Operationalizing the Transition to Value

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Agenda for Today's Discussion

- Why is it happening? Policy Context
- What is Value? How are We Currently Operationalizing Value?
- Discuss Broad Sets of Policy Tools:
  - Value-based Purchasing
  - Value-based Insurance Design
- Provide Examples from Ongoing Projects & Research

Value Based Healthcare

Why is it happening?

&

What is the Policy Context?

Policy Context: Consumers are Having Difficulty Affording Health Care

- Rising health care costs represent one of the most important challenges to the U.S. economy
- Quality of care is poor
  - Substantial underutilization of high value health care services
  - U.S. adults receive only about half of recommended care*
  - For some chronic diseases, like diabetes, patients get fewer than half of needed clinical services*

*McGlynn et al. N Engl J Med, 2003 – Seminal article you should all be familiar with

Returning Health to the Health Care Debate

- **There is little disagreement over the fact there is enough money in the US health care system**
- **Therefore, we need to focus on *how* – not simply *how much* – we spend on healthcare**
- **What can we take out?**
- **Want to improve value**

We First Need to Define Value

Value = 'bang for the buck'

- **In health care, that bang is population health**
  - **Life expectancy, quality of life, quality-adjusted life years (QALY) combines both**
- **Value is also commonly referred to as efficiency, productivity, cost-effectiveness, return on investment**
  - **How it's "labeled" is important**
- **Value is *always* relative**
  - **What added health benefits are realized for each added dollar spent on health care?**

Shark Insurance

What is the Value of Health Care?

- There is large body of literature on the cost-effectiveness of particular medical interventions
  - Many (but certainly not all) medical treatments provide reasonable value
  - These interventions constitute a very small portion of what we do in health care
- There has been comparatively little attempt to understand the value of the medical system as a whole

Four Force Shaping Future Margins

Financial, Clinical Profiles Shifting Dramatically

- **Decelerating Price Growth**
- Federal, state budget pressures constraining public payer price growth
- Payments subject to quality, cost-based risks
- Commercial cost shifting

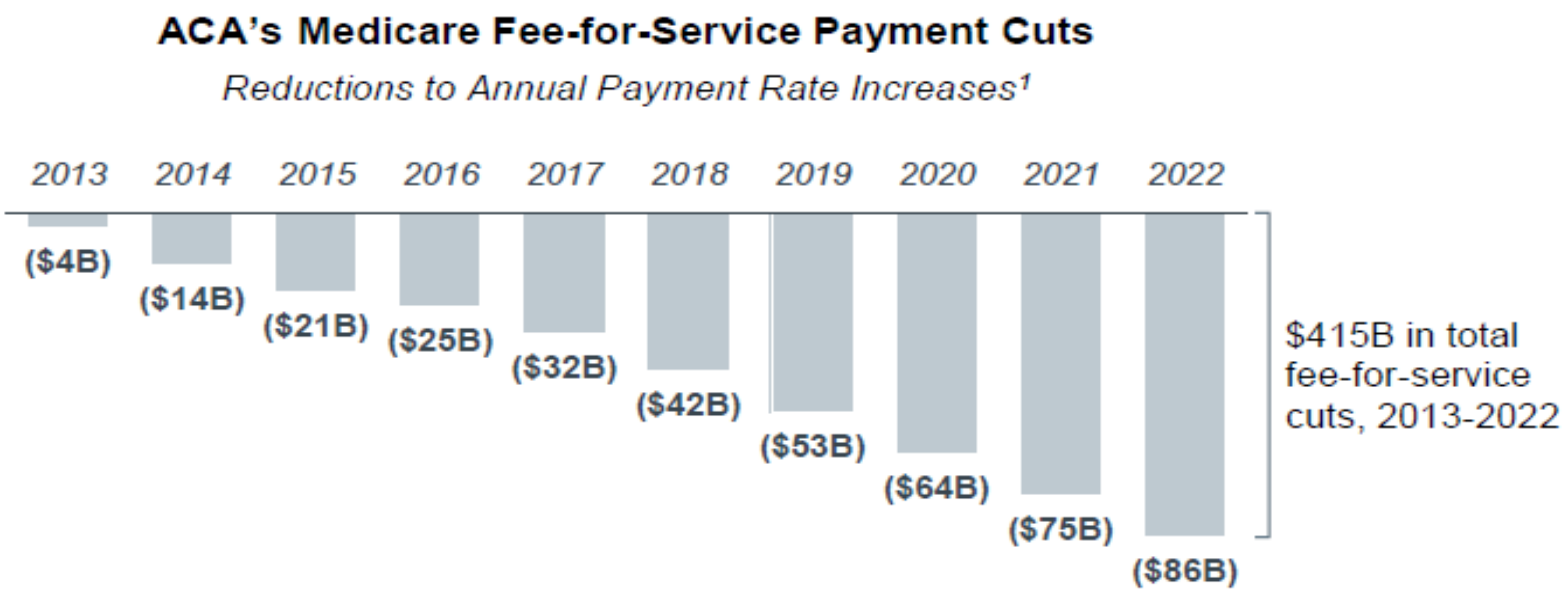
- **Continuing Cost Pressure**
- No sign of slower cost growth ahead
- Drivers of new cost growth largely non-accretive

- **Shifting Payer Mix**
- Baby Boomers entering Medicare rolls
- Coverage expansion boosting Medicaid eligibility
- Most demand growth over the next decade comes from publicly insured patients

- **Deteriorating Case Mix**
- Medical demand from aging population threatens to crowd out profitable procedures
- Incidence of chronic disease, multiple comorbidities rising

Reimbursement Already a Prime Target

- Medicare Payment Cut Becoming the Norm



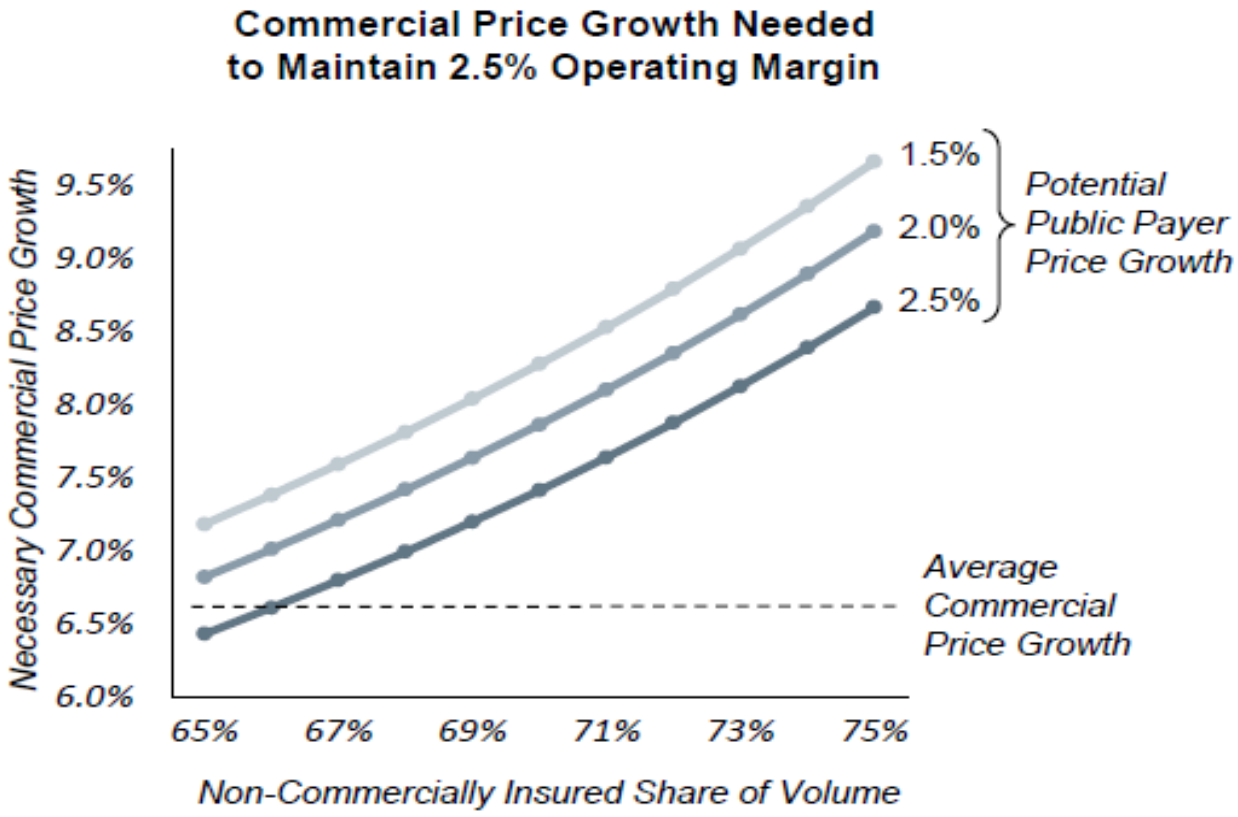
$260B
Hospital payment rate cuts, 2013-2022

$56B
Reduced Medicare and Medicaid DSH[2] payments, 2013-2022

1) Includes hospital, skilled nursing facility, hospice, and home health services; excludes physician services.
2) Disproportionate Share Hospital.

Source: CBO, "Letter to the Honorable John Boehner Providing an Estimate for H.R.6079, The Repeal of Obamacare Act," July 24, 2012, available at: www.cbo.gov; Health Care Advisory Board interviews and analysis.

Cost-Shifting Burden on Commercial Pricing Unsustainable



6-8%

Historical annual growth in commercial payer prices over last decade

3.5%

Advisory Board estimate of annualized commercial price growth, 2011-2021

- **Required Commercial Price Growth Unrealistic**

Source: American Hospital Association Chartbook, available at: http://www.aha.org/aha/research-and-trends/chartbook/index.html, accessed April 26, 2011; Health Care Advisory Board interviews and analysis.

Impact of Payment Reform-Not Limited to Government

- Commercial payers are also responding to health reform through the development of their own value-based products; Aetna, WellPoint, Inc., and UnitedHealthcare have announced that they will be revamping their physician reimbursement method nationwide.
- Anthem/WellPoint and four provider organizations jointly form a commercial ACO.
- Medica Health Plans introduces alternative PPO and POS payment products that incorporate shared savings.
- Aetna is implementing ACO initiatives with integrated health systems and is seeking clinical and IT partnerships

SOURCE: S. Delbanco et al., "Promising Payment Reform: Risk-Sharing with Accountable Care organizations," July, 2011.

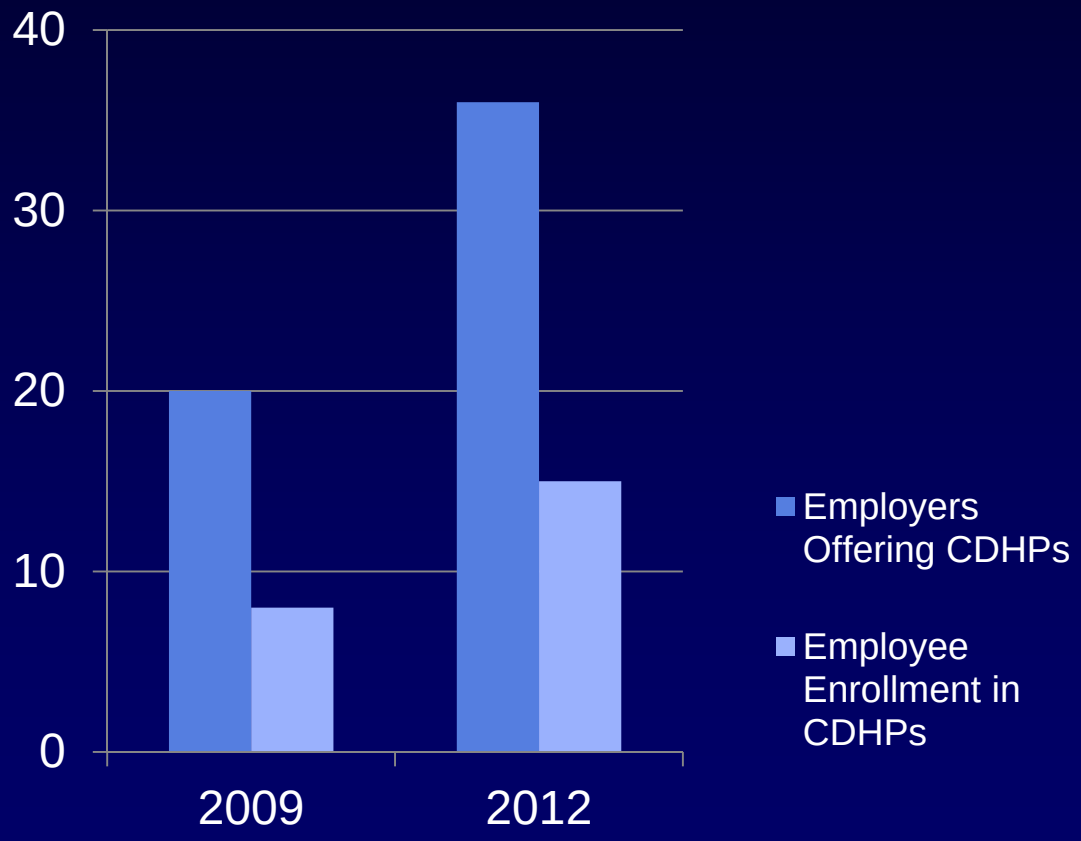
Value Based Healthcare – Game Changers

- The emergence of new partnerships:
  - Retail pharmacies
  - Community-based Clinics
  - Large employers partnering directly with providers to bring tailored healthcare solutions to their employees
  - Grocery Chains opening infusion centers

Employer-Driven Value Based Healthcare

- **Affordable Care Act will increase most employers' benefit costs by 2% to 3% in 2014.**

Employer Response- Co$t Shifting to the Employee



- **Accelerating the trend to consumer-directed health plans (CDHPs):**
  - **Proportion of large employers offering CDHPs has nearly doubled in three years, from 20% in 2009 to 36% in 2012**
  - **Employee enrollment in CDHPs has increased from 8% of covered employees to 15%**

***Oliver Wyman Group**

Value Based Healthcare

What can I do to meet these challenges?

New Care Delivery Approaches – Population Health

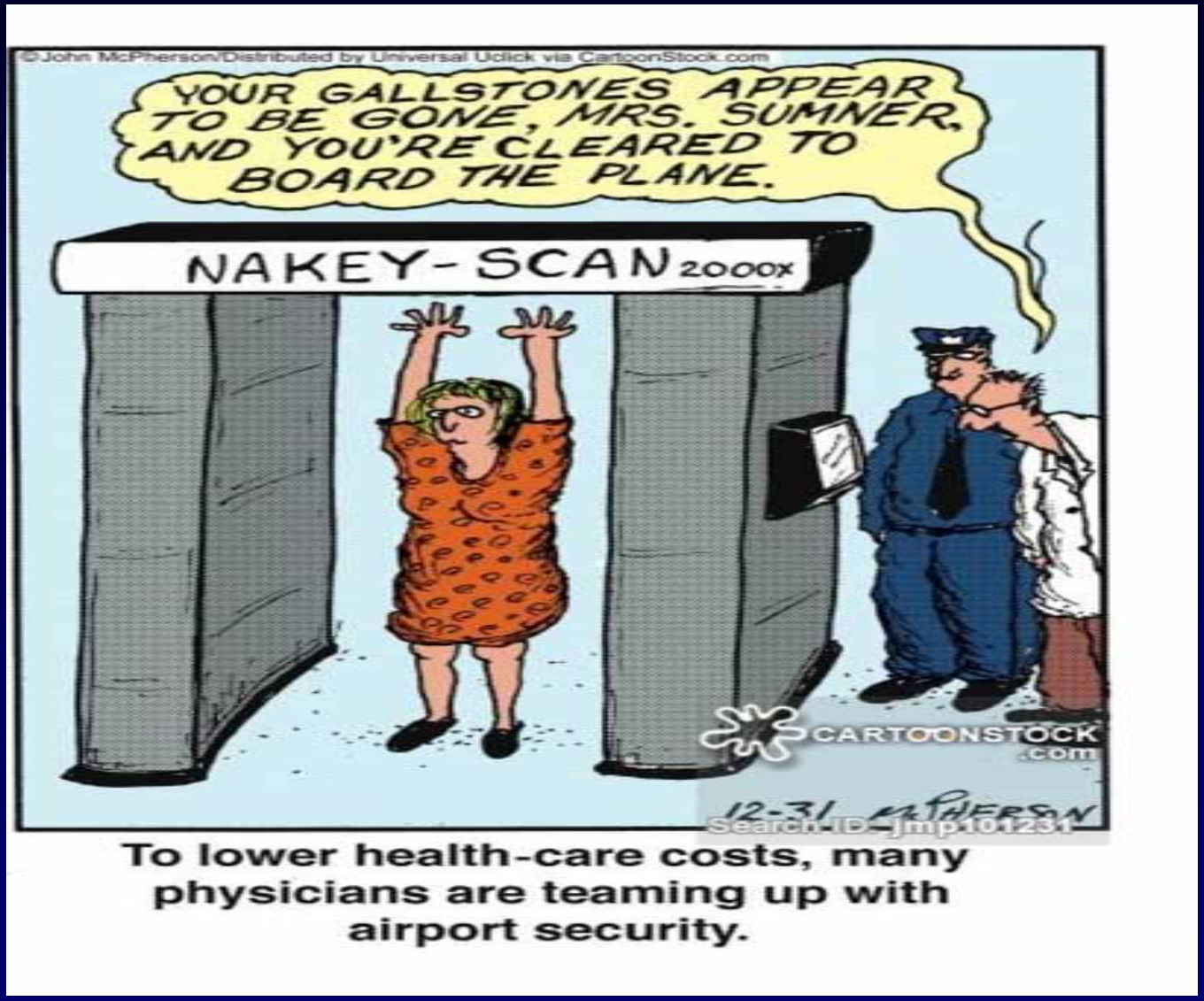
- For most employers, less than 20% of the employee population drives more than half of annual healthcare spending
  - Employers offering high touch programs
  - If providers do not offer these programs, they risk losing market share and increased administrative burden

New Care Delivery Models - PSOs

- Moving to Accountable Care Models and Contracting Directly with Provider Sponsored Organizations
  - New ACOs and PCMHs being established every month
  - Employers are increasingly supporting this provider transformation through partnering with such accountable care organizations
  - Wal-Mart launched its value-based Centers of Excellence program, contracting directly with leading providers such as the Cleveland Clinic to provide spine, heart, and transplant surgeries at no out-of-pocket cost to employees

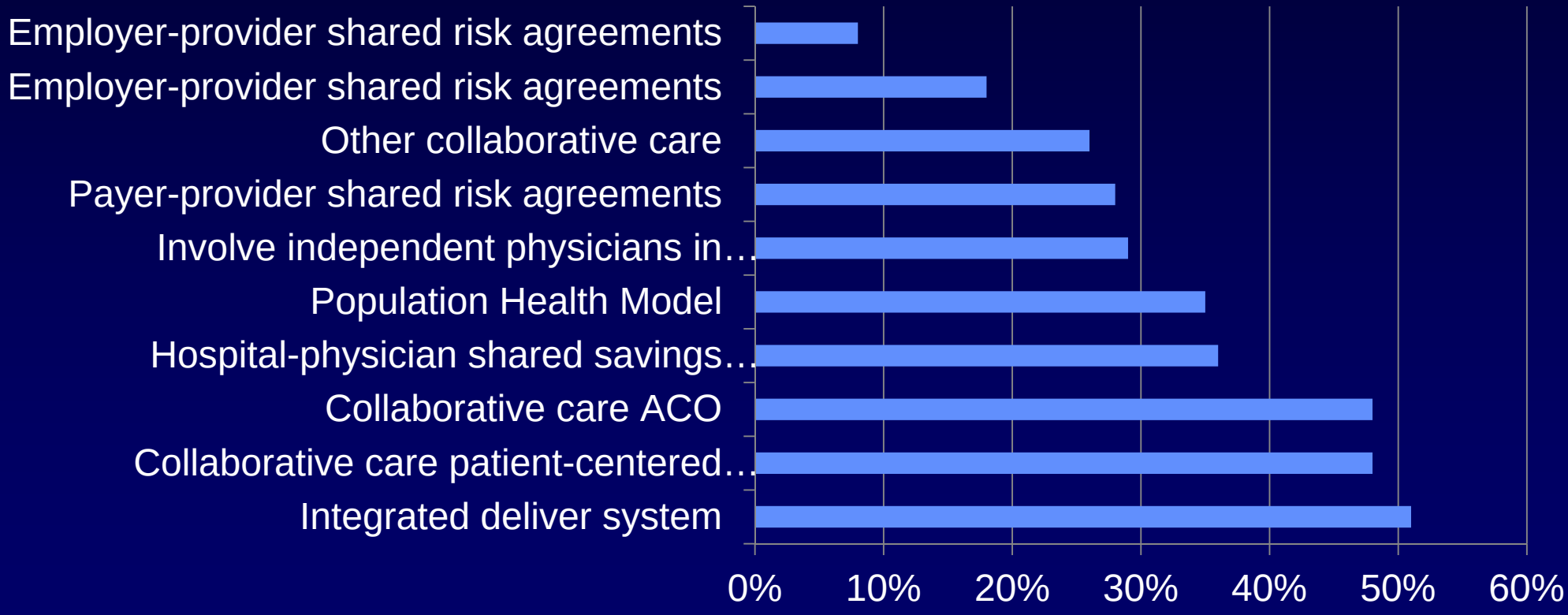
Value Based Healthcare

Financial Synergies

- 

Developing Initiatives

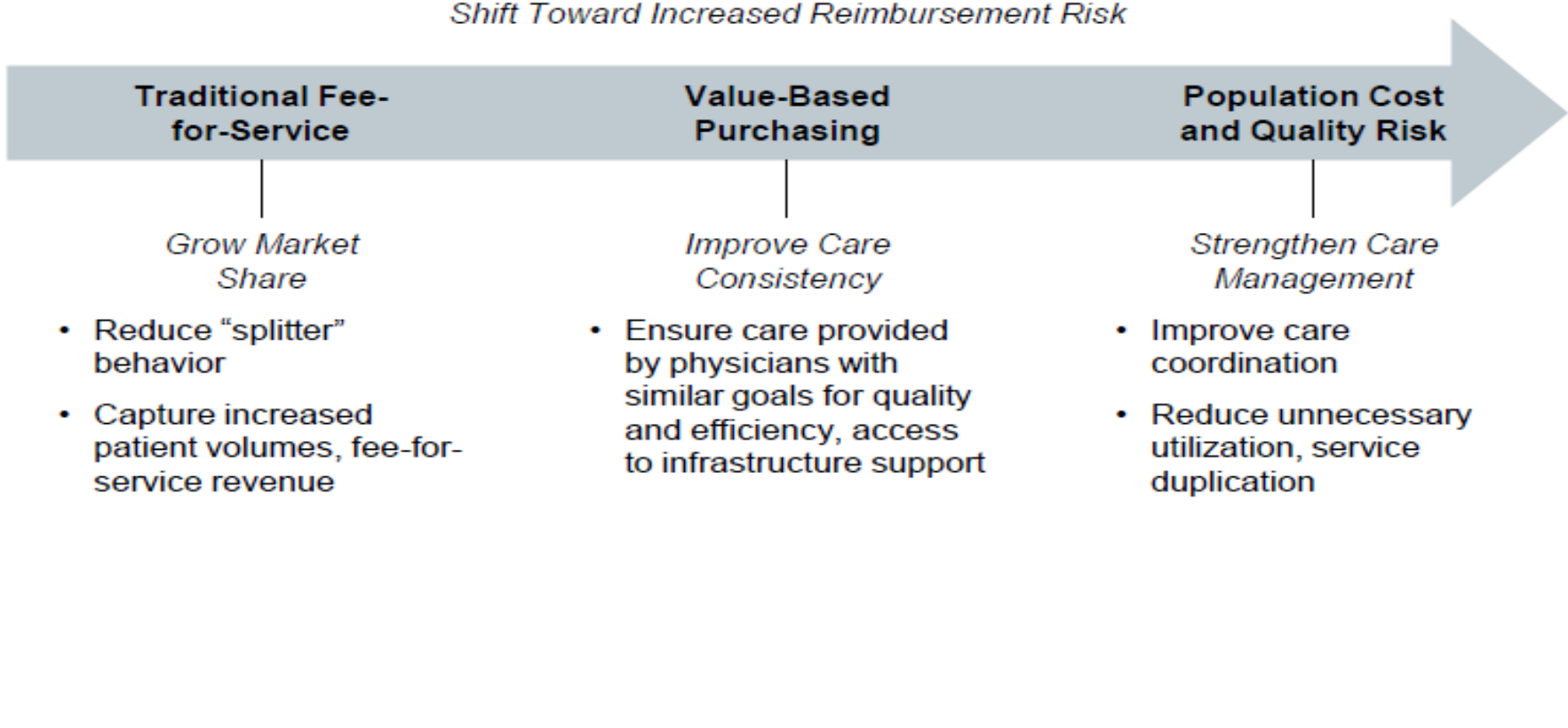
Which of the following is your organization likely to be pursuing within three years?



SOURCE: HealthLeaders Media Intelligence Report. *Collaborating to Improve Care and Cut Costs*. June 2012; http://content.hcpro.com/pdf/content/280839.pdf.

Recognizing the Importance of Referral Capture

- Keeping Patients In-Network Crucial Across Payment Paradigms



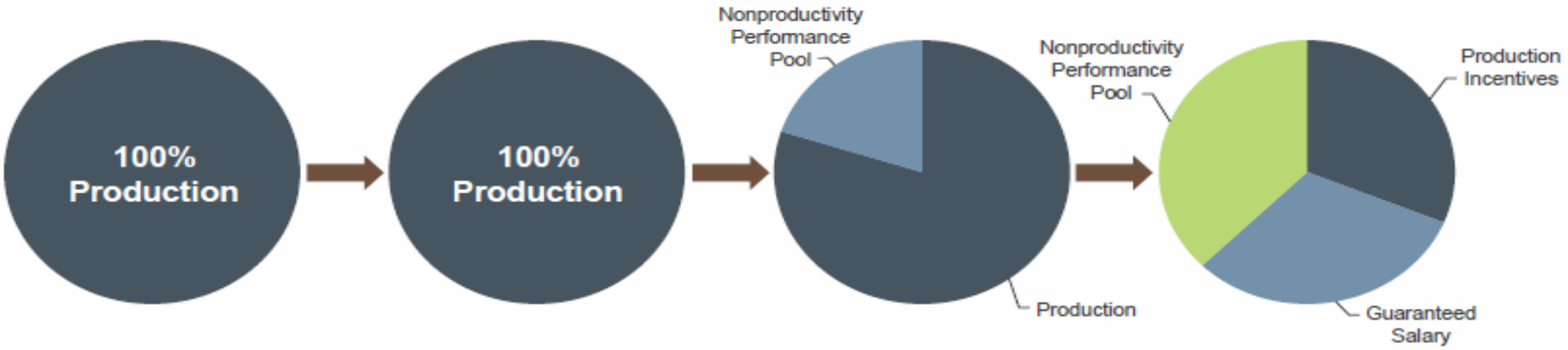
Value Based Healthcare

What can I do to meet these challenges?

- **Culture change in the organization**
  - **Devise compensation methodologies which align provider incentives**

Compensation Framework Migration Plan

The graphic below depicts how a productivity-oriented group might consider embarking on a shift to a non-productivity performance plan.



Current Plan

- Plan is assumed at 100% production.
- Major cultural shift required in transition.
- Data collection and reporting is inadequate.

Years 1 to 2

- 100% production plan continues.
- Performance measure data collected and tested.
- Shadow reports created.
- Work group created to identify nonproductivity metrics and tie them to compensation pools.

Years 3 to 5

- Production compensation reduced.
- Funding established for nonproduction pools.
- Nonproduction incentives grow every year and are continuously evaluated and improved.

Year 5-Plus

- Transition completed.
- Potential combination of production, nonproduction, and guaranteed salary components.

Value Based Healthcare

What are the tools I will need?

- **Information Technology**
  - Electronic Health Record
  - Health Information Exchange
  - Data Analytics
  - Referral management tools
  - Clinical Decision Support
  - Provider communication tools
  - Sophisticated support team

2 BROAD POLICY INITIATIVES TO IMPROVE VALUE

Critical Definitions

- **Value-based purchasing (VBP)**
  - → **Provider incentives for value**
- **Value-based insurance design (VBID)**
  - → **Patient incentives for value**
- **Remember: value is in the eye of the beholder**

Current Approaches to Cost / Quality Tradeoffs are Silo-based: Provider vs Patient as Target

- **Pay-for-performance (P4P) creates incentives for providers to improve quality**
- **Leading benefit design trend – increasing out-of-pocket (OOP) costs – creates incentives for consumers to curb use**
- **We are paying providers to subscribe beta blockers but then charging patients more to take them**
- **Silo-based approach to cost/quality tradeoffs may defy common sense**

VALUE-BASED PURCHASING

What is Value-based Purchasing (VBP)?

- **VBP refers to a broad set of performance-based payment strategies that link financial incentives to health care providers' performance on a set of defined measures**

- ***VBP = PROVIDER INCENTIVES***

- **Three broad types of VBP models:**
  1. **Pay-for-performance (P4P)**
  2. **Accountable Care Organizations (ACOs)**
  3. **Bundled Payments**

***See Damberg et al. RAND report to ASPE, 2014 – for excellent review of VBP to date**

VBP Models: Definitions

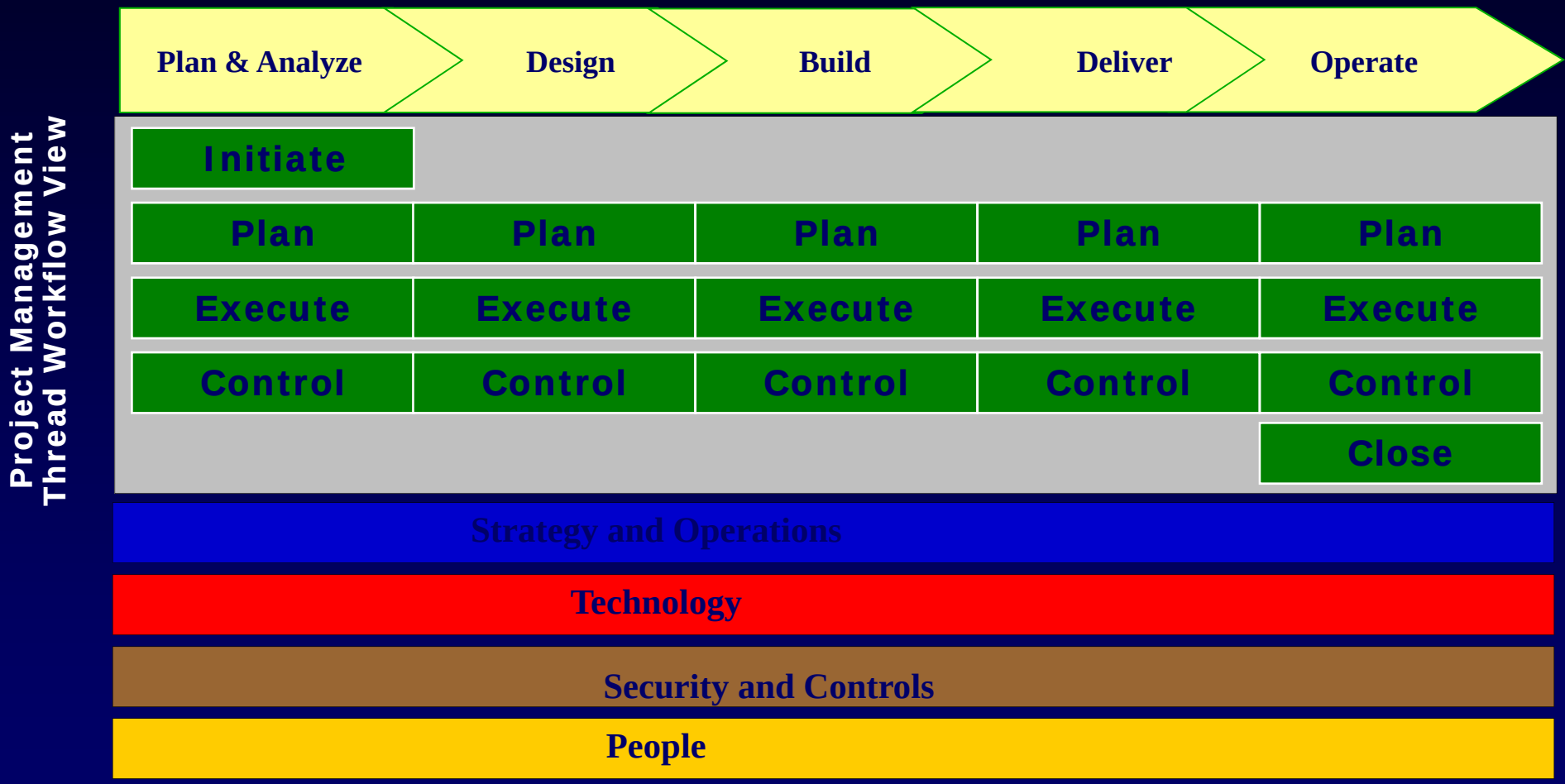
1. **Pay-for-performance (P4P): payments (or penalties) to reward providers for meeting specific quality benchmarks**
   - **E.g., >80% of CHD patients on beta blockers (HEDIS measures…)**

2. **Accountable Care Organizations (ACOs): multiple service providers organized to coordinate care across settings, and 'accountable' for performance on quality and cost measures**
   1. **ACO providers take on financial risk & eligible for share of savings**

3. **Bundled Payments: Payment based on expected cost for a clinically defined episode of care (episodes defined many ways → varying time windows, services included, etc.)**
   - **Differs from a Global Payment = fixed payment for all of a patient's care over a fixed time window (adjusted for patient risk)**

HOW DO WE OPERATIONALIZE THESE MODELS?

Overview – Workflow View with other Threads



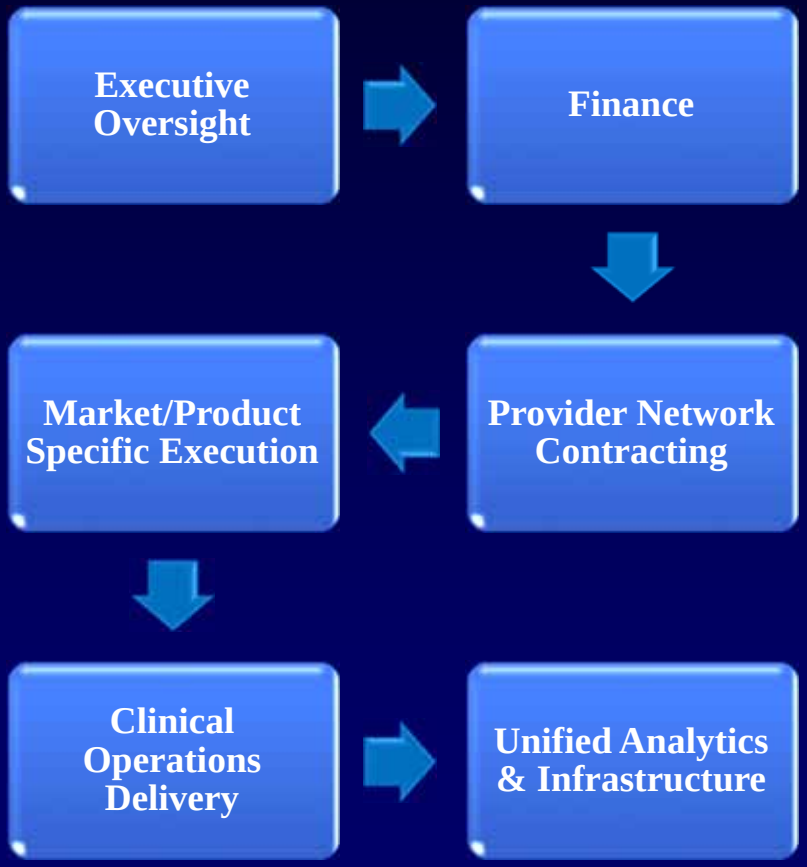
Case Study Approach

Finance & Contracting Readiness Assessment, Roadmap and Modeling Support Associated with Payment & Insurance Reform

- **Revenue and expense management – how prepared is the health system to manage gain share and risk share contracts? We will specifically answer these questions:**
  - **What systems/capabilities exist to process gain share and risk share payments today?**
  - **What systems / capabilities exist to optimize coding, which is critical to future CMS payments (inpatient, Medicare Advantage, the Exchange)?**
  - **Specifically related to a potential bundled payment budgeting**
- **Risk management, including reinsurance, stoploss, treasury, and related matters**
- **Managed care contracting**
- **Rewards, penalties, compensation**

Key Organizing Principals, Leadership Responsibilities & Risk Management

Summary Recommended Road Map



- Plan for Risks
- **Invest in Capabilities to Avoid/Mitigate Risks**
- Timelines are Important
- **Develop Detailed Implementation Plans & Execute**
- Manage Risks Across Corporate/Regional Networks

Key Risk Management Areas

Risk-Based Population Health Contract Success Metrics Recommendation

Best Practice/Recommendation for Input

Who Manages It?	Day-to-Day Functions	Potential Blind Spots that Need Transparency	Core Success Metrics	Emerging Skills & Tools to Manage the Risks
» CEO and Network CEOs (our recommendation for today) » System COO (recommendation based on best practices for the future)	» Care delivery » Staffing » Scheduling » Coding » Documentation	» Unexplained clinical practice variation » New expensive technology or devices during current contract » Disease prevalence & comorbidities in a given population » Expensive out-of-network utilization » No max $$ under ACA	» Systems to eliminate systemic patient safety risks » Systems to communicate patient clinical data to point of care in an accurate and timely manner » Avoidable utilization & cost metrics (e.g., ED, readmissions, generic Rx use rate)	» *Retool primary care practices* » *Clinically integrate delivery functions across the continuum* » *Adopt regional and local governance* » *Clarify centralized vs. decentralized* » *Clarify PHO vs. IPA vs. medical group functions, responsibilities*

Clinical and Administrative Operational Risk

Framework for linking process to-risk-to core success metrics, as hospital develops its risk-based contracting/pop. health capabilities

Risk-Based Population Health Contract Success Metrics Recommendation

Best Practice/Recommendation for Input

Who Manages It?	Day-to-Day Functions	Potential Blind Spots that Need Transparency	Core Success Metrics	Emerging Skills & Tools to Manage the Risks
» SVP Strategy, the keeper of the "proof points," pulse of market and developer of external strategic alliances › Works with hospital and physician leaders to organize and deliver	» Care facility and clinic placement » Partnerships and affiliations » Products and, service portfolio	» Unexpected patient behavior under various incentives such as high deductible health plans » Cherry picking "good risk" and dumping "bad risk" » Product, network and channel disruption based on competitors' actions or our inaction	» Lives under management » Distinctive market "proof points" re: quality, access, affordability (e.g. safety rating; patient satisfaction score; cost index)	» Comprehensive action plan re: product, network and channel tactics for growth » Includes appropriate ambulatory footprint, etc.

Competitive / Market Risk

Framework for linking process to-risk-to core success metrics, as PH develops its risk-based contracting/pop. health capabilities

Risk-Based Population Health Contract Success Metrics Recommendation

Best Practice/Recommendation for Input

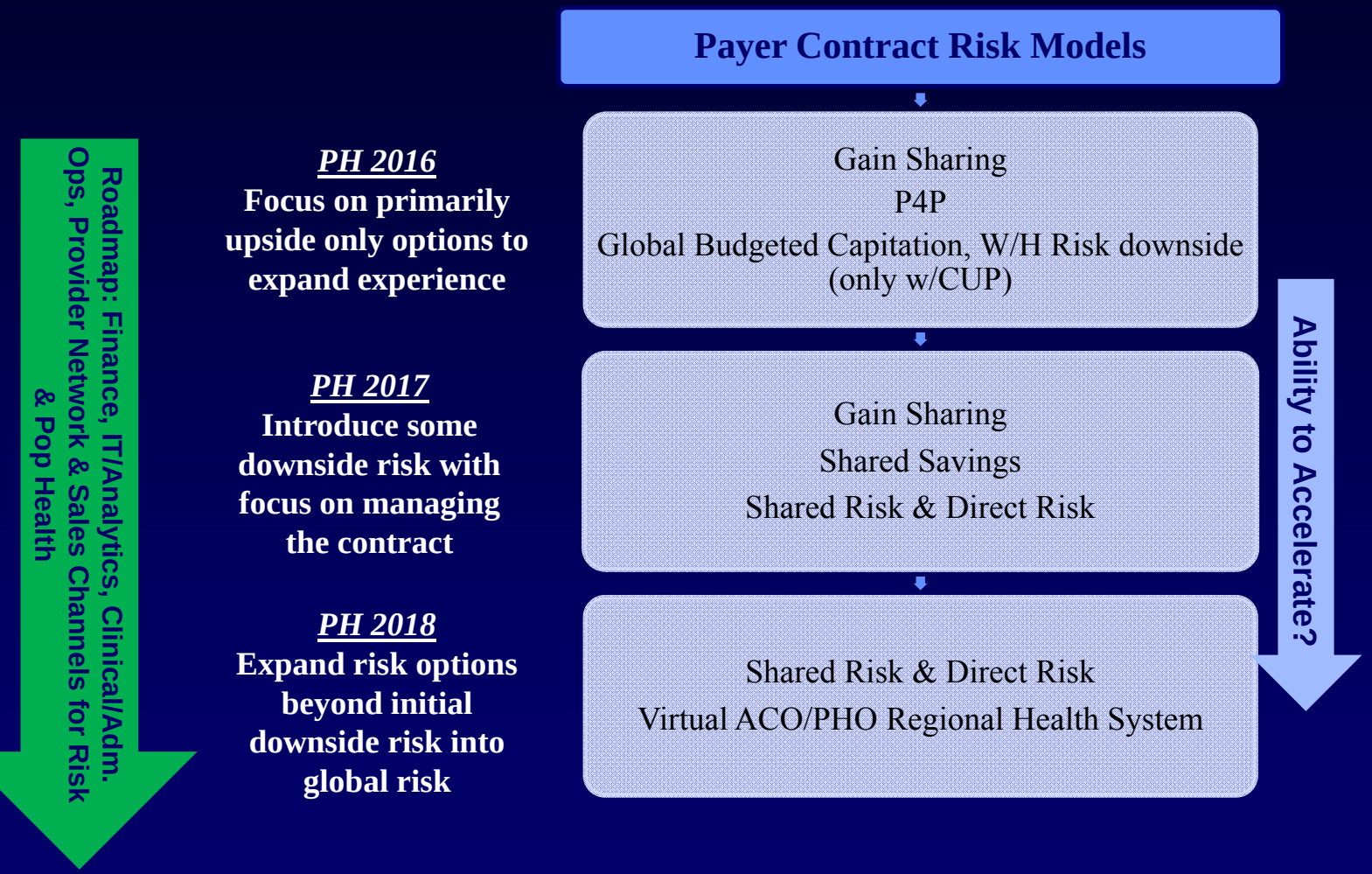
Who Manages It?	Day-to-Day Functions	Potential Blind Spots that Need Transparency	Core Success Metrics	Emerging Skills & Tools to Manage the Risks
» System CFO	» Pricing » Budgeting » Investing, Reserving » Rewards	» How various competitive, market, clinical and administrative risks factor into key pricing, budgeting, investing, etc. decisions – given that competitive and operational risks can never be fully controlled	» % Revenue with performance contracts » % PMPM the PH system directly owns of total claim dollars for population health mgmt. » Commercial pricing relativity vs. market	» Stratify and quantify patient populations » Control patient benefit design/ incentives » Manage a retail pricing strategy » Underwriting and actuarial skills » Single source of truth analytics and reporting

Financial Risk

Framework for linking process to-risk-to core success metrics, as hospital develops its risk-based contracting/pop. health capabilities

Risk-Based Contracting Overall Readiness Ratings: Managed Care Contracting Recommendations

Recommended Transitional Risk Models for Commercial & Medicare Advantage by Year



Risk Model Decisions

- **» Investment**
- **» Payout and withhold mechanics**
- **» PCP, specialty, facility % split**
- **» Metrics & measurement**
- **» Transparency**
- **» 3 year evolution**
- » Administrative fees
- » Data feeds
- » Support resources from payers

What Most Experts Have Concluded about P4P in Health Care

- **Small bonuses for performance on top of fee for service is a little like moving deck chairs on the Titanic; holistic reform is needed**

- **Pay for performance – on either quality or cost-related targets alone – is the wrong model for cost control**

- **Broader payment reforms are needed (but not sufficient)**

VALUE-BASED INSURANCE DESIGN

What is Value-Based Insurance Design (VBID)?

- **Cost-sharing structured to encourage patients to use those services with greatest potential to positively impact their health**

- **Clinically nuanced – the benefit design can differ based on the enrollee's health**

Chernew, Rosen, Fendrick.** ***Health Affairs, **2007**

Potential Solution to Cost-Related Non-Adherence

Clinically Nuanced Cost-Sharing

What is clinical nuance?

Services differ in clinical benefit produced

Clinical benefits from a specific service depend on:

Consumers Do Not Respond to Cost Sharing as Economists Would Like

- When copays are applied uniformly across services of varying health benefit, consumers reduce both excess and essential service use alike
- Evidence demonstrates that increased cost sharing leads to adverse health outcomes
  - Effects concentrated in the chronically ill and poor
- For some chronic diseases, copay-related underuse actually results in higher costs of care

Goldman et al, JAMA, 2007; Trivedi et al, NEJM 2008, 2010;

Getting Services to People Who Need Them: Should the Patient Decide?

- If increased cost sharing decreases the use of essential medications & leads to worse outcomes, is it appropriate to place the burden of weighing the benefits and costs of medical interventions on the patient?

- If not, the system should provide some guidance and incentives to promote better decisions

Getting Services to People Who Need Them: Value-Based Insurance Design

- Value-based insurance design has been proposed to realign incentives for value
- Cost sharing is based on likelihood of benefit, not (solely) the acquisition cost
  - The greater the benefit, the lower the co-pay
- Such a system would provide financial incentives to targeted patients most likely to benefit from specific therapies

Fendrick AM. Am J Managed Care, 2001. Rosen AB. Med Care, 2006. Chernew M. Health Affairs, 2007.

Value Based Insurance Design (VBID)
Ongoing Programs

- **Several ongoing experiments with VBID**
  - **These efforts initially came out of the private sector**
  - **Several state Medicaid programs experimenting with VBID**
  - **Medicare Advantage VBID demonstration pending**

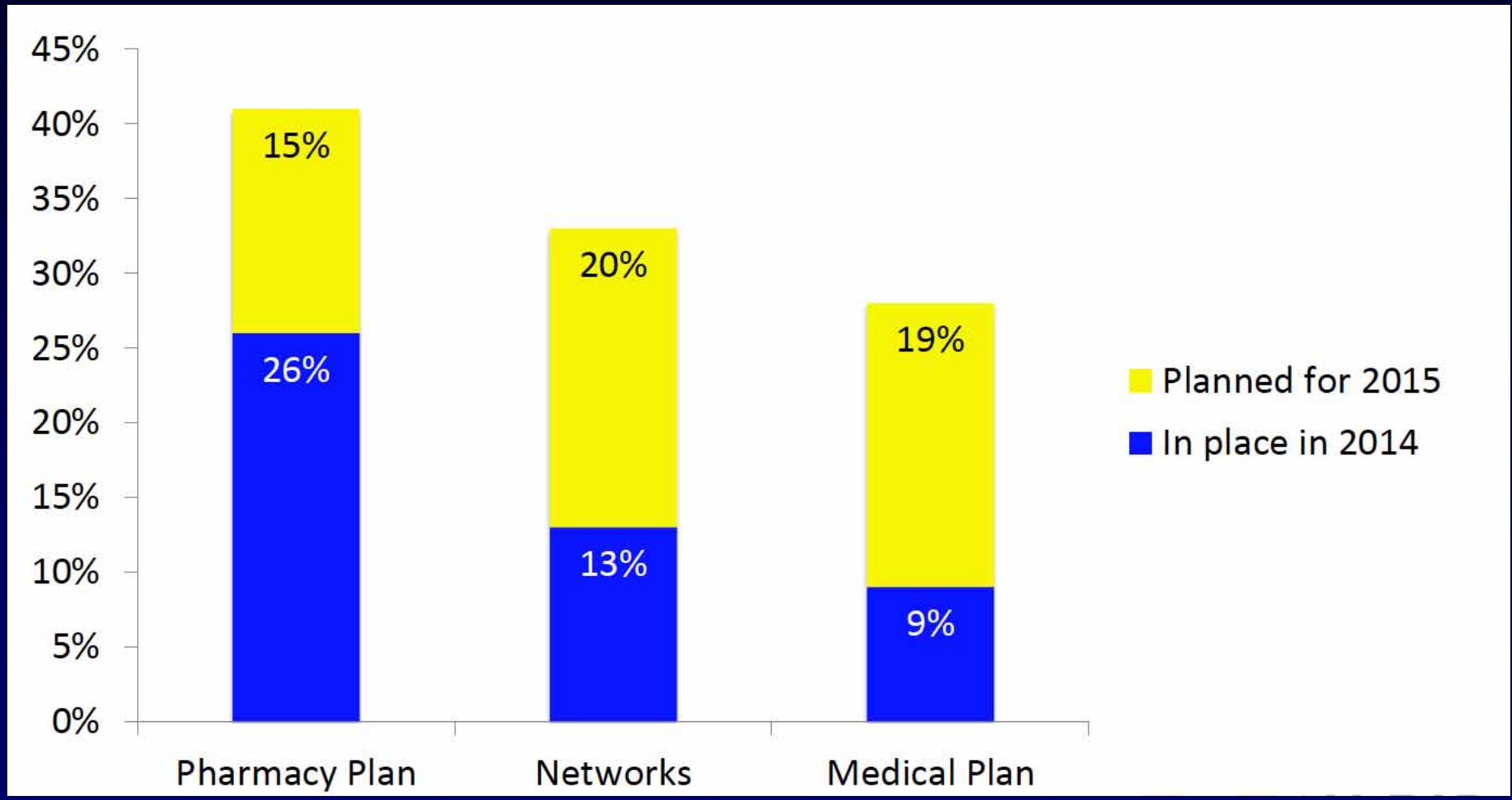
- **Targeting is key → two basic approaches**
  1. **Target services that are high value (e.g., beta blockers)**
  2. **Target patients with select clinical diagnoses (e.g., Hot spotters/High utilization)**

Value Based Insurance Design
Maximizing Return On Investment

Incremental costs of increased use of high value services can be subsidized by:

1. **Medical cost offsets**
   - **Amount saved by preventing adverse events will be directly related to level of clinical targeting**
2. **Enhanced productivity**
3. **Reduced disability costs**
4. **Higher cost sharing for services of lower value**

Uptake of VBID in the Private Sector



*Source: 19th Annual Towers Watson/National Business Group on Health employer survey

Barriers to VBID in Medicare Translating Research Into Policy

Medicare Advantage Value-based Insurance Design (VBID) Demonstration

- 5 year demo, beginning 1/1/2017, in 7 states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee

- Plans have flexibility to design VBID for any of following 7 pre-defined conditions:
  - Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Hypertension, coronary Artery Disease (CAD), Past Stroke, Mood Disorders

- VBID benefits must reduce cost-sharing (or add benefits) only: "carrot" – not "stick" – for initial years

Fundamental Health Policy Question

How do we organize and finance health care to achieve maximum value for what we spend?

****NOT: "How do we save money?"**

(wink, wink)

Thank you! Questions?

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