Alternative Payment Models:
What do neurosurgeons need to know?

ACA Task Force

Joshua Aronson, MD | Elyne Kahn, MD, MPH
Analiz Rodriguez, MD, PhD | Justin Singer, MD

September 25, 2015

Contents

ACA Task Force

Overview

Overview

ACA Task Force

- Alternative payment models (APMs) are "alternatives" to the traditional fee-for-service, volume-driven health care payment model
- APMs are meant to promote and incentivize cost containment and high quality health care
- APMs are actively being developed, tested and implemented by the Centers for Medicare and Medicaid Services (CMS) and by large private payers

Alternative Payment Models (APMs)

ACA Task Force

What?

APMs are "alternatives" to the traditional fee-for-service, volume-driven health care payment model

- CMS and others have developed a “Payment Taxonomy” that places payment models into one of four categories...

CMS's "Payment Taxonomy Framework"

ACA Task Force

Category 1:
Fee-for-service with no link to quality

"Payments are based on volume of services and not linked to quality or efficiency."

Category 2:
Fee-for-service with link to quality

"At least a portion of payments vary based on the quality or efficiency of health care delivery."

Examples:
- Hospital value-based purchasing
- Physician Value-Based Modifier
- Readmissions/ Hospital Acquired Condition Reduction Program

Category 3:
Alternative payment models built on fee-for-service architecture

"Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk."

Examples:
- Accountable care organizations
- Medical homes
- Bundled payments

Category 4:
Population-based payment

"Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 year)."

Examples:
- Certain Pioneer accountable care organizations

Adapted from: Rajkumar et al. JAMA 2014

Alternative Payment Models (APMs)

Why?

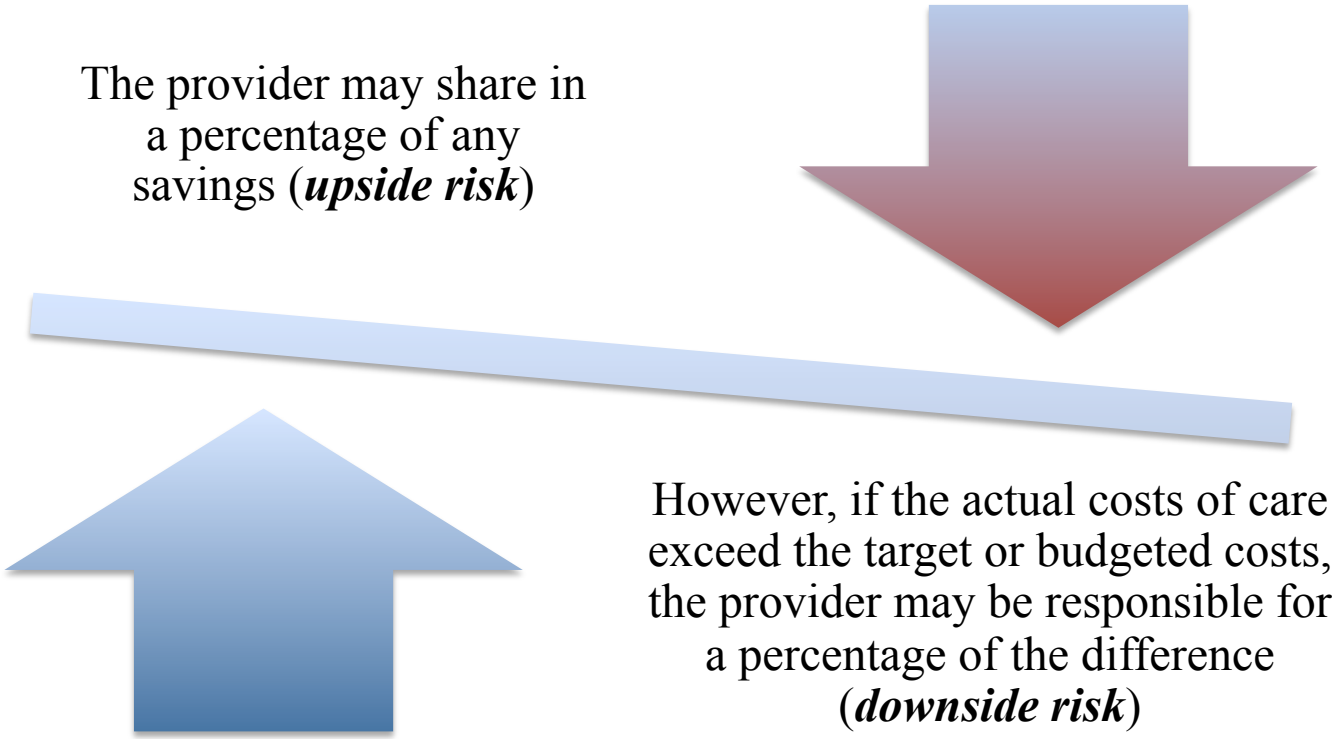
To promote and incentivize cost containment and high quality health care

- Most APMs qualify as "risk-based" payment models
  - Common theme: APMs introduce *external* motivators for providers to improve quality and efficiency of care
  - Reimbursements are often based on an *estimate* of the *expected* costs of treating a particular condition or patient population
  - The onus is on the provider to manage expected utilization and related practice expenses

“Upside” vs. “downside” risk

ACA Task Force

The provider may share in a percentage of any savings (***upside risk***)



However, if the actual costs of care exceed the target or budgeted costs, the provider may be responsible for a percentage of the difference (***downside risk***)

- Any given risk-based APM may involve upside risk, downside risk, or both

Alternative Payment Models (APMs)

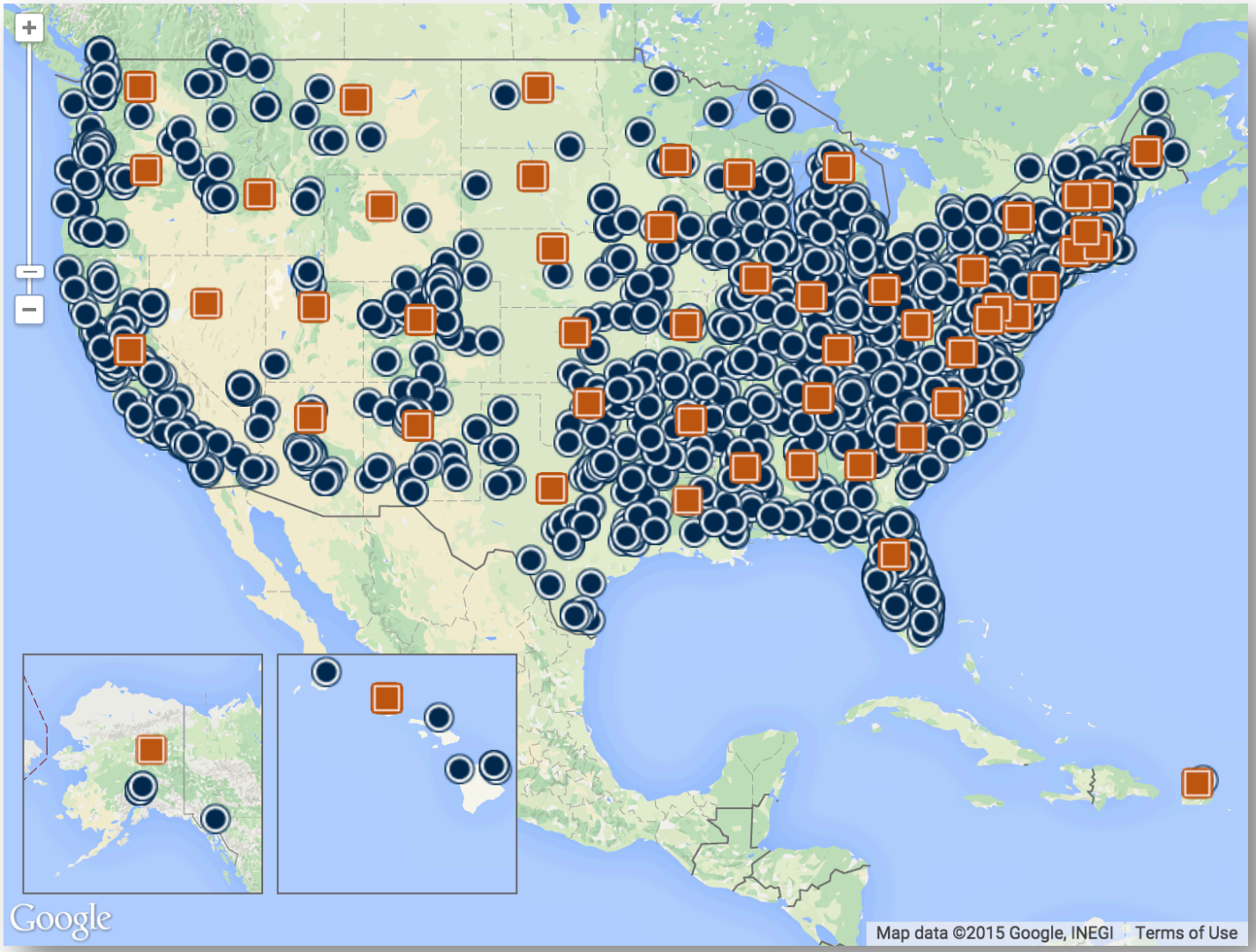
ACA Task Force

When?

APMs are actively being developed, tested and implemented by CMS and by large private payers

CMS “Innovation” Sites

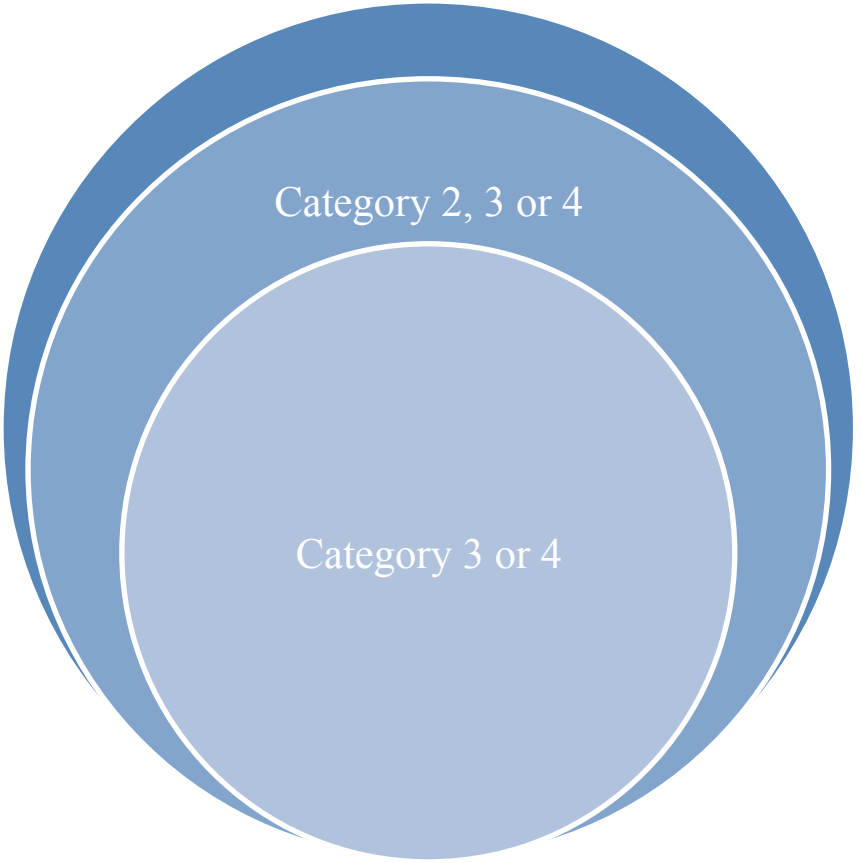
ACA Task Force



CMS's Goal

ACA Task Force

- By 2018...
  - 90% of Medicare reimbursements should be tied to quality (Categories 2, 3 or 4)
  - 50% should be associated with Category 3 or Category 4 APMs



Alternative Payment Models In Detail

Value-based Purchasing (VBP)

- Ties incentives to explicit **metrics** related to quality or value
  - **Structural measures** associated with good quality (e.g. "meaningful use" of electronic health records)
  - **Process measures** associated with what is now known to be "good" medical care (e.g. routine measurement of HgA1C in diabetics)
  - **Outcome measures** (e.g. readmission rates)
  - **Patient experience** (e.g. HCAHPS scores)

Value-based Purchasing (VBP)

- Payments may be based on...
  - Quality *attainment* or quality *improvement*
  - *Absolute* performance or *relative* performance
    - Most VBP programs pay based on relative performance (tournament style)
- By convention, organizations (hospitals) get paid and redistribute bonuses

Value-based Purchasing (VBP)

ACA Task Force

Existing programs utilize...

...to incentivize high quality, high value care

Value-based Purchasing (VBP)

ACA Task Force

- Typical sequence of VBP

Pay for Reporting

- Get providers used to collecting data
- Get providers thinking about improvement
- Establish performance benchmarks

Public Reporting

- Involve patients in performance improvement
- Establish "reputational" incentives

Pay for Performance

- Establish financial incentives for meeting benchmarks

Courtesy of A. M. Ryan

Pay-for-Performance (P4P)

- One example of VBP
- Reimbursements are tied to satisfying explicit quality measures
- Incentives are commonly in the form of bonus payments to providers (*upside risk*)
  - ...but may also involve penalization (*downside risk*)
- Limited emphasis on cost containment in pure pay for performance

Shared Savings Models

- Another example of VBP
- Involve agreements between payers and providers to provide care within specific "spending targets"
  - If the true cost of care is below the spending target, savings are shared between payers and providers
- "Savings" are typically determined retrospectively
  - Participating provider's spending is compared with that of other non-participating providers
  - If participant's spending has decreased by more than spending by other providers (or if spending has increased more slowly than it has for other providers), the participant is eligible for a bonus payment

Shared Savings Models

ACA Task Force

- Note:
  - Spending by other providers may have been in the absence of payment reform and possibly in the context of a very different patient mix
  - Each Shared Savings Program contract will specify exactly how savings are calculated and distributed. Providers should consider the length of the contract because the shared savings may diminish over time

Bundled Payments

ACA Task Force

- A group of health care providers (hospitals, physicians, other professional health care providers) share ***one prospective payment*** for a specified range of services associated with an "episode of care" (based on DRGs)
- Goal: reduce unnecessary utilization and control costs by encouraging coordination of services among providers
- Spine surgery is an early target of bundled payment initiatives

Bundled Payments

ACA Task Force

- The risk taken on by the provider is that a patient may utilize additional or higher-cost services resulting in a total cost of care that exceeds the bundled payment
  - Total cost may vary based on comorbidities, complications, and post-discharge hospital readmission

Bundled Payments

ACA Task Force

- Considerations
  - A neurosurgeon participating in a bundled payment model will need to negotiate with the collaborating hospital and other providers for an appropriate share of the payment
  - Special attention should be paid to how risk adjustment factors will be calculated and applied
  - Understand that emphasis is on reducing costs, rather than rewarding quality
  - Relies on improving processes, connectivity and communication among multiple care providers and organizations

SPECIAL CONSIDERATIONS FOR NEUROSURGEONS

Special Considerations for Neurosurgeons

ACA Task Force

- APMs are targeting the most common (and therefore most expensive) neurosurgical conditions
  - i.e. stroke and degenerative spine disease
- APMs will be less able to support expensive disposable and implantable equipment
  - i.e. endovascular procedures and spine instrumentation
- High-quality data collection and research on outcomes and cost-effectiveness will be necessary to justify our work
  - e.g. validation of efficacy of IA thrombolysis, spinal fusions
  - Registries like N^2QOD and Neurovascular Quality Initiative (NVQI) will be important tools

Managing Risk in a Risk-Based Contract

- A provider can mitigate risk by incorporating means to identify, assess, and manage risk:
  - **Technology systems** to aid in streamlining administrative operations (i.e., registries, callback systems, data systems)
  - **Data mining** to measure performance and identify areas of risk, including outliers, patient demographics, and risk factors

Selected References

ACA Task Force

- Miller, Harold D. “The Building Blocks of Successful Payment Reform: Designing Payment Systems that Support Higher-Value Health Care.” Network for Regional Healthcare Improvement’s Payment Reform Series No. 3 (2015)
- Dupree, James M., et al. "Attention to surgeons and surgical care is largely missing from early Medicare Accountable Care Organizations." Health Affairs 33.6 (2014): 972-979.
- Issar, Neil M., and A. Alex Jahangir. "The Affordable Care Act and Orthopaedic Trauma." Journal of orthopaedic trauma 28 (2014): S5-S7.
- McGirt, Matthew J., et al. "The National Neurosurgery Quality and Outcomes Database (N2QOD): general overview and pilot-year project description." Neurosurgical focus 34.1 (2013): E6.
- Meehan, Timothy M., et al. "Accountable Care Organizations: what they mean for the country and for neurointerventionalists." Journal of neurointerventional surgery (2015): neurintsurg-2015.
- Ugiliweneza, Beatrice, et al. "Spinal surgery: variations in health care costs and implications for episode-based bundled payments." Spine 39.15 (2014): 1235-1242.
- Thorpe, Ken. "Reforming How We Pay For Health Care: The Role Of Bundled Payments." Health Affairs Blog. Health Affairs (2012).
- Cromwell J, et. al. “Pay For Performance in Health Care: Methods and Approaches.” Research Triangle Institute. (2011)