Value-Based Vascular Care: What’s it Gonna Take?

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Conflicts of Interest

- **Consultant**
  - Abbott Vascular (non-compensated)
  - AOPA
  - Boston Scientific (non-compensated)
  - Cordis Corporation (non-compensated)
  - Medtronic (non-compensated)
  - Micell, Inc
  - Novella (DSMB)
  - Primacea
  - Venarum
  - Volcano/Philips

- **Equity**
  - Embolitech
  - Janacare, Inc
  - MC10
  - Northwind Medical, Inc.
  - PQ Bypass, Inc
  - Primacea
  - Sano V, Inc.
  - Vascular Therapies, Inc

- **Board Member**
  - VIVA Physicians (Not For Profit 501(c) 3 Organization)
    - www.vivapvd.com

March 2017
Thank You

4th Annual National Scientific Meeting

Loews Santa Monica Beach
March 31 – April 2, 2017
Aren’t We Living in a Completely Crazy Time in U.S. Healthcare?

In Major Defeat for Trump, Push to Repeal Health Law Fails

By ROBERT PEAR, THOMAS KAPLAN and MAGGIE HABERMAN  MARCH 24, 2017

WASHINGTON — House Republican leaders, facing a revolt among conservatives and moderates in their ranks, pulled legislation to repeal the Affordable Care Act from consideration on the House floor Friday in a major defeat for President Trump on the first legislative showdown of his presidency.

“We’re going to be living with Obamacare for the foreseeable future,” the House speaker, Paul D. Ryan, conceded.
We Spend More on Healthcare Than Anything Else

Total Federal Budget $3.5trn

- Social Security $915bn 26%
- Defense $800bn 23%
- Education $103bn 3%
- Other Healthcare $108bn 3%
- Medicaid $302bn 9%
- Medicare $512bn 15%
- Welfare $370bn 10%
- Protection $33bn 1%
- Interest $229bn 6%
- Transportation $92bn 3%
- General Government $44bn 1%
"It's the only treatment option he has under his current health plan."
The Future of Healthcare Spending?
Most U.S. health-care spending is for a small number of very expensive patients.

- Most expensive 1% of patients: 21% of health spending
- Most expensive 5%: 49%
- Most expensive 10%: 65%
- Most expensive 15%: 75%
- Most expensive 20%: 82%
- Most expensive 50%: 97%
...and this isn’t going to get any easier

Age-Adjusted Percentage* of Adults Aged ≥65 Years,† by Number of 10 Selected Diagnosed Chronic Conditions§ and Poverty Status¶ — National Health Interview Survey, 2013–2015

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5 Respondents were asked about the following 10 selected chronic conditions: hypertension, coronary heart disease, stroke, diabetes, cancer, arthritis, hepatitis, chronic obstructive pulmonary disease (COPD), weak or failing kidneys during the past 12 months, and current asthma. COPD was defined as ever having COPD or
What Does the 2017 External Environment Look Like?

**Affordable Care Act**
- Repeal/replace

**Medicare**
- IME payments
- Rural floor/area wage index
- ACOs
- MACRA
- Rx costs

**Medicaid**
- Change the MA waiver?
- Block grant proposal
- Rx costs

**NIH**
- Reduced funding?
- Geographic distribution
- Earmarking

**Price Variation Commission**
- Proposals that target Partners
- Transparency, consumer-focused changes
- Distressed hospitals
- Insurer proposals

**Budget**
- Provider caps
- Employer penalties

**HPC/CHIA**
- 3.6% cost growth benchmark
- Market impact reviews
- Annual reports

**Attorney General**
- Investigations
- Reaction to HPC
- Anti-trust

**Medicaid**
- Protect the MA waiver
- ACO transition
- NHP
- Rx costs

**Labor**
- Ballot initiative

**DPH**
- NSMC campus update
- DON rules

**Federal**

**State**
Where Do Health Care $$$ Go?

Total U.S. Health Spend $3.0trn

- Hospital Care: $972bn, 32%
- Physician and Clinical Services: $688bn, 23%
- Dental Services: $114bn, 4%
- Home Health: $83bn, 3%
- Nursing Care: $156bn, 5%
- Medical Products: $103bn, 3%
- Prescription Drugs: $298bn, 10%
- Other: $150bn, 5%
- Research and Investment: $154bn, 5%
- Insurance and Govt. Admin: $314bn, 10%
… and who costs more?
We Spend More on Healthcare Than Any Other Nation
Why? Too Many Doctors?

Nope!

[Bar chart showing the number of Practicing MDs per 1,000 pop, MD consultations per capita per year, and Practicing nurses per 1,000 pop. The chart compares the U.S. with the OECD Median.]
Too Much use of Hospital Resources?

Nope!
Maybe Overuse of Procedures?

![Bar chart showing coronary artery bypass graft cases per 100,000 population for different countries.](chart.png)
It’s Actually Just That Stuff Costs More in the U.S.

A Day in the Hospital

- U.S.: $2,000
- OECD Median: $1,000

Drugs

- U.S.: $1,200
- OECD Median: $600

Medical Devices

- U.S.: $5,000
- OECD Median: $2,500
Major Trends Impacting the Market Landscape

**Buyers**
- Breath-taking changes in Federal and state regulations push towards value and risk-based payment

**Employers**
- Employers shift cost via high deductible plans; test private exchanges and direct contracts with providers

**Suppliers**
- Insurers push cost to patients via tiered and narrow networks and cautiously increase provider risk
- Increased consolidation and new partnership models
- Facing cost containment pressure and re-tooling to manage risk, providers consolidate and partner to acquire new capabilities and scale

**New Players**
- Innovative health offerings address patients’ demand for access, convenience and transparent costs
High deductible health plans (HDHPs) continue to increase however, at a faster pace nationally than locally

Source: Pricewaterhouse Coopers. "Health and Well-being Touchstone Survey Results, June 2015"

Research has shown that high deductible plans and co-pays reduce both necessary, preventive care and elective care

Source: http://www.chiamass.gov/massachusetts-health-insurance-survey/
National insurers increasing scale through mergers and partnerships to gain scale and cost efficiencies

<table>
<thead>
<tr>
<th>Insurer Mergers</th>
<th>Insurer Provider Partnerships</th>
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</thead>
</table>
| • Insurers justify mergers as way to increase access, quality and affordability  
• Consumer advocates caution that will increase premiums and reduce provider reimbursement | • Insurers partner with providers to jointly develop ACO and other programs to increase cost efficiencies  
• Providers expand into insurance sector for opportunity to manage the entire healthcare dollar |

Source: Hospital Impact Article Sept. 2015
Innovations in healthcare technology continue to capitalize on the inefficiencies & inconveniences associated with traditional delivery models

“Let’s play health care!”
For Now Hospitals are Consolidating to Combat Growing Strategic, Economic and Regulatory Pressures

• Broader service reach
• Economies of scale
• Volume to Value focus
What is Driving Consolidation?

• Increasing margin pressure
  – Government
  – Commercial payers
  – Medical inflation costs for technologies, labor, drugs and supplies
  – Heightened regulatory scrutiny around fraud

• Increasing competition for healthcare dollars
  – Increased competition from niche players for economic efficient patients
  – Mergers with greater complexity
  – Acquisitions with greater frequency

• Physician Employment
### Physician’s Movement

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Employed Physicians</th>
<th>Number of Practices</th>
</tr>
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<tbody>
<tr>
<td>2012</td>
<td>95,000 (26%)</td>
<td>14%</td>
</tr>
<tr>
<td>2015</td>
<td>141,000 (38%)*</td>
<td>26%</td>
</tr>
</tbody>
</table>

In Midwest 49% of physicians employed*

Avalere; Physicians Advocacy Institute
Volume to Value
How Do We Get There?
Look at the Variable Pricing!
Poor Provider Response

- Reinforce RVU generation
- Exclude Physicians from policy
- Ration meds/devices based on price alone
- Focus on only profitable medical care
Optimal Provider Response

• Reinforce Value Care Providers
• Include Physicians input for policy
• Meds/devices based on data when possible
• Focus on patient optimized medical care
• Program Rationization
Program Rationalization

• Changing focus from Convenience to ”Right Care in the Right Place”
• Already has occurred EU
• Focused delivery of high priced or complex care
Historical Medical Device Market

- Hospital
  - Payor pays hospital for total procedure costs (usually including the device)
- Payor (Insurance Plan)
  - Payor pays doctor separately for performing procedure
- Manufacturer / Product
  - Hospital pays manufacturer for the device
  - Doctor chooses product to be used in procedure
- Doctor
  - 

In the historical medical device market, the payment structure involves:

- Hospitals paying the manufacturer for the device.
- Payors paying hospitals for total procedure costs, which usually include the device.
- Payors paying doctors separately for performing procedures.
Development of Office Based Labs May Be An Appropriate Competitor

• Reimbursement less
• Cost efficiency increased
• Patient satisfaction raised
• Can be more patient focused
What is the Perception of Some Regarding Office-Based Labs?

**TRENDS IN DISTRIBUTION OF PERIPHERAL AHERECTOMY (&ATH+STNT) BY PLACE OF SERVICE FROM 2011 TO 2014**

- **OUTPT ATH (and ATH+STENT)**: 47% in 2011, 42% in 2012, 38% in 2013, 44% in 2014
- **INPATIENT ATH (and ATH+STENT)**: 35% in 2011, 29% in 2012, 29% in 2013, 37% in 2014
- **PHYSICIAN OFFICE ATH (and ATH+STENT)**: 18% in 2011, 23% in 2012, 19% in 2014

Medicare PSPS Claims data (FFS data only)

Confidential, for Internal Use Only
Some Believe They Know How to Fix US Healthcare

THE STRATEGY THAT WILL FIX HEALTH CARE

Harvard Business Review October 2013
Potential System Based Value Model

Downsizing inpatient Beds, Increasing Neighborhood Care and Binding Services Lines Together Across System
From Volume...
...to Value
Value-based care means what ultimately is valuable to patients.

Sylvia Burwell, Secretary of Health and Human Services, recently announced the department’s intention to tie most Medicare fee-for-service payments to value by 2018. Nearly all commercial insurers already incentivize quality to some degree and encourage beneficiaries to consider quality and cost. Having payers aim for value should improve health system performance, certainly when compared with traditional incentives for the volume of services, which have failed to deliver the kind of care that is possible.

A century ago, these aspects of care would have been of little importance. Historically, people died within hours or days, or maybe a few weeks following becoming ill, after appearing to be fairly healthy. Now most people accumulate chronic conditions in old age. The typical 70-year-old person will need daily help from another person for an average of 2.7 years before dying, and this just to accomplish activities of daily living, including eating, dressing, and toileting.

Service delivery arrangements have neither adjusted to this new demographic reality, nor have measures of quality. People known to be dying soon are often included in...
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 510 and 512

[CMS-5519-IFC]

RIN 0938-AS90

Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs);
Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint
Replacement Model; Delay of Effective Date

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period; delay of effective date.

SUMMARY: This interim final rule with comment period (IFC) further delays the effective date of the
final rule entitled "Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac
With Such Tumult, You Must Have a Strategy

Why Strategy Matters Now
Michael E. Porter, Ph.D., and Thomas H. Lee, M.D.

Until recently, most health care organizations could get by without a real strategy, as most businesses understand that term. They didn’t need to worry about how to be different or make painful decisions about what not to do. As long as patients came in the door, they did fine, since fee-for-service contracts covered their costs and a little more.

Success came from operational effectiveness: working hard, embracing best practices, and burnishing reputations that attracted both patients and talent. Virtually every provider was included in most payers’ networks, and less profitable ones. Typically, “strategy” defaulted to having the scale and market presence to secure good rates and be included in networks.

But that era is ending. Good operational performance remains important, but reimbursement is decreasing and will often not cover full costs, as care for patients covered by public insurance accounts for a growing proportion of revenue sensitive to service quality and cost. Employers are increasing the pressure by demanding provider transparency regarding costs and quality and even by contracting directly with competitive providers. Having a good brand is no longer enough: patients and payers are looking for good value, service by service.

The time has come for health care organizations to rethink the meaning of strategy. Strategy is about making the choices necessary to distinguish an organization in meeting customers’ needs. Those choices revolve around six key questions (see table).
So, Work on What Will Always Win

• Quality
• Safety
• Efficiency/Value
• Outcomes
Quality, Safety and Outcomes for OEIS

Announcing the OEIS National Registry for Peripheral Vascular Intervention

The Outpatient Endovascular and Interventional Society (OEIS) Registry is focused on indications and outcomes measures for all office based endovascular and interventional procedures.