High Performing Health Organizations: Preparing for the Evolution of Payment Policy

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Outline

- **Vision for a High Performance Health System**
- **U.S. Health System Performance**
- **Variation Within the U.S. Shows Improvement is Possible**
- **Payers Increasingly Expect High Performance and High Performing Health Organizations are Responding**
- **What Leaders Can Do**

VISION FOR A HIGH PERFORMANCE HEALTH SYSTEM

Goals of a High Performance Health System

- **Best possible health outcomes for everyone**
- **Access to care for all**
- **Excellent patient experiences – patient-centered, coordinated, high-quality care for all**
- **Lower cost – accountable for use of resources and elimination of waste**

Five Key Strategies for High Performance

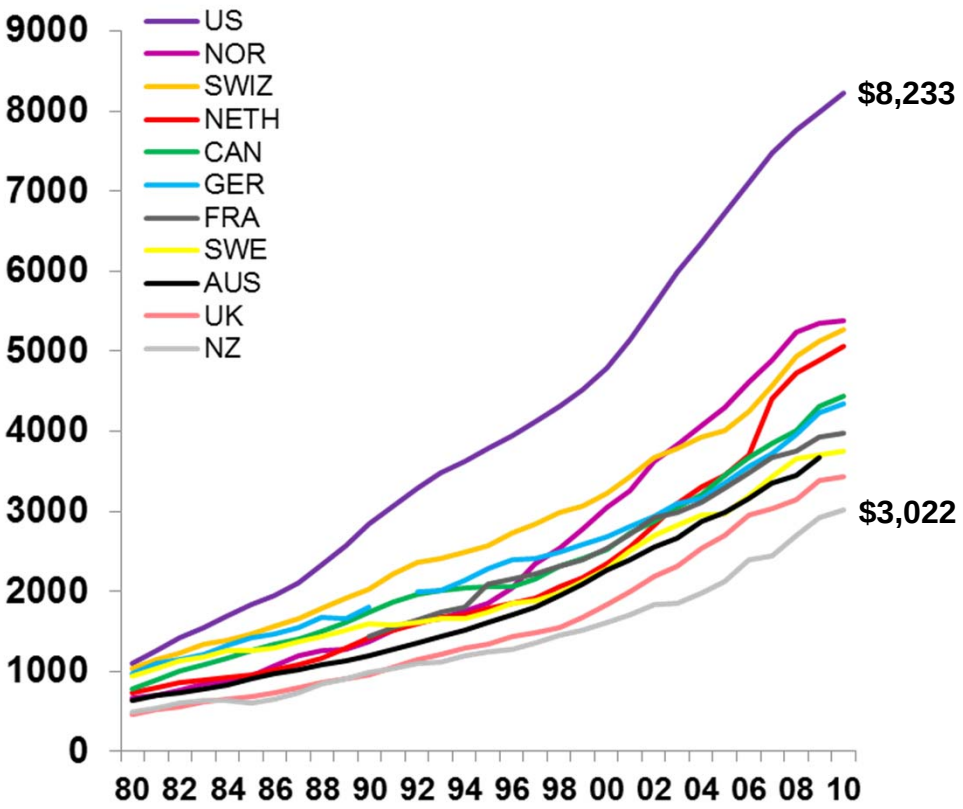
1. **Universal coverage that ensures affordable access and continuity of coverage and care, with low administrative expenses**
2. **Incentives for providers and patients aligned to promote higher quality and efficient care**
3. **Delivery system reform organized around the patient**
4. **Quality improvement and innovation; investment in public reporting; evidence-based medicine; and health information technology**
5. **Leadership and collaboration across the health system with shared goals and strategies**

Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

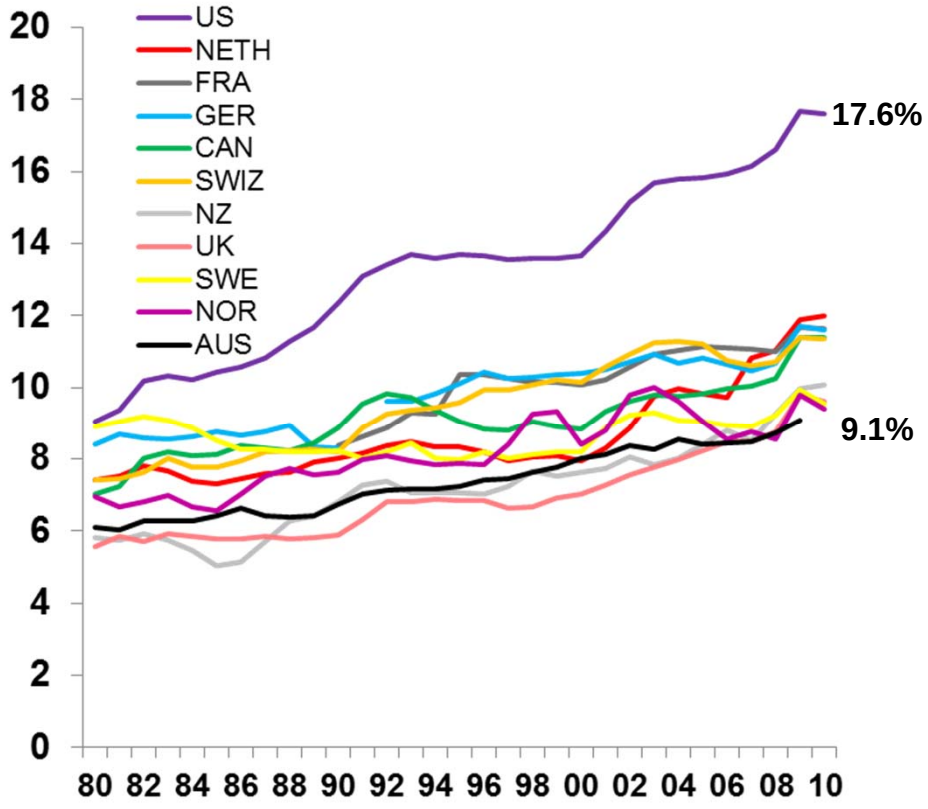
U.S. HEALTH SYSTEM PERFORMANCE

International Comparison of Spending on Health, 1980–2010

Average spending on health per capita ($US PPP)



Total expenditures on health as percent of GDP



Note: $US PPP = purchasing power parity.
Source: Organization for Economic Cooperation and Development, *OECD Health Data, 2012* (Paris: OECD, Nov. 2012).

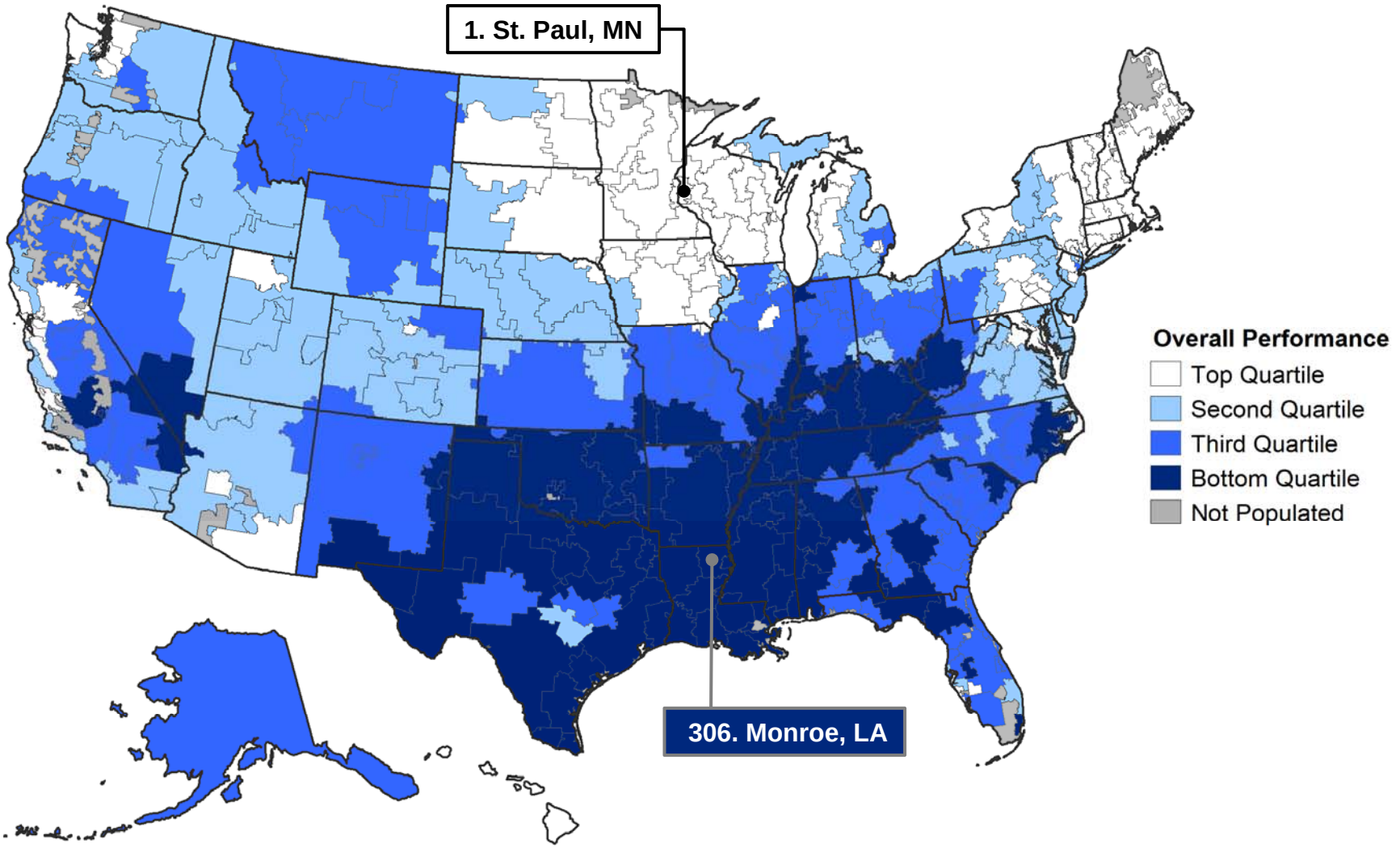
The U.S. Often Lags Rather than Leads International Peers on Multiple Dimensions

Country Rankings	
	1.00–3.66
	3.67–7.33
	7.34–11.00

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	**3**	**10**	**9**	**6**	**5**	**6**	**8**	**4**	**2**	**1**	**11**
Quality Care	**2**	**9**	**8**	**7**	**6**	**3**	**11**	**10**	**3**	**1**	**5**
Effective Care	3	7	9	6	5	2	11	10	8	1	4
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	9	8	10	5	1	6	11	3	2	7
Patient-Centered Care	5	8	9	5	7	3	11	10	1	2	4
Access	**10**	**10**	**8**	**3**	**3**	**6**	**5**	**6**	**2**	**1**	**9**
Cost-Related Problem	10	8	8	4	6	7	3	2	5	1	11
Timeliness of Care	9	11	7	4	2	5	8	10	1	3	6
Efficiency	**3**	**9**	**8**	**10**	**7**	**4**	**5**	**2**	**6**	**1**	**11**
Equity	**3**	**10**	**8**	**4**	**6**	**9**	**7**	**5**	**2**	**1**	**11**
Long, Healthy, Productive Lives	**3**	**8**	**1**	**6**	**6**	**8**	**3**	**2**	**5**	**10**	**11**
Health Expenditures/Capita, 2010	3,670	4,445	3.974	4,338	5,056	3,022	5,388	3.758	5,270	3,433	8,233

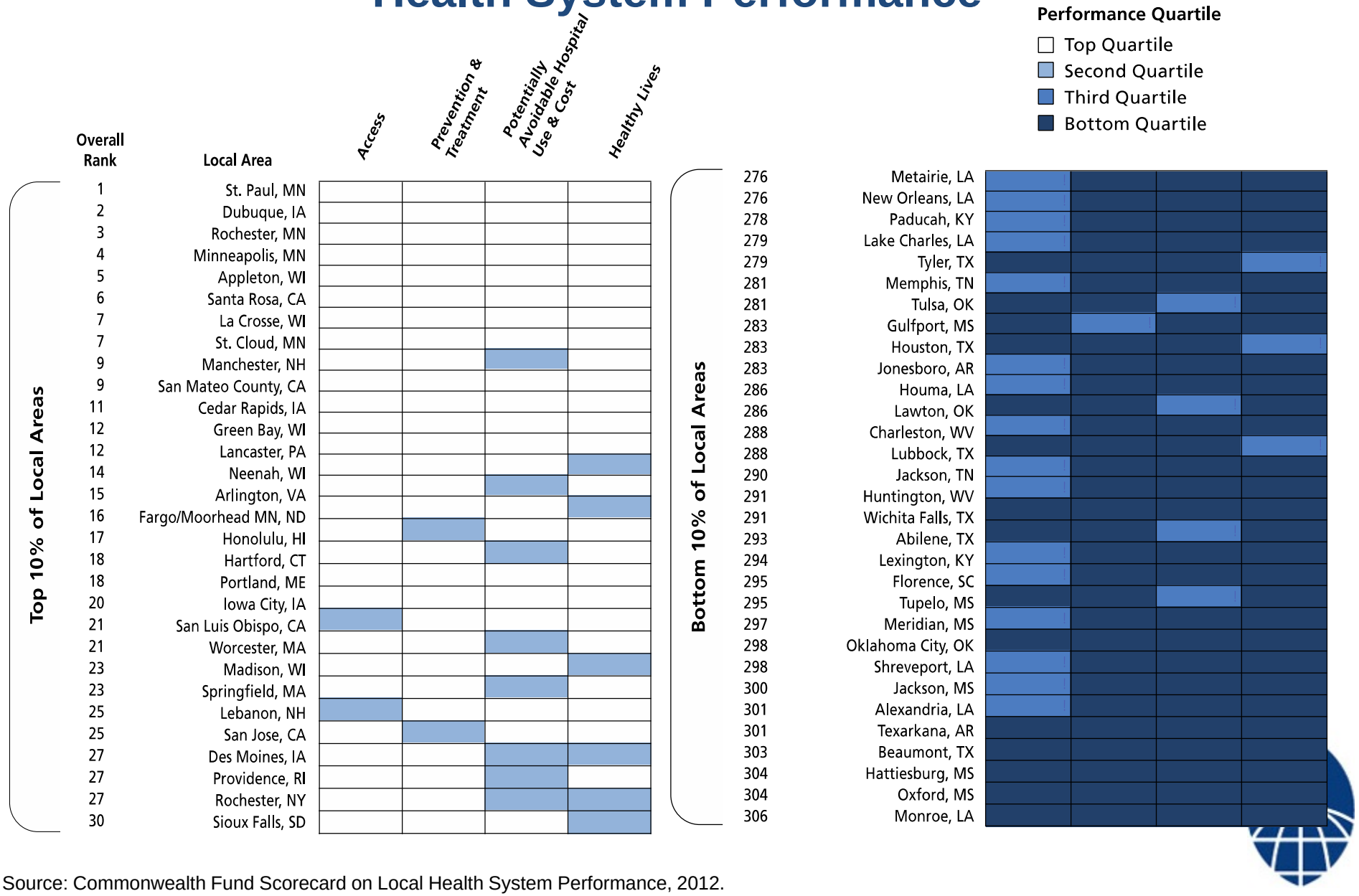
Source: K. Davis et al., *Mirror Mirror: on the Wall: How the Performance of the U.S. Health Care system Compares Internationally, 2013 Update*, forthcoming, The Commonwealth Fund.

2012 Local Scorecard on Health System Performance



Top : St. Paul MN, Dubuque IA, Rochester MN
Bottom: Shreveport LA, Jackson MS, Texarkana AR, Alexandria LA, Beaumont TX, Oxford MS, Hattiesburg MS, Monroe LA
SOURCE: Commonwealth Fund Scorecard on Local Health System Performance, 2012

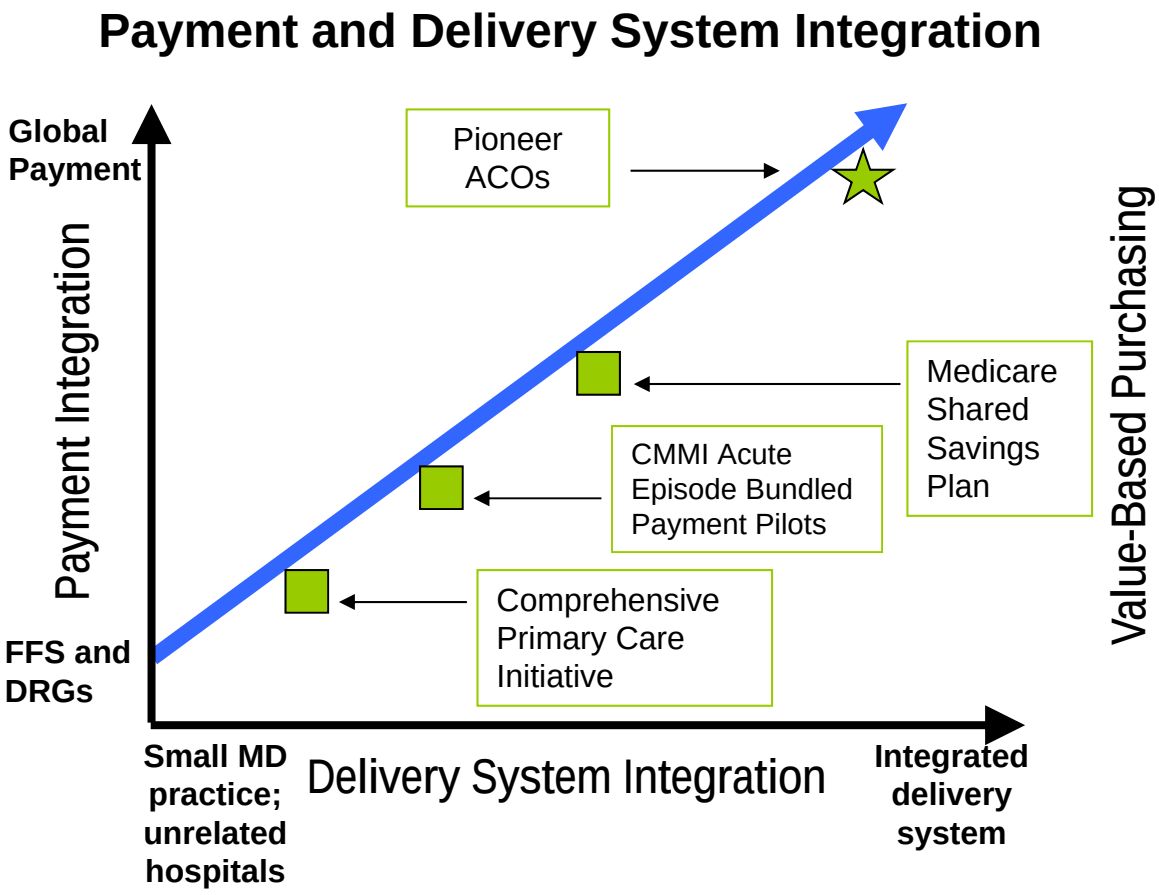
2012 Local Scorecard Summary of Health System Performance



Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

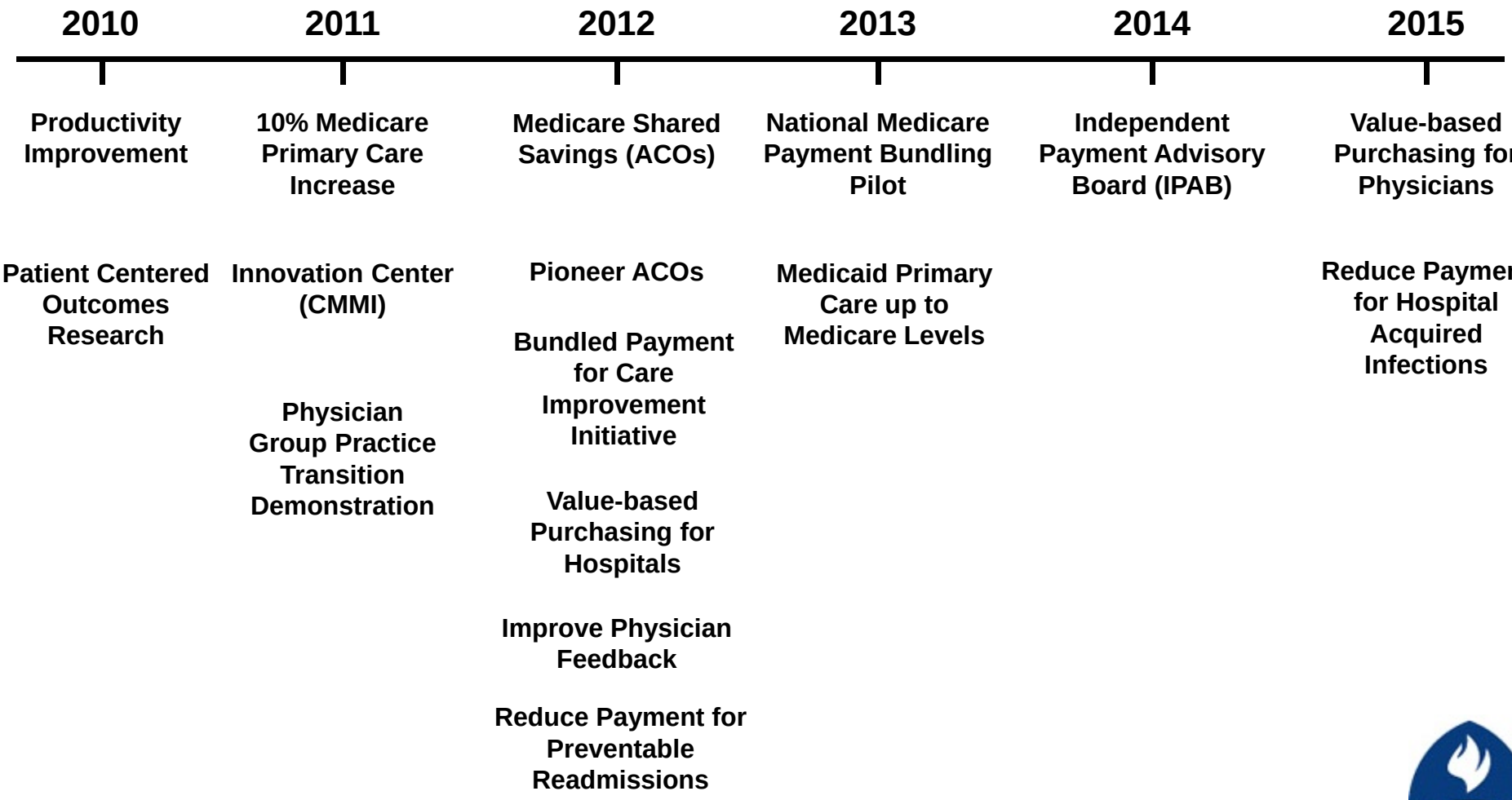
PAYERS INCREASINGLY EXPECT HIGH PERFORMANCE AND HIGH PERFORMING HEALTH ORGANIZATIONS ARE RESPONDING

Payment and Delivery System Reforms to Support a High Performance Health System: Where is Medicare Headed?



Source: Modified from The Commonwealth Fund, A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008

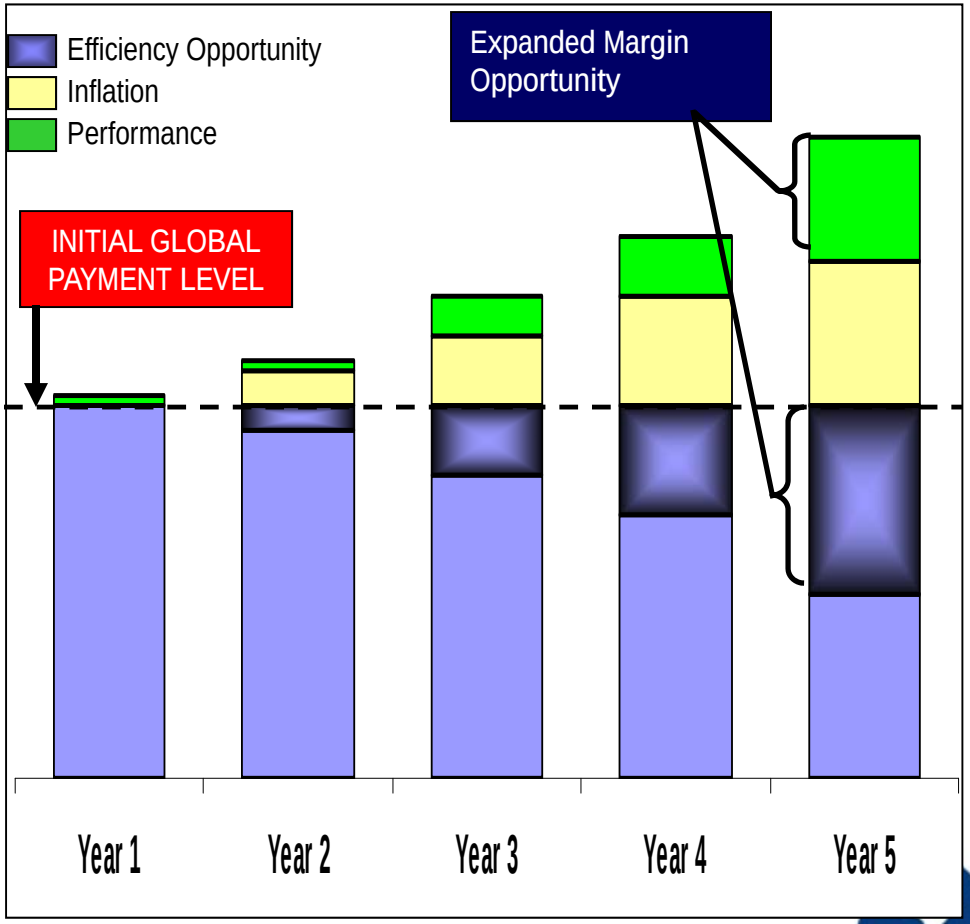
ACA Timeline for Payment and System Innovation



Source: S. Guterman, K. Davis, K. Stremikis, and H. Drake, “Innovation in Medicare And Medicaid Will Be Central To Health Reform’s Success,” *Health Affairs* 29, no. 6 (June 2010).

Blue Cross/Blue Shield of Massachusetts Alternative Quality Contract

- **Seven provider organizations entered in 2009, followed by four more organizations in 2010**
- **Overall, participation in the contract over two years led to savings of 2.8 percent (1.9 percent in year 1 and 3.3 percent in year 2) compared to spending in nonparticipating groups**
- **Savings were accounted for by lower prices achieved through shifting procedures, imaging, and tests to facilities with lower fees, as well as reduced utilization among some groups**
- **Quality of care also improved compared to control organizations, with chronic care management, adult preventive care, and pediatric care within the contracting groups improving more in year 2 than in year 1**

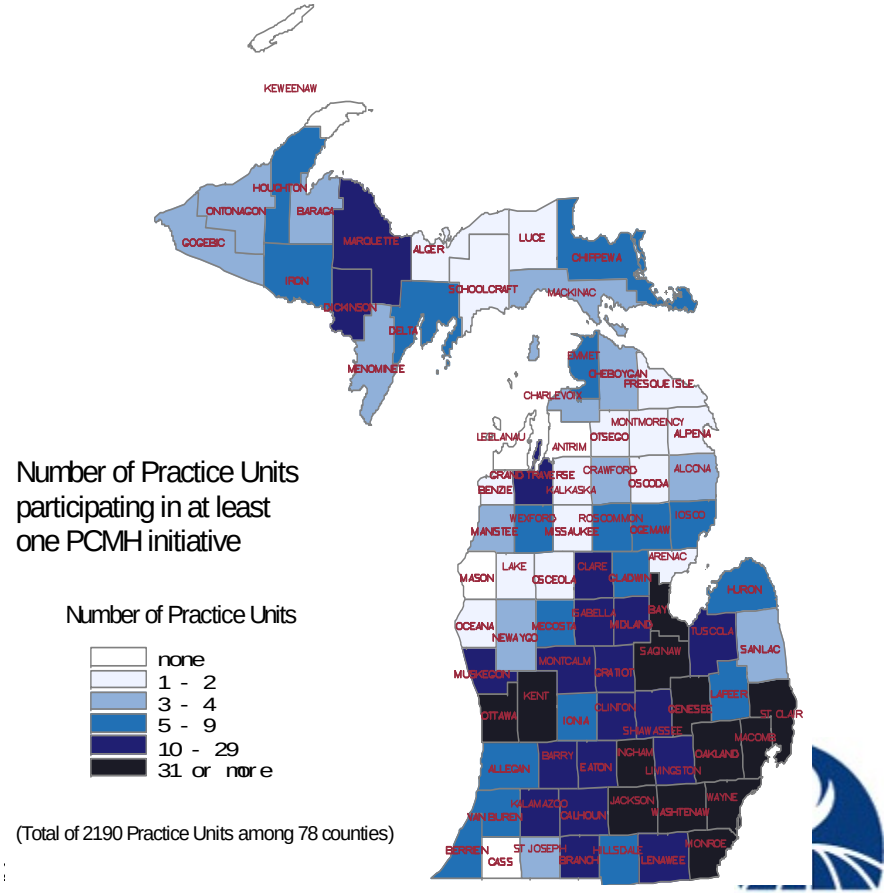


Source: Z. Song et al., "The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality," *Health Affairs*, Aug. 2012 31(8):1885–94.

Value-Based Purchasing: Michigan BCBS Physician Group Incentive Program

- **Designed in 2005 by BCBS-MI to reward high quality, cost-effective care with proactive management of patient populations**
- **As of February 2012 includes: 40 physician organizations with nearly 15,000 physicians, covering almost 2 million BCBS members with an incentive pool over $64 million (as of 2009)**

CY 2009, Risk-Adjusted	Designated PCMHs vs. Other Practices
Inpatient Admissions for Ambulatory-Care Sensitive Conditions	-16.7%
Re-Admissions within 30 Days	-6.3%
ER Visits	-4.5%
Standard Cost of Outpatient Care (PMPM)	0.5%
Standard Cost of High Tech Imaging (PMPM)	-7.2%
Standard Cost of Low Tech Imaging (PMPM)	-7.3%
Self-Referral Rate for Low Tech Imaging	-51.5%



Sources: Share DA, Mason MH. Michigan's Physician Group Incentive Program Offers A Regional Model For Incremental 'Fee For Value' Payment Reform. Health Aff (Millwood). 2012 Sep;31(9):1993-2001.

Overview of Patient-Centered Medical Home Results

PCMH Demonstration	Hospitalizations	ER Visits	Clinical Quality	Total savings per patient per year
Geisinger Health System (Danville, PA)	↓	↓	↑	$816 per patient per year
Group Health Cooperative (Seattle, WA)	↓	↓	↑	$123.60 per patient per year (ns)
Colorado Medicaid	↓	↓	↑	$169 per patient per year
Blue Cross Blue Shield of North Dakota*	↓	↓	↑	$530 per patient per year (ns)
Blue Cross Blue Shield of Michigan*	↓	↓	↑	NA
Community Care of North Carolina*	↓	↓	↑	NA

*not peer-reviewed

Overview of CMS Primary Care Payment Innovations

Demonstration	Multi-Payer Advanced Primary Care Practice Demonstration	Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration	Comprehensive Primary Care Initiative (CPCI)
Geographic Scope	ME VT, RI, NY, PA, NC, MI, MN	500+ clinic sites In 44 States	7 "Markets" : Statewide: AR, CO, NJ,OR; Mid-Hudson/Capital (NY); Cincinnati-Dayton (OH); and Greater Tulsa (OK)
Participants	Up to 1,200 practices (MD & NP) participating in state health care reform initiatives promoting APCP	FQHCs (and "look-alikes") serving relatively large numbers of Medicare beneficiaries	• 45 payers (commercial, states, unions) • 500 primary care practices • 2,144 providers serving an estimated 313,000 Medicare beneficiaries
Practice Qualifications	Dependent on state program	> 200 Medicare beneficiaries per site	High performing practices
Targeted Beneficiaries	Dependent on state program	Medicare beneficiaries	Medicare beneficiaries
Payment	Care management fee. Established by state multi-payer reform initiative	Medicare all-inclusive rate plus $6.00 PMPM care management fee	• Avg $20 PMPM (risk-adjusted) Years 1-2 • Avg. $15 Years 3-4 • Opportunity for shared savings starting Yr. 2

CPCI EHR Measures

	Domain	Measure Title
1	Clinical Process/Effectiveness	Controlling High Blood Pressure
2	Population/Public Health	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
3	Population/Public Health	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
4	Clinical Process/Effectiveness	Breast Cancer Screening
5	Clinical Process/Effectiveness	Colorectal Cancer Screening
6	Clinical Process/Effectiveness	Use of Appropriate Medications for Asthma
7	Population/Public Health	Preventive Care and Screening: Influenza Immunization
8	Clinical Process/Effectiveness	Diabetes: Hemoglobin A1c Poor Control
9	Clinical Process/Effectiveness	Diabetes: Blood Pressure Management
10	Clinical Process/Effectiveness	Diabetes: Low Density Lipoprotein (LDL) Management
11	Clinical Process/Effectiveness	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
12	Clinical Process/Effectiveness	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
13	Patient Safety	Falls: Screening for Future Fall Risk
14	Population/Public Health	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Source: Comprehensive Primary Care Initiative: Instruction guide for the reporting of EHR clinical quality measures. CMS 2013. Accessed from http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CPC_CQM_InstructionGuide.pdf

Key Elements of Success for Accountable Care Organizations

1. **Strong Primary Care Foundation**
2. **Accountability for Quality of Care, Patient Care Experiences, Population Outcomes, and Total Costs**
3. **Informed and Engaged Patients**
4. **Multi-Payer Alignment**
5. **Calculation of Shared Savings and Payment of ACOs**
6. **Innovative Payment Methods and Organizational Models**
7. **Balanced Physician Compensation Incentives**
8. **Timely Monitoring and Support**
9. **Criteria for Entry and Continued Participation**
10. **Mission**

Source: S. Guterman, S.C Schoenbaum, K. Davis, et al. *High Performance Accountable Care: Building on Success and Learning from Experience* (New York: The Commonwealth Fund Commission on a High Performance Health System, forthcoming).

ACO Quality Measures

- **Quality performance standards must be met to share in any savings created**
- **33 measures in 4 key domains**
  - **Patient/caregiver experience (7 measures)**
  - **Care coordination/patient safety (6 measures)**
  - **Preventive health (8 measures)**
  - **At-risk population:**
    - Diabetes (1 measure and 1 composite consisting of five measures)
    - Hypertension (1 measure)
    - Ischemic Vascular Disease (2 measures)
    - Heart Failure (1 measure)
    - Coronary Artery Disease (1 composite consisting of 2 measures)

Source: Accountable Care Organization 2013 Program Analysis: Quality performance standards narrative measure specifications. CMS 2012. Accessed from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf

ACO Measures: Aim to Provide Better Care for Individuals

	Domain	Measure Title
1	Patient/Caregiver Experience	CAHPS: Getting Timely Care, Appointments, and Information
2	Patient/Caregiver Experience	CAHPS: How Well Your Providers Communicate
3	Patient/Caregiver Experience	CAHPS: Patients' Rating of Provider
4	Patient/Caregiver Experience	CAHPS: Access to Specialists
5	Patient/Caregiver Experience	CAHPS: Health Promotion and Education
6	Patient/Caregiver Experience	CAHPS: Shared Decision Making
7	Patient/Caregiver Experience	CAHPS: Health Status/Functional Status
8	Patient/Caregiver Experience	Risk Standardized All Condition Readmission
9	Care Coordination/Patient Safety	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (ACO version 1.0)
10	Care Coordination/Patient Safety	Ambulatory Sensitive Conditions Admissions: Heart Failure (HF) (ACO version 1.0)
11	Care Coordination/Patient Safety	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment
12	Care Coordination/Patient Safety	Medication Reconciliation
13	Care Coordination/Patient Safety	Falls: Screening for Future Fall Risk

Source: Accountable Care Organization 2013 Program Analysis: Quality performance standards narrative measure specifications. CMS 2012. Accessed from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf

ACO Measures: Aim for Better Health for Populations

	Domain	Measure Title
14	Preventive Health	Influenza Immunization
15	Preventive Health	Pneumococcal Vaccination for Patients 65 Years and Older
16	Preventive Health	Body Mass Index (BMI) Screening and Follow-Up
17	Preventive Health	Tobacco Use: Screening and Cessation Intervention
18	Preventive Health	Screening for Clinical Depression and Follow-Up Plan
19	Preventive Health	Colorectal Cancer Screening
20	Preventive Health	Breast Cancer Screening
21	Preventive Health	Screening for High Blood Pressure and Follow-Up Documented
22	At Risk Population-Diabetes	Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (8 percent)
23	At Risk Population-Diabetes	Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein Control

Source: Accountable Care Organization 2013 Program Analysis: Quality performance standards narrative measure specifications. CMS 2012. Accessed from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf

ACO Measures: Aim for Better Health for Populations

	Domain	Measure Title
24	At Risk Population-Diabetes	Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control
25	At Risk Population-Diabetes	Diabetes Composite (All or Nothing Scoring): Tobacco Non-Use
26	At Risk Population-Diabetes	Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease
27	At Risk Population-Diabetes	Diabetes Mellitus: Hemoglobin A1c Poor Control
28	At Risk Population-Hypertension	Hypertension (HTN): Controlling High Blood Pressure
29	At Risk Population-Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (100 mg/dL)
30	At Risk Population-Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
31	At Risk Population-Heart Failure	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
32	At Risk Population-Coronary Artery Disease	Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Lipid Control
33	At Risk Population-Coronary Artery Disease	CAD Composite (All or Nothing Scoring): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF 40%)

Source: Accountable Care Organization 2013 Program Analysis: Quality performance standards narrative measure specifications. CMS 2012. Accessed from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf

Innovative Payment Models Driving Delivery System Reform at Baptist Health System in San Antonio: Gain Share Example

DRG 470 – Major Joint Replacement or Reattachment of Lower Extremity w/o MCC

Standard Payment Approach

- Surgeon = $1,200 (80%) + $300 (20% co-pay) = $1500
- Hospital = $10,400
- Patient = $ 0

Bundled Payment Approach

- Surgeon = $1,500 + up to $375 (25%) from lower cost
- Hospital = $10,400 – ($600 to CMS) + (rest of cost savings after MD share)
- Patient = $300 (up to 50% of CMS savings)

Volume **4,750 Medicare Patients**
Hospital Savings **$9,500,000**

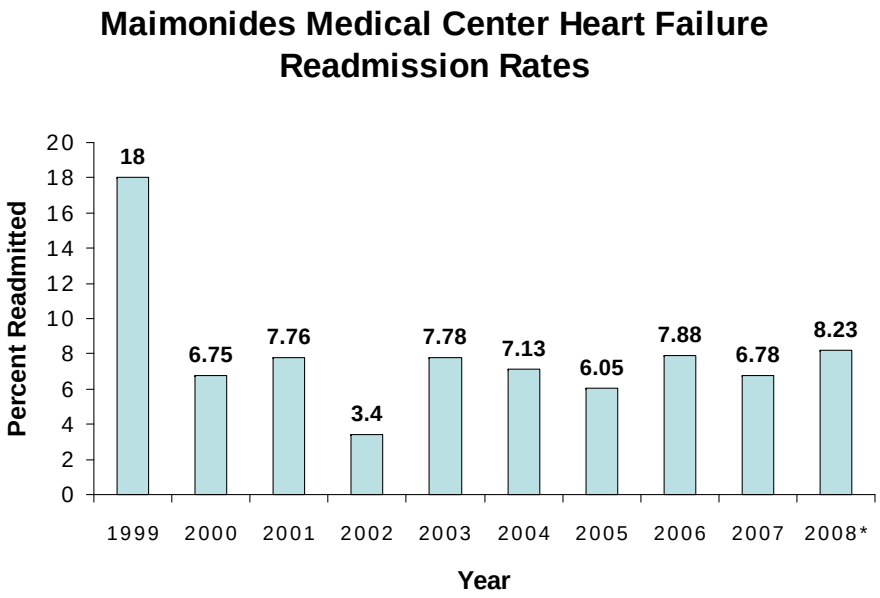
Shared Savings to Patients **$1,341,198**
Gain Share to Physicians **$1,109,415**

Zucker MC. “Innovative Payment Models Driving Delivery System Reform.” PowerPoint presentation. Bipartisan Congressional Health Policy Conference. 2013

Maimonides Medical Center (NYC) and Hospital Readmissions

2007 MedPAC report notes that 75% (13.3%/17.6%) of Medicare 30-day readmissions are potentially preventable

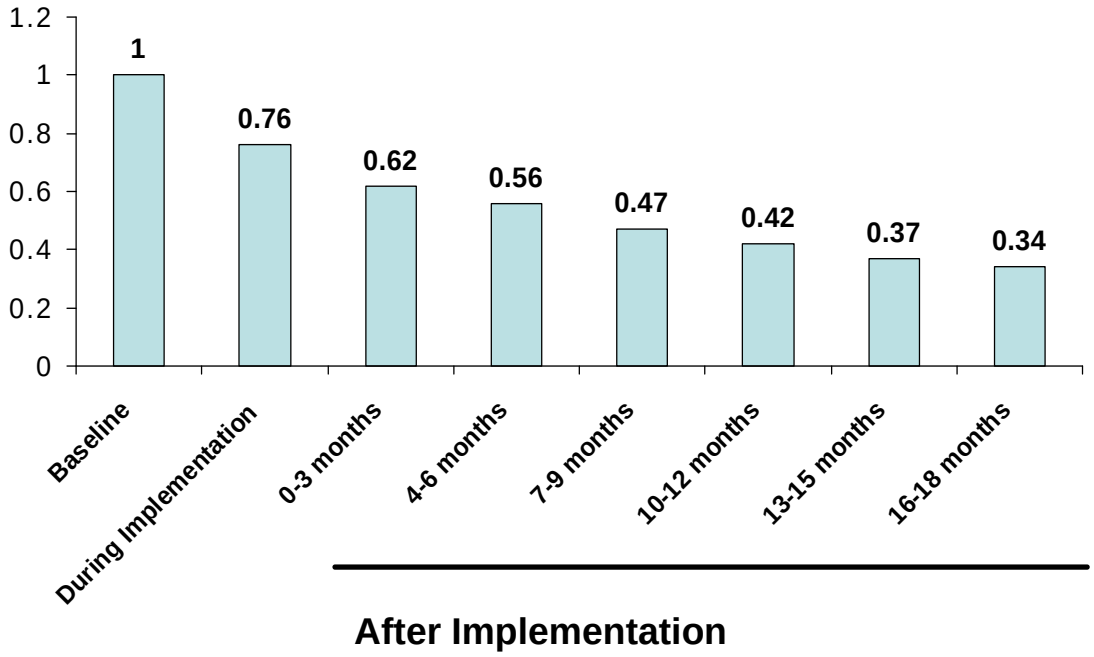
Maimonides Medical Center (NY) reduced readmissions by over 50% through coordinated team-based inpatient care and support with transition post-discharge.



Source: MedPAC Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007; Quality Matters: Mortality Data and Quality Improvement, September/October 2007, The Commonwealth Fund, Vol. 26; Maimonides Medical Center 2008

Johns Hopkins University

Incidence-Rate Ratios for Catheter-Related Bloodstream Infections



- **Peter Pronovost's "Checklist" strategy to reduce hospital infections saves 1,500 lives in Michigan ICUs in first 18 months**
  - **Hand washing**
  - **Full-barrier precautions**
  - **Chlorhexidine**
  - **Avoiding femoral site**
  - **Removing unnecessary catheters**

Source: Johns Hopkins University; P. Pronovost et al., "An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU," N Engl J Med 355;26 (December 26, 2008): 2725-2732.

WHAT LEADERS CAN DO

Compare Your Performance to Peer Health Organizations: WhyNotTheBest.org

Health Care Settings	*Measures*	*Filters*	*Benchmarks*	*Data Sources*
Hospitals • Safety-Net Hospitals • Teaching Hospitals • Academic Medical Centers • Hospital Systems **Level Profiled** • Organization • System • Counties • HRRs • State • National	• Process: HQA, HIT Adoption • Patient Experience • Outcomes: Readmissions; Mortality; Health Care-Associated Infections; ACS Admissions • Population Health • Resource Use • Costs: Average Charges & Payments; Costs per beneficiary	• Bed size • Ownership Type (For Profit, Not-For Profit, Public, Government) •Measures Reported	• Top 1% • Top 10% • Top 25% • National Average • State Average • Hospital types • HRRs • Health Systems	• CMS Hospital Compare • State All-Payer Discharge data • IOM Population Health and Utilization Indicators • AHA surveys

Leadership Roles

- Advocate for affordable health insurance for all
- Meet and raise benchmark levels of performance
- Support transparency; public reporting of clinical quality, patient-centered care, and efficiency
- Share and help spread best practices
- Accelerate adoption of IT and meaningful use
- Participate in innovative payment reform initiatives that reward high quality and efficient care
- Forge public-private partnerships
- Prepare a future generation of leaders to deliver a high performance health system that achieves better access, improved quality, and greater efficiency

Thank You!

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