HFMA OK-TX Lone Star Chapter Conference

Value-Based Payments: Assessing Readiness to Develop a Payor Contracting Strategy

September 24, 2015
I. Introduction and Objectives
II. Market Evolution Overview
III. Value-Based Readiness (VBR)
IV. Case Study
I. Introduction and Objectives

Speakers: ECG

Ken Steele
Senior Manager

Ken is a member of ECG’s Contracting and Reimbursement practice who works in ECG’s San Francisco office. He has extensive experience in managed care, including contract review, analysis, and negotiations. Additionally, Ken has a comprehensive background in hospital operations, having held multiple hospital leadership positions, including Chief Executive Officer, and successfully managing a hospital’s financial and strategic turnaround in a large, competitive market.

Jim Ryan
Senior Consultant

Based in ECG’s Dallas office, Jim works in ECG’s Contracting and Reimbursement practice. He helps hospitals and other providers improve their reimbursement from commercial payors under both traditional and innovative payment arrangements. In addition, he analyzes markets to help clients receive payments commensurate with their market positions, identifies the financial opportunities in risk-bearing contracts, and participates in strategy development for organizations seeking clinical and financial alignment.
I. Introduction and Objectives

About ECG

ECG is a national consulting firm focused on offering strategic, management, and financial advice exclusively to healthcare providers.

- We have approximately 170 consultants operating out of offices in Boston, Chicago, Dallas, San Diego, San Francisco, Seattle, St. Louis, and Washington, D.C.
- Our clients are the nation’s leading adult and pediatric hospitals, health systems, academic medical centers, and group practices.

We are particularly known as experts in strategic and business planning, hospital/physician relationships, physician compensation, operations improvement, and practice management.

We take great care to provide workable, realistic solutions and are adept at balancing the needs of numerous internal interests.
I. Introduction and Objectives
Speakers: Summit Pacific Medical Center

Renée Jensen
Chief Executive Officer

Renée Jensen has served as Chief Executive Officer for the Grays Harbor County Public Hospital District since 2007, when the district’s hospital was called Mark Reed Hospital. Under her leadership, Mark Reed Hospital was named the ninth most profitable Critical Access Hospital in the nation by *Modern Healthcare* in 2009. Renée then secured a USDA loan for hospital construction, allowing a new hospital, Summit Pacific Medical Center (SPMC), to the open to the public in 2013 and replace Mark Reed Hospital.

Will Callicoat
Chief Financial Officer

Will joined SPMC in summer 2011. He had previously spent 10 years in financial management at a variety of healthcare institutions, including serving the Washington State Hospital Association (WSHA) as Director of Financial Policy. Ultimately, Will strives to find ways for SPMC to bring new services to eastern Grays Harbor County in a way that maintains affordable care.
I. Introduction and Objectives

About SPMC

SPMC is a full-service hospital with employed physicians and outpatient clinics serving the populations of Grays Harbor, Mason, Thurston, and Jefferson Counties in Western Washington.

» Designations
  › Level V Critical Access Hospital
  › Level II Cardiac Center
  › Level III Stroke Center
  › Level IV Trauma Care

» Services
  › 10 Inpatient Beds
  › 24/7 Emergency Department (ED)
  › Diagnostic Imaging
  › Family Medicine
  › Free Insurance Enrollment
  › Lab Services
  › Physical, Occupational, and Speech Therapy
  › Skilled Nursing Rehabilitation (Swing Beds)
  › Telestroke Program
  › Urgent Care
I. Introduction and Objectives

Learning Objectives

The purpose of today’s presentation is to:

» Educate the audience on the current and projected state of value-based payments and managed care contracting.

» Provide examples of value-based payment arrangements.

» Introduce a VBR assessment tool targeted for providers.

» Gain insights from an organization that has utilized the VBR assessment tool to develop a value-based contracting strategy.
These forces demand a value-based environment, which rewards high-quality, low-cost care.
The Centers for Medicare & Medicaid Services (CMS) has used reimbursement levels as the instrument to promote hospital/physician integration and foster demonstration projects to test alternatives to the current system.

» Value-driven provider payments have gained considerable traction as a way to:
  › Improve quality.
  › Control costs.
  › Increase accountability for results.

» Medicare is on track to reduce spending while making providers accountable for quality and efficiency.

» Medicaid and commercial payors will likely follow the lead of Medicare.

» Payors will have the opportunity to:
  › Adopt the most effective Medicare initiatives.
  › Develop new products/payment methodologies that are most appropriate in each market.
In January 2015, HHS announced its adoption goals for the next 3 years.

HHS Projected Adoption Goals: 2016 and 2018

HHS plans to associate 90% of Medicare payments to quality or value and 50% to alternative methods by 2018.

Source: www.hhs.gov.
Within days of the HHS value-based payment announcement, a consortium led by large health systems and payors announced its goal of placing 75% of its members’ business into value-based arrangements by 2020.

<table>
<thead>
<tr>
<th>Six of the Nation’s Top 15 Health Systems, Including</th>
<th>Four Health Insurers</th>
<th>Other Industry Stakeholder, Such As</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners HealthCare</td>
<td>Aetna</td>
<td>Purchasers</td>
</tr>
<tr>
<td>Trinity Health</td>
<td>Blue Shield of CA</td>
<td>Patients</td>
</tr>
<tr>
<td>Ascension Health</td>
<td>Blue Cross Blue Shield (BCBS) of MA</td>
<td>Policy Experts</td>
</tr>
<tr>
<td>Dignity Health</td>
<td>Health Care Service Corporation (BCBS of IL, MT, NM, OK, and TX)</td>
<td></td>
</tr>
</tbody>
</table>

Payors and providers nationwide are recognizing the need to transition to value-based reimbursement by the end of the decade.
II. Market Evolution Overview

Payors: Innovation Examples

**UnitedHealthcare Oncology Pilot:** Rewards physicians for focusing on best treatment practices and health outcomes rather than the number of drugs they prescribe, resulting in significant cost savings without affecting the quality of care.

**Anthem and Primary Care Physicians (PCPs) in Ohio:** Utilizes monthly payments for care coordination and shared savings payments for providers focused on patient-centered care.

**Blue Shield of California:**
Pay-for-performance (P4P) program encourages best practice adherence by physicians, controls costs, and increases patient access.

**Cigna and Greater Baltimore Health Alliance:** Cigna provides physicians with compensation and rewards for PCMH activity.

**Aetna and Baptist Health System:**
Uses a shared savings model to improve quality and reduce costs.

**Blue Shield of California:**
Pay-for-performance (P4P) program encourages best practice adherence by physicians, controls costs, and increases patient access.
# II. Market Evolution Overview

## Payors: Innovation Examples (continued)

<table>
<thead>
<tr>
<th>Payor(s)</th>
<th>Metrics</th>
<th>Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS of Illinois</td>
<td>Readmissions, quality, length of stay</td>
<td></td>
</tr>
<tr>
<td>BCBS of Massachusetts</td>
<td>Nationally accepted measures focused on safe, timely, effective, and patient-centered care</td>
<td>Global payment using baseline historical costs per member plus variable quality payment</td>
</tr>
<tr>
<td>Large Midwest Equipment Manufacturer (Self-Funded Employee Health Plan)</td>
<td>Rates of readmission for heart failure, Surgical Care Improvement Project metrics</td>
<td>Annual rate increases placed at risk based on meeting quality metrics</td>
</tr>
<tr>
<td>Horizon BCBS (New Jersey)</td>
<td>Clinical process, patient safety, patient satisfaction</td>
<td></td>
</tr>
<tr>
<td>WellPoint</td>
<td>51 indicators of quality</td>
<td>Annual rate increases placed at risk based on meeting quality metrics</td>
</tr>
<tr>
<td>Midwest Blue Cross Plan</td>
<td>Potentially avoidable inpatient days based on complications, mortality, and length of stay; potentially avoidable inpatient admissions based on readmissions and quality indicators</td>
<td>Bonus for savings per admission based on reduced length of stay</td>
</tr>
<tr>
<td>Arkansas Medicaid, QualChoice of Arkansas, and Arkansas BCBS</td>
<td>Quality and total cost of care for 24 planned episodes of care</td>
<td>Shared savings under bundled payments for episodes of care</td>
</tr>
<tr>
<td>Georgia Medicaid</td>
<td>Adoption, implementation, upgrades, and demonstration of meaningful use of certified EHR technology</td>
<td>Bonus payments</td>
</tr>
<tr>
<td>Washington Medicaid</td>
<td>Infection prevention, readmissions, safe deliveries, behavioral health safety</td>
<td>Up to 1% increase in payments</td>
</tr>
</tbody>
</table>
II. Market Evolution Overview
Health System Value-Based Contract Portfolio

This health system with hospitals in three Western states has a variety of P4P incentives, which are a type of value-based reimbursement.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Value-Based Effective Date</th>
<th>Revenue</th>
<th>Percentage(^1)</th>
<th>Maximum Incentive Based on Performance</th>
<th>Performance Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan A</td>
<td>1/1/13</td>
<td>$300.00M</td>
<td>Hospital A: 0.50% Hospital B: 0.50%</td>
<td>Hospital A: $1.05M Hospital B: $500,000</td>
<td>Efficiency, quality, and coordination of care</td>
</tr>
<tr>
<td>Health Plan B</td>
<td>7/1/14</td>
<td>$37.00M</td>
<td>All Sites: 2015 — 0.50%</td>
<td>$185,000</td>
<td>Clinical outcomes, patient satisfaction, patient safety</td>
</tr>
<tr>
<td>Health Plan C</td>
<td>8/1/14</td>
<td>$23.00M</td>
<td>All Sites: % TBD</td>
<td>TBD</td>
<td>Network participation, readmissions, length of stay, adverse events, C-section rate, processes of care for various conditions, patient experience, quality reporting</td>
</tr>
<tr>
<td>Health Plan D</td>
<td>4/1/15</td>
<td>$67.00M</td>
<td>All Sites: 2015 — 0.50% 2016 — 1.50%</td>
<td>2015: $365,000 2016: $1.10M</td>
<td>Readmissions, avoidable admissions, length of stay, utilization, mortality for three conditions, National Patient Safety and National Quality Improvement Goals, HCAHPS, early elective delivery</td>
</tr>
<tr>
<td>Health Plan E</td>
<td>1/1/14</td>
<td>$54.00M</td>
<td>Hospital C: 2015 — 4.50%</td>
<td>$2.40M</td>
<td>Process-of-care measures for pneumonia, VTE, and surgeries; readmission rates for heart failure patients; catheter-associated UTI rates; use of payor’s electronic pre-certification and admission, discharge, and transfer feed</td>
</tr>
</tbody>
</table>

| Total | $481.00M | 22.00% | $4.50M |

\(^1\) Reflects revenue subject to P4P as a percentage of health system’s total net patient revenue.
II. Market Evolution Overview

Value-Based Payment Risk Continuum

Value-based payment models run on a continuum with more risk borne by payors on one side and more risk borne by providers on the other side.

- FFS
- Medical Home\(^1\)
- Bundled Payment
- Payment for Episodes of Care
- Global Payment With Performance Risk and P4P
- Gain Sharing
- Global Payment With Financial Risk

**Risk Borne By:**
- Consumers
- Employers
- Health Plans
- Government Payors

**Risk Borne By:**
- Physicians
- Medical Groups
- Hospitals
- Other Providers

\(^1\) Medical homes that receive extra dollars for patient management.


Staying too far to the left could leave providers unprepared for major payment reforms; going too far to the right too quickly could lead to large financial losses.
III. Value-Based Readiness
Where Does My Organization Stand?

Improving quality and succeeding financially under value-based payment arrangements requires providers to develop expanded and new capabilities and competencies in the following domains:

- Care Delivery Transformation
- Payment Models
- Clinical and Business Informatics
- Provider Network

The breadth and depth of an organization’s competencies and capabilities in these domains will determine which models of value-based payments it is ready for.
### A VBR assessment can help organizations take stock of their competencies and capabilities and choose the most appropriate payment models.

<table>
<thead>
<tr>
<th>VBR Competencies and Capabilities</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CARE DELIVERY TRANSFORMATION</strong></td>
<td></td>
</tr>
<tr>
<td>A. Care Coordination/Integration</td>
<td></td>
</tr>
<tr>
<td>1 Clinical coordination across continuum of care</td>
<td>Are providers from multiple organizations (hospitals, physician groups, pharmacies, SNFs, etc.) communicating and collaborating to execute patients’ care plans? This involves both interpersonal communication and management, as well as IT tools such as health information exchanges.</td>
</tr>
<tr>
<td>a. Hospital</td>
<td></td>
</tr>
<tr>
<td>b. Physician groups</td>
<td></td>
</tr>
<tr>
<td>c. Pharmacies</td>
<td></td>
</tr>
<tr>
<td>d. SNFs</td>
<td></td>
</tr>
<tr>
<td>e. Other</td>
<td></td>
</tr>
<tr>
<td>2 Care coordinators</td>
<td>Does your organization have staff dedicated to care coordination?</td>
</tr>
<tr>
<td>a. Hospital</td>
<td></td>
</tr>
<tr>
<td>b. Owned clinics</td>
<td></td>
</tr>
<tr>
<td>3 Care transition process</td>
<td>Are patients’ movements from one care setting to another well coordinated, with the appropriate providers receiving medical records and patients receiving the information they need to care for themselves?</td>
</tr>
<tr>
<td>a. Hospital</td>
<td></td>
</tr>
<tr>
<td>b. Owned clinics</td>
<td></td>
</tr>
<tr>
<td>4 Medication reconciliation</td>
<td>Are patients’ existing prescriptions being verified to ensure patients will not react adversely to new prescriptions?</td>
</tr>
</tbody>
</table>

### Features of ECG’s VBR Assessment

- It is an Excel-based tool.
- It covers more than 120 competencies.
- This self-assessment shows organizations their readiness for five value-based payment models:
  - P4P with quality/patient satisfaction bonuses
  - Pay for care coordination
  - Shared savings (upside only)
  - Shared savings (with downside risk)
  - Full risk/capitation
IV. Case Study

**Sum.mit** (sum-it) — noun
1. The highest point or part: the top. 2. The utmost level or degree obtainable. 3. The peak of performance. 4. The apex. 5. The towering height, as of achievement. 6. The pinnacle of perfection.

*ex: It takes dedication and perseverance to reach the Summit.*

Vision: **To Be the National Model for Patient-Centered Care**
IV. Case Study
Who We Are Today … Similar to You?

» SPMC is a Critical Access Hospital in Elma, Washington.
» The public hospital district serves a community of 20,000-plus.
» A $23.5 million construction project opened in February 2013.
» The organization went from 75 employees to 200 in less than 2 years.
» SPMC has a high-volume ED (13,000 visits per year).
» It emphasizes primary care with three Rural Health Clinics.
  › 13 PCPs (3 MDs, 10 ARNPs/PAs)
  › 30,000 visits per year
  › Urgent care
» Below are other pertinent facts.
  » 90% outpatient business
  » 75% Medicare/Medicaid
  » $52 million in gross revenue
IV. Case Study

Why It’s Important

» Dysfunction of current system
» Extremely high costs with corresponding poorer outcomes
» Poor health status in Grays Harbor County
  › Life span 3 years less than Washington average
  › Higher rates of drug and alcohol use and smoking
  › Unemployment rate double the state average
  › One in five adults consumes appropriate fruit and vegetables
» Alignment with SPMC vision
» Industry imperative
» Alignment of payments with quality
» Stimulation of innovation
IV. Case Study
Implementation at SPMC

Organizational Readiness: Pivot to Other Payors

- A 2-hour survey was built by ECG and completed with clinicians and operational leaders.
- The survey identified organizational strengths and deficiencies in these categories:
  - Care delivery transformation +
    - Comprehensive provider network –
    - Robust clinical informatics - -
    - Effective payment models +
    - Strong organizational foundation ++
Taking the readiness assessment helped SPMC develop its value-based contracting plan.

**Goal**

- Move payments from volume to value.

**Objectives**

- Obtain value-based payor contracts.
- Earn value-based payments.

**Strategy**

- Convince payors that SPMC can improve their patients’ health and reduce their costs.
- Make the internal changes necessary to improve patient outcomes and patient health while reducing costs.
- Obtain appropriate compensation from payors for improving health and reducing costs.

**Tactic 1:** Create a communication plan for payors.

**Tactic 2:** Focus on managing chronic conditions.

**Tactic 3:** Expand access to primary and urgent care.

**Tactic 4:** Create an internal task force focused on value.

**Tactic 5:** Align provider compensation with value.

**Tactic 6:** Standardize clinical processes.

**Tactic 7:** Integrate a psychiatric NP into the continuum of care.
"We’re hoping you’ll lead us on a journey of transformation without requiring any real changes."

© 2008 Dennis Fletcher. More at LeadershipJournal.net Cartoons
IV. Case Study
Operational and Financial Philosophy

[Diagram showing a pyramid with levels from least used to most used: ICU or Specialty Admission, General Admission, Surgeries, Specialists, ED, Primary Care. Arrows indicate increasing costs and least used.]
IV. Case Study
SPMC Objective: Obtain Value-Based Contracts and Payments

Value-based contracts need to lead to value-based payments for providers.

Key Considerations for Obtaining and Succeeding Under Value-Based Contracts

Be Proactive
- SPMC can propose its own valued-based contracting terms.

Be Selective
- Rule out Medicare Advantage and maintain a focus on MSSP.
- Prioritize commercial and Medicaid managed care partners based on interest level and ease to work with.

Limit Risk Initially
- VBR assessment results indicate that SPMC is more ready for lower-risk models, such as P4P, pay for care coordination, and upside-only shared savings.

Seek Short-Term Payments
- SPMC prefers incentives that are likely to be earned in the near future (e.g., within 1 year).

Ensure Success
- Ensure criteria for value-based payments are SMART (specific, measurable, attainable, relevant, and timely).
- Make appropriate internal changes to ensure that metrics are met.
SPMC is pursuing a three-pronged strategy to obtain value-based contracts and earn incentives from them.

**Convince Payors of SPMC’s Value**
- Explain what SPMC has accomplished to date.
- Specify what SPMC can do moving forward.

**Make Internal Changes to Improve Outcomes and Health While Reducing Costs**
- Create a task force focused on value.
- Standardize clinical processes.
- Manage care effectively.

**Obtain Appropriate Compensation for Value**
- Proactively provide payors with SPMC-specific incentives.
- Ensure that SPMC earns the incentives.
IV. Case Study
Value Proposition

What SPMC Has Accomplished

» Maintained three primary care clinics
» Created 7-day per week urgent care center
» Implemented a care coordination program for high-risk patients
» Established a value-based steering committee
» Hired a psychiatric NP

What SPMC Can Do for Payors

» Improve quality.
» Lower the total cost of care by reducing the following:
  › ED visits
  › Admissions
  › The use of specialists
» Increase patient satisfaction.

What Payors Can Do for SPMC

» Reimburse SPMC for the following:
  › Care coordination
  › Increased access to primary and urgent care
  › Quality and patient satisfaction
» Assist SPMC in developing a value-based care infrastructure.
There are plausible scenarios in which SPMC’s total revenue will decline from present levels under value-based contracts.

Utilization reductions are the biggest drivers of revenue changes under value-based contracts.
## IV. Case Study

### The Path Forward

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<th>Organizational Changes</th>
<th>Operational Changes</th>
<th>Cultural Changes</th>
<th>Technological Changes</th>
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</thead>
<tbody>
<tr>
<td>Access to Lightbeam Data</td>
<td>Expanded Patient Access</td>
<td>Provider Compensation Aligned With Value</td>
<td>Risk Stratification of Patients</td>
</tr>
<tr>
<td>Enhanced Transparency</td>
<td>Protocols as Clinical Frameworks</td>
<td>Aligned Mission</td>
<td>Population Health Software</td>
</tr>
<tr>
<td>Focus on Chronic Conditions</td>
<td>Collaboration Across Care Continuum</td>
<td>Use of Internal and External Services</td>
<td>Integrated EHR</td>
</tr>
</tbody>
</table>
Use internal medicine as a consult for family medicine.

Provide robust care coordination and transitional care management.

Integrate a psychiatric NP into care continuum.

Expand access to primary and urgent care.

Demonstrate value to payors.

Align provider compensation with value.

Identify low-cost, high-quality partners.
SPMC must decide what to do next.

Payors
» Without value-based contracts from some payors, will we begin to see disparate results within our community?
» Will our providers be able to provide care coordination to some patients but not others?

End Game
» As costs decrease, the potential for future costs savings decreases.

Bundled Payments
» How will bundled payments impact rural hospitals that provide post-acute care (swing beds and therapies)?
Questions & Discussion
Contact Information

Ken Steele
415-692-6060
ksteele@ecgmc.com
Walnut Creek, CA

Jim Ryan
469-729-2600
jryan@ecgmc.com
Dallas, TX

Renée Jensen
360-346-2244
reenej@sp-mc.org
Elma, WA

Will Callicoat
360-346-2244
willc@sp-mc.org
Elma, WA

ecgmc.com

summitpacificmedicalcenter.org