Value Based Reimbursement

Ron Walters, MD, MBA, MHA
MD Anderson Cancer Center

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Like most things…..

There are three sides to every story. My side of the story with the information I have. Your side of the story with the information you have. And the side of the story that has all the information

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If I accomplish anything today….

- What are your beliefs?
- Which perspective are you taking?
- Can you take another perspective? At least for an hour?
- If so, have you noticed any change in your beliefs?

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My own personal perspectives

- I have been a patient (odds are we all have, at least once, and will be at least once more)
- I am a hospital administrator
- I have been a health plan medical director
- I have been a medical oncologist for almost 40 years.
- I have never been part of a 'true' health care system
- I have had employer (or parent)- sponsored health insurance for all of my life and still pay premiums as a deduction from my paycheck

Agenda

- The key problems we have with value based reimbursement
  - The numerator
  - The denominator
  - The payment methodology
- If we can't measure or agree to these, how do we arrive at a value? Then, how do we value all possible values?
- Ongoing attempts
- Where are we headed?

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It starts with an impossible calculation and then it got worse

The Healthcare Value Equation

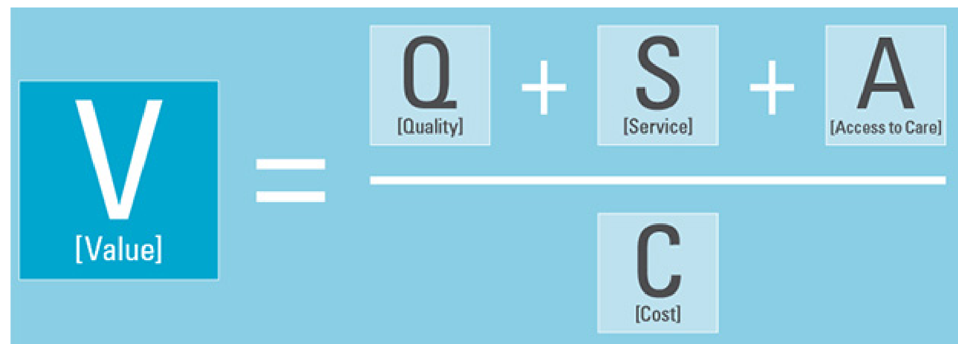
$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

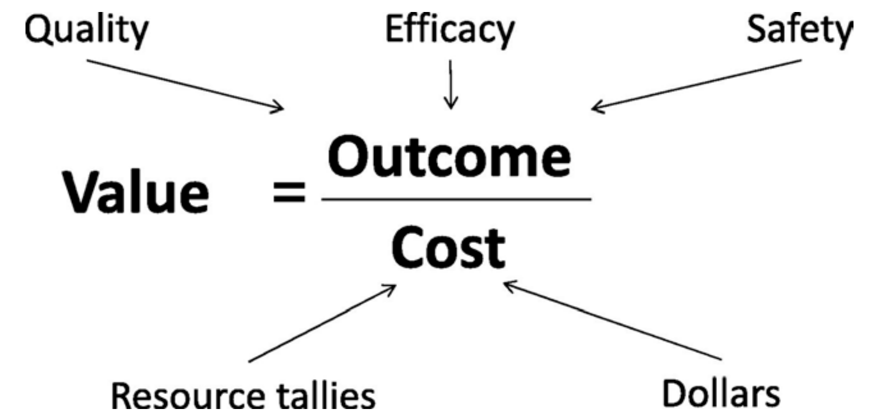
What is quality and how to measure it

What costs and whose costs

$$Q = A \times \frac{(O+S)}{W}$$

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste



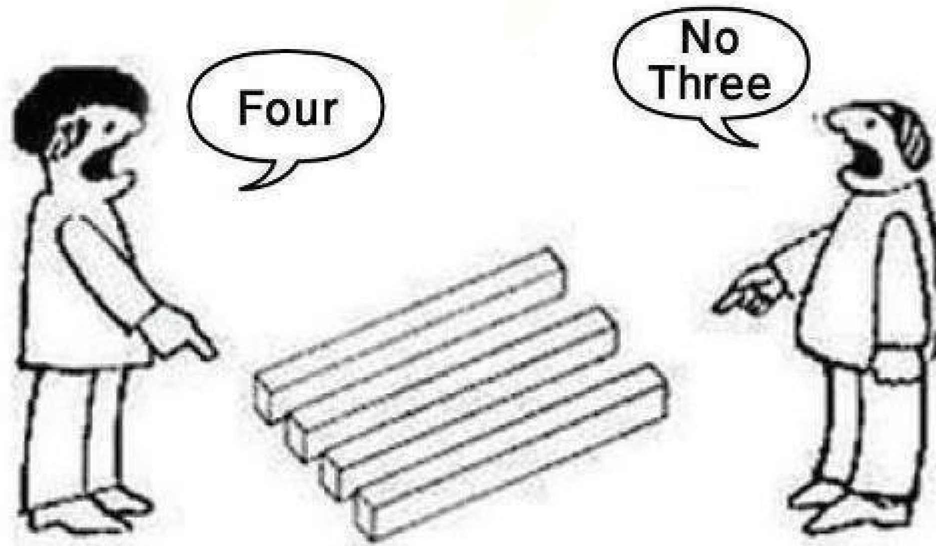


The blown tire problem

P: I JUST WANT TO DRIVE SAFELY!!!!

O: I don't' want a fatal accident

And many perspectives…



http://i.imgur.com/Kuih7oV.jpg

Patients and not-yet patients
Caregivers and support systems
Providers and all that entails
Hospitals and system components – private and public
Pharmaceutical industry
Numerous other suppliers
Payers
Community at large
Governmental entities
Etc…

Value - not a new phenomenon

- Has been provider-centric since the beginning
- Next, it was about systems of care
- Now, we are accepting that patients and caregivers are key parts of that system of care

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Provider-centric measures of value

- Training
- Education
- Certification
- Volume
- Processes of care (do we do the right thing)

JUST FIND THE BEST DOCTOR!!!

System-based measures of value

- Cost
- Resource utilization (over and under)
- Site of care and supportive infrastructure
- Care coordination between providers

JUST BUILD THE BEST TEAMS AND SHARED IT AND MEASUREMENT SYSTEM

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Patient-centric measure of value

- Patient preferences and values
- Patient experience (including satisfaction)
- Patient engagement (shared decision making (not just informed consent)
- Patient outcomes measured BY THE PATIENT and in light of their preferences and values

TECHNICAL, JUST A PART, MUCH BROADER CULTURAL AND TRUE CHANGE

Key requirements (and challenges)

- Systems thinking, training, education, AND acceptance
- Much more sophisticated and integrated data systems
- Multi-system analytics
- Transparency of data
- System attribution and accountability for outcomes
- Recognition of the fluid nature of measures over time
- CAN WE DO THIS?

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Ponder these…..

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Scenario #1

- You are a 55 year old married female who has delivered the mail for 25 years, are still employed, and carry insurance via the postal service. You are going into the hospital for an elective hip replacement which will require some rehabilitative physical therapy. (average life expectancy 30 more years)

- What do YOU value?
- What does your orthopedic surgeon value?
- What does your payer value?
- What does your family value?
- Who else?

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Scenario #2

- You are a 70 year old male, retired, on Medicare. You have just been told that you have advanced lung cancer. You have seen on TV lately that there are some exciting new treatments available. (average life expectancy 1 more year but may be changing for some)

- Now, what do YOU value?
- What does your oncologist value?
- What does Medicare value?
- What does society value?
- Who else?

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Scenario #3

- You are a 20 year old female in college, otherwise healthy, on your parents insurance. You have decided to have plastic surgery. (average life expectancy 65 more years)

- Now, what do YOU value?
- What do your parents value?
- What does your surgeon value?
- What does the payer value?
- What does society value?
- Who else?

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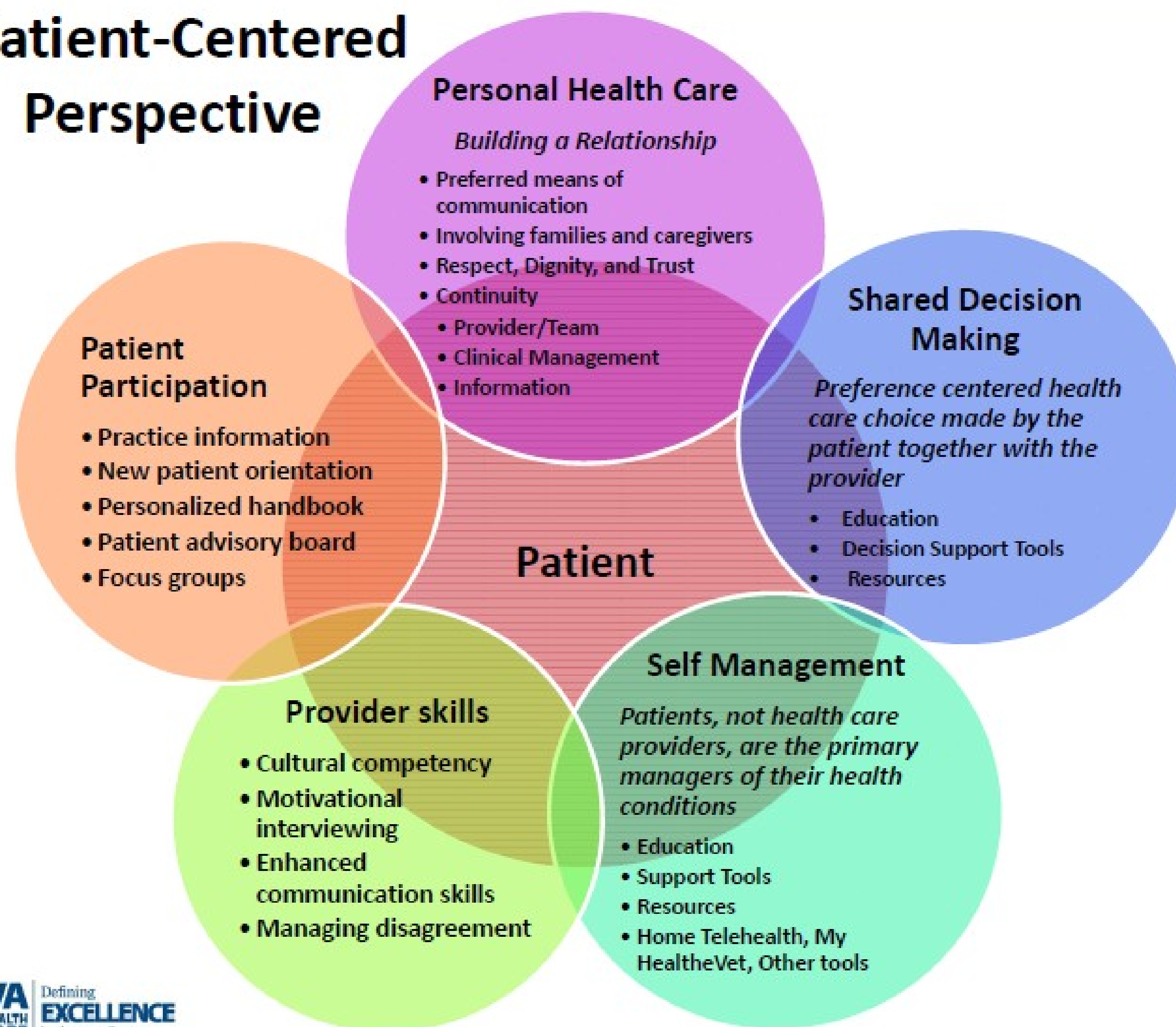
In theory there is no difference between theory and practice. In practice there is.

(Yogi Berra)

P.S. Yogi was not the first to say this

We KNOW what needs to be done – we just have to do it

Whose value (should)drives the decision?



Compare/contrast this to person-centered (not necessarily "patients")

But, a recent dilemma… and a PAIN!!!

CMS Proposes Hospital Outpatient Prospective Payment System Changes to Better Support Physicians and Improve Patient Care

Date	2016-07-06
Title	CMS Proposes Hospital Outpatient Prospective Payment System Changes to Better Support Physicians and Improve Patient Care

Provider Satisfaction Scores "versus" Pain Control

Addressing Physicians' Concerns Regarding Pain Management

Today's proposed rule would address physicians' and other health care providers' concerns that patient survey questions about pain management in the Hospital Value-Based Purchasing program unduly influence prescribing practices. While there is no empirical evidence of this effect, we propose to remove the pain management dimension from the Hospital Value-Based Purchasing program to eliminate any potential financial pressure clinicians may feel to overprescribe pain medications. CMS continues to believe that pain control is an appropriate part of routine patient care that hospitals should manage and is an important concern for patients, their families, and their caregivers. Thus, CMS is also currently developing and field testing alternative questions related to provider communications and pain to include in the program in future years. We will solicit comment on this alternative in future rulemaking.

And now think of a continuum of care – and now how does your definition of value change?

And what "value" should be reimbursed? And to whom? – aka the ATTRIBUTION ISSUE

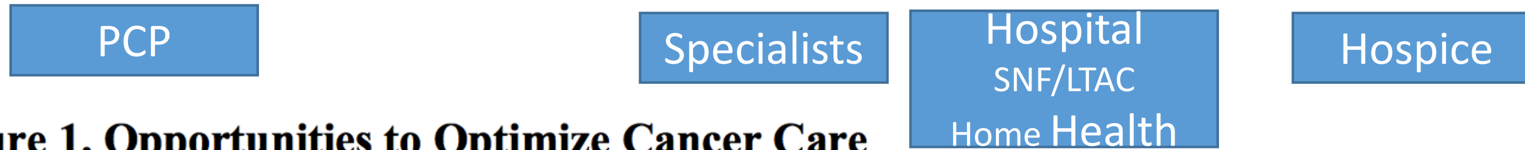


Figure 1. Opportunities to Optimize Cancer Care

Processes of Care Across the Cancer Care Continuum → **Process of care impacts** → **Patient & population outcomes**

Types of Care

Risk assessment
Age
Family Hx
Exposure Hx
Genetics
Lifestyle
Screening Hx

Primary prevention
Lifestyle counseling
Chemo prevention

Detection
Screening (Asymptomatic)
Appropriate Testing (Symptomatic)

Diagnosis
Imaging
Biopsy
Repeat Exams
Laboratory Tests
Other Appropriate Procedures

Cancer or precursor treatment
Excision
Surgery
Radiation
Adjuvant Chemo
Palliation

Post-treatment survivorship
Testing
Follow-Up Care
Palliation
Recurrence
Surveillance

End-of-life care
Palliative Care
Advanced Care Planning
Bereavement Support

Transitions in Care

Efficiency
Equity
Safety
Effectiveness
Timeliness
Patient-centeredness

Patient
Improved risk status
Biologic outcomes
Health related quality of life & well-being
Quality of death
Financial burden
Patient experience

Population
Mortality
Morbidity
Cost-effectiveness
Reduced disparities

Has it been successful, thus far?

RESEARCH REPORT

Measuring Success in Health Care Value-Based Purchasing Programs

Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions

Cheryl L. Damberg • Melony E. Sorbero • Susan L. Lovejoy

Grant Martsolf • Laura Raaen • Daniel Mandel

Sponsored by the Office of the Assistant Secretary for Planning and Evaluation

2014

129 VBP programs reviewed

- Goals difficult to quantify but probably related to proprietary nature of the published information and contractual opacity

- Generally a relatively narrow set of measures used for payment differentials
- Less than 20% of care administered is being assessed by the performance measures (except total cost of care)
- Tendency to "well-worn" measures that have been used for years, may be topped out, and generally no room for improvement

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TEP suggestions

- Process measures still far outweigh outcome measures
- Need to address patient outcomes and functional status
- Need to address appropriateness of care
- Critical that EHR's be designed to support measure collection and reporting
- Generally a need to align with consumer incentives
- Variability in benchmarks (absolute versus relative)

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Examples of Value Frameworks in Cancer

- Institute for Clinical and Economic Review – evidence, net health benefit, coverage

- ASCO – net health benefit score

- NCCN – evidence blocks – efficacy, safety, quality of evidence, consistency of evidence and affordability

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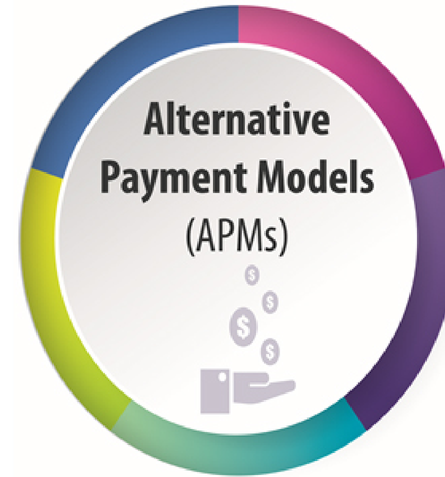
Payment models

Category 1 Fee for Service – No Link to Quality & Value	**Category 2** Fee for Service – Link to Quality & Value	**Category 3** APMs Built on Fee-for-Service Architecture	**Category 4** Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	**A** APMs with Upside Gainsharing	**A** Condition-Specific Population-Based Payment
	B Pay for Reporting	**B** APMs with Upside Gainsharing/Downside Risk	**B** Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		



Pay-for-Performance
Providers receive financial incentives for meeting performance measures related to cost-savings, favorable outcomes & following evidence-based guidelines.

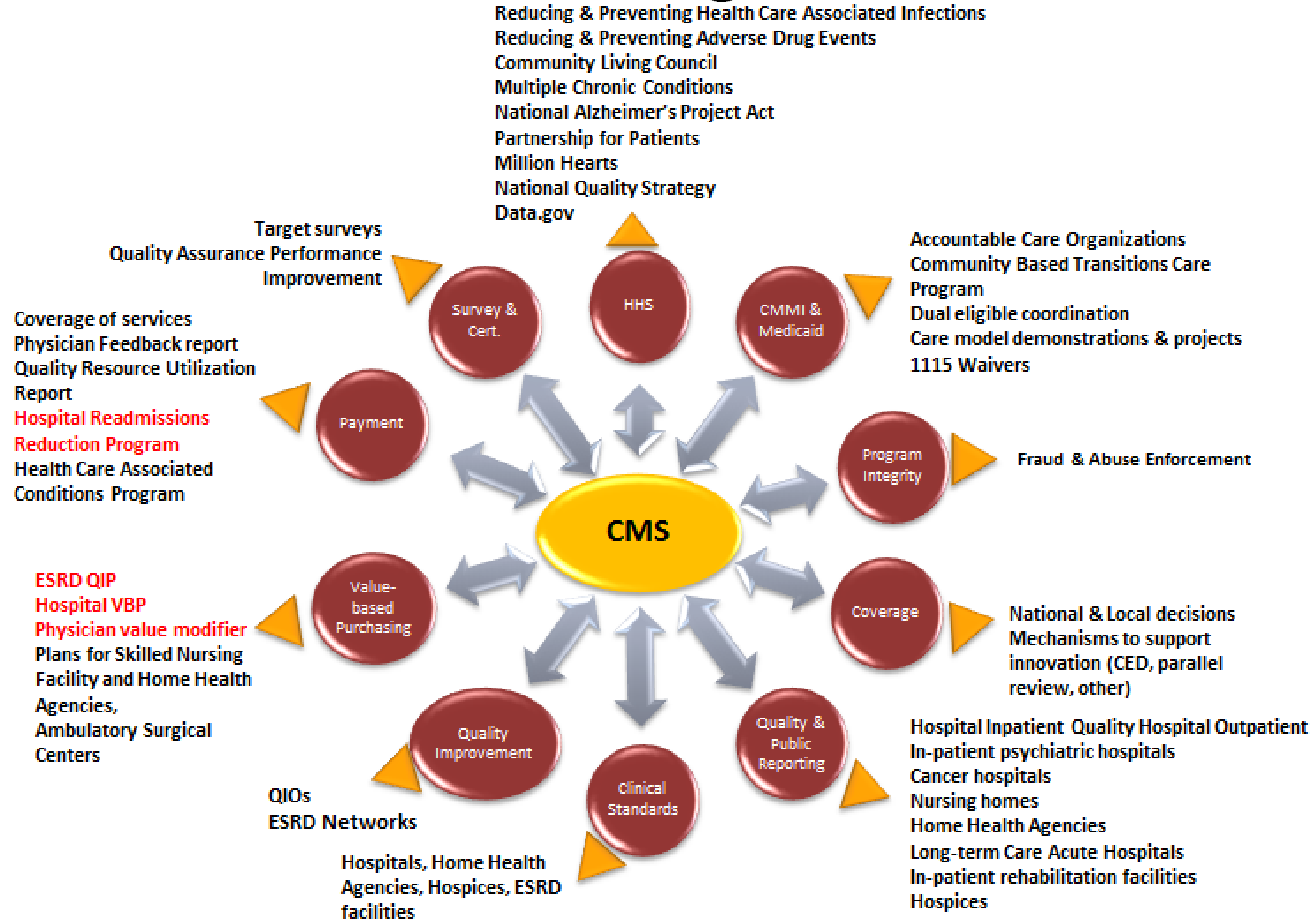
Medical Home Model
Coordination of all patient care & referrals conducted through primary care physician. Sometimes combined with shared shavings and/or value-based quality incentives.

Shared Savings
Groups of providers with shared cost-savings targets caring for set populations. Savings is typically distributed by meeting cost/ quality targets.

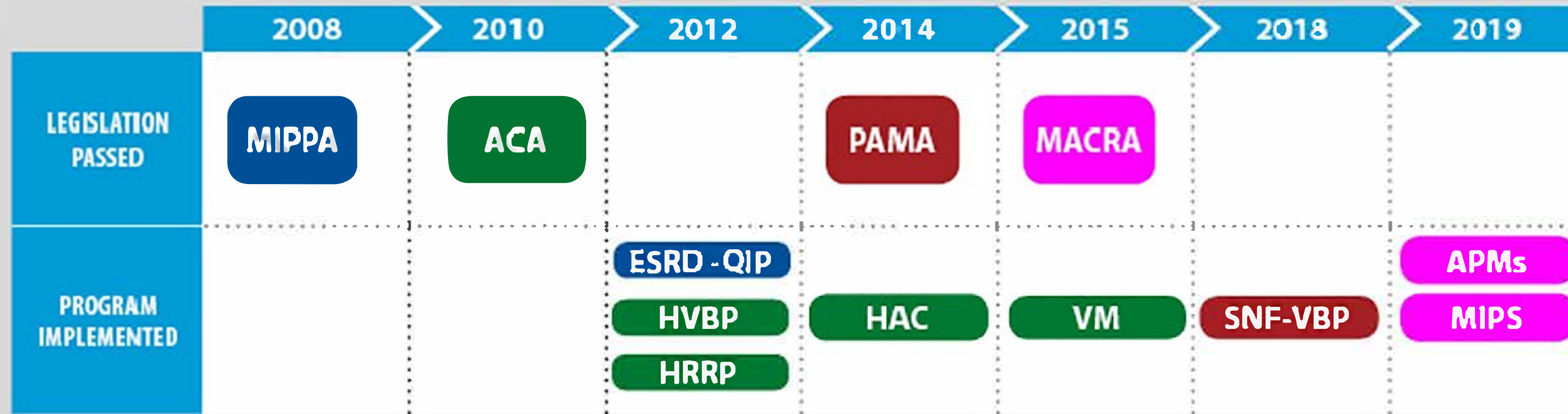
Bundled Payments
Providers receive fixed amount for all services rendered in bundle or episode of care. Bundles may cross provider organizations.

Capitation
Fixed payment per patient or per case. Often characterized as "professional" (physician services) or "institutional" (facilities).

CMS



VALUE-BASED PROGRAMS



LEGISLATION

ACA: Affordable Care Act
MACRA: the Medicare Access & CHIP Reauthorization Act of 2015
MIPPA: Medicare Improvements for Patients & Providers Act
PAMA: Protecting Access to Medicare Act

PROGRAM

APMs: Alternative Payment Models
ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
HACRP: Hospital-Acquired Condition Reduction Program
HRRP: Hospital Readmissions Reduction Program
HVBP: Hospital Value-Based Purchasing Program
MIPS: Merit-Based Incentive Payment System
VM: Value Modifier or Physician Value-Based Modifier (PVBM)
SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

State value based payment programs

Value-Based Reimbursement State-by-State

A 50-State Review of Value-Based Payment Innovation

Commissioned by Change Healthcare

Get your own copy of this white paper and exclusive additional research at [StateVBRstudy.com]

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Given where I am today….

http://mhsinfo3.mckesson.com/rs/834-UAW-463/images/Change%20Healthcare%20State-by-State%20VBR%20Study%202017%20report.pdf

Key findings of this 50-state review include:

1. More than 40 states have a state-initiated plan or strategy to move toward value-based payment, and almost half of those initiatives are multi-payer in scope.
2. Well-developed, value-based payment strategies have been implemented in six states for four years or longer, many with federal support; 23 states have initiatives that are two years or more in implementation; and 10 states are in the early stages of development.
3. As with the federal government, 23 states have established value-based payment targets or mandates that payers and providers agree to achieve.
4. Seventeen states have adopted or are considering adoption of ACOs or ACO-like entities to help manage costs and deliver better care, and 12 states have adopted or are considering adoption of episodes of care programs.
5. Many states have used value-based payment reform to engage with healthcare stakeholders in the redesign of the state healthcare system, identifying unique and innovative strategies that work for their state healthcare market.
6. Only seven states have little to no activity around value-based payment.

Overall, five states stand out for the breadth of their initiatives, their embrace of payment models that involve shared risk, and their willingness to test innovative strategies. These states include but are not limited to:

- Arkansas, which has a multi-payer EOC program in place for five years
- Colorado, which has a well-developed Medicaid ACO program, and is working with payers and large employers to implement value-based payment
- Minnesota, which was an early adopter of EOC and has now moved into ACOs
- Tennessee, which is on pace to roll out 76 episodes of care in its Medicaid and state employee programs by 2019

- Washington, which has committed to tying 80% of its state-financed health payments to value by 2021 and is seeking similar commitments from commercial payers in the state

Please see the accompanying state-by-state review matrix for details that support the above assessments.

[1] Centers for Medicare & Medicaid Services. Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume. January 1, 2015. Available: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html.

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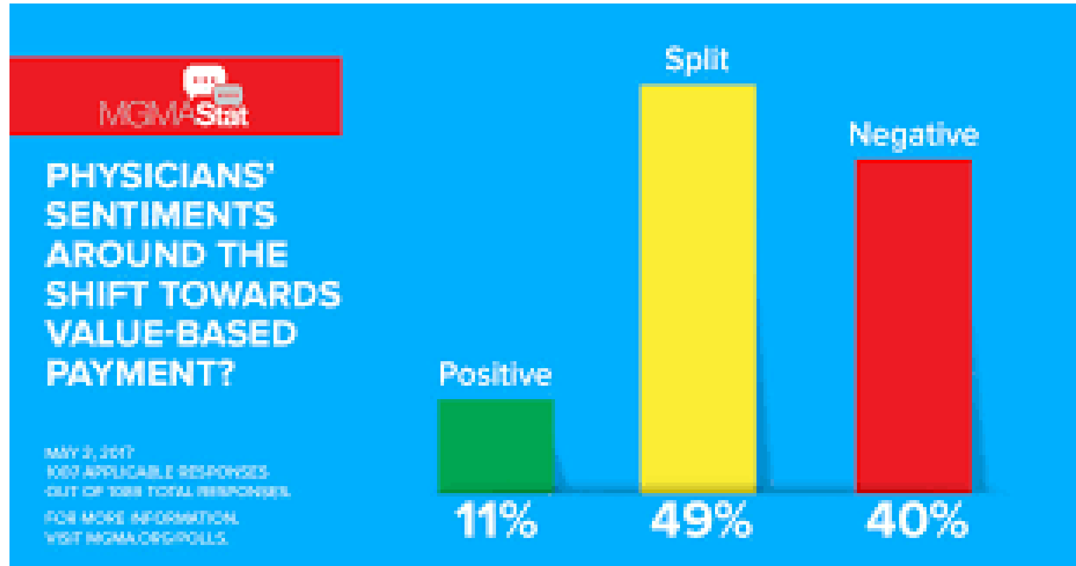
Not surprisingly…

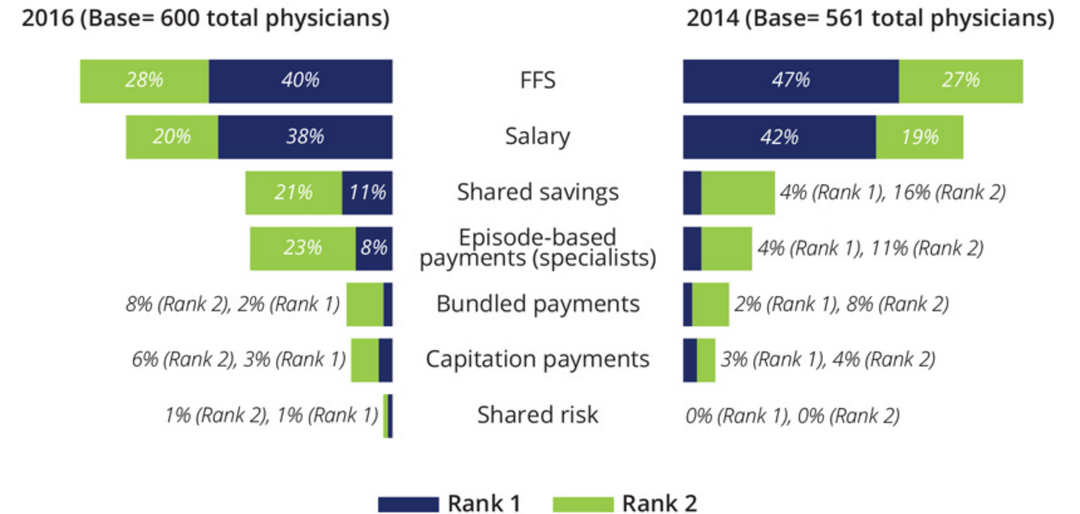


MGMA

The most amazing finding in the world???

Figure 3. Preference for shared savings and episode-based payments is increasing, but physicians like FFS and salary best.

Which of the following types of compensation arrangements would you prefer to have? Please rank your top three choices, from most preferred to least preferred, with 1 being your top choice.



Note: Only the first two ranks are depicted in the charts.

Source: Deloitte 2016 Survey of US Physicians.

Graphic: Deloitte University Press | dupress.deloitte.com

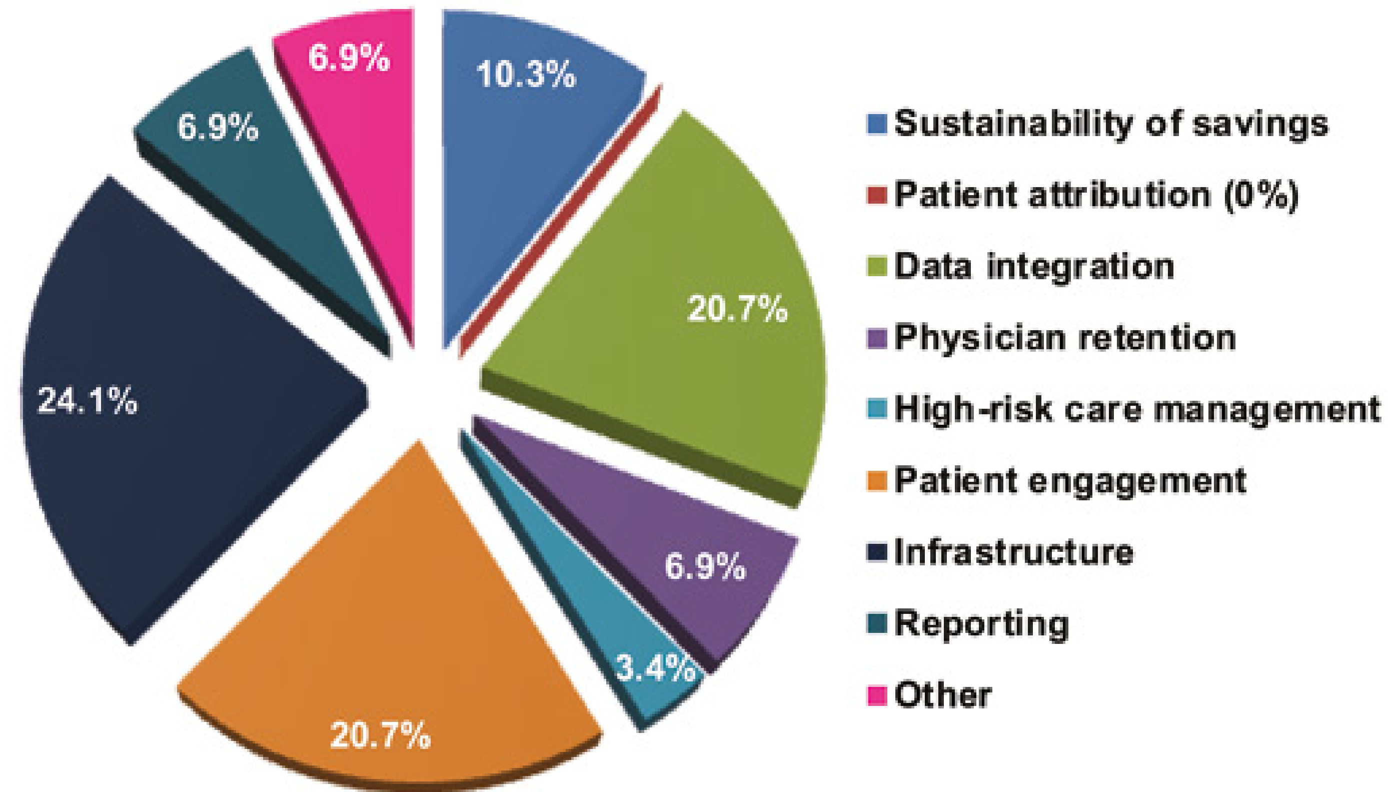
In addition, private payer collaborations are increasing

Health Insurer	Valued-Based Contracts Announced (2015-2017)
Cigna	56
Humana	54
Aetna	40
UnitedHealth	19
Anthem Blue Cross Blue Shield	15

Source: HCTTF analysis

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Still very true



OCM – Oncology Care Model (CMMI)

First Annual Report from the Evaluation of the Oncology Care Model: Baseline Period Appendices

Contract # HHSM-500-2014-00026I T0003

Final

Report Release Date: February 2018

Chock-full of reports!
No quality outcomes yet

Keep your eyes on this

OCM – Baseline reports

- Episode volume by cancer bundle
- Distribution of parts A, B, D costs
- Inpatient admissions and costs by bundle
- 30-day readmissions and costs by bundle
- ICU admissions by bundle
- Home health and SNF utilization and costs by bundle

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OCM – Baseline reports

- Imaging (standard and advanced) utilization by bundle
- Outpatient therapy utilization by bundle
- Part D RX and costs by bundle
- End of life by bundle (chemo last 14 days, hospital last 30 days, ICU last 30 days, ED last 30 days, deaths IP and ICU, never referred to hospice)
- Total cost of care (and distribution by E&M) by bundle
- **Total beneficiary cost by bundle**
- All-cause mortality by bundle

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Getting to be very common themes – ASCO, ICHOM, QPP, OCM, etc)

- Process measures still important but moving to outcomes
- Utilization of EC, readmission, tests and treatments
- Cost
- End of life
- Care coordination
- Patient experience
- Patient reported outcomes

- Definitely being linked to VBP and P4P programs

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MD Anderson and United Healthcare Pilot

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Pilot Highlights

- **Patient Population:** Newly-diagnosed, untreated cancers
- **What's Included:** 1 year of head&neck treatment at MDA, plus radiation simulation and basic dental services
  - Excludes uncovered/unrelated services, treatment outside MDA
- **Time Period:** 3-year pilot (2-year enrollment period)
  - 100-150 patients expected

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Patient Tracking Dashboard

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center Institute for Cancer Care Innovation

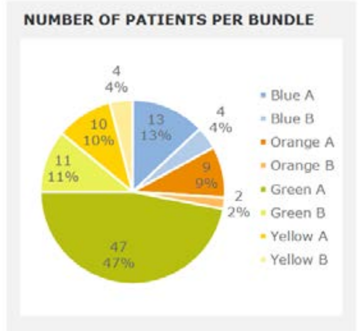
EPISODE BASED PAYMENT PILOT DASHBOARD | Dashboard 001 | Date: 11/01/14 - 11/14/14

DASHBOARD | PATIENT OUTCOMES | BLUE BUNDLE | ORANGE BUNDLE | GREEN BUNDLE | YELLOW BUNDLE | BUNDLE INFO | PATIENT DATABASE

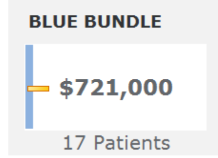
STRATEGIC INDICATORS

NOT ACTUAL DATA

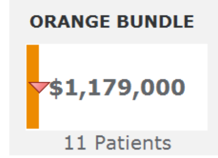
NUMBER OF PATIENTS PER BUNDLE



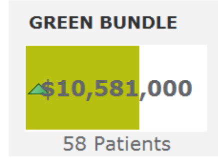
BLUE BUNDLE



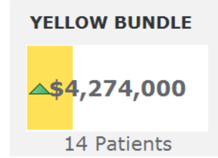
ORANGE BUNDLE



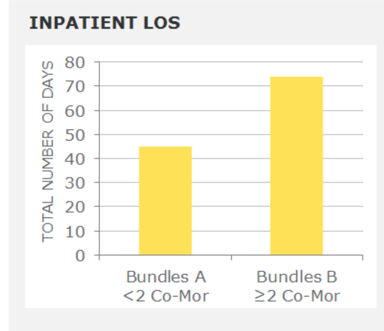
GREEN BUNDLE



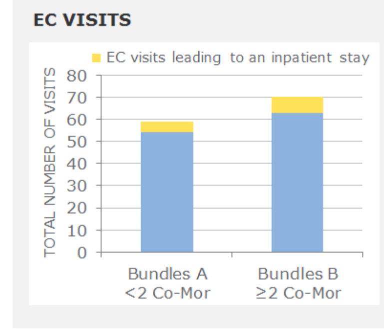
YELLOW BUNDLE



INPATIENT LOS

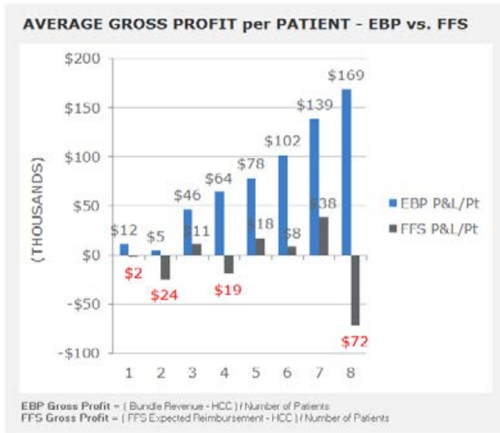


EC VISITS

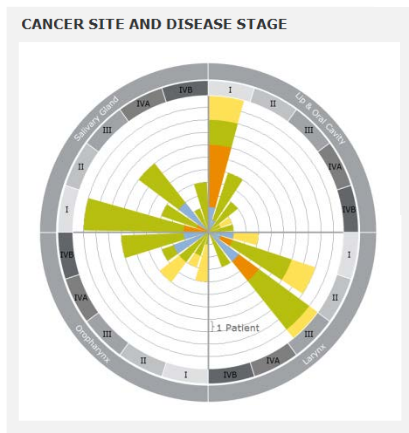


OPERATIONAL INDICATORS

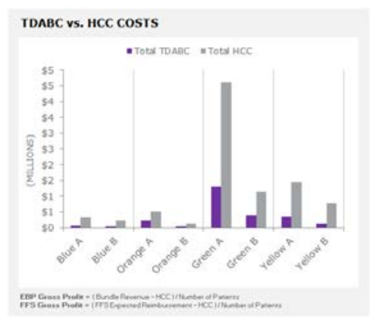
AVERAGE GROSS PROFIT per PATIENT - EBP vs. FFS



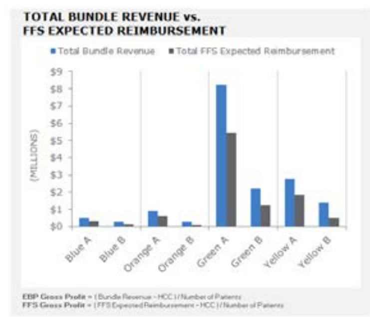
CANCER SITE AND DISEASE STAGE



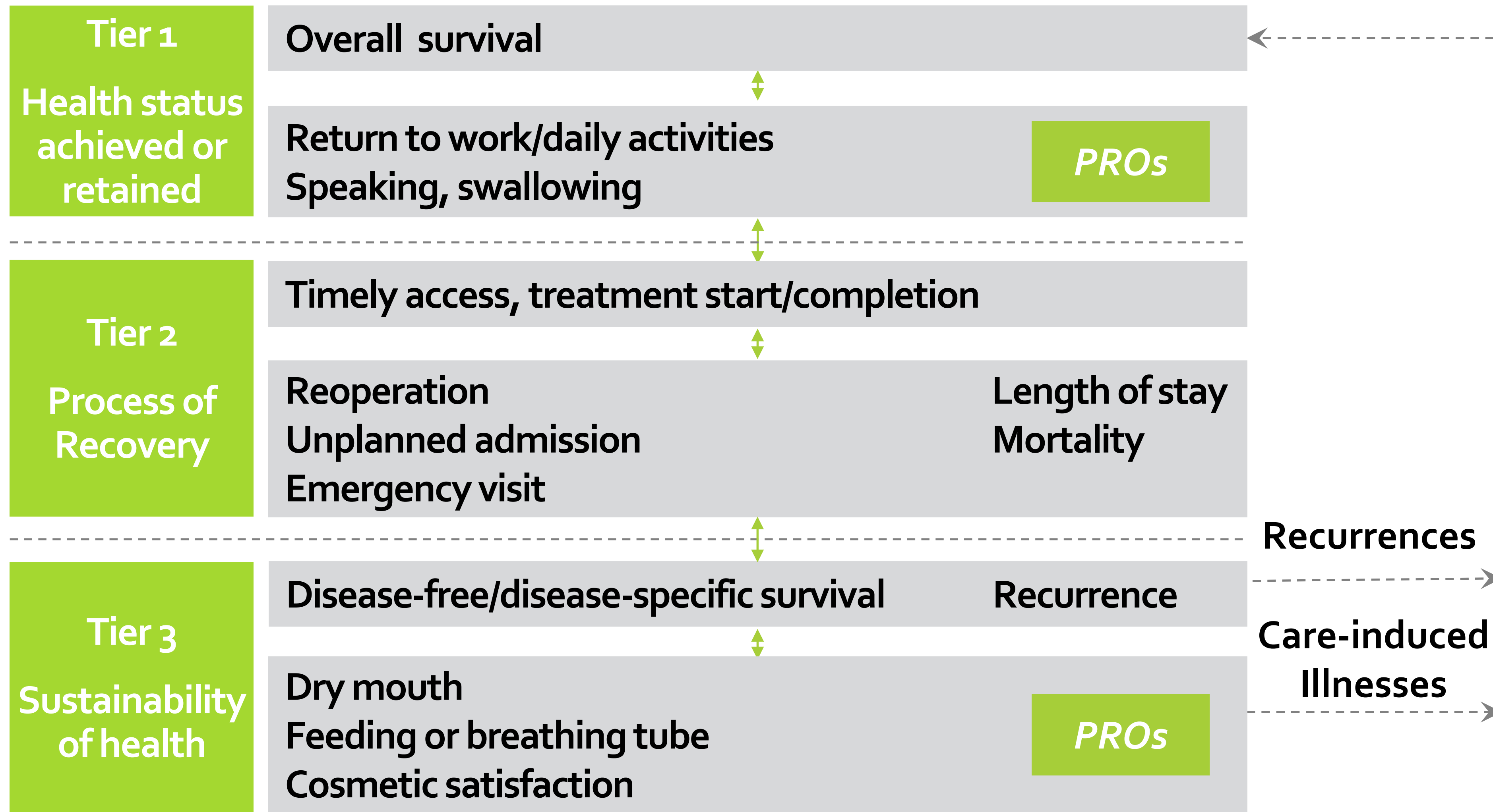
TDABC vs. HCC COSTS



TOTAL BUNDLE REVENUE vs. FFS EXPECTED REIMBURSEMENT

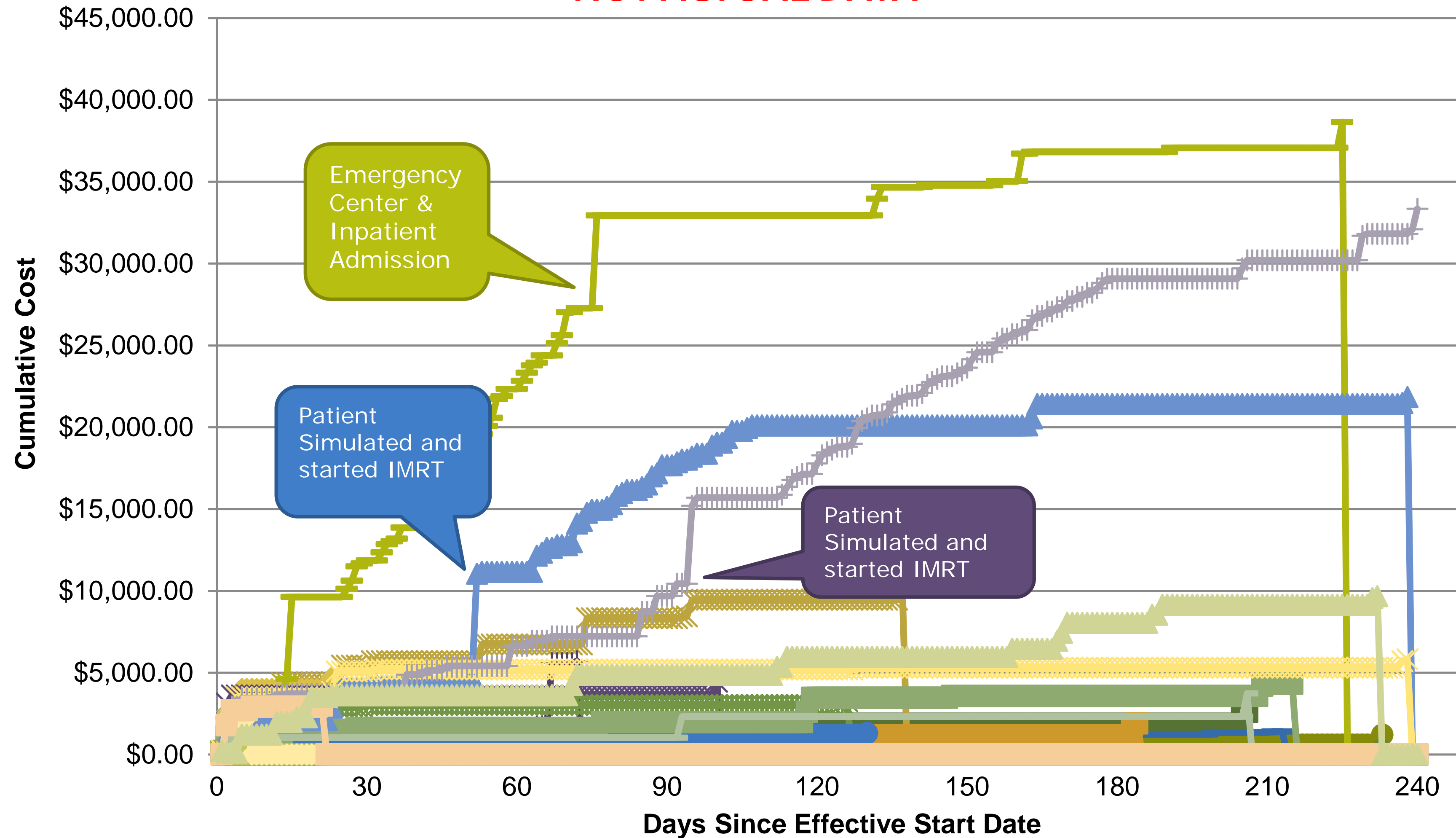


Outcome Set—Head and Neck



SOURCE Adapted from Porter, M. E. (2010). What is value in health care? *N Engl J Med*, 363(26), 2477-2481. doi: 10.1056/NEJMp1011024.

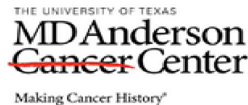
Sample Patient Cost Tracking



myMDAnderson MDASI-HN Survey

NOT ACTUAL PATIENT

- Home
- My Appointments
- My Messages
- My Health Records
- My Medicines
- My Education
- My Calendar
- My Journal
- My Billing Info
- My Account



Thoracic Center

Welcome BOBBY LISTER

Symptom Inventory » Home

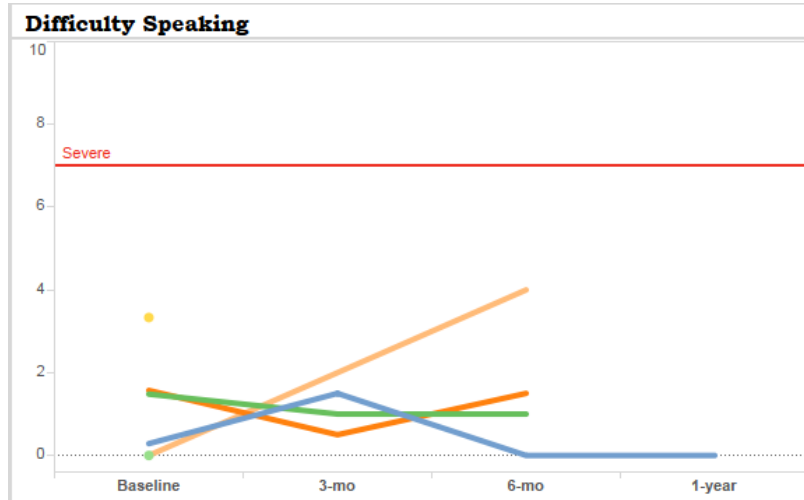
MD Anderson Symptom Inventory - Head & Neck (MDASI-HN)

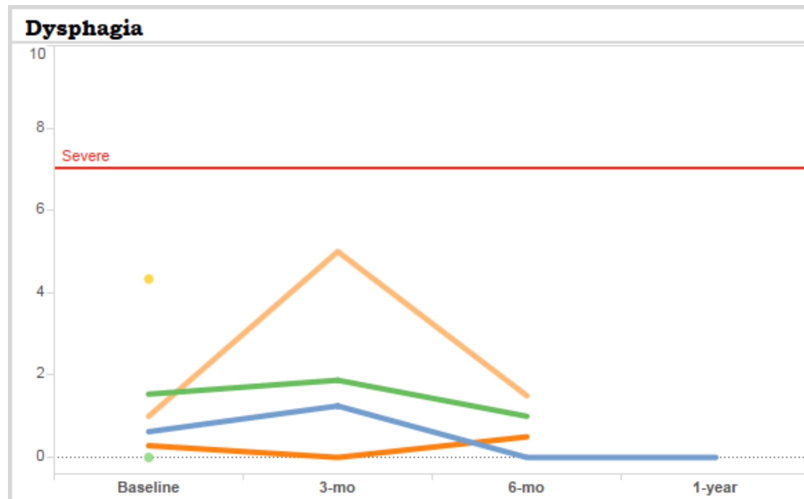
Part I. How severe are your symptoms?

People with cancer frequently have symptoms that are caused by their disease or by their treatment. We ask you to rate how severe the following symptoms have been in the past week. Please fill in the circle below from 0 (symptom has not been present) to 10 (the symptom was as bad as you can imagine it could be) for each item.

	Not Present 0	1	2	3	4	5	6	7	8	9	As Bad as You can Imagine 10
Your pain at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your fatigue (tiredness) at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your nausea at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your disturbed sleep at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your feelings of being distressed (upset) at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your shortness of breath at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your problem with remembering things at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your problem with lack of appetite at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your feeling drowsy (sleepy) at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your having a dry mouth at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your feeling sad at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your vomiting at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your numbness and tingling at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your problem with mucus in your mouth and throat at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your difficulty swallowing/chewing at its WORST?	○	○	○	○	○	○	○	○	○	○	○
Your choking/coughing (food/liquids going down the wrong pipe) at its WORST?	○	○	○	○	○	○	○	○	○	○	○

Tier 1 Health Status Patient-Reported Outcomes





Bundle	Baseline	3-mo	6-mo	1-year
Blue A	8	2	1	1
Orange A	8	2	2	
Orange B	1	1	1	
Green A	28	5	4	
Green B	1			
Yellow A	3			
Grand Total	49	10	8	1
Total No. of Patients	65	50	27	3

Bundle Type

- Blue A
- Orange A
- Orange B
- Green A
- Green B
- Yellow A

Source: *Patient-reported outcomes collected via the MD Anderson Symptom Inventory (MDASI) – Head and Neck.*

The Market Will Win – UT TRS (P.S. I work for UT)

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Important News about Your TRS-Care Health Benefits

The Pulse, June 2017 (Updated August 2017)

We have an update about changes to your TRS-Care benefits that take effect Jan. 1, 2018.

As a self-insured health benefits program, TRS-Care uses contributions from the state, public schools, employees and retirees to provide health care for participants. Over the past decade, health care costs have been skyrocketing, rising almost 10 percent each year. Without any changes to the program, TRS-Care was in danger of becoming too expensive to continue.

In order to sustain TRS-Care for current and future retirees, the 85th Texas Legislature recently passed legislation that has changed the program's benefits structure and provided additional funding to further support the program. The TRS Board of Trustees approved new plan designs and premiums that go into effect Jan. 1, 2018.

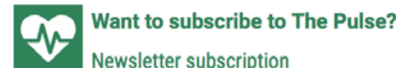
Please visit the pages below to see how the changes affect you:

In the coming months, we'll provide more information about this transition. While your plan is changing, you will still have the same broad choice of doctors and access to tools and resources that can help you get a clear picture of your new health care costs.

If you have questions or concerns about the transition, please reach out to us at 1-888-237-6762, or visit the **Health Care Benefits page**.

- TRS-Care retirees not eligible for Medicare
- TRS-Care retirees eligible for Medicare
- TRS-ActiveCare participants

Return to Health Care News Main Page



Want to subscribe to The Pulse?

Newsletter subscription

Sign into your *MyTRS* account, select *MyTRS* Email Subscriptions in the sidebar menu and you'll see the options for "TRS-Care News" or "TRS-ActiveCare News." Please note: You must be a TRS member with a *MyTRS* account to subscribe to online communications from TRS at this time.

Value Based Healthcare

- We are still learning the nuts and bolts
- We have a lot of room to go in defining “value”
- Current measures are less than ideal and not well linked to patient oriented outcomes
- Prior good performers tend to do good; do prior poor performers improve?
- Still generally unproved as to whether we really improve care?
- And, do we really improve care across the continuum?

Conclusions

- The trend will continue in a slow but deliberate manner

- We will see a movement towards more voluntary pilot programs (see CJR and OCM, among many others at the private level), especially at the governmental level and driven by politics

- We will see expansion of pilot programs with private payers

Presentation from HICOR Value in Cancer Care Summit 2018 - Please cite author when referencing content

If I were king for a day....

- Systems thinking, training, education, AND acceptance
- Much more sophisticated and integrated data systems
- Multi-system analytics
- Transparency of data
- System attribution and accountability for outcomes
- Recognition of the fluid nature of measures over time
- CAN WE DO THIS?

Thank you for having me!