Health Leaders Network
Partnership for Population Health

2020 Louisiana Department of Insurance Conference

Driving Value in Healthcare – Alternative Payment Models

Daniel Marsh, MD
Medical Director Health Leaders Network
FMOLHS

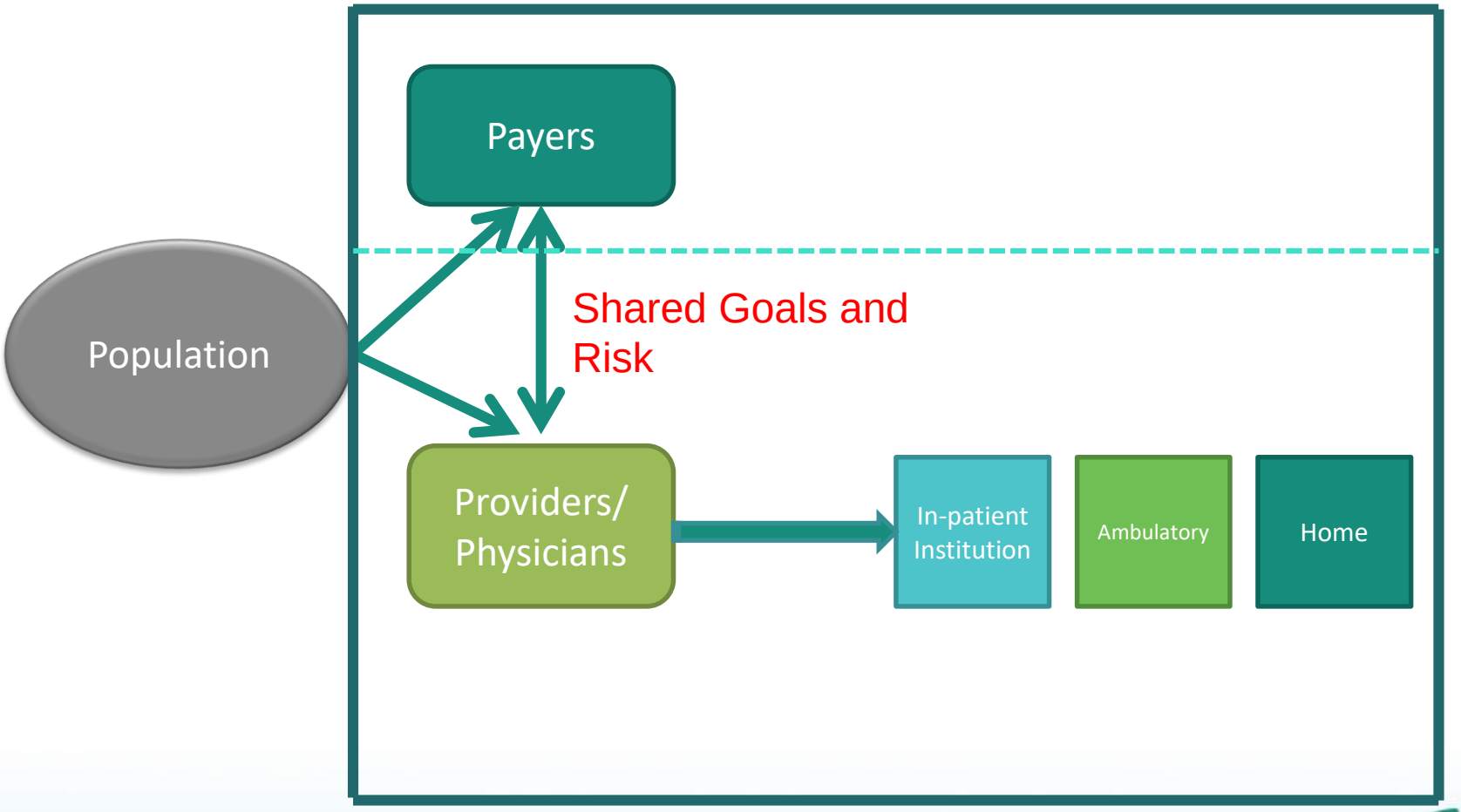
Predominant Belief:

-Healthcare value is being questioned by all.

-The trends in cost for acute, post-acute, outpatient, and ambulatory healthcare are not sustainable for patients, employers and payers.

-Providers and provider groups must compete on their ability to deliver high quality care at predictable costs and with a better patient experience.

Population Health Future State



Fee For Service

Spiraling costs and limited resources led to desire for healthcare payment reform.

FFS has never been able to control costs, no matter what has been tried.

FFS motivates provider to increase and not contain costs.

Movement for Reform Led by CMS

-Initially identified hospital expenses as a substantial driver for utilization.

-Began a steady process to convert reimbursement to providing for quality care.

-Placed quality processes in hospital care metrics.

-Method for reform:

- Report on these Metrics
- Publish results
- Alter payment based on performance.

Hospital Measures:

-Required reporting for Hospital Acquired Conditions (HAC): Surgical events, Catheter associated events (blood stream and urinary infections), Skin care events (decubitus ulcers).

-Imposed penalties for not meeting expectations.

-Refused payment for care deemed inappropriate and for repeat admissions within certain post-acute periods.

-Less than optimal success in these efforts as Physicians never truly held accountable

Physician Practice Measures:

-Quality standards set for physicians caring for Medicare and Medicaid recipients (P4P).

PQRS (Physician Quality Reporting System) - 2007.

Meaningful Use - 2009. (Pt engagement requirement)

-Initial incentives made available to entice engagement for reporting.

-Later penalties for not meeting process measures.

Move Toward Accountable Care and Clinical Integration

-CMS moved from individual efforts to drive value, to population health management with ACA in 2010.

Accountable Care Organizations as the cornerstone.

-Goal: Align providers to manage the health of an entire population to control the escalating cost of care.

Accountable Care Organizations

ACO Pioneer Demonstration Project of 2011.

- Groups of providers formed to manage their population of patients toward improved health and lower cost.

What seemed relatively straight forward, was harder to achieve:

- Medicare approved 32 Pioneer Accountable Care Organizations in December 2011.
  - 19 remained by end of 2015.

Takeaways from Pioneer Project

-ACO's led by Primary Care Providers were most successful.

-With the same population, it became more difficult to drive costs down.

-Upside only incentives were often marginally successful because providers tended to manage only the low hanging fruit.

-Altering provider practice behavior to obtain consistent cost savings is more effective when risk is involved.

-CMS subsequently approved 404 MSSP ACOs In 2015, covering over 7.3 million lives in 49 states.

Trajectory for Baseline Physician Payments

MACRA (Medicare Access and CHIP Reauthorization Act) 2015

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

1. MIPS Bonuses/Penalties

+/-4% Maximum annual adjustment, 2019

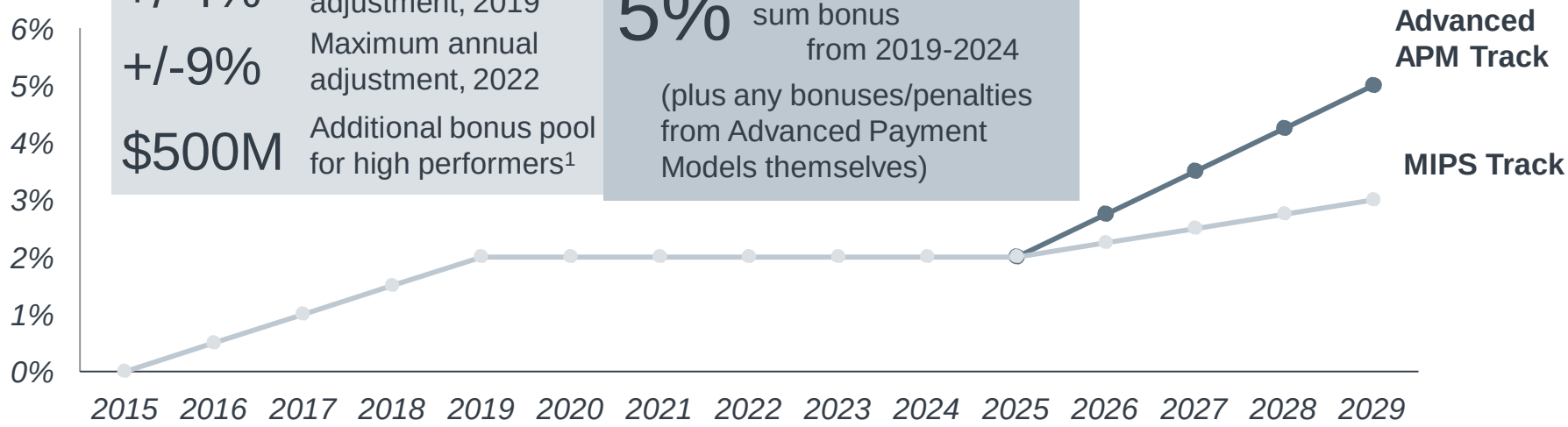
+/-9% Maximum annual adjustment, 2022

$500M Additional bonus pool for high performers[1]

2. APM Bonuses/Penalties

5% Annual lump-sum bonus from 2019-2024

(plus any bonuses/penalties from Advanced Payment Models themselves)



Baseline payment updates[1]:

2015 – 2019:
0.5% annual update (both tracks)

2020 – 2025:
Payment rates frozen (both tracks)

2026 onward:
0.25% annual update (MIPS track)
0.75% annual update (Advanced APM track)

1) Clinicians with a threshold final score of 70 or higher eligible for additional bonus.
2) Relative to 2015 payment

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, "Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," October 14, 2016; Advisory Board interviews and analysis.

Clinically Integrated Network

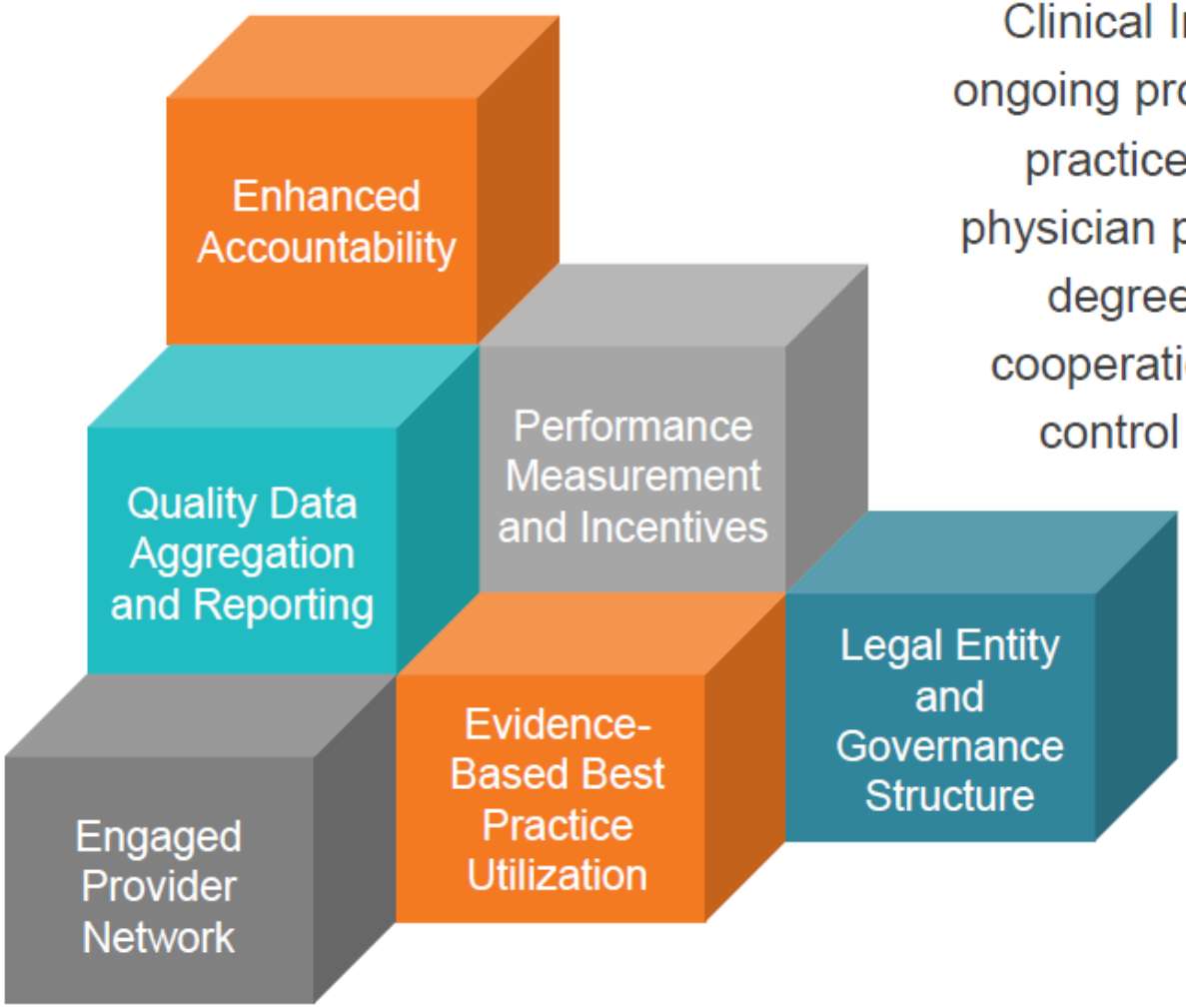
-A collection of health providers that work together to improve care and reduce costs.

primary care physicians, specialists, physician extenders, hospitals, and post-acute providers/facilities.

-Patient care is managed and coordinated between these providers, services, and settings with **aligned incentives** and **shared goals** for quality and performance.

Clinical Integration is a Defined Program by the FTC to Allow Joint Contracting Without Financial Risk

The Building Blocks of Clinical Integration



Clinical Integration is "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

-Federal Trade Commission (FTC) Definition

Value-based Contracting

-Attributed lives are the currency for value-based contracts.

-Primary Care Providers, not specialists, determine attributed lives.

-Primary Care: Pediatrics, Family Medicine, Internal Medicine, Med/Peds

Value-based Contracting

-Clinically Integrated Network (CIN) determines which Primary Care Providers will participate in a contract.

-Payer applies attribution methodology to define CIN population under contract. (claims-based vs voluntary)

-Actuaries project total costs for medical care and Rx and assign benchmarks.

-CIN negotiates shared savings/shared loss tiers based on degree below or above cost targets.

Success In Risk Contracts Driven By 5 Value Levers

Value Levers

Risk Adjustment	*Increase benchmark by up by accurately capturing patient acuity through accurate coding*
Quality	*Achieve the established quality metric thresholds to improve benchmark*
Clinical Programs	*Drive medical savings through clinical interventions to drive down total medical expense – **Transitions, Complex Care, and Advanced Illness Programs***
Network Alignment	*Processes and strategic goals applied across the network by bringing together primary care and specialties, and leverage provider networks to achieve savings – **Pharmacy, Post-acute***
Technology	*Technology to aggregate data and identify impactable opportunities, drive engagement and management of high-risk populations, and support robust tracking and measuring of performance*

Increasing risk allows clinical/financial benefits