nrhi
Network for Regional Healthcare Improvement

Getting to Affordability

National Employer Leadership Seminar Summary

Charlotte, North Carolina
May 5-6, 2016

Robert Wood Johnson Foundation

We have to do something about the cost crisis in this country, and employers have a key role to play. By coming together and learning from each other, we can accelerate transformation.

- Elizabeth Mitchell, President and CEO
Network for Regional Healthcare Improvement

INTRODUCTION

The US health care system is broken. Although the United States spends more than any other country on healthcare, outcomes for care quality and population health continue to be mediocre[1]. With over 147 million Americans enrolled in employer-sponsored health insurance, the costs of inefficient and ineffective care have impacted businesses' ability to offer high value benefits to employees and maintain a competitive position in the global economy[2].

Recognizing the need for change, local companies and communities have come together in pursuit of better quality healthcare at a more affordable price. Through the Network for Regional Health Care Improvement (NRHI), more than 35 regional health improvement collaboratives (RHICs) are illustrating how multi-stakeholder partnerships and data sharing can be used to transform healthcare. As direct purchasers of healthcare, employers play a significant role in these regional collaboratives and their

1 The Commonwealth Fund. (2015). US Health Care from a Global Perspective. Retrieved from http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective.
2 Kaiser Family Foundation. (2015). Employer Health Benefits Survey: Summary of Results. Retrieved from http://files.kff.org/attachment/summary-of-findings-2015-employer-health-benefits-survey.

communities by driving change through value-based benefit design and employee education.

To further explore employer opportunities to accelerate transformation, NRHI hosted a National Employer Leadership Seminar (NELS) in Charlotte, North Carolina, on May 5 and 6, 2016. The landmark seminar was supported by the Robert Wood Johnson Foundation as part of NRHI's Getting to Affordability initiative and focused on three objectives for moving the private sector from volume to value in healthcare:

1. Create a shared understanding of the national landscape, present and future, and the role of stakeholders toward paying for value.
2. Identify levers available for employers to influence and drive the availability of higher quality, affordable healthcare.
3. Demonstrate how regional, multi-payer data can be utilized as a catalyst for change.

Over the two-day seminar, interactive discussions revealed best practices and challenges associated with the implementation of various value-based purchasing strategies. This report provides a summary of common themes emerging from this dialogue, as well as key action steps for employers and regional collaboratives moving forward.

Participants represented large, small, national, regional, local employers; public and private employers including unionized employers; a health plan, healthcare systems, a broker, business

Case Studies:

Value-Based Purchasing

Three pioneering RHIC's shared their experiences working with local employers and TCOC measures to implement value-based purchasing strategies.

Maine Health Management Coalition (MHMC)

MHMC created the Get Better Maine website to allow patients to compare providers and hospitals using publicly-reported data on care cost and quality. Union-based employer Bath Iron Works has also partnered with MHMC to obtain benchmarking reports on claims cost drivers for identifying employee populations at risk and action steps for achieving high-value care.

Minnesota Community Measurement (MNCM)

MNCM publicly reports information on cost, quality and patient experience. Large employers, including the Minnesota State Employee Group Insurance Program use this in a variety of ways including pay for performance programs. Employers have also used TCOC as a core foundation in the creation of three tier provider networks. Employees choosing high-value providers have been rewarded with either lower premium payroll deductions or lower employee contribution through benefit design. Using this model, after studying a large core group of employers over several years, over one-half of employees did migrate to the highest value (tier 1) providers, and network cost trend was minimized to 8%.

coalitions, a university, a national foundation and regional health improvement collaboratives (RHICs).

BACKGROUND

Getting to Affordability

In November 2013, with support of the Robert Wood Johnson Foundation, NRHI launched a multi-regional initiative with five RHICs to measure Total Cost of Care and Relative Resource Use (TCOC) using the HealthPartners framework. Phase I of the project was successful at initiating transparency conversations among stakeholders in each community, in addition to producing and sharing TCOC measures with local providers.

Now in Phase II, the Getting to Affordability project has expanded to include two new regions for implementation and four additional regions to explore and overcome barriers. RHICs continue to work toward a standardized approach to reporting, sharing, and using information about the total cost of care to identify instances of potential overuse and opportunities for more efficient and effective care at a lower cost. As RHICs share this data publicly, employers have an opportunity to utilize the results to support benefit design, value-based network development, and employee education on care value.

VALUE-BASED PURCHASING

When implementing payment reform, employers can use value-based purchasing strategies as a primary lever to apply cost and quality data and

Case Studies:

Value-Based Purchasing (cont.)

Washington Health Alliance

In 2016, Washington established two value-based medical plans for state employees that hold providers financially and clinically accountable to 19 measures of performance through the Statewide Common Measure Set. By 2019, Washington is aiming to have at least 50% of commercial payments and 80% of state-financed payments linked to value.

Case Studies:

Lowe's Center of Excellence Program

National employer Lowe's has partnered with six COEs to provide joint, spine, and cardiac surgeries for employees to implement a program to ensure high quality care at a predictable cost. With locations in Washington, Missouri, California, Maryland, Pennsylvania, and Ohio, the domestic travel surgery program covers a 100% benefit for employees (waiving copayments and coinsurance), as well as flight or mileage expenses, hotel, and a daily stipend for the patient and one caregiver. By contracting prospective episode-based bundled payments, Lowe's has achieved substantial savings for medical care, while lowering readmissions, revisions and discharges to skilled nursing facilities following these procedures to nearly 0%.

achieve higher value healthcare. By rewarding providers for the quality of care delivered, rather than the volume, value-based purchasing aligns economic incentives with desired outcomes for patient health and experience. During the NELS Seminar, attendees identified three successful examples of value-based purchasing:

Accountable Care Organizations

Accountable Care Organizations (ACOs) represent a type of healthcare delivery system that links provider reimbursement to a variety of care outcomes, including quality, total cost, and patient experience. An ACO's provider network should be selected based on measures of high performance and ideally include risk-sharing arrangements in which providers are held accountable for improvements or gaps in medical cost and quality goals. As employers seek to understand options for ACO arrangements, RHICs can serve as neutral, third-party sources of data to guide or reinforce partnership and contracting decisions.

Tiered Provider Networks

Pairing TCOC with other value based measures of care, employers can restructure networks to create provider tiers based on performance for total cost, efficiency, and quality. Through benefit plan design, employers can guide employees to select provider organizations offering the highest value care. In addition to encouraging informed patient decision-making, tiered networks motivate providers to continually improve the efficiency and effectiveness of care practices.

Centers of Excellence

In recent years, some hospitals have gained recognition as Centers of Excellence (COEs) for their ability to routinely provide high quality care for certain high-cost medical procedures, including joint, spinal, and cardiac surgeries. COEs have achieved top performance nationally for low rates of complications and exceptional patient experiences. Often, bundled payments are negotiated with COEs for these services based on the absolute value of the entire episode of care. Combined with savings from fewer complications, bundled payments with COEs can reduce the cost of these procedures, even when accounting for travel and accommodations for patients and their caregivers.

PATIENT ENGAGEMENT

Though network and payment strategies are a key piece of the healthcare transformation puzzle, patient education is necessary to facilitate informed medical decision-making and to maximize the benefit of value-based purchasing. Dr. Erik Steele, Senior Vice President and Chief Medical Officer of Summa Health System, described several consumer-friendly resources that employers can share to enable better conversations between employees (patients) and providers.

Choosing Wisely Toolkit

Choosing Wisely was created by the American Board of Internal Medicine (ABIM) Foundation to empower patients with resources to choose care that is supported by evidence, free from harm, truly necessary, and that avoids duplication. Consumer Reports partnered with medical specialty societies to develop materials describing common healthcare procedures, their potential risks and benefits, and questions that should be considered when selecting treatment. Visit www.choosingwisely.org to view these resources.

Electronic Preventive Services Selector (ePSS)

The U.S. Preventive Services Task Force's free app and website provides individuals with a personalized list of recommended screenings based on age, gender, and common risk factors. The ePSS includes a definition of the screening and the recommended frequency of service, as well as the letter grade (A, B, C, D, or I) assigned to each screening and its associated clinical rationale. Visit epss.ahrq.gov to download the app on a computer or smartphone.

Cochrane Review

The Cochrane Review supports informed medical decision-making by providing systematic research reviews on the effectiveness of healthcare treatments. Cochrane's global network of 37,000 contributors provides up-to-date summaries of new healthcare research in a consumer-friendly format that includes a brief description of the study, key results, and the quality of the evidence. All Cochrane articles can be viewed at www.cochrane.org.

Dartmouth-Hitchcock Out-of-Pocket Cost Estimator

The Dartmouth-Hitchcock health system is leading the way in transparency by providing easy access to out-of-pocket cost estimates on their most common medical services. The tool categorizes procedures by office visits, lab tests, and surgeries and can account for patients with public, private, or no healthcare insurance.

You've got to have enough alignment of purchasing influence to balance the amount of influence on the other side. Providers are now very large systems. Health care payers are now very large systems. Purchasers must work together to represent the interests of society and their own employees. These are complicated relationships, but we need to make them less complicated.

- David Lansky, CEO
Pacific Business Group on Health

PUBLIC SECTOR STRATEGIES

In recent years, the Centers for Medicare and Medicaid Services (CMS) has leveraged its role as the nation's largest healthcare purchaser to forge new paths in payment transformation and help lay the foundation for other purchasers to follow suit. Dr. Patrick Conway, CMS Acting Principal Deputy Administrator and Chief Medical Officer, shared early results of CMS' delivery system reform. Through this model, CMS has adopted a framework that categorizes payments to providers based on quality, alternative payment models, and population-based metrics. Dr. Conway announced that CMS achieved its goal of tying 30% of Medicare payments to alternative payment models one year ahead of its 2016 deadline. Moving forward, CMS aims to increase this amount to 50% while also tying 90% of fee-for-service payments to quality or value by the end of 2018.

Though CMS has made significant progress toward public sector value-based purchasing, Dr. Conway invited private sector payers to match or exceed these goals, noting: "Medicare alone cannot create sustained progress. Success depends upon a critical mass of partners adopting new models." Through the Health Care Payment Learning and Action Network, CMS convenes payers, purchasers, consumers, states, and federal partners to develop common approaches and remove barriers to payment reform. With increasing participation in Medicare's 477 national ACOs and other efforts toward Comprehensive Primary Care improvement, enhanced data transparency, and bundled payment models, CMS continues to seek innovative solutions to achieve better value care.

Case Studies:

Leveraging Multi-Payer Data with Multi-Stakeholder Engagement

As one of the original five RHICs in NRHI's Getting to Affordability project, the Midwest Health Initiative (MHI) has been successful at convening diverse stakeholders to advance data transparency in Missouri. As the steward of a multi-payer claims database, MHI is working to develop a clearer understanding of the variation in care and spending across the region. Councils of local hospitals, providers, employers, and community health advocates provide input on the project focus. Using its data asset, MHI identified that a 33% reduction in unproductive healthcare spending could result in over $1 billion in savings to be reinvested in the local community. To achieve this aim, MHI is partnering with providers to identify care metrics for improvement. A public consumer website with quality information is also being developed.

EMPLOYER ROADMAPS: PATHWAYS TO USING MULTI-PAYER DATA

To illustrate how multi-payer data and partnerships can be used to achieve value-based care, NRHI created a series of Employer Roadmaps with information on key stakeholders, action steps, and timelines for success. At the center of these roadmaps are the collaborative roles of employees, employers, providers, health plans, and RHICs on the pathway to payment reform. During the seminar, attendees participated in small group workshops to share insights and suggestions for improving two roadmap examples: (1) Tiered Networks, and (2) Accountable Care Organization (ACO) Contracts. Feedback from these discussions will inform the final roadmap. Draft diagrams are included in the appendix of this report.

Workshop Feedback: Tiered Networks

Attendees acknowledged the positive impact of tiered networks on care delivery and provider selection. Still, employers expressed hesitation

about restricting employee choice, as well as a lack of clarity around how carriers identify high-performing providers. To address this concern, RHICs can support employers and providers in implementing several practices:

- Use available cost and quality data to confirm results provided by commercial carriers.
- Communicate clearly with providers and employees prior to network changes.
- Employ patient navigators to assist employees in understanding network changes, ease logistical transitions, such as finding a new provider.
- Assist provider practices in managing the influx of new patients that may result from a tiered network design.

Workshop Feedback: ACO Contracts

Discussions of successful ACO implementation emphasized the importance of shared decision-making throughout the process and the availability of transparent data on quality and total cost to support partner efforts. Employers underscored the need for customization in payment contracts to meet their unique needs. This identified an opportunity for RHICs to share data with employers on their specific populations to help with contract decisions. Attendees also requested resources to simplify the logistics of tiered networks and ACO contracting, especially for national employers that may be managing contracts in many states.

NEXT STEPS FOR REGIONAL COLLABORATION

A primary goal of the National Employer Leadership Seminar was to connect employers with other local partners to discuss actionable strategies for healthcare transformation. Following regional breakouts, RHICs and participating employers identified priority projects for the future:

- **Colorado:** Work with public employers to expand bundled payments for joint surgeries at Centers of Excellence; leverage data into

consumer-friendly tools; and create an employer-focused workgroup for regional data projects.

- **Maine:** Add independent affinity groups (e.g., employers, providers, etc.) to RHIC leadership structure; establish a more comprehensive, robust platform for provider performance.

We know change is not easy. It not only takes multiple strategies and multiple tools but the involvement of all stakeholders. Together, public and private stakeholders can chart a new course for our country in terms of what we pay for and the quality of care we are getting. We're stronger and more effective together.

- Elizabeth Mitchell, President and CEO
Network for Regional Healthcare Improvement

- **Minnesota:** Develop employer-friendly communications around TCOC measures; make Resource Utilization Index metrics transparent in the community; align private sector payment reform with public sector goals; create a shared vision among employers regarding expectations for providers and health plans.
- **Missouri:** Develop a Request for Information (RFI) to assess the current prevalence of value-based contracts in St. Louis health plans' commercial products.
- **Texas:** Create a RHIC in the Houston area to initiate stakeholder conversations around the quality and affordability of care.
- **Washington State:** Assist employers in attaining cost data from their health plans, with hopes of eventually combining quality and cost data for a full picture of care value.

As identified in these project plans, employers have an immediate opportunity to engage with stakeholders in their region to advance meaningful change in the healthcare system. Data on the total cost and quality of care can be used to identify priority areas for action among purchasers, providers, patients, and payers on the pathway to affordability. For more information about the Network for Regional Healthcare Improvement and ongoing work of Regional Health Improvement Collaboratives across the nation, please visit www.nrhi.org.

APPENDIX:

LEVERAGING REGIONAL COLLABORATION

Goals:

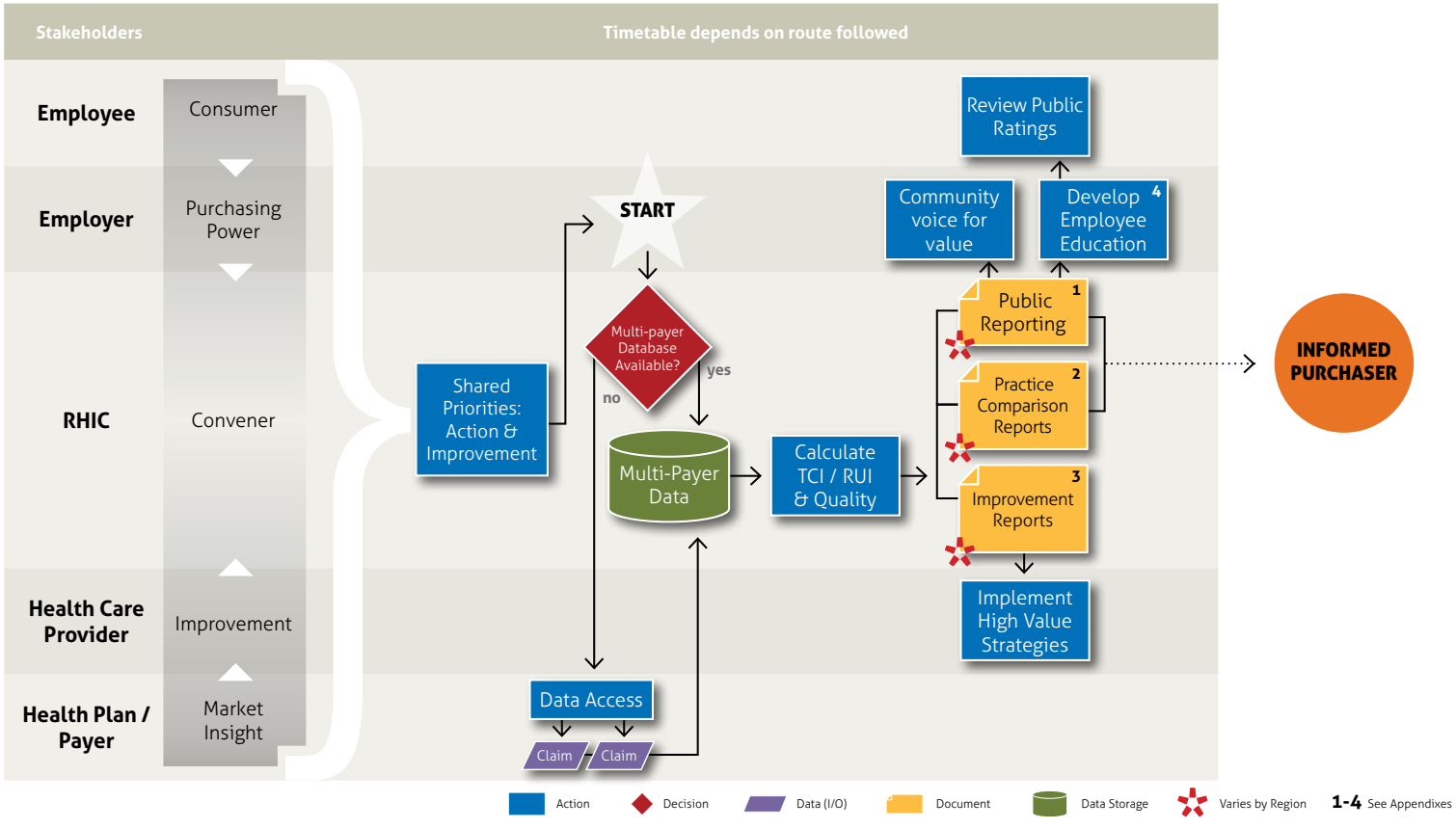
Leverage value of multi-payer database

Utilize trusted multi-stakeholder forums already in existence

Provide required healthcare comparative reporting for effective payment reform

Employer works collaboratively with others in the community to promote transparency and advocate for value

DRAFT



APPENDIX (CONT.):

TIERED NETWORKS

Goals:

Employee choice for highest value care

Reward Providers that are working hard to drive value within their own systems

Save money that could be spent in other places

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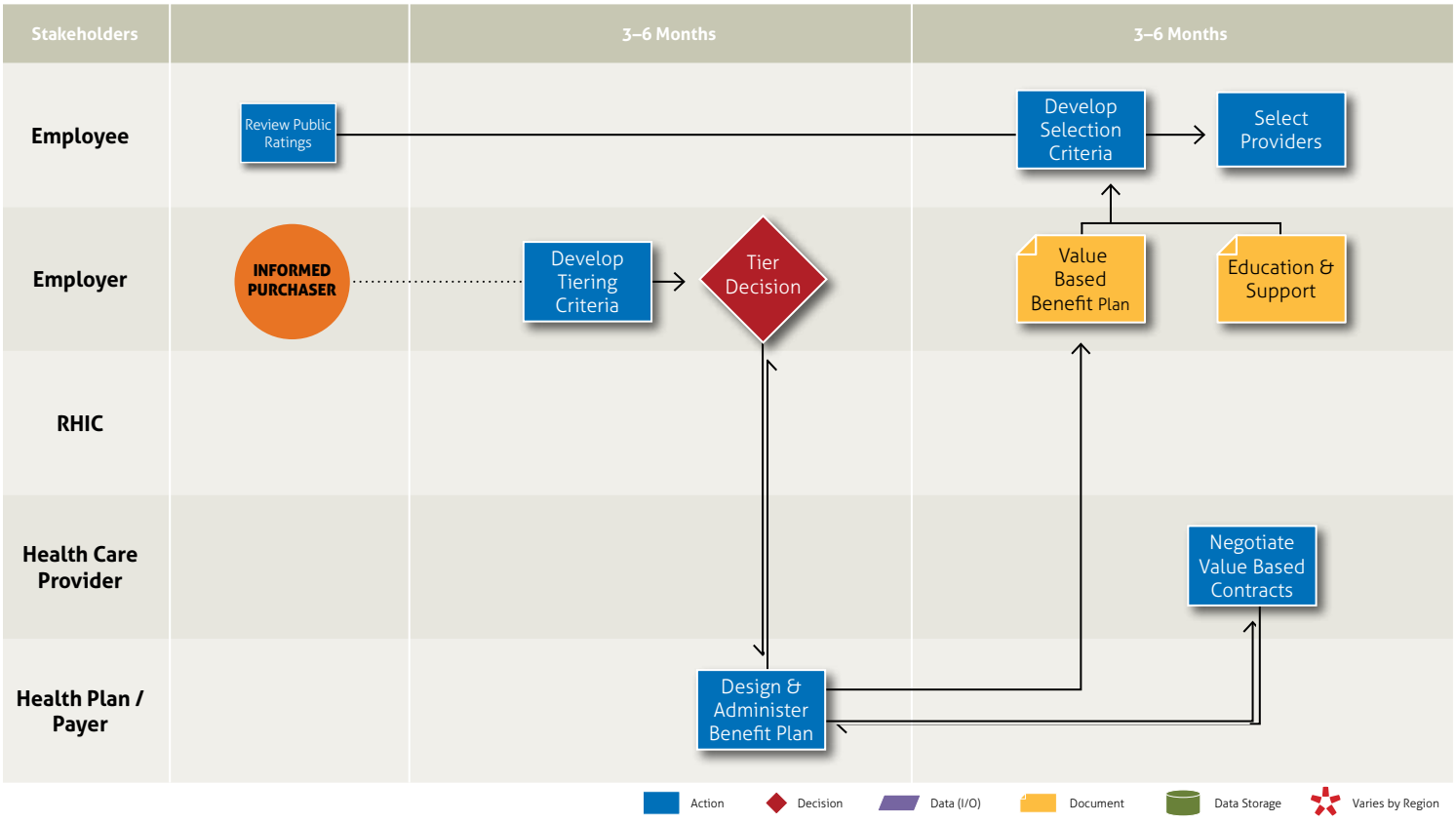

APPENDIX (CONT.):

ACCOUNTABLE CARE ORGANIZATION CONTRACTS

Goals:

Design value-based benefits through partnerships with healthcare systems who provide high quality, cost efficient care

Offer employee incentives to utilize preferred healthcare providers

Leverage value of multi-payer databases
(i.e. benchmarks, larger data set)

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