Value-Based Reimbursement Contracting: Strategies for Payer-Provider Success

Presented by:
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Agenda

Key Considerations for Value Based Contracting

• Keys for success, its implementation, and lessons learned

Cultivating Key Capabilities

• To be among the winners, health care providers must develop or acquire key capabilities

Future Directions

• Recommended future strategies
The Payment “Tipping Point”

Percentage of payments

Time

FFS

Accountable Payment

Early Adopters
Goal of Payment Change – High Value Care

1. “Value”
   - Quality
   - Patient experience
   - Cost–effectiveness

2. Other terms for Accountable Payment Change
   - Alternative Payment Models
   - Value-Based payment
   - Population–based payments
   - Person-focused payment

3. New payment models are “necessary, but not sufficient”
# Alternative Payment Model (APM) Framework

## Category 1

**FFS– No Link to Quality & Value**

- Traditional FFS
- DRGs not linked to quality

## Category 2

**FFS– Link to Quality & Value**

- Foundational Payments for infrastructure and Operations
  - Bonus payments for quality reporting
  - DRGs with rewards for quality reporting
  - FFS with rewards for quality reporting

- Pay for Reporting
  - Bonus payments for quality performance
  - DRGs with rewards for quality performance
  - FFS with rewards for quality performance

- Rewards for Performance
  - Bonus payments and penalties for quality performance
  - DRGs with rewards and penalties for quality performance
  - FFS with rewards and penalties for quality performance

- Rewards and Penalties for Performance
  - Bundled payment
  - Episode based payments for procedure-based clinical episodes
  - Primary care PCMHs
  - Oncology COEs

- Note: Upside Only

## Category 3

**APMs built on FFS architecture**

- APMs with Upside Gainsharing
  - Bundled payment
  - Episode based payments for procedure-based clinical episodes
  - Primary care PCMHs
  - Oncology COEs

- Note: Upside Only

## Category 4

**Population-Based Payments**

- A
  - Condition Specific Population-Based Payments
    - Population-based payments for condition – specific care
    - Partial population-based payments for primary care
    - Episode-based, population payments for clinical conditions

- B
  - Comprehensive Population-Based Payments
    - Full or percent of premium population-based payment
    - Integrated, comprehensive payment and delivery system
    - Population-based payment for comprehensive pediatric or geriatric care

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**Note:**

- Category 1: No link to quality
- Category 2: Link to quality
- Category 3: APMs built on FFS architecture
- Category 4: Population-based payments
Creating a successful roadmap: How to transition to VBR without ‘betting the business’

- Attribution – understand the who, how, what, and why
- Contract volume and population size – is VBR worth the investment
- Random variation - Unjustified variation is one reason health care can fail to benefit patients
- Data analytics - Providers need to master population health and episode-based data analytics
- Measuring risk through actuarial information modeling – measure financial impact and operational risk understanding
- Utilization and financial objectives – actual experience vs projected trend
- Contract duration – examine source of data, time structure, calculation details
- Respect and trust between payer and provider
Population Health Management Framework

Building Blocks

1. Structure and Strategy
   - Organizational governance
     - Pop Health Leadership
     - Program Description
     - Accountabilities
     - Guiding principles
   - Strategy
     - Goals
     - Defining success
   - Physician Alignment
   - Staffing Model
     - Roles & ratios
     - Skill sets
     - Job descriptions
     - Recruitment portfolio
   - Culture
     - Clinical Improvement
     - Team-based

2. Process
   - Population segmentation & risk stratification
   - CM Delivery methods
     - Embedded
     - Remote
     - Hospital based

3. Technology and Population Health Analytics
   - EHR leverage
   - Informatics & Analytics
     - Performance Monitoring
     - Care Gaps
     - Program Impact
   - Care Management Platform
   - Patient Engagement
   - Tele-monitoring

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Transitioning to value-based reimbursement requires various changes in how providers operate—shifts in culture and staffing, adoption of standardized best practices, alterations in how they use data, facilitation of clinical workflow, and support of evidence-based clinical decision making.
Population Health Model 2011 - 2015

GHP Leadership

Sweet Spot

Clinical Enterprise Leadership

Health Plan
- Utilization Management
- Care Management
- Clinical Informatics
- Wellness
- Disease Management

Shared Resources
- Physician leaders
- Care Management
- Analytics team

Clinical Enterprise
- ACO
- Bundles
- Innovative models
- Transfer Center
- Care Continuum
- Primary Care based population health
New Population Health Model 2016

Health System
CEO

Clinical Enterprise Leader
Health Plan Leader

Population Health Team
- Care Coordination & Integration
- Clinical Logistics
- Value-based programs
- Care Continuum
Lessons Learned

• Focus on making progress
  – Migration to value is a journey (complete with side trips, stops/stops, backseat drivers, arguing over directions!)

• Committed and experienced leadership required

• Beware of
  – Benchmarks
  – Attribution
  – Coding/billing practices

• Take advantage of opportunities to
  – Partner
  – Focus on the patient, do the right thing
  – Innovate
Future State: Considerations for New Organizational Structure

Considerations for new organizational structures

• Does it need to be a separate department?
  Isn’t population health/value management everyone’s business?

• Overlap with existing functions
  – Health Plan
  – Quality and Safety
  – Care Management
  – Third Party Contracting
  – Finance
  – Strategy and Business Development

• Physician leadership

• Tools/IT
Bundled payment structure/strategy

Pre-bundled payment considerations –
• Evaluation
• Outreach
• Education

• Organization must evaluate its ability to operationalize bundle and conduct clinical redesign and/or robust care management

Opportunity Analyses & Strategy
• Baseline
• Partners

• Understanding historic costs—payer and provider
• Evaluating, selecting and defining episodes of interest
• Identifying partners, risk arrangements and contract models

Program Implementation Plan –
• Standard analytics
• Bundled payment clinical redesign

• Payer & provider standard data analytics/reporting
• Episode target price setting
• Care Delivery Redesign - current and future state
• Care Mgmt workflow and training

Delivery Support Services Plan
• Bundled payment analytics
• Ongoing care redesign optimization

• Estimating future costs and revenue
• Developing a bundled episode budget
• Ongoing data analytics updates, trending and performance monitoring services
• Episode workflow optimization

Bundled payment go live –
• Maintenance
• Scaling and Enhancement

• Monitoring and adjusting performance
• Administering bundles
• Reconciling financial performance
• Expand volume of episodes
How does the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform Medicare payment?

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes include:

1) Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers’ services.
2) Making a new framework for rewarding health care providers for giving better care not more just more care.
3) Combining our existing quality reporting programs into one new system.
Questions?

Thank You!

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