Healthcare 7 (2019) 24–25

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/healthcare

Interview

Engage specialists to achieve value in healthcare: An interview with Brookings Institution Fellow Kavita Patel

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Dr. Kavita Patel is a nonresident senior fellow at the Brookings Institution, where she was previously a managing director for clinical transformation and delivery. She served in the Obama Administration as the director of policy for the Office of Intergovernmental Affairs and Public Engagement in the White House. Dr. Patel was also a senior aide to Valerie Jarrett, President Obama's senior advisor, and played a critical role in policy development and evaluation of policy initiatives relating to health reform, financial regulatory reform and economic recovery issues. Dr. Patel is also a practicing primary care internist at Johns Hopkins Medicine and the medical director of Johns Hopkins-affiliated Sibley Primary Care.

SG: A primary focus of your work at Brookings and previously at the White House was payment reform. Where do we stand now with respect to the journey from fee-for-service towards value-based care?

Kavita Patel (KP): We are seeing more hype than reality in achieving value-based care. Some people argue that new payment models like Accountable Care Organizations (ACOs) represent "value-based care." I fall into the minority camp arguing that anything built on a fee-for-service payment structure is by definition not "value-based care."

I am a physician practicing within an ACO. We still aim to maximize fee-for-service revenue because that is where the plurality of money comes from. When I worked in the Obama Administration, Nancy-Ann DeParle, Secretary Sebelius, and the President spoke about value in healthcare as taking accountability for the health of a community and the total cost of its care. We still have a long way to go on that front.

One major untapped opportunity I see is engaging specialists. Many startups and programs talk about primary care physicians (PCPs) holding the multi-million-dollar pen. The notion is that the PCP can direct specialty care, but this does not hold true where I practice.

I practice in a staple of American medicine: a hospital-owned ambulatory physician group. We try to keep a tight network of where we send our patients for specialty care, but in a context of mixed primary-specialty, mixed-employee, mixed-systems, I cannot control the specialists my patients see.

For example, I have no insight into whether one of my patient's oncologists makes treatment decisions for lung cancer based on the cost-effectiveness of a PD1-inhibitor–which only offers a 2–3% improvement in life expectancy over 5 years. I could argue that we probably should not offer most patients that drug, but the evidence supports it and the oncologists see it as the standard of care. How these decisions are made in specialty medicine is a huge opportunity for achieving value-based care.

I think that the next generation of high-performing primary care practices are going to be multi-specialty groups that understand how to incentivize specialists to deliver cost-effective care, either legally with a professional services agreement or economically with a joint venture. Startups focused on redesigning primary care like Iora Health or Aledade will eventually have to rethink their business plan to allow specialists to get a cut of the savings.

AB: You mentioned the challenges posed by expensive therapies in oncology, and you have worked extensively on innovations in payment for cancer care. What are a few obstacles specific to successful value-based payment reforms in oncology?

KP: Mark McClellan and I scanned many specialties looking for cost savings opportunities in the Medicare program. We kept coming back to oncology. It is a big spend area. And, due to Medicare Part B regulations, oncologists receive substantial revenue from prescribing and administering oncologic therapies. We saw an opportunity to shift this revenue model. We sketched out the early versions of the Oncology Care Model, which has been live for two years now. The model pays oncologists as they would be paid for drugs, but also includes upfront coordination of care payments and rewards for managing total cost of care.

The model has encountered several barriers. First, you need providers to believe that the floor will not collapse under them if they participate in alternative payment models. We have had challenges getting doctors to feel comfortable with two-sided financial risk. Second, the changing nature of the drugs and their price tags is challenging. Spending on cancer drugs for Medicare beneficiaries with cancer has been increasing rapidly. Importantly, this higher spending is not necessarily translating to longer, healthier, higher-quality lives. Regardless of the marginal benefits of pharmaceutical innovation, the

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[1] Disclosures: SG reports no disclosures.

https://doi.org/10.1016/j.hjdsi.2018.09.002
Received 21 June 2018; Accepted 3 September 2018
Available online 07 September 2018

expense of new therapies, like CAR-T drugs and gene therapy for retinoblastoma, will be a key barrier to reducing total spending.

SG: You helped to lay the vision for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). What's one idea you had for the legislation that was not ultimately included?

KP: The incentive programs that are phased out by MACRA–Meaningful Use, the Value-Based Modifier, the Physician Quality Reporting System–needed to be updated. Where I disagree with the legislation is the lack of a focus on board certification. I wanted to improve the board certification process and revise the role of Continuing Medical Education.

As it stands, you can pick easy goals for clinical performance improvement activities. For instance, if I am good at diabetes management, I can select diabetes. I hoped to see something in MACRA that reflects whether you are keeping up with the latest evidence in your field. The law could have encouraged a learning health system, by helping someone get up-to-date with the latest evidence on, say, reducing heart failure admissions. We failed at advocating for this idea.

Another area I wanted to see in MACRA was Graduate Medical Education (GME) reform. Medicare dollars pay for graduate slots, but a lot of clinicians at top academic medical centers tend to subspecialize in procedural-based specialties. To improve value and contain costs, we need more primary care physicians than we need subspecialists. When my husband went to NYU, for example, it seemed like everyone became a radiation oncologist or an interventional radiologist. Reforms to increase incentives for students to go into primary care were in the house version of the ACA but got dropped with the public option in the Senate version. I fought for GME reform in MACRA, but ultimately the academic medical centers and teaching hospitals shot it down.

AB: You recently took a role as medical director of Sibley Primary Care, a medical center affiliated with Johns Hopkins School of Medicine. What have you encountered in this administrative role that surprised you?

KP: I have long practiced in a primary care clinic but only recently became the clinical director. I had no idea how difficult it would be to manage physicians, nurses, the front desk staff, call system staff, and other aspects of our center. A major challenge has been the prevalence of burnout among our clinicians. I worked on burnout with a National Academy of Science workgroup but now see it more vividly than I ever have before. Regardless of age, all practicing physicians struggle with some degree of burnout. My recommendation has been to cut back from practicing full-time. Five days every week is too much.

Another challenge is working within constrained financial margins to manage increasingly complex patients while under pressure to perform in a fee-for-service system. These realities of burnout and distorted financial incentives make me dispirited. This is why I am so excited about the full-risk next generation ACOs and hope that they succeed.

SG: A cohort of healthcare leaders in the Obama administration left and moved into the venture and startup spaces. With your experience as a policymaker and partner at the venture firm New Enterprise Associates, can you speak to why such movements are common and what impact they have?

KP: I am a physician and everything else emanates from there. I joined New Enterprise Associates because Scott Gottlieb convinced me that people with practical expertise in medicine and policy can have a uniquely positive impact in the venture world. Venture capitalists devote billions of dollars to disrupting healthcare; these allocations can be improved by individuals with a sense of how healthcare plays out on a day-to-day basis.

I have been fascinated to see how people who deploy a large amount of capital in healthcare think about policy. For example, I enjoy thinking through how changing reimbursement policies affect startups launching new models of primary care, or how evolving FDA guidance affects drug development and pricing. I am particularly lucky to be at an investment firm that plays the long game. For example, NEA has been an investor for 16 years in one client I spoke with. That's the right strategy for healthcare investing, where industry players move slowly.

Of note, I would like to add training in how financial markets work into medical school curricula. It is critical for physicians to be able to understand the impact of major changes in the healthcare industry, like the Amazon/Berkshire Hathaway/JP Morgan announcement and the recent appointment of Atul Gawande as its CEO, the Aetna/CVS merger, and others. These changes generate a lot of excitement amongst providers, even in my own practices, and also create novel clinical opportunities that are shaped by decisions on Wall Street. I have often thought about designing a sub-internship or rotation at NEA so medical students can understand how decisions are made, how deals are sourced, how you incubate startups, how you think about valuations, and how you separate hype from reality in healthcare. That's not for every student or doctor–but everyone needs a basic understanding of these concepts since they will increasingly affect the way we deliver care to patients.