Effective Value-Oriented Payment Strategies

Suzanne F. Delbanco, Ph.D.
sdelbanco@catalyze.org
Executive Director
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catalyst
FOR PAYMENT REFORM

About CPR

An independent non-profit corporation **working to catalyze employers, public purchasers and others** to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

- 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
- Penn State University
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Qualcomm Incorporated
- Self-Insured Schools of California
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- Unite Here Health
- US Foods
- Walmart Stores, Inc.
- Wells Fargo & Company
- Willis Towers Watson

About CPR

Catalyst for Payment Reform's work is governed by three core beliefs:

- **A small group of empowered purchasers can change the system**
- **Consistent signals to the market will catalyze change faster**
- **We need to track progress and hold the market accountable**

About CPR

To achieve our goals, CPR provides the following:

EDUCATION

Learn about high value health care purchasing

TOOLS & SUPPORT

Take action at your organization

COORDINATION

A louder voice in the marketplace

RESEARCH & ANALYSIS

Push the market and measure progress

Key Ingredients of High-Value Health Care Going Forward

TRANSPARENCY: insight into quality and prices, building block for other reforms

BENEFIT DESIGN: incentives for consumers

PROVIDER NETWORK DESIGN: guidance for consumers, leverage for payers, volume for providers

PAYMENT REFORM: financial incentives for providers

Local Market Dynamics Impact Value Too

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

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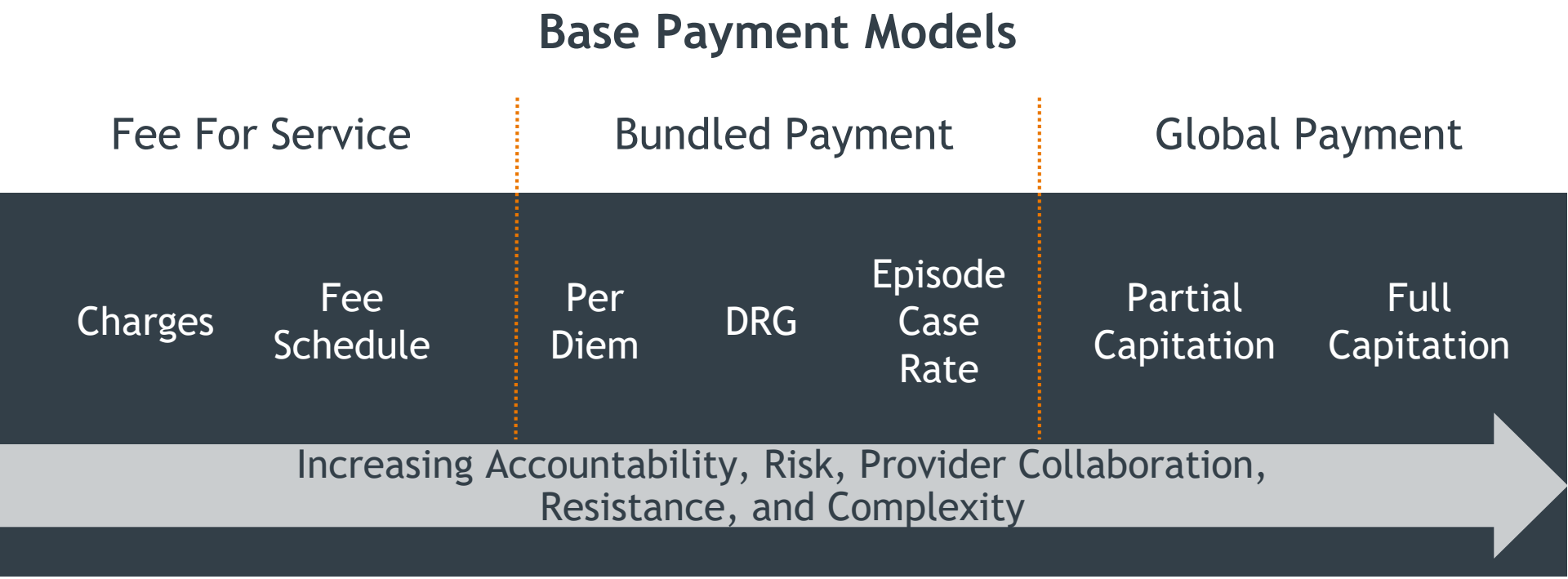
Payment Reform

CPR's Definition of Payment Reform

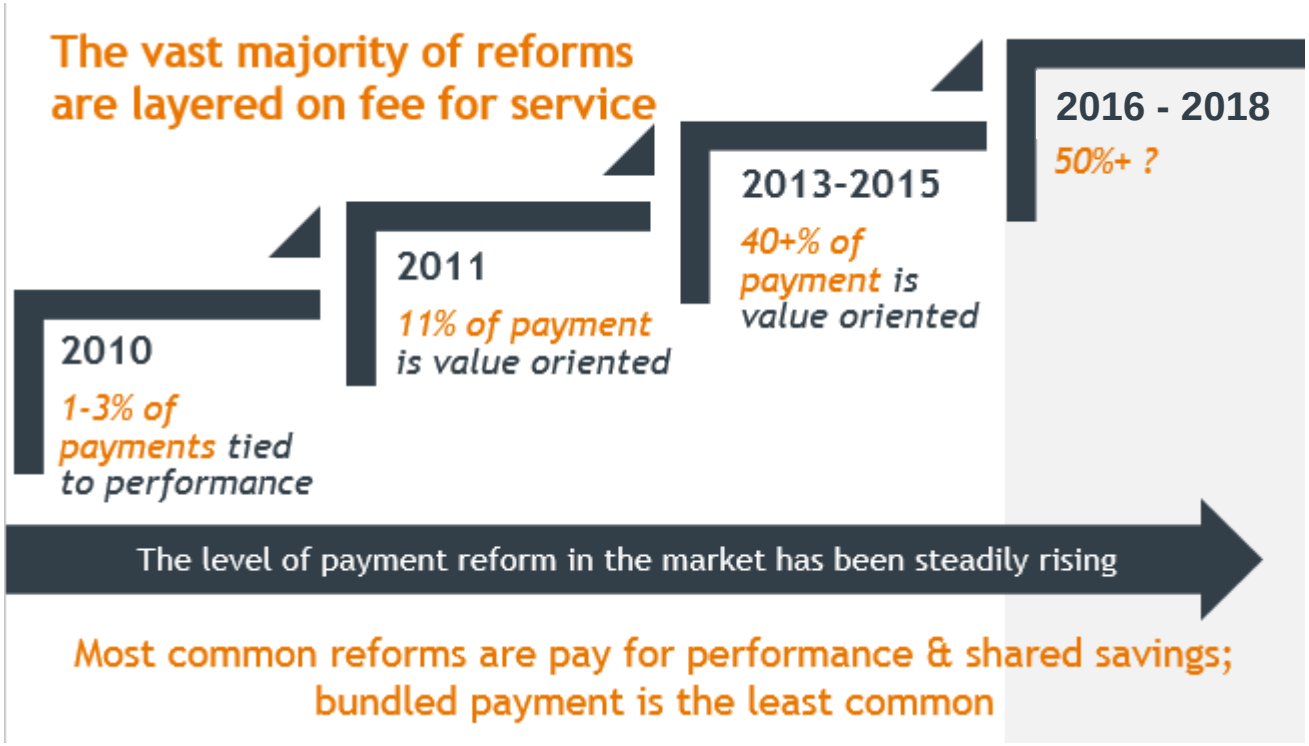
Payment reform: a range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.

Spectrum of Health Care Provider Payment Methods



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

Growth of Provider Payment Reform



WHAT'S NEXT?

- Fix the fee schedule
- Evaluate which reforms work
- Make smart pairings between provider payment methods and benefit designs

New payment methods support new health care delivery models such as patient centered medical homes, accountable care organizations….

Mixed Results for Reforms: Example of ACOs

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

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!

Mixed Results for Reforms: Example of Bundled Payment

Pennsylvania Employees Benefit Trust Fund

- Pennsylvania Employees Benefit Trust Fund (PEBTF) implemented a pilot bundled payment program for total hip and knee replacements
- The program decreased outpatient costs, on average, by $3524. However, inpatient costs remained about the same.

"One of the lessons… is that facilities and surgeons should have distinct budgets and two-sided risk arrangements. That way quality and cost improvements stemming from one cannot obliterate the lack of improvement from the other."

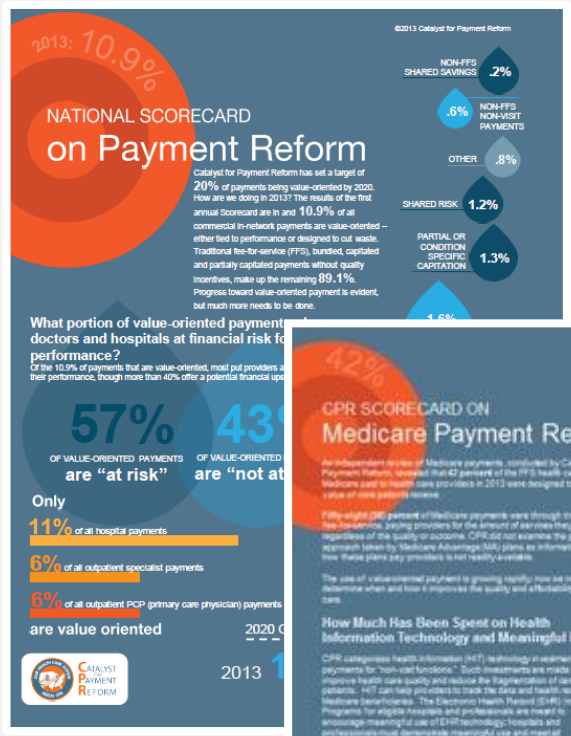
http://prometheusanalytics.net/sites/default/files/attachments/PEBTF-Case-Study_0.pdf
https://www.prnewswire.com/news-releases/pennsylvania-employees-benefit-trust-fund-bundled-payment-pilot-improves-patient-outcomes-significantly-decreases-professional-services-costs-300319932.html

Continuing to Track Progress and Impact of Payment Reforms

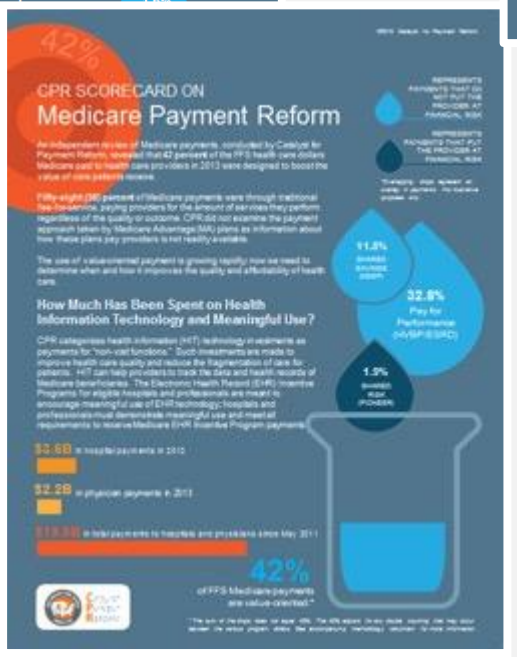
Previous Scorecards

- ✓ **National and Regional Scorecards** - the first to track the nation's (and certain states') progress in implementing value-oriented payment.

2013, 2014 National Scorecards



2015 FFS Medicare Scorecard



CA 2013, 2014

NY 2015 Medicaid & Commercial

Introducing Scorecard on Payment Reform 2.0

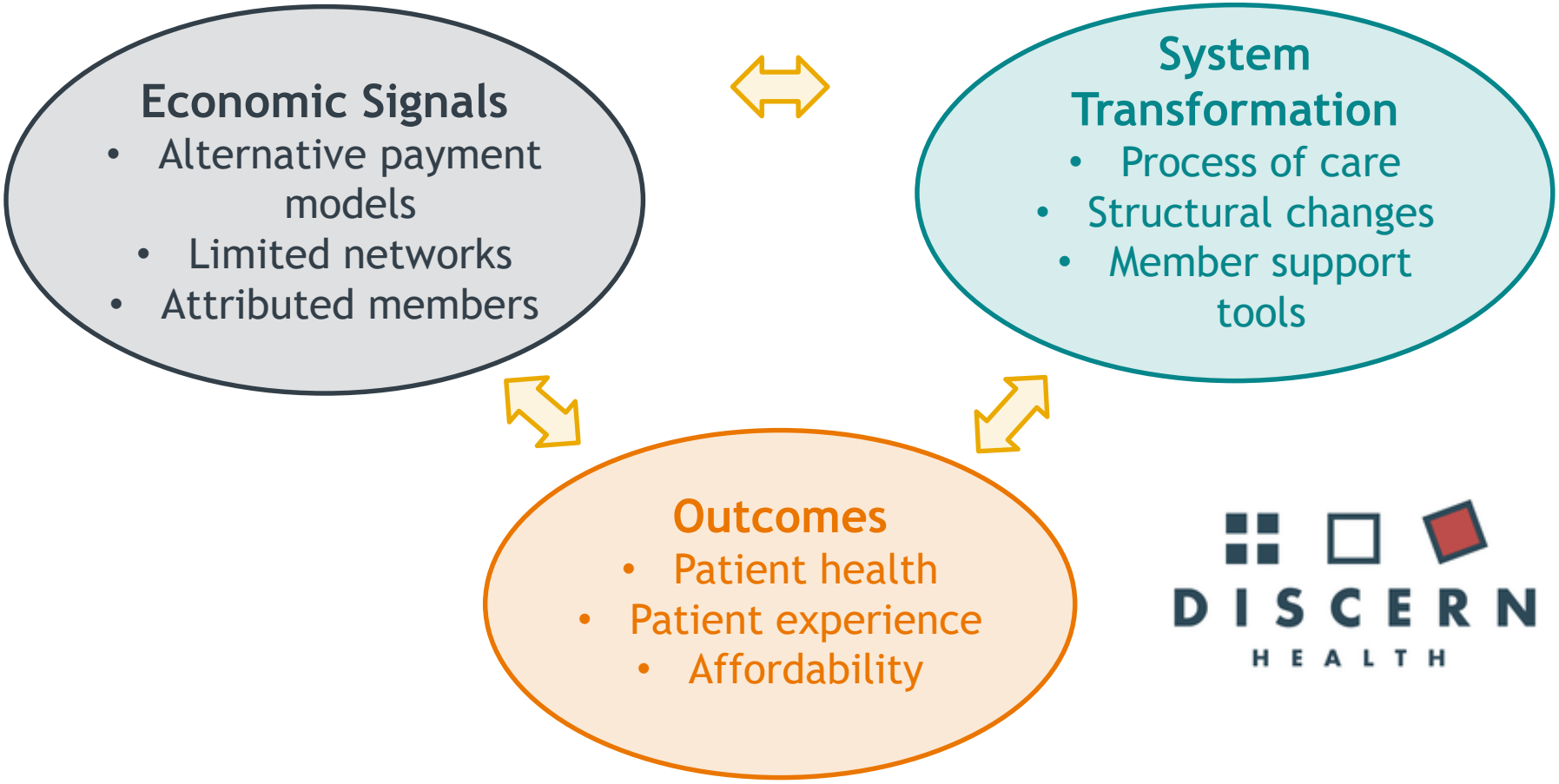
The development and piloting of Scorecard 2.0 is funded by:

GOALS:

- Help purchasers and other stakeholders in both the private and public sector **track the nation's and state's progress on payment reform.**
- Identify **high-level indicators of payment reform's impact** on the cost and quality of health care.

Scorecard 2.0 Framework

A **multi-stakeholder advisory committee** provided input on measure selection



DISCERN HEALTH

Pilots in 3 States

CPR selected the states through a **RFP process** where organizations self-identified to sponsor the project locally.

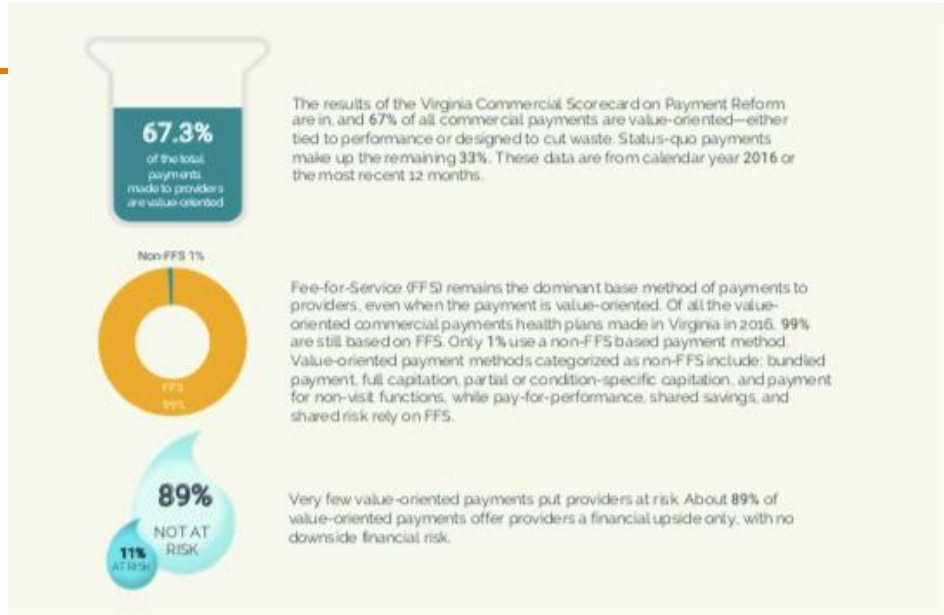
CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

NEW JERSEY HEALTH CARE QUALITY INSTITUTE
Quality powered.

VAHP
VIRGINIA ASSOCIATION OF HEALTH PLANS

VIRGINIA CENTER FOR HEALTH INNOVATION

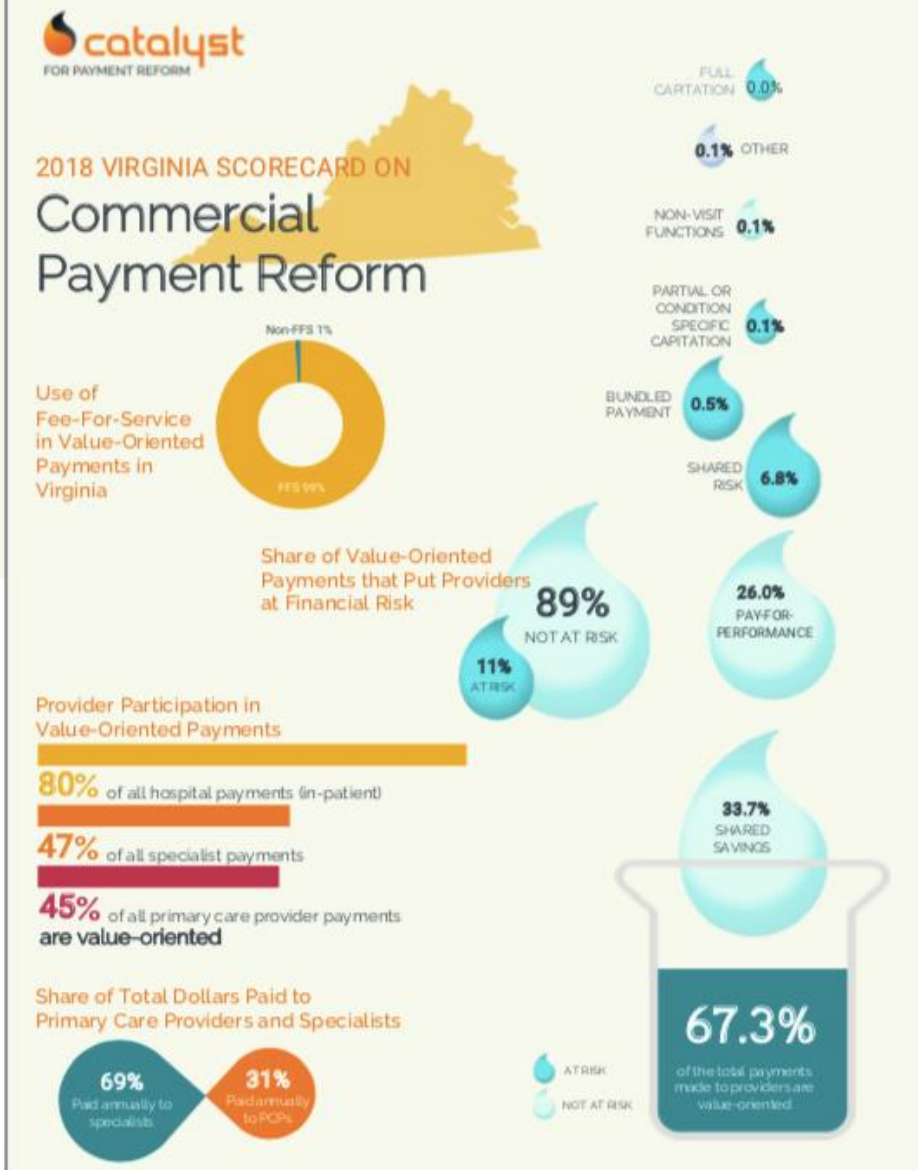
Virginia Commercial Scorecard



ACKNOWLEDGMENTS

The Virginia Commercial Scorecard on Payment Reform 2.0 was made possible by the Laura & John Arnold Foundation and the Robert Wood Johnson Foundation, as well as the leadership of the Virginia Center for Health Innovation and the Virginia Association of Health Plans. CPR thanks Beth Bortz, President & CEO of VCHI and Doug Gray, Executive Director of VAHP. CPR project leads Andrea Caballero and Alejandra Vargas-Johnson; CPR staff Lea Tessitore and Roslyn Murray; as well as the health plans that provided data for the Scorecard, for their significant contributions to this project.

Robert Wood Johnson Foundation · ljaf · Virginia Center for Health Innovation · VAHP · catalyst for payment reform

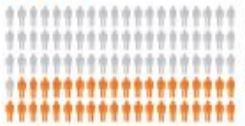


Virginia Commercial Scorecard

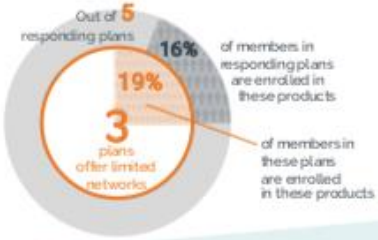
Economic Signals

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

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.

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

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

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Continued Evaluation and Transparency is Critical

E.g. CPR's Standard Plan ACO Report

- Nutrition label-format provides purchasers with a **standard, easy way to identify the value** of their health plans' ACO arrangements.
- Meaningful and comprehensive cost, quality and utilization metrics help purchasers **assess whether care is improving, staying the same, or getting worse.**

Standard Plan ACO Report

ACO Facts: Purchaser

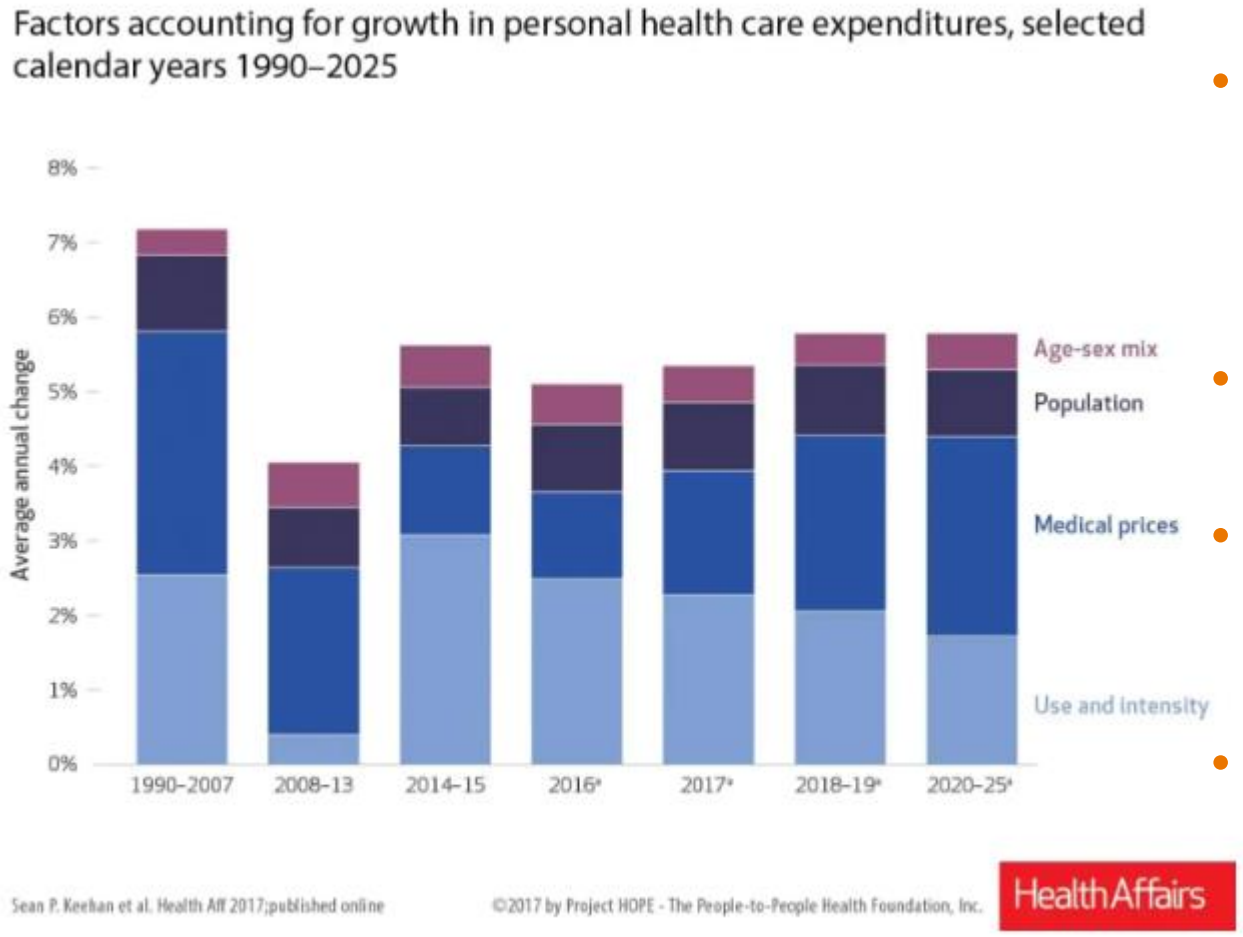
To the extent possible, all information should be ***specific to the purchaser-customer*** *requesting the report. Reference the "Definitions" tab as needed.*

Name of Administrator:		
Current Period:	[month, year] *through* [month, year]	
Administrator		#
Total current members assigned or attributed to an ACO		#
Percent of current members assigned or attributed to an ACO		#VALUE!

Cost	Prior Period	Current Period
Total per member per month spend for non-attributed/non-assigned members (specify if includes/excludes Rx)	$	$
Total per member per month spend for attributed/assigned members (specify if includes/excludes Rx)	$	$
Total cost of care (health care spend of ACOs)	$	$
Total savings produced or overspending (gross gains or losses)	(+/-)	(+/-)
Total gains or losses shared with ACOs	(+/-)	(+/-)
Total per member per month savings or losses generated from participating in the ACO	#VALUE!	#VALUE!
Total non-visit related payments charged to Company (e.g., infrastructure, management fees, quality incentives)	$	$

Based on the Nutrition Label

But Don't Forget the Prices – They Matter Too



- Provider consolidation has been driving up prices
- Consolidation will continue
- Prices have no correlation to quality of care
- High prices can negate positive impacts of reform

Health Affairs

But Don't Forget the Prices – They Matter Too

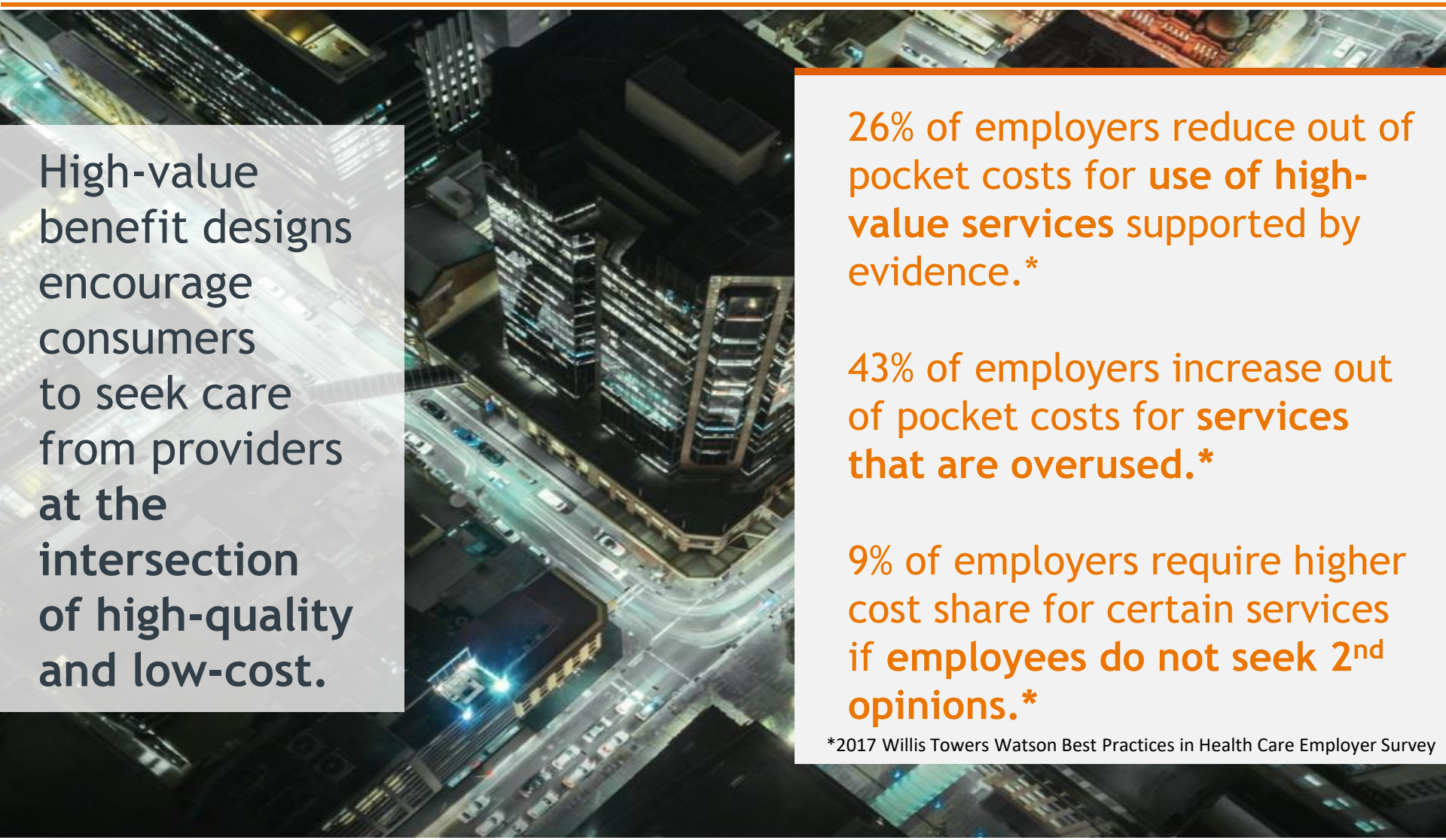
States are Taking Action

- Using Medicare as a reference point for pricing
- State purchasers have volume to pursue this approach
- Commercial purchasers are likely to have interest as well

https://khn.org/news/holy-cow-moment-changes-how-montanas-state-health-plan-does-business/?utm_campaign=KHN%3A%20First%20Edition&utm_source=hs_email&utm_medium=email&utm_content=63899645&_hsenc=p2ANqtz--XqDFBzZeQW4sOiEy0x5mD9Eta296DchNyWTfIPPr8OW6aWsZqAiiII_AwAjHyyc3ocdZCmM8bvafMgHCMeRWWOvJksA&_hsmi=63899645
https://www.thepilot.com/business/state-health-plan-launches-new-provider-reimbursement-effort/article_1a31dbf6-c7f3-11e8-bb85-6bdba81c9f16.html

Benefit Design

High-Value Benefit Designs are Taking Off



High-value benefit designs encourage consumers to seek care from providers **at the intersection of high-quality and low-cost.**

26% of employers reduce out of pocket costs for **use of high-value services** supported by evidence.*

43% of employers increase out of pocket costs for **services that are overused.***

9% of employers require higher cost share for certain services if **employees do not seek 2nd opinions.***

*2017 Willis Towers Watson Best Practices in Health Care Employer Survey

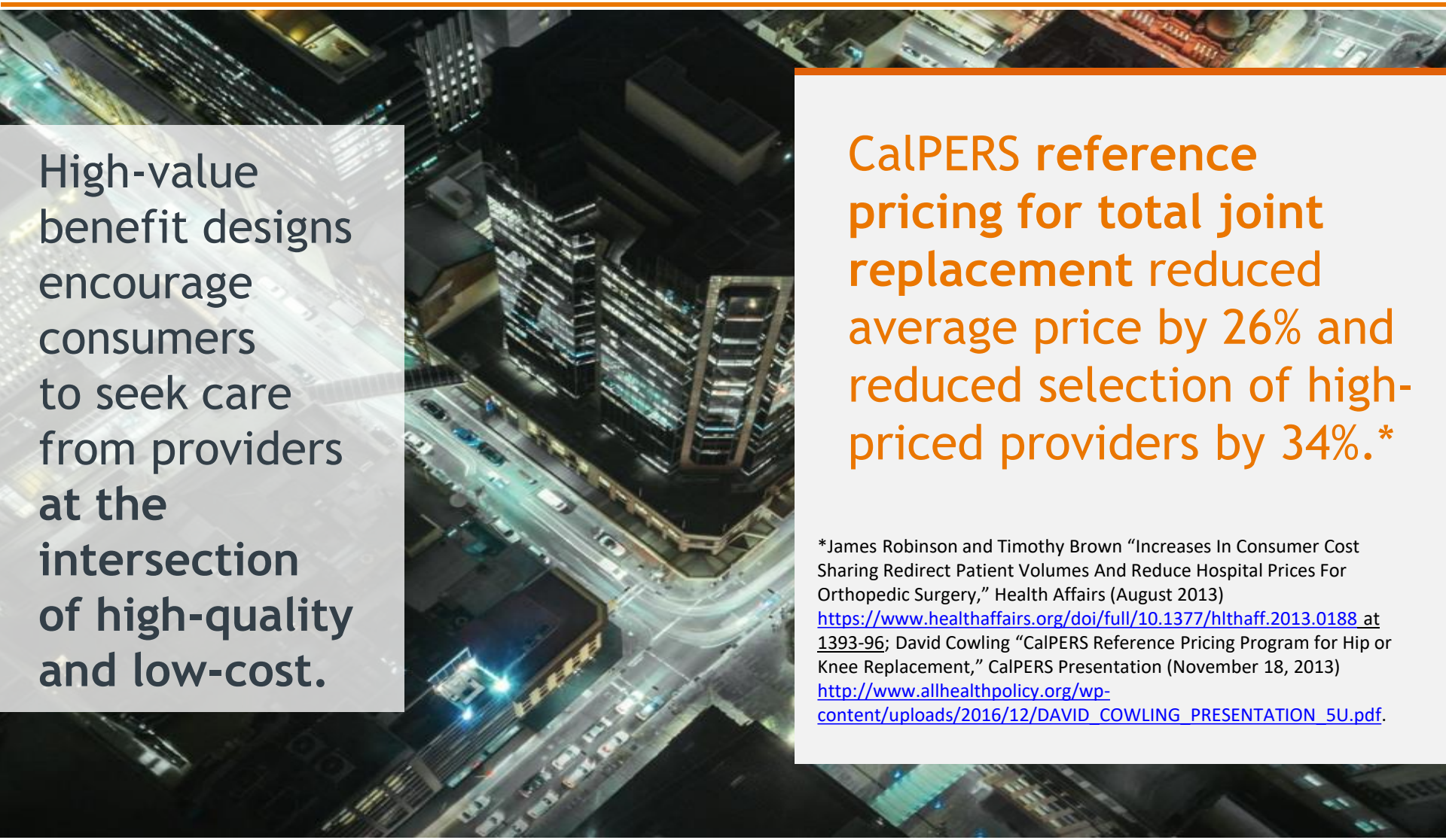
Evidence that Innovative Benefit Designs Work

High-value benefit designs encourage consumers to seek care from providers **at the intersection of high-quality and low-cost.**

Walmart's **COE for spine surgery** reduced inappropriate surgeries – 50% of associates referred for surgery were not good candidates.*

*https://www.catalyze.org/product/centers-of-excellence-walmart-employer/

Evidence that Innovative Benefit Designs Work



High-value benefit designs encourage consumers to seek care from providers **at the intersection of high-quality and low-cost.**

CalPERS **reference pricing for total joint replacement** reduced average price by 26% and reduced selection of high-priced providers by 34%.*

*James Robinson and Timothy Brown "Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery," Health Affairs (August 2013) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0188 at 1393-96; David Cowling "CalPERS Reference Pricing Program for Hip or Knee Replacement," CalPERS Presentation (November 18, 2013) http://www.allhealthpolicy.org/wp-content/uploads/2016/12/DAVID_COWLING_PRESENTATION_5U.pdf.

Network Design

Provider Network Designs Are Also Taking Off

A high-value provider network is a select group of in-network providers in a given health plan.

13% of purchasers **offer high-performance provider networks**; that number could rise to 56% by 2018.

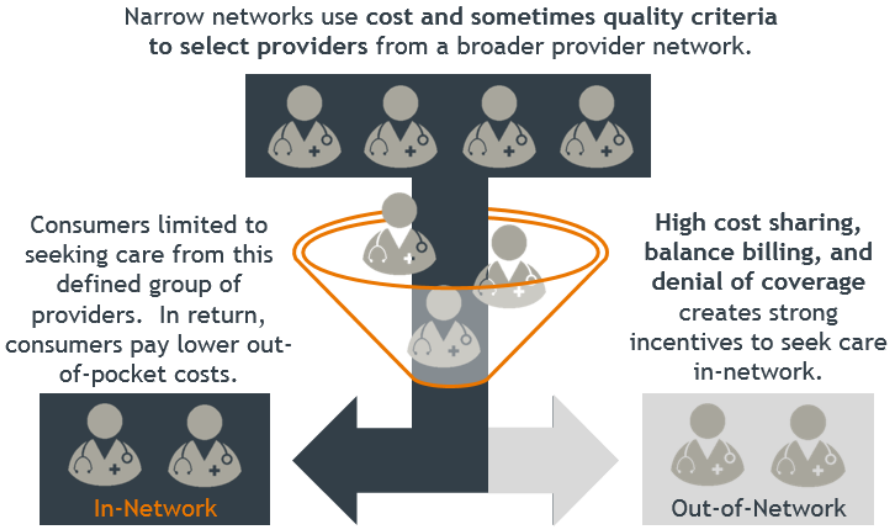
31% of employers are **using COEs;** that number could grow to 73% by 2018.

22% of employers have **onsite or near-site health centers**; that number could grow to 40% by 2018.

2017 Willis Towers Watson Best Practices in Health Care Employer Survey

Evidence that Innovative Provider Network Designs Work

- Consumers enrolled in narrow network products offered by a large payer in the southeastern U.S. had lower mean outpatient out-of-pocket expenditures and 10 percent lower premiums than individuals in the broad network plan.*



*Emily Gillen, et al. "The Effect of Narrow Network Plans on Out-of-Pocket Cost," American Journal of Managed Care (September 19, 2017) https://www.ajmc.com/journals/issue/2017/2017-vol23-n9/the-effect-of-narrow-network-plans-on-out-of-pocket-cost at 540-545, 542-543

Evidence that Innovative Provider Network Designs Work

Group Insurance Commission in MA:

- Enrollees in narrow networks **spent 36% less.***
- Tiered networks **reduced market share** of poorly performing providers by 12%.**

BCBS of MA:

- Tiered network **reduced** total adjusted medical spending per member per quarter by 5%.***

*Jonathan Gruber and Robin McKnight "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees," National Bureau of Economic Research Working Paper 20462 (September 2014) http://www.nber.org/papers/w20462.pdf at 4, 21, 23-24.

**Anna Sinaiko and Meredith Rosenthal "The Impact of Tiered Physician Networks on Patient Choice," Health Services Research (August 2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4239853/ at 1350-51, 1355-56.

Anna Sinaiko, Mary Beth Landrum, Michael Chernew "Enrollment In A Health Plan With A Tiered Provider Network Decreased Medical Spending By 5 Percent," Health Affairs (May 2017). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1087?journalCode=hlthaff at 870, 873-74.

Americans Willing to Make Trade-Offs…For Now

As the health system pushes Americans to become smarter shoppers, consumers may look closely at network offerings.

For example: Qualcomm Incorporated introduced a new ACO narrow network product in San Diego and had significantly higher enrollment than expected.*

*See case study to be released 3/5/19 at www.catalyze.org

Consider this:

- Americans willing to make tradeoffs, but could become skeptical
- Given that many plans don't consider quality…
- Transparency on quality and prices will be essential

Options for the Future

Effective Strategies for the Future?

Push for **price and quality transparency because it creates competition among providers and supports innovative benefit and provider network designs.**

Introduce **new benefit designs** that encourage employees to use high-value providers

- Reference pricing
- Centers of excellence

Customize **provider network designs** based on value.

- Narrow network
- Tiered network
- Direct contracting for ACO or episodes/procedures
- Onsite/near-site clinics

Effective Strategies for the Future?

Pay providers differently through **alternative payment methods** that hold them responsible for quality and spending.

Encourage **new entrants into the market** to compete.

- Telehealth
- Onsite/near-site clinics
- Retail clinics, urgent care centers, etc.

Take a new approach to pricing through contracting, such as using Medicare rates as a reference price

THANK YOU

Suzanne Delbanco, Ph.D.
Executive Director
sdelbanco@catalyze.org