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Specialty Payment Model Opportunities Assessment and Design

Cardiology Technical Expert Panel

April 8, 2014

Washington, DC

Overview of the Day, Cardiology Delivery and Payment Reform Framework

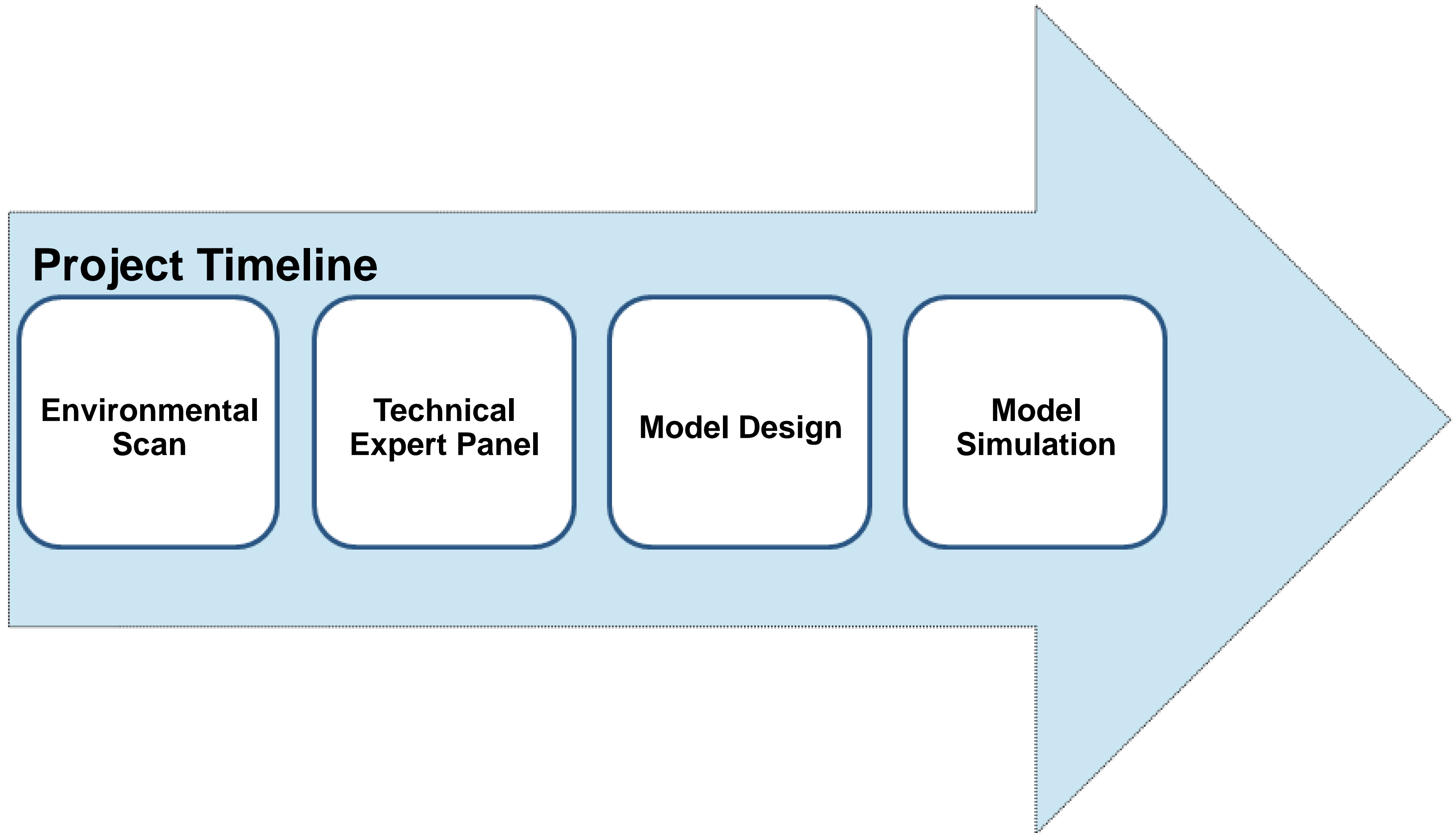
Agenda

Time	Topic
8:30 – 9:00	Check-in
9:00 – 9:15	Welcome and Introductions
9:15 – 9:30	Overview of the Day, Cardiology Delivery and Payment Reform Framework
9:30 – 10:30	*DISCUSSION PERIOD*: Management Category 1 (Population & Stable/Chronic Disease) Part 1 – Primary Care-Focused Model(s)
10:30 – 10:45	BREAK
10:45 – 11:45	*DISCUSSION PERIOD*: Management Category 1 (Population & Stable/Chronic Disease) Part 2 – Cardiology-Focused Model(s)
11:45 – 12:15	LUNCH
12:15 – 1:15	*DISCUSSION PERIOD*: Management Category 1 (Population & Stable/Chronic Disease) Part 3 – Team-Focused Model(s)
1:15 – 2:15	*DISCUSSION PERIOD*: Management Category 2 (Acute Episode)
2:15 – 2:30	BREAK
2:30 – 3:30	*DISCUSSION PERIOD*: Management Category 3 (Complex Care)
3:30 – 4:00	RAND – High Level Overview
4:00 – 4:25	TEP Review
4:25 – 4:30	Concluding Remarks
4:30	Adjourn

Project Overview

- Comprehensive scan of the payment model environment.
- Inclusion of ideas and opinions from a broad range of interested stakeholders regarding opportunities for novel payment models in cardiology.
- Insightful analysis and assessment of the opportunities for novel payment models identified.
- Collaboratively designed payment models for CMS.
- Development of medical specialty payment model options that can be realistically executable in CMS's current business environment.

Project Overview



Environmental Scan Methodology

- **The project team conducted a comprehensive environmental scan:**
  1) literature review of the existing peer-reviewed and grey literature and popular media
  2) 39 semi-structured strategic stakeholder interviews

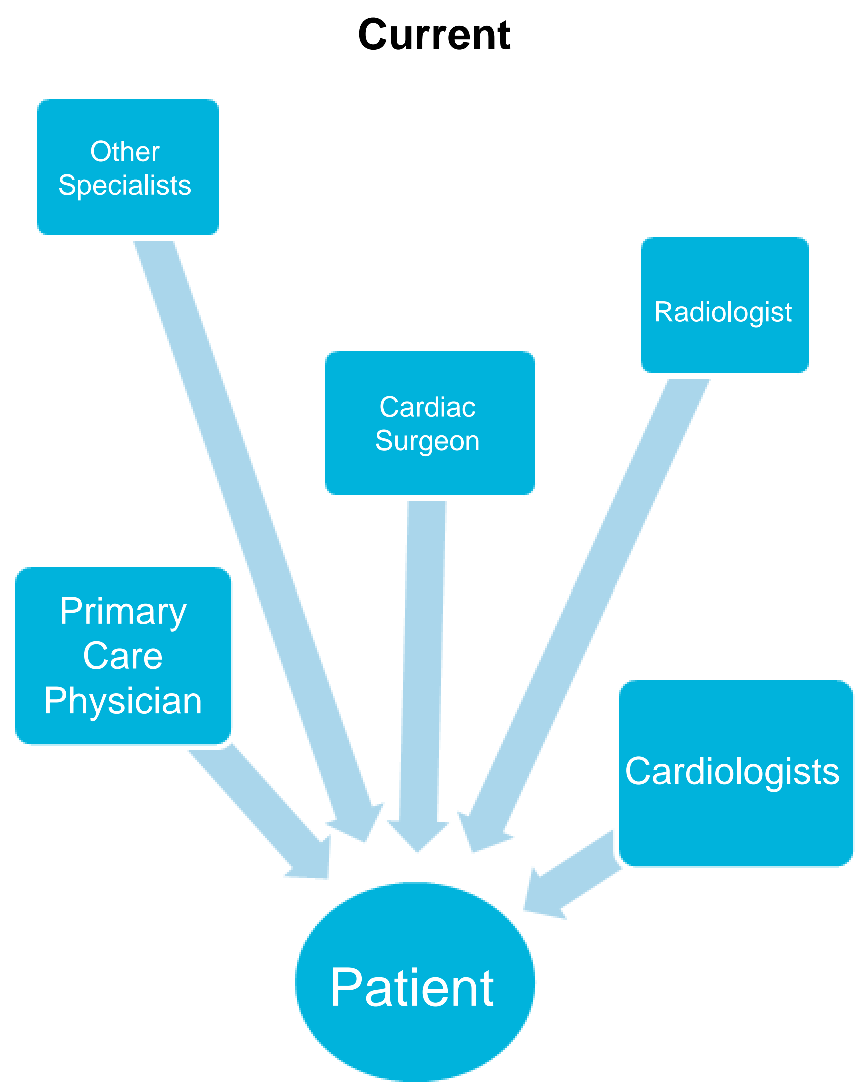
- **Stakeholders included academic researchers, providers in community and academic settings, payers, patient advocates, and heads of specialty organizations, among others.**

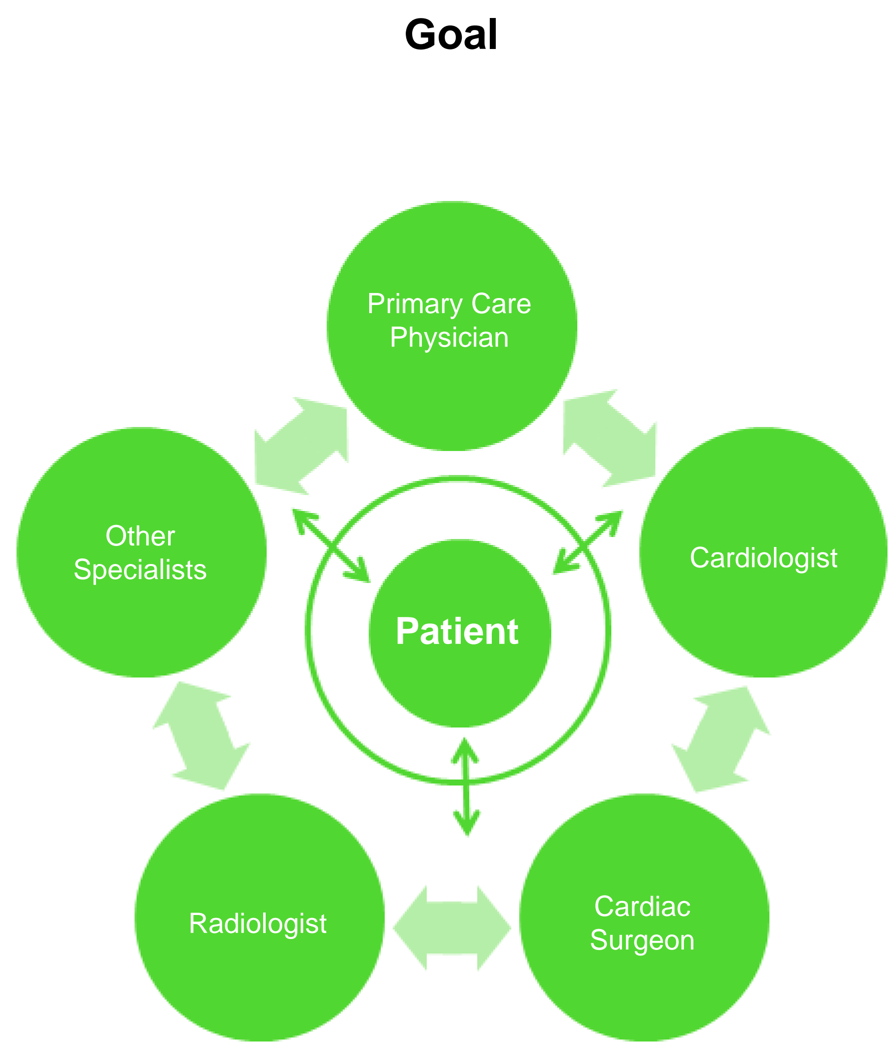
- **Following each recorded interview, comprehensive notes were then summarized by research team member.**

TEP Goals

- **Provide input on how to best design an alternative approach based on the following elements:**
  - Care delivery reform
  - Payment reform
  - Requirements for providers
  - Feasibility
  - Potential barriers

Moving Towards Greater Coordination

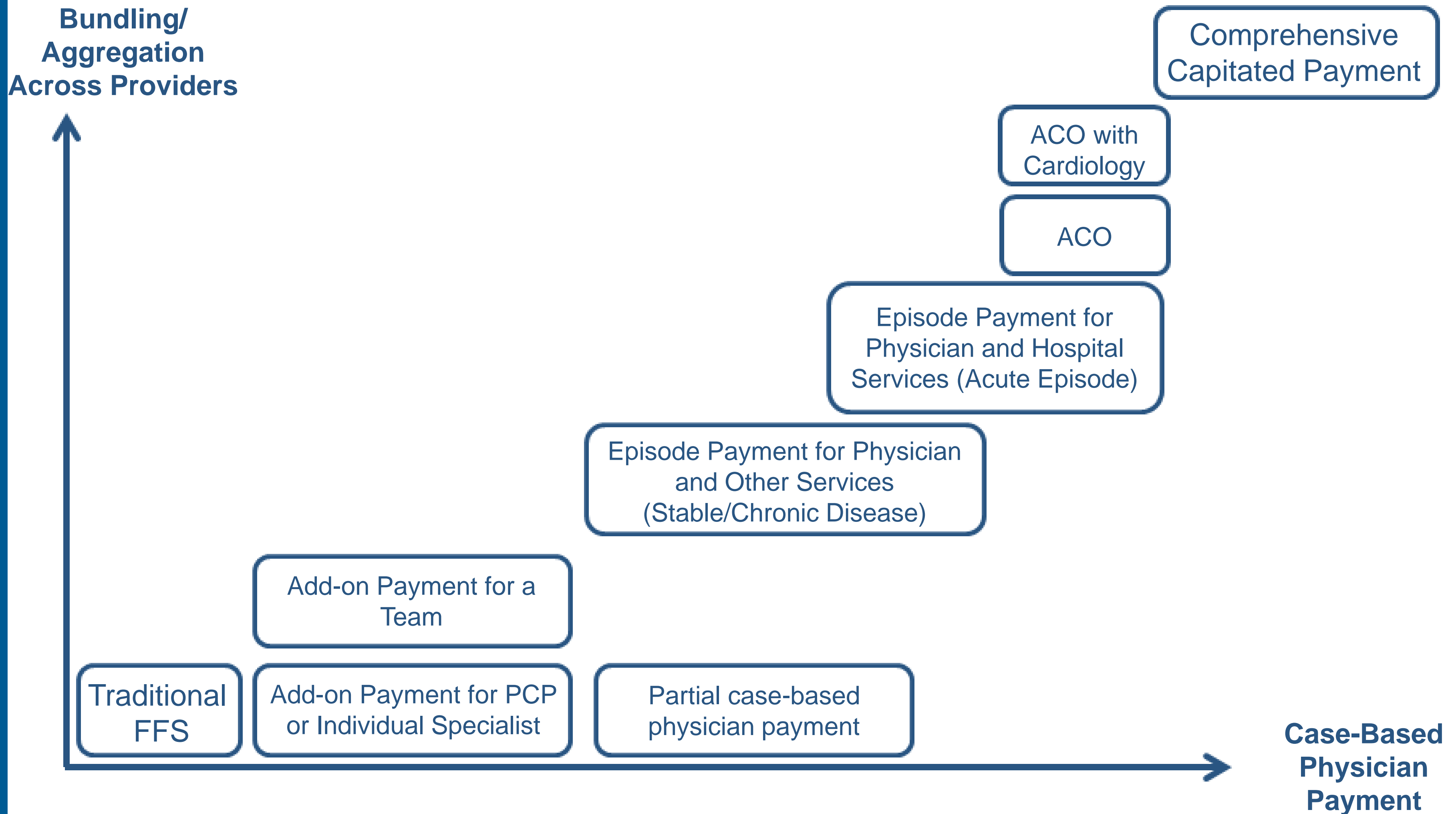




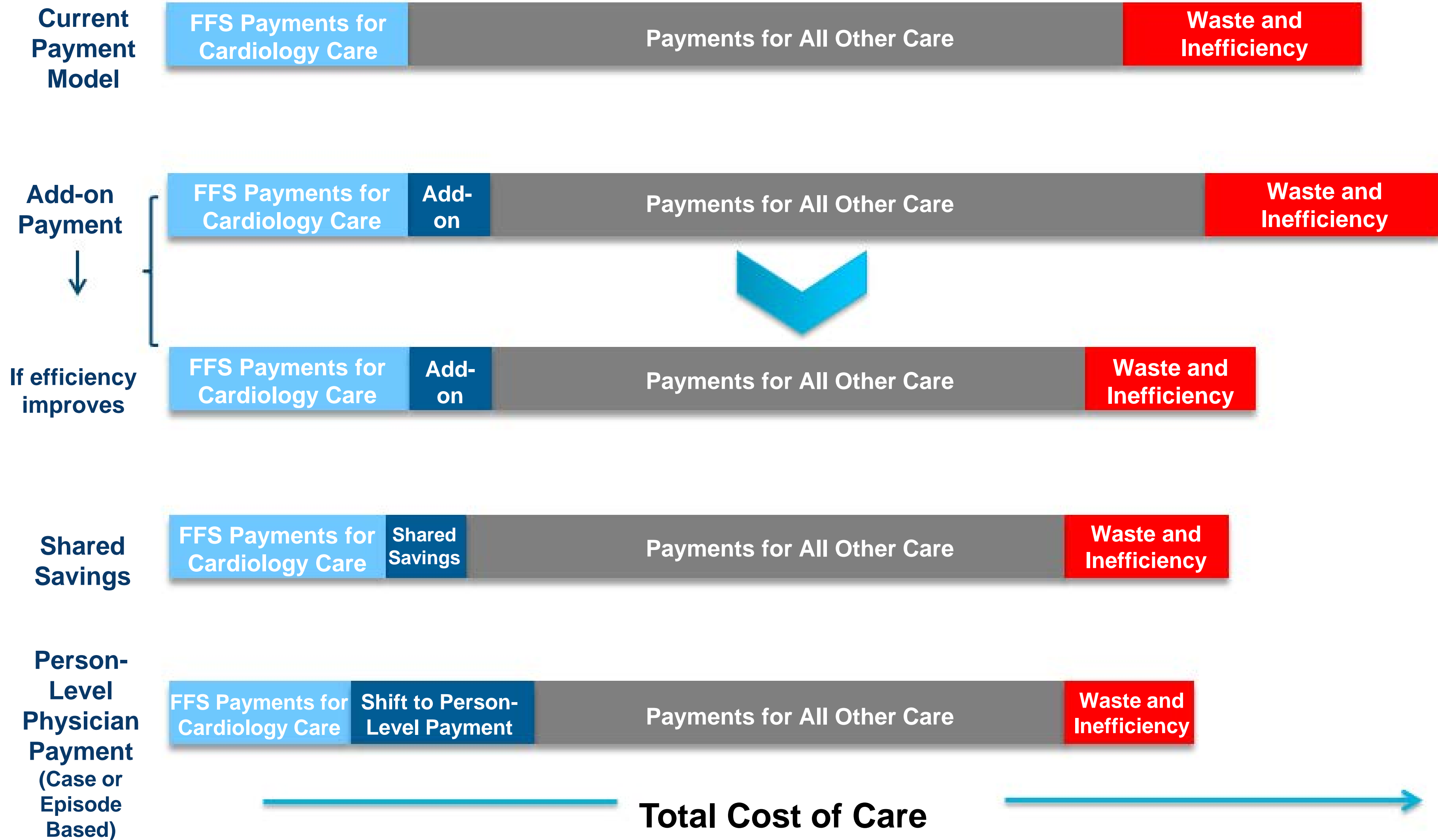
Payment Model Framework

- **Population & Stable/Chronic Disease Management**
  - Primary Care-Focused
    - Patient Centered Medical Home (PCMH)
    - Accountable Care Organization (ACO)
    - Medical Neighborhood
    - ACO including Cardiologists
  - Cardiology-Focused
    - Add-on Payment
    - Shift to Person-Level Payment (Case or Episode)
    - Shared Savings
    - Capitation
  - Team focused
    - Add-on Payment
    - Shift to Person-Level Payment (Case or Episode)
    - Shared Savings
    - Capitation
- **Acute Episode Management**
  - Major Procedures
    - Partially-Bundled Payment
    - Bundled Payment
  - Major Disease Events
    - Partially-Bundled Payment
    - Bundled Payment
- **Complex Care Management**

Payment Reforms in Cardiology Shifting Away from FFS



Payment Model Framework



Questions for Alternative Payment Model Discussions

- What should the structure of the payment models be?
- Which patient populations should be included in the models?
- How do models improve care coordination between providers, particularly PCP and Cardiologists?
- How do the models improve appropriate use of diagnostics, procedures, and/or other treatments?
- How do the models promote efficiency in care delivery?
- How should "site of service" payment differentials be addressed?
- What data and infrastructure improvements are necessary for the models to succeed?
- What quality measures are needed with the models?
- What are the key barriers to implementing the various models, especially for smaller practices and those in underserved areas?
- How feasible are the models in the short term and longer term?

DISCUSSION PERIOD: *Population & Stable/Chronic Disease*

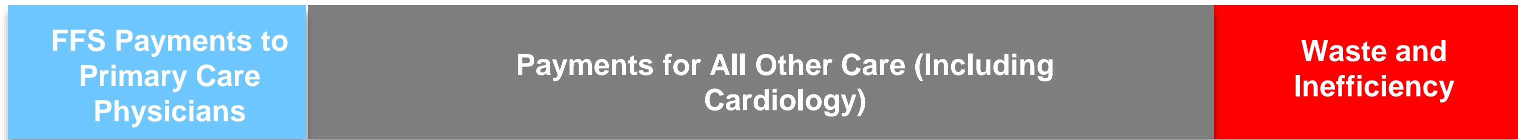
PART 1 – Primary Care-Focused

Primary Care-Focused Model(s)

- **Primary Care Payment Only**
  - No direct incentives or financial support for coordination with cardiologists/specialists
  - Savings through direct actions of PCPs
  - Selective referral/engagement with specialists who reinforce the goals of the APM
  - Models
    - PCMH
    - ACO
  - Examples
    - Iora Health
    - MA Blue Cross Blue Shield (Alternative Quality Contracts)
- **Primary Care + Cardiology Payment**
  - Some segment of specialist payment is based on quality and possibly efficiency of care
  - Cardiologists also share in overall savings with quality improvement
  - Models
    - Medical Neighborhood
    - ACO with Cardiology
  - Examples
    - Blue Cross Blue Shield of Michigan – Physician Group Incentive Program
    - Blue Cross Blue Shield of Florida ACO Program

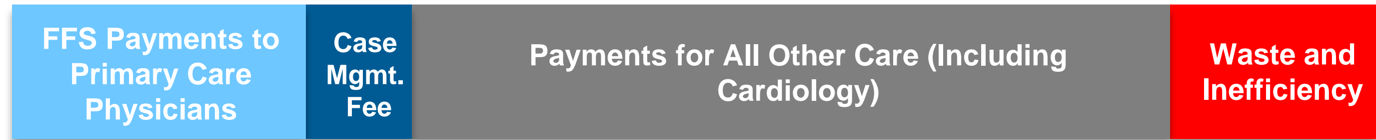
Primary Care-Focused Framework: *PCMH*

Current Payment Model

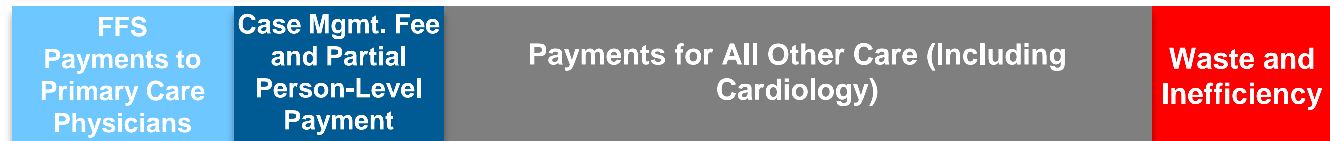


Total Physician Payment

PCMH Payment Models

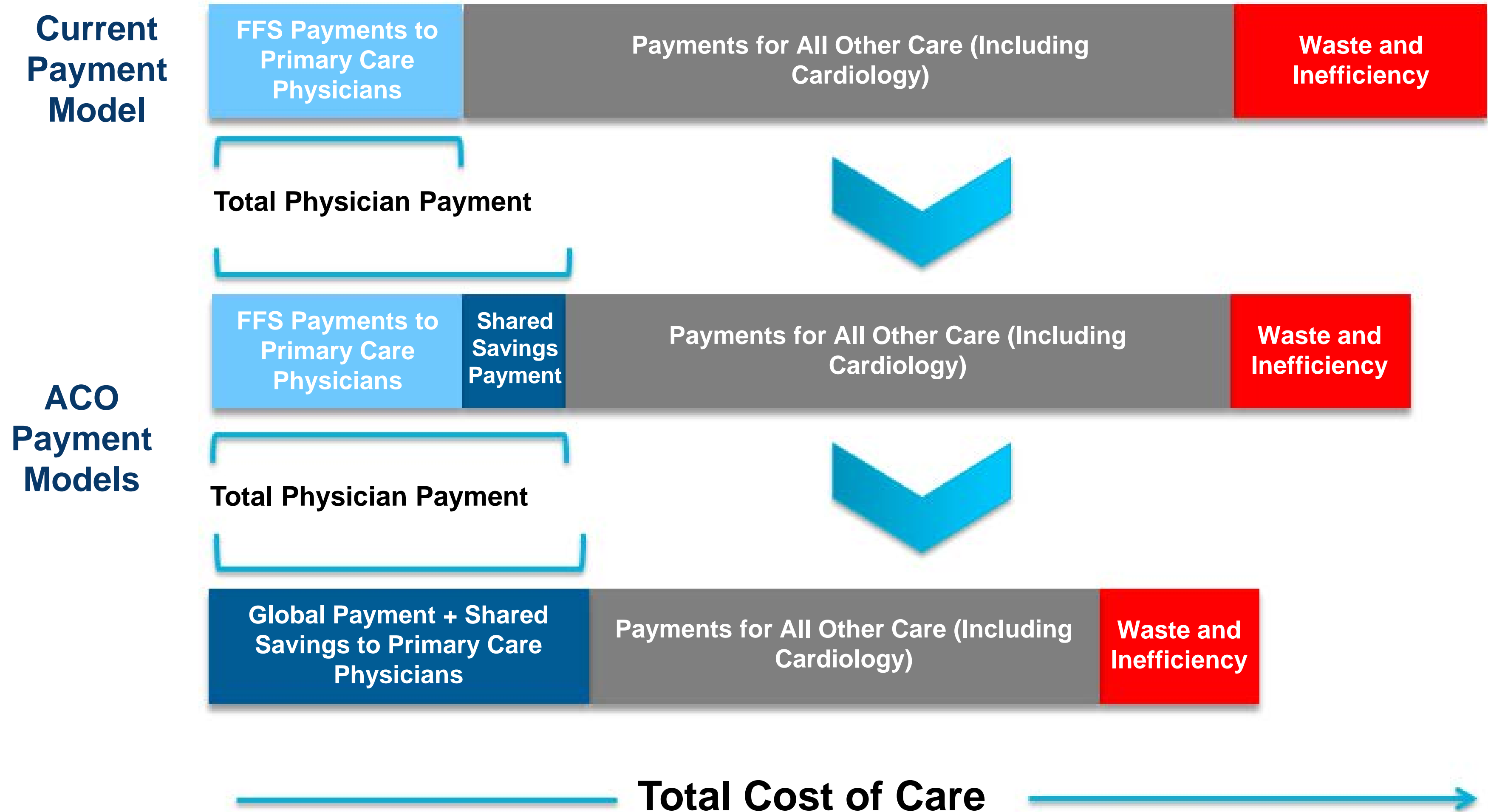


Total Physician Payment

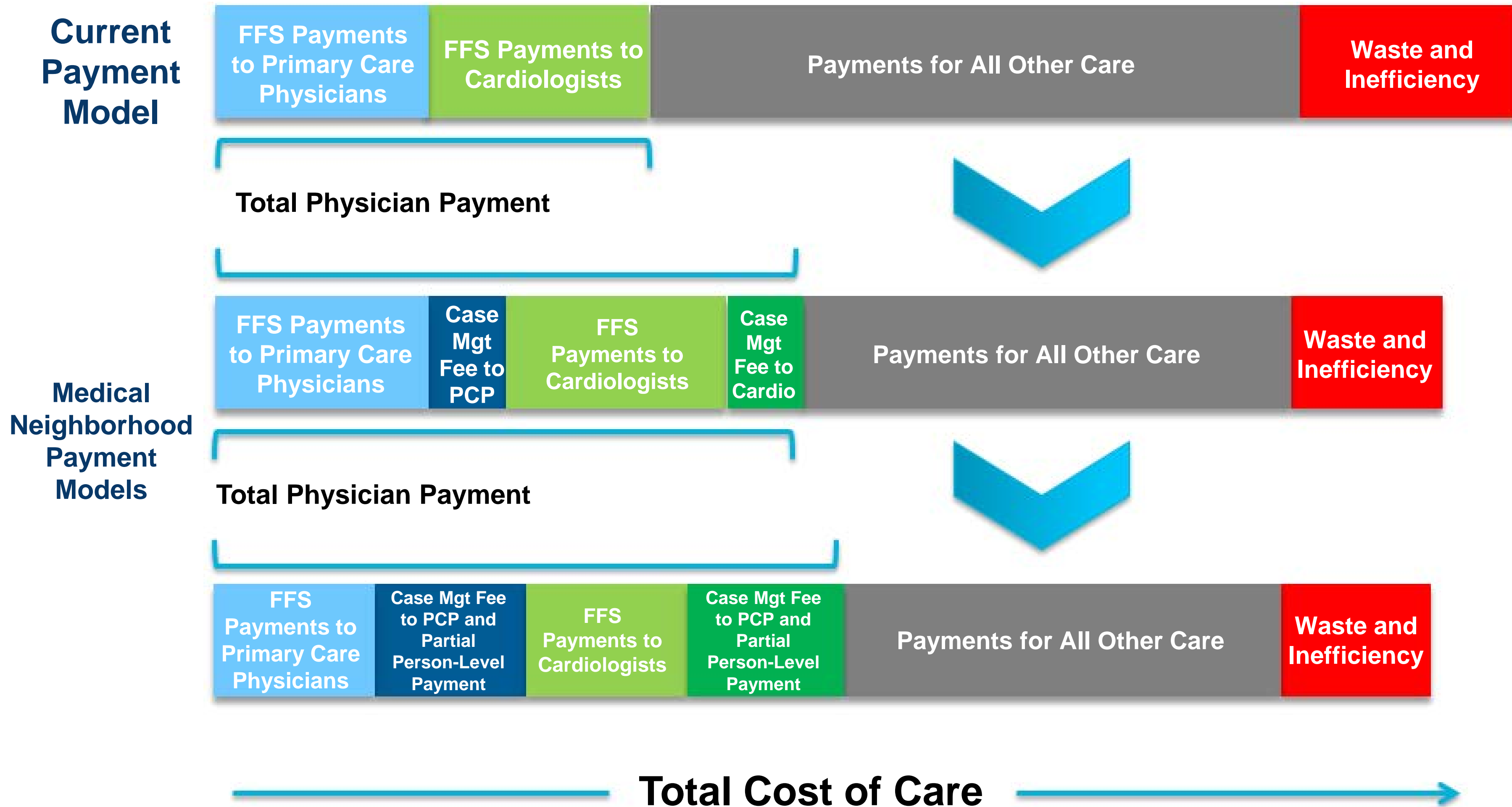


Total Cost of Care

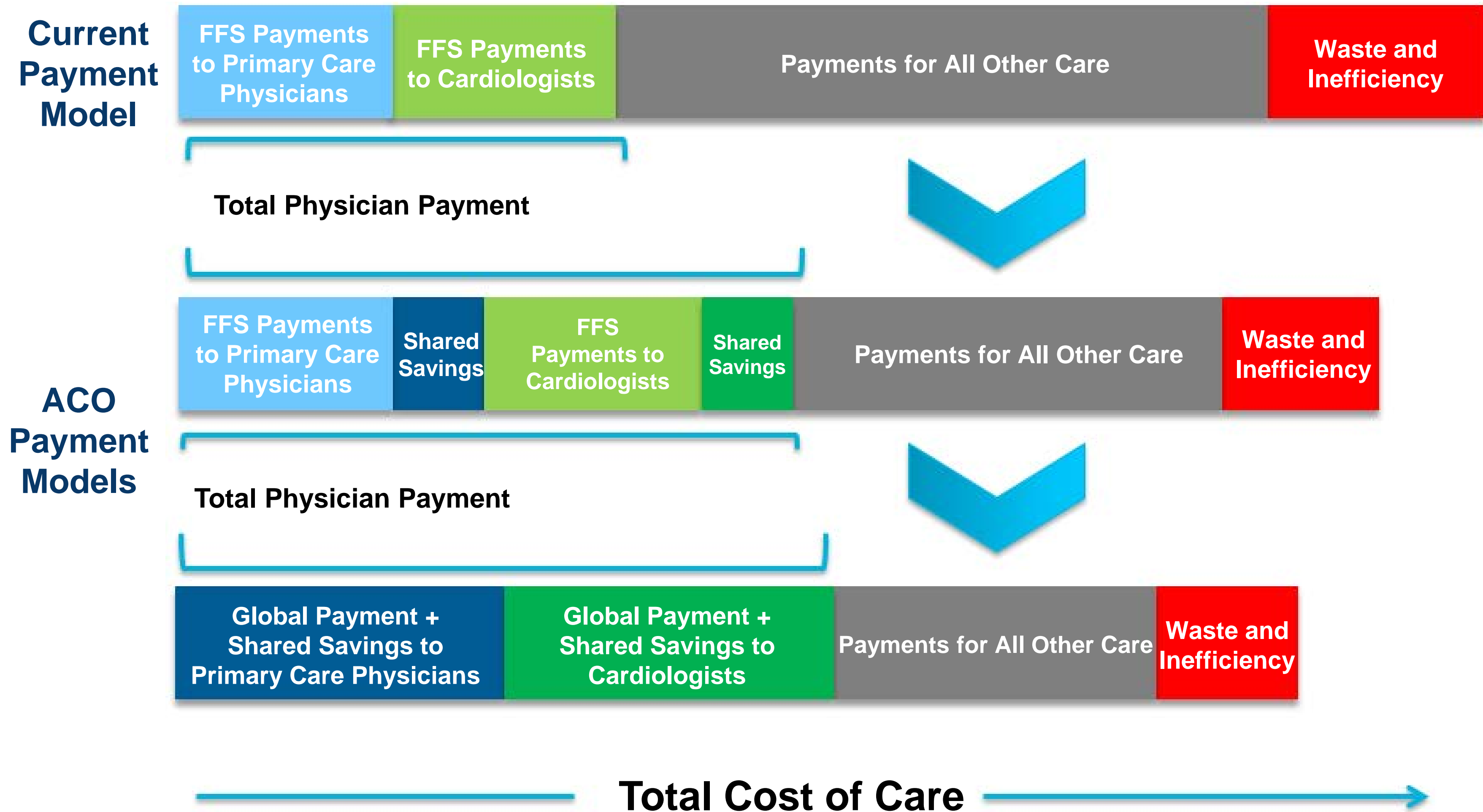
Primary Care-Focused Framework: *ACO*



Primary Care-Focused Framework: *Medical Neighborhood*



Primary Care-Focused Framework: *ACO with Cardiology*



DISCUSSION

- **What can we learn from the current PCMH/Medical neighborhood/ACO experience?**
- **What are the potential advantages for stakeholders (e.g., clinicians, patients, others)?:**
- **What conditions within cardiology can be primarily managed by a PCP?**
- **How can the models support improved coordination between primary care and cardiology?**
- **How can models improve appropriate use of diagnostic testing and/or procedures?**
- **What data and infrastructure improvements are necessary for the model to succeed?**
- **How and when should quality metrics be integrated into this model?**

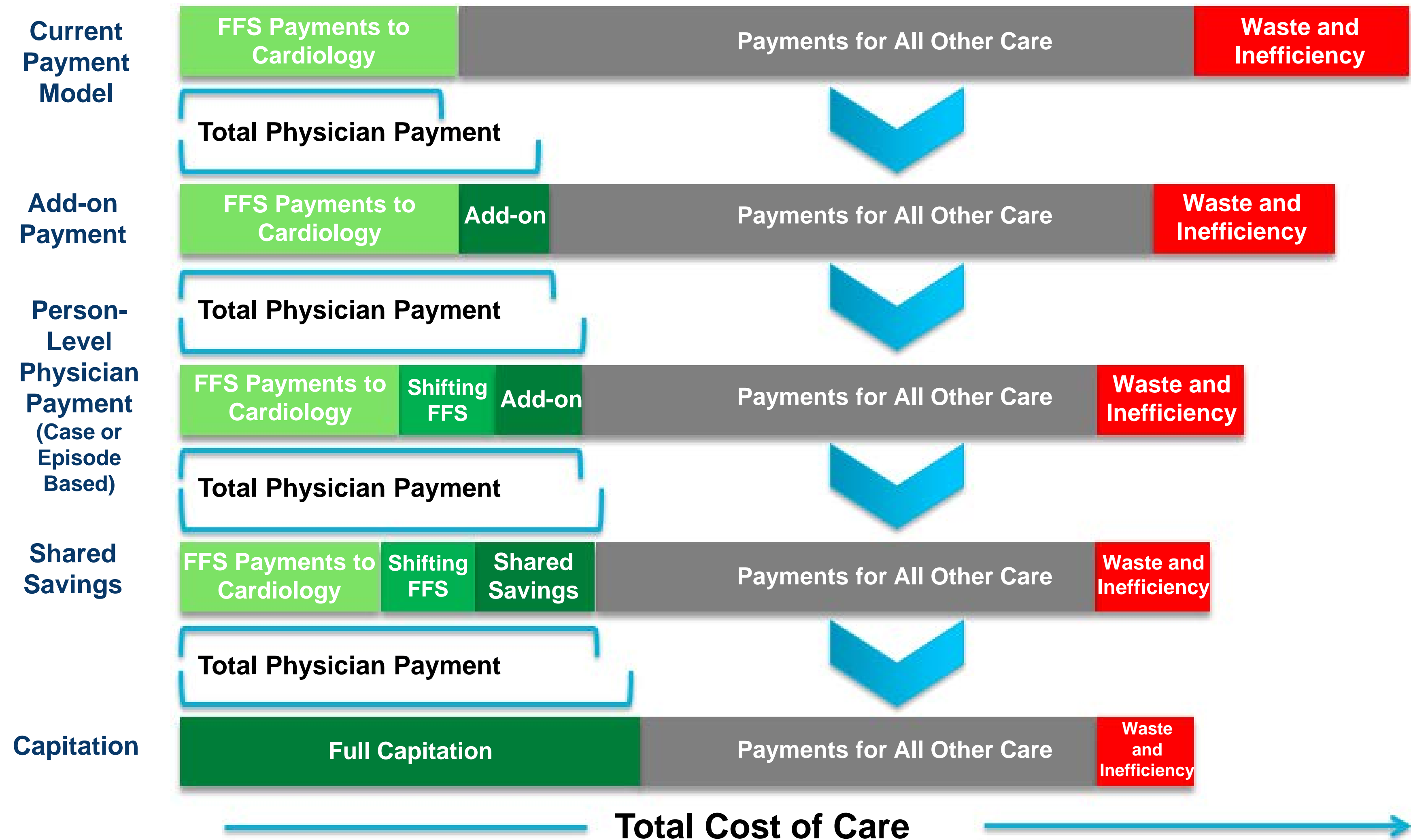
DISCUSSION PERIOD: *Population & Stable/Chronic Disease*

PART 2 – Cardiology-Focused

Cardiology-Focused Model(s)

- **Payment to cardiologists only**
- **Models**
  - Add-on payment
    - Payment for quality infrastructure such as team care, registry, decision support, data capabilities
  - Shifting FFS payments to person-level payment tied to quality (episode or case payment)
  - Shared Savings
  - Capitation
- **Examples**
  - Highmark Blue Cross Blue Shield of Delaware: Payment for EHR infrastructure and guideline adherence
  - SMARTCare: Payment for provider decision support tools, patient engagement tools and EHR capabilities

Cardiology-Focused Payment Model Framework



DISCUSSION

- How broadly can these payment reforms apply in cardiology – should some areas remain FFS?
- How much should payment reform depend on add-on fees, which types, and what is the evidence that such fees are sufficient to reduce costs?
- What diagnoses lend themselves to increased financial accountability through partial case-based or bundled payments?
- How should populations be identified for inclusion in cardiologist-led models? Should "triggers" be based on diagnosis (CHF, A Fib, CAD), and which ones, or should payments be population based?
- What are the biggest opportunities for improving appropriateness of care and efficiency?
- What data and infrastructure improvements are necessary for the model to succeed?
- What quality measures are necessary in conjunction with payment reforms?
- How can barriers to reform be addressed: lack of data and uncertainty about impact of care reforms, differences in patient mix that might be addressed through risk adjustment, etc.?

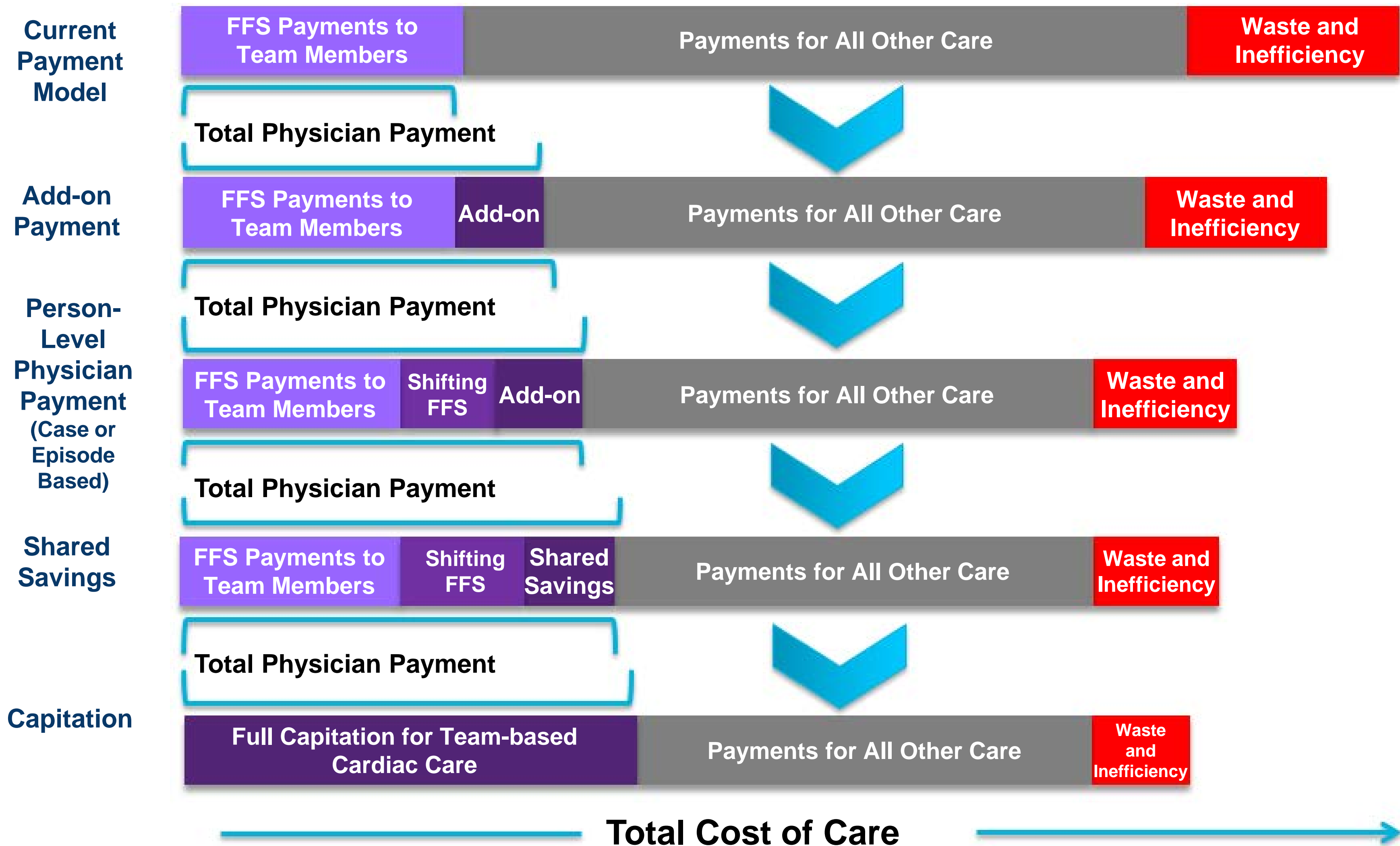
Population & Stable/Chronic Disease

PART 3 – Team-Focused

Team-Focused Model(s)

- **Multi-disciplinary team of cardiac care providers**
- **Payment for patient assessment and evidence-based care plan**
- **Models**
  - Add-on payment for care plan
  - Shifting FFS payments to person-level payment tied to quality
  - Shared Savings
  - Capitation
- **Examples**
  - STS Heart Team
  - Others (IHS, Multispecialty groups)

Team-Focused Payment Model Framework



DISCUSSION

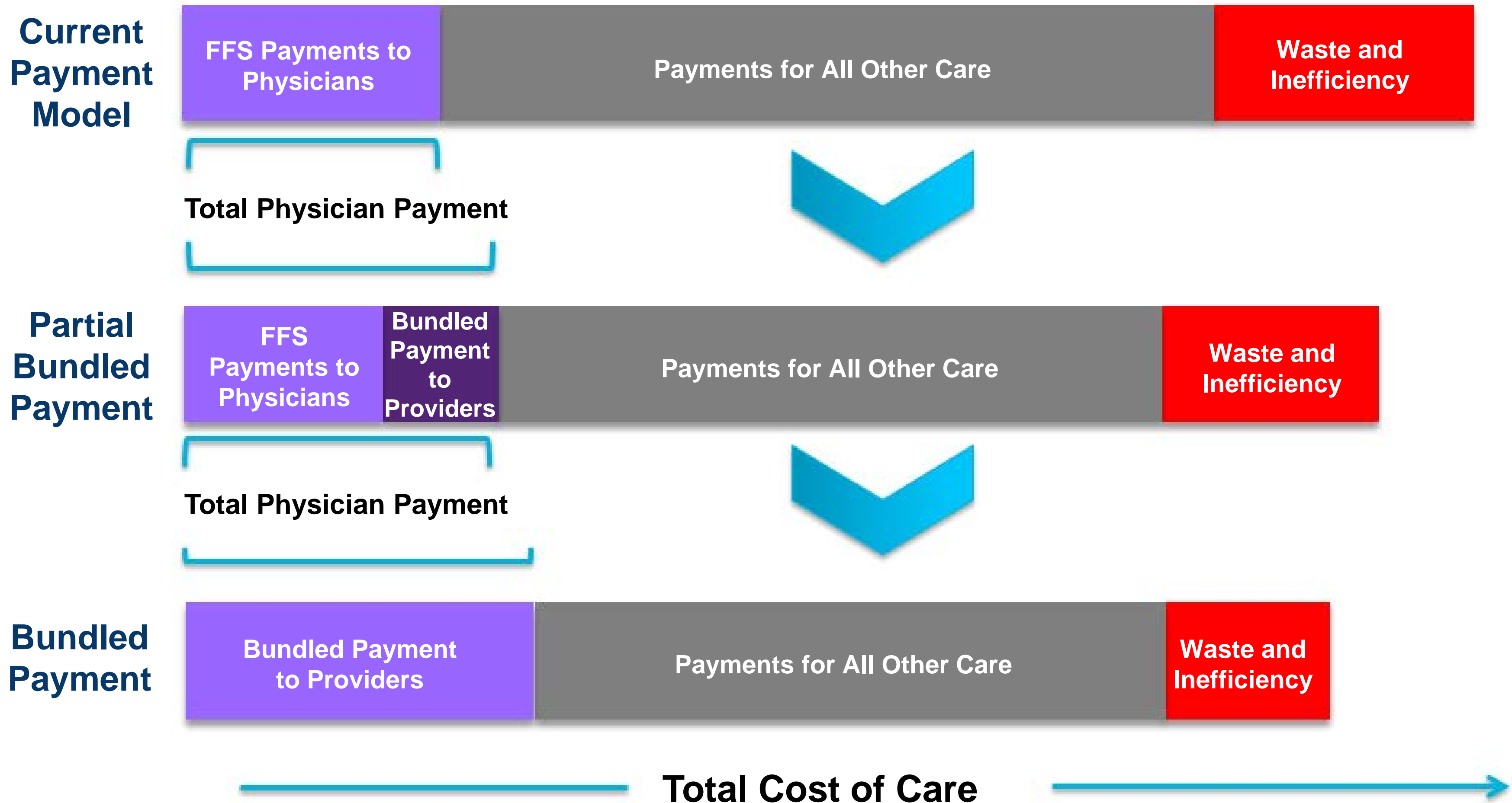
- **What are the clinical opportunities where the team model would be most applicable?**
  - What would trigger referral to the team for each clinical condition?
- **Who should be included in team payment for CAD, CHF, and A Fib?**
- **What payment structure is best to support the team model?**
  - Is an upfront payment needed?
  - Can a portion of FFS payments be shifted to the team payment?
  - How could shared savings be included?
- **How would the payment be disbursed among the team members?**
- **What is the team required to do in order to receive the payment and how would this be documented?**
- **How does the team model apply to smaller practices?**
- **How could this model complement existing models, such as ACOs, PCMHs, and Bundled payments?**
- **What data would be necessary to design this model?**
- **What quality measures are necessary?**
- **Is there a role for this model in the care of complex cardiac patients with multiple co-morbidities?**

Management Category 2: Acute Episode

Acute Episode

- **Payments for major cardiovascular events and procedures to include entire care team**
- **Most of the work in this area focuses on discrete cardiac procedures (PCI, CABG, etc)**
- **Limited application to major clinical events such as AMI or CHF exacerbation**
- **Include coordination with stable models to encourage prevention and volume control**
- **Model**
  - Bundled Payment
- **Examples**
  - Geisinger Health System *[ProvenCare]*
  - Acute Care Episode (ACE) Demonstration
  - Bundled Payments for Care Improvement (BPCI)

Acute Episode Framework: *Bundled Payment*



DISCUSSION

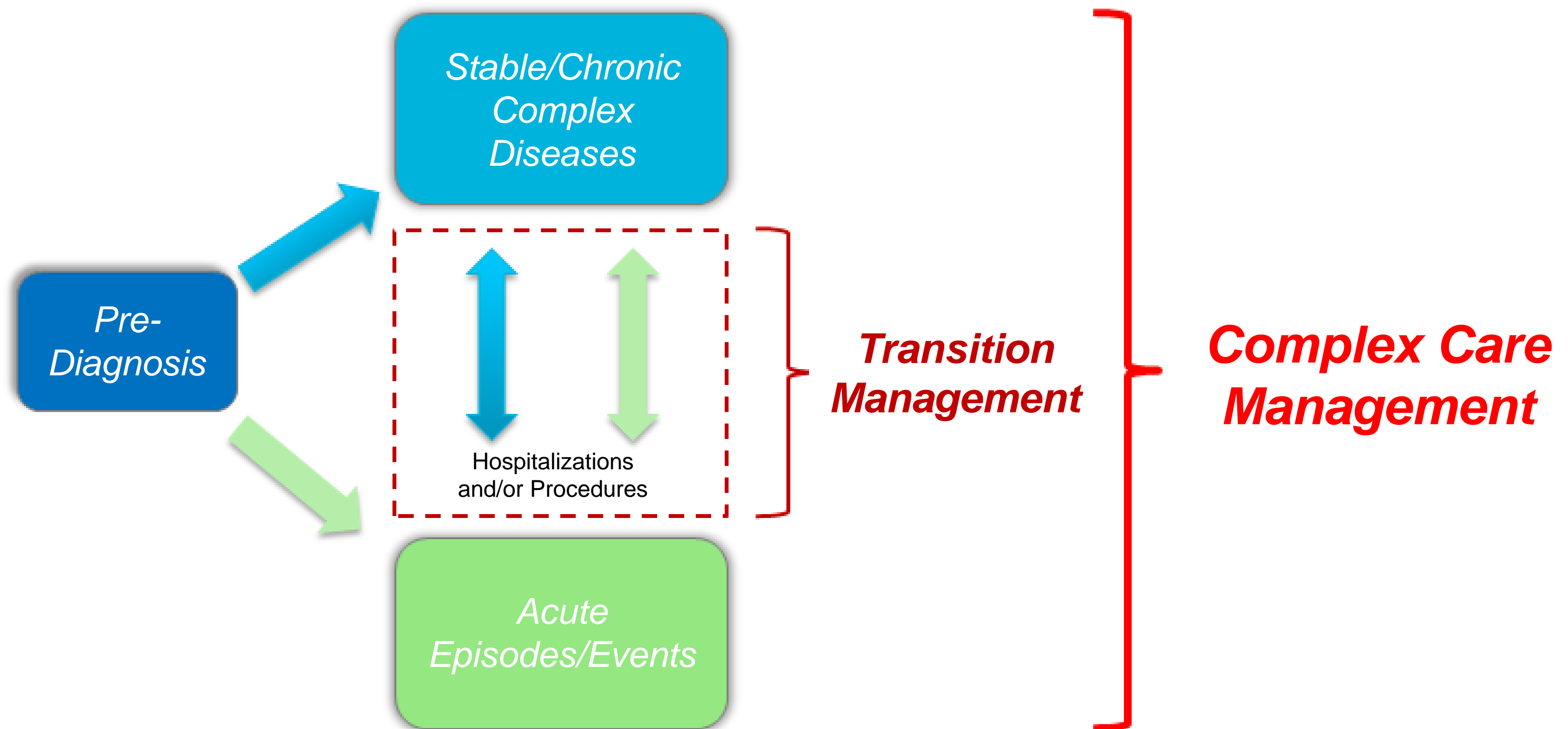
- **What opportunities are there to expand bundled payments beyond discrete procedures?**
- **How can the models support improved coordination between acute and post-acute care?**
- **How do the models ensure appropriateness of procedures?**
- **What data and infrastructure improvements are necessary for the model to succeed?**
- **What quality measures are necessary in conjunction with payment reforms?**
- **What are the barriers to implementing the various alternative payment models?**
- **What is the practicality of these reforms?**

Management Category 3: Complex Care

Complex Care Model(s)

- **Model(s)**
  - Increase financial support for specialists working with other providers to improve care and reduce costs for beneficiaries with complex medical conditions
  - Cover period of time corresponding to specialists' long term involvement with management
- **Clinical scenario(s)**
  - Higher intensity beneficiaries
  - Transitions in care between settings
  - Multiple clinician management
  - Period of instability or complexity that requires more than a single specialty or primary care practitioner
- **Examples**
  - "The Coleman Care Transitions Intervention" - Eric Coleman, MD, MPH
  - "Dual Eligible" Integrated Payments

Complex Care Environment



Clinical Example

- **Hypothetical Patient:**
  - Diabetic patient
  - Stage 2b breast cancer survivor
  - Recently evaluated for chest pain
  - Newly diagnosed with ongoing renal insufficiency (in addition to continuing cardiac symptoms)

- E.g., focus on top 5% of Medicare beneficiaries
  - Account for almost half of total health care spending
  - Almost 1/3 have 3 or more chronic conditions

DISCUSSION

- What are the clinical opportunities in the area of managing patients with multiple specialists and multiple care settings?
- What patient populations should be included, and how can they be identified to apply complex care payment reforms?
- What are the important considerations in assigning responsibility of care (e.g., co-managing specialists and/or PCP)?
- Are there models of care or potential pilots which could be implemented in community-based setting (e.g., non-integrated or capitated systems)
- How would accountability for drug utilization be factored into the payment model?
- What data and infrastructure improvements are necessary for the model to succeed?
- What quality measures should be assessed to ensure safe and effective care?
- Where are there the greatest opportunities for success and feasibility?
- What are the barriers to implementing this type of model?

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High Level Overview

TEP Review