RWHC Eye On Health

"Same problem. We were doing good until our patients couldn't afford us any longer."

Pay 4 Performance & Consumer Driven Health Care Bring Economic Incentives to Providers & Patients

Rural Wisconsin Health Cooperative

Presentation Outline

I. Couple Slides on RWHC
II. Overview Pay 4 Performance
III. Overview Consumer Driven Health Care
IV. Opportunities & Challenges
V. Discussion

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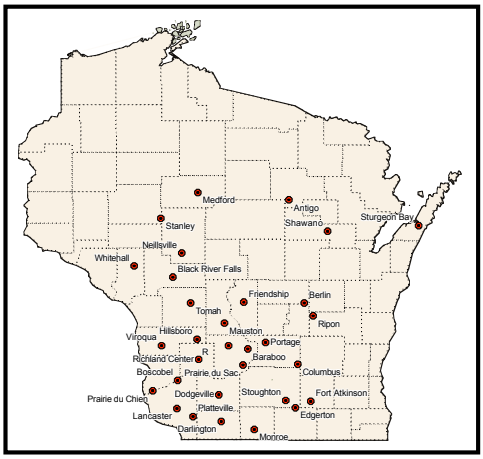
RWHC - Who We Are?

- Founded in 1979, a non-profit cooperative owned & operated by 31 community hospitals; all well < 100 beds
- Aggregate budgets >$0.5B; >2,000 hospital & nursing home beds).
- 25 are CAHs; 18 are traditional independent, 5 are with management companies & 8 are system affiliated.



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RWHC Vision & Mission

RWHC Vision (Future we want):

Rural Wisconsin communities will be the healthiest in America.

RWHC Mission (How we do it):

RWHC is a strong and innovative cooperative of diversified rural hospitals.

… is the "rural advocate of choice" for its Members.

… develops and manages a variety of products and services.

… assists Members to offer high quality, cost effective healthcare.

… assists Members to partner with others to make their communities healthier.

… generates additional revenue by services to non-Members.

… actively uses strategic alliances in pursuit of its Vision.

RWHC Strategic Plan Updated 5/4/07

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What is Pay 4 Performance?

"I just don't see what's in it for us to care about helping people stay healthy."

- Financial incentives by payer to reward/improve quality of care as well as to control costs by reducing errors & inappropriate utilization.
- 80+ health plans expected to have P4P programs in 2006, covering some 60 million members.
- Medicare calls it "Value Based Purchasing."

http://www.ahrq.gov/

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Examples of Pay 4 Performance Focus

- Utilization/cost management (e.g., average number of emergency department visits per patient per year).
- Clinical quality/effectiveness (e.g., the percentage of patients with asthma on controller medications).
- Patient satisfaction (e.g., the percentage of patients who would recommend the physician to a family member or friend).
- Administrative (e.g., the practice's level of information technology).
- Patient safety (e.g., the percentage of patients questioned about allergic drug reactions).

"The Basics of Pay for Performance," Family Practice Management 11(3):45-50, 2004.

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The Alliance's P4P Measures (Hospital Inpatient)

Varying stages of implementation

- Mortality (APR DRGs)
- Potentially Preventable Aftercare:
  - Readmissions
  - Emergency Care
  - Urgent Care
- Leapfrog ICU Standard
- Leapfrog CPOE Standard
- 3rd & 4th Degree Lacerations (Joint Commission)
- Primary C-Sections (AHRQ)

Future measures:

- Currently assimilating employer and hospital input to select next generation of measures

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The Alliance's P4P Method

Principles of the incentive structure:

- Where possible, the value of the incentive is correlated with improved care
- Employers and providers both realize a financial benefit
  - In the early yrs, providers realize majority of the savings
  - In subsequent yrs, savings is shared equally
- Neutral or positive incentive to the reimbursement model. No "downside"
- Meet the organization where they are:
  - Reward achievement of a high standard
  - Reward improvement from past time period to next

Examples of incentive level:

- Mortality: Up to 3% increase to DRG conversion factor in 1st yr
- OB: Up to 18% increase in OB-related Core Services case rates
- Potentially preventable aftercare: share 80% of savings compared to base period

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Dean Health Plan P4P '07 & *Proposed '08*

- Currently, provider eligible to earn, an additional six tenths of a percent (0.6%), based on claims payment during prior quarter.
- RWHC has 3 reps, Hospital Quality Metrics Advisory Committee.

Organization	Metric	+ $% in '07 *& '08*
Checkpoint	Report AMI, CHF, Pneumonia clinical measures.	+ .2% *& ?*
Checkpoint	Report surg.site marking, procedure verification, eliminate dangerous med abbrev., remove concentrated electrolytes, *med. reconciliation.*	+ .2% *& ?*
Checkpoint	*Achieve pneumonia care perform goal*	*?*
Leapfrog	Receive a Leapfrog score of ¼.	+ .2% *& ?*

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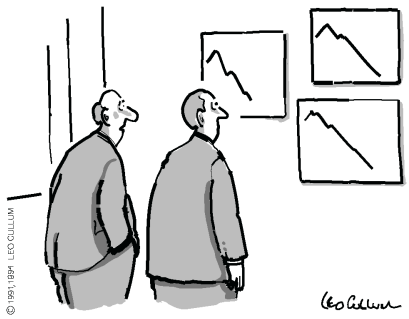
Consumer Driven Health Care

RWHC Eye On Health



"Yea, maybe we should try something different."

Much controversy:

- Some see as an appropriate way for employees to become better consumers.
- Some see it as nothing more than employers shifting cost and risk to employees.
- Some see it as the major health reform needed in America.
- Some see it as having no place in American health care.

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What is Consumer Driven Health Care?

- Narrowly, consumer driven health care refers to a high-deductible health insurance policy health insurance plans combined with a employer or employee funded Health Savings Accounts (HSAs) or employer funded Health Reimbursement Arrangements (HRAs).
- High-deductible policies cost less per month than low-deductible policies, but the user pays more upfront for medical procedures.
- More broadly defined, consumer driven health care includes the trend of employers to shift cost/risk to employees by increasing:
  - deductibles
  - co-payments or coinsurance for office visits
  - cost sharing for prescription drugs
  - the amount employees pay for premiums.

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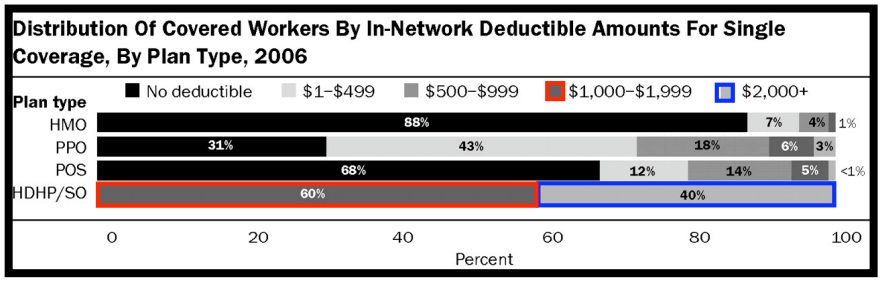
High Deductible Health Plans Live Up to Name



"Health Benefits In 2006" by Gary Claxton et al, *Health Affairs,* 25, no. 6 (2006)

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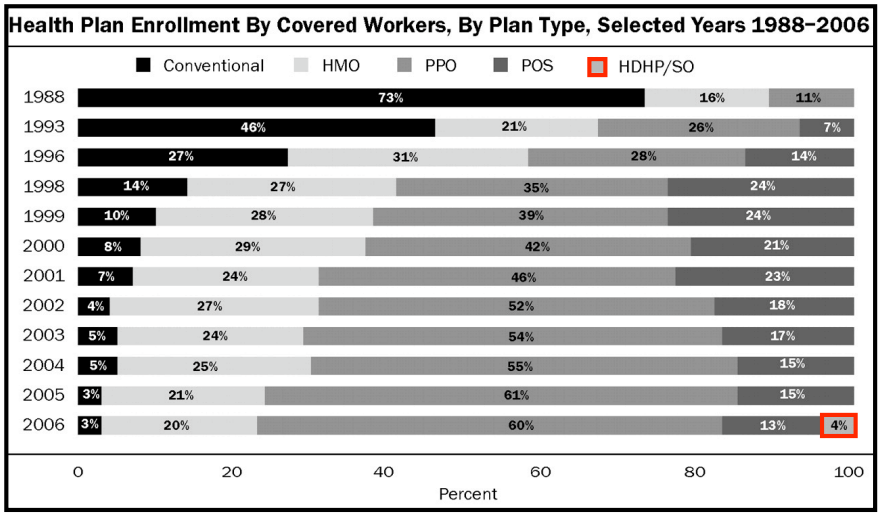
To Date: Much Talk, Less Action on HDHPs



"Health Benefits In 2006" by Gary Claxton et al,
Health Affairs, 25, no. 6 (2006)

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Employers Views about the Near Future

- 21% "very likely" to increase employee share premiums
- 12 % "very likely" to increase annual deductibles
- 10% "very likely" to increase drug co-payments
- 8% "very likely" to increase office visit co-payments
- 4% of employers not offering an HSA-qualified HDHP say that they are "very likely" to do so next year.

"Health Benefits In 2006" by Gary Claxton et al,
Health Affairs, 25, no. 6 (2006)

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The Case for Consumer Driven Health Care

- To control health care costs, someone must choose between health care and other uses of money.
- The value of most health care is experienced subjectively, as is the value of other goods and services.
- No one is in a better position to make these subjective trade-offs than patients themselves.
- The current system not only systematically denies patients the opportunity to make such choices, it distorts the incentives of providers in the process.
- Chronic patients in particular would be much better off if they could manage more of their own health care dollars and if providers were free to compete to meet their needs.

"What Is Consumer-Directed Health Care?" by John C. Goodman, *Health Affairs,* 25, no. 6 (2006)

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The Case Against Consumer Driven Health Care

- *Biased Risk Selection* When people are given a choice between a CDHP and generous traditional health insurance, healthy people will sign up with the CDHP and leave chronically-ill people in the traditional plans with higher premiums.
- *Disincentives for Preventative Care* Many may avoid needed prevention services to save the immediate expense.
- *Erodes Employee Benefit* Opens door for employers to ratchet down their contribution to health benefits. This will leave employees in the lurch paying higher out-of-pocket costs.
- *Too Complicated* CDHC expects consumers to make complicated decisions when they are sick and most vulnerable. Also, not everyone has access to the internet and is comfortable using it.

http://www.consumerdrivenhealthcare.us/

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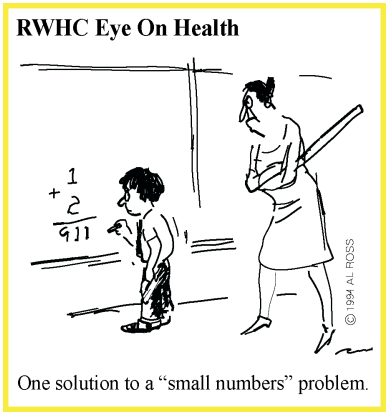
Opportunities & Challenges (1 of 3)



One solution to a "small numbers" problem.

- In a more price sensitive market, we will need to work more collaboratively, harder and smarter to make up for fewer economies of scale and higher stand-by costs.
- To date, the measures used to evaluate providers have often not addressed statistical issues of "small numbers," mix of services and characteristics of population served.

"**Small numbers are a big deal" by Tim Size,** ***Modern Healthcare,*** **5/14/07**

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Opportunities & Challenges (2 of 3)

- All providers must be given the opportunity to demonstrate that their quality of care and cost effectiveness is driven by evidence-based medicine and cost effective leadership.
- Some providers say: "they & their data should just be left alone."
- Some payers/experts say their work is complicated enough without the challenge of "small numbers."
- For whatever reason, No Data = "Backwater Status."
- Dysfunctional cacophony of measurement voices.
- Too much waste addressing multiple, similar demands.

"**Small numbers are a big deal" by Tim Size,** ***Modern Healthcare,*** **5/14/07**

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Opportunities & Challenges (3 of 3)

- A coherent strategy requires that we be "at the table."
- Confounding factors need to be considered-sickest heart attack patients may stay at hospital close to family while the healthiest are transferred to an urban hospital.
- "Small counts" raise concerns about reliability (the repeatability of the measure) and validity (whether the intended target population is being measured).
- We can expand sample size by aggregating data over time or aggregating data across metrics.
- Beyond statistical approaches, peer review mechanisms should be implemented to assure appropriate care

"Small numbers are a big deal" by Tim Size,
***Modern Healthcare*, 5/14/07**

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