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Checking Up on the Value Movement

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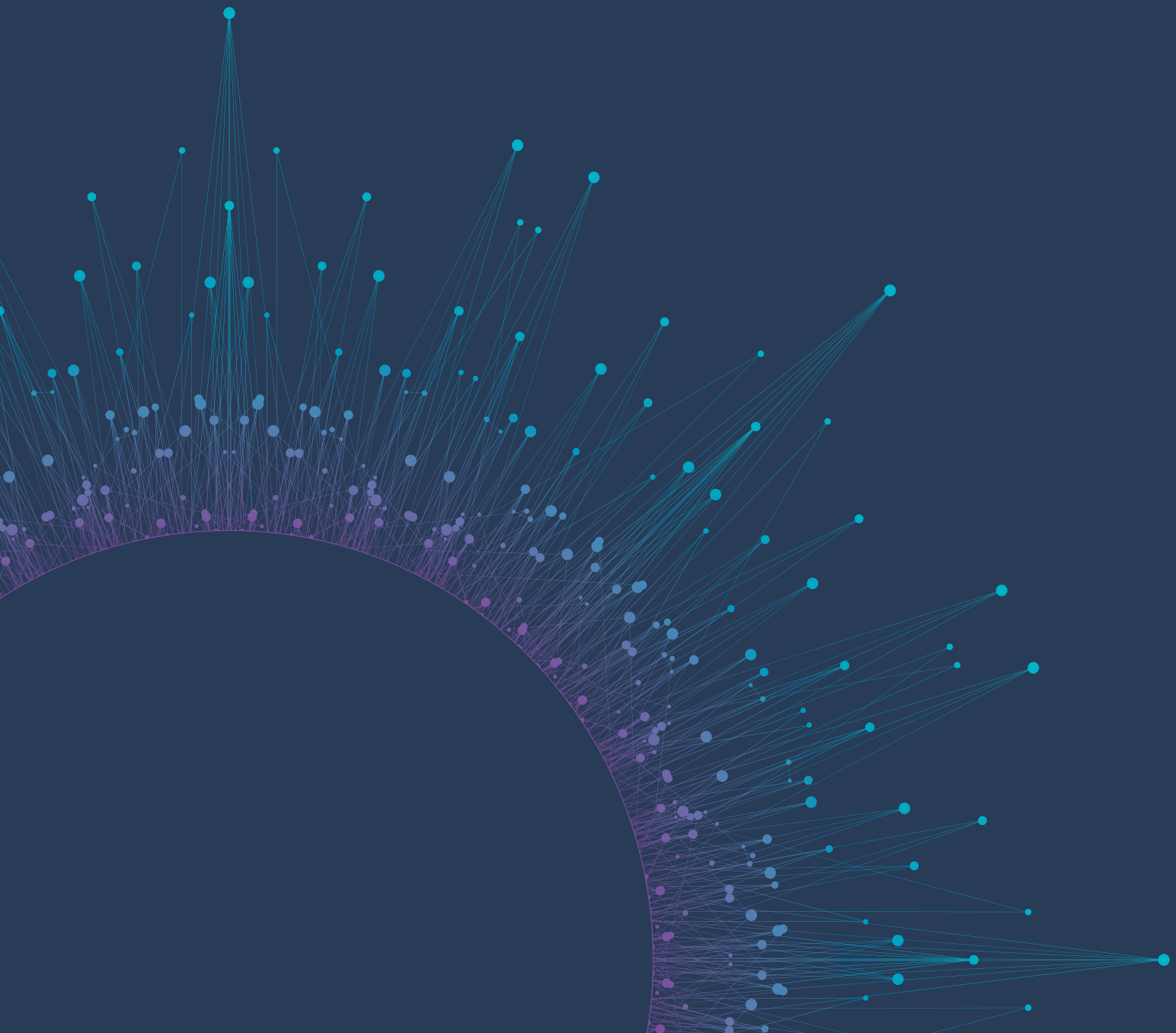

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Introduction

Transforming U.S. healthcare delivery from a system that rewards fee-for-service, or volume-based care, to value-based care offers the promise of cost containment with improved or at least similar quality. Such promise has made value-based models popular policy options at both the state and federal level over the past several years. In the lead up to the 2020 election, the U.S. shift towards paying for value in healthcare is expected to continue.

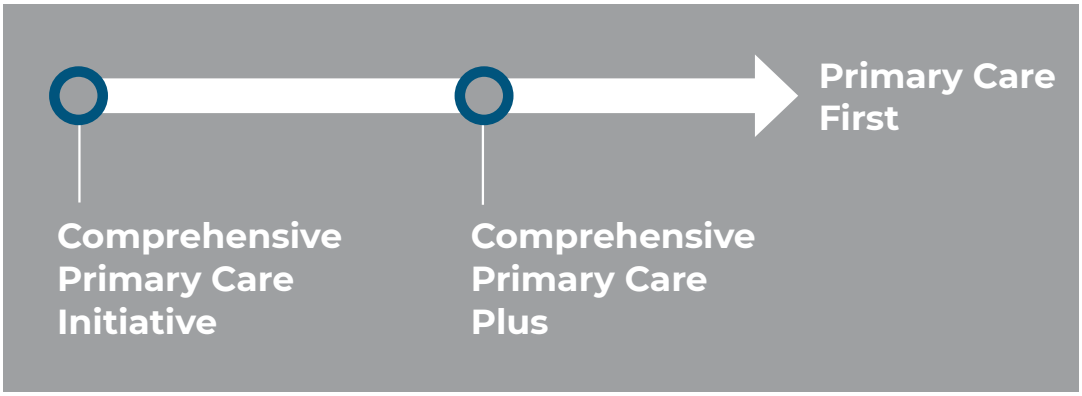
Medicare:

Steps towards Value-Based Payment Continue

The Trump Administration has continued to put its stamp on the movement from volume to value. Through requests for information, regulatory changes and new CMMI payment models, concrete principles that define this Administration's value-based agenda have emerged. Key principles include:

- Shifting risk from the federal government to providers and other entities at a local level;
- Engaging and empowering Medicare beneficiaries;
- Expanding participation in value-based models to include a broader swath of the healthcare industry; and
- Reducing regulatory burdens.

Specific examples of these initiatives include Primary Care First (PCF), Direct Contracting, and ESRD Treatment Choices (ETC).



Primary Care First

PCF represents an evolution of the advanced primary care model portfolio at CMMI. Building on the Comprehensive Primary Care (CPC) Initiative and the CPC Plus models, PCF will test whether advanced primary care can reduce total cost of care while improving or maintaining quality for Medicare beneficiaries.

Prior CPC initiatives faced criticism because they did not achieve Medicare savings. An April 2019 **evaluation report** found that CPC practices experienced slower growth in hospitalizations, emergency department visits and primary care visits than comparable non-CPC practices. CMS recently released quality and utilization results for 2018. The **data summary** shows that in 2018 CMS paid $41,528,099.80 in Performance Based Incentive Payments across all regions and 2,874 out of 2,879 practices met the model's quality reporting requirement.

Building on these results, PCF attempts to further move the needle on cost savings. The model targets advanced primary care practices that are prepared to accept financial risk as well as those that promote care for high-need, seriously ill populations that lack a primary care practitioner and/or effective care coordination. Participants in the model will receive incentives to deliver evidence-based interventions across five domains key to the delivery of comprehensive primary care:

- Access and continuity
- Care management
- Comprehensiveness and coordination
- Patient and caregiver engagement
- Planned care and population health

In PCF, the Centers for Medicare & Medicaid Services (CMS) will also solicit payers in selected regions. The new model options will be offered in 26 regions beginning in 2020.

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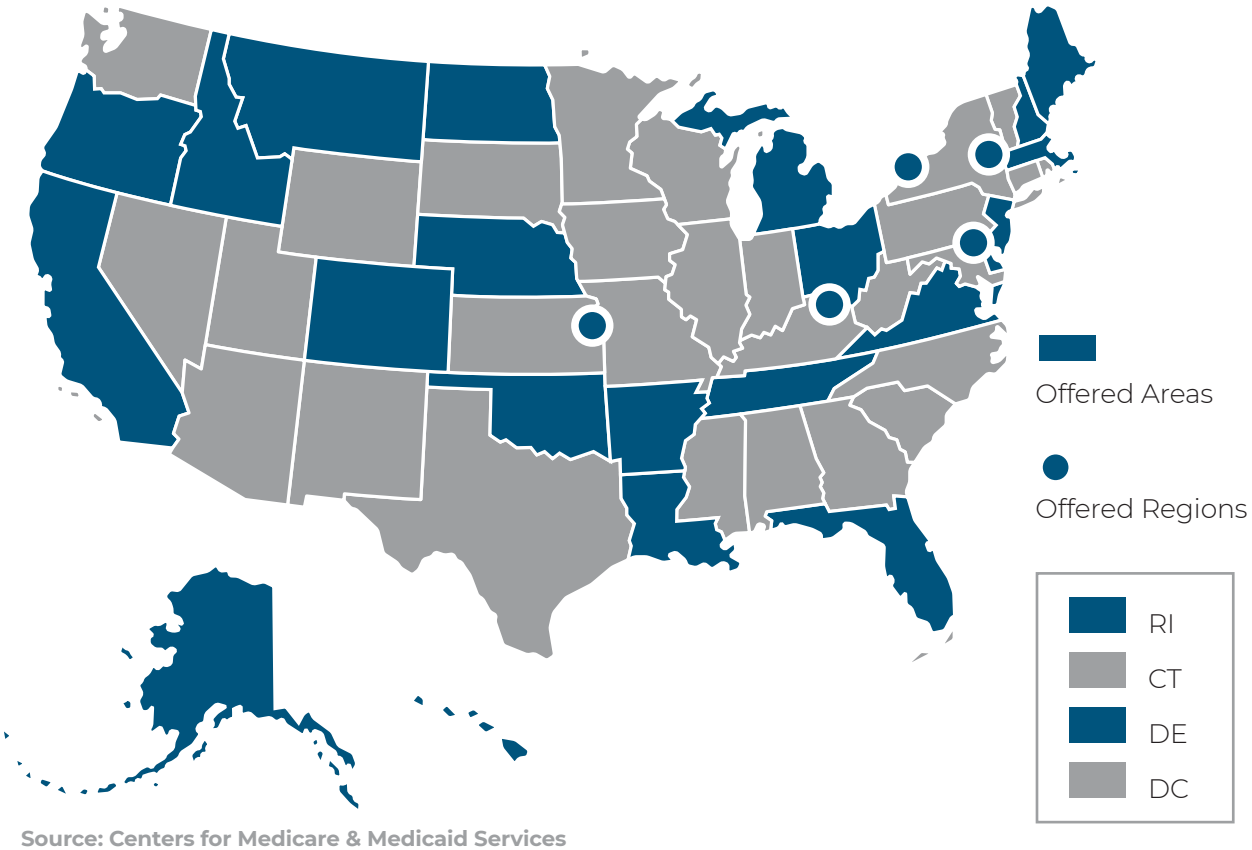
PCF will include risk-adjusted population-based payments, flat visit fees and performance-based adjustments, but specifics have not yet been released, and it remains to be seen whether and how PCF will transform payment to achieve overall savings.



Source: Centers for Medicare & Medicaid Services

Medicare Shared Savings Program Pathways to Success

Late in 2018, CMS finalized significant changes to the Medicare Shared Savings Program (MSSP) through a new rulemaking entitled Pathways to Success. Under Pathways, the MSSP will transition accountable care organizations (ACOs) from four tracks (1, 1+, 2 and 3) to two new tracks (BASIC and ENHANCED). As part of this change, new and remaining MSSP participants will be advanced automatically through greater levels of financial risk and reward. CMS's changes to the MSSP reflect the agency's frustration with MSSP ACOs that have remained in upside-only arrangements for six years. In particular, there is concern that the MSSP has allowed ACOs to take advantage of fraud and abuse waivers to consolidate without taking serious steps to reduce costs

CMS recently released results showing that MSSP generated $739.4 million in net savings across 548 ACOs in 2018. In a blog post, CMS Administrator Seema Verma **touted results showing** that ACOs achieving savings also had decreases in inpatient, emergency room, and post-acute care spending and utilization.

The first cohort of ACOs to participate under the new Pathways rules started July 1, 2019. CMS indicated that it approved 206 ACOs to begin on July 1, 2019, which increased the percentage of MSSP ACOs taking downside risk from 19 percent to 29 percent and the number of Medicare beneficiaries receiving care from a provider in an ACO increased by 400,000 fee-for-service beneficiaries. A subsequent cohort will start January 1, 2020. Although Pathways implements a more aggressive transition to risk-based payments for ACOs, many will still start with upside-only risk before transitioning to two-sided risk. It remains to be seen whether the transition to two-sided risk will reduce program participation overall, or whether existing and new ACOs will rise to the challenge of two-sided models over time.

Direct Contracting

In April 2019, CMS also announced a new group of models under the umbrella label of Direct Contracting (DC). DC includes three payment model options:

- Professional population-based payment with 50% shared savings and losses and implementation of primary care capitation
- Global population-based payment with 100% savings and losses and the option of primary care capitation or total care capitation
- Geographic population-based payment with a choice between full risk with fee-for-service claims reconciliation or total care capitation.

In many ways, the DC models evolve the Next Generation (Next Gen) ACO model. First, the professional and global population-based DC models require that at least a portion of Medicare payments flow through capitated models, whereas Next Gen has offered but not required cash flow alternatives from fee-for-service. Second,

DC models offer an opportunity for healthcare providers that do not currently have enough Medicare fee-for-service population to participate in existing ACO models where attribution relies on historical traditional Medicare utilization—potentially enabling new types of organizations to participate, such as provider organizations that have treated mostly or exclusively Medicare Advantage beneficiaries. Finally, these models are intended to allow providers additional tools to engage Medicare beneficiaries. Specifics of those enhancements are forthcoming.

What's Next for Next Gen? In 2019, 41 ACOs are participating in the Next Gen model. Many stakeholders have called on the US Department of Health and Human Services to certify and expand the Next Generation ACO program as a permanent model in the CMS portfolio. To date, only two models have been certified for expansion by the CMS actuary: the Pioneer ACO program and the Diabetes Prevention Program. Will Next Gen become the third?

Depending upon yet-to-be-released details of the model, DC has the potential to build on the success of the Next Gen model. The Next Gen ACO model has received favorable evaluations by CMS contractors, showing that model participants achieve savings and improve quality. A 2016 evaluation report for the Next Gen program showed that these ACOs saved $11.20 per beneficiary per month (a 1.1% reduction in Medicare spending). While DC may offer promise, it remains to be seen whether the new models will achieve savings and improve quality by broadening participation in capitated arrangements.

Models, Models, Models: What's Next from CMMI

In addition to further fleshing out the models in the PCF Initiative, CMMI and Trump Administration officials have hinted at numerous other models and efforts in development. Recently, the Administration announced new models designed to control costs and improve quality for beneficiaries with End Stage Renal Disease, and a mandatory radiation oncology model. CMMI has also described other potential models, such as a model to address the social determinants of health, and rural health models.

Medicaid:

States Catalyzing Healthcare Payment Reform

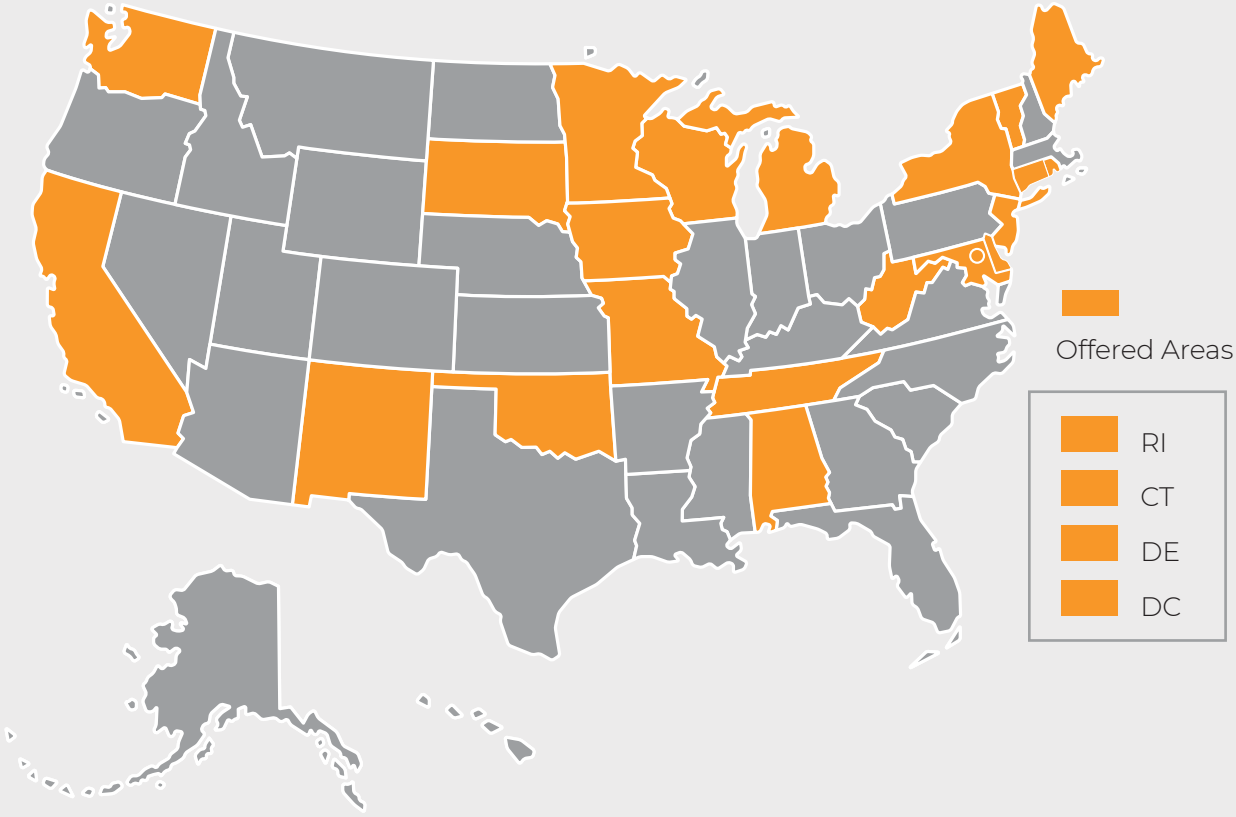
States have also embraced the promise of value-based payment. State Medicaid programs are adopting value-based payment models with the aim of improving health outcomes and quality for Medicaid beneficiaries and generating cost savings. Because states have flexibility in designing and structuring their Medicaid programs, implementation of value-based payment models varies significantly across states. As at the federal level, states often employ a combination of payment models. Many state efforts to transform healthcare delivery and payment have focused on enhancing care for chronically ill Medicaid beneficiaries, improving care coordination and rewarding value over volume. Specific approaches or models common to many states include Health Homes, Medicaid ACOs and Episodes of Care.

Health Homes

The Affordable Care Act (ACA) created an optional plan benefit for states to establish health homes. This option enables states to provide coordinated and integrated care for beneficiaries with chronic physical, mental or behavioral conditions. States have significant flexibility in designing health homes, with requirements for statewideness and comparability of services waived. States thus can target health home enrollment by geographic area or condition. States also have flexibility regarding how they pay for health home services. Those implementing health home models have typically employed per-member per-month and tiered payment structures based on condition or service.

There is also flexibility regarding where health homes fit within the existing structure of the Medicaid program in the state, which means that health homes can exist inside or outside of a Medicaid managed care organization. Despite an enhanced federal match for health home services (90% health home services for the first eight quarters), as of August 2019, only 21 states and the District of Columbia had a total of 36 approved Medicaid health homes.

States With Approved Medicaid Health Home State Plan Amendments (August 2019)



Source: Centers for Medicare & Medicaid Services

Health Homes *(continued)*

Health home results appear promising. A 2018 evaluation report examined the initial 13 health home programs across 11 states and found that health homes reduce emergency department and inpatient utilization. In states evaluated, data also suggested that cost savings are achieved via health homes. For example, it is estimated that the Missouri primary care health home generated more than $5.7 million in cost savings from reduced hospitalizations, with total savings to the Medicaid program estimated at more than $2 million. Moreover, the Missouri primary care health home improved clinical outcomes related to blood sugar, cholesterol and blood pressure levels among individuals receiving health home services, relative to the baseline period. An Iowa health home also generated savings of about $9 million, or almost 20% of total projected Medicaid spending on health home enrollees.

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Perhaps most importantly, the majority of states operating health homes have continued them past the enhanced match period, which suggests that states have found value in the health home model.

Medicaid ACOs

ACOs are another model that states have adopted as they move from paying for volume to paying for value. Compared to Medicare ACOs, however, Medicaid ACOs are still relatively new and not as widespread. In February 2018, the Center for Health Care Strategies reported that 12 states have an active Medicaid ACO program and 10 additional states are pursuing a Medicaid ACO model.

A commonly cited successful Medicaid ACO program is the Colorado Medicaid Accountable Care Collaborative (ACC). Launched in 2011 as one of the first Medicaid ACO programs in the country, the ACC focuses on improving Medicaid member access to primary care services through primary care providers that serve as medical homes and Regional Care Collaborative Organizations, which are typically Medicare managed care organizations responsible for facilitating coordinated care. The program has grown significantly since its start and now serves more than 1 million enrollees (over 75% of Colorado Medicaid members). And the State reports that the first phase of the ACC saved more than $161 million. The ACC has now transitioned into the second phase, aimed at building on the previous success and expanding to include behavioral health services. This phase will provide additional opportunities for incentive payments for improved quality.

Medicaid ACOs *(continued)*

The Colorado Medicaid ACC demonstrates what states can achieve when they have flexibility in designing programs that serve their Medicaid members. States have leveraged 1115 waivers, state plan amendments and Medicaid managed care authority to implement ACOs. Although many states have modeled their Medicaid ACOs after the MSSP, where providers have either upside-only or both upside and downside risk, states aren't required to follow this approach, and some have implemented ACOs using a global budget model. Under global budget models, Medicaid ACOs receive a per-member per-month payment and accept full risk. Medicaid ACOs will continue to evolve and grow across the country. Recent changes to the Medicare MSSP program, as described previously, do not directly affect Medicaid ACOs. However, these changes may encourage states to require more downside risk within Medicaid ACOs.

Episodes of Care

Episodes of care is a payment model that provides a single bundled payment for all the care that a patient receives in the course of treatment for a specific illness, condition or medical event. This approach to paying for value is the only model that completely rejects fee-for-service payment. Not surprisingly, very few states have adopted episodes of care.

According to the National Academy for State Health Policy, three states (Arkansas, Ohio and Tennessee) have implemented episodes of care. Tennessee kicked off the Tennessee Health Care Innovation Initiative in 2013, rolling out episodes of care in waves. There are nine waves and the state is currently implementing or previewing 48 episodes of care. The state's first wave focused on perinatal care, asthma acute exacerbation and total joint replacement (hip and knee), and in the first year reduced costs by 3.4%, 8.8% and 6.7%, respectively. When considering previous cost trends, the state estimates that in the first year, these three episodes reduced costs by $11.1 million.

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Episodes of care are at an early stage of development and use by states. However, interest is growing, and cost-savings achieved in states such as Tennessee suggest that more states will consider this approach.

Funding Value-Based Payment Models in Medicaid

Implementing value-based payment is not without start-up, administrative and maintenance costs. These costs can be placed on the provider, insurer and the state. States have leveraged federal funding opportunities to implement value-based purchasing models, including opportunities within the CMMI and the Delivery System Reform Incentive Payment (DSRIP) program.

Center for Medicare & Medicaid Innovation

CMMI provides states opportunities to implement value-based payment reform through alternative payment models for specific Medicaid populations. Currently, CMS is implementing the Integrated Care for Kids (InCK) Model, a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children covered by Medicaid and the State Children's Health Insurance Program. Key outcomes of the model are reduced avoidable inpatient stays and out-of-home placement. Under InCK, CMMI will fund up to eight cooperative agreements at a maximum of $16 million each to implement the seven-year model. Applications were accepted until June 10, 2019; decisions are expected by December 2019; and the model is expected to begin January 1, 2020.

InCK is a specific example of how CMMI is providing states with opportunities to implement value-based payment models. More state-focused opportunities are expected in the future. Additionally, more than half of all states are working with CMMI to improve quality and value through the State Innovation Models initiative, which provides states funding to develop state innovation plans.

Delivery System Reform Incentive Payment

The DSRIP is part of the broader Section 1115 waiver authority. The DSRIP program provides states funding to implement systematic Medicaid financing and delivery reforms to change how care is delivered to Medicaid beneficiaries. DSRIP focused initially on preserving supplemental payments for safety net hospitals. Now, however, states are increasingly using DSRIP to pay for delivery system redesign and transformation with a focus on models that include payment and delivery reforms.

Delivery System Reform Incentive Payment

(continued)

States are increasingly using DSRIP to support implementation of value-based payment models. For example, Arizona uses DSRIP to fund managed care organizations' incentive payments to providers that achieve certain performance metrics. In Massachusetts, DSRIP supports the state's three Medicaid ACO models. As of March 2018, 13 states have DSRIP programs.

Unfortunately, the future of DSRIP remains unclear. In 2018, MACPAC noted that CMS had indicated that it views DSRIP funding as a one-time investment and does not plan to renew DSRIP demonstrations. Instead, CMS has encouraged states to develop plans to sustain DSRIP-funded programs by incorporating value-based payment models into their managed care contracting. States and providers argue that there continues to be a need for funding to make delivery system transformations.

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