How Purchasers Can Drive Toward Higher-Value Health Care

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Agenda

AGENDA

What is Catalyst for Payment Reform (CPR)?

Implementation of Payment Reform to Date

How Well is it Working?

WHAT IS CPR?

About CPR

- 32BJ Health Fund
- 3M
- Aircraft Gear Corp.
- Aon Hewitt
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- The Boeing Company
- CalPERS
- City and County of San Francisco
- Comcast
- Compassion International
- Covered California
- Dow Chemical Company
- Equity Healthcare
- FedEx Corporation
- GE
- General Motors Company
- Google, Inc.
- Group Insurance Commission, MA
- The Home Depot
- Mercer
- Miami University (Ohio)
- Ohio Medicaid
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Qualcomm Incorporated
- Self Insured Schools of California
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- US Foods
- Wal-Mart Stores, Inc.
- Wells Fargo & Company
- Willis Towers Watson

CPR Mission and Goals

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VISION

Employers and other health care purchasers get better value for their health care spending

MISSION

Catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace

GOALS

20% of payment flows through methods **proven to improve value** by 2020.

Health care purchasers will be more **educated and activated** on the use of high-value health care purchasing strategies.

Through greater visibility & competition, **the marketplace will be more responsive** to the needs of those who use and pay for health care.

Purchasers Have a Track Record of Success

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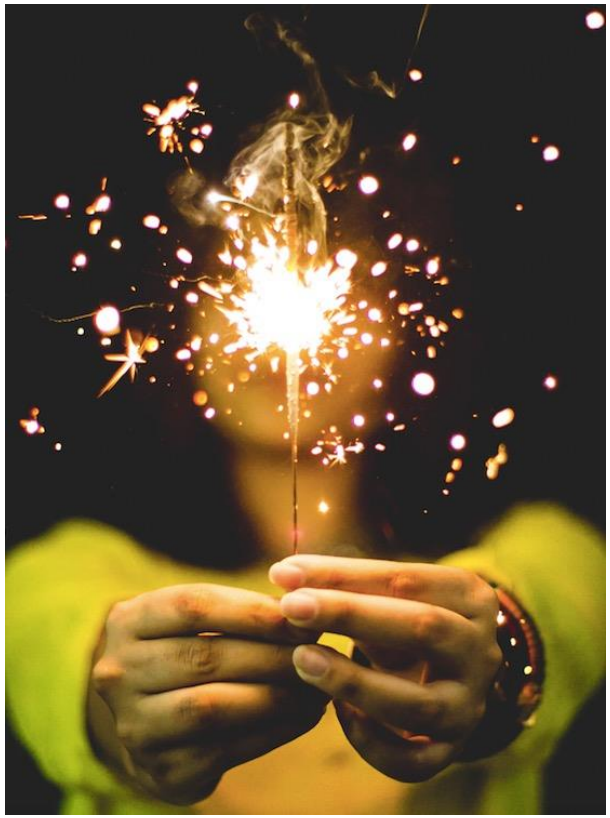
Examples:

Standard quality measurement and reporting

Payment reform in the private sector

Price transparency



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IMPLEMENTATION OF PAYMENT REFORM TO DATE

Historical Methods of Health Care Payment in the U.S.

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Payment for physicians

- Largely "fee-for-service" – a separate payment for every unit of care delivered based on a "fee schedule"
- Capitation in some states (California, Massachusetts, Minnesota) – a payment that covers all of the care a patient needs over a defined time period

Payment for hospitals

- Largely "fee-for-service"
- Some per diem payments
- Diagnosis-related group payments
- Capitation in certain states

Spectrum of Health Care Provider Payment Methods

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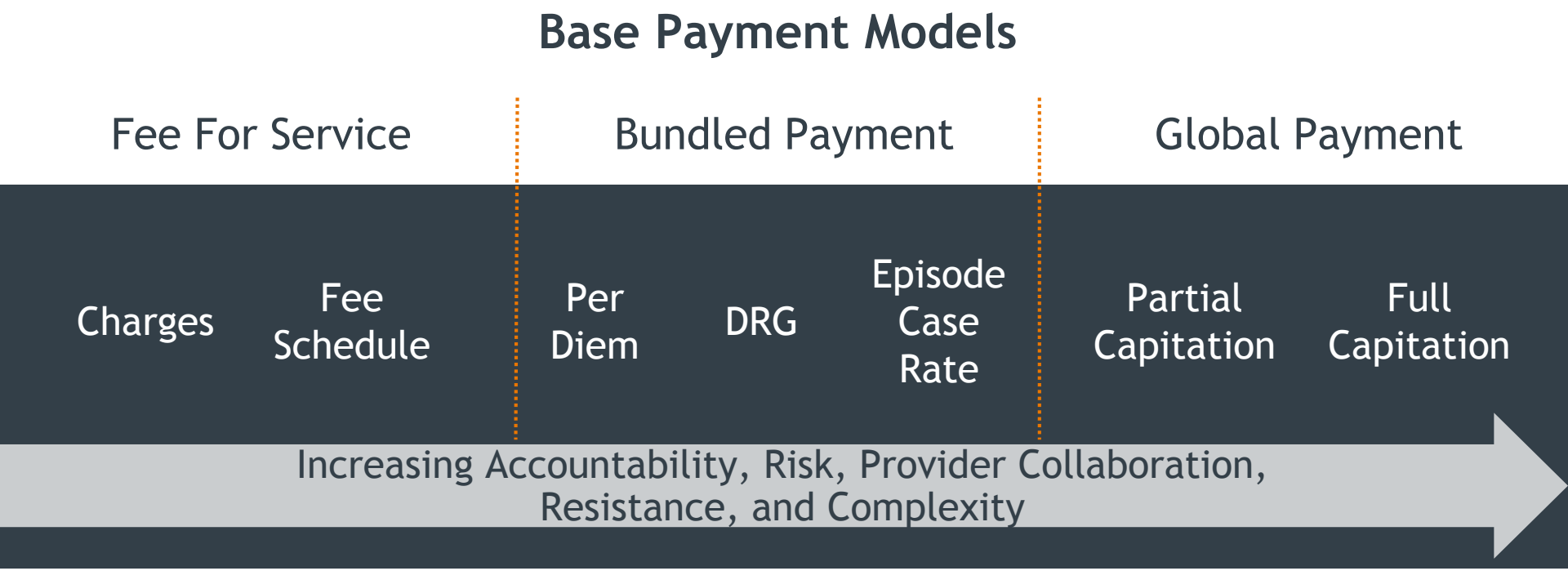

+

Performance-Based Payment or Payment Designed to Cut Waste
(financial upside & downside depends on quality, efficiency, cost, etc.)

What is Provider Payment Reform?

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Payment reform changes how we pay health care providers for delivering care and keeping patients and populations healthy.

Creates the right incentives

- Rewards or supports better performance by health care providers –
  - Better quality
  - Greater efficiency, and
  - Reductions in unnecessary spending.

What Spurred Payment Reform?

- Uneven quality, poor efficiency and rising costs
- Passage of the Affordable Care Act
- New delivery models that required new payment approaches

Patient Centered Medical Home

Emphasizes primary care, multidisciplinary care teams and care management for patients, especially those at risk of frequent hospitalizations.

Accountable Care Organizations (ACOs)

Groups of providers that share financial and medical responsibility for providing coordinated care to a patient population:

Both require new payment methods to operate

Implementation of Provider Payment Reforms

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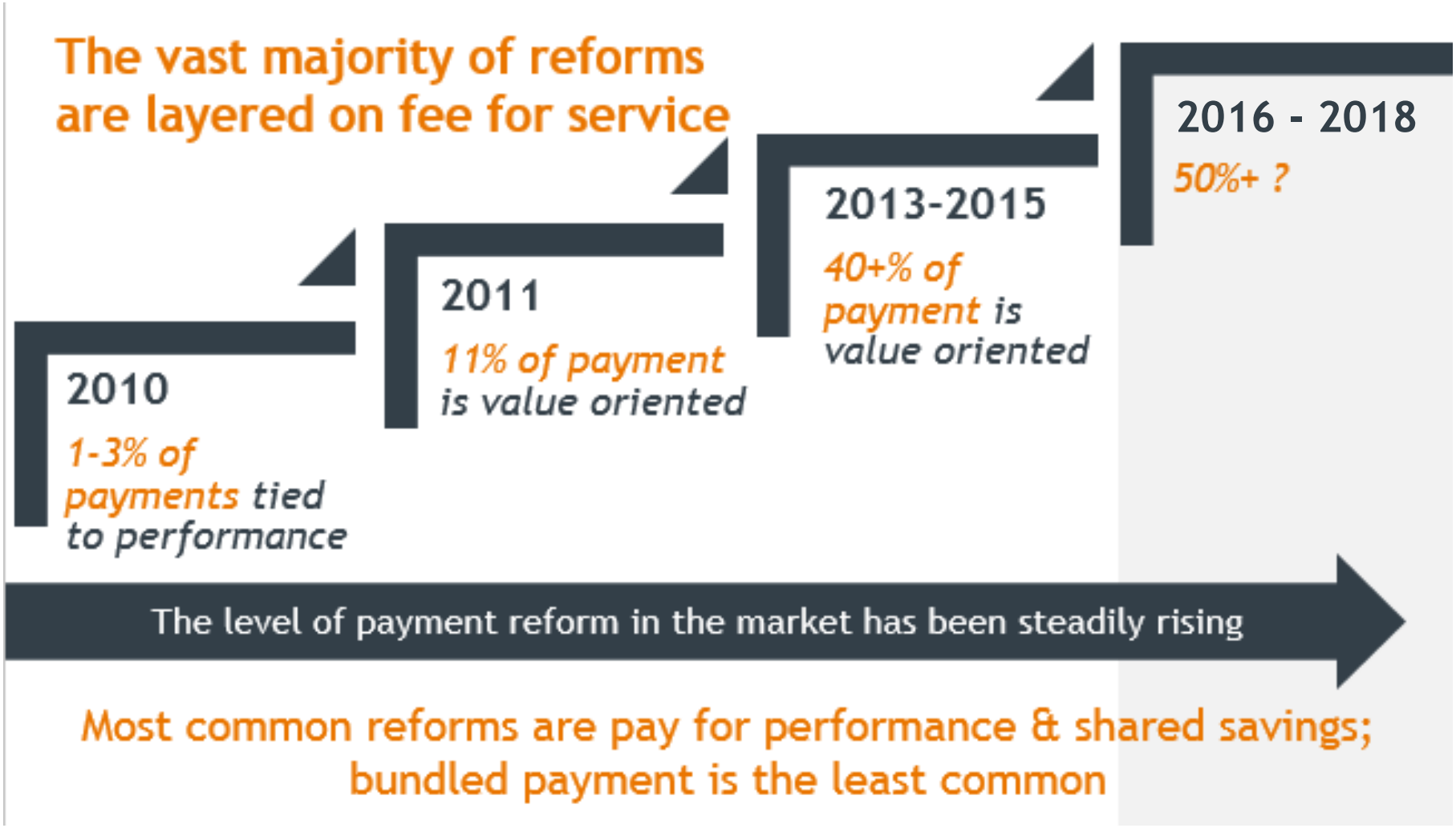
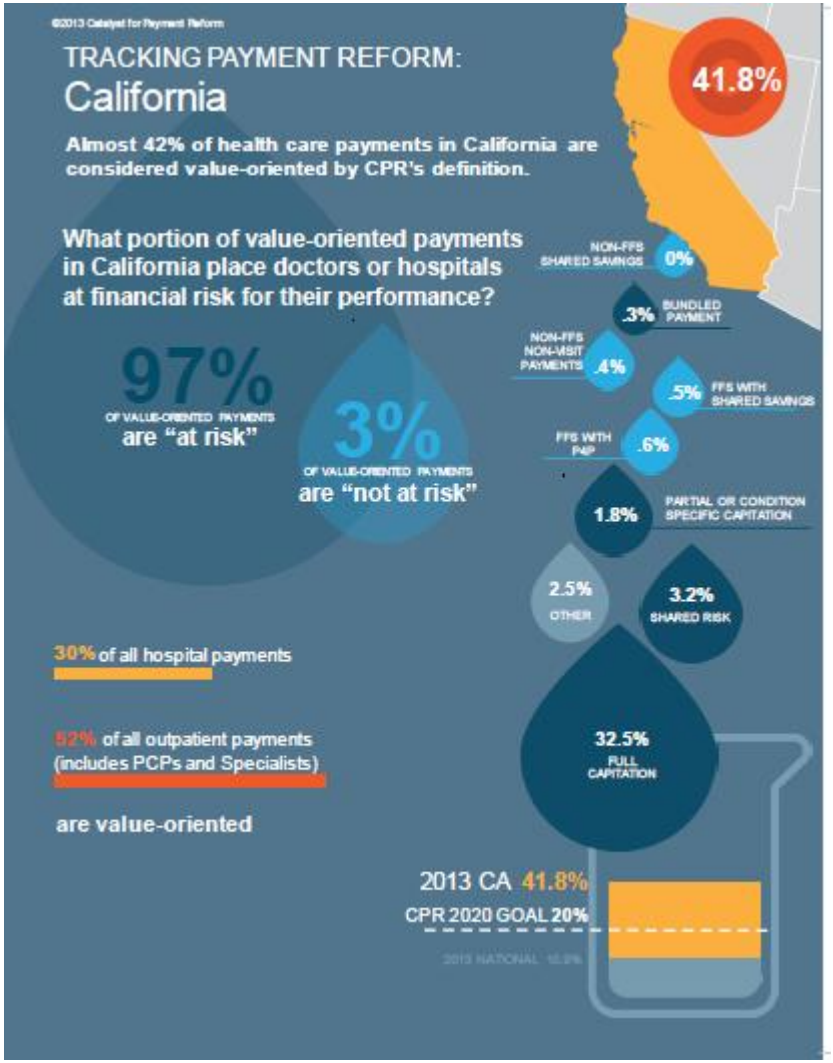


Is California Different?



As of 2013, California was on par for use of payment reforms, but with a much bigger emphasis on capitation.

Hoping to update figures in the next year or two…

Local Market Dynamics Matter

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In every local market there is a **unique dynamic** among purchasers, payers and providers (along with laws and regulations).

Is There Variation Across Health Plans?

Yes…but it's around the fringes.

Most payment reform is layered on top of fee for service and offers upside only incentives for providers.

Some plans have more bundled payment or shared risk than others.

HOW WELL IS IT WORKING?

Multiple Levels for Evaluation

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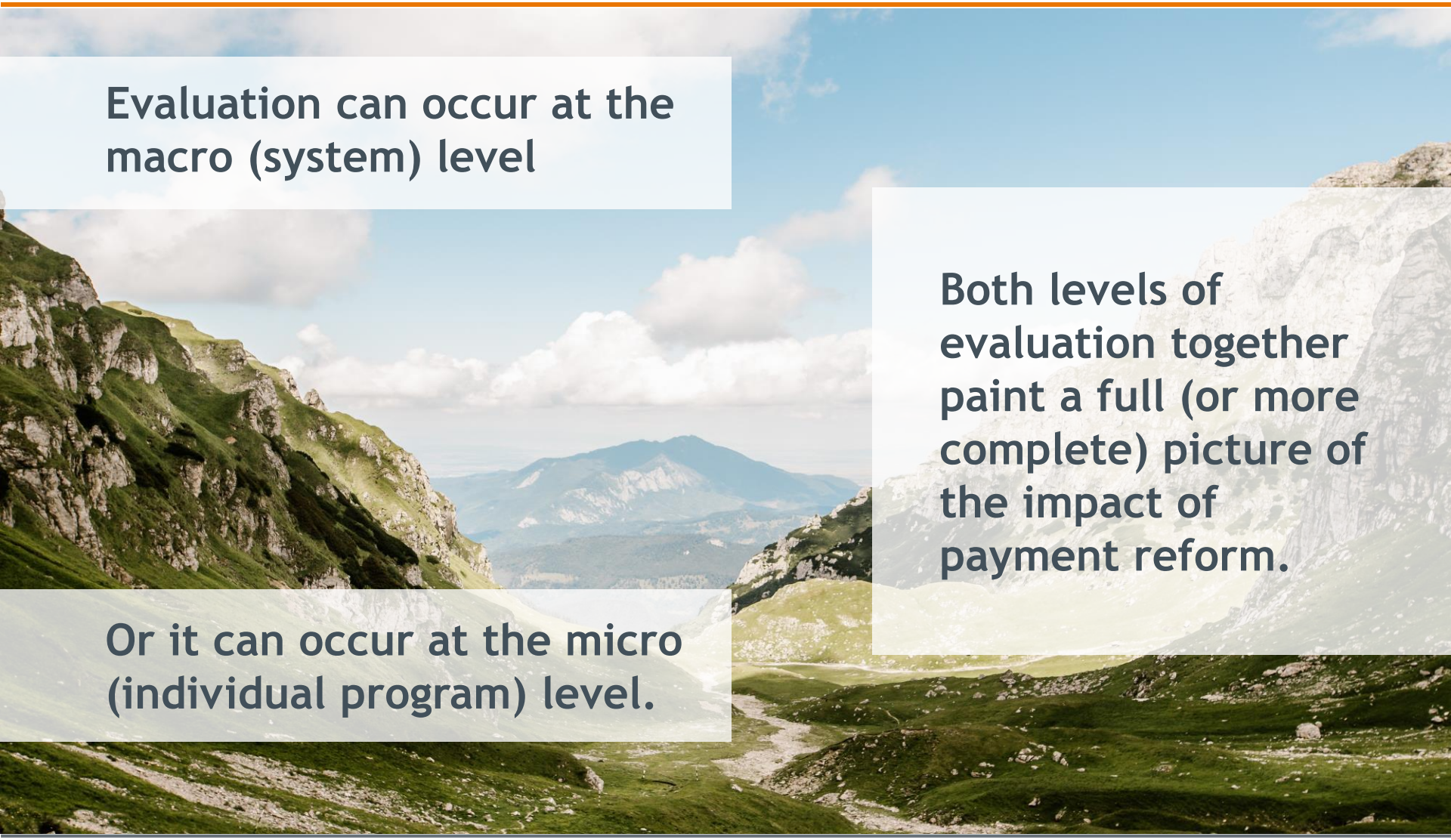

Evaluation can occur at the macro (system) level

Or it can occur at the micro (individual program) level.

Both levels of evaluation together paint a full (or more complete) picture of the impact of payment reform.

Examples of Employer-Purchaser Led Rayment Reforms

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Changes to fee schedule

- PBGH blended payment for labor and delivery – decreased Cesarean delivery by 20%
- Nonpayment (and quality improvement efforts) for early elective deliveries by South Carolina Medicaid decreased these deliveries from 10% to 3% between 2011 and 2015

Bundled payment

- Walmart COE for spine surgery supported by separate bundled payments for evaluation and surgery – 50% of patients avoided surgery after COE evaluation of appropriateness
- County of Santa Barbara bundle for total joint replacement
- PEBTF bundles for total joint replacement – savings of $70 per person in the SB health plan in the first year

Examples of Employer-Purchaser Led Rayment Reforms

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Direct contracts for accountable care

- All are direct contracts that use a shared risk payment arrangement with a quality gate
  - Intel Corporation Connected Care in Arizona and Oregon saving 17% for employees in the plan
  - The Boeing Company in Charleston, Puget Sound, Southern California and St. Louis – improvements in quality and patient experience
  - Washington State Health Care Authority ACO with Puget Sound High Value Network and UW Medicine Accountable Care Network has experienced high patient retention and 1% savings
  - Qualcomm Corporation recently launched with Scripps Health in San Diego
  - GM just launched with Henry Ford in Detroit

Is Payment Reform Working?

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Data demonstrating effectiveness of payment reforms are limited, especially in the private sector.

Federal government conducts evaluations of federal programs for elderly and disabled, but findings may not be generalizable.

Most payment reforms trace back to flawed Medicare physician fee schedule; unclear whether additional incentives layered on top can compensate for flaws.

Mixed Results for Reforms: Example of ACOs

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Medicare Shared Savings Program	
+	▪ Consistently high quality scores ▪ 31% of ACOs received shared savings bonuses in 2016
0	▪ Unchanged performance on a portion of quality measures ▪ Screening use varied
-	▪ For 2013 entrants, no early reductions in spending ▪ Medicare saw a net loss of $39 million

Connected Care (Intel)	
+	▪ High patient experience and satisfaction scores ▪ Statistically significant improvements in diabetes care
-	▪ Total costs at year end were 3.6% higher than expected

Regional Care Collaboratives (CO Medicaid)	
+	▪ Adult participants had fewer hospital readmissions and ER services than control ▪ Total reduction in spending est. $20 mill to $30 mill FY 2011-2012
0	▪ Use of ER services was about the same for children enrolled and not
-	▪ ER use was higher for enrolled participants with disabilities than those not enrolled

Can't say that ACOs are a slam dunk when it comes to procuring higher-value care!

Mixed Results for Reforms: Example of Bundled Payment

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Bundled Payments for Care Improvement (BPCI)	
+	▪ 21% lower total spending per joint replacement episode without complications ▪ 1% reduction in ER visits and readmissions
0	▪ Mixed impact on quality measures – some improved, some stayed the same and some worsened
-	▪ For spinal surgery episodes, average Medicare payments increased more for the hospitalization and 90-day post-discharge period for the BPCI than comparison

Health Care Payment Improvement Initiative (Arkansas)	
+	▪ AR BCBS trend decreased for average LOS for inpatient admissions for TJR, from 2.7 days in baseline year to 2.6 days in 2013 and 2.3 days in 2014 ▪ Medicaid 30-day wound infection rate improved to 1.7% for 2014, down from 2% in 2013
-	▪ Medicaid post-operation TJR complication rate worsened from 8% in 2013 to 14.1% in 2014

Bundles for Maternity Care (PBGH)	
+	▪ Reduction of cesareans by 20% ▪ Savings of $5,000 per averted cesarean delivery

Bundled payments are promising, but the details matter!

Tracking the Macro Impact of Payment Reform

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Measuring payment reform implementation and its impact on health care costs and outcomes

CPR is piloting Scorecard 2.0 in 3 states:

How will we measure payment reform's impact?

CPR's 2.0 metrics fall into three domains that together tell a story about the health care system.

Economic Signals like the prevalence of limited provider networks

System Transformation, like reducing low risk cesarean deliveries

Outcomes, like controlling high-blood pressure

Funded by the Laura and John Arnold and Robert Wood Johnson Foundations

Virginia Commercial Infographic

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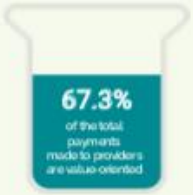
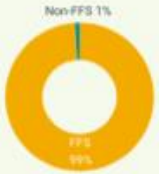


The results of the Virginia Commercial Scorecard on Payment Reform are in, and **67%** of all commercial payments are value-oriented—either tied to performance or designed to cut waste. Status-quo payments make up the remaining **33%**. These data are from calendar year **2016** or the most recent 12 months.



Fee-for-Service (FFS) remains the dominant base method of payments to providers, even when the payment is value-oriented. Of all the value-oriented commercial payments health plans made in Virginia in 2016, **99%** are still based on FFS. Only **1%** use a non-FFS based payment method. Value-oriented payment methods categorized as non-FFS include: bundled payment, full capitation, partial or condition-specific capitation, and payment for non-visit functions, while pay-for-performance, shared savings, and shared risk rely on FFS.

Very few value-oriented payments put providers at risk. About **89%** of value-oriented payments offer providers a financial upside only, with no downside financial risk.

ACKNOWLEDGMENTS

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Robert Wood Johnson Foundation · ljaf · Virginia Center for Health Innovation · VAHP · catalyst FOR PAYMENT REFORM

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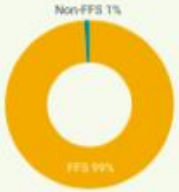
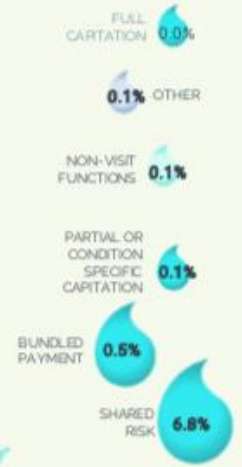
2018 VIRGINIA SCORECARD ON
Commercial Payment Reform

Use of Fee-For-Service in Value-Oriented Payments in Virginia





Share of Value-Oriented Payments that Put Providers at Financial Risk

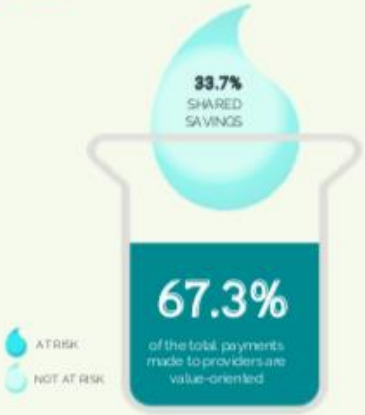
Provider Participation in Value-Oriented Payments

80% of all hospital payments (in-patient)

47% of all specialist payments

45% of all primary care provider payments **are value-oriented**

Share of Total Dollars Paid to Primary Care Providers and Specialists

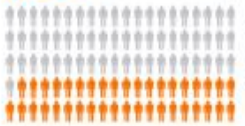


Virginia Commercial Infographic

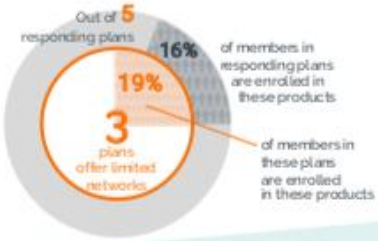
Economic Signals

ATTRIBUTED MEMBERS

39% of health plan members were attributed to **providers** participating in a payment reform contract



LIMITED NETWORKS



System Transformation

CESAREAN SECTIONS

29% of women with low-risk pregnancies* had C-sections

*NTSV measure.
Source: Analysis by VHI.

OF HEALTH PLANS OFFERING ONLINE MEMBER SUPPORT TOOLS

3 of 5 offer **quality information**

5 of 5 offer **price information**

4 of 5 offer **treatment decision information**

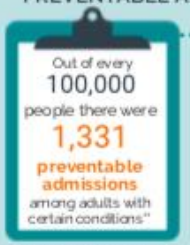
HBA1C POOR CONTROL

32% of people with diabetes had **poorly controlled** blood sugar (HbA1c >9%)

Source: NCQA

Outcomes

PREVENTABLE ADMISSIONS



ALL-CAUSE READMISSIONS

8% of hospitalizations are followed by **another hospitalization within 30 days***

Source: AHRQ, analysis by VHI. ** See Methodology for details.

Source: NCQA. *Based on VA's case mix. See Methodology for details.

Payment Reform's Impact at a Macro-Level: Leading Indicators to Watch

Together, these metrics shed light on the impact of payment reform on the health care system in Virginia.

HBA1C TESTING

90% of people with diabetes **had a blood sugar test** (HbA1c)

Source: NCQA

HEALTH-RELATED QUALITY OF LIFE

14% of adults report **fair or poor health**

Source: BRFSS, cited by CMWF 2018

UNMET CARE DUE TO COST

of adults went **without care due to cost**

Source: BRFSS, cited by CMWF 2018

SHARED RISK CONTRACTS

Insufficient data to report*

*Data withheld by CPR to preserve health plan confidentiality.

HOME RECOVERY INSTRUCTIONS

88% of adults reported being given **information about how to recover at home**

Source: HCAHPS, cited by CMWF 2018

CHILDHOOD IMMUNIZATIONS

66% of children ages 1.5 - 3 years old received **all recommended doses** of seven key vaccines

Source: NIS, cited by CMWF 2018

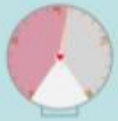
HOSPITAL-ACQUIRED PRESSURE ULCERS

adults acquired **stage III or IV pressure ulcers** during their stay

Source: 2017 Leapfrog Hospital Survey

CONTROLLING HIGH BLOOD PRESSURE

53% of people with hypertension had **adequately controlled blood pressure**



Source: NCQA

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Next Steps on Provider Payment Reform

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WHAT'S NEXT?

- Fix the fee schedule – the underlying amounts for almost all payment methods
- Continue to evaluate which reforms work
- Make smart pairings between provider payment methods and benefit designs that create incentives for consumers

CPR's Payment Reform Evaluation Framework

A standard tool that contains questions employers and other purchasers should ask health insurers and health care providers about their reform programs.

A standard evaluation process for payment reform programs could support:

- Mid-course corrections
- Cross learning, and
- Identify successful approaches.

Evaluation Domains

Program design – what is the intention of the program

Feasibility – how will it affect operations

Cost – measurements and outcomes

Quality – measurements and outcomes

Transparency from Health Plans on Accountable Care Programs

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CPR's Standard Health Plan ACO Report

Developed to help purchasers identify the performance of their health plans' ACO arrangements

The Report Includes

- Meaningful Cost, Quality and Utilization metrics
- The impact of ACOs on the purchaser's population and spending

It requires health plans to show the whole picture, not just selected results.

Based on the Nutrition Label for Packaged Food

QUESTIONS?

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