

Early Results from the Enhanced Personal Health Care Program:

LEARNINGS FOR THE MOVEMENT TO VALUE-BASED PAYMENT

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Early Results from the Enhanced Personal Health Care Program: Learnings for the Movement to Value-Based Payment

EXECUTIVE SUMMARY

More than
54,000
participating providers
that reached an estimated
4.6 million patients



The Enhanced Personal Health Care (EPHC) program is a leading value-based payment (VBP) program developed to transform primary care practices across the country through a collaborative approach between Anthem's affiliated health plans and their participating providers. The program seeks to ensure that providers have the necessary supports to transform their practices, as well as flexible contracting options to assume risk over time. Going into the fourth year, the program is gaining momentum; it involves partnerships with more than 54,000 participating providers, and reached an estimated 4.6 million patients as of the end of 2015. With the VBP landscape evolving quickly, early and rapid-cycle learnings and results from EPHC and comparable initiatives can inform the refinement and establishment of new value-based payment initiatives among other payers, including public programs such as Medicare.

This paper highlights results from the first year of the EPHC program, including the following key takeaways:

Patients in EPHC Received More Patient-Centered Care: Patients seen by providers participating in EPHC experienced improved quality and preventive service use, and reported improved access and care experience.

EPHC Patients Had Lower Costs: Patients in EPHC had per member per month costs that were \$9.51 less – a savings of 3.3 percent – than those of members seen by non-participating providers. After accounting for care coordination payments and shared savings paid to participating providers, net savings were \$6.62 per EPHC-attributed member per month.

Collaboration and Flexibility Are Key Ingredients for Provider Participation: A collaborative approach, including practice transformation support as well as flexible contracting options, allows providers of all sizes and sophistication to engage in EPHC. These factors are critical for incenting participation and retention in VBP programs.

VBPs Can Be Implemented Nationally with a Range of Providers: VBPs can be successfully implemented across the country with a range of providers at varying levels of experience in risk-sharing and value-based payment.

As policymakers seek to accelerate the number of providers and patients served under VBPs – the U.S. Department of Health and Human Services recently announced ambitious goals for moving Medicare providers to VBPs – the early results of EPHC suggest they should:

Early Result Suggestions

- 1** Extend VBP models to a broad continuum of provider types – from beginner to advanced population health managers – allowing providers to bear more risk over time.
- 2** Build on successful private-sector VBP programs and innovative delivery reforms as a platform for more rapid national adoption of Alternative Payment Models (APMs).
- 3** Encourage providers to leverage and create partnerships with health plans and other stakeholders to support their transition to VBPs using existing platforms and risk-based contracting arrangements.

INTRODUCTION

Historically, the U.S. health care system has been characterized by fragmentation and the delivery of care in silos – among and between payers and providers – resulting in costly and often low-value care for patients. Misaligned financial and clinical incentives are key drivers of this fragmentation, resulting in well-documented quality deficiencies. Over the last two

Content Highlight

Historically, payment for health care was based on the volume of services delivered. Increasingly, public and private payers alike are shifting to payment models based on the value of the care delivered. In particular, the Medicare program recently committed to accelerating this trend.

decades, numerous studies have shed light on inconsistent quality performance in the U.S. health care system. One of the first high-profile reports, *Crossing the Quality Chasm*, released in 2001 by the Institute of Medicine, called for fundamental reform of the health system to address quality problems and gaps.¹ A few years later, a groundbreaking study found that American patients received “recommended care” from their providers only 55 percent of the time.² Further, comparisons with international health systems show that the U.S. underperforms relative to other industrialized nations, even though per capita health care spending in the U.S. is approximately eight times the international average.^{3,4}

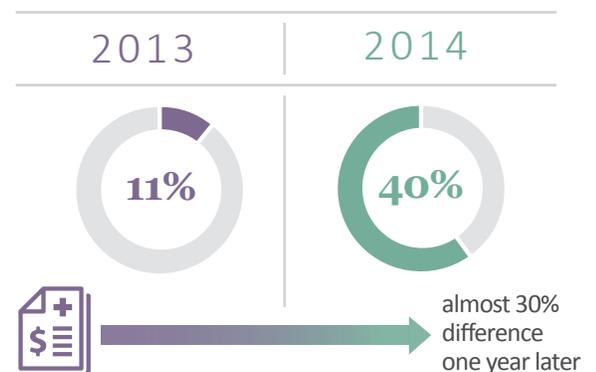
The U.S. also faces unsustainable long-term health care costs. In 1960, health care spending was 5 percent of Gross Domestic Product, and is now projected to reach 19.6 percent in 2024.^{5,6}

This unsustainable trend, coupled with evidence of quality problems, creates an imperative to transform the health care payment and delivery systems in the U.S.

For decades, fee-for-service (FFS) has been the dominant payment method for health care services in the U.S. However, paying simply for the volume of services delivered – and not for the value of those services – is one of the root causes of cost and quality problems in the system today. Beyond expanding access to health insurance coverage, one of the main goals of the Affordable Care Act was to catalyze the movement to value over volume by creating new mandatory and voluntary value-based payment programs in Medicare and fostering partnerships and innovation among public programs and private payers and providers.⁷

In the last five years, there has been an increasing industry trend toward VBP model development and implementation suggesting that the movement to paying for value is now fully underway. Private payers have been leading this transition and showing promising early results. In its first annual value “scorecard,” the Catalyst for Payment Reform reported that 11 percent of payments made to providers by commercial health insurers in 2013 were value-based.⁸ Just one year later, the 2014 scorecard showed a significant increase – with surveyed payers reporting nearly 40 percent of payments as value-based.^{9,10} It is clear that the payment landscape is changing quickly, as other sources have also cited significant percentages of payments flowing through value-based arrangements. For example, in 2012, 20 percent of medical claims payments – totaling \$65 billion – made by the Blue Cross Blue Shield Association’s member plans were through VBP programs.¹¹ Savings attributed to these value-based arrangements were estimated at \$500 million.¹² Anthem’s affiliated health plans have linked more than 50 percent of commercial plan payments to quality using a range of reimbursement methodologies. About 37 percent of payments are made currently through alternative payment models.

Percent of Value-Based Payments Made to Providers by Commercial Health Insurers



The percentage of payments shifting from FFS to VBP is only expected to grow, especially in light of two recent policy developments. In January 2015, the U.S. Department of Health and Human Services (HHS) announced ambitious goals for migrating providers from a FFS payment system to VBP or Alternative Payment Models (See Table 1).

Table 1. HHS Targets for Migrating Payments from Fee-for-Service to Value-Based Payment Arrangements in Medicare^{13,14}

Value-Based Program or Alternative Payment Model	HHS Target
Quality or Value-Based Programs (e.g., Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program)	• 85 percent of payments by 2016
	• 90 percent of payments by 2018
Alternative Payment Models (e.g., Accountable Care Organizations, Bundled Payments)	• 30 percent of payments by 2016
	• 50 percent of payments by 2018

To support achievement of these goals, HHS also launched the Health Care Payment Learning and Action Network (LAN), a network of public and private payers, providers, patient groups and consumers, employers, and other health care stakeholders, in which Anthem is participating. The LAN has several aims: facilitating joint implementation of new payment and delivery models; generating evidence, removing barriers and developing common approaches to core issues in designing and implementing new payment and delivery models; and creating implementation guides for stakeholders.¹⁵

Within months of these announcements, Congress passed and President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA repealed the Sustainable Growth Rate and replaced it with annual physician payment updates, which are ultimately tied to two new payment tracks that incent physicians toward Medicare value-based payment and alternative payment models.¹⁶ First, MACRA establishes the Merit-Based Incentive Program System (MIPS), which will replace the current Physician Quality Reporting System, Value-Based Modifier, and Meaningful Use quality and reporting programs. Starting in 2019, physicians will receive a positive or negative MIPS-adjusted payment rate based upon performance. Second, physicians who participate in an alternative payment model, such as Accountable Care Organizations or advanced Patient-Centered Medical Homes, would not be subject to MIPS and would instead receive a 5 percent bonus starting in 2019. The definition of a Qualifying APM is yet to be finalized, but an APM would need to measure quality comparably to the MIPS, use electronic health records, and accept two-sided financial risk (except for Patient-Centered Medical Homes).

These initiatives reinforce policymakers’ goals to transition facilities and individual providers from FFS to VBPs. However, to achieve a true tipping point in the movement to value across all payers, remaining barriers must be addressed. One of the most challenging barriers is inconsistent provider access to necessary data, information technology, and support tools to implement the care management, coordination, and quality measurement activities needed to succeed under VBP arrangements.

Through the Enhanced Personal Health Care program, Anthem plans have established a collaborative approach to value-based payment, including making tools and supports available that enable providers to move to risk-sharing arrangements. EPHC aligns incentives around quality, while also affording participating providers a tangible way to share in the success of managing health care costs through shared savings.

A desire for rapid evolution in the payment and delivery of health care in the U.S. will necessitate timely assessment and sharing of preliminary results and lessons learned from early adopters. As the Centers for Medicare & Medicaid Services (CMS) and an increasing number of private payers strive to achieve widespread adoption of VBP arrangements, sharing the results from programs such as EPHC – even as they are being implemented and refined – can help propel the transformation of care.

THE ENHANCED PERSONAL HEALTH CARE PROGRAM

EPHC began in 2012 and, after just three years, included 54,000 participating providers caring for 4.6 million members in Anthem plans. Growth in the program is expected to continue. EPHC is designed to accomplish three main goals:

Content Highlight

The Enhanced Personal Health Care program, a leading value-based payment model, supports providers in transforming the delivery of health care through a range of financial, clinical and analytic resources.

- 1 **Support the transformation of care delivery through collaboration with providers that have varying levels of experience with risk-based contracting**
- 2 **Improve patients' quality and experience of care and their health status and outcomes**
- 3 **Slow the growth of total cost of care in order to ensure the affordability of high-value coverage**

EPHC was designed with a flexible infrastructure in order to address the varying needs of participating providers and support practice

transformation with a range of financial, clinical, and analytic resources. In most cases, providers receive upfront clinical coordination payments to offset the costs of care coordination and program implementation. Since 2012, Anthem plans have distributed more than \$255 million in care coordination payments to participating providers. These care coordination payments allow providers to invest in the staff and technological resources necessary for managing the global wellness, prevention and chronic care needs of their patients, rather than just addressing acute conditions. In addition, EPHC providers have 24/7 access to online and virtual tools and resources, along with support from Transformation Teams that work onsite with providers and their practice staff to help establish action plans, identify high risk patients, and interpret data. These organizational resources are essential to enable practice transformation and continual improvement.

EPHC providers also receive meaningful and actionable clinical data through a web-based application, Provider Care Management Solutions, which allows providers to identify those patients who may require additional attention or interventions. Some data are updated daily, such as inpatient census information, predictive risk of readmissions, and emergency room visits, whereas other data such as care gaps and risk stratification are updated monthly. Anthem plans also supplement these data elements with quarterly performance feedback on dimensions such as medical cost performance versus targets.

In addition to upfront clinical coordination payments, EPHC providers are eligible to share in savings if attributed members have a lower cost of care than projected and, importantly, if quality of care is maintained or improved over a 12-month performance period. This quality "gate" ensures that the EPHC program rewards both parts of the value equation – reducing costs and improving quality of care.

Key EPHC Program Features

Participating Providers

Spectrum ranging from independent primary care physicians to large ACO-like organizations

Areas of Operation

Anthem affiliated health plans in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin

Payment Model

Shared savings (mostly upside only, but some providers taking on downside risk), with most providers also receiving monthly care coordination payments; "Category 3" APM

Program Scope

EPHC includes more than 44 percent of primary care physicians who contract with Anthem plans

The financial incentives in the EPHC program were designed to support providers in assuming the level of risk that most aligns with their level of readiness on the path to value-based practice transformation. In the context of other value-based payment programs, EPHC can be defined as a Category 3 APM (as per the CMS Payment Framework); that is, it is built on a FFS architecture, but offers opportunities for shared savings and 2-sided risk.¹⁷ Currently, the majority of EPHC providers are in bonus-only arrangements in which they can earn 30-35 percent shared savings. As providers move to risk-sharing, they can receive up to 50 percent of the savings, but are concurrently at risk for returning 50 percent of excess costs. In 2015, 20 percent of Anthem plans' ACOs were on a path to transition to downside risk, with approximately 5 percent transitioning to downside risk.

As a condition of participating in the program, EPHC providers also agree to:

- Provide 24/7 access to members through extended hours and/or after hours call coverage
- Have a dedicated position within their practices that supports participation in EPHC and practice transformation
- Regularly participate in collaborative learning sessions and use support tools, such as hot-spotting reports, to identify gaps in care
- Use a disease registry to manage care for patients with certain chronic conditions and engage in care planning for the high risk population
- Use generic prescription drugs when clinically appropriate
- Engage in quality and performance measurement, and meet appropriate performance standards on nationally endorsed quality measures

Finally, providers participating in EPHC are encouraged to use an electronic medical record, and are recognized for becoming certified as a Patient-Centered Medical Home by the National Committee on Quality Assurance through the quality scorecard.

EARLY RESULTS SHOW EPHC IMPROVES QUALITY, REDUCES COSTS, AND ENHANCES PATIENT EXPERIENCE

Early analysis examined the results from the first year of the EPHC program, which included 744,000 members in Anthem plans attributed to 7,974 providers from 422 participating EPHC practices. The evaluation analyzed the cost of care over a 12-month period, starting in either April or July of 2013, for members attributed to EPHC providers compared against a matched group of members attributed to providers not in the EPHC program. The initial analysis found gross medical savings of \$9.51 per attributed member per month (PaMPM) for members who saw EPHC providers compared to those who did not – a 3.3 percent reduction in medical costs. After taking into account care coordination and shared savings payments, net savings from EPHC were \$6.62 PaMPM. (See Appendix for more detailed results.)

Figure 1. EPHC Bends the Cost Curve, Improves Quality

\$9.51 PaMPM (3.3%)

Gross savings for program year 1 (\$6.62 net savings)

 **7.8% fewer** acute inpatient admits per 1000

 **5.1% PaMPM decrease** in outpatient surgery costs

 **5.7% fewer** inpatient days per 1000

 **7.4% decrease** in acute admissions for high risk patients with chronic conditions and an increase of 22.9 per 1,000 PCP visits for high risk patients

 **3.5% decrease** in ER costs, and a 1.6% decrease in ER utilization

In the first year, the savings were attributable primarily to a 7.8 percent reduction in acute inpatient admissions and 3.5 percent lower emergency room costs relative to the matched control group. Concurrently, in a separate analysis, EPHC providers also outperformed their non-participating peers in multiple categories of quality, suggesting that they more consistently provided evidence-based care as well as preventive care.

Surveys demonstrate improved consumer satisfaction with access to care. For instance, patients whose providers participated in EPHC reported better access to urgent care; those reporting they were “always” able to access urgent care services increased by 11 percentage points from 2013 to 2014. Other findings illustrate an improved consumer experience including a 5 percentage point increase in plan members reporting that their provider “always listened to them with respect,” and an 11 percentage point increase in those reporting that their providers asked about addiction and mental health conditions.

Table 2. Preliminary Results: Performance on Quality Metrics for EPHC Providers Compared to Non-Participating Peers

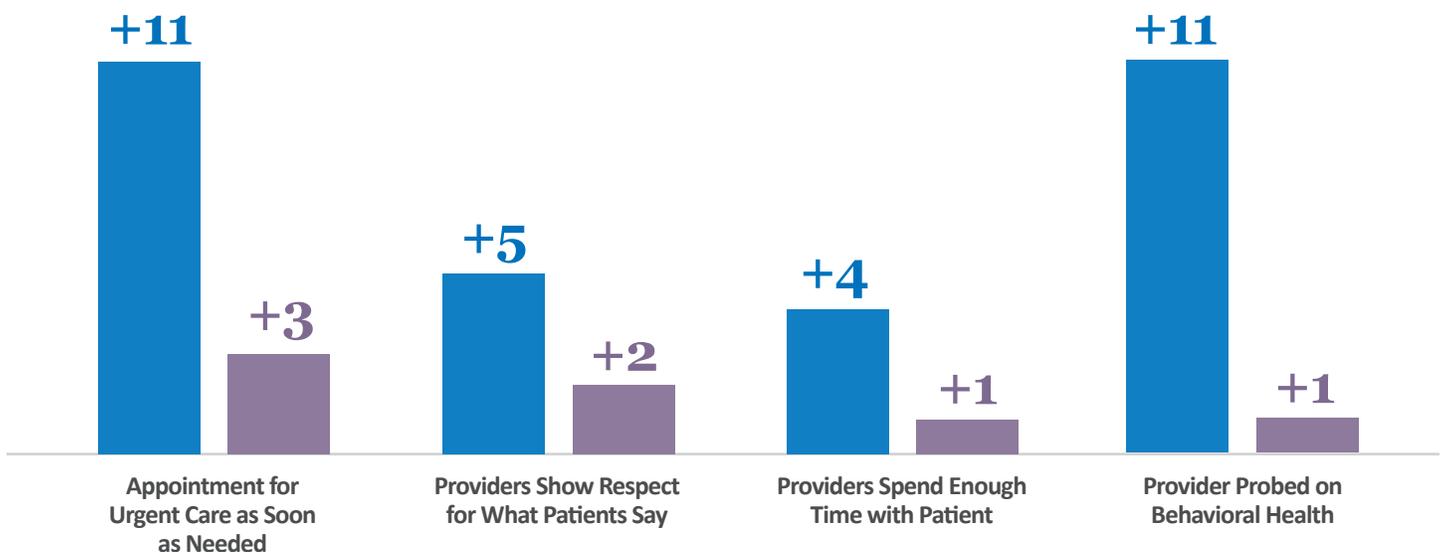
Quality Category	Percent Better Than Non-Participating Providers
Pediatric Prevention (e.g., immunizations, well-child visits)	9.6%
Annual Monitoring of Persistent Medications (e.g., diuretics)	4.8%
Diabetes Care (e.g., Eye exams, HbA1c testing)	4.3%
Adult Prevention (e.g., breast, cervical cancer screenings)	4.3%
Acute and Chronic Care Measures (e.g., asthma control, depression treatment, beta-blockers after heart attack)	3.9%

Figure 2. Significant Improvements in Member Experience

Percentage point change in member experience scores, 2013 - 2014

- ▶ Members get **appointments** for urgent care **right away**
- ▶ Physicians and staff are **attentive, thorough and available**
- ▶ Members feel more **respected and satisfied**

■ EPHC ■ Non-EPHC
Results from Enhanced Personal Health Care Program Year 1



WHAT CAN WE LEARN FROM THE EARLY RESULTS OF EPHC?

While the movement to value-based payment models is increasingly prevalent, research and evaluation gaps persist on how best to design and implement VBP programs, and in how to define “successful” programs.¹⁸ A 2014 RAND report found that there is still little known on the best ways to design and implement VBP programs.¹⁹ As payers and providers move forward on VBP efforts in response to imperatives to improve quality and reduce costs, the absence of information on key program design features and the components necessary for success could dampen results.

Content Highlight

The early results of EPHC help fill research gaps with respect to value-based payment models and highlight the features critical to success.

However, programs such as EPHC can help fill the research and evaluation gaps and begin to highlight the design and program features necessary for successful VBP programs that deliver on the promise of patient-centered care. While EPHC is still in its early stages, three essential themes have emerged:

1

Collaboration and flexibility between payers and providers is critical to success

2

VBPs can be successfully implemented with a range of providers, consistently resulting in improved patient experience and quality

3

Ongoing testing of payment and delivery reforms will need to take into account increasing complexity of evaluations

EARLY RESULTS STRESS IMPORTANCE OF COLLABORATION AND FLEXIBILITY BETWEEN PAYERS AND PROVIDERS

Based on the initial evaluation and three years of EPHC implementation, several learnings have emerged that underscore elements that are critical to the success of the EPHC model, some of which may also be applicable to VBP programs more generally.

Meet Providers Where They Are to Incent Participation and Retention in VBPs

A hallmark of the EPHC program is its ability to work with providers regardless of their readiness to assume risk, and to avoid the use of a “one-size fits all” contracting arrangement. The program focuses on inclusiveness, by working with any provider willing to engage in practice transformation and who agrees to the basic program requirements. Participating providers are given a spectrum of contracting and partnership options across the risk-bearing continuum which vary depending on providers’ abilities to manage clinical risk and assume financial risk. Steady increase in provider participation in EPHC indicates that offering a range of shared savings and risk options is important for buy-in and provider participation.

Practice Transformation Requires Upfront Investment

Provider practices vary in size and their level of financial reserves. Upfront payments are necessary to ensure that small group practices with limited care management staff – and financial reserves – can also engage in practice transformation and make the shift to VBPs. EPHC’s upfront care coordination payments help practices invest in care transformation activities. One study of the costs associated with medical homes across 35 practices found that the average total cost per full-time physician was \$517,000.²⁰ Costs associated with medical homes include support staff, general operating expenses, IT, and physician costs.²¹

ACOs are another example of VBPs that require sizable upfront investment. One survey of ACOs reported average practice management costs of \$1.5 million for the ACO, with costs likely higher in the first year.²² Even CMS has acknowledged that ACO start-up costs are significant – especially for smaller, rural providers. As a result, the Center for Medicare and Medicaid Innovation announced the Advance Payment Model to encourage participation in the Medicare Shared Savings Program. The program is designed for physician-based and rural providers that may need upfront and monthly payments to make investments necessary to coordinate care in an ACO construct.²³

Clinically Meaningful and Actionable Data Are Needed to Change Care Delivery

Anthem plans arm EPHC providers with actionable data and help them learn how best to leverage the data to improve care for their patients. The direct, customized attention from the Transformation Teams is augmented by meaningful and actionable clinical data through Provider Care Management Solutions. With this application, on any day, EPHC providers can determine which patients require their assistance and what interventions to use. In addition, data feeds include longitudinal member records as well as “hot spotter” and gaps in care reports designed to help providers target their care management efforts.

With this application, on any day, EPHC providers can determine which patients require their assistance and what interventions to use.

Other leading stakeholders agree that data needs are paramount in the shift from volume to value. For instance, the Health Care Transformation Task Force, a coalition of private stakeholders committed to moving 75 percent of their payments into value-based arrangements by 2020, called for continuous improvements in “access to complete, accurate, reliable, timely data” as part of a set of principles for Medicare, Medicaid, and commercial ACOs.²⁴ An evaluation of eight early-stage and regional VBP programs funded by the Robert Wood Johnson Foundation also concluded that a prerequisite for success included “broad and timely access to data,” including data sharing between providers and payers, in order for participating providers to deliver cost-effective care.²⁵ Timely and actionable data are critical to addressing patient needs before they require intensive care.

Payers and Providers Must Be Partners in Value-Based Payment to Deliver on Patient-Centered Care

EPHC’s early results demonstrate that cost and quality can be improved using a collaborative approach; however, provider buy-in and improved care experience for the patient are essential to expand and sustain participation. EPHC’s collaborative approach fosters care transformation and offers the partnership and support necessary for physicians to assume payment risk. A separate survey of physician groups found that major reservations to assuming more payment risk stemmed from the perceived inability to “expand... internal processes to analyze, evaluate, and manage the care they deliver.”²⁶

Anthem plans provide resources and assistance to address these challenges, in active partnership with physicians participating in EPHC, through:

Transformation Teams

EPHC providers have a designated point-of-contact at Anthem plans and on-site assistance from field teams. These Transformation Teams work collaboratively with EPHC providers to help improve work flow and processes, and develop transformation plans

Clinical Support

Seamless coordination between physicians and the health plan is facilitated through a clinical liaison that helps practices develop care management skills, interpret reports, and identify and manage high risk patients

Collaborative Learning

Peer-to-peer learning opportunities are created, and connections to other community resources are made, to support providers in care management

VALUE-BASED PAYMENTS CAN BE SUCCESSFULLY IMPLEMENTED WITH A RANGE OF PROVIDERS

Content Highlight

A flexible VBP model like EPHC can be successful in less managed insurance models such as PPOs as well as with providers and practices ranging in size and sophistication.

Few VBP programs that involve a range of commercial insurance products have been studied on a large scale. Some of the most successful VBP programs in the commercial market have been implemented by Health Maintenance Organizations (HMOs), calling into question whether similar payment arrangements would yield favorable results in Preferred Provider Organization (PPO) models, with less restrictive networks. For instance, Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract (AQC), launched in 2009, has become a national model for moving providers into VBP arrangements. Under the AQC, providers agree to a global budget and financial incentives for meeting quality benchmarks,

but also are at-risk for spending that exceeds pre-determined targets.²⁷ The AQC has shown impressive results, with 2.8 percent savings within two years of participation in the program and greater improvement in quality relative to non-participants on chronic care management, adult preventive care, and pediatric care.²⁸ However, the AQC was implemented only in HMO products, where patients were required to select a primary care physician, allowing providers and payers a greater level of influence over care coordination and service utilization than they would have under a PPO product.²⁹ Among providers, there is a perception that establishing risk-based contracts under PPO arrangements is a challenge.³⁰

However, in order for VBP models to achieve necessary rates of penetration in the commercial market, they must be implementable across insurance products, including PPOs. In 2014, PPO products were the most common plan type among individuals with employer-sponsored insurance, with 58 percent of enrollment.³¹ Indeed, most of the plan members attributed to EPHC participating providers were enrolled in PPOs. Accordingly, the EPHC program can fill a significant gap in the research and learnings around VBP implementation in PPOs. Initial ideas about how EPHC has demonstrated success under PPO arrangements include:



The attribution model, which uses an algorithm to assign members to PCPs based on visit history or proactive PCP selection, is used to identify a provider's EPHC patient population

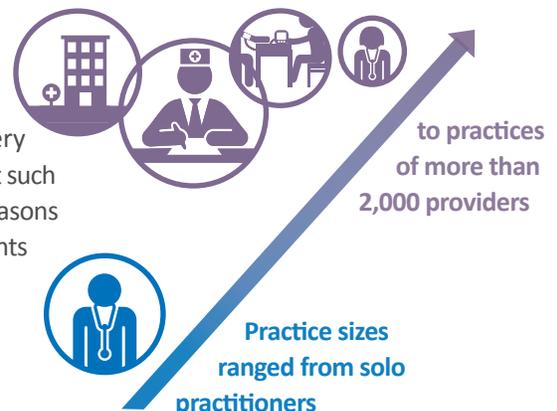


Plans' sharing of clinically meaningful data, along with tools that help providers act on that data



Improved member experience, including greater appointment availability and positive physician-patient interactions, may have prompted patients to first call their PCPs for any health care issue, mimicking an HMO model

In addition to operating mainly under PPO arrangements, EPHC was also implemented among a wide range of practices with varying levels of experience with VBPs and risk assumption. Practice sizes ranged from solo practitioners to practices of more than 2,000 providers, and included sophisticated practices within integrated delivery systems with experience managing risk as well as smaller, independent practices without such experience. Despite this variation, EPHC showed strong results in its first year. Initial reasons for success with varying practice sizes included the flexibility in contracting arrangements to meet physicians where they are; upfront care coordination payments to support investments; and collaboration through virtual resources, data tools, and Transformation Teams.



EVALUATION OF PAYMENT AND DELIVERY REFORMS WILL BECOME MORE COMPLEX

Content Highlight

Evaluation of VBP models is critical. As more providers participate, evaluations must address challenges of identifying a comparison group and isolating drivers of success.

As payment and delivery reforms continue to be implemented and examined – and increasingly become the “norm” – their evaluation will become correspondingly more complicated. The initial evaluation of the EPHC program identified early research limitations as well as three ongoing challenges, which must be taken into consideration for evaluating future iterations of EPHC as well as VBP programs more generally as their adoption spreads.

Limitations

While the early results of EPHC with respect to cost, access and patient satisfaction are promising, there are limitations given the real-world nature of the program and its implementation. First, there may be differences between providers who voluntarily chose to participate in the EPHC program at the outset relative to those in the control group who did not participate in EPHC (e.g., practice size, quality performance and experience with VBPs). While observed differences between the populations in the EPHC and control groups were small and adjusted for, there may still be differences that cannot be controlled for. Second, results from the early wave of participants were strong, but may not be sustainable as more providers with varying levels of engagement join EPHC, potentially limiting the generalizability of current results. Evaluations of future waves of EPHC may help to address some of these limitations and shed light on the generalizability of the current results for broader provider groups and patient populations.

Challenge 1

Identifying an Appropriate Comparison Group

In the initial evaluation, a matched comparison group at the patient level was used, with a difference-in-difference analysis, comparing baseline to program year for study and comparison groups. Importantly, the approach isolates the effects of EPHC above and beyond the effect of factors such as macro-level market changes, including cost growth and unit cost changes, and factors such as patient mix and product design.

However, with each subsequent wave of EPHC, a greater share of providers join the program, leaving fewer non-participating providers as a comparison for an evaluation. In addition, the EPHC

program will reach a greater number and mix of plan members.

Future analyses must explore the expected and unexpected drivers of savings (or lack thereof) in order to use those findings to improve the delivery of care.

Subsequent evaluations that include these expanded populations will provide valuable information about the impact of EPHC across diverse patient groups; however, they will also require a diverse comparison group for evaluation. The expansion of VBP programs like EPHC makes it more difficult to isolate

a comparable matched control group, have a sufficient sample size, and control for possible spillover effects. There may also be selection bias effects that cannot be controlled for among those providers who choose not to join EPHC—limiting the power of a matched control group to isolate the ongoing and longer-term effects of EPHC on cost and quality.

Challenge 2

Isolating Drivers of Change

Many successful VBP programs show early cost savings such as fewer ER visits and reduced acute inpatient hospital use. EPHC followed this expected pattern as discussed above. However, there were also unexpected results in this first wave, such as improvements in outpatient service use, and no measurable changes in readmission rates. Future analyses must explore the expected and unexpected drivers

of savings (or lack thereof) in order to use those findings to improve the delivery of care.

In addition, evaluations of EPHC will need to identify appropriate control factors to ensure that results are attributable to EPHC and not to other programs that physicians may be

Challenge 3

Continued Demonstration of Value for Purchasers

As VBP programs such as EPHC mature, their continued impact on quality improvement and cost savings, or overall value, must be demonstrated. Some of the results or impact may be one-time improvements or savings,

health plans. EPHC can also inform other efforts, including those at the Center for Medicare and Medicaid Innovation, where real-time or rapid cycle evaluation of payment reforms could be useful for refining and shaping initiatives. For instance, the Comprehensive Primary Care Initiative began in 2013 as a multi-payer effort

Those providers who are outliers – at both the high and low ends of performance – should be examined to garner insight into what facilitates successful practice transformation, or what impedes it.

participating in with other health plans or employers, Medicare, and/or Medicaid. Isolating the effects of EPHC on changes in care delivery and utilization may be difficult in the context of cross-payer programs and changes in payment methodologies. Evaluations will also need to examine the extent to which initial results may be partially attributable to early EPHC adopters having better baseline clinical and financial performance than their non-participating peers.

Finally, there is variation with respect to providers' success at driving change in quality and cost under VBP arrangements. Those providers who are outliers – at both the high and low ends of performance – should be examined to garner insight into what facilitates successful practice transformation, or what impedes it. Armed with this knowledge, policymakers, payers, and other stakeholders can advance alternative payment models to better support the successful transformation to VBPs for all providers.

but ongoing effects must be isolated and understood. This is a challenge for both public programs and private purchasers (e.g., health plans, employers) as they weigh the relative long-term potential and impact of various VBP programs, and make decisions about which programs to invest in, expand, or terminate.

Evaluators of VBP programs might focus on understanding the results along several dimensions:

- Cost effectiveness of the program relative to baseline spending
- Quality and cost improvements among participating providers relative to their own historical performance, and sustainability of trends over time
- Quality and cost improvements among participating providers relative to a control, or comparison, group

EPHC is a large scale effort that can be examined alongside other similar efforts such as those sponsored by CMS or other

to support primary care practice transformation in approximately 500 practices through care management fees, data sharing and feedback, learning activities, and technical assistance.^{32,33} First year results show 2 percent gross savings, or \$14 per beneficiary per month, which nearly offset care management fees; savings were largely driven by reduced inpatient admissions, 30-day readmissions, and ER visits.³⁴

Given the number of VBP programs and efforts being spearheaded by a range of plans and purchasers, it may also be worthwhile to construct a common evaluation framework for assessing gross and net savings and quality changes. Each of these programs includes a unique set of design elements, which can further an understanding of what works, and what does not work, but only if evaluation findings can be compared across programs. Current variation in evaluation methodologies limits these comparisons.

FUTURE OUTLOOK FOR THE SHIFT FROM VOLUME- TO VALUE-BASED PAYMENT

Content Highlight

The early experience of EPHC can inform the development and implementation of future VBP models. EPHC highlights the opportunities and challenges in moving from volume to value.

As policymakers formulate next steps in moving more providers and payments into value-based arrangements, EPHC and similar programs should be examined for their rapid-cycle learnings. First, EPHC is built on collaboration with providers through the deployment of Transformation Teams that provide a range of technical supports and resources to participants. Second, EPHC provides flexible contracting options that allow providers – regardless of their experience with VBPs – to participate and develop the competencies necessary to transform care. These early experiences with EPHC may help inform the implementation of future VBP efforts, including the new physician payment programs under MACRA.

Recommendations for CMS as the agency designs future programs or revises existing ones include:

- Focus on increasing participation and retention in VBPs with flexible contracting options that encourage providers at all levels to gradually bear more risk for the quality and cost of care they deliver to all of their patients – not just those in FFS payment systems
- Look to successful private-sector VBP programs and other innovative delivery reforms in efforts to define the parameters of APMs in Medicare and other programs
- Encourage providers to create partnerships, such as with private health plans, to facilitate their participation in VBPs, particularly for those providers who do not have the resources necessary to make the transition to an APM (e.g., ACO) on their own

Collaboration with providers is foundational to the EPHC program’s approach to transform primary care such that patient-centered care is a reality. The program’s early, but promising, results support broader efforts to shift ever more of provider payments to be value-, rather than volume-, based.

EPHC is reaching an estimated 4.6 million lives, and is demonstrating appeal among both providers and patients. Most importantly, the approach is showing early positive results on both cost and quality dimensions with a wide range of providers, and future evaluations will continue to examine the program’s impact across a wide range of patient populations and in differing provider circumstances by geography. The EPHC experience underscores the opportunities and challenges that a shift to value-based payment holds. Early findings indicate that providers are at varying levels of readiness, but health plans can offer partnership and support through the provision of tools, financial and human resources, expertise, and actionable data that support providers’ efforts to transform the delivery of care to their patients.

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The Anthem Public Policy Institute gratefully acknowledges the support of CapView Strategies in the development of this paper.

APPENDIX

Methods³⁵

The evaluation of Enhanced Personal Health Care examined the impact based on the actual observed savings as measured against a control group. The rigorous statistical analysis is the measure of the effect of EPHC on cost and utilization. A full analysis of the impact of the program on quality metrics is underway and results here are preliminary.

The results outlined in this document include data from approximately 744,000 Anthem plan members who had at least six months of plan eligibility during the baseline and study period and who were attributed to 7,974 providers from 422 Enhanced Personal Health Care Participating Providers.

The evaluation compared outcomes for plan members who saw EPHC providers against those of a matching set of plan members who saw providers who were not participating in the program. The comparison was based on two sets of 12 months of claims, one beginning April 2013 referred to as Wave 1, the other beginning July 2013, referred to as Wave 2.

The outcomes results were calculated using multivariate regression difference in difference models. The models estimate the cost and utilization changes between the study group program year and the baseline year relative to the same changes in the control group. Model results isolated the effect of the EPHC program above and beyond those explained by variables that influence trend, such as differences in geographic area, product design, provider characteristics, clinical risk characteristics of the plan members and macro market changes such as unit cost changes, population mix and general moderations in trend.

In order to create an appropriate control group for comparison, a stratified matching process was run at the state level to find plan members with common characteristics, especially with respect to factors that drive cost, such as cost risk. (Appendix Table 1)

Results³⁶

Table 1

Matching Variables	Before Match		After Match	
	EPHC Study	Non-EPHC Comparison	EPHC Study	Non-EPHC Comparison
Members	750,154	3,278,861	744,732	747,080
Average Total Cost Risk	1.25	1.36	1.15	1.17
Average Member Age	35.11	36.33	33.03	33.05
Average Provider Age	51.89	53.52	50.81	51.38
% over Age 18	0.75	0.78	0.72	0.72
% Female	0.53	0.53	0.53	0.52
% with Rx Carve-in	0.49	0.46	0.51	0.51
% HMO	0.19	0.09	0.19	0.19
% Self-Insured	0.56	0.55	0.56	0.56
% Local Group	0.81	0.82	0.81	0.81

Table 2

Category of Care Allowed \$PaMPM	Allowed \$PaMPM Gross Savings	% Chg (Rel. to Control)	P value* (Rel. to Control)	Low CI 90%ile	High CI 90%ile
Gross Medical**	-\$9.51*	-3.3%	0.000	-\$12.17	-\$6.85
Inpatient	-\$2.00*	-3.5%	0.046	-\$3.65	-\$0.35
IP Acute Admits/k	-2.6*	-7.8%	0.000	-3.5	-1.7
IP Acute Days/k	-7.9*	-5.7%	0.046	-14.6	-1.4
Outpatient	-\$5.03*	-5.5%	0.000	-\$6.20	-\$3.86
ER \$	-\$0.71*	-3.5%	0.001	-\$1.06	-\$0.37
ER Visits/k	-2.5	-1.6%	0.015	-4.3	-0.8
OP Other \$	-\$2.71*	-6.8%	0.000	-\$3.49	-\$1.93
OP Surgery \$	-\$1.58*	-5.1%	0.000	-\$2.27	-\$0.90
Professional	-\$2.25*	-1.6%	0.001	-\$3.12	-\$1.38
Prof Office Visit \$	-\$0.49*	-1.2%	0.000	-\$0.62	-\$0.37
Prof Office Visits/k	-9.7	-0.3%	NS	-19.9	0.4
Risky PCP \$***	\$0.89*	2.3%	NS	\$0.24	\$1.53
Gross Pharmacy	-\$0.79*	-1.1%	0.070	-\$1.50	-\$0.07
Brand Allowed \$	-\$0.42	-0.9%	NS	-\$1.10	\$0.25
Generic Allowed \$	-\$0.38*	-1.5%	0.002	-\$0.33	\$0.32
Total Pharmacy Scripts (PMPY)	-0.1*	-0.5%	0.080	-0.1	0.0

*Statistical significance in results is relative to change in control group, statistically significant using threshold of Pval<0.1. (NS = Not Significant)

**Medical includes all members with medical coverage, including Rx carve out.

***'Risky' members are either top 15%ile risk with Chronic Disease or had admit and in top 30%ile risk.

Please note, individual statistical models were run for each measure, results in each place of service setting will not add up to the total medical amount.

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About the Anthem Public Policy Institute

The Anthem Public Policy Institute was established to share data and insights to inform public policy and shape the health care programs of the future. The Public Policy Institute strives to be an objective and credible contributor to health care innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem's innovative programs.

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