



Comparative policy analyses for improving value

Value in Canadian Healthcare,
CHSPR Annual Health Policy Conference

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The
Commonwealth
Fund



Westat[®]

David Radley, PhD
Senior Scientist at Commonwealth Fund
Senior Study Director at Westat

'health outcomes achieved per dollar spent'

-Porter & Teisberg (2006)

Payer

- Lowering costs
- Maintaining customers
 - Maintaining a robust provider network
- Profitability

Patient

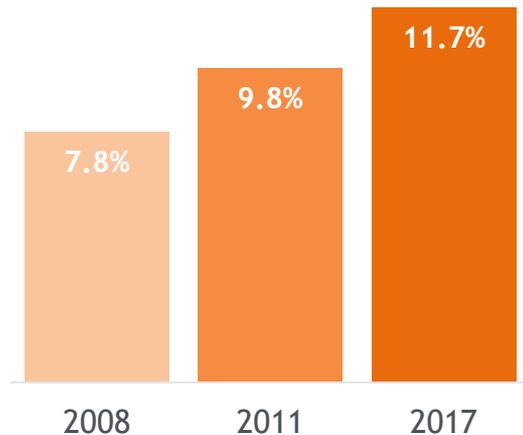
- Access to the services that will ensure the best possible outcome
- Receive care that is safe & as convenient as possible
- Feel respected and dignified
- Pay an affordable price (with no surprise bills)

Providers

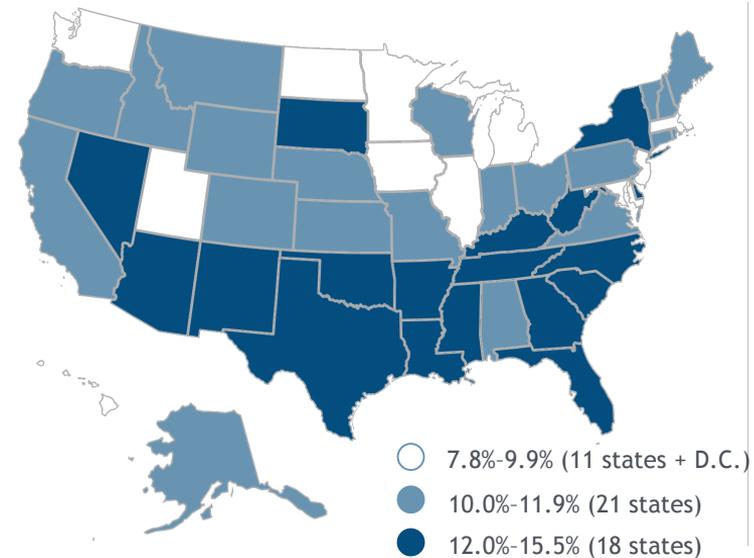
- Act in their patients' interests
- Operating costs:
 - Rents, facility maintenance, technology upgrades, staffing, etc.
- Profitability

Misalignment in payer, patient, and provider incentives contributes to higher costs for families

Average employee premium contribution + deductible as share of median income

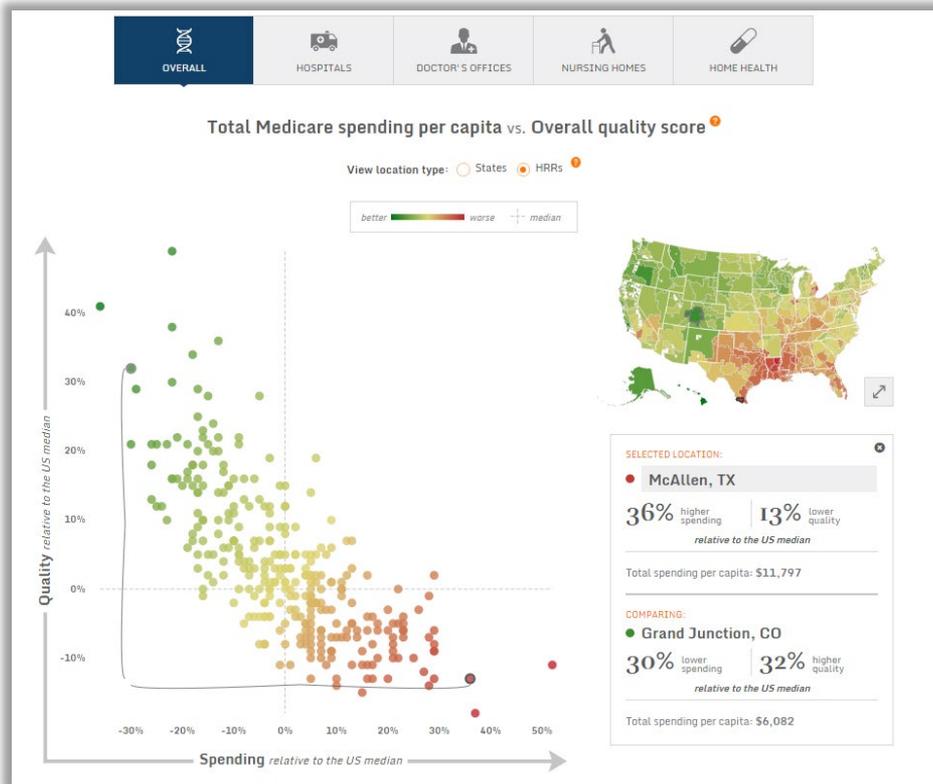


Employee premium contribution + average deductible as share of state median income, 2017



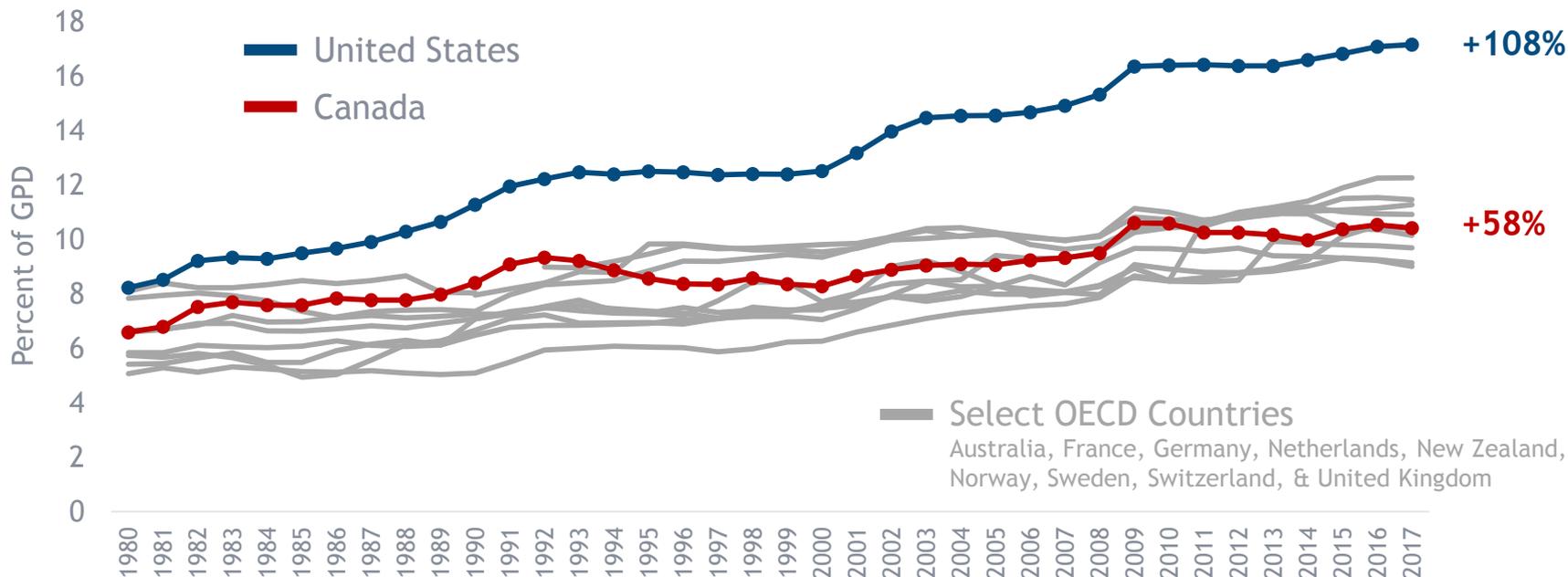
Notes & Sources: Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), which revised its income questions in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimates from 2017 are estimated from the revised income questions. Household incomes have been adjusted for the likelihood that people in the same residence purchase health insurance together. Data: Employee premium contribution and deductible: Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2008, 2011, 2017; Median household income: Current Population Survey, 2008-09, 2011-12, 2017-18. Source: Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonwealth Fund, Dec. 2018).

Achieving high value?



- Major advancements in care delivery, outcomes, life-expectancy
- High per-capita spending
- Opaque pricing
- Waste & inefficiency
- Remain ill-equipped to capture the patients' experience in the value equation

Healthcare spending as a share of GDP in U.S. and Canada with international comparison, 1980-2017



Fee-for-service payment

- Dominant form of payment among US Physicians
- Creates incentives to do more
 - Overtreatment
- Antiquated approach that does not fit with modern care delivery
- Facilitates other cost drivers

Type of Compensation
Reported by US
Physicians, 2016



Source: Deloitte 2016 Survey of US Physicians

Cost drivers

Overtreatment

- Numerous examples:
 - Regional variation within the US
 - Service use at the End of Life
 - Advances in the screening and disease detection (which can make findings non-harmful abnormalities more common)
 - Higher use of certain services (e.g. hospital admission) in the US than in other countries for similarly ill patients
- Driven by clinical uncertainty

Admin. Complexity & Fraud

- Overlapping public & private systems for financing and delivering care
- Federal government + 50 states
- Little standardization

Administration costs estimated at

\$360 Billion

Failures of Care Delivery

- Sub-optimal care with little/no therapeutic value



29%

of adults received potentially inappropriate lower back imaging at diagnosis

- Medical harm and associated treatments

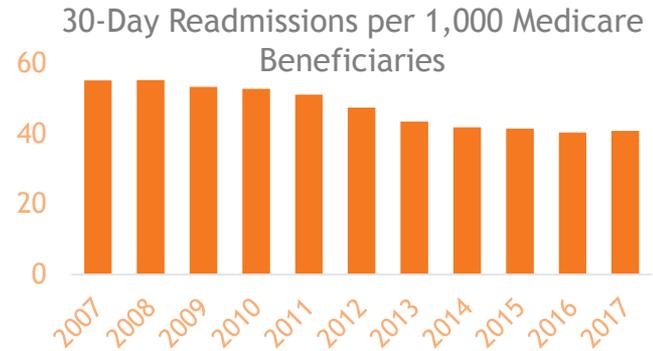


1 in 3

hospital admissions had adverse events capable of causing harm

Failures of Care Coordination

- Duplication of services (e.g. repeat lab testing and imaging)
- Re-hospitalization

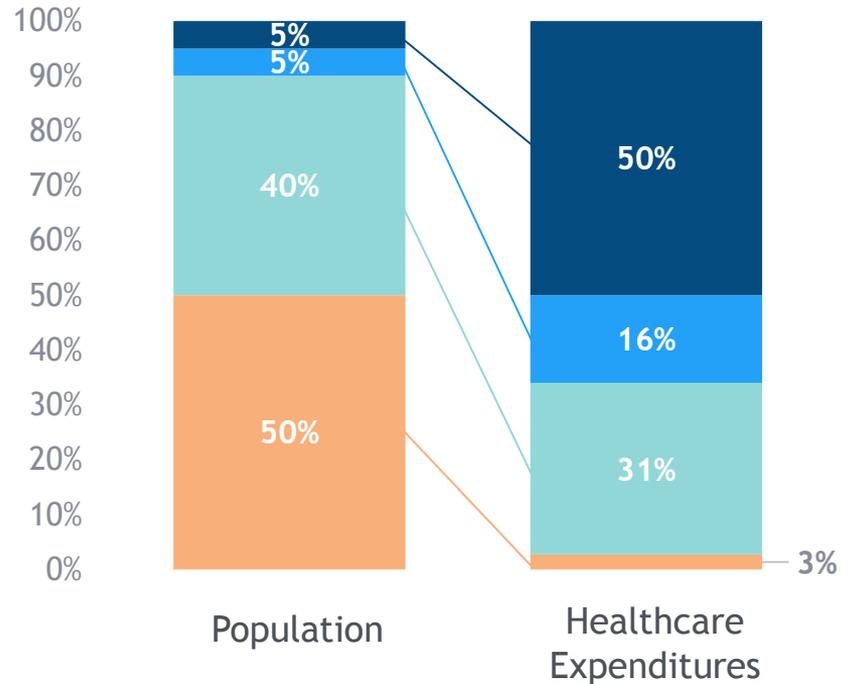


- Caring for patients with complex care needs

Healthcare spending concentrated Among complexly ill patients

- Persistently ill year-over-year
 - 28% of 'complexly ill' Medicare beneficiaries persistently high cost
 - Persistently high-cost: \$64,434 per bene per year
 - Not high-cost: \$4,538 per bene per year
- Social care needs as challenging as medical needs for many
 - Housing and food insecurity
 - Transportation

Healthcare Expenditures by Share of the U.S.



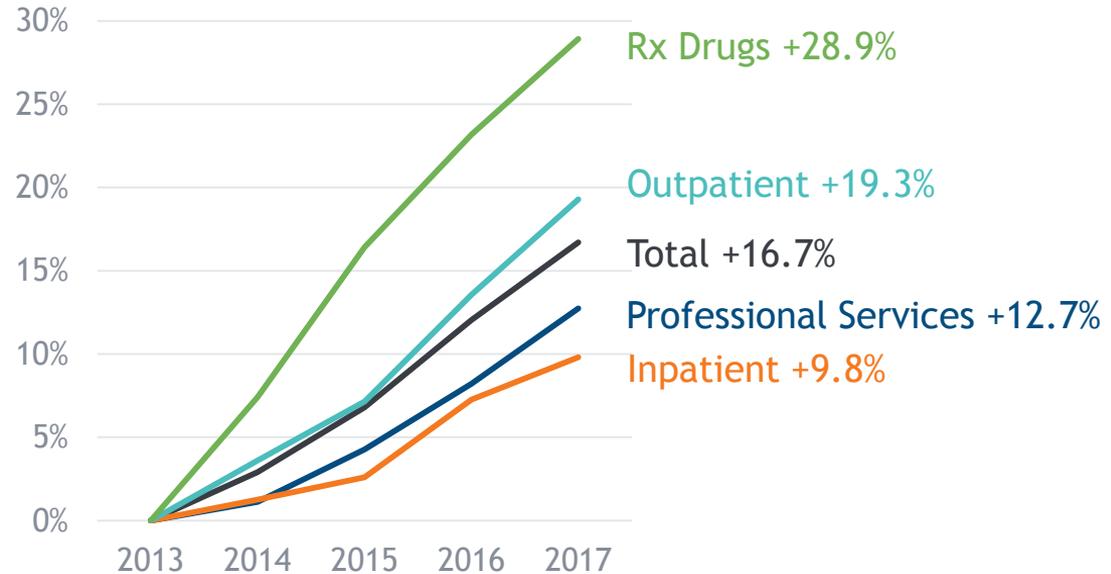
Source: Medical Expenditure Panel Survey-Household Component, 2014

“It’s the Prices Stupid...”

≈150 million Americans get health insurance through their employers

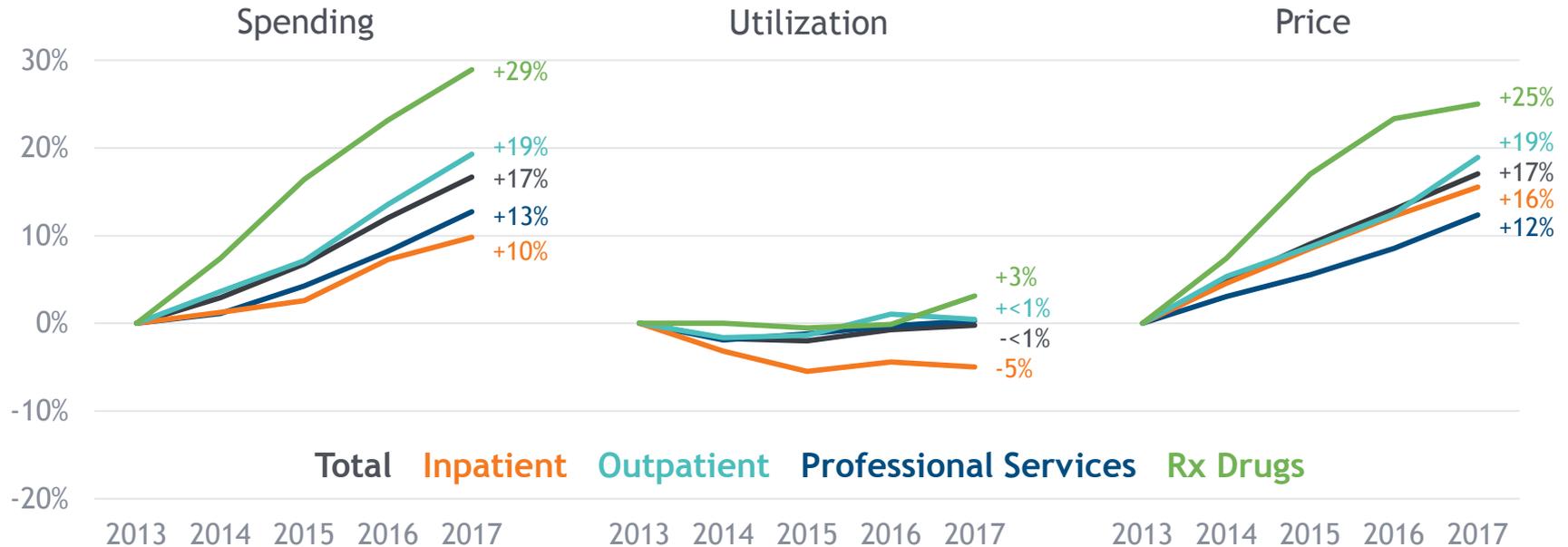
Total \$5,641	
Professional Services 34% \$1,898	Outpatient 28% \$1,580
Inpatient 19% \$1,097	Rx Drugs 19% \$1,065

Cumulative Change in Spending per Person, 2013-2017



“It’s the Prices Stupid...”

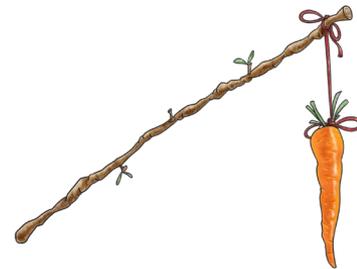
Cumulative Change in per person Spending, Utilization, Average Price, 2013-2017



Notes & Sources: Utilization and average prices account for changes in the type or intensity of services used, with the exception of prescription drugs. Prescription drug spending is the amount paid on the pharmacy claim, which reflects discounts from the wholesale price, but not manufacturer rebates. Healthcare Cost Institute, 2017 Healthcare Cost and Utilization Report. Available here: <https://www.healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report>

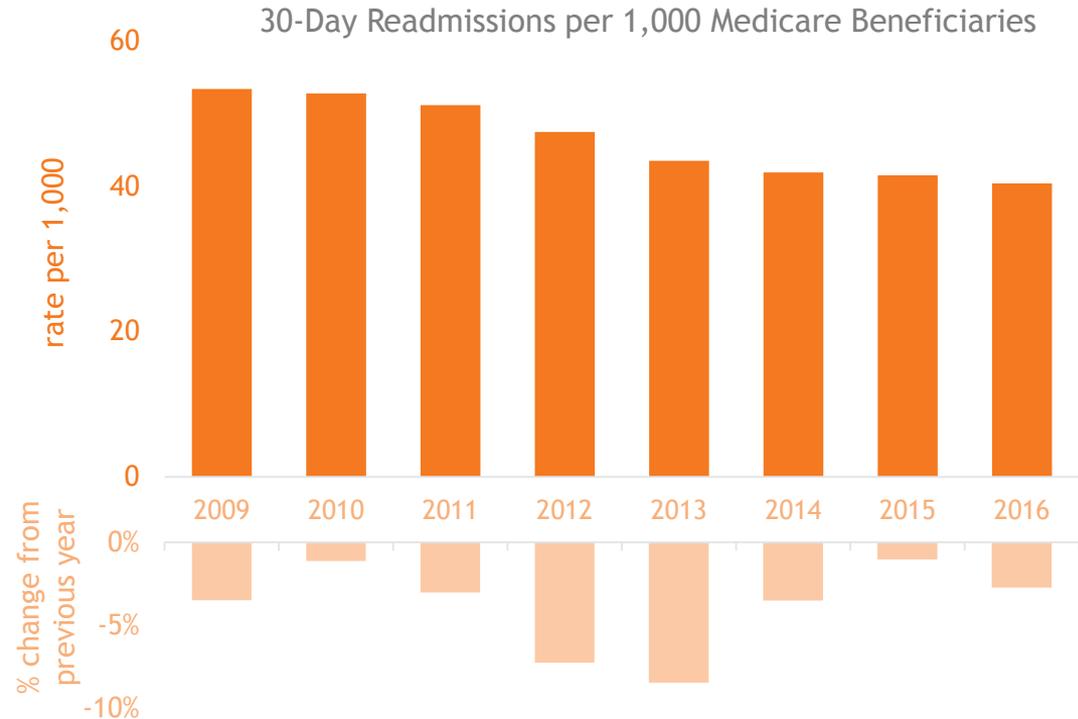
Policy-supported innovation at all levels

- Federal government
 - Medicare program, insurance coverage for ≈55 Million (mostly) elderly Americans
 - Single largest purchaser of healthcare services
 - Center for Medicare and Medicaid Innovation (CMMI) models
- States
 - Medicaid programs (with federal support) provide coverage for ≈72 million lower income Americans
 - States have (increasing) flexibility in how they implement Medicaid—can apply for ‘waivers’ to get permission to try new things
- Private / Commercial
 - ≈150 Million Americans get insurance coverage through employer-sponsored plans



Medicare program using payment authority to lower readmission rates

- Hospital Readmission Reduction Program gave the Medicare program authority to penalize hospitals with higher than expected 30-day readmission rates
- Penalties as high as 3% on all FFS Payments
- Payment penalties began in October 2012

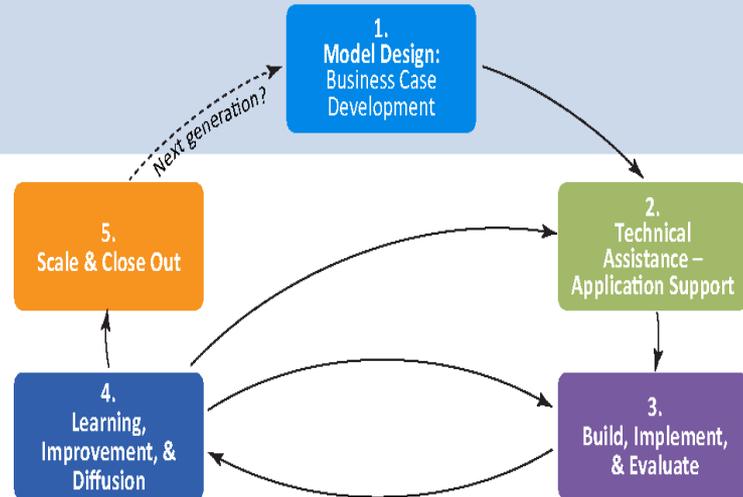


Source: Medicare claims via Feb. 2019 CMS Geographic Variation Public Use File.

CMMI innovation models

- CMMI created legislatively, and given broad authority to develop, implement, and evaluate new approaches for organizing care delivery and payment
- Providers are required to voluntarily participate
- Most “models” have some shared risk component, where participating providers have opportunity to benefit financially from providing high quality care at a lower cost

Environmental Factors Influencing Model Design, Implementation, & Evaluation:
Regulatory/policy landscape, healthcare market and infrastructure, regional/local practice patterns, social and community resources, beneficiary characteristics



System Characteristics Contributing To Model Success

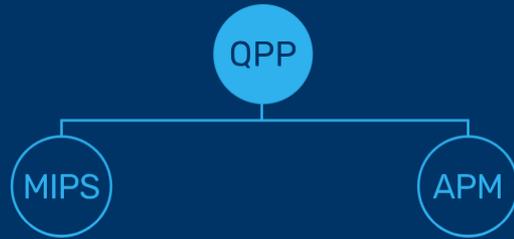
- Organization readiness
- Stakeholders
- IT infrastructure
- Self-assessment/QI
- Staffing model and training
- Leadership
- Beneficiary engagement
- Tolerance for Financial Risk

CMMI innovation models

- Accountable Care models
 - Providers coordinate patient care across different settings (outpatient, acute care, post-acute)
 - Participating organizations are given a fixed amount per beneficiary and get to keep unused portions if care quality and outcome goals are achieved
- Bundled & Episode Based Payment models
 - Condition-specific models
 - Providers given a fixed amount for providing s ‘bundle’ of related services (e.g. joint replacement)
 - Incentive to provide more efficient care to keep unused portion of the payment
- Population-focused models
 - Will apply these (and other) risk-sharing strategies to provided care to certain populations of focused interest (e.g. Medicaid beneficiaries with mental illness, beneficiaries with long-term care needs, etc.)

Quality Payment Program

The Quality Payment Program Has Two Participation Tracks



Merit-based Incentive Payment System

In MIPS, you may earn performance-based payment adjustments for the services you provide to Medicare patients.

[Explore how you can participate in MIPS](#)

Alternative Payment Model

An APM is a customized payment approach developed by CMS, often designed to provide incentives to clinicians who are providing high-quality, high value care. APMs can focus on specific clinical conditions, care episodes, or populations.

MIPS

- (most) providers who participate in Medicare are automatically enrolled in MIPS
- Medicare payments will be adjusted based on performance in Quality, Improvement Activities, Promoting Interoperability, and Cost.
- Little risk to providers, smaller performance adjustments

APMs

- Providers self select into an APM
- Eligible for incentive bonuses up to 5% annually
- Strict and comprehensive reporting and quality performance standards
- Participants bare more risk at onset

States Taking the Lead

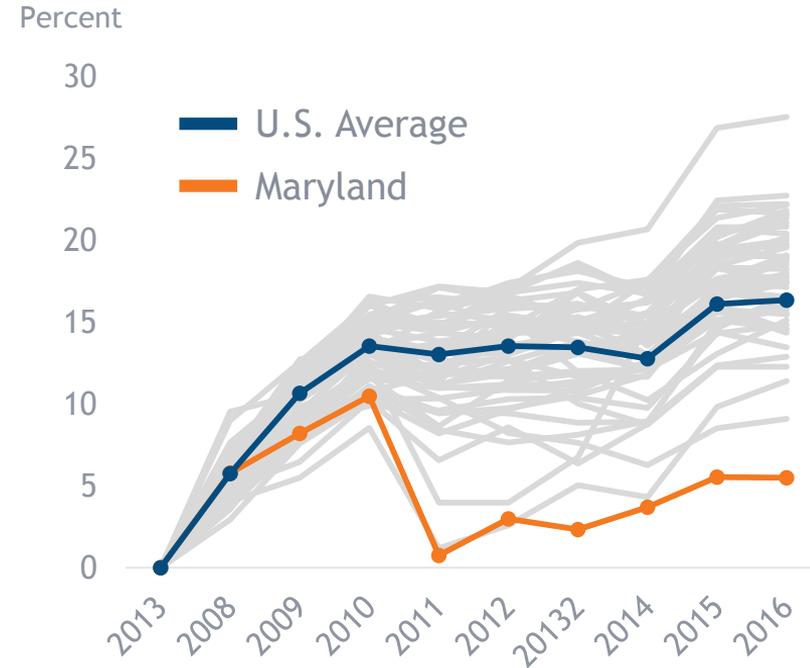
- Lower healthcare spending without compromising healthcare quality or outcomes:
 - Maryland's "All Payer Model" and "Total Cost of Care Model"
 - Vermont All Payer ACO
- Innovation in Medicaid
 - Colorado's efforts to lower prescription drug spending

Maryland



- Public rate setting for hospital services since 1970s
- (2014-2018) All-Payer Hospital Model:
 - hospitals paid on global payment model
 - Targets:
 - Growth limited to 3.58% per year
 - 5-year Medicare savings \$330M
 - Various quality and utilization targets
 - Regarded as successful - met or exceeded spending and quality targets
- (2019 and beyond) Expanding beyond hospitals in the “Total Cost of Care Model”

Cumulative Change in Medicare Per Beneficiary Spending, 2013-16



Performance Measures	Targets	2014 Results	2015 Results	2016 Results	2017 Results
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.47% growth per capita	2.31% growth per capita	0.80% growth per capita ¹	3.54% growth per capita
Medicare Savings in Hospital Expenditures	≥ \$330m cumulative over 5 years (Lower than national average growth rate from 2013 base year)	\$120 m (2.21% below national average growth)	\$275 cumulative (2.63% below national average growth since 2013)	\$586m cumulative ¹ (5.50% below national average growth since 2013)	\$916m cumulative (5.63% below national average growth since 2013)
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	\$142m (1.62% below national average growth)	\$263m cumulative (1.31% below national average growth since 2013)	\$461m cumulative ¹ (2.08% below national average growth since 2013)	\$599m cumulative (1.36% below national average growth since 2013)
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	30% reduction over 5 years	25% reduction	34% reduction since 2013	44% reduction since 2013	53% reduction since 2013
Readmissions Reductions for Medicare	≤ National average over 5 years	19% reduction in gap above nation	58% reduction in gap above nation since 2013	79% reduction in gap above nation since 2013	116% reduction in gap above nation since 2013 (Currently 0.19% lower than National RR)
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	95%	96%	100%	100%

¹During the last six months of CY 2016 (July – December of 2016), Hospitals undercharged their Global Budget Revenue mid-year targets by approximately 1 percent (\$25M dollars). The measures reported have been adjusted to 'add back' the undercharge to the period of July – December 2016 to offset the decline in savings for January – June 2017.

- The "Targets" are from the All-Payer Model Agreement, with the exception of the "Medicare Savings in Total Cost of Care" measure, which is a limitation of the Agreement.
 - All Payer Hospital Growth measure, the data is from the HSCRC monthly hospital volume and revenue data.
 - MHAC data is derived from Maryland's All Payer Hospital Acquired Conditions Program results.
 - Other measures, Maryland calculated the data from CMS monitoring data, which were included in final reports for the applicable years.

Vermont All-Payer ACO

- Partnership between the Medicare program, state Medicaid program, and the state's private insurers to develop a statewide Accountable Care framework
- Target:
 - 70% all insured Vermont residents attributed to an ACO
 - 3.5% cost growth cap across all payers
 - Increased reliance on primary care (less on specialty care)
- Unique because this is the first ACO targeting an entire state population



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CMS OKs Colorado's waiver for Medicaid value-based purchasing

By Robert King | February 25, 2019

The CMS on Monday approved a request by the state of Colorado to negotiate drug prices for Medicaid based on their effectiveness and value.

Colorado is the third state to get approval from the CMS to create such a program.

Private Sector Innovation

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TOPICS

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HEALTH AFFAIRS > VOL. 31, NO. 8: CHALLENGES FACING THE SAFETY NET

The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending And Improved Quality

Zirui Song¹, Dana Gelb Safran², Bruce E. Landon³, Mary Beth Landrum⁴, Yulei He⁵, ... See all authors ↘

Overall, participation in the contract over two years led to savings of 2.8 percent (1.9 percent in year 1 and 3.3 percent in year 2) compared to spending in nonparticipating groups. Savings were accounted for by lower prices achieved through shifting procedures, imaging, and tests to facilities with lower fees, as well as reduced utilization among some groups. Quality of care also improved compared to control organizations, with chronic care management, adult preventive care, and pediatric care within the contracting groups improving more in year 2 than

- Numerous bundled payment initiatives by large private insurers:

- **United HealthCare** - joint replacement bundles resulted in lower rehospitalization & complications. \$18 million+ in savings

- **Humana** - Maternity Episode-Based Model, a bundled payment program for low- and moderate- risk pregnancies



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Promising ideas?

- “Solutions” should not limit access for patients
 - Focus on getting the “right care, to the right person, at the right time”
- Need to get price out of the equation
 - Maryland’s All-Payer (2014-2018) and Total Cost of Care (2019+) may provide a model
- Accountable Care models have a lot of promise, it implemented at a large enough scale.
- More state level innovation—especially in states that do not have a historic reputation for innovation
- Bundled payment models are may be promising in the long run, but need work
 - Opportunity for providers to just do more bundles
 - Processes for grouping services into bundles is broken