SPRING VIRTUAL EVENT

Aligning for Action

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Health Care Payment Learning & Action Network

May 1, 2017

For Implementers

Are you participating in an alternative payment model (APM) – in whole or in part – and if so for how long?

- 3+ Years
- 1 to 2 Years
- Less than 1 Year
- Would like to participate but not ready at this time
- Not participating

For participants who are not implementers:

What is your role in advancing APMs?

- Advocacy
- Consulting
- Education/Resources
- Expertise
- Convener
- Other

Viewpoint: Patient Perspective

Nancy Michaels

Inspirational Speaker, Healthcare Speaker, Business Consultant

What are your obstacles to instituting value-based payments or APMs?

(check all that apply)

- o Leadership Support
- o Organizational Culture
- o Technology Infrastructure
- o Legislation
- o Financing
- o Access to Implementation Tools
- o Other
- o None – already implementing

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Oncology Care Model

Brian R. Bourbeau
Director of Practice Operations
Oncology Hematology Care
The US Oncology Network

Disclaimer

The statements contained in this document are solely those of the author and do not necessarily reflect the views or policies of CMS. The author assume responsibility for the accuracy and completeness of the information contained in this document.

13 locations **30,000 patients**

OHC

SPECIALISTS IN CANCER AND BLOOD DISORDERS

- 23 Medical Oncologists
- 18 Advanced Practice Providers
- 10 Radiation Oncologists
- 20 Nurse Navigators
- 2 Gynecologic Oncologists
- 11 Financial Navigators

OHC Clinical Care Model

Payment Reform

UnitedHealthcare

Humana

aetna

Anthem BlueCross BlueShield

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICARE & MEDICAID INNOVATION

MSSP ACO & Oncology Care Model

Oncology Medical Home

Comprehensive Care & Patient Navigation			Evidence -Based	Access
Care Planning	Oral Chemo Mgmt	Survivorship	Treatment Pathways	Weekend Clinic
Patient Education	Advance Directives	Financial Navigation	Triage Pathways	Urgent Visits

Accreditation

QCP QOPI Certification Program

The Joint Commission National Quality Approval Laboratory Services

Commission on Cancer® ACCREDITED ONCOLOGY MEDICAL HOME A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

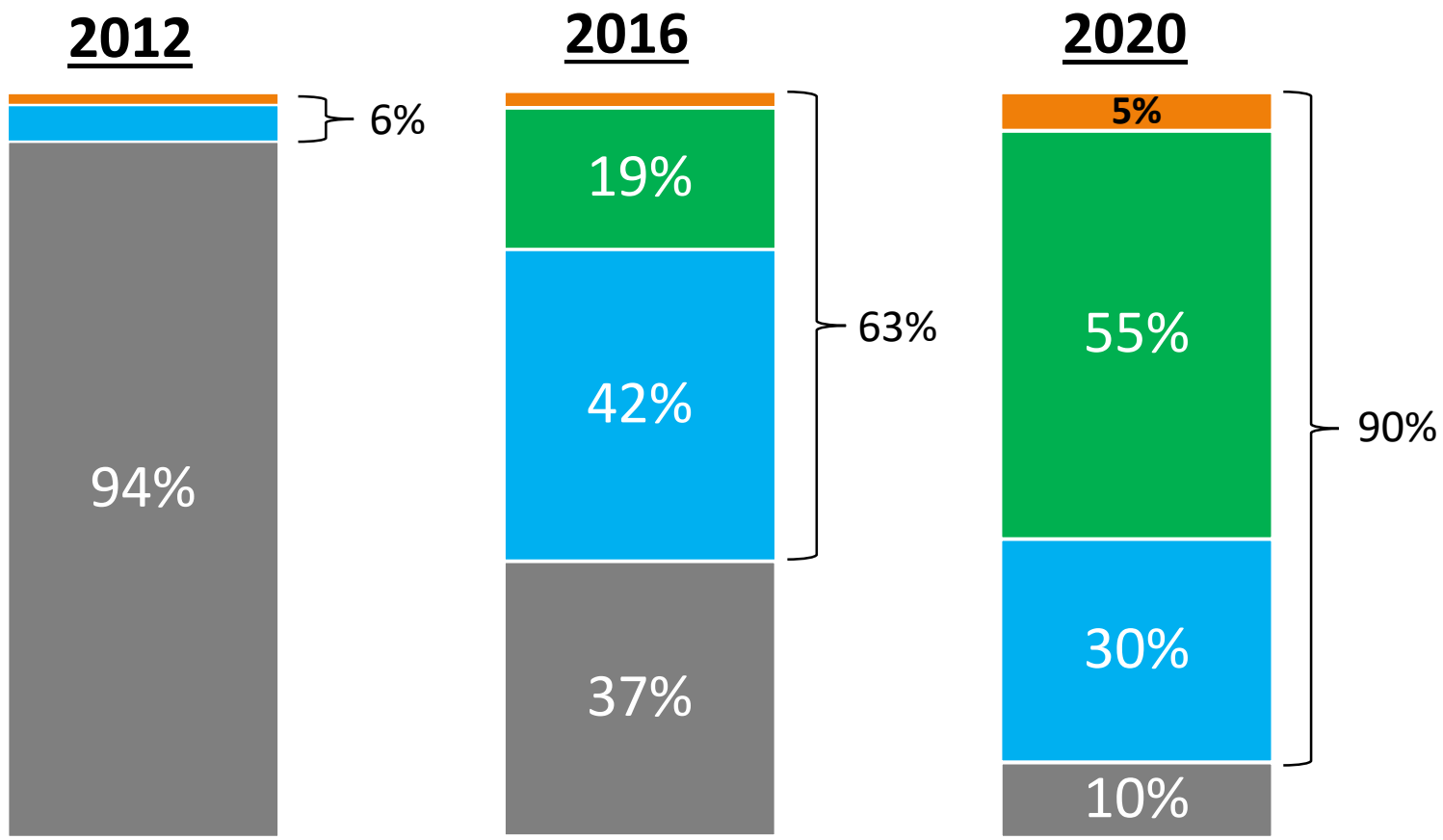
Goals for Quality & Value

Population Payments 4

Shared Savings/Risk 3

Payment for Performance 2 (C&D)

Fee-for-Service 1



Oncology Care Model

- 5-year CMMI project – July ‘16 - June ‘21
- 190 practices
- Practice redesign activities & quality measurement
- Enhanced oncology services payments
- Total cost-of-care & shared savings / risk

Care Model Redesign

Past 12 Months

Evidence Based Medicine

- Clear Value Plus Treatment Pathways
- Triage Pathways
- Data Mining

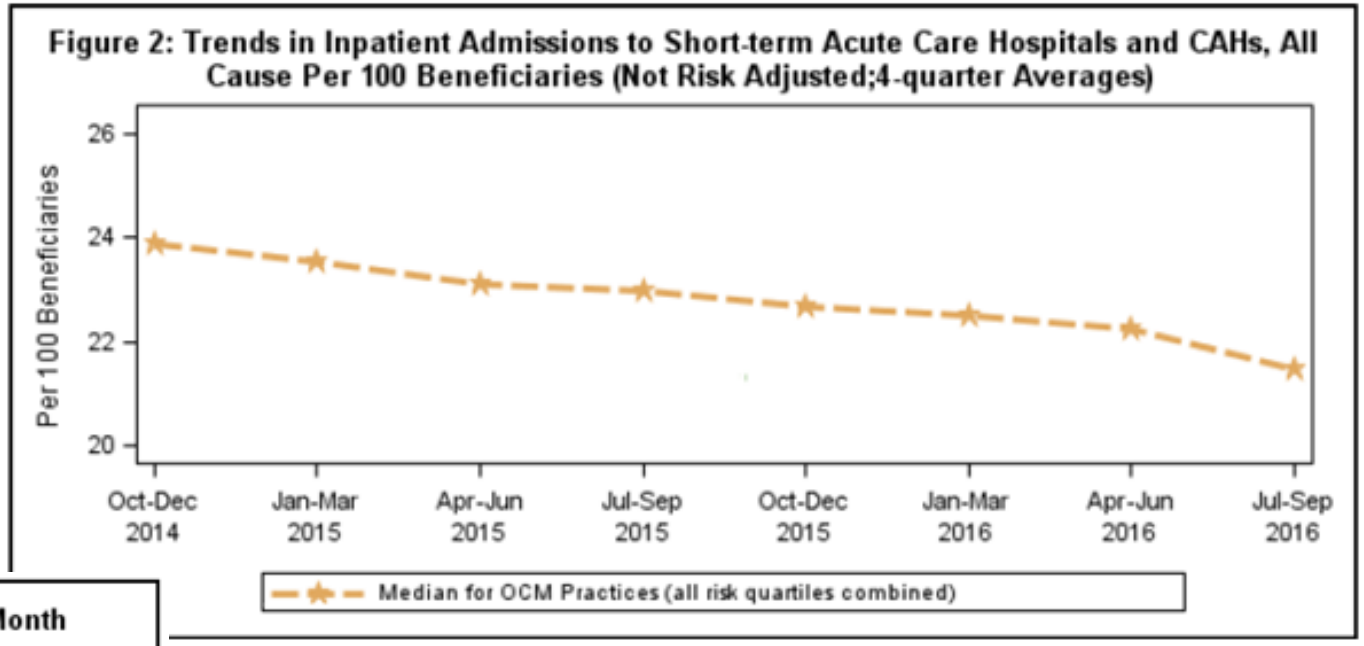
Navigation & Care Planning

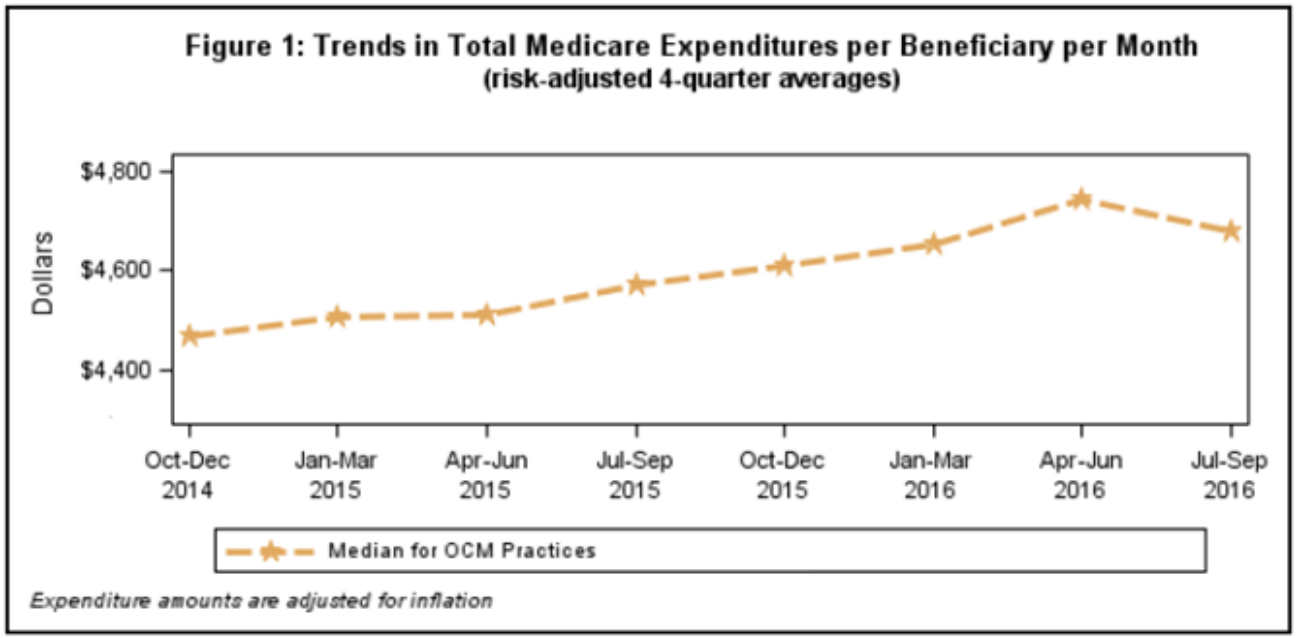
- Team-based Care Planning Sessions
- Depression Screening & Follow-up
- Advance Care Planning

ED Avoidance

- 5 RN Phone Triage Unit
- Triage Pathways
- Urgent Care Visits

Early Results





Practices are provided baseline reports, feedback reports with early results, and claims files for data mining.

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Medical Home Program

Karen S. Johnson,
Vice-President, Healthcare Insights and Partnerships,
Blue Cross and Blue Shield of Kansas City

The Story of CPC+ in Kansas City…

1 region
5 counties
2 states
825 clinicians
110 locations
1 payer

It all started in 2009 when….

"Let's improve member care by supporting the Patient-Centered Medical Home"

"This pilot is working! "

"Let's apply for CPCI!"

Higher Prevention & Screening Rates

10% Fewer Hospital Admits

12% Fewer ER Visits

$10 Less PAMPM

2009 2010 2011 2012 2013 2014 2015 2016

Medical Home Pilot

161 Physicians

38 Practices

40,000 Members

Medical Home "Program"

600+ Physicians

110 Practices

140,000 Members

Medical Home Program Evolution

800+ Physicians

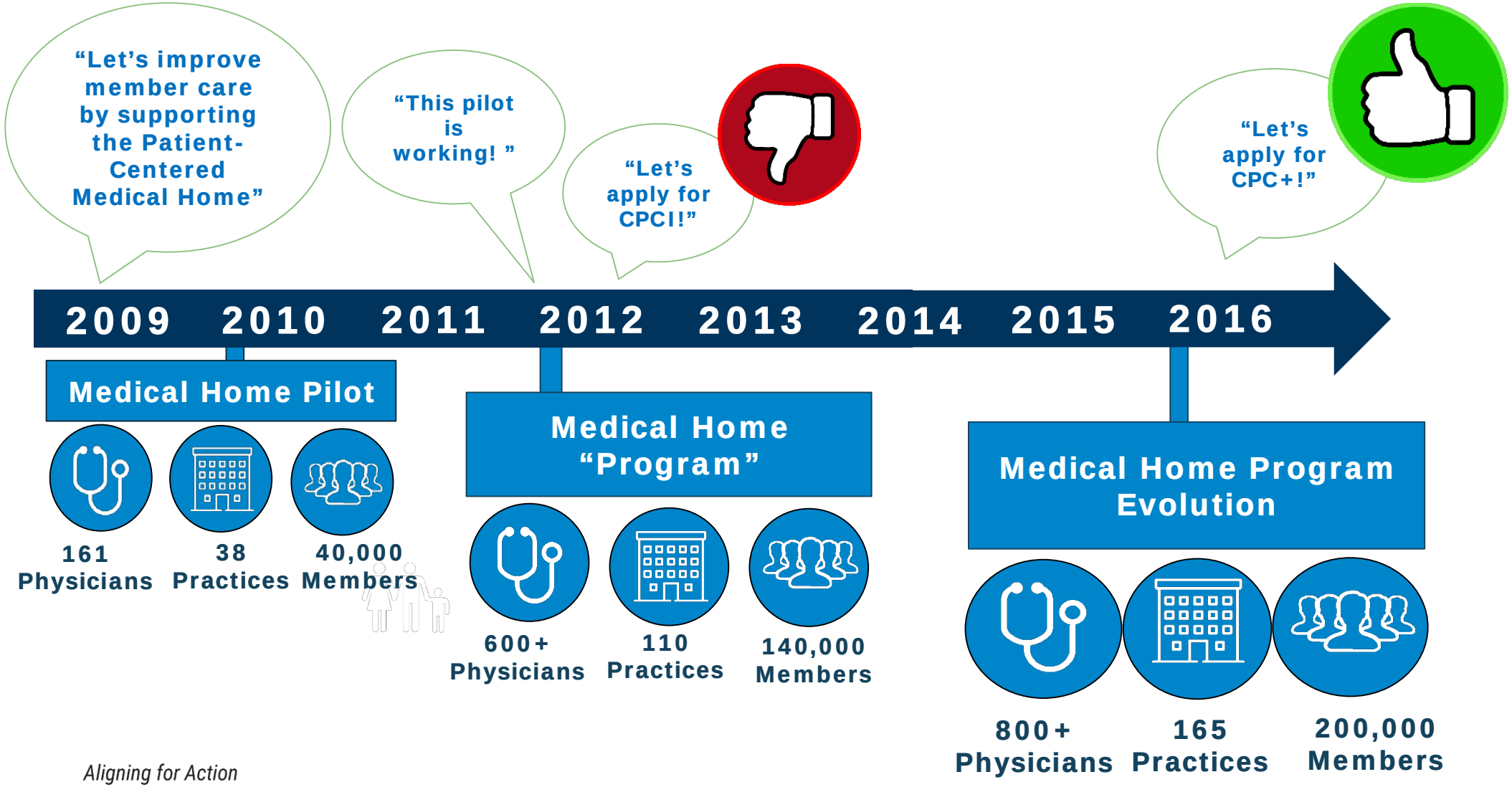
165 Practices

200,000 Members

Challenges…	Lead to successes…
Redefining the health plan role in member health	Improving member health means supporting providers differently
Talking to employers about “new” provider payments	Employers are on the journey with us
Engaging providers as partners is different than “contracting”	Understanding the provider experience

better care | smarter spending | healthier people

Back to the story…



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Atrius Health

Emily DuHamel Brower

Vice President of Population Health

Atrius Health

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Atrius Health

An innovative healthcare leader delivering a system of high-quality, patient-centered, connected care.

Dedham Medical Associates
Granite Medical Group
Harvard Vanguard Medical Associates
VNA Care

Providing care for ~ 675,000 adult and pediatric patients with 750 physicians across more than 35 specialties

Atrius Health

Inspiring Each Other…

"We always put the patient first and don't let our organizational baggage get in the way."

- Joseph R. Cunningham, MD
Blue Cross and Blue Shield of Oklahoma CMO
February 28 LANPAC Webinar

Atrius Health Core Competencies

Patient-Centered Medical Home foundation, achieving level 3 NCQA status across all primary care practices

Long history with and majority of revenue under **risk-based contracts** across commercial and public payers

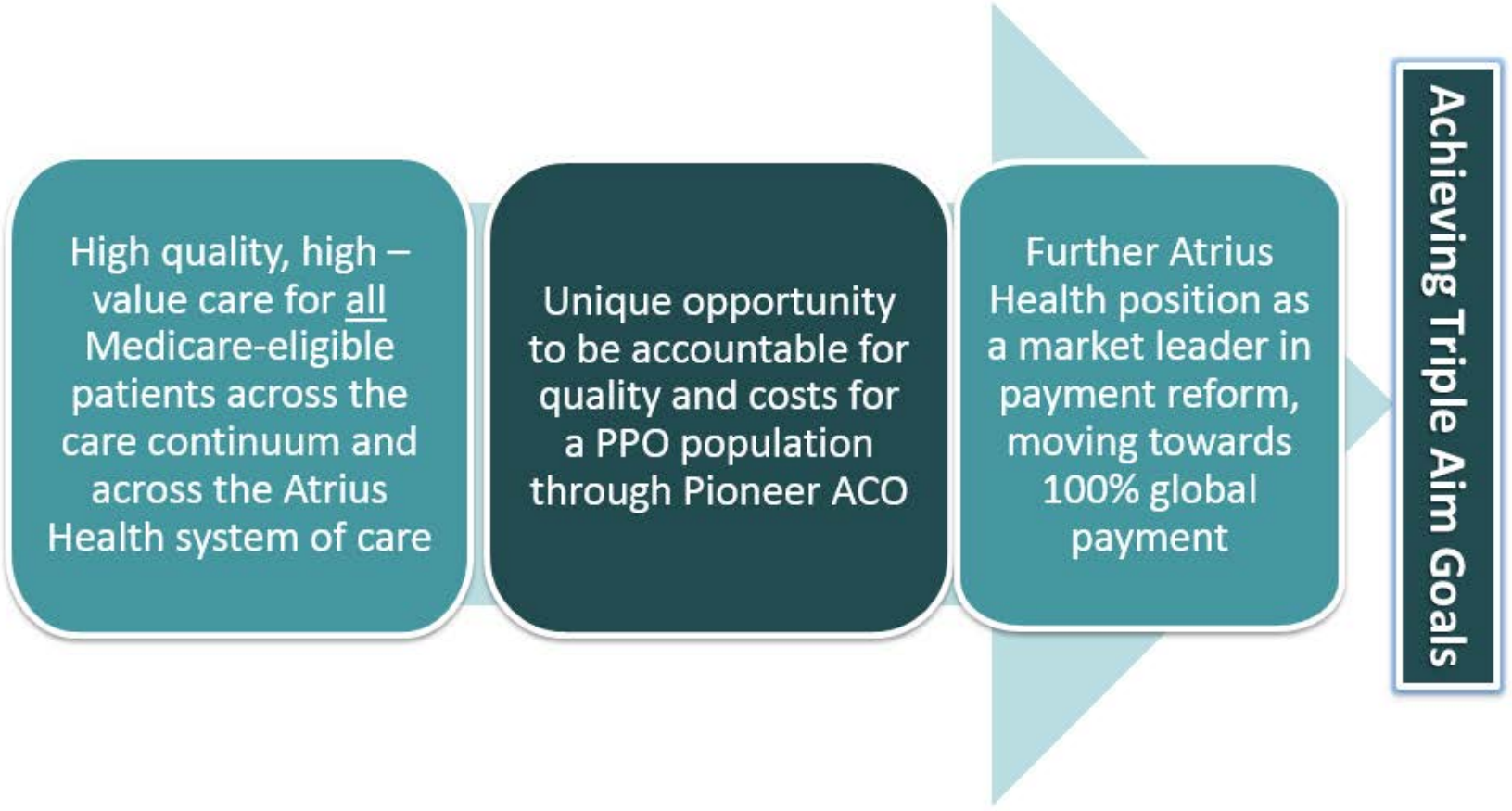
Corporate Data Warehouse integrating single platform, electronic health record data with multi-payer claims data

Widespread Extensive **Population Health Management** including disease-based and risk-based roster reviews

Sophisticated development and reporting of **Quality and Performance Measures** leading to high achievement

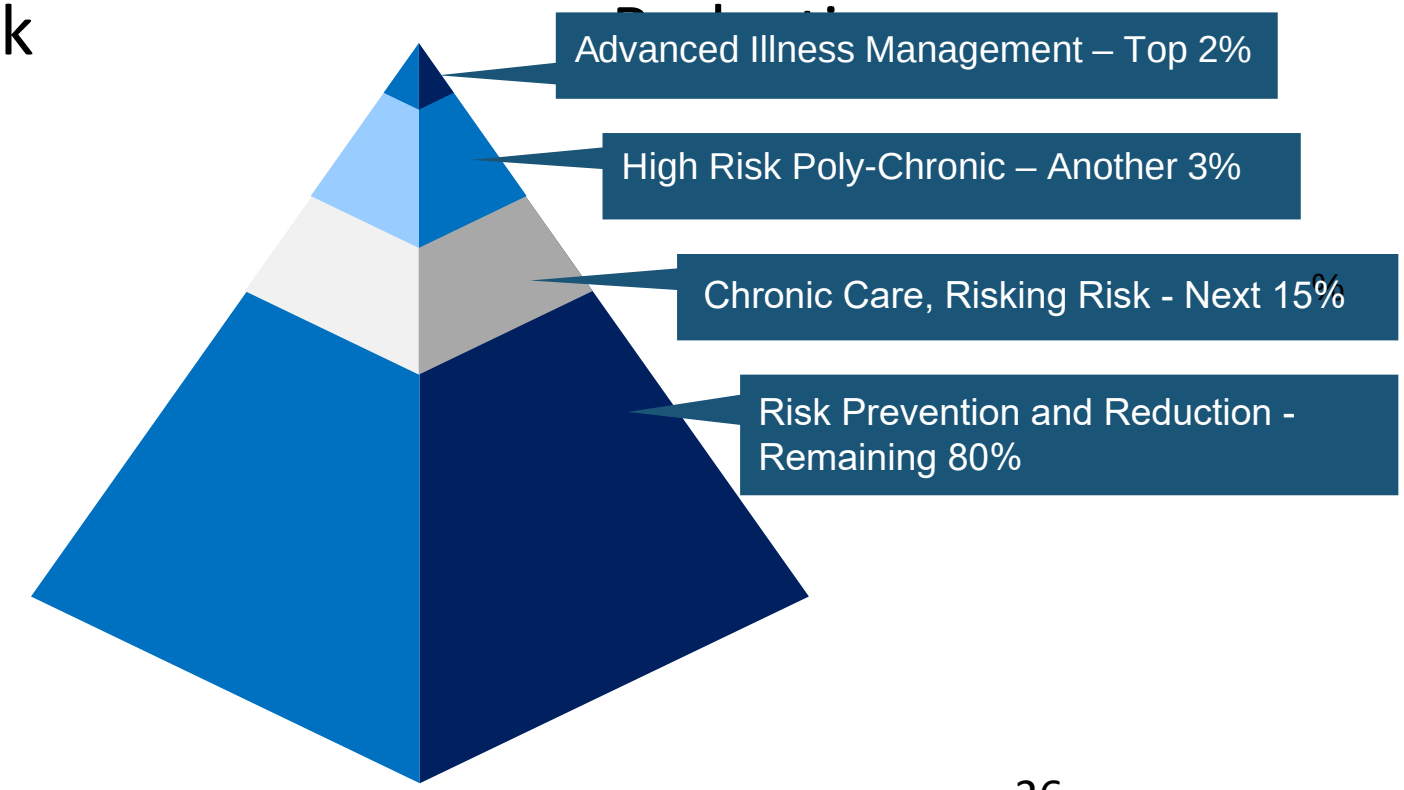
Atrius Health

Medicare Population Health Strategy: Pioneer ACO Participation Reason for Action (2013)

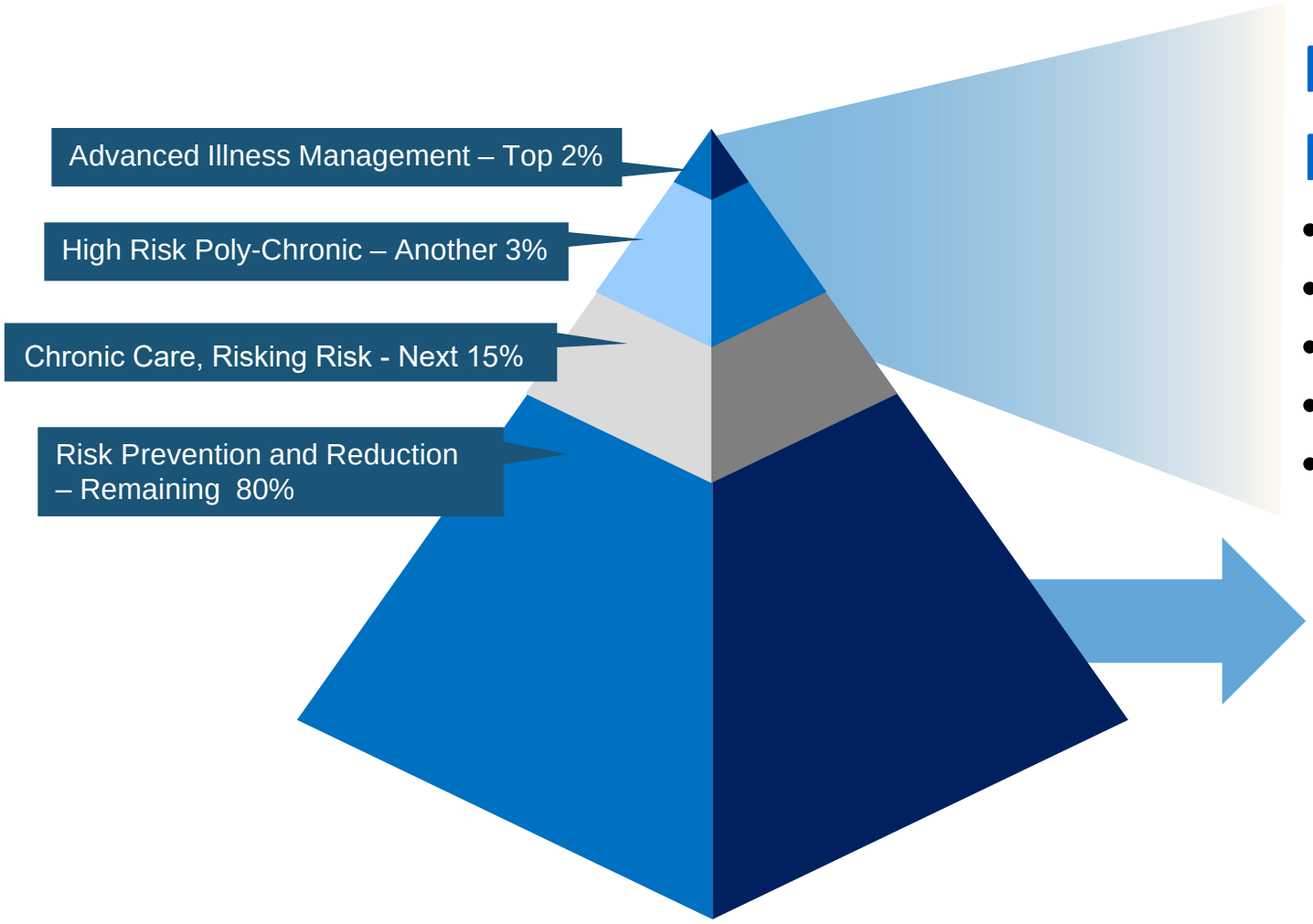


Medicare Population Health Approach

- Close medical management at end of life
- Tight coordination of 5% highest risk
- Management of chronic conditions
- Preventive care and Risk



Medicare Population Health Initiatives



Management of High Risk Patients, High Cost Events

- Patient Stratification
- Care Team Roster Reviews
- Post Acute Episode Mgmt
- Advance Care Planning
- Integrated Community Supports

Risk Identification and Prevention

- Falls Risk/Fractures
- Depression Screening
- Med Reconciliation

Pioneer ACO Performance

Low Cost* with Year over Year Improvement

Year	Percent Savings/Loss	Gross Savings	Quality Score
2012 (PY1)	1% loss in the noise	$0	Reporting Only
2013 (PY2)	1% savings in the noise	$3.1M	92.49
2014 (PY3)	1.4% savings	$4.4M	91.40
2015 (PY4)	2.6% savings	$6.8M	95.38

*Atrius Health 2014 Baseline PBPY = $9191; All Pioneer Average = $10,399; Other Massachusetts Average $11,134.

Source: Pioneer ACO Public Use File: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Pioneer/index.html
(2015 public use file not yet published)

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APM Framework Refresh

Sam R. Nussbaum

Chair, LAN Alternative Payment Model Framework Refresh Advisory Group

Senior Fellow, Schaeffer Center for Health Policy and Economics, University of Southern California

What is the APM Framework?

It's a system for classifying *value-based* APMs

+

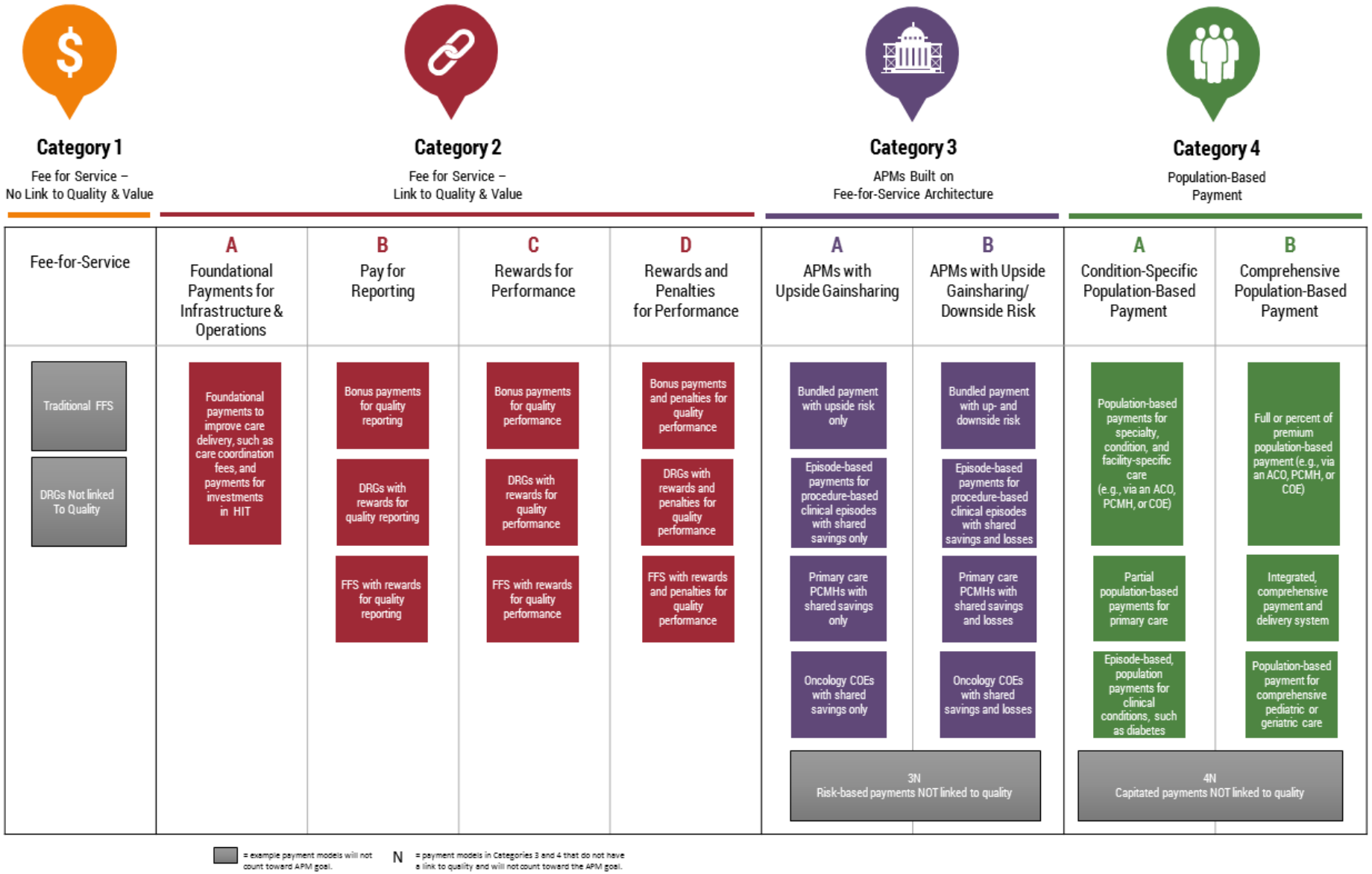
…and a set of principles, which outline the goals and purposes of payment reform.

→

It provides a rationale for payment reform, categorizes APMs at various stages of advancement, and establishes a pathway towards a value-based health care system.

More than just a set of categories…

Original APM Framework



Why refresh the APM Framework?

It’s a system for classying value-based APMs

- The foundation for implementing and evaluating progress toward health care payment reform

To remain relevant, it must reflect:

- The passage of new legislation and the issuance of new regulations
- Lessons learned and best practices in the field

Which topics does the APM Refresh Address?

- Are the principles enduring, or have they changed?
- Clarify relationships between Advanced APMs under MACRA and categories in the LAN APM Framework
- Identify where small, rural and safety net providers can participate through APM adoption
- With the growth of integrated financing and delivery systems, consider a new Category
- Identify opportunities to modify the framework in ways that expedite and simplify the progress tracking effort, while reducing burden for payers

APM Framework Refresh Advisory Group

Sam Nussbaum - **Chair**
USC Schaeffer Center for Health Policy and Economics

Reid Blackwelder
East Tennessee State University

Timothy Ferris
Partners Healthcare

Alexander Billoux
CMS

Keith Lind
AARP Public Policy Institute

Dorothy Teeter
Washington State Health Care Authority

Aparna Higgins
AHIP

Original Foundational Principles

- ✓Identified payment as one of many drivers of person-centered care
- ✓Established goals for APM adoption
- ✓Identified distinguishing characteristics of value-based APMs and conventions for classification and measurement
- ✓Provided recommendations on how to structure and distribute value-based incentives

These principles remain largely unchanged, with some notable exceptions

Changes to foundational statements

1. Payment reform is a vehicle for financing delivery systems that improve the value of care, as opposed to a goal in its own right.

2. More clearly acknowledge that for some providers, Category 2 may be the vehicle for delivering person-centered care

3. The purpose of financial incentives and financial risk is to improve the value of care, and they should be balanced to support behavior change while avoiding unintended consequences

Classification Changes

New Category 4C for Integrated Finance and Delivery Systems

Integrated finance and delivery systems employ or align payers and providers within the same organization:

- *Health plans that own provider organizations*
- *Provider organizations the sell insurance products*

Integrated finance and delivery systems:

- Integrated finance and delivery systems provide unique opportunities for transforming care delivery
- Integrated financial and delivery systems should be classified separately because they offer unique opportunities for investment and delivery system transformation.
- Further evaluation will determine whether these organizations are more effective for increasing the value of care through delivery system improvement

Classification Changes

Expanded Definition of Category 3

- Originally, cost performance against a financial benchmark was the key characteristic of Category 3 APMs
- However, in certain circumstances (such as primary care in the Medicare population) “fee-at-risk” arrangements can serve as an effective proxy for generating cost efficiencies

Key considerations with this type of model:

- Reducing hospitalizations may not be fully reflective of improved care, and may in fact indicate reductions in necessary care.
- Health plans generally have quality and performance requirements, and historically have not rewarded providers solely for reducing utilization.
- It is critical to actively take steps (e.g., contractually and through monitoring) to avoid unintended consequences of rewarding reduced utilization.

Classification Changes

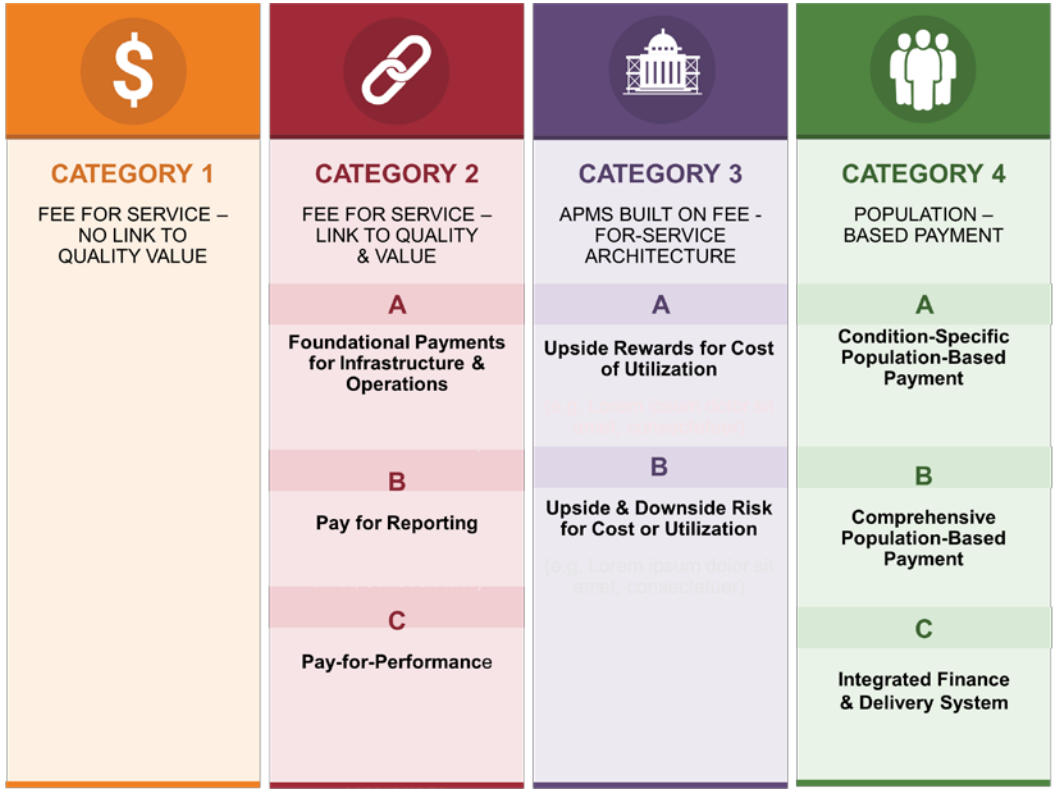
Additional Requirement for Categories 3 and 4

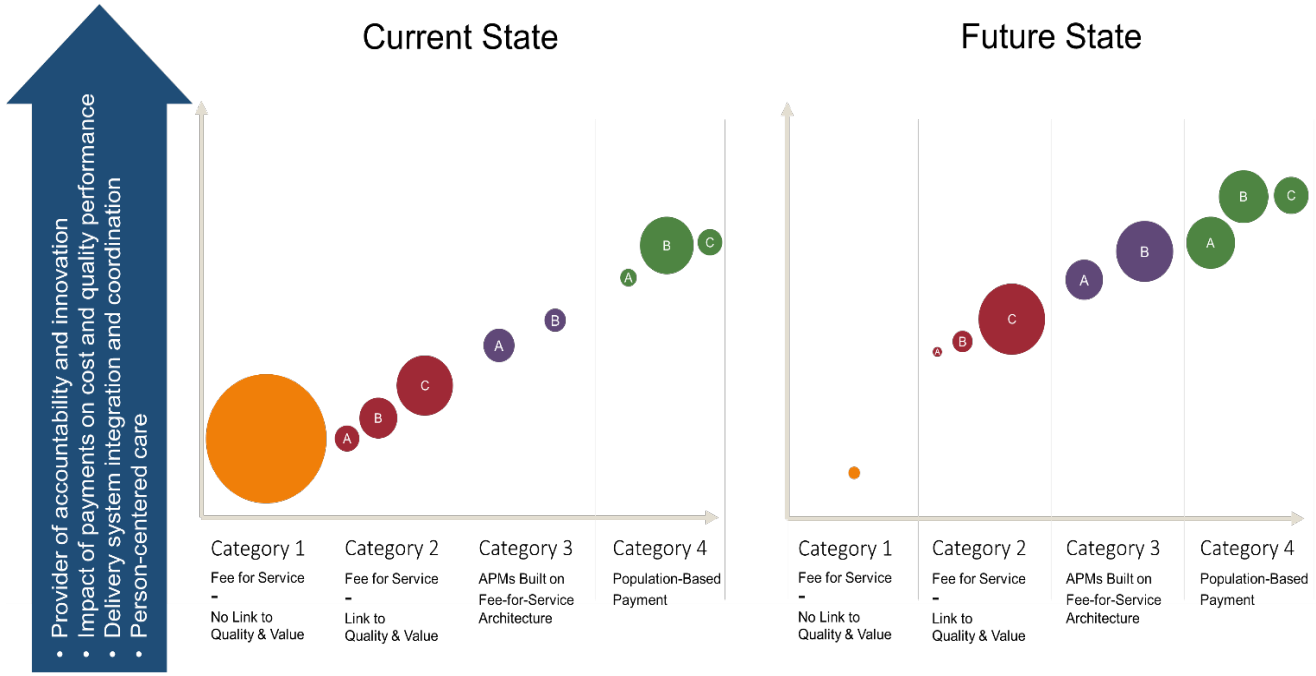
- Categories 3 and 4 entail the greatest incentives to reduce costs, but this can be accomplished by reducing necessary as well as unnecessary care.
- Therefore, Category 3 and 4 APMs must strongly encourage reductions in wasteful care by evaluating providers on the basis of "appropriate care" measures, and we have added those to go beyond quality alone.

Appropriate care measures can include:

- Preventable hospital admissions
- Unnecessary imaging
- Documentation of shared-decision-making
- Appropriate use of medications
- Rates of "never events"
- Adherence to clinical guidelines for pre-term labor and delivery and end of life care

Updated Graphics





Next Steps

- We believe these framework and other changes make the document more compelling and address the changes occurring in the health care ecosystem

- We welcome your comments during the public comment period, which will be announced shortly

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Thank you for participating!