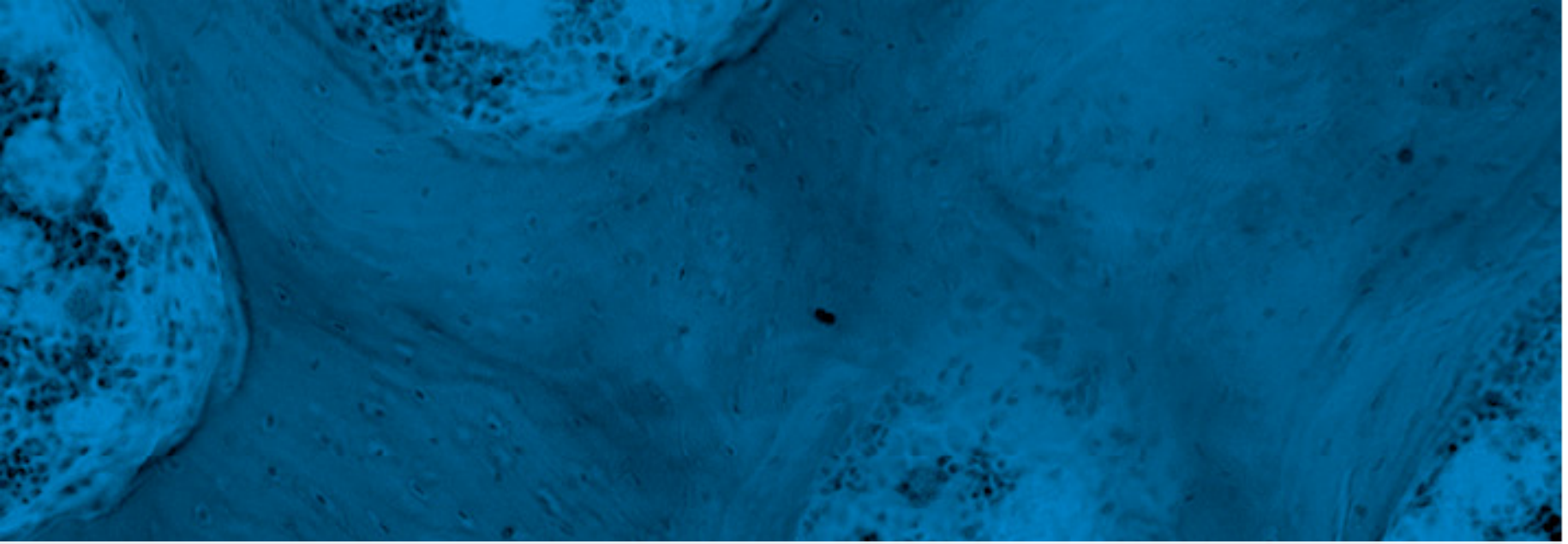
Thoughts on Future of Value-Based Care

Speakers

Jay Crosson, MD, is the immediate past chairman of the Congressional Medicare Payment Advisory Commission (MedPAC). MedPAC advises Congress on ways to promote high quality coordinated care for beneficiaries and preserve the fiscal integrity of the Medicare program. Previously, Dr. Crosson completed 35 years of clinical and executive experience with Kaiser Permanente. He was the founding executive director of The Permanente Federation, the national organization of the Permanente Medical Groups, the physician component of Kaiser Permanente. He served in that role from 1997 to 2007. Subsequently he was a senior fellow at the Kaiser Permanente Institute for Health Policy. He currently is senior lecturer at the Kaiser Permanente School of Medicine. Dr. Crosson is past chair of the governing board of the American Medical Group Association (AMGA). In 2003 he founded the Council of Accountable Physician Practices (CAPP), which promotes integrated delivery systems. From 2012 to 2014 he was a group vice-president of the American Medical Association, where he founded a department dedicated to improving physician practices. He also served on the National Advisory Committee of the Agency for Healthcare Research and Quality (AHRQ) from 2012-2015. He is a member of the editorial board of JAMA-Internal Medicine. Dr. Crosson received an undergraduate degree in political science and, in 1970, a medical degree from Georgetown University. He completed a residency in pediatrics at the New England Medical Center Hospitals and a fellowship in infectious diseases at the Johns Hopkins University Medical School. He is a graduate of the Kaiser Permanente executive program at Stanford Business School.

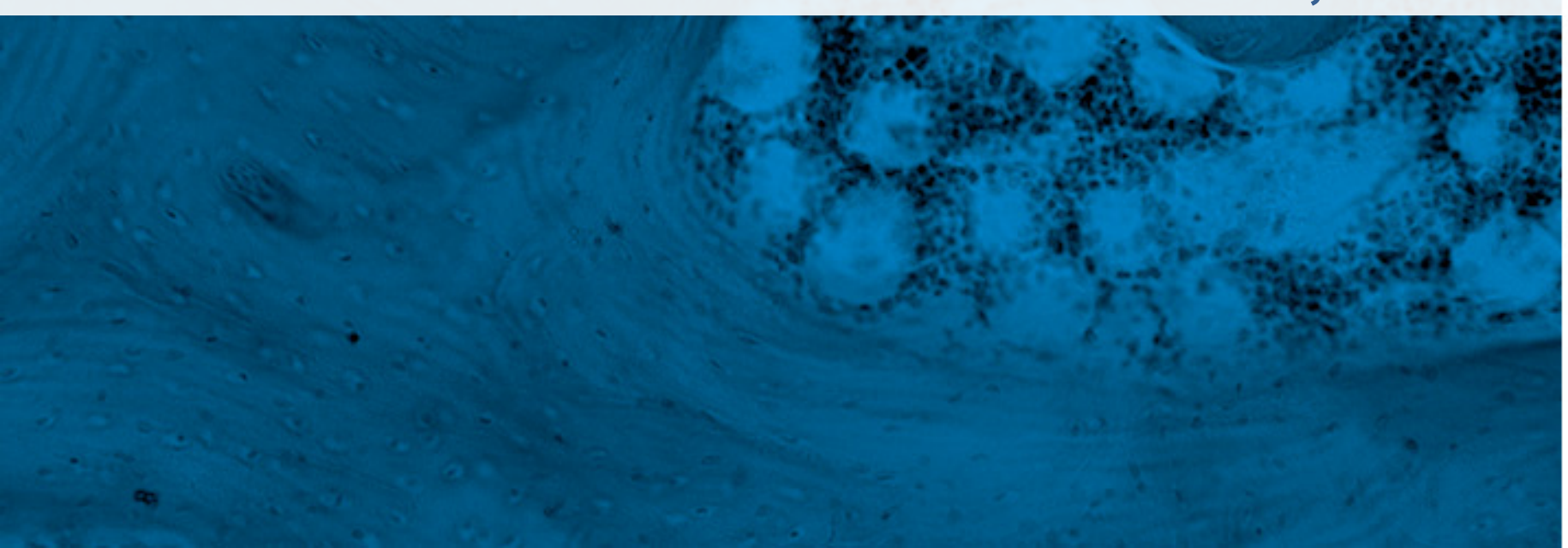
Speakers

Michael Chernew, PhD, is the Leonard D. Schaeffer Professor of Health Care Policy and the director of the healthcare markets and regulation (HMR) lab in the department of health care policy at Harvard Medical School. Dr. Chernew's research examines several areas related to improving the health care system including studies of novel benefit designs, Medicare Advantage, alternative payment models, low value care and the causes and consequences of rising health care spending. Dr. Chernew is currently serving as the chair of Medicare Payment Advisory Commission (MedPAC) while previously serving as the vice chair from 2012-2014 and a member from 2008-2012. In 2000, 2004 and 2010, he served on technical advisory panels for CMS that reviewed the assumptions used by Medicare actuaries to assess the financial status of Medicare trust funds. He is a member of the Congressional Budget Office's panel of health advisors and vice chair of the Massachusetts Health Connector Board. Dr. Chernew is a member of the National Academy of Sciences, a research associate at the National Bureau of Economic Research and a senior visiting fellow at MITRE. He is currently a co-editor of the *American Journal of Managed Care*. Dr. Chernew earned his undergraduate degree from the University of Pennsylvania and his PhD in economics from Stanford University. In 1998, he was awarded the John D. Thompson Prize for Young Investigators by the Association of University Programs in public health. In 1999, he received the Alice S. Hersh Young Investigator Award from the Association of Health Services Research.



MedPAC Thoughts on the Future of Value-Based Care in Medicare

Francis J. Crosson, M.D.



Derivation of This Presentation

***MedPAC Report to the Congress*, June 2020, Chapters 1+2**

"Realizing the promise of value-based payment in Medicare: An agenda for change" and "Challenges in maintaining and increasing savings from accountable care organizations"

http://www.medpac.gov/docs/default-source/reports/jun20_ch1_reporttocongress_sec.pdf?sfvrsn=0

http://www.medpac.gov/docs/default-source/reports/jun20_ch2_reporttocongress_sec.pdf?sfvrsn=0

The ACO Idea Was Originally Recommended by MedPAC in 2009 Prior to the ACA Passage

“ The defining characteristic of an ACO is that a set of physicians and hospitals accept joint responsibility for the quality of care and the cost of care received by the ACO’s panel of patients”

***MedPAC Report to the Congress,* June, 2009**

The New Hope

How It Can Feel at the Moment

MedPAC Continues to Advocate for the Success of the ACO Idea

- In the June 2020 Report we identified four big barriers to eventual ACO success-easy to name, harder to address-but we must do so over time.
  - Medicare beneficiaries do not understand what ACOs are and feel no particular inclination to join or cooperate with them
  - ACOs do not have incentives to manage Medicare Part D drug costs, at a time when these costs are increasing
  - Most hospitals have conflicting financial incentives with ACOs
  - Most ACOs are still wedded to FFS payment, from payers and to providers

ACOs and Medicare Beneficiary Engagement

- Most beneficiaries are not engaged with the ACO idea
- Solutions?
  - Beneficiary education about ACOs- CMS Toolkit

https://innovation.cms.gov/files/x/aco-beneficiary-engagement-toolkit.pdf

  - Incentives (two-sided risk, some CMMI DC model only):
    - Primary care visit $20. payment
    - Disease management benefit
    - Part B cost-sharing waiver
    - 3-day SNF requirement waiver

ACOs and Medicare Part D Drug Costs

- Prescription drug costs are rising, and have become a publicly recognized and politicized issue. It would be good if ACOs were part of the solution, and recognized as such
- But:
  - Not all beneficiaries have signed up for Part D
  - Part D plans are many and separate business entities
- Solutions?
  - Add Part D spending to the ACO benchmark? Not so good.
  - CMS facilitate voluntary "association" of ACOs with Part D plans, with incentive sharing. Feasible- (CVS SilverScript model)

ACOs and Hospitals

- A few hospitals work off "global payments", but most have revenue based on "heads in beds"
- In many cases the hospital revenue incentive is in conflict with the ACO cost performance incentive, even if the hospital owns the ACO. Hospital-owned ACOs cost performance is poorer.
- Solutions?
  - Increase hospitals' incentive to reduce unnecessary service use (it would have to be pretty big to counteract the value of more admissions and HOPD procedures)

ACOs and Hospitals

- **Increase practicing physicians" roles in hospital governance and management decisions** https://www.aha.org/system/files/media/file/2019/05/Integrated-Leadership-Hospitals-HealthSystems.pdf
- **Global Medicare payments to hospitals- Maryland-like?**

ACOs and Fee-For-Service Payment

- Should we *care* how ACOs are paid, or how they pay their providers, as long as they are at risk?
- But, FFS payment can create incentives for the provision of services of marginal or no value
- Solutions?
  - Increase the use of global payments to ACOs- underway
  - Create incentives for ACOs to use salary or partial capitation to pay providers (e.g. primary care, certain specialties) where feasible?
  - Do the same for Medicare Advantage plans?

Conclusion

- ✓ Over to my distinguished colleague and successor-

Dr. Michael Chernew

- ✓ Questions and discussion to follow, as time allows

Value Based Payment: Future Directions

Michael Chernew

Disclaimer

- Opinions expressed are mine alone and not those of MedPAC or any other organization I am affiliated with

Robert Wood Johnson Foundation

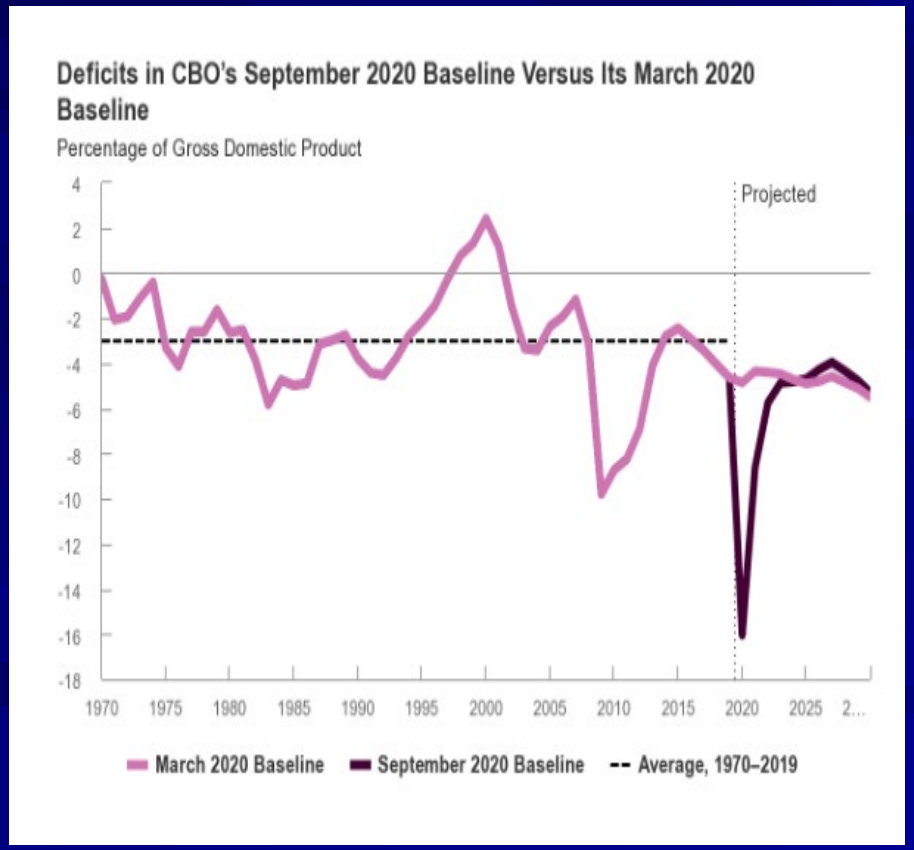
From Volume to Value

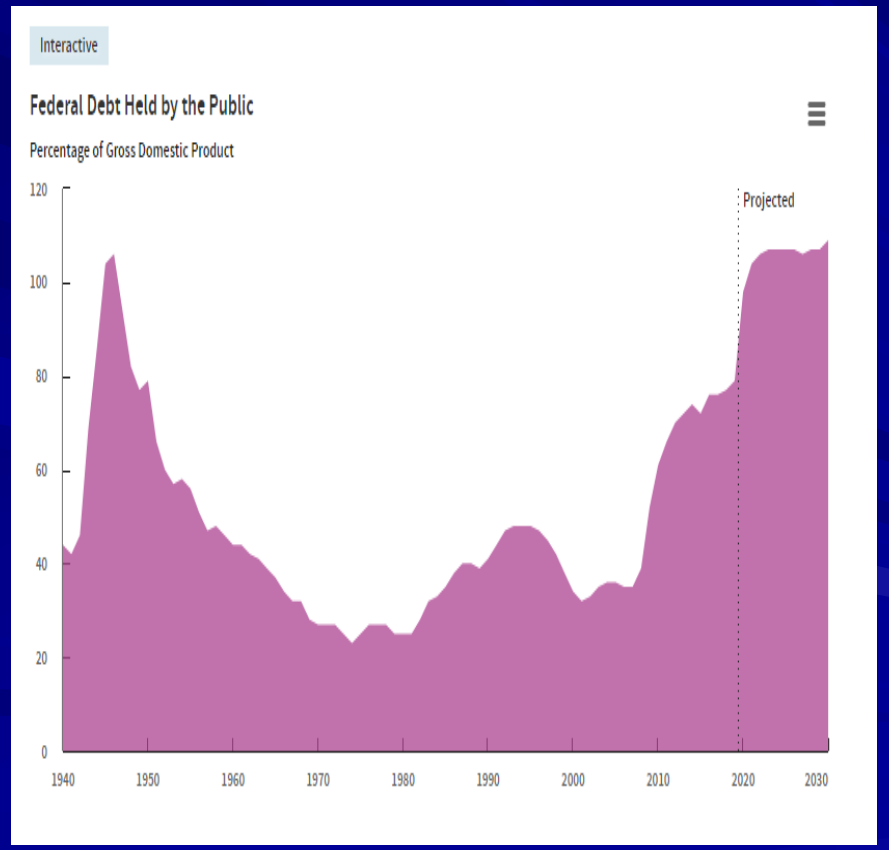
Transforming Health Care Payment and Delivery

“Value Based Payment”

Financial Pressures are Paramount

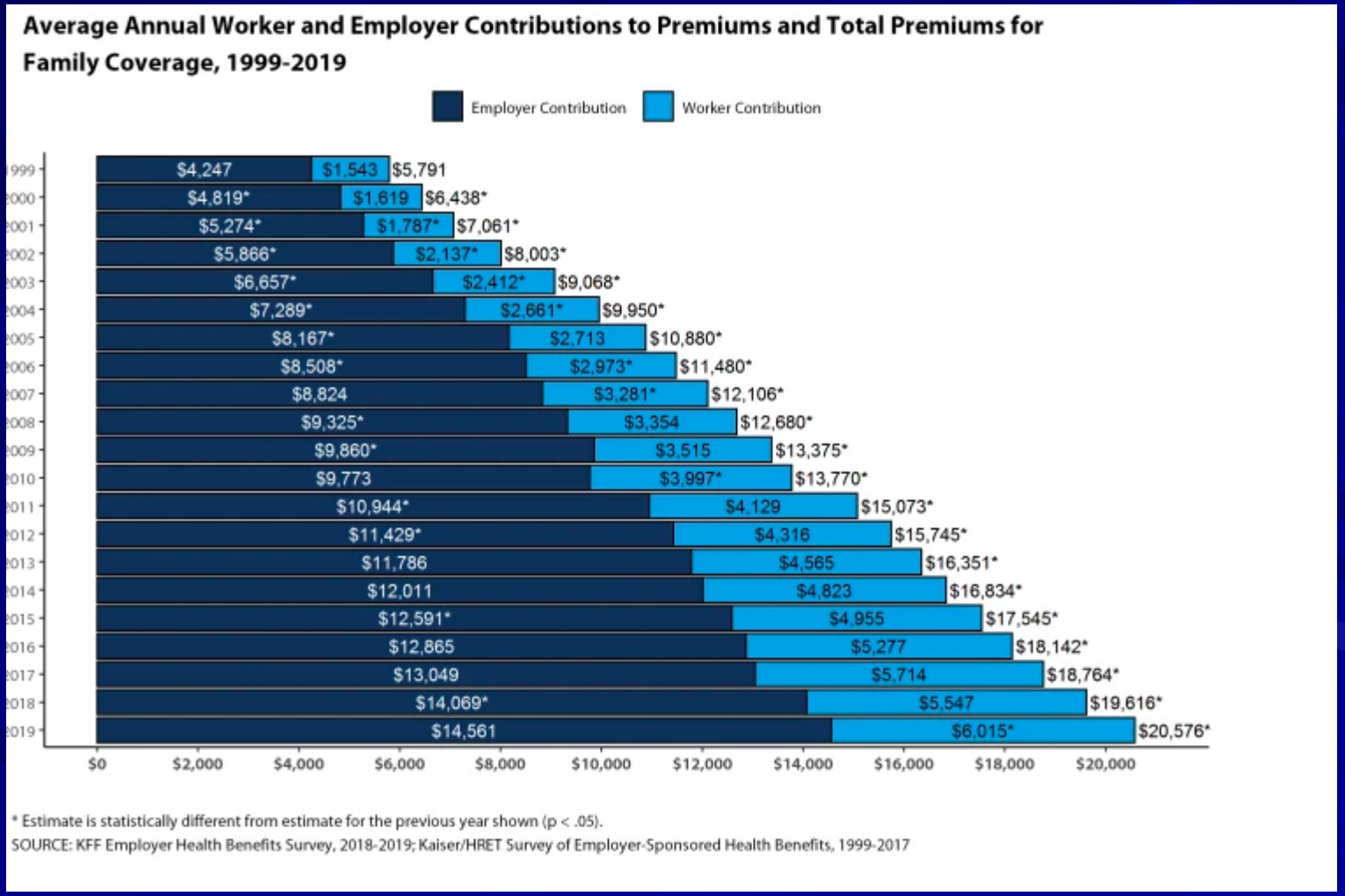
- Medicare Pt A trust fund exhaustion: 2024





https://www.cbo.gov/publication/56517#section1

Rapid Growth in Commercial Premiums



Current Situation

Demographics are a Significant Challenge

Figure 1-5a. Medicare enrollment

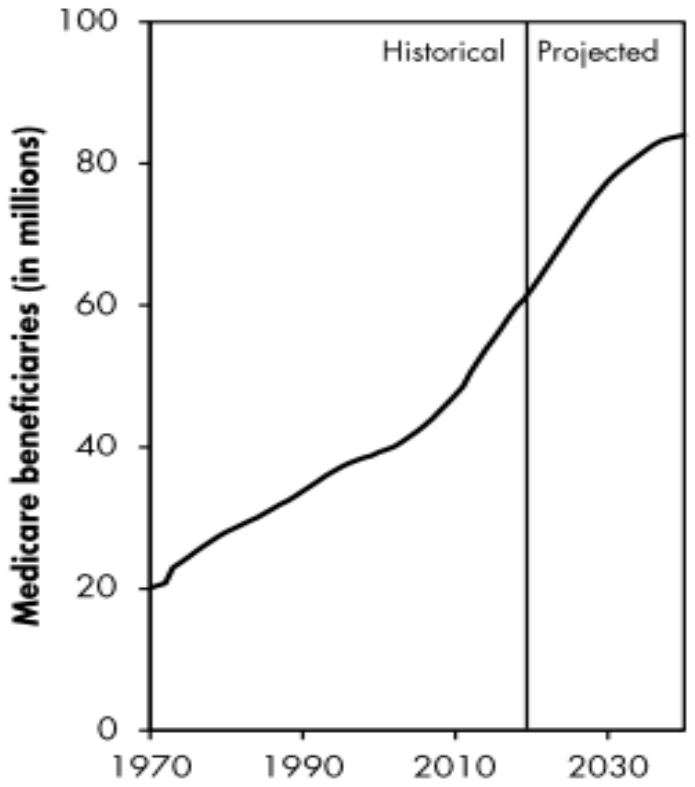
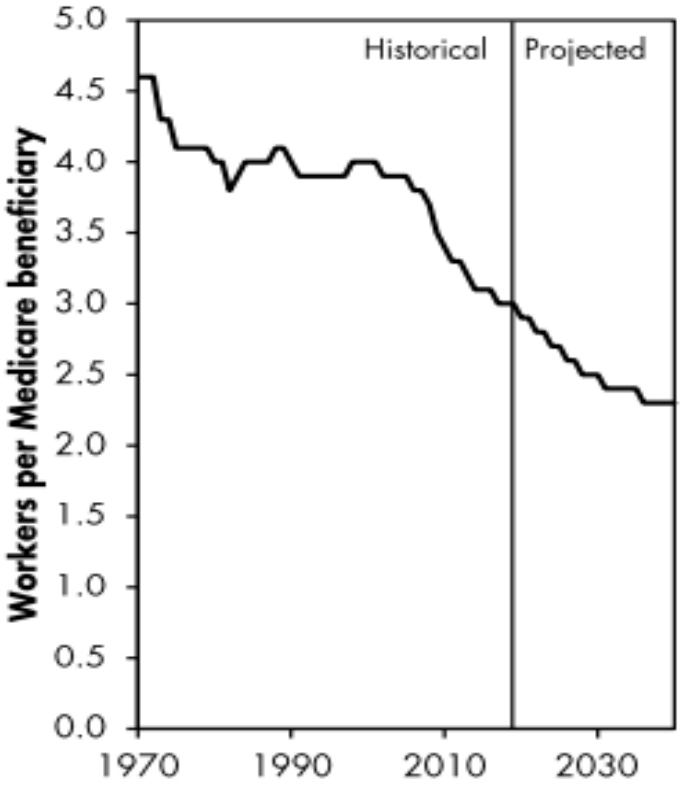


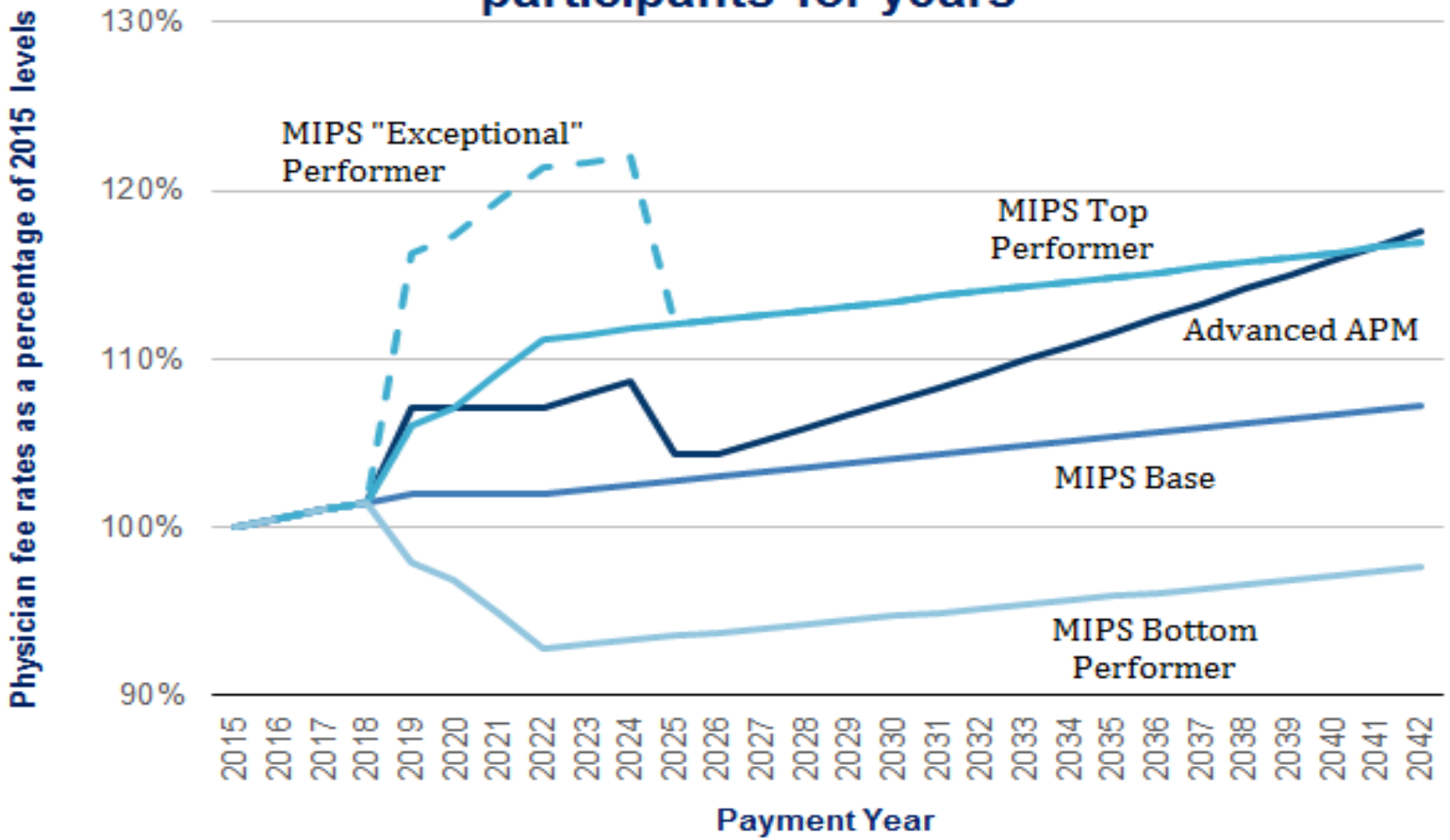
Figure 1-5b. Workers per beneficiary



Note: "Beneficiaries" referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). Part A is financed in part by Medicare's Hospital Insurance Trust Fund. The potential effects of the COVID-19 pandemic are not included in these projections.

Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

Top MIPS performers could out-earn APM participants for years



Source: Data compiled based on fee update and performance-based bonuses and penalties under the two incentive programs outlined in the Medicare Access and CHIP Reauthorization Act of 2015.

Note: Advanced APM line excludes contract performance and MIPS excludes the use of a conversion factor that can magnify a MIPS bonus or penalty by as much as three times to ensure budget neutrality.

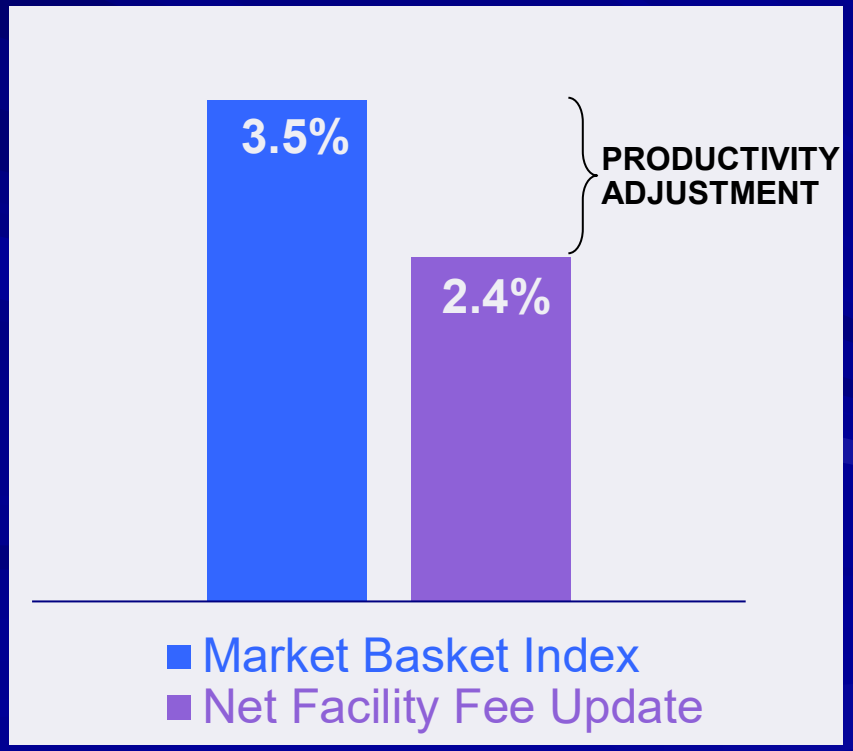
BROOKINGS

USC Schaeffer

Leonard D. Schaeffer Center for Health Policy & Economics

Productivity Adjustment

- Pre-ACA, facilities received annual fee updates to reflect price increases of inputs (*market basket*)
- ACA reduced fee updates → facilities expected to improve productivity to offset price increases of inputs
  - Market basket index reduced by about 1% annually



Source: https://www.aei.org/publication/an-aca-provision-youve-never-heard-of-could-end-up-being-very-costly/

Greater Efficiency is Essential

Theory of APMs

- Efficiency requires flexibility in how ‘inputs’ are used
- Health care services are inputs
- Health is the output
- Flexibility to substitute inputs and capture gains from efficiency are important.

Efficiency Requires Flexibility in Production

➔ APMs Can Allow that Flexibility
➔ APMs Incent Efficiency

What We Know

- Some APMs save money (ACOs, some EBPs)
  - Not much
- APMs maintain or improve quality
  - Not much

The Juice is Worth the Squeeze

- Lower spending and similar or better quality is always good
- We can perform better
- We can improve design
- Broader points
  - Diminishes consequences of poor fee schedule
  - Facilitates adoption of efficiency promoting innovations that have potential for overuse

➔ What alternative is better

Facilitates Coverage of Innovative Services

- Many regs are designed to prevent overuse
- In some cases innovative service may add substantial value IF used wisely
- APMs can permit coverage and avoid overuse concerns
  - Telehealth
  - New of care shifts
    - Hospital at home
  - Social support

Why Progress is Slow

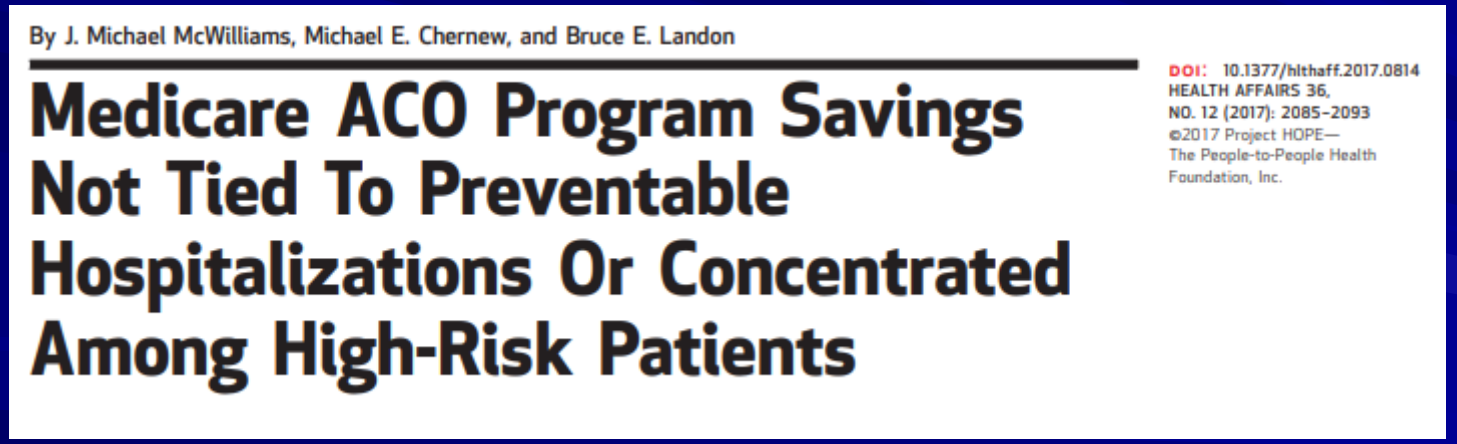
- Operational difficulties
  - Risk adjustment
  - Benchmark design
  - Attribution people to systems;
- Culture
  - Who keeps the savings
- Weak/ mixed provider incentives (provider ROI?)
- Mixed/ overwhelming messages from CMS (too many programs)
- Purchasers/ payer ROI
  - Savings get shared
- Spillover: Insurers who invest in better models may not capture all the savings

APM Challenges

- Risk adjustment
- Tweaking incentives
  - Encourage savings
  - Encourage participation
- Maintain quality
- Figuring out what works

What Works (or not)

- Target low value care
- Care coordination/ disease management?



By J. Michael McWilliams, Michael E. Chernew, and Bruce E. Landon

Medicare ACO Program Savings Not Tied To Preventable Hospitalizations Or Concentrated Among High-Risk Patients

DOI: 10.1377/hlthaff.2017.0814
HEALTH AFFAIRS 36,
NO. 12 (2017): 2085–2093

Future Direction

- Reduce the number of models
- Improve model design
  - Risk adjustment
  - Benchmark setting
- Align/ harmonize models
  - With each other
  - With Medicare Advantage

Final Thought on Risk and Benchmarks

- Downside risk overrated
  - Impact more modest than thought
  - Participation concerns
- Avoid the rachet
- Slow convergence
- Provider Premium Support
  - Use a fixed update rule
    - Regional FFS
    - National FFS
    - Fixed target
  - Converge slowly

Questions?