<1% population)
- Often follow multiple care plans across multiple providers so this program seeks to improve care coordination
- Incentives and penalties based on financial performance measures, quality of life surveys from participants, and claims data by participants, and physician quality reporting system requirements (PQRS)

Comprehensive ESRD Care Results

- Released by Ledwin Group after 1st yr implementation (2015-2016)
- Decreased hospitalizations & readmissions
  - Lower spending
  - Improved utilization of dialysis centers and follow up care
  - Improved quality

Patient Centered Medical Home



Accountable Care Organizations (ACOs)

- Comprised of many “Medical Homes” who together serve a larger population
- Utilize Medicare “Shared Savings Programs” by assuming some of the risk
- Accountable for quality, cost, and experience of care
- Encourages investment in high quality and efficient services
- ACOs models include 1 sided and 2 sided risk (incentives and penalties)
  - Next Generation ACO model increases shared risk and benefit

Initiatives within Next Gen ACO Model

- Telehealth
- Post discharge home visits
- 30 day skilled nursing facility rule: coverage eligibility within 30 days of inpatient stay
- Select physicians at UNC are participating in this model

- Results: only raw data available for 1st year's data, no summary or conclusions provided yet

Comprehensive Primary Care Plus (CPC+)

- A national advanced Patient Centered Medical Home Model
- Includes robust learning system and clinical decision support tools with feedback to guide physician decision making
- Medicare provides $ to investment in care improvements and reduce unnecessary services
- If practices do not achieve quality standards established, they are responsible for partial repayment

Comprehensive Primary Care +

Requires practices to follow defined steps to provide the following 5 primary care functions

- Access and continuity
- Risk stratified care management
- Planned care for chronic conditions and preventative care
- Patient and caregiver engagement
- Comprehensiveness and coordination of care

Oncology Care Model (OCM) - Two-Sided Risk

- Shared savings and shared losses to incentivize care coordination, appropriateness of services, and 24/7 patient access to clinician
- Increased focus on discriminating appropriateness of chemotherapy based on most current evidence based medicine
- Increased focus on treatment plans with highest promise for improving patient experience and health outcomes
- Currently used by 184 practices and 13 payers
- Care plans must contain 13 specified elements outlined in Institute of Medicine's report "Delivering High Quality Cancer Care- Charting a New Course for a System in Crisis"
- Use data for continuous quality improvement
- 5 year model running 2016-2021
- No preliminary conclusions released as of yet for care model

Summary

- We’re currently in the transition to 38 alternative payment models
- Most clinicians in UNC system are participating in MIPS
- The first year of APM incentives/penalties will be provisioned in 2019

Discussion

- Driving question: Are we doing enough in the face of population health and cost crisis?
- Avg Hospital Operating Margin was 2.7% in FY16 (Advisory Board)
- 2019 Medicare payment adjustments up to 5% could be catastrophic for underperforming healthcare agencies.
- Further increasing Medicare adjustments up to 9% by 2022 has a strong chance of delivering leaner healthcare business models

References

- Yeung, L. (2016). Implementation of MIPS and APMS: Provider compliance consideration in the new world of physician payment reform. *Journal of Health Care Compliance, 18(2)*. Retrieved from https://search-proquest-com.libproxy.lib.unc.edu/docview/1785288190?pq-origsite=summon.
- Rosencrantz, A., Nicola, G., Allen, B., Hughes, D., Hirsch, J. (2017). MACRA, MIPS, and the new medicare quality payment program: An update for radiologists. *Journal of the American College of Radiology, 14(3)*. Retrieved from https://www-clinicalkey-com.libproxy.lib.unc.edu/service/content/pdf/watermarked/1-s2.0-S1546144016310845.pdf?locale=en_US
- Fisher, E. (2016). Medicare's bundled payment program for joint replacement: promise and peril? *Journal of American Medical Association, 316(12)*. Retrieved from https://jamanetwork-com.libproxy.lib.unc.edu/journals/jama/fullarticle/2553000
- Self, R., Coffin, J. (2017). Advanced Alternative Payment models part II: understanding the next generation accountable care organization model. *The Journal of Medical Practical Management, 32(5)*. Retrieved from https://search-proquest-com.libproxy.lib.unc.edu/docview/1890105484?pq-origsite=summon
- Chen, S., Coffron, M. (2017). MARCRA and the changing medicare payment landscape. Annals of Surgical Oncology, 24(10). Retrieved from https://link-springer-com.libproxy.lib.unc.edu/article/10.1245%2Fs10434-017-5954-8
- https://www.cms.gov