Panel Discussion: *Perspectives on Developing a Pathway Toward the 2030 Goal of Having All Beneficiaries in Care Relationships with Accountability for Quality, Outcomes, and TCOC*

Panelists:

Subject Matter Experts

- **J. Michael McWilliams, MD, PhD** – Warren Alpert Foundation Professor of Health Care Policy, Professor of Medicine, Department of Health Care Policy, Harvard Medical School
- **Ezekiel J. Emanuel, MD, PhD** – Vice Provost for Global Initiatives and Professor, Department of Medical Ethics and Health Policy, University of Pennsylvania
- **Timothy G. Ferris, MD, MPH** – Founding Senior Vice President of Value Based Performance for Mass General Brigham, Inaugural Chief Transformation Officer for the National Health Service (England), Adjunct Professor of Medicine, Harvard Medical School
- **Alice Hm Chen, MD, MPH** – Chief Health Officer, Centene

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Pathway Toward Population-based Total Cost of Care Models

J. Michael McWilliams, MD, PhD

Professor of Health Care Policy and Medicine

Harvard Medical School and Brigham & Women's Hospital

September 16, 2024

Disclaimer: The views I present are my own and do not necessarily reflect those of any organization with which I am affiliated, including the Center for Medicare and Medicaid Innovation (CMMI)

Key Points

- Goal is success (participation one measure)
- Need long-term vision for payment system (and Medicare!), then back solve
- Complexity has gotten out of hand
- Program design critical (MSSP)
  - Increase savings rates
  - Improve benchmarking
    - Minimize ACO-specific ratchets (move off historical benchmarks)
    - Do not claw back all collective success – allow “wedge” to form as ACOs save
  - Avoid knee-jerk zeal for downside risk (overblown esp in voluntary program)
  - Share savings with beneficiaries to foster demand for efficiency
  - Risk adjustment…
- Can randomize program changes to inform design (learning system)
- Intersection of TCOC + PC pop-based payment needs definition
- Portfolio: MSSP + limited episodes (fewer models designed better)
- Multi-payer problem – big issue but so is getting it right in Medicare

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Ezekiel Emanuel, MD, PhD

- 2011- *present* – Vice Provost for Global Initiatives and Levy University Professor, University of Pennsylvania
- 2017- *present* – Co-Director, Penn's Healthcare Transformation Institute
- 2009-2011 – Special Advisor on Health Policy to the Director of the Office of Management and Budget and National Economic Council. Worked on developing the ACA.
- Breast Oncologist

What is causing VBP stasis?

- Transitioning to VBP is difficult and slow.
- Providers are required to change their financial and operations management.
- Physicians have refined their practice finances and workflows to FFS and are hesitant to transition without better data.

How can we reach 100% participation?

- In order for more practices to adopt VBP, they need:
  - Timely, accurate, accessible, and actionable financial data.
  - Confidence they can achieve financial success.
- CMS should facilitate the development and adoption of low-cost solutions by supporting integration with open-source packages and requiring commercial payers – MA plans, exchange plans at a minimum– to adhere to the same data standard.
- This could create new, competitive market solutions for financial modeling, and spur much-needed foundational innovation in health care finance and operations.

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TIMOTHY G. FERRIS, MD, MPH

- Founding Senior Vice President of Value Based Performance for Mass General Brigham
- Inaugural Chief Transformation Officer for the National Health Service (England)
- Adjunct Professor of Medicine, Harvard Medical School
- Former PTAC Member, 2015-2019

Key Takeaways

- **Increasing number of older US population with treatable conditions will require substantial additional resources (funding and people)**
  - Biotech Innovations add patient benefit, cost, and delivery burden
  - Substantial changes in health care delivery will be required
- **Defining accountability**
  - Burden of existing accountability substantial: conditions of participation, licensing criteria and board certifications, patient experience survey results, quality metrics, ACOs
  - Accountability is needed for structural issues affecting health care delivery (e.g., capacity); high value insurance (e.g., overhead versus patient care); tax burden of beneficiary shifting (e.g., MA to FFS); and provider price increases
- **Systems of care provide better care than unconnected individuals**
  - Hold delivery systems accountable without increasing the cost burden
  - Reward lowering provider unit cost through technology adoption that increases throughput
  - Quality metrics should be aggregated at practice (not payer)
  - Outcomes registries for procedures
  - Better alignment of payment with work (hospital and physician)

Appendix

References

1. Timothy G. Ferris. Unit cost and hope: Increased NHS resilience through tech-enabled transformation. Future Healthcare Journal, Volume 11, Issue 1, 2024. https://doi.org/10.1016/j.fhj.2024.100021.

2. Michael Porter. What is Value in Healthcare? N Engl J Med 2010;363:2477-2481

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Chief Health Officer, Centene

Centene

Leading government-sponsored and commercial healthcare programs

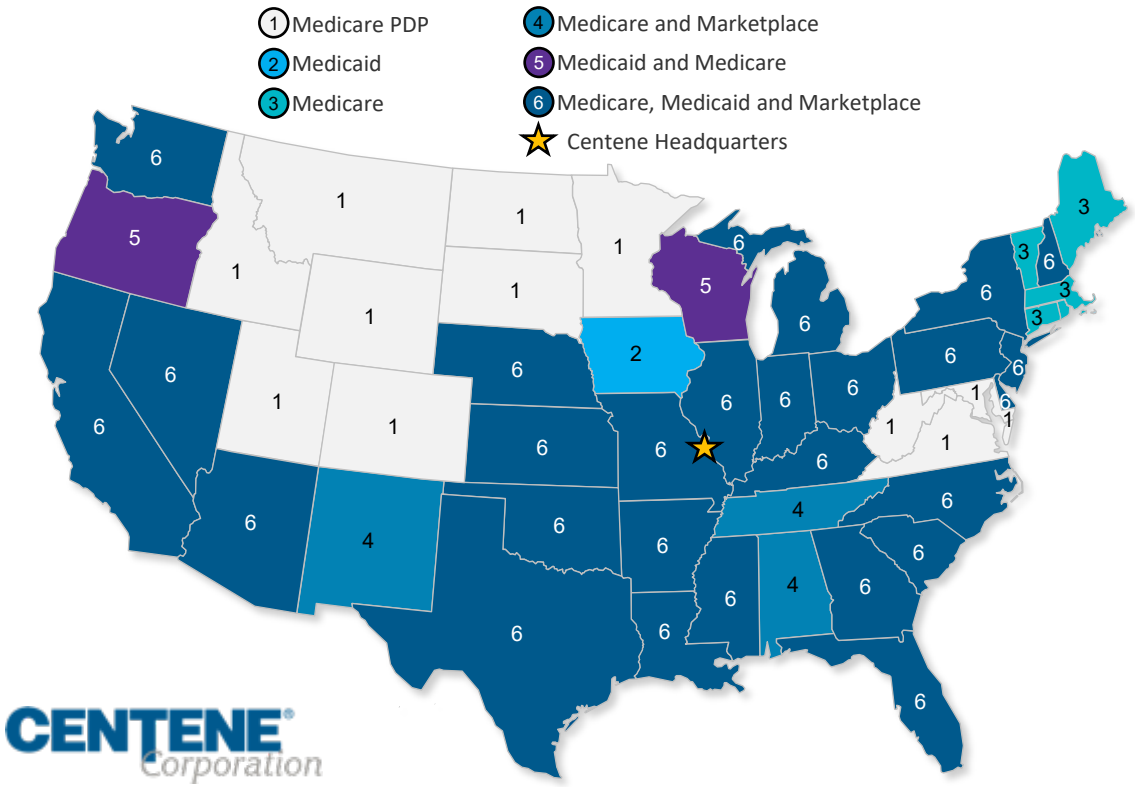
28.5 Million Members Across **50** States

13.1M Medicaid members across **30 STATES**

1.1M Medicare members across **37 STATES**

4.4M Marketplace members across **29 STATES**

6.6M Prescription Drug Plan members across **50 STATES and the District of Columbia**



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Alice Hm Chen, MD, MPH

PRACTICE → POLICY → PAYMENT

- PC internist, clinical practice in safety net
- Medical Secretary, On Lok Senior Health Services
- Medical Director, General Medicine Clinic
- Chief Integration Officer and founding director of eConsult, San Francisco General Hospital
- Deputy Secretary for Policy and Planning at California Health and Human Services Agency
- Chief Medical Officer at Covered California
- EVP, Chief Health Officer for Centene Corporation
- Co-chair of the Health Care Payment Learning & Action Network's Executive Forum

Key Takeaway | Measure Alignment

Measure Abbr	Measure (n= 170)	NCQA Medicaid Health Plan Rating (n=56)	Marketplace QRS (n=45)	Medicare (n=48)	MAC QRS (2026) (n=23)	# of Medicaid MY24 State P4P Programs (n=54)	Uniform Data System (UDS) CHC Clinical Measures (n=18)
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolit	Y	Y			1	
BPD	Blood Pressure Control for Patients with Diabetes < 140/90	Y				3	
BCS	Breast Cancer Screening	Y	Y	Y	Y	10	Y
COA-MR	Care for Older Adults Medication Review			Y			
COA-PA	Care for Older Adults Pain Screen/Assessment			Y			
CCS	Cervical Cancer Screening	Y	Y		Y	12	Y
WCV	Child and Adolescent Well-Care Visits		Y		Y	15	
CIS	Childhood Immunization Status Combination 10	Y	Y			8	Y
CIS	Childhood Immunization Status Combination 3					10	
CHL	Chlamydia Screening in Women	Y	Y			8	
COL	Colorectal Cancer Screening	Y	Y	Y	Y	2	Y
CCP	Contraceptive Care - Postpartum Women				Y		
CBP	Controlling High Blood Pressure	Y	Y	Y	Y	15	Y
EED	Eye Exam for Patients with Diabetes	Y	Y	Y		6	
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions			Y			
GSD	Glycemic Status Assessment for Patients with Diabetes (A1c < 8)	Y	Y	Y	Y	12	A1c > 9
INR	International Normalized Ratio Monitoring for Individuals on Warfarin		Y				Y
KED	Kidney Health Evaluation for Patients with Diabetes	Y	Y	Y		3	
LDM	Language Diversity of Membership	Y					
OEV	Oral Evaluation, Dental Services		Y		Y		
OMW	Osteoporosis Screening in Women Who had a Fracture			Y			
POD	Pharmacotherapy for Opioid Use Disorder	Y				4	
PCE	Pharmacotherapy Management of COPD Exacerbation (Bronchodil	Y				1	
PCE	Pharmacotherapy Management of COPD Exacerbation (Corticoste	Y				3	
PCR	Plan All Cause Readmissions	Y	Y	Y		6	
PPC	Postpartum Visit	Y	Y		Y	21	
PRS	Prenatal Immunization Status - Combination Rate	Y				3	
RDM	Race/Ethnicity Diversity of Membership	Y				1	
DSF	Screening for Depression and Follow-Up Plan		Y		Y	1	
SNS-E	Screening for Social Drivers of Health/Social Need Screening and Intervention		Y			2	
CWP	Strept Test For Pharyngitis	Y				1	
PPC	Timeliness of Prenatal Care	Y	Y		Y	21	
TRC	Transitions of Care			Y			
LBP	Use of Imaging Studies for Low Back Pain	Y	Y			1	

Abbr.	Measure Name
WCV*	Child and Adolescent Well-Care Visits
PPC*	Prenatal Care Timeliness of care
PPC*	Postpartum Care
CBP	Controlling Blood Pressure
GSD	Glycemic status <8.0%
BCS-E	Breast Cancer Screening
COL**	Colorectal Cancer Screening

MAC QRS is the Medicaid and CHIP Quality Reporting System

Uniform Data System (UDS) is HRSA's Community Health Center measure set

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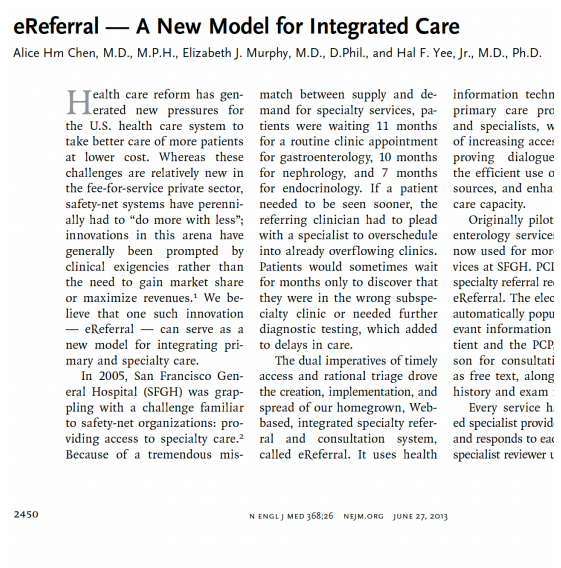
Appendix

https://www.healthaffairs.org/content/forefront/california-s-marketplace-innovations-driving-health-plan-accountability-quality-and



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