

# ARE HEALTHCARE FEE-FOR-VALUE PROGRAMS WORKING?

This session will focus on what research and reports have been done related to outcomes of Fee for Value (FFV) programs. We will discuss factors, caveats, and evaluation methodologies that need to be accounted for in constructive assessment of current and future Accountable Care Organizations and other Advanced Payment Model programs.

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**Together, all the way.®**



# Agenda and Objective

## Objective

- Perspectives and angles important to understand and assess the program and related savings claims
  - Not a critique of any program or any analysis
  - Not a comprehensive view of all the programs and savings

## Agenda

- Background
- Examples of savings claims
- Discussion on what these mean
- What to look out for as you assess these results

# Background

## Problem

Estimates of healthcare waste typically range from 20%-30%. FFV programs can target about 13-18%

- Institute of Medicine (IOM) identified waste in 2009 worth \$750 billion (iom.edu/bestcare) of which \$210 billion was unnecessary services
- The Congressional Budget Office has concluded that up to 33 percent of the health care in the U.S. is unnecessary
- Berwick estimates about 33% waste categorized as follows:

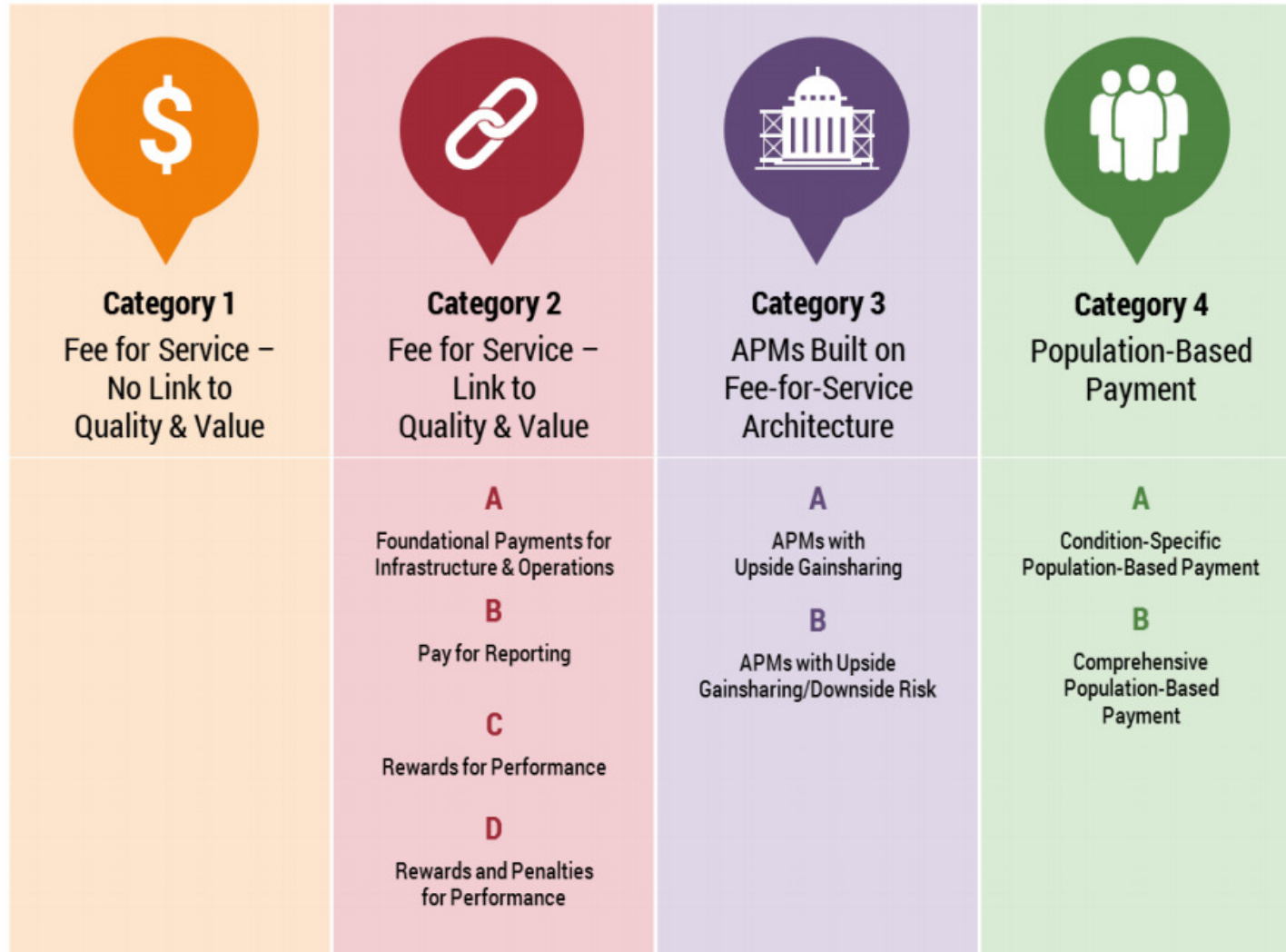
	Category	% Waste	Description
FFV Targeted Waste	Failures of Care Delivery	5%	• Adverse events due to medication error, wrong site of service
	Failures of Care Coordination	1%	• Readmission due to poor transition of care, avoidable ER
	Overtreatment	7%	• Treatment decision based on provider preference not informed by patient (e.g. end of life acute care, knee surgery instead of watchful waiting) • Over-diagnosis (e.g. PSA testing) • Use of more costly treatments when equally effective alternatives are available (e.g. generics – not great example, because this feels like mix/steering) • Treatment that provide minimal benefits (e.g. lap-band surgery for obesity, endoscopy for gastro esophageal reflux disease, lung volume reduction surgery) • Defensive medicine
	Pricing failures	5%	• Services priced above competitive benchmarks (e.g. MRI and CT more expensive in US than in Japan)
	Administrative Complexity	9%	• Complex and time-consuming billing work
	Fraud	7%	
	<b>Total</b>	<b>34%</b>	<b>Estimate ranges from 21% to 47%</b>

- Other sources (Dartmouth Atlas, PWC, McKinsey) also estimates similar ranges of waste

# Background

## Payment evolution

**Figure 1. APM Framework (At-A-Glance)**



<https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

# Background

## ACO and PCMH Programs (Examples)

### CMS

- CMS Physician Group Practice (PGP) Demonstration
- CMS MSSP (Medicare Shared Savings Program)
  - Pioneer ACO Model
  - Next Generation ACO Model
- CMS CPCI (Comprehensive Primary Care Initiative)

### Commercial

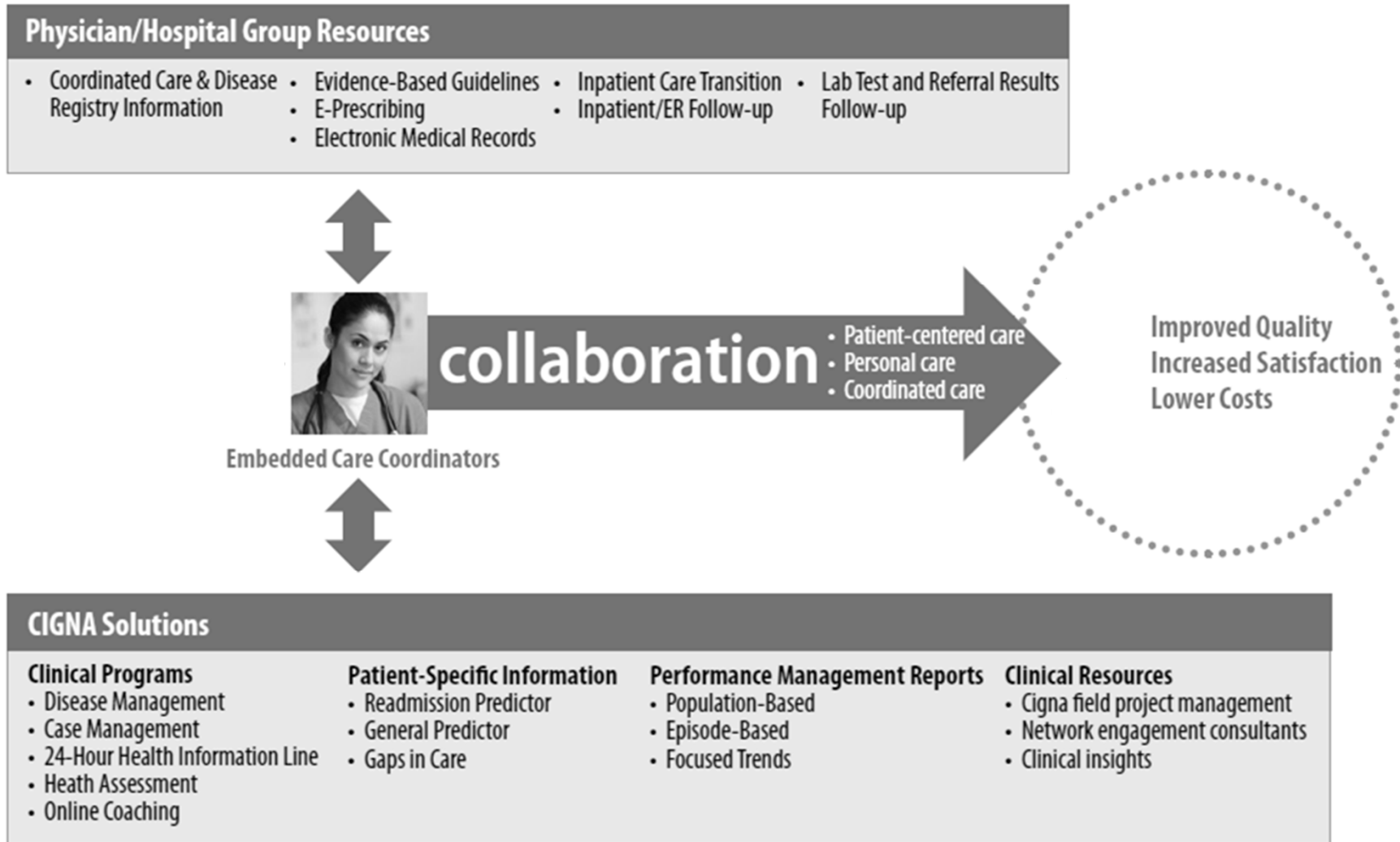
- BCBS of MA: AQC (Alternative Quality Contract)
- Cigna: CAC (Collaborative Accountable Care)
- Aetna: Aetna Whole Health
- Anthem: EPHC (Enhanced Personal Health Care)

### State run programs

- Various state initiatives and CMS grant programs

# Background

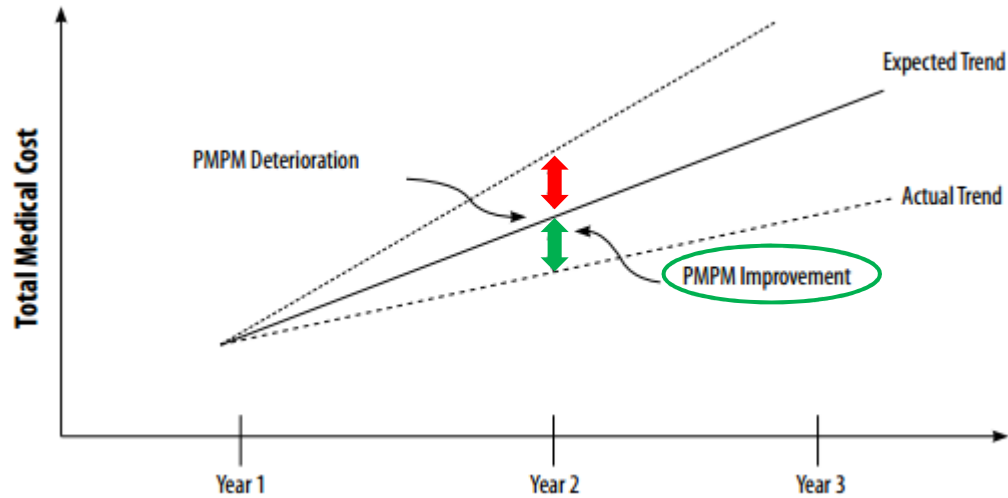
## What is expected



<https://www.cigna.com/assets/docs/employers-and-organizations/Collaborative-Care-White-Paper.pdf>

# Background

## What does a FFV arrangement look like (MSSP example)



	MSSP Track 1 Upside Only	MSSP Track 2 Up and Downside Risk	MSSP Track 3 Up and Downside Risk
Minimum Savings/Loss Rate	Sliding scale based on patient volume 2% (60k+) / 3% (10k+) / 3.9% (5k+)	Options of symmetrical MSR/MLR: 1) 0%, 0.5%, 1%, 1.5%, or 2% 2) Same as track 1	
Max Sahring/Loss Rate	Savings: Up to 50% based on quality	Savings: Up to 60% based on quality Losses: (1-sharing rate) capped at 40-60%	Savings: Up to 75% based on quality Losses: (1-sharing rate) capped at 40-75%
Payment/Loss Limit	Savings: 10%	Savings: 15% Losses: 5% (YR1) / 7.5% (YR2) / 10% (YR3+)	Savings: 20% Losses: 15%
Mechanism	Normal FFS + Annual Bonus		

# Background

## Key differences in program design

### Target setting

- Trend target vs. fixed amount target
  - Projected vs. actual (retrospective)
  - National, regional, or other neighboring states/regions
  - Prospective risk adjusted, concurrent risk adjusted, or none
  - Cumulative vs. memoryless
- *Savings relative to...?*

### Scope

- Pharmacy and Behavioral
  - Winsorized (99<sup>th</sup> percentile)
  - Exclusion/inclusion conditions
- *Net effect to total?*

### Membership (attribution)

- Prospectively vs. retrospectively identified
  - Mandatory PCP selection required product vs. PPO
- *% and type of members reflected?*



# Program outcome

## What was publically reported

### Anthem

Figure 1. EPHC Bends the Cost Curve, Improves Quality

**\$9.51 PaMPM (3.3%)**

Gross savings for program year 1 (\$6.62 net savings)



**7.8% fewer** acute inpatient admits per 1000



**5.1% PaMPM decrease** in outpatient surgery costs



**5.7% fewer** inpatient days per 1000



**7.4% decrease** in acute admissions for high risk patients with chronic conditions and an increase of 22.9 per 1,000 PCP visits for high risk patients



**3.5% decrease** in ER costs, and a 1.6% decrease in ER utilization

[http://www.thinkanthem.com/sites/default/files/EPHC\\_WhitePaper\\_ProviderCollaboration\\_FINALV2.pdf](http://www.thinkanthem.com/sites/default/files/EPHC_WhitePaper_ProviderCollaboration_FINALV2.pdf)

### CMS

- Over 400 Medicare ACOs generated more than \$466 million in total program savings in 2015, accounting for all ACOs' experiences.
- Of these, 125 qualified for shared savings payments by meeting quality performance standards and their savings threshold.
- An increasing proportion of ACOs have generated savings above their minimum savings rate each year. For PY15, 31 percent of ACOs (120 of 392) generated savings above their MSR compared to 28 percent (92 of 333) in PY14 and 26 percent (58 of 220) in PY13.

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html>

### Cigna

- 27% growth in terms of aligned Cigna customers from year-end 2014 to year-end 2015.<sup>1</sup>
- Generated savings of \$145 million through total medical cost reduction since the inception of the program.<sup>2</sup>
- One-third of physician groups active at least one year saved 3% in total medical cost, representing a \$120 annual savings per patient.<sup>3</sup>
- Overall average 2:1 ROI for physician groups active at least one year.<sup>4</sup>
- 50% of physician groups had 3% lower total medical costs than the market.<sup>5</sup>

[https://www.cigna.com/assets/docs/newsroom/collaborative-care-proofpoints-2015.pdf?WT.z\\_nav=newsroom%2Fknowledge-center%2Faco%3Bbody%3Bpdf](https://www.cigna.com/assets/docs/newsroom/collaborative-care-proofpoints-2015.pdf?WT.z_nav=newsroom%2Fknowledge-center%2Faco%3Bbody%3Bpdf)

# Program outcome

## Looking underneath the covers

### \$ vs. % savings

- MSSP savings example →

Target	Actual	\$ Savings	% Savings
\$73,297,675,699	\$72,868,421,009	<b>\$429,254,690</b>	<b>0.6%</b>

### Bias control

- Risk, demo, plan design, geo, provider group type, etc.
- Over control

### Statistical models

- Straight sum (contractual savings)
- Regression model (propensity weighted)
- Matching: EPHC example →

EPHC	Members	Risk
Pre-match	750,154	1.25
Post-match	744,730	1.15
<b>Matching loss</b>	<b>-0.7%</b>	<b>-8.0%</b>

### Accounting for payments (shared savings)

- MSSP example →
- (Negative savings can occur in upside only programs)

Payment	\$ Savings	% Savings
Gross	\$429,254,690	0.6%
Payment	-\$645,543,866	
<b>Net</b>	<b>-\$216,289,176</b>	<b>-0.3%</b>

# Program outcome

## Interesting findings and perspectives from AQC studies (BCBS of MA)

### Groups with prior risk experience

<http://www.nejm.org/doi/pdf/10.1056/NEJMsa1101416>

As compared with the control group, the prior-risk subgroup incurred nonsignificant total savings of \$9.29 (95% CI, -21.45 to 2.86), or 1.1%, per enrollee per quarter (P=0.13). In contrast, the no-prior-risk subgroup incurred larger and significant savings of \$45.52 (95% CI, -78.13 to -12.90), or 6.3% (P=0.006), suggesting that this subgroup drove the main findings.

### Groups with higher starting costs

<http://www.nejm.org/doi/full/10.1056/NEJMsa1600142>

#### Baseline Spending

Estimated savings were significantly greater for ACOs in the 2012 MSSP cohort that had baseline spending above local averages than for those that had baseline spending below local averages (difference, -\$285 per beneficiary; P=0.02). Savings in the 2012 cohort followed a similar pattern for ACOs in high-spending versus low-spending areas (Fig. 1), but the difference was not significant (P=0.09) and was uninterpretable owing to differences in precontract trends. In the 2013 cohort, savings were not evident in any subgroup defined by baseline spending.

### By group type

<http://www.nejm.org/doi/full/10.1056/NEJMsa1600142>

ACO Subgroup	No. of ACOs	Differential Change in Annual Spending (95% CI)
<b>Organization type</b>		
Independent primary care	66	
2012 Cohort	33	
2013 Cohort	33	
Independent multispecialty	76	
2012 Cohort	43	
2013 Cohort	33	
Integrated with hospitals	78	
2012 Cohort	38	
2013 Cohort	40	

# Wait, so the program doesn't work?

## Enablers

1. Investment into infrastructure / personnel / systematic changes
  - Referral systems
  - Extended hours
  - Embedded care coordinators
2. Real time data for timely care coordination
3. Engagement of physicians
  - Sharing data and/or financial incentives with physicians
  - Point of care tools
4. Engagement of patients
5. Quantified priorities, relevant to the group, to drive actions towards highest opportunity
  - True “modifiable” opportunities and their magnitude

## Measurement Issues

1. Scope - often extends beyond the level of control ACOs may have
  - Maternity patients
  - Oncology, ESRD, and other highest risk patients
  - Trade-off between amount of control ACO has vs. potential for shared savings
2. Risk adjustment - existing risk adjustment models do not support the goal of FFV programs
  - Concurrent (retrospective) risk adjustment doesn't capture health improvement
  - Prospective risk adjustment doesn't capture elective, accidental, and trauma events
  - Overall accuracy
3. Benchmark – what can be truly considered savings when there are so many moving parts?

# Looking ahead

## Questions to ask

### Does the ACO platform really work?

- Is it the platform or the execution?
- Who is actually doing what, and is that what is being measured?

### What to look for (critique) when savings claims are made

- Cherry picking?
- Statistical significance?
- What was the benchmark?
- What was the scope of conditions and populations?
- Do the savings account for natural volatility?
- What was the cost?
- What was the timeline?
- Alternative care cost?

### Evolutions

- Downside risk (in various forms including capitation and population based payment)
- Episodes/bundles
  - Prospective vs. retrospective
  - Scope of episodes (DRG < Procedural < Acute < Chronic)
- FFV on top of High Performing Networks (narrower networks)