

PCH 358 – Health care delivery and payment reforms

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Value-based purchasing

- No matter what happens with the ACA, everyone agrees that costs are “out of control”
- Even though they sort of are, and sort of aren't, and only in some places, but who are we to argue with “everyone”

$$\text{Value} = \frac{\text{quality}}{\text{cost}}$$

- Delivery reform – change how care is structured, delivered to patients
- Payment reform – change how we pay for care, to reward quality
- Patient-centered care
- Population health focus, social determinants of health

Reform video

US Health and Human Services version/goal for reform

<https://www.youtube.com/watch?v=IQDo8SMsU8Q>

The need for delivery reform

- American adults are getting 70% of recommended care (2013)
- The quality of care in CT is declining
- Typical Medicare member gets care from two PCPs and 5 specialists in a year
- 16.6% of CT adults with asthma have an ER or urgent care visit in a year
- 67 deaths of every 100,000 in CT are preventable with adequate primary care

Care coordination

US patients whose doctor has not reviewed all their medications:

Below US average income	29%
Above income	21%

Care coordination

US patients who report receiving conflicting information from different doctors :

Below US average income	21%
Above income	14%

Care coordination

US patients reporting that test reports or medical records were not available at their visit :

Below US average income	19%
Above income	14%

Duplication

US patients who report an unnecessary duplication of medical tests :

Below US average income	17%
Above income	9%

Inadequate access to primary care

US adults reporting difficulty getting care on nights, weekends or holidays without going to ER :

Below US average income	70%
Above income	60%

Inadequate access to primary care

US adults report using ER for a condition that a primary care doctor could have handled if available :

Below US average income	19%
Above income	11%

What is a PCMH?

- [Slide show of Queens-Long Island Medical Home](#)
- Patient-centered – “everything swirls around the patient”
- Comprehensive care
- Coordinated care – e.g. huddles
- Expanded access to care – open beyond business hours
- Systems-based approach to quality and safety
 - Not just individualized care, but monitor entire panel of patients, provide appropriate services, i.e. nutritionist, behavioral health specialists
- Team-based care
 - Everyone working at the top of their license
- Relies on good communication with other providers
 - Need to know when a patient enters a hospital or ER, specialists, pharmacies

What is a PCMH?

- Coordinated care delivered by someone who knows them, their history, their circumstances
- Considers the whole person
- Care plan is developed with the patient, to meet their goals
- Treatment is customized for that person
- Empower consumers with tools to maintain their own health
- Care is delivered by a team of equals, so right person working with patient on each aspect – no control freaks
- Coordinated care – no more carrying medical records around
- **Emphasizes prevention and management of disease**
- Supports primary care
- Providers are generally more satisfied practicing in a PCMH – “the way I imagined practicing when I was in school”

PCMHs and providers

- Patients and families are the center, in control
- Team-based care is the foundation of PCMHs
- “No control freaks allowed”
- Everyone working at the top of their license
- Huddles
- **Population health focus**
- More time with patients
- Learning collaboratives

PCMH transformation is an opportunity for a practice to re-think everything, everyone's role

PCMHs work

	Total Studies	 Cost Reductions	 Fewer ED Visits	 Fewer Inpatient Admissions	 Fewer Readmissions	 Improvement in Population Health	 Improved Access	 Increase in Preventive Services	 Improvement in Satisfaction
PEER-REVIEW/ACADEMIA									
Reported outcomes	(n=13)	61% (n=8)	61% (n=8)	31% (n=4)	13% (n=1)	31% (n=4)	31% (n=4)	31% (n=4)	23% (n=3)
INDUSTRY REPORTS									
Reported outcomes	(n=7)	57% (n=4)	57% (n=4)	57% (n=4)	29% (n=2)	29% (n=2)	14% (n=1)	29% (n=2)	14% (n=1)

Source: The Patient-Centered Medical Home's Impact on Cost and Quality, Millbank Fund, Jan 2014

PCMHs work

- The longer a practice has had PCMH status, the greater the cost savings and the better the improvement in care quality and outcomes
- Providers are more satisfied practicing in a PCMH
 - Better work hours
 - More time with patients
- Enhanced provider satisfaction is stabilizing primary care practice
- PCMHs are expanding primary care capacity

CT PCMHs and Medicaid

Medicaid clients cared for in PCMH practices rather than non-PCMHs are:

- 23% more likely to receive adolescent well care
- 20% more likely to receive well-child visits in the 3rd, 4th, 5th and 6th years of life
 - 26% more likely to receive adult preventive health services
- 27% more likely to receive an eye exam as part of diabetes care
- wait less time for an appointment for care that is needed right away
- more likely to get appointments for a check up or routine care with their provider
- more likely to have their child's provider listen carefully and know important information about their child's medical history

Accountable Care Organizations

- Takes PCMH to next level
- Networks of providers collectively rewarded to slow cost growth for their patients while improving quality of care
 - Can be led by large practice or hospital network
- Generally paid under shared savings
- Shifts financial risk onto providers – very new, controversial
- Patients can get care outside the network if they choose
- Quality standards must be met to get share of savings
- Medicare and private payers, some Medicaid programs implementing them
 - CT started a new ACO, shared savings system for Medicaid last year
- Very new – mixed results
 - Extremely hard to get savings – only 1 in 11 CT Medicare ACOs earned savings in first year results
 - Costs \$1.6 million to set up

The need for payment reform

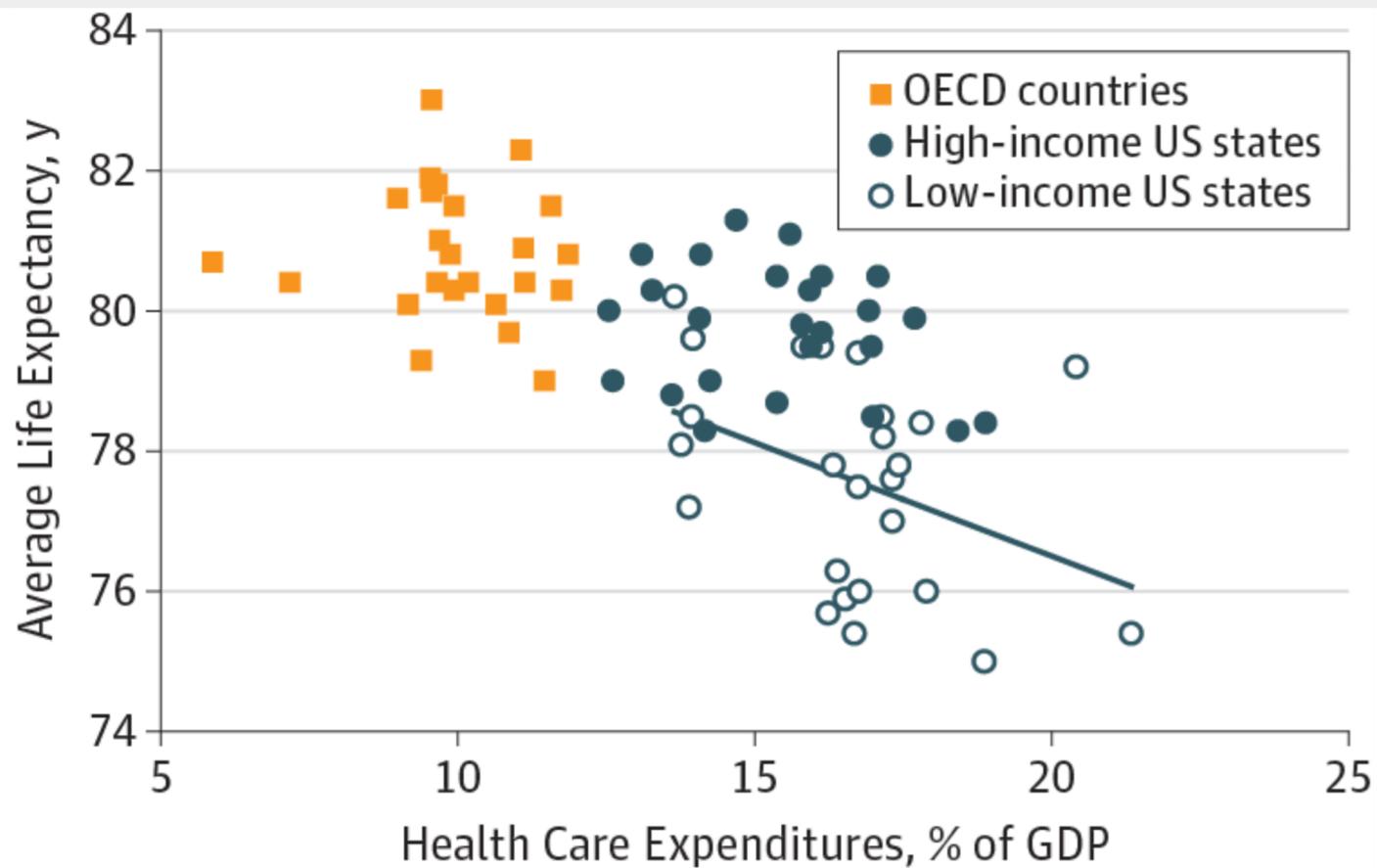
- Consumers don't see the full bill – no “skin in the game”
- Moral hazard but when sick will pay anything to get well
- Adverse selection
- Nearly impossible to price shop
 - Some early efforts for that
 - Results so far are not encouraging
- Providers drive demand
- Insurance spreads the costs
- But we pay the full bill – taxes, lost wages, out of pocket

health care not like other sectors

- Expanding supply is expensive and highly regulated
- Strong incentives to “blow leaves onto others’ lawns” = cost shift
- Tax incentives make buying health care more attractive than wages
- Essential spending – consumers in need will prioritize
- Easier to ignore/delay costs when healthy

From: Critiquing US Health Care

JAMA. Published online October 16, 2014. doi:10.1001/jama.2014.14114



Overtreatment

- \$192 billion wasted (2011)
 - Second only to administrative complexity in wastefulness
- Many drivers
- \$1 billion alone on unnecessary adult URI antibiotics
- Need more overuse research and need to use it
- Need Comparative Effectiveness Research
- Challenges
 - Research
 - Cultural changes
 - Political challenges
- Professional societies beginning to address – Choosing Wisely, Consumer Reports --- sort of

Current FFS incentives

- Pay the same for high and low quality services
- Consumers have little or no information and no incentive to choose higher quality/higher efficiency services or providers
- Encourages overuse, misuse of services
- Higher spending not correlated with higher quality
- Higher spending not correlated with better patient experience of care

- 67% of US physicians have no income tied to value
- 76% have no income tied to patient satisfaction

Fee for Service misaligned incentives

Fee for service encourages:

- More services
- Less coordination
- Incentives for duplication
- Few incentives for prevention
- Stifles innovation
- Only pays for selected, usually face-to-face services - not email, group visits, phone calls
- No link to quality
- Incentives to increase high profit services/patients and avoid low profit

Quality-based purchasing

- Rewards better outcomes
- Payments based on value -- quality balanced with cost
- Data driven
- Remove incentives for more services
- Reward providing the right services to the right patient at the right time in the most effective setting
- Flexibility for providers to customize care
- Reward patient experience of care
- Remove fragmentation and conflicting incentives
- Align provider, payer and consumer incentives to reward quality, effectiveness and efficiency

Consumers support quality-based purchasing

- 96% of Americans feel it is important to have information about the quality of care provided by different doctors and hospitals
- 89% feel it is important that they have information about the costs of care to them before they actually get care
- 85% want public and private payers to reward high quality doctors and hospitals

Barriers & resistance

- Fairness -- savings to one is loss to another stakeholder
- Complexity – unintended consequences
- **Powerful community and public health influences beyond medical model control**
- Reform is hard and complicated, people are overworked – workarounds are faster than overhauls
- Perspectives/silos – my problem but everyone else's fault
- Data, analytics, not enough CER, best practice knowledge
- Incentives to collaborate <<< incentives to overspend, overtreat

Payment reform options

- Never events
 - Price transparency
 - Pay for performance (P4P)
 - Market share – tier and steer
 - Reference pricing
 - Shared savings – one and two-sided risk
 - Episodes of care, bundled payments
 - Global capitation
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- Mixed early evidence on costs

transparency

- Report cards – hospitals, health plans, providers
- Databases allow consumers/payers to price shop
- Improve consumer access to information, prices vs. quality by provider
- Mixed results, have to be carefully designed and promoted/shared
- No danger of underservice

P4P

- Pay set fee to providers for specific things
 - E.g. lower C section rate
 - Developmental screens for kids
 - Smoking cessation counseling
- Widespread, but mixed results
- Outcomes vs. process and teaching to the test/cookbooks
- Provider resistance, low Medicaid participation rates
- No danger of underservice

Bundled payments

- Also called episodes or buckets of care
- One payment for full range of services associated with a specific event, e.g. knee replacement
- Common now for physicians in general surgery and obstetrics
- Places providers at some financial risk
- Incentives to coordinate care, nontraditional supports, reduce duplicate services
- Some danger of underservice, but easier to monitor
- But no incentive to prevent illness in the first place
- No incentive to engage public health
- Good evidence that it works to both save money and maintain/improve quality

Shared savings

- Most ACOs, incl. CT Medicaid since Jan. 1
- Allow providers to “share” some part of reductions in cost per patient, usually 50%
- Upside only (one-sided risk) vs. up and downside risk (2-sided)
- To avoid incentives to deny care, tied to quality standards, but that’s weak protection for patients
- Few save money, quality measures maybe a bit better
- Very, very new – controversial
- Significant danger of underservice

Global payment rates

- Pay one risk-adjusted rate for each patient to cover all their care for a year – in and outpatient, home health, rehab, etc.
- Quality metrics – tend to be very low, weak protection
- Mixed results so far
 - Quality up for some measures, not others
 - All groups met savings targets and received rewards
 - Savings from reducing prices, shift to outpatient care, not reduced utilization
 - But total savings did not equal total bonuses
- **Serious risk of underservice, no systems for monitoring, no penalties**
- None in CT, too similar to failed capitation
- Failed in part because of underservice

Payment reform in CT now

- ACOs – market consolidating, slow
- Very low quality standards – all easy A's
 - to entice ACOs in and
 - because cost savings is mostly what policymakers care about
 - unlikely to do anything about the horrible state of low quality in CT
- Medicaid move into Shared Savings would be a huge leap – but **serious threats from political interference**
 - E.g. notice to consumers was eviscerated after lengthy negotiated deal set, parachute and bombed
 - No meaningful evaluation
 - Underservice monitoring ??????????