How Payer Contracts Are Evolving in the Era of Big Data and Value-Based Payments

PCC User's Conference

July 21, 2017

Perspectives

Perspectives: Payer

- Moving away from fee-for-service models and paying for ‘value’ and ‘outcomes’
- Increasing pressure from employers to provide value and quality-based programs and networks
- Development of ‘value based’ contracts that include pay for performance (P4P), meeting targets to ‘earn’ incentives, per member per month (PMPM) stipends for coordinating care
- Rapidly moving toward no-pay-for-poor-performance (e.g. CMS ‘value modifier’)
- Access to certain consumers / patients based on performance, in the form of tiered networks (e.g. United Healthcare’s Tier 1 program)

Perspectives: Employer

- Moving away from premium-based insurance to ‘self-funded’ programs
- Self-funded insurance presents risk (all claims need to be paid by employer) and opportunity (driving benefit design and coverage)
- Seeking ‘direct care’ opportunities with primary care and specialist care (e.g. the Whole Foods contract with CTPCA) to lower costs and / or improve care and access for employees

Perspectives: Patient / Consumer

- Substantial ‘cost sharing’ in the form of co-insurance, deductibles and large co-payments driving decisions about access, utilization and provider selection
- Desire for convenient, efficient care and plenty of competition to serve them (retail based clinics, urgent care centers)
- Expectations for service, use of technology, ‘on demand’ interactions, social communications
- Involvement of Payer / Employer in chronic care

Perspectives: Yours!

Challenges to Independence

- Solo and small practices may not have the resources or technology to restructure operations to respond to new payment system incentives, medical home demands, expectations
- More practices merging and / or joining physician associations and organizations (ACOs, IPAs, PHOs, etc)
- Increase in physician employment at hospitals, fewer small private practices
- More complexity with insurers, many plan designs
- More complexity with regulations and government programs

The Move to Value-Based Contracts, Enabled by Big Data

Move to Value-Based Contracts

Value-based contracts are based on

- Pay-for-performance (P4P) Measures

  Typically tied to meeting certain metrics such as HEDIS rates, controlling non-par utilization and limiting brand name drug prescribing

- Pay-for-Value Structures

  Such as Clinically Integrated Networks (CINs), Patient-Centered Medical Home (PCMHs) and Accountable Care Organization (ACOs) organizations

  Typically involving ‘wrap around’ incentives such as the above and attribution per-member per-month

- **Fee-for-service (FFS) payments are being phased out and are being replaced by value-based payments**
- **Payers ‘tiering’ providers by performance**

Pay For Performance

Performance may be based simply on meeting HEDIS "quality" measures, or on "self-reported" measures, claims costs, patient utilization and so on

The National Quality Forum (NQF) is leading focused efforts to collect and normalize data, and endorse additional performance measures to be more clinically focused

- But we aren't there yet. Pediatrics is the least of Payers' concerns – they are more focused on the 'big ticket' diseases to help bring down costs.

Types of Value Based Models

It's all about value and achieving the Triple Aim of delivering payment to providers that are improving health and producing quality outcomes, resulting in a satisfied patient at a reasonable cost over time.

Commercial Payer VBP models include

- Shared Savings/Gain Sharing
- Narrow Networks
- Patient-Centered Medical Home (for primary & pediatric care)
- Accountable Care
- Bundled Episodes of Care

Moving in synch with CMS and HHS

Types of Value Based Models: Shared Saving

Shared Savings/Gain Sharing

- Currently exists mainly as Pay-For-Performance (P4P)
- Contracts are designed where a portion of the savings is returned to the practice or organization
- Hospitals / Physician Organizations share savings with physicians who implement certain cost-saving measures
- P4P Programs roll out across networks to practices of all sizes

➢ Bonuses typically between 1%-6% of FFS payments, or more if more risk is taken on

➢ Expect to see move to NP4PP (no-pay-for-poor-performance) as quality of care improves within networks

Types of Value Based Models: Narrow Networks

Narrow Networks & HIX

'Tiered' networks at the heart of the Healthcare Insurance Exchange Plans (HIX) but have gained popularity in other areas

- Only less expensive practices 'chosen' for narrow networks
- Determination of who makes the cut factors in rates, referral patterns and hospital relationships
- For HIX, lower payment for physicians in return for the benefit of 'access'

➢ Potential for Payers to drop 'poor-performing' providers from their networks; idea is to pay only for high-quality, low-cost care (UHC Medicare Advantage 'cull' a case in point)

Beware Value-Based Profiling & Tiering

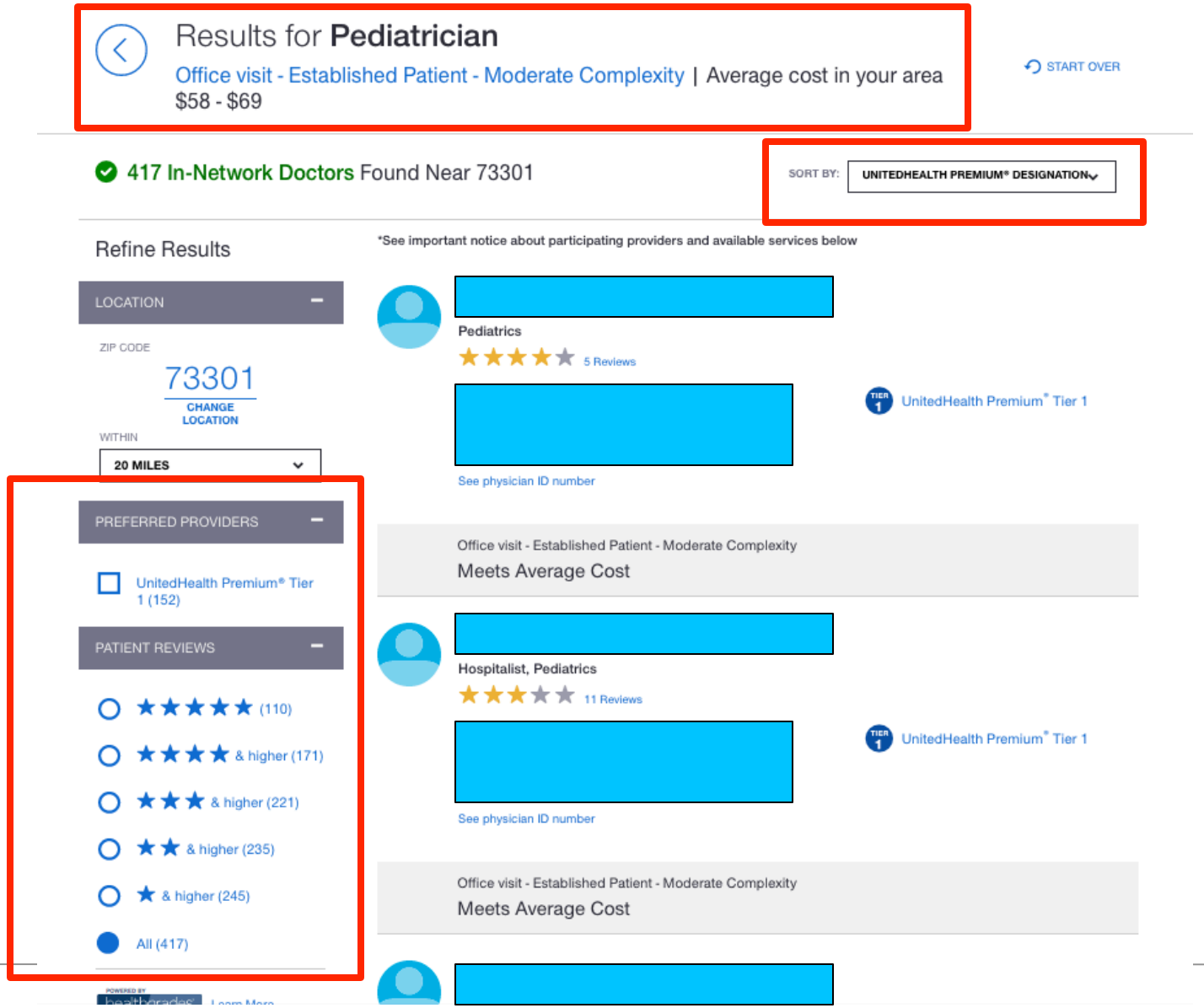
Physician ‘Profiling’

- Big data allows more visibility into payments and utilization
- Penalizes patients for selecting ‘high cost’ physicians and hospitals by imposing higher out-of-pocket costs for co-pays and co-insurance
- Performance measurement programs based on claims data primarily

➢ Patient cost share and physician payment rates are set according to tiering; higher copays for receiving care from providers with lower ‘grades’;

➢ Less pay for those providers who don’t make the grade may be coming next

Example: Physician Profiling United Healthcare



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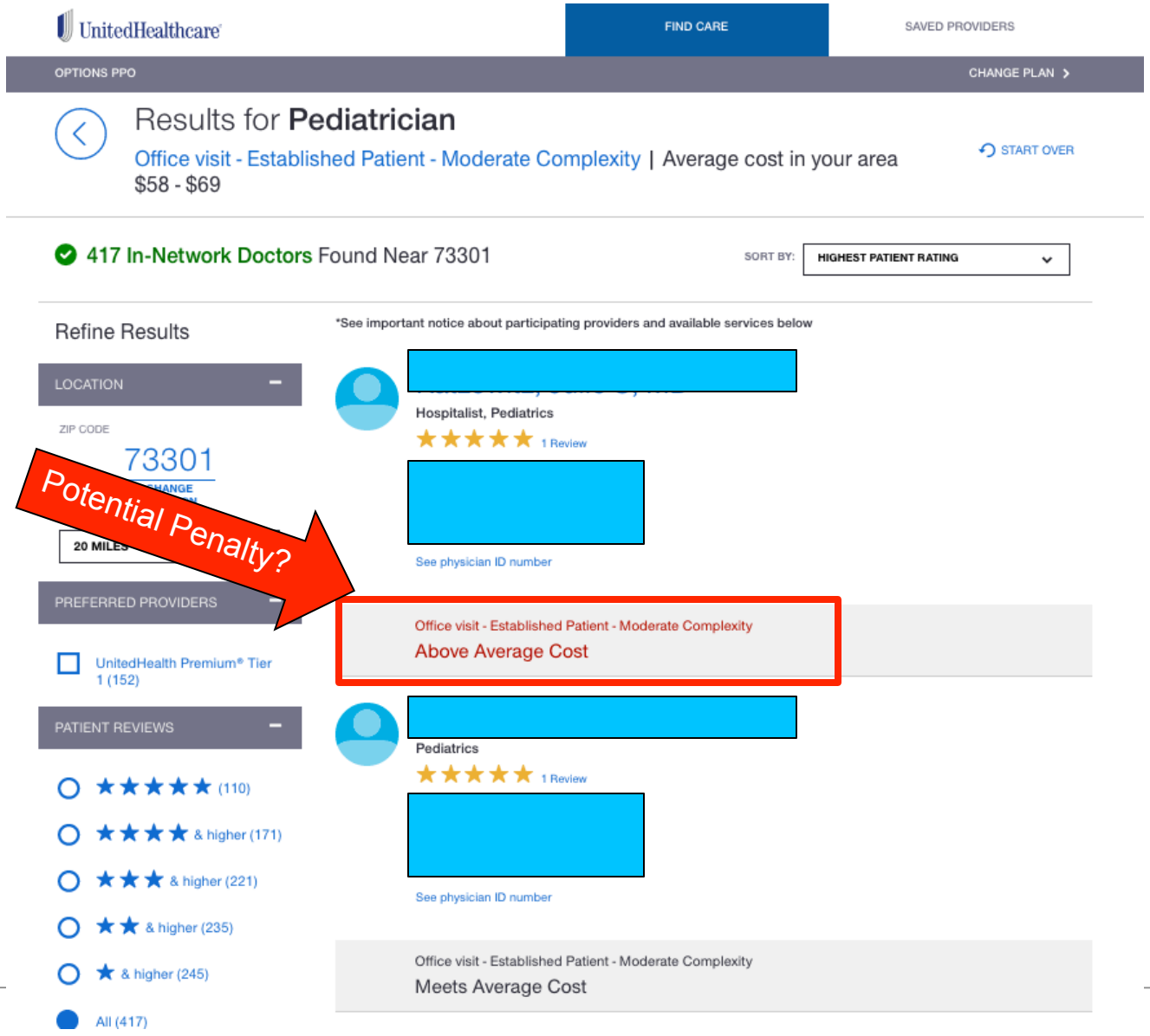
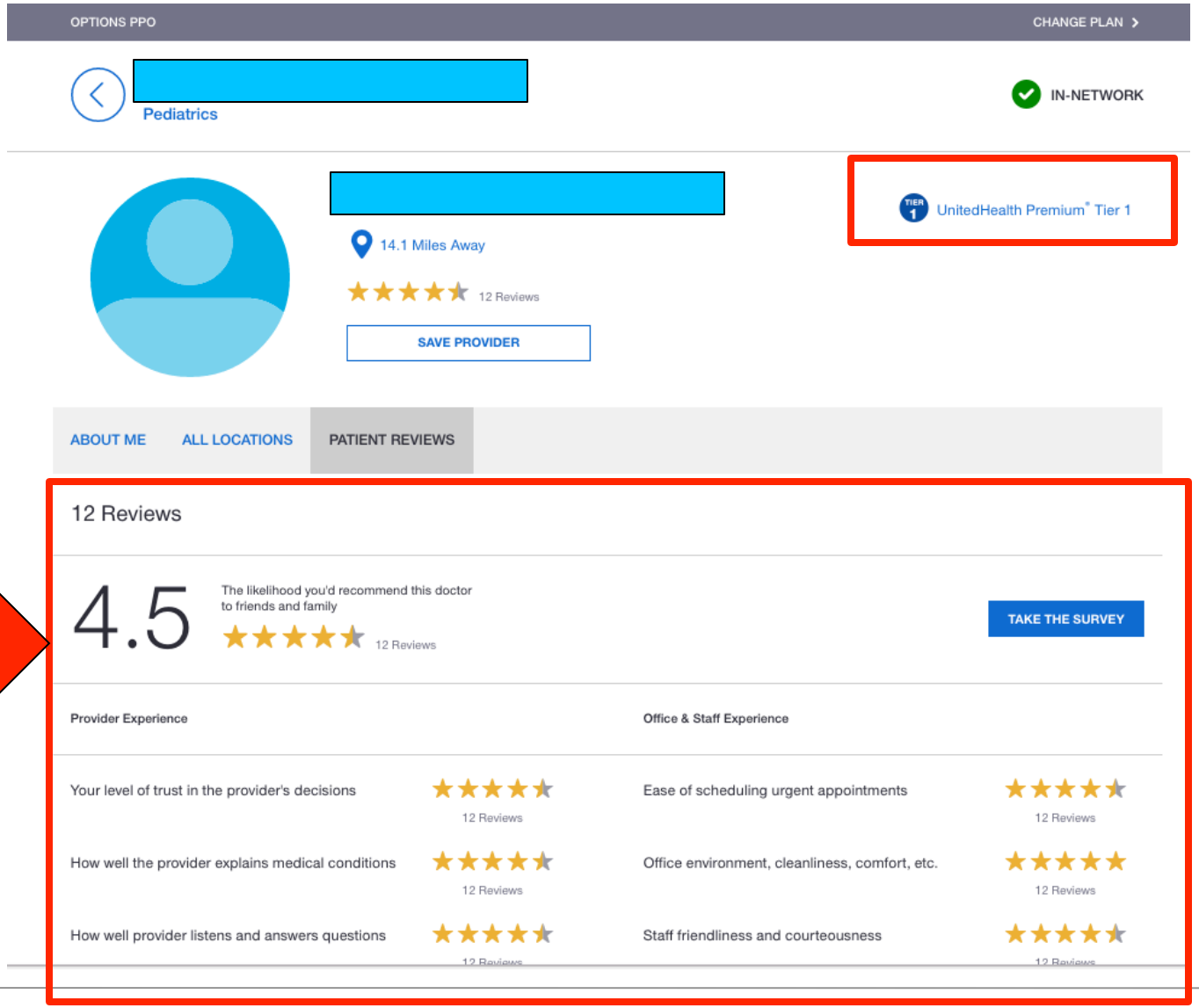


Example: Physician Profiling

Incorporation of patient preference



Examples of Profiles for Consumers

Several insurers offer their members information on costs, clinical quality and physician efficiency:

- Blue Cross and Blue Shield Plans: Blue Health Intelligence (BHI) shares health information with employers, consumers and providers.
- Humana: Has a 'Compare' tool online that shows comparison information for how often doctors adhered to specific treatment standards.
- Aetna: Provides clinical quality and efficiency information to members
- UnitedHealthcare: now embedded right into the physician profile as shown in previous example
- CIGNA: Has average cost data by facility for select procedures and service

How To Maintain A High ‘Score’

- Check your profile in the Payers directories to see how you rate
- If you have a score that is less than perfect, contact the insurance company and find out why
- Ask them to send you the underlying data supporting your score, review it, and contest the data if they are incorrect, by showing them your patient records. We have seen pediatricians get ‘dinged’ for lack of a mammography when clearly that is not a patient that should have been attributed to that physicians panel
- If you receive a packet in the mail, which you should annually, open it and review it. Contest any data that is incorrect. Payers usually give you 30 days to review and contest before they lock in the score . . .

Working With New Contract Models

Understanding the New Contracts

Understand what is being offered and how these programs work.

- Is it all upside or are there risks associated? (e.g. withheld payments)
- Are you able to effectively calculate your potential ‘bonus’?
- Do you have the ability to meet the requirements of these programs (through IT capability, provider buy-in, etc.)
- Can you effectively measure where you stand today and if targets for improvement are likely to be met within the measurement period?

Assess it from the Payer Perspective

- Do they need you in their network?
- Are you doing anything smarter, better, more efficient than your competitors?
- Are you adding other specialties or resources that allow for more comprehensive care?
- Are you consumer-focused?
- Do you have value-added programs?
- Does your data support your position? *Focus on what you have that is worth paying more for*

Know Your Value

- Increases are financed through cost savings
  - Do you have low patient ER rates?
  - Do you refer to cost-effective specialists?
  - Do you manage care based on evidence-based criteria?
- Are you currently participating in any P4P programs?
  - Often participating in one helps to encourage another Payer to offer you the same
- Is there an opportunity to help create and ‘pilot’ new programs?
  - Payers need partners for their programs

Prepare for Change

What To Do To Prepare

Assess the capabilities of your current information systems abilities to track and report the information that will be required to meet new contract terms

- Can you understand the needs of your patient population?
- Are you able to e-prescribe?
- Can you extract data from your patient records to demonstrate performance?
- Will you need to invest to fill gaps?

What To Do To Prepare

Assess the capabilities of your staff and resources to deliver care under new models

- Do you have a method for creating and implementing protocols?
- Can care be effectively coordinated by your team?
- What communication processes are currently in place with your patients? Do you have follow up procedures in place?
- Will your current resources be able to adjust their skills to meet new opportunities?

What To Do To Prepare

Assess whether the quality programs being offered by your largest plans are likely to create revenue opportunities commensurate with the effort required

- Evaluate which offerings can benefit you today
- Start preparations for mandatory changes coming tomorrow

New contracting initiatives will require physician behavior modification

- Determine how willing your physicians are to embrace change and begin planning for it now

Best Bets

- Join a larger group or organization
  - Join an IPA, ACO, Super-group or other organized entity that may offer enhanced rates in return for compliance in producing quality care
- Become a Medical Home
  - Recognition will be key to taking advantage of incentive bonuses / preserving payment rates
- Start developing clinical quality, patient education and preventive / counseling programs now

Q & A

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