Changing Tack or Staying the Course? The Politics of Value-Based Payment

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Network for Excellence in Health Innovation (NEHI)
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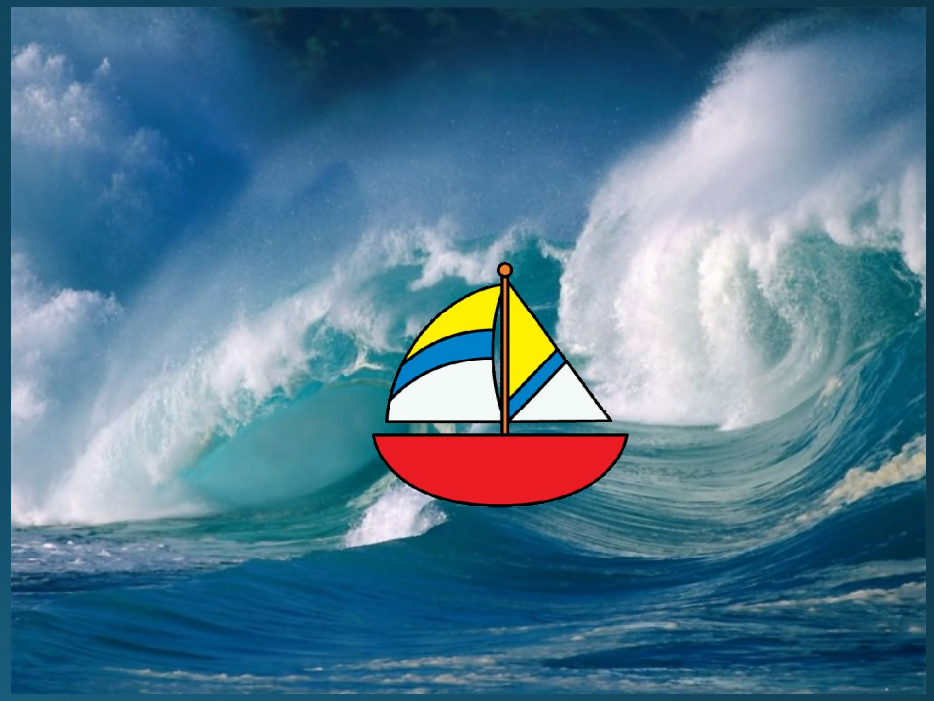
June 27, 2017

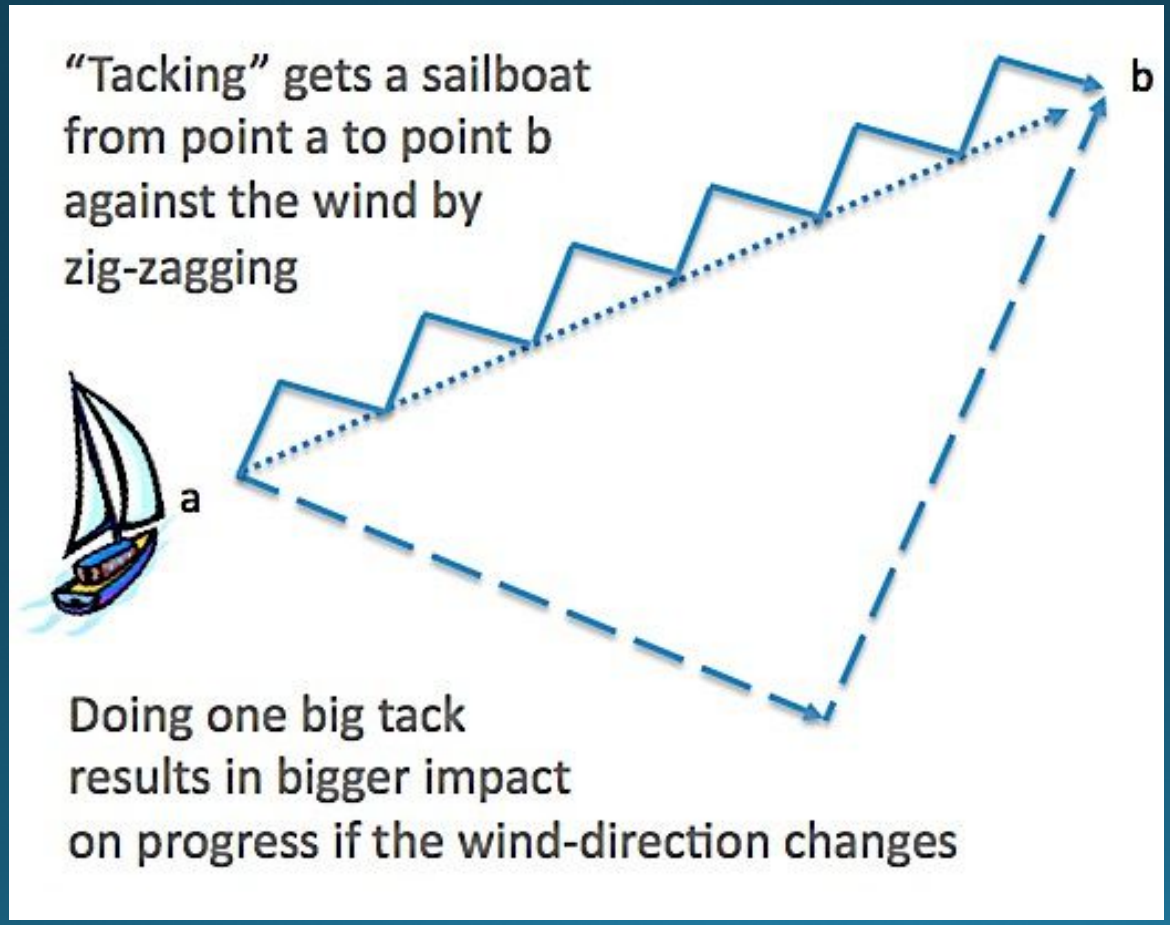
This Presentation at a Glance

- 2017: a tumultuous year for US health care that raises many questions
- What's ahead for the trend toward value-based payment and delivery reform?
- Will repealing and replacing the Affordable Care Act have an effect?
- What about rolling back Medicaid expansion nationally or capping/block granting Medicaid? What about expanded Section 1332 waivers under the Senate's proposed Better Care Reconciliation Act?
- What about CMS's payment and delivery system reforms under ACA and/or purview of Secretary of HHS?
- What about value-based contracting for biopharmaceuticals?
- And more…



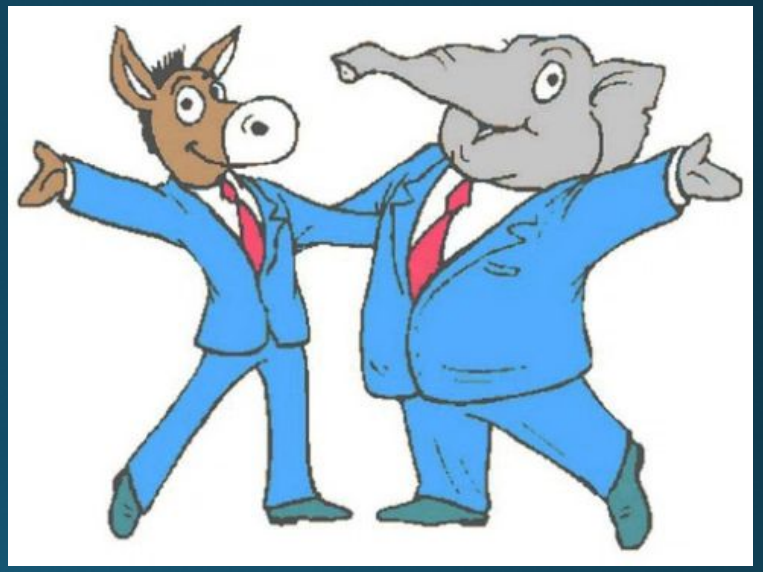
Q. Are we changing tack, or staying the course, in the movement from volume to value and value-based payment in health care?

A. Yes



Underlying hypothesis

- Notwithstanding efforts to repeal and replace the Affordable Care Act, there is one example of bipartisanship in health policy: Value-based payment driving delivery system reform
- Bipartisan history and parentage behind value-based payment initiatives
- Case examples: MACRA legislation enacted in 2015 (then-Rep. Tom Price, now Secretary of HHS, intimately involved in passage); Comprehensive Care for Joint Replacement initiative (mandatory bundle; expansion currently on hold); Maryland all-payer hospital payment



Senate CHRONIC Care Act Bill

- "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act" of 2017 (S. 870)
- In contrast to other health care legislation, crafted in open, bipartisan process in Senate; passed unanimously out of Finance Committee in May
- Would increase access to telehealth for Medicare beneficiaries with chronic illness, including those in Medicare Advantage
- Would provide more incentives for beneficiaries to join ACOs
- Would extend Independence at Home demonstration project
- Would allow reimbursement for non-health and social services
- Would permanently extend Medicare Advantage Special Needs plans

Above: Senators Ron Wyden (D-OR, left) and Orrin Hatch (R-UT), ranking member and chair, Senate Finance Committee

American Health Care Act and Better Care Reconciliation Act

- Nothing in bills specifically addresses value-based payment
- But in squeezing Medicaid, cutting subsidies to those buying coverage in individual market, and retaining ACA's Medicare cuts, surely an even greater push to "value" is inevitable
- E.g., according to Congressional Budget Office, Senate bill would result in $772 billion in savings in Medicaid from 2017-2026; by 2026 enrollment would fall by 16 percent
- States would have to find savings in new payment and delivery models, or else just cut enrollment or raise taxes

HHS Secretary Tom Price's Six Principles of Health Care*

- Affordability
- Accessibility
- Quality
- "Responsiveness"
- Innovation
- Choices (e.g., no mandatory bundles?)

*As described in his Senate confirmation hearings, January 2017, and subsequent speeches

Evidence on Effectiveness of Value-Based Payment Models: Thin Gruel?

- Only two CMMI models to date were shown to meet ACA criteria sufficient for Secretary to expand them into Medicare program
  - Pioneer ACOs (first phase)
  - Health Care Innovation Awards, Round One, Diabetes Prevention Program
- On other hand, evaluations and lessons learned have led to model adaptations – e.g., the Next Generation ACO model, based on prospective rather than retrospective spending benchmarks

To date, Little Evidence of Big Improvements

- Innovations result in some savings – e.g. , ACOs
- Savings net of bonuses paid out on quality improvement have been minimal
- Congressional Budget Office estimates just $34 billion in savings over 10 years
- Quality improvement slight as well
- What's the problem? Incentives for change not large enough?
- Hypothesis: Providers need to embrace more risk

Example: ACO Savings

- Key question: How much are ACOs really saving?
- Some analysts have concluded, based on CMS benchmark numbers and presumed counterfactual, that CMS lost about $200 million on Medicare ACOs
- Chernew et al: Because of flawed methodology behind savings calculation, actual savings are probably being underestimated
- Alternative estimates suggest $287 million in savings in 2014 alone
- Savings are growing with longer program participation

- Source: Chernew M et al, Health Affairs blog post, June 19, 2017.

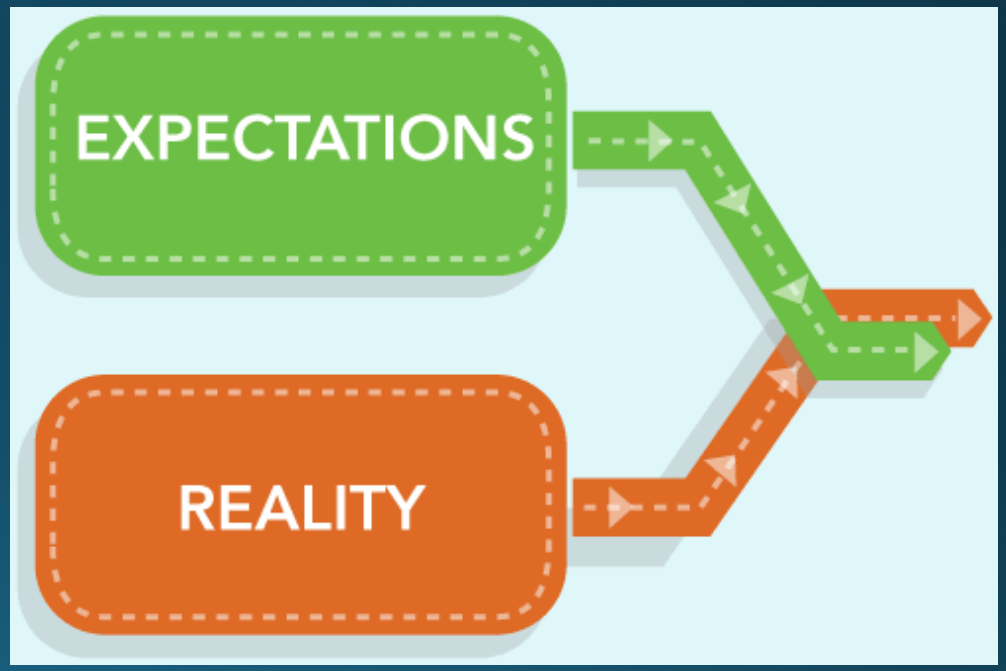
Comprehensive Care for Joint Replacement Model

- Observational study of 3942 patients who received joint replacement surgery and participated in CCJR bundle
- Decrease of $5577 (20.8%) in total spending per episode
- Most of the hospital savings came from use of lower-cost implants and supplies
- Most of the post-acute care savings came from decreased use of institutional care (e.g., via discharge to home).
- "Changes may be implemented rapidly without intensive investment in care coordination" or further testing.

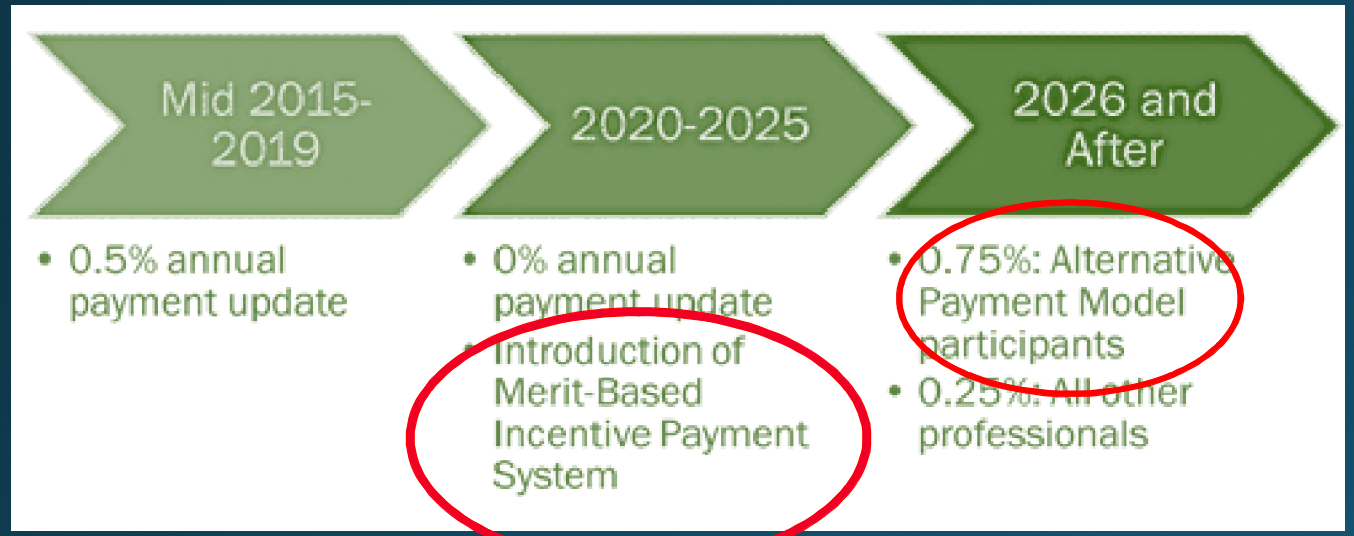
- Source: Navathe AS et al, "**Cost of Joint Replacement Using Bundled Payment Models,**" *JAMA Intern Med*. 2017;177(2):214-222.

Expectations

- Move to more population-based payment (capitation) and risk sharing is likely to continue
- Payment constraints imposed on Medicaid and Medicaid MCOs, and to lesser extent, commercial insurance make this inevitable
- Systems need to prepare



MACRA- Now the "Quality Payment Program:" Next Phases are Baked in the Cake



- Specific focus on creation of new Physician-Focused Payment Models and new process for approving these models

From MIPS to AAPMs

"MIPS APM" =
Payment model
created by CMS
for participants in
Medicare Shared
Savings Model Program
ACOs that do
not currently accept
downside risk.

MaineHealth
Accountable Care Organization

MONTHLY NEWS
April 2017

MACRA In Focus

Understanding the MIPS Advancing Care Information Performance Category

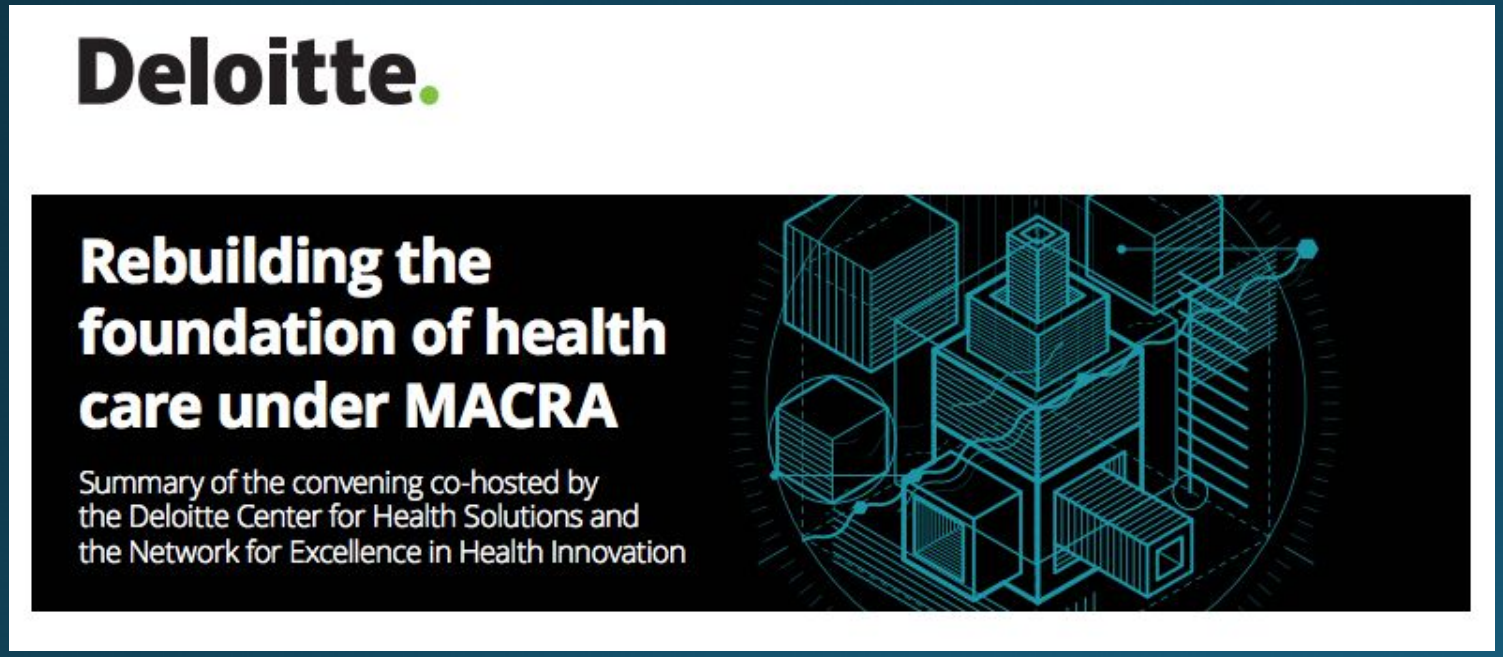
As a MaineHealth ACO participant, you are automatically enrolled in "MIPS APM," the alternative payment model created by CMS for participants in Medicare Shared Savings Program ACOs that do not currently accept downside risk. MIPS APM is seen by many as a more desirable option than standard MIPS, since it allows providers to check off certain requirements by virtue of being in an ACO. However, an important requirement remains: submitting data for the Advancing Care Information performance category. Ensuring that you report in this category is an excellent opportunity to improve your individual performance and contribute to a high score for the ACO as a whole - an outcome that all ACO participants can benefit from. For key insights into the Advancing Care Information (ACI) category, Continue reading.

We want to make sure our MIPS and MACRA information is relevant and useful to you. If you have specific MIPS and MACRA questions and concerns that you'd like us to address, please email us with your suggestions. We'll do our best to cover them in upcoming issue of this newsletter. Thanks for your input!

Physicians' Incentives to Be In Advanced Alternative Payment Models Will Accelerate Change

- Medical homes
- Comprehensive ESRD care
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program ACO's – tracks 2 and 3
- Next Generation ACO Model
- Oncology Care model – 2-sided risk (2018)
- New physician-focused payment models – TBD, but will surely include new bundles
- Medicare Advantage plans that satisfy Advanced APM criteria (providers must be at risk)

Changes facing health systems and plans



- Paramount: data and technology to support new payment systems
- New relationships – e.g., between providers and plans
- Need to develop capacity to take on greater risk

Source: Deloitte-NEHI report at https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html

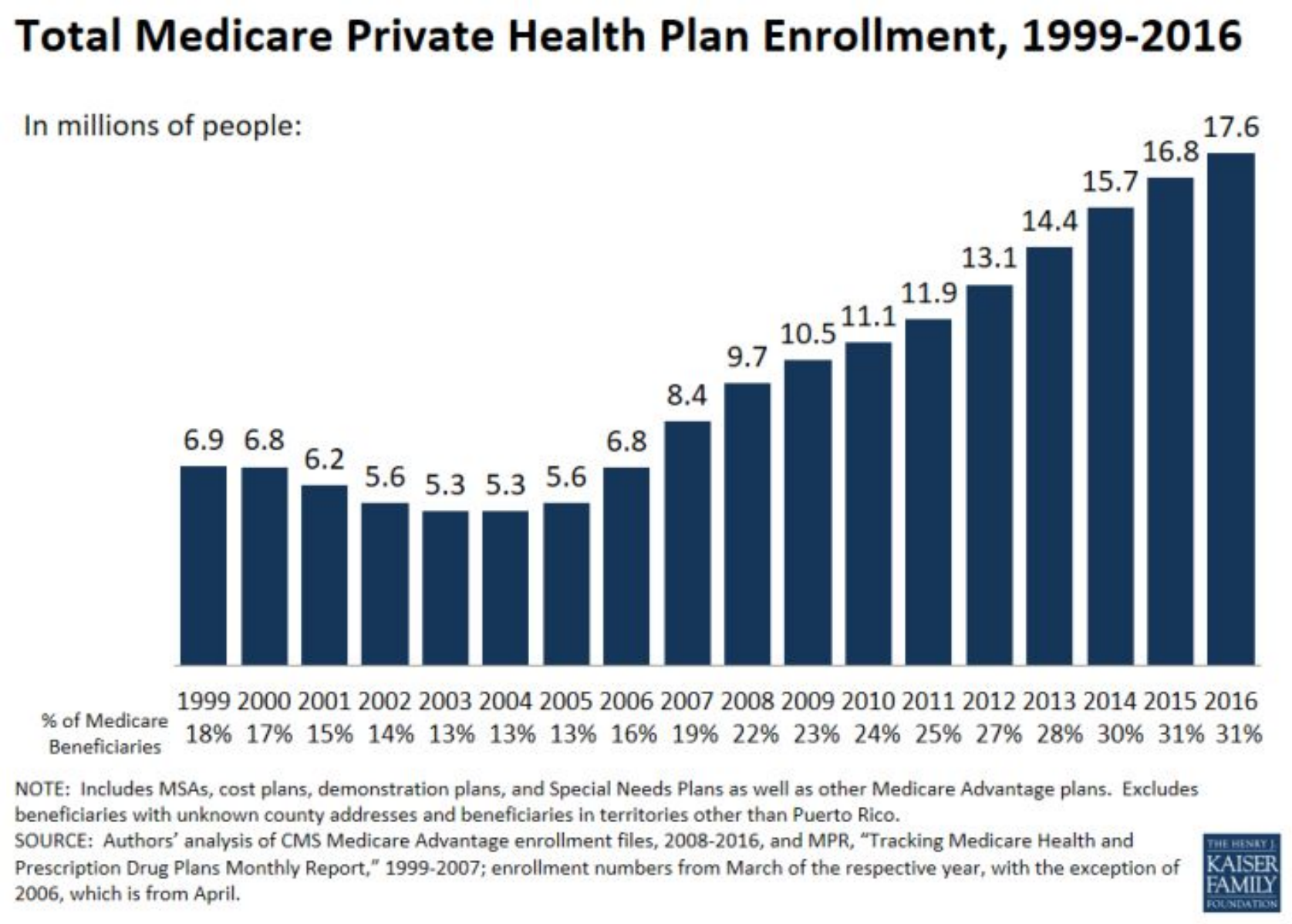
Physician-Focused Payment Models

- MACRA created authority for CMS/HHS to approve these as APMs and AAPMs
- "Physician-focused" somewhat of a misnomer; a number of eligible professionals can apply, including PTs, OTs, NPs, PAs etc.
- Law also created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review proposals and make recommendations to the Secretary of HHS
- First 3 proposals came before PTAC in April 2017; two recommended for limited testing, one rejected

Physician-Focused Payment Model Criteria: Great Definition of Value?

- Criteria that PTAC must use for reviewing models are as follows:
- Value over volume: provide incentives to practitioners to delivery high-quality health care
- Flexibility
- Improve quality at no additional cost, maintain quality while decreasing cost, or both
- Payment methodology must achieve goals of all criteria and constitute an approach that cannot be tested under other payment methodologies
- Scope: must expand the CMS APM portfolio or include APM entities whose opportunities to participate in APMs have been limited
- Ability to be evaluated
- Encouragement of greater integration and care coordination across practitioners and settings
- Encouragement of greater attention to health of population served, while also supporting the needs and preferences of individual patients
- Aim to maintain or improve patient safety standards
- Encourage use of health information technology to inform care

Medicare Advantage Growth



Common quality metrics

- Medicare Advantage "stars" program, Medicare Shared Savings Plans, and Next Generation ACO plans have fixed sets of quality measures that overlap significantly
- Providers who participate in Advanced Alternative Payment Models under MACRA, and also contract with Medicare Advantage plans, have consistent incentives to improve quality performance
- Bottom line: there are now important incentives for providers to be in these models
- "These initiatives are complex and can require careful analysis to avoid unwanted consequences."

- Source: Kunkel C et al, Milliman White Paper, "MACRA and Medicare Advantage Plans: Synergies and potential opportunities," February 2017.

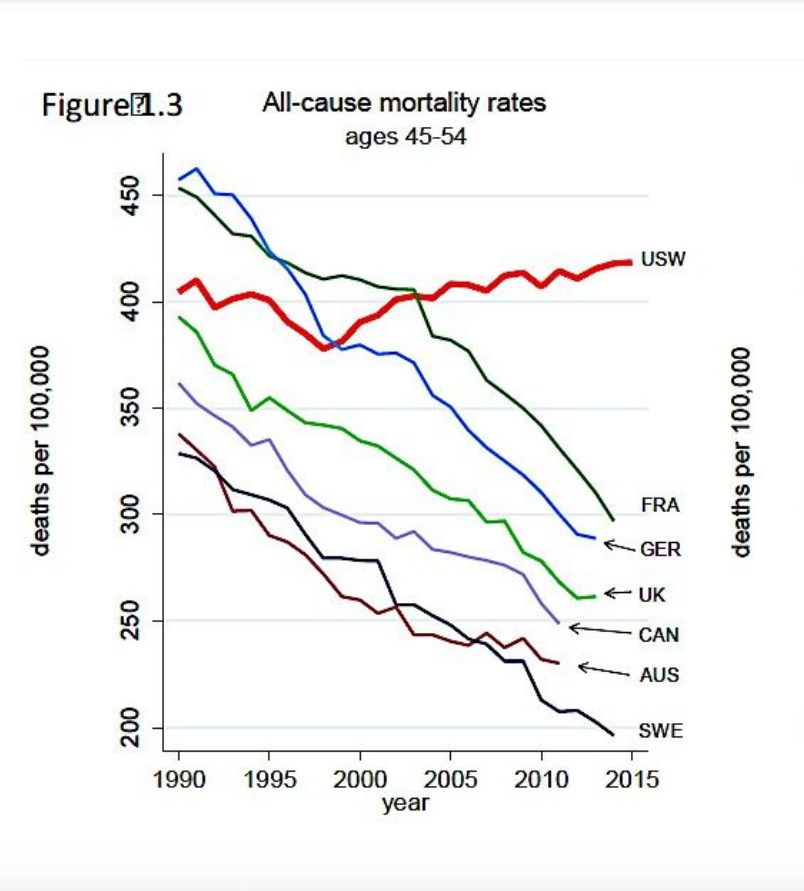
Value-Based Payment and Improving Population Health

Poorer Health: US Life Expectancy Outlook Increasingly Grim

- US life expectancy at birth already lower than most other high-income countries and has stalled or fallen in some population subgroups
- In 2030 US life expectancy estimated to be similar to Czech Republic for men, Croatia and Mexico for women
- US has highest child and maternal mortality, homicide rate, and body-mass index of any high income country
- US was first of high-income countries to experience halt or reversal of increase in height in adulthood, associated with greater longevity
- US is only country in OECD without universal health care coverage
- US has highest share of unmet health care needs due to costs

Source: Kontis V et al, "Future Life Expectancies in 30 Industrialised Countries: Projections with a Bayesian Model Ensemble,." *The Lancet*, published online, Feb. 21, 2017

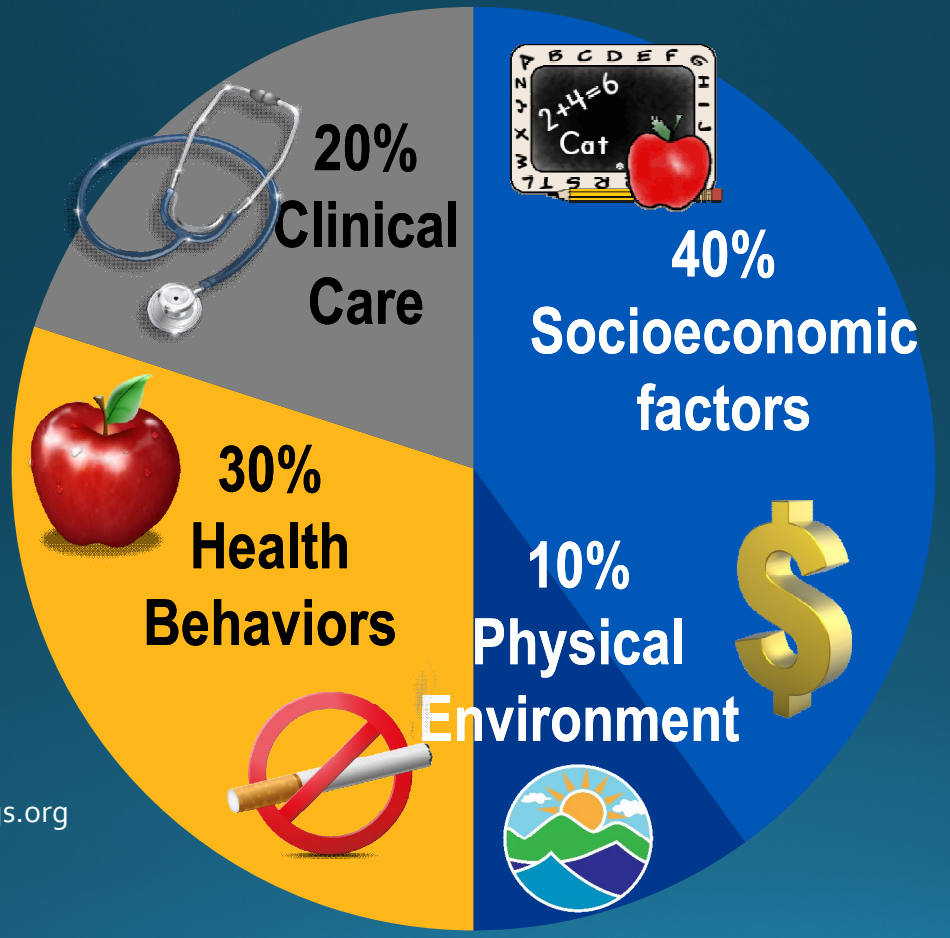
Rising U.S. mortality in middle-age, less educated whites



- Increasing rates of US "deaths of despair" due to drug overdoses, suicides, alcohol-related liver disease
- Centered on US whites with a high school education or less, in contrast to comparably aged populations in other countries
- Accompanied by deterioration in self-reported mental and physical health and chronic pain
- Explanation: Culmination of "long-term process of decline" and deterioration in social and economic structures?

Source: Anne Case and Angus Deaton, "Mortality and Morbidity in the 21st Century," Brookings Panel on Economic Activity, May 1, 2017

What drives overall health status?

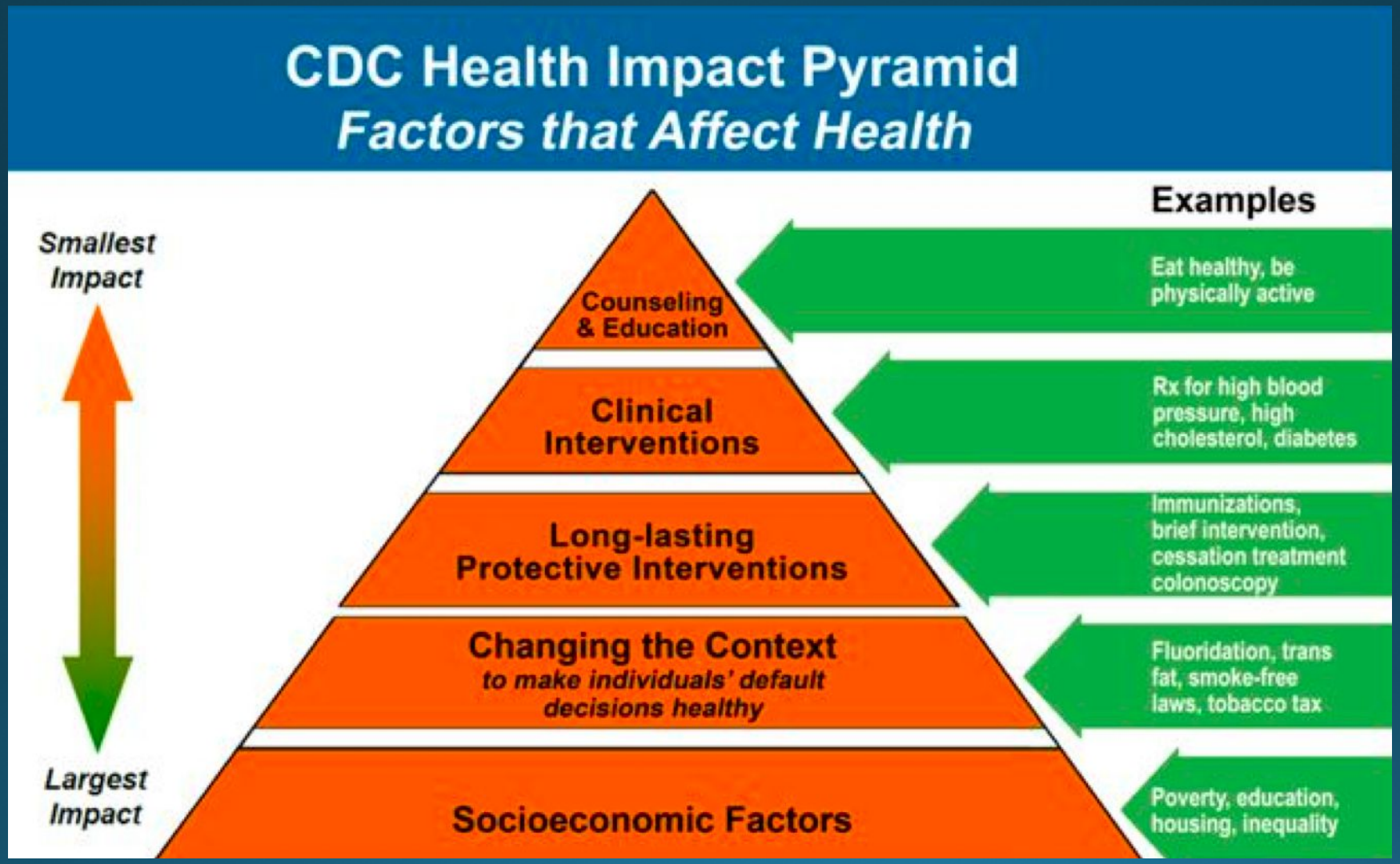


Source: www.countyhealthrankings.org

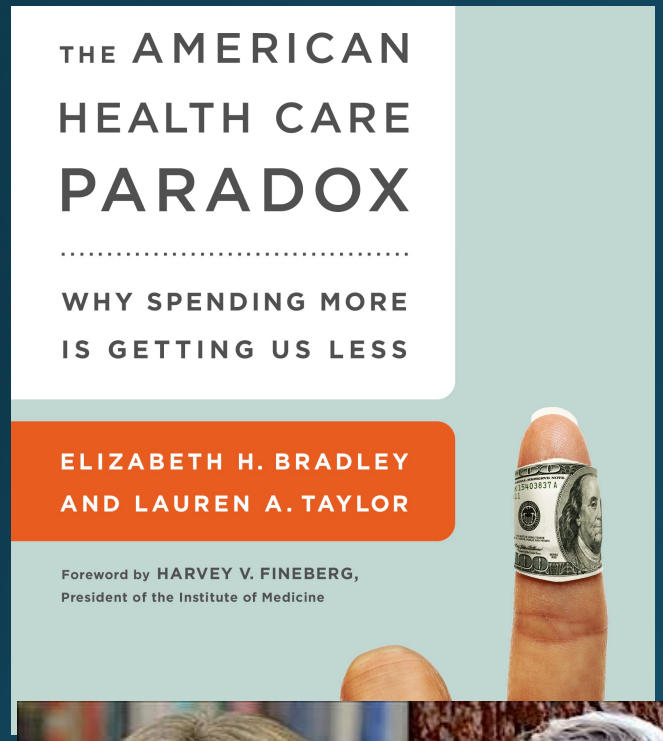
Social determinants of health

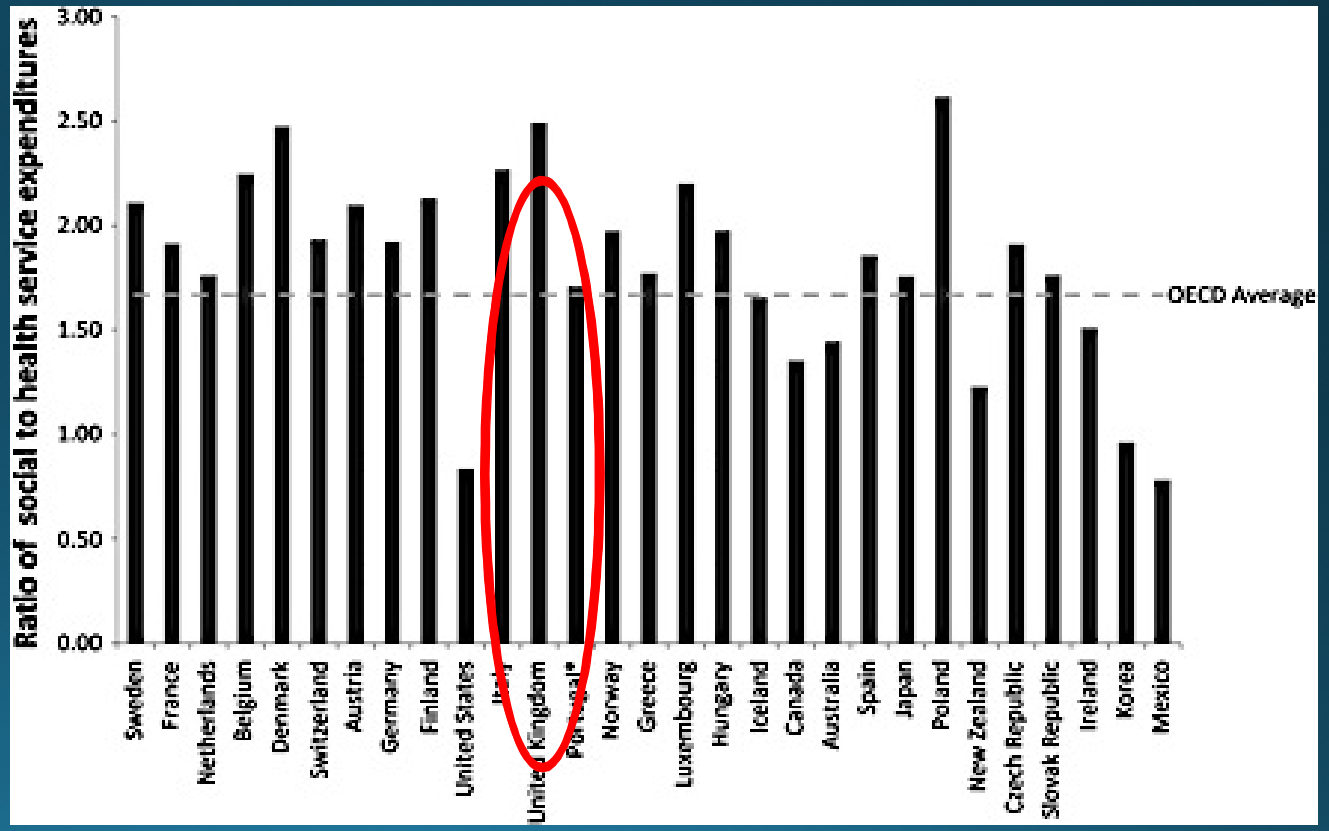
- Income and Income Distribution
- Education
- Employment or unemployment; job security; working conditions
- Early Childhood Development
- Food Insecurity
- Housing
- Social Exclusion; Social Safety Network
- Access to Health Services; Disability
- Gender, Race, Aboriginal (Native American/Indian) Status

Influencing Health



US Imbalance In Health Care Vs. Social Services Spending





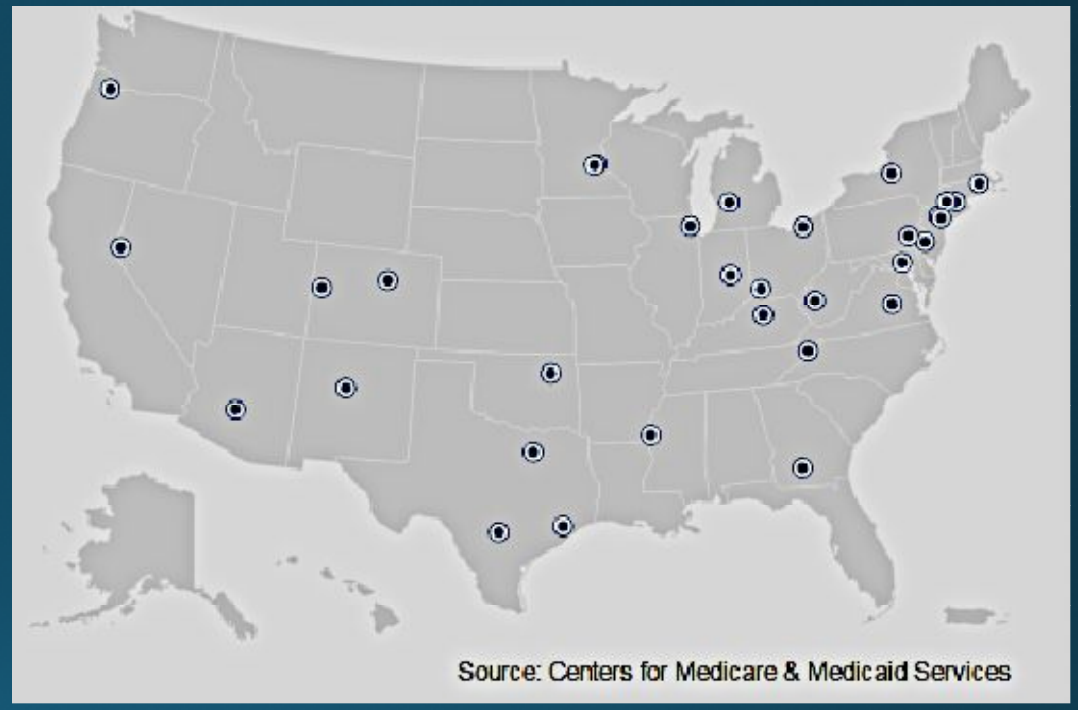
Kaiser Permanente Southern California Region: Starting by Asking People About Social Needs

- At Kaiser Permanente, 1 percent of patients account for 20 percent or more of resources
- Average annual cost $98,000-plus
- KP has begun cold calling 5,000 members in Southern California region to ask them about 12 domains of social determinants
- Each has average of 3.5 unmet needs
- High prevalence issues include financial needs, food, caregiver support

Nirav Shah, MD, Senior Vice President and Chief of Clinical Operations for Kaiser Permanente Southern California region

Accountable Health Communities

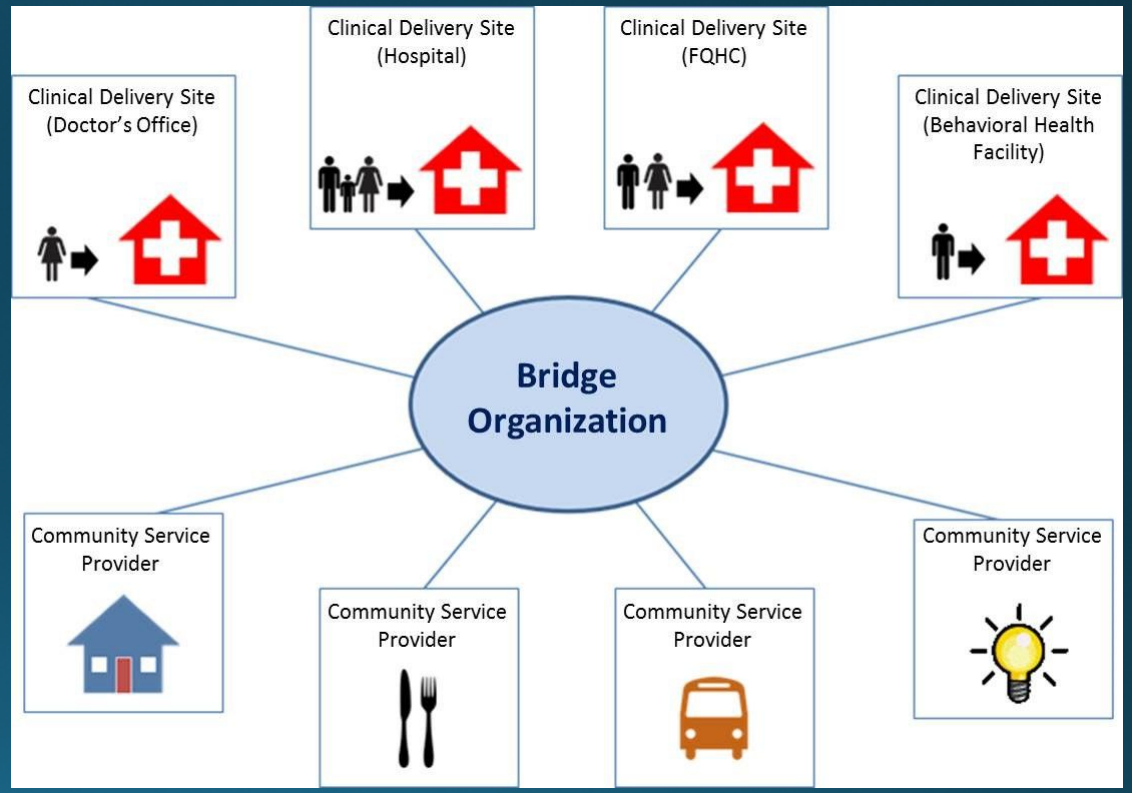
- New Center for Medicare and Medicaid Innovation model
- $157 million over five years to address "critical gap between clinical care and community services in the current delivery system"
- Universal, comprehensive screening for health related social needs of community-dwelling Medicare and Medicaid beneficiaries
- Needs included housing instability or quality, utilities, food insecurity, transportation beyond medical transportation, interpersonal violence



Source: CMS Fact Sheet at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.htmlat

Accountable Health Communities

- 32 cooperative agreements signed :
- Assistance Track: Provide community service navigation services to *assist* high-risk beneficiaries with accessing services
- Alignment Track: Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries



Source: CMS Fact Sheet at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.htmlat

The Model: Hennepin Health

- Medicaid demonstration project serving more than 10,500 in Minneapolis
- Capitated model
- Integrates safety net health care providers, behavioral health, social services and public health – all at risk in shared savings arrangement
- Links patients with vocational training and housing support; avoiding one day of hospitalization = one month's housing cost
- Early results show decreased ED utilization, inpatient admissions, higher rates of optimal care

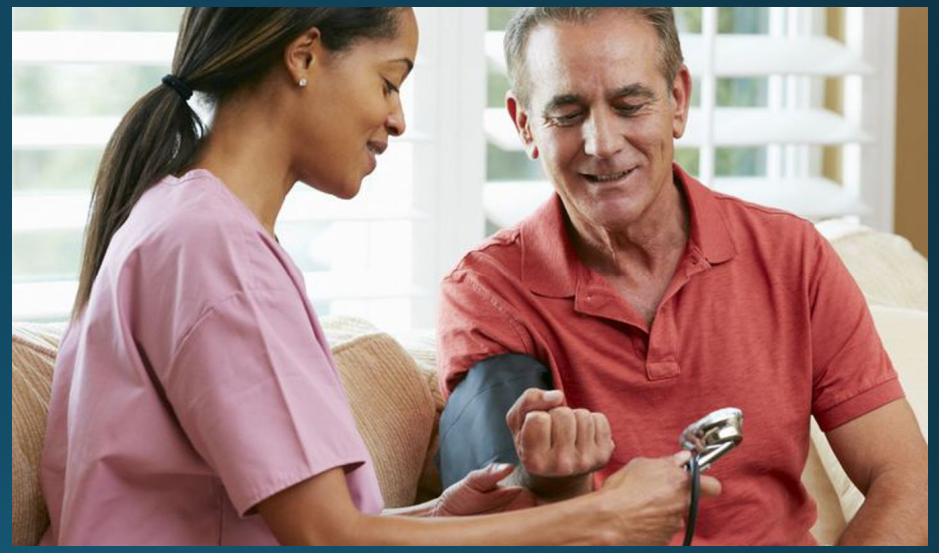
Hennepin Health
County Health Care Reform

Above: Behavioral health nurse care Coordinator Amber Morgan works with a patient at Hennepin County Mental Health Center

Source: R Tiperni et al, "Accountable Communities for Health: Moving from Providing Accountable Care To Creating Health," *Annals of Family Medicine*, vol. 13, no. 4, 367-369.

Implications for patient populations and care delivery

- Lots of chronically ill and disabled people ages 55 and older
- Tens of millions whose care will be managed outside of hospitals and nursing homes for cost and convenience reasons -- and probably by teams of care providers
- Opportunity – and obligation - for larger role of health system in prevention and focus on community/population health
- What types of health care organizations are best suited to deliver on these goals? How will they be paid?
- What is the optimal financing, management structure, and work force composition of these organizations?



No alternative but to pursue strategy of value based care and population health


WELCOME TO
REALITY
ENJOY THE JOURNEY

The End