IMPROVING HEALTH OUTCOMES THROUGH PREVENTION

PAPER 1: INCLUDING PREVENTION IN VALUE-BASED HEALTH CARE MODELS

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Shannon Haffey
American Medical Association

Jason Hirschi
Leavitt Partners

Katherine Kitterman
Leavitt Partners

Brent Palmer
Leavitt Partners

LEAVITT
PARTNERS

Health care organizations engaged in value-based or alternative payment models must invest in prevention in order to reduce the burden of chronic disease and improve the health of the nation. Fundamental changes in public and private payment models can reduce barriers in the current payment system and provide better support for delivery of high-quality, efficient care. Success under these models should extend to not only the delivery of care for those who are ill but also to those at risk *before* the onset of chronic disease. Value-based alternative payment models can provide optimal arrangements to identify and support individuals in the rising risk category, a population that has not been prioritized in the value-based payment models that have emerged to date.

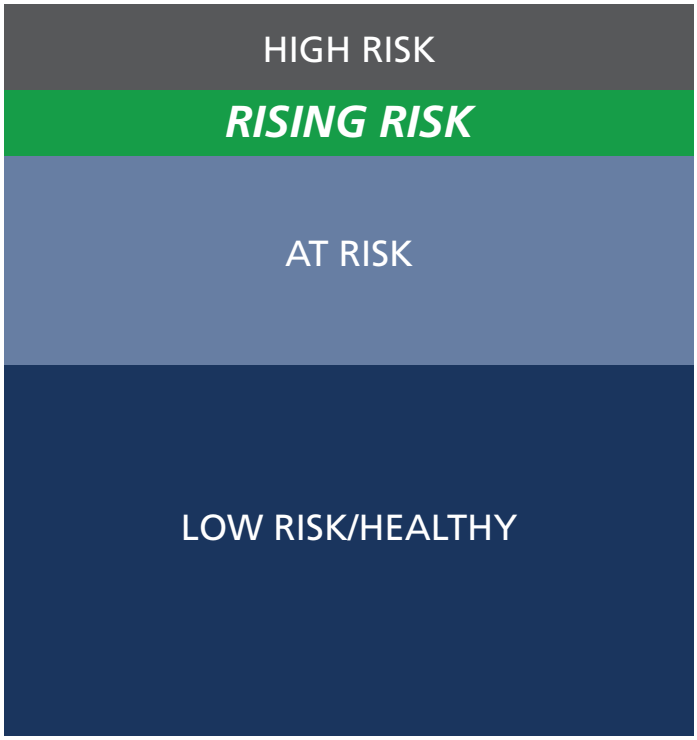
Value-based payment models should be optimal for investing in prevention as these contracts can provide physician practices with the flexibility to devote resources to high-value services, such as proactive outreach to patients at risk, which can reduce the unnecessary use of expensive services in the future. However, most contractual arrangements are still in nascent stages and focus on a small segment of the whole population that accounts for a high proportion of health care spending: those who are already sick. If those in the "rising-risk" category are not identified and treated early, any gains that value-based arrangements make for the sickest patients will be eclipsed by progression to chronic disease among those in the rising-risk population. **To succeed, value-based models need to broaden their focus to include identifying the rising-risk population and proactively incorporating interventions to prevent exacerbations of unmanaged chronic conditions.**

Chronic disease accounts for seven out of 10 deaths each year in the United States,[1] and the nation's spending on chronic conditions accounts for 86 percent of health care costs.[2] Chronic conditions are costly and common; however, they are largely preventable and certainly manageable. There are evidence-based interventions to combat progression to chronic disease, but these interventions are underutilized. Health care delivery today is directed downstream—once the chronic condition presents itself—resulting in intensive and costly disease management and adverse events. More can be done to help patients avoid chronic disease, beginning with identifying who is in the rising-risk category and understanding what can be done to help them proactively before their ailment progresses to a chronic condition.

When organizations begin moving to value-based payment arrangements, they often stratify their population in order to better understand risk and build decision support. Figure 1 represents how a health care organization might stratify their population.

- **High risk.** Historically, health systems and practices have been able to most readily identify patients with high risk because they are the population ***with chronic condition***s that most often seeks care. Provider organizations with value-based contracts typically focus their initial efforts on the chronically ill, since this population utilizes more health care services and managing their chronic conditions is

FIGURE 1.



[1] Centers for Disease Control and Prevention. Death and Mortality. NCHS FastStats website. http://www.cdc.gov/nchs/fastats/deaths.htm. Accessed Dec. 20, 2013.

[2] Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook.[PDF] AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality; 2014. Accessed Nov. 18, 2014.

costly. Improving the quality and cost of care for this population is most directly rewarded under current value-based contracts, such as shared savings arrangements. However, as these arrangements evolve, organizations are turning their attention to the other population segments as well.

- **Low risk/healthy.** Patients in the bottom population segment are those with no or ***very low risk*** of becoming chronically ill. Value-based arrangements encourage (and often cover) annual wellness visits and screenings that can engage this population. Wellness programs have flourished in recent years, particularly at large corporations and within health care systems and some advanced primary care practices. Value-based arrangements will continue to ensure this population receives clinically appropriate screenings, vaccinations, and wellness visits to help establish relationships with physicians and care teams.
- **At risk.** Most concerning are people in the middle band of Figure 1, those with clinically ***identifiable risk factors*** that can progress to chronic disease without intervention. Failure to actively manage this population carries a high risk for organizations in value-based arrangements, as the influx of new chronic condition diagnoses may outpace any gains made in disease management for the high-risk segment.
- **Rising risk.** The at-risk population can be further segmented to identify those with ***rising risk***, or those most likely to progress to a chronic disease in the near term. These individuals would benefit from targeted identification, conversations with a clinical care team and evidence-based preventive interventions. However, at-risk individuals are not always identified and educated about their risk, so they often do not use the preventive services that could deter them from acquiring a chronic disease.

Value-based arrangements designed for population health could enable identification and activation of those in the rising-risk category, improving health and reducing costs by preventing chronic disease. These payment models are designed to reward better outcomes while, at the same time, improving the management of resource allocation to better serve patients. Ideal services under value-based models are those that not only improve health, but also cost less. Preventive interventions do exactly that—they prevent progression to chronic disease and generally cost less than disease management.

However, the current design of many value-based contracts does not actually incentivize investments in prevention for the rising-risk population. Several limitations in today's value-based contracts are:

- Annual performance periods require that improvements are demonstrated within a single year. Most evidence-based lifestyle change programs take time and may not demonstrate impact within that narrow window.
- It is difficult to quantify the savings and assign credit for utilization and spending that did not occur due to provision of preventive services.
- Most quality measurements are focused on patients with chronic conditions and not those at risk of developing them.
- Financial payment arrangements are still largely based on fee-for-service, which is, in turn, generally linked to payment for acute episodes, not prevention or long-term management of chronic conditions. To be considered value-based the contracts often include incentives such as bonuses for outcomes or shared savings for reducing total cost of care or upfront care management fees. Unfortunately, the "total cost of care" is still based on the *services rendered*, although ideally at a lower unit price. This means that if a patient avoids diabetes entirely—thus bypassing associated diabetes care—those services may not qualify for the same incentives as delivering higher-quality, lower-cost diabetes care to a diabetes patient. Similarly, if management of a chronic condition prevents the condition from advancing to a more severe stage or prevents complications such as kidney disease, it is difficult to assign credit for the advanced disease that did not occur.

Despite the aforementioned challenges and limitations, organizations with value-based contracts are expanding their population health services to include evidence-based prevention for the rising risk.

[4] Medicare Access and CHIP Reauthorization Act of 2015. 114th Congress (2015-2016). Accessed Aug 2016.

New and proposed payment models outline a path to reward organizations for caring for whole populations and preventing chronic disease. The proposed Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform includes opportunities to incorporate preventive services:[3]

- Under the Merit-Based Incentive Payment System (MIPS), physicians and organizations can engage in clinical practice improvement activities to identify and manage those in the rising risk category, including:
  - o Engaging in activities that improve both the health status of communities and specific chronic conditions, which include partnerships with community partners
  - o Participating in a Centers for Medicare & Medicaid Services Innovation (CMMI) model, such as the Million Hearts Campaign
  - o Using evidence-based protocols for specific conditions to improve a patient's health
- Under alternative payment models (APMs), MACRA provides for the creation of new physician-focused APMs that will allow physicians to focus their resources on prevention and management of chronic conditions for patients in the rising-risk category. Like the population health models implemented to date, new models under development will focus on populations of patients who are at risk for or need closer management of particular conditions, such as diabetes and cancer.

For example, in listing the alternative payment model proposals in which it is most interested, the Physician-Focused Payment Model Technical Advisory Committee created by MACRA includes:

- Payments designed to enable physicians to improve care for particular subgroups of patients, e.g., patients with a severe form of a condition, patients who have an early stage of a condition where progression can be more easily prevented, patients who need special services after treatment, patients living in very rural communities, etc.
- Payments designed to enable a primary care physician or a multi-specialty group of physicians to improve care for most or all of the health conditions of a population of patients, or to prevent the development of health problems in a population of patients with particular risk factors.

In addition, PTAC documents state that the committee will be more likely to recommend proposed models that include specific mechanisms for ensuring that patients receive evidence-based services for the health condition(s) or for the delivery of the preventive or treatment service(s) that are the focus of the model.

Today's value-based payment arrangements can serve as a stepping stone toward population health by encouraging providers to take an upstream population approach. This involves physicians and care teams identifying the rising-risk population and referring eligible patients to evidence-based preventive interventions that will reduce the risk of developing chronic disease. By addressing the needs of the rising-risk population, value-based arrangements can begin to drive down the burden of costly and resource-intensive chronic condition management.

For example, 86 million American adults have prediabetes and are in the rising risk category for progressing to type 2 diabetes, but only 10 percent of these people actually know of their risk.[4] Most of this population cannot take advantage of evidence-based prevention programs such as the National Diabetes Prevention Program (National DPP).[5] The American Medical Association has partnered with the Centers for Disease Control and Prevention to spread the National DPP and research has shown that completion of the program—achieving 5–7 percent weight loss—translates to a 58 percent reduction in the onset of diabetes.[6] Type 2 diabetes affects more than 29 million American adults,[7] and costs $7,900 per patient annually to manage.[8] Conversely, the National DPP costs an average of $450 per participant per year.[9] The Centers for Medicare & Medicaid (CMS) announced a path to coverage for Medicare beneficiaries, based on the fact that the intervention improves outcomes and has projected cost savings for Medicare.[13] Applicable to value-based arrangements, the proposed 2017 Medicare fee schedule regulation even proposes reimbursement for the National DPP (called "MDPP"

[3] Medicare Access and CHIP Reauthorization Act of 2015. 114th Congress (2015-2016). Accessed August 2016.

under Medicare) based on participants' achieved health outcomes.[10]

The National DPP is a good example of a prevention program that aligns with value-based arrangements for the following reasons:

- Contracts can include quality measures for the identification of the rising risk and improved health outcomes, such as the number with prediabetes.
- Data queries can produce registries of the rising risk.
- Physicians and care teams can talk to patients and refer them to programs like the National DPP.
- Financial incentives can move towards total cost of care, where health systems can share in their savings.

As value-based models mature, more organizations engaged in those models will turn to focus on upstream populations, incorporating prevention strategies to identify rising-risk patients and prevent the onset of chronic conditions. When these models include screening measures for clinically identifiable risk factors, such as prediabetes, they will help millions of individuals already covered under the models to understand their individual risk and access evidence-based prevention programs. Emphasizing ***prevention*** in value-based models could be the key to bridging current efforts that address the quality and cost structure of care. To improve health and the outlook of health care in our nation, value-based arrangements need to set an example. Leaders can look beyond short-term opportunities and halt the trend of increasing chronic disease and the burden it places on patients, families, physicians, practices and business. If leveraged correctly, value-based models can better align priorities to identify the rising-risk population and provide preventive care before it is too late.

[4] Centers for Disease Control and Prevention. About Prediabetes & Type 2 Diabetes. January 2016. https://www.cdc.gov/diabetes/prevention/prediabetes-type2/index.html

[5] Diabetes Prevention Program Research Group, Knowler WC, Fowler SE, Hamman RF, Christophi CA, Hoffman HJ, Brenneman AT, Brown-Friday JO, Goldberg R, Venditti E, Nathan DM. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. Lancet. 2009;374(9702):1677–86. doi: 10.1016/S0140-6736(09)61457-4. Epub 2009 Oct 29.

[6] National Institute of Diabetes and Digestive and Kidney Diseases. Diabetes Prevention Program (DPP). NIH Publication No. 09–5099, 2008. http://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/Documents/DPP_508.pdf. Accessed June 17, 2016.

[7] American Diabetes Association. Statistics About Diabetes. May 18, 2015.

[8] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2012. Diabetes Care. 2013 Apr; 36(4): 1033-1046. http://dx.doi.org/10.2337/dc12-2625

[9] Avalere report.

[10] Draft physician fee schedule

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