Total Cost of Care Measurement and Affordability Within the Triple Aim

ICSI – MNCM Webinar
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ICSI

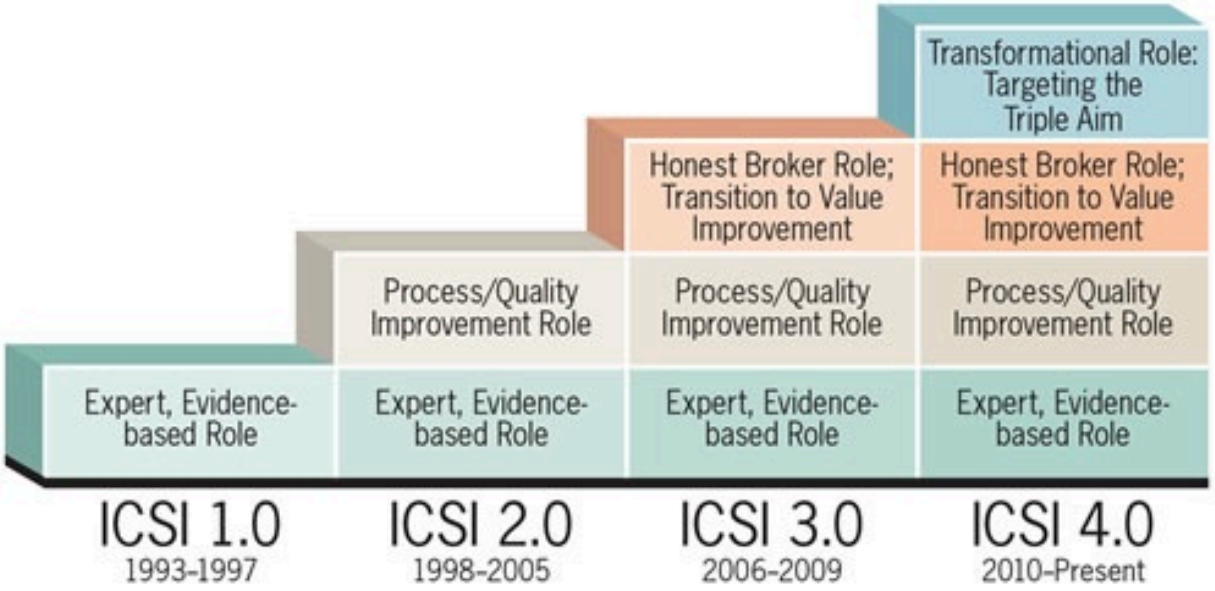
MN Community MEASUREMENT
Measure Up To Better Health

Objectives

- Provide context and URGENCY for focus on TCOC measurement to achieve affordability within the Triple Aim framework
- Define basic Total Cost of Care (TCOC) terminology, principles and variation in the market
- Review MNCM methodology specifications for TCOC measurement
- Discuss how TCOC is being reported and used in new contracting arrangements between payers and providers
- Identify opportunities to reduce TCOC through quality improvement

ICSI 4.0: 2011 – present
Plus **Change Agent for the Triple Aim**

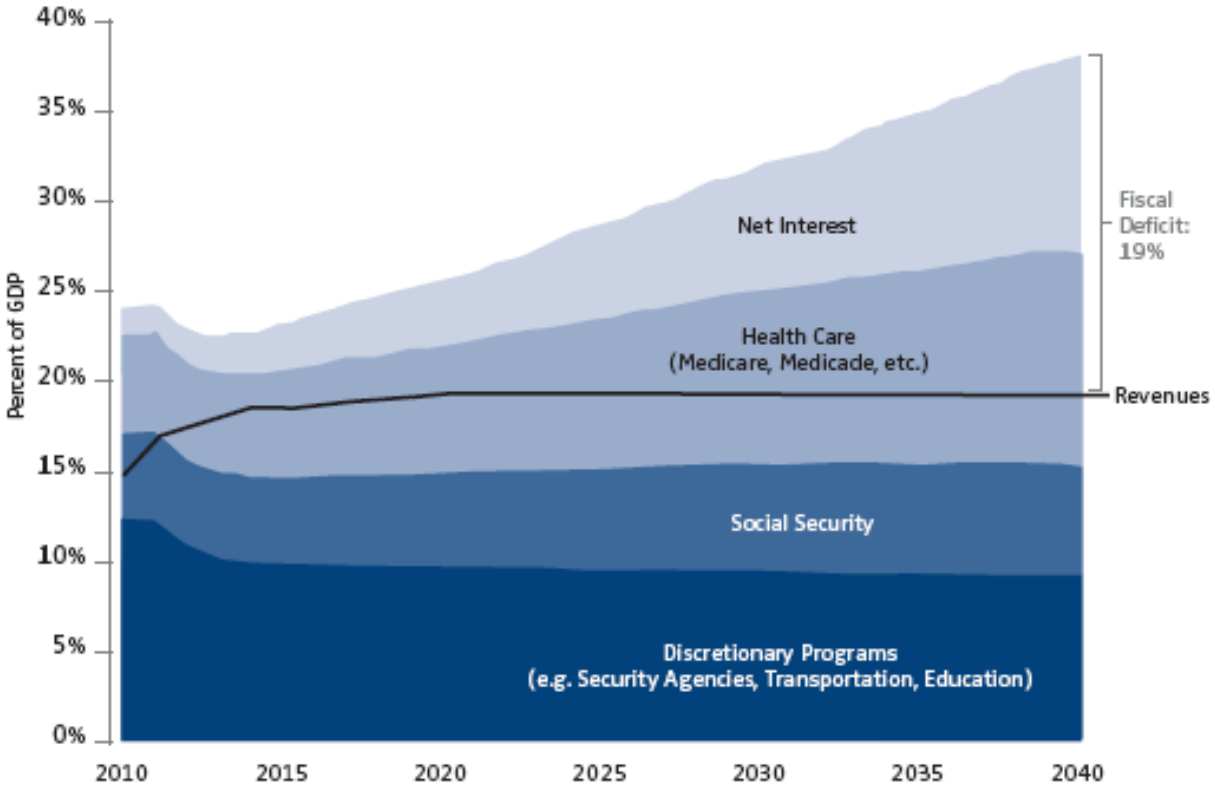
The Institute for Clinical Systems Integration (as it was originally called) was established in 1993 by HealthPartners Medical Group, Mayo Clinic and Park Nicollet Health Services, and sponsored by HealthPartners Health Plan. Its purpose was to help improve patient care in Minnesota through collaboration and innovations in evidence-based medicine. The collaborative was unique in that it brought medical organizations, health plans and business representatives into the decision-making process.



Healthcare Spending as a Driver of the National Debt

FIGURE 2. FEDERAL GOVERNMENT OUTLAYS AND REVENUES (PERCENT OF GDP), BASED ON EXPECTED LAW 2010 THROUGH 2040

Source: Congressional Budget Office



Source: KaufmannHall August 2011 newsletter (http://www.KaufmanHall.com)

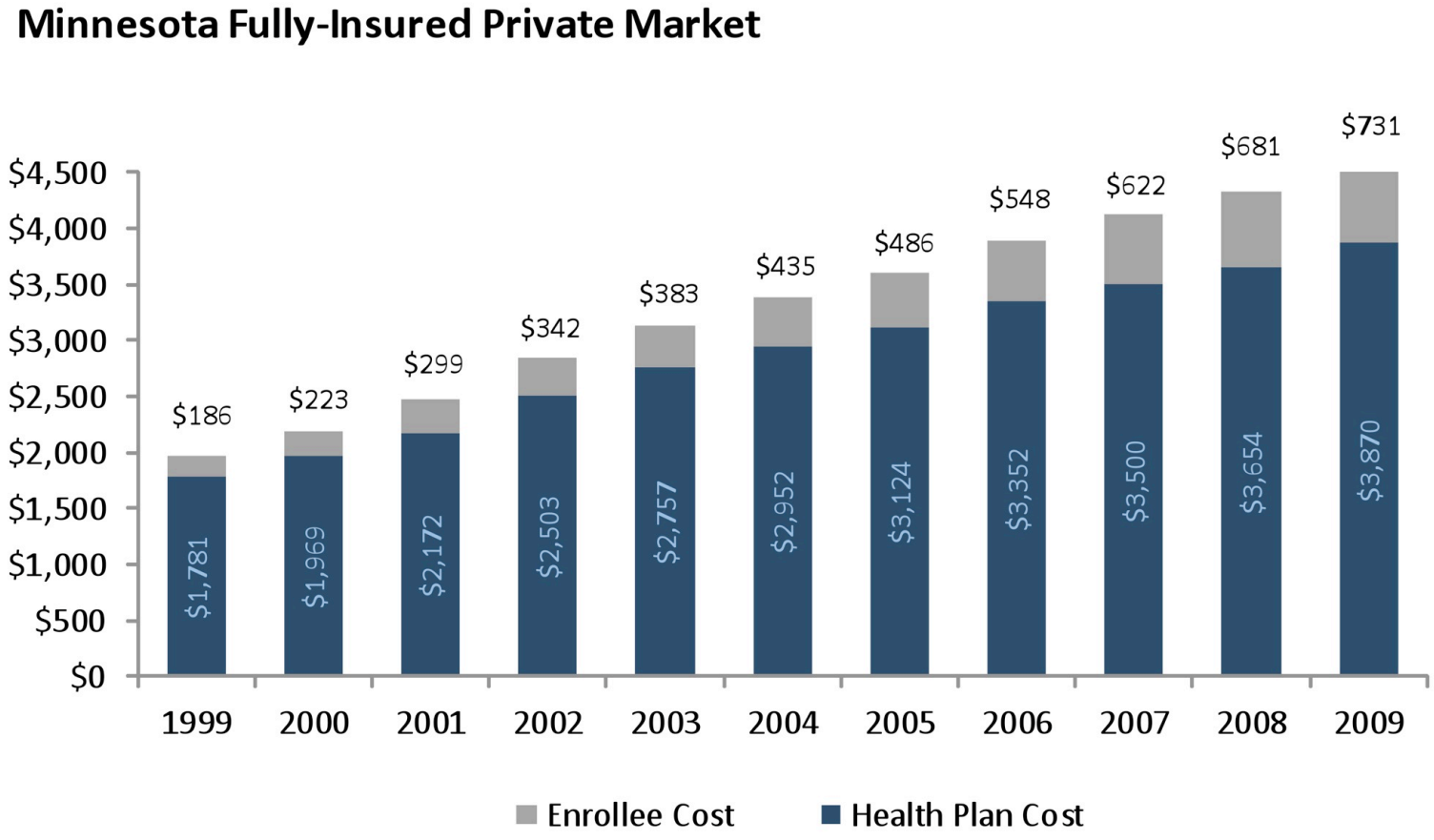
The World Health Report 2000: Spend ≠ Quality

Country	Expenditure Per Capita
United States	1
Switzerland	2
Germany	3
France	4
Luxembourg	5
Austria	6
Sweden	7
Denmark	8
Netherlands	9
Canada	10
Italy	11
Monaco	12
Japan	13
Iceland	14
Belgium	15
Norway	16
Australia	17
Finland	18
Israel	19
New Zealand	20

Ranking	Country	Expenditure Per Capita
1	France	4
2	Italy	11
3	San Marino	21
4	Andorra	23
5	Malta	37
6	Singapore	38
7	Spain	24
8	Oman	62
9	Austria	6
10	Japan	13
35	Dominica	70
36	Costa Rica	50
37	United States	1
38	Slovenia	29
39	Cuba	118
40	Brunei	32

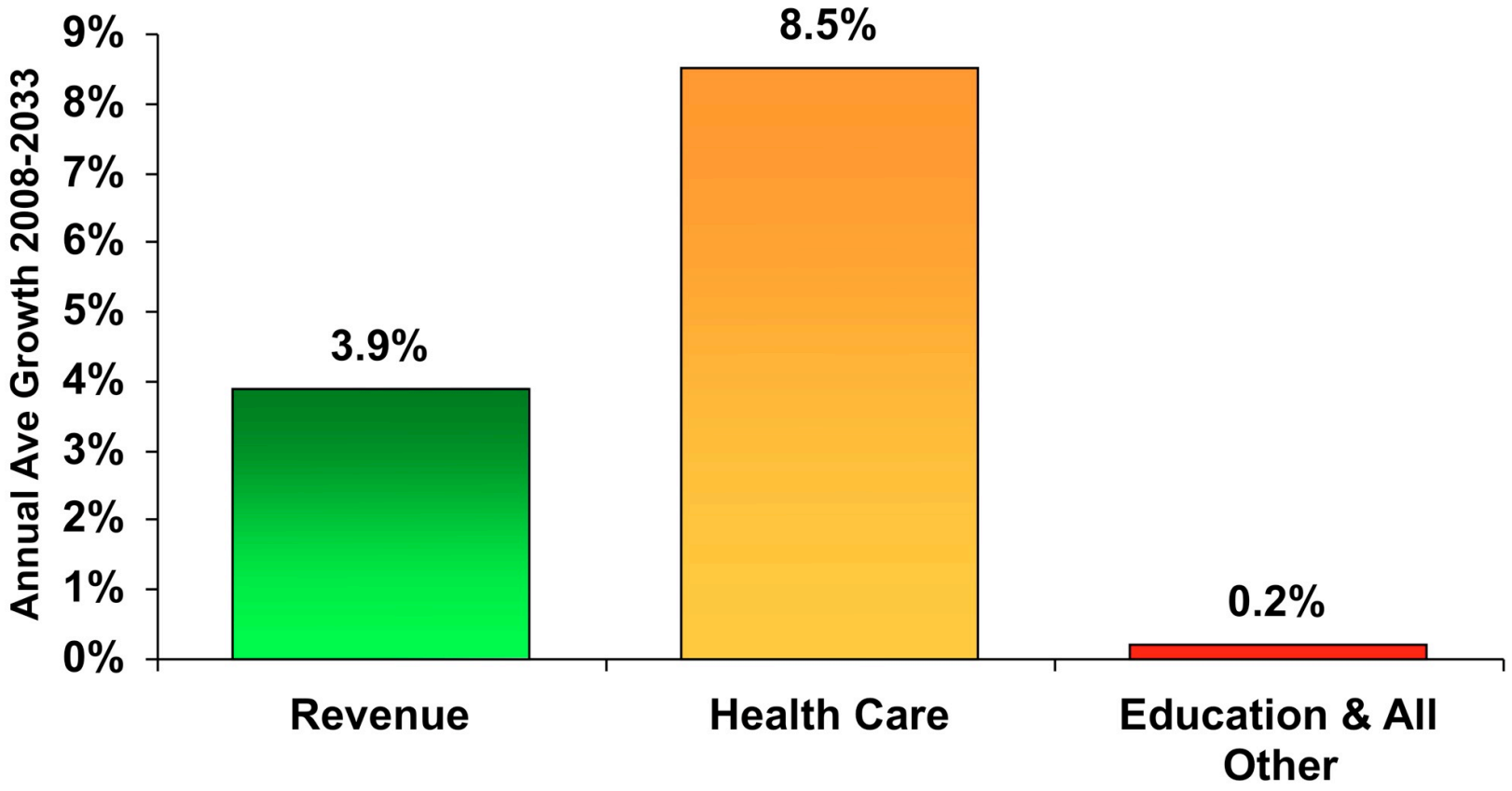
Source: http://www.who.int/whr/2000/en/whr00_en.pdf

Total Cost per Person: Health Plan & Enrollee Shares



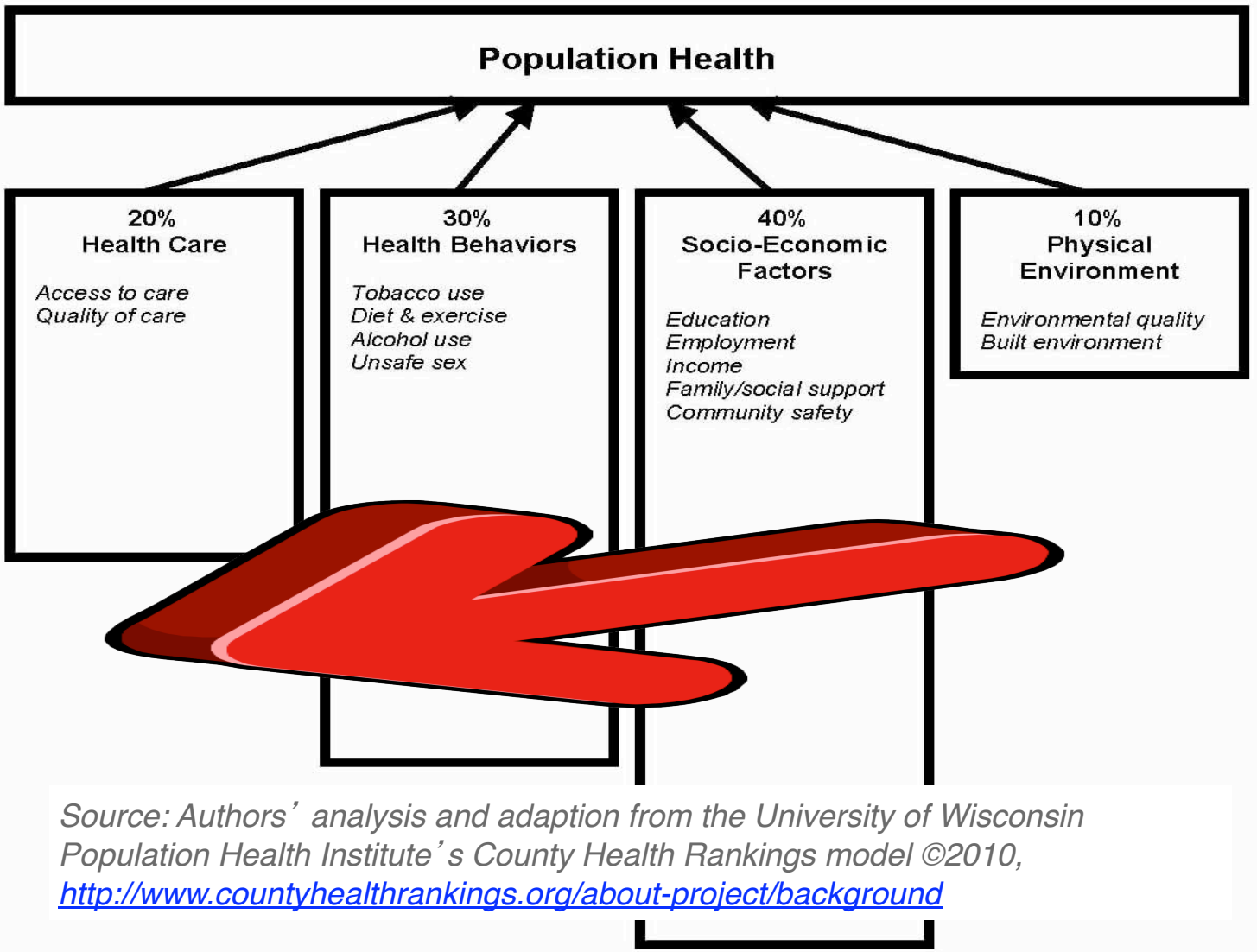
Source: MDH, Health Economics Program.

Projected State Revenue and Health Care Costs Relative to Budget



Source: General Fund Spending Outlook, presentation to the Budget Trends Commission, August 2008, Dybdal, Reitan and Broat

Social Determinants of Health



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's County Health Rankings model ©2010, http://www.countyhealthrankings.org/about-project/background

A Better State of Health Through the Triple Aim*

The Institute for Healthcare Improvement (IHI) believes that new designs can and must be developed to simultaneously accomplish three critical objectives, or what we call the "Triple Aim":

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

* The Triple Aim: Care, Health, And Cost. Berwick DM, Nolan TW and Whittington J., Health Affairs, May 2008, Vol. 27, No. 3, 759-769.

MN Community Measurement

1. Accelerates improvement by measuring performance and publicly reporting health care information
2. A non profit multi-stakeholder, neutral source
3. Emerged out of community need to have a consistent way of measurement and reporting in community
4. Helps align local and national initiatives
   - Provide focus
   - Increase efficiency of measurement
   - Reduce overall community burden
5. Supports the Triple Aim: Health, Experience, Cost

Continuum of Cost/Value

Partial Unit Prices

Total

Value

Unit Price Variation

COST TERMS/MODELS

- Partial Unit Price
- Unit Price
- DRG's
- ETG's
- Baskets of Care
- Bundled Payment
- Provider Peer Grouping
- Ad Hoc Procedure/Diagnostic Grouping
- Relative Resource Use
- Total Cost of Care
- Value Measures

Future Vision: Public Reporting of Relevant Cost, Experience and Quality Information

Medical Group	Electronic Records	Quality of Care	Patient Experience	Total Cost of Care Comparison	Resource Use Comparison	High Value (High Quality and Low Resource Use)
Evergreen	YES	Better	Average	$$	Better	
Lakestreet	YES	Better	Better	$	Better	✓
Woodland	YES	Average	Average	$$	Below	
Parkdale	NO	Below	Average	$$$	Average	
Vista	YES	Better	Better	$	Better	✓

Working Towards Sustainability: Value and Total Cost of Care

- Value=

  Quality Outcomes + Experience/Total Cost

- Total Cost=

  Unit Cost (Price) x Resource Utilization (Volume) for an Individual (or population) / Defined Period of Time

Total Cost of Care Perspectives

$$$$

TOTAL COST TO SOCIETY: MEDICAL CARE, DISABILITY, PRODUCTIVITY, LONG TERM CARE, ETC.

TOTAL COST OF MEDICAL CARE TO PURCHASERS/FUNDERS: GOVT., EMPLOYERS, INSURERS, SELF PAY INDIVIDUALS

TOTAL COST OF MEDICAL CARE ATTRIBUTED TO PROVIDERS: FOR A PATIENT AND RISK ADJUSTED

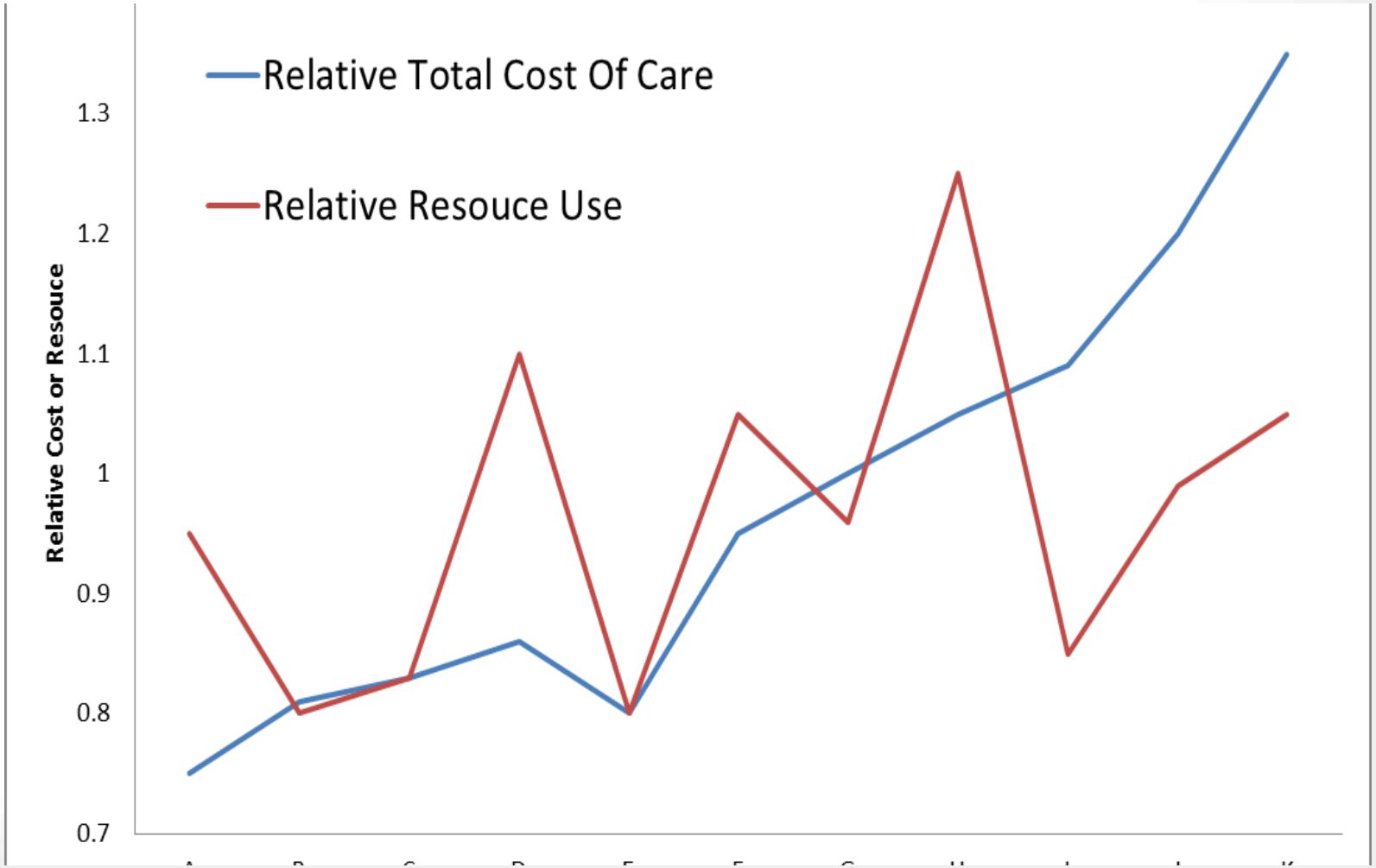
TOTAL COST OF MEDICAL CARE VISIBLE TO CONSUMERS: COPAYMENTS, OUT OF POCKET MAXIMUM, INSURANCE CONTRIBUTION, ETC.

Why a Common Methodology for Total Cost of Care?

- ***It's Step 1 in Obtaining Alignment***
- ***Promotes Transparency***
- ***Consistency: Efficient, Comparable, Replicable***
- ***To Increase Understanding: A Copay is Not the Total Cost***
- ***"Savings" in One Area Does Not Mean Savings Overall***
- ***To Support Efficiency / Resource Improvement Efforts***
- ***A Starting Point For Drilling Down***

"The Triple Aim: Care, Health, And Cost," Berwick, Nolan, Whittington, *Health Affairs*, May 2008, Vol. 27, No. 3, 759-769.

Total Cost and Price Neutral Look:



Variation and Improvement Is A Reality

- Variation of $1200 per person/per year by medical group in Minnesota.
- Variation of $1600 per person/per year for 265 groups and 750,000 Medicare recipients.
- Each percentage improvement in HbA_1c and Lipid management decreased cost by $50 PP/PY. Total $5000 per patient.
- Practices with 30-65 MD FTEs had lower total cost and sometimes greater quality than large care systems.
- Emergency department visits for non emergency care varied from 3-13%.

Dowd, Knutson, Xu, Krazewski

Balancing Total Cost of Care Standardized Methodology Elements

Balancing Methodology Element Challenges and Community Variation

- Unit of Analysis
- Attribution Model
- Risk/Severity Adjustment
- Scope/Services/Payer Type
- etc.

Standardized methodology consensus has been gained for public reporting using NQF endorsed standards thru MNCM convening efforts

Total Cost of Care		Payer						
		Medicare	**BCBS**	**HealthPartners**	**Preferred One**	**Medica**	**Health Plan SPP**	**Health Plan Medicare Adv**
Metric	**Attribution Model**	Plurality of allowed E&Ms. Two stage - primary care (GP/FP/IM/GM) then all specialties	51% of E & M Visits. Primary care includes FP/IM/OBGYN/Peds	Largest percentage of office based primary care visits. Primary care includes FP/IM/OBGYN/ Peds/Geriatrics.	Largest numer of primary care encounters. Primary care includes FP/IM/OBGYN/ Peds/Geriatrics/ Adolescent Med.	51% of Primary Care Allowed Dollars. Primary care includes FP/GP/IM/OBGYN/Peds	Enrolled/ Attributed	Enrolled/ Attributed
	Attribution Timing	Prospective: 3 years data	Concurrent	Concurrent	Concurrent	Concurrent: re-run quarterly	Combination of Above	Combination of Above
	Risk Adjustment Method	A matched reference population adjusted for ACO's age/gender distribution based on aged, disabled or ESRD.	Episode Risk Groups (ERGs): Concurrent	ACG: Concurrent	Episode Risk Groups (ERGs): Concurrent	ACG: Concurrent	Modified ACG: Concurrent	HCCs: Prospective
	Cost of Care Calculations - "Exclusions"	Prescription Drugs	Most organ/tissue transplants			Behavioral Health		Prescription Drugs
	Outlier Methodology	Any claims above the 99th percentile for national per-capita expenditures are excluded	When cost of care exceeds $200k - the member is excluded	Total claims cost per member is capped at $100k PMPY	Total claims cost per member is capped at $100k PMPY	Total claims cost per member is capped at $75k PMPY	Varies by plan	Varies by plan
	Performance Year	Calendar Year	Calendar Year	Fiscal Year Ending 6/30	Fiscal Year Ending 6/30	Fiscal Year Ending 6/30	Calendar Year	Calendar Year
	Payout Criteria	National Expenditure Target basesd on growth rates	Expenditure Target: Growth Rate vs. Negotiated Target	Expenditure Target: Growth Rate vs. Negotiated Target	Expenditure Target: Growth Rate vs. Metro Avg.	Expenditure Target: Growth Rate vs. Metro Avg.	Revenue/ Expenditure	Revenue Target

Attribution

Who Has Responsibility for the Patient?

- "Non math" prospective model

  Self enrolled vs. assigned

- "Math required" retrospective model thru claims to assign most involved provider with influence over patient
  - Primary care: majority visits vs. cost per year
  - Plurality rule: primary care, specialists
  - Look back period

"The perfect is the enemy of the good." - *Voltaire*

Considerations

- Non attributed individuals
  - Those without claims
  - Those that meet outlier status
  - Who is responsible?

- Catastrophic or carve out adjustments
  - Pharmacy, Employer carve outs
  - Payment outside of claims systems
  - Threshold amounts
  - Excess over thresholds

Cost Measure Advisory Group Membership

- **Technical Advisory Group**: Tina Morey-Allina*, Paul Berrisford-Entira Family Clinics*, Kathy Von Reuden-Essentia**, Andy McCoy-Fairview*, Rahul Koranne-Health East, Bill Telleen-Park Nicollet*, Sue Knudson/Chad Heim-HealthPartners***, Ernie Valente-BCBS*, Peter Thibodeau-Medica*, Terry Bernhard/ Margaret Ranheim-PreferredOne***, Craig Christianson-UCare, Stefan Guildemeister-MDH, Nathan Moracco-SEGIP, Pete Benner-Citizen***, Matt Flory-Citizen**, Ann Carlson-General Mills, Kris Soegaard-MNBHCAG***, Mark Sonneborn-MHA, Janny Brust-MN Council Health Plans***, Cindy Keltner-AF4Q*, Howard Epstein-ICSI, Janet Silversmith-Minnesota Medical Association***.
- **Clearing House Review Group (short term 2 meeting)**: Those above noted with a ** plus Paul Koehler-Blue Cross IT, Michelle Nied-Medica Communications
- **Standardized Methodology Subgroup (long term)**: All those noted with a * above plus Holly Rodin-HealthEast, Kevan Edwards-MDH, Britta Lindvall-ICSI

TCOC Standardized Methodology Highlights

- Recommended methodology is in alignment with national standards (NQF endorsed)
- Attribution is balanced on the side of higher confidence in attribution over quantity of attributed patients
- There will be no member attribution if there is no claim
- Will acknowledge and keep track of unattributed population for future methodology refinement
- Risk adjustment uses a standard commercial risk adjustment software (same as the NQF endorsed risk adjustment methodology)
- Outlier status threshold is balanced for fair comparison of smaller and large providers over quantity of accounted costs
- Pharmacy costs will be imputed, when needed, for self insured employers
- This will be an evolutionary process

MNCM Total Cost of Care

- Common Methodology Specifications
  - Developed by consensus with providers, provider associations, payers, purchasers and consumers
- Across multiple payers
- Defined attribution rules
  - Yearly office visit code not required
- Defined Risk Adjustment
  - Johns Hopkins ACG
- High sample size
  - Minimum of 600 patients per medical group per year
- Goal: A feasible, scientifically sound, transparent, TCOC measure specification for public reporting

Emerging Uses of TCOC Measures

- National and Local Public Reporting
- More Transparency Efforts
- Consumer, Purchaser and Provider Educational Efforts
- Efficiency/Resource Improvement Efforts
- Contracting Strategies: Upside, Downside, Shared
- Narrow or Tiered Networks
- Novel Product and Benefit Design and Tools
- Total Value Equation Development
- Movement Towards Aligning Incentives

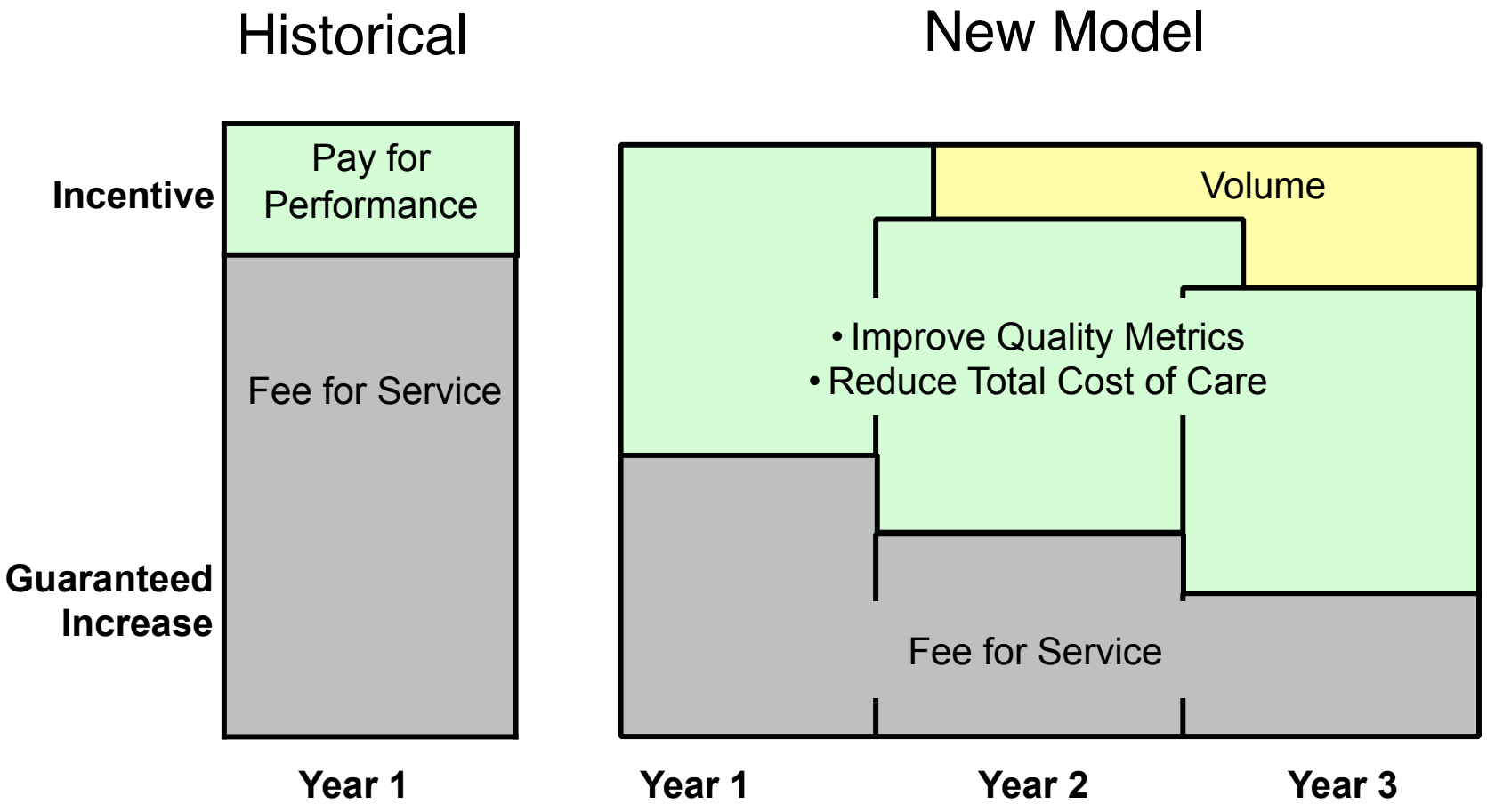
October 2012 *Consumer Reports*

- 32 page insert in Minnesota Edition
- Results of diabetes and vascular care measures at 522 physician offices
- Articles on how patients can improve their care
- February 2013 issue on prevention

Pulling Together as a Community to Reduce Total Cost of Care

MEASURE IT >>>>>>>>>> IMPROVE IT

ACOs & Aligned Incentive Contracting

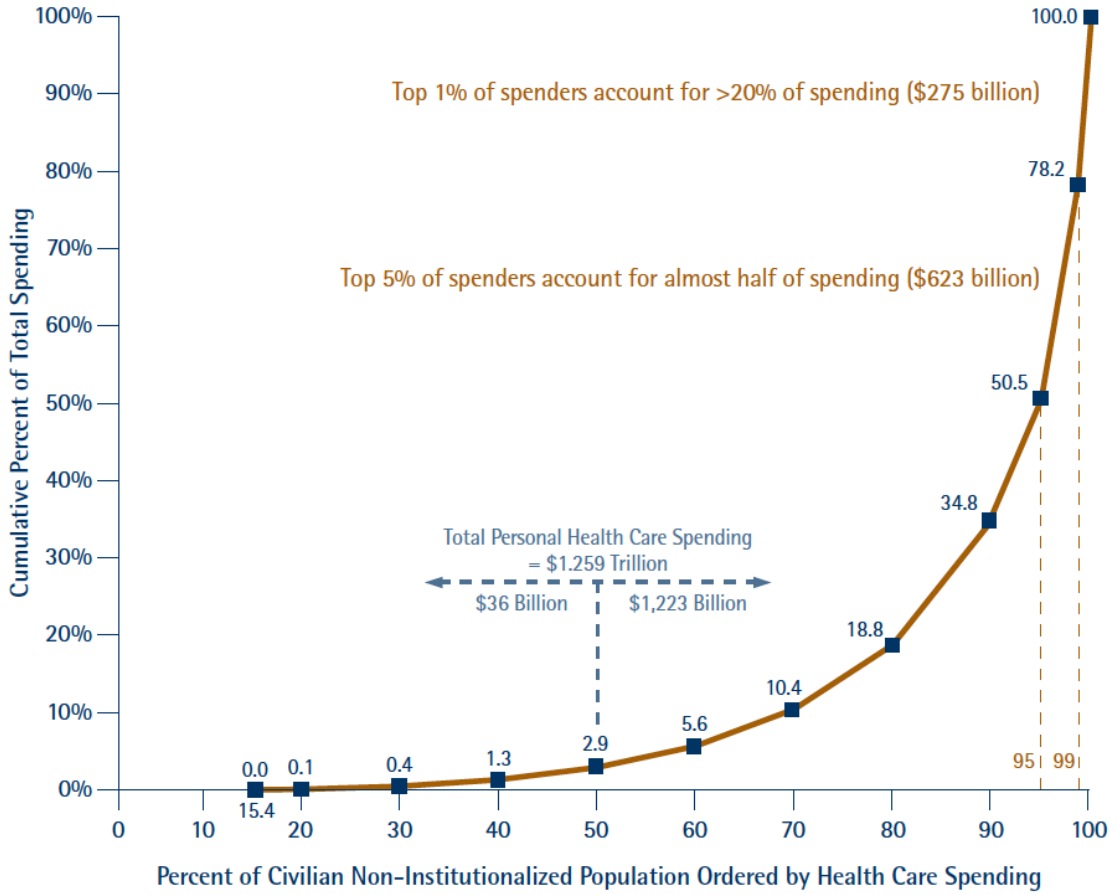


Conceptual graphs

Source: Highmark, best practice

Concentration of Health Expenditures

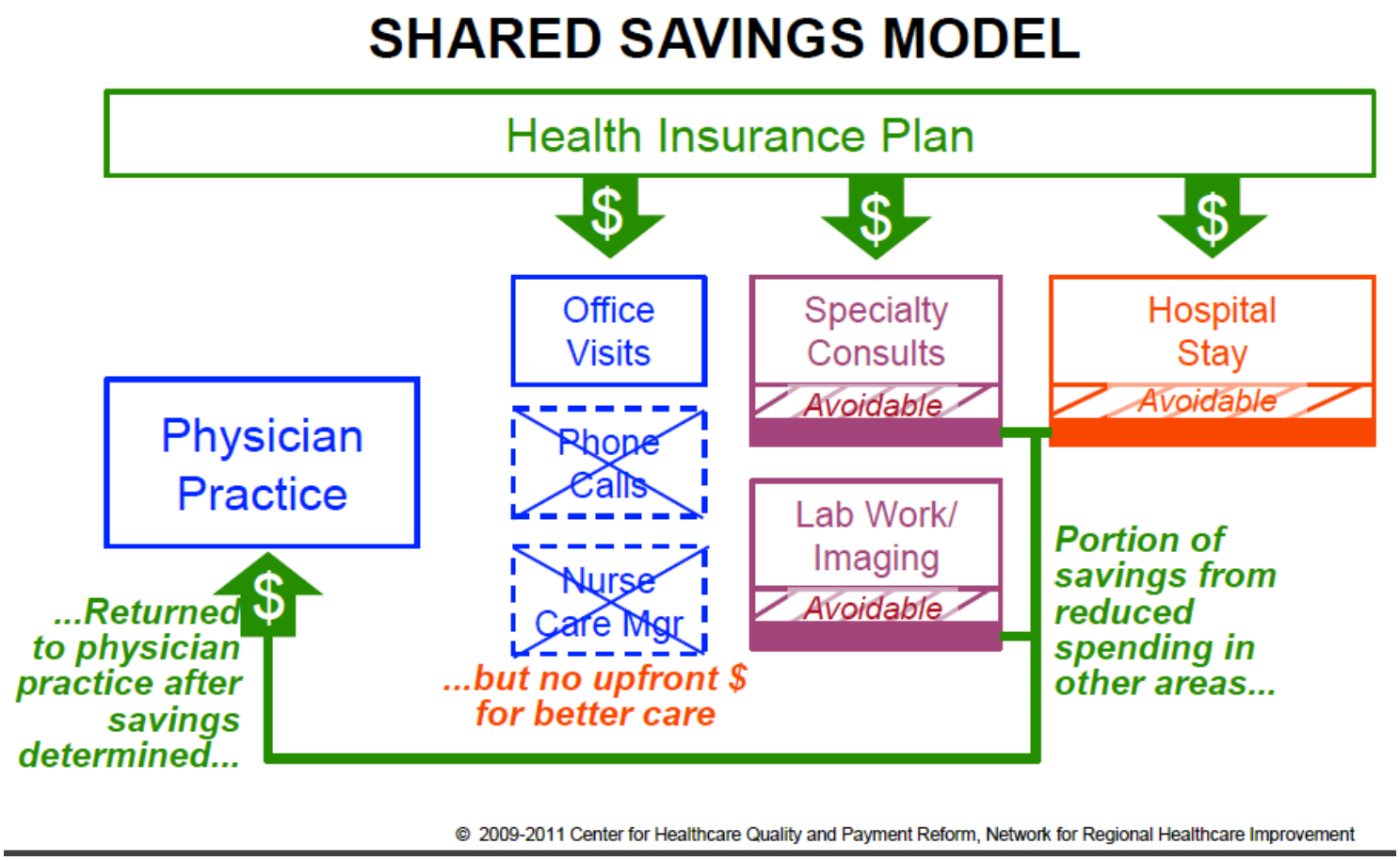
FIGURE 1. CUMULATIVE DISTRIBUTION OF PERSONAL HEALTH CARE SPENDING, 2009



NIHCM Foundation analysis of data from the 2009 Medical Expenditure Panel Survey.

http://nihcm.org/images/stories/DataBrief3_Final.pdf

TCOC and New Contracting Models



Capitation vs. Accountable Care

Key Changes from Past Capitation Models

- Awareness of fee-for-service toxicity
- Quality standards and measures
- Risk adjustment
- Reinsurance through plans
- Limited risk tied to provider capacity
- Information infrastructure
- Provider consolidation
- Product designs with patient cost-sharing
- Patients expect unfettered access to any provider

"Under global payment, services that were profit centers instantly become cost centers."

- Ann Robinow

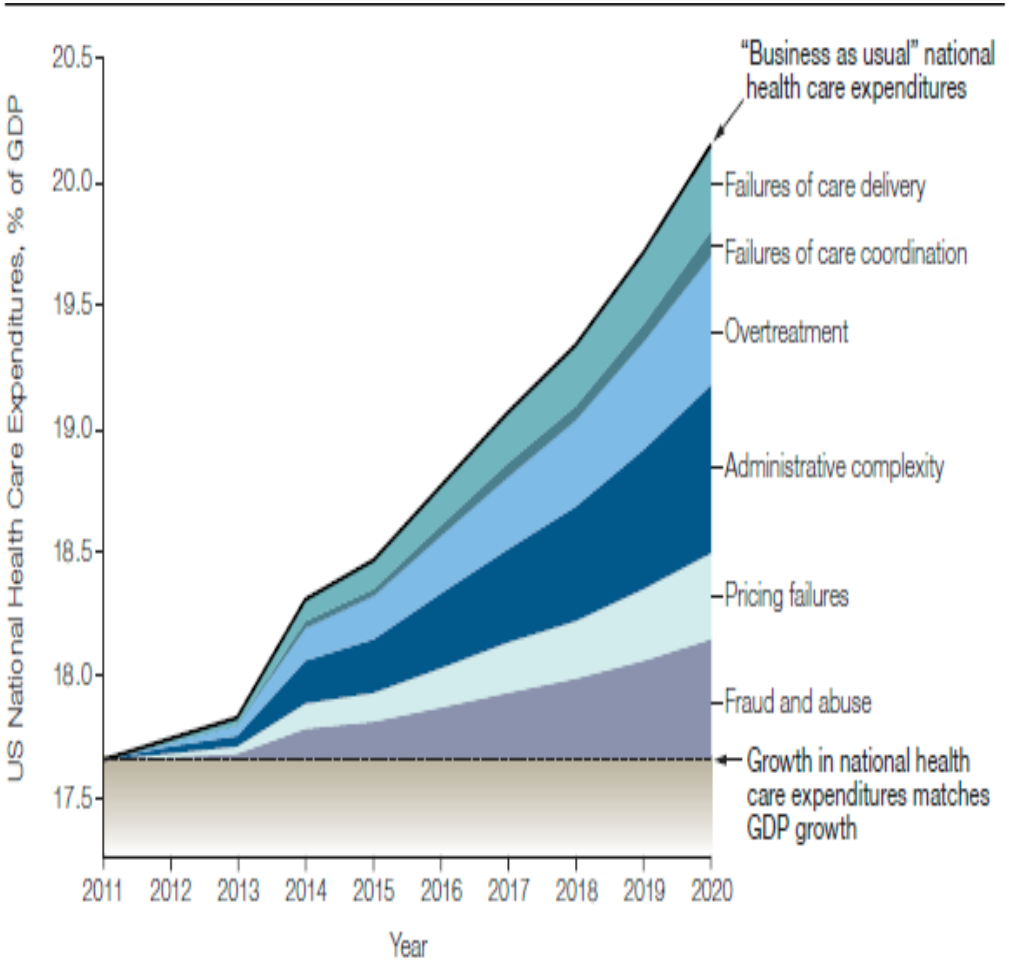
Source: A. Robinow, The Potential of Global Payment: Insights from the Field, The Commonwealth Fund, February 2010.

Wedge Model for US Health Care With Theoretical Spending Reduction Targets for 6 Categories of Waste

$2.5 T	2009
30%	WASTE
$765B	WASTE

Source: Data from workshop presentations and discussions *in The Healthcare Imperative: Lowering Costs and Improving Outcomes, IOM 2/12*

http://www.iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx

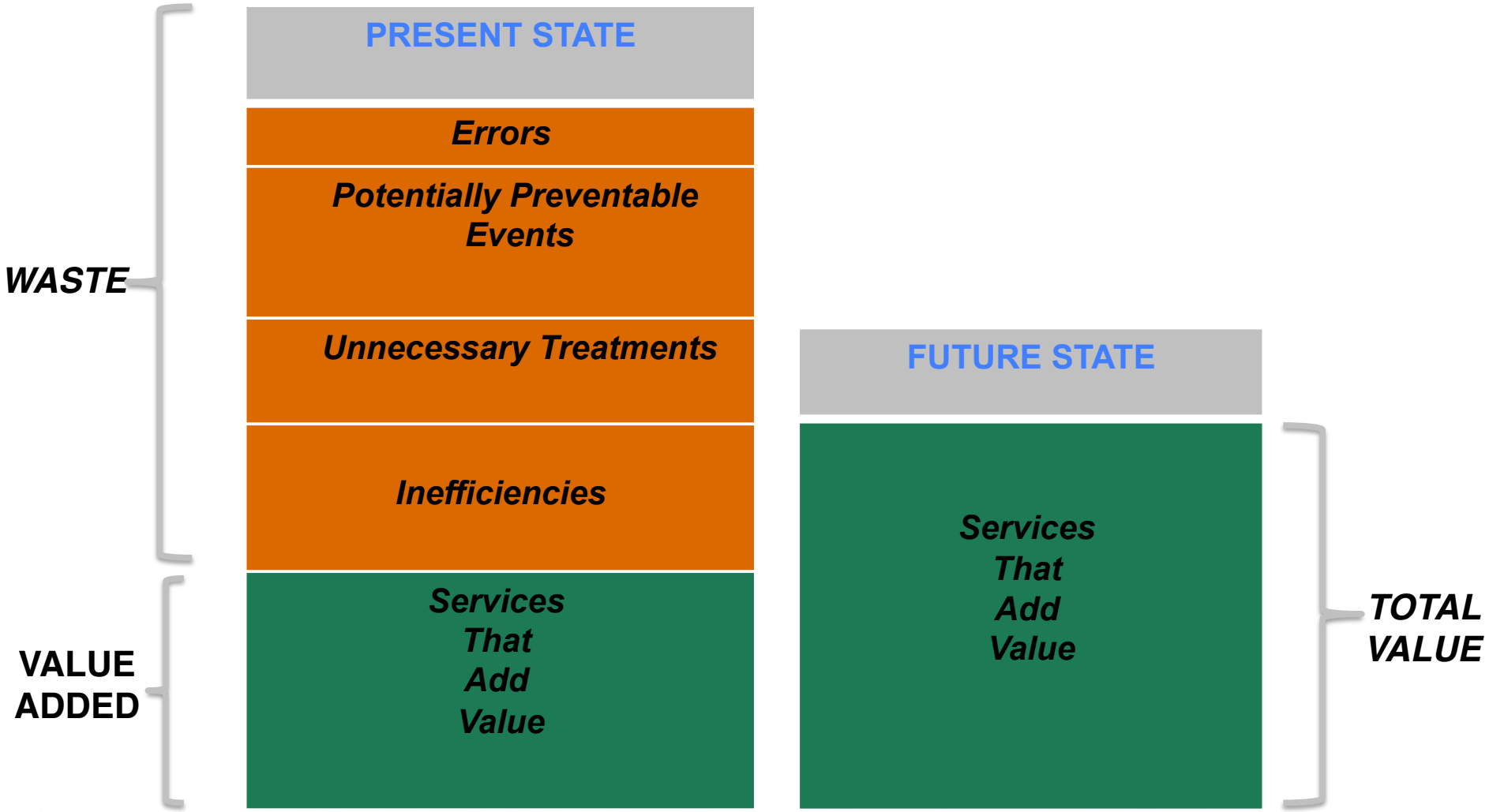


Source: Eliminating Waste in US Health Care, Berwick, D., Hackbarth, A. JAMA. 2012;307(14):1513-1516

Opportunities for Waste Reduction Efforts

	Waste Category	Subcategories
Waste Wedges	Failures of Care Delivery	Failure to focus on population health rather than episodic care
		Failure to improve safety and reduce never events and HAC's
		Failure to reduce unwarranted practice variations through guidelines and best practice standards
		Failure to implement medication management/reconciliation
	Failures of Care Coordination	Failure to increase coordination of Health Care Home
		Lack of shared registry utilization
		"Superutilizers"
		Failure to engage patients and improve patient activation
		Failure to integrate community health teams with providers
		Failure to integrate behavioral health within the medical model
		Underutilization of appropriate palliative care, ACP, EOL/hospice care
		Lack of Triple-Aim accountability
		Failure to prevent avoidable readmissions/admissions/ED visits
	Overtreatment	Failure to hardwire decision support
		Abuse, misuse, and overuse of opiates
		Supply-driven behaviors
		Demand-driven behaviors
		Utilization of non-indicated care/treatments
	Administrative Complexity	Lack of uniformity and standardization in claims forms
		Failure of HITs interoperability
		Failure to align financial incentives and measures for quality metrics
		Redundancy in care coordination and management roles (providers/purchasers)

Opportunities Abound: Focus on Waste



Choosing Wisely®

An initiative of the ABIM Foundation

National organizations representing medical specialists, as well as Consumer Reports, are working with the ABIM Foundation to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources in the United States.

AAAAI American Academy of Allergy Asthma & Immunology
www.aaaai.org

AMERICAN ACADEMY OF FAMILY PHYSICIANS

AMERICAN COLLEGE of CARDIOLOGY

ACR AMERICAN COLLEGE OF RADIOLOGY
QUALITY IS OUR IMAGE

ACP AMERICAN COLLEGE OF PHYSICIANS®
INTERNAL MEDICINE | Doctors for Adults

AGA THE AGA INSTITUTE

ASCO American Society of Clinical Oncology

ASN LEADING THE FIGHT AGAINST KIDNEY DISEASE

AMERICAN SOCIETY OF NUCLEAR CARDIOLOGY

Choosing Wisely®

An initiative of the ABIM Foundation

These *Choosing Wisely*® specialty society partners released their lists February 2013:

AAHPM

American Academy of Hospice and Palliative Medicine

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Empowering physicians to deliver the best patient care

The American College of Obstetricians and Gynecologists

WOMEN'S HEALTH CARE PHYSICIANS

AMERICAN ACADEMY OF NEUROLOGY®

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults

ASCP American Society for Clinical Pathology

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

shm Society of Hospital Medicine

Hospitalists. Transforming Healthcare. Revolutionizing Patient Care.

ICSI

ASE American Society of Echocardiography

SNMMI SOCIETY OF NUCLEAR MEDICINE AND MOLECULAR IMAGING

In Conclusion

- Addressing healthcare affordability and spending is an urgent economic and moral imperative
- Healthcare delivery and payment systems are evolving rapidly
- Useful Quality and TCOC data is essential for provider success under care and payment reform
- Transparent reporting of quality and cost info can help to optimize the value of healthcare
- There is much we can do to improve health and lower costs by reducing “waste” in the delivery system

Finally…

Additional resources from ICSI:

https://www.icsi.org/health_initiatives/health_care_affordability/

Minnesota Community Measurement
www.mncm.org

THANK YOU!

Questions?