Getting to Affordability through TCoC Phase III

The Evolving Role of the Regional Total Cost of Care Project

Concept Paper

Purpose

Changes occurring at the national level present both challenges and opportunities for the Total Cost of Care (TCoC) project. How do we rapidly engage more communities in order to reach that critical tipping point to have greater national impact? For example, what is the meaning and impact of MACRA (Medicare Access and CHIP Reauthorization Act) on TCoC? How can we engage and accelerate the role of public and private purchasers? How can TCoC data be used to influence policy-making at the state and national levels? In short, how do we provide physicians and communities with the tools and resources needed to be successful in the evolving payment reform environment?

Getting to Affordability through TCoC Phase III is designed to accelerate spread, providing opportunities to leverage the power of the TCoC project to ‘move the needle’ nationally. The TCoC project identifies regional cost drivers and provides physicians with both the data and tools to change practice habits, thereby reducing overutilization patterns and total cost. We have shown that regional health improvement collaboratives (RHICs) are ideal vehicles not only for producing and analyzing practice data and educating physicians, but also for empowering multiple stakeholders to affect local and regional change. Through its unique position and offerings, the TCoC project has enhanced relationships and trust in the regions by leveraging national effort, which is critical to gaining support for reporting TCoC. We must now rapidly put more regions on a pathway for measuring and reporting TCoC - a pathway that involves a combination of self-directed expertise (assessment, learning modules, Getting to Affordability community on the HealthDoers platform) and guided expertise (Getting to Affordability Navigator, Tech Talk Tuesdays, access to the experts through classrooms and office hours, and in-person seminars).

MACRA

A key driver of the pace of physician demand is based on what they will be subject to under MACRA, which changes the way Medicare payments are determined. MACRA ends the Sustainable Growth Rate formula, makes a new framework for rewarding quality care over quantity of care, and combines existing quality reporting programs into a single new system called the Quality Payment Program.\(^1\) MACRA provides the impetus for why docs should be paying more attention to both quality and cost, as their future fee for service (FFS) payments will be affected by how well they perform on cost and quality. The current proposed MACRA rules describe what providers will be given for reporting resource use and cost measures. Reporting will be made at the Tax ID level (TIN - which for most practices is not really actionable) and will be limited to Medicare FFS. RHICs can provide practices in their regions with more comprehensive and more detailed information about what is actually driving healthcare costs (using

\(^{1}\) www.CMS.gov (MACRA: MIPS & APMs)
multi-payer commercial data, and also more and more, Medicare and Medicaid data). Over time, physician practices will require multi-payer data. The more detailed information they have about commercial/all payer data, the more understanding they’ll have as they enter into risk-based arrangements (alternative payment models/population based payment models). Consultants are already entering the market with a range of analytic products, the cost of which will actually drive up the cost of care. The TCoC project offers not only analytics, but also orientation to the work, a pathway for reducing the cost of care, and a way to manage the health of populations through population-based payment models.

TCoC reporting is also necessary to better understand how to manage populations. Obtaining information on TCOC highlights where there are opportunities and how practices compare to each other in managing population health. This connects to MACRA and supports Category 4 APMs (population based payment). TCoC data is foundational to understanding population health management. The Institute of Medicine’s Vital Signs: Core Metrics for Health and Health Care Progress states the intertwined relationship between the health of populations, quality of care and engaged people [IOM (Institute of Medicine). 2015. Vital signs: Core metrics for health and health care progress. Washington, DC: The National Academies Press, p. 54]: “The goal of healthy people cannot be achieved without quality care or engaged people. Gains in the quality of care and population health cannot be sustained without affordable care. And care quality and affordability cannot be optimized without engaged people.” Furthermore, by investing in managing TCoC, communities can free up dollars to move towards a broader Culture of Health. As Magnan said in Kindig’s population health blog [http://www.improvingpopulationhealth.org/blog/2012/12/willie-sutton-and-population-health.html#more] “...we must focus on total health care costs if we are to identify savings that can be captured for reinvestment in the non-clinical factors that make populations healthy.”

There is another reason for driving this alignment between the TCoC project and MACRA. The aggregated commercial data and reports from the TCoC project show price and utilization variations at an actionable level, whereas Medicare reporting does not. The RHICs also provide additional quality information. The TCoC team understands what the Medicare Quality and Resource Use Reports (QRUR) entail and how these versions of cost is calculated, and agree these reports have value for helping a practice (at the TIN level) see how they are performing and what their payment adjustment will be. The eventual combination of the TCoC Project’s private insurance cost and utilization data with Medicare data will provide a truer picture of the total cost of care, best practices and opportunities for improvement. By tracking both, we can ascertain whether a reduction of costs in the Medicare population results in cost shifting to the commercial population. In other words, we could track whether or not Medicare payment reform is actually reducing the total cost of care, or simply shifting it.
**Purchasers**

During Phase III we will continue to support the TCoC efforts of current partners and bring additional partner RHICs and agencies into the project. As we do so, our primary focus will remain data driven change at the physician and practice level, ensuring reliable and actionable data and reports that identify utilization and cost patterns and variation - i.e. those areas in which physicians can affect the total cost of care. In Phase III we will also widen our focus to work more closely with public and private purchasers, i.e. employers, unions, state agencies, Medicare/Medicaid, etc. Purchasers can use TCoC information to encourage use of high value providers through network tiering, use of Centers of Excellence, and/or contracting with Accountable Care Organizations. Survey results from the 2016 National Employer Seminar were very positive; all employers who responded rated the seminar ‘excellent’. When asked “As a result of attending this seminar, what specifically will you do differently to lead change in our health system?” one respondent said: As a new board member on a regional multi-stakeholder coalition, I now (as a result of this conference) feel more prepared to discuss different methods for achieving transparency in reporting, and education on total cost of care. I feel more strongly than ever that the different stakeholders need to work collaboratively, and not in opposition to each other, and will do my best to help achieve this. Purchasers also affect factors that contribute not only to the personal health of employees but also to the health of their communities. These include income levels, housing, transportation, education, etc., a reminder that TCoC is only one measure in the total health spend, and that total health is not solely the domain of healthcare providers.

**Health Plans**

The TCoC project needs to ramp up engagement of health plans. We learned from the National Employer Seminar that employers alone are not willing or able to move the needle on pushing value based purchasing. They can certainly become more informed about why it is important and how their requests can help move it forward, but they don’t see themselves as the driver of the actual development of the products. Health plans play a key role in providing employers with data. We need to make that easier and more efficient for the health plans. For example, adoption of standardized data submission guidelines like the one developed by the Center for Healthcare Transparency (CHT) will alleviate some of the health plans’ concerns, as will working together as a community to develop models they can use across plans, instead of developing them all individually. These things will help accelerate and simplify the process. We have a specific example with one of our members, the Integrated Healthcare Association (IHA) in California, who has experience with this which we might be able to scale. Bringing health plans to the table in a multi-stakeholder forum may be an effective way to engage them and help them see value. We need information on the allowed amounts from health plans - a huge barrier for many regions - and hope that engaging them in this way will help accelerate release of that information.

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2 Gagnon, Ellen. NRHI / Getting to Affordability (NRHI brief, 2016) [www.nrhi.org](http://www.nrhi.org)
The Collaborative Health Network

The Collaborative Health Network (CHN) is the vehicle through which we will scale the TCoC project, which adds value to both the project and the CHN. The CHN is an innovative and nimble system that offers high-value, user-driven platforms for focused collaboration, connection, and sense-making to individuals, organizations and programs that have a variety of community healthcare and affordability goals. Its purpose is to accelerate improvements in the community health, healthcare and affordability aims of CHN users, i.e. HealthDoers. We have designed a pathway for spread and acceleration (See: Visual, included as an Appendix) and will implement via the CHN model and platforms. We have already launched our Getting to Affordability (G2A) community on the CHN HealthDoers platform and intend to engage all existing and future regions to scale this work through this mechanism.

The pathway is a combination of: ► in-person meetings (invitational); ► virtual meetings for sharing experience and teaching using Tech Talk Tuesdays; ► virtual classrooms and faculty office hours (via Getting to Affordability community); ► social learning by putting regions into peer groups and having them interact virtually with their peers and experts (we will use the “badge” function of the CHN to designate individuals based on their level of progression – for example – the original pilot sites will be given a certain designation as will the expansion and development sites); ► individual guidance and ongoing assessment and directional support by the G2A Navigator; and ► connection to available fee based additional support (such as office hours with a particular region, technical advisor, project manager, etc.)

Other Programs

In addition to the CHN, the TCoC project is enhanced by NRHI’s leadership in other national projects, i.e. the Center for Healthcare Transparency (CHT); and The Support and Alignment Network (SAN). The Center for Healthcare Transparency (CHT) is based on the premise that value-based healthcare requires transparency; that without transparent performance information we won’t know if or how to pay for the right care at the right cost.³ The CHT leverages local expertise to drive national transformation. The Support and Alignment Network (SAN) is a multi-faceted High-Value Care Learning Program aligned with the five phases of transformation for Practice Transformation Networks (PTNs) that includes: (a) increasing awareness around total cost of care and high-value care, including real-life ‘diagnoses’ of what drives overall cost in specific geographic regions and medical groups; and (b) a ‘care plan’ with evidence-based quality improvement (QI) ‘treatments’ or activities that have been successfully adopted by communities in response to the cost drivers.

³ Meaningful Information for Better Healthcare. Introducing the Center for Healthcare Transparency (www.nrhi.org)
Next Steps – The Pathway

TCoC measurement and reporting remains fundamental and necessary to ensure that efforts at reigning in healthcare costs are achieved while maintaining quality and patient experience (i.e. achieving the Triple Aim). Leveraging the work from Phases I and II of the TCoC project, the following pathway provides an entry point for current and new regions regardless of their current level of development in measuring and reporting TCoC. This pathway has three key components which when offered together, allows individual regions to engage in this work in a meaningful and productive way.

► Spread - Getting to Affordability – Learning & Dissemination (See Diagram – Appendix 1)

Our primary audience for these learning modules are Regional Health Improvement Collaboratives (both NRHI and non-NRHI members), All Payer Claims Database organizations and any regional or national entity interested in measuring and reporting on Total Cost of Care.

1. Add a Getting to Affordability Navigator to guide new and developing regions on how to best utilize the tools, resources and experts available. Adding this personal support will ensure that members of the G2A community have the optimal experience and remain engaged. This will follow completion of a community readiness assessment which will help inform the path forward.

2. “Pre-qualify” regions for assignment to Peer Groups (See Diagram – Appendix 1) based on their completion of the readiness assessment; follow up with the Getting to Affordability navigator, and completion of certain learning modules. Assigning like regions in cohorts (e.g. Entering, Progressing, Accomplished and Advancing) will provide a peer group to share experiences, however will also be supported by those further along. These regions may qualify for attendance at the multi-stakeholder seminars. Regions would enter the appropriate track, each of which would have certain requirements for participation and deliverables.

3. Develop and hold one Regional Multi-Stakeholder Seminar in year 1. This event will be by invitation (participants selected by the RHIC or entity leading the work in a region), and modeled after the national physician and employer seminars. What we have found very effective is when
we partner RHICs as the convener (like they are in their communities) and invite one representative from each stakeholder group (physician, purchaser, consumer and health plan) to come together with other “teams” from across their region. This helps everyone to hear together how other regions are doing this work resulting in stakeholder champions to sustain momentum and action in the region. They can then customize to fit their own unique market (local customization). The existing project team will serve as faculty to share their experience of how they work together. To enhance spread and sustainability, in year 2, a facilitation guide, content and templates packet will be made available for co-branding and local delivery.

4. Continue building out the learning modules to include products and experiences of Phase II, including those below. These modules are replicable and scalable. The number of offerings will continue to grow as we learn, and can be leveraged as learning for other projects.

i. Engaging purchasers to use multi-payer data to impact healthcare cost and quality.

ii. How Medicare TCoC Practice Level Reporting can support physicians to be successful in the MACRA environment

iii. Medicaid Practice Level Reporting

iv. Technical Resource Guide: Voices from the field

v. Teck Talk Tuesdays. We have created a forum where the team focuses on one specific technical topic for an hour. The talk is led by a team member who has expertise in the particular area. We often request questions in advance so the discussion can be tailored to address those questions as well as to allow for whatever else emerges. Talks are recorded and can be made available as add-ons to the learning modules at a later time. Sample topics will include:

a. Attribution

b. Risk Adjustment

c. Technical Specification review

d. Calculating TCRV™

e. Preparing data files for reporting

f. Addressing data quality issues
vi. Case Studies of Barrier Solutions - Obtaining Allowed Amounts; TCoC in a Capitated Environment; Engaging Physicians; Building Board Consensus for Reporting TCoC

5. Leveraging the previously held national and regional Physician Leadership Seminars, to build and offer a facilitation guide, content and templates packet for co-branding and local delivery.

6. Offer on-site stakeholder analysis session to developing regions. Session curriculum built and piloted in Phase II. Cost to region is covered time and travel expenses for one NRHI staff.

7. Offer Feedback Forums for individual regions to access a panel of experts on a specific topic – offered through the Getting to Affordability community.

► Acceleration – Breaking the Data Quality Barrier

During Phases I and II, we identified key barriers that contribute to why it takes so long to do this work and appreciate we need to accelerate the process. Working together with other regions has proven to be incredibly helpful – for example, one of the new expansion sites was the first to deliver their aggregated benchmark data to the technical advisor. Multiple root causes that stall the process have been identified and one significant issue is noted below along with a proposed solution. Additional issues remain, including sub-optimal vendor performance and inconsistency in data submissions from health plans to the multi-payer data entity (RHIC and/or APCD). NRHI will explore opportunities to work with other national entities who are faced with similar challenges, including the National Governors Association and the APCD Council/NHADO, whom NRHI has already been working with in Phase II to develop the TCoC Technical Resource Guide.

1. QC Check Plus: During Phase II, we refined and improved the data quality review and resolution process. During Phase III we will build a centralized training program that can be offered to any region interested in assessing and improving their data quality. This program will provide guidance around the most critical components necessary for accurately reporting TCoC and propose solutions to improve the quality of the data. We can leverage a peer to peer event through the Collaborative Health Network to bring both experts and potential customers together to develop the training program that can then be offered to a broader audience through the G2A community. RWJF would fund the conversion of the output into a learning module and NRHI Business Development resource to develop a business model to offer this as a paid product.
Sustainability – Preparing for Success in Alternative Payment Models

Sustainability of all investments made by RWJF will be of utmost importance in Phase III. Ensuring that the work of the collective project team continues to be available on the HealthDoers Getting to Affordability platform and that individual regions can fund ongoing measurement and reporting will require concerted effort during the first year of Phase III. Consistent with NRHI and its members’ philosophy, engaging all stakeholders is at the heart of our approach and we are proposing how to realize the full value of past and future in-person convening by building a replicable model that can be offered locally. Sustainability is dependent on both demand and supply and a thorough understanding of market needs and opportunities, both current and future, will be critical.

1. **Solution Opportunity & Market Assessment - Drill Down TCoC Reporting**
   Once physicians and healthcare systems receive practice level reports and begin to use them to identify areas of need and variation, this creates the demand for more information. This is an opportunity for regions to charge for drill-down reports and/or access to detailed data, thus establishing a revenue stream to help support ongoing TCoC reporting. Although each region will need to develop and tailor these offerings and charges based on local need and data use agreements, we would like to host a forum for them to learn from each other to make this a more effective and efficient process, thus leading to greater sustainability. Beyond that, NRHI will also engage an external consultant, under the direction of the Business Development Manager, to assess the market demand and competition for this measurement and reporting. There are no one size fits all solution, and every market is unique however previous experience has shown that working collaboratively across regions is effective in creating better solutions, faster and having a solid business model will increase likelihood of sustainability.

2. **Data for Reporting Medicare TCoC** - Many project participants are also Qualified Entities. If the Qualified Entity Program proposed rules scheduled to go into effect on 7/1/2016 contain the provisions requested to increase the ability for private reporting, then the regions are in a good position to report TCoC on Medicare. We have three regions piloting this in Phase II, and will have the technical specifications built to spread to other regions in Phase III.

3. **Sustainability of Stakeholder Engagement**
   Regional Multi-Stakeholder Summit – as mentioned above, following a pilot Regional Multi-Stakeholder Summit, a facilitation guide, content and templates packet will be made available for co-branding and local delivery. This centrally designed product would also be assessed and a possible business models explored giving guidance on to fund, including potential partnerships.
**Physician Leadership Seminar** – as mentioned above, a facilitation guide, content and templates packet will be made available for co-branding and local delivery. This centrally designed product would also be assessed and a possible business models explored giving guidance on to fund, including potential partnerships.

4. **Data Quality Assessment and Training Program (QC Plus)**
AS described above we will leverage a peer to peer event through the Collaborative Health Network to bring both experts and potential customers together to develop the training program that can then be offered to a broader audience through the G2A community. RWJF would fund the conversion of the output into a learning module and NRHI Business Development resource to develop a business model to offer this as a paid product creating a revenue stream to help fund the ongoing offering of the Getting to Affordability learning community.

5. **MACRA** encourages movement to Alternative Payment Models (APMs) and will present new issues for obtaining the necessary data to ensure we are truly reporting the “total cost of care”. As both CMS and commercial health plans move to paying for healthcare with mechanisms outside of the claims administration process (care management fees, incentive payments, shared savings, withholds, capitation, bundles, etc.), we need to account for these costs. We propose working together with HealthPartners and others in more progressive regions, such as California, to better understand and plan for these changes.

6. **ICD 10** was implemented on October 1, 2015. As regions begin to report on calendar year 2015, we need to understand the implications on measuring TCoC. The team will explore this, and incorporate new quality checks into our processes.

7. **Benchmarks** - We are hopeful that we will produce regional benchmarks during Phase II and will continue those efforts in Phase III. With our plan to scale to more regions, the benchmark pool will grow and become more valuable. Individual regions have use for this information, and often get asked how their region compares to others. We will explore the potential of charging for assessment and inclusion of regions data into the benchmark, creating a funding stream to pay for continued aggregation and reporting beyond Phase III.

8. **Mentorship/Access to Experts** - As the regions move through the various tracks, they will be required to ‘give back’ what they were given from others who were in tracks ahead of them. This ensures that the dollars spent by RWJF to pay for regions to advance their work gets passed along to those coming after them. We will structure access so that a certain level of mentorship is free and then switches to pay-as-you-go, generating income for mentors.
9. **National Partnerships** – During Phase III, NRHI will continue to explore ways to potentially partner with other entities who are embarking on similar or intersecting paths. As Phase II concludes, and the Getting to Affordability learning community grows, this will be an effective platform to host conversations and identify ways to work more collaboratively across stakeholders. The following is a list of organizations we will continue or begin to engage:

- DASH
- Academy Health
- Purchaser Value Network
- ABIM/Choosing Wisely
- County Health Rankings
- Milbank Memorial Fund
- National Academy for State Health Policy
- National Business Coalition on Health
- Healthcare Transformation Task Force
- ReThink Health

**Conclusion**

An NRHI member’s Board Member summed it up by stating, “Make the knowledge, understanding and legitimacy of TCoC the same as we did with quality years ago.” We believe the TCoC project is on that quest, and we should not rest until that mission is accomplished.