Provider and Payer Partnerships to Improve Population Health

Innovations in Care Delivery Conference
March 23, 2016

Richard Martin, MD, FAAFP
Director Continuum Care, Geisinger Health System

Keith A. Boell, DO, FAAP, FHM
Director of the Hospital Medicine Program, Geisinger Health System

Agenda

Context
• Marketplace structural change: Insurance and reimbursement
• Large employers and direct contracting
• Payers becoming providers and providers becoming payers
• Move to VBR forcing change in payer provider relationships

Payer-Provider Partnerships
• Evidence-based strategies and experience from Geisinger Health Plan

Healthcare Market Transformation - Two Major Vectors of Change
History of Payer-Provider Integration

1930-1940s Group/staff model HMOs (e.g., Kaiser, GHC, etc.)
1970-1980s IPA model HMOs (e.g., Hill Physicians)
1970-1980s 1980s: Rural-based IDNs develop health plans (Geisinger, Carle, Scott & White, etc.)
1980s Insurers acquire primary care groups, investor-owned hospitals acquire insurers
1990s Insurers sell off primary care groups to PPMs
1990s Nonprofit hospitals get into insurer business in anticipation of capitated care partly stimulated by BBA '97 (Provider-Sponsored Organizations)

Significant Shift Toward Self-Funding

Employers Bearing More Risk – Direct Engagement with Providers

Percentage of Self-Insured Employers

Employer Interest in Provider-Oriented Strategies

- Adopt new accountable payment models
- Contract directly with hospitals, physicians, ACOs
- Offer incentives for care coordination
- Offer performance-based payments

In Place in 2013 Planned for 2014

Large employers are increasingly partnering with hospital systems, primarily around bundled care for ortho/cardiac procedures for adults...

Source: AonHewitt

Strong interest from employers in creating bundled payments around high-volume procedures such as hips, knees and backs
Payers Becoming Providers

Providers Becoming Payers

Provider/Payer Partnerships

• Defining the value of provider and payer relationships from the health plan perspective

• Defining the value of provider and payer relationships from the provider perspective

• Positioning your organization for healthcare reform by aligning goals and tactics
col·lab·o·ra·tion  
ka labə rəˈʃa(ə)n/  A recursive process where two or more organizations work together to realize shared goals

part·ner·ship  
ˈpɑrtnərˌʃip  An arrangement where parties agree to cooperate to advance their mutual interests

Trust:  One party (trustor) is willing to rely on the actions of another party (trustee); the situation is directed to the future. The trustor (voluntarily or forcibly) abandons control over the actions performed by the trustee. As a consequence, the trustor is uncertain about the outcome of the other’s actions; they can only develop and evaluate expectations. The uncertainty involves the risk of failure or harm to the trustor if the trustee will not behave as desired.

Providers Trust Toward Payers
Combined Trust Measures

Reliability: organization makes every effort to honor its commitments
Honesty: organization is accurate and honest in representing itself and its intentions
Fairness: organization balances its interests with ours and doesn’t routinely take advantage of us

Combined Trust Index Score by Payor†

Source: ReviveHealth & Catalyst Healthcare Research

Geisinger Health Plan Experience
Evidence-Based Strategies in Payer Provider Partnerships
Provider/Payer Partnerships

- Trust
- Momentum
- Relationships
- Partnerships

Partnership of PCPs and GHP Provides 24/7, 360-Degree Patient Care and Navigation

It Takes a Partnership: Each Party Doing What They Do Best...

<table>
<thead>
<tr>
<th>Payer</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Population analysis</td>
<td></td>
</tr>
<tr>
<td>- Align reimbursement</td>
<td></td>
</tr>
<tr>
<td>- Finance care</td>
<td></td>
</tr>
<tr>
<td>- Engage member and employer</td>
<td></td>
</tr>
<tr>
<td>- Report population outcomes</td>
<td></td>
</tr>
<tr>
<td>- Take to market</td>
<td></td>
</tr>
<tr>
<td>- Identify best practice</td>
<td></td>
</tr>
<tr>
<td>- Design systems of care</td>
<td></td>
</tr>
<tr>
<td>- Educate patient and family</td>
<td></td>
</tr>
<tr>
<td>- Deliver care</td>
<td></td>
</tr>
<tr>
<td>- Report patient outcomes</td>
<td></td>
</tr>
<tr>
<td>- Continually improve</td>
<td></td>
</tr>
</tbody>
</table>
Who?

Segmented by:
- Group practice
- Employer group
- Coverage (line of business)
- Diagnosis (MS, diabetes)
- Region
- Town, community

What Population?

Commercial TPA Client

Risk Model

Advanced Medical Home Primary Care Components
Population Management

Care across the member’s lifespan and healthcare needs - a redesign and building of a full continuum of population management

- Wellness
  - Low risk
  - Health promotion
- Health Management
  - Moderate risk
  - Disease or condition management
- Complex Case Management
  - Highest risk
  - Comorbid condition management

How? Getting Started...

- Quality Pilots
  - Example: ACE/ARB initiative, colorectal screens, high-cost imaging
  - Pilot by program, geography, diagnosis
- Pay for Performance - P4P
- Shared savings models
Value-Based Reimbursement Model

Maintain
• Fee-For-Service
• PQS payments for quality

Earn
• Results share incentive payment
• Opportunity based on efficiency
• Distributed based on quality


**Physician Quality Summary (PQS)**

- Cervical CA
- Mammography
- Colorectal CA
- Immunizations
- Cholesterol
- Diabetes
- Strep Testing
- ACE/ARB in Diabetes/HTN
- Generic Dispensing
- Adherence
- High-Risk Meds
- Episode Profiler
- ER Utilization

**Scoring Methodology**

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Chronic Illness</td>
<td>25%</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>25%</td>
</tr>
<tr>
<td>Medication Management</td>
<td>20%</td>
</tr>
<tr>
<td>Efficiency of Care</td>
<td>10%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>15%</td>
</tr>
<tr>
<td>Medication Adherence</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Performance Rating**

- **Good:** The physician’s score equaled the Health Plan’s basic standards.
- **Very Good:** The physician’s score was above the Health Plan’s basic standards.
- **Excellent:** The physician’s score exceeded the Health Plan’s basic standards by a statistically significant amount.

Updates of data occur in October.
Site scores are available to the public.
Individual provider scores only available to the provider.
Transforming Data into Information

Information must be...
- Timely
- Accurate
- Relevant
- Actionable

Information is critical for use in longitudinal trending, benchmarking, and best practices.
Medication Adherence Profile

An Example: Kulpmont Clinic
(Four Physicians; two FT, two PT and two PAs)

Coronary Artery Disease (CAD) Patients, 562
Diabetes Patients, 715

% Compliance

Variation Examples
Can We Change Behavior?

PCP Generic Dispensing Rate
PCPs with more than 5200 scripts per year

Commercial
PCP Site Performance
Procedure Utilization

Medicare
PCP Site Performance
Procedure Utilization
Attributes - Shared Savings Model

- Create incentive to reward practice transformation.
- Create targeted cost expectations based on historical experience.
- Protect against increases in underlying risk.
- Protect against catastrophic cases, which may have an overbearing impact on group results.
- Recognize “Regression to Mean.”

Shared Savings: General Methodology

- Creating a “Target”
  Two prior years’ PMPMs are trended forward and blended using book trends. 
  Medicare vs. Commercial
  HMO vs. PPO
  Medical vs. Rx
  The use of multiple years prevents over-reliance on a single historical PMPM.

- Comparing Target to Actual
  Neutralize for changes in underlying risk.
  Any positive “risk neutral” delta between target and actual is considered savings generated by the program.
  Savings are split equally between GROUP and GHP, subject to attainment of quality goals.
  GHP funds care management infrastructure.

Example of Quality Metrics

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundles: maximum 2/5 bundles above the group standard, or improve 3/5 bundle rate from previous year</td>
<td>30%</td>
</tr>
<tr>
<td>PCP F/u: 25% or greater, pt with f/u appointment within 7 days of d/c from Hosp or SNF and 25% or greater pts with f/u visit with provider within 3 days of hosp d/c for the following diagnoses: CHF exacerbation, copd exacerbation (excluding planned readmissions)</td>
<td>10%</td>
</tr>
<tr>
<td>DH readmit rate: decrease readmit rate from previous year or maintain below the national standard</td>
<td>10%</td>
</tr>
<tr>
<td>QI Project: addressing Ed utilization: develop a multidisciplinary care plan for pts with multiple Ed visits (&gt;3 in 6 mo) or Decrease number of low acuity Ed visits</td>
<td>10%</td>
</tr>
<tr>
<td>Pharmacy: increase prescribing of ACE/ARB in appropriate diabetic population by 5%</td>
<td>10%</td>
</tr>
<tr>
<td>Prevention: increase number of completed mammograms and FOBT testing</td>
<td>10%</td>
</tr>
<tr>
<td>GHP Health managers: increase by 1% referrals/ usage of the GHP health managers for appropriate diagnoses: DM, asthma, HTN, lipids</td>
<td>10%</td>
</tr>
<tr>
<td>Advanced illness: increase total number of days pts spend in hospice by implementing a process to increase: palliative care referrals, hospice referrals, with goal to improve end of life care</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>
### PCHM - Specialty Integration Pilots

- **Potential Areas of Care Improvement**
  - Endocrinology – Diabetes
  - Nephrology – Hypertension
  - Rheumatology
  - Thoracic Medicine

### AIM FURTHER

** Attribution, Integration, Measurement, Finances And Reporting of Therapies**

- Strategic approach – biologics
  - Which biologic? Too hot, not enough data
  - Focus on efficacy
    - Collect objective measures to assess if the drug is working
    - If it’s not working, stop using the drug!
  - Focus on “bookends”
    - What do we do BEFORE we start a biologic
    - What do we do AFTER the patient has sustained disease control (de-escalation)

### ProvenCare® Modules Developed So Far

- Perinatal Care
- CABG
- Bariatric Surgery
- Surgical Management of Lung Cancer
- COPD
- Total Hip Arthroplasty
- Lumbar Spine Surgery
- Total Knee Arthroplasty
- Percutaneous Coronary Angioplasty
- Hip Fracture
ProvenCare® Chronic Disease Value-Driven Care Outcome Improvements

Heart Attack
- Less than 3 years
- 305 prevented with estimated savings of $27,111/case = $8.3M!

Stroke
- Less than 3 years
- 141 prevented with estimated savings of $2,921/case = $412K!

Retinopathy
- Less than 3 years
- 166 cases prevented!
- Quality of life maintained
- Savings...priceless!

The Functional Components of an Accountable Care Organization (ACO)

Value-Driven Acute Care: Proven Care Accrue
Value-Driven Post-Acute Care: TOC, SNFist
Value-Driven Specialty Care: AMI Integration
Value-Driven Population Care: Advanced Medical Home Clinical Redesign
Value-Driven Actuarial and Operational Informatics

Questions?