Payment Reform in Support of Population Health Management

Aligning Forces for Quality Employers - Providers Summit October 25, 2011

Charles Chodroff, MD, MBA, FACP
Senior Vice President, Chief Clinical Officer
WellSpan Health
Overview of discussion

- Moving from volume-based to value-based healthcare delivery (Accountable Care)
- WellSpan’s Population Health strategy. Managing the health of our own employee population.
- Moving beyond fee-for-service provider payments to enhance the value of healthcare.
- Engaging the employer community in value-creation health management strategies
The need for improvement

- Institute of Medicine 2001 report *Crossing the Quality Chasm*.
- RAND Corporation report – half of all adult patients fail to receive recommended care.
- AHRQ National Healthcare Quality and Disparities Reports published since 2003 demonstrate slow improvement.
- The Business Roundtable finds that U.S. health care costs are more than double those of our five largest trading partners, without evidence of better care.
Volume-based care is financially unsustainable

- Fee-for-service payments create net revenue that is directly tied to doing more procedures.
- Increased specialization and focus on acute care highly rewarded.
- Amount of revenue not linked to population outcomes or satisfaction of patients with their care.
- Third-party payments reduces incentives of individual patients or their physicians to lower the costs of services.
Value-Based Healthcare

Value = \frac{Outcomes}{Cost}
Three Drivers of Healthcare Value

- Benefit Plan design
  - What’s paid for and how costs are shared with employees

- Delivery System Design
  - How services are provided to minimize waste
  - Continuous improvement

- Provider Payment Structure
  - How providers are paid creates incentives for delivery and design of services
WellSpan Health Claims Paid
(1/1/10 – 12/31/10 by member and dollars)

<table>
<thead>
<tr>
<th>Members</th>
<th>Dollars</th>
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</thead>
<tbody>
<tr>
<td>&gt;$20,000</td>
<td>4%</td>
</tr>
<tr>
<td>to $20,000</td>
<td>6%</td>
</tr>
<tr>
<td>to $10,000</td>
<td>9%</td>
</tr>
<tr>
<td>to $5,000</td>
<td>13%</td>
</tr>
<tr>
<td>to $2,500</td>
<td>19%</td>
</tr>
<tr>
<td>&lt;$1,000</td>
<td>49%</td>
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Ten percent of the population consumes 66% of the total spend (members with > $10,000 in expenses)

49% of the population consumes only 4% of the total spend (each spends < $1,000)
Different Strategies for Different Healthcare Spend Segments

- Those who are well or think they are well
- Those with chronic illness
- Those with severe, acute illness or injuries

% Total Healthcare Spend

% of Members
Improving value requires different approaches for different populations

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<td>• <strong>Bundled Payments</strong> • Gain-sharing to align incentives • Shared savings • Pay for Performance</td>
<td>• <strong>Bundled Payments that support Medical Homes</strong> • Shared savings • Pay for performance</td>
<td>• Link reimbursement to health risk reduction • <strong>Bundled Payments</strong></td>
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A brief history of payment models

- Fee-for-Service
- Hospital Per Diems
- Partial (PCP) Capitation
- Hospital DRGs
- “Global” Capitation
- Pay-for-Performance
- Bundled Pricing with P4P
- Shared Savings with P4P
Three forms of risk assumption

**Actuarial Risk**
The risk that something unplanned will happen that will incur liability for an obligated party

**Utilization Risk**
The risk that a provider will use more resources than absolutely necessary to treat a condition

**Performance Risk**
The risk that a provider will cause a mishap or fail to perform a necessary process of care
Traditional Fee-for-Service rewards the good and the bad

Necessary services
- Evidence-based appropriate care
- Delivered at fair-market pricing

Discretionary services
- Protection against malpractice
- Technology of uncertain value
- Provider-sensitive services (Dartmouth Atlas)

Inefficient or redundant services
- Unnecessary delays during hospitalization, usually managed by UM oversight
- Poor coordination and transfer of information leading to unnecessary testing

Potentially Avoidable Complications
- Unnecessary ED visits
- Readmissions
- Complications during hospitalizations
Bundled Payments requires providers to assume some risk

Utilization and performance risk are within the control of the health care delivery system.

**Utilization Risk**

**Performance Risk**
# Relation of Payment Methodology to Provider Risk Assumption

<table>
<thead>
<tr>
<th>Payment Methodology</th>
<th>Actuarial Risk</th>
<th>Utilization Risk</th>
<th>Performance Risk</th>
<th>Provider Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-service</td>
<td>Payor</td>
<td>Payor</td>
<td>Payor</td>
<td>None</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>Payor</td>
<td>Payor</td>
<td>Provider</td>
<td>Unlikely</td>
</tr>
<tr>
<td>Per diems/DRGs</td>
<td>Payor</td>
<td>Provider</td>
<td>Provider</td>
<td>None</td>
</tr>
<tr>
<td>Bundled Payments</td>
<td>Payor</td>
<td>Provider</td>
<td>Provider</td>
<td>Potential</td>
</tr>
<tr>
<td>Global Capitation</td>
<td>Provider</td>
<td>Provider</td>
<td>Provider</td>
<td>Substantial</td>
</tr>
</tbody>
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Bundled Payments for Acute Illness and Injury
Bundled Pricing for Acute Care

- A fixed payment that covers *all* of the *associated* costs for the treatment of condition or performance of a procedure.
- Time-delimited
- Includes the cost of all associated complications for a fixed period of time. Excludes unrelated services.
- Severity adjustments improve fairness of payment
- Achievement of quality thresholds influences total payment
An hospital procedure Bundle

**Pre-hospitalization**
- Pre-operative testing

**Hospitalization**
- Inpatient hospital charges
- All professional services including attending physician or surgeon, anesthesia, consultants

**Post-hospitalization**
- Home care services
- Skilled-nursing facility
- ED visits
- Care Management
- Follow-up office visits
- Related readmissions
- Treatment of related complications

90 Days

Unrelated charges billed separately as fee-for-service

**Post-Bundle Charges**
- Billed as Fee-for-Service or part of a new Bundle
WellSpan’s Bundled Payment Strategy

• Create aligned incentives among WellSpan physicians and facilities for a limited set of common inpatient procedures
  – CABG
  – Major joint procedures
  – Back procedures
• Learn to manage costs (avoidable complications, unnecessary care) within the context of the Bundled payment price.
• Test with populations, starting with our own workforce
Requirements for Bundled Pricing

• An economic and clinically integrated group of providers who can accept and manage the risk of bundled pricing.
  – Financial strength to weather downside risk
  – Performance improvement infrastructure
• An internal payment system that shares appropriate risk and reward among various caregivers to align incentives.
• A Bundling Methodology that precisely defines the terms of the bundle including:
  – Price
  – Risk sharing between payer and provider group
  – Included and excluded services
  – Quality metrics
The PROMETHEUS Payment Model

- Development began in 2006
- Funded by The Commonwealth Fund, Robert Wood Johnson Foundation
- Based on unique definition of episodes and “gain-sharing” model built into Evidence-Informed Case Rates (ECRs)
- Multiple pilot projects underway throughout the country
PROMETHEUS Evidence-Informed Case Rates

• Patient-centered episodes of care for the treatment of an illness or condition, *severity adjusted to that patient.*

• The payment rate includes all covered services related to the care of the condition as determined by medically accepted clinical practice guidelines.

• Built to identify costs of “typical” services, or the payments for the essential services of the procedure or treatment of the condition. These are distinct from services associated with *Potentially Avoidable Complications (PACs)*
ECRs split a standard episode into its component parts

- All Costs Relevant to Episode, once triggered
  - Costs of all Typical Services
  - Costs of all Potentially Avoidable Complications (and other provider-specific variation)
  - Costs of all Base Services
  - Costs of all Severity Adjusters

Evidence-informed Case Rates
Implementing a Bundled Payment Pilot
Defining a Prometheus Pilot

1. Choose a condition
2. Define episode services (Prometheus “Playbooks”)
   - Inclusion/Exclusion
   - Time windows of episode
   - Outcomes Measures (Scorecard)
3. Determine the operational structure (claims flow)
   - Hook up to ECR Engine
4. Contract Negotiations
   - PAC Rate Analysis and average current charges help determine the starting point
   - Technical Risk Corridors and Stop Loss
     - How to protect providers against actuarial risk of catastrophic cases
     - Protect payer against padding and minimal risk assumption
   - Outcome measures risk/reward
The PROMETHEUS “Playbook” defines those ICD9 and CPT-4 codes that are either complications (included) or unrelated (excluded).
Reducing Potentially Avoidable Complications (PACs) is the Primary Driver of Patient (and Payer) Value
## Not just for procedures

<table>
<thead>
<tr>
<th>Type of ECR</th>
<th>Trigger</th>
<th>Time Window</th>
<th>ECRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Medical</td>
<td>Outpatient Professional</td>
<td>One year from trigger</td>
<td>Diabetes, CHF, COPD, Asthma, CAD, HTN, GERD</td>
</tr>
<tr>
<td>Acute Medical</td>
<td>Inpatient Facility</td>
<td>0-day look-back; 30-day look-forward</td>
<td>AMI, Stroke, Pneumonia</td>
</tr>
<tr>
<td>Inpatient Procedural</td>
<td>Inpatient Facility/Professional</td>
<td>30-day look-back; 180-day look-forward</td>
<td>Hip or Knee Replacement, CABG, Bariatric Surgery, Colon Resection</td>
</tr>
<tr>
<td>Outpatient Procedural</td>
<td>Outpatient Facility/Professional</td>
<td>30-day look-back; 180-day look-forward</td>
<td>Angioplasty (PCI), Knee arthroscopy, Hysterectomy, Cholecystectomy, Colonoscopy, Pregnancy &amp; Delivery</td>
</tr>
</tbody>
</table>
SCP Data Analysis
Data analyzed and limitations

- WellSpan Plus and Hanover Hospital members
- Date Range: 5/1/2009- 4/30/2011
  - Number of Records: 1,477,677
  - Number of Unique Patients: 21,109
  - Allowed Amounts: $214,449,890
- Limitations of Analysis:
  - Small numbers of Acute Medical, Inpatient Procedural ECRs (<30 relevant patients)
  - # Relevant Patients per practice location also <30 for most – unable to do this level of analysis even for chronic ECRs
Total Relevant Costs

### All Relevant Costs by ECR

<table>
<thead>
<tr>
<th>ECR</th>
<th>All Relevant Costs by ECR</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>$187,116</td>
<td>14</td>
</tr>
<tr>
<td>COPD</td>
<td>$381,491</td>
<td>97</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$3,241,522</td>
<td>488</td>
</tr>
<tr>
<td>Asthma</td>
<td>$1,689,039</td>
<td>616</td>
</tr>
<tr>
<td>HTN</td>
<td>$1,221,994</td>
<td>725</td>
</tr>
<tr>
<td>CAD</td>
<td>$2,634,844</td>
<td>477</td>
</tr>
<tr>
<td>GERD</td>
<td>$3,104,474</td>
<td>656</td>
</tr>
<tr>
<td>AMI</td>
<td>$739,684</td>
<td>12</td>
</tr>
<tr>
<td>Stroke</td>
<td>$104,172</td>
<td>3</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>$102,636</td>
<td>9</td>
</tr>
<tr>
<td>Hip</td>
<td>$189,210</td>
<td>5</td>
</tr>
<tr>
<td>Knee</td>
<td>$741,788</td>
<td>19</td>
</tr>
<tr>
<td>CABG</td>
<td>$340,044</td>
<td>5</td>
</tr>
<tr>
<td>Colon</td>
<td>$244,162</td>
<td>4</td>
</tr>
<tr>
<td>Bari</td>
<td>$0</td>
<td>-</td>
</tr>
<tr>
<td>Colos</td>
<td>$2,624,961</td>
<td>936</td>
</tr>
<tr>
<td>Gall</td>
<td>$754,426</td>
<td>53</td>
</tr>
<tr>
<td>Hyst</td>
<td>$656,444</td>
<td>32</td>
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<tr>
<td>Knee Arth</td>
<td>$298,448</td>
<td>40</td>
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<tr>
<td>PCI</td>
<td>$1,121,249</td>
<td>14</td>
</tr>
<tr>
<td>Preg</td>
<td>$842,956</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>$21,220,660</td>
<td>4,277</td>
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Target ECRs with high PAC % for Quality Improvement
PAC Drilldown: Diabetes

Diabetes PAC Professional ECR PAC Costs

- Emergency Room Visits: $5,419
- Acute Flare-up of Index Condition: $26,546
- Urinary Tract and other Hospital Acquired Infections: $34,536
- Diabetic Emergency, Hypo-Hyper-Glycemia: $3,059
- Subarachnoid And Intracerebral Hemorrhage (Stroke, CVA): $4,000
- Cardiac Dysrhythmias, cardiovascular problems: $23,819
- Pneumonia, Lung Complications, Respiratory Failure: $0
- Acute Renal Failure, Other Kidney Problems: $46,217
- Gastritis, Ulcer, GI Hemorrhage, Abdominal Pain: $67,219
- Syncope, Hypotension, Dizziness: $62,970
- Cellulitis, Skin Infections: $1,557
- Phlebitis, DVT, Pulm Embolism, Decubitus Ulcer: $63,369

Total Cost: $212,059

PAC Occurrences

- Occurrence
- Cost
Bundled Payments Can Reduce Costs

- Set a budget for the bundle that eliminates payment for a small portion of the PACs
- This aligns providers around reducing Potentially Avoidable Complications
Payment Reform for Chronic Illness
Improving value requires different approaches for different populations

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• Bundled Payments |
Patient Centered Medical Homes Value Proposition

• Increased access to care
• Better coordination
• Better chronic disease management
• Using ancillary staff to the “top of their licenses.”
• Results
  – Reduced ED visits
  – Reduced hospitalizations
Central Aims of Medical Home Model

- Comprehensive Care
- Patient Engagement
- Enhanced Access
- Coordinated Care

Successful implementation of a Medical Home model in a primary care practice requires extensive upgrading of staff skills and investments in care management services.
Financial Support Models for Medical Homes

**Benefit Plan coverage for “New” Services (FFS)**
- Anti-coagulant management (99363 and 99364)
- Education for self management (98960-98962)
- Medical team conference (99366 – 99368)
- Telephone services (99441 – 99443 and 98966 – 98969)

**Monthly management fee**
- Age-adjusted
- Typically $2 - $10 per month
- Needs linkage to quality metrics
- Could be applied to patients with selected medical conditions

**Bundled Payments for Selected Chronic Illness**
- Risk-adjusted payment
- Needs linkage to quality metrics
- Needs a Bundling Methodology
- Payments are retrospective

**Shared Savings Model**
- Project future spending and provide medical homes with a portion of any savings
- Payments not realized for more than a year.
- Does not provide up-front support for care management costs
- Not sustainable in long-term as savings will diminish with progressive improvements

**Capitation Models**
- Age-sex-severity adjusted
- Extensive experience with this model
- Needs to cover broad array of services (inpatient, outpatient) to provide incentives to PCPs to manage care
- Typically requires benefit plan support (mandatory PCP selection by member)

**Other Models?**
Conclusions

• Enhancing value in healthcare requires movement away from fee-for-service payments to providers
• New models of payment must support care management activities that reduce unnecessary services.
• Providers seek financial incentives to migrate from the current model
• Change requires alignment of benefit plans
• Beneficiaries need information to select the higher value providers who can better coordinate their care and assure better quality