Physician-Focused Payment Model Technical Advisory Committee

PTAC Public Meeting

March 13, 2017

Physician-Focused Payment Model Technical Advisory Committee

Chairman's Update

Jeffrey Bailet, MD, PTAC Chair

March 13, 2017

Welcome

- PTAC was created by MACRA to make comments and recommendations to the Secretary on proposals for physician-focused payment models submitted by individuals and stakeholder entities.
- PTAC is dedicated to transparent operations that encourage and incorporate feedback from the public.
- PTAC began receiving letters of intent (LOIs) on October 1, 2016 and full proposals on December 1, 2016.

Overview

- Update on proposals and letters of intent received
- Upcoming PTAC meetings and events
- Publicly available documents related to proposals
- Today’s agenda

Update on Proposals Received

PTAC has received five proposals and an additional 16 letters of intent to submit a proposal:

- *The COPD and Asthma Monitoring Project* submitted by Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group Inc. of Sacramento, California (PMA)
- *The Comprehensive Colonoscopy Advanced Alternative Payment Model for Colorectal Cancer Screening, Diagnosis and Surveillance* submitted by the Digestive Health Network
- *Project Sonar* submitted by the Illinois Gastroenterology Group and SonarMD, LLC
- *The ACS-Brandeis Advanced APM* submitted by the American College of Surgeons
- *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* submitted by Coalition to Transform Advanced Care.

All proposals and letters of intent are posted on PTAC's website, https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee.

Update on LOIs Received

PTAC has received the following 16 additional letters of intent:

- *Episodic Payments for Radiation Oncology* submitted by the American College of Radiation Oncology (ACRO)
- *Radiation Oncology Total Cost of Care Physician Focused Payment Model* submitted by the American Society for Radiation Oncology (ASTRO)
- *ACCESS Project* submitted by the University of New Mexico Health Sciences Center
- *Oncology Bundle Program* submitted by Hackensack Meridian Health and COTA
- *APM for Retinal Disease* submitted by US Retina
- *Medical Cardiology Super Bundle* submitted by Cynapse Health, Inc.
- *CAPG Medicare Alternative Payment Model – Full Risk* submitted by CAPG
- *Comprehensive Cancer Care Delivery Model* submitted by Community Oncology Alliance
- *Physiatrist Led Post-Acute Micro-Bundle Model* submitted by Edward Bumetta MD, LLC

LOIs Received (cont.)

- *A single bundled payment for comprehensive low-risk maternity and newborn care provided by midwife-led practices in independent birth centers that are clinically integrated with physician and hospital services* submitted by the Minnesota Birth Center
- *Advanced Primary Care Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care* submitted by the American Academy of Family Physicians
- *HaH-Plus (Hospital at Home Plus)* submitted by the Icahn School of Medicine at Mount Sinai
- *Project INSPIRE* submitted by the New York City Department of Health and Mental Hygiene (DOHMH)
- *Avera Health Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model* submitted by Avera Health
- *Payment Reforms to Improve Care for Patients With Serious Illness* submitted by the American Academy of Hospice and Palliative Medicine
- *Patient-Centered Asthma Care Payment (PCACP)* submitted by The American College of Allergy, Asthma & Immunology (ACAAI) and the Advocacy Council of ACAAI (AC)

LOIs must be submitted at least 30 days prior to the submission of a full proposal. There is no deadline to submit a LOI or a proposal to PTAC.

PTAC Calendar

April 10-11, 2017

- Public meeting with discussion on:
  - The COPD and Asthma Monitoring Project
  - The ACS-Brandeis Advanced APM
  - Project Sonar
  - Comprehensive Colonoscopy AAPM for Colorectal Cancer Screening, Diagnosis, and Surveillance

June 5-6, 2017

- Public meeting with deliberation and voting on proposals ready for full Committee action

Quarterly public meetings thereafter (September and December 2017; March 2018)

Note: Meeting agendas subject to change.

Publicly Available Documents Related to Proposals

- Two weeks prior to a public meeting, the following proposal-related documents will be posted on the PTAC website:
  - Preliminary Review Team (PRT) reports
  - Questions to the submitter and submitter responses
  - Any additional analyses used in PRT decision making
- LOIs and full proposals are posted on the website as they are received.
- Public comments on proposals will be posted one week following the conclusion of the comment period and updated weekly to include comments received after the deadline.
- Submitters are invited to make a statement at public meetings.
- PTAC welcomes additional public comments and questions at all public meetings.

Today's Agenda

- CMMI Presentation: Overview of Bundled Payments for Care Improvement (BPCI) Initiative and Evaluation Results
- Bundled Payments for Care Improvement (BPCI) Initiative Participants' Perspective: Successes and Challenges
- CMS Update on Health Care Innovation Award Initiative
- Time will be set aside for public comments and questions from 3:15-3:45 pm.

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

Bundled Payment Models
Where We Have Been and Where We Are Going: BPCI

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

"The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures…while preserving or enhancing the quality of care** furnished to individuals under such titles"

Section 3021 of Affordable Care Act

Three scenarios for success

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

The Case for Bundled Payments

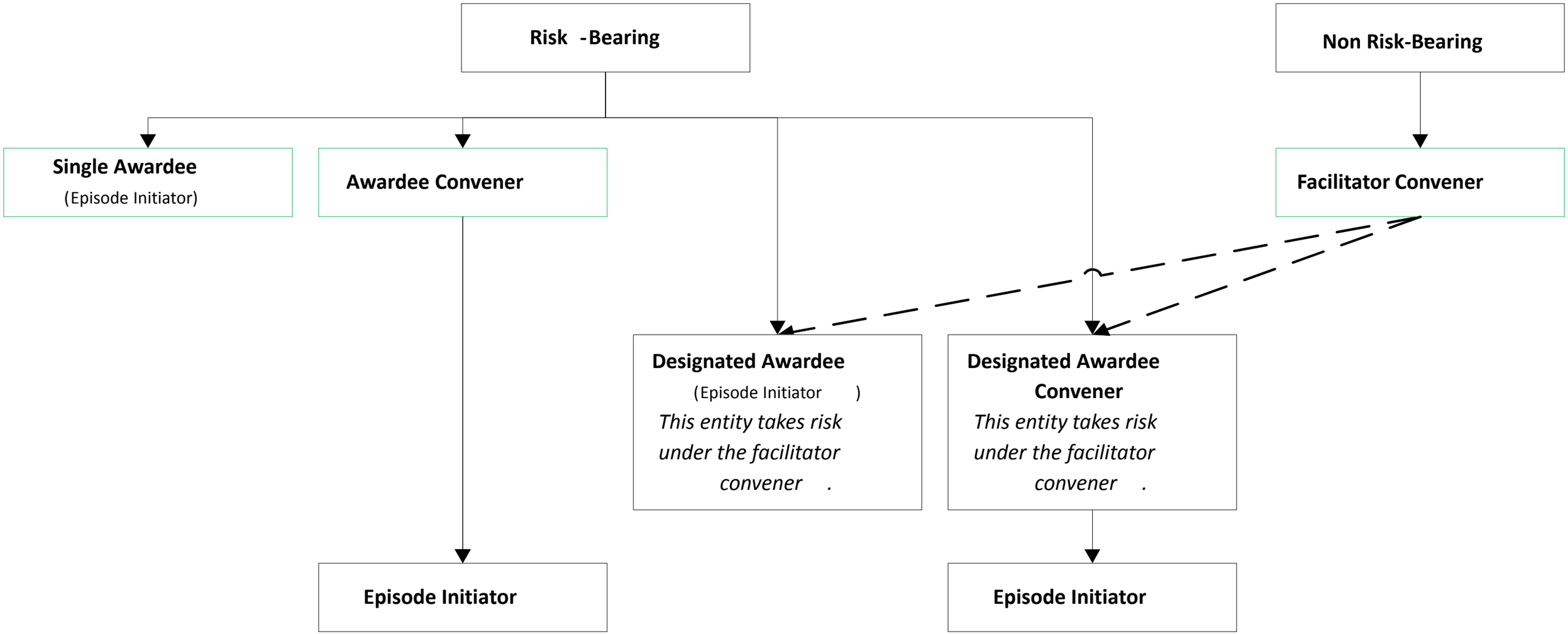
- Single bundled payment makes providers jointly accountable for patient outcomes and aligns hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
  - Opportunity to reduce costs from duplicative testing and services
  - Potential to streamline care delivery
  - Emphasis is on quality of care rather than quantity of episodes

- Valuable synergies with ACOs, Medicare's Shared Savings Program, and other payment reform initiatives
- Improvements identified via these model tests may spill over to private payers

Bundled Payments for Care Improvement (BPCI)

- The bundled payment model provides a single payment for an episode of care
  - ➢Incentivizes providers to take **accountability for both cost and quality** of care
  - ➢**Four Models – encompassing all DRGs (Model 1) or 48 targeted clinical conditions (Models 2, 3, and 4)**
    - Model 1: Acute care hospital stay only Model 2: Retrospective acute care hospital stay plus post-acute care
    - Model 3: Retrospective post-acute care only
    - Model 4: Prospective acute care hospital stay only
  - ➢Conclusion of BPCI
    - Model 1: completed December 31, 2016
    - Models 2, 3, 4: close out September 30, 2018

Description of Participant Roles in BPCI



Bundled Payments for Care Improvement: Models Overview

Model 1	• Bundled payment model for the acute inpatient hospital stay only • 0 Participants: completed December 31, 2016
Model 2	• Retrospective bundled payment model consisting of an inpatient hospital stay followed by post-acute care • 577 Participants: 177 Awardees and 400 Episode Initiators
Model 3	• Retrospective bundled payment models for post-acute care only • 779 Participants: 104 Awardees and 675 Episode Initiators
Model 4	• Prospectively administered bundled payment models for the acute inpatient hospital stay only • 5 participants: 5 Awardees and 0 Episode Initiator

As of January 1, 2017

BPCI Provider Types

Provider Type	Model 2	Model 3	Model 4	TOTAL
Acute Care Hospital	335	0	5	340
Physician Group Practice	204	48	0	252
Home Health Agency	0	81	0	81
Inpatient Rehab Facility	0	9	0	9
Long Term Care Hospital	0	0	0	0
Skilled Nursing Facility	0	620	0	620
TOTAL	539	758	5	1302

As of January 1, 2017

Trigger Clinical Conditions

Acute myocardial infarction	Major bowel procedure
AICD generator or lead	Major cardiovascular procedure
Amputation	Major joint replacement of the lower extremity
Atherosclerosis	Major joint replacement of the upper extremity
Back & neck except spinal fusion	Medical non-infectious orthopedic
Coronary artery bypass graft	Medical peripheral vascular disorders
Cardiac arrhythmia	Nutritional and metabolic disorders
Cardiac defibrillator	Other knee procedures
Cardiac valve	Other respiratory
Cellulitis	Other vascular surgery
Cervical spinal fusion	Pacemaker
Chest pain	Pacemaker device replacement or revision
Combined anterior posterior spinal fusion	Percutaneous coronary intervention
Complex non-cervical spinal fusion	Red blood cell disorders
Congestive heart failure	Removal of orthopedic devices
Chronic obstructive pulmonary disease, bronchitis, asthma	Renal failure
Diabetes	Revision of the hip or knee
Double joint replacement of the lower extremity	Sepsis
Esophagitis, gastroenteritis and other digestive disorders	Simple pneumonia and respiratory infections
Fractures of the femur and hip or pelvis	Spinal fusion (non-cervical)
Gastrointestinal hemorrhage	Stroke
Gastrointestinal obstruction	Syncope & collapse
Hip & femur procedures except major joint	Transient ischemia
Lower extremity and humerus procedure except hip, foot, femur	Urinary tract infection

BPCI Pricing – Models 2 & 3

- Baseline and Target Prices
  - Baseline prices are derived from episodes initiated during period from July 1, 2009 – June 30, 2012, updated quarterly and trended to 2012 using an annual national MS-DRG-specific growth rate
  - Target prices for each performance period are calculated by applying a national MS-DRG-specific growth rate to the baseline price and then applying the discount percentage, which ranges from 2-3% depending on model, episode length and discount
    - Target prices include direct adjustments for key payment policies including the Hospital Readmissions Reduction and Hospital Value-Based Purchasing programs
    - Target amounts are calculated as the target price times the number of episode cases for each MS-DRG

BPCI Models 2 & 3 – Net Payment Reconciliation Amount (NPRA)

- NPRA = Performance period target amount – adjusted aggregate fee-for-service payment
  - Calculated first at the MS-DRG level and then aggregated to clinical episode and episode initiator levels
- If NPRA > 0, CMS will issue payment to the awardee
- If NPRA < 0, CMS will send a demand letter to the awardee

Gainsharing of Savings Through Fraud and Abuse Waivers

- In a healthcare context, gainsharing arrangements often been found to violate the Civil Money Penalties Law and/or the Anti-Kickback Statute
- Waiver of Fraud and Abuse permits gainsharing of certain funds in BPCI under specific and limited circumstances
  - ➢ Approximately 50% of Awardees gainshare
- What funds are gainshared in BPCI?
  - ➢ Positive **"NPRA" dollars**
    - We set a **target price** for each Bundled Episode, and reconcile that against the FFS payments made to providers who furnished services to beneficiaries in Models 2 and 3
    - When our participants provide all services at a lower cost than the target price, they are eligible to gainshare, or keep the remainder, provided they meet quality performance targets
  - ➢ Funds derived from **Internal Cost Savings**
    - Actual, verifiable cost savings attributable to care redesign
    - E.g., MJRLE – bulk purchasing of a particular implant

Other BPCI Waivers

- Payment policy waivers
  - 3-Day Hospital Stay Requirement for SNF Payment (Model 2)
  - Telehealth (Models 2, 3)
  - Post-Discharge Home Visit (Models 2, 3)

- Waivers of Certain Fraud and Abuse laws
  - Available to Models 2-4
  - **Require adherence to strict requirements** in order to engage in specified gainsharing, incentive payment, and patient engagement incentive arrangements

BPCI Evaluation

- *JAMA* Article: Dummit, et al., Association between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes.
  - Objective: To evaluate whether BPCI was associated with a greater reduction in Medicare payments without loss of quality of care for lower extremity joint (primarily hip and knee) replacement episodes initiated in BPCI-participating hospitals that are accountable for total episode payments (for the hospitalization and Medicare-covered services during the 90 days after discharge).
  - Conclusion: In first 21 months of BPCI, Medicare payments declined more for lower extremity joint replacement episodes provided in BPCI-participating hospitals than for those provided in comparison hospitals, without a significant change in quality outcomes.
  - Published online September 19, 2016. doi:10.1001/jama.2016.12717; available http://jama.jamanetwork.com/article.aspx?articleid=2553001

BPCI Evaluation

- Second Annual Evaluation Report (Models 2-4) was released in September 2016
  - Available at: https://innovation.cms.gov/Data-and-Reports/index.html
  - Quantitative analyses reflects experience of Phase 2 participants during the first year (October 2013 – September 2014)
  - Qualitative analyses reflects participants' experience through June 2015
  - Future evaluation reports will have greater ability to detect changes in payment and quality due to larger sample sizes and the recent growth in participation of the initiative, which generally is not reflected in this report.

BPCI Model 2 Evaluation Highlights

- 11 out of the 15 clinical episode groups analyzed showed potential savings to Medicare
- Orthopedic surgery episodes showed statistically significant savings of $864 per episode while showing improved quality as indicated by beneficiary surveys
- Cardiovascular surgery episodes hospitals did not show any savings yet but quality of care was preserved
- Statistically significant decrease in institutional PAC use for BPCI orthopedic surgery and cardiovascular surgery episodes relative to comparison populations among those who received any PAC

BPCI Model 3 Evaluation Highlights

- Standardized SNF payments and SNF days for SNF-initiated BPCI episodes declined relative to comparison group across almost all clinical episode groups
  - Did not result in statistically significant declines in total episode payments
- Quality generally was maintained or improved relative to comparison group

Thank you!

Questions?

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Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Feedback on CMMI Bundled Payment Programs

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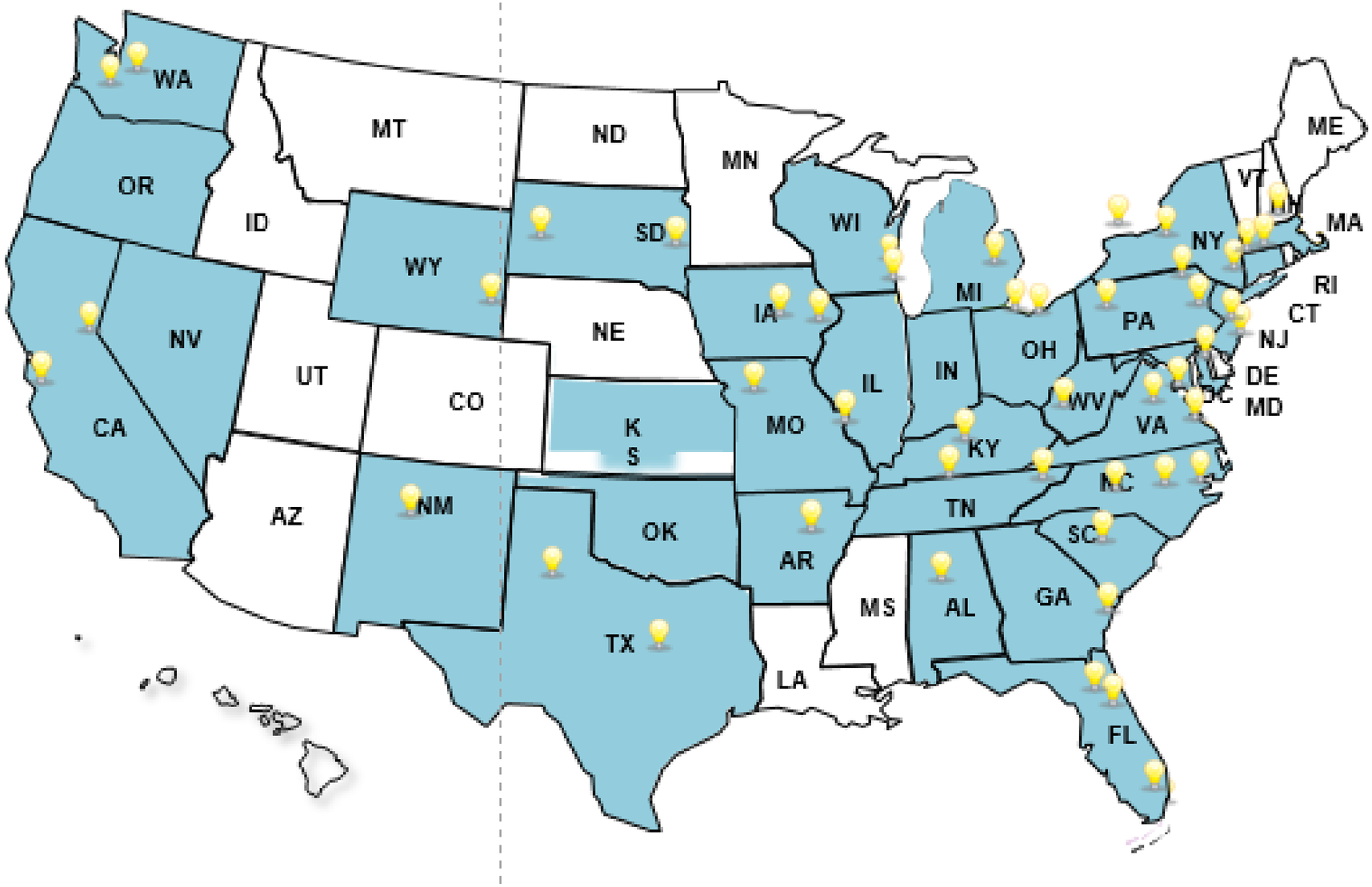
Bundle Payment Collaborative Members

BUNDLED PAYMENT COLLABORATIVE



Bundled Payment – What We Appreciate

Baseline Data

- Availability of data well in advance of decision point in order to decide whether to enter, which bundles to choose and plan care transformation

Monthly Data Feeds

- Access to monthly data drives decision making and encourages improvements, but missing substance use related claims

Voluntary Nature & Menu of Bundles

- Allow organizations to chose the model and enter when ready, as well as start small and grow into the program

Gainsharing Caps

- Support capping physician reconciliation payments at 50% of what otherwise paid

Bundled Payment – Barriers to Success

Target Pricing/Trending Methodology

- Discourages efficient organizations from participating in bundles
- Trending methodologies discourages long-term participation in bundles

Implementation Protocol

- Administratively burdensome
- Inconsistent review and feedback from CMS staff

Precedence Rules

- Creates confusion for providers and patients
- Devalues bundle participation

Uniform Discount Rates

- Discourages participation in complex medical bundles which have higher levels of variability

Bundled Payment – Barriers to Success

Risk Adjustment

- Exclusions and outlier protections insufficient
- Disconnect between baseline and performance period

Quality Metrics

- No application to payment
- No MIPS comparable measures or CEHRT requirements

Legal Waivers

- Need more tools to engage patients and encourage innovation in care
- No question mechanism to ask questions

Transparency

- No ability to replicate national numbers such as trend
- Lack of clarity on methodologies

Bundled Payment – Path to Improvement

- Ensure model is **voluntary**, and methodologies **transparent**
- Allow **annual open** application period
- Proceed with only **Model 2**
- Develop more relevant **outcomes measures** to use within this context
- Consider how to collect **patient assessment** instruments within workflow
- Research new and improved **risk adjustment** methodologies
- Increase **legal waivers** and create **FAQ process**
- Adopt **regional pricing** with at least 25% based on historical performance
- Implement **prospective target** pricing
- Adopt **trending methodology** inclusive of prior reconciliation/repayments
- Ensure **baseline data** is at least 4 months in advance and ongoing **monthly**
- **Vary discount** rates based on level of variability in a given bundle
- Base **precedence** on contribution to bundle, not physician vs. hospital
- Adopt **financial arrangement disclosures** similar to EPM
- Offer voluntary **risk tracks** similar to EPM for high variability DRG bundles
- Develop an equitable attribution of savings where **APMs overlap**

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Objective of Awardee Conveners

Enable CMS and at-risk providers to organize and finance health care delivery around a patient's episode of care

What an Awardee Convener Does

Awardee Convener Facts

- Special Purpose Entity , like an ACO or IPA
- 62% of BPCI Participants
- Lowest Cost of Entry and Admin
- Episode Initiators who work with Awardee Conveners adopt more episodes covering more patients
- Serve Hospitals, Physician Group Practices, SNFs and HHAs
- **Participating with an Awardee Convener made Participants more likely to continue in the model and less likely to withdraw from a Clinical Episode**

Remedy At a Glance

585
ACUTE CARE HOSPITALS

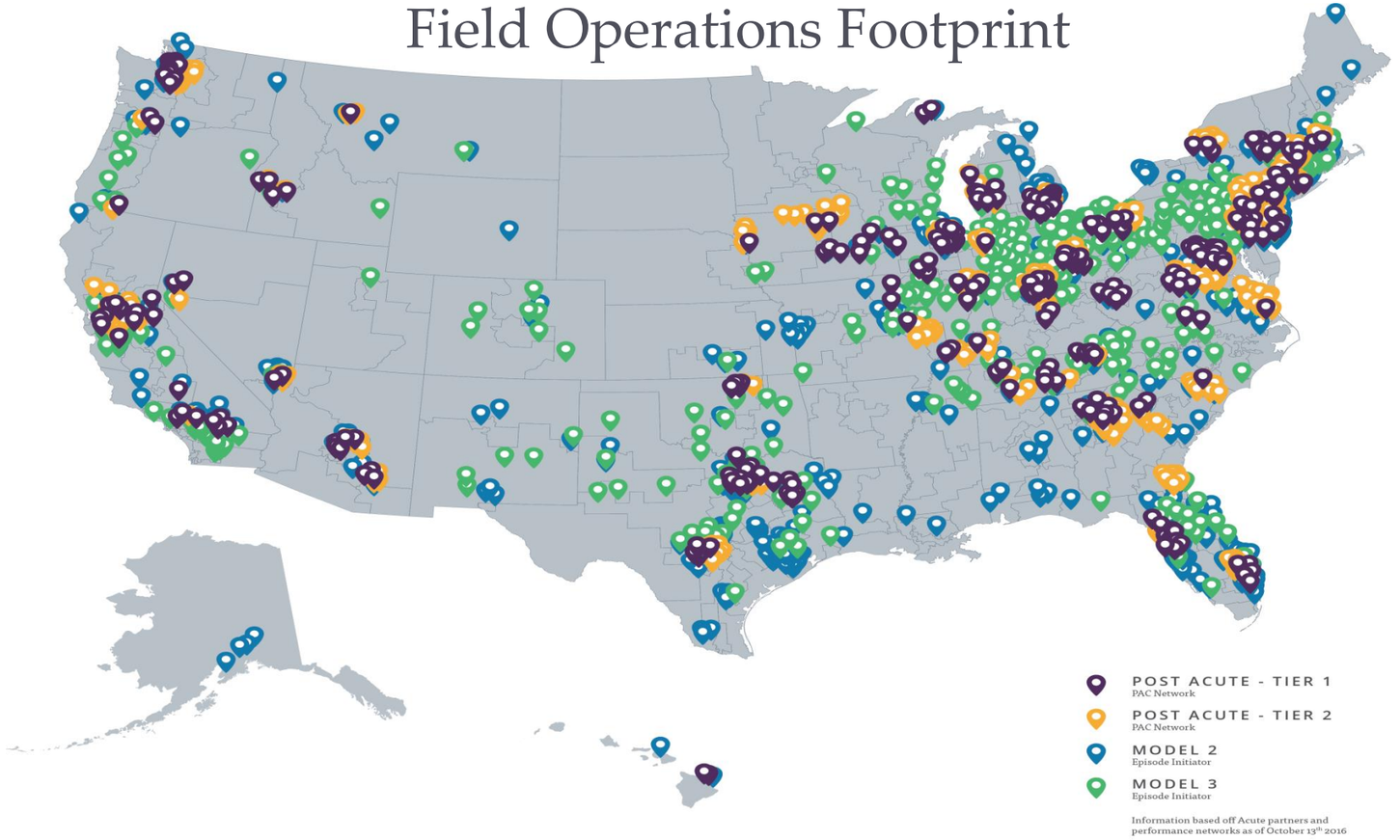
12%
OF U.S. ACUTE CARE HOSPITALS

426
SKILLED NURSING FACILITIES

67
HOME HEALTH AGENCIES

143
PHYSICIANS GROUPS

Field Operations Footprint



45
STATES OPERATIONAL

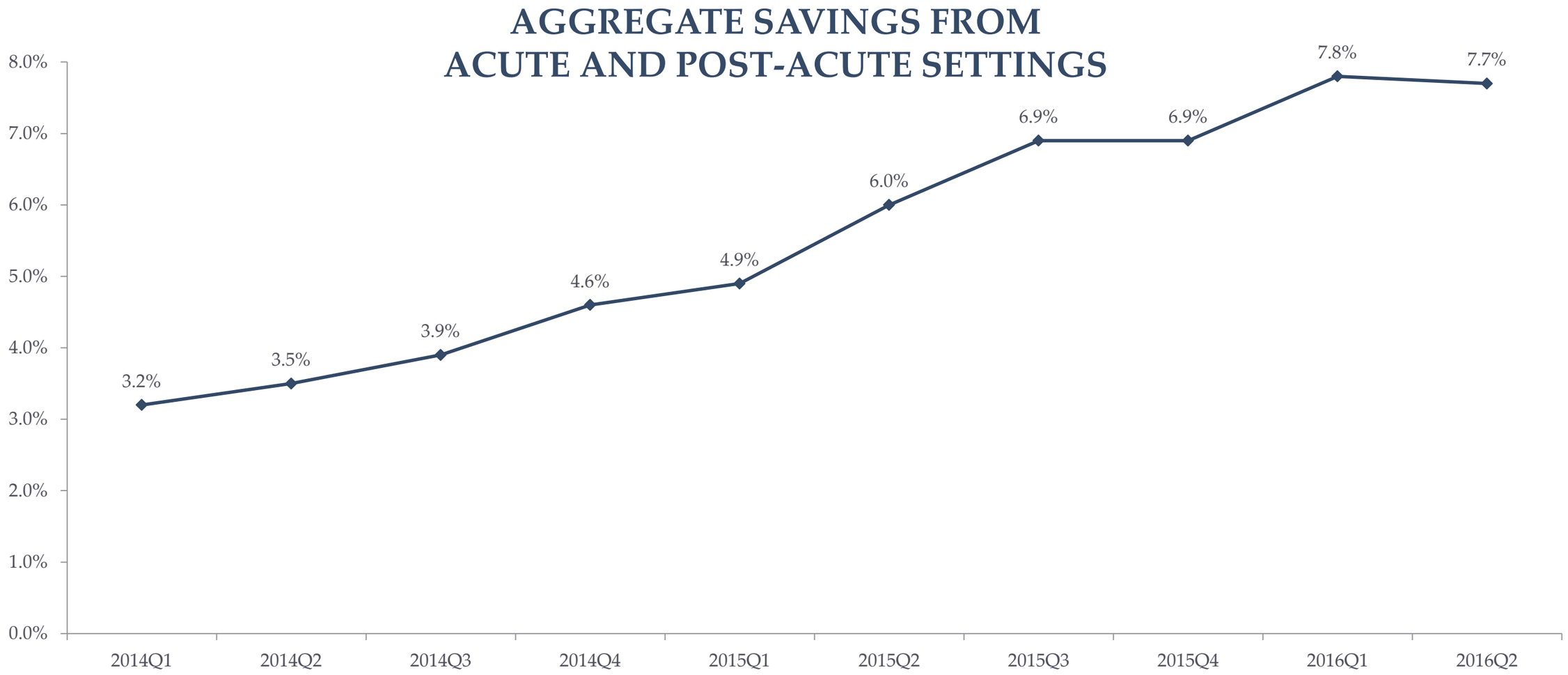
295,375
ANNUAL BPCI EPISODES

$5.7bn
MEDICARE FFS SPENDING

$120mm
ANNUAL SAVINGS FOR CMS

315
EMPLOYEES

Remedy's Proven Record: Reducing Spending



Source: Q2 2016 reconciliation, all clients

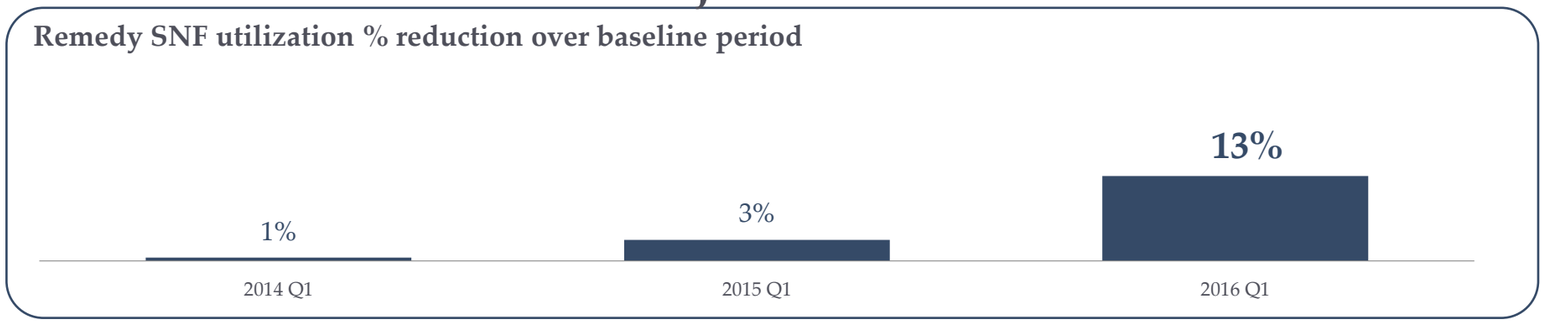
Improving Patient Outcomes

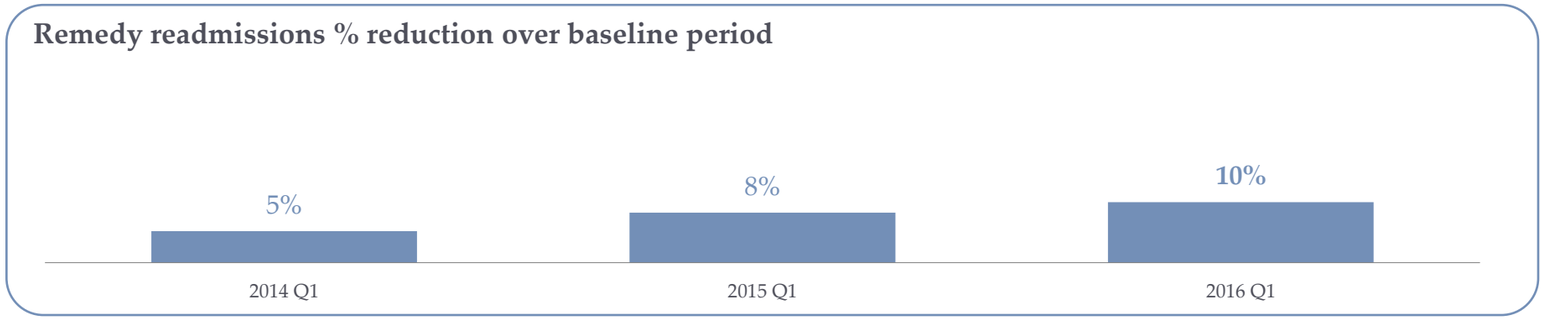
13% Reduction in SNF Admissions

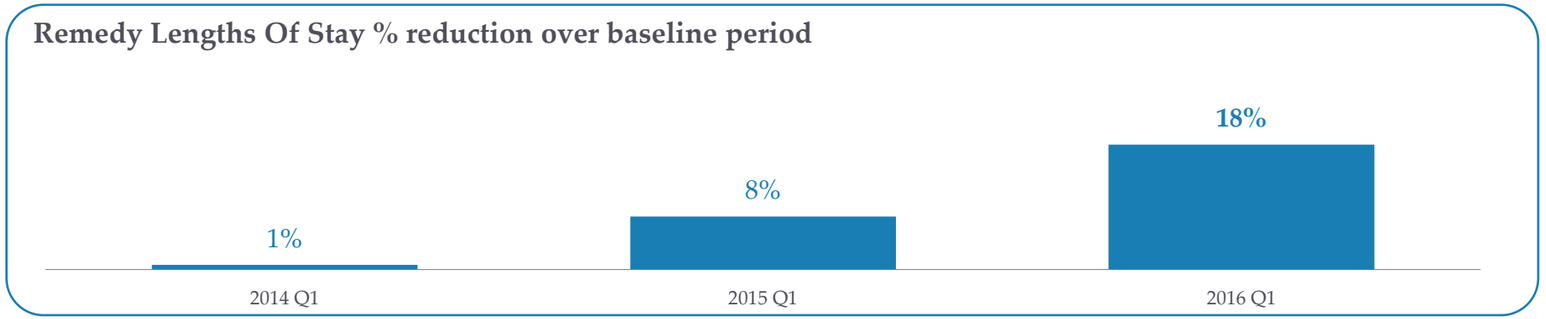
10% Reduction in Readmissions

18% Reduction in Post-Acute Lengths of Stay

Case Mix Adjusted Performance Metrics

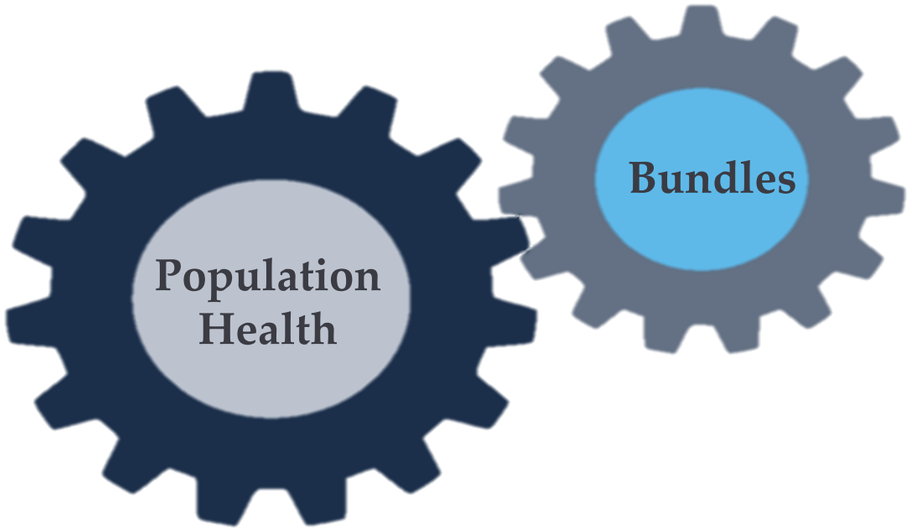






Source: Class of 2014 performance metrics, December 2016

A Powerful Combination: Bundled Payments and Population Health



Bundles Integrate into Population Health

- Redesign care around the patient
- Align incentives to improve outcomes and lower costs
- Organize Integrated Practice Units by condition
- Create platform for PCPs to select episode teams

Primary Care Physicians are best positioned to control Chronic Care Spending
Specialists are best positioned to influence Episode of Care Spending

Observations

- **CMS doing a great job**
  - Rapid adjustments to improve program – collaborative and open
  - Having a dramatic impact on health care thinking
  - Program design is largely sound. Biggest challenges have been data related
- **All types of organizations can be successful**
  - Physician Groups generally modify workflows faster and have better performance, although hospitals and SNFs can both be very successful
- **Participants are successful with Surgical and Medical Episodes**
  - Over 70% of medical episodes accrete through the E.R.
  - High performing programs are distinguished by strong leadership, adoption of systemic care redesign across multiple episodes, implementation and use of workflow and decision support tools, and creation of post-acute performance networks

Financial Considerations

- **Working Capital:**
  - Meaningful incremental costs to launch and operate bundled payments
  - Organizations who separately purchase software, analytics, post-acute network development and management, and administration/reporting incur costs of between 4-6%
  - Spreading this overhead across a very large number of providers – costs drop to 2% or less
- **Reconciliation:**
  - Continuing with quarterly reconciliations is critical, to offset the material working capital requirements to adopt the software, analytics, training and administrative capabilities required
  - Remedy raised $100M to fund working capital and has yet to recover those start-up costs. It takes time to recover the sunk costs of the development phase

Principles for Successful Bundled Payments

- **Fair and Transparent Pricing and Policies**
  - Stable baseline prices for 3 to 5 years, with quarterly trending
  - Transparency into all pricing data and calculations
- **Encourage widespread participation and large bundle sets**
    - Hospitals, Physician Groups, SNFs
    - Awardee and Facilitator Conveners
    - Incentives for taking risk on more episodes
    - Avoid prescriptions for gainsharing programs
- **Accurate and timely data**
  - Monthly claims data and quarterly reconciliations
  - Use alternatives to PECOS for patient attribution
- **Retain Medicare's Future Flexibility**
  - Precedence rules and contractual provisions should protect Medicare's ability to deploy future payment innovations


remedy partners
THE EPISODES OF CARE COMPANY

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CMS Update on Health Care Innovation Award Initiative

Renee Mentnech, Director, Research and Rapid Cycle Evaluation Group, Center for Medicare & Medicaid Innovation

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