New Models to Pay for Health Care: Lessons Learned from the NW Corner of the Country

February 20, 2013
The National Pay for Performance Summit
Accountable Medical Home
Multi-Payer Pilot Objectives

- **Test**
  - Our collective ability to implement a multi-payer payment pilot in this market (payment method, measurement, data reporting)
  - Link accountability for performance to payment

- **How our Pilot is Similar to Others**
  - Additional flexible resources to support (some) work of MH
  - Quality measurement

- **How our Pilot is Unique**
  - Practices actually accept accountability for a specific performance target *and they have to pay money back if they don’t meet it*
  - Common payment method across multiple payers (commercial and Medicaid)
Participating Payers

1. Aetna
2. CIGNA
3. Group Health Cooperative
4. Molina (managed Medicaid)
5. Community Health Plan of WA (managed Medicaid)
6. Premera Blue Cross
7. Regence Blue Shield

Not Participating:
UnitedHealthcare, Medicare, Medicaid FFS
Participating Practices

- 8 medical groups, 12 practice sites/clinics
  - 10 urban/suburban, 2 “rural”
  - 10 affiliated with larger systems (hospital-owned or multi-specialty), 2 single practice
  - All family medicine/internal medicine
  - Size: 2 11+ providers; 2 7-providers; 8 3-5 providers

Three Step “Application Process”
1. Practices applied
2. Subset selected based on competencies, plan, readiness
3. Practices Reviewed Baseline → then decision to participate
Design: Four-Part Payment Model

1. Current FFS payments for services

2. Additional PMPM payment for “care management” based on attributed patients
   - $2.50 PMPM in Year 1 (8 months)
   - $2.00 PMPM in Years 2 and 3
   - No restrictions on how money is used

3. Targets for Reducing Preventable ED/Hospital Utilization
   - Practice-specific utilization reduction targets calculated to be large enough to repay health plans for upfront PMPM payments
   - Savings/losses calculated using practice-specific standardized price based on payer mix in practice at baseline
   - Penalty for failure: Repayment of up to 50% of PMPM payment

4. Bonus for Success in Reducing Utilization Beyond Targets
   - 50/50 split of payers’ savings from reductions in ER visits and/or hospitalizations net of PMPM payment
   - Quality of care must be maintained based on agreed-upon measures
Targeted Outcomes: Practices Had Choice

1. Avoidable ER Visits
   • Using New York University ED algorithm
   • Calculates a number of preventable ER visits for the practice
   • Preferred by provider representatives
   • Baseline ~43% of ER visits “preventable”

2. Potentially Avoidable Hospitalizations (ambulatory sensitive)
   • Using AHRQ PQI
   • 13 identified inpatient admissions considered preventable with adequate primary care management
   • Actual count of preventable inpatient admissions for a practice’s attributed members
   • Baseline - Very Low Rate in the pilot practices

PLUS: Eligibility for Savings Tied to Threshold Measure - Quality Composite of 7 measures (diabetes, heart disease, depression)
Implementation - Successes

- After *long* design process, pilot LAUNCHED!
- Successfully created new payment model across multiple payers
  - Common Measures
  - Common Payment Method
- All plans and practices still in pilot after 21 months!!
- Pilot population fairly steady @ 27,000
  - Range of population varies by clinic significantly
- Payment flowing to practices
  - ~ $1.2 million since Launch
  - Total payments per clinic varies significantly
- Working well
  - Attribution reporting now on schedule
  - Practices implementing changes to impact outcomes
Practices accepting the challenge with a variety of strategies!

Finding and Using Data
- Creating ways to aggregate reports from 7 plans; make sense of disparate data
- Creating their own provider-specific, patient identified ER visit data (NYU) in the absence of clean data from the pilot
- Using registries to identify and reach out to high risk patients
- Linking practice EMR to ED EMR - real-time identification of patient visits, sharing notes (EDIE)

Changing Care Processes
- Enhancing provider visit schedules (same-day access), increasing phone access and ‘after-hours’ availability
- Designating ‘Care Coordinator’ within practice
- Calling every patient post ED/UC visit
- Proactive general education of entire panel (“ER is for Emergencies”)
- Focus practice changes on “top reason” categories for ED visits (e.g., sinusitis, UTI, headaches, asthma-related)
Ongoing Data Challenges

- Attributed patient count much smaller than expected - less resource available to practices to support interventions

- Ongoing discovery of data errors in baseline and quarterly calculations
  - For example: omissions/missing data; differing interpretation of measure specifications; didn’t use all measures; altered data reporting templates

- Less than optimal ongoing utilization information to inform interventions at practice level
  - Practices need timely data; (inconsistently) receiving data “quarterly”
  - Getting multiple reports from health plans, differing formats, differing data calculation methods

- Outcomes - practices did not received accurate data during the first two observation periods (20 months)

- Emergency room notification - practices need data in 24 hours, mixed support from ERs
Deeper Dive on “The Data Challenge”
Data PLAN

- Success of pilot extremely data dependent
  - Quality and integrity of data critical to practices’ and payers’ level of confidence in information which drives the transfer of money
  - Large amounts of data captured and analyzed at somewhat frequent intervals

- Many moving parts
  (7 plans, 8 medical groups, 12 practice sites, Milliman)
  - Several data “products” -- Baseline . . . .Ongoing
    - Attribution Counts, Patient Rosters
    - Provider Rosters
    - Outcomes (ED visits, hospitalizations): Numerators/Denominators
    - Quality Indicators: Numerators/Denominators
    - PMPM Reports
Our **Experience**: Single Process vs. Variation

- **Desired** → **Single process** = no variation among payers
  - Pros - one clear and uniform way to do things
  - Cons - takes time to develop the process up front

- **BUT** → **7 health plans with 7 ways of doing things**
  - Needed to compromise in order to have single payment method
  - Resistance to reporting data
  - Desire to avoid “extra” work

- **Resolution**: Similar but not identical processes; allowed variation in how data reporting completed but proceeded with agreed upon “methods”
  - Pros - able to launch Pilot; each plan changes existing processes to get to *similar* process and should be faster
  - Cons - process inconsistent; results hard to assess; burden on practices to compile and align
Data reporting - implementation

- Workgroup-developed timelines, methods, etc.
- Included plan representatives for contracting and data reporting

Our Experience

- More work required by each plan
- >20 people doing work for 7 plans across the country; personnel changes, inadequate documentation
- No single entry point to check quality and accuracy of data
- Many errors - significant delays
10 Lessons from the Field

Life isn’t about waiting for the storm to pass... it’s about learning to dance in the rain.
Collaboration and Design

1. Neutral, Third-party Convener Essential
   • Important to have a trusted third party to manage data transfers, calculations and quality assurance

2. Health Plan Executive-level Sponsorship/Champions Needed Initially and Ongoing
   • Important to set ground rules for collaboration vs. competition
   • Important that agreements made in collaboration are kept for the duration of the pilot
   • Important to have health plan leads accept responsibility to execute agreements within their organizations
   • Legal and data operations teams can delay work if they do not understand how it differs from routine processes.
   • All agreements need to be in writing (detailed documentation) to enable new staff to take over responsibilities
Collaboration and Design

3. Get to a SINGLE, AGREED UPON PROCESS for contracting, data calculations and data sharing
   - Much harder upfront - requires philosophical commitment
   - Much less work for health plans AND practices over life of the pilot

4. Pilot size is important
   - Administrative burden is larger with fewer people in the pilot
   - If more of the practice population is included in the pilot, it is a better incentive to make practice-wide changes.
   - Agree in advance whether plans’ ASO populations will be included -- in some markets, ASO population can account for a majority of membership
   - Increasing financial risk to practices is a barrier to entry for small practices
Practice Selection

5. Practice “readiness” very important with shared accountability model
   • Don’t assume that primary care practices linked to larger hospital-driven systems have adequate support for medical home development - important to have CFO commitment to flow PMPM and shared savings to practices
   • Small independent practices not necessarily able to absorb financial risk compared to large integrated practices

6. Don’t underestimate the need to “connect” with ERs
   • Even primary care practices linked to hospitals lack timely notification of ED visits for their patients
   • Many patients access care in multiple ERs
   • Proliferation of free standing Emergency Rooms and heavy marketing of ERs - impact practice success (and initially limited the number of practices willing to participate in the pilot)
Data, Data, Data

7. Difficult for practices to be successful without timely, actionable information
   - Practices need notification of ED visits within 24 hours if expected to reduce visits using the medical home model.
   - Data provided in pilot is not enough to prevent ED visits.
   - Additional data needed to prevent ED visits might include: date and time of ED visit, location of ED, diagnosis codes, patient experience with current provider, patient self-efficacy to manage conditions.

8. Practices want to succeed, even with all the challenges!

9. Don’t underestimate the importance and challenge of developing data sharing agreements upfront
   - This is new territory for health plans who are competitors and have a strong proprietary orientation to their data.
   - Variation in data calculations and reporting increases the work and chance for errors (serial processing of data is vulnerable for delays at every step).
   - Monitoring data for quality, accuracy and timeliness in reporting requires that all data enter in one door at one time.
10. Keeping your eye on the goal is hard but important

- The goal is to improve the effectiveness of primary care to improve patient outcomes AND reduce excessive and inappropriate use of expensive care in the acute setting
- Payment is an enabler and a driver but not the goal
- Care processes should be patient-centered
Thank You!

Susie Dade
Deputy Director
Puget Sound Health Alliance
206-454-2956
sdade@pugetsoundhealthalliance.org