Value-Based Care 201: Improving Patient Care and Lowering Costs

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AMA AMERICAN MEDICAL ASSOCIATION · AMGA Advancing High Performance Health · AMERICA'S PHYSICIAN GROUPS Taking Responsibility for America's Health · HEALTH CARE TRANSFORMATION TASK FORCE · NAACOS National Association of ACOs · PREMIER

ALLIANCE FOR VALUE-BASED PATIENT CARE

Presenters

Aisha Pittman, Senior Vice President of Government Affairs, National Association of ACOs
Aisha leads NAACOS' work to promote legislative and regulatory policies that will advance ACOs. She has 19 years of experience in healthcare payment, alternative payment models, healthcare quality measurement, and health information technology. Pittman was previously vice president of policy with Premier, Inc., a group purchasing organization of more than 4,400 hospitals and 225,000 other provider organizations, since September 2019. During her eight years with Premier, she was responsible for working with policymakers, providers, and other healthcare stakeholders to reduce costs and improve the quality of healthcare. Prior to Premier, Pittman held senior management roles with the National Quality Forum, the Maryland Health Care Commission and CenterLight Healthcare, in addition to experience at the National Committee for Quality Assurance.

Nick Uehlecke, Partner at the Todd Strategy Group
Nick is a former Senior Advisor to the Secretary of the Department of Health and Human Services. In his role, he worked on Medicare, Medicaid, commercial and general insurance issues, health care reform and a range of other topics under the jurisdiction of the Centers for Medicare and Medicaid Services and the Health Resources and Services Administration. Nick also spent time working on key areas related to regulatory burden relief, drug pricing, health care data, health IT, health system integration, and efforts to make health care more value-based in America. Prior to HHS, Nick was a Professional Staff Member for the Committee on Ways and Means in the House of Representatives for eight years, working on issues ranging from Medicare's Parts A and B, Medicare Advantage and Part D, and commercial insurance and Affordable Care Act reforms.

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Moderators

Valinda Rutledge, Executive Vice President for Advocacy and Education for America's Physician Groups
Valinda is currently the Executive Vice President for Advocacy and Education for APG where she is responsible for, and oversees, major strategic initiatives for APG, including education on aspects of value-based care, as well as supporting APG's policy and advocacy responses. Previously, she was the Executive Vice President, Federal Affairs at APG and was responsible for all federal government affairs activities in DC where she oversaw APG's legislative and regulatory agenda, the political action committee, and other aspects of a vibrant and successful federal affairs program such as analyzing legislation regulations and new payment models. She was formerly the Chief Corporate Affairs Officer for Upstream and previously worked as a founding member of the leadership team (Senior Advisor and Group Director) at the Center for Medicare and Medicaid Services Innovation (CMMI) where she helped build the Innovation Center from its startup phase and managed the design and launch of several of the Center's Alternative Payment models.

Seth Edwards, Vice President of Population Health and Value-Based Care for Premier, Inc
Seth manages PINC AI's Population Health Collaborative utilizing his expertise in the Medicare Shared Savings Program (MSSP). He has successfully assisted over 80 accountable care organizations (ACOs) with applying and contracting with the Centers for Medicare & Medicaid Services (CMS) in the MSSP, Next Generation ACO and ACO Pioneer programs. Prior to this role, Edwards was the director of federal affairs for Premier, working with lawmakers and their staff to advocate for Premier's legislative priorities and assist in developing policy positions. Edwards primarily focused on delivery system reforms (ACOs, bundled payments, etc.) and quality outcomes (readmissions and healthcare-associated infections). In addition, Edwards previously worked with national thought leaders, such as Dr. Rick Gilfillan and Lynne Rothney-Kozlak, to develop, implement and manage the PACT Collaborative.

Jeff Micklos, Executive Director for the Health Care Transformation Task Force
Jeff is the Executive Director of the Health Care Transformation Task Force. An attorney by training, Jeff is the former Executive Vice President, Management, Compliance, & General Counsel of the Federation of American Hospitals, a national trade association representing investor-owned hospitals, and a former Partner in the Health Law Department of the international law firm of Foley & Lardner LLP. Mr. Micklos began his career as a litigator and regulatory counsel for the Health Care Financing Administration, U.S. Department of Health and Human Services, and also served in the Office of General Counsel of the Social Security Administration.

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Featured Speakers

Dr. Anas Daghestani, President & Chief Executive Officer, Austin Regional Clinic
Dr. Daghestani is an Internal Medicine physician and Chief Executive Officer of Austin Regional Clinic (ARC), a 350-physician multi-specialty medical group that serves the greater Austin metropolitan area with 21 clinical locations. ARC provides care to approximately 430,000 Central Texans in seven cities and three counties. Dr. Daghestani is President of the ARC Executive Board and also serves as Medical Director of ARC's Population Health & Clinical Quality. Dr. Daghestani serves on the board of directors for America's Physician Groups.

Dr. Elisabeth Stambaugh, CMO, Wake Forest Health Network, Atrium Health Wake Forest Baptist. Since 1998 Dr. Stambaugh has practiced as an OB/GYN in High Point, NC, and now serves as chief medical officer for the Wake Forest Health Network, Atrium Health Wake Forest Baptist, having previously served as the CMO for Cornerstone Health Care, winner of the 2015 Acclaim Award. Her multispecialty group has 450 physicians and advanced practice providers located in over 100 community settings across central North Carolina. Dr. Stambaugh serves on the board of directors for AMGA.

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What is Value-Based Care?

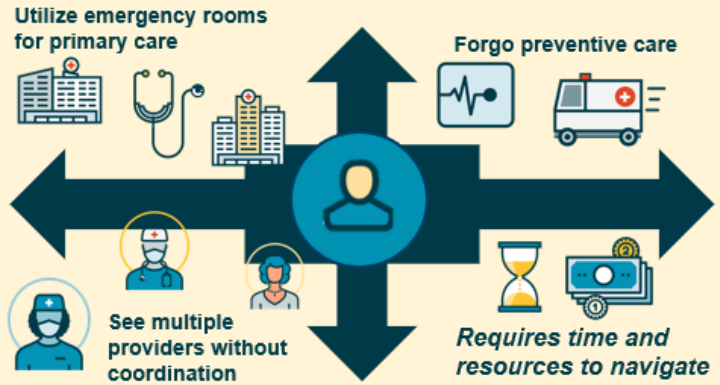
Fee-for-Service

Fragmented care. Can lead to reactive, sickness-based care:

Providers have minimal tools or incentives to proactively mange patient care

Patients must navigate a complex and disorganized health care system – which takes time and resources and can further perpetuate inequities

Results in lower quality and higher cost care as patients:



Value-based arrangements

Incents proactive and coordinated care, managing costs, and keeping a defined population healthy.

Proactive outreach to patients

Patients have **clearer communication channels with care teams** and are eligible to receive **engagement incentives**

Enhanced data collection and analysis with information across the care continuum and social determinants of health (SDOH)

Identify high-cost patients and better manage their conditions to avoid readmissions and inappropriate care and reduce costs

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Burden Reduction & Patient Benefits

Changes in Payment Arrangements

- ✓ Shared Savings – ability to have short term financial gains from FFS cuts
- ✓ Gainsharing with downstream providers
- ✓ Capitated payments
- ✓ Enhanced payments for services not usually reimbursed by Medicare FFS
- ✓ Upfront payments and investments for at-risk providers

Efficiency Opportunities

- ✓ Increased flexibilities and waivers aimed at improving access to care – including:
  - ✓ SNF 3-day waiver
  - ✓ Home health flexibilities
  - ✓ Expanded telehealth access

Enhanced Access to Data

- ✓ Monthly comprehensive claims feeds for all aligned beneficiaries
- ✓ Increased standardization of data
- ✓ Increased consumer access to clinical, quality and cost information

Beneficiary Engagement Incentives

- ✓ In-kind items/services or gift cards to incentivize beneficiary engagement and improve care

Increased ability to partner

- ✓ Fraud and Abuse waivers allow providers to more easily partner in value-based arrangements

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Types of Alternative Payment Models (APMs)

Payer-Provider Negotiated Arrangements

Traditional Medicare, Medicare Advantage, Medicaid, Commercial

Accountable for cost and quality of care for target patient population

Total Cost of Care (TCOC)

Accountable for cost and quality during an episode of care

Clinical Episode (or Bundled Payment)

Focuses on strengthening and increasing access to primary care

Primary Care Transformation

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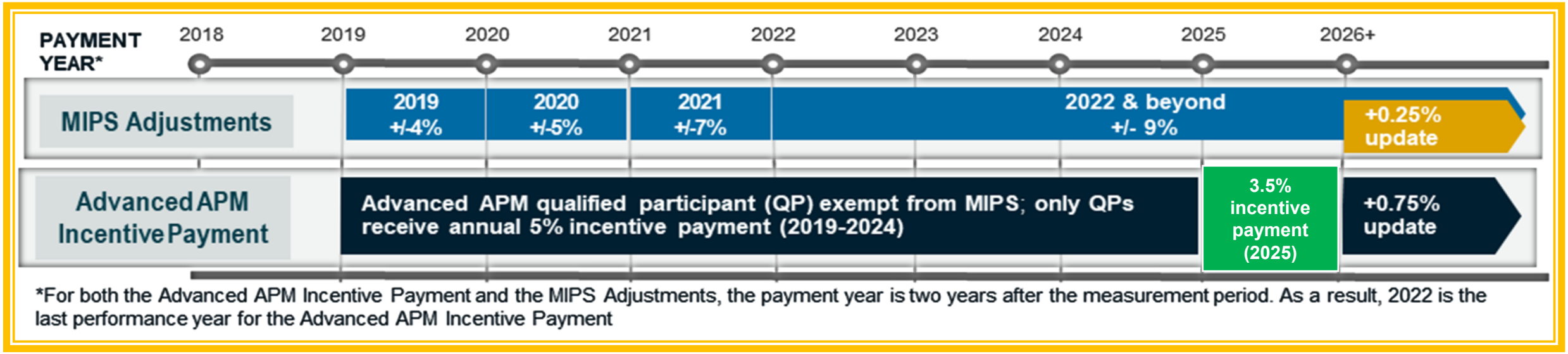
Medicare Access and CHIP Reauthorization Act

MACRA was a bipartisan law to incent the movement to value in Medicare

- Eliminated the sustainable growth rate (SGR) formula that was used by CMS to control Medicare spending
- Established unified quality reporting systems
- Provided financial incentives for clinicians to join APMs



- **Ability to qualify for advanced APM incentive bonus ended at the end of 2023**

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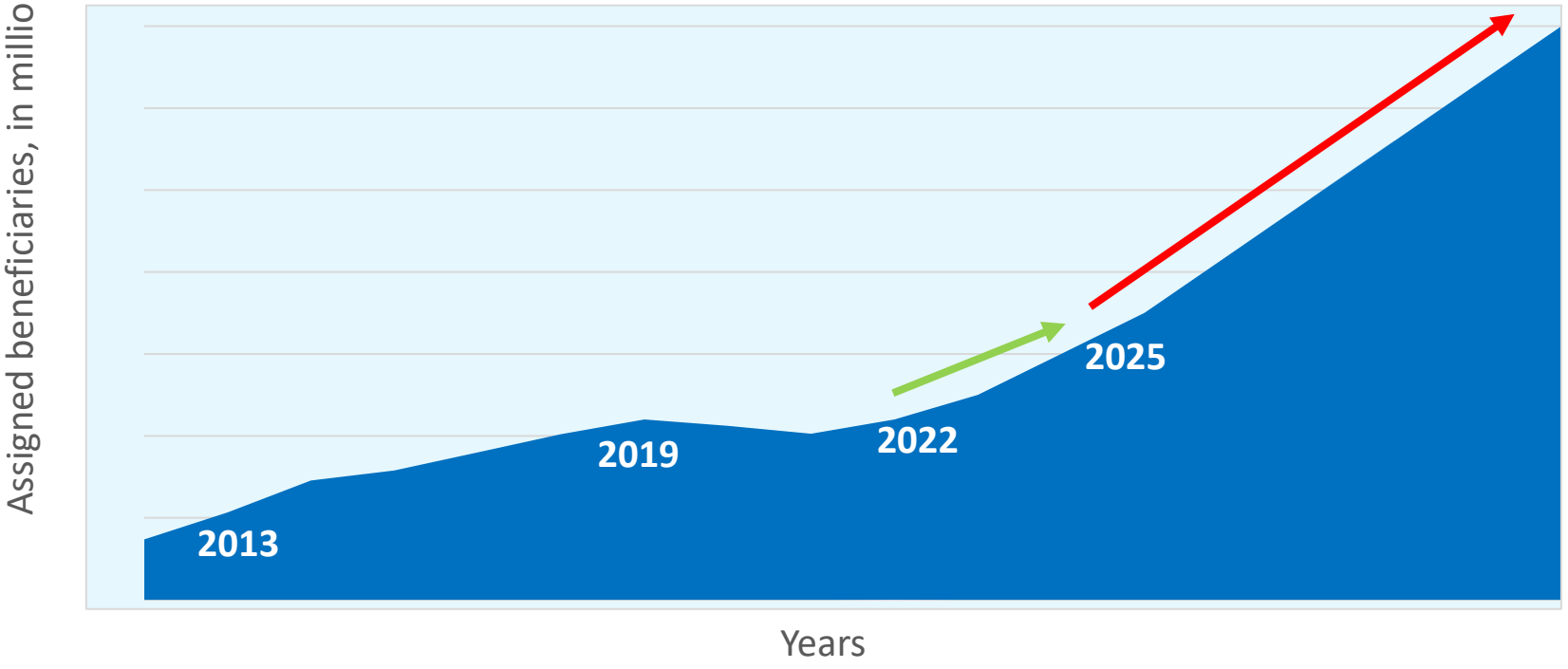
Medicare's Accountable Care Goals

*All Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by **2030***



Accountable care reduces fragmentation in patient care and cost by giving providers the incentives and tools to deliver high-quality, coordinated, team-based care. Models should increase the number of beneficiaries in accountable care relationships with providers, such as advanced primary care providers and ACOs. Quality of care and outcome measures should be measures that matter and include patient values and perspective.-- CMS

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Over a Decade of Value-Based Care Success

- Over **13 million** traditional Medicare beneficiaries in value models
- Approx. **600,000** clinicians participating in APMs, with more than 50% now participating in two-side risk models
- Since 2012, ACOs have saved Medicare **$22.4 billion** in gross savings and **$8.8 billion** in net savings (**84%** saved Medicare money in 2022)
- Actual 2022 spending on CMS programs **9% lower** than projections
- **100%** of ACOs met quality standards with data showing better performance than clinicians not in value models
- Payer-provider negotiated APM arrangements are growing in Medicare, Medicare Advantage, Medicaid, and Commercial
- CMMI tests of total cost of care, bundled payment, primary/ specialty care models show evidence of enhanced care delivery, tailoring care to local needs; and care delivery changes that extend beyond models

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Medicare's 2022 ACO Results

- *In 2022, Medicare Shared Savings Program (MSSP) ACOs…*
  - ✓ …generated **$4.3 billion in gross savings** and $1.8 billion after accounting for shared savings payments.
  - ✓ …generated an **average savings of $416 per patient** compared to their benchmarks.
  - ✓ …earned **$2.5 billion in shared savings** payments, an average of $7.2 million each in 2021, a new program high.
- *More key findings from the 2022 MSSP ACO results:*

6th
straight year MSSP ACOs delivered net savings to Medicare

100%
of ACOs met quality standards required to share in savings

84%
of ACOs saved Medicare money

59%
of ACOs were in two-sided risk tracks, a new program high

TOTAL MEDICARE ACO SAVINGS

Since 2012, ACOs have saved Medicare $22.4 billion in gross savings and $8.8 billion in net savings.

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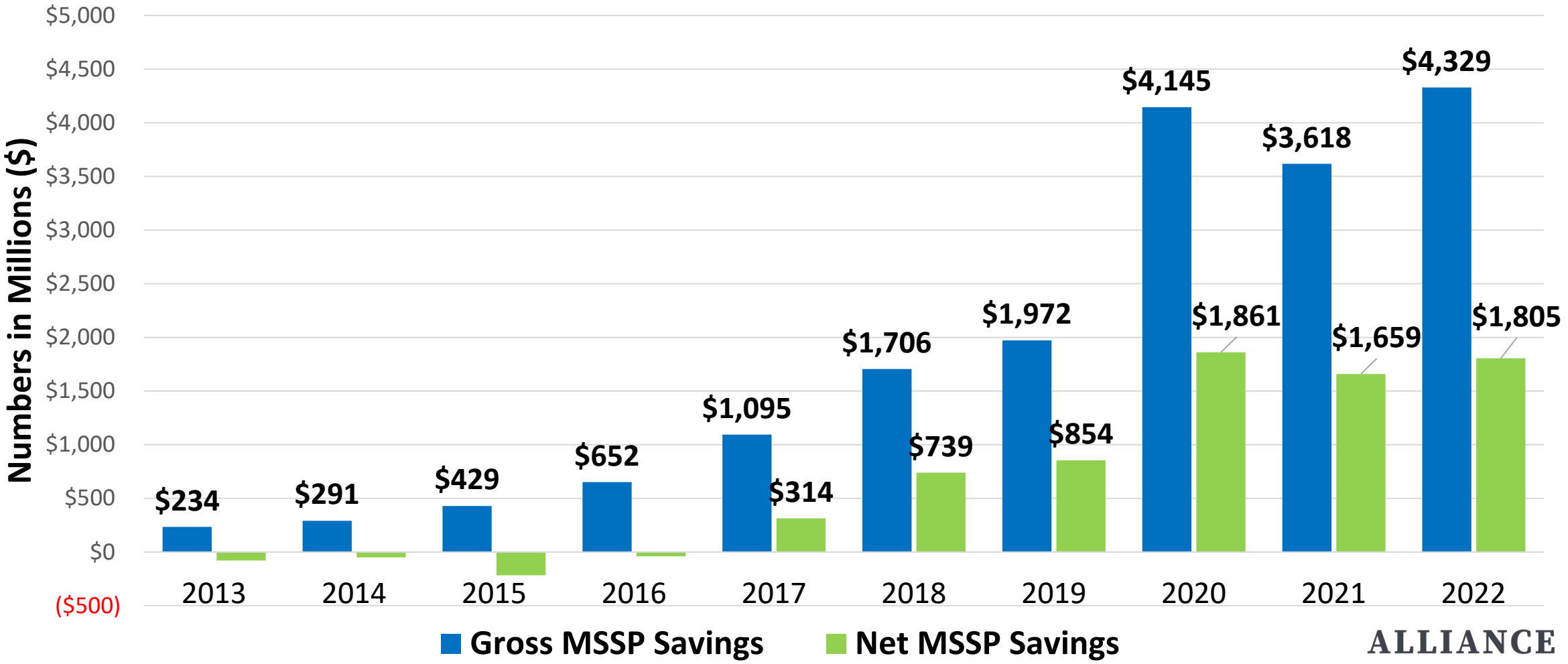
ACO Savings 2013-2022



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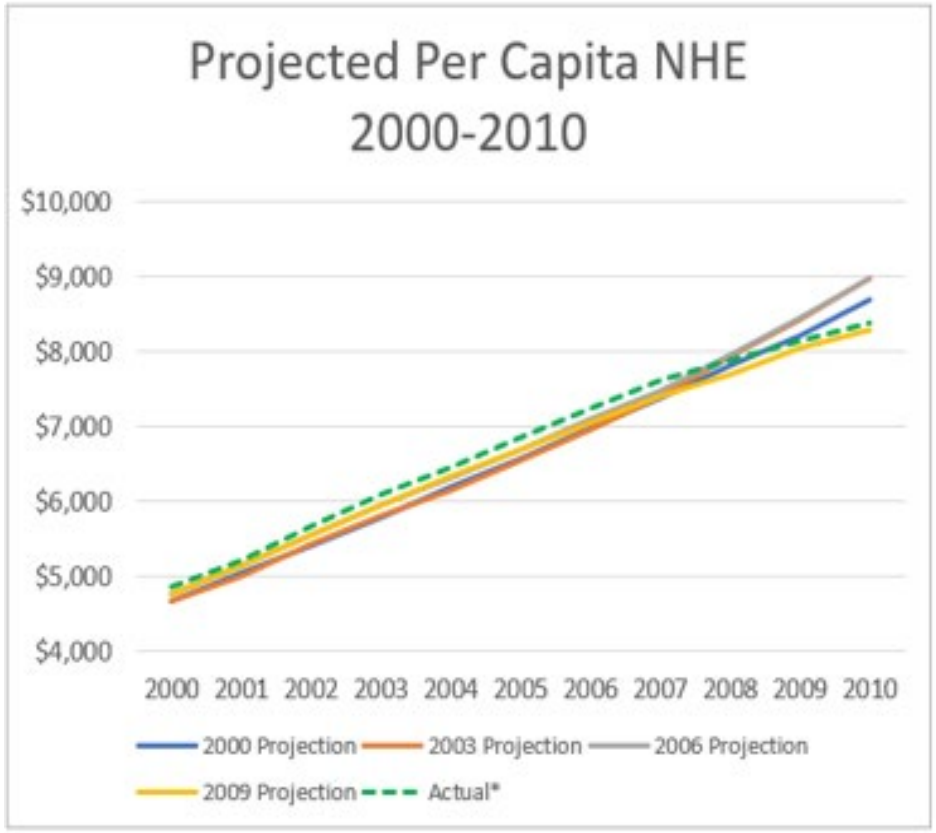
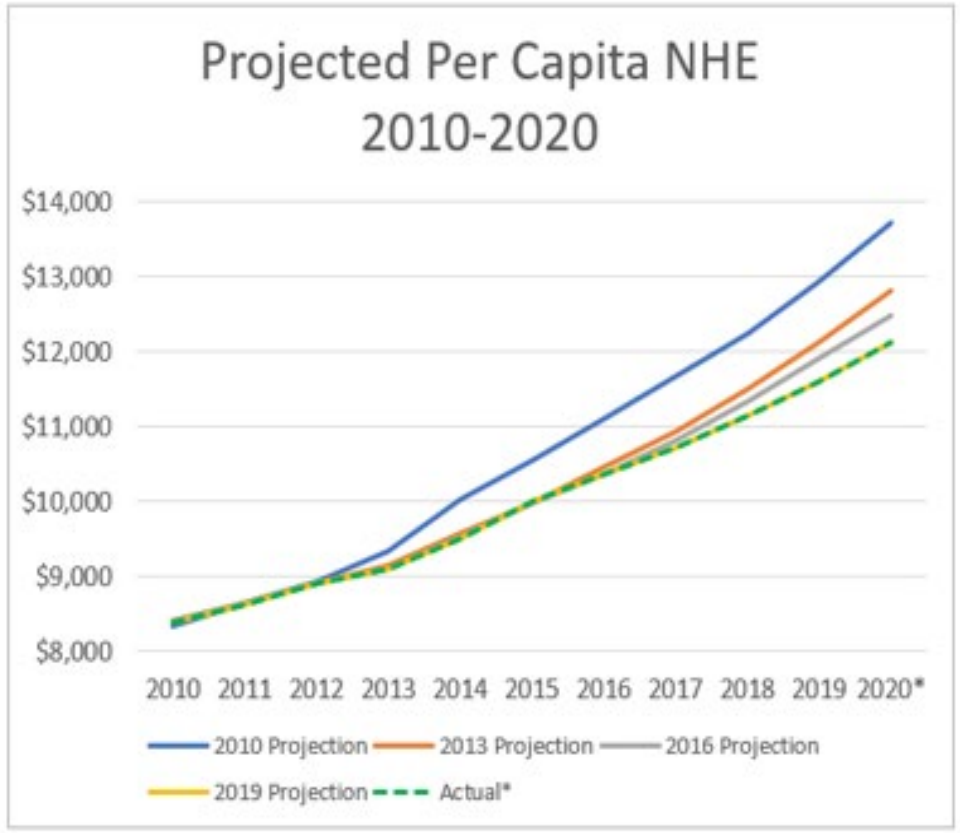
Correlation with Slower Health Care Spending





*Estimate based on 2019 NHE projections.

Source: Health Care Transformation Task Force (2021) https://hcttf.org/nhe-getting-warmer/

Actual 2022 Federal spending on Medicare and Medicaid is **9% lower** than originally projected

Improved care management and more efficient use of technology were factors

Source: Congressional Budget Office (2023): https://www.cbo.gov/system/files/2023-03/58997-Whitehouse.pdf

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Quality Continues to Improve

All MSSP ACOs met quality standards required to share in savings for the 2022 performance year.

ACOs had higher average performance on quality measures compared to clinicians not in ACOs, including better performance on:

- ✓ Diabetes and blood pressure control,
- ✓ Breast and colon cancer screenings,
- ✓ Tobacco screenings and smoking cessation
- ✓ Depression screening and follow up, and other measures.




40 ACOs recorded a quality score above 90!

"The higher quality performance by ACOs underscores how this type of coordinated, whole-person care can improve treatment of behavioral health conditions, helping to achieve the goals of the CMS' Behavioral Health Strategy and improve cancer screening rates and prevention in line with the goals of the Cancer Moonshot."
– CMS press release, August 2023

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Action Needed to Continue Movement to Value

Bolster Benefit to Patients

- Savings generated in models are reinvested in patient care
- Creates opportunity for enhanced/supplemental benefits in traditional Medicare; additional flexibility needed to adjust patient cost sharing

Ensure Strong Financial Incentives to Move to Value

- Benchmarks should reflect the complexity of the patient population and be predictable
- Recognize the up front and ongoing investments

Create Stronger Non-Financial Incentives

- Remove administrative burden and increase flexibility in models

Simplify Quality Measurement

- Thoughtfully move to digital measurement and create pathways for providing more data at the point of care

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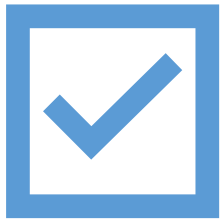
What can Congress do?



Extend Advanced Alternative Payment Model (APM) Incentive Payments

Develop Solutions to Improve Physician Payment and Continue to Encourage the Adoption of Value

Support Value-Based Care by Signing onto the Value in Health Care Act (H.R. 5013/ S. 3503)

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Value in Health Care Act (H.R. 5013 & S. 3503)

- In the last decade, APMs have generated billions in savings for taxpayers, while maintaining high-quality patient care
- A key aim of MACRA was to speed the transition to patient-centered, value-based care by encouraging physicians and other clinicians to transition into APMs
- While MACRA was a step in the right direction, more needs to be done to drive long-term system transformation
- The Value in Health Care Act is a bipartisan bill in the House & Senate that helps maintain and further strengthen the movement toward value

Extends Value-Based Care Incentives for Advanced APMs

Modifies Qualifying Thresholds to Better Reflect Current Progress in APM Participation

Ensures Participants Join and Remain in Existing APMs

Evaluates Parity Between APM and Medicare Advantage (MA) Program Requirements

Supported by 17 of the nation's leading health stakeholder groups:

Accountable for Health, American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American College of Physicians, American Hospital Association, American Medical Association, America's Essential Hospitals, AMGA, America's Physician Groups, Association of American Medical Colleges, Federation of American Hospitals, Healthcare Leadership Council, Health Care Transformation Task Force, Medical Group Management Association, National Association of ACOs, National Rural Health Association, and Premier, Inc.

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