Network for
Regional Healthcare
Improvement

Payment Reform: What's the Point?

Implementing Value-Based Payment and Improving Care in a New Environment

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President & CEO, NRHI

March, 2017

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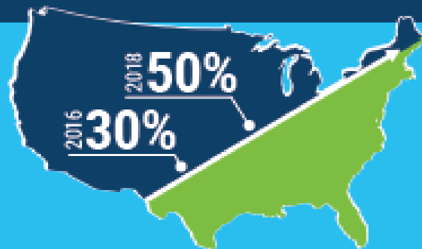
APM MEASUREMENT



Public and private health plans voluntarily participated in a national effort to measure the use of alternative payment models (APMs) as well as progress towards the LAN's goals of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

PARTICIPANTS

COMMERCIAL
26 HEALTH PLANS
90 MILLION COVERED LIVES
44% OF COMMERCIAL MARKET

MEDICARE ADVANTAGE
23 HEALTH PLANS
10 MILLION COVERED LIVES
58% OF MEDICARE ADVANTAGE

MEDICAID
28 HEALTH PLANS AND TWO STATES
28 MILLION COVERED LIVES
39% OF MEDICAID

REPRESENTING MORE THAN **128 MILLION** AMERICANS AND...

...NEARLY **44%** OF THE COVERED POPULATION IN THREE MARKET SEGMENTS

2016 RESULTS

IN APM CATEGORIES 3 & 4

% OF HEALTH CARE DOLLARS

22%	41%	18%
COMMERCIAL	MEDICARE ADVANTAGE	MEDICAID

*Data from January 1, 2016 was collected over an 8-week period and aggregated to produce results based on the LAN's APM Framework.

The U.S. Department of Health and Human Services (HHS) announced in March 2016 an estimated 30% of traditional Medicare payments are tied to APMs that reward the quality of care over quantity of services provided. These results are separate from the results shown above.
* The results are based on contracts in effect on January 1, 2016 and represent estimated spending from January – December 2016.

National Goal:
Better, More Affordable Care

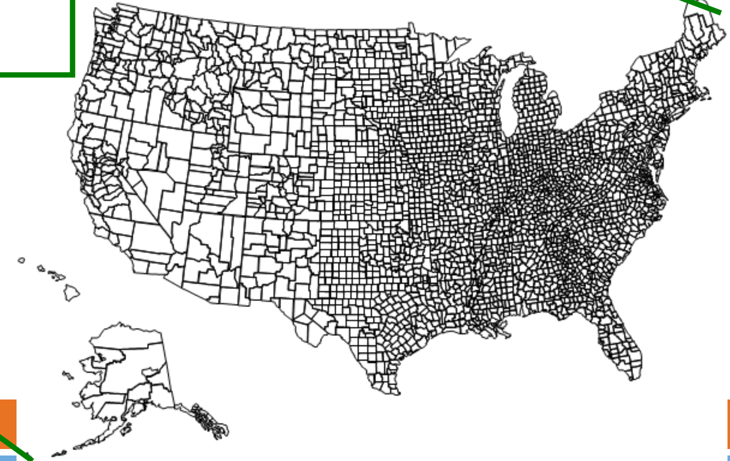
TRIPLE AIM

- **Improve Health**
- **Improve Care Quality**
- **Reduce Costs**

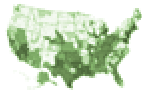
What's Needed to Make It Happen in 50 States and 3000+ Counties?

TRIPLE AIM

- **Improve Health**
- **Improve Care Quality**
- **Reduce Costs**



The Opportunities to Improve Differ from Region to Region



THE DARTMOUTH ATLAS OF HEALTH CARE

CORONARY ARTERY BYPASS GRAFTING PROCEDURES PER 1,000 MEDICARE ENROLLEES, 2007

Customize this report

Share

Layers

Legend

No data

1.5 - <3.1 (61)

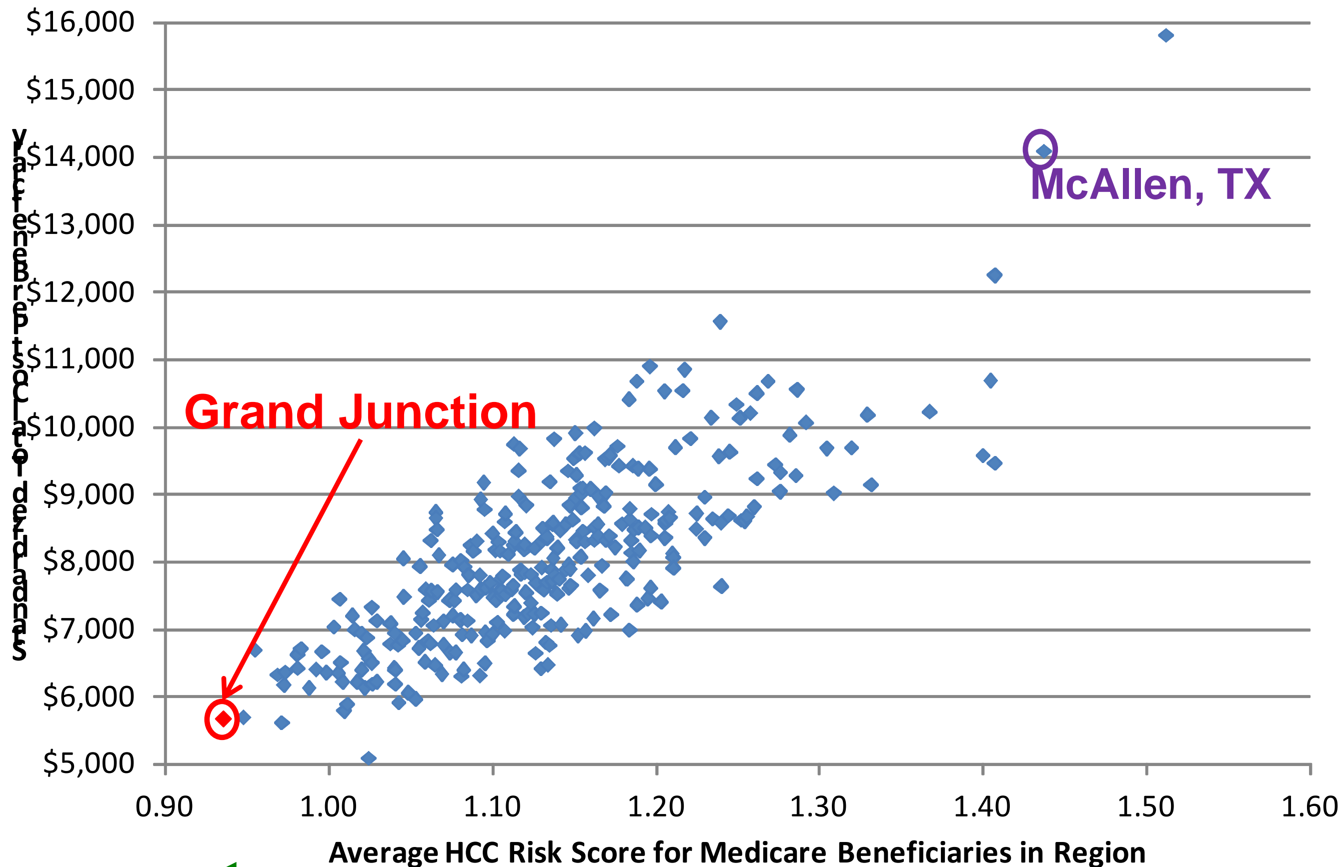
3.1 - <3.6 (61)

3.6 - <4.1 (61)

4.1 - <4.9 (61)

4.9 - 8.9 (62)

Is it Better Healthcare, Healthier Residents, or Both?

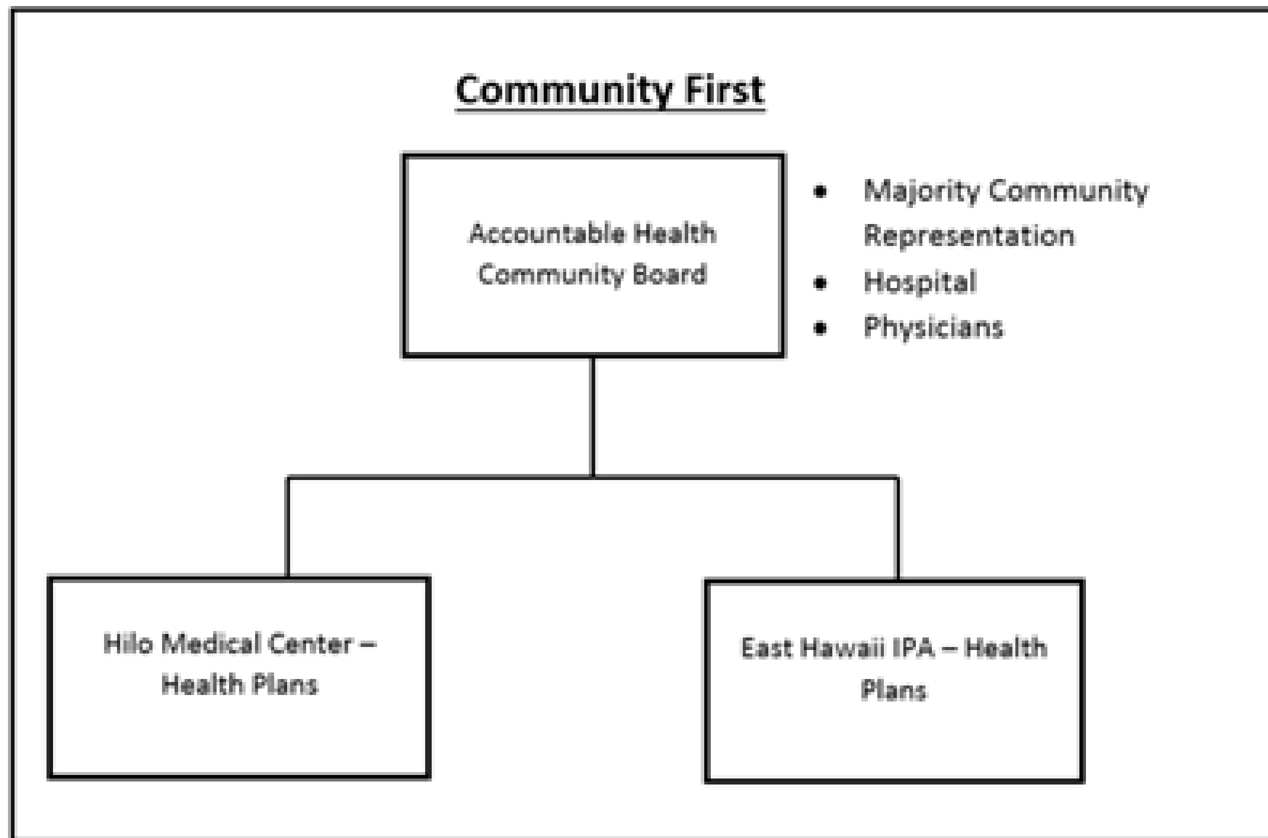


Lower Spending Per Patient

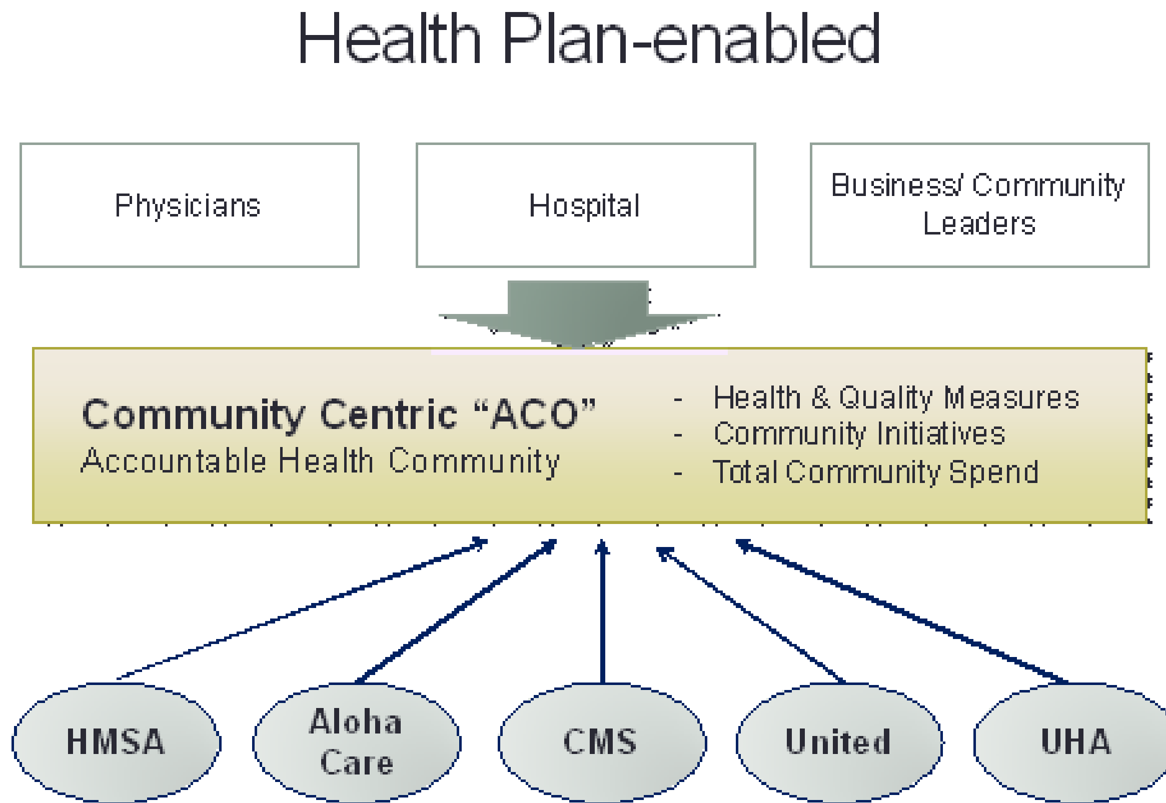
Healthier Patients

Hawaii: Community Governed ACO

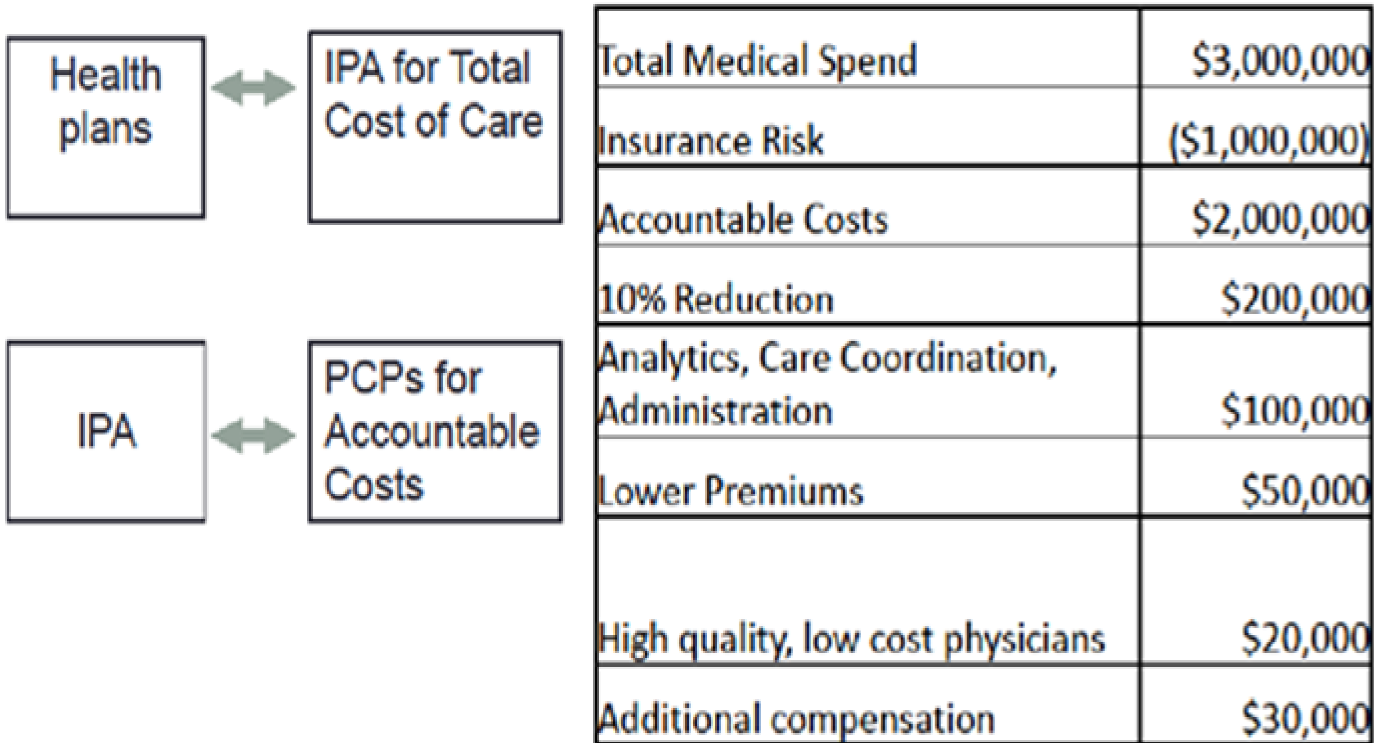
Community governance can be achieved without creating a separate ACO entity and incurring the administrative costs and complexity a small community cannot carry



Hawaii:
Health Plan-enabled Community-centric ACO



Accountable Medical Home
Numbers based on an actual EHI PCMH of 810 members



Total Medical Spend	$3,000,000
Insurance Risk	($1,000,000)
Accountable Costs	$2,000,000
10% Reduction	$200,000
Analytics, Care Coordination, Administration	$100,000
Lower Premiums	$50,000
High quality, low cost physicians	$20,000
Additional compensation	$30,000

Washington

The state is implementing three value based payment models.

1. They have entered into accountable care contracts directly with two large integrated delivery systems for public employees and dependents. The accountable care network contract links provider payment with the potential for shared savings to quality, patient experience and total cost of care requirements. The State will also be introducing a bundle for total joint replacement surgery.

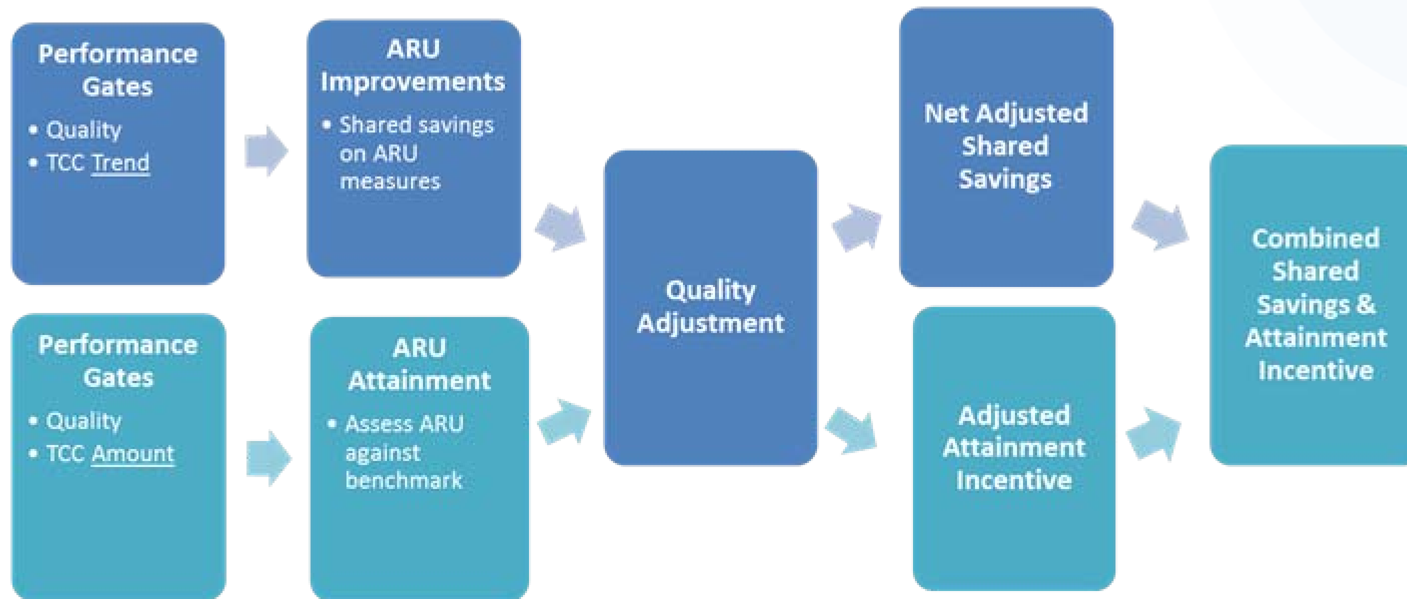
2. They are beginning to tie Medicaid contracting with managed care organizations (Medicaid health plans) to specific quality and outcome performance targets and a requirement that the MCOs institute value based contracting with providers over time.

3. The state is introducing a different provider payment model for FQHCs and some Critical Access Hospitals to incentivize care management and alternative non visit based delivery mechanisms, e.g. telehealth.

Some private employers moving in to VBP

- Boeing doing direct contracting with provider accountable care organizations and COE for cardiac surgery outside of WA,
- Starbucks introducing a private insurance exchange and value based benefit design, etc.

IHA Value Based P4P Incentive Design



To earn ANY award:

•Meet minimum level of quality
•**Meet Total Cost of Care standards**
•Net improvement on resource use measures

To MAXIMIZE award:

•Greater resource use improvement and attainment
•Higher quality

Integrated Healthcare ASSOCIATION

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IHA's Value Based P4P at a Glance

$550 million paid out in total since 2004

200+ Medical Groups and IPAs

10 Plans

Blue Shield of California
An Independent Member of the Blue Shield Association

Anthem. BlueCross

SHARP

aetna

Cigna

KAISER PERMANENTE

Western Health Advantage

Chinese Community Health Plan

CCHP

UnitedHealthcare

9.6 Million Californians

Integrated Healthcare ASSOCIATION

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Facilitating payment reform in southeast Michigan

The Greater Detroit Area Health Council (GDAHC), in partnership with NRHI

- Approximately 80 participants: purchasers (employers); providers; patients; and payers

•Leaders need to commit to showing up for hard conversations;
•Leaders need to stay in the discussion;
•Identify key change agents if not everyone comes to the table. Identify how to create “the ripple”;
•Identify an alternative payment model where payer and providers align around a model that creates a “win-win” for both—can’t end up “killing” hospitals;

•*Develop 2 to 3 action plans for southeast Michigan*

Cross-sector perspectives

ACO

- In the "cost" side of the question, we often debate the "revenue/income" for an entity on the other side of that question. As we try to rein in costs we are implicitly talking about taking revenue away from someone/something.

- None of us wants to lose revenue, but if we all continue to grow our revenue, the costs of providing health care in this country will only continue to increase.

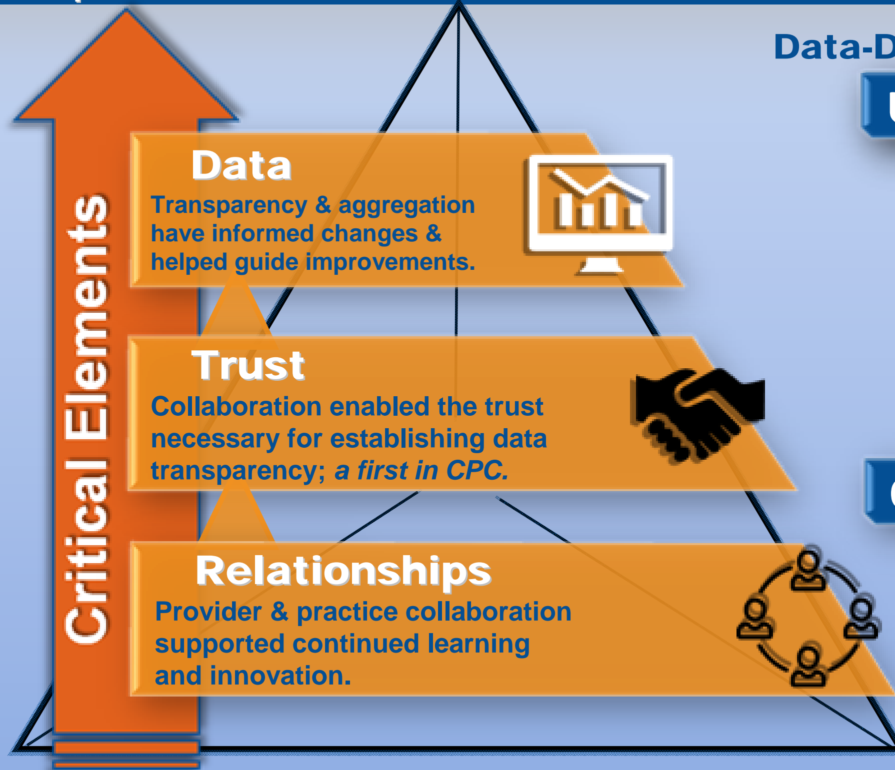
- Patients must remain in the center of these conversations.

- Talking about business models and revenue protection/ maximization loses sight of the fact that the reasons our organizations exist are to heal when possible and prevent suffering always.

CPC Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation
Project Timeline: 2013-2016

Population Health | **471,815 Empaneled Patients** | **Evidence-Based Care**



Data-Driven Improvement

Utilization

ED Visits	-2.8%
Inpatient Bed Days	-17.8%
Inpatient Discharges	-17%
Primary Care Visits	-9.1%
Specialist Visits	-10.7%

Quality

CHF Admissions	-28.4%
COPD Admissions	-13.3%
ACSC Composite	-23%

*OH/KY Risk-Adjusted All Payer Aggregate Data

#1: People Need to Know Where The Opportunities To Improve Are

Quality/Cost Analysis & Reporting

TRIPLE AIM

- **Improve Health**
- **Improve Care Quality**
- **Reduce Costs**

#2: Providers Need to Change the Way They Deliver Care

Quality/Cost Analysis & Reporting

TRIPLE AIM
- Improve Health
- Improve Care Quality
- Reduce Costs

Value-Driven Delivery Systems

#3: Payment & Benefits Need to Support Higher-Value Care

Quality/Cost Analysis & Reporting

TRIPLE AIM
- Improve Health
- Improve Care Quality
- Reduce Costs

Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery Systems

#4: Patients Need to Be Educated and Engaged

Patient Education & Engagement

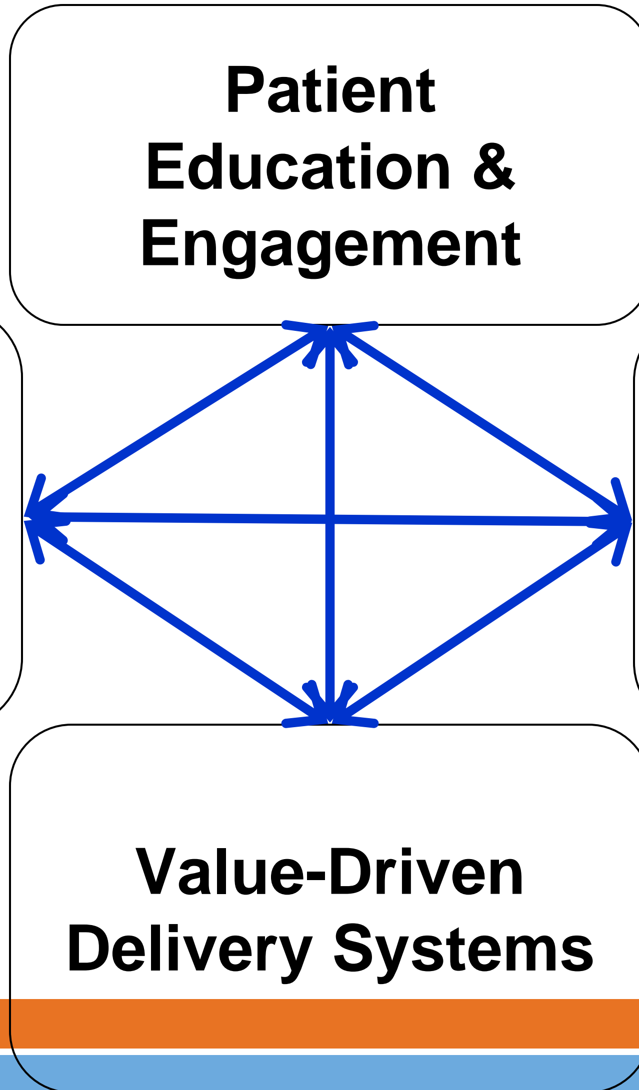
Quality/Cost Analysis & Reporting

TRIPLE AIM
- Improve Health
- Improve Care Quality
- Reduce Costs

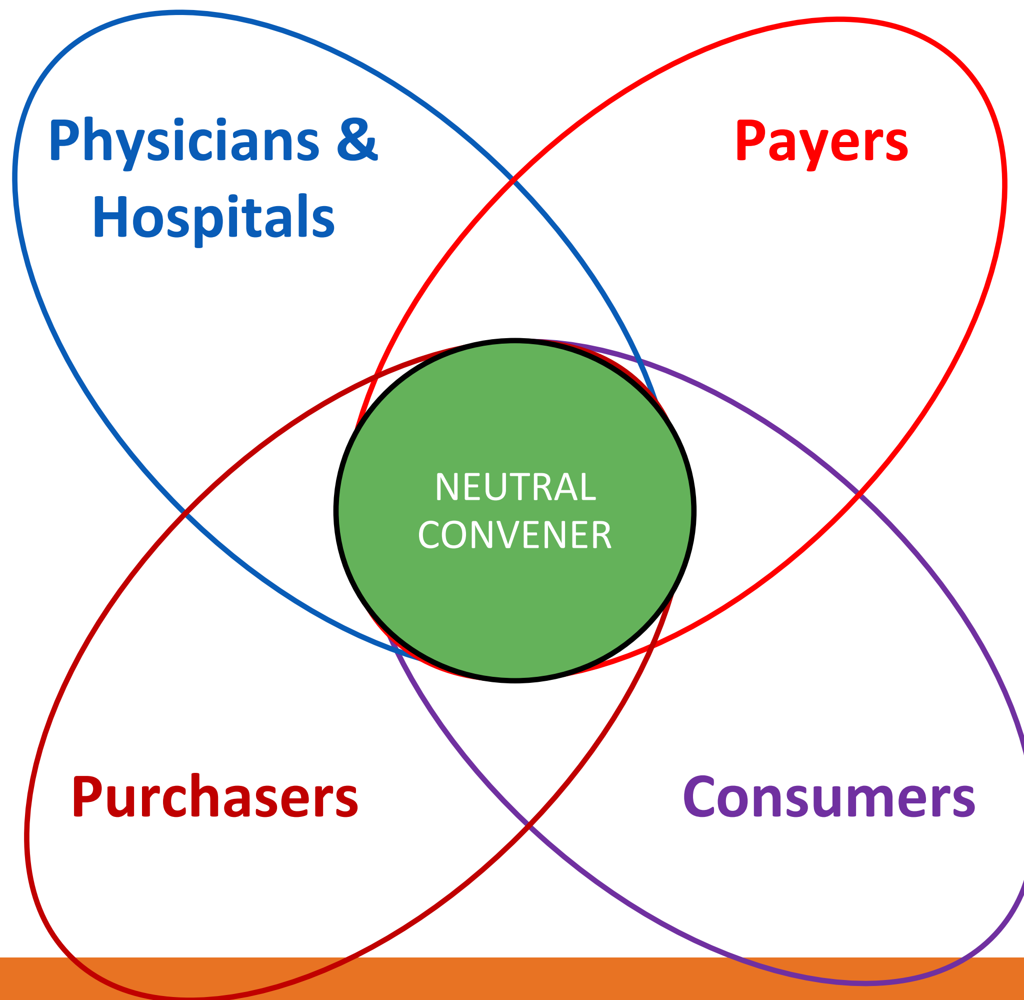
Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery Systems

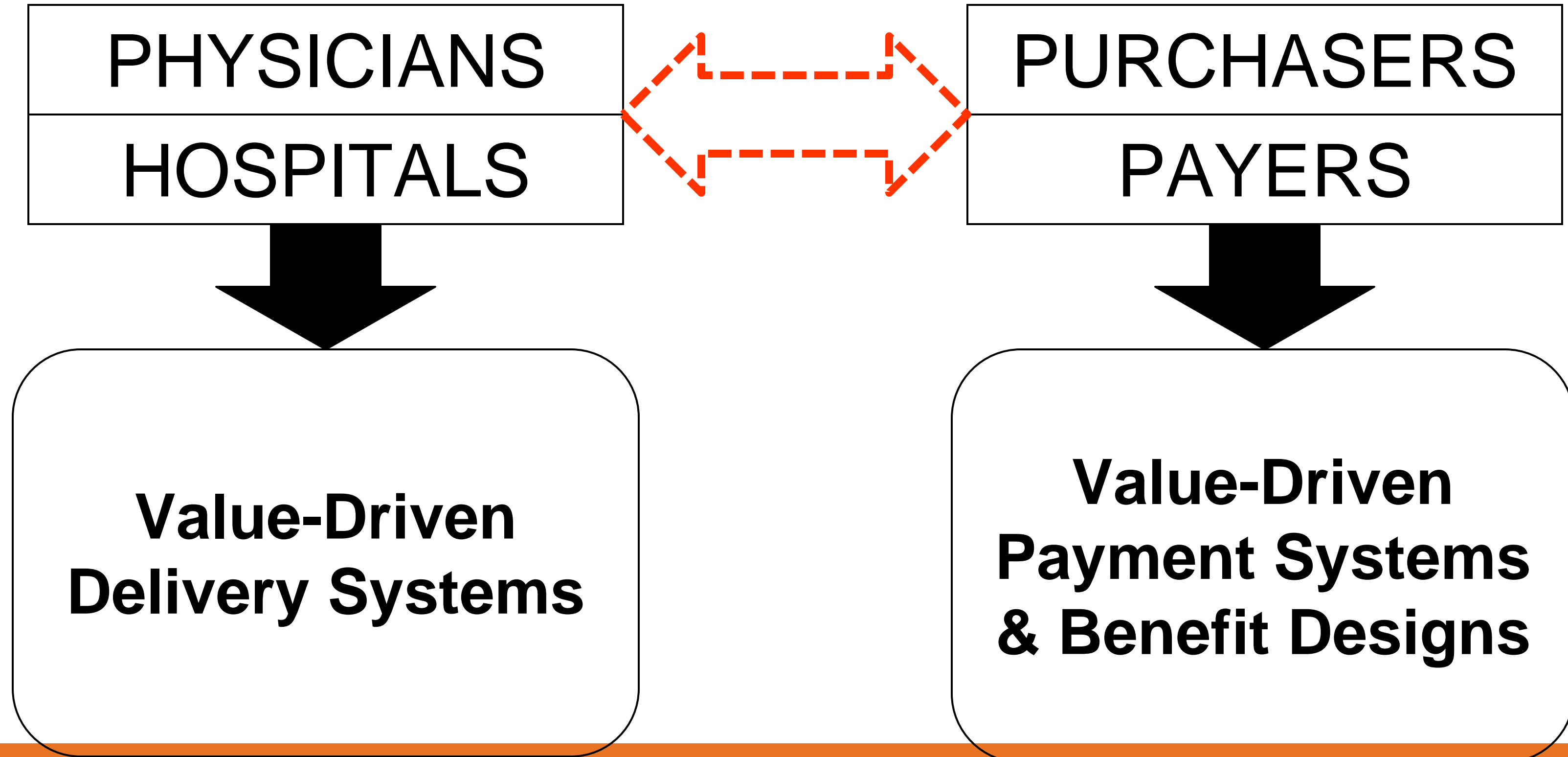
All the Pieces Have to Be Coordinated…



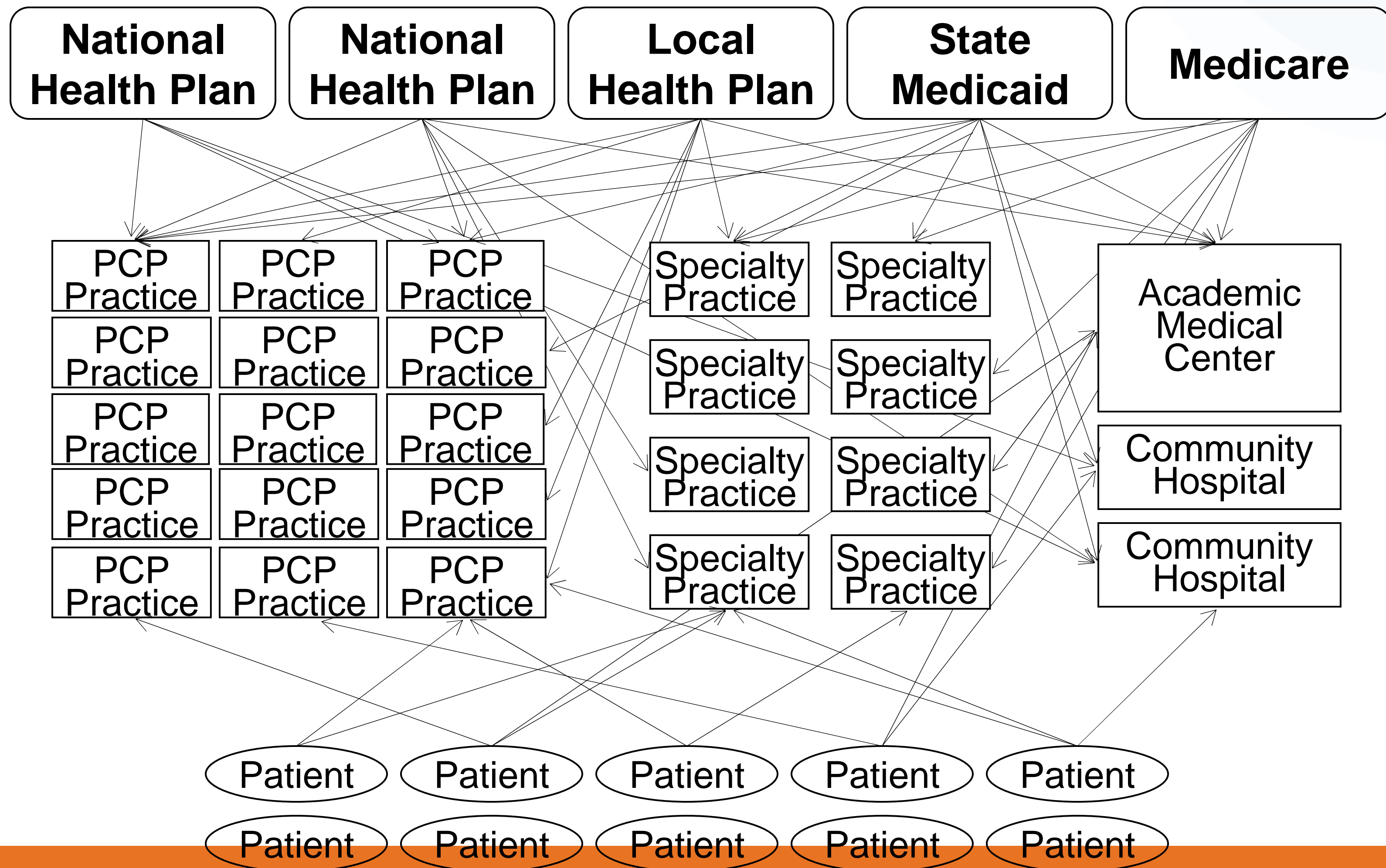
So All The Stakeholders Need to Be At a Common, Neutral Table



Solutions Impeded by Lack of Trust Between Providers & Payers

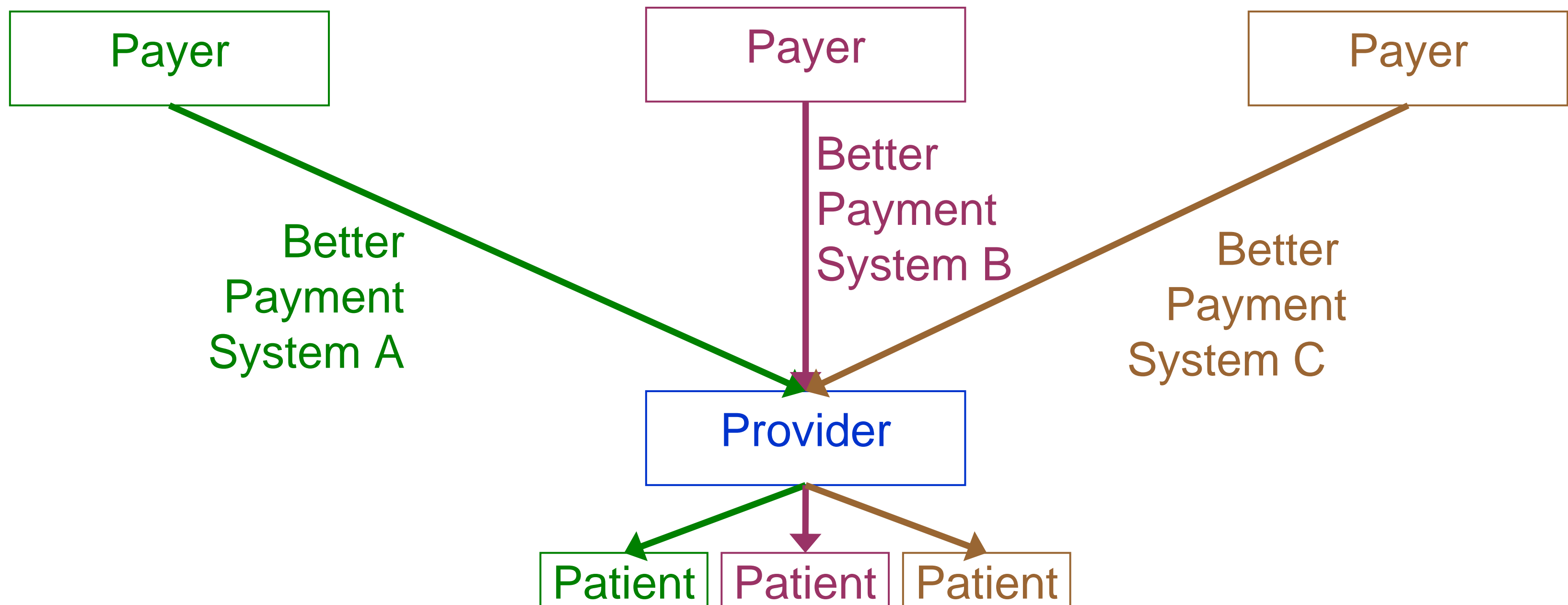


The Relationshhips in Many Communities Are *Very* Complex



Payers Need to *Align* to Allow Focus on Better Care

Even if every payer's system is better than it was,
if they're all different, providers will spend too much time
and money on administration rather than care improvement



United States Government Accountability Office

Report to Congressional Committees

October 2016

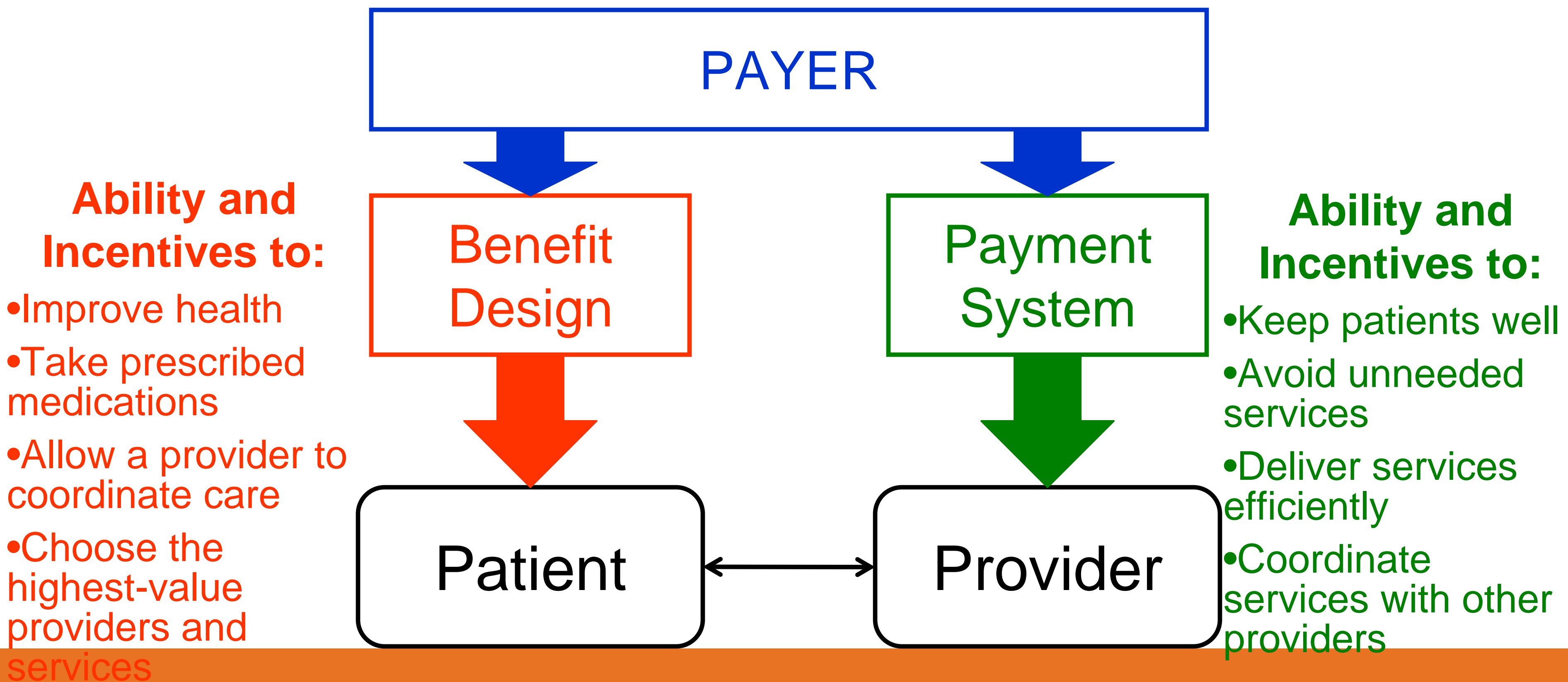
HEALTH CARE QUALITY

HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures

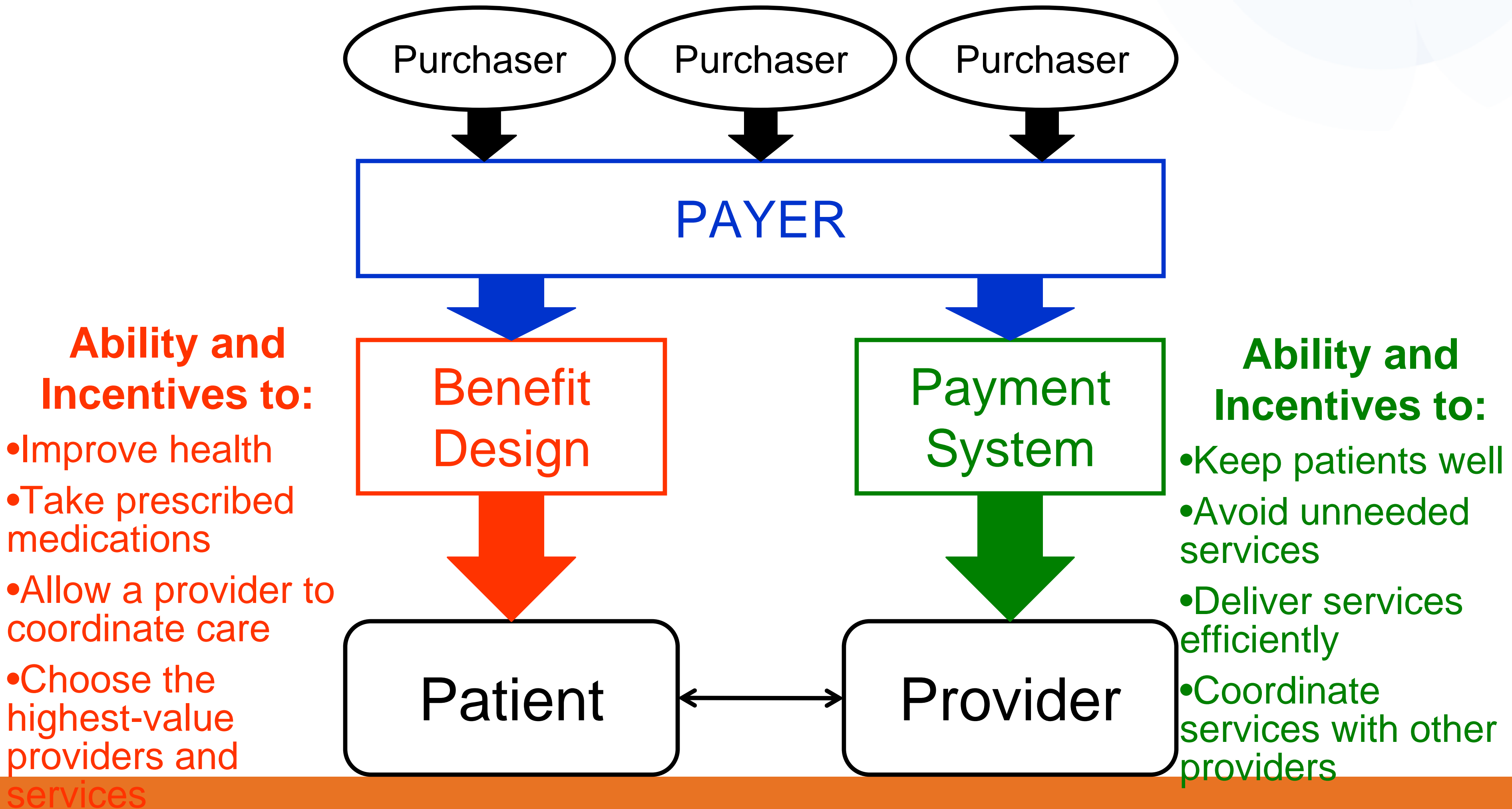
GAO-17-5

Source: GAO inpterpretation of Centers for Medicine & Medicaid Services measure for controlling high blood pressure GAO-17-5

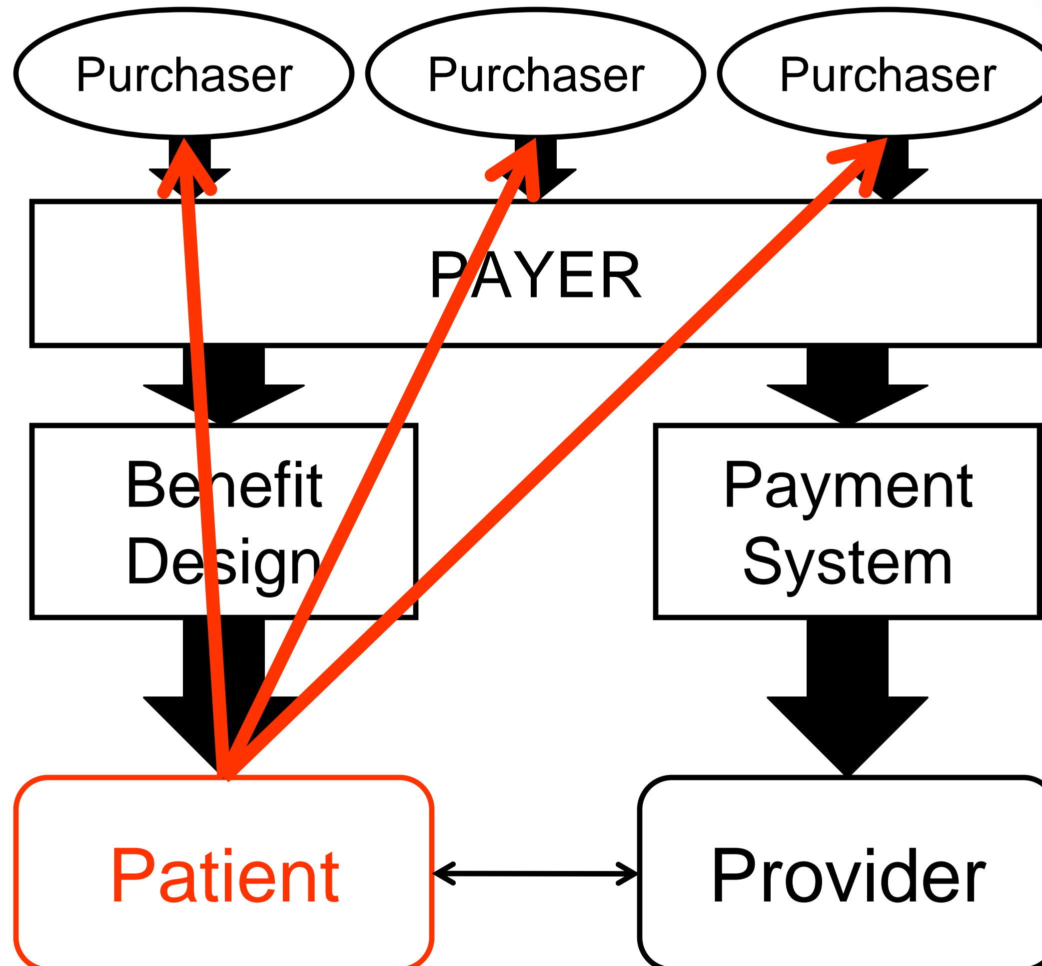
Both Payment & Benefits Are Controlled by the Payer



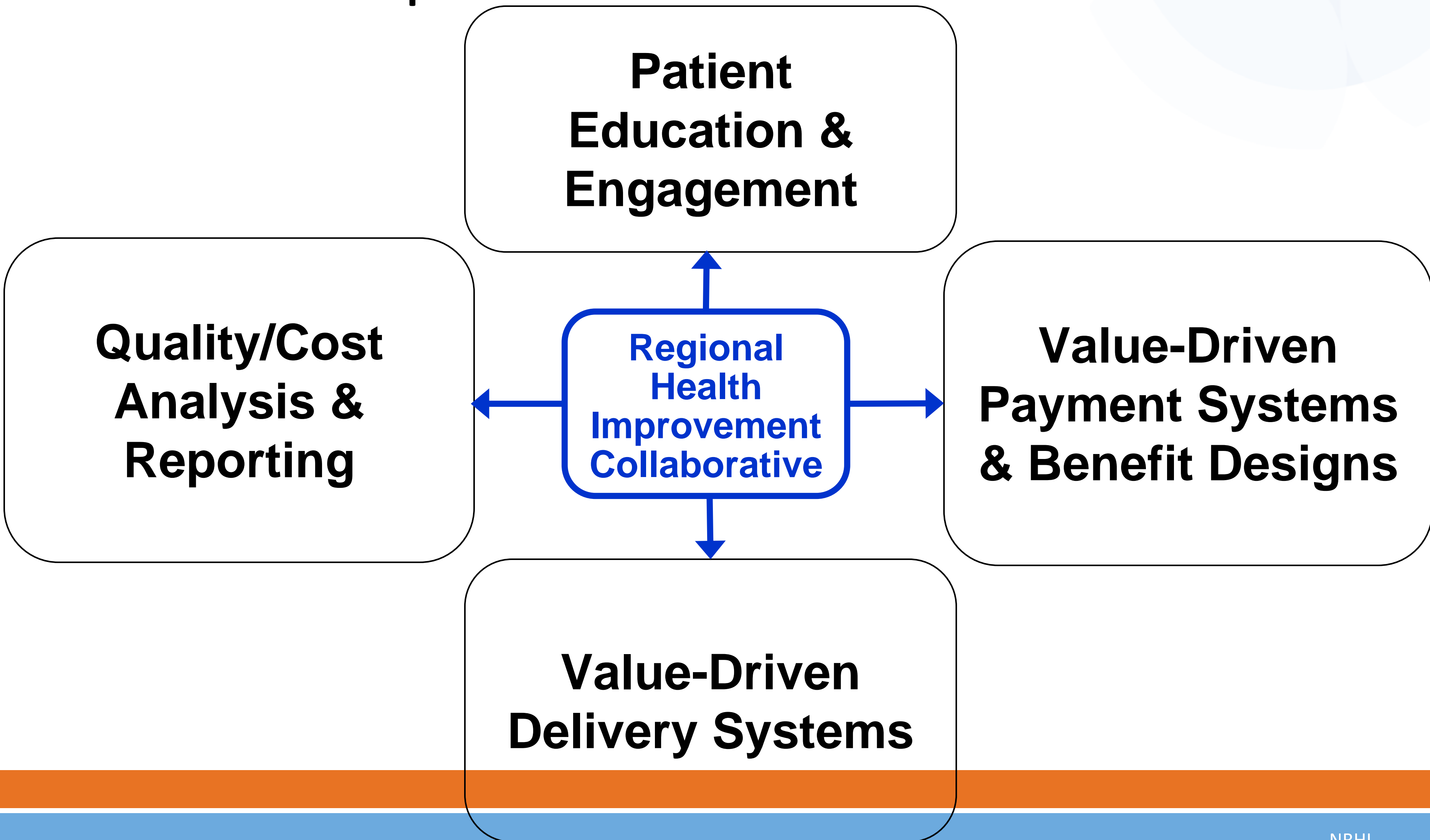
But Purchaser Support is Needed Particularly for Benefit Changes



And Consumer Support is Critical for Purchaser/Plan Support



That's the Role of Regional Health Improvement Collaboratives



How Regional Collaboratives Are Working to Support Reform

Help in Identifying Opportunities for Savings

- Assembling multi-payer data on utilization and costs
- Analyzing the data in ways that are actionable for docs

Building Consensus on Payment Reforms

- Reaching agreement among physicians, hospitals, employers, health plan, and consumers on payment reform
- Encouraging and facilitating all health plans to use the same payment methods

Providing Training & Technical Assistance

- Tools physicians and hospitals can use in redesigning care to reduce costs and improve quality

Neutral Facilitation to Achieve Win-Win Solutions

- Providing the "table" where all stakeholders can come to resolve challenges in ways that are fair to everyone

looking for healthcare data

Lack of Actionable Information About Utilization/Costs

Barrier:

- Most physician practices don't know if they have high rates of preventable hospitalizations, complications, etc.
- PCPs typically don't even know if their patients go to the ER or are hospitalized
- Prices of facilities and treatments are secret or impossible to compare

Data is the Critical Glue and a Unique Strength of RHICs

Provider needs to know what its current costs, preventable complication rates, etc. are to know whether a warrantied payment amount will cover its costs of delivering care

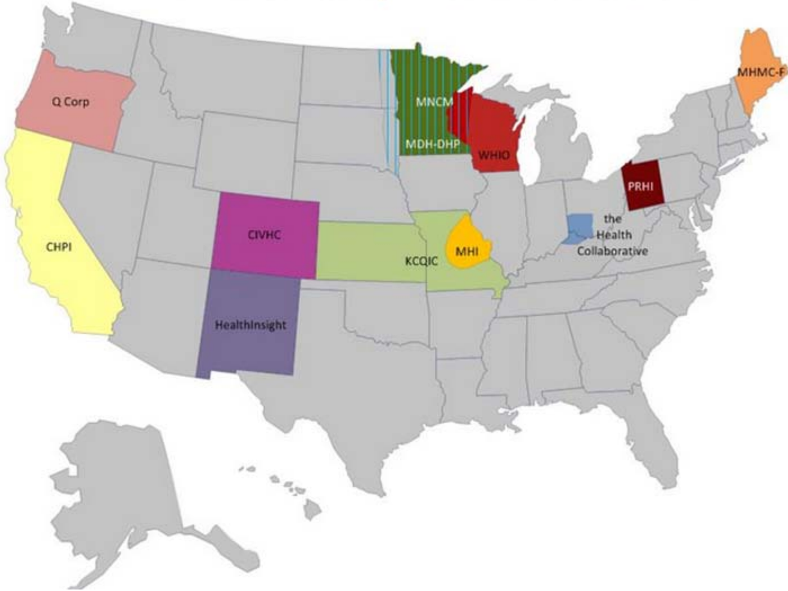
Payer needs to know what its current costs, preventable complication rates, etc. are to know whether a warrantied payment amount is a better deal than they have today

Both sets of data have to match in order for both providers and payers to agree!

A **neutral, trusted entity** with analytic skills and access to data is needed to facilitate new payment & delivery models

NRHI Members 11 of 13 Qualified Entities

CERTIFIED QUALIFIED ENTITIES

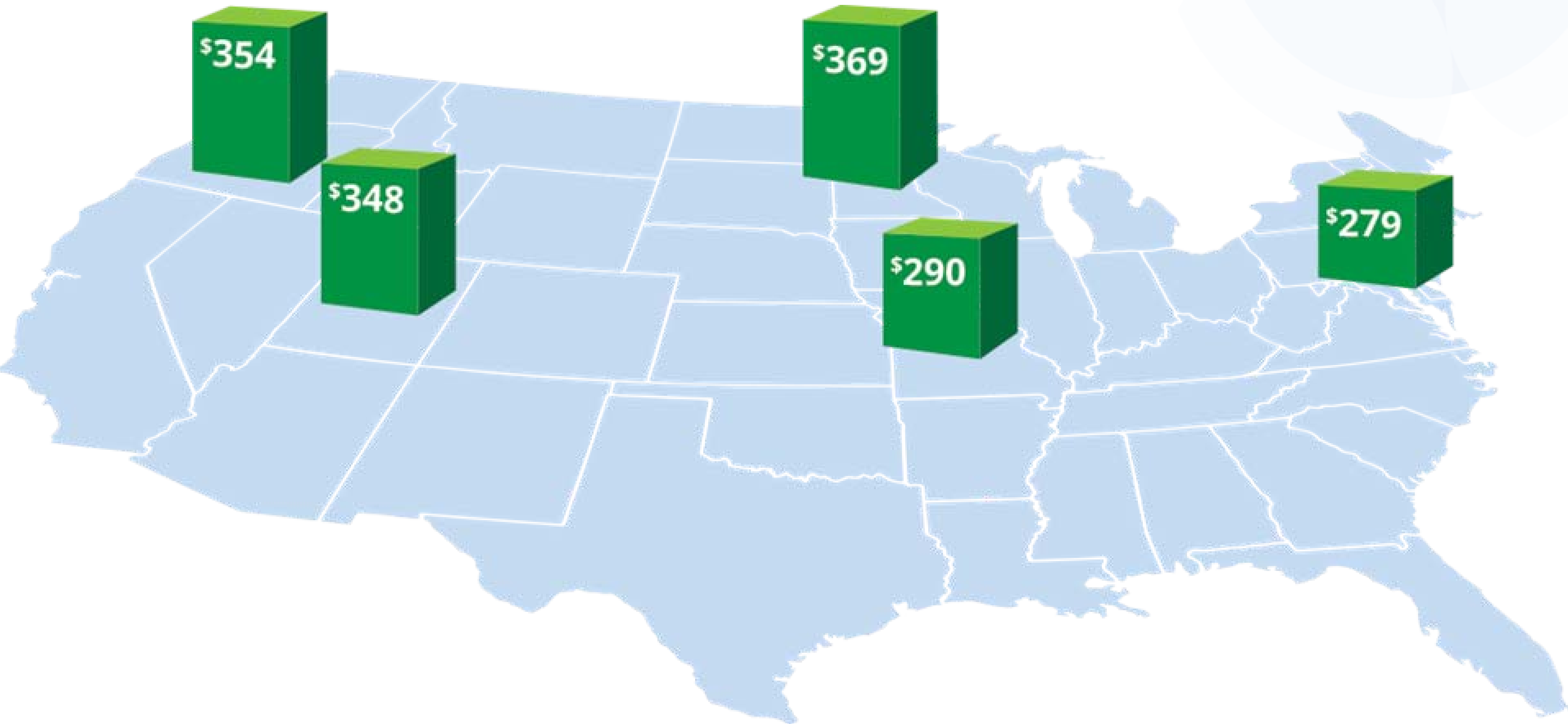


KEY

- Oregon Health Care Quality Corporation (Q Corp)
- Health Improvement Collaborative of Greater Cincinnati (the Health Collaborative)
- Kansas City Quality Improvement Consortium (KCQIC)
- Maine Health Management Coalition Foundation (MHMC-F)
- *HealthInsight*
- California Healthcare Performance Information System (CHPI)
- Pittsburgh Regional Health Initiative (PRHI)
- Minnesota Community Measurement (MNCM)
- Minnesota Department of Health, Division of Health Policy (MDH-DHP)
- Center for Improving Value in Health Care (CIVHC)
- Wisconsin Health Information Organization (WHIO)
- Midwest Health Initiative (MHI)

OREGON HEALTH CARE
QUALITY
CORPORATION

We now have some information!



2014 commercial multi-payer claims

Background: Total Cost of Care

Robert Wood Johnson Foundation

REGIONAL COMMITMENT. NATIONAL IMPACT.

The initiative was piloted by NRHI and RHICs in five regions. Their success led to the expansion to nine additional regions over the course of the project.

Pilot RHICs

- **Center for Improving Value in Health Care** | Colorado
- **Maine Health Management Coalition** | Maine*
- **Midwest Health Initiative** | St. Louis, Missouri
- **Minnesota Community Measurement** | Minnesota
- **Oregon Health Care Quality Corporation** | Oregon

Expansion Regions

- **HealthInsight Utah** | Utah
- **Health Care Improvement Foundation** | Philadelphia
- **The Health Collaborative** | Ohio
- **Maryland Health Care Commission** | Maryland
- **Massachusetts Health Quality Partners** | Massachusetts
- **The University of Texas Health Science Center at Houston** | Texas
- **Virginia Health Information** | Virginia
- **Washington Health Alliance** | Washington
- **Wisconsin Health Information Organization** | Wisconsin

Phase I and II only participant

National Benchmarking: Variation Exists

Total Cost Index and Resource Use Index:
Commercial Population 2014
Combined Attributed and Unattributed

Measure	HII Utah	MHCC Maryland	MHI St. Louis, MO	MNCM Minnesota	Q CORP Oregon
Risk Adjusted Total PMPM Per Member Per Month	\$348	\$279	\$290	\$369	\$354
TCI Price x Utilization	1.07	0.86	0.89	1.13	1.09
RUI Utilization	1.08	0.88	1.08	1.05	0.93
PI Price Index	0.99	0.97	0.82	1.08	1.17

This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN) and is used with their permission

Don’t Wait for Washington

There is no one-size-fits-all solution to reform

- Each region will need to make it happen in its own unique environment
- The best federal policy will support regional innovation

Communities should educate their stakeholders and build consensus on the multi-payer payment & delivery reforms appropriate for their community

- Organize Payment Reform Summits, as Regional Health Improvement Collaboratives in Albuquerque, Colorado, Detroit, Maine, Nevada, Ohio, Oregon, Washington, West Michigan, and Wisconsin have done

All stakeholders need to work *together* to analyze data, find win-win opportunities, design transitional payment changes, & resolve inevitable implementation problems

- Collaboratives can serve as a neutral facilitator to help plan and coordinate community initiatives

NRHI Membership

Better Health Partnership – Ohio
Center for Improving Value in Health Care – Colorado
Common Ground Health – New York
Community First – Hawaii
Greater Detroit Area Health Council – Michigan
Health Care Improvement Foundation – Pennsylvania
HealthInsight – Nevada
HealthInsight – New Mexico
HealthInsight – Utah
Healthcare Collaborative of Greater Columbus – Ohio
Institute for Clinical Systems Improvement – Minnesota
Integrated Healthcare Association – California
Iowa Healthcare Collaborative – Iowa
Kentuckiana Health Collaborative – Kentucky
Louisiana Health Care Quality Forum – Louisiana
Maine Health Management Coalition – Maine
Maine Quality Counts – Maine
Massachusetts Health Quality Partners – Massachusetts
Midwest Health Initiative – Missouri
Minnesota Community Measurement – Minnesota
Mountain-Pacific Quality Health – Montana
MyHealth Access Network – Oklahoma
New Jersey Health Care Quality Institute – New Jersey
North Coast Health Improvement and Information Network – California
Oregon Health Care Quality Corporation – Oregon
Pacific Business Group on Health – California
Pittsburgh Regional Health Initiative – Pennsylvania
The Health Collaborative – Ohio
Washington Health Alliance – Washington
WellSpan Health– Pennsylvania
Wisconsin Collaborative for Healthcare Quality – Wisconsin
Wisconsin Health Information Organization – Wisconsin

State Affiliated Partners

Integrated Healthcare Association - California
State of Maryland Health Care Commission – Maryland
University of Texas/UTHealth - Texas