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3M Health Information Systems

Five ways to strengthen your value-based payment program

A step-by-step strategy to help payers succeed in a dynamic insurance marketplace

How are you responding to the shift toward value-based care?

Payers face never-before-seen challenges as the industry shifts its payment model towards value-based contracting.

As a payer, you must reposition your business strategy to ensure financial growth in this new world of value-based payment (VBP). You now assume responsibility for strategically improving quality and reducing medical and administrative costs.

Transitioning from fee-for service (FFS) reimbursement to VBP can be a painstaking process. However, with the right data and a proven strategy to use that data effectively, it doesn't need to be a difficult journey.

The **five strategies** we outline here provide you with the information necessary to implement a successful VBP program. Our goal is to help you confidently make strategic organizational decisions that promote more efficient, quality care that, in turn, reduces costs and improves market competitiveness.

Let's get started.

How can a strong VBP program impact a payer's financial potential?

Iowa's largest health insurer, Wellmark® Blue Cross® and Blue Shield®, successfully rewards hospitals and clinics for providing high quality care. Their push for quality resulted in:

$35 million
saved in healthcare costs in 2015.[1]

"It's not about withholding care to reduce costs. It's about better health outcomes for our members, which, in turn, help control costs."

— Sheryl Terlouw, director, Network Innovation, Wellmark

Step #1: Gather the right data.

Creating a solid data foundation allows you to assess current processes, identify opportunities to improve performance and track progress. By acquiring, aggregating and refining disparate information to produce the most relevant datasets, you can accomplish one or more of these goals:

- Build programs for population health management or accountable care
- Experiment with new payment models
- Forge community partnerships to improve market competitiveness

Data acquisition and aggregation may sound straightforward; however, it's a complex process. You must approach this step with care to ensure that the dataset will support your efforts to increase value.

8 tips to create a solid data foundation

1. Secure appropriate information from internal and external sources (e.g., patient longitudinal records, claims data, health risk assessments, lab data, and HIE and public health data).
2. Create an infrastructure to house the data.
3. Check the integrity of the data.
4. Cleanse the data and resolve discrepancies, applying business rules to make it fit for use.
5. Harmonize the data by matching patient records.
6. Attribute patients to primary care physicians.
7. Apply risk adjustment to the data.
8. Test for data accuracy and completeness.

Step #2: Reduce payment variation.

Procedure pricing variation among physicians and facilities is a concern in the healthcare industry. By reducing variation in price or payment, you can better assess quality, and therefore increase the value of care.

One way to reduce price variation is to measure services using a severity- and risk-adjusted methodology, such as the **3M™ All Patient Refined DRG Classification (APR DRG) System** (inpatient) or the **3M™ Enhanced Ambulatory Patient Grouping (EAPG) System** (outpatient).

Both of these 3M methodologies classify patients into diagnostic groups. When you assign a payment weight to a risk-adjusted DRG, you justify increases in price. This normalizes the price of services across a system or network.

Risk-adjusted DRGs also let you compare facilities and physicians. For example, you can distinguish between high and low performers by examining the average outcomes for similar patient populations. You can then design incentives to help poor performers improve. You can also share the risk-adjusted data with providers to help them understand how to change their delivery of care.

Risk-adjusted data also helps you assess variation in care, enabling you to answer these questions: Why do some patients have poorer outcomes than others? Why do some patients receive optimal treatment while others don't?

Identifying how treatment gaps affect patient outcomes will help you reduce waste and improve patient health.

Step #3: Introduce value metrics.

VBP changes the basic metric of care from a visit (i.e., unit of care) to the patient (i.e., patient population). This concept considers how all aspects of care affect a single patient, rather than looking at each diagnosis or encounter individually. In theory, VBP seems like a simpler way to measure care. In practice, it has created a plethora of new measures.

Although contracts and regulations may require your organization to track and report redundant or weak measures, you aren't required to use them to manage an internal VBP program. To get started with value metrics, choose a limited number of suitable key performance indicators. Because value equals quality divided by cost, you must assess healthcare value by measuring relevant aspects of quality against the total cost of providing care. Select a core set of metrics that represent critical aspects of quality, such as:

- Health or functional status
- Changes in health risk
- Mortality
- Access to preventative care
- Continuity of care
- Chronic and follow-up visits
- Readmission and complication rates
- Imaging and emergency department utilization rates
- Composite measures

VBP value metrics should include these six attributes:

1. Serve as objective data that's derived from standardized and risk-adjusted data sets.
2. Allow for continuous measurement, even as payment models and clinical practice evolve.
3. Represent outcomes and results of care—not process of care delivery.
4. Link clinical outcomes with costs.
5. Correlate with patient experience.
6. Help clinicians and managers understand where and how to improve quality.

Can you track the impact of quality metrics?

3M quality metrics track value		
Metric	**What it does**	**How it impacts value**
3M™ Potentially Preventable Readmissions (PPRs)	Identifies 70+ types of readmissions for all payers and patients	The 3M "preventables" identify healthcare "waste"—such as overtreatment, complications, never events, unnecessary or redundant testing and services that could be provided in a more appropriate setting. They show you what could be avoided with different or timely interventions.
3M™ Potentially Preventable Complications (PPCs)	Identifies 60+ types of complications from hospital care	
3M™ Population-focused Preventables	Identifies avoidable ancillary services, initial hospitalizations and emergency department (ED) visits	
3M™ Clinical Risk Groups (CRGs)	Classifies patients into risk-adjusted groups by clinical characteristics, severity and burden of illness	3M CRGs provide insight into a patient's health status, clinical risk and expected utilization—creating a way to link the clinical and financial aspects of care.
3M℠ Value Index Score (VIS)	Assesses 16 aspects of primary care in a single composite score	3M VIS measures how well a primary care physician cares for patients, regardless of their health status, and can be linked to value-based payment.

Step #4: Reduce the total cost of care.

Healthcare costs are nearly as difficult to measure as quality. The most accessible cost metrics are Medicare (or other payer) rates and hospital charges. Though they are helpful, these metrics don't represent the complete costs including testing, medications, anesthesia and follow-up visits.

What you really need to measure is the total cost of care—that is, the paid claims and co-payments across all providers and all care delivery settings associated with an individual patient.

This information is important not only to you but also to hospitals and physicians, and it should be shared among all stakeholders. Providers in your network must understand the total cost of care for their patients—including the cost of services provided outside their own facility or practice. This includes costs for inpatient, outpatient, emergency department, laboratory, radiology and pharmacy services.

By understanding where and how costs are incurred, providers can spot opportunities to shift care to more appropriate settings. Their ability to manage total cost of care is critical to helping you remain profitable when implementing new payment models.

What is "total cost of care"?

Total cost of care is the sum of all medical expenditures for a patient or group of individuals. It's the total dollar cost of all services in the delivery of care, including what is paid by the insurers plus what's paid by the patient.

A state's success story of sustained savings

In 2011, Colorado's Medicaid program began work on the Colorado Accountable Care Collaborative (ACC). This statewide Medicaid reform program looks to improve their member's health outcomes and lower costs by reducing preventable or duplicative services.

From 2011–2015, the Colorado ACC has had a gross program savings of **$121 million.**[2]
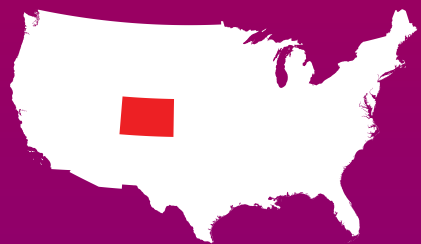
Step #5: Enable sustainability.

Quality improvement projects sometimes fail after initial goals are met. That's because managers often shift attention to other, newer projects. However, every blueprint for VBP requires ongoing attention and a plan for sustainability, including the ability to scale a pilot project across an entire network or health plan. Long-term success for your VBP plan requires you to:

Attribute patients to primary care physicians (PCPs).

To accurately attribute each patient to a PCP, you must integrate claims and eligibility data, define precise parameters, scrub and merge the data using a master patient index and create a process to reconcile redundancies and gaps. The result is a single record for each patient and a distinct patient population for each PCP.

Define episodes of care.

Patients with chronic and complex diseases don't usually experience one condition at a time. Their health is the result of multiple conditions, each affecting the other. To properly manage care and correctly anticipate the total cost of care, you must think of episodes in terms of the patient as a whole, including all of his or her diagnoses.

Provide transparency.

Healthcare transparency is more than a single snapshot of quality. Instead, it's a philosophy that all stakeholders—consumers, physicians, hospitals and payers—must adopt. Each of these stakeholders must be able to access to the right information at the right time and in the right form. A truly transparent VBP program responds completely to stakeholders' questions and decisions about cost, quality, risks and consequences.

Set metrics and benchmarks.

The saying, 'You can't manage when you don't measure,' is true. Unfortunately, some payers measure the wrong metrics, preventing them from implementing a successful VBP program. Up-to-date metrics provide consistent feedback, informing you of any mid-course adjustments that may be necessary to reach cost and quality goals.

Align incentives.

Clinicians are driven by a passion to improve the lives of their patients—not by an interest in checklists and spreadsheets. You must evaluate and compensate them based directly on clinical (health) outcomes.

How can you get started?

Our goal is to help you manage what's most important – the health of your members. At 3M, we manage health data and program design to help you change fragmented, encounter-based health care into integrated, value- based systems, such as ACOs and population health management programs.
We help you prepare for payment transformation, risk assessment and collaboration with our populations and payment solutions portfolio:

3M℠ Healthcare Transformation Suite helps healthcare payers implement and manage VBP and population health programs collaboratively with providers. The suite is a collection of consulting services and analytics tools, such as performance dashboards, predictive models, care management reports, analytics platforms and learning resources, designed to move payers and providers from volume- to value-based models of care.

3M™ 360 Encompass™ Health Analytics Suite offers advanced analytics tools to help providers manage the health of populations, measure physician performance, determine total cost of care and gain insights for a more successful entry into population health management. Each module of the suite illuminates a hospital's performance in a variety of key measures, helping organizations make the best possible strategic decisions for both today and tomorrow.

Others have proved that this strategy works.

From statewide, mature ACO programs to regional, pioneering quality programs, 3M has helped payer organizations adopt VBP models for more than a decade. With our help, clients:

- **Save more than $1 billion in medical costs[3]**
- **Improve ACO quality scores by 35 percent[4]**
- **Reduce hospital-acquired conditions by 32 percent[5]**
- **Eliminate unnecessary readmissions by 19 percent[6]**

**3M supports better health care for 53 million lives[7]**

3M Solutions for HCC Management provide software and services to help organizations capture complete HCC diagnoses across care settings, especially for outpatient and professional services. The solutions include claims analysis, medical record review, benchmarking, role-specific training, care team notifications, and computer-assisted coding—all designed to comply with clinical guidelines and regulations.

Explore more of our solutions for value-based payment design.

Let's start together

Ready to start achieving your cost and quality goals? Call 800-367-2447 to speak with a 3M representative who can draw on deep experience with VBP and population health management, or visit us online at **3mhis.com/vbc**.
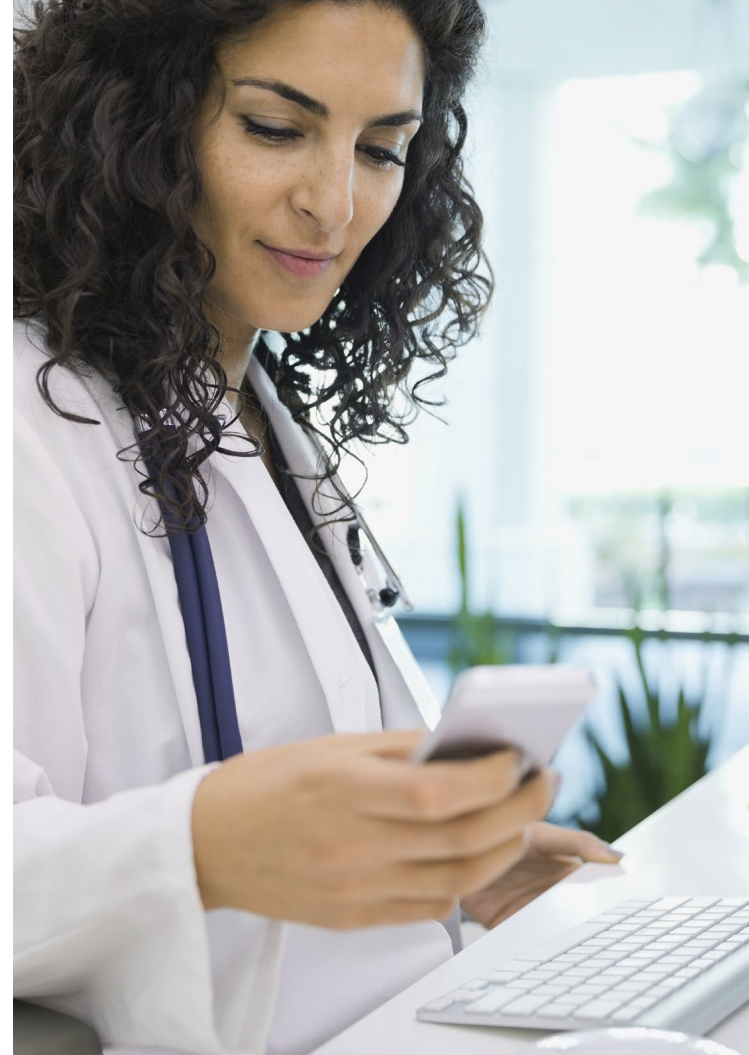
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[1] "Wellmark sees $35 million savings from ACO contracts," The Des Moines Register, published July 2016, available as of 09/15 at http://dmreg.co/2afYHpD

[2] "Accountable Care Collaborative Information for Stakeholders," Colorado Department of Health Care Policy and Financing, published 2017, available as of 09/15 at http://bit.ly/2oVt5yQ

[3] Represents a combined savings from multiple 3M clients.

[4] "Case study: Wheaton Franciscan Healthcare-Iowa and Wellmark® Blue Cross® and Blue Shield® of Iowa," 3M Health Information Systems, published June 2015, available as of 09/15 at http://bit.ly/1G73aVD

[5] Sule Calikoglu, Robert Murray and Dianne Feeney, Hospital Pay-For-Performance Programs In Maryland Produced Strong Results, Including Reduced Hospital-Acquired Conditions, Health Affairs, 31, no.12 (2012):2649-2658

[6] "RARE Campaign Prevents 7,975 Avoidable Readmissions," RARE Campaign website, published May 2014, available as of 09/15 at http://bit.ly/1YFrZn5

[7] Represents the number of unique individuals for which 3M has processed claims data.

For more information on how 3M software and services can assist your organization, contact your 3M sales representative, call us toll-free at **800-367-2447**, or visit us online at **www.3m.com/his**.

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