Commercial Payers, Value-based Payments and Positioning your Practice for Success

Prasanna Dhungel, Healthcare Data Analytics Executive Consultant
Prasanna Dhungel

- **14 years healthcare experience** working with payers, providers, health services, consulting and investment firms.
- Implemented technology data analytics solutions for population health, financial management, network and compliance.

- Previously Vice President at **D2Hawkeye**. Firm acquired by **Verisk Health**, which is a leading payer analytics firm.
- Advised leading payer-provider firm deploy its value-based solution to large health systems.
- Previously Vice President at **Valence Health**. Led new population health product development. Providers systems, IPAs, clinically integrated networks use solution to succeed in value-based payments.

- Currently, Co-Founder and Managing Partner at **GrowByData**.
- Advise stakeholders understand and succeed in value-based payments.
Topics I will cover today

1. Payer Market Dynamics

2. Provider Market Dynamics

3. How commercial payers view value-based payments

4. How you can do well in the value-based payment era

5. How you should position your practice for success
1. **Healthcare costs continue to rise**
   - 18% of US GDP. Increasing at 5.8% per year. May reach 20% of GDP by 2024 per CMS.
   - Rx costs up 13% last year, biggest in decade. Specialty drugs for cancer, Hepatitis C, MS etc. led 31% spend.
   - Specialty drugs improving patient health, but at huge cost. $94,500 for 3 month course of Hepatitis C drug.
   - Rx cost primarily, expensive procedures, millions of newly insured some with pre-existing conditions driving rise.

2. **Operating within tight margins**
   - Reimbursements dropping in Medicare and Medicaid.
   - Operating within 15% to 20% tight margins for Medical Loss Ratio regulations.
   - Cost and utilization of facilities, procedures, drugs, devices rising.
   - Pushing for rate hikes from 10% to 40%+.

3. **Healthcare Insurance is becoming retail**
   - 11.7 million Americans insured through federal/state health exchanges.
   - By 2020, per S&P Capital IQ, 90% currently getting employer health insurance will be shifted to exchanges.
   - More insurance choices means more price sensitivity and less stickiness to plans and providers.
   - Consumer friendly
Provider Market Dynamics

1. **Payers are reducing reimbursements**
   - Per Medscape, *only* 50% of family practice, 46% of Internal Medicine and 42% of OBGYN physicians feel fairly compensated.
   - Demands growing.

2. **Consolidation reducing number of independent doctors**
   - Hospitals and practice management firms have acquired hospitals, physicians and physician groups.
   - # of independent docs **dropped from 62% in 2008 to 35%**.
   - Impending provider scarcity.
   - Merging for efficiency. Advocate Health Care and Northshore in Chicago.

3. **Providers questioning payer’s value**
   - Many participating in value-based contracts to take risk.
   - Provider sponsored model like Kaiser gaining adoption. Projected to grow to 15% of membership.
   - Evolent, Valence, Lumeris, Aetna, United assisting providers to take on risk. Converted health systems and children’s hospitals.

4. **Must comply with increasing number of regulations**
   - ICD-10, Sunshine Act and others.
How commercial payers view value-based payments
What commercial payers know

1. **Change is here**
   - Current fee-for-service model is unsustainable.
   - CMS moving 50% payments to value by 2018.
   - Fee for service getting taken over by value-based payment.

2. **Profits and revenues are dropping. Business model in question**
   - Payers business is risk management.
   - Business model in question as they push risk to providers.

3. **Must collaborate and change together**
   - Must change, merge, acquire, collaborate and partner to remain valuable.
   - Provider participation is a “must” for success.
What commercial payers are doing

1. **Shifting risk to providers**
   - Value payments projected to grow from 10% now to 50% by 2020.
   - Value-based model manages cost, improves care, incentivizes performers and penalizes non-performers.
   - Incentives tied to –
     - HEDIS, PQRS, ACO, CHIPRA, readmissions, ER, admission, lab, specialist use and cost of care targets.

2. **Pushing cost and utilization**
   - Narrow provider networks.
   - Lower utilization of inpatient.
   - Wellness and preventative care.
   - Medical management and care coordination.
   - Brand to generic substitution, mail-order, formulary tiers and retail selection.
What commercial payers are doing

3. **Shifting risk to patients**
   - Defined contribution and high deductible with patient contribution rising.
     - High Deductible plans up from 4% in 2006 to 20% in 2014.
     - Per Kaiser, annual deductible for single up from $917 in 2010 to $1,217 in 2014.

4. **Consolidating**
   - Merger for efficiency and larger market share
     - Aetna-Humana $37 billion merger and Anthem-Cigna $54 billion merger.
     - United, Aetna-Humana and Anthem-Cigna will serve half health insurance market.
   - Expansion into provider market for growth
     - Highmark acquired West Penn Alleghany Health System to create Alleghany Health Network.
     - Health Plans have created ACOs with provider groups
   - PBM acquisition for leverage and control costs
     - United Healthcare purchased Catamaran for $12.8 billion.
     - Increased PBM business to cover 65 million members.
How can you do well in the value-based payment era?
Higher revenue from existing patients

A. Earn pay for quality bonus

- Bonus $ for meeting or beating negotiated rates on attributed patients
- Set on evidence based guidelines, lower spend and utilization.

- Highmark launched Accountable Care Alliance that could pay hospitals and physicians in network 30% more reimbursement for coordinating care and keeping patients healthy.
- United Healthcare awarded $54m to 4,000 providers who were winners of PATH Excellence in Patient Service Awards for improving healthcare outcomes and closing gaps in care. On average, $13,500 bonus per physician.

B. Negotiate effectively with payers with data-driven marketing

- High quality, compliance and customer service
- Coverage area, times and types of patients
- Patient financial and quality performance
- Clean reporting, low billing and prior authorization errors.
Higher revenue from existing patients

C. **Gain Upside of risk based contracts**
   - Take shared savings/bundled payments and ultimately full risk.
   - Per Medscape study, **35% of providers** participate in ACO.

   - **Upside example** -
     - United Healthcare’s value-based payments nearly tripled in last 3 years.
     - **At $38 billion.** Expects payments to rise **20%** this year and **total $65 billion** by 2018.

D. **Bill for care coordination**
   - Bill **$40** per month per qualified Medicare patient.
     - CPT code 99490 pays **$42.60** for 20 minutes of staff time
     - Can be billed once per month per patient

E. **Bill for telemedicine**
   - Select from HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) to reimburse.
Extra revenue from new services and patients

A.  **Add ancillary services**
   - Per Medscape, 23% family medicine, 20% internal medicine and 18% OBGYN offered new ancillary services in last 3 years.
   - Enable quick total care delivery and coordinated care.

B.  **Expand your provider network**
   - Acquire and partner with aligned providers and hospitals.
   - Refer in-network and retain revenue.
   - Better care coordination within network for higher quality.
   - Add profits from operational scale on admin, purchase and non-clinical areas.

C.  **Improve quality and customer services**
   - Sites like Healthgrades and ZocDoc show consumer reviews.
   - Patients increasingly seek high-ranking providers.
   - Commercial patients will visit you and refer.

D.  **Use technology for easy booking and patient/provider coordination**
Higher profits from efficiency

Select right technology, processes and staff to increase efficiency

- Per 2014 Physicians Foundation report, physicians spend **20% time on non-clinical paperwork**.
- Per Medscape, **paperwork is heavier among self-employed** PCPs. 68% spend 10+ hours per week on these tasks vs 61% of their employed peers.
- Per WSJ, U.S. doctors spend **almost an hour daily**, and $83,000 a year ... with paperwork of insurance companies. Someone at that insurance company has to process this.
- Per CMS audit on MA plans, in **61% of audits**, insurers **inappropriately rejected** claims. Over 50% of audits, beneficiaries and providers didn’t get adequate information on rejection.

- My son got pediatrician authorized test that Joint Commission suggested. Got a hefty bill from payer.
  - Insurer has to spend over **3+ hours on the phone** and work later on to review/process.
  - Provider isn’t paid. Payer has to invest $ to manage this. I am in limbo.

- **Solution** –
  - Using right technology solution for EMR, practice management, billing and patient portal.
  - Review data within your group. Use population health data analytics.
  - Practice based workflow and file adequate billing related documentation.
  - Partner and share resources with like minded practices.
How should you position your practice for success?
Start, Learn and Build

1. **Build inter-disciplinary team** of providers, nurses, practice coordinators and payer liaison.
2. **Understand** from experts, vendors and peers benefitting from value-based model.
3. **Assess your readiness.**
4. **Have a three year plan.**
5. **Utilize** right technology, personnel and processes.
6. **Be data driven.** Allow data sharing. Analyze and share data. **Use analytics.**
7. **Start now and experiment** with early adopters.
8. **Align with other practices, payers, hospitals and vendors** transitioning to value model.
9. **Adjust strategies** based on data and feedback.
10. **Get quick wins,** evangelize, build coalitions and expand.

© Greenway Health, LLC. All rights reserved. Confidential and proprietary. Not for distribution except to authorized persons.
1. **Ensure your technology partners are aligned to change.** Will have fee-for-service and value-based payments. Need tools for analytics, care coordination, patient outreach, compliance, payment and more.

2. **Add providers** to expand network and **products** to grow from pay-for-quality to shared savings to risk.

3. **Collaborate and openly communicate** to champion, share wins, seek feedback and make inclusive.

4. **Offer help,** training and support to all for technology, process and staff improvements.

5. **Be committed to change.** You will have hiccups and push-backs. You may make personnel changes. You may make technology vendor changes. Keep pushing. This is the future.
Five Key Takeaways

1. Payers’ and providers’ business is changing. Risk is shifting to providers.

2. Providers are adopting and benefiting from value-based payments.

3. You can increase revenue, new customers and profits.

4. Providers can earn more, stay happy and keep patients healthy at lower cost.

5. Start now, use technology and data, pick aligned partners, experiment, adapt and succeed!
Thank You

Prasanna Dhungel

Healthcare Data Analytics Expert
Co-Founder and Managing Partner, GrowByData

pdhungel99@gmail.com

847 274 1114 ©
Greenway Community

Greenway Community illuminates the data you need to participate in value-based programs through insight into financial and clinical performance, at every level of your enterprise.