Value-Based Payment NEWS

AMGA Survey Sees More Member Movement Toward Risk

For the fourth time, AMGA has conducted a member survey to gauge progress in the transition to value, what barriers to risk or value exist and how much member revenue is risk-based. "Findings from 2018 indicate that AMGA member revenues increasingly are risk-based," a statement says, and are "continuing the journey to value." In *Taking Risk 4.0: Clearing a Pathway to Value-Based Care, AMGA's Fourth Annual Risk Survey*, they "report clear preferences for some risk-based payment models over others."

But survey data also show "significant impediments to taking risk that slow progress toward an actual value-based healthcare system," the report points out:

- limited to access to claims data
- "duplicative" quality measure programs
- complicated regulatory schemes

One specific focus is bundled payments. Respondents "indicated little traction," the report says. "In 2018, AMGA members reported revenues from bundled payments of only 1% of federal or commercial revenues. The level of engagement in this model has remained consistent since 2015."

- 1% of revenues come from federal bundled payment models. By 2020, that's predicted to remain 1%. "This lack of involvement is consistent with all organization types, sizes and regions."
- "Similarly, there is a notable lack of traction for bundled payments in the commercial setting:" 1% of revenues, a lack of engagement that's consistent for all organization types, sizes and regions.

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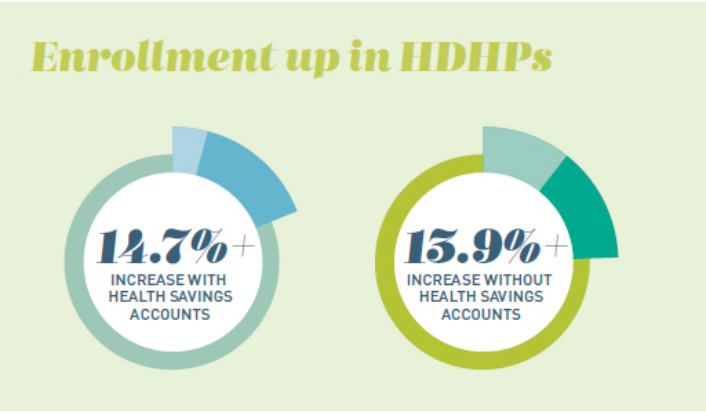
HealthEdge Assessment: 'Be Flexible Moving Forward'

In *Value-Based: A Brief History & The Road Ahead*, data manager HealthEdge looks at what created the value tidal wave and who's riding it successfully. And the company offers advice for healthcare companies that want to cut it in the cutthroat competition that's coming.



US healthcare spending grew 3.9% in 2017, to $3.5 trillion, accounting for 17.9% of GDP. "Individuals and families are feeling the financial impact through the increased popularity of High-Deductible Health Plans," HealthEdge says in the report. "According to the *American Journal of Managed Care*," it says, "among adults aged 18 to 64 with employer-based health coverage from 2007 through 2017, enrollment in HDHPs coupled with a Health Savings Account grew from 4.2% to 18.9%.

Without an HSA, the numbers grew from 10.6% to 24.5%." Members of HDHPs pay lower monthly premiums -- but more out of pocket, the statement says, "and those premiums increased 5.5% for family plans and 4.4% for individuals between 2016 and 2017."

As a result, HealthEdge says, many payers and providers "have embraced the shift toward value and are now working to bring about the change needed." The report cites a national payer study that said value-based models have also produced these yields:

- medical cost savings of 5.6% on average, with almost 25% noting savings "in excess of 7.5%"
- improvements in care quality at 80% of payers; 64% see improvements in provider relationships and 73% note improved patient engagement.

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- a faster fade for pure fee-for-service, which now "accounts for only 37.2% of reimbursement," according to the report, "and is projected to dip below 26% by 2021."

Physicians

Small and independent practices often report lacking "the resources, skills and experience with data analysis" to succeed under Alternative Payment Models," the report says. And many physicians say they don't understand "labyrinthine" new payment models. But those practices are "best positioned to make the biggest difference with value because community and primary care physicians serve as the quarterbacks who direct patients to the right care setting at the right time," the report notes, "helping to keep them out of the hospital."

Hospitals

Often well-resourced with expertise to succeed under value-based contracts, "their business models still largely depend on heads in beds," the report comments. But they need to "significantly embrace cost transformation," it adds: "Most hospitals focus on 'labor cost/productivity' and 'supply chain and other non-labor costs' as key focus areas for cost reduction. But hospitals that want to succeed should look at business and service line rationalization, physician enterprise management, clinical redesign and workforce redesign as top priorities."

Payers

"Slowly embracing value-based contracts to date," the report says, they, too, are "in many cases tied to their FFS past." They should, it adds, consider these steps to improve provider morale:

- simplify APMs to help practices focus on improving patient care as "the preferred strategy for earning financial rewards"
- slow the pace of change in payment models
- help practices invest in data management and analysis and supply "understandable" performance data to help them succeed in APMs
- consider offering upside-only APMs, or helping practices manage downside risk, such as subsidizing upfront investments in new practice capabilities
- maintain an infrastructure that allows you to be nimble to thrive in a "constantly shifting climate"

And don't forget about the $18 billion urgent care industry, which should grow 5.8% in 2019. "The threat hospitals face from urgent and retail care is real and represents a model generally favored by Millennials and Generation X," the report notes. "Both Millennials and Gen Xers are more likely than Baby Boomers to report that they have used a walk-in clinic." Only 14% of Baby Boomers have, compared to 18% of Gen Xers and 30% of Millennials.

'How an Agile Payer Wins'

HealthEdge offers this case study of a successful customer, which moved from FFS to having nearly 98% of its primary care practices in full capitation contracts – in part by adopting HealthRules, the HealthEdge core administration technology platform. It allows Independent Health, a 375,000-member non-profit health plan in Buffalo NY, to "quickly adapt to new market realities" and stay ahead of its competition.

Dave Mika, Vice President of Enterprise Core System Operations at Independent Health, recounts the story of one cardiology group in its network that wasn't nimble enough.

"The CEO was approached by a colleague from medical school who asked for a 15% rate increase to stay in business. The plan had the difficult task of denying his request, explaining that his group's outcomes were below standard and that his peers were experiencing better quality outcomes at much lower costs. That specialty cardiology group is no longer in business.

"Simultaneously, another cardiology group in the network demonstrated strong and positive clinical outcomes, which led to a 3.5% reduction in medical costs. The plan also saved $14.8 million by targeting approximately 5,000 members whose providers would partner in a post-acute care setting to reduce avoidable admissions and costly, wasteful readmissions."

HealthEdge says its enterprise solution suite, HealthRules, is built on patented technology and delivered via the HealthEdge Cloud or onsite deployment. Visit healthedge.com.

Value-Based Payment News
June First Edition 2019
Volume 4 Issue 11

ISSN Print (2327-7335)
ISSN Electronic (2327-7343)

Publisher: Clive Riddle, President, MCOL

Editor: Russell A. Jackson

Value-Based Payment News is published monthly by Health Policy Publishing LLC. Newsletter publication administration is provided by MCOL.

Value-Based Payment News

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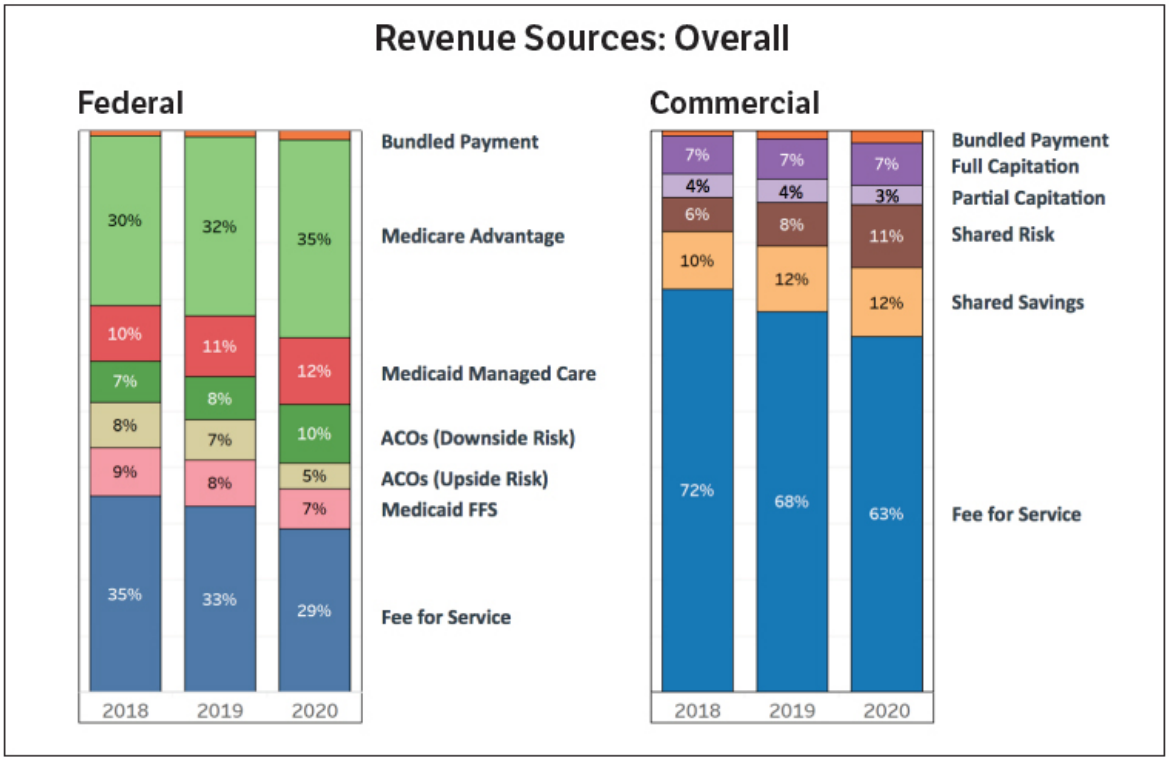

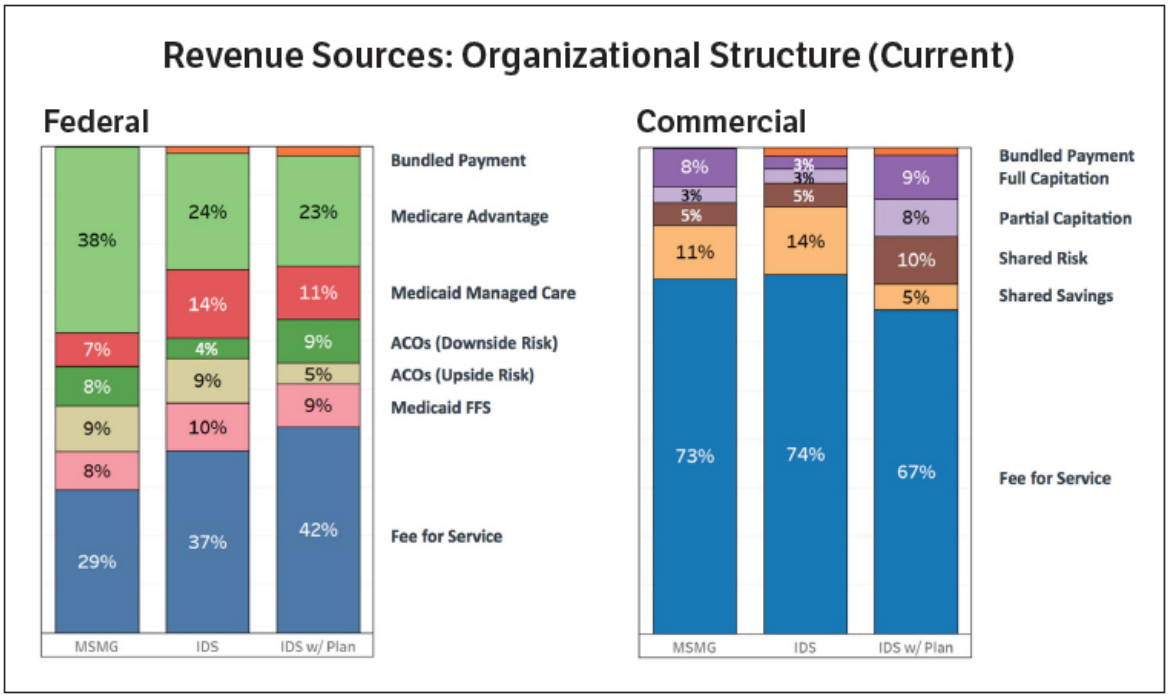

While bundled payment models “can be attractive for hospitals with strong specialty practices like orthopedics,” the report adds, AMGA respondents “are more likely to be engaged in risk models that cover large populations of patients -- particularly those with chronic, high-cost conditions -- and span their entire enterprise.”

- They’re more interested in “taking risk for all patient care and not just small, discrete parts.”
- They also say “defining the time, services and patients included could be problematic.”

Visit amga.org.

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Industry News

NAACOS Offers Feedback on New Direct Contracting Options

Not surprisingly, the National Association of Accountable Care Organizations has some feedback on the Geographic Population-Based Payment Option, one of three in the Direct Contracting model proposed by the Center for Medicare and Medicaid Innovation. "NAACOS supports introducing new Alternative Payment Models that emphasize quality and accountability for total cost of care," the group says in a letter to CMMI, but urges it "to be mindful that the option doesn't undermine the efforts of other well-established Medicare ACO models."

- Specifically, NAACOS asks the Centers for Medicare & Medicaid Services to "launch the Geographic PBP Option in areas with low, if any, ACO penetration."
- As well, "ACO-assigned beneficiaries should be excluded from the populations for which Geographic Direct Contracting Entities would be responsible, so as to not interfere with ACO participation."

While NAACOS "appreciates more opportunities that move Medicare away from a fee-for-service payment system," the letter says, "CMS must recognize the tremendous growth of ACOs in Medicare and the groundwork they've lain for future success. That work must not be disrupted."

- Data show Medicare ACOs "limit the growth of healthcare spending," the letter says, including an independent analysis that "showed the MSSP saved Medicare $2.7 billion between 2013 and 2016."
- The Next-Generation ACO Model also "had savings," it adds, "reflected in the program's first-year evaluation report, which showed 18 ACOs reduced Medicare spending by $62 million."
- Initial analysis of second-year results show, the letter adds, the program netted at least $165 million to Medicare in 2017.
- In 2017, MSSP ACOs subject to pay-for-performance measures earned an average quality score of 90.5%.

In a separate letter, NAACOS "expresses strong support for the Professional and Global Model Options," the organization notes, as they "build off of ACO programs and principles." NAACOS also offers several recommendations to "improve the options."

- Provide "necessary" fraud and abuse waivers.
- Expand utilization management tools.
- Ensure that claims payment is optional for Direct Contracting Entities.
- Apply "lessons learned from existing ACO programs and Medicare Advantage" when crafting risk adjustment and benchmarking policies.

"The Direct Contracting options represent an important next step in the Innovation Center's work on accountable care models," the group adds in the letter. "Especially if CMS adopts the recommendations, the options can improve Medicare's work to advance value-based care." NAACOS represents 330 MSSP, Next-Generation and commercial ACOs. Visit naacos.org.

Cigna Collaboration 'Helps Santa Clara County IPA Improve Quality, Lower Costs'

The "latest results" from a collaboration between Cigna Corp. (NYSE: CI) and Santa Clara County IPA "show that the program continues to drive better healthcare quality while achieving significantly better affordability," a statement says. SCCIPA "enhances care by using patient-specific data from Cigna to help identify individuals being discharged from the hospital who might be at risk for readmission," it explains, "as well as people who may be overdue for important health screenings or who may have skipped a prescription refill."

- The physician-led care team "also helps patients get follow-up care and screenings, identifies potential medication complications and helps prevent chronic conditions from worsening."
- SCCIPA's "total medical costs are 18% below market average," it says.
- Its cost trend is 2.6% lower.
- The group's quality score improved by nearly 20 percentage points, "led by better care of patients with cardiac conditions, diabetes, depression and those requiring specific preventive screenings."

"Numerous factors contributed to SCCIPA's strong results," the statement adds.

- hospital readmissions 23% lower than market
- inpatient admissions among all hospital services 10% lower
- Emergency Room visits 9% lower
- advanced imaging -- CT scans and MRIs -- used 32% less
- inpatient total medical cost (per Cigna customer) 20% lower

Since Cigna began collaborating with SCCIPA in 2014, the group "has demonstrated some of the most consistent performance, not only among other medical groups in Northern California and Cigna's Western Region," the statement says, "but also among the more than 225 Collaborative Care arrangements Cigna has with provider groups nationwide." In 2018, SCCIPA was the top performing Cigna Collaborative Care group nationally.

SCCIPA is also part of an alliance between Cigna and Good Samaritan Health System, which includes Regional Medical Center of San Jose and Good Samaritan Hospital. That alliance launched in January 2018; it offers "a customized network of primary care doctors, specialists and hospitals that provide high-value care." The SCCIPA network includes access to 13 urgent care centers, 10 hospitals, radiology, clinical labs, physical therapists and case managers.

Visit sscipa.com and cigna.com.