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

100% = $2.1 Trillion

- Federal 32%
- Private 54%
- State & Local 13%

Payor Estimate
2006, Billions of Dollars

- Government: 970.3
- Private Health Insurance: 723.4
- Out-of-Pocket: 256.5

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.

The Eroding Value of Health/Benefits Market

\[ \text{VALUE} = \frac{\text{QUALITY}}{\text{COST}} \]

Value decreases when you...

...pay the same for less  \( \downarrow \)  \[ \text{VALUE} = \frac{\downarrow \text{QUALITY}}{\text{COST}} \]

...pay more for the same  \( \downarrow \)  \[ \text{VALUE} = \frac{\uparrow \text{QUALITY}}{\text{COST}} \]

...pay more for less  \( \downarrow \)  \[ \text{VALUE} = \frac{\downarrow \text{QUALITY}}{\uparrow \text{COST}} \]}
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)

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)

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.
The Leapfrog Group - Microsoft Internet Explorer

Address: http://www.leapfroggroup.org/jsp/fmtnd-co_listings.jsp?zip=19137&radius=5Miles

Patient Safety Ratings

Overall Patient Safety Ratings

Prevent Medication Errors
Appropriate ICU Staffing
Steps to Avoid Harm
Reduce Pressure Ulcers
Reduce In-Hospital Injuries
Managing Serious Errors
Transparency Indicators
Survey Results Submitted

More Information

Click to Change Treatment

CHILDREN'S HOSPITAL OF PHILADELPHIA
PHILADELPHIA, PA

COOPER UNIVERSITY HOSPITAL
CAMDEN, NJ

MAINE HUMAN UNIVERSITY HOSPITAL
PHILADELPHIA, PA

OUR LADY OF LOURDES MEDICAL CENTER
CAMDEN, NJ

ST CHRISTOPHER'S HOSPITAL FOR CHILDREN
PHILADELPHIA, PA

Patients should choose a hospital that has a high Leapfrog Safe Practices Score. This means the hospital has put in place procedures to reduce 10 common, preventable medical errors.

Survey Results Submitted:

1/19/2008
6/27/2008
9/14/2008
6/09/2008

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)

- **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

B. Heart Failure

C. Pneumonia

D. Composite of 10 Measures
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