Health Policy After the SGR: Moving Toward Value-based Payment and Benefits

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Pacific Business Group on Health
What Problems are We Trying to Solve?

- Health care **costs** are too high, and the **quality** of care and patient experience are inconsistent.
- Innovative models of care delivery have been launched, but they haven’t **spread** widely or quickly.
- **Public policy** has been behind the curve of innovation in the private sector – until now.
The health care industry is “in the throes of great disruption. . . the most significant re-engineering of the American health system . . . since employers began providing coverage for their workers in the 1930s.”

(The Economist, March 6, 2015)
What Will Catalyze the Change?

- The **SGR replacement bill** will encourage physicians to shift from FFS toward value-based payment.
- HHS’s **ambitious targets** can accelerate the move toward value-based payment.
- **New technologies** have the potential to revolutionize the flow and use of information.
- Potential **“game changers”**
  - SGR replacement bill
  - HHS value-payment targets and Learning & Action Network
  - Health Care Transformation Task Force
Encourage the movement to effective alternative payment models (APMs)

- Higher bar: upside and downside financial risk
- Cover multiple services, spanning sites of care and providers
- Supported by evidence that they will reduce overall spending

Use meaningful performance measures

- Priority measures: clinical outcomes, patient-reported outcomes, appropriateness, and total patient cost/resource use.
- Higher bonus payment for physicians who report on more meaningful measures
- Independent, multi-stakeholder process for the selection of measures
Innovations leading to a high quality, affordable health system and better health
Purchasers Driving Change

- **Provider payment reform**
  - ACOs
  - Bundled payments for episodes of care
  - Advanced primary care

- **Benefit design, transparency, and decision tools**
  - Narrow and tiered networks; Centers of Excellence
  - VBID, reference pricing, consumer choice tools

- **Redesigning Care**
  - Intensive Outpatient Care Program (IOCP)
  - Disruptive models: onsite clinics, retail points of service, medical tourism
# Purchaser-Initiated ACOs

<table>
<thead>
<tr>
<th>Employer</th>
<th># Members with ACO Access</th>
<th>Geography</th>
<th>Contract Type</th>
<th>Financial Model</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>27,000, primarily non-union</td>
<td>Seattle, WA 2 health systems</td>
<td>Self-funded Direct Contract</td>
<td>Shared savings with upside/downside risk and quality performance requirements</td>
<td>Major reductions achieved in readmissions and inpatient days</td>
</tr>
<tr>
<td>B</td>
<td>42,000</td>
<td>Sacramento, CA Med group &amp; hospital</td>
<td>Insured through Blue Shield HMO</td>
<td>Global budget with gainsharing if targeted savings achieved</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>4,100 (ABQ) Targeted population “actionable chronics”</td>
<td>Albuquerque, NM 1 health system</td>
<td>Self funded Direct Contract</td>
<td>Shared cost with negotiated PMPM target +/- 2% corridor. P4P based on % of eligible claims using Intel 5 measures</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>26,000 in SF and Contra Costa County</td>
<td>SF Bay Area 3 Med group &amp; hospital systems</td>
<td>Insured through Blue Shield HMO</td>
<td>Global budget with risk sharing based on achieving flat trend target. Separate quality performance guarantees</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>13,000</td>
<td>SF Bay Area 1 Med group &amp; hospital</td>
<td>Self-funded; built with plan Blue Shield EPO</td>
<td>Monthly performance reviews with development of improvement plans</td>
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Purchaser-Initiated ACOs

Key Success Factors

✓ Patient choice (not “attribution”) and engagement
✓ Upside and downside financial risk
✓ Significant financial opportunity
✓ Ability to identify high-risk patients
✓ Integration of services, including mental health
✓ Quality and other performance measures
Centers of Excellence Program

- Geisinger Medical Center
- Johns Hopkins Bayview Medical Center
- Kaiser Permanente Irvine Medical Center
- Mercy Hospital, Springfield
- Virginia Mason Medical Center

- Joint Replacement
- Spine Procedure
Tiered and Narrow Networks

Minnesota state employees:
- Medical groups into four tiers, by risk-adjusted total cost of care (each roughly 10% higher premium than the next)
- Within 2 years, 85% of members select either cost level 1 or 2 providers
- **Immediate impact to trend was -7-10%**

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<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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<tbody>
<tr>
<td>Trend</td>
<td>0.0%</td>
<td>9.9%</td>
<td>6.7%</td>
<td>3.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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Massachusetts GIC employees:
- FY2012 – 31% migrated to narrow networks
- **State savings** of $20 million
- **Employee savings** $600 single, $1400 family
### Intensive Outpatient Care Program

#### IOCP Boeing Pilot results as published on Health Affairs blog 2009.10.20:

<table>
<thead>
<tr>
<th>Measure compared to baseline</th>
<th>Result</th>
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<tr>
<td>Health care costs of pilot participants versus control group</td>
<td>-20.0%</td>
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<tr>
<td>Hospital admissions</td>
<td>-28%</td>
</tr>
<tr>
<td>Improvement in mental functioning of pilot participants</td>
<td>+16.1%</td>
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<tr>
<td>Participants feeling that care was “received as soon as needed”</td>
<td>+17.6%</td>
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<tr>
<td>Average number of patient-reported workdays missed, 6 months</td>
<td>-56.5%</td>
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**In a second project in Northern California:**

- Cost per person per month down by 16%
- 44% reduction in hospital admissions
- More preventive visits
- Less outpatient surgery

**Expanded to Medicare with Innovation grant**
Advocating for policies to improve value

The Purchasers’ Agenda:

- > 50% of provider payments in **non-FFS** models by 2018
- **SGR replacement:**
  - High standards for **Alternative Payment Models** – not built on FFS chassis
  - Rapid development and use of **outcomes measures** – especially **PROMs** – that are meaningful and useful to consumers and purchasers
- **Spread** successful models more quickly and broadly
- **Align** the strategies of public and private purchasers
We must seize the opportunity to move toward value-based payment to improve quality and affordability.

Alternative payment models should move decisively away from fee-for-service toward “payment for value”

The process of selecting measures must assure the public that they’re getting value for their spending.

Private sector innovations should be adopted more quickly in public programs to accelerate adoption and alignment.

Ultimately, payment reform alone won’t be enough; we also need better consumer incentives, healthier competitive markets and a stronger information infrastructure.