

*ALIGNING FOR SHARED ACCOUNTABILITY*



# LAN SUMMIT

Health Care Payment Learning & Action Network

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## Specialty Care And APMs

# Welcome



## Aparna Higgins

President and CEO  
*Ananya Health Solutions LLC*

Policy Fellow  
*Duke-Margolis Center for Health Policy*

Visiting Scholar  
*Heller School of Social Policy and  
Management, Brandeis University*

# Panelists



**Paul Casale**

Executive Director  
*New York Quality  
Care*



**Kevin Bozic**

Chair of Surgery and  
Perioperative Care  
*Dell Medical School at  
the University of Texas  
at Austin*



**Phil Rodgers**

Clinical Professor  
*American Academy  
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Palliative Medicine*

# Specialty Care and APMs

Paul N. Casale, MD, MPH, FACC

Professor of Clinical Medicine

Weill Cornell Medicine

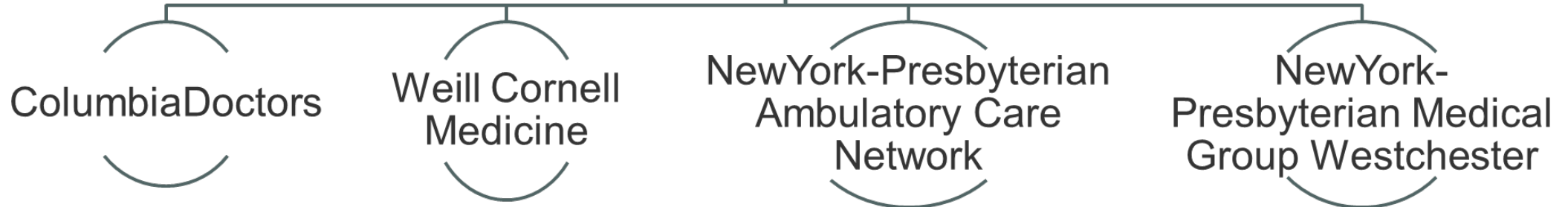
Adjunct Professor, Columbia University

Executive Director, New York Quality Care

The ACO of New York-Presbyterian • Columbia • Weill Cornell

# Overview of New York Quality Care

New York Quality Care:  
~38,000 attributed beneficiaries



*~75% of beneficiaries attributed to PCPs or APPs*

*~25% of beneficiaries attributed to Specialists*

# NYQC Performance – 2015 to 2018

Year	Total Savings	Minimum Savings	Quality Performance	Shared Savings
2015*	\$2,857,805	\$8,804,069	100%	No
2016*	\$1,719,794	\$8,961,357	94%	No
2017*	\$17,841,991	\$11,490,917	81%	Yes
2018*	\$23,446,828	\$11,654,564	89%	Yes

For 2017 performance year, NYQC earned shared savings of \$7,130,145

For 2018, NYQC earned shared savings of \$10,189,748

# Value-Based Payment Programs

- ***MSSP ACO Track 1***
- ***Oncology Care Model (OCM)***
- ***Comprehensive Care for Joint Replacement (CJR)***
- ***Comprehensive ESRD Care Model (CEC) at The Rogosin Institute***
- ***Delivery System Reform Incentive Payment (DSRIP)***
- ***Commercial Payers***

# NewYork Quality Care

- Care Management
- NYQC Analytics team
- Telehealth
- Remote Patient Monitoring
- Community Tele-Paramedicine
- Regional Health Information Exchange





# Bundled Payment for Care Improvement

- Penn Medicine Lancaster General Health
  - *Lower extremity joint replacement*
  - *Spine*
  - *CABG*
  - *PCI*
  - *Pacemaker*
  - *Cardiac Defibrillator*

# Why We Participated in BPCI

- Engage specialists in APMs
- Understand cost of care
  - Physician & Finance collaboration
- Redesign across the care continuum
  - Supply costs/length of stay
  - ED utilization/readmissions
  - Post-acute care
  - Access/patient portal
- Improve the quality of care and the patient experience

# BPCI Advanced Clinical Episodes

## (Application for Year 3 start)

### Inpatient Episodes (33):

- Acute myocardial infarction
- Congestive heart failure
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft surgery
- Transcatheter Aortic Valve Replacement (TAVR)
- COPD, bronchitis, asthma
- Simple pneumonia and respiratory infections
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic

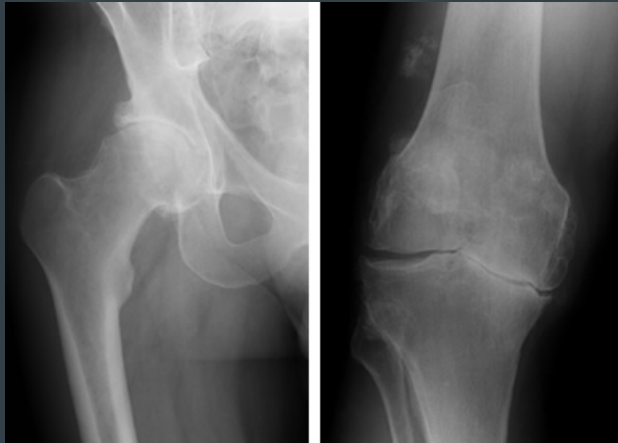
- hepatitis
- Major bowel procedure
- Bariatric Surgery
- Inflammatory Bowel Disease
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Back & neck except spinal fusion
- Spinal fusion (non-cervical)
- Cervical spinal fusion

- Combined anterior posterior spinal fusion
- Renal failure
- Sepsis
- Cellulitis
- Urinary tract infection
- Stroke
- Seizures

### Outpatient episodes (4):

- *Percutaneous coronary intervention*
- *Cardiac defibrillator*
- *Back & Neck except Spinal Fusion*
- *Total Knee Arthroplasty*


# Condition-Based Bundled Payments Drive Care Redesign to Produce Greater Value for Patients: A Case Study



**Kevin J. Bozic, MD, MBA**

**Professor and Chair, Department of Surgery and Perioperative Care  
Dell Medical School at the University of Texas at Austin  
Senior Institute Associate, Harvard Business School**


# Burden of Osteoarthritis



**30+ Million**  
US Adults have  
**Osteoarthritis**

[www.cdc.gov/arthritis](http://www.cdc.gov/arthritis)

**CDC.gov**



The High Cost of Arthritis in the US  
**\$304 BILLION**  
in 2013


Category	Amount
Medical Costs	\$140 Billion
Lost Wages	\$164 Billion

That's **\$2,117** in extra medical costs per adult with arthritis

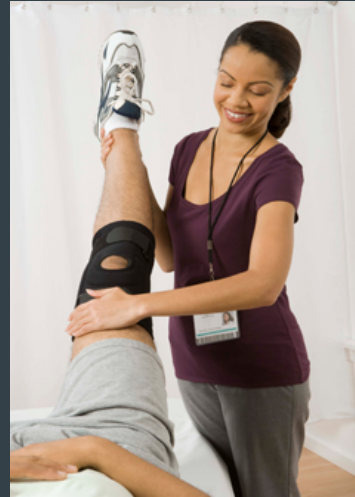
That's **\$4,040** less pay than an adult without arthritis

2/8/13/954-B

Hwang JH, Coleman MC, Pava EJ, Helmsick CC, Taylor EH. Medical expenditures and earnings losses among US adults with arthritis in 2011. Arthritis Care Res (Hoboken). 2017;29(2):doi:10.1002/acr.12425.



# Arthritis Treatment Ladder



# Growth in TJA Procedure Rates and Costs

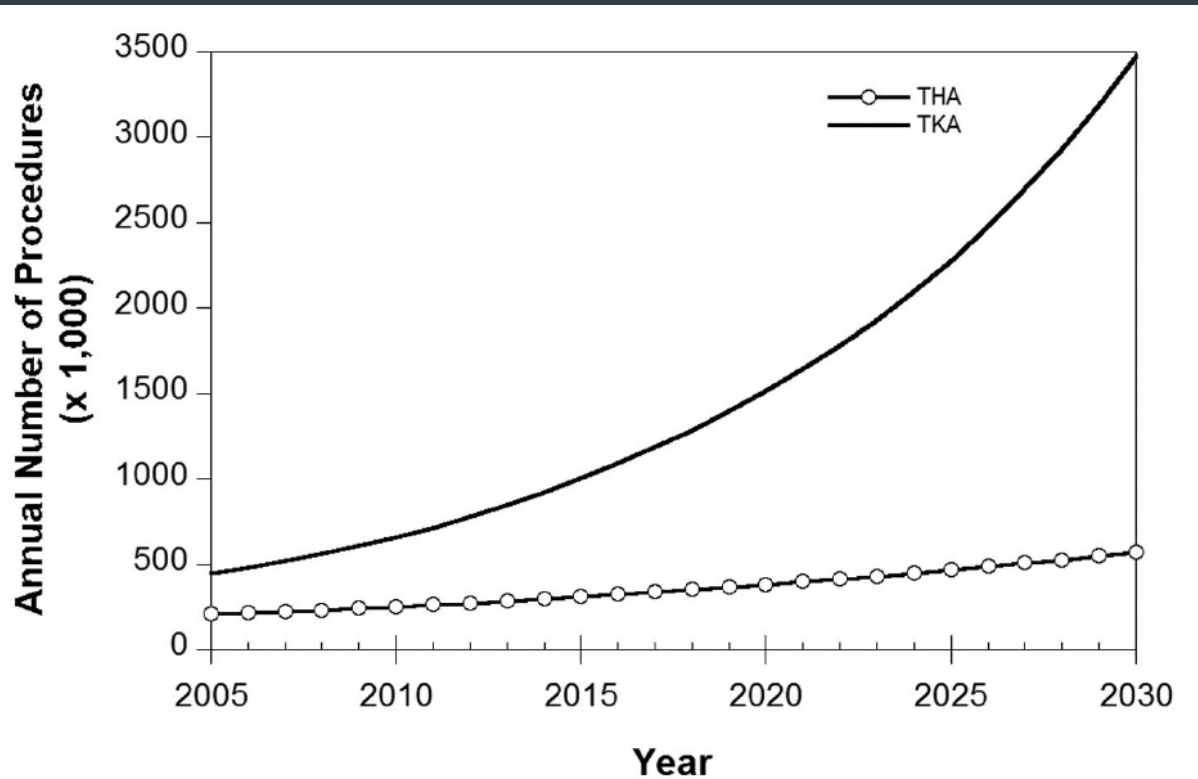
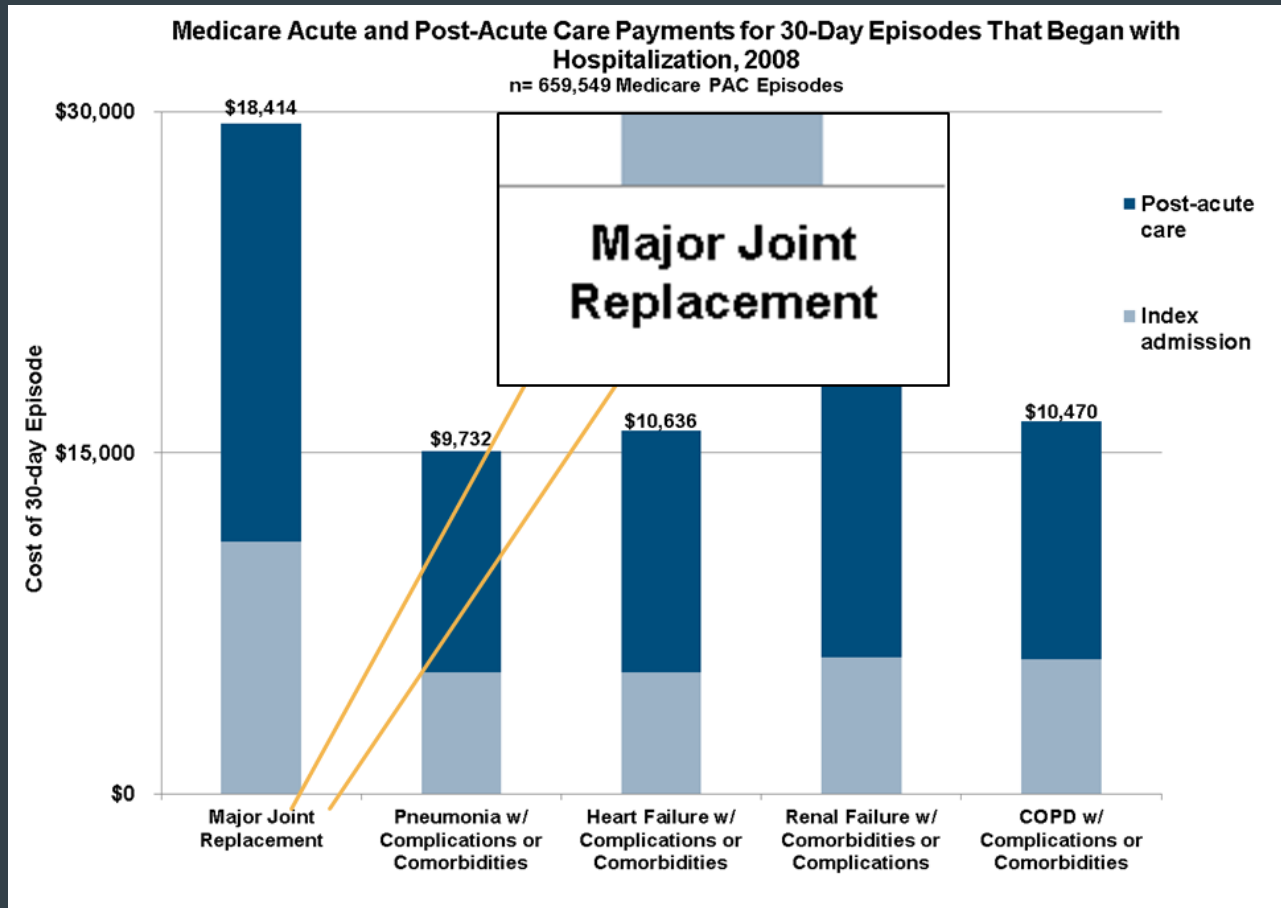


Fig. 1  
The projected number of primary total hip arthroplasty (THA) and total knee arthroplasty (TKA) procedures in the United States from 2005 to 2030.

Kurtz, Steven, Kevin Ong, Edmund Lau, Fiona Mowat, and Michael Halpern. "Projections of Primary and Revision Hip and Knee Arthroplasty in the United States from 2005 to 2030." *The Journal of Bone and Joint Surgery-American* Volume 89, no. 4 (April 1, 2007): 780–85.



Mechanic, Robert. "Post-Acute Care — The Next Frontier for Controlling Medicare Spending." *New England Journal of Medicine* 370, no. 8 (February 20, 2014): 692–94. <https://doi.org/10.1056/NEJMp1315607>.

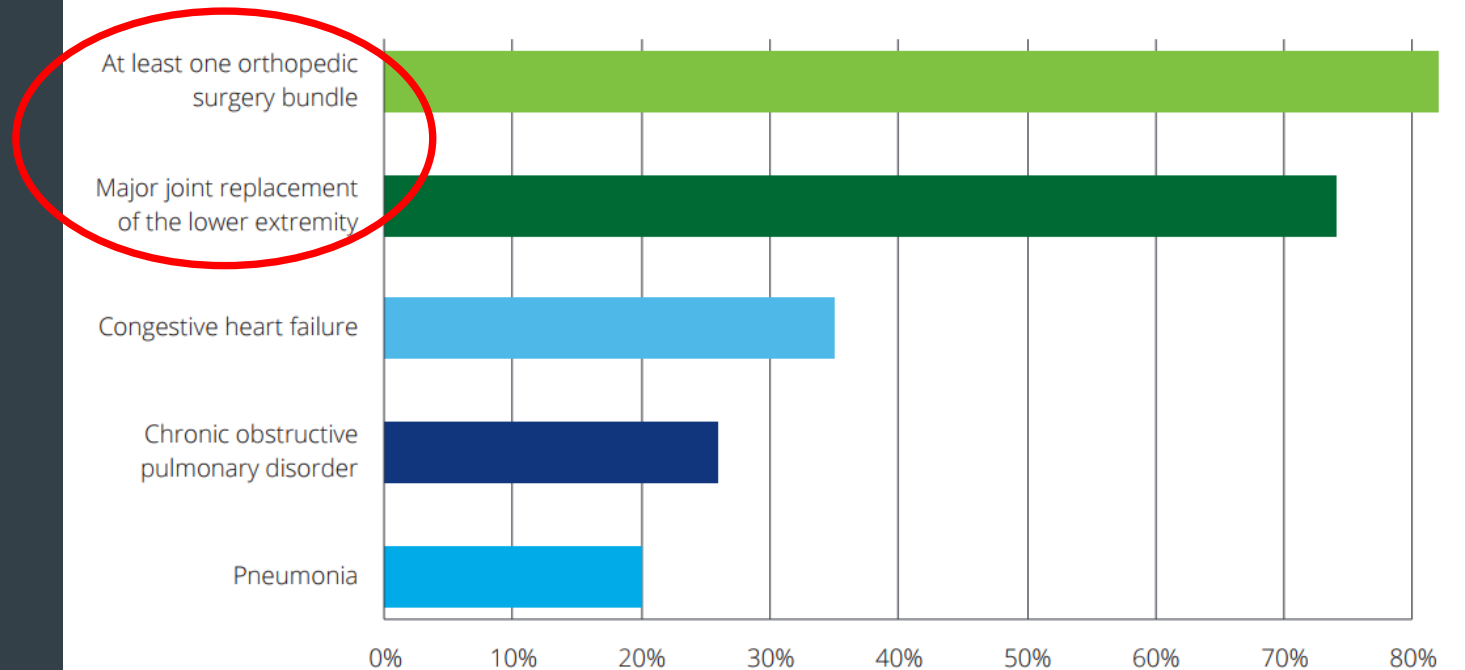
# Focus of Alternative Payment Models

Acute Care Episode (ACE)  
Demonstration



Bundled Payments for Care Improvement

Figure 3. Top five clinical episode bundles selected by Model 2 BPCI participants



Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report, 2016.



# Focus of Alternative Payment Models (cont.)

**Acute Care Episode (ACE)  
Demonstration**



**Bundled Payments for Care Improvement**

**Comprehensive Care for  
Joint Replacement (CJR) Model**



**Bundle Payment Program**  
Increasing Quality · Reducing Cost

**BPCI Advanced**

JAMA Internal Medicine | Original Investigation | HEALTH CARE REFORM

# Cost of Joint Replacement Using Bundled Payment Models

Amol S. Navathe, MD, PhD; Andrea B. Troxel, ScD; Joshua M. Liao, MD; Nan Nan, MS; Jingsan Zhu, MS; Wenjun Zhong, PhD; Ezekiel J. Emanuel, MD, PhD

Figure 1. Episode Spending for Major Joint Replacements of Lower Extremities With and Without Major Complications or Comorbidities Over ACE and BPCI

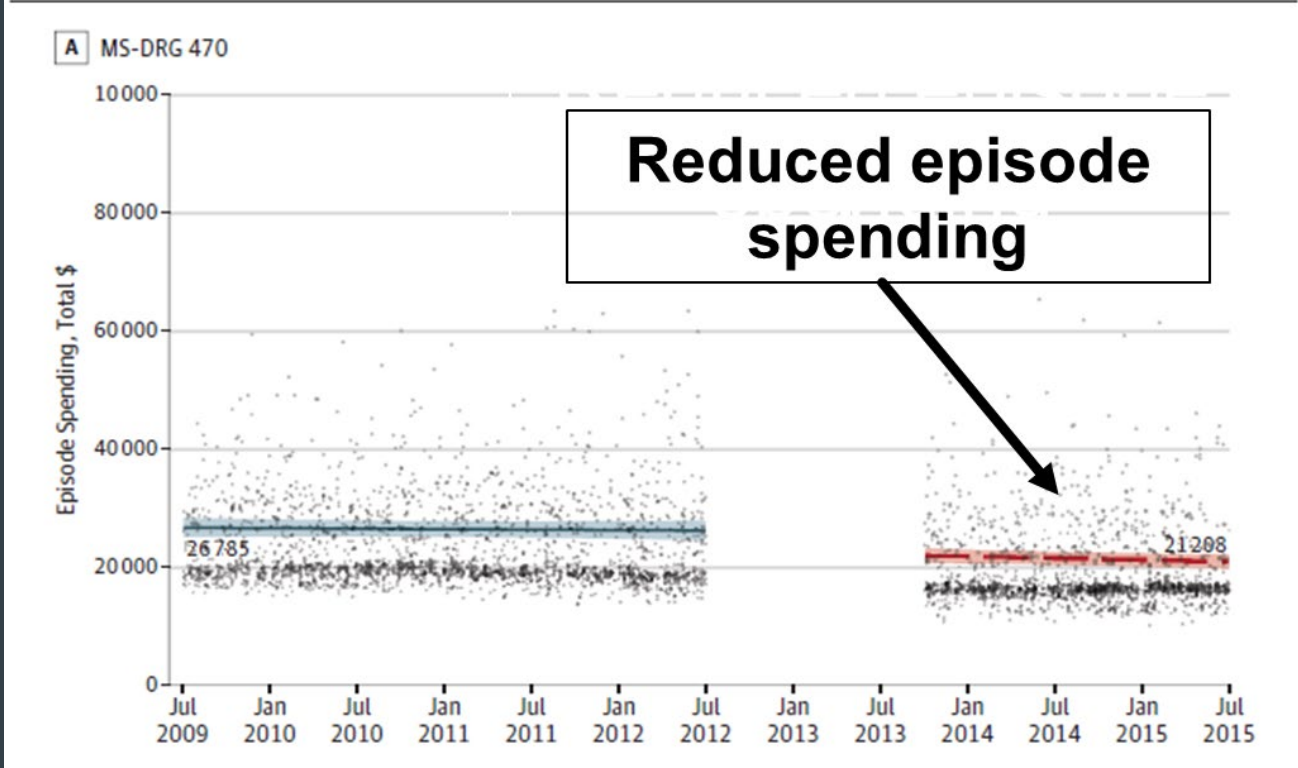
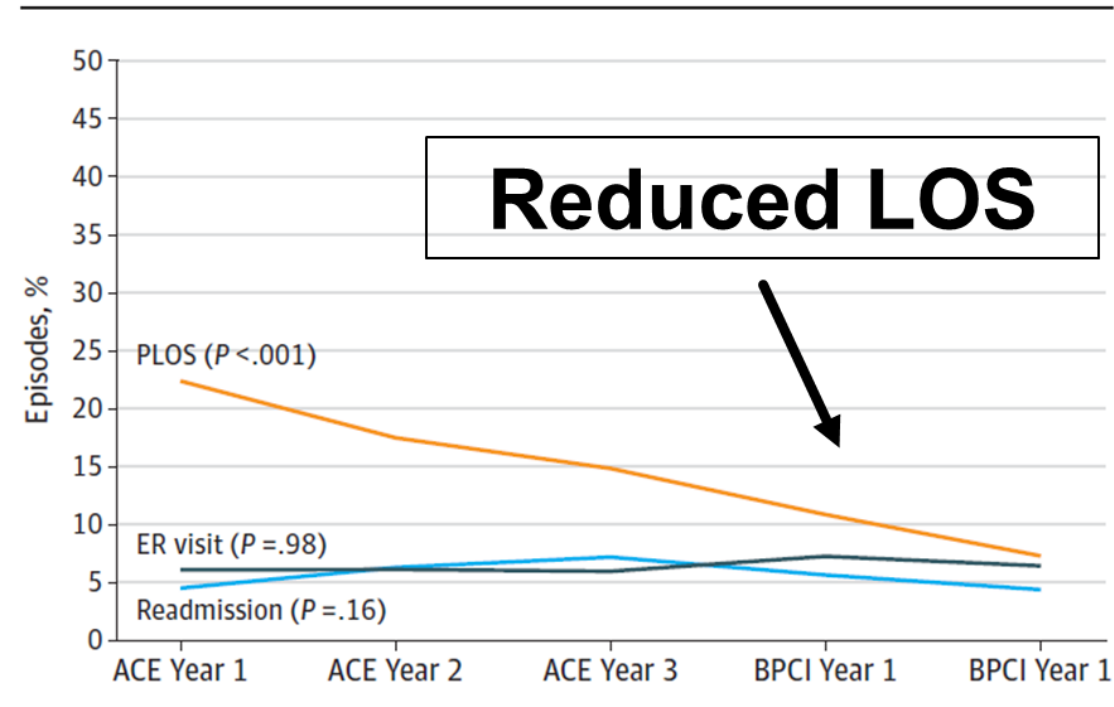
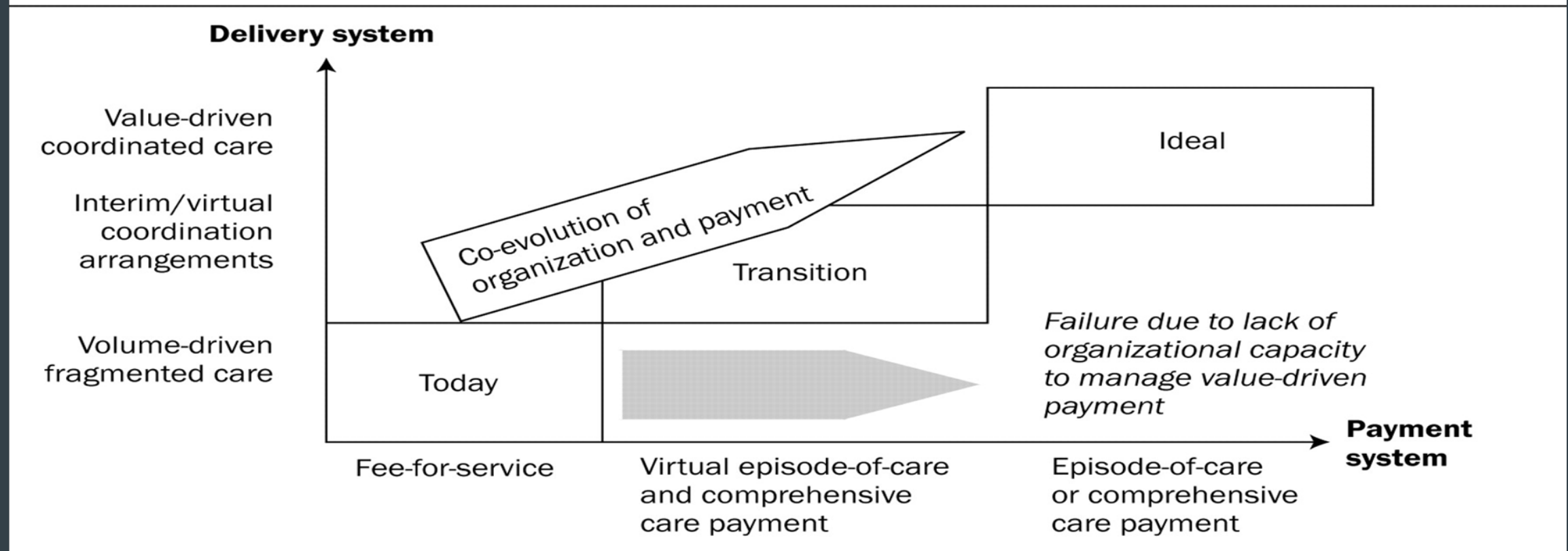


Figure 2. Quality of Care for Major Joint Replacements of Lower Extremities With and Without Major Complications or Comorbidities as Measured by ER Visits, Readmissions, and PLOS Over ACE and BPCI



# Payment Model Drives Delivery System Reform

## EXHIBIT 4 Transition In Both The Payment And The Delivery Systems



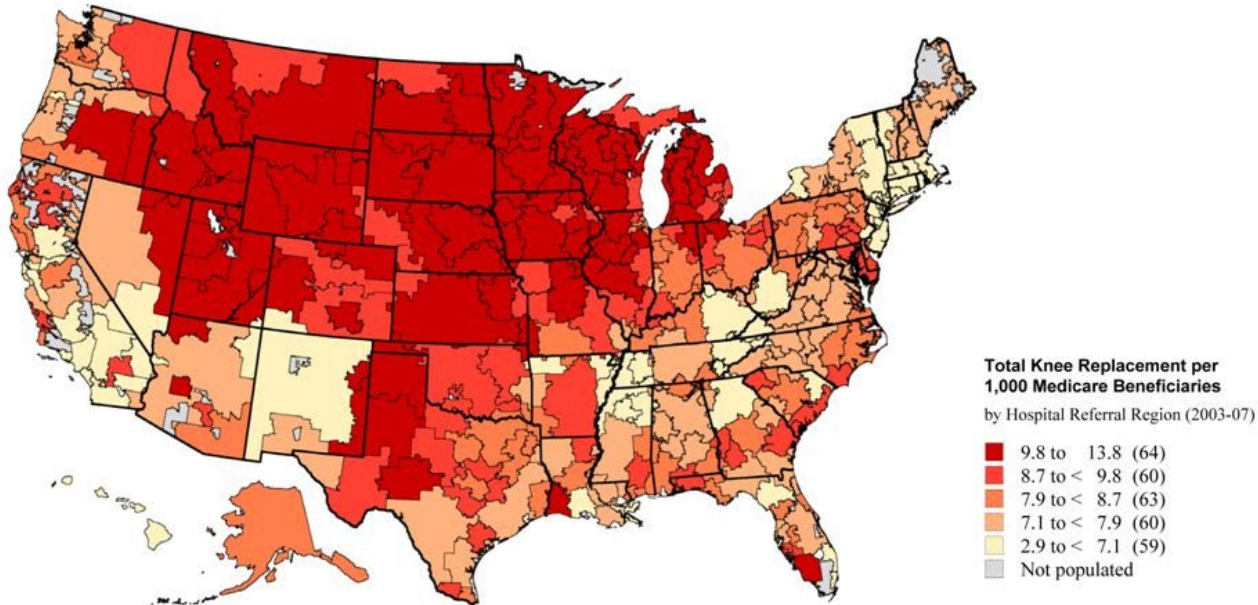
**SOURCE:** Author's analysis.

# TJR Bundles Drive Care Coordination Across Acute, Post-Acute Settings



# What's Missing from Procedure-Based Bundles?

## Dartmouth Atlas Knee Replacement Rates



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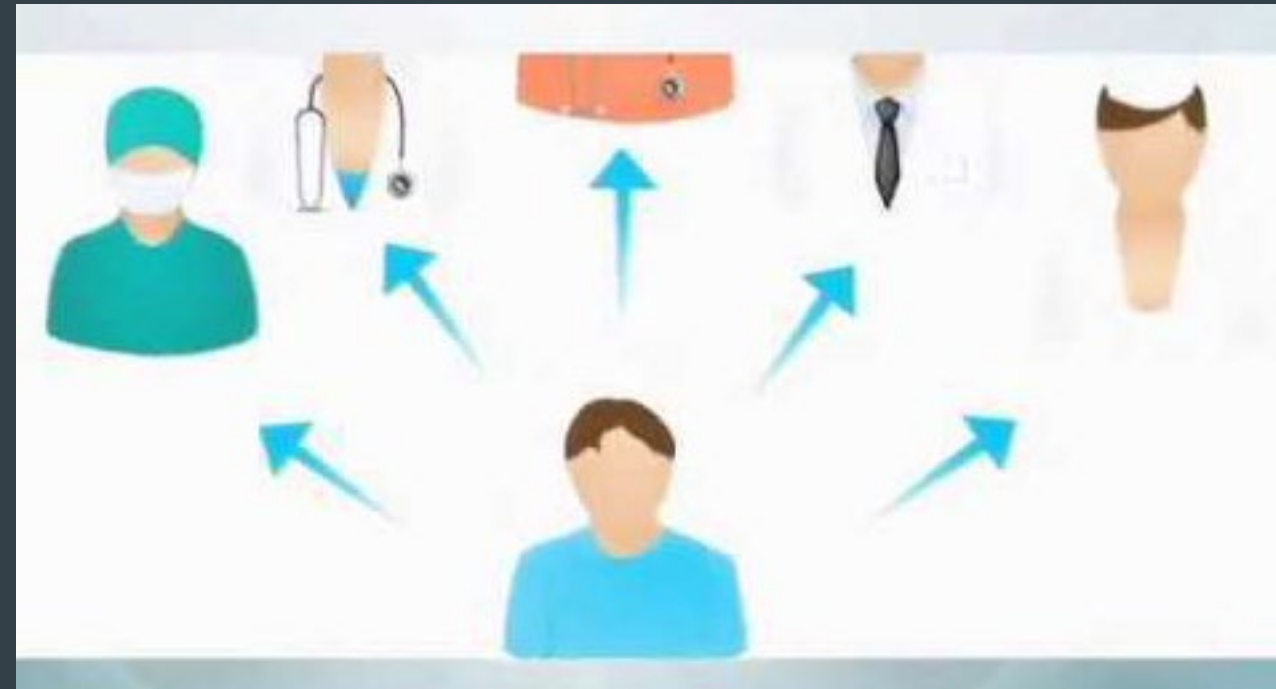


# Payment Model Drives Delivery System Reform

## TJR Bundles



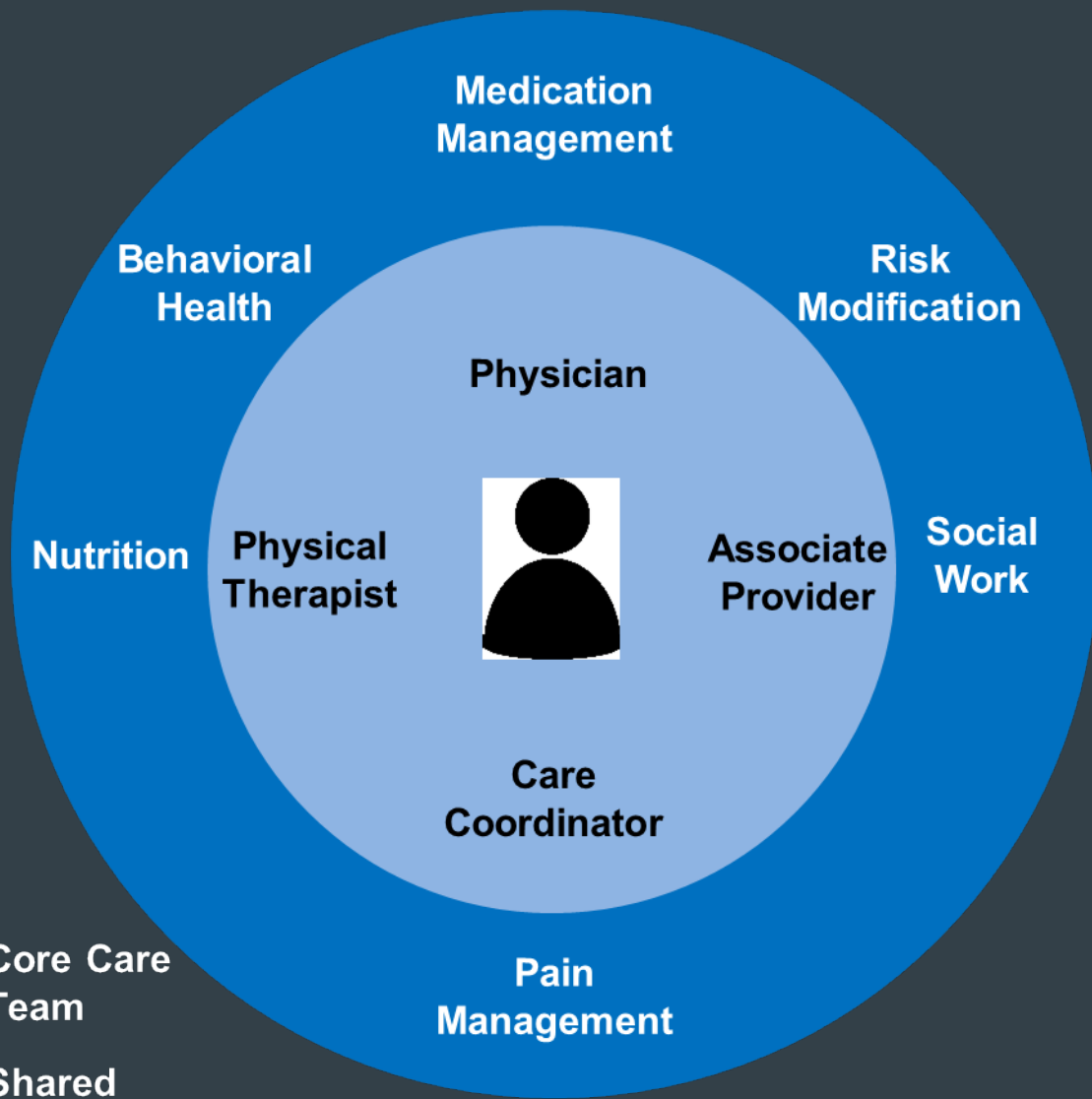
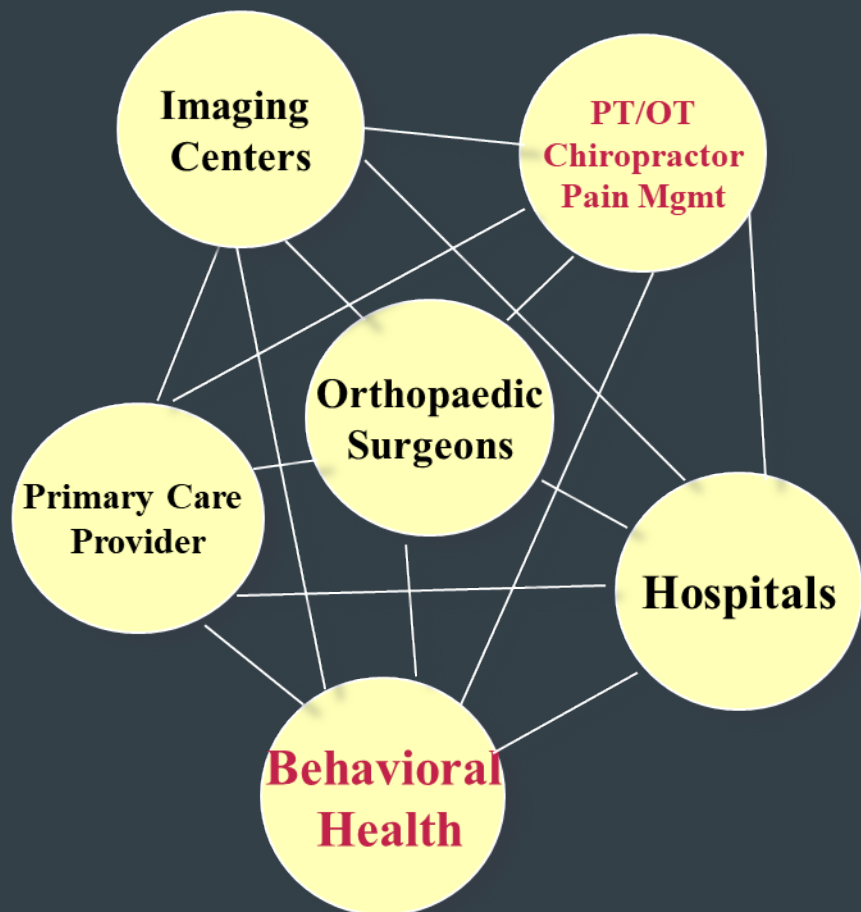
## Arthritis Bundles



# Changing the Delivery Model

## Existing Model

Organize by Specialty and Discrete Service

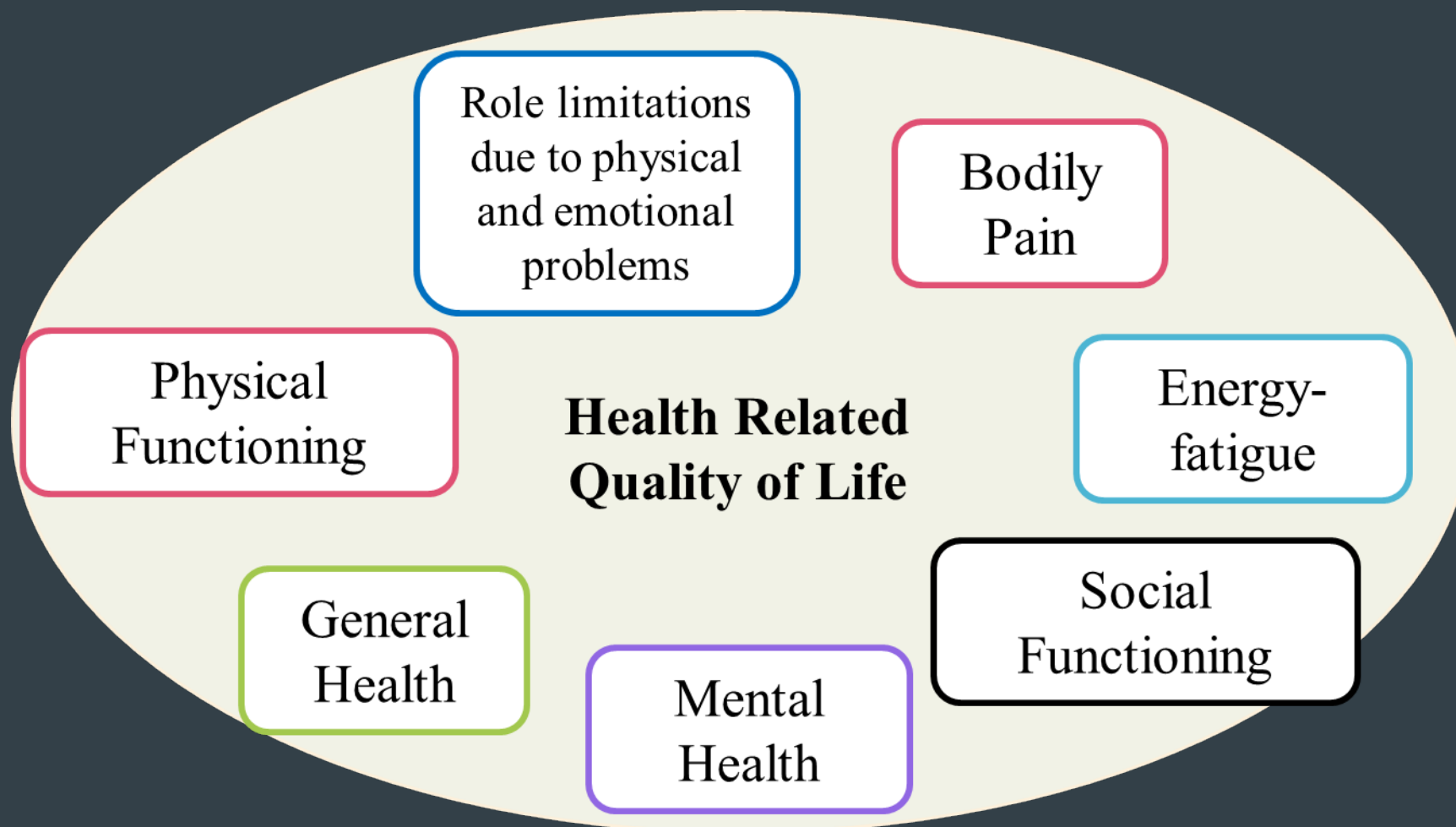


- Core Care Team
- Shared Resources

# Measuring Outcomes That Matter to Patients

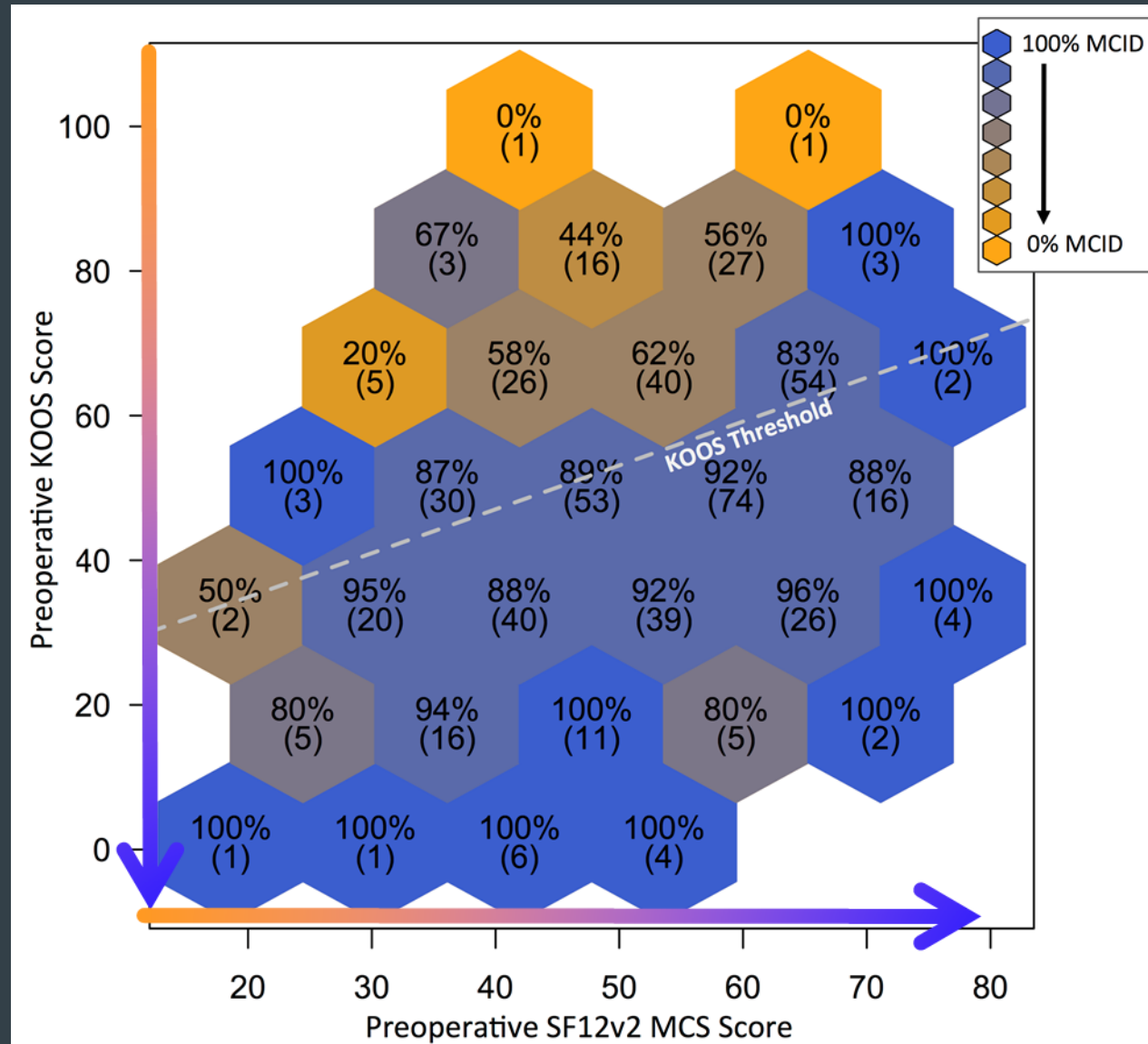
## PATIENT REPORTED Outcomes (PROs)

Report of a Patient's *Health Status* that comes directly from the patient

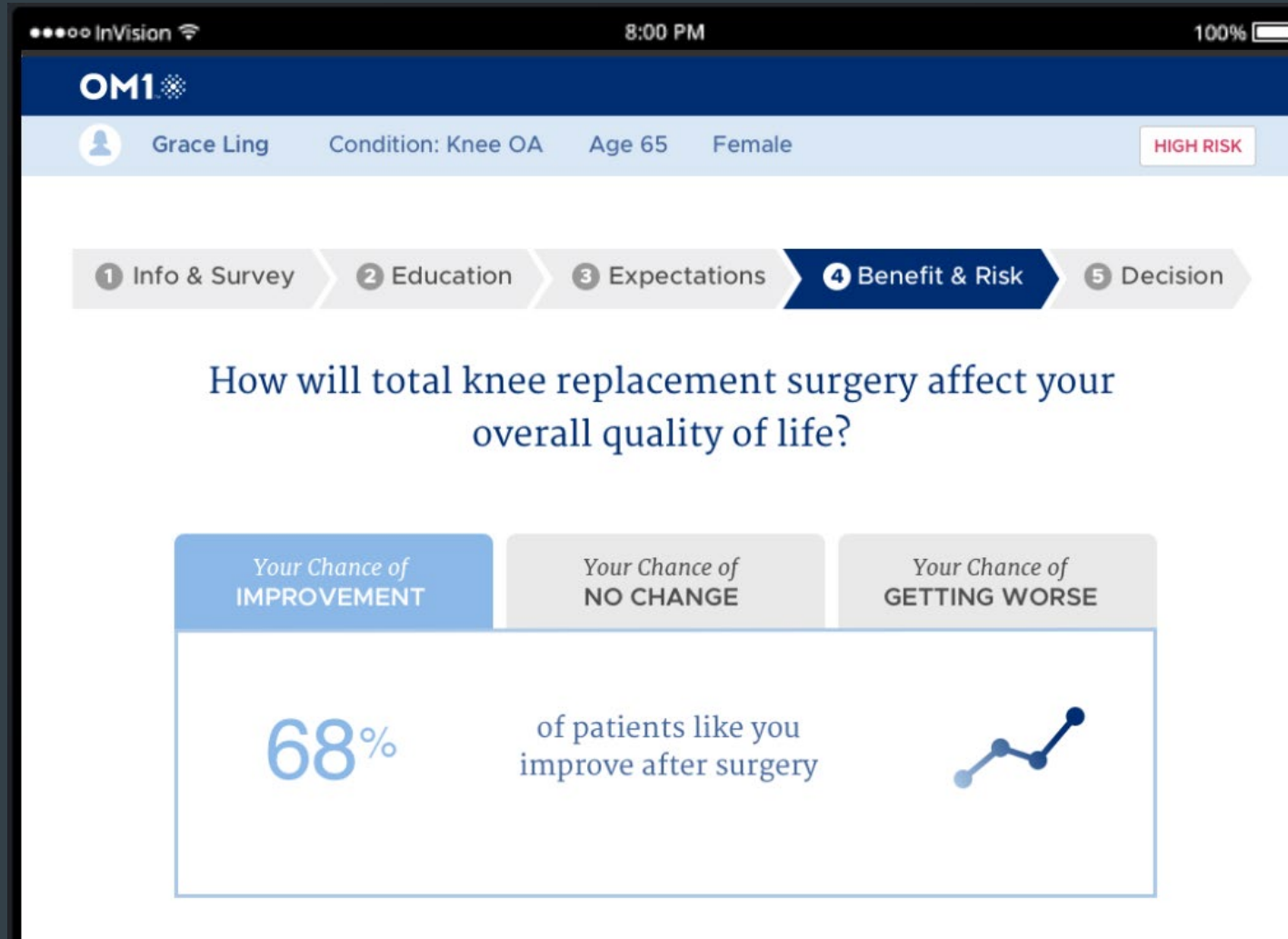




# Using Pros to Inform Appropriateness Of Surgery

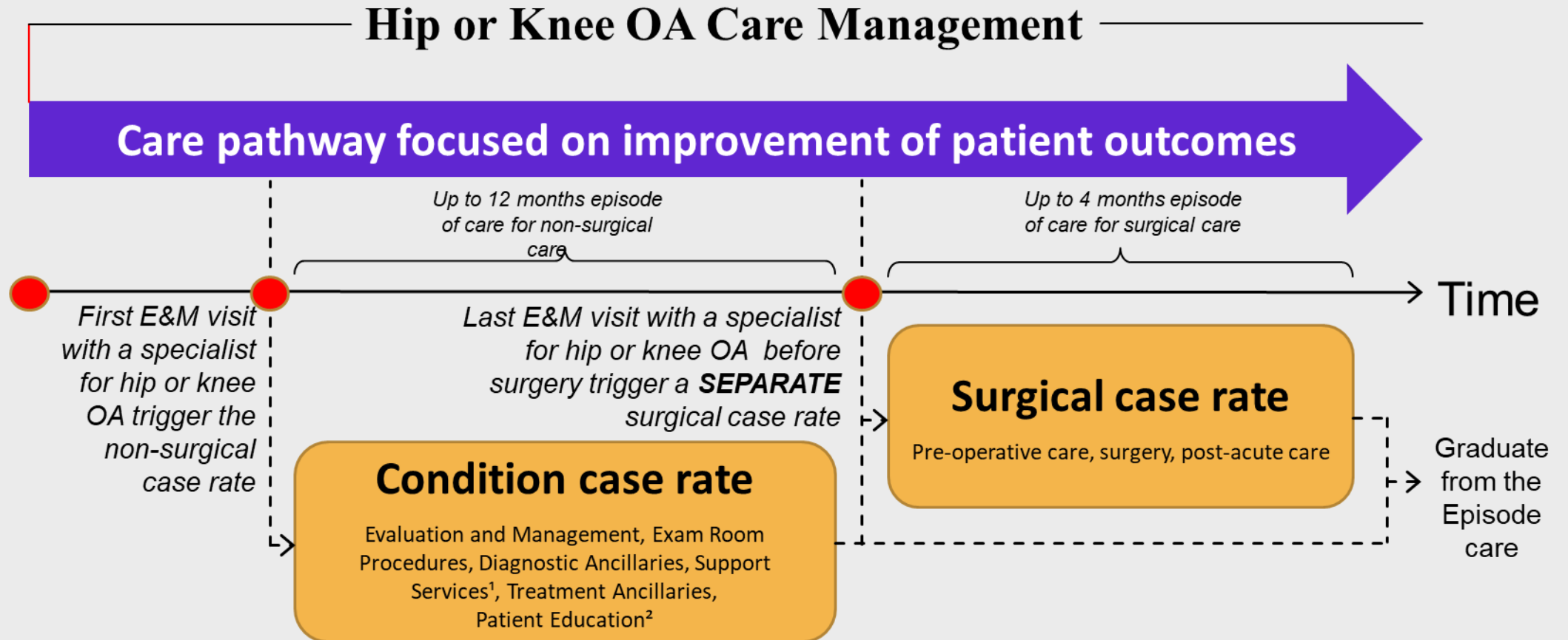


# Personalized Shared Decision Making



# Alternative Payment Models for Hip and Knee OA

Start of  
hip or  
knee OA  
care



1. Support Services include DME, immunization/vaccine, etc. (only will be given if it is necessary);
2. Patient education includes service & materials fees, patient's history, registration, education, etc.

## Summary

- **Musculoskeletal disease is prevalent, costly**
- **Management of MSK conditions is characterized by variation in treatment approach, outcome, cost**
- **SIGNIFICANT opportunity to drive value through care redesign, payment reform**
- **Procedure-based bundles will only get us so far**
- **Real opportunity lies in redesigning care across the continuum, changing payment incentives through condition-based bundles**

The University of Texas at Austin  
Dell Medical School

THIS IS THE START OF  
SOMETHING BIG.



*Thank You!!*



@KevinBozic, @DellMedSchool, @UTHealthAustin



The University of Texas at Austin  
Surgery and Perioperative Care  
Dell Medical School

*American Academy of Hospice and Palliative Medicine*

# **Patient and Caregiver Support for Serious Illness (PACSSI)**

**Phil Rodgers, MD FAAHPM**

**Professor of Family Medicine and Internal Medicine**

**University of Michigan Medical School**

**Chair, AAHPM Alternative Payment Model Task Force**

***2019 LAN Summit***

***October 24, Washington DC***



AMERICAN ACADEMY OF  
HOSPICE AND PALLIATIVE MEDICINE



# *Patient and Caregiver Support for Serious Illness* **(PACSSI)**

- Focused on seriously ill patients with likelihood of unmet symptom, care coordination and support needs who are either not eligible or not ready for hospice care
- Provides new payment for interdisciplinary Palliative Care Teams (PCTs) to deliver high-value services across settings
- PCTs receive per-enrolled beneficiary per month (PMPM) payments which are adjusted for performance on quality and spending

# AAHPM APM Development Timeline

- **June 2016** – AAHPM Board approves formation of APM Task Force
- **November 2016 - February 2017** – Task force engagement, data gathering, workgroup input, academy member input
- **March - August 2017** – Seek and incorporate feedback from members and multiple stakeholders, including CMMI
- **August 15, 2017** – Submit AAHPM-endorsed APM [proposal](#) to PTAC
- **March 26, 2018** – Present PACSSI to PTAC, which [recommends limited-scale testing](#) with high priority
- **April 2018 - present** – engagement with CMMI and key stakeholders on model development
- **April 23, 2019** – CMS announces [Primary Care First](#) Payment Model with ‘Seriously Ill Population’ (SIP) option based in part on PACSSI



# Key Model Design Elements



# Key Model Design Elements (cont.)

- **Eligibility and Services**
  - Which patients need what types of serious illness services?
  - How are patients identified, for both care delivery and control matching?
- **Quality Measures**
  - What structure, process and outcome measures of serious illness care are both viable and valuable?
  - What measures are we willing to be accountable for?
- **Payment Methodology**
  - What payment is sustainable? What 'risk' is acceptable?
  - How are spending benchmarks for serious ill patients created?

# Lessons Learned

- **Eligibility and Services**
  - Data limitations (claims vs clinical/administrative data)
  - Diversity of provider types and teams
- **Quality Measures**
  - Serious illness quality measurement still in development
  - Patient-reported outcomes challenging for seriously ill patients
- **Payment Methodology**
  - Payment needs to support diverse service delivery models and communities (in both scale and geography)
  - Needs to improve on existing FFS mechanisms

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<https://hcp-lan.org/>



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**Thank You!**