Value-Based Purchasing of Employee Health Benefits

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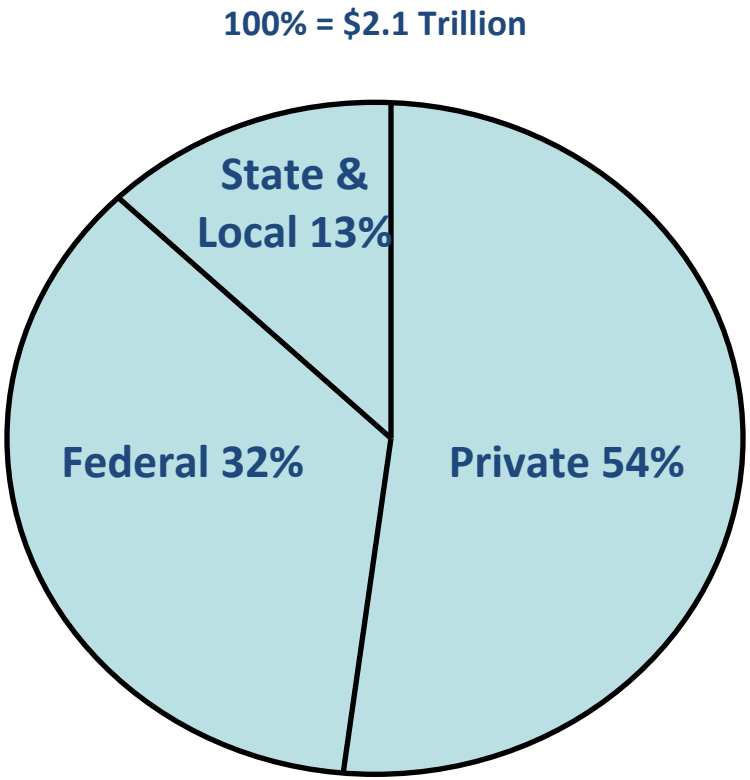
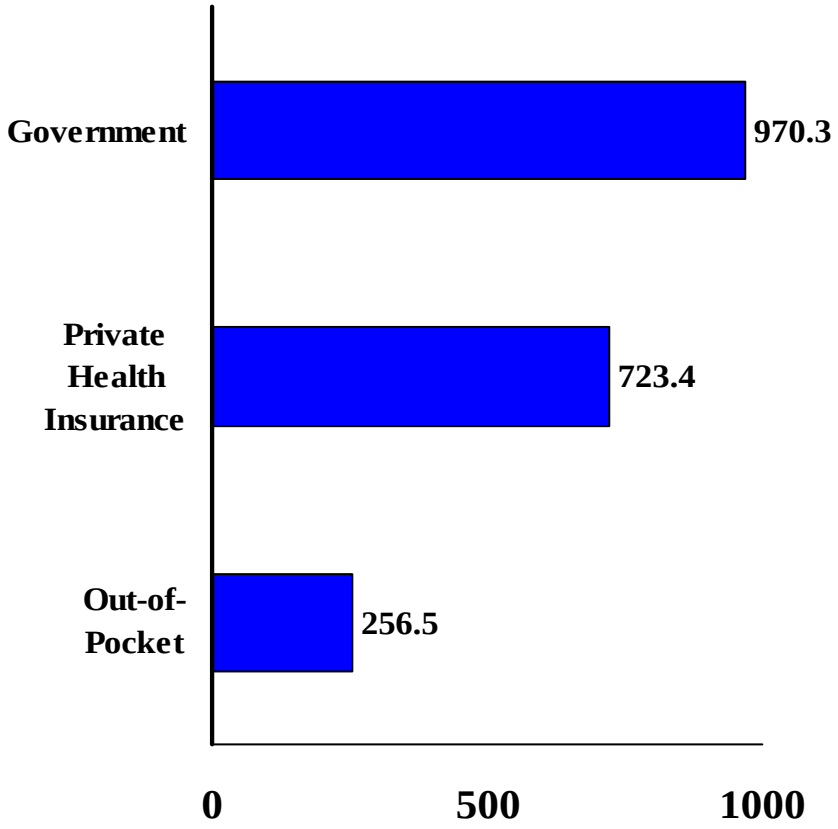
Payment for Healthcare Services Today: National Expenditures

NHE by Source of Funds
2006, Percentage

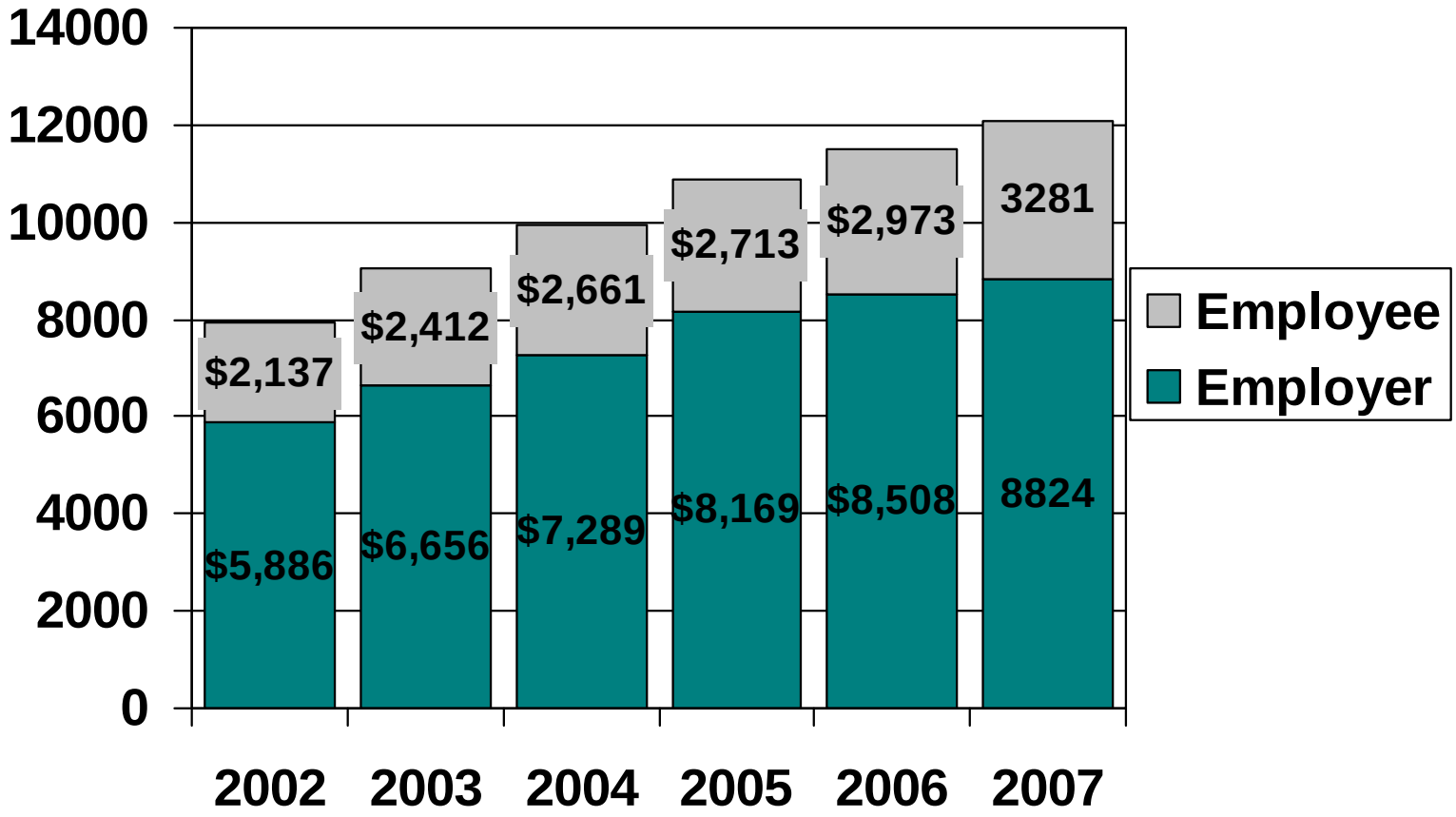


Payor Estimate
2006, Billions of Dollars



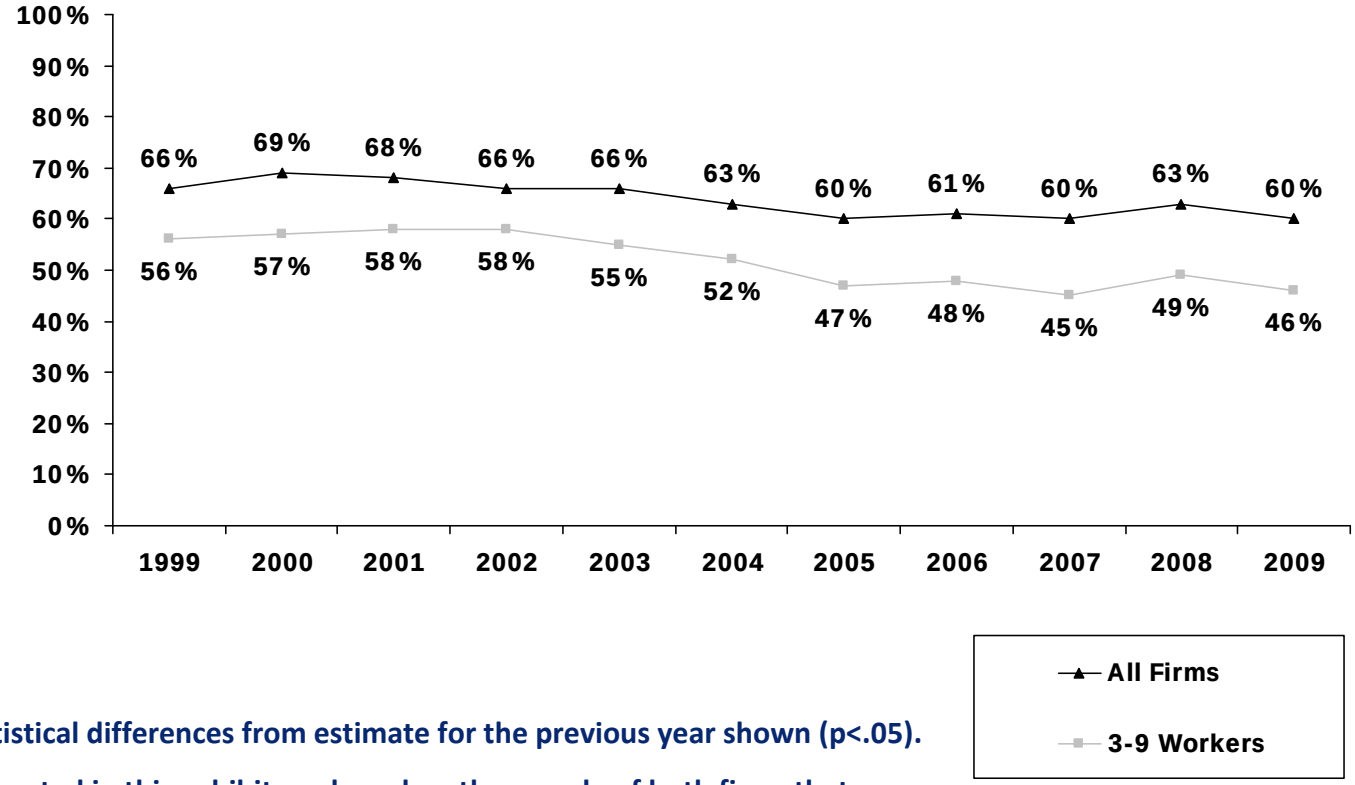
Source: Center for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data

EMPLOYER CONTRIBUTIONS TO INSURANCE PREMIUMS, 2002 – 2007 (*Based on family of four)



Source: Spending by employers on health insurance: a data brief. http:digitalcommons.ilr.cornell.edu/key_workplace/323

Percentage of All Firms Offering Health Benefits, 1999-2009*



*Tests found no statistical differences from estimate for the previous year shown ($p<.05$).

Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

The Eroding Value of Health/Benefits Market

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

Value decreases when you…

…pay the same for less ↓ **VALUE** = $\frac{\downarrow \text{QUALITY}}{\text{COST}}$

…pay more for the same ↓ **VALUE** = $\frac{\text{QUALITY}}{\uparrow \text{COST}}$

…pay more for less ↓ **VALUE** = $\frac{\downarrow \text{QUALITY}}{\uparrow \text{COST}}$

Description of the Value-Based Purchasing (VBP) Model

Definition:

"Value Based-Purchasing" refers to a range of activities initiated by public and private purchasers of health care to use comparative performance information to publicly recognize, select, and financially reward health care vendors, particularly health plans and providers. The goal of value-based purchasing is to improve the quality, safety, and affordability of health care services.

VBP Strategies

- Collecting information and data on quality
- “Value-based benefit design”
- Selective contracting with high-quality plans and providers
- Offering incentives to providers (P4P)
- Offering education and incentives to consumers
- Designing health and disease management programs

Safeway

- “Reference Pricing” for select high-volume, high-cost procedures

- 20% discount on premiums for employees who don’t smoke, and meet BMI, lipid, and blood pressure goals

VBP Case Example: Pitney-Bowes

- Analyzed data on chronic disease
- Cut co-pays for selected medications
- Created “Pitney-Bowes University”
- Redesigned and re-priced cafeteria and vending machine offerings

Pitney-Bowes Findings

- **Results**: Savings valued in millions
  ($1 Million year 1, $3 Million by year 3)
- Annual cost of care decreased for both conditions (asthma and diabetes)
- Pharmacy costs decreased
- Hospital admissions declined for people w/ asthma
  - Hospital admissions increased for people w/ diabetes (still below benchmark)
- ER visits declined for people w/ diabetes
  - ER visits unchanged for people w/ asthma
- Changes in medication/possession rates for both groups
  - improved adherence
  - Types of medications (more controllers, less rescue)

Value-Based Benefit Design

- *One* VBP Strategy

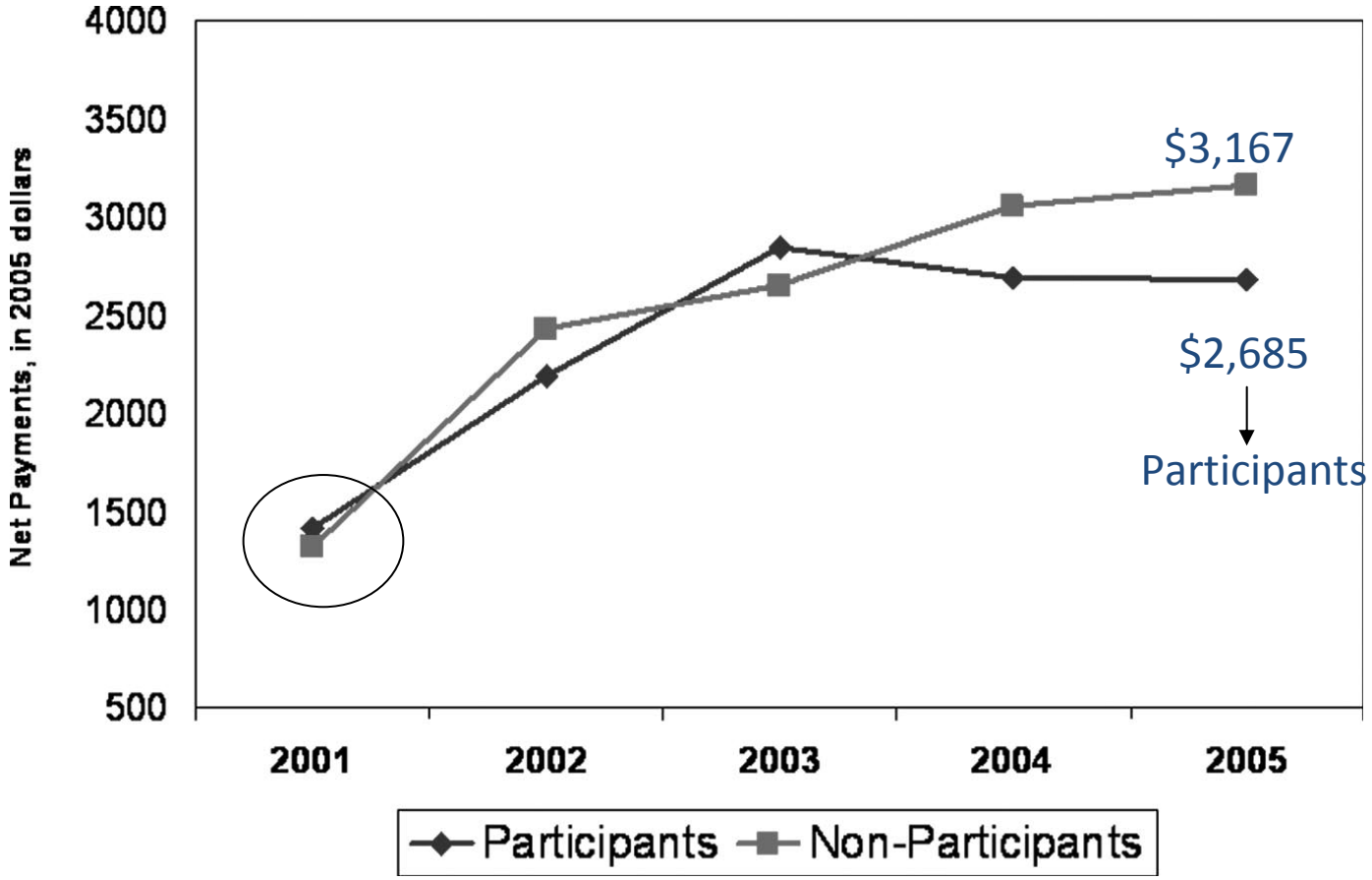
- Coverage decisions, tiers of out-of-pocket payments, reimbursement levels, and incentives all tied to the value of each individual service or drug

Perdue "Evidence-Based Plan Design"

- Participants must name a PCP and participate in the Perdue Health Improvement Program
- Participants with select conditions (e.g. diabetes) must have at least 3 PCP visits per year
- Using EBM findings from national sources, reduce coverage for low- and no-value interventions (e.g. hysterectomy, except when pt has diagnosis of cancer, covered at 70%) – second opinion service is available, to appeal coverage decisions

Source: Value: Population Health Conveyed per Dollar Spent, Roger C. Merrill, MD, Florida Health Care Coalition, Feb 2011

Case: Highmark Wellness Programs
Results (Total Net Payments Per Subject)



Source: Naydeck B, Pearson J, et al. The Impact of the Highmark Employee Wellness Programs on 4-Year Healthcare Costs. JOEM. Vol 50, No. 2 Feb. 2008

Case: Highmark Wellness Programs Results

- Largest differences between groups were found in **inpatient expenditures,** $181.78 per person per year in savings (P<.0001)

- After subtracting program costs from estimated savings, there was a **net savings of $1,335,524 over 4 years** (equated to an **ROI of $1.65** for every dollar invested)

Source: Naydeck B, Pearson J, et al. The Impact of the Highmark Employee Wellness Programs on 4-Year Healthcare Costs. JOEM. Vol 50, No. 2 Feb. 2008

Florida Health Care Coalition

- Reviewed data on hospital-specific CABG mortality
- Shared data with surgeons
- Saw mortality decrease at previously higher-mortality facilities in the following year

NBCH eValue8 RFI

- Common specifications and criteria
  - Reduce variation in information requests
  - Promote standardization
  - Improve comparative information

- Content areas:
  - Plan profile and plan-wide strategies
  - Plan administration
  - Health promotion
  - Chronic disease management
  - Patient safety
  - Pharmacy management

Leapfrog Measures

- Focus on breakthrough improvements in quality and safety practices

- Initial focus on preventing medical mistakes:
  - Computer Physician Order Entry (CPOE)
  - ICU Physician Staffing
  - Evidence-Based Hospital Referral (EHR)
  - Leapfrog Safe Practices Score – NQF 27 Safe Practices

- Voluntary hospital reporting in 28 regions
  - 817 of 1,947 hospitals as of August 2005, 1220 hospitals as of July 2008.

Jefferson School of Population Health

HC21 Data Warehouse: Data Sources

- Human Resources, hiring info
- Health Risk Appraisals
- Medical Claims (inpatient, outpatient, Rx)
- Short and long-term disability claims
- Workers compensation claims
- Employee assistance program utilization
- Worksite clinics and wellness programs
- Other vendors and programs

HC21 Data Cooperative - Formed in 2005

- 18 employers
- 30 data feeds
- Dozens of Contracts/BAA's
- 170,000 records (medical claims and Rx claims)
- 5 years of data
- Staff
  - 2 FTE analysts on staff
  - Physicians on contract
  - PhD on contract
  - Master's Level Nurse

Hospital P4P Data Sources

- Joint Commission Quality Check
- CMS Hospital Compare
- H-CAHPS
- SCIP Measures and Other Specialty-specific Measures
- PHC4 Data and Reports
- Licensures, Accreditations, Recognitions
- Leapfrog Measures

CMS Hospital Compare

- www.hospitalcompare.hhs.gov
- Create reports by hospital, region, condition
- Compares hospitals to benchmarks and each other on process measures for:
  - Heart failure
  - Heart attack
  - Pneumonia
  - Surgical intervention
- Also includes 30-day risk-adjusted mortality
- Limitation: based on Medicare data only

The Joint Commission

- Aka Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Evolution of performance measurement:
  - ORYX Initiative
  - Core Measures:
    - AMI
    - Heart failure
    - Pneumonia
    - Pregnancy and related conditions
    - Surgical infection prevention
  - QualityCheck: www.qualitycheck.org
- Collaboration with NQF, CMS, Hospital Quality Alliance

CAHPS Hospital Survey

- 27-item version endorsed by NQF in May 2005
- CMS driving national implementation
- H-CAHPS results will be integrated into public reporting by CMS, HQA, Leapfrog, etc.
- H-CAHPS domains:
  - Communication with nurses
  - Communication with doctors
  - Nursing services
  - Communication about medications
  - Pain management
  - Hospital environment
  - Discharge information
  - Overall Ratings/Recommend hospital

Never Events

- Unambiguous—clearly identifiable and measurable, and thus feasible to include in a reporting system;
- Usually preventable—recognizing that some events are not always avoidable, given the complexity of health care;
- Serious—resulting in death or loss of a body part, disability, or more than transient loss of a body function; and
- Any of the following:
  - Adverse and/or,
  - Indicative of a problem in a health care facility's safety systems and/or,
  - Important for public credibility or public accountability.

Source: CMS Website

Sample Never Events

- Surgery on wrong body part or patient
- Wrong procedure done
- Retention of foreign body
- Death or disability due to contaminated drug or device, or medication error
- Stage 3 or 4 pressure ulcer
- Hospital-acquired central line infection?

Hospital P4P: CMS/Premier Quality Incentive Demonstration

- CMS provided quality bonus payments to hospitals based on performance
  - 5 clinical areas: heart attack, heart failure, pneumonia, bypass, hip and knee replacement
  - 34 measures including process and outcomes
- 260 hospitals scored and paid by condition (DRG) in the last year of the demo (2007)
  - Top 10% get 2% bonus
  - Second decile gets 1%
  - Top 50% get public recognition
- Worst hospitals were penalized if they stayed in the bottom 2 deciles

Hospital Quality Incentive Demonstration (HQID)

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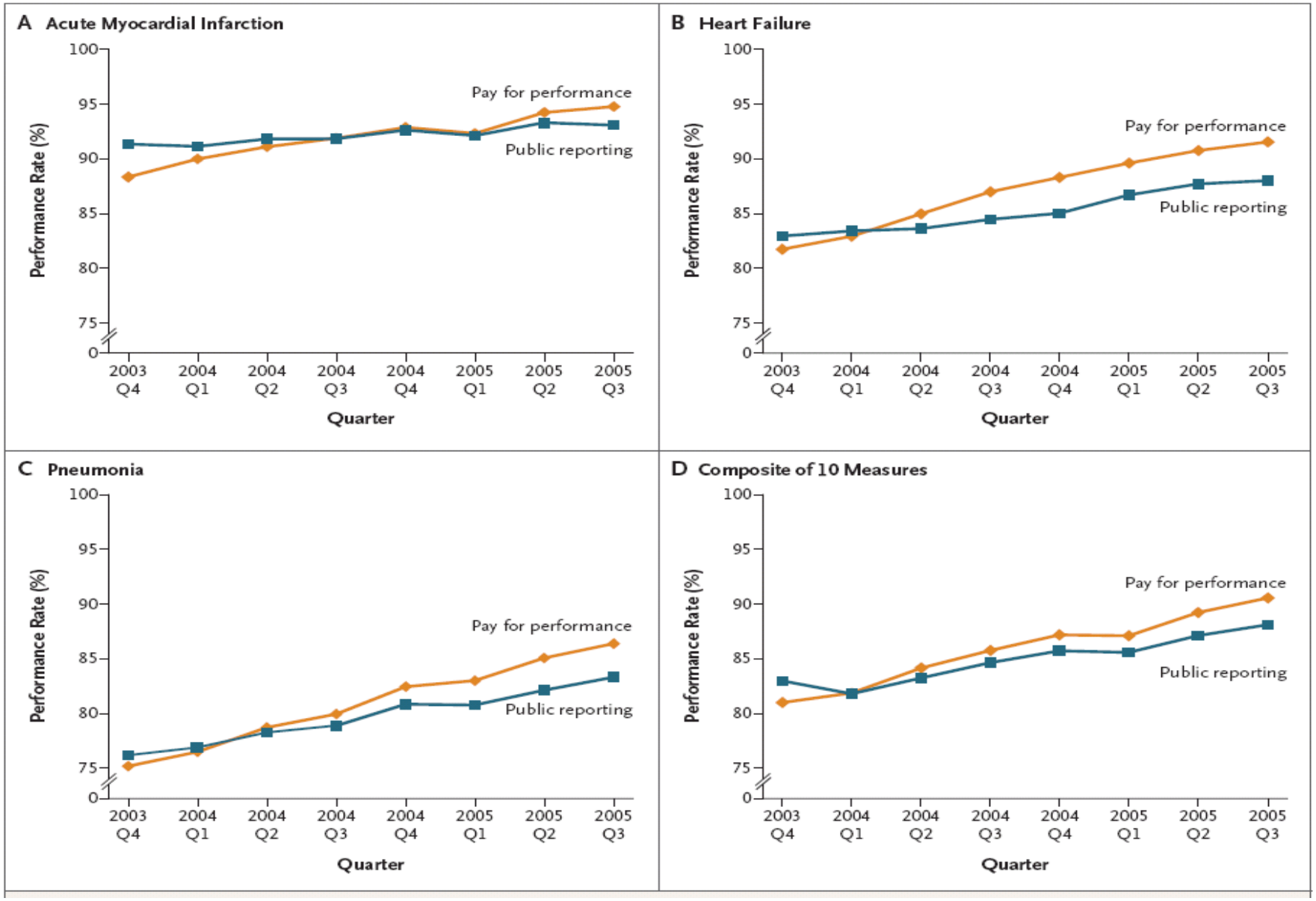
SPECIAL ARTICLE

◄ Previous Volume 356:486-496 February 1, 2007 Number 5 Next ►

Public Reporting and Pay for Performance in Hospital Quality Improvement

Peter K. Lindenauer, M.D., M.Sc., Denise Remus, Ph.D., R.N., Sheila Roman, M.D., M.P.H., Michael B. Rothberg, M.D., M.P.H., Evan M. Benjamin, M.D., Allen Ma, Ph.D., and Dale W. Bratzler, D.O., M.P.H.

- **Hospital Quality Incentive Demonstration (HQID) project**
  - Entering 5th year
  - Test payment incentives under Medicare to improve safety, quality, and efficiency
  - 5 clinical areas: heart attack, coronary bypass graft, heart failure, pneumonia, and hip and knee replacements
- **Results:**
  - Across all participants, overall quality increased 17% over four years
  - CMS awarding incentive payments of $12 million in year four to 225 hospitals


A Acute Myocardial Infarction
Performance Rate (%)
100
95
90
85
80
75
0
Pay for performance
Public reporting
2003 Q4
2004 Q1
2004 Q2
2004 Q3
2004 Q4
2005 Q1
2005 Q2
2005 Q3
Quarter
B Heart Failure
Performance Rate (%)
Pay for performance
Public reporting
Quarter
C Pneumonia
Performance Rate (%)
Pay for performance
Public reporting
Quarter
D Composite of 10 Measures
Performance Rate (%)
Pay for performance
Public reporting
Quarter

DVHCC Project

- Specifying a “high performance network”
  - Identification of providers
  - Negotiation with providers
  - Marketing to member trusts
  - Design of consumer education materials
  - Development of incentives to use the network

Physician Quality Reporting System (PQRS)

- Developed by CMS (in record time!)
- Requires special billing codes for quality (moving toward registries and EHR reporting)
- Initially “pay for reporting” (not “performance”)
- Bonuses paid out for reporting
- Moving toward disincentives as well as incentives, and public reporting of performance data
- Participation eventually expected to become mandatory

Jefferson University Physicians (JUP) Participation in Pay for Performance Programs

- Independence Blue Cross PPO
- Keystone-Mercy Health Plan (Medicaid HMO)
- Aetna
- Medicare PQRS*

*Currently pay for reporting

JUP: The provider perspective

- Need clarity and agreement on measurement parameters (and recognition of issues such as sample size, attribution)
- Need frequent, timely feedback
- Need recognition of sicker, under-served, non-adherent populations
- Need educational tools for providers and patients
- Need “meaningful use” of EMR
- Need resources to implement IT and QI
- Hospital and physician incentives need to be aligned

Key Messages for Employers

- Focus on value, not cost
- Know your data
- Manage/Measure your vendors
- Hold plans and providers accountable
- Be consistent in promoting health & wellness
- Engage, inform, empower, and support consumers
- Partner – no one can go it alone
- Take a long term view: no quick fix or silver bullet

Trends and Future Directions

- Pay for Performance
- Accountable Care Organizations
- Gainsharing Demonstrations
- Patient-Centered Medical Homes
- CMS VBP Program Proliferation and the “Berwick Effect”
- Growing List of Non-Payment Events

PPACA and Readmissions

- 1% reduction in Medicare payments for hospitals with excessive 30-day readmissions in 2013, up to 3% in 2015
- Readmission rate calculation applies to pneumonia, heart failure, heart attack; also applies to admissions at any hospital
- Rate reduction applies to ALL admissions

Barriers to Value-based Purchasing

- Limited access to data
- Limitations to quality measurement
- Limited market power for most employers (but not CMS)
- Focus on the short-term
- Resistance from organized labor
- Systemic inertia
- Limited evidence of VBP impact

Conclusions

- A critical mass of value purchasers is building; government has moved from following to leadership
- Coalitions provide additional market power for all but the largest employers
- Still need to establish the evidence of a business case for quality
- The focus on value is here to stay*

* FOR NOW