Health Reform Outlook: The Challenging Future of Patient-Centered Care

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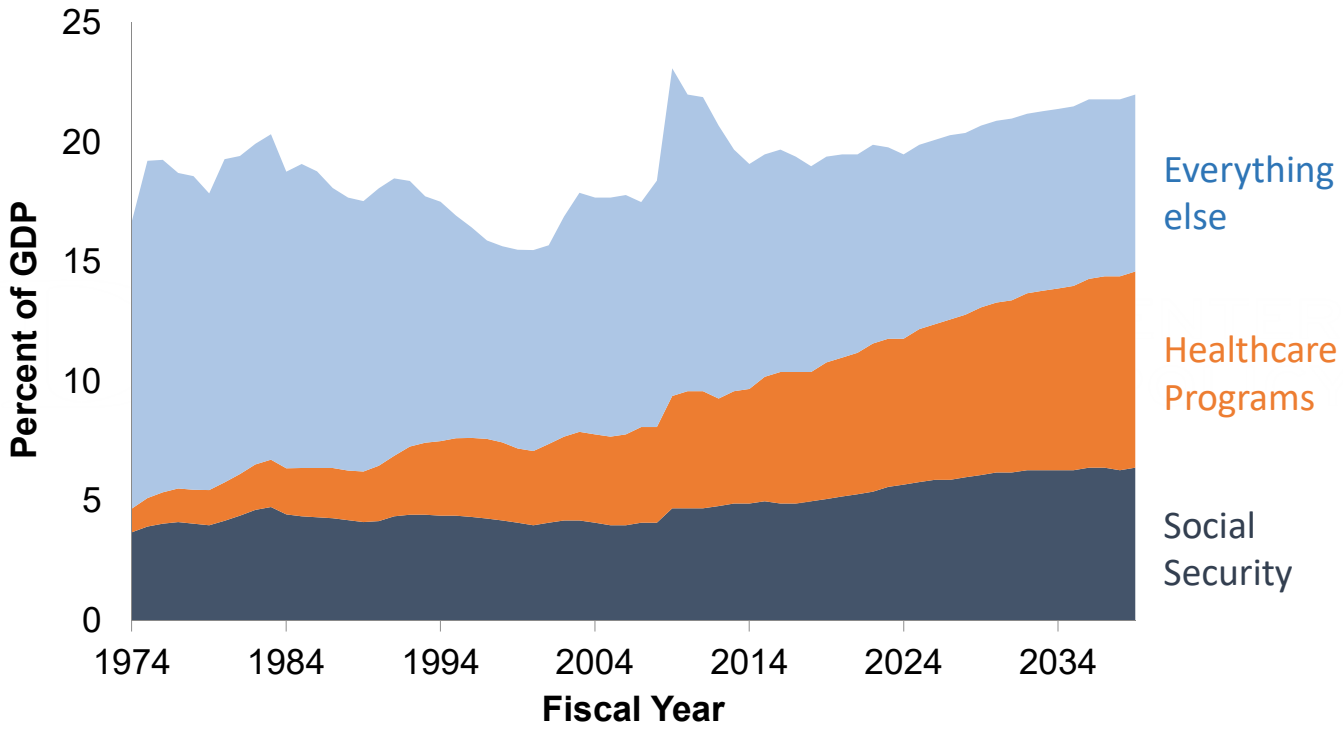
Topics

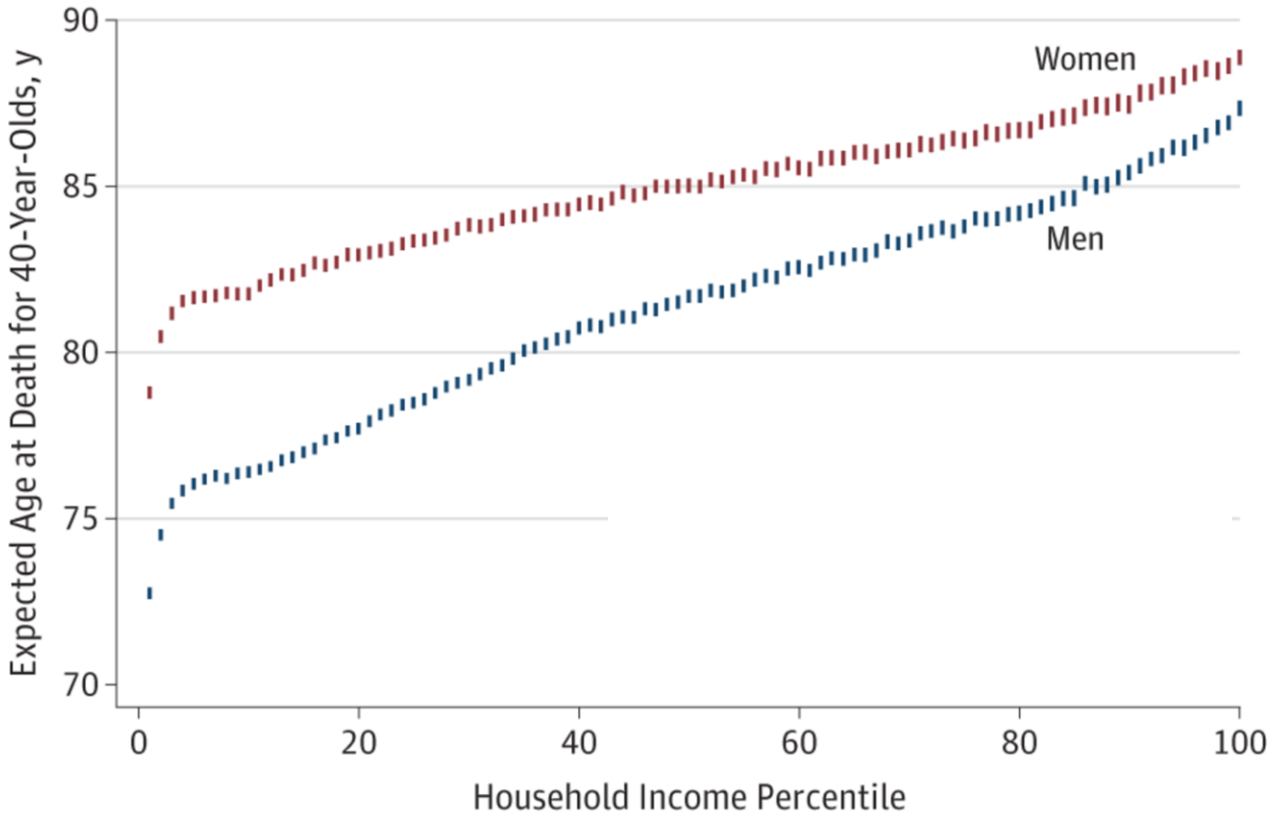
- Health policy reform fundamentals
- Health policy reform outlook
- Status of alternative payment models and value-based payment reform
- Core competencies for success in payment reform
- Discussion

Health Care and the Federal Budget



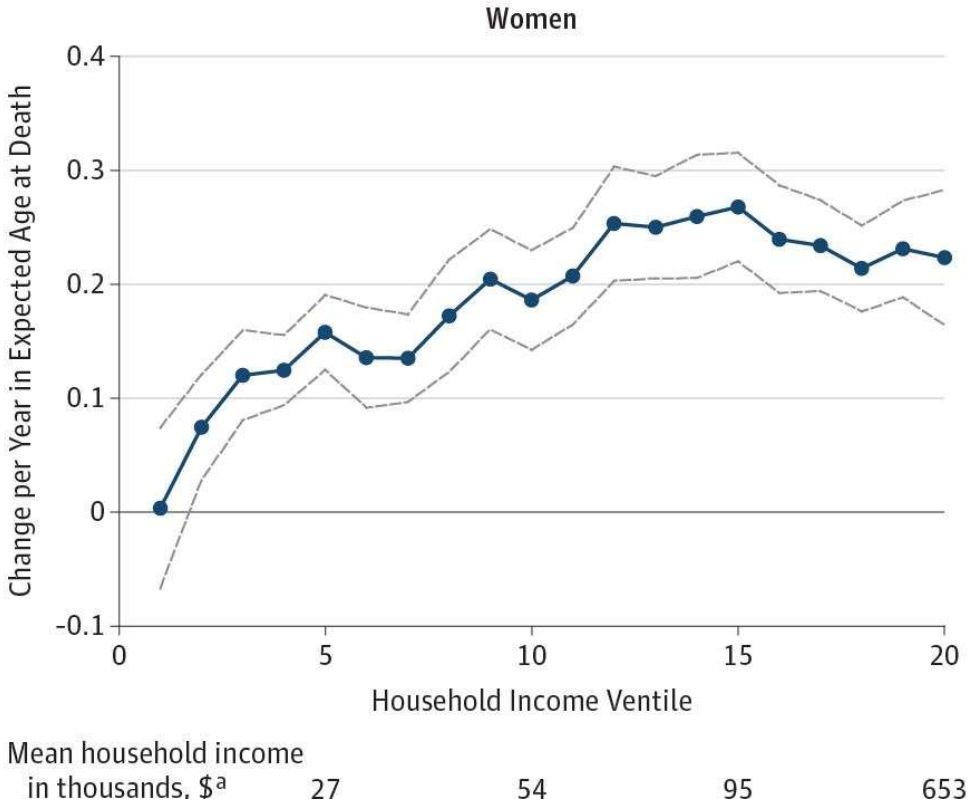
Source: Congressional Budget Office, 2016 Long-Term Budget Outlook.

Income-related health disparities are large…



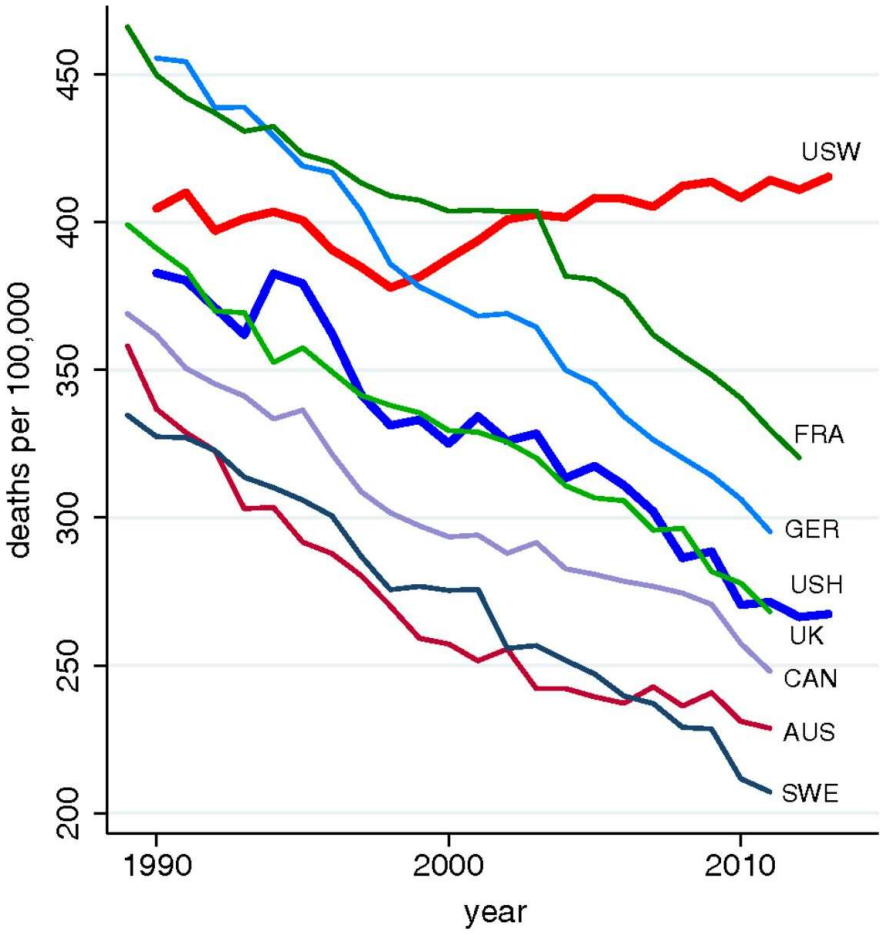
Source: Chetty et al, *JAMA* 2016.

...and Income-related health disparities are growing



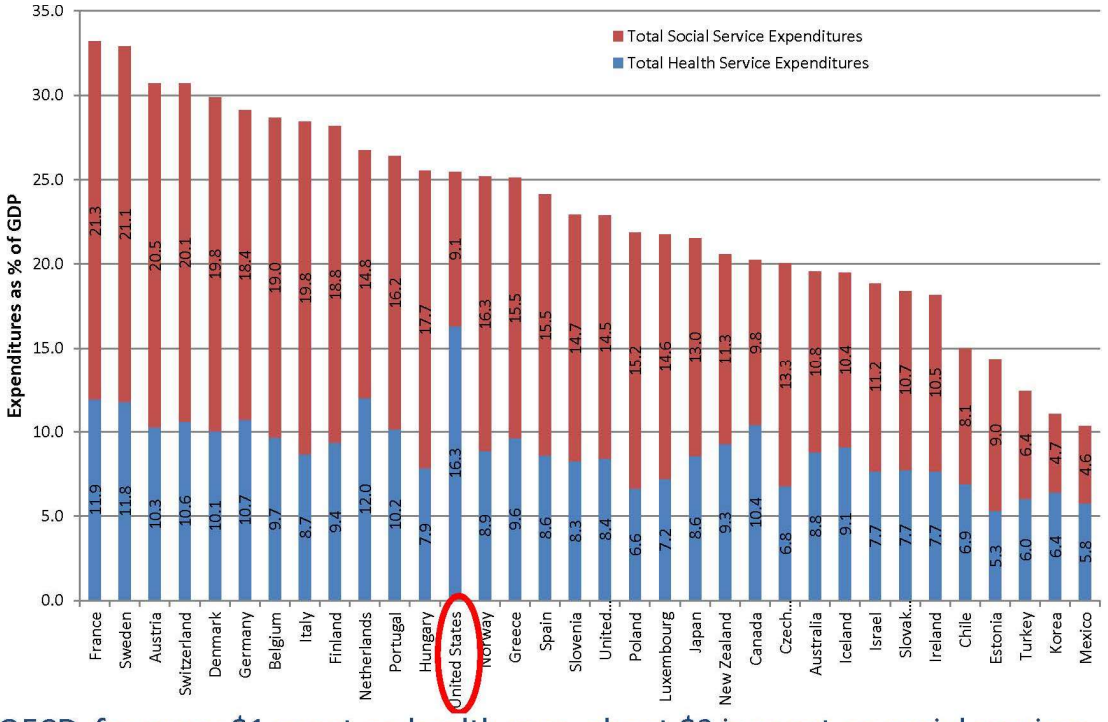
Source: Chetty et al, *JAMA* 2016.

Death rates have risen for specific American populations



Source: Case and Deaton *PNAS* 2015

Total health-service and social-service expenditures for OECD Countries

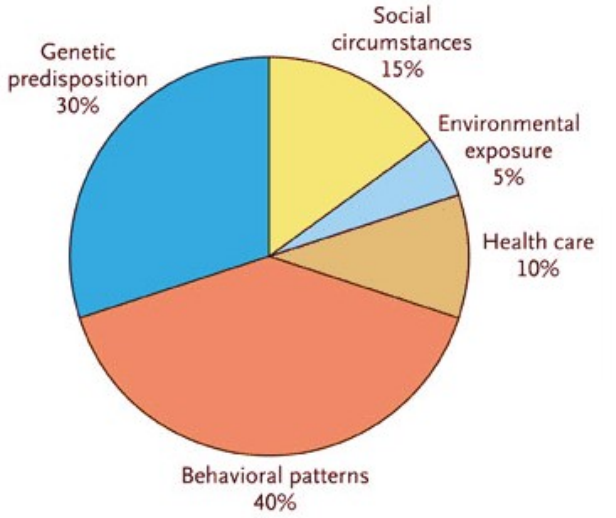


In OECD, for every $1 spent on health care, about $2 is spent on social services

In the US, for $1 spent on health care, about 55 cents is spent on social services

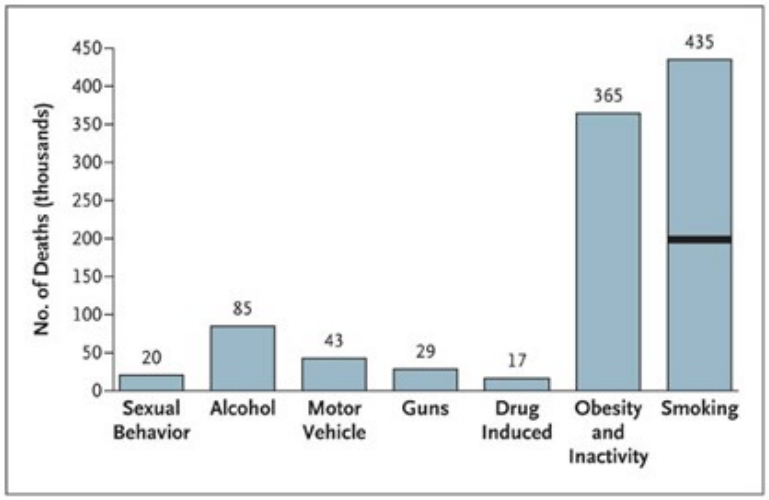
Source: Bradley and Taylor, 2013

Determinants of Health Outcomes



Determinants of Health and Their Contribution to Premature Death

McGinnis, Social Determinants of Health, 2002



Numbers of U.S. Deaths from Behavioral Causes, 2000.

Adapted from Mokdad et al.

Big Health Policy Issues for 2017

- 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

Emerging House Republican Leadership ACA Replacement Provisions

- Sooner…
  - Short-term budget provisions to help stabilize insurance exchanges
  - Refundable, age-related tax credit for those without employer coverage (indexed to CPI)
  - Health savings account (HSA) expansions
  - State Innovation Grants to support high-risk pools, other state-based reforms
  - Transition time to implement
  - Potential financing mechanisms: temporary continuation of some ACA taxes, cap on employer tax exclusion, savings from reduced long-term Medicaid costs
- Later?
  - Insurance Market Regulatory Reform
    - Guaranteed issue and only age-related premium difference based on health status for those who remain continuously enrolled in coverage
    - Interstate health insurance purchasing options

Medicaid Reform

- Legislative Proposals
  - Address Medicaid Expansion
    - Most of coverage increase in ACA
    - 31 states + DC including states with Republican governors
  - Medicaid Structural Reform
    - Shift toward per-capita or block grants to states, account for expansion costs – particularly for expansion and "optional" populations
    - Savings through lower growth rate
- Administrative Actions
  - More flexibility in Medicaid waivers
    - Medicaid managed care including dually-eligible beneficiaries, benefit and work requirements, other care reforms
  - Expanded use of other programs to support state flexibility
    - ACA Section 1332, CMMI authorities
- Opportunities for State Leadership in Health Reform

Alongside the Repeal/Replace/Repair Debate…

- Potential bipartisan interest in controlling costs
  - Drug pricing reforms likely
  - Pressure for delivery system and payment reform
- MACRA implementation (Medicare physician payment reform) will continue
- Other payment reform initiatives including CMMI activities likely to evolve, in conjunction with reform initiatives through states and private plans
- Increased focus on state-led initiatives to change payment streams and reform care

Policy approaches for reducing costs—and improving quality and outcomes

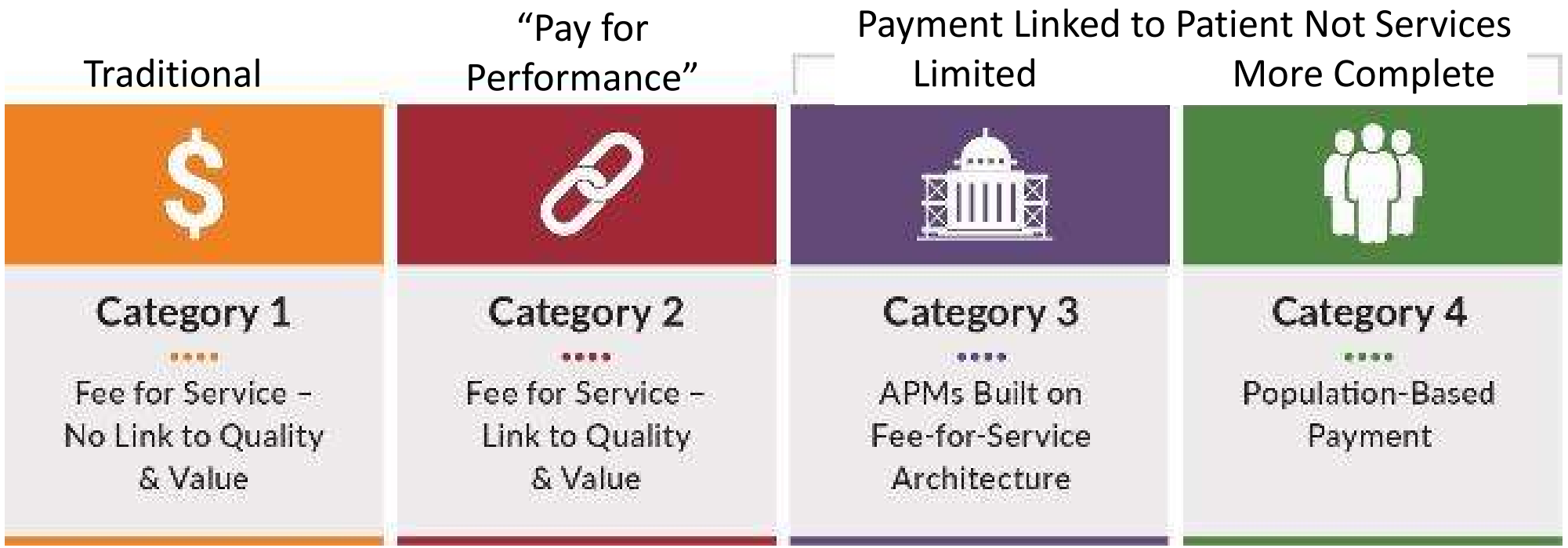
- Reduce prices
  - May limit access to care

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

Value-Based Payment Reforms

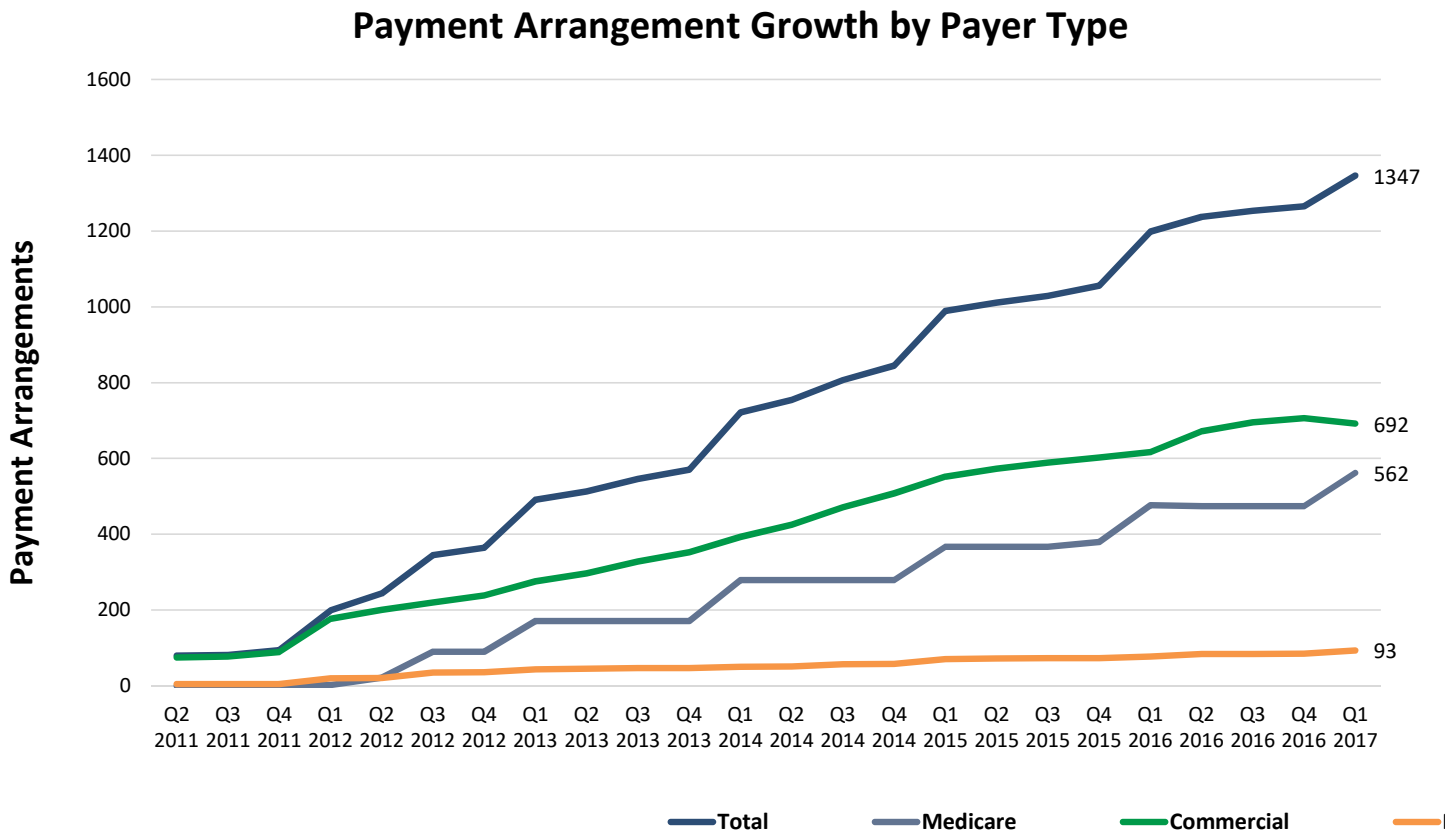
- Growing adoption of new payment models driven by health care fundamentals
- Physician payment (MACRA) implementation emphasizes expansions of alternative payment models
- Potential new directions for Center for Medicare and Medicaid Innovation (CMMI)

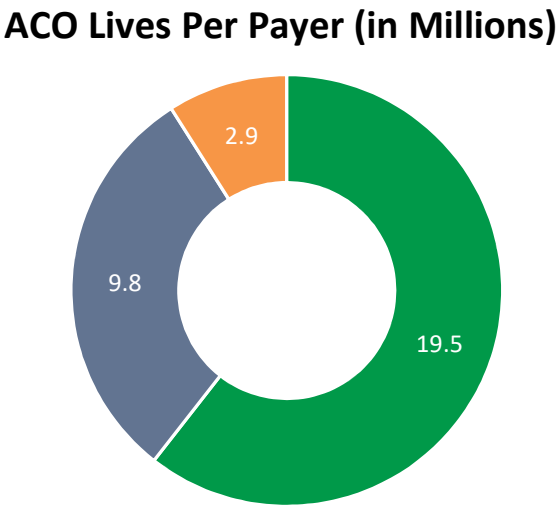
Alternative Payment Models (APMs)



HCP LAN
Health Care Payment Learning & Action Network

ACO Growth by Payer





Source: *Leavitt Partners Center for Accountable Care Intelligence*

“Component” Alternative Payment Model Examples

Primary Care Payments

- Medical home payments
- Direct primary care (PMPM) payments
- Accountability and shared savings for population outcomes and costs

Episode-Based Payments

- Elective procedure episodes (e.g., hip/knee replacement)
- Hospital admission episodes (e.g., Bundled Payment for Care Improvement initiative)
- Diagnosis-based episodes (e.g., pregnancy, back pain)
- Chronic disease episodes (e.g., oncology care model, liver disease, heat failure)

Specialized Population Payments

- Comprehensive care for high-risk patients
- End-of-life/palliative care patients
- Specialty-based care teams with overall accountability (e.g., Comprehensive ESRD Care, Project SONAR for patients with chronic GI disease)

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

PBGH PACIFIC BUSINESS GROUP ON HEALTH

HMR LAB HARVARD MEDICAL SCHOOL | Department of Health Care Policy

HCP LAN Health Care Payment Learning & Action Network

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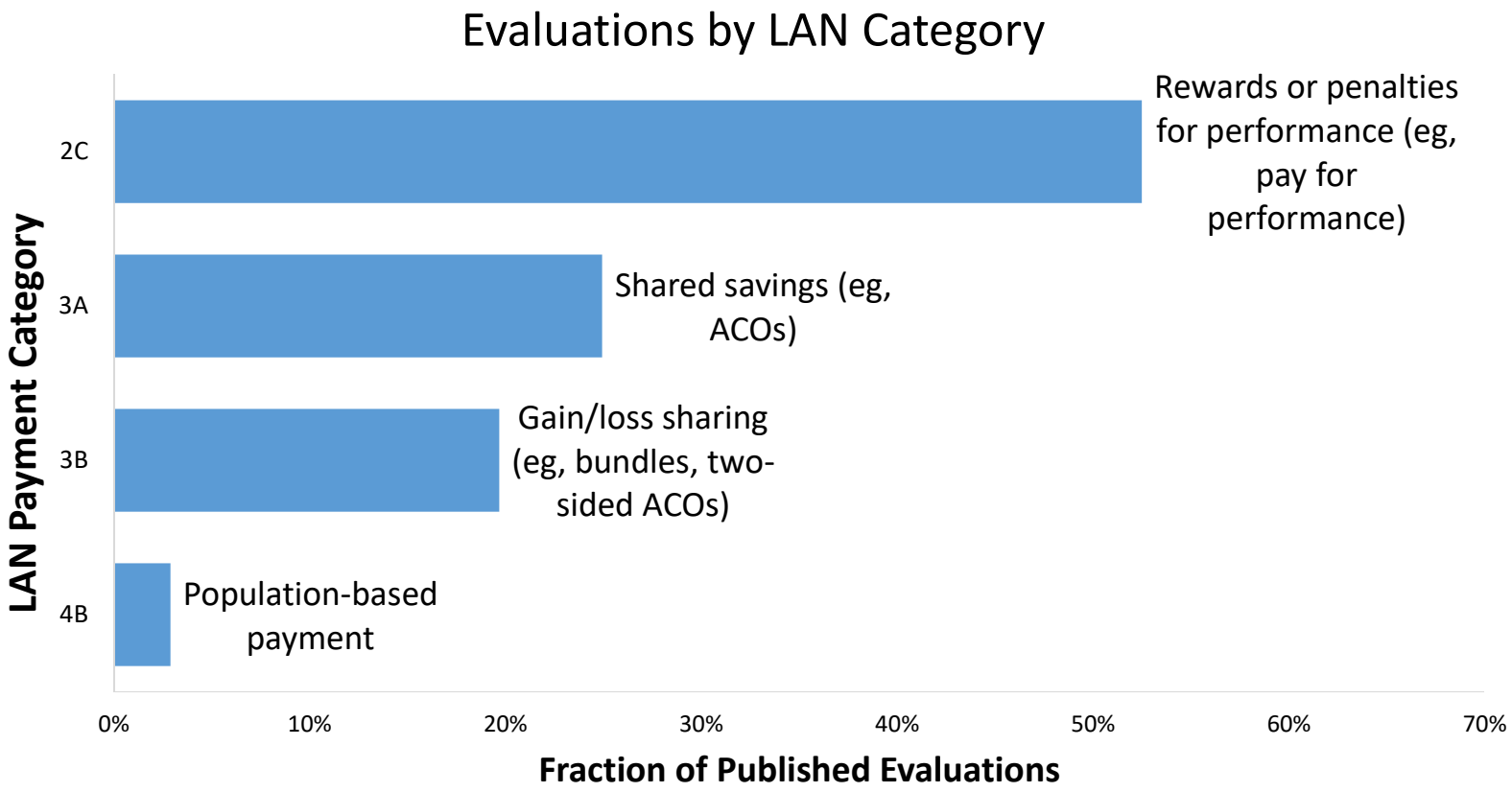
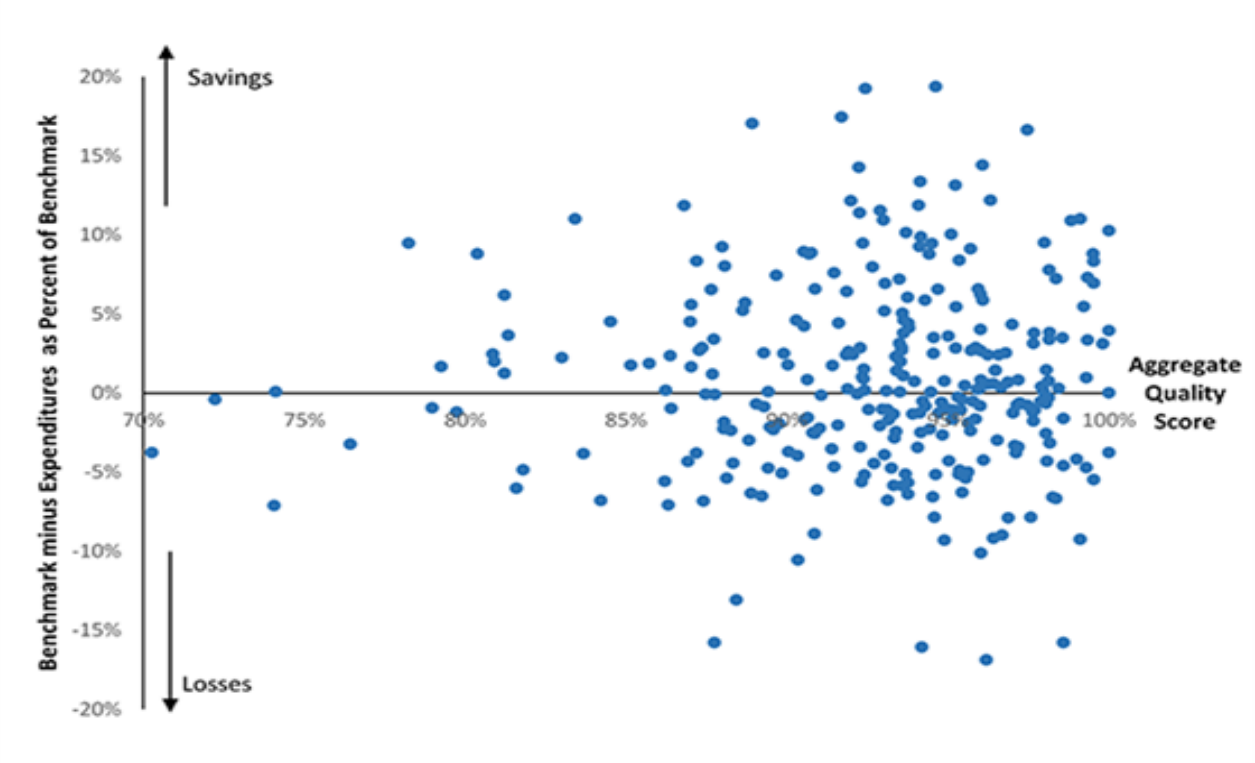
Current Evidence on Payment Reforms



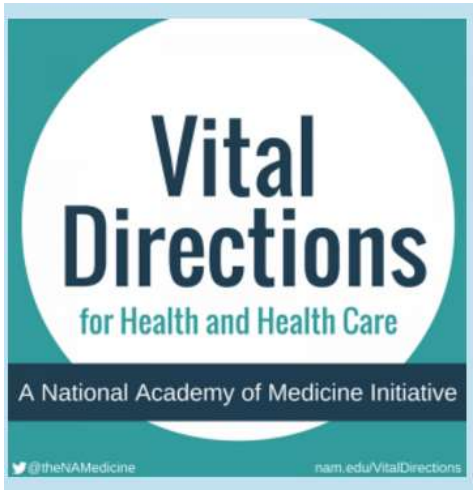
Most health care organizations not yet succeeding in value-based care models

ACCOUNTABLE CARE LEARNING COLLABORATIVE
HOUSED AT WGU



Source: Muhlestein, Saunders, and McClellan, *Health Affairs* 2016

Responding to the challenge of successful and sustainable reforms in care

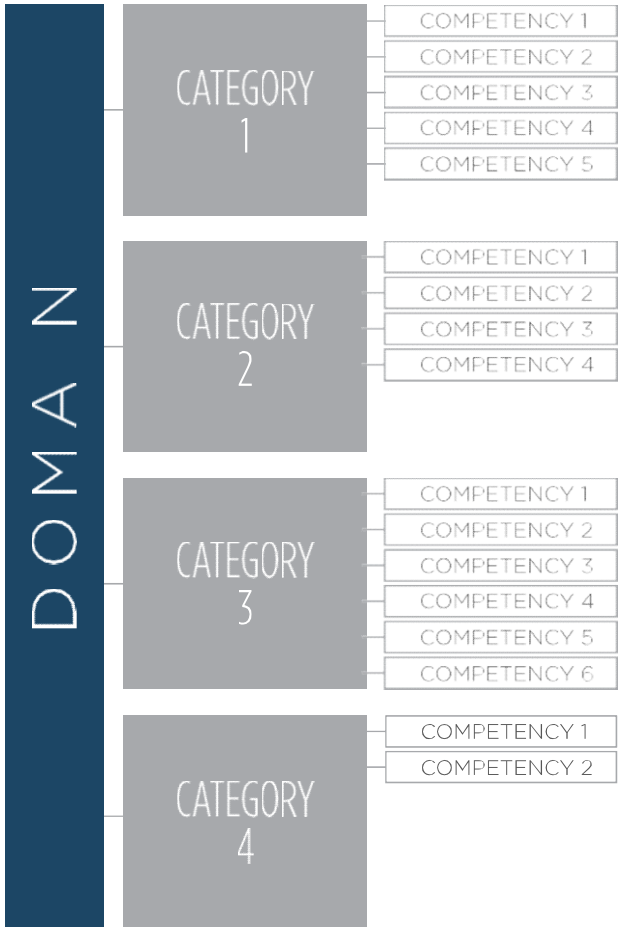


Recommendations

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

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

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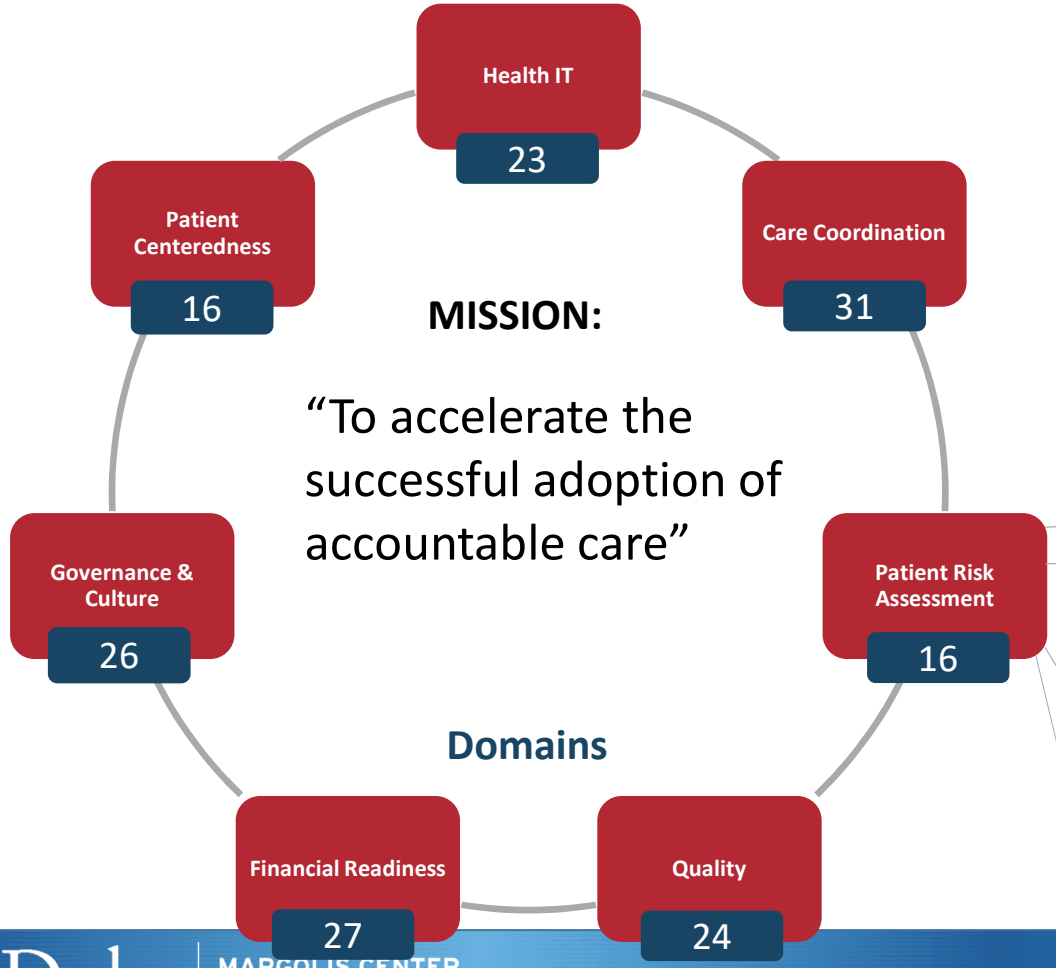

Categories

- 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

ACCOUNTABLE CARE LEARNING COLLABORATIVE

Provider Transition Glide Paths

Governance and Culture		
Leadership How a leader or a governing body uses their position, responsibility, and power to make decisions or create policies that will drive successful accountable care adoption.	GC.1.1 Identify interdisciplinary leader(s), as appropriate, who have proven reputation and abilities among peers to achieve value outcomes, carry out quality improvement initiatives, and manage risk GC.1.2 Define your organization's strategy, common terminology, and vision for the served population GC.1.3 Develop policies that support business processes, compliance, ethical behavior, patient rights, and patient-centeredness	Phase 1
Commitment to Value Encompasses values and behaviors that permeate throughout the organization and demonstrate an organization's commitment to value-based care.	GC.4.1 Align your organization's mission, vision, and strategy with your commitment to value-based care objectives GC.4.2 Align quality improvement initiatives with ethical obligations GC.4.3 Challenge the cultural assumption that High-cost treatment is the same as high-value treatment	
Financial Readiness		
Financial Systems Systems, tools, and more importantly, orientation of work process to focus on patient level, population level financial assessment.	FR.1.1 Aggregate multiple services from full episode of care for consolidated, flexible payment processing FR.1.2 Automate, centralize, and integrate authorization approvals and claims payment methodologies from all payers FR.1.3 Establish and maintain systems to track utilization, revenues, and costs when bearing financial risk FR.1.4 Establish systems that accurately capture data from all coding methodologies FR.1.5 Organize and design financial measures based on specific patient populations FR.1.6 Create a system to manage deferred or denied authorizations	
Health IT		
HIT Infrastructure Products, platforms, processes, and investments that support the organization's strategy for accessing and using health data and information that will support the organization's short and long term priorities and goals. Category	HIT.1.1 Create a comprehensive health IT strategy, inclusive of considerations for interoperability, change management plan, and payment model(s) functionality, that supports the payment model(s) and financial risk associated with your organizational goals. HIT.1.2 Analyze and mitigate privacy and security risks HIT.1.3 Assess the health IT ecosystem across the organization HIT.1.4 Develop a stable platform for information systems that is consistent and aligned with the organization's HIT strategy. HIT.1.5 Coordinate appropriate staffing to maintain infrastructure	

Industry Resource Center

Competency

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

Case Study Briefs

CSB CASE STUDY BRIEF Joint ACLC

Designing Governance for Bottom-Up Innovation
UT Southwestern's Approach

Domain: GOVERNANCE & CULTURE *Category:* CULTURE OF STAKEHOLDER ENGAGEMENT
Competency: GC.3.1 Engage physicians and clinician leaders throughout all levels of the organization to carry out and drive value-based objectives

BACKGROUND

In 2010, concerned about the sustainability of health care's economic structure, UT Southwestern's leadership (UTSW) organized an internal analysis of various approaches to financial and clinical transformation. The exercise informed a number of strategic imperatives for the system, including the need to grow its network of employed and independent primary care providers, to create greater efficiency by tracking true costs of care in every setting, and to appropriately expand its footprint through partnerships. Ultimately, these strategic objectives resulted in the formation of a new organization called Southwestern Health Resources, a partnership between UTSW and it's employed faculty (~1,700 physicians), Texas Health Resources and its employed physician group (~600 physicians), and UT Southwestern Clinically Affiliated Physician Program (UTSCAP), a group of independent providers (~385 physicians), forming a clinically integrated network with which to approach accountable care and other value-based contracting.

About Southwestern Health Resources

The SWHR network of 31 hospitals and more than 350 outpatient facilities provides improved access to high-quality care for communities throughout North Texas.

Location: Dallas-Fort Worth and the Metroplex in North Texas; Managing patients across 9 counties

VBP Activity:
- Track 1 MSSP (~82,000 beneficiaries)
- Medicare Advantage (~31,000 beneficiaries)
- Risk-based commercial arrangements with
- UnitedHealthcare and Aetna (~110,000 members)

Note: In 2017 the ACO will be joining the NGACO model and adding a commercial contract with Cigna

Website: www.utswmedicine.org/health-pros/aco/

APPROACH

Like many organizations utilizing partnerships for accountable care, UTSW has had to think about engaging physicians differently. To unify the various provider groups under common value-based objectives, UTSW created a governance structure with multiple mechanisms for meaningful frontline engagement. First, the ACO designed its governing board to have equal representation from all three of its physician group partners. The board is supported by physician-led committees that also have equal representation from all partners. The ACO then created a pod structure with 10 to 15 physicians organized by geographic region in self-governing, self-auditing groups. The multiple levels of governance, particularly the committees and pods, have been key to meaningful engagement throughout the organization. Through this structure, the ACO is able to empower its physicians with data, education, and most importantly, a meaningful seat at the table.

The ACO's pod structure has proven to be a valuable avenue for engagement in many ways. First, the pods create smaller, more tangible networks for motivation and support. For example, the ACO gives its physicians access to quality and cost outcomes data on all of their pod peers. Providers are also given pod-level transparency into the distribution of shared savings and other bonuses from the ACO's risk-based contracts, showing the amounts received and the reason. According to ACO leaders, this kind of peer pressure and sensitization has been valuable in driving higher engagement and higher performance.

Another positive but unexpected benefit of the pod structure has been its ability to facilitate bottom-up innovation. In the beginning, the ACO expected to inform all clinical care protocols and institute changes driven by the board and quality committee. However, the pods have been the primary source of practice transformation and also a system for meaningful frontline engagement. Since they were first established in 2013, the pods have produced a number of clinical care protocols, some of which have led to network-wide performance improvement initiatives. When a pod develops an idea for a new clinical protocol, the pod's elected physician representative takes the idea to the appropriate committee (e.g., Quality Performance, Utilization Review & Management, Credentialing, Network Adequacy), which then vets the proposal for the expanded use by other pods, even to potentially be instituted network-wide by the board. For example, one of these pod-driven ACO protocols asks that pod practices rotate offering extended hours at least three nights per week, allowing other pod physicians to refer patients to the open-late practice.

While the ACO's thoughtful governance structure has enabled physician engagement and enhanced participation in value-driven activities, UTSW has also implemented a number of strategies to directly engage and empower physicians. Its Quality Performance Program provides financial incentives for behavior change, independent of the ACO's risk-based contracts. In the first year, bonuses are tied to certain activities and process measures (e.g., installation of the EHR and having it functioning within 3 to 6 months, attending

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DRAFT

UT Southwestern Case Study

ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

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

CSB CASE STUDY BRIEF

Designing Governance for Bottom-Up Innovation

UT Southwestern's Approach

FEBRUARY 2017

Domain: GOVERNANCE & CULTURE **Category:** CULTURE OF STAKEHOLDER ENGAGEMENT

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Website: azconnectedcare.org

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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

Mahalo