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Economics of Health Care: A Primer for Ob/Gyns

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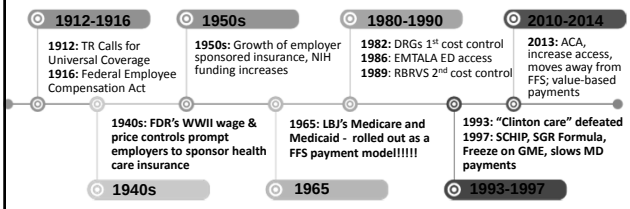
Timeline of American Health Care



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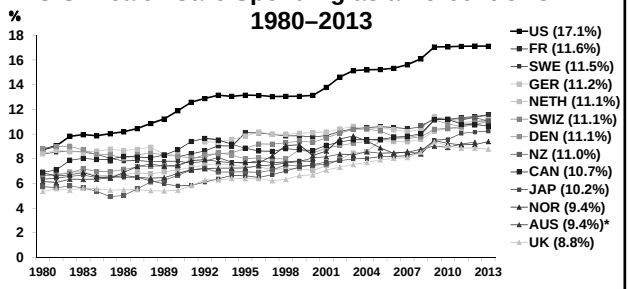
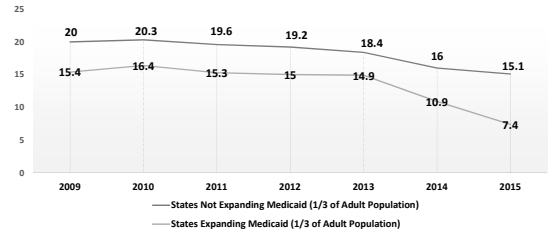
U.S. Health Care Spending as a Percent of GDP 1980–2013



Source: Organization for Economic Co-operation and Development (OECD) Health Data 2015.

Affordable Care Act

Percent of Population Without Health Insurance Coverage (under age 65)



Source: U.S. Department of Health and Human Services, McKinsey and Co.

Who will pay for federal portion of health care

Options include

- Increase payroll tax (Republicans oppose)
- Increase age of Medicare eligibility (Democrats oppose)
- Reduce payment to providers (☺)

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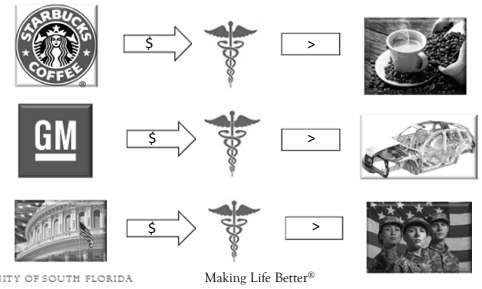
Cost Curve is **Unsustainable**



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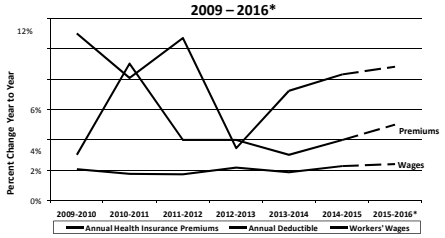
Annual Growth: Premiums, Deductibles, Wages 2009 – 2016*

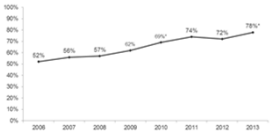


*Projected growth 2015-2016.

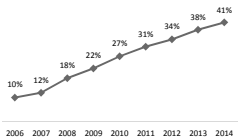
Sources: The Kaiser Family Foundation – and – Health Research & Educational Trust, Bureau of Labor Statistics, Mercer (2015/2016 US Compensation Planning Survey), The Commonwealth Fund

Shifting Risk to the Individual

Percent of Covered Workers Enrolled in a Plan That Includes a General Annual Deductible, 2006-2013



Percentage of Covered Workers with Deductibles > $1,000, 2006-2014



Emergence of Private Exchanges

- **Employers using exchanges as a way to transition from defined benefits to defined contributions**
- **Exchanges may be operated by an individual health plan, benefits consultant, or other third parties – and may offer selection from a single or multiple carriers**
- **Accenture projects that private exchanges will see enrollment increase from about 1 million in 2014 to 40 million by 2018**

Active Employees PETCO, SEARS, Walgreens, dineequality, DARDEN

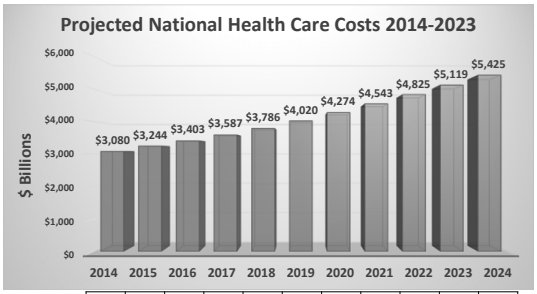
Retirees PAT, IBM, Whirlpool, TimeWarner, GE, KINDER MORGAN

Part-Time and Seasonal Employees TARGET

Who will pay for private portion of health care

Options include

- Employers pay more (easier to move jobs outside US)
- Employees pay more (high deductible, high co-insurance plans lead to decreased preventative care and may lead to increased long term costs)
- Reduce payment to providers (☺)



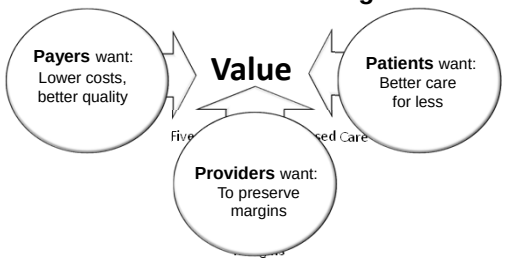
Source: Centers for Medicare & Medicaid Services, Office of the Actuary

National Population Health Outcomes and Risk Factors

Country	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]
Australia	82.2	3.6	54	28.3[e]
Canada	81.5[e]	4.8[e]	56	25.8
Denmark	80.4	3.5	—	14.2
France	82.3	3.6	43	14.5[d]
Germany	80.9	3.3	49	23.6
Japan	83.4	2.1	—	3.7
Netherlands	81.4	3.8	46	11.8
New Zealand	81.4	5.2[e]	37	30.6
Norway	81.8	2.4	43	10.0[d]
Sweden	82	2.7	42	11.7
Switzerland	82.9	3.9	44	10.3[d]
United Kingdom	81.1	3.8	33	24.9
United States	78.8	6.1[e]	68	35.3[d]
OECD median	81.2	3.5	—	28.3

[a] Source: OECD Health Data 2015. [b] Includes: HTN, CVD, DM, COPD, mental health problems, Ca, arthritis. Source: Commonwealth Fund 2014. [c] DEN, FR, NETH, NOR, SWE, and SWIZ = self-reported data; all other countries based on measured OECD data.

Demand for Change



Health care delivery is being restructured to align incentives across the spectrum to focus on value

Defining Value-Based Care

- Historically, provider incentives driven by quantity of care ("**fee-for-service**"), rather than quality of care and its costs ("**value**")
- Given mounting financial pressure, stake-holders shifting from paying for **volume** to paying for **value**
- **CMS is leading the way but others are following**

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Five Pillars of Value-Based Care

Financial drivers

Financial incentives drive operational changes and innovations in healthcare

1. Alternative Payment Models (VBP, MACRA, capitation, bundled payments)

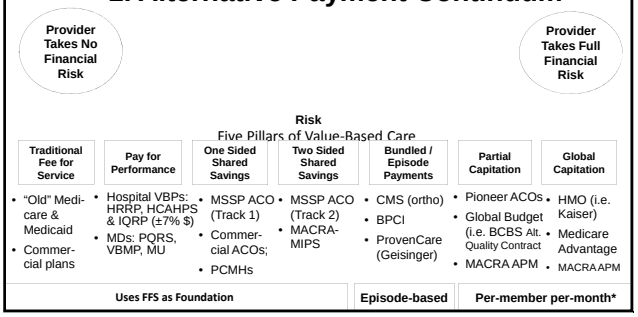
Operationalization

2. Reorganize care around patient conditions ("Integrated Practice Units") – focus factories
3. Measure patient outcomes and costs
4. Coordinate care across spectrum from birthing centers to hospice
5. Scale to drive efficiency and reduce risk

Five Pillars of Value-Based Care

Adapted from Michael Porter and Dr. Thomas Lee, "The Strategy That Will Fix Healthcare," *Harvard Business Review*, October 2013, www.hbr.org/2013/10/the-strategy-that-will-fix-healthcare

1. Alternative Payment Continuum



MACRA: Medicare Access and CHIP Reauthorization Act

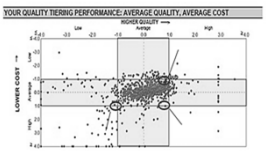
- Ends SGR
- Combines and streamlines current existing MD quality reporting programs (PQRS, VBPM, MU)
- Will have two options:
  - Merit-based incentive payment system (MIPS)
  - Advanced Alternative Payment Models (APMs)

MACRA: Merit-based incentive payment system (MIPS)

- Payment: 0.5% baseline increase 2016-2019 then 0% through 2025 with ± 9% risk*
- CMS begins measuring in 2017, adjust pay in 2019
- Payments effected by 4 factors:
  1) Quality (50%) - choose 6 specialty specific options derived from ER data (eCQMs)
  2) Meaningful use metrics (25%)
  3) Clinical Practice Improvement (15%) - QA, patient satisfaction metrics; chose from 90 options!
  4) Cost/Resource use (10%) - based on Medicare claims

* Upside potential of 27%, doesn't include bundled payments

MACRA Quality Tiering Performance: Average Quality, Average Cost

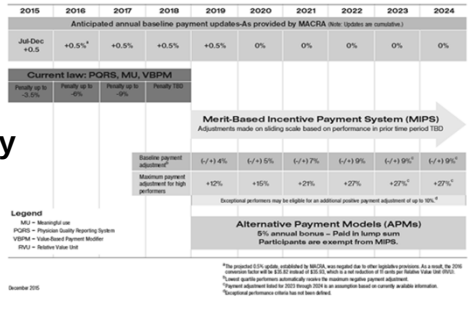


Group	Quality Composite Score	Cost Composite Score	Quality Tiering Performance	Estimated Payment Adjustment (2016)	Estimated $$ Impact (Based on $50M in Medicare Payments)
Group A	**0.84**	**-0.79**	**Average Quality Low Average Cost**	**0.00%**	N/A
Group B	**0.84**	**1.03**	**Average Quality High Average Cost**	**-1.00%**	-$500,000
Group C*	-1.05	1.02	**Low Quality Low Cost**	-2.00%	-$1,000,000

MACRA: Advanced Alternative Payment Models (APMs)

- Payment: capitated plus 5% annual bonus 2019-2024, plus keep what don't spend.
- Participants exempt from MIPS
- Options include:
    a. Comprehensive Primary Care Plus
    b. Next Generation ACO

MACRA Summary



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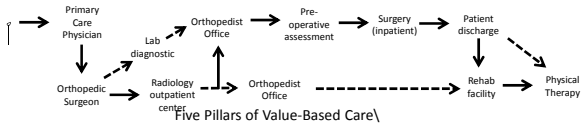
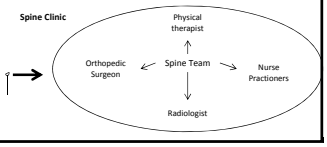
2. Integrated Practice Units: Virginia Mason Spine Clinic



Five Pillars of Value-Based Care\

Virginia Mason

- Patients call (206) 41-SPINE and are seen same day
- Patients are seen by a PT and then an MD who create treatment plan and provide both operative and non-operative options
- Additional consultations may include OT, rehab psychology, CAM, anesthesiology, radiology or neurosurgery, all at one location.



3. Measuring Outcomes: (hint - we already are)

Model	Quality Metrics	Reporting Format
VBP (Pay-for-Performance)	Performance Score (out of 100), comprised of 4 domains: Clinical Process Measures, Patient Experience of Care; Outcomes (3 mortality, 1 patient safety, 1 hospital acquired conditions)	Clinical: Hospital inpatient quality reporting program (IQR); HCAHPS Outcomes: Medicare claims
BPCI/CCJR (Bundled Payment)	Readmission Rate (30-, 60-, 90-) , Utilization (LOS, PAC days, PAC setting), Patient mix/shifting (MS-DRG case-mix index, PAC setting case-mix index; (*Note: Patient experience not rated*)	Done through existing reporting programs: IQR, PQRS
MSSP/ACO (Shared Savings)	33 measurements, 4 dimensions: Patient Experience, Care Coordination, Preventative Health (readmissions), At-Risk Population. Reported through CMS portal, provider responsible for patient survey through CMS-certified vendor.	PQRS, HCAHPS, Medicare/Medicaid EHR incentive program; ACO GPRO Web interface
BCBS AQC (Private, Global Budget)	64 process, outcome and experience measures; hospital and ambulatory care measures included	BCBS tracks claims data, creates daily reports for providers

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3. Measuring Cost

All APMs hinge on benchmarking cost and outcomes to determine "value" achieved and thereby reimbursement

Cost

Providers must understand costs to reduce them

Five Pillars of Value-Based Care\

- Use historical spend to establish target prices/budgets
- Scaling with EHR, complementing with analytics tools
- Implement enterprise data warehousing
- Looking to payers and partners to provide resources or capital for IT infrastructure

Who Sells Data Analytics and Care Management Tools?

- Conifer Health Solutions (founded by Tenet)
- CareMore (Anthem)
- Crimson (Icreon and The Advisory Board)
- Evolent Health (founded by UPMC and The Advisory Board)
- Health Catalyst (owned by Partners, Kaiser, IU, Allina and Others)
- Lumeris (founded by Essence Healthcare)
- Optum (owned by United Health)
- PRISM Connected Health Services (IBM, ATT, Verizon)
- TREO Solutions (owned by 3M)
- Valence Health (Multiple Owners)
- EPIC & Cerner (data analytics come with their IT products)

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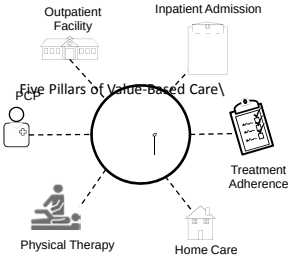
4. Coordinated Care Across Settings

Fragmented care across multiple settings (and multiple providers) leads to waste, duplicative care or delivery of care in a less optimal setting.

Care Coordination

- Organize care among providers
- Coordinate transitions between settings
- Ensure follow-up, med and treatment compliance, as well as patient education



Goals

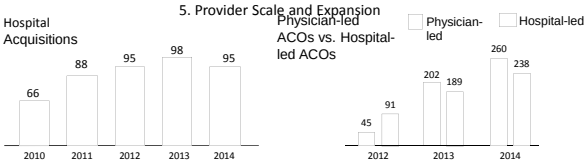
- Reduce duplicative or wasteful care
- Determine correct care setting
- Reduce readmissions

5. Provider Scale and Expansion

To survive providers need to increase coverage geographically to cover more patients, reduce outlier risk and better utilize existing assets

Drivers	Cover more patients*, win more payments	Control care outside the hospital	Acquire complementary care assets	Spread out fixed costs (i.e., EHR)	Negotiate better prices from payers

5. Provider Scale and Expansion



Source: Kaufmann Hall 2014 Hospital Transaction Report

How will all this effect Ob/Gyn Practice?

1) If you only do private Ob may have little <u>initial</u> impact
2) Small groups may be able to opt out of CMS MACRA
3) However MIPS and APMs are likely to be adopted by Medicaid and many commercial payors
4) Large Clinically Integrated Networks (CINs) are going to give rise to new models of care focusing on population health and paid by PMPM fees.
5) CINs will look to **disintermediate** payers and contract directly with employers, the self-insured, exchanges, etc. in order to "own" patient populations – and if you aren't in a CIN you may find you have a lot fewer patients!!

How will all this effect Ob/Gyn Practice?

6) In the future Gyn surgery will either be:
   a) Truly bundled (global fee for Dx, surgery, and post-op care including hospitalization or ASC fee) or
   b) Not reimbursed at all in capitated systems (your salaried and certainly not "bonused" for more volume)
7) In the future Ob care will either be:
   a) Truly bundled – global fee for all aspects of Ob care (i.e., your part plus MFM consults, genetic testing, epidurals, medications, and hospital costs) or
   b) Not reimbursed at all in capitated systems (i.e., Ob is cost center and physicians, CNMs, etc. salaried)

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Before You "Jump" Into Population Health (Total Cost of Care Risk)

Check Your Bank Account

- Risk-Based Capital (RBC) is a requirement for risk-bearing organizations, higher the risk - higher the amount of capital required.
- RBC provides cushion against insolvency for insurance companies; other strategies are stop-loss and re-insurances.
- How much RBC do you require to assume population health risk? NAIC formula includes asset, underwriting, and utilization risks. For multispeciality practice and/or teaching hospital relatively inexperienced in population health, RBC reserve equals 1 yr of premium revenues:
- for 250,000 Insured Lives (Critical Mass) x $8,000 (Annual Premium) = $2 Billion (Reserves)