Value-Based Payment and Quality in Workers Compensation

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Work-Related Injuries Workshop

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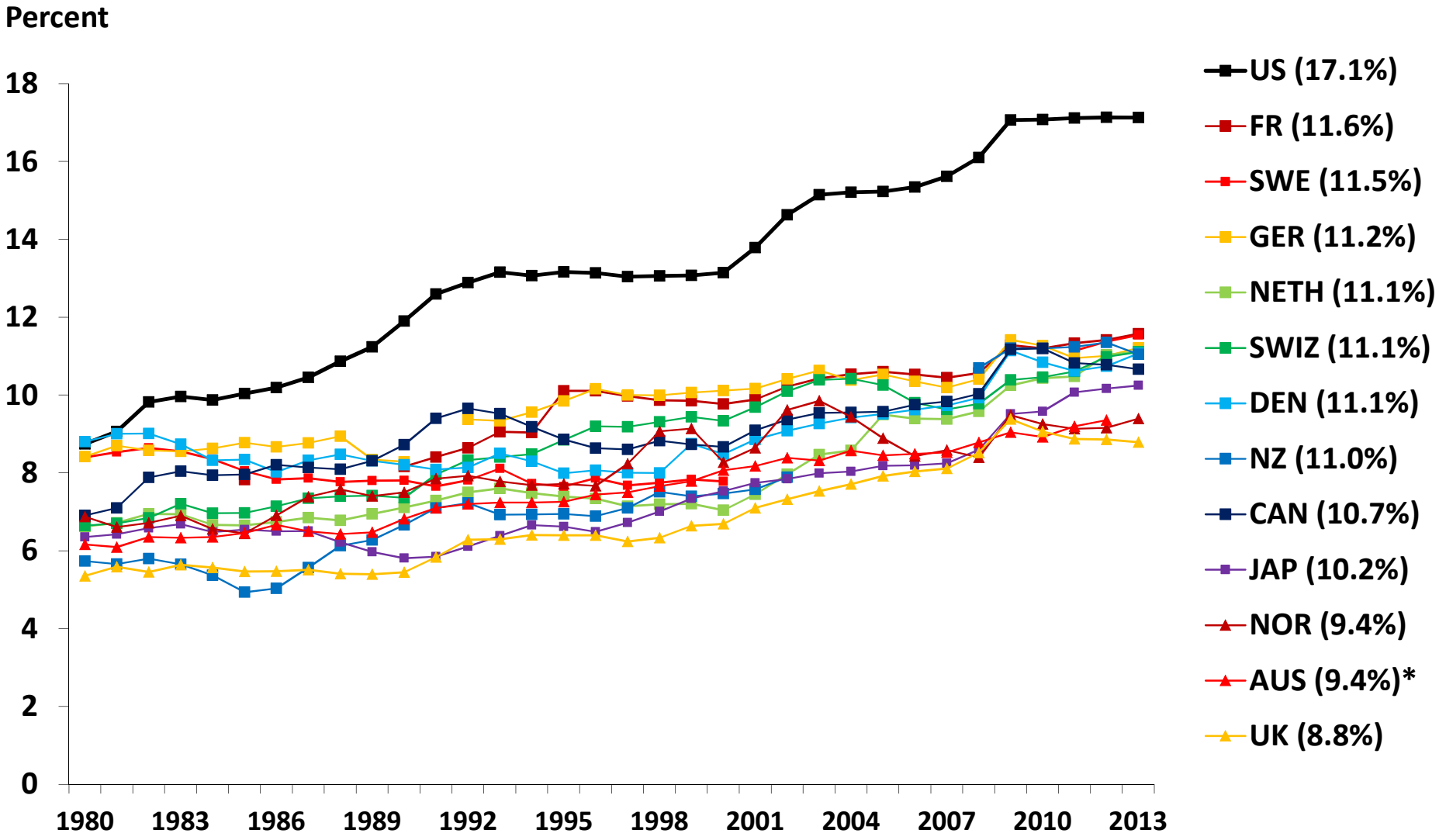
Today's discussion

- Value-based payment - commercial health trends
- How new payment models are related to quality
- When/how will this translate to WC?

Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

The COMMONWEALTH FUND

Value and Payment Reform

- There is no relationship between cost and quality at present in US healthcare, and abundant evidence of significant variability in cost.
- Virtually all proposals to reduce US healthcare costs include mechanisms to tie payments to outcomes, not to volume of services
- All payment reform models incorporate these concepts
- Other changes are required as well

Value Equation in Healthcare

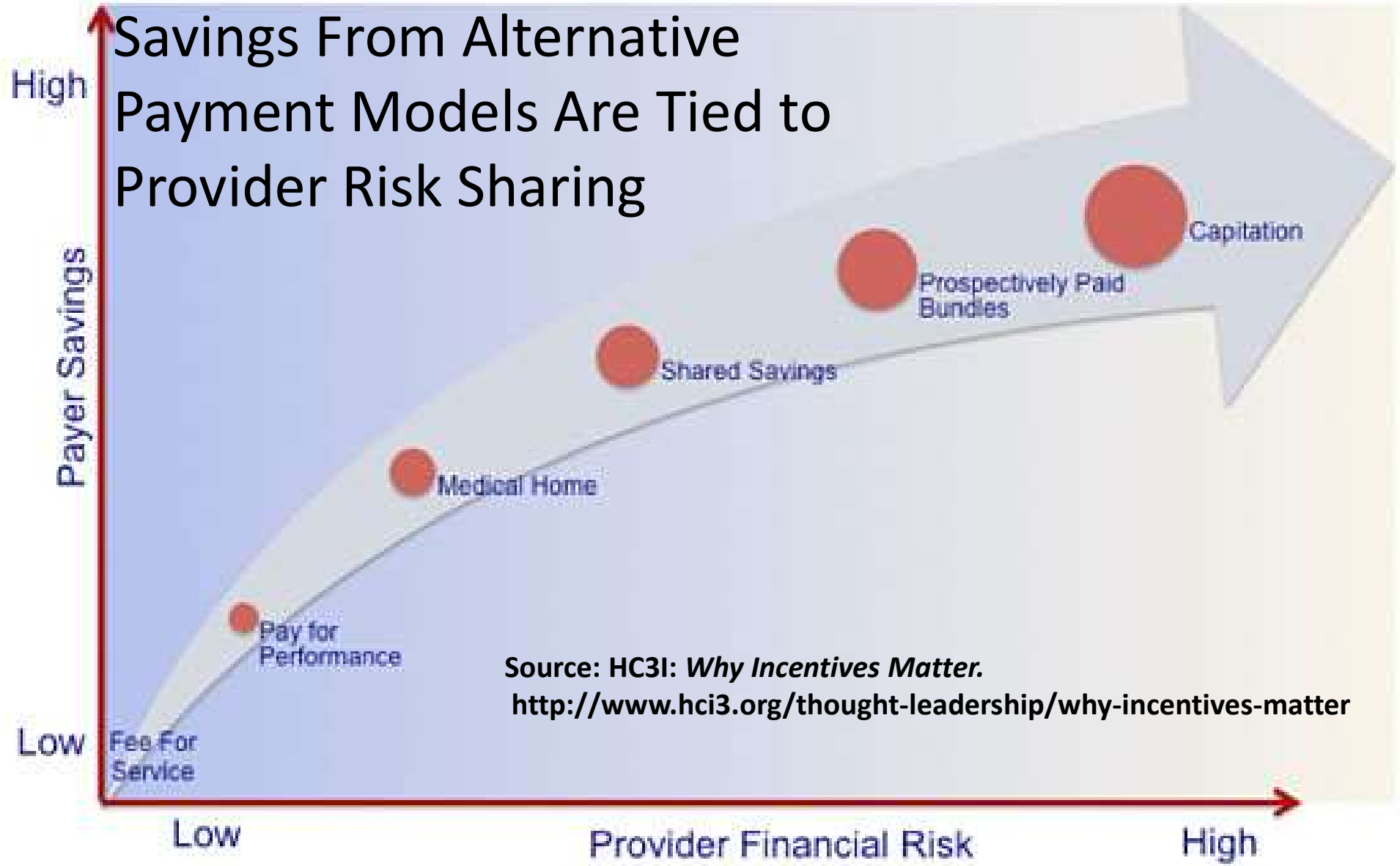
$$\text{Value} = \frac{\text{Quality (Health Outcomes)}}{\text{Cost}}$$

Paying for Value Requires:

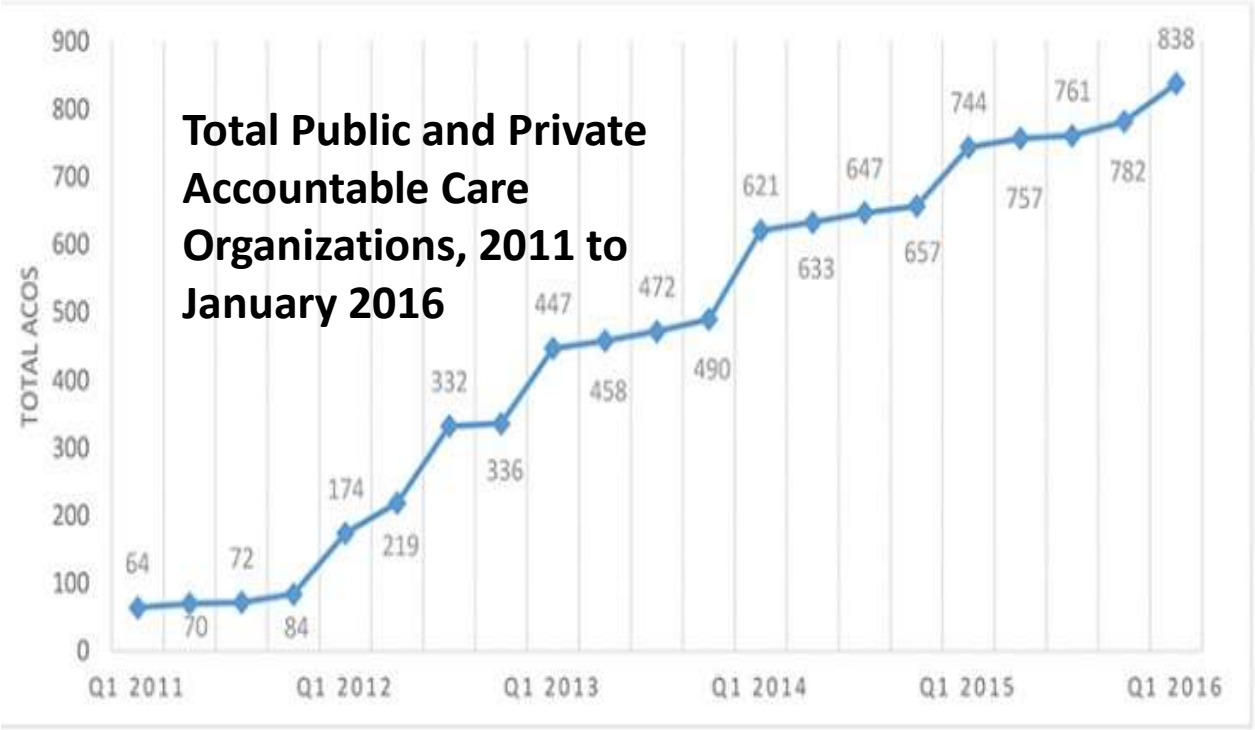
- Ability to measure and distinguish quality
  - Outcomes metrics are best, should be meaningful
  - Process measurements often substituted
- Cost accounting
  - Payers/employers need to understand what bad outcomes cost and what good outcomes save
  - Providers need to understand what services actually cost and how to price appropriately
- Accountable Entity

Accountable Care Organizations (ACOs) are the entities used by CMS and most commercial plans to drive value-based payment

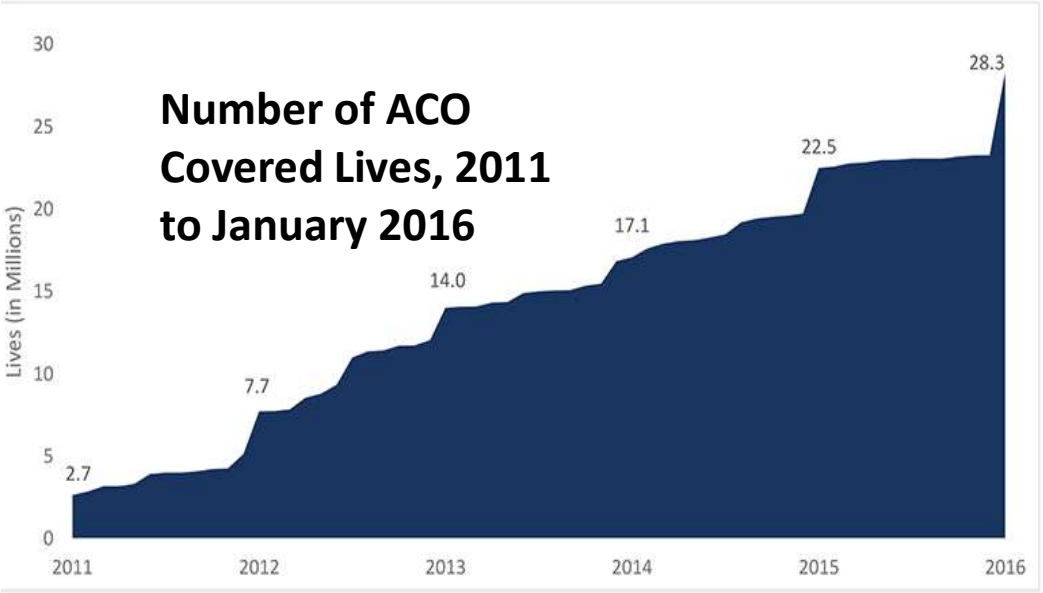
Savings From Alternative Payment Models Are Tied to Provider Risk Sharing

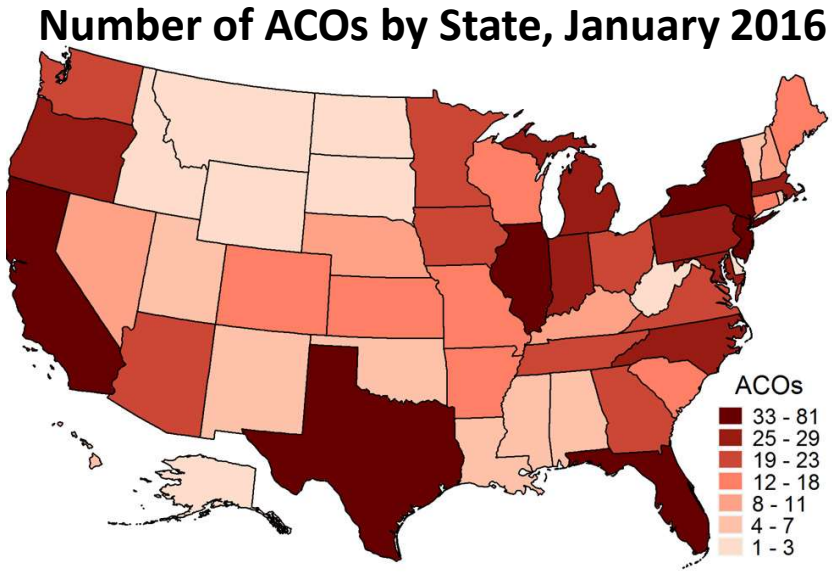


Source: HC3I: *Why Incentives Matter.*
http://www.hci3.org/thought-leadership/why-incentives-matter



ACO Growth Has Been Significant, Across All States





Source: Leavitt Partners Center for Accountable Care Intelligence, Apr 2016

As of 2017…

- ACO growth has continued
  - 12.3 MM Medicare/Medicaid beneficiaries
  - 572 ACOs participating across all CMS models

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-18.html?_cldee=ZGNkZWl0ekBjaGFydGVyLm5ldA%3d%3d&recipientid=contact-4c87a3b958a0e61180f8c4346bdc4141-34cdb5fc384f4df5999cd095c7547656&esid=6da0991d-2bdf-e611-80ff-5065f38a59a1

- Commercial plans have released additional data on their support for VBC, and shown continued savings
  - Aetna – 45% of 2016 payments tied to VBC
  - Anthem – 43% of 2016 payments in shared savings models

http://www.forbes.com/sites/brucejapsen/2017/02/02/unitedhealth-aetna-anthem-near-50-value-based-care-spending/#602738cb4722

As of 2017…(2)

- Analyses/Prognostications post-election mostly point to continued support for VBC models in CMS
  - MACRA vote in Senate (2015) was 92 – 8
  - ACA repeal/replace process has highlighted continued need for savings
  - KPMG survey of 86 plans: only 7% have no plans to implement VBC models

Quality and Savings Results in 2016 were similar to prior years

- Experience was a key predictor of cost savings for ACOs
- Quality and cost savings continued to have a relatively weak relationship
- While most plans achieved savings, not all did so; results were better in South and Midwest
- Savings were associated with better coordination of care, particularly w/r/t post-acute care

Where is Medicare going?

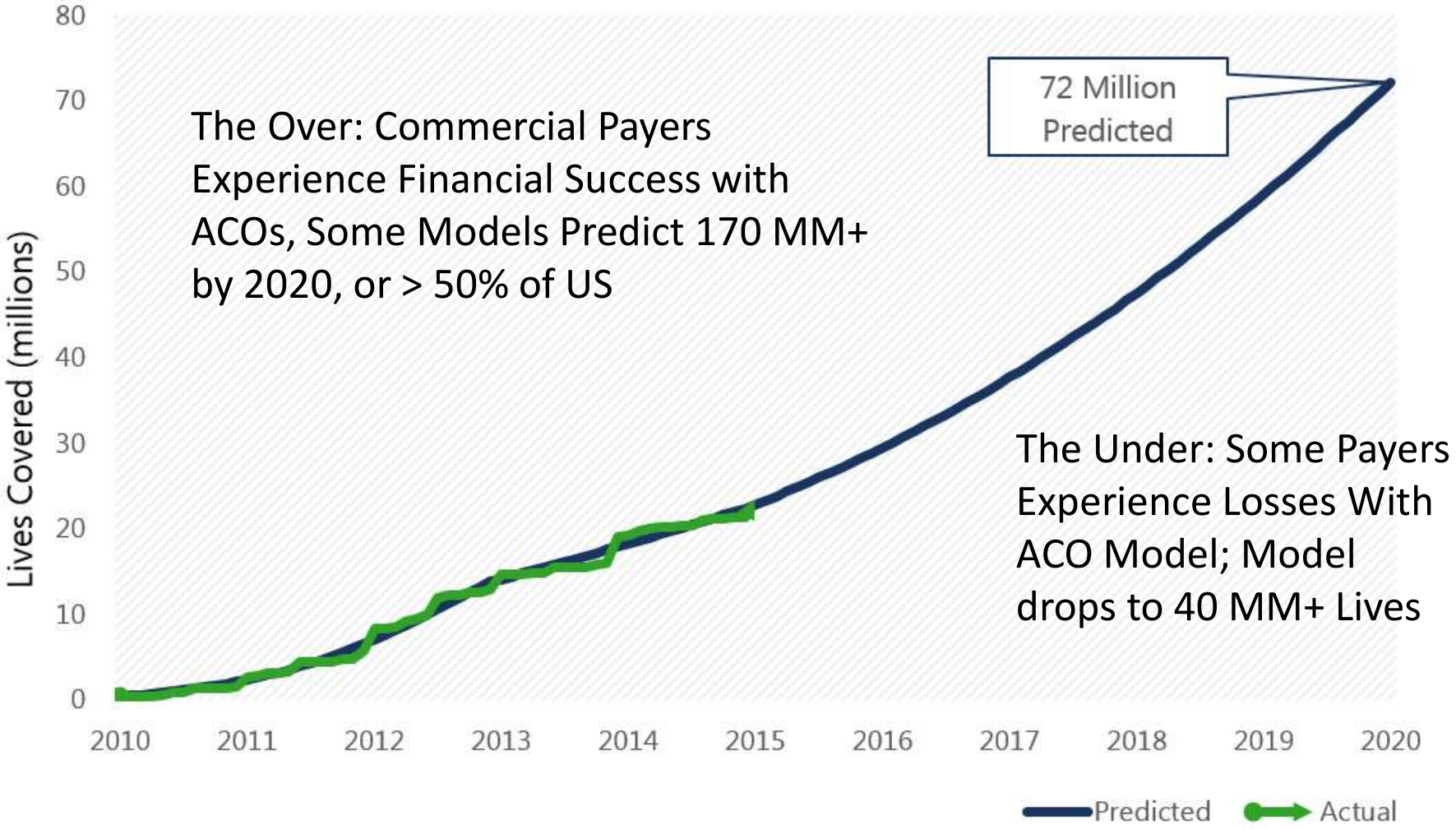
HHS Goals for 2018:

- 50% of contracts tied to alternate payment models
- 90% of all traditional Medicare payments (FFS) tied to overall quality or value
- 67 Medical Service Areas (MSAs) will be paid for a 90-day bundle of services post hip and knee replacement beginning April 1, 2016 – and will be accountable for quality and cost.
- Core quality measures announced Feb 16, 2016, will cover 7 specialty areas including orthopedics

http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html

Estimated Future Growth of Lives Covered by ACOs



Source: Leavitt Partners Center for Accountable Care Intelligence, Dec 2015

Bundled Care Payment Models under Medicare and Commercial Payment Systems Have Been Promising

- Reduced LOS for inpatient procedures
- Fewer readmissions
- New protocols allow greater use of ambulatory surgery centers
- Higher patient satisfaction
- Significant cost savings (which in commercial and Medicare models, can be shared)

Bundled Payment at Horizon BCBS

Metric	Participants	Non-Participants
Revision after Knee Replacement	1.05%	5.4%
Readmission after Knee Replacement	1.06%	1.36%
Revision after Hip Replacement	2.4%	6.1%
Readmission after Hip Replacement	0.96%	1.52%
Admission after Knee Arthroscopy	0	4.49%
Avg. Cost, Hip Replacement	$24,484	$34,840

Source: HCI3.http://www.hci3.org/wp-content/uploads/2016/02/Horizon-Prometheus-Case-Study-4-Feb-2015.pdf

What are the implications for workers compensation?

Quality Improvement and Cost Controls Cannot be Separated

- Multiple demonstrations across care continuum
- Attention to evidence-based principles is a common denominator
- Focus on better care rather than cheaper care resonates with patients and physicians.

Issues for WC:

- Data clearly indicate that outcomes from WC care are worse than commercial health in some circumstances
- RTW is an excellent outcomes metric, tied to function
- Focus in most states is on fee schedule/cost component –quality monitoring is non-existent

Care improvement doesn't happen by accident

- Re-design common across high-performing systems
- Care coordination across multiple caregivers is vital
  - More attention to post-acute care has helped to reduce complications and re-admissions
- Redesign, coordination and other improvements require investment, in personnel as well as IT

Issues for WC:

- WC care networks very fragmented
- EHRs don't do RTW/disability issues well, and payers not prepared to handle data
- Provider enthusiasm for re-design limited when WC is such a small part of many practices

Payment reform is an essential component

- Fee-for-service (FFS) payments incentivize more care, not better care
- Financial incentives that are aligned with desirable outcomes encourage innovation
- Data analytics that can reliably track outcomes are critical

Issues for WC:

- Other than RTW, metrics not well-developed
- Tying RTW outcomes back to providers will be challenging
- Entire system is tied to FFS

WC – what financial stakeholders want/expect

- Employers – high quality/low cost.
- Payers – low cost/discounts

(both happy w/ FFS because of belief it contains costs)

- Providers – fees above commercial health. Prefer FFS, especially in high fee schedule or UCR states
- Hospitals – expect WC to ”make up” lack of profitability from Medicaid/Medicare
- Vendors – generally happy w/ FFS
- Attorneys – higher prices = higher fees

Payment reform is potentially a threat to profitability for all of the above

Measurement is Essential

- Stakeholders must agree on outcomes, and how to measure them
- Patient satisfaction is an important component
- Measurement must be well-designed and not burdensome to providers

Issues for WC

- Broad agreement on RTW as a desirable outcome
- No standards on other metrics
- Data quality/measurement issues abound
- Patient satisfaction metrics are complicated in a disability context

Change takes time and isn't easy

- Clear learning curve – organizations get better with this over time
- While many physician groups and hospitals have succeeded, many have not
- Much remains to be learned

Issues for WC

- Traditional industry, resistant to change
- Overall size of WC (1.5% of US healthcare payments); low priority for most providers

Key Takeaways

- The move to value-based care will continue regardless of what happens to the ACA
- There will be continued demand for providers and hospitals to measure and improve outcomes
- Translation to WC is slow
- Bundled payment programs in WC to date have been re-branded managed care programs, focusing on cost rather than demonstrating value
- Another factor influencing cost-shifting to WC, particularly in high fee-schedule states
- We await successful models relating disability outcomes to payment in a state system or national payer

In summary

- Medical care in WC is no different from group health: there can be no meaningful change to WC care quality or cost without value-based payment reform
- The obstacles to reform are at least as formidable as any faced elsewhere in the healthcare landscape
- WC care risks becoming the ”last refuge of scoundrels” as accountability becomes the norm
- Metrics for WC will need to be different and provide appropriate incentives for managing indemnity
- The way forward will require thoughtful change to existing WC regulations in most states.

Thanks for listening!

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