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Key Issues in Choosing and Developing Your Alternative Payment Model

Session 2, March 5, 2018

Sandy Marks, Assistant Director, Federal Affairs,

American Medical Association

ENGAGED

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AMA AMERICAN MEDICAL ASSOCIATION

Conflict of Interest

Sandra S. Marks, MBA

Has no real or apparent conflicts of interest to report.

Agenda

- Why we need better payment models
- Key challenges in designing alternative payment models (APMs)
- APMs under the Medicare Access and CHIP Reauthorization Act
- Examples of physician-focused APMs
- How practices can choose an APM pathway
- Future directions
- Q & A

Learning Objectives

- Identify components of physician-focused alternative payment models that can support practice efforts to improve quality and lower costs
- Assess how physicians are solving key challenges in the design of new alternative payment models, such as risk stratification and lack of data
- Explain how practices can choose alternative payment models that will help them improve patient outcomes

Why We Need Better Payment Models

"Patients are like submarines…out there submerged. We can't see them; we don't know how they are [because] they only come in when they're in trouble. Which means that, number one, they have to recognize that they're in trouble and, number two, realize that they can't fix it themselves…So we need a sonar system to ping them."

Larry Kosinski, MD, Sonar Founder

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Larry Kosinski, MD, Sonar Founder

- There is no payment for contacting patients between visits to find out how they are doing.

"John would go into a small practice for his chemotherapy. Then he would head home afterwards with instructions to call the office with any concerns or questions. The next day he didn't feel very good. But he didn't want to bother the doctor, thinking it was a normal reaction to the chemotherapy or the underlying cancer, so he didn't call the office. … Two days later he had severe diarrhea and nausea and ended up so dehydrated that he had to go to the emergency department."

Robin Zon, MD, Patient-Centered Oncology Payment

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Robin Zon, MD, Patient-Centered Oncology Payment

- There is no payment for a nurse to help patients with complications of chemotherapy.

"Asked why she had visited the emergency department so frequently, the patient said she had lost her husband in a car accident. In the midst of her grief, she failed to manage her diabetes and made frequent trips to the emergency department, where she was stabilized. However, the medical treatment didn't address the depression underlying her apparent noncompliance with her diabetes treatment."

Heather Logan, Bridges to Care

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Heather Logan, Bridges to Care

- There is no payment to provide primary care in emergency departments.

Key Challenges in Designing APMs

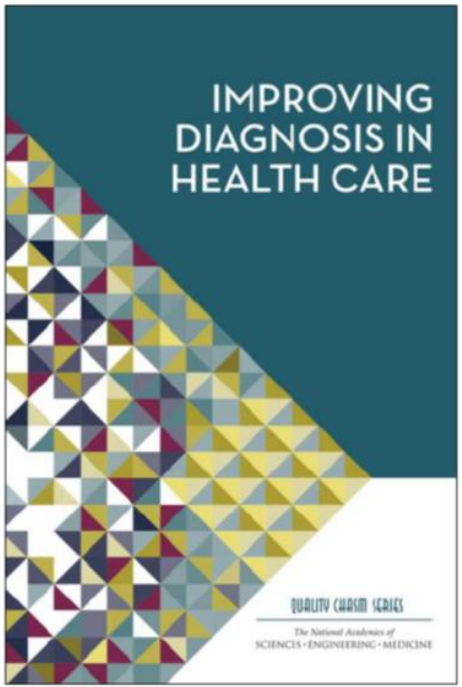
Payment Gaps for Services Patients Need

- Fee-for-service payments are tied to face-to-face services
- Little or no payment for:
  - Teamwork and collaboration with other physicians
  - Phone calls with patients or proactive outreach to them
  - Clinical decision support and shared decision-making
  - Discharge planning and coordination
  - Education in patient self-management and risk reduction
  - Palliative care
- APMs need to fill these gaps

Separate vs. Bundled Payments

- Current payments do not reflect important factors in patient care: comorbidities, functional status, disease stage, home caregiver, nutrition, genomics, social and environmental factors
- Additional separate payments, such as paying for team conferences or patient education, can fill gaps, but contribute to “piecework” payments and add new regulatory and documentation burdens
- Bundled payments lack precision of separate payments, but may be preferred due to more flexibility with fewer hassles

Finding the Right Diagnosis



- Lack of payment for work involved in getting an accurate diagnosis is a major challenge
- No payment for consultation with other physicians to help determine a diagnosis
- Delays in patient access to specialists can lead to exacerbations before a diagnosis is established and treatment plan developed
- Time lost ruling out differential diagnoses
- Pay supports doing tests and procedures, not process of deciding which tests to order
- APMs designed around an episode or procedure need to support diagnostic accuracy

Lack of Good Data

- Even robust databases cannot pair cost and quality data, with the result that no one knows how much something actually costs
- It is extremely difficult to get timely and actionable data from payers

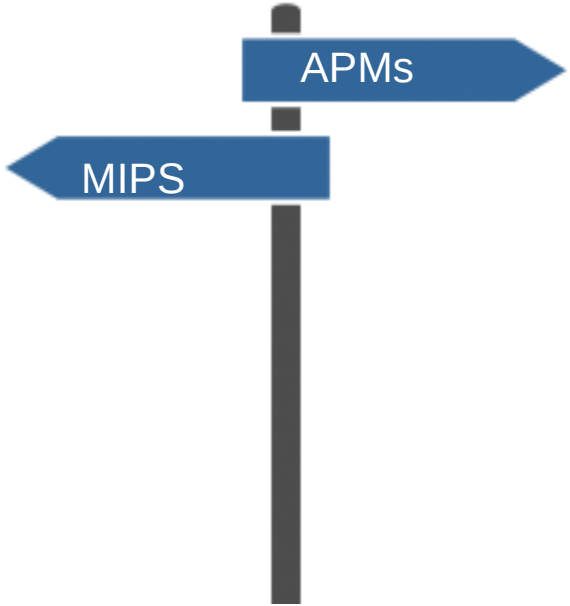
Health IT Challenges

- Many health IT products, including EHRs, are developed and certified to meet ONC and CMS requirements
- These requirements have been predominant driver of product design for 7 years—creating “one-size-fits-all” EHRs
- Certified EHR Technology (CEHRT) is now widely viewed as tool for documentation and reporting instead of improving care coordination and patient engagement
- To be successful, APM participants need health IT that responds to and supports physician, patient, and care team interactions

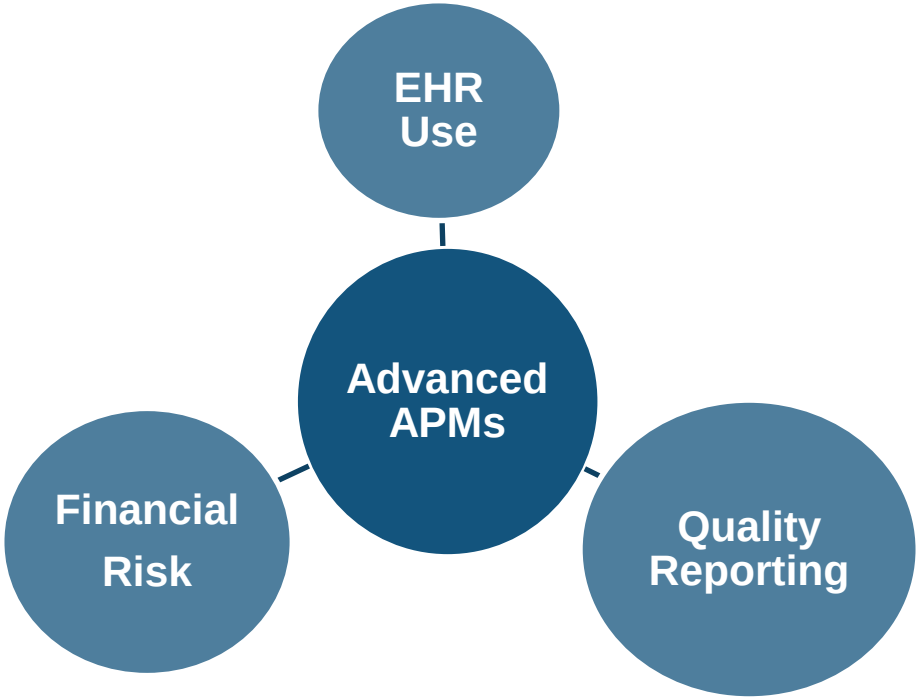
APMs Under the Medicare Access and CHIP Reauthorization Act (MACRA)

APM Pathway Under MACRA

- MACRA was designed to offer physicians new payment model pathways:
  - Modified fee-for-service model
  - Alternative payment models
- Physician payment system created by MACRA called Quality Payment Program or QPP
- QPP APMs can be developed by CMS or by physicians and other stakeholders



QPP Criteria for "Advanced APMs"



CMS Models Qualified as Advanced APMs

Comprehensive ESRD Care Model

(Subset of 37 ESCOs qualify)

Comprehensive Primary Care Plus

(2,816 Round 1 practices + 165 Round 2)

ACOs:

Tracks 1+, 2, 3 NextGen, Vermont

(159 ACOs + VT)

Bundled Payments for Care Improvement Advanced

(starts 10/1/2018)

Oncology Care Model Track 2

(Subset of 192 practices qualify)

Comprehensive Joint Replacement

(Subset of participants in 67 MSAs qualify)

Pros & Cons of CMS-developed APMs

Pros:

- Extra $$ for non-face-to-face services and support staff
- 5% annual bonus to Advanced APMs in 2019-24 with higher update after 2026
- Ease of MIPS participation for MIPS APMs and MIPS exemption for Advanced APMs
- Waivers improve patient access to telehealth and post-acute care
- Opportunities to share savings can lead to better treatment planning

Pros & Cons of CMS-developed APMs

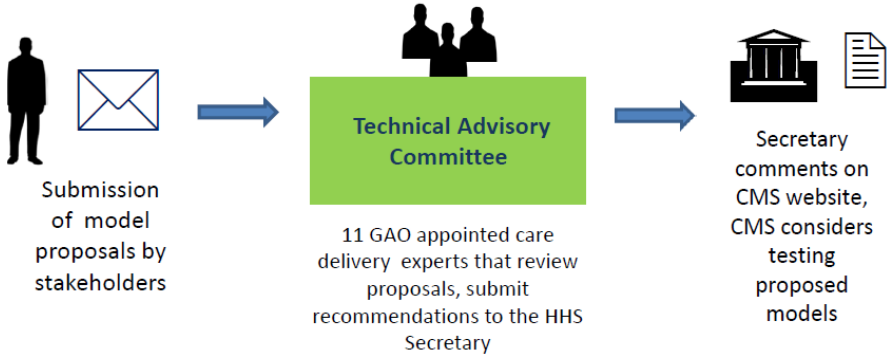
Cons:

- Financial risk rules force physicians to be accountable for costs outside their control
- Lack of risk adjustment hurts practices with more complex patients, worse functional status, poor support at home
- No incentive for HIT innovation
- Added documentation burdens
- Attribution methods limit patient access to APMs' benefits and keep physicians guessing which of their patients are in APMs
- No recognition of ACO start-up costs and ACO benchmarks hurt efficient practices
- Difficult to get timely data and feedback from CMS
- Years-long waits for shared savings payments

Physician-Focused APMs Under MACRA

PFPM = Physician-Focused Payment Model

Goal: to encourage new APM options for Medicare clinicians



Submission of model proposals by stakeholders

11 GAO appointed care delivery experts that review proposals, submit recommendations to the HHS Secretary

Secretary comments on CMS website, CMS considers testing proposed models

Definition:

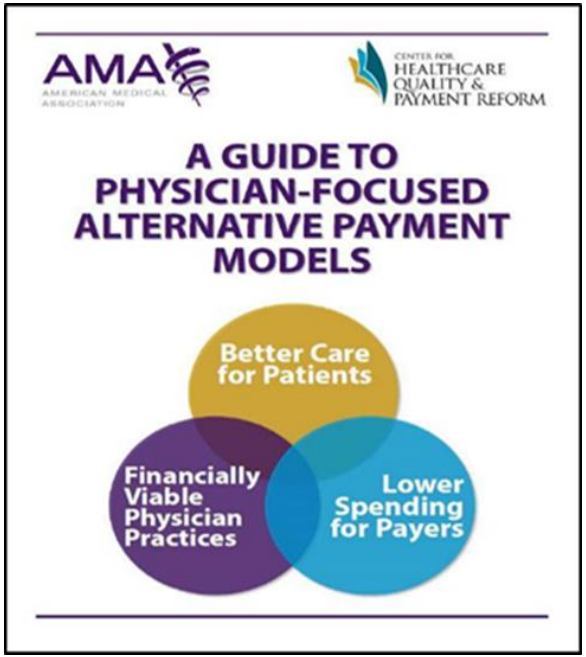
- Medicare is a payer
- MACRA-eligible clinicians are participants and play core role in implementing APM's payment methodology
- Targets quality and costs of services that clinicians participating in the APM provide, order, or can significantly influence

Physician-focused APM Technical Advisory Committee (PTAC)

- 11-members (7 MDs) created to review stakeholder APM proposals, make recommendations to HHS Secy
- 21 proposals submitted in 2017
- 14 additional Letters of Intent with future proposals expected
- In 3 public meetings to review proposals, PTAC recommended 6 models be tested or implemented:

1. Project Sonar (Crohn's Disease)
2. American College of Surgeons-Brandeis Episodes
3. Hospital at Home Plus
4. Oncology Bundled Payment Using CNA-Guided Care
5. Advanced Primary Care
6. Incident End Stage Renal Disease Clinical Episode

Medicine Responds to Opportunity for Physician-focused APMs



Clips from AMA's APM Workshop:

https://youtu.be/DdsVlS-dEMo

Examples of Physician-Focused APMs

Physician-focused APM for Crohn's Disease

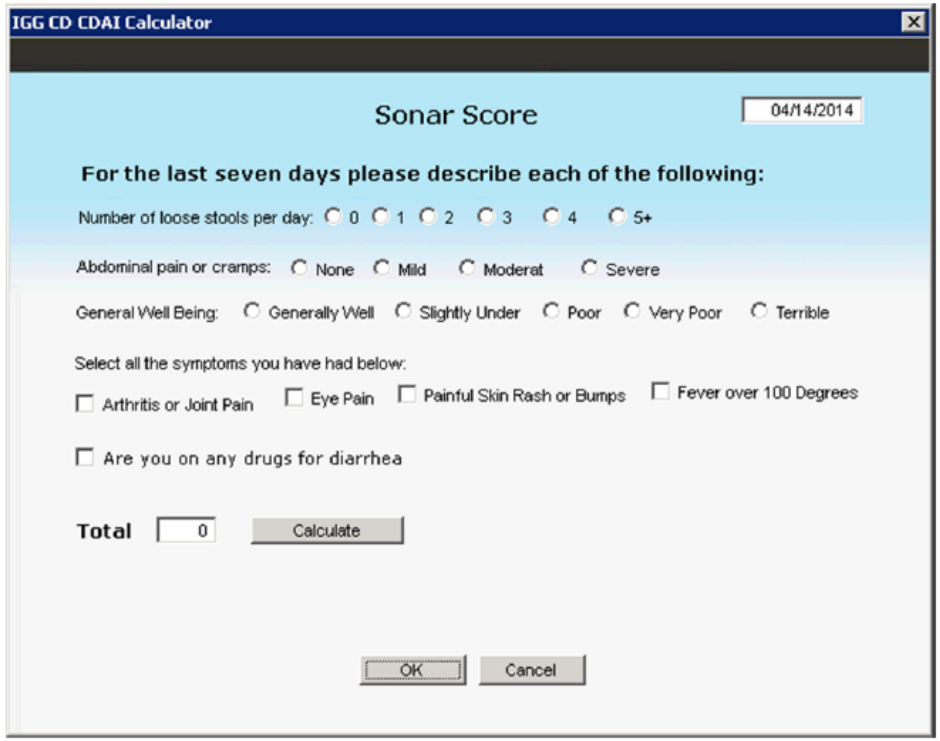
- "Patients are like submarines…out there submerged. We can't see them; we don't know how they are [because] they only come in when they're in trouble. Which means that, number one, they have to recognize that they're in trouble and, number two, realize that they can't fix it themselves…So we need a sonar system to ping them."
  Larry Kosinski, MD, Sonar Founder
- Opportunities for Improvement:
  - Payer was spending $22,000 per patient per year for Crohn's
  - >50% of spending went to hospital costs
  - 2/3 of patients had **0** physician visits 30 days before admission

Barriers to Improving Patient Care

- No process, staff, or payment for outreach to patients between visits to find out how they are doing and adjust treatment plan
- No data to show how often complications of Crohn's Disease led to emergency visits and hospitalizations
- No process for engaging patients as partners in their care
- No IT platform to share information with other team members, patients' other physicians, or patients themselves
- Financial penalties incurred by gastroenterologist for practicing more efficiently

Project Sonar Design

- Payer attributes patients based on diagnosis
- Once enrolled in Sonar, patient has enrollment visit, care management plan is developed, patient signs off
- Nurse care managers ping patients with disease specific questions
- “Sonar score” calculated based on patient’s response to ping
- Patients get immediate feedback
- Care manager uses algorithm to interpret Sonar score, contacts physician if necessary so treatment can be adjusted
- Sonar provides performance reports to practices including claims data



Sonar Score	
Question	**Metric**
Number of loose stools per day	0,1,2,3,4,5
Abdominal Pain or Cramps	0,5,10,15
General Well Being	0,7,14,21,28
Individual Items	
Arthritis or Joint Pain	0,20
Eye Pain	0,20
Painful Skin Rash or Bumps	0,20
Fever over 100 degrees	0,20
Use of drugs for diarrhea	0,30
Sonar Score	**Sum of all**

Sonar APM Yields Results

- Monthly payments support:
  - Nurse care managers
  - Clinical decision support tools
  - Proactive outreach to high-risk patients
- Hospitalization rate and emergency visits cut > 50%
- Payer spending significantly reduced
- Patient satisfaction improved
- Following PTAC recommendation to HHS Secy, Medicare now studying use of Sonar APM for other chronic conditions

Physician-focused APM for Emergency Care

- Many emergency department (ED) patients do not have a regular source of primary care or mental/behavioral health care
- Current system does not support providing primary or mental health care services in the ED; patient education and care coordination in ED; post-ED home visits; non-medical needs
- Common post-ED events: repeat ED visits, inpatient admissions, observation stays, repeat opioid overdose, death
- Opportunity to improve care by providing support for discharge planning, appropriate care transitions and post-ED care coordination

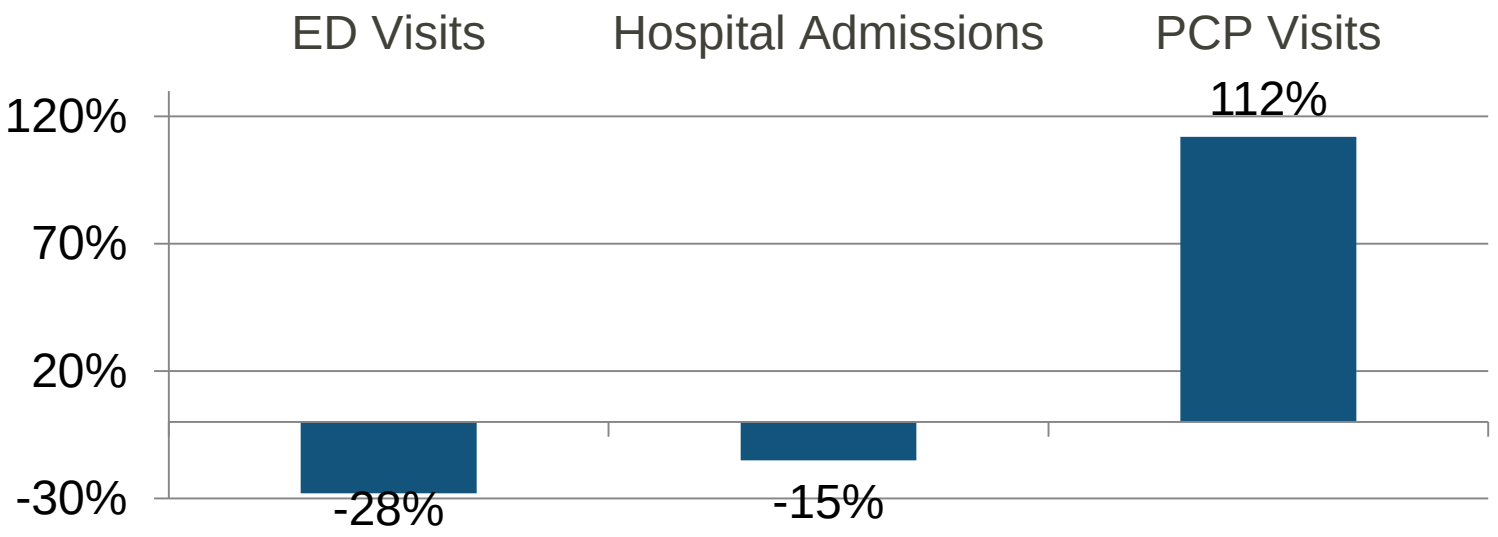
Pilot Program "Bridges to Care" (B2C)

- Funded by CMS Innovation Award
- Care coordination targeted patients with ≥ 3 ED visits in 6-month period:
  - Community health workers
  - Primary care physicians
  - Care coordinators
  - Community organizers
  - Behavioral health referrals
  - Health coaches

Coordination Program Reduced Acute Care Use And Increased Primary Care Visits Among Frequent Emergency Care Users

ABSTRACT Many high utilizers of the emergency department (ED) have public insurance, especially through Medicaid. We evaluated how participation in Bridges to Care (B2C)—an ED-initiated, multidisciplinary, community-based program—affected subsequent ED use, hospital admissions, and primary care use among publicly insured or Medicaid-eligible high ED utilizers. During the six months after the B2C intervention was completed, participants had significantly fewer ED visits (a reduction of 27.9 percent) and significantly more primary care visits (an increase of 114.0 percent), compared to patients in the control group. In a subanalysis of patients with mental health comorbidities, we found that recipients of B2C services had significantly fewer ED visits (a reduction of 29.7 percent) and hospitalizations (30.0 percent), and significantly more primary care visits (an increase of 123.2 percent), again compared to patients in the control group. The B2C program reduced acute care use and increased the number of primary care visits among high ED utilizers, including those with mental health comorbidities.

B2C Pilot Program Results



See *Health Affairs* 36, NO. 10 (2017): 1705–1711

Acute Unscheduled Care Proposal

- Initially targets Medicare patients with ED visits for: chest pain, abdominal pain, syncope, altered mental status
- Provides new payments for ED physicians to provide or coordinate telehealth, transitional care management, post-discharge home visits
- Aims to improve decisions about hospital admissions, provide safe ED discharges, reduce post-discharge adverse events

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions

A Physician-Focused Payment Model (PFPM) for Emergency Medicine

Acute Unscheduled Care Proposal

- ED physicians receive shared savings for 30-day ED episodes (or repay losses) based on performance in improving appropriateness of hospital admissions and reducing post-ED adverse events
- Clinical Emergency Data Registry will capture quality & safety performance data

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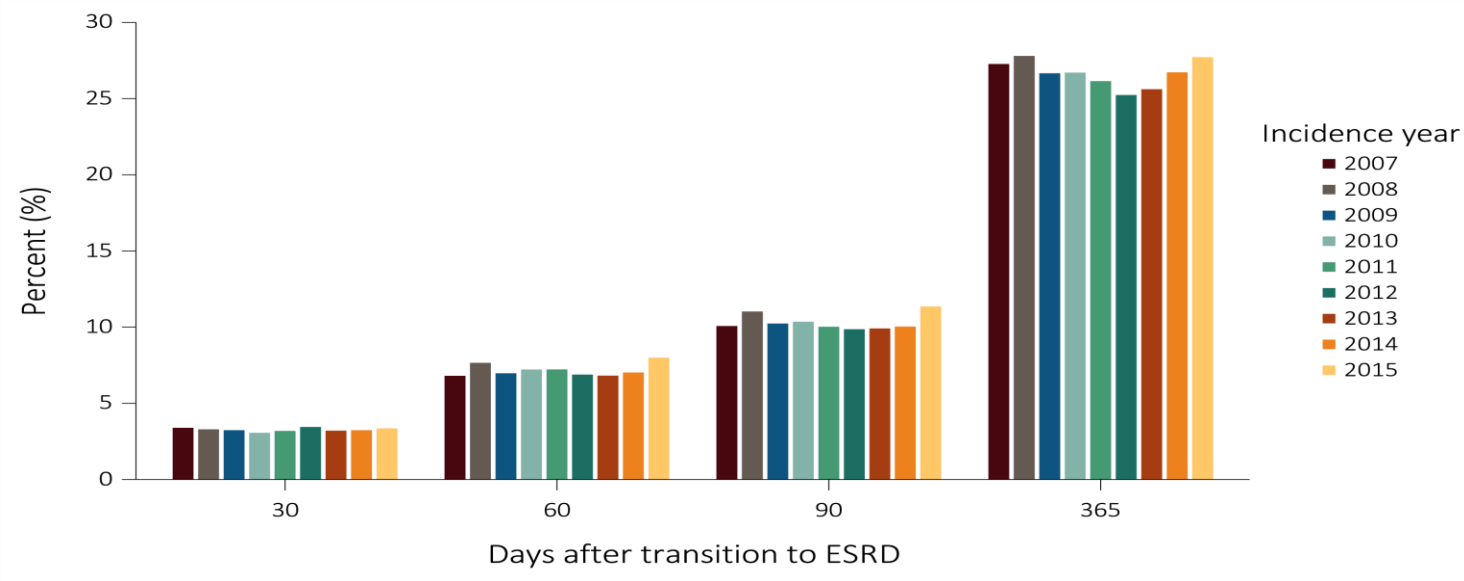
Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions

A Physician-Focused Payment Model (PFPM) for Emergency Medicine

APM Opportunity: Persistently High Mortality Rate in First Year of End Stage Renal Disease



US Renal Data System

Physician-focused APM: ESRD Clinical Episode

- PTAC submission from Renal Physicians Association
- Addresses critical need to improve care for patients transitioning from chronic kidney disease (CKD) to ESRD, who experience high rates of mortality, complications, and hospital admissions
- 1% of Medicare patients with ESRD account for 7% of Medicare costs
- Provides shared savings based on regional cost benchmarks for first 6-month episode of dialysis

Focus on:

- Choice of dialysis modality
- Vascular access preparation
- Promote renal transplants
- CKD patient education and risk reduction
- Advance care planning
- Palliative care

Kidney Quality Improvement Registry Used to Track APM Metrics

Metric	Points	How Measured
Advance care plan	15	Claims & EHR
Fistula rate (number of patients with permanent vascular access)	10	EHR
% on home dialysis vs. in-center	15	Claims
Referrals for renal transplant	10	EHR
Karnofsky functional status score	10	EHR

Physician-focused APM for Cancer Care

- "COME HOME" oncology medical home model supported by CMS Innovation Award
- Provided support for patient education and counseling to help manage psychological, physical, financial challenges of cancer
- Focused on treatment planning, appropriate use of drugs
- Care management payments allowed model to reduce nausea, pain, dehydration, fever, other complications of cancer
- Oncology practices treated complications quickly without ED visits or hospital admissions

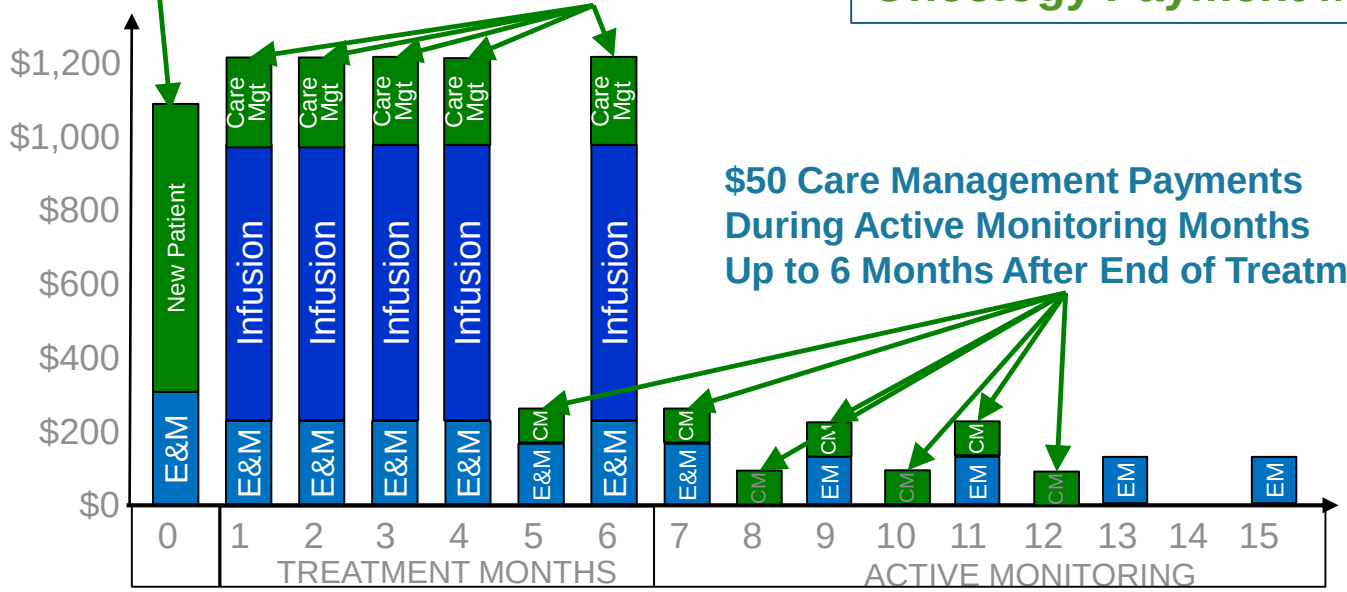
Improving Oncology Care Model (OCM)

- Medicare's OCM design built on successful COME HOME elements
- Provides Monthly Enhanced Oncology Services (MEOS) payment to support care coordination during chemotherapy episodes
- Flaws: sole focus on 6-month chemo episodes, total cost of care risk, costly administrative requirements, same payment for all patients
- Need to better support diagnosis and treatment planning: review tests and pathology reports, determine cancer type and stage, develop care plan, provide genetic, psychological, nutrition, financial counseling
- Need for support after chemo: develop survivorship or end-of-life plan, order tests to check recurrence, manage post-treatment complications

Additional $750 One-Time Payment for Each New Patient

$200 Monthly Care Management Payments During Treatment Months

American Society of Clinical Oncology's Patient-Centered Oncology Payment Model



$50 Care Management Payments During Active Monitoring Months Up to 6 Months After End of Treatment

Solutions to Key APM Design Challenges Being Used in Physician-focused APMs

Separate vs Bundled Payments

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- Stratify bundled payments based on differences in patient needs
- Combine clinical and claims data to define categories and payment levels
- Need to find the right balance of simplicity and accuracy, not choose separate payments or bundled payments exclusively

Solutions for More Accurate Diagnoses

- Pay for complete diagnostic work-up, patient education about diagnosis & self-management, development of initial treatment plan

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- Use clinical pathways to specify appropriate use of tests & imaging
- Support collaboration between pathologists, radiologists, and multiple specialists to determine accurate diagnosis
- Include pathology & outcome data in clinical data registries, plus functional status and other factors that affect treatment plans

Solutions for Data and Health IT

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- Developers encouraged to listen to APM developers and learn what they need to enter, retrieve, share, and analyze data
- Create technology that “builds on” CEHRT—leveraging EHR investments already made by physicians and health systems

How Practices Can Choose an APM Pathway

Start with a Needs Assessment

- What conditions or episodes of care does your practice manage?
- Are there opportunities to improve care for those conditions in ways that would also lower health care spending?
- What barriers in the current payment system prevent the practice from implementing these improvements?
- Is there a Qualified Clinical Data Registry to help with the APM quality measures?
- Is an APM available or could an APM be developed that would overcome these barriers and facilitate the care improvement?

Does the APM Address the Needs?

- Do the APM payments cover the cost of meeting its requirements?
- Are the APM's start-up costs and downside risks manageable?
- Are the APM's quality metrics appropriate and achievable?
- Can the practice's EHR support its participation in the APM?
- How would care provided by other physicians outside of the APM be best coordinated with the APM participants' services?
- Can you trust the payer to provide timely and actionable feedback on claims, patient attribution, and performance metrics?

Potential Future Directions

- CMS Request for Information on “New Direction”
- Blockchain Technology
- Precision Medicine
- Artificial Intelligence

Questions

- Email: Sandy.Marks@ama-assn.org
- Website with AMA resources on APMs: www.ama-assn.org/medicare-payment
- LinkedIn: https://www.linkedin.com/in/sandy-marks-1b92566/
- Twitter: @sandysspot3

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