Contemporary Capitation: Opportunities and Obstacles

October 23, 2015

Colorado Commission on Affordable Health Care

Suggested reading

- Delbanco, Susan, **"Capitation with Quality"**. Health Affairs Blog, June 6, 2014

- Frant, Austin and Mayes, Rick, **"Beyond Capitation: How New Payment Experiments Seek To Find The 'Sweet Spot' In Amount Of Risk Providers And Payers Bear"** Health Affairs, September, 2012.

- Mongan JJ, Ferris TG, Lee TH "**Options for slowing the growth of health care cost**s", n engl j med 358;14 www.nejm.org April 3, 2008

What's the Problem?

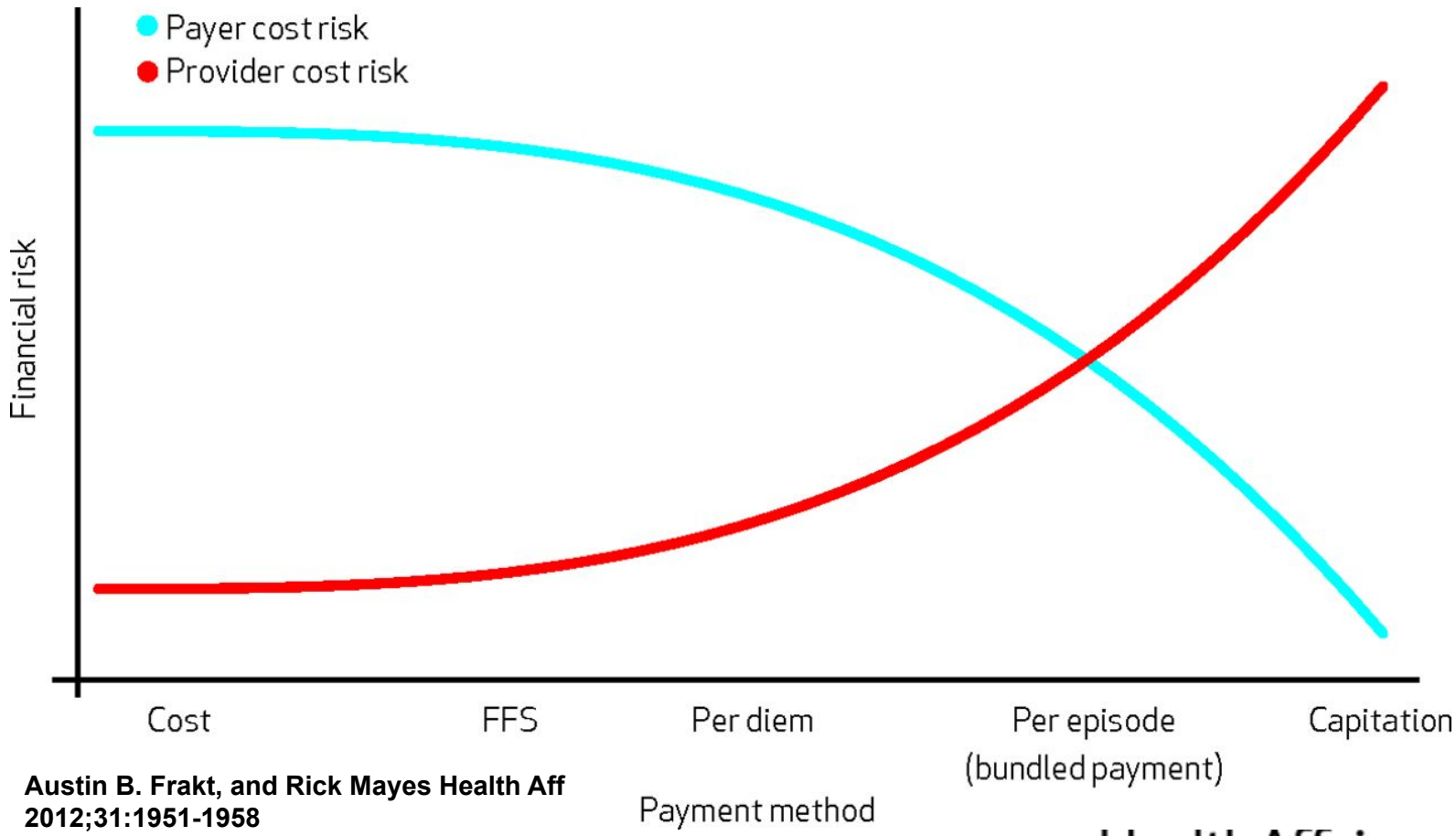
- Capitation is a payment model that creates the greatest ***financial accountability*** for cost outcomes in the delivery system.
- Capitation also creates the greatest ***flexibility*** in how insurances premiums or taxpayer funding is used to deliver services.
- The incentive for cost control inherent in capitation must be balanced with with a focus upon quality and accountability for outcomes.
- There is evidence that capitation can be used effectively to produce lower total costs and high quality, but sophisticated systems and substantial capital are required to make it work.

How Does Problem Contribute to Cost?

- Volume-based payments are inflationary;
- Providers have little incentive or opportunity to focus on outcomes when the production of more health care is the path to financial success;
- Volume-based payment within the delivery system makes high costs "someone else's problem" – ultimately, employers, individual and taxpayers.
- Capitation replaces volume with comprehensive, limited, per person reimbursement.

Traditional relationship between capitation and provider risk

Financial Risk Of Care For Provider And Payer, By Payment Method.



Austin B. Frakt, and Rick Mayes Health Aff 2012;31:1951-1958

What Does the Research Say?

- Studies of capitation (for decades) and several "thriving" examples in the market demonstrate that capitation can work.
- Capitation has also failed countless times – on a massive scale in the 1990s.
- The difference between success and failure is generally capital, competence, infrastructure and governance.

Promising Practices from the Literature – cont'd

- Is there a way to achieve some of the benefits of capitation, but mitigate the risks? Yes:
  - Adjust the ***scope*** of responsibility for services;
  - Change the ***form*** of payment but ***limit or share*** the level of risk; and / or,
  - ***Blend*** per capita with volume-based payments.

What Are Other States Doing?

- **Commercial** "global budget" agreements between payers and providers (Mass, Minn, other) – "Alternative quality contract".

- **Medicaid** "global budget" agreements between states and communities (OR, WA + Western Colorado – "Accountable care communities"

- **Medicare** "shared savings" programs "Accountable care organizations" (nationwide, including Colorado)

Governance models that support this approach

- **Corporate**: One board + one CEO runs it all.
- **Clinical Integration**: Multiple provider groups share data, merge clinical processes and take responsibility for outcomes.
- **Community**: Multiple orgs with "skin in the game" coordinate under an agreement with a single point of accountability.

Opportunities in Colorado

P ayment

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M edicaid

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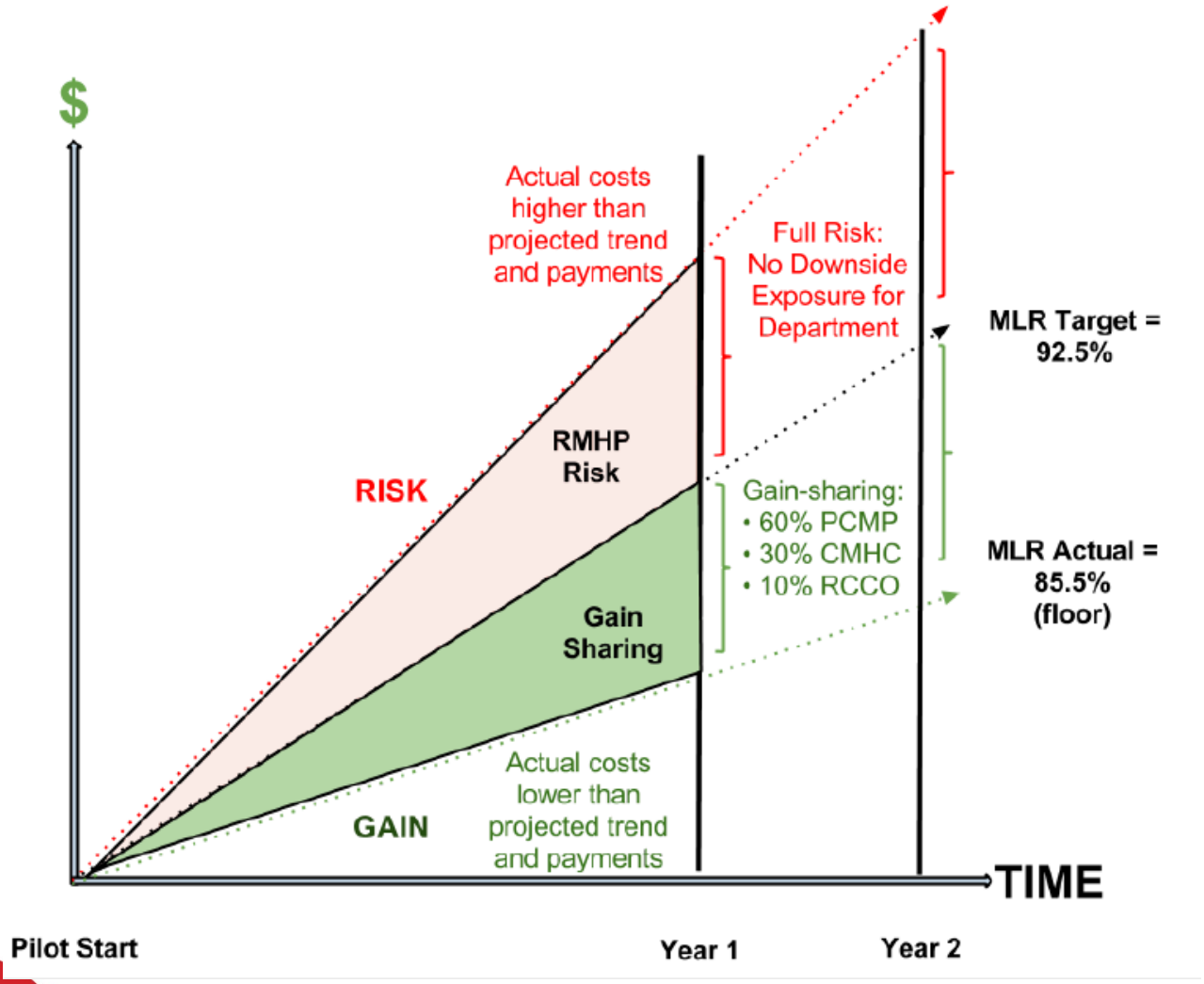
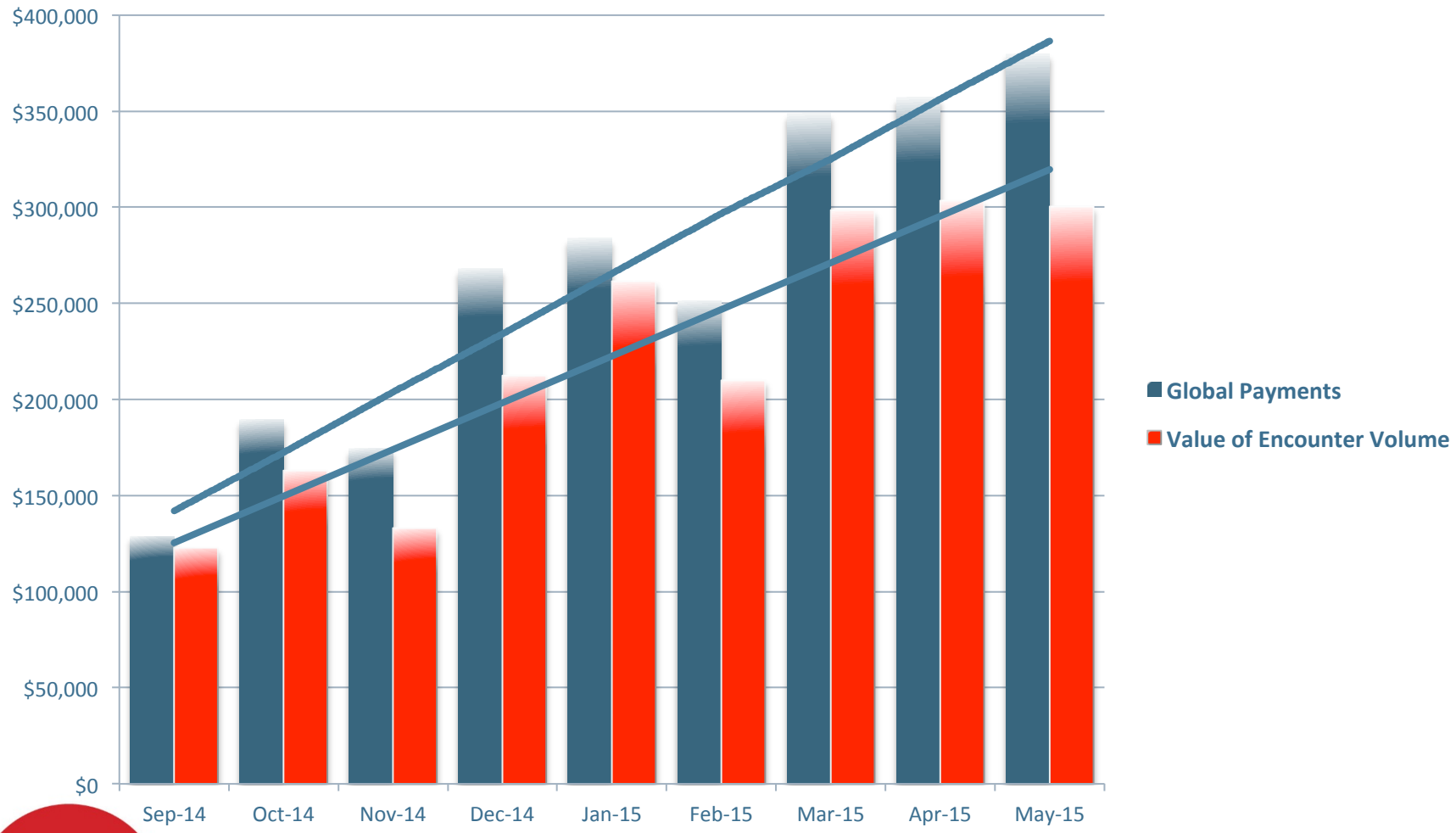
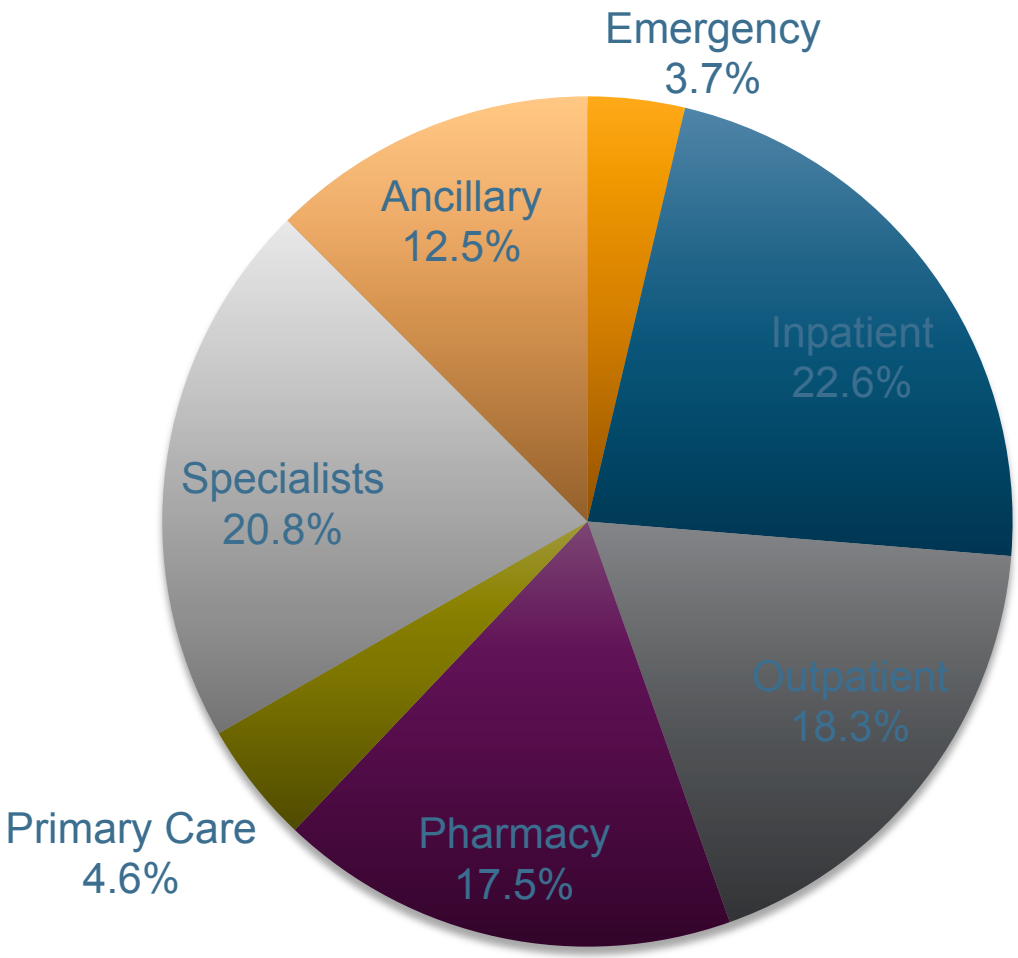
Opportunities for Cost Savings in Colorado



Global Payment vs. FFS Volume
PCMP Payments to Date in Medicaid PRIME



Value Based Payment vs. FFS Volume



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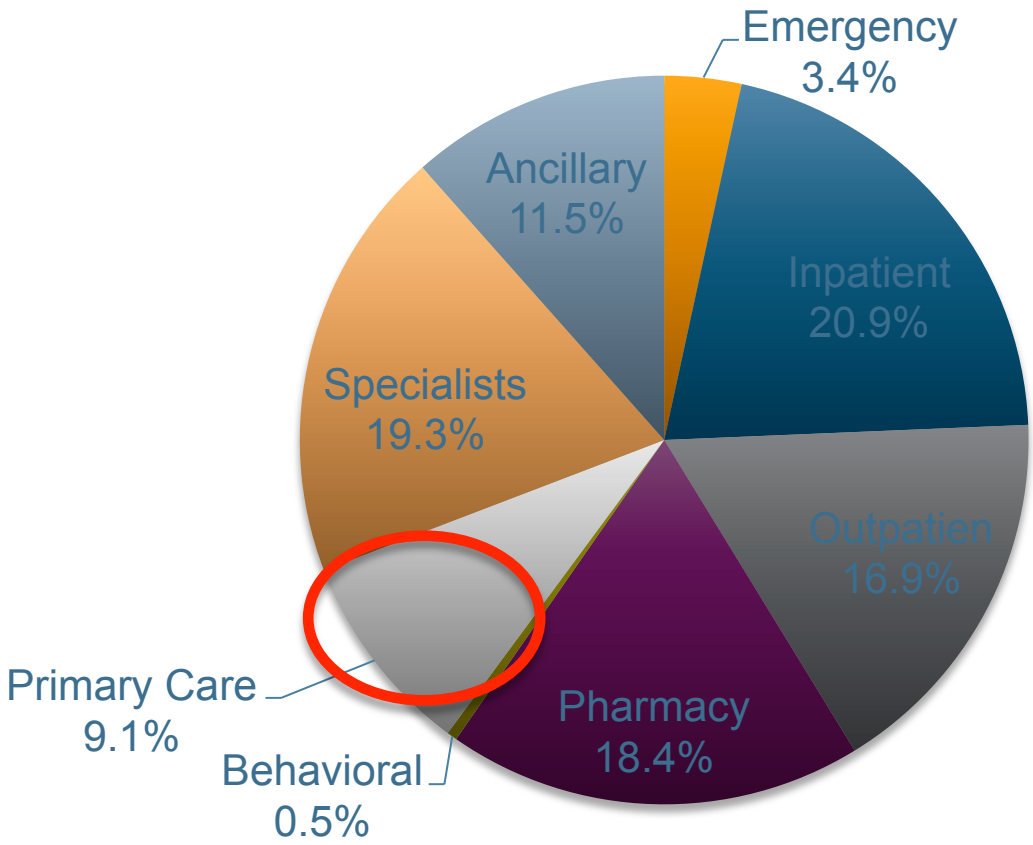

Isn't the second pie bigger? No.

	Total Cost PMPM
Advanced Practices	$479.30
Behavioral Health Payments	$4.35
Total	$482.85
Conventional Network Average	$505.83
Risk Normalized Difference	-4.54%

How Do These Apply to the Filters?

- Absolute cost: Unquantified, but entails private and public investment (most impactful when aligned).

- Actionable: yes, but several factors (e.g., capital, data, leadership, policy) must come together at once.

- Public/private markets: yes
- Future cost driver: yes
- Can be evaluated: yes

What are the Opposing Viewpoints?

- Powerful cost incentives can create misaligned payer and provider incentives.
- "I remember this and it was a disaster– what's so different now?"
- "It's the prices, stupid."
- Can "blended" or "partial" capitated models really change operations?
- "What if one or two high utilizing patients blow my budget?"
- What happens to small, vulnerable, high cost populations if payments are adjusted appropriately for risk and resource intensiveness?

Value Based Insurance Design

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What is Value Based Insurance Design (VBID)?

- Started and championed out of Univ of Michigan- Mark Fendrick, MD, Michael Chernew, PhD
- Cost sharing plays a critical role in defining health care benefits
- VBID is based on the premise that patient cost sharing should more explicitly encourage patients to use high value services and avoid low value services- "Carrots and sticks"
- Non medical benefits as well adds ROI

How Does Problem Contribute to Cost?

- Cost sharing can affect patient choices and behavior
- One size fits all cost sharing benefit in Medicare and many commercial plans
- Premises- clinical nuance
  - Medical services differ in clinical benefit
  - Value differs across patient populations
  - Cost sharing effects essential and non essential care
  - Decrease in Rx expenses 2-% for every 10% increase in cost sharing

What Does the Research Say?

- Change in drug copayments led to fewer hospitalizations and ED visits in chronically ill patients (Chernew and Fendrick, 2009)
- Medication non adherence decreased 7-14% with copay reduction(Chernew, et al, 2008)

Promising Practices from the Literature

- Pitney Bowes- Active Health Management/Aetna
  - increase statin adherence 2.8%, 4% for Plavix
  - Diabetes total cost decreased 6%, ED visits decreased 26% with reduced copay for disease management
- Novartis US- 9624 members, asthma, DM, HTN- overall savings of 2%, 13%, 9%
  - HTN office visits decreased 26%, diabetes 9%, asthma increase 14%
- UHC Diabetes Health Plan which combines VBID with wellness programs.
- Asheville, NC Project- is led by pharmacists and includes coached self-management.1.5-3.8% increase in adherence, DM, CHF
- Marriott Corporation developed value-based pharmaceutical benefits that decreased copayments for medications related to diabetes, cardiovascular disease and asthma.
- Aetna's new value-based insurance design initiative, Rx Healthy Outcomes, lowers the cost of cardiac drugs
- State of Maine SIM- $33 million grant to study VBID best practices
  - VBID Workgroup is a multi stakeholder group of health plans, purchasers and providers that are tasked with developing a VBID template

Opportunities for Cost Savings in Colorado

- Expand to other interventions beyond prescription medication such as PT, dx screening, primary care vs specialist care, patient education
- Look at outcomes to determine cost sharing vs. just in network or out of network based on providers/geography or selective contracting
- Evaluate PPACA effects on Medicare for no copay prevention activities- mammography, PAP

Barriers

- Cost of increased use of services. VBID involves lowering copayments for some underused, high-value services. Lower copayments are associated with higher costs and create concerns that VBID will increase spending, at least in the short term.
- Question whether employers can capture long-term savings has yet to be determined.
- When a system targets specific patient groups, decisions about which groups would be eligible for lower copayments can be problematic. Diabetes easily identified

Value Driven Outcomes

Medical Cost Accounting

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What is VDO?

- Robert Kaplan, PhD, and Michael Porter, PhD The Big Idea: How to Solve the Cost Crisis in Health Care.“
- Vivian Lee, MD, PhD, MBA- Univ of Utah
- VDO tool translates big data into actionable information about true costs on the patient level.
- VDO allows ability to turn data into information that can really drive improvement.

What is VDO?

- Value Driven Outcomes- University of Utah
- Value=(Quality + Service)/Cost
- Focus on measuring quality through outcomes, service through patient satisfaction but very little focus has been on measuring actual true patient costs over the care cycle.
- EHR- accounting software
  - Direct costs- patient care
  - Indirect costs- facility costs (financing dept)

How Does Problem Contribute to Cost?

- True costing numbers are critical to developing strategies to reduce costs and support adoption of value based reimbursement.
- Overall cost accounting approach
- 5 step process
  - Identify data
  - Extract data
  - Load data into enterprise data warehouse
  - Map and present data
  - Generate reports, dashboards, business analytics, scorecards

What Does the Research Say?

- Those who undergo physical therapy on the same day of their surgery have a lower total cost and decreased lengths of stay
- Reduced the cost of taking care of patients with cellulitis by $1,000 per patient with a standardized care process (antibiotics, imaging)
- 50% fewer patients seen in ED
- For the 156 cases the health system handled after creating a new care joint replacement pathway with the VDO tool, the average total facility direct cost was reduced by 8 percent and discharge delays dropped from 6 percent to 3 percent.

Promising Practices from the Literature

- Began in 2012, 6 months
- University of Utah Health Sciences Center (UUHSC)
  - University of Utah Health Care
  - University of Utah School of Medicine
  - University of Utah Medical Group
  - 4 hospitals, 10 clinics, 10,000 employee, 1200 physicians.

Opportunities for Cost Savings in Colorado

- At the end of the day, the VDO team's focus is ultimately quality, not cost.
- Increase quality, lower costs
- Standardize care, better quality
- Chicago-based University Health System Consortium
  - Alliance of academic medical centers and teaching hospitals
  - Replicate in CO health systems
  - Encourage more employer and payers to design varied cost sharing models

Payment and Delivery System Reform: Site Neutral Payment and Gifts from Industry to Providers

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What's the Problem?

- Different payment methodologies have been developed in federal law to reimburse similar or identical services

How Does Problem Contribute to Cost?

- Estimate: Potential Medicare savings ~$3 bil/yr

What Does the Research Say?

EXHIBIT 2

Differences in Medicare Program Payments and Beneficiary Cost Sharing for Midlevel Outpatient Office Visits Provided in Freestanding Practices and Hospital-Based Entities, 2014

	Service provided in freestanding physician practice	Service provided in a hospital outpatient department		
	MPFS physician office rate[a]	**MPFS physician facility rate[a]**	**OPPS rate[b]**	**Total hospital-based rate**
Program payment	$58.46	$41.26	$74.02	$115.28
Beneficiary cost sharing	$14.62	$10.32	$18.51	$28.83
Total payment	**$73.08**	**$51.58**	**$92.53**	**$144.11**

SOURCE Medicare Payment Advisory Commission table updated by the author with 2014 payment rates from Centers for Medicare and Medicaid Services website. The *Current Procedural Terminology* code used for this example under the physician fee schedule is 99213. The Healthcare Common Procedure Code Set code used for this example under the outpatient prospective payment system (OPPS) is G0462. **NOTE** MPFS is Medicare physician fee schedule. [a]Paid under the Medicare physician fee schedule. [b]Paid under the OPPS.

What Are Other States Doing?

- No actions in other states found.

How Do These Apply to the Filters?

- Absolute cost: yes
- Actionable: yes
- Public/private markets: yes
- Future cost driver: yes
- Can be evaluated: yes

What are the Opposing Viewpoints?

- Safety net function
- 24/7 availability
- Conflicting mental models
  - Private capitalist enterprise
  - Public utility
  - Financing the latter with the former

Opportunities for Cost Savings in Colorado?

- Most likely issue will be fought at the federal level
- Points up deeper issue: how do we finance 24/7 access as a matter of public safety? And how do we decide the proper level of 24/7 access?
- Not recommending site neutral payment in advance of federal precedent

What's the Problem? Gifts to Physicians by Industry

- Physicians and other providers may be influenced by payments from pharma, medical device manufacturers, and other suppliers to choose more expensive treatments because they benefit personally

How Does Problem Contribute to Cost?

- Potentially physicians forego cheaper and equally effective treatment options because judgment affected by industry influence

What Does the Research Say?

- Information from Pharmaceutical Companies and the Quality, Quantity, and Cost of Physicians' Prescribing: A Systematic Review
- Geoffrey K. Spurling , Peter R. Mansfield, Brett D. Montgomery ,Joel Lexchin, Jenny Doust, Noordin Othman, Agnes I. Vitry
- Published: October 19, 2010
- DOI: 10.1371/journal.pmed.1000352
- With rare exceptions, studies of exposure to information provided directly by pharmaceutical companies have found **associations with higher prescribing frequency, higher costs, or lower prescribing quality or have not found significant associations**. We did not find evidence of net improvements in prescribing, but the available literature does not exclude the possibility that prescribing may sometimes be improved. Still, we recommend that practitioners follow the precautionary principle and thus avoid exposure to information from pharmaceutical companies.

Promising Practices from the Literature

- AMA Code of Ethics Opinion 8.061
- Salaried physicians? Blog post from Mark Kelley (Henry Ford medical group) raises question of how salaries would be determined absent productivity

How Do These Apply to the Filters?

- Absolute cost: unknown
- Actionable: multiple actions already taken
- Public/private markets: yes
- Future cost driver: yes
- Can be evaluated: yes

What are the Opposing Viewpoints?

- Legitimate purposes for payments by industry
  - Education on scientific advances
  - Funding of educational and research activities
- Belief that professionalism prevents prescribing poorer value drugs/devices

Opportunities for Colorado?

- S. 10-124: Michael Skolnick Medical Transparency Act of 2010 requires disclosure of employment/independent contractor arrangements between practitioners and industry valued at >$5K/yr.
- S. 10-126: Requires DORA to post pharma and medical device manufacturer disclosures pursuant to transparency provisions of PPACA