Positioning Your Organization to be a Vendor/Partner

When it comes to health care reform, providers have an increasingly clearer sense of what's coming. Changes are already under-way, & payers are driving much of the overall transformation. Now health care groups have to develop the right strategies to compete in this new era, & even small to midsized organizations would be wise to align their initiatives and endeavors with payers.

In a dynamically changing market where value and quality will carry even greater importance, provider accountability is critical, and health care organizations in every size market—urban, suburban, or rural—must be ahead of the game. Strategically, this means aligning efforts based on what the market values. Generally, that often translates into these three objectives:

1. **Improving health, quality, and outcomes across a designated population**
2. **Reducing costs**
3. **Delivering an exceptional patient experience**

But what are the best ways to pursue these objectives when there are seemingly endless strategies and tactics? Where should your organization start? Each health care organization must identify what its market and payers value and then develop its best path for getting out in front of and building relationships with payers. That path may include, for example, addressing physician compensation, pursuing effective clinical integration, improving primary care, adopting EMR and meaningful use, or becoming NCQA-certified as a patient-centered medical home (PCMH) and reflecting the many quality metrics therein.

The underlying prerequisite is to ensure successful clinical and strategic alignment with the right payers and adopt those behaviors and initiatives that payers will reward.

Value-Based Reimbursement at the Rural Level: To be sure, market dynamics are driving a shift toward value-based payment models centered on better population health management in rural areas just as they are in urban and suburban ones.

For example, we have noted that some payers have adopted NCQA's PCMH standards in their entirety as the basis for reimbursement. To receive optimum reimbursement, independent and hospital-affiliated physicians must meet threshold standards, provide documentation, and score well across all six best practice categories:

1. **Enhance access and continuity**
2. **Identify and manage patient populations**
3. **Plan and manage care**
4. **Provide self-care support and community resources**
5. **Track and coordinate care**
6. **Measure and improve performance**

Many payers, however, are strategically selecting those requirements within recognized industry standards that best reflect both community health and economic objectives. One payer, for example, has established value-based reimbursements based on performance measurements and a point system that reflects efficiency measures (prescribing generic drugs versus preferred brands), qualitative measures (minimum NCQA PCMH Level 1 Recognition, NCQA Diabetes Recognition, active e-prescribing), and quantitative measures (patient satisfaction and physician quality indicators). (See "Alignment in Real Life."). From our observations, you can expect payers in rural markets to be most focused on greater primary care, the move to PCMHs, and improvements in patient satisfaction.

Meeting the Challenges: Most rural and community hospitals and their affiliated physicians are eager to consider new ways to improve care and reduce costs. Recognizing the need for payer alignment, there are some key tactics hospitals should employ. Chief among them is developing the right metrics for your market in terms of costs, quality, patient satisfaction, and/or access. For some rural physician groups, that may mean meeting all the components and standards to become a PCMH as recognized and accredited by one of four accrediting organizations including NCQA. For others, those standards may simply provide a guideline for becoming something similar as required by the key payers in their markets. The key to success is to communicate with payers since what they value and reimburse may or may not coincide with accreditation.

Another tactic that has become a strategic necessity is having electronic health record (EHR) and health information exchange (HIE) capabilities among local hospitals, health systems and physicians. Despite the considerable investment needed, rural hospitals do recognize the importance of health information technology and are managing to bridge the digital divide with their urban counterparts. According to a recent report, rural hospitals' EHR adoption rate is up 257% from 2010.

For specialty practices and physician groups, there are also some key tactics to consider that can align with payers' value-based reimbursement efforts. Some areas of measurement and focus include: Productivity, Efficiency, Cost of Care, Referring physician and patient satisfaction surveys, & Outcome measurements. As with hospitals, specialty practices should determine what payers in their markets value and reward.

Become a Partner: There is tremendous pressure on the health care industry to provide the highest quality care at the lowest possible cost. Rural and community hospitals, along with primary and specialty care providers, are vital components of our country's health care system and face some of the most difficult hurdles.

To ensure sound financial health alongside better population health, greater alignment with payers is essential. Providers should not assume their paths to accountability without first understanding what payers in their market value. Once they determine this, they can adapt accordingly.

Alignment in Real Life: What do payers value? A major payer developed its own primary care value-based payment program. Here's what health care organizations must align to for optimum reimbursement. The payment program is based on performance measures in three categories (as illustrated in the graphic below).

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Primary Care Value-Based Payment Program Terms and Conditions

Qualification for the value-based payment will be based on three performance measure categories: **Efficiency, Qualitative** and **Quantitative**. In order for primary care providers to achieve the five percent per measurement category based on medical surgical codes, they must achieve a 70-percent score in each of the three performance categories. Scores in each of the categories are combined to calculate the overall value-based payment score. Providers have the ability to receive a maximum reward of 15 percent if they achieve this target in all three categories.

Efficiency

Generic Drug Utilization Performance
Measure is based on percentage of generic prescriptions.

- >90% – **75 points**
- 88-89% – **60 points**
- 86-87% – **45 points**

Preferred Drug Utilization Performance
Measure is based on percentage of Preferred Drugs filled with provider number.

- >90% – **25 points**
- 88-89% – **20 points**
- 86-87% – **15 points**

Qualitative

Patient-Centered Medical Home (PCMH)

- NCQA* Level 3 – **75 points**
- NCQA Level 2 – **60 points**
- NCQA Level 1 – **45 points**

NCQA Diabetes – 45 points

Active E-Prescriber – 25 points

**National Committee for Quality Assurance*

Quantitative

Physician Quality Indicators
Measure is based on the weighted process of care measure.

- >2.5 – **75 points**
- 2.25-2.49 – **60 points**
- 2.0-2.24 – **45 points**

Satisfaction
Measure is based on the overall satisfaction question.

- 3 Stars – **25 points**
- 2 Stars – **20 points**

*The payment program above is based on terms and conditions distributed by a major payor in 2012.

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