Wellmark’s Current & Future Payment Strategies

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Agenda

Current Payment Strategies
- APR-DRGs
- EAPGs
- Physician Fee Schedules - RBRVS
- CoQ

Future Payment Strategies
- Potentially Preventable Readmissions
- ACO’s
- Bundled Payment
- Physician Payment Re-Design
All Patient Refined-DRGs (APR-DRGs)

– A cost-based severity-adjusted inpatient payment methodology.
– Links payment to resource use as well as the severity of the member’s condition rather than just the condition being treated.
– One set of Relative Weights is used for all Hospitals.
– All Iowa hospitals in a peer group have the same Base Rate.
– Iowa hospitals have a PPO/Indemnity and HMO Base Rate.
– Medical Education is the only add on and is hospital specific for those with a medical education program.

\[ \text{Payment} = \text{Base Rate} \times \text{APR DRG Relative Weight} \]

Enhanced Ambulatory Patient Groupings (EAPGs)

– A cost-based severity-adjusted outpatient payment methodology.
– Links payment to resource use as well as combines all the facility services received in one calendar day into “visit bundles”.
– Payment is calculated by multiplying the Base Rate times the Relative Weight for each EAPG.
– One set of Relative Weights is used for all facilities.
– Base rates vary by type of facility – hospital, ambulatory surgery center, renal dialysis and free standing substance abuse.
– Iowa hospitals have a PPO/Indemnity and HMO Base Rate.

\[ \text{Payment} = \text{Base Rate} \times \text{EAPG Relative Weight} \]
Current Payment Strategies

Physician Fee Schedules

– CMS Relative Value Units (RVU) based.
– Fee is calculated by multiplying the Wellmark Conversion Factor by the CMS RVU.
– Iowa has Universal PPO, non Universal PPO and HMO statewide fee schedules.
– Fee schedules are updated annually, each July 1.

\[ \text{Payment} = \text{Conversion Factor} \times \text{RVU} \]

Collaboration on Quality (CoQ)

– Over 1,900 clinicians participating in the 2011 program
– Quality & Efficiency metrics
– Designed in collaboration with primary care clinicians
– Paid out over $11 million in incentives for 2010 program

Timeline

– 2004/2005: Pilots with 2 clinics and less than 40 clinicians
– 2006: Diabetes and Generic Prescribing
– 2007: Hypertension added
– 2008: Asthma, Childhood Immunizations, and Cancer Screenings (Data collection) and Health IT added
– 2009: Maintained
– 2010: Coronary Artery Disease added and Health IT removed
– 2011: Focus on Wellness, Prevention and Detection for Adults, Adolescents and Children; and additional Efficiency Metric, Total Cost of Quality Care, introduced
**Future Payment Strategies**

**Potentially Preventable Readmission’s (PPRs)**

- Wellmark has been working with the hospital community on a Potentially Preventable Readmission Payment Policy for over two years.
- Issued reports the last 2 years to all Iowa Hospitals identifying their readmission rate compared to network average.

**Payment Approach:**

- Identify readmissions that are potentially preventable.
- Apply potentially preventable risk adjustment to hospital’s readmission rate.
- Compare the risk adjusted readmission rates for each hospital to 75% of best practice.
- Establish the magnitude of the hospital specific payment impacts.
- Plan to incorporate the payment adjustments into the payment update.

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**Future Payment Strategies**

**Accountable Care Organizations (ACOs)**

A local health care organization that can be held accountable for the quality and cost of care delivered to a defined population.

**Key Characteristics:**

- Does not change the payment methods in place today but places accountability with the health care organization to manage the care and budget of a specific population.
- At the core is effective primary care.
- Supported by health care reform.
- Requires member attribution to a primary care physician.
- Works best with health care organizations that have a significant number of Wellmark members.
Accountable Care Organizations (ACOs)

Key Attributes

- Requires physician to manage patients' overall health and coordinate all health care services
- Brings employers to the table to enhance accountability of member and provider
- Tests sustainability concepts

Requirements

PROVIDER

- 5-year commitment
- Critical mass of Wellmark members
- Integrated or cooperative health care organizations
- Senior level support
- Complete Treo or Other Assessment
- Dedicated staff
- IT infrastructure

EMPLOYER

- Culture of health
- Wellmark insurance
- Willing to "experiment" with new designs
- Effective employee communication
- Strong culture of HR measurement

- Patient attribution; number and cost
- Budget established for upcoming year (risk/severity adjusted)
- Providers assume performance risk not insurance risk
- Extreme outliers may be exempted
- Quality & performance measures and shared savings goal jointly set

- New benefit design aligned with payment
- Incent employees to use high performing ACO providers
- Establish quality measures and determine value, i.e., same day visit
- Require Primary Care Physician

Objective third parties will assist with measurement.

- Measurable improvement in patient experience
- Achieve quality measures, i.e., readmissions, prescribing patterns, chronic care management, clinical status
- Shared savings if under budget

Future Payment Strategies

Bundled Payments
Multiple providers paid a single sum for all services in an episode of care

Benefits:

- Control costs by aligning incentives
  - Motivate providers to contain their own costs
  - Provide incentive for providers to collaborate with more efficient partners to improve overall performance

- Improve coordination of care
  - Reduce fragmented and uncoordinated care
  - Provide incentives to reduce unnecessary care

- Achieve savings through reducing preventables
Bundled Payments: Questions to be answered

• How should bundled payments be set?
  • Historical cost or payments?
  • Apply reduction for PPEs?
  • Estimated cost based upon recommended care guidelines?

• What cost variation exists by service type for providers?

• What payment variation exists across providers by service?

• What impact does a time window have on analysis?

• Should member-based risk adjustment (CRGs) be utilized?

• Should outliers be removed when establishing a bundled payment?

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Physician Payment Re-Design

E/M services for primary care is our initial focus

Principles:

• Pays for complexity (diagnosis) as opposed to documentation (procedure code)

• Incorporate a practice level quality component in the fee

• Incorporate a practice level risk adjustment in to the fee

Needs:

• Better diagnosis coding on physician claims

• Participants in a pilot beginning in mid 2012

Why? No correlation between patient risk and the E/M level of service