

# Healthcare Financial Management Association Lone Star Chapter

Value-Based Payment Methodologies

Innovative Provider/Payor Arrangements That Drive Change

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## Agenda

- I. Introduction
- II. CMS Program Opportunities
- III. Scalable Payment Models and Implications
- IV. Recent Case Studies
- V. Discussion



*The Winds of Change...*



## I. Introduction

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### Key Discussion Questions for Today

- Given the time and investment required to evaluate new reimbursement methodologies and payor contracts, are organizations focusing on Medicare strategy, commercial payor strategy, or both simultaneously?
- Is it more advantageous to be proactive or reactive relative to payor strategy?
  - *Proactive Approach* – Health system is out in front of the payors to advance reimbursement methodologies for programs that the organization thinks it can deliver on.
  - *Reactive Approach* – Health system focuses on maximizing the current reimbursement environment but is preparing for a change in the future.
- How much change can occur without a burning platform?
- What innovative, value-based approaches are organizations contemplating?
  - Are organizations considering going to (or going back to) full global risk?
- How do health systems manage situations where the provider is taking on some risk but does not have control over patient choice in PPO-like products?

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## II. CMS Program Opportunities

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### What Medicare Reimbursement Plan Are You On?

*CMS and the Center for Medicare and Medicaid Innovation (CMMI, also known as "The Innovation Center") are inundating providers with program launches and pilot initiatives; the evaluation and participation requirements of these programs are onerous and complex.*

- Medicare Shared Savings Program (MSSP).
- Pioneer ACO.
- Bundled Payments for Care Improvement initiative.
- Comprehensive Primary Care (CPC) Initiative.
- Hospital Value-Based Purchasing (VBP).
- Other CMMI opportunities.
- Health insurance exchanges.



***Don't forget about Medicare Advantage (MA)!***

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## CMS/CMMI Will Offer Different Major Payment Initiatives in 2012

*While most programs are currently optional, the intent is for Medicare to find a program(s) that works and implement it as the primary reimbursement mechanism for all providers in the future.*

	Applies To	Participation Mandate	Exclusivity	Start Date
MSSP	All Medicare payments for attributed patients.	Optional	Exclusive	April 2012 or July 2012
Pioneer ACO	All Medicare payments for attributed patients.	Optional	Exclusive	January 2012
Bundled Payment	Specific components of pay (varies by program choice).	Optional	Nonexclusive	Rolling Basis in 2012
Comprehensive Primary Care	Attributed primary care patients.	Optional	Exclusive	2012 – To Be Determined
Independence at Home Demonstration	Chronically ill Medicare beneficiaries receiving care at home.	Optional	Exclusive	Likely in Spring of 2012
VBP	Hospital DRG payments.	Mandatory	N/A	October 2012

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## Shared Savings Payment Approaches – There’s No Additional Money!

*Facing criticism from well-integrated systems, CMS scrambled to create a Pioneer ACO that offered risk payments in Year 3.*

	MSSP		Pioneer ACO		
	One-Sided	Two-Sided	Core	Option A	Option B
<b>Year 1</b>					
Shared Savings <sup>1</sup>	50%	60%	60%	50%	70%
Risk Corridor <sup>2</sup>	0%	5%	+/-10%	+/-5%	+/-15%
<b>Year 2</b>					
Shared Savings <sup>1</sup>	50%	60%	70%	60%	75%
Risk Corridor <sup>2</sup>	0%	7.5%	+/-15%	+/-10%	+/-15%
<b>Year 3</b>					
Reimbursement	Shared Savings	Shared Savings	50% PMPM, 50% Fee-for-Service (FFS) Payment	50% PMPM, 50% FFS Payment	50% PMPM, 50% FFS Payment
Shared Savings <sup>1</sup>	50%	60%	70%	70%	75%
Risk Corridor <sup>2</sup>	10%	10%	+/-15%	+/-15%	+/-15%

<sup>1</sup> Shared savings assume 100% performance on quality indicators.

<sup>2</sup> Represents percentage of expenditure target that participant is at risk for or can maximally earn.

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## The Bundled Payment Initiative Offers Providers the Ability to Test Bundling for Specific Episodes

*CMS's Bundled Payments for Care Improvement initiative affords providers the flexibility and choice in selecting conditions to bundle, developing the delivery structure, and determining payment allocation and flow.*

Model 1: Inpatient Stay Only (Hospital Services Only)	Model 2: Inpatient Stay + Post-Discharge Services	Model 3: Post-Discharge Services Only	Model 4: Inpatient Stay Only (Hospital and Physician Services + Readmissions)
<ul style="list-style-type: none"> <li>Includes inpatient hospital services only.</li> <li>The hospital is paid a discounted IPPS payment, and the physicians are still paid FFS.</li> <li>Targeted at all MS-DRGs.</li> </ul>	<ul style="list-style-type: none"> <li>Includes inpatient hospital and physician services, related post-acute care services, and related admissions.</li> <li>Applicants will propose specific MS-DRGs.</li> <li>Medicare will provide historical claims data.</li> <li>This is a model that ECG Management Consultants, Inc., has seen work well for orthopedics.</li> </ul>	<ul style="list-style-type: none"> <li>Includes post-acute care services and related readmissions.</li> <li>Applicants will propose specific MS-DRGs.</li> <li>Medicare will provide historical claims data.</li> <li>Misaligned with standard objectives for creating bundled program.</li> <li>For example, if half of the surgeons believe in rehab after surgery and the other half do not, this model could drive standardization around select clinical care paths and protocols.</li> </ul>	<ul style="list-style-type: none"> <li>Includes inpatient hospital and physician services and related readmissions.</li> <li>Applicants will propose specific MS-DRGs.</li> <li>Medicare will provide historical claims data.</li> <li>Varies from Model 2 in that related post-acute care services are not included in the bundle.</li> <li>Limited appeal for physicians, as they believe that there is opportunity for improvement (in both savings and quality) in the post-discharge care delivery.</li> </ul>

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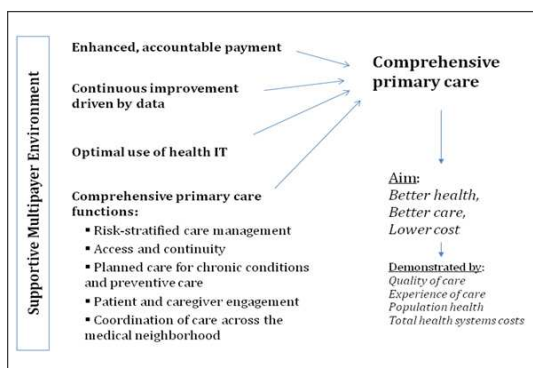
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## The CPC Initiative Focuses on Traditional Medical Home Concepts, With a Multi-Payor Approach

- Soliciting public and private healthcare payors, including Medicaid and states, to apply for a joint payor collaborative:
  - Payors in five to seven markets will be sought for collaboration.
  - Once payors and markets have been selected, CMS will solicit primary care practices in the selected markets – up to 75 practices in each market, targeted at 330,000 beneficiaries.
- Building on the medical home concept, holds practices accountable for the total cost of care.

### Framework for CPC Initiative



Source: CMS and CMMI, Solicitation for the CPC Initiative.

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## The CPC Payment Approach Combines a Primary Care Coordination Fee With Shared Savings

- CMS will make enhanced payments to these primary care practices.
  - Practices will be free to use the payments as they choose, provided they use them to invest in specific coordinated care functions.
  - Payment will average \$20 PBPM in Years 1 and 2 but will range from \$8 to \$40 based on 3 years of prior claims data and HCC scores.
  - Payment will decrease to an average of \$15 PBPM in Years 3 and 4.
  - Payors must commit to enter into similar compensation contracts with the selected providers.
- In Years 2 through 4, CMS will also share in any savings generated by the practice – calculated at the market level and not the individual practice level.
- Prospective attribution and data sharing is a prerequisite for all payors that participate.

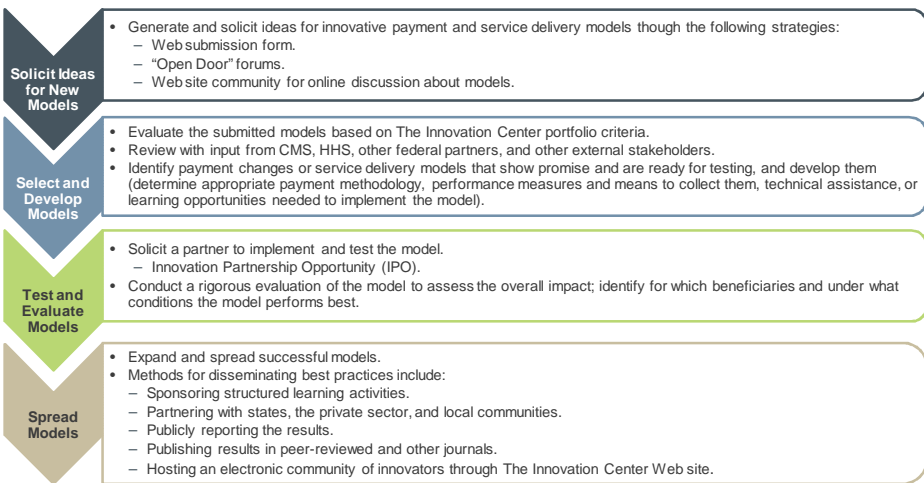
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## Other Funds and Opportunities Exist Within CMMI

*The four-step process of innovation (from idea to widespread model implementation) is designed to be transparent and competitive, yet collaborative.*



Source: <http://innovations.cms.gov>.

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### III. Scalable Payment Models and Implications

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### What Are the Recent Trends in Collaborative Care?

*Without risk, there can be no reward.*



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## Providers and Payors Are Facing Different Challenges

*How are providers and insurers responding to reform?*

As Providers See It

- Continued downward pressure on reimbursement from all payors.
- Reduced inpatient and outpatient volumes.
- Short term: increasing uncompensated care replaced by move to exchanges.
- Expense and uncertainty related to implementing ICD-10.
- Concerns about managing conflicting payment mechanisms (e.g., risk and FFS).

As Health Insurers See It

- Short-term improved utilization, as some care is deferred.
- Decreasing enrollment.
- Transition of commercial enrollees to exchanges.
- Regulatory pressures on premiums and medical loss ratio.
- Decreasing MA and Medicaid premiums.

What is your organization doing to prepare for the future?

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## Are There Opportunities When Providers and Payors Collaborate?

*The economic reality of healthcare reform has caused enormous changes in the health insurance industry; plans will need to differentiate themselves through the creation of new and innovative products.*

We are seeing more interest and openness from health plans to share data; however, the process of obtaining the claims-level data is still not easy.

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## Recent Examples Example Arrangements

### Value-Based Contracts

Provider	Key Focus
Health System – Hawaii	Negotiated a value-based agreement with a major health plan.
Multispecialty Medical Group – Missouri	Developed a risk arrangement for an MA product.
Health System – Missouri	Developed and negotiated a bundled payment arrangement for orthopedics with a major health plan.
Multispecialty Medical Group – Michigan	Reached agreement with select MA plans to collaborate on the development of patient-centered medical homes (PCMHs) supported by value-based agreements.

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## Recent Examples Example Arrangements *(continued)*

### Clinical Integration/Accountable Care Initiatives

Client	Key Focus
Health System – California	Developing its ACO and value-based care delivery goals.
Hospital and Medical Group – California	Collaborating with the largest commercial managed care payors to create innovative payment approaches.
Health System and Medical Group – Missouri	Aligning the system's facilities, payors, and physicians to support a value-based philosophy. Developing value-based payment models.
Health System – Indiana	Defining an accountable care strategy.
Health Plan – Michigan	Identified and now executing the high-priority initiatives to collaborate with providers.
Hospital and Medical Group – Michigan	Evaluating strategic options for care transformation through the development of an integrated delivery model.
Health System – Northwest	Planning for a joint venture, risk-based ACO focused on a primary care medical home concept.

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## What Are the Common Characteristics of Collaborative Care?

*New accountable care initiatives share several overarching characteristics.*

- Recognize and align the interests of facilities, physicians, and health plans.
- Use a data-driven method to identify opportunities for improvement.
- Seek a collaborative approach to improving the efficiency and quality of delivering healthcare services.
- Consider the market realities in each specific geography.
- Aim to develop a patient-centered approach.
- Understand the importance of managing the transitions across the care spectrum.
- Focus IT infrastructure to share clinical data across the continuum of care.
- Select visionary physician leadership to champion the cause.

*What other principles are critical to your organization?*

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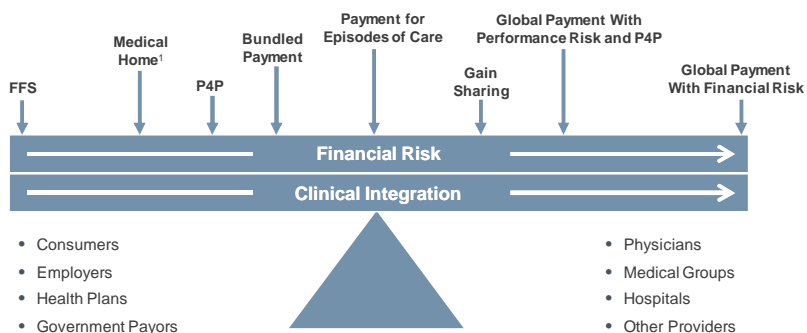
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## Value-Based Reimbursement Methodologies

*Payment methodologies are shifting risk from payors to providers and away from volume-based FFS payments to a value-based system.*

The Risk Continuum Associated With Existing and Proposed Reimbursement Structures



<sup>1</sup> Medical homes that receive extra dollars for patient management.  
Source: Healthcare Financial Management Association, "Accountable Care: The Journey Begins," August 2010.

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## Value-Based Reimbursement Methodologies *(continued)*

**More risk-based models hold providers accountable for the total health of members, from preventive to acute care.**

	P4P	PCMH	Bundled Payments	Full and Partial Risk (From Shared Savings to Full Risk)
Advantages	<ul style="list-style-type: none"> <li>• Simplicity and clarity.</li> <li>• Focused approach produces results on select measures.</li> <li>• Current models tie increased dollars to performance measures.</li> </ul>	<ul style="list-style-type: none"> <li>• Focused management of high-risk populations.</li> <li>• Patient satisfaction.</li> <li>• Facilitates integration across the care continuum.</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive, outcomes-based approach.</li> <li>• Pilots (commercial and Medicare) focus on high-cost surgical services in closely aligned physician/hospital specialties (cardiac surgery, orthopedics).</li> </ul>	<ul style="list-style-type: none"> <li>• Aligned incentives.</li> <li>• Major upside opportunity.</li> <li>• Facilities integration across the care continuum.</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>• Historically, limited dollars have been tied to outcomes.</li> <li>• Focused approach limits comprehensive overhaul.</li> </ul>	<ul style="list-style-type: none"> <li>• Major infrastructure investments.</li> <li>• Requires cross-practice coordination and cultural transformation.</li> <li>• Complicates physician compensation in the multispecialty group setting.</li> <li>• Medical cost results are still under study.</li> </ul>	<ul style="list-style-type: none"> <li>• Complexity.</li> <li>• Usually pays FFS with a manual shared savings reconciliation process.</li> <li>• Need to improve outcomes- and cost-reporting capabilities.</li> <li>• Focused approach limits comprehensive overhaul.</li> </ul>	<ul style="list-style-type: none"> <li>• Complexity.</li> <li>• Requires integration to be truly successful.</li> <li>• Infrastructure requirements.</li> <li>• Care management sophistication and focus.</li> <li>• Major downside risk.</li> </ul>

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## Collaborative Approaches Require Innovative Payment Mechanisms

**PCP-led PCMHs reward high-quality and efficient care, but they require significant front-end investment and fundamental changes to clinical processes.**

Initially, programs have targeted high-risk populations such as:

- Overutilized emergency rooms (ERs).
- Aging population.
- High-risk pregnancies.

Examples include:

- Group Health:
  - Studied 9,200 patients assigned to a medical home and experienced significant improvement in ER utilization, overall decline in inpatient stays, and in general, favorable health outcomes.
- Better birth outcome initiatives in Ohio, North Carolina, and Tennessee:
  - Focused on better prenatal care, as well as more follow-up and education for patients to improve metrics such as birth weights and premature delivery, decreasing NICU days.
  - Increases in normal birth reimbursements.
- A 200-plus multispecialty physician group developed a medical home for its largest MA plans:
  - Each physician agreed on an enhanced FFS rate structure, capital for infrastructure improvements, quality and efficiency metrics, and PMPM fees.
  - A risk pool was created because of reductions in utilization and increased risk-adjusted premiums.

**Costly infrastructure changes can be a deterrent unless providers are fully engaged and health plans are able to support the initiatives.**

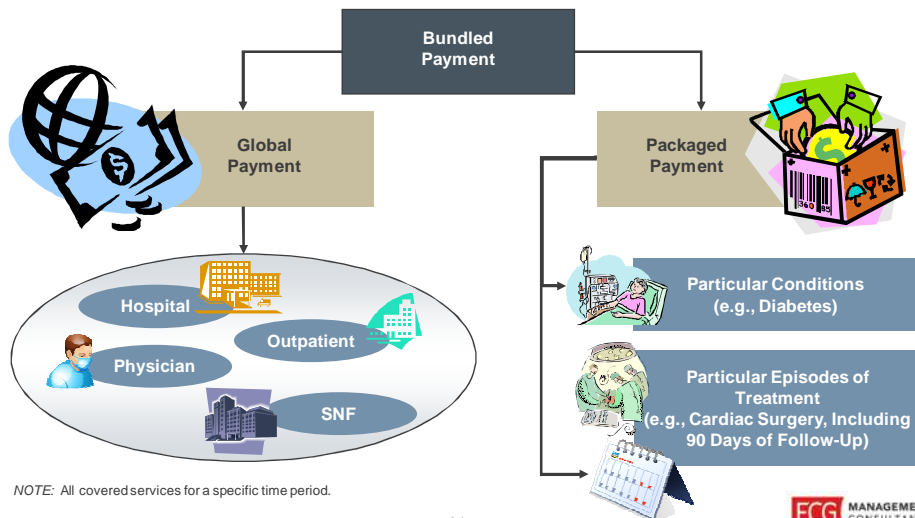
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## Collaborative Approaches Require Innovative Payment Mechanisms *(continued)*

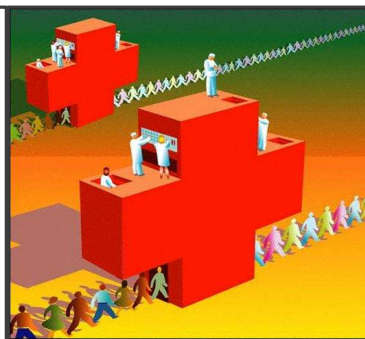
*Bundled payments, either global (multiple providers) or packaged (episodic disease treatments), encompass an all-inclusive continuum of care.*



## Self-Funded Plans Offer Employers the Opportunity to Enter Into Population Health Management

*Collaborative performance-based arrangements between TPAs and providers offer opportunities for employers to reduce the cost of caring for their employees.*

According to a survey by The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, 80% of covered employees in firms with 1,000 to 4,999 employees and 93% of covered employees in firms with 5,000 or more employees are in self-funded plans.



Source: The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2010 Annual Survey*.

**Some health systems are using their self-insured plans as a “testing ground” for population-based healthcare.**

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## IV. Recent Case Studies

*Payors and providers are learning to collaborate under alternative value-based arrangements.*

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### Innovative Approaches Were Contemplated to Prepare for Reform


*Payors and providers are learning to collaborate under alternative value-based arrangements.*

**Case Studies**

1. Blue Cross Blue Shield of Massachusetts (BCBSMA) Alternative Quality Contract (AQC).
2. MA PCMH.
3. Multiple Hospital and Region P4P.

*These examples illustrate how providers and payors have been taking transitional steps to create innovative, value-driven approaches.*

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## Case Study #1 BCBSMA Model – Global Payment Plus Risk and P4P

*Massachusetts launched the AQC in January 2009, which combines a per patient global budget rate with quality performance incentives of up to 10% more.*

### Five Key Cornerstones of the Model

1. **Global Budget + P4P** – Fixed payment using baseline historical costs per member **plus** variable quality payment based on nationally accepted measures.
2. **Performance Measures** – Focus on safe, timely, effective, and patient-centered care. Includes 32 ambulatory measures, 32 hospital measures, and 16 unexplained practice variations.
3. **Sustained Partnership** – A 5-year contract term between BCBSMA and providers (PCPs, specialists, hospitals).
4. **Clinical Integration** – PCP-led continuum of care.
5. **Savings** – Reduce duplicative services, use more cost-effective options, and eliminate preventable costs like readmissions.

### Improvements Compared to Prior “Capitation”

- AQC is appropriately funded, since the global rate is based on historical patient care, is severity-adjusted, and should not disincentivize physicians from providing care.
- Pairing the global payment with quality metrics holds providers accountable for delivery and outcomes.
- The annual severity adjustment ensures physicians do not avoid sick patients.
- This includes a range of risk-sharing and stop-loss provisions.
- The model applies an annual inflation factor of CPI to the global budget.

*Upside risk (potential savings) equals downside risk (potential losses) is the program's goal to incentivize providers to eliminate waste.*

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## Case Study #2: MA PCMH

*A PCMH infrastructure supported a P4P MA strategy.*

- 200-plus-physician multispecialty group.
- Developed a PCMH strategy with the four largest MA plans.
- Each agreement shared common methodologies:
  - Enhanced FFS.
  - Grants or investments for infrastructure.
  - Quality and/or efficiency measures.
  - PMPM medical management fee.
- Funding was based on shared savings from anticipated reductions in utilization and increased premiums due to appropriate risk adjustments from accurate hierarchical condition coding.
- While the details differed between plans, the incentives were consistent and in line with the group's infrastructure and philosophy.

*Joint marketing was an important component of this approach.*

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## Case Study #3: Commercial BCBS Plan Works With a Multiple-Hospital System Across Several Regions on P4P

*This health-plan-mandated P4P program encourages a collaborative approach.*

### Quality- and Efficiency-Based P4P

- Hospital payments include a variety of mechanisms to reward performance, with a goal of improving cost and quality while providing a mechanism to support the transition.
- Incentives and compensation support:
  - A lengthy transition period to negotiate and implement mutually agreeable quality and efficiency metrics.
  - Phased reduction in incentive “floor,” with increasing upside potential.
  - Investment dollars available to develop systems and infrastructure to support the arrangement.
  - Inpatient outlier protection aligns incentives between the hospital and health plan to reduce the length of stay for DRG-based cases.
- The program includes annual increases to protect against inflation.
- The health plan insisted on the use of a neutral third-party vendor to measure quality and efficiency metrics.

*The hospitals saw this as an opportunity to change their culture and prepare for future VBP.*

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## V. Discussion

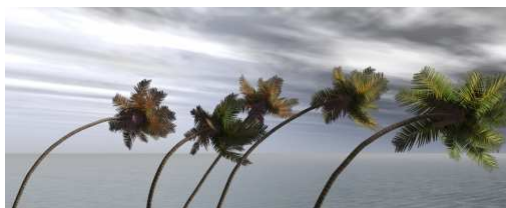
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## How Are You Navigating the Storm of Change?

- Given the time and investment required to evaluate new reimbursement methodologies and payor contracts, are organizations focusing on Medicare strategy, commercial payor strategy, or both simultaneously?
- Is it more advantageous to be proactive or reactive relative to payor strategy?
  - *Proactive Approach* – Health system is out in front of the payors to advance reimbursement methodologies for programs that the organization thinks it can deliver on.
  - *Reactive Approach* – Health system focuses on maximizing the current reimbursement environment but is preparing for a change in the future.
- Do you need to create a burning platform?
- What innovative, value-based approaches are organizations contemplating?
- Are organizations considering going to (or going back to) full global risk?
- How do health systems manage situations where the provider is taking on some risk but does not have control over patient choice in PPO-like products?



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## Questions and Answers



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