



Value Based Care- Vision for the Future

Kavita K. Patel MD, MS

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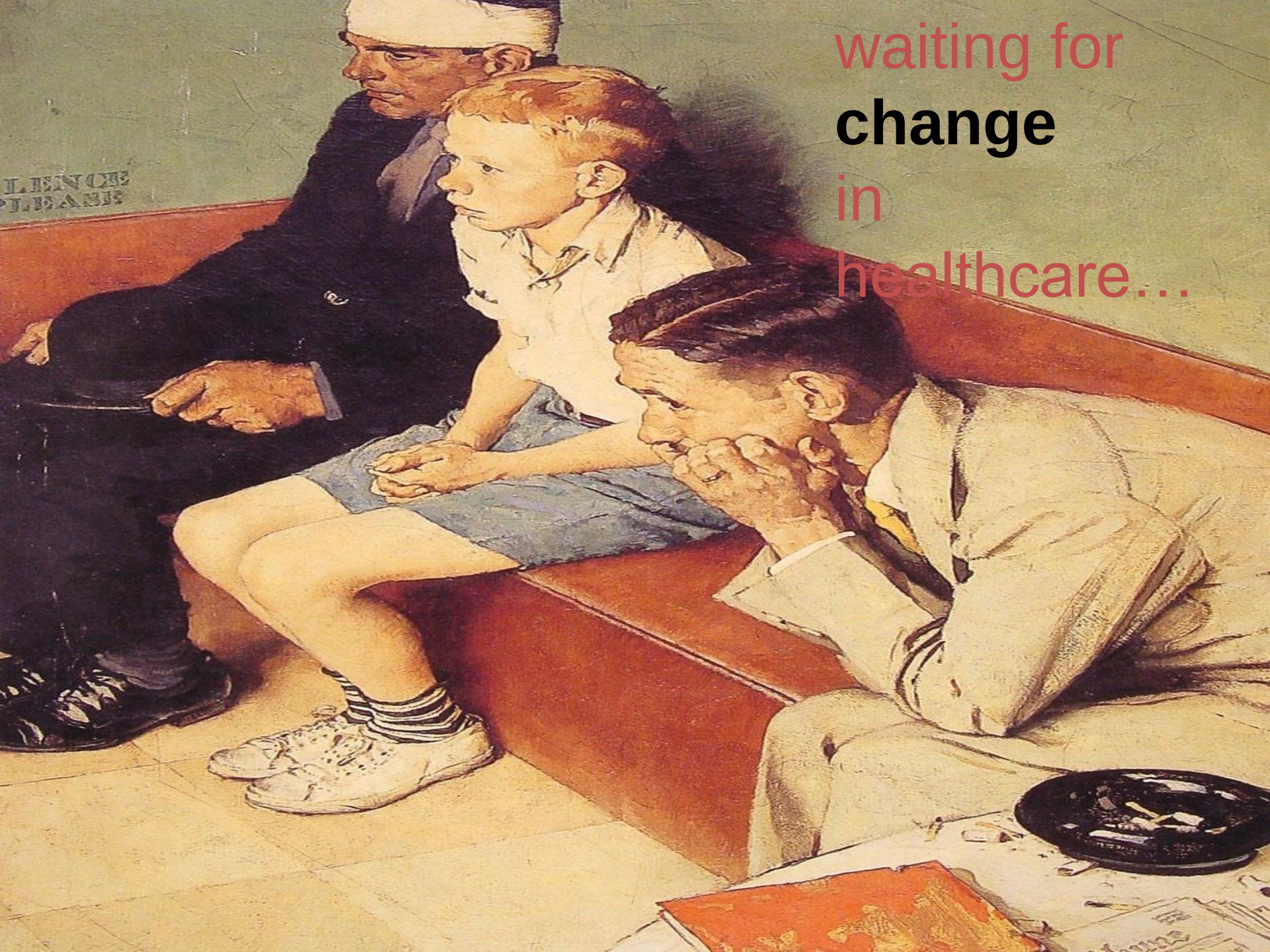

waiting for
change
in
healthcare…

…and now it's **here**

KEY QUESTIONS FOR HEALTH CARE LEADERS

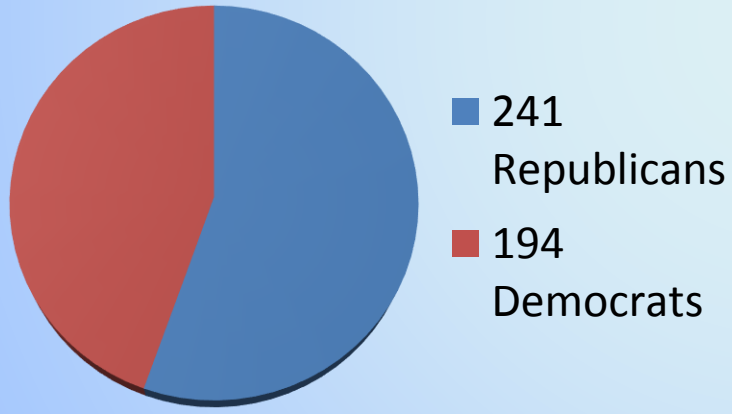
- What's going to **force us to change**?
- How do we get from **here to there**?
- **How big** do we have to be?
- **Can we take total financial risk?** And do we make, buy or ally for risk bearing?
- **What assets** do we have to bring together, and do we have to own them all?
- What are the **key competencies**?
- Do we have the **people, leaders and culture** to pull this off?

THE NEW ADMINISTRATION…AND THE OLD ONE

Election Results Produce Regime Change

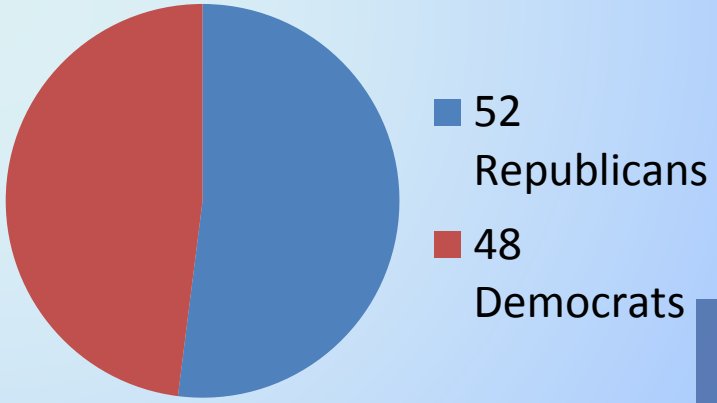
Presidential		
Electoral votes	306 Donald Trump	232 Hillary Clinton
Popular vote	46% 62.7 million	48% 65.4 million

House Members



Simple Majority Needed

Senate Members



Super Majority Needed

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New Leadership Will Determine Direction

Rep. Tom Price
Secretary of HHS

° ...man from ...ir of ...get ...tee

...rmerly Practiced ...hopedic

...ealth care a...tally con...ned about physician burden in the context of payment reform

Seema Verma
CMS Administrator

° Medicaid Consultant to IN and other states

° Architect of Healthy Indiana 2.0 Expansion Plan

° Limited Medicare Experience

° Creative and Tenacious Policymaker

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Can't We All Just Get Along?

Difficult to Overcome Gap in Party Philosophies

Problem is too much spending, not too little revenue
- Reduce entitlement spending
- Reduce taxes
- Private market should lead with government support

Problem is too little revenue, not too much spending
- Increase tax revenue
- Support entitlement spending
- Government should lead with private market support

Broad Range of Considerations in Pursuing Entitlement Reform:
- Complexity of Developing Consensus
- Constituent Impact
- Legislative Bandwidth
- Cost Considerations
- Stakeholder Engagement
- Legislative process requirements

But Not Impossible to Find Areas of Bipartisan Agreement

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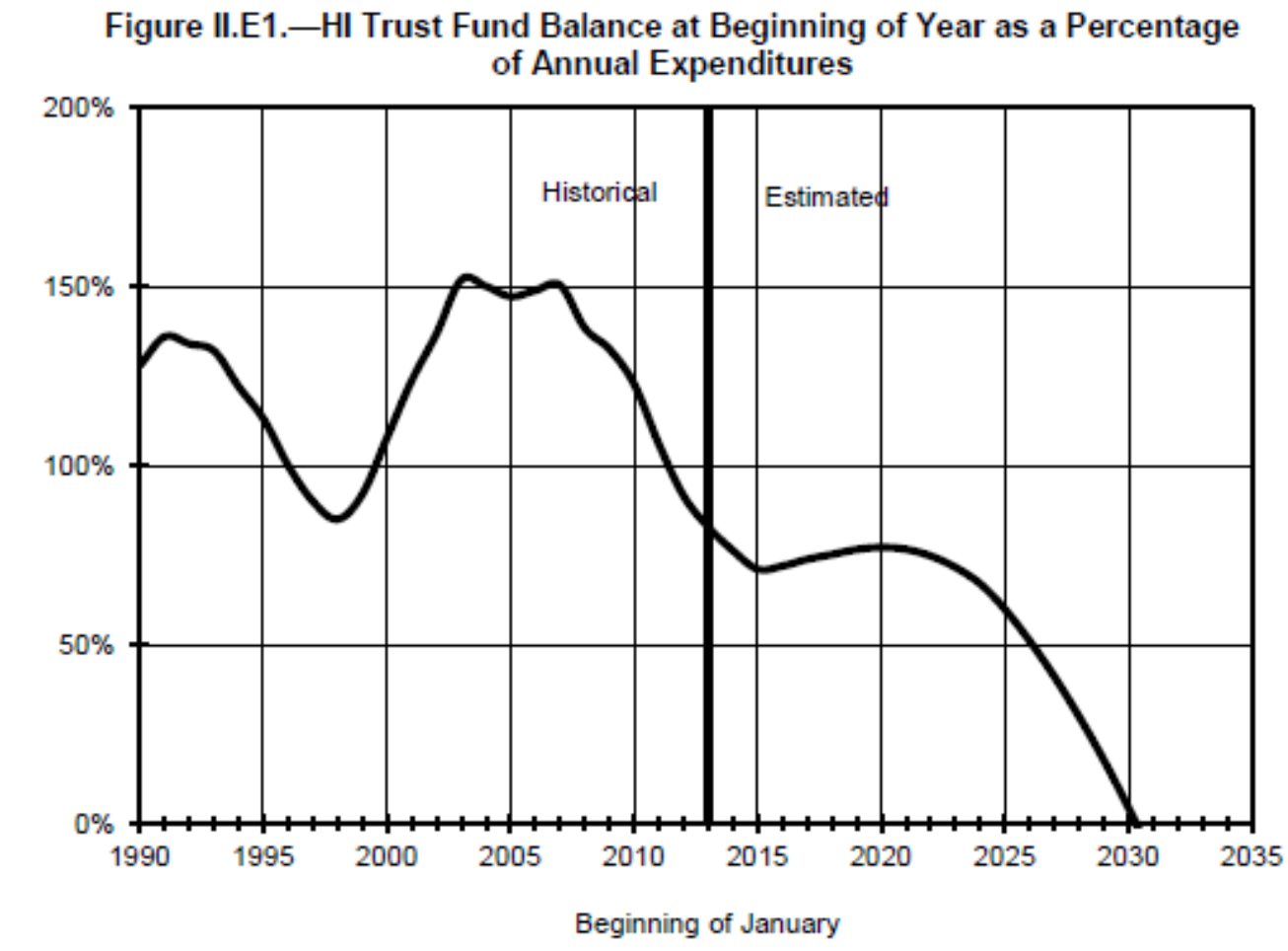
Bipartisan Goal of Medicare Sustainability



Source: 2014 Medicare Trustees Report

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Role of Medicaid Growing In Recent Years

- Emerging role as dominant source of coverage, funding
  - 1 in 5 Americans covered by Medicaid
  - Single largest coverage source in market
  - Nearly half of all births covered by Medicaid
  - Lowest cost per capita compared to other coverage sources
  - Beneficiary satisfaction favorable
- Growth in spending; ideology driving discussion
  - 2015 program spending roughly $545 billion
  - Third largest domestic program in federal budget
    - 9% of federal spending
  - Rapidly displacing education as largest growing state spending item on average

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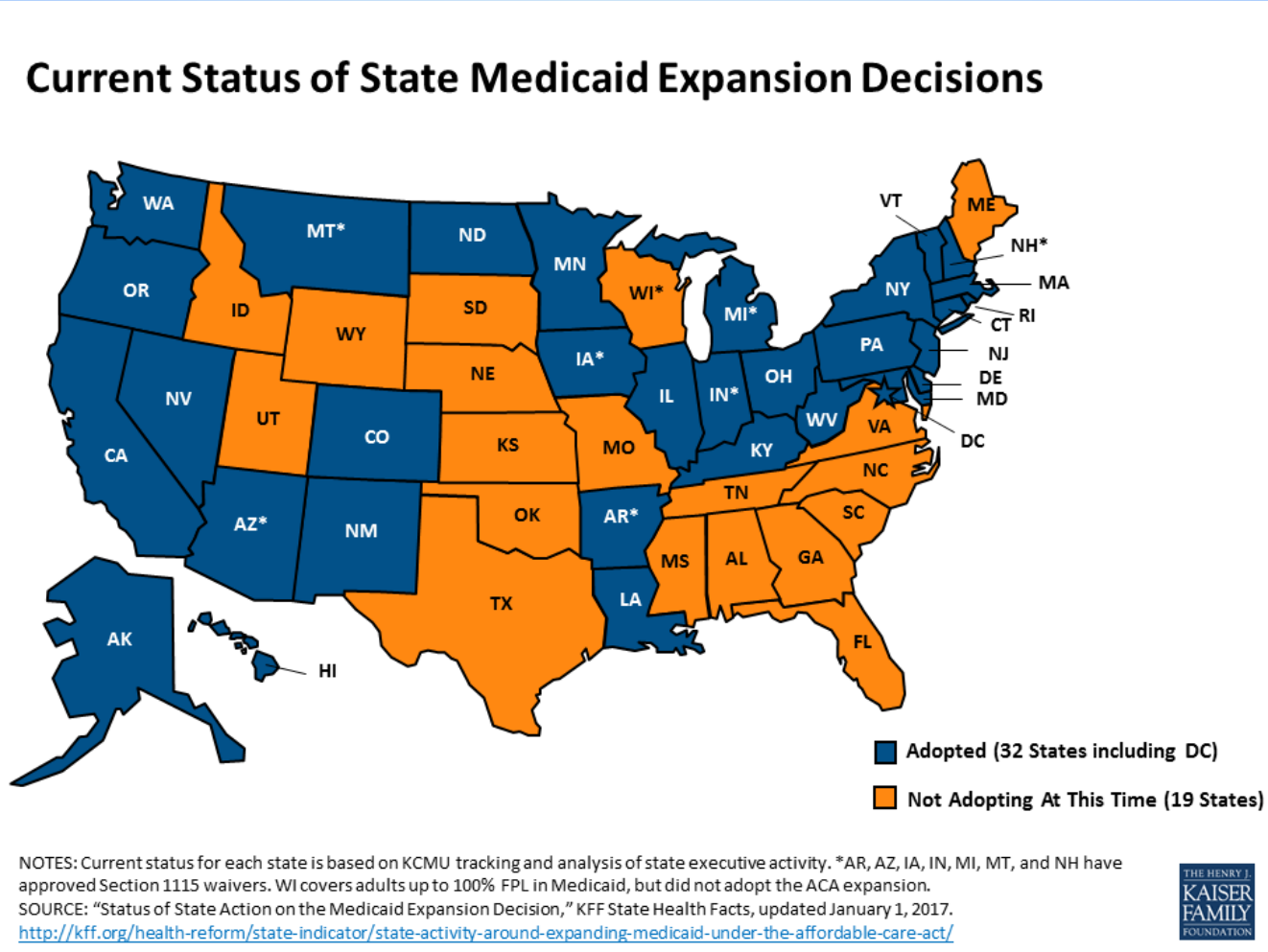
Medicaid Enrollment Expanding in Many States



Source: The Kaiser Family Foundation

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First Up: ACA Repeal or Replace

AHCA, BCRA Could Signal Shift in Overall Health Coverage Market

Provisions Targeted for Repeal or Change:

Exchange Infrastructure
-Premium Subsidies (tax credits)
-Cost Sharing reductions
-Mandates (individual, employer)
-Some market reforms (but not all)
Revenue Provisions
-Insurer, Drug and Device taxes
-Income Tax surcharge
-Cadillac Tax
-IPAB
-Medicaid Expansion Funds

Provisions Remaining In Effect:

Select Insurance Reforms
-Guaranteed Issue*
-Coverage Up To Age 26 on Parent's Plan
CMMI
-Funding
-Waiver Authority
Medicare Payment Cuts
- Productivity Adjustments for Hospitals, Post-Acute Providers, etc.
- Medicare Advantage Changes

Republican reform proposals expand beyond four corners of the ACA and seek to modify fundamental structure of Medicaid funding as well as program requirements

* May be waived by states in some circumstances under proposals

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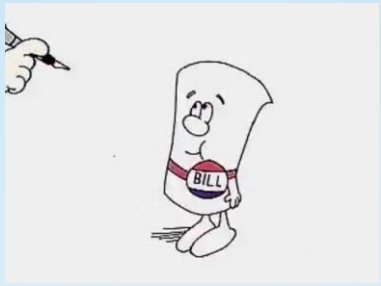
Congressional State of Play on ACA

House Activity

March 24, 2017:
First AHCA Vote
WITHDRAWN

May 4, 2017
Second AHCA Vote
PASSED

AHCA Sent to Senate for Consideration



It's Not Dead Yet
But the Road To Passage May Change

Senate Activity

June 25, 2017
Amended BCRA Vote
FAILED 43-57

July 27, 2017
Straight Repeal Vote
FAILED 45-55

July 28, 2017
Skinny Repeal Vote
FAILED 49-51

September 2017
Graham-Cassidy fails to have a scheduled vote

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Proposed Insurance Coverage Changes

Issue	ACA (Current Law)	AHCA (May 4)	BCRA (July 20)
Public Exchanges	Establishes state-based insurance markets to purchase qualified individual coverage	Maintains exchanges; eliminates metal tiers and AV structure in 2020	Maintains exchanges
Insurance Mandates	Must obtain creditable coverage or pay annual penalty (2.5% of income or $695, whichever is greater)	Repeals mandate as of Jan. 1, 2016; must maintain continuous coverage or plans may add 30% surcharge	Repeals mandate as of Jan. 1, 2016; must maintain continuous coverage or plans must apply 6 months lockout period
Premium Subsidies	Income-based tax credit for people earning up to 400% FPL, pegged to average silver plan premium	Age-based tax credits (subject to income cap) ranging from $2,000 (under 30) to $4,000 (over 60); begins 2020	Income-based tax credit for people earning up to 350% FPL, pegged to market plan with 58% AV; begins 2020; can be used to purchase some plans off exchange
Guaranteed Issue	Insurers required to offer coverage to people with pre-existing conditions during open enrollment or SEP	Guaranteed issue still applies	Guaranteed issue still applies but eases states ability to waive related requirements
Rating Rules	Age rating set at 3:1 and community rating required	Age rating allowed up to 5:1; allows states to waive community rating	Age rating allowed up to 5:1; community rating required
Plan Requirements	Must cover essential health benefits; cannot set lifetime or annual limits; annual out of pocket costs cap; preventive benefits with no cost sharing	Requirements still apply but expands states' ability to waive or limit requirements	Requirements still apply but expands states ability to waive requirements

Proposals Wind Down Medicaid Expansion

- Loss of ACA-expansion funding could begin in 2020
  - Eliminates option to extend coverage to adults up to 138% of FPL
    - AHCA ends as of 2020 while BCRA ends as of 2018
  - Sunsets enhanced FMAP for states that have already expanded
    - AHCA sunsets enhanced funding on Dec. 31, 2019 while BCRA phases down to traditional match rate by 2024
    - AHCA exception for beneficiaries who are enrolled as of that date and do not have a lapse in coverage of more than one month*
  - Exempt non-expansion states from DSH cuts and provide non-expansion states with short term funding pool to stabilize markets and offset costs of care

*Based on historic "churn" in expanded population, experts project that this will functionally end ACA coverage for the expanded population within short time frame

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Trump Health Care Priorities

- Affordable Care Act
  - Repeal and replace with “something terrific”
  - Allow plans to sell insurance across state lines
  - Allow individuals to fully deduct premiums for health insurance
  - Increase use of Health Savings Accounts (HSAs)
  - Require price transparency for all providers
- Prescription Drug Costs
  - Supports reimportation of pharmaceuticals
  - All Medicare to negotiate drug prices
- Medicaid
  - Transition to block grant program
  - Pence Plan for “Healthy Indiana” ties expansion to work program, premium contributions, use of HSAs and a benefit lockout period

What's Next

- ACA Coverage Replacement
  - Bring back high risk pools
  - Return of underwriting for chronic disease, age
  - Allow purchasing across state lines
  - Protect patients with pre-existing conditions if they maintain continuous coverage
  - Keep dependents covered until 26

Historically, Cost/Value Not Primary Factor in Physician Decision Making . . .

- Only primary care physicians cited cost as among their most important considerations, among a survey that also included oncologists, cardiologists, neurologists, dermatologists and pulmonologists
- 47% of all physicians surveyed ranked the issue as a key concern, but secondary to evidence that a drug is safe, effective and well-tolerated by patients
- 25% of cardiologists pointed to cost as the most important factor
- Difference between primary care and specialists may be that patients are more cost conscious in the primary care setting

However, under MACRA and Alternative Payment Models across payers, specialties, and settings, including primary care, greater attention will be focused on drug costs.

Source: STAT News, November 2016 article citing CMS/Compass survey, link

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HEALTHY COMMUNITIES

- “A TECHNOLOGY REVOLUTION IS TAKING THE WORLD FROM **CONNECTED** TO **HYPER-CONNECTED** AND INDIVIDUALS FROM **EMPOWERED** TO **SUPER-EMPOWERED**.
- IT IS GOING TO **CHANGE EVERYTHING** ABOUT HOW COMPANIES AND SOCIETIES OPERATE.”
  - - TOM FRIEDMAN

HOW DO WE DEAL WITH DISRUPTION?

CONSUMERS ARE NOW CO-CREATORS

THE SHIFT IS ON

FROM PUSH

Target audiences

With messages

Through channels

To drive transactions

TO PULL

Engage communities

With a shared purpose

Through experiences

That sustain

relationships

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PUTTING PATIENTS AT THE CENTER

ECHO, NEW MEXICO

ECHO Whale


PCA Espanola


Baton Rouge


Pecos Valley MC


DOH Las Cruces


SBRT-First Choice South Vc


Memorial HDX7000


LAS VEGAS ECFH

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Project ECHO

- What project ECHO represents is a bold experiment that implements a new approach to providing care.

HEPATITIS C IN NEW MEXICO

~ Estimated number is greater than 28,000

~ In 2004 Less than 5% had been treated

~ Without treatment 8,000 patients will develop cirrhosis between 2010-2015 with several thousand deaths

~ 2300 prisoners diagnosed in corrections system (expected number is greater than 2400) - None treated

~ Highest rate of chronic liver disease/cirrhosis deaths in the nation

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GOALS

~ Develop capacity to safely and effectively treat Hepatitis C in all areas of New Mexico and to monitor outcomes

~ Develop a model to treat complex diseases in rural locations and developing countries

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METHOD

~ Use Technology (multipoint videoconferencing and internet) to leverage scarce healthcare resources

~ Disease Management Model focused on improving outcomes by reducing variation in processes of care and sharing “best practices”

~ Case based learning: Co-management of patients with UNMHSC specialists (Learning by Doing)

~ HIPAA compliant centralized database to monitor outcomes

Arora S, Geppert CM, Kalishman S, et al: Acad Med. 2007 Feb;82(2): 154-60.

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STEPS

~ Train physicians, nurses, pharmacists, educators in Hepatitis C

~ Train to use web based software - “ihealth”

~ Conduct telemedicine clinics – “Knowledge Network”

~ Initiate co-management – “Learning loops”

~ Collect data and monitor outcomes centrally

~ Assess cost and effectiveness of programs

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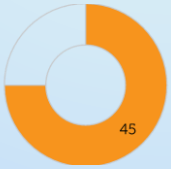
DECATUR, GA

A Different Approach to Healthcare Delivery

	Traditional Primary Care	iora
Contracts	Fee for Service	**100% Value Based**
Support Staff		
Panel Size	2,300 patients / MD	**600-1,500 patients / MD**
Access	Poor	**Same day, video, email**
Visit Length		
Cost to Patient		

- **Daily huddles**
- **Team-based care**
  - **Medical Care**
  - **Health coaching**
  - **Mental health**
- **Shared care plans**
- **Proactive population health**
- **Curated narrow networks**
- **Co-management in hospital**

20% Improvement in Health Outcomes

18% Reduction in Total Medical Costs

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What is a Relationship-Based Care Model?

We focus first on building trusting relationships:
We do what we say we will do AND we do the right thing.

Improve Health

- Food
- Exercise
- Stress
- Relationships

Improve Navigation

- Coordinate with specialists
- Co-manage in hospital
- Streamline pharmacy

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A Radically New Model of Care

- Built from the ground up to improve the health of our patients and keep them out of trouble
- Robust teams help patients make shared care plans and proactively reach out as needed:
  - interactions not just in visits but by email, phone, text and video
  - patients learn more about their conditions and how to manage them 1:1 and in groups

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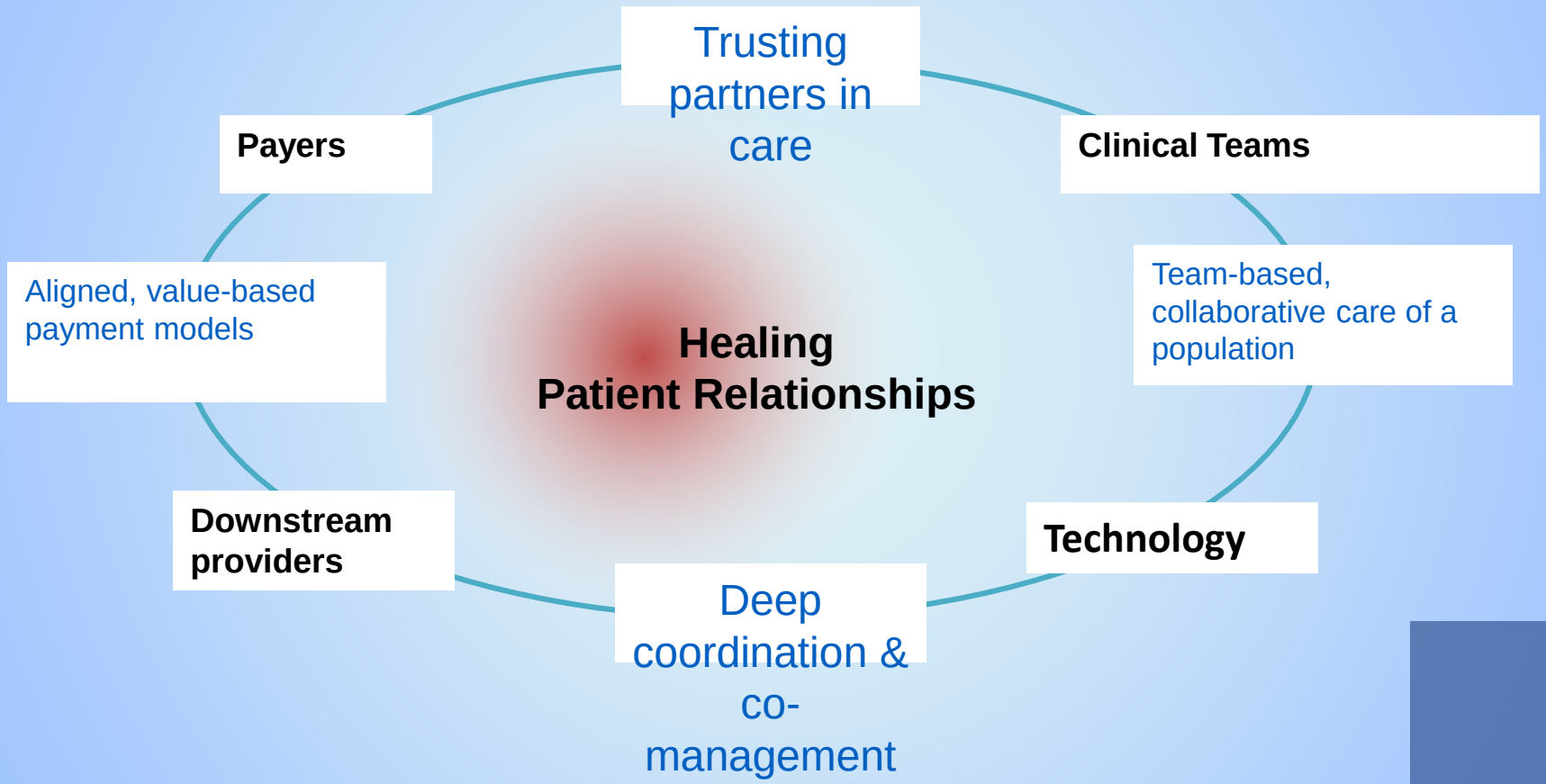
High Impact Relationship Based Care



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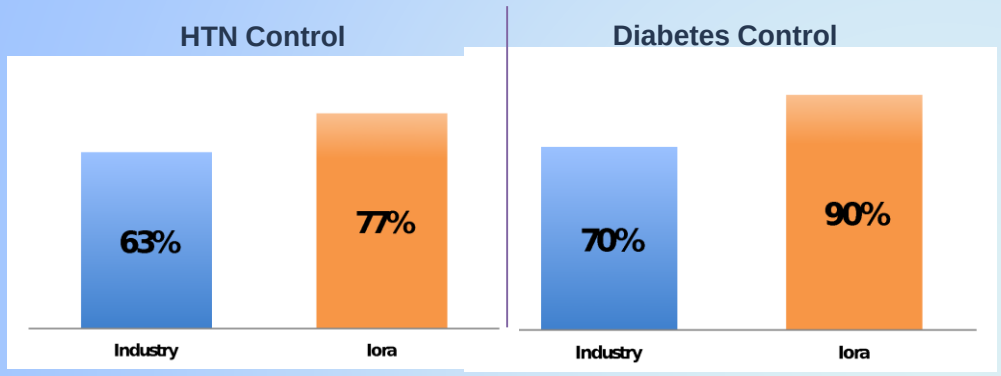
Delivering Clinical and Financial Value

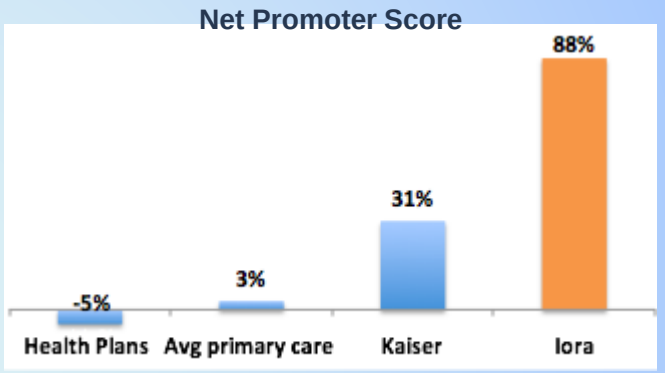
Improved Clinical Outcomes

In hypertension control and A1c, select Iora practices are outperforming the national average by over 20% in both categories



Patients Love Iora

Best-in-class Net Promoter Scores indicate high levels of patient satisfaction (which enables engagement)



Decreasing Unnecessary Utilization

By improving patients' health and increasing the coordination of care, Iora can significantly reduce unnecessary utilization:

Inpatient Admissions

Reduced by **28-41%**

Emergency Room Visits

Reduced by **30-35%**

Lowering Cost

Achieved **total cost savings of 18-20%** in multiple markets and across various patient populations

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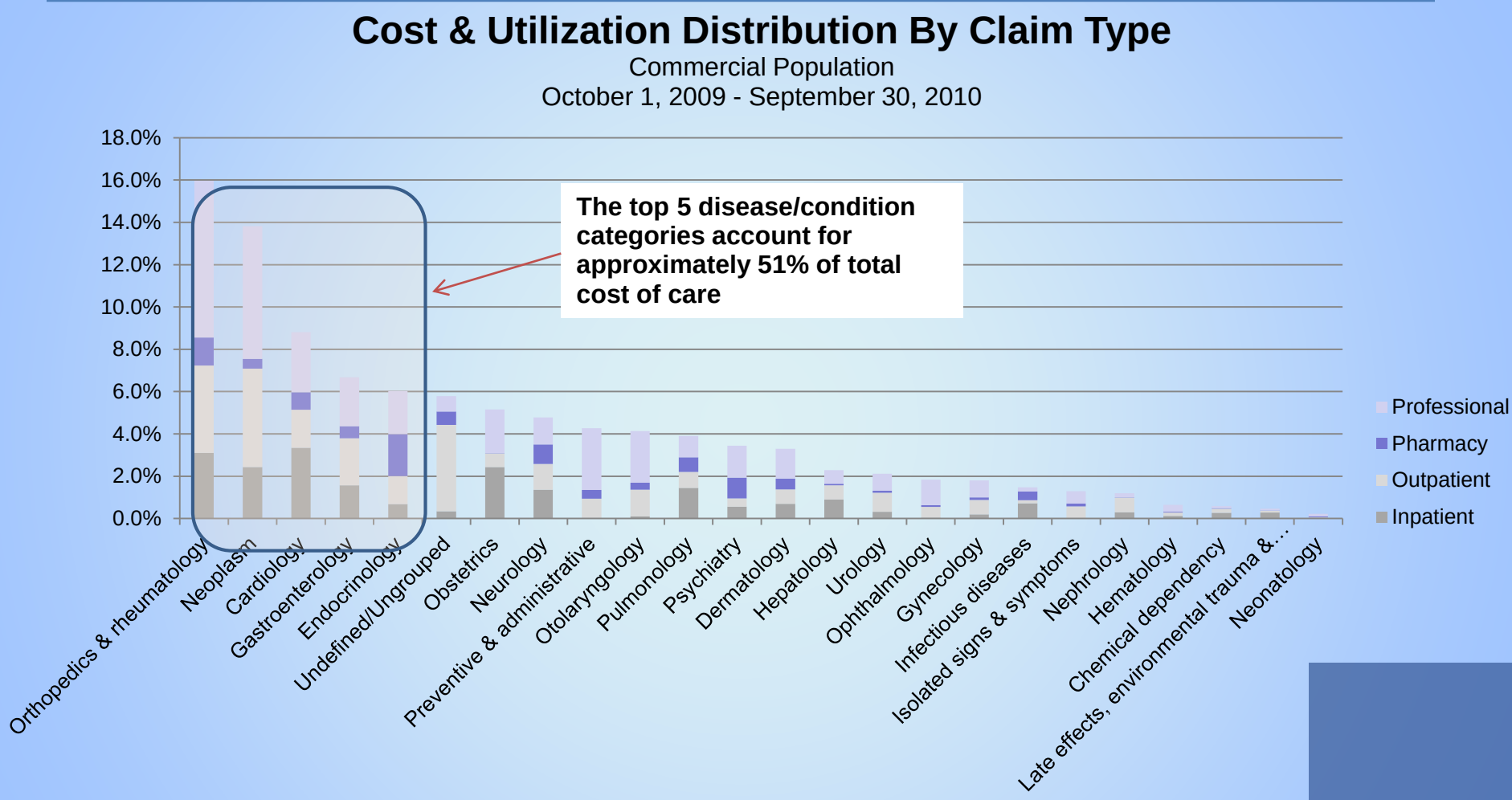
GRAND JUNCTION COLORADO

Demographics and Population Cost Distribution by Major Practice Category



Major Practice Categories (MPCs) are based on the diagnosis on claims data. They do not represent specific provider specialties. For example, claims submitted by family practice providers for treating diabetes cases would be placed in the Endocrinology MPC.

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How are social determinants & behavioral factors perceived?

- There is broad agreement social and behavioral determinants of health are important. However, what factors are the focus varies, including:
  - trauma, substance abuse, language and literacy issues, transportation access, frailty, personal behavior and support systems/relationships.

- Some struggled with collecting data ("it's uncomfortable for the providers to ask these questions"), others struggled with what to do with the data, and others lacked the resources to address issues that were identified.
- Fear that collecting and sharing information will create extra work, or double duty, if not done right.

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Though physicians see social and behavioral determinants as key factors in affecting resource allocation, we have poor methods for tracking them. In many cases, they fall back on "clinician subjective impressions."

In some cases, they work these explicitly into their risk models, in others, they apply them informally after the fact.

"WOULD YOU BE SURPRISED IF THIS PATIENT DIED IN THE NEXT 6 MONTHS??"

The consumption of hospital/clinic resources, such as ED visits, "chart length", phone calls, affects clinician impressions.

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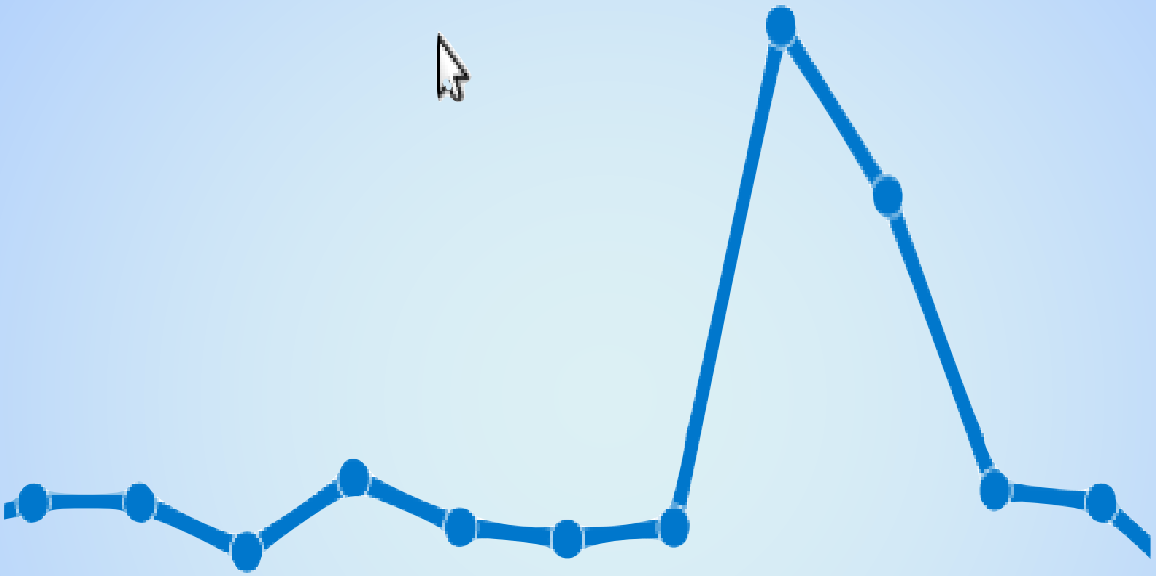
Patients fluctuate, entering and exiting crises (influencing “risk”)



- Different patients have different patterns over time of needing resources to be allocated to them based on how “risky” they are at that time

CMS Utilizing Range of Payment Model Approaches

CMS Rapidly Building Diverse Portfolio of Payment Methodologies…

Continuum of Medicare Payment Initiatives





Pay-for-Performance	Bundled Payments	Shared Savings	Shared Risk	Full Risk
• Hospital VBP Program • Hospital Readmissions Reduction Program • HAC Reduction Program • MACRA MIPS Track	• Bundled Payments for Care Improvement • Comprehensive Care for Joint Replacement Model • Oncology Care Model • Heart Attack and Bypass Model	• MSSP Track 1 (50% sharing)	• MSSP Track One+ • MSSP Track 2 (60% share) • MSSP Track 3 (up to 75% share) • Next-Generation ACO (80-85% share)	• Next-Generation ACO (optional full performance risk) • Medicare Advantage (provider-sponsored)

Increasing Financial Risk

But Too Early To Know Which Models Reduce Cost and Improve Quality Over Time

Source: The Advisory Board Company

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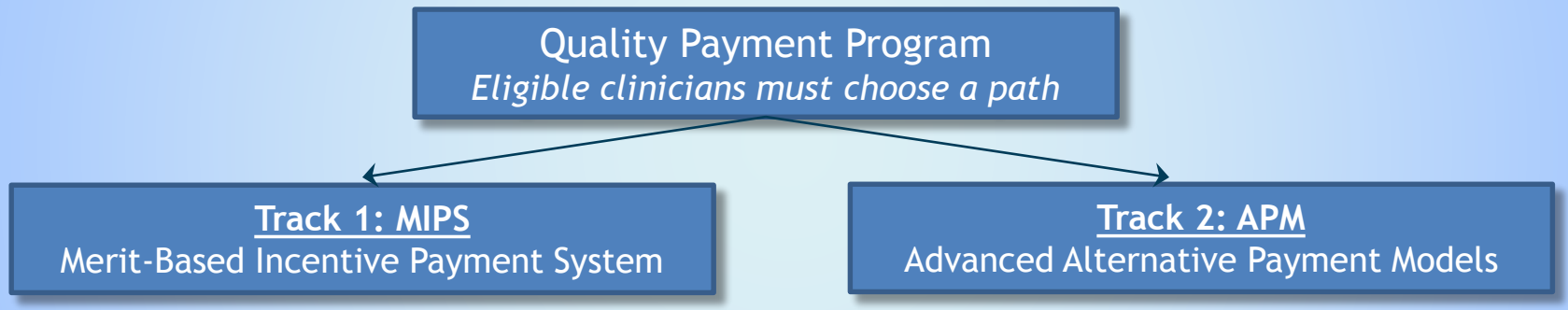
Focus on Transformation Will Remain

- Focus on Risk and Value Theoretically Supported by Both Parties
- Key Questions Looming with Change in Leadership
  - How will existing CMMI programs operate and evolve?
    - Core concepts of ACOs and bundling remain the same; program details and terminology likely to change Initiatives could accelerate if spending reduction is dominant in discussion
    - Drug pricing proposals; mandatory bundles likely to face challenges
  - What is the outlook for data and transparency initiatives?
    - Transparency touted frequently in campaign by both parties
    - Rollback of IT initiatives like ONC, meaningful use but focus on data will remain
  - Will MACRA implementation proceed and how will it change?
    - Difficult to change mid-stream but new Administration may offer continued flexibility, longer transition to impact
    - Much of MACRA framework is statutory-big changes dependent upon Congress

New Leadership Will Oversee MACRA (QPP)

- MACRA implements the Quality Payment Program (QPP), a new payment methodology for services furnished by eligible clinicians under the Part B Physician Fee Schedule
- Payment under QPP begins on **Jan. 1, 2019** but provider performance reporting that determines 2019 rate will begin in **2017**



- Providers choosing the MIPS pathway will have payments increased or decreased based on performance relative to their peers

- Physicians choosing the APM pathway will receive an incentive payment for participation

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MOTIVATION

NARRATIVE

TRUST

SHARED PURPOSE:
A TALE OF TWO COFFEES

"Make and serve the freshest, most delicious coffee and donuts quickly and courteously in modern, well-merchandised stores."

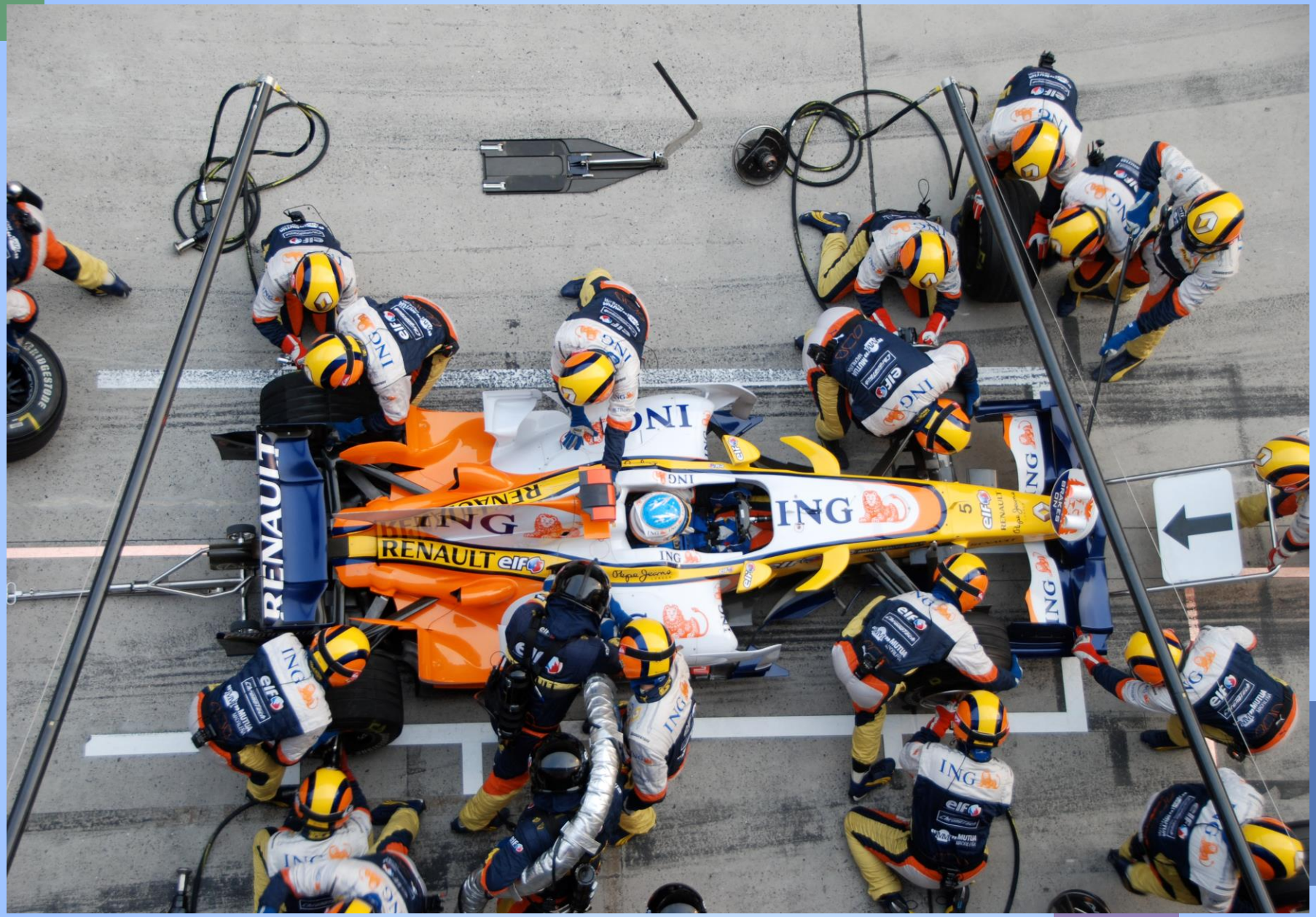
**"To inspire and nurture the human spirit —
one person,
one cup and
one neighborhood at a time."**

IF THE PURPOSE FITS …

"The adidas Group strives to be the global leader in the sporting goods industry with sports brands built on a passion for sports and a sporting lifestyle."

"To bring inspiration and innovation to every athlete* in the world.

***If you have a body, you are an athlete."**



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WHO ARE WE?
(AND HOW ARE WE PERCEIVED?)

An industry or association advancing an agenda

OR

A collaborative movement of individuals and organizations with a shared purpose?

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Thank you

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