



Deep Dive on Payment and Delivery Reform Recommendations

April 11, 2016

**Colorado Commission on
Affordable Health Care**

Revisiting Payment and Delivery Reform

- Learnings from October's presentation
 - Need to move away from the volume incentives inherent in fee-for-service.
 - Traditional capitation may not be the answer.
 - There is a need to study potential ways to better align payment and continuity of care.



Sources and Levers for Potential Recommendations

- National Experts
 - Bipartisan Policy Center
 - RAND
 - Miller Report
- State Level Policy Levers
 - What can the Commission recommend for the state to implement?
 - Legislation/rules
 - Medicaid
 - State employees/PERA



Possible State-Based Changes or Interventions

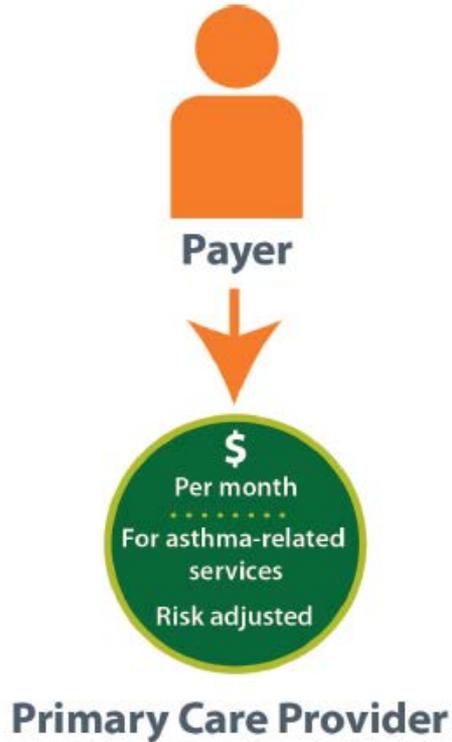
- Bundled payments for state employees and PERA
- Braided/blending funding to:
 - Merge or align state agencies
 - Pay for supportive housing
 - Expand medical homes to include social services
- Rate-setting
 - Traditional
 - Global payment
 - Cost-of-care proposal
- Value-based insurance design



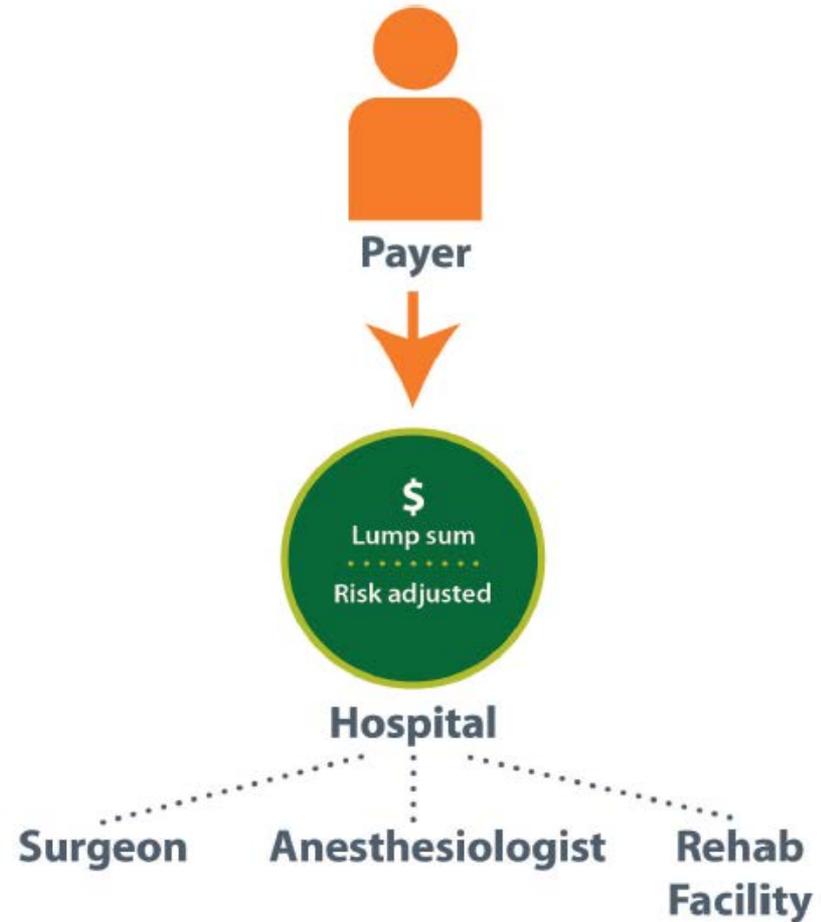
Bundled Payment

What Is Bundled Payment?

Patient = 40-year-old woman with asthma



Patient = 60-year-old woman needing knee replacement



Bundles: The Evidence

- Effective bundles
 - An easily identifiable beginning and end
 - Example: Hips and knees
 - A set time period for chronic conditions
 - Example: Congestive heart failure
- Quality improvement
 - Small improvements, but inconsistent evidence
 - Hospital readmissions, length of stay (Geisinger)

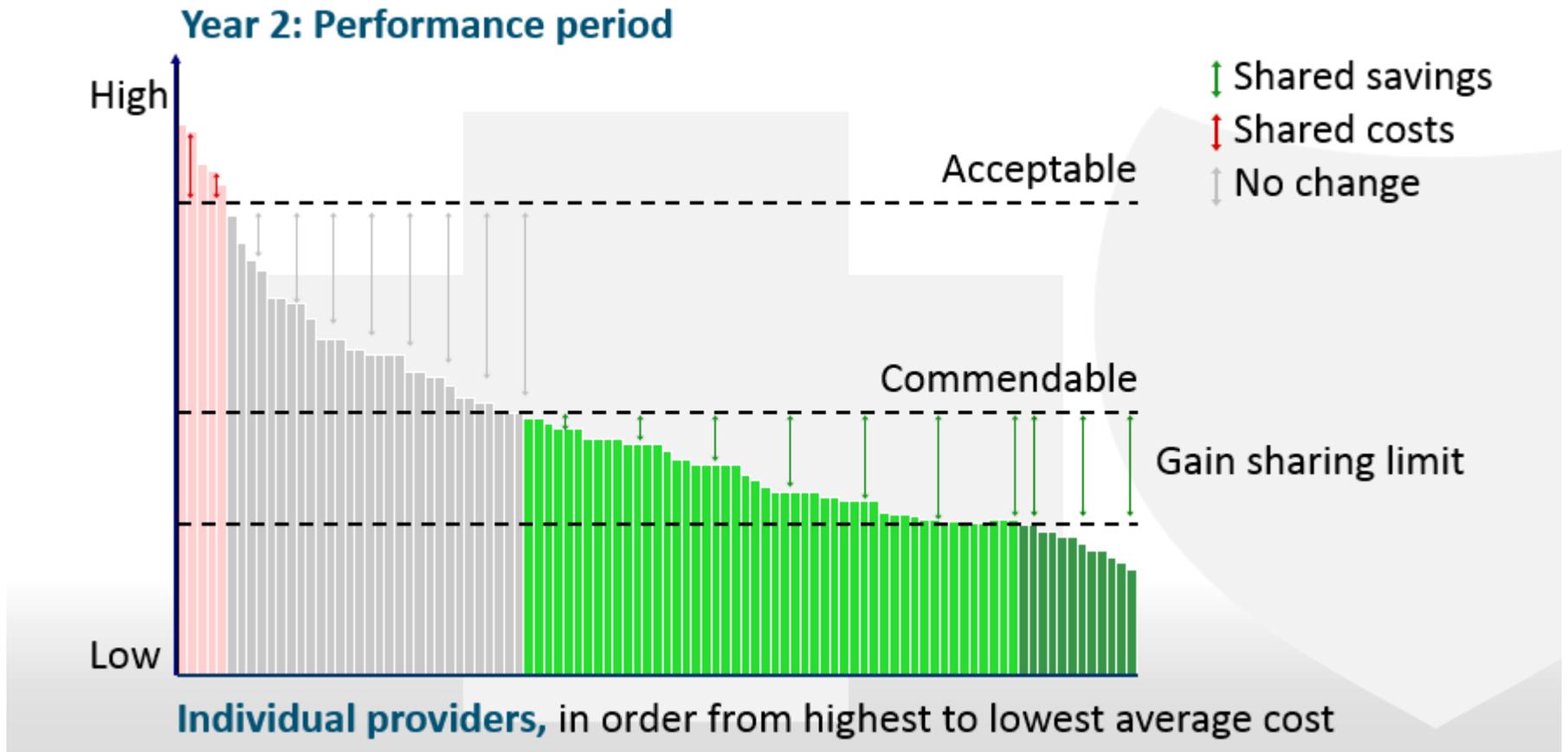


Bundles: Evidence on Cost Savings

- RAND
 - Modeling found savings of 7 to 35 percent for different bundled episodes.
- Review of completed studies
 - Savings of about 10 percent reduction in per-episode cost.



Bundles: State Example – Arkansas



Bundles: Colorado

- Colorado PERA
 - Hip and knee replacement bundle
 - Cost-sharing savings = \$6,600
 - Average price of bundled payment = Half of previous level



Bundles: Potential Recommendations

Original Commission Recommendation

- *“Adoption of bundled methodologies as appropriate for all payers including the state’s employees’ purchase of certain procedures and conditions.”*

Specific Recommendation

- Pilot a bundled payment methodology for:
 - State employees: Hips and knees, back surgery and congestive heart failure.
 - Pre-Medicare state retirees: Continue for hip and knee replacements, pilot for back surgery and congestive heart failure.



*Braided and
Blended Funding*

Defining Blended and Braided Funding

Blended Funding

Stakeholders merge funding from individual sources into one funding stream. The individual funding sources no longer have specific constraints on how they must be used. Example: Wraparound Milwaukee

Braided Funding

Coordinates funding from individual sources. Any specific constraints on how those individual funding sources must be used remain in place. Example: Colorado Opportunity Project

Source: NASHP



Braided/Blended Funding: Evidence Basis

- Providing health care and social services seamlessly = improved health outcomes and reduced costs.
- Supportive housing results in decreased utilization of emergency department visits and overnight hospital stays.
 - ROI in Massachusetts program: ~\$9,000 per person.



Braided/Blended Funding: State Examples

- New York
 - Housing for high-need Medicaid clients
 - Uses state Medicaid dollars to pay for capital, federal dollars for supportive housing and braids in other resources
- Minnesota Hennepin Health
 - ACO for high-risk Medicaid clients
 - Up-front payment for all Medicaid services with blending of county-based social service funds.
 - Decline in emergency department visits and inpatient utilization.



Original Commission Recommendation

- *“Adoption of payment structures in Medicaid, such as braided or bundled funding, that address clients’ social determinants of health.”*

Specific Recommendations

- Merge or more meaningfully align state agencies (health authority).
- Braid funding for housing.
- Expand Medicaid ACC medical home model to braid in funding for social services.



*Rate-Setting and
Global Budgets*

Defining Rate-Setting and Global Budgets

- Rate-setting programs are operated by established commissions that set limits on the rates or budgets of hospitals.
 - Maryland and West Virginia
- Global budgets set hospital revenue to a known dollar amount irrespective of the volume generated.
 - Maryland



History of Rate-Setting and Global Budgets

- Early rate-setting
 - Fallout due to rise of managed care
- Maryland rate-setting pre-2014
 - Relaxed volume controls
 - Medicare waiver test
- Global budgets
 - Rural pilot
 - All hospitals



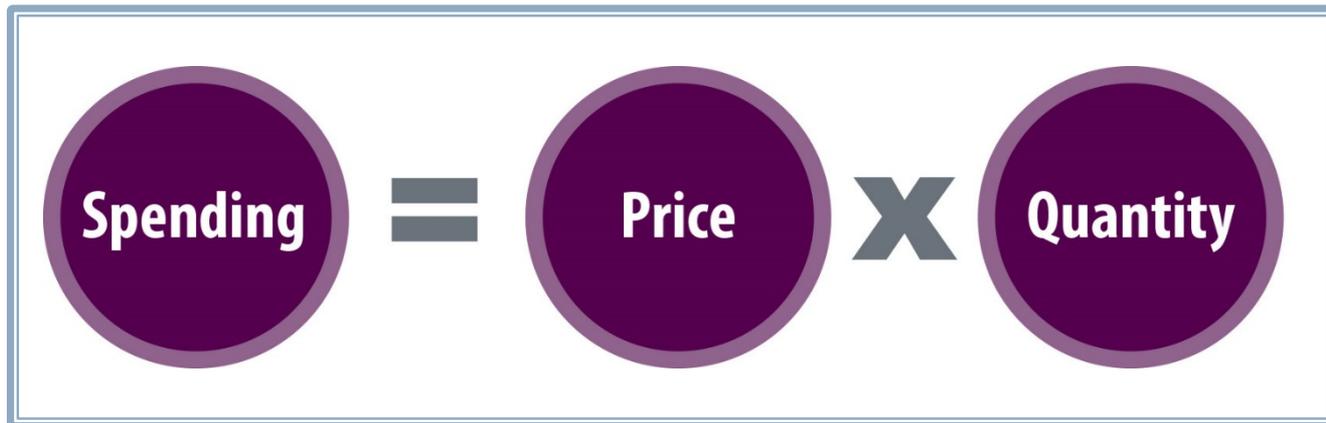
Hospital Spending in Colorado

	Colorado	United States
Per Capita Hospital Spending ('09)	\$2,150	\$2,475
Per Capita Hospital Spending Growth Rate 1991-2009	4.6%	4.7%
Per Capita Health Care Spending ('09)	\$5,994	\$6,815
Per Capital Health Care Spending Growth Rate 1991-2009	5.0%	5.3%



Rate-Setting: Evidence Basis

- Successful in controlling the increase in rate of hospital admissions in most states where it was implemented.
- Mind your p's and q's.



Rate-Setting: Potential Recommendations

Original Commission Recommendation

- Presentation from Carmela Coyle (Maryland)

Specific Recommendation

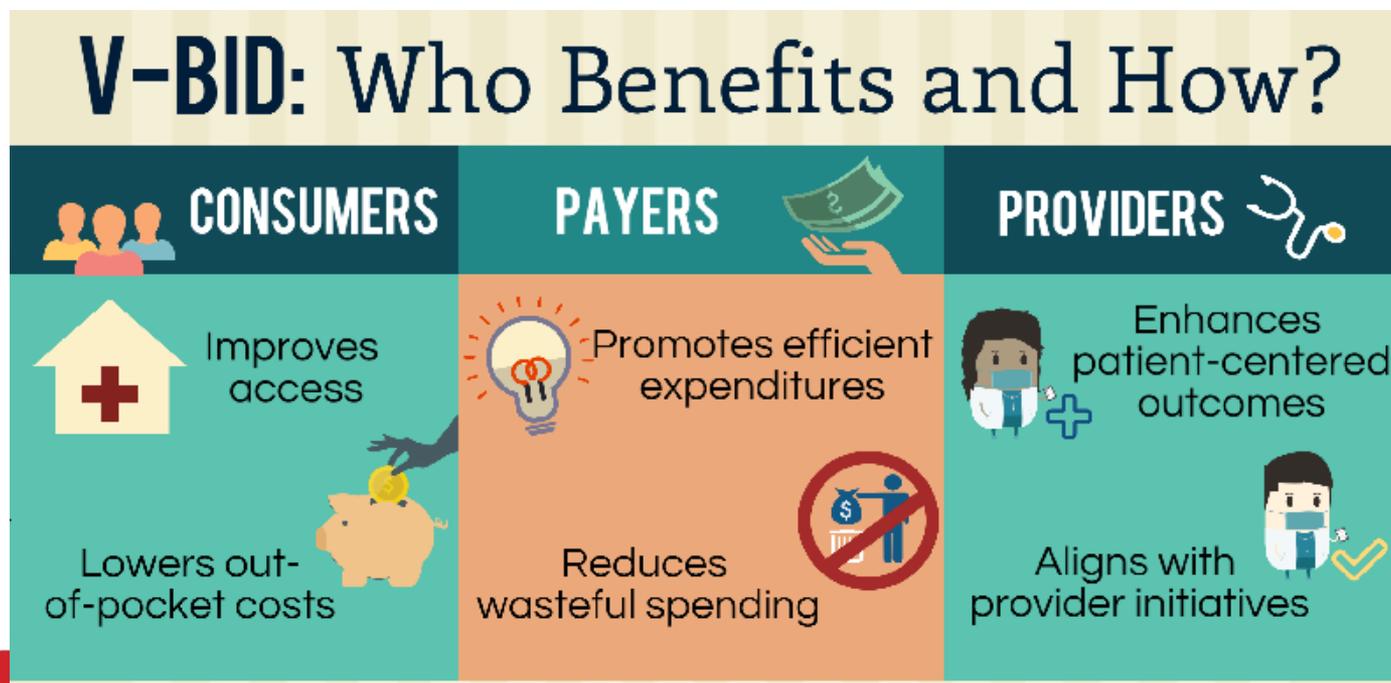
- Study traditional rate-setting for all payers
- Study global budgets for all hospitals
- Study global budgets for Medicare and commercial payers in rural hospitals



Value-Based Insurance Design

Defining value-based insurance design

- Consumer cost-sharing varies to distinguish between high-value and low-value services.
- Broad category of reform, spectrum of initiatives.



Source: V-BID Center

VBID: Evidence Basis

- Health Affairs literature review
 - Improved adherence to prescribed drugs.
 - Lowered out-of-pocket spending for drugs.
 - But did not lead to significant changes in overall medical spending.

<http://content.healthaffairs.org/content/32/7/1251.full.pdf+html>



VBID: State Examples

- Connecticut
 - Health Enhancement Program for 54,000 state employees and retirees.
 - Eliminate copays (office visits and medications) for chronic disease.
 - Satisfy requirements including health risk assessments, screenings, disease management
 - Outcomes
 - Increased use of targeted services and adherence to medications, decreased use of ED
 - Program cost savings were inconclusive and require longer follow-up period



VBID: Potential Recommendation

Original Commission Recommendation

- *“Adoption of VBID (Value Based Insurance Design) approach to benefit design for all payers including the state’s employees, (E.g. high value services with low or no copay, lower value services with higher copays, etc).”*

Specific Recommendation

- Encourage value-based insurance design for PERA and state employees for chronic disease management.



Other Recommendations

Additional Recommendations to Address

- Set a state target for increased system-wide spending on primary care, which has been shown to lower overall health care costs in R.I.
- Encourage the Direct Primary Care model.
- Enhance primary care reimbursement using value-based models like the PCMH and integrated care models, and include adequate funding to fully implement these systems.
- Expand programs that invest more in primary care in order to reduce hospital utilization to other RCCO regions.





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