THE HEALTH INDUSTRY Forum

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New Payer-Provider Partnerships

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Methodology

Look back on 2017 data

Refreshed LAN APM Framework

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A **Foundational Payments for Infrastructure & Operations** (e.g., care coordination fees and payments for HIT investments)	A **APMs with Shared Savings** (e.g., shared savings with upside risk only)	A **Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B **Pay for Reporting** (e.g., bonuses for reporting data or penalties for not reporting data)	B **APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B **Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C **Pay-for-Performance** (e.g., bonuses for quality performance)		C **Integrated Finance & Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

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BlueCross BlueShield Association

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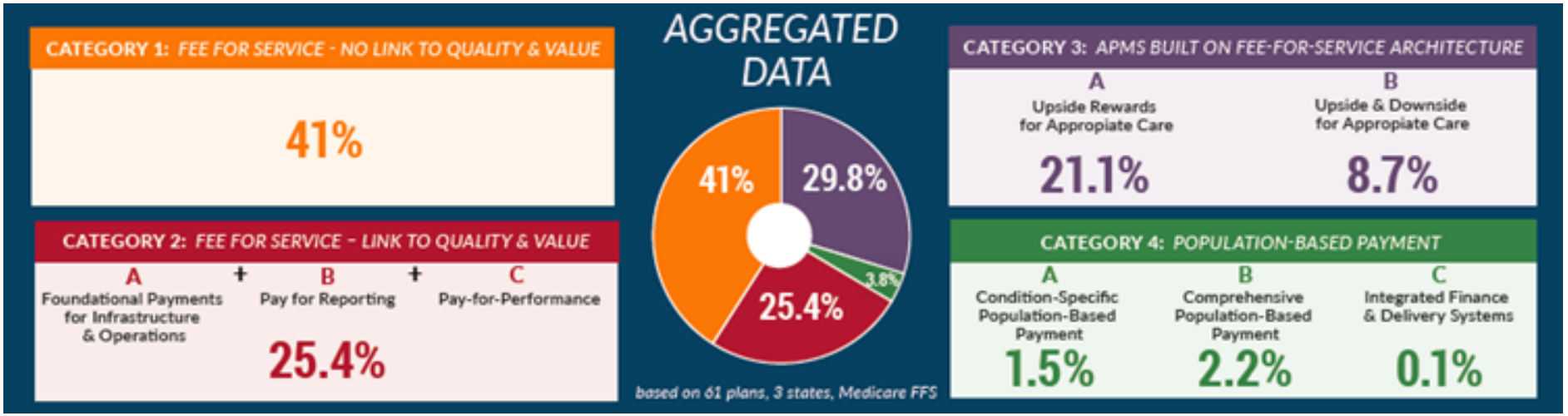
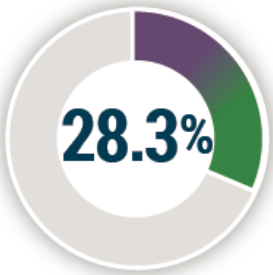
APM Adoption Results at a Glance



Categories 3 & 4 by line of business

MEDICARE ADVANTAGE

MEDICARE FFS



COMMERCIAL

MEDICAID

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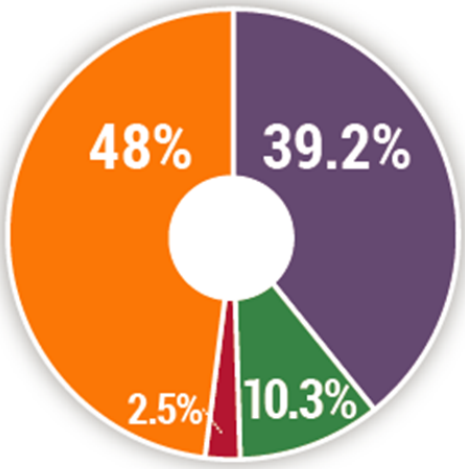
Line of Business Results – Medicare Advantage

CATEGORY 1: *FEE FOR SERVICE - NO LINK TO QUALITY & VALUE*

48%

CATEGORY 2: *FEE FOR SERVICE – LINK TO QUALITY & VALUE*

0%	Foundational Payments for Infrastructure & Operations
0%	Pay for Reporting
2.5%	Pay-for-Performance



Representativeness of covered lives: Medicare Advantage - 70%

CATEGORY 3: *APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE*

25.3%	Upside Rewards for Appropiate Care
13.9%	Upside & Downside for Appropiate Care

CATEGORY 4: *POPULATION-BASED PAYMENT*

1.2%	Condition-Specific Population-Based Payment
9%	Comprehensive Population-Based Payment
0.1%	Integrated Finance & Delivery Systems

MEDICARE ADVANTAGE

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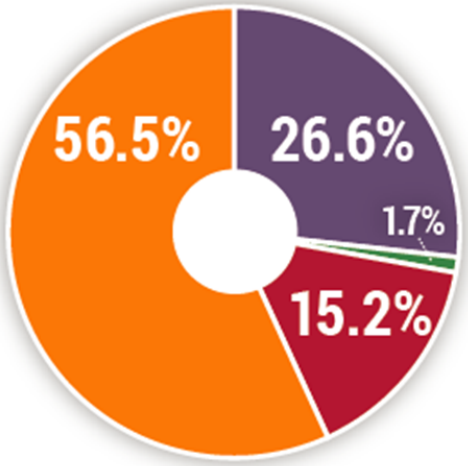
Line of Business Results - Commercial

CATEGORY 1: *FEE FOR SERVICE - NO LINK TO QUALITY & VALUE*

56.5%

CATEGORY 2: *FEE FOR SERVICE – LINK TO QUALITY & VALUE*

0.2%	Foundational Payments for Infrastructure & Operations
0%	Pay for Reporting
15%	Pay-for-Performance



Representativeness of covered lives: Commercial - 63%

CATEGORY 3: *APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE*

18.4%	Upside Rewards for Appropiate Care
8.2%	Upside & Downside for Appropiate Care

CATEGORY 4: *POPULATION-BASED PAYMENT*

0.2%	Condition-Specific Population-Based Payment
1.4%	Comprehensive Population-Based Payment
0.1%	Integrated Finance & Delivery Systems

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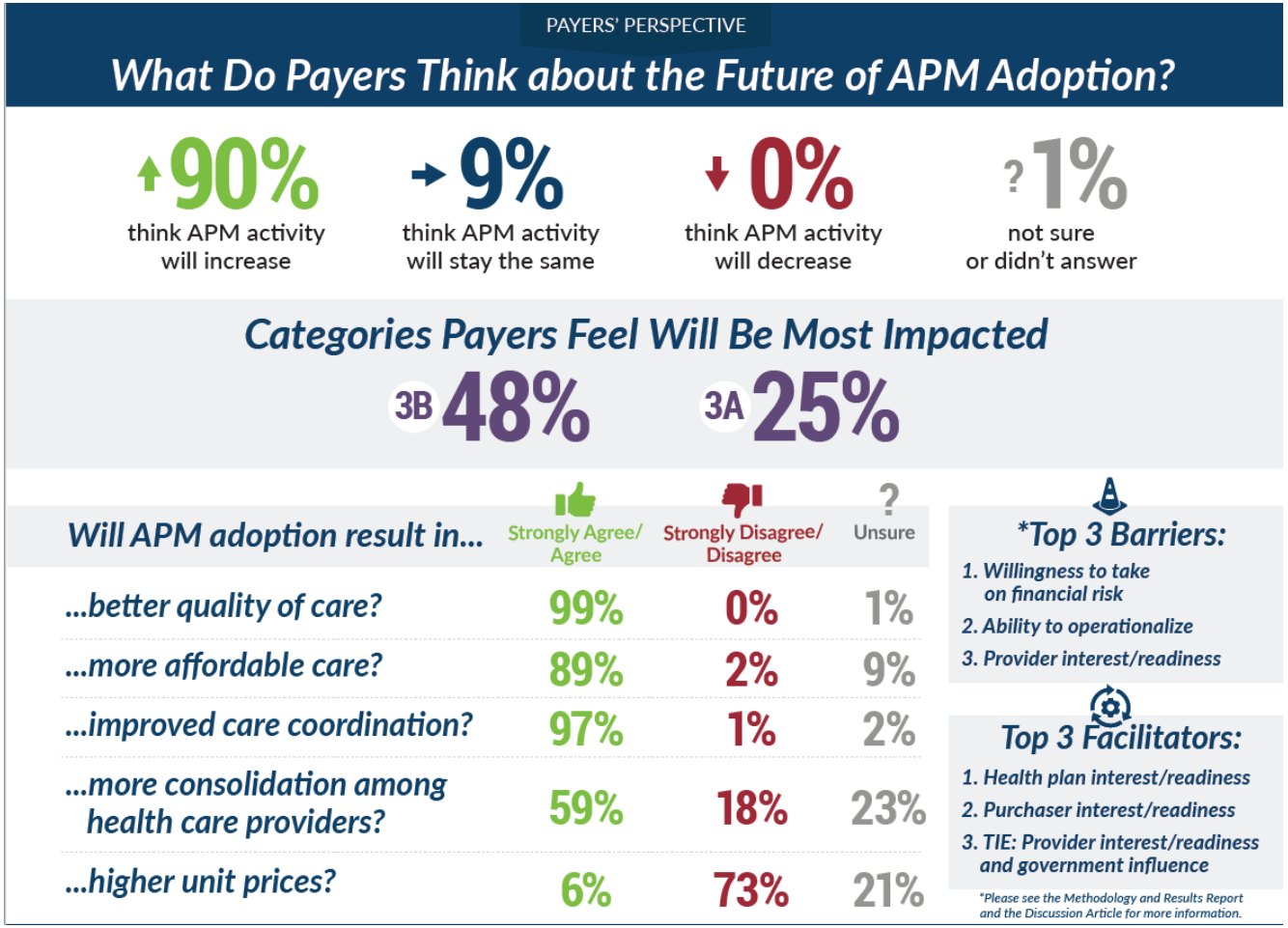
Informational Questions



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Effects of Health Care Payment Models on Physician Practice in the US: Follow Up Study

- **Persistent Findings:**
  - **Challenges Associated with Alternative Payment Models**
    - Reliance on data
    - Conflicting models and regulations
    - Core clinical work unchanged, while administrative burden up
    - Operational errors and complexity
  - **Physician Practice Strategies Regarding APMs**
    - Financial incentives for individual physicians had not substantially changed since 2014.
    - Modest bonuses for quality performance remained common, and individual physician financial incentives based on costs of care were almost nonexistent
    - Range of nonfinancial strategies to influence physician decisionmaking, such as internal performance reports, that appealed to physicians' competitiveness and self-esteem
- **New Findings:**
  - Accelerating Pace of Change in Payment Models
  - Increasing Complexity of Payment Models
  - More Prominent Risk Aversion Among Physician Practices
- **Recommendations:**
  - Simplify
  - Co-design
  - Stable, predictable, moderately paced pathway for APMs
  - Invest in capabilities and timely, accurate data
  - Incent clinical changes that physicians see as valuable

www.rand.org/t/RR2667

CQMC
Core Quality Measures Collaborative

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CMS
NQF

- Created to establish core measure sets that:
  - Align and harmonize across public and private payers,
  - Reduce reporting burden,
  - Focus improvement methods, and
  - Provide consistent signals to both providers and consumers.
- Eligibility categories multi-stakeholder voluntary effort comprised of:

Voting	Non-Voting
• Payers • Provider associations • Purchasers • Consumer groups • Regional quality collaboratives	• Measure Developers • EHR Vendors • Registries

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Workgroups and Measure Sets

- Current core measure sets:
  - Accountable Care Organizations/ Patient-Centered Medical Homes/Primary Care,
  - Cardiology,
  - Gastroenterology,
  - HIV/Hepatitis C,
  - Medical Oncology,
  - Obstetrics and Gynecology (OB/GYN),
  - Orthopedics, and
  - Pediatrics.

1. #0018 - Controlling High Blood Pressure
2. #0059 - Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
3. N/A - Breast Cancer Screening (NCQA)
4. #0032 - Cervical Cancer Screening
5. #0034 - Colorectal Cancer Screening
6. #1799 – Medication Management for People with Asthma
7. #0005 - CG CAHPS (Getting Timely Appointments, Care, and Information; How Well Providers (or Doctors) Communicate with Patients; and Access to Specialists)

Da Vinci Project

To ensure the success of the industry's **shift to Value Based Care** there is a need to establish a ***rapid multi-stakeholder*** process to identify, exercise and implement initial use cases between payers and provider organizations.

The objective is **to minimize** the development and deployment of **unique solutions with focus on reference architectures that will promote industry wide standards and adoption.**

Components for success include (and where needed, create extensions to or craft revisions for) common:

1. Standards (HL7 FHIR®),
2. Implementation guides, and
3. Reference implementations and pilot projects to guide the development and deployment of interoperable solutions on a national scale.

http://www.hl7.org/index.cfm

Da Vinci Project

30 Day Medication Reconciliation*	Coverage Requirements Discovery*	Documentation Templates and Coverage Rules**
eHealth Record Exchange: HEDIS/Stars & Clinician Exchange**	Notification (ADT): Transitions in Care, ER admit/discharge	Risk Based Contract Member Identification
Authorization Support	Quality Measure Reporting	Laboratory Results

Project Deliverables

- Define requirements (technical, business and testing)
- Create Implementation Guide
- Create and test Reference Implementation (prove the guide works
- Pilot the solution
- Deploy the solution

http://www.hl7.org/index.cfm

* In active development
** Discovery and requirements underway

Horizon Blue Cross Blue Shield of New Jersey

- Horizon BCBSNJ reported that more than 70% of its in-network primary care doctors participated in one or more of its value-based care programs- a 20% increase over the last two years.
- Value based care providers bent the cost curve: members connected to those providers experienced a 4% lower increase in the total cost of care compared to commercial members as a whole.
- When compared to all commercial members, members engaged with value-based providers in 2017 experienced a:
  - 4% lower total cost of care trend*
  - 4% lower rate of hospital inpatient admissions
  - 6% higher rate for colorectal cancer screenings
  - 7% higher rate of breast cancer screenings
- Dramatic improvements were seen in 2017 in managing members with chronic conditions under value-based providers including:
  - 24% lower rate of readmissions for patients with diabetes
  - 11% improvement in diabetes management
  - 6% lower medical cost trend for patients with congestive heart failure
  - 2% reduction in potentially avoidable ER visits year over year.

https://www.horizonblue.com/about-us/news/newsroom/patients-of-value-based-care-providers-have-better-outcomes-lower-total-cost-value-based-payments-to

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