Virtual Commission Meeting

October 11, 2021
Virtual Meeting Protocols

- This meeting is being recorded.

- Commissioners:
  - You have the ability to mute and unmute and the option to be on video.
  - Please mute yourselves when you are not speaking.
  - To indicate that you would like to speak, please use the “raise hand” feature:

- Members of the public:
  - You can listen to and view the meeting.
  - During the public comment period, you will have access to the “chat” feature for written comment, and you can use the “raise hand” feature to request to speak. You can also email comments to HealthyCAforAll@chhs.ca.gov.
  - Public comment provided during the meeting will be a part of the public record.
Opening Remarks

Mark Ghaly, MD, Commission Chair and Secretary of California Health and Human Services Agency
Today’s Agenda

- Updates on next steps and remaining meetings
- Explore how provider payments could be structured within a system of unified financing
Upcoming Meetings and Next Steps

- Revised and expanded Commissioner survey on Goals, Values and Propositions in about two weeks
- Upcoming Commission meetings
  - November 18
  - December 9
  - January 12
Presentations and Discussion
Setting the Stage: Costs, Cost Drivers, and Getting More from Our Investment in Health

Don Moulds, Ph.D.
CalPERS Chief Health Director
October 11, 2021
Health Spending as a Percentage of GDP

Health spending growth has outpaced growth of the United States Economy

Source: Peterson-KFF Healthsystemtracker.org
Health spending has outpaced both inflation and economic growth over the last 50 years.

Source: California Health Care Foundation
U.S. Spending Compared to Other Wealthy Nations

The U.S. spends the most on health care

Source: Commonwealth Fund. January 2020
## Comparing Health Outcomes

### Disease burden is higher in the U.S. than in comparable countries

<table>
<thead>
<tr>
<th>Country</th>
<th>DALY Rate per 100,000 Population, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>26,061</td>
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<tr>
<td>United Kingdom</td>
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<tr>
<td>Belgium</td>
<td>20,170</td>
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<tr>
<td>Germany</td>
<td>20,075</td>
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<tr>
<td>Canada</td>
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<tr>
<td>Australia</td>
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<tr>
<td>Austria</td>
<td>19,104</td>
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<td><strong>Comparable Country Average</strong></td>
<td><strong>18,987</strong></td>
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<tr>
<td>Netherlands</td>
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<tr>
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<tr>
<td>Japan</td>
<td>15,886</td>
</tr>
</tbody>
</table>

Source: Peterson-KFF Healthsystemtracker.org
Combined Medical and Social Services Spending in Western Countries
As a Percentage of Gross Domestic Product

CalPERS Health Spend

**$9.6 billion**
Spent to purchase health benefits in 2020

**1.5 million**
Members

**$6,457**
Annual health spend per member
Where Does the Money Go

Percentage of PMPM by Service Category

- Preventative Care: 4%
- Prescription Rx: 18%
- Inpatient: 27%
- Medical Rx: 7%
- Other Professional: 2%
- Mental Health/Substance Abuse: 3%
- Emergency Room: 7%
- Radiology: 5%
- Hospital Outpatient: 3%
- Laboratory: 4%
- Ambulatory Surgery: 10%
- Office Visit: 7%

Data as of June 23, 2021
Source: 2020 CalPERS Health Benefits Program Annual Report
Prices are Primarily Driving Health Care Costs

From 2015 to 2019 prices increased by 18.3% while the cumulative growth in utilization was only 3.6% over the same period.

Source: Health Care Cost Institute
Higher Costs ≠ Higher Quality
Healthcare Cost Variation in California

Source: 2019. Milliman
Healthcare Markets Don’t Fully Value

- Quality or Quality Improvement
- Efficiency
- Prevention
- Care Coordination
- Equity
Some Things We’ve Tried (and How They’ve Worked)

- Bundled Payments
- Hospital Readmission Penalties
- Accountable Care Organizations
- Cost Control Commissions
Another Challenge – Cost Shifting

Source: Health Care Pricing Project
Key Considerations

Universal Financing may create an environment that is more conducive to Cost Control.

BUT, right-sizing costs will require a distinct Cost Control Strategy.

Unified Health System Financing alone may not bridge the gap between U.S./CA health outcomes and other wealthy nations;

Addressing drivers outside the health system is critical.
Some Questions for the Commission

• What key strategies should we employ to right-size healthcare spending?

• Which of the payment models we employ in our current health system translate under unified financing? Which do not?

• What great payment models should we be looking to steal from other countries – e.g. NICE?

• Understanding that much of what drives health status sits outside of the healthcare system, what is our strategy for improving health? Should our goal be reducing healthcare spending to free up resources for, say, better social supports, or should we be trying to address other needs through the health system?
Value Based Payment & Health Equity: Can We Advance These in Tandem?

Dana Gelb Safran, Sc.D., President and CEO

Presented to: Healthy California for All (HCFA) Commission
11 October 2021
Roadmap for Today’s Discussion

- Alternative Quality Contract (AQC)
  - Demonstrating the value of combining accountability for cost with accountability for quality and outcomes
  - Impact on health disparities

- Investing in health equity
  - Adjusting payment rather than performance scores

- Q&A
In 2007, leaders at Blue Cross Blue Shield of Massachusetts (BCBSMA) challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.


Sources: BCBSMA; Bureau of Labor Statistics
AQC Model: Key Components

- **Unique Contract Model**
  - Accountability for quality and resource use across full care continuum
  - Long-term (5-years)

- **Controls Cost Growth**
  - Global population-based budget
  - Shared risk: 2-sided symmetrical
  - Health status adjusted
  - Annual inflation targets set at baseline annually and designed to significantly moderate cost growth

- **Improved Quality, Safety, and Outcomes**
  - Robust performance measure set creates accountability for quality, safety and outcomes across the continuum
  - Substantial financial incentives for high performance and for improvement
# AQC Measure Set for Performance Incentives

## Process
- Preventive Screenings
- Acute Care Management
- Chronic Care Management
  - Depression
  - Diabetes
  - Cardiovascular Disease

## Outcome
- Control of Chronic Conditions
  - Diabetes
  - Cardiovascular Disease
  - Hypertension

**Triple Weighted**

## Hospital
- Evidence-based care elements for:
  - Heart attack (AMI)
  - Heart failure (CHF)
  - Pneumonia
  - Surgical infection prevention

## Patient Experience
- Access, Integration
- Communication, Whole-Person Care

## Emerging
- Post-Operative Complications
- Hospital-Acquired Infections
- Obstetrical Inquiry
- Mortality (Condition-Specific)
- Discharge Quality, Staff Responsiveness
- Communication (MDs, RNs)

Up to 3 measures on priority topics for which measures lacking
Superior Quality Performance Improvement of the 2009 Cohort of AQC Groups from 2007-2014

![Graphs showing improvement in Optimal Care for Adult Chronic Care, Pediatric Care, and Adult Health Outcomes over the years from 2007 to 2014.](image-url)
EXHIBIT 1

Performance on process quality measures among Alternative Quality Contract (AQC) enrollees and comparison groups, by socioeconomic status according to enrollee area of residence, 2007-12

Health Care Spending, Utilization, and Quality 8 Years into Global Payment

Zirui Song, M.D., Ph.D., Yunan Ji, B.A., Dana G. Safran, Sc.D., and Michael E. Chernew, Ph.D.

Changes in Health Care Spending and Quality 4 Years into Global Payment


Health Care Spending and Quality in Year 1 of the Alternative Quality Contract

Investing in Health Equity

- As value-based payment models increasingly hold providers financially accountable for outcomes, there is growing concern that organizations caring for populations with greater social risk factors are unfairly penalized.

- Some argue that we should adjust performance scores for social risk to fairly assess and reward providers with great social vulnerability in their patient mix.

- Others argue that adjusting performance scores for social risk accepts a lower standard of care for socially at-risk populations, masking low performance with statistical adjustments.

- Satisfying these seemingly divergent views: Adjust payment rather than performance scores
  - Up-front payments
  - Multipliers on performance payments

Let’s Talk

NATIONAL QUALITY FORUM
www.qualityforum.org
All-Payer Global Hospital Budgets

Joshua M. Sharfstein, M.D.
October 11, 2021
Maryland’s Unique Path

Maryland has an independent commission to set all-payer hospital rates. For many years, these were fee-for-service rates. In 2014, Maryland shifted to paying hospitals through global revenues.

Under global revenues, the total amount of revenue to be earned through inpatient and outpatient charges at hospital facilities is preset. This new system incentivizes reducing preventable admissions and controlling the total cost of care, as well as improving outcomes.

Source: Donna Kinzer
Why All-Payer Global Hospital Budgets?

- Fee-for-service hospital reimbursements are expensive and are poorly aligned with improved health outcomes. They also threaten the viability of hospitals in many areas.

- By contrast, global budgets:
  - Provide stability to hospitals, allowing them to shift services based on community needs
  - Create a way for hospitals to “make money” through prevention
In Maryland, Global Hospital Budgets Have Led to…

- Care redesign efforts
- Coordination with primary care
- Regional prevention efforts (including housing investments)
- Population health goals (initially diabetes, overdose, childhood asthma & maternal health outcomes)
Maryland—Initial 5-Year Results (2014-2018)

Cost Results

$1.4B Medicare Hospital Savings

$869M Medicare TCOC Savings*

1.92% Average all-payer hospital average annual growth per capita

Quality Results

51% Reduction in complications

Better than national Medicare readmission rate

98% Maryland hospital revenues were moved to population-based payment

*Increases in non-hospital services partially offset hospital savings

Source: Report from Centers for Medicare & Medicaid Services and Maryland Health Service Cost Review Commission. Performance Year 5 Results.

Source: Donna Kinzer
RTI Evaluation

• Hospitals were able to operate within their global budgets without adverse effects on their financial status.

• Admissions for ambulatory care sensitive conditions declined in both the Medicare and commercial populations.

• Low-income Medicare patients and those with chronic conditions had more favorable outcomes.

• Also: Need for additional coordination with community providers, particularly in areas like behavioral health.
Lessons from Maryland

► All-Payer global hospital budgets are a viable health policy reform to control costs and improve outcomes, including community health.

► An important benefit is stabilizing financially vulnerable hospitals.

► Incentives alone do not necessarily lead to changes in care delivery, but they can help.

► States should consider pairing global budgets with plans for care delivery transformation. Key metrics can cover community health and health equity.

► The alignment between hospitals and their communities can have benefits well beyond clinical care provided inside a building.
Commissioner Discussion
Public Comment
Adjourn