Listening Session on Issues Related to Population-Based TCOC Models

Presenters:

- **Michael E. Chernew, PhD**, Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Director, Healthcare Markets and Regulation Lab, Harvard Medical School
- **Cheryl L. Damberg, PhD**, Principal Senior Researcher, RAND Corporation; Director, RAND's Center of Excellence on Health System Performance
- **Michael S. Adelberg, MA, MPP**, Principal, Faegre Drinker Consulting
- **Chris DeMars, MPH**, Interim Director, Delivery Systems Innovation Office; Director, Transformation Center, Oregon Health Authority

Presentation:
Thoughts on Harmonized APMs

Michael E. Chernew, PhD

Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School
Director, Healthcare Markets and Regulation Lab, Harvard Medical School

Thoughts on Harmonized APMs

Michael Chernew

Opinions are mine alone and do not reflect MedPAC's views (or those of any other organization I am affiliated with)

Theory of Value-Based Payment

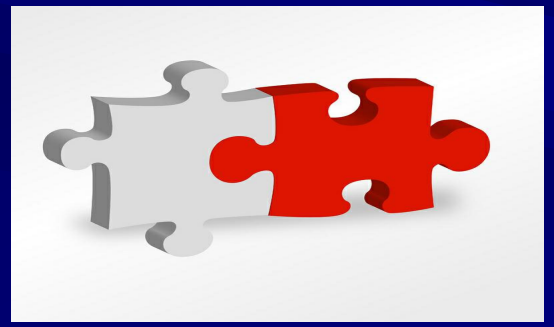
- Efficiency requires flexibility in how ‘inputs’ are used
- Health care services are inputs
- Health is the output
- Flexibility to substitute inputs and capture gains from efficiency are important

Goals

- Create incentive to save
  - Who is best suited to eliminate waste?
- Create incentives to promote access/ quality and equity
- Create incentive to participate
  - Participation is not a goal in itself, but the program cannot accomplish other goals without participation
  - How to induce/ mandate participation

Main points

- No payment model is an island



- APMs must work together

Problems with the “Let many flowers bloom/ test and diffuse paradigm”

- Uncertain future
  - Discourages participation
  - Disincentivizes savings
- Savings get siphoned away
  - Discourages participation
  - Disincentivizes savings
- Participation via model selection can be gamed
- Providers fail to commit to success

Waste as an Asset

Evidence

Population-Based Payment Evidence Summary

- Population-based payment models reduce spending (by a small amount)
  - Savings from: admissions, shift from HOPD to office, PAC
  - Some evidence of reductions in low value care
  - Independent physician groups do better
  - Results improve over time
  - Private sector models do better
- Savings get shared
  - But Medicare still saves
- Quality, equity generally the same or better

Episode Payments

- Some evidence of savings
  - Some lower spending in episodes with post-acute care[2,3]
    - PAC spending decreased ~20% (incl. SNFs, IRFs, Home Health) [3]
  - BPCI saved ~4% on orthopedic episodes[3]
  - Ark saved 5% on perinatal episodes
- Savings not uniform across episodes
- Savings may be offset by increased episode volume (Fisher, 2016)
  - Little empirical for support for this
- No consistent quality impact BPCI[1, 2]

[1] Econometrica, Inc. "Evaluation and Monitoring of the Bundled Payments for Care Improvement Model 1 Initiative." July 2015.
[2] Lewin Group. "CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report." February 2015.
[3] Dummit et al. "Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes." JAMA. 2016;316(12)

Episodes vs Population-Based Payment

- Both lower spending
- Episodes are narrower (harder to get PMPM savings)
- Not all practices can support population-based payment
- Episodes engage specialists better
- Neither have clear impacts on quality

Model Outline

MedPAC Recommendation

RECOMMENDATION 2

The Secretary should implement a more harmonized portfolio of fewer alternative payment models that are designed to work together to support the strategic objectives of reducing spending and improving quality.

Model Outline

- Multi-track population-based model
  - Risk rises with size
  - Avoid ratchet in benchmark
- Add episodes carefully
  - Avoid siphoning savings
  - Focus on episodes with
    - Clear trigger
    - Limited ability of primary care to influence

Presentation:
A Long and Winding Road: Population-Based Total Cost of Care Models

Cheryl L. Damberg, PhD
Principal Senior Researcher, RAND Corporation
Director, RAND's Center of Excellence on Health System Performance

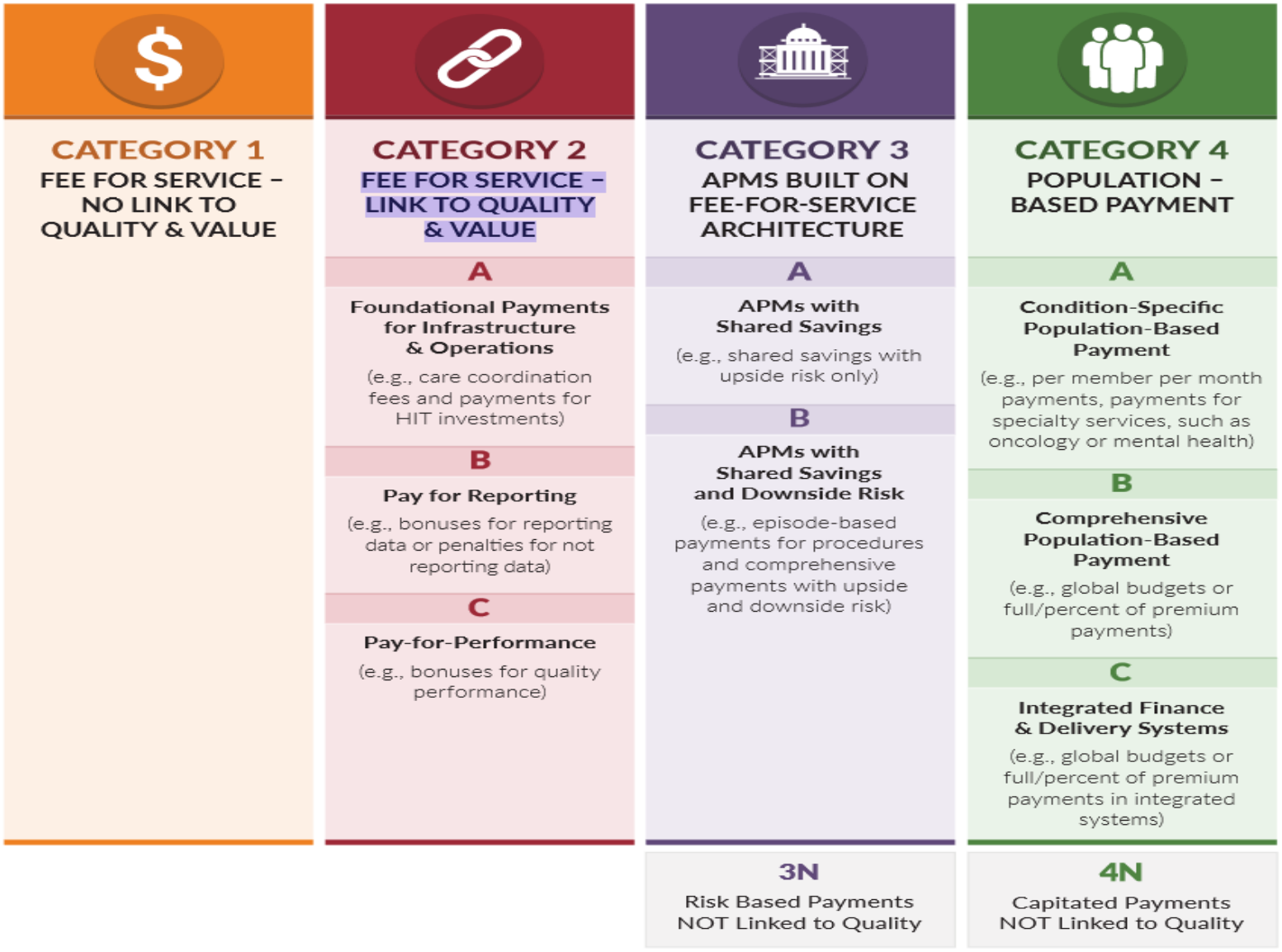
A Long and Winding Road: Population-based Total Cost of Care Models

Cheryl L. Damberg
RAND Distinguished Chair in Healthcare Payment Policy
Director, RAND Center of Excellence on Health System Performance

What have we learned from the past decade of payment reform experiments?

- Modest savings, although with time, the magnitude of savings has increased in some cases
- Quality performance has improved, though still underperforming Medicare Advantage performance in many cases
- Results vary based on contextual factors (e.g., physician-led models had better results)
  - Chernew et al. note that ACOs have stronger incentives to lower spending *on care they do not provide* than care they do provide
  - Savings vary with the strength of incentive
- Uptake of models has varied. Many high-cost players not yet at the table.
- Difficulties managing spending when the population can "leak" out to providers outside the ACO (due to underlying FFS structure)

LAN APM Framework



A Distance to Go to Get to Category 4

- Though progress towards “total cost” payment models has been made, it has been slow
- LAN survey for 2019 payments found:
  - 39.3% of dollars in Category 1 (e.g., FFS, not linked to quality)
  - 22.5% of dollars in Category 2 (e.g., pay-for-performance or care coordination fees)
  - 38.2% of dollars in a composite of Categories 3 & 4 (e.g., shared savings, shared risk, bundled payment, population-based payments, integrated finance and delivery system payments)
- 61.8% still FFS
- A substantial portion of the LAN’s combined APM category 3+4 percentage is also built on a FFS chassis

Level of Participation in ACOs Varies

- Among 477 health systems in the U.S. in 2018, there was significant variation in the percentage of their attributed FFS beneficiaries that were in CMS one-sided and two-sided ACOs
  - 34% of beneficiaries (mean); 18% of beneficiaries (median)
  - 1.9% to 70% of beneficiaries (25^{th} and 75^{th} percentiles)
- **Hard to redirect attention and resources** to population-based care delivery if a small fraction of your patients are under the total cost of care payment arrangement
- Many small practices not involved in total cost models
  - More often in LAN Category 1 and 2

Strong headwinds

- Health systems report not being able to advance care redesign as rapidly as they'd like given the small total share of revenue VBP and total cost models represent of their full "book of business"
- Among the most sophisticated health systems, their leaders reported value-based payments payments represent <5% of their revenues
- Health systems face competing forces from multiple payers with differing incentive programs
  - What do they do? They play to the middle.
    - The middle right now is skewed to the left of the LAN framework – towards FFS delivery

Incentives for value remain small for frontline physicians

JAMA Health Forum™

Original Investigation

Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems

Rachel O. Reid, MD, MS; Ashlyn K. Tom, MPH; Rachel M. Ross, MPH; Erin L. Duffy, PhD; Cheryl L. Damberg, PhD

The results of this cross-sectional study suggest that for PCPs and specialists despite receiving value-based reimbursement incentives from payers, the compensation of health system PCPs and specialists was dominated by volume-based incentives designed to maximize health systems revenue

JAMA Health Forum. 2022;3(1):e214634. doi:10.1001/jamahealthforum.2021.4634

Healthcare Markets are Restructuring in Response to Payment Reforms

- Policy changes stemming from the ACA have contributed to significant **vertical consolidation** of previously independent practices into health systems
- Why are providers integrating?
  - To participate in value-based performance contracts, providers need size (patients) to **spread and manage financial risk**
  - To direct more traffic to their hospitals to **offset loss of revenue** due to policy changes such as financial penalties and the pressure value-based payment contracts place on systems to reduce the total cost of care
  - To have **greater leverage in price negotiations** with payers

Proposed benefits of integration

- Increased efficiencies by lowering administrative costs through economies of scale
- Ability to devote more resources to improving the care delivery infrastructure:
  - clinical care redesign
  - more quality improvement staff
  - investment in interoperable HIT to improve communication
  - investing in enhanced analytics
- Improving clinical integration and coordination of care across providers within a health system – delivering the right care, in the right setting, at the right time

CLINICAL INTEGRATION

It's an assumption that vertical integration produces clinical integration

Structural integration—the physical, operational, financial, or legal ties among operating units within a health system

Functional integration—formal, written policies and protocols for activities that coordinate and support accountability and decision-making among operating units

Clinical integration—actions or activities to integrate patient care across people, functions, activities, and operating units within a health system

CLINICAL INTEGRATION

Clinical integration is harder to achieve

- Clinical integration is harder than structural integration
- It largely hasn't been achieved
- It's difficult to change physician practice patterns
- Executives recognize the necessity, but the trajectory is long
- The pace of payment reform is too slow to be transformative

Evaluation Challenges and Needs

- Quantitative assessments:
  - Voluntary model test = evaluation headache
    - Selection issues
      - Providers get to "choose" their own incentives
      - Entities most likely to succeed will sign up
    - Hard to identify comparison groups
  - Hard to isolate the effect of the APM being tested when other reforms in play
  - Poor understanding of impacts on patients with social risk factors and whether models help reduce disparities
- More qualitative work is needed to understand:
  - Contextual factors to understand the results and improve effectiveness
  - Barriers to implementation and practice change
  - Unintended effects

What is needed moving forward

- Narrow the payment options to bring greater focus
- Ensure incentives to reduce spending are high enough to induce participation and behavior change, and to cover participation costs
- Emphasize testing of models that shift towards true "population-based" payments (e.g., Direct Contracting)
- Mandatory participation to better assess impacts and avoid selection issues
- Increase real-time learnings through more qualitative evaluation
- Regularly adjust design to reflect learnings

damberg@rand.org

Presentation:
The Connection Between High Value Care and Member Affordability Best Practices in Medicare Advantage Benefits and Services

Michael S. Adelberg, MA, MPP
Principal, Faegre Drinker Consulting

The Connection between High-Value Care and Member Affordability

Best Practices in Medicare Advantage Benefits and Services

Prepared by Michael Adelberg, Faegre Drinker
For the Physician-Focused Payment Model Technical Advisory Committee

March 7, 2022

A little about Mike Adelberg

- 25 years in/around the Medicare program, including
  - 15 years at CMS; 10 yrs. in management and leadership positions, including:
    - Director of Medicare Advantage Operations; Assoc Regional Admin - Medicare
  - 10 years at health plans or advising health plans; VP for Product Dev at MAO
- Lead, Healthcare Strategy Practice for national law firm
  - Co-lead, 32-MAO benefit/services innovations consortium
  - Advise plans and provider on intelligent benefit/service design and strategy
- Published on MA in *Health Affairs*, *Stat*, *Compliance Today*, etc.
  - Actively working on two foundation-funded health policy grant projects
- Compiler of the *Digest of Innovative Benefits and Services* (DIBS)

For today's discussion:

Under Total Cost of Care models, what are the best practices for improving affordability to beneficiaries (for example, for copayments, prescription drugs, etc.)?

Assumptions…

- Varying cost sharing across works like a lever to raise or lower utilization of benefits, services, provider types, etc.
- Promoting high-value care and discouraging low value care are the most important ways that capitated MA plans and providers can free up limited funds to improve overall member/patient affordability

Affordability at Center of Total Cost of Care

There is considerable evidence that Medicare beneficiaries are sensitive to cost sharing

- Medicare beneficiaries will under-utilize services (even to their detriment) when they perceive those services as too expensive

There is also considerable evidence that health insurance literacy is low among Medicare beneficiaries, therefore…

- High cost-sharing, particularly via coinsurance, is not well understood when plans are selected; beneficiaries may not select the plan that is best for them

Providers in TCOC models have the same incentives as Medicare Advantage plans to promote high-value care and limit low value care. Below is a brief discussion of Medicare Advantage plan best practices in seeking to promote affordability through high-value care.

Levers to Encourage High-Value Care

- Low-cost sharing for high-value services (e.g., $0 primary care, $0 generic drugs)
- Rewards and incentives to enhance utilization of high-value services (e.g., $25 gift card for a flu shot, $50 in targeted OTC supplies for participating in disease management activities)
- Condition-specific supplemental benefits that reinforce necessary utilization (e.g., transportation to dialysis facilities for members with kidney failure, healthy grocery allowance for members with CHF)
- High-value provider programs that incent members to seek highest performing providers via lower cost sharing or additional benefits
- Real Time Benefit Tools that alert patients and providers to the lowest cost clinically effective drug at the time of prescription

Levers to Discourage Low Value Care

Alter cost-sharing to dissuade inefficient/avoidable care

- e.g., high ER cost sharing (and low urgent care cost sharing)

Transfer benefit value to a lower Max Out of Pocket Protection and employ deductibles to put first dollar coverage on the member

- Legitimate concerns exist regarding whether the savings derived from deductibles lead to avoidable additional expenditures

Utilization Management Tools can squeeze low value care

- Prior authorization lowers utilization (e.g., RSNAT)
- Step Therapies steer utilization toward lowest effective drug
- Legitimate concerns exist regarding how these tools are deployed in some plans

Emerging Lever: Addressing Social Needs

Medicare Advantage plans are increasingly focused on meeting the social needs of members (in the belief that doing so can lower the Total Cost of Care). Examples:

- Social Need platforms and referral services
- Supplemental benefits that address social determinants of health
  - Healthy groceries
  - Transportation
  - In-home supports
  - Socialization activities
  - Home modifications

Different Track: Levers for Marketing Sizzle

- Because Medicare Advantage plans compete for members, plan benefit design is as much about “marketing sizzle” as it is about maximizing the value of the care
- Some benefits may increase plan enrollment without significantly promoting high-value care. Examples…
  - Part B premium buy down
  - Rarely-utilized but popular gym benefits (note: well-utilized fitness benefits are valuable)

Powering the Levers via Cost-Offsetting

Cost Offsetting is the construct for considering costs avoided, modeling improved cost of care, and thereby increasing overall affordability

- Example 1: $0 generic drug increases maintenance medical adherence; medication adherence lessens rate of decline in chronic disease (cost offset: dollars spent lowering drug copay is less than the costs of slowing the progression of the chronic disease)
- Example 2: $0 transportation to dialysis facility for member with kidney failure will lessen emergency dialysis/hospitalization episodes of care (cost offset: dollars spent on transportation + increased dialysis facility utilization is less than costs associated with the avoided emergency/hospitalization dialysis episodes)

Actuaries are generally comfortable with Example 1, but only gradually coming to grips with Example 2. For high-value care to drive affordability, health plans and Total Cost of Care providers must become comfortable with Example 2.

Happy to Continue the Conversation

Michael Adelberg

Faegre Drinker
Principal | Washington, DC
D: +1 202 312 7464
michael.adelberg@faegredrinker.com

Presentation:
Oregon's Health System Reform Journey

Chris DeMars, MPH
Interim Director,
Delivery Systems Innovation Office
Director, Transformation Center,
Oregon Health Authority

Oregon's Health System Reform Journey

Chris DeMars, MPH

Interim Director, Delivery Systems Innovation Office & Director, Transformation Center

March 7, 2022

Oregon Health Authority

Outline

- Coordinated Care Organization model
- Oregon's multi-payer vision
  - Health care cost growth target
  - Spreading value-based payment (VBP) across all payers/providers
  - Regional multi-payer global budget pilot

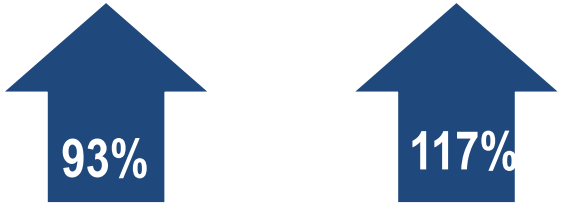
Oregon's Coordinated Care Organizations (CCOs) improve care delivery for Medicaid members

- Community-governed organizations that bring together physical, behavioral, and dental health providers to coordinate care for people on Oregon's Medicaid program (Oregon Health Plan).
- Receive fixed monthly budget from the state to coordinate physical, oral and behavioral health care for patients.
- Receive financial incentives for improving outcomes and quality.
- Have flexibility to address their members' health needs outside traditional medical services.
- This model is designed to improve member care and reduce taxpayer costs.

Oregon has made significant progress

Improved health and delivery…

Percent change among CCOs, 2011-2019



while lowering costs.

Projected expenditures versus actual

2013-2017

94% of people in Oregon are insured

Oregon Health Insurance Survey

But there's more work to do related to cost, value-based payment, social determinants of health, health inequities

High performing countries share four attributes

Affordable, universal coverage

High value and primary care

Invest in social services

Administrative burden

We've been making progress in these areas…

Affordable, universal coverage

- Built on ACA to expand coverage
- Launched statewide cost growth target

High value and primary care

- Patient-centered Primary Care Home program
- Prioritized list promotes high-value care
- CCOs promote integrated, coordinated care
- Elements of the coordinated care model in public employee plans

Social determinants

- Created blended budgets for CCOs with paths for health-related services
- CCOs have bridged connections with health/social systems

Administrative simplicity

- Health Plan Quality Metrics Committee: aligned metrics
- Spreading VBPs
- Centralized health programs in one agency

Ten-year goal: Eliminate health inequities

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

To achieve this goal, we need a simpler system focused on equity

Everyone is insured and has **access** to affordable health care, providing continuity of care as patients move through life transitions

Everyone has access to a core set of **high-value** benefits and **culturally responsive** care that promote equity, primary care, prevention

The health system uses a **fixed total cost of care global budget** with accountability for health equity and health outcomes, and **flexibility to address social needs**

Plan designs, contracts across state programs are **aligned** with **common expectations** for equity, quality, access, cost containment

Oregon's initiatives

- ✓ Achieve universal coverage
- ✓ Implement statewide cost growth target
- ✓ Delivery system and market reforms:
  - **Step 1** > Increase VBP adoption
  - **Step 2** > Align across markets
  - **Step 3** > Pilot a regional multi-payer global budget

Statewide health care cost growth target has been set for the next 10 years

Cost growth target = 3.4%

First five years

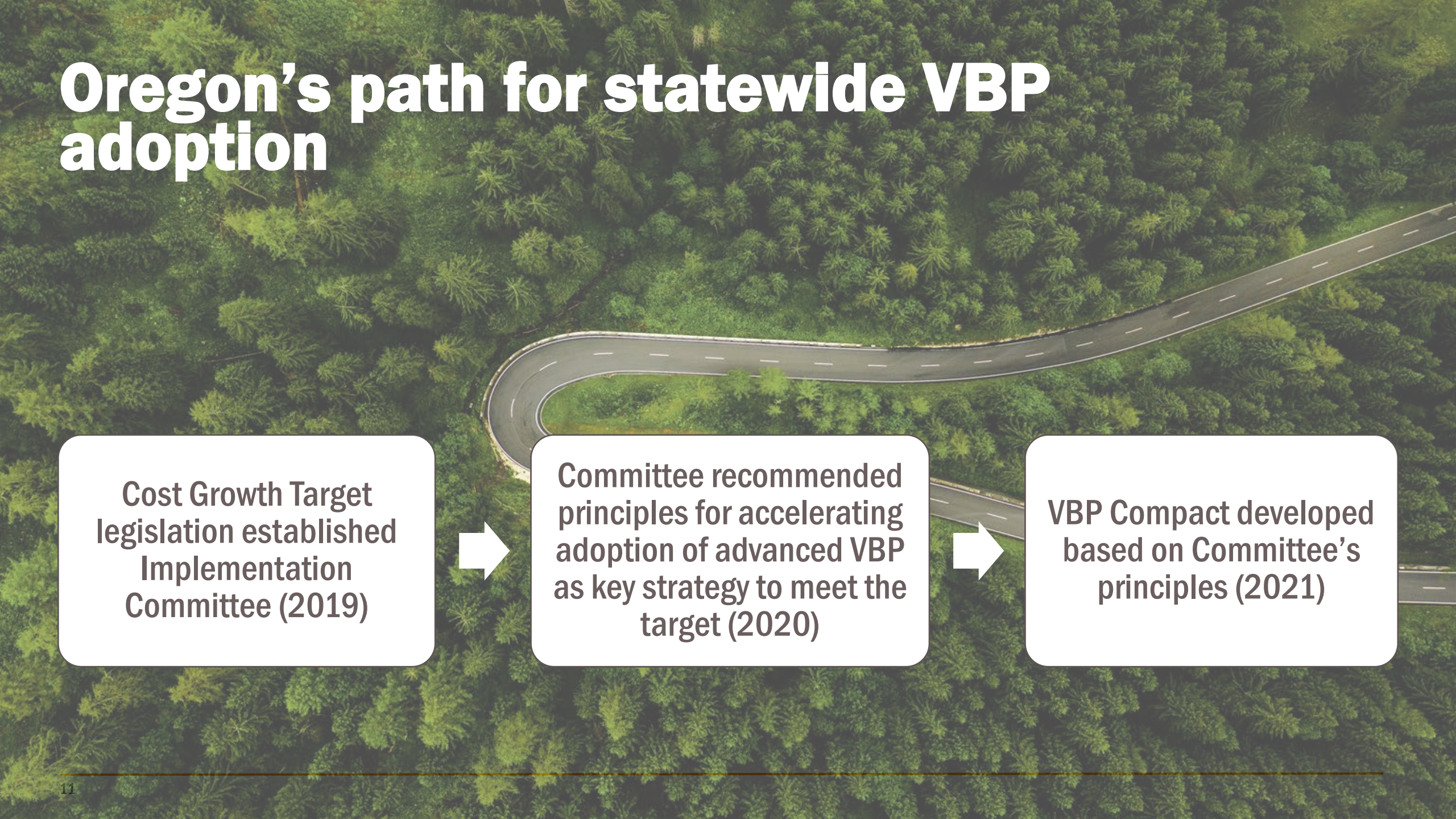
Informed by historical GDP and historical median wage

Cost growth target = 3.0%

Next five years

Oregon is projected to save $16 billion over the next five years

Oregon's path for statewide VBP adoption

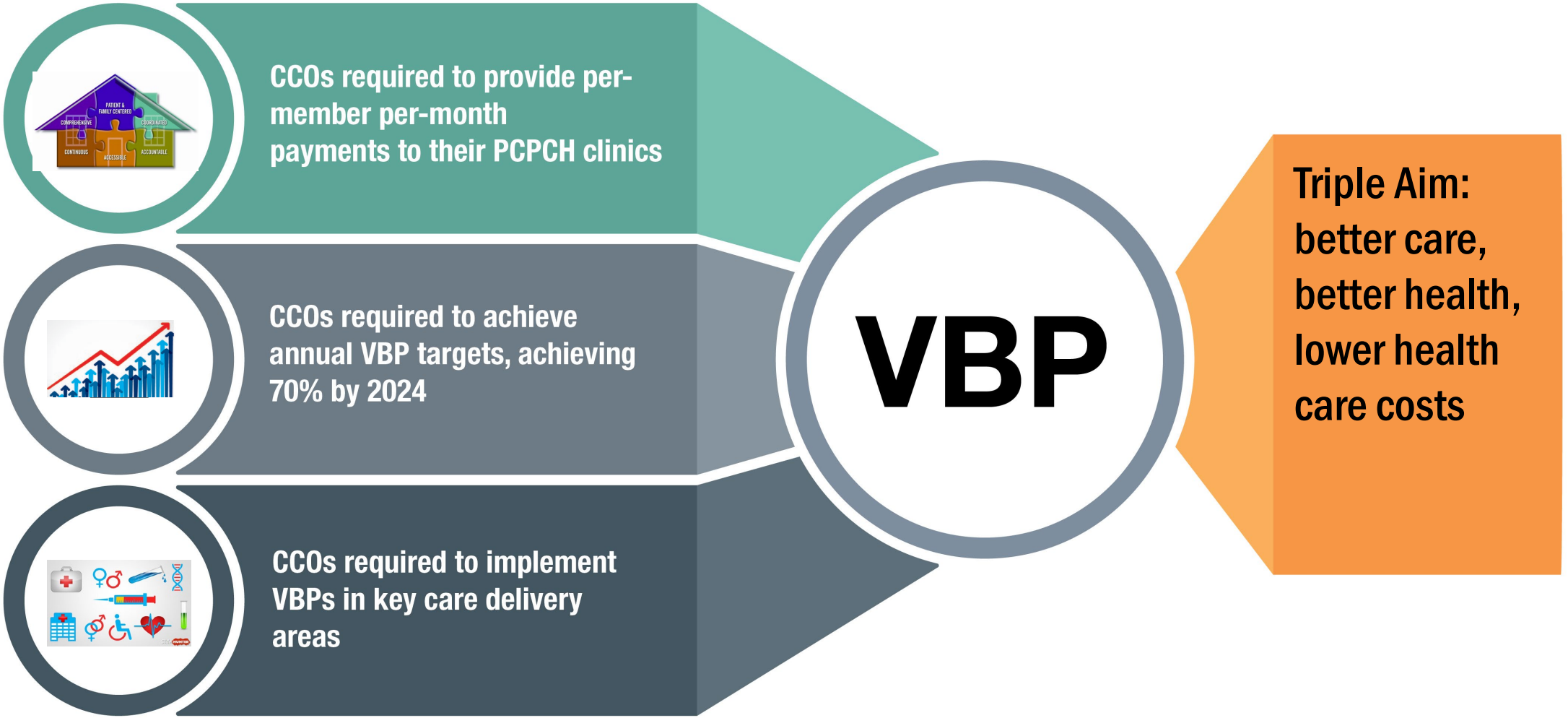


Cost Growth Target legislation established Implementation Committee (2019)

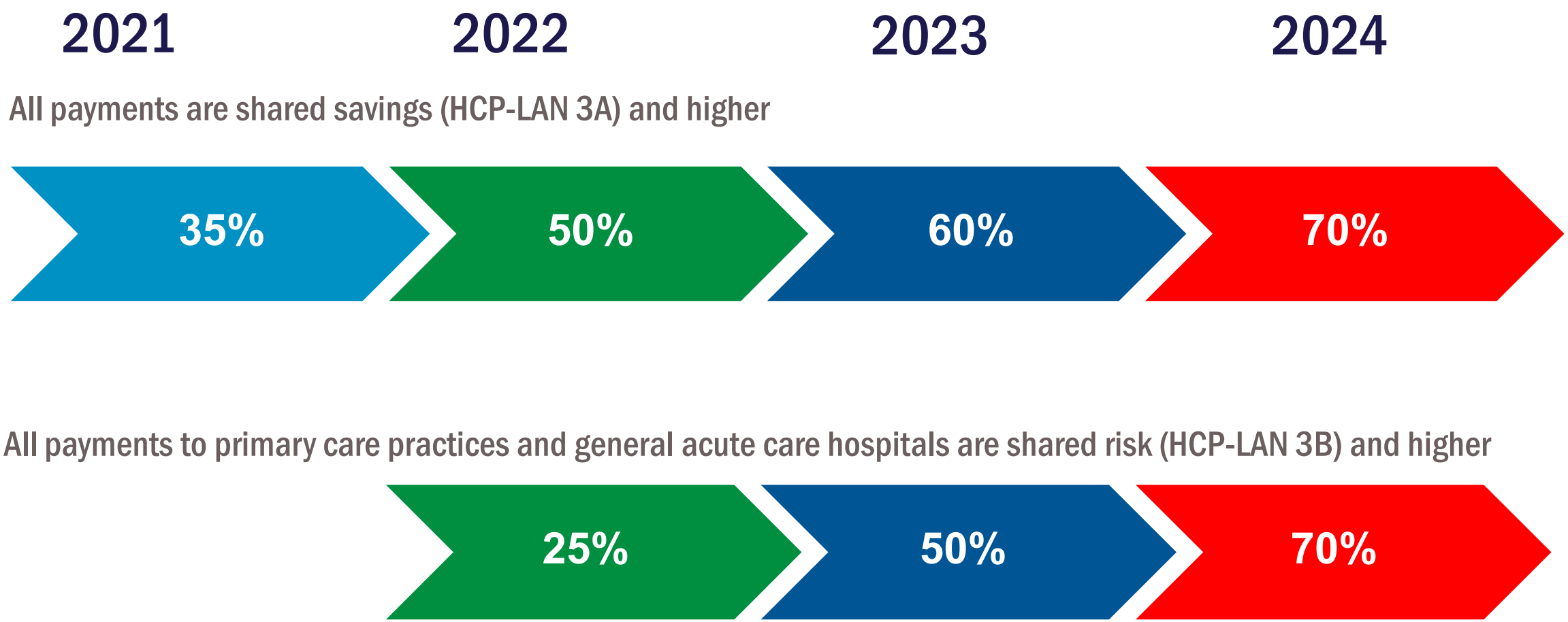
Committee recommended principles for accelerating adoption of advanced VBP as key strategy to meet the target (2020)

VBP Compact developed based on Committee's principles (2021)

Context: CCO VBP requirements began in 2020



Statewide VBP Compact: Voluntary targets build upon CCO requirements



VBP Compact

47

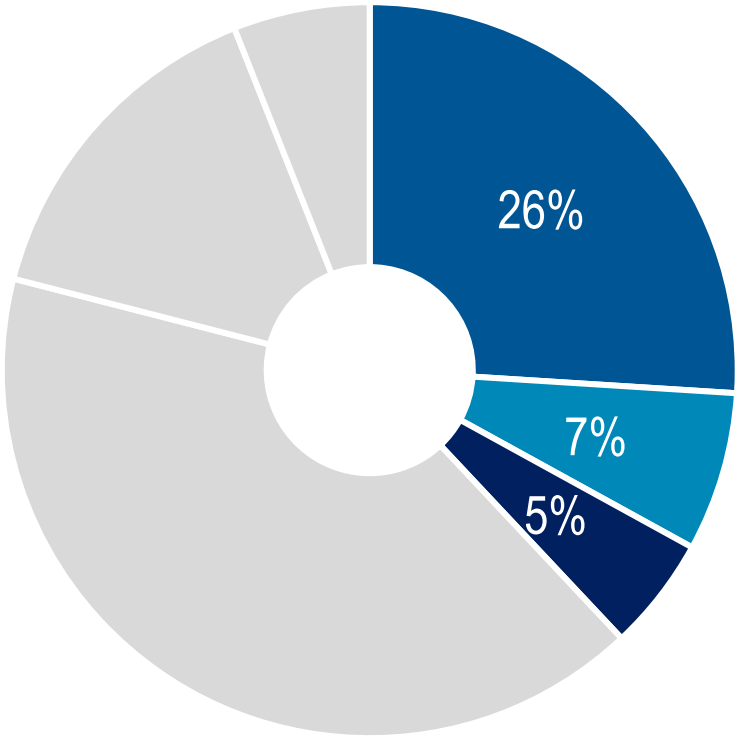
signatories, including commercial payers, Medicaid, Medicare Advantage, health systems and clinics.

73%

of Oregonians are represented by compact signatories.

http://www.orhealthleadershipcouncil.org/oregon-value-based-payment-compact/

Align across markets



- MEDICAID
- PUBLIC EMPLOYEES BENEFIT BOARD (PEBB)/OREGON EDUCATORS BENEFIT BOARD (OEBB)
- MARKETPLACE

Align across markets

Total cost of care, value-based payments, global budgets

Accountability toward equity, quality, and outcomes

Promoting community voice

Pilot a multi-payer global budget

Aligned reimbursement

Aligned metrics

Thank You

Chris DeMars
chris.demars@state.or.us

Oregon Health Authority