Succeeding in a Value-Based World: Policy Developments and Core Competencies

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Topics

• Health policy reform outlook

• Evidence on success of value-based payment reform

• Core competencies for success in value-based payment models

• Next steps
Health Care and the Federal Budget

Source: Congressional Budget Office, 2016 Long-Term Budget Outlook.
Income-related health disparities are large…

Expected Age at Death for 40-Year-Olds, y

Women
Men

Expected age at death, y

Women by household income percentile
Bottom 1%: 78.8 (95% CI, 78.7-78.9)
Top 1%: 88.9 (95% CI, 88.7-89.1)

Men by household income percentile
Bottom 1%: 72.7 (95% CI, 72.6-72.9)
Top 1%: 87.3 (95% CI, 87.2-87.5)

Source: Chetty et al, JAMA 2016.
...and Income-related health disparities are growing

Source: Chetty et al, JAMA 2016.
Death rates have risen for specific American populations

Source: Case and Deaton *PNAS* 2015
Determinants of Health Outcomes

Determinants of Health and Their Contribution to Premature Death

McGinnis, Social Determinants of Health, 2002


Adapted from Mokdad et al.
Big Health Policy Issues for 2017

• Key administration appointments and coordination with Congress
• Repeal +/- modification or replacement of ACA individual insurance market reforms and Medicaid expansion
• Medicaid reform
• Drug pricing
• “Must pass” legislation related to health: FDA user fees, Childrens Health Insurance Program (CHIP), debt limit
• Improving value and value-based payment reforms
Policy approaches for reducing costs— and improving quality and outcomes

• Reduce prices
  o May limit access to care

• Change payment and coverage to support better care
  o **Alternative payment models (APMs)** aim to align payment more closely with better and less costly care models, particularly those not supported well by FFS:
    o lower-cost care settings
    o telemedicine/mhealth
    o more efficient team-based care models
    o care coordination
    o better support for social services and non-medical interventions that can reduce complications and medical costs
  o APMs aim to provide **more flexibility** in how providers can deliver care, with **more accountability** for results and costs
Value-Based Payment Reforms

- Growing adoption of new payment models driven by health care fundamentals
- Physician payment (MACRA) implementation emphasizes expansions of alternative payment models
- Potential new directions for Center for Medicare and Medicaid Innovation (CMMI)
Alternative Payment Models (APMs)

Traditional

“Pay for Performance”

Payment Linked to Patient Not Services
Limited

More Complete

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment
Types of Alternative Payment Models with Accountability for Patient Results

Payment linked to quality and cost for a specified episode of care
Examples:
- Elective procedure episodes
- Hospital admission episodes
- Diagnosis-based episodes (e.g., pregnancy, back pain)
- Chronic disease episodes (e.g., CHF, cancer, liver disease)

Payment linked to quality and cost for a specified population
Examples:
- Accountable care organizations
- Medical home with pop. health accountability
- Comprehensive care for high-risk patients
- Specialty-based care teams with accountability
- Capitated care with pop. health accountability
MACRA Implementation Timeline

FFS
- PQRS
  - Value Modifier
  - EHR Incentives

APMs
- Advanced APMs
  - Greater than nominal downside financial risk

MIPS Payment Adjustments
- Based on MIPS Measures
  - +4%*
  - -4%*
  - +9%
  - -9%

5% Incentive Payment

Report on APM Measures

* CMS is phasing in payment adjustments
Medicare Oncology Care Model
ACO Growth by Payer

Payment Arrangement Growth by Payer Type

ACO Lives Per Payer (in Millions)

Source: Leavitt Partners Center for Accountable Care Intelligence
LAN APM Survey

The Process

APM Framework

Payer Collaborative & Pilot

Category 1
- Fee for Service - No Link to Quality & Value

Category 2
- Fee for Service - Link to Quality & Value

Category 3
- APMs Built on Fee-for-Service Architecture

Category 4
- Population-Based Payment

Population-Based Accountability

National Measurement Effort

$ 2016 30%

2018 50%
HEALTH PLANS and **TWO** Medicaid States, responded directly to the LAN.

Representing over **128 MILLION AMERICANS**, and...

Approximately **44%** of the **COVERED POPULATION**
2016 Results

25% ...In Categories 3 & 4

% of Healthcare Dollars

22% COMMERCIAL
41% MEDICARE ADVANTAGE
18% MEDICAID
30% TRADITIONAL MEDICARE

*The “25%” above does not include the “30%” traditional Medicare.
Some Major Medicare Alternative Payment Models

1. Expanded Medicare Shared Savings Program Tracks
2. Next Generation ACO Program*
3. Comprehensive Primary Care + ACO Model
4. Bundled Payment for Care Improvement
5. Comprehensive Care for Joint Replacement*
6. Comprehensive Cardiac, Hip Fracture Care*
7. Oncology Care Model
8. Comprehensive ESRD Care Model*
9. Part B Drug Payment Reform Model

Bolded reforms were newly proposed in 2016
Asterisk indicates payment model qualifies for advanced APM bonus

Accountable Care Organizations
Bundled Episode Payments
Specialized Population Management
Drug Payment Reforms Not Finalized
Potential New Emphasis Areas for Payment Reform

• CMS/CMMI Initiatives
  • Smaller physician groups
  • Reforms through and in collaboration with private plans
  • State and regional multipayer initiatives
  • Beneficiary savings
  • Quality and spending transparency

• Integration with Medicaid and state (Sec 1332) reforms
Payment Reform Evidence Hub: Better Evidence for Payment Reform

• Inventory of current payment reforms and evidence
• Best practices and tools for effective evaluation
• Integrating evidence across payment reform experiences
• Financial and technical support for payment reform evaluations
Current Evidence on Payment Reforms

- Population-based payment
- Gain/loss sharing (e.g., bundles, two-sided ACOs)
- Shared savings (e.g., ACOs)
- Rewards or penalties for performance (e.g., pay for performance)

Evaluations by LAN Category

<table>
<thead>
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<th>LAN Payment Category</th>
<th>Fraction of Published Evaluations</th>
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<tr>
<td>2C</td>
<td>50%</td>
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<tr>
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Most health care organizations not yet succeeding in value-based care models

Responding to the challenge of successful and sustainable reforms in care

Recommendations

1. Support public-private precompetitive collaboration to identify competencies and pathways to develop them
2. Develop evidence of the impact of improved competencies
3. Align federal payments with value-based health care, informed by key competencies
4. Provide federal support and incentives for key data exchange capabilities to improve care
A call for collaborative action

Leavitt Partners, Governor Michael Leavitt, Secretary, U.S. Department of Health & Human Services

Duke University, Dr. Mark McClellan, Administrator of the Centers for Medicare & Medicaid Services

CAPG, Donald H. Crane, President and CEO

Premier, Inc., Susan DeVore, President and CEO

The Dartmouth Institute for Health Policy & Clinical Practice, Dr. Elliott Fisher, Director

Trinity Health, Dr. Richard Gilfillan, President and CEO

HIMSS, Stephen Lieber, President and CEO

National Business Group on Health, Brian Marcotte, President and CEO

Heritage Provider Network, Dr. Richard Merkin, President and CEO

Integrated Healthcare Association, Dr. Jeffrey Rideout, President and CEO

DaVita Healthcare Partners Inc., Kent Thiry, Chairman and CEO
Collaborative Approach
Founding Members

Accenture
Aetna
Allergan
American College of Cardiology
American College of Healthcare Executives
American Medical Association
Aon Risk Services
Arizona Connected Care
AstraZeneca
Bi-State Primary Care Association
Center to Advance Palliative Care
Cerner
Children’s Mercy Integrated Care Solutions, Inc.
Cigna
College of American Pathologists
Community Care Network of Virginia, Inc.
Conifer Health Solutions
CQuence Health Group
Dartmouth-Hitchcock Health System
DaVita Healthcare Partners
Eastern Connecticut Health Network
Epstein Becker Green
Genentech
Greenville Health System
Hannover Re
Hawaii Health Partners
Health Catalyst
Healthcare Financial Management Association
HealthEquity
HealthInsight
Henry Ford Health System
HIMSS
Horne LLP
Humana
IBM Watson Health
Illinois Critical Access Hospital Network
Integrated Health Partners
Jefferson Center for Mental Health
Johnson & Johnson
Kansas Association for the Medically Underserved
Lumeris
Managed Health Care Associates, Inc.
Massachusetts League of Community Health Centers
Medecision
Medtronic
Merck
Mid-Atlantic Association of Community Health Centers
Milliman
Mission Hospice & Home Care
National Association of Chain Drug Stores
Foundation
National Association of Community Health Centers
New West Physicians
New York Presbyterian Hospital
Novartis Pharmaceuticals Corporation
OCHIN
Ohio Association of Community Health Centers
Ohio Shared Information Systems
Parkview Health
Pennsylvania Association of Community Health Centers, Inc.
Providence Health & Services
R1 RCM
RGV ACO Health Providers
Sanford Health
Sentara Quality Care Network
Seton Health Alliance
Signature Medical Group
Spectrum Health
St. Vincent’s Health Partners, Inc.
Takeda Pharmaceuticals U.S.A., Inc.
Tenet Healthcare
TriZetto
U.S. Medical Management
UMass Memorial ACO
UT Southwestern
Valence Health
WellSpan Health
Weitzman Institute

#HIMSS17
Key competency domains

• Governance and Culture
• Financial Readiness
• Health IT Infrastructure/ Data Use
• Patient Risk Assessment and Stratification
• Care Coordination
• Quality and Safety
• Patient Centeredness
Further Steps on Accountable Care Competencies

Mission:
“To accelerate the successful adoption of accountable care”

Domains:
- Health IT
- Care Coordination
- Patient Risk Assessment
- Governance & Culture
- Financial Readiness
- Quality

Categories:
- Patient Assessment Data
- Platform for Patient Assessment
- Patient Assessment Process
- Population Risk Assessment Dashboard

Competencies:
- Support use of multiple common analytics tools via an open API
- Enable user defined variable weights & models for multiple care programs
- Support a wide diversity of the population
- Support multiple risk assessment models based on business need
**ACLC 2017 Activities**

**Provider Transition Glide Paths**

**Industry Resource Center**

**Case Study Briefs**

**Governance and Culture**

- **Leadership**
  - Have a leader or a governing body who uses their position, responsibility, and power to make decisions or create policies that will drive successful accountable care adoption.
- **Commitment to Value**
  - Encompasses values and behaviors that permeate throughout the organization and demonstrate an organization’s commitment to value-based care.

**Financial Readiness**

- **Financial Systems**
  - Systems, tools, and more important, orientation of work process to focus on patient population level financial assessment.
- **Health IT**
  - Infrastructure, platforms, processes, and investments that support the organization’s short and long-term prioritiy lists and goals.

**Compliance**

- **Case Study Briefs**
  - MACRA
  - Associations
  - Vendors
  - Industry Case Studies
  - Webinars

**Competency**

- **Case Study Briefs**

**Designing Governance for Bottom-Up Innovation**

**BACKGROUND**

In 2016, concerned about the sustainability of health care’s environment, the Health Information Technology Task Force (HITTF) of the Alliance for Accountable Care Organizations (ACLO) organized an internal analysis of various approaches to financial and clinical integration. The internal evaluation of various strategic initiatives and practices for the organization, the need to grow a network of aligned and affiliated network providers, to create a scalable and sustainable growth strategy for the organization.

**APPROACH**

Like many organizations utilizing partnerships for accountable care, FMF has had to deal with engaging physicians differently. To fulfill the organization’s purpose, the organization used a 360°/360° model. Analyzing the current state of the organization and the role of accountable care organizations, the organization identified an innovative approach to engage physicians and patients.

**About Southeastern Health Resources**

The Southeastern Health Risk Company (SEHRC) is a division of Southeastern Health Resources, a joint venture between Southeastern Health and Rocket Mass Health, a leader in population health management and care management.

**Website:** www.southeasternhealthresources.com
Each domain has specific competencies that can be developed in phases.
Case study briefs to support competency development

- Organization overview
- Background
- Approach
- Results
- Vendors/Tools
- Challenges with implementation
- Key Learnings
- Contact information
UT Southwestern Case Study

Governance and Culture

Approach
- Created partnership organization for employed and independent providers, with representation on governing board
- Created geographic pod committees

Results
- Saved over $29M in 2015, 8th largest savings in MSSP track 1
- Shared savings bonus of $14M
- Quality score of 96.7%

Key Learnings
- Physician leadership is important
- It is difficult to get providers to change EHRs, but it’s necessary for interoperability
- Must support providers to document consistently across the organization
To learn more and download publications, visit [www.accountablecarelc.org](http://www.accountablecarelc.org)
Resources to Support Health Care Financing and Delivery Transformation

Patients and consumers, providers, health plans, employers, states, and consultants all play a critical role in transforming health care

- www.accountablecarelc.org
- www.healthpolicy.duke.edu
- www.hcp-lan.org