Q Corp Opportunities for Collaboration around Data and Payment Reform – lessons learned

TRUST, TRUST, TRUST – continuous, constant, unrelenting dedication to collaboration – Must align stakeholders and leverage focus to get the best results

Provide objective transparent facilitation that collectively holds all parties responsible for commitments and outcomes

Provide objective data to all stakeholders

Track progress and work to scale

Sense making and communications

OREGON HEALTH CARE QUALITY CORPORATION

MHMC: Leveraging Data Asset to Identify Opportunities

Findings: People with chronic illness are hospitalized at a rate 3.2x that of the normal population. 20-40% of these admissions are preventable

Savings Opportunity: If all areas of the state reduced admissions for people with chronic illness by 20%, resulting savings for MHMC members would be $32m. *This translates to an average of 3.2% PMPM savings for employers/plan sponsors.*

Priority 1: Reduce Hospital Admissions for People with Chronic Illnesses

- **Providers:** Improve care transitions; develop PCMH and CCTs; use data to analyze admissions
- **Plans:** Change reimbursement to reward primary and community based care including practice-based care management; enhance Rx coverage for patients with chronic illnesses; reduce cost sharing for preventive care; share data
- **Patients:** Participate in care management and partner with providers
- **Purchasers:** Benefit incentives for participation in care management; Education and wellness activities for employees with chronic conditions

Maine Health Management Coalition

Leveraging Data Asset to Support Purchasers in Risk-Sharing Arrangements (ACOs)

Serve as neutral "referee on the field" in administering risk-sharing arrangements between employers, providers, and carriers by:

1) Reviewing proposed contract language to ensure equitable PMPM target-setting and measurement methodology

2) Identifying list of patients at-risk during the measurement period

3) Calculating baseline, target, and measurement period PMPMs

4) Determining the amount of any risk-sharing payment due the employer or provider

5) Collaborating with outside actuarial firms for external validation

6) Commercial and Medicaid purchasers

Maine Health Management Coalition

IHA: Bundled Episode Payment & Gainsharing Demonstration (AHRQ)

Project Objectives

- Test feasibility/scalability of bundled payment episodes in multi-payer environment
- Develop 10 bundled episode definitions
- Recruit 20 physician/facilities teams for health plan
- contracting in multiple payer settings
- Research evaluation – study of the implementation of hip and knee episodes (RAND)
- Disseminate key lessons and best practices

Integrated Healthcare Association

Findings: Critical Implementation Challenges Caused Delays and Fallout

In the absence of proven models, most aspects of technical design met with administrative complexity

- Significant good will and administrative expertise was overtaken by “real world” challenges
  - Only 3 of 6 health plans signed contracts
  - Only 2 of 8 hospitals (plus 1 ASC) signed contracts
  - Volume of surgery was extremely low in hospitals
- Defining the episode bundle
- Designing a new contracting model
- Needing to overlay on existing payment systems and insurance benefit designs
- Addressing the “tug of war” around risk sharing and price
- Meeting the concerns of regulators
- Low patient volumes and competing demands

Key Implications for Researchers

- Small numbers create challenges, especially for quantitative analysis – could change with implementation of Bundled Payments for Care Improvement (BPCI)

- Quantitative data difficult to obtain
  - Many competing priorities for providers, plans
  - Requires negotiation of HIPAA and data use agreements

- Formative evaluation may be more realistic than outcome evaluation for new payment model initiatives

Integrated Healthcare Association

IHA: Value Based Pay for Performance

$500m
paid out

200
Medical Groups and IPAs
35,000 physicians

10
Plans

Blue Shield of California
An Independent Member of the Blue Shield Association
Anthem BlueCross
SHARP
Health Net
aetna
Cigna
KAISER PERMANENTE
Western Health Advantage
Chinese Community Health Plan
CCHP
UnitedHealthcare

9 Million Californians

Takeaways -- Commercial Experience

Total cost of care strongly influenced by specialist and inpatient services obtained by attributed patients

- Careful thought required when creating ACO network (physicians to whom patients will be attributed)
- Physician organizations may not have full information about costs negotiated by health plans

Benefit design has not yet caught up

- Generally, no explicit consumer-facing incentives that favor ACO network
- "Inducements" not allowed in Medicare FFS
- Patients may be unaware of ACO, or skeptical/resistant
- Without consumer-facing incentives, referral management important

Mixed financial results

- Total cost of care difficult to predict, difficult to control
- Often unclear what, specifically, resulted in shared savings

Data often still lacking to support real-time care management

- Hospitals often not inclined to notify POs when an ACO member has been admitted
- Contractual requirement for HMO enrollees but not for ACO

Proliferating measures that vary across contracts is very challenging for POs

- Potential for standardization if agreement can be reached but many plans are national

Bundled Payment: Learning From Our Failures

Tom Williams and Jill Yegian
August 5, 2014

Health Affairs

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Minimize

Bundled Payment Fails To Gain A Foothold In California: The Experience Of The IHA Bundled Payment Demonstration

M. Susan Ridgely[1,*], David de Vries[2], Kevin J. Bozic[3] and Peter S. Hussey[4]

Author Affiliations

*Corresponding author

Abstract

To determine whether bundled payment could be an effective payment model for California, the Integrated Healthcare Association convened a group of stakeholders (health plans, hospitals, ambulatory surgery centers, physician organizations, and vendors) to develop, through a consensus process, the methods and means of implementing bundled payment. In spite of a high level of enthusiasm and effort, the pilot did not succeed in its goal to implement bundled payment for orthopedic procedures across multiple payers and hospital–physician partners. An evaluation of the pilot documented a number of barriers, such as administrative burden, state regulatory uncertainty, and disagreements about bundle definition and assumption of risk. Ultimately, few contracts were signed, which resulted in insufficient volume to test hypotheses about the impact of bundled payment on quality and costs. Although bundled payment failed to gain a foothold in California, the evaluation provides lessons for future bundled payment initiatives.

Payment Reforms should Support Care Changes

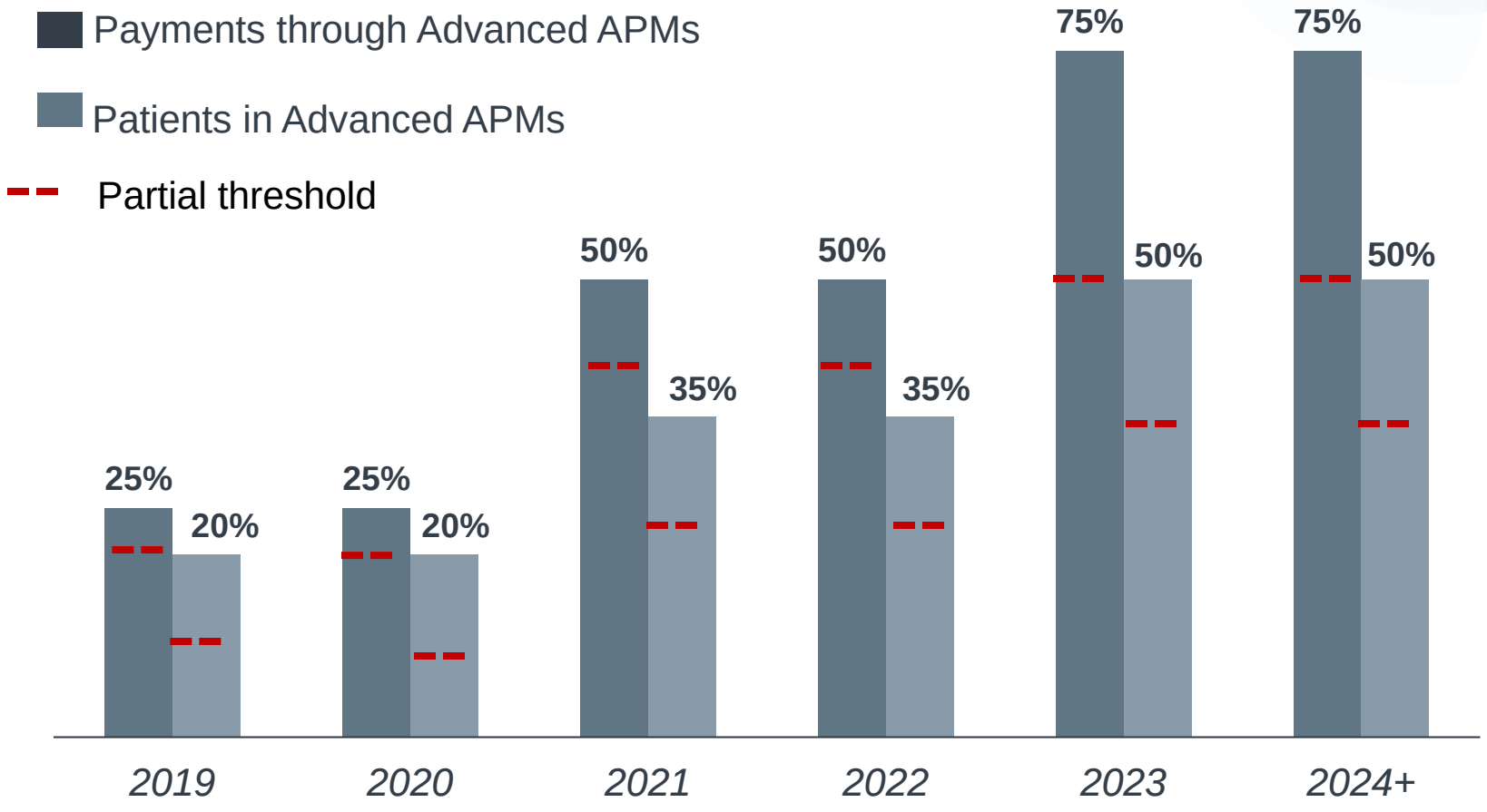
It's not about "risk" or "incentives," it's about giving healthcare providers the *ability/flexibility* to improve outcomes and reduce costs in a way that is financially feasible

Desired changes in care should drive payment reforms that support them, not the other way around

Principal Tools:

- Episode-of-Care Payment
- Risk-Adjusted Global Payment

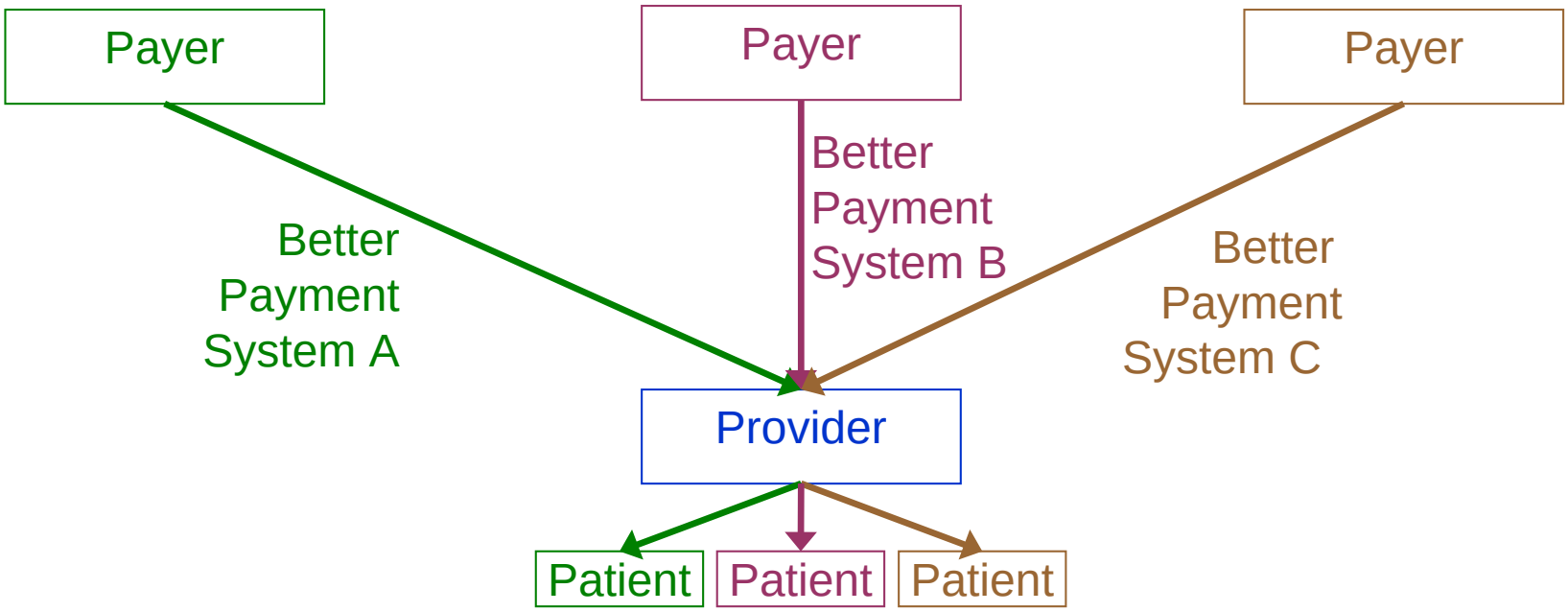
APM participants must collectively meet the participation threshold



Non-Medicare risk-bearing contracts considered

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



NRHI Membership

Aligning Forces for Quality Southcentral Pennsylvania
Better Health Partnership
California Quality Collaborative
Center for Improving Value in Healthcare
Community First, Inc.
Finger Lakes Health Systems Agency
Great Detroit Area Health Council
Health Insight Nevada
Health Insight New Mexico
Health Insight Utah
Healthcare Collaborative of Greater Columbus
Institute for Clinical Systems Improvement
Integrated Healthcare Association
Iowa Healthcare Collaborative
Kansas City Quality Improvement Collaborative
Kentuckiana Health Collaborative
Louisiana Health Care Quality Forum
Maine Health
Management Coalition
Maine Quality Counts
Massachusetts Health Quality Partners
Michigan Center for Clinical Systems Improvement
Midwest Health Initiative
Minnesota Community Measurement
Mountain Pacific Quality Health Foundation
MyHealth Access Network
New Jersey Health Care Quality Institute
North Coast Health Information Network
Oregon Health Care Quality Corporation
Pacific Business Group on Health
Pittsburgh Regional Health Initiative
The Health Care Improvement Foundation
The Health Collaborative
Washington Health Alliance
Wisconsin Collaborative for Healthcare Quality
Wisconsin Health Information Organization

Thank You

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A Perspective on Evaluation of Medicaid Payment Reforms from Washington State

David Mancuso, PhD

Guiding Objectives

- Identify practical strategies states could use to gather evidence and improve the effectiveness of payment reforms
- Understand the technical challenges states face in evaluating payment reforms
- Describe common evaluation challenges that states are facing, including access to data and analytics expertise
- Identify best practices for overcoming challenges to supporting rapid evaluation with practical applications

Types of Payment Reforms Recently Implemented in WA State

- Statewide shift of SSI clients from FFS to managed care
- Integration of Medicaid mental health and SUD treatment services into integrated behavioral health managed care "carve-outs"
- Integration of Medicaid physical and behavioral health services into fully integrated MCOs in selected counties
- Health homes for high-risk Medicaid enrollees and Medicaid-Medicare dual eligibles
- ACO-like payment structures (PEB starting in 2016)
- Quality withholds in Medicaid MCO contracts (2017)

Evaluating Payment Reforms

- **The analytical challenges are generic to program evaluation and performance measurement and not unique to payment reforms**
  - What is the payment reform? (What is the "treatment"?)
  - Who is affected? (Who gets the treatment?)
  - What outcomes are we expecting to impact?
  - Can we project the outcomes the "treatment group" would have experienced in the absence of reform?
- **Viable evaluation options depend on the design of the reform**
  - Quasi-experimental approaches are more likely to be feasible than randomized designs
  - The potential impact of selection bias in quasi-experimental designs should be recognized

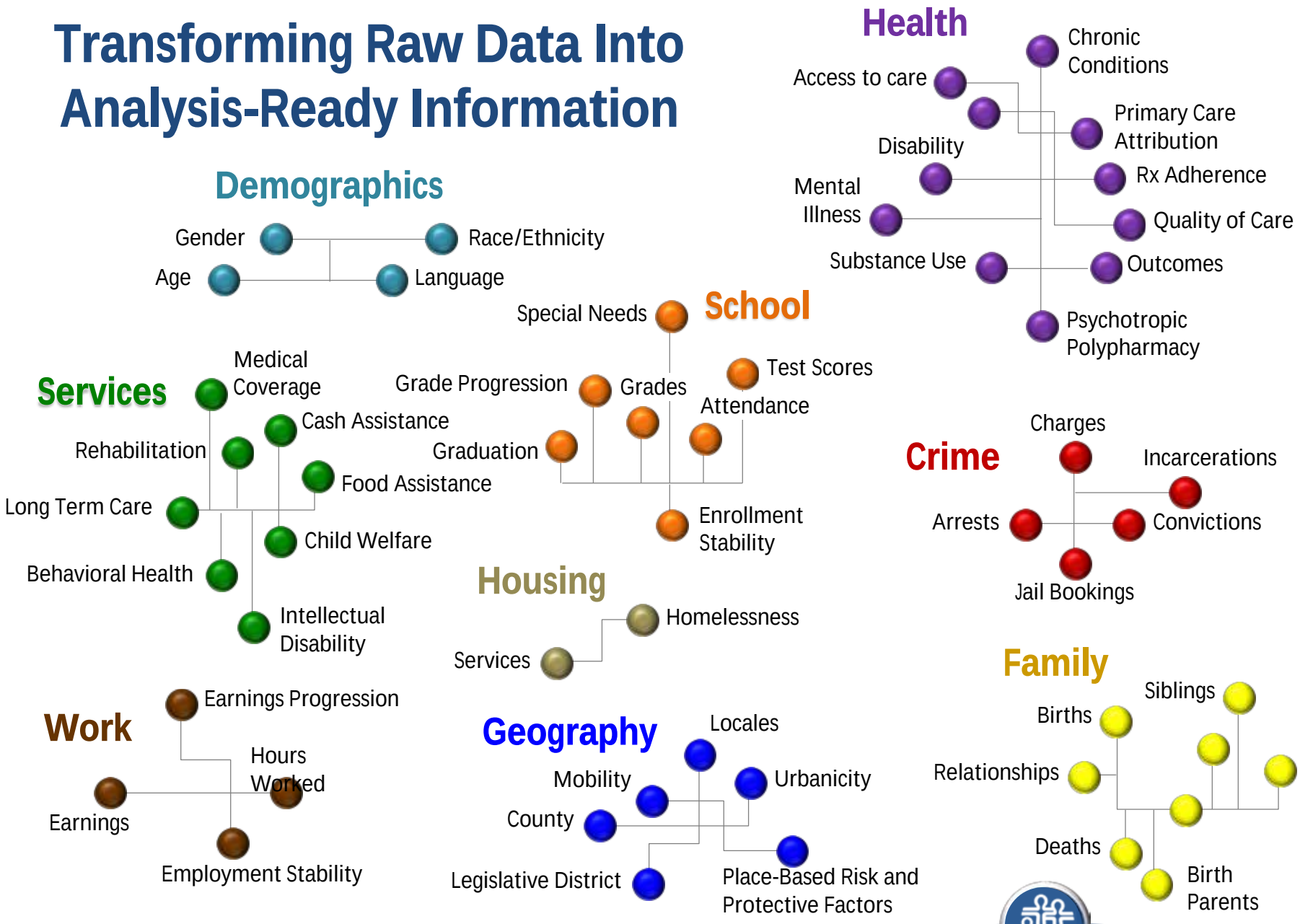
Some Factors Affecting Outcomes of Interest

- "Accountable provider" quality
- MCO quality
- Quality of services from other providers of formal or informal health or social services and supports
- Patient characteristics and behavior
- Factors affecting the availability and accessibility of services
- Random variation

Building an Analytical Data Infrastructure for Evaluation

- **If you want "rapid cycle" evaluation, it is helpful to have a data infrastructure designed for this use case**
- **Key staff resources (contractor or internal):**
  - Analytical leadership by staff who understand the tools of causal inference from observational data (and their limitations)
  - Access to clinical, policy, fiscal and IT system subject matter experts
  - PhDs in the quantitative social and health sciences are a good fit
- **Key staff activity**
  - Stewarding code sets and algorithms that define analytically meaningful concepts in your data environment
  - Parallels NCQA stewardship of HEDIS value sets and associated quality metric algorithms

Transforming Raw Data Into Analysis-Ready Information



Analytical Data Infrastructure to Evaluate Payment Reforms

- An "actuarial" data mart designed to support analysis of financial and utilization impacts
- A "performance metric" data mart populated by administrative-data-only HEDIS® and related metrics to support global analysis of quality and outcome measures
- An "all claims" repository to support exploration and development of new measurement concepts from "raw" claims/encounters and related data
- Components may be accessed through a variety of BI tools or analytical environments

Elements of an Actuarial Data Mart

- **Designed around the person-month unit of observation**
- **Key measurement dimensions include:**
  - Utilization and cost by major service modalities
  - Health risk (disease condition) indicators
  - Coverage spans
  - Managed care enrollment spans
  - Member-to-provider attribution spans
  - Residential location spans
  - Client demographics
  - Provider attributes
  - Other risk factors, services and outcomes

Elements of a Performance Metric Data Mart

- **Designed around the "person x time period x metric" unit of observation**
- **Key measurement dimensions include:**
  - Measure type and result
  - Attribution to accountable entities (plan and/or provider)
  - Coverage concepts to implement appropriate exclusions (e.g., TPL)
  - Member demographics to allow assessment of disparities and differences across communities
  - Member risk attributes to support case-mix adjustment models
- **Centralized global metric production ensures uniform quality of measurement and allows maximum flexibility in subpopulation analyses**

Part 1

Propensity Score Matching Approaches

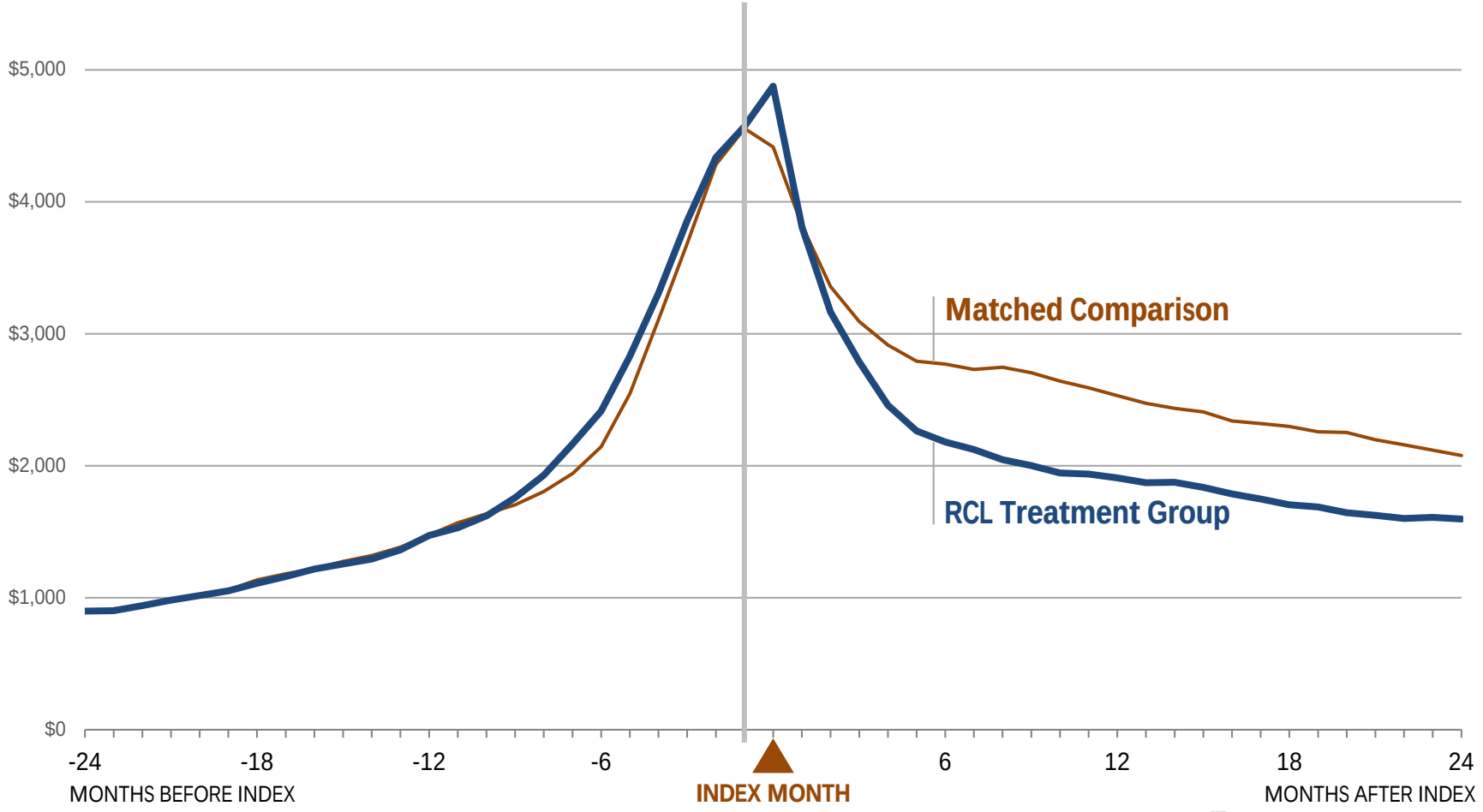
Example: Evaluating the Roads to Community Living Program

- Evaluation of a program designed to facilitate client transitions from nursing facility settings to home- or community-based long-term care
- General approach is relevant to super-utilizer programs and other programs targeting enrollment of persons with "baseline" utilization patterns that are not a credible projection of future utilization
- Addresses selection bias and regression-to-the-mean issues by matching based on baseline risk factors and utilization/cost dynamics

TOTAL – ALL LTSS COSTS, INCLUDING RCL DEMONSTRATION COSTS

HCBS, Nursing Home and RCL Demonstration Supplemental Service Costs

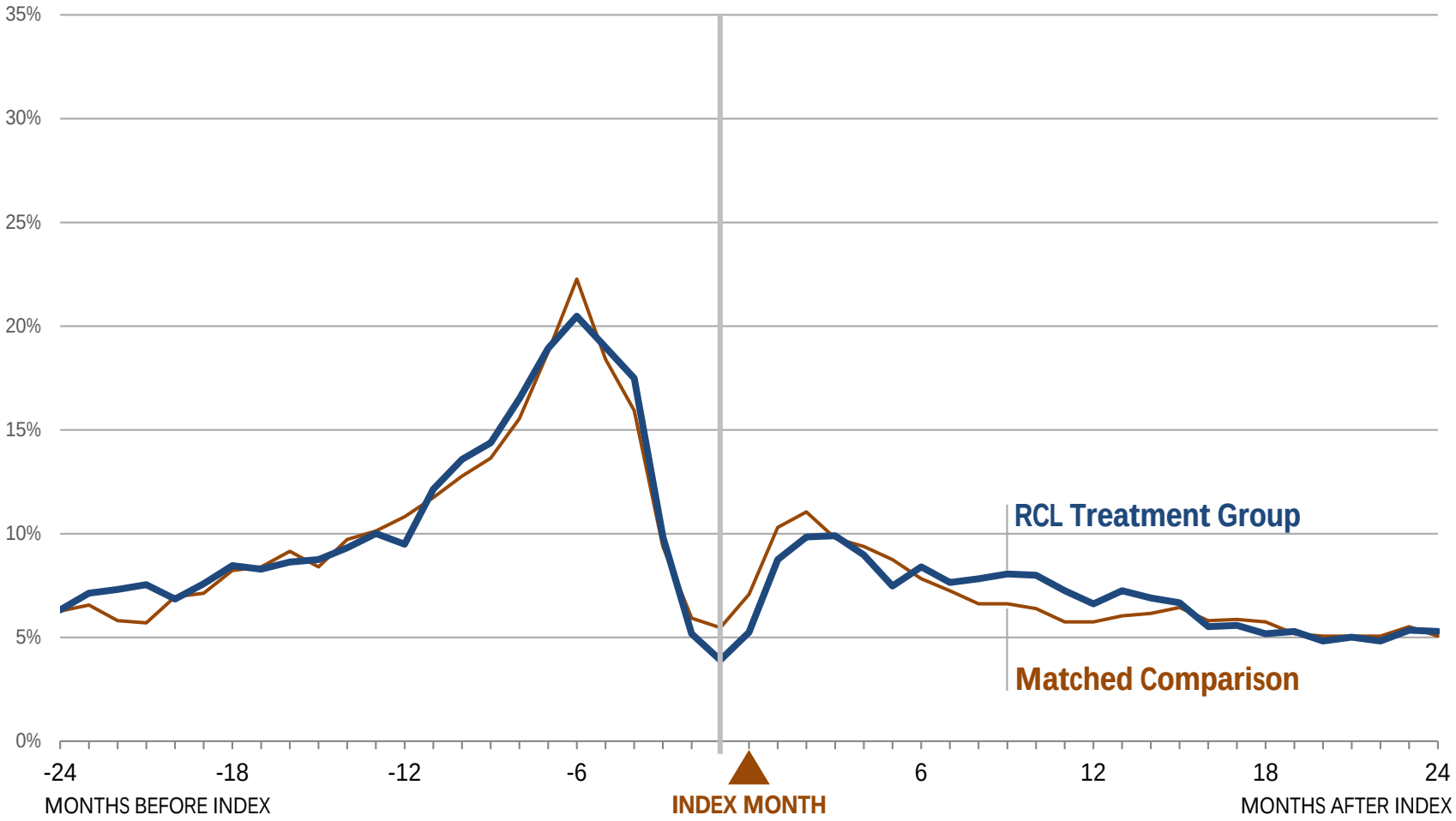
MONTHLY AVERAGE ACROSS ALL TREATMENT AND MATCHED COMPARISON GROUP MEMBERS
INCLUDING CLIENTS WITH NO COSTS WHO DID NOT RECEIVE LTSS SERVICES IN THE MONTH



DSHS Research and Data Analysis Division, Client Outcomes Database, August 2016

Monthly Proportion Experiencing Inpatient Hospitalization

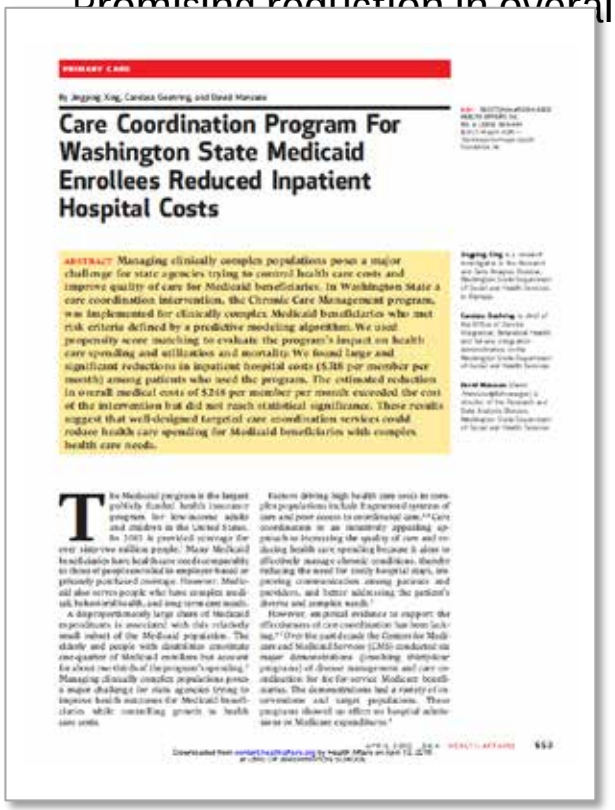
INCLUDES MEDICARE- AND MEDICAID-PAID HOSPITALIZATIONS



DSHS Research and Data Analysis Division, Client Outcomes Database, August 2016

Peer-Reviewed Journal Quality Is Possible on a Rapid-Cycle Timeline

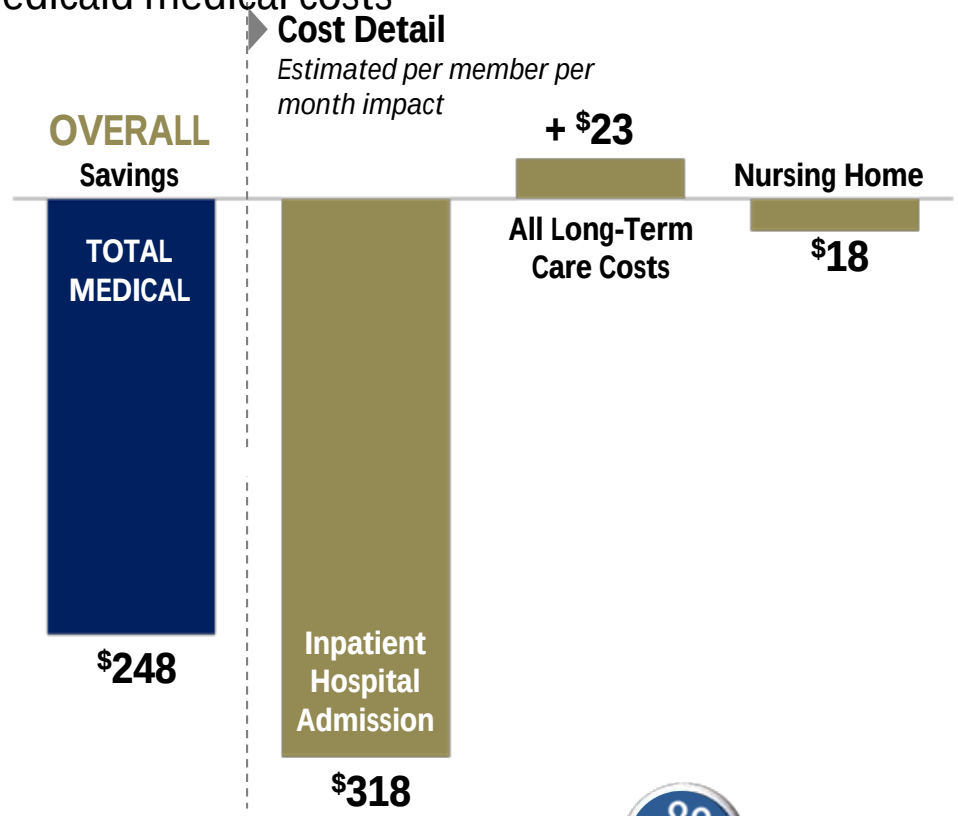
- **Example: "Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs" published in April 2015 Health Affairs**
  - Statistically significant reduction in hospital costs
  - Promising reduction in overall Medicaid medical costs



Care Coordination Program For Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs

ABSTRACT Managing clinically complex populations poses a major challenge for state agencies trying to control health care costs and improve quality of care for Medicaid beneficiaries. In Washington State a care coordination intervention, the Chronic Care Management program, was implemented for clinically complex Medicaid beneficiaries who met risk criteria defined by a predictive modeling algorithm. We used propensity score matching to evaluate the program's impact on health care spending and utilization and mortality. We found large and significant reductions in inpatient hospital costs ($318 per member per month) among patients who used the program. The estimated reduction in overall medical costs of $248 per member per month exceeded the cost of the intervention but did not reach statistical significance. These results suggest that well-designed targeted care coordination services could reduce health care spending for Medicaid beneficiaries with complex health care needs.

http://content.healthaffairs.org/search?submit=yes&fulltext=care+coordination+program+for+washington+state+medicaid+enrollees+reduced+inpatient+hospital+costs&x=0&y=0



PART 2

A Performance Measure Approach

Example: Transitioning SSI Clients from FFS to Managed Care

- **Washington State transitioned disabled Medicaid clients from FFS to managed physical health care in SFY 2013**
- **A broad set of quality and outcome measures are available to assess the relative change over time in the experiences of the affected population**
  - ED and inpatient service utilization
  - HEDIS and related quality metrics
  - "Social" outcome metrics
- **Centralized measure production supports stratification (e.g., by on behavioral health risk factors) to assess the experiences of subpopulations of interest**