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June 2023 VOL. 33 NO. 6

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REALITY CHECK

Alternative payment models are still coming into focus, but so far, they haven't lived up to the high expectations.

By **DEBORAH ABRAMS KAPLAN**

The CMS Innovation Center has launched more than 50 alternative payment models (APMs) since it was established in 2010 as part of the Affordable Care Act. The models have involved approximately 28 million patients and half a million providers and plans, and all signs point to expanding the concept. The CMS Innovation Center announced in 2021 that it wanted every Medicare member with Part A and B coverage to be in a healthcare relationship with accountability for quality and total cost of care by 2030.

It's not just government payers. Kaiser Permanente and Geisinger Health recently made news when they announced that California-based Kaiser would acquire and move Geisinger, a central Pennsylvania health system, into the newly formed Risant Health, which media reports say may eventually add five to seven more systems like Geisinger. Both Kaiser and Geisinger are among the leaders in value-based care and using technology and preventive care to reduce specialty care and hospital needs.

But are APMs working? Is value-based care the future? Not everyone thinks so.

"There's been a lot of hype that our country is moving to alternative value-based payment models. For the most part, we still pay the same way we've always paid," says Robert Berenson, M.D., a fellow at the Urban Institute Health Policy Center in Washington, D.C., and former vice chair of the Medicare Payment Advisory Commission. "And I also like to believe that a lot of the push for value-based payment models has been promulgated by those who want to leave their basic payment models alone when they are long overdue for reform. As long as everybody's running around looking for new payment models, we're going to ignore the flaws in the existing (fee-for-service) payment models, which still is how more than 90% of the money is getting paid."

Berenson may seem to be exaggerating but that's an accurate figure, according to the Health Care Payment Learning & Action Network, which measures participation in APMs. Its 2022 report showed that 92.6% of payments from all payers in 2021 were fee for service. About 20% of those payments were tied in some way to quality and value, but 40% of payments were not.

ARRIVING AT A DEFINITION

Part of the problem with APMs is a common one in U.S. healthcare delivery: People often attach the same name or label to different things or, conversely, different names or labels to the same thing. CMS has a very broad definition for APMs as "a payment approach that gives added incentive payments to provide high-quality and cost-efficient care" that might bring payment with even marginal ties to quality and cost under the APM heading. Further muddying waters is that APM is often used interchangeably with "value-based care model," when some think value-based model should be reserved for delivery systems that use APMs.

Catalyst for Payment Reform, a nonprofit working with purchasers, prefers value-oriented to value-based payment "because the base is still fee for service in most cases," observes Andréa Caballero, M.P.A., Catalyst's program director and interim co-executive director. "We define it as any kind of payment with incentives to improve quality, reduce waste, and improve or do appropriate utilization." Any payment without a quality component does not meet their model.

"I don't think value-based payments have any meaning at all at this point," says Berenson. "Some people think of it as about saving money, and other people emphasize quality improvement. I don't have a good definition of an APM other than it's different than the legacy payment."

DON'T ROCK THE BOAT

Although there will be always some debate about the metrics used, not many of the 50 CMS Innovation Center APMs can be celebrated as triumphs. A successful payment model should, ultimately, bump up the quality and cost-effectiveness of healthcare while also improving patient satisfaction, says Melissa Sherry, Ph.D., M.P.H., vice president of social care integration at Unite Us, which sells technology to identify, coordinate and track social care. Successful payment models encourage clinicians to treat the whole person and offer enough flexibility that physicians can align with patient goals to improve care. The result should be innovation that drives better health outcomes for patients and reduces healthcare spending over the long term.

Most APM evidence and documentation comes from the CMS Innovation Center. "Quality is fundamental to success. I'd love to say lower costs, but the evidence isn't there," says Caballero.

The CMS Innovation Center published its 2022 Report to Congress, noting that only six of its tested models "delivered statistically significant savings, net of any incentive or operational payments." The six exceptions to the rule were the Pioneer Accountable Care Organization (ACO) Model; ACO Investment Model; Medicare Prior Authorization Model: Repetitive, Scheduled Non-Emergent Ambulance Transport; Home Health Value-Based Purchasing Model; Maryland All-Payer Model; and Medicare Care Choices Model.

It is difficult getting a handle on the track record of commercial insurers' APMs. "There is limited evidence in the commercial market that (they) lower cost," says Caballero. The problem with commercial programs, she says, is that they do not conduct independent program evaluations. She has "healthy skepticism" about evidence shared in most commercial markets because these payers do not share raw data or the data from which they draw their conclusions. Unless evaluations are done by academics or an independent third party, it is hard to trust the results.

Sharing information is not in the interest of organizations in the private sector of U.S. healthcare, comments Berenson. "If you actually do have a smarter mousetrap, you don't tell anybody at a quasi-competitive health system."

Besides, commercial payers don't have much incentive to go all in on APMs, say some experts, because individual plans don't have enough market share to truly influence provider behavior. When a payer covers, say, 10% of a provider's patients, even the most attractive advanced payment model can accomplish only so much, say health insurance industry observers.

Berenson says most insurers aren't really interested in rocking the boat. "I think insurers are fairly complacent with the status quo," he says. "They don't have to improve value. They just have to have a bottom line that they're trying to achieve."

Some lessons learned

Experts say the successes and failures of alternative payment models (APMs) over the past decade have taught us a few things.

UPSIDE VS. DOWNSIDE RISK

The more successful programs include those with a path to risk. With upside risk, providers only gain if they exceed expectations on quality, cost or other metrics, says Corinne Lewis, program officer for delivery system reform at the Commonwealth Fund. Providers can lose revenue if they fail to meet goals with downside risk. "Evidence suggests that models using both have better outcomes," Lewis observes, because the risk of losing revenue can be a strong influence and "more motivation than a carrot." In Lewis' opinion, when designing a program, downside risk should be voluntary because it can prevent a provider from joining the program. Payers can create on-ramps to increase participation in these programs, easing providers in and providing the right incentives for meaningful change, Lewis says.

CMS is committed to moving more providers to downside risk arrangement, says Andréa Caballero, M.P.A., program director and interim co-executive director for Catalyst for Payment Reform, a nonprofit working with purchasers. Even though commercial insurers' APMs may mirror some CMS programs, they usually can't go as far as CMS APMs and must rely on upside-only arrangements. "What is going to push a provider system to negotiate lower prices and take an APM? They have very little incentive to do that," says Caballero.

PRIMARY CARE ADOPTION

The U.S underinvests in primary care, which can result in higher specialist and hospitalization costs. A report from Milbank Memorial Fund showed that in 2020, primary care spending in the U.S. across payers was 4.6% compared with 7.8% of primary care expenditures by Organization for Economic Cooperation and Development nations in 2016.

Although spending on primary care services accounts for a relatively small proportion of healthcare spending, "the primary care physician calls actually direct the vast majority of the total," says Miles Snowden, M.D., M.P.H., chief growth officer and executive vice president of physician strategy at Navvis. The population health value-based care company helps practices, mostly in primary care, adopt APMs. He says the practices they work with are experiencing success "and significant financial rewards" from directing overall patient care and doing it well.

Failure in these models occurs when primary care physicians don't comply with the common governance and single compensation model that relies on physicians doing the same thing, according to Snowden. Physicians need to stay accountable to a common uniform process instead of

WINNERS AND LOSERS

Even if fee for service has shown staying power and the APMs have fallen short, experts see some bright spots here and there.

The ACO model has been one of the most successful APMs at improving quality and lowering costs, says Corinne Lewis, M.S.W., program officer for delivery system reform at the Commonwealth Fund. ACOs led by physician groups have performed better than hospital-led ACOs in terms of greater savings. One of the main reasons is that physician groups offer a narrower set of services. Lewis says that the role of primary care providers in managing complex patients is important in ACO models and that evidence shows these models perform better on cost, quality and health outcomes than those without advanced primary care design features. These models enable providers to work together, incentivizing them to provide the right care at the right time. "When given payment upfront for each patient, they can spend it in a way to improve care and experience — in ways they typically couldn't under fee schedules," Lewis says. That includes screening for and addressing patients' social needs.

Berenson points to Medicare Shared Savings Program (MSSP) ACOs as one of the successful APMs. Section 3022 of the Affordable Care Act created the MSSP program. Unlike most of the CMS APMs, it isn't a CMS Innovation Center demonstration project, and Berenson says he believes that is one of the reasons for the relative success of the MSSP ACOs. "Demonstration (projects) affect too few providers and have too many tracks," he says. "You have to meet a threshold of either increasing quality at no increased cost or reducing costs with no diminution in quality. That's a high bar for some kinds of reforms, like for primary care." He says that primary care can't immediately lower costs, but it can do a lot to improve access to care.

Bundled payments, which pay for episodes of care rather than on a per-patient basis, have shown promise but are difficult for commercial insurers to scale, notes Caballero. Scaling is difficult because only 2% to 3% of healthcare spending is through bundled payment, she

going their own direction. "That's really common when a group of physicians who are fiercely independent stay fiercely independent," he says. If the providers or practices tweak their population health management interventions, it can result in inefficient operations. "Consistency, uniformity, scale. These are the things that are necessary," Snowden says.

Primary care may do better with a mix of capitation and fee-for-service models, says Caballero, noting the devastation experienced by some primary care practices during the early pandemic. Some had to close practices or lay off staff in large part because they relied on the delivered services payment method, she says. "When people stopped seeing them, they didn't get paid." Primary care has a good motivation to use APMs.

SPECIALIST CARE AND MIXED PROVIDER MODELS

The greatest success has been seen in accountable care organizations, with a contained system of inpatient, outpatient and specialty care. "If you're going to try to address total healthcare spending for a population, you need to include all components," says Caballero. But as long as providers coordinate with each other, they do not have to be in the same organization, and the accountable care organization can still address utilization.

Independent specialists have less of an incentive to get involved in APMs than primary care or multidisciplinary groups because they have leverage. "They don't have a reason or motivation to change how they're paid," Caballero says. As part of a system, when they have the same interests as primary care physicians and hospitals, the interests may align.

QUALITY METRICS ALIGNMENT

A big challenge in implementing APMs is alignment across payers. Providers treat patients covered by a variety of insurance types. "Providers, understandably, don't want to provide different standards of care for different patients," says Robert Berenson, M.D., a fellow at the Urban Institute Health Policy Center and former vice chair of the Medicare Payment Advisory Commission. There needs to be a tipping point, enough market share to entice them to adopt a new model.

Part of the confusion is over quality metrics. "Today we manage over 500 distinct quality metrics. That's ridiculous," says Snowden. When each payer has its own model with distinct metrics, it is difficult to administer. "Getting down to the few that matter is foundational to being successful in these models."

Determining the right quality targets for each practice is also important if high-performing providers want to move into downside risk or shared savings arrangements. Determining those quality benchmarks are important, says Caballero, especially for practices for which there is little room for improvement.

—Deborah Abrams Kaplan

adds. "It's just not making a dent," she says. "It doesn't have the volume or money that an ACO shared savings program has."

As for less successful APMs, "we don't know because they're not published," says Caballero. Programs by commercial insurers selling coverage to private employers start and stop, and there's no benefit to broadcasting news about the setbacks. As for CMS Innovation Center programs, most have not shown success at markedly lowering costs.

Lewis mentions that CMS' Comprehensive Primary Care Initiative, which had 500 primary care participants, has not produced significant savings reductions or improved quality, although she is willing to cut it some slack: "These often take time, and it is difficult to realize big changes in a couple-of-years period."

Berenson, who oversaw Medicare payment policy and managed care contracting at CMS from 1998 to 2000, notes: "There's all these demos going on, which have mostly failed." Changing the Medicare physician fee schedule to boost the payment for primary care services would be more effective than APMs, he says.

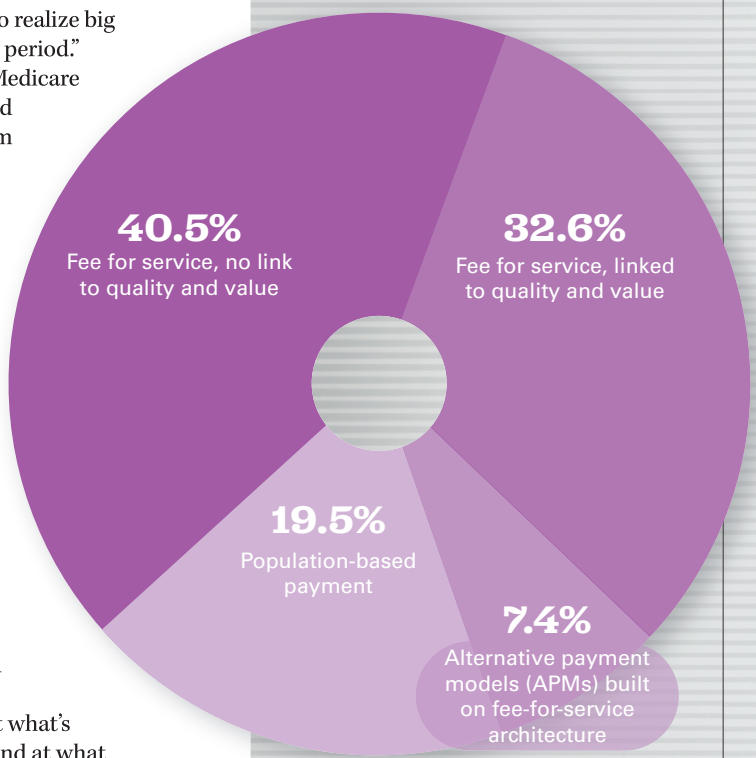
It is difficult for commercial insurers to lower costs or utilization overall, partly because the commercial market has high prices relative to the public payers. "Any APM in the commercial market won't solve the cost problem itself," says Caballero.

It also may help to look at what's working in other countries and at what has been done in the past in the U.S. to refine payment systems. "Improve our legacy payment models by making important changes in them" is Berenson's prescription. He floats the idea of a hybrid payment model for primary care physicians as well as increasing rates in the physician fee schedule. He also sees the labels as counterproductive: "Just make improvements. Don't label them as alternative payment models or value-based payment models." ◻

Deborah Abrams Kaplan *writes about medical and practice management topics for* Managed Healthcare Executive *and other publications.*

Fee for service has staying power

Although alternative payment models have been talked for years, fee for service still dominates healthcare payment



Based on 2021 data from 63 health plans, five fee-for-service Medicaid states and traditional Medicare, representing about 233 million covered lives

Source: "APM Measurement: Progress of Alternative Payment Models," Health Care Payment Learning & Action Network

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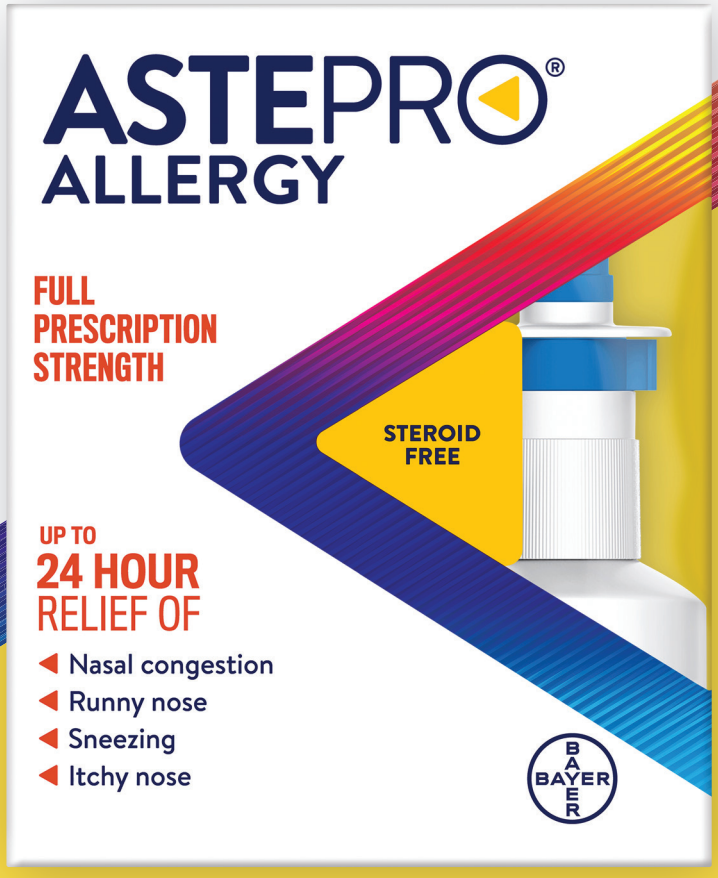

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