Delaware Center for Health Innovation

Host: Health Care Spending Benchmark Summit

Establishing the Benchmark

September 7, 2017

WELCOME

DHSS

Delaware Health Care Commission

September 7 Summit Agenda

Time	Topic
11:15 - 11:25am	Welcome and Opening Remarks
11:25 – 11:55am	The Impact of Rising Health Care Costs and Options for Delaware
11:55am – 12:10pm	Q&A
12:10 - 12:30pm	Creating Value and Lowering Costs: Perspectives from a Delaware ACO
12:30 – 12:45pm	Q&A
12:45 – 1:05pm	Convening Stakeholders and Employers for Payment Reform: Massachusetts Experience
1:05 - 1:20pm	Q&A
1:20 - 1:40pm	Considering Economic Evaluation and Data-Driven Policy Analysis: A View from Vermont's Approach
1:40 - 1:55pm	Q&A
1:55 - 2:00pm	Closing Remarks

Establishing the Benchmark

PANEL

Moderator:

Tom Brown, Co-Chair, DCHI Payment Model Monitoring Committee

Panelists:

- **Zeke Emanuel** - University of Pennsylvania Department of Medical Ethics and Health Policy
- **Farzad Mostashari** – Aledade, Inc.
- **Audrey Shelto** – Blue Cross Blue Shield of Massachusetts Foundation
- **Christine Eibner** – RAND Corporation

Q&A and Discussion

The Impact of Rising Health Care Costs and Options for Delaware

Zeke Emanuel, M.D., Ph.D. – Chair, University of Pennsylvania Department of Medical Ethics and Health Policy

Looking Ahead: The Future of American Health Care

Ezekiel J. Emanuel, M.D., Ph.D.

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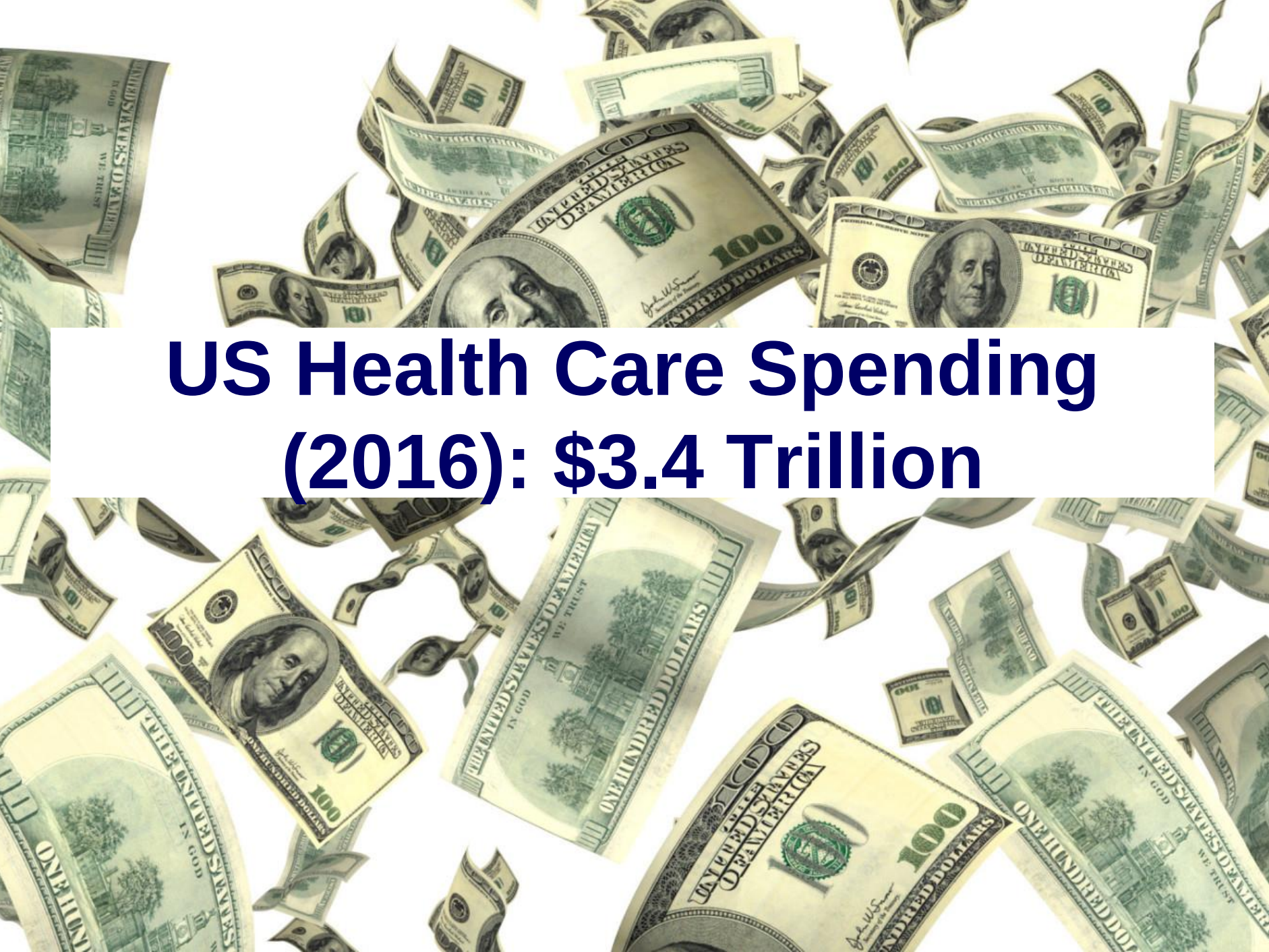
*Some slides adapted from those developed by Amol Navathe – many thanks.



US Health Care Spending (2016): $3.4 Trillion

Rx for Cost Cutting

	GDP (nominal) in 2015	Rank
USA	$17.90 trillion	#1
CHINA	$10.86 trillion	#2
JAPAN	$4.12 trillion	#3
GERMANY	$3.35 trillion	#4
UK	$2.94 trillion	#5
FRANCE	$2.42 trillion	#6
INDIA	$2.07 trillion	#7

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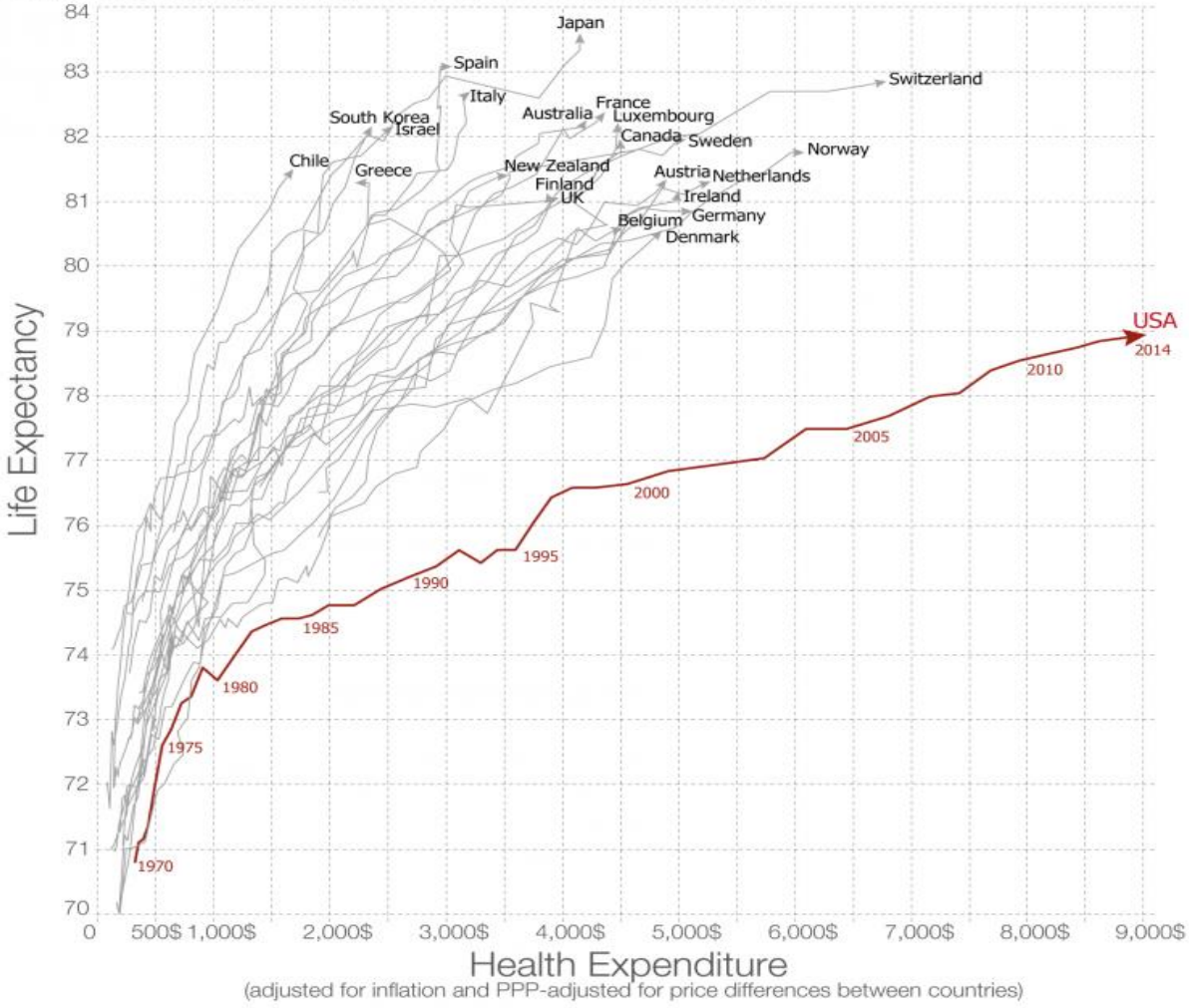
Life expectancy vs. health expenditure over time (1970-2014)

Our World in Data

Health spending measures the consumption of health care goods and services, including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments. Shown is total health expenditure (financed by public and private sources).



Data source: Health expenditure from the OECD; Life expectancy from the World Bank Licensed under CC-BY-SA by the author Max Roser.
The data visualization is available at OurWorldinData.org and there you find more research and visualizations on this topic.

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Two Trends

Measure	USA	FRANCE	GERMANY
Health Care Cost per person (2015, PPP)	$9,451	$4,407	$5,267
Average Life Expectancy	79.3 (31st)	82.4 (9th)	81.0 (24th)
Infant Mortality (per 1,000 births)	5.80	3.30	3.20
Cancer 5 year survival Breast Colon Childhood Leukemia	 88.6% 64.7% 87.7%	 86.9% 59.8% 89.2%	 85.3% 64.6% 91.8%
Years of life lost (per 100,000 inhabitants aged 0-69)	4,600	3,100	3,000
WHO Health System Ranking*	37	1	25

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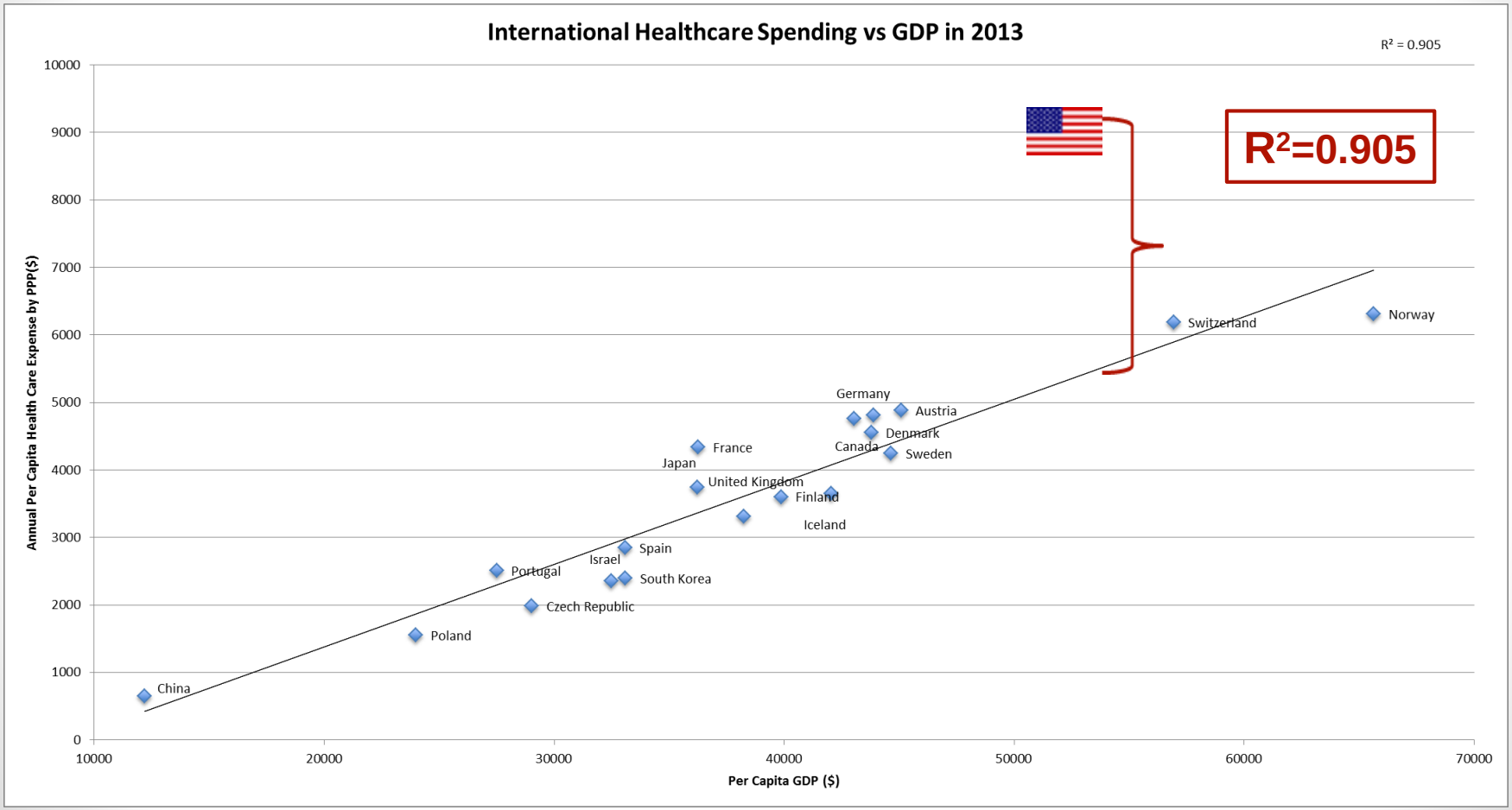
* Based on a composite score of health, health inequality, responsiveness-level, responsiveness distribution, and fair financing.

US Spending vs. Other Countries



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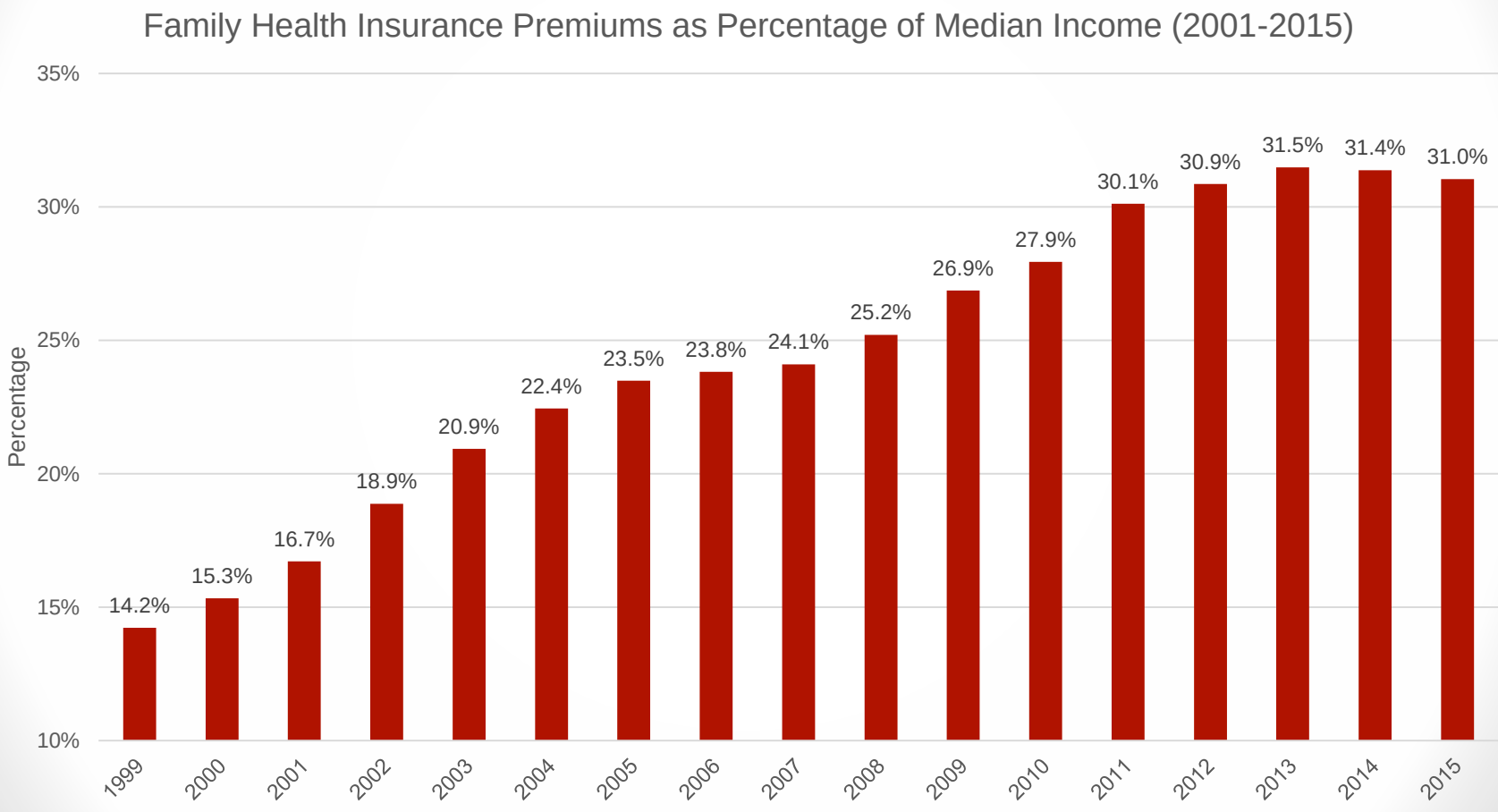
Source: World Bank, 2013

Affordability Index



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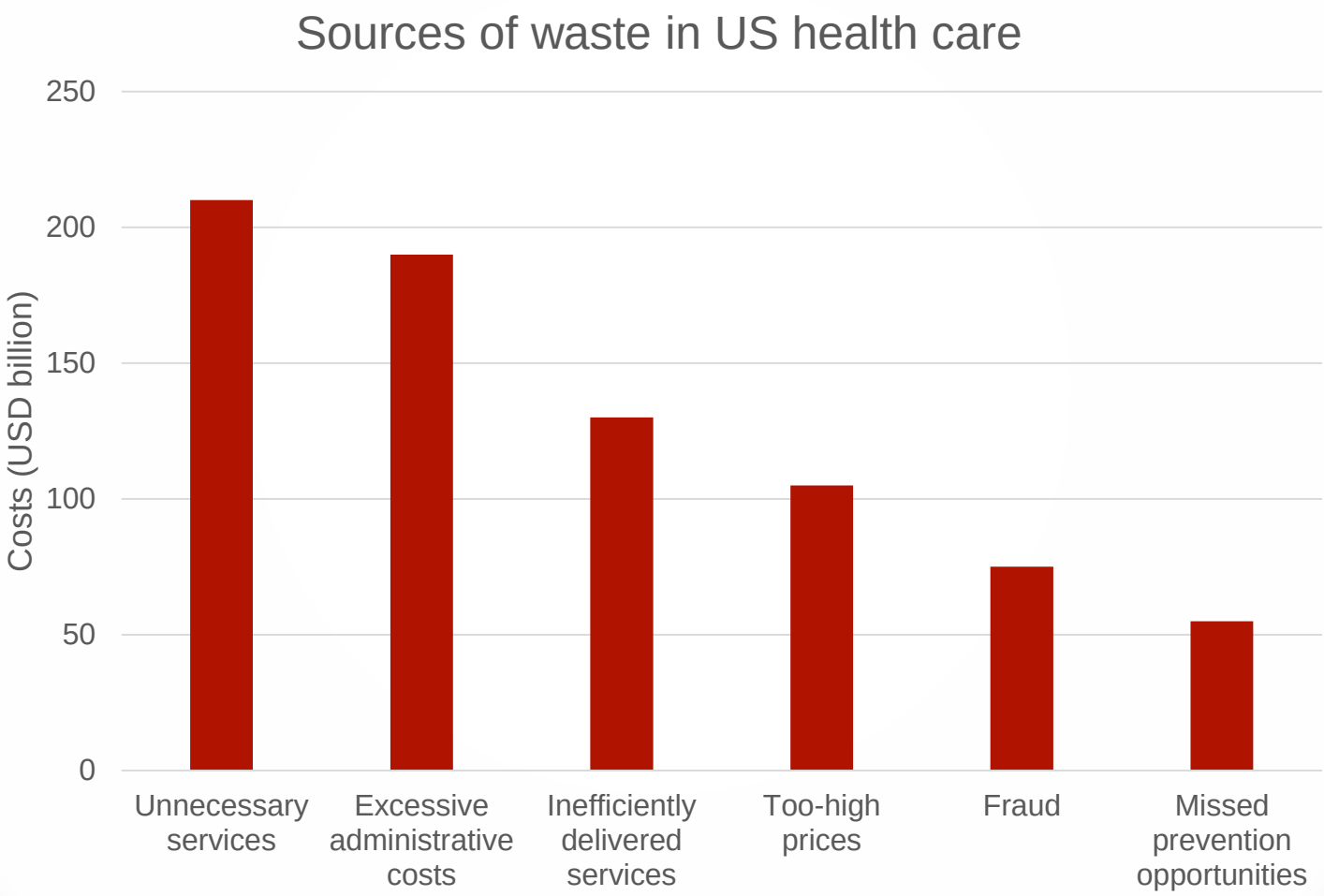
Waste in Health Care



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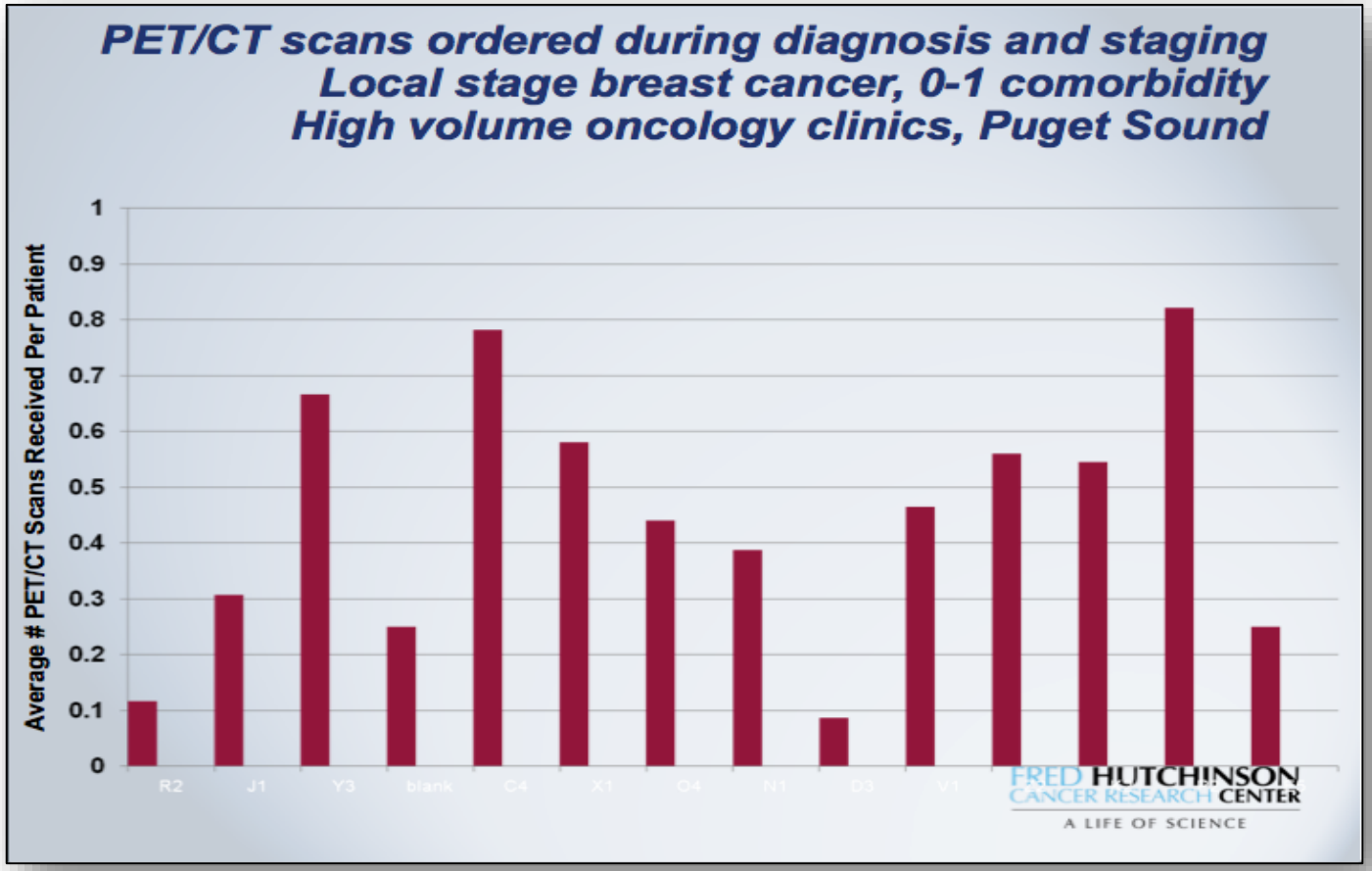
Adapted from Vox and the Institute of Medicine

Unnecessary Services



Source: Scott Ramsey. How Should We Define Value in Cancer Care. IOM Affordable Cancer Care Workshop. 8 Oct, 2012.

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Inefficient Care

- Inefficient delivery of services costs the US **$130 billion** a year.

- Ex: prescribing 7 weeks of radiation therapy for breast cancer, when a 3-week regiment has been shown to produce the same results.

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Pricing Failures

- Unreasonably high prices for medical items costs the U.S. at least **$105 billion** a year.

- Ex: Medicare pays **$2,062** for cardiac imaging done in-hospital, compared to **$626** done in-office.

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Payment Model Framework

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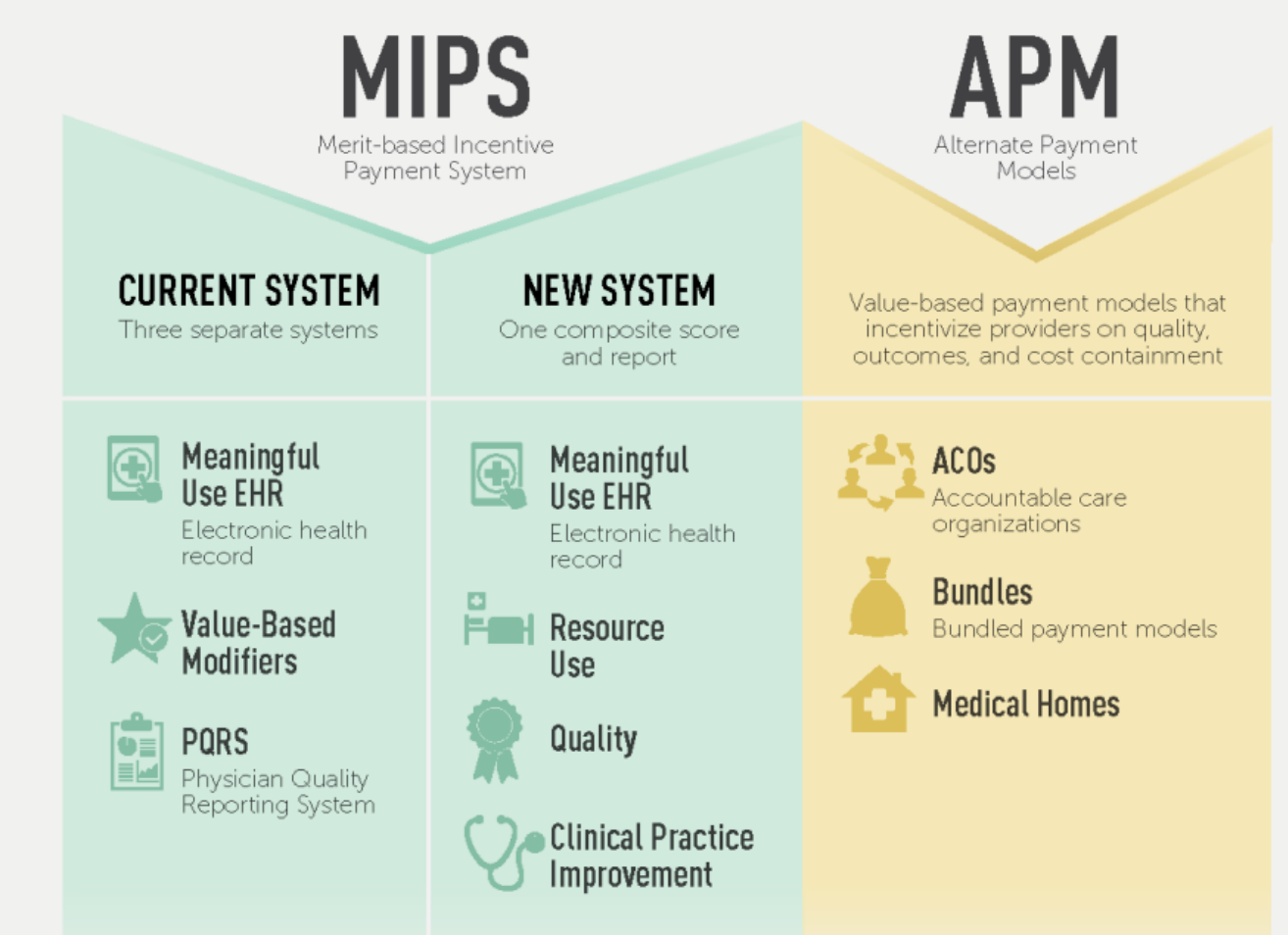
MACRA



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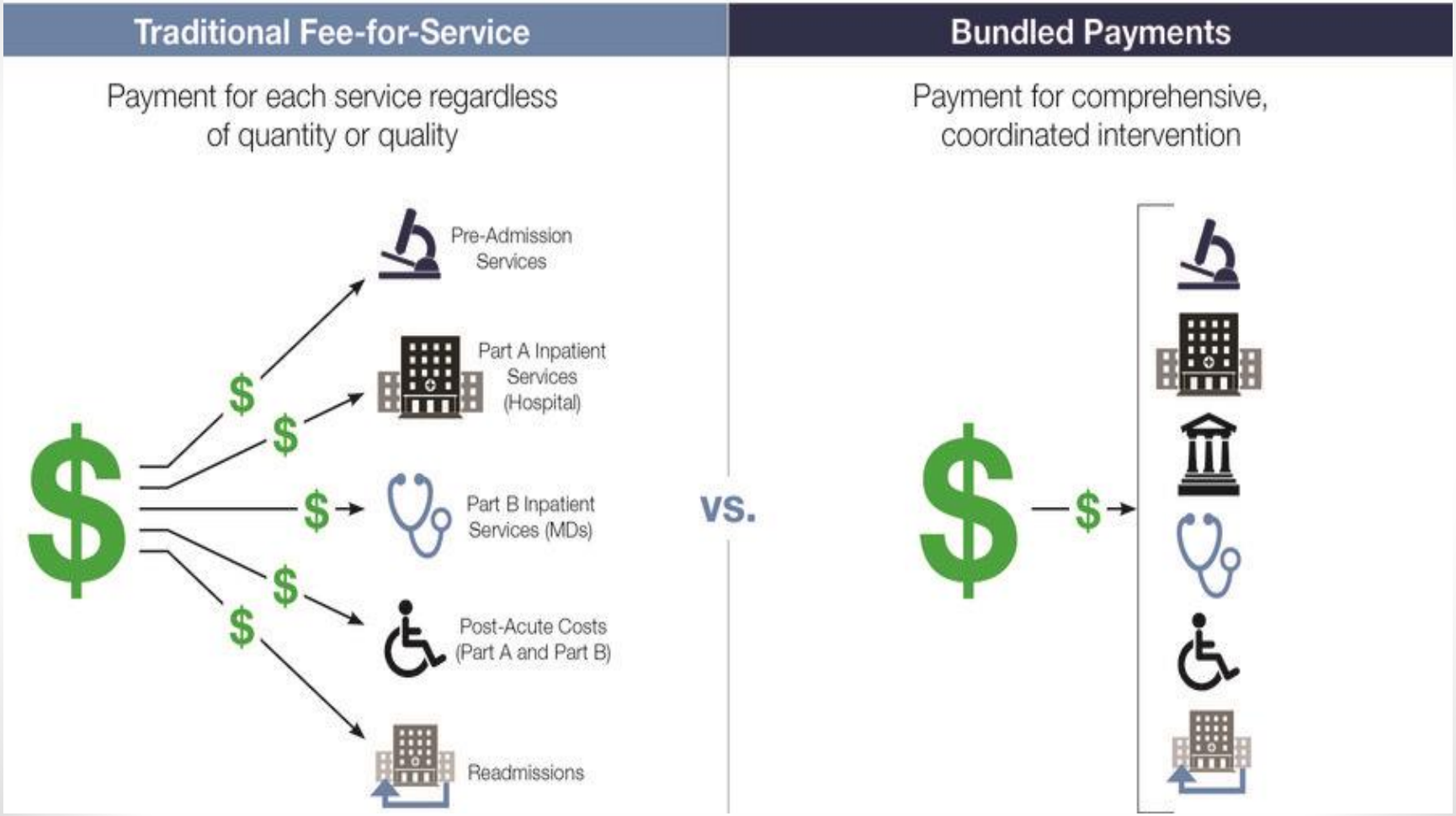
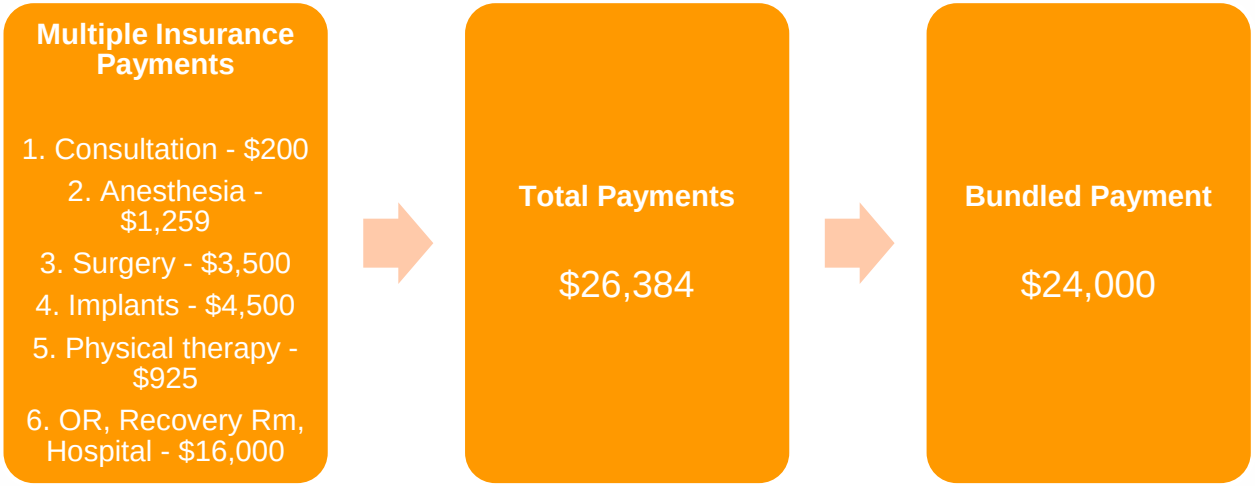
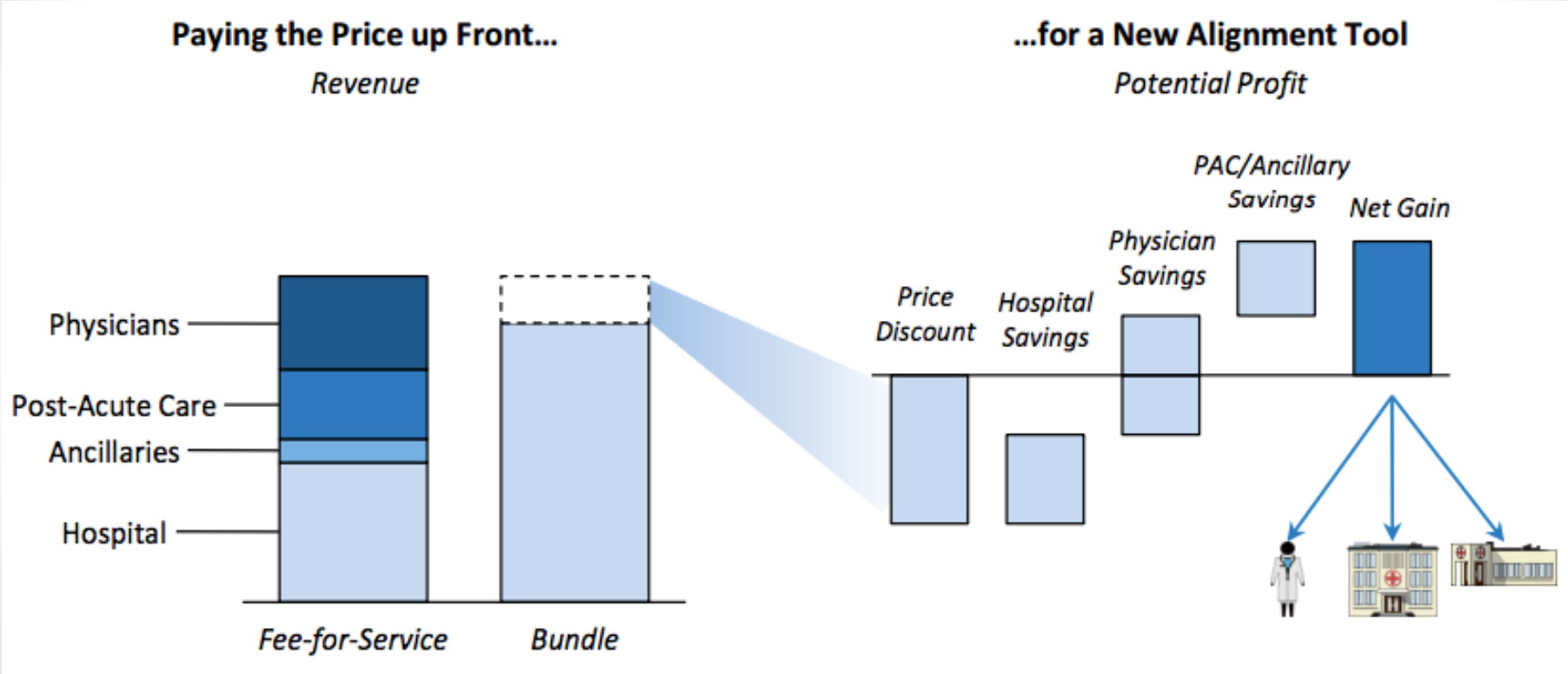
Paying for Episodes



Pricing the Bundled Payment



Savings in Bundled Payment



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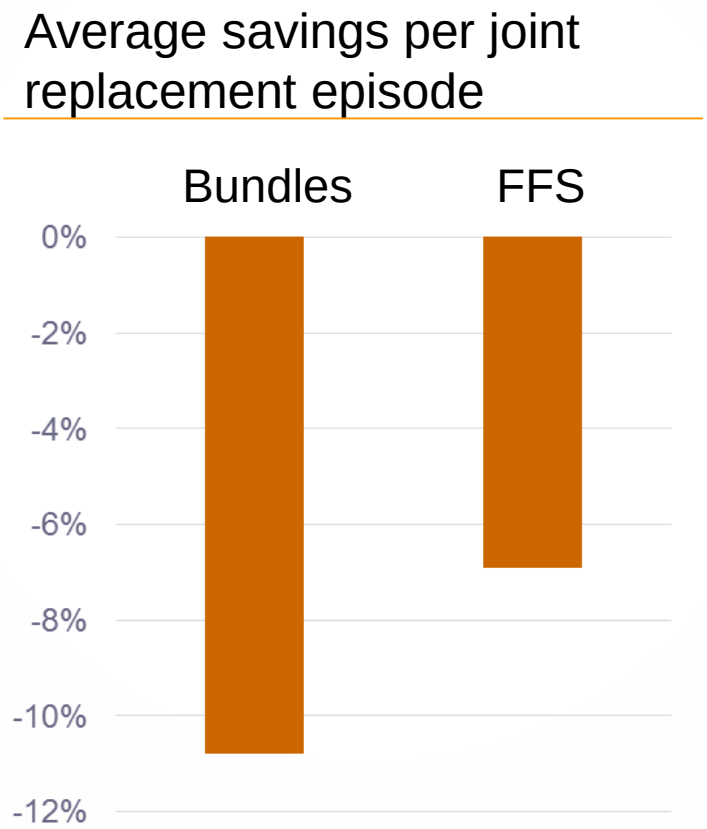
Early Evidence Mostly Positive



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Dummit LA, Kahvecioglu D, Marrufo G, et al. Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes. JAMA. Published online September 19, 2016. doi:10.1001/jama.2016.12717.

Quality

Dimension	Effect of Bundled Payment
Mortality	⟷
Readmission/ER Use	⟷
Walking up and down 12 stairs	↑ 6%
Pain limiting activity	↓ 4%
Patient Satisfaction	⟷

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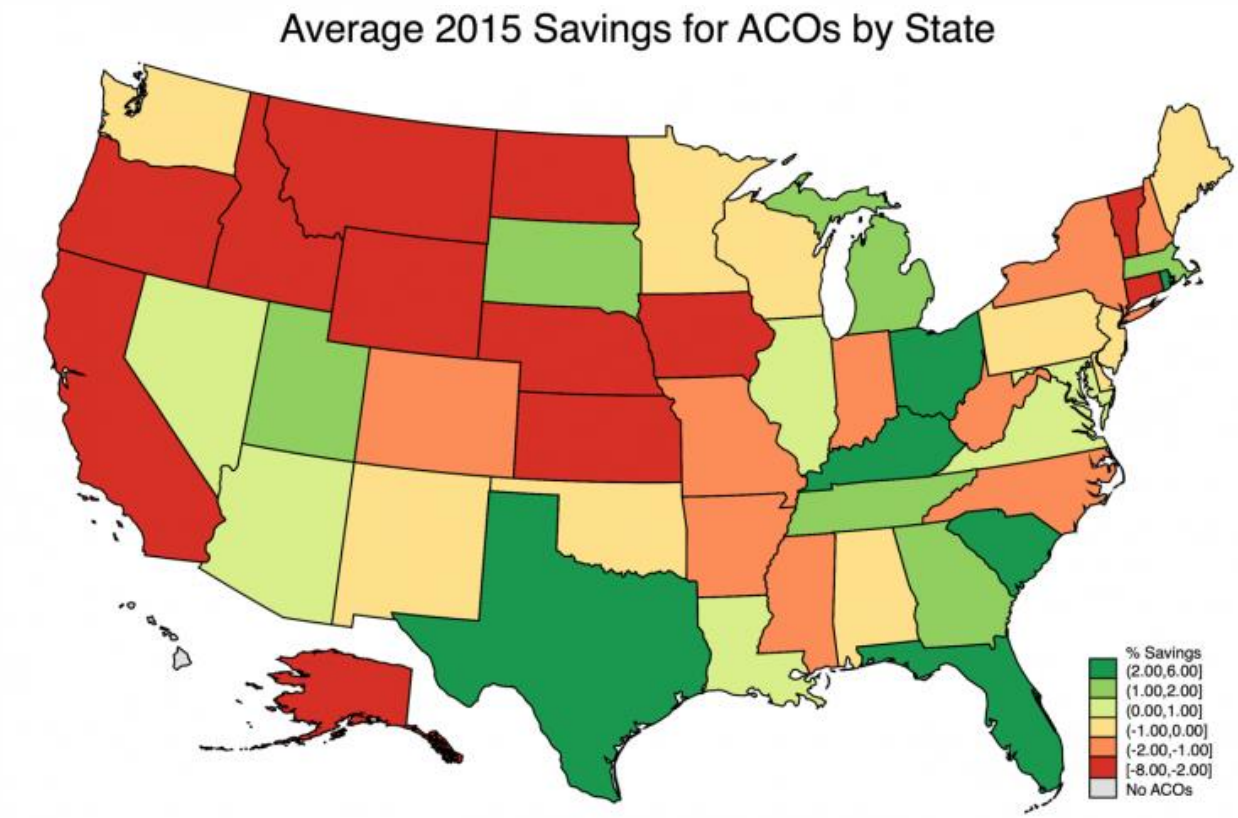
Dummit LA, Kahvecioglu D, Marrufo G, et al. Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes. JAMA. Published online September 19, 2016. doi:10.1001/jama.2016.12717.

ACO Results



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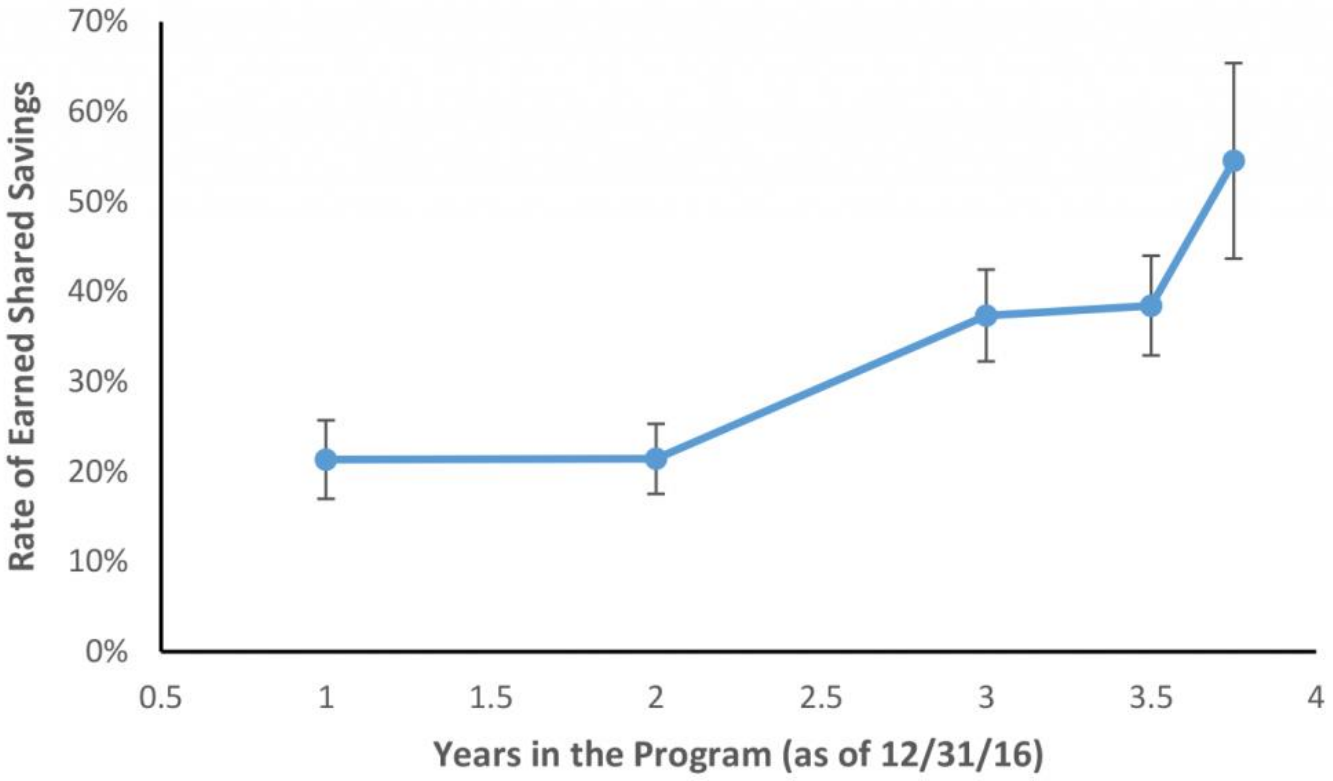
Source: David Muhlestein, Robert Saunders, and Mark McClellan. Medicare Accountable Care Organization Results For 2015: The Journey To Better Quality And Lower Costs Continues. Health Affairs Blog. September 9, 2016

ACO Results



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Source: David Muhlestein, Robert Saunders, and Mark McClellan. Medicare Accountable Care Organization Results For 2015: The Journey To Better Quality And Lower Costs Continues. Health Affairs Blog. September 9, 2016

What will the future of American health care look like?

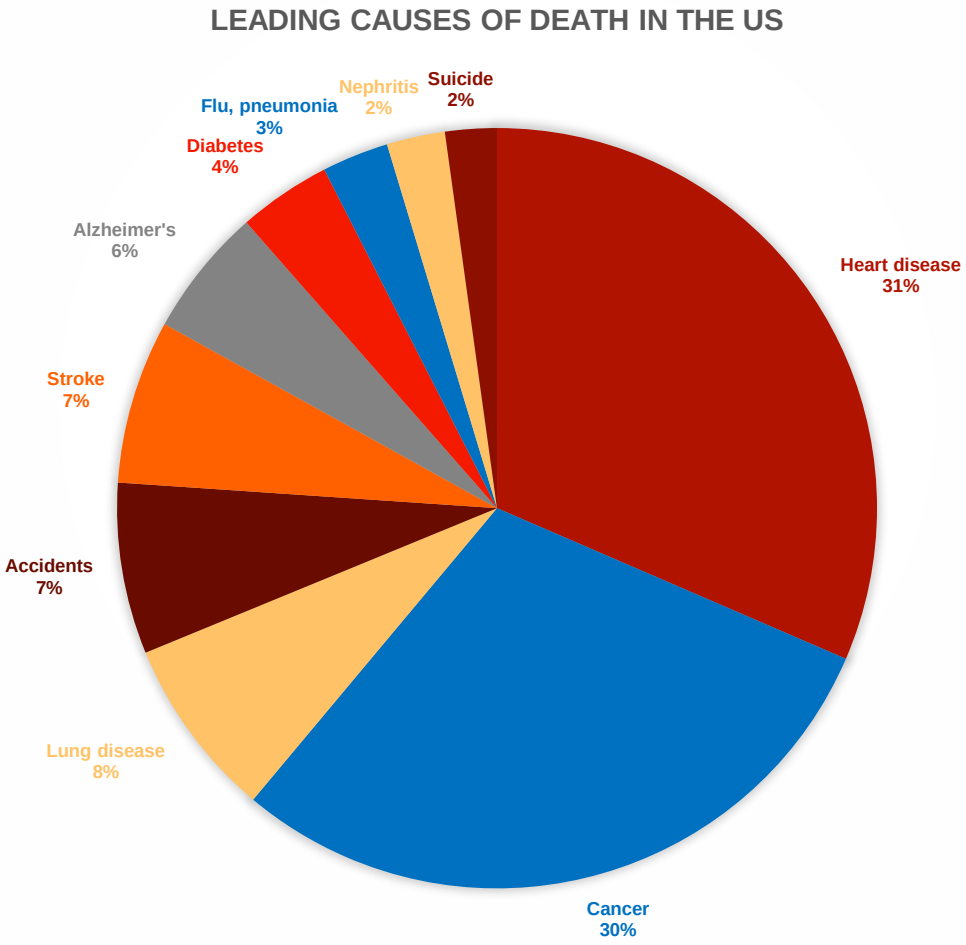
Future Trends of High-Value Care

1. The dominance of **chronic conditions**.

2. The **deinstitutionalization** of care.

3. **Standardization** and **performance measurement / feedback**.

Chronic Conditions



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Adapted from DHHS Publication No.201701232

Deinstitutionalized Care

Hospital Visits

- 34.9 million hospital admissions in 2014

Outpatient Visits

- ~1 billion outpatient visits in 2014

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Brewing Co.
Temecula, CA
BLIND PIG
SECOND ANNIVERSARY
ALE
Brewed and Bottled by The
Blind Pig Brewing Company
Inc., Temecula, CA
12 FL OZ. CA CASH REFUND
In celebration of Blind Pig's sec-
ond anniversary, the brewers
have created yet another hoppy
ale.
The style of this unfiltered ale
is what brewer Vinnie Cilurzo
calls a "Double IPA". Generous
portions of hops were added in
various stages of the brewing
process. In fact, it contains al-
most twice as many hops as the
regular IPA.
We hope
"Double
paired w
food. In
Blind Pig
will age g
for years


TANZANIA
ECUADOR
HONDURAS
ECUADOR
PHILIPPINES
72% DARK CHOC
70% DARK CHOCOLATE
+ COCOA NIBS
70% DARK CHOCOLATE
Askinosie


STAG'S LEAP WINE CELLARS
CASK 23
Cabernet Sauvignon
Estate Napa Valley


ORGANIC
MT TAM
Triple Cream
A truly hand-crafted cheese from the
COWGIRL
CREAMERY
POINT REYES STATION, CA 94956
MARIN


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The 12 Practices

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Chronic Care Coordination

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Chronic Care Coordination

"Let's face it, chronic care management is not rocket science. It's measuring lab values. It's engaging your patients. It's ensuring medication adherence…It's supporting them in doing the right behaviors, and that requires time."

~ Sachin Jain, M.D.

CEO, CareMore

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Chronic Care Coordination

Chronic Care Coordination

"Our number one complaint is that they [patients] hear from us too much. We are trying to streamline the calls and the appointment, so that you know that you're getting these [high-risk] patients in early and often."

~ Sachin Jain, M.D.

CEO, CareMore

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Chronic Care Coordination

- At Geinsinger Health System, a coordinated care model resulted in estimated annual savings of **7%.**

- Compared to FFS Medicare beneficiaries, CareMore members in 2015 saw:
  - **20%** fewer hospital admissions
  - **2.3%** fewer bed days
  - **4%** shorter length-of-stay

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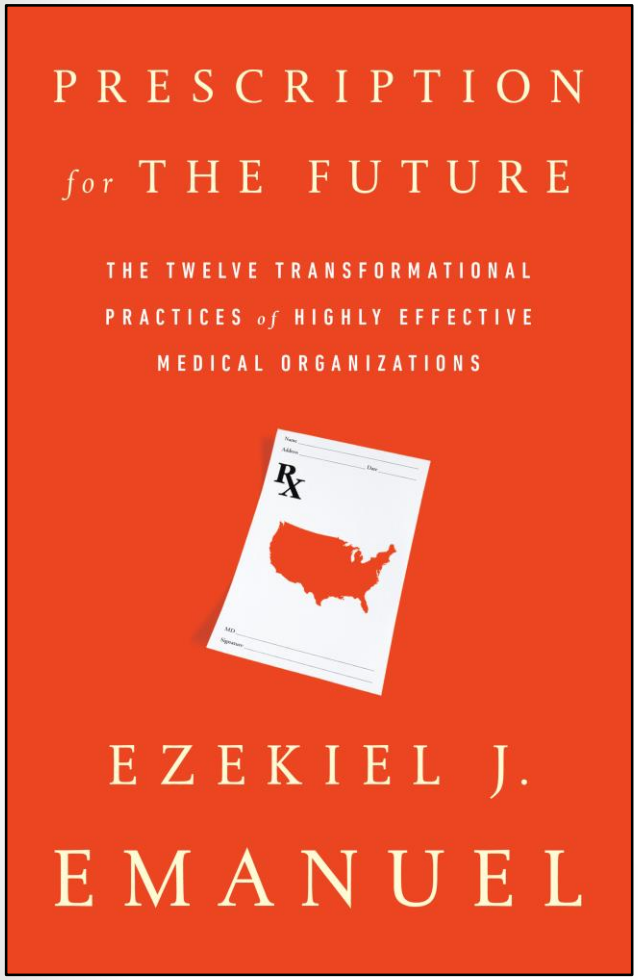
Phasing in the 12 Practices

- No single practice or health system has implemented all 12 practices.
- Instead, it is important to prioritize starting with a few key practices.
  - Scheduling
  - Chronic care management
  - Performance management
  - Site of service



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Creating Value and Lowering Costs: Perspective from a Delaware ACO

Farzad Mostashari, M.D., ScM – CEO, Aledade, Inc.

Convening Stakeholders and Employers for Payment: Massachusetts Experience

Audrey Shelto, MMHS – President, Blue Cross Blue Shield of Massachusetts Foundation

Considering Economic Evaluation and Data Driven Analyses

A View from Vermont and Other States

Christine Eibner

Data analysis can inform state policymaking at many stages

- Deciding what policies to pursue
- Supporting implementation
- Evaluating outcomes

Data analysis can inform state policymaking at many stages

- Deciding what policies to pursue
- Supporting implementation
- Evaluating outcomes

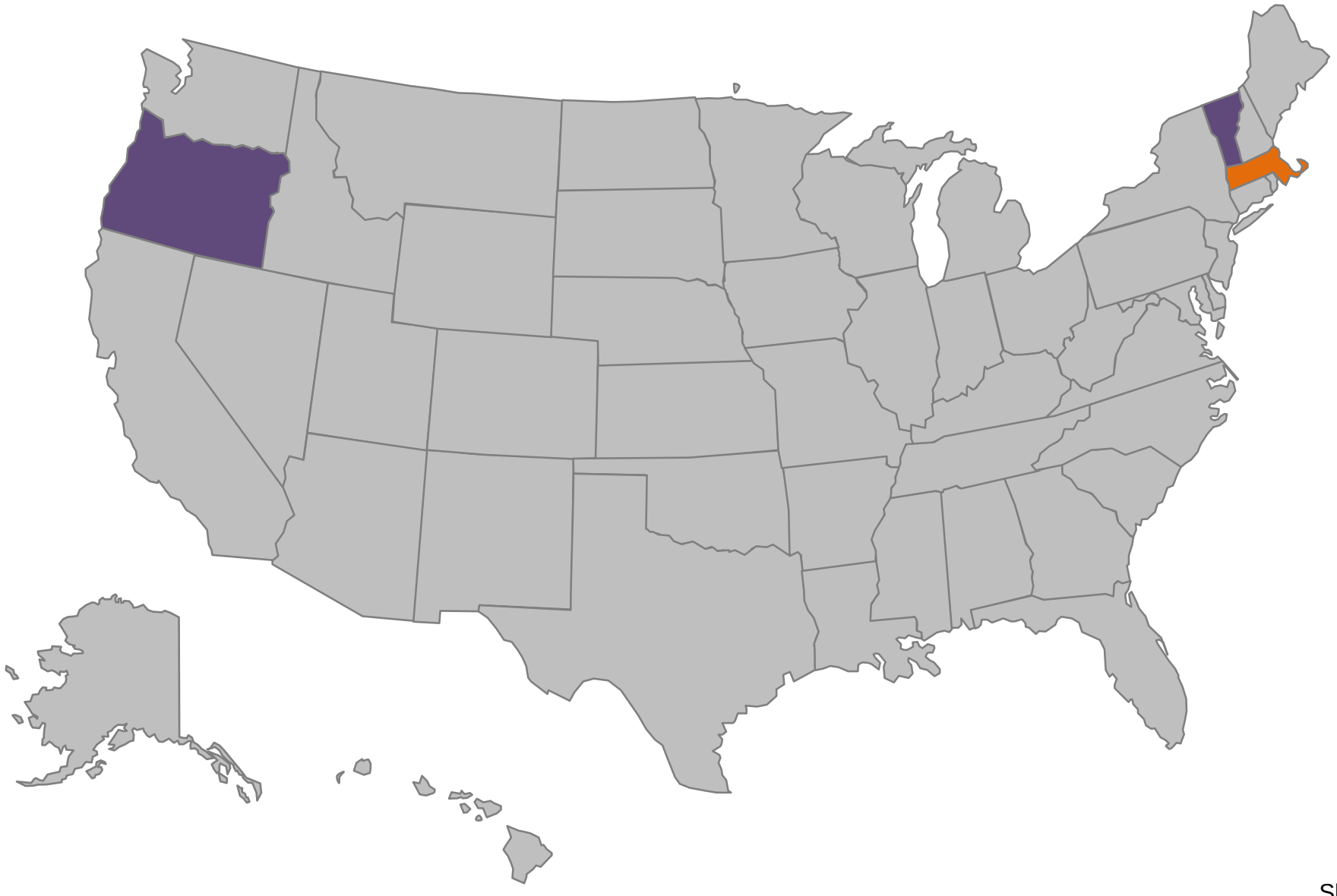
Early implementation questions that can be addressed with data include:

- Has this policy been tried elsewhere? If so, what were the lessons learned?
- What is the range of possible effects for DE?
- Are there unique features of the DE population, economy, etc. that might affect outcomes?
- Are there possible unintended consequences?
- What are the key implementation decisions?

Previous RAND work informed state health care policy questions

- How can we bend the cost curve? (MA, 2009)
- Who currently pays for health care, how much to they pay, and is this equitable? (VT, 2014)
- How can we insure more people, and what will it cost? (OR, 2016)

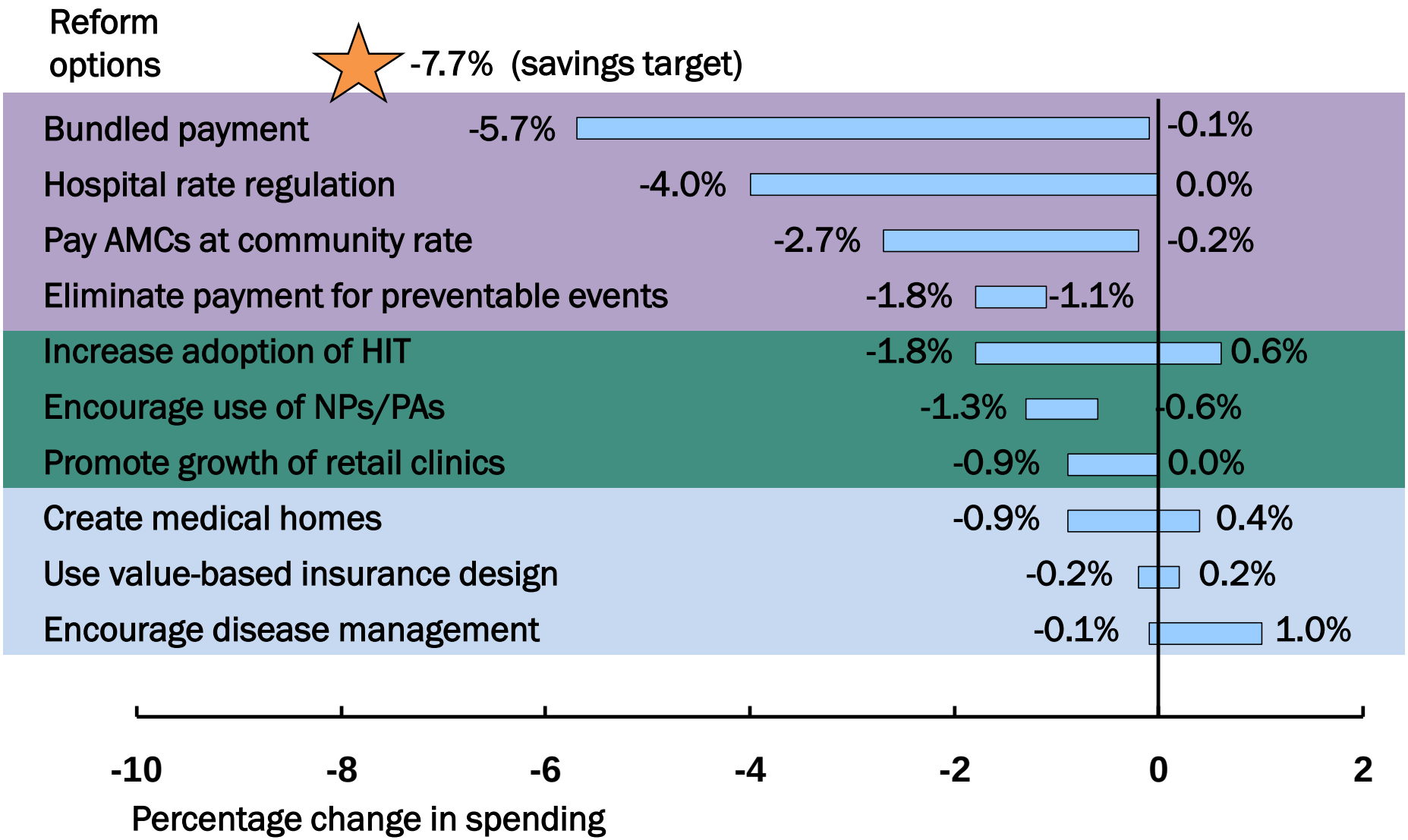
Massachusetts: Bending Costs



Massachusetts Asked RAND to Evaluate the Effect of Various Cost Containment Options

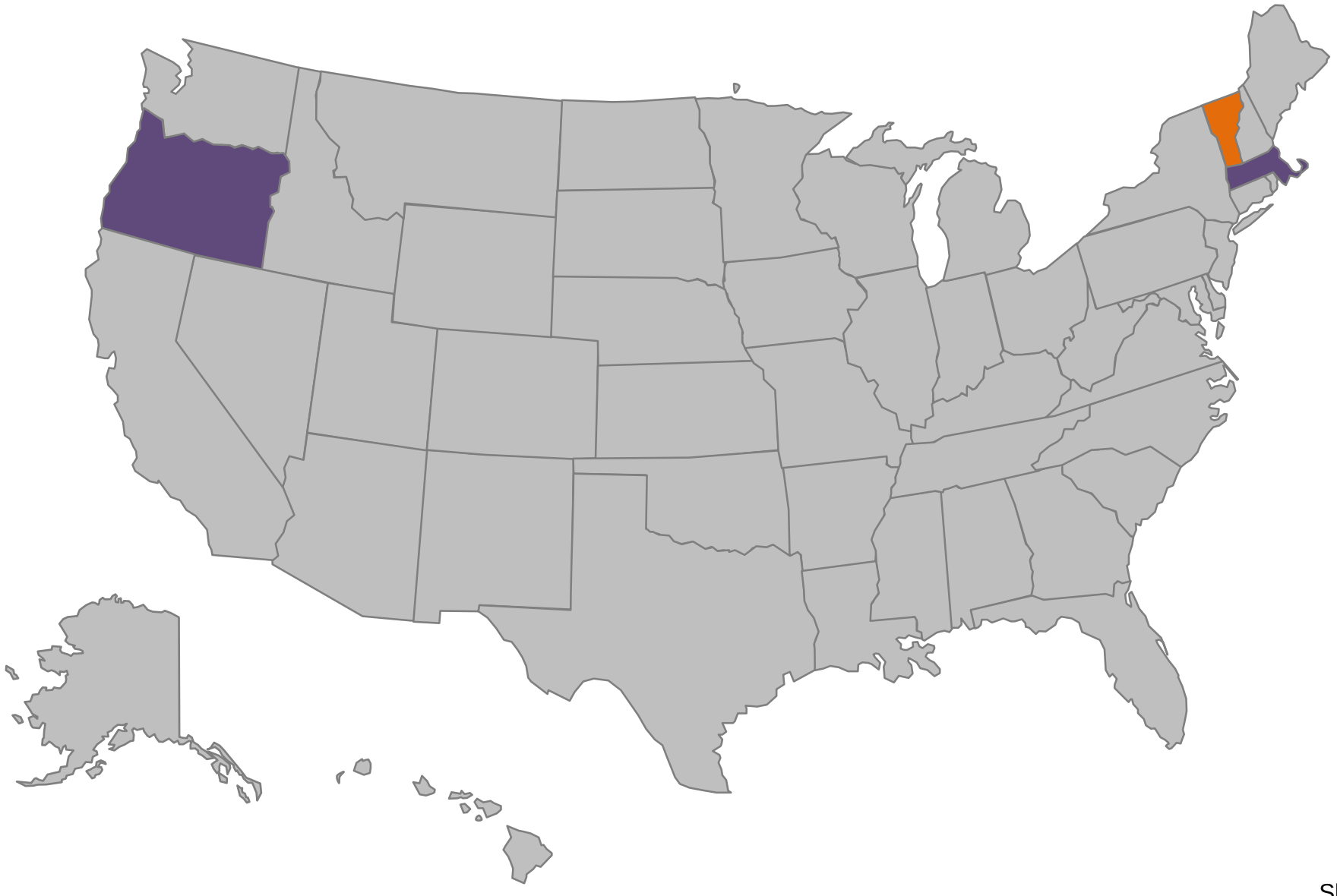
- Project involved several steps
  - Selecting policy options to consider for analysis
  - Reviewing what is known from prior experience about effects of selected options on reductions in spending
  - Modeling the impact of options that showed promise and that had a sufficient evidence base
- We identified 75 options, collapsed into 21 generally areas, and modeled impacts for 10

Results: Predicted Change in Spending, 2010-2020



Eibner et al., 2009, "Controlling Health Care Spending in Massachusetts: An Analysis of Options"

Vermont: Who Pays?



Vermont Asked RAND to Estimate Who Pays for Health Care in the State

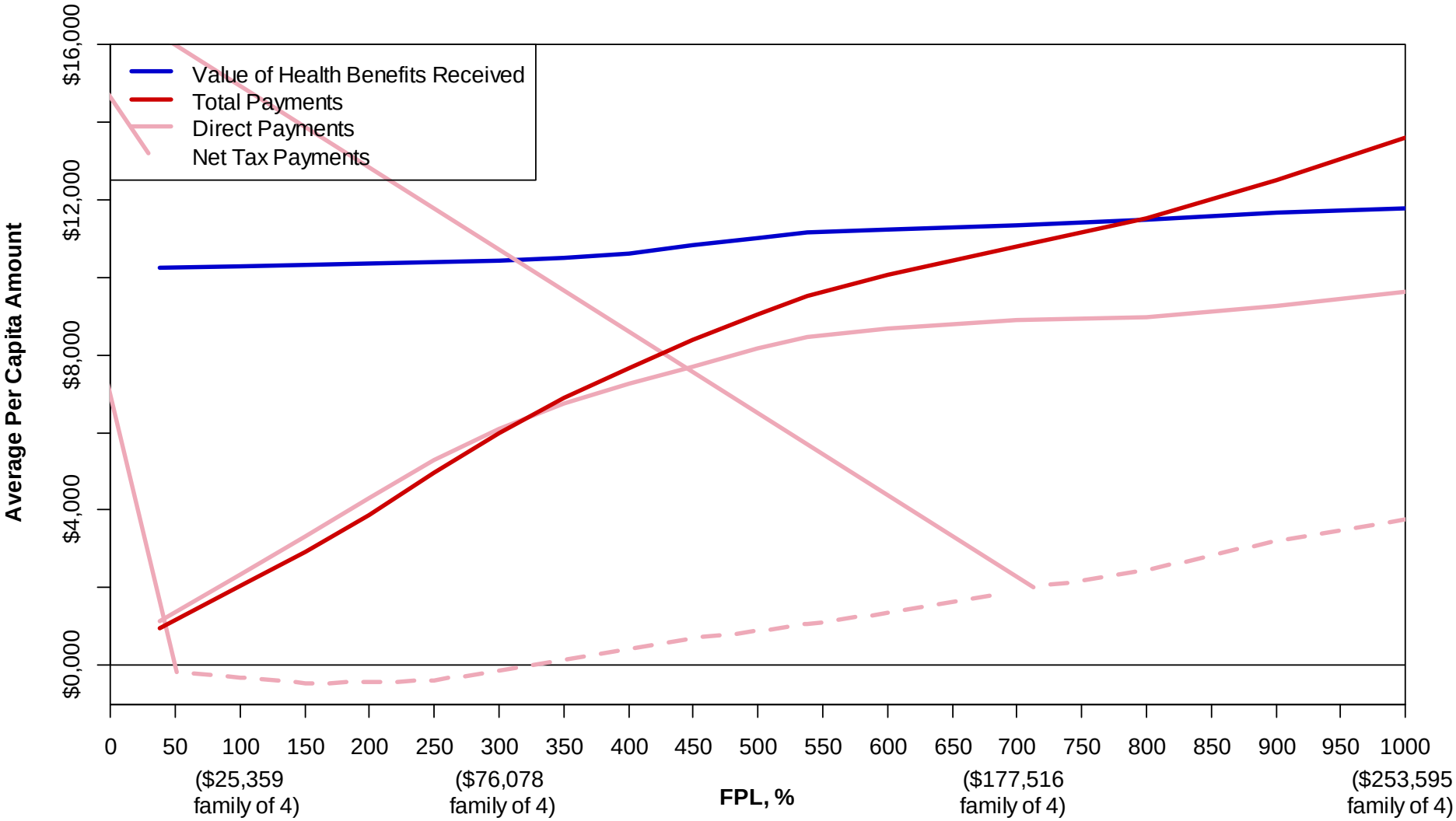
- Estimate health spending for Vermont residents
- Determine the ***economic incidence***: who is really paying, after accounting for taxes, wage effects, etc.
- Assess whether the system is equitable
  - Do those with higher incomes pay more?
  - Do those with the same income pay the same amount?
- Goal: develop a baseline for implementing Act 48

Total Expenditure (Value of Health Benefits Received) in Vermont

	2012		2017	
Total payments by Vermont residents	**$3,602**	**71%**	**$4,666**	**69%**
Direct payments	$2,670	53%	$3,592	53%
Tax payments	$932	18%	$1,073	16%
Corporate income tax payments by Vermont businesses	$55	1%	$79	1%
Vermont state tax payments by out-of-state residents	$5	<1%	$6	<1%
Net federal government inflows	**$1,412**	**28%**	**$2,044**	**30%**
Retiree health incidence	$10	<1%	$15	<1%
TOTAL	**$5,084**	**100%**	**$6,810**	**100%**

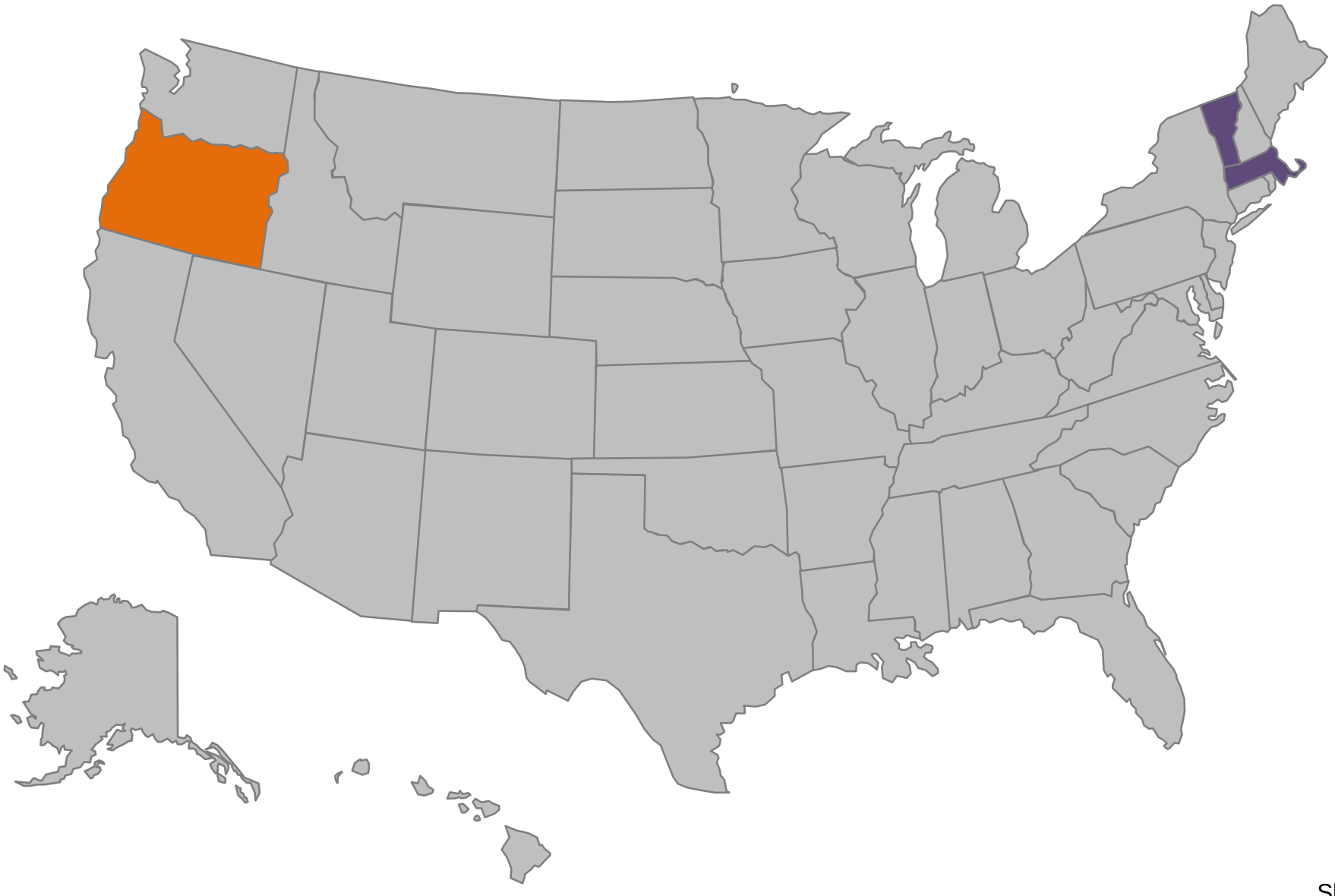
Eibner et al., 2015, "The Incidence of Health Care Spending in Vermont"

All But Highest Income VT Residents Receive More Health Benefits than They Pay For



Eibner et al., 2015, "The Incidence of Health Care Spending in Vermont"

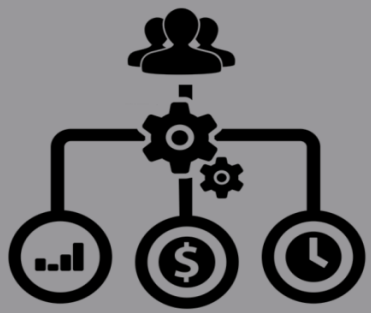
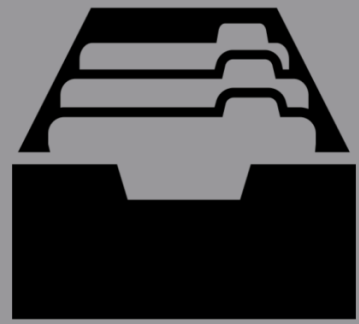
Oregon: Can We Insure More?



Oregon HB 3260 called for analysis of four policy options

SINGLE PAYER	HEALTH CARE INGENUITY PLAN (HCIP)	PUBLIC OPTION	STATUS QUO
• universal coverage • low cost sharing • state-administered plan • tax-financed	• universal coverage • income-based cost sharing • competing private plans • tax-financed	add a state-administered option in the marketplace	continue with currently available options

Analysis relied on both qualitative and quantitative methods

Projections with simulation modeling	Reviews of existing studies	Interviews with state leadership
		

Icons from the Noun Project: YuguDesign, Sagiev Farid, parkjisun, Gregor Cresnar

All three policies had pros and cons (report included dollar amounts not shown)

	SINGLE PAYER	HCIP	PUBLIC OPTION
ENROLLMENT	Large increase	Increase	Small increase
FINANCIAL BARRIERS	Much lower	Lower	Slightly lower
SYSTEM COSTS	Little change	Increase	Small decrease
PROVIDER REIMBURSMENT	Decrease	Increase	Slight decrease
SERVICE AVAILABILITY	Worsens	Improves	Little change
STATE ECONOMY	Little change	Increase GSP, employment	Little change
FEASBILITY	Major hurdles*	Major hurdles	Feasible

White et al., 2017 "A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon"

Did our analysis have any impact?

- Massachusetts Payment Reform Commission recommended a global payment approach, which the state adopted
- Vermont opted not to implement single payer, moved to all-payer approach
- Next steps in Oregon are unclear (study occurred before 2016 election)

Lessons Learned

- Data analysis can help policymakers
  - Identify promising options
  - Estimate possible effects for the state
  - Hone approaches
  - Discover unintended consequences
- Data driven considerations must be balanced with political considerations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Closing Remarks

Future Summits

Topic: **Provider/Hospital Leadership**
Host: Delaware Healthcare Association

Topic: **Legal/Regulatory Issues**
Host: To be Determined

Topic: **Governance/Authority**
Host: Delaware Center for Health Innovation

Topic: **Data Analytics (Total Cost of Care)**
Host: Delaware Health Information Network

Dates, Time, Locations, Speakers to Come

More Information

To learn more about the health care spending benchmark please visit: **http://dhss.delaware.gov/dhcc/global.html**

Send your comments about today's summit or thoughts about the future health care spending benchmark summits to:

myhealthde@state.de.us

Accelerating Payment Reform