

Purchaser Roadmap: Pathway to Better Value

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Acknowledgments

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ABOUT THE NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT (NRHI)

The Network for Regional Healthcare Improvement is a national organization representing over 35 regional multi-stakeholder groups working toward achieving the Triple Aim of better health, better care, and reduced cost through continuous improvement. NRHI and all of its members are non-profit organizations, separate from state government, working directly with physicians, hospitals, health plans, purchasers, and patients using data to improve healthcare. For more information about NRHI, visit www.nrhi.org.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

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As every purchaser knows, it's not easy or inexpensive to offer health benefits in today's complex health care environment. Average annual employer-sponsored health insurance premiums rose more than 60% from 2005 to 2015, including purchaser and worker contributions.¹ Meanwhile, purchasers adapted to unprecedented changes in regulations and documentation following the implementation of the Affordable Care Act. With more than 147 million Americans enrolled in employer-sponsored health insurance, the costs of an inefficient and ineffective system have impacted businesses' ability to offer high value benefits to employees and maintain a competitive position in the global economy.

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 Healthcare 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 buyers of healthcare, purchasers play a significant role in these regional collaboratives and their communities by driving change through value-based benefit design and employee education.

To support purchasers in their efforts, NRHI recently hosted a National Employer Leadership Seminar in Charlotte, North Carolina, May 5 & 6, 2016 (NELS). The meeting, which is described in more detail in [Getting to Affordability National Employer Leadership Seminar Summary](#) was funded with support from Robert Wood Johnson Foundation as part of [NRHI's Getting to Affordability initiative](#) and focused on three objectives for supporting purchasers in improving healthcare value:

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 purchasers 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.

¹ Foundation, K. F. (2015). *2015 Employer Health Benefits Survey*. Washington, DC: Kaiser Family Foundation and Health Research Educational Trust.

This report provides purchasers an overview of opportunities and best practices associated with the implementation of various value-based purchasing strategies shared at the two-day seminar.

Clearly, rewarding providers for the quality of care delivered, rather than the volume, aligns economic incentives with desired outcomes for patient health and experience. However, implementing value-driven payment strategies can be complex. An ideal solution might require informed purchasers, innovative health plans, enthusiastic care providers and engaged employees all focused on shared metrics for success with neutral, trusted data measuring progress. Purchasers at the NELS outlined three strategies for supporting purchasers in gaining better value and developed a roadmap for each to guide implementation. See [Appendix A](#).

Exhibits:

[Leveraging Regional Collaboration \(Exhibit 1\)](#)

[Utilizing Tiered Provider Networks \(Exhibit 2\)](#)

[Accountable Care Organization Contracts \(Exhibit 3\)](#)

LEVERAGING REGIONAL COLLABORATION

Purchasers are an important voice in driving a high-value health care market. They pay the bills, design the benefit and try to surround their employees in a culture of health. They have a direct ability to influence the behavior of patients and providers. Yet, sometimes the complexities

Case Studies:

Purchasers making it work, nationally and in their communities

Lowe's

The retailer's Centers of Excellence program provides joint, spine, and cardiac surgeries for employees. With six national locations, the domestic travel surgery program offers 100% benefit for employees (waiving copayments and coinsurance), as well as flight or mileage expenses, lodging, 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 also lowering readmissions, revisions, and discharges to skilled nursing facilities following these procedures to nearly 0%.

Bath Iron Works

Union-based purchaser Bath Iron Works has also partnered with its RHIC, Maine Health Management Coalition to obtain benchmarking reports on claims cost drivers to identify employee populations at risk and develop action steps to achieve high-value care.

Washington State

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.

of the system leave even the largest of purchasers feeling less than empowered. In developing the first roadmap, attendees identified the infrastructure they felt would be necessary for purchasers to solidify their roles as strong voices for value in their organizations, their communities and nationally.

Purchasers thought RHICs could serve an important role as a convener. It can be difficult to begin a community conversation on payment reform. If a RHIC hosted a forum for dialogue and education, as shown in the first column of the “Leveraging Regional Collaboration” roadmap (see [Exhibit 1](#) in Appendix A) it might ignite more substantive discussions between health care providers, health plans and purchasers.

Purchasers said they would appreciate access to an inexpensive, third-party data set where they could find meaningful, actionable information on differences in the quality and value of health care providers and treatments. As noted in the “Leveraging Regional Collaboration” roadmap, such a data set could be used to calculate important metrics of cost and resource use as well as serve as a platform for deeper analysis. Purchasers thought such a data set could supplement the information they receive from their health plan partners, brokers and consultants. Some purchasers noted they are currently using data provided by their local RHIC for this purpose.

UTILIZING TIERED PROVIDER NETWORKS

Using total cost of care or other value-based measures of care, purchasers can restructure networks to create provider tiers based on performance for total cost, efficiency, and quality. Through benefit plan design and

Case Studies:

Purchasers making it work, nationally and in their communities (cont.)

Minnesota Community Measurement

Minnesota Community Measurement (MNCM) publicly reports information on cost, quality and patient experience. Large purchasers, including the Minnesota State Employee Group Insurance Program use this in a variety of ways including pay for performance programs. Purchasers 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 purchasers 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%.

education, purchasers 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.

Tiered networks can range from a full-replacement strategy to the development of a “Centers of Excellence” designation for providers locally or nationally shown to provide better value for high-cost or high-volume conditions with variable outcomes. Purchasers liked this flexibility and discussed how a tiering strategy could be integrated into their existing benefit plans with minimal, if any, need to revise summary plan documents, which they noted requires a significant effort.

As shown in the “Tiered Networks” roadmap (see [Exhibit 2](#) in Appendix A) one of the first decisions for a purchaser considering tiering, is whether to use a network structure already developed by their health plan or implement independently. Many purchasers said they would prefer the simplicity of a “plug-and-play” option, they said it can be difficult to gain clarity around how carriers identify high-performing providers. To address this concern, they suggested RHICs could share with purchasers available cost and quality data to confirm results provided by commercial carriers.

While acknowledging the positive impact of tiered networks on care delivery and provider

Tools for Employee Engagement

RIGHT CARE, RIGHT TIME

Choosing Wisely, created by the ABIM Foundation, empowers patients to choose care that is supported by evidence, free from harm, truly necessary, and that avoids duplication. Educational materials developed with Consumer Reports are available at www.choosingwisely.org.

The U.S. Preventive Services Task Force’s free app, **Electronic Preventive Services Selector (ePSS)**, and website provides individuals with a personalized list of recommended screenings based on age, gender, and common risk factors. Visit <http://epss.ahrq.gov/PDA/index.jsp> to download the app on a computer or smartphone.

MANAGING COMPLEX CONDITIONS

The Cochrane Review 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. View at www.cochrane.org.

Comparative information on specialty care has been sparse historically. **Consumer Checkbook and ProPublica** now offer comparative data on outcomes for several types of specialty care. Visit them at <https://projects.propublica.org/surgeons/> and <http://www.checkbook.org/surgeonratings/>.

selection, purchasers expressed hesitation about restricting employee choice. Some suggested a tiering structure with multiple levels of in-network providers with the greatest benefits going to employees choosing the highest value providers. They hoped this would provide the signaling necessary for market movement without essentially stripping benefits from employees who did not choose top performers, for any number of reasons.

Attendees also indicated a need for resources to assist provider practices in managing the influx of new patients that may result from a tiered network design. Potential channels and support for this communication are shown in the final columns of the “Tiered Network” roadmap. Clear communication with providers and employees prior to network changes was identified as an essential strategy for success. Patient navigators can assist employees in understanding network changes, in addition to easing logistical transitions, such as finding a new provider.

BUILDING OR ACCESSING ACCOUNTABLE CARE ORGANIZATIONS

Accountable Care Organizations (ACOs) link provider reimbursement to a variety of care outcomes, including quality, total cost, and patient experience. Despite their promise to improve value, uptake in the commercial market has been uneven nationally². As noted in the first column of the “Accountable Care Organization” roadmap (see [Exhibit 3](#) in Appendix A) purchasers identified three education and dialogue opportunities as necessary to hasten adoption:

² Muhlestein, D., & McClellan, M. (2016). Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion. *Health Affairs Blog*.

Tools for Employee Engagement (cont.)

QUALITY & COST VARIATION

In addition to data provided by health plans and transparency vendors, many RHICs now provide detailed data to the public and privately for purchasers and consumers to better understand differences in quality and in some cases, cost and resource use. Visit <http://www.getbettermaine.org/> and <http://www.mnhealthscores.org/>. Contact your local RHIC or visit <http://www.nrhi.org/> for more information.

1. Partnering with RHICs to convene interested stakeholders including health plans, providers and other purchasers.
2. Leveraging RHICs' data sources to supplement data from health plans and consultants, specifically for benchmarking.
3. Educating employees about potential benefits of moving to a more aligned reimbursement model while being transparent about how patients will be protected from its risks.

While some purchasers prefer to negotiate ACO arrangements directly with health care providers, others said they lack the time, technical expertise, data and purchasing power to go it alone. They are looking to their health plans to bring more ACO options to the commercial market. Further, even some purchasers interested in direct contracting may prefer handing off administration to a health plan. All of these options are shown in the "Accountable Care Organization" roadmap, along with next steps depending on the purchaser's chosen path.

Purchasers focused much of their attention on the need for strong employee engagement. Success, they said depends on employees "buying in" to the ACO concept, selecting from the more limited ACO network and looking past initial transition hurdles such as longer wait times.

As with tiered networks, achieving such success requires coordinated communications to employees and their health care providers. The final columns of the "Accountable Care

THREE TIPS FROM PURCHASERS WHO HAVE SUCCEEDED

1. Imitation is the highest form of flattery

Even purchasers interested in direct contracting or developing their own tiering need not start from scratch. Connect with others locally and nationally and copy where it makes sense. [The Pacific Business Group on Health Purchaser Value Network](#) brings the purchaser perspective to policy conversations and informs purchasers about opportunities to drive better value via toolkits, webinars and other educational sessions. [The Catalyst for Payment Reform](#) offers a model health plan RFI, a toolkit for developing an ACO strategy and other resources.

2. Communicate, Communicate, Communicate

The need for extensive, accurate and clear communications internally and externally cannot be underestimated. One purchaser suggested planning for a year of lead time to sufficiently communicate plans and goals with employees, senior executives and community partners including providers. Some states even legally require providers receive certain communications within a specific lead time before a network can be narrowed.

3. Collaborate to Find Shared Goals for Value and Implementation

Physicians and their patients are in the best position to change the health care system. Encouraging health care providers and employee representatives to offer ideas for performance metrics, communications strategies and logistics leads to informed, actionable suggestions. It also gives other physicians and employees more confidence in the process.

Organization” roadmap show possible dissemination paths for this information. Health care providers, both inside and outside the ACO network will need to understand the program, what it will mean for patients, why they were or were not chosen and opportunities for the future. Purchasers noted the role RHICs could play in supporting purchasers and health plans with this outreach. They also suggested the development of an education campaign for the general public about differences in health care quality and value. The Washington Health Alliance, in partnership with the Washington State Health Care Authority’s Healthier Washington initiative, created a campaign called the “Savvy Health Care Shopper.” The video, infographics and brochures can support purchasers in educating patients and their families regarding how to identify high-value health care. More information is available at <http://oyh.wacomcommunitycheckup.org/category/becoming-a-savvy-healthcare-shopper/>.

CONCLUSION

The explosion of health care data availability and the spread of new payment models gives purchasers an unprecedented opportunity to redesign health care markets in their own communities and nationally. However, such a shift cannot be successful without innovative health plan and health system partners and an educated public. RHICs, with their multi-stakeholder partnerships and access to data, offer a supportive forum for purchasers looking to make these complex and important transitions.

Appendix A

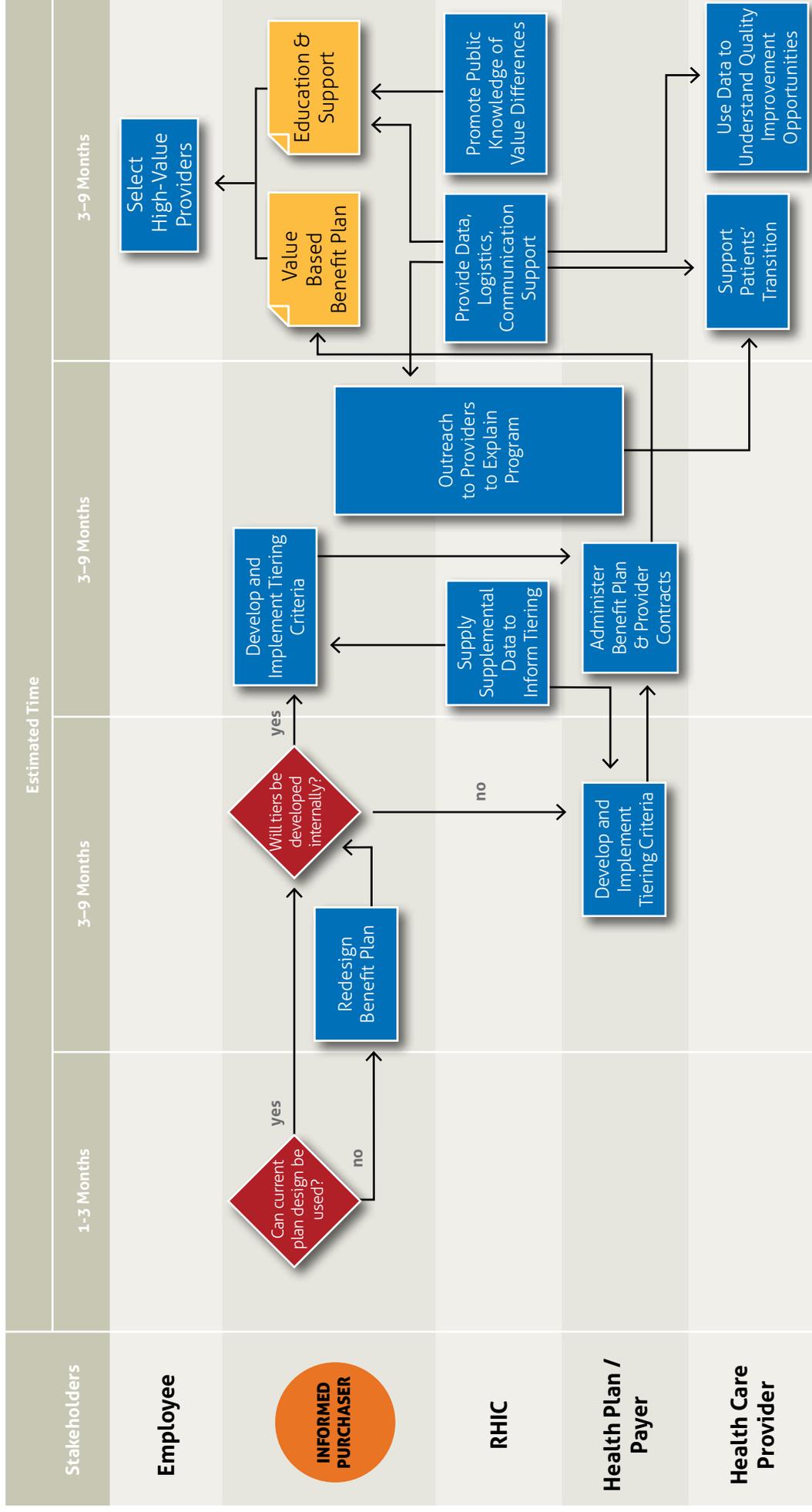
PURCHASER ROADMAPS

- [Exhibit 1](#) [Leveraging Regional Collaboration](#)
- [Exhibit 2](#) [Utilizing Tiered Provider Networks](#)
- [Exhibit 3](#) [Accountable Care Organization Contracts](#)

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

APPENDIX A: EXHIBIT 2



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)

APPENDIX A: EXHIBIT 3

