Using data to reduce price and performance variation

Lessons learned from commercial and government health plans

A 3M Health Information Systems conference examined how payers and providers across the nation are navigating the new era of value-based care. Experts engaged in healthcare transformation gathered to discuss their initiatives and strategies for changing payment and care delivery models. This news brief is part of a series that shares practical information from these leaders that healthcare executives can apply to their own value-based care initiatives.

The problem of price and performance variation

Imagine if the same bag of apples cost $5 at one store but $30 at another nearby. You would expect the store with the pricier apples to clearly post the benefits of paying more. If there was no justification for the higher price, you might expect the more expensive store to alter its price to reflect the relative quality of its apples.

This scenario represents the problem of price and quality variation in health care—the costs of services vary widely among providers, with no clear justification.

Historically, payers and providers haven’t been able to master how to reduce variation. But today, this is changing. “Without normalized data, the conversation about payment variation was based on history, and appropriate steps couldn’t be taken to drive change,” says Carole Cusack, manager, Population and Payment Solutions, 3M Health Information Systems. “Now that we have the data and the tools, the conversation is changing.”

How data is changing payer-provider conversations

With data and analytics, payers and providers can base their negotiations on risk-adjusted performance metrics. “Our conversation today is based on comparing the performance of one provider group to another and seeing who is doing a better job,” says Mike Berger, vice president and chief analytics officer of Affinity Health Plan in New York. “That’s followed by answering the question, ‘What’s the secret sauce of the high performers?’ This has changed our conversations and our relationships—it’s now a two-way dialogue between payers and providers.”

The conversation between plans and physicians is also transforming. “Internally, with physicians, we’re now talking about what it means to be high performing and the appropriate incentives to reduce variation so we can truly focus on outcomes,” says Andi Gillentine, vice president of provider performance at Superior HealthPlan in
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Texas. Blue Cross® Blue Shield® (BCBS) of Kansas City engages its stakeholders in examining value-based care and the role of risk adjustment through its Blue Ribbon panel. Karen Johnson, integrated health services consultant, BCBS Kansas City, says, “We are working on syncing up the perspectives of providers, payers, employers, and the community to identify our mutual goals and targets using data. An organic community conversation has begun.” Johnson adds that one hospital CEO on the panel noted, “It’s creating win-win-win opportunities for everyone.”

Lessons learned about variation

Among the panelists, the following lessons emerged on the topics of price and performance variation.

Understand the source of variation. For the Texas Medicaid program, variation had been built into the system over time, due to the evolution of state health policy and reimbursement processes. Billy Millwee, former Texas state Medicaid director, explained how they wrung out variation. First, they established standard dollar amounts. Then, they explained variation by applying 3M™ All Patient Refined DRG (APR DRG) codes to inpatient stays and the 3M™ Enhanced Ambulatory Patient Grouping (EAPG) System to outpatient stays. “These tools gave us a level of granularity we didn’t have before and a rationale for the variation,” says Millwee.

Align incentives with performance. Once it’s understood what’s driving variation in provider performance, plans and purchasers can better align incentives. “We realized we weren’t incentivizing the right activities,” says Berger. “We began the first generation of shared savings with providers by educating them about performance. Our approach is to first use carrots, then use sticks.”

The use of 3M™ Potentially Preventable Readmissions (PPRs) and physician dashboards in Texas has allowed Superior to implement more pay for performance programs within its Medicaid program. “We can now create a health plan that produces high outcomes for members in a predictable, reproducible and economically sustainable manner,” says Gillentine.

Engage providers with data. Not only is the conversation among payers and providers changing, so is the way providers are being engaged. They’re now given new data and technology. At Superior, physicians can gauge their performance using dashboards that get down to the individual patient level. “Our question to physicians has been, ‘Is this what you expected?’” says Gillentine. “This data helps them understand why their population may be sicker. For a lot of the physicians, this is data they have never, ever seen before.”

Recognize the importance of risk adjustment. Risk adjustment accounts for patient characteristics and severity of illness, negating the traditional provider defense for variation: “My patients are sicker.” But it also teases out variation not only among providers but also within a region. Variation can exist even within specific areas of a community. According to Johnson, adjusting for this is key to engaging providers. “If we want to keep the provider satisfaction piece at the forefront of our minds, we have to adjust for that.”

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