



Health Services Cost Review Commission

New All-Payer Model: Consumer Engagement Taskforce Meeting

Friday, January 30, 2012 - 9:30 a.m. to 12:00 p.m.

AGENDA

Consumer Engagement Task Force

- | | |
|---|------------------------|
| 1. Welcome & Intro of new staff | 9:30 - 9:35AM |
| 2. Update on NAPM implementation as appropriate | 9:35 - 9:45AM |
| 3. Charge #1: | 9:45 - 11:00AM |
| A. Definitions/Principles document - review & approve | 9:45 - 9:55AM |
| B. HCFA presentation & discussion- Suzanne Schlattman | 9:55 - 10:20AM |
| C. Consumer Views on Health Costs, Quality & Reforms | |
| 1. Consumers Union Presentation- Lynn Quincy | 10:20 - 11:00AM |
| 2. Next steps for the working group | 11:00 - 11:10AM |
| 4. Charge #2 | 11:10 - 11:45AM |
| NAPM – Discussion of two areas to gain initial thoughts on effective paths for consumer communications/engagement | |
| A. consumer protections | |
| B. real and/or perceived barriers and challenges for consumers | |
| 5. Public Comment | 11:45 - 11:55AM |
| 6. Meeting Wrap-Up & Next Steps | 11:55AM - Noon |



Maryland Health Services Cost Review Commission

**New All-Payer Model for Maryland:
Population-Based and Patient-Centered Payment Systems**

**Consumer Engagement Task Force
January 30, 2015**

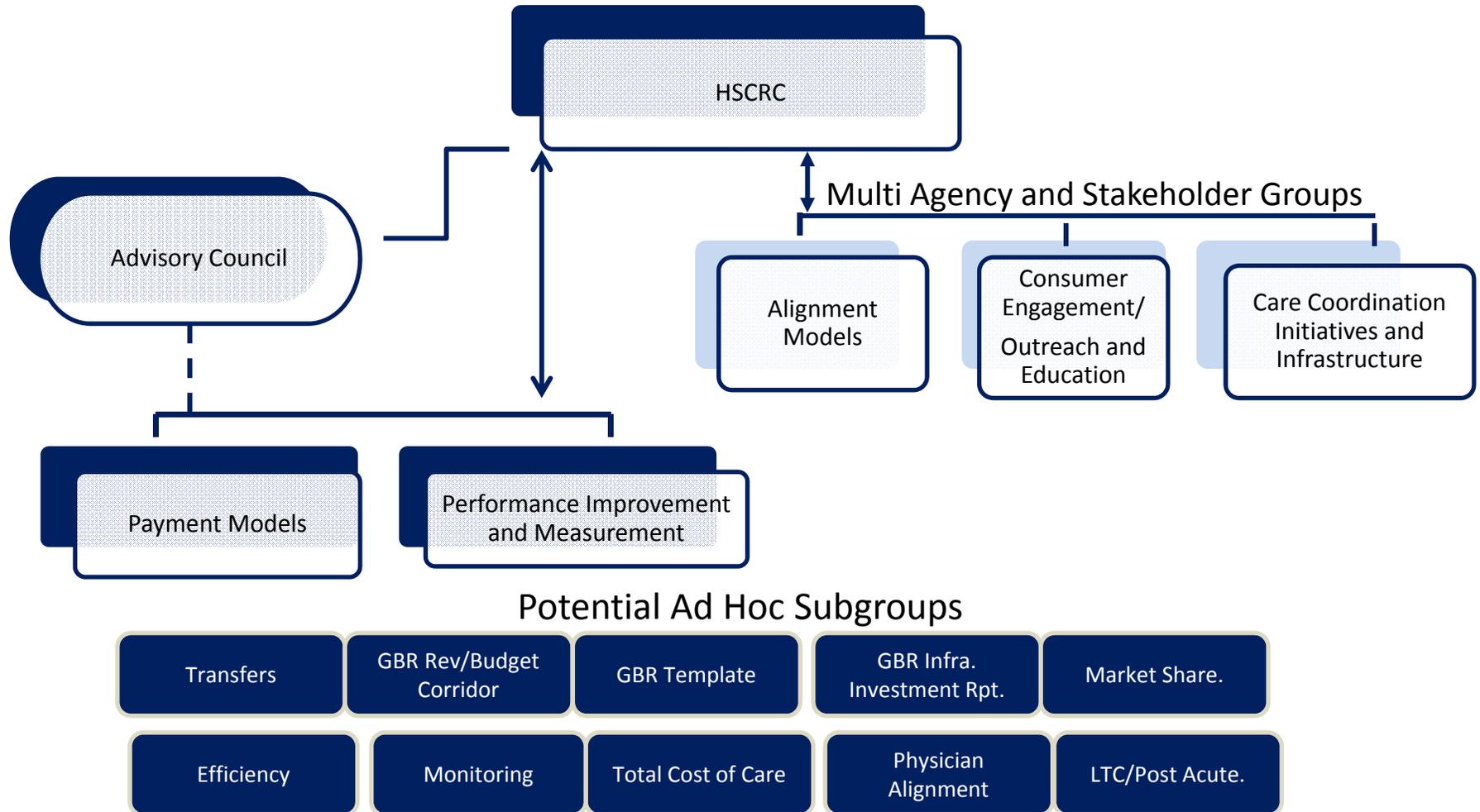
**Coalition Chair, Leni Preston
Families USA 2015 Consumer Health Advocate of
the Year**



January 26, 2015

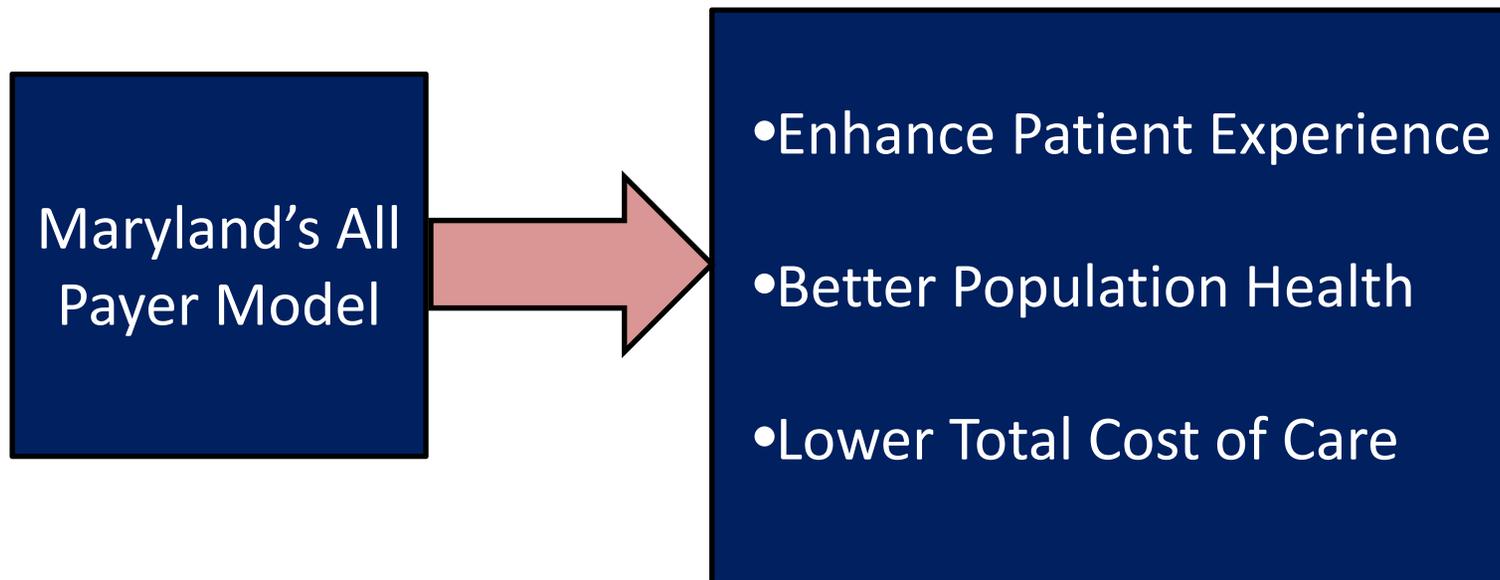
Public Engagement

Anticipated for Next Phase of Work



Focus Shifts to Patients

- Unprecedented effort to improve health, improve outcomes, and control costs for patients
- Gain control of the revenue budget and focus on providing the right services and reducing utilization that can be avoided with better care



Implications for Consumers

- **Successful hospital under a modernized waiver**
 - High quality, efficient and effective care while strategically maintaining market share
 - Partners with physicians and other practitioners, urgent care and post acute care to improve population health
 - Improves care resulting in reducing avoidable utilization freeing up funds for investments in population health and new technology and clinical services
 - High quality with reduced clinical utilization will be the most successful

Health Services Cost Review Commission
New All-Payer Model: Consumer Engagement Taskforce
Proposed Useful Definitions and Principles

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The following are based upon the Consumer and Community Engagement Framework¹ developed by Health Consumers Queensland and are proposed here as a basis for consumer engagement.

Proposed Useful Definitions

Consumers: Consumers are defined as people who use, or are potential users, of health services. This may include family members as well as those who provide care in an unpaid capacity.

Community: Community refers to groups of people or organizations with a common local or regional interest in health. There are three primary ways in which a community may be formed: (1) geographic boundaries (neighborhood, region, etc.); (2) interests such as patients, health care providers, industry sector, profession, etc.; and/or (3) specific issue such as improvements to public health or groups that share cultural backgrounds, religions or language(s).

Consumer Engagement: Consumer engagement informs broader community engagement. Health consumers are people who actively participate in their own health care and, more broadly, in health policy, planning, service delivery and evaluation at service and agency levels.

Community Engagement: Community engagement refers to the connections between government, communities and citizens in the development of policies, programs, services and projects. It encompasses a wide variety of government-community interactions ranging from information sharing to community consultation and, in some instances, active participation in government decision-making. It incorporates public participation, with individuals being empowered to contribute in decisions affecting their lives, through acquisition of skills, knowledge and experience.

¹ The full document can be found at <http://www.health.qld.gov.au/hcq/publications/consumer-engagement.pdf>

Proposed Principles - Consumer and Community Engagement

#1 - Participation: People and communities participate and are involved in decision-making about the health care system.

#2 - Person-centered: Engagement strategies and processes are centered on people and communities.

#3 - Accessible and Inclusive: The needs of people and communities, particularly those who may experience barriers to effective engagement, are considered when determining steps to enhance accessibility and inclusion.

#4 - Partnership: People, including health care providers, community and health-related organizations work in partnership.

#5 - Diversity: The engagement process values and supports the diversity of people and communities.

#6 - Mutual Respect and Value: Engagement is undertaken with mutual respect and the valuing of other's experiences and contributions.

#7 - Support: People and communities are provided with the support and opportunities they need to engage in a meaningful way with the health care system.

#8 - Influence: Consumer and community engagement influences health policy, planning and system reform, and feedback is provided about how the engagement has influenced outcomes.

#9 - Continuous Improvement: The engagement of people and communities are reviewed on an on-going basis and evaluated to drive continuous improvement.

Engaging Maryland Consumers On Health Care Cost and Value Issues

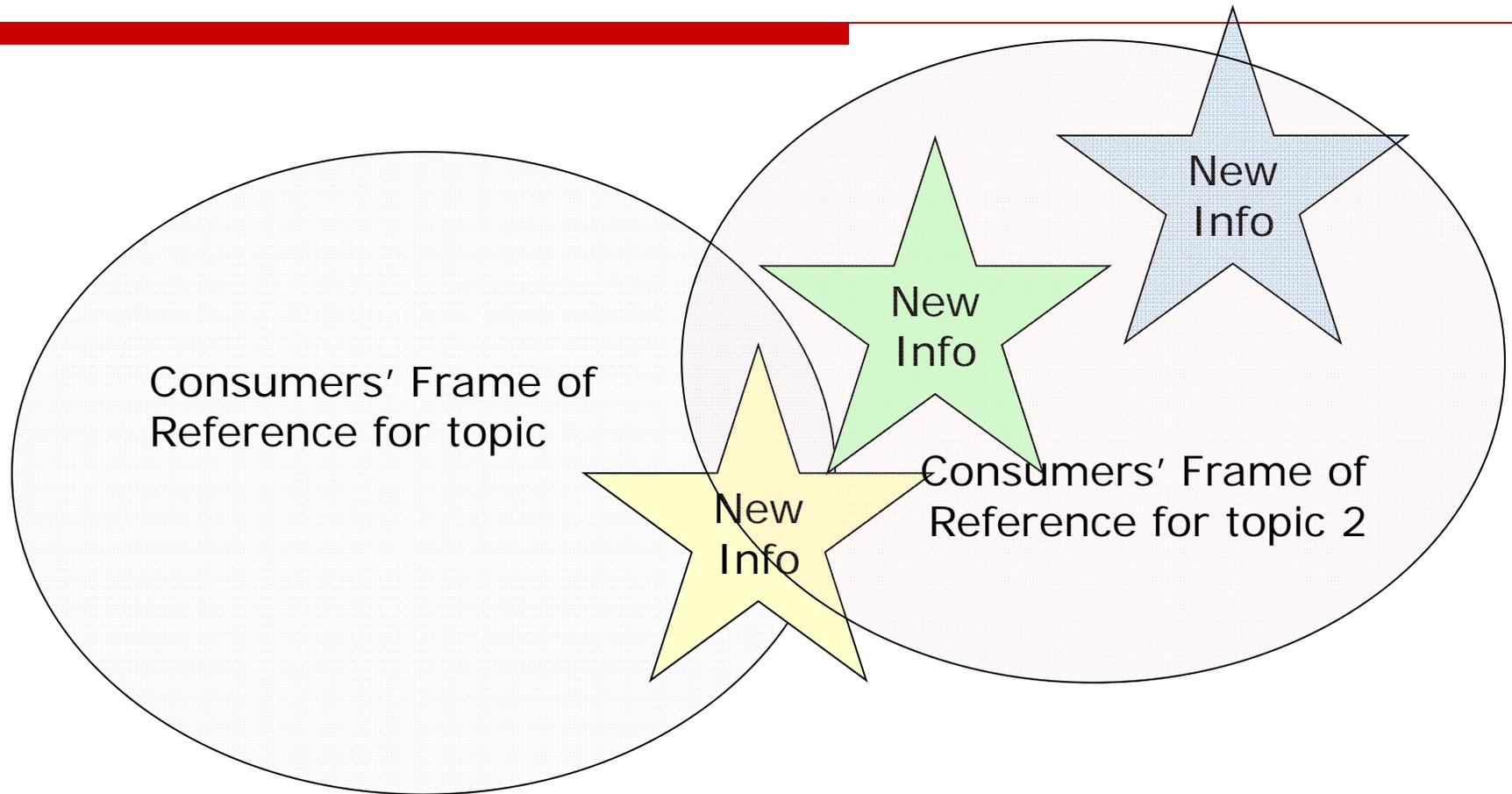
Lynn Quincy
Associate Director, Health Reform Policy
January 30, 2015



Our premise

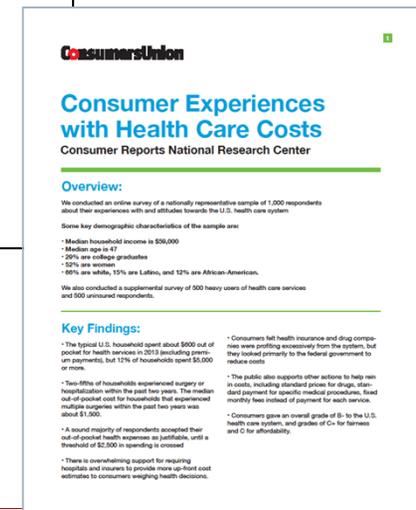
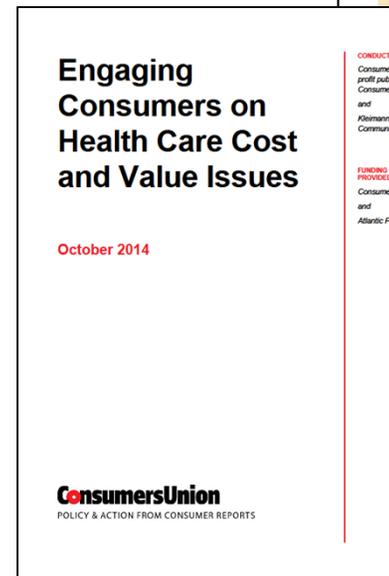
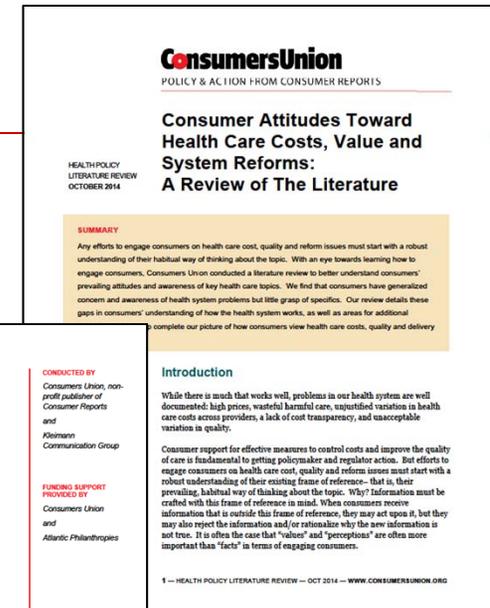
- ❑ Consumer support is fundamental for policymakers and regulator action.
- ❑ Low public awareness of system problems and potential solutions hinders progress on health care cost/value issues.
- ❑ Efforts to increase public awareness are hampered by our incomplete understanding of consumers' attitudes towards health system problems.

Why is it important to know consumers' attitudes?



A Mixed Methods Research Project

- ❑ Literature Review
- ❑ Focus Groups
- ❑ Nationally Representative Survey



High Costs Are Top-of-Mind For Consumers

Q. What is one word that describes the US health care system?

A. “Expensive,” “Money,” “High costs” or a variation

“If you take the ‘U’ and the ‘S’ part of the health care system and put them together or overlap one of them—one over the top of the other, you get a dollar sign,” (CO-Group 1)

Consumers Think About Health Costs On Two Levels

- Typically: costs they pay out of pocket.
- Sometimes: they have system-wide costs in mind when thinking about reforms, including the portion paid by third parties.
- But consumers have only a general sense of how broader system costs get paid.

Consumers Are Angry About Costs

"arbitrary"

"greed"

"not fair"

"it's a moral issue"

"gougers"

Quality Problems Are Not Top-of-mind

- ❑ Think about “health care quality” in terms of their own doctor and office staff.
 - ❑ Focus on the “softer” side of a practice: communication style of staff, careful attention to medical details and wait time.
 - ❑ Technical proficiency important to them but (falsely) assume fairly uniform.
 - ❑ Unaware of measures such as hospital infection rates, adherence to evidenced-based protocols, HEDIS, CAHPS or any common metrics that a policymaker or accreditation body might use.
-

Affordability Concerns Outweigh Quality Concerns

Q. What grade would you give the health system for...

| Topic | Grade |
|---------------------|-------|
| ...quality of care? | B |
| ...fairness? | C+ |
| ...affordability? | C |

Source: Consumers Union 2014 Nationally Representative Survey

What Motivates Consumers To Act?

- An emotional response to information
- But information must:
 - Be from a trusted source
 - Evoke an emotional response – can't be “logical”
 - Conform to their current beliefs and perceptions or “anchored” to other information they know. Local information is particularly motivating.
- And you must give them something to do!

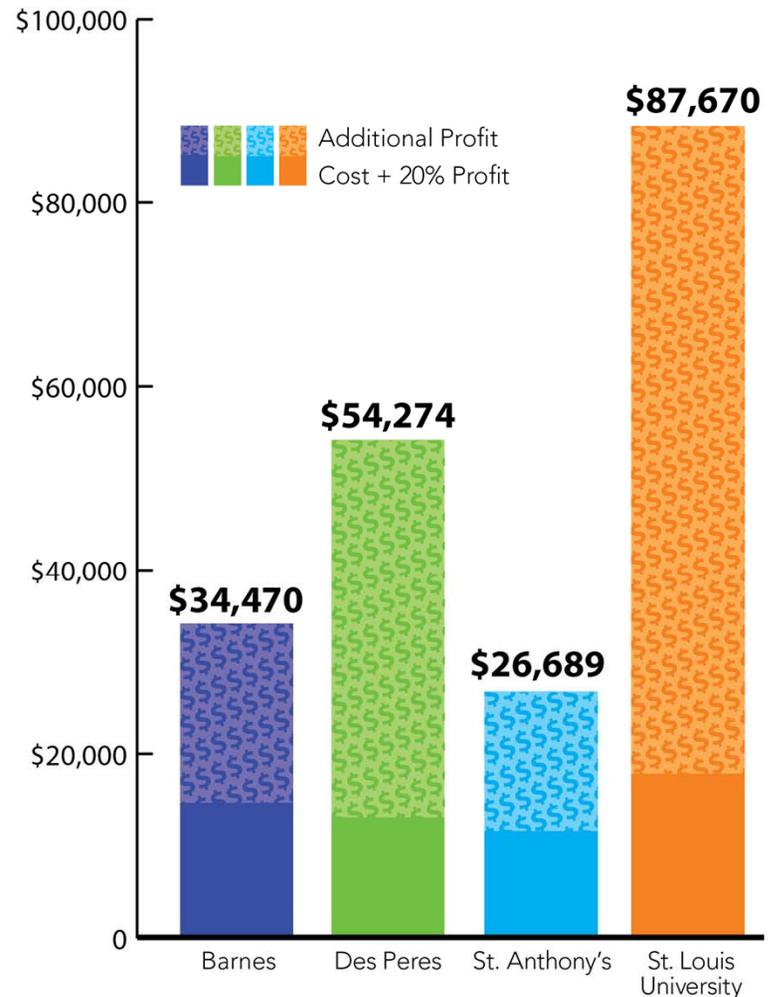
Visual Information Particularly Motivating

Infographics combine data and visuals in a way that reveals relationships and significance more quickly than verbal or text information

Same City, Same Service: How Much Price Variation is Reasonable?

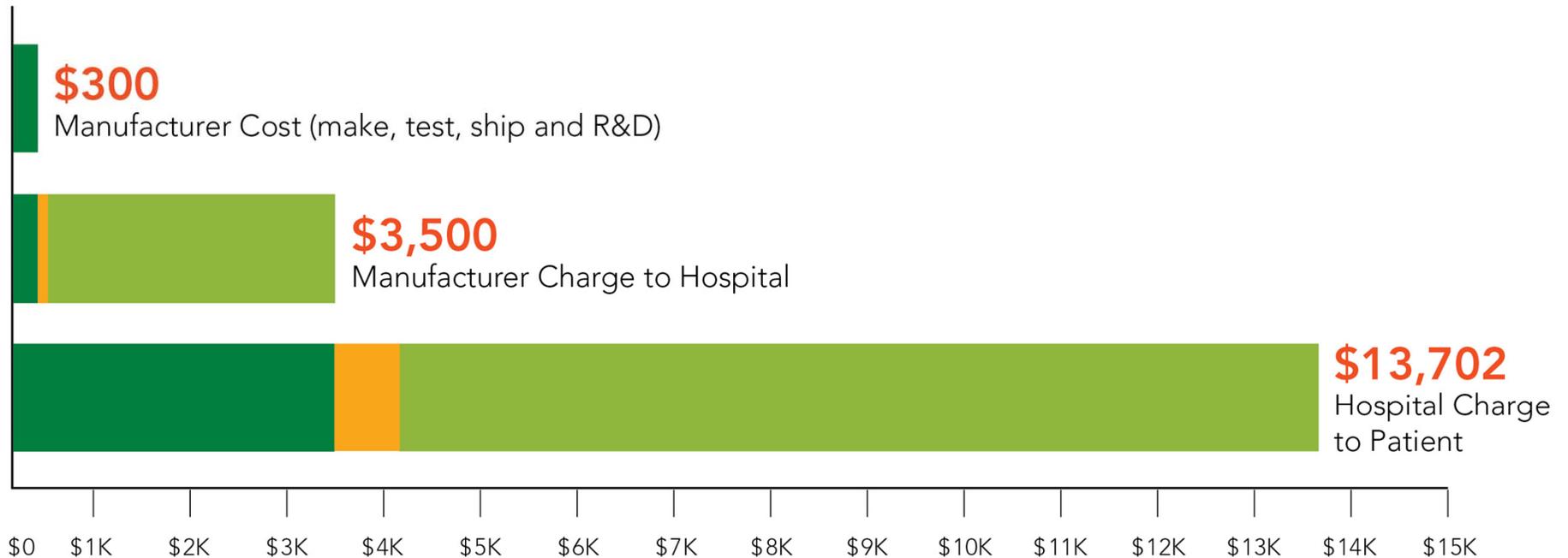
- ❑ Highly motivating!
- ❑ Local data on hospitals allowed participants to layer on their own information
- ❑ Highlighting hospital markup = emotional response
- ❑ Participants views: hospitals are a business and should make some profit but health care is a social good, so not too much!

St. Louis Hospitals: Inpatient Joint Replacement



Is the Cost Reasonable?

One Dose of Cancer Drug Rituxan



- Cost
- 20% Profit
- Additional Profit

What are consumers willing to do?

- Want to be told what to do, not have to research it themselves
 - Willing to take:
 - Personal actions (informed shopping, healthy lifestyle)
 - System-directed actions (write to legislator)
 - But want to be effective - how can we band together to amplify our voice?
-

What system level interventions would consumers support?

A broad range, including:

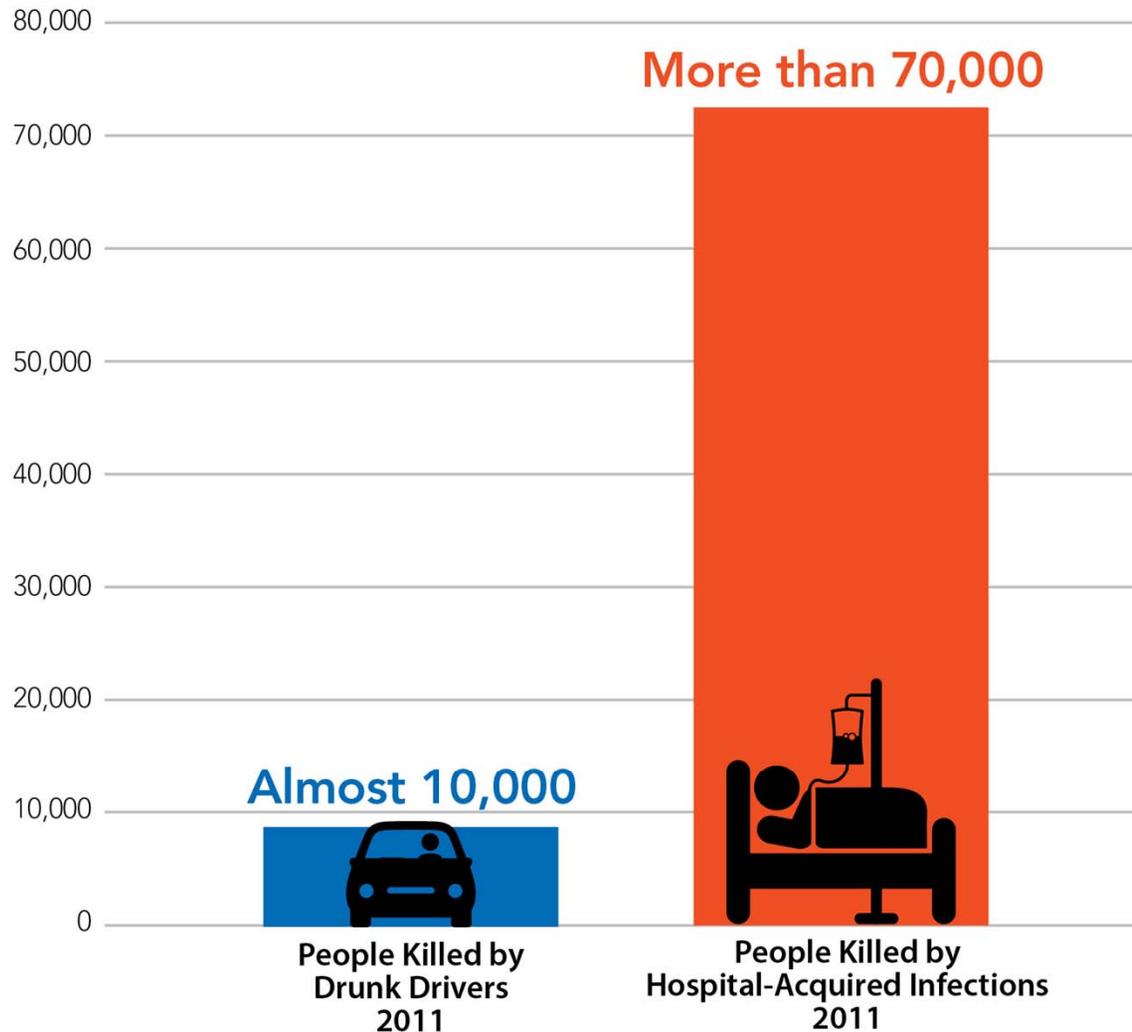
- price caps,
- provider payment reform (various),
- global budgets,
- disclosure of “fair” prices, and
- mandatory upfront cost estimates.

They like **penalties** for poor performing providers better than **rewards** for good providers.

Muted reaction to certain solutions: EHR and better coordinated care

- While EHR and coordinated care viewed favorably, improvements seemed logical → little emotional response → not tempted to act.
- **Exception:** hospital infections

Hospitals Can Be Dangerous



Every year in the U.S., drunk drivers kill almost **10,000** people, but hospital-acquired infections kill **over seven times** that many.

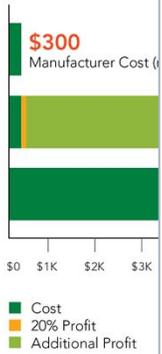
The CDC estimates these infections add **\$45 billion** every year to hospital costs.

Bottom line: Consumers highly motivated to act

- Easily motivated to “do something” about excessively high costs and high rates of hospital infections
- Harder but possible to get support for specific reforms. Try:
 - Follow rules for motivating information, connect to system problems and leverage desire to “do something”
 - Avoid short list of reforms that don’t resonate (like rewarding good doctors)

Is the Cost Reasonable?

One Dose of Cancer Drug Rituxan



Rising Health Insurance Costs

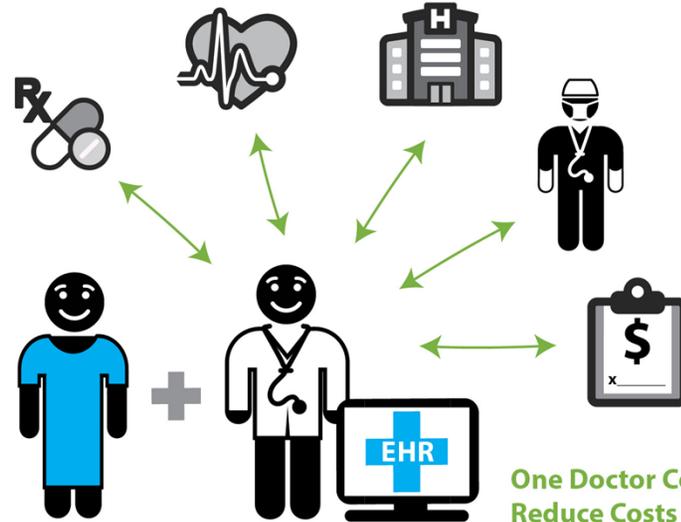
Increase in health insurance costs

From 2000 to 2010

How Health Insurance Works

High Prices Affect Your Premium

Patients Deserve Coordinated Care



One Doctor Coordinates Care to Reduce Costs and Improve Outcomes

- electronic health records (EHR)
- all information shared
- clearer communication between physicians
- faster access to test results
- improved patient safety
- better outcomes for patient

High prices mean
higher premiums
for consumers.

Thank you!

Questions:

Lquincy "at" consumer.org

Report and other materials:
[consumersunion.org/
engaging-consumers-on-
value](http://consumersunion.org/engaging-consumers-on-value)

[See also: safepatientproject.org](http://safepatientproject.org)

Engaging Consumers on Health Care Cost and Value Issues

October 2014

ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

CONDUCTED BY
*Consumers Union, non-
profit publisher of
Consumer Reports
and
Kleimann
Communication Group*

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and
Atlantic Philanthropies*



HSCRC Consumer Engagement Task Force
January 30, 2015

Maryland's New All-Payer Model A Journey Together for Care Improvement

As presented at the January 23, 2015
Care Coordination Workgroup Meeting

Focus on Clinical Improvement and Infrastructure

- ▶ HSCRC has completed its initial payment model changes that place all hospitals on global revenue models with enhanced quality and outcomes requirements.
- ▶ The focus now is on coordinating and integrating care as well as improving community based care to reduce hospitalizations.
- ▶ Solutions should be patient focused, and approaches to engage and educate patients will be needed.
- ▶ Partnerships with physicians and practitioners, long term and post acute care providers, and community health and service organizations are critical to creating effective and workable strategies, infrastructure, and operations.

Coordination of Efforts is Essential to Success

Accountable Care Organizations and Medical Homes

New All Payer Hospital Model

Medicare Care Management Fees

State Health Improvement Process- Public Health

Health Information Exchange--CRISP

Consumer Engagement, Education, and Outreach



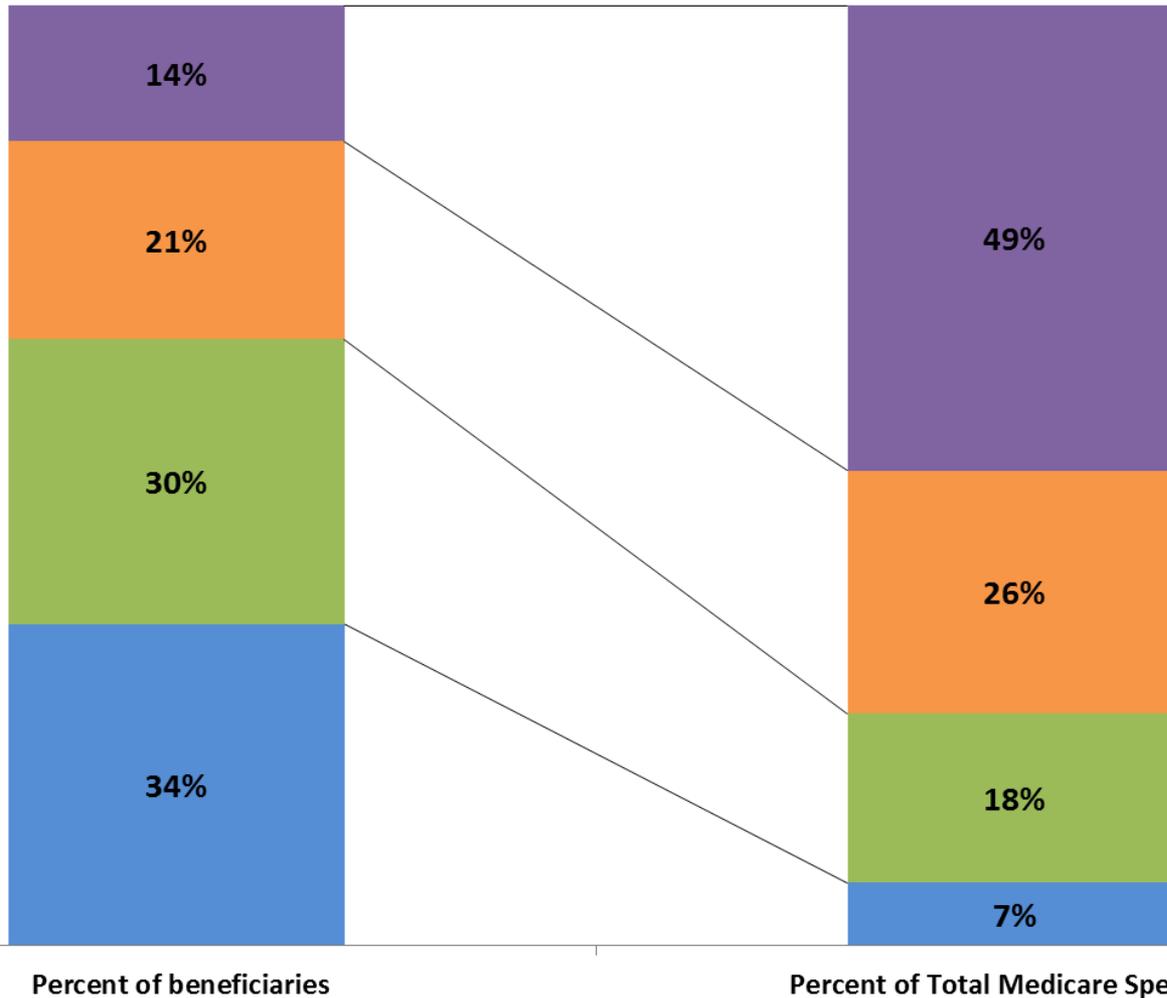
Initial Focus is Medicare

- ▶ Two thirds of high needs patients are Medicare (calculated from HSCRC data sets)
- ▶ Medicare patients have high numbers of chronic conditions. Chronic care improvement is essential for patients and also contributes to cost containment when conditions are controlled.
- ▶ Medicare patients can benefit from care coordination and customer service mechanisms that have not been supported in the fee-for-service system that is predominant in Maryland.
- ▶ Medicare savings test requires reductions in utilization beyond national progress to result in savings of ½% per year relative to the national growth rate in Medicare cost per beneficiary
- ▶ The same care processes can be used for other populations, but we will need to coordinate with commercial carriers and Medicaid MCOs

14% of Medicare Patients Drive Half of Cost

Distribution of Medicare Fee-For-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2012

■ 0 to 1 condition ■ 2 to 3 conditions ■ 4 to 5 conditions ■ 6+ conditons



Two-thirds of High Hospital Utilizers Are Medicare or Dual Eligible

- ▶ High utilizers defined as patients with 3 or more admissions
(Data based on Calendar Year 2012 HSCRC Discharge Data. Includes Inpatient and ER Charges, excludes Obstetrics)
- ▶ 2/3 of high utilizers and dollars are Medicare or Dual eligible
- ▶ High Utilizers Account for 1/3 of Included Hospital Utilization

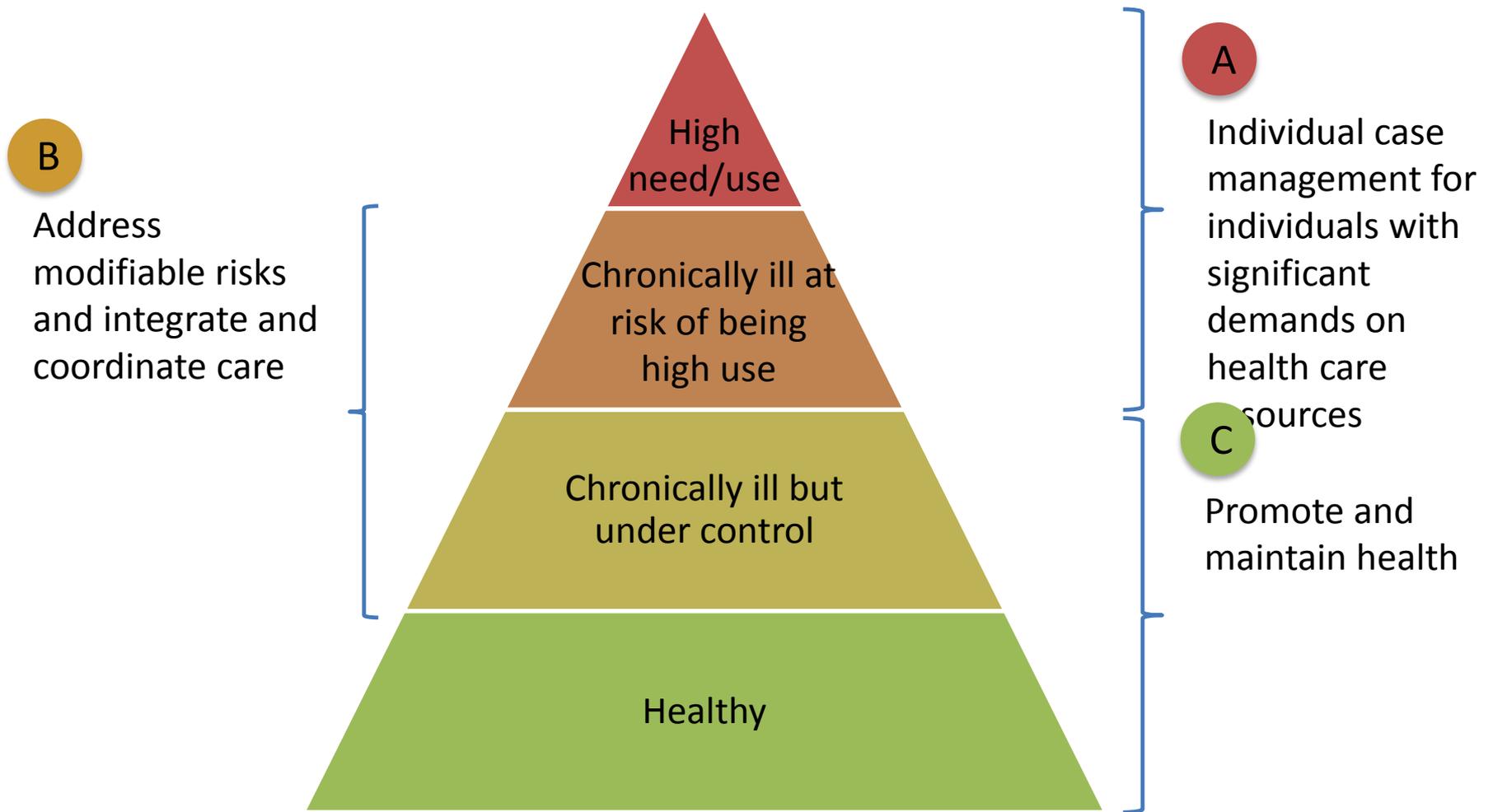
| Payer Group | # of Patients | % of Charges | Total Charges | % of Charges |
|---------------------------|---------------|--------------|------------------|--------------|
| Medicaid, Other, Self Pay | 13,731 | 34% | \$ 1,031,068,643 | 35% |
| Medicare | 20,592 | 51% | \$ 1,419,886,123 | 49% |
| Dual Eligible | 6,278 | 15% | \$ 456,370,192 | 16% |



Opportunity to Address Common Interests

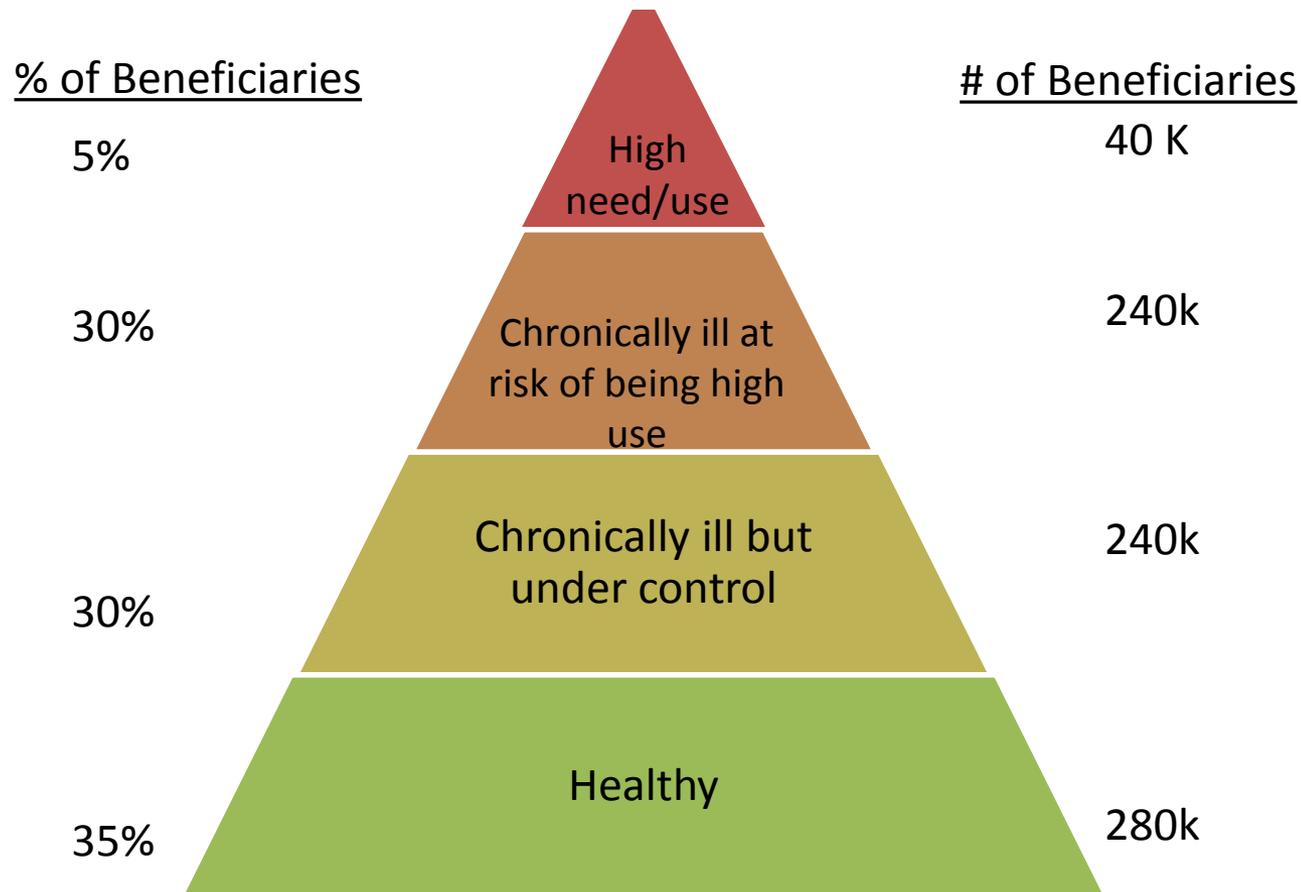
- ▶ Accountable Care Organizations, Medical Homes, and Hospitals all share a common interest in identifying patients with high needs and reducing avoidable utilization through better community based care
- ▶ Medicare has introduced a care management fee effective 1/1/15 that can be paid to physicians who provide the required services for patients with 2+ chronic conditions.
 - ▶ ~\$40 per month.
 - ▶ Financial opportunity is real—50,000 patients = \$25 million revenue opportunity.
 - ▶ NEJM estimates up to 60% of Medicare patients (there are about 800,000 beneficiaries in Maryland) may qualify for this program
- ▶ Efforts to align incentives through gain sharing and pay for performance are also needed

Vision –Target Resources Based on Patient Needs to Improve Care



Significant Efforts and Investments Needed to Scale Interventions

Rough Estimates of Scaling for Medicare in Maryland

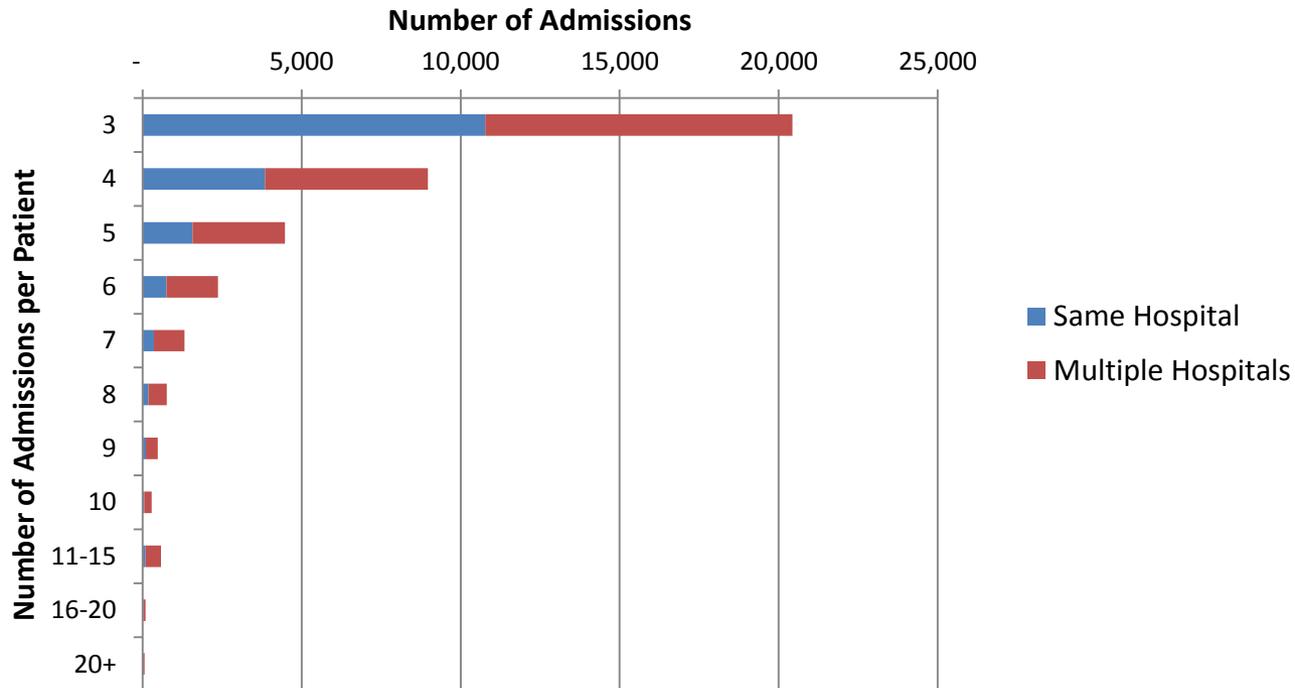


Key Strategies

- ▶ Focus on populations with the greatest opportunity to improve care and achieve return on investments in strategies – those with high need ($\cong 40K$) and chronically ill/at risk ($\cong 240K$)
 - ▶ Identify patients at high risk for poor outcomes and avoidable utilization using predictive modeling tools
 - ▶ Stratify patients to customize and focus approaches
- ▶ For selected higher risk patients (initially focused on 40k)
 - ▶ Perform assessments
 - ▶ Develop care plans
 - ▶ Provide individualized case management
 - ▶ Respond rapidly to changes in patient conditions to reduce avoidable use
- ▶ Implement approaches and interventions to reduce and modify risks and integrate care across providers and settings
- ▶ Monitor outcomes

Need for Collaboration

- ▶ High utilizers (in Maryland) with larger number of admissions are more likely to receive care at multiple hospitals
- ▶ Medicare beneficiaries (nationally) saw a median of two primary care physicians and five specialists



Opportunities to Accelerate Results

- ▶ Q: What can we do to accelerate these efforts?
 - ▶ Statewide
 - ▶ Regional
 - ▶ Local
- ▶ HSCRC and MHCC planning to initiate RFP and awards to a limited number of regional collaboratives to organize and initiate opportunities regionally

Discussion of Potential Activities for Collaboration

- ▶ What are the 3 most important activities for statewide collaboration?
- ▶ What are the 3 most important activities for regional collaboration?

Examples of Potential Activities for Statewide Collaboration for Discussion

- ▶ Medicare Data acquisition and leveraging other data sources
- ▶ Targeting and stratifying
- ▶ Patient attribution to providers
- ▶ Data sharing protocols compliant with HIPAA, data use agreements and patient preferences
- ▶ Patient engagement protocols
- ▶ Outcomes data collection and analysis
- ▶ Patient assessment standard

- ▶ Care plan tool/standard
- ▶ Learning
- ▶ Identify care gaps
- ▶ Integrating information across providers and settings
 - ▶ Collecting selected data from EMRs
 - ▶ Connecting community based providers

Examples of Potential Areas for Regional/Local Efforts for Discussion

- ▶ Care plan tool
- ▶ Call center
- ▶ Care coordinators/case managers/care teams
- ▶ Pharmacists
- ▶ Other disease management support
- ▶ Primary care supports
- ▶ Care gap analysis and work flow
- ▶ Community/faith based supports, volunteers
- ▶ Planning for needs of frail elders, assistance with activities of daily living

TO BE CONTINUED—AMBULATORY STRATEGY

- ▶ Continue with content on community based physicians, practitioners, long term care, and community supports for next meeting