Transitioning to Value Based Care Challenges and Opportunities

Michael Wok, MD, MACC
Kim Eagle, MD, MACC

Tuesday, November 24, 2015, 7pm ET

Michael Wolk, MD, MACC: Disclosures:
• Nothing to disclose

Kim Eagle, MD, MACC: Disclosures:
• Gore, Medtronic
“In Health Care, the Days of Business as Usual are Over”

The reality is:
- U.S. healthcare is too expensive.
- The quality of U.S. healthcare is variable.
- Health care delivery is changing. The ACA, employers, patients and insurers are moving in the direction of providing better value: improved outcomes at a lower cost and with less waste.
- Alternative health care payment models are being driven by CMS.
- Population management is a fundamental change of practice model, with providers earning more if they keep members healthy, and in many cases they, rather than payers, are at risk of suffering losses if they over treat.

Don’t Get Caught Sleeping on the Tracks
Prepare for the Future
Moving from Volume to Value
“A Foot in Each of Two Canoes”

Healthcare is facing a classic “Curve One / Curve Two” shift in business models. Moving too early, or too late, has its own risks and rewards.

Curve One: Fee for Service
- Volume-driven
- Maximize unit price / volume
- Little reward for quality
- No incentives for coordination of care
- Regulatory disincentives to collaboration

Curve Two: Population Health
- Return to “managed” care
- Return of the “narrow network”
- Reward lower cost / higher quality
- Incentives to reduce utilization
- Coordination of care
- Lines blurred between payers and providers

Source: Complements to Ian Morrison, The Second Curve: Managing the Velocity of Change. For a contemporary application of Morrison’s thinking to today’s healthcare world, see http://ianmorrison.com/305/
Health Care Spending as a Percentage of GDP, 1980–2013

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers. Source: OECD Health Data 2015.

Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2015

The Increasing Cost of Health Care in MA Reduces Essential Public Spending Priorities

Source: Massachusetts Budget and Policy Center

Hospital Supply and Use, 2013 or Nearest Year

Note: Data from 2012 in Australia, Canada, the Netherlands, and the U.S.
Source: OECD Health Data 2015.

Note: Data from 2012 in Australia, Canada, the Netherlands, and Switzerland; 2011 in Japan; and 2010 in Denmark, Norway, Sweden, and the U.S.
Source: OECD Health Data 2015.
Technology, a Possible Villain? Advanced Medical Imaging, Supply and Use, 2013

<table>
<thead>
<tr>
<th></th>
<th>MRI</th>
<th>CT</th>
<th>PET</th>
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<tbody>
<tr>
<td><strong>MRI</strong></td>
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<td></td>
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</tr>
<tr>
<td>Machines</td>
<td>13.4</td>
<td>27.6</td>
<td>32.7</td>
</tr>
<tr>
<td>per million pop.</td>
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<td></td>
<td>110</td>
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<tr>
<td>Exams per 1,000 pop.</td>
<td></td>
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<td>2.0</td>
</tr>
<tr>
<td><strong>CT</strong></td>
<td></td>
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</tr>
<tr>
<td>Machines</td>
<td>60.3</td>
<td>14.7</td>
<td>1.2e</td>
</tr>
<tr>
<td>per million pop.</td>
<td></td>
<td></td>
<td>132</td>
</tr>
<tr>
<td>Exams per 1,000 pop.</td>
<td></td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td><strong>PET</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Machines</td>
<td>9.4</td>
<td>14.5</td>
<td>1.4</td>
</tr>
<tr>
<td>per million pop.</td>
<td></td>
<td></td>
<td>193</td>
</tr>
<tr>
<td>Exams per 1,000 pop.</td>
<td></td>
<td></td>
<td>6.3</td>
</tr>
</tbody>
</table>

Australia | Canada | Denmark | France | Japan | Netherlands | New Zealand | Switzerland | United Kingdom | United States | OECD median |
---|---|---|---|---|---|---|---|---|---|---|
MRI machines per million pop. | 13.4 | 8.8 | — | 9.4 | 11.5 | 11.2 | — | 6.1 | 35.5 | 11.4 |
MRI exams per 1,000 pop. | 27.6 | 52.8 | 60.3 | 90.9 | 50.0 | — | 16.6 | — | 106.9 | 50.6 |
CT scanners per million pop. | 53.7 | 14.7 | 37.8 | 14.5 | 11.5 | 16.6 | 36.6 | 7.9 | 43.5 | 17.6 |
CT exams per 1,000 pop. | 110 | 132 | 142 | 193 | 71 | — | — | — | 240 | 136 |
PET scanners per million pop. | 2.0 | 2.0 | 6.1 | 1.4 | 2.2 | 1.1 | 3.5 | — | 5.0 | 1.5 |
PET exams per 1,000 pop. | 2.0 | 2.0 | 6.3 | — | 2.5a | — | — | — | 5.0 | — |

“It’s the Price, Stupid”-JAMA by Reinhardt

Prices for Hospital and Physician Services, Pharmaceuticals, and Diagnostic Imaging

<table>
<thead>
<tr>
<th></th>
<th>Total hospital and physician costs, 2013</th>
<th>Diagnostic imaging prices, 2013</th>
<th>Price comparison for in-patent pharmaceuticals, 2010 (U.S. set to 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bypass surgery</td>
<td>Appendectomy</td>
<td>MRI</td>
</tr>
<tr>
<td>Australia</td>
<td>$42,130</td>
<td>$5,177</td>
<td>$350</td>
</tr>
<tr>
<td>Canada</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>France</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Germany</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Netherlands</td>
<td>$15,742</td>
<td>$4,995</td>
<td>$461</td>
</tr>
<tr>
<td>New Zealand</td>
<td>$40,368</td>
<td>$6,645</td>
<td>$1,005</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$36,509</td>
<td>$9,845</td>
<td>$313</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>United States</td>
<td>$75,345</td>
<td>$13,910</td>
<td>$1,145</td>
</tr>
</tbody>
</table>
EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 5:

Middle:

Bottom 5:

OVERALL RANKING (2013)

Quality Care

Effective Care

Safe Care

Coordinated Care

Patient-Centered Care

Access

Cost-Related Problem

Timeliness of Care

Efficiency

Equity

Healthy Lives


Notes:

* Includes ties. ** Expenditures shown in $8,500 PPP (procuring power parity); Australian $ data are from 2013.

Sources:


U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

Overall Health Care Ranking

Source:

Mortality as a Result of Ischemic Heart Disease, 1995 to 2013

Deaths per 100,000 population

The Future: Provide Better Value!

High Value Care = Health Outcomes/Quality

Cost Waste
### Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency.</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery.</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.</td>
<td>Payment is not directly triggered by service delivery to volume. Payment is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. &gt;1 yr).</td>
</tr>
<tr>
<td><strong>Medicare FFS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Limited in Medicare fee-for-service</td>
<td>• Hospital value-based purchasing</td>
<td>• Accountable care organizations</td>
<td>• Eligible Provider accountable care organizations in years 3–5</td>
</tr>
<tr>
<td>• Majority of Medicare payments now are linked to quality.</td>
<td>• Physician Value-Based Modifier</td>
<td>• Medical homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>• Bundled payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comprehensive primary care initiative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comprehensive ESRD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare–Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
<td></td>
</tr>
</tbody>
</table>

### Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medicare FFS (Categories 1-4)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>FFS linked to quality (Categories 2-4)</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Alternative payment models (Categories 3-4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2018</th>
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<tbody>
<tr>
<td>All Medicare FFS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Medicare FFS</td>
<td></td>
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</tbody>
</table>
What is a Medicare ACO/MSSP?

**What ACOs are:**
- Provider based organizations accountable for quality and cost for defined population of fee-for-service Medicare patients
  - primary care MDs*, specialty MDs, hospitals
- Payments to ACOs linked to cost reductions and quality programs
  - performance measures to ensure savings from care improvements
- Patients still have freedom to choose their providers
  - increase challenge to generate savings

Patients are “attributed” based on where the majority of care is provided

**What ACOs are not:**
- Not an insurance plan—you don’t “sign up”
- Not a new payment model for services—still fee-for-service to providers

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BCBS Massachusetts Alternative Quality Contract

*According to a study by the New England Journal of Medicine, BCBS Massachusetts ACOs were able to achieve lower spending growth and greater quality improvements than the control group. Although the study was conducted over a four-year period, the results suggest that a shared savings model can serve as a foundation for lowering spending and improving quality.*
What Can Happen When Fee-For-Service Changes to Capitation?

Procedures per 100,000

Select Professional and Facility

Duration of Period: 8 Months

<table>
<thead>
<tr>
<th>Procedures per 100,000</th>
<th>Select Professional and Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>300</td>
<td>$6.26</td>
</tr>
<tr>
<td>70% Reduction</td>
<td>35% Reduction</td>
</tr>
<tr>
<td>90</td>
<td>$4.08</td>
</tr>
<tr>
<td>80% Reduction</td>
<td></td>
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<tr>
<td>129</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>

fee-for-service capitation

Advisory.com 2014

High Deductible Health Plan Enrollment has Grown*

<table>
<thead>
<tr>
<th>Year</th>
<th>Deductible &gt; $1,000</th>
<th>Deductible &gt; $2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>2007</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>2008</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>2009</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>2010</td>
<td>22%</td>
<td>12%</td>
</tr>
<tr>
<td>2011</td>
<td>27%</td>
<td>14%</td>
</tr>
<tr>
<td>2012</td>
<td>31%</td>
<td>15%</td>
</tr>
<tr>
<td>2013</td>
<td>34%</td>
<td>15%</td>
</tr>
<tr>
<td>2014</td>
<td>38%</td>
<td>18%</td>
</tr>
</tbody>
</table>

*Small firms (5-199 workers) have more workers covered by HDHP (> $1,000) than large firms (≥ 200 workers), 61% vs. 32%.

Steerage and Tiering

Narrow Networks

- Health Insurance Exchanges and Medicare Advantage plans are “narrowing the network” of hospitals and physicians participating in an insurance plan and negotiating lower hospital and provider fees
- Out of network if hi cost or low quality
- Insurance premiums are ~26% lower in narrow networks compared to broad networks in the same tier

“Unintended variation is stealing healthcare blind”

Donald Berwick, MD

US Institute of Medicine. Best Care at Lower Cost, 2012

Hospital Variation in Non-Acute PCI Inappropriateness

Chan, PS, et.al
WHY APPROPRIATENESS?

Background

- Significant increase in utilization and cost of imaging technology; recent slowing in growth but still questions
- Substantial regional variation
- True nature of utilization unknown
  - Overuse/Under-use/Appropriate
- Clinicians, patients, and especially payers seeking guidance

Cardiology “Choosing Wisely”

What Not to Do

- No stress cardiac imaging in first evaluation of patients without cardiac symptoms
- No annual stress cardiac imaging as part of routine follow up in asymptomatic patients
- No stress cardiac imaging as pre-op assessment in patients undergoing low-risk non-cardiac surgery
- No echocardiography as routine follow-up for mild, asymptomatic native valve disease in patients with no change in symptoms
So What Should You Expect:
Health Care Environment 2015-2020

- EHRs; meaningful use
- ICD-10
- Value Based Purchasing
- Payment cuts
- Public Reporting
- Accountable Care Organizations
- DOJ Fraud investigations
- Physician Quality Reporting System (PQRS)
- Efficiency metrics (= cut costs)
- Claims data profiling
- Preauthorization
- Payer Programs
- Utilization review
- MOC / MOL
- Bundled payments (capitation)
- Certification exams
- Appropriateness auditing

Payment & Delivery System Reform

Shifting Risk And Increasing Accountability

Preparation for an Era of Greater Accountability

Supporting Better Performance
- Pay for Reporting
  - HRRP
  - PBR
  - Stage 1 Meaningful Use
- Payment for Coordination
  - Medical Home

Paying for Better Performance
- Pay for Performance
  - Never Events
  - Future Stages of Meaningful Use
- Episode-Based Payments
  - Bundled Payments
  - Readmissions

Paying for Higher Value
- Shared Savings with Quality Improvement
  - One- or Two-sided ACO Risk Model (individual or regional)
- Partial or Full Capitation with Quality Improvement

Payment reforms progressively move away from FFS & support sustainable health care reform.

Source: The Engelberg Center for Health Reform at Brookings / The Dartmouth Institute
MACRA: Medicare Access and CHIP Reauthorization Act of 2015

**Pre-MACRA**
- 21% payment cut in 2015, continued uncertainty
- Separate quality reporting programs with separate penalties (no bonuses)
- Some regulatory flexibility for Alternative Payment Model (APM) participation

**Post-MACRA**
- Eliminates SGR; implements stable payment increases
- Streamlined quality reporting program with consolidated penalties and bonuses
- Incentives for Alternative Payment Model (APM) participation (ACO’s, MSSP, bundles, full risk) and Population Management

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**MIPS Composite: 2019**

- Meaningful Use requirements
- Meaningful Use weight may be adjusted down to 15 percent if 75% or more EPs are meaningful users
- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM

- PQRS measures
- eCQMs
- QCDR measures
- Risk-adjusted outcome measures
- Value-Based Modifier measures
- Risk-adjusted outcome measures
- Part D drug cost (if feasible)
Nearly one-fourth of Medicare spending is for hospital inpatient services

*Total Medicare Benefit Payments in 2013: $583 billion*

NOTE: Other services consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

BY ATUL GAWANDE

In Camden, N.J., one per cent of patients account for 30 per cent of the city’s medical costs. Photograph by Philip Tulkens.

residents, and looked for the hot spots. The two most expensive city blocks were in north Camden, one that had a large nursing home called Abigail House and one that had a low-income housing tower called Northgate II. He found that between January of 2002 and June of 2003 were nine hundred people in the two buildings accounted for more than four thousand hospital visits and about two hundred million dollars in health-care bills. One patient had three hundred and twenty-four admissions in five years. The most expensive patient cost insurers $1.5 million.

Concentration of Health Care Spending in the U.S. Population, 2009

<table>
<thead>
<tr>
<th>Percent of Population, Ranked by Health Care Spending</th>
<th>Percent of Total Health Care Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 1% (≥$51,951)</td>
<td>21.8%</td>
</tr>
<tr>
<td>Top 5% (≥$17,602)</td>
<td>49.5%</td>
</tr>
<tr>
<td>Top 10% (≥$9,570)</td>
<td>65.2%</td>
</tr>
<tr>
<td>Top 15% (≥$6,343)</td>
<td>74.6%</td>
</tr>
<tr>
<td>Top 20% (≥$4,586)</td>
<td>81.2%</td>
</tr>
<tr>
<td>Top 50% (≥$851)</td>
<td>97.1%</td>
</tr>
<tr>
<td>Bottom 50% (&lt;$851)</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian non-institutionalized population, including those without any health-care spending. Health-care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies. Health-insurance premiums are not included.

Million Hearts CMS CV Disease Risk Reduction Program

Background & Rationale

- Heart attack and stroke (ASCVD) are leading causes of death and disability
- In the past
  - Risk reduction focused on specific process measure targets, i.e. LDL cholesterol level and blood pressure, with the same targets applied to all patients
  - Currently, risk factors are discussed as independent conditions rather than risk factors contributing to ASCVD
  - Patients have little idea of their actual risks of heart attack and stroke
- What the model will change
  - Uses data-driven, widely accepted predictive algorithm to give individualized 10-year risk score for ASCVD to each beneficiary
  - Providers get value-based payment depending on absolute risk drop across entire panel, necessitating population health management

![ASCVD Risk Estimator](image)
Who Will Be Your Patients?
Uninsured Rate Among the Nonelderly Population, 1972-2015

Share of population uninsured:

Note: 2015 data is for Q1 and Q2 only.
Source: CDC/NCHS, National Health Interview Survey, reported in

The Challenges Ahead:
Payer mix is shifting in favor of government-reimbursed patients

Base Case: Coverage Shifts in NYC/Westchester

Source: Base Case Scenario, Deloitte Center for Health Solutions NYC includes Manhattan, Bronx, Queens, Brooklyn & Westchester

Key Drivers include: Aging Population, Medicaid Expansion, Creation of Health Insurance Exchange
Market Trends – Hospital and Payer Consolidation; Physician Employment

ACC Survey of 21,373 Cardiologists

The New Health Care Market
This Time is Different: Strategy Matters

- Cost matters, Outcomes matter
- A good brand-is not enough
- The market is moving to competition on value
- We need to do the right things
  - Meeting patients’ needs-service quality
  - Doing so as efficiently as possible-cost
  - Develop a real strategy-one goal is enough
  - Improving value for patients is an excellent goal in a time of transition
Changing the Healthcare Business Model

**Better too early than too late!!**

Curve One: Fee for Service  
Curve Two: Population Health  

Change too early…  
Risk  
- Loss of fee-for-service revenue  
Reward  
- Growth – covered lives  
- Physician alignment  

Change too late…  
Risk  
- Loss of market share  
- Physicians align with competitors  
Reward  
- Maximize fee-for-service revenues

Ideal, but feasible?

Message to CV Specialists

- Be aware of the changing landscape  
  – “You can run, but you can’t hide”  
  – Sticking your head in the sand will not work
- Understand that the New Era in Health Care Delivery will affect your practice and how you are paid in the future
- Now is the time to get involved with your DATA  
  – Quality is key- Join Registries,  
  – Physician Dashboards-both quality and efficiency metrics
“If you are not keeping score, you’re just practicing”

- Vince Lombardi

The train has left the station, and it ain’t coming back
“We’d now like to open the floor to shorter speeches disguised as questions.”