AHCCCS Payment Modernization
Blog # 6

Value Based Purchasing in the Spotlight

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Following passage of the ACA, CMS launched the CMS Innovation Center (CMMI). CMMI has established dozens of innovation models to incentivize and accelerate value based models and care delivery and payment. Now their work is receiving increased focus.

On January 26 HHS Secretary Burwell announced that with support from key stakeholders HHS has set

> *Measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.*

By 2016, 30% of Medicare fee for service [FFS] payments will be tied to alternative payment models such as ACOs or bundled payment; 50% by 2018. Also, by 2016, 85% of traditional Medicare FFS payments will be tied to **value based purchasing programs** such as the hospital readmissions reduction initiative Medicare Value Based Purchasing Sur [*Ctrl+Click the icon for a summary*]. The announcement received significant mainstream media attention, accompanied by a significant effort by HHS to reach providers.

In response, a task force of major providers and payers announced their commitment to have 75% of their business in value based arrangements by 2020, including recommendations enhancing ACOs for commercial, Medicare, and **Medicaid** programs.

With its description of the initiative, HHS, along with key stakeholders, is advocating the beginning of the end of FFS with the transition to value based models. Few argue with rewarding high quality, increasing care integration and coordination, and improving interoperability of patient information. However, as many observers note, practical barriers to system change are a complicated process, perhaps most significantly defining "value". Others question if there is sufficient actuarial risk to providers associated with the CMS initiatives to spur transformation.

With the apparent support for the HHS initiative, it appears that key stakeholders recognize that continuing the current payment and delivery system unsustainable. Experts such as Michael Porter believe that ultimately providers are the key to transformation.

> *Providers that cling to today's broken system will become dinosaurs. Reputations that are based on perception, not actual outcomes, will fade. Maintaining current cost*

> *structures and prices in the face of greater transparency and falling reimbursement levels will be untenable.*

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Smoking Cessation: Better Outcomes, Lower Costs

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It's been over 50 years since smoking was officially declared a health hazard. But 50 years later, smoking still accounts for 9% of all healthcare spending according to the CDC. For **Medicaid**, it's **15%**.

Under the ACA, smoking cessation is a required private plan benefit including coverage for at least two quitting attempts per year, and all FDA approved anti-tobacco medications. Smoking cessation therapy continues as a required **Medicaid** benefit, including in AHCCCS policy (320-27) which enables members to receive a 12 week supply of tobacco use medications or nicotine replacement therapy (NRT) in a 6 month time period, and encourages enrollment the ADHS smoking cessation services.

Researchers continue to confirm the benefits of quitting, even in middle age.

> *A focus on cessation of smoking is justified, since quitting smoking before the age of 40 years, and preferably much earlier, will reduce by about 90% the decade of life that is lost from continued smoking. Smoking is associated with a decade of lost life, and cessation reduces that loss by about 90%.*

In addition to NRT, new research is finding positive outcomes for a new, less expensive medication, cytisine.

Smoking is related to eye disease, and cancer of the skin, pancreas, and bladder, in addition to others including lung and heart disease.

Smoking cessation is a value based service. With the great cost of smoking to the health care delivery system, the high return on smoking prevention efforts, and the relatively low cost of nicotine addiction treatment, should more be done? Medicare recently decided to cover lung CT scans for older smokers.

There are no silver bullet solutions. However, Research has shown that

> *Health care providers, including physicians, nurses, psychologists, dentists, counselors and others, can make an important contribution toward increasing quit rates—and protecting the health and lives of their patients. All clinicians should screen patients for tobacco use, strongly advise smokers to quit and provide at least brief behavioral counseling and medication advice.*

More on Episodes & Bundles

Bundled Payment: Learning From Our Failures Bundled Payment, also known as Episodes of Care have been implemented over the past few years in varied settings and for varied conditions. Feedback and lessons learned are becoming increasingly available.

UnitedHealth launches pilot payment program at MD Anderson Cancer Center United Health recently announced a partnership with MD Anderson to pay for complex head and neck cancer care utilizing bundled payment. If successful they anticipate expanding to more common types of cancer care.

How Should We Pay for Health Care? In this recent white paper, Michael Porter, presents his conclusion that bundled payment is the only model that aligns providers, payers, and suppliers to increase patient value. Recent improvements in outcomes and cost measures make widespread use of bundles possible, including for chronic conditions.

The Payment Reform Landscape Does bundled payment improve quality and affordability? According to Catalyst for Payment Reform CEO Suzanne Delbanco, no large scale study has been done to answer the question for private sector initiatives, although some smaller studies show positive results. Medicare's BPCI initiative does not yet have conclusive results.