Workshop #1: Evolving Approaches to the Management of Quitlines

August 26, 2019
Minneapolis, MN
Panel 3 – Improving Quitline Business Operations through the RFP and Contracting Process

Moderator:
- Miranda Spitznagle, MPH, Commission Director, Indiana Department of Health – Tobacco Prevention and Cessation

Panelists:
- Michelle Lynch, BA, NCTTP, Tobacco Cessation Supervisor, Colorado Department of Health
- Cile Fisher, Account Manager, National Jewish Health
- Paula Celestino, MPH, Client Relations and Outreach Director, Roswell Park Cessation Services, Roswell Park Comprehensive Cancer Center

Speaker:
Rebecca Nielsen, MBA, Principal, Leavitt Partners
Opportunities for Tobacco Quitlines in the Evolution of Value-Based Care

Rebecca Nielsen
Leavitt Partners, LLC.
Opportunities for Tobacco Quitlines in the Evolution of Value-Based Care

- An Introduction to Leavitt Partners
- The Momentum of Value-Based Care
- Opportunities for State Tobacco Quitlines
- Incorporating Value-Based Contracting into state RFPs
Leavitt Partners Mission

We improve lives by advancing value-based care, striving to make our health care system more accessible, effective, and sustainable.
What is “Value-Based Care,” Anyway?

Value-based care refers to innovative payment strategies designed to incentivize care delivery practices that reduce overall costs while improving quality outcomes.

Other labels used to describe value-oriented principles include:

• Value-based payment
• Value-based contracting
• Value-based purchasing
• Value-based reimbursement
• Alternative payment models
• Accountable care
• Outcomes-based pricing
• Cost, quality, outcomes
The Theory of Health Care Reform: Defining “Value-Based Care”

Step 01
PAYMENT REFORM
Pay providers differently for care.

Step 02
DELIVERY REFORM
Providers change how they deliver care.

Step 03
ACHIEVE TRIPLE AIM
Achieve better outcomes, better experience, and lower costs.
Value-Based Care Driven by Economic Imperative

Average Health Care Spending Per Capita, 1970-2016
(Adjusted for Differences in Cost of Living)

United States in 2016: $[VALUE]

Life Expectancy at Birth in G7 Countries, 1960-2017

Source: Congressional Budget Office Data, Outlays as a Percentage of GDP

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Our 40-Year Journey to Value

Source: CBO 2018 Long-Term Budget Projections; Leavitt Partners ACO Database

- 1965: Medicare/Medicaid
- 1973: Diagnosis-related group (DRG) developed (Yale)
- 1985: Medicare adopted DRGs
- 1996: >50% of Commercial in Managed Care
- Mid 90s: Patient’s Bill of Rights
- 1992: Resource Based, Relative Value system (RBRVS)
- 1999: To Err is Human
- 2006: Medicare Part D
- 2003: MMA
- 2010: ACA
- 2012-14: Bundled Payments, Pioneer ACO, MSSP
- 2016: More Bundled Payments, MACRA, Next Gen
- 2019: Direct Contracting Model
- 2016: More Bundled Payments, MACRA, Next Gen
- 2010: ACA
- 2012-14: Bundled Payments, Pioneer ACO, MSSP
- 2019: Direct Contracting Model
According to a national survey of both public and private payers, 96% of payer contracts are still tied to a fee-for-service reimbursement foundation.

The Fee-for-Service Chassis of Value-Based Payment

41% Fee-for-Service—no link to quality & value

25% Fee-for-Service—link to quality & value

30% APMs built on FFS architecture

4% Population-based payment

Source: Health Care Payment Learning & Action Network, Annual Payer Survey October 2018
Commercial payers are “leaning in” to the value trend, tying significant percentages of their total payments to value.

Payer members of the Health Care Transformation Task Force have committed to tying 75% of their payments to value by 2020.

Source: The Health Care Transformation Task Force, 2018
Some estimate the national average health care cost per smoker per year is $37,318.

Source: WalletHub, The Real Cost of Smoking by State, Retrieved from:
Smoking-related illness costs more than $300 billion each year.

This includes $170 billion in direct medical care costs.

And more than $156 billion in lost productivity.

Smoking Reduction Saves Health Care Costs

One study suggests a reduction of $6.3 billion in health care expenditures the year following a 10% reduction in the state smoking rate relative to the national average.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4662575/
Hundreds of thousands of tobacco users receive evidence-based services each year

NRTs can increase rate of quitting by 50-70%

The majority of quitlines are already screening for chronic and behavioral health conditions

The overall spending per smoker in 2017 was $1.81 with a quit rate of 27%

Source: WalletHub, The Real Cost of Smoking by State, Retrieved from:
Value-Based Contracting Opportunity

The quitline model is conducive to outcomes-based approaches for contracting

- Quit Rate
- Engagement Rate
- Reach Rates
- Triaging callers with coverage

Incorporating Value-Based Contracting Language into State RFPs

- Payment for Quitline registrants that successfully quit who do not have other cessation benefits
- Payment for evidenced-based services correlated with quitting (e.g. counseling calls and providing medication)
- Payment for proportion of state tobacco users who successfully enroll
- Payment for moving callers with cessation benefits to their plan
Key Takeaways

Value
Health care is being driven toward value by an economic and human imperative—it’s not a matter of “if” but of “how fast?”

Opportunity
State tobacco quitlines are uniquely positioned to accelerate this transformation for hundreds of thousands of people across the United States.

Application
Incorporating value-based care language into state RFPs for tobacco quitlines has the potential to increase health care quality and reduce health care costs at both the personal and economic level.