New Payer-Provider Partnerships

Danielle A. Lloyd, MPH
SVP, Private Market Innovations & Quality Initiatives, AHIP

December 5, 2018
Washington, DC
Methodology

Refreshed LAN APM Framework

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

A
Foundational Payments for Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)

B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)

C
Pay for Performance
(e.g., bonuses for quality performance)

CATEGORY 2
FEE FOR SERVICE - LINK TO QUALITY & VALUE

A
APMs with Shared Savings
(e.g., shared savings with upside risk only)

B
APMs with Shared Savings and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

CATEGORY 3
APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A
Condition-Specific Population-Based Payment
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B
Comprehensive Population-Based Payment
(e.g., global budgets or full percent of premium payments)

C
Integrated Finance & Delivery System
(e.g., global budgets or full percent of premium payments in integrated systems)

CATEGORY 4
POPULATION - BASED PAYMENT

3N
Risk Based Payments
NOT Linked to Quality

4N
Capitated Payments
NOT Linked to Quality
APM Adoption Results at a Glance

Categories 3 & 4 by line of business:
- Medicare Advantage: 49.5%
- Medicare FFS: 38.3%
- Commercial: 28.3%
- Medicaid: 25%

Based on 61 plans, 3 states, Medicare FFS.
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

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

- 25.3% Upside Rewards for Appropriate Care
- **13.9%** Upside & Downside for Appropriate Care

**CATEGORY 4: POPULATION-BASED PAYMENT**

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

Representativeness of covered lives: Medicare Advantage - 70%
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**
- Foundational Payments for Infrastructure & Operations: 0.2%
- Pay for Reporting: 0%
- Pay-for-Performance: 15%

**CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE**
- 18.4%: Upside Rewards for Appropriate Care
- 8.2%: Upside & Downside for Appropriate 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

Representativeness of covered lives: Commercial - 63%
### Informational Questions

#### Payers' Perspective

**What Do Payers Think about the Future of APM Adoption?**

- **↑ 90%** think APM activity will increase
- **→ 9%** think APM activity will stay the same
- **↓ 0%** think APM activity will decrease
- **↑ 1%** not sure or didn’t answer

#### Categories Payers Feel Will Be Most Impacted

<table>
<thead>
<tr>
<th>Will APM adoption result in...</th>
<th>Strongly Agree/Agree</th>
<th>Strongly Disagree/Disagree</th>
<th>? Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>...better quality of care?</td>
<td>99%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>...more affordable care?</td>
<td>89%</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>...improved care coordination?</td>
<td>97%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>...more consolidation among health care providers?</td>
<td>59%</td>
<td>18%</td>
<td>23%</td>
</tr>
<tr>
<td>...higher unit prices?</td>
<td>6%</td>
<td>73%</td>
<td>21%</td>
</tr>
</tbody>
</table>

#### Top 3 Barriers:
1. Willingness to take on financial risk
2. Ability to operationalize
3. Provider interest/readiness

#### Top 3 Facilitators:
1. Health plan interest/readiness
2. Purchaser interest/readiness
3. TIE: Provider interest/readiness and government influence

*Please see the Methodology and Results Report and the Discussion Article for more information.
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
• 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:

<table>
<thead>
<tr>
<th>Voting</th>
<th>Non-Voting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Payers</td>
<td>• Measure Developers</td>
</tr>
<tr>
<td>• Provider associations</td>
<td>• EHR Vendors</td>
</tr>
<tr>
<td>• Purchasers</td>
<td>• Registries</td>
</tr>
<tr>
<td>• Consumer groups</td>
<td></td>
</tr>
<tr>
<td>• Regional quality collaboratives</td>
<td></td>
</tr>
</tbody>
</table>
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)
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

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

* In active development
** Discovery and requirements underway

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

30 Day Medication Reconciliation*

Coverage Requirements Discovery*

Authorization Support

Quality Measure Reporting

Laboratory Results

eHealth Record Exchange: HEDIS/Stars & Clinician Exchange**

Notification (ADT): Transitions in Care, ER admit/discharge

Documentation Templates and Coverage Rules**

Risk Based Contract Member Identification
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.