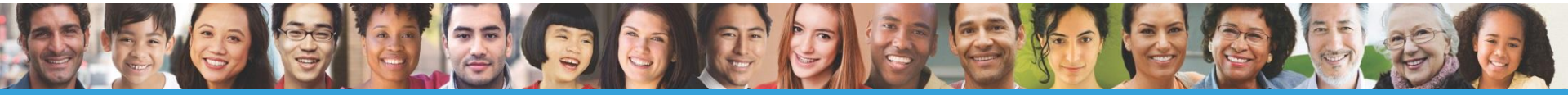
FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Reducing the Cost of Health Care: Current Innovations and Future Possibilities
Texas Medical Center Health Policy Institute

Payment Reform: View from the States

Frederick Isasi, JD MPH Executive Director
Wednesday, September 20th, 2017



Roadmap

- ☐ Families USA
- ☐ The Opportunity
- ☐ How to Focus Reforms

Who We Are

Families USA's Mission and Focus Areas

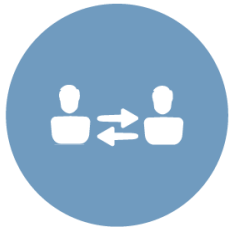
Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We advance our mission through public policy analysis, advocacy, and collaboration with partners to promote a patient-and community centered health system.

Working at the national, state and community level for over 35 years.

COVERAGE

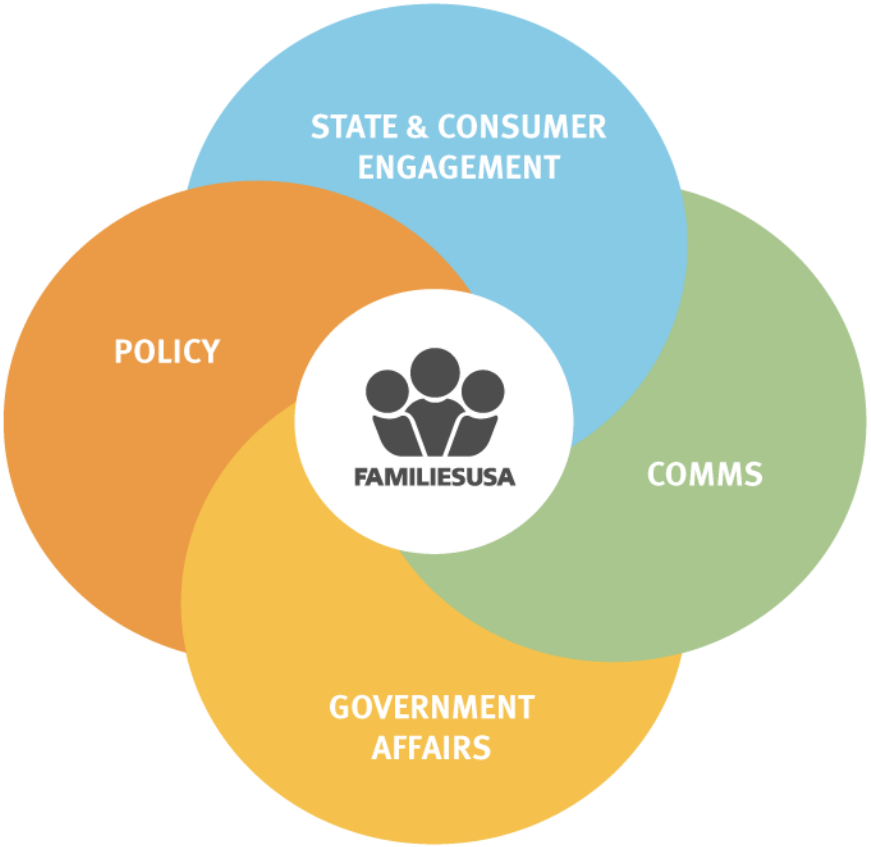
HEALTH EQUITY

HEALTH CARE VALUE

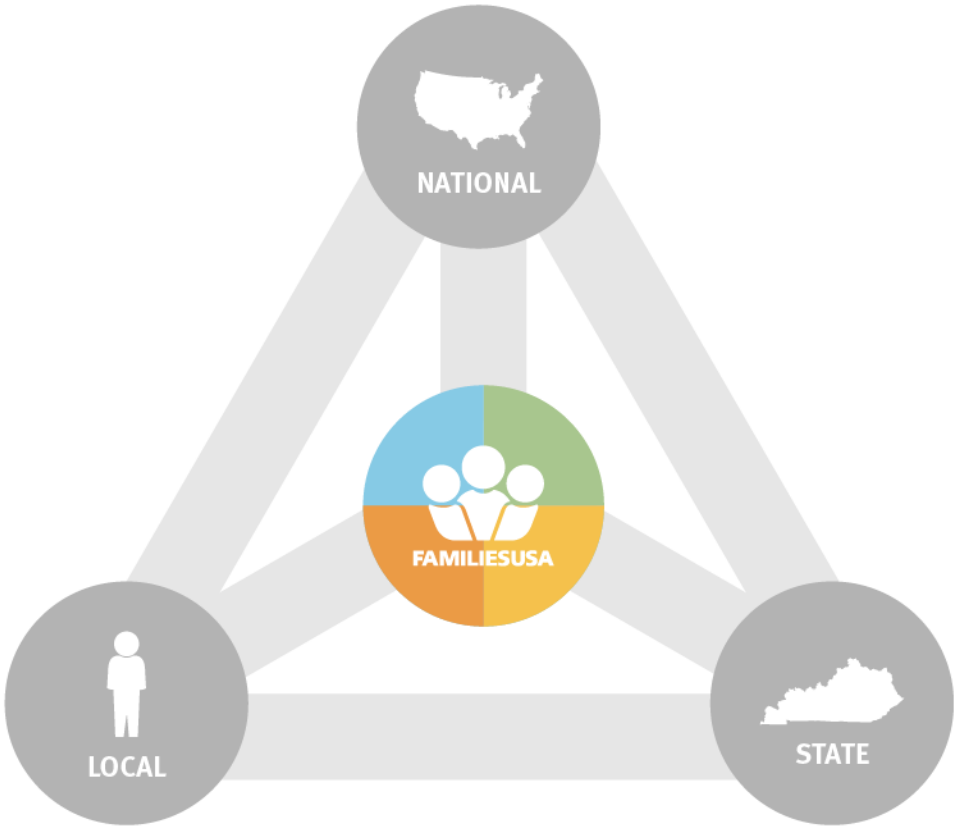


CONSUMER ENGAGEMENT

Families USA's Core Capabilities

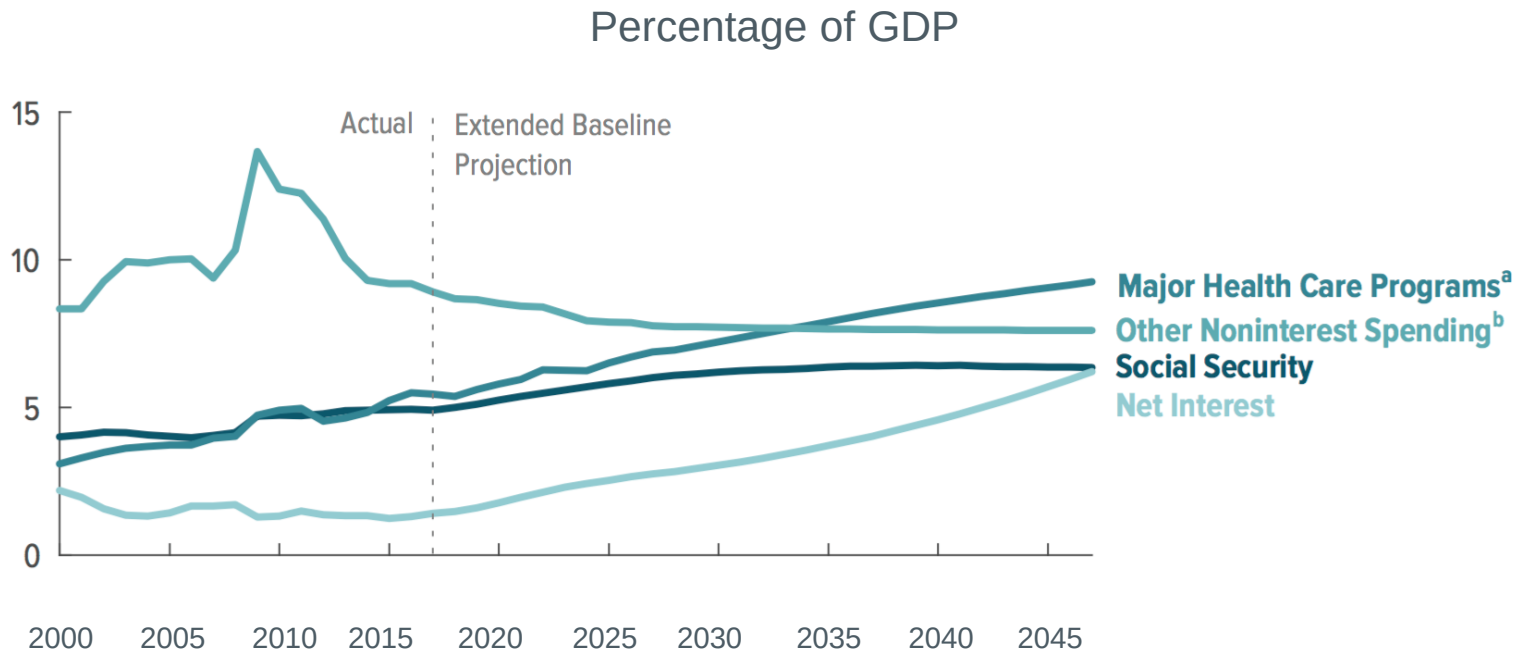


Families USA's Work on the Local, State and National Levels



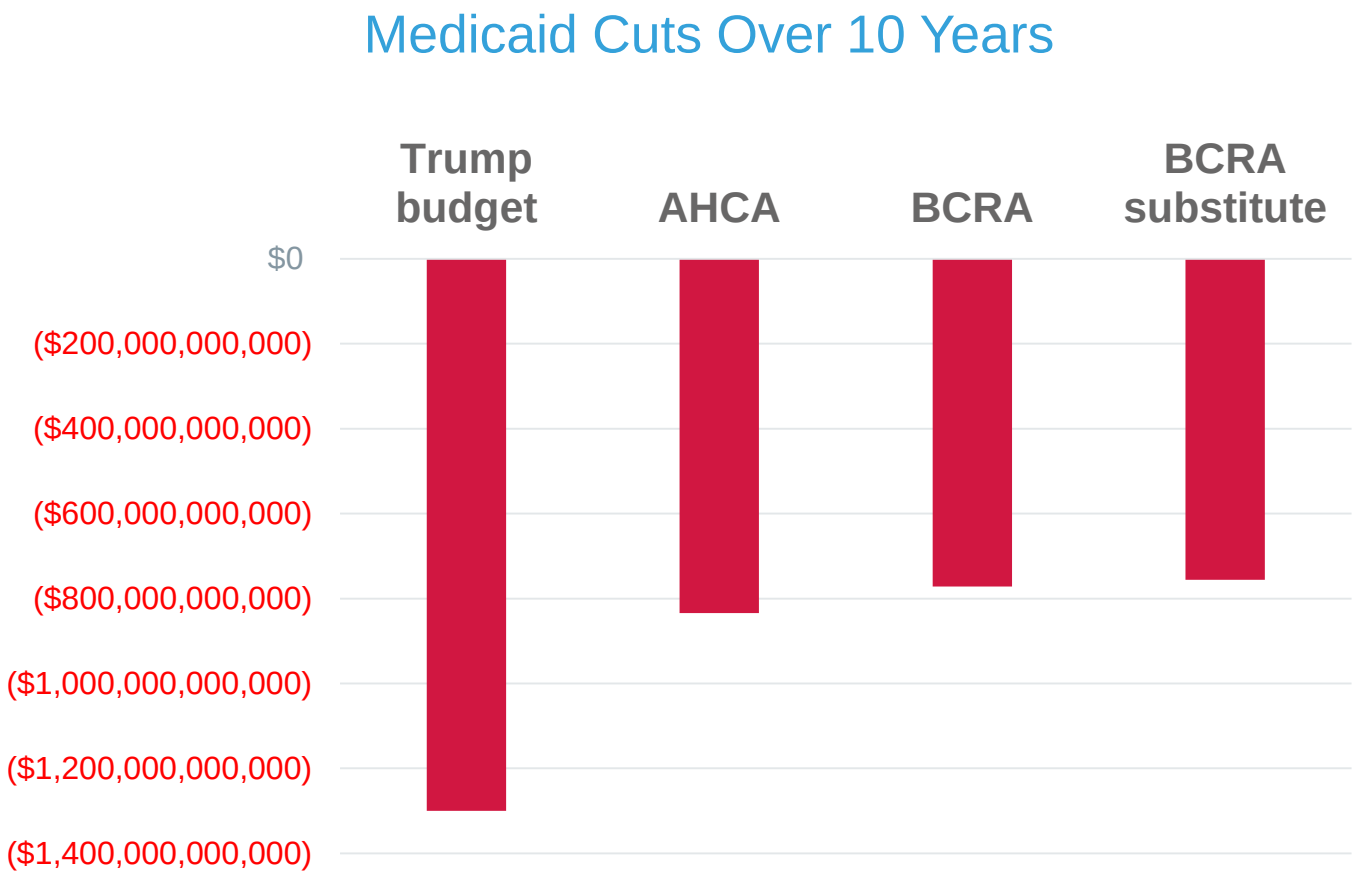
The Opportunity

National Health Care Spending Likely to Continue Growing Faster than GDP



Source: Congressional Budget Office, 2017 Long Term Budget Outlook
The extended baseline generally reflects current law, following CBO's 10-year baseline budget projections through 2027 and then extending most of the concepts underlying those baseline projections for the rest of the long-term projection period.
GDP = gross domestic product.
a. Consists of spending for Medicare (net of premiums and other offsetting receipts), Medicaid, and the Children's Health Insurance Program, as well as outlays to subsidize health insurance purchased through the marketplaces established under the Affordable Care Act and related spending.
b. Consists of all federal spending other than that for Social Security, the major health care programs, and net interest.

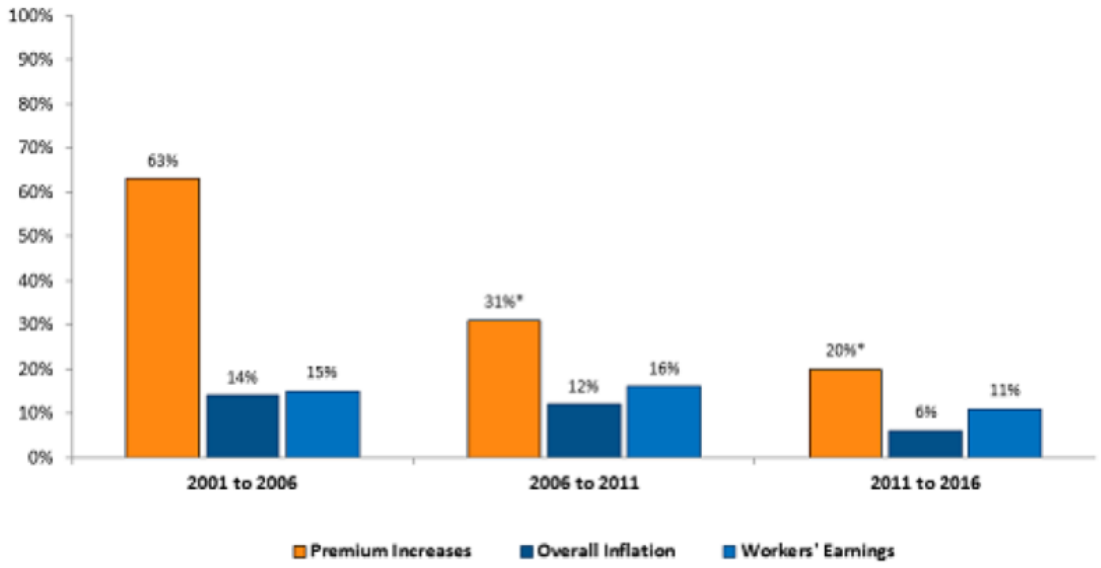
Reductions in Medicaid Spending Are Central to Congressional Efforts



Source: Various CBO Estimates

Family Premiums Increasing Faster than Other Indicators

Cumulative Premium Increases for Covered Workers with Family Coverage, 2001-2016



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).

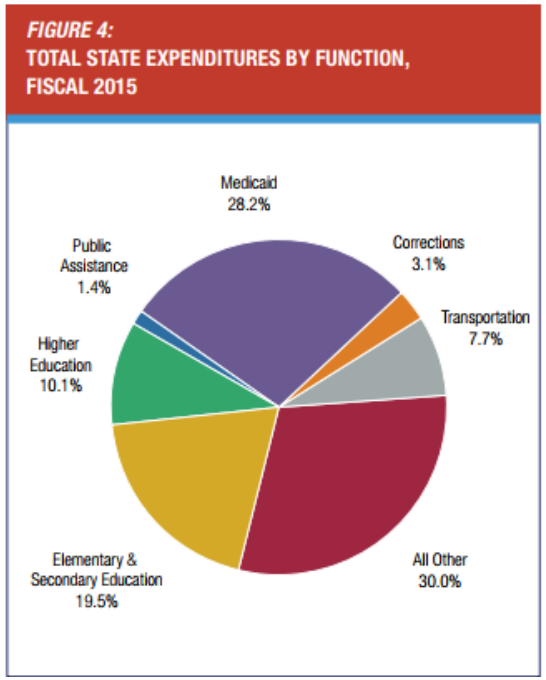
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001-2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2001-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2001-2016 (April to April).

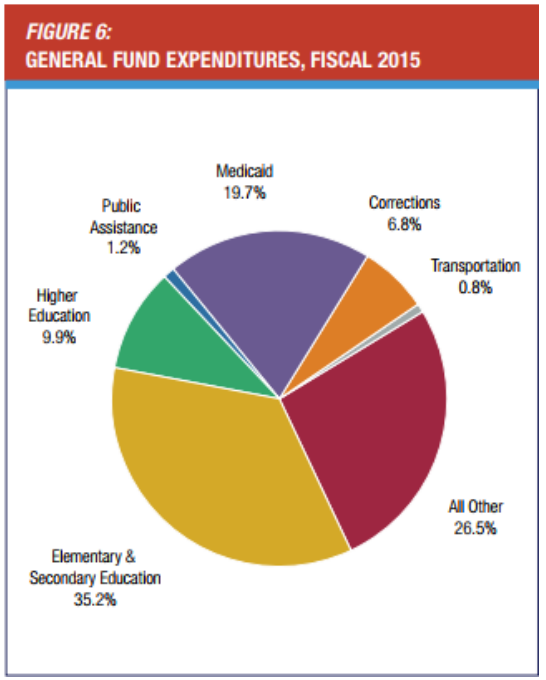
Source: KFF, 2016

Health Spending Also Major Priority for Governors

Medicaid Spending:
A Major Component of State Budget Pressures

Total Spending vs. General Funds Spending



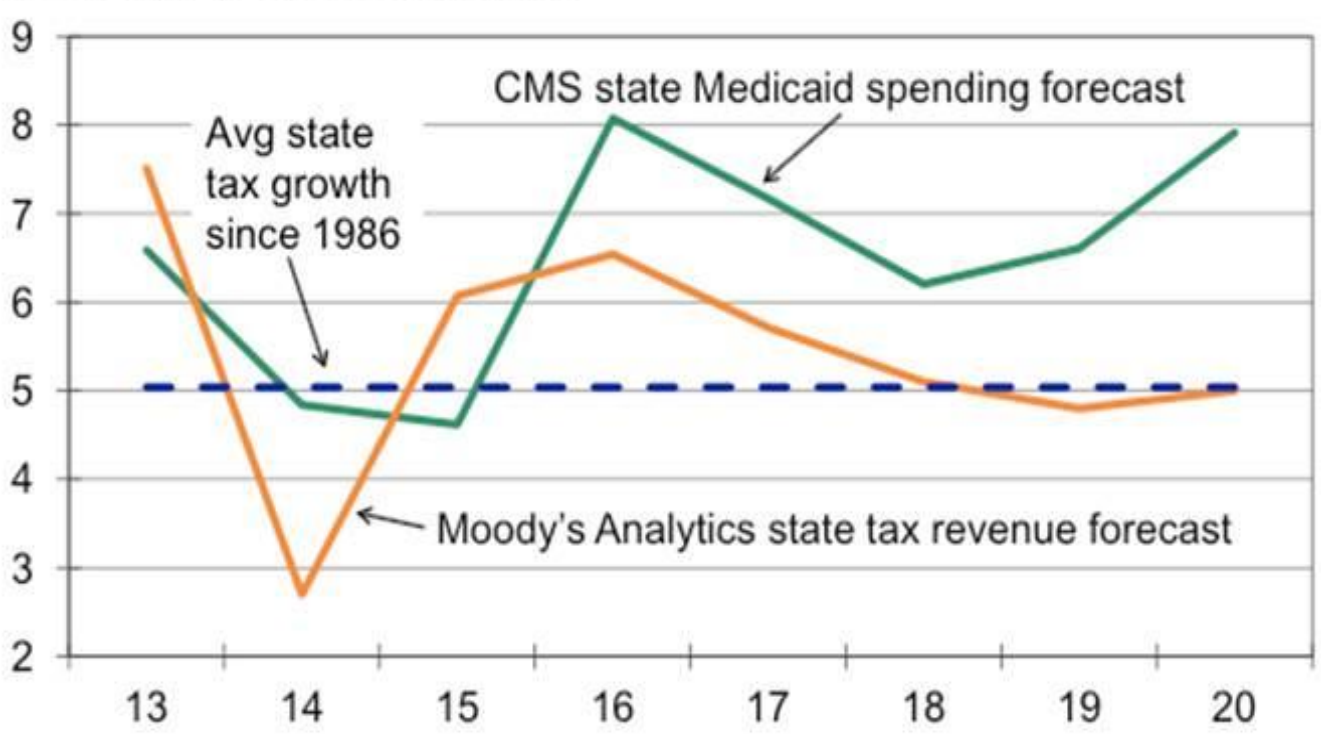


Source: NASBO State Expenditure Report 2014-2016

Medicaid Spending Likely to Outpace Growth in State Tax Revenue

Structural Imbalances Will Persist

% change yr ago, calendar yr



Source: CMS, Census Bureau, Moody's Analytics, 2015

For All of this Spending, Quality Lagging…..

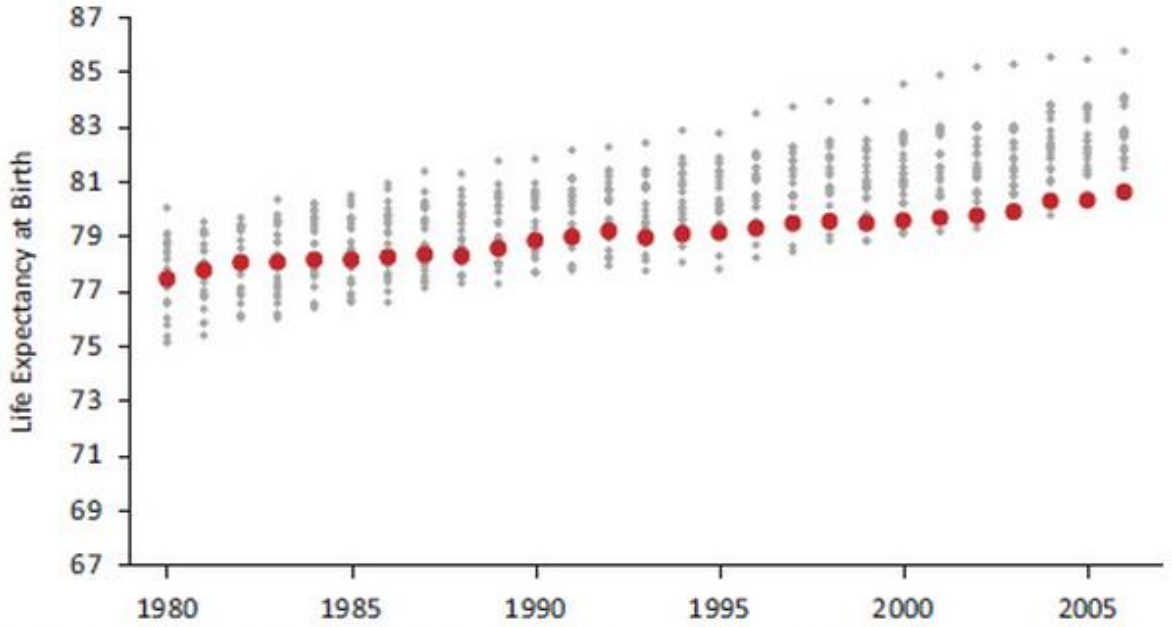


FIGURE 1-6 U.S. female life expectancy at birth relative to 21 other high-income countries, 1980-2006.
NOTES: Red circles depict newborn life expectancy in the United States. Grey circles depict life expectancy values for Australia, Austria, Belgium, Canada, Denmark, Finland, France, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and West Germany.
SOURCE: National Research Council (2011, Figure 1-4).

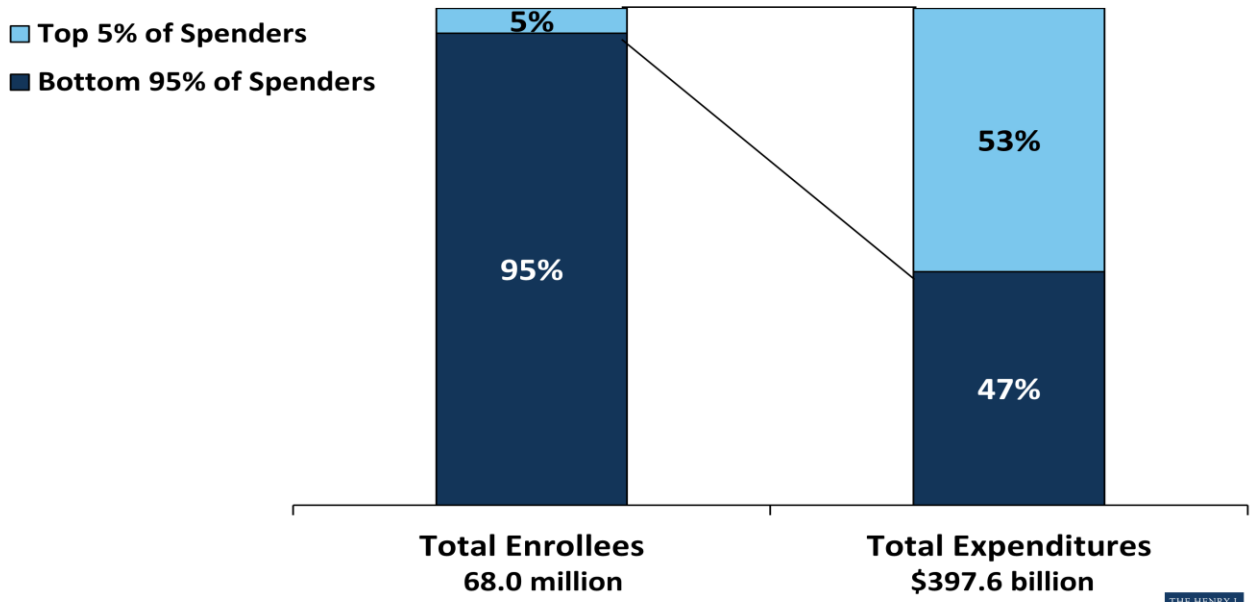
Source: Commonwealth Fund, 2013

How to Focus Reforms

A Small Percentage of Medicaid Enrollees Account for Spending

Figure 9

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2011



SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

Complex Patient Populations in Medicaid (Characteristics)

Percentage and Estimated Probability of Being a High-Expenditure Medicaid-Only Beneficiary, by Selected Conditions and Services, Fiscal Year 2009

Characteristic	Percentage of high-expenditure population	Probability of being a high-expenditure beneficiary (percent)
CONDITIONS		
Mental Health Condition	51.8	9.1
Substance Abuse	19.1	7.9
Diabetes	18.6	8.8
Asthma	14.5	6.8
HIV/AIDS	3.4	20.8
SERVICES		
Delivery/Childbirth	9.8	13.3
Long-term Care Residence	8.8	24.2

Source: GAO analysis of Centers for Medicare and Medicaid Services' data, https://www.gao.gov/assets/670/661011.pdf

EXAMPLE:

Population Characteristics in the California Frequent Users Initiative, Santa Clara County

53% minority, 63% age 40-59, 60% male, 13% married

- 96% chronic diseases
- 63% mental illness
- 62% substance abuse
- 45% homeless
- 34% 2 conditions
- 28% 3 conditions
- 22% 4-5 conditions
- 15% 1 condition
- Medi-Cal or uninsured
- Patients had 8+ ED visits in 12 months. Patients were recruited to the program from the ED.

Source: Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs, CHCS, 2013

State Efforts to Reform Medicaid

Considerations

- Address budget crisis
- Drive up value (decrease cost, improve quality)
- Complex Medicaid populations being served by larger system of insurers and providers that are ill-equipped to address complex needs
- Perverse incentives created by interplay of Medicare and Medicaid programs

Conceptual Strategy

- Review Medicaid claims data on spend and quality
- Find “impactable” populations
- Demonstrate improvements in cost and quality

Example of Seven Transformational Strategies that are Working

- Aligning economic incentives for providers and payers (using Medicaid to support the larger-shift from volume to value)
- Empowering primary care providers
- Behavioral health integration
- Addressing drivers of emergency department utilization (and related reforms)
- Evidence-based housing interventions for complex patient populations
- Bundled payment reforms
- Coordinating transitions in care

Move Toward Value: Moving Away from FFS

Aligning Economic Incentives for Health Care Providers

Core Principles

FFS is Not "Value-Neutral": Premised on the notion that Fee-for-Service (FFS) payment systems are not "value neutral"

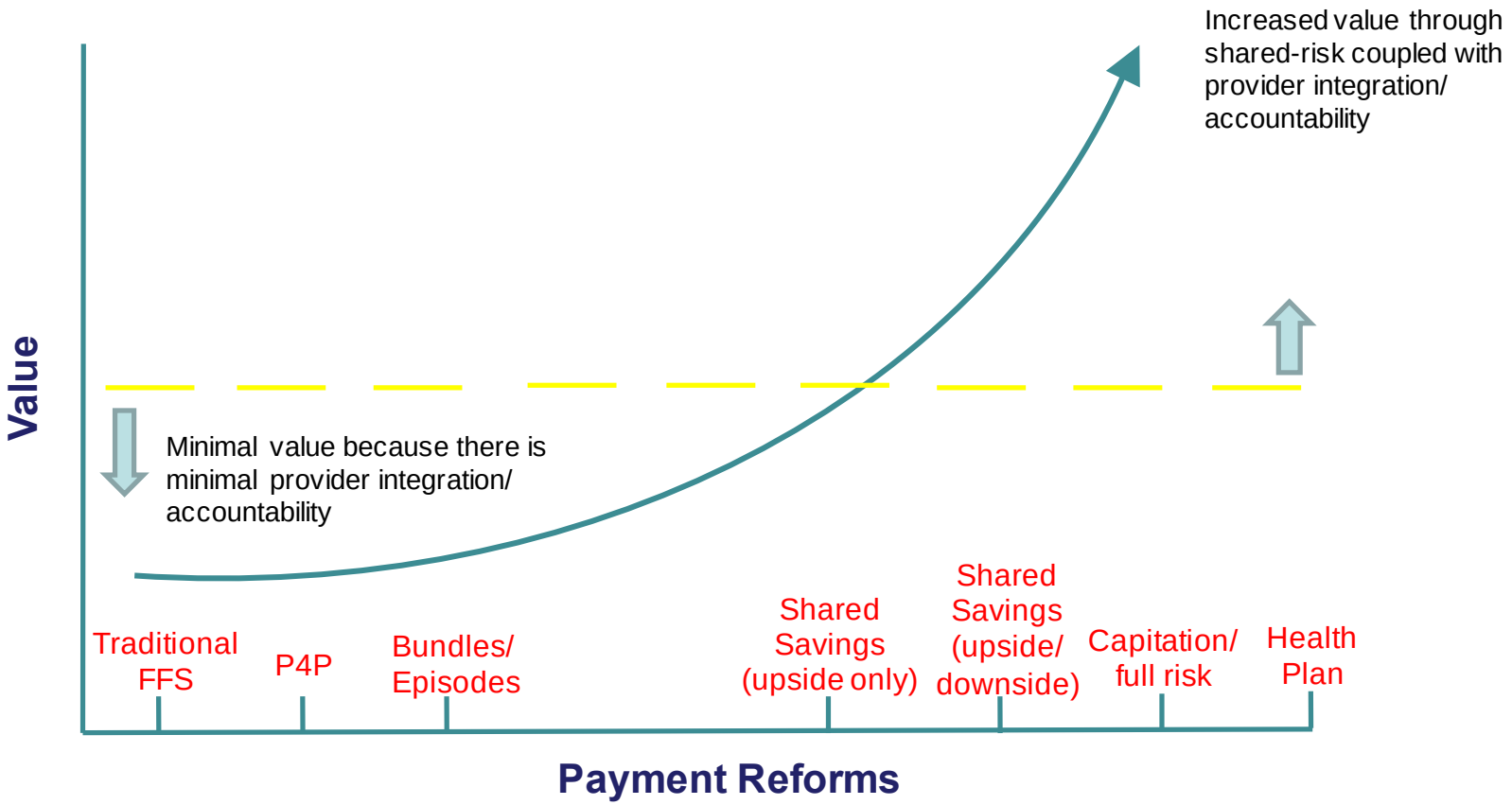
- Studies clearly indicate that FFS payment systems are highly correlated with fragmented and poor quality care and increased volume.
- Because of the asymmetry of information in health care, traditional FFS systems provide greater economic benefit to providers that do more, with little economic consequences for lower quality care.

- **Global-Risk May Incentivize Value**: To counter this, we have been experimenting for several decades with new payment models that allow providers to bear risk for outcomes.
  - The key to creating an economic incentive toward value is developing meaningful time-horizons around episodic risk and expanding risk to encompass larger episodes.
  - Many experts advise that economic incentives aren't truly aligned until a provider bears at least a year of risk for the full health of a population.
- **Devolvement of Responsibility** to community-based decision making and risk-bearing organizations allows for community-specific approaches and aggregation of economic signals.

Lessons Learned

- **High Levels of Risk-Based Payments Needed**: To make global payments and population health economically sustainable for providers, they must move quickly toward greater risk – e.g., 80 percent of a provider's full book of business in aggressive shared risk and/or capitation.
- **Data Exchange Foundational:** The exchange of data between providers and for analysis by population health managers is foundational to the success of payment reform initiatives. As payment reforms are being conceived, develop a clear and comprehensive data sharing-strategy as well.
- **Behaviorall Health Critical to Value:** Driving toward value in many instances means driving toward under-resourced areas like behavioral health and social determinants (e.g., housing insecurity), these efforts should start early, be based in community-involvement, and may require new models of health care workforce.
- **Transformation Over Five Years:** Total transformation is possible. Many health executives and experts predict a provider organization could make the full shift from FFS to global payments over a 5-year time horizon.

Value Continuum: Not all Reforms are Equal…



Targeting High Needs, High Cost Patients

5% of Beneficiaries Account for 50% of Medicaid Costs

Core Elements

- Analyze Medicaid claims, encounter, and/or pharmacy data to identify the highest utilizers (typically 1-5% utilization).
- Segment data based on common characteristics.
- Develop rule-in, rule-out criteria based on "impactability."
- Map subtypes onto available state resources to determine target population.
- Establish state framework for program, i.e. direct contracting, regional organization, or Medicaid MCO contracting.
- Select delivery model based on evidence-based best practices for the target population.
- Develop a payment strategy to incentivize best practices and move towards value.
- Develop and implement rapid cycle evaluation to track, monitor, and measure outcomes.

Lessons Learned

- Initially focus on impactable high utilizers of ED and inpatient to capture ROI and build momentum for the program.
- Allow the data to define the characteristics of the population in your state.
- Understand the limitations of the current system for the population and consider non-clinical interventions that meet the program goals, e.g. Housing First, transportation needs, etc.
- Most effective engagement strategies intervene at the point of crisis, i.e. in the ED before discharge from the hospital, etc.
- Build value-based incentives into Medicaid managed care contracts targeting high utilizer unmet needs.

Washington
ER Is For Emergencies

In the program's first year, the rate of emergency department visits declined by 9.9% and the rate of "frequent visitors" (five or more visits annually) dropped by 10.7%. The rate of visits resulting in a scheduled drug prescription fell by 24% and the rate of visits with a low-acuity (less serious) diagnosis decreased by 14.2% In the first year, the program produced nearly $34 million in savings.

Alaska
Medicaid Coordinated Care Initiative

Alaska is participating in NGA's Complex Care policy academy. Using Medicaid claims data and a hotspotting approach, they found that 25% of their highest Medicaid ED utilizers came from enrollees from one neighborhood in Anchorage. As a result, they partnered with a local community based care provider, Qualis, for face-to-face care coordination with identified individuals in that neighborhood.

Primary Care Focus

Empowering Primary Care Providers Offers Significant Savings and Return on Investment

Core Elements

- Primary Care Reforms:
  - **Medical Homes**: Coordinate and improve the efficiency of care for patients with multiple health needs ("rising risk" and "high risk" populations).
  - **Helping Guide Patients seeking Specialty Care**: PCP guides referrals for all patients seeking specialty care to the most efficient providers (high quality, lower cost)
- With regards to care coordination, most enrollees will *not* require care coordination. Develop strategy to target appropriate levels of coordination based on complexity of need.
- As primary care homes and other primary care-focused interventions mature, PCPS going to greater and greater risk for the health of their patient population.

Lessons Learned

- Ensure primary care physicians have access to the information needed to make the best choices regarding quality and cost, e.g. completed claims on member health records to manage and monitor care, access to population information to identify gaps in care, and reviews of completed care plans with notes from all of a patients health care providers.
- Financially successful programs must show measureable reduction in avoidable utilization (ED visits, ambulatory care sensitive hospitalizations, ect).
- Primary care providers can be very effective at quickly improving quality and reducing costs for specialty care when information and financial incentives are provided to allow them to understand the quality of care and utilization patterns of specialty providers.

Maryland
BCBS CareFirst PCMH

Maryland's BCBS CareFirst developed a PCMH in 2011. The core focus of the program is to provide data to primary care providers about the cost effectiveness of specialists. PCPs can earn substantial bonuses based on the savings they generate. In its first three years, the program reported more than $267 million in savings. Physicians earning the average award in 2014 gained between $41,000 and $45,000 in increased revenue.

Vermont
Blueprint For Health

Vermont's Blueprint for Health is a statewide public-private partnership that integrates community health teams with primary care providers. The integrated teams assess patient needs, coordinate community-based support services, and provide multidisciplinary care. In 2015 the program reportedly saved $482 per patient annually and $258 million over 3 years. This resulted in a 6-to-1 ROI, coupled with significant increases in the quality of care.

FAMILIESUSA

Behavioral Health Integration

One in five Medicaid enrollees has a diagnosed mental health condition or substance use disorder

Core Elements

- Understand the severity of mental illness and substance use needs; match to evidence-based practice.
- Integration in Primary Care: Collaborative Care Model (CCM) - geared towards common behavioral health conditions (depression, addiction, and alcohol and substance abuse).
- Integrating in the Community Mental Health System: community-based, multidisciplinary team model, such as assertive community treatment (ACT) teams, is an evidenced-based model for those with more severe behavioral health disorders.
- Adopt new delivery system and payment models that drive towards value, e.g. behavioral health homes for adults; systems of care for children.
- Co-locate providers on integrated teams with a common care plan.
- Utilize telehealth to increase communication between primary care and behavioral health providers to stretch scarce resources and increase access to evidence-based practices, e.g. New Mexico's Project ECHO and Massachusetts' MCPAP for children.

Lessons Learned

- Focus on quality metrics and wrap quality into program design, e.g. Kansas' KanCare selected social determinant metrics such as employment.
- Select metrics that can only be achieved through integration, e.g. cardiovascular health screen in people with schizophrenia.
- Develop payment strategies that change provider behavior and increase access to evidence based integration models.
- Social determinants interventions, e.g. Housing First, transportation, etc., are cost-effective, essential components to integration, especially for vulnerable populations.
- Provider integration can happen in a cost-effective manner independent of payment integration, e.g. carve-in.
- The largest ROI is found when CCM is used in primary care setting for those with chronic conditions.
- Evidence-based practices in behavioral health and substance abuse treatment exist and are not adequately incentivized.

Missouri *Community Mental Health Centers*

In Missouri, community mental health centers (CMHC) and federally qualified health centers (FQHC) are working with each other to provide both primary and behavioral health care. The state has 28 CMHCs, 18 FQHC, and 6 hospitals serving as Health Homes. For their primary care health homes, $30.79 is saved (per member per month) pmpm, for a total cost reduction by mid-2015 of $7.4 million. For CMHC health homes, the cost reduced by $76.33 pmpm for a total of $15.7 million by mid-2015. Health indicators were equivalent in both types of health homes.

Collaborative Care Model

CCM, developed at the University of Washington, embeds behavioral health providers with primary care providers to provide evidence-based medication and psychosocial treatments. The model serves patients with chronic medical and behavioral health conditions in primary care settings. CCM has been tested in more than 80 randomized controlled trials and results indicate that for every $1 spent, $6.50 is saved in health care costs. Texas, California, Indiana, Minnesota, New York, North Carolina, and Washington all have developed programs using the CCM model.