Episode Of Care Payments

Current State

François de Brantes | May 10th 2019

Today's Agenda

1. A Little Bit Of History
2. Evidence
3. Now & Tomorrow

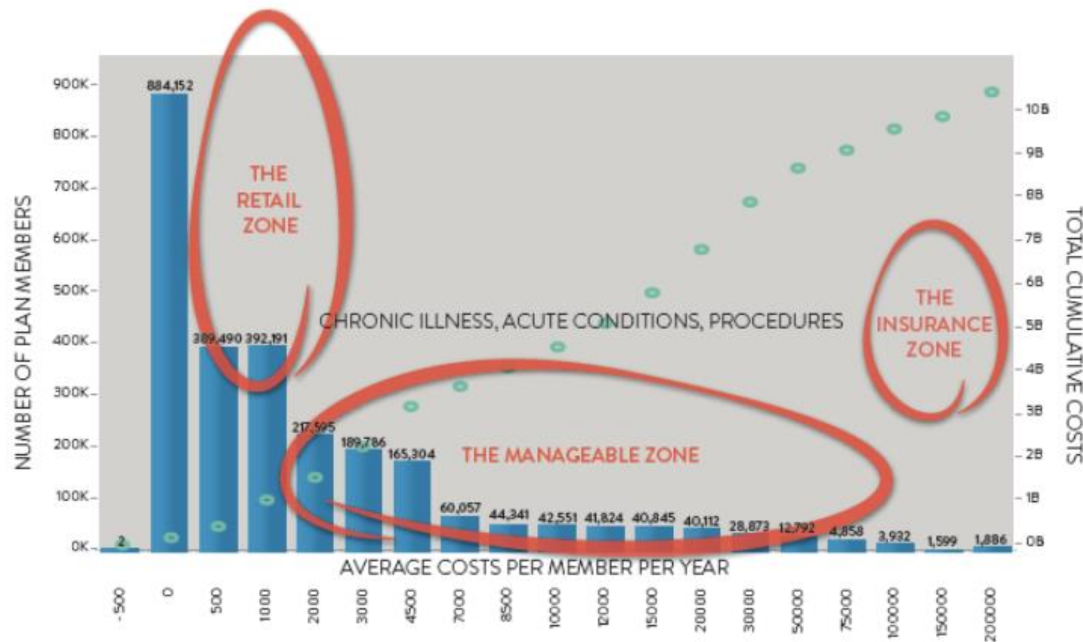
© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

Why Episodes Of Care?

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

It’s About Manageable Risk

The difference between insurance risk and care management risk



- It’s called the insurance zone for a reason
- The retail zone is already in play and consumers are engaged
- The management zone is where value can be significantly increased

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

Converting Concepts To Payment

Why certain alternative payment models work for some and not others

- **Taking risk on all zones = total costs of care (or capitation)**
- **You need A LOT of covered lives to overcome the variation in yearly costs in the insurance zone***
- **Episodes of care can cover all the care in the management zone and hold providers accountable for cost and quality outcomes**

* DeLia, December 2013, Health Services and Outcomes Research Methodology 13(2)

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

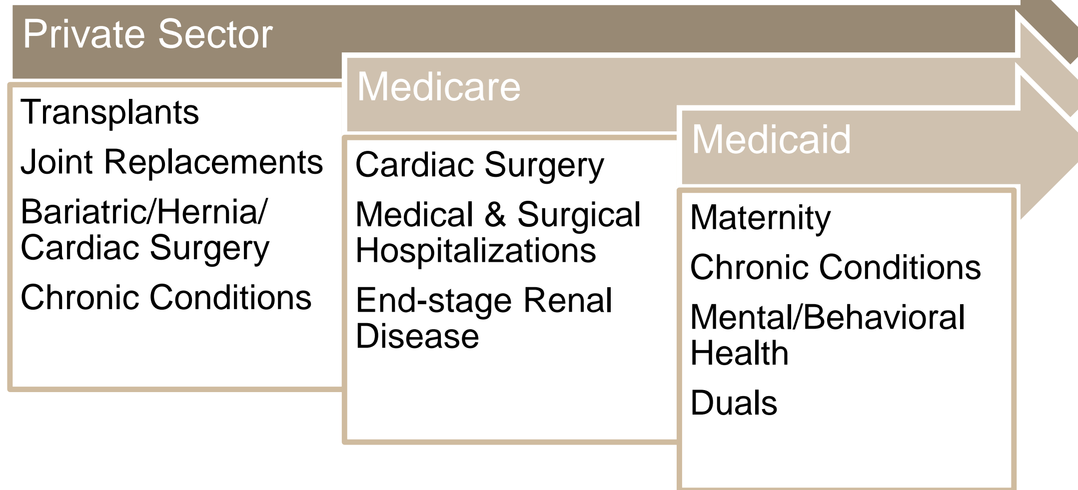
A Little Bit Of

History

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

Thirty Years Of Expanding Scope

From simple to very complex patients



- Chronic conditions, mental/behavioral health, musculoskeletal, maternity are all now in scope
- Simple and complex surgeries almost commoditized

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

How Soon We Forget

It's unclear why Episode of Care payment programs still seem "novel"

The usual measures used to document use of medical services were found insufficiently penetrating in a utilization study conducted by the authors. A useful measure which gives meaning and coherence to the units of service conventionally reported, e.g., numbers of physician visits and days of inpatient care, was found in the unifying concept of episodes of medical care.

DELINEATING EPISODES OF MEDICAL CARE

Jerry A. Solon, Ph.D., F.A.P.H.A.; James J. Feeney, M.D.; Sally H. Jones, R.N., M.S.; Ruth D. Rigg, R.N., M.N.Ed.; and Cecil G. Sheps, M.D., M.P.H., F.A.P.H.A.

Introduction

The Problem

THE kinds of data which report the use of medical services generally fall far short of representing the complex reality of medical care. More revealing measures of utilization are needed to reflect the actual course and content of the medical care received by individuals and populations.[1]

The summary statistical data used to describe the medical care received by a population usually take the form of (1) stating how many in the population have obtained medical services in a given period of time (the volume of users), and/or (2) expressing the volume of services in terms of the number of physician visits made, the days of inpatient care provided, the number of x-rays, lab tests, medications, physical therapy treatments, and so on.

These cumulations are valuable in so far as they represent, in an over-all way, the sheer volume of service. But their very simplicity, their objectivity, and apparent precision are deceptively reassuring. They create the illusion that the essential facts of utilization are thus expressed. There is much more to tell of medical care than these superficial counts reveal. And it is important to be able to tell it.

The need to design measures and methods to reflect utilization effectively is intensified as medical care itself grows more complex. Yet our data on utilization remain couched in such elementary terms as counts of visits and days. No matter how precise these traditional measures of service volume, they are by their nature incapable of adequately representing the changing scope and character of medical care.

The deficiency of the conventional measures in merely tallying a procession of units of service is that they are not addressed to the heart of the matter—to represent the "natural history" of medical care. A keen observer has aptly stated that ". . . it is the glory of science to become ever more and more precise in its measurements, and it is the agony of the scientist to discover that when his measurements are really precise, what he has measured is just to one side of what he is after."[2]

New Approach

This paper suggests and demonstrates a way of perceiving utilization which

1967

HER HEALTH ECONOMICS RESEARCH, INC.

411 Waverley Oaks Road, Suite 330
Waltham, MA 02154-8705
(781) 788-8100
(781) 788-8101 - FAX

Medicare Participating Heart Bypass Center Demonstration

Executive Summary

Final Report

Prepared by:

Jerry Cromwell, Ph.D.
Debra A. Dayhoff, Ph.D.
Nancy T. McCall, Sc.D.
Sujha Subramanian, Ph.D.
Rachel C. Freitas, B.A.
Robert J. Hart, B.A.

Health Economics Research, Inc.

With:

New England Research Institutes

Cheryl Caswell, M.B.A.

and:

William Stason, M.D., M.P.H.

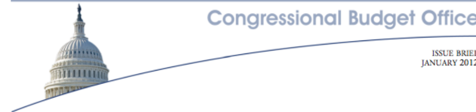
Prepared for:

Armen H. Thoumaian, Ph.D., Project Officer

Health Care Financing Adminstration

July 24, 1998

1998



Congressional Budget Office

ISSUE BRIEF
JANUARY 2012

Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment

An important part of the national debate about how to manage federal spending in the decades ahead has focused on spending for Medicare, which is expected to account for a large and ever-increasing share of the federal budget. Medicare provides health insurance to almost everyone who is 65 or older and to people under age 65 who receive Social Security Disability Insurance benefits (after a waiting period) or have certain serious health conditions. Many observers point out that improving the effectiveness of Medicare spending might allow both for reductions in federal spending from its projected path and for improved health care for Medicare beneficiaries.

Since 1967, the program has had the authority to conduct demonstrations that examine new ways to deliver and pay for health care. That authority was extended in 2010, under the Patient Protection and Affordable Care Act (Public Law 111-148), with the creation of the Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS). Under that law, CMS can expand a demonstration—and even implement it nationwide—without further approval from the Congress if the Secretary of Health and Human Services determines that such expansion would either reduce spending without reducing quality of care or improve quality of care without increasing spending.

In the past two decades, CMS has conducted two broad categories of demonstrations aimed at enhancing the quality of health care and improving the efficiency of health care delivery in Medicare's fee-for-service program.

- **Disease management and care coordination demonstrations** have sought to improve the quality of care of beneficiaries with chronic illnesses and those whose health care is expected to be particularly costly.
- **Value-based payment demonstrations** have given health care providers financial incentives to improve the quality and efficiency of care rather than payments based strictly on the volume and intensity of services delivered.

This Congressional Budget Office (CBO) issue brief reviews the outcomes of 10 major demonstrations—6 in the first category, 4 in the second—that have been evaluated by independent researchers.[1] The types of programs in those demonstrations could be implemented nationally either through the innovation center or through further legislation.

The evaluations show that most programs have not reduced Medicare spending: In nearly every program involving disease management and care coordination, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program, when the fees paid to the participating organizations were considered. Programs in which care managers had substantial direct interaction with physicians

1. For more complete discussions of the demonstration projects, see Lyle Nelson, *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination*, Congressional Budget Office Working Paper 2012-01 (January 2012), and *Lessons from Medicare's Demonstration Projects on Value-Based Payment*, Congressional Budget Office Working Paper 2012-02 (Ja[illegible] 2012).

2012

2017

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

A Fair Amount Of

Evidence

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

Thirty Years Of Evidence

And yet we still question whether it actually works

- **CMS Cardiac Bypass Demonstration deemed the only Medicare payment demonstration that saved money and improved outcomes[1]**
- **Private sector Episode of Care payments for joint replacements and cardiac procedures proven to lower costs and improve outcomes[2]**
- **CalPERS Reference Price payment and benefits program significantly reduced inpatient prices[3]**
- **PROMETHEUS Payment implementation for global maternity payments reduced costs while maintaining quality in Medicaid patients[4]**

1. GAO Report on Lessons From VBP Demonstrations, 2012
2. GAO Report on Private Sector Initiatives on Bundled Payments, 2011
3. Health Affairs, Vol 36 #12, Dec 2017
4. HCP LAN Report on Clinical Episode Payments, 2016

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

Where We Are

Where We Go

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

National Snapshot

Public sector leads by a wide margin

- Medicare’s Bundled Payment for Care Improvement (BPCI) has close to $50 Billion in program (14% of FFS)
- Arkansas, New York, Ohio and Tennessee have statewide Medicaid episode of care payment programs
- Washington, Oregon, Idaho, Rhode Island and others are incorporating EOC payments as part of Medicaid payment reform

- Catalyst For Payment Reform estimates that less than 10% of private sector health care spend is in EOC payments
- All the national plans claim to have episode of care payment programs, but very little has been contracted
- Large employers are implementing procedural carve-outs at an increasing pace, but these also represent a fraction of medical spend

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

The ”Classic” Center Of Excellence Approach

It’s insufficient to impact $5,500 PMPY in total health cost

Knee & Hip Replacement surgeries cover ~ $55 PMPY
Back surgeries cover ~ $150 PMPY
Bariatric surgery covers ~ $20 PMPY
Cardiac Bypass surgery covers ~ $25 PMPY

And that’s for all cases, inclusive of a 90 day warranty period. The subset that is done in national Centers of Excellence is a fraction of the total cases and doesn’t include a warranty.

- $250 PMPY = 4.5% of total costs per member per year
- 10% savings on the $250 is less than 0.5% savings on total health costs

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

Why The Lack Of Private Sector Progress?

1. Despite the evidence, most employers believe that EOC payments are for a handful of procedures
2. Payers say they can't find providers willing to take downside risk despite the hundreds in Medicare downside risk arrangements
3. Payers still don't have the infrastructure to automate full risk EOC payment programs
4. Most employers believe that prospectively paid episodes are the only way to create the right provider behavior* and implementing prospectively paid episodes requires significant administrative challenges**

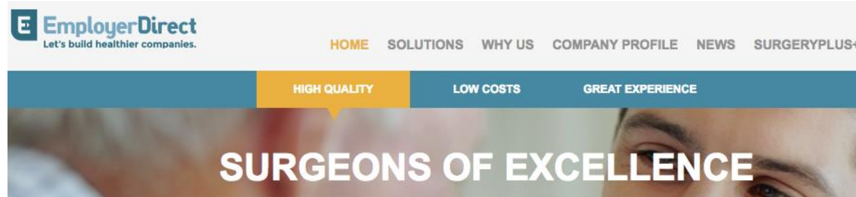
* There's no evidence that prospectively paid episodes have a greater effect than other modes of implementation

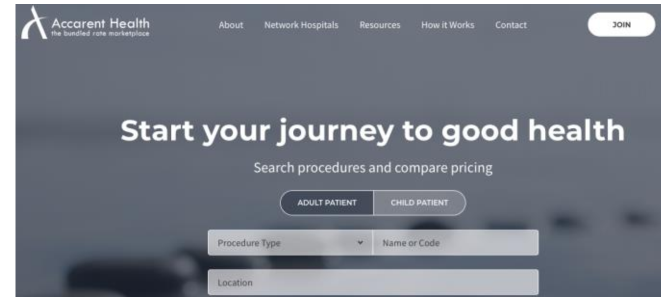
** See IHA report/study on prospectively paid joint replacement episodes

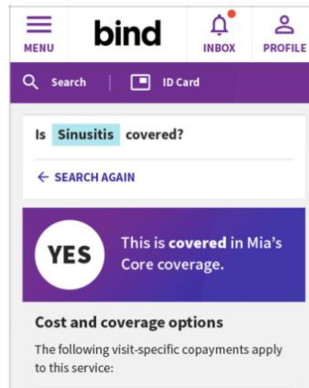
© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

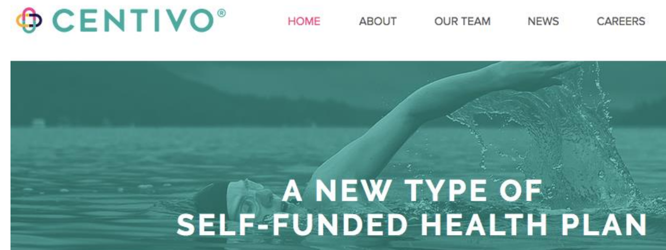
Innovators Are Filling The Gaps

EOC payment and benefits administrators responding to demand









© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

The “Right” Way To Do Episodes

Go wide and wrap in contracted Medicare-based reference prices

- **Focus on the totality of the “manageable zone” – up to 70% of medical spend**
- **Nest the program in a total cost of care (TCC) payment model – it helps you optimize TCC**
- **Use historical prices to establish target prices only if those prices are reasonable, else use Medicare-based reference prices and contract a more reasonable target price – in Indiana, RBC-M is the way to go**
- **Ultimately, if you want to create a market, you have to pull all the levers of competition**

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

The End Game

Solving for Kenneth Arrow’s information asymmetry and Uwe Reinhardt’s pricing disparities

- **CalPERS’ programs demonstrate demand will shift to lower priced providers**
- **Consumers, armed with information on cost and quality will select the higher value providers**
- **Combining EOC payment and benefits into a single program creates a real market for health care**

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential

Q&A

© 2018 Remedy Partners, Inc. All Rights Reserved.
Proprietary and Confidential