High and Low Value Care Panel

Board of Administration Offsite Meeting
Kathy Donneson
July 18, 2017

Agenda

- Background
- Panelists
- Q&A
- Next Steps

Background | What we've discussed…

Evidence based high value design

Cost Quality

Look at different perspectives to plan design:

- Consumer
- Purchaser
- Provider

Panelists

Marge Ginsburg
BSN, MPH

Former
Executive Director

Center for Healthcare Decisions

Jeffrey Rideout
MD, MA, FACP

President and CEO

Integrated Healthcare Association

Joshua Fangmeir
MPP

Research Director,
Employee Research Division

Minnesota Management and Budget

Marge Ginsburg
BSN, MPH

Former Executive Director
Center for Healthcare Decisions

Marge Ginsburg

Doing What Works

The public's views on policies for reducing low-value care

CalPERS Board of Administration Offsite

July 18, 2017

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when there are no easy answers.

chcd.org

Smart Care California

2015: Statewide Work Group on Reducing Overuse

Co-chairs:

- DHCS -- Covered California -- CalPERS

Members:

- Health plans
- Providers
- Consumer groups

Purpose:

Develop, initiate, monitor, and evaluate approaches to reducing the overuse of selected unnecessary and wasteful medical services

Admin support: Integrated Healthcare Association (IHA), supported by CHCF

The Roles of the Public in Health Care

	Purpose of Engagement		
Type of decision	Direct care	Organizational governance	Policy making
Personal e.g., which treatment is best for me?	**Patient/ consumer**		
Program e.g., how can the service improve?		**Health plan member**	
Policy e.g., to reduce harm/costs, should some treatment options be restricted?			**Citizen**

Based on K. Carman et al, Exhibit 1 in Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies. Health Affairs, February 2013

Addressing overuse *may* require trade-offs among societal values, such as:

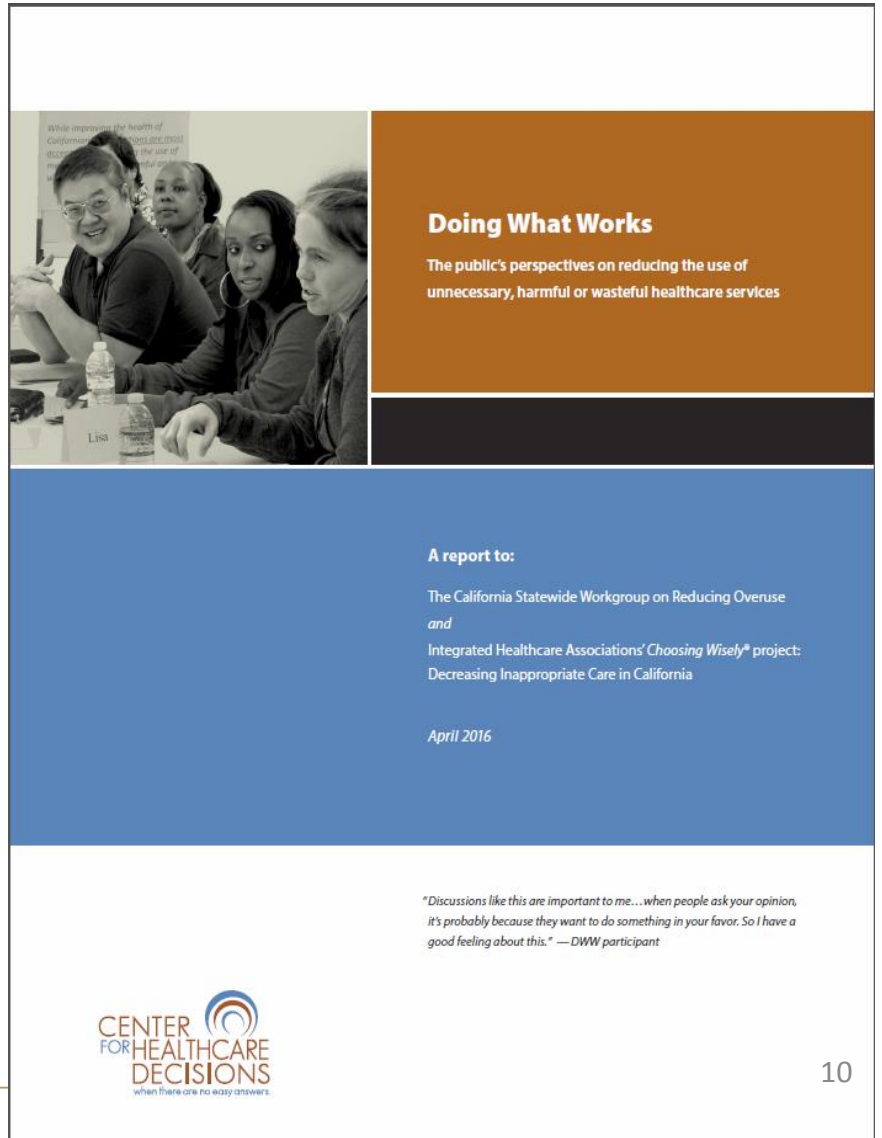
- The autonomy of individual doctors;
- Patients' access to all treatment options;
- Patients' right to decide what has personal value;
- Trust in personal doctor to deliver high quality care;
- Effective use of shared resources; controlling costs.

Doing What Works: 2015-16

What, if anything, should be done to reduce the overuse of unnecessary, wasteful medical care?

Funding:

- California Health Care Foundation
- Kaiser Permanente National Community Benefit Fund



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DWW learning objectives

1. To what extent does the public accept medical evidence as a valid reason to set limits on “unnecessary” care?
2. Are some approaches to limit-setting more acceptable to the public than others?
3. Are some types of medical services more acceptable for limit-setting than others?
4. Do differences in perspectives vary according to socio-demographics?

DWW sessions/participants

Ten half-day sessions, 9-12 people each, 117 total

- **Five sessions with Medi-Cal members (two in Spanish)**
- **Four sessions with CoveredCA members**
- **One session with CalPERS members**

All were low-to-moderate income, ages 30-60, with diverse health plans, not working in healthcare

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1

The rising cost of Health Care

$2.8 TRILLION

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2

Spending wisely: A focus on value

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3

What is low-value care?

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4

Medical Research

Good quality health care needs medical research to help doctors and patients decide what the best care is. Research also helps them avoid services that are not helpful.

Medical Research is ongoing

Research has many roles. It studies what causes illnesses; how to prevent them; ways to cure them; and better treatments for them. Medical science is an on-going discovery process. And it has

Who does this type of research?

The government or non-profit companies often fund research that compares existing treatments.

DWW Case Scenarios

① Use of antibiotics for adult bronchitis

② C-Sections with normal pregnancies

③ Use of MRI scans for low back pain

Types of approaches considered

Provider-facing: **greater oversight**

- MDs that overuse need approval from expert
- Monitoring/discipline
- Stricter rules

Provider-facing: **compensation related (rewards/ penalties)**

Patient-facing: **incentives or disincentives**

No action: continue to **leave it to doctor/patient**

Results

Preferred approaches

Provider-facing: greater oversight	**57 %**
Provider-facing: compensation related	**13 %**
Patient-facing: incentives or disincentives	**21 %**
No action: continue to leave it to doctor/ patient to decide	**9 %**

Dominant themes

① Physician leaders are responsible for resolving the over-use (low-value care) problem.

② Monetary incentives are inconsistent with medical professionalism.

③ Higher patient cost-sharing may be justified to maintain freedom of choice.

④ Responsible use of shared resources dominated the discussions.

⑤ The citizen voice is not the same as the patient voice.

PRE/POST

If my doctor and I agree on the best treatment for my problem, my health plan should pay for it, no matter what the research shows. (N = 117)

	Pre-survey responses	Post-survey responses
Agree Strongly	26%	28%
Agree	50	37
Not Sure	16	19
Disagree	5	15
Strongly Disagree	2	2

76%

65%

PRE/POST

Health plans should pay for any treatments that doctors recommend, even if research shows that a treatment does not work well for patients.

	Pre-survey responses (N=117)	Post-survey responses (n = 115)
Agree Strongly	19%	12%
Agree	36	15
Not Sure	25	22
Disagree	19	44
Strongly Disagree	2	7

55%

27%

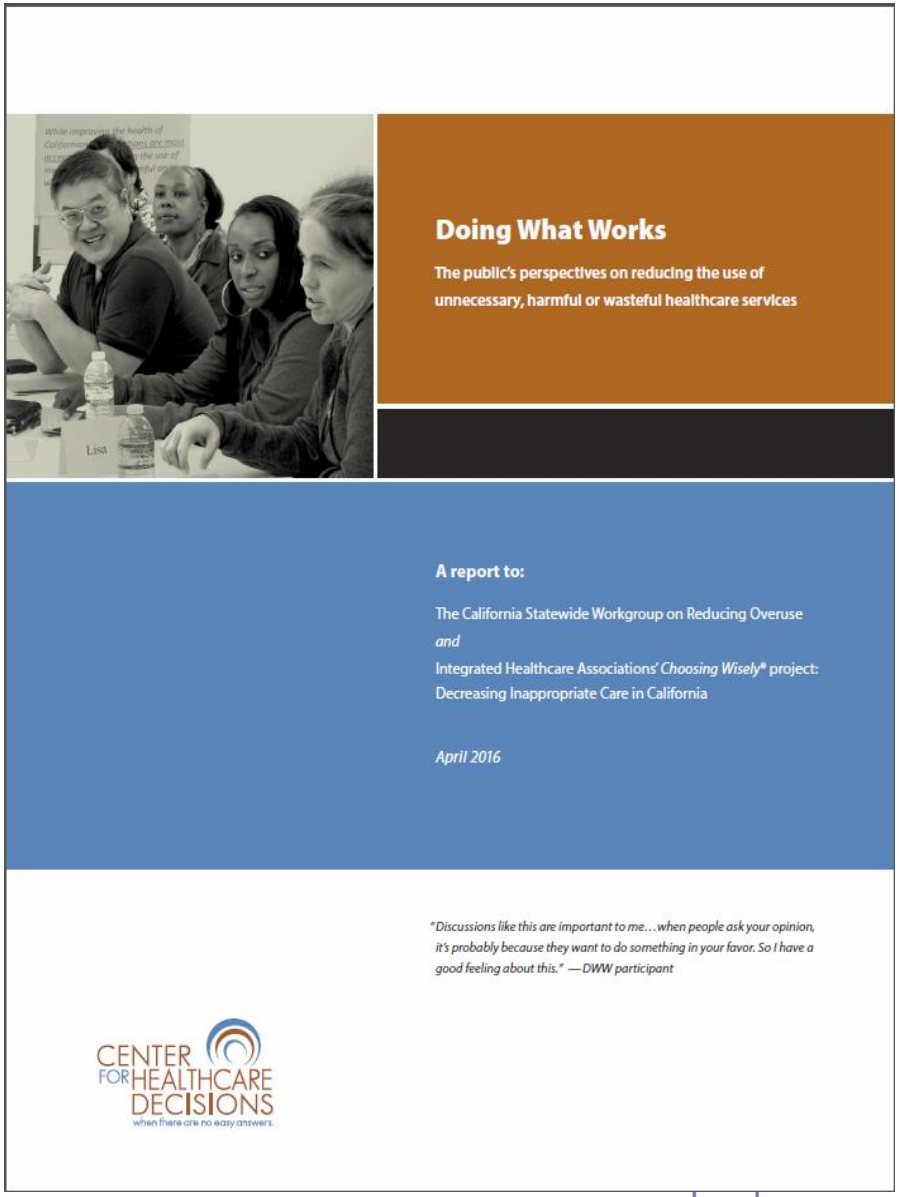
For consideration:

Are these principles reflected in current policy and practice, such as:

The Choosing Wisely ® program
CalPERS' reference pricing
CA's pay-for performance
"Blended" case rates for all first-time births

Questions and comments?

Full report available at CHCD.org



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Jeffrey Rideout
MD, MA, FACP

President and CEO
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Introduction to IHA Value of Care Programs

CalPERS Board of Administration Offsite
July 18, 2017

IHA's Strategic Focus and Key Priorities

Performance measurement & benchmarking	Industry efficiency collaborations ("utilities")	Key Stakeholder convening
Consolidated Atlas/VBP4P **Operational efficiencies** **ACO measure set** **Medi-Cal measure set** **Behavioral Health measure set**	**Encounter Data** **Provider Directory**	**High quality BoD meetings** **Convene QI/operations leads**

CA Regional Health Care Cost & Quality Atlas

Launched in 2016, the Atlas highlights variation in clinical quality, hospital utilization, and cost across 19 geographic regions of California and payer types, enabling “hot spotting” for targeted improvement efforts. Atlas 1 data cover 24 million lives in commercial, Medi-Cal, and Medicare populations and include 14 measures of quality, utilization and costs. Atlas 2, coming in late 2017, will expand to cover 30 million lives and more than triple the number of measures, including overuse and additional sub-populations like ACO members.

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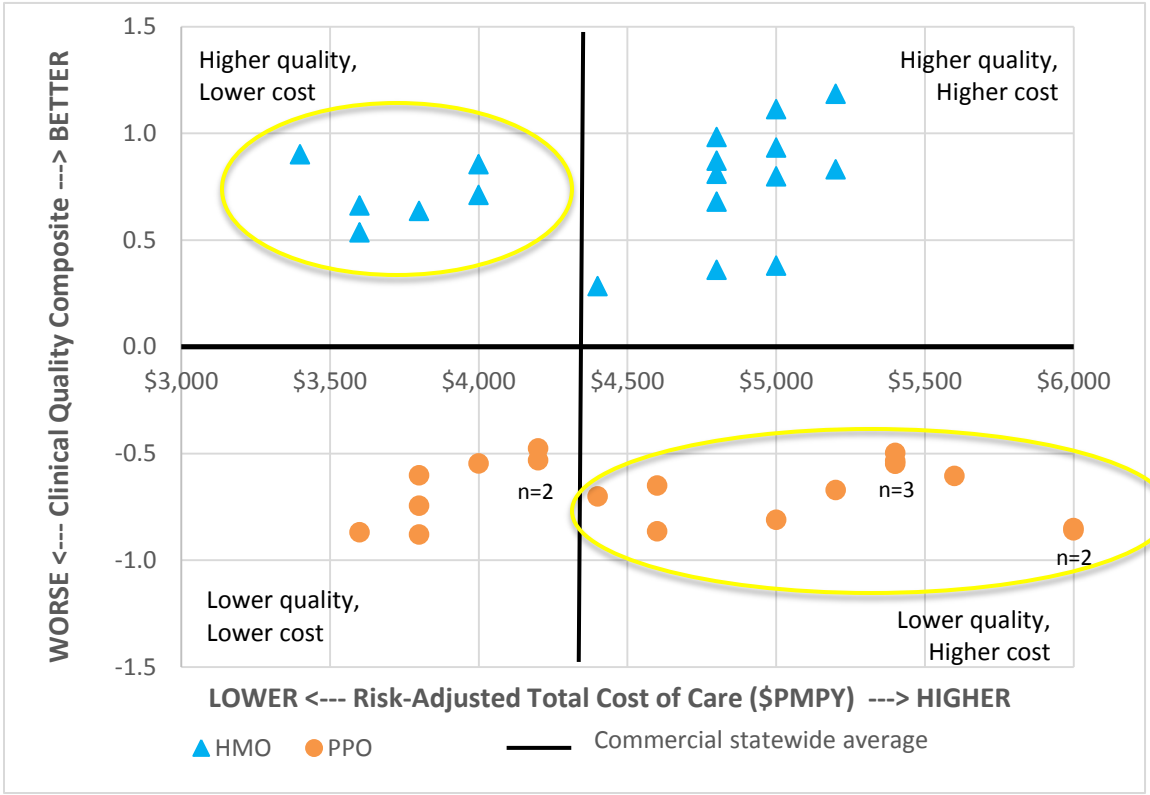
Atlas Key Findings

- Integrated care is superior value to non-integrated when patient cost share is included
  - HMO quality is 48% higher than PPO on average
  - HMO cost is 5% lower
- Striking regional variation in quality and cost regardless of product type
  - Price of services drives total cost >> volume of services used

Integrated Care Value (HMO vs PPO commercial)

Linking California Commercial HMO and PPO Quality and Cost Performance, 2013



- Only HMOs fall into the higher-quality, lower-cost quadrant
- Only PPOs fall into the lower-quality, higher-cost quadrant

Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.
Notes: Region 13, Eastern Counties, is excluded because of insufficient data. When data points overlap on the chart, the number of regions represented is labeled as "n=" on the chart. All cost values are risk adjusted and rounded to the nearest $200.

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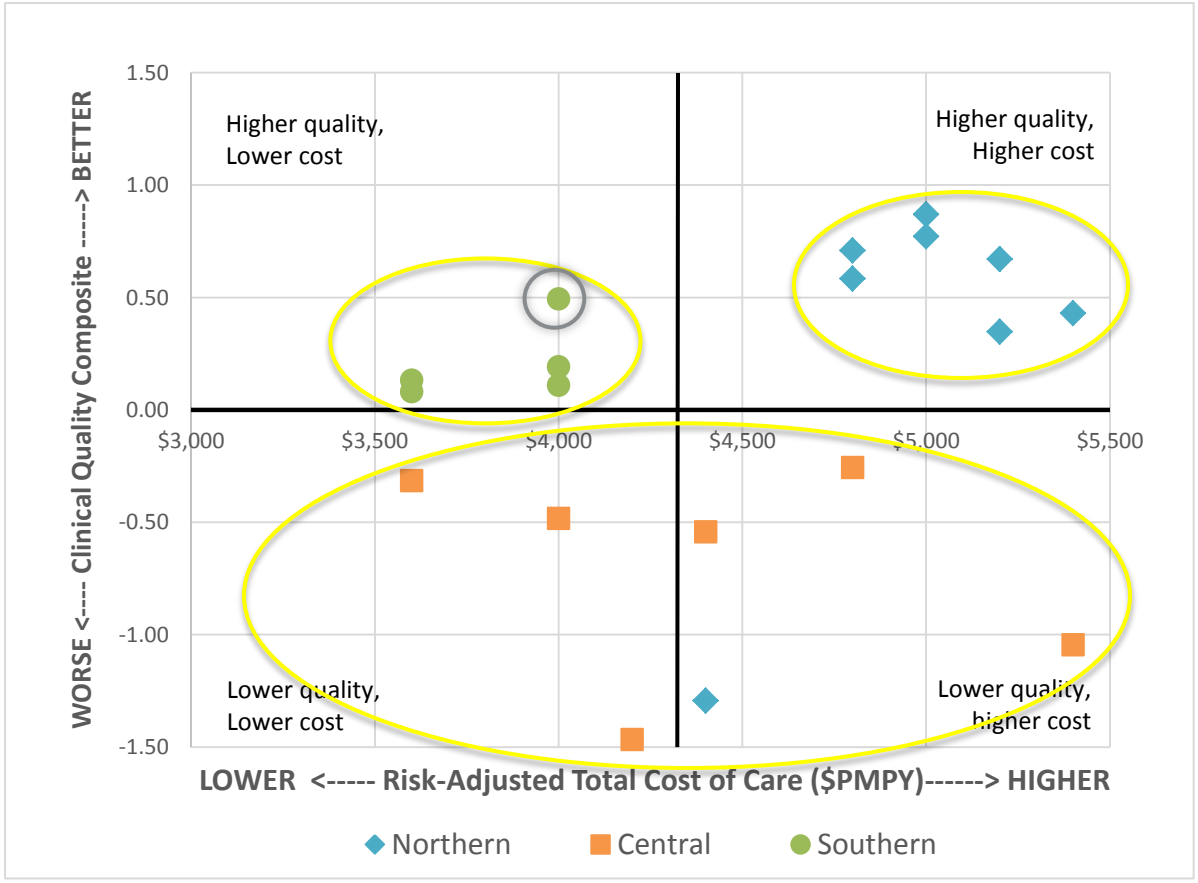
The Regional Value Equation (commercial)

California Commercial Cost-Quality Performance, by Region, 2013

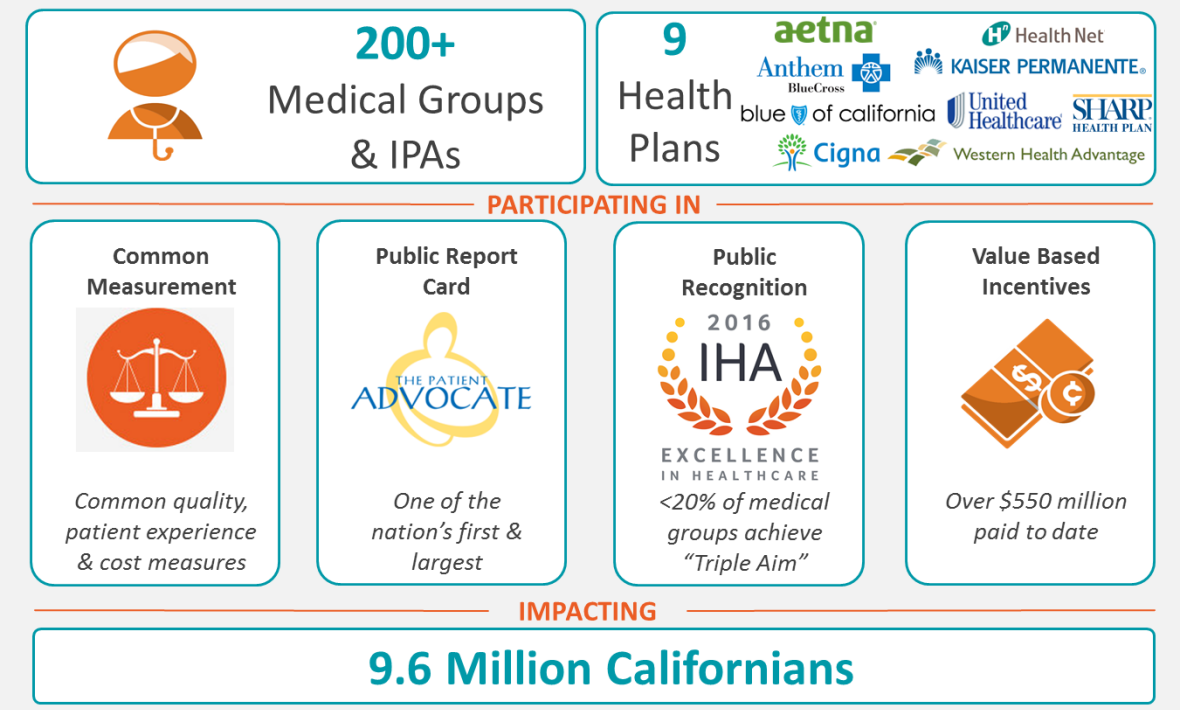


Source: California Regional Health Care Cost & Quality Atlas, commercial HMO and PPO 2013 data.

- All Northern regions in higher-quality, higher-cost quadrant except Region 1, Northern Counties
- All Southern regions in higher-quality, lower-cost quadrant
- All Central regions in lower-quality quadrants but with mixed costs
- If all regions performed like San Diego
  - 200,000 more people screened for colon cancer
  - 50,000 more women screened for breast cancer
  - $4.4 B saved (10%)

Value Based Pay for Performance (VBP4P)

Launched in 2003, VBP4P is a statewide performance improvement program and one of the nation's largest Alternate Payment Models (APM). IHA information demonstrates the care delivered by integrated physician organizations outperform non-integrated networks by an average of 48% on quality and 5% on cost.



VBP4P Key Findings and Accomplishments

- **Lasting and meaningful gains in quality performance** – 58,000 more diabetics had their blood pressure controlled and 280,000 more adults received appropriate colorectal cancer screening in 2015 compared to 2008
- **Successes of highest performing groups** – more than 40,000 diabetics would be under control and nearly $4 billion could be saved if all groups matched the performance of the high performing groups
- **Substantial opportunity to target performance improvement** – 600,000 members currently receive care from lower performing groups
- **Robust results** – without the program, half of health plan rates for provider groups would not meet validity standards for measurement
- **Trusted Governance structure** – voluntary participation representing over 95% of commercial HMO membership in California
- **A leading set of aligned, common measures and benchmarks** – currently in 14th year of measurement
- **Value based** – incorporated Total Cost of Care in measurement and reporting and implemented alternative payment model incentive design

VBP4P ACO Measurement Program

Objective: Establish common statewide measures and benchmarks for commercial ACOs; broaden IHA's measurement footprint beyond VBP4P; influence a national ACO measure set

Approach: Leverage existing performance measurement infrastructure

- Incorporate into existing IHA data collection processes
- May include public reporting and recognition
- Will **not** include standard incentive design

Measure Set: standard, broadly aligned consensus measure set including:

- Clinical quality
- Patient experience
- Resource use
- Total cost of care

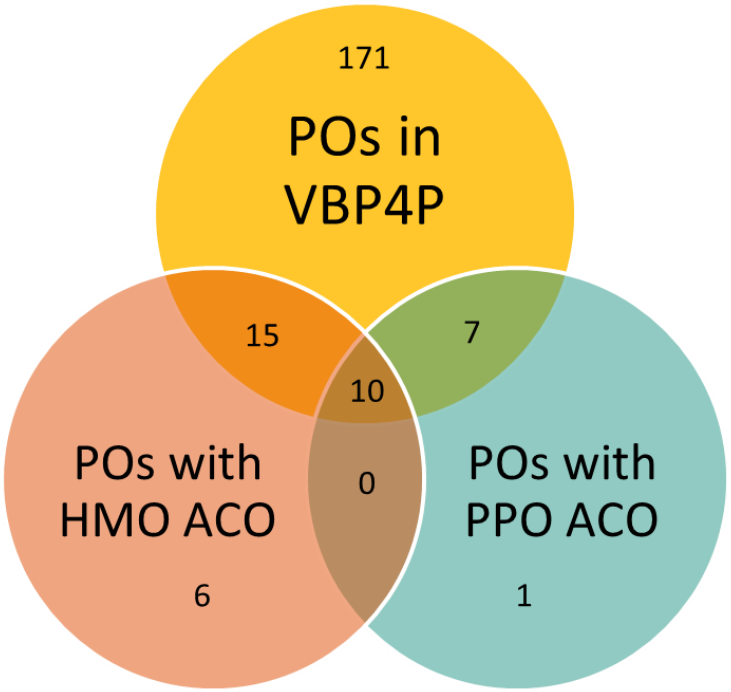
Alignment with Other ACO Initiatives

Strong coverage of key sets: Proposed ACO measure set generally covers at least half of the measures in other sets and is reflective of health plan, provider, and purchaser priorities.

Health plan ACO sets	39%
CMS-AHIP ACO & PCMH Core Set	59%
NCQA Accreditation	59%
CPR ACO Collaborative set	65%
CMS Pioneer & MSSP ACO (subset)	32%
MIPS (subset)	52%

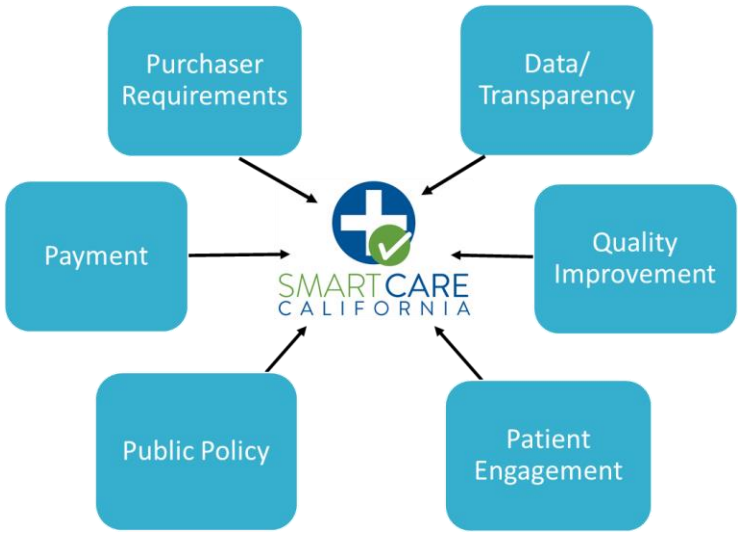
Best of all- Most ACOs already in VBP4P Program

Broad overlap with existing VBP4P participants – **over 80% of POs with ACO contracts already participate in Value Based P4P**



Smart Care California

Smart Care California is a public-private partnership working to promote safe, affordable health care in California. The group currently focuses on three issues: C-sections, opioid overuse and low back pain. Collectively, Smart Care California participants purchase or manage care for more than 16 million Californians—or 40 percent of the state. IHA convenes and coordinates the partnership with funding from the California Health Care Foundation.



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Smart Care- Accomplishments & Opportunities

Key Accomplishments:

- Created statewide priorities for reducing overuse by aligning stakeholders and leveraging existing state efforts, such as CMQCC for C-section, Stanford CERC for low back pain, and CDPH for opioids
- Developed annual honor roll award recognizing hospitals meeting or surpassing the national Healthy People 2020 goal of 23.9% for C-section births among low-risk mothers. The inaugural award was announced in October 2016 by CHHS Secretary Diana Dooley on behalf of Smart Care.
- Convened five multi-stakeholder workgroup meetings since June 2015

Key Opportunities:

- Align payment levers (e.g. contract requirements, benefit design) to reduce overuse
- Influence clinician and patient behavior to reduce overuse
- Encourage adoption of workgroup activities beyond current participants
- Attract participation from additional large self-funded purchasers and plans

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Minnesota's Tiered Network Health Plan for State Employees:

Containing Cost Through Member and Provider Incentives

Josh Fangmeier

July 18, 2017

CalPERS Board of Administration Offsite Meeting

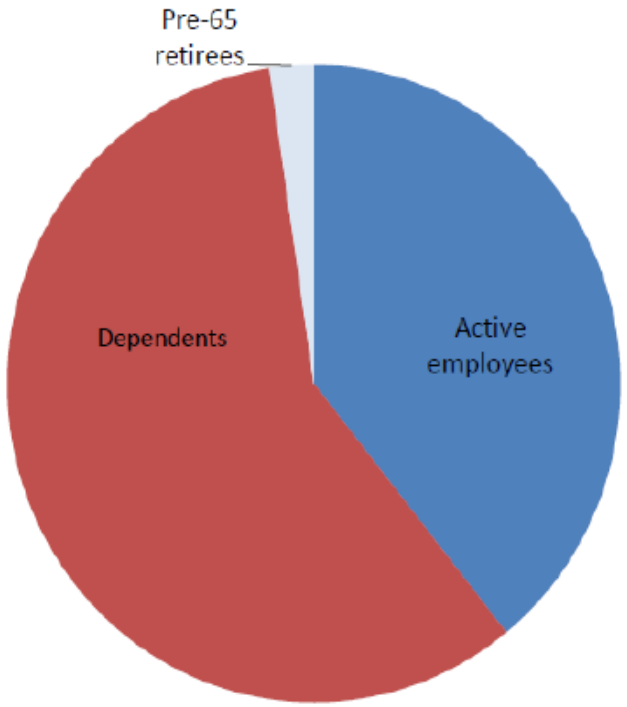
Monterey, CA

Minnesota State Employee Group Insurance Program (SEGIP): Background

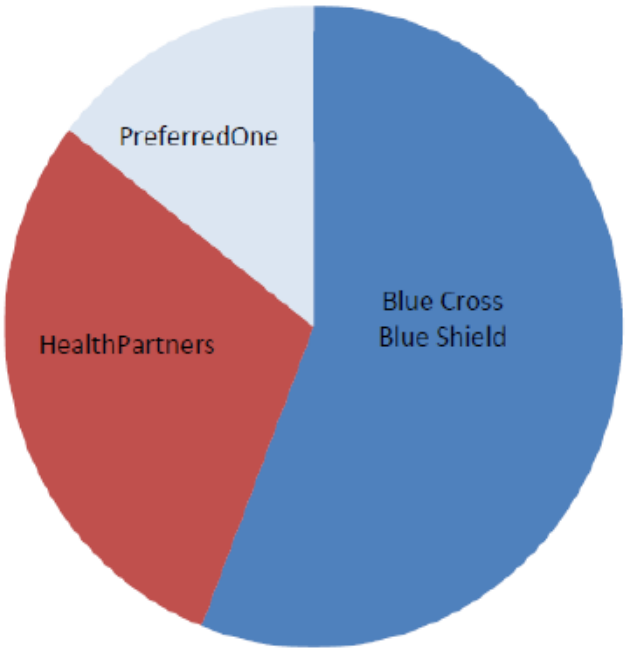
- Largest employer purchaser of health care in Minnesota (127,000 covered lives plus 23,000 in separate plan for local gov't units)
- Tiered network based on total cost of care since 2002: Minnesota Advantage Health Plan
  - Gatekeeper model: members select a primary care clinic (PCC) and must generally get referrals for other care
  - Members may change their PCC at any time (monthly)
  - Family members may choose PCCs at different cost levels
  - Provides broad choice of providers, with incentives to choose lower-cost providers

Advantage Health Plan Enrollment Overview

Over 127,000 Members



3 Health Plan Administrators



Advantage – 2016/2017 Benefit Plan Design

Benefit Provision	Level 1	Level 2	Level 3	Level 4
First $$ Deductible for ALL Services (except drugs and preventive) (S/F)	$150/$300	$250/$500	$550/$1100	$1250/$2500
Office Visit Copay (waived for preventive)	$30*	$35*	$65*	$85*
Convenience Clinic Office Visit Copay (not subject to deductible)	$10	$10	$10	$10
Emergency Room Copay	$100	$100	$100	25% coinsurance annual deductible applies
Per Admission Copay	$100	$200	$500	
Per Outpatient Surgery Copay	$60	$120	$250	
Coinsurance for MRI/CT Scan Services	5% after deductible	10% after deductible	20% after deductible	25% after deductible
Coinsurance for Services NOT Subject to Copays	5% after deductible	5% after deductible	20% after deductible	25% after deductible
Copay for Prescription Drug Plan (30 day supply)	$14 Tier1/ $25 Tier 2/ $50 Tier 3			
Maximum Drug OOP Limit (S/F)	$800/$1600			
Maximum Non-Drug OOP Limit (S/F)	$1200/$2400	$1200/$2400	$1600/$3200	$2600/$5200

**Employees who have completed a Health Assessment and agreed to accept a health coach call are entitled to a $5 copayment reduction.*

Tiering Strategy - Overview

- Benefit design sorts health care providers into tiers based on their costs
  - Member cost sharing (deductible, copay, etc.) varies by cost tier
  - Encourages members to use lower-cost providers
- This strategy has also proven to be a powerful incentive for providers to try to get into the low-cost tiers
- SEGIP has long negotiated "special deals" with providers to reduce costs for more favorable tier placement
  - Historically, based on reductions in unit price
  - More recently, also includes risk sharing/shared savings arrangements

How the Tiering Works

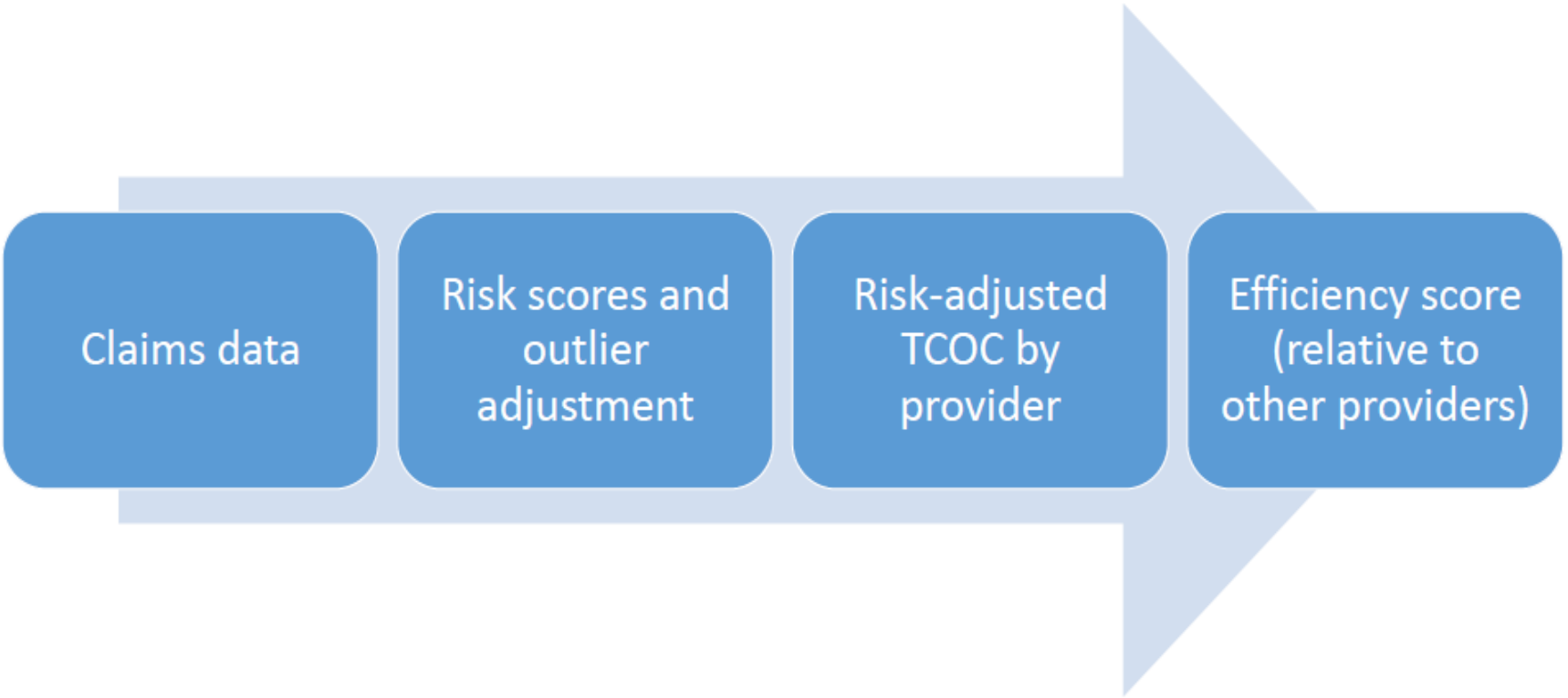
- Each year, primary care clinics (PCCs) are preliminarily assigned to one of 4 cost levels based on total cost of care:
  - Total cost of care provided to members who designated that PCC
  - Includes all paid claims for care, regardless of source/service
  - Makes adjustments for differences in risk across PCC populations and for high-cost cases
- Analysis is done in April each year, using prior year's claims data
  - Also includes provider-specific expected increases in prices for the upcoming plan year, provided by TPAs

How the Tiering Works

- Tiering typically done at medical group (care system) level –but sometimes by medical group and region
- Level of aggregation depends on provider size/membership:

Less than 10,000 member months	10,000+ member months	10,000+ member months with each TPA
Tiered by region, together with other "independent" groups	Medical group tiered for the Advantage Plan as a whole	Medical group tiered independently by TPA

Analysis Steps



Sample Results

Provider Group	Risk Adj TCOC
Provider 48	$344.38
Provider 43	$372.15
Provider 42	$376.99
Provider 27	$377.19
Provider 26	$378.78
Provider 14	$388.94
Provider 11	$394.63
Provider 32	$398.99
Provider 19	$403.06
Provider 56	$403.96
Plan Avg * X%	
Provider 40	$406.22
Provider 6	$406.99
Provider 30	$411.60
Provider 37	$415.79
Provider 64	$415.99
Provider 41	$417.46

Provider Group	Risk Adj TCOC
Provider 17	$418.37
Provider 49	$420.19
Provider 25	$421.32
Provider 53	$426.46
Provider 29	$428.30
Provider 47	$428.86
Provider 28	$430.10
Provider 5	$430.94
Provider 63	$437.51
Provider 3	$439.92
Provider 36	$441.56
Provider 23	$442.18
Provider 13	$442.62
Provider 7	$442.81
Plan Avg * Y%	
Provider 16	$446.04
Provider 9	$448.24

Provider Group	Risk Adj TCOC
Provider 22	$449.29
Provider 50	$451.15
Provider 18	$452.50
Provider 57	$452.90
Provider 44	$454.64
Provider 62	$454.91
Provider 46	$455.09
Provider 4	$457.17
Provider 2	$458.08
Provider 61	$458.89
Provider 8	$463.29
Provider 39	$464.82
Provider 21	$467.28
Provider 54	$472.14
Plan Avg * Z%	
Provider 12	$475.78
Provider 31	$484.31

Provider Group	Risk Adj TCOC
Provider 55	$489.30
Provider 33	$501.53
Provider 20	$504.32
Provider 38	$516.89
Provider 52	$518.41
Provider 15	$519.04
Provider 34	$530.38
Provider 60	$534.74
Provider 35	$537.80
Provider 1	$581.66
Provider 58	$583.42
Provider 45	$588.91
Provider 59	$630.34
Provider 24	$631.72
Provider 51	$691.08
Provider 65	$735.32
Provider 10	$815.11

Tier 1 | Tier 2 | Tier 3 | Tier 4

NOTE: Data above are for illustrative purposes only

Finalizing Tier Placement

Letters to providers

- Inform providers of initial tier assignment
- Provides info on cost performance by service category, comparison to other providers; info on referral patterns

Negotiation process

- Opportunity to negotiate more favorable tier placement
- Price reductions OR risk sharing agreement

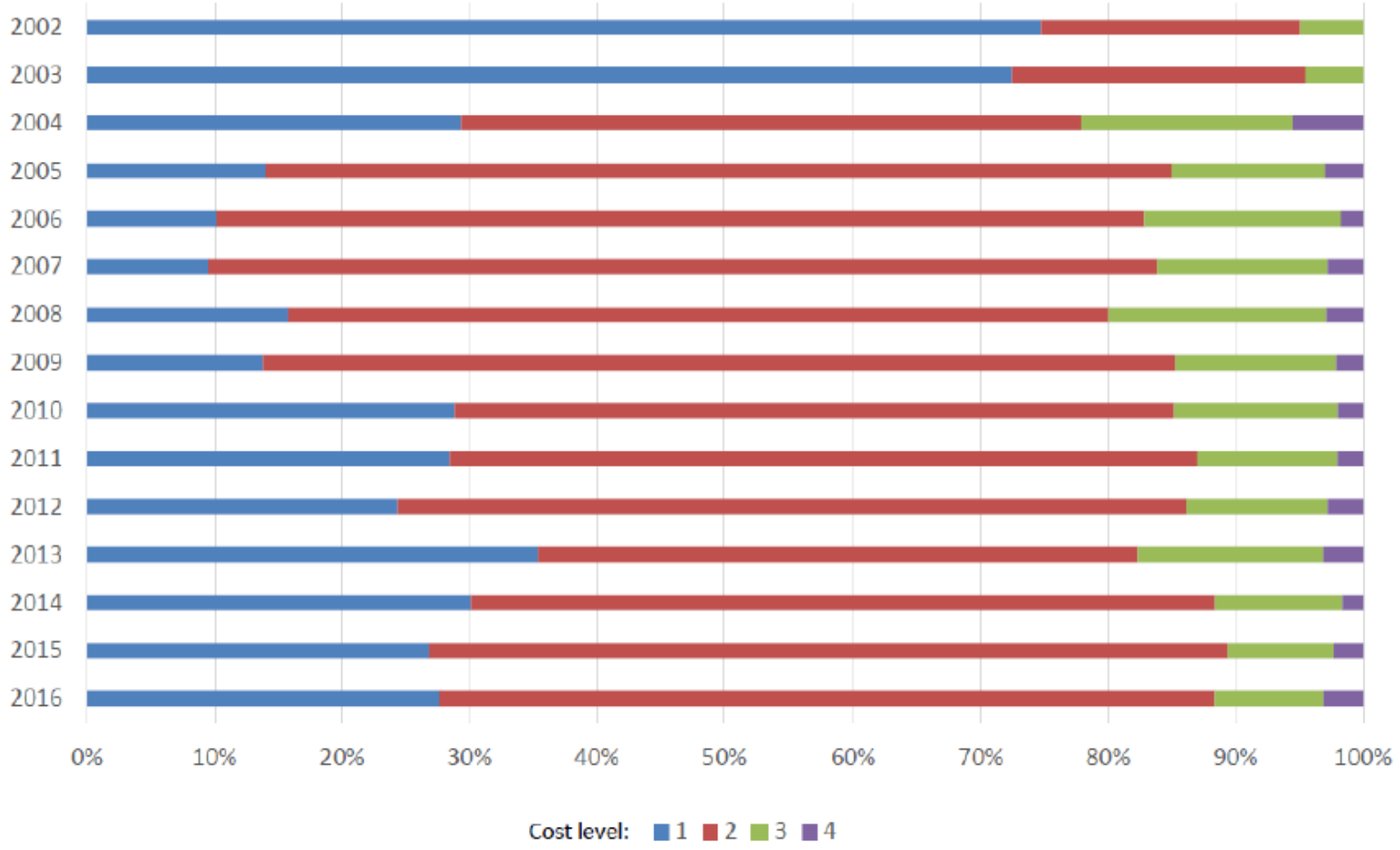
Reassignment for geographic access

- Labor contracts guarantee a clinic at or below cost level 2 within 30 miles of every worksite
- Consultation with labor unions on which clinics to reassign to cost level 2

Results

- Differences in enrollee cost sharing do influence member selection of providers
- Providers are motivated to try to move to lower cost tiers
  - In 2015 approximately 15% of our members chose clinics that had negotiated more favorable tier placement
- New University of Minnesota study funded by RWJF will help to more rigorously identify behavioral changes by consumers and providers in response to tiering

Distribution of Enrollment by Cost Level



Advantages of Tiered Network

- Unlike narrow networks, which also seek to direct members to high-value providers, the tiered network model includes almost all providers. Members can choose higher-cost providers, but must pay more to do so.
- The model includes strong incentives for consumers, but also holds providers accountable for total cost of care and rewards better provider performance (unlike HDHP designs that place all responsibility on consumer)

SEGIP Purchasing Model – What Lies Ahead?

- Expanding use of risk-sharing contracts with providers
  - Incorporating quality metrics into risk arrangements
  - Aligning with other payers (commercial and Medicaid)
- Potential for incorporating quality metrics into tiering
- Monitoring payments through alternative payment models and payments linked to quality
- Assessing potential of other value-based strategies –e.g. reference pricing, bundles, centers of excellence
- Building analytic capacity to better monitor cost, quality, and impact of strategies

Panel Q&A

Question #1

How do you address the differences between the **consumer point of view vs provider point of view** for high value care?

Question #2

Even though CalPERS is partnering and developing strategies around the value of care from the patient, provider, and purchaser point of view, **which strategies are most likely to lead to the largest gains?**

Question #3

What questions should we answer in regard to high value care when considering a **potential redesign of PERS Select**?

Open Q&A