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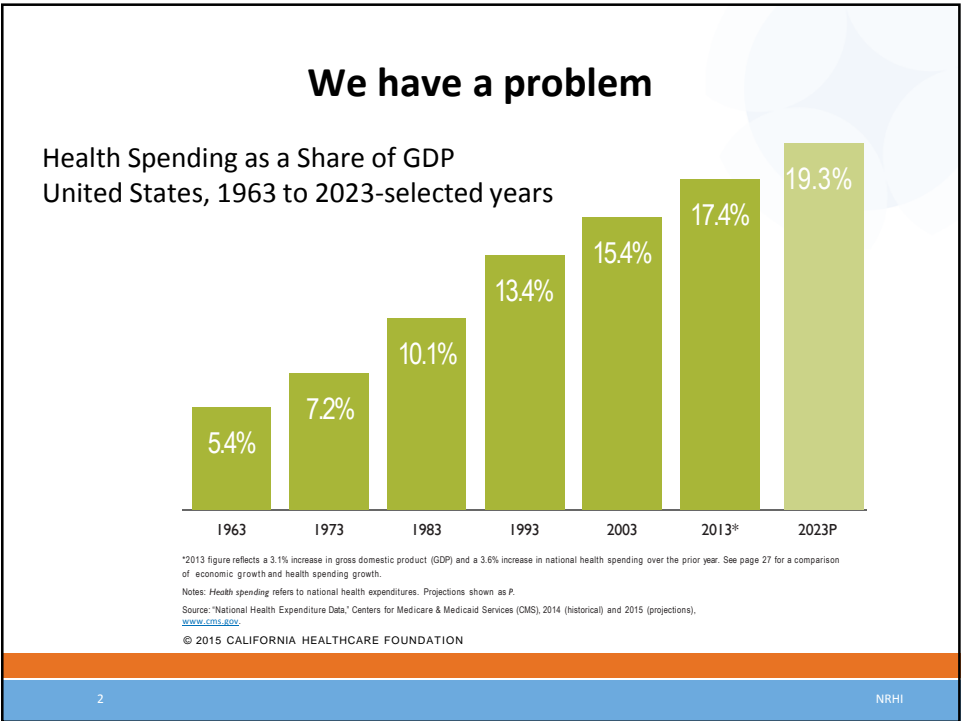
Network for
Regional Healthcare
Improvement

Transforming Healthcare in an Uncertain Environment

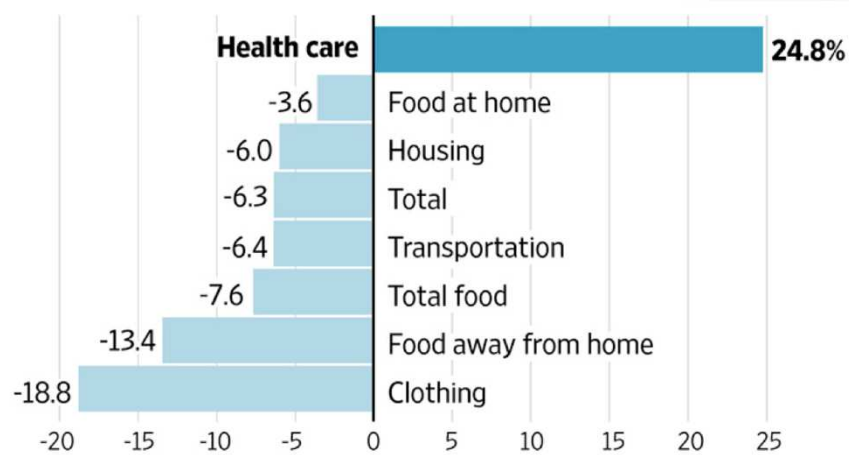
Elizabeth Mitchell, President & CEO

Network for Regional Healthcare Improvement

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

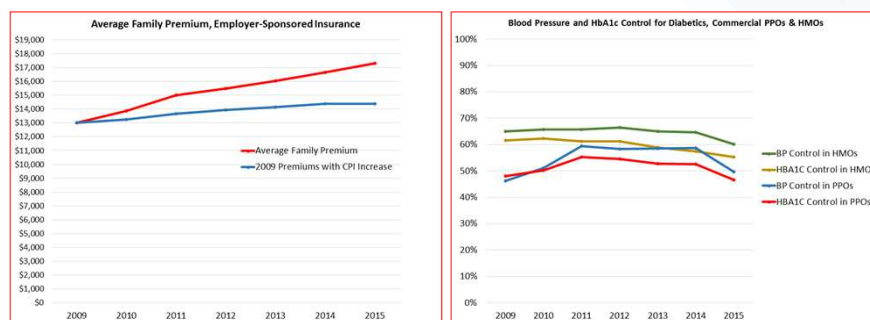


Source: Brookings Institution, Wall Street Journal

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"Value" is Lower Today Than 6 Years Ago



Higher Cost



Poor Quality

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Medicare Access and CHIP Reauthorization Act (MACRA) is part of a broader push towards value and quality.

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

Medicare Fee-for-Service

GOAL 1: **30%** 

Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2: **85%** 

Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



Set internal goals for HHS

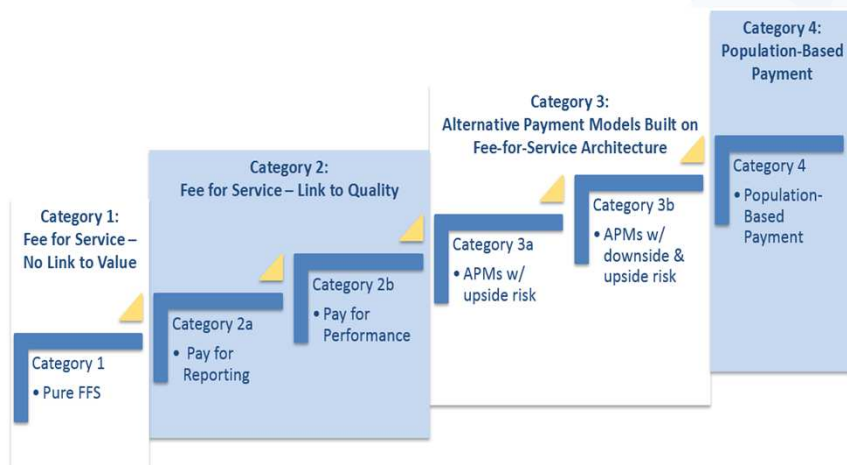


Invite private sector payers to match or exceed HHS goals

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CMS Framework for Payment Models



Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8. For limited release (LAN CMS Participants and GC Members Only)

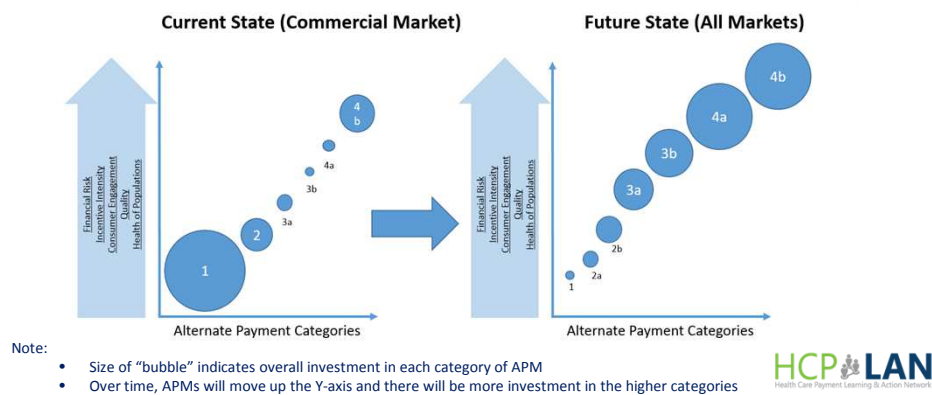
HCP LAN
Health Care Payment Learning & Action Network

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Over time, the desire is to influence a shift in payment models to Categories 3 and 4

Conceptual diagram of the desired shift in payment model application given the current state of the commercial market*



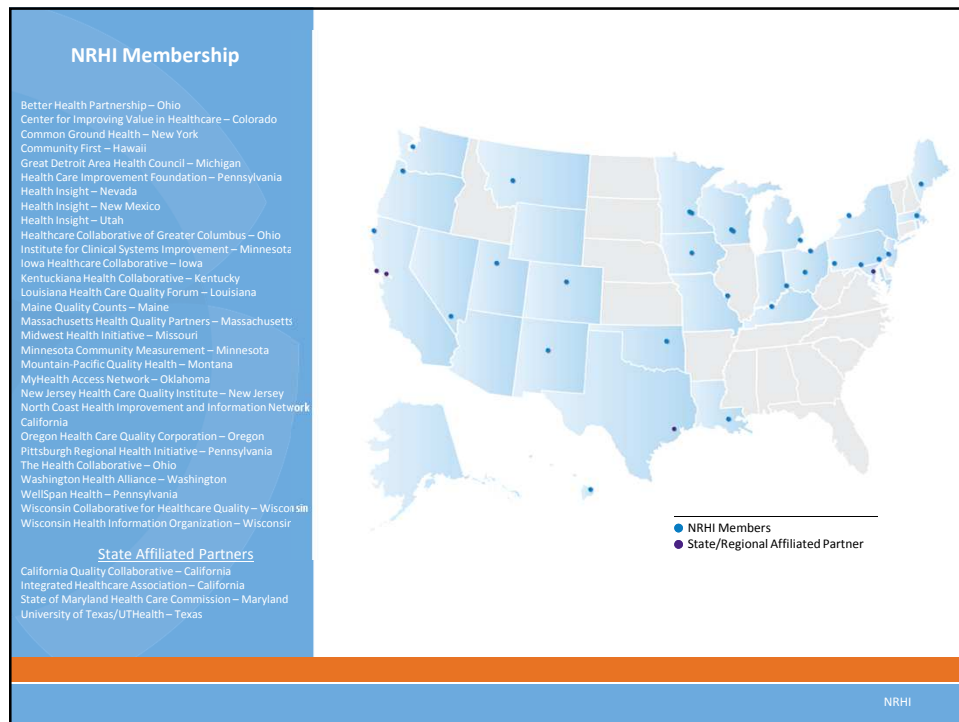
*Source: CPR 2014 National Scorecard on Payment Reform, based on the National commercial market using 2013 data.

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From Fee For Service to Population Based Payment: Changes Required

Need for new:

- Measures – quality and cost
- Shared data infrastructure
- Incentives
- Transparency
- Alignment across payers
- Care models
- Community partners
- Relationships



Reflections from the field: Barriers

Access to actionable quality data

EMR vendor support (for capture of necessary data and access to reporting)

Provider perception & frustration: *“Their hearts are in the right places but this program and the requirements are a deterrent to care”; “I just wish this would all go away. It is a lot of bookkeeping and not targeted to the wellness of the patient”.*

Reflections from the field: **What's Working**

Small practices value technical assistance support *"You don't know how helpful this phone call was."; "We had no idea that we could participate and actually meet the requirements."*

- TA provides navigation support from experts who can quickly assess what a practice needs to do to report under MIPS now; future focus will be improving performance
- Using simple tools to help a practice get started (e.g.; MIPS 9 Step document, cms.qpp.gov)
- Ability to shift perspective to view this program as supportive to the clinic's work rather than just another set of data they need to gather
- Being prepared to support specialists
- Local, trusted technical assistance support

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What do practices need to be successful under MACRA and Value Based Purchasing?

1. Data and information

2. Alignment across payers

➤ Incentives

➤ Measures

3. Technical Assistance and Support

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PTAC Letter to the Secretary

PTAC delivered a letter to the Secretary on August 4, 2017, which conveys observations and lessons learned to date:

1. Individualized Technical Assistance to Submitters in Payment Model Design

- Some proposals submitted by practicing physicians provide a clear description of the care delivery model, but the description of the payment model is underdeveloped.
- Submitters could address these gaps if they had access to assistance from individuals with expertise in payment model design.

2. Access to Data and Analysis

- Evaluating a proposal usually requires analysis of Medicare claims data that has been disaggregated into the types of conditions and procedures being addressed.
 - Large and well-resourced organizations could hire consultants to complete analyses, but the feasibility is limited for small organizations.
 - PTAC requests that a mechanism be established for submitters to obtain analyses of Medicare claims data to be incorporated within their proposals.
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PTAC Letter to the Secretary (continued)

3. Guidance and Technical Assistance on Data Sharing in HIT

- Submitters and PTAC members have had difficulties in addressing the HIT criterion (i.e., encourage use of HIT to inform care).
- Most propose some degree of data sharing, however, insufficient interoperability remains a barrier that individual submitters cannot resolve by themselves.

4. A Ready Path for “Limited Scale” Testing

- PTAC has observed that it will not be possible to fully specify the payment methodology for some proposed PFPs without the benefit of experiential data.
- PTAC believe that a path for testing on a smaller scale would be a helpful first step for many models.

5. Barriers to Innovation in Current Payment Systems

- As a way of overcoming barriers to innovation in the Physician Fee Schedule clinicians are proposing new payment models to PTAC.
 - However, in some cases, a more straight-forward approach to accomplishing the payment improvement is to remove an identified barrier in the current payment system.
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HEALTH AFFAIRS BLOG

DIFFUSION OF INNOVATION

RELATED TOPICS:
 COSTS AND SPENDING | PATIENT CARE | ORGANIZATION OF CARE | EMERGENCY DEPARTMENTS | PRIVATE HEALTH INSURANCE | PAYMENT | SYSTEMS OF CARE
 COST REDUCTION | QUALITY OF CARE | PRIMARY CARE

The Road To Affordability: How Collaborating At The Community Level Can Reduce Costs, Improve Care, And Spread Best Practices

Elizabeth Mitchell

NOVEMBER 14, 2017 DOI: 10.1377/hlthaff.2017.11.08.983176




For months, the US public has watched Congress debate the future of the US health care system—or more accurately—the future of the Affordable Care Act. But despite all we heard about deductibles and bronze versus



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November 28, 2017
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Proof of Concept: Total Cost of Care




Robert Wood Johnson Foundation



Network for Regional Healthcare Improvement

Getting to Affordability

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

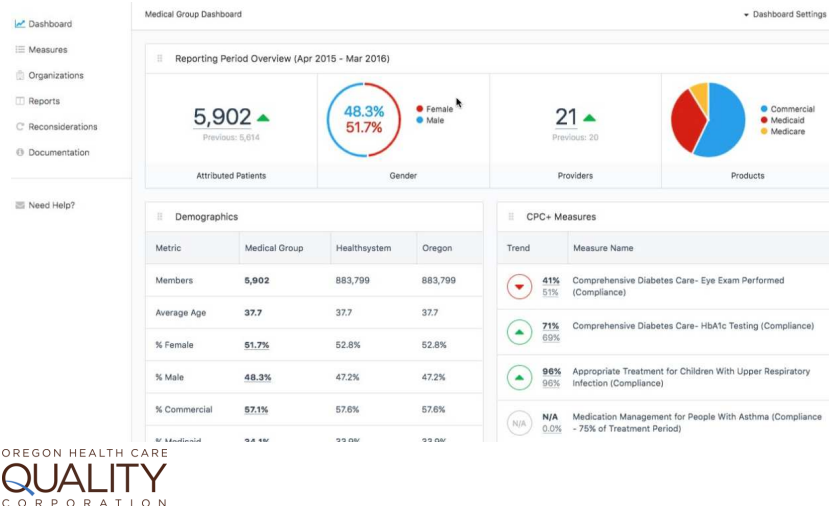
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Q Corp Voluntary Claims Data Collaborative: 2006-present

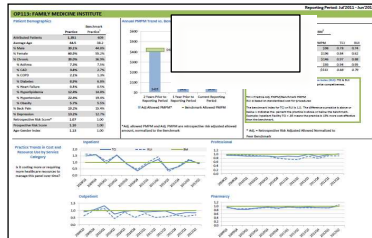
- Data Collaborative –major health plans, State of Oregon and CMS QE data
- 3.5 million unique Oregonians captured in claims 600+ million medical and pharmacy claims records
- All providers in the directory are eligible to receive quality reports with patient-level information for follow-up

Report Quality Performance to Providers

Quarterly reporting on Clinic and Provider performance on over 50 quality and utilization measures.



Primary Care Practice Report



	Practice		BM ²	
	Raw PMPM	Adj PMPM*	PMPM	TCI
Inpatient Fac.	\$82	\$77	\$98	0.78
Outpatient Fac.	\$175	\$164	\$196	0.84
Professional	\$152	\$142	\$146	0.97
Pharmacy	\$94	\$88	\$93	0.94
Overall	\$503	\$470	\$533	0.88

² BM = Peer Benchmark

Note: Retrospective Risk Score for Practice = 1.07

Displayed as an index to protect information while being transparent with relative performance.

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Louisiana Health Care Quality Forum


The Quality Forum is a private, not-for-profit organization dedicated to advancing evidence-based initiatives to improve the health of Louisiana residents.

- **PROBLEM:** Non-emergent use of hospital emergency departments (EDs) is a critical, complex and costly issue facing Louisiana.

SOLUTION: The Quality Forum leverages the statewide health information exchange (HIE) to reduce non-emergent ED visits and inpatient admissions among Medicaid patient population.

- **Louisiana Emergency Department Information Exchange (LaEDIE)**, an HIE application, receives, compiles and routes utilization data from hospital EDs to Managed Care Organizations (MCOs).
- **STRATEGIES:** MCOs use actionable, quality data from LaEDIE to conduct outreach, education and follow-up with members.

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Louisiana Health Care Quality Forum

Louisiana Health Care Quality Forum

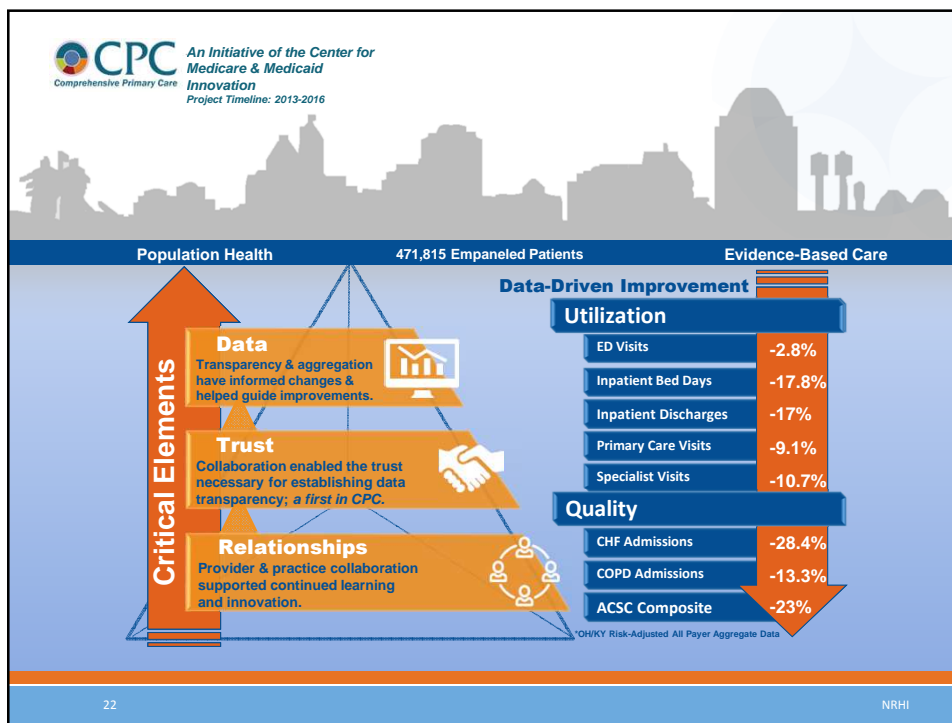
RESULTS: Reductions in ED visits and inpatient admissions were reported.

LaEDIE Pilot Project with MCO

August-December 2015


- Among the MCO's top-performing pediatrics practices:
 - Several realized **as much as a 20 percent reduction** in ED visits per 1,000 members
 - Several realized **more than a 10 percent reduction** in inpatient admissions per 1,000 members

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What GAO Found

- 5% of measures used by commercial plans were common
- Physician practices spend 785+ hours per physician per year on quality measurement
- Average annual cost of quality measurement per physician is \$40,000+



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


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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




9.6 Million Californians



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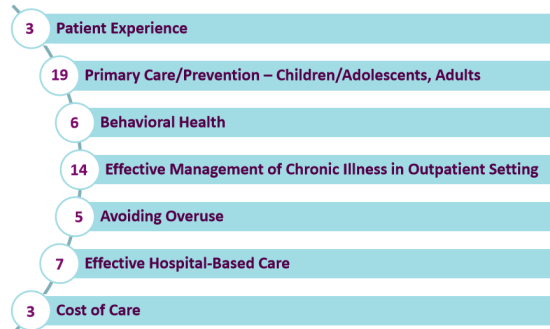
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Washington State Common Measure Set, 2017 # of Measures by Area of Focus

- The Common Measure Set is approved annually by the Governor's Performance Measures Coordinating Committee
- The Washington Health Alliance contracts with the State to:
 - Staff the Governor's Committee
 - Produce results for the Common Measure Set
 - Publicly report results on its website: www.wacommunitycheckup.org



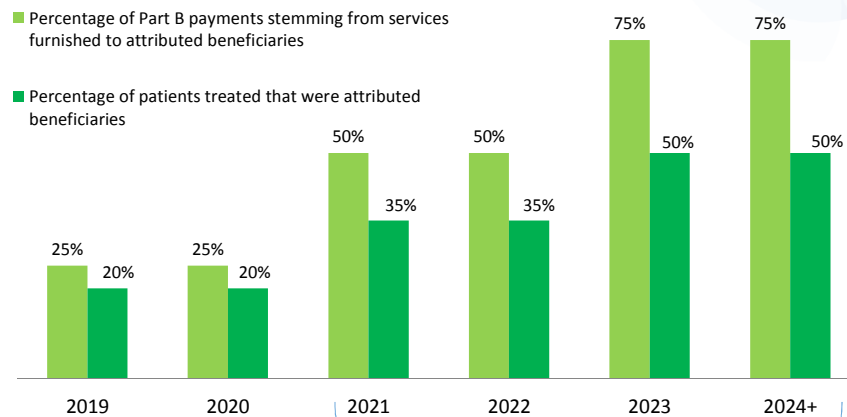
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The Move to Multi-payer:

To earn the APM Incentive Payment, Advanced APM participants must collectively meet participation thresholds



Entities can demonstrate "Other Payer APM" participation

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Greatest Opportunities to Support Pay for Value Quality Care

- We need **public and private data combined** to transform healthcare – **follow the people**
- Providers need the ability to **“see” entire population** during multiple regional and national transformation efforts – health plans and providers cannot do this on their own, no matter how large
- **Quality Improvement at the practice level** – sense making – all providers and stakeholders need this information together to improve outcomes
- **Standardize methodologies and metrics to drive care transformation**