2018 UAB Forging the Future of Palliative Care Summit:

Getting It Paid For: Alternative Payment Models

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PALLIATIVE MEDICINE
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Disclosures

- Dr. Rodgers receives support as a Cambia Health Foundation Sojourn Scholar
- He serves in several unpaid volunteer positions with the American Academy of Hospice and Palliative Medicine (AAHPM) related to advocacy and payment policy


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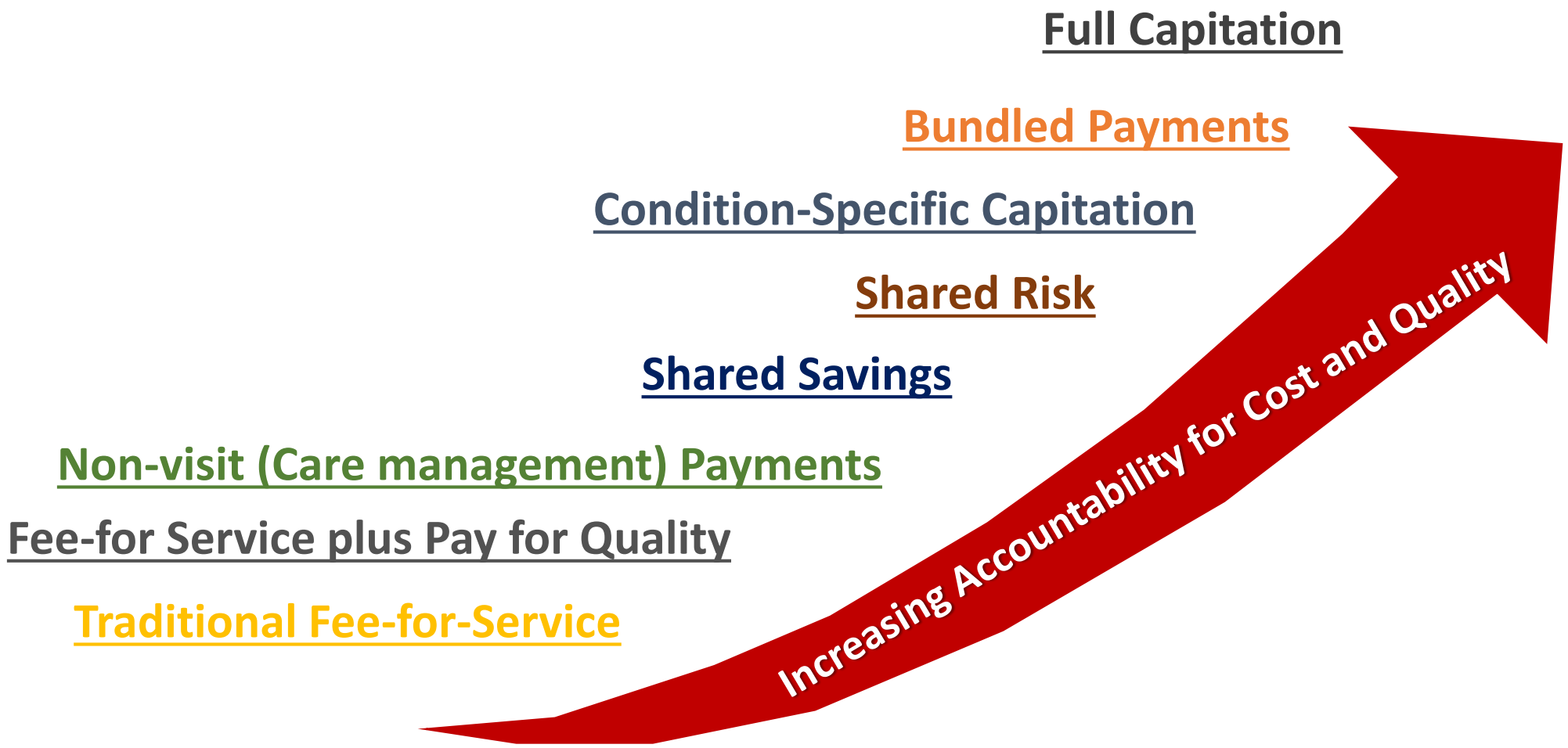
The Rise of Risk

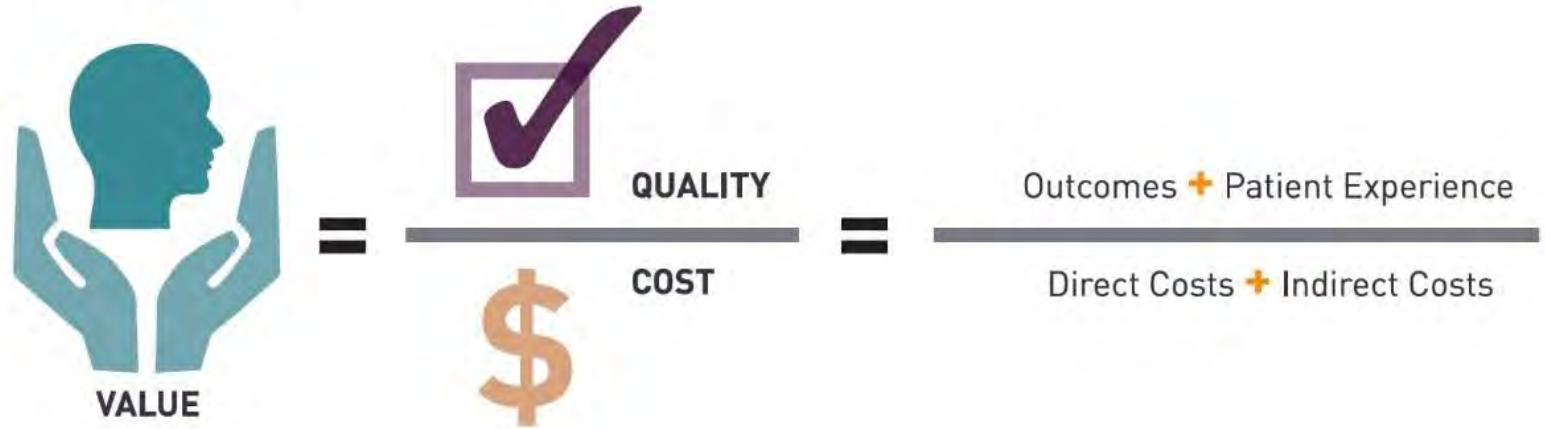


Objectives

- Understand the current Value-Based Payment (VBP) landscape, including Alternative Payment Models (APMs) under the Medicare Quality Payment Program (QPP)
- Describe the opportunities (and risks) for palliative care providers in APM and VBP engagement, to advance population health success
- Identify specific policy and program considerations for palliative care to succeed in a value-based payment present and future

Medicare Quality Payment Program

- Established by the 2015 Medicare Access and CHIP Reauthorization Act (MACRA), launched **January 1, 2017**
- Designed to move traditional Medicare program from fee-for service payment toward Value-Based Payments (VBP)



Medicare Quality Payment Program

MIPS

Merit-based Incentive Payment System

Performance-based payment adjustments based on quality, cost, care improvement and improving interoperability

APM

Alternative Payment Model

Provides greater incentives to improve quality and control costs for specific clinical conditions, care episodes or populations

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Provides greater incentives to improve quality and control costs for specific clinical conditions, care episodes or **populations**

APMs are designed to incentivize:

- Higher quality performance and quality improvement
- Better care coordination and integration
- Enhanced patient and caregiver experience
- Innovation in care delivery and integration
- Cost savings

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Significant opportunities for palliative care providers in APMs

Palliative Care Improves Care Quality

- Reduces pain and physical symptoms
- Reduces depression and psychological distress
- Improves family caregiver satisfaction
- Can improve patient reported quality of life

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Palliative Care Reduces Cost

- Reduces number of ED and hospital visits for uncontrolled symptoms
- Reduces intensive care use during hospital stays
- Reduces use of expensive but low-value interventions
- Reduces facility-based post-acute care
- Can increase use of hospice care

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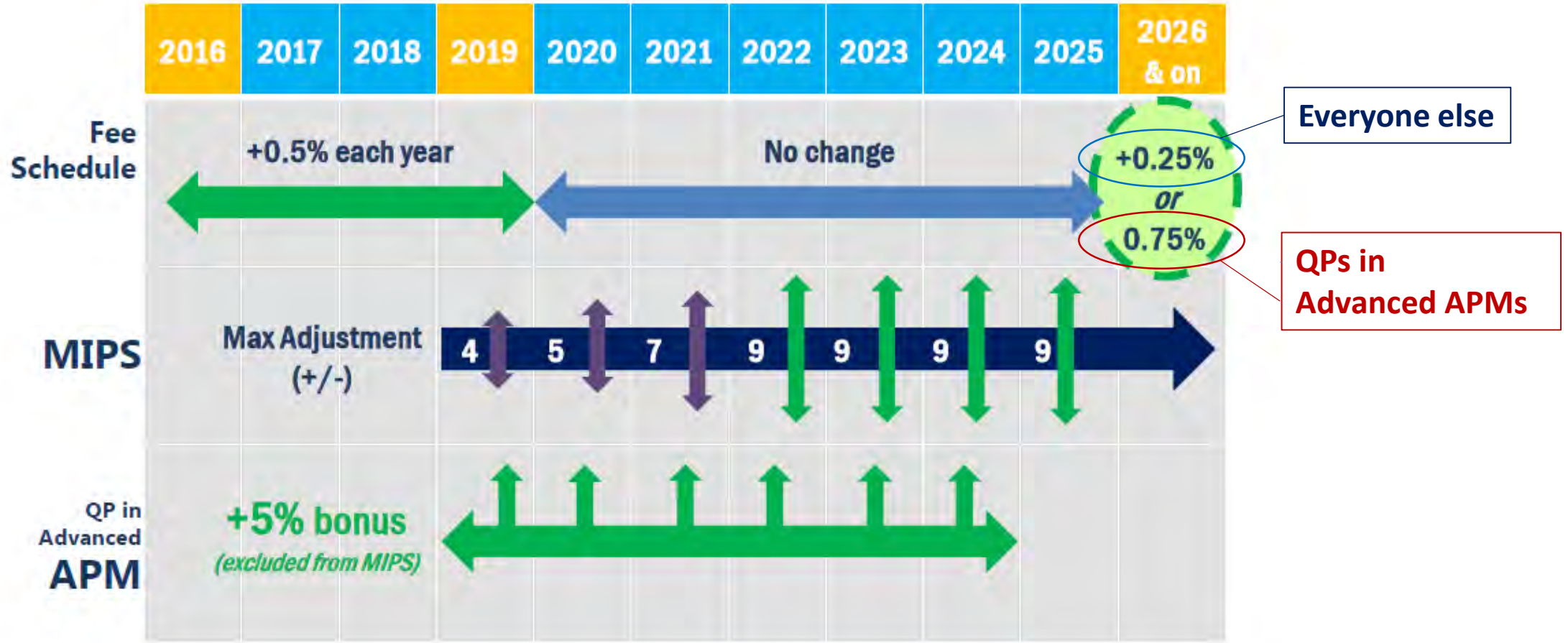
APM Participation Requires:

- **Accountability** for quality and total cost of care
- **Advanced APMs** require two-sided risk
  - Success = shared savings &/or bonus payments, and higher future FFS payments
  - Failure = financial loss
  - *Only 18% of APMs currently take two-sided risk*
- **MIPS APMs** provide smaller bonuses and lower (or no) financial risk; much more palatable to most participants

Overview of QPP Payment Incentives



Advanced APMs for 2018

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

Fee-for-Service Payment—Not Dead Yet

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- Chronic Care Management (CCM): 99490
- Complex Chronic Care Management (CCCM): 99497 & 99489 (add-on)
- Chronic Care Initiation Visit: G0506
- Transitional Care Management (TCM): 99495 & 99496
- New Evaluation and Management (E/M) Codes
  - Advance Care Planning
  - Prolonged Non Face-to-Face Services

Serious Illness Care APMs in Medicare QPP

- *Patient and Caregiver Support for Serious Illness (PACSSI)*
  - American Academy of Hospice and Palliative Medicine (AAHPM)

- *Advanced Care Model (ACM)*
  - Coalition to Transform Advanced Care (C-TAC)

HHS, CMS and CMMI leaders have shown strong interest in launching a Serious Illness Payment Model demonstration project

Medicare Advantage and Commercial Plans

- Actively contracting now for community-based palliative care services
- MA penetration rising across US, now nearly 40% of beneficiaries
- Health plans are strongly incentivized to control costs, and (increasingly) attend to quality of care and patient experience
- Palliative and serious illness care delivery is very attractive to payers:
  - Anthem has acquired Aspire Health
  - Humana has acquired Kindred Home Health and Hospice

Developing a Serious Illness Care APM

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  - Which patients need what types of serious illness services?
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- **Payment Methodology**
  - What level of payment is sustainable? What level of ‘risk’?
  - How are spending benchmarks for serious ill patients created?

Eligibility

- Defining the "Serious Illness Population"
  - *Challenge:* Requires multiple sources of data (claims, clinical, patient report)
  - *Dominant paradigm:* Diagnosis(es), Functional status and Utilization
  - *Ideal paradigm:* Identifying unmet needs across all domains (physical, emotional, spiritual, caregiving, community supports)

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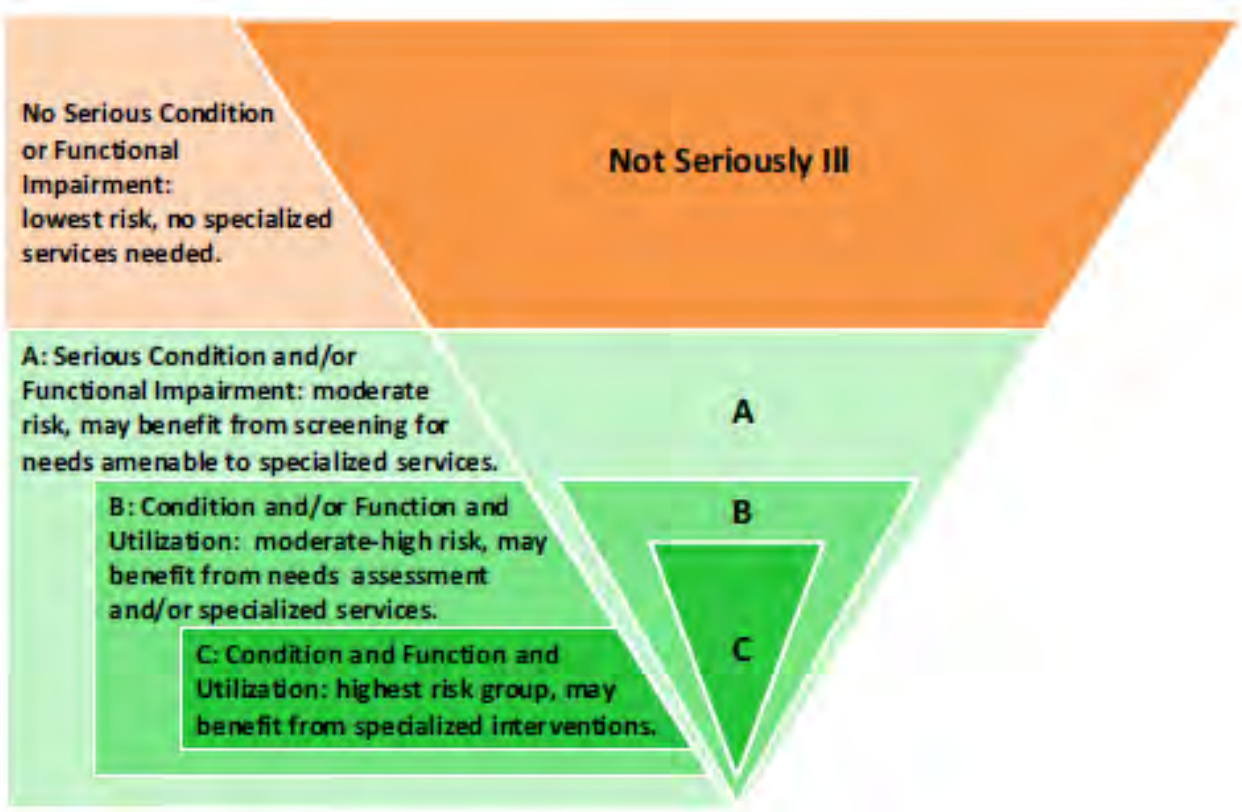
- Identifying individual patients
  - *Challenge:* Most clinical teams do not have access to adequate data analytics
  - *Dominant paradigm:* Clinical referrals, local data mining, payer identification
  - *Ideal paradigm:* Mix of patient referral **and** population-based data analytics deployed across multiple settings (payer, provider, community)

Service Delivery

- Intensity of service should:
  - Match unmet patient & caregiver needs, and 'titrate' over time
  - Integrate with other providers, services and relationships
  - Include **both** high quality disease **and** high quality symptom management
  - Be delivered at sustainable cost



Kelly A, Covinsky K, Ritchie C, et al, 2017

Quality Measurement

- Structure, Process and **Outcomes**
- "**Measuring What Matters**" – Expert Consensus on existing measures (e.g. NQF, PEACE, ACOVE) relevant to specialty palliative care
- Relevant measures in other specialty sets: e.g. Oncology, Family Medicine (PRIME)
- Ongoing generative work:
  - Measure development: AAHPM and RAND, $5M CMS grant (2018)
  - Integration of existing program and patient level registries

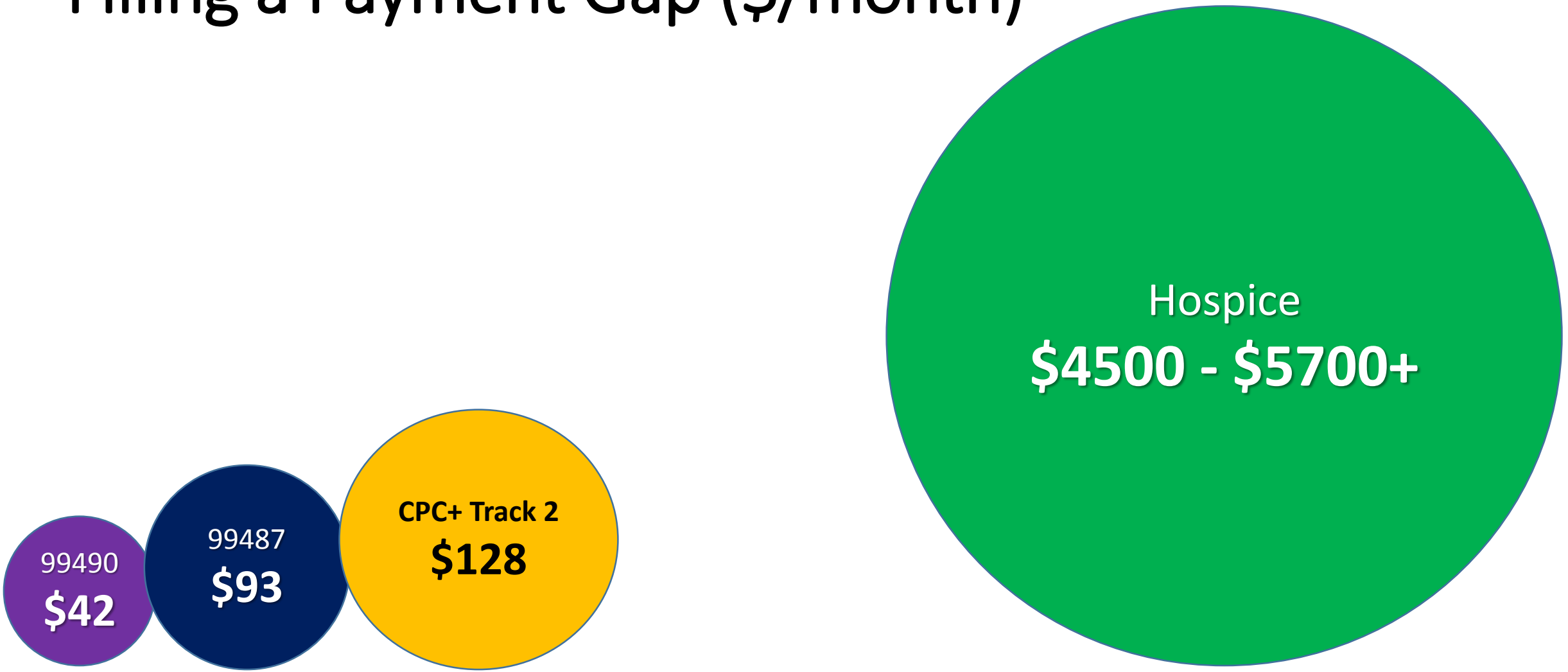
Payment Methodology

- Payment should be sufficient to support high-quality, interdisciplinary palliative and supportive care
- Payment must also allow total patient cost to remain at least neutral (Medicare QPP) or generate savings/margin (MA/commercial plans)
- Prevailing model: 'case rate' payment + at-risk payment based on quality and cost performance

Why a Case Rate-based Payment?

- Provides flexibility in care delivery (no billing provider required)
- Provides predictable revenue to enable budgeting, hiring, planning
- Administratively simpler (somewhat)
- Aligned with trend in both population-based payments, and newer codes in the fee schedule

Filling a Payment Gap ($/month)



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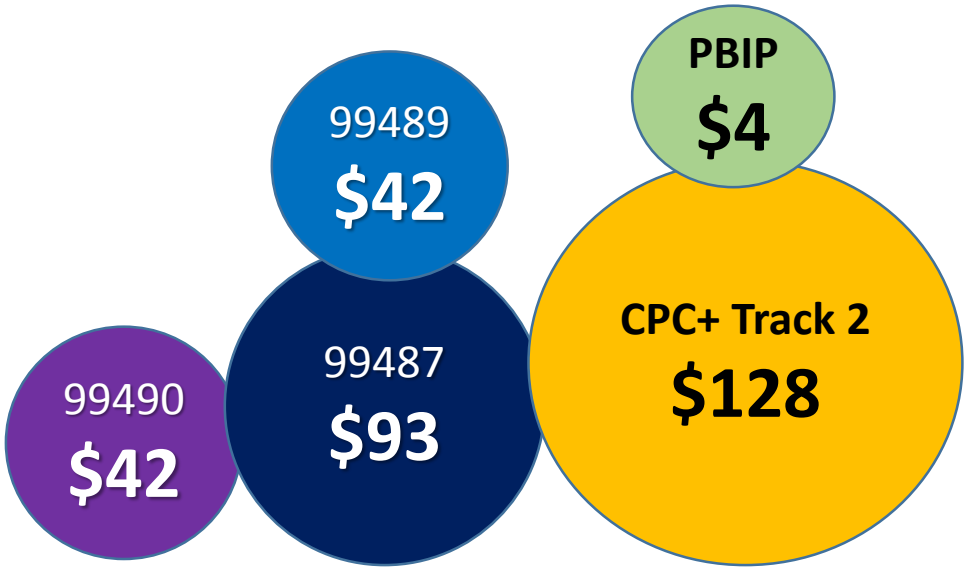

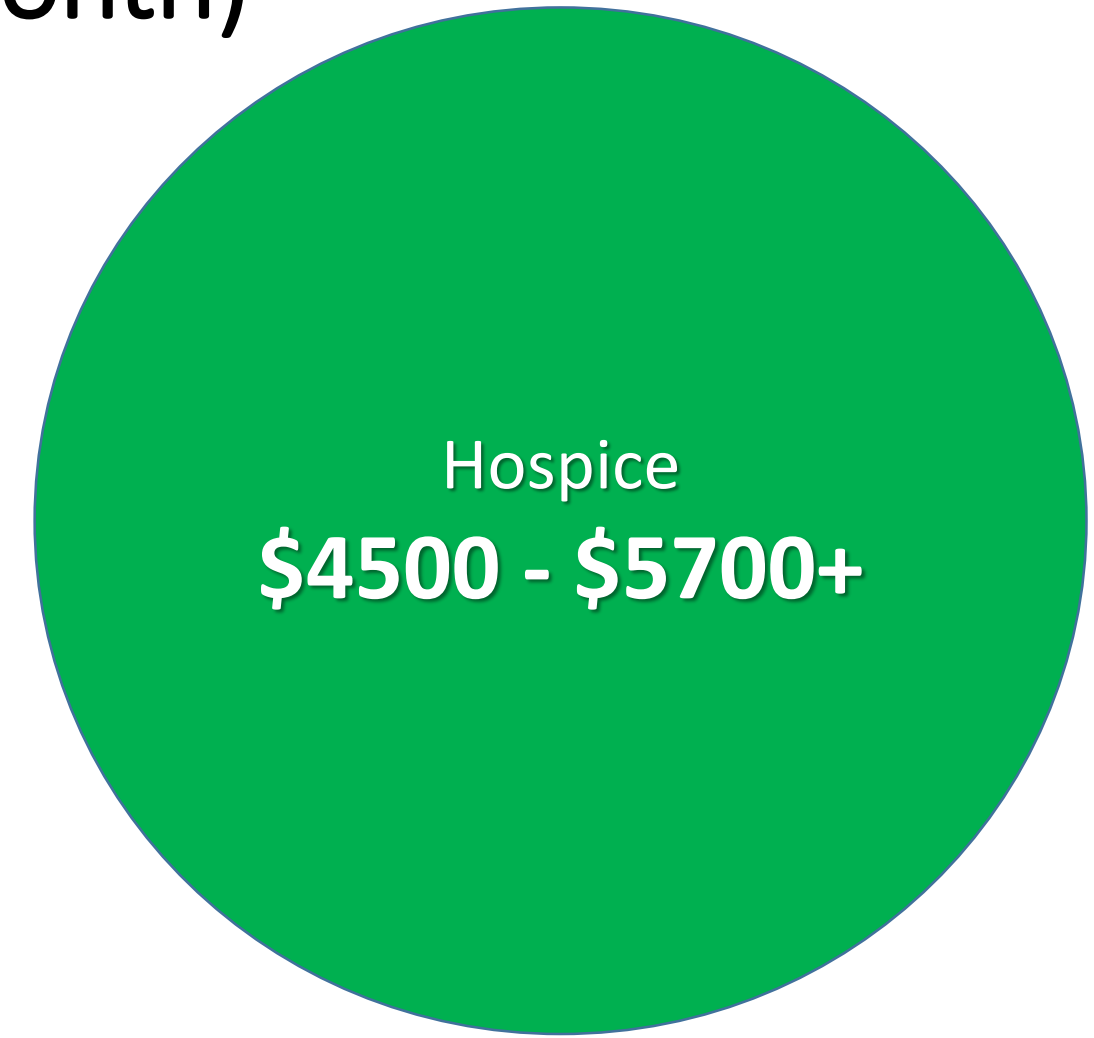

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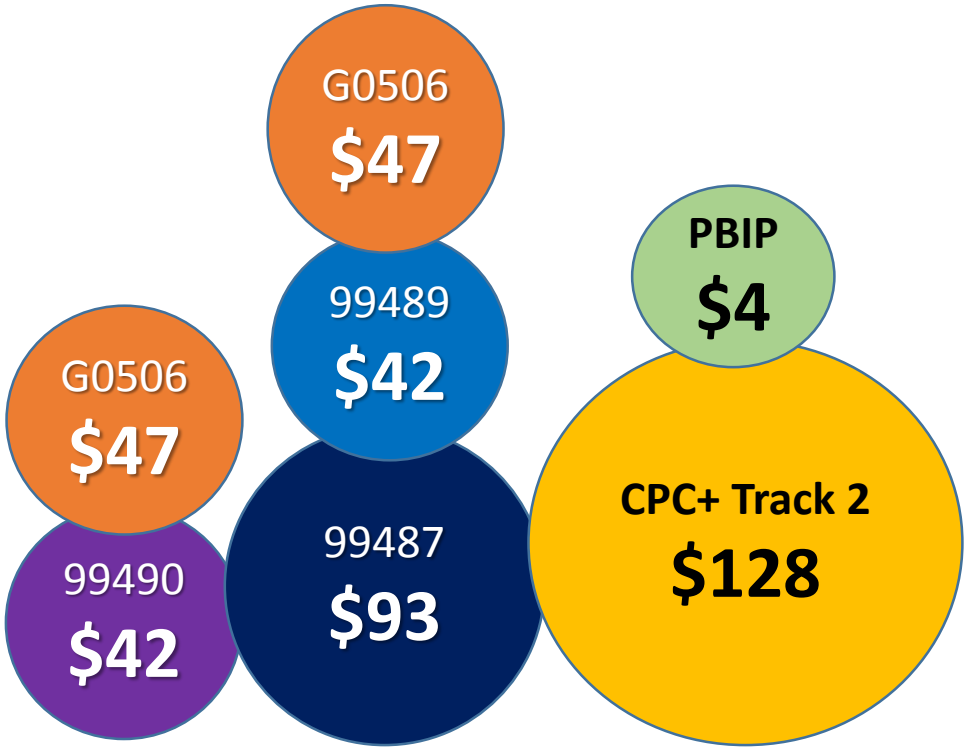

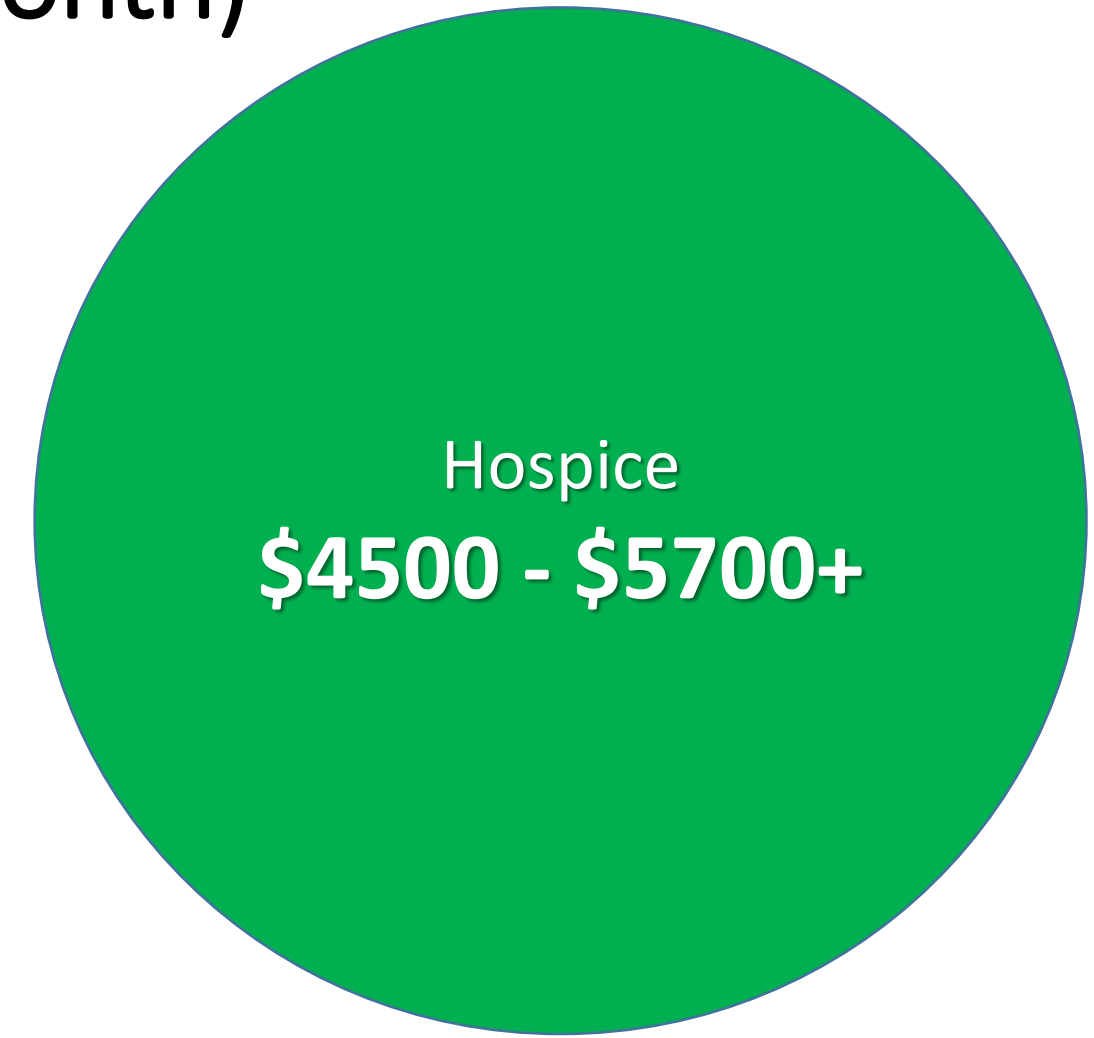

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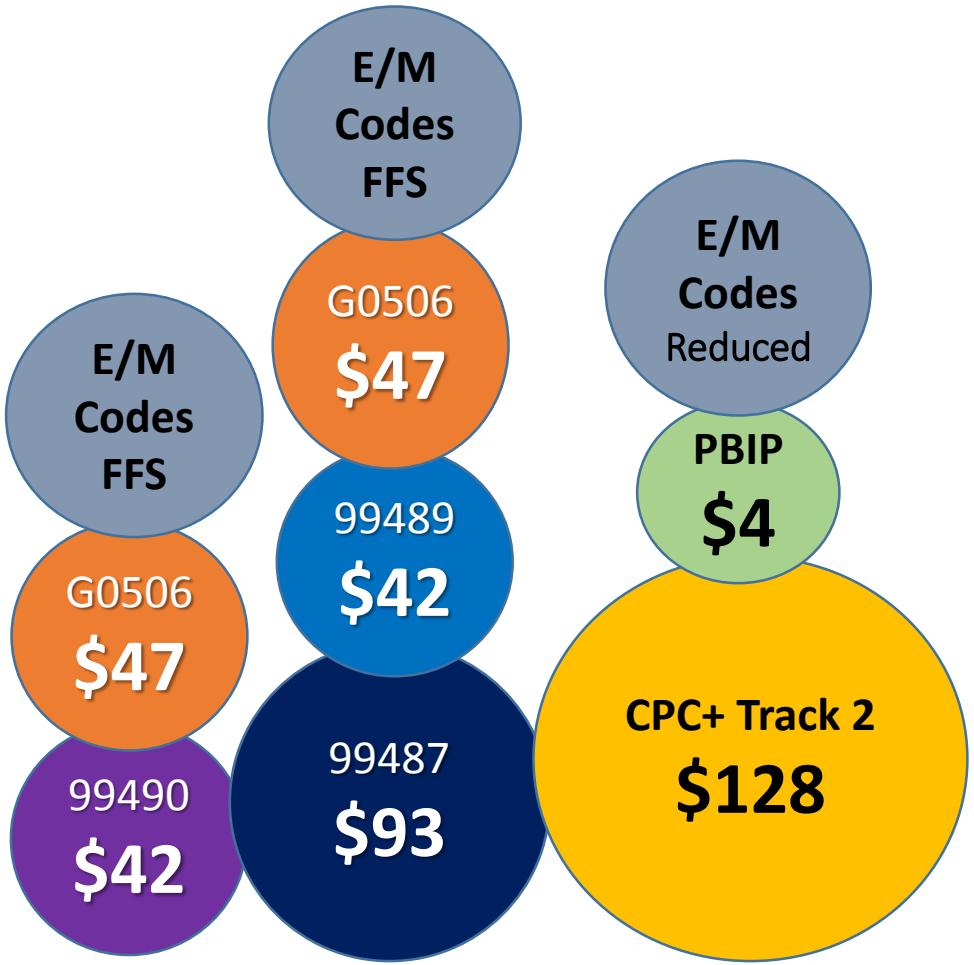

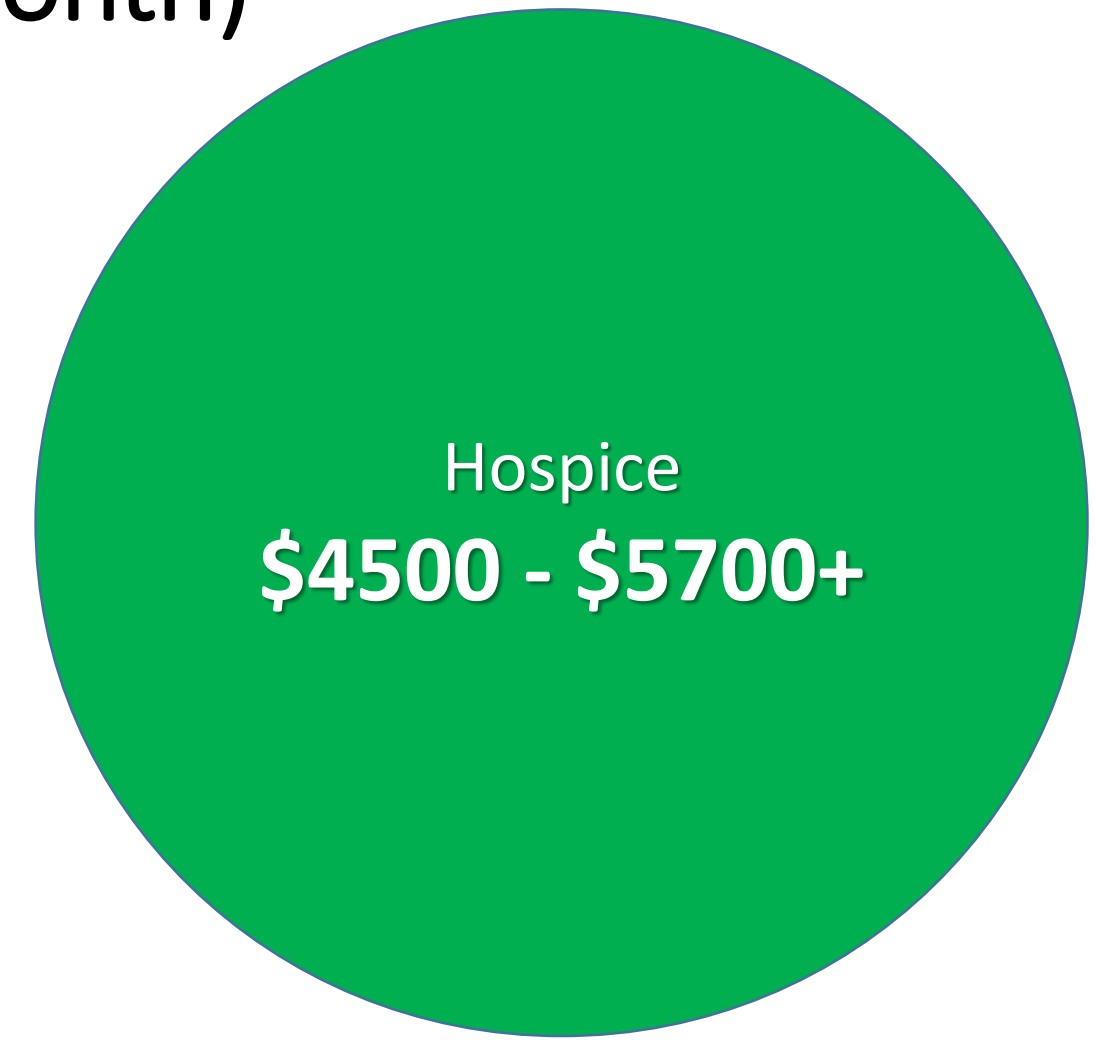

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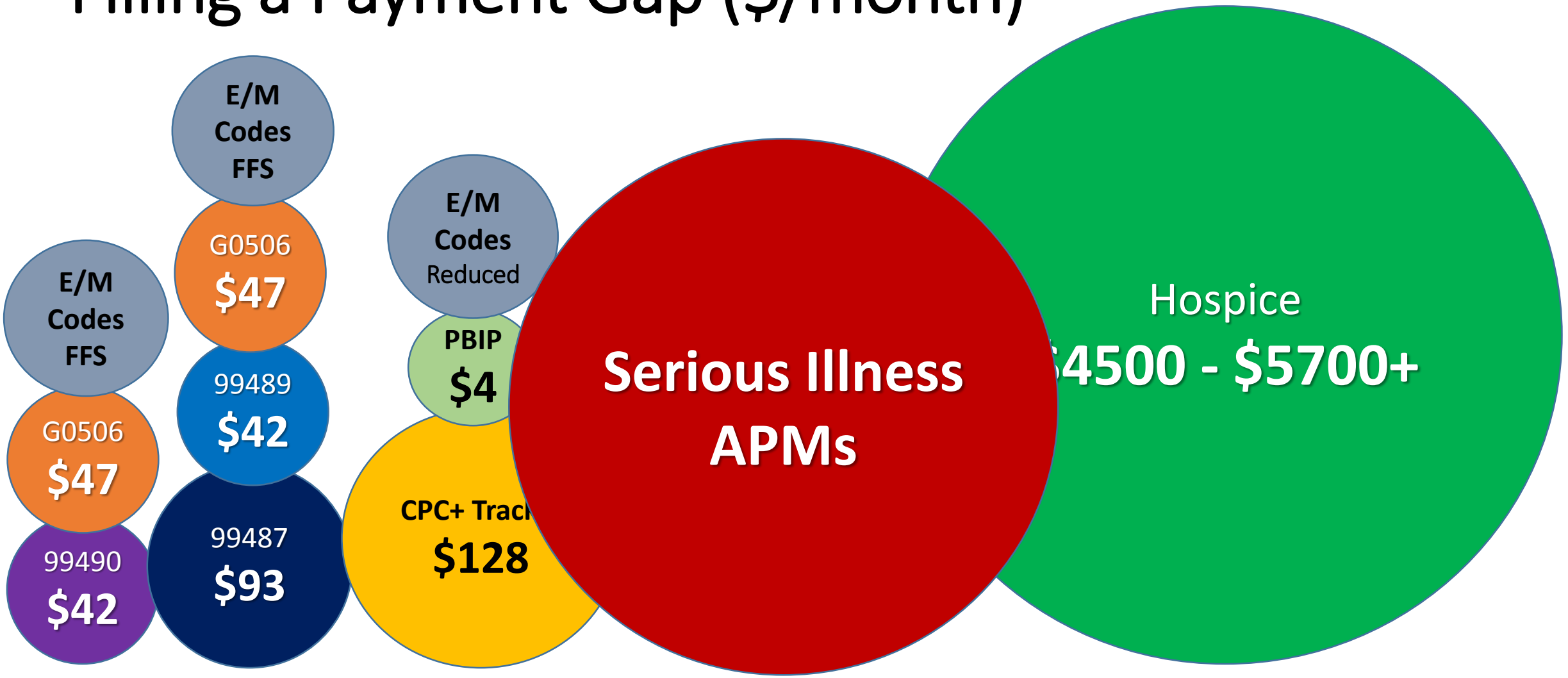
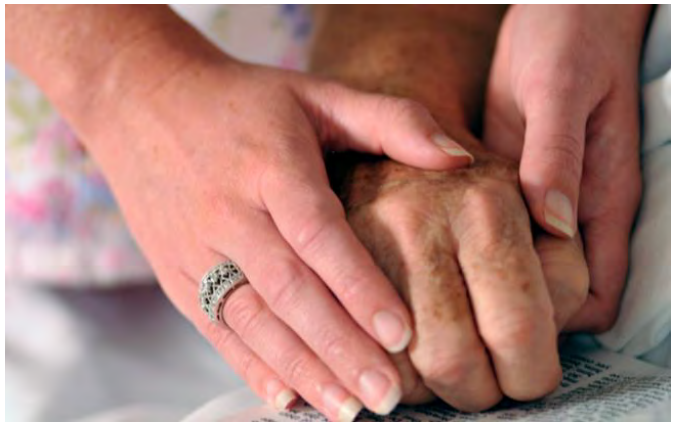


What Palliative Care Teams Need to Know and Do

- Financial and Payment Knowledge
- Program Design and Modeling
- Health Information Management
- Clinical Capabilities
- Telehealth Utilization
- Growth and Scalability
- Resilience
- Access to Capital

What should you be doing now….?

- Understand your organization’s current engagement with value-based payment models
- Get detailed information on your access to data and analytics
  - Patient identification, quality reporting, care coordination, CEHRT
- Assess your ability to provide community-based services that can deliver quality, and cost savings
- Evaluate your preparedness to provide ‘upstream’ care, including advanced disease management



…What should you be doing now?

- Optimize use of existing (and new) codes in the fee schedule
- Identify potential partners to establish a viable value-based delivery model
  - Advanced primary care practices
  - Health systems engaged in risk arrangements
  - Health plans