PILOTING CHRONIC CARE EPISODES in COLORADO:

Progress, Pitfalls, and the (Energizing) Potential

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COLORADO
BUSINESS GROUP ON
HEALTH

FOURTH NATIONAL BUNDLED PAYMENT SUMMIT

June 2014

Session Objectives

1. Demonstrate how using ***clinically-based ECRs is critical*** to improving quality and reducing costs for employees with ***chronic conditions***.
2. Share a model as to how ***employers and primary care physicians can work directly together***, without intermediaries, as well as what we've learned from doing so.
3. ***Summarize our conclusions*** after three years as to the implications for the health care market of implementing episodes of care.

Discussion Topics

1. Overview of our Payment Pilot
2. Challenges and Our Approach to Solving Them
3. What We've Seen in, and Learned from, the Analytics
4. The Demand-Supply Conundrum: Aligning Benefits Redesign and Payment Reform
5. Conclusions and Implications

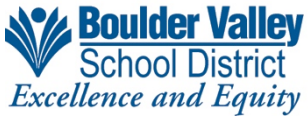
1. Overview of the
Health Incentives Payment Pilot
Using Prometheus ECRs

- About CBGH
- Why Chronic Care and Why Prometheus
- Purpose of the Project
- Feasibility Analysis
- Participants and Their Roles
- Funding and Operations

CBGH:

An employer led, non-profit organization

We champion improved healthcare value for Colorado companies and their employees through education and net-working, practical purchasing tools, and innovative programs.



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Changing the way employers purchase and provide health care.

CBGH Purchasers' Strategy

Purchasers' Internal Strategy

Value-Based Purchasing
Benefit Design
- Wellness
- Disease Management

Transparency of Cost
Transparency of Quality
Informed Consumers / Employees

Purchasers' External Strategy

Physicians

Bridges to Excellence
Physician Satisfaction Survey
Healthcare Incentives Payment Pilot (HIPP)

Hospitals

Leapfrog Hospital Survey
Patient Safety
Never Events

Health Plans

CAHPS Satisfaction Survey
HEDIS Quality Measures
eValue8 RFI
Healthcare Incentives Payment Pilot (HIPP)

Health Matters: Colorado Health Plan and Hospital Quality Report

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15 years after "To Err is Human"....

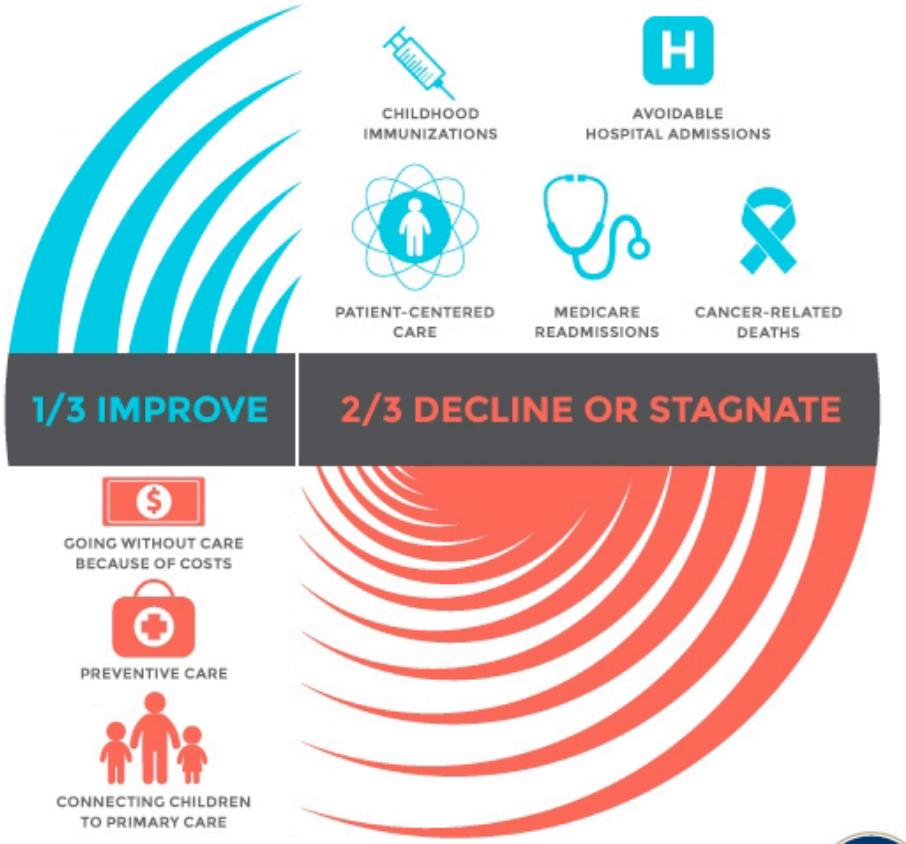
PROGRESS ON STATE HEALTH CARE PERFORMANCE

THE BAD AND THE GOOD

In the years leading up to the launch of the Affordable Care Act, improvement on critical health system measures across states was uneven at best. In most states, access to affordable care declined.

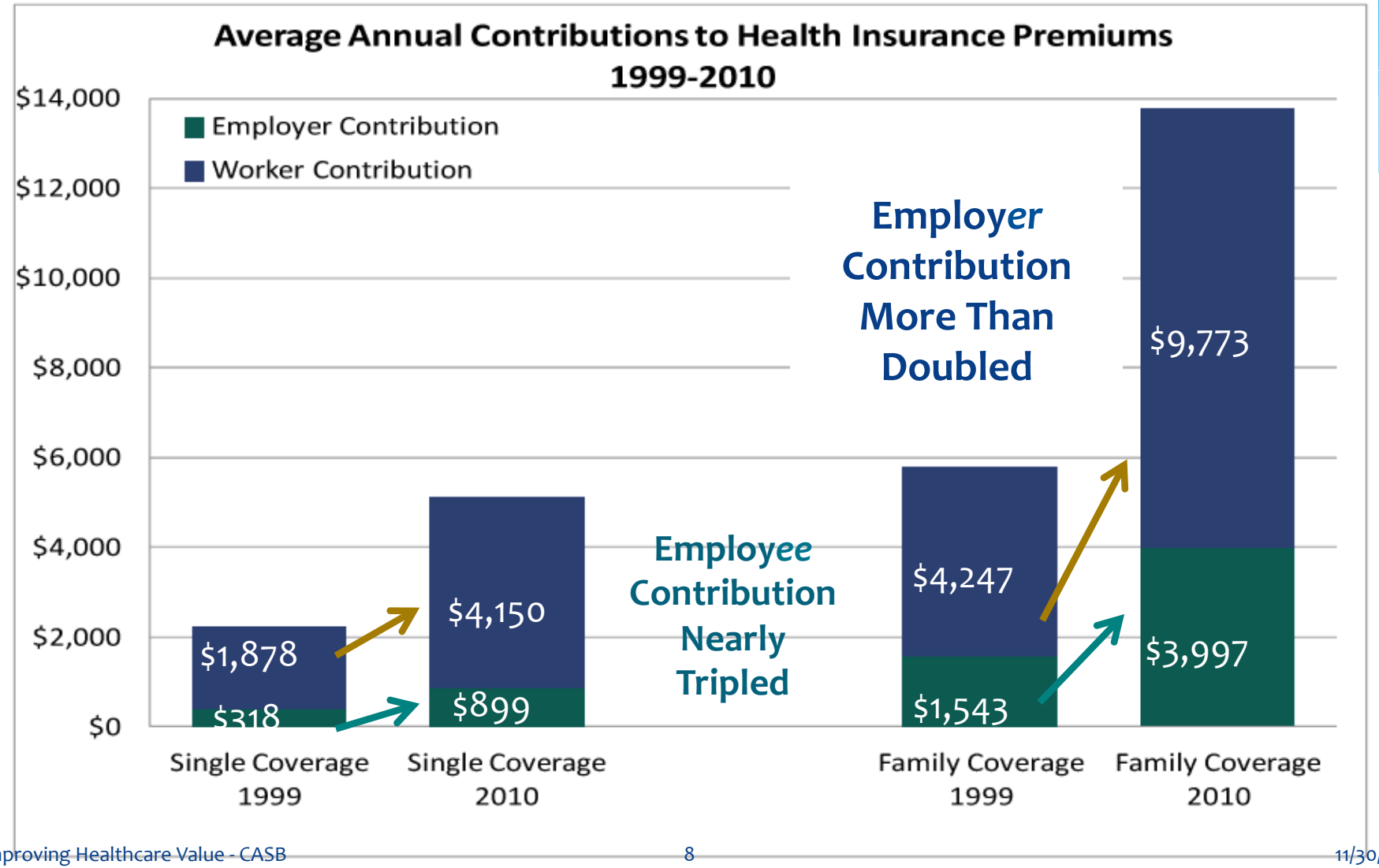
On two-thirds of the measures that could be tracked over time, a majority of states saw decline or stagnation in the five years up to 2012.

But a majority of states made progress in certain areas, particularly those that have been the focus of national, state, and local improvement efforts.

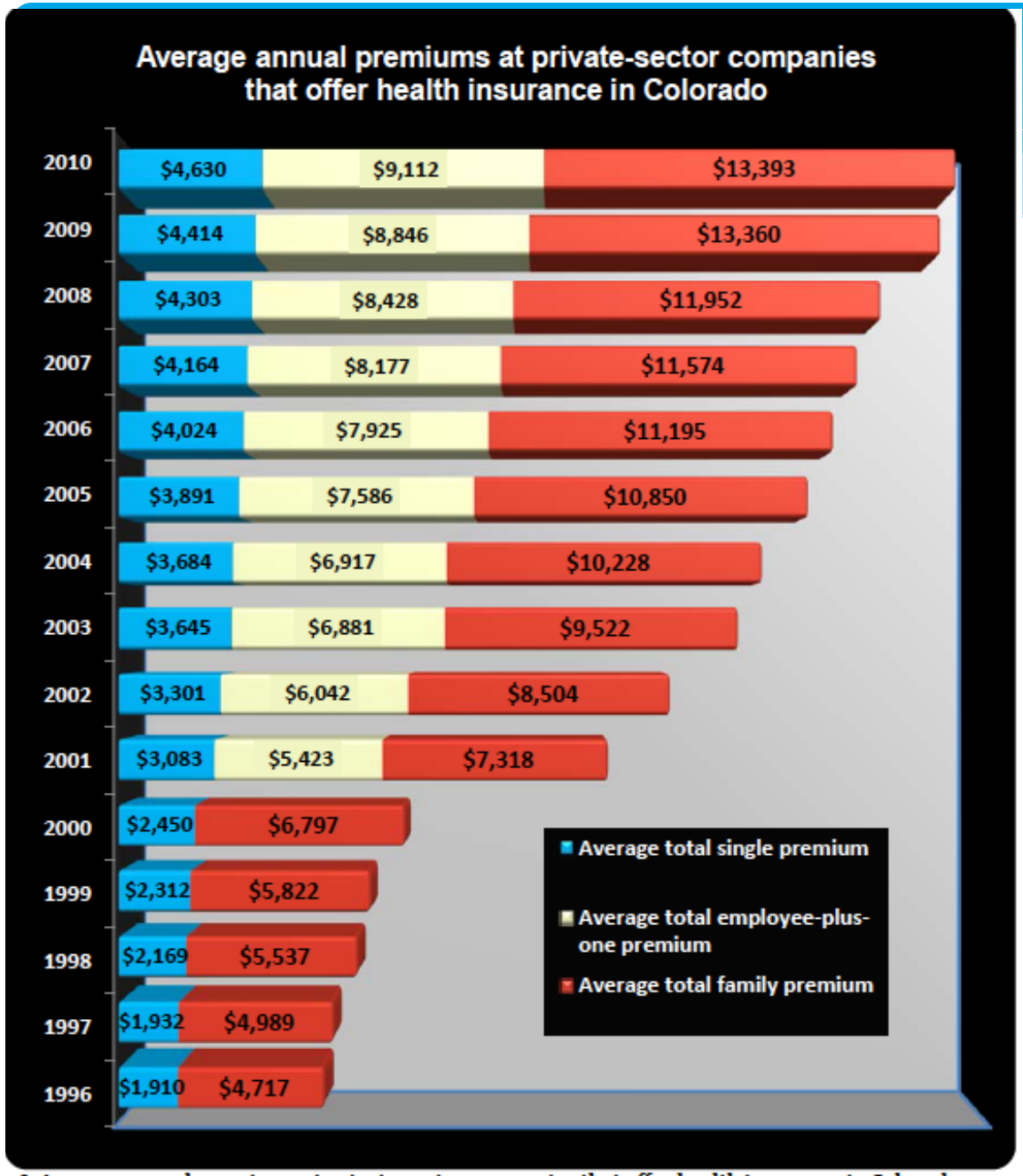


Source: D. C. Radley, D. McCarthy, J. A. Lippa, S. L. Hayes, and C. Schoen, *Aiming Higher: Results from a Scorecard on State Health System Performance*, 2014, The Commonwealth Fund, May 2014.

Meanwhile, the impact on our families, our companies, and our economy …



Source: "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For an Average US Family", Health Affairs, 2011



e 6: Average annual premiums at private-sector companies that offer health insurance in Colorado

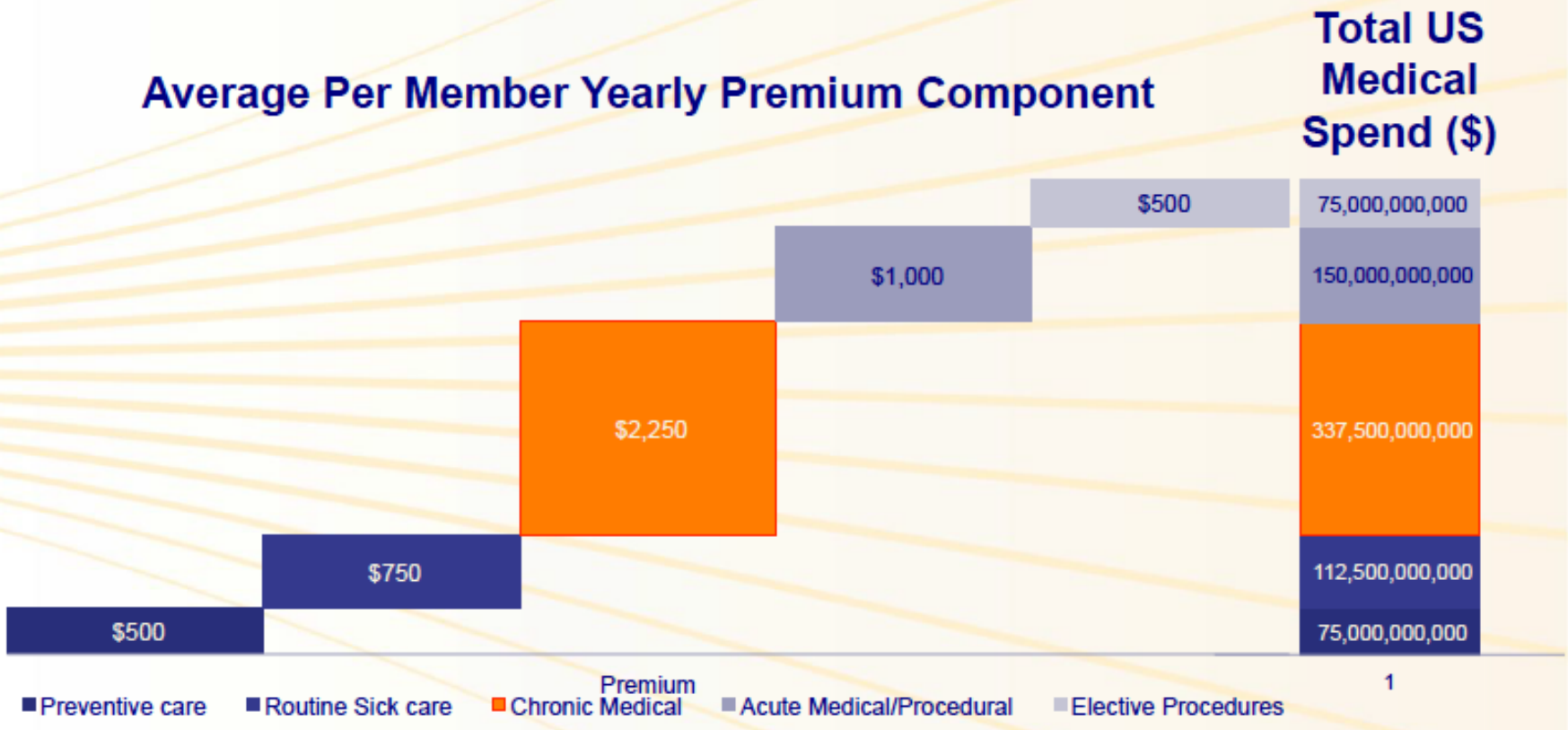
Approximate 10 year impact on SVVS:

$7m/$68k* = at least

103 fewer teaching positions

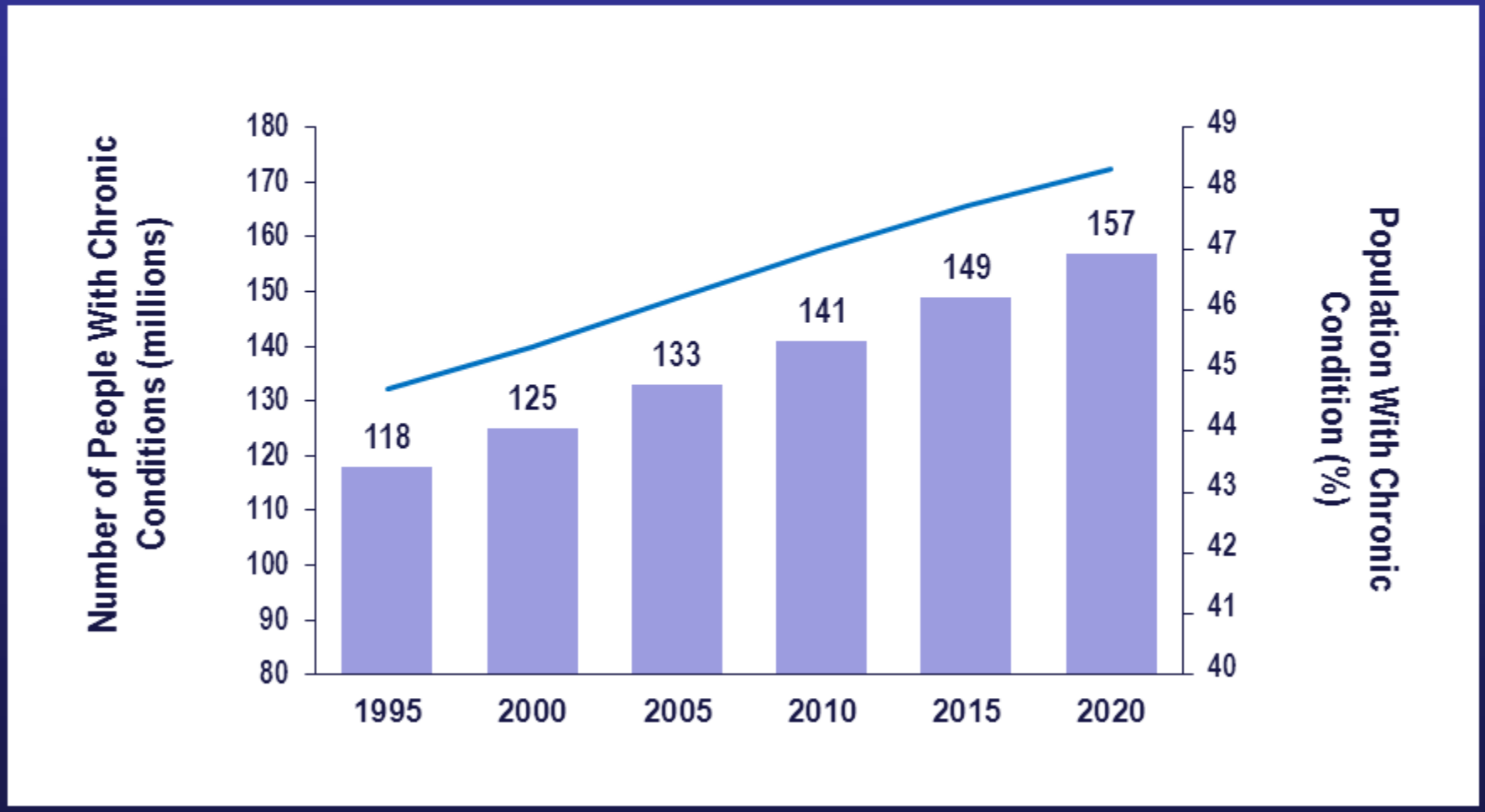
*Including benefits.

Procedures Are Important But So Is Chronic Care



- Employers cover 48% of lives in U.S.
- Chronic care management comprises 45% of total spend *(more when including elective surgeries and acute medical events)*

Increasing Prevalence of Chronic Conditions[1]



1. Adapted from: The Partnership to Fight Chronic Disease. The growing crisis of chronic disease in the United States. fightchronicdisease.org/resources/almanac-chronic-disease-0. Accessed February 1, 2013. Reprinted with permission.

Using episodes differently based on the problem.
Chronic versus Procedural Care.

Chronic Care

- **Spend**: Generally predictable (if managed) over time.
- **Issue**: Cost of unwarranted variation and complications.
- **Proposed Solution**(s):
  1. Collaborative
  2. Community defined episodes designed for better efficiency
  3. Patient-specific budgeting

Procedural Care

- **Spend**: Generally unpredictable over time.
- **Issue**: Core pricing variations due to facility and other charges.
- **Proposed Solution**(s):
  1. Competitive
  2. Provider defined episodes designed for retail markets
  3. Episode-specific pricing

Why we use

Prometheus ECRs*

A clinically-based model for measuring and managing healthcare resources

*Evidence-Informed Case Rates

A New Unit of Account
Clinically, rather than actuarially, derived

"These accumulations [use rates per thousand] are valuable in so far as they represent, in an over-all way, the sheer volume of service. But their very simplicity, their objectivity, and their apparent precision are deceptively reassuring. ***They create an illusion that the essential facts of utilization are thus expressed.*** There is much more to tell of medical care than these superficial counts reveal. ***And it is important to be able to tell it."***

From "Delineating Episode of Medical Care," Jerry Solon et al, 1967

Using clinical standards to inform a different perspective:

Measuring resource for episodes of care

* **HCI3** examined 21 conditions of care using complex algorithms.
* By applying clinical rules to each care episode, they can determine "**relevant**" vs **"irrelevant"** costs/episode.
* By applying **clinical standards**, relevant costs can be further broken down into:
  * **Typical** costs, eg., expected but not necessarily baseline or irreducible
  * **Potentially avoidable** costs due to complications

A two-step process for measuring…
Quality waste in healthcare

1. Identify Relevant Costs

Examine every claim for every eligible patient and sort as....

Charges that are **RELEVENT** to the disease and any co-morbid conditions.

$

Charges that are **IRRELEVENT** to the disease and any co-morbid conditions.

2. Separate/Segment PACs

Use clinical guidelines to sort RELEVENT claims into those associated with…

"Typically" Provided Services (and costs)

$

"Potentially" Avoidable Complications (and costs)

What Our Feasibility Analysis Showed
for Six Health Plans in Colorado

Potentially Avoidable Costs as a % of Total Spend:

PAC Percentage	CHF	COPD	DM	Asth.	HTN	CAD	GERD
Plan A	65%	47%	33%	34%	23%	18%	29%
Plan B	62%	45%	25%	32%	21%	15%	31%
Plan C	58%	45%	38%	35%	23%	33%	42%
Plan D	56%	44%	30%	36%	20%	13%	25%
Plan E	73%	47%	42%	45%	25%	11%	36%
Plan F	65%	49%	36%	37%	27%	25%	26%
CO Ave.*	63%	46%	34%	37%	23%	19%	32%
US Ave.	56%	45%	29%	29%	17%	14%	35%
US Max	69%	61%	36%	41%	25%	23%	43%
US Min	40%	26%	21%	22%	14%	9%	17%

"Every system is perfectly designed for precisely the results it gets."
Don Berwick, MD

2. Our Model and It's Challenges:

- The Model
- Aggregating Disparate Risk Pools
- Data Acquisition and Validation
- Required Innovations
- Remaining Challenges

"Warning: This Lift Serves Only Expert Runs"

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The Challenges
Implications and Approaches

* Common approach vs different tools/tactics
  * Employers agree to a common, aligned approach
  * Health plans each seek to differentiate themselves
* Employer engagement (only "innovators")
* Law of small numbers
* Legacy "punch 'n pay" software
* Patient attribution in a "go-anywhere" world
* The version
* **Data acquisition and validation**

IT innovations position us for success.

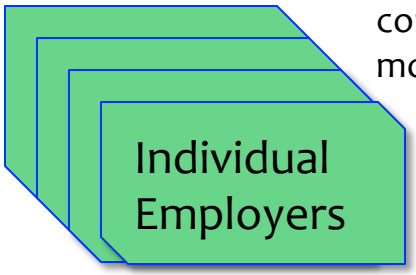
* CBGH's Innovative Responses
  * Data submission: required APCD format and dedicated 2+ FTEs to validation of data.
  * Multiple Repositories: Developed to accommodate "re-purposing" of claims data to clinical purposes beyond calculating PACs.
  * Reporting: Worked with employers and provider groups to develop succinct reporting in addition to standard Prometheus outputs.

* Bottom Line: CBGH had to develop a unique capacity to scale out an employer-based approach to implementing episodes of care for chronic disease.

Contractual Relationships

For Implementing Self-Funded Employer Agreements

Funds will flow through contractual relationships, eg., modeled after BTE)



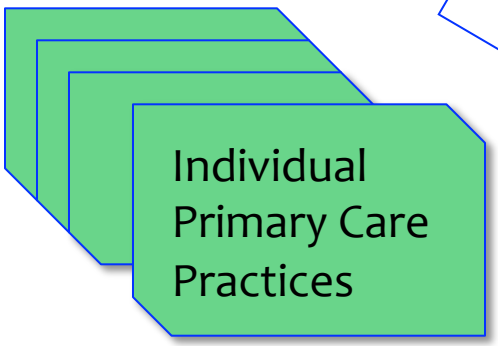
Contract

- Financially support warehouse
- Have data submitted quarterly
- Escrow potential shared savings
- Participate in "task force"

CBGH

- Accepts data feeds
- Maintains warehouse
- Proposes targets
- Runs analytics

Contract



- Meet "meaningful use"
- Redesign care processes
- Participate in "task force"

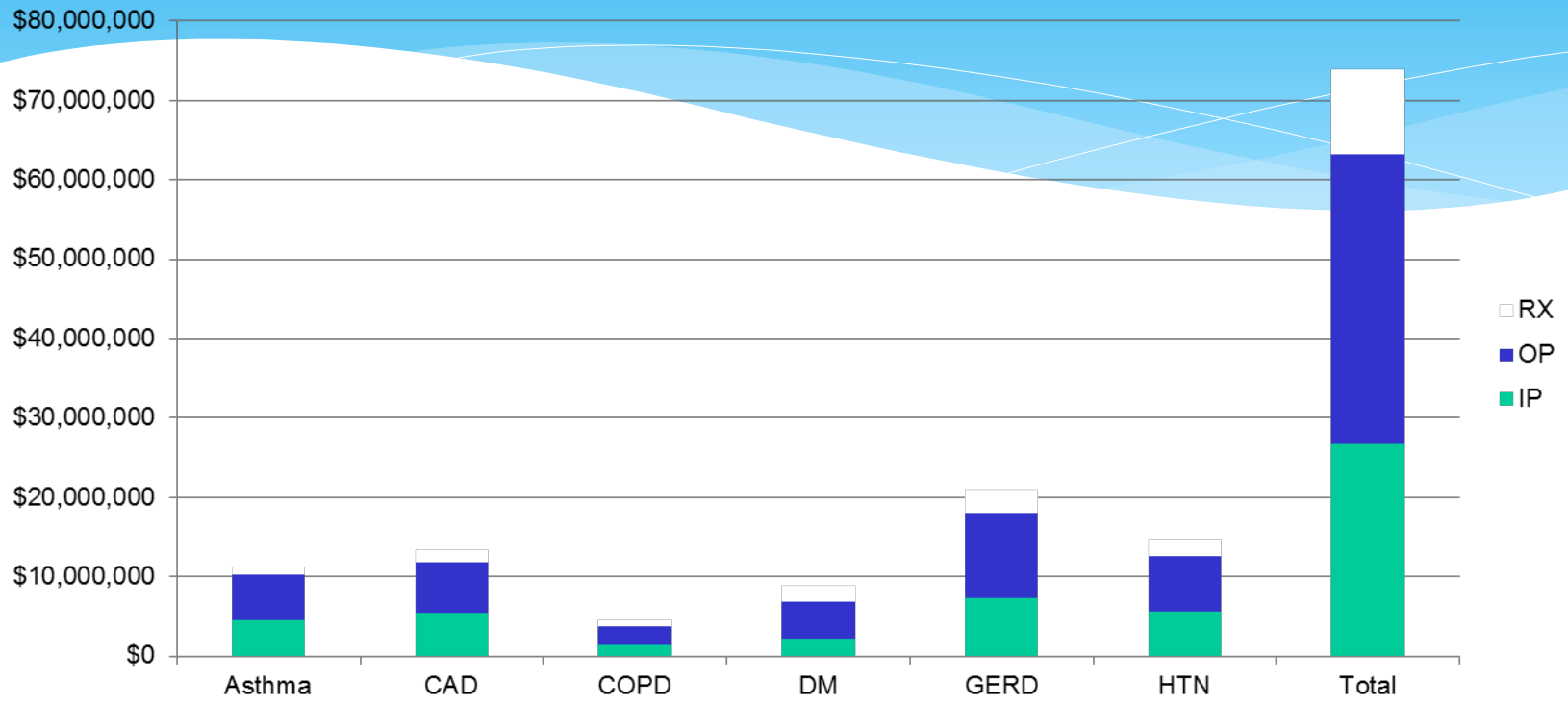
All agreements HIPAA compliant and all data transferred/stored in a secure manner.

3. The Analytics:

What We've Seen & Learned So Far

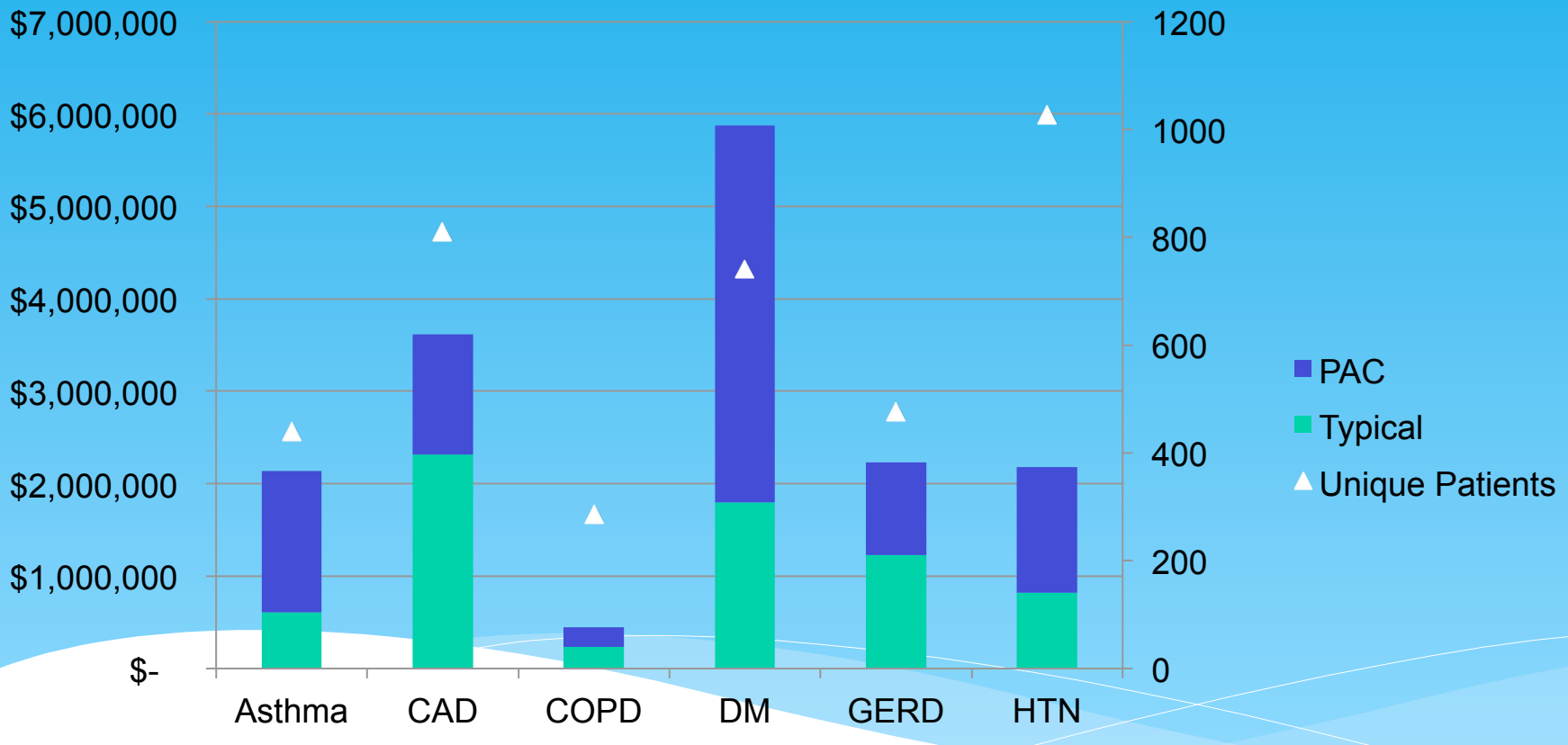
- Overall Spending
- PAC Rates
- How We Report

Total Expenditure 2011 – 2012
(for ~3k persons with chronic disease)

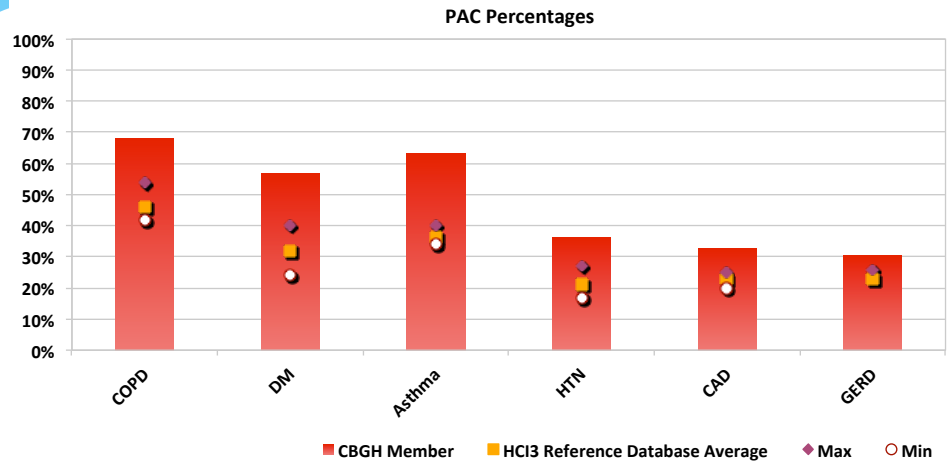


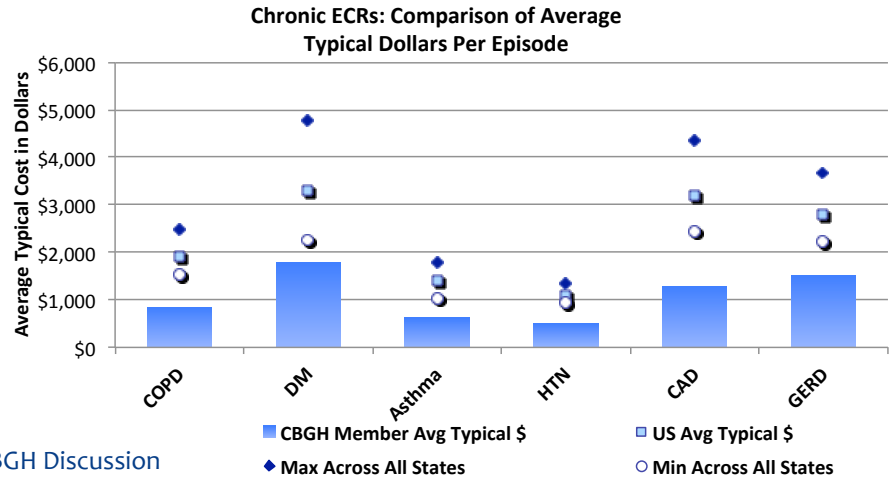
About 10% of the population triggers with a chronic disease. The two year spend was over $70 m and the average annual cost ranges from $10k to $16k per person per year, depending on the condition we are evaluating.

All Relevant Spend, Colorado Springs Community 2011-2012



Targeting ECRs with high PAC rates

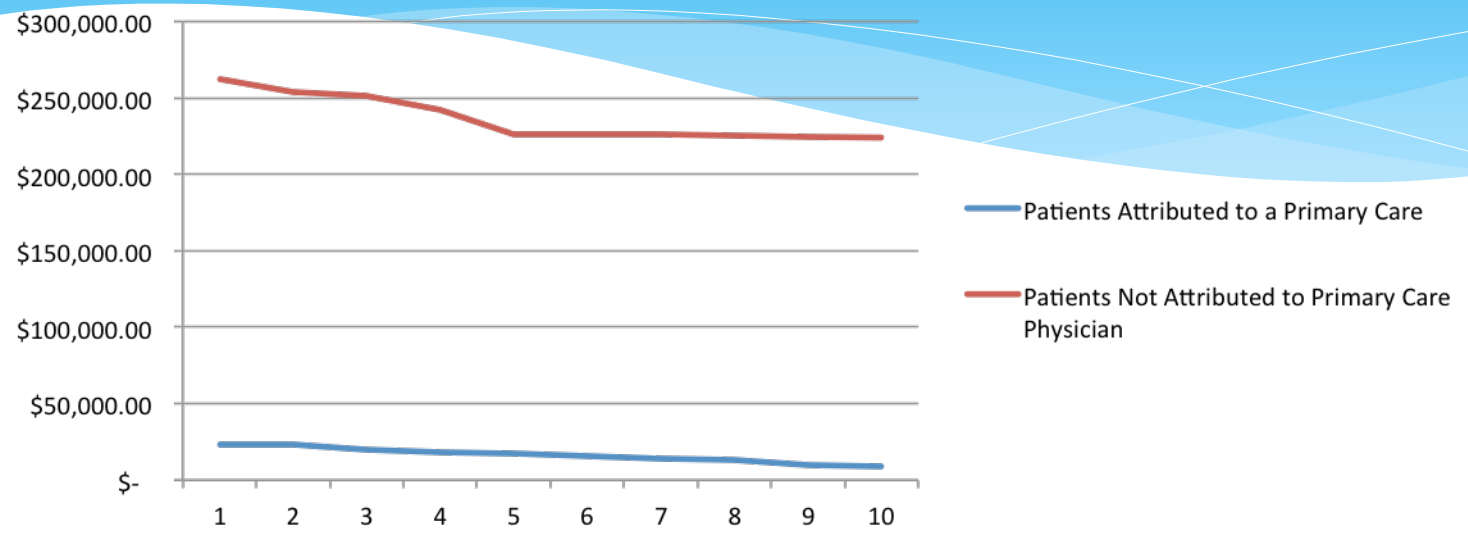




- CBGH members typically experience low typical costs and high PAC percentages – from 30-60%.
- Low contracted rates and low use of high value services result in low typical costs.
- Lesson: Purchaser is controlling unit price but aggregate costs are still high and care is not most appropriate.

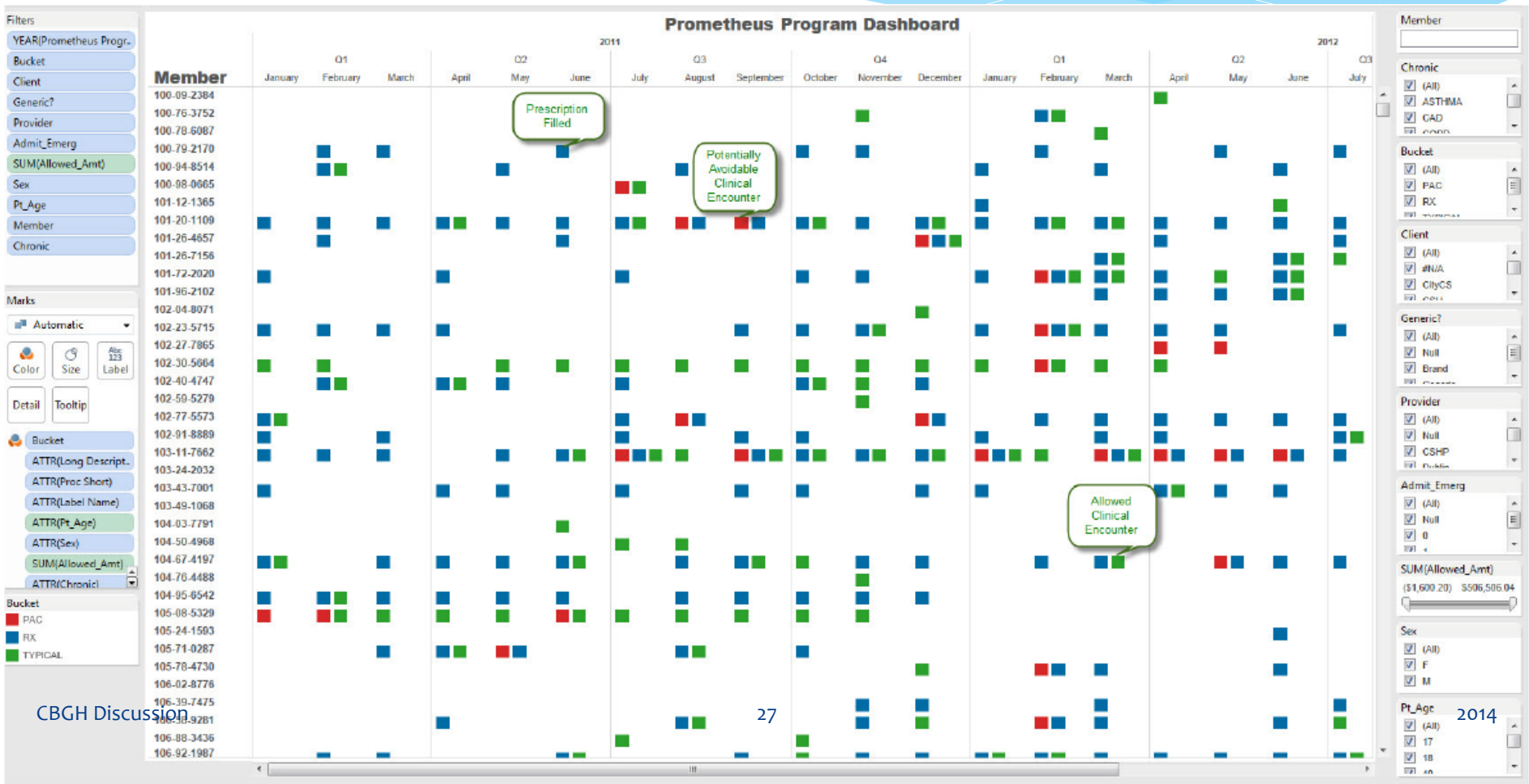
Most Costly Patients 2011-2012

Data from three of our four participating employers.



- We removed the 5 most costly patients, so we are looking at patient #6 through patient #15.
- The patients on the blue line were attributed to a primary care provider, and the patients on the red line were **not** attributed.

Practice Overview



4. The Demand-Supply Conundrum

- Sources of the Problem
- Solutions and Priorities

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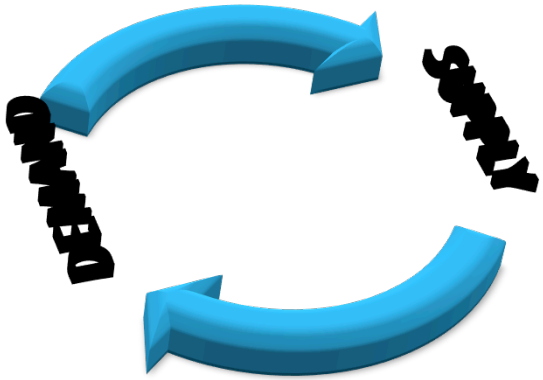
Identifying and focusing on...
Sources of the Problem

EXCESSIVE DEMAND
- 60%+ cost due to behavior
- Over-use/under-use – particularly for chronic disease

INEFFICIENT/INEFFECTIVE CARE
- 25-45% of cost due to inefficient and/or ineffective care delivery
  - 40% of services unjustified.

UNEVEN USE
- 5% EEs = 50-60% cost
- 75% based in chronic conditions (CDC)



PROVIDER PAYMENT
- 90% volume-based
- Charges vary 300%+

ENGAGEMENT
- Healthcare literacy
- 2% EEs use available tools
- Few consumer incentives

LACK of TRANSPARENCY
- Quality remains "opaque"
- Prices for component serves are of little to no use to consumers.

The two challenges require...
Separate (but aligned) solutions.

The Demand Side

- ***Each employer has unique needs*** based on their unique employee population.
- Those need must be addressed in the context of their unique ***culture/work environment***.
- ***Partners*** *in doing this are your:*
  - ***Employees***
  - ***Benefits consultant***
  - ***Health plan administrator***

The Supply Side

- ***All employers shares a common need*** based on prevalent practice patterns in their area.
- A lone employer or health plan is unlikely to realize the need to change at the ***community*** level.
- ***Partners*** *in doing this are:*
  - ***Other employers***
  - ***The local provider community***
  - ***Employees***

Guiding Employer Priorities

Demand Side

1. Chronic care/conditions (50%)*
2. Procedural care (30%)*
3. Early intervention and prevention/wellness (15%)

Supply Side

1. Direct provider engagement*
2. Use of standardized performance measures*
3. Value-based contracting*

* Episodes of care can support and advance virtually all of what we view as an employer's systemic priorities.

Employer Priorities for
Addressing Chronic Conditions

Demand Side Priority #1

Address Benefit Design in '15

- **Objectives**
  - Physician selection
  - Care plan compliance
- **Key Characteristics**
  - V-BID
  - Participation agreements
  - Phased approach

Supply Side Priority #1

Maintain Social Capital

- **Objectives**
  - Creation of "radius of trust"
  - Align community interests
- **Key Characteristics**
  - Employers-Physicians at table
  - Everything on the table
  - Objective 3rd Party (CBGH)
  - Transparency

5. Conclusions & Implications

PROMETHEUS ECRs Can Be Used to…

* **Analyze efficiency of care** for patients with chronic conditions.
* Provide medical directors and physicians with **clinically actionable feedback**.
* **Inform employers** of the need for addressing benefit design in 2015, in consult with physicians, in order to make employee's better consumers by:
  * Incentivizing compliance with recommended protocol.
  * Encouraging employee use of primary care providers recognized for improved clinical outcomes.

Where we are now…

* Infrastructure now largely in place.
* Positioned to accelerate analytics.
* While we do have some renewed health plan interest...
* HIPP is/likely to remain an employer-driven initiative.

The piloting employers and providers…

* Demonstrate patience through an ongoing commitment to piloting payment reform as the most viable way to achieve the Triple Aim.
* Have been informed of identified patients in the six chronic disease cohorts. Participating physicians have validated over 85% of these patients.
* Have gained unprecedented insights into their costs and opportunities for improvement through the analytics.
  * Employers are contributing to support of the CBGH data warehouse.
  * Are assisting in recruiting additional practices and employers.

Project Expansion

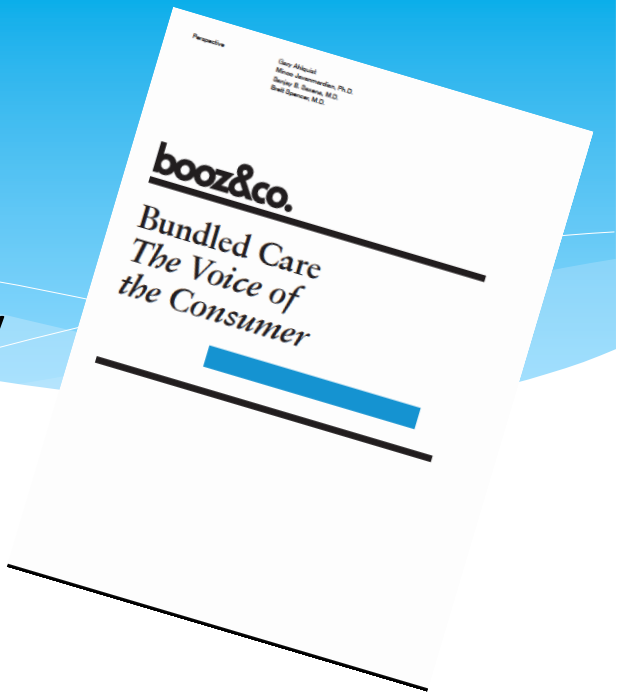
- Physician Groups
- Targeting 3 additional employers
- Working with 2 consultants
- Some interest on part of 3 health plans

Remaining Challenges:

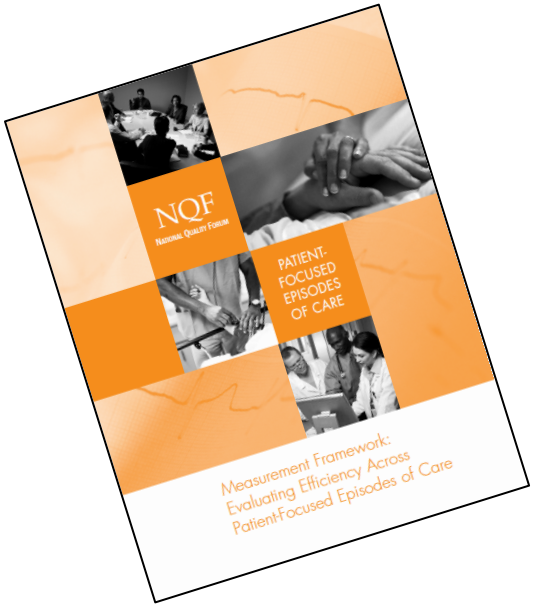
Answering how we can…

* Adjust enrollment quarterly.
* Adopt/apply effectiveness measures.
* Create State-wide benchmarks.
* Evolve “3.6” or migrate to “5.0”

Why this is important



"Healthcare bundles are the most promising strategy for systemically and sustainably reducing costs and improving healthcare quality." - Booz & Company



"A longitudinal, episode-based approach contrasts sharply with current approaches to performance assessment, which usually focus on a specific setting or provider (e.g., hospital or nursing home) and on a single point in time." - National Quality Forum

Clarifying the Employer's Role as a Proactive Purchaser of Health Care

* **IS NOT:** To redesign healthcare delivery
* **IS:** To restructure the healthcare market through…
  * Value-Based Purchasing
  * Value-Based Insurance Design

The historically **wholesale** nature
of health care contracting

Pre-ACA
(It's about plans and providers)

* Provider Pricing: Negotiated with intermediary
* Contract: Volume for discounts
* Emphasis: Market share
* Consumer:
  * Plays little, if any role
  * Has few usable tools even if incentivized to "purchase"

Post-ACA
(Still about plans and providers)

* Provider Pricing: Negotiated with intermediary, not in market
* Intermediaries double-down on "exclusive networks." So…
* Providers have even greater incentives to "integrate" (eg., ***consolidate, eg., increase cost***)
* "Consumerism" largely limited to insurance exchanges (15% of cost)
  * Tools - still limited
  * Incentives – still limited

Implications of a retail approach (procedural/episodic care)

* **For Consumers**
  * Known costs empowers consumerism
  * Makes the patient the customer, *not the health plan*
* **For Employers**: An altogether altered marketplace:
  * Promotes competition based on value, not volume
  * Exponentially expands the number of potential competitors by fostering development of "centers of excellence"
  * Provides the most tangible engagement strategy: OOP cost
* **For Providers:** Advantages can be mixed…
  * A business case for re-designing care creates winners and losers
  * Episodes will empower physicians in the market
  * Market share must be built one patient at a time

Why this is important...

Payment reform both represents and results in "disruptive innovation."

> "....just about all the ***cards are stacked against the nurturing of innovation***, especially the kinds of new ideas and disruptive innovations that generally lead to major changes in the marketplace." (*The Challenges of Innovation*, August 22, 2008)
>
> "In today's system, **institutions that control information not only lack incentives to invest in sharing it, *they have powerful incentives to maintain the status quo***." A 2007 report on HIEs

Episodes can lead to major changes *through:*

* Convening local employers and providers focused on value.
* Creating a sustainable business case for change.
* Transforming payment so as to focus on patients, not services.

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