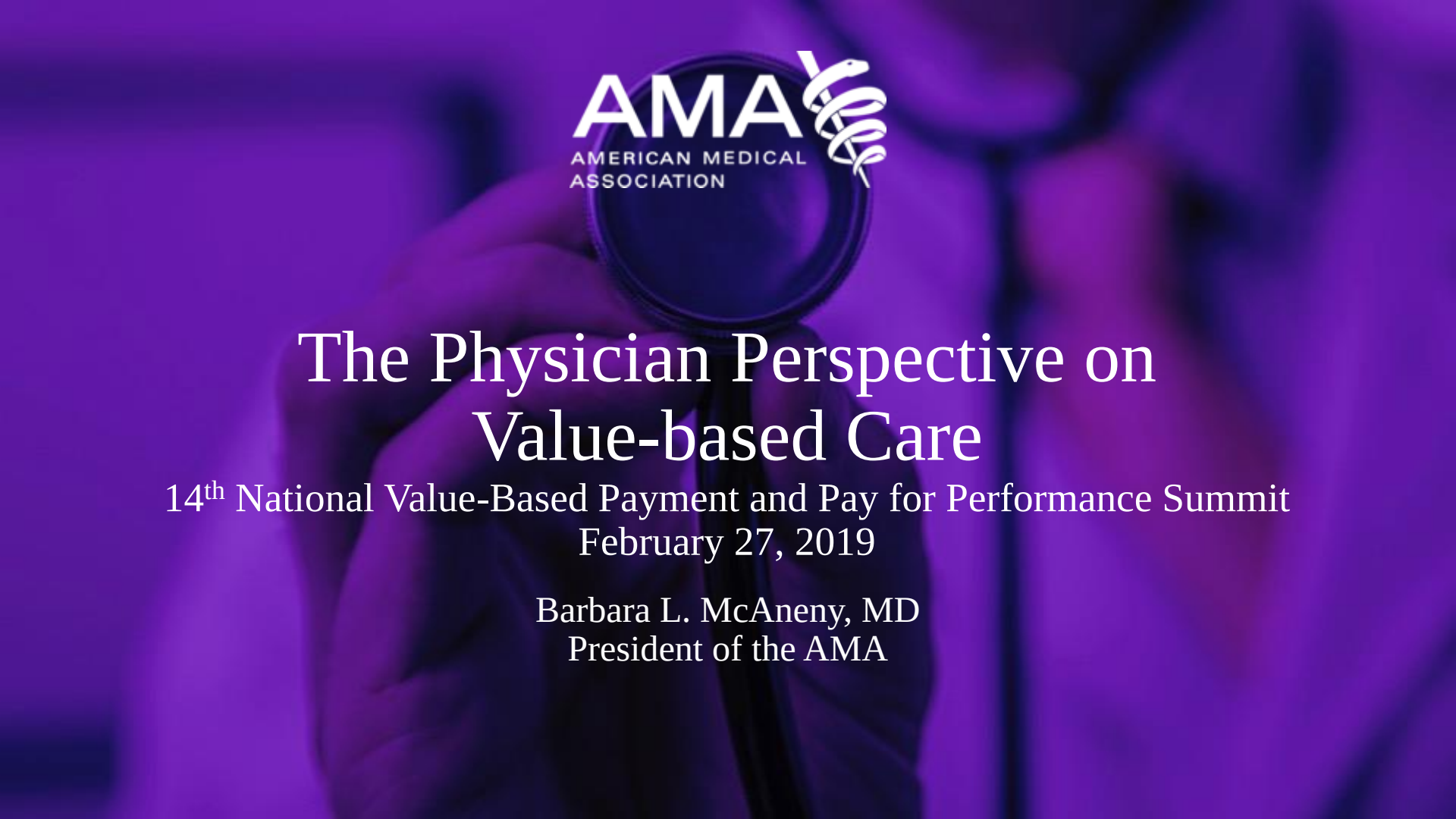


The Physician Perspective on Value-based Care

14th National Value-Based Payment and Pay for Performance Summit
February 27, 2019

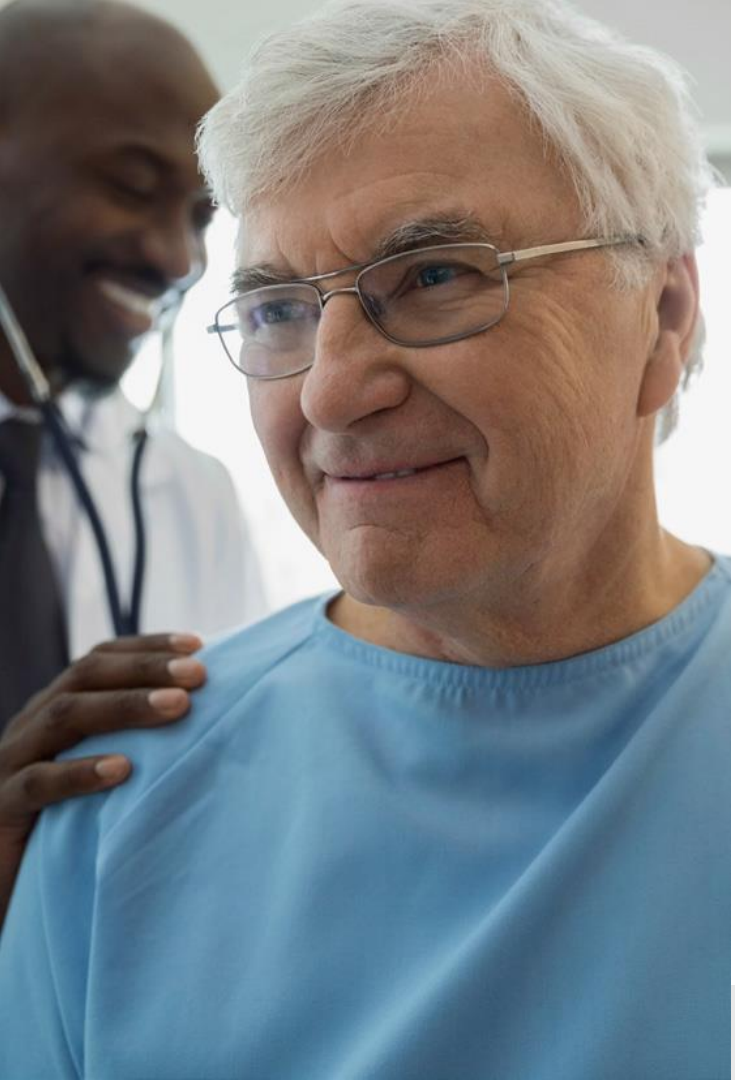
Barbara L. McAneny, MD
President of the AMA

AMA Board of Trustees

AMA supports America's physicians in delivering value-based care

Physicians are strong proponents of value-based care

- Physicians support the move to value-based care; AMA a key proponent of MACRA-QPP
- Physicians have great ideas about improving care and lowering costs
- Health system costs are unsustainable; we must reduce the cost of health care in ways that improve outcomes



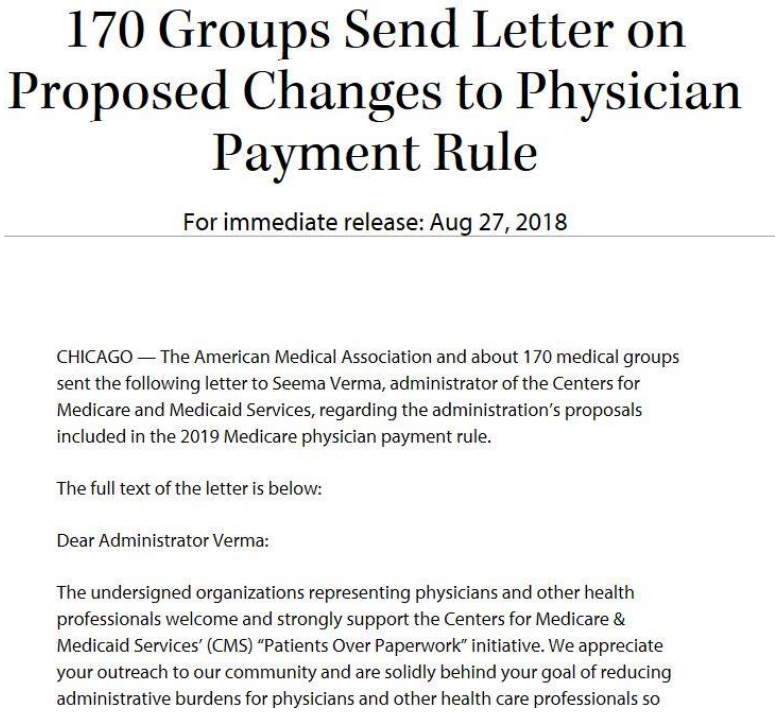
Medicare physician payment reform

What the AMA is doing:

- Advocating for payment system changes that support improvements in care rather than simply add new administrative burdens.
- Working to simplify administrative requirements in payment models to improve professional satisfaction.
- Expanding payment model options for physicians in all specialties.
- Developing simple, straightforward educational material to help physicians succeed under new payment models.

Working with CMS to reduce regulatory burdens

- AMA and 169 other health care organizations write CMS supporting proposed reductions in paperwork requirements.
- Raised concerns about proposal to collapse payment rates for office visits
  - As written, change could hurt physicians who care for patients in most dire circumstances or comprehensive care
  - Jeopardize patient access to care
- AMA/physicians committed to working with CMS to resolve issues



170 Groups Send Letter on Proposed Changes to Physician Payment Rule

For immediate release: Aug 27, 2018

CHICAGO — The American Medical Association and about 170 medical groups sent the following letter to Seema Verma, administrator of the Centers for Medicare and Medicaid Services, regarding the administration's proposals included in the 2019 Medicare physician payment rule.

The full text of the letter is below:

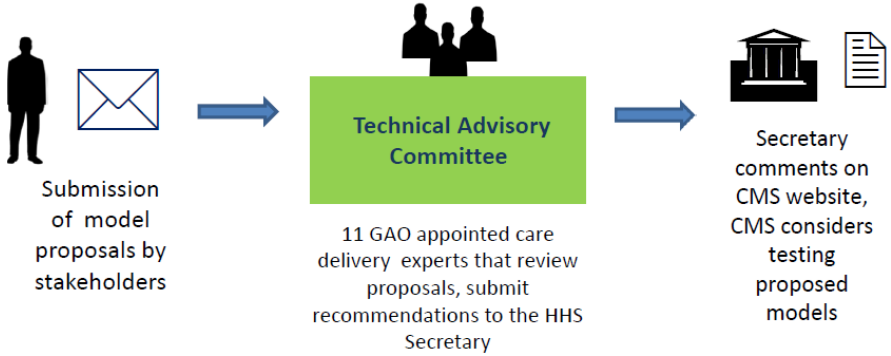
Dear Administrator Verma:

The undersigned organizations representing physicians and other health professionals welcome and strongly support the Centers for Medicare & Medicaid Services' (CMS) "Patients Over Paperwork" initiative. We appreciate your outreach to our community and are solidly behind your goal of reducing administrative burdens for physicians and other health care professionals so

Physician-focused APMs under MACRA

PFPM = Physician-Focused Payment Model

Goal: to encourage new APM options for Medicare clinicians

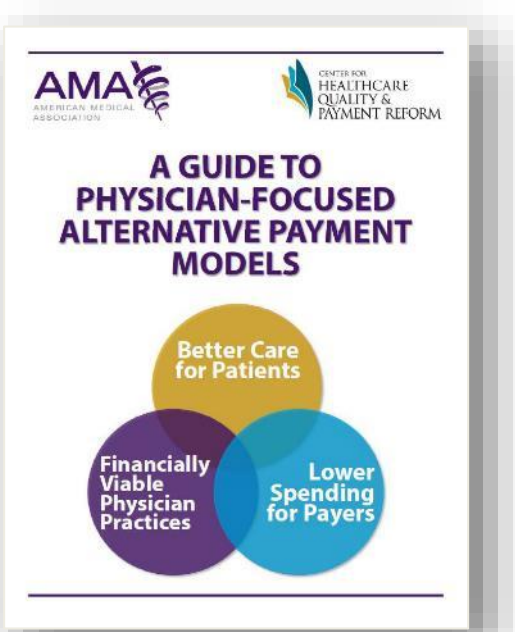


Definition:

- Medicare is a payer
- MACRA-eligible clinicians are participants and play core role in implementing APM's payment methodology
- Targets quality and costs of services that clinicians participating in the APM provide, order, or can significantly influence

AMA

AMA promotes physician-focused APMs



- Medicare payment systems are progressing toward APMs
  - See more information about AMA work on physician-focused APMs at: https://ama-assn.org/practice-management/payment-delivery-models/medicare-alternative-payment-models
- 11-member **Physician-Focused Payment Model Advisory Committee** created to review stakeholder APM proposals, make recommendations to HHS Secretary
- PTAC has recommended more than two dozen models for testing or implementation, including:
  - Making Accountable Sustainable Oncology Networks MASON, submitted by Innovative Oncology Business Solutions
- CMS recently announced it is working to develop new model tests building on ideas from models recommended by PTAC.

AMA

CMS models qualified as Advanced APMs

Comprehensive ESRD Care Model

(Subset of 37 ESCOs qualify)

Comprehensive Primary Care Plus

(2,816 Round 1 practices + 165 Round 2)

ACOs:

Tracks 1+, 2, 3 NextGen, Vermont

(159 ACOs + VT)

Bundled Payments for Care Improvement Advanced

(starts 10/1/2018)

Oncology Care Model Track 2

(Subset of 192 practices qualify)

Comprehensive Joint Replacement

(Subset of participants in 67 MSAs qualify)

AMA

Pros & cons of CMS-developed APMs

Pros:

- Extra $$ for non-face-to-face services and support staff
- 5% annual bonus to Advanced APMs in 2019-24 with higher update after 2026
- Ease of MIPS participation for MIPS APMs and MIPS exemption for Advanced APMs
- Waivers improve patient access to telehealth and post-acute care
- Opportunities to share savings can lead to better treatment planning

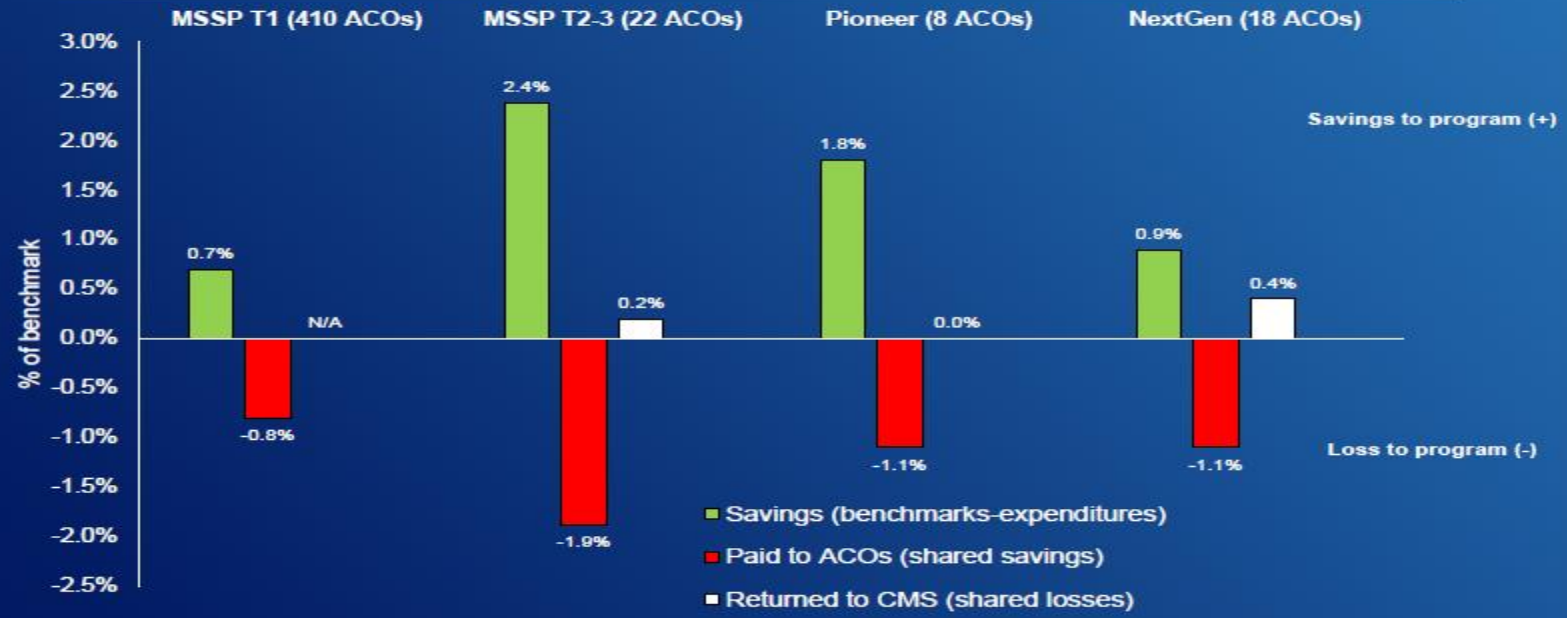
Pros & cons of CMS-developed APMs

Cons:

- Financial risk rules force physicians to be accountable for costs outside their control
- Lack of risk adjustment hurts practices with more complex patients, worse functional status, poor support at home
- No incentive for HIT innovation
- Added documentation burdens
- Attribution methods limit patient access to APMs' benefits and keep physicians guessing which of their patients are in APMs
- No recognition of ACO start-up costs and ACO benchmarks hurt efficient practices
- Difficult to get timely data and feedback from CMS
- Years-long waits for shared savings payments

AMA

ACO financial performance by ACO model, 2016



MEDPAC Source: CMS data.

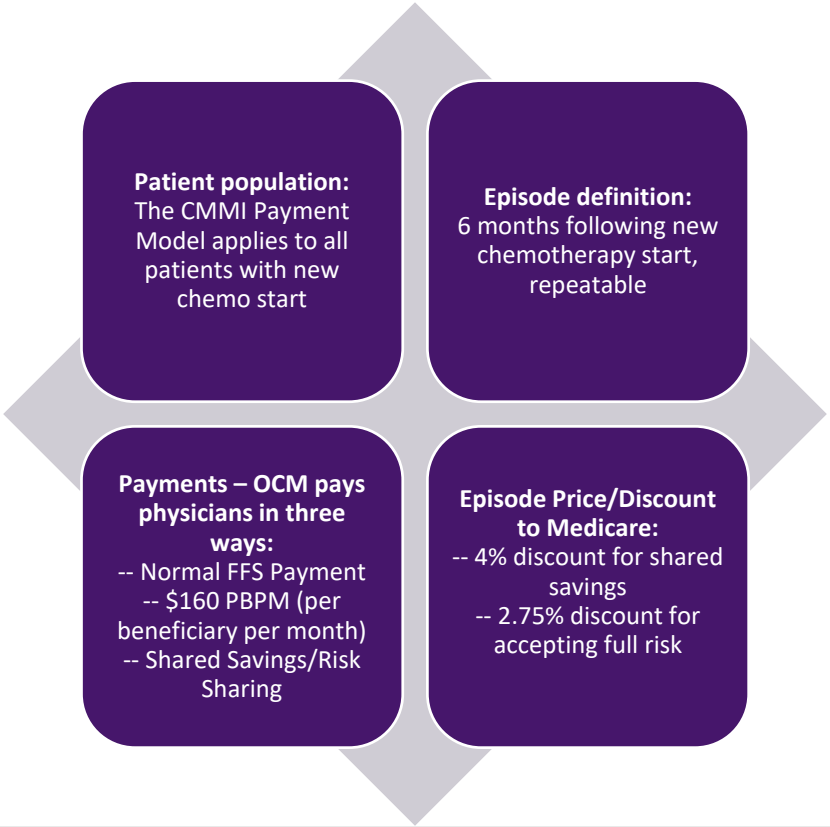
Results preliminary and subject to change.

Analysis of 2017 Medicare Shared Savings Program (MSSP)

- 472 ACOs in the MSSP spent nearly $1.1 billion less than “benchmark” spending levels.
- $799 million given back to 162 of ACOs in shared savings bonuses.
- 16 Track 2 & 3 ACOs paid penalties to CMS totaling $57 million.
- Net savings for CMS: **$313.7 million on the MSSP**
- **Is this a lot of savings?**
  - Just **$36** for each of nearly 9 million ACO beneficiaries
  - Only **.33%** of total ACO spending ($95 billion)
- Downside risk: ACOs spent **$254 more** per beneficiary than upside ACOs even after "saving" money for Medicare

Source: Harold D. Miller, Center For Healthcare Quality & Payment Reform

The Oncology Care Model (OCM)

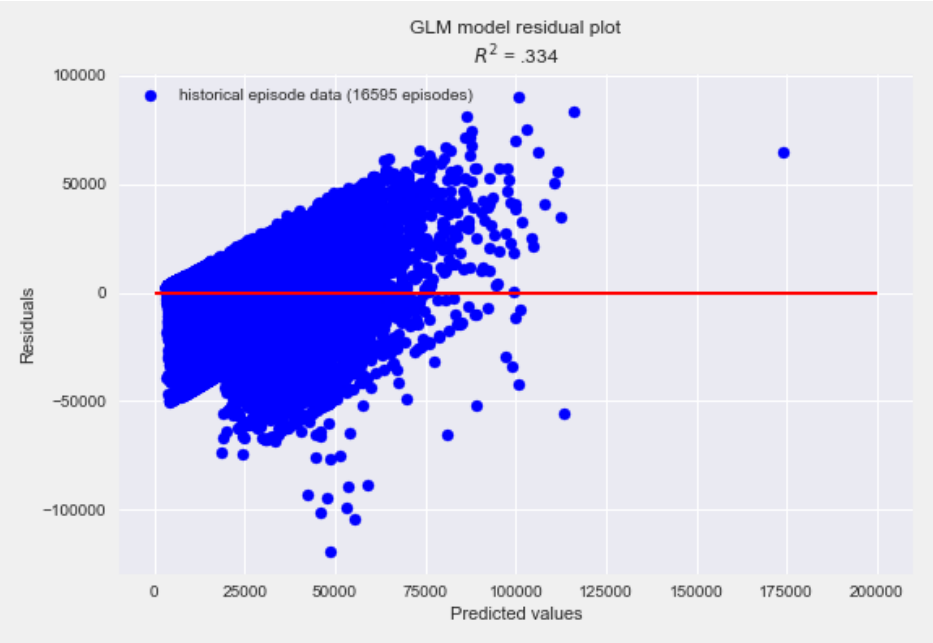


Pancreatic Cancer

- Below are 2 patients which show huge actual price differences but with identical baseline prices with the following similarities
  - Same Cancer Type , Same HCC group
  - Age, Gender
  - No Surgery, No Radiation
  - No Clinical Trial

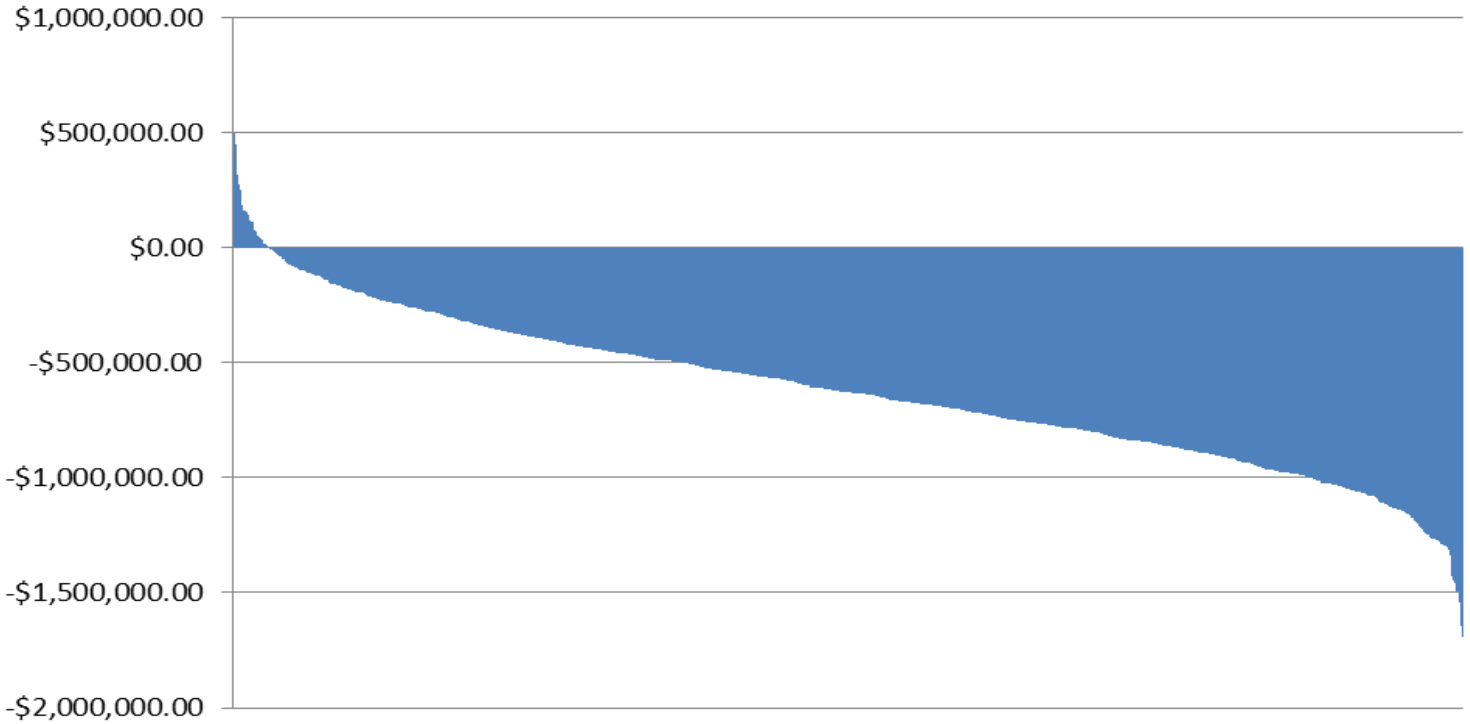
Actual Expense	Baseline Price	Age	Gender	Episode Start	Episode End	Zip
$9688.51	$22598.69	80	Male	10-01-2014	03-31-2015	45365
$49278.57	$22598.69	82	Male	10-06-2014	04-05-2015	45318

What's Problematic About the OCM: Target Calculation



- 16K historical episode data (2012-2015) from CMS
- Residual Value : OCM model predicted value - actual values for each historical episode
- Residual Plot: Scatter Plot of Residual vs Predicted Value
- If the points are not randomly dispersed across the red line, than a linear regression model is inappropriate. R-squared =0.334
- Time and Clinical data are not included in the model -> Residual plot not randomly dispersed around the red line.

Simulated PBPs – OCM Full Risk



MASON

- Transition from volume to value
- Builds on COME HOME, OCM, FFS, APC, and DRGs
- Oncology Payment Category (OPC)-Accurate Cost Target modeled on above methodology
- Tight-knit relationship between Patient ,Care team- (physicians, caregivers and family)
- Personalized care plan based on multiple factors
- Uses Cognitive computing Platform (CCP) for best Diagnostic and Therapeutic Pathways (DTP)
- 2% of OPC is reserved for a quality pool

- Practices bear Risk from the purchase of Reinsurance which covers
  - expenses over the target if the patient is an outlier above a designated amount OR
  - if the practice incurs expenses in aggregate for patients over the designated amount
  - CMS would be repaid from the reinsurance money, if payments exceed OPC
- Shared Savings for practice
  - If all quality parameters are met AND
  - Actual episode cost less than OPC

Oncology Payment Category (OPC)

- Calculated using Historical Data
- Based on Clustered data
  - Diagnosis and the relevant Hierarchical Condition Categories (HCCs)
  - Pertinent Clinical criteria, performance status, staging, and patient preferences
  - Socioeconomic factors and geographic barriers
  - Genomics

- Costs include
  - Evaluation and Management (E&M) codes, imaging, lab, radiation and surgery
  - The facility fee for infusion suite
  - Actual infusion costs
  - Medical Home PCOP payments
  - Hospital DRGs
  - Outpatient Hospital APCs
  - Excludes Drugs (reimbursed at invoice price + $40)

AMA/Rand Study

Effects of Health Care Payment Models on Physician Practice in the United States: Follow-up Study

Mark Friedberg, Peggy Chen & colleagues

RAND CORPORATION

Current study: persistent findings since 2014

- Strategies used by practices:
  - New capabilities & patient care models
  - Investment in data & analysis
  - Incentives modified within practices
- General openness to VBP as a concept despite challenges in real-world implementation, such as:
  - Data issues (timeliness, accuracy)
  - Operational errors in payment models
  - Conflicting payment models

Current study: new findings

- Pace of change has increased
  - Overwhelming to some practices
  - Unexpected APM reversals problematic
    - Some APMs reversed due to leadership changes (rather than model performance)
    - Affects practices' ability to invest, morale, willingness to participate, financial position

Current study: new findings

- Complexity of models has increased
  - Understandability a more prominent issue
  - One pathway to success: investing in ability to understand each model
    - Better understanding → new strategies to earn bonuses & avoid penalties
  - MACRA QPP a good example of complexity

Current study: new findings

- Practices expressed more risk aversion
  - Especially when burned by prior experience
  - Avoiding downside risk, in general
    - Offloading downside risk to partners
    - Shifting risk back to payers, in some categories (e.g., drug spending)
    - Willing to forego some upside bonus potential to reduce downside risk

Recommendations

- Simplify APMs to help practices focus on improving patient care
- Practices benefit from a stable, predictable, moderately-paced pathway for APMs
- Practices need new capabilities and timely data to succeed in APMs
- Consider offering upside-only APMs or help practices manage downside risk
- Design APMs to encourage clinical changes that individual physicians see as valuable

What physicians (still) need to succeed in value-based care

Keys to success:

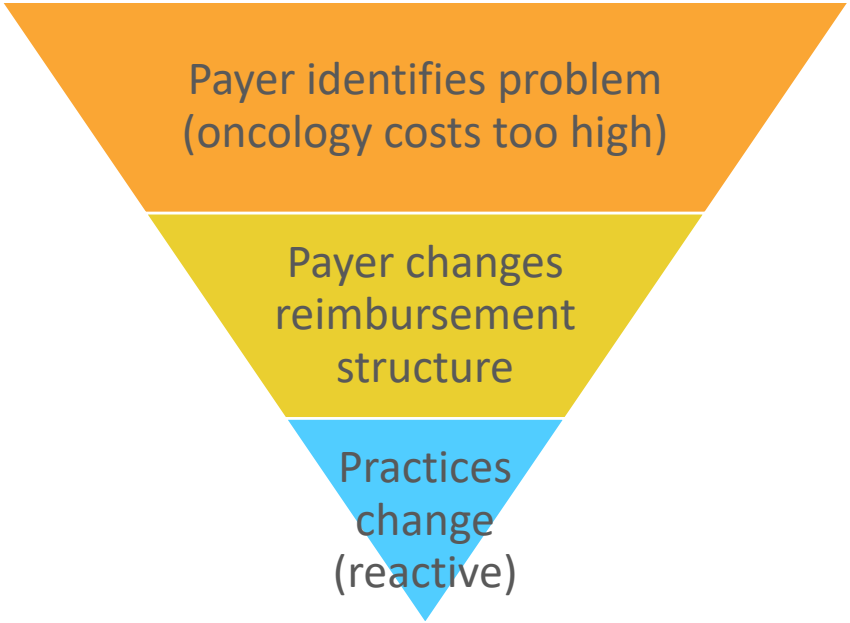
- **Physician leadership** in identifying appropriate and feasible opportunities for savings;
- **Physician leadership** in designing and implementing better approaches to care;
- Physicians must have **financial resources, regulatory flexibility, and timely and actionable data** they need to address patients' health care needs through value-based care.

Key elements missing from CMS models

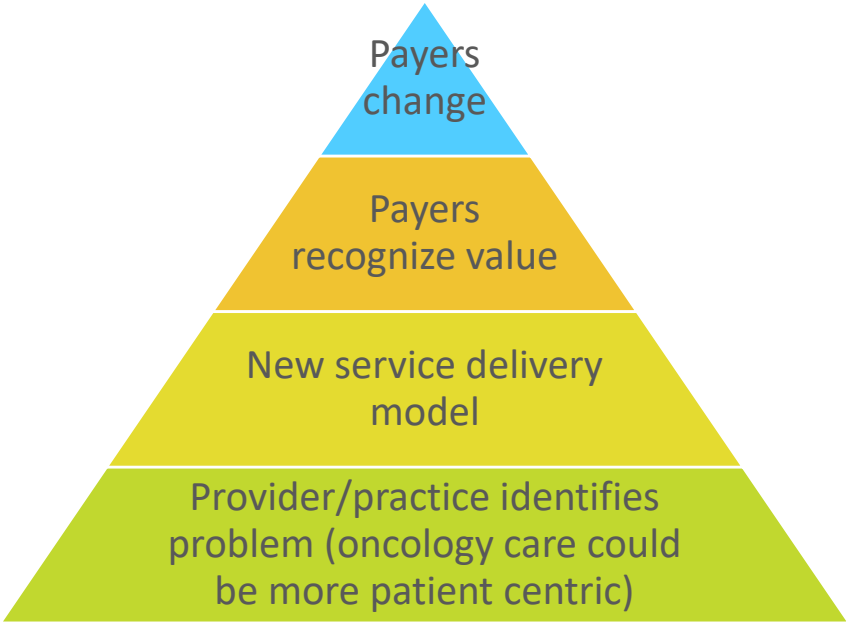
- CJR – joint replacement model only provides for participation by hospitals; no opportunity for physician leadership
- Medicare ACOs do not allow additional payments for physicians to: deliver care management; communicate with patients after hours; provide other services not funded under the Physician Fee Schedule

Reform should be driven from the bottom-up, not top-down

Payer-Driven



Provider-Driven



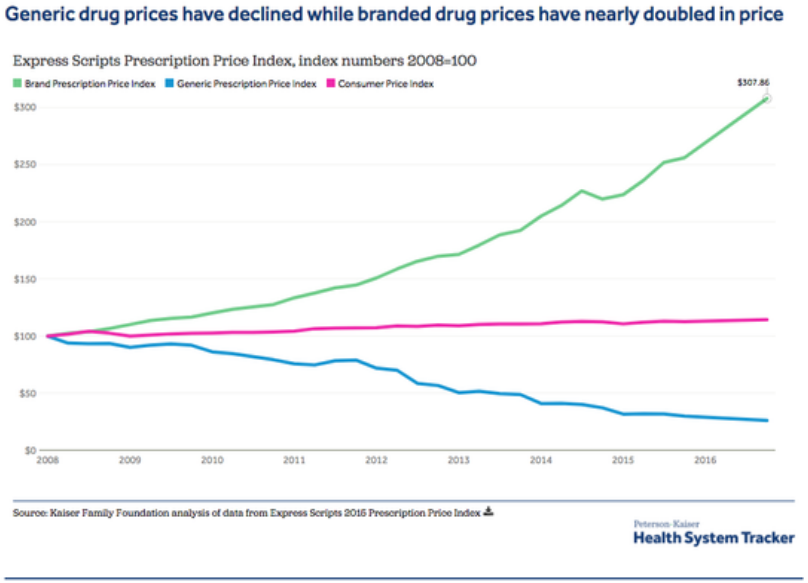
AMA

Payment models should be simple, but not simplistic

- One-size-fits-all models are more likely to harm patients without achieving savings than models that tailor services to the unique needs of patients.
- Problematic approaches: CPC+ and Oncology Care Model do not consider complexities in patient's functional status or living arrangements
- Better approach: consider disease severity, comorbidities, functional status and availability of home caregiver

Physicians willing to be accountable for costs we control, not for those we do not

- Most CMS APMs place physicians at significant financial risk for costs they cannot control, including spending on patient conditions they are not treating, and drug costs.
- CMS should build on Comprehensive Primary Care Plus (CPC+) approach which holds physicians accountable for the frequency of emergency visits and hospital admissions, but not the cost of care.



Physicians need better data to deliver value-based care

- Extremely difficult to get timely and actionable data from payers
- No support for sharing or connecting data in a meaningful way
- Physicians need access to Medicare claims data and to Health Information Exchanges

Health IT challenges

- Many health IT products, including EHRs, are developed and certified to meet ONC and CMS requirements
- These requirements have been predominant driver of product design for years—creating “one-size-fits-all” EHRs
- Certified EHR Technology (CEHRT) now widely viewed as tool for documenting, reporting and billing instead of improving clinical care, coordination, and patient engagement
- To be successful, APM participants need health IT that responds to and supports physician, patient, and care team interactions

AMA

AMA's partners in innovation

AMA

Connecting the health care innovation ecosystem

Bringing physicians and technologists/entrepreneurs together to develop health care solutions that work.

PIN currently has **4,400+ users.**

Payment models should remove barriers to innovative care

- AMA encourages CMS to build on promising approaches:

- Medicare's Diabetes Prevention Program (DPP) has encouraged development of innovative new approaches to prevention (First Mile Care), but current DPP payments do not support virtual approaches to care delivery, or cover costs for challenging patient populations

Need to try multiple approaches

- We do not know which payment and delivery reform approaches will be successful.
- Physician groups and specialty societies need support to develop multiple approaches to identify those that will be most successful.
- E.g., approach used in Medicare Part D – private plans developed a wide array of different plans and patients had lots of choices.


AMA
AMERICAN MEDICAL
ASSOCIATION