Payment Models Workgroup
August 21, 2015

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Payment Model Experiments

Payment Model Experiments:
Discussion Points

1. Details / Approach
2. Keys to success/barriers
3. Quality and financing measures of success
4. Results
5. Key takeaways for SHIP

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Payment Model Experiments:
CMMI Comprehensive Primary Care Initiative

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Payment Model Experiments:

CMMI Comprehensive Primary Care Initiative

Details:

1. 7 regions: AR, CO, NJ, NY, OH/KY, OK, & OR
2. 31 other payers provided care management fees in addition to CMS's $20 PMPM
   1. Together these fees were 19% of total (non-CPC) revenue or $70,045 per clinician
3. Fees help practices transform by providing learning activities and technical assistance as well as data feedback on cost, service use, care quality & patient and provider experience

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Payment Model Experiments:

CMMI Comprehensive Primary Care Initiative

Approach:

1. Milestones help sites build the capability to deliver CPC's five functions:
   1. Access and continuity
   2. Planned chronic and preventive care
   3. Risk-stratified care management
   4. Patient and caregiver engagement
   5. Coordination of care across the medical neighborhood

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Payment Model Experiments:

CMMI Comprehensive Primary Care Initiative

Why factors did payers conaider when deciding whether or not to participate?:

1. Internal factors, including their organization's
   1. prior initiatives
   2. business strategy
   3. available resources
2. External factors
   1. state or federal policies
   2. market dynamics

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Payment Model Experiments:

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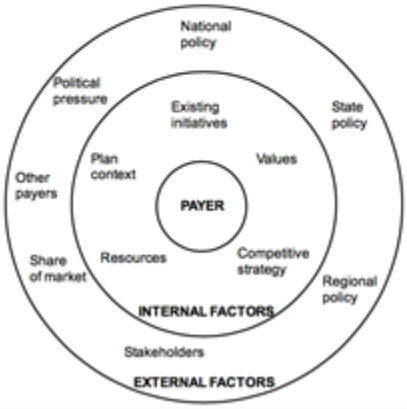
Specific reasons payers want to participate:



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Payment Model Experiments:

CMMI Comprehensive Primary Care Initiative

Payer-level keys to success:

1. CMMI was willing to negotiate terms and amount of payment based on unique characteristics of each payer's business model
2. CMMI allowed payers to excluded self-insured lines of business
3. Start dates were (somewhat) flexible
4. National payers could negotiate which regions participated

Barriers:

1. Certain lines of business were not contractually compatible with CPC
2. Lack of systems capabilities (i.e. out-daed claims database or lack of standardized claims platform between lines of business)
3. Limited concerns about free-riders (non-participating payers reaping the benefits of interventions from participating payers)

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Payment Model Experiments:

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Provider-level keys to success:

1. Prior QI or transformation experience
2. Accepted practice-specific assistance
3. Big groups = good change resources
4. Small groups = more rapid change

Barriers:

1. Poor communication/transparency from CMS
2. Forging payer collaboration
3. Poor HIT infrastructure or non-aligned EHRs
4. Key staff resisted change

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Payment Model Experiments:

CMMI Comprehensive Primary Care Initiative

Quality and financing measures of success

Service utilization and cost goals: decreased use of high cost services (ED and hospital care) and lower spending increasing compared to control populations.

Quality goals: Compliance with 4 diabetes measures, more primary care visits, more post-admission follow-ups, less ACSC (ambulatory care sensitive condition) admissions, and less readmissions.

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Payment Model Experiments:

CMMI Comprehensive Primary Care Initiative

Table ES.3. Very few early changes in CPC outcomes on Medicare FFS claims-based quality of care in first 12 months of CPC (October 2012–September 2013)

	AI	AR	CO	NJ	NY	OH/KY	OK	OR
Quality-of-care process measures								
Compliance with all 4 diabetes measures	3%	12%	8%	4%	6%	4%	-21%***	11%*
Continuity of care								
Percentage of primary care visits at attributed practice	1%	4%	2%	2%	-1%	-1%	2%	-2%
Transitional care								
14-day follow-up to hospitalization	0%	-4%	3%	0%	4%**	-2%	-2%	2%
Quality-of-care outcome measures								
ACSC admissions	1%	7%	-4%	-1%	-6%	8%	-5%	3%
Readmissions	-4%	1%	-2%	-6%	-1%	-8%	-7%	6%

Results after 1 year:

1. Most met their milestones, <10% needed corrective action, only 4/502 left the program
2. No net savings (yet), but care management fees were recovered by savings
3. 4% total decrease in readmissions

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Payment Model Experiments:

Mass. BCBS Alternative Quality Contract

Payment Model Experiments:

Mass. BCBS Alternative Quality Contract

Details:

1. Massachusetts instituted a comprehensive health care reform package in 2006.
2. Total healthcare spending in Mass. in 2009 was still $61 billion, state expenditures on healthcare was 49% of the state budget.
3. A Special Commission on the Health Care Payment System voted unanimously in July 2009 to transition from a FFS to a global payment system within 5 years
4. BCBS heeded the call offering 7 provider groups the AQC later that year
5. Inspired by the BCBS AQC, other big insurers (Harvard Pilgrim Health Care and Tufts) followed suit

Payment Model Experiments:

Mass. BCBS Alternative Quality Contract

Approach:

1. Based on global payment with shared savings and shared risk, as well as P4P incentives
2. Two-sided contract with shared savings if spending is below budget and shared risk if spending exceeds the budget
3. Quality bonuses are based on 64 measures, including data on processes, outcomes, and patients' experience.
4. Providers manage a population budget, similar a patient-centered medical home

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Payment Model Experiments:

Mass. BCBS Alternative Quality Contract

Keys to success:

1. BCBS reports cost and quality performance, including peer organization comparisons, to help providers identify areas of potential overuse and improvement
2. Innovation team included physicians, finance experts, and measurement scientists
3. Statewide health insurance reform provided initial catalyst

Barriers:

1. Enrollees in PPOs and most employees of self-insured firms remain largely outside of global payment arrangements
2. Fear of cost shifting onto the remaining FFS population
3. Fear of unintended consequences for the labor market

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Payment Model Experiments:

Mass. BCBS Alternative Quality Contract

Quality and financing measures of success

Service utilization and cost goals:

1. Decreased rate of cost increase compared to control group
2. Decreased service utilization compared to control group

Quality goals:

1. Control of the glycated hemoglobin level (≤9%)
2. Control of the low-density lipoprotein (LDL) cholesterol level (<100 mg per deciliter [2.6 mmol per liter])
3. Blood-pressure control (<140/80 mm Hg) in patients with diabetes; the same level of control of LDL cholesterol in patients with coronary artery disease
4. Blood-pressure control level of 140/90 mm Hg in patients with hypertension.

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Payment Model Experiments:

Mass. BCBS Alternative Quality Contract

Results after 3 years:

1. Quarterly increase was $15.51 less per AQC enrollee
2. Shift in ***providers of*** medical procedures, imaging and testing accounted for more than 80 percent of the savings (*not fewer, but cheaper services)
3. All AQC groups met 2009 budget targets and were eligible to share in the savings that accrued.
4. Improved performance on measures of the quality of adult chronic care and pediatric care, but not of adult preventive care.
5. Avg chronic disease management quality increased 3.9%
6. Achievement of control of the HbA1c level, the LDL level and blood pressure grew by 2.1 percentage points per year after entry into the AQC, whereas the HEDIS data remained unchanged

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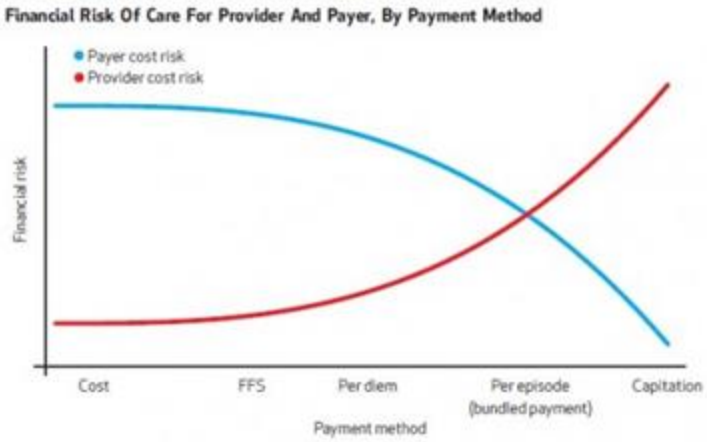
California Capitation

California Capitation:
Background: The 1990s

1. 1990s offered a private-sector experiment with high financial risk for providers: capitation
2. Growth in capitation motivated provider consolidation and coincided with rapid expansion of physician practice management companies
3. As larger, consolidated provider groups exercised their new-found market power, they regained the upper hand in negotiations with health plans.
4. They began to cancel their capitation contracts, shifting financial risk back to insurers.
5. Provider groups under capitation suffered financial losses as health care cost growth accelerated in the late 1990s
6. The entire industry lost half of its stock market value over and 8-month period in 1997-98

California Capitation:
Background: The 1990s



California Capitation:
Key features of the Current Model:

1. Payment model but also as a catalyst for the reorganization of physicians from solo / small group practices into larger groups
2. Aside from Kaiser, California largely has "capitated physician groups" (other states have HMOs that contract physicians)
3. Successful physician groups (Bristol Park, Friendly Hills, HealthCare Partners, Mullikin, and Palo Alto) treated managed care as more opportunity than threat. Their early adoption of capitated payment was key to their financial success.
4. Capital for the rapid expansion of California's medical groups and HMOs came from the reduced rates they negotiated with hospitals and from a dramatic reduction in hospital utilization.

California Capitation:
Current Payment Model Details:

1. "Capitation with Quality": capitation + payment adjustments based on measured performance and patient risk
2. Quality is how well a *group* of physicians work together to improve the health of an entire patient population
3. Contracts give a medical group a capitated rate for its professional services and created an annual "hospital risk pool"—savings on admissions were kept as profit
4. Physicians in the group create their own processes for managing care, rather than having decisions imposed upon them by a distant, anonymous third party
5. Physicians are paid similar to P4P, but expensive, low-yield services are discouraged (they reimburse less than identical services would in FFS model)

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California Capitation:
Current capitation landscape in CA:

1. 2.5% of all commercial sector health care payments flow through capitation with quality arrangements (compared to 1.6% nationwide)
2. Kaiser Foundation Health Plan is the largest nonprofit, integrated health care delivery system in the United States and pays its affiliated medical groups on a capitated basis.
3. California's health care spending per capita ranks as the ninth lowest in the nation (2012)
4. However, employer premiums are higher than the national average (likely the result of cost-shifting, since California's Medicaid reimbursement rates are relatively low).

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California Capitation:
Capitation done right:

1. Needs to include incentives and safeguards for quality
2. Optimal conditions for capitation exist when providers are in well-organized, well-managed groups with sufficient infrastructure.
3. Safeguards are need to ensure that risk cannot be shifted to either the payer or provider in the extreme.
4. Transparency is fundamental — payers and purchasers need to understand prices and quality outcomes.
5. Risk adjustment is essential to adequately compensate providers for the risk they take-on. Common risk adjustment factors in California's capitation model include age, sex, health status, prior health care utilization, and socio-demographic factors such as residence, income, etc.

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Putting it all together:

Take Home Points for the Payment Model Work Group

1. Care coordination works. Capitation works.
2. Long-term vision of healthy patient populations is a requirement for innovation.
3. Payer-Provider collaboration is possible. It starts with finding common goals and hinges on being flexible in terms of payment details.
4. Investment in care coordination and care process efficiency benefits everyone.
5. Incentives and safeguards for care quality are integral for payment model sustainability.

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Questions?

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