



# Payment and Delivery System Reform

October 2015

**Colorado Commission on Affordable  
Health Care**

# What's the Problem? Health care as runaway reactor

“The U.S. system’s cost is fueled by a runaway reactor called fee-for-service reimbursement. It has taught us that...when caregivers make more money by providing more care, supply creates its own demand. By some estimates, a staggering 50 percent of health care consumed seems to be driven by physician and hospital supply, not patient need or demand.” Clayton Christensen, *The Innovator’s Prescription*



## Study Setting

- Barnes Eye Care Network (BECN) in St. Louis
  - Created in 1994
  - 65 ophthalmologists, 85 optometrists
  - Received capitated payments from MCOs for the provision of all eye care services of their members
- Study population included all 1997-98 commercial and Medicare BECN patients (N=91,473 commercial and 14,084 Medicare)
- No change in MD population and stable patient enrollment during study period



# Shrank et al, Arch. Ophthalmology 2005

- Both commercial and Medicare patients were **about half as likely** to have cataract extraction under Contact Cap vs. FFS
- Decrease corresponded roughly to date of change in reimbursement methodology
- Cataract extraction rates quite stable among national and Missouri Medicare patients during same time period
- Cataract surgical rates affected much more than other ophthalmologic procedures.



# Change in procedure rates with change in reimbursement methodology

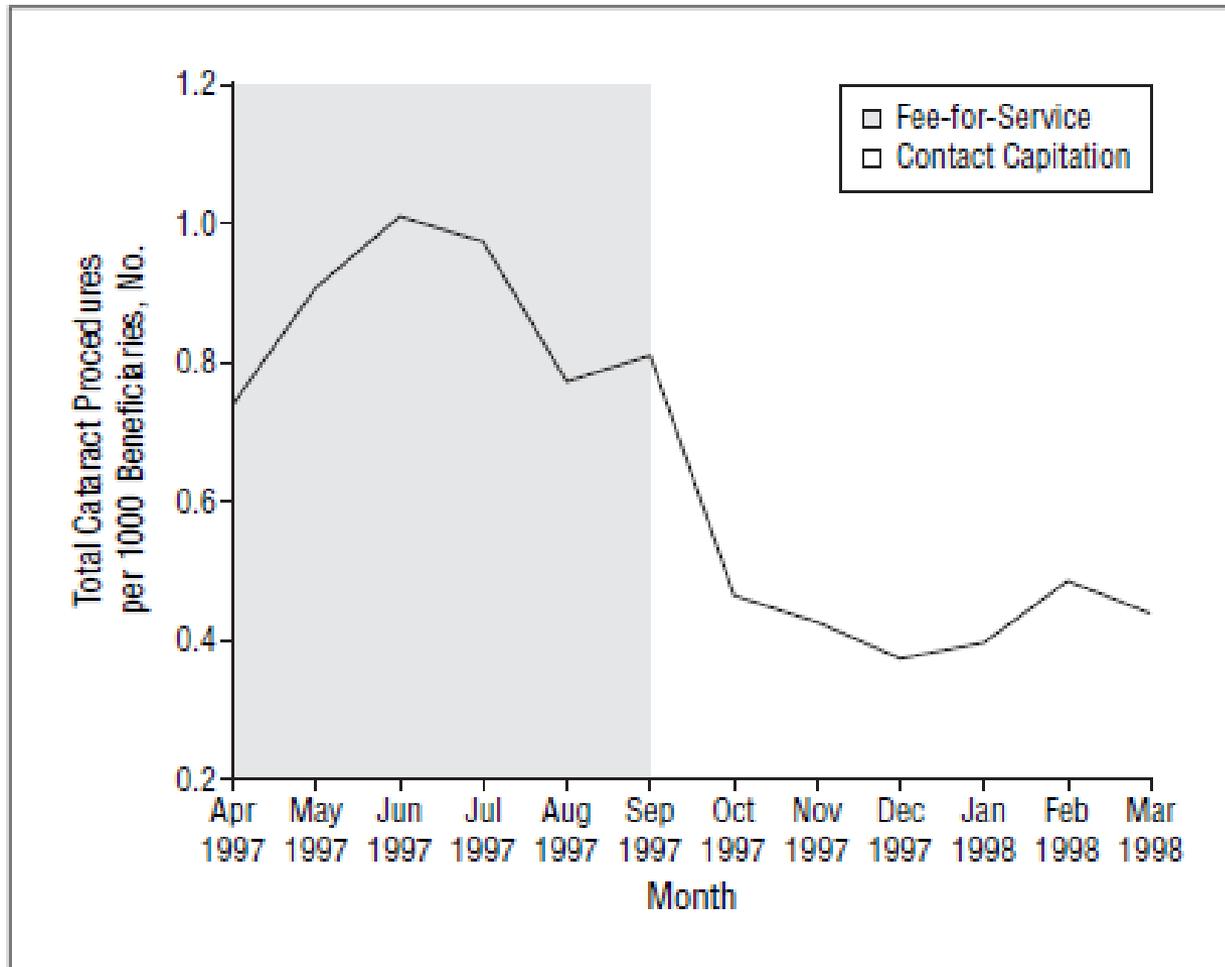


Figure 2. Cataract procedure rates per month per 1000 beneficiaries.



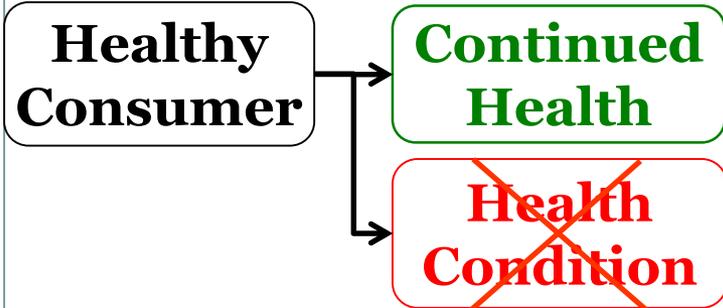
What We Need:  
A Way to Reduce Costs  
Without Rationing

It Can't Be Done from Washington...

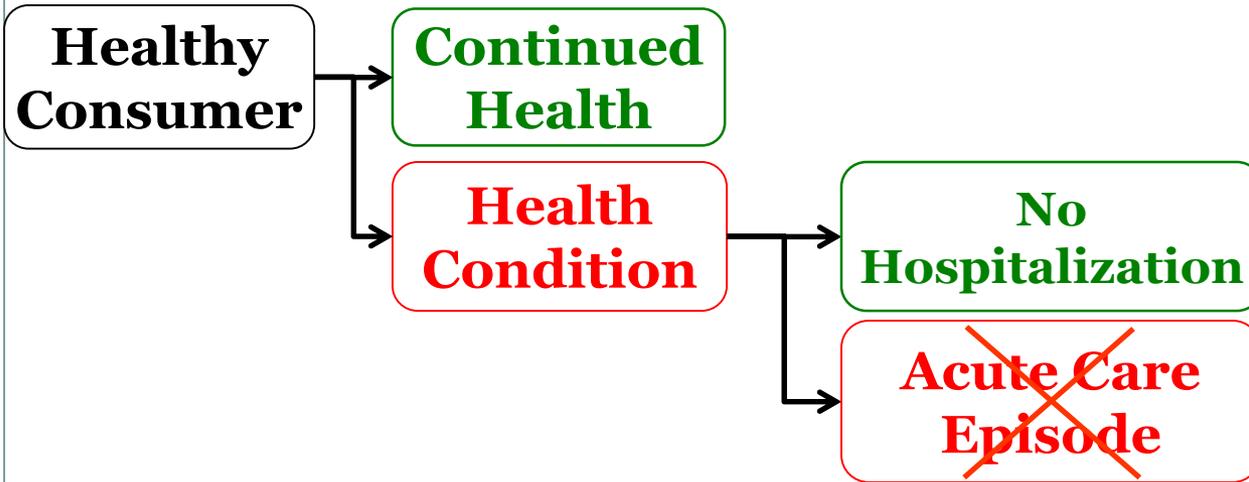
...It Has to Happen at the Local Level,  
Where Health Care is Delivered.

# Reducing Costs Without Rationing: *Can It Be Done??*

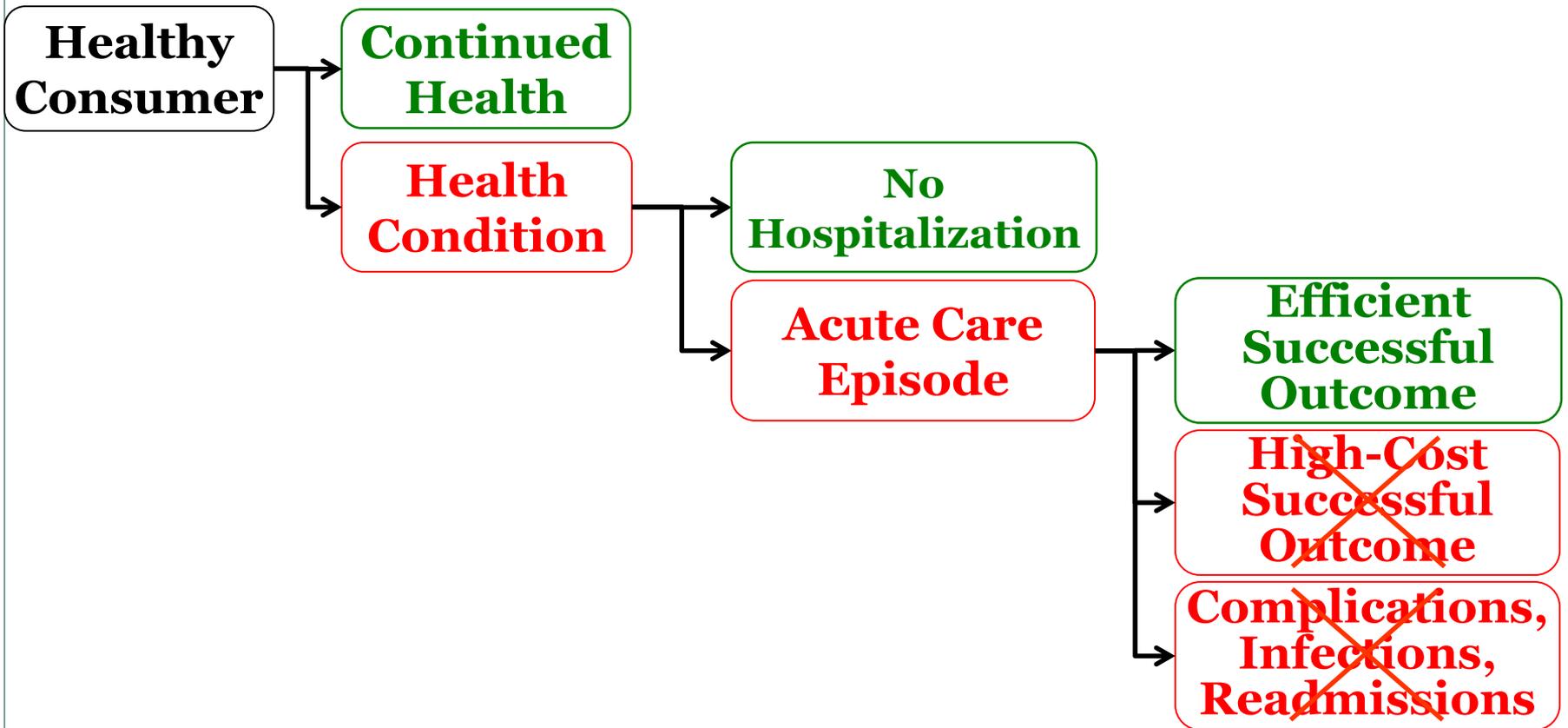
# Reducing Costs Without Rationing: Prevention and Wellness



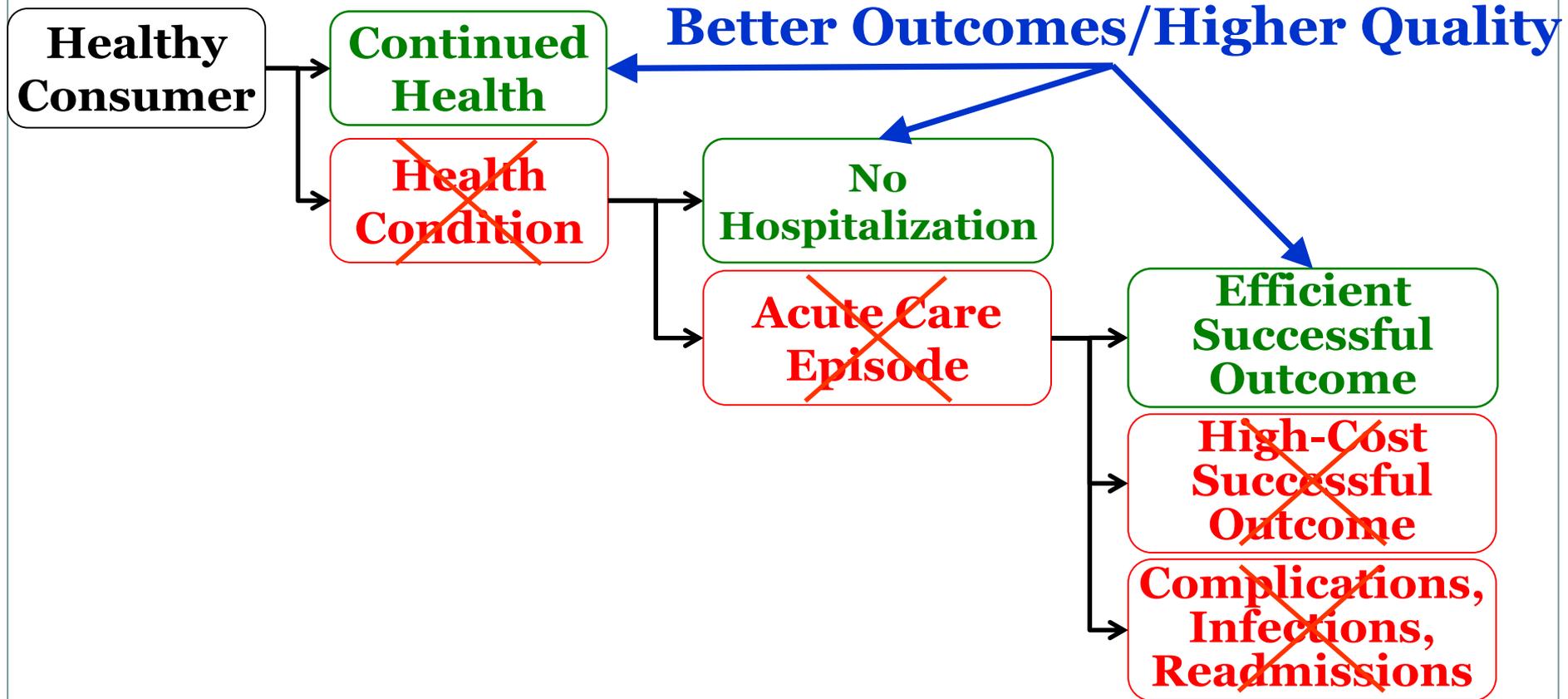
# Reducing Costs Without Rationing: Avoiding Hospitalizations



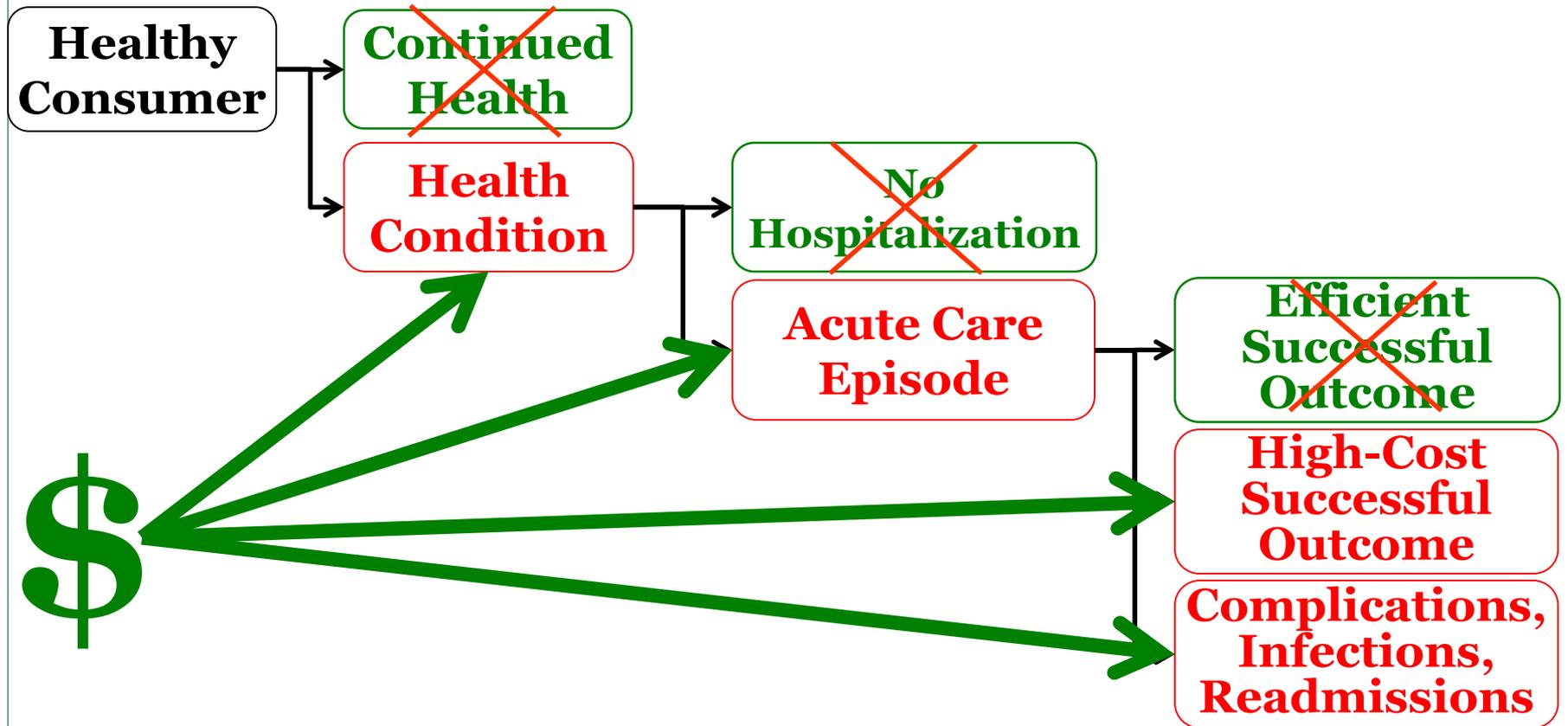
# Reducing Costs Without Rationing: Efficient, Successful Treatment



# Reducing Costs Without Rationing Is Also Quality Improvement!



# Current Payment Systems Reward Bad Outcomes, Not Better Health



# What is P4P?

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- P4P= Pay for performance
- Rewards providers for meeting or exceeding pre-established benchmarks for care processes and patient health outcomes
- Can be “carrot or stick”- PQRS
- Linked to FFS with bonus payments for process quality measures vs outcomes
- Private sector (40+) and public sector examples

# How Does Problem Contribute to Cost?

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- It is an attempt to inject quality into the present payment scheme believing improved quality will lead toward a value based payment vs. the present incentive to provide more service for more payment regardless of outcome.
- First attempt to decrease cost while preserving FFS system
- Need to go “cold turkey”

# What Does the Research Say?

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- Evidence is mixed
- Examples from both public and private pilots that have modest cost benefits and improved quality measured by process more than outcome.
- Challenge due to selection bias of variation of population being treated by each provider
- Without changing the underlying payment mechanism is this worth the effort- small effect

# Promising Practices from the Literature

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- **Medicare Premier Hospital Quality Incentive Demo**
  - 30 day mortality rates, AMI, CHF, CABG, pneumonia
  - 2004-2009- effect diminished by year 5
- **Alternative Quality Contract (AQC)- Blue Cross of MA**
  - Year 2 savings of 3.3%, \$107.00/member
  - Year3 savings of 2.8% \$90.00 /member
  - Savings on high risk patients, decreased procedures
- **Medicare Hospital Value Based Purchasing Program**
  - ✦ Payments altered <1%

# Promising Practices from the Literature – cont'd

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- **Medicare Physician Group Practice demo**
  - 10 large MD practices between 2005-2010
  - Improvement in quality but modest cost savings
  - Greatest effect in dual eligibles
- **CIGNA CAC program**
  - 50% meeting cost and quality measures
  - Outperformed controls in various metrics
    - ✦ Reduced ER visits, Improved glucose control, reduced ambulatory surgery costs

# What Are Other States Doing?

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- **California Medicaid 2002-2005**
  - No effect secondary to Medicaid population issues
- ✦ **Massachusetts Blue Cross- AQC**
  - 11 provider groups
  - Global budget
  - P4P bonuses for quality targets
- ✦ **Massachusetts Medicaid Hospital Based P4P**
  - Pneumonia antibiotics, surgical infection prevention
  - Incentive payments

# What Information Gaps Exist?

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- Questionable long term results on cost savings
- Patient mix issues- Medicaid, low income, chronic ill, risk based

# Opportunities for Cost Savings in Colorado

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- Hospital Value Based Purchasing
- Bridge to Excellence- CO Business Group on Health
- Medicaid ACC

# How Do These Apply to the Filters?

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- P4P remains popular among private and public payers with limited evidence
  - ACA incentives already in place
- Changes in Medicare physician payment
  - PQRS moving to MIPS- 2% reduction
  - More Research needed

# What are the Opposing Viewpoints?

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- Quality not cost initial variable of interest
- Some say cost containment is primary goal
- Programs should be voluntary
- Safety net hospitals and low income providers are adversely affected in quality measures due to their specific patient population
- “If you have to pay people a bonus for doing the right thing, why are you paying them in the first place”?

# What Does the Research Say?

## **Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery Jerry Cromwell, Ph.D., Debra A. Dayhoff, Ph.D., and Armen H. Thoumaian, Ph.D.**

In 1991, the Health Care Financing Administration (HCFA) began the Medicare Participating Heart Bypass Center Demonstration, in which hospitals and physicians are paid a single negotiated global price for all inpatient care for heart bypass patients. During the first 27 months of the demonstration, the Government and beneficiaries together saved more than \$17 million on bypass surgery in four participating institutions. **Average total cost per case fell in three of the four hospitals during the 1990-93 period** as the alignment of physician and hospital incentives resulted in physicians changing their practice patterns to shorten stays and reduce costs.



# What Does the Research Say?

## Bundled Payment Fails To Gain A Foothold In California: The Experience Of The IHA Bundled Payment Demonstration

[M. Susan Ridgely](#)<sup>1,\*</sup>, [David de Vries](#)<sup>2</sup>, [Kevin J. Bozic](#)<sup>3</sup> and [Peter S. Hussey](#)<sup>4</sup>

### Abstract

To determine whether bundled payment could be an effective payment model for California, the Integrated Healthcare Association convened a group of stakeholders (health plans, hospitals, ambulatory surgery centers, physician organizations, and vendors) to develop, through a consensus process, the methods and means of implementing bundled payment. **In spite of a high level of enthusiasm and effort, the pilot did not succeed in its goal to implement bundled payment for orthopedic procedures across multiple payers and hospital-physician partners. An evaluation of the pilot documented a number of barriers, such as administrative burden, state regulatory uncertainty, and disagreements about bundle definition and assumption of risk. Ultimately, few contracts were signed, which resulted in insufficient volume to test hypotheses about the impact of bundled payment on quality and costs. Although bundled payment failed to gain a foothold in California, the evaluation provides lessons for future bundled payment initiatives.**



# Promising Practices from the Literature: ProvenCare

**"ProvenCare<sup>SM</sup>": a provider-driven pay-for-performance program for acute episodic cardiac surgical care.**

Casale AS<sup>1</sup>, Paulus RA, Selna MJ, Doll MC, Bothe AE Jr, McKinley KE, Berry SA, Davis DE, Gilfillan RJ, Hamory BH, Steele GD Jr.

## **RESULTS:**

**Initially, only 59% of patients received all 40 best practice components. At 3 months, program compliance reached 100%, but fell transiently to 86% over the next 3 months. Reliability subsequently increased to 100% and was sustained for the remainder of the study period. The overall trend in reliability was significant at  $P=0.001$ . Thirty-day clinical outcomes showed improved trends ( ) but only the likelihood of discharge to home reached statistical significance. Length of stay decreased by 16% and mean hospital charges fell 5.2%. (Table is included in full-text article.)**

## **CONCLUSION:**

**A provider-driven pay-for-performance process for CABG, enabled by an electronic health record system, can reliably deliver evidence-based care, fundamentally alter reimbursement incentives, and may ultimately improve outcomes and reduce resource use.**



# What Are Other States Doing? AHCPII (Arkansas)

During the first phase of the payment initiative, the state Medicaid program, Arkansas Blue Cross and Blue Shield (AR BCBS) and QualChoice of Arkansas (QCA) agreed on design parameters and initially introduced five episodes of care:

- Upper respiratory infections (URIs)
- Total hip and knee replacements
- Congestive heart failure (CHF)
- Attention deficit hyperactivity disorder (ADHD)
- Perinatal (pregnancy)



# What Are Other States Doing? AHCPII (Arkansas)

## Episodes of Care Highlights

- A 17% drop in unnecessary antibiotic prescribing for non-specific URI
- Across the board improvements in perinatal screening rates
- AR BCBS hip/knee replacement costs were reduced by 1.4% (7% below projected costs)
- 73% of Medicaid and 60% of AR BCBS Principal Accountable Providers (PAPs) improved costs or remained in a commendable or acceptable cost range



# In Colorado: PERA Care Select

## PERACare Pre-Medicare Hip and Knee Replacement Facts

- Over 100 hip or knee replacements each year
- 65% in Front Range, 20% in other areas of Colorado
- Average plan cost ranged from \$20,000 to \$100,000
- No real difference in quality or length of stay
- Member cost ranged from \$6,050 to \$13,000
- Lack of predictability means cost confusion for individuals and prevents plan sponsors from making informed decisions about benefits and budgets



# PERA Care Select

- Contract with HealthONE system
- Multiple locations incl both inpt and ASCs
- Bundled price for knee and hip replacement
- *Copay and deductible waived for pt*
- Tracking outcomes and pt satisfaction as balancing measure



# Reference Pricing



# Where Will You Get Your Knee Replaced?

## Knee Joint Replacement



**Consumer Share  
of Surgery Cost**

**Price #1  
\$23,000**

**Price #2  
\$28,000**

**Price #3  
\$33,000**



# Copayment? Use High Price Provider

## Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓



# Coinsurance? Use High Price Provider

## Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓
10% Coinsurance w/\$2,000 OOP Max:	\$2,000	\$2,000	\$2,000 ✓



# High Deductible? Use High Price Provider

## Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓
10% Coinsurance w/\$2,000 OOP Max:	\$2,000	\$2,000	\$2,000 ✓
\$5,000 Deductible:	\$5,000	\$5,000	\$5,000 ✓



# Pay the Difference in Price? Use the High-Value Provider

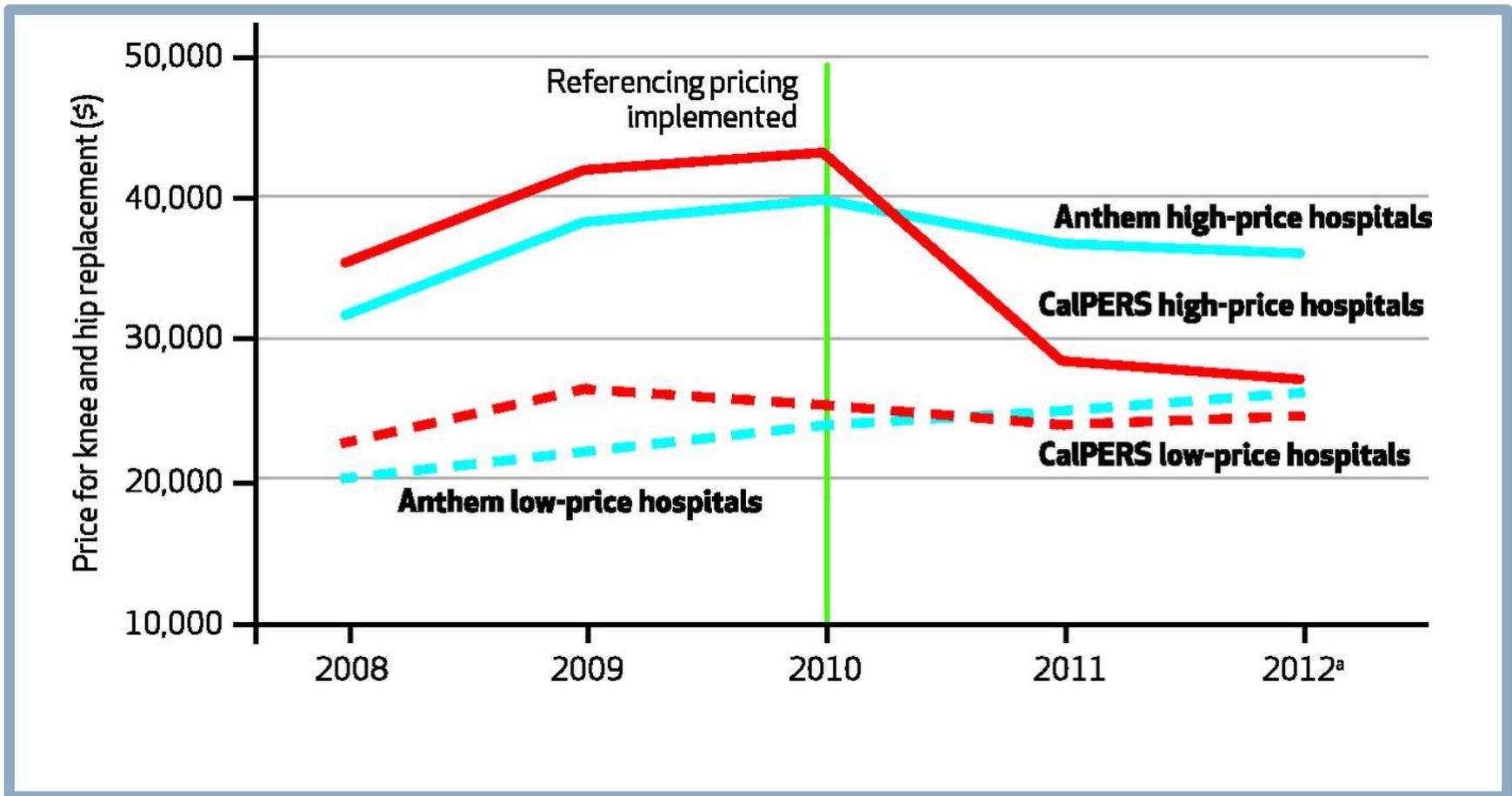
## Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓
10% Coinsurance w/\$2,000 OOP Max:	\$2,000	\$2,000	\$2,000 ✓
\$5,000 Deductible:	\$5,000	\$5,000	\$5,000 ✓
Highest-Value:	\$0 ✓	\$5,000	\$10,000



# CalPERS experiment



Robinson J C , and Brown T T Health Aff 2013;32:1392-1397

HealthAffairs



# What Information Gaps Exist?

- Unknown whether providers increase volume to compensate for lower per episode payment
- Unclear whether quality improves or declines, mixed results in data
- Data on patient satisfaction still early



# Opportunities for Cost Savings in Colorado: what could the state do?

- As purchaser: reference price elective procedures, e.g., ortho and cardiac
- Could emulate AHCPII (already implementing PCMH broadly through CPCI, TCPI), adding condition-based bundles as well as procedure-based



# How Do These Apply to the Filters?

- Absolute driver of cost: Bundles have been demonstrated to save up to 20%
- Actionable: State could take action as major purchaser, both in Medicaid and state employee purchasing
- Impacts both public and pvt markets: probably best if both change simultaneously a la Arkansas
- Future driver: Procedures and chronic conditions likely to remain majority of expenditure
- Can be measured and evaluated



# What are the Opposing Viewpoints?

- Restriction of choice
- Inducing oligopoly pricing by reducing number of competitors
- “Race to top” on pricing
- Quality
- Only 1/3 of utilization is “shoppable”, i.e., pt in position to assess value in advance of accessing services; therefore not a sole sol’n

