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College of Nursing

Up in the Air ACA: Where Will It Land?—A further case for value based care

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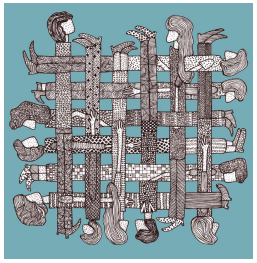
Value Based Care

- Really means
  - Cost attentive care
  - Outcome attentive care
- Great implications because workforce planning been rooted in systems developed in fee for service models

Advanced Organizer

- Slightly embellish on previous speakers
- What is outside the ACA and likely to stay
  - Value based care
  - MACRA, MIPS, and AAPM
- What does it all mean for the nursing workforce?...and our patients!

How the ACA is Woven Together-& Why



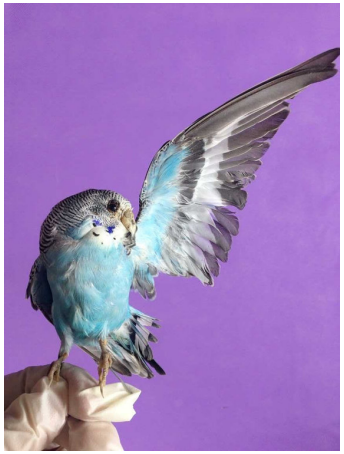
- Access to Insurance & Mechanisms to Support Coverage
  - These support financial access but don't necessarily lower overall cost of care
- Patient/Provider Relationships/Transparency
  - Shared Decision Making & Sunshine Act
- Testing of Payment Reform Models
  - This is where the cost containment is housed
  - This is where workforce redesign is fueled

ACA: Hybrid Model Toward Universal Financial Access

- Commercial Insurance
  - Individual Mandate
  - Employer Mandate
- Governmental Payers
  - Medicare
  - Medicaid
    - NB: 64.3% of US health care publically funded (2013). Canada 70% (Himmelstein & Woolhandler, 2016)

Individual Mandate and Pre-Existing Condition Coverage

- Two paired wings to enable the bird to fly



- Individual mandate once supported by GOP as alternative to single payer (Roy, 2012; Cooper, 2012)
- GOP now, in general, oppose individual mandate

AHCA--No Individual Mandate Necessitates High Risk Pools

- Some successes—need heavy subsidization (Maine/Wisconsin)
- 35 pools before ACA were very expensive and unsuccessful in providing access to quality affordable coverage (Meyer, 2017b)
- GOP Upton—AHCA $8 B amendment

If passed

- Are nurses prepared to lead models of care for pools of high cost, high care individuals?
  - Exemplars with Medicaid populations
    - Nurse and social work led models serving superutilizers
    - Health IT framework to plan individual and population based interventions…are we ready?
    - Panel Management--Essential Skill

AHCA Congressional Budget Office Report

- Reduce cumulative federal deficit by $119 B by 2026 by reducing federal investment in health care
  - More uninsured through diminished subsides
  - More underinsured (eliminate Essential Benefit Package)
  - Medicaid block grants on 2016 spending levels

Not All SENATE GOP in the Same Camp

Senate GOP healthcare reform camps

As debate begins to heat up on a healthcare bill, senators are taking position in their various corners.

Medicaid/opioid treatment caucus

Senators who want to protect Medicaid expansion and coverage for addiction care

Rob Portman, Ohio

Shelley Moore Capito, West Virginia

Dean Heller, Nevada

Jeff Flake, Arizona

Cory Gardner, Colorado

Bill Cassidy, Louisiana

Tom Cotton, Arkansas

Deregulation caucus

Senators who want to repeal most or all of the ACA's insurance market regulations, subsidies and taxes

Rand Paul, Kentucky

Mike Lee, Utah

Ted Cruz, Texas

Compromise caucus

Senators seeking ways to reach consensus and pass a bill

Lamar Alexander, Tennessee

John Thune, South Dakota

Bob Corker, Tennessee

Women's healthcare caucus

Senators who oppose defunding Planned Parenthood

Susan Collins, Maine

Lisa Murkowski, Alaska

What Will Happen in the Senate?

- Majority leader McConnell said he doesn't know how GOP would get the needed 50 votes (June 2)
- "We are getting close to having a proposal to whip and take to the floor," McConnell, R-KY, June 7

Less expensive health insurance products less expensive care

- Cost is a product of price and volume
  - Americans use too much expensive health care
- Outcomes lag
- High error rate
- Overtreatment—1/3 of what we do doesn't matter

Cost Containment—An Ethical Imperative for Nursing (and others)

- Cost erodes other spending options—options that enhance health through social determinants
  - Education
  - Infrastructure
  - Job creation

Rationale for what is outside the ACA/AHCA and likely to stay

- Insurance market reform does not get at COST of health care
- Portion of Medicare funded through trust fund projected to be bankrupt by by roughly 2030
- High Medicare costs on back of young represents intergenerational injustice (Newacheck &Benjamin, 2004)

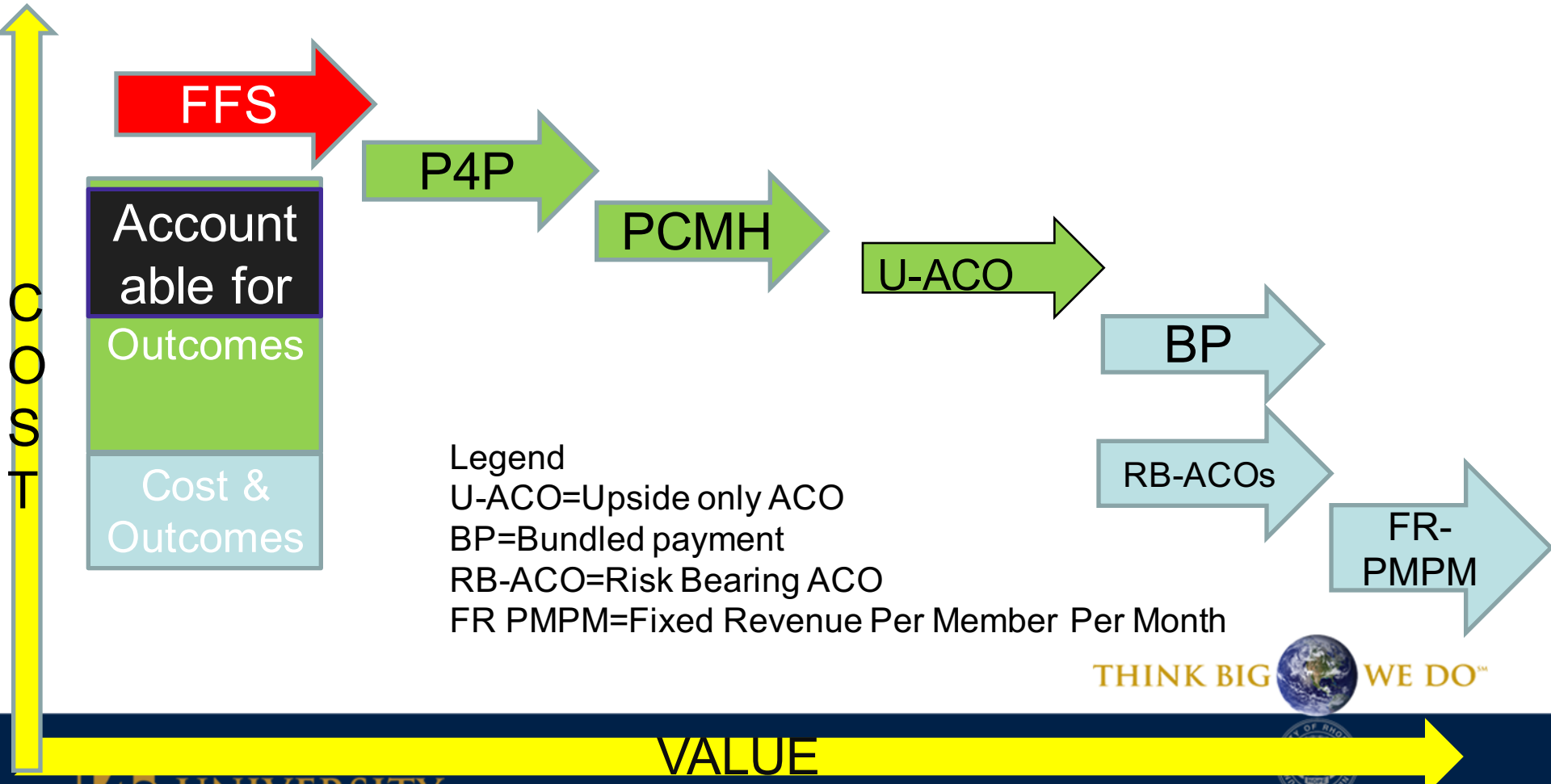
What Is Outside ACA and AHCA? Payment Reform Targeting COST and VALUE

- Both sides agree health care too expensive
- Dems more comfortable with federal solution—GOP prefer state solution
- Fairly strong agreement that fee-for-service is a problem

Reminder: What is Wrong with Fee-for-Service? Well, it Fuels…

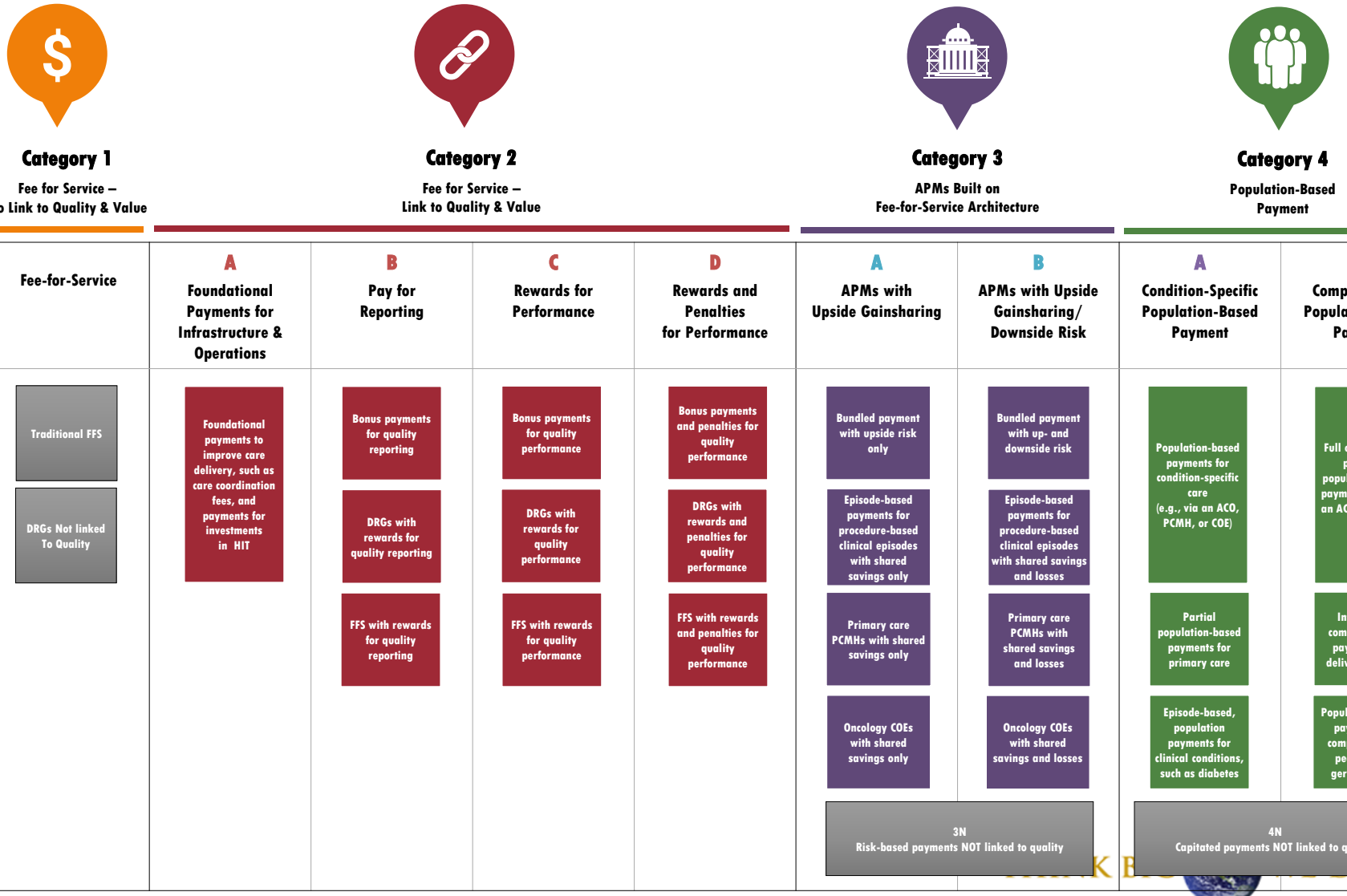
- A *more is better* approach
- Payment –and therefore treatment--silos
- Fragmented care
- Disincentives for coordination and integration
- An inability to control costs

Payment Models Conceptualized Along a Range of Most to Least Like FFS



Legend: FFS=fee for service; P4P= pay for performance; PCMH=p
ACOs=accountable care organizations

Alternative Payment Models (APM) Framework



= example payment models will not count toward APM goal.

= payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

Fee-for-Service

- Narrow accountability horizons
  - Example: likely bulimia nervosa presenting with enlarged salivary gland
- Short accountability horizons
  - Come back as much as you want (after a month if a hospital, or course, and if insured)

Other End of Spectrum—Fixed Revenue Total Cost of Care Redesigns

- Academic medical center (yes, with med school) investment in a totally NP run primary care clinic
- ”Home” visits to homeless encampments
  - Led to further community investment in housing and job training

Total Cost of Care Redesigns Continued

- Integration of mental health and substance abuse care becomes essential
- Support and Services at Home (SASH)
  - Nurse/Social worker led interventions
  - Essential when accountable for cost of long term care

Yet another hospital service area

- Hospital led long term childhood obesity reduction plan
  - EPODE—used in 100s of setting worldwide
  - Includes community-wide efforts for walkable/cycling school routes, healthier foods, behavioral interventions, etc.

The Blue H Shift—from the voice of CFOs and CEOs

- From Hospital to
- Health
- Healing
- Hope

- In other words…payment models matter

What Does It Mean To Workforce Development When

- Hospitals celebrate empty beds rather than full ones? (Berwick)
- Emergency Department High Utilization
  - Fee for Service—Revenue enhancement
  - Fixed revenue—Revenue drain

Fee-For-Service

- < 5% of revenue currently tied to alternative payment models
  - Bundled payments, accountable care organizations, population health initiatives, value based contracts
- Expect 40%+ within 2-5 years
- Behind 2015 DHHS goal of 50% by 2018
  - Significant because Trump-era projection
  - Workforce needs very different

Patient Centered Medical Homes

- Accountable for outcomes of care
- Enhanced revenue linked to meeting quality metrics
- What are the roles and workforce needs?

EXAMPLE WITHIN A SINGLE HEALTH SERVICE AREA

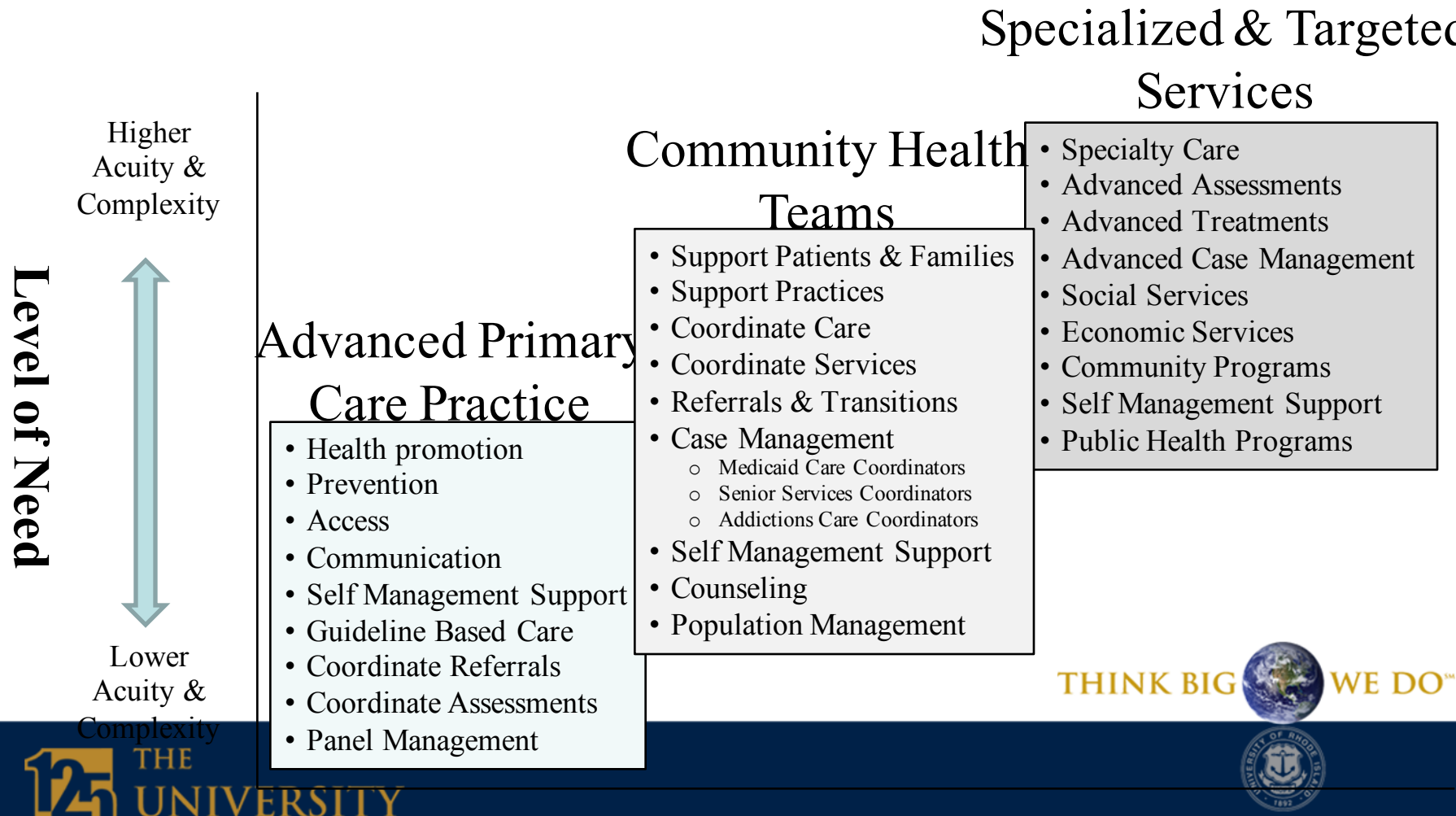
Health IT Framework

Evaluation Framework

Multi-Insurer Payment Reform Framework

- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi-insurer payment reform that supports this foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

Continuum of Health Services



Examples of CHT Team Members

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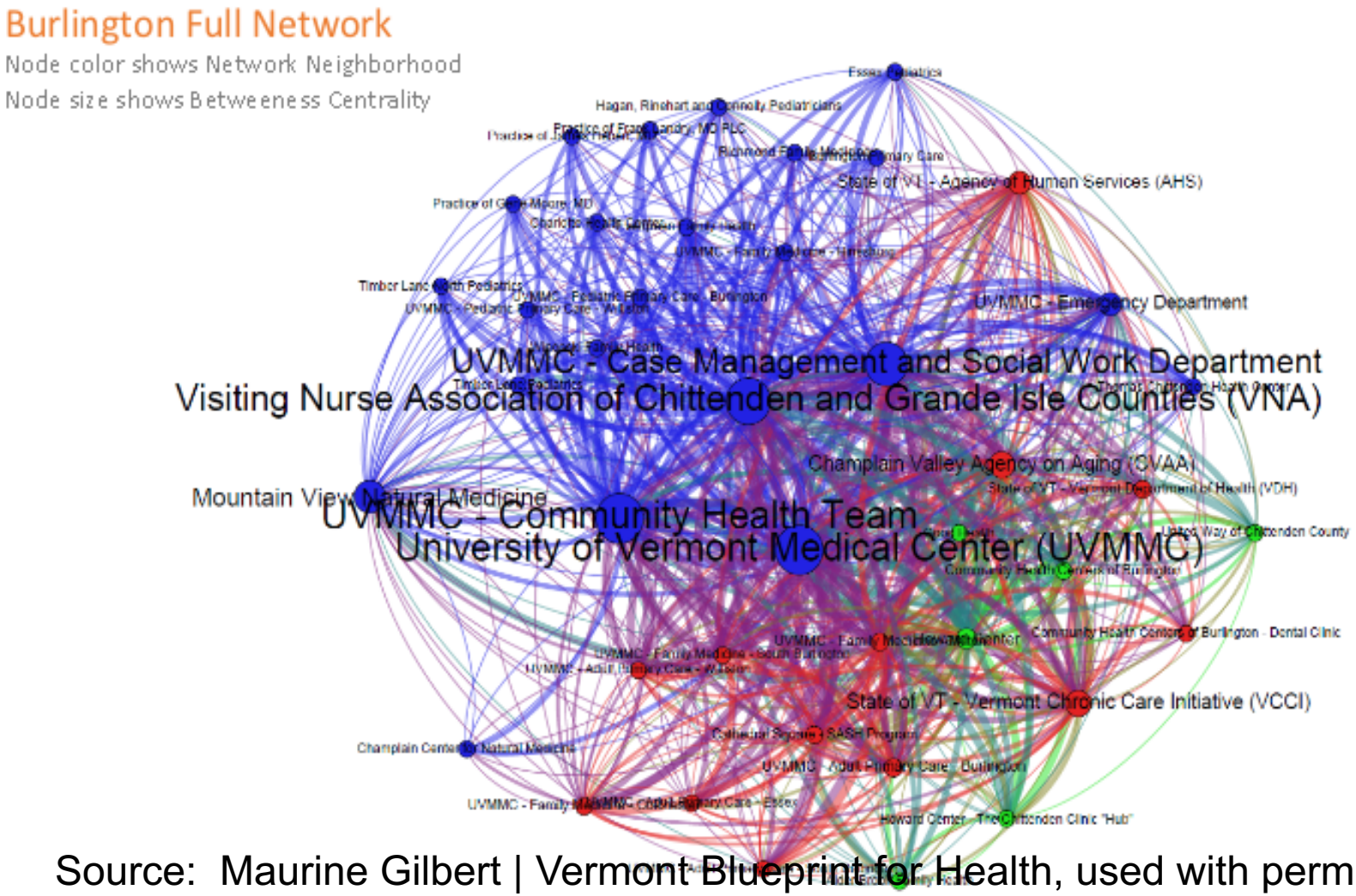
- Care Coordinators
- CHT Managers
- Registered Nurses
- Social Workers
- Mental Health/Substance Abuse Clinicians
- Pharmacists/Nutrition Specialists/Registered Dietitians
- Health Educators and Health Coaches
- Certified Diabetes Educators/Asthma Educators
- Tobacco Cessation Counselors
- Community Health Workers
- Panel Managers
- Medical Assistants
- And of course, physicians, nurse practitioners, and PAs

Who is coordinating these services?

It Take a Village!



Source: Maurine Gilbert | Vermont Blueprint for Health, used with permission

What is an ACO?

Accountable Care Organizations (ACOs)

are comprised of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population.

These providers work together to manage and coordinate care for their patients and have established mechanisms for shared governance.

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Three Iterations--Two Main Types

- Upside Only
  - Share in savings if quality metrics are met and costs are less than projected
- Risk Bearing—Upside PLUS downside
  - Same as above PLUS are accountable for costs above projected (i.e., lose money)

Upside and Downside Risk

- Downside Risk--Cost over projected
  - Offers ENORMOUS pressure to create more efficient models of care and keep people well
- Upside: Many higher performing health systems could not improve outcomes enough to receive savings
  - Dartmouth—easier for a 10 minute miler to go to 9 than a 4 minute miler to go to 3

Unanswered Question

- Have nurses, the largest segment of the health care system, informed themselves and actively promoted solutions to create savings?
- IF no, how might outcomes look differently if or when they (we) do?

Can BS Graduates and RNs at an Employment Interview Say?

- "I have noted you are moving toward a risk bearing ACO. Here are some care redesigns I can offer."
  - OR
- "I see that you are testing bundled payments for CHF and joint replacement. I have an interest in this and some ideas to enhance quality, throughput, and cost reductions.

Educators

- Is health economics, finance, and payment and delivery reform foundational, sophomore level content carried throughout the curriculum?
- Does simulated learning include panel management, population health management, performance and measurement referenced care?

Nurse As Innovator

- Rewire socialization from one who take orders and execute them to one who designs solutions to vexing health problems

Pharmaceutical Trend

- A driver of insurance cost
- What about polypharmacy?
- Nurses in an ideal role to lead…are we?
- 1) “deprescribing”
- 2) Medication reconciliation
- 3) Automated systems to alert prescribers about cost

One Powerful Payment Reform Needing Nursing Wisdom

- MACRA and MIPs
  - "Quietly transforming health care"
  - "Incentives to move away from the *often antiquated* fee-for-service model"-(Phelps, 2017, emphasis added)

What is MACRA???

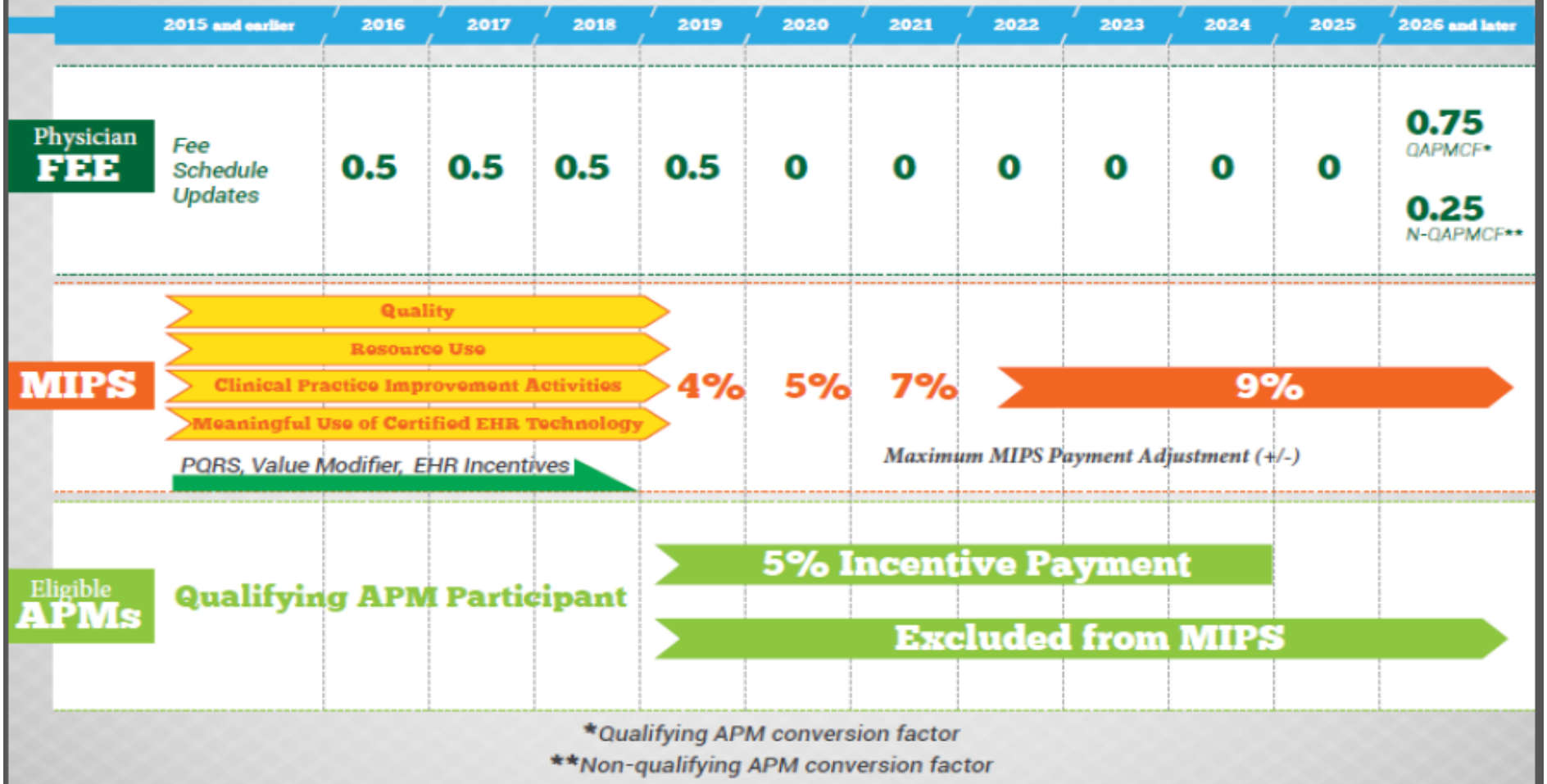
- MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)
- BIPARTISION SUPPORT--*OUTSIDE* OF THE ACA--HOUSE—392-37: Senate 98-2
  - HHS SECRETARY PRICE VOTED IN FAVOR OF MACRA when a representative
  - SENATE—98-2

MACRA & MIPs: Why it Matters to Nurses

Why it matters!

- Reimbursement incentives shape behavior
  - EXAMPLE: DRGs and hospital risk bearing for LOS
- MACRA--Most dramatic change since DRGs
- Deloitte July 2016 study found half of physicians unaware, yet must choose one of two (3) payment tracks —an advanced alternative payment model OR be subject to the Merit Incentive Program (MIPs).
- **Measurement started January 1, 2017**
  - MDs, NPs, CNS, PAs, CNA. Other professions, such as PT, anticipated.
- Although Medicare only for now, Medicaid and commercial insurance typically follow Medicare's lead
- Requirements likely to spur even more partnerships as entities scramble to have sufficient girth to withstand financial accountability for cost of care.

Timeline

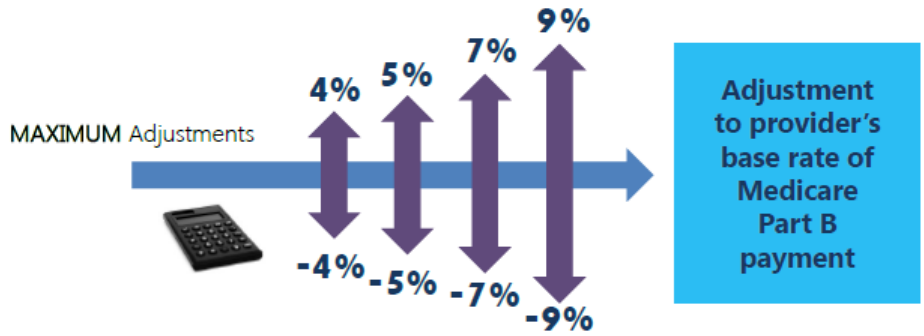


*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.



2019 2020 2021 2022 onward

Merit-Based Incentive Payment System **(MIPS)**

What models are Advanced APMs?

In 2017, the following models are Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

To be an Advanced APM, an APM must meet the following three criteria:
1. Require participants to use certified EHR technology;
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

Retrieved from https://qpp.cms.gov/learn/apms on January 20, 2017

Are we ready?

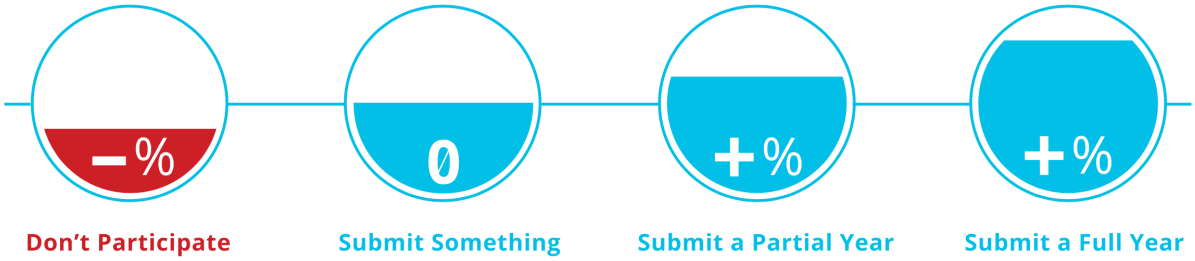
- "Most providers will choose MIPS because they are not ready to take on the other option, a qualifying alternative payment model that requires a hefty amount of risk. Many don't have the capital to set one up or to risk losing money with subpar performance. Although MIPS requires putting some profits on the line, it is much less of a gamble than heading into an APM without experience and confidence that quality measures are high." (*Few Docs Ready for Risk Under MACRA,* S. Muchmore, August 13, 2016, *Modern Healthcare)*

- The transition to MIPS may not be too difficult for those groups that have been pursuing value-based payment methods previously and have reporting mechanisms in place. But APMs are a different story." (*Few Docs Ready for Risk Under MACRA* S. Muchmore, August 13, 2016, *Modern Healthcare)*

- "Pick Your Pace" announced in October 2016

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.



Not participating in the Quality Payment Program:
If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

Full:
If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

Participate in the Advanced APM path:

If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

President Trump and GOP Control…Will MACRA & Value-Based Care Go Away?

- Health care-$3.2 trillion (2015) over $10,000/person
- Overtreatment rampant
- Medical errors 3rd leading cause of death in US (*BMJ* 2016;353:i2139)
- Mounting tax burden---64.3% of health care publically financed in 2013 (doi: 10.2105/AJPH.2015.302997)
- Mounting pressure on businesses and families
  - Health care costs built in the price for US made goods and services, property taxes, etc.

Other Unanswered Questions

- 40 % percent of Medicaid spending is for long-term care
  - Growing to 50% by 2026 (KNH, 2016)
- Entitlement funding fueled the growth of the health care system…will starving it create innovative solutions?

What Else is Possible?

- Some insurance executives suggest that insurance market financial stain opens path to national health insurance
- ("Medicare for all")

- Medicare is a publically funded single payer
- This is NOT socialized medicine

Some States Reconsidering Single Payer

- California
  - Proposed guaranteed coverage
  - No out of pocket
  - Increase total health care costs by 50 B
- New York---Proposes pooling all federal dollars in to state trust fund
- Colorado—2016 single payer ballot lost by 4:1 margin
- Vermont--abandoned effort--Shifted to all payer total cost of care model

Regardless of Path

- Cost sharing likely here to stay
  - First dollar coverage fuels “moral hazard” and overutilization
- Measurement of cost and outcomes here to stay and will become even more pervasive
    - Couples with patient preference to fuel outpatient
- Smart technology approaches will grow
- Big data for population health

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Thoughts? Questions? Answers?

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