CIN Partners Share:

Success in Payment Reform Requires More and Better Data, Plus a Dose of Experimentation

Main Takeaway:
To meet value-related goals for populations, build a multi-stakeholder forum that aligns purchasers and providers.

Payment models are proliferating as health care organizations seek ways to enhance value and reduce costs in a marketplace undergoing disruption. Spurred by recent payment changes such as those created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), simpler payment structures are giving way to combinations of new and traditional models.

California Improvement Network (CIN) partners — provider groups and coalitions, health plans, and quality improvement organizations — gathered in February 2017 to discuss the payment landscape and how to prepare for likely changes. While health care policies were being debated in Washington, DC, the partners expressed concern about potential upheaval but also hope that any changes will enable their flexibility to innovate.

Of Sprained Ankles and Value

United HealthCare engaged consumers directly in discussions of value. Its magazine ad asks: "How would you spend $1,327 on your son's skateboarding career?" and shows a list of possible expenses including lessons, protective gear, clothing — and a $124 urgent care visit for a sprained ankle, *compared to a $1,327 charge at an ER.*

Three expert guest speakers joined the CIN partners:

- Suzanne Delbanco, executive director of Catalyst for Payment Reform (CPR), a nonprofit that works on behalf of employers and other purchasers to improve health care value and marketplace functioning
- Elizabeth Mitchell, president and CEO of the Network for Regional Health Improvement, a national member organization of multi-stakeholder health improvement collaboratives
- Rachel Tobey, director at John Snow Inc., a public health research and consulting organization

Looking for Sustainable Strategies

CPR's Suzanne Delbanco focused on the need for evidence of value for different payment models and on which models are most sustainable for providers. She noted the fast rise in tying payment to value — from 1% to 3% of all dollars to providers in 2010 to 40% in 2014. At the same time, Medicare has set ambitious targets for payments tied to quality. By 2018, the goal is 50% of Medicare payments will be through alternative payment models (see definitions box, page 2).

Currently, Delbanco said, 90% of payment models in the US are based on the traditional fee-for-service (FFS) system, including pay-for-performance (P4P) programs, the fastest-growing model of payment reform. Bundled payment arrangements have grown more slowly. Health plans and other payers are moving quickly to claim large investments in value over volume. "It's an arms race out there," she noted.

To help frame the payment model possibilities, Delbanco presented the Center for Medicare & Medicaid Services categorization, which is arranged across a continuum of risk and patient-centered care. (See Figure 1.)

Payment Model Terms

Alternative payment models (APMs): Payment reforms that seek to use dollars as the lever to increase the value of health care services for stakeholders. Capitation, downside risk, upside gain-sharing, and upside risk are some of the mechanisms included in APMs.

Capitation: A fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year. Different configurations include capitation with and without a quality performance component, and capitation for patients with a specific medical condition.

Downside risk: Financial liability associated with losses.

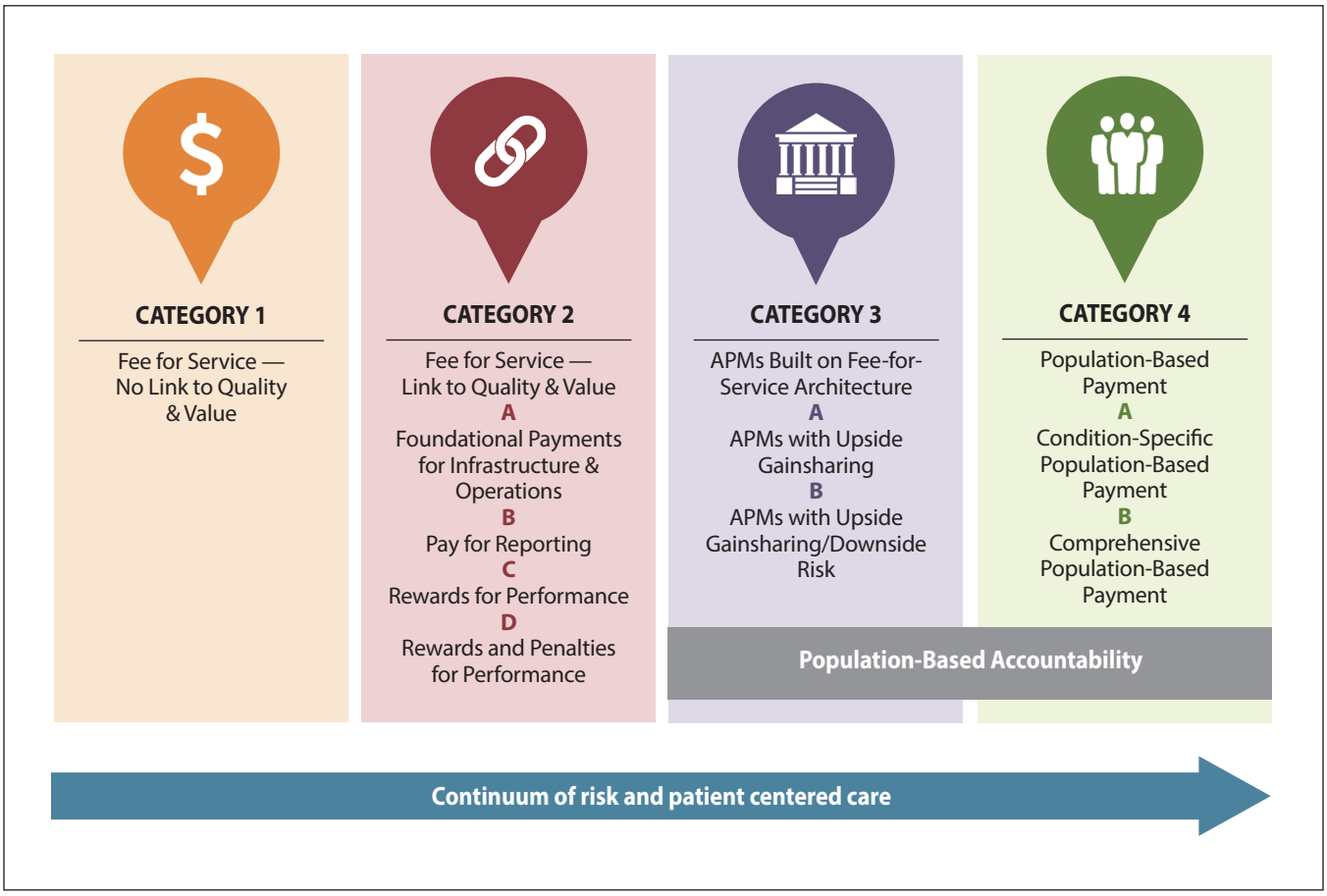
Upside gain-sharing (also known as shared-savings arrangements): Provider organizations or accountable care organizations share in any net savings that accrue to a payer for a defined panel of patients over a specified period, usually 12 months. Actual costs for the patient panel are compared to a benchmark based on historical utilization and/or cost data for that patient panel or a similar population.

Upside risk: Providers stand a chance for a financial "upside," or bonus, but not losses as in downside risk. Pay for performance is the most popular type of upside risk.

Value: Variously defined, value typically brings together metrics on the quality of health care (such as patient outcomes and health status) with metrics on the dollar outlays.

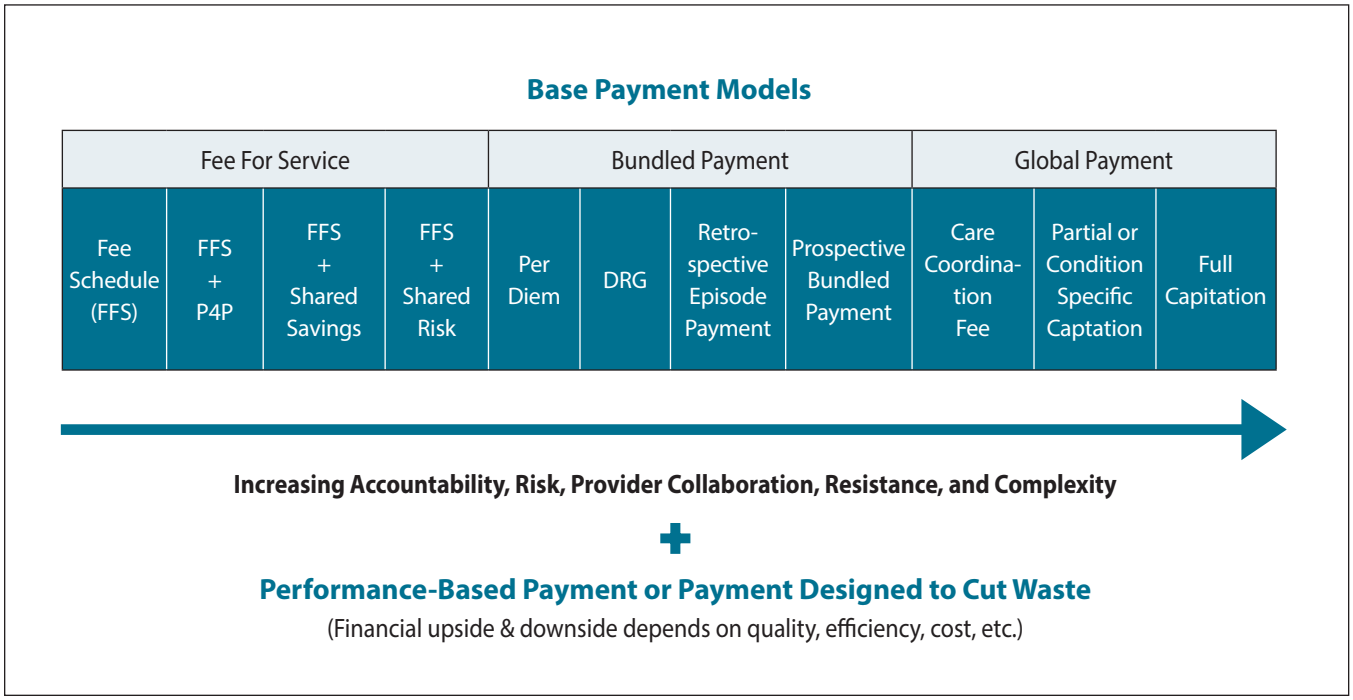
These definitions were adapted from CPR's Compendium http://compendium.catalyzepaymentreform.org/compendium-search/definitions-pmt and from the Kaiser Family Foundation http://kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/.

Figure 1. Center for Medicare & Medicaid Services' Categorization of Payment Models



Delbanco also presented CPR's categorization of payment models, with a continuum of increasing accountability, risk, provider collaboration, resistance, and complexity. (See Figure 2.)

Figure 2. Catalyst for Payment Reform's Categorization of Payment Models



While there is a progression in payment models in terms of the level of risk and accountability for provider organizations relative to payers, she noted, there is no ideal payment model that all health care organizations should adopt. "People want to hear that there is one single best payment model, but it's not that simple. We are not all on one path moving in the same direction. Some of these models would never be appropriate in certain circumstances or with certain health care providers," Delbanco said. "All of these models can be improved, including fee-for-service itself."

Delbanco predicted the near future of payment models:

- Experimentation with payment models will be critical to growing the knowledge base about what works to improve value. The future of federal support for state efforts at payment reform is unclear.
- Payers will continue to push providers to assume more financial risk through shared-risk arrangements, particularly in areas of significant and growing expense, such as pharmacy, specialty pharmacy, and behavioral health.
- Disruptive new businesses are emerging, such as telehealth vendors, who seek to improve on quality and cost and compete with traditional provider organizations by offering more accessible and affordable services.
- The trend of high-deductible health insurance products will continue, including those with a health savings account.
- Providers will be motivated to increase quality to stay in narrowing health plan networks, as consumers are willing to give up choice for the assurance of better and more affordable care.
- Health care organizations that succeed will be those with real-time data on service use, quality and costs across institutions and levels of care, and the capability to use these data to improve quality and efficiency.

As Goes Medicare . . . MACRA and MIPS

The Network for Regional Health Improvement's Elizabeth Mitchell described the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which she cited as one of the largest forces in payment reform. MACRA changes the way Medicare pays providers, ending the unworkable sustainable growth rate formula that threatened annual fee schedule cuts. It combines multiple existing quality programs, including the Physician Quality Reporting Program under the new Merit-Based Incentive Payment System (MIPS), and creates increasing upside and downside risk for practices based on performance.

MACRA also creates the opportunity to participate in a range of alternative payment models (APMs) with greater levels of risk. The changes brought about through MACRA are part of a larger strategy of the previous administration's Department of Health and Human Services, with the twin goals of tying, by the end of 2018, 50% of Medicare payments overall to quality or value through APMs, and 90% of Medicare FFS payments to quality or value.

Although payment under the new system will begin in 2019, the measurement year on which they will be based started January 1, 2017. The current payment system will continue through the end of 2018. MIPS payments will initially be based on three of four performance categories: (1) quality, (2) participation in clinical practice improvement activities, and (3) information sharing. Resource use will be included in scoring in future years. The burden of participation is low for the first year; submission of minimal, basic data allows providers to adjust to the new system with low risk and low effort.

Two payment model options are available for providers under MACRA:

- **Merit-Based Incentive Payment System (MIPS).** Pay is based on a composite score in four performance categories: quality measures, efficient resource use, clinical practice improvement activities, and "meaningful use" of a certified electronic health record technology. By 2021, the weight of scores in resource use will grow to 30% of the total score.
- **Advanced Alternative Payment Models (Advanced APMs).** Requirements for an Advanced APM include assumption of downside risk for the provider organization, payment based on quality measures comparable to MIPS measures, and others.

The Centers for Medicare & Medicaid Services (CMS) expects 60% of providers to be in MIPS in 2019, the first payment year. However, "everybody wants to participate in an Advanced APM," said Mitchell, due to that option's more advantageous fee schedule. To promote the increased effectiveness and value achieved by multipayer APMs, payment thresholds will rise over time to pay more to APMs with higher percentages of their patients and payers under value-based payment.

Technical assistance and funding from CMS is available to support the progress of payment reform initiatives through the CMS Transforming Clinical Practice Initiative. CIN partner California Quality Collaborative manages one of the six regional Practice Transformation Networks operating in the state. Technical assistance is focused in particular on small and rural practices, which typically have fewer resources to support providers' success in changing business models.

"You can't tweet about payment reform. It's very hard to make it simple."

MACRA encourages innovation in payment model design through its call for physician-focused payment models. Criteria for these models provide a framework for understanding what a payment model focused on value and efficiency should include. Models are evaluated on their strengths in promoting patient safety, patient choice, flexibility for practitioners, and evaluation goals, among other criteria. Physician-focused models may be determined to be Advanced APMs, based on CMS's judgment.

Data sharing, Mitchell emphasized, is crucial to the success of value-based payment models. "You can't be accountable if you don't know what's happening in the community," she said. "The push from MACRA will accelerate and support data-sharing." She shared a past experience in managing a regional collaborative: "Employers say, 'We are spending too much and the care isn't good enough.' Providers say, 'We want to give better care. We have the same goals.' But they did not have the information they needed to understand what was happening with patients in the community."

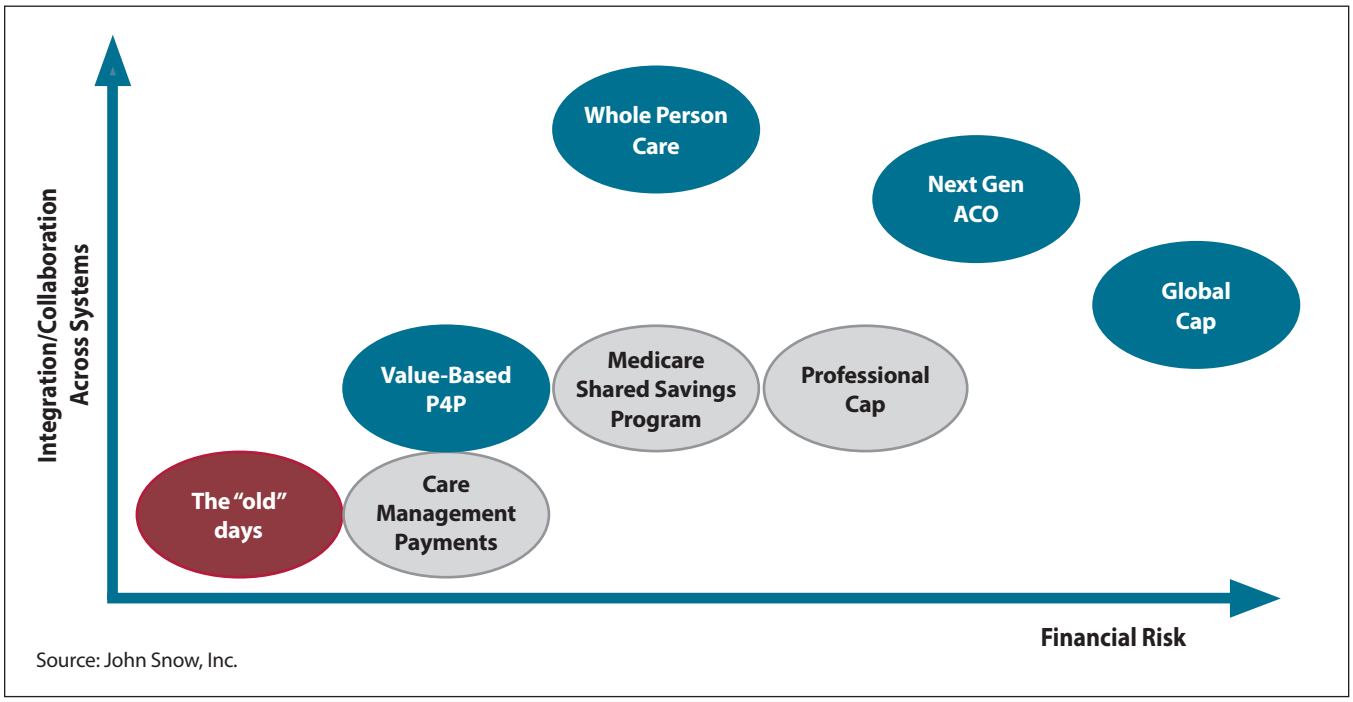
Early Lessons from California

Rachel Tobey, an expert on California payment reform, led a panel discussion on four value-based payment models currently active in the state:

- Incentives built on top of FFS, using partner examples of different models:
  - Partnership HealthPlan of California's pay-for-performance program
  - HealthCare Partners' Next Generation Accountable Care Organization
- Los Angeles County Department of Health Services' Whole-Person Care program under the state Medicaid 1115 waiver
- San Francisco Health Plan's capitation model

As shown in Figure 3, these models have varying levels of risk for provider organizations and different requirements for integration and collaboration with other entities.

Figure 3. Integration and Risk



Source: John Snow, Inc.

Value-Based Pay for Performance (P4P)

P4P has existed in California in the commercial delivery system since 2001. In both sides of the industry, as P4P evolves, payers and program managers have added high-cost utilization measures such as hospital days and emergency department (ED) visits to clinical quality measure sets to promote efficient care utilization and cost controls. Spurred by this trend, primary care providers are connecting in deeper ways to hospitals and payers, to receive better data more frequently on measures such as hospital admissions and discharges. However, many provider organizations are still working in the dark, lacking the necessary data to better prevent avoidable hospitalizations.

A limitation of P4P programs is their lack of timeliness: P4P payments and related data analyses are retrospective. This diminishes the payment's impact on provider behavior change, and also prevents up-front investment in the necessary tools and capabilities to succeed, such as better data systems and a deeper bench of analyst staff.

Quality Improvement Program of Partnership HealthPlan of California (PHC)

PHC, a Medi-Cal health plan, began its Quality Improvement Program (QIP) in 2009. QIP currently accounts for 40% of the plan's payments to their provider network. There is no downside risk for providers; QIP payments are bonuses. There are four performance domains:

- Clinical quality, with 15 measures including blood pressure control, diabetes management, and early childhood vaccinations
- Appropriate use of resources, with four measures: hospital admissions, readmissions, use of urine toxicology screenings, and pharmacy utilization
- Access to care, with three measures: avoidable ED visits, access to primary care office visits, and the practice's open status to accept new PHC members as patients
- Patient experience, using the CAHPS or other survey tool

QIP has been successful in helping focus Partnership's safety-net provider network on quality, cost, and patient experience. PHC is promoting more data transparency across their provider network to spur further improvement. A challenge for the plan and providers is access to performance measures data in real time or close to real time. Also, the program is unable to update providers throughout the year about the amount they are earning in the program, due to a rating mechanism based on providers' final scores relative to the rest of the network.

Next-Generation Accountable Care Organizations (ACO)

CMS defines ACOs as "groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients." ACOs have demonstrated equal or better quality and better patient experience scores. There are no formal Medi-Cal ACOs likely due to: (1) low per capita Medi-Cal rates (less opportunity for shared savings compared to other states), (2) absence of a state push for providers to form Medicaid ACOs, and (3) a long history of risk-bearing provider groups within the managed care system that are already functioning like ACOs. Although most first-generation ACOs did not save money, one commercial California ACO—including Hill Physicians, Dignity Health, and Blue Shield—reported savings of $20 million.

Lessons from first-generation ACOs are informing the creation of "next-generation ACOs," which CMS says will benefit from new rules and program operations intended to realize improvement and be responsive to some challenges faced by providers in earlier efforts. (Note that a next-generation ACO is not the same as an Advanced APM under MACRA, but may be categorized as such if the ACO participants apply and Advanced APM status is conferred by CMS.) Next-generation ACOs will:

- Prospectively assign beneficiaries to the ACO
- Prospectively set performance benchmarks that are designed to be more fair to participating organizations
- Allow providers to select between four distinct payment methodologies, including global per beneficiary per month capitation payments and FFS plus "first-dollar" savings that flow directly to the participating organizations rather than to CMS

"It takes money to save money."

Among the lessons learned from first-generation ACOs is the size of investments required to succeed. Such investments include getting more and better data on the assigned population, data analytics capacity and capability, and substantial time required to meet with ACO partners to build productive, trusting relationships. One ACO leader reflected to Tobey: "We had to sing a lot of 'Kumbaya.' We had to get all those executives around the table. Those meetings cost thousands of dollars. We also had to invest in data systems and retrain staff. In other words, it takes money to save money."

The Next Generation ACO of HealthCare Partners, a DaVita Medical Group

HealthCare Partners (HCP) serves more than 575,000 managed care patients in Los Angeles and Orange Counties. Its network includes more than 600 providers in the medical group and over 6,000 primary care and specialty providers in the independent practice association (IPA) model. HealthCare Partners, LLC, is the medical group's management services organization and a subsidiary of DaVita. HCP and its IPA were assigned 25,000 patients' care to manage in their Next Generation ACO. The ACO chose a full-risk performance model, in part because of HCP's 20+ years of experience in value-based care.

HCP has made large investments in modifying and improving data systems, and current efforts are focused on redesigning provider and staff workflows to focus on patients' health in the community as well as in provider offices. Providers in the Next Generation ACO will be able to qualify as an advanced alternative payment model (APM) in the Quality Payment Program under MACRA. One focus for improvement is integrating behavioral health care with primary care: "Mental health comorbidity can drive a lot of utilization for patients with chronic health conditions," said Dr. George Hong, national medical director for HealthCare Partners, DaVita Medical Group.

Global Capitation

A payer makes global capitation payments to providers or provider organizations prospectively, to fund the care of an assigned group of patients or members. Global capitation places all financial risk on the provider organization or facility for the care required. Tobey noted that many experts believe population-based payments, including global capitation, is the ultimate goal, or at least will be the ultimate result, of payment reform efforts. Success factors for global capitation include those important for ACO participants, such as strong relationships with partner organizations to perform as an integrated system of care. In addition, success in capitation requires having a sufficient number of lives and the requisite licensure to bear financial risk safely, the ability to act as both a payer and a provider of health care, the capability to manage the care and utilization of prospectively assigned members, and sufficient funding to innovate care in ways that produce beneficial cost and quality outcomes for the population.

Population-Based Capitation at San Francisco Health Plan (SFHP)

SFHP serves 160,000 managed care members. Payments to its provider network are a mix of capitation, FFS, and P4P. Its capitation arrangements cover most primary and specialty care, as well as the main hospital that treats its members, Zuckerberg San Francisco General. Pharmacy, ancillary, and other services continue to be funded using FFS arrangements. P4P accounts for approximately 20% of payments to providers. However, most primary care providers in the network experience capitation as not very different from traditional FFS; this is because the large majority of these providers work in Federally Qualified Health Centers where most of the clinics' income is through the encounter-based prospective payment system rate. In addition, delegated medical groups transition SFHP's capitation rate to an FFS rate for their providers.

Benefits of capitation for SFHP include the budget stability provided by the consistent capitation payments and easier work managing utilization and claims than would be required for FFS payments. Provider groups and clinics benefit from capitation because of the freedom it gives them in their staffing models and the ability to focus on meeting patients' needs. One drawback from the health plan perspective is the poor coding of visits and services by provider organizations since, in a capitation arrangement, payments do not hinge on submissions of complete and timely codes. The incomplete data that result from poor coding makes it impossible for SFHP to know what care is, and is not, being provided to members. Another SFHP concern is the lack of control over utilization management when that responsibility is extended to providers through the capitation agreement.

Whole-Person Care (WPC)

California's public hospital systems are engaged in groundbreaking efforts to organize and fund new levels of coordination for high-needs populations as part of the current state Medicaid payment arrangement with CMS, known as a Section 1115 waiver. WPC pilots, which are funded and managed under the waiver, are meant to improve care and the efficient use of funding for five patient populations: (1) frequent users of EDs, hospitals, and nursing facilities; (2) frequent users with two or more chronic conditions; (3) individuals with behavioral health conditions; (4) individuals who are homeless or at risk for homelessness; and (5) people who have been recently released from an institution including a hospital, nursing facility, or jail. The 47 pilots are being conducted in 18 counties for a total value of $3 billion. The program ends in 2020.

WPC is innovative in its focus on integrating different services with separate funding streams. Tobey discussed a county in which initial discussions between health care and social service providers led to a quick win for all stakeholders, particularly patients. In that discussion, providers worried about successful hospital discharges for homeless patients because there was no stable housing for them. This caused the county hospital to keep these inpatients longer than medically necessary. The local low-income housing organization's representatives at the meeting revealed that federally subsidized housing units were standing empty, because there were no on-site social services to help medically and socially complex clients succeed as tenants. This conversation led to the proposal to use WPC funding to do landlord engagement and assign case managers to support clients in the housing units, thus providing a stable and healthy place for patients to go following hospitalization.

"WPC models require peripheral vision," said Tobey. "Systems have to be aware of and work with new partners."

Whole-Person Care Pilot: Los Angeles County Department of Health Services and Partners

Los Angeles County DHS and its associated partners have been awarded the Whole-Person Care (WPC) pilot by the state Department of Health Care Services and CMS. The WPC pilot serves five target populations (homeless, criminal justice-involved, mental health, substance use, and medical high-risk individuals) with complex health conditions. The WPC program seeks to link these individuals into care and social services. LA County health leaders believe that the WPC program will improve lives and increase efficiency of medical care, behavioral health care, and social services and will shift services and costs away from areas such as the criminal justice system. To launch the initiative, the county and its partners are currently developing workflows, hiring staff, and creating a central "hub" office, as well as a Regional Coordinating Center in each of eight service areas throughout the county.

The new WPC funding could total $900 million, with half coming from the federal level and half from the county budget. A big concern is the potential cost savings, and how to sustain the WPC program once waiver funding ends. The impact on population outcomes and future utilization is also unknown, as shifts in resource use and impact on health outcomes may require longer than five years to realize. The WPC process has already resulted in some success in partnership between health, mental health, substance use, public safety, sheriff's department, social services, and community agencies. In addition, the WPC program includes an investment in hiring community health workers (see August 2016 CIN Partner Meeting Report [PDF]) and improvements in data sharing.

Ready, Get Set . . .

In wrapping up the gathering, the experts offered practical takeaways for providers and health plans as they prepare for the expected changes:

Collaborate to lead transformation of care.

- Create trust through both formal and casual connections. New relationships are required.
- In the case of ACOs and MACRA-related APMs, participate in a multipayer model if and when possible.

- Understand that nonmedical factors often drive utilization.
- Consider getting purchasers and providers in the room together, with the health plan as a broker and a support for the business relationship.

Get the right data quickly. Invest in what is needed to turn it into useful information.

- Invest and partner to gain improved data systems and analytics capabilities.
- Ensure efficient and effective health information exchange.
- Establish the correct data scope with partners. Find data that are patient-centric and community-wide, including public health statistics and data on social determinants of health. These data exist outside of electronic health records.
- Provide point-of-care access to quality and utilization data. Providers need to be able to see what is happening in care in order to improve.
- Gain a clear understanding of attribution and risk stratification, and use this knowledge in seeking and analyzing data, and in applying lessons from data.
- Increase transparency of value-related data at all levels — data on quality and on costs. More of these data will be required, and more frequently, by payers and regulators.
- In the case of health plans, choose information systems that enable flexibility in how payments are calculated, to allow adaptation to new payment models.

Improve and enhance care. Act on the expanded view provided by the data.

- Integrate behavioral health services for mental illness and addiction into primary care.
- Provide case management for high-needs populations.
- Use alerts and active monitoring to support timely panel management.
- Act on care gaps.
- Manage care transitions and close referral loops.
- Partner with community providers.

The experts agreed that all stakeholders need to support the evolution of payment models. Payers and policymakers will continue to drive changes that focus on value, and providers must be prepared to compete on value. All eyes should be on CMS for evidence of which models work to improve value.

They also emphasized some final points. Payment should support better care delivery. Providers should advocate with payers for the payment model that works best for them and supports improvement; there is no single model that works for all. Providers should note that health plans and IPAs can serve as a source of technical assistance for succeeding in new payment models. The experts also advised participants to expect challenges implementing new payment systems. Health plans can benefit from joining with leading plans nationally that are expressing readiness to move to Advanced APMs.

One thing that is clear about payment models and the path forward: It's complicated. Payment models are complex in order to balance incentives for access, flexibility, high quality, and cost efficiency. In addition, the field's understanding of the power of financial incentives to improve care and efficiency at the system level and at the individual provider level is still evolving. One participant summed it up this way: "You can't tweet about payment reform. It's very hard to make it simple."

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