Opportunities and Challenges in Overlaps of Payment Programs

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Agenda

Discussion of Issues and Challenges

- Payer
- Provider

Discussion of Progress and Solutions

Conclusions

Discussion



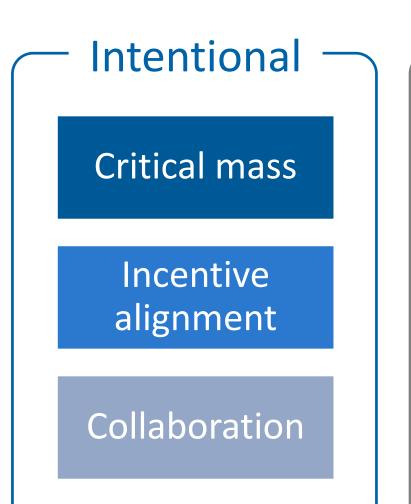
Multi-Payer Overlap







Consequences of Overlap – Intentional and Unintended



Unintended

Depleted comparison groups for evaluation

Administrative Burden

Mixed financial signals

Dilution of individual programs if layered

Free riders



Payer Challenges



 Population Differences Multi-payer efforts driven by CMS don't reflect commercial membership characteristics Measures don't recognize or emphasize the unique opportunities of payers and providers 	 Variation in payer capabilities Payers have different capabilities around payment innovation administration Payment models are not consistent 	Free Riders
Contracting cycles don't align	Differences in Reimbursement and Network structure • Commercial fee schedules, networks and benefits • Payment/Reimbursement policies	Additional Program Expense • Data aggregation • Convener



Provider Issues



Proliferation of Program Requirements	 Multiple programs with similar goals are difficult to navigate Multiple scorecards, measure set and incentive alignments 	
Payment Model	 Slightly different focus across programs can dilute incentives Additional administrative burden when models don't align 	
Population Differences	 Different product/network structures used across member groups can make pop health management more difficult Population nuances impact service needs, bundle definitions/inclusions, etc. 	
Data variation across payers	• Makes hard to interpret reporting	
Administrative headaches	 Communication overload from a variety of stakeholders Compliance requirements and infrastructure 	



Payer-Centric Solutions



Problem Category	Activities / Potency	Examples
Consistent measure set	*	RI/VT – population health measure set
Consistent reimbursement rates	**	MD - Rate setting allows payers to compete on service and experience vs discounts
Payment model consistency	0	
Reimbursement policies	*	SC – Blue and Medicaid stopped paying early elective deliveries
Free riders	0	
Capability variation	**	OH - Data Aggregator, joint stakeholder meetings
Anti-trust, collaboration optics	*	Conveners
Population differences	0	Payers try to align with bundle definitions when feasible
Efficacy and evaluation	*	Thoughts?

Scale $\star - \star \star \star \star$



Provider-Centric Solutions



Problem Category	Activities / Potency	Examples
Administrative burden Multiple measure sets Contracting Communication 	*	RI, VT working towards aligning measure sets
Program and incentive dilution*	0	*Multi-payer collaboration captures greater share of provider's book of business
Payer capability variation	*	OH – data aggregation / reporting
Payment model consistency	*	High level alignment of incentives





Conclusions

Multi-payer transformation efforts have induced a myriad of intended and unintended consequences across all participants.

Most efforts have focused on financial and administrative burden. No one has addressed all issues.

Contamination from overlap will make it difficult to detect modest impact.

Much more work is needed to promote and adjust for contamination.

- Victims of own success; will be difficult to make data-driven decisions
- Magnitude of impact will be underwhelming

Need to acknowledge tradeoff between building and sustaining market momentum vs. making sound long-term decisions of what payment innovations work.

- Multi-payer collaborative and interventions require investment mentality to spur change
- Models will need to demonstrate a sustainable business case for continued engagement



Discussion

