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Alternative Payment Models, Value-Based Care, and All-Payer Claims Databases

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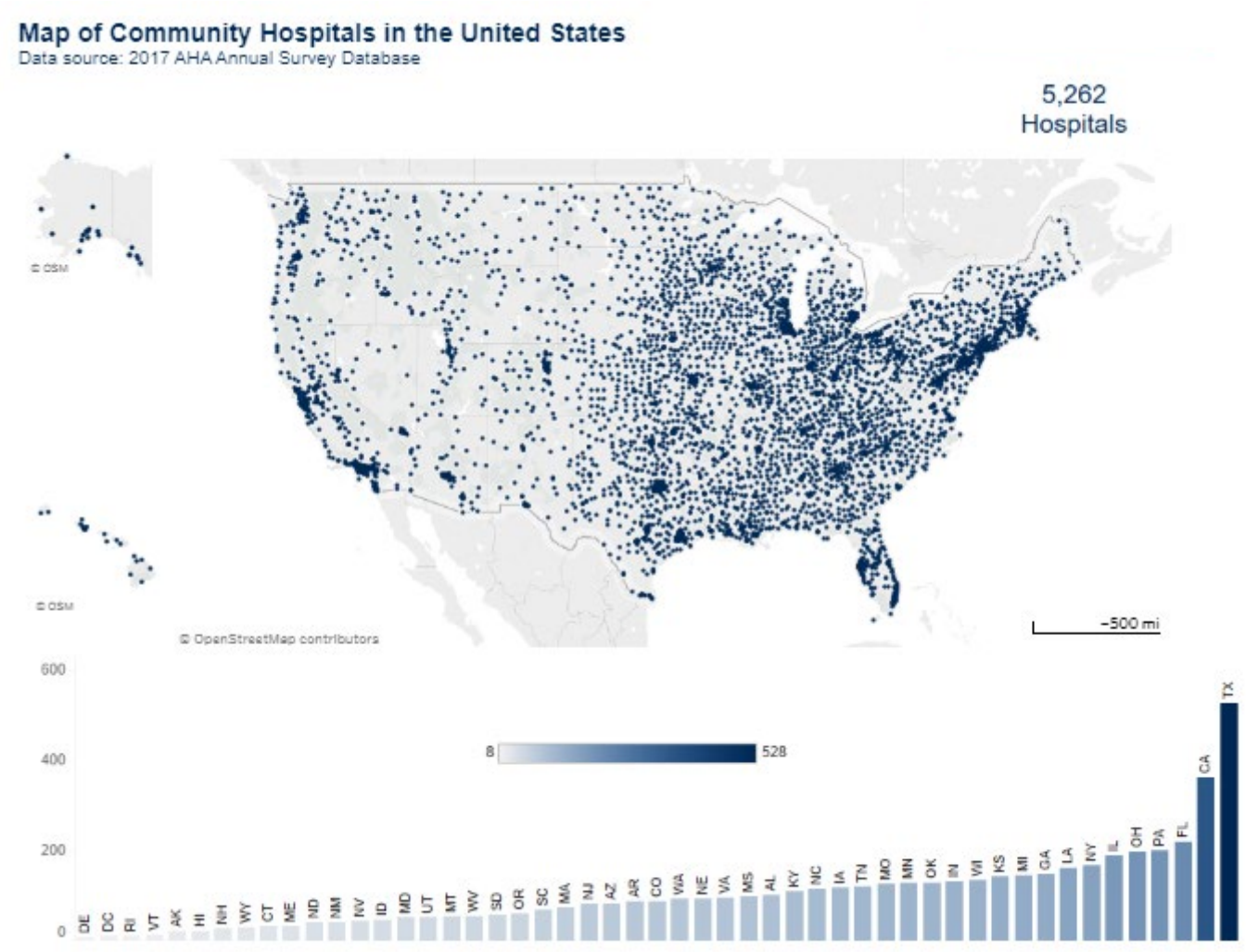
Chief Data Strategy Officer

November 8, 2019

About the AHA



- National trade association
- 5,000 hospitals, health care systems, networks, and other providers of care
- Professional membership groups comprise another 45,000 individual members
- Representation, advocacy, thought leadership, products and services, convenings, research, partnerships, pilots and initiatives
- The AHA vision is of a society of healthy communities, where all individuals reach their highest potential for health.

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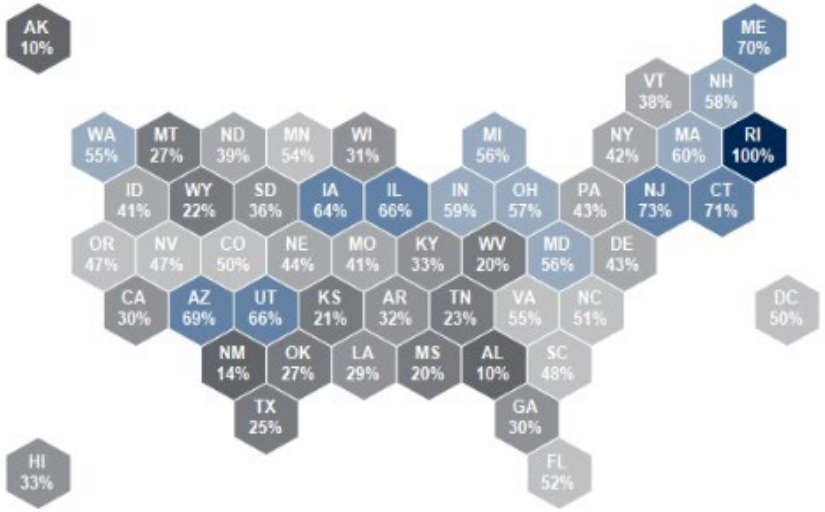
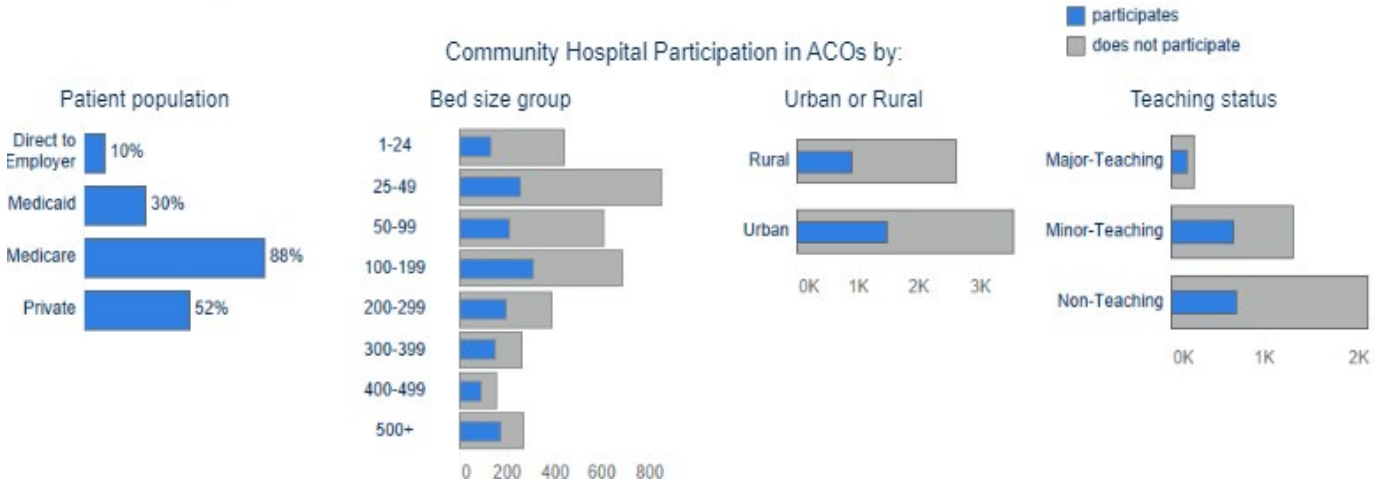
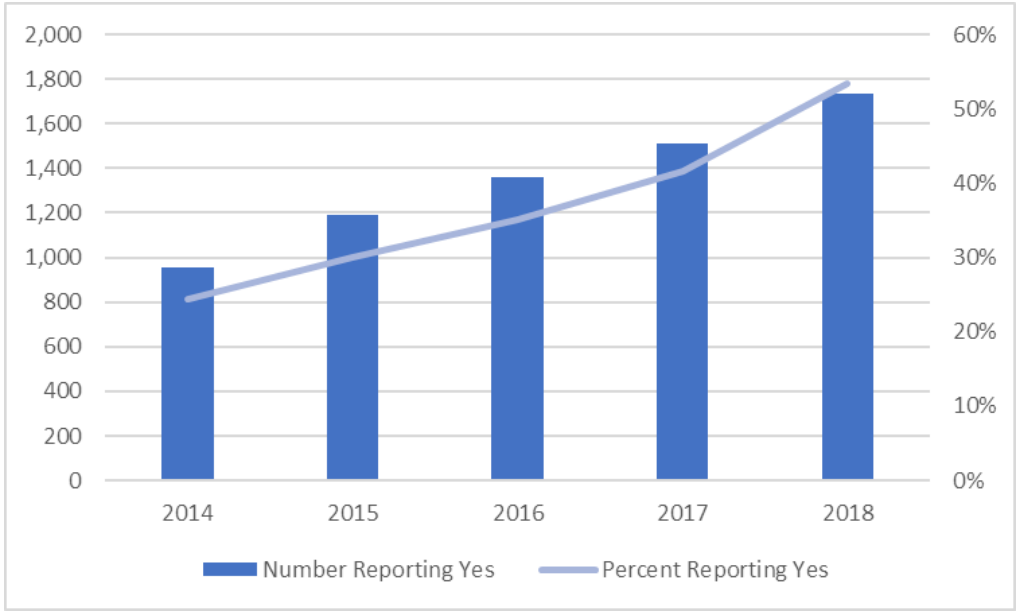
Hospital Participation in ACOs







Source: AHA Annual Surveys. Over 3,200 respondents/year

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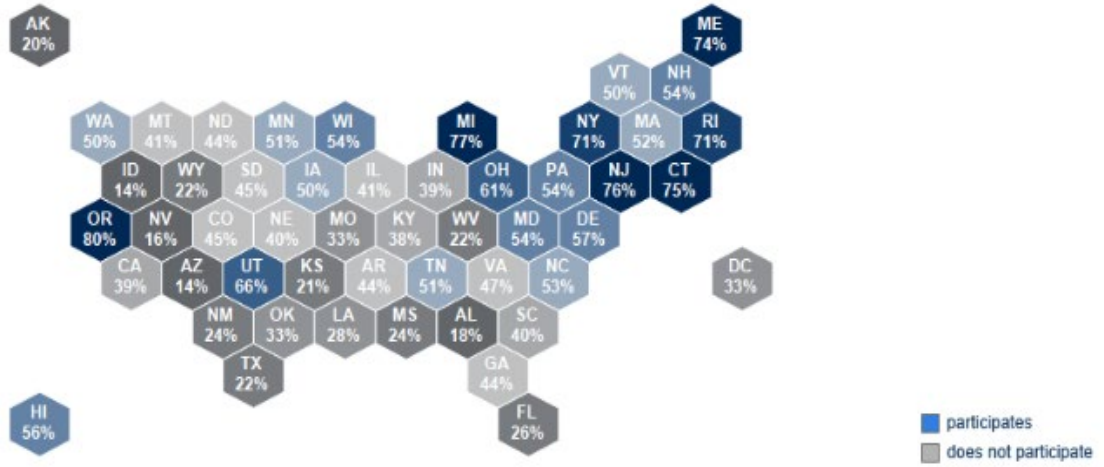
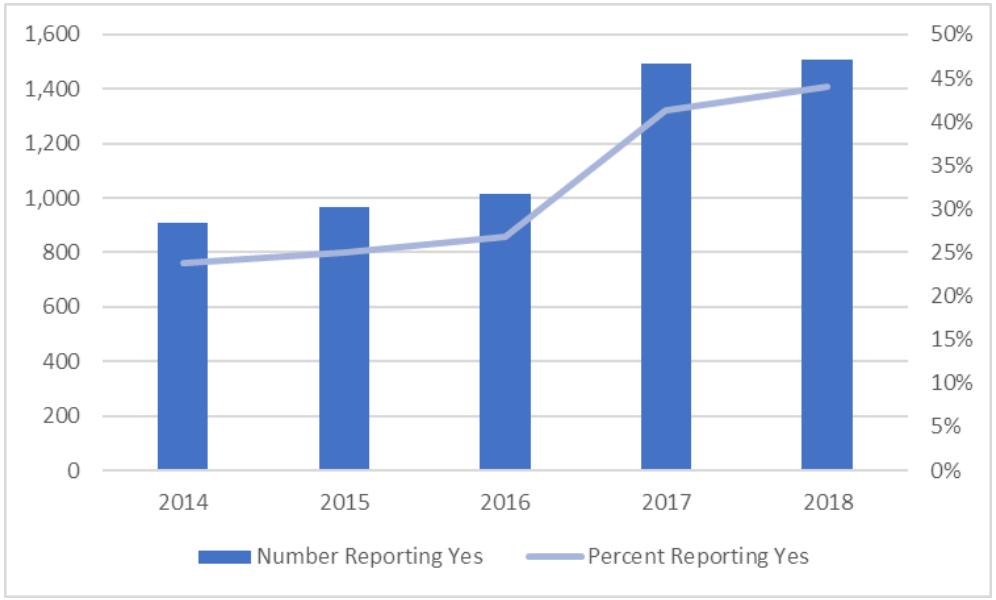
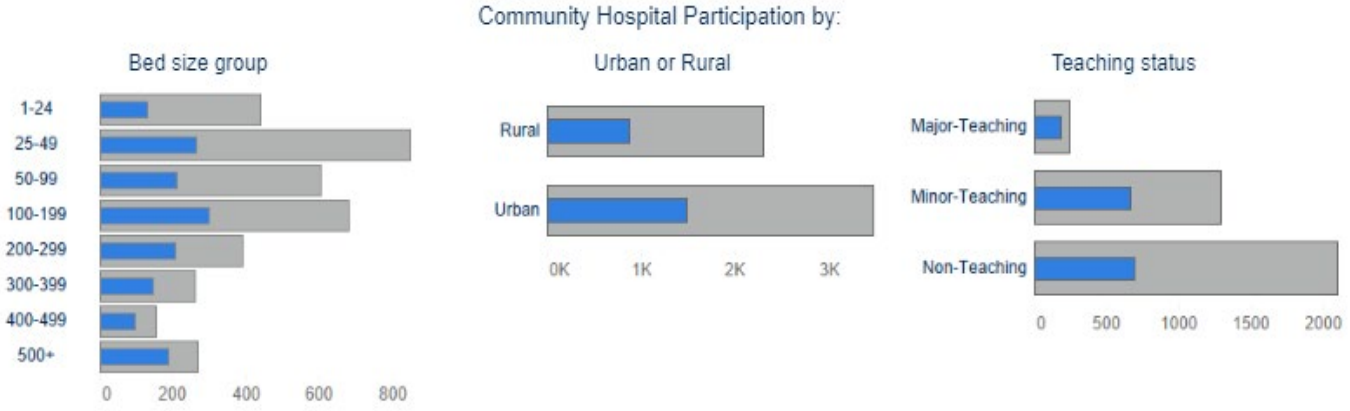
Hospital Participation in Medical Homes







Source: AHA Annual Surveys. Over 3,200 respondents/year

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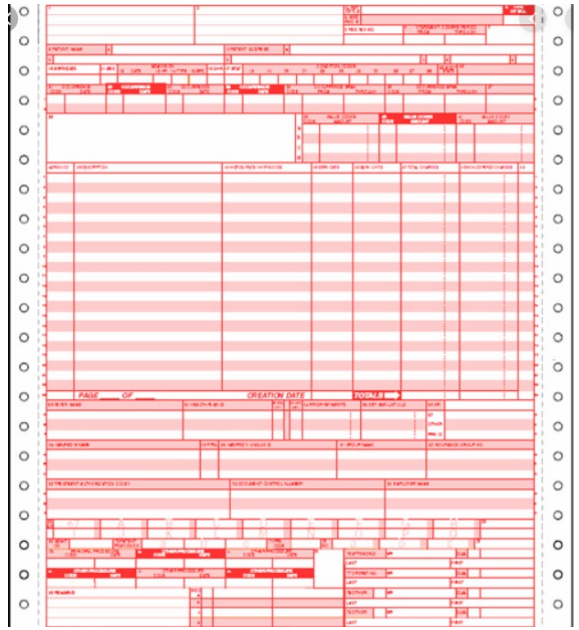
Claims Data for Quality Measurement



- Claims data are an essential part of many quality measures, though used in varying ways
- For chart and EHR-based measures, claims often used to:
  - Define patient population
  - Apply inclusions/exclusion criteria
  - Identify patient-level services (e.g., prior procedures) or co-morbid conditions that could be used in risk adjustment
- Heavy reliance on measures based **only** on claims in Medicare and private payer measurement programs
  - ~50 percent of measures used in CMS's hospital reporting and P4P programs (IQR, OQR, VBP, HAC, HRRP)
  - ~70 percent of the measures whose performance is tied to payment in CMS hospital P4P programs (VBP, HAC, HRRP)
- Should there be risk or payment adjustment to reflect Social, Economic, or REAL influences on health? If so, how?

Claims-Only Quality Measures: The Good, Bad and Ugly

- **The Good**
  - Less burdensome (little to no data abstraction required)
  - Potential for increasing the sample size (i.e., sampling not needed)
  - Claims are needed to calculate some longitudinal outcomes (e.g., readmissions, mortality)

- **The Bad**
  - Significant data lag
  - Variations in billing data across payers (means that using same specs across all payers often is not possible)

- **The Ugly**
  - Claims cannot capture all underlying clinical factors, undermining reliability and accuracy
  - Performance on measures can be sensitive to legitimate differences in coding approaches across providers

…which likely contributes to “HACcidental” Penalties

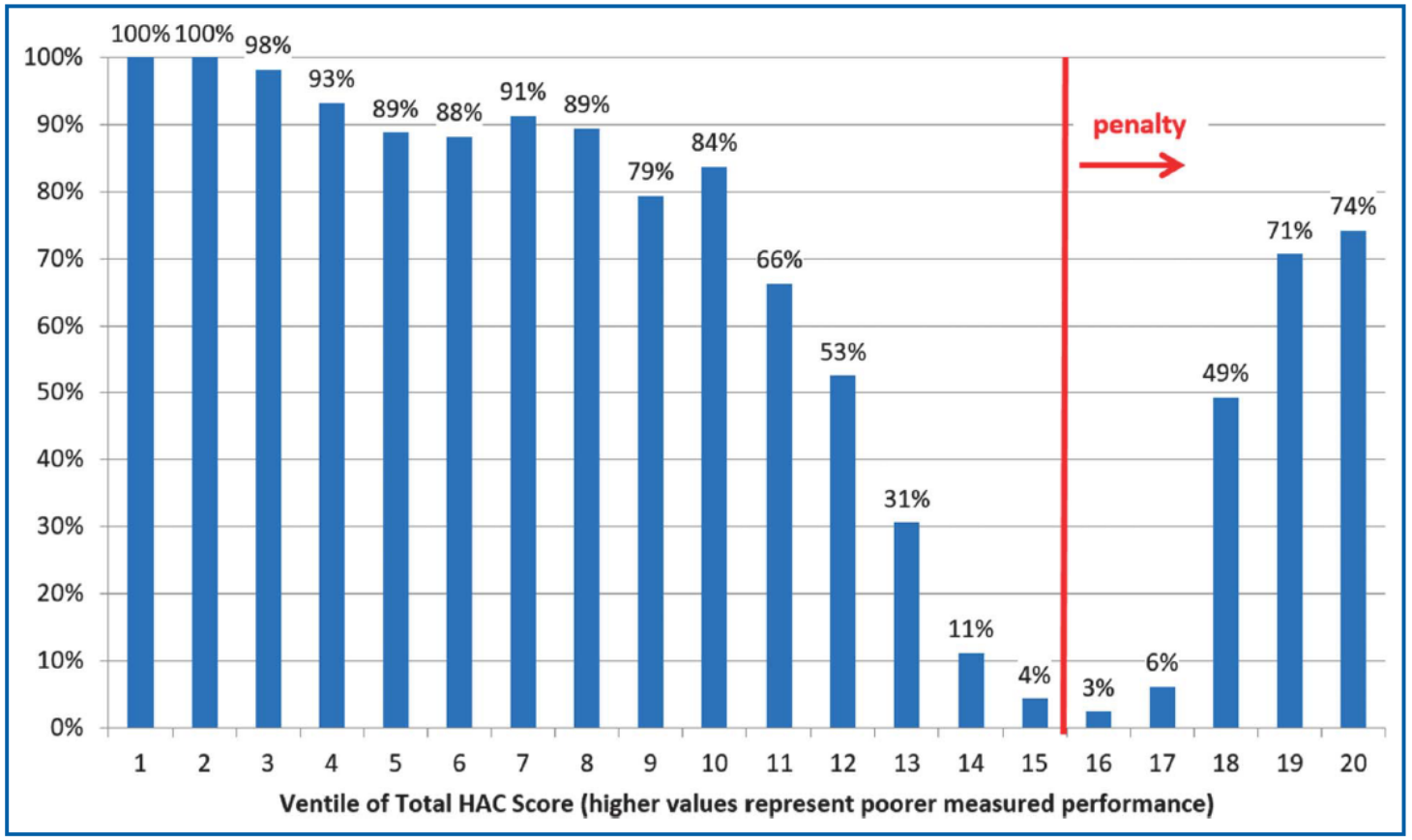


Figure 1. Percent of hospitals ($n = 3,198$) statistically significantly different from threshold, 95% significance level. Source: Authors' analysis of data from Hospital Compare.

- Penalties not based on statistically significant differences in performance
- The closer you get to penalty cut off, the more likely your performance is NOT statistically different than the cut off

Source: Soltoff S, Koenig L, Demehin A, Foster N, Vaz C. Identifying Poor-Performing Hospitals in the Medicare Hospital-Acquired Condition Reduction Program: An Assessment of Reliability. *Journal of Health Care Quality.* March 2018

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APCD Data for Performance Improvement

- APCD data is not transparent to the provider field
- Performance improvement requires a continual feedback loop
- Difficult to track and get ahead of the data
- Providers are spending millions of dollars to access claim-level, person-level data for customer activity beyond their walls

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The National Conversation is About Affordability

Cigna Value-Based Care Participation Tops 50%, Saving $600M

Cigna has passed the halfway mark on its journey to value-based care, saving more than $600 million along the way.

Source: Cigna

By Jennifer Bresnick

February 11, 2019 - Cigna **has surpassed** its goal of having 50 percent of its Medicare and commercial health reimbursements tied to value-based care models in top markets by the end of 2018, the payer announced.

Between 2013 and 2017, value-based care arrangements have produced medical cost savings of more than $600 million, illustrating how shifting away from traditional fee-for-service reimbursement can help the industry control spending at scale.

"Cigna's focus on quality and affordability enabled the company to exceed its 50 percent alternative payment goal, offering more value for our customers' and clients' health care dollars," said Scott Josephs, MD, chief medical officer at Cigna.

Dig Deeper

- Blue Cross of NC, Major Health Systems Partner for Value-Based Care
- Humana Value-Based Care Program Unveils First Participants
- Payers See Cost, Quality Gains with Value-Based Payment Models

"This is a critical milestone as we work to accelerate the pace of change in health care delivery in the United States. Our commitment to value-based care and **alternative payment models** is driving better health outcomes, increased affordability and improved patient experience for the

Humana Expands Bundled Payment Models for Spinal, Joint Surgeries

Over a dozen more providers joined Humana's bundled payment models for spinal fusion surgeries and total joint replacements.

Source: Humana

By Kelsey Waddill

July 23, 2019 - Humana recently **expanded** its value-based payment models by signing four more agreements with providers for bundled payment models for spinal fusion surgeries.

The payer also announced the growth of its bundled payment model for Medicare Advantage beneficiaries undergoing total joint replacements at certain provider practices. Eleven more practices are now part of the bundled payment program, bringing the total to 75 medical practices in 21 states.

"We're delighted to support provider groups as they quarterback a more coordinated approach to care for their patients undergoing spinal fusion surgery," said vice president of Humana's value-based strategies organization, Oraida Roman. "Humana is proud to share data and analytics with physicians and clinicians in collaboration toward improving the patient experience and health outcomes in spinal care."

Dig Deeper

- UnitedHealthcare Expands Medicare Advantage Bundled Payment Program
- Medicare Bundled Payment Programs Primed to Produce Savings

Majority of States Have Committed to Value-Based Care, Payment Reform

Almost every US state and territory is implementing value-based care models and payment reform to improve care quality and reduce costs.

Source: Thinkstock

By Jessica Kent

April 17, 2019 - There has been significant growth in the number of states and territories implementing value-based care models in the last five years, with a total of 48 committing to payment reform nationwide, including the District of Columbia and Puerto Rico, according to a **report** from Change Healthcare.

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