How Purchasers Can Drive Toward Higher-Value Health Care

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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

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CPR Mission and Goals

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.

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Purchasers Have a Track Record of Success

Examples:

Standard quality measurement and reporting

Payment reform in the private sector

Price transparency
IMPLEMENTATION OF PAYMENT REFORM TO DATE
Historical Methods of Health Care Payment in the U.S.

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

## Base Payment Models

<table>
<thead>
<tr>
<th>Fee For Service</th>
<th>Bundled Payment</th>
<th>Global Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges</td>
<td>Per Diem</td>
<td>Partial Capitation</td>
</tr>
<tr>
<td>Fee Schedule</td>
<td>DRG</td>
<td>Full Capitation</td>
</tr>
<tr>
<td>Schedule</td>
<td>Episode Case Rate</td>
<td></td>
</tr>
</tbody>
</table>

Increasing Accountability, Risk, Provider Collaboration, Resistance, and Complexity

+ Performance-Based Payment or Payment Designed to Cut Waste (financial upside & downside depends on quality, efficiency, cost, etc.)
What is Provider Payment Reform?

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

The vast majority of reforms are layered on fee for service

2010
1-3% of payments tied to performance

2011
11% of payment is value oriented

2013-2015
40+% of payment is value oriented

2016 - 2018
50%+ ?

The level of payment reform in the market has been steadily rising

Most common reforms are pay for performance & shared savings; bundled payment is the least common
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...
In every local market there is a unique dynamic among purchasers, payers and providers (along with laws and regulations).

This dynamic impacts:
- Who is a market shaper
- Who is open to innovation
- Who is driven to improve
- Responsiveness to customers

Local Market

Providers

Health Plans

Purchasers
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

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

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

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?

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**

<table>
<thead>
<tr>
<th>Medicare Shared Savings Program</th>
<th>Connected Care (Intel)</th>
<th>Regional Care Collaboratives (CO Medicaid)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>+</strong></td>
<td>▪ Consistently high quality scores</td>
<td>▪ High patient experience and satisfaction scores</td>
</tr>
<tr>
<td></td>
<td>▪ 31% of ACOs received shared savings bonuses in 2016</td>
<td>▪ Statistically significant improvements in diabetes care</td>
</tr>
<tr>
<td><strong>0</strong></td>
<td>▪ Unchanged performance on a portion of quality measures</td>
<td>▪ Total costs at year end were 3.6% higher than expected</td>
</tr>
<tr>
<td><strong>-</strong></td>
<td>▪ Screening use varied</td>
<td>▪ ER use was higher for enrolled participants with disabilities than those not enrolled</td>
</tr>
<tr>
<td></td>
<td>▪ For 2013 entrants, no early reductions in spending</td>
<td><strong>-</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Medicare saw a net loss of $39 million</td>
<td></td>
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</table>

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

<table>
<thead>
<tr>
<th>Bundled Payments for Care Improvement (BPCI)</th>
<th>Health Care Payment Improvement Initiative (Arkansas)</th>
<th>Bundles for Maternity Care (PBGH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>21% lower total spending per joint replacement episode without complications</td>
<td>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</td>
<td>Reduction of cesareans by 20%</td>
</tr>
<tr>
<td>1% reduction in ER visits and readmissions</td>
<td>Medicaid 30-day wound infection rate improved to 1.7% for 2014, down from 2% in 2013</td>
<td>Savings of $5,000 per averted cesarean delivery</td>
</tr>
<tr>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mixed impact on quality measures – some improved, some stayed the same and some worsened</td>
<td>Medicaid post-operation TJR complication rate worsened from 8% in 2013 to 14.1% in 2014</td>
<td>Bundled payments are promising, but the details matter!</td>
</tr>
<tr>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For spinal surgery episodes, average Medicare payments increased more for the hospitalization and 90-day post-discharge period for the BPCI than comparison</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Bundled payments are promising, but the details matter!
Measuring payment reform implementation and its impact on health care costs and outcomes

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

CPR is piloting Scorecard 2.0 in 3 states:

New Jersey  Colorado  Virginia
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, 66% are still based on FFS. Only 11% 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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**Virginia Commercial Infographic**

### Economic Signals

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

**Limited Networks**
- Out of 5 responding plans, 16% of members in responding plans are enrolled in these plans.
- 3 plans offer limited networks.
- Of members in these plans, 19% are enrolled in these products.

### System Transformation

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

### Outcomes

**Preventable Admissions**
- Out of every 100,000 people, there were 1,331 preventable admissions among adults with certain conditions.

**All-Cause Readmissions**
- 8% of hospitalizations are followed by another hospitalization within 30 days.

**HbA1C Poor Control**
- 32% of people with diabetes had poorly controlled blood sugar (HbA1c > 9%)
- Source: NCQA

**HbA1C Testing**
- 90% of people with diabetes had a blood sugar test (HbA1c)
- Source: NCQA

**Unmet Care Due to Cost**
- 14% of adults report fair or poor health
- Source: BRFSS, cited by CMWF 2018
- 13% 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

**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**
- 0.07 out of every 1,000 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
Next Steps on Provider Payment Reform

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

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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.

<table>
<thead>
<tr>
<th>Evaluation Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program design - what is the intention of the program</td>
</tr>
<tr>
<td>Feasibility - how will it affect operations</td>
</tr>
<tr>
<td>Cost - measurements and outcomes</td>
</tr>
<tr>
<td>Quality - measurements and outcomes</td>
</tr>
</tbody>
</table>
Transparency from Health Plans on Accountable Care Programs

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.

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QUESTIONS?

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