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Value-Based *Insurance Design*®

ALSO IN THIS ISSUE

Dual Enrollees Experience Higher Levels of Spending

Kaitlynn Ely

Patients dually enrolled in Medicare and Medicaid have higher levels of Medicare spending compared to other beneficiaries, and it can impact hospitals' performance on a Medicare cost measure, according to a study published in *Health Affairs*.

In 2015, Medicare shifted its payment plan to be based on quality through the Hospital Value-Based Purchasing (VBP) Program, a mandatory national hospital pay-for-performance program. The Medicare Spending Per Beneficiary (MSPB) measure compares a hospital's adjusted average cost for episodes of care to the national median. This is used to calculate the VBP Efficiency domain for individual hospitals. Unfortunately, the MSPB measure does not consider beneficiaries who are dually enrolled in Medicare and Medicaid, who account for 31% of total Medicare spending. Dually enrolled beneficiaries are also more likely to be admitted into safety-net hospitals with a high disproportionate share hospital index.

The study examined whether dual enrollees have higher spending on the MSPB measure and if so, which clinical conditions or care settings create that difference. Patient-level differences in episode spending were also analyzed to recognize the impact the MSPB measure has on the VBP overall performance scores for safety-net hospitals.

SPOTLIGHT ON

Value-Based **Design**®

New Value-Based Insurance Plan Helps Consumers Who Use Healthcare the Most

Laura Joszt

As the healthcare industry struggles to address rising costs and increased enrollment of people with chronic conditions in high-deductible health plans, attention is turning to value-based benefit design options. Altarum has released its outline for a new value-based insurance design model that it will test at pilot sites across the country.

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2 Clarke Drive Suite 100
Cranbury, NJ 08512

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Altarum created the Medical Episode Spending Allowance (MESA) plan with support from the Robert Wood Johnson Foundation. The model is well suited to people with chronic diseases or serious health conditions who use the most healthcare. In comparison, the use of high-deductible health plans with health savings accounts has helped lower the cost of care but can hurt patients with chronic conditions who need more care.

"Employers and consumers are looking for alternatives to increasingly unaffordable health coverage, and finding a solution that works is essential," François de Brantes, vice president and director of Altarum's Center for Payment Innovation, said in a statement. "That's what our MESA Blueprint is all about. By turning the high deductible health plan on its head, the MESA plan significantly reduces the potential for people with on-going illnesses from foregoing needed care."

MESA is based on a reference pricing model, which sets a price for services and anything above that price is paid for by the consumer. According to Altarum, the model encourages consumers to seek out high-value care and providers.

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The researchers examined admissions for Medicare fee-for-service beneficiaries from May 2013 to December 2013 by following published methods that were used to create the MSPB measure. Each episode recorded includes all Medicare Parts A and B payments acquired from 3 days before admission through 30 days after hospital discharge. Once total payments were calculated, they were compared to the total expected payments relative to the episode based on CMS' Hierarchical Condition Categories model. This model is adjusted for age, comorbidities, end-stage renal disease, and long-term institutional care, among other factors. The ratio of actual to expected payments was multiplied by the national average to calculate the MSPB measure for that hospital.

The results showed that of the 3.6 million hospital episodes in 2013 eligible for the MSPB measure, 32.5% were dually enrolled beneficiaries. Dual enrollees experienced 4.3% higher levels of spending compared to regular beneficiaries and had higher spending in 23 out of the 26 Major Diagnostic Categories. They were also more likely to use care 3 days before hospital admission and use institutional care. Safety-net hospitals had a higher proportion of patients who were dually enrolled, with most of these hospitals located in the South. Ultimately, higher MSPB scores translated into low efficiency VBP scores for safety-net hospitals.

"Dually enrolled beneficiaries were more costly under an episode-based measure of Medicare spending, due to higher utilization and spending in the postacute setting," the authors concluded. "CMS could explore adjusting the Medicare Spending per Beneficiary measure for dual-enrollment status or functional status to potentially improve the accuracy of measures for high-risk populations."

CMS Unveils New Voluntary Bundled Payment Model

Mary Caffrey

CMS on Tuesday unveiled plans for an expanded bundled payment model that calls for participants to take on risk in both inpatient and outpatient settings, and that will qualify providers for additional incentives under the 2015 Medicare Access and CHIP Reauthorization Act (MACRA).

The model, the Bundled Payments for Care Improvement (BPCI) Advanced, is the next generation of the BPCI models already operating around the country; as of October 2017, CMS reported that BPCI Model 2 had 514 participants in phase 2. Under this new step, the 32 clinical episodes include 3 outpatient episodes, in addition to inpatient episodes, which appear to largely track those previously offered through the Center for Medicare and Medicaid Innovation.

"We're very happy that it's finally here," Darcie Hurteau, MBA, director of Informatics for DataGen, said in an interview with *The American Journal of Managed Care®*. The majority of the episodes overlap with those "defined in the original program," she said, although she wants to see details before assuming they will be based on the same data.

A politically relevant aspect is that BPCI Advanced comes after CMS canceled an Obama-era proposal for mandatory bundled payments in cardiac care, as well as a mandatory expansion of a program in joint replacements. Of note, episodes included in this new voluntary model include several cardiac care episodes, including percutaneous coronary intervention and cardiac defibrillator episodes in outpatient settings; Hurteau said including these episodes should allow providers to capitalize on their preparation for the planned mandatory model.

While proponents of mandatory bundled payments said they were showing early savings, hospital groups said CMS was moving too quickly with mandatory models, and others said the program was too bureaucratic. Still others believe that the expansion of accountable care organizations represents the best way for healthcare providers to ensure better care coordination and outcomes.

BPCI Advanced will work like other bundled payment models in that providers must keep spending within a set budget while meeting or exceeding quality measures. In a statement, CMS said, "Participants bear financial risk have payments under the model tied to quality performance, and are required to use certified electronic health record technology."

CMS said this will allow providers who use the model to meet requirements of an advanced alternative payment model (APM), the more advanced of 2 value-based payment structures under MACRA. In this way, the model appears to meet expert predictions that the current administration will push providers toward risk-based reimbursement models with carrots instead of sticks.

"CMS is proud to announce this administration's first advanced APM," said CMS Administrator Seema Verma in a statement. "BPCI Advanced builds on the earlier success of bundled payment models and is an important step in

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Members in a MESA plan only pay out of pocket when their cost of care exceeds the allowance for an episode of care, and when they use network providers in risk-based models of care, they could potentially have no out-of-pocket costs.

Through MESA, consumers will also have access to tools to help them make financially savvy choices with tools to research procedures, identify providers in their area, and view cost and quality ratings for providers. MESA also identifies Potentially Avoidable Complications, which are a significant driver of cost and a reliable indicator of quality, according to the MESA blueprint.

A. Mark Fendrick, MD, director of the University of Michigan Center for Value-Based Insurance Design and co-editor-in-chief of *The American Journal of Managed Care®*, explained that MESA, and health insurance innovations like it, align consumer and provider incentives on quality and cost.

"Strategies that reduce the patients' out-of-pocket cost burden for clinically indicated services provided by high performing clinicians are necessary and important strategies to achieve the Triple Aim," Fendrick said.

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MESA will be tested at select pilot sites throughout the United States, although none have been chosen yet. Sites that are interested in becoming pilots should have current engagement in and familiarity with alternative payment models, according to Altarum.

"MESA provides a comprehensive plan that marries payment reform with benefits reform, provider engagement with consumer engagement, and physician accountability for costs of care with patient accountability for managing their health and costs of care," said Emmy Ganos, program officer at the Robert Wood Johnson Foundation. "Many of the concepts aren't new–they are tried and tested–but their combination is, quite simply, a better solution."

the move away from fee-for-service and towards paying for value. Under this model, providers will have an incentive to deliver efficient, high-value care."

Applications for the model are due on March 12, 2018, and the first cohort will begin on October 1, 2018, according to CMS. Information published Tuesday said that BPCI Advanced will initially cover 29 inpatient episodes and 3 outpatient episodes, with the possibility revising the list for both new and existing participants beginning January 1, 2020. Those who join with the first wave cannot leave the program before January 1, 2020.

Hurteau said providers will want to see additional details of the 32 episodes as well as the quality metrics, which will help them decide whether to apply this year. Positive aspects of the model, in her view, are plans to evaluate providers based on their own historical data, as well as the ability of participants to qualify for advanced APM.

Other details to be worked out, she said, including who "owns" an episode--a physician practice or an acute care provider--after the second wave of enrollment. The window for getting data, evaluating options, and making a decision is relatively short, especially for those practices that have not taken part in earlier rounds of BPCI, Hurteau said.

Chris Garcia, CEO of Remedy Partners, said in an email to *The American Journal of Managed Care®*, that the company is pleased CMS is continuing the BPCI Advanced program through 2023.

"This is another positive step forward for bundled payments being part of Medicare's permanent payment policy, and we expect it will fuel the continued expansion of bundled payment methodology into commercial, Medicaid and self-insured markets," he said. "We look forward to our continued partnership with CMS and working with many new provider participants that we anticipate will be joining the program."

Study Examines Cost-Effectiveness in Multiple Myeloma Treatments

Kaitlynn Ely

New drugs to treat multiple myeloma (MM) have provided clinical benefits, but a study published in the *Journal of Managed Care & Specialty Pharmacy* found not all of them can be considered cost effective.

Historically, 2 drugs–bortezomib (BOR) and lenalidomide (LEN)–have been used in combination with dexamethasone (DEX) to treat MM. However, 5-year survival rates remain below 50% with a single course of drug therapy costing between $75,000 and $250,000. There has not been an evaluative of the cost effectiveness of other drugs used to treat following relapse, including pomalidomide (POM), carfilzomib (CFZ), ixazomib (IX), daratumumab (DAR), elotuzumab (ELO), and panobinostat (PAN).

"The availability of effective treatment options for MM patients is of paramount importance," the authors wrote. "However, in an era of continuing increases in healthcare spending and drug prices, it is also important to understand the relationship between costs and outcomes achieved."

The study assessed the relationship between clinical outcome and monetary price of 8 regimens used to treat patients who have relapsed. A 3-state partition survival model was developed to categorize patients into progression-free survival (PFS) state, progressed disease with subsequent treatments, and death. Evidence on treatment methods was collected through a Bayesian network meta-analysis while using LEN+DEX as a baseline treatment.

The overall survival (OS) rates in relation to PFS were used to analyze the effectiveness of the treatment. Calculating total estimated treatment cost was done by applying drug unit costs to the utilization estimates. Drug costs were derived from the Final 2016 Medicare Coding & Payment for Drug Administration Services.

The results show that out of the 8 possible regimens within the cost-effective range, only 2 are considered to be value-based treatments. DAR-BOR-DEX is the most recommended treatment due to PAN-BOR-DEX's high levels of toxicity. The treatments with the most uncertainty include ELO+LEN+DEX and IX+LEN+DEX. While there has been major advancement in treating MM during relapse, these advancements have not been done in a cost-effective way. It is almost impossible to offer discounts to patients due to the high price of inputs going into treatments.

"The introduction of newer drugs and regimens to treat second- and third-line relapsed and/or refractory MM appears to provide clinical benefits by lengthening PFS and OS and improving quality of life," the authors concluded. "However, only the addition of DAR or PAN may be considered cost-effective options according to commonly cited thresholds, and PAN+BOR+DEX results require cautious interpretation. Achieving levels of value more closely aligned with patient benefit would require substantial discounts for the remaining agents evaluated."

The New Normal: How Value-Based Care Is Reaching More Patients at One Insurer

Mary Caffrey

While Congress has spent much of the year debating the fate of "Obamacare," healthcare transformation continues among payers and in practices. The quest for "patient-centered" care–which focuses on prevention, involves patients in decisions, and rewards physicians for keeping people healthy instead of paying them for every test or procedure–is far from over. But signs abound that no matter what happens in Washington, we're past the point of no return.

Such was the case in New Jersey this week when the state's largest insurer, Horizon Blue Cross Blue Shield, shared 2016 results for its top-performing patient-centered programs, which include those participating in the OMNIA Alliance. Horizon announced that 1.5 million of its 3.8 million members are participating in patient-centered programs. That share is up 50% from the prior year,

to 39.4%. The share of primary care physicians grew 10%, and payments increased 43%, to $100 million, from 2015.

This shift is significant, since physicians who treat Medicare patients but fail to move toward value-based payment structures will face financial penalties under the Medicare Access and CHIP Reauthorization Act (MACRA). Right now, practices are transitioning, as some patients are covered by value-based structures and others are still under fee-for-service contracts. Experts say that the more commercial payers do to move everyone toward value-based, patient-centered payment models, the better.

Patient-Centered Medical Home and Beyond

Thomas McCarrick, MD, chief medical officer of the Vanguard Medical Group based in Verona, New Jersey, began working with Horizon in 2011 on a pilot program to become a patient-centered medical home (PCMH) which would lead to Vanguard receiving recognition from the National Committee for Quality Assurance. From an initial group of 33 practices, McCarrick said, the initiative narrowed its focus to 8 practices working with consultants on best practices for chronic disease management, better patient monitoring, and improved care coordination that targets resources to the highest risk patients.

Over time, primary care has regained its place as the hub of care for the patient with diabetes, and that's been very rewarding. The focus is truly on helping the patient manage the disease between visits. "We're not just thinking about, 'Come in for the visit today,'" McCarrick said.

The practice now has resources like a psychiatric nurse practitioner and a certified diabetes educator. "A big part of the medical cost is the behavioral health part," he said.

It takes buy-in from multiple payers to make the strategy work, McCarrick said. Besides CMS programs, other payers in New Jersey have "piggy backed" on what Horizon has been doing. "This has been become their core thinking in primary care," he said.

Quality and Savings

Horizon said that, compared with practices operating with traditional payment structures, the patient-centered practices produced better quality measures than traditional practices in 2016, including:

- a 3% lower rate of emergency department visits
- a 3% lower rate of hospital inpatient admissions (including readmission)
- a 5% higher rate of colorectal screenings
- a 3% higher rate of breast cancer screenings
- a 3% improved rate of diabetes control, as measured by glycated hemoglobin (A1C)

Along with providing better quality, the patient-centered models are saving money: overall, Horizon said that these practices experienced a 3% lower total cost of care than traditional practices and 4% improved control of diabetes costs.

Making Models Work Financially

McCarrick and others say that, while quality measures show that patients enrolled in value-based programs are staying healthier, there's work to be done on the financial side of the equation. "Financially, the models are still a little bit stuck," he said.

Geography may matter, especially in Medicaid. A recent commentary from a North Carolina primary care physician published in *JAMA Internal Medicine* outlined the disconnect between the promise of the PCMH and the incentives in some states.

More work needs to be done to update regulations to promote flexibility, according to speakers at yesterday's Value-Based Insurance-Design Summit (VBID) in Washington, D.C. Take CMS' attempt to offer a $42 per-patient per-month chronic care management (CCM) fee, which practices were to bill to Medicare to coordinate care for seniors with more than 1 chronic condition. It was designed to give practices revenue for staff time on matters outside of the

office visit. But the requirements—and especially a co-payment that could not be waived—made administering the fee burdensome, McCarrick and other practices have reported. A speaker at yesterday's VBID Summit said collecting the co-payment has led to some curious explanations to seniors, and getting rid of it "makes sense."

By contrast, McCarrick said, taking part in the Comprehensive Primary Care Plus model, an initiative of the Center for Medicare and Medicaid Innovation, offers "much more flexibility."

The sticking points McCarrick mentions are the same ones that come up elsewhere. How can primary care practices make use of data analytics? What is the role of telemedicine? And what can be done to improve "hand-offs" with specialists?

"How do primary care practices engage with the medical neighborhood? he asked, describing the fact that he'd seen patients that morning who had been to specialist with whom he'd had "zero communication."

"That shouldn't be," he said. While technology can fill these gaps, it will take investment. "There's no easy solution," McCarrick said. "It's going to take a lot of work."

Value-Based Contracts Face Legal, Operational, and Adherence Barriers

Surabhi Dangi-Garimella, PhD

With growing competition, rising drug prices, and the broad generics market, stakeholders are demanding measurable "value" in medicinal products. While multiple deals—risk-sharing agreements or value-based contracts—are currently in place between health plans and drug manufacturers, several underlying issues can create roadblocks.

Real-world evidence is being used to develop value-based contracts that determine the relative cost-benefit of pharmaceutical products. The past 2 years has also seen the emergence of value frameworks, which have been crafted by experts from several organizations, including:

- The American Society of Clinical Oncology
- The Institute for Clinical and Economic Review
- The National Comprehensive Cancer Network
- American College of Cardiology and the American Heart Association

Just last week, FasterCures and Avalere released version 1.0 of their Patient Perspective Value Framework.

Some of the value-based contracts currently in play include:

- Outcomes-based contracts, which are designed to tie costs or outcomes to patient outcomes
- Indication-specific pricing contracts, where payments vary based on efficacy of different indications
- Expenditure-cap contracts, which limit drug costs to a certain negotiated threshold

There has been a spike in these contracts in recent years, with 16 risk-sharing contracts announced publicly between 2015 and 2017, including contracts for drugs used in treating hepatitis C, diabetes, and cholesterol. Early last year, Cigna signed contracts with both Amgen (manufacturer of evolocumab, Repatha) and Sanofi-Regeneron (alirocumab, Praluent) for their anti-cholesterol PCSK9 inhibitors that aligned payment with patient response to their respective drugs. And exactly a year later, Amgen signed another risk-sharing contract with Harvard Pilgrim: the company will refund all eligible patients who suffer a heart attack or a stroke when taking evolocumab.

The 2 parties also have a risk-sharing agreement for the anti-inflammatory drug etanercept (Enbrel), indicated for rheumatoid arthritis. Per the contract, patients who do not score a predetermined threshold score yield a lower reimbursement for Amgen.

Express Scripts, Prime Therapeutics, and CVS Health are some other payers that have entered similar outcomes-based contracts with drug manufacturers.

However, according to a survey conducted by the Pharmaceutical Research and Manufacturers of America earlier this year, stakeholders are faced with significant legal/regulatory and operational barriers. About 64% of respondents to the survey were concerned with the impact of the contract on price reporting metrics such as Medicaid Best Price and Average Manufacturer Price, along with the anti-kickback statute (46%) and FDA regulations on clinical or economic outcomes claims (46%). Some of the operational challenges identified included:

- Inability to measure outcomes (75%)
- Payer access to both medical and pharmacy data
- Incentive alignment with payers

Another important challenge is ensuring patient adherence to their prescription regimen, and these have been included in some of the existing value-based contracts. The Amgen–Harvard Pilgrim contract states that patients should adhere to the evolocumab regimen for at least 6 months before a cardiac event occurs.

The adherence factor has been on the industry's radar for a while now. Health plans recognize that low adherence is a preventable healthcare cost and manufacturers are aware of the loss associated with unfilled prescriptions. For example, health plans can track adherence by monitoring prescription refills via the pharmacy claims data and ensure their enrollees stay on track with their medications.

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