Value Based Insurance Design

Key concepts & their application at HealthPartners Health Insurance Plan

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HealthPartners Health Plan
Minneapolis, Minnesota
Agenda

• Who is HealthPartners?
• Benefit Design Strategies
• Provider Network Management
• Lessons from HealthPartners’ Experience
An integrated health care organization
An integrated health care organization

**Care Delivery**
- 1,700 physicians
- 55 medical and surgical specialties
- 48 primary care clinics
- Seven hospitals
- 1 million patients

**Financing**
- Non-profit, consumer governed health & dental insurance plan
- 1.4 million members
- Commercial, Medicare, Medicaid
- 60% of members cared for by non-owned providers

HealthPartners®

[Image of map with star indicating Minnesota]
An integrated health care organization

Triple Aim

- Improved health of the population
- Exceptional experience for the individual
- Improved Affordability
Value Based Insurance Design

Definition

The utilization of benefit design strategies to encourage beneficiary behaviors that enhance health and healthcare value.

Aim:
Link benefits to behaviors
Value Based Insurance Design

**Benefit design - HealthPartners experience**

**Strategies**

- Copayments
- Coinsurance
- Premium discounts
- Premium differentials
- Deductible reductions
- Personal health account contributions (HRA / HSA)
- Reference based pricing
Value Based Insurance Design

Benefit design - HealthPartners experience

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**Behavior Goals**
- Healthy actions / activities
  - Health risk assessment
  - Biometric screening
  - Wellness program participation
  - Disease management program participation
  - Medication adherence
- Utilization of high value treatments
  - Preventive services
  - Medications (generics & formularies)
  - Radiological diagnostics
- Utilization of high value suppliers
  - Mail order pharmacies
## Value Based Insurance Design

### What is the return on investment?

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Example
Benefit incentive for well-being program participation
- 90% member participation with 93% satisfaction
- 37% reduction of tobacco use
- 58% increase in recommended physical activity levels
- 80% increase in fruit and vegetable consumption
- 9.4% decrease in obesity
- 3:1 monetary ROI
  - Significant medical cost savings
  - Improvement health related absenteeism / presenteeism

Results

- 90% member participation with 93% satisfaction
- 37% reduction of tobacco use
- 58% increase in recommended physical activity levels
- 80% increase in fruit and vegetable consumption
- 9.4% decrease in obesity
- 3:1 monetary ROI
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Value Based Insurance Design

Benefit design - HealthPartners experience
Value Based Insurance Design

**Benefit design - HealthPartners experience**

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### Results

**Example**

Benefit incentive for pharmacist directed diabetic medication therapy management

- **Goals**: medication adherence, correct dosing, correct agents, avoid poly-pharmacy
- **44%** increase in blood pressure control
- **18%** increase in cholesterol control
- **15%** increase in hemoglobin A1C control
- Enhanced care coordination
- High member satisfaction
- **$4000** annual savings per member

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### Behavior Goals

- **Healthy actions / activities**
  - Health risk assessment
  - Biometric screening
  - Wellness program participation
  - Disease management program participation
  - **Medication adherence**

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Behavior Goals

- Utilization of high value providers
  - Telehealth, urgent care, worksite clinics
  - Accountable care organizations
  - Individual provider groups or facilities
  - Providers of select services
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Contemporary provider network management strategies
Provider Network Management

Evolution: A change in philosophy

Historical Philosophy

Administrative function

- Maximizing member choice was the overarching aim
- “Any willing provider” often included in the network
- Results
  - Adequate coverage & access
  - Insufficient attention to quality, experience, and cost management
Provider Network Management

Evolution: A change in philosophy

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Contemporary Philosophy

Strategic function to support products that enhance value

- Outcome of care delivery and member choice are important
- Network providers must meet performance thresholds
- Goals
  - Adequate coverage & access
  - Steer members to providers the deliver the best quality, experience, and affordability
Provider Network Management

Critical functions

- Provider information management
- Reimbursement for value versus volume
- Contracting flexibility & scalability
Provider Network Management

Critical functions - HealthPartners experience

• Provider information management
• Reimbursement for value versus volume
• Contracting flexibility & scalability

• Quality and experience data sources
  – HealthPartners
  – CMS
  – State of Minnesota
  – MN Community Measurement

• Cost data sources
  – HealthPartners Total Cost of Care Measure
  – HealthPartners Resource Use Measure

• Collaboration on data analysis and application
• Transparency tools
Provider Network Management

Critical functions - HealthPartners experience

- Provider information management
- Reimbursement for value versus volume
- Contracting flexibility & scalability

- 85% of our paid claims are managed under a Triple Aim provider agreement
  - Quality
  - Experience
  - Total Cost
    - Price + resources utilized
    - Member costs + paid claims

- Provider has upside and downside risk
Provider Network Management

**Critical functions - HealthPartners experience**

- Provider information management
- Reimbursement for value versus volume
- Contracting flexibility & scalability

- We have adapted our claims processing systems to meet providers where they are at
  - FFS
  - Pay for value
  - Bundles
  - Population payments
Provider Network Management

Critical functions - HealthPartners experience

- Provider information management
- Reimbursement for value versus volume
- Contracting flexibility & scalability

HealthPartners high value network configurations

- Accountable Care Organizations
- High value hospitals
- High value primary care & specialty providers
- High value providers of specific surgical and procedural services
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**Results**

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<td>Benefit incentives for utilizing high value providers</td>
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<tr>
<td>• 14% cost savings for using top hospitals</td>
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<tr>
<td>• 8% cost savings for using top primary care &amp; specialty groups</td>
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<tr>
<td>• $8,000 savings per surgical procedure</td>
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<tr>
<td>• 18% better composite clinical quality</td>
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<tr>
<td>• Maintained member access to providers</td>
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<td>• Provider satisfaction with process, transparency, and P4V</td>
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**HealthPartners high value network configurations**

• Accountable Care Organizations
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Value Based Insurance Design

Conclusions

• VBID is driving better health and enhancing healthcare value in Minnesota

• Contemporary provider network management is a key strategic function that enables successful VBID

• VBID is transferable and scalable

• VBID can be a successful strategy for Medicare
Premier’s unique provider alignment and data-driven intelligence platform allow us to help our health systems manage current challenges and build for the future… all at the same time.

- Alliance of approximately 3,400 hospitals – 68% of U.S. community hospitals – and 110,000 alternate sites of care
- 74% owned by health systems (1)
- ~$41 billion in group purchasing volume
- Insights into ~1 out of every 3 U.S. health system discharges
- Integrated clinical, financial and operational data

Data as of September 30, 2014.
(1) Following October 31, 2014 exchange.
Designing and scaling capabilities, from the inside

$265 billion of payment cuts: ACA; sequestration; 2MN.

Pay for Performance: HACs, readmissions, VBP

Bundled payment

Shared savings

Global payment

MOVEMENT TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK

High performing hospitals
- Most efficient total cost (including pre and post discharge)
- Most efficient supply chain
- Best outcomes in quality, safety
- Waste elimination
- Satisfied patients

High value episodes
- DRG and episode targeting
- Care models and gainsharing
- Data analytics
- Cost management

Population management
- Population analytics
- Care management
- Financial modeling and management
- Physician integration
- High value provider networks (post acute and ambulatory)
Value-based Purchasing across payment silos
Comprehensive Care Payment Innovation Act (113th Congress: H.R. 3796)
Rep. Black/Neal

- Introduced 12/19/13 by Reps. Diane Black (R-TN) & Richard Neal (D-MA)
- National voluntary program instead of a pilot, beginning 1/1/15
- Allows for 1st dollar shared savings with a 60% (provider)/40% CMS split
- Must meet quality thresholds
- Includes legal waivers (e.g. 3-day stay, homebound status, etc)

**Two payment models**
- Retrospective reconciliation with shared savings
- Prospective payment

**Episode begins 3 days prior to an inpatient admission and goes to 90 days following discharge**
- Acute care inpatient services
- Physician services
- Outpatient hospital services
- Post-acute care services
- Other services as the Secretary determines appropriate

**Initial conditions**
- Hip/knee joint replacement
- Lumbar spine fusion
- Coronary artery bypass graft
- Heart valve replacement
- Percutaneous coronary intervention with stent
- Colon resection
Includes all Part A & B services

Must meet NQF-endorsed quality thresholds for measures consistent with the National Quality Strategy:

- Mortality
- Patient outcomes
- Patient safety
- Avoidable hospital readmissions
- Patient experience of care
- Other measures determined appropriate by HHS

5-year contracts with rebasing between contracts.

Two-sided risk, protecting Medicare against loss of savings

Annual enrollment period

Spending targets based on historical costs in local facility

Compatible with ACOs/MSSP

Provides legal waivers related to:

- 3-day acute hospitalization prerequisite before eligibility for post-hospital extended care services
- Physician Self-Referral
- Gainsharing Civil Monetary Penalties (CMP)
- Inducement CMP
- Anti-kickback Statute
- Home health services
- Requirement that an individual be confined to his home in order to be eligible for benefits for home health services
- Limitations on the amount, frequency and duration on home health services
- OIG advisory requirement re: prohibition of free preoperative home safety assessments by home health agencies for patients scheduled to undergo surgery
Pre-Bundled Payment

1. PCP Visit, Referral to Orthopedics
2. Orthopedic Office Evaluation & Schedule of Surgery
3. Rehabilitation – SNF or Home
4. Surgery at Hospital

PCP Visit, Referral to Orthopedics → Orthopedic Office Evaluation & Schedule of Surgery → Rehabilitation – SNF or Home → Surgery at Hospital
Post-Bundled Payment

PCP visit, Referral

Orthopedic Evaluation

Pre-op Education & Compact

“Pre-hab” home visit, safety check and therapy

Surgery at Hospital (Key Metrics)

SNF at a Preferred Provider; Using Pathway & QI

Home with Preferred Provider; Physical Therapy with Pathway & QI
Why is bundled payment attractive to patients, tax payers and the government?

- Bundled payment among the most promising options to reduce healthcare spending

Why H.R. 3796 is important and necessary

- Creates permanence and in turn, confidence
- Provides clarity on waivers and overall design
- Transparency and clarity on program design, unlike BPCI, but leverages learnings
- Allows market to drive change, modification and improvement
- More attractive payment model
- Does not pick market winners or losers
- Would qualify as APM under SGR reform
Bundled payments through the Innovations Center initiative is still in the early stages. However, we have learned a number of significant things:

- Having a critical mass of volume is important – it is very difficult to achieve savings reduce costs with lower volumes.

- To achieve inpatient setting savings, alignment with physicians is a key element, and should be started early via gainsharing and other mechanisms.

- In the model, the longer episode duration (greater than 90 days) which has the lower Medicare discount (2% instead of 3%) was the most economically favorable model for all bundles for all hospitals.

- There is a great difference in the infrastructure required and effort involved between bundles that are paid retrospectively vs. prospectively.

- The post-acute episode is critical to the model, as changing utilization in these settings will have the greatest impact on cost to Medicare. Understanding the post acute utilization will be imperative to modify care delivery.