White paper

Design, align and implement an innovative provider reimbursement program

Over the course of the past few decades, provider reimbursement has taken on different forms with varying degrees of acceptance and success. There have been as many models as there are leaves on a tree. Each was supposed to be "the one" that was truly transformational but, realistically, any transformation was likely short-lived. Consequently, it is important to recognize the history of provider payment programs and their fundamental effects, and to reconcile what has been effective and what has been challenging. From these lessons, what do we know to be effective in addressing quality and cost challenges?

Intents and opportunities

There are different iterations of provider reimbursement found across the industry such as value-based care (VBC), accountable care and pay-for-performance. Many have had their share of challenges and opportunities, but for the most part, all were intended to create an environment that modified behavior, created visibility and perhaps motivated providers to achieve a particular goal(s). At best, these early programs may have achieved a short-term operational objective but also may have distracted from the patient-physician relationship.

There have been an extensive number of programs, but because of the breadth, we'll touch on a few of the more prominent ones:

Capitation

WHAT IT IS: A provider reimbursement mechanism that goes back several decades. Essentially, providers receive a prepayment for defined:

- Services
- Population
- Periods of time

HOW IT WORKS: A provider receives a fixed amount for reimbursement (usually per member per month) for clinical management or services for a defined group of patients. Those patients may or may not seek or receive treatment from that provider during that month. Ultimately, the amount is intended to cover provider expenses for managing that population's care both administratively and clinically over a period of time.

IN TYPICAL HEALTH PLAN-PROVIDER CONTRACTS: Capitation is usually provided to larger groups and organizations that have the infrastructure and size to take on the responsibility of managing the medical and financial risk of a population. Services may be holistic or may be focused more around a smaller group of services such as primary care or specialty services such cardiology.

OUTCOMES: Capitation has seen success as a model that supports population health but also its share of criticism of having a payment mechanism that could create an unintended incentive to have the potential to withhold care. Regulatory limits and added quality measures are intended to reduce that phenomenon and help create visibility and accountability to outcomes commensurate with operational performance.

Partial risk sharing

WHAT IT IS: Risk sharing may be on a percent of premium or fixed amount. The amount of risk may be limited in some cases, i.e., upside-only or limited downside exposure.

HOW IT WORKS: Under this type of contractual relationship, the provider may have elected to bear the partial or full medical risk for a member: responsibility for primary care, specialty and other outpatient services, and in some cases, even the inpatient (IP) and pharmacy exposure. At the end of the reporting period, there would be a "true up" where the prepaid percent of premium would be reconciled with all relevant expenses. Any surplus would remain with the provider organization but an overage (or deficit) would be paid to the management service organization (MSO) or health plan.

TYPICAL HEALTH PLAN-PROVIDER CONTRACT: Rarely an individual or small group practice but more commonly larger primary care settings. The financial exposure can be significant as would the ancillary support services for patient management.

OUTCOMES: Similar to capitation, taking on risk of a population can be challenging without the correct data, tools and resources. Less mature organizations may find themselves encountering substantial, unplanned deficits without the correct infrastructure. But at its core, risk sharing does create accountability for the provider organization to look across the health delivery system and emphasizes the need for primary care management as well as primary care coordination of services with visibility into quality outcomes and more efficient sites of services based upon clinical need.

Transactional incentives

WHAT IT IS: The most familiar program, sometimes called "pay-for-gap" or pay-for-performance.

HOW IT WORKS: This type of program provides a way for a health plan to drive attention and motivation towards quality for a particular measure or group of measures. The provider receives payment for satisfying a quality gap or increasing a generic dispense rates in one of the following ways:

- Programs like care coordination may receive a per member per month.
- Other programs like quality gap closure receive a fixed amount relative to value of the transaction that was satisfied.

TYPICAL HEALTH PLAN-PROVIDER CONTRACT: These typically are upside-only relationships between the health plan and provider organization where the provider receives payment for the performance, and can create momentum and recognition for improved outcomes relative to the objectives sought. With improved outcomes and maturity, and growth in membership, groups may evolve into other more sophisticated types of contracts that allow the provider organization to take on more risk.

OUTCOMES: These programs provide an opportunity for smaller or less mature provider organizations to receive member data that can lead to improved clinical outcomes and allow for some additional compensation for the practice.

Medicare Advantage programs

Medicare Advantage health plans have long been challenged by traditional fee-for-service payment — especially if a health plan had a relatively small population with a provider. With legislation such as section 115A of the Social Security Act or the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) has continued to release innovative models.

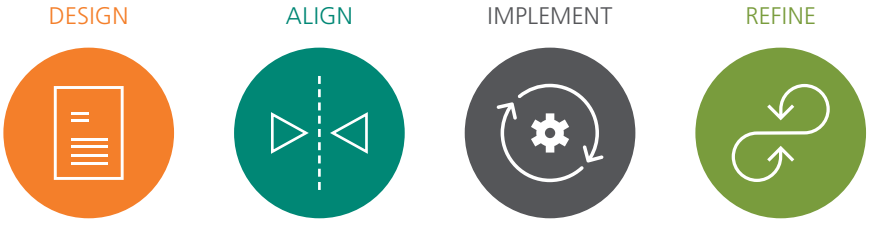
The Medicare Access and CHIP Reauthorization of Act of 2015 (MACRA) authorized alternate payment models whereby clinicians accept some risk for quality, cost outcomes and other criteria.

As is the case with many CMS programs, they often become "sticks vs. carrots" over time, reducing the fee schedule payment for providers who continue to focus only on fee-for-service (FFS) or relative value units (RVU) payments.

Additionally, the intent of CMS accountable care organizations (ACOs) allows providers to coordinate high-quality care while reducing the overall cost of care. The introduction of ACOs has helped health plans and providers align payment toward various programs. For more information, visit the following links:

- innovation.cms.gov/initiatives/#views=models&stg=accepting letters of intent, accepting applications
- innovation.cms.gov/initiatives/ACO/

With these changes in traditional Medicare reimbursement methods, now is a great time for health plans to work with providers on meaningful contract changes.



Best practices to design, align and implement innovative programs

As we look across provider payment programs, it is important to understand some of the structural preconditions that contribute to success in program development, maintenance and evolution.

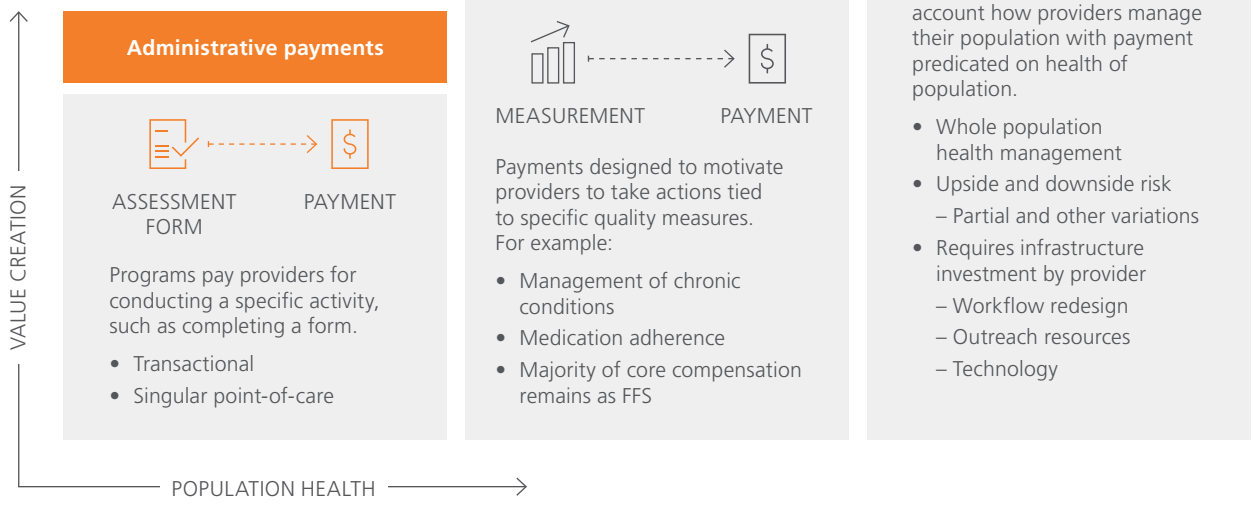
DESIGN

Health plans should design programs to create greater awareness and opportunities that support and impact population health management, whether overall or segmented, and ultimately improve quality outcomes for patients.

Programs should be designed and developed across a spectrum from infancy through maturity, as shown below. A provider or their organization should be able to participate across the spectrum. They might typically lean to one side or the other depending on scale, size and risk tolerance until one or more of these characteristics change, but as a provider organization moves across the spectrum, so do the impact considerations across a larger population of patients.

- Meaningful design and motivation that is enough to change behavior
- No overly complex calculations, tiers and gateways
- Coordinate and recognize technical and office staff workflows of busy provider organizations
- Transparent reporting
- Timely feedback and reimbursement
- Course correction and support

THE VALUE-BASED CARE SPECTRUM



PROVIDE TRANSPARENT REPORT DATA

Providers want to know how they are performing. Reporting should be transparent and provide program data so providers can see progress toward goals. Program design should allow for a minimum of monthly reporting.

- **Offer report access and delivery options** so providers can monitor progress proactively. For those that aren't proactive, be sure to communicate their progress.
- **Keep it simple.** Program and performance reporting should be reasonably simple to understand. The ability to see high-level progress or drill down to the goal is important. This leads to clear objectives, goals, reporting progress toward those goals, timing and the carrot or stick criteria.
- **Communicate clear information** about payment program objectives, how goals are evaluated and transparency of gathering or reporting data for program organization and goal alignment.
- **Deliver timely feedback** on performance information so that objectives can be redirected before it's too late.
- **Provide progress metrics.** Health plans are excellent at selecting metrics that are meaningful toward risk, quality and cost goals, but may create workflow complexity for providers as shown in the following example:
  - Example: Health plan "X" selects 10 quality measures for a program. Health plan "Y" also selects 10 measures, but only five of them are the same as health plan "X". To simplify workflow, providers may only work on the five measures that overlap.
- **Include supporting detail** to alleviate any concerns around data accuracy. When applicable, provide additional health plan metrics to eliminate barriers to provider participation.
  - Example 1: If the program is based on claims data, provide reporting that shows claims receipt and payment timelines along with final claims disposition categories.
  - Example 2: Member eligibility — a) How is attribution performed; b) Are members static once set for the year or will there be adds or deletes to the monthly reporting and calculations?

ALIGN

Program alignment should provide a common provider experience across health plans, programs, such as risk and quality, and lines of business. It should also align with health plan outcomes so both constituents are focused on achieving the quadruple aim. Program alignment should also recognize some of the following characteristics that should be part of program development or program acquisition:

- Intrinsically motivated — short-term thinking
- Not collaborative — one-sided
- Payments align with outcomes or program goals
- Meaningful (to all parties)
- Unrealistic (workflow)
- Receipt of payments: provider group administration vs. individual providers. Historically, an issue where the provider of service may not directly see the reimbursement because of the organizational or compensation structure of the employer.

It is important that the provider organization understands how the program aligns with its core objectives. For example:

- Is it good for patients?
- Is it good for business?
- Does it take up too much time for providers?
- Is it worth it?

BALANCE PROVIDER SIZE, SEGMENTATION AND MINDSHARE.

Every community has a small cluster of provider organizations that has more market share. Conversely, every community often has a health plan or small group of health plans with larger market share. This combination of market forces makes it challenging for health plans with lesser market share to get the attention and mindshare of provider organizations.

Thoughtful alignment, meaningful payments and motivational objectives can go a long way to change behavior. Another alternative is to leverage other more broadly adopted multi-health plan programs and/or align program measures to be consistent with what is already in the market. It may also be beneficial to shift health plan-to-provider contracts to outcomes-based performance models (e.g., risk sharing, capitation).

FOCUS ON HIGHLY PREVALENT MEASURES

Focus on measures like diabetes mellitus (DM) that cut across chronic condition diagnosis, treatment and documentation as well as HEDIS® quality considerations.

Begin with PCPs and then add key specialists. For example, add endocrinologists who can focus on complicated diabetic diagnoses and cardiologists who provide expertise in treating a myriad of heart-related conditions.

REIMBURSEMENT

Similar to alignment above, program reimbursement or financial recognition should include these elements:

- **Easy to administer.** From professional experience, there is little else more irritating than having a program that doesn't live up to reimbursement expectations. It is important that the program be administered efficiently so financial recognition of successful program performance is prompt and commensurate with effort.
- **Timely reimbursement.** Align directly with outcomes and provide meaningful reimbursement for increased administrative work (within fair market value). Be clear when reimbursement occurs. Quarterly payments are more engaging to providers.
- **Transparent program reimbursement guidelines.** Reimbursement paid at Taxpayer Identification Number level, ACO level, etc.
- **For providers, shifting from solely receiving provider group compensation** to allowing individual providers to receive a part of the compensation will also provide better alignment.

SUPPORT THE QUADRUPLE AIM

Focus on aligning provider payments that recognize a comprehensive approach to achieve the quadruple aim:

1. Reduce cost
2. Increase quality outcomes
3. Improve member and patient satisfaction
4. Improve provider satisfaction

COST AND QUALITY

What are the pain points from a financial perspective?

- Patient self-fragmented care, e.g., self-referral, emergency room (ER) use, prescription medications
  - Patient activation challenges
  - Provider engagement challenges
- Risk of revenue loss or deterioration
- Missed revenue opportunities, e.g., Stars, HEDIS®
  - Accurate and complete documentation and coding — make it easier but be sensitive to compliance.
- Legal considerations — reimbursement must meet all applicable regulatory requirements, which can vary from program to program and from state to state.
- Clinical outcomes — what can be impacted and by who?

MEMBER SATISFACTION

- Health outcomes
- Annual wellness visit (AWV) — weigh the pros and cons as a basis for payment.

	2017	Patients with AWV	Patients without AWV
AWV PROS		469	8,891
	Chronic condition recapture rate	81.5%	67.6%

Source: Clinovations data

- Provides opportunity to clean up the patient problem list for the current program year for all providers (primary care providers (PCP), specialists, urgent care and other same-day care providers) with access to electronic medical records (EMR).

AWV CON	AWVs have a very specific scope under CMS Medicare guidelines and may not provide the opportunity to diagnose and treat all conditions during the visit.

PROVIDER SATISFACTION

To help boost provider satisfaction, focus on these aspects:

- Provider office experience — provide field team support, etc., to assist with educational expertise and resource augmentation, if necessary
- Provider and staff experience — create ability for physician-to-physician interaction
- Quality outcomes improvement
- Complete and accurate claims data sets
- EMR integration

MEMBER AND PROVIDER SATISFACTION

It's important to think of member and provider satisfaction both separately as outlined in the previous sections but equally important to think about them together. When thinking about the member/provider intersection, consider provider size, type, location and social determinants of health (SDoH). Consider "incentives" more broadly (staffing, technology, etc.)

Optum recently asked a Federally Qualified Health Center (FQHC) about provider and member pain points. For the record, CMS reimburses FQHCs differently and they may have different needs. Here are the highlights:

- **Help me with my EMR.** *"I have a stripped down version and my patients and I would benefit from more functionality."*
- **Help me with data.** *"I don't currently have a view of aggregated population health."*

NOTE: While the above needs have a cost, not one of the providers was specifically asking for funding. Instead ways to help their patients to improve health outcomes.

REFINE

Refinement of any program is important. Build a multi-year plan with the opportunity to course-correct. For example:

Look at the regulatory environment to understand changes that might impact your program (such as removing certain HEDIS measures while adding others).

Review aggregate performance on an annual and year-over-year basis to ensure that the objectives you set out for the program are actually being realized; if not, determine what needs to change.

Annual provider contracting cycles also provide an opportunity to refine the specific program for the provider organization — often moving toward taking on higher levels of risk.

The following example shows course correction (from FFS to VBC) whereby a provider entity may be shifting from administrative reimbursement toward sharing more with the individual providers.
If providers have been reimbursed on a purely FFS/RVU basis, it will take time for the provider organization to align toward VBC compensation.

YEAR 1

First 6 months

- Select achievable measures that are aligned to the health plan contract (e.g., diabetic blood sugar control)
- Automate data management
- Provide transparent individual provider reporting

Next 6 months

"Shadow period" (no compensation change, but show impact of what change would produce).

Example: 100% RVU payments vs. 95% RVU + 100% VBC payment

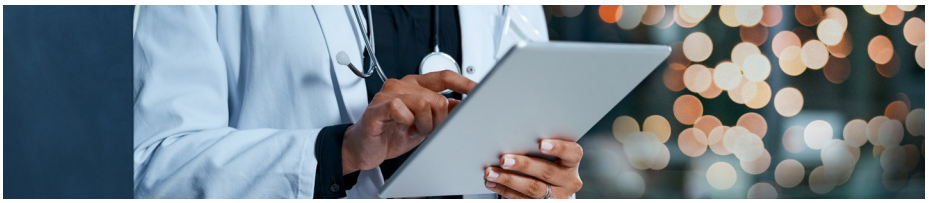
YEAR 2

Strengthen/refine data and implement

YEAR 3

Increase percentage (move toward 20–25% VBC compensation)

CASE STUDIES



CASE STUDY 1:

Do focused interventions combined with value-based provider payment really make a difference?

CHALLENGE: Integrate new programs and workflows in provider organization

SOLUTION: Three-year provider-focused efforts toward health plan payment program

- Year 1 — began with interventions on DM and associated complications
- Year 2 — looked for disparities in clinical documentation and coding
- Year 3 — used a physician champion for peer mentoring where outcomes were greater than 50th percentile of peer group

RESULTS:

Pre-intervention 2008	Post-intervention 2009-2012
6,713 office visits/1,000	7,642 office visits/1,000 (office visit increase)
Baseline RAF measured	6.1% RAF increase. Increase accuracy of CMS risk revenue ($2.5M/1,000)
Baseline ER/IP visits	11% reduction in ED/IP visits ($1.8M savings)
Baseline survival rate	82% patient survival rate; marked effect 82-96 YO

Source: Value-Based Contracting Innovated Medicare Advantage Healthcare Deliver and Improved Survival by Mandal, et. al., January 2017, American Journal of Managed Care (AJMC)

CASE STUDY 2:

The *Journal of the American Medical Association* (JAMA) published an article in 2016 that reviewed the impact of FFS providers compared with ACOs (that received incentive payments from CMS versus the FFS cohort) and reviewed results of clinically vulnerable populations.

RESULTS:

	FFS cohort 2009-2013	ACO 2009-2013
Total spend reduction	$34 per beneficiary/quarter	$114 per beneficiary/ quarter
Inpatient hospitalizations	Decrease of 1.3/1,000/quarter	Decrease of 2.9/1,000/quarter
ER visits	Decrease of 3/1,000/quarter	Decrease of 4.1/1,000/quarter

Source: Association between Medicare ACO Implementation and Spending among Clinically Vulnerable Beneficiaries by Collal, et.al. August 2016 JAMA Internal Medicine

In closing …

ENABLE MORE COLLABORATION
between the health plan and provider.

GET BACK TO BASICS
Continue efforts toward "SMART" goals — Specific, Measureable, Achievable, Relevant and Time-bound — and transparent reporting. Remove overly complex calculations, tiers and gateways.

INCREASE USE OF TECHNOLOGY
(e.g., full EMR integration for the largest providers organizations and health care systems).

CONTINUE EFFORTS AROUND HIGH COST
that focus where care is performed (e.g., episodes, conditions, specialists).

PLACE EMPHASIS ON THE PATIENT SATISFACTION
component of the quadruple aim. For example, incorporate social determinants of health (SDoH) at some level.

KEEP IT SIMPLE
At the end of the day, health plans and providers want the same thing — to provide care that the members need. Starting from a common purpose, we can strike a balance where we all win!

Contact Optum to learn more today.

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