Payer’s Perspective on Clinical Pathways and Value-based Care
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Dr. Perkins has nothing to disclose.
Learning Objectives

• Understand the opportunities of using clinical pathways and value-based design in an Integrated Delivery and Finance System (UPMC Health Plan)

• Examine the benefits of a payer-provider relationship in setting clear goals and expectations in value-based payment

• Determine how to optimize total cost of care, quality, and patient satisfaction in effectively implementing clinical pathways and a value-based plan
Case Study: UPMC Health System

Over 20 years ago, UPMC Health System launched an integrated delivery and finance system to respond to increasingly complex care and needs for the communities it served. The strategy focused, and continues to focus, on:

• Improving the health of the communities
• Implementing cost-effective solutions
• Providing service excellence
• Innovating care and payment
• Leveraging our unique structure to partner with all stakeholders: community providers, patients, members, and employers
Supporting Our Vital Mission, Controlling Our Own Fate

UPMC’s History of Proactive Transformation

- **1980s**: Built Academic Medical Center with University of Pittsburgh
  - Clinical proceeds to reinvest in academic excellence

- **1990s**: Created Integrated Health Care System
  - Merged Regional Hospitals & Employed Community Physicians
  - Increasing market share to secure economic efficiency and scale

- **2000s**: Entered Insurance Market To Become Payer-Provider
  - Initiated International & Commercial Ventures
  - Diversification to protect our base

- **2010s to future**: Continued Market Leadership

Staying Ahead of Market Challenges

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UPMC Today

65K employees

$14B Integrated Global Health Enterprise

Insurance Services
- 3M+ members
- Top ranked quality
- 11,000 employers
- 4.5 Star Medicare
- $7+B Premium

Health Services Division
- 25+ hospitals
- 600+ outpatient locations
- 5,700 affiliated physicians
- Ranked #12 U.S. News World Report

UPMC Enterprises

UPMC International Services
- 20+ countries
- Transplant Hospital: Italy
- Advisory Services: British Columbia, Kazakhstan, China, Lithuania
- Cancer Services: Ireland

Affiliated with the University of Pittsburgh

Research: #5 in NIH funding ($475 million)
Training: 1,800 residents and fellows
Innovation Drives Company Growth

UPMC Insurance Services

- MyFlex Advantage
- UPMC Health Plan
- UPMC for Life
- UPMC for Life Special Needs
- UPMC for You
- UPMC for Kids
- UPMC Vision Advantage
- UPMC Dental Advantage
- Community Care Behavioral Health
- Workers’ Compensation Solutions
- UPMC WorkPartners
- EAP LifeSolutions

UPMC Products

- Commercial Products
- Medicare Products
- Medicaid Products
- Behavioral Products
- Health & Disability
- Ancillary Products

Cost
Experience
Quality
Innovation Laboratory

Large Network Anchored by UPMC

Innovation Lab

UPMC Clinical Enterprise

UPMC Health Plans

Contracted Network and Partners

More than 3.2 million members strong
UPMC HP Evolution to Alternative Payment Models (APMs)

- Start Small
  - Engagement
  - Shared savings
  - Limited geography/risk

- Evolution
  - Climb the stairs
  - Early quality and financial wins encourage transformation
APM Framework

**Category 1**
Fee for Service, No Link to Quality & Value

**Category 2**
Fee for Service, Link to Quality and Value Performance

**Category 3**
APMs Built on Fee-For-Service Architecture

**Category 4**
Population-based Payment
## UPMC Programs in the APM Framework

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<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<tr>
<td>Fee-For-Service</td>
<td>A</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>2008 First Patient Centered Medical Home</td>
<td>A - Fundamentals Payments for Infrastructure &amp; Operations</td>
<td>C - Rewards for Performance</td>
<td>A - APM’s with Upside Gainsharing</td>
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<td>B - Pay for Reporting</td>
<td>D - Rewards and Penalties for Performance</td>
<td>B - APM’s with Upside Gainsharing / Downside Risk</td>
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<td>2009 Hospital Partners Program</td>
<td>10/1/16 OCM Project (Year One)</td>
<td>1/1/17 Total Joint Bundle</td>
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<td>2009 UPMC P4P Program</td>
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<td>1/1/18 100% Professional Capitation</td>
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<td>1/1/19 Global Capitation</td>
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<td><strong>B</strong> - Comprehensive Population – Based Payment</td>
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</table>

### APM’s with Upside Gainsharing
- 7/1/11 Shared Savings
- 7/1/13 Total Joint Bundle
- 1/1/15 Spine Bundle
- 3/1/17 OB Bundle
- 3/1/17 Post-Acute Bundle
- 2012 UPMC High Value Care for Kids

### Comprehensive Population – Based Payment
- 1/1/18 (Year 2- ) OCM Project
UPMC Health Plan Bundle Payment History

**Total Joint Bundle**
- Since July 2013
- Focused on hips and knees
- 30 days pre and 90 days post

**Spine Bundle**
- Since January 2015
- Focused on cervical and lumbar
- 90 days post

**OCM Bundle**
- Since October 2016
- Provide oncology practice with an infrastructure support fee
- Monitors and reports total cost of care for patients

**OB Bundle**
- Since 2017
- Focused on mothers and normal newborns
- 270 days pre and 30 days post
Overview: Oncology Care Model (OCM)

Why Participation by UPMC HP?

• CMS-CMMI specialty alternative payment model for cancer chemotherapy treatment
  – Improve quality, efficiency of care
  – Improve care coordination and unplanned care
  – Address end-of-life care management
  – Decrease overall total cost of cancer care
  – Monitor adherence to best practices and outcomes from chemotherapy

CMS = Centers for Medicare & Medicaid Services; CMMI = Center for Medicare and Medicaid Innovation.
Overview: OCM (Cont’d)

CMS Medicare FFS

- 5-year model, started 7/1/16
- 6-month episodes with initiation of chemotherapy (can recur)
- Care coordination fee paid for each episode, no limit to episodes
- Clinical quality metrics for utilization, hospice management, incorporation of patient functional outcomes (pain, depression, etc)
- Effectiveness of treatment measured via clinical registry of pathway adherence and outcomes
- All types of cancer using IV or PO chemotherapy
- Phase in of +/- risk

FFS = fee for service; IV = intravenous; PO = oral.
Overview: CMS Practice Requirements

• CMS FFS emphasis on comprehensive care plan; requirements include:
  – Provide every patient with advanced care plan
  – Provide every patient with survivorship plan
  – Provide every patient with an estimate of the total costs of care and out-of-pocket expenses
Private payers invited to join as collaborators
- CMS recognition of difficulty to be in traditional FFS and alternative payment at the same time
- Encouraged to mirror features and metrics
  - Flexible for selection of quality metrics, lines of business, and payment of care coordination fee
  - CMS request to not add administrative burden
- Private payers do not participate or receive data from registry
- Comprehensive Care Plan/Survivorship and personalized cost estimate not required
Alignment with UPMC Cancer Center

• One of the largest integrated community networks of cancer care specialists in the country
• Provides cancer prevention, detection, diagnosis, and treatment
• Partners with University of Pittsburgh Cancer Institute
• Ranked 5th in NIH funding among all universities
• Comprises academic and research activities for UPMC and the University of Pittsburgh
UPMC Cancer Center

• One of the most extensive clinical cancer programs in the world, and one of the largest oncology networks in the country
  – Over 74,000 individuals treated each year
  – 50+ network sites, including collaborations overseas

• Hub and satellite—centralization of specialized/complex offerings and inpatient activity

• Standard care pathways, technology, and policies allow for uniform standards of care throughout our network

• Commercial initiative incubator including:
  – Via Oncology Solutions
  – UPMC International
UPMC Care Pathways: Alignment with Clinical Pathways of Via Oncology

- Clinical pathways utilized through nationally recognized guidelines
- Evidence-based decision support algorithms for medical oncology drug treatment, work-up, diagnostics/biomarkers, surveillance, symptom management, and palliative care
- Covers 90% of cancer types including common cancers, hematologic malignancies, and rare tumor types
- Integrated approach with UPMC Health Plan during and after guideline development
- >85% pathway adherence
Oncology Hematology Associates (OHA), Pittsburgh, PA

- 47-physician oncology group covering Western Pennsylvania
  - 19 offices, rural and urban coverage
- Annual new office visits (FY 2016) – 9,680
- Annual Return Office visits (FY 2016) – 100,814
- 26% of patient visits are UPMC health plan members
Overview: OHA Oncology Chemotherapy

- The number of new patients initiating treatment every 6 months only varied significantly for breast cancer patients.
- 45% of all patients diagnosed with cancer were within one of the Medicare lines of business.
- The median length of treatment regardless of type of diagnosis was 7 months.
- The average total cost of care regardless of diagnosis was over $100,000.

From June 2010 to June 2015—6,685 patients with cancer diagnoses were treated at OHA.

The 5-year total cost of care for cancer patients treated at OHA was over $670 million.

- Self Insured (ASO) and Commercial Fully Insured (CM FI) were the most costly health plans in terms of both median cost per member during the entire study period at $69,000 and $63,000, respectively.

Cost breakdown:
- Chemotherapy (48%)
- Surgery (25%)

28% of patients had a primary diagnosis of breast cancer, followed by 12% with lung cancer, and 11% with lymphoma.
UPMC Health Plan collaboration with CMS FFS

• Benefits of Pilot Participation
  – Aligned with health plan strategic goals for increase in value-based payments and transformed health care
  – Improves care coordination and unplanned care
  – Addresses patient engagement and patient functional outcomes
  – Specialty-based model advances specialist physician engagement
  – Leverages established relationships within integrated delivery and financial system
  – Minimizes provider difficulties of being in traditional FFS at the same time as alternative payment system
Care Management Plan

- Provides information on diagnosis and specific staging, biomarkers, treatment goals, plan benefits and harms
- Additional IOM requirements added to include:
  - Estimated total and out-of-pocket costs
  - Advanced care plans
  - Addressing psychosocial needs

IOM = Institute of Medicine.
Enhancement of Advanced Care Planning

• In collaboration with UPMC Palliative and Supportive Care Institute
  – For consultation and care plan development
  – Direct training of specialists in advanced and palliative care with patient, family, and other care providers
• Incorporates triage training, advance care planning, and crucial conversations to facilitate hospice and palliative discussion early in treatment
Cost Savings Opportunities: Managing the Total Cost of Care (TCOC)

- Consistent use of clinical pathways during work-up and treatment
- Symptom management
- Extended access
- Decrease in unplanned care services
  - Emergency department
  - Unplanned admissions/observation care
  - Urgent care
- Improved coordination of care among specialists/PCP in patients with multiple chronic conditions

PCP = primary care physician.
Benefits to Healthcare Consumers

- Improved health outcomes due to physician’s consistent use of decision-support tools
- Reduced hospitalizations and emergent/urgent care
- Improved transition of care
- Shared decision making with the patient
- Increased engagement in preventive health services, health risk management, and wellness
- Improved patient satisfaction in care
UPMC Implementation of OCM

- All lines of business and populations
- Year 1: unlike CMS, include all chemotherapy patients (not limited to new starts)
- Infrastructure support fee:
  - *Once* per unique member
  - $960 PM fee paid in 2 installments: $720 at episode trigger and the remainder on attainment of performance metrics
  - Elected 1-time fee per member (instead of per member per month fee - PMPM)
- Quality Metrics Performance Period: 1 full calendar year followed by typical claims run out

PMPM = per member per month.
Data-driven Healthcare: Early Actionable Reporting

- Market-leading analytics drive UPMC innovation
- UPMC payer-provider model and scale offers valuable source of data
- Aligns with our providers for real time reporting—actionable information to the practicing provider
- Close collaboration and integration assist in predictive modeling and reporting
Real-time and Monthly Reporting

• Automatic Data Transmission (ADT - real-time) feeds provided to practices of members presenting to the ED but discharged or admitted under another service

• Monthly reports
  – Financial: Total cost of care
  – Clinical
    ▪ Comorbidities identified
    ▪ Unplanned care use
    ▪ Serious Mental Illness
  – Key Performance Indicators (KPIs)
    ▪ Admits
    ▪ ED visits
    ▪ Readmission rates
    ▪ Total PMPM costs

ED = emergency department.
Clinical Quality of Cancer Care

• Multiple areas of focus on the enhancement of quality care
  – Use of Via Oncology Pathways and decision support software
  – Measurement and provision of required CMS and internal metrics
  – Use of ARIA EHR software
  – Incorporation of PROMIS tool into care: multidisciplinary approach (anxiety, depression, fatigue, physical function, pain interference)
  – Participation in QOPI—oncologist led quality-based practice improvement program

HER = electronic health record; QOPI = Quality Oncology Practice Initiative.
UPMC Implementation: Clinical Quality Metrics

• 2 categories:
  – Subject to withhold
  – Quality monitoring/informational only

• Performance period: 1 full calendar year (dates of service)
  – Differs from CMS
  – Emphasized importance of coordinating with PCP and opportunity to avoid unplanned care after chemotherapy

• ISF Year 1 payment
  – Must meet/exceed All Cause Hospital Admission measure and meet or exceed at least 5 of remaining 6 Quality Goals
  – Subsequent years must meet all
<table>
<thead>
<tr>
<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>Proportion of patients with all-cause hospital admissions within a 6-month episode</td>
</tr>
<tr>
<td>Proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode</td>
</tr>
<tr>
<td>Oncology: Medical and Radiation-Pain Intensity Quantified</td>
</tr>
<tr>
<td>Oncology: Medical and Radiation—Plan of Care for Pain</td>
</tr>
<tr>
<td>Proportion receiving chemotherapy in the last 14 days of life</td>
</tr>
<tr>
<td>Proportion of patients who died who were admitted to hospice for 3 or more days</td>
</tr>
<tr>
<td>Screening for depression and follow-up plan</td>
</tr>
</tbody>
</table>
## All-cause Admissions and All-cause ED Alternate Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients with all-cause hospital admissions within a 6-month episode (OCM-1)</td>
<td></td>
</tr>
<tr>
<td>All-cause hospital admissions within a 6-month episode (per 1,000 member months)</td>
<td></td>
</tr>
<tr>
<td>Proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode (OCM-2)</td>
<td></td>
</tr>
<tr>
<td>All-cause ED visits that did not result in a hospital admission within the 6-month episode (per 1,000 member months)</td>
<td></td>
</tr>
</tbody>
</table>

*OCM* stands for *Outcome Cost Management*. This table highlights measures used to evaluate healthcare outcomes, specifically focusing on hospital admissions and ED visits.
## Quality and Efficiency Metrics for Informational Purposes

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days in hospice</td>
<td></td>
</tr>
<tr>
<td>Proportion in hospice</td>
<td></td>
</tr>
<tr>
<td>Proportion receiving chemotherapy in the last 30 days of life</td>
<td></td>
</tr>
<tr>
<td>Proportion receiving chemotherapy in the last 90 days of life</td>
<td></td>
</tr>
<tr>
<td>Proportion with at least 1 ED visit in the last 30 days of life</td>
<td></td>
</tr>
<tr>
<td>All-cause ED visits that did not result in a hospital admission during the last 30 days of life</td>
<td></td>
</tr>
<tr>
<td>Number ICU days during the last 90 days of life</td>
<td></td>
</tr>
<tr>
<td>Proportion admitted to the ICU in the last 30 days of life</td>
<td></td>
</tr>
<tr>
<td>Mean total cost of care (PMPM)</td>
<td></td>
</tr>
<tr>
<td>Mean total cost of care last 90 days of life (PMPM)</td>
<td></td>
</tr>
</tbody>
</table>

ICU = intensive care unit.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of members in hospice</td>
<td>n=66</td>
<td>n=112</td>
</tr>
<tr>
<td>Proportion receiving chemotherapy in the last 30 days of life</td>
<td>n=27</td>
<td>n=112</td>
</tr>
<tr>
<td>Proportion receiving chemotherapy in the last 90 days of life</td>
<td>n=64</td>
<td>n=112</td>
</tr>
<tr>
<td>Proportion admitted to the ICU in the last 30 days of life</td>
<td>n=6</td>
<td>n=112</td>
</tr>
<tr>
<td>Proportion of members with 2 or more ED visits in the last 30 days of life</td>
<td>n=6</td>
<td>n=112</td>
</tr>
</tbody>
</table>
OCM Sample Reporting: Total Episodes, Percentage of and TCOC

Breast Cancer - Commercial Percentage of Spend

- Hematology Oncology Drugs: 44%
- Other: 21%
- Radiology Therapy: 8%
- High Tech Radiology: 6%
- Inpatient: 5%
- Chemo Admin: 4%
- Non Hematology/Oncology Drugs: 4%
- Non Chemo Admin: 3%
- Diagnostic Lab: 2%
- RX Non-Chemo Drugs: 2%

Total: 100%
Progress to Date

• Officially started Oct 1, 2016
• Confirmed roster of patients from initial months
  – Created draft annual report from 2015 data
  – Collaborative process to ensure data meaningful and to refine monthly reports
• Quality data from EHR
• Practices reorganizing workflows to incorporate quality metrics, such as depression screening
• Incorporating all lines of business required increased evaluation for quality, metrics, and reporting
Oncology Care Model and MACRA

- Final MACRA rule, OCM with downside risk as advanced alternative payment model in 2017
  - *Models without downside risk would qualify as MIPS APM*
- UPMC Health Plan evaluating introduction of downside risk in contract year 3 (Oct 2018)
  - *Potential qualifier as “other payer advanced APM” in contract year 3 (2019 data year)*

MACRA = Medicare Access and CHIP Reauthorization Act of 2015; MIPS = merit-based incentive payment system.