Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

Payment Reform Evidence Hub: State and Regional Evaluation Perspectives

Payment Reform Evidence Hub: Better Evidence for Payment Reform

LAN Summit

October 25, 2016

PBGH
PACIFIC BUSINESS GROUP ON HEALTH

HMR LAB
HEALTHCARE MARKETS AND REGULATION

HARVARD MEDICAL SCHOOL | Department of Health Care Policy

HCP LAN
Health Care Payment Learning & Action Network

Context for Evaluations

- In order for payment reforms to succeed, we need more evidence about which models work in today's complex healthcare environment.

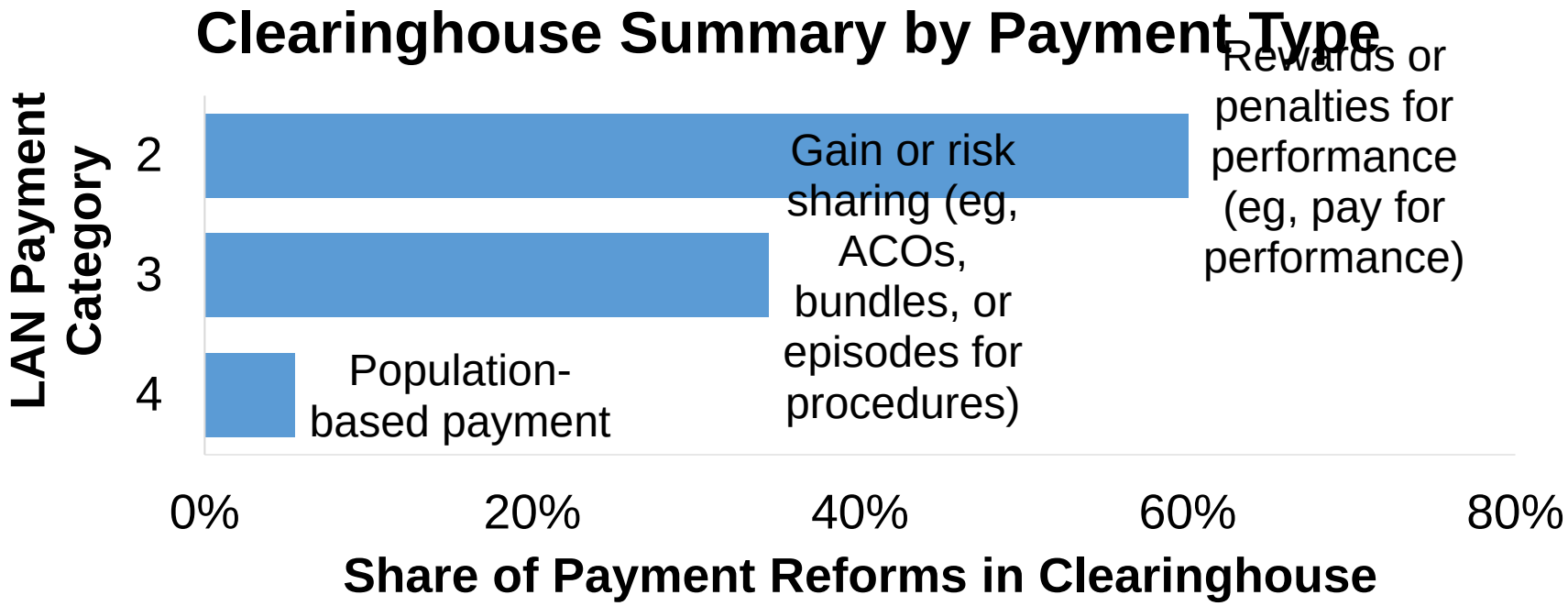
- Evaluations are essential both for providing evidence on a particular program and building an evidence base for further work.

- The Payment Reform Evidence Hub is a partnership that can help stakeholders work together to increase evaluations.

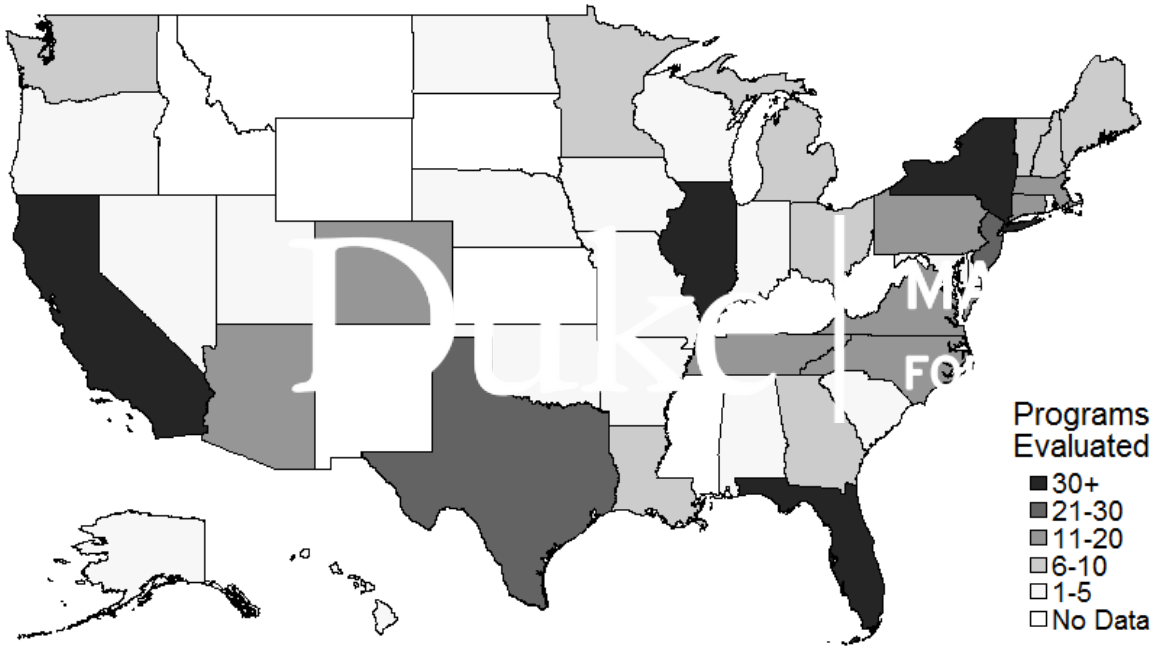
Goals for Evidence Hub

- Disseminate lessons learned from existing evaluations
- Provide tools that organizations can use when considering evaluating their initiatives
- Coordinate new evaluations of promising care delivery and payment models.

What Payment Reforms Do Current Evaluations Need to Address?

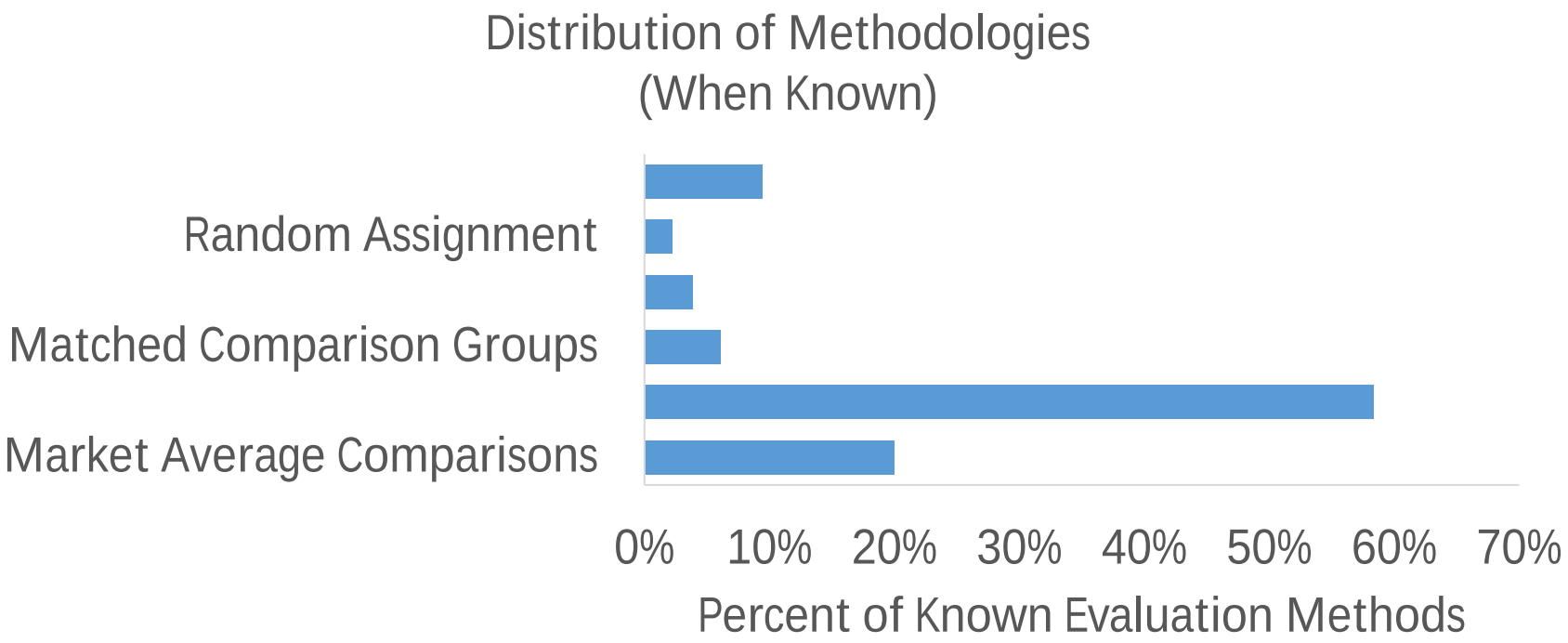


Where are evaluations taking place?



- Highly populated states with large urban areas receive the most evaluations.
- More evaluations needed in rural areas.
- Most available evaluations are for public programs. Just 10% of commercial evaluations are publicly available.

What methodologies do evaluations use?



We Need Your Help

- Have you evaluated a payment initiative and would be willing to share the results?
- Would you be willing to share what payment reforms you have underway (regardless of whether they've been evaluated)?
- Would you be interested in partnering on an evaluation done of an existing or upcoming payment initiative?
- If you have any questions, please feel free to e-mail Rob Saunders, PhD at robert.saunders@duke.edu

2016 LAN Fall Summit

State and Regional Perspectives with Multipayer Reform: Payment Reform Evaluation

October 25th, 2016

Frederick Isasi, JD, MPH
Director, Health Division
National Governors Association
Center for Best Practices

Purpose of this Session

- **Brief overview of the National Governors Association**
- **Evaluation goals**
- **Evaluation challenges**
- **Sampling of newest evaluation strategies in-play across the states**

About the NGA's Health Work

Today's discussion provided by the NGA Center:

- Does **not** represent the official position of the Governors or NGA;
- I will be speaking from direct experience of working with Governors and state leaders; and
- My comments are off-the-record and not for attribution.

About the National Governors Association

- Nation's oldest organization serving the needs of governors and their staff (founded in 1908)
- Bipartisan Leadership: Chair Gov. McAuliffe (D-VA) and Vice-Chair Gov. Sandoval (R-NV)
- NGA Office of Government Relations (OGR): serves as the collective voice of the nation's governors in Washington, DC
- NGA Center for Best Practices: a hybrid think thank/consultancy that works to surface evidence-based practices, works directly with governors on specific policy projects, and provides support to OGR. The NGA Center divisions are:
  - Health
  - Education
  - Energy, Environment, and Transportation
  - Human Services and Workforce
  - Homeland Security and Public Safety

About the NGA's Health Work

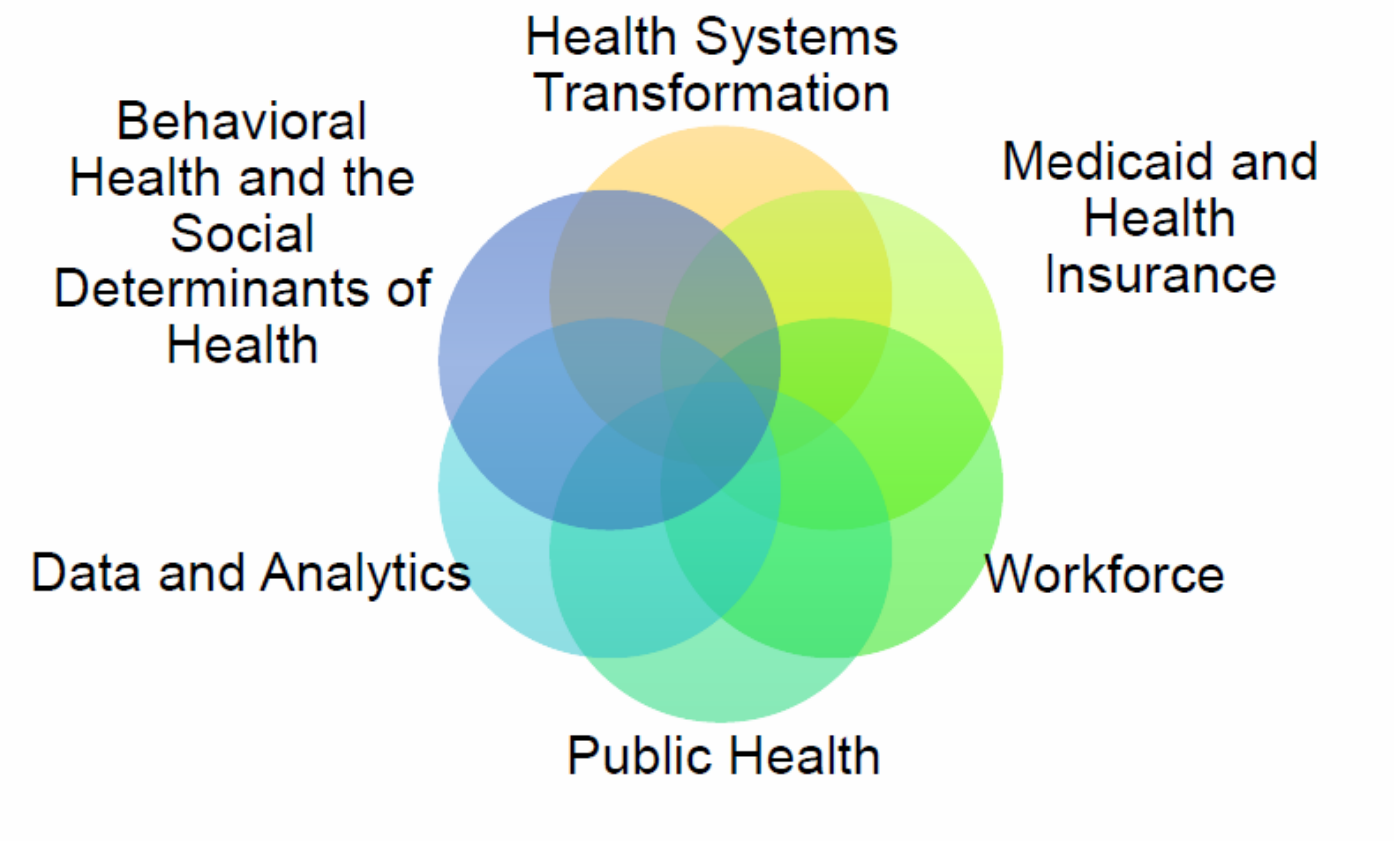
- **NGA Center Health Division:**
  - Work focuses on governors most pressing and important health care issues
  - Typically, project-based through competitive RFA process with governors and their state leaders
  - Our work is provided as a service, free of charge – projects are funded through cooperative agreements with the federal government, grants, and donations.

Continuum of Health Division Activities

Target Audience	Health Division Activities
Most Focused	• Governor Healthcare Leadership Retreats • In-State Policy Retreats • State-specific Technical Assistance • Policy Academies
	• Convenings of States
Most Broad	• Collaboration with NGA's Office of Federal Relations • Medicaid Transformation Toolkit, Opioid Roadmap • Other Publications

NGA's Current Focus Areas in Health

Six Core Focus Areas Support and Build on Each Other



Overarching Evaluation Goals

- **Evolving evaluation strategies from "passive payer" role to "active purchaser" role**
  - Evaluation that allows Governors and states leaders to deliver on the promise of better health for all state residents, better health care, and lower overall spending for residents, states, and the federal government.
  - Moving away from a narrow focus on "check-the-box" process measures to metrics that focus on systems of care, cost and quality outcomes, and overall population health
  - Evaluation that drives across private and public payer systems to create "directional" change within and across states (e.g., leverage the NAM *Vital Signs* work focused on healthy people, care quality, care cost, engaged people).
  - Allowing governors and state leaders to establish accountability across state government agencies for the highest-level gubernatorial priorities (e.g., decreased state spending, improved health, improved economic output, improved educational outcomes, decreased criminality, increased employment, etc.)
  - Designing a measurement system that allows for a "learning process", rapid- cycle-evaluation, and course-corrections.

Evaluation Challenges

- In many instances, the underlying state level data systems are profoundly siloed and antiquated, preventing state leaders from integrating data, developing baseline comparisons, or applying sophisticated analytics

- Developing evaluation strategy that allows for the realities of state-level efforts:
  - Respects governors' "four-year" window: allows for early reporting in the context of public and state house dialogues, that conclusively demonstrates return on investment (e.g., in a "directional" sense as opposed to a granular and comprehensive assessment)
  - Allows for non-randomized design
  - Allows for shifting baselines
  - Allows for rapid cycle evaluation and intervention improvements mid-evaluation

- Designing metrics that allow for measurement across sites of care and conditions to allow for evaluation of longer and longer episodes of care within a system

- Designing metrics that can evaluate the underlying economic incentives at play within communities and markets

Alabama's Regional Care Organizations

STRATEGY	METRICS
Reimbursement: Transition of Medicaid program from fee-for-service reimbursement system to a capitated risk-based system that incentivizes improved health outcomes and care coordination via Regional Care Organizations (RCO)	State-formed Quality Assurance Committee created 42 quality measures that will be used for monitoring RCOs' performance. 10 of these measures will be incentivized through the new payment system.
Incentive: New Medicaid funding available to incentivize RCOs to meet certain quality measures throughs a 1115 waiver	The first two years of the program will focus more generally on process measures including readiness requirement and transition to new system. After first year, 10 quality measures will be incentivized through funding, including well-child/well-care visits, ambulatory care-sensitive condition admissions, and timeliness of prenatal visits.

Core Metrics for Evaluating Complex Care Initiatives

DESIGNING METRICS

Lessons Learned from Successful Programs

- Collaboration with **stakeholders** is important to ensure that states are selecting metrics that providers, health plans, and others are able to use and report on and also that these entities will accept evaluations based on these metrics
- Start with a few simple metrics that provide **actionable information** that is highly likely to impact change
- Use **valid metrics** that have clear specifications and can be measured consistently
- Focus on **Return on Investment (ROI)**

Core Metrics

- **Basics Measures:**
  - Unnecessary or potentially preventable ED use
  - Potentially Preventable Hospitalizations
  - Total cost of care
  - Linkage with appropriate primary and behavioral health care
- **More Advanced Measures:**
  - Utilization and cost measures: Other Institutional Care
    - Rate of incarceration, rate of stat in detoxification facility, rate of nursing home care
  - Appropriate care and patient outcomes: Community care and Health improvement
    - Disease specific measures, quality of life
- **Social Determinants:** Housing solutions for high-need, high-cost populations: Housing First Outcome Measures
  - Housing retention
  - Reason for exit
  - Cost savings

Kansas State Medicaid Program (KanCare) Quality Measurement Approach

STRATEGY	METRICS
Payment: KanCare's pay-for-performance program incentivizes health plans to meet state-required performance targets by withholding a percentage of payments until performance has been evaluated at the end of the year. The amount returned is dependent on the plans performance outcomes	For the first year, the state chose six performance measures related to operations: timely claims processing, encounter data submission, credentialing process for providers, grievances, appeals, customer services
Quality: After the first year,15 quality measures were chosen from three categories as performance targets that plans are required to meet	Physical Health – Comprehensive diabetes care, well-child visits in the first 15 months of life, preterm births, annual monitoring for patients on persistent medications, follow-up after hospitalization for mental illness Behavioral, LTC, and HCBS Waivers – Rate of competitive employment among patients, National Outcome Measures (NOMs), utilization of in-patient services, life expectancy, integration of care Long-term Care – nursing facility claim denials, fall risk management, hospital admission after nursing facility discharge, nursing facility days of care, use of Promoting Excellent Alternatives in Kansas (PEAK)

EVALUATION

KanCare plans are required to submit a written Quality Assessment and Performance Improvement (QAPI) program plan for the state's approval. QAPI plan explains how the health plan will meet quality targets.

Missouri Behavioral Health Integration

HEALTH HOMES

- Health Homes provide integrated physical and behavioral health care and long-term services and supports for high-need, high-cost Medicaid populations in order to improve health care quality and reduce costs.
- Bi-directional integration: patients receive comprehensive, integrated care at either a Primary Care Facility or a Community Mental Health Center (CMHC).
    - Physical health outcomes are equivalent regardless of the Health Home model used.

STRATEGY

Payment: Missouri implemented pay-for-performance measures into Health Homes to improve patient outcomes and integrate levels of care. Per-member-per-month (PMPM) payments are linked to metric standards of care coordination. Health homes are unable to enroll consumers the month after falling below standards.

METRICS

Percent of clients with one or more hospitalizations; days in hospital and ER; hospital and ER encounters per client per year; percent of people with multiple chronic conditions; daily living activities assessment; percent of diabetics with normal blood pressure, blood sugar, and cholesterol, percent of people who have hypertension and cardiovascular disease with good cholesterol and normal blood pressure; metabolic syndrome screening; and medication adherence; calculated cost savings

OUTCOMES

- Health Homes have saved Missouri an estimated $36.3 million ($60 PMPM).
- CMHC Health Homes have saved Missouri $31 million ($98 PMPM).
- Those enrolled in the Missouri Health Homes experienced improved health outcomes including reduction in cholesterol, blood pressure and cardiovascular complications.

Rhode Island's Strategic Plan on Opioid Use Disorder & Overdose

STRATEGY	METRICS
Treatment: System of Medication Assisted Treatment (MAT) at every location where opioid users are found	Number of patients w/ opioid disorder, number of patients receiving MAT per year, retention in MAT programs, medication utilized
Rescue: Sustainable source of naloxone for community and first responder distribution & high coverage of naloxone among at-risk populations	Monthly number of naloxone prescribers; number of naloxone prescriptions dispensed to patients receiving opioid prescriptions
Prevention: Prescriber prescription monitoring program and system-level efforts to reduce co-prescription of benzodiazepines with opioids	Monthly number of benzodiazepines and opioid prescriptions dispensed within 30 days for same patient; number of patients in opioid treatment programs who are receiving prescribed benzodiazepine
Recovery: Large-scale expansion of recovery coach reach and capacity	Monthly number of peer recovery coach encounters to ED, hospital, prison, in-street outreach sessions; rate of referral and retention to treatment, MAT, and recovery supports

Maryland's Payment Reform for Opioid Treatment Program

STRATEGY	METRICS
Payment: Re-bundle Medicaid payments to Opioid Treatment Programs (OTP) by separating payments for Methadone from counseling services Expand beneficiary access to MAT by offering a daily reimbursement rate for "guest dosing" from providers that are not the patients "home" provider	Number of patients receiving counseling for opioid use disorder, number of "guest dosing" events, adherence to prescribed methadone

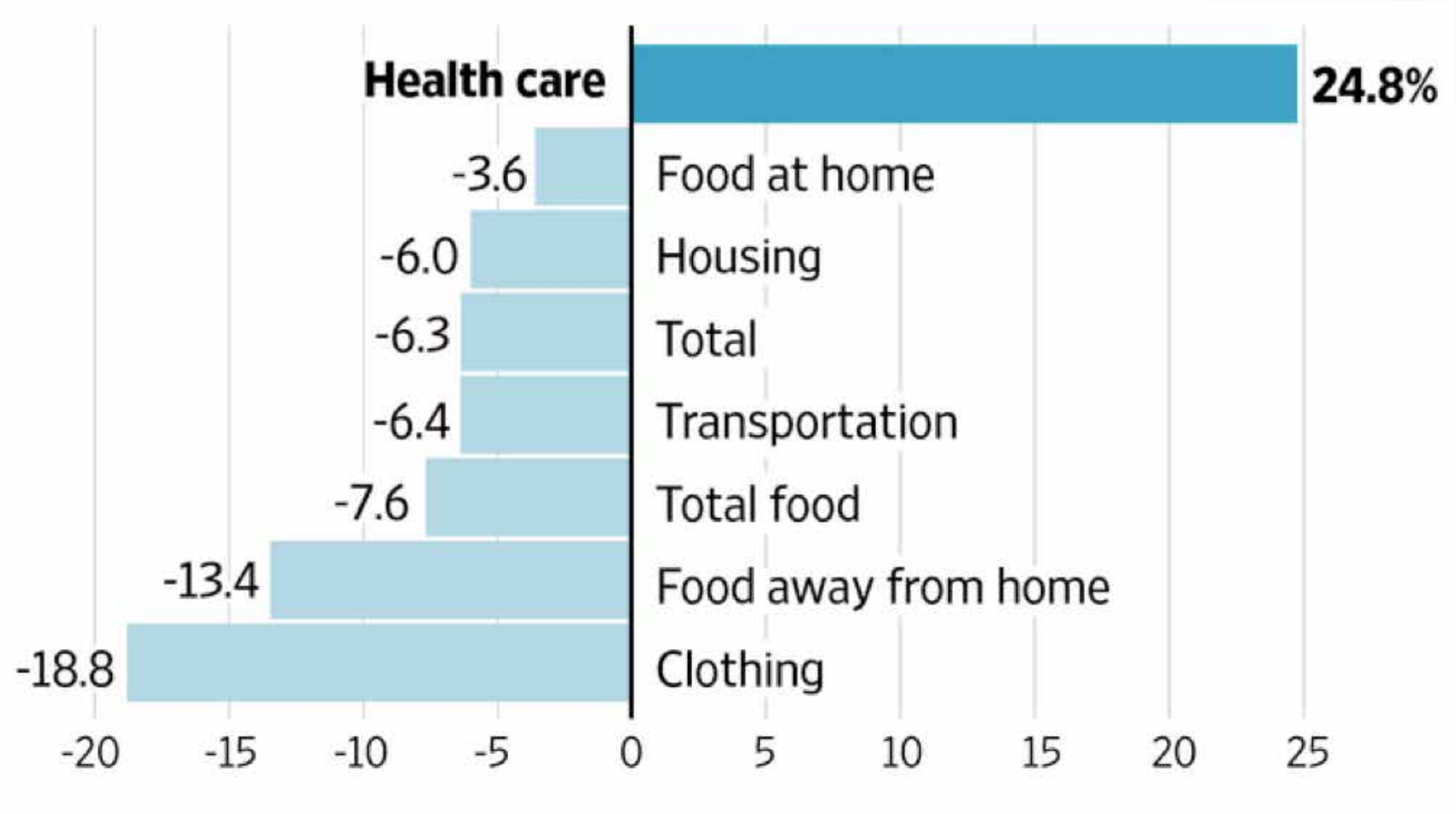
Regional Lessons in Payment Reform

What can We Learn?

Elizabeth Mitchell, President & CEO
Network for Regional Healthcare Improvement

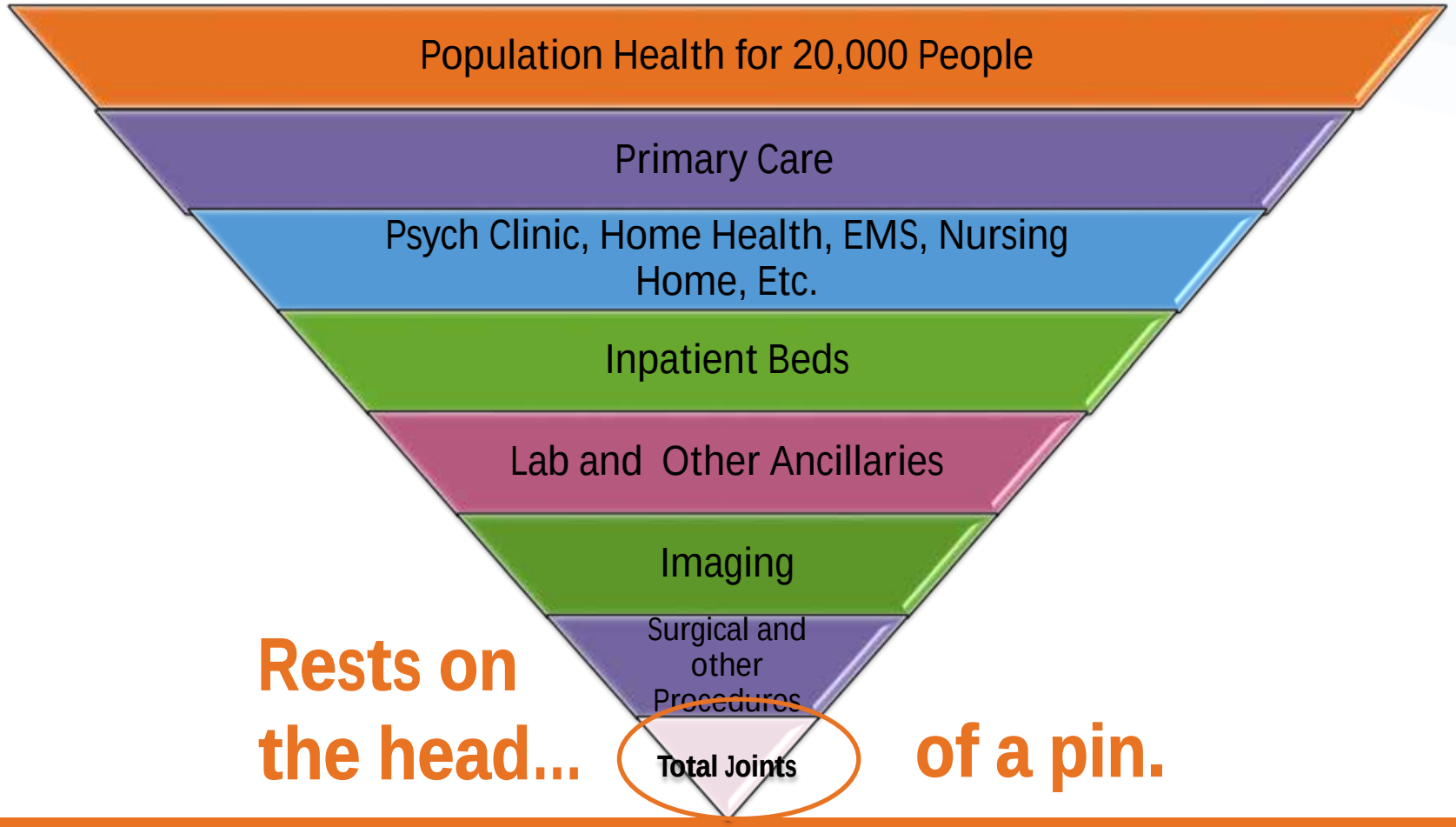
October 25, 2016

Percent change in middle-income households' spending on basic needs (2007-2014)



Source: Brookings Institution, Wall Street Journal

Dr. Steele: The Way YOU Pay is a Major Part of the Problem!



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Rests on the head... of a pin.

From FFS to PBP: Some Changes Required

- New measures – quality and cost
- New shared data infrastructure
- New incentives
- Transparency
- Alignment across payers
- New care models
- New community partners
- New relationships

2006 situation...looking for healthcare data

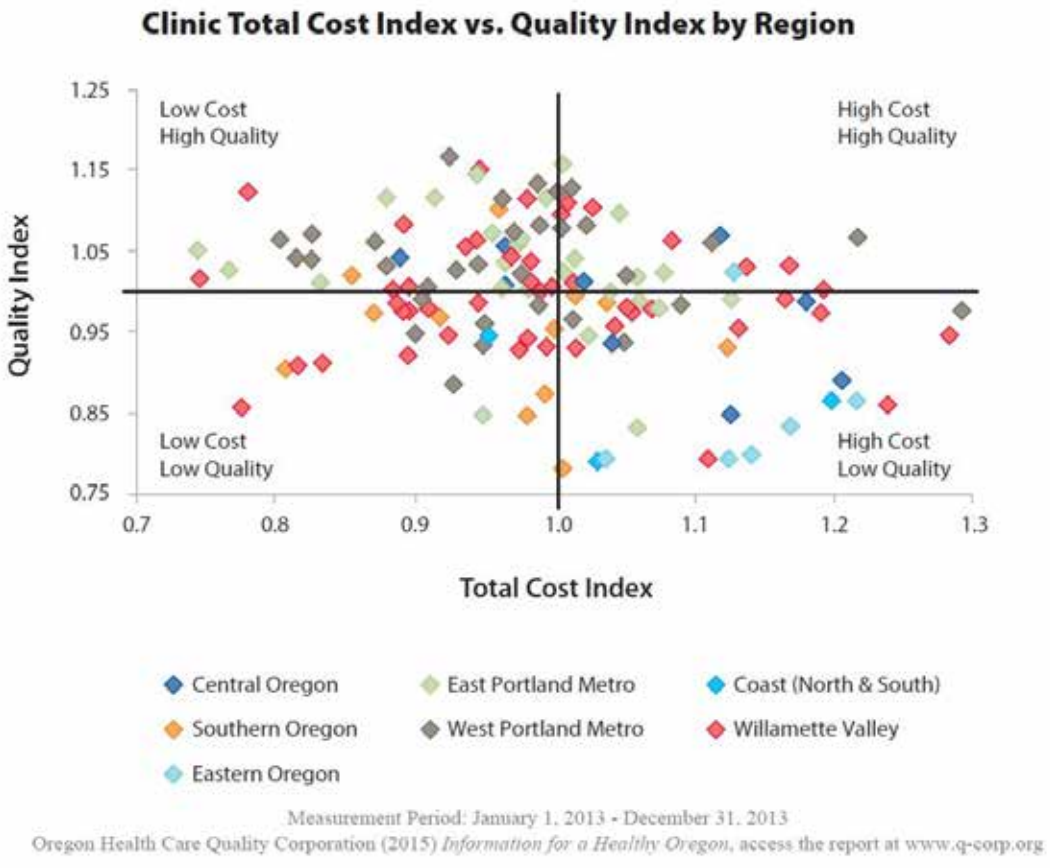
OREGON HEALTH CARE QUALITY CORPORATION

Q Corp Voluntary Claims Data Collaborative: 2006-present

- Data Collaborative –major health plans, State of Oregon Medicaid and CMS QE Medicare data
- 3.5 million unique Oregonians captured in claims 600+ million medical and pharmacy claims records
- All providers in the directory are eligible to receive quality reports with patient-level information for follow-up

Early Findings

- Considerable variation among clinics and between regions acros Oregon
- Rural clinics show higher cost and lower quality, on average
- Q Corp is working to better understand cost drivers and what providers can do to influence them



OREGON HEALTH CARE QUALITY CORPORATION

Payment Reform Uses – evolution

2006-2008	• Early pioneering of quality measures and public reporting
2008-2010	• Education about opportunities for quality improvement
2010-2012	• Pay for performance contracting, multi payer collaborative efforts around primary care • Q Corp data used to evaluate quality and utilization
2012-2014	• Major transformation in State Medicaid programing - PCPCH and use of Q Corp measures • Oregon Exchange measures • Coordinated Care Measure Validation
2014-2016	• Continued use in contracting and P4P, TCOC introduced, community planning around CPC+ and MACRA

OREGON HEALTH CARE QUALITY CORPORATION